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State of Nebraska, Department of Administrative Services (DAS), Materiel Division, State Purchasing Bureau (SPB)

NE EMS Consulting Services

Original

November 26, 2018

RFP#: 5947 Z1

Annette Walton
1526 K St. Suite 130
Lincoln, NE 68508

ORIGINAL

PUBLIC CONSULTING GROUP

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Austin, TX 78701
Tel. 512-407-9680, Fax. 512-407-9249
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PUBLIC CONSULTING GROUP

Public Focus. Proven Results.™

November 26, 2018

Ms. Annette Walton
Buyer
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

Dear Ms. Walton:

Public Consulting Group, Inc. (PCG) is pleased to present this proposal to the State of Nebraska State Purchasing Bureau in response to *Request for Proposal (RFP) 5947 Z1*. PCG's experience providing consulting services to nearly every Medicaid agency nationwide (currently contracting with 35) and more than 200 Emergency Medical Service Providers across the country sets us apart from other firms. Through this experience, we have built an unparalleled level of project management expertise , financial acumen, program knowledge, and operational and technical capability to perform the required services at the highest level of quality.

PCG and its subcontractor, Riddle & Associates, have partnered as a team of financial and programmatic subject matter experts, particularly with a focus on Emergency Medical Services. With PCG's 32 years of comprehensive program evaluation and government contracting experience and Ken Riddle's experience in roles including Paramedic, Deputy Fire Chief, Senior Consultant, and Independent Fire and EMS Consultant, our proposed team is able to guide a program like this through the three primary stages of the comprehensive EMS assessment. The proposed project team is well-versed in federal rules and regulations governing EMS and our approach will draw upon national best practices to exceed DHHS' project requirements.

The principal point of contact to answer questions or provide additional information for this proposal will be Mr. James Dachos. Mr. Dachos can be reached as follows:

James Dachos, Associate Manager
Public Consulting Group, Inc.
999 18th St., Suite 1425
Denver, CO. 80202
jdachos@pcgus.com
512-287-4675

We appreciate the opportunity to assist the State of Nebraska on this important initiative and look forward to your review of our proposal. PCG is prepared to begin work immediately if we are selected.

Sincerely,

James Dachos

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Request for Proposal for
Contractual Services Form

1. Request for Proposal for Contractual Services Form

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the procedures stated in this Request for Proposal, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder maintains a drug free work place.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ NEBRASKA CONTRACTOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

_____I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED USING AN INDELIBLE METHOD (NOT ELECTRONICALLY)

FIRM:	Public Consulting Group
COMPLETE ADDRESS:	816 Congress Ave. Suite 1110
TELEPHONE NUMBER:	(512) 287-4662
FAX NUMBER:	(512) 407-9249
DATE:	11-16-18
SIGNATURE:	Marc Stambley
TYPED NAME & TITLE OF SIGNER:	Marc Stambley Practice Area Director

2. Corporate Overview

2a. Bidder Identification and Information
2b. Financial Statements
2c. Change of Ownership
2d. Office Location
2e. Relationships with the State
2f. Bidder's Employee Relations to State
2g. Contract Performance
2h. Summary of Bidder's Corporate Experience
2i. Summary of Bidder's Proposed Personnel/ Management Approach
2j. Subcontractors

PUBLIC CONSULTING GROUP

2a. Bidder Identification and Information

CORPORATE OVERVIEW

a. Bidder Identification and Information

The bidder should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

Bidder Identification and Information	
Full Company Name	Public Consulting Group, Inc.
Headquarter Address	148 State Street, 10th Floor Boston, MA 02109-2510
Entity Organization	S-Corporation
Incorporated State	Massachusetts
Year Organized	1986
Name Change	Not Applicable

2b. Financial Statements

CORPORATE OVERVIEW

b. Financial Statements

The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

PCG's Financial Capability

Public Consulting Group, Inc. (PCG), a privately held Corporation, was founded in 1986 by its current President and CEO, William S. Mosakowski. PCG has more than 2,100 employees in more than 60 offices. PCG has over 2,000 contracts and operates throughout all fifty states, Canada, the European Union, the United Kingdom, and Australia.

Through stringent internal controls, well-maintained procedures and proven methodologies, PCG consistently meets its contract obligations. A large part of PCG's continued success is the company's ability to provide cost-effective, high-quality services along with the flexibility required to meet the ever-changing needs of our customers. Since our founding, PCG has sustained dynamic growth through sound financial management and astute contract administration.

PCG has consistently maintained a strong and stable financial position while experiencing steady growth, even in challenging economic environments. For the fiscal years ended 2018 and 2017, PCG's Revenue exceeded $459 million and $379 million, respectively. In addition, PCG has achieved double digit growth rates nearly every year for over three decades and expects to continue that growth in fiscal year 2019. PCG has also remained profitable throughout its history and expects to remain profitable in fiscal year 2019.

PCG has a very strong balance sheet as evidenced by its low debt (approximately $65 million), $50 million revolving line of credit with a major regional bank, over $30 million of cash on hand and in excess of $130 million in trade receivables. As a professional services company, a significant portion of PCG'S asset value relates to accounts receivable from client invoicing. Based on the reliable nature of PCG's client base (primarily government clients), only a very small percentage of receivables become

uncollectible. As a result, management is confident that PCG has the resources and capacity to fund both near term operations and future growth.

PCG adheres to the highest standards of fiscal integrity and financial accountability. The company's financial management system complies with generally accepted accounting principles (GAAP) as prescribed by the Financial Accounting Standards Board. PCG undergoes annual Financial Statement and Yellow Book audits. During PCG's history, those audits have resulted in no "going concern" statements nor qualified opinions.

Citizens
Commercial Banking

April 4, 2018

Reference
Public Consulting Group, Inc.
148 State Street
Boston, MA 02109

To Whom It May Concern:

This letter will confirm that Public Consulting Group, Inc. ("PCG") is a commercial banking client of Citizens, NA ("the Bank"). We have worked with PCG for many years and they have always handled their relationship in an exemplary fashion.

PCG maintains a low-eight figure deposit relationship with the Bank, a mid-eight figure term loan and a low eight-figure line of credit. The line of credit is unused and has been infrequently used in the last six years.

Overall, PCG is an excellent customer of the Bank and we value the relationship.

Should you have any further questions regarding PCG, please do not hesitate to call me at 617-725-5754

Very truly yours,

Robert Anastasio
Senior Vice President

2c. Change of Ownership

CORPORATE OVERVIEW

c. Change of Ownership

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

There is no anticipated change in ownership or control of Public Consulting Group, Inc. (PCG) during the twelve months following the proposal due date.

2d. Office Location

CORPORATE OVERVIEW

d. Office Location

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

For the scope of services set forth in this proposal, Public Consulting Group, Inc. (PCG) will rely on a Massachusetts-based project team located at 148 State Street in Boston, Massachusetts.

2e. Relationships with the State

CORPORATE OVERVIEW

e. Relationships with the State

The bidder should describe any dealings with the State over the previous two (2) years. If the organization, its predecessor, or any Party named in the bidder's proposal response has contracted with the State, the bidder should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

Public Consulting Group, Inc. (PCG) has had no dealings with the State of Nebraska over the previous two years and no such contracts exist.

2f. Bidder's Employee Relations to State

CORPORATE OVERVIEW

f. Bidder's Employee Relations to State

If any Party named in the bidder's proposal response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare

No party named in Public Consulting Group, Inc. (PCG)'s proposal is or was an employee of the State of Nebraska within the past twelve months and no such relationships exist.

2g. Contract Performance

CORPORATE OVERVIEW

g. Contract Performance

If the bidder or any proposed subcontractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

Neither Public Consulting Group, Inc. (PCG) nor our proposed subcontractor have experienced such termination within the past five years.

2h. Summary of Bidder's Corporate Experience

CORPORATE OVERVIEW

h. Summary of Bidder's Corporate Experience

The bidder should provide a summary matrix listing the bidder's previous projects similar to the scope of this RFP. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder should address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this RFP. These descriptions should include:

a) The time period of the project;

b) The scheduled and actual completion dates;

c) The Contractor's responsibilities;

d) For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and

e) Each project description should identify whether the work was performed as the prime Contractor or as a subcontractor. If a bidder performed as the prime Contractor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currantly planned) completion date and actual (or currently planned) budget.

ii. Contractor and subcontractor(s) experience should be listed separately. Narrative descriptions submitted for subcontractors should be specifically identified as subcontractor projects.

iii. If the work was performed as a Subcontractor, the narrative description should identify the same information as requested for the Contractors above. In addition, subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a subcontractor.

PCG Corporate Overview

Public Consulting Group, Inc. (PCG) is a government management and operations consulting firm headquartered at 148 State Street, in Boston Massachusetts. Established in 1986, PCG has been serving primarily public sector clients on both national and global scales. The firm has extensive experience in all 50 states, clients in six Canadian provinces, and a growing practice in the European Union.

Today, with more than 2,000 professionals in over 50 offices, our firm is committed to providing proven solutions and outstanding customer service to our clients. Since our inaugural years, we have grown significantly and have extended into five practice areas with different specialties – Health, Technology, Human Services, Education and Public Partnerships. Each Practice Area is managed by a Practice Area Director that reports directly to the President, CEO, and Founder, William S. Mosakowski. PCG Health's Healthcare Financing Solutions Center of Excellence will be taking the lead on this engagement.

PCG Health
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PCG Health helps state and municipal health agencies respond optimally to reform initiatives, restructure service delivery systems, maximize program revenue, and achieve regulatory compliance. The Practice Area uses industry best practices to help organizations with constrained resources deliver quality services, offering expertise in strategy and finance, revenue cycle management, and payer support services. PCG Health is a recognized leader in health care reform and health benefits exchange consulting, a leading provider of revenue enhancement, rate setting, and cost settlement services, and a long-time leader in health care expense management services.

PCG is the nation's leading EMS consultant – we can help Nebraska fulfill its mission to strengthen emergency care by providing proven, effective consulting services.

Throughout our 30+ years of experience, PCG Health has worked with nearly every Medicaid agency, including the District of Columbia. Today, we work with a total of 33 of those agencies (see *Figure 1*). PCG is one of the leading Medicaid policy consulting firms nationwide, and through our work, we've become the nation's leader in EMS revenue maximization and consulting. **With our experience, we are prepared to help the State of Nebraska fulfill its mission to strengthen emergency care through cooperative partnerships and promote the well-being of its citizens.**

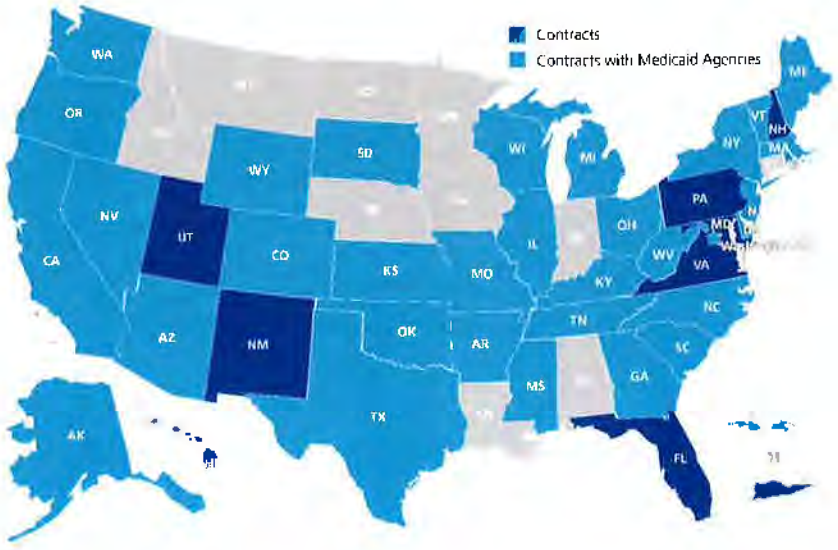

Figure 1: PCG Health's Agency Relationships. PCG has significant experience working with Medicaid agencies and EMS programs and we will bring our knowledge to the State of Nebraska.

PCG has significant experience conducting assessments across a variety of public sectors. For example, in 2011, PCG was contracted by the **State of Texas, Health and Human Services Commission (HHSC), Department of State Health Services (DSHS)** to conduct a comprehensive assessment of the State's public behavioral health system and to develop recommendations for intermediate and long-term system redesign, focusing on improved access, service utilization, patient outcomes and system efficiencies. This work has helped develop a strong foundation for our team's approach to conducting similar studies on behalf of state health agencies. In the realm of EMS, **PCG contracts with over 200 EMS providers across the country to administer revenue maximization and compliance services**

and operates two state-wide ambulance supplemental reimbursement programs on behalf of **Colorado Department of Health Care Policy and Financing** and **Massachusetts Executive Office of Health and Human Services**. PCG's wide array of experience, coupled our subcontractor's extensive EMS consulting background, will provide a robust and comprehensive solution to the State of Nebraska.

PCG contracts with over 200 EMS providers across the country.

The matrix below provides a summary of three projects similar to the scope of this RFP. The engagements we listed were completed by Riddle & Associates, PCG's subcontractor for this engagement. Riddle & Associates served as the prime contractor for those projects listed. Projects summarized in this section include the following:

1. Colorado Regional Emergency Medical & Trauma Advisory Councils (RETAC): Standardized (Regional) Needs Assessment Project (SNAP)
2. Northwest Colorado RETAC: Standardized (Regional) Needs Assessment Project (SNAP)
3. Central Mountains RETAC: Standardized (Regional) Needs Assessment Project (SNAP)

The project team will draw from direct experience, lessons learned, and project outcomes to customize the best approach to meet the needs of this engagement.

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Summary Matrix

Project Name	Project Description	Time Period	Completed	PCG's Responsibility	Client	Budget
Colorado Regional Emergency Medical & Trauma Advisory Councils (RETAC): Standardized (Regional) Needs Assessment Project (SNAP)	Prime Contractor: This project included a statewide assessment of Colorado's 11 RETACs representing EMS and Trauma in 64 counties. Most of these counties are designated either rural or frontier. Each RETAC consisted of 5 – 6 counties. A SWOT analysis was completed for each RETAC as well as a Benchmarks, Indicators, and Scoring Instrument (BIS) that was based on the State's 15 components of an EMTS system. A problem ranking survey was also included. There were 219 EMS agencies or facilities	December 2008 – December 2011 (36 months)	October 2010 (22 months)	Responsibilities included the following components: • Complete 2 – 4 RETAC assessments per year • Review of relevant documents • Development of RETAC specific questions • Attend RETAC meetings • Onsite visits, interviews & Town Hall meetings • Distribute BIS & problem ranking surveys • Tabulation & analysis of BIS & problem ranking surveys • Conclusions & Recommendations • Draft final reports for each RETAC • Draft final report of	Colorado Department of Public Health & Environment: Health Facilities and Emergency Medical Services Division Randy Kuykendall, division director randy.kuykendall@state.co.us 303-692-2945	$300,000 over 3 years

Project Name	Project Description	Time Period	Completed	PCG's Responsibility	Client	Budget
	that participated; 141 personal interviews; 14 Town Hall meeting with 211 participants; 115 BIS surveys returned and 109 problem ranking surveys returned.			all RETACS • Presentation to RETAC Board members for each (11) RETACs) • Presentation to Colorado Advisory Board for Public Health & Environment: Health Facilities & EMS Division		
Northwest Colorado RETAC: Standardized (Regional) Needs Assessment Project (SNAP)	Prime Contractor: This project included an assessment of the NW CO RETAC that included EMS agencies & facilities in 5 counties. Most of these counties are designated either rural or frontier. A SWOT analysis was completed as well as a Benchmarks, Indicators, and Scoring Instrument (BIS) that was based on the State's 15 components of an EMTS system. A	October 2009 – May 2010	May 2010 (6 months)	• Review of relevant documents • Development of RETAC specific questions • Attend NW CO RETAC meetings • Onsite visits, interviews & Town Hall meetings • Distribute BIS & problem ranking surveys • Tabulation & analysis of BIS & problem ranking surveys • Conclusions & Recommendations	Colorado Department of Public Health & Environment: Health Facilities and Emergency Medical Services Division Randy Kuykendall, Division Director randy.kuykendall@state.co.us 303-692-2945	Included in above budget

Project Name	Project Description	Time Period	Completed	PCG's Responsibility	Client	Budget
	problem ranking survey was also included. There were 22 EMS agencies or facilities that participated; 25 personal interviews; 1 Town Hall meeting with 12 participants; 11 BIS surveys returned and 10 problem ranking surveys returned.			• Draft final report for NW CO RETAC • Presentation to NW CO RETAC Board members		
Central Mountains RETAC: Standardized (Regional) Needs Assessment Project (SNAP)	Prime Contractor: This project included an assessment of the Central Mountains RETAC that included EMS agencies & facilities in 6 counties. Most of these counties are designated either rural or frontier. A SWOT analysis was completed as well as a Benchmarks, Indicators, and Scoring Instrument	May 2009 – June 2009	June 2008 (2 months)	• Review of relevant documents • Development of RETAC specific questions • Attend CM RETAC meetings • Onsite visits, interviews & Town Hall meetings • Distribute BIS & problem ranking surveys • Tabulation & analysis of BIS &	Colorado Department of Public Health & Environment: Health Facilities and Emergency Medical Services Division Randy Kuykendall, Division Director randy.kuykendall@state.co.us 303-692-2945	Included in above budget

Project Name	Project Description	Time Period	Completed	PCG's Responsibility	Client	Budget
	(BIS) that was based on the State's 15 components of an EMTS system. A problem ranking survey was also included. There were 23 EMS agencies or facilities that participated; 26 personal interviews; 1 Town Hall meeting with 20 participants; 11 BIS surveys returned and 10 problem ranking surveys returned.			problem ranking surveys • Conclusions & Recommendations • Draft final report for CM RETAC • Presentation to CM RETAC Board members		

2i. Summary of Bidder's Proposed Personnel/ Management Approach

CORPORATE OVERVIEW

i. Summary of Bidder's Proposed Personnel/ Management Approach

The bidder should present a detailed description of its proposed approach to the management of the project.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this RFP. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the RFP in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State

PCG's Proposed Personnel

To support the various work streams for the tasks and deliverables identified in the solicitation, Public Consulting Group, Inc. (PCG) has developed a solid staffing plan that will allow the Department and providers to receive myriad levels of support to meet their needs. Our goal is to provide effective support and oversight over several work streams, which requires us to utilize proven mechanisms to recruit, retain, and deploy the right resources at the right time. Using our resource pool of more than 2,000 staff, we can identify and deploy the right person, in the right project role, at the right time. Our approach is to act as one integrated team, deploying the best staff to meet the needs of our client and satisfy the responsibilities identified in the project's scope of work.

To accomplish the project's objectives, the integrated PCG team will implement a project management approach based on industry standards and best practices that are tailored to the specific needs of the Department. This project management approach will be used for all phases of the project and will apply to all the deliverables submitted. Project Management is the application of knowledge, skills, tools and techniques to tasks and activities required to meet initial project requirements. Project Management also requires the ability to refine plans in the face of changing goals and requirements. PCG understands how essential project management is to the success of any project and will deploy a concentrated project management methodology to ensure information is communicated across all team members so that project deliverables remain on task and are accurately completed.

Project Team

For the scope of services set forth in this proposal, PCG will rely on highly experienced consultants and specialists from a Boston, Massachusetts based project team. The team has unparalleled skills and proficiency in providing services pertaining to EMS consulting initiatives and in-depth knowledge and experience working with fire departments and ambulance services providers.

Key Personnel

Our Key Personnel include a Project Manager, Technical Advisors, a Legal Advisor, Project Team members. We will also include additional Project Support as needed. The organizational chart below provides an overview of the key members of the PCG team dedicated to this engagement, and their respective roles on the project. The consultants and operational staff on our project team have the technical skills necessary to execute the deliverables set forth in this proposal.

On the following pages, we have included resumes highlighting the project work and credentials of the PCG team that will be managing the daily activities of this engagement and ensuring the timely completion of deliverables.

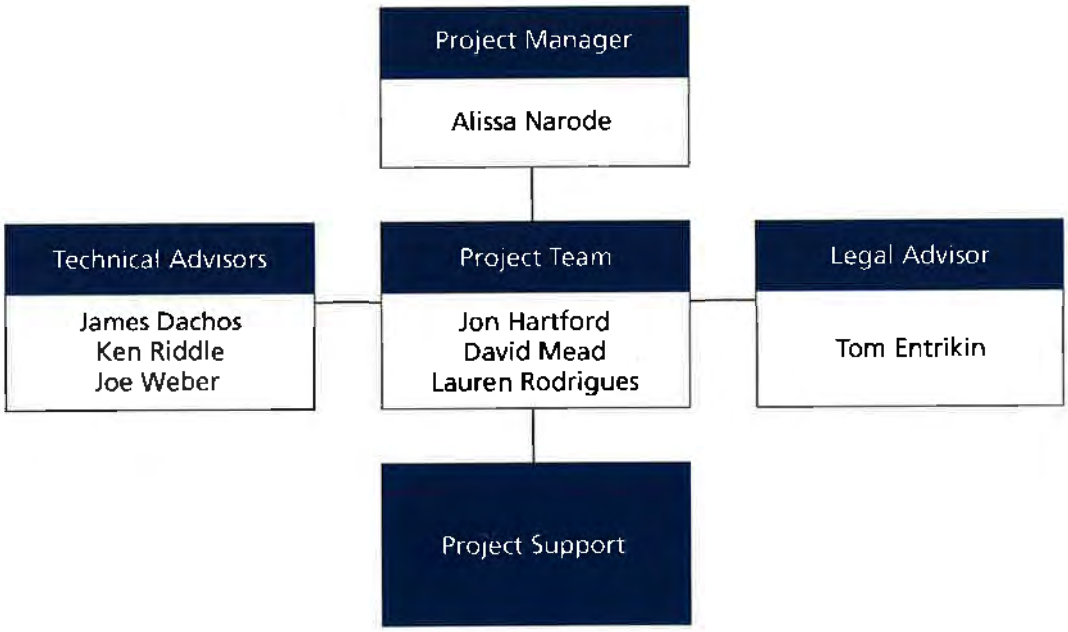

Figure 2.i.1: PCG's Proposed Organizational Chart. PCG has proposed a diverse group of not only qualified, but extremely experienced, individuals to serve the Department.

JAMES DACHOS

UNDERSTANDING OF THE PROCESS AND BIO

James Dachos will serve as a Technical Advisor for this engagement. Mr. Dachos has extensive experience leading statewide projects and working with EMS providers. Mr. Dachos' understanding of this project is to conduct a thorough assessment of Emergency Medical Service providers in the state Nebraska to identify strengths, weaknesses, and gaps across EMS delivery. The selected vendor will utilize site visits, interviews, and data collection to evaluate providers across eight key performance areas identified by DHHS. The final step of the process will entail the development of a comprehensive final report, which will summarize findings and offer recommendations to improve EMS service delivery.

James Dachos serves as the program manager for EMS Cost Recovery and Compliance initiatives for five states including Texas, Florida, Washington, Colorado, and Oklahoma. As the program manager, Mr. Dachos is directly responsible for the development, design, implementation, cost reporting, and ongoing administration of EMS reimbursement programs. He currently oversees ambulance supplemental payment services for over 50 clients across the state of Texas, more than 40 ambulance providers in Florida, and over 60 providers in the state of WA. Mr. Dachos also oversees the project team dedicated to providing statewide EMS consulting, cost collection, and auditing service on behalf of the state of Colorado.

Mr. Dachos has worked closely with state Medicaid departments in the design, development, and gain federal approval for cost-based EMS and school-based services (SBS) programs. He has worked with CMS on behalf of numerous states responding to requests for information pertaining to the State Plan Amendment and other related program components. He has also led comprehensive SBS and Local Health Jurisdiction (LHJ) assessments on behalf of state health departments.

RELEVANT PROJECT EXPERIENCE

Houston Fire Department, Dallas Fire-Rescue Department, MedStar (Tarrant County), Montgomery County Hospital District, Galveston County Health District, and Garland Fire Department (among approximately 50 active clients), State of Texas

Ambulance Supplemental Payment Program (August 2012 - Present): Program Manager

Mr. Dachos: Contracted by multiple providers throughout the state of Texas to provide consulting services to design, gain approval for, and implement the Ambulance Supplemental Payment Program (ASPP). Manage the preparation of annual cost reports and provide comprehensive support throughout the State's desk reviews. PCG prepared and submitted the Federal Fiscal Year 2011 through 2016 cost reports for PCG's providers, which has generated significant revenue for the programs.

Miami-Dade Fire Rescue, Orange County Fire Rescue Department, Hillsborough County Fire Rescue, Tampa Fire Rescue, Palm Beach County Fire Rescue (among approximately 45 active clients), State of Florida

Ground Emergency Medical Transport Program (May 2016 - Present): Program Manager

Mr. Dachos: Contracted with 45 departments across the state of Florida to administer consulting services around program design, implementation, cost reporting, and compliance for the Ground Emergency Medical Transportation (GEMT) program. Mr. Dachos leads a team of 20 staff to facilitate the compilation of the annual cost report and provide audit support. Mr. Dachos and his team developed a web-based cost reporting solution to facilitate cost reporting analysis and help ensure compliance.

State of Washington – Approximately 60 public EMS providers

Ground Emergency Medical Transport Program (May 2016 - Present): Program Manager

Mr. Dachos: Contracted with 60 departments across the state of Washington to administer consulting services around program design, implementation, cost reporting, and compliance for the Ground Emergency Medical Transportation (GEMT) program.

Oklahoma Ambulance Association (OKAMA), State of Oklahoma
EMS Cost Recovery Program (March 2014 - Present): Program Manager

Mr. Dachos: Contracted with OKAMA to establish the most appropriate and effective EMS Cost Recovery Program for the Oklahoma EMS provider community. Responsible for designing, gaining state and federal approval, designing, and administering the program for all eligible participating EMS departments across the state of OK.

Colorado Department of Health Care Policy and Financing, State of Colorado
EMS Supplemental Reimbursement Initiative (December 2016 – Present): Program Manager

Mr. Dachos: Contracted to design cost-based reimbursement program for public ambulance providers across the state of Colorado. Gained federal approval and currently in the process of implementing program on implementing program on behalf of HCPF. Developed web-based cost report portal with pre-payment audit controls.

School Health Services: School Based Cost Reporting and Cost Settlement (October 2010 – Present): Project Manager

Mr. Dachos: Serves as program manager responsible for client management, execution of contract deliverables, subject matter expertise, and the supervision of the processing of school-based cost reports under Medicaid State Plan. Enforces program compliance and revenue maximization. Executes annual audits of school districts to ensure program compliance. Overseas training efforts for school districts on cost reporting and cost settlement procedures.

Department of Community Health, State of Georgia
Children's Intervention School Services (October 2010 – Present): Project Manager

Mr. Dachos: Oversees team dedicated to Medicaid state-wide cost reporting and cost settlement operations. Serves as project manager responsible for client management, execution of contract deliverables, subject matter expertise, and the supervision of the processing of school-based cost reports under Medicaid State Plans. Assisted the state in developing and executing audit plan for quarterly Local Education Agency monitoring. Enforces program compliance and revenue maximization. Overseas training efforts for 145 school districts on cost reporting procedures for web-based Medicaid cost reporting and claiming system.

Kansas Department of Health and Environment, State of Kansas
School Based Services Cost Reporting / Reconciliation Initiative (October 2010 – Present): Project Manager

Mr. Dachos: Oversees team dedicated to Medicaid state-wide cost reporting and cost settlement operations. Serves as project manager responsible for client management, execution of contract deliverables, subject matter expertise, and the supervision of the processing of school-based cost reports under Medicaid State Plans. Enforces program compliance and revenue maximization. Developed and executed audit plan for annual school district monitoring. Overseas training efforts for school district staff on cost reporting procedures for web-based Medicaid cost reporting and claiming system.

Department of Social Services, State of Missouri
School Based Services Cost Reporting Initiative (December 2015 – Present): Project Manager

Mr. Dachos: Project lead responsible for identifying how the State of Missouri can maximize school-based Medicaid funding streams, while maintaining the utmost level of compliance. Team is contracted to review Missouri's current school district transportation reimbursement methodology

and providing recommendations on how Missouri could maximize federal reimbursement. Additionally, is reviewing school-based clinic models around the country as an approach to maximize federal funding streams.

Health Care Authority, State of Washington
Financial Audit of Local Health Jurisdiction Medicaid Administrative Claiming (September 2013 – March 2014): Project Manager

Project: Conducted a multi-faceted analysis of the Medicaid Administrative Claiming (MAC) program for the State's Local Health Jurisdictions (LHJs). The audit focused on five key review areas: MAC invoice, Certified Public Expenditures, funding offset, indirect cost rate, and Federally Qualified Health Center encounter rate. Analysis and recommendations were derived from a comprehensive data analysis, on-site interviews with LHJ staff, and an examination of pertinent federal and state regulations. Findings and recommendations pertaining to each of the key review areas were presented in the final report.

PROFESSIONAL BACKGROUND

Public Consulting Group, *Boston, MA* — December, 2006 - Present

Watson Wyatt Worldwide, Newton, MA — September, 2004 – May, 2006

EDUCATION

Clark University, *Worcester, MA*
Masters of Business Administration, 2011

Bates College, Lewiston, MA
Bachelor's Degree, Sociology, 2004

REFERENCES

Shannon Huska
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1570 Grant Street
Denver, CO 80203
Phone: 303-866-3131

Richard Ngugi
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Financial & Personnel Support Bureau
1500 Marilla Street
Dallas, TX 75201
Phone: 214-671-8038

Scott Mendelsberg
Address: Miami-Dade Fire Rescue
9300 NW 41st Street
Doral, FL 33178
Phone: 786-331-5121

KENNETH D. RIDDLE JR.

UNDERSTANDING OF THE PROCESS AND BIO

Ken Riddle will serve as a Technical Advisor for this engagement. Mr. Riddle's understanding of this project is to conduct a comprehensive needs assessment of the entire realm of EMS delivery throughout the state of Nebraska with a focus on the rural and frontier regions. The process used for this assessment includes the review of relevant documents, onsite visits and interviews of stakeholders, including the public at large and representatives from all agencies and facilities supporting the EMS system being studied. The results of the study will provide the State with concise, comparable data logically summarized to assist the State of Nebraska with improving EMS statewide.

RELEVANT EXPERIENCE

Medical Transportation Management (MTM), Inc
State Education, Training, and Outreach Coordinator (2016 – Present)

Project: Responsible for community outreach to medical facilities in the State of Nevada and Idaho, working with case managers, social workers, and other medical professionals regarding non-emergency medical transportation services for Medicaid recipients.

Nevada Fire Chiefs Association
Executive Director (2007 – Present)

Project: Member of the Board of Trustees. Responsible for the day-to-day administration and management of a non-profit member driven organization. Manage three federal grants for the recruitment and retention of volunteer firefighters in rural Nevada.

Riddle & Associates, Nevada
Independent Fire and EMS Consultant (2006 – Present)

Project: Served as an independent contractor for fire and EMS studies for a few select fire/EMS consulting firms including the Abaris Group, The Ludwing Group, FACETS Consulting and a few others.

Completed several fire and EMS studies including the following:

City of Tukwila (WA) Fire Station Location Study (2017)
City of Houston (TX) Fire Department Operational Assessment (2016)
City of Phoenix (AZ) Fire Department Ambulance Deployment and Staffing (2016)
Fort Wayne (IN) Fire Department EMS Transport Feasibility Study (2016)
City of San Antonio (TX) Fire Department EMS Study
Orange County (FL) Fire Department Consolidation Study
New York Power Authority EMS Study
Sugar Foods Corporation (CA) Fire Safety Study
EMD Pharmaceuticals- Cyanide Antidote Medical Advisory Member
US Fire Administration-Coordinated the rewrite of the EMS Safety and Infection Control Manuals
Fire and Emergency Television Network-Researched and developed two national training programs, Fire Department response to Bomb incidents and Cold and Ice Water Rescue
Several Telephone Consulting projects for investment or equity firms related to fire/ EMS and ambulance services, SCBA, software, safety equipment, ePCR, PPE and use of unmanned aircraft systems

National Fire Protection Association, Massachusetts
Fire Service Training Consultant (2010 – 2011)

Project: Subject matter expert in developing training programs for fire and EMS response to emergencies involving electric and hybrid vehicles. Participated as a team member to develop the NFPA's Emergency Response to hybrid and electric vehicle incidents.

The Abaris Group, California
Senior Consultant (1999 – 2013)

Project: Lead consultant on several fire and EMS studies:

State of Colorado EMS Department Regional Emergency and Trauma Advisory Councils (RETAC) assessment and strategic planning
City of Spokane (WA) Fire Department EMS Study
City of Great Falls (MT) Fire Department EMS Assessment
El Paso (TX) Hospital Study regarding the impact of EPFD establishing hospital destination policy
City of Clinton (IA) EMS Study
Santa Clara County (CA) EMS Study
City of San Diego (CA) Fire Department EMS Study
Merced County (CA) EMS Ambulance RFP Evaluator
Monterey County (CA) EMS Ambulance RFP Evaluator
Sonoma County (CA) EMS Study and Development of Ambulance RFP
Multnomah County (OR) EMS Ambulance RFP Evaluator
Hamilton County (OH) Fire Department EMS Study
Town of Pahrump (NV) Fire Department EMS Study
Washington DC Fire Department EMS System, Consultant and Subject Matter Expert for Mayor's Office
Researched and wrote the 2011 edition *of Trends in the Ambulance Industry* for The Abaris Group

PROFESSIONAL BACKGROUND

IAFC On Scene- EMS Update Column (Intermittently): Writer	1995- Present
Mobile Healthcare Network: Vice-President of Operations	2012 – 2017
Fire Chief Recruiters: Senior Recruiter	2012 – 2013
Las Vegas Fire News: Writer	1993 – 2006
City Of Las Vegas Department of Fire & Rescue: Chief	1978 – 2006
International Association of Fire Chiefs: Board of Directors	1993 – 2006
Southern Nevada Fire Chiefs Association: President	2001 – 2004
Southern Nevada Fire Chiefs Association: Vice-President	1997 – 2001

EDUCATION

Polytechnical College, *Cupertino, CA*
Fire Administration, Part-Time Upper Level courses, 2001-2006

National Fire Academy, *Emmitsburg, MD*
Executive Fire Officer Program, 1995-1999

Clark County Community College, *North Las Vegas, NV*
Associates of Applied Science – Fire Service Management, 1982-1986

Clark County Community College, *North Las Vegas, NV*
Associates of Applied Science – Fire Service Technology, 1982-1986

CERTIFICATIONS / PUBLICATIONS / SPECIAL SKILLS

IAFC On Scene: International Firefighter Safety Stand Down and EMS (June 2006)
JEMS Supplement: Hydrogen Cyanide: Fire Smoke's Silent Killer (Summer 2004)
IAFC On Scene: EMS Update – New Treatment for Smoke Inhalation and Cyanide Poisoning (2004)
IAFC On Scene: Las Vegas Fire & Rescue hosts first annual PIO conference (January 2004)
EMS Best Practices: Las Vegas Doubles Cardiac Arrest Save Rates (July 1998)
Fire Chief: EMS Viewpoints – AEDs Increase Odds in Las Vegas Casinos & Hotels (June 1998)
Fire Chief: EMS Viewpoints: Opinions Sought for EMS Action Plan (September 1995)

REFERENCES

Fergus Laughridge
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Jay Wittwer
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Bill Bullard
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309 Conor Court
Forestville, CA 95436
Phone: 707-292-7286

JOSEPH WEBER, PMP

UNDERSTANDING OF THE PROCESS AND BIO

Joe Weber will serve as a Technical Advisor for this engagement. Mr. Weber has extensive experience conducting large statewide system assessments for a wide range of provider types including behavioral health, development disabilities, school-based health service providers, and other community-based health care providers. Mr. Weber understands that as a part of this engagement, he will assist with programmatic and financial analyses, facilitate interviews, and contribute to the comprehensive final report with recommendations for system improvement.

In addition to his experience with large system assessments, Mr. Weber has an intricate understanding of both federal and state regulations governing cost accounting and third-party compliance reporting. Mr. Weber has previously led PCG's efforts to establish a statewide EMS supplemental payment program in Massachusetts and to establish cost based reimbursement methodologies for school based health programs in six states.

RELEVANT PROJECT EXPERIENCE

Department of Health, State of New York

Delivery System Reform Incentive Payment (DSRIP) Program Independent Assessor (August 2014 – Present): Project Manager

Project: Assisting the state with the implementation of the DSRIP program, including the development of an application and scoring methodology for Performing Provider Systems (PPS). Developing validation review protocols and policies to conduct ongoing assessments of PPS performance for the purpose of determining performance payments. Providing ongoing support through the development of policy guidance. Facilitating statewide PPS Learning Symposiums to share the best practices being implemented across the state. Assisting the state in completing mandatory reporting requirements on quarterly progress to CMS.

Mr. Weber: Manage the overall project effort for all tasks associated with PCG's role as the DSRIP Independent Assessor. Provide technical assistance to the state in ensuring all aspects of the program are implemented consistent with the waiver. Monitor financial aspects of the program including calculation of semi-annual performance payments.

Health and Human Services Commission, Department of State Health Services, State of Texas

Study of the Texas Public Behavioral Health System (July 2011– October 2012): Project Manager

Project: Conducted a review of the current public behavioral health system in Texas. Assessed the system's strengths and weaknesses programmatically and financially to assist in making recommendations for system redesign. Conducted seven public stakeholder forums to gather stakeholder input on the current behavioral health system.

Mr. Weber: Met with mental health and substance abuse providers, advocacy groups, and other stakeholders. Provided the State with a report on the current system. Developed recommendations for system redesign in preparation for federal health care reform as it currently stands. Conducted an additional seven public stakeholder forums to gain stakeholder feedback on the proposed recommendations. Produced a final report for the State outlining recommendations for system redesign in three key areas: service delivery system, governance and oversight, and funding and financing.

Utah State Legislature, Executive Appropriations Committee, State of Utah

Study on the Feasibility of Privatization of Parts of the Utah State Hospital and Utah State Developmental Center (April 2010 – September 2010): Financial Analysis Lead

Project: Conducted an assessment on the feasibility of privatizing the Forensic Unit at Utah State Hospital (USH) and the semi-secure units at the Utah State Developmental Center (USDC). Conducted a peer state analysis of like facilities and prepared a financial analysis illustrating potential areas for cost savings through privatization.

Mr. Weber: Produced a final report for the state on the feasibility of privatizing the units identified.

Franciscan Hospital for Children

Strategic Planning Analysis (October 2012 – April 2013): Financial Analysis Lead

Project: Assisted the Franciscan Hospital for Children (FHC) with a comprehensive strategic planning analysis. Provided the FHC administration and Board with a comprehensive strategic planning report outlining those areas that should be considered for continuing investment and those areas that should be considered for consolidation.

Mr. Weber: Reviewed all components of FHC operations including administrative and patient care centers. Conducted a financial analysis of the patient care centers to identify those that were profitable and those that were underperforming. Completed a market analysis of similar providers and programs in the region to determine current and project future market demand for FHC service offerings. Reviewed staffing ratios for all patient care centers and benchmarked against peer facilities.

Department of Health, State of New York

Pre-School and School Supportive Health Services Program Design and Implementation (January 2012 – Present): Engagement Manager

Project: Assist the state in designing and implementing a cost based reimbursement methodology for the school based health services program known as SSHSP.

Mr. Weber: Assisted in developing the SPA document outlining the new methodology and all accompanying documents including the cost report and cost reporting guide. Prepared responses to CMS' Requests for Additional Information pertaining to the SPA and other related documents. Conducted trainings for school districts across the state to introduce the new methodology and all of the new program requirements. Conducting financial trainings to assist the LEAs in completing the annual cost report.

Department of Health Services, State of Wisconsin

Web-Based Cost Report Tool Development (April 2014 – Present): Engagement Manager

Project: Assist the state to develop a new web-based cost reporting tool for WIMCR. Facilitated meetings with state and county agency staff to get buy-in on proposed cost report changes. Worked with state staff to determine most appropriate approaches for identifying and reporting direct costs and for allocating overhead costs in the new cost report tool. Established a consistent approach for cost reporting for all participating county agencies that streamlined the amount of work for county agency staff. Provided comprehensive training for county agency staff on the new cost report tool and cost reporting requirements. Provide ongoing support to county agency staff throughout the cost reporting period.

Mr. Weber: Manage the overall project effort of PCG's project team. Completing desk reviews of all completed cost reports. Assist in generating the Provider Summary Report (PSRs), the Maintenance of Effort (MOE) calculations, and the County Treasury Reports (CTRs) for all county agencies upon completion of the cost reports and desk reviews.

Executive Office of Health and Human Services (EOHHS), Office of Medicaid, Commonwealth of Massachusetts

Supplemental Payment Program for EMS Providers (July 2013 – June 2014): Technical Advisor

Project: Worked with EOHHS on CMS approval for, and the implementation of a MassHealth Supplemental Payment Program to generate incremental federal Medicaid revenue for local governmental providers of ambulance/emergency medical services (EMS) to MassHealth beneficiaries. Facilitated the creation of a Medicaid State Plan Amendment and its submission to CMS. Organized a workgroup with 6 EMS providers to understand financial and reporting capabilities and finalize reporting methodologies. Developed cost report and cost reporting guide utilizing feedback from the workgroup.

PROFESSIONAL BACKGROUND

Public Consulting Group, *Boston, MA* July 2005 – Present

EDUCATION

Clark University, *Worcester, MA*
Masters of Business Administration, 2009

College of the Holy Cross, *Worcester, MA*
Bachelor of Arts in Economics, 2005

PROFESSIONAL ASSOCIATIONS

Healthcare Financial Management Association (HFMA)
Project Management Institute, National and Upstate New York Chapters

REFERENCES

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Greg Allen
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99 Washington Avenue, Suite 720
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Phone: 518-473-0919

Steve Milioto
Address: Wisconsin Department of Health Services
Division of Medicaid Services
1 West Wilson Street
Madison, WI 53709
Phone: 608-266-3802

ALISSA NARODE

UNDERSTANDING OF THE PROCESS AND BIO

Alissa Narode will serve as Project Manager for this engagement. Ms. Narode has extensive experience managing statewide projects and working with EMS providers. Ms. Narode understands that as a part of this project, she will serve as the main point of contact between the technical advisors, legal advisor, project team and support and the Department of Health and Human Service (DHHS). In addition, Ms. Narode will be involved in all three stages of the scope of work ensuring that the needs of DHHS and the Nebraska EMS community are met.

Ms. Narode is a team lead on the Florida Public Emergency Medical Transportation and previous team lead on Washington Ground Emergency Medical Transportation programs where she works with multiple EMS providers in completing Medicaid cost reports. She obtains data from these EMS providers to properly analyze charges, revenue, and expenditures. In addition, she completes a thorough review of all expenditures to ensure that all allowable costs were captured and reported in the cost reports. For the State of Illinois, Ms. Narode has conducted independent rate studies on Community Care Programs. For the New York State Department of Health School Supportive Health Services Program, Ms. Narode serves as the project manager and assists in reviewing completed Medicaid cost, and works closely with Local Education Agencies (LEAs) to ensure that finalized reports are completed accurately and in compliance. On behalf of the Wisconsin Department of Health Services, Ms. Narode works hand-in-hand with county-based health service providers to ensure the accuracy and completeness of annual Medicaid cost reports. In addition, Ms. Narode served as the project manager for the Wisconsin Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) rate setting project. Ms. Narode joined PCG with broad policy and healthcare experience including more than three years with the New York State Assembly Ways and Means Committee where she served as the Principal Health Budget Analyst. Ms. Narode acquired extensive knowledge of the state budgeting process, health and public policy, working with data sets and completing research.

RELEVANT PROJECT EXPERIENCE

Department on Aging, State of Illinois

Rate Study for the Community Care Program (January 2018 – Present): Team Lead

Project: Conducting independent rate studies on four Community Care Programs as part of complying with the renewal of their Medicaid Home and Community-Based Services (HCBS) waiver program including Emergency Home Response Services (EHRS), Adult Day, Adult Day Transportation, and In-Home Care Services.

Ms. Narode: Lead team in reviewing how In-Home Care and EHRS services are currently administered, determined if the current rates are adequate, efficient, cost effective, and allow for services to be delivered by an array of providers. In addition, Ms. Narode compared current rates to other state's rates and to rates paid by other public or private payors for services and provided recommendations to change current reimbursement rates as appropriate.

Department of Health, State of New York

School Supportive Health Services Program (SSHSP) (May 2015 – Present): Project Manager

Project: Implemented a cost-based reimbursement methodology for the school-based health services program known as SSHSP. Conducted financial trainings to assist the Local Education Agencies (LEAs) in completing an annual cost report. Provided support to school districts and

counties in the completion of the fiscal year 2014 and 2015 Medicaid cost reports to identify the Medicaid allowable and non-allowable costs for school-based health services.

Ms. Narode: Reviews completed reports for accuracy and reasonability. Provides support to LEAs throughout the preparation and review of cost reports. Conducts in person and WebEx trainings to LEAs on how to complete cost reports.

Department of Health Services, State of Wisconsin

Wisconsin Medicaid Cost Reporting (WIMCR) (May 2015 – Present): WIMCR Support

Project: Collaborated with Wisconsin DHS to implement a WIMCR reporting methodology which consolidates twelve Medicaid reimbursable programs into a single web based financial report. Supported county-based providers in cost report completion within a web-based cost reporting tool. Drafted State Plan Amendment (SPA) language and supported the state in obtaining CMS program approval.

Ms. Narode: Developed guidance documents for counties to aid in the completion of WIMCR reports. Provided support to DHS in ongoing State Plan Amendment (SPA) discussions with the federal Centers for Medicare and Medicaid Services (CMS). Works closely with county providers to assist in annual Medicaid cost report completion, including conducting in person trainings.

Collier County EMS BOCC, Fort Lauderdale Fire Rescue, Hallandale Beach Fire Rescue, Hollywood Fire Rescue, North Lauderdale Fire Rescue, Osceola County EMS, Pompano Beach Fire Rescue, and Polk County EMS, State of Florida

FL EMS Public Emergency Medical Transportation (PEMT) Program (January 2017 – Present): Team Lead and Project Support

Project: Prepare Medicaid cost reports on behalf of eight governmental EMS providers. Obtain data from the facilities in order to properly analyze charges, revenue, and expenditures. Complete a thorough review of all expenditures to ensure that all allowable costs were captured and reported in the cost reports. Provide comprehensive audit support to providers.

Ms. Narode: Reviews completed reports for accuracy and reasonability to determine Medicaid allowable costs. Facilitates ongoing support between the EMS providers and the State of Florida's Agency for Health Care Administration (ACHA).

Benton County Fire Protection District #2, Benton County Fire Protection District #4, Grant County First District #8, Kittitas Valley Fire Rescue, State of Washington

WA EMS Ground Emergency Medical Transportation (GEMT) Program (February 2018 – June 2018): Team Lead and Project Support

Project: Prepare Medicaid cost reports on behalf of four governmental EMS providers. Obtain data from the facilities in order to properly analyze charges, revenue, and expenditures. Complete a thorough review of all expenditures to ensure that all allowable costs were captured and reported in the cost reports. Provide comprehensive audit support to providers.

Ms. Narode: Reviews completed reports for accuracy and reasonability to determine Medicaid allowable costs. Facilitates ongoing support between the EMS providers and the Washington State Health Care Authority (HCA).

Department of Health Services, State of Wisconsin

Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) Rate Setting (October 2015 – July 2017): Project Manager

Project: Public Consulting Group (PCG) has been charged with transitioning the FQHC reasonable cost reimbursement system (alternative payment methodology) to a prospective payment system (PPS) reimbursement methodology for non-tribal FQHCs. To date, PCG has developed rates for non-tribal FQHCs and developed scope change policy. Additionally, PCG determined which individual PPS rate reimbursement policy considerations would be the best fit for the Department and presented recommendations to FQHC stakeholders. Lastly, PCG also analyzed multiple years of claims data to determine shifts in services and intensity and developed data profiles of each FQHC with future, current and historical cost information.

Ms. Narode: Completed site visits of all non-tribal FQHCs in Wisconsin to discuss their organization, address their concerns and review compiled data. Conducted and presented extensive research relating to policy options, national best practices and state and federal requirements. Provided policy recommendations to the Department of Health Services and worked collaboratively to establish a policy direction. Created an enhanced cost report for FQHCs to complete to establish new PPS rates. Reviewed cost reports and completed desk reviews for accuracy, completeness and to mitigate audit risk.

PROFESSIONAL BACKGROUND

Public Consulting Group, *Albany, NY* — May 2015 – Present

New York State Assembly, *Albany, NY* — January 2012 – May 2015

EDUCATION

State University of New York at Binghamton, *Binghamton, NY*
Master of Public Administration, Health Policy Concentration, 2010

State University of New York at Cortland, *Cortland, NY*
Bachelor of Science, Athletic Training, 2006

REFERENCES

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Steve Milioto
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Division of Medicaid Services
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Phone: 608-266-3802

Frank Galgano
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120 SW 3rd Street
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Phone: 754-224-8457

THOMAS ENTRIKIN

UNDERSTANDING OF THE PROCESS AND BIO

Thomas Entrikin will serve as a Legal Advisor for this engagement. Mr. Entrikin understands that he will assist the State and the PCG project team with any questions concerning Medicaid law, regulations, policies and instructions applicable to the project. Mr. Entrikin will identify all applicable requirements and promptly deliver complete written analyses upon request. Mr. Entrikin's analysis will be utilized to develop the comprehensive final report.

