COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

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

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

Date: August 21, 2019

Subject: Request for Rulemaking Hearing concerning 6 CCR 1015-2 Rules Pertaining to the Implementation of Cardiopulmonary Resuscitation (CPR) Directives by Emergency Medical Service Providers

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In 1992 the General Assembly enacted Section 15-18.6-101, *et seq.*, C.R.S., for the purpose of establishing who may execute, and who may comply with and implement, a cardiopulmonary resuscitation (CPR) directive. Section 15-18.6-103, C.R.S., specifically requires the Board of Health to promulgate rules and protocols for Emergency Medical Service providers when implementing CPR directives. These rules were last revised in 2010.

Pursuant to the Section 24-4-103.3, C.R.S., and Department policy, the Department must review its rules every five to seven years to ensure their continued efficiency, effectiveness, and essentialness. Accordingly, in 2017 the Department undertook the review of existing 6 CCR 1015-2, Rules Pertaining to the Implementation of Cardiopulmonary Resuscitation (CPR) Directives by Emergency Medical Service Personnel.

With the exception of one technical amendment to the tissue donation provision in Section 15-18.6-103(2)(i), C.R.S., the General Assembly has not modified this controlling statutory provision since the last rule review, nor have State courts issued any relevant construing case law. Consequently the intent, purpose, and operation of the statute, and of these rules, have not been affected. Therefore, the Department is proposing to incorporate only non-substantive clarifying or conforming changes that update terminology, definitions, and a statutory citation. SEMTAC has approved the Department's recommendation not to form a work group to propose these non-substantive revisions to the existing rules, and the Department has distributed these proposed rules to interested stakeholders for comment in order to conduct a transparent rulemaking process.

The Department submitted the proposed rules to the State Emergency Medical and Trauma Services Advisory Council (SEMTAC) for review and discussion on July 11, 2019. On that date, SEMTAC recommended the proposed revisions be presented by the Department to the Board for a rulemaking hearing in October 2019. (The July 11, 2019 SEMTAC letter is attached).

The Department has become aware of Senate Bill 19-073 concerning a statewide system of advance medical directives that was signed into law and became effective August 2, 2019. This law creates a statewide system that will allow qualified individuals, including emergency medical service providers, to access CPR directives electronically. Section 25-54-102(3), C.R.S., will operate to immunize EMS providers from civil or criminal liability if they comply with a CPR directive accessed from the electronic system. The current proposed rule that SEMTAC has approved contains a similar immunity provision in section 5.1 that does not apply to the future statewide electronic system. The Department plans to seek SEMTAC's approval on October 3, 2019 of an amendment to proposed section 5.2 that includes this new statutory immunity provision.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
6 CCR 1015-2, Rules Pertaining to the Implementation of Cardiopulmonary Resuscitation (CPR) Directives by Emergency Medical Service Providers

Basis and Purpose.

Section 15-18.6-103(1), C.R.S., requires the Board of Health to promulgate rules and protocols that implement CPR Directives by emergency medical service (EMS) providers. The CPR directives authorized in this statute are specific to CPR directives implemented by EMS providers; the rule does not limit an individual's ability to enter into other forms of CPR directives.

The rules must include:

- Uniform methods of identifying individuals who have executed a CPR directive;
- Methods for quickly identifying individuals who have executed a CPR directive;
- Controlled distribution of the methods of identifying persons who have executed a CPR directive; and
- The following information concerning the person that is the subject of the CPR directive:
  - Name, date of birth, and sex;
  - Eye and hair color;
  - Race or ethnic background;
  - If applicable, the name of the hospice program in which the person is enrolled;
  - Signature or mark, or that of the authorized agent, and the date the directive was signed;
  - The directive concerning whether or not CPR shall be administered, countersigned by the person's attending physician; and
  - The directive concerning tissue donation as authorized by Section 15-18.6-103(2)(i), C.R.S., and the Revised Uniform Anatomical Gift Act, Section 15-19-201, *et seq.*, C.R.S.

The proposed amendments in this rulemaking process are either non-substantive conforming or clarifying changes that update terminology, definitions, and statutory citations. Consequently SEMTAC approved the Department's recommendation not to form a work group to propose revisions to the existing rules. Nevertheless the Department has distributed these proposed rules to interested stakeholders for comment in order to conduct a transparent rulemaking process.

