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

Adopted by the Chief Medical Officer on October 29, 2021. Effective December 30, 2021.

SECTION 1 – Purpose and Authority for Establishing Rules

1.1 These rules define the authorized medical acts of Emergency Medical Service (EMS) providers in the settings in which they may practice: prehospital, as defined by Sections 25-3.5-206(5)(b) and 25-3.5-209, C.R.S. and these rules; out-of-hospital, as defined by 6 CCR 1011-3 and these rules; and clinical, as defined by Section 25-3.5-207(1)(a), C.R.S and these rules.

1.2 These rules also define medical director qualifications and duties within EMS agencies, Community Integrated Health Care Service (CIHCS) agencies, and clinical settings. These rules apply to any physician functioning as a medical director in these settings.

1.3 These rules also define the duties of medical supervisors of EMS providers in the clinical setting.

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

SECTION 2 – Definitions

2.1 All definitions that appear in Sections 25-3.5-103, 25-3.5-205 – 207, C.R.S., and 6 CCR 1015-3, Chapter One shall apply to these rules. Unless otherwise stated, the definitions in this section shall apply to:

2.1.1 Prehospital and Interfacility Transport settings,

2.1.2 CIHCS (Out- of- Hospital) settings, and

2.1.3 Clinical settings.

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

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

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

2.5 “Certificate” - designation as having met the requirements of Section 5 of Chapter One, 6 CCR 1015-3, issued to an individual by the Department. Certification is equivalent to licensure for purposes of the State Administrative Procedure Act, Section 24-4-101, *et seq.*, C.R.S.

2.6 “Clinical Medical Director” - for purposes of these rules, a physician licensed in Colorado and in good standing who determines, authorizes, and directs, through protocols, standing orders, and operational policies or procedures developed by the facility’s medical staff, the medical acts performed by EMS providers in a clinical setting. The clinical medical director is also responsible for assuring the competency of the performance of those acts by EMS providers as described in the Facility’s Medical Continuous Quality Improvement Program.

2.7 "Clinical Setting" - a health care facility licensed or certified by the Department pursuant to Section 25-1.5-103(1)(a), C.R.S.

2.8 "Colorado Medical Board" - the Colorado Medical Board established in Title 12, Article 240, C.R.S.

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

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

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

2.9.3 Services authorized under the scope of practice as set forth in this chapter.

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

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

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

2.12 "Consumer" - an individual receiving community integrated health care services.

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

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

2.15 "Direct Verbal Order" - verbal authorization given by a physician to an EMS provider for the performance of specific medical acts through a Medical Base Station or in person; or in a clinical setting, given by a physician contemporaneous to when a patient is receiving treatment or by a medical supervisor as an instruction based on a physician order.

2.16 "Emergency Medical Practice Advisory Council (EMPAC)" - the council established pursuant to Section 25-3.5-206, C.R.S. that is responsible for advising the Department regarding the appropriate scope of practice for EMS providers and for the criteria for physicians to serve as EMS agency medical directors, CIHCS Agency medical directors or clinical medical directors.

2.17 "Emergency Medical Technician (EMT)" - an individual who has a current and valid EMT certificate or license issued by the Department and who is authorized to provide basic emergency medical care in accordance with these rules.

2.18 "Emergency Medical Technician with Intravenous Authorization (EMT-IV)" - an individual who has a current and valid EMT certificate or license issued by the Department and who has met the conditions defined in Section 6.6 of these rules.

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

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

2.21 "EMS Provider" - means an individual who holds a valid emergency medical service provider certificate or license issued by the Department and includes Emergency Medical Technician, Advanced Emergency Medical Technician, Emergency Medical Technician-Intermediate, and Paramedic.

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

2.23 "Graduate Advanced EMT" - an individual who has a current and valid Colorado EMT certification or license issued by the Department and who has successfully completed a Department-recognized AEMT initial course but has not yet successfully completed the certification or licensing requirements set forth in the Rules Pertaining to EMS and EMR Education, EMS Certification or Licensure, and EMR Registration, 6 CCR 1015-3, Chapter One, for the AEMT level.

2.24 "Graduate Paramedic" - an individual who has a current and valid Colorado EMT certificate or license, AEMT certificate or license, or EMT-I certificate or license issued by the Department and who has successfully completed a Department-recognized Paramedic initial course but has not yet successfully completed the certification or licensing requirements set forth in the Rules Pertaining to EMS and EMR Education, EMS Certification and Licensure, and EMR Registration, 6 CCR 1015-3, Chapter One for the Paramedic level.

2.25 "In-Scope Tasks and Procedures" - tasks and procedures performed by an EMS provider within the EMS provider's scope of practice in a clinical setting as set forth in these rules.

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

2.27 "International Board of Specialty Certification (IBSC)" - a non-profit organization that develops and administers a national Community Paramedic certification exam.

2.28 "Licensed in Good Standing" - as used in these rules, means that a physician functioning as a medical director, or a physician, physician assistant, advanced practice nurse, or registered nurse functioning as a medical supervisor, holds a current and valid Colorado license to practice the applicable profession.

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

2.30 "Medical Acts"- as used in these rules, means the tasks, medications, or procedures that an EMS provider is authorized to perform or administer within the EMS provider's applicable scope of practice including in-scope tasks and procedures in a clinical setting.

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

2.32 "Medical Direction" - may include, but is not limited to, the following duties:

2.32.1 Approval of the medical components of treatment protocols and appropriate prearrival instructions;

2.32.2 Routine review of program performance and maintenance of active involvement in quality improvement activities, including access to prehospital recordings as necessary for the evaluation of care;

2.32.3 Authority to recommend appropriate changes to protocols for the improvement of patient care;

2.32.4 Provision of oversight for the ongoing education, training, and quality assurance of EMS providers as appropriate for the medical acts being performed in the prehospital, out-of-hospital, or clinical setting in which the EMS provider is practicing; and

2.32.5 Reporting of any misconduct by certified or licensed EMS providers that the medical director knows or reasonably believes has occurred.