Mr. Thomas Entrikin has over 45 years of experience with the Medicaid and Medicare programs. From 1972 to 1979 he was a Medicare program specialist with the Social Security Administration, Bureau of Health Insurance. From 1981 to 1992, he was a Medicaid law, regulations, and policy specialist with the Health Care Financing Administration (HCFA), now CMS, providing technical assistance to the States of Vermont, Connecticut, and Massachusetts on Medicaid eligibility, coverage, and reimbursement; provider certification and enrollment; program integrity; recovery of third party liabilities; Medicaid Management Information System (MMIS) performance specifications and operations; interagency agreements; contracts with managed care organizations; and Medicaid waiver programs. While at HCFA, he assisted the State of Vermont in developing its first home and community-based services waiver for individuals with developmental disabilities, and he received a HCFA Administrator's Citation for his work achieving savings in Medicaid prescription drug reimbursement systems.

Since coming to PCG in 1992, he has assisted in the design, development, and implementation of revenue projects for school based health services; hospital-based and municipal projects for pregnant women, infants, and children; state services offered through youth services, child welfare, mental health, substance abuse, and public health agencies; and reimbursement systems for hospitals, long term care facilities, and community-based waiver programs. He has made presentations at national conferences on Medicaid waiver programs and participated in the development of a manual on consumer self-determination under waiver programs for the Robert Wood Johnson Foundation.

RELEVANT PROJECT EXPERIENCE

Department of Public Health, Department of Mental Health, Commonwealth of Massachusetts

Revenue Maximization (July 1998 – February 2010): Advisor

Project: Established FFP claiming process for early intervention services provided to EPSDT children by developmental educators.

Mr. Entrikin: Designed and implemented Medicaid FFP claiming process. Recommended improvements in intergovernmental transfers of funds (IGT) procedures. Provided recommendations for improvements in annual caseload and expenditure projections for state budget purposes. Evaluated commercial insurance and HMO coverage and billing requirements for services provided by developmental educators and recommended improvements in third party collections. Performed legal, regulatory, and policy research in support of Medicaid FFP and TANF claiming activities.

Department of Mental Health, Commonwealth of Massachusetts

Community-Based Services Rate Setting (July 1998 – June 2002): Advisor

Project: Developed enhanced encounter rate for hospital and community-based crisis intervention and crisis stabilization services offered through managed care and fee-for service arrangements.

Developed Medicaid State plan amendment and calculated Medicaid payment rates for the services.

Mr. Entrikin: Designed and implemented encounter rate for crisis intervention and crisis stabilization services. Performed analysis of the federal Olmstead decision and other case law on home and community-based services. Drafted planning APD for a DMH management information system integrated with the Medicaid agency's MMIS.

North Carolina Department of Health and Human Services, State of North Carolina

Advisory Services (July 1994 – June 2006): Advisor

Project: Developed state Medicaid plan amendment for upper payment limit (UPL) adjustments for public health and behavioral health clinics. Identified FFP revenue maximization opportunities in disproportionate share hospital (DSH) payment adjustments for mental health facilities and in State services for children, the elderly, and disabled groups. Developed Medicaid State plan amendment for State psychiatric hospital DSH reimbursement. Identified additional DSH eligible facilities and allowable costs. Recommended improvements in cost allocation methods. Recommended new procedures on certifications of public expenditures. Evaluated compliance with certification requirements for inpatient psychiatric residential treatment facilities. Performed legal and regulatory research.

Mr. Entrikin: Advised on all project processes and requirements.

Department of Health and Human Services, State of New Hampshire

Revenue Maximization (July 1994 – June 2003): Advisor

Project: Provided recommendations on upper payment limit (UPL) adjustments for county operated nursing facilities, intergovernmental transfers of funds (IGTs), development of waiver programs, payment reform, and disproportionate share hospital (DSH) payment adjustments.

Mr. Entrikin: Developed Section 1115 research and demonstration waiver proposal to expand Medicaid eligibility for low income children and to provide capitated mental health care. Analyzed community mental health center utilization and expenditure data. Developed recommendations to re-design state contracting and oversight of community mental health centers. Participated in public meetings on the re-design process with provider and consumer representatives. Provided recommendations on incorporating evidence-based practices in Medicaid coverage and reimbursement instructions. Evaluated provider-related tax requirements applicable to community based providers. Identified opportunities to obtain revenue for mental health services provided in residential programs for delinquent youth. Evaluated compliance with certification requirements for inpatient psychiatric residential facilities. Performed legal, regulatory, and policy research.

PROFESSIONAL BACKGROUND

Public Consulting Group, Inc., *Boston, MA* Aug 1992 – Present

EDUCATION

Harvard University, *Cambridge, MA*
Master of Public Administration, June 1980

University of Massachusetts, Amherst, Massachusetts
Bachelor of Arts, May 1971

REFERENCES

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Denver, Colorado 80202
Phone: 512-287-4675

JONATHAN HARTFORD

UNDERSTANDING OF THE PROCESS AND BIO

Jonathan Hartford will serve as a member of the project team for this engagement. Mr. Hartford has served as project lead and project manager for several statewide Medicaid cost reporting projects the past 8 years. Mr. Hartford understands that as a part of this engagement, he will assist in communicating with stakeholder, analyzing data, and communicating outcomes to DHHS.

Mr. Hartford has extensive experience working directly with state Medicaid agencies on large scale initiatives. Primarily, Mr. Hartford serves as the main client lead on four statewide Medicaid school-based services projects. In addition, to his school-based experience, Mr. Hartford has played a variety of roles in other projects, including Emergency Medical Services work.

RELEVANT PROJECT EXPERIENCE

Arizona Health Care Cost Containment System, State of Arizona

School Based Services Direct Service Claiming Program (2010 - Present): Client Lead

Mr. Hartford: Executed Medicaid state-wide cost reporting and cost settlement operations efforts. Developed comprehensive training materials for Local Education Agencies throughout the state. Led statewide trainings on cost settlement methodology. Processes school based cost reports under Medicaid State Plan. Enforces program compliance and revenue maximization by training school district staff on cost reporting procedures for web-based Medicaid cost reporting and claiming system

Department of Community Health, State of Georgia

Children's Intervention School Services (2011 - 2013): Client Lead

Mr. Hartford: Led statewide trainings on Medicaid state-wide cost reporting and cost settlement operations. Developed training material for the school based cost reports under approved Medicaid State Plan. Enforces program compliance through monitoring validation review efforts and by training school district staff on state and federal regulations on cost reporting procedures.

Department of Health and Environment, State of Kansas

School Based Services Cost Reporting (2010 - Present): Client Lead

Mr. Hartford: Led team in statewide school based services cost settlement efforts. Developed comprehensive trainings materials and led statewide trainings along with conducting monitoring reviews. Spearheaded efforts in developing statewide compliance material.

Department of Health and Human Services, Division of Medical Assistance, State of North Carolina

Provider Assessment Services (2010): Project Support

Mr. Hartford: Contributed to analytical efforts to determine the feasibility of implementing a variety of provider assessments. Assessments included; inpatient and outpatient hospitals, IMDs, pharmaceutical services and CAP MR-DD providers. Assisted the State to obtain approval for hospital assessment and to evaluation of other assessment initiatives.

State of North Carolina

School Based Services Medicaid Cost Reporting (2013 – Present): Project Support

Mr. Hartford: Facilitated efforts to ensure the completion of Local Education Agency specific cost reports throughout the state to validate accuracy and ensure program compliance. Ensured quality control efforts were followed to verify and compile requires statewide Medicaid cost reports.

Department of Health Services, State of Wisconsin

School Based Services Cost Reporting / Reconciliation Initiative (2010 – Present): Client Lead

Mr. Hartford: Executed efforts relating to Medicaid state-wide cost reporting and cost settlement operations. Developed material for statewide school based services audit guide for the Department. Led training efforts for statewide auditors and developed comprehensive training materials and facilitated trainings for all school districts.

Department of Social Services, State of Missouri

School-Based Health Clinic and Specialized Transportation Study (2015 –Present): Contributor

Mr. Hartford: Co-authored feasibility study and assessment on potential opportunities to increase f federal reimbursement for school-based specialization transportation providers and school-based health clinics. Provided subject matter expertise based on current national work, along with conducting intense research on Medicaid programs nationally.

Kansas Emergency Medical Services Association, State of Kansas

Emergency Medical Services Feasibility Study (2016 - 2017): Client Lead

Mr. Hartford: Spearheaded efforts with the Kansas Emergency Medical Services Association (KEMSA) and the Kansas Department of Health and Environment (KDHE) to perform a feasibility study on EMS providers throughout the state to identify opportunities for further federal reimbursement.

Public Emergency Medical Transportation (PEMT) Program, State of Florida

PEMT Initiative (2017 - Present): Client Lead

Mr. Hartford: Serves as the client lead for several public EMS and Fire Department providers, including Broward County. Works directly with clients to gather and analyze data for cost report submittal to the Agency for Health Care Administration (AHCA) in the state of Florida.

PROFESSIONAL BACKGROUND

Public Consulting Group, *Austin, TX* September 2010 – Present

EDUCATION

St. Anselm College, *Manchester, MA*
Bachelor of Arts, Politics, 2004

Clark University, Worcester, MA
Master of Business Administration, 2014

CERTIFICATIONS / PUBLICATIONS / SPECIAL SKILLS

Healthcare Financial Management Association (HFMA)

REFERENCES

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Steve Milioto
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Rowena Regier
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900 SW Jackson #900
Topeka, Kansas 66612
Phone: 785-291-3625

DAVID MEAD

UNDERSTANDING OF THE PROCESS AND BIO

David Mead will serve as a member of the project team for this engagement. Mr. Mead serves on a number of projects that support state and local health agencies in improving their fiscal operations. He has six years of experience on healthcare finance projects ranging from Medicaid claiming and cost reporting to provider auditing. Mr. Mead understands that as a part of this engagement. He will assist in conducting surveys, collecting and analyzing data, and communicating results to stakeholders.

Mr. Mead has been a key contributor in revenue maximization engagements for EMS provider communities in seven states. He works closely with ambulance providers, conducting feasibility studies, designing and developing supplemental reimbursement initiatives, and preparing Medicaid cost reports and other key deliverables. He currently serves as the project manager for EMS engagements in Oklahoma & Texas.

Mr. Mead has experience in Medicaid billing and denied claims analysis for participant directed service programs in several states including Indiana, New Jersey, Oklahoma, Pennsylvania, and West Virginia. Additionally, he served a key role in a financial audit project of Medicaid administrative claiming by Local Health Jurisdictions (LHJs) in the State of Washington. Mr. Mead's other assignments have included serving in project support capacity for School-Based Services initiatives serving districts in Arizona and Colorado.

RELEVANT PROJECT EXPERIENCE

50+ Governmental Ambulance Service Providers, State of Texas
Ambulance Supplemental Payment Program (September 2013 – Present): Project Manager

Project: Work with fire departments and third-service ambulance providers to determine feasibility, gain approval for, and implement the Ambulance Supplemental Payment Program (ASPP), a federally approved program that provides additional reimbursement for governmental providers that serve Medicaid and Uninsured patients. Develop appropriate allocation methodologies and apply federal cost determination rules to prepare annual cost reports. Provide comprehensive support throughout the State's desk review process. Have helped providers recover more than $200 million in additional revenues through implementation of this program.

Oklahoma Ambulance Association (OKAMA), State of Oklahoma
EMS Supplemental Reimbursement Initiative (July 2015 – Present): Project Staff

Project: Conducted a feasibility study for a provider assessment initiative for the state's EMS provider community. Led data collection efforts with the OKAMA stakeholder group and developed provider assessment models. Based on modeling results, determined that a Certified Public Expenditure (CPE) Program would be the optimal approach to generate the greatest net benefit to the state's providers. Currently providing OKAMA and the Oklahoma Health Care Authority (OHCA) with support to successfully stand up a CPE Program.

West Metro Fire Protection District, State of Colorado
Cost of Service Analysis & Rate Analysis Initiative (September 2018 – Present): Project Staff

Project: Conducting cost of service analysis and rate analysis to provide stakeholders opportunity to make data-driven decisions on service delivery and billing operations. Findings and recommendations to be provided in final report in December 2018.

East Pierce Fire Rescue Department, State of Washington
Enumclaw Fire Department, State of Washington
King County #20 Fire & Rescue, State of Washington
Pierce County #23 Fire & Rescue, State of Washington
Riverside Fire & Rescue, State of Washington
South Kitsap Fire & Rescue, State of Washington

Southeast Thurston Fire Authority, State of Washington
Ground Emergency Medical Transportation (GEMT) Program (July 2018 – Present): Team Lead

Project: Prepare Medicaid cost reports on behalf of seven governmental EMS providers. Obtain data from the facilities to properly analyze charges, revenue, and expenditures. Complete a thorough review of all expenditures to ensure that all allowable costs were captured and reported in the cost reports. Provide comprehensive audit support to providers.

Bay County EMS, State of Florida
Brevard County Fire Rescue, State of Florida
Lake Mary Fire Department, State of Florida
Leon County EMS, State of Florida
Sanford Fire Department, State of Florida
Seminole County Fire Rescue, State of Florida
Winter Park Fire-Rescue Department, State of Florida
Public Emergency Medical Transportation (PEMT) Program (September 2016 – June 2018): Team Lead

Project: Prepare Medicaid cost reports on behalf of seven governmental EMS providers. Obtain data from the facilities in order to properly analyze charges, revenue, and expenditures. Complete a thorough review of all expenditures to ensure that all allowable costs were captured and reported in the cost reports. Provide comprehensive audit support to providers.

Kansas Emergency Medical Services Association (KEMSA), State of Kansas
EMS Supplemental Reimbursement Initiative (July 2016 – December 2016): Project Staff

Project: Contributed to efforts to examine approaches to generate additional Medicaid revenues for Kansas' EMS provider community. Led data collection efforts for the state's 170+ providers. Provided analysis on the optimal method to implement in Kansas. Currently working with the key stakeholder group to build a consensus to present recommendations to the state Medicaid agency.

Executive Office of Health and Human Services, Commonwealth of Massachusetts
Emergency Medical Services Certified Public Expenditure Program (May 2015 – May 2016): Project Staff

Project: Developed online cost reporting tool and training materials for providers participating in a CPE program for ambulance providers. Conducted outreach and provided training and support to providers completing the annual cost report. Managed the cost settlement process and enforced compliance with state and federal Medicaid claiming regulations.

Department of Health Care Policy & Financing, State of Colorado
School Health Services Program (May 2014 – May 2015): Project Staff

Project: Supported Medicaid state-wide cost reporting and cost settlement operations. Responsible for the processing of the school based cost reports under new Medicaid State Plans. Enforced program compliance and revenue maximization by training school district staff on cost reporting procedures for web-based Medicaid cost reporting and claiming system.

Health Care Authority (HCA), State of Washington
Financial Audit of Medicaid Administrative Claiming for Local Health Jurisdictions (September 2013 – January 2014): Project Staff

Project: Conducted a multi-faceted analysis of the Medicaid Administrative Claiming (MAC) program for the State's Local Health Jurisdictions (LHJs). The audit focused on five key review areas: MAC invoice, Certified Public Expenditures, funding offset, indirect cost rate, and Federally Qualified Health Center encounter rate. Analysis and recommendations were derived from a comprehensive data analysis, on-site interviews with LHJ staff, and an examination of pertinent federal and state regulations. Findings and recommendations pertaining to each of the key review areas were presented in the final report.

Health Care Cost Containment System, State of Arizona
Three Point Check Review (March 2014 – April 2014): Project Staff

Project: Conducted a review of direct medical costs reported by Local Education Agencies (LEAs) to monitor programmatic compliance for costs reported on the annual Medicaid cost report. The purpose of the review was to verify that the LEAs' reported salary and benefit costs were accurate according to supporting documentation. Included in the review was verification of Individualized Education Plans (IEPs) in order to calculate each LEA's IEP ratio.

PROFESSIONAL BACKGROUND

Public Consulting Group, *Boston, MA* — October 2012 – Present

Oklahoma State University, *Stillwater, OK* — August 2010 – May 2012

Padre Island National Seashore, *Corpus Christi, TX* — March 2012 – July 2010

EDUCATION

Oklahoma State University, *Stillwater, OK*
Master of Business Administration, 2012

Oklahoma State University, *Stillwater, OK*
Bachelor of Science, Biology, 2001

REFERENCES

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1500 Marilla St., 7AS
Dallas, TX 75201
Phone: 214-671-8038

Steve Heath
Address: Carrollton Fire Rescue
1945 E. Jackson Road, Carrollton
Texas 75006
Phone: 972-466-3393

Greg Reid
Address: Oklahoma Ambulance Association
2504 W. Owen K. Garriott #302
Enid, OK 73703
Phone: 405-613-7443

LAUREN RODRIGUES

UNDERSTANDING OF THE PROCESS AND BIO

Lauren Rodrigues will serve as a member of the project team for this engagement. Ms. Rodrigues has seven years of experience working on healthcare finance projects ranging from cost reporting and rate setting to healthcare auditing. Ms. Rodrigues holds a Masters of Business Administration and a Bachelor of Science degree in Finance from Bentley University in Waltham, Massachusetts. Ms. Rodrigues understands that as a part of this engagement, she will assist in conducting surveys, collecting and analyzing data, and communicating results to stakeholders.

Ms. Rodrigues has a deep understanding of EMS providers costs, having completed Medicaid cost reports for EMS providers in Florida and Washington, and has managed the Commonwealth of Massachusetts' Medicaid Supplemental Payment Program for EMS providers since 2013. Ms. Rodrigues also has considerable experience assisting states with programmatic assessments and obtaining feedback from stakeholders to guide policy decisions. Ms. Rodrigues will be able to leverage her understanding of EMS provider costs and operations with her program assessment experience as a member of the project team.

RELEVANT PROJECT EXPERIENCE

Executive Office of Health and Human Services (EOHHS), Office of Medicaid, Commonwealth of Massachusetts

Supplemental Payment Program for EMS Providers (July 2013 – Present): Project Manager

Project: Worked with EOHHS on CMS approval for, and the implementation of a MassHealth Supplemental Payment Program to generate incremental federal Medicaid revenue for local governmental providers of ambulance/emergency medical services (EMS) to MassHealth beneficiaries. Facilitated the creation of a Medicaid State Plan Amendment and its submission to CMS. Organized a workgroup with 6 EMS providers to understand financial and reporting capabilities and finalize reporting methodologies. Developed cost report and cost reporting guide utilizing feedback from the workgroup.

Boynton Beach Fire Rescue, State of Florida
Kissimmee Fire Department, State of Florida
Orlando Fire Department, State of Florida
Polk County Fire Rescue, State of Florida
Osceola County Fire Rescue, State of Florida

Supplemental Payment Program for EMS Providers (September 2016 – June 2018): Project Manager

Project: Prepared Medicaid cost reports on behalf of five municipal EMS providers. Obtained data from the facilities in order to properly analyze charges, revenue, and expenditures. Completed a thorough review of all expenditures to ensure that all allowable costs were captured and reported in the cost reports.

Central Mason Fire and EMS, State of Washington
Lewis County Fire District 1, State of Washington
Mason County Fire District 4, State of Washington
Lewis County Fire District 3, State of Washington
West Thurston Fire, State of Washington
Thurston County Fire District 12, State of Washington

Supplemental Payment Program for EMS Providers (July 2018 – Present): Project Manager

Project: Prepared Medicaid cost reports on behalf of six municipal EMS providers. Obtained data from the facilities in order to properly analyze charges, revenue, and expenditures. Completed a thorough review of all expenditures to ensure that all allowable costs were captured and reported in the cost reports.

Executive Office of Health and Human Services, Commonwealth of Massachusetts

CBFS Stakeholder Engagement (December 2016 – March 2017): Project Manager

Project: Community Based Flexible Supports is a DMH program designed to provide a continuum of care to individuals served by DMH in the community. In order to solicit feedback from community stakeholders regarding the program's redesign and development of reimbursement package PCG is facilitating two stakeholder work groups and two public meetings. PCG will prepare a Briefing, or summary, of workgroup and public meeting input, to be used for the final public meeting and to inform CBFS program design and rate methodology.

Department of Mental Health, Commonwealth of Massachusetts

Privatization Analysis of DMH Emergency Service Programs (April 2015 – December 2015): Team Lead

Project: The Department of Mental Health (DMH) is considering privatizing its state-operated Emergency Service Programs (ESPs) in the DMH Southeast Area. Chapter 296 of the Acts of 1993 (the "Privatization Law") requires that a particular process be followed in assessing whether privatization would be cost effective. As part of this process, PCG was tasked with conducting the required cost analyses and preparing necessary documentation; assisting in developing and executing a procurement plan; assisting in providing necessary support to any employee organization interested in bidding on the procurement; assisting and completing a management study; documenting analyses and conclusions; and compiling this information into a cohesive report for submission to the Office of the State Auditor.

Cambridge Health Alliance, Commonwealth of Massachusetts

Financial Assessment (September 2017 – Present): Project Manager

Project: PCG will perform a financial assessment of CHA to identify significant cost drivers, pinpoint areas in which CHA's reported metrics exceed those of its peer group, determine whether costs are accurately categorized for cost reports and other external reporting, and provide recommendations for opportunities in which CHA can seek to reduce costs.

Executive Office of Health and Human Services, Commonwealth of Massachusetts

Economic Analysis of the Cost Adjustment Factor, Cost Increment Factor, and a Proposed Cost Adjustment Factor Methodology (April 2017 – May 2017): Project Manager

Project: PCG worked with EOHHS to provide a detailed economic analysis of the Cost Adjustment Factor (CAF) and the Cost Increment Factor (CIF). This included a review of the elements contributing to the CAF and CIF for FY13 through present to compare each inflation factor to the actual cost increases in each period. PCG provided EOHHS with a report summarizing this analysis and proposing a consistent methodology for EOHHS' use.

Executive Office of Health and Human Services, Commonwealth of Massachusetts

Rate Review and Rate Development for Social Services (July 2015 – December 2016): Team Lead

Project: Assisted with the review of dozens of rates in order to confirm that they adhere to all applicable provisions for social service program rates as provided under MGL Chapter 118E

Section 13D (commonly referred to as "Chapter 257"). These provisions include: (a) the reasonable cost to social service program providers; (b) a cost adjustment factor to reflect changes in reasonable costs of goods and services of social service; and (c) geographic differences in wages, benefits, housing, and real estate costs.

Assisted with the development of rates for three social services programs across two agencies. Efforts include developing, distributing, and collecting a web-based survey intended to capture high-level financial and programmatic information in order to inform rate development; assisting each agency understand their core services and how those services should be procured; developing multiple rate recommendations for each program

Professional Background

Public Consulting Group, *Boston, MA* — January 2011 – Present

State Street Corporation, *Boston, MA* — May 2009 – January 2011

Education

Bentley University, *Waltham, MA*
Master's in Business Administration, 2010

Bentley University, *Waltham, MA*
Bachelor of Science, Finance, 2008

References

Mike Berolini
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Boston, MA 02111
Phone: 617-210-5064

Brooke Doyle
Address: Massachusetts Department of Mental Health
25 Stanford Street
Boston, MA 02114
Phone: 617-626-8097

2j. Subcontractors

CORPORATE OVERVIEW

j. Subcontractors

If the bidder intends to subcontract any part of its performance hereunder, the bidder should provide:

i. name, address, and telephone number of the subcontractor(s);

ii. specific tasks for each subcontractor(s);

iii. percentage of performance hours intended for each subcontract; and

iv. total percentage of subcontractor(s) performance hours.

Public Consulting Group, Inc. (PCG) is pleased to subcontract certain components of this project to Riddle & Associates. You can find the requested information for Riddle & Associates below:

Contact Information

Mr. Ken Riddle
10652 Primrose Arbor Avenue
Las Vegas, NV 89144

Office: 702-982-3433
Mobile: 702-287-6546

Subcontractor Responsibilities

Mr. Ken Riddle of Riddle & Associates will serve as one of the three Technical Advisors responsible for providing subject matter expertise across all stages of this project. Riddle & Associates extensive knowledge pertaining to Emergency Medical Services and experience conducing similar assessments, coupled with PCG's vast healthcare background, uniquely positions our team to meet the requirements of this engagement. Below is a summary of the tasks Riddle & Associates will be responsible for throughout the duration of the project.

Stage One

- Prepare draft work plan highlighting project milestones and key dates
- Develop conference call agenda and questionnaire
- Assist with the facilitation of conference call with DHHS and EMS service(s) to determine the full scope of the assessment and priorities

Stage Two

- Work with project team to develop tools and resources for assessments
- Support team conducting site visits and interviews of community leaders, public officials, business officials, and others who may provide
- Review notes and data compiled from interviews to draw meaningful conclusions

Stage Three

- Develop outline for comprehensive reports
- Review draft reports for completeness and accuracy
- Offer recommendations based on findings, analysis, and industry best practices
- Provide answers to DHHS questions related to reports

Percentage of Performance Hours by Subcontract

Below is a breakdown of the percentage of performance hours intended for each subcontract by stage, per assessment.

Stage One: 9%

Stage Two: 20%

Stage Three: 21%

Total Percentage of Subcontractor Performance Hours

PCG intends to contract with only one subcontractor for the purposes of this project. Therefore, the total percentage of performance hours remains consistent with those listed in the section above.

Stage One: 9%

Stage Two: 20%

Stage Three: 21%

3. Technical Approach

3a. Understanding of Project Requirements
3b. Bidder Requirements
3c. Deliverables

PUBLIC CONSULTING GROUP

3a. Understanding of Project Requirements

TECHNICAL APPROACH

a. Understanding of the Project Requirements

Public Consulting Group, Inc. (PCG) will provide its own supplies and equipment throughout the term of the contract including but not limited to: transportation, workspace, cell phone, computer, email, internet etc.

3b. Bidder Requirements

TECHNICAL APPROACH

b. Bidder Requirements-F1

Please describe your company's qualifications including but not limited to history, approach, mission, areas of expertise, resources available to perform EMS assessments and that your company has the ability to stay current with the full spectrum of Emergency Medical Services.

PCG's Qualifications

Public Consulting Group, Inc. (PCG) has a long and storied history working in the public sector. For over 31 years, PCG has been committed to providing state agencies and public providers with high quality work and proven results. Our work has spanned across multiple services, from hospitals, nursing homes, schools, and EMS. PCG has been at the forefront of developing EMS initiatives across the country, both at the stage agency and provider level. This includes our expert team of resources, who will be playing a pivotal role on this project, preparing and completing cost reports on behalf of a myriad of different size providers in Texas, Florida, Missouri and Washington. In addition, we have worked in partnership with state agencies in Massachusetts and Colorado to develop and implement statewide projects. Our firm has also completed feasibility studies in Kansas and worked with contacts in Oklahoma to help spearhead their program. Our breadth of knowledge in the EMS arena truly covers all programmatic facets.

This deep experience in EMS is complemented by our proven work ethic and ability to get the job done. PCG understands the State of Nebraska is committed to partnering with a vendor with an intrinsic knowledge and skill set in performing programmatic assessments. Not only does PCG have an understanding and level of expertise with all levels of EMS programmatic data, ranging from Computer Aided Dispatch (CAD) data to Medicaid and private insurance billing data to how departments and agencies classify and report expenditures, we understand how to utilize this data for outcome-based results. PCG also knows and understands how these types of assessments are performed across other providers, as we have completed these types of assessments for the State of Texas, specifically related to Behavioral Health.

PCG's subcontracting partner, Riddle & Associates, has completed multiple EMS assessments with EMS providers. These EMS assessments have been conducted in multiple states, at the city and county level, across city and rural providers, and have covered a diverse subject area. These subjects include location studies, operational assessments and ambulance deployment and staffing to name a few. The State of Nebraska can be assured that PCG team's history will allow us to effectively and diligently perform this work.

Our Approach

PCG will utilize a comprehensive and detailed approach to meet the needs of DHHS. This approach is two-fold. Our goal is to concentrate on building relationships, and then digging deep into the data. First, PCG understands the need to build strong partnerships with DHHS staff. Our relationships will be the foundation of our work and allow us to proactively communicate with, and update, project liaisons on all phases

Our relationships with DHHS and all relevant stakeholders will be crucial to the success of this initiative.

of the project. Proactive communication will ensure that vendor and State staff to be on the same page when it relates to all timelines, and project expectations. Building on this partnership will be pivotal throughout the lifecycle of the project, from communicating with EMS Services to gathering a stakeholder group, and ultimately, providing the final assessment report. Our work is only as good as our partnerships, and we are strongly committed to building this relationship with DHHS.

While our partnership with DHHS is vital, PCG also knows how important it is to build successful relationships with other the relevant stakeholders. These stakeholders are at the heart of this work and transparency around project goals will be critical. Our communication to these stakeholders will be key: fully explaining the goals and the objectives of this project, which will ultimately benefit the public good of all EMS services. PCG has developed these types of successful relationships with EMS providers and fire departments across the country, and we feel strongly that this can be replicated successfully in the State of Nebraska. We know this will not always be easy and understand the challenges that providers go through on a daily basis, first-hand. PCG has spent countless hours building these types of relationships. The work will rely heavily on the information collected, and the people and providers it is collected from, so building these types of relationships matter.

Finally, as important as these relationships will be to foster, the true work lies in our research and data analytics. Our ability to review this comprehensive data in a timely fashion will be of the utmost importance to project success. The PCG team has completed this type of work on a variety of different projects nationally. Our ability to analyze data in Texas, West Virginia, and South Carolina as part of assessment work are all examples of our thorough and complete past engagements. Our work in Texas is a great example of our comprehensive approach. As part of our Behavioral Health Analysis initiative, we were able to leverage significant stakeholder engagement to allow us to analyze programmatic, financial and policy work to support our final system recommendations to our client in a clear and articulate manner.

Our Mission

It is important to reiterate that PCG's qualifications and expectations for this initiative rely heavily on the mission of our organization. PCG's firm-wide mission is clear; Public Focus. Proven Results. PCG is a leading public-sector management consulting and operations improvement firm that partners with health, education, and human services agencies to improve lives. **This mission directly relates, and has carried over, to all of our EMS work.** Time and again, PCG has gone above and beyond to provide our clients at the provider and state level with high quality, proven results. We do not view our mission as just a tag line or phrase. PCG's reputation has been built upon always going above and beyond for our clients. This is something that the State of Nebraska can count on.

Our Resources

The PCG project team assembled for this effort is comprised of a team of experts with comprehensive experience working with EMS providers nationally. Every individual listed on our resource team, as part of the project team, has direct experience with this line of work. PCG's rapidly growing EMS portfolio has led us to be an industry leader in all facets of policy, reimbursement, and departmental operations. These personnel resources are supported by an ever-growing, national PCG network. This includes technological support and data analytic experts, on whom the PCG team on this engagement can rely. PCG's data analytics experts have developed a complex Tableau platform for EMS, which has been used nationally to assess data points across the board.

Our Ability to Stay Current with EMS Services

A sometimes-complicated set of federal and state rules govern EMS services. PCG understands this as will be described in *Section 3b-Bidder Requirement-F4*. We have walked through those rules with states and providers many times, helping state departments, EMS providers, and fire departments meet their goals. The implementation of a Texas Supplemental Payment Program as part of a Medicaid 1115 Waiver, we have been there. Completing GEMT cost reports as part of new State Plan Amendment Approvals in Washington and Florida, we have done that. Completing a feasibility study comparing a Provider Assessment, Certification of Public Expenditure (CPE) program, or Intergovernmental (IGT) program in Kansas, we have been there *and* done that.

PCG has extensive knowledge of state and federal Medicaid billing and reimbursement requirements related to EMS. We constantly review regulations and legislation at both the state and federal levels to ensure that practices are current. Our technical advisor on this project, Tom Entrikin, has over 40 years of experience in this realm, formally working for the predecessor to CMS. In addition to Mr. Entrikin's expertise, additional PCG legal and regulatory staff regularly review the Office of Inspector General (OIG), CMS, and other EMS audit reports throughout the nation, some of which result in policy modifications. PCG reviews whether any of these reforms impact current EMS guidelines and will make suggestions to enhance procedures proactively addressing the concerns outlined in other audits.

Lastly, our PCG EMS team regularly attends conferences, both small and large, on an almost weekly basis, all over the country, networking with EMS policy experts. This practice allows us to constantly be tuned in to issues departments may be facing and how state and federal policy plays into these concerns. **We excel at policy related to our work because we understand that goals differ by state and by program area.** This work is not new to us. Overall, as our experience has matured, we have come to understand the diverse business functions of EMS departments, from billing to cost reporting, financial management to programmatic oversight, program integrity to information technology. Each one of those areas comes with its own set of policies, and most of these policies interact across departmental functions. To fully understand these functions, and the rules and regulations that govern them, is fundamental to our work in the EMS sector and ultimately to the assessment work the State of Nebraska is looking to embark on. We look forward to providing these services to the State of Nebraska and DHHS.

b. Bidder Requirements-F2

Please describe your company's experience in conducting comprehensive EMS assessments; please address experience in rural areas and volunteer workforces.

Experience in Conducting Comprehensive EMS Assessments

The team assembled for this engagement includes staff with significant experience in conducting regional and statewide EMS assessments. This experience includes engaging a diverse group of stakeholders across various types of regions including urban, suburban, rural, and frontier areas of the state. As a result of this experience, our team has a deep understanding of the challenges faced by each of the identified regional characterizations. We can leverage our unique understanding to ensure these challenges are adequately incorporated into the scope of this project. An additional challenge of rural and frontier areas is the common use of volunteer workforces, which poses its own series of challenges. The most common issue stems from the ability to recruit and retain qualified staff without payment or other compensation. Based on our prior experience, our team can identify suggested areas of improvement to help encourage the recruitment and retention of critical staff for these areas. In the pages that follow, we highlight our key experience from notable projects in the State of Colorado and detail the key findings from these engagements. We will take our lessons learned from these projects to identify improvements to previous processes and develop a robust assessment plan for the State of Nebraska.

Central Mountains Regional Emergency and Trauma Advisory Council, Standardized Needs Assessment

Riddle & Associates was contracted by the EMTS Section within the Health Facilities and Emergency Services Division of the Colorado Department of Public Health and Environment (CDPHE) to conduct a needs assessment of the Central Mountains Regional Emergency and Trauma Advisory Council's (CMRETAC) Emergency Medical and Trauma Services (EMTS) system beginning in May 2009 and concluding in June 2009. This assessment included comprehensive assessments of the EMTS systems of 11 Regional Emergency medical and Trauma Advisory Councils (RETACs) in Colorado over course of three fiscal years. The assessment included on-site visits and interviews with the CMRETAC stakeholders, the use of two surveys, the standardized Benchmarks, Indicators, and Scoring (BIS) survey instrument, and a problem ranking survey.

The BIS survey uses a weighted scoring system with 0 meaning "I don't know" and 5 meaning a program or EMTS component is comprehensive and well established. BIS questions scored with higher numbers (4s and 5s) indicate that the component or program is comprehensive and well established. 20 CMRETAC EMTS stakeholder agencies participated in the assessment process, including representation from ambulance services, fire departments, hospitals, trauma centers, clinics, and emergency management agencies. The findings from these assessments were formatted into a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis to identify opportunities and areas of improvement in the region.

The assessment identified high scores in the areas of integration of health services, legislation and regulation, system finance, and clinical care. Lower scores were indicated for EMTS research, public access, medical direction, mass casualty, public education, prevention, and information systems. The Problem Ranking Survey indicated that the two biggest challenges faced by providers are administrative support and medical director involvement. The least challenging issue is billing/accounts receivable.

Upon completion of the assessment process, a final report was drafted with actionable recommendations. The recommendations for the CMRETAC included both short-term and long-term activities such as regional medical direction and standardized protocol algorithms, consolidated disaster planning, regional training opportunities to mitigate duplication, and the use of existing EMTS data to drive Continuous Quality Improvement (CQI) and other initiatives.

Colorado Department of Public Health and Environment, Emergency Medical and Trauma Services, Standardized (Regional) Needs Assessment Project

The goal of the Standardized (Regional) Needs Assessment Project (SNAP) was twofold: to support each of Colorado's RETACS in completing an assessment process as required by statute and to assess local and regional EMTS in a way that provides consistent results which could be the basis for future development of biennial plans that address those needs and accurately identify the policies and resources necessary to meet the future system requirements. This scope also included providing a final report with EMTS data and information to the CDPHE EMTS Section which identified the future needs for the 11 RETACs. Additional information was compiled identifying common EMTS themes observed across the State over the course of the engagement, as well as recommendations for future needs assessments or reassessments of the RETACs.

The assessment included RETACS covering a diverse geographical area including urban, rural and frontier regions.

Over the course of the engagement, 219 Colorado EMTS agencies or facilities participated in the SNAP process including 141 personal interviews, 211 participants at 14 town hall meetings held around the state, 115 BIS surveys returned and 109 problem ranking surveys completed. Input was provided from all EMTS disciplines. This assessment was conducted statewide and included EMTS agencies in rural/frontier areas of the State, as well as urban and suburban regions. The project was initially expected to span over the course of three years, but we were able to complete the engagement in only 22 months.

The strengths, weaknesses, opportunities and threats (SWOT) analysis of the EMTS systems within each RETAC revealed that the primary strengths are the RETAC board members and the RETAC coordinators/executive directors. The main weaknesses are the geography and RETAC boundaries as well as recruitment and retention of qualified EMTS personnel. Opportunities include enhanced system finances and a move towards more regionalization and standardization. The primary potential threats consist of decreased system finances and lack of qualified EMTS personnel. There were several common EMTS themes identified during the SNAP process including a move towards more regionalization and standardization with regional patient care protocols and written regional MCI or Communications plans. Recommendations for future needs assessments or reassessments include using an alternate survey instrument in lieu of the BIS survey; conducting more town hall and focus group type meetings; limiting the scope of assessments; and, including the RETAC coordinators/executive directors as active participants in the assessment process.

Northwest Colorado Regional Emergency and Trauma Advisory Council, Standardized Needs Assessment

The Abaris Group conducted a needs assessment for the Northwest Colorado Regional Emergency and Trauma Advisory Council's (NWRETAC) Emergency Medical and Trauma Services (EMTS) system

beginning in October 2009 and concluding in May 2010. The RETAC consists of a diverse geographical area, covering five counties including urban, rural and frontier regions. The assessment included onsite visits and interviews with the NWRETAC stakeholders, the use of two surveys; a standardized Benchmarks, Indicators, and Scoring (BIS) survey instrument and a problem ranking survey.

Identified challenges included limited ALS level continuing education in the frontier and rural areas of the state.

The comments from the onsite assessments were formatted into a Strengths, Weaknesses, Opportunities and Threats (SWOT) format. Additional analysis was conducted on the data from the two surveys to complete the needs assessment and provide recommendations for the NWRETAC's consideration to enhance the EMTS system in Northwest Colorado. From the problem ranking survey results, the issues that were identified as most challenging for the Pre-Hospital respondents were Recruitment and Retention of Personnel. For Hospital respondents, Agency Funding/Financial Viability and Billing/Accounts Receivable were their most challenging issues. Because of the diversity between urban, rural and frontier regions within the RETAC there were differences in the challenges faced by the NWRETAC stakeholders. The level of care in the region is primarily ALS provided by both paid and volunteer staffs at the paramedic and intermediate level with more intermediates in the rural and frontier communities. It was found that ALS level continuing education is limited in some of the frontier and rural areas of the region.

b. Bidder Requirements-F3

Please describe your company's proposed approach to completing the in Section V.C. Scope of Work. Provide an in-depth description of the services you propose to provide, the methods you will use, and the outcomes you propose to achieve.

Public Consulting Group, Inc. (PCG) understands that the State of Nebraska DHHS is seeking a comprehensive EMS consultation for selected services or region(s) to assess a number of factors such as strengths, weaknesses, gaps in coverage, shortfalls in funding and workforce, sustainability, benchmarks and quality indicators, and future needs for pre-hospital care. In the following pages, we outline our proposed approach to providing the full scope of services as defined in the three stages outlined in *Section* V.C. of this RFP.

Stage One

PCG initiates every new engagement with a project kick-off meeting between our project team and a team of representatives for our client. These project kick-off meetings are viewed as an opportunity to formally introduce our team members that will be managing the engagement and the staff that will be carrying out the tasks necessary to complete the scope of work to the state staff that we will most frequently be engaged with for the duration of the engagement.

The project kick-off meeting also serves as an opportunity for PCG and our client to review the scope of work, the anticipated deliverables, and the proposed approach and timeline for completing the scope of work. For this engagement, the project kick-off meeting will be critical to the success of the project as many key decisions will need to be made in order to finalize the project approach and timelines. Specifically, PCG understands that the project kick-off for this engagement will used to determine the EMS Service(s) or regions that will be included in the assessment.

Once the final decision is made in conjunction with DHHS, PCG will work to revise our proposed approach and timelines, as necessary, to reflect the final scope of work to be completed and the priorities within that scope.

As part of this initial stage, PCG also understands that it may be necessary to conduct preliminary interviews with additional stakeholders identified by DHHS in order to fully define the final scope of work and project priorities. Our team will work with DHHS during the project kick-off meeting to determine the need for further interviews and to document an outreach process for the stakeholders to be included as part of the preliminary interview process.

Following the approval of the scope of work and agreement upon project priorities, PCG will deliver a final project work plan and timeline for DHHS review and approval. This final project work plan and timeline will serve as the basis for monitoring progress towards completing the scope of work and deliverables throughout the life of the engagement.

PCG has a proven approach to conducting EMS and statewide system assessments that can be tailored to the specific EMS services chosen by NE DHHS for this engagement.

Stage Two

The delivery of a final project work plan and timeline will serve as the starting point for PCG's efforts on Stage Two of this engagement. PCG understands that this second

stage of the engagement is critical to delivering a comprehensive report to DHHS that can help to direct future policy and program decisions. Our high-level approach to executing on all tasks defined in the RFP for this critical stage can be applied regardless of the decisions made during the first stage of the engagement in relation to the specific EMS service(s) or region(s) to be included in the assessment. The specific tasks needed to execute this approach will be tailored to address the unique nature of the specific EMS service(s) or region(s).

Stakeholder Engagement

PCG's experience in conducting EMS and large statewide system assessments has proven that the engagement of key stakeholders at the outset of the effort is instrumental in delivering a final product that accurately reflects the current environment and the future needs of the system. As part of the stakeholder engagement effort, PCG will work with DHHS to develop a comprehensive stakeholder registry to identify all stakeholders that PCG will outreach to. These stakeholders may include:

- state agency staff;
- community partners such as public officials, business leaders, and law enforcement officials;
- healthcare administrators and professionals;
- emergency communication personnel;
- ambulance service providers; and
- health care consumers.

PCG also understands that while all efforts will be made to identify all relevant stakeholders at the outset of the project, it may be necessary to expand the list to ensure that any interested stakeholders are provided the opportunity to share information that may be useful in completing the assessment and developing the recommendations. Our team will work with DHHS throughout this stage of the project to identify any new stakeholders that were not part of the initial registry and to obtain approval for their inclusion in this process.

Once the list of stakeholders is identified, PCG will initiate a process to obtain input from these stakeholders using a mix of interviews and stakeholder forums. Through our experience in conducting similar EMS and other large statewide assessments, we have found that a mix of individual interviews and group forums provides for a diverse set of feedback, important to understanding the current environment.

To facilitate these stakeholder interviews and forums, PCG will develop a set of standard questions that will be used to guide the discussion. These questions will be focused on the major topic areas to be included as part of the assessment: organizational structure and system design, EMS response time reliability, fiscal structure and stability, and the delivery and quality of clinical care including the use of quality improvement. The use of a standard set of questions as the starting point for all stakeholder engagement activities is necessary for capturing input in a manner that allows for comparison across the different stakeholder groups. For individual stakeholder interviews, our team will work to develop additional questions to focus on the specific interactions of the stakeholder with the EMS services.

Another key component of stakeholder engagement is process transparency. PCG will capture all feedback provided through the individual stakeholder interviews and the stakeholder forums. We will provide these documents to DHHS for review and will work to identify an opportunity for these materials to be shared back with the stakeholders. We have found that this process helps to ensure that the feedback

from the stakeholders is appropriately documented which helps to minimize negative stakeholder feedback when the final report is released.

Current Environment Assessment

PCG's approach to completing the current environment assessment will focus on four major tasks:

1. Documentation Review
2. Engagement of Key Stakeholders
3. Development and Administration of Surveys
4. Perform Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

The execution of these four major tasks will provide our team with the necessary data and information to accurately document the current environment and to develop a set of conclusions and recommendations that are well defined and actionable.

Documentation Review

Simultaneous to PCG's stakeholder engagement efforts, our team will also be working to conduct our comprehensive assessment of the selected EMS service(s) or region(s). PCG's initial efforts for the assessment phase will focus on reviewing all publicly available documentation for the specific EMS service(s) or region(s) that will be part of the assessment. This review will include any financial records, existing annual plans and budgets, basic profile data, and any regulatory or statutory information that can be obtained through public websites or databases. We will also leverage the data that will be supplied by DHHS including Trauma Registry, Crash Outcome Data Evaluation Systems (CODES), and eNARSIS data.

Our team will make every effort to obtain data from publicly available sources and to leverage the initial data provided by DHHS; however, our experience in conducting similar assessments has demonstrated that there are likely to be additional data elements that are not publicly available. In order to capture those additional data elements, our team will develop a detailed data request including, where possible, examples of the data we are looking to obtain. We will work directly with the DHHS appointed liaison to review this request and to manage the intake of the requested information.

PCG's documentation review process will serve to establish the baseline understanding of the current environment and will help to inform the development of our survey tools and future stakeholder outreach and engagement.

Engagement of Key Stakeholders

As noted, PCG's approach to assessments of similar scope as requested in this RFP relies on a comprehensive stakeholder engagement strategy. Our team will work closely with DHHS to identify the key stakeholders to be engaged throughout the life of this assessment, and we will leverage a strategy that combines individual interviews as well as public forums to obtain feedback from a diverse set of perspectives.

Development and Administration of Surveys

The third major task for our approach to completing the current environment assessment is to develop and administer two surveys; a standardized Benchmarks, Indicators, and Scoring (BIS) survey and a Problem Ranking survey. These two survey instruments will provide additional forums for stakeholders to

provide meaningful feedback about the current environment and the areas that present opportunities for future changes.

Benchmarks, Indicators, and Scoring (BIS) Survey

The BIS survey will be an important source of information for this project as it represents a standardized approach to collecting stakeholder feedback on the current environment. The BIS survey will be crafted to generate feedback on the major components of the EMS program on a consistent set of questions and indicators.

At a minimum, PCG anticipates including three main indicators as part of this survey:

- **Structure:** this includes legislation, rules or regulations, bylaws or charters, policies and procedures or authority
- **Process:** is there a process in place to implement requirements or expectations contained in the structure indicator? If so, does the process reflect the requirements contained in the structure?
- **Outcome:** Are there tools in place to measure the effectiveness of the process? Are measurements or evaluations ongoing? Is data used to drive improvements?

Respondents will be asked to indicate a score, on a scale of 1 through 5 for each indicator under each component in the survey. The scores are intended to reflect the progress toward, or compliance, with each indicator for the organization completing the survey.

In a prior engagement, the BIS survey was administered to obtain feedback on 15 components across four indicators. The figure below provides an example of the type of question that would be included as part of the BIS survey for this effort.

Emergency Medical and Trauma System (EMTS) Component: System Finance	
4. All disciplines are financially stable organizations with approved budgets that are aligned with the Regional EMTS plan and priorities.	
Structure Indicator	*Scoring*
4.1 Cost, charge, collection and reimbursement data are projected and collected; are compared to (benchmarked) against industry data; and, are used in strategic and budget planning.	0. Don't Know 1. Cost, charge, collection and reimbursement data are not collected. 2. Cost, charge, collection and reimbursement data are collected. 3. Cost, charge, collection and reimbursement data are collected and analyzed by internal or external finance experts. 4. Cost, charge, collection and reimbursement data are collected and analyzed by internal or external finance experts e.g. CPA, but are not benchmarked against industry data. 5. Cost, charge, collection and reimbursement data are collected and analyzed by internal or external finance experts and are benchmarked against industry data. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: System Finance	
Process Indicator	*Scoring*
4.2 Budgets are approved and based on historic and projected cost, charge, collection, reimbursement and public/private support data.	0. Don't Know 1. There is no data that can be accessed for budgetary planning purposes. 2. Data is collected but reports are not routinely generated that can be used for budget planning. 3. Data is collected and reports generated, but there is no formal budget planning process. 4. Data is collected, reports generated and there is an expense budget process, but it is not linked to revenue. 5. Data is collected, reports generated, and revenue and expense budgets are produced and approved by the governing body. Progress against budget projections is monitored throughout the budget cycle. **Agency/Facility Score** | **System Score**

Figure 3.B.1: Example of BIS Survey Question. The PCG team will use a BIS survey similar to this sample to collect feedback on the current environment in the State of Nebraska.

We anticipate leveraging the 18 identified attributes of a successful EMS agency in developing this survey instrument. PCG will work with DHHS to finalize the structure and content of the BIS survey and the process for distributing the survey to the necessary stakeholders. In prior engagements, this survey has been administered through a mix of in-person sessions, through email, or by posting on an agreed upon website.

The data collected through the BIS survey will be used to inform the SWOT analysis and ultimately the final conclusions and recommendations.

Problem Ranking Survey

The Problem Ranking Survey will be designed to have respondents rank a set of ten issues that cross the major focal points for this assessment; organizational structure and system design, EMS response time reliability, fiscal structure and stability, and the delivery and quality of clinical care. The Problem Ranking

Survey will require respondents to assign a value to each of the issues to identify the most challenging to least challenging issue.

