

FRANK R. PENATER, M.D., F.A.A.F.P.
824 North 24th Street
Allentown, PA 18104-3912
Phone 610-433-8301

July 30, 1999

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Bush

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

Dear Mr. Nyce:

I am writing regarding the proposed amendments to 28PA, code part VII (relating to emergency medical services) as published in the PA Bulletin, vol. 29, #7 part II dated 2/13/99, in reference to the proposed definition of "Board Certification" (page 919 of proposed rulemaking).

By way of introduction, I am an emergency physician in practice at Gnadon Huetten Memorial Hospital in Lehighton, PA. I am residency trained and board certified in Family Practice which is a broad based specialty encompassing many different subspecialty groups including training in emergency medicine. Emergency medicine residencies are also broad based and include training in Family Practice and these two specialties have many rotations that overlap. I have been successful and effectively working in these specialties since completing my residency 28 years ago and keep myself current and up to date via journal, conferences and continuing medical education courses. I am also board certified in emergency medicine through the Board of Certification in Emergency Medicine under the umbrella of the American Association of Physician Specialists (AAPS).

The American Association of Physician Specialists, Inc. 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 AAPPS is the administrative home for twelve Boards of Certification. Each AAPS affiliated board of certification has established criteria for examination, developments, examination validation, and candidate admission to the certification process.

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.

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FEDERAL BUREAU OF INVESTIGATION

I am writing you to encourage your support for recognition of my emergency medicine certification under the auspices of Amendment 28 PA, code VII. Under the proposed regulatory language only emergency physicians certified by American Board of Medical Specialists (ABMS) and American Osteopathic Association (AOA) are to be recognized.

It is my belief that many of my colleagues and I, who have long, excellent emergency practice careers in Pennsylvania and are boarded by BCEM/AAPS deserve the same recognition. Therefore, I 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,

A handwritten signature in black ink, appearing to read "F Penater". The signature is fluid and cursive, with a large initial "F" and a long, sweeping underline.

Frank R. Penater, MD, FAAFP, BCEM

#2003
MTC on 4/5/99

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Eligibility Requirements For Three EM Boards

(From the Editor) LITERATURE REVIEW COMMISSION

Ever wonder what it takes to become eligible to take the different emergency medicine board exams? There are three main exams available for physicians to become certified in EM, and their eligibility criteria differ somewhat.

The three are the American Board of Emergency Medicine (ABEM, an ABMS affiliate, recognized by ACEP), the American Osteopathic Board of Emergency Medicine (AOBEM, an AOA affiliate, also recognized recently by ACEP), and the Board of Certifica-

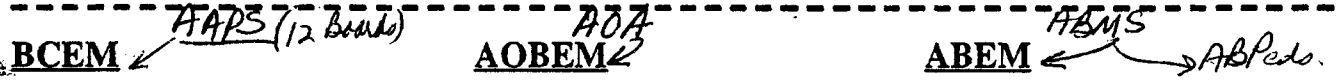
tion in Emergency Medicine (BCEM, an AAPS affiliate).

The eligibility requirements for ABEM changed about 10 years ago, when the now controversial "practice track" expired. There are a reported 8,000 emergency physicians certified by ABEM under "practice track" or "academic internist" criteria, and approximately that many more certified via the current criteria, which includes EM residency training. The requirements for BCEM eligibility also changed recently, with the expiration of their version of the "practice track" (one that allowed eligibility based on

years and hours of practice in EM without requiring completion of any residency). Some can still become a candidate for BCEM by satisfying a "special considerations" pathway, which includes completing a primary care residency, attaining other certifications, and meeting years and hours of EM work criteria.

All three boards now require recertification every 10 years.

What follows below is a synopsis of the eligibility requirements for these three boards:



1. Graduate of recognized College of Medicine.
2. Must hold valid license to practice medicine in his/her resident state or province.
3. Must be in conformity with the Code of Ethics of the AAPS, and known in community as an ethical member of the profession and an active specialist in EM.
4. Certified on the "provider" level in ACLS and ATLS.
5. Be qualified under one of the following:
 - a. Completed an EM residency; or
 - b. Completed primary care residency, practiced EM full-time for 5 years and a minimum of 7,000 hours; or
 - c. Practiced EM for 6 years and minimum of 10,000 hours prior to December 31, 1997, i.e. now expired.
6. Recertify every 10 years.

1. Graduate of AOA-accredited college of osteopathic medicine.
2. Licensed to practice in resident state or territory.
3. Conformity with Code of Ethics of AOA.
4. Member of AOA or Canadian OA at least 2 years prior to exam.
5. Completed an AOA-approved internship.
6. Satisfactory completion of 3 years of training in EM in AOA-approved residency. (practice option expired)
7. One full year of EM practice prior to exam.
8. Recertify every 10 years.

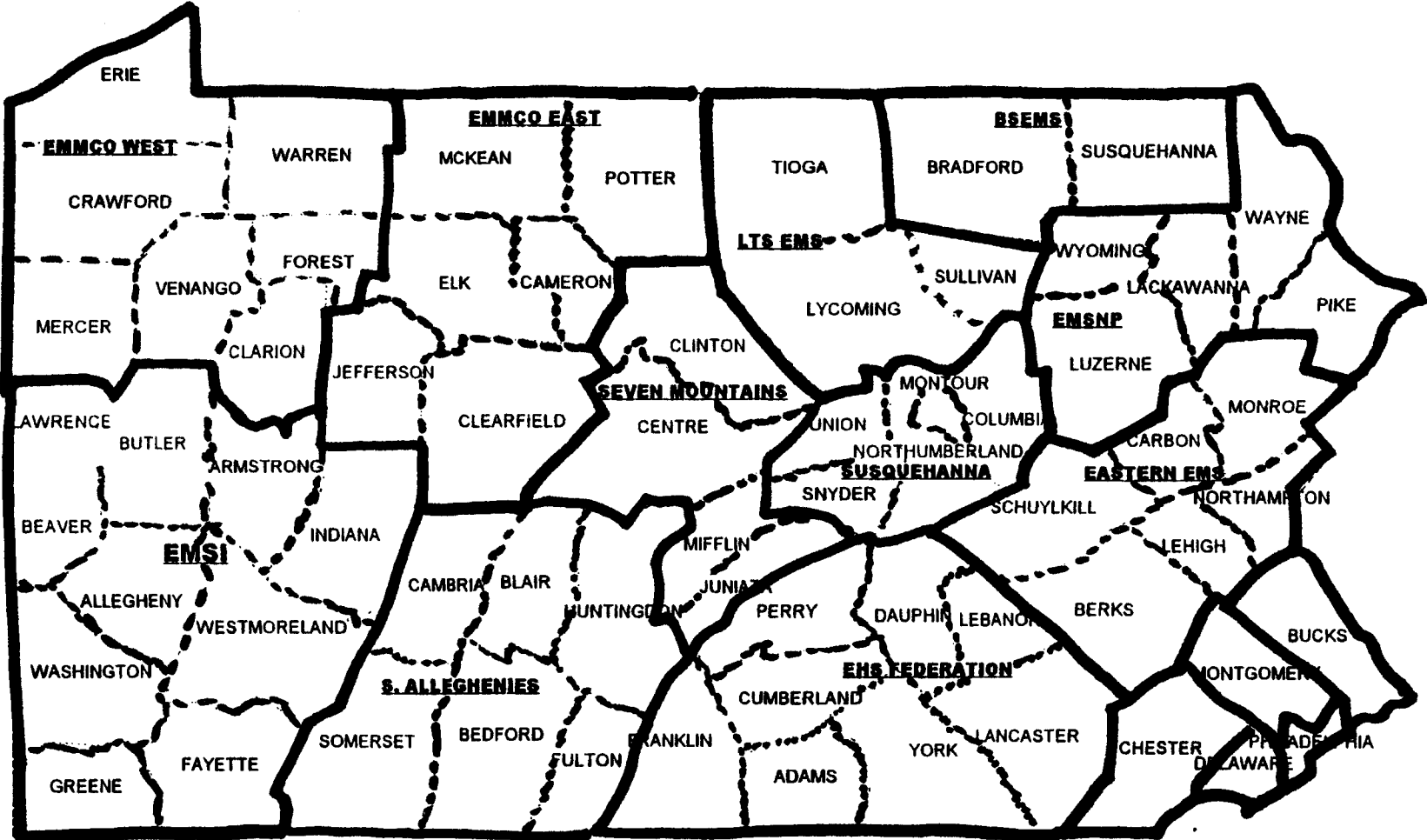
1. Must satisfy all credential requirements at time of application.
2. Medical school graduate (non-USA or Canadian school - need verified diploma).
3. Must hold valid license to practice medicine in USA or Canada.
4. Successful completion of EM residency program accredited by Residency Review Committee for EM or by the Royal College of Physicians and Surgeons of Canada. (practice option expired)
5. Recertify every 10 years. ■

AAPS = Amer Assoc of Physician Spec. (allo + osted)
AOA = Amer. Osteop. Assoc.
ABMS = Amer. Board of Med Spec.

Certification Process & Implications
 Certification Process & Implications is a newsletter of the Section of Certification Process & Implications for Emergency Medicine of the American College of Emergency Physicians.
 All correspondence and address changes should be addressed to the Certification Process & Implications Section, ACEP, PO Box 619911, Dallas, TX 75261-9911
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EMS REGIONS



TRAUMA SYSTEMS FOUNDATION

April 16, 1998

William J. Carbone
Executive Director

American Association of Physician Specialists Video tape and pamphlets in file
804 Main Street, Suite D
Forest Park, GA 30050

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APR 22 1998

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AMERICAN ASSOCIATION OF
PHYSICIAN SPECIALISTS, INC.

Dear Mr. Carbone:

This letter is in response to your October 14, 1997 letter to Bruce M. Bartels, Chairman of the Pennsylvania Trauma Systems Foundation.