2.33 "Medical Supervision" - the oversight, guidance, and instructions that a medical supervisor provides to an EMS provider in a clinical setting, as defined in Section 25-3.5-207(1)(d), C.R.S. and these rules.

2.34 "Medical Supervisor" - in a clinical setting, means a Colorado licensed physician, physician assistant, advanced practice nurse, or registered nurse.

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

2.36 "Out-of-hospital Medical Services" - services performed by a Paramedic with a Community Paramedic endorsement, including the initial assessment of the patient and any subsequent assessments, as needed; the furnishing of medical treatment and interventions; care coordination; resource navigation; patient education; medication inventory, compliance and administration; gathering of laboratory and diagnostic data; nursing services; rehabilitative services; complementary health services; as well as the furnishing of other necessary services and goods for the purpose of preventing, alleviating, curing, or healing human illness, physical disability, physical injury; alcohol, drug, or controlled substance abuse; behavioral health services that may be provided in an out-of-hospital setting; and the medical acts identified in Appendix G of these rules. Out-of-hospital medical services cannot be provided or performed in the prehospital setting.

2.37 "Paramedic" - for purposes of this Chapter Two, an individual who has a current and valid Paramedic certificate or license issued by the Department and who is authorized to provide advanced emergency medical care in a prehospital or clinical setting in accordance with these rules.

2.38 "Paramedic with Community Paramedic Endorsement (P-CP)" - an individual who has a current and valid Paramedic certificate or license issued by the Department and who has met the requirements in these rules to obtain a Community Paramedic endorsement from the Department and is authorized to provide acts in accordance with these rules relating to community integrated health care services, and as set forth in Sections 25-3.5-206, C.R.S., and 25-3.5-1301, *et seq.*, C.R.S.

2.39 "Paramedic with Critical Care Endorsement (P-CC)" - an individual who has a current and valid Paramedic certificate or license issued by the Department and who has met the requirements in these rules to obtain a Critical Care endorsement from the Department and is authorized to provide acts in accordance with conditions defined in these rules relating to critical care and as set forth in Section 25-3.5-206, C.R.S.

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

2.41 "Prehospital Care" - any medical acts performed prior to a patient receiving care at a licensed healthcare facility.

2.42 "Prehospital Setting" - means one of the following settings in which an EMS provider performs patient care, which care is subject to medical direction by an EMS agency medical director at the site of an emergency, during emergency transport, or during interfacility transport.

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

2.44 "Scope of Practice" - refers to the tasks, medications, and procedures (medical acts) that an EMS provider is authorized to perform or administer in accordance with Sections 25-3.5-203 and 25-3.5-206, C.R.S., and rules promulgated pursuant to those sections.

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

2.46 "Standing Order" - written authorization provided in advance by a medical director for the performance of specific medical acts by EMS.

2.47 "Supervision" - as applicable to physician medical direction, means the oversight, direction, or medical management that the medical director provides to an EMS provider in any setting. Supervision may be through direct observation or by indirect oversight as defined in the medical director's CQI program.

2.48 "Waiver" - a Department-approved exception to these rules granted to an EMS agency medical director.

2.49 "Written Order" - written authorization that a physician issues to an EMS provider for the performance of specific medical acts.

SECTION 3 – Emergency Medical Practice Advisory Council

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

3.2 The EMPAC shall consist of the following thirteen members:

3.2.1 Ten voting members appointed by the governor as follows:

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

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

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

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

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

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

G) One clinical psychiatrist licensed in good standing in Colorado who is recommended by a statewide association of psychiatrists;

H) One anesthesiologist licensed in good standing in Colorado who is recommended by a statewide association of anesthesiologists;

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

3.2.3 Two nonvoting ex officio members appointed by the executive director of the Department.

3.3 EMPAC members shall serve four-year terms.

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

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

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

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

3.8 The duties of the EMPAC include:

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

3.8.2 Advise or make recommendations to the Department on:

A) The acts and medications that EMS providers are authorized to perform or administer under the direction of all medical directors.

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

C) Modifications to EMS provider certification or licensing levels and capabilities.

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

SECTION 4 – Medical Director Qualifications and Duties

4.1 All medical directors subject to these rules shall be a physician currently licensed in good standing to practice medicine in the State of Colorado.

4.2 In addition to 4.1 above, the expectations and requirements of a physician acting as a medical director are located in the following sections:

4.2.1 For EMS agency medical director, see Section 5 of these rules,

4.2.2. For CIHCS agency (out-of-hospital) medical director, see Section 18, and

4.2.3 For clinical medical director, see Section 19.

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

4.4 Departmental review of all medical directors

4.4.1 The Department may review the records of any medical director subject to these rules to determine compliance with the requirements and standards in these rules and with accepted standards of medical oversight and practice.

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

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

SECTION 5 - EMS Agency Medical Directors

5.1 EMS agency medical directors are responsible for the medical direction of EMS providers in the prehospital setting. Their duties shall include:

5.1.1 Be actively involved in the provision of emergency medical services in the community served by the EMS service agency being supervised. Involvement does not require that a physician have such experience prior to becoming a medical director but does require such involvement during the time that he or she acts as a medical director. Active involvement in the community could include, by way of example and not limitation, those inherent, reasonable, and appropriate responsibilities of a medical director to interact with patients, the public served by the EMS service agency, the hospital community, the public safety agencies, and the medical community and should include other aspects of liaison, oversight, and communication normally expected in the supervision of EMS providers.

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

5.1.3 Notify the Department on an annual basis and upon any change of medical direction of the EMS service agencies for which medical direction is being provided in a manner and form as determined by the Department.

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

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

5.1.6 Provide monitoring and supervision of the medical field performance of EMS providers. This includes ensuring that EMS providers have adequate clinical knowledge of, and are competent in performing, medical acts within the EMS provider's scope of practice authorized by the medical director. These duties and operations may be delegated to other physicians or other qualified health care professionals designated by the medical director. However, the medical director shall retain ultimate authority and responsibility for the monitoring and supervision, for establishing protocols and standing orders, and for the competency of the performance of authorized medical acts.