The results from this survey will provide for a discrete ranking of the issues that exist within the current environment and can be used to focus attention on the issues viewed as presenting the greatest challenges for stakeholders.

Perform Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

The final major task of the assessment effort will be the completion of a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis. The SWOT analysis will leverage the information collected through the documentation review, stakeholder engagement, and two surveys. Where possible, PCG will look to document at least one strength, weakness, opportunity, and threat for each of the major topic areas identified in *Section V.C.4.* of the RFP.

The SWOT analysis will help to frame the final report to be delivered to DHHS and articulate the areas that present opportunities for improvement.

Stage Three

The final stage of this engagement will result in the delivery of a final, comprehensive report that documents the current environment, provides the results of the stakeholder engagement and survey efforts, and outlines PCG's findings and recommendations. Our team understands that a final report following an assessment effort like this must also go beyond simply making recommendations and must include actionable items to move stakeholders towards progress and advancement. To that end, the report developed for DHHS will provide a clear plan for implementing the recommended system enhancements.

PCG's approach to developing final reports, following system assessments is one that calls for multiple internal and external reviews prior to the report being considered final. PCG will follow a process where the initial report will be subject to at least two rounds of internal review prior to delivery to DHHS. Upon delivery of the initial report to DHHS, PCG will conduct a walk-through of the report and will discuss the major highlights with DHHS staff. Our team will then conduct a follow up discussion with DHHS to collect feedback and to document any necessary revisions following DHHS review.

Once DHHS has completed its review of the initial report, PCG will review the DHHS feedback and suggested revisions. Our team will work to revise the report as necessary and provide DHHS with an updated report and an inventory of the changes made following the initial review. While PCG does not anticipate the need for multiple rounds of DHHS review and subsequent revisions, our team is committed to working with DHHS to ensure the final product meets and exceeds the expectations for this engagement.

Following DHHS approval of the report, PCG will finalize the document and prepare the report for release in accordance with DHHS directions. While not specifically requested in the RFP, PCG will be prepared to develop companion documents to be used for public distribution of this report. In past assessment engagements, these companion documents have included a PowerPoint presentation that summarizes the assessment, findings, and recommendations and an Executive Summary document that focuses on the findings and recommendations from the assessment.

b. Bidder Requirements-F4

Please describe your knowledge of federal and State of Nebraska EMS laws and regulations.

PCG's Knowledge Base

For over 30 years, PCG has proven that we have an extensive knowledge base of federal and state laws across the public sector. PCG employs individuals that have extensive backgrounds in federal and state policies which allows us to assist our state clients in navigating the complicated world of laws and regulations. The EMS world is no exception. As explained previously in this proposal, PCG has worked at the state and provider level on a variety of EMS projects including provider assessments and standardized needs assessments. In addition, PCG has provided consulting services to EMS providers to design, gain approval for, and implement the Ambulance Supplemental Payment Program.

PCG Knows Federal EMS Laws and Regulations

The nature of our work requires PCG to always understand and follow what is happening at the federal level. PCG is consistently monitoring what information is being distributed out of the National Highway Traffic Safety Administration's (NHTSA) Office of Emergency Medical Services and the Federal Office of Rural Health Policy to ensure our state clients are in compliance with federal regulations and to monitor any new policy. In addition, PCG has worked with providers that have received Health Resources and Services Administration (HRSA) funding and we understand the requirements of the Medicare Rural Hospital Flex program.

PCG's also has experience within the Medicaid sector and supplemental payment programs. Our work in these areas has allowed us to understand the Centers for Medicare and Medicaid (CMS) laws around allowable costs when completing cost reports and billing requirements. PCG has been a leader in the development and implementation of revenue maximization projects for EMS providers across the country. PCG has expertise in the service, financial and billing components pertinent to EMS agencies, which has enabled us to develop revenue enhancement programs customized to provider needs. PCG's EMS-specific engagements include projects with a variety of EMS providers in Florida, Texas, the Commonwealth of Massachusetts and Washington.

PCG Knows State of Nebraska EMS Laws and Regulations

PCG will effectively provide EMS assessments because PCG has extensive knowledge of all the State of Nebraska EMS laws and regulations. PCG has reviewed and understands the statutes pertaining to the Emergency Medical Services Practice Act and the EMS Personnel Licensure Interstate Compact. PCG has also reviewed the Title 172 of the State of Nebraska Administrative Code that pertains to the licensing of out-of-hospital emergency care providers, the credentialing of EMS and EMS Training Agencies. All of these regulations are intended to bring the best quality emergency care to the people of the State of Nebraska. The PCG team will bring this comprehensive knowledge to each EMS assessment we do.

PCG recognizes that there are policies around data collection as part of the State of Nebraska Rules and Regulations. The National Emergency Medical Service Information System (NEMSIS) data allows local agencies to measure performance and quality improvement which is crucial in emergency situations. We also are aware that the State of Nebraska is required to meet the NEMSIS standard and is fully transitioning to the NEMSIS 3.4 dataset by January 1, 2019. PCG may also leverage the State of

Nebraska's Ambulance Rescue Service Information System (eNARSIS) since it is required that all ambulance services submit electronic records.

Our team brings to the State of Nebraska an extensive background on monitoring legislation and understands the State of Nebraska's legislative and budget processes. If there was legislation that would impact the State of Nebraska's EMS services, PCG would monitor the legislation through bill introduction to final reading to the Governor's office. For example, PCG followed the legislation of "LB578-Adopt the Ground Emergency Medical Transport Act" during the legislative session last year where it was approved by the Governor on May 23, 2017.

PCG will partner with the State of Nebraska to ensure that we have a full grasp on all the State of Nebraska Statutes, Rules and Regulations so that when we complete these assessments on EMS services, we completey understand how theses services are governed and how they should perform.

b. Bidder Requirements-F5

Provide three examples of final reports that your company has provided to customers.

PCG's Example Reports

The following three reports demonstrate our experience performing comprehensive EMS assessments in line with the requirements set forth in *RFP 5947 Z1*. Please note that these reports were developed by PCG's subcontractor, Ken Riddle, who was the sole author during his employment with Abaris Group. Abaris Group was made aware and agreed to PCG's use of the following reports as part of our RFP response.

1. *Colorado DPHE Emergency Medical and Trauma Services Standardized (Regional) Needs Assessment (June 2009)*
2. *Colorado DPHE Emergency Medical and Trauma Services Standardized (Regional) Needs Assessment (December 2010)*
3. *Colorado DPHE Emergency Medical and Trauma Services Standardized (Regional) Needs Assessment (July 2010)*

Additionally, in *'Addendum One Questions and Answers'*, permission to use the listed reports was granted in the below response by the State of Nebraska Purchasing Bureau on November 7, 2018. Please see below for reference.

Question Number 9: To meet this requirement, can we submit three final reports that our lead consultant completed that are from a different company that released the reports for this project as examples of our consultant's work?

State Response: Yes, however the reports have to be relevant to the requirements of this RFP.

3c. Deliverables

3. TECHNICAL APPROACH

c. Deliverables

The technical approach section of the Technical Proposal should consist of the following subsections:

c. Deliverables

Please see Cost Proposal.

5. Appendix

5a. Form A Bidder Contact Sheet
5b. Terms and Conditions
5c. Final Report Examples

PUBLIC CONSULTING GROUP

5a. Form A Bidder Contact Sheet

Form A
Bidder Contact Sheet
Request for Proposal Number 5947 Z1

Form A should be completed and submitted with each response to this RFP. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	Public Consulting Group, Inc.
Bidder Address:	999 18th Street, 1425N, Denver, CO 80202
Contact Person & Title:	James Dachos, Associate Manager
E-mail Address:	jdachos@pcgus.com
Telephone Number (Office):	(512) 287-4675
Telephone Number (Cellular):	(781) 424-7316
Fax Number:	(512) 407-9249

Each bidder should also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	Public Consulting Group, Inc.
Bidder Address:	999 18th Street, 1425N, Denver, CO 80202
Contact Person & Title:	James Dachos, Associate Manager
E-mail Address:	jdachos@pcgus.com
Telephone Number (Office):	(512) 287-4675
Telephone Number (Cellular):	(781) 424-7316
Fax Number:	(512) 407-9249

5b. Terms and Conditions

II. TERMS AND CONDITIONS

Bidders should complete Sections II through VII as part of their proposal. Bidder is expected to read the Terms and Conditions and should initial either accept, reject, or reject and provide alternative language for each clause. The bidder should also provide an explanation of why the bidder rejected the clause or rejected the clause and provided alternate language. By signing the RFP, bidder is agreeing to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the proposal. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the proposal. The State of Nebraska is soliciting proposals in response to this RFP. The State of Nebraska reserves the right to reject proposals that attempt to substitute the bidder's commercial contracts and/or documents for this RFP.

The bidders should submit with their proposal any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the contract. The State will not consider incorporation of any document not submitted with the bidder's proposal as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one Party has a particular clause then that clause shall control;
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MD			

The contract resulting from this RFP shall incorporate the following documents:

1. Request for Proposal and Addenda;
2. Amendments to the RFP;
3. Questions and Answers;
4. Contractor's proposal (RFP and properly submitted documents);
5. The executed Contract and Addendum One to Contract, if applicable ; and,
6. Amendments/Addendums to the Contract.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) executed Contract and any attached Addenda, 3) Amendments to RFP and any Questions and Answers, 4) the original RFP document and any Addenda, and 5) the Contractor's submitted Proposal.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth below, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

C. GOVERNING LAW (Statutory)

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state and federal laws, ordinances, rules, orders, and regulations.

D. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

E. CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State and the Contractor, upon the written agreement, may make changes to the contract within the general scope of the RFP. Changes may involve specifications, the quantity of work, or such other items as the State may

find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Contractor may not claim forfeiture of the contract by reasons of such changes.

The Contractor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Contractor's proposal, were foreseeable, or result from difficulties with or failure of the Contractor's proposal or performance.

No change shall be implemented by the Contractor until approved by the State, and the contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

F. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MJ			

If Contractor breaches the contract or anticipates breaching the contract, the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

G. BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MJ			

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

The State's failure to make payment shall not be a breach, and the Contractor shall retain all available statutory remedies and protections.

H. NON-WAIVER OF BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MD			

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

I. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MD			

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

J. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MD			

1. GENERAL

The Contractor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a

license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. **PERSONNEL**
The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Contractor.

4. **SELF-INSURANCE**
The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 et seq. and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

K. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MS			

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if order by the court, including attorney's fees and costs, if the other Party prevails.

L. ASSIGNMENT, SALE, OR MERGER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MS			

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Contractor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Contractor's business. Contractor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Contractor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

M. CONTRACTING WITH OTHER NEBRASKA POLITICAL SUB-DIVISIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. §81-145, to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

N. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event"). The Party so affected shall immediately make a written request for relief to the other Party, and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

O. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

P. OFFICE OF PUBLIC COUNSEL (Statutory)

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract.

Q. LONG-TERM CARE OMBUDSMAN (Statutory)

Contractor must comply with the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq. This section shall survive the termination of this contract.

R. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MS			

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.
2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.
3. The State may terminate the contract immediately for the following reasons:
   - a. if directed to do so by statute;
   - b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   - c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
   - d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
   - e. an involuntary proceeding has been commenced by any Party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
   - f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
   - g. Contractor intentionally discloses confidential information;
   - h. Contractor has or announces it will discontinue support of the deliverable; and,
   - i. In the event funding is no longer available.

S. CONTRACT CLOSEOUT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MS			

Upon contract closeout for any reason the Contractor shall within 30 days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State,
2. Transfer ownership and title to all completed or partially completed deliverables to the State;
3. Return to the State all information and data, unless the Contractor is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures;
4. Cooperate with any successor Contactor, person or entity in the assumption of any or all of the obligations of this contract;

5. Cooperate with any successor Contactor, person or entity with the transfer of information or data related to this contract;
6. Return or vacate any state owned real or personal property; and,
7. Return all data in a mutually acceptable format and manner.

Nothing in this Section should be construed to require the Contractor to surrender intellectual property, real or personal property, or information or data owned by the Contractor for which the State has no legal claim.

III. CONTRACTOR DUTIES

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MJ			

It is agreed that the Contractor is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Contractor is solely responsible for fulfilling the contract. The Contractor or the Contractor's representative shall be the sole point of contact regarding all contractual matters.

The Contractor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Contractor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Contractor to the contract shall be employees of the Contractor or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor or the subcontractor respectively.

With respect to its employees, the Contractor agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding;
2. Any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. Damages incurred by Contractor's employees within the scope of their duties under the contract;
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law; and
5. Determining the hours to be worked and the duties to be performed by the Contractor's employees.
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Contractor, its officers, agents, or subcontractors or subcontractor's employees)

If the Contractor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the bidder's proposal. The Contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or subcontractor employee.

Contractor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Contractor shall include a similar provision, for the protection of the State, in the contract with any subcontractor engaged to perform work on this contract.

B. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MS			

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the RFP response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory)

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all subcontracts for services to be covered by any contract resulting from this RFP.

D. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MS			

Contractor may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Contractor shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the performance of work by any other contractor or individual. Contractor is not required to compromise Contractor's intellectual property or proprietary information unless expressly required to do so by this contract.

E. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MJ			

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Contractor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

F. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MJ			

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Contractor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

G. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MJ			

The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor;
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Contractor has verified that each subcontractor has the required coverage; or,
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage

The Contractor shall not allow any subcontractor to commence work until the subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within one (1) year of termination or expiration of the contract, the Contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and one (1) year following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this contract, the State may recover up to the liability limits of the insurance policies required herein.

1. **WORKERS' COMPENSATION INSURANCE**

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter**. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
Independent Contractors	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
USL&H Endorsement	Statutory
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$2,000,000 per occurrence
PROFESSIONAL LIABILITY	
All Other Professional Liability (Errors & Omissions)	$1,000,000 Per Claim / Aggregate
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

If the mandatory COI subrogation waiver language or mandatory COI liability waiver language on the COI states that the waiver is subject to, condition upon, or otherwise limit by the insurance policy, a copy of the relevant sections of the policy must be submitted with the COI so the State can review the limitations imposed by the insurance policy.

3. **EVIDENCE OF COVERAGE**

The Contractor shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

Department of Health and Human Services
Attn: Program Manager Emergency Health Systems
301 Centennial Mall S.
Lincoln, NE 68509

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage

4. **DEVIATIONS**

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.

H. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

I. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that there does not now exist a relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this RFP or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or an appearance of conflict of interest.

The bidder certifies that it will not knowingly employ any individual known by bidder to have a conflict of interest.

The Parties shall not knowingly, for a period of two years after execution of the contract, recruit or employ any employee or agent of the other Party who has worked on the RFP or project, or who had any influence on decisions affecting the RFP or project.

J. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

K. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Statutory)

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's

performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

L. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MJ			

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

M. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MJ			

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

IV. PAYMENT

A. PROHIBITION AGAINST ADVANCE PAYMENT (Statutory)

Payments shall not be made until contractual deliverable(s) are received and accepted by the State.

B. TAXES (Statutory)

The State is not required to pay taxes and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

C. INVOICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MJ			

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Invoices shall be sent to Department of Health and Human Services, Office of Emergency Health Systems, 301 Centennial Mall S, PO Box 95026, Lincoln, NE 68509-5026. Invoices to included project being billed for. Payment should be subject to DHHS approval of deliverables. The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

D. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MJ			

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

E. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MJ			

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. (Neb. Rev. Stat. Section 73-

506(1)) Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date of the contract, and the Contractor hereby waives any claim or cause of action for any such services.

F. LATE PAYMENT (Statutory)

The Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408).

G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MS			

The State's obligation to pay amounts due on the Contract for a fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

H. RIGHT TO AUDIT (First Paragraph is Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
MS			

The State shall have the right to audit the Contractor's performance of this contract upon a 30 days' written notice. Contractor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. The State may audit and the Contractor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Contractor shall make the Information available to the State at Contractor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Contractor so elects, the Contractor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Contractor be required to create or maintain documents not kept in the ordinary course of Contractor's business operations, nor will Contractor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to Contractor.

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one-half of one percent (.5%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Contractor, the Contractor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety days of written notice of the claim. The Contractor agrees to correct any material weaknesses or condition found as a result of the audit.

5c. Final Report Examples

I. Colorado DPHE Emergency Medical and Trauma Services Standardized (Regional) Needs Assessment (June 2009)
II. Colorado DPHE Emergency Medical and Trauma Services Standardized (Regional) Needs Assessment (December 2010)
III. Colorado DPHE Emergency Medical and Trauma Services Standardized (Regional) Needs Assessment (July 2010)

I. Colorado DPHE Emergency Medical and Trauma Services Standardized (Regional) Needs Assessment (June 2009)

Colorado Department of Public Health and Environment
Emergency Medical and Trauma Services

Standardized (Regional) Needs Assessment Project

Central Mountains
Regional Emergency Medical and Trauma Advisory Council (CMRETAC)
Final Report

A report from:

The Abaris Group
Walnut Creek, CA

June 2009

Colorado Department of Public Health and Environment
Emergency Medical and Trauma Services

Standardized (Regional) Needs Assessment Project
Central Mountains RETAC

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Executive Summary

The Abaris Group conducted a needs assessment of the Central Mountains Regional Emergency and Trauma Advisory Council's (CMRETAC) Emergency Medical and Trauma Services (EMTS) system beginning in May 2009 and concluding in June 2009. The assessment included on-site visits and interviews with the CMRETAC stakeholders, the use of two surveys; the standardized Benchmarks, Indicators, and Scoring (BIS) survey instrument and a problem ranking survey. The comments from the on-site assessments and town hall were formatted into a Strengths, Weaknesses, Opportunities and Threats (SWOT) format and the data from the two surveys was entered into several spreadsheets for analysis. This report contains the results of the needs assessment and recommendations for the CMRETAC's consideration to enhance the EMTS system in Central Mountains.

Twenty CMRETAC EMTS stakeholder agencies participated in the assessment process, including representation from ambulance services, fire departments, hospitals, trauma centers, clinics, and emergency management agencies. Eleven BIS surveys were returned and 10 problem ranking surveys were completed. The data from the surveys was incorporated into several spreadsheets for analysis, including average scores, frequency, and proportion for each question or issue.

The CMRETAC has good participation and cooperation between board members and stakeholder agencies. This will provide the foundation to implement the opportunities and recommendations provided in this report. Some of the major recommendations are a regional medical direction program, consolidated and contiguous disaster planning, formalized injury prevention programs that can be replicated by any agency, coordinated regional training to minimize duplication of efforts, and utilizing existing EMTS data to implement regional CQI programs.

The BIS survey instrument revealed high scores in the areas of integration of health services, legislation and regulation, system finance, and clinical care. Lower scores were indicated for EMTS research, mass casualty, prevention, and information systems.

Per the problem ranking survey, the most challenging issues are the administrative support and medical direction involvement. The least challenging issues included billing/accounts receivable.

The recommendations for the CMRETAC include both short-term and long-term activities. The CMRETAC members should review and prioritize them for the region. Inclusion of these activities into the 2009 biennial plan is highly suggested.

Background and Project Overview

In September 2008, the EMTS Section within the Health Facilities and Emergency Services Division of the Colorado Department of Public Health and Environment (CDPHE) notified The Abaris Group of its intent to award to the firm a contract to conduct comprehensive assessments of the EMTS systems of 11 Regional Emergency medical and Trauma Advisory Councils (RETACs) of Colorado over the next three fiscal years, anticipating three or four assessments may be completed each fiscal year. Colorado Revised Statute (CRS), 25-3.5-704 (2) (c) (II) (F), requires "The identification of regional EMTS needs through the use of a needs-assessment instrument developed by the department; except that the use of such instrument shall be subject to approval by the counties and city and counties included in a RETAC." The EMTS Section, in partnership with Colorado's RETACs, established a task force to address a Standardized, regional Needs Assessment Project (SNAP). The goal of this project is to support each of Colorado's RETACs in completing an assessment process as required by statute, but, more importantly, to assess local and regional EMTS in a way that provides consistent results that can be the basis for future development of biennial plans that addresses those needs and accurately identify the policies and resources necessary to meet the future system requirements.

In 2006, the Western RETAC completed a comprehensive assessment that was funded through a grant from the Department of Local Affairs (DOLA). A requirement of the DOLA grant was that all assessment tools, products and processes of the Western RETAC model would be made available to the RETACs across the state of Colorado for possible standardization and replication. The SNAP Task Force reviewed the Western RETAC model which used on-site assessments of the RETAC stakeholders, a problem ranking survey, and an assessment instrument that included BIS sections based on the 15 trauma/EMS components identified within the Colorado Administrative Code. The SNAP Task Force modified the BIS assessment instrument to measure Colorado's EMTS system development from a RETAC perspective. (For more information on the BIS instrument, read the WRETAC final report available on the EMTS website.)

In collaboration with staff from EMTS and the SNAP Task Force, three RETACs were identified for the first-year assessment. The selected RETACs included:

- Southern Colorado RETAC
- Central Mountains RETAC
- San Luis Valley RETAC

The award of this contract was delayed until mid-January 2009 and The Abaris Group was able to start work on this project in April 2009.

Methodology

The methods utilized for the CMRETAC assessment consisted of the following:

- Review of documents – Several CMRETAC documents related to the EMTS systems in Colorado, including relevant CRS, 2007 biennial plan, agency profiles, meeting minutes, website, and the budget were reviewed.
- Development of RETAC specific questions – The BIS instrument is designed to accommodate one question specific to the RETAC in each of the 15 Colorado trauma/EMS components. CMRETAC specific questions were provided to The Abaris Group for inclusion on the BIS instrument.
- Attend CMRETAC Meeting – The Abaris Group attended the CMRETAC meeting prior to the on-site assessments, presented an overview of the SNAP, and introduced the BIS instrument and problem ranking survey to the CMRETAC Board members.
- Distribution of BIS and Problem Ranking Survey – The BIS instrument and problem ranking survey were provided to the CMRETAC stakeholders via email, its website, and in person.
- On-site Assessments – In collaboration with the CMRETAC coordinator, The Abaris Group met with a sampling of the CMRETAC stakeholders. A SWOT analysis of the CMRETAC was performed with the information provided by the CMRETAC's stakeholders.
- Tabulation and Analysis of BIS and Problem Ranking Survey – The returned, completed BIS data and problem ranking surveys were entered into a database. The BIS scoring and problem rankings were analyzed.
- Conclusions and Recommendations – Based on the data from the on-site assessments as well as the BIS and problem ranking survey, conclusions and recommendations for CMRETAC system improvements were identified.
- Draft Report – A draft report with conclusions and recommendations was submitted to the CMRETAC for confirmation of factual data.
- Presentation of the Final Report – The final report will be presented to the CMRETAC Board.

Overview of the CMRETAC

The CMRETAC consists of six counties; Chaffee, Eagle, Lake, Park, Pitkin, and Summit. The CMRETAC Board of Directors is composed of six directors, one from each county and a paid, full-time coordinator. The board has a president, vice-president, and a secretary/treasurer. CMRETAC meetings are held the second Thursday every month to two months. The CMRETAC meetings are well attended by the board members and stakeholders.

The CMRETAC coordinator acts as a liaison between the RETAC and various state entities, including the CDPHE and State Emergency Medical and Trauma Services Advisory Council (SEMTAC), other RETACs as well as other agencies or organizations that affect the concerns and decisions of the CMRETAC.

The CMRETAC EMTS system consists of 28 primary agencies consisting of:

- 13 transport agencies

- 6 dispatch centers
- 3 Level III trauma centers/hospitals
- 2 Level IV trauma centers/hospitals
- 2 Level V trauma centers/clinics
- 2 hospitals

Other agencies include first responders, fire departments, law enforcement, public health, and emergency management. Staffing of CMRETAC EMTS agencies includes either paid and volunteer personnel or a combination of the two.

CMRETAC On-site Activities

The Abaris Group attended the CMRETAC meeting on May 14, 2009. At that meeting, an overview of the SNAP was provided and the BIS and problem ranking survey were introduced to the board members and stakeholders in attendance.

On-site assessments were conducted on May 14 – 15. The assessments consisted of traveling to a sampling of the above agencies/organizations' primary place of business or a mutually agreed upon location and interviewing one or more representatives. Participants were asked questions regarding their organization and the CMRETAC, including a SWOT analysis of both. The results are included in this report.

The following agencies/organizations participated in the site visits:

- Breckenridge Medical Clinic
- Chaffee County EMS
- CMRETAC (President, Treasurer, and Coordinator)
- Eagle County Ambulance District
- Heart of the Rockies Regional Medical Center
- Red, White, & Blue Fire Protection District
- South Park Ambulance District
- St. Anthony Keystone Medical Clinic
- St. Anthony Summit Medical Center
- St. Vincent Hospital and EMS District
- Summit County Ambulance Service
- Vail Valley Medical Center

A Town Hall meeting was conducted on June 11, 2009. A SWOT analysis methodology was used to stimulate discussions. Notes were taken during the meeting and are summarized in this report. Similarly, those stakeholders that were unavailable to meet during the site visit or the town hall, were interviewed by phone and comments incorporated into the report.

Representatives from the following agencies/organizations were in attendance at the Town Hall meeting:

- Aspen Ambulance District
- Aspen Valley Hospital
- Basalt & Rural Fire Protection District
- Breckenridge Medical Clinic
- Breckenridge Ski Patrol
- Burning Mountain Fire Department
- CDPHE
- Chaffee County EMS
- CMRETAC (President, Treasurer, and Coordinator)
- Eagle County Ambulance District
- Heart of the Rockies Regional Medical Center
- Red, White, & Blue Fire Protection District
- Snowmass-Wildcat Fire Protection District
- St. Anthony Keystone Medical Clinic
- St. Anthony Summit Medical Center
- St. Vincent Hospital and EMS District
- Summit County Ambulance Service
- Ute Pass Ambulance District
- Vail Valley Medical Center
- Western Eagle County Ambulance District

Some stakeholders were unable to meet in person or at the Town Hall. Phone interviews were conducted to ensure representation in the report:

- Pitkin County Emergency Management
- Park County Emergency Management
- Summit County Emergency Management

On-site SWOT Analysis

There were on-site interviews with representatives of 12 CMRETAC EMTS agencies/organizations. There were 20 CMRETAC EMTS agencies/organizations represented at the Town Hall meeting and another 3 through phone interviews. Overall, either through individual interviews or by attending the Town Hall, input was received from 23 CMRETAC EMTS agencies and organizations. The comments from the interviews and Town Hall meeting were organized into the following format and are summarized below:

Strengths

- CMRETAC Board – Tenure, experience, consistency, and diversity of board members
- Networking – The very existence of the RETAC promotes an informal network for EMS and hospital providers to share information with one another with no one seeing it as competition
- Injury Prevention – Conducted as semi-regional programs, especially between hospitals and clinics, with a strong emphasis on helmet use in all activities
- Trauma Data – All trauma centers, even Level IV/Vs, report their registry data electronically
- Medical Clinics – The clinics at the ski mountains are operated at a Level IV trauma center standard; Colorado refers to them as Level V as they are not open year-round
- Mutual Aid – The CMRETAC system providers are all committed to and provide mutual aid whenever it is necessary
- Dispatch – Many counties have consolidated dispatch centers that centralize 9-1-1 call processing and resource management
- Service Areas – CMRETAC has no gaps in service in its region
- Ambulance Tax District - South Park Ambulance District is an excellent example of a well-funded, rural EMS service providing ALS level care; other agencies could utilize South Park's model to improve their own situations
- Hospital Inter-facility – The region has done an excellent job of allowing paramedics to transport patients to Denver or Colorado Springs hospitals without requiring a hospital nurse to accompany the patient
- Trauma Nurse Meetings – The trauma nurse coordinators meet regularly to discuss their programs and share ideas; Level V actively participate in trauma peer review for cases they transferred

Weaknesses

- Geography – Significant isolation challenges between agencies due to extreme mountain terrain and super-rural region
- Medical Direction – There are currently multiple medical directors covering the first responder and ambulance providers with little coordination
- Radio Communications – Not all agencies are using the same radio frequencies and cannot communicate during a major incident or mutual aid request

- All Hazards Region – The CMRETAC is different than the All Hazards region, but have overlapping priorities, grant opportunities, and demands on stakeholder participation with each organization sometimes creating a duplication of efforts
- Polarized Diversity – Three of the counties are very well financed and the remaining three struggle to meet their needs
- Air Transportation – EMS helicopters are often grounded due to poor weather causing significant delays in reaching Level I and II trauma centers as well as STEMI Receiving Centers; CDPHE implemented a rotation system for air providers, yet some helicopters cannot reach the CMRETAC hospitals due to altitude causing delays in patient care
- EMS Data – At one time, all ambulance providers used the same software; that vendor left the industry and the result is a conglomeration of different systems that cannot produce comparable data
- Training – Current approach is segmented by agency or county, leading to duplication of classes
- Fire Departments – Unless they transport, not usually represented at CMRETAC meetings

Opportunities

- Medical Direction – Regional medical direction, possibly underneath a regional medical coordinator, to standardize protocols and ensure clinical oversight (look at SCRETAC for a successful model)
- Bi-Annual Plan Implementation – Ensure all action items are developed and tracked through regular review at regional meetings to prevent items from being overlooked
- Pre-made Projects – Consider creating and posting online successful projects that can be easily reproduced by other agencies, such as injury prevention
- Data Driven Quality Improvement – Develop a program to define goals and objectives, track patient care, and produce effective policies and protocols; the CMRETAC should attempt to obtain its EMTS data that the state is already collecting
- Radio Communications – All pre-hospital and hospital providers should be using a standard radio system, such as 800Mhz
- Air Transportation – Request an exemption from current CDPHE policy of rotating helicopter providers due to high altitude requirements that only certain providers can achieve
- Regional Events – The CMRETAC experiences a significant number of special events that cross multiple agency and county borders; a coordinated approach should be utilized to streamline the process, provide uniform communication, and ensure all agencies are notified of the events
- Trauma Data – Existing trauma registry software needs to be upgraded for enhanced reporting capabilities; $6,000/center
- Trainer Networking – Invite training coordinators to one or two CMRETAC meetings annually to improve networking and sharing of programs and ideas
- Regional Training – Develop regional training calendar for all agencies to consolidate and not overlap training; possibly posted/coordinated by CMRETAC
- Patient Tracking – Implement a system to track EMS patients into the hospital(s) and through to discharge for better outcome data that can drive future EMS protocols

- County Funding – Instead of providing a set amount (e.g. $15,000) to each county annually, have the county apply for the funds and allow CMRETAC to evaluate the application to ensure it is for EMTS needs
- Meeting Locations – Rotate meetings throughout the various counties and have each "host" agency provide a short presentation on its history and services

Threats

- Training – Nurse and paramedic training are only available in Eagle County requiring significant travel and commitment (Southern CMRETAC often uses training classes in the Southern Colorado RETAC); EMT certification is not as challenging; recertification and continuing education are available locally
- Recruitment & Retention – Significant concerns for Park, Chafee & Lake counties as well as resort/seasonal communities
- MCI Planning – All counties and agencies have different Multi-Casualty Incident (MCI) plans that will cause problems during a disaster
- Hospital Inter-facility – CDPHE severely limits what medications paramedics can transport between hospitals; serious challenge with rural and critical access hospitals that don't have a nurse to send with the ambulance (i.e. what works in Denver Metro is not applicable in CMRETAC)
- Authority – RETAC has no statutory power to direct or enforce EMS guidelines and policies
- Succession – Some concern about what would happen if two or more counties left the CMRETAC and it dissolved
- Funding – Current economic environment will limit growth of services and effectiveness, especially in poorer counties

Benchmarks, Indicators, and Scoring (BIS) Instrument – Results, Analysis, and Recommendations

This section of the report contains the analysis of the BIS instrument including both the agency/facility scores and the system (CMRETAC) scores. There were a total of 11 completed BIS surveys returned – 4 hospital providers, 4 pre-hospital providers, 2 emergency managers, and 1 respondent did not fill in the demographic information. One hospital provider did not answer any of the systems questions, but did respond to the agency and RETAC questions and so those scores were included in the analysis. The remaining 10 respondents who did score the systems questions more frequently responded with a zero, indicating they "don't know." There also appeared to be relatively equal scoring across provider types for both the agency and system scores. Overall, the respondents most frequently rated the survey items with scores of four or five, but there were also some occasions when opinions were highly divided.

Integration of Health Services

The majority of participants felt that both their agency and system participated in a regional committee that meets regularly, but disagreed as to the extent and the multi-disciplinary composition of the group. Respondents also indicated that their agencies' communication to stakeholders is articulated in the system plan, but that no policies were written and that they only periodically review system integration.

The majority of respondents felt that the system has policies and procedures in place to communicate changes with stakeholders, but was fairly divided over the review of its activities. Over one-quarter of respondents felt that the system had a plan, but no method to measure the progress.

Participants were also divided regarding the CMRETAC's activities, with 27.3 percent claiming that there is an informal/sporadic integration process, 27.3 percent claiming that there is a multidisciplinary reactionary group, and 27.3 percent claiming that a multidisciplinary group regularly reviews system plans and continuously improves efforts.

Recommendations

- Encourage participation of law enforcement, dispatch centers, public health, and fire departments
- Establish standing or ad-hoc committees under the CMRETAC for each of the underrepresented disciplines to address their specific issues in relation to the overall CMRETAC
- Create a method to measure the CMRETAC activities and clearly communicate the review and results to the CMRETAC stakeholders

EMTS Research

The vast majority of respondents claimed that neither their agency nor system participated in research or had a policy regarding research efforts. However, there were still 36.4 percent who believed that their agency and system at least had policies that allow participation in research. Between one-quarter and one-third of respondents stated that they had no knowledge of the system's policies or participation in

research efforts. Lastly, one-third of participants had no knowledge of the RETAC's efforts, while one-quarter stated that the RETAC was not involved.

Recommendations

- Determine areas of interest and topics for system research
- Establish a data collection committee regarding system research topics
- Encourage system stakeholders to participate in system research
- Collaborate with hospitals and educational institutions to conduct system research in areas of mutual interest
- Publish and share the results of system research with stakeholders

Legislation and Regulation

Participants overall scored their agency and system's legal and regulatory compliance with high marks. Almost all, 81.8 percent, stated that their agency demonstrates full compliance and maintains proper documentation. Furthermore, 45.5 percent believed that their agency regularly surpasses legal/regulatory requirements and has regular third-party reviews its operations. Notably, 45.5 percent also felt that their agency was in full compliance and did not necessarily surpass expectations.

Most respondents claimed that their system is mostly or completely in compliance with laws/regulations and that their decision-making and operations typically meet or exceed expectations. Fewer respondents agreed regarding third-party reviews of their systems operations and over one-quarter were unaware of any system operation reviews.

A majority, 81.8 percent, was convinced that the CMRETAC regularly reviews and updates its policies to ensure compliance, but did not believe that the CMRETAC regularly arranged for third-party reviews.

Recommendations

- Review current bylaws and ensure the board of directors is in compliance or amend as appropriate
- Develop a mechanism to communicate to system stakeholders the CMRETAC's compliance to laws and regulations
- Arrange for an expert, third-party review of its plan, policies, and conduct that ensure compliance with all laws, rules, bylaws, and contracts, possibly through the CDPHE EMTS Section

System Finance

A resounding majority stated that their agency finance data and planning was more than adequate. Approximately 54.5 percent stated that their financial data was collected and analyzed, but not benchmarked, while 27.3 percent felt that the data was benchmarked. Almost all, 81.8

percent, stated that reports and budgets are approved by the governing body and progress against the budget is regularly monitored. Also, 54.5 percent stated that planning was conducted, priorities were identified, linked to the budget, and revenue sources were identified. Another third did not feel that revenue sources were identified or allocated.

Many respondents did not know of the system's financial plans or operations; when they did, they most often responded similarly to their agency financial operations. More than one-third felt that the budget process was thorough and regularly reviewed; more than one-quarter thought that planning and priorities were linked to the budget and revenue sources were identified.

Almost two-thirds of respondents stated that the CMRETAC involves staff in the annual budget and provides regular performance monitoring.

Recommendations

- Develop a benchmarking tool through a standard template that agencies can use to collect financial and operational data, including the cost to provide services, appropriate charges, collection, and reimbursement data
- Provide the CMRETAC financial data, including the annual operating budget and monitoring reports to system stakeholders on a regular basis

Human Resources

In regards to the agencies, 54.5 percent stated that there were regular recruiting programs and retention policies, while 36.4 percent stated their recruiting program was more proactive. Almost three-quarters of respondents claimed that the staff is frequently involved in feedback mechanisms and that management responds appropriately to the results. A majority also felt that there was low turnover and that they were adequately staffed, but did not maintain a pool of candidates.

Most participants could not respond to the system's human resource conditions; however, those that did claimed that the staff recruitment, retention, and feedback procedures were adequate.

Respondents appeared divided for the CMRETAC, with 27.3 percent stating that it had a capable staff, but is not viewed as a resource, while another 27.3 percent thought that the CMRETAC was a good resource for assistance.

Recommendations

- Ensure CMRETAC is seen as a resource by all stakeholders through focused communication messages and methods that best match the intended recipients

Education Systems

Most respondents stated that their agencies' education and training programs were at least adequate for their needs. More than half stated that there are ongoing educational needs based on data. Individuals were split, 45.5 percent, regarding the initial and continuing education, where some felt that it was competency-based and fit best practices, while others did not believe it had reached that goal. One-third of respondents stated that there were only monthly continuing education and annual competency evaluations, but that it does not drive education methods.

Similar to previous questions, many respondents did not know of the system's activities regarding education and training. Of those who did know, most stated that there was a structure in place that provided comprehensive education that met the standard of care.

Almost half, 45.5 percent, of the respondents claimed that the CMRETAC does not assess or evaluate regional education programs.

Recommendations

- Continue the development of the regional education and continuing education system
- Develop or formalize a standardized competency evaluation process

Public Access

The respondent opinions were somewhat mixed regarding public access in their agencies, where 63.6 percent felt there was a comprehensive communications plan with emerging technologies. Yet, 45.5 percent stated that there was merely an informal process for addressing the needs of the public. More than half of the respondents stated that there were adequate accommodations for special populations.

The majority of respondents had no knowledge of their system's public access activities; although, 36.4 percent responded that the system had a comprehensive communications plan.

Many respondents, 36.4 percent, claimed that the CMRETAC had no involvement in the communications planning, while 45.5 felt that the CMRETAC at least helped to coordinate public access efforts.

Recommendations

- Share system's communications plan with stakeholders and support individual agency plan development
- Ensure agency and system communications plans are comprehensive and contiguous with each other

Evaluation

In regards to the agencies, the majority of respondents claimed that there are computer systems for data and performance monitoring and that patient care data is collected for both internal and state use. The involvement of the medical community in evaluations was split with 36.4 percent stating that the agency has an integrated process improvement program, while 27.3 percent felt that there was no medical community involvement.

Individuals reported that their system has a computer system in place, but disagreed as to the inclusion of assessment tools. Over one-third stated that their system at least collects patient care data for statewide and internal use. Most respondents also reported that they were either in the process of or, already have in place, collaborations with the medical community on quality improvement efforts. Respondents disagreed whether the CMRETAC was partially involved in system oversight or whether they acted as a leader in evaluation efforts.

Recommendations

- Ensure the medical community is integrated into agency evaluations
- Determine what data is currently collected that can also be used to evaluate the system
- Develop a list of data components useful for system evaluation
- Develop a research and evaluation agenda with service providers, hospitals, trauma centers, and the medical community
- Develop a process improvement program to improve clinical and administrative services

Communications System

The majority of respondents appear pleased with the communications systems of their agencies, with 63.6 percent stating that there is a comprehensive plan with full integration with other agencies. Approximately 45.5 percent claimed that there are comprehensive needs assessments regarding procurement of equipment. Also, 27.3 percent said that the system has been evaluated in a multi-agency process, while a slightly greater number of respondents, 36.4 percent, felt that the agency had a rigorously tested system with annual drills.

Between 36 and 45 percent of respondents did not know of the system's efforts regarding communications systems. The few that did know were divided as to the extent of their involvement.

Similarly, respondents were divided on the RETAC's involvement in communications systems, with equal proportions reporting "don't know," "plan addresses at least half of the issues," or "plan addresses all issues, but half or less are support."

Recommendations

- Ensure regional communications plan is fully integrated
- Incorporate the communications system components in annual drills and exercises to test reliability and interoperability

- Develop a system for documenting communications system problems and failures

Medical Direction

Almost three-quarters of respondents stated that the agency medical director has a written job description, but no specific authority, and yet has implemented protocols and quality improvement programs. The remaining respondents felt that the medical director did have formal responsibilities and duties. Most respondents also felt that there were effective multi-agency protocols with proper feedback mechanisms for improvement. While most stated that there was comprehensive medical oversight with review processes, others felt that there was not adequate review or a multidisciplinary approach.

Again, most respondents were unaware of the system's activities. A few had claimed that the system has adequate medical director involvement and that there is multidisciplinary development of protocols with medical oversight.

Over half of the respondents stated that the CMRETAC does not provide technical, training, or other assistance regarding medical direction to the local agencies.

Recommendations

- Develop a system/regional medical director coordinator position and identify a funding source to pay for it
- Survey stakeholder agencies regarding their needs for medical direction
- Consolidate the many individual agency and county protocols into a standardized set for CMRETAC

Clinical Care

The majority of respondents reported that the agency clinical care systems were well-defined, comprehensive, systematically reviewed, and involved a data-driven quality improvement program.

Respondents were more divided regarding the system's involvement in each of the three items, although most were positive and indicated at least adequate protocols and involvement.

More than half of the respondents stated that the CMRETAC is currently in the process of establishing a protocol and CQI plan.

Recommendations

- Finalize the regional CQI plan
- Develop a standardized, uniform clinical documentation format or template in conjunction with regional medical coordination

Mass Casualty

The majority of respondents claimed that their agency and system have disaster system plans and cooperate in drills; however, in the case of agencies, 45.5 percent thought that the training and exercises were haphazard and siloed. Respondents mostly could not comment on the system's involvement in training and exercises. There was also disagreement regarding the frequency of drills and the extent of system review.

The RETAC reportedly only provided limited assistance in disaster planning efforts.

Recommendations

- Collect agency disaster plans and review the level of system support required for each
- Create a regional mass casualty plan in conjunction with each county's emergency managers
- Conduct regional exercises and drills based on the regional plan at least annually
- Develop an evaluation process for mass casualty exercises and drills
- Identify necessary supplies and equipment for mass casualty incidents; develop inventory, strategic placement locations, and monitoring procedures

Public Education

Respondents appear equally divided across all items regarding both agency and system public education efforts. The scoring was relatively balanced, except that for agency involvement, slightly more respondents agreed that there were no public education plans, routine contact with the public, or community support.

The respondents were equally divided regarding the CMRETAC's involvement in public education efforts, with slightly more individuals stating that it was not involved.

Recommendations

- Establish a public education committee to formalize an annual regional education plan with clear objectives
- Ensure that all stakeholders have the opportunity to participate in the regional education plan and activities
- CMRETAC should assume a supportive and coordinating role in the provision of public education through collaboration with the agencies
- Develop an annual, continuous public education campaign to promote awareness of the EMTS system, including the promotion of wellness and prevention
- Explore funding sources, including pooling of funds to support the regional public education campaign
- Develop "off-the-shelf" public education programs that individual agencies can implement

Prevention

While there was some discrepancy regarding the extent of the agencies' injury/illness prevention plans, many reported that the review systems were comprehensive and assist with improvement efforts. Many respondents did not know of any system efforts, but those that did were relatively divided as well. The CMRETAC involvement was similarly split, but a little over one-third stated that the CMRETAC has begun sharing injury/illness data.

Recommendations

- Establish an injury/illness prevention committee
- Collect data from all stakeholders and review for trends to be addressed
- Develop a coordinated comprehensive regional injury/illness prevention program

Information Systems

Respondents were mostly divided among both agency and system efforts in information systems. For agencies, most determined that the information system was robust and integrated and is sometimes used for review and oversight. There was less agreement regarding the implementation of performance and compliance measures in the system.

Most respondents could not comment on the system's involvement in information systems and those that did comment were evenly divided on each of the items. Lastly, most stated that the RETAC utilizes one or more data sources to monitor regional performance and provide feedback.

Recommendations

- Formalize the monitoring of regional performance, related feedback, and communicate with the stakeholders regularly
- Establish an information systems committee to determine what data is of interest and its availability
- Identify the key performance indicators necessary to monitor and evaluate the system
- Integrate pre-hospital, hospital, and trauma data to assess the quality of the regional EMTS system
- Use the integrated information to drive policy and protocol decisions within the CQI plan
- Provide feedback to management and providers on a regular basis

Problem Ranking Survey – Results and Analysis

The problem ranking survey asked respondents to rank ten listed issues from most challenging (1) to least challenging (10) for their specific agency or facility. The ten issues listed on the survey were:

- Administrative Support
- Aging Building/Equipment
- Cooperation with Other Agencies
- Medical Director Involvement
- Retention of Personnel
- Agency Funding/Financial Viability
- Billing/Accounts Receivable
- Initial/Continuing Education
- Recruitment of New Personnel
- Support from RETAC

There were only 10 respondents to this survey, 3 of which either did not complete or did not properly fill in their survey responses. One survey respondent did not indicate their provider type, but since the respondent filled in the survey correctly the results were included in the analysis. Therefore, only seven survey responses were utilized for the analysis. Although the low response rate affects the quantitative significance of the results, qualitative evaluations can still be utilized. Of the respondents, the majority stated that both administrative support and medical director involvement were the most challenging items. The reported least challenging item was billing/accounts receivable. Lastly, there does not appear to be congruence in the ranking among provider types.

Table A below summarizes the responses by agency/organization type.

Table A

Issue	1	2*	3	4	5	6	7	8	9	10
Administrative Support	na	10	10	6	7	8	1	1	1	9
Agency Funding/Financial Viability	na	10	8	7	8	9	7	8	3	2
Aging Building/Equipment	na	10	9	9	4	1	2	6	5	3
Billing/Accounts Receivable	na	10	7	10	na	10	5	7	2	10
Cooperation with Other Agencies	na	10	6	4	3	5	6	na	7	4
Initial/Continuing Education	na	10	1	2	5	3	4	na	4	6
Medical Director Involvement	na	10	5	1	1	4	3	na	10	1
Recruitment of New Personnel	na	6	4	8	9	7	9	na	6	8
Retention of Personnel	na	6	2	5	2	2	8	na	9	7
Support from RETAC	na	9	3	3	6	6	10	na	8	5
Hospital Providers	Pre-Hospital Providers				Emergency Management				Unknown	

* Survey not filled out correctly, na = not applicable

Table B lists the frequency of each issue by rank.

Table B

CMRETAC Problem Ranking Frequency of Each Issue by Rank										
	Frequency by Rank									
Issue	1	2	3	4	5	6	7	8	9	10
Administrative Support	3	0	0	0	0	1	1	1	1	1
Agency Funding/Financial Viability	0	1	1	0	0	0	2	3	1	0
Aging Building/Equipment	1	1	1	1	1	1	0	0	2	0
Billing/Accounts Receivable	0	1	0	0	1	0	2	0	0	3
Cooperation with Other Agencies	0	0	1	2	1	2	1	0	0	0
Initial/Continuing Education	1	1	1	2	1	1	0	0	0	0
Medical Director Involvement	3	0	1	1	1	0	0	0	0	1
Recruitment of New Personnel	0	0	0	1	0	1	1	2	2	0
Retention of Personnel	0	3	0	0	1	0	1	1	1	0
Support from RETAC	0	0	2	0	1	2	0	1	0	1

Table C lists the proportion of issue by rank.

Table C

CMRETAC Problem Ranking Proportion of Each Issue by Rank										
	Proportion by Rank									
Issue	1	2	3	4	5	6	7	8	9	10
Administrative Support	18.8%	0.0%	0.0%	0.0%	0.0%	6.3%	6.3%	6.3%	6.3%	6.3%
Agency Funding/Financial Viability	0.0%	6.3%	6.3%	0.0%	0.0%	0.0%	12.5%	18.8%	6.3%	0.0%
Aging Building/Equipment	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	0.0%	0.0%	12.5%	0.0%
Billing/Accounts Receivable	0.0%	6.3%	0.0%	0.0%	6.3%	0.0%	12.5%	0.0%	0.0%	18.8%
Cooperation with Other Agencies	0.0%	0.0%	6.3%	12.5%	6.3%	12.5%	6.3%	0.0%	0.0%	0.0%
Initial/Continuing Education	6.3%	6.3%	6.3%	12.5%	6.3%	6.3%	0.0%	0.0%	0.0%	0.0%
Medical Director Involvement	18.8%	0.0%	6.3%	6.3%	6.3%	0.0%	0.0%	0.0%	0.0%	6.3%
Recruitment of New Personnel	0.0%	0.0%	0.0%	6.3%	0.0%	6.3%	6.3%	12.5%	12.5%	0.0%
Retention of Personnel	0.0%	18.8%	0.0%	0.0%	6.3%	0.0%	6.3%	6.3%	6.3%	0.0%
Support from RETAC	0.0%	0.0%	12.5%	0.0%	6.3%	12.5%	0.0%	6.3%	0.0%	6.3%

Conclusion

The CMRETAC has adequate representation from the six counties it represents with board members that are engaged and cooperate well together. The CMRETAC president and coordinator both provide the leadership necessary to improve the EMTS system in the Central Mountains Region. The 2007 biennial plan addresses some of the needs of the CMRETAC and new priorities are currently being incorporated into the 2009 version to reflect the progress it has made in reaching its goals. The major report recommendations that should be considered at a minimum include regional medical direction and standardized protocol algorithms, consolidated disaster planning, regional training opportunities to mitigate duplication, and the use of existing EMTS data to drive CQI and other initiatives.

