COLORADO
Department of Public Health & Environment

To: Eric France, M.D., M.S.P.H., Chief Medical Officer, Colorado Department of Public Health and Environment

From: Donnie Woodyard, Jr., Chief, EMTS Branch

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

Date: October 22, 2020

Subject: Rulemaking Hearing by the Chief Medical Officer concerning 6 CCR 1015-3, Chapter Two, Rules Pertaining to EMS Practice and Medical Director Oversight

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Historically Emergency Medical Service (EMS) providers were limited to practicing in prehospital settings. The provider's scope of practice was defined by the medical acts he or she could perform at the site of an emergency, during emergency transport and the interfacility transport of patients.

In 2016, the legislature passed SB 16-069 to allow certain types of medical providers to perform out-of-hospital services in a residential setting while employed and medically directed by Community Integrated Health Care Services (CIHCS) agencies. The legislation also created a new Community Paramedic (P-CP) endorsement that allows a P-CP to provide non-emergency in-scope services in home settings upon completion of specialized education and training. For the first time, this legislation expanded the scope of practice of EMS providers to allow this one restricted P-CP classification to perform additional medical acts outside of an emergent prehospital setting.

Now, with the passage of SB 19-052, the General Assembly has further expanded the settings in which <u>all</u> EMS providers may perform medical acts within their scopes of practice. As enacted, this legislation mandates that, with certain required safeguards, EMS providers may perform their full complement of medical acts within their applicable scopes of practice in a clinical setting, as well as in the prehospital setting. The new law now ties the medical acts that EMS providers are authorized to perform with the setting in which they may perform them. These proposed rules implement the expanded scope of practice for all EMS providers.

The proposed rules also update the medical acts EMS providers may perform and the medications they may administer. The modifications align Colorado's rules with the national scope of practice adopted by the National Registry of Emergency Medical Technicians (NREMT), reflect the current standard of EMS practice, and recognize EMS's role in public health initiatives such as Hepatitis A vaccinations and COVID-19 testing.

Pursuant to Section 25-3.5-206(4) (a), C.R.S., the Chief Medical Officer is responsible for adopting rules concerning EMS providers' scope of practice. The Division respectfully requests Chief Medical Officer France to adopt the proposed rules with a January 1, 2021 effective date.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to 6 CCR 1015-3, Chapter Two,
Rules Pertaining to EMS Practice and Medical Director Oversight

Basis and Purpose.

Section 25-3.5-201, *et seq.*, C.R.S., the statute that sets forth Colorado EMS providers' roles and responsibilities has, until recently, restricted EMS providers to practicing within their scope in the emergent prehospital setting only.[1] With the enactment of Senate Bill 19-052 on April 17, 2019, the General Assembly has created the "clinical setting" venue in which Colorado's Emergency Medical Service (EMS) providers can practice their profession. This change in EMS scope of practice presented a challenge to the Division and its advisory board for EMS provider practice and medical director oversight, the Emergency Medical Advisory Practice Council (EMPAC). They were tasked with promulgating rules that carve out the new clinical setting scope of practice without interfering with the prehospital setting scope of practice that has worked so well for so long.

Senate Bill 19-052 required EMPAC to recommend regulations for the new clinical setting that include all necessary standards concerning appropriate medical oversight and patient safety. Pursuant to statute, facilities that will benefit from on-staff EMS providers must ensure that EMS providers only perform authorized in-scope acts under medical direction ***and*** medical supervision from on-site physicians or mid-level providers who can administer instructions and assistance, if necessary. The proposed rules therefore incorporate two significant operational mandates: (1) heightened oversight duties for facilities and their clinical medical directors, and (2) a new medical supervisor framework.

The proposed rules also align with national standards the medical acts Colorado certified-and licensed-EMS providers may perform.

Clinical Settings
A clinical setting is defined as any Department-licensed or -certified health facility.[2] Senate Bill 19-052 enables all levels of EMS providers to perform authorized in-scope medical acts in a "clinical setting," pursuant to Chapter Two, as long as the provider is under medical direction and medical supervision. While this change significantly expands the settings in which an EMS provider may practice, it does not affect the medical acts or medications that are within the provider's scope of practice unless specifically noted in Appendices A-G or by the applicable medical director. This legislation therefore ties settings to EMS providers' scopes of practice. Henceforth, EMS providers may practice all authorized in-scope medical acts in different authorized settings.

Medical Direction
Medical direction has always been an essential required component of emergency medical services. In Colorado it has provided the framework by which every level of EMS provider is

[1] In 2016 the General Assembly passed legislation that allows a paramedic with a Community Paramedic endorsement (P-CP) to perform out-of-hospital services in a residential setting under medical direction if employed by a Community Integrated Health Care Services (CIHCS) agency. See Section 25-3.5-1301, *et seq.*, C.R.S.
[2] Section 25-3.5-207(1) (a), C.R.S.

authorized to deliver needed emergency medical treatments in a prehospital setting. Medical direction authority is also required to allow endorsed Community Paramedics to provide out-of-hospital medical services in a patient's home. Now, medical direction is integrated into the clinical setting to enable certified or licensed EMS providers to work within their respective scopes of practice in hospitals, nursing homes, assisted living residences and other types of facilities. In all of these instances, the physician medical director is ultimately responsible for ensuring the competence of the EMS provider to perform the authorized medical acts in the relevant setting.[3]

The proposed rules require any medical director to be a Colorado licensed physician in good standing and to have the training and experience in the "acts and skills for which they are providing" medical direction. Clinical medical directors must also ensure, through collaboration, review, oversight, training, and communication among supervisors and providers alike, that each EMS provider is only authorized to perform specific in-scope acts.

Medical Supervision

In the traditional prehospital emergent setting, physician medical directors are charged with medical direction and supervision oversight duties. In the clinical setting, the General Assembly saw fit to ensure patient safety by imposing a supervision component that is new to EMS practice. SB 19-052 provides that EMS providers who practice under medical direction in the clinical setting must also be supervised by an on-site physician, physician assistant, registered nurse, or advanced practice nurse who are Colorado-licensed in good standing and who are trained and experienced in the medical acts that EMS providers perform within their scopes of practice. The legislation now allows non-physician medical providers to give in-scope medical orders and instructions regarding patient care to EMS providers under their supervision. The on-site requirement contemplates that the medical supervisor will be immediately available to provide oversight, guidance, or instruction to the EMS provider who is providing patient care.

Medical Acts

Finally, the proposed rules modify the existing lists of authorized medications and acts that fall within EMS providers' scopes of practice. The proposed changes achieve the following: 1) align Colorado EMS practice rules with the national scope of practice standards; 2) incorporate public health initiatives such as COVID-19 testing and Hepatitis A vaccinations into EMS provider scopes of practice; 3) provide clarification regarding allowable medications and acts in the different settings; and 4) update the scope standards to reflect the current state of EMS practice. These changes will improve patient care by clearly setting forth the updated standards by which EMS providers will operate.

The Division is requesting a January 1, 2021 effective date for these rules.

Specific Statutory Authority.

Statutes that require or authorize rulemaking:

- Section 25-3.5-203(1)(a.5), C.R.S. (authorizes Chief Medical Officer to adopt rules regarding EMS provider regulation)

[3] See 6 CCR 1015-3, Chapter Two, Section 5.1.6 (EMS agency medical director), Section 18.3.5 (CIHCS agency medical director) and Section 19.3.7(Clinical medical director).

- Section 25-3.5-206(4)(a), C.R.S. (authorizes Chief Medical Officer to adopt rules concerning EMS provider scope of practice, medical director qualifications, defining medical direction and criteria for granting waivers)
- Section 25-3.5-207(4), C.R.S. (authorizes adoption of rules to implement clinical setting parameters)

Other relevant statutes:
Section 25-3.5-207, C.R.S. (authorizes EMS provider to work within applicable scope of practice in clinical settings under medical direction and medical supervision; and establishes criteria for medical supervision)

Is this rulemaking due to a change in state statute?

__X___ Yes, the bill number is SB 19-052. Rules are _X__ authorized; some provisions are _X_ required.

_____ 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.

___ Yes.

This rule includes a new state mandate or increases the level of service required to comply with an existing state mandate, and local government will not be reimbursed for the costs associated with the new mandate or increase in service. The state mandate is categorized as:

___ Necessitated by federal law, state law, or a court order
___ Caused by the State's participation in an optional federal program
___ Imposed by the sole discretion of a Department
___ Other: _____
(i.e. requested by local governments and consensus was achieved)

Has an elected official or other representatives of local governments disagreed with this categorization of the mandate? ___Yes _X__No. If "yes," please explain why there is disagreement in the categorization.

REGULATORY ANALYSIS
for Amendments to 6 CCR 1015-3, Chapter Two,
Rules Pertaining to EMS Practice and Medical Director Oversight

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.

Group of persons/entities Affected by the Proposed Rule	Size of the Group	Relationship to the Proposed Rule Select category: C/CLG/S/B
Licensed or Certified:		
Assisted living residences	706	C/S
Hospitals, including general, psychiatric, rehabilitation, critical access, children's, long and short term, and hospital units	96	C/S/CLG
Nursing care facilities	230	C/S
Dialysis clinics	82	C/S
Community clinics	73	C/S
Convalescent centers	13	C/S
Community mental health centers	24	C/S
Acute treatment units	5	C/S

Facilities for persons with developmental disabilities-includes intermediate care facilities for individuals with developmental disabilities and residential care facilities for the developmentally disabled	139	C/S
Hospice care	105	C/S
Ambulatory surgical centers	131	C/S
Birthing centers	7	C/S
Home care agencies	Approximately 763	C/S
Emergency Medical Service Providers EMS Agencies EMS Education Programs	18,586 ~200 ground ambulance agencies 34 air ambulance agencies 210	C/S S C/S
Persons accessing or utilizing impacted licensed health care facilities	Unknown	B
Colorado licensed registered nurses, advance practice nurses, physician assistants and physicians (as medical supervisors) Licensed physicians (as EMS medical directors)	RNs=61,000 APRNs=Unknown PAs=3450 Physicians=7300 141	C C C
Regional Emergency Medical and Trauma Advisory Councils (RETACs)	11	CLG/S

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.

Economic outcomes

Summarize the financial costs and benefits, include a description of costs that must be incurred, costs that may be incurred, any Department measures taken to reduce or eliminate these costs, any financial benefits.

C Possible financial costs or benefits to Customers:

- **Certified or licensed EMS providers** who practice within their scope of practice in a clinical setting will not incur any additional costs either from the clinical setting statute or from the Emergency Medical Practice Advisory Committee's (EMPAC) recommended scope changes to authorized medical acts and medications. The statutory mandate merely expands the setting in which EMS providers may practice; it does not expand the medical acts they may perform or the medications they may administer. Consequently, EMS providers will not have to undergo any additional training or education to practice in the clinical setting.

  As noted, the General Assembly enacted SB 19-052 to broaden the settings in which EMS providers can safely perform their in-scope medical services. Stakeholder and community support for this expansion has been uniformly positive. As a result, the Department expects that certified or licensed EMS providers will benefit from expanded employment opportunities in the clinical setting workforce. If made permanent employees, it is foreseeable that these providers may receive higher compensation packages than their counterparts who either practice in the prehospital setting or supplement their prehospital EMS income with part-time work in health facilities as medical technicians.

- **Licensed or certified health care facilities** will not incur any expenses associated with the recommended expansion to EMS scope as it relates to medical acts and medications.

  Licensed or certified health care facilities that will employ EMS providers to practice in the clinical setting must appoint a clinical medical director to provide medical oversight of EMS providers and their scopes of practice. The

Department cannot reduce or eliminate this expense since EMS providers must practice within their scope in any setting "subject to the medical direction of a licensed physician." Section 25-3.5-203(1) (a.5), C.R.S. On the other hand, these facilities will not incur any costs associated with the additional training or education of EMS providers since their scopes of practice are portable and remain the same regardless of the setting.

Though supporting data is currently lacking, the Department anticipates that these facilities may benefit financially by employing EMS providers in a clinical setting. As discussed, the scope of practice for EMS providers has been traditionally limited to the prehospital setting. Consequently, EMS providers who work outside of the prehospital setting have, up to now, been practicing outside their scopes of practice. In the licensed health care facilities setting, these EMS providers are referred to as medical technicians who practice under the delegation authority conferred in the Medical Practice Act, Section 12-240-107(3)(1), C.R.S.[4] The delegation practice operates by permitting physicians to extend their authority to medical technicians to conduct specific medical acts. However, physician delegators frequently restrict medical technicians from performing their full range of authorized EMS in-scope medical acts in the clinical setting.

By creating the new setting construct, the legislature now authorizes EMS providers to identify as EMS providers who can operate within their full scopes of practice in a supervised clinical setting. Licensed health care facilities that supplement their medical staffs with EMS providers pursuant to the proposed legislation and rule should benefit from the efficiencies and increased productivity that these providers will be able to generate in the clinical setting when practicing their full complement of authorized in-scope medical acts.

- **Registered nurses, advanced practice nurses, physician assistants, and licensed physicians** are expressly identified by the legislation as health care professionals who, in the clinical setting, must serve as "medical supervisors" of EMS providers. The Department does not anticipate that costs or financial benefits will result from the recommended medical act scope changes for EMS providers.

- **Medical directors in a clinical setting** are required by rule to be Colorado-licensed physicians in good standing, and to be trained and experienced in all acts and skills for which they are providing oversight and authorization to EMS providers. The Department is unaware of any costs or expenses these individuals must absorb to become eligible to provide oversight and authorization to EMS providers in a clinical setting.

- **Medical directors in all settings** should neither be adversely impacted by costs or expenses nor benefit financially when overseeing the medical act scope changes.

[4] The delegation practice is regulated through the Colorado Medical Board's oversight and its Rule 800.

- **EMS education programs** will be required to implement the recommended medical act scope changes for EMS providers by incorporating new content into their Emergency Medical Services curricula. However, the recommended changes mainly expand the medications that certain EMS providers are authorized to administer within their scope of practice. Educational programs will have to modify their courses to include these skills, but any cost associated with these curriculum changes should be nominal. The Department does not foresee that these programs will benefit financially when educating EMS providers about these few medical act scope modifications.

CLG Possible financial costs or benefits to local government:

- **Licensed or certified health care facilities that are owned by local governments, e.g., hospitals** will not incur any expenses associated with the recommended expansion to EMS scope as it relates to medical acts and medications. As outlined above, their EMS providers must be medically directed in the clinical setting, and so these health care facilities will incur the same expenses as other licensed or certified health care facilities. They will likewise benefit financially from the increased access to a new pool of staff and productivity that EMS providers will generate in the clinical setting.

  The fiscal note for SB 19-052 does not include information concerning Local Government impact.

- **Regional Emergency Medical and Trauma Advisory Councils (RETACS)** are not operational and will neither incur expenses nor financially benefit from either the clinical setting or recommended medical act or medication scope expansion rules.

S Possible financial costs or benefits to Stakeholders:

- **All licensed or certified health care facilities** will incur the expense of employing a clinical medical director but will not bear the cost of additionally training or educating EMS providers to practice in a clinical setting. They will also, as outlined above, financially benefit from the efficiencies resulting from more productive EMS providers who can perform all in-scope medical acts in that setting. No costs or financial benefits are associated with the recommended expansion to EMS medical acts and medications scope changes.

- **EMS education programs** will incur minimal costs and minimal or negligible financial benefits, as outlined above.

- **Regional Emergency Medical and Trauma Advisory Councils (RETACS)** will not incur expenses benefit financially, from either the clinical setting or recommended medical act or medication scope expansion rules.

- **EMS Agencies** that employ EMS providers to practice in the prehospital setting will not financially benefit from the expanded clinical setting rule, nor will

they suffer a specific cost or expense. However, because the creation of the clinical setting authorizes EMS providers to practice their full complement of in-scope activities in non-emergent settings, these providers will benefit from increased employment opportunities. Traditional EMS agencies that employ EMS providers to provide prehospital emergent care and transport to and between health facilities will now compete with licensed or certified health care facilities when employing skilled EMS personnel. Consequently, EMS agencies may lose providers to health facilities, if EMS providers are able to earn consistently higher incomes in the clinical setting.

B Possible financial costs or benefits to Beneficiaries:

- **Health care facility patients** will not incur costs from implementation of this rule. However, to the extent the clinical setting implementing rule allows health care facilities to supplement their medical staff with licensed or certified EMS providers, patients who can access health care locally may save themselves the cost of having to travel outside the region for health care.

Non-economic outcomes

Summarize the anticipated favorable and non-favorable non-economic outcomes (short-term and long-term), and, if known, the likelihood of the outcomes for each affected class of persons by the relationship category.

C Possible non-economic outcomes to Customers:

- **Certified or licensed EMS providers** will now be able to practice as EMS providers and perform all authorized in-scope medical acts in a clinical setting under medical direction and medical supervision. The creation of the new setting that permits EMS providers to perform authorized medical acts within a uniform scope of practice clarifies two key beneficial outcomes for EMS providers. First, these implementing rules clarify that EMS providers are authorized to practice the full extent of their in-scope medical acts in different settings. Like other health care professionals, EMS providers will carry their scopes of practice with them to different settings. Second, although the rule expressly permits EMS providers to operate under delegation authority when necessary, these providers who practice in-scope acts under medical direction and medical supervision in the clinical setting will not have to operate under the frequently narrower, non-uniform delegation authority a physician is willing to extend to them.

