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Emergency Medical & Trauma Services Annual Report 2025

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State Emergency Medical and Trauma Services Advisory Council

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COLORADO
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Table of Contents

Executive Summary	3
I: EMS System Overview	4
Figure 1: Map of all Colorado Licensed Ground Ambulance Services and Regional Emergency Medical and Trauma Services Advisory Councils (RETACs)	5
Figure 2: Heat Map of Licensed Ground Ambulance Service Areas by County	6
Figure 3: Count of Ground Ambulance Services that also provide Behavioral Health Secure Transport Services	7
Figure 4: Map of Colorado Community Integrated Health Care Service (CIHCS) Licensed Agencies and County Urbanicity	8
Figure 5: Count of Licensed Ground Ambulance Services by Type and Urbanicity	9
Figure 6: Volunteerism in Licensed Ground Ambulance Services by Urbanicity	10
Figure 7: Vehicle age by Urbanicity	11
Figure 8: Count of FY25 Funded Grant Applications and Dollar Amounts by Urbanicity	12
Figure 9: Count of FY25 Funded Grant Applications by Type and Urbanicity of Recipient	13
Figure 10: Ground Ambulance Service Level of Care by Urbanicity	14
Figure 11: Map of Education Centers by Highest Level of Initial Training	15
Figure 12: Count of Certified or Licensed EMS Clinician by Level and Home Address Urbanicity	16
II. EMS Patient Care Reporting	17
Figure 13: Count of Licensed Ambulance Patient Care Reports (ePCRs) by Incident Urbanicity	17
Figure 14: Proportion of Licensed Air Ambulance Patient Care Reports by Type of Service and Urbanicity of Incident Location	18
Figure 15: Mean Interfacility Transport (IFT) Time on Task by Incident Urbanicity	19
Figure 16: IFTs by Hour of Day and Incident Urbanicity	20
Figure 17: Proportion of Medical vs Trauma Responses by Incident Location Urbanicity	21
Figure 18: Top Primary Impression by Urbanicity	22
Figure 19: Count of Infant PCRs by Primary Impression (Less than 1 Year Old)	23
Figure 20: Count of PCRs by Age Group and Primary Impression	25
Figure 21: Quarterly Statewide Average of National EMS Quality Alliance (NEMSQA) Measures (Pediatric)	26
Figure 22: Quarterly Statewide Average of National EMS Quality Alliance (NEMSQA) Measures (Adult)	27

Figure 23: Count of Waivers by Licensed Ground Ambulance Agency Urbanicity	28
Figure 24: Count of Scope of Practice Waiver Utilizations by Waiver type	29
Figure 25: Blood Product Administrations by Incident Urbanicity and Trauma vs. Medical..	30
III. Trauma Care in Colorado.....	31
Figure 26: Map of all Colorado Designated Trauma Facilities and Regional Emergency Medical and Trauma Services Advisory Councils (RETACs).....	32
Figure 27: Trauma Centers and Record Counts by Designation Level	33
Figure 28: Proportion of Trauma Records by Mode of Arrival and Designation Level.....	34
Figure 29: Count of Trauma Facilities and Trauma Records by Facility Urbanicity	35
Figure 30: Percent of Emergency Department (ED) Transfers by Urbanicity.....	36
Figure 31: Count of All Transferred Patients (ED or Hospital) by Destination Facility County	37
Figure 32: Median ED Length of Stay (HH:MM) by Facility Urbanicity for ED Transfers.....	38
Figure 33: Percent of Trauma by Fall Categories (LI-III)	39
Figure 34: Top Fall Categories by Age	40
Figure 35: Top Causes of Injury (excluding Falls) by County of Residence	41
Figure 36: Count of Trauma Records by Out-of-State Residence	42
Conclusion	43

Executive Summary

The 2025 Colorado Emergency Medical and Trauma Services (EMTS) Annual Data Report provides an analysis of information reported to the Emergency Medical and Trauma Services Branch within the Colorado Department of Public Health and Environment (CDPHE). This report assists in understanding the current state of Colorado's emergency medical and trauma system and provides information to improve performance, identify opportunities for system enhancement, and describe emergency medical and trauma care delivered throughout the state.

The following is an overview of key findings from the report:

- More than half of licensed ambulance agencies rely on at least one volunteer provider, and nearly one-third of frontier agencies remain entirely volunteer staffed.
- Community Integrated Health Care Service (CIHCS) programs served 6,672 Coloradans in 2025, a 55% increase from the previous year. Two-thirds reported reductions in non-urgent emergency department utilization among the populations they serve.
- Licensed Colorado ambulance agencies submitted 819,105 patient care reports in 2025, a 3.8% increase from 2024. Ground ambulance responses increased approximately 4%, while air ambulance responses remained relatively stable.
- Interfacility transports place a disproportionate burden on rural and frontier EMS systems. The average frontier interfacility transport requires more than four hours of ambulance unit time, compared to less than two hours in urban areas.
- Air ambulance responses account for less than 2% of EMS records statewide but are a critical resource for rural and frontier communities. While these areas represent only 14% of EMS responses, they account for 46% of all air ambulance transports.
- Approximately 30% of emergency responses involve traumatic injuries, and that proportion increases to 35% in rural and frontier communities.
- Behavioral health-related responses represent a remarkably large share of EMS encounters for children over the age of 6, representing the top primary impression for ages 13-17 and second leading primary impression in ages 6-12.
- Statewide EMS quality measures continued to improve throughout 2025. Stroke assessment performance improved from 68% to 84%, while trauma assessment documentation remained consistently above 90%.
- Nearly one in five trauma patients required transfer to another facility for ongoing care; frontier trauma facilities transferred more than half of trauma patients they treated, emphasizing their essential role in stabilization and coordination of care for rural and frontier residents.
- Skiing, snowboarding, and other pedestrian conveyance-related injuries remain a leading source of trauma among younger Coloradans and visitors, while slipping, tripping, and stumbling injuries predominate among older adults.
- Colorado's trauma system cared for more than 3,300 injured patients from outside the state, demonstrating its role as both a regional referral network and a destination trauma system supporting tourism, recreation, and interstate travel.

I: EMS System Overview

In response to the passage of Senate Bill 22-225, the Colorado Department of Public Health and Environment (CDPHE) established a state-level licensing system for ground ambulance agencies effective July 1, 2024. Alongside licensing, SB22-225 established the Emergency Medical Services (EMS) System Sustainability Task Force to evaluate and recommend improvements to EMS systems statewide, focusing on equitable access, workforce stability, and sustainable funding. This comprehensive approach aims to enhance the consistency, quality, and oversight of emergency medical care across Colorado. More information about this task force can be found at <https://cdphe.colorado.gov/emergency-care/engage-with-us/councils-boards-and-task-forces/ems-system-sustainability-task-force>.

State level licensing coupled with the collaboration of the sustainability task force has ensured that the EMTS branch of CDPHE has a more complete and accurate picture of the landscape of emergency medical services being provided across the state. Figure 1 shows a map of all licensed ground ambulance agencies as well as the Regional Emergency Medical and Trauma Services Advisory Council (RETAC) in which they reside.

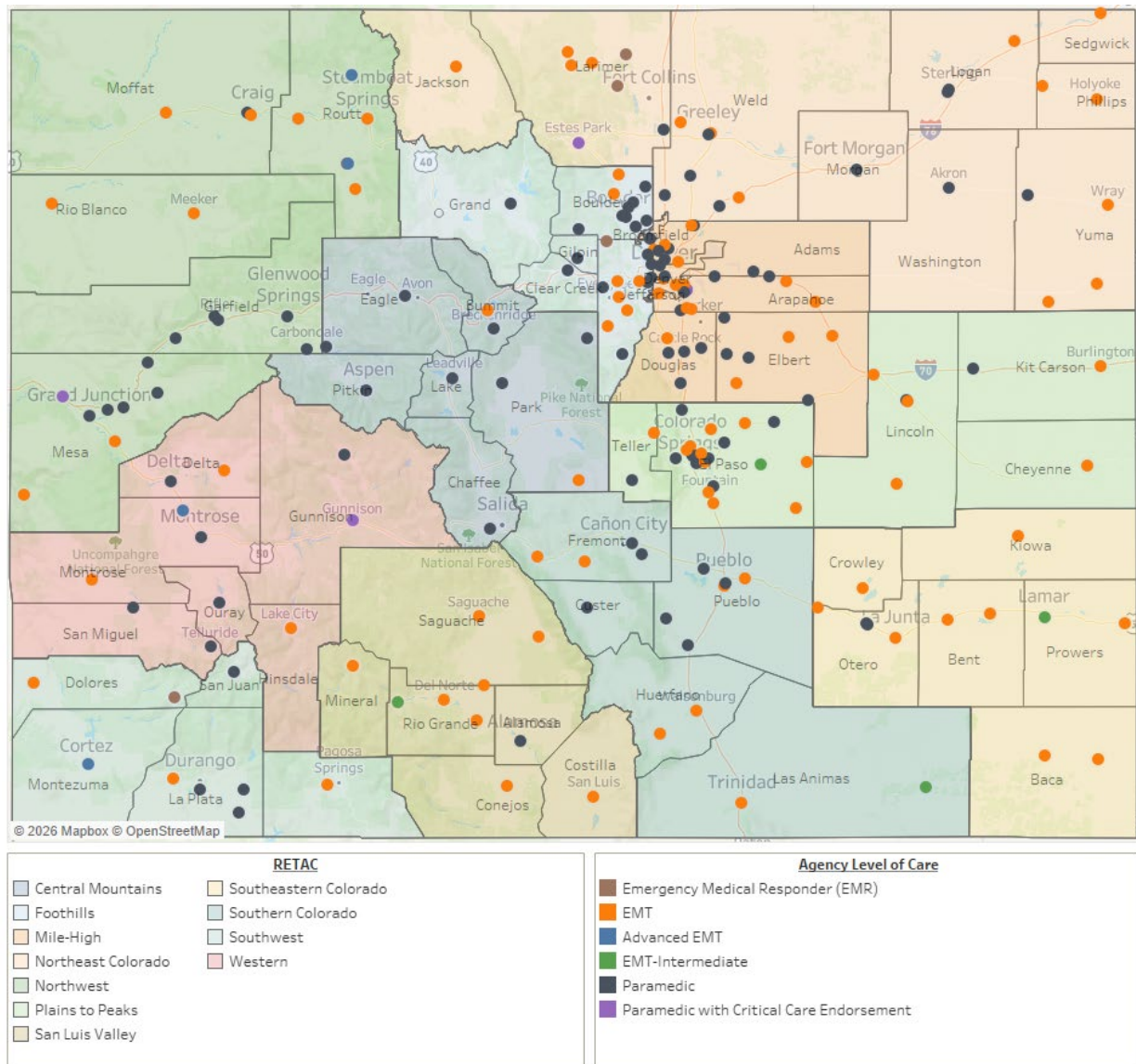


Figure 1: Map of all Colorado Licensed Ground Ambulance Services and Regional Emergency Medical and Trauma Services Advisory Councils (RETACs)

Licensed ground ambulance agency location acquired from Organizational Profile service physical address data provided by agency in the License Management System (LMS). Additionally, Agency Level of Care acquired from Organizational Profile response to "level of service at which the agency provides EMS care for every request for service (the minimum level)." Data extracted March 2026. n=212 (map excludes out of state agencies and agencies with both air and ground ambulance licenses)

In 2025, Colorado licensed 244 ambulance agencies (air and ground) operating within the state. While Figure 1 focuses on the 212 Colorado-based ground ambulance agencies, Colorado's EMS system also relies on resources originating outside the state, including 29 licensed air ambulance agencies and three licensed ground ambulance agencies based in neighboring states. The presence of these agencies highlights the importance of cross-border resources in supporting patient care, particularly in rural and frontier communities.

The geographic distribution of agencies demonstrates the concentration of EMS resources along the Front Range while also illustrating the broad geographic responsibility of agencies serving Colorado's rural and frontier regions. Statewide licensing has improved visibility into these service patterns and provides a stronger foundation for evaluating system sustainability, resource allocation, and equitable access to emergency medical services.

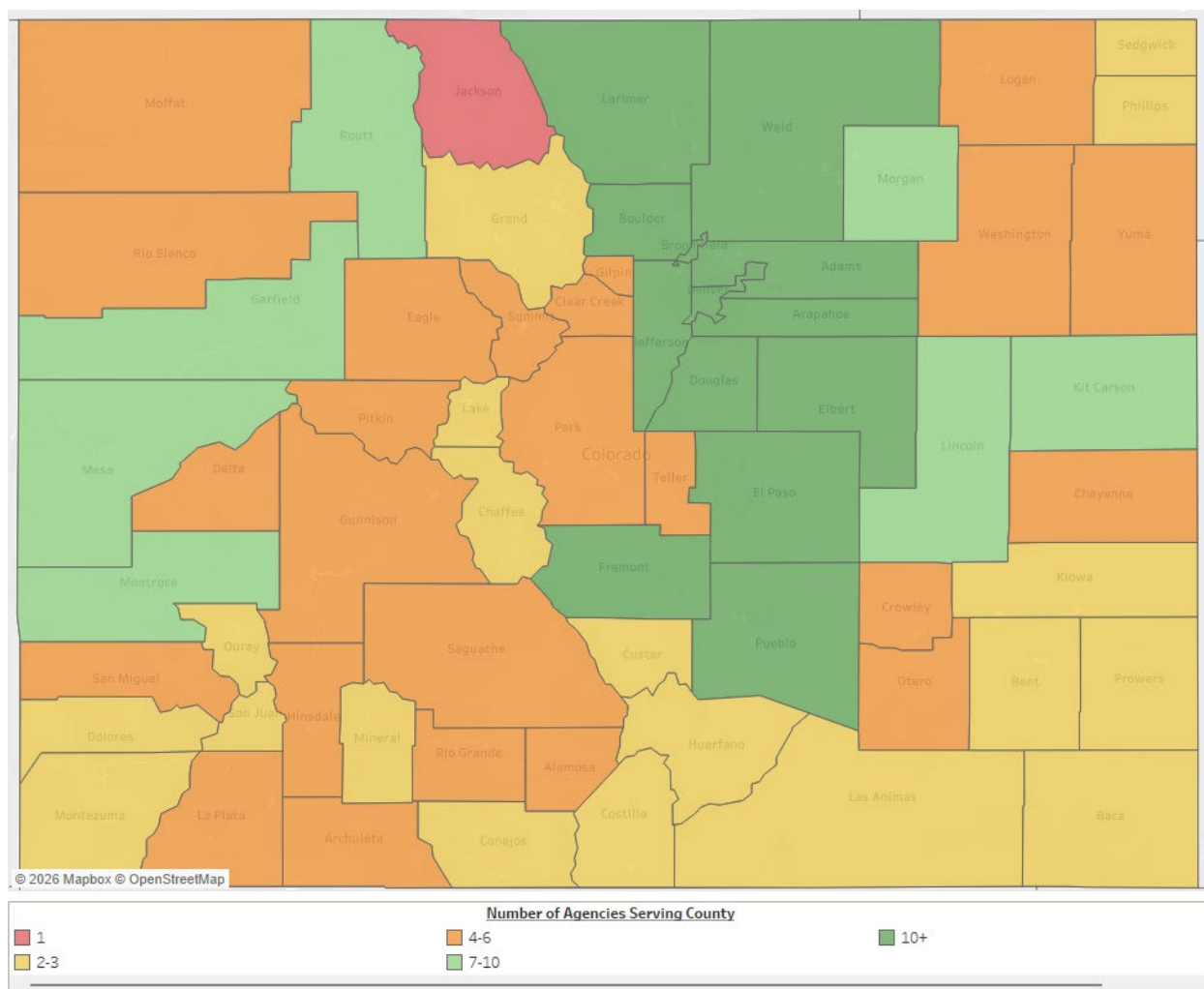


Figure 2: Heat Map of Licensed Ground Ambulance Service Areas by County
Service area county acquired from Ground Ambulance License application data provided by agency in the License Management System (LMS). Data extracted March 2026. n=211 (one agency excluded due to inaccuracies)

The number of agencies serving each county varies considerably across Colorado. Twenty of Colorado's 64 counties have three or fewer licensed ambulance agencies providing service within their boundaries. It is important to note that the number of agencies serving a county does not necessarily indicate complete countywide coverage, as service areas may overlap or cover only portions of a county.

The map highlights the challenges associated with providing EMS coverage in Colorado's most rural and frontier regions. Jackson County, for example, is served by a single licensed ground ambulance agency and has no designated trauma facility within the county. Counties with limited agency redundancy may be particularly vulnerable to staffing shortages, vehicle downtime, severe weather events, and prolonged transport times. These findings reinforce the importance of ongoing EMS system sustainability efforts aimed at maintaining reliable emergency medical access across geographically isolated communities.

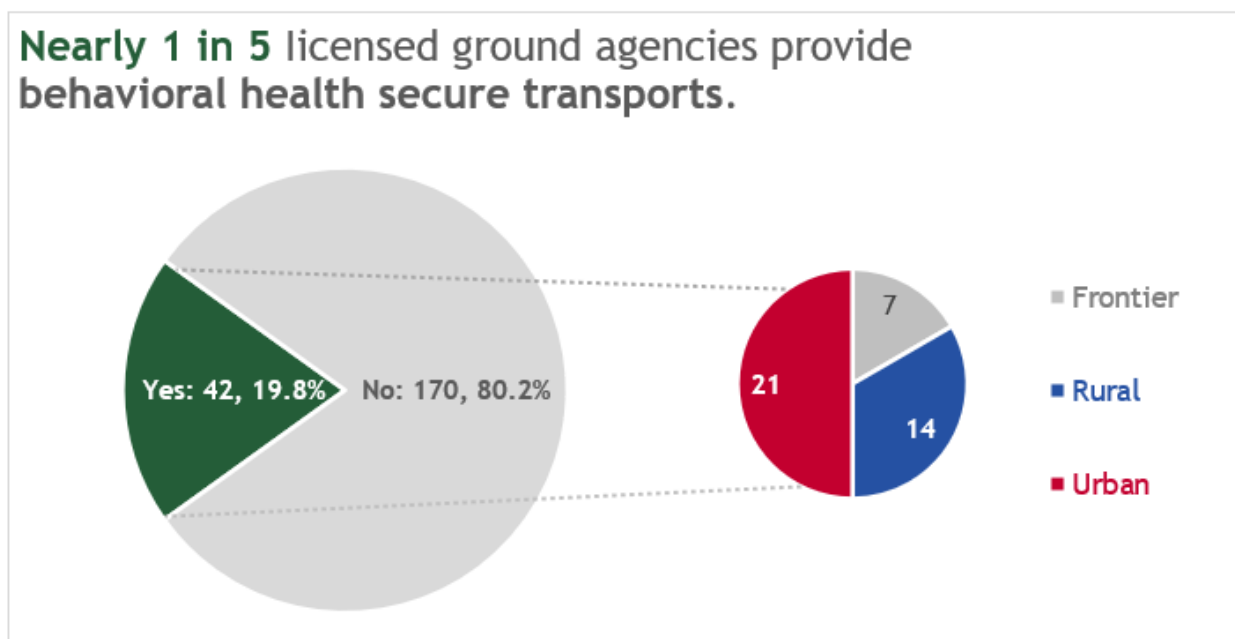


Figure 3: Count of Ground Ambulance Services that also provide Behavioral Health Secure Transport Services

Behavioral Health Secure Transport (BHST) information acquired from Organizational Profile service self-reported data in the License Management System (LMS). n=212 (excludes out of state agencies and agencies with both air and ground ambulance licenses)

Emergency medical services in Colorado provide a wide range of services beyond traditional emergency response and patient transport. One example is Behavioral Health Secure Transport (BHST), a program that supports the safe transportation of individuals experiencing behavioral health crises. The Department of Health Care Policy and Financing began enrollment in the behavioral health secure transportation benefit on July 1, 2023. Licensed ground ambulance agencies are exempt from additional secure transportation licensing requirements and may receive reimbursement when operating in accordance with state regulations.