The BIS survey instrument revealed high scores in the areas of integration of health services, legislation and regulation, system finance, and clinical care. Lower scores were indicated for EMTS research, public access, medical direction, mass casualty, public education, prevention, and information systems.

The Problem Ranking Survey indicated that the two biggest challenges are administrative support and medical director involvement. The least challenging issue is billing/accounts receivable.

The recommendations for the CMRETAC include both short-term and long-term activities. The board members should review and prioritize the recommendations for the region. Inclusion of these recommendations into the biennial plan is highly recommended.

Central Mountains Regional Emergency Medical and Trauma Advisory Council Standardized (Regional) Needs Assessment Project Benchmarks, Indicators and Scoring (BIS)

The Colorado Department of Health and Environment Emergency Medical and Trauma Services (EMTS) Division has contracted with The Abaris Group to conduct a needs assessment of each Regional Emergency Medical and Trauma Advisory Council (RETAC) areas. This assessment will consist of on-site visits with EMTS agencies and individuals, town hall meetings and analysis of an anonymous survey completed by EMTS stakeholders. The results of the assessment will be presented to the local RETAC and the Colorado EMTS Division. Your local RETAC Coordinator will be actively involved in the assessment process.

The survey below is referred to as Benchmarks, Indicators and Scoring, or "BIS." We are asking for your input by completing the BIS prior to a meeting that will be held in your community during the on-site phase of the assessment. We also hope you will be able to attend the meeting held in your community where we will review and discuss results of the BIS scoring and provide a "town hall" like forum where you can help us understand issues and challenges facing your agency, your community and your region.

To assist us in this task we have developed Indicators and Scoring that relate to the 15 components contained in the Colorado EMTS Plan. Those components are:

1. Integration of Health Services
2. EMTS Research
3. Legislation and Regulations
4. System Finance
5. Human Resources
6. Education Systems
7. Public Access
8. Communications Systems
9. Medical Direction
10. Clinical Care
11. Mass Casualty
12. Public Education
13. Prevention
14. Information Systems
15. Evaluation

For each of the 15 "Benchmarks" there are 4 indicators that relate to Structure, Process, Outcome and the RETAC. These indicators are described as follows:

1. Structure – legislation; rules or regulations; bylaws or charter; policies and procedures or authority
2. Process – Is there a process in place to implement requirements or expectations contained in the structure indicator? If so, does the process reflect the requirements or expectations contained in the structure?
3. Outcome – Are there tools in place to measure the effectiveness of the process (e.g. data collection)? Are measurements or evaluations ongoing? Is data used to drive improvements?
4. These are Regional Emergency Medical and Trauma Council (RETAC) indicators and measure or create expectations for the RETACs that support either local EMTS agencies within the RETAC or that drive statewide improvements through RETAC representation on state advisory bodies.

For each of these indicators, we ask that you mark or circle the score that most closely reflects your knowledge of or opinion of the progress toward or compliance with each indicator. As you read through the scoring, you will see that each score, from 1 – 5 describes a rank in system development. **Remember, you are ranking your own organization within the Regional Emergency Medical and Trauma system.** If you are a rural system with limited resources you may rank low in score. This does not mean you are a "bad" system. It simply reflects the reality of your resources, be they human or mechanical. If you do not have sufficient information to mark a score, mark or circle "0" = I don't know.

Please note: **In each scoring box there are boxes for 2 separate scores.** In the box marked "**Agency/Facility Score**," please score your agency or organization. In the box marked "**System Score**" please score the overall Regional Emergency Medical and Trauma System as you perceive it. In many cases, the two scores will be different. For example, you may score your agency higher or lower disaster response capabilities than you score the overall system in your area.

During the meeting to be held in your community we will combine your score with those of your peers and other stakeholders to arrive at a consensus score. Your agency or system can use this consensus score to help drive performance improvement plans and activities. This assessment tool can be used 1, 2 or 3 years in the future to assist you in determining the growth in your system over time and to show your accomplishments in system improvement.

Please take a few minutes to complete the BIS prior to your community meeting. **Please bring the completed BIS with you to the meeting. If you cannot attend the meeting, please give the completed BIS to a colleague or supervisor so your opinion can be counted.**

If you have any questions regarding this assessment or the BIS, contact your local RETAC Coordinator, **Melody Mesmer** at 303-252-0159, or by email at melody@cmretac.org or **Ken Riddle**, The Abaris Group, at 702-287-6546, or by email at kriddle@abarisgroup.com.

Central Mountains Regional Emergency Medical and Trauma Advisory Council
Standardized (Regional) Needs Assessment Project
Benchmarks, Indicators and Scoring (BIS)

Demographical Information: (Indicate provider type and check all that apply below the provider type selected.)

__ **Pre-Hospital Provider**
__ Volunteer __ Paid
__ BLS __ ALS
__ Fire/Rescue
__ Ambulance
__ Other

__ **Hospital Provider**
__ Trauma Center Level
__ MD
__ RN
__ Administration

__ **Other Provider**
__ Law Enforcement
__ Dispatch/Communications
__ Emergency Management
__ Public Health
__ Elected Official
__ Other

Note: The word "system" in this survey is defined as the local RETAC comprised of multiple counties.

Emergency Medical and Trauma System Component (EMTS): Integration of Health Services	
1. All disciplines that influence patient care within the system work together within their regional communities as a whole to assure integration and coordination of patient care.	
Structure Indicator	*Scoring*
1.1 Your agency/facility participates in multidisciplinary planning within your regional system.	0. Don't Know 1. There is no evidence of partnerships, alliances, or working together to integrate the system. 2. There have been limited attempts to organize local groups, but to date no ongoing regional system committees meet regularly to design or implement a regional system. 3. Our agency/facility participates in a regional committee/group that meets regularly to develop and implement a comprehensive system plan. 4. Our agency/facility either brings together or participates in, a multidisciplinary EMTS group that is developing, implementing, and maintaining a comprehensive system plan. 5. Our agency/facility has brought together or participated in a stakeholder group to assist with, the development and implementation of the EMTS system, through a multidisciplinary committee. Multiple stakeholders from various disciplines are routinely recruited to participate in system operational issues and refinement depending on expertise needed (e.g., public health, public safety) and as part of a comprehensive system planning process.

Agency/Facility Score	System Score

Emergency Medical and Trauma System Component (EMTS): Integration of Health Services	
Process Indicator	*Scoring*
1 2 There is a clearly defined process to nmunicate and notify all stakeholders regarding planning efforts or changes that may affect patient care or the delivery of patient care within your region.	0. Don't Know 1. There is no defined process for communicating important issues and planning efforts that affect patient care. 2. There is an unwritten/informal process that is used when convenient, although not regularly or consistently utilized. 3. The process for communication and notification to all stakeholders regarding planning and proposed changes in the delivery of patient care is articulated within the system plan, although it has not been fully implemented. Policies are not written. 4. The process for communication and notification to all stakeholders regarding changes in patient care is contained within and guided by the system plan. There are current policies and procedures in place to notify our stakeholders regarding possible changes in patient care issues. 5. There is a clearly defined written process for notification of all stakeholders regarding changes in patient care that impact the agency/facility. The process is stated in the system plan and incorporated into the policy and procedures for the service provider. Stakeholders are actively engaged in issues affecting patient care to resolve issues and to improve the program and its integration within other health care and public safety efforts in the community and the region. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Integration of Health Services	
Outcome Indicator	*Scoring*
1.3 Your agency/facility has clearly stated goals and objectives to assure effective care of patients within the system. These goals and objectives contain all disciplines and there is a system in place to measure progress.	0. Don't Know 1. There is no plan with goals and objectives pertaining to system integration. 2. There is a plan in place for system integration, but no method to measure progress. 3. Our agency/facility leadership periodically reviews its activities related to system integration without input from various stakeholders. 4. A multidisciplinary group/committee is in place that reacts to issues that demonstrate a lack of appropriate system integration, e.g. did one agency's/facility's protocols affect another's? 5. A multidisciplinary group/committee regularly reviews our agency's/facility's progress towards the goals and objectives pertaining to system integration at the local and regional level and assists in the continuous refinement of those efforts. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS)Component: Integration of Health Services	
RETAC Indicator	*Scoring*
1 4 The RETAC conducts or coordinates activities mprove patient care through collaborative efforts among health related agencies, facilities and organizations within the region. The RETAC encourages groups involved in Emergency Medical and Trauma System (EMTS) to work with other entities (e.g. health related, state, local and private agencies and institutions) to share expertise, to evaluate and make recommendations, and mutually address and solve problems within the region.	0. Don't Know 1. There is no process to measure progress towards goals and objectives pertaining to regional EMTS integration. 2. There is an informal or sporadic process that reacts to concerns regarding lack of integration with other health care and public safety assets. 3. RETAC leadership and staff periodically reviews its activities related to system integration without input from various stakeholders. 4. The multidisciplinary RETAC stakeholders group reacts to issues that demonstrate a lack of appropriate system integration, e.g. a patient is not transported to the appropriate health care facility based on previously adopted protocols. 5. The multidisciplinary RETAC stakeholders group regularly reviews the RETAC's system wide plan and progress towards the goals and objectives pertaining to system integration at the sub-regional, regional and state level and assists in the continuous refinement of those efforts. **RETAC Score**

*Emergency Medical and Trauma System (EMTS) Component: **Research***	
2. All disciplines participate in and contribute to research efforts that increase the evidence upon which the system design is based.	
Structure Indicator	*Scoring*
2.1 Your agency/facility and stakeholders group s sufficient policies to conduct and participate system research efforts. Note: In this context, research is defined as a "systematic process of inquiry, using the scientific method, aimed at discovering, interpreting and revising facts." (as differentiated from Evaluation)	0. Don't Know 1. Our agency/facility does not conduct or participate in research efforts as no policy exists. 2. Our agency/facility does not conduct or participate in research efforts even though policies permit participation. 3. Our agency/facility has policies that allow contribution of data to research efforts. 4. Our agency/facility conduct research in collaboration with physicians and research centers to increase the evidence upon which system design, patient care and specific interventions are based. 5. Our agency/facility policies promote system research in collaboration with physicians and research centers. The data are used to analyze and improve system design, patient care and specific interventions. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS)Component: Research	
Process Indicator	*Scoring*
2.2 Your agency/facility and/or stakeholders up cooperate to conduct and participate in system research efforts. Research efforts may include collaboration with social scientists, economists, health services researchers, epidemiologists, operations researchers, and other clinical scientists.	0. Don't Know 1. Our agency/facility does not conduct research. 2. Our agency/facility conducts limited local research but does not cooperate on research projects of broader scope. 3. Our agency/facility participates in or conducts cooperative research. 4. Our agency/facility supports (e.g. through upgrades in computer technology or dedicating staff time) research as the basis for clinical and operational practices, and some providers become active participants in the research process. 5. Our agency/facility is actively involved in conducting cooperative research that involves internal and external stakeholders and research centers or qualified scientists. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Research	
Outcome Indicator	*Scoring*
2.3 Your agency/facility is integrated with external stakeholders in creating, applying and publishing research projects.	0. Don't Know 1. Our agency/facility does not contribute to research projects. 2. Our agency/facility contributes to research projects. 3. Our agency/facility contributes to, evaluate and apply appropriate research results. 4. The efforts of system professionals, delivery systems, academic centers and public policy makers are organized to support and apply research. 5. The efforts of system professionals, delivery systems, academic centers and public policy makers are organized to support, implement evidence-based practices and publish the results of research in peer reviewed journals. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Research	
RETAC Indicator	*Scoring*
2.4 The RETAC leads or coordinates efforts to determine the effectiveness and efficiency of the Emergency Medical and Trauma System (EMTS) through research. A continuous and comprehensive effort is initiated and sustained to validate current Emergency Medical and Trauma System (EMTS) practices in an effort to improve patient care, determine the appropriate allocation of resources to prevent injury, illness, death and disability.	0. Don't Know 1. The RETAC is not involved in research planning or activities. 2. The RETAC plan makes research a future priority. 3. The RETAC has implemented a research plan that identifies and disseminates existing research findings. 4. The RETAC identifies, coordinates, implements and disseminates research efforts and results. 5. The RETAC is a research implementation catalyst by delivering technical assistance that produces research methodology content training to system participants. As a result of this technical assistance, a cadre of agency investigators works in partnership with hospitals, academic centers, policy makers, public health departments, funding sources and others as appropriate, to identify, coordinate, implement and disseminate research. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Legislation & Regulation	
3. All disciplines are in compliance with all applicable federal, state, and local laws, rules, ordinances, contracts, and/or bylaws.	
Structure Indicator	*Scoring*
Your agency/facility is in full compliance with all applicable laws, rules, ordinances, contracts, etc. that govern all aspects of their operation and maintain current copies of all relevant policies and required licenses, certifications, insurance policies, etc.	0. Don't Know 1. There is no evidence that our agency is aware of applicable laws, rules, ordinances, and contracts that govern our operation or maintains any required documentation. 2. Our agency/facility can demonstrate that it is aware of applicable laws, rules, ordinances and contracts that govern our operation but we only maintains documentation of some of the specific requirements (e.g. vehicles properly licensed, inspected, and insured) 3. Our agency/facility has committed in writing to compliance with all applicable laws, rules, ordinances and contracts, but it only maintains documentation of some of the specific requirements. 4. Our agency/facility can demonstrate compliance with most applicable laws, rules, ordinances and contracts that govern our operation and maintains documentation of most (> 50%) of the specific requirements. 5 Our agency/facility demonstrates full compliance with all applicable laws, rules, ordinances and contracts that govern our operation and our agency maintains documentation of all specific requirements. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Legislation & Regulation	
Process Indicator	*Scoring*
Your agency/facility makes decisions and operates based upon internal policies, and the applicable laws, rules, ordinances and contracts that govern operations.	0. Don't Know 1. The decision-making and operations of our agency/facility are routinely not in compliance with applicable policies, laws, rules, ordinances, and contracts. 2. The decision-making and operations of our agency/facility are sometimes not in compliance with applicable policies, laws, rules, ordinances, and contracts. 3. The decision-making and operations of our agency/facility are generally in compliance with applicable policies, laws, rules, ordinances and contracts. 4. The decision-making and operations of our agency/facility are in compliance with applicable policies, laws, rules, ordinances, and contracts. If an area of non-compliance is identified, immediate corrective action is taken. 5. The decision-making and operations of our agency/facility demonstrate that it regularly surpasses the requirements and expectations of applicable policies, laws, rules, ordinances, and contracts. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Legislation & Regulation	
Outcome Indicator	*Scoring*
Your agency/facility is reviewed periodically by objective, third-party experts, reviewers, or regulators to ensure that it functions in compliance with all applicable policies, laws, rules, ordinances, and contracts that govern its operation.	0. Don't Know 1. Our agency/facility has never had an objective external review. 2. Our agency/facility has had episodic, objective external reviews of a limited number of specific operational areas (e.g. financial audit or equipment inspection). 3. Our agency/facility has had regular objective external reviews of a limited number of operational components that include compliance with some applicable policies, laws, rules, ordinances, and contracts. 4. Our agency/facility has regular objective external reviews of a wide range of operational areas to ensure compliance with applicable policies, laws, rules, ordinances, and contracts. These reviews are then tied into timely quality improvement activities to help ensure corrective action whenever required. 5. Our agency/facility has regular objective external reviews of all operational areas to ensure compliance with all applicable policies, laws, rules, ordinances, and contracts. Such reviews have led to agency/service accreditation and re-accreditation from an independent third party such as the Joint Commission, Commission on the Accreditation of Ambulance Services or the Commission on the Accreditation of Air Medical Transport Systems. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Legislation & Regulation	
RETAC Indicator	*Scoring*
_. 4 The RETAC has developed its biennial plan according to Chapter Four of Colorado State Rules Pertaining to the Statewide Emergency Medical and Trauma Care System, and reviews its plan, policies and operations at least annually to ensure it is in compliance with its plan and state rules.	0. Don't Know 1. The RETAC does not review its plan, policies and conduct to ensure compliance with applicable laws, rules, by-laws, and contracts, 2. The RETAC sporadically reviews its plan, policies and conduct to ensure compliance. 3. The RETAC regularly reviews its plan, policies and conduct to ensure compliance with applicable laws, rules, by-laws, and contracts. 4. The RETAC regularly reviews its plan, policies and conduct to ensure compliance with applicable laws, rules, by-laws, and contracts and has a clearly defined process with time-frame expectations to ensure corrective action as needed. 5. The RETAC periodically arranges for an expert, third-party review of its plan, policies, and conduct to ensure compliance with all laws, rules, by-laws, and contracts. All findings from such a review are used as a basis for quality improvements and timely corrective actions as necessary. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: System Finance	
All disciplines are financially stable organizations with approved budgets that are aligned with the Regional EMTS plan and priorities.	
Structure Indicator	*Scoring*
4.1 Cost, charge, collection and reimbursement data are projected and collected; are compared to (benchmarked) against industry data; and, are used in strategic and budget planning.	0. Don't Know 1. Cost, charge, collection and reimbursement data are not collected. 2. Cost, charge, collection and reimbursement data are collected. 3. Cost, charge, collection and reimbursement data are collected and analyzed by internal or external finance experts. 4. Cost, charge, collection and reimbursement data are collected and analyzed by internal or external finance experts e.g. CPA, but are not benchmarked against industry data. 5. Cost, charge, collection and reimbursement data are collected and analyzed by internal or external finance experts and are benchmarked against industry data. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: System Finance	
Process Indicator	*Scoring*
4.2 Budgets are approved and based on historic and projected cost, charge, collection, reimbursement and public/private support data.	0. Don't Know 1. There is no data that can be accessed for budgetary planning purposes. 2. Data is collected but reports are not routinely generated that can be used for budget planning. 3. Data is collected and reports generated, but there is no formal budget planning process. 4. Data is collected, reports generated and there is an expense budget process, but it is not linked to revenue. 5. Data is collected, reports generated, and revenue and expense budgets are produced and approved by the governing body. Progress against budget projections is monitored throughout the budget cycle. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: System Finance	
Outcome Indicator	*Scoring*
Financial resources exist that support the planning, implementation and ongoing management of the administrative and clinical care components of your agency/facility.	0. Don't Know 1. Administrative, management and clinical care planning is not conducted. 2. Administrative, management and clinical care planning is conducted, but priorities are not identified. 3. Administrative, management and clinical care planning is conducted and priorities are identified, but are not linked to the budget process. 4. Administrative, management and clinical care planning is conducted, priorities are identified and linked to the expense budget, but revenue sources are not identified or allocated. 5. Administrative, management and clinical care planning is conducted, priorities are identified and linked to the expense budget, and revenue sources are identified and allocated. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: System Finance	
RETAC Indicator	*Scoring*
4.4 The RETAC board adopts an annual operating budget and monitors financial performance compared to the budget at least quarterly.	0. Don't Know 1. The RETAC submits an operating budget to the state but does not monitor performance compared to the budget. 2. The RETAC submits an operating budget annually for board approval and monitors financial performance annually. 3. The RETAC submits an operating budget annually for board approval and monitors performance at least twice a year. 4. The RETAC submits an operating budget annually for board approval and monitors financial performance compared to the budget at least quarterly. 5. The RETAC involves RETAC staff and leadership in development of an annual operating budget and provides detailed quarterly and annual monitoring of performance compared to the budget **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Human Resources	
5. All disciplines have sufficient capacity and ability to recruit, train, support, and maintain adequate numbers and an appropriate mix of volunteer and/or paid personnel consistent with its written plan and commensurate with identified needs within the community.	
Structure Indicator	*Scoring*
5.1 Your agency/facility has personnel recruitment and retention policies and programs to maintain adequate numbers of trained and licensed personnel (paid and/or volunteer) to meet performance standards for level of care and response times. **Formal personnel policies are reviewed regularly by your agency/facility governing authority and clearly identify expectations and responsibilities for both the agency and staff.**	0. Don't Know 1. Our agency/facility has no formal or ongoing policies or programs for the recruitment and retention of personnel. There are no personnel policies identifying the expectations and responsibilities of the agency or its staff. 2. Our agency/facility periodically organizes a program to recruit new staff on an as-needed basis. There are no personnel policies identifying the expectations and responsibilities of the agency or its staff. 3. Our agency/facility periodically organizes a program to recruit new staff on an as-needed basis. Personnel policies are informal or although written are not reviewed regularly. 4. Our agency/facility has a regular program to recruit new staff as needed and also has an ongoing program to retain current staff through formal process and providing supportive and improved incentives as appropriate. Personnel policies are written, reviewed, and updated regularly. 5. Our agency/facility maintains optimal staffing levels through a pro-active recruitment and retention program that provide benefits and incentives to help ensure staff satisfaction and stability. Personnel policies are written, regularly reviewed, clearly communicated and fairly applied. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS)Component: Human Resources	
Process Indicator	*Scoring*
5.2 Standardized feedback processes reflect that personnel understand applicable policies and procedures and demonstrate awareness of accessibility to required and advanced training, leadership opportunities, and stress management services as needed.	0. Don't Know 1. There are no regular opportunities for staff feedback. 2. Feedback is informally requested from staff on a limited and/or episodic basis with no commitment towards utilizing the results for positive change. 3. Staff is invited to provide feedback on a regular basis, but it is limited to specific issues identified by management and there is no expectation for a response from management. 4. Staff is invited to provide feedback/input on a wide variety of topics, including working conditions, personnel policies, training needs, etc. There is no expectation for a response from management 5. Staff is regularly surveyed and/or invited to provide feedback/input on a regular basis on a wide variety of topics. Management commits itself to acknowledging the feedback/input and explaining its responses and decisions as appropriate. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Human Resources	
Outcome Indicator	*Scoring*
[illegible] Your agency/facility is fully staffed. All [illegible]sonnel understand policies and their job duties/ responsibilities. Staff indicates that they have input into operational decisions, and have reasonable access to needed equipment, supplies, training, and support.	0. Don't Know 1. Our agency/facility is constantly under-staffed and excessive turnover is an ongoing problem. 2. Our agency/facility is periodically under-staffed due to turnover. 3. Our agency/facility is usually able to maintain an adequate staff to perform the mission, but turnover and recruitment of new personnel is a challenge. 4. Our agency/facility has low turnover and is able to recruit personnel as needed to fill any gaps. Personnel indicate that they are satisfied with working conditions and personnel policies. 5. Our agency/facility maintains a pool of candidates to fill any vacancies in a timely manner. The staff indicates high satisfaction with their working conditions, input into decision-making, and access to equipment, training, and supportive services. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS)Component: Human Resources	
RETAC Indicator	*Scoring*
5.4 Its stakeholders and organizational members view the RETAC as a source of technical assistance and support to improve Emergency Medical and Trauma System (EMTS) related human services capability and functioning within [illegible] region through policy development, medical, [illegible]hnical and leadership training, and facilitating access to supportive services like critical incident stress management. Provider recruitment and retention challenges identified in RETAC assessments are prioritized accordingly in the biennial plan.	0. Don't Know 1. The RETAC experiences high stakeholder turnover and staff instability. The RETAC is not viewed as a resource to improve and enhance agency-related human services in the region. 2. The RETAC has a capable and stable staff, but is not viewed by its stakeholders and organizational members as a resource to improve and enhance agency-related human services in the region. 3. The RETAC provides some support to stakeholders and member organizations regarding staffing challenges, personnel policies, and access to needed agency-related training. 4. The RETAC is viewed as a key resource for technical assistance and support with human resources matters and as a source of training opportunities by its stakeholders and organizational members. 5. The RETAC is highly skilled in human resources matters and regularly provides related technical assistance and support to stakeholders and organizational members. The RETAC provides, facilitates, and supports a wide range of technical, medical, leadership and personal growth/wellness training opportunities. The RETAC ensures access to CISM services as needed. **RETAC Score**

Emergency Medical and Trauma System (EMTS)Component: Education Systems	
6. All disciplines provide appropriate, competency based education programs to assure a competent work force.	
Structure Indicator	*Scoring*
Your agency/facility has written educational requirements and a structure in place to provide education and maintenance of clinical skills consistent with state and national levels of training.	0. Don't know 1. Our agency/facility has no written policy regarding education and continuing education requirements. 2. Our agency/facility has written policies regarding minimum education requirements but has no structure in place to support those policies. 3. Our agency/facility has written policies regarding minimum education and requirements and has a structure in place to provide some education and skill maintenance for its employees. 4. Our agency/facility has a structure in place to provide the educational needs of its employees. 5. Our agency/facility bases its education and continuing education programs on local data as well as national standards and evidence. There is a process in place to provide for the on-going educational needs of the employees. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Education Systems	
Process Indicator	*Scoring*
Your agency/facility provides initial and continuing education programs with competency testing, consistent with state and national recognized levels of care.	0. Don't know 1. Our agency/facility provides no initial or continuing education to its employees. 2. Our agency/facility provides some initial and continuing education for its employees. 3. Our agency/facility provides for a program of initial and continuing education to its employees 4. Our agency/facility provides a comprehensive program of initial and continuing education for its employees consistent with state and nationally recognized levels of care. 5. The agency provides for competency-based initial and continuing education consistent with state and nationally recognized levels of care. Continued competency is assured by periodic testing. Training programs are based on current best practices and are supported by distance learning resources. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Education Systems	
Outcome Indicator	*Scoring*
6.3 Your agency/facility measures the effectiveness of its continuing education program by evaluating competency on a regular basis and bases continuing education and remedial education on structured performance improvement processes.	0. Don't know 1. There is no evaluation or measurement of the adequacy or effectiveness of initial or ongoing education programs. 2. Clinical or field procedural problems are occasionally addressed in continuing education programs. There is no regular, consistent evaluation of competency. 3. Monthly continuing education is provided and individual competency is measured at least annually. 4. Monthly continuing education is provided based on regular competency evaluations. Quality improvement information is available but does not drive continuing education methods or content. 5. There is a regular, consistent measure of competency. Continuing education programs are integrated with competency assurance and driven by service quality improvement programs with input from the service provider medical director. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Education Systems	
RETAC Indicator	*Scoring*
6.4 The RETAC assesses the quality and accessibility of education and training for all providers within the Emergency Medical and Trauma System (EMTS) and documents efforts to coordinate and evaluate programs to ensure they meet the needs of the Emergency Medical and Trauma System (EMTS).	0. Don't know 1. The RETAC does not assess or evaluate education programs within the region 2. The RETAC assesses the availability of education programs within the region. 3. The RETAC assesses the availability and quality of education programs within the region. 4. The RETAC provides some coordination to ensure education programs meet the needs of the EMTS system. 5. The RETAC provides coordination with local, regional and state education resources to ensure education programs meet the needs of the EMTS system. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Public Access	
7. The public has reliable, robust and redundant access to a system that can dispatch appropriate resources promptly and accurately to the location of the patient and provide potential lifesaving services prior to their arrival. Access should be universally available regardless of incident location, socio-economic status, age, or special need and an integral part of the Regional EMTS plan.	
Structure Indicator	*Scoring*
7.1 There is a universal access number for citizens to access the system, with dispatch of appropriate medical resources in accordance with a written plan. The dispatch system utilizes Enhanced-9-1-1 and Wireless-9-1-1 technologies and provide pre-arrival medical instructions to callers **The universal access number is part of a central communications system and plan that ensures bidirectional communication, inter-facility dialogue, and disaster communications among all system participants.**	0. Don't Know 1. There is no 911 system in place. 2. There is a 911 system in place but it does not offer emergency medical dispatch. 3. There is a 911 system in place that also offers emergency medical dispatch. 4. The agency has adopted a communications plan that was developed with multiple stakeholder groups, and endorsed by those agencies, including emergency medical dispatch. However, the integration of Enhanced-911, Wireless-911 and other emerging technologies are not included. 5. A comprehensive communications plan has been developed, and adopted in conjunction with stakeholder groups, including emergency medical dispatch. It also includes the integration of Enhanced-911, Wireless-911 and other emerging technologies. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Public Access	
Process Indicator	*Scoring*
7.2 An assessment of the needs of the general public and their ability to access the system has been conducted and the results integrated into the system plan.	0. Don't Know 1. There is no routine or planned contact with the general public. 2. Contact with the public is addressed when system failures occur. 3. Information has been informally gathered from the general public. However, no formal process is in place to address their needs. 4. The general public has been formally asked about the ability to access the system however changes have not been made to the system or to the systems plan. 5. General public needs have been identified and integrated into a plan and changes are routinely made to increase the public's ability to access the system in a timely manner. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Public Access	
Outcome Indicator	*Scoring*
7.3 Our community's special populations (e.g., language, socially disadvantaged, migrant/transient, remote, rural, and others) have access to the system.	0. Don't Know 1. There has been no consideration of the needs of special populations to access patient care within the system. 2. The system and stakeholders are beginning to consider the needs of special populations. 3. The system has identified the special populations that may require special accommodations to access the system. 4. The system has accommodations for special populations that allow them to effectively access the system. 5. The system has accommodated the needs of special populations that allow them to effectively access the system. Routine monitoring, review, and reporting of these populations are incorporated into the evaluation of system effectiveness. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Public Access	
RETAC Indicator	*Scoring*
7.4 The RETAC supports the development of efficient public service access points and emergency medical dispatch throughout the region through programs involving collaboration, resource sharing and technical support. Additionally, it supports policy change at state and regional levels to ensure that goals pertaining to timely and efficient dispatch across the entire region can be achieved.	0. Don't Know 1. The RETAC is not involved in regional communications planning. 2. The RETAC is a stakeholder in regional efforts to develop efficient and effective communications and dispatch models. 3. The RETAC coordinates efforts to dispatch resources and emergency providers to assure that appropriate and timely care is provided for medical emergencies within the region. 4. A regional communications plan, including citizen access and emergency medical dispatch is in place but is not formally monitored or evaluated. 5. A regional communications plan, including citizen access and emergency medical dispatch is in place and is evaluated and revised at least annually. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Communications Systems	
8. All disciplines are able to transmit and receive electronic voice and data signals between its own agency assets, between the agency and other community stakeholders, and between the agency and regional/state response partners.	
Structure Indicator	*Scoring*
8.1 Your agency/facility has worked with local/regional stakeholders to develop and adopt a communications plan to enhance all voice and electronic data transmissions at all levels to improve the delivery of emergency services	0. Don't Know 1. There is no system communications plan, and one is not in progress. 2. Draft elements of a formal communication plan are in place but not formalized o are under development. 3. Our agency/facility has adopted a system communications plan. However, the plan has not been endorsed by multiple stakeholder organizations. 4. Our agency/facility has adopted a communications plan that was developed with multiple stakeholder groups, and endorsed by those agencies. However, issues of integration and inter-operability have not been fully resolved. 5. A comprehensive system communications plan has been developed, and adopted in conjunction with stakeholder groups and includes full integration and interoperability between communications assets of all agency, health care, public safety and public health assets at local, sub-regional, regional and state levels. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Communications Systems	
Process Indicator	*Scoring*
8.2 Your agency/facility's purchases and configurations of communications equipment are coordinated to standardize the equipment at the local, regional and state level.	0. Don't Know 1. Needs assessments are not conducted prior to communications equipment upgrades. 2. Needs assessments are conducted and procurement needs identified but are not coordinated with other agencies, jurisdictions, or disciplines. 3. Needs assessments are conducted and procurement needs are coordinated with other agencies, jurisdictions, and disciplines. However, the results are not used to guide investment in communications infrastructure improvement. 4. Needs assessments are conducted and procurement needs are coordinated with other agencies, jurisdictions, and disciplines. 5. Comprehensive system communications needs assessments are conducted, procurement needs are coordinated and the results are used to guide investment in communications infrastructure improvement at community, sub-regional, regional and state levels. This has resulted in efficiencies and economies across the EMTS communications system. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Communications Systems	
Outcome Indicator	*Scoring*
• 3 The communications system is routinely luated and tested to ensure its reliability, redundancy and interoperability during routine applications.	0. Don't Know 1. The communications system is not evaluated for its reliability, or redundancy. 2. The communications system has been evaluated at a local level and issues of reliability within the agency have been addressed within the system's primary service response area. 3. The communications system has been evaluated at a local level through a multi-agency process and issues of reliability have been addressed by all agencies within the system's primary service response area. 4. The communications system has been evaluated at a regional level through a multi-agency process and issues of reliability have been addressed by all agencies within the system's primary service and mutual aid response areas. 5. The local, regional and state communications system are rigorously tested at least annually in drills, simulations and real events (routine and multi-agency) and issues involving reliability, redundancy and interoperability have been addressed. Back-up systems have also been fully exercised.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Communications Systems	
RETAC Indicator	*Scoring*
8.4 The RETAC plan includes a description of regional communications issues as outlined in the ional communications plan.	0. Don't Know 1. Plan does not address communication issues. 2. Plan addresses at least half of the issues. 3. Plan addresses all issues, but no strategies are implemented. 4. Plan addresses all issues, but half or less are supported. 5. Plan addresses all issues, and they are all supported by the RETAC.

RETAC Score

Emergency Medical and Trauma System (EMTS) Component: Medical Direction	
9. Your facility/agency has a physician medical director that has received medical director training, been recognized by the state and is actively involved in Regional EMTS issues including triage, treatment, and transport, dispatch, quality improvement, education and training.	
Structure Indicator	*Scoring*
9.1 Your agency/facility medical director has clear-cut responsibility and the authority to adopt protocols, implement a quality improvement process, and to restrict the practice of providers within the system to assure medical appropriateness within the system.	0. Don't Know 1. There is no agency/facility medical director. 2. There is an agency/facility medical director with a written job description; however, the individual has no specific time allocated for these tasks. 3. There is an agency/facility medical director with a written job description and whose specific authorities and responsibilities are formally granted. 4. There is an agency/facility medical director with a written job description, but with no specific authority. The system medical director has adopted protocols, has implemented a quality improvement program, and is taking steps to improve the medical appropriateness of the system. . 5. There is an agency/facility medical director with a written job description who has authorities and responsibilities that are formally granted. There is written evidence that the facility/agency medical director has, consistently used their formal authority to adopted protocols, implemented a quality improvement program and to fully integrate the facility/agency into the health care system **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Medical Direction	
Process Indicator	*Scoring*
9.2 Your agency/facility medical director is actively involved with the development, implementation, and ongoing evaluation of protocols to assure they are congruent with other agencies/providers. These protocols include, but are not limited to, which resources to dispatch (ALS vs. BLS), air-ground coordination, triage, and early notification of the medical care facility, pre-arrival instructions, treatment, transport and other procedures necessary to ensure the optimal care of ill and injured patients.	0. Don't Know 1. There are no protocols. 2. Protocols have been adopted, but they are in conflict with the other agencies/providers resources. 3. Protocols have been adopted and are not in conflict with other agencies/providers resources, but there has been no effort to coordinate the use of protocols between the agency and the other agencies/providers within the system. 4. Protocols have been developed in close coordination with the other agencies/providers within the system and are congruent with the local resources. 5. Protocols have been developed in close coordination with other agencies/providers within the system and are congruent with the local resources. There are established procedures to involve the appropriate dispatch, public safety and other critical stakeholder personnel and their supervisors in quality improvement and there is a "feedback link" to change protocols or to update education when appropriate. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Medical Direction	
Outcome Indicator	*Scoring*
The retrospective medical oversight of your agency/facility protocols, including but not limited to, triage, communication, treatment, and transport is accomplished in a timely manner and is closely coordinated with the established quality improvement processes within the local healthcare system.	0. Don't Know 1. There is no retrospective medical oversight procedure for communication, treatment, and transport protocols. 2. There is occasional retrospective medical oversight procedure of protocols, but it is neither regular nor timely and is often as a result of a reported breach in those protocols. 3. There is timely retrospective medical oversight procedure for protocols by the quality improvement processes of the agency/facility. 4. There is timely retrospective medical oversight of protocols that is coordinated with partners within the local healthcare system. 5. There is timely retrospective medical oversight of protocols through the system that includes a multidisciplinary review coordinated with partners in the local healthcare system. There is evidence this procedure is being regularly used to monitor system performance and to make system improvements. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Medical Direction	
RETAC Indicator	*Scoring*
9.4 The RETAC assists with appropriate local physician medical direction by providing technical assistance, training and other resources to local ergency Medical and Trauma System (EMTS) gencies.	0. Don't Know 1. The RETAC does not provide technical assistance, training or other resources to local agencies. 2. The RETAC provides technical assistance to establish or improve local medical direction when requested. 3. The RETAC monitors the provision of medical direction and provides technical assistance when necessary. 4. The RETAC provides technical assistance when necessary and makes medical direction courses and other resources available on a regularly scheduled basis throughout the region. 5. The RETAC monitors the quality of medical direction in local agencies and facilities and supports consistency of medical direction throughout the region by providing medical directors' courses and other resources **System Score**

Emergency Medical and Trauma System (EMTS) Component: Clinical Care	
10. All disciplines are integrated into a resource-efficient, inclusive network that meets required standards and that provides optimal care for all patients.	
Structure Indicator	*Scoring*
10.1 Your agency/facility has a clearly defined plan that outlines roles and responsibilities of agency/facility personnel. Evidence based written patient care protocols and guidelines are maintained and updated.	0. Don't Know 1. Our agency/facility has no plan that outlines roles and responsibilities of personnel. No written patient care protocols exist. 2. Our agency/facility has a plan that outlines roles and responsibilities of personnel, but no written patient care protocols and guidelines exist. 3. Our agency/facility has a plan and patient care protocols exist but are not reviewed and updated regularly. 4. Our agency/facility plan clearly defines the roles and responsibilities of agency/facility personnel and emergency department personnel in treatment facilities for trauma patients. Written protocols and prehospital care guidelines exist and are reviewed and updated at regularly. 5. Our agency/facility plan clearly defines the roles and responsibilities of agency/facility personnel and emergency department personnel in treatment facilities for both trauma and medical patients. The plan is reviewed and updated at least annually. Evidence based written treatment protocols and care guidelines exist for personnel. Critical patient protocols are jointly practiced by prehospital and hospital personnel. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Clinical Care	
Process Indicator	*Scoring*
10.2 Clinical care is documented in a manner that enables your agency/facility to provide information to be used for system wide quality monitoring and performance improvement.	0. Don't Know 1. Clinical care is documented but documentation is not reviewed for local or regional quality monitoring or performance improvement. 2. Clinical care is documented and limited review is done at the local level. 3. Clinical care documentation is systematically reviewed at the agency/facility level but is not available electronically for quality monitoring and performance improvement. 4. Clinical care documentation is systematically reviewed at the local/regional and system level and procedures exist to utilize care data to drive performance improvement 5. Clinical care is systematically reviewed by the agency/facility Medical Director at the agency/facility level and is documented in a manner that enables agency and system-wide data from other health care and public safety agencies to be used for quality monitoring and performance improvement. Oversight of the performance improvement process is done through the agency/facility Medical Director. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Clinical Care	
Outcome Indicator	*Scoring*
10.3 Patient outcomes and quality of care are monitored. Deficiencies are recognized and corrective action is implemented.	0. Don't Know 1. There is no procedure for our agency/facility and local hospital to monitor patient outcome and prehospital quality of care. 2. Our agency/facility maintains a quality of care system including patient outcomes, but they do not regularly monitor these outcomes, or quality of care, nor do they regularly review findings together. 3. An ongoing agency/facility quality improvement program is in place to monitor and assure that quality of care is consistent with adopted protocols. 4. Our agency/facility quality improvement program monitors patient outcomes, and uses these data in an ongoing quality improvement program, and benchmarks outcomes against regional or statewide standards. 5. Our agency/facility quality improvement program monitors patient outcomes, and uses these data in an ongoing quality improvement/performance improvement program. Deficiencies in meeting the local standards are recorded, and corrective action plans are instituted. Results of comparisons with State or national norms are regularly documented, along with an explanation for significant variations from these norms, and a written plan to reduce unacceptable variations. There is a process for confidentiality of findings and recommendations of performance improvement (PI) activities. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Clinical Care	
RETAC Indicator	*Scoring*
.4 The RETAC establish continuing quality improvement (CQI) plans with goals, system monitoring protocols, and periodically assess the quality of their emergency medical and trauma system. The regional CQI plan is utilized in evaluating the effectiveness of the regional EMTS systems.	0. Don't Know 1. The RETAC is not involved in quality assessment or protocol monitoring. 2. The RETAC has identified regional CQI as a goal but has not established a CQI plan. 3. The RETAC is in the process of establishing a protocol monitoring and CQI plan but the plan is not implemented. 4. The RETAC has implemented a protocol monitoring and CQI plan but has not reported results. 5. The RETAC has implemented a protocol monitoring and CQI plan and uses data from the plan to drive quality improvement throughout the region. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Mass Casualty	
11. All disciplines are integrated with, and complementary to, the comprehensive mass casualty plan for natural disasters and manmade disasters, including an all-hazards approach to disaster planning and operations.	
Structure Indicator	*Scoring*
11.1 Your agency/facility has an operational plan and has established an ongoing cooperative working relationship with other stakeholders.	0. Don't Know 1. There is no agency/facility plan and no system for integration between disciplines. 2. There have been discussions between the agency/facility and the disaster system, but no inclusive formal plans have been developed. 3. Formal plans for our agency/facility and other disaster services systems integration are in development. Working relationships have been formed and cooperation is evident. 4. There are plans in place to ensure that our agency/facility and the disaster system are integrated and operational. Disaster exercises and drills have the cooperation and participation. 5. Our agency/facility system and the disaster system plans are integrated and operational. Routine working relationships are present with cooperation and sharing of information to improve system readiness for "all-hazard" multiple patient events. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Mass Casualty	
Process Indicator	*Scoring*
11.2 Our disaster training and exercises routinely include situations involving an all hazards approach, that test expanded response capabilities and surge capacity that are consistent on a regional basis.	0. Don't Know 1. Disaster training and exercise is not a routine part of the system. 2. Disaster training and exercises are conducted haphazardly by our agency/facility alone without other stakeholders involvement. 3. Disaster training and exercises are conducted regularly and include agency/facility response capabilities to all hazards. 4. Our agency/facility, Emergency Management, trauma partners, public safety and public health stakeholders have begun training and exercises in an all-hazards approach to disaster situations. 5. Exercises and training in all-hazards disaster situations are regularly conducted and include testing of agency/facility surge capacity. These exercises include agencies, trauma, public safety and public health stakeholders. Debriefing sessions occur after each drill or event. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Mass Casualty	
Outcome Indicator	*Scoring*
11.3 There are formal mechanisms to activate response to all-hazard events in accordance with regional disaster response plans that are consistent with system resources and capabilities.	0. Don't Know 1. No feedback or after action process results from various all-hazards exercises or events. 2. Our agency/facility conducts our own after action quality improvement processes, in isolation, following each exercise or event; there is no system-wide evaluation. 3. There are sporadic, informal, non-documented "debriefings" involving multiple agencies following each exercise or event. Results of these activities do not necessarily translate to improvement processes. 4. A system-wide "debriefing" occurs following each exercise or event. Reports are written but often do not lead to improvement processes. 5. A formal system-wide analysis of after action reports and performance improvement process is in place and implemented at the conclusion of each all-hazard exercise or response. The results of the process result in improvements in the plans, targeted training and/or corrective actions. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Mass Casualty	
RETAC Indicator	*Scoring*
11.4 The RETAC provides technical assistance and serves as a resource to facilitate the integration of emergency medical and trauma services with other local, state, and federal agency disaster plans.	0. Don't know 1. The RETAC is not involved in providing any technical assistance or facilitation relating to disaster planning. 2. The RETAC provides technical assistance only upon request. 3. The RETAC participates in local and regional disaster planning but provides only limited assistance or facilitation. 4. The RETAC participates in local and regional disaster planning and provides technical assistance and facilitation to RETAC member agencies 5. The RETAC takes a leadership role in local, regional and statewide disaster planning. RETAC staff and leadership provide technical assistances and facilitation with local, state and federal planning efforts. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Public Education	
12. The agency/facility informs and educates the local constituencies and policy makers to foster collaboration and cooperation for the enhancement of Regional Emergency Medical and Trauma Services as a whole.	
Structure Indicator	*Scoring*
12.1 Your agency/facility has a public information and education program that heightens public awareness of the preventability of injury and/or illness.	0. Don't know 1. Our agency/facility has no program/plan that provides information and education that heightens public awareness or injury and/or illness prevention and control. 2. Our agency/facility has a public awareness and injury/illness prevention program but linkages between programs and implementation of specific objectives is sporadic. 3. Our agency/facility has a public awareness and injury/illness prevention program. Linkages between programs and implementation occur regularly, but are not measured 4. Our agency/facility has a public awareness and injury/illness prevention program. Linkages between programs and implementation occur regularly. We are just beginning to gather data to measure outcomes. 5. Our agency/facility has a public awareness and injury/illness prevention program. Public information and education plan is being implemented in accordance with the timelines. Data concerning the effectiveness of the strategies are used to modify the plan and programs.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Public Education	
Process Indicator	*Scoring*
12.2 An assessment of the needs of the general public concerning Emergency Medical and Trauma Care information has been conducted.	0. Don't know 1. There is no routine or planned contact with the general public. 2. Plans are in place to provide information to the general public in response to a particular acute illness or traumatic event. 3. The general public has been formally asked about what types of information would be helpful in understanding and supporting agency/facility issues. 4. General public information resources have been developed, based on the stated needs of the general public themselves, and general public representatives are included in agency/facility informational events. 5. In addition to routine contact, the general public is involved in various oversight activities such as local and regional advisory councils.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Public Education	
Outcome Indicator	*Scoring*
3 Your local agency/facility seeks and receives strong public support.	0. Don't know. 1. Our local agency/facility has not been able to generate community and political support for systems improvements, e.g. increased mill levies. 2. There has been sporadic community and political support of agency/facility needs, e.g. one time budget requests for new equipment. 3. There is an ongoing, but inadequate level of funding and community/political support for our agency/facility. 4. Our agency/facility has strong support from the community and political constituency that includes an ongoing budget that is adequate to meet the routine operating costs of the system. 5. Our agency/facility has strong support from the community and political constituency that includes not only an ongoing budget, but support for improvements and expansion. This support could be manifested by special assessments, one-time budget requests in addition to ongoing budgets, fund-raising campaigns widely supported by the community, etc. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Public Education	
RETAC Indicator	*Scoring*
12.4 The RETAC plan includes regional education efforts to promote and raise awareness of EMTS ·ncies and organizations and to promote ..ellness and prevention within the region.	0. Don't know 1. The RETAC is not currently involved in public education efforts. 2. The RETAC plan contains a public education component but there are no activities related to this component. 3. The RETAC is involved with others in public education about EMTS systems. 4. The RETAC plan drives activities that promote and raise awareness of the EMTS system within the region. 5. The RETAC is taking a leadership role in promoting the EMTS system and in promoting wellness and prevention within the region. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Injury/Illness Prevention	
13. All disciplines actively support community wellness and prevention activities.	
Structure Indicator	*Scoring*
1 A written injury/ illness prevention plan is developed and coordinated with other agencies/facilities. The injury/illness program is data driven, and targeted programs are developed based on high injury/illness risk areas. Specific goals with measurable objectives are incorporated into the injury/illness prevention plan.	0. Don't know 1. There is no written plan for a coordinated injury/illness prevention program. 2. There are multiple injury and/or illness prevention programs that may conflict or overlap with each others with no coordination within the region. 3. There is a local written plan for a coordinated regional injury/illness prevention program that is linked to the agency/facility plan and that has goals and measurable objectives. 4. The regional injury/illness prevention program is being implemented and will include established timelines. 5. A regional injury/illness prevention program is being implemented in accordance with the timelines; data concerning the effectiveness of the plan are collected and are used to validate, evaluate, and modify the plan. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Injury/Illness Prevention	
Process Indicator	*Scoring*
13.2 Injury/illness prevention programs use our agency/facility information to develop intervention strategies.	0. Don't know 1. There is no evidence to suggest that our agency/facility data are used to determine injury/illness prevention strategies. 2. There is some evidence that our agency/facility data is available for injury/illness prevention program strategies, but its use is limited and sporadic. 3. Our agency/facility data is routinely provided to the injury/illness prevention programs. The usefulness of the reports has not been measured, and prevention stakeholders are just beginning to use our agency/facility data for programmatic strategies and decision-making. 4. Our agency/facility reports on the status of illness/injury and injury mechanisms are routinely available to prevention stakeholders and are used routinely to realign prevention programs to target the greatest need. 5. A well-integrated agency/facility data system exists. Evidence is available to demonstrate how prevention stakeholders routinely use the information to identify program needs, to develop strategies on program priorities, and to set annual goals for injury/illness prevention. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Injury/Illness Prevention	
Outcome Indicator	*Scoring*
13.3 The effect or impact of injury and/or illness prevention programs is evaluated as part of a system performance improvement process.	0. Don't know 1. There is no effort to review the activities of our agency/facility in prevention efforts. 2. There is no routine evaluation of prevention activities accruing within this jurisdiction. 3. Our agency/facility does internal monitoring and evaluations of our efforts in prevention activities. 4. Our agency/facility participates with other key stakeholders in our region in evaluating prevention intervention activities. The programs are regularly assessed for effectiveness. 5. Our agency/facility along with other key stakeholders routinely uses data to implement prevention programs and to communicate prevention efforts through periodic reports. Evaluation processes are institutionalized and used to enhance future prevention activities on a regional level. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Injury/Illness Prevention	
RETAC Indicator	*Scoring*
13.4 The region-wide Emergency Medical and Trauma System (EMTS) and the public health system have established linkages including programs with an emphasis on population-based public health surveillance, and evaluation for acute injury/illness prevention. Regional prevention efforts include pediatric injury prevention.	0. Don't know 1. There is no evidence that demonstrates program linkages, a working relationship, or the sharing of data between public health and the EMTS. Population-based public health surveillance for acute or chronic traumatic injury and illness has not been integrated with the RETAC. 2. There is little population-based public health surveillance shared with the EMTS, and program linkages are rare. Routine public health status reports are available for review by the RETAC and its constituent agencies. 3. The EMTS and the public health system have begun sharing public health surveillance data for acute and chronic illness and injury. Program linkages are in the discussion stage. 4. The EMTS has begun to link with the public health system, and the process of sharing public health surveillance data is evolving. Routine dialogue is occurring between programs. 5. The EMTS and the public health system are integrated. Routine reporting, programmatic participation, and system plans are fully vested. Operational integration is routine, and measurable progress can be demonstrated. (Demonstrated integration and linkage could include such activities as rapid response and notification in disasters, integrated data systems, communication cross-operability, and regular epidemiology report generation.) **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Information Systems	
14. There is an information system within the EMTS that can evaluate system performance, track provider skills, and formulate policies based on the analysis of collected data.	
Structure Indicator	*Scoring*
14.1 Your agency/facility participates in a system data collection and information data sharing network, collects pertinent data from providers on each episode of care, and uses data for system improvements.	0. Don't know 1. There is no routine collection of data or data collection system used by our agency/facility. 2. There is a minimal data set collected but it cannot be shared with other entities nor used for system improvements. 3. There is a data collection system, and some users access the information for system improvement activities. The use of the data is random and unfocused. 4. A regional data collection system is in place and used routinely by providers. The integration and use by other stakeholders is not completed. 5. There is a robust information system that is integrated with other databases. Our agencies/facilities input data into the data collection system on each episode of care. The data are used to analyze system performance and to make adjustments in education, training or policy as applicable. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Information Systems	
Process Indicator	*Scoring*
14.2 An information system is available for routine Emergency Medical and Trauma System and public health surveillance. It can be accessed individual users as well as management for system oversight.	0. Don't know 1. There is no information system in place within our agency/facility. 2. There is an information system in place but it is not used by our agency/facility. 3. There is an information system in place but its use is sporadic; some system oversight is done using the information system that is in place. 4. The information system is in place and is integrated with other databases. It is used in some instances to review system performance but regular reports and system oversight using the information system has not been fully accomplished. 5. There is a fully integrated information system that routinely and regularly reports on individual and system performance. The system is used to make regular reports to management, and for establishing policy changes. Individual agencies/facilities can access the database and produce reports. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Information Systems	
Outcome Indicator	*Scoring*
14.3 An information system is used to assess system and provider performance, measure compliance with standards/rules and to allocate resources to areas of greatest need or acquire new resources as necessary.	0. Don't know 1. There is no information system such as the one described in use within our agency/facility. 2. Our agency/facility information system is limited in scope and the data is generally used for billing purposes. 3. Our agency/facility information system is sometimes used to review system issues or individual performance. 4. Our agency/facility information system is used by some providers to review system performance and compliance with applicable standards. The use of the data system is usually associated with an unusual occurrence rather than the routine course of system oversight, although efforts to make the system more accessible are in process. 5. There is a comprehensive information system that is used to assess system performance, measure compliance with applicable standards and allocate resources. Our agency/facility integrates the information system with other data bases to assist in routine analysis of system performance.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Information Systems	
RETAC Indicator	*Scoring*
14.4 The RETAC utilizes data from local agencies and state data collection programs as well as periodic regional assessments as a tool to monitor the regional EMTS system. Information from all sources is integrated in a manner that drives regional continuous quality improvement efforts.	0. Don't know 1. The RETAC does not currently utilize objective data to drive regional quality improvement. 2. The RETAC has access to state trauma register and EMS agency information but does not use the information to drive regional quality improvement. 3. The RETAC utilizes one or more data sources to monitor regional performance and provides feedback and assistance to local agencies 4. There is a formal QI program that utilizes one or more data sources to measure targeted RETAC performance. 5. The RETAC regularly integrates trauma register, EMS information system, regional assessment and other data to assess the quality of its emergency medical and trauma system. The regional CQI system drives system wide performance improvement.

