

**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 all 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.<sup>1</sup> 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.<sup>2</sup> 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

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<sup>1</sup> 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.

<sup>2</sup> 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.<sup>3</sup>

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)

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<sup>3</sup> 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)

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Is this rulemaking due to a change in state statute?

Yes, the bill number is SB 19-052. Rules are  authorized; some provisions are  required.  
 No

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

Yes  URL  
 No

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

Yes  
 No

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

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  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
<b>Licensed or Certified:</b>		
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
Birth centers	7	C/S
Home care agencies	Approximately 763	C/S
Emergency Medical Service Providers	18,586	C/S
EMS Agencies	~200 ground ambulance agencies 34 air ambulance agencies	S
EMS Education Programs	210	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)	RNs=61,000 APRNs=Unknown PAs=3450 Physicians=7300	C C
Licensed physicians (as EMS medical directors)	141	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.<sup>4</sup> 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.

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<sup>4</sup> 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.<sup>5</sup> 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:

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<sup>5</sup> 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.

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

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

<p>1. Reduce Greenhouse Gas (GHG) emissions economy-wide from 125.716 million metric tons of CO<sub>2</sub>e (carbon dioxide equivalent) per year to 119.430 million metric tons of CO<sub>2</sub>e per year by June 30, 2020 and to 113.144 million metric tons of CO<sub>2</sub>e by June 30, 2023.</p> <p><input type="checkbox"/> Contributes to the blueprint for pollution reduction</p> <p><input type="checkbox"/> Reduces carbon dioxide from transportation</p> <p><input type="checkbox"/> Reduces methane emissions from oil and gas industry</p> <p><input type="checkbox"/> Reduces carbon dioxide emissions from electricity sector</p>
<p>2. Reduce ozone from 83 parts per billion (ppb) to 80 ppb by June 30, 2020 and 75 ppb by June 30, 2023.</p> <p><input type="checkbox"/> Reduces volatile organic compounds (VOC) and oxides of nitrogen (NO<sub>x</sub>) from the oil and gas industry.</p> <p><input type="checkbox"/> Supports local agencies and COGCC in oil and gas regulations.</p> <p><input type="checkbox"/> Reduces VOC and NO<sub>x</sub> emissions from non-oil and gas contributors</p>
<p>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.</p> <p><input type="checkbox"/> Increases the consumption of healthy food and beverages through education, policy, practice and environmental changes.</p> <p><input type="checkbox"/> Increases physical activity by promoting local and state policies to improve active transportation and access to recreation.</p> <p><input type="checkbox"/> 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.</p>
<p>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.</p> <p><input type="checkbox"/> Ensures access to breastfeeding-friendly environments.</p>

<p>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.</p> <ul style="list-style-type: none"><li>___ 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.</li><li>___ Performs targeted programming to increase immunization rates.</li><li>___ Supports legislation and policies that promote complete immunization and exemption data in the Colorado Immunization Information System (CIIS).</li></ul>
<p>6. Colorado will reduce the suicide death rate by 5% by June 30, 2020 and 15% by June 30, 2023.</p> <ul style="list-style-type: none"><li>___ Creates a roadmap to address suicide in Colorado.</li><li>___ Improves youth connections to school, positive peers and caring adults, and promotes healthy behaviors and positive school climate.</li><li>___ Decreases stigma associated with mental health and suicide, and increases help-seeking behaviors among working-age males, particularly within high-risk industries.</li><li>___ Saves health care costs by reducing reliance on emergency departments and connects to responsive community-based resources.</li></ul>
<p>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.</p> <ul style="list-style-type: none"><li>___ Conducts a gap assessment.</li><li>___ Updates existing plans to address identified gaps.</li><li>___ Develops and conducts various exercises to close gaps.</li></ul>
<p>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.</p> <ul style="list-style-type: none"><li>___ Uses an assessment tool to measure competency for CDPHE's response to an outbreak or environmental incident.</li><li>___ Works cross-departmentally to update and draft plans to address identified gaps noted in the assessment.</li><li>___ Conducts exercises to measure and increase performance related to identified gaps in the outbreak or incident response plan.</li></ul>

<p>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.</p> <p><input type="checkbox"/> Implements the CDPHE Digital Transformation Plan.</p> <p><input type="checkbox"/> Optimizes processes prior to digitizing them.</p> <p><input type="checkbox"/> Improves data dissemination and interoperability methods and timeliness.</p>
<p>10. Reduce CDPHE’s Scope 1 &amp; 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.</p> <p><input type="checkbox"/> Reduces emissions from employee commuting</p> <p><input type="checkbox"/> Reduces emissions from CDPHE operations</p>
<p>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.</p> <p><input type="checkbox"/> Used a budget equity assessment</p>

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 10<sup>th</sup> 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.
- 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-I's, 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-IIs and paramedics. Because some remote regions do not have adequate access to EMT-IIs 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.<sup>6</sup> 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.

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<sup>6</sup> 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: _____ _____





# An Act

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:

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*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

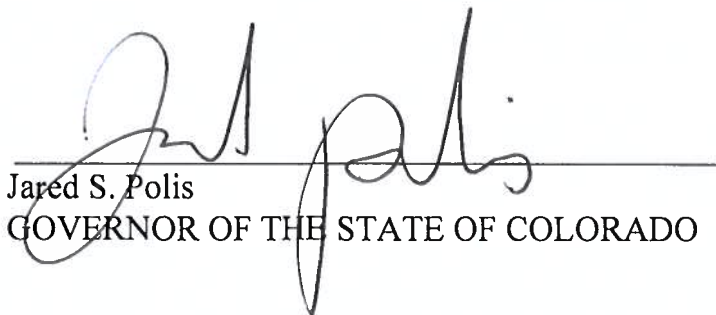


Cindi L. Markwell  
SECRETARY OF  
THE SENATE



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



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

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

5 **SECTION 1 – Purpose and Authority for Establishing Rules**

6 1.1 ~~THESE RULES DEFINE THE AUTHORIZED MEDICAL ACTS OF EMERGENCY MEDICAL SERVICE (EMS)~~  
7 ~~PROVIDERS IN THE SETTINGS IN WHICH THEY MAY PRACTICE: PREHOSPITAL, AS DEFINED BY SECTION 25-~~  
8 ~~3.5-206(5)(B), C.R.S. AND THESE RULES; OUT-OF-HOSPITAL, AS DEFINED BY 6 CCR 1011-3 AND THESE~~  
9 ~~RULES; AND CLINICAL, AS DEFINED BY SECTION 25-3.5-207(1)(A), C.R.S AND THESE RULES.~~

10 1.2 ~~The purpose of these~~THESE rules is to ALSO define the MEDICAL DIRECTOR qualifications and duties  
11 ~~of medical directors~~ WITHIN EMS AGENCIES, COMMUNITY INTEGRATED HEALTH CARE SERVICE  
12 (CIHCS) AGENCIES, AND CLINICAL SETTINGS. THESE RULES apply to ~~and are controlling for any~~  
13 ~~physician functioning as a medical director in THESE SETTINGS. to Emergency Medical Services~~  
14 ~~(EMS) agencies~~

15 1.3 ~~THESE RULES ALSO DEFINE THE DUTIES OF MEDICAL SUPERVISORS OF EMS PROVIDERS IN THE CLINICAL~~  
16 ~~SETTING.~~

17 1.4 The general authority for the promulgation of these rules by the executive director or chief  
18 medical officer of the ~~department~~DEPARTMENT is set forth in Sections 25-3.5-203, ~~and~~206, AND  
19 207, C.R.S.

20 1.3 ~~These rules apply to and are controlling for any physician functioning as a medical director to an~~  
21 ~~EMS organization and who authorizes and directs the performance of medical acts by EMS~~  
22 ~~providers at all levels of certification in the State of Colorado. These rules also define the scope of~~  
23 ~~practice for EMS providers.~~

24 **SECTION 2 – Definitions**

25 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,  
26 CHAPTER ONE shall apply to these rules. ~~UNLESS OTHERWISE STATED, THE DEFINITIONS IN THIS~~  
27 ~~SECTION SHALL APPLY TO:~~

28 2.1.1 ~~PREHOSPITAL AND INTERFACILITY TRANSPORT SETTINGS,~~

29 2.1.2 ~~CIHCS (OUT- OF- HOSPITAL) SETTINGS, AND~~

30 2.1.3 ~~CLINICAL SETTINGS.~~

31 2.42 “Advanced Cardiac Life Support (ACLS)” - a course of instruction designed to prepare students in  
32 the practice of advanced emergency cardiac care.

33 2.23 “Advanced Emergency Medical Technician (AEMT)” - an individual who has a current and valid  
34 AEMT certificate OR LICENSE issued by the Department and who is authorized to provide limited  
35 acts of advanced emergency medical care in accordance with these rules.

36 2.34 “Care eCoordination” - the deliberate organization of patient care activities between two or more  
37 participants, including the patient, involved in a THE patient’s care to facilitate the appropriate  
38 delivery of medical care services.

- 39 2.5 "CERTIFICATE" – DESIGNATION AS HAVING MET THE REQUIREMENTS OF SECTION 5 OF CHAPTER ONE, 6  
 40 CCR 1015-3, ISSUED TO AN INDIVIDUAL BY THE DEPARTMENT. CERTIFICATION IS EQUIVALENT TO  
 41 LICENSURE FOR PURPOSES OF THE STATE ADMINISTRATIVE PROCEDURE ACT, SECTION 24-4-101, ET  
 42 SEQ., C.R.S.
- 43 2.6 "CLINICAL MEDICAL DIRECTOR" – FOR PURPOSES OF THESE RULES, A PHYSICIAN LICENSED IN COLORADO  
 44 AND IN GOOD STANDING WHO DETERMINES, AUTHORIZES, AND DIRECTS, THROUGH PROTOCOLS,  
 45 STANDING ORDERS, AND OPERATIONAL POLICIES OR PROCEDURES DEVELOPED BY THE FACILITY'S  
 46 MEDICAL STAFF, THE MEDICAL ACTS PERFORMED BY EMS PROVIDERS IN A CLINICAL SETTING. THE  
 47 CLINICAL MEDICAL DIRECTOR IS ALSO RESPONSIBLE FOR ASSURING THE COMPETENCY OF THE  
 48 PERFORMANCE OF THOSE ACTS BY EMS PROVIDERS AS DESCRIBED IN THE FACILITY'S MEDICAL  
 49 CONTINUOUS QUALITY IMPROVEMENT PROGRAM.
- 50 2.7 "CLINICAL SETTING" – A HEALTH CARE FACILITY LICENSED OR CERTIFIED BY THE DEPARTMENT PURSUANT  
 51 TO SECTION 25-1.5-103(1)(A), C.R.S.
- 52 2.48 "Colorado Medical Board" - the Colorado Medical Board established in Title 12, Article 36240,  
 53 C.R.S., ~~formerly known as the state Board of Medical Examiners.~~
- 54 2.59 "Community Integrated Health Care Service (CIHCS)" – the provision of certain out-of-hospital  
 55 medical services that a community paramedic may provide and may include:
- 56 2.59.1 Services authorized pursuant to Section 25-3.5-1203(3), C.R.S.
- 57 2.59.2 Services authorized pursuant to 6 CCR 1011-3, Standards for Community Integrated  
 58 Health Care Service Agencies.
- 59 2.59.3 Services authorized under the scope of practice as set forth in this chapter.
- 60 2.59.4 Services authorized pursuant to Section 25-3.5-206(4)(A A.5)(II), C.R.S.
- 61 2.610 "Community Integrated Health Care Service Agency (CIHCS Agency)" – a sole proprietorship,  
 62 partnership, corporation, nonprofit entity, special district, governmental unit or agency, or licensed  
 63 or certified health care facility that is subject to regulation under Article 1.5 or 3 of Title 25, C.R.S.,  
 64 that manages and offers, directly or by contract, community integrated health care services.
- 65 2.711 "CIHCS Agency ~~m~~Medical ~~d~~Director" – as used in these rules, means a Colorado licensed  
 66 physician in good standing who is identified as being responsible for supervising, directing, and  
 67 assuring the competency of those individuals who are employed by or contracted with the CIHCS  
 68 Agency to perform community integrated health care services on behalf of the agency.
- 69 2.812 "Consumer" – an individual receiving ~~C~~COMMUNITY ~~I~~NTTEGRATED ~~H~~HEALTH ~~C~~CARE ~~S~~SERVICES.
- 70 2.913 "Consumer ~~s~~Service ~~p~~Plan" – the approved written plan specific to each consumer receiving  
 71 CIHCS in a series of visits that: identifies the consumer's physical, medical, social, mental health,  
 72 and/or environmental needs, as necessary; sets forth the out-of-hospital medical services the  
 73 CIHCS Agency agrees to provide to the consumer; and is overseen by the CIHCS Agency  
 74 medical director.
- 75 2.4014 "Department" - the Colorado Department of Public Health and Environment.
- 76 2.4415 "Direct Verbal Order" - verbal authorization given BY A PHYSICIAN to an EMS provider for the  
 77 performance of specific medical acts through a Medical Base Station or in person; OR IN A  
 78 CLINICAL SETTING, GIVEN BY A PHYSICIAN CONTEMPORANEOUS TO WHEN A PATIENT IS RECEIVING  
 79 TREATMENT OR BY A MEDICAL SUPERVISOR AS AN INSTRUCTION BASED ON A PHYSICIAN ORDER.

