COLORADO

Department of Regulatory Agencies

Colorado Office of Policy, Research & Regulatory Reform

2024 Sunset Review

Community Integrated Health-Care Service Agencies

October 15, 2024

COLORADO
Department of Regulatory Agencies
Executive Director's Office

October 15, 2024

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The Colorado General Assembly established the sunset review process in 1976 as a way to analyze and evaluate regulatory programs and determine the least restrictive regulation consistent with the public interest. Pursuant to section 24-34-104(5)(a), Colorado Revised Statutes (C.R.S.), the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) at the Department of Regulatory Agencies (DORA) undertakes a robust review process culminating in the release of multiple reports each year on October 15.

A national leader in regulatory reform, COPRRR takes the vision of their office, DORA and more broadly of our state government seriously. Specifically, COPRRR contributes to the strong economic landscape in Colorado by ensuring that we have thoughtful, efficient, and inclusive regulations that reduce barriers to entry into various professions and that open doors of opportunity for all Coloradans.

As part of this year's review, COPRRR has completed an evaluation of community integrated health-care service agencies. I am pleased to submit this written report, which will be the basis for COPRRR's oral testimony before the 2025 legislative committee of reference.

The report discusses the question of whether there is a need for the regulation provided under Part 13 of Article 3.5 of Title 25, C.R.S. The report also discusses the effectiveness of the Colorado Department of Public Health and Environment in carrying out the intent of the statutes and makes recommendations for statutory changes for the review and discussion of the General Assembly.

To learn more about the sunset review process, among COPRRR's other functions, visit coprrr.colorado.gov.

Sincerely,

Patty Salazar
Executive Director

Community Integrated Health-Care Service Agencies

Background

What is regulated?

A community integrated health-care service (CIHCS) agency is typically an emergency medical service agency, such as an ambulance service, that is authorized to provide non-urgent medical care, and other services, to individuals outside of hospital settings.

The purpose of CIHCS, also known as paramedicine or mobile integrated health care, is to improve access to care in underserved areas or populations.

A CIHCS agency may employ community paramedics and other health-care practitioners, such as nurses, nurse aides and social workers.

Why is it regulated?

The licensing of CIHCS agencies is necessary to ensure that patients who are receiving direct health-care services, often in private settings, are being provided safe, appropriate and effective care by qualified practitioners.

Who is regulated?

In fiscal year 22-23, the Colorado Department of Public Health and Environment (CDPHE) licensed 11 CIHCS agencies.

How is it regulated?

CDPHE is charged with licensing CIHCS agencies. The CIHCS program is located within the Health Facilities and Emergency Medical Services Division (Division) in CDPHE, and the State Board of Health (Board of Health) is granted rulemaking authority.

For a license, an agency must submit an application with evidence of general liability insurance, a community needs assessment and policies and procedures consistent with the Board of Health rules. Each agency must also have a medical director, and each owner and administrator must undergo a fingerprint-based criminal history record check.

What does it cost?

In fiscal year 22-23, the Division spent $9,741 and 0.07 full-time equivalent employees to regulate CIHCS agencies. Division staff is cross trained and share responsibility for regulating CIHCS agencies and other health-care facilities.

What disciplinary activity is there?

From fiscal year 18-19 to fiscal year 22-23, the Division issued one citation against a CIHCS agency for allowing services to be provided by an unqualified practitioner.

Key Recommendations

- **Continue the licensure of CIHCS agencies for nine years, until 2034.**
- **Include the acceptance by a court of a plea of guilty or *nolo contendere* in the authority to revoke or refuse to renew a CIHCS license on the grounds that the owner, manager or administrator has been convicted of a felony or a misdemeanor involving conduct that could pose a risk to the health, safety or welfare of the agency's patients.**

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Background

Sunset Criteria

Enacted in 1976, Colorado's sunset law was the first of its kind in the United States. A sunset provision repeals all or part of a law after a specific date, unless the legislature affirmatively acts to extend it. During the sunset review process, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) within the Department of Regulatory Agencies (DORA) conducts a thorough evaluation of such programs based upon specific statutory criteria[1] and solicits diverse input from a broad spectrum of stakeholders including consumers, government agencies, public advocacy groups, and professional associations.

Sunset reviews are guided by statutory criteria and sunset reports are organized so that a reader may consider these criteria while reading. While not all criteria are applicable to all sunset reviews, the various sections of a sunset report generally call attention to the relevant criteria. For example,

- In order to address the first criterion and determine whether the program under review is necessary to protect the public, it is necessary to understand the details of the profession or industry at issue. The Profile section of a sunset report typically describes the profession or industry at issue and addresses the current environment, which may include economic data, to aid in this analysis.
- To address the second sunset criterion--whether conditions that led to the initial creation of the program have changed--the History of Regulation section of a sunset report explores any relevant changes that have occurred over time in the regulatory environment. The remainder of the Legal Framework section addresses the fifth sunset criterion by summarizing the organic statute and rules of the program, as well as relevant federal, state and local laws to aid in the exploration of whether the program's operations are impeded or enhanced by existing statutes or rules.
- The Program Description section of a sunset report addresses several of the sunset criteria, including those inquiring whether the agency operates in the public interest and whether its operations are impeded or enhanced by existing statutes, rules, procedures and practices; whether the agency or the agency's board performs efficiently and effectively and whether the board, if applicable, represents the public interest.
- The Analysis and Recommendations section of a sunset report, while generally applying multiple criteria, is specifically designed in response to the fourteenth criterion, which asks whether administrative or statutory changes are necessary to improve agency operations to enhance the public interest.

[1] Criteria may be found at § 24-34-104, C.R.S.

These are but a few examples of how the various sections of a sunset report provide the information and, where appropriate, analysis required by the sunset criteria. Just as not all criteria are applicable to every sunset review, not all criteria are specifically highlighted as they are applied throughout a sunset review. While not necessarily exhaustive, the table below indicates where these criteria are applied in this sunset report.

