

VIRGINIA FAMILY PHYSICIAN

THE OFFICIAL PUBLICATION OF THE VIRGINIA ACADEMY OF FAMILY PHYSICIANS

VAFP Member Cynthia Romero, MD, Nominated For AAFP Board Of Directors Seat

For several years, the new physicians constituency has sought a seat on the AAFP Board of Directors. That possibility came one step closer to reality during the AAFP National Conference of Special Constituencies held April 25-27 in Kansas City, Missouri.

The New Physicians Constituency nominated Cynthia Romero, MD, Virginia Beach, as its choice for the Board seat for a one year term. The AAFP Congress of Delegates last year amended the AAFP bylaws to allow a designated seat for a new physician and Romero's candidacy will be forwarded to the AAFP Congress of Delegates this fall for confirmation as the AAFP Board's first member representing new physicians.

Dr. Romero, who currently serves on the VAFP Board of Directors, is in practice with her mother, Dr. Aleli Romero, in Virginia Beach. She received her undergraduate degree from the University of Virginia and her Medical Doctorate from Eastern Virginia Medical School. She completed her Family Practice Residency at Riverside Family Practice Residency Program. In addition to being a member on the AAFP Commission on Continuing Medical Education, Dr. Romero currently serves as President of the Norfolk Academy of Medicine as well as President of the Tidewater Academy of Family Physicians. Congratulations, Dr. Romero.



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Directors.

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Virginia Family Physician

*Spring
2002*

LETTERS TO THE EDITOR

The Virginia Family Physician welcomes reader commentary on each issue, as well as local, state and national topics of interest to Academy members. Letters to the Editor should be addressed to the Virginia Academy of Family Physicians, 2301 N. Parham Road, Ste. 4, Richmond, VA 23229 or faxed to (804) 968-4418. Letters should include the writer's full name, address and day-time phone number, and may be edited for the purposes of clarity or space.

Joseph A. Leming, MD
VAFP President

Dear Fellow Academy Member:
The seasons change around us and the warmth of the summer sun beckons to us around the next sunrise so it seems. HMO's come and go (fortunately.) But people continue to develop illness and disability and they continue to (want to) seek out their own Family Physician.

The "privilege" of being a Family Physician has never been greater and the challenges of keeping up-to-date (or even keeping solvent) have never been greater.

The Medicare Fee Reduction that took place this January is just being felt by most accounts receivables and the dramatic rise in Medical Malpractice Premiums are being felt immediately in the accounts payables. HIPPA looms

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around the corner. We all yearn for an efficient EMR interfaced with an even more efficient Practice Management System. We are told that the Government is increasing its funding for "coding fraud" investigations.

But in the exam room our patient's continue to look to us for our ability to talk with them, take their history, diagnosis their problem(s), assess their needs and recommend solutions that best fit

their individual situations. The patient's confidence seems unshaken. Yes, they have been "on the net" and yes they are more informed but they come to us to talk about risks and benefits. They know and clearly understand that computers can make flawless mathematical decisions but are unable to make decisions intelligently about a persons (myriad of) complexities.

Thus it is for us every day that we pick up our stethoscope. Every day we strive to be better physicians for our patients. Every day we ARE better physicians for our patients. They come to us with simple problems at first. Then their spouses. Next we learn that the woman we are seeing as a new patient is their Aunt. Next we are asked to care for their cousin. Suddenly we are caring for 3 generations of a family. There is no mistake, the "computer" that

they are all seeking is their competent, up-to-date, caring and communicating

Family Physician. After they get their recommendations from their specialist(s) many will appear in our offices with their scripts "just to ask if you think it is a good idea" or if you think it is "OK." They know that there is really just one physician looking out for their "global" good.

This past year I learned from one of our Academic Family Physicians that many Family Physicians were not



"happy" in their profession anymore. He actually feared student exposure to these "unhappy" physicians would turn students off to a potential future in family medicine. I am still in disbelief and denial. When I am in an exam room with a patient it remains the most joyous expression of our art to talk to, then have the permission to touch and examine, to diagnosis and to make plans with a patient. We need to guard ourselves against how much of the other "stuff" comes through that exam room door when we walk in to see that patient waiting (often for months) to see you.

Some in the Academy fear that the Family Physician is a dying breed. I believe I see a vision where and when they are needed more than ever to deliver quality caring health care to a nation (of patients) in need. Please join me in that vision -- be careful what you bring with you when you come through my exam room door to see me as your next patient.

VIRGINIA FAMILY PHYSICIAN OF THE YEAR AWARD

REQUEST FOR NOMINATION

Please nominate a member of the VAFP for this prestigious award. Nominees should:

1. Provide his/her community with compassionate, comprehensive and caring medical service on a continuing basis.
2. Be directly and effectively involved in community affairs and activities that enhance the quality of life of his/her home area.
3. Provide a credible role model as a healer and human being to his/her community, and as a professional in the science and art of medicine to colleagues, other health professionals and especially, to young physicians in training and to medical students.
4. Be in good standing in his/her medical community.
5. Be a member of the VAFP.

The nomination process is easy. Just complete the nomination form below and mail or fax to the VAFP Headquarters Office with a one or two page letter outlining why you believe the nominee should be selected for the award. Nominating material must be received no later than June 18, 2002. Award recipients will receive a commemorative certificate during the Annual Scientific Assembly, land travel expenses, one night's lodging and a \$100 honorarium.

Nominee's Name: _____ Nominator's Name: _____

Address: _____ Address: _____

City/St./Zip: _____ City/St./Zip: _____

Phone: _____ Phone: _____

Send form to: VAFP Headquarters / 2301 N. Parham Rd. Ste. 4 / Richmond, VA 23229 or FAX to: 804-968-4418.

F. ELLIOTT OGLESBY, M.D.

VOLUNTEER OF THE YEAR AWARD

"The voluntary gift of one's time on behalf of our profession is one of the greatest gifts one can make"

In honor of former VAFP President F. Elliott Oglesby, MD, the Virginia Academy of Family Physicians' Board of Directors has established the "F. Elliott Oglesby, MD Volunteer of the Year Award." The award is designed to recognize annually a Virginia Family Physician whose service to his or her profession and/or community exemplifies the true nature of volunteerism. Award recipients will receive a commemorative certificate during the Annual Scientific Assembly, land travel expenses, one night's lodging and a \$100 honorarium. In addition, the award recipient will be provided a \$1,000 grant to donate in his or her name to the organization of their choice. Just complete the nomination form below and mail or fax to the VAFP Headquarters Office with a one or two page letter outlining why you believe the nominee should be selected for the award. Nominations must be received no later than June 18, 2002.

Nominee's Name: _____ Nominator's Name: _____

Address: _____ Address: _____

City/St./Zip: _____ City/St./Zip: _____

Phone: _____ Phone: _____

Send form to: VAFP Headquarters / 2301 N. Parham Rd. Ste. 4 / Richmond, VA 23229 or FAX to: 804-968-4418.

JAMES P. CHARLTON, M.D.
TEACHER OF THE YEAR AWARD IN FAMILY MEDICINE
 REQUEST FOR NOMINATION

In memory of James P. Charlton, M.D., a VAFP Past President, the VAFP awards annually the James P. Charlton, M.D. Award for excellence in teaching in family medicine. Nominees may include teachers of family medicine who participate in teaching at the medical school level, residency faculty level or community preceptorship level. The nomination process is easy. Just complete the nomination form below and mail or fax to the VAFP Headquarters Office with a one or two page letter outlining why you believe the nominee should be selected for the award. Nominating material must be received no later than June 18, 2002. Award recipients will receive a commemorative certificate during the Annual Scientific Assembly, land travel expenses, one night's lodging and a \$100 honorarium.

Nominee's Name: _____ Nominator's Name: _____
 Address: _____ Address: _____
 City/St./Zip: _____ City/St./Zip: _____
 Phone: _____ Phone: _____

Send form to: VAFP Headquarters / 2301 N. Parham Rd. Ste. 4 / Richmond, VA 23229 or FAX to: 804-968-4418.



REPORTING CME HOURS IT'S A MUST!

Don't let yourself get caught out on a limb! Remember that all Active members of the Academy are required to report at least 150 hours of CME every three years, of which at least 75 must be Prescribed (AAFP approved) credit and at least 25 of the 150 must be obtained from group activities.

You can now review and report your CME hours online via the AAFP website. To access your CME record online, first go to the AAFP's website which you'll find at this address:

<http://www.aafp.org>

and select AAFP Online. Your user name or user ID is your AAFP identification number. Your password is your last name all in caps with no punctuation. then click on "What's New" or "CME" and follow the directions.

VAFP Receives Two National Membership Awards

During the AAFP Annual Leadership Forum held in Kansas City, Missouri April 26-27, the Virginia Academy of Family Physicians received two national membership awards. The VAFP placed second nationally in having the highest percentage increase in the Active member category and also placed second nationally in having the second highest retention rate in the Active member category. The awards were presented during the joint NCSC/ALF luncheon on April 26.



AAFP President, Warren Jones, MD (center) congratulates VAFP officers Cynthia Romero, MD (left) and Shane Kraus, MD (right).

Mark Your Calendars

Virginia Academy Of Family Physicians
Winter Family Practice Weekend

January 31 - February 2, 2003

Wintergreen Resort, Wintergreen, Virginia

2002 Virginia Health Care Legislation

By K. Marshall Cook, VAFP General Counsel

The 2002 Session of the Virginia General Assembly was about money, with state funding shortages taking center stage on most issues. More than 2900 legislative proposals were introduced in the 2002 Session. Nearly 1600 passed.

The uncertain economic climate in Virginia and nationally affects physicians in a number of ways, just as it affects state government. One of the best examples is the professional liability insurance market. When physicians renew their malpractice coverage, significant premium increases (if coverage is renewed at all) are the norm. The St. Paul Company, which insured as many as one-third of all Virginia physicians a few years ago, announced it was leaving the medical professional liability insurance market because of its underwriting losses (\$1 billion in 2001). Other insurers either cannot or will not absorb St. Paul's business in Virginia.

As liability insurance premiums rise and managed care reimbursements fall, physicians' shrinking margins shrink even further. As effective as Virginia's tort reform initiatives may be compared to other states, they may not be effective enough. Significant tort reform again may be necessary to return reasonably priced professional liability coverage to Virginia physicians and ease the threat to patients' access to health care.

Virginia Birth Injury Program

The Virginia Birth Injury Program was just such a tort reform measure adopted by the General Assembly in 1987. A series of emotional articles last year in a Richmond newspaper focused legislative attention on the program in the 2002 Session. Just prior to the beginning of the 2002 General Assembly Session, the Joint Legislative Audit and Review Commission agreed to study the birth injury program, and that study has begun.

With the support of Virginia's trial lawyers, HB 714 then was introduced by Delegate Ward Armstrong to transfer jurisdiction to determine eligibility and make awards regarding birth-related neurological injuries from the Workers' Compensation Commission to circuit courts. The board of directors of the Birth-Related Neurological Injury Compensation Program would be

eliminated, and management of the Birth-Related Neurological Injury Compensation Fund would be transferred to the Virginia Retirement System. Participation in the Program by physicians and hospitals would be mandatory under the legislation, and failure to pay assessments will waive liability limits currently applicable to medical malpractice claims. The measure also provides that the Act would not deprive a parent of the right to bring a wrongful death action if a child who would be eligible for benefits under the Program dies shortly after birth.