- 80 2.42~~16~~ “Emergency Medical Practice Advisory Council (EMPAC)” - the council established pursuant to  
81 Section 25-3.5-206, C.R.S. that is responsible for advising the Department regarding the  
82 appropriate scope of practice for EMS providers and for the criteria for physicians to serve as  
83 EMS AGENCY medical directors, ~~CIHCS AGENCY MEDICAL DIRECTORS OR CLINICAL MEDICAL~~  
84 ~~DIRECTORS.~~
- 85 2.43~~17~~ “Emergency Medical Technician (EMT)” - an individual who has a current and valid EMT  
86 certificate ~~OR LICENSE~~ issued by the Department and who is authorized to provide basic  
87 emergency medical care in accordance with these rules.
- 88 2.44~~18~~ “Emergency Medical Technician with Intravenous Authorization (EMT-IV)” - an individual who has  
89 a current and valid EMT certificate ~~OR LICENSE~~ issued by the Department and who has met the  
90 conditions defined in Section ~~5.5~~ 6.6 of these rules.
- 91 2.45~~19~~ “Emergency Medical Technician-Intermediate (EMT-I)” - an individual who has a current and valid  
92 EMT-Intermediate certificate ~~OR LICENSE~~ issued by the Department and who is authorized to  
93 provide limited acts of advanced emergency medical care in accordance with these rules.
- 94 2.46~~20~~ “EMS AGENCY MEDICAL DIRECTOR” - FOR PURPOSES OF THESE RULES, MEANS A PHYSICIAN LICENSED  
95 IN COLORADO AND IN GOOD STANDING WHO AUTHORIZES AND DIRECTS, THROUGH PROTOCOLS AND  
96 STANDING ORDERS, THE PERFORMANCE OF STUDENTS-IN-TRAINING ENROLLED IN DEPARTMENT-  
97 RECOGNIZED EMS EDUCATION PROGRAMS, GRADUATE AEMTs, EMT-IS, OR PARAMEDICS, OR EMS  
98 PROVIDERS OF A PREHOSPITAL EMS SERVICE AGENCY AND WHO IS SPECIFICALLY IDENTIFIED AS BEING  
99 RESPONSIBLE TO ASSURE THE COMPETENCY OF THE PERFORMANCE OF THOSE ACTS BY SUCH EMS  
100 PROVIDERS AS DESCRIBED IN THE PHYSICIAN’S MEDICAL CQI PROGRAM.
- 101 2.21 “EMS Provider” - means an individual who holds a valid emergency medical service provider  
102 certificate ~~OR LICENSE~~ issued by the Department and includes Emergency Medical Technician,  
103 Advanced Emergency Medical Technician, Emergency Medical Technician-Intermediate, and  
104 Paramedic.
- 105 2.47~~22~~ “EMS ~~s~~SERVICE ~~a~~Agency ~~OR EMS AGENCY~~” - any organized agency including but not limited to a  
106 “rescue unit” as defined in Section 25-3.5-103(11), C.R.S., using EMS providers to render initial  
107 emergency medical care to a patient prior to or during transport. This definition does not include  
108 criminal law enforcement agencies, unless the criminal law enforcement personnel are EMS  
109 providers who function with a “rescue unit” as defined in Section 25-3.5-103(11), C.R.S. or are  
110 performing any medical act described in these rules.
- 111 2.48~~23~~ “Graduate Advanced EMT” - an individual who has a current and valid Colorado EMT certification  
112 ~~OR LICENSE~~ issued by the Department and who has successfully completed a Department-  
113 recognized AEMT initial course but has not yet successfully completed the certification ~~OR~~  
114 ~~LICENSING~~ requirements set forth in the Rules Pertaining to EMS ~~AND EMR~~ Education, ~~EMS~~  
115 ~~CERTIFICATION OR LICENSURE, AND EMR REGISTRATION, 6 CCR 1015-3, Chapter One, FOR THE~~  
116 ~~AEMT LEVEL.~~
- 117 2.19 — “Graduate EMT-Intermediate” — an individual who has a current and valid Colorado EMT or AEMT  
118 certification issued by the Department and who has successfully completed a Department-  
119 recognized EMT-Intermediate course but has not yet successfully completed the certification  
120 requirements set forth in the Rules Pertaining to EMS Education, and Certification, 6 CCR 1015-  
121 3, Chapter One.
- 122 2.20~~24~~ “Graduate Paramedic” - an individual who has a current and valid Colorado EMT certificate ~~OR~~  
123 ~~LICENSE~~, AEMT certificate ~~OR LICENSE~~, or EMT-I certificate ~~OR LICENSE~~ issued by the Department  
124 and who has successfully completed a Department-recognized paramedic initial course but has  
125 not yet successfully completed the certification ~~OR LICENSING~~ requirements set forth in the Rules



- 126 Pertaining to EMS AND EMR Education, EMS CERTIFICATION AND LICENSURE, AND EMR  
127 REGISTRATION and Certification, 6 CCR 1015-3, Chapter One FOR THE PARAMEDIC LEVEL.
- 128 2.25 "IN-SCOPE TASKS AND PROCEDURES" – TASKS AND PROCEDURES PERFORMED BY AN EMS PROVIDER  
129 WITHIN THE EMS PROVIDER'S SCOPE OF PRACTICE IN A CLINICAL SETTING AS SET FORTH IN THESE  
130 RULES.
- 131 2.2426 "Interfacility Transport" - any transport of a patient from one licensed healthcare facility to another  
132 licensed healthcare facility, after a higher level medical care provider (i.e. a physician, physician  
133 assistant, or an individual of similar/equivalent training, certification, LICENSING, and patient  
134 interaction) has initiated treatment.
- 135 2.2227 "International Board of Specialty Certification (IBSC)" –a non-profit organization that develops and  
136 administers a national community paramedic certification exam.
- 137 2.2328 "Licensed in Good Standing" - as used in these rules, means that a physician functioning as a  
138 medical director, OR A PHYSICIAN, PHYSICIAN ASSISTANT, ADVANCED PRACTICE NURSE, OR REGISTERED  
139 NURSE FUNCTIONING AS A MEDICAL SUPERVISOR, holds a current and valid COLORADO license to  
140 practice medicine THE APPLICABLE PROFESSION. in Colorado that is not subject to any restrictions.
- 141 2.2429 "Maintenance" – to observe the patient while continuing, assessing, adjusting, and/or  
142 discontinuing care of a previously established medical procedure or medication via standing  
143 order, written physician order, or the direct verbal order of a physician.
- 144 2.30 "MEDICAL ACTS"- AS USED IN THESE RULES, MEANS THE TASKS, MEDICATIONS, OR PROCEDURES THAT  
145 AN EMS PROVIDER IS AUTHORIZED TO PERFORM OR ADMINISTER WITHIN THE EMS PROVIDER'S  
146 APPLICABLE SCOPE OF PRACTICE INCLUDING IN-SCOPE TASKS AND PROCEDURES IN A CLINICAL SETTING.
- 147 2.2531 "Medical Base Station" - the source of direct medical communications with EMS providers.
- 148  
149 2.32 "MEDICAL DIRECTION" – MAY INCLUDE, BUT IS NOT LIMITED TO, THE FOLLOWING DUTIES:  
150 (A) APPROVAL OF THE MEDICAL COMPONENTS OF TREATMENT PROTOCOLS AND APPROPRIATE  
151 PREARRIVAL INSTRUCTIONS;  
152 (B) ROUTINE REVIEW OF PROGRAM PERFORMANCE AND MAINTENANCE OF ACTIVE INVOLVEMENT IN  
153 QUALITY IMPROVEMENT ACTIVITIES, INCLUDING ACCESS TO PREHOSPITAL RECORDINGS AS NECESSARY  
154 FOR THE EVALUATION OF CARE;  
155 (C) AUTHORITY TO RECOMMEND APPROPRIATE CHANGES TO PROTOCOLS FOR THE IMPROVEMENT OF  
156 PATIENT CARE;  
157 (D) PROVISION OF OVERSIGHT FOR THE ONGOING EDUCATION, TRAINING, AND QUALITY ASSURANCE OF  
158 EMS PROVIDERS AS APPROPRIATE FOR THE MEDICAL ACTS BEING PERFORMED IN THE PREHOSPITAL,  
159 OUT-OF-HOSPITAL, OR CLINICAL SETTING IN WHICH THE EMS PROVIDER IS PRACTICING; AND  
160 (E) REPORTING OF ANY MISCONDUCT BY CERTIFIED OR LICENSED EMS PROVIDERS THAT THE MEDICAL  
161 DIRECTOR KNOWS OR REASONABLY BELIEVES HAS OCCURRED.  
162
- 163 2.26 "Medical Director" – for purposes of these rules means a physician licensed in good standing who  
164 authorizes and directs, through protocols and standing orders, the performance of students in  
165 training enrolled in Department-recognized EMS education programs, graduate AEMTs, EMT-Is  
166 or paramedics, or EMS providers of a prehospital EMS service agency and who is specifically  
167 identified as being responsible to assure the competency of the performance of those acts by  
168 such EMS providers as described in the physician's medical CQI program.
- 169 2.33 "MEDICAL SUPERVISION" – THE OVERSIGHT, GUIDANCE, AND INSTRUCTIONS THAT A MEDICAL  
170 SUPERVISOR PROVIDES TO AN EMS PROVIDER IN A CLINICAL SETTING, AS DEFINED IN SECTION 25-3.5-  
171 207(1)(D), C.R.S. AND THESE RULES.

- 172 2.34 "MEDICAL SUPERVISOR" – IN A CLINICAL SETTING, MEANS A COLORADO LICENSED PHYSICIAN, PHYSICIAN  
173 ASSISTANT, ADVANCED PRACTICE NURSE, OR REGISTERED NURSE.
- 174 2.2735 "Monitoring" – to observe and detect changes, or the absence of changes, in the clinical status of  
175 the patient for the purpose of documentation.
- 176 2.2836 "Out-of-hospital ~~medical services~~ MEDICAL SERVICES" – services performed by a PParamedic with  
177 A Community Paramedic Endorsement ~~provided by a CHCS Agency~~, including the initial  
178 assessment of the patient and any subsequent assessments, as needed; the furnishing of  
179 medical treatment and interventions; care coordination; resource navigation; patient education;  
180 medication inventory, compliance and administration; gathering of laboratory and diagnostic data;  
181 nursing services; rehabilitative services; complementary health services; as well as the furnishing  
182 of other necessary services and goods for the purpose of preventing, alleviating, curing, or  
183 healing human illness, physical disability, physical injury; alcohol, drug, or controlled substance  
184 abuse; ~~and~~ behavioral health services that may be provided in an out-of-hospital setting; AND THE  
185 MEDICAL ACTS IDENTIFIED IN APPENDIX G OF THESE RULES. OUT-OF-HOSPITAL MEDICAL SERVICES  
186 CANNOT BE PROVIDED OR PERFORMED IN THE PREHOSPITAL SETTING.
- 187 2.2937 "Paramedic" -- FOR PURPOSES OF THIS CHAPTER TWO, an individual who has a current and valid  
188 paramedic certificate OR LICENSE issued by the Department and who is authorized to provide  
189 advanced emergency medical care in A PREHOSPITAL OR CLINICAL SETTING IN accordance with  
190 these rules.
- 191 2.3038 "Paramedic with Community Paramedic Endorsement (P-CP)" – AN An individual who has a  
192 current and valid paramedic certificate OR LICENSE issued by the Department and who has met  
193 the requirements in these rules to obtain a community paramedic endorsement from the  
194 Department and is authorized to provide acts in accordance with THESE RULES the Rules  
195 Pertaining to EMS Practice and Medical Director Oversight relating to community integrated  
196 health care services, AND as set forth in SECTIONS 25-3.5-206, C.R.S., and 25-3.5-1301, et seq.,  
197 C.R.S.
- 198 2.3139 "Paramedic with Critical Care Endorsement (P-CC)" – An AN individual who has a current and  
199 valid PParamedic certificate OR LICENSE issued by the Department and who has met the  
200 requirements in these rules to obtain a critical care endorsement from the Department and is  
201 authorized to provide acts in accordance with conditions defined in THESE RULES the Rules  
202 Pertaining to EMS Practice and Medical Director Oversight relating to critical care AND as set forth  
203 in SECTION 25-3.5-206, C.R.S.
- 204 2.3240 "Point of eCare tTesting (POCT)"– medical diagnostic testing performed outside the clinical  
205 laboratory in close proximity to where the patient is receiving care, the results of which are used  
206 for clinical decision-making.
- 207 2.3341 "Prehospital Care" – any medical ~~procedures or~~ acts performed prior to a patient receiving care at  
208 a licensed healthcare facility.
- 209 2.42 "PREHOSPITAL SETTING" – MEANS ONE OF THE FOLLOWING SETTINGS IN WHICH AN EMS PROVIDER  
210 PERFORMS PATIENT CARE, WHICH CARE IS SUBJECT TO MEDICAL DIRECTION BY AN EMS AGENCY  
211 MEDICAL DIRECTOR AT THE SITE OF AN EMERGENCY, DURING EMERGENCY TRANSPORT, OR DURING  
212 INTERFACILITY TRANSPORT.
- 213 2.3443 "Protocol" - written standards for patient medical assessment and management approved by a  
214 medical director.

- 215 ~~2.35~~ “Rules Pertaining to EMS and EMR Education, EMS Certification, and EMR Registration” rules  
 216 governing the education of EMS and EMR, certification of EMS providers and registration of  
 217 EMR, located at 6 CCR 1015-3, Chapter One, promulgated by the state Board of Health.
- 218 ~~2.36~~<sup>44</sup> “Scope of Practice” - refers to the **TASKS, MEDICATIONS, AND PROCEDURES (MEDICAL ACTS) THAT AN**  
 219 **EMS PROVIDER IS AUTHORIZED TO PERFORM OR ADMINISTER IN ACCORDANCE WITH SECTIONS 25-3.5-**  
 220 **203 AND 25-3.5-206, C.R.S., AND RULES PROMULGATED PURSUANT TO THOSE SECTIONS.** ~~medication~~  
 221 ~~administration and acts authorized in these rules for EMS providers.~~
- 222 ~~2.37~~<sup>45</sup> “State Emergency Medical and Trauma Services Advisory Council (SEMTAC)” - a council created  
 223 in the Department pursuant to Section 25-3.5-104, C.R.S., that advises the Department on all  
 224 matters relating to emergency medical and trauma services.
- 225 ~~2.38~~<sup>46</sup> “Standing Order” - written authorization provided in advance by a medical director for the  
 226 performance of specific medical acts by EMS providers ~~independent of making medical base~~  
 227 ~~station contact.~~
- 228 ~~2.39~~<sup>47</sup> “Supervision” – **AS APPLICABLE TO PHYSICIAN MEDICAL DIRECTION, MEANS THE OVERSIGHT, DIRECTION,**  
 229 **OR MEDICAL MANAGEMENT THAT THE MEDICAL DIRECTOR PROVIDES TO AN EMS PROVIDER IN ANY**  
 230 **SETTING** ~~oversee, direct or manage.~~ Supervision may be through direct observation or by indirect  
 231 oversight as defined in the medical director’s CQI program.
- 232 ~~2.40~~<sup>48</sup> “Waiver” - a Department-approved exception to these rules granted to a **AN EMS AGENCY** medical  
 233 director.
- 234 ~~2.41~~<sup>49</sup> “Written Order” - written authorization ~~given~~ **THAT A PHYSICIAN ISSUES** to an EMS provider for the  
 235 performance of specific medical acts.