- **Licensed or certified health care facilities** that employ EMS providers in the clinical setting will be able to tap into a health care provider resource capable of providing a broad array of in-scope medical acts to its patients. The effective use of this resource should help facilities relieve short- or long-term medical care shortages. In turn, facilities will be able to provide their underserved communities with increased vital access to medical resources and care. And the opportunity to utilize EMS providers to practice within their scope in the clinical setting should give all facilities a tool with which to help

manage the workloads of their mid-level providers whose skills may be better utilized performing medical acts outside the scope of EMS providers.

- **Registered nurses, advanced practice nurses, physician assistants, and licensed physicians** are expressly identified by the legislation as health care professionals who, in the clinical setting, must serve as "medical supervisors" of EMS providers. Accordingly, they will be required to be credentialed in the acts they supervise, and know and apply the scope of practice pertinent to each supervised EMS provider. However, the Department also anticipates that these professionals may be relieved from performing the medical acts that fall within EMS providers' scope of practice, allowing them to manage their time and duties more effectively.

- **Medical directors in a clinical setting** are required by rule to evaluate and authorize the acts each EMS provider can perform in the clinical setting, communicate that scope to the provider and all medical supervisors, and to oversee and ensure the training and competency of EMS providers. These responsibilities are central to ensuring safe in-scope EMS provider practice in the clinical setting; therefore, the relative success or failure of the EMS practice in each facility will largely depend upon the effectiveness of the medical director. The medical director will have a favorable or unfavorable outcome depending upon the success or failure of the EMS clinical program.

- **Medical directors in all settings** will be required to implement or apply the recommended medical act scope changes for EMS providers but should not experience any non-economic outcomes as a result of the clinical setting rules. The Department recognizes they will have to devote time to become educated about the medication scope rule changes.

- **EMS education programs** that implement the recommended medical act scope changes for EMS providers will not foreseeably experience any non-economic outcomes.

CLG Possible non-economic outcomes to local government:

- **Licensed or certified health care facilities that are owned by local governments, e.g., hospitals** will receive the same anticipated benefits as other licensed or certified health care facilities, outlined above.

- **Regional Emergency Medical and Trauma Advisory Councils (RETACS)** are statutorily charged with providing plans that, among other things, address the provision of regional emergency medical and trauma and health care facility services. Accordingly, RETACS will observe and monitor the extent to which EMS providers in regional clinical settings impact the provision of EMS, trauma, and facility services within their geographical area. The Department anticipates that RETACS will benefit from the rule since the use of EMS providers in clinical settings will augment the medical resources available to communities in their region.

S Possible non-economic outcomes to Stakeholders:

- **All licensed or certified health care facilities** will receive the anticipated benefits as outlined above.

- **EMS education programs** will not foreseeably experience any non-economic outcomes resulting from the proposed rule.

- **Regional Emergency Medical and Trauma Advisory Councils (RETACS)** will receive the anticipated benefits as outlined above.

- **EMS Agencies** that employ and medically direct EMS provider practice in the prehospital setting may be impacted financially because of increased employment competition, as discussed above, but they should not be impacted non-economically by the proposed rule. In fact, the proposed rule change entirely preserves the existing EMS prehospital emergency treatment and transport system because it operates efficiently and effectively. The rule that allows EMS providers to practice in a clinical setting augments, rather than undermines, the traditional EMS prehospital setting.

B Possible non-economic outcomes to Beneficiaries:

- **Health care facility patients** will receive skilled medical care from licensed or certified EMS providers who are now authorized to perform authorized in-scope acts in clinical settings. The law and its implementing rules protect patients' safety by requiring EMS providers to practice under medical direction and the supervision of on-site mid-level medical supervisors who can assist with patient care as needed. Additionally, the ability of health care facilities to employ EMS providers to perform in-scope medical acts in a clinical setting will allow Colorado patients to have improved access to health care. This is a significant benefit for all patients, particularly for rural and other medically underserved populations.

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:

Clinical Settings:

The fiscal note for SB 19-052 stated that the Department's workload and costs for the rulemaking process should be minimal. This assessment was based on the statute identifying the general parameters for expanding the scope of practice. Therefore, any necessary work should be accomplished within existing appropriations.

Departmental costs to implement the proposed rules should also be minimal. As previously discussed, passage of SB 19-052 will allow the EMS provider to work within his or her scope of practice subject to medical direction and medical

supervision, and will enable the provider to be identified according to certification or licensure level. While opening new venues with different oversight requirements could prove challenging, the Department does not anticipate that there will be an increase in investigations or disciplinary actions because of the proposed rule. To the extent any investigations or disciplinary actions result from the proposed rule, the Department anticipates they will be few in number.[5] Therefore, there should not be any increased costs to the Department because of the implementation and enforcement of the rule.

Medical Act Scope Expansion

Implementation of the proposed additions and deletions of medications, and expansion of EMS provider types allowed to perform certain acts or administer specific medications, should be cost-neutral to the Department.

B. Anticipated CDPHE Revenues:

N/A

C. Anticipated personal services, operating costs or other expenditures by another state agency:

Department of Regulatory Agencies (DORA)

Clinical Settings**:**

The final fiscal note for Senate Bill 19-052 states that the expanded clinical setting will necessarily require the Colorado Medical Board and Colorado Nursing Board to revise their rules to address the increased medical supervision duties required of registered and advanced practice nurses, and physicians and physician assistants. Significantly, this proposed rulemaking does not impact Rule 800, the delegation rule that is administered by the Colorado Medical Board, so DORA will not have to revise that rule in any way. The workload impact for this agency is expected to be minimal. The fiscal note states that these rule revisions can be accomplished within DORA's existing appropriations.

Anticipated Revenues for another state agency (DORA):

N/A

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

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

[5] In the event that the Department finds that disciplinary actions increase because of the proposed rules, it will monitor the number of additional disciplinary cases, and take appropriate action.

__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.
__X__ Maintain alignment with other states or national standards.
__X__ Implement a Regulatory Efficiency Review (rule review) result
__X__ Improve public and environmental health practice.
__X__ 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.

- To the extent these rules clarify and update EMS regulations, the Division's goal is to provide the regulated community with a set of standards that are relevant, simple, clear, and not redundant. This rule revision significantly clarifies the requirements.
- The modifications also update the scope of practice of EMS providers to reflect the national EMS standards and current standards of care; eliminate outdated medications and provide non-opioid alternatives for pain management; align requirements with current public health initiatives; codify departmental waiver allowing EMS providers to perform oral and nasal swab sample collections; and eliminate inconsistencies.
- Promulgation of these rules implements new legislation (SB 19-052) in accordance with the Division's Regulatory Review #2 strategic priority.

The costs and benefits of the proposed rule will not be incurred if inaction was chosen. Costs and benefits of inaction not previously discussed include:

Clinical Setting Requirements:

Inaction was not an option. The statute allows EMS providers to work in clinical settings and rules must be proposed to implement the statute.

Medical Act Scope Expansion:

The scope was updated to make Colorado's EMS provider scope congruent with the national scope of practice adopted by the National Registry of Emergency Medical Technicians (NREMT), reflect the current standard of EMS practice, and recognize EMS's role in public health initiatives. Inaction would cause Colorado EMS providers to lag behind the national scope of practice for their profession.

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

   Rulemaking is proposed when it is the least costly method or the only statutorily allowable method for achieving the purpose of the statute. The specific revisions proposed in this rulemaking were developed in conjunction with EMPAC, which is composed of experts in the EMS profession and its scopes of practice and standards of care. The benefits, risks and costs of the proposed revisions to the medical act scope expansion were also compared to the costs and benefits of other options and the merits of all options were discussed. The proposed clinical setting and medical scope revisions provide the most benefit to patients and the EMS provider community with the least amount of cost and in the most feasible manner to achieve compliance with statute.

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

   Alternatives to rulemaking were not considered for the clinical setting legislation. Senate Bill 19-052 mandates that rules must be promulgated concerning EMS provider practice in a clinical setting.

   The Division collaborated with EMPAC to promulgate rules that align with NREMT national standards and current standards of practice for EMS provider medical acts and medications. The waiver process was not considered as an alternative to rulemaking as it only applies to the prehospital setting and is meant to be utilized on a situational basis. The goal of the EMPAC and Division was to update and apply uniform EMS scopes of practice.

   EMPAC members did review EMS agency medical director duties that are codified at 6 CCR 1015-3 Chapter Two, Section 4.2 to determine whether and to what extent they apply to the duties that a clinical medical director will be required to fulfill. After consideration, the members agreed that some duties apply globally to medical directors in all settings and rejected other EMS agency medical director duties as inapplicable to the responsibilities of a clinical medical director. EMPAC directed Division staff to augment the proposed rule with clinical medical director duties that hew closely to, and will effectuate and strengthen, the evaluation, communication, and collaboration requirements set forth in statute.

   EMPAC also engaged in thoughtful discussion about the authority of Advanced Emergency Medical Technician (AEMT) providers to administer pain management narcotic and analgesic medications as provided in Appendix B-8. A rural medical

director requested EMPAC to expand the AEMT scope to permit them to dispense these medications because of paramedic shortages. The members originally rejected the request based on the lack of available data informing AEMT administration of these medications. EMPAC also reasoned that the waiver process is available to EMS agencies for this kind of situation. However, when a member re-raised the issue, EMPAC considered AEMT educational requirements, rejected approval of the requested wholesale scope expansion pertaining to AEMTs and narcotics, but acknowledged that some rural and mountain agencies are forced to operate without sufficient paramedics. Therefore, it voted to permit AEMTs to administer two discrete narcotics--fentanyl and morphine--after receiving a physician's verbal order, but decided against expanding the AEMT scope beyond administration of these two medications.

A similar discussion occurred when a rural medical director requested EMPAC to expand the scope of AEMTs, as provided in Appendix B.10, to administer three benzodiazepine medications for seizures. The members initially rejected the proposal because these medical acts are outside the national scope of practice. However, EMPAC considered the issue further after a pediatrician identified the harm that will result to children if these medications aren't timely administered during seizures. The members reasoned that two of the three medications can be administered safely by AEMTs pursuant to limited administration routes. Consequently, it rescinded its earlier rejection of the AEMT scope change and voted to permit this classification of providers to administer diazepam via rectal suppository, and to administer midazolam intranasally. EMPAC unanimously rejected the balance of the requested scope changes for AEMTs in Appendix B.10.

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.

This rulemaking did not utilize quantifiable data but did rely extensively on stakeholder expertise and feedback. EMPAC provided significant information concerning appropriate medications and medical acts that should be included within the scopes of practice of different classifications of EMS providers, the current state of emergency medical practice, and the applicable standards that should reasonably apply to clinical medical directors and medical supervisors. Additionally, staff relied on the fiscal note analysis that was prepared for Senate Bill 19-052.

STAKEHOLDER ENGAGEMENT
for Amendments to 6 CCR 1015-3, Chapter Two,
Rules Pertaining to EMS Practice and Medical Director Oversight

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:
While this was not a Department sponsored bill, the Department hosted a meeting with interested individuals and/or entities. The following attendees were invited to provide input on the proposed legislation:

Organization	Representative Name and Title (if known)
Invitees to Discussion of Draft Bill January 22, 2019	
	Sean Caffrey, Crested Butte Fire
	Ray Jennings, Grand County EMS
	Darren Ross, Senator Garcia's Office
	Tim Dienst, Ute Pass Regional Health Service District
	Chris Montera, Chief Executive Officer, Eagle County Health Service District
	Charlie Mains, M.D., SEMTAC Chair
	Kevin McVaney, M.D., Denver Health & Hospital, and EMPAC
	Rick Lewis, Battalion Chief, South Metro Fire Rescue Authority
	Gary Bryskiewicz, Chief Paramedic, Denver Health
	Jackie Zheleznyak, Denver Health, Director, Government Relations

	Laura Rappaport, M.D., Denver Health
	Karen McGovern, DORA
	Gary Breese, Fire Chiefs Association

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

Organization	Representative Name and Title (if known)
EMTS on the Go (newsletter mailing list)	This weekly newsletter is emailed to a list of 1800+ constituents from the EMS and trauma systems and provides details for all public meetings hosted by the EMTS Branch. The newsletter notified interested parties of all EMPAC meetings concerning revisions to EMS Chapter Two over the course of the stakeholder process.
Emergency Medical Practice Advisory Council	11-member, governor and CDPHE executive director appointed advisory council which MUST recommend any draft rule changes prior to presenting the proposed rules to the Chief Medical Officer. Periodic updates concerning the proposed rules were given throughout the rule revision process. The Department provided EMPAC with the final proposed rules for Chapter Two in May 2020. The Department received EMPAC's vote of support on August 10, 2020.

The Department relied upon the EMPAC as its stakeholder group. This decision was based on the technical medical expertise that was required to formulate and evaluate the proposed rules. Four stakeholder meetings were held in conjunction with regular EMPAC meetings beginning in November 2019. Participation was available via telephone and web conference. Draft rules were available on the Department's website. Information about each meeting was sent to the public through the weekly "EMTS on the Go." A sample notice is listed here:

> **Regional Medical Directors (RMD) Committee and Emergency Medical Practice Advisory Council (EMPAC) Meeting** -- Aug. 10, 8:00 a.m. to 4 p.m.; Virtual Meeting. Teleconferencing will be available 669-900-6833, Code:151 379 393 PW: 411483. The meeting will also be

broadcast over Zoom. Meeting materials will be available here. If you have any questions please email Michael Bateman.

Stakeholder Group Notification

The stakeholder group will be provided notice of the rulemaking hearing and provided with a copy of the proposed rules or the internet location where the rules may be viewed. Notice will be 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).

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

__X__ Yes. This is selected for the rulemaking to document that timely division notification will occur.

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.

EMPAC was tasked with developing proposed rules with two different objectives while Chapter Two was opened. First, it was asked to consider closing the gap between the tasks and medications that existing rule allows different EMS providers to provide within their scopes of practice, and those that EMS providers may perform and dispense under NREMT's national scope of practice. Second, EMPAC's advice and expertise was necessary to help the Division formulate the proposed rules for the new clinical setting created in SB 19-052.

- Scope of practice alignment to national standards

EMPAC thoroughly reviewed all of Colorado's scope of practice rules for EMS provider classifications that do not align with the national scope of practice and discussed the merits of each proposed modification.

While EMPAC ultimately voted to incorporate almost all of the proposed modifications to reach the desired alignment, it calibrated some to accommodate Colorado's provider practices and unique regional issues. For example, NREMT's scope of practice permits paramedics to administer thrombolytics without restriction. EMPAC concluded that the risk attendant to administering this medication is high and voted against adopting this national standard. However, it did agree to permit paramedics to oversee thrombolytics during interfacility transport as a maintenance function. See Appendix D.1. EMPAC also had to consider whether to change scope of practice for Emergency Medical Technicians with Intravenous Authorization (EMT-IV) and Emergency Medical Technicians-Intermediate (EMT-I), classifications that are not included in the national scope. For instance, it agreed to permit AEMTs, EMT-Is, and paramedics to administer acetaminophen intravenously, pursuant to the recommended national standard. However, after discussion about sufficiency of training and scope creep, EMPAC rejected the notion that EMT-IVs should be allowed to administer that medication within their scope of practice. See Appendix B.8. Finally, as noted in Section 6 of the Regulatory Analysis, EMPAC accommodated the request of rural medical directors to permit AEMTs to administer certain medications that, until now, can only be administered by

EMT-Is and paramedics. Because some remote regions do not have adequate access to EMT-Is or paramedics, EMPAC decided, after discussion, to allow AEMTs to administer certain medications either by a specific route or after receiving a verbal order. See Appendices B.8 and B.10.

- Clinical setting regulations

Section 25-3.5-201, *et seq.*, C.R.S., the statute that sets forth Colorado EMS providers' roles and responsibilities has, until recently, restricted EMS providers to practicing within their scope in the emergent prehospital setting only.[6] With the passage of SB 19-052, the General Assembly now permits all levels of EMS providers to perform authorized in-scope medical acts in a clinical setting under medical direction and pursuant to Chapter Two. This legislation therefore ties settings to EMS providers' scopes of practice; henceforth EMS providers may practice their authorized in-scope medical acts in different settings. This change in EMS scope of practice presented EMPAC and the Division with the broad challenge of promulgating rules that carve out the new clinical scope of practice without interfering with the prehospital scope of practice that has worked so well for so long.

Moreover, the new statute presented EMPAC with the task of promulgating regulations for a new clinical setting that incorporate two significant operational mandates: (1) heightened oversight duties for facilities and their clinical medical directors, and (2) a novel supervisory infrastructure. Facilities that will benefit from on-staff EMS providers must ensure that EMS providers only perform authorized in-scope acts under medical direction ***and*** medical supervision from on-site physicians or mid-level providers who can administer instructions and assistance, if necessary. Clinical medical directors must also ensure, through collaboration, review, oversight, training, and communication among supervisors and providers alike, that each EMS provider is only authorized to perform specific in-scope acts.

EMPAC first directed its attention to constructing the duties of the newly-created clinical director position from scratch. As noted in section 6 in the Regulatory Analysis, EMPAC identified the EMS agency medical director duties that equally apply in the clinical setting, and then directed staff to incorporate all additional oversight, collaboration, communication, training, and competence duties necessary to carry out the legislative requirements.