Nearly one in five licensed ground ambulance agencies (19.8%) reported providing BHST services in 2025. Participation was observed across all urbanicity classifications; however, frontier communities had proportionally fewer agencies offering the service. As behavioral health needs continue to increase statewide, BHST programs represent an important aspect of that, as patient movement is a key element to mental health care in the state.

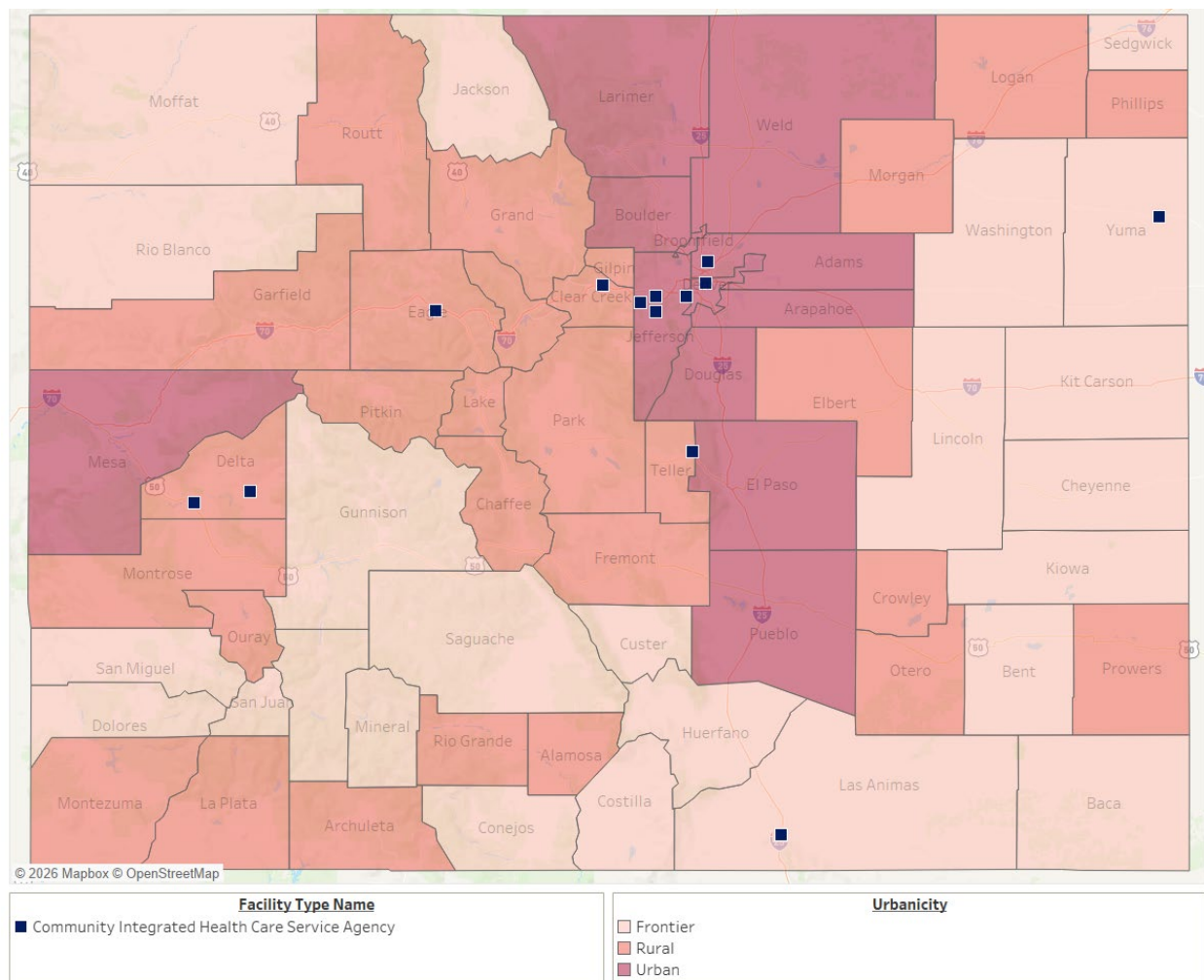


Figure 4: Map of Colorado Community Integrated Health Care Service (CIHCS) Licensed Agencies and County Urbanicity

Community Integrated Health Care Service (CIHCS) location acquired from the physical address provided by the service in the facility license. Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine which counties are classified as rural, urban, or super rural/frontier. Data extracted March 2026. n=13

Community Integrated Health Care Services (CIHCS), often referred to as community paramedicine or mobile integrated health care, represent one of the most significant evolutions in modern EMS delivery. These programs extend the role of EMS beyond emergency response by providing preventive, supportive, and coordinated healthcare services within patients' homes and communities.

CIHCS agencies perform a variety of functions, including wellness checks, chronic disease management, medication assistance, behavioral health support, referrals to community resources, and transportation to medically necessary appointments. Many programs were initially developed to address healthcare gaps in rural and underserved communities, though their benefits have increasingly been recognized in urban and suburban settings as well.

In 2025, CIHCS programs reported serving 6,672 Coloradans, a substantial increase from 4,301 individuals served in 2024. Additionally, two-thirds of participating agencies reported reductions in non-urgent emergency department utilization among the populations they serve. These findings suggest that community paramedicine programs continue to mature as an effective strategy for improving access to care, reducing avoidable healthcare utilization, and addressing unmet social and medical needs throughout Colorado.

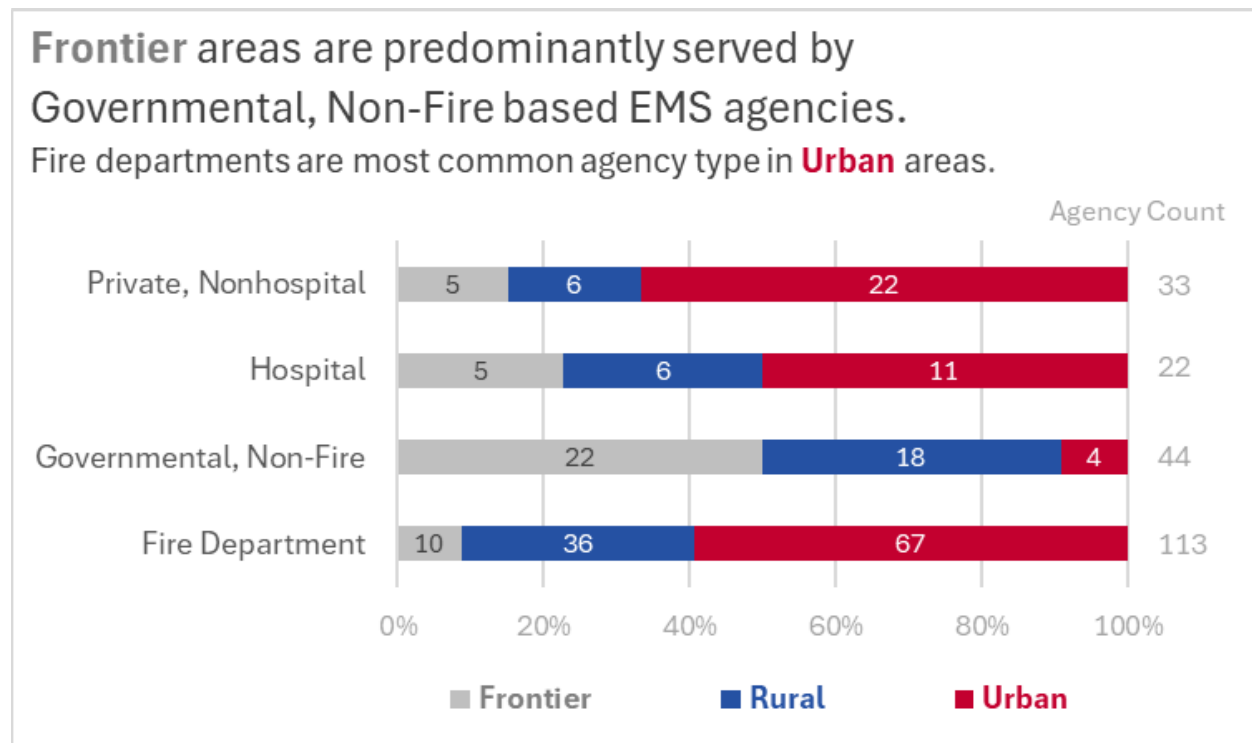


Figure 5: Count of Licensed Ground Ambulance Services by Type and Urbanicity
Organization Type data obtained from self-reported Organizational Profile. Urbanicity determined using Ground Ambulance License service physical address provided by the agency via the License Management System (LMS) and geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine county urbanicity. n=212

The organizational structure of ambulance agencies varies considerably across Colorado and reflects differences in community needs, governance models, and available resources. Fire department-based ambulance services represent the most common organizational type statewide, accounting for 113 of Colorado's 212 licensed ground ambulance agencies.

Urban areas are predominantly served by fire department-based EMS services, while governmental non-fire agencies represent the most common service model in frontier communities. More than 80% of frontier agencies are publicly funded government or fire departments, highlighting the critical role local governments and fire departments play in maintaining emergency medical services in areas where population density and call volume may not support alternative operational models.

Hospital-based agencies are also an important component of Colorado's EMS system, with approximately one-quarter located in frontier communities. This distribution reflects the importance of hospital and EMS partnerships in rural regions and demonstrates the diversity of EMS delivery models utilized throughout the state.

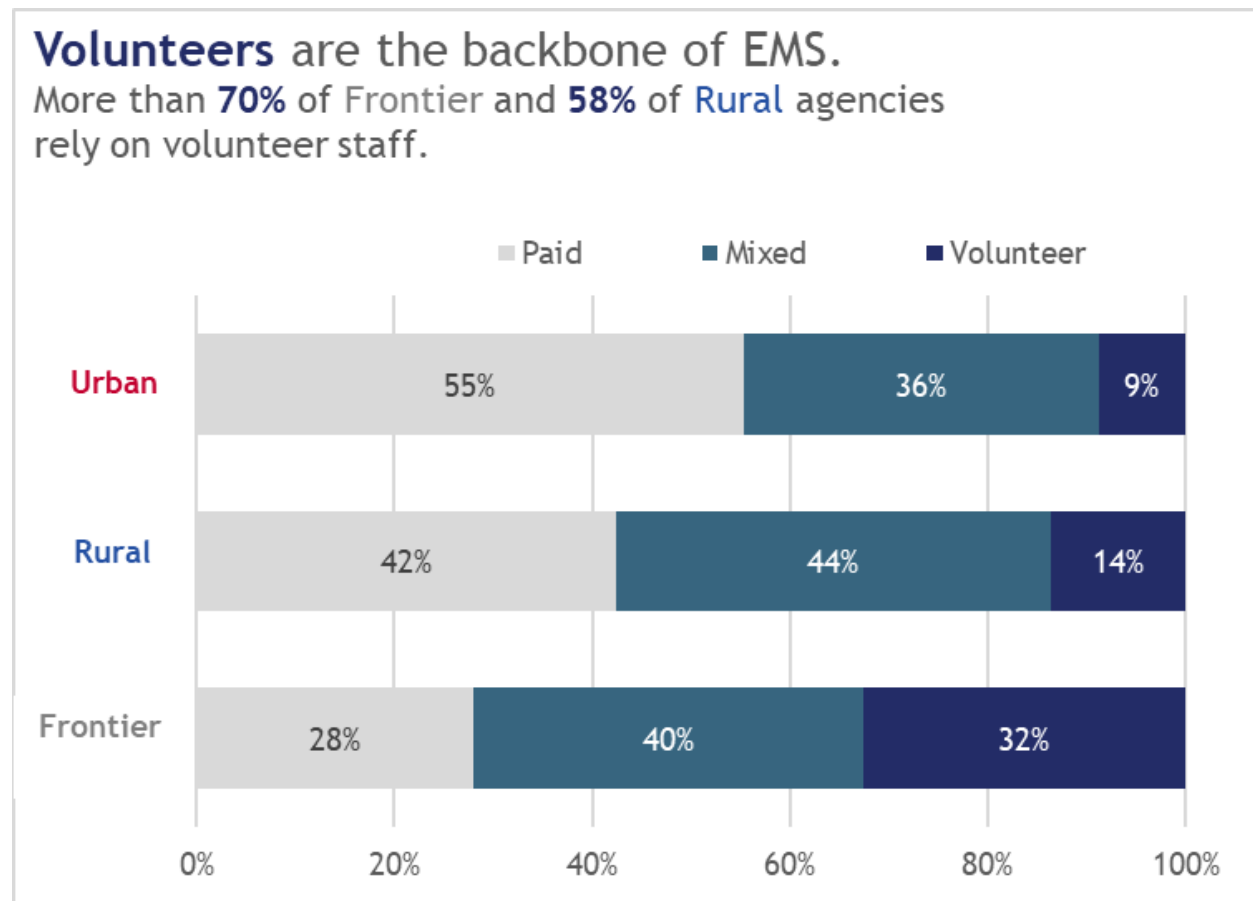


Figure 6: Volunteerism in Licensed Ground Ambulance Services by Urbanicity
Data on Organization Status obtained from self-reported Organizational Profile in the License Management System (LMS). Mixed refers to services that have at least one volunteer. Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine county urbanicity. n=212

Volunteer personnel continue to play a vital role in Colorado's EMS workforce. More than half of licensed ground ambulance agencies statewide rely on at least one volunteer to support service delivery, underscoring the importance of volunteerism to EMS system sustainability.

Volunteer involvement is particularly prominent in rural and frontier communities. More than 70% of frontier agencies and 58% of rural agencies reported utilizing volunteer staff. Additionally, nearly one-third of frontier agencies rely entirely on volunteers to provide ambulance services. While volunteer personnel are often associated with rural communities, mixed staffing models that combine paid and volunteer personnel are present throughout the state, including

many agencies located within urban counties. These findings demonstrate that volunteer EMS providers remain an essential component of Colorado's emergency medical services infrastructure and continue to support access to care in communities that may otherwise struggle to maintain adequate staffing levels.

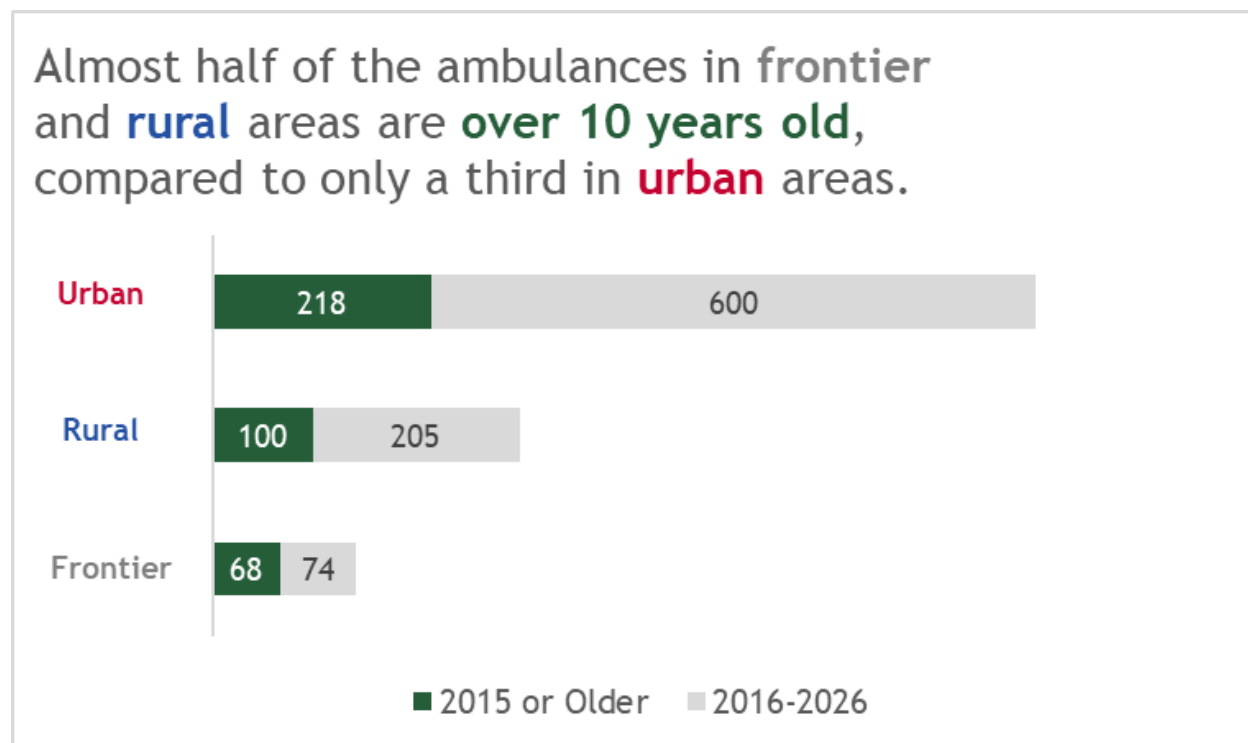


Figure 7: Vehicle age by Urbanicity

Vehicle age acquired from Ground Ambulance License application data provided by agency in the License Management System (LMS). Data extracted March 2026. Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine county urbanicity. n=1,265

Colorado permitted 1,265 ground ambulances in 2025. Overall, approximately 30% of these vehicles were ten years old or older. Vehicle age varied substantially by urbanicity, with rural and frontier agencies operating older fleets than their urban counterparts; only 26% of ambulances in urban areas were more than ten years old, compared with nearly half of all ambulances operating in rural and frontier communities.