Table 1
Application of Sunset Criteria

Sunset Criteria	Where Applied
(I) Whether regulation or program administration by the agency is necessary to protect the public health, safety, and welfare.	• Profile of the Services • Recommendation 1, 2 • Administrative Rec. 1
(II) Whether the conditions that led to the initial creation of the program have changed and whether other conditions have arisen that would warrant more, less, or the same degree of governmental oversight.	• History of Regulation
(III) If the program is necessary, whether the existing statutes and regulations establish the least restrictive form of governmental oversight consistent with the public interest, considering other available regulatory mechanisms.	• Legal Framework
(IV) If the program is necessary, whether agency rules enhance the public interest and are within the scope of legislative intent.	• Legal Framework • Program Description and Administration
(V) Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures, and practices and any other circumstances, including budgetary, resource, and personnel matters.	• Legal Framework • Program Description and Administration • Recommendation 2
(VI) Whether an analysis of agency operations indicates that the agency or the agency's board or commission performs its statutory duties efficiently and effectively.	• Program Description and Administration
(VII) Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates.	• Program Description and Administration
(VIII) Whether regulatory oversight can be achieved through a director model.	• Program Description and Administration
(IX) The economic impact of the program and, if national economic information is not available, whether the agency stimulates or restricts competition.	• Profile of the Services

Sunset Criteria	Where Applied
(X) If reviewing a regulatory program, whether complaint, investigation, and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession or regulated entity.	• Complaint Activity • Disciplinary Activity
(XI) If reviewing a regulatory program, whether the scope of practice of the regulated occupation contributes to the optimum use of personnel.	• Licensing
(XII) Whether entry requirements encourage equity, diversity, and inclusivity.	• Legal Framework • Program Description and Administration
(XIII) If reviewing a regulatory program, whether the agency, through its licensing, certification, or registration process, imposes any sanctions or disqualifications on applicants based on past criminal history and, if so, whether the sanctions or disqualifications serve public safety or commercial or consumer protection interests. To assist in considering this factor, the analysis prepared pursuant to subsection (5)(a) of this section must include data on the number of licenses, certifications, or registrations that the agency denied based on the applicant's criminal history, the number of conditional licenses, certifications, or registrations issued based upon the applicant's criminal history, and the number of licenses, certifications, or registrations revoked or suspended based on an individual's criminal conduct. For each set of data, the analysis must include the criminal offenses that led to the sanction or disqualification.	• Collateral Consequences
(XIV) Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.	• Recommendations 1-3 • Administrative Rec. 1

Sunset Process

Regulatory programs scheduled for sunset review receive a comprehensive analysis. The review includes a thorough dialogue with agency officials, representatives of the regulated profession and other stakeholders. Anyone can submit input on any upcoming sunrise or sunset review on COPRRR's website at coprrr.colorado.gov.

The functions related to community integrated health-care service (CIHCS) agencies and the Colorado Department of Public Health and Environment (CDPHE), as enumerated in Part 13 of Article 3.5 of Title 12, Colorado Revised Statutes (C.R.S.), shall terminate on September 1, 2025, unless continued by the General Assembly. During the year prior to this date, it is the duty of COPRRR to conduct an analysis and evaluation of the licensing of CIHCS agencies pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the currently prescribed regulation should be continued and to evaluate the performance of CDPHE. During this review, CDPHE staff must demonstrate that the program serves the public interest. COPRRR's findings and recommendations are submitted via this report to the Office of Legislative Legal Services.

Methodology

As part of this review, COPRRR staff interviewed CDPHE staff, practitioners and officials with state and national associations and reviewed Colorado statutes and the State Board of Health rules.

The major contacts made during this review include, but are not limited to:

- Colorado Department of Law,
- Colorado Department of Public Health and Environment,
- Colorado Hospital Association,
- Colorado Medical Association,
- Emergency Services Medical Association of Colorado,
- Home Care and Hospice Association of Colorado,
- International Board of Specialty Certification, and
- National Association of Mobile Integrated Healthcare Providers.

Profile of Community Paramedicine and Mobile Integrated Health Care

In a sunset review, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) is guided by the sunset criteria located in section 24-34-104(6)(b), C.R.S. The first criterion asks whether regulation by the agency is necessary to protect the public health, safety, and welfare.

To understand the need for regulation, it is first necessary to recognize what community paramedicine or mobile integrated health care is, where it is provided, who it serves and any necessary qualifications.

Community paramedicine started in Nova Scotia where residents struggled to access primary care and emergency medical technicians (EMTs) and paramedics were often the only available medical providers. In Colorado, Eagle County was an early adopter of community paramedicine.[2]

Community paramedicine allows emergency medical service (EMS) providers to deliver primary health care and preventative services to residents in their homes without transporting them to an emergency department, which can significantly reduce the cost of health care. Twenty-five percent of emergency room visits are associated with approximately five percent of patients. Community paramedicine leverages the skills and knowledge of paramedics to provide care and services traditionally provided by home health workers.[3]

The purpose of community paramedicine is to expand access to primary and preventative care and to reduce emergency department use. Since EMS providers are located in nearly all communities, rural areas and other underserved communities can benefit from community paramedicine.[4]

EMTs and paramedics are trained to evaluate injuries and illnesses, deliver emergency medical care and transport patients to hospitals. They are also trained to evaluate a patient's condition and respond to emergency respiratory, cardiac and trauma events. Some EMTs may have additional training that qualifies them to administer intravenous fluids, some medications and other advanced care. Paramedics have more advanced training than EMTs and are qualified to provide the same care as EMTs and perform

[2] Colorado Department of Public Health and Environment. *Community paramedicine delivers short-term care at home.* Retrieved November 15, 2023, from cdphe.colorado.gov/press-release/community-paramedicine-delivers-short-term-care-at-home

[3] National Conference of State Legislatures. *Community Paramedicine: Connecting Patients to Care and Reducing Costs.* Retrieved November 14, 2023, from www.ncsl.org/state-legislatures-news/details/community-paramedicine-connecting-patients-to-care-and-reducing-costs

[4] National Conference of State Legislatures. *Community Paramedicine: Connecting Patients to Care and Reducing Costs.* Retrieved November 14, 2023, from www.ncsl.org/state-legislatures-news/details/community-paramedicine-connecting-patients-to-care-and-reducing-costs

higher-level tasks, such as monitoring heart function and administering additional medications.[5]

EMTs and paramedics are regulated in all states. The qualifications to work as an EMT or paramedic differ from state to state.[6]

EMT educational programs vary from under a year to two years, depending on the certification being sought, such as basic or intermediate. Most EMT educational programs do not result in a degree. However, some paramedic educational programs lead to an associate or a bachelor's degree.[7]

National certification for EMTs and paramedics is available through the National Registry of Emergency Medical Technicians (NREMT), a private professional association. Certification requires passage of a national examination. States often require EMTs and paramedics to have NREMT certification.[8]

The largest employers of EMTs and paramedics are ambulance services. Local governments and private hospitals also hire EMTs and paramedics.[9]

The services that may be provided in a community paramedicine program differ depending on the state. In general, they include:[10]

- Primary care;
- Post-hospital care;
- Integrated services with public health agencies, home health agencies, health systems and other providers;
- Health education and promotion; and
- Connecting clients to primary, preventative and other services.

In addition to EMTs and paramedics, nurses and other health-care providers may be utilized to increase the level of care available to patients through community paramedicine. This model is often referred to as mobile integrated health care.[11] These terms are often used interchangeably.

