PRESENTATION OF THE
HAWAII MEDICAL BOARD

TO THE HOUSE COMMITTEE ON HEALTH

TWENTY-SEVENTH LEGISLATURE
Regular Session of 2014

Friday, March 7, 2014
9:30 a.m.

TESTIMONY ON SENATE BILL NO. 2467, RELATING TO PODIATRISTS.

TO THE HONORABLE DELLA AU BELATTI, CHAIR,
AND MEMBERS OF THE COMMITTEE:

My name is Constance Cabral, and I am one of the Executive Officers of the Hawaii Medical Board ("Board"). Thank you for the opportunity to provide testimony on Senate Bill No. 2467, Relating to Podiatrists. The Board has no objections to this bill.

Again, thank you for the opportunity to provide testimony on Senate Bill No. 2467.

TLC

THE LEGISLATIVE CENTER

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March 7, 2014

Testimony To: House Committee Health
Representative Della Au Belatti, Chair

Presented By: Tim Lyons, Legislative Liaison
Hawaii Podiatric Medical Association

Subject: S.B. 2467 - RELATING TO PODIATRISTS

Chair Belatti and Members of the Committee:

I am Tim Lyons, Legislative Liaison for the Hawaii Podiatric Medical Association and we support this bill but request an amendment since. Since the time of the hearing on this bill in the Senate, the parties have reached an agreement as found in H.B. 1880, HD 2 and, therefore, we request you replace the contents of this bill with that found in H.B. 1880, HD 2.

With that amendment, we recommend your favorable adoption.

Thank you.

DOUGLAS BIRCH, DPM
ALOHA FAMILY FOOTCARE, LLC
DBA MAUI FAMILY FOOTCARE
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FACSIMILE TRANSMITTAL SHEET

TO: Chair Della Au Belatti
FROM: JoAnn
COMPANY: Committee on Health (House)
DATE: 3-6-14
FAX NUMBER: 1-800-535-3859
TOTAL NO. OF PAGES INCLUDING COVER: 6
RE: Podiatry Scope of Practice

DOUGLAS BIRCH, DPM
Podiatric Physician & Surgeon

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March 6, 2014

Dear Sir or Madam,

I am a voting constituent and am writing in support of SB2467 relating to Podiatry Scope of Practice. I am a Doctor of Podiatric Medicine practicing in Maui County. I have been here for over ten years now. I operate at Maui Memorial Medical Center and Aloha Surgical Center.

I have established myself as a respected member of the Surgery Department at Maui Memorial Medical Center and have in fact operated on many members of the nursing staff and medical staff.

This bill, SB2467, will increase my scope of practice and allow me to serve my community better. There are several limitations that prohibit my patients from receiving the best care possible. We are the experts at limb salvage in conjunction with our vascular surgeon colleagues. We are experts at diabetic wound care and when necessary we are trained to remove appropriate portions of people's feet.

Recently, two studies were done, one by Thomson Reuters and one by Duke University that showed the tremendous benefit of Podiatric Doctors in the treatment of diabetes. The results were significant in the areas of cost savings and lower incidence of amputation due to quality of care. Please see the "Study Details" that are accompanying this letter.

It is widely known by health care professionals that once an ulcer is had by a patient, there is a large incidence of lower extremity amputations and ultimately mortality.

I will say that in my personal practice there have been countless times that I was unable to take care of patients to the best of my ability due to the limitations the current law imposes on our scope of practice. There are surgeries that can be done above the ankle that can significantly reduce pressures on certain portions of the feet. As a podiatrist, I understand the biomechanical and surgical considerations that are necessary to save feet, save limbs and ultimately save lives.

We have been educated and trained in treating below the knee. We are requesting your consideration in this matter. This proposed legislation is good for the people and economics of Hawaii.

Thank you for your consideration.

Douglas Birch, DPM

STUDY DETAILS

Thomson Reuters Study: "The Economic Value of Specialized Lower-Extremity Medical Care by Podiatric

Physicians in the Treatment of Diabetic Foot Ulcers," Journal of the American Podiatric Medical Association, Vol. 101, No 2, March/April 2011.

- The study focused on one specific aspect of diabetic foot care:

o identifying individuals with diabetes who developed a foot ulcer;

o of those who developed a foot ulcer, examining whether they had received any care from a podiatrist in the year prior to development of the ulcer.

- The study compared individuals who had at least one visit to a podiatrist prior to developing the foot ulcer to those who had no podiatry care in the year prior to developing the foot ulceration.
- Thomson Reuters Healthcare utilized its MarketScan Data Base to examine claims from 316,527 patients with commercial insurance (64 year of age and younger) and 157,529 patients with Medicare and an employer-sponsored secondary insurance.

Duke Study: Sloan, F. A., Feinglos, M. N. and Grossman, D. S., RESEARCH ARTICLE: Receipt of Care and Reduction of Lower Extremity Amputations in a Nationally Representative Sample of US Elderly. Health

Services Research, no. doi: 10.1111/j.1475-6773.2010.01157.x

- The study followed individuals with diabetes for six years, tracking visits to podiatrists and other health care professionals.

• Researchers stratified subjects into four stages based on disease severity:

o Stage One—Neuropathy, parasthesia, pain in feet, diabetic amyotrophy;

o Stage Two—Cellulitis, Charcot feet;

o Stage Three—Ulcer; and

o Stage Four - Osteomyelitis, gangrene.

COST SAVINGS

Thomson Reuters Study:

• Average savings over a three-year time period (year before ulceration and two years after ulceration occurred):

o Commercial Insurance: Savings of $19,686 per patient if he or she had at least one visit to a podiatrist in the year preceding his or her ulceration

o Medicare Insured: Savings of $4,271 per patient

• If extrapolated, these results indicate that if all individuals with diabetes insured by commercial and Medicare plans who are at risk for a foot ulceration had a visit to a podiatrist:

o $1.97 billion could be saved in the commercial insurance group in one year

o $1.53 billion could be saved in the Medicare insurance group in one year

• Savings result from effective evaluation, prevention, and treatment of diabetic foot care complications by a podiatrist, effective treatment of ulcerations and prevention of amputations, and reductions in hospital admissions and lengths of stay. More than 65,000 lower limbs are amputated annually due to diabetes. After an amputation, the chance of

another amputation within three to five years is as high as 50 percent.

QUALITY OF CARE

Duke Study:

- Persons visiting a podiatrist and/or a lower-extremity clinician specialist within a year before developing all-stage complications were between 23 percent and 69 percent less likely to have an amputation compared with individuals who visited other health professionals.
- Podiatrists provide a unique and valuable service that is distinct from the services that allopathic and osteopathic physicians provide, and provide the highest benefit to those persons at risk of lower extremity complications as a consequence of diabetes.
- Conclusion: Care by a podiatrist and/or a lower extremity clinician specialist in the year before the lower extremity complication diagnosis reduced the potential for undergoing lower extremity amputation, suggesting a benefit from multidisciplinary care.

Thomson Reuters Study:

- Podiatrists see patients who are sicker and have more comorbidities.
- Among non-Medicare patients with foot ulcer, those seen previously by a podiatrist had a 20 percent lower risk of amputation and a 26 percent lower risk of hospitalization compared with patients not previously seen by a podiatrist.
- Among Medicare eligible patients with foot ulcer, those seen by a podiatrist had a 23 percent lower risk of amputation and a 9 percent lower risk of hospitalization compared with patients not previously seen by a podiatrist.
- Conclusion: Care by podiatrists prior to the first evidence of foot ulcers in patients with diabetes

prevents or delays lower extremity amputations and hospitalizations.

POLICY IMPLICATION

Podiatrists receive the education, training, and experience necessary to provide quality foot and ankle care to patients, and at the same time present cost containment solutions to our health-care delivery and financing systems. Moreover, when compared to other health care professionals who treat the diabetic foot, podiatrists are more likely to reduce hospitalizations and prevent amputations.

Providing access to podiatrists is an important component in ensuring quality of care. The growing epidemics of diabetes and obesity and their concurrent complications, along with the aging of the population, are among the many reasons podiatrists are necessary and important members of the physician community and demand for their services is increasing.

HAWAII MEDICAL ASSOCIATION
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TO: COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Dee Morikawa, Vice Chair

DATE: Friday, March 07, 2014
TIME: 9:30 AM
PLACE: Conference Room 329

FROM: Hawaii Medical Association
Dr. Walton Shim, MD, President
Dr. Linda Rasmussen, MD, Legislative Co-Chair
Dr. Ron Kienitz, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: SB 2467

HMA reached an agreement with the Hawaii Podiatric Medical Association. HMA will support this legislation with the following amendments added to the bill:

A podiatric physician may perform ankle fracture surgery if board qualified or board certified in reconstructive rearfoot ankle surgery by the American Board of Podiatric Surgery and completed a 36 month podiatric surgical residency.

We would also like to see HB 1880 & HB 1882 combined into one bill given that training and scope expansion go hand in hand.

Thank you for the opportunity to testify.

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467-Relating to Podiatrists
3/7/14 9:30am
Presented by: Dr. Robert LaReaux

Chair Au Belatti and Members of the Committee:

I am Dr. Robert LaReaux, President of the Hawaii Podiatric Medical Association and we support this bill.

Currently, 45 states allow podiatrists full ankle privileges.

In Hawaii podiatrists already operate on the ankle. We are asking to include ankle fractures in our scope of practice. The training of Hawaii podiatrists has been in the 45 states that include ankle fractures in the scope of practice. Unfortunately, this restriction has contributed to a shortage of podiatrists in Hawaii. We have half the number of podiatrists we should have in Hawaii. Hawaii has the worst amputation in the country. Podiatrists save limbs.

There is an overall **physician shortage in Hawaii** and it is projected to worsen over the next 6 years. On the neighbor islands, patients have had to fly over to Oahu to have surgical repair of their ankle fractures. Several years ago at my hospital (Castle Medical Center), orthopedic trauma cases including ankle fractures had to be diverted to Queens due to a lack of orthopedic coverage.

Podiatric surgical training is beyond criticism. Compare orthopedist surgical training to podiatric surgical training: The average number of **foot and ankle surgeries** an **orthopedic surgical resident** performs is about **110. Podiatry residents** perform about **1100 foot and ankle surgeries**.

All nine colleges of **podiatric medicine** are part of **large health universities**. Typically, courses taken in the first 2 years are the same; anatomy, physiology, pharmacology, etc. Studies have demonstrated, **in classes** where **podiatrists and** their allopathic colleagues (**DO or MD**), **there is no difference in academic performance**.

We have worked with the Hawaii Medical Association to amend the bill. We are very happy to have gained their support.

Thank you

APMA
American Podiatric Medical Association

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February 12, 2014

The Honorable Della Au Belatti, Chair
House Committee on Health
Hawaii State Capitol, Room 331
Honolulu, HI 96813

The Honorable Angus L.K. McKelvey, Chair
House Committee on Consumer Protection & Commerce
Hawaii State Capitol, Room 320
Honolulu, HI 96813

RE: Support for ~~HB 1880~~ SB 2467 and ~~HB 1882~~ SB 2468

Dear Representatives Belatti and McKelvey:

On behalf of the American Podiatric Medical Association (APMA) and our member podiatrists, I write this letter in support of HB 1880 and HB 1882. APMA is the premier professional organization representing the vast majority of the estimated 15,000 doctors of podiatric medicine, also known as podiatrists, in the country. APMA supports modernizing Hawaii's podiatric scope of practice law as it will ensure the legal authority to practice podiatric medicine and surgery in Hawaii is commensurate with the education, training, and experience of doctors of podiatric medicine.

APMA defines podiatric medicine as the profession of health sciences concerned with diagnosing and treating conditions affecting the human foot, ankle, and their governing and related structures, including the local manifestations of systemic conditions, by all appropriate systems and means. Podiatrists are specialists educated and trained to address conditions affecting the lower extremity and are recognized as physicians in the majority of states and by the federal government. Given its specialization, podiatric medicine is to the foot and ankle what ophthalmology is to the eye or cardiology is to the heart.

I. Education and Training for Doctors of Podiatric Medicine

Similar to allopathic medical training, the education, training and experience of doctors of podiatric medicine include four years of undergraduate work, followed by four years in an accredited podiatric medical school. Following graduation, podiatric medical doctors complete a three-year residency in an approved hospital-based program. Additionally, like our MD colleagues, some podiatrists complete fellowships for additional training in a specialty area. The significant difference between education training models of allopathic doctors and podiatric medical doctors is that podiatric medical education begins to focus on the specialty area earlier on in the educational process.

According to the American Medical Association's Health Care Careers Directory, "Colleges of podiatric medicine offer a core curriculum similar to that in other schools of medicine." Podiatric medical college is a four-year program with the first two years focused on the basic medical sciences and the second two years focused on clinical medical education. The

first two years of education at podiatric medical colleges are devoted to medical sciences including, but not limited to, gross and microscopic anatomy, biochemistry, pathology, microbiology, physiology, and pharmacology. During the third and fourth years, students engage in clinical education based in accredited hospitals, clinics, and private practice settings. During these third-and fourth-year rotations, students are afforded intense medical and surgical training related to the human body with emphasis on the lower extremity."

With earlier exposure to the specialty occurring in the colleges of podiatric medicine, graduates are well prepared for the more intensely focused clinical training provided in their subsequent podiatric residency program. Following graduation from podiatric medical college, doctors of podiatric medicine participate in a hospital-based three-year comprehensive podiatric medicine and surgery residency program. During residency, podiatrists receive advanced training in general medicine and surgery and participate in clinical rotations in anesthesiology, internal medicine, pathology, radiology, emergency medicine, and orthopedic and general surgery as well as elective rotations. Throughout residency training, emphasis is placed on diagnosing and managing patients with lower extremity pathology. Importantly, podiatric medical residency training programs have incorporated training in the treatment of the ankle since the 1970s.

Much of the opposing commentary gives the false impression that a broadly trained orthopedic surgeon, by virtue of the number of years in residency and fellowship, has received superior training to that of specifically trained, board-certified podiatric surgeons. Unlike orthopedic residency training that does not universally require a commitment to the surgical management of the foot and ankle, podiatric residency programs approved by the Council on Podiatric Medical Education (CMPE) must meet minimum requirements for training that include hundreds of patient diagnoses, foot and ankle procedures, and disease management experience. CPME, recognized by the United States Department of Education, is the accrediting entity analogous to the Accreditation Council for Graduate Medical Education (ACGME).

Podiatrists work collaboratively with their MD and DO colleagues in diagnosis and treatment, while also working together to effectively educate patients on the importance of healthy lifestyles, diabetes, and other issues affecting the lower extremity. Many orthopedic surgeons recognize the value of care by podiatrists. Kaiser San Rafael Medical Center Orthopedic Surgeons Alex Prescott, MD and John Safanda, MD stated in their letters to Hawaii legislators that they "have been involved in training podiatry residents in ankle fractures and have seen firsthand their competency." These orthopedic surgeons support this legislation because it "allows doctors of podiatric medicine to practice to the level of medicine and surgery to which they been trained." In fact, medical specialists in endocrinology, vascular surgery, rheumatology, and geriatrics routinely refer patients to podiatrists.

II. Specialty Board Certification

Board certification indicates that a podiatrist has demonstrated a cognitive knowledge of a special area of practice. CPME, through the Joint Committee on the Recognition of Specialty

Boards (JCRSB), is responsible for monitoring specialty certifying boards in podiatric medicine. JCRSB recognition of certifying boards is analogous to the American Board of Medical Specialties in its recognition of more than 20 specialty boards in allopathic medicine.

CPME recognizes two certifying boards: the American Board of Podiatric Medicine and the American Board of Podiatric Surgery. The American Board of Podiatric Medicine offers certification in podiatric medicine. The American Board of Podiatric Surgery (ABPS) offers certification in foot surgery and certification in reconstructive rearfoot/ankle surgery. Hospitals and third party payers regularly verify the credentials of ABPM and ABPS board-qualified and board-certified podiatrists.

III. Podiatric Scope of Practice

Podiatrists are recognized by all 50 states, the federal government, and national accrediting agencies as independent health-care practitioners who are permitted to provide medical and surgical care within their scope of practice. Every state has a podiatric scope of practice statute and regulatory entity that oversees the practice of podiatric medicine. 45 states and the District of Columbia authorize surgical treatment at or above the ankle in the scope of practice for podiatrists. Of the 46 jurisdictions, only three states—Maryland, Tennessee, and Utah—limit surgical treatment of some ankle fractures. Furthermore, of those 46 jurisdictions, only Hawaii prohibits podiatrists to perform surgical treatment of all ankle fractures. By prohibiting the treatment of ankle fractures, Hawaii's podiatric scope of practice statute clearly does not reflect the education, training, and experience of podiatric physicians.

Furthermore, APMA believes that scope of practice should operate as a ceiling, not a floor. The scope of practice should never be the lowest common denominator for a medical profession or specialty; rather, it should represent the maximum level to which a medical professional can provide patient care. The degree to which podiatrists practice their specialty must be demonstrated by the individual's requisite education, training, and experience. Just as allopathic and osteopathic doctors exercise medical and ethical judgment about their practices, doctors of podiatric medicine are required to do the same.

Similar to their orthopedic and other MD and DO colleagues, podiatric physicians must obtain hospital privileges to surgically treat ankle fractures. A hip and knee orthopedist, or other broadly trained orthopedists, would not be granted hospital privileges to surgically treat ankle fractures, and podiatric physicians and surgeons should be held to the same standard. Those podiatric physician and surgeons that can demonstrate the requisite education, training, and experience should be privileged by their hospital.

IV. Residency Requirements

APMA also supports HB 1882. This legislation requires that DPMs complete at least a two-year residency prior to application for licensure. While MD and DO colleagues are only

required to complete at least a one-year residency prior to licensure[1], Hawaii podiatrists support HB 1882 to ensure a higher standard for newly licensed podiatrists.

V. Value of Care by Podiatrists

Our health-care system increasingly requires the skills of podiatrists because we play a critical role in treating lower extremity complications related to diabetes, obesity and other chronic conditions. Take diabetes as an example: The early-warning signs of diabetes are often found in manifestation of complications in the lower extremity. As such, podiatrists are frequently the first health-care provider to detect, treat, and therefore significantly prevent or reduce complications, such as lower limb amputations.

According to the CDC, nearly 26 million Americans live with diabetes. Diabetes is the leading cause of non-traumatic lower-limb amputation; however, amputations can be prevented. Two peer-reviewed published studies evaluated care by podiatrists for patients with diabetes and demonstrated that compared to other health-care professionals, podiatrists are best equipped to treat lower extremity complications from diabetes, prevent amputations, reduce hospitalizations and provide savings to our health-care delivery systems.