### 236 SECTION 3 – Emergency Medical Practice Advisory Council

- 237 3.1 The Emergency Medical Practice Advisory Council (EMPAC), under the direction of the executive  
 238 director of the ~~department~~ **DEPARTMENT**, shall advise the ~~department~~ **DEPARTMENT** in the areas set  
 239 forth below in Section 3.8.
- 240 3.2 The EMPAC shall consist of the following eleven members:
- 241 3.2.1 Eight voting members appointed by the governor as follows:
- 242 A) Two physicians licensed in good standing in Colorado who are actively serving  
 243 as EMS **AGENCY** medical directors and are practicing in rural or frontier counties;
- 244 B) Two physicians licensed in good standing in Colorado who are actively serving  
 245 as EMS **AGENCY** medical directors and are practicing in urban counties;
- 246 C) One physician licensed in good standing in Colorado who is actively serving as  
 247 an EMS **AGENCY** medical director in any area of the state;
- 248 D) One EMS provider certified **OR LICENSED** at an advanced life support level who is  
 249 actively involved in the provision of emergency medical services;
- 250 E) One EMS provider certified **OR LICENSED** at a basic life support level who is  
 251 actively involved in the provision of emergency medical services; and
- 252 F) One EMS provider certified **OR LICENSED** at any level who is actively involved in  
 253 the provision of emergency medical services;

- 254 3.2.2 One voting member who is a member of the SEMTAC, appointed by the executive  
255 director of the ~~department~~ DEPARTMENT; and
- 256 3.2.3 Two nonvoting ex officio members appointed by the executive director of the ~~department~~  
257 DEPARTMENT.
- 258 3.3 EMPAC members shall serve four-year terms.
- 259 3.4 A vacancy on the EMPAC shall be filled by appointment by the appointing authority for that  
260 vacant position for the remainder of the unexpired term.
- 261 3.5 EMPAC members serve at the pleasure of the appointing authority and continue in office until the  
262 member's successor is appointed.
- 263 3.6 The EMPAC shall meet at least quarterly and more frequently as necessary to fulfill its  
264 obligations.
- 265 3.7 The EMPAC shall elect a chair and vice-chair from its members.
- 266 3.8 The duties of the EMPAC include:
- 267 3.8.1 Provide general technical expertise on matters related to the provision of patient care by  
268 EMS providers.
- 269 3.8.2 Advise or make recommendations to the ~~department~~ DEPARTMENT on:
- 270 A) The acts and medications that EMS providers are authorized to perform or  
271 administer under the direction of a-ALL medical directors.
- 272 B) Requests by medical directors for waivers to the scope of practice of EMS  
273 providers as established in these rules.
- 274 C) Modifications to EMS provider certification OR LICENSING levels and capabilities.
- 275 D) Criteria for physicians to serve as EMS AGENCY medical directors.

## 276 SECTION 4 – Medical Director Qualifications and Duties

- 277 4.1 ALL medical directors SUBJECT TO THESE RULES shall BE A PHYSICIAN CURRENTLY LICENSED IN GOOD  
278 STANDING TO PRACTICE MEDICINE IN THE STATE OF COLORADO. ~~possess the following minimum~~  
279 ~~qualifications:~~
- 280 4.1.1 ~~Be a physician currently licensed to practice medicine in the State of Colorado.~~
- 281 4.1.2 ~~Be trained in Advanced Cardiac Life Support.~~
- 282 4.2 IN ADDITION TO 4.1 ABOVE, THE EXPECTATIONS AND REQUIREMENTS OF A PHYSICIAN ACTING AS A  
283 MEDICAL DIRECTOR ARE LOCATED IN THE FOLLOWING SECTIONS:
- 284 4.2.1 FOR EMS AGENCY MEDICAL DIRECTOR, SEE SECTION 5 OF THESE RULES,
- 285 4.2.2. FOR CIHCS AGENCY (OUT-OF-HOSPITAL) MEDICAL DIRECTOR, SEE SECTION 18, AND
- 286 4.2.3 FOR CLINICAL MEDICAL DIRECTOR, SEE SECTION 19.



- 287 4.1.33 Physicians acting as medical directors for ~~department~~ DEPARTMENT-recognized EMS education  
288 programs must possess authority under their licensure to perform any and all medical acts to  
289 which they extend their authority to EMS providers, including any and all curricula presented by  
290 EMS education programs.
- 291 4.34 Departmental review of ALL medical directors
- 292 4.34.1 The ~~department~~ DEPARTMENT may review the records of ANY medical director SUBJECT TO  
293 THESE RULES to determine compliance with the requirements and standards in these rules  
294 and with accepted standards of medical oversight and practice.
- 295 4.34.2 Complaints in writing against medical directors for violations of these rules may be  
296 initiated by any person, the Colorado Medical Board, or the ~~department~~ DEPARTMENT.
- 297 4.34.3 Complaints in writing against medical directors may be referred to the Colorado Medical  
298 Board for review as deemed appropriate by the ~~department~~ DEPARTMENT.
- 299 4.2 ~~The duties of a medical director shall include:~~
- 300 **SECTION 5 - EMS AGENCY MEDICAL DIRECTORS**
- 301 5.1 EMS AGENCY MEDICAL DIRECTORS ARE RESPONSIBLE FOR THE MEDICAL DIRECTION OF EMS PROVIDERS  
302 IN THE PREHOSPITAL SETTING. THEIR DUTIES SHALL INCLUDE:
- 303 ~~4.2.4~~5.1.1 Be actively involved in the provision of emergency medical services in the  
304 community served by the EMS service agency being supervised. Involvement does not  
305 require that a physician have such experience prior to becoming a medical director but  
306 does require such involvement during the time that he or she acts as a medical director.  
307 Active involvement in the community could include, by way of example and not limitation,  
308 those inherent, reasonable, and appropriate responsibilities of a medical director to  
309 interact with patients, the public served by the EMS service agency, the hospital  
310 community, the public safety agencies, and the medical community and should include  
311 other aspects of liaison, oversight, and communication normally expected in the  
312 supervision of EMS providers.
- 313 ~~4.2.2~~5.1.2 Be actively involved on a regular basis with the EMS service agency being  
314 supervised. Involvement does not require that a physician have such experience prior to  
315 becoming a medical director but does require such involvement during the time that he or  
316 she acts as a medical director. Involvement could include, by way of example and not  
317 limitation, involvement in continuing education, audits, and protocol development.  
318 Passive or negligible involvement with the EMS service agency and supervised EMS  
319 providers does not meet this requirement.
- 320 ~~4.2.3~~5.1.3 Notify the Department on an annual basis and upon any change of medical  
321 direction of the EMS ~~S~~ Service A Agencies for which medical ~~control functions are being~~  
322 DIRECTION IS BEING provided in a manner and form as determined by the Department.
- 323 ~~4.2.4~~5.1.4 Establish a medical continuous quality improvement (CQI) program for each  
324 EMS service agency being supervised. The medical CQI program shall assure the  
325 continuing competency of the performance of that agency's EMS providers. This medical  
326 CQI program shall include, but not be limited to: appropriate protocols and standing  
327 orders and provision for medical care audits, observation, critiques, continuing medical  
328 education, and direct supervisory communications.

- 329 ~~4.2.5~~5.1.5 Submit to the ~~department~~ DEPARTMENT an affidavit that attests to the  
330 development and use of a medical CQI program for all EMS service agencies supervised  
331 by the medical director. As set forth ~~below in section 4.3~~ SECTION 4.4, the ~~department~~  
332 DEPARTMENT may review the records of a medical director to determine compliance with  
333 the CQI requirements in these rules.
- 334 ~~4.2.6~~5.1.6 Provide monitoring and supervision of the medical field performance of EMS  
335 providers. This includes ensuring that EMS providers have adequate clinical knowledge  
336 of, and are competent in performing, medical ~~skills and~~ acts within the EMS provider's  
337 scope of practice authorized by the medical director. These duties and operations may be  
338 delegated to other physicians or other qualified health care professionals designated by  
339 the medical director. However, the medical director shall retain ultimate authority and  
340 responsibility for the monitoring and supervision, for establishing protocols and standing  
341 orders, and for the competency of the performance of authorized medical acts.
- 342 ~~4.2.7~~5.1.7 Ensure that all protocols issued by the medical director are appropriate for the  
343 certification ~~OR LICENSE~~ and skill level of each EMS provider to whom the performance of  
344 medical acts is ~~delegated and~~ authorized and compliant with accepted standards of  
345 medical practice. Ensure that a system is in place for timely access to communication of  
346 DIRECT verbal orders.
- 347 ~~4.2.8~~5.1.8 Be familiar with the training, knowledge, and competence of EMS providers  
348 under his or her supervision and ensure that EMS providers are appropriately trained and  
349 demonstrate ongoing competency in all ~~skills, procedures and medications~~ MEDICAL ACTS  
350 authorized in accordance with Section ~~4.2.7~~ 15.1 AND, AS APPLICABLE, APPENDICES A-G.
- 351 ~~4.2.9~~5.1.9 Be aware that certain ~~skills, procedures and medications~~ MEDICAL ACTS  
352 authorized in accordance with Section ~~4.2.7~~ 15.1 AND, AS APPLICABLE, APPENDICES A-G  
353 (and as identified by the ~~DEPARTMENT-department~~) may not be included in the National  
354 EMS Education Standards and ensure that appropriate additional training is provided to  
355 supervised EMS providers.
- 356 ~~4.2.10~~5.1.10 Ensure that any data and/or documentation required by these rules are submitted  
357 to the ~~department~~ DEPARTMENT.
- 358 ~~4.2.11~~5.1.11 Notify the ~~department~~ DEPARTMENT within fourteen business days excluding  
359 state holidays prior to his or her cessation of duties as medical director.
- 360 ~~4.2.12~~5.1.12 Notify the ~~department~~ DEPARTMENT within fourteen business days excluding  
361 state holidays of his or her termination of the supervision of an EMS provider for reasons  
362 that may constitute good cause for disciplinary sanctions pursuant to the Rules Pertaining  
363 to EMS ~~AND EMR~~ Education, EMS ~~and~~ Certification ~~OR LICENSURE, AND EMR~~  
364 REGISTRATION 6 CCR 1015-3, Chapter One. Such notification shall be in writing and shall  
365 include a statement of the actions or omissions resulting in termination of supervision and  
366 copies of all pertinent records.
- 367 ~~4.2.13~~5.1.13 Physicians acting as medical directors for EMS education programs recognized  
368 by the ~~department~~ DEPARTMENT that require clinical and field internship performance by  
369 students shall be permitted to delegate authority to a student-in-training during their  
370 performance of program-required medical acts and only while under the control of the  
371 education program.
- 372 ~~4.2.14~~5.1.14 Physicians acting as medical directors responsible for the supervision and  
373 authorization of a P-CC shall have training and experience in the ~~acts and skills~~ MEDICAL  
374 ACTS for which they are providing supervision and authorization. Additional duties related

375 to medical directors responsible for the supervision and authorization of a P-CC are set  
376 forth in Section 4617 of these rules.

377 **5.2 EMS AGENCY MEDICAL DIRECTORS SHALL BE TRAINED IN ADVANCED CARDIAC LIFE SUPPORT.**

378 ~~4.2.15—Physicians acting as medical directors for a Community Integrated Health Care Service~~  
379 ~~Agency pursuant to section 25-3.5-1303(1)(a), C.R.S. that are responsible for the~~  
380 ~~supervision and authorization of a P-CP shall have training and experience in the acts~~  
381 ~~and skills for which they are providing supervision and authorization. Additional duties~~  
382 ~~related to medical directors responsible for the supervision and authorization of a P-CP~~  
383 ~~are set forth in Section 17 of these rules.~~

384 ~~4.3—Departmental review of medical directors~~

385 ~~4.3.1—The department may review the records of a medical director to determine compliance~~  
386 ~~with the requirements and standards in these rules and with accepted standards of~~  
387 ~~medical oversight and practice.~~

388 ~~4.3.2—Complaints in writing against medical directors for violations of these rules may be~~  
389 ~~initiated by any person, the Colorado Medical Board or the department.~~

390 ~~4.3.3—Complaints in writing against medical directors may be referred to the Colorado Medical~~  
391 ~~Board for review as deemed appropriate by the department.~~

392 **SECTION 56 – Medical Acts Allowed for the EMT**

393 ~~56.1~~ **56.1** An EMT may, under the supervision and authorization of a **AN EMS AGENCY MEDICAL DIRECTOR OR**  
394 **CLINICAL** medical director, perform emergency medical acts consistent with and not to exceed  
395 those listed in Appendices A and C of these rules for an EMT.

396 ~~56.2~~ **56.2** An EMT may, under the supervision and authorization of a **AN EMS AGENCY MEDICAL DIRECTOR OR**  
397 **CLINICAL** medical director, administer and monitor medications and classes of medications  
398 consistent with and not to exceed those listed in Appendices B and D of these rules for an EMT.

399 ~~56.3~~ **56.3** Any EMT who is a member or employee of an EMS service agency and who performs ~~said~~  
400 ~~emergency~~ medical acts **IN A PREHOSPITAL SETTING** must have authorization and be supervised by  
401 **a AN EMS AGENCY** medical director to perform ~~said emergency~~ **THE** medical acts.

