From: <DeReamus@aol.com>
To: DOH-DOM1.PO-1(PTRIMBLE),DOH-DOM1.GWIA("pehsc@pehsc...
Date: Mon, Mar 15, 1999 2:53 am
Subject: Ambulance Association of Pennsylvania's Comments on Proposed Regulations

Please accept the comments on the Proposed Rules and Regulations to the
Emergency Medical Services Act, Act of 1985, P.L. 164, No. 45 as approved by
the Board of Directors of the Ambulance Association of Pennsylvania on Friday,
March 12, 1999 during the conference call.

These comments are to be forward by Elloise Frazier, Equire to the Independent
Regulatory Review Committee (IRRC) at thier request.

On behalf of Barry Albertson, President and the Ambulance Association of
Pennsylvania I must commend the work of the Department of Health - Emergency
Medical Services Office and Ms. Margaret E. Trimble and staff for an excellent
job on the revisions. EMS in Pennsylvania will benefit greatly under these
rules.

Respectfully submitted on behalf of the Board of Directors,

Donald A. DeReamus, Chairman
Department of Health/ACT 45 Committee
Ambulnace Association of Pennsylvania

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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1001.2. Definitions.

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 - page 918
Department of Health Document – page 76

Ambulance call report – A summary of an emergency ambulance response, nonemergency ALS response, interfacility transport, or nonemergency BLS transport that becomes an emergency. The report shall contain information in a format provided by the Department.

Comment/Recommendation:

The Ambulance Association of Pennsylvania respectfully requests a cost analysis be considered to assess the fiscal impact of this transition (paper to electronic data) on small and rural providers in the Commonwealth.

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
Ambulance Association of Pennsylvania
3600 Raymond Street
Reading, PA 19605
1-888-AMB-9121
FAX: 610-921-3075

COMMENT FORM FOR PROPOSED REGULATIONS
FEBRAURY 13, 1999

§1001.2. Definitions.

Department of Health Document – Page 80

Comment: The definition of ***Emergency*** should be revised to reflect the American College of Emergency Physician's prudent layperson definition of emergency which is prevalent in other legislation today.

Recommendation:

Emergency—[A combination of circumstances resulting in a need for immediate medical intervention.] The sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual, or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;

(2) serious impairment to bodily functions, or

(3) serious dysfunction of any bodily organs or parts.

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
Ambulance Association of Pennsylvania
3600 Raymond Street
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1001.2. Definitions.

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 921
Department of Health Document – page 85

Comment: The definition of ***receiving facility*** was revised to specify an organized department with a physician who is trained to manage cardiac, trauma, and pediatric emergencies. There appears to be a void of medical and psychiatric emergencies due to the specificity in the area of management. We believe the Department's intent was to have a physician that is well rounded in all disciplines.

Recommendation:

Receiving facility – A fixed facility that provides an organized emergency department [of emergency medicine], with a [licensed and ACLS certified] physician who is trained to manage cardiac, trauma, pediatric, **medical and psychiatric** emergencies, and is present in the facility [who is] and available to the emergency department 24 [hours a day] hours-a-day, 7 [hours a week] days-a-week, and a registered nurse who is present in the emergency department 24 [hours a day] hours-a-day, 7 [hours a week] days-a-week. The [facilities] facility shall also comply with Chapter 117 (relating to emergency services).

Contact Person: Donald A DeReamus, DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1003.23. EMT.

(e) Scope of practice

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 935
Department of Health Document – page 143

Comment: In §1003.23. EMT., (e) Scope of practice, the line **(2)** is a new addition and states:

(2) Transportation of a patient with an indwelling intravenous catheter without medication running.

With the advent of shorter patient inpatient stays and home health care, patients are using a vast array of patient controlled devices and other pumps monitored by visiting nurses. The language in the scope of practice is too specific and may cause potential confusion for an EMT finding a patient on an insulin pump, CADD pump, PCA pump, etc. If the medication is not the result of the problem or part of a normal outpatient treatment plan, it should not matter whether it is running or not.

Recommendation:

(e) Scope of practice
(2) Transportation of a patient with an indwelling intravenous catheter without medication running, **unless the medication is part of the patient's normal outpatient treatment plan.**

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1005.2. Applications.

§§(a), (5)

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 946
Department of Health Document – page 182

Comment: In §1005.2. Applications., (a), (5) has been reworded to state:

(5) [Service] The emergency service area [served – both primary and mutual-aid] the applicant commits to serve, or alternatively, a statement that the applicant intends to engage primarily in interfacility transports.

The Association feels that there is no need for an ambulance service to stipulate its business intent in the application process to become licensed. A licensed ambulance service in the Commonwealth is licensed to engage in whatever activity (emergency/non-emergency transportation and treatment) regardless of the arena they intend to perform in.

Recommendation:

§1005.2. Applications., (a)
(5) [Service] The emergency service area [served – both primary and mutual-aid] **the applicant is available to serve in.**

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1005.2. Applications.

§§(a), (9)

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 946
Department of Health Document – page 182

Comment: In §1005.2. Applications., (a), (9) is a new revision and states:

(9) Primary physical building locations, and other building locations out of which it will operate ambulances or a full description of how its ambulances will be placed and respond to emergency calls if they will not be operated out of other building locations.

The Association feels this question is answered in (a), (5) and an ambulance service should not have to stipulate in the application process to become licensed if they engage in system status management practice.

Recommendation:

§1005.2. Applications., (a)
(9) Primary physical building location, and other building locations out of which it will operate ambulances.

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1005.2. Applications.

§§(e)

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 946
Department of Health Document – page 183

Comment: In §1005.2. Applications., (e) is a new revision and states:

(e) An ambulance service shall apply for and secure an amendment to its license prior to substantively altering the location or operation of its ambulances in an EMS region, such as a change in location or operations which would not enable it to timely respond to emergencies in the emergency service area it committed to serve when it applied for a license. The application for an amendment of an ambulance service license shall be submitted to the regional EMS council on a form prescribed by the Department.

The Association feels this entry would be better defined with the addition of physical building in two areas before the word location and deleting committed and replacing it with the word available.

Recommendation:

§1005.2. Applications.

(e) An ambulance service shall apply for and secure an amendment to its license prior to substantively altering the **physical building** location or operation of its ambulances in an EMS region, such as a change in **physical building** location or operations which would not enable it to timely respond to emergencies in the emergency service area it is [committed] **available** to serve when it applied for a license. The application for an amendment of an ambulance service license shall be submitted to the regional EMS council on a form prescribed by the Department.

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1005.10. Licensure and general operating standards.

§§(a) *Documentation requirements.*, (4)

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 948
Department of Health Document – page 189

Comment: In §1005.10. Licensure and general operating standards., (a) *Documentation requirements.*, (4) the line has been revised and states:

> (a) *Documentation requirements.*
>
> (4) [Copies of mutual-aid agreements with other ambulance services which service the applicant's community or applicant's service area.] A record of the time periods for which the ambulance service notified the PSAP that it would not be available to respond to a call.

The Association would like to know on whom the burden would fall to record a service's unavailability. Some services that may not acknowledge an initial dispatch may never be aware the dispatch was missed creating inaccurate statistics. Additionally, a service may have its resources committed and be unable to respond. We believe the PSAP should be responsible for collecting this information for the unavailability of a service to meet its primary dispatch obligation.

Recommendation:

§1005.10 Licensure and general operating standards.

> (a) *Documentation requirements.*
>
> (4) [Copies of mutual aid agreements with other ambulance services which service the applicant's community or applicant's service area.] A record of the time periods **or specific dispatches as recorded by the PSAP for which the ambulance service was unable to respond to a primary emergency dispatch in it coverage area.**

Contact Person: Donald DeReamu. DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1005.10. Licensure and general operating standards.

§§(e) *Communicating with PSAPs.*, (4) Response to dispatch by PSAP.

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 950
Department of Health Document – page 194

Comment: In §1005.10. Licensure and general operating standards., (e) Communication with PSAPs., line (4) *Response to dispatch by PSAP* has been added and states:

(4) Response to dispatch by PSAP. An ambulance service shall respond to a call for emergency assistance as communicated by the PSAP.

The Association feels this line is not needed as this is covered in the previous three line. Additionally, the intent of the word shall lends one to the thought of potential liability.

Recommendation:

§1005.10. Licensure and general operating standards.
(e) *Communication with PSAPs.*
[(4) *Response to dispatch by PSAP.* An ambulance shall respond to a call for emergency assistance as communicated by the PSAP.]

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1001.2. Definitions.

Text discrepancies between the *Pennsylvania Bulletin* and Department of Health Document as retrieved from the Department of Health EMS Office website.

ALS service medical director – the words **[set forth]** are deleted in the *Pennsylvania Bulletin* but appear in the Department of Health Document.

Air ambulance medical director – the words **[set forth]** are deleted in the *Pennsylvania Bulletin* but appear in the Department of Health Document.

Critical care specialty receiving facility – **including, in one** of is present in the *Pennsylvania Bulletin* as opposed to **but not limited to, one** in the Department of Health Document.

EMSOF – the word **under** is present in the *Pennsylvania Bulletin* as opposed to **pursuant to** in the Department of Health Document.

Federal KKK standards – the words **[set up]** are deleted and replaced with the word **adopted** in the *Pennsylvania Bulletin.*

Medical [control] coordination – in (iv) **[Medical] Transfer and treatment** are present in the Pennsylvania Bulletin as opposed to **Transfer and [M]medical treatment** in the Department of Health Document.

Prehospital personnel – the entire line **Any one of these individuals is a "prehospital practitioner"** is not present in the *Pennsylvania Bulletin* but in the Department of Health Document.

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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Joseph E. McAndrew MD
275 Treasure Lake
DuBois, PA 15801
Home Phone (814)375-2327
Email josephmc@key-net.net

March 11, 1999

John R. McGinley Jr., Esq.
Chairman
Pennsylvania Independent Regulatory Review Committee
Harrisburg, PA 17120

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Dear Mr. McGinley,

Please review my attached letter to the Emergency Services Office regarding proposed amendments to 28 PA Code Part VII (relating to emergency medical services), proposed Chapter 1001, Subchapter A, Section 1001.2 (Definitions) and the potential effects of the proposed definition of "Board Certification" (page 119 of proposed rulemaking).

Most physicians practicing emergency medicine in rural Pennsylvania are not residency trained and board certified in Emergency Medicine. It is a supply and demand issue here and across the United States. Most of these individuals gravitate to the urban/suburban areas where pay and other benefits are higher. Physicians with training in Family and General Practice, Internal Medicine and other specialties competently provide the majority of care for our rural citizens. The situation is not likely to change in the near future.

The American Association of Physician Specialists, Inc (AAPS) Board of Certification in Emergency Medicine (BCEM) currently affords the only opportunity to provide board certification to physicians who have not completed a residency in emergency medicine. The so-called "practice-track" (establishment of eligibility to undergo testing for medical boards based on previous experience in the field) have been closed by the other major boards, ABEM (American Board of Emergency Medicine) and AOBEM (Osteopathic Board of Emergency Medicine).

Recognition of the AAPS Board of Certification in Emergency Medicine (BCEM) by the State of Pennsylvania is needed. It offers an opportunity for the rural physician to obtain a certification which will result in greater competence in emergency care and provide better service to the population he/she serves. Thank you for your attention to this issue.

Sincerely,

Joseph E. McAndrew MD
(St. Bonaventure Univ. '78)

Joseph E. McAndrew MD
275 Treasure Lake
DuBois, PA 15801
Home Phone (814)375-2327

ATTACHMENT

March 11, 1999

Ms. Margaret Trimble
Director
Emergency Medical Sevices Office
Department of Health
1027 Health and Welfare Building
P.O. Box 90
Harrisburg, PA 17108

Dear Ms Trimble,

I am writing to comment on proposed amendments to 28 PA Code Part VII (relating to emergency medical services) as published in the Pennsylvania Bulletin, Volume 29, Number 7, Part II, dated February 13, 1999. My comment is directed to proposed Chapter 1001, Subchapter A, Section 1001.2 (Definitions) and the effects of the proposed definition of "Board Certification" (page 119 of proposed rulemaking).

Physician board certification is becoming an essential element in the credentialling process for hospital and health care organizational accreditation, physician medical staff membership and soon for third party reimbursement. Medical specialty certification of physicians, however, remains a voluntary procedure in the United States. Many physicians have elected to seek formal recognition of their proficiency in their chosen area of medicine by presenting themselves for examination before specialty boards comprised of their peers. The definition of each specialty, in addition to the education and other requirements leading to accceptance into the certification process are developed by consensus within the medical profession. Specialty certification is separate and distinct from licensure.

I chose to present myself for the American Association of Physician Specialists, Inc. (AAPS) afffiliated Board of Certification in Emergency Medicine (BCEM). Like most physicians in rural Pennsylvania, and the United States, I am not residency trained in emergency medicine. To demonstrate my competence in emergency medicine, beyond the confidence my local medical and EMS staff have in my abilities, and to improve my knowledge base, I have applied and been accepted to sit for the BCEM boards. Other emergency medicine boards have been closed to individuals such as myself: those proficient in the practice of emergency medicine through years of experience, the so-called "practice track," and many with residency training in other areas of medicine such as internal medicine, family practice and general surgery (my area of previous training).

The proposed regulatory language of the above amendment will affect my practice directly, potentially limiting or eliminating my ability to practice in the area of medicine where I have practiced the past 10 years.

The Department seeks to define "board certification" in a manner that will exclude one private certifying body over another. Similar issues have been addressed at the federal level:

James M. Talent, Chair of the House of Representatives Committee on Small Business, in a request to the U.S. General Accounting Office to conduct a study on the professional certification practices and requirements of federal agencies, stated "diversity of certification has led, in some instances, to an informal system of preferences for one certification over another." He further stated that "these preferences often occur without any objective justification." This is an important point because these certifications are often a prerequisite for federal or state contracting opportunities or a requirement for compliance with regulations and guidelines.