RETAC Score

Emergency Medical and Trauma System (EMTS) Component: Evaluation	
15. All disciplines use its management information system to facilitate on-going assessment and assurance of system performance and outcomes and provide a basis for continuously improving the Regional Emergency Medical and Trauma System.	
Structure Indicator	*Scoring*
15.1 Our agency/facility has computer based analytical tools for monitoring system performance Note: In this context, Evaluation is defined as "Utilization of system data to effect continuous quality or performance improvement.	0. Don't know 1. There is (are) no computer(s) to analyze or monitor system performance. 2. There is a basic computer program that collects the minimum state required data. 3. A computer system is in place and is used by providers to collect patient care information. Data is submitted to the state on the required submission schedule; however analytical tools are not used for system monitoring. 4. A computer system is in place and analytical tools are in use to assess system performance. 5. An upgraded and technically advanced computer system and analytical tool set is available for system monitoring and individual performance review. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Evaluation	
Process Indicator	*Scoring*
15.2 Your agency/facility collects and evaluates patient care data within the system and has a mechanism to evaluate identified trends and outliers.	0. Don't Know 1. Our agency/facility is not collecting patient care information for each episode of care. 2. Our agency/facility collects patient care information to use for internal decision making and billing. 3. Our agency/facility collects patient care data and provides the minimum data set to an approved statewide database. 4. Our agency/facility collects patient care data and provides the data to an approved statewide database as well as uses the data for its own internal monitoring. 5. Our agency/facility participates in a comprehensive data collection system that is integrated into the hospital system. Routine evaluation and assessment of system performance and administrative services is completed and shared with stakeholders. A comprehensive process improvement (PI) system is in place. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Evaluation	
Outcome Indicator	*Scoring*
15.3 Your agency/facility engages the medical community in assessing and evaluating patient care. These assessments are coordinated into quality care efforts. Findings from other quality improvement efforts are translated into improved service.	0. Don't Know 1. Our agency/facility has no relationship with the medical community to assist in evaluating system service delivery and quality of care. 2. Our agency/facility is engaged in projects but the medical community is not active in these efforts. 3. Our agency/facility is working with the medical community to develop a plan for assessing and evaluating system services and participating in research opportunities. 4. Our agency/facility participates with the medical community in evaluating system service to improve service delivery and patient care. 5. Our agency/facility has a process improvement (PI) program integrated in the medical community in system service delivery and patient care. Data is translated into routine reports for assessing performance, measuring compliance and conducting research all in an effort to improve services both clinically and administratively. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Evaluation	
RETAC Indicator	*Scoring*
15.4 The RETAC is a leader within its jurisdiction in the evaluation and research of Emergency Medical and Trauma System (EMTS) activities, services and system oversight.	0. Don't Know 1. The RETAC does not serve as a leader of system activities within the area of jurisdiction. 2. The RETAC is beginning a dialogue with the service providers and hospitals on regional evaluation and research needed to evaluate and improve services and patient care. 3. The RETAC engages some providers and hospitals in system oversight and evaluation but it is not across the entire region. 4. The RETAC serves as a leader in system activities and has begun a research and evaluation agenda with service providers, hospitals and the medical community. 5. The RETAC serves as a leader in EMTS and is instrumental in working with providers, hospitals and other stakeholders in conducting research, evaluating service delivery and providing oversight to the region. **RETAC Score**

Please printout, complete survey form and bring completed survey form to your RETAC Town Hall Meeting or return to Melody Mesmer or Bill Bullard.

Central Mountains Regional Emergency Medical and Trauma Advisory Council
Standardized (Regional) Needs Assessment Project
Problem Ranking Survey

Demographical Information: (Indicate provider type and check all that apply below the provider type selected.)

__ Pre-Hospital Provider
__ Volunteer __ Paid
__ BLS __ ALS
__ Fire/Rescue
__ Ambulance
__ Other

__ Hospital Provider
__ Trauma Center Level
__ MD
__ RN
__ Administration

__ Other Provider
__ Law Enforcement
__ Dispatch/Communications
__ Emergency Management
__ Public Health
__ Elected Official
__ Other

- Please rank the following ten listed issues from 1 (most challenging) to 10 (least challenging)
- Note: Use each value (1 through 10) only once

____ **Agency Funding/Financial Viability**

Comments:

____ **Recruitment of New Personnel**

Comments:

____ **Retention of Personnel**

Comments:

____ **Aging Building/Equipment**

Comments:

____ **Initial/Continuing Education**

mments:

____ **Billing/Accounts Receivable**

Comments:

____ **Medical Director Involvement**

Comments:

____ **Support form RETAC**

mments:

____ **Administrative Support**

Comments:

____ **Cooperation with Other Agencies**

Comments:

- **Please send this to: Bill Bullard, bbullard@abarisgroup.com or fax to 707-922-0211**

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II. Colorado DPHE Emergency Medical and Trauma Services Standardized (Regional) Needs Assessment (December 2010)

Colorado Department of Public Health and Environment
Emergency Medical and Trauma Services

Standardized (Regional) Needs Assessment Project

Colorado Regional Emergency Medical and Trauma Advisory Councils

Final Report

A report from:

The Abaris Group
Walnut Creek, CA

December 2010

Colorado Department of Public Health and Environment
Emergency Medical and Trauma Services

Standardized (Regional) Needs Assessment Project
Colorado Regional Emergency Medical and Trauma Advisory Councils

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Executive Summary

The goal of the Standardized (Regional) Needs Assessment Project (SNAP) is to support each of Colorado's RETACS in completing an assessment process as required by statute, but more importantly to assess local and regional EMTS in a way that provides consistent results that can be the basis for future development of biennial plans that addresses those needs and accurately identifies the policies and resources necessary to meet the future system requirements.

In addition to the specific RETAC assessment component of this project, the SNAP scope also included providing this report with EMTS data and information to the CDPHE EMTS Section identifying the future needs for the 11 RETACs. Additional information regarding common EMTS themes observed across the state over the past 22 months and collateral EMTS system information not related to the scored indicators are included in this report. Also included are recommendations for any future needs assessments or reassessments of the RETACs.

Over the past 22 months The Abaris Group has been leading the SNAP process for the state EMTS Section. Over this time 219 Colorado EMTS agencies or facilities participated in the SNAP process including 141 personal interviews, 211 participants at 14 town hall meetings held around the state, 115 BIS surveys returned and 109 problem ranking surveys completed. Seven RETACs developed RETAC specific questions and eight RETACS held one or more town hall meeting. Input was provided from all EMTS disciplines as determined in the original scope for this project.

The strengths, weaknesses, opportunities and threats (SWOT) analysis of the EMTS systems within each RETAC revealed that the primary strengths are the RETAC board members and the RETAC coordinators/executive directors. The main weaknesses are the geography and RETAC boundaries as well as recruitment and retention of qualified EMTS personnel. Opportunities include enhanced system finances and a move towards more regionalization and standardization. The primary potential threats consist of decreased system finances and lack of qualified EMTS personnel.

Analysis of the 115 returned BIS surveys resulted in the highest scored components consisting of *Integration of Health Services, Legislation and Regulation, and Medical Direction.* The lowest scores were in the areas of *EMTS Research, Injury/Illness Prevention, and Information Systems.* The problem ranking survey, 109 returned, identified the most challenging issues for EMTS stakeholders as recruitment of new personnel, retention of personnel, and agency funding and financial viability. The three least challenging issues were support from the RETAC, cooperation with other agencies, and administrative support.

There were several common EMTS themes identified during the SNAP process including a move towards more regionalization and standardization with regional patient care protocols and written regional MCI or Communications plans. In addition to the common themes identified during the SNAP process, additional collateral information of interest to the CDPHE EMTS Section not related to the BIS indicators is included in this report.

Recommendations for future needs assessments or reassessments include not using a BIS type survey instrument; conducting more town hall and focus group type meetings; limiting the scope of assessments; and, including the RETAC coordinators/executive directors as active participants in the assessment process.

Background and Project Overview

In September 2008, the EMTS Section, within the Health Facilities and Emergency Services Division of the Colorado Department of Public Health and Environment (CDPHE) notified The Abaris Group of its intent to award to the firm a contract to conduct comprehensive assessments of the EMTS systems of 11 regional emergency medical and trauma advisory councils (RETACs) of Colorado over the next three fiscal years, anticipating three or four assessments may be completed each fiscal year. Colorado Revised Statute (CRS), 25-3.5-704 (2) (c) (II) (F), requires "The identification of regional EMTS through the use of a needs-assessment instrument developed by the department; except that the use of such instrument shall be subject to approval by the counties and city and counties included in a RETAC." The EMTS Section, in partnership with Colorado's RETACs, established a task force to address a Standardized, regional Needs Assessment Project (SNAP). The goal of this project is to support each of Colorado's RETACS in completing an assessment process as required by statute, but more importantly to assess local and regional EMTS in a way that provides consistent results that can be the basis for future development of biennial plans that addresses those needs and accurately identifies the policies and resources necessary to meet the future system requirements.

In 2006, the Western RETAC completed a comprehensive assessment that was funded through a grant from the Department of Local Affairs (DOLA). A requirement of the DOLA grant was that all assessment tools, products and processes of the Western RETAC model would be made available to the RETACs across the state of Colorado for possible standardization and replication. The SNAP Task Force reviewed the Western RETAC model which used onsite assessments of the RETAC stakeholders, a problem ranking survey, and an assessment instrument that included benchmarks, indicators, and scoring (BIS) sections based on the 15 trauma/EMS components identified within the Colorado Administrative Code. The SNAP Task Force modified the BIS assessment instrument to measure Colorado's EMTS system development from a RETAC perspective. (For more information on the BIS instrument, read the WRETAC final report available on the CDPHE EMTS website.)

Assessments were completed on four RETACs in the first year of this project. The second and third years of this project were combined with the goal to complete the remaining 8 RETAC assessments by June 30, 2010. The project was extended an additional three months and concluded in October 2010. The actual completion dates for each assessment of the 11 RETACs is listed below.

- Southern Colorado – June 2009
- Central Mountains – June 2009
- San Luis Valley – July 2009
- Plains to Peaks – January 2010
- Northeast Colorado – April 2010
- Southeastern Colorado – June 2010

- Western – July 2010
- Northwest – July 2010
- Southwest – October 2010
- Foothills – October 2010
- Mile-High – October 2010

Methodology

The methods utilized for each RETAC assessment consisted of the following:

- Review of documents – Several documents related to the EMTS systems in Colorado, including relevant CRS, RETAC Biennial Plans, RETAC agency profiles, RETAC meeting minutes, and the RETAC budgets. Additional RETAC documents were provided by the RETAC coordinators/executive directors, including each county EMS plan, a recruitment and retention assessment, and many documents related to disasters in the region.

- Development of RETAC specific questions – The BIS instrument is designed to accommodate additional RETAC specific questions related to the 15 Colorado trauma/EMS components. Seven RETACs developed RETAC specific questions.

- Attend RETAC Meetings – The Abaris Group attended the RETAC board meetings prior to the onsite assessments, presented an overview of the SNAP and introduced the BIS instrument and problem ranking survey to the RETAC Board members.

- Distribution of BIS and Problem Ranking Survey – The BIS instrument and problem ranking survey were provided to the RETAC stakeholders electronically and in paper form.

- Onsite Assessments – In collaboration with the RETAC coordinator/executive director, The Abaris Group met with a sampling of the RETAC EMTS stakeholders. There were individual interviews, group interviews, and town hall meetings for the purpose of getting input from as many of the RETAC's stakeholders as possible. A SWOT analysis of the RETAC was performed with the information provided by the RETAC's stakeholders. In addition to these onsite activities, telephone interviews or follow-up phone calls were conducted.

- Tabulation and Analysis of BIS and Problem Ranking Survey – The returned, completed BIS data and completed problem ranking surveys were entered into a data base. The BIS scoring and problem rankings were analyzed.

- Conclusions and Recommendations – Based on the data from the onsite assessments, BIS and problem ranking survey, conclusions and recommendations for RETAC system enhancements were identified.

- Draft Final Report – A draft report with conclusions and recommendations was submitted to the RETAC Coordinator/Executive Director and Chairperson for confirmation of factual data.

- Presentation to RETAC Board – Conclusions from the draft report were presented to the RETAC board members, with the exception of the SWRETAC, MHRETAC and FRETAC boards.

All of the RETAC Coordinators or Executive Directors and the RETAC chairpersons actively participated in the SNAP process. There were a total of 219 Colorado EMTS agencies or facilities that participated in the SNAP process through individual interviews, town hall meetings, or by completion of the surveys. The consultants conducted 141 personal interviews of EMTS stakeholders and approximately 211 stakeholders attended the town hall meetings. There were 115 BIS surveys returned and 109 problem ranking surveys completed.

Seven of the RETACs developed RETAC specific questions, five used scored questions and two RETACs used open-ended questions. RETAC specific questions were used by the following RETACs:

- CMRETAC – Various scored questions.
- FRETAC – Ten open-ended questions; two related to Injury/Illness Prevention, three related to MCI, one related to Communications Systems, one related to Evaluation, and three regarding RETAC/System Issues.
- NCRETAC – Seven scored questions related to cardiac care in the region.
- NWRETAC – Seven scored questions; four related to System Finance, two related to Education Systems, and one on MCI.
- SCRETAC – Various scored questions
- SLVRETAC – Five open-ended questions related to Communications Systems.
- WRETAC – Five scored questions; one each related to Integration of Health Services, System Finance, Education Systems, and Communications Systems, and one question specific to cardiac care in the region.

Eight RETACs conducted one or more town halls meetings within their regions for a total of 14 town hall meetings with approximately 211 EMTS Stakeholders attending. Three RETACs did not hold any town hall meetings because they felt that adequate numbers of EMTS stakeholders had participated in individual or telephone interviews. Town hall meetings were held in the following RETACs:

- CMRETAC – One town hall meeting.
- FRETAC – Two town hall meetings.
- MHRETAC – Three town hall meetings.
- NCRETAC – Two town hall meetings.
- NWRETAC – Two town hall meetings.
- PTPRETAC – Two town hall meetings.
- SCRETAC – One town hall meeting.
- SLVRETAC – One town hall meeting.

SWOT Analysis Summary of All RETACs

Based on the individual interviews and participation at the town hall meetings strengths, weaknesses, threats, and opportunities (SWOT) were assessed by the consultants for each RETAC. These are listed in each individual RETAC report. Overall, the top two strengths, weaknesses, threats, and opportunities statewide include the following:

Strengths

- RETAC Board Members – Diversity; tenure; commitment; dedication; cooperative and collaborative nature; integrated health services representation; good attendance and participation; actively involved

- RETAC Coordinators – Dedicated and committed; knowledgeable; well respected; represent all disciplines and urban – frontier regions equally; tenure; work ethic; productive

Weaknesses

- Geography/RETAC Boundaries – Urban, suburban, rural, and frontier areas; time commitment to travel to meeting and training; geographical barriers (mountains); large RETAC areas; not aligned with other regional state organizations boundaries, i.e. All Hazards Regions, Public Health, etc.

- Recruitment and Retention of EMTS Personnel – Primarily in rural and frontier areas; lack of qualified volunteers; lack of specialty medical services or physicians

Opportunities

- System Finance – Increased DMV fees; CDPHE EMTS grants; other grants; enhanced billing and collections systems and training; group purchasing programs; economy of scale activities

- Regionalization/Standardization – Medical direction; regional programs; standardized protocols; standardized equipment and inspection process; patient care records; MCI plans and other regional plans

Threats

- System Finance – Decreasing insurance reimbursement; lack of access to grant funds;

- Lack of EMTS Personnel (Volunteer and Paid) – Recruitment and retention issues; lack of education and training programs; rural and frontier areas quality of life issues

Benchmarks, Indicators, and Scoring (BIS) Instrument – Summary of Results and Analysis

There were 115 completed BIS surveys returned – 62 from pre-hospital providers; 40 from hospital providers; 6 from emergency management officials; 4 from communications/dispatch centers; one elected official; one technical college; and, one unknown provider.

The BIS uses a weighted scoring system with 0 meaning "I don't know" and 5 indicating a program or EMTS component that is comprehensive and well established. Scores with higher numbers indicate that the component or program is comprehensive and well established. The scores for each RETAC were entered into an Excel spreadsheet for analysis and provided to each RETAC Coordinator/Executive Director and the CDPHE EMTS Section. The BIS instrument is based on the 15 components of an EMTS system as defined by the state of Colorado. They include the following categories:

1. **Integration of Health Services**
2. **EMTS Research**
3. **Legislation and Regulation**
4. **System Finance**
5. **Human Resources**
6. **Education Systems**
7. **Public Access**
8. **Evaluation**
9. **Communications System**
10. **Medical Direction**
11. **Clinical Care**
12. **Mass Casualty**
13. **Public Education**
14. **Injury/Illness Prevention**
15. **Information Systems**

From a statewide perspective the highest and lowest scored components are as follows:

High BIS Scores

- Integration of Health Services
- Legislation and Regulation
- Medical Direction

Lowest BIS Scores

- EMTS Research
- Injury/Illness Prevention
- Information Systems

Based on the scores from each RETAC and the information gained from interviews, town hall meetings, and a review of each RETAC's biennial plan and other available documents, several recommendations were made for each RETAC to consider. The

recommendations for each RETAC included both short-term and long-term activities. The RETAC board members should review and prioritize the recommendations for their region. Inclusion of these recommendations into the biennial plan is highly encouraged. The complete list of recommendations for each RETAC is included in Appendix A of this report.

Problem Ranking Survey – Summary of Results and Analysis

The problem ranking survey asked EMTS stakeholders to rank ten listed issues from most challenging (1) to least challenging (10). The ten issues listed on the survey were:

- Administrative Support
- Aging Building/Equipment
- Cooperation with Other Agencies
- Medical Director Involvement
- Retention of Personnel
- Agency Funding/Financial Viability
- Billing/Accounts Receivable
- Initial/Continuing Education
- Recruitment of New Personnel
- Support from RETAC

There were 109 completed surveys returned – 52 from pre-hospital agencies; 48 from hospital facilities; four emergency management agencies; two from elected officials; one from a public health official; and, two from unknown providers. Overall, the three most challenging and the three least challenging issues for both pre-hospital and hospital respondents were identified as:

Most Challenging Issues

- Recruitment of New Personnel
- Retention of Personnel
- Agency Funding/Financial Viability

Least Challenging Issues

- Support from RETAC
- Cooperation with Other Agencies/Facilities
- Administrative Support

Common EMTS Themes Across Colorado

Over the assessment period certain themes related to the EMTS system in Colorado became apparent from each RETAC SNAP process. The primary commonalities identified across the state include the following listed below in no particular order.

- Regional Medical Direction – Many of the agencies and facilities throughout Colorado share medical direction with a single medical director. Some medical directors have several agencies that they provide this service for. Many of the RETACs are looking at regionalizing medical direction within the RETAC. This includes expectations and guidelines for system medical directors as well as combining the funds necessary to pay for this service.

- Regional/Standardized Protocols – Several of the RETACs have or are in the process of developing standardized regional protocols for pre-hospital providers including destination criteria, standard operating procedures (SOPs), and patient treatment guidelines. Some of the RETACs have made printed versions of their protocols available to other RETACs. Many of these standardized regional protocols are based on the Mile High RETAC protocols and revised to reflect the regions capabilities and level of care provided.

- Regional Mass Casualty Plans – Many of the RETACs have or are in the process of developing regional mass casualty plans, field guides, MCI training, and exercises or drills. These plans and their format should be shared between RETACs to identify best practice MCI regional plans. There is some difficulty with coordination and overall responsibility for MCI events in some of the RETACs because their boundaries encompass more than one All-Hazards Region or there are multiple agencies or organizations that have responsibility for disaster planning, preparedness and response.

- CDPHE Grant Requests – All RETACs were heavily involved in the grant process during the SNAP process. There were varied perceptions regarding the CDPHE grant process including, individual agency grants versus regional grant projects, the selection and award process, and other perceptions. Many expressed concerns with the time involved in the grant process from beginning to end. Overall, everyone appreciates and values the CDPHE grants; some have questions about the process.

- CDOT/CSP Grant Requests – All RETACs have received grant funds from either the Colorado Department of Transportation (CDOT), Colorado State Patrol (CSP), or both. The grants are used for occupant traffic safety programs including seat belt usage, infant/child car seats, and DUI awareness programs. Some of the RETACs have identified specific problems in their region and developed specific programs, as an example there was one region that developed a campaign to educate teen drivers about the dangers of texting on a cell phone and driving.

- Initial and Continuing Education Needs – Although initial EMTS education, training and continuing education is available throughout the state, there were several concerns about the current state and the potential availability of this education and training in the future. In some regions there have been changes in the college systems that provide EMTS education and

training. The cost for training has increased in some areas of the state and the rural and frontier providers must travel long distances for some education or training opportunities. Most agencies/facilities throughout the state share education and training opportunities.

- Recruitment and Retention Issues – The recruitment and retention of both pre-hospital EMS volunteers and hospital specialty staff is a major issue in the frontier and rural areas of the state. Many of the RETACs support the statewide "join EMS" initiative which includes printed brochures and a website developed through a grant from the Colorado Rural Health Center. The website is updated and maintained by the Plains-to-Peaks RETAC. Many of the volunteer and combination fire and EMS agencies have had to start compensating staff to ensure availability. Many of the frontier and rural areas have staff shortages within the region's hospitals and medical centers, especially in the areas of specialty medical practices.

- Aging Buildings and Equipment – Many of the EMTS stakeholders, in the frontier and rural areas primarily, indicated that their facilities were old, in need of major repair, doesn't meet the agencies needs anymore, or needed to be replaced.

- 800 MHz Digital Trunked Radio System – There were several issues raised regarding the statewide 800 MHz digital trunked radio system (DTR). There were several comments regarding the lack of existing infrastructure needed to integrate the regions EMTS stakeholders. Also mentioned was the expense for equipment and maintenance to participate in the state DTR system was prohibitive for their agency/facility. In every RETAC the issue of adequate training for using the radios and the system was mentioned as an issue, especially for the infrequent DTR user. Most everyone that participated in the SNAP process expressed concerns regarding the system not being used to its full capacity.

Collateral EMTS Information not Related to BIS Scores

During the assessment process the consultants were able to observe and were provided information regarding several aspects of Colorado's EMTS system. These observations and the information provided were not necessarily related to the BIS questions or the problem ranking survey but may be useful to CDPHE EMTS Section and its EMTS stakeholders in determining short and long term activities related to enhancing EMTS delivery in the state. In no particular order, listed below is the collateral information gained during the SNAP process.

- Local Issues versus Regional Issues – It was apparent in some RETACs that the issues related to local EMTS concerns or needs is not always the same concerns or needs of the region. Most RETAC Boards work well with that issue but occasionally territorialism develops between agencies/facilities.

- RETAC and All-Hazards Regions Boundaries – The non-alignment of RETAC boundaries with the boundaries of the state's All Hazards Regions results in some of the RETACs having to interact with multiple agencies. The question of "who is in charge" occasionally becomes an issue when dealing with multiple agencies that all have similar missions.

- Volunteer EMTS Personnel – There are hundreds of volunteer EMS and fire agencies throughout the frontier and rural areas of Colorado providing some form of pre-hospital care, many at the ALS level. Many of these volunteers are extremely dedicated with long tenures with their agency. Many volunteer for more than one agency when there is a need. They all help each other out during MCI events or when a particular service lacks adequate volunteers.

- Time Commitments – Specific to the frontier and rural regions of the state, the time commitment to participate in meetings, education and training, continuing education and other EMTS related activities is enormous. Travel time alone can take most of a day for a one or two hour meeting. Many of the RETACs move the location of meetings and education or training programs around the region to minimize the time commitment impact to EMTS stakeholders. Many expressed concerns with less participation of the EMTS stakeholders because of the time commitment required.

- RETAC's Reliance on Volunteers – In addition to volunteer EMTS providers providing patient care, many RETAC activities, including committee meetings, other meetings, programs, and projects are accomplished by EMTS stakeholders or board members on a volunteer basis. The amount of time for these individuals to participate in RETAC activities can be overwhelming considering their full-time positions in the region. Several of these volunteers serve on multiple committees or participate in several RETAC activities. The RETAC coordinators/executive directors rely heavily on these volunteers to accomplish RETAC activities.

- Innovations – There were all kinds of innovative approaches to providing EMTS throughout the state, many in the frontier and rural regions. In one RETAC two volunteer ambulance services share EMS volunteers to meet both agencies staffing needs. In another region of the state, the ambulance personnel send a cell phone text message with a picture of the patient's 12 lead EKG attached to the receiving hospital's emergency department staff.

- Limited Knowledge of Regional System – Most of the stakeholders and RETAC board members were knowledgeable about local or county EMTS capabilities and programs but had limited knowledge from a regional perspective regarding the EMTS system's capabilities or programs. This is also verified by the high number of "I don't know" answers on the BIS related to the RETAC system questions.

- RETAC Focus – In most of the RETACs EMTS stakeholders indicated that their perception was that the RETAC was either more focused on pre-hospital issues or more focused on hospital issues. Many times when EMS was used in conversations with hospital personnel the response came in the form of a correction that in Colorado it is an EMTS system and don't forget the "T" or trauma component. All of the RETACs have a fair balance of pre-hospital and hospital representation on their governing boards. Sometimes the perception of a particular focus is based on the RETAC coordinator/executive director's personality or affiliation with either a pre-hospital agency or a hospital. There is a fine line to balancing the equation and some RETACs are able to achieve that balance of pre-hospital and hospital focused approach.

- RETAC Coordinators/Executive Directors – With very few exceptions, most of the EMTS stakeholders within each RETAC considered their coordinator/executive director as one of the primary strengths of the RETAC. The coordinators were described as knowledgeable, well respected, and supported by the RETAC board members. Most of the stakeholders felt they represented the needs of the frontier, rural, and urban areas equally.

  It is the consultant's observation that there is no consistency between the RETACs regarding the coordinators/executive directors in the areas of:
  - Job descriptions, roles and responsibilities, defined performance expectations and performance review
  - Compensation and benefits
  - Workloads
  - Ancillary staff or assistants

- RETAC Administrative Communications – The various forms of communications used to provide information and data to the RETAC's EMTS stakeholders was an issue frequently raised. Many stated that they received too many emails from the RETAC coordinator/executive director. There was frustration expressed by the RETAC coordinators/executive directors in not getting responses back on emails or messages regarding RETAC issues or attempting to get input on a specific issue.

- RETAC Websites – Nine RETACs have websites where information is available regarding the RETAC and EMTS activities including education and training opportunities, announcements, and EMTS agency/facility information. Some of these websites are excellent sources of information. Each one is unique and there is no conformity or standardization from one website to the other.

- Consolidation Opportunities- There are several opportunities to consolidate functions, especially between the multiple emergency communications centers and public safety answering points (PSAPs). Some counties have multiple dispatch agencies with many of them not providing pre-arrival emergency medical directions or any call prioritization screening. In some counties emergency calls are transferred to multiple agencies.

- RETAC County Funds – There is no consistency between how CDPHE funds are distributed back to the counties within each RETAC. In some RETACS all the county funds go back to the counties in others only a portion goes back to the counties and the RETAC uses those funds for regional projects. The issue of what the counties expect from each RETAC is also based around these funds and in some instances determines the level of participation and integration with the RETAC.

- EMTS Data – The collection of data is considered important and valuable by the majority of Colorado's EMTS stakeholders. Several RETACs have active data collection committees and all of the agencies/facilities are involved in data collection. Several comments regarding the inability to get data back in a timely meaningful fashion were made. In addition the variety of data collection systems make it difficult to avoid redundant data entry into each system. There is a desire to standardize data collection and reporting systems, but there are no dedicated funding mechanisms.

- Patient Outcome Data – Many of the RETACs are discussing ways to track patients through the healthcare system from beginning of treatment through their final discharge from the system, especially patients that may receive care by multiple pre-hospital providers and then several hospital or medical facilities. The purpose for the tracking is to obtain outcome data and provide feedback to the initial healthcare providers.

Future RETAC Needs Assessments

Future needs assessments of Colorado's eleven RETACs can provide the CDPHE EMTS Section information to compare progress made with the recommendations in each RETAC SNAP report completed as part of this project. There are a few methods that were more valuable than others over the course of this assessment. There were also a few methods employed that did not yield the results desired.

The BIS instrument was viewed as too time consuming for most EMTS stakeholders to complete. Those stakeholders that did complete the BIS should be commended. An average of two-hours was required to read and complete the BIS. Many stakeholders that completed the BIS did so incorrectly by either not entering a score or indicating N/A where a score was required. Because of the diverse regions – frontier, rural and urban – the scores were inconsistent between respondents. The BIS is a good tool for developing a consensus approach to each of the 15 EMTS components. Most respondents answered with a zero, meaning "I don't know" on the RETAC system questions. Most of the RETAC board members did complete the BIS survey. The use of a BIS type survey instrument should be avoided in any future RETAC needs assessments process.

There were 14 town hall meetings that worked very well and stimulated discussion and input from EMTS stakeholders that may not have been able to have input any other way. Many times during these discussions, additional points regarding a particular EMTS component were brought forward. The town hall meetings ranged from approximately 45 participants down to ones with six participants. The small group forums with specific similar EMTS disciplines were the most productive.

The SNAP attempted to identify the needs of the EMTS stakeholders within each RETAC in all of the 15 Colorado EMTS components. The state definition for each of the 15 EMTS components consists of several sub-components further expanding the scope of this assessment. In additional to the BIS components, a problem ranking survey was used with 10 additional categories, and in some RETACs, RETAC specific questions were also posed to the respondents. In any future assessments this all encompassing approach should be avoided or at least simplified in order to obtain meaningful data. Consider conducting mini-assessments specific to one or two issues of importance to the EMTS Section on a quarterly basis.

The most valuable resource in conducting the SNAP was the RETAC coordinators/executive directors. Their knowledge of the EMTS resources, issues and history was extremely helpful in this assessment process. Most of them are experienced EMTS providers and have patient care as the primary goal within the RETAC. Some RETAC coordinator/executive directors scheduled all the appointments with the key EMTS stakeholders within the RETAC which enhanced the assessment process by maximizing the

number of opportunities to gain knowledge of the regions EMTS system. In any future needs assessments of the issues from the RETAC perspective should include the RETAC coordinators and executive directors as active participants in the process.

Conclusion

Over the past 22 months The Abaris Group has been leading the SNAP process for the state EMTS Section. Over this time 219 Colorado EMTS agencies or facilities participated in the SNAP process including 141 personal interviews, 211 participants at 14 town hall meetings held around the state, 115 BIS surveys returned and 109 problem ranking surveys completed. Seven RETACs developed RETAC specific questions and eight RETACS held one or more town hall meeting. Input was provided from all EMTS disciplines as determined in the original scope for this project.

The strengths, weaknesses, opportunities and threats (SWOT) analysis of the EMTS systems within each RETAC revealed that the primary strengths are the RETAC board members and the RETAC coordinators/executive directors. The main weaknesses are the geography and RETAC boundaries as well as recruitment and retention of qualified EMTS personnel. Opportunities include enhanced system finances and a move towards more regionalization and standardization. The primary potential threats consist of decreased system finances and lack of qualified EMTS personnel.

Analysis of the 115 returned BIS surveys resulted in the highest scored components consisting of *Integration of Health Services, Legislation and Regulation, and Medical Direction.* The lowest scores were in the areas of *EMTS Research, Injury/Illness Prevention, and Information Systems.* The problem ranking survey, 109 returned, identified the most challenging issues for EMTS stakeholders as recruitment of new personnel, retention of personnel, and agency funding and financial viability. The three least challenging issues were support from the RETAC, cooperation with other agencies, and administrative support.

There were several common EMTS themes identified during the SNAP process including a move towards more regionalization and standardization with regional patient care protocols and written regional MCI or Communications plans. In addition to the common themes identified during the SNAP process, additional collateral information of interest to the CDPHE EMTS Section not related to the BIS indicators is included in this report.

Recommendations for future needs assessments or reassessments include not using a BIS type survey instrument; conducting more town hall and focus group type meetings; limiting the scope of assessments; and, including the RETAC coordinators/executive directors as active participants in the assessment process.

The SNAP process has validated many issues that were already known to the CDPHE EMTS Section leadership regarding the needs of the Colorado EMTS system. Additional information unrelated to the BIS survey instrument may also be useful in enhancing EMTS in Colorado. In some cases these issues and additional information obtained can be prioritized and a statewide approach can enhance and expedite projects or programs within each RETAC.

The recommendations for the each of the RETACs include both short-term and long-term activities. The RETAC council members should review and prioritize the recommendations for the region. Inclusion of these recommendations into the RETAC biennial plan is highly encouraged. All of the recommendations made for each RETAC are included as Appendix A.

Appendix A: RETAC Specific Recommendations

RETAC	EMTS Component: Integration of Health Services
CMRETAC	Encourage participation of law enforcement, dispatch centers, public health, and fire departments
	Establish standing or ad-hoc committees under the CMRETAC for each of the underrepresented disciplines to address their specific issues in relation to the overall CMRETAC
	Create a method to measure the CMRETAC activities and clearly communicate the review and results to the CMRETAC stakeholders
FRETAC	Communicate with other non-traditional EMTS agencies (ski patrol and SAR) and invite them to participate in RETAC meetings and activities
	Strongly encourage participation in the RETAC from larger ground transport agency management personnel
	Ensure all stakeholders receive RETAC EMTS information and meeting minutes
MHRETAC	Communicate with other non-traditional EMTS agencies (ski patrol and SAR) and invite them to participate in RETAC meetings and activities
	Encourage the private-for-profit ground ambulance providers to increase participation and input through the MHRETAC
NCRETAC	Consider inviting other non-EMS or hospital representatives to RETAC meetings on a regular basis
	Consider enhancing small volunteer fire department involvement in RETAC activities
	Ensure all stakeholders receive RETAC EMTS information and meeting minutes
NWRETAC	Communicate with other non-traditional EMTS agencies and invite them to participate in RETAC meetings and activities
	Increase involvement of Public Health agencies
	Ensure all stakeholders receive RETAC EMTS information and meeting minutes
PTPRETAC	Publish biennial plan on the Plains to Peaks RETAC website and email copies to Plains to Peaks RETAC stakeholders
	Develop a formal process for communicating with the Plains to Peaks RETAC stakeholders, including written communication back to each county represented, i.e. EMS Councils and elected officials, and underrepresented agencies
SCRETAC	Encourage participation of law enforcement, dispatch, public health and fire departments
	Establish standing or ad hoc committees under the SCRETAC for each of the under-represented disciplines to address their specific issues in relation to the overall SCRETAC
	Encourage and assist law enforcement agencies to develop AED programs
	Develop a regional public access AED program
	Develop a formal process for communicating with the SCRETAC stakeholders, including written communication back to each county represented, i.e. EMS Councils and elected officials
SECRETAC	Continue to involve EMTS stakeholders as General Members of the SECRETAC

	Ensure all stakeholders receive RETAC EMTS information and SECRETAC meeting minutes
SLVRETAC	Establish standing or ad hoc subcommittees under the SLVRETAC for the development of regional programs for education/training; medical direction; treatment protocols; injury/illness prevention; mutual-aid; communications; and, quality improvement
	Publish biennial plan on SLVRETAC website and email copies to SLVRETAC stakeholders
	Develop a formal process for communicating with the SLVRETAC stakeholders, including written communication back to each county represented, i.e. EMS Councils and elected officials
	Provide individual EMS agency capabilities to the EDs, especially for inter-facility transfers
SWRETAC	Communicate with other non-traditional EMTS agencies (ski patrol and SAR) and invite them to participate in RETAC meetings and activities
	Ensure all stakeholders receive RETAC EMTS information and meeting minutes
WRETAC	Consider inviting other non-EMS or hospital representatives to WRETAC meetings on a regular basis
	Ensure all stakeholders receive WRETAC EMTS information and meeting minutes
	Maintain focus/inclusion of hospitals within the WRETAC

RETAC	EMTS Component: EMTS Research
CMRETAC	Determine areas of interest and topics for system research
	Establish a data collection committee regarding system research topics
	Encourage system stakeholders to participate in system research
	Collaborate with hospitals and educational institutions to conduct system research in areas of mutual interest
	Publish and share the results of system research with stakeholders
FRETAC	No major recommendations, continue to address the concerns with privacy and discoverability issues with CDPHE
MHRETAC	Identify regional system research topics with input from the MHRETAC EMTS stakeholders
	Address privacy/confidentiality and HIPAA concerns to reduce barriers to EMTS system research
NCRETAC	Determine if there is any interest in conducting research through the RETAC
	Identify resources, both personnel and financial, to undertake research if the RETAC so desires
	Continue the current periodic survey process used by the RETAC
	Encourage system stakeholders to participate in research conducted by the few agencies/facilities that do
	Collaborate with hospitals and educational institutions to conduct research in areas of mutual interest
NWRETAC	Determine if there is any interest in conducting research through the RETAC
	Identify resources, both personnel and financial, to undertake research if the RETAC so desires
	Consider collaboration with hospitals and educational institutions to conduct research in areas of mutual interest
PTPRETAC	Determine if there is any interest in conducting research through the RETAC
	Identify resources, both personnel and financial, to undertake research if the RETAC so desires

	Continue the current survey process used by the RETAC
	Encourage system stakeholders to participate in research conducted by the few agencies/facilities that do
	Collaborate with hospitals and educational institutions to conduct research in areas of mutual interest
SCRETAC	Determine areas of interest and topics for system research
	Provide direction to the data collection committee regarding system research topics
	Encourage system stakeholders to participate in system research
	Collaborate with hospitals and educational institutions to conduct system research in areas of mutual interest
	Publish and share with stakeholders the results of system research
SECRETAC	Determine if there is any interest in conducting research through the RETAC
	Identify resources, both personnel and financial, to undertake research if the RETAC so desires
	Consider collaboration with hospitals and educational institutions to conduct research in areas of mutual interest
SLVRETAC	Determine areas of interest and topics for system research
	Encourage system stakeholders to participate in system research
	Collaborate with hospitals and educational institutions to conduct system research in areas of mutual interest
	Publish and share with stakeholders the results of system research
SWRETAC	Determine if there is any interest in conducting research through the RETAC
	Identify resources, both personnel and financial, to undertake research if the RETAC so desires
	Consider collaboration with hospitals and educational institutions to conduct research in areas of mutual interest
WRETAC	Determine if there is any interest in conducting research through the WRETAC
	Identify resources, both personnel and financial, to undertake research if the WRETAC so desires
	Encourage system stakeholders to participate in research, if identified as a WRETAC priority
	Collaborate with hospitals and educational institutions to conduct research in areas of mutual interest

RETAC	EMTS Component: Legislation and Regulation
CMRETAC	Review current bylaws and ensure the board of directors is in compliance or amend as appropriate
	Develop a mechanism to communicate to system stakeholders the CMRETAC's compliance to laws and regulations
	Arrange for an expert, third-party review of its plan, policies, and conduct that ensure compliance with all laws, rules, bylaws, and contracts, possibly through the CDPHE EMTS Section
FRETAC	No major recommendations, the RETAC Coordinator provides adequate information to the EMTS agencies/facilities
	Review the need for an external review of the RETAC and EMTS agencies/facilities regarding compliance to legislation and regulations
MHRETAC	Seek input from EMTS stakeholders regarding enhancing ambulance inspection process
	Review the need for an external review of the RETAC and EMTS agencies/facilities regarding compliance to legislation and

	regulations
NCRETAC	No major recommendations, the RETAC Coordinator provides adequate information to the EMTS agencies/facilities
	Review the need for an external review of the RETAC and EMTS agencies/facilities regarding compliance to legislation and regulations
NWRETAC	No major recommendations, the RETAC Coordinator provides adequate information to the EMTS agencies/facilities
	Review the need for an external review of the RETAC and EMTS agencies/facilities regarding compliance to legislation and regulations
PTPRETAC	No major recommendations, the RETAC Coordinator provides adequate information to the EMTS agencies/facilities
	Review the need for an external review of the RETAC and EMTS agencies/facilities regarding compliance to legislation and regulations
SCRETAC	Develop a mechanism to communicate to system stakeholders the SCRETAC's compliance to laws and regulations
	Arrange for an expert, third party review of its plan, policies, and conduct to ensure compliance with all laws, rules, by-laws and contracts, possibly through the CDPHE EMTS Section
SECRETAC	No major recommendations, the RETAC Coordinator provides adequate information to the EMTS agencies/facilities
	Review the need for an external review of the RETAC and EMTS agencies/facilities regarding compliance to legislation and regulations
SLVRETAC	Develop a mechanism to communicate to system stakeholders the SLVRETAC's compliance to laws and regulations
	Arrange for an expert, third-party review of its plan, policies, and conduct to ensure compliance with all laws, rules, by-laws, and contracts, possibly through the CDPHE EMTS Section
SWRETAC	No major recommendations, the RETAC Executive Director provides adequate information to the EMTS agencies/facilities
	Review the need for an external review of the RETAC and EMTS agencies/facilities regarding compliance to legislation and regulations
WRETAC	No major recommendations, the WRETAC Executive Director shares legislative and regulatory information with the EMTS agencies/facilities
	Ensure biennial plan is in compliance with state rules

RETAC	EMTS Component: System Finance
CMRETAC	Develop a benchmarking tool through a standard template that agencies can use to collect financial and operational data, including the cost to provide services, appropriate charges, collection, and reimbursement data
	Provide the CMRETAC financial data, including the annual operating budget and monitoring reports to system stakeholders on a regular basis
FRETAC	Continue to provide the FRETAC financial data, including the annual operating budget and monitoring reports to system stakeholders on a regular basis

	Continue to identify and apply for grants to enhance EMTS delivery throughout the region
	Consider activities to assist EMTS stakeholders with enhancing revenues from insurance reimbursement
	Maintain $25,000 Certificate of Deposit that is drawing interest
MHRETAC	Provide the MHRETAC financial data, including the annual operating budget and monitoring reports to system stakeholders on a regular basis
	Continue to assist EMTS agencies identify and apply for grants to enhance EMTS delivery
	Consider activities and educational opportunities to assist EMTS stakeholders with enhancing revenues from insurance reimbursement
NCRETAC	Provide the NCRETAC financial data, including the annual operating budget and monitoring reports to system stakeholders on a regular basis
	Continue to assist EMTS agencies identify and apply for grants to enhance EMS delivery
NWRETAC	Continue to provide the NWRETAC financial data, including the annual operating budget and monitoring reports to system stakeholders on a regular basis
	Continue to assist EMTS agencies identify and apply for grants to enhance EMTS delivery
	Consider activities to assist EMTS stakeholders with enhancing revenues
PTPRETAC	Survey Plains to Peaks ground ambulances regarding the rates they currently charge
	Develop a standard template that stakeholders can use to collect financial data, including the cost to provide services, determine appropriate charges, enhance collections and reimbursements
	Provide the Plains to Peaks RETAC financial data, including the annual operating budget and monitoring reports to system stakeholders on a regular basis
	Continue to assist EMTS agencies identify and apply for grants to enhance EMS delivery
SCRETAC	Develop a standard template that stakeholders can use to collect financial data, including the cost to provide services, appropriate charges, collection and reimbursement data
	Provide the SCRETAC financial data, including the annual operating budget and monitoring reports to system stakeholders on a regular basis
	Provide information and assistance to system stakeholders on the availability of funding opportunities, including grants, tax districts, and fee structures
SECRETAC	Continue to provide the SECRETAC financial data, including the annual operating budget and monitoring reports to system stakeholders on a regular basis
	Continue to assist EMTS agencies identify and apply for grants to enhance EMS delivery in the region
	Consider activities to assist EMTS stakeholders with enhancing revenues
SLVRETAC	Develop a standard template that stakeholders can use to collect financial data, including the cost to provide services, appropriate charges, collection, and reimbursement data
	Provide the SLVRETAC financial data, including the annual operating budget and monitoring reports to system stakeholders on a

	regular basis
	Provide information and assistance to system stakeholders on the availability of funding opportunities, including grants, tax districts, and fee structures
SWRETAC	Continue to provide the SWRETAC financial data, including the annual operating budget and monitoring reports to system stakeholders on a regular basis
	Continue to assist EMTS agencies identify and apply for grants to enhance EMTS delivery
	Consider activities to assist EMTS stakeholders with enhancing revenues from insurance reimbursement
WRETAC	Continue to share the WRETAC financial data, including the annual operating budget and monitoring reports to system stakeholders on a regular basis
	Continue to assist EMTS agencies identify and apply for grants to enhance EMS delivery

RETAC	EMTS Component: Human Resources
CMRETAC	Ensure CMRETAC is seen as a resource by all stakeholders through focused communication messages and methods that best match the intended recipients
FRETAC	No major recommendations, continue to assist rural agencies with recruitment efforts
MHRETAC	Consider incentive programs to recruit specialty medical professionals that are in demand, i.e. trauma surgeons, etc.
	Enhance recruitment and retention efforts in the rural area
	Consider low cost outreach education/training programs for the rural areas
NCRETAC	Consider a system wide focused recruitment and retention program
	Consider sharing volunteer EMS personnel between EMS transport agencies
NWRETAC	Consider a system wide focused recruitment and retention program
	Consider sharing volunteer on-call EMS personnel between EMS transport agencies where geographically appropriate (This works well in the San Luis Valley RETAC with agencies that share on-call or on-site EMS responders.)
PTPRETAC	Continue the recruitment and retention program initiated by the RETAC
	Explore funding sources for advertising recruitment needs and increase no fee advertising, such as public service announcements and other ways to let the communities know volunteers are needed
	Consider sharing volunteer EMS personnel between EMS transport agencies
SCRETAC	Develop an ad-hoc committee or task force to examine human resource needs on a system-wide basis
	Provide assistance to stakeholders with inadequate staff, i.e. shared personnel, regional work schedule
	Provide information and assistance to system stakeholders on the availability of funding opportunities for personnel, including grants, tax districts, and fee structures
	Apply for a regional recruitment and retention grant for emergency services personnel, i.e. Staffing for Adequate Fire and Emergency Response (SAFER) grant