EMPAC did raise one potential policy issue concerning clinical medical direction: it was concerned that the medical director would be exposed to legal liability should EMS providers stray beyond their scope of practice in the clinical setting. This issue was resolved when the EMPAC was advised that clinical medical directors satisfy their obligations so long as they comply with their Chapter Two duties. EMPAC was also reminded that SB 19-052 expressly permits delegation practice to occur in a clinical setting. An EMS provider who performs acts outside scope of practice via delegation in a clinical setting is not acting under Chapter Two medical direction. Consequently, the clinical medical director who plays no role in this exercise of delegated authority cannot be held responsible for those out-of-scope medical acts.

[6] In 2016 the General Assembly passed legislation that allows a paramedic with a Community Paramedic endorsement (P-CP) to perform out-of-hospital services in a residential setting under medical direction if employed by a Community Integrated Health Care Services (CIHCS) agency. See Section 25-3.5-1301, *et seq.*, C.R.S.

EMPAC next directed its attention to promulgating rules necessary to operationalize the statute's new medical supervision requirements. EMPAC codified the required supervisory parameters and otherwise tried to refrain from imposing unnecessary or overly-burdensome regulations on facilities and their staff. It did encounter and resolve two issues concerning the medical supervision requirement during the rulemaking process.

First, it questioned whether medical supervisors may perform their supervisory duties via telehealth. This issue was dispatched by the statutory language, which expressly requires medical supervisors to be on-site with the EMS provider while providing medical supervision.

Second, it encountered the issue of how to operationalize physicians' direct verbal orders to EMS providers who are medically supervised by someone other than the ordering physician. In the prehospital setting, EMS providers typically receive contemporaneous verbal orders from their medical directors via radio or telephone contact. In the clinical setting, however, the EMS provider may be supervised by a medical supervisor other than the physician who issues the contemporaneous direct verbal order. EMPAC resolved the issue by agreeing to include a provision in the direct verbal order rule that takes the clinical setting medical supervisor into account. Pursuant to Section 15.3.2.A, physicians may issue a contemporaneous verbal order to the EMS provider directly, or the physician may issue a contemporaneous written or verbal order to the medical supervisor who, in turn, may instruct the EMS provider to perform the authorized medical act. See also Section 2.15.

No other major policy or factual issues were encountered.

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:_____ _____

SENATE BILL 19-052

BY SENATOR(S) Garcia, Bridges, Cooke, Crowder, Fields, Gardner, Ginal, Gonzales, Lee, Marble, Moreno, Priola, Rankin, Scott, Smallwood, Story, Tate, Todd;
also REPRESENTATIVE(S) Mullica, Arndt, Beckman, Bird, Buckner, Caraveo, Duran, Exum, Galindo, Hooton, Jackson, Jaquez Lewis, Kipp, Liston, Lontine, McCluskie, McLachlan, Melton, Michaelson Jenet, Roberts, Saine, Snyder, Soper, Tipper, Valdez A., Valdez D., Becker.

CONCERNING EXPANSION OF AN EMERGENCY MEDICAL SERVICE PROVIDER'S SCOPE OF PRACTICE.

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

SECTION 1. In Colorado Revised Statutes, 25-3.5-103, **add with amended and relocated provisions** (8.8) as follows:

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

(8.8) **[Formerly 25-3.5-203 (5)]** ~~For the purposes of this article, unless the context otherwise requires,~~ "Medical direction" includes, but is not limited to, the following:

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

(a) Approval of the medical components of treatment protocols and appropriate prearrival instructions;

(b) Routine review of program performance and maintenance of active involvement in quality improvement activities, including access to dispatch tapes as necessary for the evaluation of procedures;

(c) Authority to recommend appropriate changes to protocols for the improvement of patient care; and

(d) ~~Provide~~ PROVISION OF oversight for the ongoing education, training, and quality assurance for providers of emergency care.

SECTION 2. In Colorado Revised Statutes, 25-3.5-203, **amend** (1)(b)(IV) and (1)(b)(V); and **add** (1)(b)(VI) as follows:

25-3.5-203. Emergency medical service providers - certification - renewal of certificate - duties of department - rules - criminal history record checks - definitions. (1) (b) The department shall certify emergency medical service providers. The board shall adopt rules for the certification of emergency medical service providers. The rules must include the following:

(IV) Disciplinary sanctions, which ~~shall~~ MUST include provisions for the denial, revocation, and suspension of certificates and the suspension and probation of certificate holders; ~~and~~

(V) An appeals process pursuant to sections 24-4-104 and 24-4-105 ~~C.R.S.~~, that is applicable to department decisions in connection with certifications and sanctions; AND

(VI) A STATEMENT THAT AN EMERGENCY MEDICAL SERVICE PROVIDER MAY PRACTICE IN A CLINICAL SETTING, AS DEFINED IN SECTION 25-3.5-207 (1)(a), SUBJECT TO THE REQUIREMENTS OF SECTION 25-3.5-207 AND RULES ADOPTED BY THE BOARD.

SECTION 3. In Colorado Revised Statutes, 25-3.5-205, **amend** (2) and (5)(a) as follows:

25-3.5-205. Emergency medical service providers - investigation - discipline. (2) An emergency medical service provider, THE MEDICAL SUPERVISOR OF AN EMERGENCY MEDICAL SERVICE PROVIDER IN A CLINICAL SETTING, AS THOSE TERMS ARE DEFINED IN SECTION 25-3.5-207 (1), the employer of an emergency medical service provider, a medical director, and a physician providing medical direction of an emergency medical service provider shall report to the department any misconduct that is known or reasonably believed by the person to have occurred.

(5) For the purposes of this section:

(a) "Medical director" means a physician who ~~supervises certified~~ PROVIDES MEDICAL DIRECTION TO emergency medical service providers consistent with the rules adopted by the ~~executive~~ director or chief medical officer, as applicable, under section 25-3.5-206.

SECTION 4. In Colorado Revised Statutes, 25-3.5-206, **amend** (4)(a) introductory portion, (4)(a)(III), and (4)(a.5)(I); and **add** (5) as follows:

25-3.5-206. Emergency medical practice advisory council - creation - powers and duties - emergency medical service provider scope of practice - definitions - rules. (4) (a) 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 emergency medical service providers. ~~for prehospital care.~~ The rules must include the following:

(III) Criteria for requests to waive the scope of practice rules IN A PREHOSPITAL SETTING and the conditions for ~~such~~ THE waivers;

(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.

(5) AS USED IN THIS SECTION:

(a) "INTERFACILITY TRANSPORT" HAS THE MEANING SET FORTH IN SECTION 25-3.5-207 (1)(c).

(b) "PREHOSPITAL SETTING" MEANS ONE OF THE FOLLOWING SETTINGS IN WHICH AN EMERGENCY MEDICAL SERVICE PROVIDER PERFORMS PATIENT CARE, WHICH CARE IS SUBJECT TO MEDICAL DIRECTION BY A MEDICAL DIRECTOR:

(I) AT THE SITE OF AN EMERGENCY;

(II) DURING EMERGENCY TRANSPORT; OR

(III) DURING INTERFACILITY TRANSPORT.

(c) "SCOPE OF PRACTICE" HAS THE MEANING SET FORTH IN SECTION 25-3.5-207 (1)(f).

SECTION 5. In Colorado Revised Statutes, **add** 25-3.5-207 as follows:

25-3.5-207. Ability of certified emergency medical service providers to work in clinical settings - restrictions - definitions - rules. (1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "CLINICAL SETTING" MEANS A HEALTH FACILITY LICENSED OR CERTIFIED BY THE DEPARTMENT PURSUANT TO SECTION 25-1.5-103 (1)(a).

(b) "IN-SCOPE TASKS AND PROCEDURES" MEANS TASKS AND PROCEDURES PERFORMED BY AN EMERGENCY MEDICAL SERVICE PROVIDER WITHIN THE EMERGENCY MEDICAL SERVICE PROVIDER'S SCOPE OF PRACTICE.

(c) "INTERFACILITY TRANSPORT" MEANS THE MOVEMENT OF A PATIENT FROM ONE LICENSED HEALTH CARE FACILITY TO ANOTHER LICENSED HEALTH CARE FACILITY.

(d) "MEDICAL SUPERVISION" MEANS THE OVERSIGHT, GUIDANCE, AND INSTRUCTIONS THAT A MEDICAL SUPERVISOR PROVIDES TO AN EMERGENCY MEDICAL SERVICE PROVIDER.

(e) "MEDICAL SUPERVISOR" MEANS A COLORADO-LICENSED PHYSICIAN, PHYSICIAN ASSISTANT, ADVANCED PRACTICE NURSE, OR REGISTERED NURSE.

(f) "SCOPE OF PRACTICE" MEANS THE TASKS, MEDICATIONS, AND PROCEDURES THAT AN EMERGENCY MEDICAL SERVICE PROVIDER IS AUTHORIZED TO PERFORM OR ADMINISTER IN ACCORDANCE WITH SECTIONS 25-3.5-203 AND 25-3.5-206 AND RULES PROMULGATED PURSUANT TO THOSE SECTIONS.

(2) IN ACCORDANCE WITH THE LIMITATIONS CONTAINED IN THIS ARTICLE 3.5, AN EMERGENCY MEDICAL SERVICE PROVIDER MAY WORK IN A CLINICAL SETTING SUBJECT TO THE FOLLOWING CONDITIONS:

(a) THE EMERGENCY MEDICAL SERVICE PROVIDER MAY PERFORM ONLY TASKS AND PROCEDURES THAT ARE WITHIN THE EMERGENCY MEDICAL SERVICE PROVIDER'S APPLICABLE SCOPE OF PRACTICE;

(b) THE EMERGENCY MEDICAL SERVICE PROVIDER SHALL PERFORM IN-SCOPE TASKS AND PROCEDURES PURSUANT TO ORDERS OR INSTRUCTIONS FROM, AND UNDER THE MEDICAL SUPERVISION OF, A MEDICAL SUPERVISOR;

(c) MEDICAL SUPERVISION MUST BE PROVIDED BY A MEDICAL SUPERVISOR WHO IS IMMEDIATELY AVAILABLE AND PHYSICALLY PRESENT AT THE CLINICAL SETTING WHERE THE CARE IS BEING DELIVERED TO PROVIDE OVERSIGHT, GUIDANCE, OR INSTRUCTION TO THE EMERGENCY MEDICAL SERVICE PROVIDER DURING THE EMERGENCY MEDICAL SERVICE PROVIDER'S PERFORMANCE OF IN-SCOPE TASKS AND PROCEDURES;

(d) THE MEDICAL SUPERVISOR OF THE EMERGENCY MEDICAL SERVICE PROVIDER MUST BE LICENSED IN GOOD STANDING; AND

(e) EACH CLINICAL SETTING AT WHICH AN EMERGENCY MEDICAL SERVICE PROVIDER PERFORMS IN-SCOPE TASKS AND PROCEDURES PURSUANT TO THIS SECTION SHALL, IN COLLABORATION WITH ITS MEDICAL STAFF, ESTABLISH OPERATING POLICIES AND PROCEDURES THAT ENSURE THAT EMERGENCY MEDICAL SERVICE PROVIDERS PERFORM TASKS AND PROCEDURES AND ADMINISTER MEDICATIONS WITHIN THEIR SCOPE OF PRACTICE.

(3) NOTHING IN THIS SECTION ALTERS THE AUTHORITY OF A PHYSICIAN OR REGISTERED NURSE IN A CLINICAL SETTING TO DELEGATE ACTS, INCLUDING THE ADMINISTRATION OF MEDICATIONS, THAT ARE OUTSIDE OF AN EMERGENCY MEDICAL SERVICE PROVIDER'S SCOPE OF PRACTICE PURSUANT TO SECTION 12-36-106 OR 12-38-132, AS APPROPRIATE.

(4) THE BOARD MAY PROMULGATE RULES AS NECESSARY TO IMPLEMENT THIS SECTION.

SECTION 6. Repeal of provisions being relocated in this act. In Colorado Revised Statutes, **repeal** 25-3.5-203 (5).

SECTION 7. Act subject to petition - effective date - applicability. (1) This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 2, 2019, if adjournment sine die is on May 3, 2019); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2020 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

(2) This act applies to conduct occurring on or after the applicable effective date of this act.

Leroy M. Garcia
PRESIDENT OF
THE SENATE

KC Becker
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED April 17, 2019 at 1:42 p.m.
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

COLORADO
Department of Public Health & Environment

Emergency Medical Practice Advisory Council

August 26, 2020

Eric France, MD, MSPH
Chief Medical Officer
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South, EDO-A5
Denver, CO 80246-1530

Dear Dr. France:

At the August 10, 2020 meeting of the Emergency Medical Practice Advisory Council (EMPAC), the Colorado Department of Public Health and Environment proposed revisions to 6 CCR 1015-3, Chapter Two - Rules Pertaining to EMS Practice and Medical Director Oversight. These rule revisions implement the provisions of SB 19-052. This law authorizes, with certain required safeguards, all EMS providers to perform their full complement of medical acts within their applicable scopes of practice in a clinical setting, as well as in the prehospital setting. Additionally, the proposed rules update the medical acts EMS providers may perform and the medications they may administer. The EMPAC was involved in the development of the rules.

A motion was made and unanimously passed recommending that the chief medical officer adopt the proposed revisions.

Sincerely yours,

Kevin Weber MD, FACEP

Kevin Weber, MD, FACEP
EMPAC Chairman

CHAPTER TWO – RULES PERTAINING TO EMS PRACTICE AND MEDICAL DIRECTOR OVERSIGHT

Chapter 2 Adopted by the ~~Executive Director and~~ Chief Medical Officer on ~~October 19, 2017~~ OCTOBER 22, 2020. Effective ~~January 1, 2018~~ JANUARY 1, 2021.

SECTION 1 – Purpose and Authority for Establishing Rules

1.1 THESE RULES DEFINE THE AUTHORIZED MEDICAL ACTS OF EMERGENCY MEDICAL SERVICE (EMS) PROVIDERS IN THE SETTINGS IN WHICH THEY MAY PRACTICE: PREHOSPITAL, AS DEFINED BY SECTION 25-3.5-206(5)(B), C.R.S. AND THESE RULES; OUT-OF-HOSPITAL, AS DEFINED BY 6 CCR 1011-3 AND THESE RULES; AND CLINICAL, AS DEFINED BY SECTION 25-3.5-207(1)(A), C.R.S AND THESE RULES.

1.2 ~~The purpose of these~~THESE rules ~~is to~~ ALSO define ~~the~~ MEDICAL DIRECTOR qualifications and duties ~~of medical directors~~ WITHIN EMS AGENCIES, COMMUNITY INTEGRATED HEALTH CARE SERVICE (CIHCS) AGENCIES, AND CLINICAL SETTINGS. THESE RULES apply to ~~and are controlling for~~ any physician functioning as a medical director in THESE SETTINGS. ~~to Emergency Medical Services (EMS) agencies~~

1.3 THESE RULES ALSO DEFINE THE DUTIES OF MEDICAL SUPERVISORS OF EMS PROVIDERS IN THE CLINICAL SETTING.

1.4 The general authority for the promulgation of these rules by the executive director or chief medical officer of the ~~department~~DEPARTMENT is set forth in Sections 25-3.5-203, ~~and~~ 206, AND 207, C.R.S.

~~1.3 These rules apply to and are controlling for any physician functioning as a medical director to an EMS organization and who authorizes and directs the performance of medical acts by EMS providers at all levels of certification in the State of Colorado. These rules also define the scope of practice for EMS providers.~~

SECTION 2 – Definitions

2.1 All definitions that appear in Sections 25-3.5-103, 25-3.5-205 – 207, C.R.S., and 6 CCR 1015-3, CHAPTER ONE shall apply to these rules. UNLESS OTHERWISE STATED, THE DEFINITIONS IN THIS SECTION SHALL APPLY TO:

2.1.1 PREHOSPITAL AND INTERFACILITY TRANSPORT SETTINGS,

2.1.2 CIHCS (OUT- OF- HOSPITAL) SETTINGS, AND

2.1.3 CLINICAL SETTINGS.

2.1~~1~~2 “Advanced Cardiac Life Support (ACLS)” - a course of instruction designed to prepare students in the practice of advanced emergency cardiac care.

2.2~~3~~3 “Advanced Emergency Medical Technician (AEMT)” - an individual who has a current and valid AEMT certificate OR LICENSE issued by the Department and who is authorized to provide limited acts of advanced emergency medical care in accordance with these rules.

2.3~~4~~4 “Care ~~c~~Coordination” - the deliberate organization of patient care activities between two or more participants, including the patient, involved in ~~a~~ THE patient’s care to facilitate the appropriate delivery of medical care services.

2.5 "CERTIFICATE" – DESIGNATION AS HAVING MET THE REQUIREMENTS OF SECTION 5 OF CHAPTER ONE, 6 CCR 1015-3, ISSUED TO AN INDIVIDUAL BY THE DEPARTMENT. CERTIFICATION IS EQUIVALENT TO LICENSURE FOR PURPOSES OF THE STATE ADMINISTRATIVE PROCEDURE ACT, SECTION 24-4-101, *ET SEQ.*, C.R.S.

2.6 "CLINICAL MEDICAL DIRECTOR" – FOR PURPOSES OF THESE RULES, A PHYSICIAN LICENSED IN COLORADO AND IN GOOD STANDING WHO DETERMINES, AUTHORIZES, AND DIRECTS, THROUGH PROTOCOLS, STANDING ORDERS, AND OPERATIONAL POLICIES OR PROCEDURES DEVELOPED BY THE FACILITY'S MEDICAL STAFF, THE MEDICAL ACTS PERFORMED BY EMS PROVIDERS IN A CLINICAL SETTING. THE CLINICAL MEDICAL DIRECTOR IS ALSO RESPONSIBLE FOR ASSURING THE COMPETENCY OF THE PERFORMANCE OF THOSE ACTS BY EMS PROVIDERS AS DESCRIBED IN THE FACILITY'S MEDICAL CONTINUOUS QUALITY IMPROVEMENT PROGRAM.