My specialty society, The American Association of Physician Specialists, Inc. (AAPS), is a national organization incorporated in 1952 to provide a clinically-recognized mechanism for specialty certification of physicians. The AAPS is the administrative home for twelve boards of certification. Each AAPS affiliated board of certification has established criteria for examination development, examination validation, and candidate admission to the certification process. In recognition of the multiple mechanisms in the health care system that continuously monitor physician performance, each board provides a measureable, objective mechanism to meet the accreditation requirements of the multitude of organizations involved in accreditation and health care delivery.

The Regional Emergency Medical Services Council of New York City, Inc and the Regional Emergency Medical Advisory Committee of New York (REMAC) has recognized that the AAPS board, the Board of Certification in Emergency Medicine (BCEM) is equivalent to the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM). The New York REMAC determined, with the aid of counsel, that the examinations and requirements for admission to the certification process are equivalent, that there were no issues of quality of care provided by BCEM-certified physicians. The REMAC council further stated that, should the REMAC exclude BCEM-certified physicians, similarly certified ABEM physicians (those certified via the practice track) would also have to be excluded.

Even though the General Provisions of the proposed rulemaking provide that reference to specific certifying bodies would not preclude the department from considering persons with certifications by other private certifying bodies, the effect of the proposed language in the regulation will effectively exclude a cohort of physicians from participation in the Pennsylvania emergency medical system. Many private organizations, hospitals, health care insurers, managed-care organizations, and others generally follow the regulations established by the local governmental body. As such, many of these organizations will exclude those physicians certified by the American Association of Physician Specialists, Inc. (AAPS) boards of certification thinking they are in compliance with state regulations.

Therefore, we request that the language in proposed PA Code Chapter 1001, Subchapter A, Section 1001.2 (Definitions) be amended to include the American Association of Physician Specialists, Inc.

Our organization is prepared and willing to work with the Department of Health and the Emergency Medical Services Office in reaching appropriate criteria for recognition of boards of certification, and amending the language of the proposed regulation.

Sincerely,

Joseph E. McAndrew MD

DuBois Regional Medical Center
Making the difference for life.

EMERGENCY DEPARTMENT
P.O. BOX 447
100 HOSPITAL AVENUE
DUBOIS, PA 15801

FAX # (814) 375-3472

FAX NUMBER: (717) 783-2664

TO: JOHN R. MCGINLEY JR., ESQ / IRRC Chair

FROM: J. McAndrew MD

DATE: 3/11/99

TIME:

PAGES SENT *(including lead sheet)*: (5)

MESSAGE:

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If you do not receive all of the pages in good condition, please call Joseph McAndrew, MD, at (814) 375-~~3420~~ 3470.

Russell E. James II MD
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March 10, 1999

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Independent Regulatory Review Commission
John R.McGinley Jr. Esq.
Chairman
333 Market St.
Harrisburg, Pa. 17101

Dear Mr. McGinley and Comission Members:

My name is Russell E. James II MD and I am currently a licensed physician in the state of Pennsylvania. I am writing this letter to request your input into the proposed amendments to the EMS code in the state of Pennsylvania. Specifically I am referring to 28 PA Code Part VII, relating to the Emergency Medical Services as published in the Pennsylvania Bulletin, Volume 29, Number 7, Part II, dated February 13, 1999, My comment is directed at Chapter 1011, Subchapter A Section 1001.2 (Definitions) and the effects of the proposed definition of "Board Certification"(page 919 of the proposed rulemaking)
Enclosed you will find a letter to Ms. Trimble addressing this problem. I implore you to push for the acceptance of American Academy of Physician Specialists as an accepted board of certification. Currently the only accepted boards of certification which are the American Board of Emergency Medicine and the Osteopathic Board of Emergency Medicine. These were the only boards that were around when EMS was developed. The American Academy of Physician Specialists is an independent boar similar to the other boards but it has a total of twelve independent boards of certification including surgery, radiology, dermatology and others. I believe it is time to allow another board to be recognized and accepted.
If you have any questions do not hesitate to contact me or contact the board. The executive offices are located at 2296 Henderson Mill Road, Suite 206, Atlanta ,Georgia 30345. The telephone is 770-939-8559.
The review will be conducted starting on March 12 and your input would be so appreciated and important. This decision could affect the livelihoods of many of the physicians in the commonwealth in many ways in the future.
Thank you for your time..

Sincerely,

Russell E. James II MD

Russell E. James II MD
62 Division St.
Kingston, Pa. 18704
Fax 331-0710
Home Phone 570-288-0497
Email rjames8083@aol.com

March 10, 1999

Ms. Margaret E. Trimble
Director
Emergency Medical Services Office
Department of Health and Welfare Building
P.O. Box 90
Harrisburg, Pa. 17108

ORIGINAL: 2003
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Dear Ms. Trimble:

I am writing to comment on the proposed amendments to 28 PA Code Part VII,relating to Emergency Medical Services, as published in the Pennsylvania Bulletin, Volume 29, Number 7, Part II, dated February 13,1999. My comment is directed to proposed Chapter 1001, Subchapter A, Section 1001.2(Definitions) and the effects of the proposed definition of "Board Certification" (page 919 of proposed rulemaking).

Physician board certification has become an essential element in many instances of credentialing for the purposes of reimbursement, hospital and health care organizational accreditation, and physician staff membership. Medical specialty certification of physicians, however , remains a voluntary procedure in the United States. Some physicians have elected to seek formal recognition of their proficiency in their chosen field by presenting themselves for examination before specialty boards that are comprised of their professional peers. The definition of each specialty, in addition to the education and other requirements leading to the acceptance into the certification process are developed by consensus within the medical profession. Specialty certification is separate from licensure.

I choose to present myself for the American Association of Physician Specialists, Inc. (AAPS) affiliated Board of Certification in Emergency Medicine because in order to belong to this you must have multiple qualifications before you even take the examination including being board certified in another field not to mention multiple hours working as a full time emergency physician. Currently by not being recognized has cost me multiple hours of working in an emergency department because with a wife and four children I was unable to recertify in ATLS and my medical command was revoked. Our ABEM brethren do not have to take this course again without fear of their medical command being removed. I should also note that I have taken the course two times in the past and have passed at the instructors status. I have functioned as an ALS medical director, director of an emergency department and director of paramedic operations for years.

The proposed regulatory language will affect my practice directly by in many ways including possibly limiting my medical command status, directorships and making individuals subject to certain regulations that the recognized boards are not subject to. I should also remind you that the a good majority of individuals that are ABEM have become that way through the practice track not through residency training. This would also include members that sit on the national board of ACEP.

The department seeks to define "board certification" in a manner that will exclude one private certifying body in preference to other private certifying bodies. This preferential use of a board certifying organization has been recognized by the United States Congress. In a request to the U.S. General Accounting Office to conduct a study

on the professional certification practices ad requirements of federal agencies, James M. Talent, Chair of the Representatives Committee on Small Business, expressed concern that " diversity of certification has led, in some circumstances, to an informal system of preferences for one certification over another."
The American Association of Physician Specialists, Inc. (AAPS) has been recognized since 1952 to provide a clinically recognized mechanism for specialty certification of physicians with advanced training through an examination process. The AAPS currently has Twelve boards of certification. each AAPS affiliated board of certification has established criteria for examination development, examination validation and candidate admission to the certification process. AAPS boards provide a measurable objective mechanism to meet the accreditation requirements of the multitude of organizations involved in the accreditation and the health care delivery.

Recently in New York State specifically New York City, AAPS was recognized as an equivalent board. The Regional Emergency Medical Advisory Board of Certification has recognized that AAPS boards, specifically its board certification in emergency medicine is equivalent to the American Board of Emergency Medicine and the American Osteopathic Board. The New York REMAC determined at that time , with the aid of counsel, that the examinations and requirements for admission to the certification process equivalent and the council further stated that there were no issues of quality care provided by AAPS certified individuals. The REMAC council further stated that, should REMAC exclude AAPS certified physicians similarly certified ABEM physicians(those not certified by the practice track) would also have to be excluded.

Even though the general provisions of the proposed rule making provide some reference to specific certifying bodies would not preclude the department from considering persons with certifications by other private certifying bodies. the effect of the proposed language in the regulation will effectively exclude a cadre of physicians from participation in the Pennsylvania emergency medical system. As you well know many private organizations, hospital, health care insurers, managed care organizations, and others generally follow the regulations established by the local governmental bodies. As such many of these organizations will exclude those physicians certified by one of the AAPS affiliated boards of certification

Therefore we request that the language in proposed PA. Code Chapter 1001, Subchapter A, Section 1001.2 be amended to include AAPS Inc.

In the alternative our organization is prepared and willing to work with the Department of health and the Emergency Services Office in reaching appropriate criteria for recognition of boards of certification, and amending the language of the proposed regulation.

Russell E. James II MD

Wyoming Valley Health Care System, Inc.

Date: 3/10/99 Confidential: ☐ YES ☐ NO

To: Independent Regulatory Review Commission

Company:

Fax Telephone Number: (717) 783 - 2664

From: Dr. Russell Jamy

☒ Wilkes-Barre General ☐ Nesbitt ☐ Other

Total number of pages, including this cover letter: 4

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DEPARTMENT OF HEALTH
...in pursuit of good health

(717) 787-8740

March 10, 1999

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Mr. Robert E. Nyce
Executive Director
Independent Regulatory Review Commission
14th Floor, Harristown II
333 Market Street
Harrisburg, PA 17101

RE: Proposed Regulations
Emergency Medical Services
No. 10-143

Dear Mr. Nyce:

The Pennsylvania Department of Health has recently received the enclosed public comments to the above-referenced regulations. These comments were previously forwarded to you without a cover letter.

Sincerely,

Margaret E. Trimble

Margaret E. Trimble
Director
Emergency Medical Services Office

MET:dlw

Enclosures

LATROBE AREA HOSPITAL

121 W. 2ND AVENUE
LATROBE, PA
15650 - 1096
724 / 537 - 1000

ORIGINAL: 2003
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March 8, 1999

Independent Regulatory Review Commission
14th Floor, 333 Market St.
Harrisburg, PA 17101

Gentlemen:

I am an emergency medicine physician in Latrobe, Pennsylvania. I am board certified in Emergency Medicine by the American Association of Physician Specialists in this specialty. I endured two years of self study, a minimum of five years of clinical practice, and a rigorous three-day examination to prove my proficiency in emergency medicine.

Imagine my surprise and chagrin to learn that my boards are not recognized in Pennsylvania! However, amendments to 28 PA Code Part VII (Emergency Medical Services), proposed Chapter 1001, Subchapter A, Section 1001.2 (Definitions) change this to the betterment of emergency medical practices in this state.

Since my boards are not recognized in this state, I am not eligible to become ALS Medical Director, nor am I eligible to become director of my own department despite more than 20,000 hours of providing top-notch care to my patients and their families.

You can help me. Please include the American Association of Physician Specialists in the definition of accepted boards for this state. This Association is recognized almost everywhere else in the United States; it was established in 1950 to provide speciality certification of physicians.

If I am not considered board certified, I must spend about $1000 this year alone to update ACLS/ATLS certification. This is NOT required for ABEM/AAOS-certified physicians. I feel this is grossly unfair. If my association boarding is accepted by this state, then I can proceed with my career plans and not be required to maintain superfluous certifications.

Please consider amending PA Code Chapter 1001, Subchapter A, Section 1001.2 (Definitions) to include the American Association of Physician Specialists, Inc. Thank you.

Sincerely,

Terry Linville, M.D.

CC: MARY LOU HARRIS
JOHN H. JEWETT
JAMES M. SMITH

SPECIAL THANKS MR. JEWETT FOR SPEAKING WITH ME ON 3/8/99! TL

DEBRA K. HERMANY, D.O.

BOARD CERTIFICATION IN EMERGENCY MEDICINE
199 DOCK STREET
SCHUYLKILL HAVEN, PENNSYLVANIA 17972-1208
U.S.A.

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March 07, 1999

John R. McGinley, Jr. Esq.
Chairman
Independent Regulatory Review Commission
Commonwealth of Pennsylvania
333 Market Street Floor 14
Harrisburg, Pennsylvania 17101

ORIGINAL: 2003
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Originals to:
McGinley, Coccodrilli
Harbison, Mizner
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Dear Attorney McGinley,

I am writing to comment on proposed amendments to 28 PA. Code Part VII (relating to emergency medical services) as published in the Pennsylvania Bulletin, Volume 29, Number 7, Part II, dated February 13, 1999. My comment is directed to proposed Chaprter 1001, Subchapter A, Section 1001.2 (Definitions) and the effects of the proposed definition of "Board Certification" (page 919 of proposed rulemaking).

Physician board certification has become an essential element in many instances of credentialing for the purposes of reimbursement, hospital and health care organizational accreditation, and physician staff membership. Medical specialty certification of physicians, however, remains a voluntary procedure in the United States. Some physicians have elected to seek formal recognition of their proficiency in their chosen field by presenting themselves for examination before specialty boards comprised of their professional peers. The definition of each specialty, in addition to the education and other requirements leading to acceptance into the certification process are developed by consensus within the medical profession. Specialty certification is separate and distinct from licensure.

I chose to present myself for the American Association of Physician Specialists, Inc. (AAPS) affiliated Board of Certification in Emergency Medicine because they represent the same ideals in emergency medicine for which I stand, they are comprised of both allopathic and osteopathic physicians rather than subdivided as MD vs DO, and there is a constant involvement in the forfront of issues directly affecting my practice as a physician for which AAPS is there to help mold the pathes of these isssues.