Your request generated considerable discussion and input from several sources. Hence the length of time prior to response. The Foundation recently completed a review of its current Standard and policies regarding Board Certification. The information you supplied with your October 14 letter was reviewed during several meetings and conference calls. After consultation with professional medical organizations, including the American College of Surgeons Committee on Trauma (ACSCOT) and the Pennsylvania Medical Society, the Foundation reaffirmed the current Standard as noted in the *1996-98 Standards for Trauma Center Accreditation*, Standard VI, C2 (Enclosed). Please Note: The Pennsylvania Standards for Trauma Center Accreditation are required by law to include, at a minimum, the current guidelines for trauma care by the ACSCOT.

The Foundation did not approve the addition of the American Association of Physician Specialists board certification to either the Standards or Board Certification policies. However, an *Alternate Pathway to Board Certification as Criterion for Trauma Panel* modified from the ACSCOT *Alternate Pathway* was approved (Enclosed). Any physician or surgeon not meeting the current Standard for Board Certification as written in the *1996-98 Standards for Trauma Center Accreditation* may use this alternate pathway as a possible mechanism for participation in trauma patient care at a Pennsylvania accredited trauma center.

Please contact me if you have any further questions or comments.

Sincerely yours,

Carol Forrester Staz
Executive Director

Enclosures

cc: Bruce M. Bartels; Chairman, PTSF Board of Directors
C. William Schwab, MD, FACS; Chairman, PTSF Standards Committee

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PTSF POLICY, March 12, 1998

based on the American College of Surgeons Committee on Trauma
Alternate Pathway to Board Certification as Criterion for Trauma Panel appended
(May 15, 1997) to the *Resources for Optimal Care of the Injured Patient: 1993*

In rare circumstances, a non-board certified surgeon or physician may be included on the trauma team. This situation may arise when the number of surgeons or physicians is limited in a community that desires to establish an accredited trauma program. To assist these programs in providing optimal care to the injured patients with existing surgical/medical resources, the following alternate pathway to board certification has been developed. This option cannot be used for the trauma program medical director of the trauma program. When considering the alternate pathway, the Pennsylvania Trauma Systems Foundation Board of Directors/Executive Committee will look for the following documentation.

1. The specialist successfully completed an accredited residency training program in that specialty. This should be certified by a letter from the program director.
2. Documentation of current provider or instructor ATLS verification.
3. A list of the required number of hours of trauma-related CME over the past three years.
4. Documentation that the physician is present in at least 50 percent of the trauma Quality Management and educational meetings.
5. Documentation of membership or attendance at local, regional, and national trauma meetings over the past three years.
6. A list of patients treated over the past year with accompanying ISS and outcome.
7. Quality Management assessment by the trauma program medical director showing that the morbidity and mortality results of the physician compare favorably with the morbidity and mortality results for comparable patients treated by the other members of the trauma team.
8. A letter by the trauma program medical director demonstrating this critical need in the trauma program because of the surgeon's/physician's experience or the limited surgeon/physician resources in that specialty within the hospital trauma program.

The request for consideration of the alternative pathway must be submitted in writing with the required supporting documentation to the PTSF Executive Director. The information will be presented in a blinded (anonymous) manner to the PTSF Board of Directors and/or Executive Committee for review and final determination.

Reference: *1996-98 Standards for Trauma Center Accreditation, Standard VI, C2*
1996-98 Standards for Pediatric Trauma Center Accreditation, Standard VI, C2

3/30/98

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General Standards

Standard VI - Physician Credentials, Certifications, and Continuing Medical Education	Regional Resource Trauma Center (Level I)	Regional Trauma Center (Level II)	Additional Qualifications in Pediatric Trauma (Level I/II)
2. Board Certification: All physicians listed who care for trauma patients will be Board Certified by the appropriate specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association or active candidates as defined by their respective boards. If an individual has not been certified within 5 years after successful completion of an ACGME or Canadian residency, that individual is unacceptable for inclusion on the trauma team until Board Certification is achieved.	E	E	*
a. Surgical Specialties			
1. Cardiac Surgery	E	E	*
2. General Surgery	E	E	*
3. Neurologic Surgery	E	E	*
4. Obstetric and Gynecologic Surgery	E	E	*
5. Ophthalmic Surgery	E	E	*
6. Oral/Maxillofacial Surgery	E	E	*
7. Orthopaedic Surgery	E	E	*
8. Otorhinolaryngologic Surgery	E	E	*
9. Pediatric Surgery	E	E	*
10. Plastic Surgery	E	E	*
11. Thoracic Surgery	E	E	*
12. Urologic Surgery	E	E	*
b. Non-Surgical Specialties			
1. Anesthesiology	E	E	*
2. Cardiology	E	E	*
3. Emergency Medicine	E	E	*
4. Family Medicine	E	E	*


E = Essential

D = Desired

* = Level I or Level II standard must be met depending on level of application

Pennsylvania

TRAUMA SYSTEMS FOUNDATION

TO: Trauma Center Contacts
FROM: Carol Forrester Staz 
DATE: March 31, 1998
SUBJECT: Standard VI - Physician Credentials, Certifications, and Continuing Medical Education, C2, Board Certification

The Foundation has received several inquiries during the past six to eight months regarding acceptable Board certification and whether the American Association of Physician Specialists can be regarded as a certifying body.

After seeking consultation with the Pennsylvania Medical Society and the American College of Surgeons Committee on Trauma, the Executive Committee reaffirmed the current Standard as noted in the *1996-98 Standards for Trauma Center Accreditation* and *1996-98 Standards for Pediatric Trauma Center Accreditation*, Standard VI, C2.

Previous reviews of this issue provided information from the American Board of Medical Specialties and the American Association of Physician Specialists; this information was reviewed again during the recent discussions.

In summary, following are existing Foundation policies that were previously approved by the Board of Directors and remain in effect. The policies were provided to all accredited trauma centers and published in past issues of *Foundation News*.

Only certification by American boards are recognized by the Pennsylvania Trauma Systems Foundation. Therefore, all physicians caring for trauma patients at Pennsylvania's accredited trauma centers must be board certified or an active candidate for board certification by the appropriate specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association.

The American Board of Anesthesiology previously recognized as comparable boards the Fellowship certificates awarded by the Australian and New Zealand College of Anaesthetists, the Royal College of Physicians and Surgeons of Canada, the Royal College of Anaesthetists of England, the Faculty of Anaesthetists of the Royal College of Surgeons in Ireland, and the Faculty of Anaesthetists of the College of Medicine of

Trauma Center Contacts
March 31, 1998
Page 2

South Africa. The ABA's policy regarding comparability expired December 31, 1993. Anesthesiologists who received Fellowship certificates prior to December 31, 1993 will continue to be recognized as meeting the Pennsylvania Trauma Systems Foundation Standards for the duration of their current certification.

Physicians currently on staff at a Pennsylvania (see following list) trauma center to be grandfathered into the current standard and policy regarding Board Certification, and henceforth, only certification by a specialty board of the American Board of Medical Specialties or the American Osteopathic Association will be acceptable.

NOTE: [The policy included the names of seven surgeons and physicians. Institutions at which these surgeons and physicians practice were notified by letter.]

ADDENDUM (Approved by the Executive Committee on January 8, 1998): Since the American College of Surgeons Committee on Trauma accepts Canadian Boards for members of the trauma team, a surgeon/physician certified by the appropriate Canadian board is eligible to be involved in trauma care at a Pennsylvania trauma center.

After careful and thorough review of the current Board Certification issues as well as the history of the Board Certification standard, the Executive Committee agreed to add the American College of Surgeons Committee on Trauma *Alternate Pathway to Board Certification as Criterion for Trauma Panel* (December 1997) to the Foundation's policies related to Board Certification.

NOTE: Minor modifications were made to the ACSCOT *Alternate Pathway* to accommodate Pennsylvania's trauma center accreditation process. The information requested in the *Alternate Pathway* must be sent to the Foundation's Executive Director for preparation and presentation to the Board of Directors. The information, like all other accreditation-related and hospital specific information, will be presented to the Board of Directors and/or Executive Committee for review in a blinded (anonymous) fashion. Please review the enclosed policy for more detailed information.

Contact Valeric Snook or me if you have any questions about the new policy.

Enclosure

cc: Bruce Bartels; Chairman, PTSF Board of Directors
Scott Becker; Chairman, PTSF Policy and Procedures Committee
C. William Schwab, MD, FACS; Chairman, PTSF Standards Committee
Board of Directors
Standards Committee
Trauma Program Medical Directors

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PTSF POLICY regarding Board Certification
March 12, 1998

Board Certification by the appropriate specialty board of the American Board of Medical Specialties, American Osteopathic Association, and Canadian boards¹, are deemed acceptable for meeting the PTSF *Standards for Trauma Center Accreditation*, Standard VI, C2.

¹Reference: American College of Surgeons Committee on Trauma *Resources for Optimal Care of the Injured Patient: 1993*

PTSF POLICY, March 12, 1998
based on the American College of Surgeons Committee on Trauma
Alternate Pathway to Board Certification as Criterion for Trauma Panel appended
(May 15, 1997) to the *Resources for Optimal Care of the Injured Patient: 1993*

-Page 1-

In rare circumstances, a non-board certified surgeon or physician may be included on the trauma team. This situation may arise when the number of surgeons or physicians is limited in a community that desires to establish an accredited trauma program. To assist these programs in providing optimal care to the injured patients with existing surgical/medical resources, the following alternate pathway to board certification has been developed. This option cannot be used for the trauma program medical director of the trauma program. When considering the alternate pathway, the Pennsylvania Trauma Systems Foundation Board of Directors/Executive Committee will look for the following documentation.

1. The specialist successfully completed an accredited residency training program in that specialty. This should be certified by a letter from the program director.
2. Documentation of current provider or instructor ATLS verification.
3. A list of the required number of hours of trauma-related CME over the past three years.
4. Documentation that the physician is present in at least 50 percent of the trauma Quality Management and educational meetings.
5. Documentation of membership or attendance at local, regional, and national trauma meetings over the past three years.
6. A list of patients treated over the past year with accompanying ISS and outcome.
7. Quality Management assessment by the trauma program medical director showing that the morbidity and mortality results of the physician compare favorably with the morbidity and mortality results for comparable patients treated by the other members of the trauma team.