402 **6.4 ANY EMT WHO PERFORMS MEDICAL ACTS IN A CLINICAL SETTING MUST HAVE THE AUTHORIZATION OF A**  
403 **CLINICAL MEDICAL DIRECTOR AND BE SUPERVISED BY A MEDICAL SUPERVISOR.**

404 ~~5.46.5~~ **5.46.5** **AN EMTs** may carry out a physician order for a mental health hold as set forth in Section 27-65-  
405 105(1), C.R.S. Such physician order may be a direct verbal order or by electronic  
406 communications.

407 ~~5.56.6~~ **5.56.6** An EMT who has successfully completed a ~~department~~ **DEPARTMENT**-recognized Intravenous  
408 Therapy and Medication Administration Course may be referred to as an Emergency Medical  
409 Technician with Intravenous Authorization (EMT-IV). Any provisions of these rules that are  
410 applicable to an EMT shall also be applicable to an EMT-IV. In addition to the acts an EMT is  
411 allowed to perform, an EMT-IV may, under supervision and authorization of a **AN EMS AGENCY**  
412 **MEDICAL DIRECTOR OR CLINICAL** medical director, perform medical acts consistent with and not to  
413 exceed those listed in Appendices A and C of these rules for an EMT-IV. In addition to the  
414 medications and classes of medications an EMT is allowed to administer and monitor pursuant to  
415 these rules, an EMT-IV may, under supervision and authorization of a **AN EMS AGENCY MEDICAL**  
416 **DIRECTOR OR CLINICAL** medical director, administer and monitor medications and classes of

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

419 ~~5-6.6.7~~ An EMT-IV may, under the supervision and authorization of a **AN EMS AGENCY MEDICAL DIRECTOR**  
420 **OR CLINICAL** medical director, administer and monitor medications and classes of medications  
421 which exceed those listed in Appendices B and D of these rules for an EMT-IV under the direct  
422 visual supervision of an AEMT, EMT-I, or paramedic **WHEN IN THE PREHOSPITAL SETTING, OR THE**  
423 **MEDICAL SUPERVISOR IN A CLINICAL SETTING**, when the following conditions have been established:

424 ~~5-6.4.6.7.1~~ The patient must be in cardiac arrest or in extremis.

425 ~~5-6.2.6.7.2~~ Drugs administered must be limited to those authorized by these rules for an  
426 AEMT, EMT-I, or paramedic as stated in Appendices B and D.

427 ~~5-6.3.6.7.3~~ The **EMS AGENCY MEDICAL DIRECTOR OR CLINICAL** medical director shall amend the  
428 appropriate protocols and medical CQI program used to supervise the EMS  
429 providers to reflect this change in patient care. The **APPLICABLE** medical director  
430 and the protocols of the EMT-IV and the AEMT, EMT-I, or paramedic shall all be  
431 in agreement.

432 ~~5-7.6.8~~ In the event of a governor-declared disaster or public health emergency, the ~~Chief~~ **Medical**  
433 ~~Officer for the Department or his or her~~ designee may temporarily authorize the performance of  
434 additional medical acts, such as the administration of other immunizations, vaccines, biologicals,  
435 or tests not listed in these rules.

#### 436 **SECTION 67 – Medical Acts Allowed for the Advanced EMT**

437 ~~67.1~~ An AEMT may, under the supervision and authorization of a **AN EMS AGENCY MEDICAL DIRECTOR**  
438 **OR CLINICAL** medical director, perform ~~emergency~~ medical acts consistent with and not to exceed  
439 those listed in Appendices A and C of these rules for an AEMT.

440 ~~67.2~~ An AEMT may, under the supervision and authorization of a **AN EMS AGENCY MEDICAL DIRECTOR**  
441 **OR CLINICAL** medical director, administer and monitor medications and classes of medications  
442 consistent with and not to exceed those listed in Appendices B and D of these rules for an AEMT.

443 ~~67.3~~ Any AEMT who is a member or employee of an EMS service agency and who performs ~~said~~  
444 ~~emergency~~ medical acts **IN A PREHOSPITAL SETTING** must have authorization and be supervised by  
445 a **AN EMS AGENCY** medical director to perform said ~~emergency~~ medical acts.

446 **7.4 ANY AEMT WHO PERFORMS MEDICAL ACTS IN A CLINICAL SETTING MUST HAVE THE AUTHORIZATION OF A**  
447 **CLINICAL MEDICAL DIRECTOR AND BE SUPERVISED BY A MEDICAL SUPERVISOR.**

448 ~~6-4.7.5~~ **AN AEMTs** may carry out a physician order for a mental health hold as set forth in Section 27-65-  
449 105(1), C.R.S. Such physician order may be a direct verbal order or by electronic  
450 communications.

451 ~~6-5.7.6~~ An AEMT may, under the supervision and authorization of a **AN EMS AGENCY MEDICAL DIRECTOR**  
452 **OR CLINICAL** medical director, administer and monitor medications and classes of medications  
453 which exceed those listed in Appendices B and D of these rules for an AEMT under the direct  
454 visual supervision of an EMT-I or paramedic when **IN THE PREHOSPITAL SETTING, OR A MEDICAL**  
455 **SUPERVISOR IN A CLINICAL SETTING, AND** the following conditions have been established:

456 ~~6-5.4.7.6.1~~ The patient must be in cardiac arrest or in extremis.

457 ~~6.5.27.6.2~~ 6.27.6.2 Drugs administered must be limited to those authorized by these rules for EMT-I  
458 or paramedic as stated in Appendices B and D.

459 ~~6.5.37.6.3~~ 6.37.6.3 The ~~EMS AGENCY MEDICAL DIRECTOR OR CLINICAL~~ medical director shall amend the  
460 appropriate protocols and medical CQI program used to supervise the EMS providers to  
461 reflect this change in patient care. The ~~APPLICABLE~~ medical director and the protocols of  
462 the AEMT and the EMT-I or paramedic shall all be in agreement.

463 ~~6.67.7~~ 6.67.7 In the event of a governor-declared disaster or public health emergency, the ~~Chief~~ ~~Medical~~  
464 ~~Officer~~ for the ~~Department~~ or his or her designee may temporarily authorize the performance of  
465 additional medical acts, such as the administration of other immunizations, vaccines, biologicals  
466 or tests not listed in these rules.

## 467 SECTION 78 – Medical Acts Allowed for the EMT-Intermediate

468 78.1 In addition to the acts an EMT, an EMT-IV, and an AEMT are allowed to perform pursuant to  
469 these rules, an EMT-I may, under the ~~supervision and~~ authorization of a ~~AN EMS AGENCY MEDICAL~~  
470 ~~DIRECTOR OR CLINICAL~~ medical director, perform ~~advanced emergency medical care~~ acts  
471 consistent with and not to exceed those listed in Appendices A and C of these rules for an EMT-I.

472 78.2 In addition to the medications and classes of medications an EMT, an EMT-IV, and an AEMT are  
473 allowed to administer and monitor pursuant to these rules, an EMT-I may, under the ~~supervision~~  
474 ~~and~~ authorization of a ~~AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL~~ medical director, administer  
475 and monitor medications and classes of medications defined in Appendices B and D of these  
476 rules for an EMT-I.

477 8.3 ANY EMT-I WHO IS A MEMBER OR EMPLOYEE OF AN EMS SERVICE AGENCY AND WHO PERFORMS  
478 MEDICAL ACTS IN A PREHOSPITAL SETTING MUST HAVE THE AUTHORIZATION OF AND BE SUPERVISED BY  
479 AN EMS AGENCY MEDICAL DIRECTOR.

480 8.4 ANY EMT-I WHO PERFORMS MEDICAL ACTS IN A CLINICAL SETTING MUST HAVE THE AUTHORIZATION OF A  
481 CLINICAL MEDICAL DIRECTOR AND BE SUPERVISED BY A MEDICAL SUPERVISOR.

482 ~~7.38.5~~ 7.38.5 An EMT-I may carry out a physician order for a mental health hold as set forth in Section 27-65-  
483 105(1), C.R.S. Such physician order may be a direct verbal order or by electronic  
484 communications.

485 ~~7.48.6~~ 7.48.6 An EMT-I may, under the ~~supervision and~~ authorization of a ~~AN EMS AGENCY MEDICAL DIRECTOR~~  
486 ~~OR CLINICAL~~ medical director, administer and monitor medications and classes of medications  
487 which exceed those listed in Appendices B and D of these rules for an EMT-I under the direct  
488 visual supervision of a paramedic ~~IN A PREHOSPITAL SETTING, OR A MEDICAL SUPERVISOR IN A~~  
489 ~~CLINICAL SETTING~~, when the following conditions have been established:

490 ~~7.4.18.6.1~~ 7.4.18.6.1 Drugs administered must be limited to those authorized by these rules for  
491 paramedics as stated in Appendices B and D.

492 ~~7.4.28.6.2~~ 7.4.28.6.2 The ~~EMS AGENCY MEDICAL DIRECTOR OR CLINICAL~~ medical director shall amend the  
493 appropriate protocols and medical CQI program used to supervise the EMS providers to  
494 reflect this change in patient care. The ~~APPLICABLE~~ medical director and protocols of the  
495 EMT-I and paramedic shall all be in agreement.

496 ~~7.58.7~~ 7.58.7 In the event of a governor-declared disaster or public health emergency, the ~~Chief~~ ~~Medical~~  
497 ~~Officer~~ for the ~~Department~~ or his or her designee may temporarily authorize the performance of  
498 additional medical acts, such as the administration of other immunizations, vaccines, biologicals,  
499 or tests not listed in these rules.

**500 SECTION 89 – Medical Acts Allowed for the Paramedic**

501 ~~89.1~~ In addition to the acts ~~an EMT-1 is~~ **ALL OTHER EMS PROVIDERS ARE** allowed to perform pursuant to  
502 these rules, a paramedic may, under the ~~supervision and~~ authorization of a **AN EMS AGENCY**  
503 **MEDICAL DIRECTOR OR UNDER THE AUTHORIZATION OF A CLINICAL** medical director **AND SUPERVISION**  
504 **OF A MEDICAL SUPERVISOR**, perform advanced ~~emergency~~ medical ~~care~~ acts consistent with and  
505 not to exceed those listed in Appendices A and C of these rules for a paramedic.

506 ~~89.2~~ In addition to the medications and classes of medications ~~an EMT-1 is~~ **ALL OTHER EMS PROVIDERS**  
507 **ARE** allowed to administer and monitor pursuant to these rules, a paramedic may, under the  
508 ~~supervision and~~ authorization of a **AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL** medical  
509 director, administer and monitor medications and classes of medications defined in Appendices B  
510 and D for a paramedic.

511 ~~89.3~~ Paramedics may carry out a physician order for a mental health hold as set forth in Section 27-  
512 65-105(1), C.R.S. Such physician order may be a direct verbal order or by electronic  
513 communications.

514 ~~89.4~~ **ANY PARAMEDIC WHO IS A MEMBER OR EMPLOYEE OF AN EMS SERVICE AGENCY AND WHO PERFORMS**  
515 **SAID MEDICAL ACTS IN A PREHOSPITAL SETTING MUST HAVE THE AUTHORIZATION OF AND BE SUPERVISED**  
516 **BY AN EMS AGENCY MEDICAL DIRECTOR TO PERFORM SAID MEDICAL ACTS.**

517 ~~9.5~~ **ANY PARAMEDIC WHO PERFORMS SAID MEDICAL ACTS IN A CLINICAL SETTING MUST HAVE THE**  
518 **AUTHORIZATION OF A CLINICAL MEDICAL DIRECTOR AND BE SUPERVISED BY A MEDICAL SUPERVISOR TO**  
519 **PERFORM SAID MEDICAL ACTS.**

520 ~~9.6~~ In addition to the acts of a paramedic, a P-CC may, under the supervision and authorization of a  
521 **AN EMS AGENCY MEDICAL DIRECTOR OR UNDER THE AUTHORIZATION OF A CLINICAL** medical director  
522 **AND SUPERVISION OF A MEDICAL SUPERVISOR** perform advanced ~~emergency~~ medical ~~care~~ acts  
523 consistent with and not to exceed those authorized in Appendix E of these rules for Critical Care.

524 ~~8-59.7~~ In addition to the medications a paramedic is allowed to administer and monitor, a P-CC may,  
525 under the ~~supervision and~~ authorization of a **AN EMS OR CLINICAL** medical director, administer and  
526 monitor medications defined in Appendix F of these rules for Critical Care.

527 ~~8-69.8~~ In addition to the acts of a paramedic, a P-CP may, under the supervision and authorization of a  
528 CIHCS Agency medical director **OR UNDER THE AUTHORIZATION OF A CLINICAL MEDICAL DIRECTOR**  
529 **AND SUPERVISION OF A MEDICAL SUPERVISOR** perform out-of-hospital medical services **AND MEDICAL**  
530 **ACTS** consistent with and not to exceed those authorized in Appendix G of these rules for  
531 Community Paramedics.

532 ~~8-79.9~~ In addition to the medications a paramedic is allowed to administer and monitor, a P-CP may,  
533 under the supervision and authorization of a CIHCS Agency medical director **OR UNDER THE**  
534 **AUTHORIZATION OF A CLINICAL MEDICAL DIRECTOR**, administer and monitor medications defined in  
535 Appendix G of these rules for Community Paramedics.

