COLORADO
Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

To: Members of the State Board of Health

From: Jeanne-Marie Bakehouse, Emergency Medical and Trauma Services Branch Chief

Through: D. Randy Kuykendall, Health Facilities and Emergency Medical Services Division Director, DRK

Date: August 16, 2017

Subject: **Request for Rulemaking Hearing**
Proposed Amendments to **6 CCR 1015-3 Emergency Medical Services** with a request for a rulemaking hearing to be set for October of 2017

The Department is proposing revisions throughout 6 CCR 1015-3, Chapter One and Chapter Two. The proposed revisions are necessary for the creation of a Community Paramedic (CP) endorsement for emergency medical service providers, as required by Senate Bill 16-069. Senate Bill 16-069 requires the adoption of rules implementing a CP endorsement for emergency medical service providers on or before January 1, 2018. Revisions to Chapter One, Rules Pertaining to EMS and EMR Education, EMS Certification, and EMR Registration are being submitted to the Board of Health for a request for rulemaking. Revisions to Chapter Two, Rules Pertaining to EMS Practice and Medical Director Oversight are also attached to this package for reference because some of the proposed changes are also a result of Senate Bill 16-069. Other changes found in Chapter Two are a result of the Department's regular review of EMS provider scope of care. Chapter Two is presented to the Board of Health to provide the full context of the changes resulting from Senate Bill 16-069; however, the Chapter 2 rules are promulgated by the Executive Director.

Changes in the health care delivery system across the country have been taking place over the past several years. One prevailing innovative program that has emerged is referred to as community paramedicine. Community paramedicine recognizes that emergency medical service (EMS) providers are a highly skilled medical resource that can be utilized in non-emergent situations. Currently patients who lack resources, financial or otherwise, rely on the 911 and emergency department setting to be treated for non-emergent care. Under the community paramedicine model, EMS providers can provide non-emergent care to patients in an out-of-hospital setting and help navigate patients to the most appropriate level of care.

Senate Bill 16-069, codified within Title 25, Part 3.5 of the Colorado Revised Statutes, creates three new community healthcare constructs.

First, Senate Bill 16-069 creates a CP endorsement for emergency medical service providers who meet certain educational and other credentialing requirements. The statute allows one level of EMS provider – a paramedic - to become endorsed as a CP upon receipt of a certificate of completion from an accredited paramedic training center or an accredited college or university, and the passing of a nationally offered CP exam. The only currently offered national exam is specific to the paramedic level EMS provider and therefore only paramedics may apply for and receive the CP endorsement at this time. Once endorsed, the CP will have an expanded scope of care that can be provided in a Community Integrated Health Care Service Agency setting.

The Department formed a task force to develop the proposed CP endorsement rule changes to Chapter One and Chapter Two of 6 CCR 1015-3. The education and certification requirements for EMS providers are set forth in 6 CCR 1015-3, Chapter One. The scope of practice (acts and medications) for EMS providers is set forth in 6 CCR 1015-3, Chapter Two. The addition of a CP scope of practice is being submitted for adoption by the executive director and chief medical officer, Dr. Larry Wolk, in October 2017.

Second, the statute creates Community Assistance Referral and Education Services ("CARES") programs to provide consumers with medical resource navigation and referral information as alternatives to 911 and emergency medical services. The statute does not allow regulation of CARES programs other than annual reporting requirements for new programs.

Third, the statute creates a new licensing category for agencies to offer out-of-hospital medical services as licensed Community Integrated Health Care Service (CIHCS) Agencies. The Department convened a separate task force to develop rules for CICHS Agencies that met in parallel to the CP endorsement task force. The proposed rules for 6 CCR 1011-3, Standards for Community Integrated Health Care Service Agencies, will be presented to the Board of Health for adoption in October 2017.

An excerpt from SB16-069 and the letter of approval from SEMTAC are included in this packet.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
6 CCR 1015-3 Emergency Medical Services

Basis and Purpose.

Senate Bill 16-069 was signed into law on June 8, 2016. The legislation creates a new emergency medical services (EMS) provider endorsement. The proposed revisions to Chapter One place in rule the education standards for the issuance of a community paramedicine endorsement by the Department. The endorsement is not a new certification level. Rather, EMS providers may apply to the Department to receive an endorsement to provide out-of-hospital medical services in a Community Integrated Health Care Service Agency setting after obtaining a certificate of completion for a course in community paramedicine from an accredited paramedic training center, college, or university, and passing a nationally offered examination that is recognized in Colorado.

Currently the only national community paramedicine test is offered by the International Board of Specialty Certification (IBSC) for individuals at the paramedic level. Consequently, EMS providers of any level other than paramedic cannot take the test at this time; only individuals certified as paramedics will be able to receive this endorsement. The IBSC anticipates developing national CP competency tests for non-paramedic EMS providers in the future.

Senate Bill 16-069 directed the Department to develop a scope of practice under which a community paramedicine endorsed paramedic may practice under the appropriate supervision of a physician medical director in a Community Integrated Health Care Service Agency. Revisions have been made in Chapter Two to provide consistency throughout the chapter for the introduction of the new community paramedicine endorsement. Additional changes have been made as part of the Department's customary review of all EMS providers' scopes of practice.

The bill also required the creation of rules regarding the Community Integrated Health Care Service Agency. The proposed rules for 6 CCR 1011-3, Standards for Community Integrated Health Care Service Agencies, will be presented to the Board of Health for hearing in October 2017.

Also created by statute is the Community Assistance Referral and Education Services (CARES) programs. The purpose of CARES programs is to provide consumers with medical resource navigation and referral information as alternatives to 911 and emergency medical services. The Department was not granted authority to create rules and regulations for CARES programs.

Senate Bill 16-069 requires the rules to be in effect on or before January 1, 2018; therefore, the Department requests an effective date of December 31, 2017.

Specific Statutory Authority.
These rules are promulgated pursuant to the following statutes:

Section 25-3.5-203.5, C.R.S.
Section 25-3.5-206(4)(a.5)(I), C.R.S.

Is this rulemaking due to a change in state statute?

__X____ Yes, the bill number is Senate Bill 16-069. Rules are ___ authorized X required.
_____ No

Is this rulemaking due to a federal statutory or regulatory change?

_____ Yes
X_____ No

Does this rulemaking incorporate materials by reference?

_____ Yes
X_____ No

If "Yes," the rule needs to provide the URL of where the material is available on the internet (CDPHE website recommended) or the Division needs to provide one print or electronic copy of the incorporated material to the State Publications Library. § 24-4-103(12.5)(c), C.R.S.

Does this rulemaking create or modify fines or fees?

_____ Yes
X_____ No

REGULATORY ANALYSIS
for Amendments to
6 CCR 1015-3 Emergency Medical Services

1. A description of the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

The proposed amendments would create a new endorsement for individual paramedic providers to perform Community Paramedicine medical acts and procedures in a Community Integrated Health Care Service (CIHCS) Agency setting. The Division will not charge a fee to apply for the endorsement. However, there is a fee associated with sitting for the Certified Community Paramedic exam offered by the International Board of Specialty Certification (IBSC). The IBSC certification is a necessary requirement for an individual to receive the CP endorsement. The exam can cost up to $435, depending on whether the test is paper- or computer-based.

Existing emergency medical service agencies that are currently utilizing EMS providers of all levels in non-emergent settings will need to determine if the services being offered meet the definition of CIHCS or Community Assistance Referral and Education Services (CARES). If the services offered are in-line with CIHCS, the EMS agency will need to either change its programs or apply for a CIHCS Agency license and use only CP endorsed paramedics (CP-P) or other non-EMS personnel to provide direct CIHCS. Any qualified applicant who seeks to manage and offer, directly or by contract, community integrated health care services in the State of Colorado will be required to apply for and receive a CIHCS Agency license.