Older vehicle fleets may reflect the financial challenges associated with replacing ambulances in lower-volume systems where funding opportunities are limited. Aging fleets can increase maintenance costs, contribute to vehicle downtime, and create operational challenges for agencies serving geographically large areas. These findings highlight the continued importance of capital funding programs that support ambulance replacement and modernization efforts.

Rural agencies received the most grant dollars in fiscal year 2025.

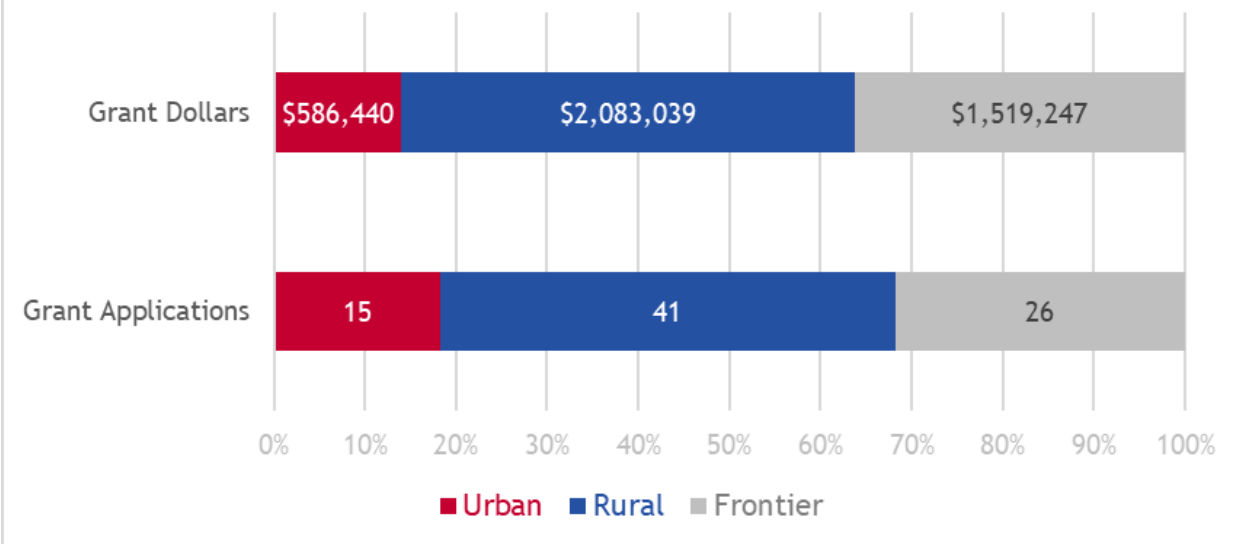


Figure 8: Count of FY25 Funded Grant Applications and Dollar Amounts by Urbanicity

Grant application data from funded grants acquired from Zoom Grants. EMTS Organization location acquired from Organizational Profile service physical address data provided by agency in the License Management System (LMS). Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine county urbanicity.

The Colorado Emergency Medical and Trauma Services (EMTS) system is supported through Highway Users Tax Fund (HUTF) revenues. These funds help sustain critical statewide EMS and trauma infrastructure, including CDPHE EMTS Branch staff, statewide EMS and trauma data systems, Regional Emergency Medical and Trauma Services Advisory Council (RETAC) coordination, and grants that support local EMS agencies and providers. These grant funds remain an important mechanism for supporting EMS agencies throughout Colorado. In fiscal year 2025, rural agencies received the largest share of awarded grant dollars and submitted the greatest number of successful applications. Rural agencies accounted for 41 funded applications and received more than \$2 million in grant funding, exceeding both urban and frontier recipients. Frontier agencies also received substantial support, receiving more than \$1.5 million in awarded funds despite a smaller number of funded applications.

The distribution of funding reflects both the continued needs of rural and frontier EMS systems and the effectiveness of these agencies in pursuing available grant opportunities. These investments support critical infrastructure, workforce development, equipment acquisition, and operational sustainability efforts across Colorado's most geographically challenging regions.

Most grant dollars go to **rural vehicles**, followed by equipment in **frontier** areas.

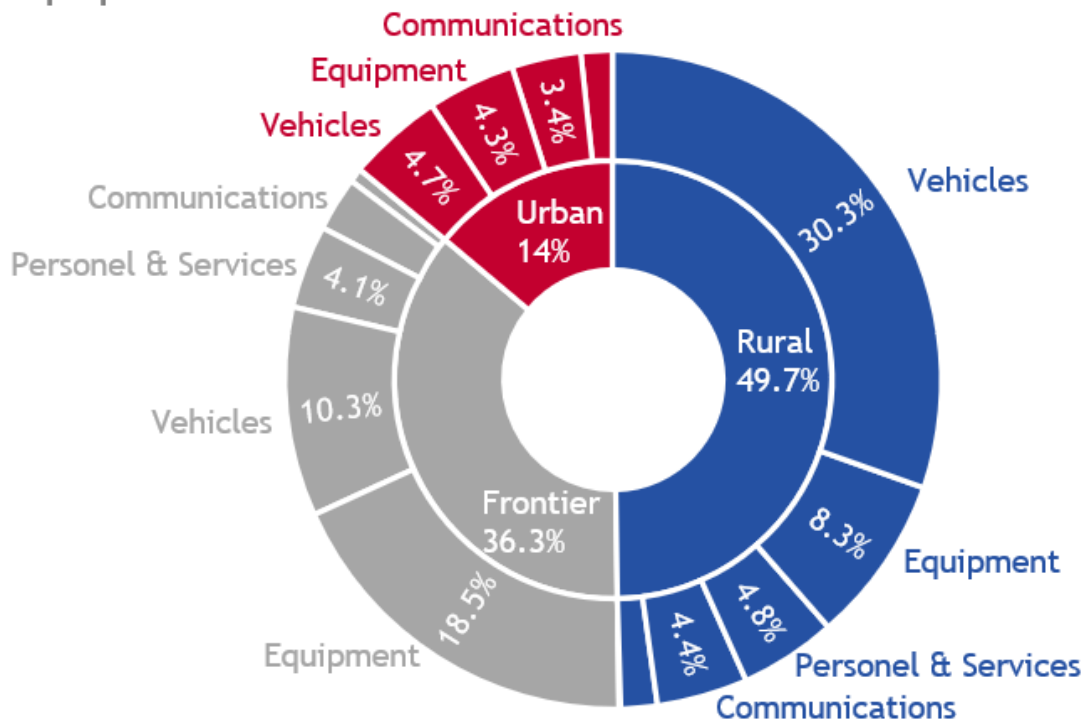


Figure 9: Count of FY25 Funded Grant Applications by Type and Urbanicity of Recipient
Grant application data from funded grants acquired from Zoom Grants. EMTS Organization location acquired from Organizational Profile service physical address data provided by agency in the License Management System (LMS). Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine county urbanicity.

Grant funding priorities varied by both project type and community characteristics. Vehicle purchases represented the largest category of funded projects statewide, with rural agencies receiving the greatest share of vehicle-related funding. Equipment purchases in frontier communities represented the second-largest funding category.

The prominence of vehicle and equipment funding requests reflects the ongoing capital needs of EMS agencies and the substantial costs associated with maintaining operational readiness. These investments are particularly important in rural and frontier areas, where agencies often cover large geographic service areas, operate older vehicle fleets, and have fewer local funding resources available to support major capital expenditures.

Most agencies that can send a **paramedic** to every call are in **Urban** areas, while **EMTs** are most often the highest level of care in **Frontier** areas.

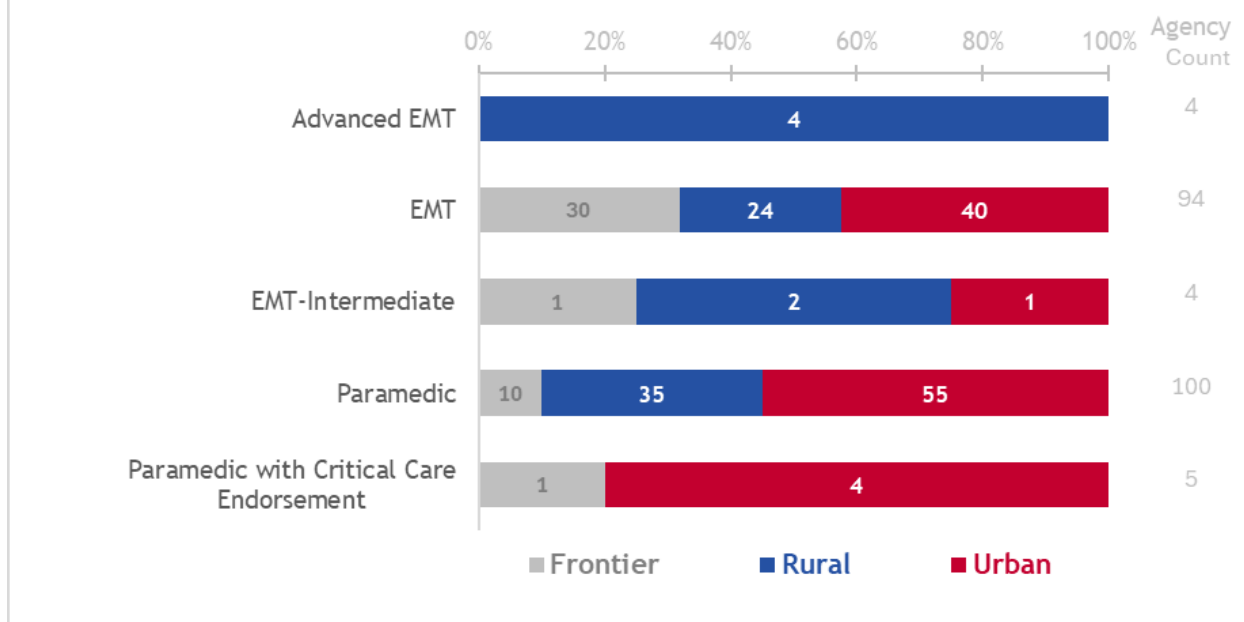
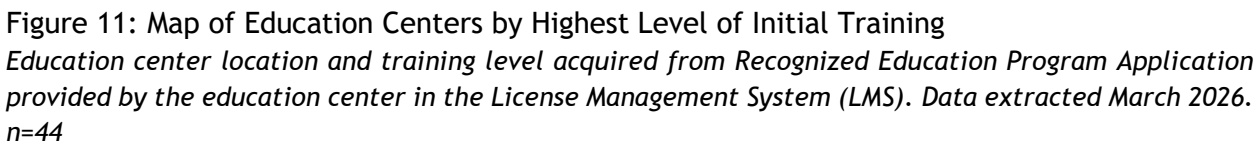


Figure 10: Ground Ambulance Service Level of Care by Urbanicity

Data on Level of Care obtained from self-reported Organizational Profile in the License Management System (LMS). Additionally, Agency Level of Care acquired from Organizational Profile response to “level of service at which the agency provides EMS care for every request for service (the minimum level)”. Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine Urbanicity. n=207 (excludes agencies where EMT was reported as the highest level)

The minimum level of care available on every EMS response differs substantially across Colorado. Urban communities are significantly more likely to receive Advanced Life Support (ALS) care, while frontier agencies more commonly operate at the EMT level. Approximately 60% of urban agencies reported that a paramedic is available on every call, compared with substantially lower rates in rural and frontier communities. More than 70% of frontier agencies reported that EMTs represent the highest level of care routinely available for every response.

These findings reflect differences in workforce availability, population density, and operational models across the state. While EMT-based systems remain highly effective in many rural and frontier settings, the distribution highlights ongoing challenges associated with recruiting and retaining paramedics in geographically isolated communities.



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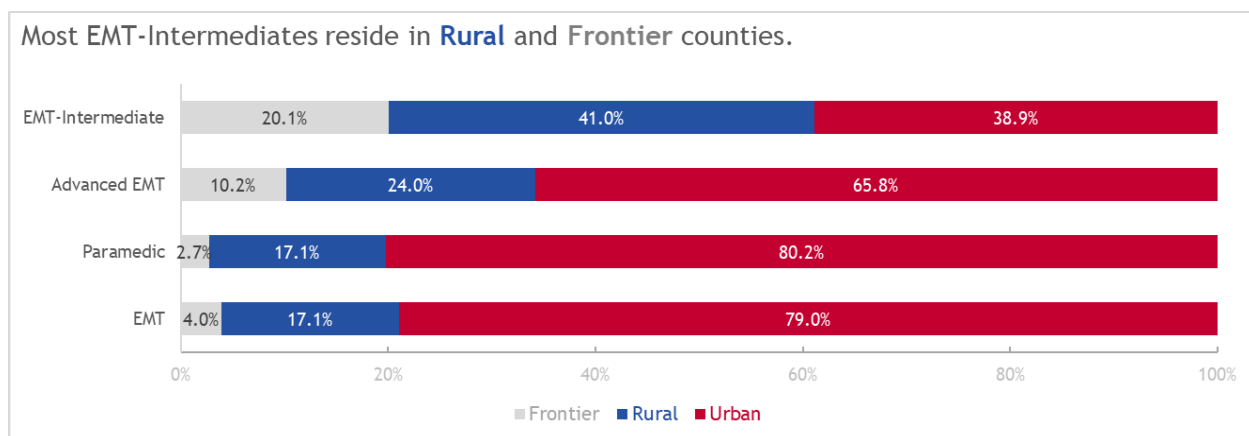


Figure 12: Count of Certified or Licensed EMS Clinician by Level and Home Address Urbanicity
EMS Clinician residential location and certification level acquired from EMS Provider Certification/License Application in the License Management System (LMS). Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine Urbanicity. Data extracted March 2026. n=21,162 (1,735 out of state addresses and 275 with invalid county data were excluded)

Colorado's EMS workforce distribution varies significantly by certification level. More than 80% of paramedics reside in urban counties, while Advanced EMTs and EMT-Intermediates are disproportionately concentrated in rural and frontier communities.

Over 60% of EMT-Intermediates and Advanced EMTs reside in rural or frontier counties, demonstrating the important role these providers play in delivering advanced prehospital care outside metropolitan areas. In contrast, paramedics remain heavily concentrated in urban settings where larger healthcare systems, educational programs, and employment opportunities are located.

These workforce patterns mirror the agency-level service models observed throughout the state and illustrate how rural and frontier communities frequently rely on EMTs, Advanced EMTs, and EMT-Intermediates to provide care in environments where paramedic staffing may be more difficult to sustain.

II. EMS Patient Care Reporting

All licensed ambulance agencies are required to submit information on the patients and care provided while under the supervision of an EMS provider per 6 CCR 1015-3. The patient care data elements are collected using the National Emergency Medical Services Information System (NEMSIS) data standard. This information is utilized by the CDPHE's EMTS branch to not only understand the system, but also ensure high-quality care is provided to residents and visitors across the state.

This section aims to quantify EMS care provided by licensed ambulance agencies in 2025 (January 1, 2025 - December 31, 2025). In Colorado, an ambulance agency is legally defined as any entity engaged in transporting patients by ambulance, which requires a license (§ 25-3.5-103(1.5), C.R.S.). While many other entities such as non-transport fire departments, search and rescue organizations, and ski patrols provide emergency medical care and may submit data on that care to the state, the Colorado regulations currently only provide oversight for licensed ambulance agencies, therefore this report will focus on the care provided by these services. Overall, 964,924 Colorado patient care reports were submitted to the state repository, with licensed Colorado ambulance agencies accounting for approximately 85% of all records, which is expected given the reporting requirements of these agencies.

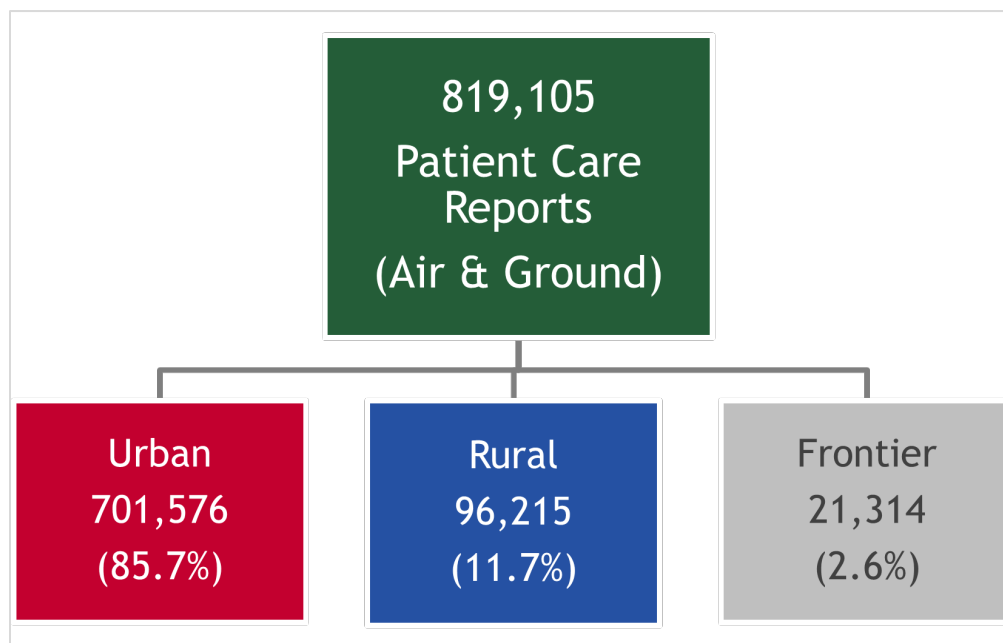


Figure 13: Count of Licensed Ambulance Patient Care Reports (ePCRs) by Incident Urbanicity
Duplicate records, identified by NEMSIS variables (eResponse.01, eRecord.01, eTimes.03, and eResponse.14), were removed. Additionally, records with missing incident location information in key variables (eScene.18 Incident State, eScene.19 Incident Postal Code) and those outside Colorado were excluded. Active license status was identified using the License Management System (LMS). Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine Urbanicity. n=819,105(808 records missing incident zip information were excluded)

Licensed Colorado ambulance agencies submitted 819,105 patient care reports (ePCRs) in 2025, representing an increase from 789,525 reports submitted in 2024. Ground ambulance responses continue to drive the vast majority of EMS activity in Colorado. Ground agencies submitted 803,800 records in 2025, an increase of approximately 4.0% from 773,101 records in 2024. In contrast, air ambulance agencies submitted 15,951 records, a slight decrease from the previous year.

Incident location data further illustrates Colorado's population distribution, with more than 86% of EMS responses occurring in urban counties, 11.7% in rural counties, and 2.6% in frontier counties. While frontier responses account for a relatively small percentage of statewide activity, these communities often require substantial EMS resources due to long transport distances and limited healthcare infrastructure.