536 ~~9.10~~ **ANY P-CP WHO IS A MEMBER OR EMPLOYEE OF AN CIHCS AGENCY AND WHO PERFORMS SAID MEDICAL**  
537 **ACTS IN AN OUT-OF-HOSPITAL SETTING MUST HAVE AUTHORIZATION AND BE SUPERVISED BY A CIHCS**  
538 **AGENCY MEDICAL DIRECTOR TO PERFORM SAID MEDICAL ACTS.**

539 ~~9.11~~ **ANY P-CP WHO PERFORMS SAID MEDICAL ACTS IN A CLINICAL SETTING MUST HAVE THE AUTHORIZATION**  
540 **OF A CLINICAL MEDICAL DIRECTOR AND BE SUPERVISED BY A MEDICAL SUPERVISOR TO PERFORM SAID**  
541 **MEDICAL ACTS.**



542 ~~8-8~~9.12 In the event of a governor-declared disaster or public health emergency, the ~~e~~Chief ~~m~~Medical  
 543 ~~e~~Officer for the Department or his or her designee may temporarily authorize the performance of  
 544 additional medical acts, such as the administration of other immunizations, vaccines, biologicals,  
 545 or tests not listed in these rules.

#### 546 **SECTION 910 – Graduate Advanced EMTs, ~~Graduate EMT-Intermediates~~ and Graduate Paramedics**

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

#### 560 **SECTION ~~40~~11 – General Acts Allowed**

561 ~~40~~11.1 Any EMS provider working for an EMS service agency shall be supervised by an ~~n~~ EMS AGENCY  
 562 medical director who complies with the requirements in these rules.

563 11.2 EMS PROVIDERS WHO ARE PROVIDING MEDICAL CARE IN A CLINICAL SETTING MUST FUNCTION UNDER  
 564 THE AUTHORITY OF A CLINICAL MEDICAL DIRECTOR AND UNDER THE MEDICAL SUPERVISION OF A MEDICAL  
 565 SUPERVISOR.

566 ~~40-2~~ 11.3 AN EMS AGENCY MEDICAL DIRECTOR, CIHCS AGENCY MEDICAL DIRECTOR, OR CLINICAL  
 567 medical director may limit the scope of practice of any EMS provider ~~OVER WHOM THEY PROVIDE~~  
 568 ~~MEDICAL DIRECTION.~~

569 ~~40-3~~11.4 IN A PREHOSPITAL SETTING, ~~T~~The gathering of laboratory and/or other diagnostic data for  
 570 the sole purpose of providing information to another health care provider does not require a  
 571 waiver provided:

572 ~~40-3-1~~11.4.1 The method by which the data is gathered is within the scope of practice of the  
 573 EMS provider as contained in these rules;

574 ~~40-3-2~~11.4.2 The collection method and analysis of the information collected is done in  
 575 accordance with applicable regulations including, but not limited to, the Clinical  
 576 Laboratory Improvement Amendments (CLIA) and FDA requirements; and,

577 ~~40-3-3~~11.4.3 Unless otherwise allowed in Table A.6, the information obtained will not be used  
 578 to alter the prehospital treatment or destination of the patient without a direct verbal  
 579 order.

580 ~~40-3-4~~ Paramedics with a community paramedic endorsement working in a CIHCS Agency can  
 581 perform and interpret POCT, excluding imaging procedures that are not performed by the  
 582 P-CP in real time, as defined in Appendix G.

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

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

587 ~~10.3.5 A CIHCS Agency medical director may limit the scope of practice of any P-CP provider.~~

588 **11.4.4** A medical director shall obtain a waiver as set forth in Section ~~44~~ **12** of these rules for  
 589 any other data gathering activities that do not meet the provisions listed above.

590 ~~10.4 EMS providers who are providing medical care outside of an EMS agency setting must function~~  
 591 ~~under the auspices of a medical director AND be in compliance with the Colorado Medical~~  
 592 ~~Board's statutes and rules.~~

593 ~~10.4.1 EMS providers who are providing out-of-hospital medical services for a CIHCS Agency~~  
 594 ~~must obtain a community paramedic endorsement. An endorsed community paramedic~~  
 595 ~~may only provide out-of-hospital medical services as defined in these rules while~~  
 596 ~~employed by or contracting with a CIHCS Agency.~~

597 **11.5 EMS PROVIDERS WHO ARE PROVIDING OUT-OF-HOSPITAL MEDICAL SERVICES, AS SPECIFICALLY DEFINED**  
 598 **IN SECTION 2.36 OF THESE RULES, FOR A CIHCS AGENCY OR IN A CLINICAL SETTING MUST OBTAIN A**  
 599 **COMMUNITY PARAMEDIC ENDORSEMENT.**

600 **11.5.1 AN ENDORSED COMMUNITY PARAMEDIC MAY PROVIDE OUT-OF-HOSPITAL MEDICAL SERVICES AS**  
 601 **DEFINED IN THESE RULES WHILE EMPLOYED BY OR CONTRACTING WITH A CIHCS AGENCY.**

602 **11.5.2 PARAMEDICS WITH A COMMUNITY PARAMEDIC ENDORSEMENT WORKING IN A CIHCS AGENCY**  
 603 **CAN PERFORM AND INTERPRET POCT, EXCLUDING IMAGING PROCEDURES THAT ARE NOT**  
 604 **PERFORMED BY THE P-CP IN REAL TIME, AS DEFINED IN APPENDIX G.**

605 **A) A P-CP MAY INTERPRET POCT FOR CLINICAL DECISION MAKING BASED ON THE**  
 606 **PROTOCOLS AND PROCEDURES OF THE CIHCS AGENCY MEDICAL DIRECTOR.**

607 **B) A P-CP MAY INTERPRET LABORATORY STUDIES OUTSIDE OF POCT IF PART OF A**  
 608 **PRESCRIBED SERVICE PLAN APPROVED BY THE CIHCS AGENCY MEDICAL DIRECTOR.**

609 **11.5.3 AN ENDORSED COMMUNITY PARAMEDIC MAY PROVIDE OUT-OF-HOSPITAL MEDICAL SERVICES IN**  
 610 **THE CLINICAL SETTING PURSUANT TO THE PROVISIONS SET FORTH IN SECTION 9 OF THESE RULES.**

611 ~~40.5~~ **11.6 EMS providers may not practice in camps in a nursing capacity including the dispensing of**  
 612 **medications.**

### 613 **SECTION 4412 – Waivers to Scope of Practice FOR EMS PROVIDERS IN PREHOSPITAL SETTINGS**

614 **4412.1 Any EMS AGENCY medical director may apply to the department DEPARTMENT for a waiver to the**  
 615 **scope of practice set forth in these rules for EMS providers under his or her supervision in**  
 616 **specific circumstances, based on established need, provided that on-going quality assurance of**  
 617 **each EMS provider's competency is maintained by the medical director. WAIVERS TO SCOPE OF**  
 618 **PRACTICE ARE LIMITED TO PREHOSPITAL SETTINGS.**

619 **4412.2 A waiver is not necessary for the allowed skills and medications MEDICAL ACTS listed in**  
 620 **Appendices A, B, C, or D of this rule.**

621 **44.12.2.1 In addition to the skills and medications MEDICAL ACTS allowed in**  
 622 **Paragraph SECTION 4412.2, a P-CC does not require a waiver for the allowed skills and**  
 623 **medications MEDICAL ACTS listed in Appendices E and F.**



- 624 4412.2.2 In addition to the ~~skills and medications~~ **MEDICAL ACTS** allowed in Paragraph  
625 **SECTION 4412.2**, a P-CP does not require a waiver for the allowed out-of-hospital medical  
626 services listed in Appendix G when providing medical services in a CIHCS Agency  
627 setting.
- 628 4412.3 All levels of EMS provider may, under the supervision and authorization of a **AN EMS AGENCY**  
629 medical director, perform specific skills or administer specific medications not listed in  
630 Appendices A, B, C, D, E, or F of this rule, only if the **EMS AGENCY** medical director has been  
631 granted a waiver from the ~~department~~ **DEPARTMENT** for that specific skill or medication.
- 632 **12.3.1** Waivered skills or medication administration may be authorized by the EMS agency  
633 medical director under standing orders or direct verbal orders of a physician, including by  
634 electronic communications.
- 635 **12.3.2** No EMS provider shall function beyond the scope of practice identified in these rules for  
636 their level until their EMS agency medical director has received official written  
637 confirmation of the waiver being granted by the ~~department~~ **DEPARTMENT**.
- 638 4412.4 ~~Medical~~ **EMS AGENCY MEDICAL** directors seeking a waiver shall submit a completed application to  
639 the ~~department~~ **DEPARTMENT** in a form and manner determined by the ~~department~~ **DEPARTMENT**.
- 640 4412.4.1 The application shall include, but not be limited to, a description of the act or  
641 medication to be waived, information regarding the justification for the waiver, the  
642 proposed education, training, and quality assurance process, literature review, and  
643 copies of the applicable protocols. The forms and affidavit required by Section 4-5 of  
644 these rules shall also be included.
- 645 4412.4.2 The ~~department~~ **DEPARTMENT** may require the applicant to provide additional  
646 information if the initial application is determined to be insufficient.
- 647 4412.4.3 An application shall not be considered complete until the required information is  
648 submitted.
- 649 4412.4.4 The completed waiver application shall be submitted to the ~~department~~  
650 **DEPARTMENT** in a timely fashion as specified by the ~~department~~ **DEPARTMENT**.
- 651 4412.4.5 The application shall be a matter of public record and is subject to disclosure  
652 requirements under the Colorado Open Records Act (~~C.R.S. §~~ **SECTION 24-72-200.1 et**  
653 **seq., C.R.S.**
- 654 4412.5 The EMPAC shall review waiver requests and make recommendations to the ~~department~~  
655 **DEPARTMENT**. The EMPAC may make recommendations, including but not limited to: deny,  
656 approve, table, request more information from the **EMS AGENCY** medical director, or impose  
657 special conditions on the waiver.
- 658 4412.6 After receiving recommendations from the EMPAC, the ~~department~~ **DEPARTMENT** shall make a  
659 decision on the waiver request and send notice of that decision to the **EMS AGENCY** medical  
660 director within thirty (30) calendar days of the recommendation. If granted, the notice shall include  
661 the effective date and expiration date of the waiver.
- 662 4412.6.1 If the waiver is granted, the ~~department~~ **DEPARTMENT** may:
- 663 A) Specify the terms and conditions of the waiver.
- 664 B) Specify the duration of the waiver.

- 665 C) Specify any reporting requirements.
- 666 4412.6.2 The ~~department~~ DEPARTMENT may require the submission of data or other  
667 information regarding waivers.
- 668 A) Unless otherwise specified by the ~~department~~ DEPARTMENT, any data or  
669 information submitted to the ~~department~~ DEPARTMENT shall not contain patient-  
670 identifying information.
- 671 B) If the ~~department~~ DEPARTMENT requires submission of data or reports containing  
672 patient-identifying information for purposes of overseeing a statewide continuing  
673 quality improvement system, that information shall be kept confidential pursuant  
674 to ~~C.R.S. §~~ SECTION 25-3.5-704(2)(h)(I)(E), C.R.S.
- 675 C) If the ~~department~~ DEPARTMENT requires submission of data, information, records,  
676 or reports related to the identification of individual patient's, provider's, or facility's  
677 care outcomes for purposes of overseeing a statewide continuing quality  
678 improvement system, that information shall be kept confidential pursuant to  
679 ~~C.R.S. §~~ SECTION 25-3.5-702704(2)(h)(II), C.R.S.
- 680 4412.6.3 The ~~department~~ DEPARTMENT may deny, revoke, or suspend a waiver if it  
681 determines:
- 682 A) That its approval or continuation jeopardizes the health, safety, and/or welfare of  
683 patients.
- 684 B) The EMS AGENCY medical director has provided false or misleading information in  
685 the waiver application.
- 686 C) The EMS AGENCY medical director has failed to comply with conditions or  
687 reporting on an approved waiver.
- 688 D) That a change in federal or state law prohibits continuation of the waiver.
- 689 4412.7 If the ~~department~~ DEPARTMENT denies a waiver application or revokes or suspends a waiver, it  
690 shall provide the EMS AGENCY medical director with a notice explaining the basis for the action.  
691 The notice shall also inform the EMS AGENCY medical director of his or her right to appeal and the  
692 procedure for appealing the action.
- 693 4412.8 Appeals of ~~e~~Departmental actions shall be conducted in accordance with the state Administrative  
694 Procedure Act, Section 24-4-101, *et seq.*, C.R.S.
- 695 4412.9 If the rule pertaining to a waived ~~skill or medication administration~~ MEDICAL ACT is amended or  
696 repealed obviating the need for the waiver, the waiver shall expire on the effective date of the rule  
697 change.
- 698 4412.10 If a AN EMS AGENCY medical director has made timely and sufficient application for  
699 renewal of a waiver and the ~~department~~ DEPARTMENT fails to take action on the application prior  
700 to the waiver's expiration date, the existing waiver shall not expire until the ~~department~~  
701 DEPARTMENT acts upon the application. The ~~department~~ DEPARTMENT, in its sole discretion, shall  
702 determine whether the application was timely and sufficient.
- 703 4412.11 In the case of exigent circumstances, including but not limited to the death or  
704 incapacitation of a AN EMS AGENCY medical director or the termination of the relationship between  
705 a EMS AGENCY medical director and an EMS service agency, the ~~department~~ DEPARTMENT may

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

#### 709 SECTION 4213 – Technology and Pharmacology Dependent Patients IN PREHOSPITAL SETTINGS

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

#### 716 SECTION 4314 – Combination Benzodiazepine and Opiate Therapy

717 4314.1 The administration of a combination of benzodiazepines and opiates, for the purpose of pain  
718 management, anxiolysis, and/or muscle relaxation is permitted. Safeguards shall be taken to  
719 maximize patient safety including but not limited to the patient's ability to:

720 4314.1.1 Independently maintain an open airway and normal breathing pattern,

721 4314.1.2 Maintain normal hemodynamics, and

722 4314.1.3 Respond appropriately to physical stimulation and verbal commands.

723 4314.2 The administration of combination therapy requires appropriate monitoring and care including, but  
724 not limited to: IV or IO access, continuous waveform capnography, pulse oximetry, ECG  
725 monitoring, blood pressure monitoring, and administration of supplemental oxygen.