2. To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

Individuals applying for the CP endorsement will need to obtain a certificate of completion from an accredited paramedic training center or an accredited college or university, as well as pass the IBSC CP exam. The cost of the education will be variable, as current CP classes range from semester-long courses to multi-day events. The IBSC does not offer special exam-specific training, and it will be necessary for individuals to determine the training that fits their time and financial constraints.

The IBSC certification is a necessary requirement for an individual to receive the CP endorsement. The exam can cost up to $435, depending on whether the test is paper- or computer-based.

3. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

The implementation costs of the department to endorse CP-P will be absorbed as part of the existing computer system used for certification of EMS providers.
Paramedic training centers and university and colleges that wish to offer courses in community paramedicine will need to develop a curriculum and ensure that they have appropriate staff to teach the material. The cost of this will be dependent on several different factors. The Department will be releasing guidance for education programs concerning which learning domains such a curriculum should cover.

4. A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Inaction is not an option. Senate Bill 16-069 requires the implementation of the CP endorsement by January 1, 2018.

5. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There is no less costly or intrusive method for achieving the purpose of the proposed rules. Senate Bill 16-069 requires that rules be promulgated.

6. Alternative Rules or Alternatives to Rulemaking Considered and Why Rejected.

   There is no less costly or intrusive method for achieving the purpose of the proposed rules. Senate Bill 16-069 requires rules to be promulgated by January 1, 2018. A task force has been meeting at least once a month from September 2016 through May 2017 to reach consensus on the education and testing requirements, and the medical acts and procedures allowed.

7. To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.

   Senate Bill 16-069 requires that CP endorsement candidates obtain training from an accredited paramedic training program, college, or university, and receive a passing score from a nationally-offered test. The IBSC advised the task force that only a paramedic-level provider is currently eligible to sit for the Certified Community Paramedic exam, the only exam offered at this time. The IBSC is currently working on the creation of CP exams for additional EMS providers.

   The task force also received information regarding the variety of community paramedicine trainings and education that is currently being offered. Based on the research and presentations, the task force determined it was best that the Department not mandate any particular organization's curriculum or dictate in rule requirements for an individual to sit for the IBSC Certified Community Paramedic exam. Instead, the Department has developed guidance for Colorado-based accredited community paramedicine training programs on suggested learning domains for paramedics to provide care in a non-acute setting. Not listing a specific education course or curriculum in the rules will allow individuals and agencies the flexibility to determine how best to prepare for the certification test. Receipt of a passing grade on the IBSC exam provides sufficient assurance that an individual possesses the necessary skills and competency to be endorsed as a CP-P.

   In determining other changes made to EMS provider scope of practice, outside of the additional scope created for community paramedicine endorsed individuals, the Emergency Medical Practice Advisory Council relied on current medical practice and standards and review of the medical acts and skills that have previously been waivered.

STAKEHOLDER COMMENTS
for Amendments to
6 CCR 1015-4 Emergency Medical Services

State law requires agencies to establish a representative group of participants when considering to adopt or modify new and existing rules. This is commonly referred to as a stakeholder group.

Early Stakeholder Engagement:
The following individuals and/or entities were invited to provide input and included in the development of these proposed rules:

The Department formed a task force comprised of interested stakeholders to provide input in the development of the proposed rules. The membership included:

Representative	Organization
Stein Bronsky	Emergency Medical Practice Advisory Council (EMPAC) - primary
Bill Hall	EMPAC - primary
Will Dunn	EMPAC - secondary
Tom Candlin	EMPAC - secondary
Mark Homan	Emergency Medical Services Association of Colorado (EMSAC) - primary
James McLaughlin	EMSAC - secondary
Ted Beckman	Colorado Hospital Association (CHA) – primary
Michael Grill	CHA - secondary
John Welton	Colorado Nurses Association - primary
Anne Montera	Colorado Nurses Association - secondary
Iva Lou Bailey	Home Care Association - primary
Suzanne Todd	Home Care Association - secondary
Beth Lattone	State Board of Community Colleges - primary
Dennis Edgerly	State Board of Community Colleges - secondary
Kimberly Whitten	State Board of Community Colleges - secondary
Lori Rae Hamilton	State Board of Community Colleges - secondary
EMTS Medical Director	Jeff Beckman

All task force meetings were appropriately noticed and open to the public.

The proposed rules were presented to EMPAC and the regional medical directors on May 8, 2017 and the State Emergency Medical and Trauma Services Advisory Council (SEMTAC) on July 27, 2017. On that date, SEMTAC voted and approved to recommend the proposed rules to the Department for rule-making by Board of Health.

The draft proposed rules have also been available on the EMTS website since June 2017, with notice and a link being sent out through the weekly newsletter, *EMTS on the GO* since July 5, 2017. This newsletter currently reaches over 1,000 individuals.

Stakeholder Group Notification
The stakeholder group was provided notice of the rulemaking hearing and provided a copy of the proposed rules or the internet location where the rules may be viewed. Notice was

provided prior to the date the notice of rulemaking was published in the Colorado Register (typically, the 10th of the month following the Request for Rulemaking).

X Not applicable. This is a Request for Rulemaking Packet. Notification will occur if the Board of Health sets this matter for rulemaking.

____ Yes.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

The task force members and interested stakeholders spent a significant amount of time discussing the appropriate level of education and training an individual must obtain by rule. The group eventually reached consensus that passing the IBSC Certified Community Paramedic exam would demonstrate an individual's receipt of the appropriate and necessary training, and the task force ultimately decided it is inappropriate for the Department to make determinations concerning the specifics of any given training or curriculum.

The task force reached consensus and approved the draft rules on May 31, 2017.

Please identify health equity and environmental justice (HEEJ) impacts. Does this proposal impact Coloradoans equally or equitably? Does this proposal provide an opportunity to advance HEEJ? Are there other factors that influenced these rules?

Community paramedicine recognizes that emergency medical service (EMS) providers are a highly skilled medical resource that can be utilized in non-emergent situations. Currently these consumers lack the resources, financial or otherwise, to be treated outside a 911 or emergency department setting. Under the community paramedicine model, EMS providers can provide non-emergent care to patients in an out-of-hospital setting and help navigate patients to the most appropriate level of care. The Department anticipates that the proposed rules will advance health equity for Coloradans.

SENATE BILL 16-069

BY SENATOR(S) Garcia, Newell, Donovan, Lambert, Lundberg, Guzman, Kerr, Merrifield, Ulibarri, Aguilar, Carroll, Crowder, Heath, Hodge, Johnston, Kefalas, Todd;
also REPRESENTATIVE(S) Pabon, Williams, Esgar, Hamner, Lebsock, Salazar, Young, Duran, Ginal, Kraft-Tharp, Lee, Lontine, Melton, Mitsch Bush, Primavera, Ryden, Vigil, Winter, Hullinghorst.

CONCERNING MEASURES TO PROVIDE COMMUNITY-BASED OUT-OF-HOSPITAL MEDICAL SERVICES, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 25-3.5-103, **add** (4.3) and (4.5) as follows:

25-3.5-103. Definitions. As used in this article, unless the context otherwise requires:

(4.3) "COMMUNITY INTEGRATED HEALTH CARE SERVICE" MEANS THE PROVISION OF CERTAIN OUT-OF-HOSPITAL MEDICAL SERVICES, AS DETERMINED BY RULE, THAT A COMMUNITY PARAMEDIC MAY PROVIDE.

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

(4.5) "COMMUNITY PARAMEDIC" MEANS AN EMERGENCY MEDICAL SERVICE PROVIDER WHO OBTAINS AN ENDORSEMENT IN COMMUNITY PARAMEDICINE PURSUANT TO SECTION 25-3.5-206.