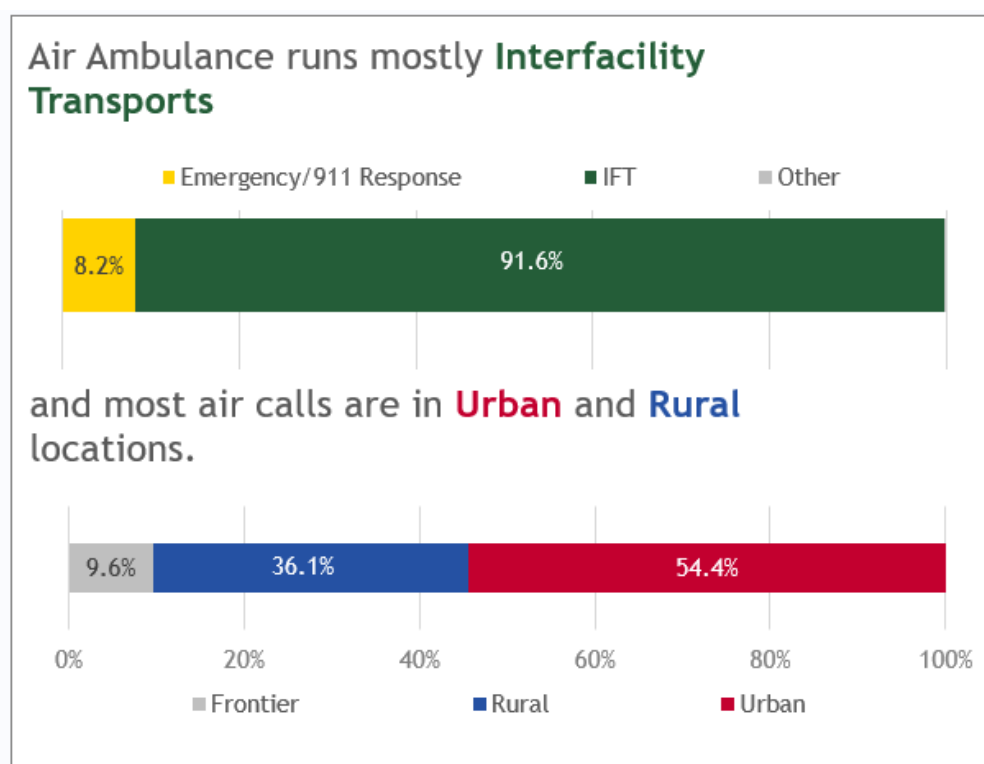


Figure 14: Proportion of Licensed Air Ambulance Patient Care Reports by Type of Service and Urbanicity of Incident Location

The NEMSIS variable eResponse.05 was utilized for classification. The responses were grouped into three categories: Interfacility Transports/Medical Transports (abbreviated as IFTs), Emergency Responses, and Other. IFTs include responses such as Interfacility Transport, Hospital to Hospital Transfer, Hospital to Non-Hospital Facility Transfer, and Medical Transport. Emergency Responses include 911 Response (Scene), Emergency Response (Intercept), Emergency Response (Primary Response Area), and Mutual Aid. All remaining responses not listed specifically as Interfacility Transports or Emergency Response are classified as Other. Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine Urbanicity. Urbanicity classification was based on the county where the incident occurred. n=15,951

Air ambulance responses account for less than 2% of all EMS records submitted in Colorado; however, they represent a critical resource for patients requiring rapid access to specialty and definitive care. More than 91% of licensed air ambulance responses were interfacility transports, highlighting the essential role air medical programs play in moving patients between healthcare facilities.

Although most air ambulance activity occurs in urban and rural counties, air resources are disproportionately utilized in rural and frontier communities. Frontier incidents represent only 3% of all EMS responses statewide, yet account for nearly 10% of all air ambulance responses. Similarly, rural counties generate approximately 12% of overall EMS activity but account for more than one-third of all air ambulance records.

These findings demonstrate the critical importance of air medical transport in supporting healthcare access across geographically isolated regions where definitive care may be several hours away by ground transportation.

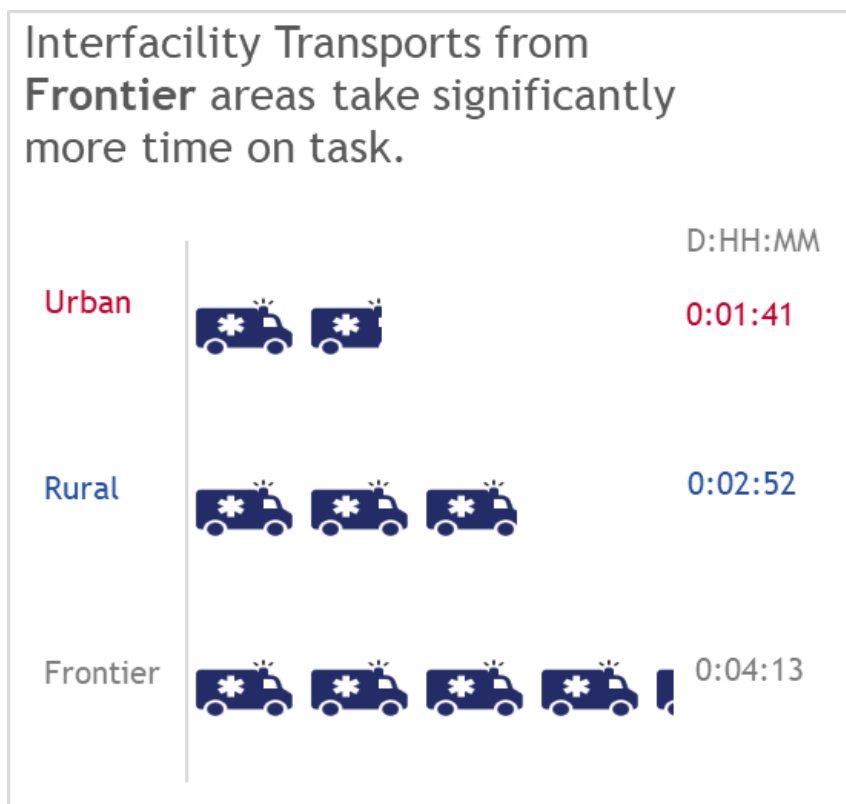


Figure 15: Mean Interfacility Transport (IFT) Time on Task by Incident Urbanicity

The difference between the NEMSIS variables eTimes13 and eTimes.03 were used to calculate time on task. Values less than 1 minute and greater than 1 day were excluded from the analysis. IFTs include Interfacility Transport, Hospital to Hospital Transfer, Hospital to Non-Hospital Facility Transfer, and Medical Transport. Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine Urbanicity. Urbanicity classification was based on the county where the incident occurred. n=165,623 (Records with missing incident location were excluded)

Interfacility transports continue to represent a growing portion of Colorado's EMS workload. In 2025, interfacility transports accounted for 181,581 responses, representing 22% of total EMS call volume statewide. This reflects a continued upward trend from 21% in 2024 and 20% in 2023.

The operational burden associated with interfacility transport varies considerably across Colorado because of the disparity in distance to definitive care. Urban interfacility transports required an average of 1 hour and 41 minutes of unit time, compared with 2 hours and 52 minutes in rural communities and more than 4 hours in frontier communities. As a result, even though interfacility transports account for only 14% of call volume in frontier areas, they consume approximately 34% of all ambulance unit time.

These findings illustrate how patient movement between healthcare facilities can place substantial strain on EMS resources, particularly in geographically remote regions where extended transport distances reduce ambulance availability for emergency response.

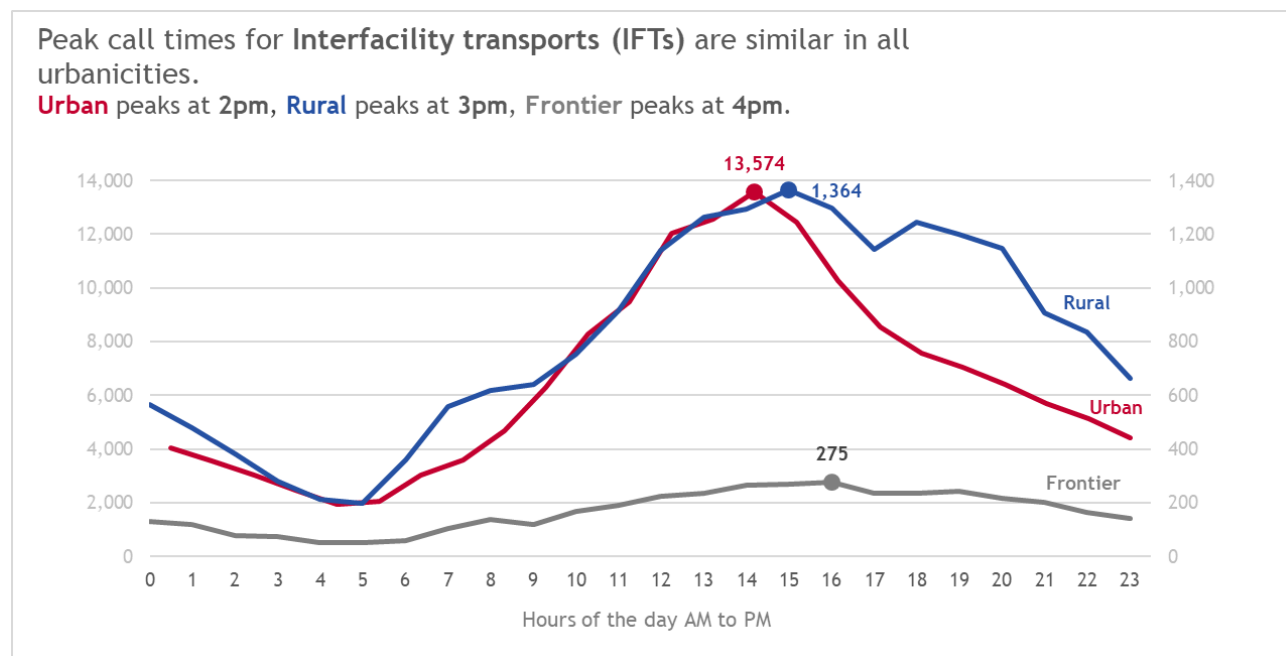


Figure 16: IFTs by Hour of Day and Incident Urbanicity

The NEMSIS variable *eTimes.03*, which indicates the date and time the responding unit was notified by emergency dispatch, was used for classification. IFTs include Interfacility Transport, Hospital to Hospital Transfer, Hospital to Non-Hospital Facility Transfer, and Medical Transport. Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine Urbanicity. Urbanicity classification was based on the county where the incident occurred. N=181,581

Interfacility transport activity follows a similar daily pattern across all urbanicity classifications, with peak volumes occurring during the afternoon hours. Urban transport activity peaks around 2:00 PM, followed by rural activity at 3:00 PM and frontier activity at 4:00 PM.

Although transport volume decreases overnight, a meaningful number of interfacility transports continue to occur during higher-risk overnight hours. Approximately 16% of all frontier interfacility transports begin between 11:00 PM and 5:00 AM. Given the significantly longer transport times observed in frontier communities, these overnight transports may further reduce ambulance availability during periods when staffing resources are already limited as well as increase the risk associated with these long transfers.

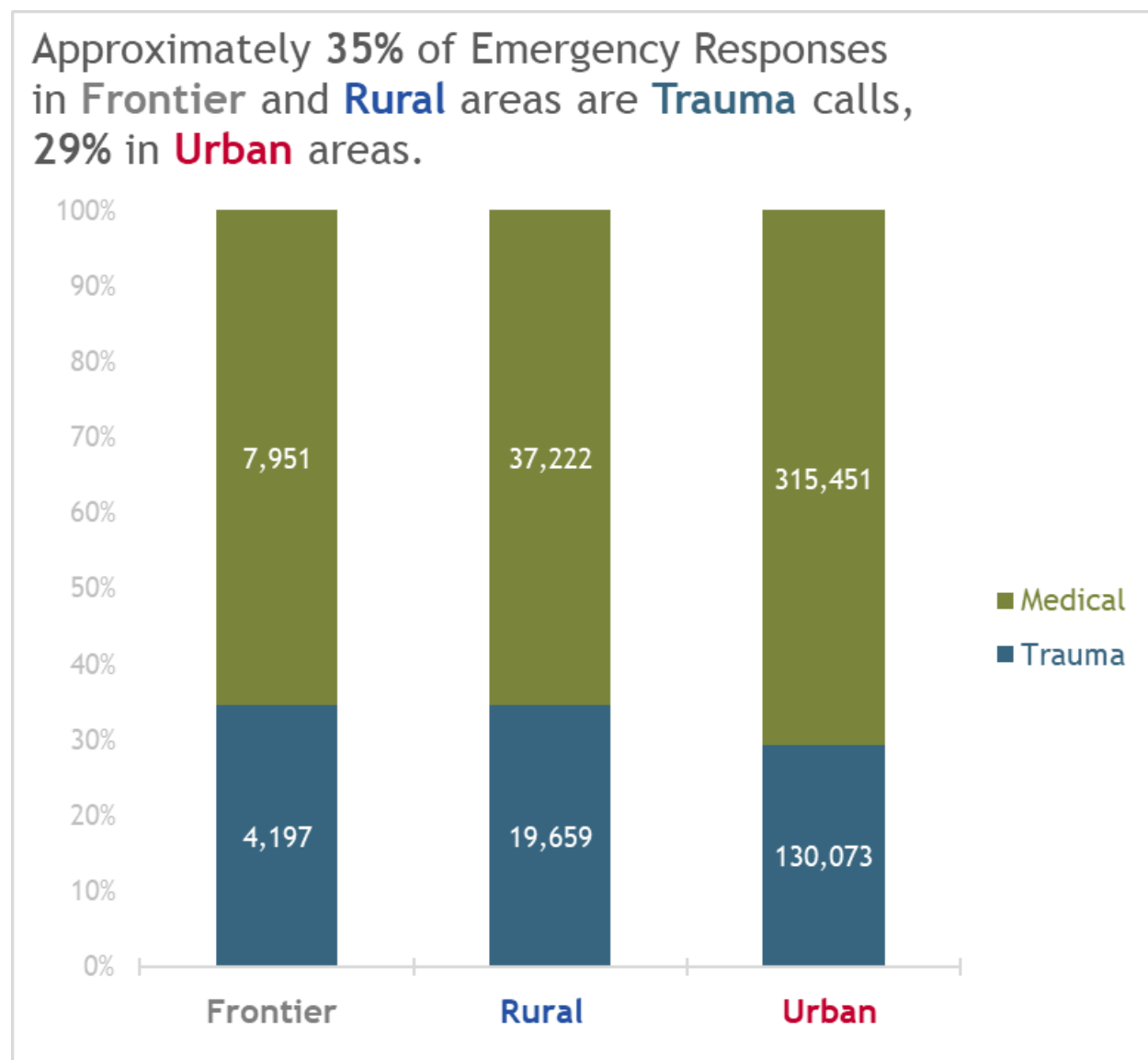


Figure 17: Proportion of Medical vs Trauma Responses by Incident Location Urbanicity
The NEMSIS variable possible injury (eSituation.02) was utilized for display. Only records where eResponse.05 indicated an Emergency Response and eDisposition.27 indicated Patient Contact Made were considered. Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine Urbanicity. Urbanicity classification was based on the county where the incident occurred. n=514,553

Trauma-related incidents represent a substantial portion of Colorado's EMS patient care. Overall, approximately 30% of emergency responses involve patients with suspected traumatic injuries. However, trauma accounts for a greater proportion of EMS activity in rural and frontier communities, where approximately 35% of emergency responses are trauma-related.

Several factors likely contribute to this difference, including increased exposure to transportation-related injuries, agricultural activities, outdoor recreation, and longer travel distances in rural areas. The higher proportion of trauma responses in frontier and rural communities reinforces the importance of maintaining trauma-ready EMS systems and ensuring access to advanced trauma care throughout the state.

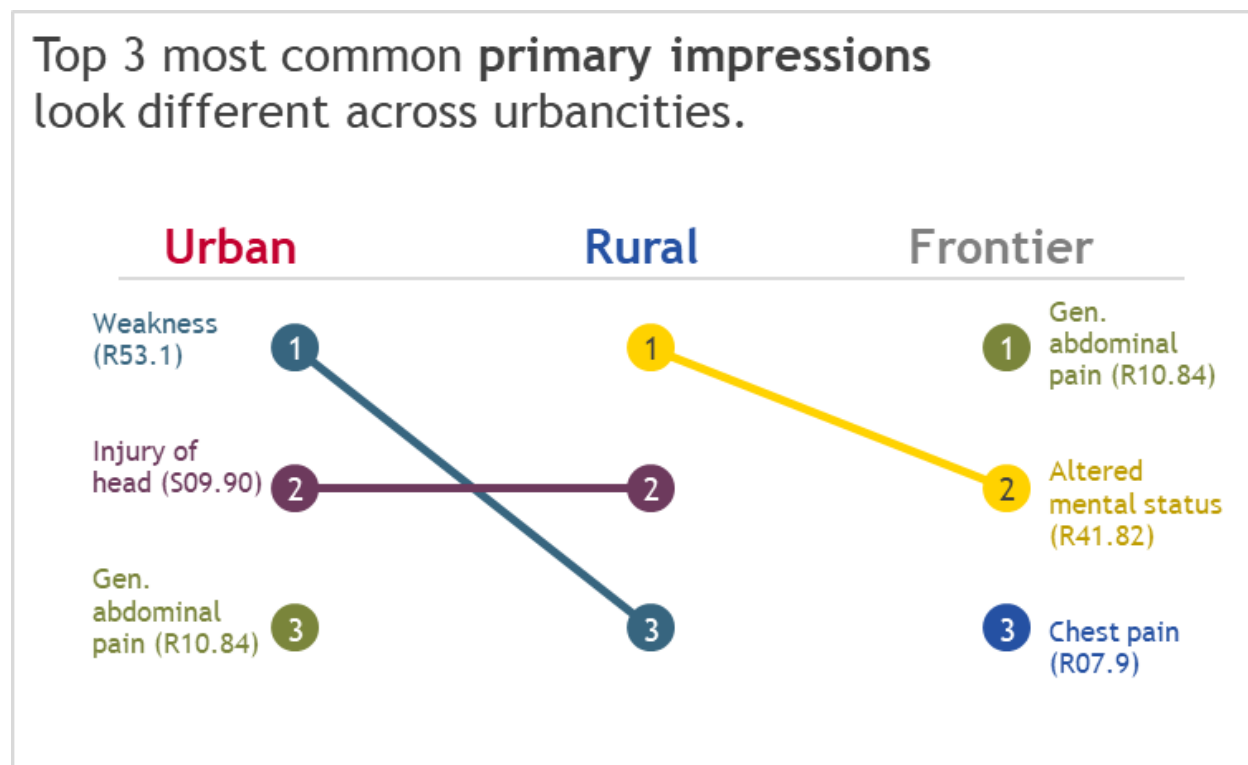


Figure 18: Top Primary Impression by Urbanicity

Only records were included where patient contact was made by an air or licensed ground agency, and primary impression (eSituation.11) was recorded. Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine Urbanicity. Urbanicity classification was based on the county where the incident occurred.