2.7 "CLINICAL SETTING" – A HEALTH CARE FACILITY LICENSED OR CERTIFIED BY THE DEPARTMENT PURSUANT TO SECTION 25-1.5-103(1)(A), C.R.S.

2.48 "Colorado Medical Board" - the Colorado Medical Board established in Title 12, Article ~~36~~240, C.R.S.~~, formerly known as the state Board of Medical Examiners.~~

2.~~5~~9 "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~~9.1 Services authorized pursuant to Section 25-3.5-1203(3), C.R.S.

2.~~5~~9.2 Services authorized pursuant to 6 CCR 1011-3, Standards for Community Integrated Health Care Service Agencies.

2.~~5~~9.3 Services authorized under the scope of practice as set forth in this chapter.

2.~~5~~9.4 Services authorized pursuant to Section 25-3.5-206(4)(~~A~~ A.5)(II), C.R.S.

2.~~6~~10 "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, C.R.S., that manages and offers, directly or by contract, community integrated health care services.

2.~~7~~11 "CIHCS Agency ~~m~~Medical ~~d~~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~~12 "Consumer" – an individual receiving ~~C~~COMMUNITY ~~I~~INTEGRATED ~~H~~HEALTH ~~C~~ CARE ~~S~~SERVICES.

2.~~9~~13 "Consumer ~~s~~Service ~~p~~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~~14 "Department" - the Colorado Department of Public Health and Environment.

2.~~11~~15 "Direct Verbal Order" - verbal authorization given BY A PHYSICIAN to an EMS provider for the performance of specific medical acts through a Medical Base Station or in person; OR IN A CLINICAL SETTING, GIVEN BY A PHYSICIAN CONTEMPORANEOUS TO WHEN A PATIENT IS RECEIVING TREATMENT OR BY A MEDICAL SUPERVISOR AS AN INSTRUCTION BASED ON A PHYSICIAN ORDER.

2.~~12~~16 "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 AGENCY medical directors, CIHCS AGENCY MEDICAL DIRECTORS OR CLINICAL MEDICAL DIRECTORS.

2.~~13~~17 "Emergency Medical Technician (EMT)" - an individual who has a current and valid EMT certificate OR LICENSE issued by the Department and who is authorized to provide basic emergency medical care in accordance with these rules.

2.~~14~~18 "Emergency Medical Technician with Intravenous Authorization (EMT-IV)" - an individual who has a current and valid EMT certificate OR LICENSE issued by the Department and who has met the conditions defined in Section ~~5.5~~ 6.6 of these rules.

2.~~15~~19 "Emergency Medical Technician-Intermediate (EMT-I)" - an individual who has a current and valid EMT-Intermediate certificate OR LICENSE issued by the Department and who is authorized to provide limited acts of advanced emergency medical care in accordance with these rules.

2.~~16~~20 "EMS AGENCY MEDICAL DIRECTOR" - FOR PURPOSES OF THESE RULES, MEANS A PHYSICIAN LICENSED IN COLORADO AND 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.

2.21 "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.

2.~~17~~22 "EMS ~~s~~SERVICE ~~a~~Agency OR EMS 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~~23 "Graduate Advanced EMT" - an individual who has a current and valid Colorado EMT certification OR LICENSE issued by the Department and who has successfully completed a Department-recognized AEMT initial course but has not yet successfully completed the certification OR LICENSING requirements set forth in the Rules Pertaining to EMS AND EMR Education, EMS CERTIFICATION OR LICENSURE, AND EMR REGISTRATION, 6 CCR 1015-3, Chapter One, FOR THE AEMT LEVEL.

~~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~~24 "Graduate Paramedic" - an individual who has a current and valid Colorado EMT certificate OR LICENSE, AEMT certificate OR LICENSE, or EMT-I certificate OR LICENSE issued by the Department and who has successfully completed a Department-recognized paramedic initial course but has not yet successfully completed the certification OR LICENSING requirements set forth in the Rules

Pertaining to EMS AND EMR Education, EMS CERTIFICATION AND LICENSURE, AND EMR REGISTRATION ~~and Certification~~, 6 CCR 1015-3, Chapter One FOR THE PARAMEDIC LEVEL.

2.25 "IN-SCOPE TASKS AND PROCEDURES" – TASKS AND PROCEDURES PERFORMED BY AN EMS PROVIDER WITHIN THE EMS PROVIDER'S SCOPE OF PRACTICE IN A CLINICAL SETTING AS SET FORTH IN THESE RULES.

2.~~21~~26 "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, LICENSING, and patient interaction) has initiated treatment.

2.~~22~~27 "International Board of Specialty Certification (IBSC)" –a non-profit organization that develops and administers a national community paramedic certification exam.

2.~~23~~28 "Licensed in Good Standing" - as used in these rules, means that a physician functioning as a medical director, OR A PHYSICIAN, PHYSICIAN ASSISTANT, ADVANCED PRACTICE NURSE, OR REGISTERED NURSE FUNCTIONING AS A MEDICAL SUPERVISOR, holds a current and valid COLORADO license to practice ~~medicine~~ THE APPLICABLE PROFESSION. ~~in Colorado that is not subject to any restrictions.~~

2.~~24~~29 "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.

2.30 "MEDICAL ACTS"- AS USED IN THESE RULES, MEANS THE TASKS, MEDICATIONS, OR PROCEDURES THAT AN EMS PROVIDER IS AUTHORIZED TO PERFORM OR ADMINISTER WITHIN THE EMS PROVIDER'S APPLICABLE SCOPE OF PRACTICE INCLUDING IN-SCOPE TASKS AND PROCEDURES IN A CLINICAL SETTING.

2.~~25~~31 "Medical Base Station" - the source of direct medical communications with EMS providers.

2.32 "MEDICAL DIRECTION" – MAY INCLUDE, BUT IS NOT LIMITED TO, THE FOLLOWING DUTIES:
(A) APPROVAL OF THE MEDICAL COMPONENTS OF TREATMENT PROTOCOLS AND APPROPRIATE PREARRIVAL INSTRUCTIONS;
(B) ROUTINE REVIEW OF PROGRAM PERFORMANCE AND MAINTENANCE OF ACTIVE INVOLVEMENT IN QUALITY IMPROVEMENT ACTIVITIES, INCLUDING ACCESS TO PREHOSPITAL RECORDINGS AS NECESSARY FOR THE EVALUATION OF CARE;
(C) AUTHORITY TO RECOMMEND APPROPRIATE CHANGES TO PROTOCOLS FOR THE IMPROVEMENT OF PATIENT CARE;
(D) PROVISION OF OVERSIGHT FOR THE ONGOING EDUCATION, TRAINING, AND QUALITY ASSURANCE OF EMS PROVIDERS AS APPROPRIATE FOR THE MEDICAL ACTS BEING PERFORMED IN THE PREHOSPITAL, OUT-OF-HOSPITAL, OR CLINICAL SETTING IN WHICH THE EMS PROVIDER IS PRACTICING; AND
(E) REPORTING OF ANY MISCONDUCT BY CERTIFIED OR LICENSED EMS PROVIDERS THAT THE MEDICAL DIRECTOR KNOWS OR REASONABLY BELIEVES HAS OCCURRED.

~~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.~~

2.33 "MEDICAL SUPERVISION" – THE OVERSIGHT, GUIDANCE, AND INSTRUCTIONS THAT A MEDICAL SUPERVISOR PROVIDES TO AN EMS PROVIDER IN A CLINICAL SETTING, AS DEFINED IN SECTION 25-3.5-207(1)(D), C.R.S. AND THESE RULES.

2.34 "MEDICAL SUPERVISOR" – IN A CLINICAL SETTING, MEANS A COLORADO LICENSED PHYSICIAN, PHYSICIAN ASSISTANT, ADVANCED PRACTICE NURSE, OR REGISTERED NURSE.

2.~~27~~35 "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~~36 "Out-of-hospital ~~medical services~~ MEDICAL SERVICES" – services performed by a P~~p~~aramedic with A Community Paramedic Endorsement ~~provided by a CIHCS Agency,~~ including 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; AND THE MEDICAL ACTS IDENTIFIED IN APPENDIX G OF THESE RULES. OUT-OF-HOSPITAL MEDICAL SERVICES CANNOT BE PROVIDED OR PERFORMED IN THE PREHOSPITAL SETTING.

2.~~29~~37 "Paramedic" -- FOR PURPOSES OF THIS CHAPTER TWO, an individual who has a current and valid paramedic certificate OR LICENSE issued by the Department and who is authorized to provide advanced emergency medical care in A PREHOSPITAL OR CLINICAL SETTING IN accordance with these rules.

2.~~30~~38 "Paramedic with Community Paramedic Endorsement (P-CP)" – AN ~~An~~ individual who has a current and valid paramedic certificate OR LICENSE 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 THESE RULES ~~the Rules Pertaining to EMS Practice and Medical Director Oversight~~ relating to community integrated health care services, AND as set forth in SECTIONS 25-3.5-206, C.R.S., and 25-3.5-1301, *et seq.*, C.R.S.

2.~~31~~39 "Paramedic with Critical Care Endorsement (P-CC)" – ~~An~~ AN individual who has a current and valid P~~p~~aramedic certificate OR LICENSE 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 THESE RULES ~~the Rules Pertaining to EMS Practice and Medical Director Oversight~~ relating to critical care AND as set forth in SECTION 25-3.5-206, C.R.S.

2.~~32~~40 "Point of ~~c~~Care ~~t~~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~~41 "Prehospital Care" – any medical ~~procedures or~~ acts performed prior to a patient receiving care at a licensed healthcare facility.

2.42 "PREHOSPITAL SETTING" – MEANS ONE OF THE FOLLOWING SETTINGS IN WHICH AN EMS PROVIDER PERFORMS PATIENT CARE, WHICH CARE IS SUBJECT TO MEDICAL DIRECTION BY AN EMS AGENCY MEDICAL DIRECTOR AT THE SITE OF AN EMERGENCY, DURING EMERGENCY TRANSPORT, OR DURING INTERFACILITY TRANSPORT.

2.~~34~~43 "Protocol" - written standards for patient medical assessment and management approved by a medical director.

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

2.~~36~~44 "Scope of Practice" - refers to the TASKS, MEDICATIONS, AND PROCEDURES (MEDICAL ACTS) THAT AN EMS PROVIDER IS AUTHORIZED TO PERFORM OR ADMINISTER IN ACCORDANCE WITH SECTIONS 25-3.5-203 AND 25-3.5-206, C.R.S., AND RULES PROMULGATED PURSUANT TO THOSE SECTIONS. ~~medication administration and acts authorized in these rules for EMS providers.~~

2.~~37~~45 "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~~46 "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~~47 "Supervision" – AS APPLICABLE TO PHYSICIAN MEDICAL DIRECTION, MEANS THE OVERSIGHT, DIRECTION, OR MEDICAL MANAGEMENT THAT THE MEDICAL DIRECTOR PROVIDES TO AN EMS PROVIDER IN ANY SETTING ~~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~~48 "Waiver" - a Department-approved exception to these rules granted to ~~a~~ AN EMS AGENCY medical director.

2.~~41~~49 "Written Order" - written authorization ~~given~~ THAT A PHYSICIAN ISSUES to an EMS provider for the performance of specific medical acts.

SECTION 3 – Emergency Medical Practice Advisory Council

3.1 The Emergency Medical Practice Advisory Council (EMPAC), under the direction of the executive director of the ~~department~~ DEPARTMENT, shall advise the ~~department~~ DEPARTMENT in the areas set forth below in Section 3.8.

3.2 The EMPAC shall consist of the following eleven members:

3.2.1 Eight voting members appointed by the governor as follows:

A) Two physicians licensed in good standing in Colorado who are actively serving as EMS AGENCY medical directors and are practicing in rural or frontier counties;

B) Two physicians licensed in good standing in Colorado who are actively serving as EMS AGENCY medical directors and are practicing in urban counties;

C) One physician licensed in good standing in Colorado who is actively serving as an EMS AGENCY medical director in any area of the state;

D) One EMS provider certified OR LICENSED at an advanced life support level who is actively involved in the provision of emergency medical services;

E) One EMS provider certified OR LICENSED at a basic life support level who is actively involved in the provision of emergency medical services; and

F) One EMS provider certified OR LICENSED at any level who is actively involved in the provision of emergency medical services;

3.2.2 One voting member who is a member of the SEMTAC, appointed by the executive director of the ~~department~~ DEPARTMENT; and

3.2.3 Two nonvoting ex officio members appointed by the executive director of the ~~department~~ DEPARTMENT.

3.3 EMPAC members shall serve four-year terms.

3.4 A vacancy on the EMPAC shall be filled by appointment by the appointing authority for that vacant position for the remainder of the unexpired term.

3.5 EMPAC members serve at the pleasure of the appointing authority and continue in office until the member's successor is appointed.

3.6 The EMPAC shall meet at least quarterly and more frequently as necessary to fulfill its obligations.

3.7 The EMPAC shall elect a chair and vice-chair from its members.

3.8 The duties of the EMPAC include:

3.8.1 Provide general technical expertise on matters related to the provision of patient care by EMS providers.

3.8.2 Advise or make recommendations to the ~~department~~ DEPARTMENT on:

A) The acts and medications that EMS providers are authorized to perform or administer under the direction of ~~a~~ ALL medical directorS.

B) Requests by medical directors for waivers to the scope of practice of EMS providers as established in these rules.

C) Modifications to EMS provider certification OR LICENSING levels and capabilities.

D) Criteria for physicians to serve as EMS AGENCY medical directors.

SECTION 4 – Medical Director Qualifications and Duties

4.1 ALL medical directorS SUBJECT TO THESE RULES shall BE A PHYSICIAN CURRENTLY LICENSED IN GOOD STANDING TO PRACTICE MEDICINE IN THE STATE OF COLORADO. ~~possess the following minimum qualifications~~:

~~4.1.1 Be a physician currently licensed to practice medicine in the State of Colorado.~~

~~4.1.2 Be trained in Advanced Cardiac Life Support.~~

4.2 IN ADDITION TO 4.1 ABOVE, THE EXPECTATIONS AND REQUIREMENTS OF A PHYSICIAN ACTING AS A MEDICAL DIRECTOR ARE LOCATED IN THE FOLLOWING SECTIONS:

4.2.1 FOR EMS AGENCY MEDICAL DIRECTOR, SEE SECTION 5 OF THESE RULES,

4.2.2. FOR CIHCS AGENCY (OUT-OF-HOSPITAL) MEDICAL DIRECTOR, SEE SECTION 18, AND

4.2.3 FOR CLINICAL MEDICAL DIRECTOR, SEE SECTION 19.

4.~~1.3~~3 Physicians acting as medical directors for ~~department~~ DEPARTMENT-recognized EMS education programs must possess authority under their licensure to perform any and all medical acts to which they extend their authority to EMS providers, including any and all curricula presented by EMS education programs.

4.~~3~~4 Departmental review of ALL medical directors

4.~~3~~4.1 The ~~department~~ DEPARTMENT may review the records of aNY medical director SUBJECT TO THESE RULES to determine compliance with the requirements and standards in these rules and with accepted standards of medical oversight and practice.

4.~~3~~4.2 Complaints in writing against medical directors for violations of these rules may be initiated by any person, the Colorado Medical Board, or the ~~department~~ DEPARTMENT.

4.~~3~~4.3 Complaints in writing against medical directors may be referred to the Colorado Medical Board for review as deemed appropriate by the ~~department~~ DEPARTMENT.

~~4.2 The duties of a medical director shall include:~~

SECTION 5 - EMS AGENCY MEDICAL DIRECTORS

5.1 EMS AGENCY MEDICAL DIRECTORS ARE RESPONSIBLE FOR THE MEDICAL DIRECTION OF EMS PROVIDERS IN THE PREHOSPITAL SETTING. THEIR DUTIES SHALL INCLUDE:

~~4.2.1~~5.1.1 Be actively involved in the provision of emergency medical services in the community served by the EMS service agency 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. 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 with patients, the public served by the EMS service agency, the hospital community, the public safety agencies, and the medical community and should include other aspects of liaison, oversight, and communication normally expected in the supervision of EMS providers.

~~4.2.2~~5.1.2 Be actively involved on a regular basis with the EMS service agency 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 EMS service agency and supervised EMS providers does not meet this requirement.

~~4.2.3~~5.1.3 Notify the Department on an annual basis and upon any change of medical direction of the EMS ~~S~~ service ~~A~~ Agencies for which medical ~~control functions are being~~ DIRECTION IS BEING provided in a manner and form as determined by the Department.

~~4.2.4~~5.1.4 Establish a medical continuous quality improvement (CQI) program for each EMS service agency being supervised. The medical CQI program shall assure the continuing competency of the performance of that agency's EMS providers. This medical CQI program shall include, but not be limited to: appropriate protocols and standing orders and provision for medical care audits, observation, critiques, continuing medical education, and direct supervisory communications.

~~4.2.5~~5.1.5 Submit to the ~~department~~ DEPARTMENT an affidavit that attests to the development and use of a medical CQI program for all EMS service agencies supervised by the medical director. As set forth ~~below~~ in ~~section~~ ~~4.3~~ SECTION 4.4, the ~~department~~ DEPARTMENT may review the records of a medical director to determine compliance with the CQI requirements in these rules.