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

5.1.8 Be familiar with the training, knowledge, and competence of EMS providers under his or her supervision and ensure that EMS providers are appropriately trained and demonstrate ongoing competency in all medical acts authorized in accordance with Section 15.1 and, as applicable, Appendices A-G.

5.1.9 Be aware that certain medical acts authorized in accordance with Section 15.1 and, as applicable, Appendices A-G (and as identified by the Department) may not be included in the National EMS Education Standards and ensure that appropriate additional training is provided to supervised EMS providers.

5.1.10 Ensure that any data and/or documentation required by the rules are submitted to the Department.

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

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

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

5.1.14 Physicians acting as medical directors responsible for the supervision and authorization of a P-CC shall have training and experience in the medical acts for which they are providing supervision and authorization. Additional duties related to medical directors responsible for the supervision and authorization of a P-CC are set forth in Section 17 of these rules.

5.2 EMS agency medical directors shall be trained in Advanced Cardiac Life Support.

SECTION 6 – Medical Acts Allowed for the EMT

6.1 An EMT may, under the authorization of an EMS agency medical director or clinical medical director, perform medical acts consistent with and not to exceed those listed in Appendices A and C of these rules for an EMT.

6.2 An EMT may, under the authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications consistent with and not to exceed those listed in Appendices B and D of these rules for an EMT.

6.3 Any EMT who is a member or employee of an EMS service agency and who performs medical acts in a prehospital setting must have authorization and be supervised by an EMS agency medical director to perform the medical acts.

6.4 Any EMT who performs medical acts in a clinical setting must have the authorization of a clinical medical director and be supervised by a medical supervisor.

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

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

6.7 An EMT-IV may, under the authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications which exceed those listed in Appendices B and D of these rules for an EMT-IV under the direct visual supervision of an AEMT, EMT-I, or Paramedic when in the prehospital setting, or the medical supervisor in a clinical setting, when the following conditions have been established:

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

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

6.7.3 The EMS agency medical director or clinical medical director shall amend the appropriate protocols and medical CQI program used to supervise the EMS providers to reflect this change in patient care. The applicable medical director and the protocols of the EMT-IV and the AEMT, EMT-I, or Paramedic shall all be in agreement.

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

SECTION 7 – Medical Acts Allowed for the Advanced EMT

7.1 An AEMT may, under the authorization of an EMS agency medical director or clinical medical director, perform medical acts consistent with and not to exceed those listed in Appendices A and C of these rules for an AEMT.

7.2 An AEMT may, under authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications consistent with and not to exceed those listed in Appendices B and D of these rules for an AEMT.

7.3 Any AEMT who is a member or employee of an EMS service agency and who performs medical acts in a prehospital setting must have authorization and be supervised by an EMS agency medical director to perform medical acts.

7.4 Any AEMT who performs medical acts in a clinical setting must have the authorization of a clinical medical director and be supervised by a medical supervisor.

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

7.6 An AEMT may, under the authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications which exceed those listed in Appendices B and D of these rules for an AEMT under the direct visual supervision of an EMT-I or Paramedic when in the prehospital setting, or a medical supervisor in a clinical setting, and the following conditions have been established:

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

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

7.6.3 The EMS agency medical director or clinical medical director shall amend the appropriate protocols and medical CQI program used to supervise the EMS providers to reflect this change in patient care. The applicable medical director and the protocols of the AEMT and the EMT-I or Paramedic shall all be in agreement.

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

SECTION 8 – Medical Acts Allowed for the EMT-Intermediate

8.1 In addition to the acts an EMT, an EMT-IV, and an AEMT are allowed to perform pursuant to these rules, an EMT-I may, under the authorization of an EMS agency medical director or clinical medical director, perform medical acts consistent with and not to exceed those listed in Appendices A and C of these rules for an EMT-I.

8.2 In addition to the medications and classes of medications an EMT, an EMT-IV, and an AEMT are allowed to administer and monitor pursuant to these rules, an EMT-I may, under the authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications defined in Appendices B and D of these rules for an EMT-I.

8.3 Any EMT-I who is a member or employee of an EMS service agency and who performs medical acts in a prehospital setting must have the authorization of and be supervised by an EMS agency medical director.

8.4 Any EMT-I who performs medical acts in a clinical setting must have the authorization of a clinical medical director and be supervised by a medical supervisor.

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

8.6 An EMT-I may, under the authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications which exceed those listed in Appendices B and D of these rules for an EMT-I under the direct visual supervision of a Paramedic in a prehospital setting, or a medical supervisor in a clinical setting, when the following conditions have been established:

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

8.6.2 The EMS agency medical director or clinical medical director shall amend the appropriate protocols and medical CQI program used to supervise the EMS providers to reflect this change in patient care. The applicable medical director and protocols of the EMT-I and Paramedic shall all be in agreement.

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

SECTION 9 – Medical Acts Allowed for the Paramedic

9.1 In addition to the acts all other EMS providers are allowed to perform pursuant to these rules, a Paramedic may, under the authorization of an EMS agency medical director or under the authorization of a clinical medical director and supervision of a medical supervisor, perform advanced medical acts consistent with and not to exceed those listed in Appendices A and C of these rules for a Paramedic.

9.2 In addition to the medications and classes of medications all other EMS providers are allowed to administer and monitor pursuant to these rules, a Paramedic may, under the authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications defined in Appendices B and D for a Paramedic.

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

9.4 Any Paramedic who is a member or employee of an EMS service agency and who performs medical acts in a prehospital setting must have the authorization of and be supervised by an EMS agency medical director to perform medical acts.

9.5 Any Paramedic who performs medical acts in a clinical setting must have the authorization of a clinical medical director and be supervised by a medical supervisor to perform medical acts.

9.6 In addition to the acts of a Paramedic, a P-CC may, under the supervision and authorization of an EMS agency medical director or under the authorization of a clinical medical director and supervision of a medical supervisor perform advanced medical acts consistent with and not to exceed those authorized in Appendix E of these rules for Critical Care.