[5] U.S. Bureau of Labor Statistics. *EMTs and Paramedics.* Retrieved November 15, 2023, from www.bls.gov/ooh/healthcare/emts-and-paramedics.htm
[6] U.S. Bureau of Labor Statistics. *EMTs and Paramedics.* Retrieved November 15, 2023, from www.bls.gov/ooh/healthcare/emts-and-paramedics.htm
[7] U.S. Bureau of Labor Statistics. *EMTs and Paramedics.* Retrieved November 15, 2023, from www.bls.gov/ooh/healthcare/emts-and-paramedics.htm
[8] U.S. Bureau of Labor Statistics. *EMTs and Paramedics.* Retrieved November 15, 2023, from www.bls.gov/ooh/healthcare/emts-and-paramedics.htm
[9] U.S. Bureau of Labor Statistics. *EMTs and Paramedics.* Retrieved November 15, 2023, from www.bls.gov/ooh/healthcare/emts-and-paramedics.htm
[10] National Conference of State Legislatures. *Community Paramedicine: Connecting Patients to Care and Reducing Costs.* Retrieved November 14, 2023, from www.ncsl.org/state-legislatures-news/details/community-paramedicine-connecting-patients-to-care-and-reducing-costs
[11] National Conference of State Legislatures. *Community Paramedicine: Connecting Patients to Care and Reducing Costs.* Retrieved November 14, 2023, from www.ncsl.org/state-legislatures-news/details/community-paramedicine-connecting-patients-to-care-and-reducing-costs

Regulation of community paramedicine varies from state to state. States may require EMTs and paramedics to have additional qualifications in order to practice community paramedicine.

In Colorado, an organization that provides community paramedicine or mobile integrated health care is referred to as a community integrated health-care service (CIHCS) agency.

The public benefits from community paramedicine since it helps to fill gaps in available health care, improve patient outcomes and provide basic health-care services to patients in their homes rather than transporting them to an emergency room.

During the COVID-19 pandemic, the benefits of community paramedicine was clear. By allowing patients to be cared for in their homes, community paramedics reduced the stress on emergency rooms and emergency room staff, which were overwhelmed by the influx of COVID-19 patients. Additionally, patients benefited by obtaining care more quickly and avoiding a trip to the hospital where they may be exposed to COVID-19 and other infectious diseases.

While many of the services provided by community paramedics overlap with home care providers, they are complementary models of care. For instance, patients who are not eligible for home care can benefit from community paramedicine.[12] Also, some areas have little to no access to home care services, and community paramedicine may allow patients in these areas to continue living in their homes.

Hospice providers may also benefit by partnering with community paramedicine. Families often call 911 when hospice patients are struggling at home. Rather than transporting the patient to an emergency room and risk disenrolling the patient in hospice care, along with other negative outcomes, a community paramedic can help to alleviate patient suffering by administering the medications that the patient already has at home.[13]

The ninth sunset criterion questions the economic impact of the program and, if national economic information is not available, whether the agency stimulates or restricts competition.

One of the economic benefits of community paramedicine and mobile integrated health care is the reduction in health-care costs, which is beneficial to private and public health-care payers as well as health-care systems.

[12] National Association of Emergency Medical Technicians. *EMS and Home Health: Partners in Improving Patient Outcomes and Lowering Costs.* Retrieved November 15, 2023, from www.naemt.org/docs/default-source/community-paramedicine/mih-cp-toolkit/ems_homehealth.pdf

[13] Journal of Emergency Medical Services. *Establishing Partnerships Between Home Health and EMS-Based Mobile Integrated Healthcare*. Retrieved November 15, 2023, from www.jems.com/administration-and-leadership/establishing-partnerships-between-home-health-and-ems-based-mobile-integrated-healthcare/

Two studies found that community paramedicine reduced the incidence of 911 calls, which significantly decreased health-care costs. An evaluation of a pilot program in California found that community paramedicine reduced medical costs associated with serving over 4,300 patients, by about $3 million.[14]

Since 2020, nearly 9,700 Coloradans have received services through CIHCS agencies, and 71 percent of CIHCS agencies reported a reduction in non-urgent emergency department visits.

In addition to decreasing health-care costs, community paramedicine also expands the services that paramedics may deliver, which will likely increase job opportunities for paramedics, especially as the need for health-care services to be provided to an aging population continues to grow.

[14] National Conference of State Legislatures. *Community Paramedicine: Connecting Patients to Care and Reducing Costs.* Retrieved November 14, 2023, from www.ncsl.org/state-legislatures-news/details/community-paramedicine-connecting-patients-to-care-and-reducing-costs

Legal Framework

History of Regulation

In a sunset review, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) is guided by the sunset criteria located in section 24-34-104(6)(b), Colorado Revised Statutes (C.R.S.). The first and second sunset criteria question:

> Whether regulation or program administration by the agency is necessary to protect the public health, safety, and welfare; and
>
> Whether the conditions that led to the initial creation of the program have changed and whether other conditions have arisen that would warrant more, less or the same degree of governmental oversight.

One way that COPRRR addresses this is by examining why the program was established and how it has evolved over time.

After identifying gaps in health-care services, Eagle County began working with the Colorado Department of Public Health and Environment (CDPHE) to pilot a community paramedicine program. Then CDPHE granted Eagle County a conditional license that required frequent reporting and intensive monitoring by the state.

In 2016, Senate Bill 069 authorized community paramedicine to be provided throughout the state. The bill created an endorsement in community paramedicine for emergency medical service (EMS) providers, and it required agencies that offer community integrated health-care service (CIHCS) to be licensed by CDPHE.

This is the first sunset review of the CIHCS program.

Legal Summary

The third, fourth and fifth sunset criteria question:

> Whether the existing statutes and regulations establish the least restrictive form of governmental oversight consistent with the public interest, considering other available regulatory mechanisms;
>
> Whether agency rules enhance the public interest and are within the scope of legislative intent; and
>
> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures, and practices and any other circumstances, including budgetary, resource, and personnel matters.

A summary of the current statutes and rules is necessary to understand whether regulation is set at the appropriate level and whether the current laws are impeding or enhancing the agency's ability to operate in the public interest.

The statutes governing CIHCS agencies are located in Part 13 of Article 3.5 of Title 25, Colorado Revised Statutes (C.R.S.) (Act).

CIHCS is defined as the provision of out-of-hospital medical services that community paramedics and other qualified health-care practitioners may deliver according to their respective scopes of practice,[15] including:[16]

- Patient assessments;
- Medical interventions;
- Care coordination;
- Resource navigation;
- Patient education;
- Medication administration, inventory and compliance; and
- Laboratory and diagnostic data collection.

A community paramedic is an EMS provider who has an endorsement in community paramedicine.[17] EMS providers who are not endorsed as community paramedics are prohibited from providing out-of-hospital medical services to CIHCS patients.[18]

While the Act and the State Board of Health (Board of Health) rules refer to someone who receives CIHCS services as a "consumer," CIHCS agencies typically use "patient" when referring to someone receiving medical interventions and "client" when referring to someone receiving non-clinical services. For readability, this report simply refers to "patients."