SECRETAC	Consider a system wide focused recruitment and retention program
	Consider sharing volunteer EMS personnel between EMS transport agencies where feasible
SLVRETAC	Develop an ad-hoc committee or task force to examine human resource needs on a system-wide basis
	Provide assistance to stakeholders with inadequate staff, e.g. shared personnel, regional work schedule
	Provide information and assistance to system stakeholders on the availability of funding opportunities for personnel, including grants, tax districts, and fee structures
	Apply for a regional recruitment and retention grant for emergency services personnel, e.g. Staffing for Adequate Fire and Emergency Response (SAFER) grant
SWRETAC	Consider a system wide focused recruitment and retention program
	Continue recruitment efforts on SWRETAC website
	Consider sharing volunteer on-call EMS personnel between EMS transport agencies where geographically appropriate (This works well in the San Luis Valley RETAC with agencies that share on-call or on-site EMS responders.)
WRETAC	Support retention programs, including continuing education, as needed to maintain licensure
	Consider supporting and legislation for the addition of EMS providers to the state's firefighter retirement program

RETAC	EMTS Component: Education Systems
CMRETAC	Continue the development of the regional education and continuing education system
	Develop or formalize a standardized competency evaluation process
FRETAC	Consider an education/training needs survey of FRETAC stakeholders regarding accessibility and availability of education and training
	Enhance the share educational opportunities among EMTS agencies/facilities; consider outreach programs for rural agencies
	Consider alternative electronic services to provide education to rural EMS providers
MHRETAC	Consider an education/training needs survey of MHRETAC stakeholders regarding accessibility and availability of education and training
	Enhance and continue to share educational opportunities among EMTS agencies/facilities
	Consider rotating the location of education/training opportunities to increase participation from volunteer EMTS providers outside of Denver Metro area
NCRETAC	Continue to enhance the current regional education and continuing education system
	Continue to share educational opportunities among EMTS agencies/facilities
	Consider an education/training needs survey of NCRETAC stakeholders
NWRETAC	Consider an education/training needs survey of NWRETAC stakeholders regarding accessibility and availability of education and training
	Continue to conduct the Northwest RETAC Leadership conference
	Enhance and continue to share educational opportunities among EMTS agencies/facilities

PTPRETAC	Consider enhancing the current regional education and continuing education system
	Continue to share educational opportunities among EMTS agencies/facilities
	Schedule educational programs on evenings and weekends to accommodate volunteer EMS providers
SCRETAC	Develop a standardized evaluation tool for initial education and training
	Develop a standardized evaluation tool for continuing education
	Continue the development of the regional education and continuing education system
	Develop a standardized competency evaluation process
SECRETAC	Consider an education/training needs survey of SECRETAC stakeholders
	Continue to provide scholarships and financial support for EMS education/training
	Enhance and continue to share educational opportunities among EMTS agencies/facilities
	Explore alternative education/training options for ALS personnel
SLVRETAC	Conduct a needs assessment or survey of SLVRETAC EMTS agencies to identify educational needs
	Consider the development of a regional education and continuing education system
	Encourage stakeholders to share education and training programs with all pre-hospital agencies
	Schedule educational programs on evenings and weekends to accommodate volunteer EMS providers
	Encourage hospital facilities to provide monthly continuing education on a rotating basis
SWRETAC	Consider an education/training needs survey of SWRETAC stakeholders regarding accessibility and availability of education and training
	Enhance and continue to share educational opportunities among EMTS agencies/facilities
	Consider rotating the location of education/training opportunities to increase participation from volunteer EMTS providers outside of La Plata County
WRETAC	Share successful agency education and injury prevention programs with other member agencies
	Develop regional education and Continuous Quality Improvement (CQI) to identify training opportunities
	Continue to share educational opportunities among EMTS agencies/facilities
	Consider an education/training needs survey of WRETAC stakeholders

RETAC	EMTS Component: Public Access
CMRETAC	Share system's communications plan with stakeholders and support individual agency plan development
	Ensure agency and system communications plans are comprehensive and contiguous with each other
FRETAC	Explore the feasibility of regional consolidated state of the art emergency medical dispatch/communications centers
	Provide consistent pre-arrival instructions in rural communities, possibly by transferring calls that need pre-arrival instructions from law enforcement dispatch centers to a dispatch agency that does provides EMD
MHRETAC	Provide consistent pre-arrival instructions in the rural areas, possibly by transferring calls that need pre-arrival instructions from

	law enforcement dispatch centers to a dispatch agency that does provides pre-arrival instructions
NCRETAC	Explore the feasibility of creating additional consolidated state of the art emergency medical dispatch centers
	Provide consistent pre-arrival instructions in the frontier/rural counties, possibly by transferring calls that need pre-arrival instructions to a dispatch agency that does provide them
NWRETAC	Explore the feasibility of consolidated state of the art emergency medical dispatch centers
	Provide consistent pre-arrival instructions in the frontier/rural counties, possibly by transferring calls that need pre-arrival instructions to a dispatch agency that does provide them
PTPRETAC	Develop emergency response guidelines for emergency response agencies to consider, including a non-red lights and siren policy for frontier/rural EMS response agencies
	Explore the feasibility of creating a consolidated state of the art emergency medical dispatch center in Cheyenne, Kit Carson, and Lincoln counties or consider joining the El Paso-Teller County 911 Authority
	Provide consistent pre-arrival instructions in the frontier/rural counties, possibly by transferring calls that need pre-arrival instructions to a dispatch agency that does provide them
SCRETAC	Consult with the public safety access points (PSAPs) to determine the availability of 911 access throughout the region, especially for special populations
	Establish an EMD committee composed of dispatch center personnel and pre-hospital providers
	Develop a regional communications plan
	Develop emergency response guidelines for emergency response agencies to consider, including a non-red lights and siren policy
	Explore the feasibility of creating a state of the art consolidated emergency medical dispatch center
SECRETAC	Explore the feasibility of consolidated state of the art emergency medical dispatch centers
	Provide consistent pre-arrival instructions in the frontier/rural counties, possibly by transferring calls that need pre-arrival instructions to a dispatch agency that does provide them
SLVRETAC	Consult with the Public Safety Access Points (PSAPs) to determine the availability of 9-1-1 access throughout the region, especially for special populations
	Establish an emergency medical dispatch committee composed of dispatch center personnel and pre-hospital providers
	Develop a regional communications plan
	Develop emergency response guidelines for emergency response agencies to consider, including a non-red lights and siren policy
	Explore the feasibility of creating a state of the art consolidated emergency medical dispatch center
SWRETAC	Explore the feasibility of consolidated state of the art emergency medical dispatch/communications centers
	Provide consistent pre-arrival instructions, possibly by transferring calls that need pre-arrival instructions from law enforcement dispatch centers to a dispatch agency that does provides EMD
WRETAC	Ensure the one dispatch center successfully implements emergency medical dispatch in a timely manner
	Develop public access plans for special population needs
RETAC	**EMTS Component: Evaluation**

CMRETAC	Ensure the medical community is integrated into agency evaluations
	Determine what data is currently collected that can also be used to evaluate the system
	Develop a list of data components useful for system evaluation
	Develop a research and evaluation agenda with service providers, hospitals, trauma centers, and the medical community
	Develop a process improvement program to improve clinical and administrative services
FRETAC	No major recommendations, FRETAC has identified this as a goal in 2009 – 2011 Biennial Plan
	Assist FRETAC EMTS agencies/organizations in developing agency/organization evaluation processes
MHRETAC	Develop a regional continuous quality improvement process
	Identify regional performance improvement indicators
	Assist MHRETAC EMTS agencies/organizations in developing agency/organization evaluation processes
NCRETAC	Address QA/QI information concerns with discoverability
	Determine what data is currently collected that can be used to evaluate the system
	Develop a list of data components useful for system evaluation
	Consider the development of a research and evaluation agenda with service providers, hospitals, NPAB and the medical community at large
	Assist pre-hospital agencies in developing a CQI program or facilitate their participation in another agencies CQI process
NWRETAC	Determine what data is currently collected that can be used to evaluate the system
	Develop a list of data components useful for system evaluation
	Consider the development of a research and evaluation agenda with service providers, hospitals, community colleges and the medical community at large
	Assist pre-hospital agencies in developing a CQI program or facilitate their participation in another agencies CQI process
PTPRETAC	Determine what data is currently collected that can be used to evaluate the system
	Develop a list of data components useful for system evaluation
	Consider the development of a research and evaluation agenda with service providers, hospitals and the medical community at large
	Assist pre-hospital agencies in developing a CQI program or facilitate their participate in another agencies CQI process
SCRETAC	Determine what data is currently collected that can be used to evaluate the system
	Develop a list of data components useful for system evaluation
	Develop a research and evaluation agenda with service providers, hospitals and the medical community at large
	Develop a process improvement (PI) program to improve clinical and administrative services
SECRETAC	Determine what data is currently collected that can be used to evaluate the system
	Develop a list of data components useful for system evaluation
	Consider the development of a research and evaluation agenda with service providers, hospitals, community colleges and the medical community at large

	Assist pre-hospital agencies in developing a CQI program or facilitate their participation in another agencies CQI process
SLVRETAC	Determine what data is currently collected that can be used to evaluate the system
	Develop a list of data components useful for system evaluation
	Develop a research and evaluation agenda with service providers, hospitals and the medical community at large
	Develop a Process Improvement (PI) program to improve clinical and administrative services
SWRETAC	No major recommendations – encourage participation by all SWRETAC EMTS providers to use the System Improvement Plan and process to enhance EMTS delivery
	Assist SWRETAC EMTS agencies/organizations in developing agency/organization evaluation processes
WRETAC	Determine how the data collected for CDPHE can be used to evaluate the system on a regional basis
	Consider the development of a research and evaluation agenda with service providers, hospitals, and the medical community at large
	Develop a regional CQI program or facilitate an inter-agency CQI process that identifies training and educational needs

RETAC	EMTS Component: Communications System
CMRETAC	Ensure regional communications plan is fully integrated
	Incorporate the communications system components in annual drills and exercises to test reliability and interoperability
	Develop a system for documenting communications system problems and failures
FRETAC	Consider surveying FRETAC EMTS stakeholders regarding 800 DTR issues
	Develop a FRETAC Communications Plan for EMTS incorporating the current radio frequencies in use
	Provide routine ongoing education and training on the use of the 800 DTR system for inexperienced or infrequent users
	Incorporate the communications system components in annual drills and exercises to test reliability and interoperability
MHRETAC	Consider surveying MHRETAC EMTS stakeholders regarding 800 DTR issues
	Provide routine ongoing education and training on the use of the 800 DTR system for inexperienced or infrequent users
	Incorporate the communications system components in annual drills and exercises to test reliability and interoperability
NCRETAC	Provide routine ongoing education and training on the use of the 800 DTR system for inexperienced or infrequent users
	Incorporate the communications system components in annual drills and exercises to test reliability and interoperability
NWRETAC	Continue with the phased-in process for 800 DTR infrastructure throughout the region
	Develop a NWRETAC Communications Plan for EMTS incorporating the current radio frequencies in use
	Provide routine ongoing education and training on the use of the 800 DTR system for inexperienced or infrequent users
	Incorporate the communications system components in annual drills and exercises to test reliability and interoperability
PTPRETAC	Enhance the regional communications plan with the All Hazards Region agencies
	Conduct a comprehensive system-wide regional communications needs assessment
	Provide additional training for the 800MHz radios to agencies having difficulties

	Establish talk groups on a regional basis
	Develop a communications manual and quick reference guide to enhance communications between agencies, disciplines and counties
	Incorporate the communications system components in annual drills and exercises to test reliability and interoperability
	Develop a system for documenting communications system problems and failures in dispatch centers
SCRETAC	Develop a regional communications plan
	Conduct a comprehensive system-wide regional communications needs assessment
	Incorporate the communications system components in annual drills and exercises to test reliability and interoperability
	Develop a system for documenting communications system problems and failures
SECRETAC	Develop a SECRETAC Communications Plan for EMTS incorporating the current radio frequencies in use
	Provide routine ongoing education and training on the use of the 800 MHz DTR system for inexperienced or infrequent users
	Continue to incorporate the communications system components in annual drills and exercises to test reliability and interoperability
SLVRETAC	Develop a regional communications plan
	Conduct a comprehensive system-wide regional communications needs assessment
	Provide additional training for the 800MHz radios to agencies having difficulties
	Establish talk groups on a regional basis
	Incorporate the communications system components in annual drills and exercises to test reliability and interoperability
	Develop a system for documenting communications system problems and failures; include the CSP and other dispatch centers
SWRETAC	Consider surveying SWRETAC EMTS stakeholders regarding 800 DTR issues
	Develop a SWRETAC Communications Plan for EMTS incorporating the current radio frequencies in use
	Provide routine ongoing education and training on the use of the 800 DTR system for inexperienced or infrequent users
	Incorporate the communications system components in annual drills and exercises to test reliability and interoperability
	Address communications concerns/issues with aeromedical transport providers
WRETAC	Develop an implementation plan to standardize communication between member agencies/facilities as well as allied partners
	Incorporate the communications system components in annual drills and exercises to test reliability and interoperability

RETAC	**EMTS Component: Medical Direction**
CMRETAC	Develop a system/regional medical director coordinator position and identify a funding source to pay for it
	Survey stakeholder agencies regarding their needs for medical direction
	Consolidate the many individual agency and county protocols into a standardized set for CMRETAC
FRETAC	Consider a regional forum to bring all Medical Directors together at least annually
	Enhance the feedback process from the Medical Director to the pre-hospital agency director or chief

	Develop clear consistent regional guidelines and expectations for FRETAC Medical Directors
MHRETAC	Formalize the Denver Metro Physicians group
	Enhance the feedback process from the Medical Director to the pre-hospital agency director or chief
	Develop clear consistent regional guidelines and expectations for MHRETAC Medical Directors
NCRETAC	Support and encourage active participation of the Northeast Physicians Advisory Board
	Survey stakeholder agencies regarding their needs for medical direction and their level of satisfaction with the current system of medical direction
	Enhance the feedback process from the Medical Director to the pre-hospital agency director or chief
NWRETAC	Survey stakeholder agencies regarding their needs for medical direction and their level of satisfaction with the current system of medical direction
	Continue to support NWRETAC Medical Directors education track at the Northwest RETAC Leadership conference
	Enhance the feedback process from the Medical Director to the pre-hospital agency director or chief
PTPRETAC	Continue the current system for Medical Direction provided by the two primary Medical Directors
	Develop a written description of duties that a medical director should perform
	Expand the medical director duties to include system oversight or consider the use of an assistant system medical director for the system
	Survey stakeholder agencies regarding their needs for medical direction and their level of satisfaction with the current system of medical direction
	Enhance the feedback process from the Medical Director to the pre-hospital agency director or chief
SCRETAC	Identify a funding source for continuation of the system medical director
	Expand the medical director duties to include system oversight or consider the use of an assistant system medical director
	Survey stakeholder agencies regarding their needs for medical direction and their level of satisfaction with the current system of medical direction
SECRETAC	Survey stakeholder agencies regarding their needs for medical direction and their level of satisfaction with the current system of medical direction
	Enhance the feedback process from the Medical Director to the pre-hospital agency director or chief
SLVRETAC	Consider the implementation of a regional medical director program, including a funding source
	Develop a written description of duties that a medical director should perform
	Expand the medical director duties to include system oversight or consider the use of an assistant system medical director
	Survey stakeholder agencies regarding their needs for medical direction and their level of satisfaction with the current system of medical direction
SWRETAC	Consider a regional forum to bring all Medical Directors together at least annually
	Enhance the feedback process from the Medical Director to the pre-hospital agency director or chief
	Develop clear consistent regional guidelines and expectations for SWRETAC Medical Directors

WRETAC	Support and encourage the creation of and active participation in a Physicians Advisory Group to direct protocol development and standardization, where possible

RETAC	EMTS Component: Clinical Care
CMRETAC	Finalize the regional CQI plan
	Develop a standardized, uniform clinical documentation format or template in conjunction with regional medical coordination
FRETAC	Consider moving towards standardized regional medical protocols with agency specific variations
	Assist EMTS agencies with the development of in-house Continuous Quality Improvement (CQI) activities specific to individual patient care
MHRETAC	No major recommendations, high-quality clinical care exists in the urban and suburban areas
	Assist the rural EMTS stakeholders with enhancing the level of clinical care provided
NCRETAC	Consider moving towards standardized medical protocols with agency specific variations
	Consider the development of a regional Continuous Quality Improvement (CQI) plan or at least a template for a comprehensive CQI plan that can be adopted by system stakeholders
	Expand the implementation of electronic patient care report systems, including funding assistance for the purchase of such systems for those agencies not using ePCR systems
NWRETAC	Consider moving towards standardized medical protocols with agency specific variations
	Consider the development of a regional Continuous Quality Improvement (CQI) plan or at least a template for a comprehensive CQI plan that can be adopted by system stakeholders
PTPRETAC	Continue the movement towards standardized medical protocols with agency specific variations
	Consider the development of a regional Continuous Quality Improvement (CQI) plan or at least a template for a comprehensive CQI plan that can be adopted by system stakeholders
	Expand the implementation of electronic patient care report systems, including funding assistance for the purchase of such systems for those agencies not using ePCR systems
SCRETAC	Develop a regional Continuous Quality Improvement (CQI) plan or at least a template for a comprehensive CQI plan that can be adopted by system stakeholders
	Develop a standardized uniform clinical documentation format or template
	Explore the implementation of electronic patient care report systems, including funding assistance for the purchase of such systems
SECRETAC	Consider moving towards standardized medical protocols with agency specific variations
	Consider the development of a regional Continuous Quality Improvement (CQI) plan or at least a template for a comprehensive CQI plan that can be adopted by system stakeholders
SLVRETAC	Establish a standing committee to develop and maintain regional patient treatment protocols

	Develop a regional Continuous Quality Improvement (CQI) plan or at least a template for a comprehensive CQI plan that can be adopted by system stakeholders
	Develop a standardized uniform clinical documentation format or template
	Explore the implementation of electronic patient care report systems, including funding assistance for the purchase of such systems
SWRETAC	Consider moving towards standardized regional medical protocols with agency specific variations
	Encourage participation of EMTS stakeholders in the SWRTEAC Regional Systems Improvement Plan
	Assist EMTS agencies with the development of in-house Continuous Quality Improvement (CQI) activities specific to individual patient care
WRETAC	Consider moving towards standardized medical protocols with agency specific variations as needed
	Consider the development of a regional CQI plan or at least a template for a comprehensive CQI plan that can be adopted by system stakeholders
	Expand the implementation of electronic patient charting systems, including funding assistance for the purchase of such systems for those agencies not using electronic patient care report systems

RETAC	EMTS Component: Mass Casualty
CMRETAC	Collect agency disaster plans and review the level of system support required for each
	Create a regional mass casualty plan in conjunction with each county's emergency managers
	Conduct regional exercises and drills based on the regional plan at least annually
	Develop an evaluation process for mass casualty exercises and drills
	Identify necessary supplies and equipment for mass casualty incidents; develop inventory, strategic placement locations, and monitoring procedures
FRETAC	No major recommendations – continue enhancing the FRETAC mass casualty incident (MCI) program and continue development of education plan for MCI training throughout the region
MHRETAC	Update current MCI Plan on a regular basis and document updates
	Clarify the responsibility for coordination, planning and exercising the MCI Plan
NCRETAC	Continue to participate in local, regional, and state mass casualty exercises and drills
	Conduct regional exercises and drills based on the RETAC MCI plan
	Develop an evaluation process for mass casualty exercises and drills
NWRETAC	Update the current NWRETAC Mass Casualty Plan to include agencies/facilities current capabilities
	Continue to participate in local, regional, and state mass casualty exercises and drills
	Conduct regional exercises and drills based on each counties plan
	Develop an evaluation process for mass casualty exercises and drills

PTPRETAC	Continue to participate in local, regional, and state mass casualty exercises and drills
	Clearly communicate that the Mass Casualty plan in the Plains to Peaks RETAC is agency specific and the responsibility of the All Hazards Region agency
	Conduct regional exercises and drills based on the specific plans of each county
	Develop an evaluation process for mass casualty exercises and drills
	Obtain surplus supplies and equipment for mass casualty incidents and an inventory and monitoring procedure
SCRETAC	Participate in local, regional, and state mass casualty exercises and drills
	Update the regional mass casualty plan in conjunction with the region's emergency managers
	Conduct exercises and drills based on the regional plan
	Develop an evaluation process for mass casualty exercises and drills
	Obtain surplus supplies and equipment for mass casualty incidents and an inventory and monitoring procedure
SECRETAC	Continue to participate in local, regional, and state mass casualty exercises and drills
	Continue to conduct regional exercises and drills based on each counties plan
	Enhance the evaluation process for mass casualty exercises and drills
SLVRETAC	Continue to participate in local, regional, and state mass casualty exercises and drills
	Develop a regional mass casualty plan in conjunction with the region's emergency managers
	Conduct exercises and drills based on the regional plan
	Develop an evaluation process for mass casualty exercises and drills
	Obtain surplus supplies and equipment for mass casualty incidents and an inventory and monitoring procedure
SWRETAC	No major recommendations – continue enhancing the SWRETAC mass casualty incident (MCI) program and Phase II training
WRETAC	Ensure all agencies/facilities continue to participate in local and regional mass casualty exercises and training
	Develop a WRETAC MCI plan that coordinates with the needs and resources of member agencies
	Conduct regional exercises and drills based on the WRETAC MCI plan developed

RETAC	EMTS Component: Public Education
CMRETAC	Establish a public education committee to formalize an annual regional education plan with clear objectives
	Ensure that all stakeholders have the opportunity to participate in the regional education plan and activities
	CMRETAC should assume a supportive and coordinating role in the provision of public education through collaboration with the agencies
	Develop an annual, continuous public education campaign to promote awareness of the EMTS system, including the promotion of wellness and prevention
	Explore funding sources, including pooling of funds to support the regional public education campaign
	Develop "off-the-shelf" public education programs that individual agencies can implement

FRETAC	Assume a leadership role in the provision of public education through collaboration with the EMTS providers
	Identify agencies and organizations that currently provide good public education programs
	Partner with the hospitals and conduct public education campaigns on a rotating basis
	Develop an annual, continuous public education campaign to promote awareness of the EMTS system programs, including the promotion of wellness and prevention
	Explore funding sources and grants, including pooling of funds to support a regional public education campaign
	Develop "off-the-shelf" public education programs that individual agencies/facilities can implement
MHRETAC	Assume a leadership role in the provision of public education through collaboration with the EMTS providers
	Identify agencies and organizations that currently provide good public education programs
	Partner with the hospitals and conduct public education campaigns on a rotating basis
	Develop an annual, continuous public education campaign to promote awareness of the EMTS system programs, including the promotion of wellness and prevention
	Explore funding sources and grants, including pooling of funds to support a regional public education campaign
	Develop "off-the-shelf" public education programs that individual agencies/facilities can implement
NCRETAC	Assume a leadership role in the provision of public education through collaboration with the EMTS providers
	Identify agencies and organizations that currently provide good public education programs
	Partner with the hospitals and conduct public education campaigns on a rotating basis
	Develop an annual, continuous public education campaign to promote awareness of the EMTS system, including the promotion of wellness and prevention
	Continue to explore funding sources and grants, including pooling of funds to support a regional public education campaign
	Develop "off-the-shelf" public education programs that individual agencies/facilities can implement
NWRETAC	Engage the Education and Public Information and Injury Prevention committees
	Assume a leadership role in the provision of public education through collaboration with the EMTS providers
	Identify agencies and organizations that currently provide good public education programs
	Partner with the hospitals and conduct public education campaigns on a rotating basis
	Develop an annual, continuous public education campaign to promote awareness of the EMTS system programs, including the promotion of wellness and prevention
	Explore funding sources and grants, including pooling of funds to support a regional public education campaign
	Develop "off-the-shelf" public education programs that individual agencies/facilities can implement
PTPRETAC	Assume a leadership role in the provision of public education through collaboration with the EMTS providers
	Identify agencies and organizations that currently provide good public education programs
	Partner with the hospitals and conduct public education campaigns on a rotating basis
	Develop an annual, continuous public education campaign to promote awareness of the EMTS system, including the promotion of wellness and prevention

	Continue to explore funding sources and grants, including pooling of funds to support a regional public education campaign
	Develop "off-the-shelf" public education programs that individual agencies/facilities can implement
SCRETAC	Assume a leadership role in the provision of public education through collaboration with the EMTS providers
	Develop an annual, continuous public education campaign to promote awareness of the EMTS system, including the promotion of wellness and prevention
	Explore funding sources, including pooling of funds to support a regional public education campaign
	Develop "off-the-shelf" public education programs that individual agencies/facilities can implement
SECRETAC	Assume a leadership role in the provision of public education through collaboration with the EMTS providers
	Identify agencies and organizations that currently provide good public education programs
	Partner with the hospitals and conduct public education campaigns on a rotating basis
	Develop an annual, continuous public education campaign to promote awareness of the EMTS system programs, including the promotion of wellness and prevention
	Explore funding sources and grants, including pooling of funds to support a regional public education campaign
	Develop "off-the-shelf" public education programs that individual agencies/facilities can implement
SLVRETAC	Assume a leadership role in the provision of public education through collaboration with the EMTS providers
	Identify agencies and organizations that currently provide good public education programs
	Partner with the hospitals and conduct public education campaigns on a rotating basis
	Develop an annual, continuous public education campaign to promote awareness of the EMTS system programs, including the promotion of wellness and prevention
	Explore funding sources and grants, including pooling of funds to support a regional public education campaign
	Develop "off-the-shelf" public education programs that individual agencies/facilities can implement
SWRETAC	Assume a leadership role in the provision of public education through collaboration with the EMTS providers
	Identify agencies and organizations that currently provide good public education programs
	Partner with the hospitals and conduct public education campaigns on a rotating basis
	Develop an annual, continuous public education campaign to promote awareness of the EMTS system programs, including the promotion of wellness and prevention
	Explore funding sources and grants, including pooling of funds to support a regional public education campaign
	Develop "off-the-shelf" public education programs that individual agencies/facilities can implement
WRETAC	Partner with the hospitals and conduct public education campaigns on a rotating basis
	Develop an annual, continuous public education campaign to promote awareness of the EMTS system, including the promotion of wellness and prevention
	Continue to explore funding sources and grants, including pooling of funds to support a regional public education campaign
	Share successful public education campaigns/programs with other agencies
	Develop "off-the-shelf" public education programs that individual agencies/facilities can implement

RETAC	EMTS Component: Illness/Injury Prevention
CMRETAC	Establish an injury/illness prevention committee
	Collect data from all stakeholders and review for trends to be addressed
	Develop a coordinated comprehensive regional injury/illness prevention program
FRETAC	Develop partnerships and linkages with the public health system and area hospitals to identify prevention program goals based on most recent gap analysis study
	Regionalize prevention activities
	Include illness prevention activities
MHRETAC	Assume a leadership role in the provision of illness and injury prevention through collaboration with the EMTS providers
	Develop partnerships and linkages with the public health system and area hospitals to identify prevention program goals
	Identify sources of information, including public health surveillance and emergency department data to identify the types of injuries and illness that may be prevented in the region
NCRETAC	Consider having the current NCRETAC ad hoc Prevention Committee develop a coordinated comprehensive regional injury/illness prevention program
	Develop partnerships and linkages with the public health system and area hospitals to identify program
	Identify sources of information, including public health surveillance and emergency department data to identify the types of injuries and illness that may be prevented in the region
NWRETAC	Engage the Education and Public Information and Injury Prevention committees
	Develop partnerships and linkages with the public health system and area hospitals to identify program goals
	Identify sources of information, including public health surveillance and emergency department data to identify the types of injuries and illness that may be prevented in the region
PTP RETAC	Establish an ad hoc injury/illness prevention committee through the RETAC
	Develop partnerships and linkages with the public health system and area hospitals
	Identify sources of information, including public health surveillance and emergency department data to identify the types of injuries and illness that may be prevented in the region
	Develop a coordinated comprehensive regional injury/illness prevention program
SCRETAC	Establish an injury/illness prevention committee
	Develop partnerships and linkages with the public health system
	Identify sources of information, including public health surveillance and emergency department data to identify the types of injuries and illness that may be prevented
	Develop a coordinated comprehensive regional injury/illness prevention program
SECRETAC	Develop partnerships and linkages with the public health system and area hospitals to identify program goals

	Identify sources of information, including public health surveillance and emergency department data to identify the types of injuries and illness that may be prevented in the region
SLVRETAC	Establish an injury/illness prevention committee
	Develop partnerships and linkages with the public health system and area hospitals
	Identify sources of information, including public health surveillance and emergency department data to identify the types of injuries and illness that may be prevented in the region
	Develop a coordinated comprehensive regional injury/illness prevention program
SWRETAC	Provide information to the SWRETAC EMTS stakeholders regarding the RETACS injury prevention activities and programs
	Develop partnerships and linkages with the public health system and area hospitals to identify prevention program goals
	Identify sources of information, including public health surveillance and emergency department data to identify the types of injuries and illness that may be prevented in the region
WRETAC	Expand regional programs beyond occupant safety program
	Consider having the current WRETAC Injury Prevention Committee develop a coordinated comprehensive regional injury/illness prevention program
	Develop partnerships and linkages with the public health system and area hospitals to identify programs
	Identify sources of information, including public health surveillance and emergency department data, to identify the types of injuries and illness that may be prevented in the region

RETAC	EMTS Component: Information Systems
CMRETAC	Formalize the monitoring of regional performance, related feedback, and communicate with the stakeholders regularly
	Establish an information systems committee to determine what data is of interest and its availability
	Identify the key performance indicators necessary to monitor and evaluate the system
	Integrate pre-hospital, hospital, and trauma data to assess the quality of the regional EMTS system
	Use the integrated information to drive policy and protocol decisions within the CQI plan
	Provide feedback to management and providers on a regular basis
FRETAC	No major recommendations, continue active regional data collection activities
	Explore options for an integrated hospital and pre-hospital data collection system and interoperability
MHRETAC	Determine what information and data sources are currently available from the EMTS stakeholders
	Identify data elements necessary to monitor and evaluate the system
	Identify funding sources for hardware and software to collect data
	Integrate pre-hospital, hospital, and trauma data to assess the quality of the regional EMTS system
	Use the integrated information to drive policy and protocol decisions
	Provide feedback to management and providers on a regular basis

NCRETAC	Determine what information and data sources are currently available from the EMTS stakeholders
	Identify data elements necessary to monitor and evaluate the system
	Identify funding sources for hardware and software to collect data
	Integrate pre-hospital, hospital, and trauma data to assess the quality of the regional EMTS system
	Use the integrated information to drive policy and protocol decisions
	Provide feedback to management and providers on a regular basis
	Consider a system to provide patient feedback to frontier/rural EMS providers, especially for medical patients
NWRETAC	Determine what information and data sources are currently available from the EMTS stakeholders
	Identify data elements necessary to monitor and evaluate the system
	Identify funding sources for hardware and software to collect data
	Integrate pre-hospital, hospital, and trauma data to assess the quality of the regional EMTS system
	Use the integrated information to drive policy and protocol decisions
	Provide feedback to management and providers on a regular basis
PTPRETAC	Determine what information and data sources are currently available from the EMTS stakeholders
	Identify data elements necessary to monitor and evaluate the system
	Identify funding sources for hardware and software to collect data
	Integrate pre-hospital, hospital, and trauma data to assess the quality of the regional EMTS system
	Use the integrated information to drive policy and protocol decisions
	Provide feedback to management and providers on a regular basis
	Consider a system to provide patient feedback to frontier/rural EMS providers, especially for medical patients
SCRETAC	Have the Data Collection Committee determine what information and data sources are currently available from the EMTS stakeholders
	Identify data elements necessary to monitor and evaluate the system
	Integrate pre-hospital, hospital and trauma data to assess the quality of the regional EMTS system
	Use the integrated information to drive policy and protocol decisions
	Provide feedback to management and providers on a regular basis
SECRETAC	Determine what information and data sources are currently available from the EMTS stakeholders
	Identify data elements necessary to monitor and evaluate the system
	Identify funding sources for hardware and software to collect data
	Integrate pre-hospital, hospital, and trauma data to assess the quality of the regional EMTS system
	Use the integrated information to drive policy and protocol decisions
	Provide feedback to management and providers on a regular basis
SLVRETAC	Determine what information and data sources are currently available from the EMTS stakeholders
	Identify data elements necessary to monitor and evaluate the system

	Identify funding sources for hardware and software to collect data
	Integrate pre-hospital, hospital, and trauma data to assess the quality of the regional EMTS system
	Use the integrated information to drive policy and protocol decisions
	Provide feedback to management and providers on a regular basis
SWRETAC	Determine what information and data sources are currently available from the EMTS stakeholders
	Identify data elements necessary to monitor and evaluate the system
	Identify funding sources for hardware and software to collect data
	Integrate pre-hospital, hospital, and trauma data to assess the quality of the regional EMTS system
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WRETAC	Determine what information and data sources are currently available from the EMTS stakeholders
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	Integrate pre-hospital, hospital, and trauma data to assess the quality of the regional EMTS system
	Use the integrated information to drive policy and protocol decisions
	Provide feedback to management and providers on a regular basis
	Consider a system to provide patient feedback to EMTS providers, especially for medical patients

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III. Colorado DPHE Emergency Medical and Trauma Services Standardized (Regional) Needs Assessment (July 2010)

Colorado Department of Public Health and Environment
Emergency Medical and Trauma Services
Standardized (Regional) Needs Assessment Project

Northwest Colorado
Regional Emergency Medical and Trauma Advisory Council
Final Report

A report from:

The Abaris Group
Walnut Creek, CA

July 2010

Colorado Department of Public Health and Environment
Emergency Medical and Trauma Services

Standardized (Regional) Needs Assessment Project
Northwest Colorado RETAC

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Executive Summary

The Abaris Group conducted a needs assessment for the Northwest Colorado Regional Emergency and Trauma Advisory Council's (NWRETAC) Emergency Medical and Trauma Services (EMTS) system beginning in October 2009 and concluding in May 2010. The assessment included onsite visits and interviews with the NWRETAC stakeholders, the use of two surveys; a standardized Benchmarks, Indicators, and Scoring (BIS) survey instrument and a problem ranking survey. The BIS uses a weighted scoring system with 0 meaning "I don't know" and 5 meaning a program or EMTS component is comprehensive and well established. BIS questions scored with higher numbers (4s and 5s) indicate that the component or program is comprehensive and well established. The comments from the onsite assessments were formatted into a Strengths, Weaknesses, Opportunities and Threats (SWOT) format and the data from the two surveys was entered into several spreadsheets for analysis. This report contains the results of the needs assessment and recommendations for the NWRETAC's consideration to enhance the EMTS system in Northwest Colorado.

The overall BIS scores revealed that the average score for the agency/facility was 2.9 and the average score for the system was a 1.7. The respondents most frequently scored their own agency or facility with threes or fours, indicating that these categories are mostly beyond the planning or discussion phase but not yet comprehensively established. However, respondents were not able to score many of the questions as they related to the overall system's efforts. Respondents answered "I don't know" to 43 percent of the questions as they related to the overall EMTS system. Respondents were most aware of overall system efforts in the areas of Integration of Health Services, EMTS Research, and Legislation and Regulation.

The hospital providers scored their facility higher on average than the pre-hospital respondents (3.2 vs. 2.8). Both hospital and pre-hospital respondents scored the overall EMTS system similarly (1.7 vs. 1.6). Overall, EMTS Research received the lowest combined score (1.4) while Integration of Health Services received the highest (3.1).

Individual questions that received the highest scores were Integration of Health Service structure (Q 1.1), System Finance outcomes (Q 4.3), Regulation and Legislation structure (Q 3.1), and Public Access structure (Q 7.1). Questions that received the lowest scores were RETAC communication systems (Q 9.4), RETAC information systems (Q 15.4), and EMTS Research outcomes (Q 2.3).

The NWRETAC developed seven RETAC specific questions; four related to System Finance (Q 4.5, 4.6, 4.7, 4.8); two related to Educations Systems (Q 6.5 and 6.6); and one question regarding the Mass Casualty component. The BIS results and scores for these questions are addressed under each specific component in this report and on the excel spreadsheets provided with this report.

From the problem ranking survey results, the issues that were identified as most challenging for the Pre-Hospital respondents were Recruitment and Retention of Personnel. For Hospital respondents, Agency Funding/Financial Viability and Billing/Accounts Receivable were their most challenging issues. Overall, both pre-hospital and hospital respondents reported that their least challenge issues were Support from RETAC, Cooperation with Other Agencies, and Medical Director Involvement.

The recommendations for the Northwest Colorado RETAC include both short-term and long-term activities. The council members should review and prioritize the recommendations for the region. Inclusion of these recommendations into the biennial plan is highly encouraged.

Background and Project Overview

In September 2008, the EMTS Section, within the Health Facilities and Emergency Services Division of the Colorado Department of Public Health and Environment (CDPHE) notified The Abaris Group of its intent to award to the firm a contract to conduct comprehensive assessments of the EMTS systems of 11 regional emergency medical and trauma advisory councils (RETACs) of Colorado over the next three fiscal years, anticipating three or four assessments may be completed each fiscal year. Colorado Revised Statute (CRS), 25-3.5-704 (2) (c) (II) (F), requires "The identification of regional EMTS through the use of a needs-assessment instrument developed by the department; except that the use of such instrument shall be subject to approval by the counties and city and counties included in a RETAC." The EMTS Section, in partnership with Colorado's RETACs, established a task force to address a Standardized, regional Needs Assessment Project (SNAP). The goal of this project is to support each of Colorado's RETACS in completing an assessment process as required by statute, but more importantly to assess local and regional EMTS in a way that provides consistent results that can be the basis for future development of biennial plans that addresses those needs and accurately identifies the policies and resources necessary to meet the future system requirements.

In 2006, the Western RETAC completed a comprehensive assessment that was funded through a grant from the Department of Local Affairs (DOLA). A requirement of the DOLA grant was that all assessment tools, products and processes of the Western RETAC model would be made available to the RETACs across the State of Colorado for possible standardization and replication. The SNAP Task Force reviewed the Western RETAC model which used onsite assessments of the RETAC stakeholders, a problem ranking survey, and an assessment instrument that included benchmarks, indicators, and scoring (BIS) sections based on the 15 trauma/EMS components identified within the Colorado Administrative Code. The SNAP Task Force modified the BIS assessment instrument to measure Colorado's EMTS system development from a RETAC perspective. (For more information on the BIS instrument, read the WRETAC final report available on the EMTS website.)

Assessments were completed on four RETAC in the first year of this project. The second and third years of this project were combined with the goal to complete the remaining 8 RETAC assessments by June 30, 2010. In collaboration with staff from EMTS and the SNAP Task Force, the eight RETACs for the second-year assessment were divided into two groups.

<u>July - January</u>

- Northeast Colorado RETAC
- Northwest RETAC
- Plains to Peaks RETAC
- Southeastern Colorado RETAC

<u>January – June</u>

- Foothills RETAC
- Mile-High RETAC
- Southwest RETAC
- Western RETAC

Methodology

The methods utilized for the NWRETAC assessment consisted of the following:

- Review of documents – Several documents related to the EMTS systems in Colorado, including relevant CRS, NWRETAC Biennial Plan, NWRETAC agency profiles, NWRETAC meeting minutes, and the NWRETAC budget.
- Development of RETAC specific questions – The BIS instrument is designed to accommodate additional RETAC specific questions related to the 15 Colorado trauma/EMS components. The NWRETAC developed seven specific questions, four related to system finance, two related to education systems and one related to mass casualty.
- Attend NWRETAC Meeting – The Abaris Group attended the NWRETAC board meeting prior to the onsite assessments, presented an overview of the SNAP and introduced the BIS instrument and problem ranking survey to the NWRETAC Board members.
- Distribution of BIS and Problem Ranking Survey – The BIS instrument and problem ranking survey were provided to the NWRETAC stakeholders electronically and in paper form.
- Onsite Assessments – In collaboration with the NWRETAC coordinator, The Abaris Group met with a sampling of the NWRETAC stakeholders. A SWOT analysis of the NWRETAC was performed with the information provided by the NWRETAC's stakeholders.
- Tabulation and Analysis of BIS and Problem Ranking Survey – The returned, completed BIS data and completed problem ranking surveys were entered into a data base. The BIS scoring and problem rankings were analyzed.
- Conclusions and Recommendations – Based on the data from the onsite assessments, BIS and problem ranking survey, conclusions and recommendations for NWRETAC system enhancements were identified.
- Draft Report – A draft report with conclusions and recommendations was submitted to the NWRETAC Coordinator and Chairperson for confirmation of factual data. Several comments were made and a follow-up phone call to discuss the report with the NWRETAC Chair and Coordinator was completed on June 10, 2010.
- Report Presentation – Conclusions from the draft report were presented to the NWRETAC in an open forum on May, 10, 2010. The final report will be distributed to the NWRETAC Board and interested stakeholders.

Overview of the Northwest Colorado RETAC

The NWRETAC is a council that serves the five counties of Garfield, Mesa, Moffat, Rio Blanco, and Routt. The NWRETAC Board is composed of 15 voting members representing each of the five counties. The Board members represent primarily pre-hospital and hospital disciplines. The NWRETAC Bylaws allows for three alternate members from each county. The organizations currently represented on the RETAC Board include the following:

Garfield County

- Carbondale and Rural Fire Protection District
- Grand River Hospital District
- Valley View Hospital

Mesa County

- Community Hospital
- Grand Junction Fire Department
- Mesa County EMS

Moffat County

- Moffat County Office of Emergency Management
- The Memorial Hospital
- EMS Medical Director - Moffat County

Rio Blanco County

- Pioneers Medical Center
- Rangely District Hospital
- Rio Blanco Fire Protection District

Routt County

- Routt County Emergency Management
- Steamboat Springs Fire-Rescue
- Yampa Valley Medical Center

The Council has an elected Executive Committee consisting of a chairperson, vice-chairperson, secretary, and a treasurer. The NWRETAC has contracted with a coordinator who performs specific tasks on a part-time basis. The NWRETAC Bylaws allow for the establishment of a number of committees as needed to address specific EMTS and RETAC issues. Current active committees are the Budget and Planning Committee, Trauma Coordinators Committee and Leadership Conference Committee. Other committees that may be established by the Board include:

- Grants and Donations
- Transportation
- Facilities
- Quality Assurance and Performance Improvement
- Peer Review
- Ambulance Licensing
- Injury Prevention
- Data and Trauma Registry
- Education and Public Information
- Mass Casualty Incident Management

The NWRETAC meetings are held every other month. The meeting location is in Meeker at the offices of the Rio Blanco Fire Protection District. The NWRETAC meetings are well attended by the board members, alternate members, and other interested EMTS stakeholders.

The NWRETAC is described in its Bylaws as "the representative body" for the five counties within the NWRETAC. It is not a quasi-government agency or non-profit agency and therefore has limitations in regards to certain administrative and business activities. They recently entered into an agreement with the Western RETAC to serve as their fiscal agent in order to receive funds from the CDPHE EMTS Section.

The NWRETAC Coordinator acts as a liaison between the RETAC agencies and various state entities, including the CDPHE, SEMTAC, other RETACs as well as other agencies or organizations that affect the concerns and decisions of the NWRETAC. Currently, the NWRETAC Coordinator position is a part-time contracted position.

The Northwest Colorado RETAC EMTS system consists of a combination of paid and volunteer EMTS agencies and facilities. There are approximately 62 ambulances in the region operated by 25 licensed transport agencies and eight receiving facilities. Because of the large geographic remote areas of the NWRETAC, utilization of most ambulances in the region is low. The types of agencies and facilities include the following:

- 5 County EMTS Councils
- First-response agencies, including ski patrols and search and rescue organizations
- Paid and volunteer fire department first-responders
- 25 licensed transport agencies
- 1Level II hospitals/trauma center
- 1 Level III hospitals/trauma center
- 6 Level IV hospitals/trauma centers
- 1 Non-designated hospital
- 1 Veterans Administration (VA) hospital
- 4 state-approved EMS training centers (3 associated with community colleges) and 6 state-approved EMS training groups
- 6 Public Safety Answering Points (PSAP)
- 3 County communications centers
- 2 City communications centers (one is a consolidated center)
- 1 Regional communications center
- 5 Emergency Management offices
- 5 Search and Rescue agencies
- 1 Helicopter Ambulance

Other agencies include law enforcement, public health, nurse associations and county fire chief forums. Staffing of NWRETAC EMTS pre-hospital agencies includes a combination of paid and volunteer personnel. In the frontier and rural areas in each county, EMS is primarily provided by volunteer or part-time personnel.

Northwest Colorado RETAC Onsite and Offsite Activities

The Abaris Group consultant attended a special meeting of the NWRETAC on October 12, 2009 in Meeker. At that meeting, an overview of the SNAP was provided and the BIS and problem ranking survey were introduced to the council members.

Onsite assessments were conducted on October 12 - 14 and November 9, 2009. Onsite assessments consisted of traveling to a sample of the EMTS agencies and organizations' primary place of business or a mutually agreed upon location and interviewing one or more representatives. Participants were asked to provide an overview of their organization and the NWRETAC, including a SWOT assessment of both related to the 15 Colorado EMTS components. The results of the SWOT analysis are included in this report.
The following 12 agencies/organizations representatives participated in the onsite visits or telephone interviews:

- Burning Mountain Fire Protection District
- Carbondale and Rural Fire Protection District
- Clifton Fire Protection District
- Grand Junction Fire Department
- Lower Valley Fire Protection District
- Mesa County EMS
- Pioneers Medical Center
- Plateau Valley Fire Protection District
- Rio Blanco County EMTS Council
- Rio Blanco Fire Protection District
- St. Mary's Hospital
- Steamboat Springs Fire-Rescue

A Town Hall meeting was held in conjunction with the NWRETAC Board meeting November 9, 2009 in Meeker, CO. A SWOT analysis format was used to stimulate discussions related to each of the 15 Colorado trauma/EMS components. Notes were taken during the meeting and are summarized in this report.

Representatives from the following 12 agencies and organizations were in attendance at the Town Hall meeting:

- Carbondale and Rural Fire Protection District
- Grand Junction Fire Department
- Grand River Hospital District
- Moffat County Emergency Management
- Moffat County EMTS Council
- NWRETAC Coordinator
- Pioneers Medical Center
- Rio Blanco Fire Protection District

- St. Mary's Care Flight
- St. Mary's Hospital
- Steamboat Springs Fire-Rescue
- Yampa Valley Medical Center

In addition to the interviews and town hall meeting, there were representatives from 13 EMTS agencies/facilities that completed the BIS survey or the problem ranking survey, or both. They were:

- Carbondale and Rural Fire Protection District
- Clifton Fire Protection District
- Grand River Hospital District
- Mesa County EMS
- Moffat County Emergency Management
- Oak Creek Fire Protection District
- Pioneers Medical Center
- Rio Blanco County EMTS Council
- Rio Blanco Fire Protection District
- Steamboat Springs Fire-Rescue
- Valley View Hospital
- West Routt Fire Protection District
- Yampa Fire Protection District

In total, there were 22 agencies or facilities involved in this assessment process with over 25 individuals providing some form of input either through onsite or telephone interviews, town hall meetings, or the completion of the BIS or problem ranking survey.

Offsite activities included reviewing several documents and other sources related to the NWRETAC. These sources include the following:

- NWRETAC 2009 - 2011 Biennial Plan
- NWRETAC 2009/2010 budget
- NWRETAC Bylaws (2009 edition)
- Internet search on NWRETAC

The NWRETAC currently does not have a website resulting in most documents being provided by the NWRETAC Coordinator or through the CDPHE EMTS Section website.

Onsite SWOT Analysis

There were onsite or telephone interviews with representatives of 12 NWRETAC EMTS agencies/organizations. There were 12 NWRETAC EMTS agencies/organizations represented at the Town Hall meetings. Overall, either through individual interviews or by attending the Town Hall, input was received from 22 NWRETAC EMTS agencies and organizations.

The NWRETAC is attempting to meet the needs of its EMTS stakeholders in a variety of ways. Since most RETAC Board members have full-time positions as EMTS providers and the RETAC Coordinator position is part-time, the NWRETAC has had to be selective in the activities it undertakes. The NWRETAC Biennial Plan identifies clinical care, mass casualty and prevention have been identified as the system components with the most urgent needs while improvements to clinical care, communications systems and mass casualty are considered the highest priority. The part-time RETAC Coordinator is an effective leader who is well respected and viewed as one of the strengths of the RETAC.

The NWRETAC is well integrated with participation from both pre-hospital and hospital stakeholders as well as emergency management officials. A desire for more involvement of non-traditional EMS groups such as ski patrol and search and rescue was expressed by some. EMTS research is virtually non-existent partially because of the lack of resources and low call/patient volumes. The NWRETAC Coordinator expressed to the consultant that EMTS research generally has a low return on investment and that it requires a considerable amount of resources and the end result has minimal impact on patient care or agency operations. Legislation and regulation issues are handled well by the RETAC with the Coordinator keeping the EMTS stakeholders informed. The NWRETAC was instrumental in persuading the CDPHE EMTS Section to maintain EMT-I level certifications. Advanced life support (ALS) in northwest Colorado is primarily provided by EMT-P personnel in Garfield and Mesa Counties, as well as in Steamboat Springs. In the rural and frontier areas of the region, EMT-I personnel are the primary providers of ALS. The funds available for the NWRETAC are inadequate to fund a full-time Coordinator. The NWRETAC currently authorizes the counties to use the entire state allocation of $15,000 per county to support local programs that maintain or improve the EMTS system. There have instances in the past where county funds were used for regional projects or programs through the RETAC. Human resources issues with recruitment and retention is a major concern for the NWRETAC region. Education system needs involve the need for outreach training and additional opportunities for ALS training, including continuing education. The NWRETAC conducts an annual Northwest RETAC Leadership conference that involves the regions Medical Directors as well. Public access to 9-1-1 is available throughout the region although there are dead spots for cell phones along the highways.

