DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
Health Facilities and Emergency Medical Services Division

STANDARDS FOR COMMUNITY INTEGRATED HEALTH CARE SERVICE AGENCIES

6 CCR 1011-3

Adopted by the Board of Health on _____________ 2017, Effective __________, 2017.

SECTION 1. STATUTORY AUTHORITY AND APPLICABILITY

1.1 The statutory authority for the promulgation of these rules is set forth in Sections 25-3.5-1301, et seq., and 26-3.1-111, C.R.S.

1.2 Any entity that performed any of the services that may be provided through a Community Assistance Referral and Education Services Program (“CARES Program”) pursuant to Section 25-3.5-1203(3), C.R.S. before January 1, 2015 may continue to offer such services and need not comply with the requirements of Section 25-3.5-1201 through Section 25-3.5-1204, C.R.S.. However, an Agency that performs the services set forth in Section 25-3.5-1303(1), C.R.S., must comply with the requirements set forth in Section 25-3.5-1301, C.R.S. et seq., and these rules.

SECTION 2. DEFINITIONS

2.1 Administrator: The term “Administrator” is synonymous with the term “Manager” pursuant to Section 25-3.5-1301(2), C.R.S. For purposes of these rules, the term “Administrator” shall be used and means a person who controls and supervises or offers or attempts to control and supervise the day-to-day operations of a Community Integrated Health Care Service agency.

2.2 Advanced Practice Nurse (APN): An Advanced Practice Registered Nurse who is a professional nurse and is licensed to practice pursuant to Title 12, Article 38, who obtains specialized education or training as provided in Sections 12-38-103 (8.5), and 12-38-111.5, C.R.S. and who applies to and is accepted by the State Board of Nursing for inclusion in the advanced practice registry.

2.3 At-Risk Adult: An individual eighteen years of age or older who is susceptible to mistreatment or self-neglect because the individual is unable to perform or obtain services necessary for his or her health, safety, or welfare, or lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his or her person or affairs.

2.4 Authorized Entity: A licensed ambulance service; a fire department of a town, city, or city and county, a fire protection district, ambulance district, health assurance district, health service district, or metropolitan district, or special district authority; or a health care business entity, including a licensed or certified health care facility that is subject to regulation under Article 3 of Title 25 that performs any of the services that may be provided through a Community Assistance Referral and Education Services Program pursuant to Section 25-3.5-1203(3), C.R.S..

2.5 Care Coordination: The deliberative organization of consumer care activities between two or more participants, including the consumer, involved in a consumer’s care to facilitate the delivery of out-of-hospital medical services.
2.6 Care Provider: For the purposes of these rules, a Care Provider is a person who, under state law, has the authority to provide, coordinate, or order out-of-hospital medical services for his or her patients to be provided by CIHCS Providers, and who collaborates with CIHCS agencies on the patient’s behalf.

2.7 CIHCS Medical Director (Medical Director): A Colorado licensed physician and/or APN 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; except that if the agency hires or contracts with a Community Paramedic, only a licensed physician in good standing may supervise, direct, and assure the competency of Community Paramedics.

2.8 Community Assistance Referral and Education Services Program (CARES Program): A program established by an authorized entity as defined in Section 25-3.5-1202(1), C.R.S. to provide community outreach and health education to residents within the authorized entity’s jurisdiction with the purposes of preventing illness and injury, or reducing the incidence of 911 calls and hospital emergency department visits made for the purpose of obtaining nonemergency, non-urgent medical care or services.

2.9 Community Integrated Health Care Services Provider (CIHCS provider): A person who, through employment or under contract, performs certain out-of-hospital medical services, as determined by rule, on behalf of a CIHCS Agency:

2.9.1 A Community Paramedic as defined in Section 2.11 of these rules acting within his or her scope of practice.

2.9.2 An individual who:

A) Is a health care provider who holds a valid Colorado license, registration, or certification by the Colorado Department Of Regulatory Agencies (DORA) and is in good standing; and

B) While acting within the scope of his or her license or certificate is supervised and directed by a CIHCS agency medical director.

2.9.3 An individual who is employed by or contracted with the CIHCS agency who is not subject to regulation by DORA but who otherwise lawfully engages in unregulated practices, including but not limited to, dietetics, nutrition counseling, x-ray technology or phlebotomy while under the supervision and direction of a CIHCS Agency medical director to furnish community integrated health care services as defined in Section 25-3.5-103(4.3), C.R.S. and as defined in these rules.

2.9.4 Anyone employed by or contracted with the CIHCS Agency who is involved in the fulfillment of a consumer’s service plan.

2.9.5 Except as provided in Section 5.3.4(C), EMS Providers who are not endorsed Community Paramedics are prohibited from providing out-of-hospital medical services to a consumer when employed by or contracting with a CIHCS Agency.

2.10 Community Integrated Health Care Services (CIHCS): The provision of certain out-of-hospital medical services as determined by these rules that a Community Paramedic and other qualified CIHCS Providers may provide and may include:
2.10.1 Services authorized pursuant to Section 25-3.5-1203(3) C.R.S. and as set forth in this rule;

2.10.2 Services authorized under the scope of practice as set forth in 6 CCR 1015-3, Chapter Two for a currently certified Colorado paramedic in good standing who is endorsed as a Community Paramedic; and

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

2.11 Community Integrated Health Care Service Agency (CIHCS Agency or 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 Article 3 of Title 25 that manages and offers, directly or by contract, community integrated health care services.

2.12 Community Paramedic: An emergency medical service provider as defined in Section 25-3.5-104(8), C.R.S. who obtains an endorsement in community paramedicine pursuant to Sections 25-3.5-203.5 and 206, C.R.S. and performs, in addition to a paramedic’s scope of practice, authorized tasks and procedures and acts within the scope of practice as established in these rules, and 6 CCR 1015-3, Chapter Two including:

2.12.1 An initial assessment of the patient and any subsequent assessments, as needed;

2.12.2 Medical interventions;

2.12.3 Care coordination;

2.12.4 Resource navigation;

2.12.5 Patient education;

2.12.6 Inventory, compliance, and administration of medications; and

2.12.7 Gathering of laboratory and diagnostic data.

2.13 Consumer (CIHCS Consumer or Consumer): Means an individual receiving community integrated health care services.


2.15 DORA: The Colorado Department of Regulatory Agencies.

2.16 Initial Assessment: As used in these rules, means the Agency’s evaluation of the consumer’s immediate needs.

2.17 Licensed in Good Standing: As used in these rules, means any individual providing services pursuant to these rules who holds a current and valid Colorado license, registration, or certification to provide services under the applicable licensing, registration, or certification authority and who is not subject to any restrictions.

2.18 Medical Direction: For purposes of these rules means the supervision and direction of individuals who perform acts on behalf of an Agency by a physician and/or advanced practice
registered nurse (APN) who is licensed in Colorado and is in good standing, and who is identified as being responsible for assuring the competency of those individuals in the performance of acts on behalf of the Agency. If the Agency hires or contracts with a Community Paramedic, only a Colorado-licensed physician in good standing may provide medical direction for a Community Paramedic provider.