SECTION 2. In Colorado Revised Statutes, **add** 25-3.5-203.5 as follows:

25-3.5-203.5. Community paramedic endorsement - rules. (1) ON OR BEFORE JANUARY 1, 2018, THE BOARD SHALL ADOPT RULES IN ACCORDANCE WITH ARTICLE 4 OF TITLE 24, C.R.S., FOR COMMUNITY PARAMEDICS INCLUDING STANDARDS FOR:

(a) THE DEPARTMENT'S ISSUANCE OF AN ENDORSEMENT IN COMMUNITY PARAMEDICINE TO AN EMERGENCY MEDICAL SERVICE PROVIDER;

(b) VERIFYING AN EMERGENCY MEDICAL SERVICE PROVIDER'S COMPETENCY TO BE ENDORSED AS A COMMUNITY PARAMEDIC. THE STANDARDS MUST INCLUDE A REQUIREMENT THAT THE EMERGENCY MEDICAL SERVICE PROVIDER HAS OBTAINED FROM AN ACCREDITED PARAMEDIC TRAINING CENTER OR AN ACCREDITED COLLEGE OR UNIVERSITY A CERTIFICATE OF COMPLETION FOR A COURSE IN COMMUNITY PARAMEDICINE WITH COMPETENCY VERIFIED BY A PASSING SCORE ON AN EXAMINATION OFFERED NATIONALLY AND RECOGNIZED IN COLORADO FOR CERTIFYING COMPETENCY TO SERVE AS A COMMUNITY PARAMEDIC; AND

(c) CONTINUING COMPETENCY TO MAINTAIN A COMMUNITY PARAMEDIC ENDORSEMENT.

(2) RULES ADOPTED UNDER THIS SECTION SUPERSEDE ANY RULES OF THE COLORADO MEDICAL BOARD REGARDING THE MATTERS SET FORTH IN THIS PART 2.

SECTION 3. In Colorado Revised Statutes, 25-3.5-206, **add** (4) (a.5) as follows:

25-3.5-206. Emergency medical practice advisory council - creation - powers and duties - emergency medical service provider scope of practice - rules. (4) (a.5) (I) ON OR BEFORE JANUARY 1, 2018, THE DIRECTOR, OR, IF THE DIRECTOR IS NOT A PHYSICIAN, THE CHIEF

MEDICAL OFFICER SHALL ADOPT RULES IN ACCORDANCE WITH ARTICLE 4 OF TITLE 24, C.R.S., CONCERNING THE SCOPE OF PRACTICE OF A COMMUNITY PARAMEDIC. AN EMERGENCY MEDICAL SERVICE PROVIDER'S ENDORSEMENT AS A COMMUNITY PARAMEDIC, ISSUED PURSUANT TO THE RULES ADOPTED UNDER SECTION 25-3.5-203.5, IS VALID FOR AS LONG AS THE EMERGENCY MEDICAL SERVICE PROVIDER MAINTAINS HIS OR HER CERTIFICATION BY THE DEPARTMENT.

(II) THE RULES MUST ESTABLISH THE TASKS AND PROCEDURES THAT AN EMERGENCY MEDICAL SERVICE PROVIDER WITH A COMMUNITY PARAMEDIC ENDORSEMENT IS AUTHORIZED TO PERFORM IN ADDITION TO AN EMERGENCY MEDICAL SERVICE PROVIDER'S SCOPE OF PRACTICE, INCLUDING:

(A) AN INITIAL ASSESSMENT OF THE PATIENT AND ANY SUBSEQUENT ASSESSMENTS, AS NEEDED;

(B) MEDICAL INTERVENTIONS;

(C) CARE COORDINATION;

(D) RESOURCE NAVIGATION;

(E) PATIENT EDUCATION;

(F) INVENTORY, COMPLIANCE, AND ADMINISTRATION OF MEDICATIONS; AND

(G) GATHERING OF LABORATORY AND DIAGNOSTIC DATA.

SECTION 4. In Colorado Revised Statutes, **add** parts 12 and 13 to article 3.5 of title 25 as follows:

PART 12
COMMUNITY ASSISTANCE REFERRAL AND EDUCATION SERVICES (CARES) PROGRAM

25-3.5-1201. Short title. THE SHORT TITLE OF THIS PART 12 IS THE "COMMUNITY ASSISTANCE REFERRAL AND EDUCATION SERVICES (CARES) PROGRAM ACT".

COLORADO
Department of Public
Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

State Emergency Medical and Trauma Services Advisory Council

July 27, 2017

Mr. Tony Cappello, President
State Board of Health
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South, EDO-A5
Denver, CO 80246-1530

Dear Mr. Cappello:

At the July 27, 2017 meeting of the State Emergency Medical and Trauma Services Advisory Council (SEMTAC) of the Colorado Department of Public Health and Environment, proposed revisions to 6 C.C.R 1015-3, Chapter 1- Rules Pertaining to EMS and EMR Education, EMS Certification, and EMR Registration, were reviewed and discussed. The rule revisions create the educational and additional requirements necessary for an EMS provider to receive a community paramedic endorsement, as well as continuing competencies. A motion was made and passed to approve the proposed revisions.

Sincerely yours,

Chief Richard A. Martin
Chairman

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

EMERGENCY MEDICAL SERVICES

6 CCR 1015-3

Adopted by the Board of Health on_____. Effective _____.

CHAPTER ONE – RULES PERTAINING TO EMS AND EMR EDUCATION, EMS CERTIFICATION, AND EMR REGISTRATION

*****

Section 2 – Definitions

*****

2.28 "International Board of Specialty Certification (IBSC)" – A non-profit organization that develops and administers a national community paramedic certification exam.

2.29 "Letter of Admonition" - A form of disciplinary sanction that is placed in an EMS provider's or EMR's file and represents an adverse action against the certificate holder.

2.30 "Medical Director" – For the purposes of these rules, a physician licensed in good standing who authorizes and directs, through protocols and standing orders, the performance of students-in-training enrolled in Department-recognized EMS or EMR education programs and/or EMS certificate holders who perform medical acts, and who is specifically identified as being responsible to assure the performance competency of those EMS Providers as described in the physician's medical continuous quality improvement program.

2.31 "National Registry of Emergency Medical Technicians (NREMT)" - A national non-governmental organization that certifies entry-level and ongoing competency of EMS providers and EMRS.

2.32 "Paramedic" - An individual who has a current and valid Paramedic certificate issued by the Department and who is authorized to provide acts of advanced emergency medical care in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight. For the purposes of these rules, Paramedic includes the historic EMS Provider level of EMT-Paramedic (EMT-P).

2.33 "Paramedic with Community Paramedic Endorsement (P-CP)" – An individual who has a current and valid paramedic certificate issued by the Department and who has met the requirements in these rules to obtain a community paramedic endorsement from the Department and is authorized to provide acts in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight relating to community integrated health care services, as set forth in 25-3.5-206, C.R.S and 25-3.5-1301, *et seq* C.R.S.

2.33 "Paramedic with Critical Care Endorsement (P-CC)" – An individual who has a current and valid Paramedic certificate issued by the Department and who has met the requirements in these rules to obtain a critical care endorsement from the Department and is authorized to provide acts in accordance with ~~conditions defined in~~ the Rules Pertaining to EMS Practice and Medical Director Oversight relating to critical care, as set forth in 25-3.5-206, C.R.S.

2.34 "Practical Skills Examination" - A skills test conducted at the end of an initial course and prior to application for national or state certification.

2.35 “Provisional Certification” - A certification, valid for not more than 90 days, that may be issued by the Department to an EMS PROVIDER applicant seeking certification.

2.36 “Provisional Registration” – A registration, valid for not more than 90 days, that may be issued by the Department to an EMR applicant seeking registration.

2.37 “Refresher Course” - A course of study based on the Department approved curriculum that contributes in part to the education requirements for renewal of a certificate or registration.