9.7 In addition to the medications a Paramedic is allowed to administer and monitor, a P-CC may, under the authorization of an EMS or clinical medical director, administer and monitor medications defined in Appendix F of these rules for Critical Care.

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

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

9.10 Any P-CP who is a member or employee of an CIHCS Agency and who performs medical acts in an out-of-hospital setting must have authorization and be supervised by a CIHCS Agency medical director to perform medical acts.

9.11 Any P-CP who performs medical acts in a clinical setting must have the authorization of a clinical medical director and be supervised by a medical supervisor to perform medical acts.

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

SECTION 10 – Graduate Advanced EMTs and Graduate Paramedics

Medical directors may supervise Graduate AEMTs and Paramedics acting as AEMTs or Paramedics for a period of no more than six months following successful completion of an appropriate Department-recognized initial course. Upon expiration of this six month period, such Graduate AEMTs and Graduate Paramedics must successfully complete certification or licensing requirements, as specified in Rules Pertaining to EMS and EMR Education, EMS Certification or Licensure, and EMR Registration 6 CCR 1015-3, Chapter One, to continue to function under the provisions of these rules.

SECTION 11 – General Acts Allowed

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

11.2 EMS providers who are providing medical care in a clinical setting must function under the authority of a clinical medical director and under the medical supervision of a medical supervisor.

11.3 An EMS agency medical director, CIHCS agency medical director, or clinical medical director may limit the scope of practice of any EMS provider over whom they provide medical direction.

11.4 In a prehospital setting, the gathering of laboratory and/or other diagnostic data for the sole purpose of providing information to another health care provider does not require a waiver provided:

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

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

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

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

11.5 EMS providers who are providing out-of-hospital medical services, as specifically defined in Section 2.36 of these rules, for a CIHCS agency or in a clinical setting must obtain a Community Paramedic endorsement.

11.5.1 An endorsed Community Paramedic may provide out-of-hospital medical services as defined in these rules while employed by or contracting with a CIHCS agency.

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

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

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

11.5.3 An endorsed Community Paramedic may provide out-of-hospital medical services in the clinical setting pursuant to the provisions set forth in Section 9 of these rules.

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

SECTION 12 – Waivers to Scope of Practice for EMS Providers in Prehospital Settings

12.1 Any EMS agency medical director may apply to the Department for a waiver to the scope of practice set forth in these rules for EMS providers under his or her supervision in specific circumstances, based on established need, provided that on-going quality assurance of each EMS provider's competency is maintained by the medical director. Waivers to scope of practice are limited to prehospital settings.

12.2 A waiver is not necessary for the allowed medical acts listed in Appendices A, B, C, or D of this rule.

12.2.1 In addition to the medical acts allowed in Section12.2, a P-CC does not require a waiver for the allowed medical acts listed in Appendices E and F.

12.2.2 In addition to the medical acts allowed in Section 12.2, a P-CP does not require a waiver for the allowed out-of-hospital medical services listed in Appendix G when providing medical services in a CIHCS agency setting.

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

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

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

12.4 EMS agency medical directors seeking a waiver shall submit a completed application to the Department in a form and manner determined by the Department.

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

12.4.2 The Department may require the applicant to provide additional information if the initial application is determined to be insufficient.

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

12.4.4 The completed waiver application shall be submitted to the Department in a timely fashion as specified by the Department.

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

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

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

12.6.1 If the waiver is granted, the Department may:

A) Specify the terms and conditions of the waiver.

B) Specify the duration of the waiver.

C) Specify any reporting requirements.

12.6.2 The Department may require the submission of data or other information regarding waivers.

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

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

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

12.6.3 The Department may deny, revoke, or suspend a waiver if it determines:

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

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

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

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

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

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

12.9 If the rule pertaining to a waived medical act is amended or repealed obviating the need for the waiver, the waiver shall expire on the effective date of the rule change.

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

12.11 In the case of exigent circumstances, including but not limited to the death or incapacitation of an EMS agency medical director or the termination of the relationship between a EMS agency medical director and an EMS service agency, the Department may transfer waivers upon request by a replacement EMS agency medical director for a period not to exceed six (6) months. The EMS agency medical director shall then apply for new waiver(s) for consideration and Department action within sixty (60) days of the transfer.

SECTION 13 – Technology and Pharmacology Dependent Patients in Prehospital Settings

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

SECTION 14 – Combination Benzodiazepine and Opiate Therapy

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

14.1.1 Independently maintain an open airway and normal breathing pattern,

14.1.2 Maintain normal hemodynamics, and

14.1.3 Respond appropriately to physical stimulation and verbal commands.

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

SECTION 15 – Scope of Practice

15.1 All of the following appendices define the maximum medical acts an EMT, EMT-IV, AEMT, EMT-I, and Paramedic may be authorized to perform under appropriate medical direction by the applicable medical director for each setting.

15.2 A medical director may establish the methods by which an EMS provider obtains authorization in the prehospital or clinical setting to perform any medical acts contained in these rules including, but not limited to: advanced standing orders that are written or electronically conveyed, contemporaneous orders that are direct verbal orders, or written orders that are conveyed in real-time.

15.3 As used in all of the Appendices, the following terms are defined to mean:

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

15.3.2 "VO" = Verbal Order: Indicates a category of medical acts or medications that EMS providers may only perform or administer within their scopes of practice after receiving authorization from a physician. Such authorization shall be communicated by direct verbal or written order received from a physician contemporaneous to when patient is receiving treatment, unless specific exception criteria are established by the applicable medical director.

A) In a clinical setting, a medical supervisor may instruct EMS providers to perform a medical act or administer a medication that requires a physician's authorization only if the physician has contemporaneously communicated the direct verbal or written order to the medical supervisor.

B) Exception criteria may include, but are not limited to cardiac arrest, behavioral management, or communications failure.

C) Medical Directors shall not develop exception criteria that merely waive all direct verbal order requirements.