2.19 Out-of-Hospital Medical Services: For purposes of these rules means performing the initial assessment of the consumer and any subsequent assessments, as needed, furnishing of medical treatment and interventions, care coordination, resource navigation, patient education, medication inventory, compliance, and administration, and gathering of laboratory and diagnostic data. Such services also include nursing services, rehabilitative services, complementary health services, and behavioral health services that may be provided out-of-hospital, as well as the furnishing of other necessary out-of-hospital services and goods for the purpose of preventing, alleviating, curing or healing human illness, physical disability, physical injury, or alcohol, drug, or controlled substance abuse. All out-of-hospital medical services must be performed within each CIHCS Provider’s scope of practice.

2.20 Owner: An officer, director, general partner, limited partner, or other person having a financial or equity interest of twenty-five percent or greater.

2.21 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.

SECTION 3. REQUIRED POLICIES AND PROCEDURES

All policies and procedures shall be documented in writing and available for Department inspection.

3.1 Related to Consumer Rights

3.1.1 The Agency shall develop and implement policies and procedures regarding rights of the consumer. These policies and procedures shall be made available in writing to the consumer at the initiation of community integrated health care services. At a minimum, the policies and procedures shall include:

A) The right of the consumer to participate in the development of the service plan;

B) The right of the consumer and his or her property to be treated with respect;

C) The right of the consumer to be free from discrimination in the provision of services;

D) The right of the consumer to consent to receive and to discontinue Agency services at any time;

E) The right of the consumer to have personally identifying health information protected from unnecessary disclosure;
The right of the consumer or his or her representative to file a complaint with the Agency and/or Department concerning services or care that is or is not furnished, and receive documentation of the existence of the investigation and resolution of the complaint, including providing the complainant with the results of the investigation and the Agency’s plan to resolve any identified issues;

The right of the consumer to file a complaint with the Agency and/or Department without fear of discrimination or retaliation by the CIHCS Agency owner, administrator, or any CIHCS provider or Agency staff; and

The right of the consumer to formulate an advanced directive.

### 3.2 Related to Staffing

#### 3.2.1 The Agency shall develop and implement policies and procedures establishing that each employee and contracted staff possesses, at a minimum:

A) The education, experience, and training, including adequate clinical knowledge of and competence in performing medical skills and acts within the CIHCS provider’s scope of practice, to provide services in the homes of consumers, in compliance with Sections 5.3.1 through 5.3.5 of these rules; and

B) Good moral character. If the Agency employs or contracts with any individual convicted of a felony or misdemeanor, the Agency shall develop policies and procedures to ensure that the individual does not pose a risk to the health, safety and welfare of the consumer.

#### 3.2.2 The Agency shall also develop and implement policies and procedures:

A) Ensuring adequate staffing and resources to meet each consumer’s needs;

B) Concerning the supervision of CIHCS providers, and the evaluation of their performance, to comport with the requirements of Sections 5.1.1(C)(i) and 5.2.3(A)(i) and (ii) of these rules;

C) Establishing that any on-call medical director[s], administrator, and/or CIHCS provider[s] will have access to all pertinent current consumer information;

D) Ensuring proper staff utilization and availability, in compliance with these rules;

E) Designating medical direction back-up, in accordance with the requirements of Sections 5.1.1(C)(ii) and 5.2.3(A)(vii) of these rules, for when the Agency medical director is unavailable;

F) Designating administrative back-up when the Agency administrator is unavailable, in accordance with the requirements of Section 5.1.1(B)(iv) of these rules;

G) Ensuring that the Agency complies with the requirements of Sections 26-3.1-107(6), C.R.S, on and after January 1, 2019.
3.2.3 The Agency shall also develop and implement training policies and procedures that:

A) Ensure the Agency’s oversight of training that is specific to the community integrated health care services provided to the community and to the equipment used by the Agency;

B) Establish the minimum amount of training its providers must receive annually;

C) Promote consumer dignity, independence, self-determination, privacy, choice and rights; and

D) Without limitation, address the following items:
i) Abuse and neglect prevention and reporting requirements;

ii) Behavior management techniques;

iii) Disaster and emergency procedures;

iv) Infection control, including standard universal precautions; and

v) Topics and subject matter that educate providers on community resources and other available services.

3.3 Related to Initial and Subsequent Assessments, Service Planning, and Care Coordination

3.3.1 The Agency shall develop and implement policies and procedures concerning the assessment, service planning, and care coordination services it conducts when providing out-of-hospital medical services to the consumer. At a minimum, such policies and procedures shall establish how the Agency will:

A) Secure consent to obtain the consumer’s medical records;

B) Determine the consumer’s eligibility for recurrent services, in compliance with Section 6.1 of these rules;

C) Comply with the initial and subsequent consumer assessments requirements set forth in Section 8.4 of these rules;

D) Develop and execute consumer service plans in accordance with Sections 8.3 and 8.5 of these rules;

E) Determine and document the appropriate CIHCS provider[s] who are necessary to fulfill the consumer’s service plan goals;

F) Coordinate care across multiple providers, as applicable;

G) Require providers to document every consumer visit in compliance with Section 7.1.5 of these rules;

H) Refer consumers to a higher level of medical care and/or to other appropriate resources that may assist in the resolution of other issues identified in the
initial and any subsequent assessments, in compliance with Section 7.1.1 of these rules; and

I) Under circumstances in which the Agency has co-medical directors, delineate the line of authority and medical oversight each medical director must exercise with respect to each consumer.

3.4 Related to Access to Services and Consumer Records

3.4.1 The Agency shall develop and implement policies and procedures describing, at minimum:

A) How consumers may contact the CIHCS Agency;

B) That the consumer’s documentation of diagnostic and therapeutic procedures, treatments, tests and their results, if applicable, are available upon request; and

C) That all releases of personally identifying health information are consistent with applicable state and federal law.

3.5 Related to Discharge

3.5.1 The Agency shall develop and implement policies and procedures concerning the consumer’s discharge in accordance with Section 8.6 of these rules that, at minimum, shall require that:

A) Discharge planning be initiated in a timely manner to allow for the arrangement of any other appropriate and necessary care;

B) A discharge plan and summary be included in the consumer’s CIHCS Agency record; and

C) The Agency solicit consumer input regarding his or her satisfaction with the CIHCS provider and services received for quality management purposes.

3.6 Related to Complaints

The CIHCS Agency shall develop and implement policies and procedures that address, at a minimum, the following:

3.6.1 The CIHCS Agency’s duty to provide consumers with contact information for the Department and Agency staff responsible for complaint intake and problem resolution;

3.6.2 The process by which consumers or others can submit verbal or written complaints to the Department and/or directly to the Agency about services or care;

3.6.3 How the Agency will document investigation of, and resolution process for, any complaint made concerning Agency services and providers, including the Agency’s mandatory notification to the complainant about the results of the investigation and the agency’s plan to resolve the identified issue(s);
3.6.4 The Agency’s incorporation of the substantiated findings of any complaint into its quality management program for the purpose of evaluating and implementing systematic changes where needed; and

3.6.5 The Agency’s explicit statement that it does not discriminate or retaliate against a consumer for expressing a complaint or multiple complaints.

3.7 Related to Required Reporting

3.7.1 The Agency shall develop and implement policies and procedures regarding occurrences and other reporting requirements in Sections 10.1 and 10.2 of these rules.

3.7.2 Every CIHCS Agency shall develop and implement a policy and procedure regarding its duty to define deaths reportable to the local county coroner under Section 30-10-606(1), C.R.S. in a manner consistent with the local coroner’s reporting policy.