The most frequently documented primary impressions vary considerably across Colorado's urban, rural, and frontier communities, reflecting differences in demographics, healthcare access, and injury patterns.

In urban counties, weakness, head injury, and generalized abdominal pain represent the three most common primary impressions. Rural communities report altered mental status, head injury, and weakness as the leading impressions, while frontier communities most frequently document generalized abdominal pain, altered mental status, and chest pain.

These differences likely reflect variations in population age, healthcare utilization patterns, chronic disease burden, and access to primary care services. Understanding these regional differences helps inform EMS training priorities and resource planning efforts tailored to the needs of individual communities.

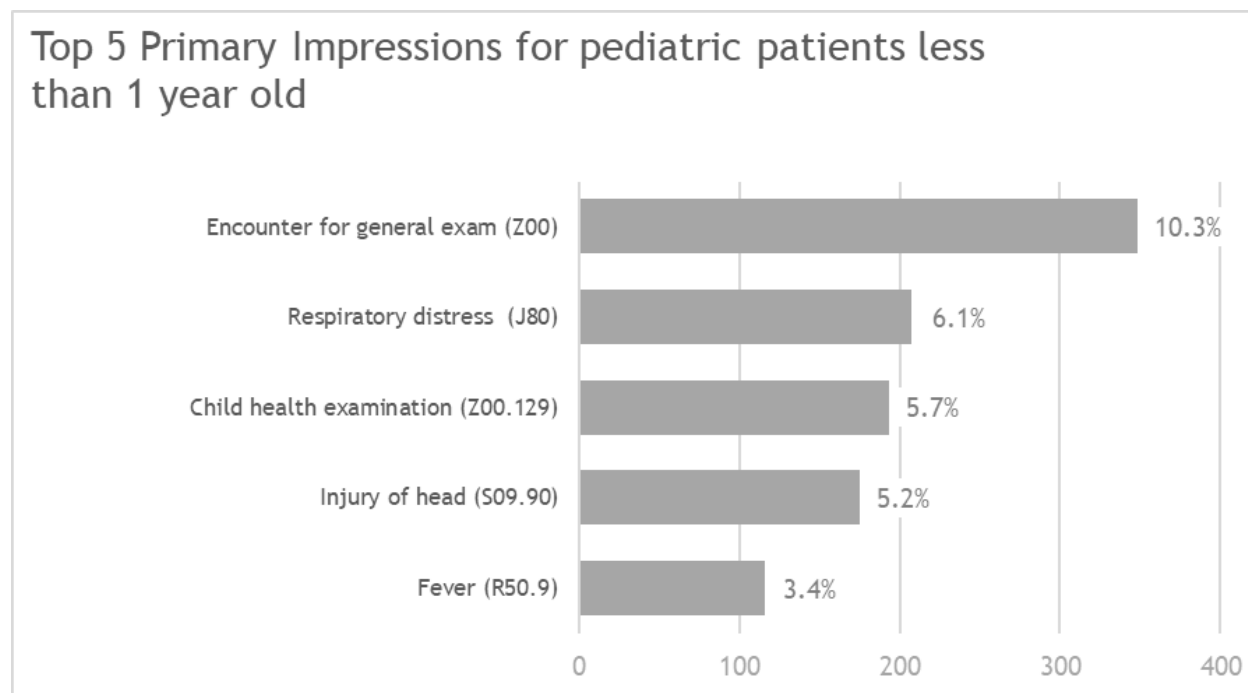


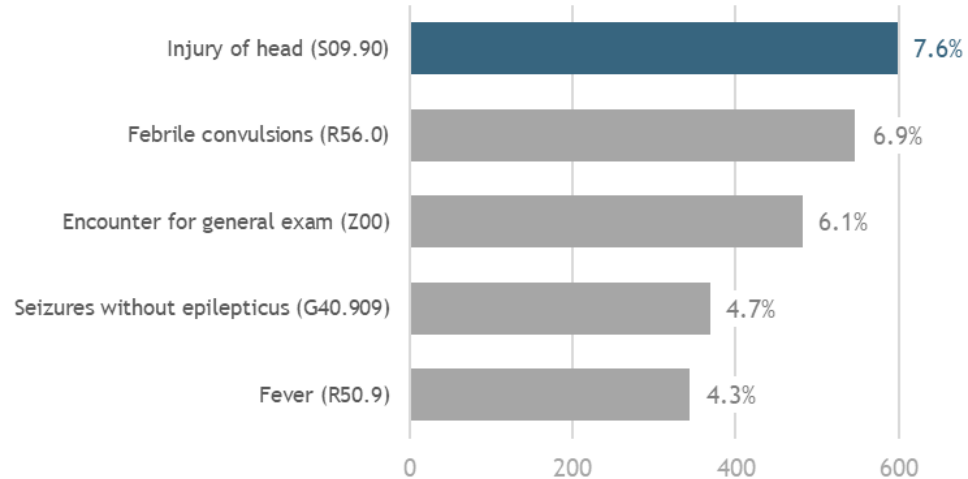
Figure 19: Count of Infant PCRs by Primary Impression (Less than 1 Year Old)

Patient age was determined using NEMSIS element ePatient.15, which calculates the patient's age based on their date of birth or the best available approximation. Only records were included where patient contact was made by an air or licensed ground agency, and primary impression (eSituation.11) was recorded.

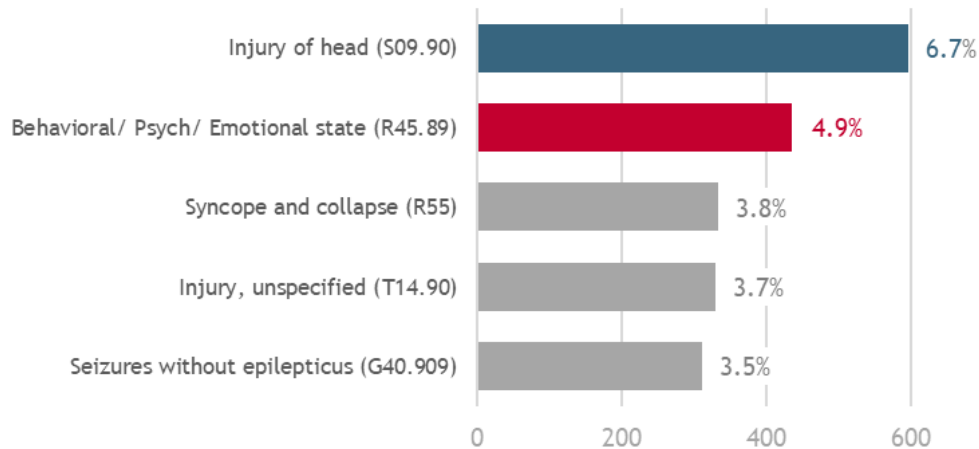
EMS encounters involving infants younger than one year of age differ substantially from those observed among older children and adults. Encounters for general examinations, respiratory distress, head injuries, and fever represent the most common primary impressions documented for infants.

Respiratory complaints and fever-related conditions are particularly prominent in this age group, reflecting the unique physiological vulnerabilities of infants and the increased concern caregivers often have regarding illness in very young children. These findings underscore the importance of pediatric-specific assessment skills and ongoing education for EMS clinicians caring for Colorado's youngest patients.

Top 5 Primary Impressions for pediatric patients ages 1-5



Top 5 Primary Impressions for pediatric patients ages 6-12



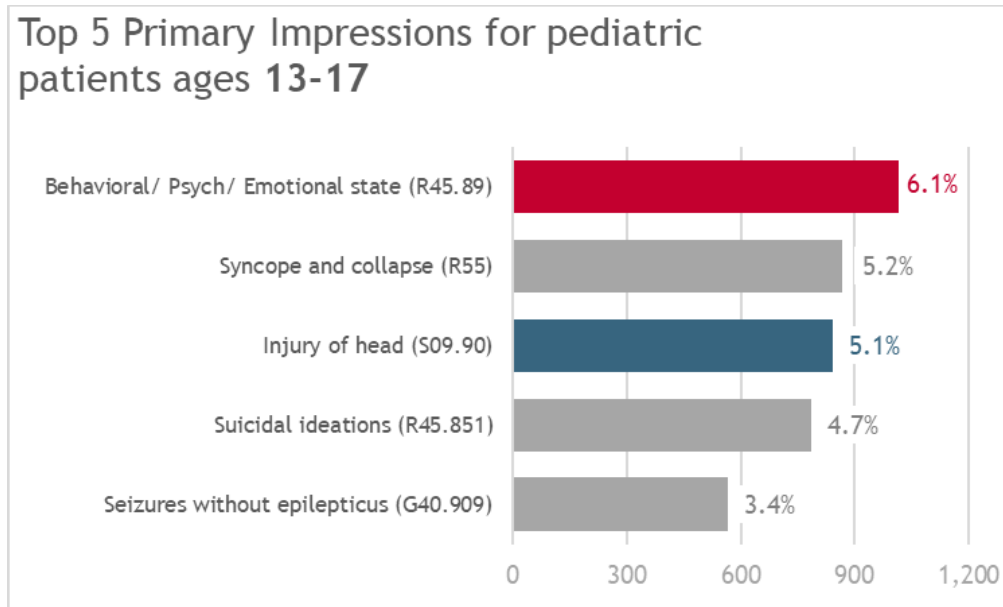


Figure 20: Count of PCRs by Age Group and Primary Impression

Patient age was determined using NEMSIS element ePatient.15, which calculates the patient's age based on their date of birth or the best available approximation. Only records were included where patient contact was made by an air or licensed ground agency, and primary impression (eSituation.11) was recorded.

Primary impressions among pediatric patients change substantially as children age. For children younger than five years, injuries remain the most common reason for EMS encounters, with head injuries consistently ranking among the leading primary impressions. Among children ages 6 to 12 years, behavioral health and emotional conditions emerge as the second most common primary impression, while becoming the most frequently documented primary impression among adolescents ages 13 to 17 years. Suicidal ideation also appears among the top documented impressions for adolescents.

These findings mirror broader national concerns regarding youth mental health and demonstrate the increasingly important role EMS plays in responding to behavioral health emergencies involving children and adolescents. Although pediatric patients account for a relatively small proportion of overall EMS volume, behavioral health-related responses represent a disproportionately large share of pediatric EMS encounters.

Statewide, the percent of **pediatric patients** (under age 18) **who received weight-based meds and had documented weight** in the report exceeds the **benchmark**.

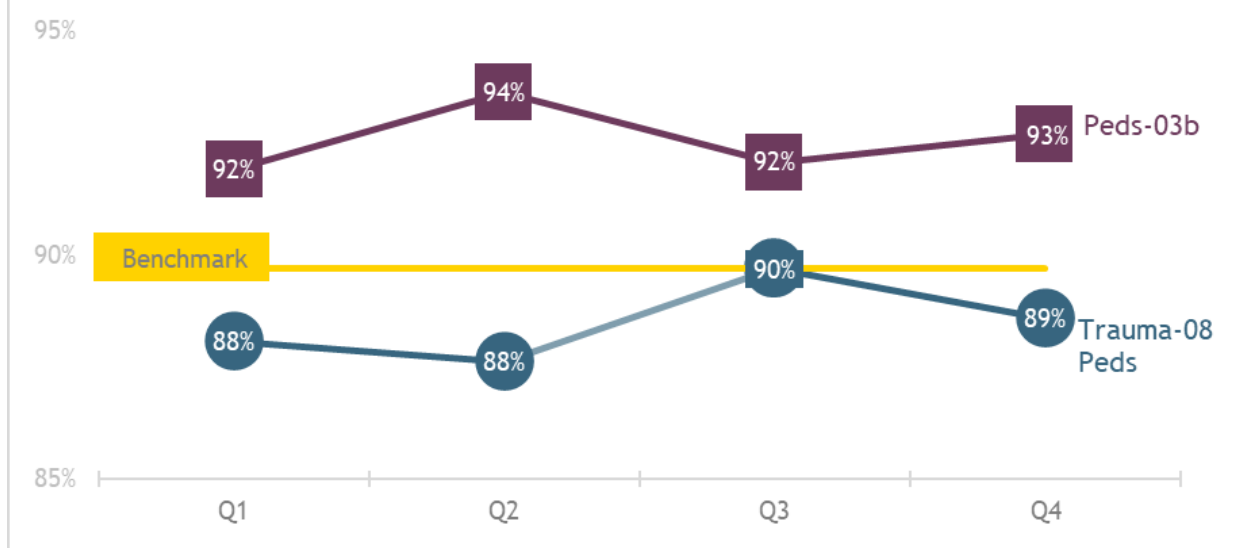


Figure 21: Quarterly Statewide Average of National EMS Quality Alliance (NEMSQA) Measures (Pediatric)

Trauma-08: Percentage of EMS transports originating from a 911 request for patients with trauma during which Glasgow Coma Scale (GCS), systolic blood pressure, and respiratory rate are documented. Only records where eResponse.05 indicated an Emergency Response and eDisposition.27 indicated Patient Contact was made were included. Pediatric patients are defined as less than 18 years of age. Pediatric patients: N=8333

Ped-03b: Percentage of EMS transports where patients aged less than 18 years old who received a weight-based medication, also had a patient weight documented in kg. Only records where eResponse.05 indicated an Emergency Response and eDisposition.27 indicated Patient Contact was made were included. Pediatric patients are defined as less than 18 years of age. Pediatric patients: N=9503

Colorado EMS agencies continue to demonstrate strong performance on pediatric quality measures. Statewide performance on the Pediatric Weight Documentation measure (Ped-03b) exceeded the national benchmark throughout all four quarters of 2025, remaining consistently above 90%. Performance on the Pediatric Trauma Assessment measure (Trauma-08) also remained high and improved during the year, reaching the benchmark during the third quarter before ending the year at 89%. These findings reflect Colorado EMS agencies' continued commitment to pediatric readiness and high-quality clinical documentation.

Statewide, the percentage of **suspected stroke patients who had a stroke assessment performed during the EMS response** continues to increase every quarter.

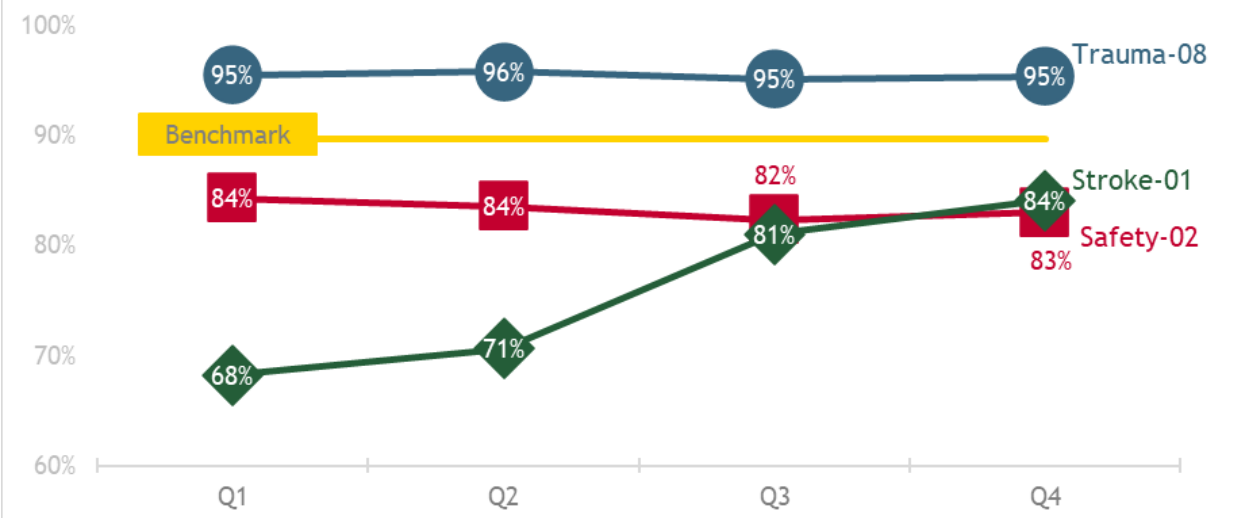


Figure 22: Quarterly Statewide Average of National EMS Quality Alliance (NEMSQA) Measures (Adult)

Trauma-08: Percentage of EMS transports originating from a 911 request for patients with trauma during which Glasgow Coma Scale (GCS), systolic blood pressure, and respiratory rate are documented. Only records where eResponse.05 indicated an Emergency Response and eDisposition.27 indicated Patient Contact was made were included. Pediatric patients are defined as less than 18 years of age. All patients: N=106011

Percentage of 911 Suspected Stroke Responses with Stroke Assessment Documented

Stroke-01: Percentage of EMS responses originating from a 911 request for patients suffering from a suspected stroke who had a stroke assessment performed during the EMS response. Only records where eResponse.05 indicated an Emergency Response and eDisposition.27 indicated Patient Contact was made, and provider primary impression eSituation.11 or secondary impression eSituation.12 indicated a stroke were considered. N=11059

Safety-02: Percentage of EMS transports originating from a 911 request during which lights and sirens were not used during patient transport. Only records where eResponse.05 indicated an Emergency Response and eDisposition.27 indicated Patient Contact was made were included. N=382555

Statewide EMS quality measures continued to improve throughout 2025, reflecting ongoing efforts to improve clinical care, data quality and reporting adherence. Performance on the Stroke-01 measure increased substantially during the year, rising from 68% in the first quarter to 84% in the fourth quarter. Trauma assessment performance remained consistently high at approximately 95% throughout the year.

Several statewide initiatives likely contributed to these improvements, including the EMTS branch-sponsored EMS Excellence in Quality Care and Data Reporting Award, quarterly regional performance reports, agency-level feedback reports, targeted technical assistance, and strong

stakeholder collaboration. Established in 2025, the EMS Excellence in Quality Care and Data Reporting Award was designed to transform performance data into a catalyst for quality improvement and organizational engagement. The results have been measurable. Beyond improvements in statewide performance measures, the program has encouraged technical assistance engagement with dozens of agencies and fostered data-driven quality improvement discussions across the EMS community. The substantial increase in stroke assessment performance demonstrates the impact that focused performance feedback and recognition programs can have on statewide clinical practice.