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

15.3.4 "EMT" = Medical acts that may be performed or administered by an EMT with appropriate medical director authorization and training recognized by the Department.

15.3.5 "EMT-IV" = Medical acts that may be performed or administered by an EMT-IV with appropriate medical director authorization and training recognized by the Department.

15.3.6 "AEMT" = Medical acts that may be performed or administered by an AEMT with appropriate medical director authorization and training recognized by the Department.

15.3.7 "EMT-I" = Medical acts that may be performed or administered by an EMT-I with appropriate medical director authorization and training recognized by the Department.

15.3.8 "P" = Medical acts that may be performed or administered by a Paramedic with appropriate medical director authorization and training recognized by the Department.

Note: Section 16 – INTERFACILITY TRANSPORT begins following APPENDIX B.

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

Note: Section 18 – COMMUNITY PARAMEDIC begins following APPENDIX F.

Note: Section 19 – CLINICAL SETTING begins following APPENDIX G.

APPENDIX A

MEDICAL ACTS ALLOWED

A.1.1 In the prehospital setting, additions to these medical acts are not allowed unless a waiver has been granted as described in Section 12 of these rules. A waiver may not be granted for medical acts in the out-of-hospital or clinical settings.

A.1.2 Not all medical acts allowed are included in initial education for various EMS provider levels. All medical directors subject to these rules shall ensure providers are appropriately trained as noted in Sections 5.1.8 and 5.1.9, Sections 18 (CIHCS) and 19 (Clinical Settings).

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

TABLE A.1 – AIRWAY/VENTILATION/OXYGEN

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Airway – Supraglottic	Y	Y	Y	Y	Y
Airway – Nasal	Y	Y	Y	Y	Y
Airway – Oral	Y	Y	Y	Y	Y
Bag – Valve – Mask (BVM)	Y	Y	Y	Y	Y
Carbon Monoxide Monitoring	Y	Y	Y	Y	Y
Chest Decompression – Needle	N	N	N	Y	Y
Chest Tube Insertion	N	N	N	N	N
CPAP	Y	Y	Y	Y	Y
PEEP	Y	Y	Y	Y	Y
Cricoid Pressure – Sellick's Maneuver	Y	Y	Y	Y	Y
Cricothyroidotomy – Needle	N	N	N	N	Y
Cricothyroidotomy – Surgical	N	N	N	N	Y
End Tidal CO2 Monitoring/Capnometry/ Capnography	Y	Y	Y	Y	Y
Flow Restrictive Oxygen Powered Ventilatory Device	Y	Y	Y	Y	Y
Gastric Decompression – NG/OG Tube Insertion	N	N	N	N	Y
Inspiratory Impedence Threshold Device	Y	Y	Y	Y	Y
Intubation – Digital	N	N	N	N	Y
Intubation – Bougie Style Introducer	N	N	N	Y	Y
Intubation – Lighted Stylet	N	N	N	Y	Y
Intubation – Medication Assisted (non-paralytic)	N	N	N	N	N
Intubation – Medication Assisted (paralytics) (RSI)	N	N	N	N	N
Intubation – Maintenance with paralytics	N	N	N	N	N
Intubation – Nasotracheal	N	N	N	N	Y
Intubation – Orotracheal	N	N	N	Y	Y
Intubation – Retrograde	N	N	N	N	N
Extubation	N	N	N	Y	Y
Obstruction – Direct Laryngoscopy	N	N	N	Y	Y
Oxygen Therapy – Humidifiers	Y	Y	Y	Y	Y
Oxygen Therapy – Nasal Cannula	Y	Y	Y	Y	Y
Oxygen Therapy – Non-rebreather Mask	Y	Y	Y	Y	Y
Oxygen Therapy – Simple Face Mask	Y	Y	Y	Y	Y
Oxygen Therapy – Venturi Mask	Y	Y	Y	Y	Y
Peak Expiratory Flow Testing	N	N	N	Y	Y
Pulse Oximetry	Y	Y	Y	Y	Y
Suctioning – Tracheobronchial	N	N	Y	Y	Y
Suctioning – Upper Airway	Y	Y	Y	Y	Y

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Tracheostomy Maintenance – Airway management only	Y	Y	Y	Y	Y
Tracheostomy Maintenance – Includes replacement	N	N	N	N	Y
Ventilators – Automated Transport (ATV)[1]	N	N	N	N	Y

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

TABLE A.2 – CARDIOVASCULAR/CIRCULATORY SUPPORT

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

[2] Targeted Temperature Management (TTM)

1. Approved methods of cooling include:

   a. Surface cooling methods including ice packs, evaporative cooling, and surface cooling blankets or surface heat-exchange devices.

   b. Internal cooling with the intravenous administration of cold crystalloids (4°C / 39°F)

2. Esophageal temperature probe allowed for monitoring core temperatures in patients undergoing TTM.

3. The medical director should work with the hospital systems to which their agencies transport in setting up a "systems" approach to the institution of TTM. Medical directors should not institute TTM without having receiving facilities that also have TTM programs to which to transport these patients.

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

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

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

TABLE A.5 – MEDICATION ADMINISTRATION ROUTES

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Aerosolized	Y	Y	Y	Y	Y
Atomized	Y	Y	Y	Y	Y
Auto-Injector	Y	Y	Y	Y	Y
Buccal	Y	Y	Y	Y	Y
Endotracheal Tube (ET)	N	N	N	Y	Y
Extra-abdominal umbilical vein	N	N	N	Y	Y
Intradermal	N	N	N	Y	Y
Intramuscular (IM)	Y	Y	Y	Y	Y
Intranasal (IN)	Y	Y	Y	Y	Y
Intraosseous	N	Y	Y	Y	Y
Intravenous (IV) Piggyback	N	N	N	Y	Y
Intravenous (IV) Push	N	Y	Y	Y	Y
Nasogastric	N	N	N	N	Y
Nebulized	Y	Y	Y	Y	Y
Ophthalmic	N	N	N	Y	Y
Oral	Y	Y	Y	Y	Y
Rectal	N	N	N[3]	Y	Y
Subcutaneous	N	N	Y	Y	Y
Sublingual	Y	Y	Y	Y	Y
Sublingual (nitroglycerin)	Y	Y	Y	Y	Y
Topical	Y	Y	Y	Y	Y
Use of Mechanical Infusion Pumps	N	N	N	Y	Y