~~4.2.6~~5.1.6 Provide monitoring and supervision of the medical field performance of EMS providers. This includes ensuring that EMS providers have adequate clinical knowledge of, and are competent in performing, medical ~~skills and~~ acts within the EMS provider's scope of practice authorized by the medical director. These duties and operations may be delegated to other physicians or other qualified health care professionals designated by the medical director. However, the 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.

~~4.2.7~~5.1.7 Ensure that all protocols issued by the medical director are appropriate for the certification OR LICENSE 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 DIRECT verbal orders.

~~4.2.8~~5.1.8 Be familiar with the training, knowledge, and competence of EMS providers under his or her supervision and ensure that EMS providers are appropriately trained and demonstrate ongoing competency in all ~~skills, procedures and medications~~ MEDICAL ACTS authorized in accordance with Section ~~4.2.7~~ 15.1 AND, AS APPLICABLE, APPENDICES A-G.

~~4.2.9~~5.1.9 Be aware that certain ~~skills, procedures and medications~~ MEDICAL ACTS authorized in accordance with Section ~~4.2.7~~ 15.1 AND, AS APPLICABLE, APPENDICES A-G (and as identified by the DEPARTMENT ~~department~~) may not be included in the National EMS Education Standards and ensure that appropriate additional training is provided to supervised EMS providers.

~~4.2.10~~5.1.10 Ensure that any data and/or documentation required by thes~~e~~ rules are submitted to the ~~department~~ DEPARTMENT.

~~4.2.11~~5.1.11 Notify the ~~department~~ DEPARTMENT within fourteen business days excluding state holidays prior to his or her cessation of duties as medical director.

~~4.2.12~~5.1.12 Notify the ~~department~~ DEPARTMENT within fourteen business days excluding state holidays of his or her termination of the supervision of an EMS provider for reasons that may constitute good cause for disciplinary sanctions pursuant to the Rules Pertaining to EMS AND EMR Education, EMS ~~and~~ Certification OR LICENSURE, AND EMR REGISTRATION 6 CCR 1015-3, Chapter One. Such notification shall be in writing and shall include a statement of the actions or omissions resulting in termination of supervision and copies of all pertinent records.

~~4.2.13~~5.1.13 Physicians acting as medical directors for EMS education programs recognized by the ~~department~~ DEPARTMENT that require clinical and field internship performance by students shall be permitted to delegate authority to a student-in-training during their performance of program-required medical acts and only while under the control of the education program.

~~4.2.14~~5.1.14 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~~ MEDICAL ACTS for which they are providing supervision and authorization. Additional duties related

to medical directors responsible for the supervision and authorization of a P-CC are set forth in Section ~~16~~17 of these rules.

5.2 EMS AGENCY MEDICAL DIRECTORS SHALL BE TRAINED IN ADVANCED CARDIAC LIFE SUPPORT.

~~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.~~

~~4.3 Departmental review of medical directors~~

~~4.3.1 The department may review the records of a medical director to determine compliance with the requirements and standards in these rules and with accepted standards of medical oversight and practice.~~

~~4.3.2 Complaints in writing against medical directors for violations of these rules may be initiated by any person, the Colorado Medical Board or the department.~~

~~4.3.3 Complaints in writing against medical directors may be referred to the Colorado Medical Board for review as deemed appropriate by the department.~~

SECTION ~~5~~6 – Medical Acts Allowed for the EMT

~~5~~6.1 An EMT may, under the ~~supervision and~~ authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director, perform ~~emergency~~ medical acts consistent with and not to exceed those listed in Appendices A and C of these rules for an EMT.

~~5~~6.2 An EMT may, under the ~~supervision and~~ authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director, administer and monitor medications and classes of medications consistent with and not to exceed those listed in Appendices B and D of these rules for an EMT.

~~5~~6.3 Any EMT who is a member or employee of an EMS service agency and who performs ~~said emergency~~ medical acts IN A PREHOSPITAL SETTING must have authorization and be supervised by ~~a~~ AN EMS AGENCY medical director to perform ~~said emergency~~ THE medical acts.

6.4 ANY EMT WHO PERFORMS MEDICAL ACTS IN A CLINICAL SETTING MUST HAVE THE AUTHORIZATION OF A CLINICAL MEDICAL DIRECTOR AND BE SUPERVISED BY A MEDICAL SUPERVISOR.

~~5.4~~6.5 AN EMT~~s~~ may carry out a physician order for a mental health hold as set forth in Section 27-65-105(1), C.R.S. Such physician order may be a direct verbal order or by electronic communications.

~~5.5~~6.6 An EMT who has successfully completed a ~~department~~ DEPARTMENT-recognized Intravenous Therapy and Medication Administration Course may be referred to as an Emergency Medical Technician with Intravenous Authorization (EMT-IV). Any provisions of these rules that are applicable to an EMT shall also be applicable to an EMT-IV. In addition to the acts an EMT is allowed to perform, an EMT-IV may, under ~~supervision and~~ authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director, perform medical acts consistent with and not to exceed those listed in Appendices A and C of these rules for an EMT-IV. In addition to the medications and classes of medications an EMT is allowed to administer and monitor pursuant to these rules, an EMT-IV may, under ~~supervision and~~ authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director, administer and monitor medications and classes of

medications consistent with and not to exceed those listed in Appendices B and D of these rules for an EMT-IV.

~~5.6~~6.7 An EMT-IV may, under the ~~supervision and~~ authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director, administer and monitor medications and classes of medications which exceed those listed in Appendices B and D of these rules for an EMT-IV under the direct visual supervision of an AEMT, EMT-I, or paramedic WHEN IN THE PREHOSPITAL SETTING, OR THE MEDICAL SUPERVISOR IN A CLINICAL SETTING, when the following conditions have been established:

~~5.6.1~~6.7.1 The patient must be in cardiac arrest or in extremis.

~~5.6.2~~6.7.2 Drugs administered must be limited to those authorized by these rules for an AEMT, EMT-I, or paramedic as stated in Appendices B and D.

~~5.6.3~~6.7.3 The EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director shall amend the appropriate protocols and medical CQI program used to supervise the EMS providers to reflect this change in patient care. The APPLICABLE medical director and the protocols of the EMT-IV and the AEMT, EMT-I, or paramedic shall all be in agreement.

~~5.7~~6.8 In the event of a governor-declared disaster or public health emergency, the ~~c~~Chief ~~m~~Medical ~~o~~Officer for the ~~d~~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 ~~6~~7 – Medical Acts Allowed for the Advanced EMT

~~6~~7.1 An AEMT may, under the ~~supervision and~~ authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director, perform ~~emergency~~ medical acts consistent with and not to exceed those listed in Appendices A and C of these rules for an AEMT.

~~6~~7.2 An AEMT may, under ~~the supervision and~~ authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director, administer and monitor medications and classes of medications consistent with and not to exceed those listed in Appendices B and D of these rules for an AEMT.

~~6~~7.3 Any AEMT who is a member or employee of an EMS service agency and who performs ~~said emergency~~ medical acts IN A PREHOSPITAL SETTING must have authorization and be supervised by ~~a~~ AN EMS AGENCY medical director to perform said ~~emergency~~ medical acts.

7.4 ANY AEMT WHO PERFORMS MEDICAL ACTS IN A CLINICAL SETTING MUST HAVE THE AUTHORIZATION OF A CLINICAL MEDICAL DIRECTOR AND BE SUPERVISED BY A MEDICAL SUPERVISOR.

~~6.4~~7.5 AN AEMT~~s~~ may carry out a physician order for a mental health hold as set forth in Section 27-65-105(1), C.R.S. Such physician order may be a direct verbal order or by electronic communications.

~~6.5~~7.6 An AEMT may, under the ~~supervision and~~ authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director, administer and monitor medications and classes of medications which exceed those listed in Appendices B and D of these rules for an AEMT under the direct visual supervision of an EMT-I or paramedic when IN THE PREHOSPITAL SETTING, OR A MEDICAL SUPERVISOR IN A CLINICAL SETTING, AND the following conditions have been established:

~~6.5.1~~7.6.1 The patient must be in cardiac arrest or in extremis.

~~6.5.2~~7.6.2 Drugs administered must be limited to those authorized by these rules for EMT-I or paramedic as stated in Appendices B and D.

~~6.5.3~~7.6.3 The EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director shall amend the appropriate protocols and medical CQI program used to supervise the EMS providers to reflect this change in patient care. The APPLICABLE medical director and the protocols of the AEMT and the EMT-I or paramedic shall all be in agreement.

~~6.6~~7.7 In the event of a governor-declared disaster or public health emergency, the ~~c~~Chief ~~m~~Medical ~~o~~Officer for the ~~d~~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 ~~7~~8 – Medical Acts Allowed for the EMT-Intermediate

~~7~~8.1 In addition to the acts an EMT, an EMT-IV, and an AEMT are allowed to perform pursuant to these rules, an EMT-I may, under the ~~supervision and~~ authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director, perform ~~advanced emergency~~ medical ~~care~~ acts consistent with and not to exceed those listed in Appendices A and C of these rules for an EMT-I.

~~7~~8.2 In addition to the medications and classes of medications an EMT, an EMT-IV, and an AEMT are allowed to administer and monitor pursuant to these rules, an EMT-I may, under the ~~supervision and~~ authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director, administer and monitor medications and classes of medications defined in Appendices B and D of these rules for an EMT-I.

8.3 ANY EMT-I WHO IS A MEMBER OR EMPLOYEE OF AN EMS SERVICE AGENCY AND WHO PERFORMS MEDICAL ACTS IN A PREHOSPITAL SETTING MUST HAVE THE AUTHORIZATION OF AND BE SUPERVISED BY AN EMS AGENCY MEDICAL DIRECTOR.

8.4 ANY EMT-I WHO PERFORMS MEDICAL ACTS IN A CLINICAL SETTING MUST HAVE THE AUTHORIZATION OF A CLINICAL MEDICAL DIRECTOR AND BE SUPERVISED BY A MEDICAL SUPERVISOR.

~~7.3~~8.5 An EMT-I may carry out a physician order for a mental health hold as set forth in Section 27-65-105(1), C.R.S. Such physician order may be a direct verbal order or by electronic communications.

~~7.4~~8.6 An EMT-I may, under the ~~supervision and~~ authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director, administer and monitor medications and classes of medications which exceed those listed in Appendices B and D of these rules for an EMT-I under the direct visual supervision of a paramedic IN A PREHOSPITAL SETTING, OR A MEDICAL SUPERVISOR IN A CLINICAL SETTING, when the following conditions have been established:

~~7.4.1~~8.6.1 Drugs administered must be limited to those authorized by these rules for paramedics as stated in Appendices B and D.

~~7.4.2~~8.6.2 The EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director shall amend the appropriate protocols and medical CQI program used to supervise the EMS providers to reflect this change in patient care. The APPLICABLE medical director and protocols of the EMT-I and paramedic shall all be in agreement.

~~7.5~~8.7 In the event of a governor-declared disaster or public health emergency, the ~~c~~Chief ~~m~~Medical ~~o~~Officer for the ~~d~~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 ~~8~~9 – Medical Acts Allowed for the Paramedic

~~8~~9.1 In addition to the acts ~~an EMT-I is~~ ALL OTHER EMS PROVIDERS ARE allowed to perform pursuant to these rules, a paramedic may, under the ~~supervision and~~ authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR UNDER THE AUTHORIZATION OF A CLINICAL medical director AND SUPERVISION OF A MEDICAL SUPERVISOR, perform advanced ~~emergency~~ medical ~~care~~ acts consistent with and not to exceed those listed in Appendices A and C of these rules for a paramedic.

~~8~~9.2 In addition to the medications and classes of medications ~~an EMT-I is~~ ALL OTHER EMS PROVIDERS ARE allowed to administer and monitor pursuant to these rules, a paramedic may, under the ~~supervision and~~ authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director, administer and monitor medications and classes of medications defined in Appendices B and D for a paramedic.

~~8~~9.3 Paramedics may carry out a physician order for a mental health hold as set forth in Section 27-65-105(1), C.R.S. Such physician order may be a direct verbal order or by electronic communications.

~~8~~9.4 ANY PARAMEDIC WHO IS A MEMBER OR EMPLOYEE OF AN EMS SERVICE AGENCY AND WHO PERFORMS ~~SAID~~ MEDICAL ACTS IN A PREHOSPITAL SETTING MUST HAVE THE AUTHORIZATION OF AND BE SUPERVISED BY AN EMS AGENCY MEDICAL DIRECTOR TO PERFORM SAID MEDICAL ACTS.

9.5 ANY PARAMEDIC WHO PERFORMS SAID MEDICAL ACTS IN A CLINICAL SETTING MUST HAVE THE AUTHORIZATION OF A CLINICAL MEDICAL DIRECTOR AND BE SUPERVISED BY A MEDICAL SUPERVISOR TO PERFORM SAID MEDICAL ACTS.

9.6 In addition to the acts of a paramedic, a P-CC may, under the supervision and authorization of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR UNDER THE AUTHORIZATION OF A CLINICAL medical director AND SUPERVISION OF A MEDICAL SUPERVISOR perform advanced ~~emergency~~ medical ~~care~~ acts consistent with and not to exceed those authorized in Appendix E of these rules for Critical Care.

~~8.5~~9.7 In addition to the medications a paramedic is allowed to administer and monitor, a P-CC may, under the ~~supervision and~~ authorization of ~~a~~ AN EMS OR CLINICAL medical director, administer and monitor medications defined in Appendix F of these rules for Critical Care.

~~8.6~~9.8 In addition to the acts of a paramedic, a P-CP may, under the supervision and authorization of a CIHCS Agency medical director OR UNDER THE AUTHORIZATION OF A CLINICAL MEDICAL DIRECTOR AND SUPERVISION OF A MEDICAL SUPERVISOR perform out-of-hospital medical services AND MEDICAL ACTS consistent with and not to exceed those authorized in Appendix G of these rules for Community Paramedic~~ine~~s.

~~8.7~~9.9 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 OR UNDER THE AUTHORIZATION OF A CLINICAL MEDICAL DIRECTOR, administer and monitor medications defined in Appendix G of these rules for Community Paramedic~~ine~~s.

9.10 ANY P-CP WHO IS A MEMBER OR EMPLOYEE OF AN CIHCS AGENCY AND WHO PERFORMS SAID MEDICAL ACTS IN AN OUT-OF-HOSPITAL SETTING MUST HAVE AUTHORIZATION AND BE SUPERVISED BY A CIHCS AGENCY MEDICAL DIRECTOR TO PERFORM SAID MEDICAL ACTS.

9.11 ANY P-CP WHO PERFORMS SAID MEDICAL ACTS IN A CLINICAL SETTING MUST HAVE THE AUTHORIZATION OF A CLINICAL MEDICAL DIRECTOR AND BE SUPERVISED BY A MEDICAL SUPERVISOR TO PERFORM SAID MEDICAL ACTS.

~~8.8~~9.12 In the event of a governor-declared disaster or public health emergency, the ~~c~~Chief ~~m~~Medical ~~o~~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 ~~9~~10 – Graduate Advanced EMTs~~, Graduate EMT-Intermediates~~ and Graduate Paramedics

Medical directors may supervise graduate AEMTs AND PARAMEDICS ~~as defined in these rules~~ acting as AEMTs OR PARAMEDICS for a period of no more than six months following successful completion of an appropriate ~~d~~ Department-recognized initial course. ~~Medical directors may supervise graduate EMT-Is as defined in these rules acting as EMT-Is for a period of no more than six months following successful completion of an appropriate department-recognized initial course~~. ~~Medical directors may supervise graduate paramedics as defined in these rules acting as paramedics for a period of no more than six months following successful completion of an appropriate department-recognized initial course.~~ UPON EXPIRATION OF THIS SIX MONTH PERIOD, ~~S~~such graduate AEMTs~~, graduate EMT-Is~~ and graduate paramedics must successfully complete certification OR LICENSING requirements, as specified in Rules Pertaining to EMS AND EMR Education, ~~and~~ EMS Certification OR LICENSURE, AND EMR REGISTRATION 6 CCR 1015-3, Chapter One, ~~within six months of the successful completion of a department-recognized initial course~~ to continue to function under the provisions of these rules.

SECTION ~~10~~11 – General Acts Allowed

~~10~~11.1 Any EMS provider working for an EMS service agency shall be supervised by aN EMS AGENCY medical director who complies with the requirements in these rules.

11.2 EMS PROVIDERS WHO ARE PROVIDING MEDICAL CARE IN A CLINICAL SETTING MUST FUNCTION UNDER THE AUTHORITY OF A CLINICAL MEDICAL DIRECTOR AND UNDER THE MEDICAL SUPERVISION OF A MEDICAL SUPERVISOR.

~~10.2~~ 11.3 AN EMS AGENCY MEDICAL DIRECTOR, CIHCS AGENCY MEDICAL DIRECTOR, OR CLINICAL medical director may limit the scope of practice of any EMS provider OVER WHOM THEY PROVIDE MEDICAL DIRECTION.

~~10.3~~11.4 IN A PREHOSPITAL SETTING, ~~T~~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:

~~10.3.1~~11.4.1 The method by which the data is gathered is within the scope of practice of the EMS provider as contained in these rules;

~~10.3.2~~11.4.2 The collection method and analysis of the information collected is done in accordance with applicable regulations including, but not limited to, the Clinical Laboratory Improvement Amendments (CLIA) and FDA requirements; and,

~~10.3.3~~11.4.3 Unless otherwise allowed in Table A.6, the information obtained will not be used to alter the prehospital treatment or destination of the patient without a direct verbal order.