A study conducted by Thomson Reuters Healthcare and published in the *Journal of the American Podiatric Medical Association* compared outcomes of care for patients with diabetes treated by podiatrists versus outcomes of care provided by other physicians. The study estimated that $10.5 billion in savings over three years can be realized if every at-risk patient with diabetes sees a podiatrist at least one time in a year preceding the onset of an ulceration. The value of podiatrists in treating and preventing complications from diabetes was supported by an independent study conducted by Duke University and published in *Health Services Research*, which found that Medicare-eligible patients with diabetes were less likely to experience a lower extremity amputation if a podiatrist was a member of the patient care team, and patients with severe lower extremity complications who only saw a podiatrist experienced a lower risk of amputation compared with patients who did not see a podiatrist.

The current Hawaii scope of practice can adversely affect podiatrists' ability to provide timely care to their patients. For example, when an individual has diabetic neuropathy, the ankle joint may break down and become deformed secondary to Charcot neuroarthropathy. This disorder, if severe enough and not receiving proper treatment which may include surgery, can eventually lead to a lower-leg amputation. Podiatrists in Hawaii are prohibited by the law from treating some conditions that manifest from the foot to the ankle. This restriction is not because podiatrists lack the medical expertise or judgment, but because the condition has crossed the anatomical border. With your support and passage of HB 1880 and HB 1882 these barriers for patients to receive timely and quality care from podiatrists will be removed.

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[1] HRS § 453-4 (2013).

APMA urges support for HB 1880 and HB 1882 because Hawaii health-care consumers will reap the benefits of increased access to quality health care when the legal authority to practice podiatric medicine is consistent with our education, training, and experience.

APMA welcomes the opportunity to serve as a resource. For more information on the podiatric medical profession, contact Associate Director for APMA Center for Professional Advocacy Chad Appel, JD, at cappel@apma.org or 301-581-9230.

Finally, APMA looks forward to holding its 2014 Annual Scientific Meeting in Honolulu from July 24 to 27. The 2008 Annual Scientific Meeting in Hawaii was such a success that podiatrists and their families are eager to return. APMA's Annual Scientific Meeting is the premier foot and ankle medical and surgical conference for podiatric medical professionals. Approximately 1500 podiatrists and their guests will have an opportunity to attend symposia and specialty tracks, participate in hands-on training at surgical workshops, including a workshop on ankle arthroscopy, peruse the vast exhibit hall, and explore Hawaii!

Sincerely,

Matthew G. Garoufalis, DPM
President

LATE

Maui Medical Group, Inc.

Health Care Excellence For Maui Since 1961

February 5, 2014

To Whom It May Concern:

The Board of Directors of Maui Medical Group supports and encourages the passing of Hawaii State Bills 2467 and 2468.

The Maui Medical Group has 4 satellite clinics comprising of 64 providers and 250 employees servicing approximately 45,000 patients on the island of Maui.

William H. Mitchell, MD
President, CEO

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LAHAINA: 130 Prison Street, Lahaina, Maui, Hawaii 96761 / Telephone: 661-0051 / Fax: 661-5975
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KIHEI: 2349 S. Kihei Road, Unit 2, Kihei, Maui, Hawaii 96753 / Telephone: 270-1528 / Fax 270-4772

Maui Medical Group, Inc.

Health Care Excellence For Maui Since 1961

2/10/2014

Request for Support

Hawaii State Senate Bills 2467 and 2468

Aloha,

The Hawaii Podiatric Medical Association has submitted two vital health care bills to legislation. We are requesting passage of these bills to allow equal economic opportunity for equal medical training and expanded privileges to allow better continuation of care for our needful and large Hawaii Diabetic Population.

Bill 2468 is asking to add a requirement of completing an accredited residency program in order to obtain a license for podiatric medicine for the state of Hawaii. Most all other states have already the same requirement in place.

Bill 2467 is in regards to scope of practice for podiatrists. Podiatrists, have extensive training, experience and qualifications to perform all levels of foot, ankle and lower leg surgery. The bill allows podiatrists to perform to the level of the foot and ankle as they are trained. As with any scope of practice issue, the individual surgeon must provide the proper documentation of residency training, board qualification/certification and undergo the appropriate granting of privileges, proctoring and peer review by the surgical facility in which they practice.

Thank you for supporting our efforts in regards to the Hawaii State Bills 2467 and 2468 and our efforts to ensure the most up to date quality foot and lower extremity care for our Hawaii Ohana.

Mahalo,

Dr. Steven King
Maui Medical Group Inc. Member and Co-Owner
Hawaii and American Podiatric Medical Associations Member
Maui Memorial Medical Center Staff Member
Aloha Surgery Center Staff Member
Co-Principal Investigator SBIR A11-109 US Department of Defense and Army Medical Research and Materials Command "Advanced Composite Combat Boots for Reduction of Stress Fractures"
Managing Member Kingetics LLC- a veteran owned Hawaii Small Business

morikawa2-Joanna

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 05, 2014 1:18 PM
To: HLTtestimony
Cc: Ter@hawaii.rr.com
Subject: *Submitted testimony for SB2467 on Mar 7, 2014 09:30AM*

SB2467
Submitted on: 3/5/2014
Testimony for HLT on Mar 7, 2014 09:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Terri Pacheco APRN	Individual	Support	No

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

Do not reply to this email. This inbox is not monitored. For assistance please email webmaster@capitol.hawaii.gov

Chair Della Au Belatti, Committee on Health

Re: Relating to Podiatry: HB 1880/1882 and SB 2467/2468

Position: Support

Healthcare is changing. Medical care has become more specialized and focused in order to create and maintain a level of care that is required to continually deliver the highest quality care to every patient.

Podiatrists have become the primary providers of foot and ankle surgery. Training has changed over the past 20 years to create an environment where podiatrists are an essential part of a well-rounded healthcare team. The ever increasing diabetes population relies on the specialized foot and ankle care that podiatrists provide to ensure comprehensive care for hospital and outpatient care.

I moved back home to Kauai in 1999 and joined Kauai Medical Clinic and became a part of the Allied Healthcare Staff at Wilcox Memorial Hospital. After establishing myself to be an essential part of the healthcare team, hospital policy was revised to allow podiatrists to become part of the medical staff of Wilcox Memorial Hospital. Together with several orthopedic surgeons and a physiatrist, in 2004 we established the Bone and Joint Center at Kauai Medical Clinic to provide comprehensive care for the people of Kauai as well as our large visitor population.

Current Hawaii state law does not reflect the current standard of training and ability of podiatrists. Current law restricts podiatrists from doing "any amputation, except for digital amputation". Obviously, this law is outdated and does not reflect the current standard for the rest of the country. I know that I am the best trained and qualified to treat my diabetic patients, and I believe my colleagues on the medical staff at Wilcox Memorial Hospital know that no one is more passionate about healing these complicated wounds than myself.

The proposed bills allow podiatrists to perform to the level of the foot and ankle as they are trained. In fact, **45** states allow podiatrists to provide comprehensive foot and ankle care. In the esteemed orthopedic journal, Journal of Bone and Joint Surgery America in 2012, Augusto Sarmiento, MD from the University of Miami School of Medicine wrote:

> *"...podiatrists, who for generations had limited their work to minor surgeries of the toes, managed, over a very short period of time, to become doctors/surgeons who currently care for patients with all types of musculoskeletal conditions below the knee. They treat traumatic injuries as well as degenerative, infectious, and congenital diseases with clinical and surgical means. They perform internal fixation of fractures of the tibia, ankle, os calcis, hindfoot, and forefoot. In addition, they perform total ankle arthroplasties and tendon transfers. In the process, they have become experts in the field to the point that it is ludicrous to argue that their qualifications do not allow them to cover such a wide territory."*

I am the only full time resident podiatrist on Kauai and I have an overwhelming population of patients in need of care. It is not unusual for a patient with foot pain to wait 3 months for a consultation. I would like to have a skilled surgical foot and ankle partner, but the best trained podiatrists find the Hawaii state law to be prohibitive and restrictive. In fact, my group has tried for several years to hire an orthopedist interested in the foot and ankle, but that has proved very difficult.

I have dedicated my professional life to providing the best podiatric foot and ankle care to the residents and visitors of Kauai. I was raised on Kauai and graduated from Kauai High School. Coming home to serve the people of Kauai has been wonderful, and I plan to continue to work to keep medical care on Kauai and in Hawaii up to the standards of modern medicine in 2014.

Hawaii is one of the last 5 states restricting the ability of skilled podiatrists to care for patients appropriately, and it is time to revise our state standards.

Thank you for your time and consideration.

Tyler Akira Chihara, DPM, FACFAS

Bone and Joint Center at Wilcox Health
Medical Staff, Wilcox Memorial Hospital
Treasurer, Hawaii Podiatric Medical Association

Dear Chair Della Au Belatti and the Committee on Health:

I am Linda Ho practicing podiatrist and I support Bill 2467. I was born and raised here, a proud graduate of Pearl City High School Class of 2002, and I studied in the mainland, always with the intent of going home to bring back and contribute what I was able to find as my purpose in life back home. As fate would have it, the path led to podiatric medicine. Podiatric medicine is a profession that is an untapped resource whose potential can only bring benefit to the people of Hawaii. With Hawaii's population of growing diabetic patients, Hawaii's population of increasingly active seniors with the baby boomers, our generalized population of proudly barefooted walkers, it is our profession that helps keep our nation healthy and on their feet. Bill 2467 will assist with fortifying our profession's goal to uphold the quality of care that Hawaii's people deserve to keep them on their feet: to ensure that qualified and trained podiatrists can fully demonstrate what we were trained to do from an either 24 month or 36 month residency. I have colleagues who are also Kama'aina who are training in the mainland, with the intention to return home to indeed serve our home. I am hopeful that this Bill will enable them to fill the constant brain drain that this state is suffering from.

These bills offer to increase the chance for newly trained podiatrists to demonstrate what further training and skills that have been developed to improve the care of the people of Hawaii. Innovation brings the SINGLE chance of improvement and change...fear and apathy established with the status quo promises no offer of change and improvement. If it is the opinion that the current foot care for the people of Hawaii is of contention, closing the doors on bringing new talent only fosters this negative attitude. It is not an issue of self interest that I offer this testimony: rather it is from bearing witness to multiple hands other than mine that offer the skill and care that we all want for our community. I want to give that opportunity to those I've seen heal, and I dont' want the people of Hawaii to be robbed of that opportunity.

Thank you for your consideration.

Linda Ho DPM

morikawa2-Joanna

From: mailinglist@capitol.hawaii.gov
Sent: Thursday, March 06, 2014 8:11 AM
To: HLTtestimony
Cc: drdavidwinglee@gmail.com
Subject: Submitted testimony for SB2467 on Mar 7, 2014 09:30AM

SB2467
Submitted on: 3/6/2014
Testimony for HLT on Mar 7, 2014 09:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
David Lee	Individual	Support	No

Comments: To the Chair and Members of the Committee: My name is David Lee and I wish to express support for SB2467 as it relates to the practice of podiatry. Last year I joined Maui Family Footcare on the island of Maui as the fourth surgical podiatrist, and one of two independent podiatrists, working on the island. I recently completed a three year surgical program that specializes in diabetic limb salvage, after graduating from Temple University's School of Podiatric Medicine. During my time at Washington Hospital Centers/Georgetown University's residency program in Washington DC, I participated in surgeries alongside many orthopedic, plastic, vascular, and podiatric surgeons, each leaders in limb salvage for their respective specialties. I was privileged to come from a culture where teamwork amongst each of the surgical disciplines and collaboration with the medicine specialties was key to providing the best patient outcomes in order to drive down the financial impact on our entire system. Many scholarly articles have been written about this team approach to support this claim and many of my attending physicians and mentors host the annual Diabetic Limb Salvage Conference in Washington DC. As you already know, diabetic patients can be very complicated to manage and these complicated cases have unfortunately taxed our entire system. During my residency, I managed over 300 surgical cases, the majority of whom are diabetic and followed many of these same patients during the various rotations in anesthesiology, emergency medicine, vascular surgery, orthopedic surgery, plastic surgery, pediatric surgery, radiology, internal medicine, infectious disease, psychiatry, dermatology and endocrinology. This exposure and training enables me to better educate and manage my patients and has shaped my measure for success that is based on preventing them from entering the hospital and operating room. This upcoming bill allows me to provide the best continuity of care for my patients. It is often difficult to find another surgeon willing to take on such patients, especially when it is urgent. The patients that do end up in the operating room are often perplexed about why I cannot continue their care despite my training adding to their grief and frustration with their current condition. Being able to perform amputations throughout the foot will reduce the incidence of leg amputations and decrease the medical morbidities and financial costs associated with the greater amputation. Your support of these bills will allow greater care for our patients on the Maui. Thank you for your consideration to this bill and for allowing my testimony. Best regards, David Lee, DPM

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

Do not reply to this email. This inbox is not monitored. For assistance please email webmaster@capitol.hawaii.gov

Subject: HB 1880 and 1882 / SB 2468 and 2467
Position: Support

March 4, 2014

To Whom It May Concern:

I am writing in support of two legislative bills (HB1882/SB2468 and HB1880/SB2467). I am a practicing Internal Medicine physician who works closely with a podiatrist in my clinic. He has been a valued asset to many of our patients with various foot disorders. His training and expertise in surgical procedures is highly regarded among all of his colleagues. I believe that allowing him to broaden the scope of his care (for which he is trained) is of utmost importance to the welfare of our patients. The bills cited above ensure that practicing podiatrists (such as my colleague) have the qualifications necessary to provide such care and allow them to practice safely under the scope of training they have received.

Sincerely,

Lisa Splittstoesser, MD
Board Certified Internal Medicine physician

Ken Tsubata, DPM
3rd year resident at DVA- Greater Los Angeles, Olive View Medical Center UCLA

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB 2467 Relating to Podiatrists
3/7/14 9:30am
In support of bill SB 2467

My name is Ken Tsubata, I am a podiatry resident finishing my third year of residency in Los Angeles and I support this bill.

I was born at Castle Hospital in Kailua and raised in Kaneohe. I have been away since high school which includes 4 years of undergraduate school at the University of Washington, 4 years of podiatry school, and 2.5 soon to be 3 years of residency. My plan has always been to return home to Hawaii to work.

My residency includes an intern year which includes rotations in internal medicine, emergency medicine, infectious disease, radiology, pathology, physical medicine, general surgery and anesthesia. On these rotations we work alongside UCLA residence and are trained to manage our own patients. I work in three different hospital settings that vary greatly, the Veterans Hospital, the county hospital Olive View Medical Center UCLA, and Kaiser Woodland Hills. At all three hospitals the podiatry service is the quarterback for all diabetic foot infections, amputations, trauma of the foot and ankle including ankle fractures.

In the hospitals I have worked at there is no question of podiatry's ability to manage the problems mentioned above. In fact, 45 other states also seem to think podiatry is well trained to treat ankle fractures, 43 other states feel podiatry is trained to perform partial foot amputations.

At these hospitals we work closely with the other services. For example, amputee clinic at the Veterans hospital involves the collaboration of orthopedics, vascular surgery, podiatry, and rehabilitation medicine that meet weekly in order to fully assess the entire patient to save their limb. This type of communication and cooperation is what is needed for these complex diabetic patients.

I am excited to finally return home in a few months but I am worried that I will be limited by the law and unable to utilize the full extent of my training. I urge you to support this bill in order to bring Hawaii's scope of practice up to the standard of the rest of the nation.

Thank you for your time,
Ken Tsubata, DPM

March 5, 2014

Testimony to: COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Dee Morikawa, Vice Chair

Subject: SB 2467—Expanding the scope of practice

Presented by: Liane Lin-Watanabe, DPM
New PMSR/RRA graduate

Chair Della Au Belatti, Vice Chair Dee Morikawa, and Members of the Committee:

I am Liane Lin-Watanabe, DPM, a November 2013 graduate of a three-year podiatric medicine and surgery residency program with the added reconstructive rearfoot and ankle credential, and I support this bill.

In regards to the scope of practice, please consider that as of July 1, 2011, the CPME formally increased the national residency standard from two-year and three-year residencies in Podiatric Medicine and Surgery (PM&S-24 and PM&S-36) to a single three-year residency—the Podiatric Medicine and Surgery Residency (PMSR). Furthermore, as dictated by the CPME, "residencies that can provide a sufficient volume and diversity in reconstructive rearfoot and ankle (RRA) procedures may grant an added RRA credential."[1]
Thus, all podiatric residency programs are now three years; and furthermore, majority of these programs have earned the Reconstructive Rearfoot and Ankle credential (RRA). Please refer to the attached chart.[2]

Also note that the current podiatric medicine and surgery training includes pre-, intra-, and post-operative care as well as required rotations in medical imaging, pathology, behavioral science, infectious disease, internal medicine, general surgery, anesthesiology, and emergency medicine. Residents also rotate in medical subspecialties such as dermatology, endocrinology, neurology, pain management, physical medicine and rehabilitation, and rheumatology. Surgical subspecialties include orthopedic surgery, plastic surgery, and vascular surgery.[3]

Expanding the scope of practice will allow new graduates like myself to fully utilize our specialized and multi-disciplinary training to help provide the necessary care to Hawaii. As a recent graduate who was born and raised in Hawaii and a product of the public school system and the University of Hawaii, my goal has always been to sacrifice a few years on the mainland to ultimately return home where I could utilize my training to give back to Hawaii.

I appreciate your time and consideration. Thank you for allowing my testimony.

Sincerely,
Liane Lin-Watanabe, DPM

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[1] cpme.org
[2] See attached Podiatry Residency Summary document.
[3] See attached CPME 320 document.

STANDARDS AND REQUIREMENTS FOR APPROVAL OF PODIATRIC MEDICINE AND SURGERY RESIDENCIES

COUNCIL ON PODIATRIC MEDICAL EDUCATION

TABLE OF CONTENTS

INTRODUCTION

Following four years of professional education, graduates of colleges or schools of podiatric medicine enter postgraduate residency programs that are conducted under the sponsorship of health-care institutions. Residencies afford these individuals structured learning experiences in patient management along with training in the diagnosis and care of podiatric pathology. The individuals involved in these training programs are referred to as "residents" and are recognized as such by the institutions sponsoring the programs.

The Council on Podiatric Medical Education (CPME) is an autonomous, professional accrediting agency designated by the American Podiatric Medical Association (APMA) to serve as the accrediting agency in the profession of podiatric medicine. The Council evaluates, accredits, and approves educational institutions and programs. The scope of the Council's approval activities extends to institutions throughout the United States and its territories and Canada.

The mission of the Council is to promote the quality of doctoral education, postdoctoral education, certification, and continuing education. By confirming that these programs meet established standards and requirements, the Council serves to protect the public, podiatric medical students, and doctors of podiatric medicine.

The Council has been authorized by the APMA to approve institutions that sponsor residency programs that demonstrate and maintain compliance with the standards and requirements in this publication. Podiatric residency approval is based on programmatic evaluation and periodic review by the Residency Review Committee (RRC) and the Council.

Standards and requirements in this publication are divided into institutional standards and requirements and program standards and requirements. Standard 6.0 and the associated requirements were developed as a collaborative effort of the Council on Podiatric Medical Education, the American Board of Podiatric Medicine (ABPM), and the American Board of Podiatric Surgery (ABPS).