HB 714 was carried over for consideration in the 2003 Session of the General Assembly, presumably to provide an alternative to whatever recommendation(s) is made by JLARC.

On January 29, the Virginia Court of Appeals decided the case of Coffey v. Virginia Birth-Related Neurological Injury Compensation Program. This decision, which the Program's Board of Directors chose not to appeal, significantly expands the possibility that claims to the Program will be awarded. The 2003 General Assembly Session unquestionably will consider substantive legislation concerning this Program.

Other significant legislation passed or carried over by the 2002 Session is summarized below. The effect date for legislation passed by the 2002 Session of the General Assembly generally is July 1, 2002. While this article will not discuss each health care bill passed or carried over by the legislature, it will summarize major enactments that may affect the delivery of a provider's health care services. Legislation has been categorized into substantive areas. These summaries are no substitute for actual statutory language. Copies of specific legislation may be obtained from the Virginia Division of Legislative Information, P. O. Box 406, Richmond, Virginia 23203, or through the General Assembly's web site at <http://legis.state.va.us>.

Academic

HB 19; SB 35 Eastern Virginia Medical School (emergency legislation) — Revises the legal name of the Medical College of Hampton Roads to be consistent with its commonly accepted popular name "Eastern Virginia Medical School" and strengthens and modernizes the school's authorities and sta-

tus. This bill clarifies that (i) the board of visitors take office on July 1 of the appointment year; (ii) the rector or any three members may call special meetings of the board and the board may appoint an executive committee of at least three members to transact business in the recess of the board; (iii) the school may operate and own medical and health care, education, research and associated programs and establish satellite offices and facilities for such programs within or without the Commonwealth or the United States; (iv) the board of visitors has authority to contract with domestic and foreign entities for its activities; and (v) the board of visitors has authority to obtain patents, copyrights, and trademarks for intellectual properties and to administer, manage, market, transfer, and convey any interest in such intellectual properties. The bill also provides exceptions, parallel to those exceptions provided for publicly supported medical schools, from the prohibited contracts provisions of the conflicts of interest law, and the records disclosure and closed meeting provisions of the Freedom of Information Act. The bill reinforces the fact that the Administrative Process Act and the Public Procurement Act do not apply to Eastern Virginia Medical School which, although established in law, is not a state-owned institution of higher education.

Courts-Related

HB 37 Communications between physicians and patients — Provides that a diagnosis or treatment plan of the practitioner, as documented in the patient's medical record, during the time of the practitioner's treatment, may be disclosed in discovery or in testimony. To be admissible at trial, the diagnosis must be offered at a reasonable degree of medical probability.

HB 294 Child abuse and neglect investigations — Requires all mandatory reporters of child abuse and neglect who maintain a record on the alleged victim to make information, records and reports that are relevant to the investigation available to the child protective services investigator. The bill adds immunity from civil or criminal prosecution or administrative penalty or sanction for persons providing information or records in good

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faith. Both amendments parallel provisions already existing in the adult abuse reporting statute. The bill also clarifies that the information may be provided irrespective of the prohibition against disclosing communications between physicians and patient.

HB 923 Discovery of medical evidence at trial — Modifies current law that when the physical or mental condition of the patient is at issue in a civil action, facts communicated to, or otherwise learned by, such practitioner in connection with such attendance, examination or treatment shall be disclosed by a method other than discovery pursuant to the Rules of Court to provide that no order shall be entered compelling a party to sign a release for medical records from a health care provider unless the health care provider is located outside the Commonwealth or is a federal facility.

HB 1001 Custody and Visitation — Provides that in any case in which custody or visitation of a minor child is at issue, any information obtained during therapy and the records kept by any licensed mental health care provider concerning a parent shall be privileged and confidential. Additionally, a mental health care provider may not be required to testify on behalf of or against a parent or adult relative of the parent. The bill does not apply when an independent mental health evaluation is conducted pursuant to a court order.

SB 316 Civil law; immunity in sharing patient safety information — Provides civil immunity for committee or board members, or consultants thereto, for functions related to patient safety, including entering into contracts with patient safety organizations. The bill also provides that reports or patient safety data in possession of a patient safety organization is confidential and that an employer may not retaliate against employees who make good faith reports to such organizations. As introduced, the bill was a recommendation of the Joint Commission on Health Care.

SB 355 Blood alcohol test admissibility— Provides that a blood alcohol test is admissible as a hospital business record in a prosecution for driving under the influence if the test was taken in a hospital emergency room. The bill also provides that such blood alcohol tests are not considered confidential medical records and that anyone who takes blood, conducts tests or offers testimony is immune from civil liability for breach of confidentiality or unauthorized release of medical records.

HB 400 Civil immunity for certain boards (carried over to 2003 Session) — Adds hospitals to the list of those immune from civil liability while in the performance of duties, including the reliance upon recommendations of hospital committees. Additionally, the bill adds the proceedings, minutes, records and reports of hospital risk managers to the list of privileged communications.

Insurance

HB 414 Insurance; medical savings accounts — Revises the Virginia Medical Savings Account Program by deleting references to the Workers' Compensation Commission and the Department of Medical Assistance Services. The plan would now be developed and implemented by the Department of Taxation and the Bureau of Insurance. The Department of Taxation is to report to the Joint Commission on Health Care by November 1, 2002. This is a recommendation of the Joint Commission on Health Care.

SB 183 Health insurance; external review of adverse decisions — Authorizes a designee of the Commissioner of Insurance to act on his behalf in exercising certain powers pertaining to the Bureau of Insurance's conduct of independent external reviews of adverse utilization review decisions.

HB 622 Insurance; fair carrier business practices (carried over to 2003 Session) — Requires carriers to pay, within 10 days of receipt, any "clean" claim pertaining to prescription drug benefits that is submitted electronically by a pharmacist and that includes all information and documentation that are customarily required by the carrier to process and pay claims of the type submitted. Currently, carriers are required to pay claims within 40 days of receipt of the claim. If such a claim is submitted electronically by a pharmacist, the carrier shall, within five days after receipt of such material, request any additional information and documentation that the carrier reasonably requires to process and pay the claim or to determine if the claim is a clean claim. Currently, a carrier's post-submission requests for such information and documentation must be made within 30 days after receipt of the claim.

HB 623 Pharmacy provider panels (carried over to 2003 Session) — Prohibits health insurers and other carriers from requiring a pharmacist to participate in any other provider panel as a condition of the pharma-

cist's participation on a specific provider panel. Carriers are also prohibited from conditioning their consent to allowing a pharmacist to participate in a preferred provider organization or other preferred provider network arrangement upon the pharmacist's agreeing to enter into contracts or arrangements with the carrier that are not part of the preferred provider organization or network organization. A carrier also shall not contract with an unaffiliated carrier to include such pharmacist on the provider panel of the unaffiliated carrier.

HB 913 Medicaid eligibility (carried over to 2003 Session) — Raises the income eligibility standards for Medicaid for aged and disabled individuals from 80 percent to 100 percent of the federal poverty level as allowed by federal law.

Medications

HB 90 Policies regarding medication recommendations by school personnel — Requires the Board of Education to develop and implement policies prohibiting school personnel from recommending the use of psychotropic medications for any student. The policies will not prohibit school health staff from recommending that a student be evaluated by an appropriate medical practitioner, or prohibit school personnel from consulting with such practitioner, with the written consent of the student's parent. "Psychotropic medications" is defined as those medications the prescribed intention of which is to alter mental activity or state, including, but not limited to, antipsychotic, antidepressant, and anxiolytic medication and behavior-altering medication. Medications such as Ritalin (methylphenidate), Prozac (fluoxetine), and Paxil (Paroxetine) would be included in this classification.

HB 127 Minors' consent to treatment for substance abuse — Provides that a parent, legal guardian or person standing in loco parentis will not be prevented from obtaining the results of a minor's nondiagnostic drug test when the minor is not receiving care, treatment or rehabilitation for substance abuse.

HB 154 Health; certain unused drugs provided to free clinics — Permits nursing homes to enter into voluntary agreements with pharmacists to return any drugs that are no longer necessary for their residents in order that the pharmacy may dispense such drugs to the indigent, free of charge, subject

to certain restrictions. The drugs must be in the manufacturers' original sealed containers or sealed individual dose or unit dose package and the return must comply with federal law. Only an authorized person will accom-

plish the physical transfer, consent must be obtained from the relevant patient or his authorized representative for return of the medication, the expiration date remains, all identifying data relating to the patient for whom the drug was dispensed must be removed, inventories must accompany the transferred drugs, and outdated drugs cannot be transferred and must be destroyed according to the Board's regulations. The pharmacist-in-charge at the participating pharmacy will be responsible for determining the suitability of the drug for redispensing. Prescriptions dispensed for Medicaid or children's health insurance program recipients cannot be donated. The Board of Pharmacy shall promulgate emergency regulations to implement the program.

The uncertain economic climate in Virginia and nationally affects physicians in a number of ways, just as it affects state government. One of the best examples is the professional liability insurance market.

gent program. The participating practitioner and the pharmacy are prohibited from charging the patient a fee for the medication. A reasonable dispensing or administrative fee to offset the cost of dispensing may be charged, use of chart orders with multiple prescriptions to allow for such orders for home infusion and hospice patients; clarifies that a combination of manual and automated record-keeping may be used, so long as the required prescription information is maintained and retrievable; and authorizes alternate delivery sites for prescriptions, such as "drop stations" where patients may pick up the drugs from a central location.

Practice-Related

HB 44 Health professions; pronouncement of death — Allows registered nurses, in situations meeting certain explicit criteria, to pronounce death when they are employed by a hospital or nursing home. State-operated hospitals are to be considered hospitals for these purposes. Registered nurses employed by home health organizations, hospices or the Department of Corrections already may pronounce death. Specific criteria are established in this law for those patients who may be pronounced dead by registered nurses, i.e., those patients whose deaths were expected, who had valid do not resuscitate orders and who were under the care of a physician who could not be present within a reasonable period of time. The nurse is required to notify the patient's attending and consulting physicians as soon as practical.

HB 179 Neighborhood Assistance Plan; donation — Adds nurses to the list of medical professionals who may donate time and services to an approved clinic that provides health care services without charge, or the basis of the patients' ability to pay, and receive a tax credit under the Neighborhood Assistance Plan.

HB 1185 Health care provider's records — Provides authorized insurers access to copies of a health care provider's records for a reasonable charge.

SB 101 Practice of physical therapy — Adds nurse practitioners as authorized in their practice protocols to the list of health care professionals who may order physical therapy services. At this time, physical therapy orders may be issued by doctors of medicine, osteopathy, chiropractic, podiatry, or dental surgery.

