POLICY BACKGROUND MEMO:

EMS Innovations

1 INTRODUCTION

Across the state of Colorado, health care leaders are finding innovative ways to meet the needs of their community. As these innovations evolve, it is important that the regulatory framework simultaneously evolves to ensure patient safety and appropriate oversight. One area of exciting innovation is in Emergency Medical Services (EMS). In 2015-16, Center for Health Progress had supported a conversation to achieve a policy framework that will support existing and newly developed EMS innovations programs, while at the same time allowing programmatic flexibility to meet the unique needs of the community they serve.

As Center for Health Progress had met with representatives of existing programs around the state, we had discovered that there was confusion and disagreement on what existing policies allowed EMS to do outside of responding to emergency situations. To provide clarity on what existing policies allow for us as well as to help guide the conversation on needed changes, if any, we outlined some relevant pieces from our research in statutes and regulation for EMS and home health care.

It is important to note that we did not do any federal policy research; therefore, that is not included here.

2 STATE POLICY RESEARCH

In summary, Colorado Department of Public Health and Environment (CDPHE) regulates home care agencies, and home health is defined broadly by the services provided within the patient's home with few exceptions. The licensure has been set up to regulate this type of business. Previously, CDPHE had regulated some EMS innovations entities as home health until roles were better clarified in 2016.

CDPHE also regulates individual EMS providers, but counties regulate EMS agencies. Though CDPHE sets minimum standards for counties' regulation on agencies, CDPHE cannot directly regulate EMS agencies.

2.1 HOME HEALTH POLICY

In discussing health care entities that require a license, Colorado statute, CRS 25-3-101, states that it is "unlawful for any person, partnership, association, or corporation to open, conduct, or maintain any general hospital, hospital unit, psychiatric hospital, community clinic, rehabilitation hospital, convalescent center, community mental health center, acute treatment unit, facility for persons with development disabilities, nursing care facility, hospice care, assisted living residence, dialysis treatment clinic, ambulatory surgical center, birthing center, home care agency, or other facility of a like nature, except those wholly owned and operated by any governmental unit or agency, without first having obtained a license from the department of public health and environment." Simply put, any health care provision within a facility (with exception of provider offices or federally qualified health centers) must be licensed by CDPHE, with the exception of

government-owned and -funded entities. Home care agencies are included in the definition of facility for these purposes.

Outlined in CRS 25-27.5-102, skilled home health services are "health and medical services furnished to a home care consumer in the home care consumer's temporary or permanent home or place of residence that include wound care services; use of medical supplies including drugs and biologicals prescribed by a physician; in-home infusion services; nursing services; home health aide or certified nurse aide services that require the supervision of a licensed or certified care professional acting within the scope of his or her license or certificate; occupational therapy; physical therapy; respiratory care services; dietetics and nutrition counseling services; medication administration; medical social services; and speech-language pathology services." It does not include delivery of durable medical equipment or medical supplies.

Home health care agency regulations are outlined in 6 CCR 1011-1 Chapter 26, for reference as needed.

2.2 EMS POLICY

Colorado statute, CRS 25-3.5-102, authorizes CDPHE to "assist, when requested by local government entities, in planning and implementing any one such subsystems [of at least treatment, transportation, communication, and documentation subsystems] so it [EMS systems] meets local and regional needs and requirements […] so that they interface with an overall state system providing maximally effective [EMS]."

CRS 25-3.5-104 charges SEMTAC (the State Emergency Medical and Trauma Services Advisory Council) with the following duties:

- Advise the department on all matters relating to EMS programs;
- Make recommendations concerning the development and implementation of statewide EMS services
- Identify and make recommendations concerning EMS needs;
- Review and approve new rules and modifications to rules prior to adoption by board of health
- Review and make recommendations concerning guidelines and standards for delivery of EMS services, including:
    - Establish a list of minimum equipment requirements and making recommendations on the process used by counties in the licensure of ambulance services;
    - Develop curricula for the training of EMS personnel.

CRS 25-3.5-202 states that the board of county commissioners establishes qualifications for personnel employed by the ambulance service for that county. The minimum requirement is possession of a certificate issued by CDPHE. CRS 25-3.5-301 states that no person shall provide ambulance service publicly or privately in the state unless person holds a valid license by the board of county commissioners for that county. Commissioners may impose additional requirements for ambulances within that county on top of the state requirements.

In 2016, the legislature passed a law recognizing EMS innovations in SB16-069, which is now known as CRS 25-3.5-1201 and -1301, recognizing Community Assistance, Referral, and Education Services (CARES) and Community Integrated Health Care Services (CIHCS), respectively. The CARES program is in effect from 2018 to 2021, when it

sunsets, and CARES entities that fit the definition have to register with CDPHE so it is publicly available. CARES entities provide health education and information and referrals for and information concerning low-cost medication programs and alternative resources to the 911 system. This would all be done in collaboration with health care facilities, primary care and other providers, and social services agencies.

CIHCS agencies on the other hand have to be licensed to do their work, and the distinction of CIHCS agencies is that they employ community paramedics to do work within their scope of practice. CIHCS can also do the tasks of a CARES program.

Colorado code of regulations, 6 CCR 1015-3 Chapter 2, outlines EMS practice and medical director oversight, for reference as needed.

3 CONCLUSIONS

To license innovative EMS programs that are supporting patients by providing non-emergency in-home care, CDPHE had previously used the broad home health regulation to regulate some community paramedic groups as agencies, since their authority before 2016 for EMS oversight was limited to EMS personnel (which did not include agencies). Because of the difference between business models, CDPHE could only require a provisional home health license with waivers for some groups. That temporary solution was problematic for some groups, so groups worked together to pass SB16-069, which created a new licensure category for agencies employing community paramedics. CDPHE worked on regulation and oversight details that are more suitable to these agencies.