3.8 Related to Quality Management Program

3.8.1 The Agency shall develop and implement policies and procedures that require and document that the quality management program complies with Section 7.2 of these rules.

3.9 Related to Records

3.9.1 The Agency shall develop and implement policies and procedures that establish and document its record retention requirements, including the length of time the Agency must retain records for Department inspection in compliance with Section 4.6.3 of these rules.

3.9.2 The Agency shall develop and implement policies and procedures that establish and document its personnel file retention requirements for all employees.

A) Personnel records for all employees shall include references, dates of employment and separation from the Agency, and the reason for separation.

B) Personnel records for all employees shall also include:

i) Current documentation of qualifications and any licenses, certifications, endorsements, or registrations. Qualifications include confirmation of type and depth of experience, advanced skills, training and education, and appropriate, detailed and observed competency evaluation and written testing overseen by a person with the same or higher validated qualifications;

ii) Orientation to the Agency;

iii) Job descriptions for all positions assigned by the Agency; and

iv) Annual performance evaluation for each employee.

SECTION 4. LICENSING

4.1 License Required
4.1.1 On or after July 1, 2018, a person, 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 Article 3 of Title 25, C.R.S. shall not manage and offer, directly or by contract, community integrated health care services or operate or maintain a CIHCS Agency without having submitted a completed application for licensure as a Community Integrated Health Care Service Agency.

4.1.2 On or after December 31, 2018, a person, 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 Article 3 of Title 25, C.R.S. shall not operate or maintain a CIHCS Agency without a community integrated health care services license issued by the Department.

4.1.3 A license as a Community Integrated Health Care Service Agency is not required for an entity that only provides the following services:

A) Health education and information available on relevant services; and/or

B) Referrals for and information concerning low-cost medication programs and alternative resources to the 911 system.

4.1.4 A person, including an owner or administrator of a CIHCS Agency, who violates Sections 4.1.1 and 4.1.2 of these rules shall be guilty of a misdemeanor and, upon conviction thereof:

A) Shall be punished by a fine of not less than fifty dollars nor more than five hundred dollars; and

B) May be subject, pursuant to Section 25-3.5-1302(2)(a)(ii), C.R.S., to a civil penalty assessed by the Department for an amount of up to $10,000 per violation of Sections 4.1.1 and 4.1.2.

4.2 License Procedure

4.2.1 No later than July 1, 2018, an applicant as described in Section 4.1.1 of these rules that provides or intends to provide, directly or by contract, community integrated health care services must submit a completed application in the manner and form required by the department.

4.2.2 An applicant for an initial license, or a licensee holding a Community Integrated Health Care Service Agency license, shall comply with the requirements of 6 CCR 1011-1, Chapter 2, Section 2.7 regarding the process for change of ownership.

4.2.3 When applying for an initial or renewal license, the applicant Agency shall include evidence of either general liability insurance coverage or a surety bond in lieu of general liability insurance coverage. Such coverage shall be maintained for the duration of the license period and shall include coverage for the Agency and any staff that the Agency employs or contracts with.

A) An applicant Agency that is not granted qualified immunity under Section 24-10-101, C.R.S., et seq., shall provide proof of either general liability insurance...
or a surety bond. The minimum amount of general liability insurance coverage or surety bond shall be as set forth in Section 24-10-114(1)(a), C.R.S.

B) An applicant Agency that is granted qualified immunity under the Colorado Governmental Immunity Act, Sections 24-10-101, C.R.S. et seq., shall provide proof of general liability insurance in an amount not less than the amount calculated in accordance with Section 24-10-114(1) (a)(1) and (1)(b), C.R.S.

4.2.4 Fingerprints

A) With the submission of an application for an Agency license, or within ten (10) calendar days after a change in the Agency owner and/or Agency administrator, each owner and administrator of an Agency applying for a license shall submit a complete set of his or her fingerprints to the Colorado Bureau of Investigation for the purpose of conducting a state and national fingerprint-based criminal history record check utilizing the records of the Colorado Bureau of Investigation and the Federal Bureau of Investigation.

B) Each owner and administrator is responsible for paying the fee established by the Colorado Bureau of Investigation for conducting the criminal history record check.

C) If an owner or administrator has twice submitted to a fingerprint-based criminal history record check to either the Federal Bureau of Investigation or the Colorado Bureau of Investigation, and the fingerprints are deemed unclassifiable, then the department may acquire a Colorado Bureau of Investigation and/or Federal Bureau of Investigation name-based criminal history report.

4.2.5 The Department may deny a license or renewal of a license if the applicant or Agency owner or administrator has been convicted of a felony or misdemeanor which involves conduct that the Department determines could pose a risk to the health, safety, or welfare of community integrated health care services consumers.

4.2.6 The Department may review and investigate each initial and renewal license application to ensure the applicant’s compliance with these rules. The licensing determination shall be based on one or more of the following:

A) An on-site investigation of the Agency;

B) A review of the application and associated documents;

C) A review of the Agency’s compliance history, including the results of complaint investigations and occurrence reports;

D) Interviews with consumers and/or staff;

E) A review of required Agency policies and procedures; and

F) Any other information the Department determines is necessary to make a licensing determination.
4.2.7 Except as otherwise specified in these or other applicable rules, the Department shall issue or renew a license when it is satisfied that the applicant or licensee complies with these rules. The Department may refuse to issue or renew the license of an applicant or Agency that is out of compliance with the requirements of Section 25-3.5-1301, et seq, C.R.S. or these rules.

4.2.8 A license issued or renewed pursuant to this Section 4 shall expire after one (1) year.

4.2.9 A Community Integrated Health Care Service Agency license is not transferable. The license is only valid while in the possession of the licensee to whom it is issued and shall not be subject to sale, assignment or other transfer, voluntary or involuntary, nor shall a license be valid for any purposes other than those for which it was originally issued.

4.2.10 If the Department denies an application for an initial or renewal license, the Department shall notify the applicant in writing of such denial by mailing a notice to the applicant at the address shown on the application.

4.2.11 Denial of a license may be appealed within 60 days of receipt of the written notice of denial. Requests for the Department to set a hearing must be in writing.

4.2.12 All hearings on license denials shall be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101, C.R.S., et seq.

4.3 Required License Information

In addition to any other information requested in the Department approved application, the applicant shall provide the following:

4.3.1 Community Needs Assessment

A) Any applicant for a Community Integrated Health Care Services Agency license shall submit the following information:

i) A description of the program, population to be served, and types of services the applicant intends to provide;

ii) A description of the geographic area that it intends to serve and a list of the contiguous counties that it plans to serve within the declared geographical area;

iii) A description of how the applicant intends to coordinate with existing resources and programs, including licensed health care facilities;

iv) A description or plan of how the applicant will identify the needs of the community that it will serve;

v) Identification of:

   a) Any partners the applicant intends to work and collaborate with, if any, to achieve program goals, and the groups or organizations within the community that support the program, if any; and
b) A community’s specific needs, such as communication or language barriers, social support systems, environmental concerns, transportation accessibility issues, and any other appropriate information regarding barriers to meeting a consumer’s non-medical goal and/or health related outcomes within the community.

B) If the licensee modifies its community needs assessment, it shall notify the Department in writing at the time it submits its license renewal application to the Department.

C) The Department may request supplemental information for clarification of any information submitted for the community needs assessment prior to initial or ongoing licensing approval.