SB 218 Newborn testing — Adds to the list of inherited disorders for which newborn testing is required by the Commonwealth, a

not to exceed the comparable allowable fee reimbursed by the Virginia Medicaid program; however, if the patient is unable to pay the dispensing or administrative fee, this fee must be waived. In addition, practitioners of medicine or osteopathy are authorized to provide controlled substances to their own patients in free clinics without charge when the drugs have been donated by an entity other than a pharmaceutical manufacturer. The practitioner must first obtain a controlled substances registration and will be required to comply with the existing labeling and packaging requirements. Enactment clauses require emergency regulations and mandate that the Board of Pharmacy advise and assist free clinics in revolving issues relating to the practice of pharmacy and the Drug Control Act.

HB 560 Health; pharmaceutical assistance — Expands the toll-free resource and referral program relating to pharmaceutical companies' free drug programs for indigents to include information on pharmaceutical discount card programs and locations of Pharmacy Connect programs in the state.

HB 625 Practice of pharmacy — Provides greater flexibility in the practice of pharmacy to be consistent with current health care practice trends while still providing sufficient safeguards for the integrity of controlled substances and patient safety. This bill changes the definition of the "pharmacy" to include any establishment in which drugs, medicines or medicinal chemicals are dispensed or offered for sale and, thereby, authorizes pharmacists to practice in locations other than permitted pharmacies, e.g., in a clinical oncology practice providing chemotherapy; softens the restrictions on the

HB 487; SB 145 Practice of pharmacy — This legislation was drafted and supported by the Virginia Academy of Family Physicians. It provides two exceptions from the requirements for the practice of pharmacy for practitioners of medicine or osteopathy relating to obtaining prescription drugs without charge for indigent patients, i.e., through pharmaceutical manufacturers' indigent programs and through donations from other entities. Practitioners who participate in pharmaceutical manufacturers' indigent programs in which the manufacturer donates a stock bottle of the prescription drug that is to be dispensed to an indigent patient are provided authority to dispense such drugs. The labeling and packaging standards will apply (packaging can be changed by the practitioner or the patient) and the drug cannot be used for any other purpose, unless the manufacturer authorizes dispensing to another indigent patient. Practitioners may, in lieu of dispensing directly to the patient, transfer the stock bottle to a pharmacy participating in the indi-

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fatty acid oxidation disorder known as MCAD or MCADH, i.e., median-chain acyl-CoA dehydrogenase, which inhibits the proper metabolism of stored fat. Individuals with MCAD, if left untreated, have episodes of hypoglycemia and Reye's syndrome, which may result in fever, vomiting, coma, disorientation, and fatty infiltration of the liver. Implementation of this test will require the purchase of tandem mass spectrometers, which are technologically advanced analytic instruments that can be used to test newborns for more than 20 treatable metabolic disorders by sorting molecules in blood samples according to weight in a similar fashion to machines that sort coins. This provision will only become effective one year after the date that sufficient funds are appropriated or otherwise secured to (i) support the Virginia Department of Health's costs for start-up professional and family education and (ii) the purchase of the necessary equipment for implementation of the testing program in the Division of Consolidated Laboratories.

SB 542 Human research, participation, informed consent, review — Revises the definition of human research. The bill adds agents appointed under advanced directives, legal guardians, spouses, adult children, and adult siblings to the list of people authorized to give consent to human research under the definition of "legally authorized representative". The bill provides that if two or more legally authorized representatives having the same priority disagree on participation in human research, the subject will not participate. The bill also changes competent and not-competent to capable or incapable of making an informed decision. Human research review committees are given the additional responsibility of determining whether the risks to the subjects are minimized by using sound research designs and whether additional safeguards are included when the subjects are a vulnerable population.

SB 651 Physical therapy; referrals by licensed physician assistant — Adds to the list of persons who make referrals to physical therapists a licensed physician assistant acting under the supervision of a licensed physician. Referrals are currently made by a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery.

HB 517 Preschool eye examinations (carried over and referred to the Joint Commission on Health Care for study) — Adds a comprehensive eye examination conducted by an optometrist or ophthalmologist

to the preschool health examination requirements for first-time enrollment in kindergarten or elementary school. Referrals for these examinations must include names of optometrists and ophthalmologists participating in FAMIS or Medicaid.

Forms for reporting comprehensive eye examinations, to be developed by the Departments of Education and Health, shall include a statement that such examination may be provided by a qualified optometrist or ophthalmologist licensed by the Commonwealth of the parent's choosing. Such forms shall be available to the public through electronic mail or websites maintained by the Departments of Education and Health and shall be used by the examining optometrist or ophthalmologist to report the results of the comprehensive eye examination.

The Department of Medical Assistance Services, within both the Medicaid program and FAMIS Plan, shall continue to provide coverage for comprehensive eye examinations, including, but not limited to, children of kindergarten age. The Department of Medical Assistance Services shall revise its regulations to offset any proportional increase in costs resulting from any increased utilization of covered vision care services by amending the period of time and frequency for which comprehensive eye examinations are available as a covered service for children of preschool age. The Departments of Education and Health shall seek advice from the Virginia Optometric Association and the Virginia Society of Ophthalmology in the development of the form for reporting of a comprehensive eye examination.

Similar to the current practice for the required physical examination, the eye examination must be offered by local health departments free of charge for medically indigent children. In addition, the current exemption on religious grounds applicable to the physical examination is extended to the eye examination.

Regulatory/Enforcement

HB 213 Board of Medicine regulations — Requires the Board of Medicine to promulgate regulations governing the practice of medicine related to the administration of anesthesia in physicians' offices. This bill notes the Board's authority, pursuant to § 54.1-2400, to establish the qualifications for registration, certification or licensure that are necessary to ensure competence and integrity to engage in the regulated practice. In compliance with the second enactment, the Board is required to promulgate emergency

regulations to implement this provision. In doing so, the Board must solicit and respond to public comment prior to adoption.

HB 531 Department of Professional and Occupational Regulation; tattoo parlors and body-piercing salons — Provides for the licensure of tattoo parlors, body-piercing salons and those individuals who practice tattooing or body piercing by the Board of Barbers and Cosmetology. The bill requires the Board to adopt regulations establishing the requirements for licensure of any tattoo parlor, body-piercing salon and those individuals who practice tattooing or body-piercing. Currently, these establishments are regulated at the local level. The bill removes the authority of localities to regulate tattoo parlors and body-piercing salons.

HB 664 Health professionals to report injuries associated with terrorism — Requires the Board of Health to mandate reporting of diseases by physicians and laboratory directors that may be caused by exposure to an agent or substance that has the potential for use as a weapon and that the reports will be given directly to Commissioner or his designee using an emergency response system maintained by the Department of Health and operated 24 hours a day. This bill also modifies the present immunity from liability provision relating to required reports or disclosures of disease to provide that physicians and laboratory directors will be held to a reasonable professional standard for recognizing agents or suspecting the presence of any conditions and will be immune from liability when making reports in good faith without gross negligence and within the usual scope of his practice. The Board of Health's responsibility to conduct disease surveillance and investigation (such as contact tracing) is modified to require the Commissioner or his designee to immediately report any outbreak or occurrence of a disease identified as being caused by exposure to an agent or substance that has the potential for use as a weapon to the Department of State Police for investigator. The State Police will report these incidents to the local police chief or sheriff (with law-enforcement authority) or both in the jurisdiction in which the patient resides and where he received treatment. The State Police may also transmit the report to federal and military law-enforcement authorities. The State Police and law-enforcement will immediately determine and implement the appropriate law-enforcement responses to the reports, according to their jurisdiction. These reports will be held confidential and

not subject to the Freedom of Information Act; however, the reports will be maintained in the central repository already established by the Department of State Police. Further, the Department of State Police, and any local law enforcement official, may release all or part of any report made or other information obtained pursuant to this section (i) where the release of such report or information may assist in the prevention of imminent harm to public health or safety, or (ii) where the release of such report or information, with patient identifying information removed, may be useful for education of the public on health, safety or homeland defense issues. The Board of Health also is specifically authorized to develop procedures to respond to any bioterrorism.

HB 665 Nursing; licensure — Provides an exemption from the nursing licensure requirements for a period of 30 days pending licensure in Virginia for nurses holding a current unrestricted license in Canada whose training was obtained in a nursing school in Canada where English was the primary language and requires the Board of Nursing to issue licenses by endorsement to applicants who hold current unrestricted licenses in Canada whose training was obtained in a nursing school in Canada where English was the primary language and who have passed the Canadian Registered Nurses Examination (CRNE). Current law already provides for licensure by endorsement for nurses licensed in other states, the District of Columbia, and any U.S. possession or territory provided the applicant meets the qualifications required of nurses in the Commonwealth.

HB 687 Physician assistants — Clarifies that the physician must provide continuous supervision of the assistant; however, the requirement for physician supervision of assistants must not be construed as requiring the physical presence of the supervising physician during all times and places of service delivery by an assistant. Further, this bill details that each team of supervising physician and physician assistant must identify the relevant physician assistant's scope of practice, including, but not limited to, the delegation of medical tasks as appropriate to the physician assistant's level of competence, the physician assistant's relationship with and access to the supervising physician, and an evaluation process for the physician assistant's performance. The Board of Medicine is required, pursuant to a second enactment clause, to promulgate emergency regulations to implement this provision.

HB 1154 Medically induced infanticide;

penalty — Creates a Class 4 felony for any person to cause the death of a living fetus by deliberately and intentionally performing either: (i) the delivery of a living fetus or a substantial portion thereof into the vagina for the purpose of performing a subprocedure intended to kill the fetus, performing the subprocedure and completing the delivery of the fetus regardless of whether death occurs before or after delivery or (ii) surgically accessing a living fetus by Caesarian section for the purpose of performing a subprocedure intended to kill the fetus, performing the subprocedure and delivering the fetus whether death occurs before or after delivery. The procedure is deemed necessary for the preservation of the life or health of the pregnant woman only if it will avert her death or avoid a serious risk of substantial and irreversible impairment of a major bodily function. The bill includes a severability clause.

HB 1283; SB 601 Certain disclosure of prehospital patient care reports — Authorizes each licensed emergency medical services agency to disclose the prehospital patient care report to law-enforcement officials when the patient is the victim of a crime, upon a determination that such disclosure is not in violation of the federal Department of Health and Human Services regulations relating to the electronic transmission of data and patient privacy promulgated as required by HIPAA. The Patient Health Records Privacy law is also amended to add this disclosure to the list of permissible releases of patient records.

HB 1318 Volunteer services by certain providers of health care — Exempts from the Virginia licensure or certification requirements of the Board for Opticians and the Board of Dentistry, Medicine, Nursing, Optometry, Pharmacy, and Veterinary Medicine certain out-of-state practitioners who (i) do not regularly practice in Virginia, (ii) hold current valid licenses or certificates to practice in another state, territory, district or possession of the United States, (iii) volunteer to provide free health care to an underserved area of this Commonwealth under the auspices of a publicly supported all-volunteer, nonprofit organization with no paid employees that sponsors the provision of health care to populations of underserved people throughout the world, (iv) file copies of the licenses or certificates issued in such other jurisdiction with the appropriate board, (v) notify the appropriate board, within 15 days prior to the voluntary provision of services of the dates and location of such services, and (vi) acknowledge in writing that such licensure exemption shall only be valid during the

limited period that such free health care is made available on the dates and at the location filed with the various boards. Enactment clauses require emergency regulations and authorize the various boards to require the sponsoring organization to register and pay a fee prior to delivery services in Virginia.