The proposed regulatory language will affect my 12 years of Emergency Medicine practice in the future directly by 1)changing my status as an Emergency Medical Command physician for the institutions in which I work, 2) I will loose my status as Medical Director of the Hamburg Basic Life Support Emergency Medical Services and soon to be Advanced Life Support Services, and 3) my livelihood as an Emergency physician in the State of Pennsylvania.

The Department seeks to define "board certification" in a manner that will exclude one private certifying body in preference to other private certifying bodies without having established criteria for recognition of certifying bodies. This preferential use of a particular board certifying organization has been recognized by the United States Congress. In a request to the U.S. General Accounting Office to conduct a study on the professional certification practices and requirements of federal agencies, James M. Talent, Chair of the House of Representatives Committee on Small Business, expressed concern that "diversity of certification has led, in some instances, to an informal system of preferences for one certification over another." The Chair further stated that "these preferences often occur without any objective justification." This is an important issue because these certifications are often a

prerequisite for federal or state contracting opportunities or a requirement for compliance with regulations and quidelines.

Representative Robert Stump, Chair of the House Committee on Veterans' Affairs, had similar concerns regarding the Department of Veteran Affairs and recognition of particular board certifying organizations. He was most interested in what criteria were used to evaluate the two organizations the Department of Veteran Affairs chose to recognize in an informational letter (IL 10-97-031 dated August 12, 1997).

The American Association of Physician Specialists, Inc. (AAPS) is a national organization established in 1950 and incorporated in 1952 to provide a clinically-recognized mechanism for specialty certification of physicians with advanced training through an examination process. The AAPS is the administrative home for twelve Boards of Certification. Each AAPS affiliated board of certification had established criteria for examination development, examination validation, and candidate admission to the certification process. In ecognition of the multiple mechanisms in the health care delivery system that continuously monitor physician performance (the fact that physicians must learn a substantial amount of medicine in a clinical practice setting; the difficulty of physicians in a particular cohort to enter approved residency training programs; the emerging importance of specialty certification in the health care delivery system; and the variety of career paths leading physicians to particular emphasis in their practice of medicine). AAPS-affiliated boards provide a measurable, objective mechanism to meet the accreditation requirements of the multitude of organizations involved in accreditation and health care delivery.

The Regional Emergency Medical Services Council of New York City, Inc. and the Regional Emeregency Medical Advisory Committtee of New York (REMAC) has recognized that the AAPS boards, in particular the Board of Certification in Emergency Medicine (BCEM) is equivalent to the American Board of Emergency Medicne (ABEM) and the American Osteopathic Board of Emergency Medicne (AOBEM). The New York REMAC determined, with the aid of counsel, that the examinations and requirements for admission to the certification process are equivalent, that there were no issues of quality of care provided by BCEM-certified physicians. The REMAC council further stated that, should the REMAC exclude BCEM-certified physicians, similarly certified ABEM and AOBEM physicians (those certified via the practice track) would also have to be excluded.

Even though the General Provisions of the Proposed Rulemaking provide that reference to specific certifying bodies would not preclude the Department from considering persons with certifications by other private certifying bodies, the effect of the proposed language in the regulation will effectively exclude a cohort of physicians from participation in the Pennsylvania emergency medical system. Many private organizations, hospital, health care insurers, managed-care organizations, and others generally follow the regulations established by the local governmental body. As such, many of these organizations will exclude those physicians certified by one of the American Association of Physician Specialists, Inc. (AAPS) affiliated boards of certification thinking that they are in compliance with State Regulations.

Therefore, we request that the language in proposed PA. Code Chapter 1001, Subchapter A, Section 1001.2 (Definitions) be amended to include the American Association of Physican Specialists, Inc.

In the alternative our organization is prepared and willing to work with the Department of Health and the Emergency Medical Services Office in reaching appropriate critieria for recognition of boards of certification, and amending the language of the proposed legislation.

Sincerely yours,

Debra K Hermany DO

Debra K. Hermany, D.O.

George Grof-Tisza, M. D., FAEP, BCEM
PO Box 771
Somerset, PA 15501
(814) 443-1085
March 4, 1999

Ms. Fiona E. Wilmarth/ Regulatory Analyst
Independent Regulatory Review Commission
14th Floor
333 Market Street
Harrisburgh, PA 17101

ORIGINAL: 2003 BUSH
Originals to: McGinley, Coccodrilli, Bush, Harbison, Nyce, Sandusky, Shomper, Wyatte, Wilmarth, Jewett, Smith, Tyrrell, Nanorta, de Bien, Harris

Dear Ms. Wilmarth:

I am writing to comment on proposed amendments to 28 PA. Code part VII (relating to emergency medicine services) as published in the Pennsylvania Bulletin, Volume 29, Number 7, Part II, dated February 13, 1999. My comment is directed to proposed Chapter 1001, Subchapter A, Section 1001.2 (Definitions) and the effects of the proposed definition of "Board Certification" (page 919 of proposed rulemaking).

I chose to present myself for the American Association of Physician Specialists, Inc. (AAPS) affiliated Board of Certification in Emergency Medicine, because although board certification is voluntary in the United States, there is increasing pressure on all physicians to complete this credentialing process. The boards of other certifying bodies were closed to me since they had closed their practice track years ago. The proposed regulatory language will affect my practice directly because I may be unable to practice emergency medicine.

This will also have a detrimental effect on under served areas. It is the small rural and inner city hospital that is served by physicians like myself. Narrowing the definition of "board certification" may very likely leave them without physicians.

Specialty certification is voluntary. It is distinctly separate from licensure. It is the formal recognition of a specialty board that a physician has reached proficiency in their chosen field. The definition of each specialty, in addition to the education and other requirements leading to the acceptance into certification is developed by consensus within the medical profession.

The Department seeks to define "board certification" in a way that will exclude one ***private*** certifying body in preference to other private certifying bodies without having established criteria for recognition of certifying bodies. The US Congress has requested the US General Accounting Office to study preferential use of a particular ***private*** certifying board to the exclusion of all others. The chair found that "these preferences often occur without any objective justification."

This is an important issue because these certifications are often prerequisites for federal or state contracting opportunities or a requirement for compliance with regulations and guidelines. Representative Robert Stump, Chair of the House committee on Veterans' Affairs, had similar concerns regarding preferential treatment in their recognition of particular board certifying organizations. He was most interested in criteria used to evaluate the organizations. (Il 10-97-031 dated August 12, 1997).

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The Regional Emergency Medical Services Council of New York City, Inc. and the Regional Emergency Medical Advisory Committee of New York (REMAC) has recognized the AAPS boards, in particular the Board of Certification in Emergency Medicine **(BCEM) is equivalent to** the American Board of Emergency Medicine **(ABEM) and** the American Osteopathic Board of Emergency Medicine **(AOBEM)**. The New York REMAC determined, with the aid of consel, that **the examinations and requirements for admission to the certification process are equivalent**, that there were no issues of quality of care provided by BCEM-certified individuals. The REMAC counsel further stated that, should REMAC exclude BCEM -certified physicians, similarly certified ABEM physicians (those certified via the practice track) would also have to be excluded.

Although the General Provision of the Proposed Rulemaking provide that reference to specific certifying bodies would not preclude the Department from considering persons with certifications by other private certifying bodies, the effect of the proposed language in the regulation will effectively exclude a cohort of physicians from participation in the Pennsylvania emergency medical system. Many private organizations, hospitals, health care insurers, managed-care organizations, and others generally follow the regulations established by the local governmental body. As such, many of these organizations will exclude those physicians certified by one of the American Association of Physician Specialists, Inc. (AAPS)-affiliated boards of certification thinking that they are in compliance with State Regulations.

Therefore, we request that the language in proposed PA. Code Chapter 1001, Subchapter A, Section 1001.2 (Definitions) be amended to include the American Association of Physician Specialists, Inc.

Sincerely,

George Grof-Tisza, M.D., FAEP

From: <DeReamus@aol.com>
To: DOH-DOM1.PO-1(PTRIMBLE),DOH-DOM1.GWIA("pehsc@pehsc...
Date: Mon, Mar 15, 1999 2:53 am
Subject: Ambulance Association of Pennsylvania's Comments on Proposed Regulations

Please accept the comments on the Proposed Rules and Regulations to the
Emergency Medical Services Act, Act of 1985, P.L. 164, No. 45 as approved by
the Board of Directors of the Ambulance Association of Pennsylvania on Friday,
March 12, 1999 during the conference call.

These comments are to be forward by Elloise Frazier, Equire to the Independent
Regulatory Review Committee (IRRC) at thier request.

On behalf of Barry Albertson, President and the Ambulance Association of
Pennsylvania I must commend the work of the Department of Health - Emergency
Medical Services Office and Ms. Margaret E. Trimble and staff for an excellent
job on the revisions. EMS in Pennsylvania will benefit greatly under these
rules.

Respectfully submitted on behalf of the Board of Directors,

Donald A. DeReamus, Chairman
Department of Health/ACT 45 Committee
Ambulnace Association of Pennsylvania

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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1001.2. Definitions.

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 - page 918
Department of Health Document – page 76

Ambulance call report – A summary of an emergency ambulance response, nonemergency ALS response, interfacility transport, or nonemergency BLS transport that becomes an emergency. The report shall contain information in a format provided by the Department.

Comment/Recommendation:

The Ambulance Association of Pennsylvania respectfully requests a cost analysis be considered to assess the fiscal impact of this transition (paper to electronic data) on small and rural providers in the Commonwealth.

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRAURY 13, 1999

§1001.2. Definitions.

Department of Health Document – Page 80

Comment: The definition of ***Emergency*** should be revised to reflect the American College of Emergency Physician's prudent layperson definition of emergency which is prevalent in other legislation today.

Recommendation:

Emergency—[A combination of circumstances resulting in a need for immediate medical intervention.] The sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual, or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;

(2) serious impairment to bodily functions, or

(3) serious dysfunction of any bodily organs or parts.

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1001.2. Definitions.

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 921
Department of Health Document – page 85

Comment: The definition of ***receiving facility*** was revised to specify an organized department with a physician who is trained to manage cardiac, trauma, and pediatric emergencies. There appears to be a void of medical and psychiatric emergencies due to the specificity in the area of management. We believe the Department's intent was to have a physician that is well rounded in all disciplines.

Recommendation:

Receiving facility – A fixed facility that provides an organized emergency department [of emergency medicine], with a [licensed and ACLS certified] physician who is trained to manage cardiac, trauma, pediatric, **medical and psychiatric** emergencies, and is present in the facility [who is] and available to the emergency department 24 [hours a day] hours-a-day, 7 [hours a week] days-a-week, and a registered nurse who is present in the emergency department 24 [hours a day] hours-a-day, 7 [hours a week] days-a-week. The [facilities] facility shall also comply with Chapter 117 (relating to emergency services).

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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1003.23. EMT.

(e) Scope of practice

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 935
Department of Health Document – page 143

Comment: In §1003.23. EMT., (e) Scope of practice, the line **(2)** is a new addition and states:

(2) Transportation of a patient with an indwelling intravenous catheter without medication running.

With the advent of shorter patient inpatient stays and home health care, patients are using a vast array of patient controlled devices and other pumps monitored by visiting nurses. The language in the scope of practice is too specific and may cause potential confusion for an EMT finding a patient on an insulin pump, CADD pump, PCA pump, etc. If the medication is not the result of the problem or part of a normal outpatient treatment plan, it should not matter whether it is running or not.

Recommendation:

(e) Scope of practice
(2) Transportation of a patient with an indwelling intravenous catheter without medication running**, unless the medication is part of the patient's normal outpatient treatment plan.**

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1005.2. Applications.

§§(a), (5)

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 946
Department of Health Document – page 182

Comment: In §1005.2. Applications., (a), (5) has been reworded to state:

(5) [Service] The emergency service area [served – both primary and mutual-aid] the applicant commits to serve, or alternatively, a statement that the applicant intends to engage primarily in interfacility transports.

The Association feels that there is no need for an ambulance service to stipulate its business intent in the application process to become licensed. A licensed ambulance service in the Commonwealth is licensed to engage in whatever activity (emergency/non-emergency transportation and treatment) regardless of the arena they intend to perform in.

Recommendation:

§1005.2. Applications., (a)
(5) [Service] The emergency service area [served – both primary and mutual-aid] **the applicant is available to serve in.**

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1005.2. Applications.

§§(a), (9)

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 946
Department of Health Document – page 182

Comment: In §1005.2. Applications., (a), (9) is a new revision and states:

(9) Primary physical building locations, and other building locations out of which it will operate ambulances or a full description of how its ambulances will be placed and respond to emergency calls if they will not be operated out of other building locations.

The Association feels this question is answered in (a), (5) and an ambulance service should not have to stipulate in the application process to become licensed if they engage in system status management practice.

Recommendation:

§1005.2. Applications., (a)
(9) Primary physical building location, and other building locations out of which it will operate ambulances.

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1005.2. Applications.

§§(e)

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 946
Department of Health Document – page 183

Comment: In §1005.2. Applications., (e) is a new revision and states:

(e) An ambulance service shall apply for and secure an amendment to its license prior to substantively altering the location or operation of its ambulances in an EMS region, such as a change in location or operations which would not enable it to timely respond to emergencies in the emergency service area it committed to serve when it applied for a license. The application for an amendment of an ambulance service license shall be submitted to the regional EMS council on a form prescribed by the Department.

The Association feels this entry would be better defined with the addition of physical building in two areas before the word location and deleting committed and replacing it with the word available.

Recommendation:

§1005.2. Applications.

(e) An ambulance service shall apply for and secure an amendment to its license prior to substantively altering the **physical building** location or operation of its ambulances in an EMS region, such as a change in **physical building** location or operations which would not enable it to timely respond to emergencies in the emergency service area it is [committed] **available** to serve when it applied for a license. The application for an amendment of an ambulance service license shall be submitted to the regional EMS council on a form prescribed by the Department.

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1005.10. Licensure and general operating standards.