PTSF POLICY, March 12, 1998

**based on the American College of Surgeons Committee on Trauma
Alternate Pathway to Board Certification as Criterion for Trauma Panel appended
(May 15, 1997) to the *Resources for Optimal Care of the Injured Patient: 1993***

-Page 2-

8. A letter by the trauma program medical director demonstrating this critical need in the trauma program because of the surgeon's/physician's experience or the limited surgeon/physician resources in that specialty within the hospital trauma program.

The request for consideration of the alternative pathway must be submitted in writing with the required supporting documentation to the PTSF Executive Director. The information will be presented in a blinded (anonymous) manner to the PTSF Board of Directors and/or Executive Committee for review and final determination.

Reference: *1996-98 Standards for Trauma Center Accreditation, Standard VI, C2*
1996-98 Standards for Pediatric Trauma Center Accreditation, Standard VI, C2

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99 APR -9 AM 9:03
INDEPENDENT REGULATORY
REVIEW COMMISSION

April 8, 1999

Ms. Mary Lou Harris
Independent Regulatory Review Committee
State of Pennsylvania
14th Floor, 333 Market Street
Harrisburg, PA 17101

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Video tape and pamphlets in file

Dear Ms. Harris:

I enjoyed speaking with you today and appreciated your desire to research further the issue of the definition of board certification as presently proposed by the Pennsylvania Department of Health's Office of Emergency Medical Services.

As I explained during our conversation today, AAPS has 136 Diplomates in Pennsylvania of which 45 are certified in Emergency Medicine. However, the proposed rule adversely affects all AAPS Diplomates because any law stipulating acceptance of certain board-certified physicians over others is scrutinized by managed care organizations, hospitals, insurance companies, etc. If these organizations note that physicians certified by AAPS-affiliated Boards of Certification are not included in the Trauma Center rules, they will base their credentialing and privileging decisions for all AAPS specialty physicians on that exclusion. Thus, this practice engenders discrimination.

Although two of our boards allow eligibility through a "practice track", this does not mean that all physicians certified by those boards did not complete a residency in their specialty. Further, just because the ABMS and AOA boards presently require a residency, it does not necessarily follow that all physicians certified by these boards have completed one in the specialty in which they were certified. Many non-residency physicians were "grandfathered in" through previous practice tracks.

I have enclosed some interesting correspondence we received last year from the Pennsylvania Trauma Systems Foundation concerning an *Alternative Pathway to Board Certification as Criterion for Trauma Panel*. Apparently, the present standards are based on those of the American College of Surgeons Committee on Trauma (ASCOT). The ASCOT is a specialty society composed primarily of ABMS and AOA-board certified surgeons.

EXECUTIVE OFFICES

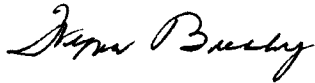
2296 HENDERSON MILL ROAD, SUITE 206, ATLANTA, GEORGIA 30345 • TELEPHONE 770-939-8555 • FAX 770-939-8559 • TOLL FREE 800-447-9397

Ms. Mary Lou Harris
April 8, 1999
Page 2

In the accompanying materials, you will note that several foreign certifications were "grandfathered in". These include the Australian and New Zealand College of Anaesthetists, the Royal College of Physicians and Surgeons of Canada, the Royal College of Anaesthetists of England, the Faculty of Anaesthetists of the Royal College of Surgeons in Ireland, and the Faculty of Anaesthetists of the College of Medicine of South Africa. However, physicians certified by an American board such as the Board of Certification in Anesthesiology are still not included.

I have also enclosed additional AAPS materials for your review. If you or Senator Hughes should have other questions, please do not hesitate to call or contact me by e-mail at wynn.busby@aaps.cobbmail.com.

Sincerely,



Wynn E. Busby
Director of Governmental Affairs

WEB:cs

Enclosures

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REGIONAL EMERGENCY MEDICAL SERVICES COUNCILS
 Revised - August 1998

REGIONAL EMS COUNCIL	COUNTIES/CODE	REGION CODE
Robert D. Cooney, EHS Program Manager Bradford Susquehanna EMS Council The Mansfield University Center 200 South Wilbur Avenue Sayre, PA 18840-1698 (717) 882-4604 FAX (717) 882-4413	Bradford (8) Susquehanna(58)	01
Joseph W. Schmider, Director Bucks County Emergency Health Services 50 North Main Street Doylestown, PA 18901 (215) 348-6100 FAX (215) 348-2019	Bucks (09)	10
Stephen S. Webb, EHS Program Manager Chester County EMS Council Department of Emergency Services Chester County Government Services Center 601 Westtown Road -- Suite 12 West Chester, PA 19382-4558 (610) 344-5000 FAX (610) 344-5050	Chester (15)	11
Maureen Hennessey Herman Regional Director Delaware County EHS Council, Inc. 201 W. Front Street Government Center Building, Room 117 Media, PA 19063 (610) 891-5310 FAX (610) 566-3947	Delaware (23)	12
Everitt F. Binns, Ph.D., Executive Director Eastern PA EMS Council, Inc. 1405 North Cedar Crest Blvd. - Suite 208 Allentown, PA 18104 (610) 820-9212 FAX (610) 820-5620	Berks (6) Monroe (45) Carbon (15) Northampton (48) Lehigh (39) Schuylkill (54)	02
Cynthia S. Ehlers, President EHS Federation, Inc. 722 Limekiln Road New Cumberland, PA 17070 (717) 774-7911 FAX (717) 774-6163	Adams (1) Lancaster (36) Cumberland (21) Lebanon (38) Dauphin (22) Perry (50) Franklin (28) York (67)	03

REGIONAL EMS COUNCIL	COUNTIES/CODE	REGION CODE
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Richard R. Harden, Ph.D., Executive Director
Emergency Medical Service Institute
 221 Penn Avenue, Suite 2500
 Pittsburgh PA 15221
 (412) 242-7322 FAX (412) 242-7434

Allegheny (2) Greene (30)
 Armstrong (3) Indiana (32)
 Beaver (4) Lawrence (37)
 Butler (10) Washington (63)
 Fayette (26) Westmoreland (65)

04

Jerome E. Ozog, Executive Director
EMMCO East, Inc.
 1411 Million Dollar Highway
 Kersey, PA 15846
 (814) 834-9212 FAX (814) 781-3881

Cameron (12) Jefferson (33)
 Clearfield (17) McKean (42)
 Elk (24) Potter (55)

19

Richard Gibbons, Executive Director
EMMCO West, Inc.
 Suite 101
 16271 Conneaut Lake Road
 Meadville, PA 16335-3814
 (814) 337-5380 FAX (814) 337-0871

Clarion (16) Mercer (43)
 Crawford (20) Venango (61)
 Erie (25) Warren (62)
 Forest (27)

18

John E. Campos, Executive Vice President
EMS of Northeastern Pa, Inc.
 1153 Oak Street
 Pittston, PA 18640
 (717) 655-6818 FAX (717) 655-6824

Lackawanna (35)
 Luzerne (40)
 Pike (52)
 Wayne (64)
 Wyoming (66)

05

Gary S. Hutchinson, Executive Director
LTS EMS Council
 2130 County Farm Road
 Montoursville, PA 17754-9621
 (800) 433-9063 FAX (717) 433-4435
 (717) 327-2447

Lycoming (41)
 Sullivan (57)
 Tioga (59)

07

David Paul Brown, Director
**Montgomery County Emergency
 Medical Services**
 Office of Emergency Medical Services
 50 Eagleville Road
 Eagleville, PA 19403
 (610) 631-6520 FAX (610) 631-9864

Montgomery (46)

13

REGIONAL EMS COUNCIL	COUNTIES/CODE	REGION CODE
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Ralph A. Halper, Director
Philadelphia EMS Council
Philadelphia Fire Department
240 Spring Garden Street
Philadelphia, PA 19123-2991
(215) 686-1313 FAX (215) 686-1321

City of Philadelphia (51) **14**

Stephen M. Koon, Director
Seven Mountains EMS Council, Inc.
523 Dell Street
Bellefonte, PA 16823
(814) 355-1474 FAX (814) 355-5149

Centre (14)
Clinton (18)
Juniata (34)
Mifflin (44) **08**

Sandra L. Jablonski, Executive Director
Southern Alleghenies EMS Council, Inc.
Olde Farm Office Centre - Carriage House
Duncansville, PA 16635
(814) 696-3200 FAX (814) 696-0101

Bedford (5) Fulton (29)
Blair (7) Huntingdon (31)
Cambria (110) Somerset (56) **09**

Ralph J. Cope, Director
Susquehanna EHS Council, Inc.
249 Market Street
Sunbury, PA 17801-3401
(717) 988-3443 FAX (717) 988-3446

Columbia (19)
Montour (47)
Northumberland (49)
Snyder (55)
Union (60) **15**

Emergency Medical Services Office
State EMS Office – 8:00 a.m. - 5:00 p.m.

Margaret E. Trimble, Director
Pennsylvania Department of Health
P.O. Box 90 -- Harrisburg, PA 17108
(717) 787-8740
FAX (717) 772-0910

PENNSYLVANIA EHS COUNCIL
State Advisory Council - 8:00 a.m. - 5:00 p.m.

Richard D. Flinn, Jr., Executive Director
Pennsylvania EHS Council
Maple Building, Suite 210 -- 5012 Lenker Street
Mechanicsburg, PA 17055
(717) 730-9000
FAX (717) 730-9200

GUTHRIE Clinic

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99 MAR 18 AM 9:14

REGULATORY REVIEW COMMISSION

March 10, 1999.

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

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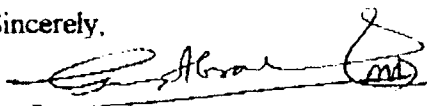
I am writing to comment on proposed amendments to 28 PA. Code Part VII (relating to emergency medical services) as published in the Pennsylvania Bulletin, Volume 29, Number 7, Part II, dated February 13, 1999. My comment is directed to the proposed definitin of "Board Certification" (page 919 of proposed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

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. I chose to present myself for the American Association of Physician Specialists, Inc. (AAPS) affiliated Board of Certification in Emergency Medicine because it is one of the three certifying bodies in the United States for Emergency Medicine and had a practice track open for certification.