Under no circumstances may the standards and requirements for approval by the Council supersede federal or state law.

Prior to adoption, all Council policies, procedures, standards, and requirements are disseminated widely in order to obtain information regarding how the Council's community of interest may be affected.

The Council formulates and adopts its own approval procedures. These procedures are stated in CPME 330, *Procedures for Approval of Podiatric Residencies*. This document, as well as CPME 320, may be obtained on the Council's website at www.cpme.org or by contacting the Council office.

ABOUT THIS DOCUMENT

This publication describes the standards and requirements for approval of podiatric residency programs. The standards and requirements, along with the procedures for approval, serve as the basis for evaluating the quality of the educational program offered by a sponsoring institution and holding the institution and program accountable to the educational community, podiatric medical profession, and the public.

The **standards** for approval of residency programs serve to evaluate the quality of education. These standards are broad statements that embrace areas of expected performance on the part of the sponsoring institution and the residency program. Compliance with the standards ensures good educational practice in the field of podiatric medicine and thus enables the Council to grant or extend approval.

Related to each standard is a series of specific **requirements**. Compliance with the requirements provides an indication of whether the broader educational standard has been satisfied. During an on-site evaluation of a residency program, the evaluation team gathers detailed information about whether these requirements have been satisfied. Based upon the extent to which the requirements have been satisfied, the Council determines the compliance of the sponsoring institution and the residency program with each standard. In the requirements, the verb "shall" is used to indicate conditions that are imperative to demonstrate compliance.

The **guidelines** are explanatory materials for the requirements. Guidelines are used to indicate how the requirements either must be interpreted or may be interpreted to allow for flexibility, yet remain within a consistent framework. The following terms are used within the guidelines:

- The verbs "must" and "is" indicate how a requirement is to be interpreted, without fail. The approval status of a residency program is at risk if noncompliance with a "must" or an "is" is identified.

- The verb "should" indicates a desirable, but not mandatory, condition.

- The verb "may" is used to express freedom or liberty to follow an alternative.

Throughout this publication, the use of the terms "institution" and "program" is premised on the idea that the program exists within and is sponsored by an institution.

The terms "college" and "school" are used interchangeably throughout this document.

GLOSSARY

The Council strongly encourages sponsoring institutions and program directors to become familiar with the following definitions to ensure complete understanding of this publication.

Academic Health Center

Academic health centers bring together programs of instruction and research in the health sciences and the delivery of health services. The Association of Academic Health Centers (AAHC) defines an academic health center as consisting of an allopathic or osteopathic school of medicine, at least one other health professions school or program, and one or more teaching hospitals, health systems, or other organized health care services. The AAHC also notes that the organization and structure of these institutions may vary. Academic health centers function either as component units of public or private universities, of state university systems, or as free-standing institutions.

Accreditation

Accreditation is the recognition of institutional or program compliance with standards established by the Council on Podiatric Medical Education, based on evaluation of the institution's own stated objectives. Accreditation is a voluntary process of peer review. The Council is responsible for accrediting colleges of podiatric medicine related to the four-year curriculum leading to the degree of Doctor of Podiatric Medicine.

Affiliated Training Site

An affiliated training site is an institution or facility that provides a rotation(s) for residents. Examples of sites include: a college of podiatric medicine, a teaching hospital including its ambulatory clinics and related facilities, a private medical practice or group practice, a skilled nursing facility, a federally qualified health center, a public health agency, an organized health care delivery system, or a health maintenance organization (clinical facility).

American Board of Podiatric Medicine (ABPM)

ABPM is the specialty board recognized by the Council on Podiatric Medical Education's Joint Committee on the Recognition of Specialty Boards to certify in the specialty area of podiatric medicine and orthopedics. ABPM maintains one certification pathway leading to certification in podiatric orthopedics and primary podiatric medicine.

American Board of Podiatric Surgery (ABPS)

ABPS is the specialty board recognized by the Council on Podiatric Medical Education's Joint Committee on the Recognition of Specialty Boards to certify in the specialty area of podiatric surgery. ABPS maintains two certification pathways: foot surgery and reconstructive rearfoot/ankle surgery. The foot surgery status is a prerequisite for the reconstructive rearfoot/ankle status.

Approval

Approval is the recognition of a podiatric residency program, podiatric fellowship program, or sponsor of continuing education that has attained compliance with standards established by the Council on Podiatric Medical Education. Approval is a program-specific form of accreditation.

Centralized Application Service for Podiatric Residencies (CASPR)

CASPR is a service of the American Association of Colleges of Podiatric Medicine (AACPM) and its Council of Teaching Hospitals (COTH). CASPR enables graduates of colleges and schools of podiatric medicine to apply simultaneously to podiatric residency programs approved by the Council. The goal of CASPR is to facilitate residency selection by centralizing and streamlining the application process.

Certification

Certification is a process to provide assurance to the public that a podiatric physician has successfully completed an approved residency and an evaluation, including an examination process designed to assess the knowledge, experience, and skills requisite to the provision of high quality care in a particular specialty.

Collaborative Residency Evaluator Committee (CREC)

CREC is an effort of ABPM, ABPS, and the Council to improve the methods by which residency evaluators and team chairs are selected, trained, assessed, remediated, and dismissed. The composition of the Committee includes three individuals from each organization, one of whom must be the executive director or that individual's designee, who must be an employee of the organization represented.

Competencies

Competencies are those elements and sub-elements of practice that define the full scope of podiatric training. The Council has identified competencies that must be achieved by the resident upon completion of the podiatric medicine and surgery residency. ABPM and ABPS have identified competencies related to certification pathways.

Council of Teaching Hospitals (COTH)

COTH is a membership organization comprised of institutions sponsoring Council-approved podiatric residency programs (including programs holding provisional and probationary approval). The goals of COTH include fostering excellence in residency training, promoting a code of ethics, developing policy, and serving as a forum for the exchange of ideas on residency education. COTH is a component of the American Association of Colleges of Podiatric Medicine (AACPM). The Council on Podiatric Medical Education and the RRC encourage sponsoring institutions to participate in COTH.

Curriculum

The curriculum is the residency program's unique organization and utilization of its clinical and didactic training resources to assure that the resident achieves the competencies identified by the Council and is prepared to enter clinical practice upon completion of the residency.

Due Process

Due process is a defined procedure established by the sponsoring institution that is utilized whenever any adverse action is proposed or taken against a resident. All parties to a residency program are protected when there is a reasonable opportunity provided to present pertinent facts.

External Assessments

External assessments are standardized evaluations of residents that are monitored and/or delivered by organizations external to the residency program for the purpose of validating the resident's experiences and development. An example is an annual in-training examination conducted by a specialty board.

Health-care Institution

A health-care institution is an organization or corporation (such as a hospital or academic health center) established under the control and direction of a governing board. The mission of such an institution includes the evaluation, diagnosis, and treatment of disease and injury. Private individuals and/or groups of private individuals are not viewed to be health-care institutions.

Hospital

A hospital is an institution that provides diagnosis and treatment of a variety of medical conditions in inpatient and outpatient settings. The institution may provide training in the many special professional, technical, and economic fields essential to the discharge of its proper functions.

Internal Assessments

Internal assessments are those evaluations of residents that are conducted within the residency program by faculty, staff, peers, and patients for the purpose of validating the serial acquisition of necessary knowledge, attitudes, and skills by the residents. Knowledge, attitudes, and skills should be evaluated separately. Knowledge may be assessed with internal modular testlets. Attitudes may be assessed with an attitudinal assessment form. Skills may be assessed by utilizing a standardized technical skills assessment form and observing a particular skill set.

In-training Examination

Administered by the specialty board, the in-training examination serves as an external assessment of the resident's development towards readiness for board qualification by the specialty board.

Joint Committee on the Recognition of Specialty Boards (JCRSB)

The JCRSB is a committee established by the Council on Podiatric Medical Education on behalf of the podiatric medical profession to recognize specialty boards. The recognition of a specialty board by the JCRSB serves to provide important information to the podiatric medical profession, health-care institutions, and the public about the sound operations and fair conduct of the board's certification process. The Council and JCRSB are committed to a process that assures the public that those podiatric physicians who are certified have successfully completed the requirements for certification in an area of specialization. The Council's authority for the recognition of specialty boards through the JCRSB is derived solely from the House of Delegates of the American Podiatric Medical Association. The JCRSB recognizes the American Board of Podiatric Medicine and the American Board of Podiatric Surgery.

Podiatric Medicine and Surgery

Podiatric medicine and surgery is the profession and medical specialty that includes the study, prevention, and treatment of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures by medical, surgical, and physical methods.

Residency

A residency is a postgraduate educational program conducted under the sponsorship of a hospital or academic health center. The purpose of a residency is to further develop the competencies of graduates of colleges of podiatric medicine through clinical and didactic experiences.

A residency program is based on the resource-based, competency-driven, assessment-validated model of training:

- Resource-based implies that the program director constructs the residency program based upon the resources that are available. While the Council recognizes that available resources may differ among institutions, the program director is responsible for

determining how the unique resources of the particular residency program will be organized to assure the resident opportunity to achieve the competencies identified by the Council.

- Competency-driven implies that the program director assures that the resident achieves the competencies identified by the Council for successful completion of the residency. Each of these specific competencies must be achieved by every resident identified by the sponsoring institution as having successfully completed the residency program.

- Assessment-validated implies that the serial acquisition and final achievement of the competencies are validated by assessments of the resident's knowledge, attitudes, and skills. To provide the most effective validation, assessment is conducted both internally (within the program) and externally (by outside organizations).

Residency Review Committee (RRC)

The RRC is responsible for determining eligibility of applicant institutions for initial on-site evaluation, authorizing increases in and reclassification of residency positions, and recommending to the Council approval of residency programs. The RRC reviews reports of on-site evaluations, progress reports, and other requested information submitted by sponsoring institutions. The RRC may modify its own policies and/or recommend to the appropriate ad hoc committee modifications in standards, requirements, and procedures for residency program evaluation and approval.

Composition of the RRC includes two representatives each from ABPM and ABPS, one representative from COTH, one representative from residency programs at large (selected by the Council), and at least two Council members.

Although the RRC is the joint responsibility of various organizations, the Council and its staff administer the affairs of the RRC. Appropriate agreements and financial compensation are arranged among the participating organizations for the administration of the RRC.

Training Resources

Training resources are the physical facilities, faculty, patient population, and adjunct support that allow the achievement of specific competencies (knowledge, attitudes, and skills) by a resident exposed to those resources. Training resources are represented generally by the various medical and surgical subspecialties.

STANDARDS FOR APPROVAL OF PODIATRIC RESIDENCY PROGRAMS

The following standards pertain to all residency programs for which initial or continuing approval is sought. The standards encompass essential elements including sponsorship, administration, program development, clinical expectations, and assessment.

INSTITUTIONAL STANDARDS:

1.0 The sponsorship of a podiatric medicine and surgery residency is under the specific administrative responsibility of a health-care institution or college of podiatric medicine that develops, implements, and monitors the residency program.

2.0 The sponsoring institution ensures the availability of appropriate facilities and resources for residency training.

3.0 The sponsoring institution formulates, publishes, and implements policies affecting the resident.

4.0 The sponsoring institution reports to the Council on Podiatric Medical Education regarding the conduct of the residency program in a timely manner and at least annually.

PROGRAM STANDARDS:

5.0 The residency program has a well-defined administrative organization with clear lines of authority and a qualified faculty.

6.0 The podiatric medicine and surgery residency is a resource-based, competency-driven, assessment-validated program that consists of three years of postgraduate training in inpatient and outpatient medical and surgical management. The sponsoring institution provides training resources that facilitate the resident's sequential and progressive achievement of specific competencies.

7.0 The residency program conducts self-assessment and assessment of the resident based upon the competencies.

INSTITUTIONAL STANDARDS AND REQUIREMENTS

1.0 The sponsorship of a podiatric medicine and surgery residency is under the specific administrative responsibility of a health-care institution or college of podiatric medicine that develops, implements, and monitors the residency program.

1.1 The sponsor shall be a hospital, academic health center, or college of podiatric medicine. Hospital facilities shall be provided under the auspices of the sponsoring institution or through an affiliation with an accredited institution(s) where the affiliation is specific to residency training.

A surgery center may co-sponsor a residency with a hospital, academic health center, and/or college of podiatric medicine but cannot be the sole sponsor of the program.

Institutions that co-sponsor a residency program must define their relationship to each other to delineate the extent to which financial, administrative, and teaching resources are to be shared. The document defining the relationship between the co-sponsoring institutions and the resident contracts must describe arrangements established for the residency program and the resident in the event of dissolution of the co-sponsorship.

1.2 The health-care institution(s) in which residency training is primarily conducted shall be accredited by the Joint Commission, the American Osteopathic Association, or a health-care agency approved by the Centers for Medicare and Medicaid Services. The college of podiatric medicine shall be accredited by the Council on Podiatric Medical Education.

1.3 The sponsoring institution shall formalize arrangements with each training site by means of a written agreement that defines clearly the roles and responsibilities of each institution and/or facility involved.

When training is provided at an affiliated training site, the participating institutions must:

- Indicate their respective training commitments through an affiliation agreement that is reaffirmed at least once every five years.

This document must:

- Acknowledge the affiliation and delineate financial support (including resident liability) and educational contributions of each training site.

- Be signed and dated by the chief administrative officer or designee of each participating institution or facility.

- Be forwarded to the program director.

If the program director does not participate actively at the affiliated institution or facility, or if a significant portion of the program is conducted at the affiliated institution or facility, a site coordinator must be designated formally to ensure appropriate conduct of the program at this training site. The site coordinator must hold a staff appointment at the affiliated site and be a faculty member actively involved in the program at the affiliated institution or facility. Written confirmation of this appointment must include the signatures of the program director and the site coordinator.

The expected daily commute to each sponsoring and affiliated training site must not have a detrimental effect upon the educational experience of the resident. Training provided abroad may not be counted toward the requirements of any training resource.

2.0 The sponsoring institution ensures the availability of appropriate facilities and resources for residency training.

2.1 The sponsoring institution shall ensure that the physical facilities, equipment, and resources of the primary and affiliated training site(s) are sufficient to permit achievement of the stated competencies of the residency program.

The physical plant must be well maintained and properly equipped to provide an environment conducive to teaching, learning, and providing patient care. Adequate patient treatment areas, adequate training resources, and a health information management system must be available for resident training.

The sponsoring institution must have been in operation for at least 12 months before submitting an application for approval to assure that sufficient resources are available for the residency program. The institution should have had an active podiatric service for at least 12 months prior to submitting an application for approval.

2.2 The sponsoring institution shall afford the resident ready access to adequate library resources, including a diverse collection of current podiatric and non-podiatric medical texts and other pertinent reference resources (i.e., journals and audiovisual materials/instructional media).

Library resources should be located on site or within close geographic proximity to the institution(s) at which the resident is afforded training. Library services must include the electronic retrieval of information from medical databases.

2.3 The sponsoring institution shall afford the resident ready access to adequate information technologies and resources.

2.4 The sponsoring institution shall afford the resident ready access to adequate office and study spaces at the institution(s) in which residency training is primarily conducted.

2.5 The sponsoring institution shall provide designated support staff to ensure efficient administration of the residency program.

The institution must ensure that neither the program director nor the resident assumes the responsibility of clerical personnel. The institution must ensure that the resident does not assume the responsibilities of nurses, podiatric medical assistants, or operating room or laboratory technicians.

3.0 The sponsoring institution formulates, publishes, and implements policies affecting the resident.

3.1 The sponsoring institution shall utilize a residency selection committee to interview and select prospective resident(s). The committee shall include the program director and individuals who are active in the residency program.

3.2 The sponsoring institution shall conduct its process of interviewing and selecting residents equitably and in an ethical manner.

The sponsoring institution must inform the prospective resident in writing of the selection process and conditions of appointment established for the program. Interviews must not occur prior to, or be in conflict with, interview dates established by the national resident application matching service with which the residency program participates. The sponsoring institution must make the residency curriculum available to the prospective resident.

3.3 The sponsoring institution shall participate in a national resident application matching service. The sponsoring institution shall not obtain a binding commitment from the prospective resident prior to the date established by the national resident matching service in which the institution participates.

3.4 Application fees, if required, shall be paid to the sponsoring institution and shall be used only to recover costs associated with processing the application and conducting the interview process.

The sponsoring institution must publish its policies regarding application fees (i.e., amount, due date, uses, and refunds).

3.5 The sponsoring institution shall inform all applicants as to the completeness of the application as well as the final disposition of the application (acceptance or denial).

3.6 The sponsoring institution shall accept only graduates of colleges of podiatric medicine accredited by the Council on Podiatric Medical Education. Prior to beginning the residency, all applicants shall have passed the Parts I and II examinations of the National Board of Podiatric Medical Examiners.

3.7 The sponsoring institution shall ensure that the resident is compensated equitably with and enjoys the same rights and privileges as other residents at the institution.

If the sponsoring institution does not offer other residency programs, then the resident must be compensated equitably with other residents in the geographic area.

The stipend offered by the institution is determined as an annual salary. The amount of resident compensation must not be contingent on the productivity of the individual resident.

The resident cannot be hired as an independent contractor; rather, the resident must be an employee of the institution.

The sponsoring institution should disclose annually to the program director the current amounts of direct and indirect graduate medical education reimbursement received by the sponsoring institution.

3.8 The sponsoring institution shall provide the resident a written contract or letter of appointment. The contract or letter shall state whether the reconstructive rearfoot/ankle credential is being offered and the amount of the resident stipend. The contract or letter shall be signed and dated by the chief administrative officer of the institution or appropriate senior administrative officer, the program director, and the resident.

When a letter of appointment is utilized, a written confirmation of acceptance must be executed by the prospective resident and forwarded to the chief administrative officer or appropriate senior administrative officer. In the case of a co-sponsored program, the contract or letter of appointment must be signed and dated by the chief administrative officer of each co-sponsoring institution, the program director, and the resident.

Programs that exceed 36 months of training must state the extended program length in the contract.

3.9 The sponsoring institution shall include or reference the following items in the contract or letter of appointment:

a. resident duties and hours of work.

The sponsoring institution must prohibit resident participation in any outside activities that could adversely affect the resident's ability to function in the training program.

b. duration of the agreement.

c. health insurance benefits.

The sponsoring institution must provide health insurance for the resident for the duration of the training program. The resident's health insurance must be at least equivalent to that afforded other entry-level professional employees at the sponsoring institution.

d. professional, family, and sick leave benefits.

The resident's leave benefits must be at least equivalent to those afforded other entry-level professional employees at the sponsoring institution.

e. leave of absence.

The sponsoring institution must establish a policy pertaining to leave of absence or other interruption of the resident's designated training period. In accordance with applicable laws, the policy must address continuation of pay and benefits and the effect of the leave of absence on meeting the requirements for completion of the residency program.

f. professional liability insurance coverage.