SB 59 Board of Medicine — Revises the statute that sets forth the data required for the profiles of doctors of medicine, osteopathy, and podiatry. The Board will require telephone numbers and access to translating services for all practice settings, and will remove the mandatory reporting of insurance participation while allowing voluntary reporting of this information. For the sole purpose of expedited dissemination of information about a public health emergency, doctors must also provide any e-mail addresses or facsimile numbers. The e-mail addresses and facsimile numbers will not be published on the profile database or released or made available for any other purpose other than the public health emergency. In addition, the scope of data to be made available on malpractice claims has been clarified to prohibit the release of specific numeric values of reported paid claims in any individually identifiable manner under any circumstances. A second enactment clause requires the Board of Medicine to promulgate emergency regulations and a provision for the display of final disciplinary orders of the Board together with notices thereof and any summary suspension of a license.

SB 398 Disciplinary proceedings of health regulatory boards — Revises the authority of health regulatory boards relating to disciplinary proceedings to (i) amend the present exemption to authorize closed meetings of health regulatory boards or conference committees to consider settlement proposals in pending disciplinary actions or modifications to previously issued board orders as requested by either of the parties; (ii) authorize health regulatory boards to meet by telephone conference call to consider settlement proposals in matters pending before special conference committees or matters referred for formal proceedings or to consider modifications of previously issued board orders when such considerations have been requested by either of the parties; (iii) correct references to court or agency orders to more accurately refer to "documentation" of the order; and (iv) authorize, if reasonable notice of the information is given to the person, the health regulatory boards to consider other information concerning possible violations of

(cont. on page 12)

(cont. from page 11)

Virginia law in hearings relating to suspensions because of felony convictions or adjudications of incapacity.

SB 503 Health professions; dental hygienists — Requires the Board of Dentistry to adopt regulations to allow for the “general supervision” of dental hygienists by dentists. “General supervision” means that a dentist has evaluated the patient and prescribed authorized services to be provided by a dental hygienist; however, the dentist need not be present in the facility while the authorized services are being provided. This bill is a recommendation of the Joint Commission on Health Care.

HB 299 Health professions; director (carried over to 2003 Session) — Includes in the powers of each health regulatory board the ability to issue advisory opinions to members of that profession pursuant to the system established by the Director of the Department of Health Professions with regard to requests by individual practitioners for guidance on questions as to whether the facts of a particular case would constitute a violation of provisions governing the practice of that profession. The Director would review each opinion, with the assistance of the Office of the Attorney General, if necessary, prior to the issuance of such opinion. If a

complaint is filed against the practitioner involving such actions, the practitioner may introduce the advisory opinion into evidence at his hearing.

HB 1259 Health professions; surgical assistants (carried over to 2003 Session) — Defines a “nonphysician surgical assistant” and “intraoperative surgical care” and requires the Board of Medicine to establish a procedure for the certification of such individuals who meet the requirements established by the Board. Nonphysician surgical assistants are certified individuals who provide such services, under the direction of a physician or, in the absence of a physician, that of a registered nurse, as positioning and draping the patient, observing the operative site, assisting in incision closing or wound dressing, and any other task that may be delegated by the physician or, in the absence of a physician, by a registered nurse that is within the scope of practice of a certified non-physician surgical assistant.

SB 478 Regulation of specialty services (carried over to 2003 Session) — Removes specialty services from the certificate of public need requirements so long as such facilities participate in Virginia Medicaid and do not consider the ability of their patients to pay when providing treatment. Specialty ser-

vices are defined as any specialized center or clinic or that portion of a physician’s office developed for the provision of computed tomographic (CT) scanning, lithotripsy, magnetic resonance imaging (MRI), positron emission tomographic (PET) scanning, radiation therapy, or nuclear medicine imaging. The Board of Health must license specialty services; however, deemed status will be accorded for facilities accredited by the American College of Radiology or the American College of Radiation Oncology or another accrediting agency approved by the Board. In addition, specialty services will be required to contribute and be eligible to receive payments from the Indigent Health Care Trust Fund in the same manner as hospitals. The Board and Director of Medical Assistance Services (the administrators of the Trust Fund) will be required to report by December 1, 2003, on the results of this new requirement. Enactment clauses allow specialty services to make capital investments and other expenditures in order to plan the implementation of a facility upon enactment of this provision; however, no specialty service can initiate operation without licensure. The Boards of Health and Medical Assistance Services must promulgate emergency regulations.

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Type	Introduced	Passed House	Passed Senate	Passed Both	Continued	Failed	Approved	Vetoed
HB	1373	658	573	569	361	443	561	1
HJR	514	428	412	410	26	78	1	0
HR	25	25	0	25	0	0	0	0
SB	693	334	420	330	111	253	326	0
SJR	279	231	233	231	19	29	1	0
SR	23	0	22	22	0	1	0	0
Totals	2907	1676	1660	1587	517	804	889	1

The Virginia Academy of Family Physicians' Resident Chapter each year schedules elections for Virginia Family Practice residents who are candidates for various offices either in the VAFP Resident Chapter or as VAFP Resident Directors on the VAFP Board of Directors. Ballots were mailed in late April to all VAFP resident members and the results of the elections are as follows:

VAFP Resident Chapter President

P. Marline Capps MD
Riverside Family Practice Residency

VAFP Resident Chapter Vice President

Linh C Hguyen MD
Lynchburg Family Practice Residency

Resident Board Members

Twanna Belinda Dixon MD
Lynchburg Family Practice Residency

Monique M. Lee MD
Portsmouth Family Practice Residency

Mark Ryan MD
Blackstone Family Practice Residency

Congratulations to the following VAFP student members who were selected to serve as Student Board Members on the VAFP Board of Directors:

Mr. Scott Backus
Virginia Commonwealth University/Medical College of Virginia

Ms. Emmeline Gasink
Eastern Virginia Medical School

Ms. Erin Drifmeyer
University of Virginia Medical School

Pembroke Occupational Health

A national narcotic drug administrative firm located in Richmond, Virginia is hiring part time medical review officers to do phone interviews with drug positive job applicants and employees.

Interviews can be done by phone at home.

For additional information please call Mike Stephens at 804-346-1010 Ext. 150
or email jobs@pembroke.com.

Primary Care Research Network: ACORN

The Virginia Commonwealth University Department of Family Practice has a long interest in primary care practice-based research, dating to the Virginia Study in the 1970s, which was among the first efforts to catalogue the essential components of primary care. In the 1990s, the Department was funded by the National Cancer Institute Prescribe for Health Program to study the use of office-based computer technology to improve the delivery of clinical preventive services.

A research committee meets regularly to manage the portfolio of research projects. This committee includes David Marsland, M.D., Dr. Robert E. Johnson, PhD, Dr. Woolf, Dr. Stephen F. Rothemich, MD, practicing physician faculty members, Family Medicine Resident(s), VCU School of Medicine student(s), and administrative faculty.

The faculty members who are engaged in the following research efforts, are active participants in the North American Primary Care Research Group and other national research organizations.

Since 1996 the Department has been developing and operating a state-wide practice-based research network, the Virginia Ambulatory Care Outcomes Research Network (ACORN), the mission of which is to collect longitudinal data on the health status of primary care patients and on the effectiveness and quality of the care they receive. The objectives are to provide observational data on important trends and patterns in primary care practice in Virginia and a research platform for the performance of clinical trials to test the effectiveness of interventions to improve quality and health outcomes. The information is intended for clinicians, to improve care practices; for policy makers, to understand and evaluate primary care in Virginia; for researchers, as a unique longitudinal data set for observational and experimental studies; and for the public.

ACORN is one of 18 practice-based research networks around the country that have been funded for infrastructure devel-

opment by the Agency for Healthcare Research and Quality. The ACORN effort has also received funding from the Health Resources and Services Administration. ACORN is a member of the Federation of Practice-Based Research Networks and participates nationally and internationally in research conferences, symposia, and peer-reviewed publications concerned with health services and primary care research.

An example of the type of research conducted within ACORN is a randomized controlled trial of an intervention to improve the frequency with which primary care physicians offer smoking cessation counseling. Stephen F. Rothemich, MD, principal investigator for this study, is funded under a Robert Wood Johnson Foundation Generalist Physician Faculty Scholar award to conduct this study at 12 practice sites within ACORN. The trial tests whether counseling rates improve when smoking status is assessed routinely along with other vital signs.

Steven H. Woolf, MD, MPH and Anton J. Kuzel, MD are also engaged in studying the definition and epidemiology of medical errors and patient safety in primary care. They were among the first six centers to receive funding from the Agency for Healthcare Research and Quality as part of its increased interest in medical errors research. The project aims to create a typology of medical errors based on the way patients describe errors that they have experienced in primary care settings. Information obtained in direct interviews with patients and in interviews and surveys of primary care physicians are being examined using qualitative research methods. This project is being conducted in collaboration with the Department of Family Practice at Northeastern Ohio University College of Medicine and with social scientists and human factors experts in both the United States and United Kingdom.

The Department of Family Practice leads the United States component of a six-country international study of medical errors in primary care organized by the American Academy of Family Physicians Robert Graham Center for Policy Studies in



Steven H. Woolf, MD, MPH

Primary Care. The six countries include the United States, Canada, the United Kingdom, the Netherlands, Australia, and New Zealand, and Drs. Woolf and Kuzel are responsible for the U.S. effort. In this project, family physicians and general practitioners use computer software to report errors they observe in clinical practice, which are transmitted anonymously via the Internet to a centralized database for research analysis. The Department of Family Practice is responsible for organizing error reporting by family physicians in the U.S., who are located in Virginia, Ohio, New York, and New Hampshire.

Steven H. Woolf, MD, MPH, Professor and Director of Research at the Department of Family Practice currently leads the research activities of the department. He is a member of the U.S. Preventive Services Taskforce, and has recently been elected to the Institute of Medicine, National Academy of Sciences.

Faculty in the Department of Family Practice have individual research interests that often involve collaborations with other colleagues, VCU departments, and other academic centers. For example, Dr. Woolf engages in research on evidence-based medicine, systematic reviews, medical technology assessment, and practice guideline development. Dr. Johnson conducts research on advanced techniques in biostatistical data analysis. Further information about the research program at the Department can be obtained by contacting Dr. Woolf at his clinical practice (703) 391-2020, fax (703)715-8300, by email: swoolf@vcu.edu, or the Department's research office at (804)828-9625, or Amy Burgett, RN ACORN Network Coordinator, (804)828-9628, aburgett@hsc.vcu.edu.

George G. “Bud” Wedd, MD Receives AAFP Research Grant

Virginia Commonwealth University’s Stephen Rothmich, M.D., Department of Family Practice (left), and David Marsland, M.D., (right), Chair, Department of Family Practice, congratulate George G. “Bud” Wedd, M.D., on receiving a \$1000 Research Grant from the American Academy of Family Physicians. The nomination was forwarded to AAFP by the Virginia Academy of Family Physicians, whose Executive Vice President Terry Schulte, (second from left), presents the award check.