§§(a) *Documentation requirements.*, (4)

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 948
Department of Health Document – page 189

Comment: In §1005.10. Licensure and general operating standards., (a) *Documentation requirements.*, (4) the line has been revised and states:

> (a) *Documentation requirements.*
>
> (4) [Copies of mutual-aid agreements with other ambulance services which service the applicant's community or applicant's service area.] A record of the time periods for which the ambulance service notified the PSAP that it would not be available to respond to a call.

The Association would like to know on whom the burden would fall to record a service's unavailability. Some services that may not acknowledge an initial dispatch may never be aware the dispatch was missed creating inaccurate statistics. Additionally, a service may have its resources committed and be unable to respond. We believe the PSAP should be responsible for collecting this information for the unavailability of a service to meet its primary dispatch obligation.

Recommendation:

§1005.10 Licensure and general operating standards.

> (a) *Documentation requirements.*
>
> (4) [Copies of mutual aid agreements with other ambulance services which service the applicant's community or applicant's service area.] A record of the time periods **or specific dispatches as recorded by the PSAP for which the ambulance service was unable to respond to a primary emergency dispatch in it coverage area.**

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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1005.10. Licensure and general operating standards.

§§(e) *Communicating with PSAPs.*, (4) Response to dispatch by PSAP.

Pennsylvania Bulletin, Vol. 29, No. 7, February 13, 1999 – page 950
Department of Health Document – page 194

Comment: In §1005.10. Licensure and general operating standards., (e) Communication with PSAPs., line (4) *Response to dispatch by PSAP* has been added and states:

(4) Response to dispatch by PSAP. An ambulance service shall respond to a call for emergency assistance as communicated by the PSAP.

The Association feels this line is not needed as this is covered in the previous three line. Additionally, the intent of the word shall lends one to the thought of potential liability.

Recommendation:

§1005.10. Licensure and general operating standards.
(e) *Communication with PSAPs.*
[(4) *Response to dispatch by PSAP.* An ambulance shall respond to a call for emergency assistance as communicated by the PSAP.]

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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COMMENT FORM FOR PROPOSED REGULATIONS
FEBRUARY 13, 1999

§1001.2. Definitions.

Text discrepancies between the *Pennsylvania Bulletin* and Department of Health Document as retrieved from the Department of Health EMS Office website.

ALS service medical director – the words **[set forth]** are deleted in the *Pennsylvania Bulletin* but appear in the Department of Health Document.

Air ambulance medical director – the words **[set forth]** are deleted in the *Pennsylvania Bulletin* but appear in the Department of Health Document.

Critical care specialty receiving facility – **including, in one** of is present in the *Pennsylvania Bulletin* as opposed to **but not limited to, one** in the Department of Health Document.

EMSOF – the word **under** is present in the *Pennsylvania Bulletin* as opposed to **pursuant to** in the Department of Health Document.

Federal KKK standards – the words **[set up]** are deleted and replaced with the word **adopted** in the *Pennsylvania Bulletin.*

Medical [control] coordination – in (iv) **[Medical] Transfer and treatment** are present in the Pennsylvania Bulletin as opposed to **Transfer and [M]medical treatment** in the Department of Health Document.

Prehospital personnel – the entire line **Any one of these individuals is a "prehospital practitioner"** is not present in the *Pennsylvania Bulletin* but in the Department of Health Document.

Contact Person: Donald DeReamus, DOH/ACT45 Committee Chairman
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Original copies to: McGinley, Harbison, Coccodrilli, Mizner

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cc: Harris
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George Grof-Tisza, M.D.
PO Box 771
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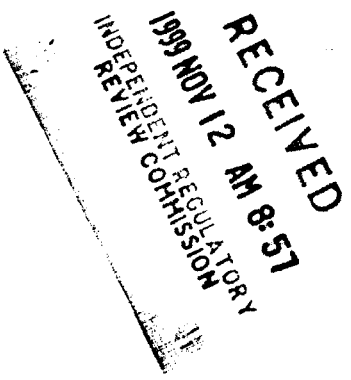
November 3, 1999



Mr. Robert E. Nyce/Executive Director
Independent Regulatory Review Commission
14th Floor 333 Market Street
Harrisburg, PA 17120

Dear Mr. Nyce

I am writing to comment on proposed amendments to 28 PA. Code part VII (relating to emergency medicine services) as published in the Pennsylvania Bulletin, Volume 29, Number 7, Part II, dated February 13, 1999. My comment is directed to proposed Chapter 1001, Subchapter A, Section 1001.2 (Definitions) and the effects of the proposed definition of "Board Certification" (page 919 of proposed rulemaking). Thereby limiting recognition of Board Certification only to specialties recognized by American Board of Medical Specialists (ABEM) and American Osteopathic Association (AOBEM), and excluding BCEM certified physicians.

I chose to present myself for the American Association of Physician Specialists, Inc. (AAPS) affiliated Board of Certification in Emergency Medicine (BCEM), because although board certification is voluntary in the United States, there is increasing pressure on all physicians to complete this credentialing process. The boards of other certifying bodies were closed to me since they had closed their practice track years ago. The proposed regulatory language will affect my practice directly because I (and many of my colleagues) may be unable to practice emergency medicine in Pennsylvania. Ratification of this proposal would make me ineligible to participate in direct emergency medicine care, provide medical command, and treat Pennsylvania citizens in need of emergent care which I have been providing for over ten years.

This will have a detrimental effect on under served areas. It is the small rural and inner city hospital that is served by physicians like myself. Narrowing the definition of "board certification" may very likely leave them without physicians.

Specialty certification is voluntary. It is distinctly separate from licensure. It is the formal recognition of a specialty board that a physician has reached proficiency in their chosen field. The definition of each specialty, in addition to the education and other requirements leading to the acceptance into certification is developed by consensus within the medical profession.

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This is an important issue because these certifications are often prerequisites for federal or state contracting opportunities or a requirement for compliance with regulations and guidelines.

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Although the General Provision of the Proposed Rulemaking provide that reference to specific certifying bodies would not preclude the Department from considering persons with certifications by other private certifying bodies, the effect of the proposed language in the regulation will effectively exclude a cohort of physicians from participation in the Pennsylvania emergency medical system. Many private organizations, hospitals, health care insurers, managed-care organizations, and others generally follow the regulations established by the local governmental body. As such, many of these organizations will exclude those physicians certified by one of the American Association of Physician Specialists, Inc. (AAPS)-affiliated boards of certification thinking that they are in compliance with State Regulations.

Since physicians certified by the AAPS-affiliated BCEM have met the same minimum standards as those certified by ABEM, these physicians should be included in the proposed rules. Therefore, we respectfully request that the language in proposed PA. Code Chapter 1001, Subchapter A, Section 1001.2 (Definitions) be amended to include the American Association of Physician Specialists, Inc.

Sincerely,

George Grof-Tisza, M.D., FAEP, AAEP, Diplomate BCEM

PENNSYLVANIA ACADEMY OF FAMILY PHYSICIANS

November 23, 1998

ORIGINAL: 2003
BUSH
COPIES: Harris
Smith
Jewett
Sandusky
Legal

James Steele, Esq.
Acting Chief Counsel
Department of Health
Health & Welfare Building
Room 813, P.O. Box 90
Harrisburg, PA 17108

Re: Family Physicians as Emergency Department Directors

Dear Mr. Steele:

The Pennsylvania Academy of Family Physicians represents over 4,300 members. Many of the Academy's physician members actively practice in hospital emergency departments. A substantial number of those physicians are actually Directors of hospital Emergency Departments.

Following the Legislature's "sunsetting" of the Certificate of Need provisions of the Health Care Facilities Act, the Department of Health convened Task Forces designed to develop recommendations that may ultimately be included in new facility licensure regulations. We understand that the Task Force analyzing Hospital Emergency Department quality issues recommended a substantial change in hospital Emergency Department Medical Director eligibility requirements. The recommendation states as follows:

> Physician Staff (Post Graduate Residents) – The Medical Director of an emergency service shall be Board Certified or at least Board Eligible in Emergency Medicine with "Board Certified" being defined as a physician licensed to practice medicine in the Commonwealth who has successfully passed an examination and has maintained certification in the relevant medical specialty and/or subspecialty area offered by one of the following groups: (1) American Board of Medical Specialties; (2) American Osteopathic Association; or (3) the Foreign equivalent of

5600 Derry Street • Harrisburg, Pennsylvania 17111 • Phone: (717) 561-5365 • 1-800-648-5623 • Fax: (717) 561-4235

> either of the above. "Board eligible" is defined as a physician licensed to practice medicine in the Commonwealth who has completed the preliminary requirements necessary to take an examination by the American Board of Medical Specialties, the American Osteopathic Association, or the Foreign equivalent of either group, and who is presently eligible to take the examination and is within 3 years of attaining eligibility.
>
> A Medical Director who does not meet this standard may continue to serve as the Medical Director for that emergency service if the Credentialing Committee of the hospital determines that such physician has obtain[sic] equivalent qualifications.

The Academy understands the foregoing is a Task Force recommendation, but is unsure whether the Department of Health has endorsed this and whether the Department plans to include it in any draft or proposed regulations. Existing quality rules do not define Board Certification and permit Board Certified Family Physicians to serve as Medical Directors of Emergency Departments when they have demonstrated necessary experience and training. Many Family Physicians have been Board Certified by an alternate Emergency Medicine Board, the Board of Certification in Emergency Medicine ("BCEM").

The Academy has adopted a policy position opposing the Task Force recommendation quoted above. A majority of experienced, well-trained and successful career emergency physicians practicing today are not allowed to sit for the American Board of Emergency Medicine ("ABEM") exam as the Task Force recommendation would require. ABEM, the designated American Board of Medical Specialties board in emergency medicine, closed its "practice track" pathway to exam eligibility in 1988. This closure has prevented in excess of 14,000 highly experienced emergency physicians from taking the ABEM exam nationwide. Based upon our research, this substantial group of emergency physicians has been denied access to the ABEM exam despite having equal, or better, academic and training backgrounds than the physicians who were granted access to the ABEM exam via the practice track. Interestingly, some of those physicians admitted to the ABEM practice track had not completed any formal emergency medicine residency or, in some cases, a residency in any field. This has resulted in antitrust litigation challenging the closure of the practice track in the Western District of New York. The litigation, however, is not the Academy's primary concern. The Academy's policy position focuses on ensuring quality of care, particularly in rural areas, to patients in emergency conditions. Further, the Academy's policy position seeks to secure equitable scope of practice rules for its physician constituency.

Based on the foregoing, the Academy encourages the Department of Health to modify the Emergency Department Medical Director requirements stated above to include Board Certified Family Physicians who also have achieved ACLS and ATLS certification. Existing Department of Health regulations implementing the Emergency Medical Services Act provide strong policy support for this position. Those regulations state as follows:

> Medical Command Facility Medical Director.
>
> ...
>
> (b) Minimum Qualifications.
>
> (1) A Medical Command Facility Medical Director shall have the following qualifications: (i) be a medical command physician; (ii) Board Certification in Emergency Medicine or, in lieu of this, ***current ACLS and ATLS certification along with Board Certification in*** surgery, internal medicine, ***family medicine***, pediatrics or anesthesiology.

28 Pa. Code § 1003.3(b)(1)(ii). The Academy also believes it would be appropriate to require that the Medical Director of an Emergency Department possess 7,000 hours and 60 months of emergency medicine practice experience. These requirements were created by ABEM as the criteria for certification through the practice track that is now closed. Use of this widely accepted benchmark would ensure that Medical Directors in Emergency Departments possess high level of experience necessary to properly oversee the delivery of quality care in emergency departments throughout Pennsylvania. It would foster inclusion of qualified Board Certified Family Physicians and ensure quality of care.

The Academy would like to meet with you, Dean Glick of the Bureau of Facility Licensure and Certification, and any other individuals you deem appropriate so that our physicians who practice as Medical Directors in Emergency Departments can more fully explain the clinical veracity of the Academy's policy position. Charles I. Artz, Esq., the Academy's general counsel, will follow-up with you in an effort to schedule a

meeting. Thank you in advance for your cooperation and consideration. We look forward to working closely with the Department on this and other issues affecting primary care physicians and their patients.

Sincerely,

Todd A. Sagin, M.D., J.D.
President

cc: PAFP Board of Directors
PAFP Public Policy Commission
Leo M. Hartz, M.D. – PAFP Public Policy Chair
John S. Jordan – PAFP Executive Vice President
Charles I. Artz, Esq. – PAFP General Counsel
John A. Nikoloff – PAFP Lobbyist

Original: 2003
Bush
cc: All Commissioner
Harris
Smith
Jewett
Nyce
Sandusky
Legal

A. G. Deininger, MD
390 Park Ave.
Meadville, Pa 16335
PH: 814 724 5200
FAX: 814 333 2925

October 18, 1999

Mr. Robert E. Nyce
14th Floor 333 Market St.
Harrisburg, Pa 17120

Dear Mr. Robert E. Nyce:

This letter is about giving the citizens of Pennsylvania the knowledge they need to evaluate the quality of care in the Emergency Room of their hospital. They should know if the physician is board certified. "Board Certification" is an honor recognition given for the dedicated work and study necessary to become a specialist in a branch of medical science. Most people do not realize that over one half of the physicians working in the emergency rooms in the United States are not board certified in Emergency Medicine by any certifying organization.

You will be asked to vote to amend 28 Pa. Code Part VII , Subchapter A section 1001.1, page 919, relating to Emergency Services as published in the Pa Bulletin vol 29, #7, part II, dated 021399, in reference to the proposed definition of "Board Certification." This document indicates the recognition of Board Certification in Emergency Medicine should only be given to physicians certified by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA). I am asking you to include board certification as recognized by the American Association of Physician Specialist (AAPS).