2.38 “Registered Emergency Medical Responder (EMR)” - An individual who has successfully completed the training and examination requirements for EMRs, who provides assistance to the injured or ill until more highly trained and qualified personnel arrive, and who is registered with the Department pursuant to section 6 of these rules.

2.39 “Rules Pertaining to EMS Practice and Medical Director Oversight” - Rules adopted by the Executive Director or Chief Medical Officer of the Department upon the advice of the EMPAC that establish the responsibilities of medical directors and all authorized acts of EMS certificate holders, located at 6 CCR 1015-3, Chapter Two.

2.40 “State Emergency Medical and Trauma Services Advisory Council (SEMTAC)” – A council created in the Department pursuant to Section 25-3.5-104, C.R.S., that advises the Department on all matters relating to emergency medical and trauma services.

Section 3 - State Recognition of Education Programs

****

3.1 Specialized Education Curricula

3.1.1 The specialized education curricula established by the Department may include, but are not limited to, the following:

A) EMR initial and refresher courses

B) EMT initial and refresher courses

C) Intravenous therapy (IV) and medication administration course

D) AEMT initial and refresher courses

E) EMT-I initial and refresher courses

F) Paramedic initial and refresher courses

****

3.2.11 Applicants for education program recognition shall submit the following documentation to the Department:

****

D) program policies and procedures, which at a minimum shall address:

****

10) description of insurance coverage for students, both health and liability ~~personal liability and worker's compensation~~;

3.4 Incorporation by Reference

3.4.1 These rules incorporate by reference the Commission on Accreditation of Allied Health Education Programs (CAAHEP) Standards and Guidelines for the Accreditation of

Educational Programs in the Emergency Medical Services Professions as revised in ~~2005~~ 2015. Such incorporation does not include later amendments to or editions of the referenced material. The Health Facilities and Emergency Medical Services Division of the Department maintains copies of the incorporated material for public inspection during regular business hours, and shall provide certified copies of any non-copyrighted material to the public at cost upon request. Information regarding how the incorporated material may be obtained or examined is available from the Division by contacting:

EMTS Branch Chief
Health Facilities and EMS Division
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246-1530

3.4.2 The incorporated material may be obtained at no cost from the website of the Committee on Accreditation of Education Programs for the Emergency Medical Services Professions at ~~www.coaemsp.org/standards.htm~~ http://coaemsp.org/Documents/EMSP-April-2015-FINAL.pdf.

*****

Section 5 - Emergency Medical Services Provider Certification

5.2 Initial Certification

*****

5.2.2. Applicants for initial certification shall submit to the Department a completed application provided by the Department, including the applicant's signature in a form and manner as determined by the Department, that contains the following:

*****

C) Evidence of current and valid professional level Basic Cardiac Life Support (CPR) course completion from a national or local organization approved by the Department, except as provided for in Paragraph ~~G~~H below.

D) In additional to paragraph C, above, EMT-I and Paramedic applicants shall submit evidence of current and valid Advanced Cardiac Life Support (ACLS) course completion from a national or local organization approved by the Department, except as provided in Paragraph ~~G~~H below.

E) In addition to paragraph C and D above, a P-CC applicant shall submit evidence of current and valid Critical Care Paramedic or Flight Paramedic certification issued by the BCCTPC.

F) In additional to paragraphs C and D above, a P-CP applicant shall submit the following additional information:

1) Current and valid community paramedicine certification issued by the IBSC.

2) Proof of completion of a course in community paramedicine from one of the following institutions:

a. an accredited paramedic training program,

b. a college accredited by an educational accrediting body, or

c. a university accredited by an educational accrediting body.

~~F~~G) Evidence of lawful presence in the United States.

~~G~~H) While stationed or residing within Colorado, all veterans, active military service members, and members of the national guard and reserves that are separating from an active duty tour, or the spouse of a veteran or a member, may apply for certification to practice in Colorado. The veteran, member, or spouse is exempt from the requirements of paragraphs C and D.

1) The Department may require evidence of military status and appropriate orders in order to determine eligibility for this exemption.

*****

5.3 Renewal of Certification

*****

5.3.3 Education Requirements to Renew a Certificate Without the Use of a Current and Valid NREMT Certification

*****

4) Education cannot be used in lieu of current and valid community paramedicine certification issued by the IBSC.

*****

Section 7 - Disciplinary Sanctions and Appeal Procedures for EMS Provider Certification or EMR Registration

*****

7.3 Good cause for disciplinary sanctions also includes conviction of, or a plea of guilty, or of no contest, to a felony or misdemeanor that relates to the duties and responsibilities of a certificate or registration holder, including patient care and public safety. For purposes of this paragraph, “conviction” includes the imposition of a deferred sentence.

7.3.1 The following crimes set forth in the Colorado Criminal Code (Title 18, C.R.S.) are considered to relate to the duties and responsibilities of a certificate holder:

A) offenses under Article 3 - offenses against a person.

B) offenses under Article 4 - offenses against property.

C) offenses under Article 5 - offenses involving fraud.

D) offenses under Article 6 - offenses involving the family relations.

E) offenses under Article 6.5 - wrongs to at-risk adults.

F) offenses under Article 7 - offenses related to morals.

G) offenses under Article 8 - offenses - governmental operations.

H) offenses under Article 9 - offenses against public peace, order and decency.

I) offenses under Article 17 - Colorado Organized Crime Control Act.

J) offenses under Article 18 - Uniform Controlled Substances Act of ~~1992~~ 2013.

****

CHAPTER TWO - RULES PERTAINING TO EMS PRACTICE AND MEDICAL DIRECTOR OVERSIGHT
(promulgated by the Executive Director)

****

SECTION 2 - Definitions - All definitions that appear in Section 25-3.5-103, C.R.S., and 6 CCR 1015-3, CHAPTER ONE shall apply to these rules.

2.1 "Advanced Cardiac Life Support (ACLS)" - a course of instruction designed to prepare students in the practice of advanced emergency cardiac care.

2.2 "Advanced Emergency Medical Technician (AEMT)" - an individual who has a current and valid AEMT certificate issued by the department and who is authorized to provide limited acts of advanced emergency medical care in accordance with these rules.

~~2.3 "Board for Critical Care Transport Paramedic Certification (BCCTPC)"- a non-profit organization that develops and administers the Critical Care Paramedic Certification and Flight Paramedic Certification exam.~~

2.3 "Care coordination" - the deliberate organization of patient care activities between two or more participants, including the patient, involved in a patient's care to facilitate the appropriate delivery of medical care services.

2.4 "Colorado Medical Board" - the Colorado Medical Board established in Title 12, Article 36, C.R.S., formerly known as the state Board of Medical Examiners.

2.5 "Community Integrated Health Care Service (CIHCS)" – the provision of certain out-of-hospital medical services that a community paramedic may provide and may include:

2.5.1 Services authorized pursuant to Section 25-3.5-1203(3), C.R.S;

2.5.2 Services authorized pursuant to 6 CCR 1011-3, Standards for Community Integrated Health Care Service Agencies;

2.5.3 Services authorized under the scope of practice as set forth in this chapter;

2.5.4 Services authorized pursuant to Section 25-3.5-206(4)(A.5)(II), C.R.S.

2.6 "Community Integrated Health Care Service Agency (CIHCS Agency)" – a sole proprietorship, partnership, corporation, nonprofit entity, special district, governmental unit or agency, or licensed or certified health care facility that is subject to regulation under Article 1.5 or 3 of Title 25 that manages and offers, directly or by contract, community integrated health care services.

2.7 "CIHCS Agency medical director" – as used in these rules, means a Colorado licensed physician in good standing who is identified as being responsible for supervising, directing, and assuring the competency of those individuals who are employed by or contracted with the CIHCS Agency to perform community integrated health care services on behalf of the agency.

2.8 "Consumer" – an individual receiving Community Integrated Health Care Services.