A strong advocate for primary care research, Dr. Wedd has a long-standing relationship with VCU’s Department of Family Practice, and its Virginia Ambulatory Care Outcomes Research Network, a state-wide practice-based research network headed by Dr. Marsland.



VAFP Past President Honored By The Blue Ridge Academy Of Family Physicians

VAFP Past President J. Albert Hagy MD, Rocky Mount, was honored at the Spring Meeting of the Blue Ridge Academy of Family Physicians as the Gene E. Clapsaddle MD *Family Physician of the Year*. Dr. Hagy served as Director of the Carilion Family Medicine Program from 1990 to 2000 and as Associate Director from 1975 to 1990. He is currently active in The Center for Healthy Aging and is Interim Director for the Acute Care for the Elderly Unit at Carilion Roanoke Memorial Hospital. He also serves as Volunteer Medical Director for the Rescue Mission Clinic. Dr. Hagy’s award states “In recognition of your dedication, leadership and unparalleled contributions to the specialty of Family Practice and for your outstanding achievements as a family practice educator, clinician, mentor and role model.”



Gene E. Clapsaddle, MD (left) presents the Family Physician of the Year Award to J. Albert Hagy, MD.

Emergency Regulations Governing Durable Do Not Resuscitate Orders Approved

The Emergency Regulations Governing Durable Do Not Resuscitate Orders have been approved as of March 27, 2002 and are now in effect as the Regulations Governing Durable Do Not Resuscitate Orders. The current Durable DNR Order form can still be used. Protocols and regulations can be accessed online at: www.vdh.state.va.us/oems/licensur.htm.

Virginia Durable Do Not Resuscitate Protocols for EMS Personnel

March 27, 2002



Virginia Durable Do Not Resuscitate Implementation Protocols For Emergency Medical Service Personnel

The Virginia Durable Do Not Resuscitate (DNR) Order provides the ability to honor a patient's request for humane comfort measures, while avoiding resuscitation. State legislation, originally passed in 1992 and most recently amended in 1999, enables the emergency medical services (EMS) provider to honor such a request, when properly executed in writing and with proper documentation.

The Virginia Durable DNR Order and other authorized DNR Orders (see Page 2) are the only Do Not Resuscitate Orders that can be honored by Virginia EMS personnel.

This document explains Virginia's Durable DNR Protocols and how they apply to the pre-hospital EMS provider.

Important Information about the EMS Do Not Resuscitate Order

The Virginia Department of Health no longer issues the EMS DNR Form. All EMS DNR Orders that were in effect on July 1, 1999, or issued after that date, are considered Durable DNR Orders and shall remain valid until revoked.

Definitions

Virginia Durable Do Not Resuscitate (DNR) Order - A written physician's order, in a form approved by the Board of Health, which authorizes qualified health care personnel to withhold or withdraw cardiopulmonary resuscitation from a particular patient in the event of cardiac or respiratory arrest. Durable DNR Orders can be recognized by qualified EMS personnel at all times and in all settings.

Durable DNR Orders shall not authorize the withholding of other medical interventions, such as intravenous fluids, oxygen or other therapies deemed necessary to provide comfort care or to alleviate pain. [VA. Code Section 54.1-2987.1] Valid EMS DNR Orders are considered Durable DNR Orders and do not expire if issued on or after July 2, 1998.

Alternate Form of Durable DNR Identification (Bracelets/Necklaces) - In conjunction with the issuance of Durable DNR Orders, the Board of Health has authorized an approved bracelet or necklace as an alternate form of Durable DNR Order Identification. Any such alternate form may be utilized to validate the Durable DNR or in place of an original Durable DNR Order. It must contain the following information: patient's full legal name, Durable DNR number on the Virginia Durable DNR form or a number unique to the patient that is assigned by the vendor, the words - Virginia Do Not Resuscitate, vendor's 24-hour phone number and physician's name and phone number.

Virginia Durable DNR Form - Unique document printed on distinctive paper by the Virginia Department of Health. The form has three sections: Physician's Order, Patient's Signature and Signature of Designated Agent or Other Authorized Decision Maker. (See example on page 4.)

Other Do Not Resuscitate Orders - Any DNR Order not issued on the Durable DNR Order Form. These orders must be written or verbally given by a physician, who has a bona fide physician/patient relationship, directing that a patient not be resuscitated. The order must include the patient's full legal name, physician's signature and date issued. Examples of other DNR Orders are:

- DNR Order written for a patient who is currently admitted to a hospital or other health care facility in accordance with accepted medical practice. To be honored by EMS personnel, such other DNR Orders must contain a do not resuscitate determination, physician's signature and date of issue or, if applicable, the person authorized to consent on the patient's behalf. If the patient experiences cardiac or respiratory arrest during transport to another facility, EMS personnel must document in writing on the patient care report that they received a doctor's verbal order or were shown a valid DNR order.
- Direct order by a physician, who is physically present in attendance of a patient in cardiac or respiratory arrest, can be recognized by qualified EMS personnel.

Cardiopulmonary Resuscitation - For the purpose of this protocol means medical procedures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, and defibrillation and related procedures.

Cardiac Arrest - The cessation of a functional heartbeat.

Qualified emergency medical services personnel - Persons, as defined in § 32.1-111.1, Code of Virginia, responsible for the direct provision of emergency medical services in a given medical emergency when acting within the scope of their certification.

Physician - A person licensed to practice medicine in the Commonwealth of Virginia or in the jurisdiction where the treatment is to be rendered or withheld.

Virginia Durable Do Not Resuscitate Protocol - The standardized method or procedure for the withholding or withdrawal of cardiopulmonary resuscitation by qualified health care personnel from patients with a valid DNR order in the event of cardiac or respiratory arrest.

Health Care Facility - Any institution, place, building or agency required to be licensed under Virginia law, including, but not limited to, any hospital, nursing facility or nursing home, adult care residence, assisted living facility or ambulatory surgical center.

Virginia Durable DNR Associated Responsibilities

Patient Responsibility - Make an informed decision concerning withholding or withdrawing resuscitation from cardiac or respiratory arrest. Ensure that family members are aware of this decision and the location of the Virginia Durable DNR Order Form. The patient or family is encouraged to notify its local EMS agency of the decision and meet with agency personnel to discuss their response and care in this situation. The patient should understand that revocation is possible at any time by destroying the Virginia Durable DNR Order Form or removing the approved alternate form of Durable DNR Identification or by simply stating (or otherwise indicate) that he or she wishes to be resuscitated.

Physician Responsibility - Discuss the information on the Durable DNR Form with the patient or the person authorized to consent on the patient's behalf.

- Discuss significance of the Durable DNR and its provisions. Make sure the patient knows that his life will not be saved in a cardiac or respiratory arrest emergency.
- Physician signs and issues form
- Physician explains how the Durable DNR Order can be revoked

EMS Agency Responsibility - Educate agency personnel about Virginia's Durable DNR Order, the EMS DNR Order and other DNR orders.

Meet with nursing homes, adult homes, hospitals, home health care nurses and hospice units to educate their personnel about the Virginia Durable DNR Order, other DNR orders and advance directives. Provide information to these health care facilities about what to expect when an EMS agency responds and what the agency needs from the health care facility.

EMS Provider Responsibility - Evaluate the patient's status and needs through assessment. This law applies only to cardiac arrest or respiratory arrest in patients with an original Virginia Durable DNR Order form, bracelet or necklace; EMS DNR Order (valid on or after July 1, 1999); or other DNR orders issued in a hospital or other health care facility.

If there is an emotional confrontation with the patient's family, continue comfort care to the patient. If CPR is indicated and the family insists on resuscitation, transport the patient to the ambulance and contact on-line Medical Direction for further instructions. To avoid the likelihood of this type of misunderstanding, encourage patients and their families to contact the EMS agency in their area and discuss expectations. If you have a question concerning the validity of a Virginia Durable DNR Order, begin resuscitation and contact on-line Medical Direction.

The greatest insurance against misunderstanding among EMS agency staff, the patient and the family is to have an informal meeting of these parties. EMS agency staff members can request the meeting with the patient and significant family members. During this contact, the protocols can be discussed in a general fashion but specific enough so all present are aware of what is and what is not likely to happen. This would help ease the anxiety of all participants and ensure that the patient's wishes will be respected.

If the Virginia Durable DNR Order has been revoked, begin usual treatment of patient, including resuscitation, and notify the patient's physician or on-line Medical Direction.

EMS Agency Operational Medical Director Responsibility - Be a resource about the Virginia Durable DNR and advance directives legislation. Assume that EMS agency policy is consistent with the protocols in this document, which is provided to all EMS agencies. Encourage EMS agency representatives to visit the patient and/or family to initially discuss the agency's role.

Emergency Department Physician Responsibility (On-Line OMD) - Understand the Virginia Durable DNR Order and advance directives legislation. Intervene in pre-hospital management of patient when necessary and be a resource for EMS personnel should problems develop during a call. When necessary, interface with the physician with whom the patient has a bona fide physician/patient relationship.

Virginia Durable DNR Form

Parts of the Form

- Physician Order with signature
- Patient's Signature
- Signature of Designated Agent or Other Authorized Decision Maker

No Time Limit of Virginia Durable DNR Order - It is valid until revoked.

Copies Versus the Original Form - The original Virginia Durable DNR Order Form should be kept by the patient. The original Virginia Durable DNR Order Form is printed on distinctive paper. EMS personnel must see the original Virginia Durable DNR Form, or the unaltered approved Virginia Durable DNR alternate identification on the patient. It would be helpful to give a copy (for informational purposes) to the patient's physician for his records, the emergency department most likely to receive the patient, and the EMS agency serving the patient. Copies of the Virginia Durable DNR Form can be made only with the consent of the patient or the patient's designated agent or the person authorized to consent on the patient's behalf. However, copies of the original Durable DNR Order are not valid for withholding cardiopulmonary resuscitation.

Distribution of Virginia Durable DNR Forms and Alternate Forms of Durable DNR Identification (Bracelets/Necklaces) - The Virginia Department of Health issues the Durable DNR Order forms and instructions to physicians, hospitals, nursing homes, hospices and home health agencies. The Virginia Department of Health and health care facilities cannot issue forms directly to a patient. **Only physicians can issue a Durable DNR Order to his or her patient.** Physicians and health care facilities must request the Durable DNR Order forms on office or health care facility letterhead and mail or fax their requests to the Office of Emergency Medical Services, Virginia Department of Health. Any patient with a Durable DNR Order who wants a bracelet or necklace must order these directly from an approved vendor. A list of approved vendors is available from the Office of Emergency Medical Services.

Location of Form in Patient's Residence - To aid in quickly determining DNR status, the original Virginia Durable DNR Order Form should be located at the patient's bedside (bedside table), on the back of the patient's bedroom door or on the refrigerator. When traveling or being transported by ambulance, the original Virginia Durable DNR Form should be with the patient or the patient should wear an approved alternate form of the Durable DNR Order identification. If a patient is using an approved Durable DNR bracelet or necklace as Durable DNR identification, they must wear one of these on their body.