4.3.2 Other required information

A) Proof of general liability insurance or surety bond as specified in Section 4.2.3 of these rules;

B) Identification of the Agency’s medical director(s);

C) Identification of the Agency’s administrator;

D) The CIHCS Agency shall make available copies of its policies and procedures required by Section 4.2.4 of these rules;

E) Compliance with fingerprint requirements in Section 4.2.4 of these rules;

F) After January 1, 2019, compliance with the Colorado Adult Protective Services Data System (CAPS Check) requirements set forth in Section 26-3.1-111, C.R.S.;

G) The CIHCS Agency shall make available the quality management program to the Department for review during the initial licensure survey and all subsequent surveys; and

H) Any other information the Department determines is necessary to make a licensing determination.

4.3.3 In addition to the information required by Sections 4.3.1 and 4.3.2 of these rules, an applicant shall provide written notification to the Board of County Commissioners of the jurisdictions in which it plans to operate that the applicant intends to obtain a Community Integrated Health Care Service license. The applicant shall also provide a copy of the written notification to the Department.

4.3.4 The appropriate fee(s) shall accompany the initial or renewal license application.

4.4 Provisional License

4.4.1 Circumstances warranting a provisional license

A) The Department may issue a provisional license to any applicant for an initial license to operate a Community Integrated Health Care Service Agency for a period of ninety (90) days if the applicant is temporarily unable to conform to
all the minimum standards required by this chapter. However, no provisional license shall be issued to an applicant if the operation of the applicant’s CIHCS Agency will adversely affect the health, safety, or welfare of the CIHCS consumers.

B) The Department may issue a second provisional license for the same duration if the Department determines substantial compliance with these requirements is occurring and shall charge the same fee as for the first provisional license. If the licensee has made a timely and sufficient application for renewal of the provisional license, the existing license shall not expire until the Department has acted upon the renewal application. The Department may not issue a third or subsequent provisional license to the applicant, and in no event shall an Agency be provisionally licensed for a period to exceed one hundred eighty (180) calendar days.

C) As a condition of obtaining a provisional license, the applicant shall show proof to the Department that attempts are being made to conform and comply with applicable standards.

4.5 License Fees

All fees shall be based on the Department’s direct and indirect cost of implementing the program. Any entity, including an Agency wholly owned and operated by a governmental unit or agency, which applies to operate a CIHCS Agency shall pay the applicable fees.

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4.6 Inspections

4.6.1 The Department may conduct an inspection or re-inspection of the Agency and all aspects of its operations including policies and procedures, equipment, consumer records, staffing records, and other documentation, at any time it deems necessary to ensure compliance with these rules and to protect the health, safety and welfare of the Agency’s consumers. Additionally, the Department may conduct complaint and other investigations as needed.

4.6.2 Inspections may include evaluation of care and services at the consumer’s home with the consumer’s consent.

4.6.3 The CIHCS Agency shall retain its consumer records in accordance with state and federal requirements, but for no less than four (4) years and those records shall be readily available to the Department during inspection and/or investigation. The...
Department will keep medical records and personally identifying health information obtained during an inspection confidential, and those records are exempt from disclosure.

4.6.4 Consumer records kept in the home or individual consumer documents not included in the CIHCS Agency permanent record shall be made available to the Department within two hours of request if the visit occurred 14 or more days prior to the request. The time for production may be extended at the Department’s discretion.

4.6.5 The consumer file and administrative records, including, but not limited to, census and demographic information, complaint and incident reports, meeting minutes, quality management and annual program review documents, shall be provided to the Department commencing within 30 minutes of request. The time for production may be extended at the Department’s discretion.

4.7 Plan of Correction

4.7.1 After any Department inspection or complaint investigation, the Department may request a plan of correction from a CIHCS Agency. A plan of correction shall be in the format prescribed by the Department and shall address, at minimum, the following:

A) Corrective action that will be accomplished for those consumers who have been affected by the deficient practice;

B) Identification of other consumers having the potential to be affected by the same deficient practice and the corrective action implemented;

C) Root cause(s) that led to the deficient practice; identify measures that will be put into place, along with any systemic changes made to ensure the deficient practice will not recur;

D) Monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency(ies) cited remains corrected and/or in compliance with the regulatory requirements;

E) Overall date when corrective action will be completed.

4.7.2 Completed plans of correction shall be:

A) Submitted within ten (10) calendar days after the date of the Department’s mailing of the written notice of deficiencies to the agency, unless otherwise required or approved by the Department; and

B) Signed by the Agency administrator.

4.7.3 The Department has the discretion to approve, modify or reject plans of correction.

A) If the plan of correction is accepted, the Department shall notify the Agency by issuing a written notice of acceptance within thirty (30) calendar days of receipt of the plan.

B) If the plan of correction is unacceptable, the Department shall notify the Agency in writing, and the Agency shall submit a revised plan of correction to
the Department within fifteen (15) calendar days of the date of the written notice.

C) If the Agency fails to comply with the requirements or deadlines for submission of a plan or fails to submit a revised plan of correction, the Department may reject the plan of correction and impose intermediate restrictions or conditions as set forth in Section 4.8 of these rules.

D) If the Agency fails to timely implement the actions agreed to in the plan of correction, the Department may impose intermediate restrictions or conditions as set forth in Section 4.8 of these rules.

4.8 Intermediate Restrictions or Conditions

4.8.1 The Department may impose intermediate restrictions or conditions on an Agency for violation of these rules that may include at least one of the following:

A) Retaining a consultant to address corrective measures;

B) Monitoring by the Department for a specific period;

C) Providing additional training to employees, owners, or administrators of the Agency;

D) Complying with a directed written plan to correct the violation; or

E) Paying a civil penalty of up to $10,000 per violation.

4.8.2 If the Department imposes an intermediate restriction or condition that is not the result of a serious and immediate threat to health or welfare, the Department shall provide the Agency with written notice of the restriction or condition. No later than ten (10) calendar days after receipt of the notice, the Agency shall submit a written plan to the Department setting forth the time frame in which it will complete the directed plan of correction.

4.8.3 If the Department imposes an intermediate restriction or condition that is the result of a serious and immediate threat to health, safety or welfare, the Department shall notify the Agency in writing, by telephone, or in person during an on-site visit.

A) The Agency shall remedy the circumstances creating the harm or potential harm immediately upon receiving notice of the restriction or condition.

B) If the Department provides notice of a restriction or condition by telephone or in person, the Department shall send written confirmation of the restriction or condition to the Agency within two (2) business days.

C) If the Department imposes an intermediate restriction or condition that requires payment of a civil penalty, the Agency may request and the Department shall grant a stay in payment of the penalty until final disposition of the restriction or condition. Additionally, the Department shall provide the Agency with an opportunity for a hearing in accordance with Section 24-4-105, C.R.S. on any civil penalty assessed.
4.9 Revocation or Suspension of License or Refusal to Renew License

4.9.1 The Department may revoke, suspend or refuse to renew the license of a Community Integrated Health Care Service Agency that is out of compliance with the requirements of Section 25-3.5-1301 et seq., C.R.S., other applicable laws, or these rules.

4.9.2 Revocation or suspension of an existing license or refusal to renew a license shall be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101, et seq., C.R.S.

4.10 Summary Suspension

4.10.1 The Department may summarily suspend an Agency’s license if it finds, after full investigation, that the Agency has engaged in deliberate and willful violation of Section 25-3.5-1301, et seq., C.R.S., other applicable laws, or these rules, or that the public health, safety, or welfare immediately requires emergency action.