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

TABLE A.6 – MISCELLANEOUS

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Aortic Balloon Pump Monitoring	N	N	N	N	N
Assisted Delivery	Y	Y	Y	Y	Y
Capillary Blood Sampling	Y	Y	Y	Y	Y
Diagnostic Interpretation – Blood Glucose[4]	Y	Y	Y	Y	Y
Diagnostic Interpretation – Blood Lactate[4]	N	N	Y	Y	Y
Dressing/Bandaging	Y	Y	Y	Y	Y
Esophageal Temperature Probe for TTM	N	N	N	VO	Y
Eye Irrigation Noninvasive	Y	Y	Y	Y	Y
Eye Irrigation Morgan Lens	N	N	N	Y	Y
Maintenance of Intracranial Monitoring Lines	N	N	N	N	N
Physical examination	Y	Y	Y	Y	Y
Public Health Related-Oral/Nasal Swab Sample Collection	Y	Y	Y	Y	Y
Restraints – Verbal	Y	Y	Y	Y	Y
Restraints – Physical	Y	Y	Y	Y	Y
Restraints – Chemical	N	N	N	Y	Y
Urinary Catheterization – Initiation	N	N	N	N	Y
Urinary Catheterization – Maintenance	Y	Y	Y	Y	Y
Venous Blood Sampling – Obtaining	N	Y	Y	Y	Y

[4] See also Section 11.4

APPENDIX B

FORMULARY OF MEDICATIONS ALLOWED

B.1.1 In prehospital settings, additions to this medication formulary are not allowed unless a waiver has been granted as described in Section 12 of these rules.

B.1.2 Not all medical acts allowed are included in initial education for various EMS provider levels. All medical directors subject to these rules shall ensure providers are appropriately trained as noted in Sections 5.1.8 and 5.1.9 (Prehospital), 18.3.6 (CIHCS), 19.3.7, 19.3.8, and 19.3.9 (Clinical Setting).

TABLE B.1 – GENERAL

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

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

TABLE B.2 – ANTIDOTES

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Atropine	N	N	N	VO	Y
Calcium salt – Calcium chloride	N	N	N	N	Y
Calcium salt – Calcium gluconate	N	N	N	N	Y
Cyanide antidote	N	N	N	Y	Y
Glucagon	N	N	VO	VO	Y
Naloxone	Y	Y	Y	Y	Y
Nerve agent antidote	Y	Y	Y	Y	Y
Pralidoxime	N	N	N	N	Y
Sodium bicarbonate	N	N	N	N	Y

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	Y	Y
Benzodiazepine – Lorazepam	N	N	N	Y	Y
Benzodiazepine – Midazolam	N	N	N	Y	Y
Diphenhydramine	N	N	N	VO	Y
Ketamine (Ketalar)	N	N	N	N	N

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
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

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

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	N	N	N	Y	Y

TABLE B.7 – GASTROINTESTINAL MEDICATIONS

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Anti-nausea – Droperidol	N	N	N	VO	Y
Anti-nausea – Metoclopramide	N	N	N	VO	Y
Anti-nausea – Ondansetron ODT	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

TABLE B.8 – PAIN MANAGEMENT

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Acetaminophen (Tylenol) IV	N	N	Y	Y	Y
Anesthetic – Lidocaine (for intraosseous needle insertion)	N	N	Y	Y	Y
Benzodiazepine – Diazepam	N	N	N	Y	Y
Benzodiazepine – Lorazepam	N	N	N	Y	Y
Benzodiazepine – Midazolam	N	N	N	Y	Y
General – Nitrous oxide	N	N	Y	Y	Y
Ketorolac (Toradol)	N	N	N	N	Y
Narcotic Analgesic – Fentanyl	N	N	VO	Y	Y
Narcotic Analgesic – Hydromorphone	N	N	N	N	Y
Narcotic Analgesic – Morphine sulfate	N	N	VO	Y	Y
Ophthalmic anesthetic-Ophthaine	N	N	N	Y	Y
Ophthalmic anesthetic-Tetracaine	N	N	N	Y	Y
Topical Anesthetic – Benzocaine spray	N	N	N	N	Y
Topical Anesthetic – Lidocaine jelly	N	N	N	N	Y

TABLE B.9 – RESPIRATORY AND ALLERGIC REACTION MEDICATIONS

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Antihistamine – Diphenhydramine	N	N	Y	Y	Y
Bronchodilator – Anticholinergic – Atropine (aerosol/nebulized)	N	N	N	VO	Y
Bronchodilator – Anticholinergic – Ipratropium	Y	Y	Y	Y	Y
Bronchodilator – Beta agonist – Albuterol	Y	Y	Y	Y	Y
Bronchodilator – Beta agonist – L-Albuterol	Y	Y	Y	Y	Y
Bronchodilator – Beta agonist – Metaproterenol	N	N	N	VO	Y
Bronchodilator – Beta agonist – Terbutaline	N	N	N	N	Y
Corticosteroid – Dexamethasone	N	N	N	Y	Y
Corticosteroid – Hydrocortisone	N	N	N	Y	Y
Corticosteroid – Methylprednisolone	N	N	N	Y	Y
Corticosteroid – Prednisone	N	N	N	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

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Racemic Epinephrine	N	N	N	Y	Y
Short Acting Bronchodilator meter dose inhalers (MDI) (Patient assisted)	VO	VO	VO	Y	Y
Short Acting Bronchodilator meter dose inhalers (MDI)	Y	Y	Y	Y	Y

TABLE B.10 – SEIZURE MANAGEMENT

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Benzodiazepine – Diazepam	N	N	N	Y	Y
Benzodiazepine – Diazepam – rectal administration	N	N	Y	Y	Y
Benzodiazepine – Lorazepam	N	N	N	Y	Y
Benzodiazepine – Midazolam	N	N	N	Y	Y
Benzodiazepine – Midazolam – intranasal administration	N	N	Y	Y	Y
OB – associated – Magnesium sulfate – bolus infusion only	N	N	N	Y	Y

TABLE B.11 – VACCINES

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

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
Topical hemostatic agents	Y	Y	Y	Y	Y

SECTION 16 – Interfacility Transport

16.1 The EMS agency medical director shall have protocols in place to ensure the appropriate level of care is available during interfacility transport.