2.9 "Consumer service plan" – the approved written plan specific to each consumer receiving CIHCS in a series of visits that: identifies the consumer's physical, medical, social, mental health, and/or environmental needs, as necessary; sets forth the out-of-hospital medical services the CIHCS Agency agrees to provide to the consumer; and, is overseen by the CIHCS Agency medical director.

2.10 "Department" - the Colorado Department of Public Health and Environment.

2.11 "Direct Verbal Order" - verbal authorization given to an EMS provider for the performance of specific medical acts through a Medical Base Station or in person.

2.12 “Emergency Medical Practice Advisory Council (EMPAC)” - the council established pursuant to Section 25-3.5-206, C.R.S., that is responsible for advising the department regarding the appropriate scope of practice for EMS providers and for the criteria for physicians to serve as EMS medical directors.

2.13 “Emergency Medical Technician (EMT)” - an individual who has a current and valid EMT certificate issued by the department and who is authorized to provide basic emergency medical care in accordance with these rules.

2.14 “Emergency Medical Technician with Intravenous Authorization (EMT-IV)” - an individual who has a current and valid EMT certificate issued by the department and who has met the conditions defined in Section 5.5 of these rules.

2.15 “Emergency Medical Technician-Intermediate (EMT-I)” - an individual who has a current and valid EMT-Intermediate certificate issued by the department and who is authorized to provide limited acts of advanced emergency medical care in accordance with these rules.

2.16 “EMS Provider” - means an individual who holds a valid emergency medical service provider certificate issued by the department and includes Emergency Medical Technician, Advanced Emergency Medical Technician, Emergency Medical Technician-Intermediate and Paramedic.

2.17 “EMS service agency” - any organized agency including but not limited to a “rescue unit” as defined in Section 25-3.5-103(11), C.R.S., using EMS providers to render initial emergency medical care to a patient prior to or during transport. This definition does not include criminal law enforcement agencies, unless the criminal law enforcement personnel are EMS providers who function with a “rescue unit” as defined in Section 25-3.5-103(11), C.R.S. or are performing any medical act described in these rules.

2.18 “Graduate Advanced EMT” - an individual who has a current and valid Colorado EMT certification issued by the department and who has successfully completed a department-recognized AEMT initial course but has not yet successfully completed the certification requirements set forth in the Rules Pertaining to EMS Education and Certification, 6 CCR 1015-3, Chapter One.

2.19 “Graduate EMT-Intermediate” - an individual who has a current and valid Colorado EMT or AEMT certification issued by the department and who has successfully completed a department-recognized EMT-Intermediate course but has not yet successfully completed the certification requirements set forth in the Rules Pertaining to EMS Education and Certification, 6 CCR 1015-3, Chapter One.

2.20 “Graduate Paramedic” - an individual who has a current and valid Colorado EMT certificate, AEMT certificate, or EMT-I certificate issued by the department and who has successfully completed a department-recognized paramedic initial course but has not yet successfully completed the certification requirements set forth in the Rules Pertaining to EMS Education and Certification, 6 CCR 1015-3, Chapter One.

2.21 “Interfacility Transport” - any transport of a patient from one licensed healthcare facility to another licensed healthcare facility, after a higher level medical care provider (i.e. a physician, physician assistant, or an individual of similar/equivalent training, certification, and patient interaction) has initiated treatment.

2.22 “International Board of Specialty Certification (IBSC)” – A non-profit organization that develops and administers a national community paramedic certification exam.

2.23 “Licensed in Good Standing” - as used in these rules, means that a physician functioning as a medical director holds a current and valid license to practice medicine in Colorado that is not subject to any restrictions.

2.24 “Maintenance” – to observe the patient while continuing, assessing, adjusting and/or discontinuing care of a previously established medical procedure or medication via standing order, written physician order, or the direct verbal order of a physician.

2.25 "Medical Base Station" - the source of direct medical communications with EMS providers.

2.26 "Medical Director" - for purposes of these rules means a physician licensed in good standing who authorizes and directs, through protocols and standing orders, the performance of students-in-training enrolled in department-recognized EMS education programs, graduate AEMTs, EMT-Is or paramedics, or EMS providers of a prehospital EMS service agency and who is specifically identified as being responsible to assure the competency of the performance of those acts by such EMS providers as described in the physician's medical CQI program.

2.27 "Monitoring" – to observe and detect changes, or the absence of changes, in the clinical status of the patient for the purpose of documentation.

2.28 "Out-of-hospital medical services" – Services performed by a Paramedic with Community Paramedic Endorsement provided by a CIHCS Agency. Shall include the initial assessment of the patient and any subsequent assessments, as needed; the furnishing of medical treatment and interventions; care coordination; resource navigation; patient education; medication inventory, compliance and administration; gathering of laboratory and diagnostic data; nursing services; rehabilitative services, complementary health services; as well as the furnishing of other necessary services and goods for the purpose of preventing, alleviating, curing or healing human illness, physical disability, physical injury; alcohol, drug or controlled substance abuse; and behavioral health services that may be provided in an out-of-hospital setting.

2.29 "Paramedic" - an individual who has a current and valid paramedic certificate issued by the department and who is authorized to provide advanced emergency medical care in accordance with these rules.

2.30 "Paramedic with Community Paramedic Endorsement (P-CP)" – An individual who has a current and valid paramedic certificate issued by the Department and who has met the requirements in these rules to obtain a community paramedic endorsement from the Department and is authorized to provide acts in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight relating to community integrated health care services, as set forth in 25-3.5-206, C.R.S and 25-3.5-1301, *et seq* C.R.S.

2.31 "Paramedic with Critical Care Endorsement (P-CC)" – An individual who has a current and valid Paramedic certificate issued by the Department and who has met the requirements in these rules to obtain a critical care endorsement from the Department and is authorized to provide acts in accordance with ~~conditions defined in~~ the Rules Pertaining to EMS Practice and Medical Director Oversight relating to critical care, as set forth in 25-3.5-206, C.R.S..

2.32 "Point of care testing (POCT)" – medical diagnostic testing performed outside the clinical laboratory in close proximity to where the patient is receiving care, the results of which are used for clinical decision making.

2.33 "Prehospital Care" – any medical procedures or acts performed prior to a patient receiving care at a licensed healthcare facility.

2.34 "Protocol" - written standards for patient medical assessment and management approved by a medical director.

2.35 "Rules Pertaining to EMS Education and Certification" - rules governing the education and certification of EMS providers, located at 6 CCR 1015-3, Chapter One, promulgated by the state Board of Health.

2.36 "Scope of Practice" - refers to the medication administration and acts authorized in these rules for EMS providers.

2.37 "State Emergency Medical and Trauma Services Advisory Council (SEMTAC)" - a council created in the department pursuant to Section 25-3.5-104, C.R.S., that advises the department on all matters relating to emergency medical and trauma services.

2.38 "Standing Order" - written authorization provided in advance by a medical director for the performance of specific medical acts by EMS providers independent of making medical base station contact.

2.39 "Supervision" - oversee, direct or manage. Supervision may be through direct observation or by indirect oversight as defined in the medical director's CQI program.

2.40 "Waiver" - a department-approved exception to these rules granted to a medical director.

2.41 "Written Order" - written authorization given to an EMS provider for the performance of specific medical acts.

SECTION 3 - Emergency Medical Practice Advisory Council

****

3.3 EMPAC members shall serve four-year terms~~; except that, of the members initially appointed to the EMPAC by the governor, four members shall serve three-year terms~~.

****

SECTION 4 - Medical Director Qualifications and Duties

****

4.2 The duties of a medical director shall include:

****

4.2.3 Notify the department on an annual basis and upon any change of medical direction of the EMS Service Agencies for which medical control functions are being provided in a manner and form as determined by the department.

****

4.2.7 Ensure that all protocols issued by the medical director are appropriate for the certification and skill level of each EMS provider to whom the performance of medical acts is delegated and authorized and compliant with accepted standards of medical practice. Ensure that a system is in place for timely access to communication of verbal orders.