4.10.2 If the Department summarily suspends an Agency’s license, it shall provide the Agency with notice explaining the basis for the summary suspension. Additionally, the notice shall inform the Agency of its right to appeal the action and that it is entitled to a prompt hearing concerning the revocation or suspension of the Agency license.

4.10.3 Appeals of a summary suspension shall be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101, et seq., C.R.S.

4.11 Annual Reporting to the Department

4.11.1 Within forty-five (45) days after an Agency’s annual license expiration, the Agency shall submit, in the format determined by the Department, the following information:

A) The number of persons served by the CIHCS Agency for the annual reporting period;

B) The types of CIHCS services provided;

C) The types of providers utilized by the Agency, including whether the CIHCS providers hold any licenses, registrations, or certifications;

D) The number of visits performed by each CIHCS provider type;

E) The number of consumers who received community integrated health care services from a single visit;

F) The number of consumers who received community integrated health care services from recurrent visits;

G) An evaluation and determination of whether the Agency meets the needs it identified in its community needs assessment;

H) A measurement of any reduction in visits to an emergency department for nonemergency, non-urgent medical assistance by persons served by the CIHCS Agency; and
The results of any Agency performance reviews received from consumers and collaborative partners.

SECTION 5. ADMINISTRATOR, MEDICAL DIRECTOR AND OTHER STAFF

5.1 Administrator

5.1.1 Minimum Qualifications

A) The administrator shall:

i) Be at least 21 years of age and of good moral character;

ii) Be qualified by education, knowledge and experience to oversee the community integrated health care services provided; and

iii) Have at least two (2) years healthcare, emergency medical service agency or health service administration experience with at least one (1) year of supervisory experience in home care, emergency medical services, or a closely related health program.

B) Responsibilities

The administrator shall assume authority for the CIHCS Agency’s business operations including, but not limited to:

i) Managing the business affairs and the overall operation of the CIHCS Agency;

ii) Organizing and directing the Agency’s ongoing functions;

iii) Overseeing a budgeting and accounting system;

iv) Designating in writing a qualified back up administrator to act in the administrator’s absence;

v) Maintaining availability of a qualified administrator at all hours employees are providing services;

vi) Ensuring the Agency’s community integrated health care services are in compliance with all applicable federal, state and local laws;

vii) Ensuring the completion, maintenance and submission of such reports and records as required by the Department;

viii) Providing ongoing liaison with the CIHCS providers, Agency staff members and the community;

ix) Establishing a current organizational chart to show lines of authority down to the consumer level;

x) Maintaining appropriate personnel records, financial and administrative records and all policies and procedures of the Agency;
Ensuring that marketing, advertising and promotional information accurately represents the CIHCS Agency, and addresses the care, treatment and services that the Agency can provide directly or through contractual arrangement; and

Hiring and employing or contracting with sufficient qualified personnel to operate the Agency’s services in accordance with:

a) Written job descriptions;

b) Applicable licensing, certification or registration requirements in compliance with state laws and regulations;

c) Each CIHCS provider’s scope of practice, if applicable; and

d) The provisions of Sections 26-3.1-111(6), C.R.S., on or after January 1, 2019. Prior to hiring or contracting with a person who will provide direct care to an at-risk adult as defined in Section 2.3 of these rules, the administrator shall ensure that it has required each prospective Agency employee and contractor to submit to a CAPS Check, as defined in section 26-3.1-101(1.8), C.R.S.

The administrator shall, in collaboration with the Agency’s medical director:

i) Ensure appropriate education, supervision and evaluation of Agency staff;

ii) Designate through policy a backup for medical direction for when the Agency medical director is unavailable in accordance with the requirements of Section 5.2.3(A)(vii) of these rules; and

iii) Develop and implement a quality management program for the Agency and CIHCS provider services.

5.2 Medical Director’s Qualifications, Duties and Training

5.2.1 Nothing in these rules prohibits a CIHCS Agency from employing or contracting with an APN and physician medical director to serve as co-medical directors for the Agency. The Agency shall clearly delineate and document those CIHCS providers over whom each co-medical director retains supervisory and medical direction oversight as defined in Section 2.18 of these rules.

5.2.2 Qualifications. A CIHCS Agency’s medical director as defined in Section 2.7 of these rules, must possess the following minimum qualifications:

A) Physician medical directors:

i) Must be a physician currently licensed in good standing to practice medicine in the State of Colorado;

ii) Must possess authority under their licensure to perform all medical acts to which they extend their authority to CIHCS providers; and
iii) Must satisfy all requirements mandated in 6 CCR 1015-3, Chapter Two if the medical director also serves as an EMS Agency medical director.

B) Advanced Practice Registered Nurse (APN) medical directors:

i) Must be currently licensed in good standing to practice advanced practice nursing in the State of Colorado;

ii) Must possess authority under their licensure to perform all nursing functions and delegated medical functions in accordance with accepted practice standards for which they extend their authority to non-Community Paramedic-endorsed CIHCS providers;

iii) Must not be a medical director for any Community Paramedic-endorsed provider delivering medical services; and

iv) May only issue standing orders and protocols as authorized by law.

5.2.3 Responsibilities

A) A CIHCS Agency shall ensure that all CIHCS Agency medical directors perform the following responsibilities and duties:

i) Be actively involved in the provision of community integrated health care services within the community served by the CIHCS Agency. Involvement does not require that a physician or APN have such community involvement prior to becoming a medical director, but does require active involvement as the medical director. Community involvement could include, by way of example and not limitation, those inherent, reasonable and appropriate responsibilities of a medical director to interact, and, as necessary, collaborate with the community served by the CIHCS Agency, the hospital community, the public safety agencies, home care, hospice, and the medical community, and should include other aspects of liaison oversight and communication expected in the supervision of CIHCS providers;

ii) Be actively involved on a regular basis with the CIHCS Agency providers. Such involvement shall include at minimum, overseeing continuing education, provider supervision, care and service audits, developing protocols, and/or treatment policies and procedures;

iii) In collaboration with the administrator, develop a quality management program for the Agency and CIHCS provider services;

iv) In accordance with Agency policy, participate in the supervision and evaluation of the performance of CIHCS providers. This includes ensuring that CIHCS providers have adequate clinical knowledge of, and are competent in performing medical skills and acts performed on behalf of the CIHCS Agency within the CIHCS provider’s scope of practice and in accordance with state licensure, certification or registration requirements as applicable;
v) In collaboration with the administrator, oversee training and education programs for CIHCS Agency personnel regarding the provision of out-of-hospital medical services;

vi) Notify the Department within fourteen (14) business days of changes to the medical director’s position, including cessation of duties as the Agency’s medical director;

vii) In collaboration with the Agency administrator, designate through policy a backup for medical direction in accordance with the requirements of Section 3.2.2(E) of these rules for when the agency medical director is unavailable;

viii) Establish standards governing the CIHCS Agency services that can be provided to consumers during a single visit, pursuant to Section 8.2 of these rules;

ix) In conjunction with the CIHCS consumer’s care provider, if applicable, develop, monitor, and evaluate service plans as required by Section 8.5.1 of these rules;

x) When implementing the consumer service plan, ensure that consumer chart reviews are performed in compliance with the quality management plan to determine if appropriate assessments, referrals, documentations, and communications are occurring between the care provider(s), CIHCS providers, and the consumer; and

xi) In conjunction with the consumer’s care provider(s), if applicable, and CIHCS provider(s), develop and implement discharge summaries as part of each consumer’s service plan.