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

16.3 The interfacility transport typically involves three types of patients:

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

16.3.2 Those patients whose safe transport can be accomplished by ambulance, under the care of a Paramedic, but may require medical acts that are outside the medical acts allowed under these rules, but which acts have been approved through waiver granted by the Department.

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

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

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

16.5.1 Additions to these medical acts are not allowed unless a waiver has been granted as described in Section 12 of these rules.

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

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

16.6 Any of the medical acts and medications allowed in interfacility transport in Appendices C and D may be performed in the clinical setting under the medical direction of a clinical medical director and under medical supervision.

APPENDIX C

INTERFACILITY TRANSPORT

MEDICAL ACTS ALLOWED

TABLE C.1 – AIRWAY/VENTILATION/OXYGEN

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

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

TABLE C.2 – CARDIOVASCULAR/CIRCULATORY SUPPORT

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

APPENDIX D

FORMULARY OF MEDICATIONS ALLOWED – INTERFACILITY TRANSPORT

TABLE D.1 – CARDIOVASCULAR

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Anti-arrhythmic – Amiodarone – continuous infusion	N	N	N	Y	Y
Anti-arrhythmic – Lidocaine – continuous infusion	N	N	N	Y	Y
Anticoagulant – Glycoprotein inhibitors	N	N	N	N	Y
Anticoagulant – Heparin (unfractionated)	N	N	N	N	Y
Anticoagulant – Low Molecular Weight Heparin (LMWH)	N	N	N	N	Y
Diltiazem	N	N	N	N	Y
Dobutamine	N	N	N	N	N
Dopamine – Monitoring and Maintenance	N	N	N	N	Y
Epinephrine – infusion	N	N	N	N	Y
Nicardipine	N	N	N	N	Y
Nitroglycerin, intravenous	N	N	N	N	Y
Norepinephrine	N	N	N	N	Y
Thrombolytics – Monitoring and Maintenance	N	N	N	N	Y

TABLE D.2 – HIGH RISK OBSTETRICAL PATIENTS

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

TABLE D.3 – INTRAVENOUS SOLUTIONS

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

TABLE D.4 – MISCELLANEOUS

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

SECTION 17 – Critical Care

17.1 In addition to the medical acts within the scope of practice of a Paramedic contained within Appendices A, B, C, and D, a P-CC may perform the medical acts contained within this section, Appendices E and F, under the authorization of an EMS agency medical director or clinical medical director.

17.1.1 Additions to these medical acts in a prehospital setting are not allowed unless a waiver has been granted as described in Section 12 of these rules.

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

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

17.3 In addition to the duties of an EMS agency medical director or clinical medical director outlined in Sections 5 and 19 of these rules, the duties of such a medical director responsible for authorization of a P-CC shall include:

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

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

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

Appendix E – MEDICAL ACTS ALLOWED

TABLE E.1

Skill	**P-CC**
Manual Transport Ventilators	Y
Blood Chemistry Interpretation	Y
Rapid Sequence Intubation – Adult (age 13 & over)	Y
Transvenous Pacing – Monitoring and Maintenance	Y

Appendix F – FORMULARY OF MEDICATIONS ALLOWED

TABLE F.1 – CRITICAL CARE FORMULARY

Medications	**P-CC**
Acetylcysteine (Mucomyst)	Y
Antibiotics	Y
Bilvalirudin (Angiomax)	Y
Blood Products	Y
Dobutamine (Dobutamine)	Y
Esmolol (Brevibloc)	Y
Etomidate (Amidate)	Y
Fosphenytoin (Cerebyx)	Y
Ketamine (Ketalar)	Y (may only be used for analgesia, rapid sequence induction (RSI), and post-intubation management)
Labetalol (Normodyne)	Y
Levetiracetam (Keppra)	Y
Metoprolol (Lopressor)	Y
Phenytoin (Dilantin)	Y
Propofol (Diprivan)	Y
Rocuronium (Zemuron)	Y
Succinylcholine (Anectine)	Y
tPA infusion	Y
Tranexamic acid (TXA)	Y
Vecuronium (Norcuron)	Y

SECTION 18 – Community Paramedic

18.1 In addition to the medical acts within the scope of practice of a Paramedic contained within Appendices A, B, C, and D, a P-CP may perform the out-of-hospital medical services contained within this section and Appendix G, under the authorization of a CIHCS Agency medical director while providing community integrated health care services. A P-CP may also provide those medical acts that are out-of-hospital medical services contained in this Section, Appendix G, and Section 19 under the authorization of a clinical medical director and under the medical supervision of a medical supervisor.

18.1.1 A waiver cannot be granted to expand the out-of-hospital medical services that a P-CP may perform in a CIHCS setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18.3.13 Physicians acting as medical directors for a Community Integrated Health Care Service agency pursuant to Section 25-3.5-1303(1)(a), C.R.S. that are responsible for the supervision and authorization of a P-CP shall have training and experience in the acts and skills for which they are providing supervision and authorization.

18.4 A clinical medical director's responsibilities for authorizing a P-CP in a clinical setting shall include those located in Section 19.3 of these rules.

Appendix G – OUT-OF-HOSPITAL MEDICAL SERVICES ALLOWED

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

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

G.3 Provide allowable services as an employee or contractor of a Community Assistance Referral and Education Services (CARES) Program, as set forth in Section 25-3.5-1203(3), C.R.S.