****

4.2.14 Physicians acting as medical directors responsible for the supervision and authorization of a P-CC shall have training and experience in the acts and skills for which they are providing supervision and authorization. Additional duties related to ~~the~~ medical directors responsible for the supervision and authorization of a P-CC ~~is located~~ are set forth in Section 16 of these rules.

4.2.15 Physicians acting as medical directors for a Community Integrated Health Care Service Agency pursuant to section 25-3.5-1303(1)(a), C.R.S. that are responsible for the supervision and authorization of a P-CP shall have training and experience in the acts and skills for which they are providing supervision and authorization. Additional duties related to medical directors responsible for the supervision and authorization of a P-CP are set forth in Section 17 of these rules.

****

SECTION 8 - Medical Acts Allowed for the Paramedic

****

8.6 In addition to the acts of a paramedic, a P-CP may, under the supervision and authorization of a CIHCS Agency medical director, perform out-of-hospital medical services consistent with and not to exceed those authorized in Appendix G of these rules for Community Paramedicine.

8.7 In addition to the medications a paramedic is allowed to administer and monitor, a P-CP may, under the supervision and authorization of a CIHCS Agency medical director, administer and monitor medications defined in Appendix G of these rules for Community Paramedicine.

8.~~6~~8 In the event of a governor-declared disaster or public health emergency, the chief medical officer for the department or his or her designee may temporarily authorize the performance of additional medical acts, such as the administration of other immunizations, vaccines, biologicals or tests not listed in these rules.

****

SECTION 10 - General Acts Allowed

****

10.3 The gathering of laboratory and/or other diagnostic data for the sole purpose of providing information to another health care provider does not require a waiver provided:

****

10.3.4 Paramedics with a community paramedic endorsement working in a CIHCS Agency can perform and interpret POCT, excluding imaging procedures that are not performed by the P-CP in real time, as defined in Appendix G.

A) A P-CP may interpret POCT for clinical decision making based on the protocols and procedures of the CIHCS Agency medical director.

B) A P-CP may interpret laboratory studies outside of POCT if part of a prescribed service plan approved by the CIHCS Agency medical director.

10.3.5 A CIHCS Agency medical director may limit the scope of practice of any P-CP provider.

A medical director shall obtain a waiver as set forth in Section 11 of these rules for any other data gathering activities that do not meet the provisions listed above.

10.4 EMS providers who are providing medical care outside of an EMS agency setting ~~may function in acute care settings. Functioning in this environment~~ must function under the auspices of a medical director and be in compliance with the Colorado Medical Board's statutes and rules~~, under the auspices of a medical director and within parameters of the acts allowed or waiver as described in these rules~~.

10.4.1 EMS providers who are providing out-of-hospital medical services for a CIHCS Agency must obtain a community paramedic endorsement. An endorsed community paramedic may only provide out-of-hospital medical services as defined in these rules while employed by or contracting with a CIHCS Agency.

SECTION 11 - Waivers to Scope of Practice

****

11.2 A waiver is not necessary for the allowed skills and medications listed in Appendices A, B, C or D of this rule.

11.2.1 In addition to the skills and medications allowed in Paragraph 11.2, a P-CC does not require a waiver for the allowed skills and medications listed in Appendices E and F.

11.2.2 In addition to the skills and medications allowed in Paragraph 11.2, a P-CP does not require a waiver for the allowed out-of-hospital medical services listed in Appendix G when providing medical services in a CIHCS Agency setting.

****

SECTION 12 - Technology and Pharmacology Dependent Patients

The transport of patients with ~~continuous intravenously~~ continuously administered medications, continuous technology support, and nutritional support, previously prescribed by licensed health care workers and typically managed day-to-day at their residence by either the patient or caretakers, shall be allowed. The EMS provider is not authorized to discontinue, interfere with, alter or otherwise manage these patient medication/nutrition systems except by direct verbal order or where cessation and/or continuation of medication pose a threat to the safety of the patient.

****

SECTION 14 - Scope of Practice

****

14.2 A medical director may establish the ~~circumstances and~~ methods by which an EMS provider obtains authorization in the field to perform any medical act, skill or medication contained in these rules including, but not limited to: advanced standing orders that are written or electronically conveyed, contemporaneous orders that are direct verbal orders or written orders that are conveyed in real-time.

14.2.1 "Y" = YES: May be performed or administered by EMS providers with physician supervision as described in these rules.

14.2.2 "VO" = Verbal Order: May only be performed or administered by EMS providers if authorized by direct verbal or written order received from ~~by~~ a physician contemporaneous to when patient is receiving treatment, unless specific exception criteria are established by the supervising physician. Exception criteria may include, but are not limited to cardiac arrest, behavioral management or communications failure. Supervising physicians shall not develop exception criteria that merely waive all direct verbal order requirements.

****

APPENDIX A

PREHOSPITAL

MEDICAL SKILLS AND ACTS ALLOWED

****

A.1.3 In addition to the medical skills and acts allowed in Appendix A, EMS providers may provide services allowable under the Community Assistance Referral and Education Services (CARES) Program, as set forth in Section 25-3.5-1203(3),C.R.S.

TABLE A.1 - AIRWAY/VENTILATION/OXYGEN

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Airway - Supraglottic	Y	Y	Y	Y	Y
Airway - Nasal	Y	Y	Y	Y	Y
Airway - Oral	Y	Y	Y	Y	Y
Bag - Valve - Mask (BVM)	Y	Y	Y	Y	Y
Carbon Monoxide Monitoring	Y	Y	Y	Y	Y
Chest Decompression - Needle	N	N	N	Y	Y
Chest Tube Insertion	N	N	N	N	N
CPAP	Y	Y	Y	Y	Y
PEEP	Y	Y	Y	Y	Y
Cricoid Pressure - Sellick's Maneuver	Y	Y	Y	Y	Y
Cricothyroidotomy - Needle	N	N	N	N	Y
Cricothyroidotomy - Surgical	N	N	N	N	Y
End Tidal CO_2 Monitoring/Capnometry/ Capnography	Y	Y	Y	Y	Y
Flow Restrictive Oxygen Powered Ventilatory Device	Y	Y	Y	Y	Y
Gastric Decompression - NG/OG Tube Insertion	N	N	N	N	Y
Inspiratory Impedence Threshold Device	Y	Y	Y	Y	Y
Intubation - Digital	N	N	N	N	Y
Intubation - Bougie Style Introducer	N	N	N	Y	Y
Intubation - Lighted Stylet	N	N	N	Y	Y
Intubation - Medication Assisted (non-paralytic)	N	N	N	N	N
Intubation - Medication Assisted (paralytics) (RSI)	N	N	N	N	N
Intubation - Maintenance with paralytics	N	N	N	N	N
Intubation - Nasotracheal	N	N	N	N	Y
Intubation - Orotracheal	N	N	N	Y	Y

Intubation - Retrograde	N	N	N	N	N
Extubation	N	N	N	Y	Y
Obstruction - Direct Laryngoscopy	N	N	N	Y	Y
Oxygen Therapy – Humidifiers	Y	Y	Y	Y	Y
Oxygen Therapy - Nasal Cannula	Y	Y	Y	Y	Y
Oxygen Therapy - Non-rebreather Mask	Y	Y	Y	Y	Y
Oxygen Therapy - Simple Face Mask	Y	Y	Y	Y	Y
Oxygen Therapy - Venturi Mask	~~N~~Y	~~N~~Y	Y	Y	Y
Peak Expiratory Flow Testing	N	N	N	Y	Y
Pulse Oximetry	Y	Y	Y	Y	Y
Suctioning – Tracheobronchial	N	N	Y	Y	Y
Suctioning - Upper Airway	Y	Y	Y	Y	Y
Tracheostomy Maintenance - Airway management only	Y	Y	Y	Y	Y
Tracheostomy Maintenance - Includes replacement	N	N	N	N	Y
Ventilators - Automated Transport (ATV) [1]	N	N	N	N	Y