There is some evaluation of the EMTS system and most evaluation of patient care is agency/facility specific in each county. There is very little evaluation of the EMTS system on a regional basis because of concerns regarding discoverability and the lack of guidelines or rules from the CDPHE EMTS Section. The communication system in the NWRETAC is fragmented with 800 Digital Trunked Radio (DTR) system used sporadically and the use of UHF and VHF radio frequencies also used. The infrastructure required for the 800 DTR is being phased in over the next few years. Although medical direction is provided by multiple medical directors in the region, they actively communicate between each other and meet at least annually at the Leadership conference. There is a high level of clinical care being provided in the region with most agencies providing ALS patient care. There is a NWRETAC specific mass casualty plan in place, although it has not been updated in the past few years to reflect the current capabilities. There are a few public education and illness/injury prevention programs in place, most are agency/facility specific, although the NWRETAC received a grant to build a regional coalition to implement an occupant protection program.

The information systems used throughout the RETAC vary from pen and paper systems to high tech electronic patient care reporting (ePCR) systems.

The comments from the interviews and Town Hall meeting were organized in a format indicating strengths, weaknesses, opportunities, and threats (SWOT). These comments are summarized below.

Strengths

- NWRETAC Board Members – Diversity of Board members (small and large agencies represented); common and shared core beliefs and values; good communications; non-competitive; neighborly and strong bonds with partners; blending of frontier and urban ideas, procedures, and processes; cohesive
- RETAC Coordinator – Respected and very knowledgeable; good Board support; understands and integrates urban, rural and frontier EMTS issues; advocates for all regions of the RETAC; good liaison, attends meetings and updates stakeholders
- County EMTS Councils – All five counties have active EMTS councils that interact with the NWRETAC
- Integration/Cooperation – Hospitals and pre-hospital personnel work well together and assist each other as needed
- Medical Direction – Medical Directors meet annually at the NWRETAC Leadership conference
- Education/Training – Three colleges in region provide EMTS training and education; St. Mary's outreach training programs
- County Funding - The entire $15,000 state allotment per county goes to each county (expressed as both a strength and weakness); no funding back to RETAC unless there is county support for a regional project that benefits the entire region
- Grant Opportunities – Grants have been extremely beneficial to enhance EMTS delivery in the region

Weaknesses

- RETAC Boundaries – Long distances to travel for meetings or training
- RETAC Coordinator Workload – Coordinator part-time position and must prioritize RETAC activities
- EMTS Personnel/Staffing – Recruitment and retention of EMS and pre-hospital volunteer EMS agencies and some of the rural hospital personnel; lack of management depth; lack of succession planning for rural/volunteer agencies
- Communications – With non-traditional EMTS agencies, i.e. ski patrols and search and rescue agencies; between RETAC and county EMTS Councils; from CDPHE EMTS Section to RETAC
- Radio Communications - Multiple radio systems including 800, UHF, and VHF, inadequate 800 infrastructure in place
- RETAC Funding – No increase in funding since 1998; the entire $15,000 state allotment per county goes to each county (expressed as both a weakness and a strength)
- Quality Improvement – Very little pre-hospital evaluation and QI activities throughout region, better in urban areas and hospitals
- Education/Training – High cost for initial and continuing education provided through community colleges; the availability of ALS continuing education in frontier/rural areas

Opportunities

- Focus on Issues – Because of the non-competiveness of the NWRETAC Board members, easy to focus on specific issues
- Non-Traditional EMTS Stakeholders – Improve communications and increase involvement with these groups
- Education/Training – Continue to work closely with the three colleges and all the hospitals in the region to enhance education and training
- Technology Use – Better use of technology to reduce travel for meetings and training; enhance communications throughout RETAC; develop NWRETAC website to enhance information distribution

Threats

- Loss of RETAC Coordinator – Due to inadequate funding
- Funding – Inadequate or loss of funding to RETAC and counties
- EMTS Personnel/Staffing – Retention/recruitment of hospital and EMS providers in rural/frontier areas; reliance on EMS volunteers in many communities
- Time and Distance – Travel time and expense to meetings and training resulting in less participation

Benchmarks, Indicators, and Scoring (BIS) Instrument – Results, Analysis and Recommendations

This section of the report contains the analysis of the BIS instrument including both the agency/facility scores and the system (Northwest Colorado RETAC) scores. The BIS uses a weighted scoring system with 0 meaning "I don't know" and 5 meaning a program or EMTS component is comprehensive and well established. Scores with higher numbers indicate that the component or program is comprehensive and well established. In addition to the 45 BIS questions (4/category), the NWRETAC added seven RETAC specific questions.

Twelve organizations from the Northwest RETAC responded to the survey, including four hospitals and eight pre-hospital providers. Although for many of the topics there was great variation between how the respondents answered, they still provided some valuable insight into how respondents view the efforts of both their agencies and the NWRETAC system.

Overall, the average score for the agency/facility was 2.9 and the average score for the system was a 1.7. The respondents most frequently scored their own agency or facility with threes or fours, indicating that these categories are mostly beyond the planning or discussion phase but not yet comprehensively established. However, respondents were not able to score many of the questions as they related to the overall system's efforts. Respondents answered "I don't know" to 43 percent of the questions as they related to the overall EMTS system. Respondents were most aware of overall system efforts in the areas of Integration of Health Services, EMTS Research, and Legislation and Regulation.

The hospital providers scored their facility higher on average than the pre-hospital respondents (3.2 vs. 2.8). Both hospital and pre-hospital respondents scored the overall EMTS system similarly (1.7 vs. 1.6). Overall, EMTS Research received the lowest combined score (1.4) while Integration of Health Services received the highest (3.1).

Individual questions that received the highest scores were Integration of Health Service structure (Q 1.1), System Finance outcomes (Q 4.3), Regulation and Legislation structure (Q 3.1), and Public Access structure (Q 7.1). Questions that received the lowest scores were RETAC communication systems (Q 9.4), RETAC information systems (Q 15.4), and EMTS Research outcomes (Q 2.3).

Integration of Health Services

The majority of respondents (58.3 percent) stated that their agency participates regularly in a committee to develop a system plan, with most reporting that there is a process in place for communicating changes to patient care to all stakeholders. The majority also reported that their leadership periodically reviews its activities towards system integration.

Similarly, respondents generally felt that the RETAC is involved in developing a system plan with, 36.4 percent saying that RETAC leadership and staff periodically reviews its activities related to system integration without input from various stakeholders and another 34.6 percent saying that the multidisciplinary RETAC stakeholders group reacts to issues that lack appropriate system integration.

Overall, respondents demonstrated high knowledge to all components of Q1 with < 10% answering "I don't know" to Question 1 components.

Recommendations

- Communicate with other non-traditional EMTS agencies and invite them to participate in RETAC meetings and activities
- Increase involvement of Public Health agencies
- Ensure all stakeholders receive RETAC EMTS information and meeting minutes

EMTS Research

A majority of respondents believe that their agency does not participate in, collaborates on, or publishes any research and/or has no policy to do so. Most respondents also felt that RETAC is not involved with research efforts. Many also reported they that did not know about RETAC's research efforts.

No respondents felt that their agency/or facility policies promotes system research in collaboration with physicians and research centers and uses data to analyze and improve system design, patient care and specific interventions.

Interviews with NWRETAC EMTS stakeholders revealed very little research is being done on an agency or system basis.

Recommendations

- Determine if there is any interest in conducting research through the RETAC
- Identify resources, both personnel and financial, to undertake research if the RETAC so desires
- Consider collaboration with hospitals and educational institutions to conduct research in areas of mutual interest

Legislation and Regulation

Most respondents (54.5 percent) claimed that their agency was in full compliance with laws and regulations and that their agency operates based on laws/regulations. Another 36.4 percent said that they are in compliance for most requirements. The majority also stated that the decision making and operations of the agency are in compliance with applicable policies, laws, rules, ordinances, and contracts.

The majority of respondents (54.5%) answered that they have regular objective external reviews of a wide range of operational areas to ensure compliance with applicable policies, laws, rules, ordinances, and contracts. These reviews are then tied into timely quality improvement activities to help ensure corrective action whenever required.

Almost half of respondents (45.5%) did not know whether RETAC was reviewed externally, but most (54.5%) did say that the RETAC regularly reviews its plan, policies and conduct to ensure compliance with applicable laws, rules, by-laws, and contracts and has a clearly defined process with time-frame expectations to ensure corrective action as needed.

Recommendations

- No major recommendations, the RETAC Coordinator provides adequate information to the EMTS agencies/facilities

- Review the need for an external review of the RETAC and EMTS agencies/facilities regarding compliance to legislation and regulations

System Finance

Fifty-percent of respondents indicated that their agency collects data, generates reports, has a governing body produce and approve revenue and expense reports, and that progress against budget projections is monitored throughout the budget cycle. Several respondents (41.7%) indicated that administrative, management and clinical care planning is conducted, priorities are identified and linked to the expense budget, but revenue sources are not identified or allocated.

Several respondents (41.7%) did not know whether or not the long-term viability of their agencies or facilities is reasonably assured because they are founded on sustainable operating and financial models, and professionally managed. Another 41.7 percent did not know if patient revenues and insurance reimbursements are maximized by timely, accurate billing and collection efforts by trained personnel.

There was a significant amount of respondents that did not know the status of most of the components of overall system finances. However, 54.5 percent of respondents did indicate that administrative, management and clinical care planning is conducted, priorities are identified and linked to the expense budget, and revenue sources are identified and allocated and 45.5 percent said that the RETAC involves RETAC staff and leadership in development of an annual operating budget and provides detailed quarterly and annual monitoring of performance compared to the budget.

There were four NWRETAC specific questions included on the BIS. The respondents overall scored the questions as "0" indicating that they did not know, specifically the results are as follows:

- Q 4.5 – Nearly 64 percent indicated that do not know if the long-term viability of agencies/facilities is based on sustainable operating or financial models that are professionally managed. Another 18.2 percent indicated that the operating plan for their agency/facility is formally reviewed on a regular basis.
- Q 4.6 – There were 45.5 percent of respondents do not know if there are stable funding sources in areas with low patient volumes. Twenty-seven percent indicated that had stable funding.
- Q 4.7 – All (100 percent) of respondents do not know if revenues and insurance reimbursements are maximized through specific processes.
- Q 4.8 – For this question regarding the adequate funding for the RETAC, 54.5 percent did not know and 36 percent indicated that RETAC has no recognized organization form and uses a fiscal agent.

Recommendations

- Continue to provide the NWRETAC financial data, including the annual operating budget and monitoring reports to system stakeholders on a regular basis
- Continue to assist EMTS agencies identify and apply for grants to enhance EMTS delivery
- Consider activities to assist EMTS stakeholders with enhancing revenues

Human Resources

Respondents generally gave favorable scores to their agency or facility's human resource components. 41.7 percent said that their agency/facility maintains optimal staffing levels through a pro-active recruitment and retention program that provide benefits and incentives to help ensure staff satisfaction and stability.

Respondents generally reported that they did not know about the human resources in the overall system. 72.7% said that they did not know if the overall system has personnel recruitment and retention policies and programs to maintain adequate numbers of trained and licensed personnel (paid and/or volunteer) to meet performance standards for level of care and response times.

Responses varied on the extent to which the RETAC is viewed as a key resource for technical assistance and support with human resources matters and as a source of training opportunities.

Recommendations

- Consider a system wide focused recruitment and retention program
- Consider sharing volunteer on-call EMS personnel between EMS transport agencies where geographically appropriate (This works well in the San Luis Valley RETAC with agencies that share on-call or on-site EMS responders.)

Education Systems

Several respondents (41.7%) reported that their agency or facility has a structure in place to provide the educational needs of its employees and that they provide a comprehensive program of initial and continuing education for its employees consistent with state and nationally recognized levels of care.

Additionally, 41.7 percent of respondents also reported that clinical or field procedural problems are occasionally addressed in continuing education programs but there is no regular, consistent evaluation of competency. However, 50 percent indicated that there is a regular continuing education program offered by their agency/facility that includes all specialized topic areas required to maintain certification or licensure.

In general, knowledge about the overall system's educational system was limited. 72.7 percent of respondents indicated that they did not know if the overall system offered any continuing educational programs in specialty topics and 63.6 percent indicated that they did not know if the effectiveness of continuing educational programs were measured in any way.

Many respondents (45.5%) felt that the RETAC does not assess the availability of education programs within the region.

There were two NWRETAC specific questions included in this category. The first (Q 6.5) asked whether regular continuing education in specialty topics is available and locally coordinated between agencies. Seventy-two percent indicated that they did not know, another 18.2 percent felt that this type of continuing education is available as part of a regular continuing education program but in many cases at least one

day of travel is required. The second question (Q 6.6) asked about the accessibility of testing sites for initial certification, 45.5 didn't know and 36.4 percent indicated that testing sites are accessible but typically require 12 – 16 hours of travel.

Recommendations

- Consider an education/training needs survey of NWRETAC stakeholders regarding accessibility and availability of education and training
- Continue to conduct the Northwest RETAC Leadership conference
- Enhance and continue to share educational opportunities among EMTS agencies/facilities

Public Access

Respondents were relatively varied in their responses to the Public Access component of the survey. A majority of respondents (58.3%) believed that their agency or facility has accommodations for special populations that allow them to effectively access the system. However, a third of respondents (33.3%) said there is no routine or planned contact with the general public.

Respondents most frequently answered "I don't know" to the overall systems approach to public access.

Recommendations

- Explore the feasibility of consolidated state of the art emergency medical dispatch centers
- Provide consistent pre-arrival instructions in the frontier/rural counties, possibly by transferring calls that need pre-arrival instructions to a dispatch agency that does provide them

Evaluation

Two thirds of respondents (66.7%) said that a computer system is in place at their agency/facility and is used by providers to collect patient care information and that data is submitted to the state on the required submission schedule but analytical tools are not used for system monitoring.

Responses were varied as they related to the overall system's approach to evaluation. Most respondents indicated that they did not know if the computer based analytical tools for monitoring system performance were in place or if patient care data within the system was being collected and evaluated to identified trends and outliers.

Also, 36.4 percent of respondents said that the RETAC does not serve as a leader of system activities within the area of jurisdiction, although 18.2 percent believe the RETAC engages some providers and hospitals in system oversight and evaluation but it is not across the entire region and another 18.2 percent believe the REATC does serve as a leader of activities. Based on the decentralized, grass roots philosophy of the NWRETAC and the ability of the counties through their individual County EMTS Councils, leadership is provided at the county level by design.

Recommendations

- Determine what data is currently collected that can be used to evaluate the system
- Develop a list of data components useful for system evaluation
- Consider the development of a research and evaluation agenda with service providers, hospitals, community colleges and the medical community at large
- Assist pre-hospital agencies in developing a CQI program or facilitate their participation in another agencies CQI process

Communications System

Two thirds of respondents (66.7%) said that their agency or facility's needs assessments are conducted and procurement needs are coordinated with other agencies, jurisdictions, and disciplines. 58.3 percent said that their agency/facility has adopted a communications plan that was developed with multiple stakeholder groups, and endorsed by those agencies but that issues of integration and inter-operability have not been fully resolved.

A majority of respondents (54.5%) also indicated that the overall system needs assessments are conducted and procurement needs are coordinated.

A majority (63.6%) of respondents said that they "did not know" if the RETAC plan includes a description of regional communications issues as outlined in the regional communications plan.

Recommendations

- Continue with the phased-in process for 800 DTR infrastructure throughout the region
- Develop a NWRETAC Communications Plan for EMTS incorporating the current radio frequencies in use
- Provide routine ongoing education and training on the use of the 800 DTR system for inexperienced or infrequent users
- Incorporate the communications system components in annual drills and exercises to test reliability and interoperability

Medical Direction

Most respondents said that their agency/facility has a medical director and 41.7 percent said that their medical director has formal authorities and responsibilities, and that there is evidence that he/she has used this authority to adopt protocols, implement a quality improvement program, and to fully integrate the facility/agency into the health care system.

Two thirds (66.7%) also stated that protocols have been developed in close coordination with the other agencies/providers within the system and are congruent with the local resources. Every respondent said that they have at least occasional retrospective medical oversight procedure for protocols, with 50 percent saying that this oversight is timely within their agency or facility.

Responses varied as to whether or not the RETAC provides technical assistance or monitors the medical direction. 27.8 percent said the RETAC provides assistance when requested and another 27.3 percent said the RETAC provides technical assistance when necessary and makes medical direction courses and other resources available on a regularly scheduled basis throughout the region.

Recommendations

- Survey stakeholder agencies regarding their needs for medical direction and their level of satisfaction with the current system of medical direction
- Continue to support NWRETAC Medical Directors education track at the Northwest RETAC Leadership conference
- Enhance the feedback process from the Medical Director to the Pre-hospital agency director or chief

Clinical Care

In general, respondents gave high scores to their agency/facility's provision of clinical care. Many respondents (41.7%) indicated that clinical care protocols are written and followed, care is documented and data is used to drive performance improvement, and patient outcome and quality of care is monitored and corrective action takes place when deficiencies are discovered.

However, some respondents (25%) did indicate that there is no procedure for their agency/facility and local hospital to monitor patient outcome and pre-hospital quality of care.

The majority of respondents did not know the overall system's provision of clinical care. Responses were mixed over whether the RETAC establishes continuing quality improvement (CQI) plans with goals, system monitoring protocols, and periodically assess the quality of their emergency medical and trauma system.

Recommendations

- Consider moving towards standardized medical protocols with agency specific variations
- Consider the development of a regional Continuous Quality Improvement (CQI) plan or at least a template for a comprehensive CQI plan that can be adopted by system stakeholders

Mass Casualty

Respondents generally scored their own agency or facility high under the Mass Casualty components. 41.7 percent indicated that their agency/facility system and the disaster system plans are integrated and operational and that routine working relationships are present with cooperation and sharing of information to improve system readiness for "all-hazard" multiple patient events.

The majority of respondents (58.3%) also reported that a system-wide "debriefing" occurs following each mass casualty exercise or event and that reports are written but often do not lead to improvement processes.

Most respondents did not know the overall system's mass casualty plans and operations. 54.5 percent did not know if reports following mass casualty events lead to any improvement processes at the system level. Responses were varied over whether or not the RETAC provides technical assistance and serves as a resource to facilitate the integration of emergency medical and trauma services with other local, state, and federal agency disaster plans. Only 9.1 percent believed that RETAC was not involved in any way while 18.2 percent said that the RETAC takes a leadership role in local, regional and statewide disaster planning.

There was one NWRETAC specific question (Q 12.5) added to the Mass Casualty category regarding the utilization of EMTS personnel employed by more than one EMTS agency/facility in the region included in collaborative emergency operations plans. Thirty-six percent didn't know and another 27 percent indicated that agency/facility plan was prepared internally and assumes some personnel will not be available for deployment because of possible deployment by another agency/facility.

Recommendations

- Update the current NWRETAC Mass Casualty Plan to include agencies/facilities current capabilities
- Continue to participate in local, regional, and state mass casualty exercises and drills
- Conduct regional exercises and drills based on each counties plan
- Develop an evaluation process for mass casualty exercises and drills

Public Education

The level of public education programs varies greatly between each of the responding agencies. No agency or facility indicated that the general public is involved in various oversight activities such as local and regional advisory councils. Also, no agency or facility reported having a public awareness and injury/illness prevention program that uses data to assess the effectiveness of the strategies and modify the plan and programs accordingly. Some (25%) reported having strong support from the community and political constituency that includes not only an ongoing budget, but support for improvements and expansion.

Most respondents either indicated that the RETAC is involved with others in public education about EMTS systems (36.4%) or that they didn't know if the RETAC had any involvement with public education.

Recommendations

- Engage the Education and Public Information and Injury Prevention committees
- Assume a leadership role in the provision of public education through collaboration with the EMTS providers
- Identify agencies and organizations that currently provide good public education programs
- Partner with the hospitals and conduct public education campaigns on a rotating basis
- Develop an annual, continuous public education campaign to promote awareness of the EMTS system programs, including the promotion of wellness and prevention
- Explore funding sources and grants, including pooling of funds to support a regional public education campaign
- Develop "off-the-shelf" public education programs that individual agencies/facilities can implement

Prevention

Overall, respondents indicated that their agency or facility is not involved in a coordinated community prevention effort. Half of the respondents said that they do not have a written plan for a coordinated injury/illness prevention program and a third reported that there are multiple injury and/or illness prevention programs that may conflict or overlap with each others with no coordination within the region. Three quarters of respondents said that there is no evidence to suggest that agency/facility data are used to determine injury/illness prevention strategies and two thirds said there is no effort to review the activities of our agency/facility in prevention efforts.

Respondents most often answered "I don't know" to the components for the overall systems involvement in community prevention. A few respondents (27.3%) believe that there is little population-based public health surveillance shared with the EMTS, and program linkages are rare.

Recommendations

- Engage the Education and Public Information and Injury Prevention committees
- Develop partnerships and linkages with the public health system and area hospitals to identify program goals
- Identify sources of information, including public health surveillance and emergency department data to identify the types of injuries and illness that may be prevented in the region

Information Systems

More than half (58.3%) of the respondents said that there is a data collection system in place, but that the use of the data is random and unfocused. Respondents reported limited information system capabilities, with only one agency reporting a fully-integrated and usable information system in place. Most respondents claimed that their information system is sometimes used to review system issues or individual performance (41.7%) or that there is no information system to review system or individual performance in use within their agency/facility (33.3%).

Most respondents are unaware of the data collection and information systems that RETAC has in place. Those with some awareness said that the RETAC does not currently utilize objective data to drive regional quality improvement (36.4%).

Recommendations

- Determine what information and data sources are currently available from the EMTS stakeholders
- Identify data elements necessary to monitor and evaluate the system
- Identify funding sources for hardware and software to collect data
- Integrate pre-hospital, hospital, and trauma data to assess the quality of the regional EMTS system
- Use the integrated information to drive policy and protocol decisions
- Provide feedback to management and providers on a regular basis

Problem Ranking Survey – Results and Analysis

The problem ranking survey asked respondents to rank ten listed issues from most challenging (1) to least challenging (10). The ten issues listed on the survey were:

- Administrative Support
- Aging Building/Equipment
- Cooperation with Other Agencies
- Medical Director Involvement
- Retention of Personnel
- Agency Funding/Financial Viability
- Billing/Accounts Receivable
- Initial/Continuing Education
- Recruitment of New Personnel
- Support from RETAC

There were 11completed surveys returned, eight from pre-hospital agencies and three from hospitals. The issues that were identified as most challenging for the Pre-Hospital respondents were Recruitment and Retention of Personnel. For Hospital respondents, Agency Funding/Financial Viability and Billing/Accounts Receivable were their most challenging issues.

Overall, both pre-hospital and hospital respondents reported that their least challenge issues were Support from RETAC, Cooperation with Other Agencies, and Medical Director Involvement.

Table A below summarizes the responses by agency/organization type.

Table A

Issue	1	2	3	4	5	5	7	8	9	10	11
Administrative Support	5	7	6	9	9	3	9	3	7	9	6
AgencyFunding/Financial Viability	7	4	4	5	3	8	4	4	4	2	1
Aging Building/Equipment	8	3	7	1	2	1	3	6	3	5	9
Billing/Accounts Receivable	4	6	2	4	5	4	7	5	2	1	4
Cooperation with Other Agencies	6	8	8	10	10	7	6	10	8	10	3
Initial/Continuing Education	2	5	5	7	7	6	5	7	6	6	5
Medical Director Involvement	9	10	9	8	8	5	10	8	10	7	2
Recruitment of New Personnel	3	1	3	2	1	9	1	2	1	4	8
Retention of Personnel	1	2	1	3	4	10	2	1	5	3	10
Support from RETAC	10	9	10	6	6	2	8	10	9	8	7
	Pre-Hosp								Hospital		

Table B lists the frequency of each issue by rank.

Table B

NWRETAC Problem Ranking Frequency of Each Issue by Rank										
	Frequency by Rank									
Issue	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Administrative Support	0	0	2	0	1	2	2	0	4	0
Agency Funding/Financial Viability	1	1	1	5	1	0	1	1	0	0
Aging Building/Equipment	2	1	3	0	1	1	1	1	1	0
Billing/Accounts Receivable	1	2	0	4	2	1	1	0	0	0
Cooperation with Other Agencies	0	0	1	0	0	2	1	3	0	4
Initial/Continuing Education	0	1	0	0	4	3	3	0	0	0
Medical Director Involvement	0	1	0	0	1	0	1	3	2	3
Recruitment of New Personnel	4	2	2	1	0	0	0	1	1	0
Retention of Personnel	3	2	2	1	1	0	0	0	0	2
Support from RETAC	0	1	0	0	0	2	1	2	2	3

Table C lists the proportion of issue by rank.

Table C

NWRETAC Problem Ranking Proportion of Each Issue by Rank										
	Proportion by Rank									
Issue	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Administrative Support	0.0%	0.0%	18.2%	0.0%	9.1%	18.2%	18.2%	0.0%	36.4%	0.0%
Agency Funding/Financial Viability	9.1%	9.1%	9.1%	45.5%	9.1%	0.0%	9.1%	9.1%	0.0%	0.0%
Aging Building/Equipment	18.2%	9.1%	27.3%	0.0%	9.1%	9.1%	9.1%	9.1%	9.1%	0.0%
Billing/Accounts Receivable	9.1%	18.2%	0.0%	36.4%	18.2%	9.1%	9.1%	0.0%	0.0%	0.0%
Cooperation with Other Agencies	0.0%	0.0%	9.1%	0.0%	0.0%	18.2%	9.1%	27.3%	0.0%	36.4%
Initial/Continuing Education	0.0%	9.1%	0.0%	0.0%	36.4%	27.3%	27.3%	0.0%	0.0%	0.0%
Medical Director Involvement	0.0%	9.1%	0.0%	0.0%	9.1%	0.0%	9.1%	27.3%	18.2%	27.3%
Recruitment of New Personnel	36.4%	18.2%	18.2%	9.1%	0.0%	0.0%	0.0%	9.1%	9.1%	0.0%
Retention of Personnel	27.3%	18.2%	18.2%	9.1%	9.1%	0.0%	0.0%	0.0%	0.0%	18.2%
Support from RETAC	0.0%	9.1%	0.0%	0.0%	0.0%	18.2%	9.1%	18.2%	18.2%	27.3%

Conclusion

The Northwest Colorado RETAC has good representation and participation from the EMTS disciplines and stakeholders in the Northwest Colorado region. The current RETAC Board members represent primarily hospital and pre-hospital providers, but Emergency Management and local government is also represented well on the Board. The RETAC meetings are well attended and there is always a quorum to carry out RETAC business. The RETAC Chairperson and Coordinator both provide the leadership necessary to improve the EMTS system in the Northwest Colorado. The RETAC Coordinator position is a part-time position resulting in the Coordinator having to prioritize RETAC activities.

The RETAC consists of a diverse geographical area, covering five counties. The NWRETAC Board uses a county-wide approach to EMTS through its five county EMTS Councils. There are very few RETAC funded regional projects, but because of the structure and relation between the county EMTS Councils and the RETAC, there is some regionalization. The NWRETAC Biennial Plan goals are focused on the EMTS system needs at a regional level and emerge from county goals. When all of the counties identify a similar goal or when an issue transcends county jurisdictions, it becomes a regional issue or goal. The RETAC Coordinator has an excellent understanding of the issues affecting urban, rural, and frontier EMTS systems. The NWRETAC has a comprehensive and aggressive biennial plan that identifies clinical care, mass casualty, and prevention as the system components with the most urgent needs while improvements to clinical care, communications systems and mass casualty are considered the highest priority.

The annual Northwest RETAC Leadership conference is supported by the RETAC and includes the involvement of the regions Medical Directors. The NWRETAC does not have a website limiting access and information available to the regions EMTS stakeholders. There are four state-approved training centers, including three community colleges in the region that provide both initial and continuing education. Additional continuing education and training is provided by the regions hospitals and through one of the six state approved training groups. The County EMTS Councils also provide significant financial support for training and education of EMTS providers. ALS level continuing education is limited in some of the frontier and rural areas of the region..

The overall BIS scores revealed that the average score for the agency/facility was 2.9 and the average score for the system was a 1.7. The respondents most frequently scored their own agency or facility with threes or fours, indicating that these categories are mostly beyond the planning or discussion phase but not yet comprehensively established. However, respondents were not able to score many of the questions as they related to the overall system's efforts. Respondents answered "I don't know" to 48 percent of the questions as they related to the overall EMTS system. Respondents were most aware of overall system efforts in the areas of Integration of Health Services, EMTS Research, and Legislation and Regulation.

The hospital providers scored their facility higher on average than the pre-hospital respondents (3.2 vs. 2.8). Both hospital and pre-hospital respondents scored the overall EMTS system similarly (1.7 vs. 1.6). Overall, EMTS Research received the lowest combined score (1.4) while Integration of Health Services received the highest (3.1).

Individual questions that received the highest scores were Integration of Health Service structure (Q 1.1), System Finance outcomes (Q 4.3), Regulation and Legislation structure (Q 3.1), and Public Access structure (Q 7.1). Questions that received the lowest scores were RETAC communication systems (Q 9.4), RETAC information systems (Q 15.4), and EMTS Research outcomes (Q 2.3).

From the problem ranking survey results, the issues that were identified as most challenging for the Pre-Hospital respondents were Recruitment and Retention of Personnel. For Hospital respondents, Agency Funding/Financial Viability and Billing/Accounts Receivable were their most challenging issues. Overall, both pre-hospital and hospital respondents reported that their least challenge issues were Support from RETAC, Cooperation with Other Agencies, and Medical Director Involvement.

Because of the diversity between urban, rural and frontier regions within the RETAC there are differences in the challenges faced by the NWRETAC stakeholders. The level of care in the region is primarily ALS provided by both paid and volunteer staffs at the paramedic and intermediate level with more intermediates in the rural and frontier communities.

The recommendations for the Northwest Colorado RETAC include both short-term and long-term activities. The council members should review and prioritize the recommendations for the region. Inclusion of these recommendations into the biennial plan is highly encouraged.

Northwest Regional Emergency Medical and Trauma Advisory Council Standardized (Regional) Needs Assessment Project Benchmarks, Indicators and Scoring (BIS)

The Colorado Department of Health and Environment Emergency Medical and Trauma Services (EMTS) Division has contracted with The Abaris Group to conduct a needs assessment of each Regional Emergency Medical and Trauma Advisory Council (RETAC) areas. This assessment will consist of on-site visits with EMTS agencies and individuals, town hall meetings and analysis of an anonymous survey completed by EMTS stakeholders. The results of the assessment will be presented to the local RETAC and the Colorado EMTS Division. Your local RETAC Coordinator will be actively involved in the assessment process.

The survey below is referred to as Benchmarks, Indicators and Scoring, or "BIS." We are asking for your input by completing the BIS prior to a meeting that will be held in your community during the on-site phase of the assessment. We also hope you will be able to attend the meeting held in your community where we will review and discuss results of the BIS scoring and provide a "town hall" like forum where you can help us understand issues and challenges facing your agency, your community and your region.

To assist us in this task we have developed Indicators and Scoring that relate to the 15 components contained in the Colorado EMTS Plan. Those components are:

1. Integration of Health Services
2. EMTS Research
3. Legislation and Regulations
4. System Finance
5. Human Resources
6. Education Systems
7. Public Access
8. Evaluation
9. Communications Systems
10. Medical Direction
11. Clinical Care
12. Mass Casualty
13. Public Education
14. Prevention
15. Information Systems

For each of the 15 "Benchmarks" there are 4 indicators that relate to Structure, Process, Outcome and the RETAC. These indicators are described as follows:

1. Structure – legislation; rules or regulations; bylaws or charter; policies and procedures or authority
2. Process – Is there a process in place to implement requirements or expectations contained in the structure indicator? If so, does the process reflect the requirements or expectations contained in the structure?
3. Outcome – Are there tools in place to measure the effectiveness of the process (e.g. data collection)? Are measurements or evaluations ongoing? Is data used to drive improvements?
4. These are Regional Emergency Medical and Trauma Council (RETAC) indicators and measure or create expectations for the RETACs that support either local EMTS agencies within the RETAC or that drive statewide improvements through RETAC representation on state advisory bodies.

For each of these indicators, we ask that you mark or circle the score that most closely reflects your knowledge of or opinion of the progress toward or compliance with each indicator. As you read through the scoring, you will see that each score, from 1 – 5 describes a rank in system development. **Remember, you are ranking your own organization within the Regional Emergency Medical and Trauma system.** If you are a rural system with limited resources you may rank low in score. This does not mean you are a "bad" system. It simply reflects the reality of your resources, be they human mechanical. If you do not have sufficient information to mark a score, mark or circle "0" = I don't know.

Please note: In each scoring box there are boxes for 2 separate scores. In the box marked "**Agency/Facility Score**," please score your agency or organization. In the box marked "**System Score**" please score the overall Regional Emergency Medical and Trauma System as you perceive it. In many cases, the two scores will be different. For example, you may score your agency higher or lower in disaster response capabilities than you score the overall system your area.

During the town hall meeting to be held in your community we will have an informal discussion regarding the strengths, weaknesses, opportunities and threats (SWOT) regarding each one of the 15 EMTS components as defined by the State of Colorado specific to your RETAC. The BIS tool scores and the town hall meeting will allow each agency or system will help drive performance improvement plans and activities. This assessment process can be used 1, 2 or 3 years in the future to assist you in determining the growth in your system over time and to show your accomplishments in system improvement.

Please take a few minutes to complete the BIS prior to your community meeting. **If you plan on attending the town hall meeting, please bring the completed BIS with you to the meeting. If you cannot attend the meeting, please fax or email the BIS answer sheet to your RETAC Coordinator or The Abaris Group at 925-946-0911.**

If you have any questions regarding this assessment or the BIS, contact your local RETAC Coordinator, **Eric Schmidt** at 719-330-1214, or by email emssvcs@aol.com or **Ken Riddle**, The Abaris Group, at 702-287-6546, or by email at kriddle@abarisgroup.com.

Northwest Regional Emergency Medical and Trauma Advisory Council
Standardized (Regional) Needs Assessment Project
Benchmarks, Indicators and Scoring (BIS)

Demographical Information: (Indicate provider type and check all that apply below the provider type selected.)

__ **Pre-Hospital Provider**
__ Volunteer __ Paid
__ BLS __ ALS
__ Fire/Rescue
__ Ambulance
__ Other

__ **Hospital Provider**
__ Trauma Center Level
__ MD
__ RN
__ Administration

__ **Other Provider**
__ Law Enforcement
__ Dispatch/Communications
__ Emergency Management
__ Public Health
__ Elected Official
__ Other

Note: The word "system" in this survey is defined as the local RETAC comprised of multiple counties.

Emergency Medical and Trauma System Component (EMTS): Integration of Health Services	
1. All disciplines that influence patient care within the system work together within their regional communities as a whole to assure integration and coordination of patient care.	
Structure Indicator	*Scoring*
1.1 Your agency/facility participates in multidisciplinary planning within your regional system.	0. Don't Know 1. There is no evidence of partnerships, alliances, or working together to integrate the system. 2. There have been limited attempts to organize local groups, but to date no ongoing regional system committees meet regularly to design or implement a regional system. 3. Our agency/facility participates in a regional committee/group that meets regularly to develop and implement a comprehensive system plan. 4. Our agency/facility either brings together or participates in, a multidisciplinary EMTS group that is developing, implementing, and maintaining a comprehensive system plan. 5. Our agency/facility has brought together or participated in a stakeholder group to assist with, the development and implementation of the EMTS system, through a multidisciplinary committee. Multiple stakeholders from various disciplines are routinely recruited to participate in system operational issues and refinement depending on expertise needed (e.g., public health, public safety) and as part of a comprehensive system planning process.

Agency/Facility Score	**System Score**

Emergency Medical and Trauma System Component (EMTS): Integration of Health Services	
Process Indicator	*Scoring*
1.2 There is a clearly defined process to communicate and notify all stakeholders regarding planning efforts or changes that may affect patient care or the delivery of patient care within your region.	0. Don't Know 1. There is no defined process for communicating important issues and planning efforts that affect patient care. 2. There is an unwritten/informal process that is used when convenient, although not regularly or consistently utilized. 3. The process for communication and notification to all stakeholders regarding planning and proposed changes in the delivery of patient care is articulated within the system plan, although it has not been fully implemented. Policies are not written. 4. The process for communication and notification to all stakeholders regarding changes in patient care is contained within and guided by the system plan. There are current policies and procedures in place to notify our stakeholders regarding possible changes in patient care issues. 5. There is a clearly defined written process for notification of all stakeholders regarding changes in patient care that impact the agency/facility. The process is stated in the system plan and incorporated into the policy and procedures for the service provider. Stakeholders are actively engaged in issues affecting patient care to resolve issues and to improve the program and its integration within other health care and public safety efforts in the community and the region. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Integration of Health Services	
Outcome Indicator	*Scoring*
1.3 Your agency/facility has clearly stated goals and objectives to assure effective care of patients within the system. These goals and objectives contain all disciplines and there is a system in place to measure progress.	0. Don't Know 1. There is no plan with goals and objectives pertaining to system integration. 2. There is a plan in place for system integration, but no method to measure progress. 3. Our agency/facility leadership periodically reviews its activities related to system integration without input from various stakeholders. 4. A multidisciplinary group/committee is in place that reacts to issues that demonstrate a lack of appropriate system integration, e.g. did one agency's/facility's protocols affect another's? 5. A multidisciplinary group/committee regularly reviews our agency's/facility's progress towards the goals and objectives pertaining to system integration at the local and regional level and assists in the continuous refinement of those efforts. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Integration of Health Services	
RETAC Indicator	*Scoring*
1.4 The RETAC conducts or coordinates ivities to improve patient care through ollaborative efforts among health related agencies, facilities and organizations within the region. The RETAC encourages groups involved in Emergency Medical and Trauma System (EMTS) to work with other entities (e.g. health related, state, local and private agencies and institutions) to share expertise, to evaluate and make recommendations, and mutually address and solve problems within the region.	0. Don't Know 1. There is no process to measure progress towards goals and objectives pertaining to regional EMTS integration. 2. There is an informal or sporadic process that reacts to concerns regarding lack of integration with other health care and public safety assets. 3. RETAC leadership and staff periodically reviews its activities related to system integration without input from various stakeholders. 4. The multidisciplinary RETAC stakeholders group reacts to issues that demonstrate a lack of appropriate system integration, e.g. a patient is not transported to the appropriate health care facility based on previously adopted protocols. 5. The multidisciplinary RETAC stakeholders group regularly reviews the RETAC's system wide plan and progress towards the goals and objectives pertaining to system integration at the sub-regional, regional and state level and assists in the continuous refinement of those efforts. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Research	
2. All disciplines participate in and contribute to research efforts that increase the evidence upon which the system design is based.	
Structure Indicator	*Scoring*
2.1 Your agency/facility and stakeholders oup has sufficient policies to conduct and articipate in system research efforts. Note: In this context, research is defined as a "systematic process of inquiry, using the scientific method, aimed at discovering, interpreting and revising facts." (as differentiated from Evaluation)	0. Don't Know 1. Our agency/facility does not conduct or participate in research efforts as no policy exists. 2. Our agency/facility does not conduct or participate in research efforts even though policies permit participation. 3. Our agency/facility has policies that allow contribution of data to research efforts. 4. Our agency/facility conduct research in collaboration with physicians and research centers to increase the evidence upon which system design, patient care and specific interventions are based. 5. Our agency/facility policies promote system research in collaboration with physicians and research centers. The data are used to analyze and improve system design, patient care and specific interventions. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS)Component: Research	
Process Indicator	*Scoring*
2.2 Your agency/facility and/or stakeholders group cooperate to conduct and participate in system research efforts. Research efforts may include collaboration with social scientists, economists, health services researchers, epidemiologists, operations researchers, and other clinical scientists.	0. Don't Know 1. Our agency/facility does not conduct research. 2. Our agency/facility conducts limited local research but does not cooperate on research projects of broader scope. 3. Our agency/facility participates in or conducts cooperative research. 4. Our agency/facility supports (e.g. through upgrades in computer technology or dedicating staff time) research as the basis for clinical and operational practices, and some providers become active participants in the research process. 5. Our agency/facility is actively involved in conducting cooperative research that involves internal and external stakeholders and research centers or qualified scientists. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Research	
Outcome Indicator	*Scoring*
2.3 Your agency/facility is integrated with external stakeholders in creating, applying and publishing research projects.	0. Don't Know 1. Our agency/facility does not contribute to research projects. 2. Our agency/facility contributes to research projects. 3. Our agency/facility contributes to, evaluate and apply appropriate research results. 4. The efforts of system professionals, delivery systems, academic centers and public policy makers are organized to support and apply research. 5. The efforts of system professionals, delivery systems, academic centers and public policy makers are organized to support, implement evidence-based practices and publish the results of research in peer reviewed journals. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Research	
RETAC Indicator	*Scoring*
2.4 The RETAC leads or coordinates efforts to determine the effectiveness and efficiency of the Emergency Medical and Trauma System (EMTS) through research. A continuous and comprehensive effort is initiated and sustained to validate current Emergency Medical and Trauma System (EMTS) practices in an effort to improve patient care, determine the appropriate allocation of resources to prevent injury, illness, death and disability.	0. Don't Know 1. The RETAC is not involved in research planning or activities. 2. The RETAC plan makes research a future priority. 3. The RETAC has implemented a research plan that identifies and disseminates existing research findings. 4. The RETAC identifies, coordinates, implements and disseminates research efforts and results. 5. The RETAC is a research implementation catalyst by delivering technical assistance that produces research methodology content training to system participants. As a result of this technical assistance, a cadre of agency investigators works in partnership with hospitals, academic centers, policy makers, public health departments, funding sources and others as appropriate, to identify, coordinate, implement and disseminate research. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Legislation & Regulation	
3. All disciplines are in compliance with all applicable federal, state, and local laws, rules, ordinances, contracts, and/or bylaws.	
Structure Indicator	*Scoring*
3.1 Your agency/facility is in full compliance with all applicable laws, rules, ordinances, contracts, etc. that govern all aspects of their operation and maintain current copies of all relevant policies and required licenses, certifications, insurance policies, etc.	0. Don't Know 1. There is no evidence that our agency is aware of applicable laws, rules, ordinances, and contracts that govern our operation or maintains any required documentation. 2. Our agency/facility can demonstrate that it is aware of applicable laws, rules, ordinances and contracts that govern our operation but we only maintains documentation of some of the specific requirements (e.g. vehicles properly licensed, inspected, and insured) 3. Our agency/facility has committed in writing to compliance with all applicable laws, rules, ordinances and contracts, but it only maintains documentation of some of the specific requirements. 4. Our agency/facility can demonstrate compliance with most applicable laws, rules, ordinances and contracts that govern our operation and maintains documentation of most (> 50%) of the specific requirements. 5 Our agency/facility demonstrates full compliance with all applicable laws, rules, ordinances and contracts that govern our operation and our agency maintains documentation of all specific requirements. **Agency/Facility Score** | **Syatem Score**

Emergency Medical and Trauma System (EMTS) Component: Legislation & Regulation	
Process Indicator	*Scoring*
3.2 Your agency/facility makes decisions and operates based upon internal policies, and the applicable laws, rules, ordinances and contracts that govern operations.	0. Don't Know 1. The decision-making and operations of our agency/facility are routinely not in compliance with applicable policies, laws, rules, ordinances, and contracts. 2. The decision-making and operations of our agency/facility are sometimes not in compliance with applicable policies, laws, rules, ordinances, and contracts. 3. The decision-making and operations of our agency/facility are generally in compliance with applicable policies, laws, rules, ordinances and contracts. 4. The decision-making and operations of our agency/facility are in compliance with applicable policies, laws, rules, ordinances, and contracts. If an area of non-compliance is identified, immediate corrective action is taken. 5. The decision-making and operations of our agency/facility demonstrate that it regularly surpasses the requirements and expectations of applicable policies, laws, rules, ordinances, and contracts.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Legislation & Regulation	
Outcome Indicator	*Scoring*
3.3 Your agency/facility is reviewed periodically by objective, third-party experts, reviewers, or regulators to ensure that it functions in compliance with all applicable policies, laws, rules, ordinances, and contracts that govern its operation.	0. Don't Know 1. Our agency/facility has never had an objective external review. 2. Our agency/facility has had episodic, objective external reviews of a limited number of specific operational areas (e.g. financial audit or equipment inspection). 3. Our agency/facility has had regular objective external reviews of a limited number of operational components that include compliance with some applicable policies, laws, rules, ordinances, and contracts. 4. Our agency/facility has regular objective external reviews of a wide range of operational areas to ensure compliance with applicable policies, laws, rules, ordinances, and contracts. These reviews are then tied into timely quality improvement activities to help ensure corrective action whenever required. 5. Our agency/facility has regular objective external reviews of all operational areas to ensure compliance with all applicable policies, laws, rules, ordinances, and contracts. Such reviews have led to agency/service accreditation and re-accreditation from an independent third party such as the Joint Commission, Commission on the Accreditation of Ambulance Services or the Commission on the Accreditation of Air Medical Transport Systems.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Legislation & Regulation	
RETAC Indicator	*Scoring*
3. 4 The RETAC has developed its biennial plan according to Chapter Four of lorado State Rules Pertaining to the atewide Emergency Medical and Trauma Care System, and reviews its plan, policies and operations at least annually to ensure it is in compliance with its plan and state rules.	0. Don't Know 1. The RETAC does not review its plan, policies and conduct to ensure compliance with applicable laws, rules, by-laws, and contracts, 2. The RETAC sporadically reviews its plan, policies and conduct to ensure compliance. 3. The RETAC regularly reviews its plan, policies and conduct to ensure compliance with applicable laws, rules, by-laws, and contracts. 4. The RETAC regularly reviews its plan, policies and conduct to ensure compliance with applicable laws, rules, by-laws, and contracts and has a clearly defined process with time-frame expectations to ensure corrective action as needed. 5. The RETAC periodically arranges for an expert, third-party review of its plan, policies, and conduct to ensure compliance with all laws, rules, by-laws, and contracts. All findings from such a review are used as a basis for quality improvements and timely corrective actions as necessary. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: System Finance	
4. All disciplines are financially stable organizations with approved budgets that are aligned with the Regional EMTS plan and priorities.	
Structure Indicator	*Scoring*
4.1 Cost, charge, collection and imbursement data are projected and llected; are compared to (benchmarked) against industry data; and, are used in strategic and budget planning.	0. Don't Know 1. Cost, charge, collection and reimbursement data are not collected. 2. Cost, charge, collection and reimbursement data are collected. 3. Cost, charge, collection and reimbursement data are collected and analyzed by internal or external finance experts. 4. Cost, charge, collection and reimbursement data are collected and analyzed by internal or external finance experts e.g. CPA, but are not benchmarked against industry data. 5. Cost, charge, collection and reimbursement data are collected and analyzed by internal or external finance experts and are benchmarked against industry data. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: System Finance	
Process Indicator	*Scoring*
4.2 Budgets are approved and based on historic and projected cost, charge, collection, reimbursement and public/private support data.	0. Don't Know 1. There is no data that can be accessed for budgetary planning purposes. 2. Data is collected but reports are not routinely generated that can be used for budget planning. 3. Data is collected and reports generated, but there is no formal budget planning process. 4. Data is collected, reports generated and there is an expense budget process, but it is not linked to revenue. 5. Data is collected, reports generated, and revenue and expense budgets are produced and approved by the governing body. Progress against budget projections is monitored throughout the budget cycle. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: System Finance	
Outcome Indicator	*Scoring*
4.3 Financial resources exist that support the planning, implementation and ongoing management of the administrative and clinical care components of your agency/facility.	0. Don't Know 1. Administrative, management and clinical care planning is not conducted. 2. Administrative, management and clinical care planning is conducted, but priorities are not identified. 3. Administrative, management and clinical care planning is conducted and priorities are identified, but are not linked to the budget process. 4. Administrative, management and clinical care planning is conducted, priorities are identified and linked to the expense budget, but revenue sources are not identified or allocated. 5. Administrative, management and clinical care planning is conducted, priorities are identified and linked to the expense budget, and revenue sources are identified and allocated. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: System Finance	
RETAC Indicator	*Scoring*
4.4 The RETAC board adopts an annual operating budget and monitors financial performance compared to the budget at least quarterly.	0. Don't Know 1. The RETAC submits an operating budget to the state but does not monitor pertormance compared to the budget. 2. The RETAC submits an operating budget annually for board approval and monitors financial performance annually. 3. The RETAC submits an operating budget annually for board approval and monitors performance at least twice a year. 4. The RETAC submits an operating budget annually for board approval and monitors financial performance compared to the budget at least quarterly. 5. The RETAC involves RETAC staff and leadership in development of an annual operating budget and provides detailed quarterly and annual monitoring of performance compared to the budget **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: System Finance	
Outcome Indicator	*Scoring*
4.5 The long-term viability of agencies/facilities is reasonably assured because they are founded on sustainable operating and financial models, and professionally managed.	0. Don't Know 1. There is no formal basis for the operational or financial structure of my agency/facility. There are no educational or experience requirements for the executive officers or financial managers. 2. There was an operating plan when my agency/facility was founded, but it has not ever been reviewed or updated. Financial plans are limited to the annual operating budget. There are no educational requirements for the executive officers or financial managers. 3. The operating plan for my agency/facility is formally reviewed on regular basis. Financial plans include a capital budget and at least five years of projected operating performance. Executive officers and financial managers are required to have at least two years of formal training or commensurate experience. 4. The operating plan for my agency/facility and its major program areas are formally reviewed on regular basis. Financial plans include a capital budget, dedicated resources for capital replacement and five years or more of projected financial performance. Executive officers and financial managers are required to have a degree, at least four years of formal training or commensurate experience. 5. The operating plan for my agency/facility and all programs areas are assessed regularly through valid methods to ensure they meet patients expectations, fulfill a community need, are consistent with the agency/facility mission and generate revenues in excess of costs. Programs that operate at a deficit have an identified, stable source of subsidy. Financial plans include a capital budget, dedicated resources for capital replacement and five years or more of projected financial performance. Executive officers and financial managers are required to have an advanced degree, or a degree plus professional certification or licensure, and meet annual continuing education requirements. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: System Finance	
Outcome Indicator	*Scoring*
4.6 Agencies/facilities providing essential services in areas with low patient volume have stable funding sources to make up the deficit between revenues from patient billings and expenses.	0. Don't Know 1. There is no identified source of subsidy. 2. Grants, donors, government subsidies and other funding sources are solicited when the agency/facility runs low on money. 3. Grants, donors, government subsidies and other funding sources are solicited when the agency/facility prepares an annual budget and the estimated subsidy is known. 4. Agencies/facilities in low volume areas create annual projections to estimate future subsidies and hold some financial resources or have secured a taxing district to fund projected deficits in the near term. 5. Agencies/facilities in low volume areas continually create long term financial plans to estimate future subsidies and hold reserves or have secured a taxing district, endowment or other reliable financial resources sufficient to cover projected deficits. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: System Finance	
Outcome Indicator	*Scoring*
4.7 Patient revenues and insurance reimbursements are maximized by timely, ;urate billing and collection efforts by ..ained personnel.	0. Don't Know 1. Billing and collections are subordinate to the primary mission of patient care. Operational or administrative personnel tend to it when they have time. 2. Billing and collections are performed in-house by operational or administrative personnel. Timing of bills and aging of receivables are not monitored. There are no educational or experience requirements for billing and collection personnel. 3. More than 95 percent of all bills are sent within 14 days of service and the average age of collectibles is 180 days or less. More than 10 percent of bills are rejected or delayed for billing errors. Billing and collections are performed by dedicated resources with some specialized training or experience. 4. More than 95 percent of all bills are sent within seven days of service and the average age of collectibles is 120 days or less. Fewer than 10 percent of bills are rejected or delayed for billing errors. Billing and collections are performed by dedicated resources. Billing and collection personnel are required to meet educational or experience requirements. 5. More than 95 percent of all bills are sent within three days of service and the average age of collectibles is 90 days or less. Fewer than five percent of bills are rejected or delayed for billing errors. Billing and collections are performed by personnel dedicated specifically to billing and collection. Billing and collection personnel are required to hold industry-recognized certifications or credentials, meet educational or experience requirements, and participate in continuing education. NA. Not applicable, agency/facility does not bill for services. **Agency/Facility Score** | **System Score** |