The objection for this inclusion from the ABMS and AOA is based on the fact the residency (a three year training program) is not required for certification by the AAPS. The value of residency is not questioned for those young physicians starting practice or for those beginning to work in Emergency Rooms, but is somewhat redundant for experienced physicians who continually adjust to the rapid changes that occur over the years in this specialty.

The AAPS recognizes the unique value of extensive experience in Emergency Medicine as well as requiring the board candidate to pass a comprehensive oral and written examination.

There is no logic to exclude the AAPS. I have been in practice for 35 years, part-time in Emergency Medicine for 20 years and full-time for the past 10 years, I have always tried to do what is best for the patient, and not be deterred by political or financial pressures or self serving organizations as I believe are factors in why the AAPS is not included.

The best course of action in this issue is to assure the patient is aware of the quality of care they are receiving and have intrusted their hospital to provide. They should know who has "Board Certification" and all who have dedicated themselves to qualify as a specialist in Emergency Medicine.

Please vote for an amendment to 28 Pa. code, Pare VII, code chapter 1001 subchapter A, section 1011.2 to include AAPS physicians in the proposed definition of Board Certification. Their qualifications and efforts deserve to be recognized. More importantly, the public deserves it.

Sincerely,

Arthur G. Deininger, MD
Hamot Medical Center
201 State St
Erie, Pa 16501
Board Certification
-Family Practice with
added Qual in Geriatrics
-Emergency Medicine through AAPS

Original: 2003
Bush
cc: Harris
Smith
Jewett
Sandusky, Legal

SUDHA T. BABRA, M.D; BCEM.
251 Collegiate Dr.
Johnstown, PA 15904
(814) 266-4576
Oct. 19, 1999

Robert E. Nyce.
(Executive Director)
14th Floor 333 Market Street
Harrisburg, PA 17120

Re: Board certification in Emergency Medicine.
Ref: Pennsylvania Bulletin Vol 29, No 7 Part II, Feb 13 1999
Proposed rule making Department of Health 28 PA CODE CHS 1001 etc

Dear Director Nyce

I am a physician practicing Emergency medicine for the past Ten years. Because Practice pack certification was closed to us at the time. I took BCEM/AAPS certification as soon as I could. In the past ABEM certification was open to people with exactly similar requirements.

I have all mandatory requirements needed by an Emergency Physician including Board certification (BCEM/AAPS)

certification by BCEM is just as demanding as that of ABEM

I would therefore like to request you to support to rectify the Amendment 28 PA Code Part VII to include BCEM/AAPS certification. So that numerous Emergency Physician Practicing in Pennsylvania are not inadvertantly excluded from the proposed Bill

It could be determental to the served patient population and our Careers.

Thank you for taking interest in the matter and your support.

Sincerely

Sudha T. Babra MD.

SUDHA T. BABRA, MD; BCEM

RECEIVED
1999 OCT 25 AM 8:35
INDEPENDENT REGULATORY
REVIEW COMMISSION

*ABEM = American Board Emergency medicine)
*BCEM = Board certified Emergency medicine) *AAPS = American Association of Physicians Specialty

Original: 2003
Bush
cc: Harris
Smith
Jewett
Sandusky, Legal

Mr. Robert Nyce
Executive Director
Independent Regulation and Review Commission

Oct. 11, 1999

Dear Sir;

We are writing in support of amendment of 28 PA Code Part 7 regarding EMS, specifically the definition of Board Certification in Emergency Medicine. We have personally practiced Emergency Medicine in Pennsylvania on a full time basis for 11 years. We are Board Certified/Residency trained in Family Practice but the "grandfather clause" in Emergency Medicine (offered by the American Board of Emergency Medicine-ABEM) closed prior to our eligibility. Hundreds of practicing emergency physicians in Pennsylvania never completed a residency yet were able to "test out" and become certified through this process. The only current process available to physicians like ourselves is an equivalent (in the mind of many) board known as Board Certification in Emergency Medicine (BCEM). This board is mirrored to the ABEM board, but due to what we feel is restraint of trade, there is an active process to exclude this certification as acceptable in this state. The supply of "certified" physicians directly drives the reimbursement they will receive. We would appreciate your consideration in amending the upcoming revision in Pennsylvania Code to include BCEM in the definition of board certification.

Sincerely,

Bruce R. Guerdan, M.D.
Associate Director
Emergency Medicine
UPMC-Beaver Valley
2500 Hospital Drive
Aliquippa, Pa. 15001
724-857-1274

Gail J. Shumway, M.D.
Attending Physician
Emergency Medicine
The Medical Center
1000 Dutch Ridge Rd.
Beaver, Pa. 15009
724-728-7110

AUTOMATIC COVER SHEET

DATE: OCT-17-1999 SUN 08:40 PM

TO:

FAX #: 917177832664

FROM: UPMC B V ER

FAX #: 17248571396

02 PAGES WERE SENT

(INCLUDING THIS COVER PAGE)

Original: 2003
Bush
cc: Harris
Smith
Jewett
Sandusky
Legal

October 15,1999

Robert E. Nyce
Executive Director
Independent Regulatory Review Commission
14th Floor Market Street
Harrisburg, PA 17120

Dear Mr. Nyce:

I am writing to comment on proposed amendments to 28 PA Code Part VII (relating to emergency medicine services) as published in the Pennsylvania Bulletin, Volume 29, Number 7, Part II dated February 13, 1999. My comment is directed to proposed Chapter 1001, Subchapter A, Section 1001.2 (Definitions) and the effects of the proposed definition of "Board Certification" (page 919 of proposed rulemaking).

I chose to present myself to the American Association of Physician Specialists, Inc. (AAPS) affiliated Board of Certification in Emergency Medicine. I am also certified by the American Board of Family Practice. Although board certification is voluntary, there is increasing pressure on all physicians to complete this credentialing process. The boards of other emergency medicine certifying bodies were closed to me because they had closed there practice track years ago. I have been practicing emergency medicine since 1993 and actually have more formal medical training than many of those certified by these bodies. The proposed regulatory language may cause me to be unable to practice emergency medicine.

The proposal will also have a detrimental effect on under-served areas. Excluding a certifying body indiscriminately may very likely leave these areas without physicians. Specialty certification is voluntary. It is distinct from licensure. It is the formal recognition of a specialty board that a physician has reached proficiency in their chosen field. The Department seeks to define "board certification" in a way that will exclude one private certifying body while giving preference to other certifying bodies without having established criteria for recognition of certifying bodies. The chair of the US General Accounting Office found that " these preferences often occur without any objective justification."

This issue is important because these certifications are often prerequisites for federal or state contracting opportunities or a requirement for compliance with regulations and guidelines. Rep. Robert Stump, Chair of the House Committee on Veterans' Affairs, had similar concerns regarding preferential treatment in their recognition of particular board certifying organizations. He was most interested in criteria used to evaluate the organizations. (II 10-97-031 dated August 12, 1994).

The American Association of Physician Specialists, Inc. (AAPS) is a national organization established in 1950 and incorporated in 1952 to provide a recognized mechanism for specialty certification of physicians through an examination process. The AAPS is the administrative home for twelve Boards of Certification. Each AAPS affiliated board of certification has established criteria for examination development, validation, and candidate admission to the certification process. AAPS affiliated boards provide a measurable, objective mechanism to meet the accreditation requirements of the many organizations involved in the health care accreditation and delivery.

The Regional Emergency Medical Services Council of New York City, Inc. and the Regional Emergency Medical Advisory Committee of New York (REMAC) has recognized that the AAPS affiliated Board of Certification in Emergency Medicine **(BCEM) is equivalent** to the American Board of Emergency Medicine **(ABEM)** and the American Osteopathic Board of Emergency Medicine **(AOBEM)**. New York REMAC determined, with the aid of counsel, **that the examinations and requirements for admission to the certification process are equivalent**, and that there were no issues of quality with care provided by BCEM- certified physicians. The REMAC counsel further stated that, should REMAC exclude BCEM- certified physicians, similarly certified ABEM physicians (those certified via the practice track) would also have to be excluded.

Although the General Provision of the Proposed Rulemaking provide that reference to specific certifying bodies would not preclude the Department from considering persons with certifications by other private certifying bodies, the effect of the proposed language in the regulation will effectively exclude a cohort of physicians from participation in the Pennsylvania emergency medical system. Many private organizations, hospitals, health care insurers, managed-care organizations, and others generally follow the regulations established by the local governmental body. As such, many of these organizations will exclude those physicians certified by one of the American Association of Physician Specialist, Inc. (AAPS) affiliated boards of certification thinking that they are in compliance with State Regulations.

Therefore, we request that the language in proposed PA. Code Chapter 1001, Subchapter A, Section 1001.2 (Definitions) be amended to include the American Association of Physician Specialists, Inc.

Sincerely,

Michael W. Kruczek, MD
112 Edgewater Drive
Monaca, PA 15061
Phone (724) 775-4145

Fax

To: Robert E. Nyce **From:** Dr. Michael Kruczek

Fax: (717) 783 - 2664 **Fax:**

Phone: **Phone:** (724) 775 -4145

Date: 10/20/99 **Pages:** 3

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply**

• **Comments:**

Original: 2003
Bush
cc: Harris, Smith, Jewett, Sandusky, Legal

October 15, 1999

Robert E. Nyce
Executive Director
Independent Regulatory Review Commission
14th Floor Market Street
Harrisburg, PA 17120

Dear Mr. Nyce:

I am writing to comment on proposed amendments to 28 PA Code Part VII (relating to emergency medicine services) as published in the Pennsylvania Bulletin, Volume 29, Number 7, Part II dated February 13, 1999. My comment is directed to proposed Chapter 1001, Subchapter A, Section 1001.2 (Definitions) and the effects of the proposed definition of "Board Certification" (page 919 of proposed rulemaking).

I chose to present myself to the American Association of Physician Specialists, Inc. (AAPS) affiliated Board of Certification in Emergency Medicine. I am also certified by the American Board of Family Practice. Although board certification is voluntary, there is increasing pressure on all physicians to complete this credentialing process. The boards of other emergency medicine certifying bodies were closed to me because they had closed there practice track years ago. I have been practicing emergency medicine since 1993 and actually have more formal medical training than many of those certified by these bodies. The proposed regulatory language may cause me to be unable to practice emergency medicine.

The proposal will also have a detrimental effect on under-served areas. Excluding a certifying body indiscriminately may very likely leave these areas without physicians. Specialty certification is voluntary. It is distinct from licensure. It is the formal recognition of a specialty board that a physician has reached proficiency in their chosen field. The Department seeks to define "board certification" in a way that will exclude one private certifying body while giving preference to other certifying bodies without having established criteria for recognition of certifying bodies. The chair of the US General Accounting Office found that " these preferences often occur without any objective justification."

This issue is important because these certifications are often prerequisites for federal or state contracting opportunities or a requirement for compliance with regulations and guidelines. Rep. Robert Stump, Chair of the House Committee on Veterans' Affairs, had similar concerns regarding preferential treatment in their recognition of particular board certifying organizations. He was most interested in criteria used to evaluate the organizations. (II 10-97-031 dated August 12, 1994).

The American Association of Physician Specialists, Inc. (AAPS) is a national organization established in 1950 and incorporated in 1952 to provide a recognized mechanism for specialty certification of physicians through an examination process. The AAPS is the administrative home for twelve Boards of Certification. Each AAPS affiliated board of certification has established criteria for examination development, validation, and candidate admission to the certification process. AAPS affiliated boards provide a measurable, objective mechanism to meet the accreditation requirements of the many organizations involved in the health care accreditation and delivery.

The Regional Emergency Medical Services Council of New York City, Inc. and the Regional Emergency Medical Advisory Committee of New York (REMAC) has recognized that the AAPS affiliated Board of Certification in Emergency Medicine **(BCEM) is equivalent to** the American Board of Emergency Medicine **(ABEM)** and the American Osteopathic Board of Emergency Medicine **(AOBEM)**. New York REMAC determined, with the aid of counsel, **that the examinations and requirements for admission to the certification process are equivalent**, and that there were no issues of quality with care provided by BCEM- certified physicians. The REMAC counsel further stated that, should REMAC exclude BCEM- certified physicians, similarly certified ABEM physicians (those certified via the practice track) would also have to be excluded.

Although the General Provision of the Proposed Rulemaking provide that reference to specific certifying bodies would not preclude the Department from considering persons with certifications by other private certifying bodies, the effect of the proposed language in the regulation will effectively exclude a cohort of physicians from participation in the Pennsylvania emergency medical system. Many private organizations, hospitals, health care insurers, managed-care organizations, and others generally follow the regulations established by the local governmental body. As such, many of these organizations will exclude those physicians certified by one of the American Association of Physician Specialist, Inc. (AAPS) affiliated boards of certification thinking that they are in compliance with State Regulations.

Therefore, we request that the language in proposed PA. Code Chapter 1001, Subchapter A, Section 1001.2 (Definitions) be amended to include the American Association of Physician Specialists, Inc.

Sincerely,

Michael W. Kruczek, MD
112 Edgewater Drive
Monaca, PA 15061
Phone (724) 775-4145

ORIGINAL: 2003
BUSH
COPIES: Harris
Smith
Jewett
Sandusky
Wyatte

October 14, 1999

Mr. Robert Nyce
Executive Director,
Independent Regulatory and Review Commission
333 Market Street
Harrisburg, PA 17101
Fax: 717-783-2664

RE: 28 PA Code Part VII Relating To Emergency Medical Services As Published In The PA Bulletin, Vol. 29, #7, Part II, Chapter 1001, Subchapter A, Section 1001.2, Pg. 919, **"Definition of Board Certification"**, Dated February 13, 1999.

Dear Mr. Nyce:

The above proposed amendment may have a far-reaching effect, not only in Pennsylvania, but throughout the nation, so please very carefully consider this proposal. By mentioning specifically the American Board of Medical Specialties and the American Osteopathic Association, lack of recognition is thus accorded to the **American Association of Physician Specialists (AAPS)** affiliated Board of Certification in Emergency Medicine(BCEM).