~~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.~~

11.4.4 A medical director shall obtain a waiver as set forth in Section ~~11~~ 12 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 must function under the auspices of a medical director AND be in compliance with the Colorado Medical Board's statutes and 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.~~

11.5 EMS PROVIDERS WHO ARE PROVIDING OUT-OF-HOSPITAL MEDICAL SERVICES, AS SPECIFICALLY DEFINED IN SECTION 2.36 OF THESE RULES, FOR A CIHCS AGENCY OR IN A CLINICAL SETTING MUST OBTAIN A COMMUNITY PARAMEDIC ENDORSEMENT.

11.5.1 AN ENDORSED COMMUNITY PARAMEDIC MAY PROVIDE OUT-OF-HOSPITAL MEDICAL SERVICES AS DEFINED IN THESE RULES WHILE EMPLOYED BY OR CONTRACTING WITH A CIHCS AGENCY.

11.5.2 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.

11.5.3 AN ENDORSED COMMUNITY PARAMEDIC MAY PROVIDE OUT-OF-HOSPITAL MEDICAL SERVICES IN THE CLINICAL SETTING PURSUANT TO THE PROVISIONS SET FORTH IN SECTION 9 OF THESE RULES.

~~10.5~~11.6EMS providers may not practice in camps in a nursing capacity including the dispensing of medications.

SECTION ~~11~~12 – Waivers to Scope of Practice FOR EMS PROVIDERS IN PREHOSPITAL SETTINGS

~~11~~12.1 Any EMS AGENCY medical director may apply to the ~~department~~ DEPARTMENT for a waiver to the scope of practice set forth in these rules for EMS providers under his or her supervision in specific circumstances, based on established need, provided that on-going quality assurance of each EMS provider's competency is maintained by the medical director. WAIVERS TO SCOPE OF PRACTICE ARE LIMITED TO PREHOSPITAL SETTINGS.

~~11~~12.2 A waiver is not necessary for the allowed ~~skills and medications~~ MEDICAL ACTS listed in Appendices A, B, C, or D of this rule.

~~11.~~12.2.1 In addition to the ~~skills and medications~~ MEDICAL ACTS allowed in ~~Paragraph~~SECTION ~~11~~12.2, a P-CC does not require a waiver for the allowed ~~skills and medications~~ MEDICAL ACTS listed in Appendices E and F.

~~11~~12.2.2 In addition to the ~~skills and medications~~ MEDICAL ACTS allowed in ~~Paragraph~~ SECTION ~~11~~12.2, 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.

~~11~~12.3 All levels of EMS provider may, under the supervision and authorization of ~~a~~ AN EMS AGENCY medical director, perform specific skills or administer specific medications not listed in Appendices A, B, C, D, E, or F of this rule, only if the EMS AGENCY medical director has been granted a waiver from the ~~department~~ DEPARTMENT for that specific skill or medication.

12.3.1 Waivered skills or medication administration may be authorized by the EMS agency medical director under standing orders or direct verbal orders of a physician, including by electronic communications.

12.3.2 No EMS provider shall function beyond the scope of practice identified in these rules for their level until their EMS agency medical director has received official written confirmation of the waiver being granted by the ~~department~~ DEPARTMENT.

~~11~~12.4 ~~Medical~~ EMS AGENCY MEDICAL directors seeking a waiver shall submit a completed application to the ~~department~~ DEPARTMENT in a form and manner determined by the ~~department~~ DEPARTMENT.

~~11~~12.4.1 The application shall include, but not be limited to, a description of the act or medication to be waived, information regarding the justification for the waiver, the proposed education, training, and quality assurance process, literature review, and copies of the applicable protocols. The forms and affidavit required by Section ~~4~~ 5 of these rules shall also be included.

~~11~~12.4.2 The ~~department~~ DEPARTMENT may require the applicant to provide additional information if the initial application is determined to be insufficient.

~~11~~12.4.3 An application shall not be considered complete until the required information is submitted.

~~11~~12.4.4 The completed waiver application shall be submitted to the ~~department~~ DEPARTMENT in a timely fashion as specified by the ~~department~~ DEPARTMENT.

~~11~~12.4.5 The application shall be a matter of public record and is subject to disclosure requirements under the Colorado Open Records Act (~~C.R.S. §~~ SECTION 24-72-200.1 *et seq.*, C.R.S.

~~11~~12.5 The EMPAC shall review waiver requests and make recommendations to the ~~department~~ DEPARTMENT. The EMPAC may make recommendations, including but not limited to: deny, approve, table, request more information from the EMS AGENCY medical director, or impose special conditions on the waiver.

~~11~~12.6 After receiving recommendations from the EMPAC, the ~~department~~ DEPARTMENT shall make a decision on the waiver request and send notice of that decision to the EMS AGENCY medical director within thirty (30) calendar days of the recommendation. If granted, the notice shall include the effective date and expiration date of the waiver.

~~11~~12.6.1 If the waiver is granted, the ~~department~~ DEPARTMENT may:

A) Specify the terms and conditions of the waiver.

B) Specify the duration of the waiver.

C) Specify any reporting requirements.

~~11~~12.6.2 The ~~department~~ DEPARTMENT may require the submission of data or other information regarding waivers.

A) Unless otherwise specified by the ~~department~~ DEPARTMENT, any data or information submitted to the ~~department~~ DEPARTMENT shall not contain patient-identifying information.

B) If the ~~department~~ DEPARTMENT requires submission of data or reports containing patient-identifying information for purposes of overseeing a statewide continuing quality improvement system, that information shall be kept confidential pursuant to ~~C.R.S. §~~ SECTION 25-3.5-704(2)(h)(I)(E), C.R.S.

C) If the ~~department~~ DEPARTMENT requires submission of data, information, records, or reports related to the identification of individual patient's, provider's, or facility's care outcomes for purposes of overseeing a statewide continuing quality improvement system, that information shall be kept confidential pursuant to ~~C.R.S. §~~ SECTION 25-3.5-~~702~~704(2)(h)(II), C.R.S.

~~11~~12.6.3 The ~~department~~ DEPARTMENT may deny, revoke, or suspend a waiver if it determines:

A) That its approval or continuation jeopardizes the health, safety, and/or welfare of patients.

B) The EMS AGENCY medical director has provided false or misleading information in the waiver application.

C) The EMS AGENCY medical director has failed to comply with conditions or reporting on an approved waiver.

D) That a change in federal or state law prohibits continuation of the waiver.

~~11~~12.7 If the ~~department~~ DEPARTMENT denies a waiver application or revokes or suspends a waiver, it shall provide the EMS AGENCY medical director with a notice explaining the basis for the action. The notice shall also inform the EMS AGENCY medical director of his or her right to appeal and the procedure for appealing the action.

~~11~~12.8 Appeals of ~~d~~Departmental actions shall be conducted in accordance with the state Administrative Procedure Act, Section 24-4-101, *et seq*., C.R.S.

~~11~~12.9 If the rule pertaining to a waived ~~skill or medication administration~~ MEDICAL ACT is amended or repealed obviating the need for the waiver, the waiver shall expire on the effective date of the rule change.

~~11~~12.10 If ~~a~~ AN EMS AGENCY medical director has made timely and sufficient application for renewal of a waiver and the ~~department~~ DEPARTMENT fails to take action on the application prior to the waiver's expiration date, the existing waiver shall not expire until the ~~department~~ DEPARTMENT acts upon the application. The ~~department~~ DEPARTMENT, in its sole discretion, shall determine whether the application was timely and sufficient.

~~11~~12.11 In the case of exigent circumstances, including but not limited to the death or incapacitation of ~~a~~ AN EMS AGENCY medical director or the termination of the relationship between a EMS AGENCY medical director and an EMS service agency, the ~~department~~ DEPARTMENT may

transfer waivers upon request by a replacement EMS AGENCY medical director for a period not to exceed six (6) months. The EMS AGENCY medical director shall then apply for new waiver(s) for consideration and ~~department~~ DEPARTMENT action within sixty (60) days of the transfer.

SECTION ~~12~~13 – Technology and Pharmacology Dependent Patients IN PREHOSPITAL SETTINGS

The transport of patients with 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 ~~13~~14 – Combination Benzodiazepine and Opiate Therapy

~~13~~14.1 The administration of a combination of benzodiazepines and opiates, for the purpose of pain management, anxiolysis, and/or muscle relaxation is permitted. Safeguards shall be taken to maximize patient safety including but not limited to the patient's ability to:

~~13~~14.1.1 Independently maintain an open airway and normal breathing pattern,

~~13~~14.1.2 Maintain normal hemodynamics, and

~~13~~14.1.3 Respond appropriately to physical stimulation and verbal commands.

~~13~~14.2 The administration of combination therapy requires appropriate monitoring and care including, but not limited to: IV or IO access, continuous waveform capnography, pulse oximetry, ECG monitoring, blood pressure monitoring, and administration of supplemental oxygen.

SECTION ~~14~~ 15 – Scope of Practice

~~14~~15.1 All of the following appendices define the maximum MEDICAL ACTS ~~skills, acts or medications~~that ~~may be delegated to~~ an EMT, EMT-IV, AEMT, EMT-I, and paramedic MAY BE AUTHORIZED TO PERFORM under appropriate ~~supervision~~ MEDICAL DIRECTION by ~~a~~ THE APPLICABLE medical director FOR EACH SETTING.

~~14~~15.2 A medical director may establish the methods by which an EMS provider obtains authorization in the ~~field~~ PREHOSPITAL OR CLINICAL SETTING to perform any medical act~~s, 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.

15.3 AS USED IN ALL OF THE APPENDICES, THE FOLLOWING TERMS ARE DEFINED TO MEAN:

~~14~~15.~~2~~3.1 "Y" = YES: May be performed or administered by EMS providers with ~~physician~~ supervision as described in these rules.

~~14~~15.~~2.~~3.2 "VO" = Verbal Order: ~~May only be performed or administered by EMS providers if authorized by direct verbal or written order received from 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.~~

INDICATES A CATEGORY OF MEDICAL ACTS OR MEDICATIONS THAT EMS PROVIDERS MAY ONLY PERFORM OR ADMINISTER WITHIN THEIR SCOPES OF PRACTICE AFTER RECEIVING AUTHORIZATION FROM A PHYSICIAN. SUCH AUTHORIZATION SHALL BE COMMUNICATED BY DIRECT VERBAL OR WRITTEN ORDER RECEIVED FROM A PHYSICIAN CONTEMPORANEOUS TO WHEN PATIENT IS RECEIVING TREATMENT, UNLESS SPECIFIC EXCEPTION CRITERIA ARE ESTABLISHED BY THE APPLICABLE MEDICAL DIRECTOR.

A) IN A CLINICAL SETTING, A MEDICAL SUPERVISOR MAY INSTRUCT EMS PROVIDERS TO PERFORM A MEDICAL ACT OR ADMINISTER A MEDICATION THAT REQUIRES A PHYSICIAN'S AUTHORIZATION ONLY IF THE PHYSICIAN HAS CONTEMPORANEOUSLY COMMUNICATED THE DIRECT VERBAL OR WRITTEN ORDER TO THE MEDICAL SUPERVISOR.

B) EXCEPTION CRITERIA MAY INCLUDE, BUT ARE NOT LIMITED TO CARDIAC ARREST, BEHAVIORAL MANAGEMENT, OR COMMUNICATIONS FAILURE.

C) MEDICAL DIRECTORS SHALL NOT DEVELOP EXCEPTION CRITERIA THAT MERELY WAIVE ALL DIRECT VERBAL ORDER REQUIREMENTS.

~~14~~15.~~2~~3.3 "N" = NO: May not be performed or administered by EMS providers except with an approved waiver as described in Section 12~~11~~ of these rules.

~~14~~15.~~2~~3.4 "EMT" = Medical acts~~, skills or medications~~ that may be performed or administered by an EMT with appropriate medical director ~~supervision~~ AUTHORIZATION and training recognized by the ~~department~~ DEPARTMENT.

~~14~~15.~~2~~3.5 "EMT-IV" = Medical acts~~, skills or medications~~ that may be performed or administered by an EMT-IV with appropriate medical director ~~supervision~~ AUTHORIZATION and training recognized by the DEPARTMENT ~~department~~.

~~14~~15.~~2~~3.6 "AEMT" = Medical acts~~, skills or medications~~ that may be performed or administered by an AEMT with appropriate medical director ~~supervision~~ AUTHORIZATION and training recognized by the DEPARTMENT ~~department~~.

~~14~~.15.~~2~~3.7 "EMT-I" = Medical acts~~, skills or medications~~ that may be performed or administered by an EMT-I with appropriate medical director AUTHORIZATION and training recognized by the ~~department~~ DEPARTMENT.

~~14~~15.~~2~~3.8 "P" = Medical acts~~, skills or medications~~ that may be performed or administered by a paramedic with appropriate medical director ~~supervision~~ AUTHORIZATION and training recognized by the ~~department~~ DEPARTMENT.

Note: SECTION ~~15~~16 – INTERFACILITY TRANSPORT begins following APPENDIX B.

Note: Section ~~16~~17 – CRITICAL CARE begins following APPENDIX D.

NOTE: SECTION 18 – COMMUNITY PARAMEDIC BEGINS FOLLOWING APPENDIX F.

NOTE: SECTION 19 – CLINICAL SETTING BEGINS FOLLOWING APPENDIX G.

APPENDIX A

~~PREHOSPITAL~~

MEDICAL ~~SKILLS AND~~ ACTS ALLOWED

A.1.1 IN THE PREHOSPITAL SETTING, additions to these medical ~~skills and~~ acts ~~allowed cannot be delegated~~ ARE NOT ALLOWED unless a waiver has been granted as described in Section ~~11~~ 12 of these rules. A WAIVER MAY NOT BE GRANTED FOR MEDICAL ACTS IN THE OUT-OF-HOSPITAL OR CLINICAL SETTINGS.

A.1.2 Not all medical ~~skills and~~ acts allowed are included in initial education for various EMS provider levels. ~~Medical~~ ALL MEDICAL directors SUBJECT TO THESE RULES shall ensure providers are appropriately trained as noted in Sections 4.2.8 and 4.2.9, SECTIONS 18 (CIHCS) AND 19 (CLINICAL SETTINGS).

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	Y	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

Skill	EMT	EMT-IV	AEMT	EMT-I	P
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

[1] Use of automated transport ventilators (ATVs) is restricted to the manipulation of tidal volume (TV or VT), respiratory rate (RR), fraction of inspired oxygen (FIO2), and positive end expiratory pressure (PEEP). Manipulation of any other parameters of mechanical ventilation devices by EMS providers requires a waiver to these rules.

TABLE A.2 – CARDIOVASCULAR/CIRCULATORY SUPPORT

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Cardiac Monitoring – Application of electrodes and data transmission	Y	Y	Y	Y	Y
Cardiac Monitoring – Rhythm and diagnostic EKG interpretation	N	N	N	Y	Y
Cardiopulmonary Resuscitation (CPR)	Y	Y	Y	Y	Y
Cardioversion – Electrical	N	N	N	N	Y
Carotid Massage	N	N	N	N	Y
Defibrillation – Automated/Semi-Automated (AED)	Y	Y	Y	Y	Y
Defibrillation – Manual	N	N	N	Y	Y
External Pelvic Compression	Y	Y	Y	Y	Y
Hemorrhage Control – Direct Pressure	Y	Y	Y	Y	Y
Hemorrhage Control – Pressure Point	Y	Y	Y	Y	Y
Hemorrhage Control – Tourniquet	Y	Y	Y	Y	Y
Implantable cardioverter/defibrillator magnet use	N	N	N	N	N
Mechanical CPR Device	Y	Y	Y	Y	Y
Transcutaneous Pacing	N	N	N	Y	Y
Transvenous Pacing – Maintenance	N	N	N	N	N
~~Therapeutic Induced Hypothermia (TIH)~~ TARGETED TEMPERATURE MANAGEMENT[2]	N	N	N	VO	Y
Arterial Blood Pressure Indwelling Catheter – Maintenance	N	N	N	N	N
Invasive Intracardiac Catheters – Maintenance	N	N	N	N	N
Central Venous Catheter Insertion	N	N	N	N	N
Central Venous Catheter Maintenance/Patency/Use	N	N	N	Y	Y
Percutaneous Pericardiocentesis	N	N	N	N	N

[2] ~~Therapeutic Induced Hypothermia (TIH)~~TARGETED TEMPERATURE MANAGEMENT (TTM)

1. Approved methods of cooling include:
   a. Surface cooling methods including ice packs, evaporative cooling, and surface cooling blankets or surface heat-exchange devices.
   b. Internal cooling with the intravenous administration of cold crystalloids (4°C / 39°F)
2. Esophageal temperature probe allowed for monitoring core temperatures in patients undergoing ~~TIH~~ TTM.
3. The medical director should work with the hospital systems to which their agencies transport in setting up a "systems" approach to the institution of ~~TIH~~ TTM. Medical directors should not institute ~~TIH~~TTM without having receiving facilities that also have ~~TIH~~ TTM programs to which to transport these patients.