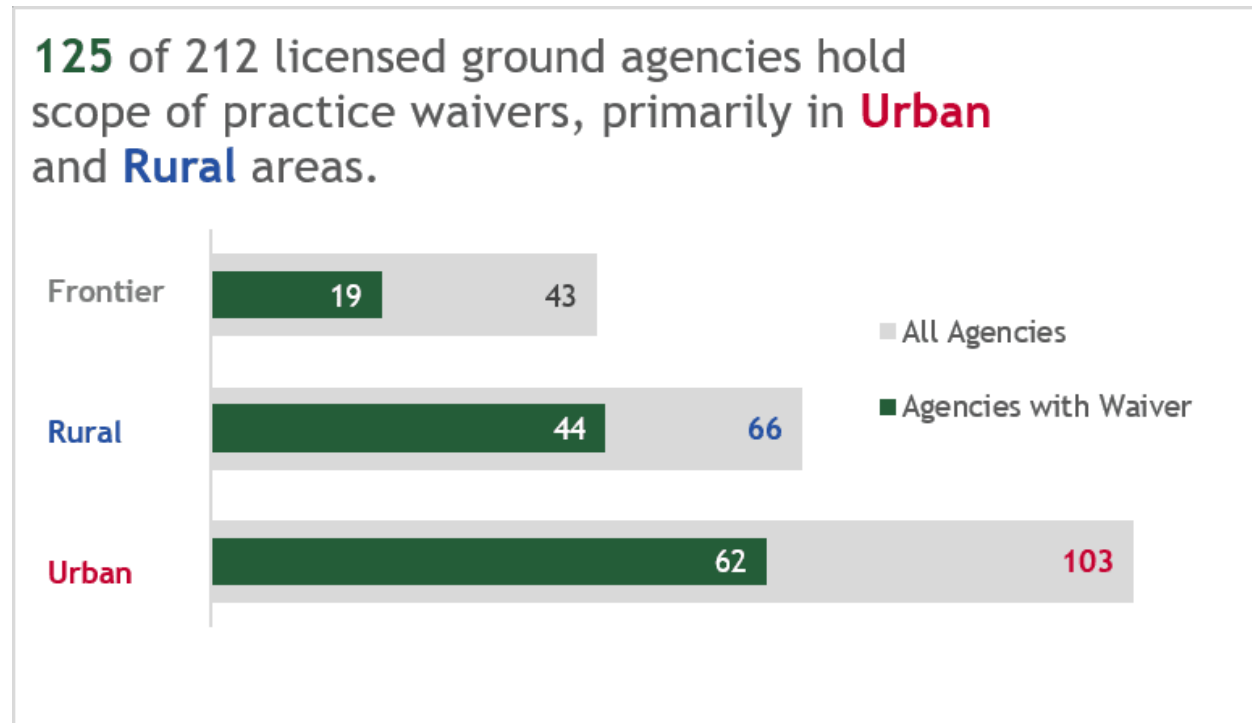


Figure 23: Count of Waivers by Licensed Ground Ambulance Agency Urbanicity
Scope of Practice Waiver data obtained from approved Scope of Practice Waiver Application in the License Management System (LMS). Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine agency Urbanicity. n=470 (63 non-licensed agency waivers and 37 air ambulance agencies excluded)

Colorado's EMS scope of practice framework allows medical directors to request waivers for approved procedures and medications that fall outside the standard scope of practice when supported by clinical need. These waivers also provide a mechanism for innovation and allow EMS systems to adopt emerging practices that improve patient care.

In 2025, there were 570 active scope of practice waivers in Colorado. Of these, 470 were associated with licensed ground ambulance agencies, while 63 were associated with non-licensed EMS organizations and 37 with air ambulance agencies. Overall, 125 of Colorado's 212 licensed ground ambulance agencies—approximately 59%—held at least one approved waiver.

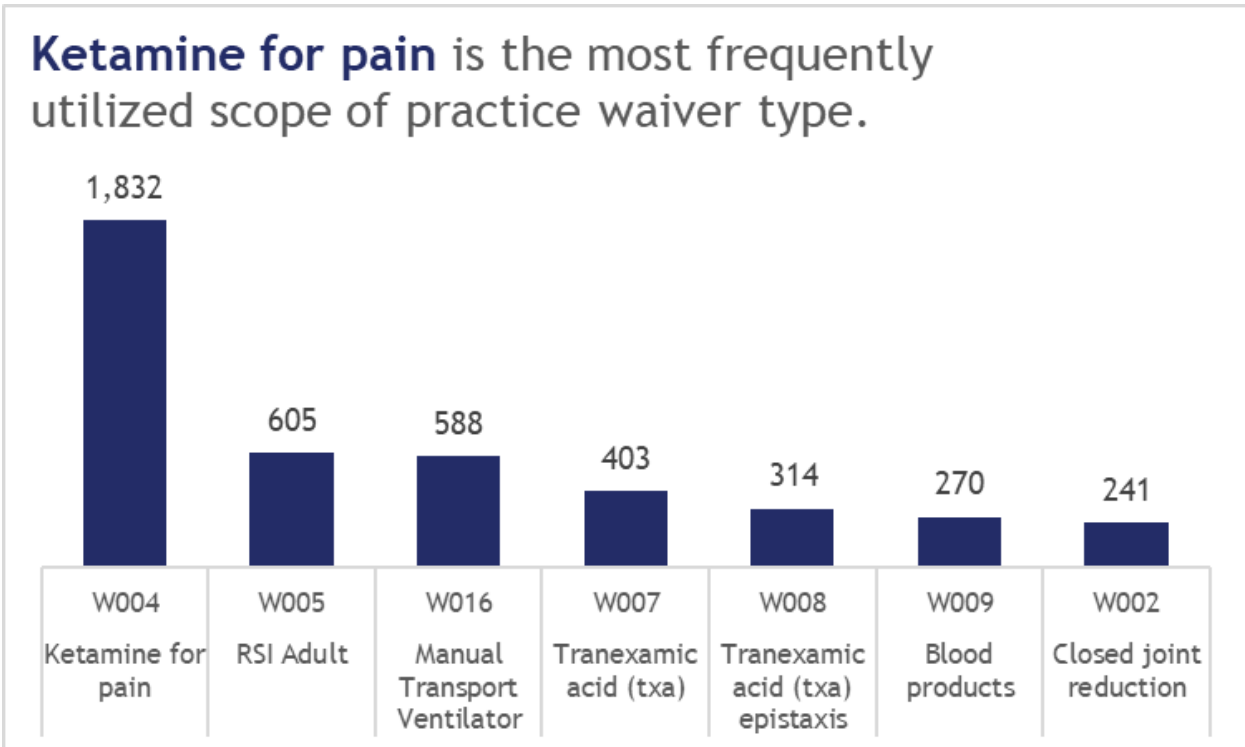


Figure 24: Count of Scope of Practice Waiver Utilizations by Waiver type

Scope of Practice Waiver utilization data obtained from required Patient Care Reports (PCRs) in the Elite EMS State Repository. The NEMSIS variables eMedications.03 (Medications Administered) or eProcedures.03 (Procedure), which indicates which medications were given or procedures were performed, were used for classification. Approved waiver guidelines were utilized to determine inclusion criteria for each Scope of Practice Waiver type.

Colorado currently maintains approved guidelines for 44 distinct scope of practice waiver types. Ketamine administration for pain management was the most frequently utilized waiver in 2025, accounting for 1,832 documented uses. Other commonly utilized waivers included rapid sequence intubation, manual transport ventilator, tranexamic acid administration for hemorrhage or epistaxis, blood product transfusions, and closed joint reduction.

The prominence of ketamine for pain management waivers highlights the importance of effective prehospital pain control and reinforces the role EMS clinicians play in improving patient comfort and outcomes. The utilization of advanced trauma and critical care interventions further demonstrates the increasing sophistication of prehospital medicine throughout Colorado.

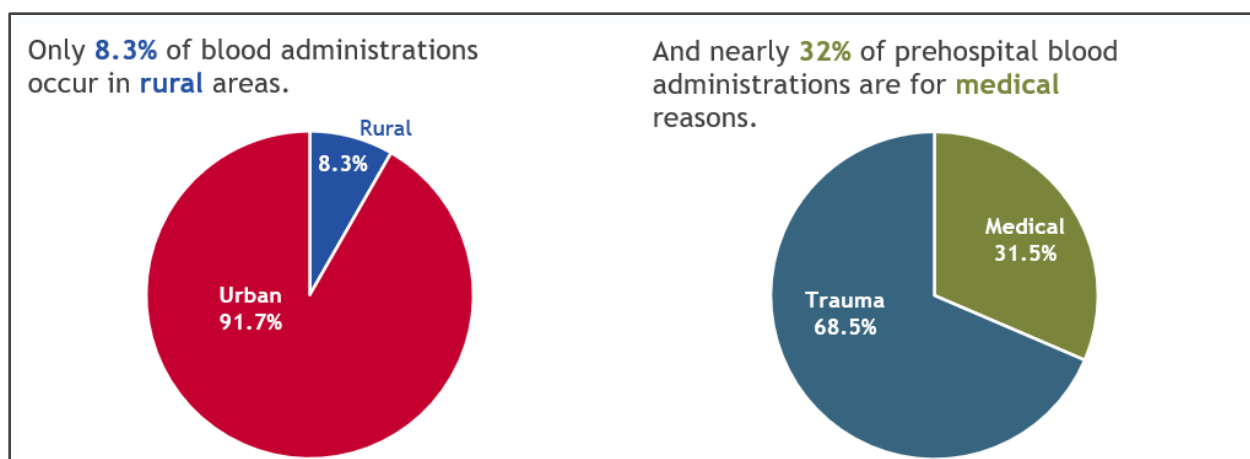


Figure 25: Blood Product Administrations by Incident Urbanicity and Trauma vs. Medical
The NEMSIS variables eMedications.03 (Medications Administered) or eProcedures.03 (Procedure), which indicates which medications were given or procedures were performed, were used for classification. The NEMSIS variable possible injury (eSituation.02) was utilized for display of medical vs trauma. Only records where eResponse.05 indicated an Emergency Response and eDisposition.27 indicated Patient Contact Made were considered. Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine Urbanicity. Urbanicity classification was based on the county where the incident occurred. n=350

The administration of blood products in the prehospital setting represents one of the most significant advancements in emergency care available to EMS providers. In 2023, the Emergency Medical Practice Advisory Council recommended approval of Colorado's blood product waiver, allowing qualified agencies to administer blood products before arrival at a hospital.

In 2025, eleven agencies reported administering blood products in the field, accounting for 350 documented transfusions. Nearly 69% of these administrations were provided to trauma patients, while approximately 31% were provided for medical conditions requiring transfusion support.

Most blood product administrations occurred in urban counties, reflecting both population distribution and the concentration of agencies currently authorized and equipped to provide this intervention. As additional EMS systems adopt blood transfusion capabilities and outcome data become available through Colorado's emerging hospital outcome linkage initiatives, prehospital blood administration is expected to play an increasingly important role in improving outcomes for critically injured and ill patients.

III. Trauma Care in Colorado

The data contained in this report are extracted from the Colorado Trauma Registry. All healthcare facilities that treat patients for traumatic injuries, defined as blunt, penetrating or thermal injury or wound to a living person caused by the application of an external force or by violence, are considered part of the trauma system and are required to submit information on these patients and the care provided per § 25-3.5-703. This information is utilized by the Colorado Department of Public Health and Environment's Emergency Medical and Trauma Services (EMTS) branch to understand the system and ensure high-quality care is provided to residents and visitors across the state.

This report provides an analysis of data reported to the EMTS Colorado Trauma Registry in 2025. In Colorado, a trauma patient is defined as a patient sustaining a traumatic injury within 14 days of initial encounter, has a diagnosed traumatic injury, and was identified as an in-patient or observation patient, transferred from one facility to another, or suffered death related to the traumatic injury. Colorado's criteria for inclusion into the trauma registry can be found here: <https://cdphe.colorado.gov/emergency-care/trauma/colorado-trauma-registry>. In Colorado, the trauma system encompasses facilities with varying levels of care capabilities.

These facilities undergo a designation process in which CDPHE assigns a status to a healthcare facility based on the level of trauma services the facility is capable of and committed to providing to injured persons. These designation levels are defined below:

- Nondesignated, for facilities that do not meet the criteria required for Level I to V facilities, but that receive and are accountable for injured persons, accountability includes having a transfer agreement to transfer persons to Level I to V facilities.
- Level V, for basic trauma care in rural areas, including resuscitation, stabilization, and transfer of all patients with potentially life- or limb-threatening injuries.
- Level IV, for basic trauma care, including resuscitation, stabilization, and arrangement for appropriate transfer of persons requiring a higher level of care based upon patient criticality and triage practices within each facility.
- Level III, for general trauma care, including resuscitation, stabilization, and assessment of injured persons, and either the provision of care for the injured person or appropriate transfer based upon patient criticality and triage practices within each facility.
- Level II, for major trauma care based upon patient criticality and triage practices within each facility. This type of facility may serve as a resource for lower level facilities, but it is not a facility required to conduct research or provide comprehensive services through subspecialty units such as, but not limited to, burn units, spinal cord injury centers, eye trauma centers, and reimplantation centers.
- Level I, for comprehensive trauma care, including the acute management of the most severely injured patients, which is a facility that may serve as the ultimate resource for lower level facilities or as the key resource facility for a trauma area and which is a facility that provides education in trauma-related areas for health-care professionals and performs trauma research.

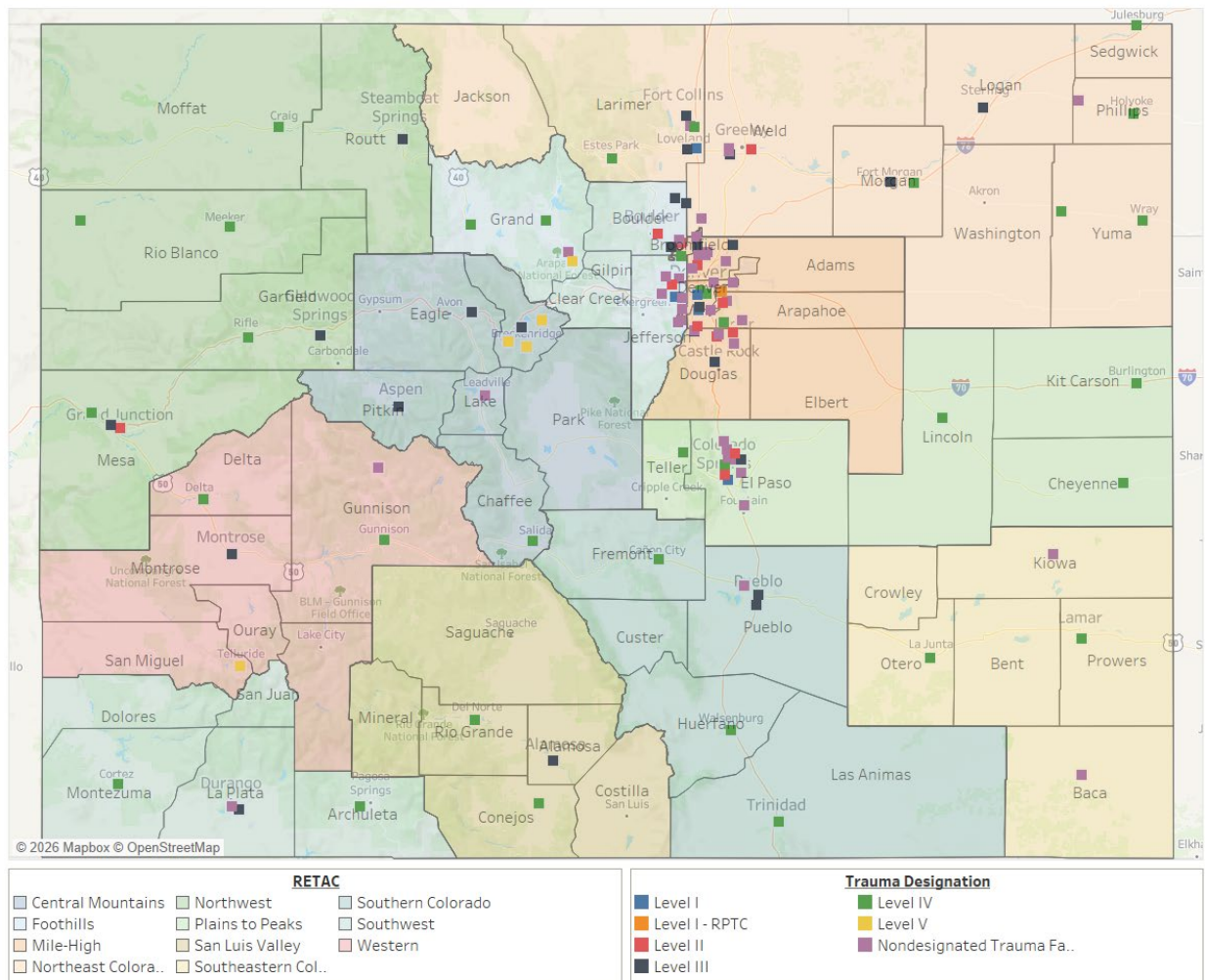


Figure 26: Map of all Colorado Designated Trauma Facilities and Regional Emergency Medical and Trauma Services Advisory Councils (RETACs)
Trauma facility location acquired from facility license information. Designation level acquired from License Management System (LMS). Data extracted March 2026. n=126

Colorado's trauma system included 126 facilities in 2025, 86 designated trauma facilities and 40 nondesignated facilities distributed across the state's 11 Regional Emergency Medical and Trauma Services Advisory Council (RETAC) regions. The designated facilities range from Level I trauma centers capable of providing comprehensive trauma care to Level V facilities focused on stabilization and transfer of critically injured patients. In 2025, two trauma facilities closed—one designated Level III trauma center and one nondesignated facility—further highlighting ongoing challenges in maintaining access to trauma care.

Despite this extensive network, access to trauma care remains geographically uneven. Ten Colorado counties do not contain a designated trauma facility, requiring injured patients to travel outside the county for trauma services; highlighting the challenges associated with delivering trauma services across a large and diverse state.

Though *nondesignated trauma facilities* are the most common facility type, they see only 4.5% of all trauma patients.