The proposed regulatory language will affect my practice directly by loss of job as ALS service medical director and medical control physician. I feel that, should AAPS's BCEM(Board of Certification in Emergency Medicine)-certified physicians be excluded, similarly certified ABEM (via practice track) physicians also would have to be excluded.

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

Sincerely,



George P. Abraham, M.D; F.A.C.S; M.H.A.

Troy Family Health Center Regional Office

Guthrie Clinic Ltd.
125 Center Street
Troy, Pennsylvania 16947
717 297-4104

A member of the Guthrie Healthcare System

**TROY COMMUNITY HOSPITAL
100 JOHN STREET
TROY, PA 16947**

Telephone: (717) 297-2121

Fax: (717) 297-3970

FACSIMILE TRANSMISSION

Date: 03-12-99

To: Margaret Lumbale Fax No.: 717-772-0910

Company: EMS Office - DOH

Address: H'burg

From: Dr. Geo. Abraham, E.R. Director

Company: TCH

Address: _____

Pages to follow: 1

Message: letter re: proposed amendments

Note: If you do not receive all the pages, please contact the above at your convenience. Thank you.

The information contained in this facsimile message is privileged and confidential information intended for the use of the addressee listed above. If you are neither the intended recipient or the employee or agent responsible for delivering this information to the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the content of this telecopied information is strictly prohibited. If you have received this copy in error, please immediately notify us by telephone to arrange destruction of the documents.

March 12, 1999

Ms. Margaret Trimble
Emergency Medical Services
PA Department of Health
PO Box 90
Harrisburg PA 17108

Dear Ms. Trimble,

I am writing to comment on the proposed rules re: EMS Medical Command requirements that recognize only AMS and AOA approved boards. I believe that is unfair and the state is being misled. It is only fair to recognize BCEM/AAPS boards as well.

Briefly, the majority of professional, full time emergency physicians are not boarded. Of those boarded by ABEM and AOBEM, the majorities are not residency trained in emergency medicine. Unlike most/many of those credentialed by those two boards, the vast majority, I believe, of those credentialed by BCEM have completed residency training in another speciality relating to the practice of emergency medicine in ADDITION to the numerous hours of emergency medicine required to sit for the BCEM exam.

Unfortunately, I believe, from talking to your staff, that the state has been drawn into the economically-based internal politics of emergency medicine. Most of those, I believe, that serve on the boards from whom you receive council are, like myself, members of ACEP. ACEP, unfortunately, is politically tied to ABEM (they appoint board members to ABEM) and in fact founded ABEM. As I understand it, ABEM is putting pressure on ACEP for their very recent recognition of AOBEM; pressure that is currently preventing ACEP recognition of BCEM (or rather delaying BCEM from requesting that recognition).

The rules and regulations of the state should do one thing. That is to ensure the highest quality EMS command. If you ask the correct questions of the different organizations you will find that:

- 1) The BCEM exam is as rigorous as, or more so than the other two exams.
- 2) The BCEM diplomats are at least as well trained as the majority of the diplomats of the other 2 boards.
- 3) The BCEM diplomats are as professional and dedicated as the diplomats of the other two boards.

Enclosed is my CV to give you documentation as to my credentials. I hope that this aids you in correcting the proposed rules. Feel free to contact me if I can be of any further assistance.

Most Sincerely,



Geoffrey Ruben, MD

CURRICULUM VITAE**GEOFFREY L. RUBEN, M. D.****ADDRESS:**

Professional: Emergency Trauma Center
 Wheeling Hospital
 One Medical Park
 Wheeling, WV 26003

Residence: 375 Woodside Drive
 Washington, PA 15301
 (724) 223-8447

POSTGRADUATE APPOINTMENTS:

10/90 - Present Staff Physician, Department of Emergency Medicine
 Wheeling Hospital
 Wheeling, WV 26003

7/90 - Present Clinical Instructor
 Department of Emergency Medicine
 West Virginia University Hospitals
 Medical Center Drive, Department 220
 Morgantown, WV 26506

11/88 - 7/90 Instructor, Departments of Surgery and Pediatrics
 Department of Emergency Medicine
 West Virginia University Hospitals
 Medical Center Drive, Department 220
 Morgantown, WV 26506

Associated Positions

Present Team Physician Group, Wheeling Nailers Professional Ice Hockey
 Wheeling, WV

Present Medical Director, Dallas Volunteer Fire Department
 Dallas, WV

1991-1994 Medical Director, Bethany Volunteer Fire Department
 Bethany, WV

CURRICULUM VITAE
GEOFFREY RUBEN, MD

PAGE 2

POSTGRADUATE TRAINING.**"Fellowship" in Emergency**

Medicine
11/88 - 7/90
Department of Emergency Medicine
WVU School of Medicine
Morgantown, WV 26506

Pediatric
Residency
1985 - 1988

Department of Pediatrics
West Virginia University Hospital
Morgantown, WV 26506

EDUCATION:

MD
1985

West Virginia University
School of Medicine
Morgantown, WV 26506

1982

Diploma of Health Sciences
St. Georges University
School of Medicine
St. Georges, Grenada

Completed one
year of Ph.D.
program in
Environmental
Toxicology

University of Cincinnati
College of Medicine
Cincinnati, OH

B.A.
Biology/Chemistry

Antioch College
Yellow Springs, OH

BOARD CERTIFICATION:

Board Certified in Emergency Medicine (BCEM)

Board Certified in Pediatrics (ABP)

Diplomate of the National Board of Medical Examiners

CURRICULUM VITAE
GEOFFREY RUBEN, MD

PAGE 3

STATE LICENSURE:

West Virginia #14966

Pennsylvania MD - 043663 - E

REGISTRATIONS AND CERTIFICATIONS:

ACLS Certification - Current

PALS Certification - Instructor - Current

BTLS Certification - Instructor - Current

ATLS Certification - Current

PROFESSIONAL AFFILIATIONS:

1997 - present	Member, American Association of Physician Specialties
1998 - present	Secretary/Treasurer, WV Chapter, American College of Emergency Physicians
1988 - present	Member, WV Chapter, American College of Emergency Physicians
1995 - present	Member, American College of Physician Executives
1993 - present	Charter Member, Association of Emergency Physicians
1990 - present	Member, Ohio County Medical Society
1987 - present	Member, American Medical Association
1988 - present	Member, Society of Academic Emergency Medicine
1987 - present	Member, WV Medical Association
1980 - 1990	Member, Physicians for Social Responsibility

FAX

Date: Monday, March 15, 1999

Pages including cover sheet: 11

To:	Pennsylvania Department
Phone	
Fax Phone	(717)772-0910

From:	Donald DeReamus
	765 Prospect Street
	Tatamy
	PA 18085
Phone	+1(610)559-9454
Fax Phone	+1(610)559-9454

NOTE:

99 MAR 18 AM 9:20
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 PENNSYLVANIA DEPARTMENT OF REVENUE
 PHOENIX, PA



RECEIVED

99 MAR 16 AM 9:36

INDEPENDENT REGULATORY
REVIEW COMMISSION

March 11, 1999

Mr. John F. Mizner, Esq.
Independent Regulatory Review Commission
State of Pennsylvania
14th Floor, 333 Market Street
Harrisburg, PA 17101

ORIGINAL: 2003

BUSH

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Originals to: McGinley, Bush
Cocodrilli, Harbison, Mizner

(Packet of informantion in file)

Dear Commissioner Mizner:

You will soon have the opportunity to review the amendments to Act 82 of the Pennsylvania Consolidated Statutes relative to Emergency Medical Services.

As presently published in the Pennsylvania Bulletin of February 13, 1999, Chapter 1001, Subchapter A, Section 1001.2 (Definitions) excludes the American Association of Physician Specialists, Inc., a legitimate, medical-specialty, board-certification organization. This section of the rule proposed by the Office of Emergency Medical Services, Pennsylvania Department of Health, defines board certification as "current certification in a medical specialty or subspecialty by either the American Board of Medical Specialties or the American Osteopathic Association." This statutory exclusion affects the ability of AAPS-certified Diplomates to practice their medical specialties in the state of Pennsylvania.

Last July during a similar public comment period, AAPS provided the Office of Emergency Medical Services (OEMS) factual information concerning the equivalency of certification standards of the AAPS-affiliated Board of Certification in Emergency Medicine with those of other organizations. However, the OEMS declined to include AAPS in the statutory definition. Although Ms. Margaret Trimble of the OEMS assured our organization that they would consider applications on an individual basis, their action set the state standard for certification which was followed by private entities in Pennsylvania and, consequently, affected the employment status of many AAPS-certified physicians.

I have taken the liberty to include a comparative analysis of the certification standards published by the three major physician-certifying organizations in the United States for your information. One problematic factor in the certification process appears to be the current "practice track" offered by the AAPS-affiliated boards which allows physicians who are not residency trained in their chosen specialty to be certified in that specialty. However, both the American Board of Medical Specialties (ABMS) and the American

EXECUTIVE OFFICES

2296 HENDERSON MILL ROAD, SUITE 206, ATLANTA, GEORGIA 30345 • TELEPHONE 770-939-8555 • FAX 770-939-8559 • TOLL FREE 800-447-9397

Mr. John F. Mizner
March 11, 1999
Page 2

Osteopathic Association (AOA) offered similar practice tracks to certification in the past. Many ABMS and AOA-certified physicians currently practicing were "grand-fathered in" when these practice tracks were closed. Therefore, many ABMS and AOA physicians are not residency-trained in their medical specialty.

Please consider revision of the amendments to Act 82 when they come before your commission to include the American Association of Physician Specialists, Inc. in the proposed definitions section so that these physicians are not precluded from obtaining licensure and practicing their medical specialty in Pennsylvania and, therefore, are not hampered in their ability to support their families.

Sincerely,

A handwritten signature in cursive script that reads "Wynn E. Busby".