Virginia Durable DNR Protocol

The responding EMS provider should:

1. Perform routine patient assessment and resuscitation or intervention until it is confirmed that the patient has either a Virginia Durable DNR Order or the EMS DNR Order, that was in effect on July 1, 1999.
2. Request the original Virginia Durable DNR Form or the EMS DNR Order or look for either form at the patient's bedside, on the back of the patient's bedroom door, on the refrigerator or in the patient's wallet. If either of these forms has been defaced, consider the DNR Order to be invalid. An approved Durable DNR necklace or bracelet, being worn on the patient's body, can be honored in place of the original Durable DNR form.
3. Make a good faith effort to verify identity of the patient through family, friends, and other health care personnel present or photo ID (such as a driver's license).
4. Be aware that a Virginia Durable DNR or EMS DNR can be revoked by the following persons:
 - The patient, by destroying the Virginia Durable DNR Form or EMS DNR Form or by verbally withdrawing consent to the order.
 - The person authorized to consent on the patient's behalf.
 - A physician who is physically present at the patient's side.

These comforting interventions are encouraged:

- Airway (excluding intubation or advanced airway management)

- Suction
- Supplemental oxygen delivery devices
- Pain medications or intravenous fluids
- Bleeding control
- Patient positioning
- Other therapies deemed necessary to provide comfort care or to alleviate pain

Contact patient's physician or On-Line Medical Direction if questions or problems arise.

These resuscitative measures should be avoided:

Withhold or withdraw if resuscitation has begun prior to confirmation of Virginia Durable DNR status:

- Cardiopulmonary resuscitation (CPR)
- Endotracheal intubation or other advanced airway management
- Artificial ventilation
- Defibrillation
- Cardiac resuscitation medications
- Continuation of related procedures, as prescribed by the patient's physician or medical protocols

6. Document the call:

- a. Complete the standard Pre-Hospital Patient Care Report (PPCR) or agency run report and document which identification was used to confirm DNR status: Virginia Durable DNR Order form, bracelet or necklace; EMS DNR Order form; or other DNR form.
- b. Indicate the Virginia Durable DNR Order form number and the patient's attending physician's name.
- c. Comfort the family if, on arrival, the patient has expired and follow agency's procedure for death at home.

For more information or clarification on Virginia's Durable DNR program contact:
 Ruth Robertson, Public Relations and Marketing Manager, Office of Emergency Medical Services, Virginia Department of Health, 1538 East Parham Road, Richmond, VA 23228
 804-371-3500 • 800-523-6019
www.vdh.state.va.us/ems

**Virginia Department of Health
Regulations Governing
Durable Do Not Resuscitate Orders**

PART I - DEFINITIONS

12VAC5-65-10 Definitions

The following words and terms, when used in these regulations, shall have the following meaning unless the context clearly indicates otherwise:

"Agent" means an adult appointed by the declarant under an advance directive, executed or made in accordance with the provisions of Section 54.1-2987.1 of the Code of Virginia, to make health care decisions for him. The declarant may also appoint an adult to make, after the declarant's death, an anatomical gift of all or any part of his body pursuant to Article 2 (§32.1-289 et seq.) of Chapter 8 of Title 32.1.

"Board" means the State Board of Health.

"Cardiac arrest" means the cessation of a functional heartbeat.

"Cardiopulmonary resuscitation (CPR)" means medical procedures including chest compression, basic airway management, artificial ventilation, defibrillation, and related procedures.

"Commissioner" means the State Health Commissioner.

"Durable Do Not Resuscitate Order or Durable DNR Order" means a written physician's order issued pursuant to §54.1-2987.1 in a form authorized by the Board to withhold cardiopulmonary resuscitation from an individual in the event of cardiac or respiratory arrest. For purposes of these regulations, cardiopulmonary resuscitation shall include cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, and defibrillation and related procedures. As the terms "advance directive" and "Durable Do Not Resuscitate Order" are used in this article, a Durable Do Not Resuscitate Order is not and shall not be construed as an advance directive. When used in these regulations, the term "Durable DNR Order" shall include any authorized alternate form of identification issued in conjunction with an original Durable DNR Order form.

"Emergency Medical Services (EMS)" means the services utilized in responding to the perceived individual needs for immediate medical care in order to prevent loss of life, aggravation of physiological or psychological illness or injury including any of all services which could be described as first response, basic life support, advanced life support, specialized life support, patient transportation, medical control, and rescue rendered by an agency licensed by the Virginia Office of Emergency Medical Services, an equivalent agency licensed by another state or a similar agency of the federal government when operating within this Commonwealth.

"Emergency Medical Services Agency (EMS Agency)" means any person licensed to engage in the business, service, or regular activity, whether or not for profit, of transporting and/or rendering immediate medical care to such persons who are sick, injured, wounded or otherwise incapacitated or helpless.

"Incapable of making an informed decision" means the inability of an adult patient, because of mental illness, mental retardation, or any other mental or physical disorder which precludes communication or impairs judgment and which has been diagnosed and certified in writing by his physician with whom he

has a bona fide physician/patient relationship and a second physician or licensed clinical psychologist after personal examination of such patient, to make an informed decision about providing, withholding or withdrawing a specific medical treatment or course of treatment because he is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision. For purposes of these regulations, persons who are deaf, dysphasic or have other communication disorders, who are otherwise mentally competent and able to communicate by means other than speech shall not be considered incapable of making an informed decision.

"Person Authorized to Consent on the Patient's Behalf" means any person authorized by law to consent on behalf of the patient incapable of making an informed decision or, in the case of a minor child, the parent or parents having custody of the child or the child's legal guardian or as otherwise provided by law.

"Physician" means a person licensed to practice medicine in the Commonwealth of Virginia or in the jurisdiction where the treatment is to be rendered or withheld.

"Qualified emergency medical services personnel," means personnel as defined by 32.1-111.1 when acting within the scope of their certification.

"Qualified Health Care Personnel" means any licensed health care practitioner, healthcare provider or person functioning in any facility, program or organization operated or licensed by the State Board of Health, or by the Department of Mental Health, Mental Retardation and Substance Abuse Services or created, licensed or owned by another state agency. For the purposes of these regulations, this definition shall include any qualified emergency medical services personnel.

"Respiratory arrest" means cessation of breathing.

"Terminal condition" means a condition caused by injury, disease or illness from which, to a reasonable degree of medical probability, a patient cannot recover and (i) the patient's death is imminent or (ii) the patient is in a persistent vegetative state, as defined in Section 54.1-2982 of the Code of Virginia.

PART II - PURPOSE AND APPLICABILITY

12VAC5-65-20 Authority for Regulation

Section 54.1-2987.1 of the Code of Virginia (1950), as amended, vests authority for the regulation of Durable DNR Orders in the State Board of Health and directs the Board to prescribe by regulation the procedures, including the requirements for forms, to authorize qualified health care personnel to follow Durable DNR Orders. All EMS DNR Orders issued or in effect between July 1, 1999 and the effective date of this regulation are to be considered Durable DNR Orders and shall remain valid until revoked. All EMS DNR Orders issued between January 3, 2000 and the date that the Durable DNR forms were made available are considered Durable DNR Orders.

12VAC5-65-30 Purpose of Regulations

The Board has promulgated these emergency regulations in order to ensure timely and appropriate implementation and application of the Durable DNR Order Statute, effective July 1, 1999.

12VAC5-65-40 Administration of Regulations

These regulations shall be administered by the following:

- A. **The State Board of Health** – The Board shall have the responsibility to promulgate and amend, as appropriate, regulations governing Durable DNR Orders;
- B. **The State Health Commissioner** – The Commissioner, pursuant to his authority under Section 32.1-20, shall administer these regulations.

12VAC5-65-50 Application of Regulations

These regulations shall have general application throughout the Commonwealth.

12VAC5-65-60 Effective Date of Regulations

These regulations shall become effective January 3, 2001.

PART III - REQUIREMENTS AND PROVISIONS

Article 1 - General Provisions

12VAC5-65-70 The Durable Do Not Resuscitate Order Form

The Durable DNR Order Form shall be a unique document printed on distinctive paper, as approved by the Board, and consistent with these regulations. The following requirements and provisions shall apply to the approved Durable DNR Order Form.

A. **Content of the Form** – A valid Durable DNR Order Form shall contain the do not resuscitate determination from the physician with whom the patient has a bona fide physician/patient relationship and must be signed and dated by this physician. The Order must also be signed by the patient who is the subject of the Order or, if applicable, the person authorized to consent on the patient's behalf.

B. **Effective Period for a Signed Durable DNR Order Form** – A signed Durable DNR Order shall remain valid until revoked.

C. **Original Durable DNR Order Form** – An original Durable DNR Order Form, shall be valid for purposes of withholding or withdrawing cardiopulmonary resuscitation qualified health care personnel in the event of cardiac or respiratory arrest in any facility, program or organization operated or licensed by the State Board of Health, or by the Department of Mental Health, Mental Retardation and Substance Abuse Services or operated, licensed or owned by another state agency. The original Durable DNR Order Form shall be maintained and displayed at the patient's current location or residence in one of the places designated on the form, or shall accompany the patient, if traveling. The original form shall be maintained and displayed at the patient's home in one of the places designated on the form or shall accompany the patient, if traveling. Copies of the Durable DNR Order Form may be given to other providers or persons for information, with the express consent of the patient the person authorized to consent on the patient's behalf. However, such copies of the Durable DNR Order Form are not valid for withholding cardiopulmonary resuscitation.

D. **Revocation of a Durable DNR Order** – A Durable DNR Order may be revoked at any time by the patient (i) by physical cancellation or destruction of the Durable DNR Order Form and/or any alternate form of identification by the patient or another in his presence and at his direction, or (ii) by oral expression of intent to revoke by the patient or the person authorized to consent on the patient's behalf.

E. **Distribution of Durable DNR Order Forms** – Authorized Durable DNR Forms, with instructions, shall be available only to physicians and to any facility, program or organization operated or licensed by the Board of Health, or by the Department of Mental Health, Mental Retardation and Substance Abuse Services, or operated, licensed or owned by another state agency.

12VAC5-65-80 Authorized Alternate Forms of Durable DNR Order Identification

The Board may authorize the issuance of alternate forms of Durable DNR Order identification in conjunction with the issuance of Durable DNR Orders. Any such alternate forms of identification which are issued in conjunction with a Durable DNR Order may be utilized either to validate the Durable DNR Order or in place of an original Durable DNR Order Form issued in compliance with these regulations. Such alternate forms of Durable DNR Order identification shall be uniquely designed and easily identifiable. In order to be honored by qualified health care personnel in place of the original Durable

DNR Order Form, such alternate forms of identification must contain the minimum information approved by the State Board of Health.

12VAC5-65-90 Other Do Not Resuscitate Orders

A. Nothing in these regulations or in the definition of Durable DNR Orders provided in Section 54.1-2982 shall be construed to limit the issuance of, or the authorization of physicians and those persons designated in Section 54.1-2901 to follow Do Not Resuscitate Orders other than Durable DNR Orders for patients who are currently admitted to a hospital or other health care facility in accordance with accepted medical practice.