As proposed, the Department requests the Board to consider the following revisions:

- The term "Emergency Medical Service Personnel" has been revised to "Emergency Medical Service Provider" to reflect the profession's current terminology. (See, e.g., Section 1.2, 1.5, 2.11, 3.1.3, 4.1.1, 5.1). Further, the definition for "Emergency Medical Service Provider has been modified to align with the definition used in associated EMS rules and statutes. (See Section 2.11)

- The definition for the term "Palliative Services" has been revised to conform with the definition of "palliative care" as used in associated health facility rules. (See Section 2.13)

- The obsolete statutory citation for The Revised Uniform Anatomical Gift Act is eliminated and replaced with the current statutory citation (See Section 3.1.1.g)

- Section 4.2.3 of the existing rule is duplicative of Section 3.2.1 with the exception of one sentence that places limitations upon family or bystanders to revoke a CPR directive. The proposed rule relocates this last sentence to new Section 3.2.2 and strikes the balance of duplicative Section 4.2.3. (See Sections 3.2.1 and 3.2.2)

- The current rule includes an immunity provision. This provision is updated to acknowledge Section 25-54-102(3), C.R.S. This new statutory provision was included in SB 19-073 and took effect on August 2, 2019. Section 25-54-102(3), C.R.S., provides, in pertinent part:

> Emergency medical service personnel, an individual health care provider, a health care facility, or any other person or entity that complies with an advance health care directive accessed from the system is not subject to civil or criminal liability or regulatory sanction for action taken in accordance with the advance health care directive, unless the person or entity has actual knowledge of an advance health care directive…that is uploaded to the system.

Specific Statutory Authority.

Statutes that require or authorize rulemaking: Section 15-18.6-103, C.R.S.

Statutes that inform or direct the rule content:

- Section 15-18.6-103(2)(i), C.R.S., pertains to CPR directive protocols concerning tissue donation.
- Section 15-19-201, *et seq.*, C.R.S., pertain to proxy decision-makers involved in CPR directives.
- Section 25-54-101, *et seq.*, C.R.S., pertain to a new statewide electronic system for advance health care directives, including cardiopulmonary resuscitation (CPR) directives, that allow qualified EMS providers to access and comply with electronically uploaded CPR directives. The statute confers immunity upon EMS providers who comply in good faith with such directives accessed from the statewide system.
- The balance of the rule is informed or directed by Section 15-18.6-101, *et seq.*, C.R.S.

Is this rulemaking due to a change in state statute?

_____ Yes, the bill number is _____. Rules are ___ authorized ___ required.

___X__ No

Does this rulemaking include proposed rule language that incorporate materials by reference?

_____ Yes ___ URL

__X___ No

Does this rulemaking include proposed rule language to create or modify fines or fees?

_____ Yes

__X___ No

Does the proposed rule language create (or increase) a state mandate on local government?

_X__ No.

- The proposed rule does not require a local government to perform or increase a specific activity for which the local government will not be reimbursed;
- The proposed rule requires a local government to perform or increase a specific activity because the local government has opted to perform an activity, or;
- The proposed rule reduces or eliminates a state mandate on local government.

REGULATORY ANALYSIS
Amendments to
6 CCR 1015-2, Rules Pertaining to the Implementation of Cardiopulmonary Resuscitation (CPR) Directives by Emergency Medical Service Providers

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

The proposed rule amendments are non-substantive clarifying and conforming changes that do not alter how classes of persons are affected by the existing rule. To the extent these non-substantive revisions impact any groups, they are the two primary classes to which the rule is intended to apply:

Group of persons/entities Affected by the Proposed Rule	Size of the Group	Relationship to the Proposed Rule Select category: C/CLG/S/B
EMS Providers	Approximately 18,000	C
Individuals who execute CPR Directives	Unknown	B

While all are stakeholders, groups of persons/entities connect to the rule and the problem being solved by the rule in different ways. To better understand those different relationships, please use this relationship categorization key:

C = individuals/entities that implement or apply the rule.
CLG = local governments that must implement the rule in order to remain in compliance with the law.
S = individuals/entities that do not implement or apply the rule but are interested in others applying the rule.
B = the individuals that are ultimately served, including the customers of our customers. These individuals may benefit, be harmed by or be at-risk because of the standard communicated in the rule or the manner in which the rule is implemented.