Wynn E. Busby
Director of Governmental Affairs

WEB:cs

Enclosure

Annex A

TITLE 28. HEALTH AND SAFETY
PART VII. EMERGENCY MEDICAL SERVICES
CHAPTER 1001. ADMINISTRATION OF THE EMS
SYSTEM

Subchapter A. GENERAL PROVISIONS

GENERAL INFORMATION

§ 1001.1. Purpose.

The [Department has the duty under the act] purpose of this part is to plan, guide, assist and coordinate the development of regional EMS systems into a unified Statewide system and to coordinate the system with similar systems in neighboring states, and to otherwise implement the Department's responsibilities under the act consistent with the Department's rulemaking authority. [The Department will accomplish this purpose through this part.]

§ 1001.2. Definitions.

The following words and terms, when used in this part, have the following meanings, unless the context clearly indicates otherwise:

*ACLS course—Advanced cardiac life support course—*A course in advanced cardiac life support sanctioned by the American Heart Association.

*ALS ambulance service—Advanced life support ambulance service—*An entity licensed by the Department to provide ALS services [and transportation] by ambulance to seriously ill or injured patients. The term includes mobile ALS ambulance services that may or may not transport patients.

*ALS service medical director—Advanced life support service medical director—*A medical command physician or a physician meeting the equivalent qualifications [set forth] in § 1003.5 (relating to ALS service medical director) who is employed by, contracts with or volunteers with, either directly, or through an intermediary, an ALS ambulance service to make medical command authorization decisions, provide medical guidance and advice to the ALS ambulance service and [to] evaluate the quality of patient care provided by the prehospital personnel utilized by the ALS ambulance service.

*ALS services—Advanced life support services—*The advanced prehospital and interhospital emergency medical care of serious illness or injury by appropriately trained health professionals and [certified] EMT-paramedics.

*APLS course—Advanced pediatric life support course—*A course in advanced pediatric life support sanctioned by the American Academy of Pediatrics and the American College of Emergency Physicians.

*ATLS course—Advanced trauma life support course—*A course in advanced trauma life support sanctioned by the American College of Surgeons Committee on Trauma.

* * * * *

*Air ambulance—*A rotorcraft [licensed by the Department for use as an EMS vehicle] specifically designed, constructed or modified and equipped, used or intended to be used, and maintained or operated for the purpose of providing emergency medical care to, and air transportation of, patients.

[*Air ambulance medical crew member—*A licensed physician, registered nurse or certified EMT-paramedic, who meets the qualifications required by Chapter 1007 (relating to licensing of air ambulance services—rotor craft) and who is employed to provide prehospital medical care and services to patients transported by air ambulance.]

*Air ambulance medical director—*A medical command physician or a physician meeting the minimum qualifications [set forth] in [§ 1003.41 (relating to air ambulance medical director)] § 1003.5 who is employed by, or contracts with, or volunteers with, either directly, or through an intermediary, an air ambulance service to make medical command authorization decisions, provide medical guidance and advice to the [ALS] air ambulance service, and [to] evaluate the quality of patient care provided by the prehospital personnel utilized by the air ambulance service.

*Air ambulance service—*An agency or entity licensed by the Department to provide transportation and ALS care of patients by air ambulance.

* * * * *

*Ambulance—*A vehicle specifically designed, constructed or modified and equipped, used or intended to be used, and maintained or operated for the purpose of providing emergency medical care to patients, and the transportation of [,] patients if used for that purpose. The term includes ALS or BLS vehicles that may or may not transport patients.

*Ambulance attendant—*An individual who [holds a valid certificate evidencing the successful completion of a course in advanced first aid sponsored by the American Red Cross and a valid certificate evidencing the successful completion of a course in CPR sponsored by the American Heart Association or the American Red Cross, or an individual who can evidence the successful completion of an equivalent training program approved by the Department] possesses the qualifications in § 1003.21(b) (relating to ambulance attendant).

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

*Ambulance identification number—*A number issued by the Department to each ambulance operated by an ambulance service.

*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.

Ambulance service affiliate number—[The] A unique number assigned by the Department to an ambulance service, the first two digits of which designate the county in which the ambulances of the ambulance service are based.

FROM : Panasonic PPF

PROPOSED RULEMAKING

919

[Ambulance trip report number—A unique number assigned to an ambulance response and recorded on the ambulance trip report form.]

BLS ambulance service—Basic life support ambulance service—An entity licensed by the Department to provide BLS services and transportation by ambulance to [seriously ill or injured] patients.

BLS services—Basic life support services—The basic prehospital or interhospital emergency medical care and management of illness or injury performed by specially trained [and], certified or licensed personnel.

[BLS training institute—Basic life support training institute—An entity accredited by the Department to conduct BLS training courses designed to prepare individuals to render prehospital and interhospital BLS within an organized EMS system.]

Basic rescue practices technician—An individual who [holds a valid certificate of successful completion of a rescue training program conducted in accordance with the training curriculum approved by the Department] is certified by the Department to possess the training and skills to perform a rescue operation as taught in a basic rescue practices technician program approved by the Department.

Basic vehicle rescue technician—An individual who [holds a valid certificate of successful completion of a vehicle rescue training program conducted in accordance with the training curriculum approved by the Department] is certified by the Department to possess the training and skills to perform a rescue from a vehicle as taught in a basic vehicle rescue technician program approved by the Department.

Board certification—Current certification in a medical specialty or subspecialty recognized by either the American Board of Medical Specialties or the American Osteopathic Association.

CPR—Cardiopulmonary resuscitation—The combination of artificial respiration and circulation which is started immediately as an emergency procedure when cardiac arrest or respiratory arrest occurs [, by those properly trained and certified to do so] .

CPR [Certification] course—Cardiopulmonary resuscitation [certification] course—A [certificate evidencing successful completion of a] course of instruction in CPR, meeting the [most current American Heart Association] Emergency Cardiac Care Committee National Conference on CPR and Emergency Cardiac Care standards. The [certification] course shall [have a current valid date and] encompass one and two-rescuer adult, infant and child CPR, and obstructed airway methods.

[Closest available ambulance—An ambulance, which as a result of a combination of location and other factors, such as traffic conditions, weather, and the like, can reach a patient most promptly.]

Continuing education—Learning activities intended to build upon the education and experiential basis of prehospital personnel for the enhance-

ment of practice, education, administration, research or theory development, to strengthen the quality of care provided.

Continuing education sponsor—An entity or institution that [applies to the Department and satisfies the Department's requirements to become an] is accredited by the Department as a sponsor of continuing education courses.

Council—The [State Advisory Council, which shall be known as the] Board of Directors of the Pennsylvania Emergency Health Services Council.

Critical care specialty receiving facility—[Facilities] A facility identified by [their] its capability of providing specialized emergency and continuing care to patients [within], including, in one of the following medical areas: poisoning, neonatal, spinal cord injury, behavioral, burns, cardiac and trauma.

* * * * *

Department [of Health certification] identification number—A number issued [through the Department's computer system] by the Department that identifies an individual who participates in the Statewide EMS system and, who has been certified [as an EMT, EMT-paramedic, EMT instructor, first responder, and the like. The certification includes the expiration date and the status level], recognized or otherwise assigned an identification number by the Department.

Direct support of EMS systems—Activities, equipment and supplies that are involved in the planning, initiation, maintenance, expansion or improvement of EMS systems.

EMSOF—Emergency Medical Services Operating Fund—Moneys appropriated to the Department under section 14(e) of the act (36 P. S. § 6934(e)) and which are not assigned to the Catastrophic Medical and Rehabilitation Fund.

* * * * *

[EMS council—A nonprofit incorporated entity or appropriate equivalent whose function is to plan, develop, maintain, expand and improve EMS systems within a specific geographical area of this Commonwealth and which is deemed by the Department as being representative of health professions and major public and voluntary agencies, organizations and institutions concerned with providing EMS. See the definition of "regional EMS council."]

* * * * *

EMS training institute—Emergency medical services training institute—An institute accredited by the Department to provide a course required for the certification or recognition of a prehospital practitioner.

* * * * *

EMT—Emergency medical technician—An individual trained to provide prehospital emergency medical treatment and certified as such by the Department in accordance with the current [NSC for basic EMTs] EMT-NSC, as set forth in this part.

FROM : Panasonic PPF

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99 MAR 12 PM 4: 34
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REVIEW COMMISSION

FAX TRANSMISSION COVER SHEET

AMERICAN ASSOCIATION OF PHYSICIAN SPECIALISTS, INC.
EXECUTIVE OFFICES
2296 HENDERSON MILL ROAD, SUITE 206
ATLANTA, GEORGIA 30345
770-939-8555
FAX: 770-939-8559
www.aapsga.com

Date: March 12, 1999 Time: 4:15 p.m. Pages (including cover): 5

To: Mr. John H. Jewett, Regulatory Analyst

Fax: (717) 783-2664 Phone: _____

From: Wynn E. Busby, Director of Governmental Affairs

FYI Please Comment Per Your Request Other

Faxed at the request of Terry L. Linville, M.D.

Mark your calendars:

- ◆ **May 19 - 26, 1999** **Comprehensive Emergency Medicine Interactive Review Course in Atlanta, Georgia**
- ◆ **June 10 - 13, 1999** **Annual Scientific Meeting in San Diego, California**
- ◆ **July 29 - August 1, 1999** **Board Certification Examinations in Atlanta, Georgia**

Kim Garner

To: Mary Lou Harris; James M. Smith; jjewett; Richard M. Sandusky; Mary S. Wyatte
Cc: Kris Shomper
Subject: FW: AAPS

ORIGINAL: 2003
BUSH
COPIES: Harris
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Jewett
Sandusky
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-----Original Message-----

From: John Columbus [SMTP:johncolumbus@earthlink.net]
Sent: Wednesday, March 31, 1999 3:12 AM
To: IRRC@irrc.state.pa.us
Subject: AAPS

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

31 March 1999

Dear Sirs:

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 919 of proposed rulemaking).