The sponsoring institution must provide professional liability insurance for the resident that is effective when training commences and continues for the duration of the training program. This insurance must cover all rotations at all training sites and must provide protection against awards from claims reported or filed after the completion of training if the alleged acts or omissions of the resident were within the scope of the residency program. The sponsoring institution must provide the resident with proof of coverage upon request.

g. other benefits if provided (e.g., meals, uniforms, vacation policy, housing provisions, payment of dues for membership in national, state, and local professional organizations, and disability insurance benefits).

3.10 The sponsoring institution shall develop a residency manual to include, but not be limited to the policies and mechanisms affecting the resident, rules and regulations, curriculum, training schedule, assessments, didactic activities schedule, and journal review schedule.

The sponsoring institution must ensure that the residency manual is distributed to and acknowledged in writing by the resident at the beginning of the program and following any revisions. The manual must be distributed at the beginning of the training year to the faculty and administrative staff involved in the residency.

The manual may be in written or electronic format. The manual must include CPME 320, *Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies* and 330, *Procedures for Approval of Podiatric Medicine and Surgery Residencies*.

3.11 The sponsoring institution shall provide the resident a certificate verifying satisfactory completion of training requirements. The certificate shall identify the program as a Podiatric Medicine and Surgery Residency and shall state the date of completion of the resident's training.

The certificate must include the statement "Approved by the Council on Podiatric Medical Education." The certificate must, at minimum, be signed and dated by the program director and the chief administrative officer, or designee. In the case of a co-sponsored program, the certificate must be signed and dated by the chief administrative officer of each co-sponsoring institution and the program director.

If applicable, the certificate also verifies successful completion of training requirements for the added reconstructive rearfoot/ankle credential. The certificate would identify the added credential as "Reconstructive Rearfoot/Ankle Surgery." At its discretion, the sponsoring institution may instead issue an additional certificate verifying successful completion of training requirements for the added credential. The second certificate must include the signatures of the program director and the chief administrative officer, or designee and the date of completion, and identify the added credential as "Reconstructive Rearfoot/Ankle Surgery." The additional certificate also must include the statement "Approved by the Council on Podiatric Medical Education."

3.12 The sponsoring institution shall ensure that the residency program is established and conducted in an ethical manner.

The conduct of the residency program must focus upon the educational development of the resident rather than on service responsibility to individual faculty members.

3.13 The sponsoring institution shall ensure that the following written policies and mechanisms are included in the residency manual:

a. the mechanism of appeal.

The sponsoring institution must establish a written mechanism of appeal that ensures due process for the resident and the sponsoring institution, should there be a dispute between the parties. Any individual possessing a conflict of interest related to the dispute, including the program director, must be excluded from all levels of the appeal process.

b. the remediation methods established to address instances of unsatisfactory resident performance.

The sponsoring institution must establish and delineate remediation methods to address instances of unsatisfactory resident performance (academic and/or attitudinal) and that identify the time frame allowed for remediation. Remediation methods may include, but not be limited to, requiring that the resident repeat particular training experiences, spend additional hours in a clinic, or complete additional assigned reading to facilitate achievement of the stated competencies of the curriculum. Remediation should be completed no later than three months beyond the normal length of the residency program.

c. the rules and regulations for the conduct of the resident.

4.0 The sponsoring institution reports to the Council on Podiatric Medical Education regarding the conduct of the residency program in a timely manner and at least annually.

4.1 The sponsoring institution shall report annually to the Council office on institutional data, residents completing training, residents selected for training, changes in the curriculum, and other information requested by the Council and/or the Residency Review Committee.

4.2 The sponsoring institution shall inform the Council office in writing within 30 calendar days of substantive changes in the program.

The sponsoring institution must inform the Council of changes in areas including, but not limited to, sponsorship, affiliated training sites, appointment of a new program director, curriculum, a significant increase or decrease in faculty, and resident transfer.

4.3 The sponsoring institution shall provide the Council office copies of its correspondence to program applicants, and current and incoming residents informing them of adverse actions or voluntary termination of the program. Program applicants shall be notified prior to the interview.

The institution must submit either the program applicants' and the current and incoming residents' written acknowledgment of the status of the program or verifiable documentation of the program applicants' and the current and incoming residents' receipt of the institution's letter (i.e., signed copies of return receipts for certified mail). These materials must be received in the Council office within 50 calendar days of the program director's receipt of the letter informing the institution of the action taken by the Review Committee or the Council.

Adverse actions include denial of eligibility for initial on-site evaluation, probation, administrative probation, withholding of provisional approval, withdrawal of approval, and denial of an increase in positions. Programs are strongly encouraged to notify program applicants and/or incoming residents of denial of eligibility for initial on-site evaluation.

PROGRAM STANDARDS AND REQUIREMENTS

5.0 The residency program has a well-defined administrative organization with clear lines of authority and a qualified faculty.

5.1 The sponsoring institution shall designate one podiatric physician as program director to serve as administrator of the residency program. The program director shall be provided proper authority by the sponsoring institution to fulfill the responsibilities required of the position.

The sponsoring institution must provide compensation to the program director. This compensation must be commensurate with that provided other residency directors at the institution. If the sponsoring institution does not offer other residency programs, then the program director must be compensated equitably with other program directors in the geographic area.

The program director must be a member of the medical staff of the sponsoring institution, or in the case of a co-sponsorship, at one of the sponsoring institutions. The program director must be a member of the graduate medical education committee or equivalent within the institution. The program director should be a member of national, state and/or local professional organization(s).

Because of the potential of creating confusion in the leadership and direction of the program, co-directorship is specifically prohibited; however, the program director may appoint an assistant director to assist in administration of the residency program. A residency training committee also may be established to assist the program director in the administration of the residency program.

The sponsoring institution must provide an orientation when the program director is new to this position. A consultant may be utilized to present or participate in this orientation.

Co-sponsoring institutions must designate one program director responsible for the entire co-sponsored residency. This individual must be provided the authority and have the ability to oversee resident training at all sites.

5.2 The program director shall possess appropriate clinical, administrative, and teaching qualifications suitable for implementing the residency and achieving the stated competencies of the residency.

The program director should be certified in the specialty area(s) by the American Board of Podiatric Medicine and/or the American Board of Podiatric Surgery.

5.3 The program director shall be responsible for the administration of the residency in all participating institutions. The program director shall be able

to devote sufficient time to fulfill the responsibilities required of the position. The program director shall ensure that each resident receives equitable training experiences.

The director is responsible for maintenance of records related to the educational program, communication with the Residency Review Committee and Council on Podiatric Medical Education, scheduling of training experiences, instruction, supervision, evaluation of the resident, periodic review and revision of curriculum content, and program self-assessment. In a co-sponsored program, the director is responsible for ensuring that the Council is provided requested information for all residents at all training sites, not just at one of the co-sponsoring sites (e.g., the institution at which the director is based).

The director must not delegate to the resident maintenance of records related to the educational program, communication with the Residency Review Committee and Council on Podiatric Medical Education, scheduling of training experiences, instruction, supervision, evaluation of the resident, periodic review and revision of curriculum content, and program self-assessment.

The director must ensure resident participation in training resources and didactic experiences (e.g., lectures, journal review sessions, conferences, and seminars).

5.4 The program director shall participate at least annually in faculty development activities (i.e., administrative, organizational, teaching, and/or research skills for residency programs).

The faculty development activities should be approved as continuing education programs by the Council on Podiatric Medical Education or another appropriate agency. Formal faculty development programs provided by teaching hospitals and colleges that do not offer continuing education activities also will be acceptable if appropriate documentation is provided of the program's nature, duration, and attendance.

5.5 The residency program shall have a sufficient complement of podiatric and non-podiatric medical faculty to achieve the stated competencies of the residency and to supervise and evaluate the resident.

The complement of faculty relates to the number of residents, institutional type and size, organization and capabilities of the services through which the resident rotates, and training experiences offered outside the sponsoring institution.

Faculty members must take an active role in the presentation of lectures, conferences, journal review sessions, and other didactic activities. Faculty members must supervise and evaluate the resident in clinical sessions and assume responsibility for the quality of care provided by the resident during the clinical sessions that they supervise. Faculty members must discuss patient evaluation,

treatment planning, patient management, complications, and outcomes with the resident and review records of patients assigned to the resident to ensure the accuracy and completeness of these records.

5.6 Podiatric and non-podiatric medical faculty members shall be qualified by education, training, experience, and clinical competence in the subject matter for which they are responsible.

The active podiatric faculty must include sufficient representation by individuals certified by each board recognized by the Joint Committee on the Recognition of Specialty Boards, or by individuals possessing other specialized qualifications acceptable to the Residency Review Committee.

Podiatric faculty should participate in faculty development activities to improve teaching, research, and evaluation skills.

6.0 The podiatric medicine and surgery residency is a resource-based, competency-driven, assessment-validated program that consists of three years of postgraduate training in inpatient and outpatient medical and surgical management. The sponsoring institution provides training resources that facilitate the resident's sequential and progressive achievement of specific competencies.

The resident must be afforded training in the breadth of podiatric health care. Completion of a podiatric residency leads to the following certification pathways -- the American Board of Podiatric Medicine (ABPM) and foot surgery of the American Board of Podiatric Surgery (ABPS).

Completion of a podiatric residency with the added credential in Reconstructive Rearfoot/Ankle surgery leads to the reconstructive rearfoot/ankle surgery certification pathway of the ABPS.

All required curricular elements must be completed within 36 months. Additional educational experiences may be added to the curriculum allowing up to 48 months. Programs that extend the residency beyond 36 months must present a clear educational rationale consistent with program requirements. The program director must obtain the approval of the sponsoring institution and the Residency Review Committee prior to implementation and at each subsequent approval review of the program.

The Council and the RRC view the following experiences to be essential to the conduct of a residency (although experiences need not be limited to the following):

- Clinical experience, providing an appropriate opportunity to expand the resident's competencies in the care of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures by medical, biomechanical, and surgical means.

- Clinical experience, providing participation in complete preoperative and postoperative patient care in order to enhance the resident's competencies in the perioperative care of diseases, disorders, and injuries of the foot, ankle, and their governing and related structures.

- Clinical experience, providing an opportunity to expand the resident's competencies in the breadth of podiatric and non-podiatric medical and surgical evaluation and management.

- Didactic experience, providing an opportunity to expand the resident's knowledge in the breadth of podiatric and non-podiatric medical and surgical evaluation and management.

6.1 The curriculum shall be clearly defined and oriented to assure that the resident achieves the competencies identified by the Council.

The curriculum must be distributed at the beginning of the training year to all individuals involved in the training program including residents and faculty.

The curriculum must provide the resident a sufficient volume and diversity of experiences in the supervised diagnosis and management of patients with a variety of diseases, disorders, and injuries through achievement of the competencies listed below.

A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity.

1. Perform and interpret the findings of a thorough problem-focused history and physical exam, including problem-focused history, neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination, biomechanical examination, and gait analysis.

2. Formulate an appropriate diagnosis and/or differential diagnosis.

3. Perform (and/or order) and interpret appropriate diagnostic studies, including:
   - Medical imaging, including plain radiography, stress radiography, fluoroscopy, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, vascular imaging.
   - Laboratory tests in hematology, serology/immunology, toxicology, and microbiology, to include blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, urinalysis.
   - Pathology, including anatomic and cellular pathology.
   - Other diagnostic studies, including electrodiagnostic studies, non-invasive vascular studies, bone mineral densitometry studies, compartment pressure studies.

4. Formulate and implement an appropriate plan of management, including:
   - Direct participation of the resident in the evaluation and management of patients in a clinic/office setting.
     - perform biomechanical cases and manage patients with lower extremity disorders utilizing a variety of prosthetics, orthotics, and footwear.
   - Management when indicated, including
     - dermatologic conditions.
     - manipulation/mobilization of foot/ankle joint to increase range of motion/reduce associated pain and of congenital foot deformity.
     - closed fractures and dislocations including pedal fractures and dislocations and ankle fracture/dislocation.
     - cast management.
     - tape immobilization.
     - orthotic, brace, prosthetic, and custom shoe management.
     - footwear and padding.
     - injections and aspirations.
     - physical therapy.
     - pharmacologic management, including the use of NSAIDs, antibiotics, antifungals, narcotic analgesics, muscle relaxants, medications for neuropathy, sedative/hypnotics, peripheral vascular agents, anticoagulants, antihyperuricemic/uricosuric agents, tetanus toxoid/immune globulin, laxatives/cathartics, fluid and electrolyte management, corticosteroids, anti-rheumatic medications.
   - Surgical management when indicated, including
     - evaluating, diagnosing, selecting appropriate treatment and avoiding complications.
     - progressive development of knowledge, attitudes, and skills in preoperative, intraoperative, and postoperative assessment and management in surgical areas including, but not limited to, the following: Digital Surgery, First Ray Surgery, Other Soft Tissue Foot Surgery, Other Osseous Foot Surgery, Reconstructive Rearfoot/Ankle Surgery (added credential only), Other Procedures (see Appendix A regarding the volume and diversity of cases and procedures to be performed by the resident).
   - Anesthesia management when indicated, including local and general, spinal, epidural, regional, and conscious sedation anesthesia.
   - Consultation and/or referrals.
   - Lower extremity health promotion and education.

5. Assess the treatment plan and revise it as necessary.
   - Direct participation of the resident in urgent and emergent evaluation and management of podiatric and non-podiatric patients.

B. Assess and manage the patient's general medical and surgical status.

1. Perform and interpret the findings of comprehensive medical history and physical examinations (including pre-operative history and physical examination), including (see Appendix A):
   - Comprehensive medical history.
   - Comprehensive physical examination.
     - vital signs.
     - physical examination including head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, neurologic examination.

2. Formulate an appropriate differential diagnosis of the patient's general medical problem(s).

3. Recognize the need for (and/or order) additional diagnostic studies, when indicated, including (see also section A.3 for diagnostic studies not repeated in this section).
   - EKG.
   - Medical imaging including plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound.
   - Laboratory studies including hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, synovial fluid analysis, urinalysis.
   - Other diagnostic studies.

4. Formulate and implement an appropriate plan of management, when indicated, including appropriate therapeutic intervention, appropriate consultations and/or referrals, and appropriate general medical health promotion and education.

5. Participate actively in medicine and medical subspecialties rotations that include medical evaluation and management of patients from diverse populations, including variations in age, sex, psychosocial status, and socioeconomic status.

6. Participate actively in general surgery and surgical subspecialties rotations that include surgical evaluation and management of non-podiatric patients including, but not limited, to:
   - Understanding management of preoperative and postoperative surgical patients with emphasis on complications.
   - Enhancing surgical skills, such as suturing, retracting, and performing surgical procedures under appropriate supervision.
   - Understanding surgical procedures and principles applicable to non-podiatric surgical specialties.

7. Participate actively in an anesthesiology rotation that includes pre-anesthetic and post-anesthetic evaluation and care, as well as the opportunity to observe and/or assist in the administration of anesthetics. Training experiences must include, but not be limited to:
   - Local anesthesia.
   - General, spinal, epidural, regional, and conscious sedation anesthesia.

8. Participate actively in an emergency medicine rotation that includes emergent evaluation and management of podiatric and non-podiatric patients.

9. Participate actively in an infectious disease rotation that includes, but is not limited to, the following training experiences:
   - Recognizing and diagnosing common infective organisms.
   - Using appropriate antimicrobial therapy.
   - Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiosis monitoring.
   - Exposure to local and systemic infected wound care.

10. Participate actively in a behavioral science rotation that includes, but is not limited to:
    - Understanding of psychosocial aspects of health care delivery.
    - Knowledge of and experience in effective patient-physician communication skills.
    - Understanding cultural, ethnic and socioeconomic diversity of patients.
    - Knowledge of the implications of prevention and wellness.

C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.

1. Abide by state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), governing the practice of podiatric medicine and surgery.

2. Practice and abide by the principles of informed consent.

3. Understand and respect the ethical boundaries of interactions with patients, colleagues, and employees.

4. Demonstrate professional humanistic qualities.

5. Demonstrate ability to formulate a methodical and comprehensive treatment plan with appreciation of health-care costs.

D. Communicate effectively and function in a multi-disciplinary setting.

1. Communicate in oral and written form with patients, colleagues, payers, and the public.

2. Maintain appropriate medical records.

E. Manage individuals and populations in a variety of socioeconomic and health-care settings.

1. Demonstrate an understanding of the psychosocial and health-care needs for patients in all life stages: pediatric through geriatric.

2. Demonstrate sensitivity and responsiveness to cultural values, behaviors, and preferences of one's patients when providing care to persons whose race, ethnicity, nation of origin, religion, gender, and/or sexual orientation is/are different from one's own.

3. Demonstrate an understanding of public health concepts, health promotion, and disease prevention.

F. Understand podiatric practice management in a multitude of health-care delivery settings.

1. Demonstrate familiarity with utilization management and quality improvement.

2. Understand health-care reimbursement.

3. Understand insurance issues including professional and general liability, disability, and Workers' Compensation.

4. Understand medical-legal considerations involving health-care delivery.

5. Demonstrate understanding of common business practices.

G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.

1. Read, interpret, and critically examine and present medical and scientific literature.

2. Collect and interpret data and present the findings in a formal study related to podiatric medicine and surgery.

3. Demonstrate information technology skills in learning, teaching, and clinical practice.

4. Participate in continuing education activities.

6.2 The sponsoring institution shall require that the resident maintain web-based logs in formats approved by the RRC documenting all experiences related to the residency.

6.3 The program shall establish a formal schedule for clinical training. The schedule shall be distributed at the beginning of the training year to all individuals involved in the training program including residents, faculty, and administrative staff.

The schedule must reflect the experiences provided the resident at all training sites. The program director is responsible for assuring that the schedule is followed; however, it may be reviewed and modified as needed to ensure an appropriate sequencing of training experiences consistent with the residency curriculum. The residency must be continuous and uninterrupted unless extenuating circumstances are present.

Twenty percent is the maximum proportion of residency education that is acceptable to be conducted in a podiatric private practice office-based setting.

6.4 The residency program shall provide rotations that enable the resident to achieve the competencies identified by the Council and any additional competencies identified by the residency program. These rotations shall include: medical imaging; pathology; behavioral sciences; internal medicine and/or family practice; medical subspecialties; infectious disease; general surgery; surgical subspecialties; anesthesiology; emergency medicine; podiatric surgery; and podiatric medicine. The residency curriculum shall provide the resident patient management experiences in both inpatient and outpatient settings.

The program director must, in collaboration with appropriate individuals, construct the program curriculum based on available resources.

In developing the curriculum, the program director must consult with faculty to identify resources available to enable resident achievement of the stated competencies of the curriculum. Members of the administrative staff and the office of graduate medical education of the sponsoring institution may be involved in the development of the curriculum.