5.2.4 Additional physician medical director responsibilities for Community Paramedic oversight.

A) In addition to the responsibilities set forth in Section 5.2.3(A) of these rules, all physician medical directors shall:

i) Develop protocols and standing orders which are appropriate for the care and services offered by the Agency and conform to the certification, skill level and scope of practice of each CIHCS provider type.

ii) Conduct a review of the protocols and standing orders on an annual basis.

iii) Retain ultimate authority for establishing all protocols and standing orders pertaining to community integrated health care services provided by Community Paramedics.

B) In addition to the responsibilities set forth in Section 5.2.3(A) of these rules, a physician medical director who oversees Community Paramedics shall:
i) Oversee the training, knowledge and competency of endorsed Community Paramedics under his or her supervision and ensure that Community Paramedics are appropriately trained and demonstrate ongoing competency in all skills, procedures and medication administration and management as authorized in accordance with Section 6 CCR 1015-3, Chapter 2.

ii) Ensure that appropriate additional education and training is provided to supervised Community Paramedics and understand that certain skills, procedures and medications authorized in accordance with Section 6 CCR 1015-3, Chapter 2 (and as identified by the Department) may not be included in the education and training of Community Paramedics.

iii) Retain ultimate authority and responsibility for monitoring, supervising, evaluating and ensuring the competency of Community Paramedics in the delivery of care and services and the performance of authorized medical acts.

5.3 Staff and CIHCS Providers

5.3.1 General Requirements

A) The Agency shall ensure that each employee or contracted staff possesses the education, good moral character and experience to provide services in the homes of consumers in accordance with Agency policy, these regulatory requirements, state practice acts, and professional standards of practice.

B) The Agency shall ensure its providers and other relevant staff receive appropriate training.

i) The CIHCS Agency shall develop and implement a provider training policy that requires its CIHCS providers to undergo a minimum amount of annual training specific to the CIHCS Agency services provided to the community and the equipment used.

ii) The CIHCS Agency shall establish by policy the minimum annual amount of continuing education required of each CIHCS provider and, as applicable, administrative staff.

a) The minimum amount of required continuing education shall not be less than twelve (12) hours or twelve (12) educational sessions per year.

b) Continuing education requirements that CIHCS providers complete to maintain certification, license, or registration may apply to satisfy the annual minimum twelve (12) hour mandatory continuing education requirement.

C) All training and continuing education records shall be documented and retained by the Agency.

5.3.2 Responsibilities of all CIHCS Providers
A) CIHCS providers, acting within the scope of their relevant certification, license or registration, shall:

i) Participate as part of a community based team to provide integrated out-of-hospital medical services to address a consumer’s particular non-urgent medical condition; and

ii) Provide information to CIHCS Agency consumers about relevant local community resources and other collaborative services.

B) As required by these regulations and in accordance with Agency policy and procedures, the duties of a CIHCS provider shall at a minimum include:

i) Preparing clinical notes;

ii) Coordinating services;

iii) Communicating appropriate medical status and treatment information to the consumer and/or designated representative and, if applicable, consumer’s care provider; and

iv) Comply with all Agency reporting requirements set forth in Agency policy and these rules.

5.3.3 Requirements Applicable To Specific CIHCS Providers

A) CIHCS providers who are not regulated under DORA shall, at a minimum, meet the following requirements:

i) A registered dietician shall have successfully completed a program of formal training in nutrition with successful completion of the registration examination for dieticians.

ii) An X-ray technician shall:

   a) Have successfully completed a program of formal training in X-ray technology of not less than twenty-four (24) months in a school approved by the Committee on Allied Health Education and Accreditation of the American Medical Association or by the American Osteopathic Association; or

   b) Meet the requirements of 6 CCR 1007-1, Part Two (Appendix 2D—X-ray System Operator Adequate Radiation Safety Training And Experience, Including Limited Scope X-ray Machine Operator); or

   c) Have earned a bachelor’s or associate’s degree in radiological technology from an accredited college or university.

iii) A phlebotomist shall:
a) Have successfully completed an approved phlebotomy training course or have equivalent experience through previous employment; and

b) Have two (2) years of verifiable phlebotomy experience.

5.3.4 CIHCS Agency Provider Scopes of Practice

A) Community Paramedic scope of practice when providing out-of-hospital medical services on behalf of a CIHCS Agency.

i) Under the supervision and direction of the Agency’s physician medical director, an endorsed Community Paramedic may, in addition to performing his or her other authorized activities within the paramedic scope of practice, perform the following medical tasks and procedures:

a) An initial assessment of the consumer and any subsequent assessments, as needed, within the rules as promulgated in 6 CCR 1015-3, Chapter Two;

b) Medical interventions that are deemed permissible tasks and procedures as promulgated in 6 CCR 1015-3, Chapter Two, and are conducted within the rules set forth therein;

c) Care coordination;

d) Resource navigation;

e) Patient education;

f) Inventory, compliance, and administration of medications conducted within the rules promulgated in 6 CCR 1015-3, Chapter Two;

g) Gathering of laboratory and diagnostic data conducted within the rules promulgated in 6 CCR 1015-3, Chapter Two; and

h) Other community paramedic tasks and procedures as promulgated within the rules of 6 CCR 1015-3, Chapter Two.

B) Any services provided must not exceed the scope of practice of the Community Paramedic.

C) EMS Providers who are not endorsed Community Paramedics are prohibited from providing out-of-hospital medical services to a consumer when employed by or contracting with a CIHCS Agency; except that, in their capacity as CIHCS Agency providers, unendorsed EMS providers may perform:

i) Ancillary non-medical services with respect to non-emergent conditions (i.e. driving); and
Any of the services that may be provided through a CARES Program as set forth in Section 25-3.5-1203(3), C.R.S.

5.3.5 Other CIHCS Agency Providers When Performing Out-Of-Hospital Medical Services On Behalf Of a CIHCS Agency.

A) Under the supervision and direction of the Agency’s medical director, a CIHCS Agency provider who holds a license, registration or certificate to practice a profession in good standing may perform the authorized activities and skills listed for the provider’s license, registration, or certificate level on behalf of a CIHCS Agency within the applicable scope of practice as described in statute and rule.

SECTION 6. ELIGIBILITY STANDARDS

6.1 Standards Governing Eligibility for CIHCS Agency Services

6.1.1 Licensed CIHCS Agencies may provide out-of-hospital medical services to consumers who:

A) Over-utilize the 911 system; or

B) i) Do not qualify for home care or hospice services; or

ii) Have been rejected from, or have declined, or are unable to utilize home care or hospice services.

6.1.2 If a CIHCS Agency is going to provide continuing services to a particular consumer, the CIHCS Agency shall confirm and document that the consumer has been rejected from or is not appropriate for home care or hospice services, has declined home care or hospice services, or is otherwise unable to utilize home care or hospice services.

SECTION 7. STANDARDS GOVERNING CIHCS AGENCY OPERATIONS

7.1 A CIHCS Agency shall:

7.1.1. As necessary, refer consumers to a higher level of medical care and/or to other appropriate resources that may assist in the resolution of other issues identified in the initial and subsequent assessments;

7.1.2 Not utilize its license to circumvent licensing requirements of other facility (Agency) services;

7.1.3 Only enroll consumers with the reasonable expectation their needs can be met.

A) The Agency and consumer shall agree to the tasks to be provided and the frequency of visits.