In addition to community paramedics, other health-care practitioners, such as nurses, nurse aides and social workers, may also provide CIHCS services. In order to provide CIHCS services, a health-care practitioner must have a license, certificate or registration in good standing and may only act within the scope of practice authorized under their license, certificate or registration.[19] Other practitioners, such as nutritionists, phlebotomists and X-ray technicians, who are not required by the state to be licensed or certified, may also provide CIHCS services.[20]

CIHCS also include services authorized through the Community Assistance Referral and Education Services (CARES) program, such as:[21]

[15] 6 CCR § 1011-3 2.10, Standards for Community Integrated Health Care Service Agencies.
[16] 6 CCR § 1011-3 2.12, Standards for Community Integrated Health Care Service Agencies.
[17] 6 CCR § 1011-3 2.12, Standards for Community Integrated Health Care Service Agencies.
[18] 6 CCR § 1011-3 2.9.5, Standards for Community Integrated Health Care Service Agencies.
[19] 6 CCR § 1011-3 2.9.2, Standards for Community Integrated Health Care Service Agencies.
[20] 6 CCR § 1011-3 2.9.3, Standards for Community Integrated Health Care Service Agencies.
[21] §§ 25-3.5-1303(1) and 25-3.5-1203(3), C.R.S.

- Health education and information, and
- Referrals to low-cost medication programs and alternatives to the 911 system.

A CIHCS agency is required to retain an administrator to control and supervise the day-to-day operations of the CIHCS agency.[22]

A CIHCS agency must also employ a medical director who is charged with supervising, providing direction to, and ensuring the competence of CIHCS contractors and staff.[23] The medical director may be a licensed physician or an advanced practice registered nurse. However, only a medical director who is a licensed physician may act as a medical director for a community paramedic.[24]

The medical director is also responsible for developing protocols and standing orders, as appropriate, for the agency's services, which must align with the scope of practice and skill level of each CIHCS provider.[25]

When appropriate, the medical director must work with the patient's care provider to develop, monitor and evaluate the patient's service plan.[26]

Before employing anyone to provide direct care to an at-risk adult, the Act requires a CIHCS agency to check the Colorado Adult Protective Services Data System in the Department of Human Services.[27]

To provide CARES program services and avoid service duplication, a CIHCS agency may collaborate with other community resources, including:[28]

- Health-care facilities,
- Primary care providers,
- Other health-care providers, and
- Social service agencies.

A CIHCS agency may be a sole proprietorship, partnership, corporation, nonprofit entity, special district, governmental unit or agency, or licensed or certified health-care facility.[29]

A license is required to operate a CIHCS agency.[30] Anyone who operates a CIHCS agency without a license is guilty of a misdemeanor, punishable by between $50 and $500.

[22] 6 CCR § 1011-3 2.1, Standards for Community Integrated Health Care Service Agencies.
[23] 6 CCR § 1011-3 2.7, Standards for Community Integrated Health Care Service Agencies.
[24] 6 CCR § 1011-3 5.2.2(B)(iii), Standards for Community Integrated Health Care Service Agencies.
[25] 6 CCR § 1011-3 5.2.4(A)(i), Standards for Community Integrated Health Care Service Agencies.
[26] 6 CCR § 1011-3 5.2.3(A)(ix), Standards for Community Integrated Health Care Service Agencies.
[27] § 25-3.5-1303(2), C.R.S.
[28] § 25-3.5-1203(3)(b), C.R.S.
[29] § 25-3.5-1301(1), C.R.S.
[30] § 25-3.5-1302(1), C.R.S.

CDPHE may also assess a civil penalty of up to $10,000 for operating a CIHCS agency without a license. All civil penalties are directed to the General Fund.[31]

As required by statute, the Board of Health has established rules concerning:[32]

- Inspections by CDPHE,[33]
- CIHCS provider qualifications,[34]
- Occurrence reporting,
- Recordkeeping, and
- Annual reports to CDPHE.

The Board of Health maintains a schedule of application and license fees based on CDPHE's direct and indirect costs as it is statutorily required to do.[35]

Each owner, manager and administrator of a CIHCS agency must undergo a fingerprint-based criminal history record check when an application for an initial or renewal license is submitted.[36]

If an applicant is temporarily unable to meet all the requirements for a license, CDPHE has the authority to issue a 90-day provisional license, which may be renewed one time only. A provisional license is only allowed if the operation of the CIHCS agency will not put patients at risk of harm.[37]

As required by the Act, the Board of Health rules require an applicant to provide evidence of general liability insurance or a surety bond.[38]

The Act requires CDPHE to inspect a CIHCS agency as necessary to protect the health, safety and welfare of the agency's patients, and it also requires a CIHCS agency to submit a report to CDPHE describing a plan to correct any violations identified during an inspection.[39]

Additionally, CDPHE may require CIHCS agencies to:[40]

- Hire a consultant to address corrective measures;
- Undergo monitoring for a period of time;
- Provide additional training to CIHCS providers, owners, managers and administrators; and
- Comply with a plan to correct a violation.

[31] § 25-3.5-1302(2)(a), C.R.S.
[32] § 25-3.5-1303(1), C.R.S.
[33] 6 CCR § 1011-3 4.6, Standards for Community Integrated Health Care Service Agencies.
[34] 6 CCR §§ 1011-3 5.1.1 and 5.3.1, Standards for Community Integrated Health Care Service Agencies.
[35] § 25-3.5-1303(1)(d)(I), C.R.S.
[36] § 25-3.5-1305(3)(a)(I), C.R.S.
[37] § 25-3.5-1305(3)(c), C.R.S.
[38] 6 CCR § 1011-3 4.2.3, Standards for Community Integrated Health Care Service Agencies.
[39] § 25-3.5-1305(2)(a), C.R.S.
[40] § 25-3.5-1306(4), C.R.S.

Finally, CDPHE has the authority to suspend, revoke or refuse to renew a license for a violation of the Act or the Board of Health rules,[41] and CDPHE may deny, refuse to renew or revoke a license based on a criminal conviction.[42]

[41] § 25-3.5-1306(2), C.R.S.
[42] §§ 25-3.5-1305(3)(b) and 25-3.5-1306(3), C.R.S.

Program Description and Administration

In a sunset review, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) is guided by sunset criteria located in section 24-34-104(6)(b), Colorado Revised Statutes (C.R.S.). The fifth and sixth sunset criteria question:

> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures, and practices and any other circumstances, including budgetary, resource, and personnel matters; and
>
> Whether an analysis of agency operations indicates that the agency or the agency's board or commission performs its statutory duties efficiently and effectively.

In part, COPRRR utilizes this section of the report to evaluate the agency according to these criteria.

The Colorado Department of Public Health and Environment (CDPHE) is charged with licensing community integrated health-care service (CIHCS) agencies. The CIHCS program is located within the Health Facilities and Emergency Medical Services Division (Division) in CDPHE, and the State Board of Health (Board of Health) is granted rulemaking authority.