****

TABLE A.4 - INTRAVENOUS CANNULATION / FLUID ADMINISTRATION / FLUID MAINTENANCE

Skill	**EMT**	**EMT-IV**	**AEMT**	**EMT-I**	**P**
Blood/Blood By-Products Initiation (out of facility initiation)	N	N	N	N	N
Colloids - (Albumin, Dextran) - Initiation	N	N	N	N	N
Crystalloids (D5W, LR, NS) - Initiation/Maintenance	N	Y	Y	Y	Y
Intraosseous - Initiation	N	N	Y	Y	Y
Intraosseous Initiation – In Extremis	N	Y	Y	Y	Y
Medicated IV Fluids Maintenance - As Authorized in Appendix B	N	N	N	Y	Y
Peripheral - Excluding External Jugular - Initiation	N	Y	Y	Y	Y
Peripheral - Including External Jugular - Initiation	N	N	Y	Y	Y
Use of Peripheral indwelling Catheter for IV medications (Does not include PICC)	N	Y	Y	Y	Y

TABLE A.5 - MEDICATION ADMINISTRATION ROUTES

Skill	**EMT**	**EMT-IV**	**AEMT**	**EMT-I**	**P**
Aerosolized	Y	Y	Y	Y	Y
Atomized	Y	Y	Y	Y	Y
Auto-Injector	Y	Y	Y	Y	Y
Buccal	Y	Y	Y	Y	Y
Endotracheal Tube (ET)	N	N	N	Y	Y
Extra-abdominal umbilical vein	N	N	N	Y	Y
Intradermal	N	N	N	Y	Y
Intramuscular (IM)	~~N~~ Y	~~N~~ Y	Y	Y	Y
Intranasal (IN)	~~N~~ Y	Y	Y	Y	Y
Intraosseous	N	~~N~~ Y	Y	Y	Y
Intravenous (IV) Piggyback	N	N	N	Y	Y
Intravenous (IV) Push	N	Y	Y	Y	Y
Nasogastric	N	N	N	N	Y
Nebulized	Y	Y	Y	Y	Y
Ophthalmic	N	N	N	Y	Y
Oral	Y	Y	Y	Y	Y
Rectal	N	N	N	Y	Y
Subcutaneous	N	N	Y	Y	Y
Sublingual	Y	Y	Y	Y	Y
Sublingual (nitroglycerin)	Y	Y	Y	Y	Y
Topical	Y	Y	Y	Y	Y

Use of Mechanical Infusion Pumps	N	N	N	Y	Y

TABLE A.6 - MISCELLANEOUS

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Aortic Balloon Pump Monitoring	N	N	N	N	N
Assisted Delivery	Y	Y	Y	Y	Y
Capillary Blood Sampling	Y	Y	Y	Y	Y
Diagnostic Interpretation - Blood Glucose [3]	Y	Y	Y	Y	Y
Diagnostic Interpretation - Blood Lactate [3]	N	N	Y	Y	Y
Dressing/Bandaging	Y	Y	Y	Y	Y
Esophageal Temperature Probe for TIH	N	N	N	VO	Y
Eye Irrigation Noninvasive	Y	Y	Y	Y	Y
Eye Irrigation Morgan Lens	N	N	N	Y	Y
Maintenance of Intracranial Monitoring Lines	N	N	N	N	N
~~MAST/Pneumatic Anti-Shock Garment~~	~~Y~~	~~Y~~	~~Y~~	~~Y~~	~~Y~~
Physical examination	Y	Y	Y	Y	Y
Restraints - Verbal	Y	Y	Y	Y	Y
Restraints - Physical	Y	Y	Y	Y	Y
Restraints - Chemical	N	N	N	Y	Y
Urinary Catheterization - Initiation	N	N	N	N	Y
Urinary Catheterization - Maintenance	Y	Y	Y	Y	Y
Venous Blood Sampling - Obtaining	N	Y	Y	Y	Y

APPENDIX B

PREHOSPITAL

FORMULARY OF MEDICATIONS ALLOWED

****

TABLE B.6 - ENDOCRINE AND METABOLISM

Medications	EMT	EMT-IV	AEMT	EMT-I	P
IV Dextrose	N	Y	Y	Y	Y
Glucagon	N	N	Y	Y	Y
Oral glucose	Y	Y	Y	Y	Y
Thiamine	N	N	N	N	Y
Corticosteroid – Solucortef	N	N	N	VO	Y

TABLE B.7 – GASTROINTESTINAL MEDICATIONS

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Anti-nausea – Droperidol	N	N	N	VO	Y
Anti-nausea – Metoclopramide	N	N	N	VO	Y
Anti-nausea – Ondansetron ODT	~~VO~~Y	~~VO~~Y	Y	Y	Y
Anti-nausea – Ondansetron IM/IVP	N	~~N~~ Y	Y	Y	Y
Anti-nausea - Prochlorperazine	N	N	N	N	Y
Anti-nausea - Promethazine	N	N	N	VO	Y
Decontaminant - Activated charcoal	Y	Y	Y	Y	Y
Decontaminant - Sorbitol	Y	Y	Y	Y	Y

****

TABLE B.9 - RESPIRATORY AND ALLERGIC REACTION MEDICATIONS

Medications	EMT	EMT-IV	AEMT	EMT-I	P

Antihistamine - Diphenhydramine	N	N	VO	VO	Y
Bronchodilator - Anticholinergic - Atropine (aerosol/nebulized)	N	N	N	VO	Y
Bronchodilator - Anticholinergic - Ipratropium	N	N	VO	VO	Y
Bronchodilator - Beta agonist - Albuterol	~~VO~~Y	~~VO~~Y	~~VO~~Y	~~VO~~ Y	Y
Bronchodilator - Beta agonist - L-Albuterol	VO	VO	VO	VO	Y
Bronchodilator - Beta agonist - Metaproterenol	N	N	N	VO	Y
Corticosteroid - Dexamethasone	N	N	N	~~N~~VO	Y
Corticosteroid - Hydrocortisone	N	N	N	VO	Y
Corticosteroid - Methylprednisolone	N	N	N	VO	Y
Corticosteroid – Prednisone	N	N	N	~~N~~VO	Y
Epinephrine 1:1,000 IM or SQ Only	~~N~~ Y	~~N~~ Y	~~VO~~ Y	~~VO~~ Y	Y
Epinephrine IV Only	N	N	N	VO	Y
Epinephrine Auto-Injector	Y	Y	Y	Y	Y
Magnesium Sulfate - bolus infusion only	N	N	N	N	Y
Racemic Epinephrine	N	N	N	VO	Y
Short Acting Bronchodilator meter dose inhalers (MDI) (Patient assisted)	VO	VO	VO	Y	Y
Short Acting Bronchodilator meter dose inhalers (MDI)	VO	VO	VO	VO	Y
Terbutaline	N	N	N	N	Y

****

SECTION 15 - INTERFACILITY TRANSPORT

****

15.4 The hemodynamically unstable patient or patient who may require Intensive Care Unit level of treatment, regardless if coming from an Intensive Care Unit, ~~(typically from an Intensive Care setting)~~ who requires special monitoring (e.g. central venous pressure, intracranial pressure), multiple cardioactive/vasoactive medications, or specialized critical care equipment (i.e. intra-aortic balloon pump) should remain under the care of an experienced critical care practitioner, and every attempt should be made to transport that patient while maintaining the appropriate level of care. The capabilities of the institution, the capabilities of the transporting agency and, most importantly, the safety of the patient should be considered when making transport decisions.