Physician board certification has become an essential element in many instances of credentialing for the purpose 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 composed of their professional peers. The definition of each specialty, in addition to the education and other professional requirements leading to acceptance into the certification process are developed by consensus within the medical profession. Specialty certification is separate from licensure.

I chose to present myself for the American Association of Physician Specialists, Inc. (AAPS) affiliated Board of Certification in Emergency Medicine. This is in part because the practice track in ABEM was closed at the time I was prepared to take the examination. I have completed the same amount of experience and expertise as most

ABEM certified physicians. I love emergency medicine and the patients I care for both night and day.

Before leaving active duty in the USAF, I personally directed change in the Department of Defense with regard to the qualifications and training of rescue and special operations medics and received a Meritorious Service Medal for this upon Honorable Discharge. Through my efforts USAF Pararescuemen, Navy Seal medics and US Army Special Forces medics are now trained beyond the level of their civilian counterparts. I currently teach on the faculty of the University of Pittsburgh School of Medicine in the Advanced Trauma Life Support Course sponsored by the American College of Surgeons. My point is simple, I am a highly qualified, highly recommended emergency physician (references can be provided) who is Board Certified by a board recognized by the state of New York and others. AAPS Board Certified physicians have the same level of experience and expertise, the same level of skill and compassion and the same level of dedication to the profession of medicine and the specialty of emergency medicine that most ABEM certified physicians in this state do. The residents of the State of Pennsylvania would benefit from my care and the care of other AAPS Board Certified in Emergency Medicine physicians any time, day or night, and I urge you to vote to provide them the opportunity to receive it.

Sincerely,

John T. Columbus MD
628 Lincoln Highlands Dr
Coraopolis, PA 15108
Ohio License 67843

ORIGINAL: 2003

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EMERGENCY DEPARTMENT SURVEY COMMENTS
BY HOSPITAL

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SEP 31 AM 8:41

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REVIEW COMMISSION

1.

#6: Nurse practitioners during identified "fast track" hours. This would free up the physicians for the more critical patients. It could be detrimental if all patients were critical during peak times. It should be researched and well planned.

#7: The scope of service in ED medicine and nursing is ever changing. The patients we see are more acutely ill and others are spending longer time in the ED for "observation and re-evaluation." Because of these changing times, it is imperative to maintain adequate staffing and ensure that the staff is well-oriented to the stressful and demanding but also very rewarding pace of emergency department medicine/nursing. Monitoring PI indicators, staffing levels, and get satisfaction surveys are paramount.

2.

#3b: it is preferred but not all have it

#3c: it is preferred but not all have it

#4c: it is preferred but not all have it

#6: It is unlikely that the medical staff would approve the action.

3.

#2a: Some of physicians are Board certified in Emergency Medicine but not all doctors.

4.

#7: If you do not use Board certified emergency physicians, physicians hired should be Board certified in Internal Medicine/Family Practice with ED experience (min. 3 yrs.).

5.

#5a: As additional M.D. coverage , not the only M.D.

#6: I would consider (and do use) as additional support.

#7: As above, the use of Physician Assistants and non-physicians as support staff greatly enhances patient turn around time.

6.

#1b: Family Practice

7.

#7: Most of our ER physicians are Board certified. We contract for physicians.

8.

#1b: Ophthalmology

#7: This is basically an ophthalmology emergency department. We do handle medical emergencies occurring in-house as well as post-op neurosurgical problems. All residents

are covered by attending physician on call.

9.

#6: We use physician assistants in the ED and fast track.

10.

#3a: Even our Board certified physicians

#7: Renew CPR certification every year, regardless of 2-year CPR card.

12.

#7: Majority of Emergency Department physicians on staff here are Board certified in emergency medicine.

14.

#5a: Only used for double coverage

#6: fast-track; we are a 2-site hospital with 1 hospital treating only 1-2 patients between 12 midnight and 8 a.m., on average usually with low intensity of service. A Nurse Practitioner not Physician Assistant would be ideal in this situation.

15.

#6: Physician on call back up.

18.

#7: Board certification in Emergency Medicine is too tough a standard for rural hospitals. It's a supply and demand issue and there are not enough EM trained physicians to meet the demand. We could support Board certification in a related specialty, e.g., IM or Family Medicine.

19.

#1b: Family Medicine

21.

#7: Why not make requirements similar to Act 45? Anything very different would create a lot of confusion.

22.

#4c: Nurses are not eligible to take ATLS.

#5: We use moonlighters but only as "double coverage," on with a full time ED attending.

25.

#6: Nurse Practitioners could be utilized only if an emergency department physician is physically present in the department. Would not use non-physician providers if only contact with MD was by phone.

27.

#6: Qualified, credentialed nurse practitioners, operating under approved clinical protocols, with on-call physician back up would be appropriate for night coverage and our E.D. New York State has done this for years, with good results. It is poor stewardship to mandate on-site physician coverage for nights with low volume (1-2 patients/shift) emergency departments.

#7: Good luck! I have advocated for years with no success. I encourage you to study the New York State results of many years. Politics aside, it is a wise move.

28.

#1b: Internal Medicine

29.

#4a: Must maintain ACLS & PALS in addition to CEN or CCRN.

#6: Midnight during the mid-week. Fast track/Nonurgent care.

30.

#1b: Internal Medicine

#7: Board certification in EM may be appropriate for tertiary/academic/trauma facilities but not at the community level where acuity is less severe, physician supply is challenged and where 70% of care is not emergency medicine. It is primary care.

31.

#1b: Emergency Medicine

32.

#6. If we had a fast track. The PA or nurse practitioner would work along side the ER physician.

42.

#5: As a second MD during hours of double coverage.

43.

#7: Requirement for Administrative Nursing Directors, now require CPR certification, ACLS certification. I feel the person should have progressive experience and certification prior to assuming the Administrator role. It is difficult to keep up with these certifications while focusing on Budgets, Strategic Plans, etc.

45.

#1b: Internal Medicine

#7: Small community hospitals such as ours continually strive to staff ER with the physicians qualified to treat the range of cases we normally see. Trauma cases are generally not seen here.

48.

#7: Nursing staff complete pediatric education program with critical care topics.

50.

#1b: Internal Medicine

#7: This whole certification thing is just one more attack by the big teaching hospitals in Pittsburgh and Philadelphia to drive the small rural hospitals out of existence.

52.

#6: Currently use NP for fast track are next to ED.

#7: ACLS/ATLS/PALS courses are not necessary for board certified EM physicians. Totally redundant/expensive/superficial and unnecessary burden for physicians.

53.

#6: Would like an N.P. for our fast track.

#7: All our MDs in ED are Board certified. PALS and CEN is optional--encouraged for RN staff.

56.

#1b: Family Practice

#6: 11P - 7A

58.

#1b: Internal Medicine

59.

#7: We have in house pediatric coverage and therefore do not require PALS. One pediatrician manages the sick infants/children along the the ED doctors.

60.

#4c: Currently ACS does not permit nurses to "certify."

61.

#7: With in house pediatric coverage 24 hours/day, PALS for the MDs is not required.

63.

#1b: Family Practice

65.

#7: Not all ED physicians are board certified in emergency medicine or another primary care specialty, but those that are not, are board prepared.

67.

#3a-c: All four are certified in each.

69.

#3a-c: All are required even with board certification.

71.

#7: The fiscal practices of managed care are weakening the quality and availability of emergency care in many communities around the country. The PA Department of Health should take responsibility to assure that our citizens have sound access to emergency care centers around the state and that the quality of attending staff is not diminished. The public health interests of the Commonwealth outweigh the short term financial interest of managed care.

73.

#1b: Family Practice

74.

#5: But not as solo coverage.

75.

#6: In addition to a physician.

76.

#2a: Approximately 70% of physician staff is ER board certified.

#2b: 90% of the time, a board certified physician covers the ER.

#6: The ER physician would need to be on site. Non-physician providers could be used in conjunction with physicians.

#7: The number of board certified physicians is less than 50% of the amount needed in the U.S.

77.

#1b: Internal Medicine

78.

#7: Nurse practitioner works in the Emergency Department in conjunction with physicians, caring for the less acute patients (fast track)

79.

#7: As long as financially possible it would be our intent to maintain physician coverage in our ER.

81.

#6: If reimbursement is cut under APC to put ID only as we can stay open 24 hours. 11-7 with physician backup for second ER.

#7: Please don't make it more difficult/impossible for small hospitals to staff their ERs by requiring board certified ER doctors. The proposed cuts in reimbursement and increased requirement for credentials will put smaller ERs out of business.

82.

#1b: Internal Medicine

83.

#7: We do not require ATLS course. However, we provide a one week trauma nurse course which all RNs and CSTs are required to take. Twelve hours of continuing trauma education yearly.

84.

#4b: Use ENPC

#7: All ER RNs need to complete Emergency Nurse Pediatric Care.

87.

#7: Staffed at 2.5 hppd excluding physicians.

89.

#4a: Certification and ACLS required for all staff. ACLS must be obtained within 1 year of employment. CEN obtained within 3 years of employment.

#4c: Small percentage have audited ATLS.

91.

#3: Currently we only accept residency trained emergency physicians.

#7: Emergency Department should be staffed by emergency physicians.

92.

#2: No, but within next 3 months all will be board certified or board prepared in emergency medicine.

#5: We will be next month--using 4th year emergency medical residents to supplement (with unrestricted licenses) staffing.

95.

#7: Additional physician backup on call should be available . Career committed Emergency physicians board certified in a different specialty may provide excellent staffing use of "moonlighting." Physicians from another specialty should be eliminated.

100.

#3b: Preferred

#3c: Preferred

#4c: Encouraged; paid for

#6: Unknown at this time.

#7: All but one of our regular full- and part-time RNs employed in the Emergency Department have CEN status.

101.

#5a: Residents are used only to work along with our full time E.D. physicians.

102.

#3a-c: Several moonlighting physicians for emergency staffing who are boarded in Internal Medicine or Family Practice with all three.

#4a: But 100% have ACLS.

#7: We are part of an emergency medicine residency and staffing is very important for education also.

103.

#3a: Required to be Board certified.

104.