More than one category may be appropriate for some stakeholders.

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.

The proposed rule amendments are non-substantive clarifying and conforming changes.

The noneconomic impact that these proposed revisions will have upon EMS providers and individuals who execute CPR directives is that the updated terminology, statutory references, and definitions will align this rule with current practice, law, and other associated rules. The proposed revisions result in regulatory consistency and minimize

confusion concerning implementation of this rule by EMS providers and State-registered Emergency Medical Responders (formerly identified as "first responders"). Clarifying the rule supports EMS providers in making swift and accurate determinations regarding the identification of individuals who have executed CPR directives.

These proposed rule amendments will not result in a quantitative or economic impact upon EMS providers and individuals who execute CPR directives.

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.

   A. Anticipated CDPHE personal services, operating costs or other expenditures: N/A

      Anticipated CDPHE Revenues: N/A

   B. Anticipated personal services, operating costs or other expenditures by another state agency: N/A

      Anticipated Revenues for another state agency: N/A

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

   No benefit results from the delay of updating the terms, citations and language to align with current practice.

   Along with the costs and benefits discussed above, the proposed revisions:

   _x_ Comply with a statutory mandate to promulgate rules.
   _x_ Comply with federal or state statutory mandates, federal or state regulations, and department funding obligations.
   ___ Maintain alignment with other states or national standards.
   _x_ Implement a Regulatory Efficiency Review (rule review) result
   _x_ Improve public and environmental health practice.
   ___ Implement stakeholder feedback.

   Advance the following CDPHE Strategic Plan priorities (select all that apply):

1. Reduce Greenhouse Gas (GHG) emissions economy-wide from 125.716 million metric tons of CO2e (carbon dioxide equivalent) per year to 119.430 million metric tons of CO2e per year by June 30, 2020 and to 113.144 million metric tons of CO2e by June 30, 2023. ___ Contributes to the blueprint for pollution reduction ___ Reduces carbon dioxide from transportation ___ Reduces methane emissions from oil and gas industry ___ Reduces carbon dioxide emissions from electricity sector
2. Reduce ozone from 83 parts per billion (ppb) to 80 ppb by June 30, 2020 and 75 ppb

by June 30, 2023.

___ Reduces volatile organic compounds (VOC) and oxides of nitrogen (NOx) from the oil and gas industry.
___ Supports local agencies and COGCC in oil and gas regulations.
___ Reduces VOC and NOx emissions from non-oil and gas contributors

3. Decrease the number of Colorado adults who have obesity by 2,838 by June 30, 2020 and by 12,207 by June 30, 2023.

___ Increases the consumption of healthy food and beverages through education, policy, practice and environmental changes.
___ Increases physical activity by promoting local and state policies to improve active transportation and access to recreation.
___ Increases the reach of the National Diabetes Prevention Program and Diabetes Self-Management Education and Support by collaborating with the Department of Health Care Policy and Financing.

4. Decrease the number of Colorado children (age 2-4 years) who participate in the WIC Program and have obesity from 2120 to 2115 by June 30, 2020 and to 2100 by June 30, 2023.

___ Ensures access to breastfeeding-friendly environments.

5. Reverse the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023.

___ Reverses the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023.
___ Performs targeted programming to increase immunization rates.
___ Supports legislation and policies that promote complete immunization and exemption data in the Colorado Immunization Information System (CIIS).

6. Colorado will reduce the suicide death rate by 5% by June 30, 2020 and 15% by June 30, 2023.

___ Creates a roadmap to address suicide in Colorado.
___ Improves youth connections to school, positive peers and caring adults, and promotes healthy behaviors and positive school climate.
___ Decreases stigma associated with mental health and suicide, and increases help-seeking behaviors among working-age males, particularly within high-risk industries.
___ Saves health care costs by reducing reliance on emergency departments and connects to responsive community-based resources.

7. The Office of Emergency Preparedness and Response (OEPR) will identify 100% of jurisdictional gaps to inform the required work of the Operational Readiness Review by June 30, 2020.