#### 726 SECTION 44 15 – Scope of Practice

727 4415.1 All of the following appendices define the maximum MEDICAL ACTS skills, acts or medications that  
728 may be delegated to an EMT, EMT-IV, AEMT, EMT-I, and paramedic MAY BE AUTHORIZED TO  
729 PERFORM under appropriate supervision MEDICAL DIRECTION by a THE APPLICABLE medical director  
730 FOR EACH SETTING.

731 4415.2 A medical director may establish the methods by which an EMS provider obtains authorization in  
732 the field PREHOSPITAL OR CLINICAL SETTING to perform any medical acts, skill or medication  
733 contained in these rules including, but not limited to: advanced standing orders that are written or  
734 electronically conveyed, contemporaneous orders that are direct verbal orders, or written orders  
735 that are conveyed in real-time.

#### 736 15.3 AS USED IN ALL OF THE APPENDICES, THE FOLLOWING TERMS ARE DEFINED TO MEAN:

737 4415.23.1 "Y" = YES: May be performed or administered by EMS providers with physician  
738 supervision as described in these rules.

739 4415.2.3.2 "VO" = Verbal Order: May only be performed or administered by EMS providers if  
740 authorized by direct verbal or written order received from a physician contemporaneous  
741 to when patient is receiving treatment, unless specific exception criteria are established  
742 by the supervising physician. Exception criteria may include, but are not limited to cardiac  
743 arrest, behavioral management or communications failure. Supervising physicians shall  
744 not develop exception criteria that merely waive all direct verbal order requirements.

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

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

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

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

760 4415.23.3 "N" = NO: May not be performed or administered by EMS providers except with  
 761 an approved waiver as described in Section 1244 of these rules.

762 4415.23.4 "EMT" = Medical acts, ~~skills or medications~~ that may be performed or  
 763 administered by an EMT with appropriate medical director ~~supervision~~ AUTHORIZATION  
 764 and training recognized by the ~~department~~ DEPARTMENT.

765 4415.23.5 "EMT-IV" = Medical acts, ~~skills or medications~~ that may be performed or  
 766 administered by an EMT-IV with appropriate medical director ~~supervision~~ AUTHORIZATION  
 767 and training recognized by the ~~DEPARTMENT~~ department.

768 4415.23.6 "AEMT" = Medical acts, ~~skills or medications~~ that may be performed or  
 769 administered by an AEMT with appropriate medical director ~~supervision~~ AUTHORIZATION  
 770 and training recognized by the ~~DEPARTMENT~~ department.

771 44.15.23.7 "EMT-I" = Medical acts, ~~skills or medications~~ that may be performed or  
 772 administered by an EMT-I with appropriate medical director AUTHORIZATION and training  
 773 recognized by the ~~department~~ DEPARTMENT.

774 4415.23.8 "P" = Medical acts, ~~skills or medications~~ that may be performed or administered  
 775 by a paramedic with appropriate medical director ~~supervision~~ AUTHORIZATION and training  
 776 recognized by the ~~department~~ DEPARTMENT.

777 **Note: SECTION 4516 – INTERFACILITY TRANSPORT begins following APPENDIX B.**

778 **Note: Section 4617 – CRITICAL CARE begins following APPENDIX D.**

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

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

781 **APPENDIX A**

782 **PREHOSPITAL**

783 **MEDICAL ~~SKILLS AND~~ ACTS ALLOWED**

- 784 A.1.1 ~~IN THE PREHOSPITAL SETTING~~, additions to these medical skills and acts allowed cannot be  
 785 ~~delegated~~ ARE NOT ALLOWED unless a waiver has been granted as described in Section 44 12 of  
 786 these rules. A WAIVER MAY NOT BE GRANTED FOR MEDICAL ACTS IN THE OUT-OF-HOSPITAL OR CLINICAL  
 787 SETTINGS.
- 788 A.1.2 Not all medical skills and acts allowed are included in initial education for various EMS provider  
 789 levels. ~~Medical~~ ALL MEDICAL directors SUBJECT TO THESE RULES shall ensure providers are  
 790 appropriately trained as noted in Sections 4.2.8 and 4.2.9, SECTIONS 18 (CIHCS) AND 19 (CLINICAL  
 791 SETTINGS).
- 792 A.1.3 In addition to the medical skills and acts allowed in Appendix A, EMS providers may provide  
 793 services allowable under the Community Assistance Referral and Education Services (CARES)  
 794 Program, as set forth in Section 25-3.5-1203(3),C.R.S.

795 **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 <sub>2</sub> 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 Impedance 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) <sup>1</sup>	N	N	N	N	Y

796 <sup>1</sup> Use of automated transport ventilators (ATVs) is restricted to the manipulation of tidal volume (TV or VT), respiratory rate (RR),  
 797 fraction of inspired oxygen (FIO<sub>2</sub>), and positive end expiratory pressure (PEEP). Manipulation of any other parameters of  
 798 mechanical ventilation devices by EMS providers requires a waiver to these rules.

799 **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 <sup>2</sup>	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

800 <sup>2</sup> Therapeutic Induced Hypothermia (TIH)-TARGETED TEMPERATURE MANAGEMENT (TTM)

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

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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 <sup>3</sup>	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



815 <sup>3</sup>AEMTs may not employ the rectal administration route in any situation except for the one exception set out in Table B.10,  
816 "Benzodiazepine –Diazepam rectal administration."

817 **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 <sup>4</sup>	Y	Y	Y	Y	Y
Diagnostic Interpretation – Blood Lactate <sup>4</sup>	N	N	Y	Y	Y
Dressing/Bandaging	Y	Y	Y	Y	Y
Esophageal Temperature Probe for <del>TTM</del> <b>TTM</b>	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
<b>PUBLIC HEALTH RELATED-ORAL/NASAL SWAB SAMPLE COLLECTION</b>	<b>Y</b>	<b>Y</b>	<b>Y</b>	<b>Y</b>	<b>Y</b>
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

818 <sup>4</sup> See also Section 40.3 **11.4**

819 **APPENDIX B**

820 **PREHOSPITAL**

821 **FORMULARY OF MEDICATIONS ALLOWED**

822 B.1.1 ~~Additions~~ **IN PREHOSPITAL SETTINGS, ADDITIONS** to this medication formulary ~~cannot be delegated~~  
823 **ARE NOT ALLOWED UNLESS** a waiver has been granted as described in Section 44 **12** of these rules.

824 B.1.2 Not all medical ~~skills and~~ acts allowed are included in initial education for various EMS provider  
825 levels. **ALL** medical directors **SUBJECT TO THESE RULES** shall ensure providers are appropriately  
826 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,**  
827 **19.3.8, AND 19.3.9 (CLINICAL SETTING).**

828 **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 <sup>1</sup>	VO	VO	VO	VO	V O

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

832 **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	<del>VO</del> Y	Y
Benzodiazepine – Lorazepam	N	N	N	<del>VO</del> Y	Y
Benzodiazepine – Midazolam	N	N	N	<del>VO</del> 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	<del>N</del>	<del>N</del>	<del>N</del>	<del>VO</del>	<del>Y</del>
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 – <del>Solu</del> cortef	N	N	N	<del>VO</del> 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
<b>ACETAMINOPHEN (TYLENOL) IV</b>	<b>N</b>	<b>N</b>	<b>Y</b>	<b>Y</b>	<b>Y</b>
Anesthetic – Lidocaine (for intraosseous needle insertion)	N	N	Y	Y	Y
Benzodiazepine – Diazepam	N	N	N	<del>VO</del> Y	Y
Benzodiazepine – Lorazepam	N	N	N	<del>VO</del> Y	Y
Benzodiazepine – Midazolam	N	N	N	<del>VO</del> Y	Y
General – Nitrous oxide	N	N	<del>VO</del> Y	<del>VO</del> Y	Y
<b>KETOROLAC (TORADOL)</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>Y</b>
Narcotic Analgesic – Fentanyl	N	N	<del>N</del> VO	<del>VO</del> Y	Y
Narcotic Analgesic – Hydromorphone	N	N	N	N	Y
Narcotic Analgesic – Morphine sulfate	N	N	<del>N</del> VO	<del>VO</del> Y	Y
Ophthalmic anesthetic- <del>Ophthaine</del> <b>OPHTHAINE</b>	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	<del>VO</del> Y	<del>VO</del> Y	Y
Bronchodilator – Anticholinergic – Atropine (aerosol/nebulized)	N	N	N	VO	Y
Bronchodilator – Anticholinergic – Ipratropium	<del>N</del> Y	<del>N</del> Y	<del>VO</del> Y	<del>VO</del> Y	Y
Bronchodilator – Beta agonist – Albuterol	Y	Y	Y	Y	Y
Bronchodilator – Beta agonist – L-Albuterol	<del>VO</del> Y	<del>VO</del> Y	<del>VO</del> Y	<del>VO</del> Y	Y
Bronchodilator – Beta agonist – Metaproterenol	N	N	N	VO	Y
<b>BRONCHODILATOR – BETA AGONIST – TERBUTALINE</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>Y</b>
Corticosteroid – Dexamethasone	N	N	N	<del>VO</del> Y	Y
Corticosteroid – Hydrocortisone	N	N	N	<del>VO</del> Y	Y
Corticosteroid – Methylprednisolone	N	N	N	<del>VO</del> Y	Y
Corticosteroid – Prednisone	N	N	N	<del>VO</del> 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	<del>VO</del> -Y	Y
Short Acting Bronchodilator meter dose inhalers (MDI) (Patient assisted)	VO	VO	VO	Y	Y
Short Acting Bronchodilator meter dose inhalers (MDI)	<del>VO</del> Y	<del>VO</del> -Y	<del>VO</del> -Y	<del>VO</del> -Y	Y
<del>Terbutaline</del>	<del>N</del>	<del>N</del>	<del>N</del>	<del>N</del>	<del>Y</del>

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

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

842 **TABLE B.11 – VACCINES**

Medications	EMT	EMT-IV	AEMT	EMT-I	P
<b>POST-EXPOSURE, EMPLOYMENT, OR PRE-EMPLOYMENT RELATED –HEPATITIS A</b>	<del>N</del>	<del>N</del>	<del>N</del>	<del>N</del>	<del>Y</del>
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	<del>N</del>	<del>N</del>	<del>N</del>	<del>VO</del>	<del>Y</del>
Narcotic Analgesic – Fentanyl for TIH	<del>N</del>	<del>N</del>	<del>N</del>	<del>VO</del>	<del>Y</del>
Topical <del>H</del> Hemostatic agents	Y	Y	Y	Y	Y

844 **SECTION 4516 – INTERFACILITY TRANSPORT**

845 4516.1 The EMS AGENCY medical director shall have protocols in place to ensure the appropriate level of  
846 care is available during interfacility transport.

- 847 4516.2 The transporting EMS provider may decline to transport any patient he or she believes requires a  
848 level of care beyond his or her capabilities.
- 849 4516.3 ~~Interfacility~~ **THE INTERFACILITY** transport typically involves three types of patients:
- 850 4516.3.1 Those patients whose safe transport can be accomplished by ambulance, under  
851 the care of an EMT, EMT-IV, AEMT, EMT-I, or paramedic, within the **MEDICAL** acts  
852 allowed under these rules.
- 853 4516.3.2 Those patients whose safe transport can be accomplished by ambulance, under  
854 the care of a paramedic, but may require **MEDICAL ACTS** ~~skills to be performed or~~  
855 ~~medications to be administered~~ that are outside the **MEDICAL** acts allowed under these  
856 rules, but **WHICH ACTS** have been approved through waiver granted by the **DEPARTMENT**  
857 ~~department~~.
- 858 4516.3.3 Those patients whose safe transport requires the skills and expertise of a critical  
859 care transport team under the care of an experienced critical care practitioner.
- 860 4516.4 The hemodynamically unstable patient or patient who may require Intensive Care Unit level of  
861 treatment, regardless if coming from an Intensive Care Unit, who requires special monitoring (e.g.  
862 central venous pressure, intracranial pressure), multiple cardioactive/vasoactive medications, or  
863 specialized critical care equipment (i.e. intra-aortic balloon pump) should remain under the care of  
864 an experienced critical care practitioner, and every attempt should be made to transport that  
865 patient while maintaining the appropriate level of care. The capabilities of the institution, the  
866 capabilities of the transporting agency and, most importantly, the safety of the patient should be  
867 considered when making transport decisions.
- 868 4516.5 Unless otherwise noted, the following Appendices C and D indicate hospital/facility initiated  
869 interventions and/or medications.
- 870 4516.5.1 Additions to these medical ~~skills and acts allowed cannot be delegated~~ **ARE NOT**  
871 **ALLOWED** unless a waiver has been granted as described in Section 4412 of these rules.
- 872 4516.5.2 The following medical ~~skills and acts~~ are approved for interfacility transport of  
873 patients, with the requirements that the ~~skill, act or medication~~ **MEDICAL ACTS** allowed must  
874 have been initiated in a medical facility under the direct order and supervision of licensed  
875 medical providers and are NOT authorized for field initiation. EMS continuation and  
876 monitoring of these interventions is to be allowed with any alterations in the therapy  
877 requiring direct verbal order. The EMS provider should continue the same medical  
878 standards of care with regards to patient monitoring that were initiated in the facility.
- 879 4516.5.3 It is understood that these ~~skills and acts~~ **MEDICAL ACTS** may not be addressed in  
880 the National EMS Education Standards for EMT, AEMT, EMT-I, or paramedic. As such, it  
881 is the joint responsibility of the **EMS AGENCY** medical director and individuals performing  
882 these ~~skills~~ **MEDICAL ACTS** to obtain appropriate additional training needed to safely and  
883 effectively utilize and monitor these interventions in the interfacility transport environment.
- 884 **16.6 ANY OF THE MEDICAL ACTS AND MEDICATIONS ALLOWED IN INTERFACILITY TRANSPORT IN APPENDICES C**  
885 **AND D MAY BE PERFORMED IN THE CLINICAL SETTING UNDER THE MEDICAL DIRECTION OF A CLINICAL**  
886 **MEDICAL DIRECTOR AND UNDER MEDICAL SUPERVISION.**

## 887 APPENDIX C

### 888 INTERFACILITY TRANSPORT — ONLY

889 **MEDICAL SKILLS AND ACTS ALLOWED**890 **TABLE C.1 – AIRWAY/VENTILATION/OXYGEN**

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Ventilators – Automated Transport (ATV) <sup>1</sup>	N	N	N	N	Y

891 <sup>1</sup> Use of automated transport ventilators (ATVs) is restricted to the manipulation of tidal volume (TV or VT), respiratory rate (RR),  
 892 fraction of inspired oxygen (FIO<sub>2</sub>), and positive end expiratory pressure (PEEP). Manipulation of any other parameters of  
 893 mechanical ventilation devices by EMS providers requires a waiver to these rules.