The statutes governing CIHCS agencies are located in Part 13 of Article 3.5 of Title 25, Colorado Revised Statutes, (C.R.S.) (Act).

A CIHCS agency is typically an emergency medical service agency, such as an ambulance service or fire department, which is authorized to provide non-urgent medical care to patients outside of hospital settings, such as in their homes and in the community. Individuals who rely on these services may have been denied services by home care agencies, or they may frequently use 911 or emergency rooms to access non-urgent care.[43]

Care provided by a CIHCS agency is provided by community paramedics and may also be provided by other health-care practitioners, such as nurses, nurse aides and social workers, who are acting within their respective scopes of practice.[44]

The program is cash funded by application and license fees.

[43] Colorado Department of Public Health and Environment. *Community Integrated Health Care Services.* Retrieved February 20, 2024, from cdphe.colorado.gov/community-integrated-health-care-services-and-community-assistance-referral-and-education-services

[44] Colorado Department of Public Health and Environment. *Community Integrated Health Care Services.* Retrieved February 20, 2024, from cdphe.colorado.gov/community-integrated-health-care-services-and-community-assistance-referral-and-education-services

Table 2 illustrates the program expenditures and staffing over a five-year period.

Table 2
Program Expenditure and Staffing

Fiscal Year	Total Program Expenditure	FTE
18-19	$6,646	0.05
19-20	$9,443	0.07
20-21	$8,315	0.06
21-22	$7,290	0.06
22-23	$9,741	0.07

The CIHCS program is small compared to licensing programs for other types of health-care facilities within CDPHE. The program expenditures fluctuate slightly from year to year depending on the workload.

The full-time equivalent (FTE) employee numbers reported in the above table represent the percentage of an FTE spent on the CIHCS program and do not represent staff dedicated to the program. Division staff is cross trained and share responsibility for regulating CIHCS agencies and other health-care facilities. On average, the program required six percent of an FTE each fiscal year.

In fiscal year 23-24, the functions of the program were accomplished by two positions:

- **Licensing and Certification Specialist** (0.06 FTE, Technician III), who processes applications and performs licensing functions; and

- **Health Compliance Inspector** (0.01 FTE, Health Professional IV), who identifies program deficiencies through periodic inspections of agencies and reviews plans to mitigate deficiencies.

Like other health-care facility license types, CIHCS license fees are statutorily required to be established in rule. The Division determines the license fees by conducting an analysis of the survey process and regulatory oversight. For the CIHCS program, the Division based this analysis on other similar programs. The Board of Health then adopted the license fees through rulemaking.

The license and administrative fees, from fiscal year 18-19 to fiscal year 22-23, were:

- $3,000 for an initial license,
- $1,700 to renew a license,
- $3,000 to change license ownership, and
- $75 to change a license name or address.

Community Paramedic Endorsement

In order to practice community paramedicine, Colorado requires an individual to obtain an emergency medical service (EMS) certificate and a community paramedic endorsement. CDPHE offers several types of EMS certificates:[45]

- Emergency medical technician,
- Emergency medical technician–intermediate,
- Advanced emergency medical technician, and
- Paramedic.

Each level of EMS certification has a specific scope of practice, and the paramedic level has the most advanced scope of practice. Only a paramedic may obtain an endorsement in community paramedicine.

To obtain an EMS certificate, an applicant must submit to a fingerprint-based criminal history record check and provide evidence of registration with the National Registry of Emergency Medical Technicians and certification in cardiopulmonary resuscitation. An applicant must also provide evidence of successful completion of an educational course appropriate to the EMS provider type. An applicant seeking a paramedic certificate must also provide evidence of certification in advanced cardiovascular life support.[46]

An EMS certificate must be renewed every three years.[47]

The requirements for a community paramedic endorsement include completion of a course in community paramedicine and a certificate from the International Board of Specialty Certification (IBSC).[48] To obtain IBSC certification in community paramedicine, a paramedic must pass an examination to demonstrate competence in mobile integrated health care and expanded EMS services in rural and urban settings.[49]

As of June 30, 2024, Colorado had a total of 51 community paramedics.

Licensing CIHCS Agencies

To operate a CIHCS agency, a license is required.[50] A CIHCS agency must have a medical director who is an advanced practice registered nurse or a Colorado-licensed physician. While an advanced practice registered nurse may act as a medical director for other

[45] 6 CCR § 1015-3 5.1.1, Emergency Medical Services Rules.
[46] 6 CCR § 1015-3 5.1.2, Emergency Medical Services Rules.
[47] 6 CCR § 1015-3 5.1.4, Emergency Medical Services Rules.
[48] 6 CCR § 1015-3 5.1.2(F), Emergency Medical Services Rules.
[49] International Board of Specialty Certification. *For Community Paramedics*. Retrieved on August 15, 2024, from https://www.ibscertifications.org/roles/community-paramedic#gsc.tab=0
[50] 6 CCR § 1011-3 4.1.2, Standards for Community Integrated Health Care Service Agencies.

health-care practitioners who are providing CIHCS services, only a licensed physician may act as a medical director for a community paramedic.[51]

To obtain a CIHCS license, an applicant must submit a completed application to the Division.[52] Each applicant must also provide evidence of general liability insurance or a surety bond in lieu of general liability insurance,[53] and each owner and administrator must submit a set of their fingerprints to the Colorado Bureau of Investigation for a state and national criminal history record check.[54]

Additionally, an applicant for a CIHCS agency must submit a completed community needs assessment that details:[55]

- The program population to be served and types of services to be provided;
- The geographic area to be served;
- A plan to coordinate with other existing resources and programs;
- A plan to identify the needs of the community to be served;
- Partners in the community and groups or organizations that support the program; and
- Specific needs of the community, such as language barriers, environmental concerns and transportation accessibility issues.

The applicant must also adopt policies and procedures that are consistent with the requirements established in the program rules.[56]

Division staff then reviews the application and supporting documentation. Division staff may also:[57]

- Conduct an onsite inspection,
- Review the applicant's compliance history,
- Interview patients and staff,
- Review the applicant's policies and procedures, and
- Review any other information that the Division deems applicable.

If an applicant is unable to comply with all the licensure requirements, the Division may issue a provisional license for a period of 90 days. However, the Division may not issue a provisional license if the operation of the CIHCS agency will adversely affect the public health, safety and welfare. The provisional license may only be renewed one

[51] 6 CCR § 1011-3 2.7, Standards for Community Integrated Health Care Service Agencies.
[52] 6 CCR § 1011-3 4.2.1, Standards for Community Integrated Health Care Service Agencies.
[53] 6 CCR § 1011-3 4.2.3, Standards for Community Integrated Health Care Service Agencies.
[54] 6 CCR § 1011-3 4.2.4, Standards for Community Integrated Health Care Service Agencies.
[55] 6 CCR § 1011-3 4.3.1, Standards for Community Integrated Health Care Service Agencies.
[56] 6 CCR § 1011-3 4.2.6(E), Standards for Community Integrated Health Care Service Agencies.
[57] 6 CCR § 1011-3 4.2.6, Standards for Community Integrated Health Care Service Agencies.

time for a period of 90 days.[58] The Division rarely issues provisional licenses to health-care facilities, and it has never issued a provisional license to a CIHCS agency.