G.4 Medical interventions, as set forth in a patient service plan:

Table G.1

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

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

G.6 Gather laboratory and diagnostic data for POCT

Table G.2

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

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

SECTION 19 - Clinical Setting

19.1 Any licensed or certified EMT, AEMT, EMT-I, or Paramedic may perform the medical acts within their applicable scope, as set forth in Appendices A, B, C, D, E, F, and G in a clinical setting pursuant to orders or instructions from, and under the medical supervision of, a medical supervisor.

19.1.2 An EMT-IV may perform the medical acts within the EMT-IV scope of practice in a clinical setting if authorized by a clinical medical director consistent with Section 6.6 and pursuant to orders or instructions from, and under the medical supervision of, a medical supervisor.

19.1.3 A Paramedic with a Critical Care endorsement may perform the medical acts within the P-CC scope, as set forth in Appendices E and F, in a clinical setting pursuant to orders or instructions from, and under the medical supervision of, a medical supervisor.

19.1.4 A Paramedic with a Community Paramedic endorsement may perform the medical acts within the P-CP scope, as set forth in Appendix G, in a clinical setting pursuant to orders or instructions from, and under the medical supervision of, a medical supervisor.

19.1.5 Nothing in these rules alters the authority of a physician or registered nurse to delegate acts to an EMS provider that are outside of the EMS provider's applicable scope of practice in the clinical setting, pursuant to Sections 12-240-107 and 12-255-131, C.R.S.. Such delegation shall be in conformance with the applicable rules of the Colorado Medical Board and the Colorado Nursing Board.

19.2 A licensed or certified health care facility that employs EMS providers to perform in-scope tasks and procedures in a clinical setting shall:

19.2.1 Collaborate with its clinical medical director, medical supervisors, and EMS providers to establish policies and procedures ensuring that EMS providers are limited to performing medical acts within their scopes of practice.

19.2.2 Require its clinical medical director to:

(i) Determine and document each EMS provider's scope of practice in the clinical setting; and

(ii) Communicate the authorized medical acts that each individual EMS provider may perform under medical supervision to the facility's medical supervisors.

19.3 Clinical medical directors are responsible for the medical direction of EMS providers in the clinical setting. Their duties shall include:

19.3.1 Being aware of and familiar with the medical acts that all EMS provider types may be authorized to perform in a clinical setting pursuant to the scope of practice put forth in these rules in Appendices A, B, C, D, E, F, and G, as applicable.

19.3.2 Collaborating with the medical supervisor(s) and EMS providers to establish policies and procedures ensuring that EMS providers only perform medical acts that are within the applicable EMS provider's scope of practice.

19.3.3 Ensuring that each EMS provider working in the clinical setting is limited to performing medical acts that are within the applicable scope of practice and are performed competently under medical supervision. This shall include, but not be limited to, determining those medical acts that each EMS provider may perform under medical supervision and communicating to the medical supervisor(s) the authorized medical acts that each individual EMS provider may perform.

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

19.3.5 Being actively and routinely involved with the EMS providers providing care in the clinical setting. Involvement does not require that a physician have such experience prior to becoming a clinical medical director, but it does require such involvement during the time that the physician acts as a medical director. Involvement could include, by way of example and not limitation, involvement in continuing education, audits, and protocol development. Passive or negligible involvement with the EMS providers does not meet this requirement.

19.3.6 Being actively involved in the facility's medical continuous quality improvement (CQI) program for EMS providers. The medical CQI program shall assure the continuing competency of the performance of the EMS providers. This medical CQI program shall include, but not be limited to: appropriate protocols and standing orders applicable to the EMS providers' scopes of practice, provision for medical care audits, observation, critiques, continuing medical education, and supervisory communications.

19.3.7 Providing oversight, direction, and medical management of the medical performance of EMS providers in the clinical setting. This includes ensuring that EMS providers have adequate clinical knowledge of and are competent in performing medical acts within the EMS provider's scope of practice authorized by the clinical medical director. These duties and operations may be delegated to other physicians or other qualified health care professionals designated by the clinical medical director. However, the clinical medical director shall retain ultimate authority and responsibility for the oversight, direction, and medical management of the medical performance of EMS providers in the clinical setting, for establishing protocols and standing orders, and for the competency of the performance of authorized medical acts.

19.3.8 Being familiar with the training, knowledge, and competence of EMS providers subject to their oversight and ensuring that EMS providers are appropriately trained and demonstrate ongoing competency in all medical acts authorized to be performed under medical supervision.

19.3.9 Being aware that certain skills, procedures, and medications contained within Appendices A, B, C, D, E, F, and G may not be included in the National EMS Education Standards and ensuring that appropriate additional training is provided to EMS providers, if necessary, for the performance of an authorized skill or act.

19.3.10 Physicians acting as clinical medical directors responsible for the oversight and authorization of a P-CC shall have training and experience in the acts and skills for which they are providing oversight and authorization. Additional duties related to clinical medical directors responsible for the oversight and authorization of a P-CC are set forth in Section 17 of these rules.

19.3.11 Physicians acting as clinical medical directors responsible for the oversight and authorization of a P-CP shall have training and experience in the acts and skills for which they are providing oversight and authorization. Additional duties related to clinical medical directors responsible for the oversight and authorization of a P-CP are set forth in Section 18 of these rules.

19.4 Medical supervision of the EMS provider in a clinical setting must be provided by a medical supervisor who is:

19.4.1 A Colorado licensed physician, physician assistant, advanced practice nurse, or registered nurse licensed in good standing,

19.4.2 Trained and experienced in the acts and skills for which supervision is being provided,

19.4.3 Knowledgeable about the maximum skills, acts, or medications that an EMT, EMT-IV, AEMT, EMT-I, Paramedic, P-CC, and P-CP are authorized to perform pursuant to these rules, and

19.4.4 Immediately available and physically present at the clinical setting where the care is being delivered to provide oversight, guidance, or instruction to the EMS provider during the performance of medical acts.