In addition to podiatric medicine and podiatric surgery, the following rotations are required:

a. Medical imaging.
b. Pathology.
c. Behavioral sciences.
d. Infectious disease.
e. Internal medicine and/or family practice.
f. Medical subspecialties. Rotations that satisfy the medical subspecialty requirement include at least two of the following: dermatology, endocrinology, neurology, pain management, physical medicine and rehabilitation, rheumatology, or wound care.
g. General surgery.
h. Surgical subspecialties: Training resources that satisfy the surgical subspecialty requirement must include at least one of the following: orthopedic, plastic, or vascular surgery.
i. Anesthesiology.
j. Emergency medicine. Training resources may include emergency room service, urgent care center, trauma service, and critical care unit service.

The time spent in infectious disease (d) plus the time spent in internal medicine and/or family practice (e) plus the time spent in medical subspecialties (f) must be equivalent to a minimum of three full-time months of training.

6.5 The residency program shall ensure that the resident is certified in advanced cardiac life support for the duration of training.

Resident certification must be obtained as early as possible during the training year but no later than six months after the resident's starting date.

6.6 The residency curriculum shall afford the resident instruction and experience in hospital protocol and medical record-keeping.

The program director must assure that patient records accurately document the resident's participation in performing history and physical examinations and recording of operative reports, discharge summaries, and progress notes. The resident should participate in quality assurance and utilization review activities.

6.7 Didactic activities that complement and supplement the curriculum shall be available at least weekly.

Didactic activities must be provided in a variety of formats. These formats may include lectures, case discussions, clinical pathology conferences, morbidity and mortality conferences, cadaver dissections, tumor conferences, informal lectures, teaching rounds, and/or continuing education.

The majority of didactic activities must include participation by faculty.

The residency curriculum must include instruction in research methodology. The resident should participate in research activities to broaden the scope of training. The program director may appoint a faculty member to coordinate didactic activities.

6.8 A journal review session, consisting of faculty and residents, shall be scheduled at least monthly to facilitate reading, analyzing, and presenting medical and scientific literature.

The curriculum must afford the resident instruction in the critical analysis of scientific literature. The resident should present current articles and analyze the content and validity of the research.

6.9 The residency program shall ensure that the resident is afforded appropriate faculty supervision during all training experiences.

7.0 The residency program conducts self-assessment and assessment of the resident based upon the competencies.

7.1 The program director shall review, evaluate, and verify resident logs on a monthly basis.

The program director must review the logs for accuracy to ensure that there is no duplication, miscategorization, and/or fragmentation of procedures into their component parts. Procedure notes must support the selected experience.

7.2 The faculty and program director shall assess and validate, on an ongoing basis, the extent to which the resident has achieved the competencies.

The program director must conduct a formal semi-annual meeting with the resident to review the extent to which the resident is achieving the competencies. Information from patients and/or peers having direct contact with the resident may contribute to the assessments.

The assessments must be written or completed in an electronic format. The assessment instrument must identify the dates covered and the name of the faculty member. The assessment must be signed (signature and printed name) and dated by the faculty member, the resident, and the program director. The instrument must include assessment of the resident in areas such as communication skills, professional behavior, attitudes, and initiative. The timing of the assessment for each competency must allow sufficient opportunity for remediation.

The program should require that the resident take in-training examinations as prescribed by JCRSB-recognized specialty boards. If the resident is required to

take an in-training examination(s), the sponsoring institution must pay any fees associated with the examinations. Examination results are used as a guide for resident remediation and as part of the annual self-assessment of the program.

7.3 The program director, faculty, and resident(s) shall conduct an annual self-assessment of the program's resources and curriculum. Information resulting from this review shall be used in improving the program.

The review must include evaluation of the program's compliance with the current standards and requirements of the Council, the resident's formal evaluation of the program, and the director's formal evaluation of the faculty.

The curriculum must be assessed to determine if it is relevant to the competencies. The review must determine the extent to which the competencies are being achieved, whether all those involved understand the competencies, and whether resources need to be enhanced, modified, or reallocated to assure that the competencies can be achieved. The review also must determine the extent to which didactic activities complement and supplement the curriculum. The review must use performance data such as resident performance on external exams and attainment of board certification and state licensure to support the program's goal of assuring resident achievement of the competencies.

The review should include measures of program outcomes such as success of previous residents in private practice and teaching environments, hospital appointments, and publications.

APPENDIX A: VOLUME AND DIVERSITY REQUIREMENTS

A. Patient Care Activity Requirements (Abbreviations are defined in section B.)

	MAV
Case Activities	
Podiatric clinic/office encounters	1000
Podiatric surgical cases	300
Trauma cases	50
Podopediatric cases	25
Biomechanical cases	75
Comprehensive medical histories and physical examinations	50
Procedure Activities	
First and second assistant procedures (total)	400
First assistant procedures, including:	
Digital	80
First Ray	60
Other Soft Tissue Foot Surgery	45
Other Osseous Foot Surgery	40
Reconstructive Rearfoot/Ankle (added credential only)	50

B. Definitions

1. Levels of Resident Activity for Each Logged Procedure

First assistant: The resident participates actively in the procedure **under direct supervision of the attending**.

Second assistant: The resident participates in the procedure. Participation may include retracting and assisting, or performing limited portions of the procedure **under direct supervision of the attending**.

2. Minimum Activity Volume (MAV)

MAVs are patient care activity requirements that assure that the resident has been exposed to adequate diversity and volume of patient care. MAVs are not minimum repetitions to achieve competence. For some residents, the minimum repetitions may be higher or lower than the MAVs. It is incumbent upon the program director and the faculty to assure that the resident has achieved a competency, regardless of the number of repetitions.

3. Required Case Activities

A case is defined as an encounter with a patient that includes resident activity in one or more areas of podiatric or non-podiatric evaluation or management. Multiple procedures or activities performed on the same patient by a resident at the same time constitute one case. An individual patient can be counted towards fulfillment of more than one activity.

a. Podiatric clinic/office encounters. This activity includes direct participation of the resident in the clinical evaluation and management of patients with foot and ankle complaints. The sponsoring institution must document the availability of at least 1,000 encounters per resident

b. Podiatric surgical cases. This activity includes participation of the resident in performing foot and ankle (and their governing and related structures) surgery during a single patient encounter.

c. Trauma cases. This activity includes resident participation in the evaluation and/or management of patients who present immediately after traumatic episodes. Trauma cases may be related to any procedure. Only one resident may take credit for the encounter. Medical histories and physical examinations are components of trauma cases and can be counted towards the volume of required cases. At least 25 of the 50 required trauma cases must be foot and/or ankle trauma.

   Surgical management of foot and ankle trauma may count towards 25 of the 50 trauma cases even if the resident is only active in the immediate perioperative care of the patient. This data may be counted as both a surgical case and a trauma case by one resident or one resident may log the surgery and one resident may log the trauma. The resident must participate as first assistant for the surgery to count towards the requirement.

d. Podopediatric cases. This activity includes resident participation in the evaluation and/or management of patients who are less than 18 years of age.

e. Biomechanical cases. This activity includes direct participation of the resident in the diagnosis, evaluation, and treatment of locomotor disorders caused by acquired, post-traumatic, congenital, neurological, or heritable factors. These experiences include, but are not limited to, performing comprehensive lower extremity biomechanical examinations and gait analyses, comprehending the processes related to these examinations, and understanding the techniques and interpretations of gait evaluations of neurologic and pathomechanical disorders.

f. Comprehensive medical history and physical examinations: Admission, preoperative, and outpatient medical H&Ps may be used as acceptable forms of a comprehensive H&P. A focused history and physical examination does not fulfill this requirement.

The resident must demonstrate competency through a diversity of comprehensive history and physical examinations that also include evaluations in the diagnostic medicine evaluation categories. The resident must develop the ability to utilize information obtained from the history and physical examination and ancillary studies to arrive at an appropriate diagnosis and treatment plan. Documentation of the approach to treatment must reflect adequate investigation, observation, and judgment.

4. Required Procedure Activities

A procedure is defined as a specific clinical task employed to address a specific podiatric or non-podiatric problem. Note: Fragmentation of procedures into component parts is unacceptable. For example, if a surgical procedure employed to correct a hammertoe includes a proximal interphalangeal joint component and a metatarsophalangeal joint component, these components cannot be counted as separate procedures.

Elective and non-elective soft tissue RRA procedures may be substituted in the Other Soft Tissue Foot Surgery category, while elective and non-elective osseous RRA procedures may be substituted in the Other Osseous Foot Surgery category whenever there are deficiencies.

C. Assuring Diversity of Surgical Experience

The construct of the procedure categories assures some degree of diversity in the resident's surgical training experience. The two paragraphs below relate to first assistant procedures only.

To assure proper diversity within each procedure category and subcategory, at least 33 percent of the procedure codes within each category and subcategory must be represented with first assistant procedures. For example, in the Other Osseous Foot Surgery category, at least 6 of the 18 different procedure codes must have at least one activity as first assistant.

To avoid overrepresentation of one procedure within a category and subcategory, one procedure code must not represent more than 33 percent of the total number of procedures logged in each procedure category and subcategory. This statement applies more to a resident just meeting the minimum procedure requirement in a procedure category than to a resident significantly exceeding the procedure requirement in a procedure category. For example, the number of partial ostectomies must not exceed 26 when the minimum of 80 required Digital procedures are logged.

D. Programs with Multiple Residents or Fellows

1. Only one resident may take credit for first assistant participation on any one procedure.

2. More than one resident may take credit for second assistant participation.

3. The activity of a fellow should not be allowed to jeopardize the case or procedure volume or diversity of a resident at the same institution.

4. When multiple procedures are performed on a single patient, more than one resident or fellow may participate actively, but first assistant activity may be claimed by only one resident or fellow per procedure.

APPENDIX B: SURGICAL PROCEDURE CATEGORIES AND CODE NUMBERS

The following categories, procedures, and codes must be used for logging surgical procedure activity:

1 Digital Surgery (lesser toe or hallux)

1.1 partial ostectomy/exostectomy
1.2 phalangectomy
1.3 arthroplasty (interphalangeal joint [IPJ])
1.4 implant (IPJ)
1.5 diaphysectomy
1.6 phalangeal osteotomy
1.7 fusion (IPJ)
1.8 amputation
1.9 management of osseous tumor/neoplasm
1.10 management of bone/joint infection
1.11 open management of digital fracture/dislocation
1.12 revision/repair of surgical outcome
1.13 other osseous digital procedure not listed above

2 First Ray Surgery

Hallux Valgus Surgery
2.1.1 bunionectomy (partial ostectomy/Silver procedure)
2.1.2 bunionectomy with capsulotendon balancing procedure
2.1.3 bunionectomy with phalangeal osteotomy
2.1.4 bunionectomy with distal first metatarsal osteotomy
2.1.5 bunionectomy with first metatarsal base or shaft osteotomy
2.1.6 bunionectomy with first metatarsocuneiform fusion
2.1.7 metatarsophalangeal joint (MPJ) fusion
2.1.8 MPJ implant
2.1.9 MPJ arthroplasty

Hallux Limitus Surgery
2.2.1 cheilectomy
2.2.2 joint salvage with phalangeal osteotomy (Kessel-Bonney, enclavement)
2.2.3 joint salvage with distal metatarsal osteotomy
2.2.4 joint salvage with first metatarsal shaft or base osteotomy
2.2.5 joint salvage with first metatarsocuneiform fusion
2.2.6 MPJ fusion
2.2.7 MPJ implant
2.2.8 MPJ arthroplasty

Other First Ray Surgery

2.3.1 tendon transfer/lengthening/capsulotendon balancing procedure
2.3.2 osteotomy (e.g., dorsiflexory)
2.3.3 metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)
2.3.4 amputation
2.3.5 management of osseous tumor/neoplasm (with or without bone graft)
2.3.6 management of bone/joint infection (with or without bone graft)
2.3.7 open management of fracture or MPJ dislocation
2.3.8 corticotomy/callus distraction
2.3.9 revision/repair of surgical outcome (e.g., non-union, hallux varus)
2.3.10 other first ray procedure not listed above

3 Other Soft Tissue Foot Surgery

3.1 excision of ossicle/sesamoid
3.2 excision of neuroma
3.3 removal of deep foreign body (excluding hardware removal)
3.4 plantar fasciotomy
3.5 lesser MPJ capsulotendon balancing
3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)
3.7 open management of dislocation (MPJ/tarsometatarsal)
3.8 incision and drainage/wide debridement of soft tissue infection (including plantar space)
3.9 plantar fasciectomy
3.10 excision of soft tissue tumor/mass of the foot (without reconstructive surgery)
3.11 (procedure code number no longer used)
3.12 plastic surgery techniques (including skin graft, skin plasty, flaps, syndactylization, desyndactylization, and debulking procedures limited to the forefoot)
3.13 microscopic nerve/vascular repair (forefoot only)
3.14 other soft tissue procedures not listed above (limited to the foot)
3.15 excision of soft-tissue tumor/mass of the ankle (without reconstructive surgery)
3.16 external neurolysis/decompression (including tarsal tunnel)

4 Other Osseous Foot Surgery

4.1 partial ostectomy (including the talus and calcaneus)
4.2 lesser MPJ arthroplasty
4.3 bunionectomy of the fifth metatarsal without osteotomy
4.4 metatarsal head resection (single or multiple)
4.5 lesser MPJ implant
4.6 central metatarsal osteotomy
4.7 bunionectomy of the fifth metatarsal with osteotomy
4.8 open management of lesser metatarsal fracture(s)
4.9 harvesting of bone graft distal to the ankle

4.10 amputation (lesser ray, transmetatarsal amputation)
4.11 management of bone/joint infection distal to the tarsometatarsal joints (with or without bone graft)
4.12 management of bone tumor/neoplasm distal to the tarsometatarsal joints (with or without bone graft)
4.13 open management of tarsometatarsal fracture/dislocation
4.14 multiple osteotomy management of metatarsus adductus
4.15 tarsometatarsal fusion
4.16 corticotomy/callus distraction of lesser metatarsal
4.17 revision/repair of surgical outcome in the forefoot
4.18 other osseous procedures not listed (distal to the tarsometatarsal joint)
4.19 detachment/reattachment of Achilles tendon with partial ostectomy

5 Reconstructive Rearfoot/Ankle Surgery

Elective - Soft Tissue

5.1.1 plastic surgery techniques involving the midfoot, rearfoot, or ankle
5.1.2 tendon transfer involving the midfoot, rearfoot, ankle, or leg
5.1.3 tendon lengthening involving the midfoot, rearfoot, ankle, or leg
5.1.4 soft tissue repair of complex congenital foot/ankle deformity (clubfoot, vertical talus)
5.1.5 delayed repair of ligamentous structures
5.1.6 ligament or tendon augmentation/supplementation/restoration
5.1.7 open synovectomy of the rearfoot/ankle
5.1.8 (procedure code number no longer used)
5.1.9 other elective reconstructive rearfoot/ankle soft-tissue surgery not listed above

Elective - Osseous

5.2.1 operative arthroscopy
5.2.2 (procedure code number no longer used)
5.2.3 subtalar arthroereisis
5.2.4 midfoot, rearfoot, or ankle fusion
5.2.5 midfoot, rearfoot, or tibial osteotomy
5.2.6 coalition resection
5.2.7 open management of talar dome lesion (with or without osteotomy)
5.2.8 ankle arthrotomy with removal of loose body or other osteochondral debridement
5.2.9 ankle implant
5.2.10 corticotomy or osteotomy with callus distraction/correction of complex deformity of the midfoot, rearfoot, ankle, or tibia
5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above

Non-Elective - Soft Tissue

5.3.1 repair of acute tendon injury
5.3.2 repair of acute ligament injury
5.3.3 microscopic nerve/vascular repair of the midfoot, rearfoot, or ankle
5.3.4 excision of soft tissue tumor/mass of the foot (with reconstructive surgery)
5.3.5 (procedure code number no longer used)

5.3.6 open repair of dislocation (proximal to tarsometatarsal joints)
5.3.7 other non-elective reconstructive rearfoot/ankle soft tissue surgery not listed above
5.3.8 excision of soft tissue tumor/mass of the ankle (with reconstructive surgery)

Non-Elective - Osseous

5.4.1 open repair of adult midfoot fracture
5.4.2 open repair of adult rearfoot fracture
5.4.3 open repair of adult ankle fracture
5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations
5.4.5 management of bone tumor/neoplasm (with or without bone graft)
5.4.6 management of bone/joint infection (with or without bone graft)
5.4.7 amputation proximal to the tarsometatarsal joints
5.4.8 other non-elective reconstructive rearfoot/ankle osseous surgery not listed above

6 Other Podiatric Procedures (these procedures **cannot** be counted toward the minimum procedure requirements)

6.1 debridement of superficial ulcer or wound
6.2 excision or destruction of skin lesion (including skin biopsy and laser procedures)
6.3 nail avulsion (partial or complete)
6.4 matrixectomy (partial or complete, by any means)
6.5 removal of hardware
6.6 repair of simple laceration (no neurovascular, tendon, or bone/joint involvement)
6.7 biological dressings
6.8 extracorporeal shock wave therapy
6.9 taping/padding (limited to the foot, and ankle)
6.10 orthotics (limited to the foot, and ankle casting for foot orthosis and ankle orthosis)
6.11 prosthetics (including prescribing and/or dispensing toe filler and prosthetic feet)
6.12 other biomechanical experiences not listed above (may include, but is not limited to, physical therapy, shoe prescription shoe modification)
6.13 other clinical experiences
6.14 percutaneous procedures, i.e., coblation, cryosurgery, radiofrequency ablation, platelet-rich plasma.

7 Biomechanics

7.1 biomechanical case; must include diagnosis, evaluation (biomechanical and gait examination), and treatment.