894 **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

895

896 **APPENDIX D**897 **FORMULARY OF MEDICATIONS ALLOWED – INTERFACILITY TRANSPORT**898 **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
<b>DOPAMINE – MONITORING AND MAINTENANCE</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>Y</b>
Epinephrine – infusion	N	N	N	N	<del>Y</del>
Nicardipine	N	N	N	N	Y
Nitroglycerin, intravenous	N	N	N	N	Y
Norepinephrine	N	N	N	N	<del>Y</del>
<b>THROMBOLYTICS – MONITORING AND MAINTENANCE</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>Y</b>

899 **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

900 **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

901 **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
<b>ANTIVIRAL INFUSION</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>Y</b>	<b>Y</b>
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

902 **SECTION 4617 – CRITICAL CARE**

903 ~~4617.1~~ In addition to the medical ~~skills and~~ acts within the scope of practice of a paramedic contained  
 904 within Appendices A, B, C, and D, a P-CC may perform the medical ~~skills and~~ acts contained  
 905 within this section, Appendices E and F, under the ~~direction~~ **AUTHORIZATION** of a ~~qualified~~ **AN EMS**  
 906 **AGENCY MEDICAL DIRECTOR OR CLINICAL** medical director.

907 ~~4617.1.1~~ Additions to these medical acts ~~skills and acts allowed~~ **IN A PREHOSPITAL SETTING**  
 908 ~~cannot be delegated~~ **ARE NOT ALLOWED** unless a waiver ~~had~~ **HAS** been granted as  
 909 described in Section ~~44~~ **12** of these rules.

910 ~~4617.1.2~~ It is understood that these medical ~~skills and~~ acts may not be addressed in the  
 911 National EMS Education Standards for Paramedics. As such, it is the joint responsibility  
 912 of the **APPLICABLE** medical director and individuals performing these ~~skills~~ **MEDICAL ACTS** to  
 913 obtain appropriate additional training needed to safely and effectively utilize and monitor  
 914 these interventions in the critical care environment.

915 ~~4617.2~~ A P-CC may decline transport of any patient that requires a level of care outside of their defined  
 916 scope of practice or that the P-CC believes is beyond their capabilities.

917 ~~4617.3~~ In addition to the duties of a **AN EMS AGENCY MEDICAL DIRECTOR OR CLINICAL** medical director  
 918 outlined in ~~SECTIONS 45 AND 19~~ of these rules, the duties of **SUCH** a medical director responsible  
 919 for ~~supervision and~~ authorization of a P-CC shall include:

920 ~~4617.3.1~~ Be qualified, by education, training, and experience in the medical ~~skills and~~ acts  
 921 for which the **APPLICABLE** medical director is authorizing the P-CC to practice.

922 ~~4617.3.2~~ Have protocols in place clearly defining which medical ~~skills and~~ acts, from  
 923 Appendices E and F, the **APPLICABLE** medical director is authorizing the P-CC to perform.

924 ~~4617.3.3~~ Have protocols in place to ensure the appropriate level of care is available during  
 925 critical care transport. The capabilities of the transporting agency and the safety of the  
 926 patient should be considered when making transport decisions.

927 **Appendix E – MEDICAL SKILLS AND ACTS ALLOWED**

928 **TABLE E.1**

Skill	P-CC
-------	------

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

929 **Appendix F – FORMULARY OF MEDICATIONS ALLOWED**930 **TABLE F.1 – CRITICAL CARE FORMULARY**

<b>Medications</b>	<b>P-CC</b>
Acetylcysteine (Mucomyst)	Y
<del>alteplase (Activase)</del>	<del>Y</del>
Antibiotics	Y
<del>B</del> ilvalirudin (Angiomax)	Y
<b>BLOOD PRODUCTS</b>	<b>Y</b>
<del>diazepam (Valium)</del>	<del>Y</del>
<del>D</del> obutamine (Dobutamine)	Y
Eesmolol (Brevibloc)	Y
Eetomidate (Amidate)	Y
<del>fentanyl (Sublimaze)</del>	<del>Y</del>
<del>F</del> osphenytoin (Cerebyx)	Y
<del>K</del> etamine (Ketalar)	Y
<del>L</del> abetalol (Normodyne)	Y
levitracetam <b>LEVETIRACETAM</b> (Keppra)	Y
<del>M</del> etoprolol (Lopressor)	Y
<del>midazolam (Versed)</del>	<del>Y</del>
morphine sulfate	<del>Y</del>
<del>norepinephrine (Levophed)</del>	<del>Y</del>
<del>P</del> henytoin (Dilantin)	Y
<del>P</del> ropofol (Diprivan)	Y
<del>R</del> ocuronium (Zemuron)	Y
<del>S</del> uccinylcholine (Anectine)	Y
<del>TNKase (Tenecteplase)</del>	<del>Y</del>
tPA infusion	Y
<b>TRANEXAMIC ACID (TXA)</b>	<b>Y</b>
<del>V</del> ecuronium (Norcuron)	Y

931 **Section 1718 – Community Paramedicine**

932 1718.1 In addition to the medical skills and acts within the scope of practice of a paramedic contained  
 933 within Appendices A, B, C, and D, a P-CP may perform the out-of-hospital medical services  
 934 contained within this section **AND** Appendix G, under the **direction AUTHORIZATION** of a CIHCS  
 935 Agency medical director while providing community integrated health care services. **A P-CP MAY**  
 936 **ALSO PROVIDE THOSE MEDICAL ACTS THAT ARE OUT-OF-HOSPITAL MEDICAL SERVICES CONTAINED IN THIS**  
 937 **SECTION, APPENDIX G, AND SECTION 19 UNDER THE AUTHORIZATION OF A CLINICAL MEDICAL DIRECTOR**  
 938 **AND UNDER THE MEDICAL SUPERVISION OF A MEDICAL SUPERVISOR.**

939 1718.1.1 **Additions** **A WAIVER CANNOT BE GRANTED TO EXPAND THE** to these out-of-hospital  
 940 medical services **THAT A P-CP MAY PERFORM IN A CIHCS SETTING. allowed cannot be**  
 941 **delegated unless a waiver had been granted as described in Section 11 of these rules.**

942 1718.1.2 It is understood that these out-of-hospital medical services may not be addressed  
 943 in the National EMS Education Standards for Paramedics. As such, it is the joint  
 944 responsibility of the CIHCS Agency **APPLICABLE** medical director and P-CPs performing



- 945 these services to obtain appropriate additional training needed to safely and effectively  
946 utilize and monitor these interventions in the out-of-hospital **AND CLINICAL SETTING**  
947 environments.
- 948 **4718.2** A CIHCS Agency **OR CLINICAL** medical director may limit the scope of a P-CP. A P-CP may  
949 decline to provide out-of-hospital medical services to any individual that requires a level of care  
950 outside of their defined scope of practice or that the P-CP believes is beyond their capabilities.
- 951 **4718.3** The duties of a CIHCS Agency medical director responsible for supervision and authorization of a  
952 P-CP, in addition to those located at 6 CCR 1011-3, Section 5.2, shall include:
- 953 **4718.3.1** Be actively involved in the provision of community integrated health care services  
954 in the community served by the CIHCS Agency. Involvement does not require that a  
955 physician have such experience prior to becoming a medical director but does require  
956 such involvement during the time that he or she acts as a CIHCS medical director. Active  
957 involvement in the community could include, by way of example and not limitation, those  
958 inherent, reasonable, and appropriate responsibilities of a medical director to interact and  
959 as needed collaborate with the community served by the CIHCS Agency, the hospital  
960 community, the public safety agencies, home care, hospice, and the medical community.  
961 **ACTIVE INVOLVEMENT** and should include other aspects of liaison oversight and  
962 communication normally expected in the supervision of CIHCS providers.
- 963 **4718.3.2** Be actively involved on a regular basis with the P-CP being supervised.  
964 Involvement does not require that a physician have such experience prior to becoming a  
965 medical director, but it does require such involvement during the time that he or she acts  
966 as a medical director. Involvement could include, by way of example and not limitation,  
967 involvement in continuing education, audits, and protocol development. Passive or  
968 negligible involvement with the CIHCS Agency and supervised P-CP does not meet this  
969 requirement.
- 970 **4718.3.3** In conjunction with the CIHCS Agency administrator, develop and implement **A**  
971 quality management policy for the CIHCS Agency and P-CP that includes consumer  
972 chart reviews in order to determine that appropriate assessments, referrals,  
973 documentation, and communication are occurring between the consumer's care  
974 providers, P-CPs, and the consumer.
- 975 **4718.3.4** Ensure that all issued protocols are appropriate for the skill level of each  
976 authorized P-CP to whom the performance of medical acts is delegated and are  
977 compliant with accepted standards of medical practice.
- 978 **4718.3.5** Develop, implement, and annually review protocols, guidelines, and standing  
979 orders regarding medical supervision, consultation requirements, and follow up care by  
980 other medical professionals. CIHCS Agency medical directors will ensure that P-CPs  
981 have adequate clinical knowledge of, and are competent in, out-of-hospital medical  
982 services performed on behalf of the CIHCS Agency. These duties and operations may be  
983 delegated to other physicians or other qualified health care professionals designated by  
984 the medical director. However, the CIHCS Agency medical director shall retain ultimate  
985 authority and responsibility for the monitoring and supervision, for establishing protocols  
986 and standing orders and for the competency of the performance of authorized medical  
987 acts of P-CP providers.
- 988 **4718.3.6** Oversee the ongoing training and education programs for P-CP personnel for the  
989 provision of out-of-hospital medical services. Ensure the competence of the P-CP under  
990 his or her supervision in all skills, procedures, and medications authorized.

- 991 4718.3.7 Notify the Department within fourteen business days of the cessation of duties as  
992 the CIHCS Agency's medical director;
- 993 4718.3.8 In collaboration with the CIHCS Agency administrator, designate through policy  
994 when the CIHCS Agency medical director is unavailable, a backup for medical direction  
995 in accordance with the requirements of 6 CCR 1011-3, Section 5.2.
- 996 4718.3.9 Ensure that medical direction is available at all appropriate times as determined  
997 by the CIHCS Agency policy.
- 998 4718.3.10 Provide evaluation, treatment, and transportation guidelines and protocols for  
999 non-urgent CIHCS Agency consumers.
- 1000 4718.3.11 In conjunction with the CIHCS consumer's care provider, if applicable, develop,  
1001 monitor, and evaluate consumer service plans.
- 1002 4718.3.12 In conjunction with the CIHCS consumer's care provider(s), if applicable, and the  
1003 P-CP, develop and implement a discharge summary as part of each consumer's service  
1004 plan.
- 1005 18.3.13 PHYSICIANS ACTING AS MEDICAL DIRECTORS FOR A COMMUNITY INTEGRATED HEALTH  
1006 CARE SERVICE AGENCY PURSUANT TO SECTION 25-3.5-1303(1)(A), C.R.S. THAT ARE  
1007 RESPONSIBLE FOR THE SUPERVISION AND AUTHORIZATION OF A P-CP SHALL HAVE TRAINING AND  
1008 EXPERIENCE IN THE ACTS AND SKILLS FOR WHICH THEY ARE PROVIDING SUPERVISION AND  
1009 AUTHORIZATION.
- 1010 18.4 A CLINICAL MEDICAL DIRECTOR'S RESPONSIBILITIES FOR AUTHORIZING A P-CP IN A CLINICAL SETTING  
1011 SHALL INCLUDE THOSE LOCATED IN SECTION 19.3 OF THESE RULES.

1012 **Appendix G – OUT-OF-HOSPITAL MEDICAL SERVICES ALLOWED**

- 1013 G.1 An initial assessment of the patient and any subsequent assessments, care coordination,  
1014 resource navigation, as needed, in an out-of-hospital setting over one or more visits.
- 1015 G.2 Patient education that may include, but is not limited to, a patient's family or caregiver.
- 1016 G.3 Provide allowable services as an employee or contractor of a Community Assistance Referral and  
1017 Education Services (CARES) Program, as set forth in Section 25-3.5-1203(3), C.R.S.
- 1018 G.4 Medical interventions, as set forth in a patient service plan:

1019 **Table G.1**

1020

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

1021 G.5 Assist with the inventory, compliance, and administration of, or may directly administer,  
 1022 specialized medications prescribed to the individual by a prescribing physician under a care plan.  
 1023 The route of administration must be within the provider’s scope as listed in Appendix A and this  
 1024 Appendix G.