****

SECTION 16 - CRITICAL CARE

****

Appendix F – FORMULARY OF MEDICATIONS ALLOWED

TABLE F.1 – ~~RAPID SEQUENCE INTUBATION AND/OR MAINTENANCE OF ALREADY INTUBATED PATIENTS~~ CRITICAL CARE FORMULARY

Medications	P-CC
acetylcysteine (Mucomyst)	Y
alteplase (Activase)	Y
antibiotics	Y
bilvalirudin (Angiomax)	Y
diazepam (Valium)	Y
dobutamine (Dobutamine)	Y
esmolol (Brevibloc)	Y
etomidate (Amidate)	Y
fentanyl (Sublimaze)	Y
fosphenytoin (Cerebyx)	Y
ketamine (Ketalar)	Y
labetalol (Normodyne)	Y
levitiracetam (Keppra)	Y
metoprolol (Lopressor)	Y
midazolam (Versed)	Y
morphine sulfate	Y

norepinephrine (Levophed)	Y
phenytoin (Dilantin)	Y
propofol (Diprivan) – ~~maintenance only~~	Y
rocuronium (Zemuron)	Y
succinylcholine (Anectine)	Y
TNKase (Tenecteplase)	Y
tPA infusion	Y
vecuronium (Norcuron)	Y

~~TABLE F.2 – CRITICAL CARE INTERFACILITY FORMULARY~~

~~**Medications**~~	~~**P-CC**~~
~~acetylcysteine (Mucomyst)~~	~~Y~~
~~alteplase (Activase)~~	~~Y~~
~~bilvalirudin (Angiomax)~~	~~Y~~
~~dobutamine (Dobutamine)~~	~~Y~~
~~esmolol (Brevibloc)~~	~~Y~~
~~fosphenytoin (Cerebyx)~~	~~Y~~
~~labetalol (Normodyne)~~	~~Y~~
~~levitiracetam (Keppra)~~	~~Y~~
~~metoprolol (Lopressor)~~	~~Y~~
~~norepinephrine (Levophed)~~	~~Y~~
~~phenytoin (Dilantin)~~	~~Y~~
~~TNKase (Tenecteplase)~~	~~Y~~
~~tPA infusion maintenance~~	~~Y~~

Section 17 – Community Paramedicine

17.1 In addition to the medical skills and acts within the scope of practice of a paramedic contained within Appendices A, B, C, and D, a P-CP may perform the out-of-hospital medical services contained within this section, Appendix G, under the direction of a CIHCS Agency medical director while providing community integrated health care services.

17.1.1 Additions to these out-of-hospital medical services allowed cannot be delegated unless a waiver had been granted as described in Section 11 of these rules.

17.1.2 It is understood that these out-of-hospital medical services may not be addressed in the National EMS Education Standards for Paramedics. As such, it is the joint responsibility of the CIHCS Agency medical director and P-CPs performing these services to obtain appropriate additional training needed to safely and effectively utilize and monitor these interventions in the out-of-hospital environment.

17.2 A CIHCS Agency medical director may limit the scope of a P-CP. A P-CP may decline to provide out-of-hospital medical services to any individual that requires a level of care outside of their defined scope of practice or that the P-CP believes is beyond their capabilities.

17.3 The duties of a CIHCS Agency medical director responsible for supervision and authorization of a P-CP, in addition to those located at 6 CCR 1011-3, Section 5.2, shall include:

17.3.1 Be actively involved in the provision of community integrated health care services in the community served by the CIHCS Agency. Involvement does not require that a physician have such experience prior to becoming a medical director, but does require such involvement during the time that he or she acts as a CIHCS medical director. Active involvement in the community could include, by way of example and not limitation, those inherent, reasonable and appropriate responsibilities of a medical director to interact and as needed collaborate with the community served by the CIHCS Agency, the hospital community, the public safety agencies, home care, hospice, and the medical community, and should include other aspects of liaison oversight and communication normally expected in the supervision of CIHCS providers.

17.3.2 Be actively involved on a regular basis with the P-CP being supervised. Involvement does not require that a physician have such experience prior to becoming a medical director, but does require such involvement during the time that he or she acts as a medical director. Involvement could include, by way of example and not limitation, involvement in continuing education, audits and protocol development. Passive or negligible involvement with the CIHCS Agency and supervised P-CP does not meet this requirement.

17.3.3 In conjunction with the CIHCS Agency administrator, develop and implement quality management policy for the CIHCS Agency and P-CP that includes consumer chart reviews in order to determine that appropriate assessments, referrals, documentation, and communication are occurring between the consumer's care providers, P-CPs, and the consumer.

17.3.4 Ensure that all issued protocols are appropriate for the skill level of each authorized P-CP to whom the performance of medical acts is delegated and are compliant with accepted standards of medical practice.

17.3.5 Develop, implement, and annually review protocols, guidelines, and standing orders regarding medical supervision, consultation requirements, and follow up care by other medical professionals. CIHCS Agency medical directors will ensure that P-CPs have adequate clinical knowledge of, and are competent in, out-of-hospital medical services performed on behalf of the CIHCS Agency. These duties and operations may be delegated to other physicians or other qualified health care professionals designated by the medical director. However, the CIHCS Agency medical director shall retain ultimate authority and responsibility for the monitoring and supervision, for establishing protocols and standing orders and for the competency of the performance of authorized medical acts of P-CP providers.

17.3.6 Oversee the ongoing training and education programs for P-CP personnel for the provision of out-of-hospital medical services. Ensure the competence of the P-CP under his or her supervision in all skills, procedures and medications authorized.

17.3.7 Notify the department within fourteen business days of the cessation of duties as the CIHCS Agency's medical director;

17.3.8 In collaboration with the CIHCS Agency administrator, designate through policy when the CIHCS Agency medical director is unavailable, a backup for medical direction in accordance with the requirements of 6 CCR 1011-3, Section 5.2.

17.3.9 Ensure that medical direction is available at all appropriate times as determined by the CIHCS Agency policy.

17.3.10 Provide evaluation, treatment, and transportation guidelines and protocols for non-urgent CIHCS Agency consumers.

17.3.11 In conjunction with the CIHCS consumer's care provider, if applicable, develop, monitor, and evaluate consumer service plans.

17.3.12 In conjunction with the CIHCS consumer's care provider(s), if applicable, and the P-CP develop and implement a discharge summary as part of each consumer's service plan.

Appendix G – OUT-OF-HOSPITAL MEDICAL SERVICES ALLOWED

G.1 An initial assessment of the patient and any subsequent assessments, care coordination, resource navigation, as needed, in an out-of-hospital setting over one or more visits.

G.2 Patient education that may include, but is not limited to, a patient's family or caregiver.

G.3 Provide allowable services as an employee or contractor of a Community Assistance Referral and Education Services (CARES) Program, as set forth in Section 25.3.5.1203(3), C.R.S.

G.3 Medical interventions, as set forth in a patient service plan:

Table G.1

Intervention	P-CP
Access central lines, indwelling venous ports, peritoneal dialysis catheters, or percutaneous tubes	Y
Assist with home mechanical ventilators	Y
Complex wound closure (suturing, steri strips, adhesive glue, staples)	N
Ostomy care	Y
Simple wound closure (limited to dressings, bandages, butterfly closures)	Y
Simple wound care (monitor progress, simple dressing change, wet-to-dry dressing change, suture removal)	Y
Ultrasound - assist procedures	Y
Ultrasound - diagnosis	N

G.4 Assist with the inventory, compliance, and administration of, or may directly administer, specialized medications prescribed to the individual by a prescribing physician under a care plan. The route of administration must be within the provider's scope as listed in Appendix A and this Appendix G.

G.5 Gather laboratory and diagnostic data for POCT

Table G.2

Sites	P-CP
Indwelling ports or drains	Y
Nasal	Y
Oral	Y
Skin	Y
Urine	Y
Stool	Y

G.6 Vaccinations as part of a consumer service plan.