8 History and Physical Examination

8.1 comprehensive history and physical examination
8.2 problem-focused history and physical examination

9 Surgery and surgical subspecialties

9.1 general surgery
9.2 orthopedic surgery
9.3 plastic surgery
9.4 vascular surgery

10 Medicine and medical subspecialty experiences

10.1 anesthesiology
10.2 cardiology
10.3 dermatology
10.4 emergency medicine
10.5 endocrinology
10.6 family practice
10.7 gastroenterology
10.8 hematology/oncology
10.9 imaging
10.10 infectious disease
10.11 internal medicine
10.12 neurology
10.13 pain management
10.14 pathology
10.15 pediatrics
10.16 physical medicine and rehabilitation
10.17 psychiatry/behavioral medicine
10.18 rheumatology
10.19 sports medicine
10.20 wound care
10.21 other

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PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0337 **Adv IL Masonic Med Ctr/SCPM** CRIP: No	$0.00	PMSR/RRA:	3	3	$41,000	$52,522	$54,933	
0701 **Albert Einstein Medical Center** CRIP: Section 2	$35.00	PMSR/RRA:	1	1	$49,929	$51,332	$52,514	
0456 **Alliance Community Hospital** CRIP: No	$0.00	PMSR/RRA:	3	3	$46,500	$47,200	$49,000	
0716 **Aria Health Hospital** CRIP: No	$0.00	PMSR/RRA:	3	3	$47,048	$50,369	$51,506	
0542 **Aventura Hospital and Medical Center** CRIP: Section 1	$35.00	PMSR/RRA:	2	2	$40,000	$42,000	$44,000	
0809 **Bellevue Hospital/SMHN** CRIP: Section 2	$0.00	PMSR:	2	2	$55,000	$58,000	$61,000	
0601 **Beth Israel Deaconess Medical Center** CRIP: Section 2	$50.00	PMSR/RRA:	2	2	$55,736	$57,234	$59,804	
0858 **Beth Israel Medical Center - NY** CRIP: No	$0.00	PMSR/RRA:	3	3	$58,863	$62,720	$66,445	
0536 **Bethesda Memorial Hospital** CRIP: Section 2	$30.00	PMSR/RRA:	2	2	$38,500	$40,000	$42,000	
0629 **Boston University Medical Center** CRIP: Section 2	$0.00	PMSR:	1	1	$54,217	$56,268	$58,914	
0443 **Botsford Hospital** CRIP: Section 1	$40.00	PMSR/RRA:	4	4	$45,184	$46,776	$47,888	
0631 **Bridgeport Hospital** CRIP: Section 2	$0.00	PMSR:	2	2	$52,684	$56,096	$57,721	
0704 **Bryn Mawr Hospital** CRIP: No	$0.00	PMSR/RRA:	2	2	$51,527	$52,673	$53,816	
0602 **Cambridge Health Alliance** CRIP: Section 2	$35.00	PMSR/RRA:	2	2	$55,080	$57,293	$59,522	
0538 **Carilion Roanoke Memorial Hospital** CRIP: Section 1	$20.00	PMSR/RRA:	2	2	$49,019	$50,490	$52,005	

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PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0803 **Catholic Hlth/Sisters of Charity** CRIP: Section 2	$0.00	PMSR/RRA:	2	2	$46,000	$47,000	$48,000	
0463 **CCF/Mercy Regional Medical Center** CRIP: No	$0.00	PMSR/RRA:	2	2	$48,919	$50,102	$51,521	
0102 **Cedars Sinai Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$51,072	$52,711	$54,784	
0246 **Central Iowa Health System** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$54,150	$55,150	$56,650	
0705 **Chestnut Hill Hospital** CRIP: No	$0.00	PMSR/RRA:	2	2	$53,000	$54,000	$55,500	
0152 **Chino Valley Medical Ctr** CRIP: Section 1		PMSR/RRA:	2	2	$42,900	$48,800	$51,300	
0457 **Christ Hospital** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$49,057	$50,529	$52,045	
0706 **Christiana Care Health Services** CRIP: Section 2	$0.00	PMSR/RRA:	2	2	$54,529	$56,044	$58,753	
0458 **Cleveland Clinic Foundation** CRIP: No	$0.00	PMSR/RRA:	4	4	$48,435	$49,874	$51,521	
0361 **Columbia St Mary's Hospital** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$54,500	$55,500	$56,500	
0355 **Community Westview Hospital** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$52,624	$56,264	$60,008	
0804 **Coney Island Hospital** CRIP: No	$0.00	PMSR:	2	2	$55,858	$58,168	$62,789	
0634 **Cooper University Hospital** CRIP: No	$35.00	PMSR:	2	2	$48,981	$50,899	$52,350	
0245 **Covenant Medical Center** CRIP: No	$35.00	PMSR/RRA:	1	1	$48,500	$50,500	$52,500	
0710 **Crozer Chester Medical Center** CRIP: Section 2	$0.00	PMSR/RRA:	4	4	$48,902	$51,087	$52,912	

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PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0523 **DeKalb Medical Center** CRIP: Section 2	$25.00	PMSR/RRA:	4	4	$47,840	$49,300	$50,800	
0251 **DePaul Health Center** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$42,800	$45,025	$47,065	
0444 **Detroit Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	5	5	$49,709	$51,149	$52,589	
0109 **Doctors Hospital of West Covina** CRIP: No	$0.00	PM&S-36:	2	2	$29,250	$32,250	$35,850	
0506 **DVA - Atlanta** CRIP: Section 2	$0.00	PMSR/RRA:	3	3	$42,944	$45,330	$48,312	
0507 **DVA - Augusta (Charlie Norwood)** CRIP: Section 2	$0.00	PMSR:	1	1	$41,098	$43,381	$46,235	
0338 **DVA - Chicago (Jesse Brown)** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$45,000	$47,500	$51,000	
0459 **DVA - Cleveland (Louis Stokes)** CRIP: No	$0.00	PMSR/RRA:	3	3	$42,275	$45,098	$48,065	
0336 **DVA - Cntrl Alabama Hlthcare Sys** CRIP: Section 1	$0.00	PMSR:	2	2	$42,113	$44,452	$46,235	
0460 **DVA - Dayton** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$41,846	$44,171	$47,077	
0242 **DVA - Eastern Colorado Hlth Care System** CRIP: No	$0.00	PMSR:	3	3	$44,107	$46,558	$49,621	$52,684
0111 **DVA - Gr Los Angeles Hlthcare Sys** CRIP: Section 1	$0.00	PMSR/RRA:	4	4	$41,388	$43,852	$46,316	
0712 **DVA - Lebanon** CRIP: Section 2	$0.00	PMSR:	1	1	$41,098	$43,381	$46,235	
0112 **DVA - Loma Linda (Jerry L. Pettis)** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$45,778	$48,321	$51,500	
0362 **DVA - Madison** CRIP: No	$0.00	PMSR/RRA:	2	2	$41,098	$43,381	$46,235	

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PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0537 **DVA - Maryland Health Care System** CRIP: Section 2	$0.00	PMSR/RRA:	5	3	$44,500	$47,000	$50,000	
0509 **DVA - Miami** CRIP: No	$0.00	PMSR:	2	2	$42,113	$44,452	$47,377	
0360 **DVA - Mountain Home** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$41,098	$43,381	$46,235	
0254 **DVA - New Mexico Hlthcare System** CRIP: Section 1	$0.00	PMSR/RRA:	4	4	$41,098	$43,381	$46,235	
0807 **DVA - New York Harbor Healthcare** CRIP: Section 2	$0.00	PMSR/RRA:	4	4	$46,339	$48,914	$52,132	
0635 **DVA - NJ Health Care System** CRIP: Section 2	$0.00	PMSR/RRA:	3	3	$46,339	$48,914	$52,132	
0808 **DVA - Northport** CRIP: Section 2	$0.00	PMSR/RRA:	3	3	$46,339	$48,339	$52,132	
0113 **DVA - Palo Alto Hlthcare Sys** CRIP: Section 1	$0.00	PMSR:	4	4	$48,654	$51,357	$54,736	
0714 **DVA - Philadelphia** CRIP: No	$0.00	PMSR:	1	1	$43,844	$46,280	$49,325	
0239 **DVA - Phoenix (Carl T. Hayden)** CRIP: No	$0.00	PMSR/RRA:	4	4	$37,850	$40,103	$42,356	
0114 **DVA - Puget Sound Hlthcare Sys** CRIP: Section 1	$0.00	PMSR:	2	2	$43,852	$46,288	$49,333	
0539 **DVA - Richmond (McGuire)** CRIP: Section 2	$0.00	PMSR:	1	1	$41,929	$44,259	$47,170	
0543 **DVA - Salem** CRIP: Section 2		PMSR:	1	1	$41,098	$43,381	$46,235	
0115 **DVA - San Francisco** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$48,654	$51,357	$54,736	
0240 **DVA - So AZ Hlth Care System** CRIP: Section 1	$0.00	PMSR/RRA:	4	4	$41,098	$43,381	$46,235	

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PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0511 **DVA - Tampa (J.A. Haley)** CRIP: No	$0.00	PMSR/RRA:	3	3	$42,100	$44,400	$47,300	
0358 **East Jefferson General Hospital** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$48,500	$49,500	$52,000	
0636 **Englewood Hospital and Medical Center** CRIP: Section 2	$30.00	PMSR:	2	2	$50,783	$52,880	$55,000	
0514 **Florida Hospital East Orlando** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$48,500	$50,500	$52,500	
0842 **Forest Hills Hospital** CRIP: Section 2	$0.00	PMSR/RRA:	3	3	$62,500	$64,500	$66,500	
0120 **Fountain Valley Regional Hospital** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$46,800	$48,700	$50,600	
0352 **Franciscan Alliance St Margaret/MWU** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$48,143	$49,813	$52,366	
0121 **Franciscan Health System-St Francis Hosp** CRIP: Section 1	$25.00	PMSR/RRA:	2	2	$41,278	$44,717	$50,083	
0708 **Geisinger Community Medical Ctr** CRIP: Section 2	$35.00	PMSR/RRA:	5	5	$43,535	$46,609	$50,397	
0445 **Genesys Regional Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$45,691	$47,295	$48,942	
0850 **Good Samaritan Hospital Medical Center** CRIP: Section 2	$0.00	PMSR/RRA:	3	3	$51,508	$54,213	$57,461	
0461 **Grant Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	4	4	$48,318	$49,795	$51,272	
0363 **Gundersen Lutheran Med Foundation** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$56,500	$58,200	$59,700	
0747 **Hahnemann University Hospital** CRIP: No	$0.00	PMSR/RRA:	5	5	$50,898	$52,356	$53,949	
0248 **HealthPartners Institute/Regions Hosp** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$50,049	$51,702	$53,406	

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PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0249 **Hennepin County Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$50,093	$51,689	$53,390	
0446 **Henry Ford Macomb Hospital** CRIP: No	$0.00	PMSR/RRA:	2	2	$49,000	$51,000	$53,000	
0447 **Henry Ford Wyandotte Hospital** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$49,000	$51,000	$53,000	
0718 **Heritage Valley Beaver** CRIP: Section 2	$0.00	PMSR/RRA:	2	2	$45,000	$47,500	$50,000	
0243 **Highlands/ Presbyterian St Luke's** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$51,084	$52,958	$55,016	
0637 **Hoboken University Medical Center** CRIP: Section 2	$35.00	PMSR/RRA:	3	3	$51,316	$54,794	$58,148	
0614 **Howard University Hospital** CRIP: Section 2	$0.00	PMSR:	1	1	$47,802	$49,000	$51,059	
0256 **Hunt Regional Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$41,600	$44,000	$46,400	
0541 **Inova Fairfax Hospital** CRIP: Section 2	$0.00	PMSR:	5	5	$55,824	$58,636	$61,119	
0640 **Inspira Health Network** CRIP: Section 2	$35.00	PMSR/RRA:	3	3	$47,000	$49,000	$51,000	
0811 **Interfaith Medical Center** CRIP: Section 2	$0.00	PMSR:	1	1	$59,000	$65,000	$72,000	
		PMSR/RRA:	1	1	$59,000	$65,000	$72,000	$75,000
0264 **Intermountain Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	6	6	$41,098	$54,142	$56,243	
0526 **Jackson North Medical Center** CRIP: Section 2	$35.00	PM&S-36:	2	1	$43,471	$45,446	$47,420	
0516 **Jackson South Community Hospital** CRIP: Section 2	$35.00	PMSR/RRA:	1	1	$46,566	$48,682	$50,796	

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PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0812 **Jamaica Hospital Medical Center** CRIP: No	$0.00	PMSR/RRA:	2	2	$57,456	$62,301	$68,352	
0647 **Jersey Shore University Medical Center** CRIP: Section 2	$0.00	PMSR/RRA:	2	2	$50,794	$54,246	$57,574	
0356 **Jewish Hospital & St Mary's HealthCare** CRIP: No	$0.00	PMSR/RRA:	3	3	$47,428	$48,600	$50,701	
0462 **Jewish Hospital of Cincinnati** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$50,500	$52,250	$54,050	
0517 **JFK Medical Center** CRIP: Section 2	$25.00	PMSR/RRA:	2	2	$40,000	$42,000	$44,000	
0257 **John Peter Smith Hospital** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$47,278	$49,795	$51,106	
0129 **Kaiser Permanente - Santa Clara** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$54,210	$59,215	$64,485	
0130 **Kaiser Permanente - Vallejo** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$57,399	$62,106	$69,739	
0116 **Kaiser SF Bay Area Foot & Ankle** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$56,399	$61,606	$69,489	
0365 **Katherine Shaw Bethea Hospital** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$49,000	$50,000	$51,000	
0518 **Kendall Regional Medical Center** CRIP: Section 2	$35.00	PMSR/RRA:	1	1	$49,651	$51,428	$53,454	
0638 **Kennedy University Hospital** CRIP: No	$0.00	PMSR/RRA:	3	3	$47,000	$50,000	$52,000	
0823 **Kingsbrook Jewish Med Ctr** CRIP: Section 2	$0.00	PMSR:	2	2	$59,876	$65,079	$70,550	
		PMSR/RRA:	1	1	$59,876	$65,079	$70,550	
0801 **Kingston Hospital** CRIP: No	$0.00	PMSR/RRA:	2	2	$42,179	$43,856	$46,488	

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PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0258 **Kingwood Medical Center** CRIP: Section 1	$0.00	PM&S-36:	3	3	$37,500	$39,500	$41,500	
0131 **Lakewood Regional Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$49,000	$51,000	$53,000	
0521 **Larkin Community Hospital** CRIP: Section 2	$0.00	PMSR:	2	2	$42,000	$43,000	$44,000	
0132 **Legacy Health/Kaiser Permanente** CRIP: Section 1	$35.00	PMSR/RRA:	4	4	$51,500	$53,500	$56,000	
0133 **Long Beach Memorial Med Ctr** CRIP: Section 1	$35.00	PMSR/RRA:	2	2	$50,283	$52,004	$54,050	
0813 **Long Island Jewish Medical Center** CRIP: Section 2	$0.00	PMSR/RRA:	4	4	$65,500	$67,500	$69,500	
0341 **Loyola University Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$49,400	$49,920	$50,960	
0814 **Lutheran Medical Center - NY** CRIP: Section 2	$35.00	PMSR/RRA:	2	2	$58,169	$62,276	$65,635	
0150 **Madigan Army Medical Center** CRIP: Unsure	$0.00	PMSR/RRA:	1	1	$42,000	$42,000	$42,000	
0241 **Maricopa Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$49,644	$51,386	$53,762	
0618 **Massachusetts General Hospital** CRIP: Section 2	$0.00	PMSR:	1	0	$57,000	$59,100	$61,959	
		PMSR/RRA:	1	1	$57,000	$59,100	$61,959	
0449 **McLaren Oakland Hospital** CRIP: Section 1	$40.00	PMSR/RRA:	2	2	$42,700	$44,200	$45,700	
0626 **MedStar Washington Hospital Center** CRIP: Section 2	$0.00	PMSR/RRA:	5	5	$50,800	$51,500	$54,800	
0619 **Memorial Hospital of Rhode Island** CRIP: Section 2	$50.00	PMSR/RRA:	2	2	$50,125	$51,552	$54,711	

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PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0515 **Memorial Regional Hospital South** CRIP: Section 1	$40.00	PMSR/RRA:	2	2	$42,000	$45,000	$50,000	
0250 **Mercy Hospital - MN** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$40,040	$42,203	$43,472	
0342 **Mercy Hospital & Medical Center - IL** CRIP: No	$0.00	PM&S-36:	2	2	$48,360	$50,040	$51,660	
0503 **Mercy Hospital/BUSPM** CRIP: Section 2	$0.00	PMSR/RRA:	3	3	$40,000	$42,000	$44,000	
0464 **Mercy St Vincent Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$49,400	$51,200	$52,900	
0722 **Mercy Suburban Hospital** CRIP: No	$0.00	PMSR/RRA:	2	2	$46,000	$48,000	$49,500	
0827 **Metropolitan Hosp Ctr/NYCPM** CRIP: No	$0.00	PMSR/RRA:	2	2	$45,000	$46,000	$47,000	
0621 **MetroWest Medical Center** CRIP: Section 2	$25.00	PMSR/RRA:	2	2	$53,269	$54,787	$56,472	
0724 **Millcreek Community Hospital** CRIP: Section 2	$0.00	PMSR/RRA:	4	4	$40,000	$41,000	$42,000	
0252 **Mineral Area Regional Medical Center** CRIP: Section 1	$0.00	PM&S-36:	2	2	$32,000	$34,000	$36,000	
0836 **Montefiore Medical Center** CRIP: Section 2	$25.00	PMSR/RRA:	5	5	$58,000	$61,000	$64,000	
0639 **Morristown Memorial Hospital** CRIP: Section 2	$40.00	PMSR/RRA:	3	3	$53,750	$55,600	$58,300	
0633 **Mount Auburn Hospital** CRIP: Section 2	$50.00	PMSR/RRA:	2	2	$53,152	$55,112	$60,582	
0815 **Mount Sinai Hospital Manhattan** CRIP: Section 2	$0.00	PMSR/RRA:	8	8	$58,437	$61,795	$65,116	
0343 **Mt Sinai Hospital/DVA-North Chicago** CRIP: No	$0.00	PMSR/RRA:	3	3	$45,036	$47,538	$48,566	

2014 CASPR Program Summary Chart

PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0522 **Mt Sinai Medical Center - FL** CRIP: Section 2	$40.00	PMSR/RRA:	2	2	$49,651	$51,482	$53,454	
0852 **Mt Vernon Hospital** CRIP: Section 2	$0.00	PMSR:	1	1	$50,274	$52,222	$54,373	
		PMSR/RRA:	1	1	$50,274	$52,222	$54,373	
0816 **New York Community Hospital** CRIP: No	$0.00	PMSR:	2	2	$55,000	$56,000	$57,000	
0859 **New York Hospital Queens** CRIP: Section 2	$0.00	PM&S-36:	4	4	$58,195	$62,255	$62,315	$63,860
0848 **New York Methodist Hosp** CRIP: Section 2	$0.00	PMSR:	2	2	$59,857	$65,098	$71,070	
		PMSR/RRA:	3	3	$59,857	$65,098	$71,070	
0244 **North Colorado Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$49,560	$51,183	$52,693	
0465 **Northside Medical Center (WRHE)** CRIP: Section 1	$25.00	PMSR/RRA:	4	4	$43,500	$44,779	$46,453	
0524 **Northwest Medical Center - FL** CRIP: Section 2	$30.00	PMSR/RRA:	2	2	$40,000	$42,000	$44,000	
0357 **Norton Audubon Hospital** CRIP: No	$0.00	PMSR/RRA:	2	2	$46,000	$47,500	$49,000	
0344 **Norwegian American Hospital** CRIP: No	$35.00	PMSR/RRA:	1	1	$32,000	$36,000	$40,000	
0863 **NSLIJ - Lenox Hill Hospital** CRIP: Section 2		PMSR/RRA:	2	2	$63,000	$65,000	$67,000	
0448 **Oakwood Annapolis Hospital** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$50,128	$51,668	$53,664	
0472 **Oakwood Southshore Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$48,214	$49,359	$50,835	