B. Nothing in these regulations or in the definition of Durable DNR Orders provided in Section 54.1-2982 shall be construed to limit the authorization of qualified health care personnel to follow Do Not Resuscitate Orders other than Durable DNR Orders which are written by a physician, with whom the patient has a bona fide physician/patient relationship, for the duration of the patient's transfer to another facility. Such other DNR Orders issued in this manner shall be valid until a Durable DNR Order or other valid DNR Order is issued by the physician assuming responsibility for the treatment and care of the patient, but not to exceed twenty-four (24) hours. Such other DNR Orders issued in this manner shall contain the information listed in 12VAC5-65-70 A. and the time of issuance by the physician.

C. Nothing in these regulations shall prohibit qualified health care personnel from following any direct order issued by a licensed physician not to resuscitate a patient in cardiac or respiratory arrest when such physician is in attendance of such patient.

D. The provisions of these regulations shall not authorize any qualified emergency medical services personnel or licensed health care provider or practitioner who is attending the patient at the time of cardiac or respiratory arrest to provide, continue, withhold or withdraw treatment if such provider or practitioner knows that taking such action is protested by the patient whether or not incapable of making an informed decision. No person shall authorize providing, continuing, withholding or withdrawing treatment pursuant to this section that such person knows, or upon reasonable inquiry ought to know, is contrary to the religious beliefs or basic values of a patient incapable of making an informed decision or the wishes of such patient fairly expressed when the patient was capable of making an informed decision. Further, this section shall not authorize the withholding of other medical interventions, such as intravenous fluids, oxygen or other therapies deemed necessary to provide comfort care or to alleviate pain.

PART IV - IMPLEMENTATION PROCEDURES

12VAC5-65-100 Issuance of a Durable DNR Order

A Durable DNR Order may be issued by a physician with whom the patient has established a bona fide physician/patient relationship, as defined by the Board of Medicine in their current guidelines, only with the consent of the patient or if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the person authorized to consent on the patient's behalf.

The physician shall explain to the patient or the person authorized to consent on the patient's behalf, the alternatives available, including issuance of a Durable DNR Order. If the option of a Durable DNR Order is agreed upon, the physician shall have the following responsibilities.

- A. Obtain the signature of the patient or the person authorized to consent on the patient's behalf.
- B. Execute and date the Physician Order on the Durable DNR Order Form.

C. Issue the original Durable DNR Order Form.

D. Explain how to, and who may revoke the Durable DNR Order.

12VAC5-65-110 Durable DNR Order Implementation Procedures

Qualified health care personnel shall comply with the following general procedures and published Virginia Durable DNR Order Implementation Protocols when caring for a patient who is in cardiac or respiratory arrest and who is known or suspected to have a Durable DNR Order in effect.

A. Initial Assessment and Intervention

Perform routine patient assessment and resuscitation or intervention until the Durable DNR Order or other DNR Order validity status is confirmed, as follows.

1. Determine the presence of a Durable DNR Order Form or an approved alternate form of Durable DNR identification.
2. Determine that the Durable DNR item is not altered.
3. Verify, through Driver's License or other identification with photograph and signature, patient's hospital identification, or by positive identification by a family member or other person that knows patient, that the patient in question is the one for whom the Durable DNR Order or other DNR Order was issued.
4. If no Durable DNR Order or other approved form of identification is found, ask a family member or other person to look for the original Durable DNR Order Form or other written DNR order.
5. If the Durable DNR Order or alternate form of identification is not intact or has been altered or other DNR Order not meeting these requirements is produced, the qualified health care personnel shall consider the Durable DNR Order to be invalid.

B. Resuscitative Measures to be Withheld or Withdrawn

In the event of cardiac or respiratory arrest of a patient with a valid Durable DNR Order under the criteria set forth above, the following procedures should be withheld or withdrawn by qualified health care personnel unless otherwise directed by a physician physically present at the patient location:

1. Cardiopulmonary Resuscitation (CPR)
2. Advanced airway management
3. Artificial Ventilation
4. Defibrillation
5. Cardiac resuscitation medications
6. Continuation of related procedures, as prescribed by the patient's physician or medical protocols.

C. Procedures to Provide Comfort Care or to Alleviate Pain

In order to provide comfort care or to alleviate pain for a patient with a valid Durable DNR Order or other DNR Order, the following interventions may be provided, depending on the needs of the particular patient.

1. Airway management (excluding intubation or advanced airway management)
2. Suction
3. Supplemental oxygen delivery devices

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4. Pain medications or intravenous fluids

5. Bleeding control

6. Patient positioning or

7. Other therapies deemed necessary to provide comfort care or to alleviate pain.

D. Revocation

These regulations shall not authorize any qualified health care personnel to follow a Durable DNR Order for any patient who is able to, and does, express to such qualified health care personnel the desire to be resuscitated in the event of cardiac or respiratory arrest.

If the patient is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the patient be resuscitated by the person authorized to consent on the patient's behalf shall so revoke the qualified health care personnel's authority to follow a Durable DNR Order or other DNR Order.

The expression of such desire to be resuscitated prior to cardiac or respiratory arrest shall constitute revocation of the Order; however, a new Order may be issued upon consent of the patient or the person authorized to consent on the patient's behalf.

E. Documentation

When following a Durable DNR Order or other DNR Order for a particular patient, qualified health care personnel shall document in the patient's medical record the care rendered or withheld in the following manner:

1. Use standard patient care reporting documents (i.e. patient's chart, pre-hospital patient care report).
2. Describe assessment of patient's status.
3. Document which identification (Durable DNR Order Form or other DNR Order or alternate form of identification) was used to confirm Durable DNR status and that it was intact, not altered, not canceled, or not officially revoked.
4. Record actual Durable DNR Order Number and name of patient's physician.
5. If the patient is being transported, keep the Durable DNR Order with the patient.

F. General Considerations

The following general principles shall apply to implementation of Durable DNR Orders:

1. If there is misunderstanding with family members or others present at the patient's location or if there are other concerns about following the Durable DNR Order, contact the patient's physician or EMS medical control for guidance.
2. If there is any question about the validity of a Durable DNR Order, resuscitative measures should be administered until the validity of the Durable DNR is established.

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CARILION HEALTH SYSTEM has several positions available for Virginia licensed, board certified Family Practice physicians to join their network of primary care practices in a variety of settings and locations in western Virginia. CARILION is the 2002 recipient of the prestigious National Quality Award, listed in the nation's Top 30 integrated health systems, and is the largest not for profit health system in Virginia, with 12 hospitals, 45+ primary and surgical care sites, plus 6 residency programs that are affiliated with UVA. If you are interested in continuing your medical career with a nationally recognized, quality organization, please contact us to discuss your interest, review of credentials, or to request additional information. Review of CV's will begin immediately and continue until positions are filled.

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Life Insurance Trusts Should You Establish One?

As you probably know, life insurance is often purchased to provide a source of cash to help pay estate taxes. If you own your life insurance policy, the proceeds paid at your death will be part of your estate and, as such, they may be subject to estate tax. However, life insurance proceeds might not be subject to estate taxes if your insurance policy is owned by a special type of trust called an irrevocable life insurance trust.

How Does The Trust Work?

A life insurance trust is a separate legal entity that is established to own a life insurance policy and pay the policy premiums.

If you're planning to buy a new policy, the smart thing to do is to set up the trust first and have it buy the insurance. Then you never are the policy owner. If you already own the insurance policy, you can set up the trust and transfer the policy to it. If the transfer is done correctly and you've paid careful attention to the tax and legal requirements, the insurance proceeds should be removed from your estate.

Whether you can benefit from a life insurance trust depends on your individual situation. Though the 2001 Tax Act increases the amount that can pass to your beneficiaries free of estate tax and eliminates the estate tax in 2010, a trust may still be a useful planning tool.

How Large Is Your Estate?

The amount exempt from federal estate tax rises from \$1,000,000 in 2002 to \$3,500,000 in 2009. If your estate exceeds the current exemption amount, or is likely to grow beyond the exemption amount in the future, an irrevocable life

insurance trust could help in two ways. First, making gifts of policies or premium payments to the trust removes their value from your estate. Second, the policy proceeds may provide the cash your heirs need to pay your estate expenses.

What Type Of Assets Do You Own?

Say the bulk of your estate is an IRA or a 401(k) account. If your heirs are forced to tap these accounts in order to pay your estate expenses, ordinary income tax is due and tax-deferred growth stops. An irrevocable trust could help your heirs avoid that outcome by giving them another source of cash.

If your estate consists mainly of real estate or a family business, your heirs may not be able to quickly liquidate assets or raise money to pay estate expenses. Insurance proceeds held in a trust may help provide liquidity.

What Does The Future Hold?

The tax rules change constantly. The same tax law that gradually reduces and eventually eliminates the estate tax in 2010 restores it in 2011.

If you own your life insurance policy, the proceeds paid at your death will be part of your estate and, as such, they may be subject to estate tax.

Business Alert IRS Liberalizes Policy

A recent change in IRS policy will allow many businesses to change from the accrual method of accounting to the cash method. Most small business owners prefer the cash method because it requires less bookkeeping, it's easier to understand and it matches cash receipts with a company's income tax liability.

Under the cash method, taxpayers generally report income to the IRS in the year they receive payment from customers. Under the accrual method, taxpayers report income when a sale is made to a customer regardless of when the bill is paid. An accrual method taxpayer may have to come up with the cash to pay income tax before customers pay their bills.

Before this policy change, businesses that carried inventories could use the cash method only if they had annual gross receipts of \$1 million or less. Now businesses with revenue of \$10 million or less will be eligible to use the cash method.

Some businesses are prohibited from using the cash method even though their income doesn't exceed \$10 million. This includes retailers, wholesalers, certain manufacturers, mining operations, and publishing or recording businesses. Certain entities, such as C corporations and partnerships with corporate partners, are also excluded from using the cash method.

Think About Taxes Before Deciding Where To Invest Your Money

Are you wondering how to get a higher return from your investments without taking on any more risk? If you're like many investors, some simple tax planning might do the trick. By setting up your investment portfolio to take advantage of the current tax rules, you may be able to increase the after-tax return on your investments.

Start by evaluating whether you're maximizing your tax-deferred investment opportunities, such as IRAs, 401(k)s and other retirement plans. Remember, you owe no taxes on the investment income earned within these accounts until you withdraw the money. The contribution limits for all retirement plans increase this year, so you can put aside even more investment dollars in these tax-deferred accounts.

How advantageous is tax-deferred growth? If you invest \$10,000 in a tax-deferred account earning 8% a year, your investment will grow to \$46,600 in 20

the alternative minimum tax or subject otherwise tax-free social security benefits to tax.

As you choose investments, consider which type of investment belongs in which type of account. Keep in mind that investments like tax-free municipal bonds should not be held in retirement accounts. You'll earn a lower return and convert what would be tax-free income into a taxable distribution.

High-dividend stocks may be a good choice for your tax-deferred accounts. But growth stocks, where the return comes mostly from capital appreciation, should probably go in your taxable accounts. There you can take advantage of the lower tax rates on long-term capital gains.