This amendment would directly affect myself and similar colleagues throughout Pennsylvania who not only practice emergency medicine but are actively involved with the Emergency Medical Services (EMS) community. Specifically, I had won an election two years ago to be the Regional Medical Director in Bucks County, one of this state's 16 regional EMS systems. However, when it was realized that my Board Certification was "only" in Family Practice, the election was invalidated. This led me to seek the only available means to become board certified in emergency medicine, since the "practice track" of other boards had been closed, so I passed the oral and written examinations of the Board Certification in Emergency Medicine, administered by the AAPS. Currently, I am still active in EMS regionally, but holding a state recognized position would be impossible for me under the proposed guidelines.

Emergency Medicine is a young specialty, this year celebrating only its 25th anniversary. Until the practice track was closed in 1989, most physicians who became board certified did so throughout a "grandfathering" process. This meant having only a specified number of years of experience before taking an examination. Even residency training was optional, and *in fact many, currently grandfathered EM physicians never completed a residency in any field of medicine*.

In no way am I trying to denigrate the certifications of my colleagues, just to point out that the qualifications that exist and enabled me to become board certified are no different then those that existed for a large segment of the emergency medicine community.

Specialty certification is a voluntary process and distinctly separate from licensure. It is the formal recognition, through examination, that a physician has reached proficiency in a chosen field. The definition of each specialty, in addition to the educational requirements, leading to acceptance by certification, is and should be developed by a consensus within the medical profession, and not by the state government.

The Department of Health seeks to define "board certification" in a way that will exclude one private certifying body in preference to other private certifying bodies without having established criteria for recognition of certifying bodies. The US Congress has requested the US General Accounting Office to study preferential use of a particular private certifying board to the exclusion of all others, finding that "these preferences often occur without any objective justification."

The American Association of Physician Specialists (AAPS) is a national organization established in 1950 to provide a clinically recognized mechanism for specialty certification of physicians with advanced training, through an examination process. The AAPS is headquartered in Atlanta and is the home to twelve Boards of Certification. Each AAPS affiliated board has established criteria for examination development, examination validation, and candidate admission to the certification process. In recognition of the multiple mechanisms in the health care delivery system that continuously monitor physician performance, AAPS-affiliated boards provide a measurable, objective mechanism to meet the accreditation requirements of the multitude of organizations involved in accreditation and health care delivery.

New York City and New York State have already recognized that the AAPS boards, in particular the Board of Certification in Emergency Medicine (BCEM), is equivalent to the American Medical Specialty and the American Osteopathic Emergency Medicine Boards. New York determined that the examinations and requirements for admission to the certification process are equivalent, and that there were no issues of quality of care provided by BCEM-certified physicians. *New York further stated that should they exclude BCEM-certified physicians, they would equally have to exclude all practice-track certified emergency physicians, regardless of their certification.*

The effect of the proposed language in the Pennsylvania regulation will effectively exclude myself and a large cohort of equally well-qualified emergency physicians from participating in the Pennsylvania EMS system. Many hospitals and health care insurers follow the regulations established by the local government. Thus, these organizations may exclude physicians certified by the AAPS and the BCEM, thinking that they are in compliance with State Regulations, only further creating a statewide emergency physician shortage.

To conclude, I respectfully request that the language in proposed PA Code Chapter 1001, Subchapter A, Section 1001.2 (Definitions) be amended to **include the American Association of Physician Specialists.**

Sincerely,

Gary Glassman, MD
Emergency Department
St. Mary Medical and Trauma Center
Langhorne, PA 19047

Original: 2003
Bush
cc: Harris
Smith
Jewett
Sandusky
Legal

Sanders S. Ergas MD
259 Old Ridge Road
Hollsopple, Pa. 15935

Dear Robert Nyce,

I am writing in regard to your definition of board certification in emergency medicine. I have been a full-time emergency physician at Lee Hospital in Johnstown, Pa. for 13 years. You are presently considering legislation that defines board certification in emergency medicine. As the legislation now stands, it defines board certification to include only A.B.E.M. and A.O.B.E.M. boards. I strongly feel B.C.E.M. board certification should be added. B.C.E.M. requires identical length of practice and identical testing as required to "grandfather" A.B.E.M. and A.O.B.E.M. boards.

I refer you to legislation from:
Pa. Dept. of Health
28 Pa code part VII
relating EMS services
reference to Pa bulletin vol. 29
#7 Saturday Feb. 13, 1999
part 2, chapter 1001
subchapter A
section 1002.2
page 919

I feel exclusion of B.C.E.M. diplomats will negatively effect our states medical emergency care, by excluding highly qualified emergency physicians. I have included my curriculum vitae.

Please give this critical matter your utmost consideration. My home phone is: 814-479-2357. My work phone is: 814-533-0109. Please call or write if I can be of any assistance.

Yours truly,
Sanders S. Ergas MD
Associate Director Lee Hospital Emergency Department

CURRICULUM VITAE
Sanders S. Ergas, MD

Business Address:

Lee Hospital
320 Main St.
Johnstown, PA 15901
(814) 533-0789

Home Address:

RD #2, Box 110 B
Holsopple, PA 15935
(814) 479-2357

Education:

High School:	Morris Hills High School - Rockaway, New Jersey 07866 (1964-68)
College:	Pennsylvania State College (1968-1972) State College, PA 15651
Med. School:	Thomas Jefferson University Medical College (1972-1976), Philadelphia, PA
Internship:	Latrobe Area Hospital (June 1976-1977) Family Practice
Residency:	Latrobe Area Hospital (June 1977-1979) Family Practice

Licensures:

Pennsylvania 1977-79 - Renewed 1986 Colorado 1979-87

Nature of Practice:

Family Practice, Lake County Medical Associates, Leadville, CO 80461
Emergency Department Family Practice - St. Vincent General Hospital, Leadville, CO 80461, 40 hrs. per week (1979-87)
Lee Hospital, Emergency Medicine (1987 - present) - currently Assistant Chairman

Hospital Appointments:

Lee Hospital, Johnstown, PA 15901 (1987 - present)
St. Vincent General Hospital, Leadville, CO 80461 (1979-87)
Latrobe Area Hospital, Latrobe, PA 15650 (1976-79) Emergency Physician - multiple shifts during residency (1978-79)

Medical Societies:

Cambria County Medical Society
Colorado Medical Society (1979-87)
Lake County Medical Society (1979-87)

Boards:

American Academy of Family Practice - Recertification 1998
Board Certified - Emergency Medicine - American Assoc. of Osteopathic Specialists - 6/93

Certifications:

Basic Life Support
Advanced Cardiac Life Support
Advanced Cardiac Life Support Instructor
Advanced Trauma Life Support
Advanced Pediatric Life Support
Advanced Pediatric Life Support Instructor

Other:

Associate Chairman, Lee Hospital Emergency Department (1994-present)
Credentials Committee, Lee Hospital (1995 - present), Chairman (1997 - present)
Executive Committee, Lee Hospital (1997 - present)
Physician Director - Emergency Department, St. Vincent General Hospital
Physician Course Director - Emergency Medical Technician basic and intermediate (1984-86)
President Medical Staff - St. Vincent General Hospital, Leadville, CO 80461 (1983-84)
(1986-87)

updated 3/98

Original: 2003
Bush
cc: Harris
Smith
Jewett
Sandusky
Legal

292 Primrose Lane
Hanover, PA 17331
717-633-6293
Email: rcontino@blazenet.net

October 6, 1999

Reference: **28 PA Code Part VII Relating to Emergency Medical Services**
PA Bulletin Volume 29 Number 7
Saturday February 13, 1999 Part II Chapter 1001 Subchapter A
Section 1001.2 Page 919
Concerning the definition of Board Certification

Dear Mr. Nyce:

I am writing concerning the recognition of Board Certification of Emergency Medicine (BCEM). I would like to express my opinion that BCEM is an equivalent board certifying organization to ABEM and ABOEM. Currently the state of Pennsylvania only recognizes ABEM and ABOEM. It is before you now to show support for BCEM. I would strongly encourage you to do so. Many excellent physicians in Pennsylvania are certified by BCEM. Without complete statewide recognition of their board certification, their jobs remain in jeopardy.

To be certified by BCEM, a physician must complete a written exam, oral exam, and submit case studies. The process is roughly equivalent to ABEM. The difference being, BCEM offers the exam to physicians who are board certified in other primary care specialties, or have significant professional experience in emergency medicine. ABEM did the same thing until it chose an arbitrary date to close the "grandfather" process.

I would like to relate my personal experience and how I came to be certified by BCEM. I completed an approved osteopathic emergency residency. My residency director was also the sitting president of the American Osteopathic Emergency Physicians and held office on the certifying board (ABOEM). All of the residents in his program were offered jobs within his emergency medical firm. All were also offered jobs at a substantially reduced salary. Anyone who did not work for him, did not pass the ABOEM exam. There were multiple of us involved. Anyone who returned to work for him passed with the next exam seating. I refused to work for a tyrant, and did not pass. Shortly after the completion of my residency, federal investigators visited me. It would seem my old director was double billing Medicare. They wanted to question me. My old boss lost his job, but retained a high office on the board. Some time after his departure from Pennsylvania, he was arrested for other medical issues and, as I understand it, sent to jail for a brief period. Unfortunately, by the time he no longer had influence on my board exam results seven years had passed. Seven years is the time limit to pass the osteopathic boards post residency graduation. I attempted to sit for ABEM with an extensive explanation of my situation. In years past, ABEM allowed physicians who completed an osteopathic approved residency to sit for the exam. I was denied. I did not meet the requirements of the "grandfather clause." I found this very frustrating. I worked with physicians with one-year general internship, no specialty training, who could sit for the ABEM board. Enter BCEM.

I sat for the BCEM exam. I was told it was roughly the same as the ABEM exam. I needed to confirm to myself that my failure on the osteopathic boards was from tyrannical suppression rather than my lack of knowledge. I passed BCEM on the first try.

Although my story may make better reading as a soup opera or lawsuit script, it does demonstrate that there are many questions to be raised about boards already recognized by Pennsylvania. BCEM easily stands up to the standards of currently recognized boards in candidate selection and certification process.

Sincerely,

Ross Contino DO

Ross Contino, D.O.
Department of Emergency Medicine
Hanover Hospital

Original: 2003
Bush
cc; Harris
Smith
Jewett
Sandusky
Legal

October 7, 1999

Dear Mr Nyce

I am a life-long resident of the state of Pennsylvania and have been practicing medicine in this state since 1981. I am currently Board Certified in the practice of Emergency Medicine, as well as Family Practice and am currently on staff at St. Francis Central Hospital in Downtown, Pittsburgh since 1985.

The reason for my letter is to ask for your review and consideration of an upcoming bill in the Pennsylvania Department of Health proposed amendment #28 to the Pennsylvania Code Part VII, relating to emergency medical services. This article can be found in the Pennsylvania Bulletin Volume 29, #7, Saturday, February 13,1999, Part II, Chapter 1001, Subchapter A, Section 1001 and 1002, page 919, regarding definition of Board Certification. This proposed amendment would define Board Certification in Emergency Medicine following the guidelines established by the American Board of Emergency Medicine and the American Osteopathic Board of Emergency Medicine and exclude any other board certified candidates who did not fit these guidelines. I, myself, am a Board Certified Emergency physician through the authority of the American Association of Physician Specialists which is based in Atlanta, Georgia which has been in existence over forty years providing certification to physicians in various medical specialties including Emergency Medicine. If this legislation is allowed to pass as it stands, physicians like myself who have been providing competent emergency medical services in the state of Pennsylvania will no longer be allowed to provide the service known as medic command to emergency medical vehicles. We also run the distinct risk of losing our employment with various hospitals in the state of Pennsylvania. The physicians like myself who have attained this certification were unable to obtain certification through the ABM and AOBEM boards due to the fact that our primary training was not in emergency medical residency. Physicians like myself have been trained in other fields, such as Family Practice, Internal Medicine, General Surgery, etc. and many of us are board certified in those fields. We all, however, have dedicated our practice to emergency medicine for extended periods of time. We had to meet extensive requirements based on length of time of practice in emergency medicine, as well as pass a rigorous two day examination in Atlanta, Georgia. Physicians like myself feel that our certification was difficult to obtain and once attained was well earned. Our reason for obtaining

such certification is to add to our credibility amongst our standing in the medical community in our state as well as our medical staff. By disallowing our participation in such legislation, surely would be a serious blow to not only our credibility amongst the medical community but also to our ability to earn a living and pay taxes in the Commonwealth of Pennsylvania.

I would appreciate your intervention on behalf of myself and other physicians like myself to add the designation of physicians who are members of the Board Certification in Emergency Medicine through the American Association of Physician Specialists to be included in the recognition of Board Certification in the aforementioned legislation. I appreciate your time and would welcome any additional questions or comments.

Sincerely,

Mark J. Henzes, M.D.

MJH/alh

& CLINICAL Dr.
McKeesport PA
15135
412-751-3249

RECEIVED
1999 OCT -6 PM 1:38
INDEPENDENT REGULATORY
REVIEW COMMISSION

Mr. Robert Nyce
Executive Director
Independant Regulatory Review Commission
14th Floor
333 Market Street
Harrisburg, Pa 17101

Original: 2003
Bush
cc: Harris
Smith
Jewett
Sandusky
Legal

Dear Sir:

I am writing this letter in reference to the prposed amendments to the Pa Department of Health, 28 PA Code, Part VII, relating to Emergency Medical Services. The issue is outlined in PA Bulletin Vol 29 #7, Saturday February 13, 1999 (Part 2, chapter 1001, subchapter A, section 1001.2, page 919, the Definition of Board Certification in Emergency Medicine). Currently Pennsylvania law arbitrarily recognizes only two of the three Board Certification agencies in Emergency Medicine, the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM). I, and many other Emergency Physicians in the commonwealth are certified by the third agency, the Board of Certification in Emergency Medicine (BCEM). I have been an Emergency Physician in Pennsylvania for twelve years, and worked and studied VERY hard for my board certification examination. If the Commonwealth of Pennsylvania chooses arbitrarily to refuse to recognize my Board Certification, my livelihood is in jeopardy. Hospitals increasingly require Board Certification in a given specialty for credentialing physicians; if the commonwealth does not recognize my Board Certification, I may not be able to acquire privileges to work, since Emergency Medicine is entirely hospital based. Ability to bill for services is also increasingly linked to documentation of Board Certification.