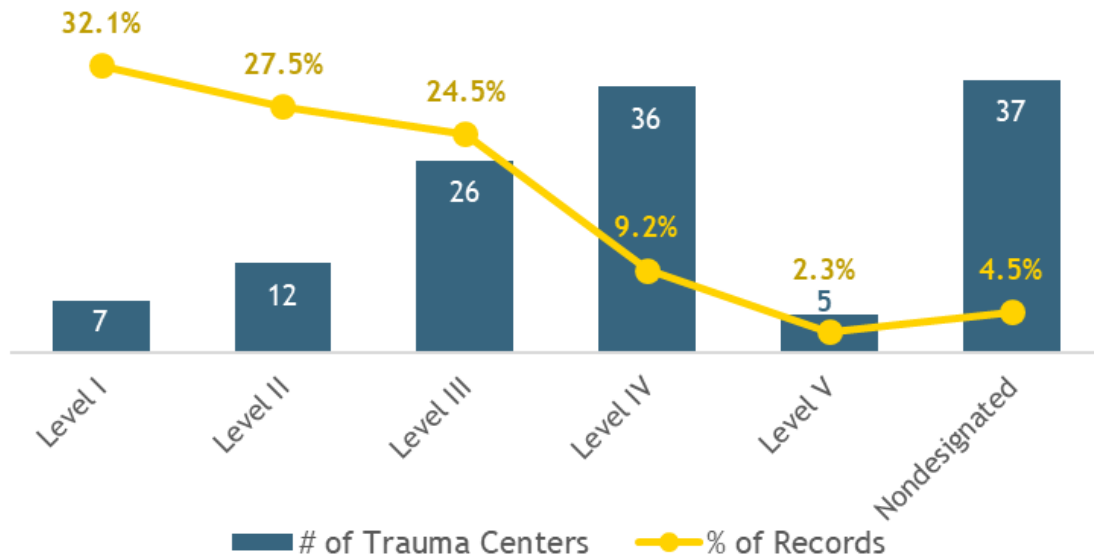


Figure 27: Trauma Centers and Record Counts by Designation Level

Duplicate records, identified by Trauma Registry Number and Facility Name were removed. Additionally, only Level I-V records which were marked as complete and met requirements for the state inclusion criteria were included. Three Nondesignated facilities had no data to report and therefore are not represented. n=48469

Although Level I and Level II trauma centers account for only 19 of Colorado's 126 trauma facilities, they care for nearly 60% of all trauma patients statewide. Specifically, Level I trauma centers receive 32.1% of trauma records while Level II centers receive an additional 27.5%. Together, these facilities serve as the backbone of Colorado's trauma system, providing care for the most severely injured patients and serving as referral centers for lower-level facilities.

In contrast, nondesignated facilities represent the most common facility type in Colorado, accounting for 40 facilities statewide, yet they treat only 4.5% of trauma registry patients. This pattern demonstrates the tiered design of Colorado's trauma system, where lower levels of care and nondesignated facilities frequently stabilize patients before transferring them to facilities with greater trauma capabilities when necessary.

More than 80% of trauma patients at Level I trauma facilities arrive via ambulance, while **85%** of trauma patients arrive at Nondesignated facilities by their own means.

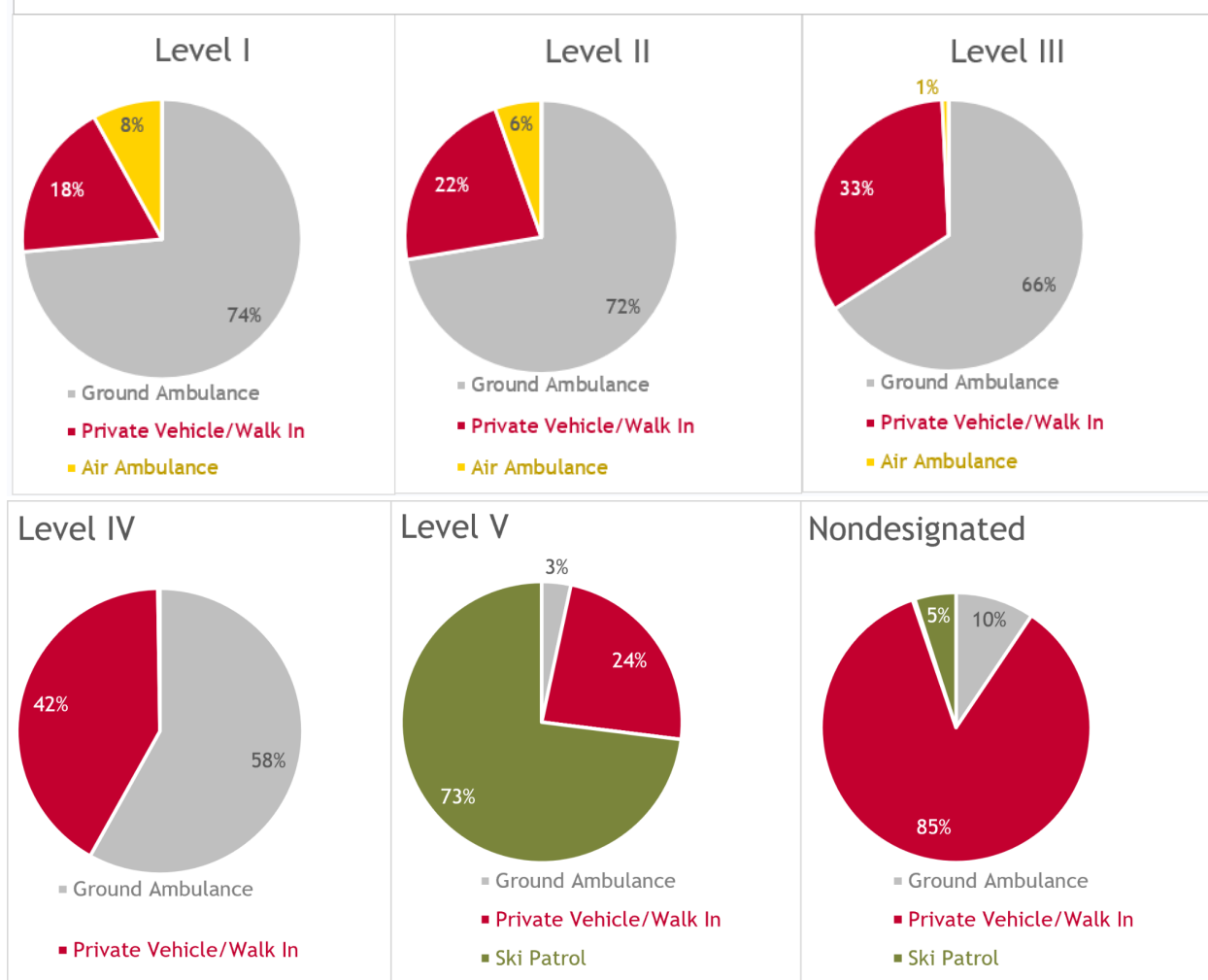


Figure 28: Proportion of Trauma Records by Mode of Arrival and Designation Level
Mode of Arrival categorized using the reported Transport Mode. n=48469

Mode of arrival differs substantially by trauma facility designation level. More than 80% of trauma patients treated at Level I trauma centers arrive by ground or air ambulance, demonstrating the critical role EMS plays in directing seriously injured patients to the highest levels of trauma care. As designation level decreases, the proportion of patients arriving by ambulance also decreases while the proportion arriving by private vehicle or walk-in increases. This trend is most pronounced among nondesignated facilities, where 85% of trauma patients arrive through their own means rather than through EMS transport.

These findings suggest that higher-level trauma centers disproportionately care for patients requiring formal EMS activation and transport, while lower-level and nondesignated facilities frequently serve patients with less severe injuries who self-present for care. The pattern further supports the effectiveness of Colorado's trauma triage system in directing the most seriously injured patients toward facilities with the greatest trauma capabilities.

Frontier facilities comprise 13.8% of trauma facilities, but account for only 2.6% of all trauma records.

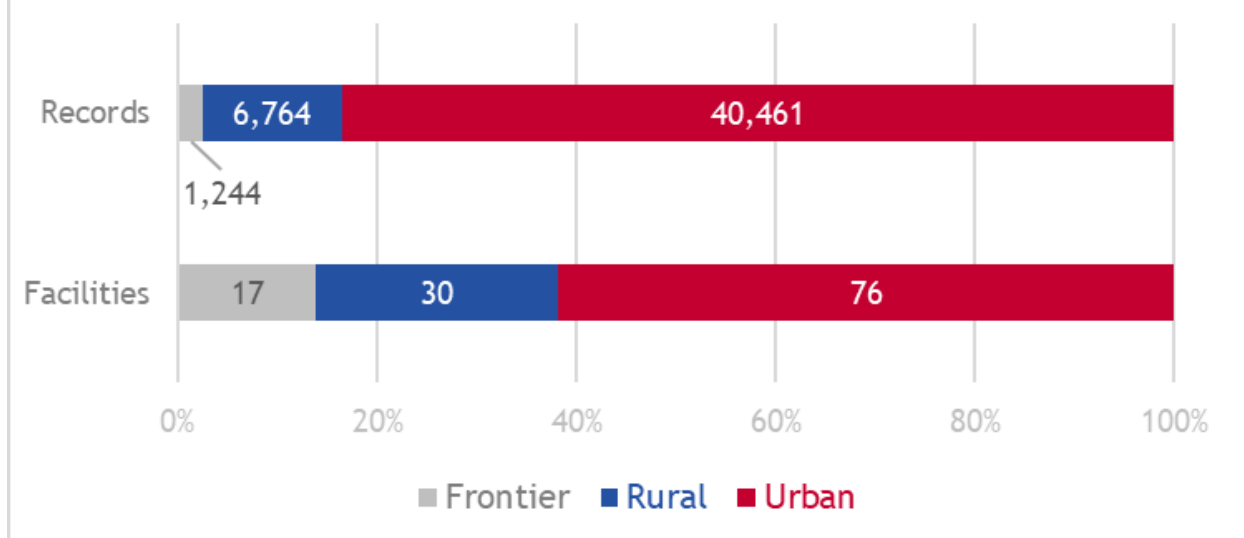


Figure 29: Count of Trauma Facilities and Trauma Records by Facility Urbanicity
Facility Count pulled from facility license information entered in the License Management System (LMS). Geographic guidelines established by the Federal Office of Rural Health Policy (FORHP) were used to determine Urbanicity. Urbanicity classification was based on the facility county address. Trauma registry record count extracted from Colorado Trauma Registry May 07, 2026. n=48469

The geographic distribution of trauma facilities mirrors Colorado's population distribution, with urban communities accounting for the majority of both facilities and trauma patients. Urban counties contain 76 trauma facilities and account for more than 40,000 trauma records annually, representing over 83% of all trauma registry patients. Frontier counties account for approximately 14% of Colorado's trauma facilities but receive only 2.6% of trauma records. Rural counties occupy an important middle ground, providing regional trauma resources while facilitating transfers to higher levels of care when necessary.

The relationship between facility distribution and patient volume highlights the operational challenges facing low-volume trauma facilities in rural and frontier communities. Maintaining trauma readiness requires substantial preparedness regardless of patient volume, making these facilities essential yet often resource-intensive components of the statewide trauma system.

Frontier facilities transfer nearly 52% of their trauma patients but account for less than 10% of all transfers in the system.

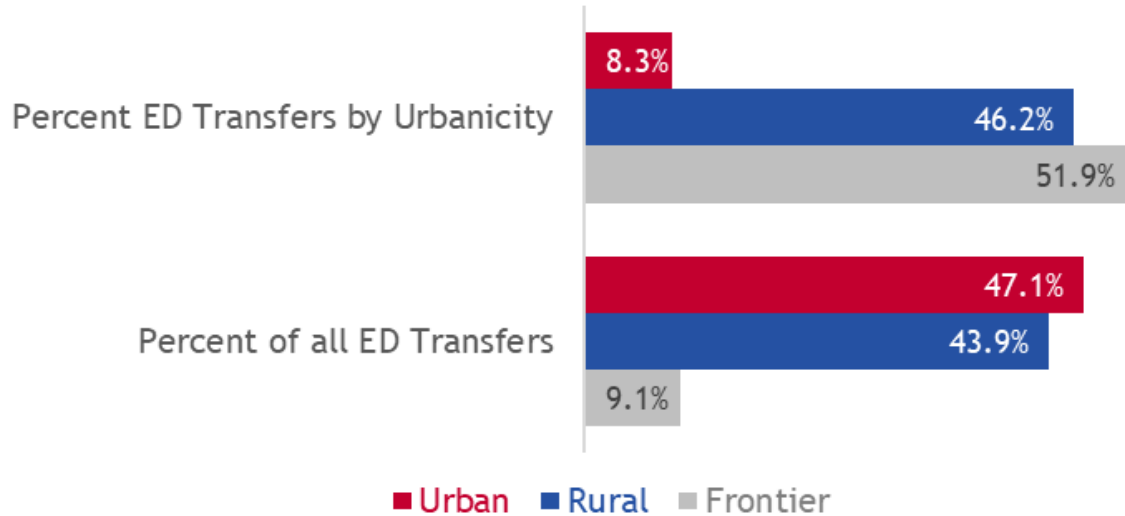


Figure 30: Percent of Emergency Department (ED) Transfers by Urbanicity

Record type determined by ED disposition (Level I-V), Disposition Type (Nondesignated) and Readmission. Transfer from ED includes all records where ED Disposition listed as Transferred to Another Hospital OR Disposition Type listed as Seen in ED then Transferred Out by EMS or Seen in ED then Released or Referred POV. Readmissions were excluded. Urbanicity classification was based on the facility county address. Trauma registry record count extracted from Colorado Trauma Registry May 07, 2026. n=47907

Nearly one in five trauma patients in Colorado is transferred from the emergency department to another facility for ongoing care. Transfer rates vary considerably by urbanicity, reflecting differences in available specialty services and trauma capabilities. Frontier facilities transfer approximately 52% of trauma patients treated in their emergency departments, compared with 46% in rural facilities and only 8% in urban facilities. Despite this high transfer rate, frontier facilities account for only 9% of all trauma transfers statewide due to their comparatively lower patient volume.

The high transfer rates observed in frontier communities demonstrate the effectiveness of Colorado's trauma system in moving patients to appropriate levels of care while allowing smaller facilities to maintain an important stabilization role within the system.

El Paso county receives the most transfers of all Colorado counties.

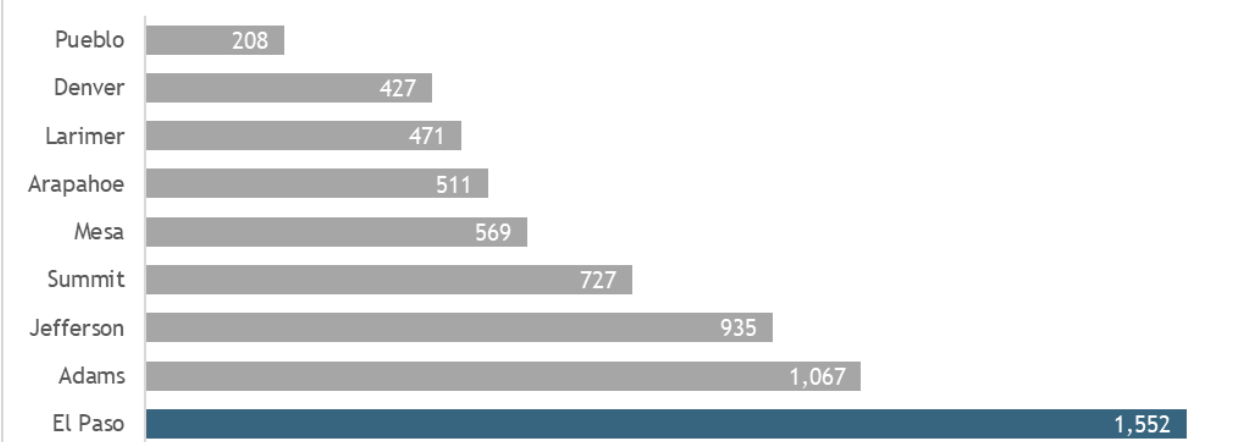


Figure 31: Count of All Transferred Patients (ED or Hospital) by Destination Facility County
Record type determined by ED disposition (Level I-V), Disposition Type (Nondesignated) or Hospital Disposition. Transfer from ED includes all records where ED Disposition listed as Transferred to Another Hospital OR Disposition Type listed as Seen in ED then Transferred Out by EMS or Seen in ED then Released or Referred POV. Transfer from Hospital includes all records where Hospital Disposition equals Discharge/Transferred to a short-term general hospital for inpatient care. Readmissions were excluded. County classification was based on the Hospital Transferred To facility address. Trauma registry record count extracted from Colorado Trauma Registry May 07, 2026. n=7609

Trauma patient transfers are concentrated within a relatively small number of destination counties. El Paso County receives the largest number of transferred trauma patients statewide, followed by Adams, Jefferson, Summit, Mesa, and Arapahoe counties.

These counties serve as regional referral hubs and contain many of Colorado's higher-level trauma facilities capable of providing specialized surgical, neurosurgical, orthopedic, and critical care services. The concentration of transfers into these counties illustrates the regionalized nature of trauma care and demonstrates how higher-level trauma centers support surrounding communities across large geographic areas. The transfer patterns also highlight the importance of transportation infrastructure and coordinated trauma networks in ensuring patients can access definitive care when it is not available locally.

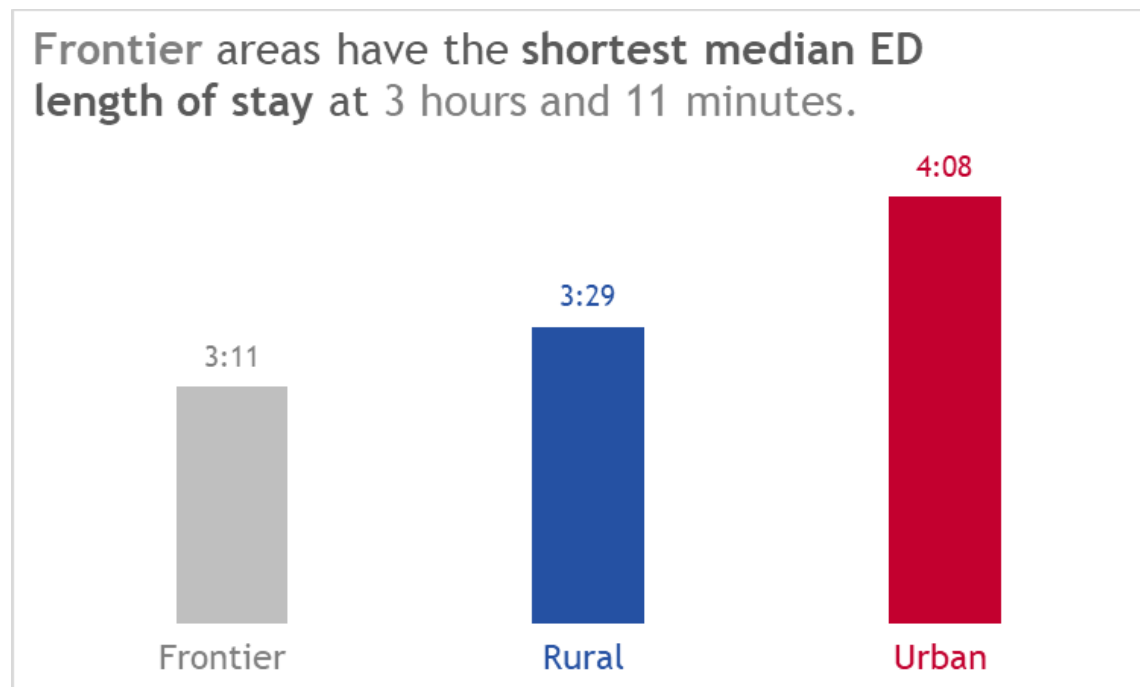


Figure 32: Median ED Length of Stay (HH:MM) by Facility Urbanicity for ED Transfers
Record type determined by ED disposition (Level I-V), Disposition Type (Nondesignated) or Hospital Disposition. Transfer from ED includes all records where ED Disposition listed as Transferred to Another Hospital OR Disposition Type listed as Seen in ED then Transferred Out by EMS or Seen in ED then Released or Referred POV. Missing, negative, and times greater than three days were excluded. Readmissions, deceased, and hospice records were excluded. Urbanicity classification was based on the facility county address. Trauma registry record count extracted from Colorado Trauma Registry May 07, 2026. n=9136

Emergency department transfer patients generally spend relatively little time at the originating facility before being moved to another hospital. Frontier facilities demonstrated the shortest median emergency department length of stay among transferred patients at 3 hours and 11 minutes, followed by rural facilities at 3 hours and 29 minutes. Urban facilities reported a median transfer-related emergency department stay of 4 hours and 8 minutes. The shorter ED arrival to transfer times observed in frontier communities likely reflect the optimized time efficiencies while dealing with the limited specialty resources available in these facilities and the recognition that many seriously injured patients will require definitive care elsewhere. Rapid identification and transfer of patients requiring higher levels of care are key components of an effective trauma system and help reduce delays to definitive treatment. These findings suggest Colorado's trauma facilities are generally successful in facilitating timely transfers when patients require services beyond the capabilities of the originating facility.

