At-a-glance: Major themes

Terminology tightened and standardized (e.g., new "Contemporaneous Order," expanded use of protocols & guidelines, unified QA program language).

Scope of practice is now explicitly tied to setting (prehospital, interfacility, clinical, CIHCS), with Community Paramedicine Endorsements defined across all provider levels (EMT-CPE, AEMT-CPE, EMT-I-CPE, P-CPE).

Appendices reworked and expanded to clarify standard acts/medications (A/B), interfacility acts/meds (C/D), critical care paramedic acts/meds (E/F), and community paramedicine out-of-hospital services/screenings (G).

Medical director's duties strengthened (active involvement, training/experience requirements, QA affidavit cadence, and notification timelines).

Structural & organizational clean-up

Consistent "PARTSECTION" and renumbering; the Index reflects re-ordered Parts 1–19 and the move of detailed scope into Appendices.

Appendices A–G now carry most scope details, with notes pointing to where Interfacility (Part 16/Appendices C/D), Critical Care (Part 17/Appendices E/F), Community Paramedicine (Part 18/Appendix G), and Clinical settings (Part 19) begin.

Key terminology & definitions changes

Contemporaneous Order added and used broadly—real-time written, digital, or verbal authorization while the patient is being treated (replaces/absorbs "Direct Verbal Order" in many places).

Scope of practice = acts + the settings where those acts occur (prehospital, interfacility, clinical, CIHCS).

CIHCS definition aligned (also referencing Mobile Integrated Health Care) and EMS Providers with a Community Paramedicine Endorsement (EMS-CPE) are defined across levels (EMT-CPE, AEMT-CPE, EMT-I-CPE, P-CPE).

Medical Protocol term standardized; Written Order removed as duplicative under "Contemporaneous Order."

QA Program explicitly defined and mapped to statutory Quality Management/Continuous Quality Improvement programs for confidentiality/privilege alignment.

Medical director rules (applies across settings)

Must be a Colorado-licensed physician in good standing; duties now explicitly include active involvement, protocol/guideline development, and competency oversight.

QA affidavit: submit on initial registration and annually thereafter; Department may review records for compliance.

Notification: Department must be notified of any change or cessation of medical direction (e.g., EMS agency or CIHCS) with a 14 business-day timeline.

For P-CC authorization, medical directors must have training/experience in the acts they authorize; corresponding duties spelled out in Part 17.

Provider scope highlights by level

EMT / EMT-IV

EMT acts/meds clarified in Appendices A/B; EMT-IV pathways consolidated (e.g., IV/IO allowances, "in extremis" conditions under direct visual supervision).

Mental health holds: EMTs (and higher) may carry out physician orders via contemporaneous verbal/electronic communications.

Disaster/public health emergency: Chief Medical Officer may temporarily authorize additional acts (e.g., vaccines/tests/countermeasures).

EMT-CPE: explicit limits—no 911 care, no transport, acts confined to out-of-hospital under CIHCS authorization and supervision; meds per Appendix G.

AEMT / EMT-I

Airway/ventilation updates: High-flow nasal cannula (HFNC) allowed AEMT+; CPAP remains allowed across levels; BIPAP constrained (see Interfacility notes).

Medication formulary consolidations (e.g., antihistamines, benzodiazepine intranasal routes, opioids grouping) adjust permissions/VO requirements.

AEMT-CPE / EMT-I-CPE: same CIHCS limits and Appendix G services/meds as EMT-CPE, scoped to endorsement and authorization.

Paramedic

Paramedic scope clarified; P-CC and P-CPE tracks detailed: advanced/critical care acts (Appendices E/F) vs. CIHCS out-of-hospital services (Appendix G).

P-CPE cannot perform out-of-hospital services in 911 or during transport; must be under CIHCS authority or clinical medical director + medical supervisor.

Interfacility transport (Part 16 / Appendices C & D)

Reorganized: clear differentiation that interfacility acts/meds are hospital/facility initiated, with EMS continuation/monitoring; changes require contemporaneous order.

Automated Transport Ventilators (ATV): EMS may only manipulate TV/VT, RR, FiO_2, PEEP unless a waiver is granted.

Airway support: BIPAP/HFNC in interfacility are AEMT+ with specifics; Chest tube monitoring allowed for Paramedic; Central venous pressure interpretation not authorized.

Medication tables (Appendix D) consolidated: continuous infusions (anti-arrhythmic, vasoactive agents, anticoagulants, OB meds) typically Paramedic; crystalloids maintenance for EMT-IV+; blood components Paramedic only.