#6: Maybe if urgent care established. At this time not.

105.

#7: We do utilize PA's to supplement staffing. Primarily the PA's manage the "fast track" low acuity patients under the supervision of the E.D. physician.

108.

#1b: OB/GYN

#4c: Neonatal resuscitation

#7: Nursing staff is cross trained with M-SICU staff. All are ACLS certified.

109.

#7: Directors of Emergency Departments should be Board Certified in Emergency Medicine.

110.

#6: Use Nurse Practitioner for fast track.

111.

#1b: Internal Medicine

112.

#7: All Emergency Room physicians are board certified, except 2. (2/10)

113.

#7: Would use NP/PA model if we had separate prompt care service within the hospital.

114.

#1b: Internal Medicine

#6: Supervision of a physician

116.

#1b: Internal Medicine

117.

#7: All nursing staff is required to maintain ACLS regardless to CEN.

118.

#7: 50% of the RN staff are CENs at this time.

119.

#4c: Not a course for nurses.

120.

#2a: 7 am - 7 pm Yes; 7 pm - 7 am EM residents

#2b: 7 am - 7 pm Yes; 7 pm - 7 am EM residents

#3b: Recommended

#5c: Recommended

121.

#2a: 97% Board Certified/eligible

#3b: Recommended

#7: CRNP with MD interaction for convenience care (fast track). Paramedics to assist with staffing!

122.

#1a: Taking ABEM Part I 11/7/98

126.

#4b: Emergency Nursing Pediatric course

129.

#2b: Not all are certified; most are boarded in their specialties

#4c: Most but not all. All will have completed process within the next two months.

#6: As a low volume service in this community, physician extenders could treat most patients presenting. With off-site physician back-up, it would be more cost efficient to employ the extenders and it would not compromise the quality of care being provided.

#7: Despite being the most rural state in the country, Pennsylvania ranks at the bottom of the list in recognizing and facilitating access to medical care in these small rural communities. The new regulations for E.R. that are being proposed will only exacerbate the problem of access in underserved areas.

131.

#1a: Also general internal medicine.

#3a: Required with Board certification in EM

#3b: CHOP-next door. HUP patients are 14 years old or older.

#4c: Trauma nurse course at Penn

#6: CNPs are in place for non-trauma visits in the fast track area.

132.

#5a: Rarely

134.

#3: All are board certified.

#4c: Nursing trauma course

135.

#6: Physician back-up must be on-site readily available.

136.

#2b: Physician is board eligible in Internal Medicine.

137.

#5a: Occasionally

#7: Trauma center obligations

140.

#4b: Highly encouraged

#4c: Not a nurse course

141.

#6: We currently utilize a physician assistant or Nurse practitioner with physician back-up during regular business hours.

#7: This facility has a Level III Emergency Room, which provides for non-trauma and mostly non-acute patient care.

144.

#4b: Encourage

#6: If physician meeting ED MD staffing requirements was physically on the premises but performing non-emergent patient care or administrative duties.

#7: I feel strongly that ED physicians should at least meet the same standard as Medical Command physicians as defined in EMS law, Act 45, et. al.

145.

#4a: PALS we are a pediatric center

#5a: We have 24 hour coverage with residents and attendings

147.

#3a-c: All physicians

149.

#4b: Recommended

150.

#4c: Trauma nursing course

#6: PTSF would prohibit this

151.

#7: We have fixed staffing of both RNs and physicians and availability to increase staff as situations dictate. All full-time ED physicians are board certified in emergency medicine. Eight of 10 part-time ED physicians are board certified in emergency medicine. Of the 2 part-time ED physicians not board certified in emergency medicine one will be pursuing this. One has been working here prior to our policy initiation of 1996, which states board certification will occur within 5 years of hire date.

152.

#7: In addition to having board certified emergency room physicians on duty, there are board certified medical internists on duty 24 hours a day as back-up to the ED.

153.

#6: Would consider use as a physician extender for peak times.

154.

#4b: Recommended, not required

#6: Physician assistants are currently used as second or this provider.

155.

#1b: Internal medicine

#6: With administrative staff booking and the physician would have to be on-site (not called-in). Would never staff with ONLY non-physician providers.

158.

#7: All hospitals should strive to achieve 24 hour staffing with Emergency Medicine Board certified physicians.

159.

#6: Temple--No. However, maybe yes with our other affiliates.

161.

#1b: Family Medicine

#4b: Eleven out of twelve completed

163.

#4b: We are an adult Emergency Department

#4c: 40 hour trauma nurse course required of all RN staff

164.

#7: Currently use PA-C on weekends and holidays for back up.

165.

#7: The Department Chairman is responsible for staffing physicians qualified to work in the ER. Need not have board certification in Emergency Medicine but must be able to care for patients in accordance with the quality indicators of the department.

166.

#7: All ED nursing staff complete 4-day PTSFTrauma Nursing Course.

167.

#7: Whether nurses or physicians are certified, current ACLS is required. Staffing is also reflective of a 3-year Emergency Medicine Residency Program.

168.

#1b: Medicine

#6: Only for a "fast track area."

169.

#3b: Encouraged

#4b: encouraged

172.

#7: It is very difficult to recruit and to staff ED's with certified, qualified, experienced ED personnel in all areas--MD's, nursing, and paramedics. The job is difficult with high stress and most hours worked are evenings, nights, and weekends.

173.

#4b: Suggested

#4c: Suggested

174.

#1a: Board eligible

#6: I would prefer utilizing nurse practitioners during day shift hours when there are physicians office hours in the building. However, I believe they can be utilized on a 24-hour basis if they have proper credentials.

176.

#7: Our medical center does not have an emergency department as defined by JCAHO standards, but rather a triage area where walk-ins can be treated as necessary.

177.

#1b: Family Medicine

#6: During certain low volume periods we might consider such a change although we haven't examined the implications yet.

#7: A requirement for Emergency Medicine Boards in low volume ED's will only serve exacerbate an already difficult recruitment and staffing situation.

EDWARD E. JANUS, D.O.
Internal Medicine
Doctors Plaza, 217 West 11th Street
Erie, PA 16501

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REVIEW COMMISSION
EMERGENCY MED. SVC.
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Ms. Margaret E. Trimble
Director
Emergency Medical Services Office
Department of Health
1027 Health and Welfare Building
P.O. Box 90
Harrisburg, PA 17108
(717) 787-8740

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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 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 Int. Med., because (insert reasons here).

The proposed regulatory language will affect my practice directly by (insert how you will be affected directly, such as inability to practice, loss of job as ALS service medical director or medical control physician.)

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

Ms. Margaret E. Trimble

Page 2.

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 guidelines.

Representative Robert Stump, Chair of the House Committee on Veterans' Affairs, had similar concerns regarding the Department of Veteran Affairs and their 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 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 (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 Emergency Medical Advisory Committee 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 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 individuals. 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, hospital, health care insurers, managed-care organizations, and others generally follow the regulations established by the local governmental

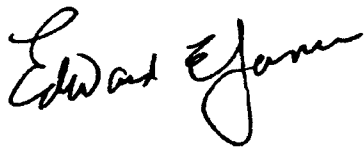
Ms. Margaret E. Trimble
Page 3.

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.

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 criteria for recognition of boards of certification, and amending the language of the proposed regulation.

Sincerely,

A handwritten signature in cursive script that reads "Edward E. Janus".

EDWARD E. JANUS, D.O.
Internal Medicine
Doctors Plaza, 217 West 11th Street
Erie, PA 16501

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INDEPENDENT EMERGENCY
REVIEW COMMISSION

**PA EMERGENCY MANAGEMENT AGENCY
BUREAU OF PLANS
P.O. BOX 3321
HARRISBURG, PA. 17105-3321**

Date March 22, 1999
Number of pages including cover sheet 2

To: **Ms. Margaret Trimble**
Director Emgy. Med. Svcs. Office
Dept. of Health

Phone: 717-787-8740
Fax Phone: 717-772-0910
CC: PEHSC

FROM:

- Josef Jordan
- Doug Fleck
- Robert Herrick
- Andy Simpson
- Marv Stern
- Beverly Addison
- Robert Broyles
- Carl Gustafson
- Monty Monoriti
- Norm Smith
- Piyush Gandhi
- Ann Thomas

Phone 717-651-2193
Fax Phone 717-651-2125
Email emonoriti@pema.state.pa.us



SUBJECT: Proposed Regulations

REMARKS:

- Reply ASAP
- Urgent
- For Your Review
- As Discussed
- Please Comment

Reference: Discussion with Ms. Debby Wells on March 19.

Information of the Proposed Rule Making was received in PEMA from the PEHSC, in their recognition that PEMA had an interest in the proposed changes. A copy of the PA Bulletin, Vol. 29 -No.27 was subsequently received from Ms. Chiquita Morrison.

A meeting with Ms. Trimble or her designated representative to discuss and coordinate the changes—specifically to Chapter 1013, Special Events EMS, is desired. Three other documents, one promulgated by the Governor, the Commonwealth Emergency Operations Plan, contains 22 pages devoted to Special Events, the second, a Special Event Emergency Action Plan Guide, was prepared and distributed by PEMA, for which changes will be required to synchronize and reflect consistency. The third, a circular, currently updated in draft, "Planning Guidance for Mass Fatalities Incidents", references the Emergency Medical Services Act (28 Pa. Code, Chapters 1001-1013), the Commonwealth EOP, and the Special Events Planning Guide, among others.

At a minimum, a reference to the Governor's Commonwealth EOP, and the Special Events Guide should be acknowledged when finalized.

A specific example of where there is a need to ensure consistency in the documents is indicated in the attached page 16 of the Special Event Planning Guide. The guide currently indicates that a licensed physician is required when attendance at an event will be between 30000 to 60000 persons, while the proposed ruling will be changed to 25,000.

If you do not receive all of the pages, please contact us as soon as possible at the telephone number listed above.