1025 G.6 Gather laboratory and diagnostic data for POCT

1026 **Table G.2**

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

1027 G.7 Vaccinations as part of a consumer service plan.

1028

1029 ~~17.1.1 Additions to these out-of-hospital medical services allowed cannot be delegated unless a waiver~~  
 1030 ~~had been granted as described in Section 11 of these rules.~~

1031 ~~17.1.2 It is understood that these out-of-hospital medical services may not be addressed in the~~  
 1032 ~~National EMS Education Standards for Paramedics. As such, it is the joint responsibility~~  
 1033 ~~of the CIHCS Agency medical director and P-CPs performing these services to obtain~~  
 1034 ~~appropriate additional training needed to safely and effectively utilize and monitor these~~  
 1035 ~~interventions in the out-of-hospital environment.~~

1036

1037 **SECTION 19 - CLINICAL SETTING**

1038 **19.1 ANY LICENSED OR CERTIFIED EMT, AEMT, EMT-I, OR PARAMEDIC MAY PERFORM THE MEDICAL ACTS**  
 1039 **WITHIN THEIR APPLICABLE SCOPE, AS SET FORTH IN APPENDICES A, B, C, D, E, F, AND G IN A CLINICAL**  
 1040 **SETTING PURSUANT TO ORDERS OR INSTRUCTIONS FROM, AND UNDER THE MEDICAL SUPERVISION OF, A**  
 1041 **MEDICAL SUPERVISOR.**

1042 **19.1.2 AN EMT-IV MAY PERFORM THE MEDICAL ACTS WITHIN THE EMT-IV SCOPE OF PRACTICE IN A**  
 1043 **CLINICAL SETTING IF AUTHORIZED BY A CLINICAL MEDICAL DIRECTOR CONSISTENT WITH SECTION**  
 1044 **6.6 AND PURSUANT TO ORDERS OR INSTRUCTIONS FROM, AND UNDER THE MEDICAL**  
 1045 **SUPERVISION OF, A MEDICAL SUPERVISOR.**

1046 **19.1.3 A PARAMEDIC WITH A CRITICAL CARE ENDORSEMENT MAY PERFORM THE MEDICAL ACTS WITHIN**  
 1047 **THE P-CC SCOPE, AS SET FORTH IN APPENDICES E AND F, IN A CLINICAL SETTING PURSUANT TO**  
 1048 **ORDERS OR INSTRUCTIONS FROM, AND UNDER THE MEDICAL SUPERVISION OF, A MEDICAL**  
 1049 **SUPERVISOR.**

1050 **19.1.4 A PARAMEDIC WITH A COMMUNITY PARAMEDIC ENDORSEMENT MAY PERFORM THE MEDICAL ACTS**  
 1051 **WITHIN THE P-CP SCOPE, AS SET FORTH IN APPENDIX G, IN A CLINICAL SETTING PURSUANT TO**

- 1052 ORDERS OR INSTRUCTIONS FROM, AND UNDER THE MEDICAL SUPERVISION OF, A MEDICAL  
1053 SUPERVISOR.
- 1054 19.1.5 NOTHING IN THESE RULES ALTERS THE AUTHORITY OF A PHYSICIAN OR REGISTERED NURSE TO  
1055 DELEGATE ACTS TO AN EMS PROVIDER THAT ARE OUTSIDE OF THE EMS PROVIDER'S  
1056 APPLICABLE SCOPE OF PRACTICE IN THE CLINICAL SETTING, PURSUANT TO SECTIONS 12-240-  
1057 107 AND 12-255-131, C.R.S.. SUCH DELEGATION SHALL BE IN CONFORMANCE WITH THE  
1058 APPLICABLE RULES OF THE COLORADO MEDICAL BOARD AND THE COLORADO NURSING BOARD.
- 1059 19.2 A LICENSED OR CERTIFIED HEALTH CARE FACILITY THAT EMPLOYS EMS PROVIDERS TO PERFORM IN-  
1060 SCOPE TASKS AND PROCEDURES IN A CLINICAL SETTING SHALL:
- 1061 19.2.1 COLLABORATE WITH ITS CLINICAL MEDICAL DIRECTOR, MEDICAL SUPERVISORS, AND EMS  
1062 PROVIDERS TO ESTABLISH POLICIES AND PROCEDURES ENSURING THAT EMS PROVIDERS ARE  
1063 LIMITED TO PERFORMING MEDICAL ACTS WITHIN THEIR SCOPES OF PRACTICE.
- 1064 19.2.2 REQUIRE ITS CLINICAL MEDICAL DIRECTOR TO:
- 1065 (i) DETERMINE AND DOCUMENT EACH EMS PROVIDER'S SCOPE OF PRACTICE IN THE  
1066 CLINICAL SETTING; AND
- 1067 (ii) COMMUNICATE THE AUTHORIZED MEDICAL ACTS THAT EACH INDIVIDUAL EMS PROVIDER  
1068 MAY PERFORM UNDER MEDICAL SUPERVISION TO THE FACILITY'S MEDICAL  
1069 SUPERVISORS.
- 1070 19.3 CLINICAL MEDICAL DIRECTORS ARE RESPONSIBLE FOR THE MEDICAL DIRECTION OF EMS PROVIDERS IN  
1071 THE CLINICAL SETTING. THEIR DUTIES SHALL INCLUDE:
- 1072 19.3.1 BEING AWARE OF AND FAMILIAR WITH THE MEDICAL ACTS THAT ALL EMS PROVIDER TYPES MAY  
1073 BE AUTHORIZED TO PERFORM IN A CLINICAL SETTING PURSUANT TO THE SCOPE OF PRACTICE PUT  
1074 FORTH IN THESE RULES IN APPENDICES A, B, C, D, E, F, AND G, AS APPLICABLE.
- 1075 19.3.2 COLLABORATING WITH THE MEDICAL SUPERVISOR(S) AND EMS PROVIDERS TO ESTABLISH  
1076 POLICIES AND PROCEDURES ENSURING THAT EMS PROVIDERS ONLY PERFORM MEDICAL ACTS  
1077 THAT ARE WITHIN THE APPLICABLE EMS PROVIDER'S SCOPE OF PRACTICE.
- 1078 19.3.3 ENSURING THAT EACH EMS PROVIDER WORKING IN THE CLINICAL SETTING IS LIMITED TO  
1079 PERFORMING MEDICAL ACTS THAT ARE WITHIN THE APPLICABLE SCOPE OF PRACTICE AND ARE  
1080 PERFORMED COMPETENTLY UNDER MEDICAL SUPERVISION. THIS SHALL INCLUDE, BUT NOT BE  
1081 LIMITED TO, DETERMINING THOSE MEDICAL ACTS THAT EACH EMS PROVIDER MAY PERFORM  
1082 UNDER MEDICAL SUPERVISION AND COMMUNICATING TO THE MEDICAL SUPERVISOR(S) THE  
1083 AUTHORIZED MEDICAL ACTS THAT EACH INDIVIDUAL EMS PROVIDER MAY PERFORM.
- 1084 19.3.4 ENSURING THAT ALL CLINICAL PROTOCOLS ISSUED BY THE CLINICAL MEDICAL DIRECTOR ARE  
1085 APPROPRIATE FOR THE CERTIFICATION OR LICENSE AND SKILL LEVEL OF EACH EMS PROVIDER  
1086 TO WHOM THE PERFORMANCE OF MEDICAL ACTS IS AUTHORIZED AND COMPLIANT WITH  
1087 ACCEPTED STANDARDS OF MEDICAL PRACTICE. ENSURE THAT A SYSTEM IS IN PLACE FOR TIMELY  
1088 ACCESS TO COMMUNICATION OF VERBAL ORDERS.
- 1089 19.3.5 BEING ACTIVELY AND ROUTINELY INVOLVED WITH THE EMS PROVIDERS PROVIDING CARE IN THE  
1090 CLINICAL SETTING. INVOLVEMENT DOES NOT REQUIRE THAT A PHYSICIAN HAVE SUCH  
1091 EXPERIENCE PRIOR TO BECOMING A CLINICAL MEDICAL DIRECTOR, BUT IT DOES REQUIRE SUCH  
1092 INVOLVEMENT DURING THE TIME THAT THE PHYSICIAN ACTS AS A MEDICAL DIRECTOR.  
1093 INVOLVEMENT COULD INCLUDE, BY WAY OF EXAMPLE AND NOT LIMITATION, INVOLVEMENT IN

- 1094 CONTINUING EDUCATION, AUDITS, AND PROTOCOL DEVELOPMENT. PASSIVE OR NEGLIGIBLE  
1095 INVOLVEMENT WITH THE EMS PROVIDERS DOES NOT MEET THIS REQUIREMENT.
- 1096 19.3.6 BEING ACTIVELY INVOLVED IN THE FACILITY'S MEDICAL CONTINUOUS QUALITY IMPROVEMENT  
1097 (CQI) PROGRAM FOR EMS PROVIDERS. THE MEDICAL CQI PROGRAM SHALL ASSURE THE  
1098 CONTINUING COMPETENCY OF THE PERFORMANCE OF THE EMS PROVIDERS. THIS MEDICAL CQI  
1099 PROGRAM SHALL INCLUDE, BUT NOT BE LIMITED TO: APPROPRIATE PROTOCOLS AND STANDING  
1100 ORDERS APPLICABLE TO THE EMS PROVIDERS' SCOPES OF PRACTICE, PROVISION FOR MEDICAL  
1101 CARE AUDITS, OBSERVATION, CRITIQUES, CONTINUING MEDICAL EDUCATION, AND SUPERVISORY  
1102 COMMUNICATIONS.
- 1103 19.3.7 PROVIDING OVERSIGHT, DIRECTION, AND MEDICAL MANAGEMENT OF THE MEDICAL  
1104 PERFORMANCE OF EMS PROVIDERS IN THE CLINICAL SETTING. THIS INCLUDES ENSURING THAT  
1105 EMS PROVIDERS HAVE ADEQUATE CLINICAL KNOWLEDGE OF AND ARE COMPETENT IN  
1106 PERFORMING MEDICAL ACTS WITHIN THE EMS PROVIDER'S SCOPE OF PRACTICE AUTHORIZED BY  
1107 THE CLINICAL MEDICAL DIRECTOR. THESE DUTIES AND OPERATIONS MAY BE DELEGATED TO  
1108 OTHER PHYSICIANS OR OTHER QUALIFIED HEALTH CARE PROFESSIONALS DESIGNATED BY THE  
1109 CLINICAL MEDICAL DIRECTOR. HOWEVER, THE CLINICAL MEDICAL DIRECTOR SHALL RETAIN  
1110 ULTIMATE AUTHORITY AND RESPONSIBILITY FOR THE OVERSIGHT, DIRECTION, AND MEDICAL  
1111 MANAGEMENT OF THE MEDICAL PERFORMANCE OF EMS PROVIDERS IN THE CLINICAL SETTING,  
1112 FOR ESTABLISHING PROTOCOLS AND STANDING ORDERS, AND FOR THE COMPETENCY OF THE  
1113 PERFORMANCE OF AUTHORIZED MEDICAL ACTS.
- 1114 19.3.8 BEING FAMILIAR WITH THE TRAINING, KNOWLEDGE, AND COMPETENCE OF EMS PROVIDERS  
1115 SUBJECT TO THEIR OVERSIGHT AND ENSURING THAT EMS PROVIDERS ARE APPROPRIATELY  
1116 TRAINED AND DEMONSTRATE ONGOING COMPETENCY IN ALL MEDICAL ACTS AUTHORIZED TO BE  
1117 PERFORMED UNDER MEDICAL SUPERVISION.
- 1118 19.3.9 BEING AWARE THAT CERTAIN SKILLS, PROCEDURES, AND MEDICATIONS CONTAINED WITHIN  
1119 APPENDICES A, B, C, D, E, F, AND G MAY NOT BE INCLUDED IN THE NATIONAL EMS EDUCATION  
1120 STANDARDS AND ENSURING THAT APPROPRIATE ADDITIONAL TRAINING IS PROVIDED TO EMS  
1121 PROVIDERS, IF NECESSARY, FOR THE PERFORMANCE OF AN AUTHORIZED SKILL OR ACT.
- 1122 19.3.10 PHYSICIANS ACTING AS CLINICAL MEDICAL DIRECTORS RESPONSIBLE FOR THE OVERSIGHT AND  
1123 AUTHORIZATION OF A P-CC SHALL HAVE TRAINING AND EXPERIENCE IN THE ACTS AND SKILLS  
1124 FOR WHICH THEY ARE PROVIDING OVERSIGHT AND AUTHORIZATION. ADDITIONAL DUTIES  
1125 RELATED TO CLINICAL MEDICAL DIRECTORS RESPONSIBLE FOR THE OVERSIGHT AND  
1126 AUTHORIZATION OF A P-CC ARE SET FORTH IN SECTION 17 OF THESE RULES.
- 1127 19.3.11 PHYSICIANS ACTING AS CLINICAL MEDICAL DIRECTORS RESPONSIBLE FOR THE OVERSIGHT AND  
1128 AUTHORIZATION OF A P-CP SHALL HAVE TRAINING AND EXPERIENCE IN THE ACTS AND SKILLS  
1129 FOR WHICH THEY ARE PROVIDING OVERSIGHT AND AUTHORIZATION. ADDITIONAL DUTIES  
1130 RELATED TO CLINICAL MEDICAL DIRECTORS RESPONSIBLE FOR THE OVERSIGHT AND  
1131 AUTHORIZATION OF A P-CP ARE SET FORTH IN SECTION 18 OF THESE RULES.
- 1132 19.4 MEDICAL SUPERVISION OF THE EMS PROVIDER IN A CLINICAL SETTING MUST BE PROVIDED BY A MEDICAL  
1133 SUPERVISOR WHO IS:
- 1134 19.4.1 A COLORADO LICENSED PHYSICIAN, PHYSICIAN ASSISTANT, ADVANCED PRACTICE NURSE, OR  
1135 REGISTERED NURSE LICENSED IN GOOD STANDING,
- 1136 19.4.2 TRAINED AND EXPERIENCED IN THE ACTS AND SKILLS FOR WHICH SUPERVISION IS BEING  
1137 PROVIDED,

1138 19.4.3 KNOWLEDGEABLE ABOUT THE MAXIMUM SKILLS, ACTS, OR MEDICATIONS THAT AN EMT, EMT-IV,  
1139 AEMT, EMT-I, PARAMEDIC, P-CC, AND P-CP ARE AUTHORIZED TO PERFORM PURSUANT TO  
1140 THESE RULES, AND

1141 19.4.4 IMMEDIATELY AVAILABLE AND PHYSICALLY PRESENT AT THE CLINICAL SETTING WHERE THE CARE  
1142 IS BEING DELIVERED TO PROVIDE OVERSIGHT, GUIDANCE, OR INSTRUCTION TO THE EMS  
1143 PROVIDER DURING THE PERFORMANCE OF MEDICAL ACTS.

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