2014 CASPR Program Summary Chart

PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0359 **Ochsner Medical Center - Kenner** CRIP: No	$0.00	PMSR/RRA:	1	1	$40,000	$43,000	$46,000	
0467 **Ohio State University Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$49,332	$51,041	$52,661	
0366 **OSF St Anthony Medical Center** CRIP: Section 1	$20.00	PMSR/RRA:	2	2	$46,500	$48,000	$49,500	
0835 **Our Lady of Lourdes Memorial Hospital** CRIP: Section 2	$0.00	PMSR/RRA:	4	4	$42,095	$44,621	$47,313	
0525 **Palmetto General Hospital** CRIP: No	$0.00	PM&S-36:	3	3	$43,000	$45,000	$47,000	
0740 **Penn Presbyterian Medical Center** CRIP: No	$35.00	PM&S-36:	4	4	$48,865	$50,200	$51,700	$54,850
0751 **Phoenixville Hospital** CRIP: No	$0.00	PMSR/RRA:	2	2	$50,000	$51,000	$52,000	
0749 **Pinnacle Health Hospitals** CRIP: Section 2	$0.00	PMSR/RRA:	2	2	$53,300	$55,500	$58,000	
0348 **Presence St Joseph Hospital/Chicago** CRIP: No	$0.00	PMSR/RRA:	5	5	$43,146	$46,808	$49,196	
0450 **Providence Hospital** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$45,450	$46,899	$48,779	
0750 **Reading Hospital** CRIP: Section 2	$0.00	PMSR/RRA:	2	2	$51,646	$54,475	$56,222	
0622 **Roger Williams Medical Center** CRIP: Section 2	$25.00	PMSR/RRA:	3	3	$55,191	$56,753	$60,206	
0730 **Roxborough Memorial Hospital** CRIP: Section 2	$35.00	PMSR/RRA:	4	4	$46,000	$48,000	$50,000	
0346 **Rush Univ Med Ctr/Oak Park** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$48,922	$51,972	$53,605	
0259 **Scott & White Memorial Hospital** CRIP: No	$0.00	PMSR/RRA:	6	4	$48,705	$50,049	$51,175	

2014 CASPR Program Summary Chart

PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0143 **Scripps Mercy Hospital** CRIP: Section 1	$35.00	PMSR/RRA:	4	4	$51,145	$53,145	$55,356	
0531 **Shands Jacksonville Medical Center** CRIP: Section 2	$0.00	PMSR/RRA:	3	3	$47,798	$49,246	$50,985	
0104 **Silver Lake Medical Center** CRIP: Section 1	$35.00	PMSR/RRA:	1	1	$42,000	$44,500	$47,000	
0860 **South Nassau Communities Hospital** CRIP: Section 2	$0.00	PMSR:	2	2	$52,000	$55,000	$58,000	
0451 **Southeast Michigan Surgical Hosp (Kern)** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$45,000	$46,500	$50,000	
0648 **Southwestern Vermont Medical Center** CRIP: Section 2		PMSR/RRA:	2	2	$45,640	$47,466	$49,365	
0838 **St Barnabas Hospital - NY** CRIP: Section 2	$0.00	PMSR:	3	3	$47,995	$50,880	$54,388	
		PMSR/RRA:	3	2	$47,955	$50,880	$54,388	$57,313
0641 **St Barnabas Medical Center - NJ** CRIP: No	$0.00	PM&S-36:	3	3	$49,809	$52,723	$55,727	
0623 **St Francis Hospital & Med Ctr - CT** CRIP: Section 2	$25.00	PMSR/RRA:	2	2	$54,700	$57,200	$60,000	
0452 **St John Hospital and Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	4	4	$45,400	$46,900	$48,800	
0453 **St John Macomb - Oakland Hospital** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$45,450	$46,899	$48,772	
0853 **St John's Episc Hosp-South Shore** CRIP: No	$0.00	PMSR/RRA:	2	2	$57,583	$61,746	$66,590	
0861 **St Joseph Hospital - NY** CRIP: Section 2		PMSR:	1	1	$45,000	$50,000	$55,000	
		PMSR:	1	1	$45,000	$50,000	$55,000	
		PMSR/RRA:	1	1	$45,000	$50,000	$55,000	

2014 CASPR Program Summary Chart

PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0260 **St Joseph Medical Center - TX** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$41,600	$43,300	$45,000	
0351 **St Joseph Reg Med Ctr - IN** CRIP: Section 1	$25.00	PMSR/RRA:	2	2	$46,259	$47,574	$50,472	
0733 **St Joseph's Hospital/NPHS** CRIP: No	$0.00	PMSR:	1	1	$44,000	$46,000	$48,500	
0734 **St Luke's Hospital - Allentown Campus** CRIP: Section 2	$35.00	PMSR/RRA:	3	3	$51,470	$54,610	$56,795	
0454 **St Mary Mercy Livonia** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$48,604	$50,604	$52,604	
0353 **St Mary's Health System - IN** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$45,200	$47,400	$50,000	
0642 **St Mary's Hospital - NJ** CRIP: Section 2	$0.00	PMSR/RRA:	1	1	$45,000	$48,000	$52,000	
0145 **St Mary's Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$49,884	$53,716	$56,066	
0643 **St Michael's Medical Center** CRIP: No	$40.00	PMSR/RRA:	1	1	$47,866	$51,364	$54,650	
0468 **St Rita's Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$43,000	$45,000	$48,000	
0469 **St Vincent Charity Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$49,017	$50,453	$52,766	
0354 **St Vincent Hospital - IN** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$50,500	$51,000	$52,000	
0625 **St Vincent Hospital/WMC** CRIP: Section 2	$35.00	PMSR/RRA:	2	2	$52,718	$54,168	$55,673	
0530 **St Vincent's Medical Center - FL** CRIP: Section 2	$0.00	PMSR:	2	2	$45,700	$47,200	$48,500	
0843 **Staten Island University Hospital** CRIP: No	$0.00	PMSR/RRA:	3	3	$62,069	$66,262	$73,479	

2014 CASPR Program Summary Chart

PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0630 **Steward - St. Elizabeth's Medical Center** CRIP: Section 2	$35.00	PMSR/RRA:	2	2	$52,832	$55,598	$58,344	
0349 **Sts Mary & Elizabeth Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$44,009	$47,744	$50,180	
0470 **Summa Western Reserve Hospital** CRIP: No	$0.00	PMSR/RRA:	1	1	$45,000	$46,000	$47,500	
0255 **Surgical Hosp of Oklahoma/CCF** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$42,000	$39,000	$41,000	
0139 **Swedish Medical Center** CRIP: Section 1	$50.00	PMSR/RRA:	2	2	$50,500	$52,500	$54,500	
0736 **Temple University Hospital** CRIP: No	$0.00	PMSR/RRA:	4	3	$50,586	$52,354	$53,768	$55,661
0644 **Trinitas Regional Medical Center** CRIP: Section 2	$0.00	PMSR/RRA:	2	2	$47,867	$51,365	$54,605	
0247 **Trinity Regional Hospital** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$38,000	$40,000	$44,000	
0253 **Truman Medical Center Lakewood** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$40,000	$41,000	$42,000	
0266 **Tucson Medical Center/Midwestern** CRIP: Section 1		PMSR/RRA:	2	2	$50,000			
0466 **UHRegional Hospitals-Kent State** CRIP: No	$0.00	PMSR:	4	4	$46,276	$47,882	$49,882	
		PMSR/RRA:	6	6	$46,276	$47,882	$49,882	
0844 **United Health Services Hospitals** CRIP: Section 2	$0.00	PMSR/RRA:	3	3	$55,000	$55,500	$56,000	
0742 **Univ of Pittsburgh Med Ctr Mercy** CRIP: Section 2	$40.00	PMSR/RRA:	6	6	$50,669	$52,166	$53,186	$55,806
0261 **Univ of Texas Hlth Science Ctr** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$41,098	$48,431	$49,989	

2014 CASPR Program Summary Chart

PROGRAM NAME	PROGRAM FEE	CPME APPROVAL Type	# Approved	# Funded	STIPEND Year One	Year Two	Year Three	Year Four
0262 **University General Hospital** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$42,000	$44,000	$46,000	
0645 **University Hospital/UMDNJ** CRIP: Section 2	$30.00	PMSR/RRA:	2	2	$50,808	$54,251	$57,572	
0471 **University Hospital/Univ of Cincinnati** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$50,142	$51,354	$52,617	$54,585
0350 **Vanguard Weiss Memorial Hosp** CRIP: Section 1	$0.00	PMSR/RRA:	3	3	$45,304	$47,071	$48,400	
0646 **Virtua Health System** CRIP: No	$0.00	PMSR/RRA:	3	2	$46,675	$48,776	$51,875	
0263 **West Houston Med Ctr** CRIP: Section 1	$0.00	PMSR/RRA:	4	4	$37,500	$39,500	$41,500	
0533 **Westchester General Hospital** CRIP: Section 2	$45.00	PMSR:	2	2	$43,000	$45,000	$47,000	
		PMSR/RRA:	2	2	$43,000	$45,000	$47,000	
0745 **Western Pennsylvania Hospital** CRIP: No	$50.00	PMSR/RRA:	3	3	$47,484	$47,999	$48,429	
0535 **Westside Regional Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	2	2	$40,000	$42,000	$44,000	
0364 **Wheaton Franciscan Hlthcare - St Joseph** CRIP: No	$0.00	PMSR/RRA:	2	2	$55,400	$56,400	$57,400	
0146 **White Memorial Medical Center** CRIP: Section 1	$0.00	PMSR/RRA:	1	1	$51,323	$52,659	$55,536	
0534 **Womack Army Medical Center** CRIP: Section 2	$0.00	PMSR/RRA:	2	2	$66,364	$66,364	$66,364	
0846 **Wyckoff Heights Med Ctr** CRIP: No	$25.00	PMSR:	8	8	$58,988	$64,761	$70,532	
		PMSR/RRA:	3	3	$58,988	$64,761	$70,532	$72,704

2014 CASPR Program Summary Chart

			CPME APPROVAL		STIPEND			
PROGRAM NAME	PROGRAM FEE	Type	# Approved	# Funded	Year One	Year Two	Year Three	Year Four
0627 **Yale New Haven/DVA Hlthcare System**	$0.00	PMSR/RRA:	5	5	$45,295	$60,700	$63,800	
CRIP: Section 2								

Subject HB 1880 and 1882 / SB 2468 and 2467 - Relating to Podiatrists

Position Support

To whom it may concern,

As a family doctor, I rely on the expertise of our local podiatrists for care of our patients.

I support bill HB1882/SN2468 and bill 1880/SB2467 as a means to continue that care.

Sincerely,

Thomas B Williamson, MD

Re: Relating to Podiatry: HB 1880/1882 and SB 2467/2468

Position: Support

2/11/14

To whom it may concern,

As an infectious disease specialist I have worked closely with many Podiatrist in the state of Hawaii as well of other states. I strongly believe that proper training is critical and support Bill HB1880/SB2467 to the fullest. Please consider passing this important bills when they are brought up for voting.

Thank you very much,

Dr. James Yoon

Subject: HB 1880 and 1882 / SB 2468 and 2467 - Relating to Podiatrists

Position: Support

From: Christopher Jordan, MD, FACS

To Our Hawai'i Congressional Leaders

As a practicing general surgeon at Wilcox Hospital I would like to add my support for HB1882/SB 2468 as well as HB1880/SB2467. We are fortunate to have a wonderful podiatrist at our hospital and it is a shame that he cannot practice to the full extent of his capabilities. It would be much better for our patients.

Sincerely,

Chris Jordan MD

Christopher Jordan MD, FACS
Past Chief of Staff, Wilcox Hospital

Subject: HB 1880 and 1882 / SB 2468 and 2467 - Relating to Podiatrists

From: Elna Masuda, MD
Vascular Surgeon
Straub Hospital

February 27, 2014

RE: Advancement of privileges for future podiatrists

To Whom It May Concern:

I can only attest to the skills of the podiatrist I have been fortunate to work with over the last 20 years. I could attest that Dr. Tyler Chihara is highly skilled and is very capable in performing procedures that extend beyond the toes and up into the foot, and above the ankle. I also would confer the competence of Dr. David Yee and Dr. Christopher Yee, whom I have had the honor and privilege to work with over the last 20 years as well. These individuals set the bar for future podiatrists in terms of quality of care and good outcomes following procedures. I would strongly recommend that the proposed bill be looked at in light of the excellent outcomes that have been the product of these three podiatrists mentioned.

This is being sent to you as an observer by a vascular surgeon who works very intimately with podiatrists in providing as best as we can excellent care of not only the toes but the foot and ankle, the entire limb and the entire individual.

Sincerely yours,

Elna M Masuda, MD

EMM/t43IR3 D:02/27/2014 T:02/28/2014 C:574785 J:65004266

Subject: HB 1880 and 1882 / SB 2468 and 2467 - Relating to Podiatrists

Position: Support

As an Orthopedic Physicians Assistant practicing on the island of Kauai's for more than 20 years, I recognize the importance of podiatrists functioning within the healthcare system. Their education and training has changed over the past 20 years, and state law should reflect the current level of training and ability by podiatrists.

A three year residency has been standard for over 10 years now, and current law should require completion of an approved residency program prior to obtaining licensure in the state of Hawaii. HB 1882and SB 2468 increases the minimum residency requirement to 24 months and I support this increase in order to ensure Hawaii law maintains competency for new podiatrists entering the state to practice

I support HB 1880 and SB 2467, which brings Hawaii up to the current standards of foot and ankle care that is already recognized in 45 other states. Podiatrists are the primary providers of care for the diabetic foot, and our current law is restrictive and does not allow podiatrists to function to their full ability and training. Diabetic foot and ankles issues are complex and require a team approach to address appropriately. Podiatrists are an essential part of this team, and Hawaii law should not restrict the optimum care delivered to our patients.

Terrie Johnson PA- C
Kaua'i Medical Clinic
Bone and Joint Center

Subject: HB 1880 and 1882 / SB 2468 and 2467 - Relating to Podiatrists

Position: Support

Dear Hawaii State Leaders in the Senate and House of Representatives,

I am writing in support of HB1880 and SB2467, regarding the practice rights of podiatrists in the state of Hawaii. I am a board certified orthopedic surgeon currently in practice on Kauai. I have reviewed the text of both bills, and feel they are long overdue. Podiatric surgeons are held to high standards during training and throughout practice, and are fully qualified to perform all duties as outlined. Broadening their scope of practice in Hawaii will elevate them to standards typically found on the mainland, and will increase access to foot and ankle care for the residents of Hawaii. I have extensive personal experience working alongside podiatrists, and have confidence in their abilities pertaining to the treatment of foot and ankle conditions, including surgical treatment. Please support these two bills with your vote to improve the quality of medical care in Hawaii

Sincerely,

Derek Johnson, DO
Chief of Orthopedic Surgery
Kauai Medical Clinic and Wilcox Memorial Hospital

Subject: HB 1880 and 1882 / SB 2468 and 2467 - Relating to Podiatrists

Position: Support

To Whom It May Concern,

I am writing a letter in support of two news bills which effect one of my Podiatry colleagues, Dr. Tyler Chihara. The bills are Bill HB1882/SB2468 and Bill HB1880/SB2467. I have been informed that these bills are long overdue and feel strongly that they are passed so that our podiatrists can continue to serve the community. Dr. Chihara is invaluable to caring for our patients on Kaua'i, and passing these bills will help to ensure he gets to continue treating the scope of diseases he was trained to do.

Sincerely,

Amy T Rodriguez, MD
General Surgery
Kaua'i Medical Clinic
808-245-1505

February 20, 2014

Subject: HB 1880 and 1882 / SB 2468 and 2467 - Relating to Podiatrists

Position: Support

As a primary care physician practicing on the island of Kauai, I recognize the importance of podiatrists functioning within the healthcare system. Their education and training has changed over the past 20 years, and state law should reflect the current level of training and ability by podiatrists.

A three year residency has been standard for over 10 years now, and current law should require completion of an approved residency program prior to obtaining licensure in the state of Hawaii. HB 1882and SB 2468 increases the minimum residency requirement to 24 months and I support this increase in order to ensure Hawaii law maintains competency for new podiatrists entering the state to practice.

I support HB 1880 and SB 2467, which brings Hawaii up to the current standards of foot and ankle care that is already recognized in 45 other states. Podiatrists are the primary providers of care for the diabetic foot, and our current law is restrictive and does not allow podiatrists to function to their full ability and training. Diabetic foot and ankles issues are complex and require a team approach to address appropriately. Podiatrists are an essential part of this team, and Hawaii law should not restrict the optimum care delivered to our patients.

Owen Muana, MD
Internal Medicine and Geriatric Medicine
Kaua'i Medical Clinic
3-3420 B Kuhio Highway
Lihue, HI 96766
Tel: 808-245-1504
Fax: 808-246-1363

To the State Legislature of Hawaii,

I am writing in support of Bill HB 1882/SB 2468, which would help improve the standard of care provided by Podiatrists in our state. This bill would require those practicing podiatry here in Hawaii to have completed an accredited residency program prior to obtaining their state license. I am a practicing anesthesiologist at Wilcox Hospital in Kauai and the knowledge that I obtained in residency training in anesthesiology have been invaluable in my everyday medical practice. I hope that this bill will help bring about quality podiatry care to the people of Hawaii by requiring accredited residency training for practicing podiatrists of our State

I also like to lend my support for Bill HB1880/SB2467 which would broaden the scope of practice for the podiatrists to perform comprehensive foot and ankle care in Hawaii. I have worked with various skilled podiatrists in Kauai for the past 4 years and have seen them expertly perform all levels of foot, ankle, and leg surgery. Moreover, other specialists such as orthopedic surgeons will often confer with our hospital podiatrists on how to adequately manage many lower leg surgeries. With the high number of people in Hawaii plagued by diabetes, allowing our podiatrists to provide comprehensive lower leg surgeries will provide diabetic patients will more access to much needed quality surgical care.

Mahalo for Your Time
Howard Chen MD

Wilcox Memorial Hospital
hchenmd28@yahoo.com
3-3420 Kuhio Highway
Lihue Kauai 96766
808-245-1020

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467-Relating to Podiatrists
3/7/14 9:30am

Chair Au Bellati and members of the Committee:

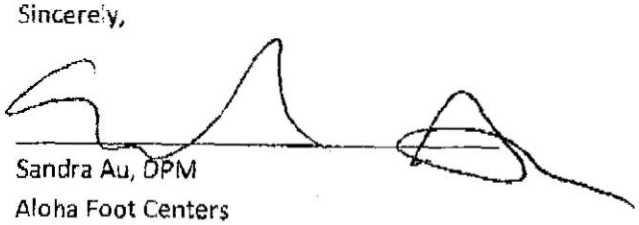
My name is Sandra Au, I am a podiatrist practicing on the Windward side of the island and I support this bill. I was born and raised on Oahu graduating from McKinley High School. I returned to Hawaii just 6 months ago after being away for 11 years, completing 4 years of undergraduate, 4 years of podiatry school, and 3 years of a foot and ankle surgical residency in California. I had always planned to return to Hawaii to practice and serve the people of Oahu but was discouraged to do so when I learned that the scope of practice laws for podiatrists were so restricted compared to California and the rest of the nation. There are only 5 states that do not allow podiatrists to treat ankle fractures and only 7 states that do not allow podiatrists to do partial foot amputations, Hawaii being one of them for both. My mentors and physicians that trained me were disappointed that I would not be able to use all the surgical skills that they taught me. Many of them urged me to stay and offered me an amazing job in California. The offer was very tempting but Hawaii was my home and I felt obligated to come back to change things for the better. That is why I am here standing before you in support of this bill. If this bill does not pass a lot of well skilled surgeons would be discouraged from coming to Hawaii to practice.