SPECIAL EVENT EMERGENCY ACTION PLAN GUIDE

6. DEVELOPING AN EAP: PART II - RESPONSIBILITIES

SPECIAL EVENT EMS

EVENT POPULATION PARTICIPANTS AND ATTENDEES	STAFFED & LICENSED AMBULANCE	LICENSED PHYSICIAN	ON-SITE TREATMENT FACILITY
10,000 to 30,000	1		
30,000 to 60,000	2	1	YES
60,000 +	3	1	YES

Plan must be reviewed annually or 60 days prior to event.

**DEPARTMENT OF
HEALTH**

...in pursuit of good health

(717) 787-8740

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INDEPENDENT REGULATORY
REVIEW COMMISSION

March 22, 1999

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

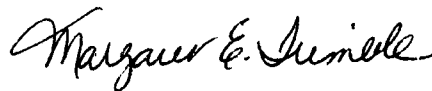
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RE: Proposed Regulations
Emergency Medical Services
No. 10-143

Dear Mr. Nyce:

The Pennsylvania Department of Health has recently received the enclosed public comments to the above-referenced regulations.

Sincerely,



Margaret E. Trimble
Director
Emergency Medical Services Office

MET:dlw

Enclosures

Sample

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99 MAR 19 AM 11:30
LAH EMERGENCY
HEALTH COMMISSION

Ms. Margaret E. Trimble
Director
Emergency Medical Services Office
Department of Health
1027 Health and Welfare Building
P.O. Box 90
Harrisburg, PA 17108
(717) 787-8740

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Ms. Margaret E. Trimble

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FROM : Panasonic PFF

918

PROPOSED RULEMAKING

ANNEX A

TITLE 28. HEALTH AND SAFETY
PART VII. EMERGENCY MEDICAL SERVICES
CHAPTER 1001. ADMINISTRATION OF THE EMS SYSTEM

Subchapter A. GENERAL PROVISIONS

GENERAL INFORMATION

§ 1001.1. Purpose.

The [Department has the duty under the act] purpose of this part is to plan, guide, assist and coordinate the development of regional EMS systems into a unified Statewide system and to coordinate the system with similar systems in neighboring states, and to otherwise implement the Department's responsibilities under the act consistent with the Department's rulemaking authority. [The Department will accomplish this purpose through this part.]

§ 1001.2. Definitions.

The following words and terms, when used in this part, have the following meanings, unless the context clearly indicates otherwise:

*ACLS course—Advanced cardiac life support course—*A course in advanced cardiac life support sanctioned by the American Heart Association.

*ALS ambulance service—Advanced life support ambulance service—*An entity licensed by the Department to provide ALS services [and transportation] by ambulance to seriously ill or injured patients. The term includes mobile ALS ambulance services that may or may not transport patients.

*ALS service medical director—Advanced life support service medical director—*A medical command physician or a physician meeting the equivalent qualifications [set forth] in § 1003.5 (relating to ALS service medical director) who is employed by, contracts with or volunteers with, either directly, or through an intermediary, an ALS ambulance service to make medical command authorization decisions, provide medical guidance and advice to the ALS ambulance service and [to] evaluate the quality of patient care provided by the prehospital personnel utilized by the ALS ambulance service.

*ALS services—Advanced life support services—*The advanced prehospital and interhospital emergency medical care of serious illness or injury by appropriately trained health professionals and [certified] EMT-paramedics.

*APLS course—Advanced pediatric life support course—*A course in advanced pediatric life support sanctioned by the American Academy of Pediatrics and the American College of Emergency Physicians.

*ATLS course—Advanced trauma life support course—*A course in advanced trauma life support sanctioned by the American College of Surgeons Committee on Trauma.

*Air ambulance—*A rotorcraft [licensed by the Department for use as an EMS vehicle] specifically designed, constructed or modified and equipped, used or intended to be used, and maintained or operated for the purpose of providing emergency medical care to, and air transportation of, patients.

*[Air ambulance medical crew member—*A licensed physician, registered nurse or certified EMT/paramedic, who meets the qualifications required by Chapter 1007 (relating to licensing of air ambulance services—rotor craft) and who is employed to provide prehospital medical care and services to patients transported by air ambulance.]

*Air ambulance medical director—*A medical command physician or a physician meeting the minimum qualifications [set forth] in [§ 1003.41 (relating to air ambulance medical director)] § 1003.5 who is employed by, or contracts with, or volunteers with, either directly, or through an intermediary, an air ambulance service to make medical command authorization decisions, provide medical guidance and advice to the [ALS] air ambulance service, and [to] evaluate the quality of patient care provided by the prehospital personnel utilized by the air ambulance service.

*Air ambulance service—*An agency or entity licensed by the Department to provide transportation and ALS care of patients by air ambulance.

* * * * *

*Ambulance—*A vehicle specifically designed, constructed or modified and equipped, used or intended to be used, and maintained or operated for the purpose of providing emergency medical care to patients, and the transportation of [,] patients if need for that purpose. The term includes ALS or BLS vehicles that may or may not transport patients.

*Ambulance attendant—*An individual who [holds a valid certificate evidencing the successful completion of a course in advanced first aid sponsored by the American Red Cross and a valid certificate evidencing the successful completion of a course in CPR sponsored by the American Heart Association or the American Red Cross, or an individual who can evidence the successful completion of an equivalent training program approved by the Department] possesses the qualifications in § 1003.21(b) (relating to ambulance attendant).

*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 specified in a format provided by the Department.

*Ambulance identification number—*A number issued by the Department to each ambulance operated by an ambulance service.

*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.

Ambulance service affiliate number—[The] A unique number assigned by the Department to an ambulance service, the first two digits of which designate the county in which the ambulances of the ambulance service are based.

FROM : Panasonic PPF

PROPOSED RULEMAKING

919

[Ambulance trip report number—A unique number assigned to an ambulance response and recorded on the ambulance trip report form.]

BLS ambulance service—Basic life support ambulance service—An entity licensed by the Department to provide BLS services and transportation by ambulance to [seriously ill or injured] patients.

BLS services—Basic life support services—The basic prehospital or interhospital emergency medical care and management of illness or injury performed by specially trained [and], certified or licensed personnel.

[BLS training institute—Basic life support training institute—An entity accredited by the Department to conduct BLS training courses designed to prepare individuals to render prehospital and interhospital BLS within an organized EMS system.]

Basic rescue practices technician—An individual who [holds a valid certificate of successful completion of a rescue training program conducted in accordance with the training curriculum approved by the Department] is certified by the Department to possess the training and skills to perform a rescue operation as taught in a basic rescue practices technician program approved by the Department.

Basic vehicle rescue technician—An individual who [holds a valid certificate of successful completion of a vehicle rescue training program conducted in accordance with the training curriculum approved by the Department] is certified by the Department to possess the training and skills to perform a rescue from a vehicle as taught in a basic vehicle rescue technician program approved by the Department.

Board certification—Current certification in a medical specialty or subspecialty recognized by either the American Board of Medical Specialties or the American Osteopathic Association.

CPR—Cardiopulmonary resuscitation—The combination of artificial respiration and circulation which is started immediately as an emergency procedure when cardiac arrest or respiratory arrest occurs [, by those properly trained and certified to do so].

CPR [Certification] course—Cardiopulmonary resuscitation [certification] course—A [certificate evidencing successful completion of a] course of instruction in CPR, meeting the [most current American Heart Association] Emergency Cardiac Care Committee National Conference on CPR and Emergency Cardiac Care standards. The [certification] course shall [have a current valid date and] encompass one and two-rescuer adult, infant and child CPR, and obstructed airway methods.

[Closest available ambulance—An ambulance, which as a result of a combination of location and other factors, such as traffic conditions, weather, and the like, can reach a patient most promptly.]

Continuing education—Learning activities intended to build upon the education and experiential basis of prehospital personnel for the enhance-

ment of practice, education, administration, research or theory development, to strengthen the quality of care provided.

Continuing education sponsor—An entity or institution that [applies to the Department and satisfies the Department's requirements to become an] is accredited by the Department as a sponsor of continuing education courses.

Council—The [State Advisory Council, which shall be known as the] Board of Directors of the Pennsylvania Emergency Health Services Council.

Critical care specialty receiving facility—[Facilities] A facility identified by [their] its capability of providing specialized emergency and continuing care to patients [within], including, in one of the following medical areas: poisoning, neonatal, spinal cord injury, behavioral, burns, cardiac and trauma.

Department [of Health certification] identification number—A number issued [through the Department's computer system] by the Department that identifies an individual who participates in the Statewide EMS system and, who has been certified [as an EMT, EMT-paramedic, EMT instructor, first responder, and the like. The certification includes the expiration date and the status level], recognized or otherwise assigned an identification number by the Department.

Direct support of EMS systems—Activities, equipment and supplies that are involved in the planning, initiation, maintenance, expansion or improvement of EMS systems.

EMSCF—Emergency Medical Services Operating Fund—Monies appropriated to the Department under section 14(c) of the act (35 P.S. § 4934(c)) and which are not assigned to the Catastrophic Medical and Rehabilitation Fund.

[EMS council—A nonprofit incorporated entity or appropriate equivalent whose function is to plan, develop, maintain, expand and improve EMS systems within a specific geographical area of this Commonwealth and which is deemed by the Department as being representative of health professions and major public and voluntary agencies, organizations and institutions concerned with providing EMS. See the definition of "regional EMS council."]

EMS training institute—Emergency medical services training institute—An institute accredited by the Department to provide a course required for the certification or recognition of a prehospital practitioner.

EMT—Emergency medical technician—An individual trained to provide prehospital emergency medical treatment and certified as such by the Department in accordance with the current [NSC for basic EMTs] EMT-NSC, as set forth in this part.

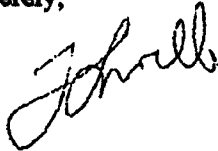
Ms. Margaret E. Trimble
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body. As such, many of these organizations will exclude those physicians certified by one of the American Association of Physician Specialists, Inc. (AAPS) affiliated boards of certification thinking that they are in compliance 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.

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 criteria for recognition of boards of certification, and amending the language of the proposed regulation.

Sincerely,

A handwritten signature in cursive script, appearing to read "J. Hall", is written below the word "Sincerely,".