Table 3 shows the total number of initial and renewal licenses issued to CIHCS agencies over a five-year period.

Table 3
CIHCS Licenses

Fiscal Year	Initial	Renewal	Total
18-19	3	0	3
19-20	4	3	7
20-21	3	6	9
21-22	1	8	9
22-23	3	8	11

Since the program started on January 1, 2018, no licenses were renewed in fiscal year 18-19.

In fiscal year 18-19, the first full fiscal year of the program, only three entities were licensed. On average, about three new CIHCS licenses were issued each year from fiscal year 18-19 to fiscal year 22-23. It is unknown why only one new CIHCS agency was licensed in fiscal year 21-22.

When an application is filed with the Division, a licensing and certification specialist reviews the application and conducts an initial fitness review to determine whether there are any concerns related to the applicant's ability to provide services. During the initial fitness review, staff conducts background checks and criminal history record checks on the individuals identified in the application. If the Division finds any information of concern, it will request more information.

Table 4 provides the total number of initial fitness reviews conducted by Division staff over a five-year period.

[58] 6 CCR § 1011-3 4.4.1, Standards for Community Integrated Health Care Service Agencies.

Table 4
Initial Fitness Reviews

Fiscal Year	Reviews
18-19	5
19-20	4
20-21	2
21-22	2
22-23	4

The total number of initial fitness reviews conducted each year depends on the number of CICHS applications received by the Division. However, the total number of initial fitness reviews conducted in a particular year does not necessarily equal the total number of licenses issued that year since a license may not necessarily be issued the same year an application is submitted.

No initial fitness reviews over the five-year period resulted in a license denial.

CIHCS licenses must be renewed annually, and licensees are required to submit a report to the Division within 45 days of renewing a license.

The annual report must include:[59]

- The number of individuals served,
- The types of services provided,
- The types of providers utilized and their license types,
- The number of visits performed by each provider type,
- The number of patients that received services from a single visit,
- The number of patients who received services from recurrent visits,
- An evaluation regarding whether the CIHCS agency meets the needs identified in its community needs assessment,
- A measurement of the reduction in visits to an emergency department for medical assistance unrelated to urgent or emergency care, and
- The results of any performance reviews provided by patients and collaborative partners.

[59] 6 CCR 1011-3 § 4.11.1, Standards for Community Integrated Health Care Service Agencies.

Complaints

The tenth sunset criterion requires COPRRR to examine whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession or regulated entity.

In part, COPRRR utilizes this section of the report to evaluate the program according to this criterion.

Anyone may file a complaint against a CIHCS agency, including patients, family members, health-care practitioners and other regulatory agencies. A CIHCS agency must furnish patients with contact information for filing complaints. Patients may file complaints with the Division or with the CIHCS agency itself.[60]

From fiscal year 18-19 to fiscal year 22-23, the Division opened one complaint against a CIHCS agency following an investigation into an emergency medical service agency that is also licensed as a CIHCS agency.

In fiscal year 21-22, the Division found that a CIHCS agency had allowed a paramedic, who was not a qualified community paramedic, to provide non-urgent out-of-hospital medical care to a CIHCS patient. The investigation also found that the CIHCS agency had a policy that allowed a community paramedic to delegate care to a paramedic as long as the care falls within the scope of practice of a paramedic. However, the scope of practice of a paramedic does not include non-urgent out-of-hospital services, so the CIHCS agency's policy was out of compliance with the CIHCS Act and the Board of Health rules.

Disciplinary Activity

The tenth sunset criterion requires COPRRR to examine whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession or regulated entity.

In part, COPRRR utilizes this section of the report to evaluate the program according to this criterion.

If the Division finds a CIHCS agency has violated the Act or the Board of Health rules, it may require a CIHCS agency to:[61]

[60] 6 CCR § 1011-3 9.1.1, Standards for Community Integrated Health Care Service Agencies.
[61] § 25-3.5-1306(4), C.R.S.

- Hire a consultant to address corrective measures;
- Undergo monitoring for a period of time;
- Provide additional training to staff, owners, managers and administrators; and
- Comply with a plan to correct a violation.

The Division also has the authority to suspend, revoke or refuse to renew a license.[62]

Table 5 demonstrates the total number of disciplinary actions taken against CIHCS agencies over five fiscal years.

Table 5
Disciplinary Actions

Type of Action	FY 18-19	FY 19-20	FY 20-21	FY 21-22	FY 22-23
Refusal to Renew	0	0	2	0	1
Agency Citation	0	0	0	1	0
Total Disciplinary Actions	**0**	**0**	**2**	**1**	**1**

The Division did not deny or revoke any CIHCS licenses over the five-year period.

However, in fiscal year 21-22, the Division issued one citation, following a complaint investigation that found a CIHCS agency had a policy that was out of compliance with state law and, based on this policy, an unqualified paramedic had provided non-urgent out-of-hospital medical services to a CIHCS patient. The Division required the agency to correct the violation, and following this the CIHCS agency was brought into compliance and no other deficiencies were identified.

The Division also issued three notices to agencies that the Division would refuse to renew their licenses. When agencies fail to submit renewal applications or fees, the Division will issue a notice. However, a notice does not mean that a license has been denied. Typically, when a CIHCS agency receives a notice, the CIHCS agency takes the necessary steps to renew the license.

Despite the notices issued in the previous table, the Division has not denied any license renewals. In one case, the CIHCS agency had already ceased providing CIHCS services, so it voluntarily agreed to surrender its license. The Division renewed the other two licenses.

[62] § 25-3.5-1306(2), C.R.S.

Inspections

The Division conducts inspections during initial licensure, renewals and changes of ownership. It also conducts inspections periodically, approximately every three years, and it may conduct an inspection based on a complaint.

During an inspection for an initial license, an inspector conducts a site visit where they review the CIHCS agency's policies and procedures for compliance with the Act and the Board of Health rules. The inspector interviews agency staff about the community needs assessment and asks questions about how the agency enrolls new patients. They also check the licenses of anyone providing patient care to ensure that CIHCS providers have the appropriate credentials.

An inspection of a CIHCS agency with an existing license is similar to an inspection for an initial license, but the inspector also examines the care and services that are being provided to patients.

When an inspection is conducted due to a complaint, an inspector will examine the care related to the complaint. However, an inspection is not necessarily required based on an individual complaint.

Table 6 provides the number of inspections conducted each year from fiscal year 18-19 to fiscal year 22-23.