812 **TABLE A.3 – IMMOBILIZATION**

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Spinal Immobilization – Cervical Collar	Y	Y	Y	Y	Y
Spinal Immobilization – Long Board	Y	Y	Y	Y	Y
Spinal Immobilization – Manual Stabilization	Y	Y	Y	Y	Y
Spinal Immobilization – Seated Patient	Y	Y	Y	Y	Y
Splinting – Manual	Y	Y	Y	Y	Y
Splinting – Rigid	Y	Y	Y	Y	Y
Splinting – Soft	Y	Y	Y	Y	Y
Splinting – Traction	Y	Y	Y	Y	Y
Splinting – Vacuum	Y	Y	Y	Y	Y

813 **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

814 **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)	Y	Y	Y	Y	Y
Intranasal (IN)	Y	Y	Y	Y	Y
Intraosseous	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[3]	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

[3]AEMTs may not employ the rectal administration route in any situation except for the one exception set out in Table B.10, "Benzodiazepine –Diazepam rectal administration."

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[4]	Y	Y	Y	Y	Y
Diagnostic Interpretation – Blood Lactate[4]	N	N	Y	Y	Y
Dressing/Bandaging	Y	Y	Y	Y	Y
Esophageal Temperature Probe for ~~TIH~~ TTM	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
Physical examination	Y	Y	Y	Y	Y
PUBLIC HEALTH RELATED-ORAL/NASAL SWAB SAMPLE COLLECTION	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

[4] See also Section ~~10.3~~ 11.4

APPENDIX B

~~PREHOSPITAL~~

FORMULARY OF MEDICATIONS ALLOWED

B.1.1 ~~Additions~~ IN PREHOSPITAL SETTINGS, ADDITIONS to this medication formulary ~~cannot be delegated~~ ARE NOT ALLOWED UNLESS a waiver has been granted as described in Section ~~11~~ 12 of these rules.

B.1.2 Not all medical ~~skills and~~ acts allowed are included in initial education for various EMS provider levels. ALL medical directors SUBJECT TO THESE RULES shall ensure providers are appropriately trained as noted in Sections ~~4.2.8~~ 5.1.8 and ~~4.2.9~~ 5.1.9 (PREHOSPITAL), 18.3.6 (CIHCS), 19.3.7, 19.3.8, AND 19.3.9 (CLINICAL SETTING).

TABLE B.1 – GENERAL

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Over-the-counter-medications	Y	Y	Y	Y	Y
Oxygen	Y	Y	Y	Y	Y
Specialized prescription medications to address acute crisis[1]	VO	VO	VO	VO	VO

[1] EMS providers may assist with the administration of, or may directly administer, specialized medications prescribed to the patient for the purposes of alleviating an acute medical crisis event provided the route of administration is within the provider's scope as listed in Appendix A.

TABLE B.2 – ANTIDOTES

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Atropine	N	N	N	VO	Y

Calcium salt – Calcium chloride	N	N	N	N	Y
Calcium salt – Calcium gluconate	N	N	N	N	Y
Cyanide antidote	N	N	N	Y	Y
Glucagon	N	N	VO	VO	Y
Naloxone	Y	Y	Y	Y	Y
Nerve agent antidote	Y	Y	Y	Y	Y
Pralidoxime	N	N	N	N	Y
Sodium bicarbonate	N	N	N	N	Y

833 **TABLE B.3 – BEHAVIORAL MANAGEMENT**

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Anti-Psychotic – Droperidol	N	N	N	VO	Y
Anti-Psychotic – Haloperidol	N	N	N	VO	Y
Anti-Psychotic – Olanzapine	N	N	N	VO	Y
Anti-Psychotic – Ziprasidone	N	N	N	VO	Y
Benzodiazepine – Diazepam	N	N	N	~~VO~~ Y	Y
Benzodiazepine – Lorazepam	N	N	N	~~VO~~ Y	Y
Benzodiazepine – Midazolam	N	N	N	~~VO~~ Y	Y
Diphenhydramine	N	N	N	VO	Y

834 **TABLE B.4 – CARDIOVASCULAR**

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Adenosine	N	N	N	VO	Y
Amiodarone	N	N	N	VO	Y
Aspirin	Y	Y	Y	Y	Y
Atropine	N	N	N	VO	Y
Calcium salt – Calcium chloride	N	N	N	N	Y
Calcium salt – Calcium gluconate	N	N	N	N	Y
Diltiazem – bolus infusion only	N	N	N	N	Y
Dopamine	N	N	N	N	Y
Epinephrine	N	N	N	VO	Y
Lidocaine	N	N	N	VO	Y
Magnesium sulfate – bolus infusion only	N	N	N	N	Y
~~Morphine sulfate~~	~~N~~	~~N~~	~~N~~	~~VO~~	~~Y~~
Nitroglycerin – sublingual (patient assisted)	VO	VO	Y	Y	Y
Nitroglycerin – sublingual (tablet or spray)	N	N	Y	Y	Y
Nitroglycerin – topical paste	N	N	VO	VO	Y
Norepinephrine	N	N	N	N	Y
Sodium bicarbonate	N	N	N	VO	Y
Vasopressin	N	N	N	VO	Y
Verapamil – bolus infusion only	N	N	N	N	Y

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836 **TABLE B.5 – DIURETICS**

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Bumetanide	N	N	N	N	Y
Furosemide	N	N	N	VO	Y
Mannitol (trauma use only)	N	N	N	N	Y

837 **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	Y

838 **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	Y	Y	Y	Y	Y
Anti-nausea – Ondansetron IM/IVP	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

839 **TABLE B.8 – PAIN MANAGEMENT**

Medications	EMT	EMT-IV	AEMT	EMT-I	P
ACETAMINOPHEN (TYLENOL) IV	N	N	Y	Y	Y
Anesthetic – Lidocaine (for intraosseous needle insertion)	N	N	Y	Y	Y
Benzodiazepine – Diazepam	N	N	N	~~VO~~ Y	Y
Benzodiazepine – Lorazepam	N	N	N	~~VO~~ Y	Y
Benzodiazepine – Midazolam	N	N	N	~~VO~~ Y	Y
General – Nitrous oxide	N	N	~~VO~~ Y	~~VO~~ Y	Y
KETOROLAC (TORADOL)	N	N	N	N	Y
Narcotic Analgesic – Fentanyl	N	N	~~N~~ VO	~~VO~~ Y	Y
Narcotic Analgesic – Hydromorphone	N	N	N	N	Y
Narcotic Analgesic – Morphine sulfate	N	N	~~N~~ VO	~~VO~~ Y	Y
Ophthalmic anesthetic-~~Opthaine~~ OPHTHAINE	N	N	N	Y	Y
Ophthalmic anesthetic-Tetracaine	N	N	N	Y	Y
Topical Anesthetic – Benzocaine spray	N	N	N	N	Y
Topical Anesthetic – Lidocaine jelly	N	N	N	N	Y

840 **TABLE B.9 – RESPIRATORY AND ALLERGIC REACTION MEDICATIONS**

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Antihistamine – Diphenhydramine	N	N	~~VO~~ Y	~~VO~~ Y	Y
Bronchodilator – Anticholinergic – Atropine (aerosol/nebulized)	N	N	N	VO	Y
Bronchodilator – Anticholinergic – Ipratropium	~~N~~ Y	~~N~~ Y	~~VO~~ Y	~~VO~~ Y	Y
Bronchodilator – Beta agonist – Albuterol	Y	Y	Y	Y	Y
Bronchodilator – Beta agonist – L-Albuterol	~~VO~~ Y	~~VO~~ Y	~~VO~~ Y	~~VO~~ Y	Y
Bronchodilator – Beta agonist – Metaproterenol	N	N	N	VO	Y
BRONCHODILATOR – BETA AGONIST – TERBUTALINE	N	N	N	N	Y
Corticosteroid – Dexamethasone	N	N	N	~~VO~~ Y	Y
Corticosteroid – Hydrocortisone	N	N	N	~~VO~~ Y	Y
Corticosteroid – Methylprednisolone	N	N	N	~~VO~~ Y	Y
Corticosteroid – Prednisone	N	N	N	~~VO~~ Y	Y
Epinephrine 1:1,000 IM or SQ Only	Y	Y	Y	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	Y
Short Acting Bronchodilator meter dose inhalers (MDI) (Patient assisted)	VO	VO	VO	Y	Y
Short Acting Bronchodilator meter dose inhalers (MDI)	~~VO~~ Y	~~VO~~ Y	~~VO~~ Y	~~VO~~ Y	Y
~~Terbutaline~~	~~N~~	~~N~~	~~N~~	~~N~~	~~Y~~

841 **TABLE B.10 – SEIZURE MANAGEMENT**

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Benzodiazepine – Diazepam	N	N	N	~~VO~~Y	Y
BENZODIAZEPINE – DIAZEPAM – RECTAL ADMINISTRATION	N	N	~~N~~Y	~~VO~~Y	Y
Benzodiazepine – Lorazepam	N	N	N	~~VO~~Y	Y
Benzodiazepine – Midazolam	N	N	N	~~VO~~ Y	Y
BENZODIAZEPINE – MIDAZOLAM – INTRANASAL ADMINISTRATION	N	N	~~N~~Y	~~VO~~Y	Y
OB – associated – Magnesium sulfate – bolus infusion only	N	N	N	~~VO~~ Y	Y

842 **TABLE B.11 – VACCINES**

Medications	EMT	EMT-IV	AEMT	EMT-I	P
POST-EXPOSURE, EMPLOYMENT, OR PRE-EMPLOYMENT RELATED –HEPATITIS A	N	N	N	N	Y
Post-exposure, employment, or pre-employment related – Hepatitis B	N	N	N	N	Y
Post-exposure, employment, or pre-employment related – Tetanus	N	N	N	N	Y
Post-exposure, employment, or pre-employment related – Influenza	N	N	N	N	Y
Post-exposure, employment, or pre-employment related – PPD placement & interpretation	N	N	N	N	Y
Public Health Related – Vaccine administration in conjunction with county public health departments and local EMS medical direction, after demonstration of proper training, will be authorized for public health vaccination efforts and pandemic planning exercises.	N	N	Y	Y	Y

843 **TABLE B.12 – MISCELLANEOUS**

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Analgesic Sedative – Etomidate	N	N	N	N	N
Benzodiazepine – Midazolam for TIH	N	N	N	VO	Y
~~Lidocaine bolus for intubation of head injured patients~~	~~N~~	~~N~~	~~N~~	~~VO~~	~~Y~~
~~Narcotic Analgesic – Fentanyl for TIH~~	~~N~~	~~N~~	~~N~~	~~VO~~	~~Y~~
Topical H~~H~~emostatic agents	Y	Y	Y	Y	Y

844 **SECTION ~~15~~16 – INTERFACILITY TRANSPORT**

845 ~~15~~16.1 The EMS AGENCY medical director shall have protocols in place to ensure the appropriate level of
846 care is available during interfacility transport.

~~15~~16.2 The transporting EMS provider may decline to transport any patient he or she believes requires a level of care beyond his or her capabilities.

~~15~~16.3 ~~Interfacility~~ THE INTERFACILITY transport typically involves three types of patients:

~~15~~16.3.1 Those patients whose safe transport can be accomplished by ambulance, under the care of an EMT, EMT-IV, AEMT, EMT-I, or paramedic, within the MEDICAL acts allowed under these rules.

~~15~~16.3.2 Those patients whose safe transport can be accomplished by ambulance, under the care of a paramedic, but may require MEDICAL ACTS ~~skills to be performed or medications to be administered~~ that are outside the MEDICAL acts allowed under these rules, but WHICH ACTS have been approved through waiver granted by the DEPARTMENT ~~department~~.

~~15~~16.3.3 Those patients whose safe transport requires the skills and expertise of a critical care transport team under the care of an experienced critical care practitioner.

~~15~~16.4 The hemodynamically unstable patient or patient who may require Intensive Care Unit level of treatment, regardless if coming from an Intensive Care Unit, 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.

~~15~~16.5 Unless otherwise noted, the following Appendices C and D indicate hospital/facility initiated interventions and/or medications.

~~15~~16.5.1 Additions to these medical ~~skills and~~ acts ~~allowed cannot be delegated~~ ARE NOT ALLOWED unless a waiver has been granted as described in Section ~~11~~12 of these rules.

~~15~~16.5.2 The following medical ~~skills and~~ acts are approved for interfacility transport of patients, with the requirements that the ~~skill, act or medication~~ MEDICAL ACTS allowed must have been initiated in a medical facility under the direct order and supervision of licensed medical providers and are NOT authorized for field initiation. EMS continuation and monitoring of these interventions is to be allowed with any alterations in the therapy requiring direct verbal order. The EMS provider should continue the same medical standards of care with regard~~s~~ to patient monitoring that were initiated in the facility.

~~15~~16.5.3 It is understood that these ~~skills and acts~~ MEDICAL ACTS may not be addressed in the National EMS Education Standards for EMT, AEMT, EMT-I, or paramedic. As such, it is the joint responsibility of the EMS AGENCY medical director and individuals performing these ~~skills~~ MEDICAL ACTS to obtain appropriate additional training needed to safely and effectively utilize and monitor these interventions in the interfacility transport environment.

16.6 ANY OF THE MEDICAL ACTS AND MEDICATIONS ALLOWED IN INTERFACILITY TRANSPORT IN APPENDICES C AND D MAY BE PERFORMED IN THE CLINICAL SETTING UNDER THE MEDICAL DIRECTION OF A CLINICAL MEDICAL DIRECTOR AND UNDER MEDICAL SUPERVISION.

APPENDIX C

INTERFACILITY TRANSPORT ~~– ONLY~~

MEDICAL ~~SKILLS AND~~ ACTS ALLOWED

TABLE C.1 – AIRWAY/VENTILATION/OXYGEN

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Ventilators – Automated Transport (ATV)[1]	N	N	N	N	Y

[1] Use of automated transport ventilators (ATVs) is restricted to the manipulation of tidal volume (TV or VT), respiratory rate (RR), fraction of inspired oxygen (FIO_2), and positive end expiratory pressure (PEEP). Manipulation of any other parameters of mechanical ventilation devices by EMS providers requires a waiver to these rules.

TABLE C.2 – CARDIOVASCULAR/CIRCULATORY SUPPORT

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Aortic Balloon Pump Monitoring	N	N	N	N	N
Chest Tube Monitoring	N	N	N	N	Y
Central Venous Pressure Monitor Interpretation	N	N	N	N	N

APPENDIX D

FORMULARY OF MEDICATIONS ALLOWED – INTERFACILITY TRANSPORT

TABLE D.1 – CARDIOVASCULAR

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Anti-arrhythmic – Amiodarone – continuous infusion	N	N	N	Y	Y
Anti-arrhythmic – Lidocaine – continuous infusion	N	N	N	Y	Y
Anticoagulant – Glycoprotein inhibitors	N	N	N	N	Y
Anticoagulant – Heparin (unfractionated)	N	N	N	N	Y
Anticoagulant – Low Molecular Weight Heparin (LMWH)	N	N	N	N	Y
Diltiazem	N	N	N	N	Y
Dobutamine	N	N	N	N	N
DOPAMINE – MONITORING AND MAINTENANCE	N	N	N	N	Y
Epinephrine – infusion	N	N	N	N	~~N~~Y
Nicardipine	N	N	N	N	Y
Nitroglycerin, intravenous	N	N	N	N	Y
Norepinephrine	N	N	N	N	~~N~~Y
THROMBOLYTICS – MONITORING AND MAINTENANCE	N	N	N	N	Y

TABLE D.2 – HIGH RISK OBSTETRICAL PATIENTS

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Magnesium sulfate	N	N	N	N	Y
Oxytocin – infusion	N	N	N	N	Y

TABLE D.3 – INTRAVENOUS SOLUTIONS

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Monitoring and maintenance of hospital/medical facility initiated crystalloids	N	Y	Y	Y	Y
Monitoring and maintenance of hospital/medical facility initiated colloids (non-blood component) infusions	N	N	N	Y	Y
Monitoring and maintenance of hospital/medical facility initiated blood component infusion	N	N	N	N	Y
Initiate hospital/medical facility supplied blood	N	N	N	N	Y

component infusions					
Total parenteral nutrition (TPN) and/or vitamins	N	N	N	Y	Y

TABLE D.4 – MISCELLANEOUS

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Antibiotic infusions	N	N	N	Y	Y
Antidote infusion – Sodium bicarbonate infusion	N	N	N	N	Y
ANTIVIRAL INFUSION	N	N	N	Y	Y
Electrolyte infusion – Magnesium sulfate	N	N	N	N	Y
Electrolyte infusion – Potassium chloride	N	N	N	N	Y
Insulin	N	N	N	N	Y
Mannitol	N	N	N	N	Y
Methylprednisolone – infusion	N	N	N	N	Y
Octreotide	N	N	N	N	Y
Pantoprazole	N	N	N	N	Y

SECTION ~~16~~17 – CRITICAL CARE

~~16~~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-CC may perform the medical ~~skills and~~ acts contained within this section, Appendices E and F, under the ~~direction~~ AUTHORIZATION of ~~a qualified~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director.

~~16~~17.1.1 Additions to these medical acts ~~skills and acts allowed~~ IN A PREHOSPITAL SETTING ~~cannot be delegated~~ ARE NOT ALLOWED unless a waiver ~~had~~ HAS been granted as described in Section ~~11~~12 of these rules.

~~16~~17.1.2 It is understood that these medical ~~skills and~~ acts may not be addressed in the National EMS Education Standards for Paramedics. As such, it is the joint responsibility of the APPLICABLE medical director and individuals performing these ~~skills~~ MEDICAL ACTS to obtain appropriate additional training needed to safely and effectively utilize and monitor these interventions in the critical care environment.