I would very much appreciate your assistance in amending the above Pa Code to include the BCEM in the Definition of Board Certification, as outlined above. It is unfair for Pennsylvania to arbitrarily decide to exclude one of the three certifying boards. Please don't hesitate to call me at my home (570-992-2062) for more information.

Thank you very much!

Sincerely,

Richard Cornish MD

RECEIVED
1999 OCT -6 PM 1:38
INDEPENDENT REGULATORY
REVIEW COMMISSION

POCONO MEDICAL CENTER

FAX COVER SHEET

DATE: 6 OCT 99 **NUMBER OF PAGES:** 2
(Including Cover Sheet)

FROM: RICHARD CORRIGAN MD, ASSOCIATE DIRECTOR, DEPARTMENT OF EMERGENCY MEDICINE
POCONO MEDICAL CENTER, E STROUDSBURG PA 18301

PHONE: (570) 476-3353
FAX: (570) 421-6801

TO: MR. ROBERT WISE

SPECIAL INSTRUCTIONS/REMARKS:

MAIL ADDRESS: RD 6 BOX 6126
STROUDSBURG, PA 18360

Original: 2003

Regional Medical Transport
BUCKS COUNTY SQUAD 102
241 Philmont Avenue • Trevose, PA 19053
Office (215) 357-6474 Fax (215) 357-4981

May 30, 2000

Robert E. Nyce, Executive Director
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

VIA TELEFAX

RE: Discrepancies between the Emergency Medical Services Act 45 and the regulations as promulgated by the Department of Health.

Dear Mr. Nyce:

I am writing with several concerns regarding the proposed regulations that were submitted by the Department of Health, Emergency Medical Services Office (EMSO). Title 28, Chapters 1001-1013 et. seq., and there conflict with the statutory language of Act 45, Emergency Medical Services Act.

I have outlined our concerns for your review. Although we are aware the official comment period has expired, some of these discrepancies only recently came to our attention and we understand your office is permitted to review discrepancies on an on-going basis.

I have also attached a letter issued recently by the Department of Health, which clearly shows the intent of the Department to regulate out-of-state providers in conflict with both the Act and regulations promulgated, and event those proposed.

Should you have any questions, please feel free to contact me.

Sincerely,

ROBERT M. SKLAR
Executive Director

SECTION 1001.2 - DEFINITIONS

Under the definition for "ambulance service" we have noticed a large discrepancy regarding both the current regulations and proposed regulations issued by the Department of Health in contrast to the EMS Act.

Proposed / Current regulations:

> *Ambulance service* -- An entity which regularly engages in the business or service of providing emergency medical care and transportation of patients ***in*** this Commonwealth. The term includes [mobile] ALS ambulance services that may or may not transport patients.

EMS Act 45 – Section 3 - Definitions

> "Ambulance service." An entity which regularly engages in the business or service of providing emergency medical care and transportation of patients ***within*** this Commonwealth. The term includes mobile advanced life support services that may or may not transport patients.

The EMS act appears to only give the Department the ability to regulate emergency medical care and transportation that take place within (point-to-point) in the Commonwealth and additionally, the term *regularly* is not defined. The Department has stated that even a single transport would be a violation, yet this is clearly not the intent of the Act.

Additionally, under Section 1005.6 The Department of Health attempts to regulate out-of-state ambulance providers by stating that if the out-of-state company regularly engages in transports from within the Commonwealth to a location outside the commonwealth, they must be licensed. The Department proposes further that transports from outside the Commonwealth to a location within the Commonwealth of a regular basis (again – undefined) would need to be licensed.

There appears to be no statutory basis in the Act to allow the Department to promulgate regulations that conflict with the statutory definition of an ambulance service (i.e., service *within* the Commonwealth)

SECTION 1005 – LICENSING OF BLS AND ALS AMBULANCE SERVICES

Proposed / Current Regulations:

> **§1005.6. Out-of-State providers.**
> Ambulance services located or headquartered outside of this Commonwealth that [have primary response areas or routinely] regularly engages in the business of providing emergency medical *care and* transportation of patients from within this Commonwealth, to facilities within or outside this Commonwealth, are required to be inspected and licensed by the Department.

EMS Act 45: - Section 12

> Section 12(t) Exemptions – The following are exempt from the licensing provisions of this act:
> (3) Services located or headquartered outside this Commonwealth which do not routinely transport patients from locations beyond the limits of this Commonwealth to locations within this Commonwealth.

These two sections appear to contradict each other in that the Act provides that licensure would not be required for an out-of-state provider who does not transport patients from out-of-state to location in the Commonwealth, unless it is done on a regular basis (although this term is not defined), in which case licensure would be required.

In contrast, the Current and proposed regulation appear to allow the reverse, stating that an out-of-state provider only need become licensed if it regularly engages in transporting patients from inside the Commonwealth to locations either inside or outside the Commonwealth.

The act appears to allow out-of-state providers unlimited transports from inside the Commonwealth to locations out-of-state, yet the regulations appear to preclude that. In essence, the regulations are not supported by the Act in this matter.

SECTION 1005 - LICENSING OF AMBULANCE SERVICES

The regulations, both promulgated and proposed, outline the application process, inspection process, criteria for ambulance licensure and grounds for refusal of an ambulance license and licensure standards.

Despite this, the Department of Health has denied licensure using only Section 12(h)(1) of the EMS Act which states:

"The department shall issue a license to an ambulance service pursuant to this act when it is satisfied that the following standards have been met:
(1) The ambulance service is staffed by responsible persons."

We are concerned about several issues regarding this application.

1. The Department is disregarding the regulations and the 19 criteria promulgated which are basis for denial or refusal of a license.
2. The term "responsible person." is not defined.
3. This leaves the Department with the latitude to impart a completely subjective decision regarding who is responsible or not.
4. "service staffed by responsible persons." Fails to define what "staffed" means and the criteria used to determine who is responsible or not.

The only place the Department has begun to use the term "responsible person" is in reference to ambulance drivers being added to Section 1005.10(d)(3) in which the Department defined the qualifications of a responsible person.

1005.5(a) A license to operate as an ambulance service will be issued by the Department when it has [been] determined that requirements for licensure have been met.

Despite the language of the regulations, the requirements for licensure are not clear. If the Department lists the standards for licensure, the grounds for denial and yet can fall back on a subjective and undefined requirement "responsible persons."

This clears the way for the Department to make arbitrary and capricious decisions without adequate notice to the applicant of what the expectations are. Additionally, with the Department clarifying that the requirements for renewal of license are the same as an initial license, this issue becomes more important.

SECTION 1005.4 NOTIFICATION OF DEFICIENCIES

Under Section 12(o) of the EMS Act 45, the section deals with the process in which an ambulance service it notified and given an opportunity to correct any violations of the Act or regulations promulgated under the act.

The proper procedures, i.e., 30-days to enter into corrective action plan, cure violations, etc., is not promulgated in the regulations.

The Department has taken the liberty of ignoring this notice and corrective action requirements by allowing the Department to move directly to a hearing and suspension process for alleged violations.

It is not clear why the regulations make a limited reference to a 30-day period to correct "deficiencies" rather than the legislative intent of correcting any violation(s).

Sections 1005.4 and 1005.12(a) should be reviewed, as they do not appear to comply with the statutory intent of the EMS Act.

DEPARTMENT OF HEALTH
...in pursuit of good health

(717) 783-2500

May 26, 2000

Ann Luberto
Accurate Medical
17 Wellington Court
Sayreville, NJ 08872

Dear Ms. Luberto:

This is in reply to your May 17, 2000 letter sent to Sandra Jablonski, Executive Director of Southern Alleghenies EMS Council. I will respond to the inquiries contained in your letter.

I am the Director of the Emergency Medical Services Office (EMS Office) of the Pennsylvania Department of Health (Department). By statute, the Department is designated as the lead agency for EMS in Pennsylvania. Southern Alleghenies EMS Council is a regional EMS council, under contract with the Department to assist the Department administer the EMS Act in the Southern Alleghenies EMS Region. Your inquiries are most properly addressed by the Department's EMS Office. The answers to your questions are as follows.

1. Under what circumstances does an out-of-state ambulance service need licensure in Pennsylvania?

The EMS Act prohibits an entity from operating as an ambulance service in Pennsylvania unless it is licensed as an ambulance service by the Department (35 P.S. §6932(a)) or is exempt from the licensure requirement. An out-of-state ambulance service does not enjoy a licensure exemption unless it is involved in transporting a patient from a location outside of Pennsylvania to a location inside Pennsylvania and does not engage in that activity on a routine basis (35 P.S. §6932(t)(3)); it is owned and operated by an agency of the Federal Government (35 P.S. §6932(t)(4)); it is dispatched to an emergency when ambulances based in a Pennsylvania locality are insufficient to render the services required (35 P.S. §6932(t)(2)); or the Governor of Pennsylvania declares a state of emergency in Pennsylvania or an area of Pennsylvania and suspends operation of the ambulance service licensure laws during the period of that emergency (35 Pa.C.S. §7301). The operation of an out-of-state ambulance service in Pennsylvania, other than pursuant to a Pennsylvania license or under one of these exemptions, constitutes a summary offense (35 P.S. §6936).

2. Can an out-of-state ambulance service transport a patient from Pennsylvania who is returning to the out-of-state location? Does that service require licensing?

In answer to the first question, subject to the applicable exemptions referenced in my answer to question 1 (this would not include the 35 P.S. §6932(t)(3) exemption), and assuming that the out-of-state service is not licensed as an ambulance service by the Department, the answer is "no" unless the nature of the transport does not require that it be accomplished by an ambulance. Under those circumstances laws of Pennsylvania other than the EMS Act may still need to be satisfied. In answer to the second question, the service would require a license from the Department subject to the caveats mentioned in my answer to your first question.

3 Does a service that brings patients from outside the Commonwealth to a hospital inside the Commonwealth require licensure in Pennsylvania?

Yes, except as previously explained. For purposes of emphasis, I reiterate that pursuant to 35 P.S. §6932(t)(3), an out-of-state ambulance service not licensed in Pennsylvania may transport patients from outside of Pennsylvania, to hospitals inside of Pennsylvania, provided it does not perform those transports on a routine basis.

4. Based on the regulations addressing out-of state providers, what are the requirements for licensure of out-of-state services that provide occasional services within the Commonwealth?

Keeps state regulating engages

The occasional offering of services in Pennsylvania by out-of-state ambulance services not licensed in Pennsylvania is not permitted except pursuant to the exemptions previously discussed. The requirements for licensure are no different than for ambulance services that operate routinely in Pennsylvania. However, the Department may grant exceptions to Pennsylvania licensure requirements that are not imposed by statute if the ambulance service operates in a contiguous state. The circumstances under which exceptions may be granted are enumerated in Department regulation 28 Pa. Code §1005.1(d).

I hope you find this reply fully responsive to the questions presented in your letter.

Sincerely,

Margaret E. Trimble

Margaret E. Trimble

cc: Sandra L. Jablonski

FACSIMILE COVER PAGE

Date: 7/26/00
Time: 15:12:04
Pages: 8

To: Robert E. Nyce
Company: PA IRRC
Fax #: 717-783-2664

From: RMT OPERATIONS
Title: TREVOSE
Company: REGIONAL MEDICAL TRA
Address: 241 PHILMONT AVE
TREVOSE, PA 19053
Fax #: 215-357-4981
Voice #: 215-357-6474

Message:

Mr. Nyce:

As per our discussion here are the concerns we have. I have enclosed 4 issues along with a letter from the Department of Health that makes a contradictory refence to the regulations and EMS Act.

Thanks,

Bob

Eckert, Christina A.

From: Brody, Kenneth [kbrody@state.pa.us]
Sent: Friday, May 26, 2000 3:29 PM
To: 'IRRC@IRRC.STATE.PA.US'
Cc: Trimble, Peggy
Subject: Emergency Medical Services Regulations

Original: 2003

Attention: Mary Lou Harris

Thank you and the other members of IRRC staff for informally reviewing with Peg Trimble and me your concerns and questions regarding the draft final EMS regulations. During our 5/24/00 telephone call we agreed to provide you with the following information:

1. Subpoenas are considered orders of a court under both the Commonwealth's Rules of Civil and Criminal Procedure. See Pa.R.C.P No. 234.1(a) and Pa.R.Crim.P. 9016. Nevertheless, not all subpoenas may be accorded similar stature. Consequently, §1001.42(a)(4) will probably be revised to include only a subpoena that does constitute a court order, as follows:

(4) Under an order of a court of competent jurisdiction, INCLUDING A SUBPOENA WHEN IT CONSTITUTES A COURT ORDER, EXCEPT WHEN THE INFORMATION IS OF SUCH NATURE THAT DISCLOSURE PURSUANT TO A SUBPOENA IS NOT AUTHORIZED BY LAW.

2. The provisions in the Confidentiality of HIV-Related Information Act that prohibit release of confidential HIV-related information pursuant to a subpoena are 35 P.S. §§7607(a)(10) and (e) and 7608.