___ Conducts a gap assessment. ___ Updates existing plans to address identified gaps. ___ Develops and conducts various exercises to close gaps.
8. For each identified threat, increase the competency rating from 0% to 54% for outbreak/incident investigation steps by June 30, 2020 and increase to 92% competency rating by June 30, 2023. ___ Uses an assessment tool to measure competency for CDPHE's response to an outbreak or environmental incident. ___ Works cross-departmentally to update and draft plans to address identified gaps noted in the assessment. ___ Conducts exercises to measure and increase performance related to identified gaps in the outbreak or incident response plan.
9. 100% of new technology applications will be virtually available to customers, anytime and anywhere, by June 20, 2020 and 90 of the existing applications by June 30, 2023. ___ Implements the CDPHE Digital Transformation Plan. ___ Optimizes processes prior to digitizing them. ___ Improves data dissemination and interoperability methods and timeliness.
10. Reduce CDPHE's Scope 1 & 2 Greenhouse Gas emissions (GHG) from 6,561 metric tons (in FY2015) to 5,249 metric tons (20% reduction) by June 30, 2020 and 4,593 tons (30% reduction) by June 30, 2023. ___ Reduces emissions from employee commuting ___ Reduces emissions from CDPHE operations
11. Fully implement the roadmap to create and pilot using a budget equity assessment by June 30, 2020 and increase the percent of selected budgets using the equity assessment from 0% to 50% by June 30, 2023. ___ Used a budget equity assessment

_x__ Advance CDPHE Division-level strategic priorities.

- The proposed revision ensures the rules are current and aligned with associated statutory and regulatory law.

Costs and benefits of inaction not previously discussed include: N/A

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

These ministerial changes do not impact cost, nor do they impose any additional burdens upon EMS providers and individuals who execute CPR directives.

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

SEMTAC approved the Department's request to make ministerial amendments to the rules without a formal working group. The Department recognized, and SEMTAC agreed, that convening a formal working group for the purpose of making non-substantive conforming and complying amendments would have been an ineffective and poor use of stakeholder time.

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.

N/A

STAKEHOLDER ENGAGEMENT
for Amendments to
6 CCR 1015-2, Rules Pertaining to the Implementation of Cardiopulmonary Resuscitation (CPR) Directives by Emergency Medical Service Providers

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 proposed amendments are either non-substantive conforming or clarifying changes that update terminology, definitions, and statutory citations. No formal work group or meetings were necessary. The Department distributed these proposed rules to interested stakeholders for comment in order to conduct a transparent rulemaking process.

Organization	Representative Name and Title (if known)
State Emergency Medical and Trauma Services Advisory Council (SEMTAC)	
Regional Emergency Medical and Trauma Services Advisory Councils (RETAC)	
Emergency Medical Services Association of Colorado	

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.

No major factual or policy issues were encountered.

Apart from SEMTAC's approval, the Department received no comments or other input from these stakeholder groups. If this matter is set for hearing, the draft rulemaking documents will be posted on the Department's website and the department will review any stakeholder feedback received.

Please identify the determinants of health or other health equity and environmental justice considerations, values or outcomes related to this rulemaking. Overall, after considering the benefits, risks and costs, the proposed rule:

Select all that apply.

	Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.	X	Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.
	Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.		Reduces occupational hazards; improves an individual's ability to secure or maintain employment; or, increases stability in an employer's workforce.
	Improves access to food and healthy food options.		Reduces exposure to toxins, pollutants, contaminants or hazardous substances; or ensures the safe application of radioactive material or chemicals.
X	Improves access to public and environmental health information; improves the readability of the rule; or, increases the shared understanding of roles and responsibilities, or what occurs under a rule.		Supports community partnerships; community planning efforts; community needs for data to inform decisions; community needs to evaluate the effectiveness of its efforts and outcomes.
	Increases a child's ability to participate in early education and educational opportunities through prevention efforts that increase protective factors and decrease risk factors, or stabilizes individual participation in the opportunity.		Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
	Monitors, diagnoses and investigates health problems, and health or environmental hazards in the community.	X	Ensures a competent public and environmental health workforce or health care workforce.
	Other:_____ _____		Other:_____ _____

COLORADO
Department of Public Health & Environment

State Emergency Medical and Trauma Services Advisory Council

July 11, 2019

Mr. Matthew VanAuken, 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. VanAuken:

At the July 11, 2019, 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 CCR 1015-2 were reviewed and discussed. These rule revisions were non-substantive in nature and included standardized and updated formatting for consistency across current rules.