B) If the consumer’s service plan requires care or services to be delivered at specific times, the Agency shall ensure it either employs qualified staff in sufficient quantity or has other effective back-up plans to ensure the needs of the consumer are met.
C) If applicable, to ensure the needs of the consumer are met, the Agency shall
provide the consumer with its after-hours contact information and/or with
contact information for the Agency's back-up provider.

D) In the event of the need to alter the consumer’s agreed-upon schedule of
visits, the consumer shall be notified as soon as practicable. If the consumer
has time-sensitive needs, the Agency shall initiate effective back-up plans to
ensure patient safety.

E) If there is a missed visit, services shall be provided as agreed upon by the
consumer and Agency.

7.1.4 Ensure that its operation and staff utilization will not place CIHCS consumers at risk of
harm or disrupt any other Agency services, including emergency services, the Agency
may be authorized to provide.

7.1.5 Ensure that its providers document each consumer visit/contact and include such
documentation in the consumer’s records.

7.1.6 Document evidence of the minimum qualifications and competencies of the Agency’s
medical director(s) and the administrator and his/her qualified substitutes.

7.1.7 Ensure that its CIHCS providers that are licensed, certified or registered meet the
requirements for their practice or profession.

7.2 Standards for Quality Management Program

7.2.1. Every CIHCS Agency applicant or licensee shall establish and implement a quality
management program that is appropriate to the size and type of the agency, evaluates
the quality of consumer care and safety, and complies with the requirements of this
section.

7.2.2 The program shall include, at minimum:

A) A general description of the types of cases, problems, or risks to be reviewed
and criteria for identifying potential risks, including without limitation any
incidents that may be required by Department regulations to be reported to
the Department;

B) Identification of the personnel responsible for coordinating quality
management activities, the means of reporting to the Agency administrator,
and the prescribed time within which the reporting must occur;

C) A description of the method(s) for:

i) Investigating and analyzing the frequency and causes of individual
problems and patterns of problems;

ii) Taking corrective action to address the problems, including prevention
and minimizing problems or risks;

iii) Evaluating corrective action[s] to determine the effectiveness of such
action[s];
iv) Coordinating all pertinent case, problem, or risk review information with other applicable quality assurance and/or risk management activities, such as review of consumer care; review of staff or CIHCS provider conduct; the consumer complaint system; and education and training programs;

D) Documentation of required quality management activities, including cases, problems, or risks identified for review; findings of investigations; and any actions taken to address problems or risks; and

E) A schedule for program implementation not to exceed 90 days after the date of the initial inspection.

7.2.3 The CIHCS Agency shall evaluate the discharge planning process periodically for effectiveness.

7.2.4 The CIHCS Agency shall periodically review treatment protocols and compliance with such protocols.

SECTION 8. PERMISSIBLE CIHCS AGENCY SERVICES

8.1 Purpose

The activities of licensed CIHCS Agencies are directed towards integrating the services of a community-based team of qualified CIHCS providers, based on local need, to address gaps in a community’s primary and public health care systems, to assess and treat consumers outside of the hospital setting for the purpose of preventing or improving a particular medical condition, and to reduce the burden of patients with non-emergent conditions who access the larger health care system through the emergency medical services system. CIHCS Agency services are intended to address the unmet needs of individuals who are experiencing intermittent health care issues and to prevent duplication of out-of-hospital medical care and services.

8.2 Standards Governing CIHCS Agency Evaluation and Treatment Services for Single Visits

8.2.1 A CIHCS Agency, under medical direction and within the applicable scope of the provider’s practice, may utilize its appropriate personnel to assess, provide, and/or coordinate out-of-hospital medical services during single visits.

8.2.2 A CIHCS Agency that is also an emergency medical services agency or that has contracted with an emergency medical services agency may utilize its appropriate personnel to:

A) Treat and release consumers with non-emergent conditions instead of transporting the consumer to a hospital or emergency department;

B) Treat and transport, as authorized by law, consumers with non-emergent conditions to appropriate destinations other than a hospital or an emergency department;

C) Treat and refer consumers with non-emergent conditions to a primary care or urgent care facility;
Assess the consumer with a non-emergent condition and communicate with a care provider to determine an appropriate course of action.

8.3 Standards Governing Recurrent CIHCS Agency Services

8.3.1 If the eligible consumer’s care provider, as defined in Section 2.6 of these rules, orders a CIHCS Agency to provide services specific to the consumer’s needs in a series of visits, the CIHCS Agency shall approve a service plan before providing services to the consumer. For purposes of these rules, “approval” of the service plan means, at minimum, that the Agency must review the service plan and, pursuant to these rules and the Agency’s policies and procedures, confirm that its providers can supply the ordered services within their scopes of practice.

8.3.2 If the Agency determines the consumer lacks adequate resources to obtain or access necessary out-of-hospital medical services, the CIHCS Agency may provide the consumer with such necessary services through a series of visits established in the consumer service plan that the CIHCS medical director shall approve.

8.3.3 The Agency will provide the services in accordance with the consumer’s service plan within the scope of services of the Agency, and will ensure continuous oversight of the consumer’s care up to and until the consumer’s discharge.

8.3.4 Evaluations of the consumer’s progress based on the goals established in the service plan shall be conducted as set forth in Sections 8.4.2 and 8.5.2 and documented in the consumer’s service records. CIHCS providers shall notify the Agency and/or the care provider regarding any changes that suggest a need to alter the service plan.

8.3.5 Each consumer service plan shall incorporate a defined discharge summary, as required in Sections 8.5.1(H) and 8.6 of these rules.

8.4 Standards Governing Initial and Subsequent Assessments

8.4.1 Initial Consumer Assessment

A) The CIHCS Agency shall ensure a qualified CIHCS provider conducts an assessment of the consumer’s immediate needs at the initial encounter.

B) The CIHCS Agency assessment shall:

i) Evaluate the consumer’s physical and psychological status, if applicable, including but not limited to the consumer’s special needs, communication or language barriers, capabilities, limitations, and short-term and long-term goals;

ii) Evaluate or screen the consumer for medical, therapeutic, social, nursing, and dietary service needs;

iii) Obtain a list of the consumer’s current medications and medication schedules;

iv) Identify social support systems, evaluate environment and discuss any transportation accessibility issues and barriers; and
Assess, obtain and identify other systems, situations, and information as deemed appropriate to improve the consumer’s life and/or health related outcomes.

8.4.2 Subsequent Assessments

A) CIHCS providers shall document and submit an individualized subsequent assessment that:

i) Accurately reflects the consumer’s current health status, goals, and timeframes for meeting the goals;

ii) Includes information that may be used to demonstrate the consumer’s progress toward achievement of the desired outcomes; and

iii) Identifies whether the consumer requires continuing CIHCS services or may be discharged.

B) Subsequent assessments shall occur when there is a significant change of condition.

C) Each subsequent assessment shall be submitted to the Agency for evaluation and use during the Agency’s preparation of periodic service plan reviews, as required in Section 8.5.2 of these rules.