Table 6
Inspections

Fiscal Year	Inspections
18-19	3
19-20	4
20-21	3
21-22	1
22-23	9

From fiscal year 18-19 to fiscal year 21-22, most of the inspections were likely related to initial licensure. In fiscal year 22-23, the increase in inspections is due to several CICHS agencies undergoing periodic inspections and one inspection that was conducted following a change of ownership.

Fining Activity

The Division has the authority to assess a civil penalty of up to $10,000 per violation.[63] No civil penalties were assessed from fiscal year 18-19 to fiscal year 22-23.

Collateral Consequences – Criminal Convictions

The thirteenth sunset criterion requires COPRRR to examine whether the agency, through its licensing, certification or registration process, imposes any sanctions or disqualifications on applicants based on past criminal history and, if so, whether the sanctions or disqualifications serve public safety or commercial or consumer protection interests.

COPRRR utilizes this section of the report to evaluate the program according to this criterion.

The Act authorizes the Division to deny, refuse to renew or revoke a CIHCS license if an owner, manager or administrator has a felony conviction or a misdemeanor that involves conduct that increases the risk of harm to CIHCS patients.

From fiscal year 18-19 to fiscal year 22-23, the Division did not deny, refuse to renew or revoke any CIHCS licenses based on criminal history.

[63] § 25-3.5-1306(4)(e), C.R.S.

Analysis and Recommendations

The final sunset criterion questions whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest. The recommendations that follow are offered in consideration of this criterion, in general, and any criteria specifically referenced in those recommendations.

Recommendation 1 — Continue the licensure of community integrated health-care service agencies for nine years, until 2034.

A community integrated health-care service (CIHCS) agency is typically an emergency medical service (EMS) agency, such as an ambulance service, that is authorized to provide non-urgent medical care and other services to individuals outside of hospital settings.[64]

A CIHCS agency may employ community paramedics and other health-care practitioners, such as nurses, nurse aides and social workers, among others, to provide care within their respective scopes of practice.[65]

The purpose of community integrated health-care service, also known as paramedicine or mobile integrated health care, is to improve access to care in underserved areas or populations.

The Colorado Department of Public Health and Environment (CDPHE) is charged with licensing CIHCS agencies. The CIHCS program is located within the Health Facilities and Emergency Medical Services Division (Division) in CDPHE, and the State Board of Health (Board of Health) is granted rulemaking authority.

The statutes governing CIHCS agencies are located in Part 13 of Article 3.5 of Title 25, Colorado Revised Statutes (C.R.S.) (Act).

Prior to obtaining a CIHCS license, an applicant must perform a community needs assessment to identify any unmet needs and existing resources in the proposed service area. Because access to care is different in each community, the services that CIHCS agencies provide varies from community to community.

A CIHCS agency may perform wellness checks and assess a client's home to ensure the client has sufficient food and to address problem areas that may cause accidents. Often

[64] Colorado Department of Public Health and Environment. *Community Integrated Health Care Services.* Retrieved February 20, 2024, from cdphe.colorado.gov/community-integrated-health-care-services-and-community-assistance-referral-and-education-services

[65] Colorado Department of Public Health and Environment. *Community Integrated Health Care Services.* Retrieved February 20, 2024, from cdphe.colorado.gov/community-integrated-health-care-services-and-community-assistance-referral-and-education-services

CIHCS agencies help connect clients with other health-care providers and services that are available to them.

Some CIHCS agencies provide primary, preventative and palliative care to patients who live in rural areas where home care and hospice services are not available. They may also coordinate with primary care providers and take vitals, assist with medication, draw blood for lab work and transport patients to medically necessary appointments.

Other CIHCS agencies focus on providing behavioral health services to areas where substance abuse and mental health services are inaccessible. An agency may provide education and referrals, conduct mental health screenings, support patients in recovery, respond to mental health crises, and dispense and administer medication.

While community paramedicine and mobile integrated health care were first established in rural areas, these services are also found to be beneficial in urban and suburban areas.

Since 2020, nearly 9,700 Coloradans have received services through CIHCS agencies, and 71 percent of CIHCS agencies reported a reduction in non-urgent emergency room visits.

During the sunset review, an important issue was raised that is outside the purview of the sunset review. Currently, an EMS provider who does not have a community paramedic endorsement can only provide services authorized through the Community Assistance Referral and Education Services program, such as providing health education and information, or ancillary non-medical services, such as driving.[66]

Only a paramedic is currently authorized to be granted a community paramedic endorsement by CDPHE. While EMT's may provide some services through a CIHCS agency, they are not able to provide out-of-hospital medical services, such as taking vitals or drawing blood, which may otherwise be within their scope of practice. According to stakeholders, allowing EMTs to provide out-of-hospital medical services within their scope of practice could create some efficiencies in CIHCS agencies and extend the care provided by community paramedics.

As this issue is rooted in the regulation of individual EMS providers and not the regulation of CIHCS agencies, which is the subject of this report, the Colorado Office of Policy, Research and Regulatory Reform cannot make a recommendation in this report. However, nearly all stakeholders who participated in the sunset review supported allowing EMTs who are employed by or contracting with a CIHCS agency to provide out-of-hospital non-urgent medical services within their scope of practice.

[66] 6 CCR § 1011-3 5.3.4(C), Standards for Community Integrated Health Care Service Agencies.

Sunset reviews are guided by statutory criteria established in section 24-34-104, C.R.S., and the first criterion questions whether regulation is necessary to protect the public health, safety and welfare.

The licensing of CIHCS agencies is necessary to ensure that patients who are receiving direct health-care services, often in private settings, are being provided safe, appropriate and effective care by qualified practitioners. CIHCS patients may be frail, homebound, bedbound or otherwise isolated; they may also have issues with substance abuse, mental health or chronic illnesses.

The Act protects the public by authorizing CDPHE to deny, refuse to renew, suspend or revoke the license of a CIHCS agency. The Act also authorizes CDPHE to fine a CIHCS agency or impose intermediate restrictions or conditions on a CIHCS agency for failing to comply with the Act or the Board of Health rules.

Between fiscal year 18-19 and fiscal year 22-23, CDPHE only received one complaint against a CIHCS agency. Following an investigation by another branch, the Division learned that a CIHCS agency had allowed unqualified staff to provide wound care to a CIHCS patient. The Division issued a citation and brought the agency into compliance.

The Division took a few other disciplinary actions against CIHCS agencies, but these were related to administrative violations, such as failing to renew a license or pay the license fee.

Additionally, the Act and the Board of Health rules serve to protect the health, safety and welfare of CIHCS patients by requiring the Board of Health to adopt the minimum standards for the operation of CIHCS agencies[67] and to inspect CIHCS agencies.[68] From fiscal years 18-19 to 22-23, CDPHE conducted 20 inspections.