A motion was made and passed to approve the proposed revisions.

Sincerely yours,

Dr. Charles W. Mains
SEMTAC Chairman

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

~~RULES PERTAINING TO THE~~ IMPLEMENTATION OF CARDIOPULMONARY RESUSCITATION (CPR) DIRECTIVES BY EMERGENCY MEDICAL SERVICE ~~PERSONNEL~~ PROVIDERS

6 CCR 1015-2

Adopted by the Board of Health on _____, 2019. Effective _____, 2019.

Section 1 - Purpose and Authority

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1.2 Section 15-18.6-103, C.R.S., directs the State Board of Health to promulgate rules and protocols for implementation of CPR Directives by emergency medical service ~~personnel~~ PROVIDERS.

***

1.5 A CPR Directive shall not preclude evaluation by emergency medical service ~~personnel~~ PROVIDERS for appropriate and available medical and palliative services.

***

1.7 It is the intention of these regulations to protect the welfare of patients and to respect the appropriate exercise of professional judgments made in good faith by emergency medical service ~~personnel~~ PROVIDERS.

Section 2 - Definitions

***.

2.3 “Authorized Agent” means any person who, pursuant to the laws of this state or any other state, is authorized to make medical treatment decisions concerning the withholding of CPR for an adult who lacks decisional capacity or for a minor, pursuant to Section 15-18.6-102, C.R.S. “Authorized Agent” includes but is not limited to a court-appointed guardian, an agent with healthcare decision-making authority appointed in a power of attorney, and/or a proxy DECISION-MAKER selected pursuant to Section 15-18.5-103, C.R.S.

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2.11 ~~“Emergency Medical Service (EMS) Personnel” means any emergency medical technician at any level who is certified or licensed by the Department of Public Health and Environment. “EMS Personnel” also includes a first responder certified by the Department of Public Safety, in accordance with Section 24-33.5-1203, C.R.S.~~

“EMERGENCY MEDICAL SERVICE (EMS) PROVIDER” MEANS AN INDIVIDUAL WHO HOLDS A VALID EMERGENCY MEDICAL SERVICE PROVIDER CERTIFICATE OR LICENSE ISSUED BY THE DEPARTMENT AND INCLUDES EMERGENCY MEDICAL TECHNICIAN, ADVANCED EMERGENCY MEDICAL TECHNICIAN, EMERGENCY MEDICAL TECHNICIAN INTERMEDIATE, AND PARAMEDIC. “EMS PROVIDER” ALSO INCLUDES AN EMERGENCY MEDICAL RESPONDER (EMR) REGISTERED WITH THE DEPARTMENT, IN ACCORDANCE WITH SECTION 25-3.5-1101, *ET SEQ.*, C.R.S.

***

2.13 ~~"Palliative" refers to measures and treatments intended for relief of pain and suffering including, but not limited to, medication by any route, positioning, oxygen, suction, and manual treatment of airway obstruction as needed for comfort.~~

"PALLIATIVE SERVICES" MEANS SPECIALIZED MEDICAL CARE FOR PEOPLE WITH SERIOUS ILLNESSES THAT IS FOCUSED ON PROVIDING COMFORT AND RELIEF FROM THE SYMPTOMS, PAIN, AND STRESS OF SERIOUS ILLNESS, WHATEVER THE DIAGNOSIS. THESE SERVICES ARE APPROPRIATE AT ANY AGE, AND AT ANY STAGE IN A SERIOUS ILLNESS. UNLESS OTHERWISE INDICATED, THE TERM "PALLIATIVE" IS SYNONYMOUS WITH THE TERMS "COMFORT CARE", "SUPPORTIVE CARE", AND SIMILAR TERMINOLOGY.