8.5 Standards Governing CIHCS Agency Service Plans for Recurrent Services

8.5.1 This Section shall not apply to single visits described in Section 8.2 of these rules. Based on the initial assessment described in Section 8.4.1 of these rules, the CIHCS Agency shall ensure that a written service plan is developed or amended as needed to address the consumer’s pertinent diagnoses and needs. The service plan must include at minimum information on:

A) The consumer’s physical and mental status;

B) The consumer’s short and long-term healthcare needs and any goals, and timeframes for meeting those needs and goals;

C) A description of the out-of-hospital medical service[s] needed to address and satisfy the consumer’s health-care needs and any non-medical goals;

D) The frequency of visits along with the projected number of visits that may be required to address the consumer’s healthcare needs and any non-medical goals;

E) Identification of and written documentation setting forth the CIHCS Agency’s coordination of services provided to the consumer, including non-medical related goal outcomes;

F) A description of any equipment needed;

G) Limitations on the consumer’s activities; and
8.5.2 For recurrent services provided pursuant to Sections 8.3 and 8.5 of these rules the CIHCS Agency shall ensure that either the Agency medical director or the consumer’s care provider evaluates the subsequent assessments submitted by the CIHCS providers pursuant to Section 8.4.2 of these rules, and shall re-review the service plan when there is a significant change of condition.

8.6 Standards Governing Discharge

8.6.1 The Agency shall establish and follow a discharge planning process as set forth in Section 8.3.5 of these rules.

8.6.2 The CIHCS Agency shall develop a discharge summary for each consumer.

8.6.3 The discharge summary shall be discussed with the consumer or designated representative prior to discharge and shall include:

A) An evaluation of the post-CIHCS care needs and goals as outlined in the service plan, and a summary of the services the consumer received.

B) Contact information for the consumer to call in case the consumer has questions after discharge.

C) Written instructions about self-care, follow-up care, modified diet, medications, and signs and symptoms to be reported to the consumer’s care provider(s).

SECTION 9. COMPLAINTS

9.1 When services commence, the Agency shall provide each consumer with:

9.1.1 Contact information for the Department and the Agency staff responsible for complaint intake and problem resolution;

9.1.2 Information regarding how to initiate a complaint; and

9.1.3 Information regarding the Agency’s investigation and resolution process.

9.2 Complaints may be reported to the CIHCS Agency and/or the Department.

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

9.3.1 The Department may refer complaints made against medical directors to the Colorado Medical Board or the Colorado Board of Nursing for review.

9.4 The Agency shall refer to the appropriate regulatory body any credible allegation made against a CIHCS Agency provider who is licensed, regulated, or certified concerning the provision of care to the consumer, including an allegation concerning a provider acting outside of his or her scope of practice.
SECTION 10. REPORTING REQUIREMENTS

10.1 Occurrences

10.1.1 Pursuant to Section 25-3.5-1303(1)(f), C.R.S., each CIHCS Agency licensed pursuant to Section 25-3.5-1301 et seq., C.R.S., shall report to the Department the occurrences specified at Section 25-1-124 (2), C.R.S.

10.1.2 The Agency shall report the following occurrences to the Department in the format required by the Department by the next business day after the occurrence or when the CIHCS Agency becomes aware of the occurrence:

A) Any occurrence that results in the death of a consumer of the CIHCS Agency and is required to be reported to the coroner pursuant to Section 30-10-606, C.R.S., as arising from an unexplained cause or under suspicious circumstances;

B) Any occurrence that results in any of the following serious injuries to a consumer:

   i) Brain or spinal cord injuries;

   ii) Life-threatening complications of anesthesia or life-threatening transfusion errors or reactions;

   iii) Second or third degree burns involving twenty percent or more of the body surface area of an adult consumer or fifteen percent or more of the body surface area of a child consumer;

C) Any time that a consumer of the CIHCS Agency cannot be located following a reasonable search of the area, and there are circumstances that place the consumer’s health, safety, or welfare at risk or, regardless of whether such circumstances exist, the consumer has been missing for eight hours;

D) Any occurrence involving physical, sexual, or verbal abuse of a consumer, as described in Sections 18-3-202, 18-3-203, 18-3-204, 18-3-206, 18-3-402, 18-3-403, 18-3-404, or 18-3-405, C.R.S., by an employee or contractor of the CIHCS Agency;

E) Any occurrence involving neglect of a consumer as described in Section 26-3.1-101(7) (b), C.R.S.

F) Any occurrence involving misappropriation of a consumer’s property. For purposes of this paragraph, “misappropriation of a consumer’s property” means a pattern of or deliberately misplacing, exploiting, or wrongfully using, either temporarily or permanently, a consumer’s belongings or money without the consumer’s consent;

G) Any occurrence in which drugs intended for use by consumers are diverted to use by other persons; and

H) Any occurrence involving the malfunction or intentional or accidental misuse of consumer care equipment that occurs during treatment or diagnosis of a
consumer and that significantly adversely affects or if not averted would have
significantly adversely affected a consumer of the CIHCS Agency.

10.1.3 Any Agency reports submitted shall be strictly confidential in accordance with and
pursuant to Sections 25-1-124 (4), (5), and (6), C.R.S.

10.1.4 The Department may request further oral or written reports of the occurrence if it
determines such report is necessary.

10.1.5 No CIHCS Agency owner, administrator, or employee thereof shall discharge or in any
manner discriminate or retaliate against any consumer of a CIHCS Agency, relative or
sponsor thereof, employee of the CIHCS Agency, or any other person because such
person, relative, legal representative, sponsor, or employee has made in good faith or
is about to make in good faith, a report pursuant to this Section 10.1 or has provided
in good faith or is about to provide in good faith evidence in any proceeding or
investigation relating to any occurrence required to be reported by a CIHCS Agency.

10.1.6 Nothing in this Section 10 shall be construed to limit or modify any statutory or
common law right, privilege, confidentiality or immunity.

10.1.7 Nothing in this Section 10 shall affect a person's access to his or her medical record as
provided in Section 25-1-801, C.R.S., nor shall it affect the right of a family member or
any other person to obtain medical record information upon the consent of the
consumer or his/her authorized representative.

10.2 Other Required Reporting

10.2.1 The Agency shall ensure that:

A) All staff have knowledge of Article 3.1, Part 1 of Title 26, C.R.S., regarding
protective services for at-risk adults;

B) All staff have knowledge of Article 3, Part 3 of Title 19, C.R.S., if the Agency
provides services to pediatric consumers; and

C) All incidents involving neglect, abuse or financial exploitation are reported
immediately, through established procedure, to the Agency owner and
administrator.

10.2.2 In addition to the Agency’s reporting requirements described in Sections 10.1 and
10.2.1 of these rules, the Agency shall report all incidents described in Sections
10.1.1(D) of these rules to the appropriate officials as specified in statute. The Agency
shall make copies of all such reports available to the Department upon request.

Section 11. STANDARDS GOVERNING CIHCS AGENCY PROVISION OF CARES PROGRAM SERVICES

11.1 In addition to the services a CIHCS Agency may perform as authorized by these rules, a CIHCS
Agency may perform any of the community assistance referral and education services that
may be provided through a CARES Program as provided in Section 25-3.5-1203(3), C.R.S.

11.2 In addition to the reporting requirements required by Section 25-3.5-1303, C.R.S. and these
rules, any CIHCS Agency providing authorized community assistance referral and education
services shall comply with all service, notification, and reporting requirements set forth in Section 25-3.5-1201, *et seq.*, C.R.S.