Critical Care Endorsed Paramedic (P-CC) (Part 17 / Appendices E & F)

Medical director duties specific to P-CC authorization outlined (training/experience, protocols/guidelines, transport level-of-care considerations).

Acts: blood chemistry interpretation, cardiac assist device maintenance, intra-arterial line monitoring, transvenous pacing monitoring/maintenance, chest tube (insertion/maintenance), finger thoracostomy, and medication-assisted airway (with RSI adult delineation reflected).

Meds: expanded critical care formulary (e.g., NMBA/paralytics, ketamine, propofol, etomidate, vasopressors/inotropes, tPA, TXA, direct thrombin inhibitors), with usage constraints noted.

Community Paramedicine (Part 18 / Appendix G)

Out-of-hospital medical services explicitly listed: assessments, care coordination/resource navigation, patient education, telemedicine/tele-behavioral coordination, point-of-care testing (POCT), simple wound care/closure, ostomy/gastric/foley maintenance, and vaccinations under service plan or contemporaneous order.

POCT interpretation: permitted within CIHCS scope for EMS-CPE, based on agency protocols; imaging not performed real-time by EMS-CPE.

Accessing central lines/ports/peritoneal dialysis catheters generally limited to P-CPE; other maintenance acts tiered by endorsement level in Table G.1.

Screening/referrals (e.g., behavioral health, falls/mobility, social drivers of health, ADLs, harm-reduction) enumerated in Table G.2.

Key Scope of Practice Changes for Our System

- **Medications**
  - **IV Tylenol for EMT-IV**
  - **Antibiotic**
  - **Antihistamine is a "no" for levels below AEMT (*does this include over the counter meds like Zyrtec*)**
  - **Blood products**
  - **Buprenorphine**
  - **Epinephrine IN for all levels**
  - **Ketamine for analgesia**
  - **Beta blockers**
  - **TXA but for paramedic only, will need to keep epistaxis waiver for EMTs.**

Waivers (Part 12)

Waivers limited to prehospital settings only; not needed for acts already listed in Appendices A–G.

Application content expanded (education/training/QA, literature review, protocols/guidelines); EMPAC review and Department decision timelines clarified; conditions for deny/revoke/suspend and data confidentiality aligned with statute.

Clinical settings (Part 19)

Facilities employing EMS providers must define scopes, set policies, and ensure medical supervision (physician/PA/APN/RN present and immediately available) for authorized acts.

Clinical medical director duties mirror prehospital requirements (protocols/guidelines, QA, competency oversight) and include training/experience requirements when authorizing P-CC or EMS-CPE.

Clarifies that physicians/RNs may delegate acts outside EMS scope in clinical settings under their respective boards' rules (statutory references noted).

Appendices A & B (standard acts/meds) — notable tweaks

Airway/ventilation: HFNC added (AEMT+), BIPAP set to P only in standard table, needle thoracostomy terminology standardized, and ATV parameter limits reiterated.

Monitoring/interventions: Targeted Temperature Management guidance updated (includes esophageal temperature probe with VO at EMT-I).

Medication formulary: consolidation (e.g., opioids grouped; butyrophenones combine haloperidol/droperidol), route permissions/VO refined (e.g., nitroglycerin SL/paste levels; diazepam rectal allowed for AEMT+).

Vaccination administration clarified (public health, employment/pre-employment, PPD placement/interpretation levels).

Other general provisions updated

Technology/pharmacology-dependent patient transports: EMS may maintain continuous meds/technology; changes require contemporaneous physician order unless patient safety is at risk.

Combination benzodiazepine + opioid therapy: safety safeguards and monitoring requirements spelled out.

Pre-veterinary emergency care to dogs/cats allowed per statute; camp nursing prohibition referenced (dispensing meds).

What does this mean (action checklist)

Update protocols & guidelines across prehospital, interfacility, clinical, and CIHCS to reflect new definitions (especially Contemporaneous Orders) and scope tables.

Re-affirm QA program documentation and submit the affidavit on initial registration and annually, aligning with Department expectations.

Train/refresh on newly permitted acts (e.g., HFNC, ATV parameter limits, TTM monitoring) and revised medication routes/VO requirements.

For CIHCS/Mobile Integrated Health, ensure EMS-CPE endorsement pathways, POCT interpretation policies, and service plans are in place; reinforce no 911/no transport while acting in CIHCS capacity.

For critical care transports, verify P-CC medical director training/experience alignment and ensure Appendices E/F are integrated into your credentialing and competency processes.