The rules for Roth IRAs are different, because Roth earnings can be tax-free. Consider keeping those investments which generate the greatest total earnings in your Roth IRA.

By setting up your investment portfolio to take advantage of the current tax rules, you may be able to increase the after-tax return on your investments.

years. Assuming a 35% tax rate, a similar investment held in a taxable account would grow to just \$27,600.

Don't overlook the tax-free savings opportunities currently available to you, including Roth IRAs for your retirement or education savings accounts and Section 529 plans for your children's education. When you withdraw money from these accounts, you'll generally owe no income tax on the earnings, as long as certain conditions are met.

If you're not in one of the higher tax brackets, switching to tax-exempt bonds and bond funds might increase the after-tax return on your investments. But be aware that this strategy could also trigger

Tax Talk

IRS Plans New Audits

The Internal Revenue Service has proposed a plan to randomly audit approximately 50,000 returns to measure how well taxpayers are complying with the tax laws.

The new program, called the National Research Project, is scheduled to begin this fall. The Service plans to use the statistics gathered from these audits to design new standards for its general audit selection process.

In order to gather tax compliance data, the IRS proposal intends to do the following:

- ✦ Compare about 8,000 tax returns with other information filed with the IRS.
- ✦ Conduct about 9,000 correspondence audits asking about apparent errors on tax returns.
- ✦ Select portions of about 30,000 tax returns to audit.
- ✦ Perform line-by-line audits on about 2,000 returns. The IRS says these complete audits won't be as arduous as the old TCMP (Taxpayer Compliance Measurement Program) audits, which one taxpayer described as undergoing an autopsy without the benefit of death.

Don't Lend Money To The IRS

Will your income and deductions change this year? If so, consider adjusting your withholding at work so the amount your employer withholds comes closer to what you will actually owe on your 2002 tax return.

If you're required to make estimated tax payments, be aware that the prior-year safe-harbor percentage for higher-income taxpayers increases from 110% to 112% this year.

If you underpay your 2002 income taxes, you may face penalties. If you overpay, your making an interest-free loan to the IRS.



Get Off To A Good Start By Making The Right Business Choices

Part of the challenge in starting a new business is making the right choices before you begin. Here are some issues you need to consider to help ensure your business's survival.

Choose The Right Legal Form

The form of business entity that you choose for your new business can make a difference in the taxes you pay, the costs of doing business, and the amount of paperwork and red tape you'll have. There are several forms to choose from, and each has advantages and drawbacks.

Sole proprietorships are perhaps the easiest form of business to operate, but they provide no protection from personal liability.

Corporations are separate legal entities that pay their own income tax and provide liability protection to their owners, but they can be costly to set up and administer.

Limited liability companies and S corporations are hybrid entities that provide liability protection to their owners, but owners report profits or losses on their personal tax returns.

Plan Your Cash Needs

You'll probably need capital to start your business, plus a cash reserve until your business becomes self-sufficient. Plan your cash needs carefully and realistically, and provide a generous cushion for setbacks and unexpected expenses.

Decide To Lease Or Buy

The main advantage of leasing the building and/or equipment your business will need is that your initial cash outlay is generally less than if you purchase. However, the main disadvantage of leasing is that you could pay out more over the

term of the lease than if you purchased the asset. And when the lease term expires, you must return the asset or buy it.

One way to determine whether buying or leasing is better is to do a cash flow analysis. You will then have an estimate of how much cash you would need to set aside today to cover the cost of each alternative. To do an analysis, you'll need to consider such things as the terms of the lease and purchase options, the asset's expected useful life and its estimated value at the end of its life, interest rates and income tax rates.

Hire The Right Employees

You need a plan to attract the best people. What special skills are you looking for? How much can you afford to pay? What benefits (health insurance, sick or vacation pay, etc) will you offer? Would you be better off contracting for services rather than hiring employees?

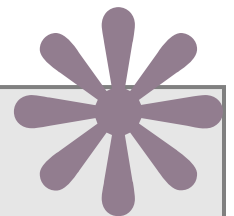
Consider Pricing Issues

Pricing is more than just determining how much to charge for a product or service. Customers now look at delivery time, return policies and technical assistance as part of what they are buying. While it can be difficult to compete on price with large companies that can buy in quantity, you might offer more customized services to support a higher price.

Establish Credit Policies

Many business owners are so concerned about marketing and selling their product or service that they neglect billing and collection efforts. Every new business should establish credit, billing and collection procedures.

The form of business entity that you choose for your new business can make a difference in the taxes you pay, the costs of doing business, and the amount of paperwork and red tape you'll have.



Before making important financial or business decisions this year, be sure to contact your accountant or tax consultant to discuss these changes and any other tax concerns you may have.

Tax Update information should not be acted upon without further details and/or professional assistance. Tax Update is provided by Wells, Coleman & Co., L.L.P., 3800 Patterson Ave., Richmond, Virginia.

Your 2002 Tax Numbers

	2002	2001
* Standard deduction		
- Single	\$ 4,700	\$ 4,550
- Married filing jointly	7,850	7,600
- Married filing separately	3,925	3,800
- Head of household	6,900	6,650
- Additional deduction – Single 65 and older/blind	1,150	1,100
Married 65 and older/blind	900	900
* Personal Exemption	3,000	2,900
* Personal exemption phase-out (AGI)		
- Single	137,300 - 259,800	132,950 - 255,450
- Joint returns & surviving spouses	206,000 - 328,500	199,450 - 321,950
- Married filing separately	103,000 - 164,250	99,725 - 160,975
- Head of household	171,650 - 294,150	166,200 - 288,700
* Limit on itemized deductions (AGI)		
- Single/joint/head of household	137,300	132,950
- Married filing separately	68,650	66,475
* Automobile standard mileage rate		
- Business	36.5 cents	34.5 cents
- Charitable work	14 cents	14 cents
- Medical/moving expense	13 cents	12 cents
* Social security tax wage base	84,900	80,400
* Medicare tax wage base	No limit	No limit
* Social security earnings limit		
- Under age 65	11,280	10,680
- Age 65 and over	No limit	No limit
* Retirement plan contribution limits		
- IRA (under age 50)	3,000	2,000
- IRA (age 50 or over)	3,500	2,000
- SIMPLE (under age 50)	7,000	6,500
- SIMPLE (age 50 or over)	7,500	6,500
- 401(k) (under age 50)	11,000	10,500
- 401(k) (age 50 or over)	12,000	10,500
* IRA deductibility phase-out (AGI)		
- Single/head of household	34,000 - 44,000	33,000 - 43,000
- Joint returns & surviving spouses	54,000 - 64,000	53,000 - 63,000
- Married filing separately	0 - 10,000	0 - 10,000
- When spouse has company pension	150,000 - 160,000	150,000 - 160,000
* Interest deduction on higher education loans	2,500	2,500
* Contribution limit for education savings accounts (education IRAs)	2,000	500
* Annual gift tax exclusion	11,000	10,000
* Estate tax exemption	1,000,000	675,000

2002 Taxable Income Brackets

Tax Rate	Single	Married (Joint)*	Head of Household
10%	\$ 1 - 6,000	\$ 1 - 12,000	\$ 1 - 10,000
15%	\$ 6,001 - 27,950	\$ 12,001 - 46,700	\$ 10,001 - 37,450
27%	\$ 27,951 - 67,700	\$ 46,701 - 112,850	\$ 37,451 - 96,700
30%	\$ 67,701 - 141,250	\$ 112,851 - 171,950	\$ 96,701 - 156,600
35%	\$ 141,251 - 307,050	\$ 171,951 - 307,050	\$ 156,601 - 307,050
38.6%	Over 307,050	Over 307,050	Over 307,050

* Married filing separate amounts are 50% of joint amounts.

Virginia Academy Of Family Physicians

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July 18 - 21, 2002
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Don't miss the premier CME conference of the year! Over 22 hours of outstanding continuing medical education covering the latest in clinical updates. In addition, specially designed workshops focused on HIPAA, coding, contracting, PDAs, joint injections, casting and splinting, and more will also be offered.

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For fast and easy registration, go online: www.vafp.org. For more program information, or if you have questions, call 1-800-THE-VAFP.

CME At The Beach



Credentialing Made Easier

CAQH Credentialing Data Initiative Alleviates Administrative Headaches

It can take longer than some surgeries; those time-consuming forms listing a healthcare provider's credentials required by health plans and other healthcare organizations. Few things put such a drain on a practice's administrative staff as the credentialing process.

A solution promising relief is here, thanks to the Coalition for Affordable Quality Healthcare (CAQH), a not-for-profit alliance of 25 of the nation's largest health plans and their trade associations, including Trigon Blue Cross

on file is complete and accurate. What's more, there is a system in place to notify health plans automatically when the healthcare provider's information changes.

- * Participating health plans, then, can access the credentialing information at any time as long as the provider has authorized it.
- * Health plans continue to do the data verification and review, and make an independent decision about whether a physician meets that organization's standards for participation.

With providers contracting with a

system will be borne by all of the participating health plans. Healthcare providers in Virginia and Colorado will be the first to implement the system and other states across the country will join beginning in June.

In developing the system, CAQH worked closely with health plans, physicians, professional associations, and accreditation organizations to help make the system meet the needs of those involved in the credentialing process. CAQH selected GeoAccess, the leader in healthcare data management, as its technology partner. GeoAccess will collect, maintain and secure all data in its state-of-the-art data center.

"We are pleased to be a part of the solution to streamline the administrative process for healthcare providers," says Snead. "By easing paperwork, we are making it easier for healthcare providers to attend to the more important work of caring for patients."

CAQH's mission is the improvement of healthcare access and quality for patients and the reduction of the administrative burden for healthcare providers and their office staff. CAQH's member organizations provide healthcare coverage for more than 110 million Americans. The CAQH Credentialing Data Initiative is one of several collaborative efforts that CAQH is undertaking to accomplish its mission. To learn more about CAQH and the new credentialing data initiative, please visit the CAQH Website at www.CAQH.org, where you can view an online demonstration of the system. You can also contact Trigon for additional information.

The innovative system being introduced by CAQH works this way: Each physician or healthcare provider will submit just one standard application to a single database that is designed to meet the informational needs of participating health plans.

Blue Shield. CAQH has developed a secure, online database that helps eliminate the need for physicians and other healthcare providers and their office staff to fill out and submit multiple applications.

The innovative system being introduced by CAQH works this way: Each physician or healthcare provider will submit just one standard application to a single database that is designed to meet the informational needs of participating health plans.

Benefits include:

- * The information can be submitted online, or by fax.
- * Providers can easily update their information at anytime and will be asked quarterly whether the information

dozen or more health plans, the benefits offered by the CAQH Credentialing Data Initiative are plain to see.

"The CAQH Credentialing Data Initiative and database will dramatically simplify the credentialing process and reduce paperwork for both the healthcare providers and the health plans with which they contract," says Tom Snead, Chairman and CEO of Trigon Blue Cross Blue Shield. "It has the added benefit of encouraging easy-to-use electronic submissions that can be updated regularly."

There is no cost for physicians and other healthcare providers to submit information to the credentialing data collection system. The costs associated with developing and maintaining the



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