The Act also protects the public by requiring each owner, manager and administrator of a CIHCS agency to submit to a fingerprint-based criminal history record check during the application process,[69] and requiring each CIHCS agency to employ a medical director to supervise community paramedics and other health-care practitioners who are serving patients.[70]

Like other health-care facilities, the Board of Health requires CIHCS agencies to report to CDPHE certain events in which a patient or client is harmed or may be at risk of harm, such as misappropriation of a patient's property or drug diversion.

[67] § 25-3.5-1303(1), C.R.S.
[68] § 25-3.5-1305(2)(a), C.R.S.
[69] § 25-3.5-1305(3)(a)(I), C.R.S.
[70] § 25-3.5-1303(1)(a), C.R.S.

Finally, the Board of Health rules protect the public by establishing the rights of CIHCS patients and directing the CIHCS agencies to establish policies and procedures that incorporate these rights.[71]

As regulation of CIHCS agencies is necessary to protect the health, safety and welfare of the public, it should be continued. Since few substantive issues were raised during the sunset review, the licensure of CIHCS agencies should be continued for nine years.

Therefore, the General Assembly should continue the licensure of CIHCS agencies for nine years, until 2034.

Recommendation 2 — Incorporate a plea of guilty or *nolo contendere* with the authority to deny, revoke or refuse to renew a CIHCS license on the grounds that the owner, manager or administrator has been convicted of a felony or misdemeanor involving conduct that could pose a risk to the health, safety or welfare of the agency's patients.

The Act currently authorizes CDPHE to deny, refuse to renew or revoke the license of a CIHCS agency if the owner, manager or administrator has been convicted of a felony or misdemeanor involving conduct that could pose a risk to the health, safety or welfare of the agency's patients.

Typically, in Colorado, the grounds for discipline in regulatory programs also include the acceptance by a court of a plea of guilty or *nolo contendere*.

This additional language is necessary because a defendant may plead guilty or *nolo contendere* to criminal charges and receive a deferred sentence with a probationary period of up to four years. As long as the defendant meet the terms required by the court during the probationary period, the charges will be dismissed.[72]

The first and fifth sunset criteria question whether regulation is necessary to protect the health, safety and welfare of the public, whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes.

The purpose of the CIHCS licensure program is to protect patients from harm. The Act currently allows CDPHE to withdraw the authority for an agency to provide non-urgent out-of-hospital medical services if it is owned or managed by an individual who is a threat to CIHCS patients as demonstrated by a criminal conviction. However, if someone enters into a plea deal and is granted a deferred sentence, patients may still be at risk.

[71] 6 CCR § 1011-3 3.1.1, Standards for Community Integrated Health Care Service Agencies.
[72] Colorado Legal Defense Group. *"Deferred Sentence" in Colorado—How does it work?* Retrieved August 16, 2024, from www.shouselaw.com/co/defense/sentencing/deferred-judgment/

Authorizing disciplinary action to be taken only in the case of a criminal conviction unnecessarily delays CDPHE's ability to take action necessary to protect the public considering the facts of the case. Instead, it must wait until a conviction is entered, which, in the case of a deferred sentence, could take several years and only happens if the individual violates the terms of the deferred sentence.

When a CIHCS agency is licensed by CDPHE, it creates the impression that the agency is safe to provide medical care and other services to patients. If a defendant pleads guilty or *nolo contendere*, the Division should be granted the authority to protect the public from harm regardless of an ultimate conviction. Otherwise, the CIHCS license could provide the public with a false sense of security.

While this change would grant the Division with the authority to take action based on a plea of guilty or *nolo contendere*, it would not require the Division to take action if the facts of the case do not support doing so. The Division would still have discretion to take action as it does in the case of a felony or misdemeanor conviction.

Therefore, the General Assembly should incorporate the acceptance by a court of a plea of guilty or *nolo contendere* with the authority to deny, revoke or refuse to renew a CIHCS agency license on the grounds that the owner, manager or administrator has a felony or a misdemeanor conviction involving conduct that could pose a risk to the health, safety or welfare of the agency's patients.

Recommendation 3 — Make technical amendments to the Act.

The Act has only been in place for a few years. However, as with any law, it contains instances of outdated and confusing language, and the Act should be revised to reflect current terminology and administrative practices. These changes are technical in nature, so they will have no substantive impact on the supervision of CIHCS agencies.

Therefore, the General Assembly should make the following technical changes:

- Amend the Act to make it gender neutral by replacing terms, such as "him," "her," "he" and "she" with gender-neutral terms;
- Amend the Act to change the term "consumers" to "patients or clients";
- Reference the definition of "community integrated health-care service," located in section 25-1.3-103(4.3), C.R.S., in the Act's definition of a "community integrated health-care service agency" for clarity;
- Clarify that community integrated health-care service as it relates to CIHCS agencies may also include mobile integrated health care; and
- Clarify that community integrated health-care service as it relates to CIHCS agencies may also include, as determined by rule, care and services provided by practitioners other than community paramedics.

Administrative Recommendation 1 — The Board of Health should repeal unnecessary rules.

During the sunset review, several rules were identified by stakeholders that should be repealed. These rules:

- Limit services provided by agencies to patients who overutilize 911 services or who do not have access to home care services,
- Require CIHCS providers to document that the patient has been rejected or is not appropriate for home care or hospice services, and
- Distinguish between single and recurrent visits.

The first and third sunset criterion questions whether regulation is necessary to protect the public and whether the existing rules establish the least restrictive form of governmental oversight consistent with the public interest, considering other available regulatory mechanisms.

The above rules were adopted when the licensing of CIHCS agencies was new to Colorado, and the purpose of the rules was to differentiate a CIHCS agency from a home care agency and to prevent duplication of services.

However, the program has been in place for several years, and these rules have proven to be unnecessary. CIHCS agencies are reportedly collaborating with health-care providers, home care agencies and other organizations in the communities where they are located, and no duplication of services has been reported.

As a condition of licensure, the Board of Health rules also require a CIHCS agency to perform a community needs assessment, which is better suited to differentiate a CIHCS agency from a home care agency and prevent duplication of services.

In a community needs assessment, a CIHCS agency must:

- Define the population and types of services to be provided,
- Define the geographic area to be served,
- Identify any unmet needs in the area to be served,
- Identify existing resources,
- Identify partners that support the program, and
- Coordinate with other resources and programs in the area.

The community needs assessment, while a significant undertaking, is valued by CIHCS agencies and other stakeholders, and it serves to ensure that CIHCS agencies are coordinating with other practitioners and organizations and closing gaps in access to health care as intended.

The rules previously outlined, however, unnecessarily limit the services that CIHCS agencies may provide and require unnecessary documentation in order to provide vital medical care and other services to members of the community.

Considering this, the Board of Health should repeal rules that:

- Limit services provided by agencies to patients who overutilize 911 services or who do not have access to home care services,
- Require CIHCS providers to document that the patient has been rejected or is not appropriate for home care or hospice services, and
- Distinguish between single and recurrent visits.