Emergency Medical and Trauma System (EMTS) Component: System Finance	
RETAC Indicator	*Scoring*
4.8 The RETAC is adequately funded and is a stable organizational form that enhances its fiscal accountability, and capacity to comply with statutory requirements, provide technical assistance and contract with grantors for the benefit of EMTS agencies in the Region.	0. Don't Know 1. The RETAC has no recognized organizational form, no fiscal agent and cannot accept statutory funding or grants. The RETAC has no reserves. The RETAC submits an operating budget to the state but does not monitor performance compared to budget. 2. The RETAC has no recognized organizational form but contracts with the state through a fiscal agent. The RETAC has no reserves and only receives the minimum statutory funding. A significant portion of the statutory funding is directed to the fiscal agent by agreement and the agreement prohibits the RETAC from accepting grants. The RETAC creates an operating budget, submits it to the state and monitors performance compared to budget at least annually. 3. The RETAC has no recognized organizational form but contracts with the state and grantors through a fiscal agent. The RETAC has some reserves and receives interest on deposits in addition to the minimum statutory funding. A portion of the statutory funding is directed to the fiscal agent by agreement and the agreement allows the RETAC to accept grants within reasonable limits. The RETAC submits an operating budget, submits it to the state and monitors performance compared to budget at least quarterly. 4. The RETAC has a recognized organizational form and contracts directly with the state and grantors. The RETAC has reserves, and manages its own finances to maximize revenues from interest on deposits, program income, statutory funding and supplemental state funding and minimize expenses. The RETAC accepts grant funding consistent with its mission and biennial plan. The RETAC creates and approves an operating budget, submits it to the state and monitoring agencies, formally appropriates funds, monitors performance compared to budget at all regular meetings and provides audited financial reports annually. 5. The RETAC has a recognized organizational form and contracts directly with the state and grantors. The RETAC has reserves adequate to service grants funded on a reimbursement basis, annual income sufficient to finance all aspects of operations and manages its own finances to maximize revenues from interest on deposits, program income, statutory funding and supplemental state funding and minimize expenses. The RETAC accepts grant funding consistent with its mission and biennial plan. The RETAC creates and approves an operating budget, submits it to the state and monitoring agencies, formally appropriates funds, all interested stakeholders receive monthly financial statements comparing actual results to budget and audited financial reports annually. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Human Resources	
All disciplines have sufficient capacity and ability to recruit, train, support, and maintain adequate numbers and appropriate mix of volunteer and/or paid personnel consistent with its written plan and commensurate with identified needs within the community.	
Structure Indicator	*Scoring*
5.1 Your agency/facility has personnel recruitment and retention policies and programs to maintain adequate numbers of trained and licensed personnel (paid and/or volunteer) to meet performance standards for level of care and response times. **Formal personnel policies are reviewed regularly by your agency/facility governing authority and clearly identify expectations and responsibilities for both the agency and staff.**	0. Don't Know 1. Our agency/facility has no formal or ongoing policies or programs for the recruitment and retention of personnel. There are no personnel policies identifying the expectations and responsibilities of the agency or its staff. 2. Our agency/facility periodically organizes a program to recruit new staff on an as-needed basis. There are no personnel policies identifying the expectations and responsibilities of the agency or its staff. 3. Our agency/facility periodically organizes a program to recruit new staff on an as-needed basis. Personnel policies are informal or although written are not reviewed regularly. 4. Our agency/facility has a regular program to recruit new staff as needed and also has an ongoing program to retain current staff through formal process and providing supportive and improved incentives as appropriate. Personnel policies are written, reviewed, and updated regularly. 5. Our agency/facility maintains optimal staffing levels through a pro-active recruitment and retention program that provide benefits and incentives to help ensure staff satisfaction and stability. Personnel policies are written, regularly reviewed, clearly communicated and fairly applied. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS)Component: Human Resources	
Process Indicator	*Scoring*
5.2 Standardized feedback processes reflect that personnel understand applicable policies and procedures and demonstrate awareness of accessibility to required and advanced training, leadership opportunities, and stress management services as needed.	0. Don't Know 1. There are no regular opportunities for staff feedback. 2. Feedback is informally requested from staff on a limited and/or episodic basis with no commitment towards utilizing the results for positive change. 3. Staff is invited to provide feedback on a regular basis, but it is limited to specific issues identified by management and there is no expectation for a response from management. 4. Staff is invited to provide feedback/input on a wide variety of topics, including working conditions, personnel policies, training needs, etc. There is no expectation for a response from management 5. Staff is regularly surveyed and/or invited to provide feedback/input on a regular basis on a wide variety of topics. Management commits itself to acknowledging the feedback/input and explaining its responses and decisions as appropriate. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Human Resources	
Outcome Indicator	*Scoring*
5.3 Your agency/facility is fully staffed. All personnel understand policies and their job ...ies/ responsibilities. Staff indicates that ...ey have input into operational decisions, and have reasonable access to needed equipment, supplies, training, and support.	0. Don't Know 1. Our agency/facility is constantly under-staffed and excessive turnover is an ongoing problem. 2. Our agency/facility is periodically under-staffed due to turnover. 3. Our agency/facility is usually able to maintain an adequate staff to perform the mission, but turnover and recruitment of new personnel is a challenge. 4. Our agency/facility has low turnover and is able to recruit personnel as needed to fill any gaps. Personnel indicate that they are satisfied with working conditions and personnel policies. 5. Our agency/facility maintains a pool of candidates to fill any vacancies in a timely manner. The staff indicates high satisfaction with their working conditions, input into decision-making, and access to equipment, training, and supportive services.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS)Component: Human Resources	
RETAC Indicator	*Scoring*
5.4 Its stakeholders and organizational members view the RETAC as a source of technical assistance and support to improve Emergency Medical and Trauma System (EMTS) related human services ...pability and functioning within the region ...rough policy development, medical, technical and leadership training, and facilitating access to supportive services like critical incident stress management. Provider recruitment and retention challenges identified in RETAC assessments are prioritized accordingly in the biennial plan.	0. Don't Know 1. The RETAC experiences high stakeholder turnover and staff instability. The RETAC is not viewed as a resource to improve and enhance agency-related human services in the region. 2. The RETAC has a capable and stable staff, but is not viewed by its stakeholders and organizational members as a resource to improve and enhance agency-related human services in the region. 3. The RETAC provides some support to stakeholders and member organizations regarding staffing challenges, personnel policies, and access to needed agency-related training. 4. The RETAC is viewed as a key resource for technical assistance and support with human resources matters and as a source of training opportunities by its stakeholders and organizational members. 5. The RETAC is highly skilled in human resources matters and regularly provides related technical assistance and support to stakeholders and organizational members. The RETAC provides, facilitates, and supports a wide range of technical, medical, leadership and personal growth/wellness training opportunities. The RETAC ensures access to CISM services as needed.

RETAC Score

Emergency Medical and Trauma System (EMTS)Component: Education Systems	
6. All disciplines provide appropriate, competency based education programs to assure a competent work force.	
Structure Indicator	*Scoring*
6.1 Your agency/facility has written ıcational requirements and a structure in ρıace to provide education and maintenance of clinical skills consistent with state and national levels of training.	0. Don't know 1. Our agency/facility has no written policy regarding education and continuing education requirements. 2. Our agency/facility has written policies regarding minimum education requirements but has no structure in place to support those policies. 3. Our agency/facility has written policies regarding minimum education and requirements and has a structure in place to provide some education and skill maintenance for its employees. 4. Our agency/facility has a structure in place to provide the educational needs of its employees. 5. Our agency/facility bases its education and continuing education programs on local data as well as national standards and evidence. There is a process in place to provide for the on-going educational needs of the employees. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Education Systems	
Process Indicator	*Scoring*
Your agency/facility provides initial and continuing education programs with competency testing, consistent with state and national recognized levels of care.	0. Don't know 1. Our agency/facility provides no initial or continuing education to its employees. 2. Our agency/facility provides some initial and continuing education for its employees. 3. Our agency/facility provides for a program of initial and continuing education to its employees 4. Our agency/facility provides a comprehensive program of initial and continuing education for its employees consistent with state and nationally recognized levels of care. 5. The agency provides for competency-based initial and continuing education consistent with state and nationally recognized levels of care. Continued competency is assured by periodic testing. Training programs are based on current best practices and are supported by distance learning resources. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Education Systems	
Outcome Indicator	*Scoring*
6.3 Your agency/facility measures the effectiveness of its continuing education program by evaluating competency on a regular basis and bases continuing education and remedial education on structured performance improvement processes.	0. Don't know 1. There is no evaluation or measurement of the adequacy or effectiveness of initial or ongoing education programs. 2. Clinical or field procedural problems are occasionally addressed in continuing education programs. There is no regular, consistent evaluation of competency. 3. Monthly continuing education is provided and individual competency is measured at least annually. 4. Monthly continuing education is provided based on regular competency evaluations. Quality improvement information is available but does not drive continuing education methods or content. 5. There is a regular, consistent measure of competency. Continuing education programs are integrated with competency assurance and driven by service quality improvement programs with input from the service provider medical director.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Education Systems	
RETAC Indicator	*Scoring*
6.4 The RETAC assesses the quality and accessibility of education and training for all providers within the Emergency Medical and Trauma System (EMTS) and documents efforts to coordinate and evaluate programs to ensure they meet the needs of the Emergency Medical and Trauma System (EMTS).	0. Don't know 1. The RETAC does not assess or evaluate education programs within the region 2. The RETAC assesses the availability of education programs within the region. 3. The RETAC assesses the availability and quality of education programs within the region. 4. The RETAC provides some coordination to ensure education programs meet the needs of the EMTS system. 5. The RETAC provides coordination with local, regional and state education resources to ensure education programs meet the needs of the EMTS system.

RETAC Score

Emergency Medical and Trauma System (EMTS) Component: Education Systems	
RETAC Indicator	*Scoring*
E 5 Regular continuing education in specialty topics (advanced procedures, geriatrics, pediatrics, obstetrics, orthopedics, pain management, etc.) is available locally and coordinated between agencies/facilities.	0. Don't know 1. There are no continuing education opportunities offered in my community. 2. Specialty topics are not included in the regular continuing education opportunities offered in my community. Providers must leave the area for one day or more for travel to regional, state or national conferences to acquire continuing education in specialty topics. 3. Continuing education in specialized topic areas is available occasionally as a part of the regular continuing education program in my community. Providers usually must leave the area for one day or more for travel to regional, state or national conferences to acquire education in specialized topic areas required to maintain certification or licensure. TNCC, PALS and other standardized specialty courses are offered about every 2-3 years. 4. There is a regular continuing education program offered by my agency/facility that includes all specialized topic areas required to maintain certification or licensure. State or nationally recognized instructors are used occasionally. TNCC, PALS and other standardized specialty courses are offered annually. 5. Specialized topic areas are fully integrated into the regular continuing education program offered by my agency/facility. The continuing education program includes all specialized topic areas to meets all agency/facility and medical director requirements for providers and surpass all regulatory requirements to maintain certification or licensure. Continuing education is linked to a system quality improvement process and coordinated between agencies/facilities. State or nationally recognized instructors are used regularly. TNCC, ACLS, PALS and other standardized courses are offered more than once each year. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Education Systems	
RETAC Indicator	*Scoring*
6.6 Testing sites for initial certification or licensure are easily accessible, have convenient hours of operation, and provide prompt, courteous customer service for applicants. Round trip travel and testing requires one-half day or less.	0. Don't know 1. There are no testing sites in the area. Applicants must travel four hours or more to reach a testing site. Hours of operation are limited. Testing center equipment is out of service frequently and applicants are not notified until they arrive at the testing center. Customer service problems are ignored. Applicants typically require more than 16 hours for travel and testing. 2. Testing sites are accessible but located further than two hours of driving time. Hours of operation are limited to 0800-1700 Monday-Friday. Testing center equipment is out of service regularly and applicants are not notified until they arrive at the testing center. Customer service problems are rarely resolved to the applicant's satisfaction. Applicants typically require 12-16 hours for travel and testing. 3. Testing sites are accessible and located within two hours of driving time. Operating hours are limited to 0800-1700 Monday-Friday. The testing center has occasional down time for technological problems, but tries to notify applicants before the scheduled test time. Customer service problems receive some attention and are sometimes resolved to the applicant's satisfaction. Applicants typically require 8-12 hours for travel and testing. 4. Testing sites are reasonably accessible and located within two hours of driving time. Operating hours include some evenings or weekends. The testing center may have occasional down time for technological problems, but applicants receive notification at least two hours before the scheduled test time so they can be diverted to another testing center or the test can be rescheduled. Customer service problems receive attention and are usually resolved to the applicant's satisfaction. Testing centers may use customer satisfaction surveys to improve quality of service. Applicants typically require eight hours or less for travel and testing. 5. Testing sites are easily accessible and located within one hour driving time, or have a mobile center that can provide testing on-site. Operating hours include evenings and weekends to accommodate applicant's family, work or other commitments. The testing center has a resilient system so tests are always administered as scheduled. Customer service problems receive prompt, professional attention and are resolved to the applicant's satisfaction. Testing centers use results of valid customer satisfaction surveys to continually improve quality of service. Applicants typically require four hours or less for travel and testing.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Public Access	
7. The public has reliable, robust and redundant access to a system that can dispatch appropriate resources promptly and accurately to the location of the patient and provide potential lifesaving services prior to their arrival. Access should be universally available regardless of incident location, socio-economic status, age, or special need and an integral part of the Regional EMTS plan.	
Structure Indicator	*Scoring*
7.1 There is a universal access number for citizens to access the system, with dispatch of appropriate medical resources in accordance with a written plan. The dispatch system utilizes Enhanced-9-1-1 and Wireless-9-1-1 technologies and provide pre-arrival medical instructions to callers **The universal access number is part of a central communications system and plan that ensures bidirectional communication, inter-facility dialogue, and disaster communications among all system participants.**	0. Don't Know 1. There is no 911 system in place. 2. There is a 911 system in place but it does not offer emergency medical dispatch. 3. There is a 911 system in place that also offers emergency medical dispatch. 4. The agency has adopted a communications plan that was developed with multiple stakeholder groups, and endorsed by those agencies, including emergency medical dispatch. However, the integration of Enhanced-911, Wireless-911 and other emerging technologies are not included. 5. A comprehensive communications plan has been developed, and adopted in conjunction with stakeholder groups, including emergency medical dispatch. It also includes the integration of Enhanced-911, Wireless-911 and other emerging technologies. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Public Access	
Process Indicator	*Scoring*
An assessment of the needs of the general public and their ability to access the system has been conducted and the results integrated into the system plan.	0. Don't Know 1. There is no routine or planned contact with the general public. 2. Contact with the public is addressed when system failures occur. 3. Information has been informally gathered from the general public. However, no formal process is in place to address their needs. 4. The general public has been formally asked about the ability to access the system however changes have not been made to the system or to the systems plan. 5. General public needs have been identified and integrated into a plan and changes are routinely made to increase the public's ability to access the system in a timely manner. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Public Access	
Outcome Indicator	*Scoring*
7.3 Our community's special populations (e.g., language, socially disadvantaged, migrant/transient, remote, rural, and others) have access to the system.	0. Don't Know 1. There has been no consideration of the needs of special populations to access patient care within the system. 2. The system and stakeholders are beginning to consider the needs of special populations. 3. The system has identified the special populations that may require special accommodations to access the system. 4. The system has accommodations for special populations that allow them to effectively access the system. 5. The system has accommodated the needs of special populations that allow them to effectively access the system. Routine monitoring, review, and reporting of these populations are incorporated into the evaluation of system effectiveness.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Public Access	
RETAC Indicator	*Scoring*
7.4 The RETAC supports the development of efficient public service access points and emergency medical dispatch throughout the region through programs involving collaboration, resource sharing and technical support. Additionally, it supports policy change at state and national levels to ensure that goals pertaining to timely and efficient dispatch across the entire region can be achieved.	0. Don't Know 1. The RETAC is not involved in regional communications planning. 2. The RETAC is a stakeholder in regional efforts to develop efficient and effective communications and dispatch models. 3. The RETAC coordinates efforts to dispatch resources and emergency providers to assure that appropriate and timely care is provided for medical emergencies within the region. 4. A regional communications plan, including citizen access and emergency medical dispatch is in place but is not formally monitored or evaluated. 5. A regional communications plan, including citizen access and emergency medical dispatch is in place and is evaluated and revised at least annually.

RETAC Score

Emergency Medical and Trauma System (EMTS) Component: Evaluation	
8. All disciplines use its management information system to facilitate on-going assessment and assurance of system performance and outcomes and provide a basis for continuously improving the Regional Emergency Medical and Trauma System.	
Structure Indicator	*Scoring*
8.1 Our agency/facility has computer based analytical tools for monitoring system performance Note: In this context, Evaluation is defined as "Utilization of system data to effect continuous quality or performance improvement.	0. Don't know 1. There is (are) no computer(s) to analyze or monitor system performance. 2. There is a basic computer program that collects the minimum state required data. 3. A computer system is in place and is used by providers to collect patient care information. Data is submitted to the state on the required submission schedule; however analytical tools are not used for system monitoring. 4. A computer system is in place and analytical tools are in use to assess system performance. 5. An upgraded and technically advanced computer system and analytical tool set is available for system monitoring and individual performance review. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Evaluation	
Process Indicator	*Scoring*
8.2 Your agency/facility collects and evaluates patient care data within the system and has a mechanism to evaluate identified trends and outliers.	0. Don't Know 1. Our agency/facility is not collecting patient care information for each episode of care. 2. Our agency/facility collects patient care information to use for internal decision making and billing. 3. Our agency/facility collects patient care data and provides the minimum data set to an approved statewide database. 4. Our agency/facility collects patient care data and provides the data to an approved statewide database as well as uses the data for its own internal monitoring. 5. Our agency/facility participates in a comprehensive data collection system that is integrated into the hospital system. Routine evaluation and assessment of system performance and administrative services is completed and shared with stakeholders. A comprehensive process improvement (PI) system is in place. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Evaluation	
Outcome Indicator	*Scoring*
8.3 Your agency/facility engages the medical community in assessing and evaluating patient care. These assessments are coordinated into quality care efforts. Findings from other quality improvement efforts are translated into improved service.	0. Don't Know 1. Our agency/facility has no relationship with the medical community to assist in evaluating system service delivery and quality of care. 2. Our agency/facility is engaged in projects but the medical community is not active in these efforts. 3. Our agency/facility is working with the medical community to develop a plan for assessing and evaluating system services and participating in research opportunities. 4. Our agency/facility participates with the medical community in evaluating system service to improve service delivery and patient care. 5. Our agency/facility has a process improvement (PI) program integrated in the medical community in system service delivery and patient care. Data is translated into routine reports for assessing performance, measuring compliance and conducting research all in an effort to improve services both clinically and administratively. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Evaluation	
RETAC Indicator	*Scoring*
8.4 The RETAC is a leader within its jurisdiction in the evaluation and research of Emergency Medical and Trauma System (EMTS) activities, services and system oversight.	0. Don't Know 1. The RETAC does not serve as a leader of system activities within the area of jurisdiction. 2. The RETAC is beginning a dialogue with the service providers and hospitals on regional evaluation and research needed to evaluate and improve services and patient care. 3. The RETAC engages some providers and hospitals in system oversight and evaluation but it is not across the entire region. 4. The RETAC serves as a leader in system activities and has begun a research and evaluation agenda with service providers, hospitals and the medical community. 5. The RETAC serves as a leader in EMTS and is instrumental in working with providers, hospitals and other stakeholders in conducting research, evaluating service delivery and providing oversight to the region. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Communications Systems	
9. All disciplines are able to transmit and receive electronic voice and data signals between its own agency assets, between the agency and other community stakeholders, and between the agency and regional/state response partners.	
Structure Indicator	*Scoring*
9.1 Your agency/facility has worked with local/regional stakeholders to develop and adopt a communications plan to enhance all voice and electronic data transmissions at all levels to improve the delivery of emergency services	0. Don't Know 1. There is no system communications plan, and one is not in progress. 2. Draft elements of a formal communication plan are in place but not formalized o are under development. 3. Our agency/facility has adopted a system communications plan. However, the plan has not been endorsed by multiple stakeholder organizations. 4. Our agency/facility has adopted a communications plan that was developed with multiple stakeholder groups, and endorsed by those agencies. However, issues of integration and inter-operability have not been fully resolved. 5. A comprehensive system communications plan has been developed, and adopted in conjunction with stakeholder groups and includes full integration and interoperability between communications assets of all agency, health care, public safety and public health assets at local, sub-regional, regional and state levels.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Communications Systems	
Process Indicator	*Scoring*
Your agency/facility's purchases and configurations of communications equipment are coordinated to standardize the equipment at the local, regional and state level.	0. Don't Know 1. Needs assessments are not conducted prior to communications equipment upgrades. 2. Needs assessments are conducted and procurement needs identified but are not coordinated with other agencies, jurisdictions, or disciplines. 3. Needs assessments are conducted and procurement needs are coordinated with other agencies, jurisdictions, and disciplines. However, the results are not used to guide investment in communications infrastructure improvement. 4. Needs assessments are conducted and procurement needs are coordinated with other agencies, jurisdictions, and disciplines. 5. Comprehensive system communications needs assessments are conducted, procurement needs are coordinated and the results are used to guide investment in communications infrastructure improvement at community, sub-regional, regional and state levels. This has resulted in efficiencies and economies across the EMTS communications system.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Communications Systems	
Outcome Indicator	*Scoring*
9.3 The communications system is routinely evaluated and tested to ensure its reliability, redundancy and interoperability during routine applications.	0. Don't Know 1. The communications system is not evaluated for its reliability, or redundancy. 2. The communications system has been evaluated at a local level and issues of reliability within the agency have been addressed within the system's primary service response area. 3. The communications system has been evaluated at a local level through a multi-agency process and issues of reliability have been addressed by all agencies within the system's primary service response area. 4. The communications system has been evaluated at a regional level through a multi-agency process and issues of reliability have been addressed by all agencies within the system's primary service and mutual aid response areas. 5. The local, regional and state communications system are rigorously tested at least annually in drills, simulations and real events (routine and multi-agency) and issues involving reliability, redundancy and interoperability have been addressed. Back-up systems have also been fully exercised. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Communications Systems	
RETAC Indicator	*Scoring*
The RETAC plan includes a description of regional communications issues as outlined in the regional communications plan.	0. Don't Know 1. Plan does not address communication issues. 2. Plan addresses at least half of the issues. 3. Plan addresses all issues, but no strategies are implemented. 4. Plan addresses all issues, but half or less are supported. 5. Plan addresses all issues, and they are all supported by the RETAC. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Medical Direction	
10. Your facility/agency has a physician medical director that has received medical director training, been recognized by the state and is actively involved in Regional EMTS issues including triage, treatment, and transport, dispatch, quality improvement, education and training.	
Structure Indicator	*Scoring*
10.1 Your agency/facility medical director has clear-cut responsibility and the authority to adopt protocols, implement a quality improvement process, and to restrict the practice of providers within the system to assure medical appropriateness within the system.	0. Don't Know 1. There is no agency/facility medical director. 2. There is an agency/facility medical director with a written job description; however, the individual has no specific time allocated for these tasks. 3. There is an agency/facility medical director with a written job description and whose specific authorities and responsibilities are formally granted. 4. There is an agency/facility medical director with a written job description, but with no specific authority. The system medical director has adopted protocols, has implemented a quality improvement program, and is taking steps to improve the medical appropriateness of the system. . 5. There is an agency/facility medical director with a written job description who has authorities and responsibilities that are formally granted. There is written evidence that the facility/agency medical director has, consistently used their formal authority to adopted protocols, implemented a quality improvement program and to fully integrate the facility/agency into the health care system

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Medical Direction	
Process Indicator	*Scoring*
10.2 Your agency/facility medical director is actively involved with the development, implementation, and ongoing evaluation of protocols to assure they are congruent with other agencies/providers. These protocols include, but are not limited to, which resources to dispatch (ALS vs. BLS), air-ground coordination, triage, and early notification of the medical care facility, pre-arrival instructions, treatment, transport and other procedures necessary to ensure the optimal care of ill and injured patients.	0. Don't Know 1. There are no protocols. 2. Protocols have been adopted, but they are in conflict with the other agencies/providers resources. 3. Protocols have been adopted and are not in conflict with other agencies/providers resources, but there has been no effort to coordinate the use of protocols between the agency and the other agencies/providers within the system. 4. Protocols have been developed in close coordination with the other agencies/providers within the system and are congruent with the local resources. 5. Protocols have been developed in close coordination with other agencies/providers within the system and are congruent with the local resources. There are established procedures to involve the appropriate dispatch, public safety and other critical stakeholder personnel and their supervisors in quality improvement and there is a "feedback link" to change protocols or to update education when appropriate.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Medical Direction	
Outcome Indicator	*Scoring*
10.3 The retrospective medical oversight of your agency/facility protocols, including) not limited to, triage, communication, ..eatment, and transport is accomplished in a timely manner and is closely coordinated with the established quality improvement processes within the local healthcare system.	0. Don't Know 1. There is no retrospective medical oversight procedure for communication, treatment, and transport protocols. 2. There is occasional retrospective medical oversight procedure of protocols, but it is neither regular nor timely and is often as a result of a reported breach in those protocols. 3. There is timely retrospective medical oversight procedure for protocols by the quality improvement processes of the agency/facility. 4. There is timely retrospective medical oversight of protocols that is coordinated with partners within the local healthcare system. 5. There is timely retrospective medical oversight of protocols through the system that includes a multidisciplinary review coordinated with partners in the local healthcare system. There is evidence this procedure is being regularly used to monitor system performance and to make system improvements.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Medical Direction	
RETAC Indicator	*Scoring*
10.4 The RETAC assists with appropriate local physician medical direction by providing technical assistance, training and other resources to local Emergency Medical d Trauma System (EMTS) agencies.	0. Don't Know 1. The RETAC does not provide technical assistance, training or other resources to local agencies. 2. The RETAC provides technical assistance to establish or improve local medical direction when requested. 3. The RETAC monitors the provision of medical direction and provides technical assistance when necessary. 4. The RETAC provides technical assistance when necessary and makes medical direction courses and other resources available on a regularly scheduled basis throughout the region. 5. The RETAC monitors the quality of medical direction in local agencies and facilities and supports consistency of medical direction throughout the region by providing medical directors' courses and other resources

System Score

Emergency Medical and Trauma System (EMTS) Component: Clinical Care	
11. All disciplines are integrated into a resource-efficient, inclusive network that meets required standards and that provides optimal care for all patients.	
Structure Indicator	*Scoring*
11.1 Your agency/facility has a clearly defined plan that outlines roles and responsibilities of agency/facility personnel. Evidence based written patient care protocols and guidelines are maintained and updated.	0. Don't Know 1. Our agency/facility has no plan that outlines roles and responsibilities of personnel. No written patient care protocols exist. 2. Our agency/facility has a plan that outlines roles and responsibilities of personnel, but no written patient care protocols and guidelines exist. 3. Our agency/facility has a plan and patient care protocols exist but are not reviewed and updated regularly. 4. Our agency/facility plan clearly defines the roles and responsibilities of agency/facility personnel and emergency department personnel in treatment facilities for trauma patients. Written protocols and prehospital care guidelines exist and are reviewed and updated at regularly. 5. Our agency/facility plan clearly defines the roles and responsibilities of agency/facility personnel and emergency department personnel in treatment facilities for both trauma and medical patients. The plan is reviewed and updated at least annually. Evidence based written treatment protocols and care guidelines exist for personnel. Critical patient protocols are jointly practiced by prehospital and hospital personnel. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Clinical Care	
Process Indicator	*Scoring*
11.2 Clinical care is documented in a manner that enables your agency/facility to provide information to be used for system wide quality monitoring and performance improvement.	0. Don't Know 1. Clinical care is documented but documentation is not reviewed for local or regional quality monitoring or performance improvement. 2. Clinical care is documented and limited review is done at the local level. 3. Clinical care documentation is systematically reviewed at the agency/facility level but is not available electronically for quality monitoring and performance improvement. 4. Clinical care documentation is systematically reviewed at the local/regional and system level and procedures exist to utilize care data to drive performance improvement 5. Clinical care is systematically reviewed by the agency/facility Medical Director at the agency/facility level and is documented in a manner that enables agency and system-wide data from other health care and public safety agencies to be used for quality monitoring and performance improvement. Oversight of the performance improvement process is done through the agency/facility Medical Director. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Clinical Care	
Outcome Indicator	*Scoring*
11.3 Patient outcomes and quality of care are monitored. Deficiencies are recognized d corrective action is implemented.	0. Don't Know 1. There is no procedure for our agency/facility and local hospital to monitor patient outcome and prehospital quality of care. 2. Our agency/facility maintains a quality of care system including patient outcomes, but they do not regularly monitor these outcomes, or quality of care, nor do they regularly review findings together. 3. An ongoing agency/facility quality improvement program is in place to monitor and assure that quality of care is consistent with adopted protocols. 4. Our agency/facility quality improvement program monitors patient outcomes, and uses these data in an ongoing quality improvement program, and benchmarks outcomes against regional or statewide standards. 5. Our agency/facility quality improvement program monitors patient outcomes, and uses these data in an ongoing quality improvement/performance improvement program. Deficiencies in meeting the local standards are recorded, and corrective action plans are instituted. Results of comparisons with State or national norms are regularly documented, along with an explanation for significant variations from these norms, and a written plan to reduce unacceptable variations. There is a process for confidentiality of findings and recommendations of performance improvement (PI) activities. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Clinical Care	
RETAC Indicator	*Scoring*
11.4 The RETAC establish continuing quality improvement (CQI) plans with goals, system monitoring protocols, and periodically assess the quality of their emergency medical and trauma system. The regional CQI plan is utilized in evaluating the effectiveness of the regional EMTS systems.	0. Don't Know 1. The RETAC is not involved in quality assessment or protocol monitoring. 2. The RETAC has identified regional CQI as a goal but has not established a CQI plan. 3. The RETAC is in the process of establishing a protocol monitoring and CQI plan but the plan is not implemented. 4. The RETAC has implemented a protocol monitoring and CQI plan but has not reported results. 5. The RETAC has implemented a protocol monitoring and CQI plan and uses data from the plan to drive quality improvement throughout the region. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Mass Casualty	
12. All disciplines are integrated with, and complementary to, the comprehensive mass casualty plan for natural disasters and manmade disasters, including an all-hazards approach to disaster planning and operations.	
Structure Indicator	*Scoring*
12.1 Your agency/facility has an operational plan and has established an ongoing cooperative working relationship with other stakeholders.	0. Don't Know 1. There is no agency/facility plan and no system for integration between disciplines. 2. There have been discussions between the agency/facility and the disaster system, but no inclusive formal plans have been developed. 3. Formal plans for our agency/facility and other disaster services systems integration are in development. Working relationships have been formed and cooperation is evident. 4. There are plans in place to ensure that our agency/facility and the disaster system are integrated and operational. Disaster exercises and drills have the cooperation and participation. 5. Our agency/facility system and the disaster system plans are integrated and operational. Routine working relationships are present with cooperation and sharing of information to improve system readiness for "all-hazard" multiple patient events.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Mass Casualty	
Process Indicator	*Scoring*
12.2 Our disaster training and exercises routinely include situations involving an all hazards approach, that test expanded response capabilities and surge capacity that are consistent on a regional basis.	0. Don't Know 1. Disaster training and exercise is not a routine part of the system. 2. Disaster training and exercises are conducted haphazardly by our agency/facility alone without other stakeholders involvement. 3. Disaster training and exercises are conducted regularly and include agency/facility response capabilities to all hazards. 4. Our agency/facility, Emergency Management, trauma partners, public safety and public health stakeholders have begun training and exercises in an all-hazards approach to disaster situations. 5. Exercises and training in all-hazards disaster situations are regularly conducted and include testing of agency/facility surge capacity. These exercises include agencies, trauma, public safety and public health stakeholders. Debriefing sessions occur after each drill or event.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Mass Casualty	
Outcome Indicator	*Scoring*
12.3 There are formal mechanisms to ivate our response to all-hazard events in accordance with regional disaster response plans that are consistent with system resources and capabilities.	0. Don't Know 1. No feedback or after action process results from various all-hazards exercises or events. 2. Our agency/facility conducts our own after action quality improvement processes, in isolation, following each exercise or event; there is no system-wide evaluation. 3. There are sporadic, informal, non-documented "debriefings" involving multiple agencies following each exercise or event. Results of these activities do not necessarily translate to improvement processes. 4. A system-wide "debriefing" occurs following each exercise or event. Reports are written but often do not lead to improvement processes. 5. A formal system-wide analysis of after action reports and performance improvement process is in place and implemented at the conclusion of each all-hazard exercise or response. The results of the process result in improvements in the plans, targeted training and/or corrective actions.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Mass Casualty	
RETAC Indicator	*Scoring*
12.4 The RETAC provides technical assistance and serves as a resource to facilitate the integration of emergency dical and trauma services with other local, state, and federal agency disaster plans.	0. Don't know 1. The RETAC is not involved in providing any technical assistance or facilitation relating to disaster planning. 2. The RETAC provides technical assistance only upon request. 3. The RETAC participates in local and regional disaster planning but provides only limited assistance or facilitation. 4. The RETAC participates in local and regional disaster planning and provides technical assistance and facilitation to RETAC member agencies 5. The RETAC takes a leadership role in local, regional and statewide disaster planning. RETAC staff and leadership provide technical assistances and facilitation with local, state and federal planning efforts.

RETAC Score

Emergency Medical and Trauma System (EMTS) Component: Mass Casualty	
RETAC Indicator	*Scoring*
12.5 Your agency/facility emergency operational plan was created in collaboration with all other stakeholders, articulates with all other emergency operational plans in the area and clearly defines how personnel employed by multiple agencies will be utilized.	0. Don't know 1. There is no agency/facility emergency operational plan. 2. The agency/facility emergency operational plan was prepared internally and assumes all employed personnel will be available for recall when the plan is activated. 3. The agency/facility emergency operational plan was prepared internally but assumes some employed personnel will not be available for recall because they are absent or deployed elsewhere when the plan is activated. 4. The agency/facility emergency operational plan was prepared in cooperation with some other stakeholders and identifies some employed personnel will not be available for recall because they are absent or deployed elsewhere when the plan is activated. 5. The agency/facility emergency operational plan was prepared in collaboration with all other stakeholders in the area and articulates directly with plans created by other stakeholders. The plan clearly identifies expected reductions in available personnel due to absence and specifies a common process for utilizing personnel employed by multiple agencies.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Public Education	
13. The agency/facility informs and educates the local constituencies and policy makers to foster collaboration and cooperation for the enhancement of Regional Emergency Medical and Trauma Services as a whole.	
Structure Indicator	*Scoring*
13.1 Your agency/facility has a public information and education program that heightens public awareness of the preventability of injury and/or illness.	0. Don't know 1. Our agency/facility has no program/plan that provides information and education that heightens public awareness or injury and/or illness prevention and control. 2. Our agency/facility has a public awareness and injury/illness prevention program but linkages between programs and implementation of specific objectives is sporadic. 3. Our agency/facility has a public awareness and injury/illness prevention program. Linkages between programs and implementation occur regularly, but are not measured 4. Our agency/facility has a public awareness and injury/illness prevention program. Linkages between programs and implementation occur regularly. We are just beginning to gather data to measure outcomes. 5. Our agency/facility has a public awareness and injury/illness prevention program. Public information and education plan is being implemented in accordance with the timelines. Data concerning the effectiveness of the strategies are used to modify the plan and programs.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Public Education	
Process Indicator	*Scoring*
13.2 An assessment of the needs of the general public concerning Emergency Medical and Trauma Care information has been conducted.	0. Don't know 1. There is no routine or planned contact with the general public. 2. Plans are in place to provide information to the general public in response to a particular acute illness or traumatic event. 3. The general public has been formally asked about what types of information would be helpful in understanding and supporting agency/facility issues. 4. General public information resources have been developed, based on the stated needs of the general public themselves, and general public representatives are included in agency/facility informational events. 5. In addition to routine contact, the general public is involved in various oversight activities such as local and regional advisory councils.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Public Education	
Outcome Indicator	*Scoring*
13.3 Your local agency/facility seeks and receives strong public support.	0. Don't know. 1. Our local agency/facility has not been able to generate community and political support for systems improvements, e.g. increased mill levies. 2. There has been sporadic community and political support of agency/facility needs, e.g. one time budget requests for new equipment. 3. There is an ongoing, but inadequate level of funding and community/political support for our agency/facility. 4. Our agency/facility has strong support from the community and political constituency that includes an ongoing budget that is adequate to meet the routine operating costs of the system. 5. Our agency/facility has strong support from the community and political constituency that includes not only an ongoing budget, but support for improvements and expansion. This support could be manifested by special assessments, one-time budget requests in addition to ongoing budgets, fund-raising campaigns widely supported by the community, etc.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Public Education	
RETAC Indicator	*Scoring*
13.4 The RETAC plan includes regional education efforts to promote and raise awareness of EMTS agencies and organizations and to promote wellness and prevention within the region.	0. Don't know 1. The RETAC is not currently involved in public education efforts. 2. The RETAC plan contains a public education component but there are no activities related to this component. 3. The RETAC is involved with others in public education about EMTS systems. 4. The RETAC plan drives activities that promote and raise awareness of the EMTS system within the region. 5. The RETAC is taking a leadership role in promoting the EMTS system and in promoting wellness and prevention within the region. **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Injury/Illness Prevention	
14. All disciplines actively support community wellness and prevention activities.	
Structure Indicator	*Scoring*
14.1 A written injury/ illness prevention plan is developed and coordinated with other agencies/facilities. The injury/illness program is data driven, and targeted programs are developed based on high injury/illness risk areas. Specific goals with measurable objectives are incorporated into the injury/illness prevention plan.	0. Don't know 1. There is no written plan for a coordinated injury/illness prevention program. 2. There are multiple injury and/or illness prevention programs that may conflict or overlap with each others with no coordination within the region. 3. There is a local written plan for a coordinated regional injury/illness prevention program that is linked to the agency/facility plan and that has goals and measurable objectives. 4. The regional injury/illness prevention program is being implemented and will include established timelines. 5. A regional injury/illness prevention program is being implemented in accordance with the timelines; data concerning the effectiveness of the plan are collected and are used to validate, evaluate, and modify the plan. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Injury/Illness Prevention	
Process Indicator	*Scoring*
14.2 Injury/illness prevention programs) our agency/facility information to uevelop intervention strategies.	0. Don't know 1. There is no evidence to suggest that our agency/facility data are used to determine injury/illness prevention strategies. 2. There is some evidence that our agency/facility data is available for injury/illness prevention program strategies, but its use is limited and sporadic. 3. Our agency/facility data is routinely provided to the injury/illness prevention programs. The usefulness of the reports has not been measured, and prevention stakeholders are just beginning to use our agency/facility data for programmatic strategies and decision-making. 4. Our agency/facility reports on the status of illness/injury and injury mechanisms are routinely available to prevention stakeholders and are used routinely to realign prevention programs to target the greatest need. 5. A well-integrated agency/facility data system exists. Evidence is available to demonstrate how prevention stakeholders routinely use the information to identify program needs, to develop strategies on program priorities, and to set annual goals for injury/illness prevention. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Injury/Illness Prevention	
Outcome Indicator	*Scoring*
14.3 The effect or impact of injury and/or ;ess prevention programs is evaluated as part of a system performance improvement process.	0. Don't know 1. There is no effort to review the activities of our agency/facility in prevention efforts. 2. There is no routine evaluation of prevention activities accruing within this jurisdiction. 3. Our agency/facility does internal monitoring and evaluations of our efforts in prevention activities. 4. Our agency/facility participates with other key stakeholders in our region in evaluating prevention intervention activities. The programs are regularly assessed for effectiveness. 5. Our agency/facility along with other key stakeholders routinely uses data to implement prevention programs and to communicate prevention efforts through periodic reports. Evaluation processes are institutionalized and used to enhance future prevention activities on a regional level. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Injury/Illness Prevention	
RETAC Indicator	*Scoring*
14.4 The region-wide Emergency Medical and Trauma System (EMTS) and the public health system have established linkages including programs with an emphasis on population-based public health surveillance, and evaluation for acute injury/illness prevention. Regional prevention efforts include pediatric injury prevention.	0. Don't know 1. There is no evidence that demonstrates program linkages, a working relationship, or the sharing of data between public health and the EMTS. Population-based public health surveillance for acute or chronic traumatic injury and illness has not been integrated with the RETAC. 2. There is little population-based public health surveillance shared with the EMTS, and program linkages are rare. Routine public health status reports are available for review by the RETAC and its constituent agencies. 3. The EMTS and the public health system have begun sharing public health surveillance data for acute and chronic illness and injury. Program linkages are in the discussion stage. 4. The EMTS has begun to link with the public health system, and the process of sharing public health surveillance data is evolving. Routine dialogue is occurring between programs. 5. The EMTS and the public health system are integrated. Routine reporting, programmatic participation, and system plans are fully vested. Operational integration is routine, and measurable progress can be demonstrated. (Demonstrated integration and linkage could include such activities as rapid response and notification in disasters, integrated data systems, communication cross-operability, and regular epidemiology report generation.) **RETAC Score**

Emergency Medical and Trauma System (EMTS) Component: Information Systems	
15. There is an information system within the EMTS that can evaluate system performance, track provider skills, and formulate policies based on the analysis of collected data.	
Structure Indicator	*Scoring*
15.1 Your agency/facility participates in a system data collection and information data sharing network, collects pertinent data from providers on each episode of care, and uses data for system improvements.	0. Don't know 1. There is no routine collection of data or data collection system used by our agency/facility. 2. There is a minimal data set collected but it cannot be shared with other entities nor used for system improvements. 3. There is a data collection system, and some users access the information for system improvement activities. The use of the data is random and unfocused. 4. A regional data collection system is in place and used routinely by providers. The integration and use by other stakeholders is not completed. 5. There is a robust information system that is integrated with other databases. Our agencies/facilities input data into the data collection system on each episode of care. The data are used to analyze system performance and to make adjustments in education, training or policy as applicable. **Agency/Facility Score** | **System Score**

Emergency Medical and Trauma System (EMTS) Component: Information Systems	
Process Indicator	*Scoring*
15.2 An information system is available for routine Emergency Medical and Trauma System and public health surveillance. It can be accessed by individual users as well as management for system oversight.	0. Don't know 1. There is no information system in place within our agency/facility. 2. There is an information system in place but it is not used by our agency/facility. 3. There is an information system in place but its use is sporadic; some system oversight is done using the information system that is in place. 4. The information system is in place and is integrated with other databases. It is used in some instances to review system performance but regular reports and system oversight using the information system has not been fully accomplished. 5. There is a fully integrated information system that routinely and regularly reports on individual and system performance. The system is used to make regular reports to management, and for establishing policy changes. Individual agencies/facilities can access the database and produce reports.

Agency/Facility Score	Syatem Score

Emergency Medical and Trauma System (EMTS) Component: Information Systems	
Outcome Indicator	*Scoring*
15.3 An information system is used to assess system and provider performance, measure compliance with standards/rules and to allocate resources to areas of greatest need or acquire new resources as necessary.	0. Don't know 1. There is no information system such as the one described in use within our agency/facility. 2. Our agency/facility information system is limited in scope and the data is generally used for billing purposes. 3. Our agency/facility information system is sometimes used to review system issues or individual performance. 4. Our agency/facility information system is used by some providers to review system performance and compliance with applicable standards. The use of the data system is usually associated with an unusual occurrence rather than the routine course of system oversight, although efforts to make the system more accessible are in process. 5. There is a comprehensive information system that is used to assess system performance, measure compliance with applicable standards and allocate resources. Our agency/facility integrates the information system with other data bases to assist in routine analysis of system performance.

Agency/Facility Score	System Score

Emergency Medical and Trauma System (EMTS) Component: Information Systems	
RETAC Indicator	*Scoring*
15.4 The RETAC utilizes data from local agencies and state data collection programs as well as periodic regional assessments as a tool to monitor the regional EMTS system. Information from all sources is integrated in a manner that drives regional continuous quality improvement efforts.	0. Don't know 1. The RETAC does not currently utilize objective data to drive regional quality improvement. 2. The RETAC has access to state trauma register and EMS agency information but does not use the information to drive regional quality improvement. 3. The RETAC utilizes one or more data sources to monitor regional performance and provides feedback and assistance to local agencies 4. There is a formal QI program that utilizes one or more data sources to measure targeted RETAC performance. 5. The RETAC regularly integrates trauma register, EMS information system, regional assessment and other data to assess the quality of its emergency medical and trauma system. The regional CQI system drives system wide performance improvement. **RETAC Score**

Please printout and complete the survey answer form and send to the NCRETAC Coordinator, Eric Schmidt at emssvcs@aol.com or to Ken Riddle at fax 925-946-0911 or email at kriddle@abarisgroup.com

Northwest Regional Emergency Medical and Trauma Advisory Council
Standardized (Regional) Needs Assessment Project
Problem Ranking Survey

Demographical Information: (Indicate provider type and check all that apply below the provider type selected.)

__ Pre-**Hospital Provider**
__ Volunteer __ Paid
__ BLS __ ALS
__ Fire/Rescue
__ Ambulance
__ Other

__ Hospital **Provider**
__ Trauma Center Level
__ MD
__ RN
__ Administration

__ Other **Provider**
__ Law Enforcement
__ Dispatch/Communications
__ Emergency Management
__ Public Health
__ Elected Official
__ Other

- Please rank the following ten listed issues from 1 (most challenging) to 10 (least challenging)
- Note: Use each value (1 through 10) only once

Agency Name:

____ **Agency Funding/Financial Viability**

Comments:

____ **Recruitment of New Personnel**

Comments:

____ **Retention of Personnel**

Comments:

____ **Aging Building/Equipment**

Comments:

____ **Initial/Continuing Education**

Comments:

____ **Billing/Accounts Receivable**

Comments:

____ **Medical Director Involvement**

Comments:

____ **Support form RETAC**

Comments:

____ **Administrative Support**

Comments:

____ **Cooperation with Other Agencies**

Comments:

- Please send this and the BIS tool answer sheet to: Ken Riddle – kriddle@abarisgroup.com or fax to 707-922-0211

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