~~16~~17.2 A P-CC may decline transport of any patient that requires a level of care outside of their defined scope of practice or that the P-CC believes is beyond their capabilities.

~~16~~17.3 In addition to the duties of ~~a~~ AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL medical director outlined in SECTIONS ~~4~~5 AND 19 of these rules, the duties of SUCH a medical director responsible for ~~supervision and~~ authorization of a P-CC shall include:

~~16~~17.3.1 Be qualified, by education, training, and experience in the medical ~~skills and~~ acts for which the APPLICABLE medical director is authorizing the P-CC to practice.

~~16~~17.3.2 Have protocols in place clearly defining which medical ~~skills and~~ acts, from Appendices E and F, the APPLICABLE medical director is authorizing the P-CC to perform.

~~16~~17.3.3 Have protocols in place to ensure the appropriate level of care is available during critical care transport. The capabilities of the transporting agency and the safety of the patient should be considered when making transport decisions.

Appendix E – MEDICAL ~~SKILLS AND~~ ACTS ALLOWED

TABLE E.1

Skill	P-CC

Manual Transport Ventilators	Y
Blood Chemistry Interpretation	Y
Rapid Sequence Intubation – Adult (age 13 & over)	Y
TRANSVENOUS PACING – MONITORING AND MAINTENANCE	Y

Appendix F – FORMULARY OF MEDICATIONS ALLOWED

TABLE F.1 – CRITICAL CARE FORMULARY

Medications	P-CC
Aacetylcysteine (Mucomyst)	Y
~~alteplase (Activase)~~	~~Y~~
Antibiotics	Y
Bbilvalirudin (Angiomax)	Y
BLOOD PRODUCTS	Y
~~diazepam (Valium)~~	~~Y~~
Ddobutamine (Dobutamine)	Y
Eesmolol (Brevibloc)	Y
Eetomidate (Amidate)	Y
~~fentanyl (Sublimaze)~~	~~Y~~
Ffosphenytoin (Cerebyx)	Y
Kketamine (Ketalar)	Y
Llabetalol (Normodyne)	Y
~~levitiracetam~~ LEVETIRACETAM (Keppra)	Y
M metoprolol (Lopressor)	Y
~~midazolam (Versed)~~	~~Y~~
~~morphine sulfate~~	~~Y~~
~~norepinephrine (Levophed)~~	~~Y~~
Pphenytoin (Dilantin)	Y
Ppropofol (Diprivan)	Y
Rrocuronium (Zemuron)	Y
Ssuccinylcholine (Anectine)	Y
~~TNKase (Tenecteplase)~~	~~Y~~
tPA infusion	Y
TRANEXAMIC ACID (TXA)	Y
Vvecuronium (Norcuron)	Y

Section ~~17~~18 – Community Paramedic~~ine~~

~~17~~18.1 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 AND Appendix G, under the ~~direction~~ AUTHORIZATION of a CIHCS Agency medical director while providing community integrated health care services. A P-CP MAY ALSO PROVIDE THOSE MEDICAL ACTS THAT ARE OUT-OF-HOSPITAL MEDICAL SERVICES CONTAINED IN THIS SECTION, APPENDIX G, AND SECTION 19 UNDER THE AUTHORIZATION OF A CLINICAL MEDICAL DIRECTOR AND UNDER THE MEDICAL SUPERVISION OF A MEDICAL SUPERVISOR.

~~17~~18.1.1 ~~Additions~~ A WAIVER CANNOT BE GRANTED TO EXPAND THE ~~to these~~ out-of-hospital medical services THAT A P-CP MAY PERFORM IN A CIHCS SETTING. ~~allowed cannot be delegated unless a waiver had been granted as described in Section 11 of these rules~~.

~~17~~18.1.2 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~~ APPLICABLE 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 AND CLINICAL SETTING environments.

~~17~~18.2 A CIHCS Agency OR CLINICAL 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~~18.3 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~~18.3.1 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. ACTIVE INVOLVEMENT ~~and~~ should include other aspects of liaison oversight and communication normally expected in the supervision of CIHCS providers.

~~17~~18.3.2 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 it 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~~18.3.3 In conjunction with the CIHCS Agency administrator, develop and implement A 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~~18.3.4 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~~18.3.5 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~~18.3.6 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~~18.3.7 Notify the Department within fourteen business days of the cessation of duties as the CIHCS Agency's medical director;

~~17~~18.3.8 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~~18.3.9 Ensure that medical direction is available at all appropriate times as determined by the CIHCS Agency policy.

~~17~~18.3.10 Provide evaluation, treatment, and transportation guidelines and protocols for non-urgent CIHCS Agency consumers.

~~17~~18.3.11 In conjunction with the CIHCS consumer's care provider, if applicable, develop, monitor, and evaluate consumer service plans.

~~17~~18.3.12 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.

18.3.13 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.

18.4 A CLINICAL MEDICAL DIRECTOR'S RESPONSIBILITIES FOR AUTHORIZING A P-CP IN A CLINICAL SETTING SHALL INCLUDE THOSE LOCATED IN SECTION 19.3 OF THESE RULES.

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.4 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,	Y

simple dressing change, wet-to-dry dressing change, suture removal)	
Ultrasound - assist procedures	Y
Ultrasound – diagnosis	N

G.5 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.6 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.7 Vaccinations as part of a consumer service plan.

~~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.~~

SECTION 19 - CLINICAL SETTING

19.1 ANY LICENSED OR CERTIFIED EMT, AEMT, EMT-I, OR PARAMEDIC MAY PERFORM THE MEDICAL ACTS WITHIN THEIR APPLICABLE SCOPE, AS SET FORTH IN APPENDICES A, B, C, D, E, F, AND G IN A CLINICAL SETTING PURSUANT TO ORDERS OR INSTRUCTIONS FROM, AND UNDER THE MEDICAL SUPERVISION OF, A MEDICAL SUPERVISOR.

19.1.2 AN EMT-IV MAY PERFORM THE MEDICAL ACTS WITHIN THE EMT-IV SCOPE OF PRACTICE IN A CLINICAL SETTING IF AUTHORIZED BY A CLINICAL MEDICAL DIRECTOR CONSISTENT WITH SECTION 6.6 AND PURSUANT TO ORDERS OR INSTRUCTIONS FROM, AND UNDER THE MEDICAL SUPERVISION OF, A MEDICAL SUPERVISOR.

19.1.3 A PARAMEDIC WITH A CRITICAL CARE ENDORSEMENT MAY PERFORM THE MEDICAL ACTS WITHIN THE P-CC SCOPE, AS SET FORTH IN APPENDICES E AND F, IN A CLINICAL SETTING PURSUANT TO ORDERS OR INSTRUCTIONS FROM, AND UNDER THE MEDICAL SUPERVISION OF, A MEDICAL SUPERVISOR.

19.1.4 A PARAMEDIC WITH A COMMUNITY PARAMEDIC ENDORSEMENT MAY PERFORM THE MEDICAL ACTS WITHIN THE P-CP SCOPE, AS SET FORTH IN APPENDIX G, IN A CLINICAL SETTING PURSUANT TO

ORDERS OR INSTRUCTIONS FROM, AND UNDER THE MEDICAL SUPERVISION OF, A MEDICAL SUPERVISOR.

19.1.5 NOTHING IN THESE RULES ALTERS THE AUTHORITY OF A PHYSICIAN OR REGISTERED NURSE TO DELEGATE ACTS TO AN EMS PROVIDER THAT ARE OUTSIDE OF THE EMS PROVIDER'S APPLICABLE SCOPE OF PRACTICE IN THE CLINICAL SETTING, PURSUANT TO SECTIONS 12-240-107 AND 12-255-131, C.R.S.. SUCH DELEGATION SHALL BE IN CONFORMANCE WITH THE APPLICABLE RULES OF THE COLORADO MEDICAL BOARD AND THE COLORADO NURSING BOARD.

19.2 A LICENSED OR CERTIFIED HEALTH CARE FACILITY THAT EMPLOYS EMS PROVIDERS TO PERFORM IN-SCOPE TASKS AND PROCEDURES IN A CLINICAL SETTING SHALL:

19.2.1 COLLABORATE WITH ITS CLINICAL MEDICAL DIRECTOR, MEDICAL SUPERVISORS, AND EMS PROVIDERS TO ESTABLISH POLICIES AND PROCEDURES ENSURING THAT EMS PROVIDERS ARE LIMITED TO PERFORMING MEDICAL ACTS WITHIN THEIR SCOPES OF PRACTICE.

19.2.2 REQUIRE ITS CLINICAL MEDICAL DIRECTOR TO:

(I) DETERMINE AND DOCUMENT EACH EMS PROVIDER'S SCOPE OF PRACTICE IN THE CLINICAL SETTING; AND

(II) COMMUNICATE THE AUTHORIZED MEDICAL ACTS THAT EACH INDIVIDUAL EMS PROVIDER MAY PERFORM UNDER MEDICAL SUPERVISION TO THE FACILITY'S MEDICAL SUPERVISORS.

19.3 CLINICAL MEDICAL DIRECTORS ARE RESPONSIBLE FOR THE MEDICAL DIRECTION OF EMS PROVIDERS IN THE CLINICAL SETTING. THEIR DUTIES SHALL INCLUDE:

19.3.1 BEING AWARE OF AND FAMILIAR WITH THE MEDICAL ACTS THAT ALL EMS PROVIDER TYPES MAY BE AUTHORIZED TO PERFORM IN A CLINICAL SETTING PURSUANT TO THE SCOPE OF PRACTICE PUT FORTH IN THESE RULES IN APPENDICES A, B, C, D, E, F, AND G, AS APPLICABLE.

19.3.2 COLLABORATING WITH THE MEDICAL SUPERVISOR(S) AND EMS PROVIDERS TO ESTABLISH POLICIES AND PROCEDURES ENSURING THAT EMS PROVIDERS ONLY PERFORM MEDICAL ACTS THAT ARE WITHIN THE APPLICABLE EMS PROVIDER'S SCOPE OF PRACTICE.

19.3.3 ENSURING THAT EACH EMS PROVIDER WORKING IN THE CLINICAL SETTING IS LIMITED TO PERFORMING MEDICAL ACTS THAT ARE WITHIN THE APPLICABLE SCOPE OF PRACTICE AND ARE PERFORMED COMPETENTLY UNDER MEDICAL SUPERVISION. THIS SHALL INCLUDE, BUT NOT BE LIMITED TO, DETERMINING THOSE MEDICAL ACTS THAT EACH EMS PROVIDER MAY PERFORM UNDER MEDICAL SUPERVISION AND COMMUNICATING TO THE MEDICAL SUPERVISOR(S) THE AUTHORIZED MEDICAL ACTS THAT EACH INDIVIDUAL EMS PROVIDER MAY PERFORM.

19.3.4 ENSURING THAT ALL CLINICAL PROTOCOLS ISSUED BY THE CLINICAL MEDICAL DIRECTOR ARE APPROPRIATE FOR THE CERTIFICATION OR LICENSE AND SKILL LEVEL OF EACH EMS PROVIDER TO WHOM THE PERFORMANCE OF MEDICAL ACTS IS AUTHORIZED AND COMPLIANT WITH ACCEPTED STANDARDS OF MEDICAL PRACTICE. ENSURE THAT A SYSTEM IS IN PLACE FOR TIMELY ACCESS TO COMMUNICATION OF VERBAL ORDERS.

19.3.5 BEING ACTIVELY AND ROUTINELY INVOLVED WITH THE EMS PROVIDERS PROVIDING CARE IN THE CLINICAL SETTING. INVOLVEMENT DOES NOT REQUIRE THAT A PHYSICIAN HAVE SUCH EXPERIENCE PRIOR TO BECOMING A CLINICAL MEDICAL DIRECTOR, BUT IT DOES REQUIRE SUCH INVOLVEMENT DURING THE TIME THAT THE PHYSICIAN 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 EMS PROVIDERS DOES NOT MEET THIS REQUIREMENT.

19.3.6 BEING ACTIVELY INVOLVED IN THE FACILITY'S MEDICAL CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRAM FOR EMS PROVIDERS. THE MEDICAL CQI PROGRAM SHALL ASSURE THE CONTINUING COMPETENCY OF THE PERFORMANCE OF THE EMS PROVIDERS. THIS MEDICAL CQI PROGRAM SHALL INCLUDE, BUT NOT BE LIMITED TO: APPROPRIATE PROTOCOLS AND STANDING ORDERS APPLICABLE TO THE EMS PROVIDERS' SCOPES OF PRACTICE, PROVISION FOR MEDICAL CARE AUDITS, OBSERVATION, CRITIQUES, CONTINUING MEDICAL EDUCATION, AND SUPERVISORY COMMUNICATIONS.

19.3.7 PROVIDING OVERSIGHT, DIRECTION, AND MEDICAL MANAGEMENT OF THE MEDICAL PERFORMANCE OF EMS PROVIDERS IN THE CLINICAL SETTING. THIS INCLUDES ENSURING THAT EMS PROVIDERS HAVE ADEQUATE CLINICAL KNOWLEDGE OF AND ARE COMPETENT IN PERFORMING MEDICAL ACTS WITHIN THE EMS PROVIDER'S SCOPE OF PRACTICE AUTHORIZED BY THE CLINICAL MEDICAL DIRECTOR. THESE DUTIES AND OPERATIONS MAY BE DELEGATED TO OTHER PHYSICIANS OR OTHER QUALIFIED HEALTH CARE PROFESSIONALS DESIGNATED BY THE CLINICAL MEDICAL DIRECTOR. HOWEVER, THE CLINICAL MEDICAL DIRECTOR SHALL RETAIN ULTIMATE AUTHORITY AND RESPONSIBILITY FOR THE OVERSIGHT, DIRECTION, AND MEDICAL MANAGEMENT OF THE MEDICAL PERFORMANCE OF EMS PROVIDERS IN THE CLINICAL SETTING, FOR ESTABLISHING PROTOCOLS AND STANDING ORDERS, AND FOR THE COMPETENCY OF THE PERFORMANCE OF AUTHORIZED MEDICAL ACTS.

19.3.8 BEING FAMILIAR WITH THE TRAINING, KNOWLEDGE, AND COMPETENCE OF EMS PROVIDERS SUBJECT TO THEIR OVERSIGHT AND ENSURING THAT EMS PROVIDERS ARE APPROPRIATELY TRAINED AND DEMONSTRATE ONGOING COMPETENCY IN ALL MEDICAL ACTS AUTHORIZED TO BE PERFORMED UNDER MEDICAL SUPERVISION.

19.3.9 BEING AWARE THAT CERTAIN SKILLS, PROCEDURES, AND MEDICATIONS CONTAINED WITHIN APPENDICES A, B, C, D, E, F, AND G MAY NOT BE INCLUDED IN THE NATIONAL EMS EDUCATION STANDARDS AND ENSURING THAT APPROPRIATE ADDITIONAL TRAINING IS PROVIDED TO EMS PROVIDERS, IF NECESSARY, FOR THE PERFORMANCE OF AN AUTHORIZED SKILL OR ACT.

19.3.10 PHYSICIANS ACTING AS CLINICAL MEDICAL DIRECTORS RESPONSIBLE FOR THE OVERSIGHT AND AUTHORIZATION OF A P-CC SHALL HAVE TRAINING AND EXPERIENCE IN THE ACTS AND SKILLS FOR WHICH THEY ARE PROVIDING OVERSIGHT AND AUTHORIZATION. ADDITIONAL DUTIES RELATED TO CLINICAL MEDICAL DIRECTORS RESPONSIBLE FOR THE OVERSIGHT AND AUTHORIZATION OF A P-CC ARE SET FORTH IN SECTION 17 OF THESE RULES.

19.3.11 PHYSICIANS ACTING AS CLINICAL MEDICAL DIRECTORS RESPONSIBLE FOR THE OVERSIGHT AND AUTHORIZATION OF A P-CP SHALL HAVE TRAINING AND EXPERIENCE IN THE ACTS AND SKILLS FOR WHICH THEY ARE PROVIDING OVERSIGHT AND AUTHORIZATION. ADDITIONAL DUTIES RELATED TO CLINICAL MEDICAL DIRECTORS RESPONSIBLE FOR THE OVERSIGHT AND AUTHORIZATION OF A P-CP ARE SET FORTH IN SECTION 18 OF THESE RULES.

19.4 MEDICAL SUPERVISION OF THE EMS PROVIDER IN A CLINICAL SETTING MUST BE PROVIDED BY A MEDICAL SUPERVISOR WHO IS:

19.4.1 A COLORADO LICENSED PHYSICIAN, PHYSICIAN ASSISTANT, ADVANCED PRACTICE NURSE, OR REGISTERED NURSE LICENSED IN GOOD STANDING,

19.4.2 TRAINED AND EXPERIENCED IN THE ACTS AND SKILLS FOR WHICH SUPERVISION IS BEING PROVIDED,

19.4.3 KNOWLEDGEABLE ABOUT THE MAXIMUM SKILLS, ACTS, OR MEDICATIONS THAT AN EMT, EMT-IV, AEMT, EMT-I, PARAMEDIC, P-CC, AND P-CP ARE AUTHORIZED TO PERFORM PURSUANT TO THESE RULES, AND

19.4.4 IMMEDIATELY AVAILABLE AND PHYSICALLY PRESENT AT THE CLINICAL SETTING WHERE THE CARE IS BEING DELIVERED TO PROVIDE OVERSIGHT, GUIDANCE, OR INSTRUCTION TO THE EMS PROVIDER DURING THE PERFORMANCE OF MEDICAL ACTS.