3. The two cases I mentioned that pertain to the release of information under the Disease Prevention and Control Law of 1955 are Brown v. Commonwealth, Department of Health, 495 Pa. 456, 434 A.2d 1179 (1981), and Commonwealth v. Moore, 526 Pa. 152, 584 A.2d 936 (1991).

4. The observation that the draft preamble did not respond to IRRC's comment relative to §1003.4(d)(1) and (2) was correct. The draft preamble does mention the comment, but only responds to the first part of the comment. This will be corrected in the final preamble and annex.

5. The language in §1005.10(d)(1)(iii)(A), "SUCH STAFF BEING THE STAFF OF THE AMBULANCE SERVICE EXCEPT AS OTHERWISE AUTHORIZED BY THIS SUBSECTION", was included to address the problem the EMS Office has encountered with ambulance services that respond with less than required minimum staff and then contend that their staffing requirements are satisfied when their staff is supplemented by staff from another responding ambulance service. The sharing of personnel from two responding ambulance services to meet minimum staffing standards is not acceptable except when an ALS squad unit

responds
to an ALS call. In that case, a BLS ambulance also needs to be dispatched
because the ALS squad unit is not equipped to transport the patient. In this situation the required minimum staff of one ALS practitioner (i.e., EMT-paramedic or health professional) and one person at least at the level
of an EMT, may be satisfied by the ALS practitioner of the ALS ambulance service and an EMT from the BLS ambulance service. This is addressed in §1005.10(d)(1)(ii)(C). If the patient is an ALS patient and requires transport to a receiving facility, the ALS practitioner boards the BLS ambulance and tends to the patient during the transport.
I believe we have provided you with all of the information that was requested. Please advise if we forgot something.

Independence Blue Cross

RECEIVED
99 MAR 18 AM 9:09
INDEPENDENT REGULATORY REVIEW COMMISSION

ORIGINAL: 2003
BUSH
COPIES: Harris
Smith
Jewett
Sandusky
Legal

1901 MARKET STREET
PHILADELPHIA, PA 19103-1480

September 4, 1998

CERTIFIED MAIL

Joel Miller, DO
3998 Red Lion Road
Suite 208
Frankford- Torres Medical Bldg.
Philadelphia, PA 19114

RE: RECREDENTIALING APPLICATION APPEAL

Dear Dr. Miller:

Recently, the Independence Blue Cross (IBC) integrated Credentialing Committee received your recredentialing application appeal.

The Committee reviewed the information regarding Board Certification you supplied.

As a result of that review, the Committee has denied the appeal for recredentialing.

If you have any questions please contact Elizabeth C. Coan at (215) 988-6506.

Sincerely,

Michael N. Dubroff, DO
Chairman Credentialing Committee

MD\ecc

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FILE
O'Neill

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Original: 2003
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cc: Harris
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Sandusky
Legal
All Commissioners

August 19, 1999

99 AUG 23 AM 8:47

Mr. Robert E. Nyce
Executive Director
Independent Regulatory Review Commission
14th Floor 333 Market Street
Harrisburg, PA 17120

Dear Mr. Nyce:

Subject: To broaden the definition of "Board Certification" in emergency medicine in the Proposed Amendments to 28 Pa. Code Part VII (relating to emergency medical services) as published in the *Pennsylvania Bulletin*, Volume 29, Number 7, Part II, dated February 13, 1999.

By way of introduction, I am an emergency physician in practice at Mercy Hospital in Pittsburgh, Pennsylvania, a Level I Regional Trauma Center. I received my M.D. degree from the Pennsylvania State University Medical School in 1982. I have been an attending physician in emergency medicine at Mercy Hospital since 1990.

I chose to present myself for the American Association of Physician Specialists, Inc. (AAPS) affiliated Board of Certification in Emergency Medicine. Although board certification is voluntary in the United States, there is increasing pressure on all physicians to complete this credentialing process. *The boards of other certifying bodies were closed to me since they had closed their practice track years ago.* The proposed regulatory language will affect my practice directly because I may be unable to practice emergency medicine if the language change is not broadened to include my Board of Certification in Emergency Medicine from the American Association of Physician Specialists.

Speciality certification is voluntary. It is distinctly separate from licensure. It is the formal recognition of a speciality board that a physician has reached proficiency in their chosen field. The definition of each specialty, in addition to the education and other requirements leading to the acceptance into certification, is developed by consensus within the medical profession.

The American Association of Physician Specialists, Inc. (AAPS) is a national organization established in 1950 and incorporated in 1952 to provide a clinically - recognized mechanism for speciality certification of physicians with advanced training through an examination process. The AAPS is the administrative home for Twelve Boards of Certification. Each AAPS affiliated board of certification has established criteria for examination development, examination validation, and candidate admission to the certification process. The AAPS affiliated boards provide a measurable, objective mechanism to meet the certification requirements of the multitude of organizations involved in accreditation and health care delivery.

The Regional Emergency Medical Services Council of New York City, Inc. and the Regional Emergency Medical Advisory Committee of New York (REMAC) have recognized the American Association of Physician Specialists (AAPS) boards, in particular the Board of Certification in Emergency Medicine (BCEM) to be equivalent to the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM). The New York state REMAC determined, with the aid of counsel, that **the examinations and requirements for admission to the certification process are equivalent, and that there were no issues of quality of care provided by the physicians under AAPS's Board of Certification in Emergency Medicine (BCEM).**

As a member of the American Association of Physician Specialists (AAPS), I am asking that the language in "Board Certification" in Emergency Medical Services in Proposed Pa. Code, Part VII, Chapter 1001, Subchapter A, Section 1001.2 (Definition) be amended to include the American Association of Physician Specialists (AAPS).

I appreciate the time you have taken to read my letter and ask that you extend your leadership on my behalf and that of the American Association of Physician Specialists.

Sincerely,

MD, MPH

Joan M. Mavrinac, M.D., M.P.H.
5 Grandview Avenue, #305
Pittsburgh, PA 15211

412-481-4373

Thomas Michael, MD 120 Moffett Run Road Aliquippa, PA 15001 Phone: 724-375-2860

99 AUG -9 AM 8:01

Original: 2003
Bush
cc: Harris
Smith
Jewett
Sandusky
Legal

Independent Regulatory Review Commission
14th Floor
333 Market St.
Harrisburg, PA 17120

August 8, 1999

Dear Commission Members:

I am writing to comment on proposed amendments to 28 PA. Code part VII (relating to emergency medicine services) as published in the Pennsylvania Bulletin, Volume 29, Number 7, Part II dated February 13, 1999. My comment is directed to proposed Chapter 1001, Subchapter A, Section 1001.2 (Definitions) and the effects of the proposed definition of "Board Certification" (page 919 of proposed rulemaking).

I chose to present myself to the American Association of Physician Specialists, Inc. (AAPS) affiliated Board of Certification in Emergency Medicine. I am also certified by the American Board of Family Practice. Although board certification is voluntary, there is increasing pressure on all physicians to complete this credentialing process. The boards of other emergency medicine certifying bodies were closed to me because they have closed there practice track years ago. I have been practicing Emergency Medicine since 1991 and actually have more formal medical training than many of those certified by these bodies. The proposed regulatory language may cause me to be unable to practice emergency medicine.

The proposal will also have a detrimental effect on under-served areas. Excluding a certifying body indiscriminately may very likely leave these areas without physicians. Specialty certification is voluntary. It is distinct from licensure. It is the formal recognition of a specialty board that a physician has reached proficiency in their chosen field. The Department seeks to define "board certification" in a way that will exclude one private certifying body while giving preference to other certifying bodies without having established criteria for recognition of certifying bodies. The chair of the US General Accounting Office found that "these preferences often occur without any objective justification."

This issue is important because these certifications are often prerequisites for federal or state contracting opportunities or a requirement for compliance with regulations and guidelines. Rep. Robert Stump, Chair of the Hose Committee on Veterans' Affairs, had similar concerns regarding preferential treatment in their recognition of particular board certifying organizations. He was most interested in criteria use to evaluate the organizations. (fl 10-97-031 dated August 12, 1991).

99 AUG -9 AM 8:01

The American Association of Physician Specialists, Inc. (AAPS) is a national organization established in 1950 and incorporated in 1952 to provide a recognized mechanism for specialty certification of physicians through an examination process. The AAPS is the administrative home for twelve Boards of Certification. Each AAPS affiliated board of certification has established criteria for examination development, validation and candidate admission to the certification process. AAPS affiliated boards provide a measurable, objective mechanism to meet the accreditation requirements of the many organizations involved in health care accreditation and delivery.

The Regional Emergency Medical Services Council of New York City, Inc. and the Regional Emergency Medical Advisory Committee of New York (REMAC) has recognized that the AAPS affiliated Board of Certification in Emergency Medicine (BCEM) is equivalent to the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM). The New York REMAC determined, with the aid of counsel, that the examinations and requirements for admission to the certification process are equivalent, and that there were no issues of quality with care provided by BCEM-certified physicians. The REMAC counsel further stated that, should REMAC exclude BCEM-certified physicians, similarly certified ABEM physicians (those certified via the practice track) would also have to be excluded.

Although the General Provision of the Proposed Rulemaking provide that reference to specific certifying bodies would not preclude the Department from considering persons with certifications by other private certifying bodies, the effect of the proposed language in the regulation will effectively exclude a cohort of physicians from participation in the Pennsylvania emergency medical system. Many private organizations, hospitals, health care insurers, managed-care organizations, and others generally follow the regulations established by the local governmental body. As such, many of these organizations will exclude those physicians certified by one of the American Association of Physician Specialists, Inc. (AAPS) affiliated boards of certification thinking that they are in compliance with State Regulations.

Therefore, we request that the language in proposed PA. Code Chapter 1001, Subchapter A, Section 1001.2 (Definitions) be amended to include the American Association of Physician Specialists, Inc.

Sincerely,

Thomas Michael MD

Thomas Michael, MD

ORIGINAL: FORTHCOMING
RR: SANDUSKY 8/13
GELNETT
NYCE 8/11

Pennsylvania State Association of Township Supervisors

Original: 2003
Bush
cc: Harris
Smith
Jewett
Sandusky
Legal

August 4, 1997

Kum S. Ham, Ph.D., Director
Division of EMS Services
Room 1033
Health and Welfare Building
Harrisburg, Pennsylvania 17120

Dear Dr. Ham:

On behalf of the state's 1,457 townships and their more than 4.6 million residents, the Pennsylvania State Association of Township Supervisors would like to offer its comments on the proposed revisions to the Emergency Medical Services Act Regulations.

The Association's major concerns rest with Section 1001.8. of the proposed revisions, which deals with **primary response areas**. These revisions would strip a municipality of its authority to establish which BLS (Basic Life Support) ambulance service or ALS (Advanced Life Support) ambulance service would be the primary response provider when an ambulance is dispatched to the scene of an emergency.

Under the proposed revisions, the regional EMS council would be authorized to assign the ALS and BLS ambulance services to primary response areas. Our concern is that private emergency responders would be *competing* for service areas and *monopolize* the regions. Local fire departments, volunteer ambulance companies and township residents could be short-changed as a result. While local emergency responders could find themselves squeezed out of response areas, residents who are accustomed to paying an annual $30 subscriber's fee for unlimited ambulance services could find themselves, according to some township officials, paying fees in excess of $225 to private responders for each emergency response.

The Association believes that the local volunteer fire and ambulance departments should be given the first right to the primary response areas. ***In 1995, over 70 percent of all emergency incidents were responded to in less than five minutes by local responders***. The proposed regulations establish 10 to 20 minute response times, which are much longer than the response time that local responders have been providing to residents.

The Association appreciates and supports the mission of the EMS Councils and the Pennsylvania Department of Health to evaluate, develop and coordinate emergency medical services in the commonwealth. However, we believe that *local officials know best* the capability of their volunteers, the residents' needs and the service area.

3001 GETTYSBURG ROAD • CAMP HILL, PENNSYLVANIA 17011-7296 • TELEPHONE (717) 763-0930 • FAX (717) 763-9732
PUBLISHER OF THE PENNSYLVANIA TOWNSHIP NEWS MAGAZINE

Thank you for considering our comments and concerns about these proposed revisions. We would be more than willing to discuss any questions or concerns you may have with our comments. We look forward to hearing from you.

Sincerely,

Elam M. Herr
Director of Legislation

kg

cc: John R. McGinley, Jr., IRRC
Rick Flinn, Pa. Emergency Health Services Council
Honorable Dennis M. O'Brien, House Health and Human Services Committee
Honorable Frank L. Oliver, House Health and Human Services Committee
Senator Harold F. Mowery, Jr., Senate Public Health and Welfare Committee
Senator Hardy Williams, Senate Public Health and Welfare Committee
Honorable Lynn B. Herman, House Local Government Committee
Honorable Terry E. Van Horne, House Local Government Committee
Senator James Gerlach, Senate Local Government Committee
Senator Roy C. Afflerbach, Senate Local Government Committee

Original: 2003
Bush
cc; Harris
Smith
Jewett
Sandusky
Legal

193 Bonehedge Rd.
Hollidaysburg, PA 16648
May 19, 1999

Director of the Independent Regulatory Review Commission
Director Robert F. Nyce
14th Floor, Harristown 2
333 Market Street
Harrisburg, PA 17101

Dear Director Nyce:

This is a brief letter of thanks to your commission's appraisal of the Pennsylvania Department of Health's Emergency Medical Services regulatory language, in amendment to 28 PA code pt. 7 Chapter 1001 Sub-chapter A section 1001.2.

This is the issue related to board certification. Your commission's comment, "The Department should justify the need and reasonableness of limiting board certification to ABMS and AOA certification," is resoundingly accurate in my opionion. This is important to me because I am currently boarded in emergency medicine by BCEM/AAPS and feel it should be included in the current regulatory language.

Once again thank you for your careful consideration of this issue.

Sincerely

Ronald W. Gregory, D.O.