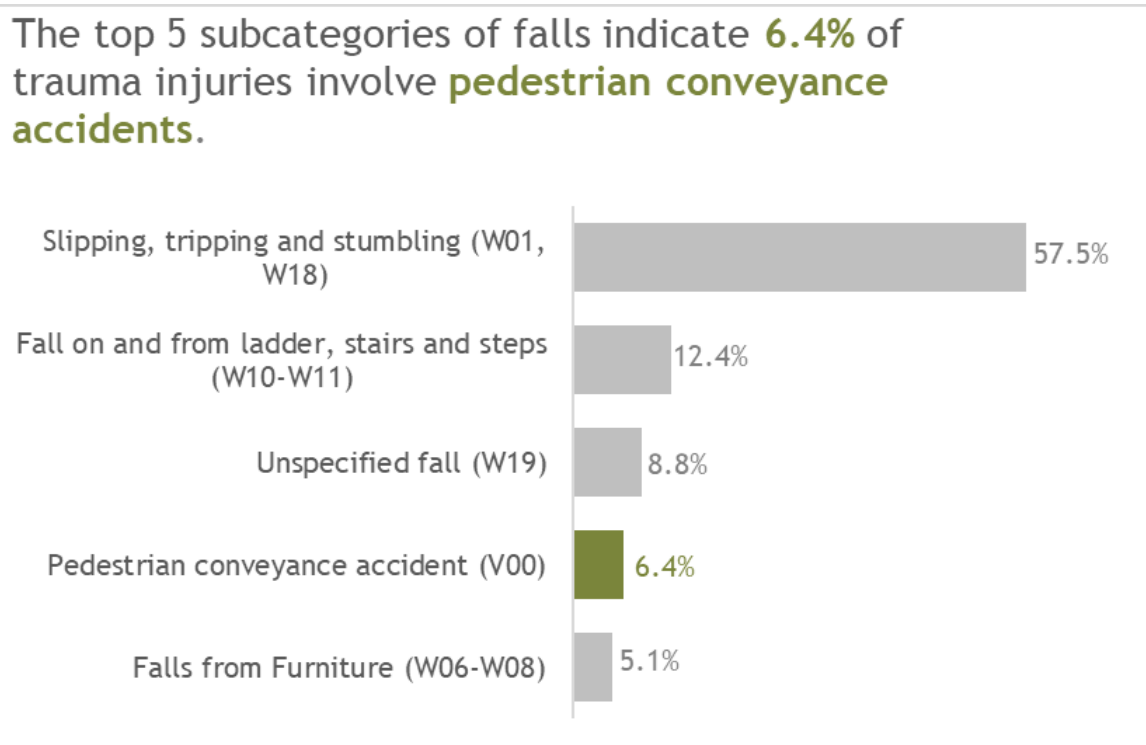


Figure 33: Percent of Trauma by Fall Categories (LI-III)

Readmissions and Transfers Out were excluded. Injury category determined using the primary ICD-10-CM External Cause Code documented. Only records from Level I-III included. n=23598

Falls remain the leading cause of traumatic injury in Colorado, accounting for approximately 65% of all trauma cases included in this analysis. Within the fall category, slipping, tripping, and stumbling account for more than half of all fall-related injuries, making them the single largest fall mechanism statewide. Falls from ladders, stairs, and steps represent the second most common fall category, while pedestrian conveyance incidents account for 6.4% of fall-related injuries. This category includes many of Colorado's ski and snowboard injuries and reflects the substantial role outdoor recreation plays in the state's trauma burden.

Analysis of statewide snow sport injury data demonstrates that falls account for approximately 73% of all ski and snowboard injuries, while collisions account for only 17%. Injured patients are predominantly male, most commonly between the ages of 20 and 29 years, and frequently sustain extremity fractures requiring significant medical intervention. Nearly 40% of these patients ultimately require operative management, illustrating the substantial impact recreational injuries have on Colorado's trauma system.

Pedestrian conveyance accidents are most common for those under 40 years; while **slipping, tripping, stumbling is most common** in ages 41 and up.

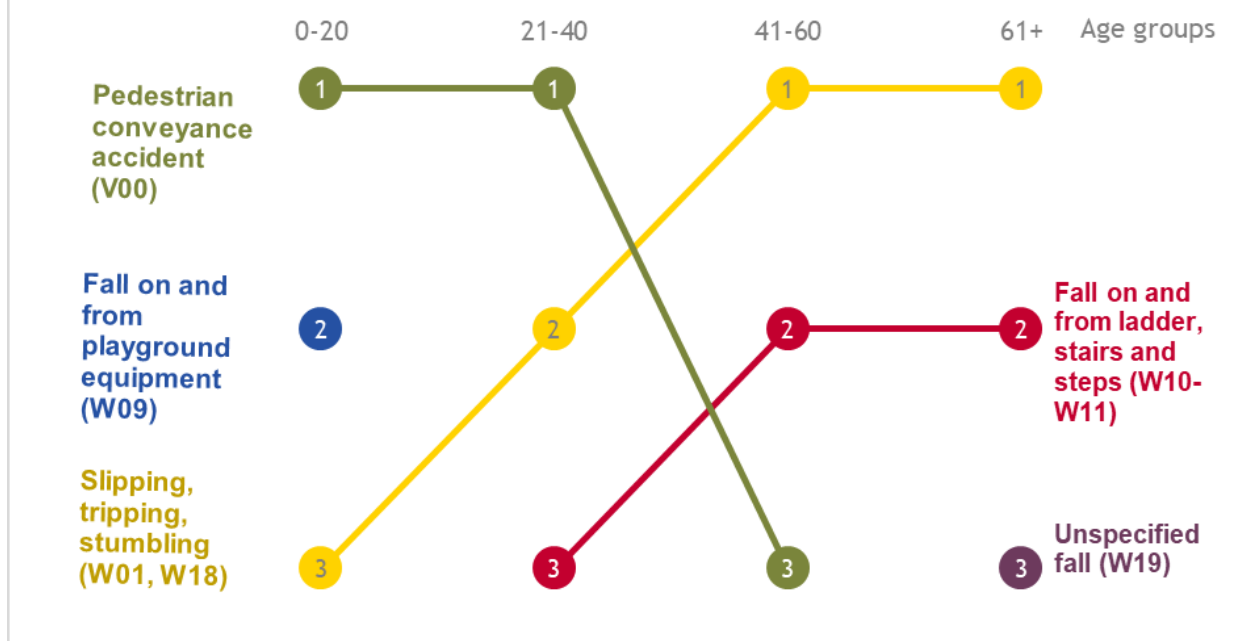


Figure 34: Top Fall Categories by Age

Readmissions and Transfers Out were excluded. Injury category determined using the primary ICD-10-CM External Cause Code documented. Only records from Level I-III included. The age of the patient was determined based on their date of birth or the best available approximation. N=23598 (only top causes shown n=20,325)

The leading causes of falls vary considerably by age group. Pedestrian conveyance incidents, including ski and snowboard injuries, are the most common fall category among patients younger than 40 years of age. These recreational injuries remain a prominent cause of trauma through middle adulthood, ranking among the leading fall categories for patients ages 41 to 60 years as well. Falls involving slipping, tripping, and stumbling, ladders, stairs, and steps become increasingly prominent in the older age population.

These findings demonstrate that fall prevention strategies must be tailored to the populations they serve. Recreational injury prevention efforts may be most effective among younger adults, while fall prevention programs focused on balance, mobility, environmental hazards, and aging populations may have the greatest impact among older Coloradans.

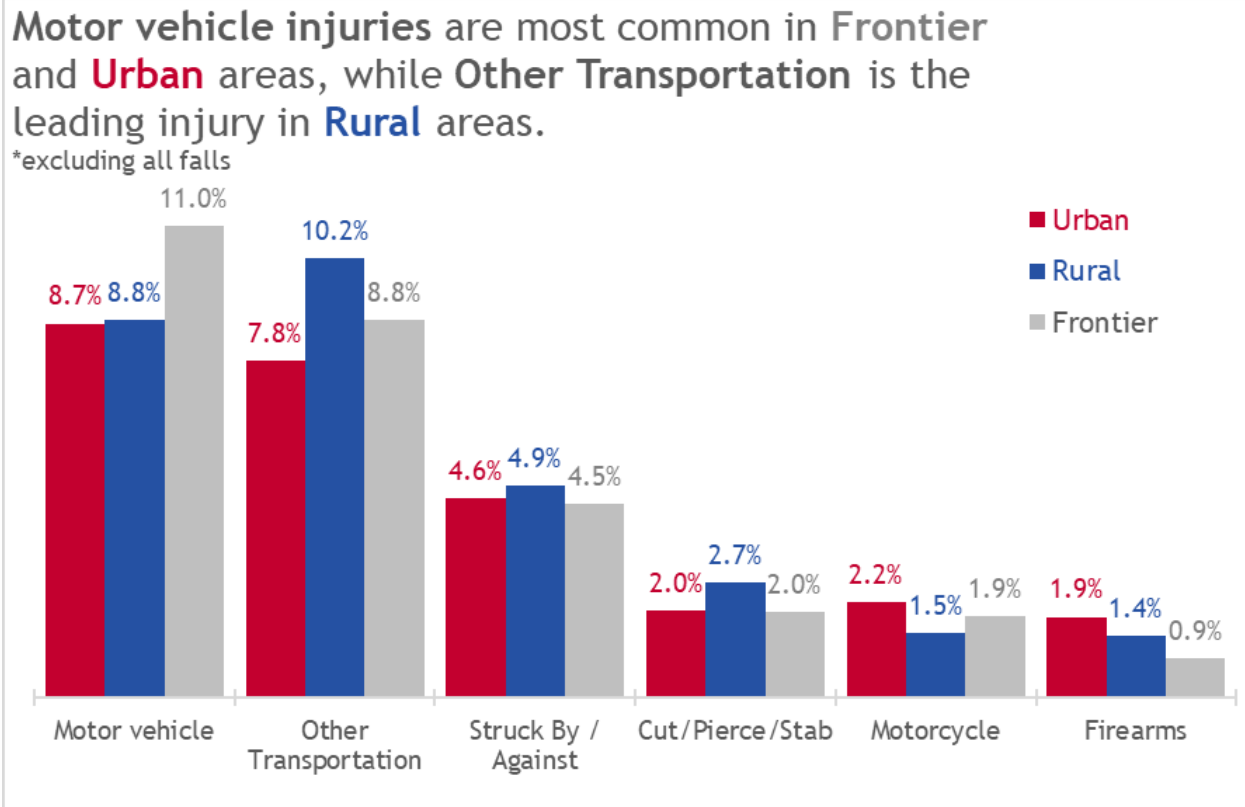


Figure 35: Top Causes of Injury (excluding Falls) by County of Residence
Readmissions and Transfers Out were excluded. Injury category determined using the primary ICD-10-CM External Cause Code documented (Level I-III) or Cause of Injury Category (Level IV, V, and Nondesignated).

When falls are removed, transportation-related injuries emerge as a significant contributor to trauma across Colorado. In frontier communities, transportation incidents account for approximately one in five trauma patients, highlighting the continued importance of roadway safety and transportation-related injury prevention in these regions. The analysis also demonstrates the growing influence of "other transportation" injuries, which include incidents involving vehicles such as bicycles, electric bicycles (e-bikes), electric scooters, all-terrain vehicles (ATVs), utility terrain vehicles (UTVs), snowmobiles, and other recreational or alternative modes of transportation.

In urban areas, increasing use of e-bikes and e-scooters may be contributing to the growing number of these injuries. In rural communities, other transportation injuries account for more trauma patients than traditional motor vehicle crashes, reflecting the widespread use of off-highway and recreational vehicles. These findings suggest opportunities for targeted injury prevention and public education efforts focused on safe operation of both emerging transportation technologies and recreational vehicles.

Patients from **Texas** are the most frequent out of state residents in the trauma registry.

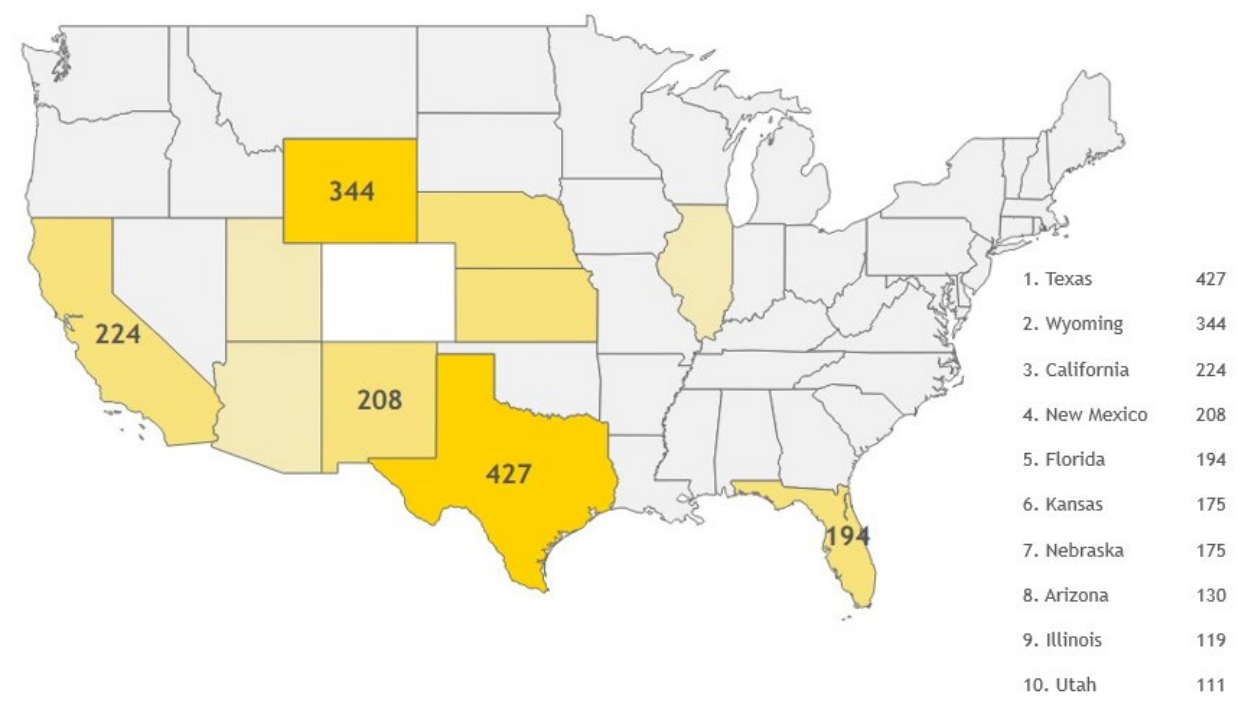


Figure 36: Count of Trauma Records by Out-of-State Residence

Readmissions and Transfers Out were excluded. County of Residence determined using Patient Home Zip Code. n=3376

Colorado's trauma system serves not only residents of the state, but also a substantial number of visitors and travelers from across the country. In 2025, 3,376 trauma registry records were associated with patients whose residence was outside Colorado, representing approximately 7% of all trauma registry records included in this report.

Texas residents accounted for the largest number of out-of-state trauma patients, followed by residents of Wyoming, California, New Mexico, and Florida. Neighboring states such as Wyoming, New Mexico, Kansas, Nebraska, and Utah collectively represent a significant portion of Colorado's out-of-state trauma population, reflecting the state's role as a regional healthcare destination for the Rocky Mountain West. At the same time, the presence of large numbers of patients from Texas, California, Florida, and Illinois highlights Colorado's popularity as a tourism and recreation destination.

These findings demonstrate that Colorado's trauma system supports a population that extends well beyond state borders. Seasonal tourism, outdoor recreation, interstate travel, and regional referral patterns all contribute to trauma care demand within the state. Understanding the

geographic origins of trauma patients is important for resource planning, preparedness activities, and evaluating the broader impact Colorado's trauma system has on both residents and visitors.

Conclusion

The 2025 Colorado Emergency Medical and Trauma Services Annual Data Report highlights both the strengths and challenges of delivering emergency and trauma care across a geographically diverse state. Data from licensed ambulance agencies, EMS clinicians, trauma facilities, and healthcare partners demonstrate a system that continues to adapt to evolving patient needs while maintaining a commitment to high-quality care.

This year's findings illustrate the critical role of Colorado's EMS and trauma systems. Volunteer providers, rural and frontier ambulance agencies, trauma facilities, air medical resources, and interfacility transfer networks work together to ensure patients have access to appropriate care regardless of where an emergency occurs. At the same time, increasing interfacility transport demands, workforce distribution challenges, and geographic disparities in access to care highlight ongoing opportunities for system improvement.

The report also demonstrates meaningful progress in areas such as EMS quality performance, behavioral health services, community integrated healthcare services, and advanced prehospital interventions including blood product administration. These innovations reflect the continued evolution of emergency medical services beyond traditional emergency response and underscore the important role EMS plays within Colorado's broader healthcare system.

As Colorado continues to strengthen its EMS and trauma system, data will remain an essential tool for understanding system performance, guiding decision-making, identifying emerging trends, and improving outcomes for both residents and visitors. The EMTS Branch remains committed to working with stakeholders across the state to ensure that Colorado's EMS and trauma facilities remain responsive, sustainable, and prepared to meet the needs of the communities they serve.