****

Section 3 - General Provisions for CPR Directives

3.1 CPR Directive

3.1.1 A CPR Directive, executed pursuant to these rules, shall contain the following information:

a) name, date of birth, sex, eye and hair color, and race or ethnic background;

b) if applicable, the name of the hospice program in which the individual is enrolled;

c) the directive concerning the administration of CPR to the individual;

d) the signature or mark of the individual or authorized agent;

e) the date on which the CPR Directive was signed by the individual or authorized agent;

f) the name, address, telephone number, and signature of the attending physician; and

g) a written statement and signature(s) indicating a decision regarding tissue donation upon a patient's death, consistent with the R~~r~~evised U~~u~~niform A~~a~~natomical G~~g~~ift A~~a~~ct, Section ~~12-34-101~~ 15-19-201, ~~C.R.S.,~~ et seq., C.R.S.~~, then in effec~~t. The written statement may be in the form authorized in Section 15-18.6-103, C.R.S.

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3.1.3 Any CPR Directive that is apparent and immediately available to EMS ~~personnel~~ PROVIDER and which directs that resuscitation not be attempted constitutes lawful authority to withhold or discontinue CPR.

***

3.2 Revocation of a CPR Directive

3.2.1 A CPR Directive may be revoked at any time by the ~~individual~~ DECLARANT who is the subject of such directive or by the authorized agent for th~~eat individual~~ DECLARANT. However, only those CPR Directives executed originally by a guardian, agent, or proxy decision maker may be revoked by a guardian, agent, or proxy decision maker.

3.2.2 FAMILY OR BYSTANDERS, WHO ARE NOT THE DECLARANT OR THE DECLARANT'S AUTHORIZED AGENT, MAY NOT REVOKE A CPR DIRECTIVE.

Section 4 - General Protocol for Implementation of CPR Directives

4.1 Purpose

4.1.1 To provide guidance for the implementation of CPR Directives by EMS ~~personnel~~ PROVIDERS.

4.2. General

***

4.2.2 An individual with a CPR Directive shall receive evaluation by EMS ~~personnel~~ PROVIDERS and be provided appropriate and available palliative treatment and measures.

~~4.2.3 A CPR Directive may be revoked at any time by the individual who is the subject of such directive or by the authorized agent for that individual. However, only those CPR Directives executed originally by a guardian, agent or proxy decision maker may be revoked by a guardian, agent or proxy decision maker. Family or bystanders who are not the declarant may not revoke a CPR Directive.~~

4.2.~~4~~3 A valid CPR Directive constitutes lawful authority to withhold or discontinue CPR. EMS ~~personnel~~ PROVIDERS shall comply with an individual's CPR Directive that is apparent and immediately available.

a) "CPR" includes, but is not limited to, artificial ventilation, chest compression, delivering electric shock, placing tubes in the airway to assist breathing, or other basic and advanced resuscitative therapies.

b) A valid CPR Directive that has been photocopied, scanned, faxed or otherwise reproduced shall be honored.

4.2.~~5~~4 In the absence of a CPR Directive, consent to CPR is presumed.

4.3 Procedure

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4.3.3 When presented with any valid CPR Directive, EMS ~~personnel~~ PROVIDERS shall not attempt to resuscitate that individual. If CPR has been initiated, it shall be discontinued. Local medical direction and prehospital protocols shall be followed.

4.3.4 Nothing in these rules shall be construed to require EMS ~~personnel~~ PROVIDERS to initiate CPR in the absence of a CPR Directive.

Section 5.0 - Immunity

5.1 Any EMS ~~personnel~~ PROVIDER~~,~~ who, in good faith, complies with a CPR Directive, shall not be subject to civil or criminal liability or regulatory sanction for such compliance, pursuant to Section 15-18.6-104, C.R.S.

5.2 ANY EMS PROVIDER WHO, IN GOOD FAITH, COMPLIES WITH A CPR DIRECTIVE ACCESSED VIA THE STATEWIDE ELECTRONIC SYSTEM FOR ADVANCE HEALTH CARE DIRECTIVES PURSUANT TO SECTION 25-54-101, *ET SEQ*. C.R.S., SHALL NOT BE SUBJECT TO CIVIL OR CRIMINAL LIABILITY OR REGULATORY SANCTION FOR ANY ACTION TAKEN UNLESS THE EMS PROVIDER HAS ACTUAL KNOWLEDGE OF A CPR DIRECTIVE PROPERLY EXECUTED AFTER THE DATE OF THE ADVANCE HEALTH CARE DIRECTIVE IN THE ELECTRONIC SYSTEM, PURSUANT TO SECTION 25-54-102(3), C.R.S.