There are only a few foot and ankle orthopedic physicians in Hawaii which means a huge shortage in well qualified foot and ankle specialists that are able to treat ankle fractures and perform limb salvage amputations. This shortage is even more apparent on the neighbor islands where a patient may have to fly to Oahu with a fractured ankle just to have the procedure done.

In the last 2 years I have surgically fixed 70 ankle fractures. If the law does not get changed then those skills that I have attained would go to waste and it will be the patients that will suffer by not having access to a foot and ankle specialist. It frustrates me to have the skills and knowledge to be able to treat my patients but because of the law I have to turn them away and send them to someone else that may not have done as many ankle fractures or foot amputations that I have. Orthopedic surgeons after 5 years of residency on average have only performed 109 foot and ankle cases total. The training podiatrists receive today to treat ankle fractures is more than the training that most orthopedic surgeons get in their 5 years. We should be allowed to do the procedures that we were trained to do.

Thank you for your time and consideration and allowing my testimony.

Sincerely,



Sandra Au, DPM
Aloha Foot Centers

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467-Relating to Podiatrists
3/7/14 9:30am

Chair and Members of the Committee:

I am Wendell Ferguson, MD Orthopaedic Surgeon of Kaiser Vacaville Medical Center and I support this bill.

I have been involved in training podiatry residents in ankle fractures and have seen firsthand their competency. This bill allows doctors of podiatric medicine to practice to the level of medicine and surgery to which they have been trained.

Over the past two decades podiatry training has progressed significantly and the scope of practice should reflect this.

Thank you for allowing my testimony.

Sincerely,

Wendell Ferguson, MD
Kaiser Vacaville Medical Center

KOKUA KALIHI VALLEY
Comprehensive Family Services
2239 North School Street, Honolulu, Hawaii 96819
Phone (808) 791-9400 ♦ Fax (808) 848-0979

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467-Relating to Podiatrists
3/7/14 9:30am
Presented by: Dr. Fernandes in support

Chair Au Belatti and Members of the Committee:

Honorable Chair and Committee Members:

I am writing to testify in strong support for ~~HB1880~~ SB2467 relating to podiatry scope of practice. I am a physician working at Kokua Kalihi Valley and Kalihi Palama Health Center. I am also Associate Professor of Geriatric Medicine, JABSOM. My research focus is diabetes. I am co-Principal Investigator for Medicaid Incentives for the Prevention of Chronic Diseases in Hawaii.

It is with great pleasure that I support ~~HB1880~~ SB2467 allowing increase of scope of podiatric medicine to national standards to include the foot and ankle. In the last few decades the training and skill set of a podiatrist to treat the lower extremity has significantly increased. My patients have a long wait to see an orthopedic or general surgeon for foot problems.

Our federally qualified health centers have been most pleased with the service from the community podiatrists and our patients have a high satisfaction with care received from podiatrists. We serve a populations with a high prevalence of diabetes. Podiatrists are the first line of defense in diabetic foot complications, and having them unable to do as they are trained is detrimental to the diabetic community – especially in the area of wound care. It is imperative to treat diabetes foot complications in a timely fashion so that persons living in Hawaii do not have to undergo unnecessary foot amputations.

Please do the right thing for the people of Hawaii and pass ~~HB1880~~ SB2467 Thank you for the opportunity to testify.

Sincerely,

Ritabelle Fernandes, MD, MPH, FACP
Internist & Geriatrician

Testimony to: Representative Della Au Belatti, Chair

House Committee on Health

Subject: SB 2467-Relating to Podiatrists

Dear Chair Au Belatti and Members of the Committee:

I am L. Richard Fried, Jr., Esq. and I support this bill. It allows doctors of podiatric medicine to practice to the level of medicine and surgery to which they have been trained. Podiatry has progressed significantly over the past 20 years; consequently, the scope of practice needs to be updated accordingly.

Thank you for allowing my written testimony.

Sincerely,

L. Richard Fried, Jr., Esq.

L. Richard Fried, Jr., Esq.

Cronin, Fried, Sekiya, Kekina & Fairbanks

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(808) 524-1433

rfried@croninfried.com

Testimony To: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467 Relating to Podiatrists
Presented by: Gregory C. Gifford, M.D., J.D.

Chair Au Belatti and Members of the Committee:

I am Dr. Gregory C. Gifford, M.D., J.D., former Chief of Medical Staff at Castle Medical Center, and am very familiar with the rationale and the entire process by which the first Podiatric Surgeon was granted surgical privileges at a hospital in Hawaii. That was Dr. Robert LaReaux at Castle Medical Center in 1987. Dr. LaReaux has since developed an international reputation for excellent care, once even being flown to Moscow to operate on the wife of a member of the Russian Federal Assembly.

As a former Emergency Medicine Director at Castle Medical Center, I fully support the quality of surgical care that well-trained podiatrists can provide for both emergent and non-emergent patients. When fully trained including a twenty-four month residency program I believe vetted podiatrists can provide the same high quality of surgical care at the level of the ankle that they have clearly demonstrated in the rest of the foot. Hand and wrist MD/DO surgeons are essential anatomic and functional specialists; ankle and foot Podiatric/MD/DO surgeons are no less essential and specialized. The level of Podiatric surgical skill has progressed from the foot to the ankle in the last 27 years; the legislation allowing them to use these skills needs, after 27 years, to advance as well.

Thank you for allowing this testimony.
Gregory C. Gifford, M.D., J.D.

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467-Relating to Podiatrists
3/7/14 9:30am
Presented by: Dr. Senft

Chair Au Belatti and Members of the Committee:

I have been practicing in Hawaii for almost 15 years. I came to Kona from Houston, Texas where I had been in private practice for 15 years. My training started in California in 1984-5 with a surgical residency program sanctioned by the California College of Podiatric Medicine, now the California School of Podiatry. After my residency training, I was in private practice in Houston, Texas for approximately 15 years until the year 2000.

In that time, I spent my time working as an attending physician with 2 residency programs in the Houston area. The Podiatric Surgery scope of practice included basic forefoot procedures rear foot and ankle reconstruction procedures. This has been enforced since the beginning of my practice in 1985.

At that time in 1985, we had a 12 month residency program and 24 month residency program this was present until the late 90s where a PSR 36 or 3 year program was introduced and made the standard of care. I worked as a teaching, lecturing and contributing attending physician.

Eventually, I became residency director of the Doctor's Hospital PSR 24 residency program, (part of the Columbia health System). I also worked very closely with the Harris County PSR 36 residency program with an additional 1 year fellowship.

I have been Board Certified in Foot Ankle and Leg Reconstructive Surgery since 1988. The programs that I have worked with and was director of, are extremely competitive and offered a terrific opportunity for young doctors desiring to increase their knowledge base, surgical skills at this level.

Also, I am a noted Speaker for the International Foot and Ankle Foundation,Seattle, Washington; Colorado Podiatric State Board; European Foot and Ankle society in Lubeck, Germany. Four times a year I am a guest speaker for the Hui Malama Diabetic education group in West Hawaii.

The scope of podiatric medicine has changed tremendously in the last 20 or more years. I have had an opportunity to read many responses from Podiatrists and Orthopedic surgeons in the Honolulu area. It is quite apparent many orthopods are not up to date on current podiatric abilities and scope of training and practice.

It is most evident that they are unaware that the ABPS, THE Surgical Certifying Body, is undergoing a name change across the United States that will place it in a category that is recognized by State medical boards in 50 states and many foreign countries. The name change will reflect the name American Board of Foot and Ankle Surgery. This may even be a board that will become the standard for any surgeon who desires a specialty in foot, ankle and leg reconstructive surgery and may eventually

become a requirement for orthopedic surgeons to pass in all states who hold themselves out to the public as Foot and Ankle specialists.

Podiatry has gone through many changes throughout its over 100 year existence. Many older physicians may choose not to increase their scope of practice due to areas of training and/or experience. However, this new delineation of scope is directed more toward recent graduates of 24 and 36 month programs within the last 25 or 30 years.

The law as it is on the books in Hawaii at this time, were developed over 20 years ago when huge Podiatric residency evolution was happening in the United States. Podiatry education and training has changed drastically over the last 25-30 years. Many allied professionals such as Anesthesia, General Surgery and Primary Care Medicine are more in touch with what our abilities are in 2014. And, I have always contended that the OR nursing staff has the best insight as to who is competent and who is not. And, I mean, ANY surgical specialty! General, Ortho, Podiatry, GI, and the list goes on. Perhaps they should weigh in on this?

In my opinion, if the State of Hawaii wants to remain out of touch with the rest of the medical community in the United States, stay the course and maintain the Good Old Boy cartel, keep the laws the same. Not to evolve would be an injustice to the People of The Great State of Hawaii!

I, Mark T Senft, DPM, speak with over 25+ years experience, am in favor HB 1880 to increase the Scope of Podiatric Medicine and Surgery. This will strengthen our state medically, attracting competent Podiatric Physicians and surgeons for the betterment of our Island communities.

Much Mahalo for allowing me to express my feelings and understanding out of interest in the betterment of the State of Hawaii and its medical care system. My information is based on first hand and involved experience in the profession for 30 years.

Thank you.

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467-Relating to Podiatrists
3/7/14 9:30am
Presented by: Dr. Stephen Kominsky in support

Chair Au Belatti and Members of the Committee:

I am Dr Stephen Kominsky and I support this bill.

From 1989 to 2011 I was the director of podiatric medical education at the Washington Hospital Center, in Washington DC. That institution is the largest teaching hospital in the mid-Atlantic region. It has 1100 beds, and trains physicians in 19 different residencies and fellowships. Our hospital is a level one trauma center with a very active helicopter medical assist program. The podiatry program at the WHC currently trains 15 residents per year, and is about to grow to 16. The curriculum includes all of the medical and surgical rotations as required by CPME. In addition however, our residents not only rotate on the general orthopedic service, but spend three months during their third year on the orthopedic foot and ankle service. During those 6 months the residents gain a vast exposure to, and experience with diagnosing and treating all of the hind foot pathology and trauma. They have the opportunity almost on a daily basis to perform all of the surgical procedures which you are trying to gain privileges for. In addition, the residents at the WHC admit over 1000 patients per year to their service to be managed as in-patients. The great majority of these patients have diabetes and lower extremity diabetes related pathology. Typically, by the completion of the third month of the first year, each of our residents has performed over 50 amputations and debridements.

Understanding that the Washington Hospital Center is larger than most of the podiatry training hospitals nationally, the scope of the training that I have highlighted is standard today. The numbers may vary somewhat , but the training is uniform.

I would be delighted to provide any additional information that may be helpful to you .

Best regards,

Stephen Kominsky DPM
Clinical Professor
Department of Surgery
George Washington University Medical Center

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467-Relating to Podiatrists
3/7/14 9:30am
Presented by: Dr. Greg Morris in support

Chair Au Belatti and Members of the Committee:

I am Dr Greg Morris and I support this bill.

I perform over 400 podiatric/orthopedic foot and ankle surgeries at Queens Medical Center yearly. I graduated from Stanford University. I finished in the top of my class from podiatric medical school and completed a 24 month reconstructive foot and ankle surgery residency at one of the top podiatry residencies in the San Francisco Bay Area. I am a past president of the Hawaii Podiatric Medical Association. I serve on the podiatry advisory committee to the Hawaii Medical Board and have submitted background material in support of this bill to the board to aide them in evaluating the bill.

Podiatrists are on the forefront of diabetic foot care. We perform the majority of diabetic foot and ankle wound care. We are greatly limited by the current restriction of being only abie to perform digital amputations. Podiatrists are the diabetic limb salvaging experts. Unfortunately, diabetic limbs are not always able to be saved and require partial amputations of the foot. It is a relatively simple and straight forward surgery to do amputations. It is especially difficult on patients not only to have to have a partial foot amputation but also having to scramble to find a surgeon who will perform the amputation. Many times these patients have been treated for months or years by their podiatrist for wound care only to have a partial foot amputation by a surgeon they are unfamiliar with. Most podiatric surgeons in Hawaii work closely with vascular surgeons, orthopedic surgeons, general surgeons and wound care centers. We would be even more beneficial to the medical community if we are allowed to perform amputation surgery to level that we were trained.

The current Hawaii scope of practice for podiatrists already allows for podiatric surgeons to perform surgery on the ankle and we have been doing them at our respective hospitals for years. The changes being proposed will allow us to do what 45 other states allow podiatrists to do: to perform ankle fracture surgery. We would like to bring the podiatric scope of practice in Hawaii up to the national norm.

At Queens and other hospitals, podiatrists follow the same rules of credentialing, residency requirements, board certification, proctoring and peer review to perform surgeries that all other surgeons do. Ultimately, the hospital insures to the public that the doctors operating in their operating rooms have demonstrated the training and competency to perform the procedures they request.

Thank you for allowing my testimony.

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467-Relating to Podiatrists
3/7/14 9:30am

Chair and Members of the Committee:

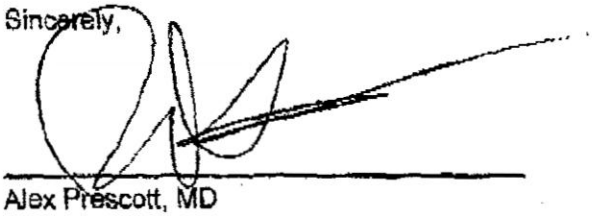
I am Alex Prescott, MD Orthopaedic Surgeon of Kaiser San Rafael Medical Center and I support this bill.

I have been involved in training podiatry residents in ankle fractures and have seen firsthand their competency. This bill allows doctors of podiatric medicine to practice to the level of medicine and surgery to which they have been trained.

Over the past two decades podiatry training has progressed significantly and the scope of practice should reflect this.

Thank you for allowing my testimony.

Sincerely,



Alex Prescott, MD
Kaiser San Rafael Medical Center

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467-Relating to Podiatrists
3/7/14 9:30am

Chair Baker and Members of the Committee:

I am Jason Provus, MD Orthopaedic Surgeon of Kaiser Vacaville Medical Center and I support this bill.

I have been involved in training podiatry residents in ankle fractures and have seen firsthand their competency. This bill allows doctors of podiatric medicine to practice to the level of medicine and surgery to which they have been trained.

Over the past two decades podiatry training has progressed significantly and the scope of practice should reflect this.

Thank you for allowing my testimony.

Sincerely,

Jason Provus, MD
Kaiser Vacaville Medical Center

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467-Relating to Podiatrists
3/7/14 9:30am

Chair and Members of the Committee:

I am Solon Rosenblatt, MD Orthopaedic Surgeon of Kaiser San Rafael Medical Center and I support this bill.

I have been involved in training podiatry residents in ankle fractures and have seen firsthand their competency. This bill allows doctors of podiatric medicine to practice to the level of medicine and surgery to which they have been trained.

Over the past two decades podiatry training has progressed significantly and the scope of practice should reflect this.

Thank you for allowing my testimony.

Sincerely,

Solon Rosenblatt, MD
Kaiser San Rafael Medical Center

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467-Relating to Podiatrists
3/7/14 9:30am

Chair and Members of the Committee:

I am John Safanda, MD Orthopaedic Surgeon of Kaiser San Rafael Medical Center and I support this bill.

I have been involved in training podiatry residents in ankle fractures and have seen firsthand their competency. This bill allows doctors of podiatric medicine to practice to the level of medicine and surgery to which they have been trained.

Over the past two decades podiatry training has progressed significantly and the scope of practice should reflect this.

Thank you for allowing my testimony.

Sincerely,

John Safanda, MD
Kaiser San Rafael Medical Center

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467-Relating to Podiatrists
3/7/14 9:30am

Chair and Members of the Committee:

I am Theodore Yee, MD Orthopaedic Surgeon of Kaiser Vacaville Medical Center and I support this bill.

I have been involved in training podiatry residents in ankle fractures and have seen firsthand their competency. This bill allows doctors of podiatric medicine to practice to the level of medicine and surgery to which they have been trained.

Over the past two decades podiatry training has progressed significantly and the scope of practice should reflect this.

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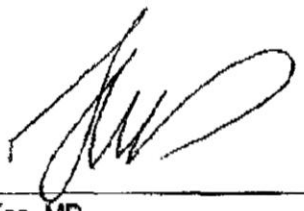

Theodore Yee, MD
Kaiser Vacaville Medical Center

Testimony to: Representative Della Au Belatti, Chair
House Committee on Health
Subject: SB2467-Relating to Podiatrists
3/7/14 9:30am
Presented by: Dr. Nathalie Sowers in support

Chair Au Belatti and Members of the Committee:

I am Dr Nathalie Sowers and I support this bill.

By prohibiting the treatment of ankle fractures, Hawaii's podiatric scope of practice statute clearly does not reflect the education, training, and experience of podiatric physicians.

The majority of states, 45 states, as well as the District of Columbia permit podiatrists to perform surgery on ankles (including the surgical treatment of ankle fractures).

Similar to allopathic medical education, the education that podiatric physicians receive include four years of undergraduate work, followed by four years in an accredited podiatric medical school. Following graduation, DPMs complete a three-year residency in an approved hospital-based program. The significant difference between education training models of allopathic doctors and podiatric medical doctors is that podiatric medical education begins to focus on the specialty area earlier on in the educational process.

According to the American Medical Association's Health Care Careers Directory, "Colleges of podiatric medicine offer a core curriculum similar to that in other schools of medicine." Podiatric medical college is a four-year program with the first two years focused on the basic medical sciences and the second two years focused on clinical medical education. The first two years of education at podiatric medical colleges are devoted to medical sciences including, but not limited to, gross and microscopic anatomy, biochemistry, pathology, microbiology, physiology, and pharmacology. During the third and fourth years, students engage in clinical education based in accredited hospitals, clinics, and private practice settings. During these third-and fourth-year rotations, students are afforded intense medical and surgical training related to the human body with emphasis on the lower extremity.

Importantly, podiatric medical residency training programs have incorporated training in the treatment of the ankle since the 1970s. Most telling about the progress of podiatric medicine and its inclusion of advanced education and training focusing on the ankle was the introduction of board certification for ankle surgery. Since its inception in 1975, the American Board of Podiatric Surgery (ABPS) has included ankle surgery in both the case credentialing and the oral examination for certification. In 1991, based upon evidence gathered by ABPS that significant curriculum and training opportunities related to the ankle were available to podiatric medical students and especially residents, ABPS created two certification tracks: one in Foot Surgery and the other in Reconstructive Rearfoot/Ankle Surgery. Complete surgical treatment of the ankle is clearly within our training and expertise.

Thank you for allowing my testimony.