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The Homestead Resort
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VAFP Mission Statement

The mission of the VAFP is to:

- Improve the health care of patients, their families and the citizens of Virginia.
- Serve the unique needs of members with professionalism, leadership and creativity.
- Advance and represent the specialty of family medicine.

VAFP Vision Statement

The Virginia Academy of Family Physicians strives to ensure quality, accessible health care, dedicated to the dignity and well being of the citizens of Virginia and guided by the principle that the family physician is the specialist of choice.

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President's Message

Wayne J. Reynolds, DO

As we move into spring, I hope everyone's year is going well so far. We have had a busy one here at the VAFP Headquarters with an upcoming move to our new office just around the corner, sorting and packing has been keeping everyone working extra long hours. The Board approved the move to the new office space at its past meeting and the staff is looking forward to settling in over the next month after a little spring-cleaning. Please feel free to stop by and see our new "digs" this summer if you're in the neighborhood as our staff always welcomes visitors and would welcome the opportunity to show off our new Headquarters! The Academy will send a postcard to all members with the new address and contact information in May.

And all this has been on the heels of another active Virginia General Assembly. See the accompanying article by our eyes and ears at General Assembly; Mr. Seth Ginther who helped spread the message of the importance of Family Medicine to the legislators very effectively this year. His hard work was very much appreciated not only by our VAFP staff, but also by all those who participated in the Family Physician of the Day and the introductions he was able to facilitate to help carry our message to those who cast the votes on our behalf and our patients' behalf. I would also like to personally thank all those who participated in the Family Physician of the Day and I hope everyone found it to be a rewarding experience. Please do consider putting it on your calendar for next year and even encouraging a colleague to join you.

Once again, it was a sold out crowd for our Winter Family Medicine Weekend at Wintergreen and hopefully everyone was able to get in a little skiing or snowboarding between catching up on some of the hot topics in CME. We truly are blessed by the continued support for this program by all our supporters and hope all of our membership can let them know we appreciate them when they have the chance during visits to their offices. We also had great attendance at the AAFP Annual Convocation of Practices and Networks held this year in Virginia at the Founders Inn in Virginia Beach and hope all those who attended found the program informative and educational as they work toward improving their practice-based research efforts and develop new ideas to improve the quality of care in their offices.

Planning is deep underway for our summer meeting to be held for the first time this year at The Homestead Resort in Hot Springs, Virginia and hope you're planning to attend August 9-12, 2007. Whether this is your first time to The Homestead or a return visit, we know you will have a great time with so many great activities available for the entire family from the spa to golfing, swimming, hiking or horseback riding. We are looking for a sold out event with our first visit to this unique spot in the Virginia Mountains. We also have several SAM programs in the works for the spring, summer and fall. See page 6 for more information. With so many great CME opportunities offered within our own state, one hardly even needs to consider leaving the state to pursue additional CME!

This year the Virginia Academy is very fortunate to be putting forward a nomination for the National AAFP Board of Directors in the support of VAFP Past President David Ellington, MD, Lexington, VA. I would ask all of our membership to consider their support of David this year for his Board bid as we are very proud of all his hard work as Past President of the VAFP, VAFP Treasurer, Past President of the MSV, and VAFP Delegate to the AAFP. The high regard he is held in at the national level is a testament to this fact. We are all confident David will do well working toward his goal.

Virginia remains very well represented at the National AAFP level with members serving on three National Commissions – the Commission of Public Policy, the Commission of Science, and the Commission of Continuing Professional Development with each member also serving on a multitude of subcommittees. Our Commission members would welcome any comments or input from members at anytime. Simply address these comments to our Headquarters staff and they will direct the comments to the appropriate Commission member.

With such an active Academy, it is easy for me to take PRIDE and be proud everyday to be a Family Physician as I hope it is for you too. The VAFP is here for you and if there is anything we can do for you, please do let us know. Family Medicine is evolving and we want you to remain part of that evolution.

Pulling your hair out trying to complete the ABFM's new Maintenance of Certification requirements?

Attend a VAFP group learning session and make it easy!!

SHOULD I ATTEND? The answer is YES if you are an American Board of Family Medicine (ABFM) Board Certified physician and you certified or recertified in July 2003 or after. For more information on specific recertification requirements from the ABFM, please call 888-995-5700 or visit http://mcfp.theabfm.org and enter the year that you certified/recertified.

The Virginia Academy of Family Physicians is offering group learning sessions to assist Academy members with the completion of the Self Assessment Modules (SAM) that are required by the American Board of Family Medicine (ABFM) for completion of the Maintenance of Certification process.

It is the Academy's experience through previous SAM workshops that for many physicians, this group learning approach is a much more effective (and efficient!) way for them to both satisfy the ABFM SAM requirement for Maintenance of Certification and to learn practical applications of the material.

The SAM is a 60 question internet based exam and on-line patient management module. The faculty team will present each of the 60 questions on the test and discuss the important teaching points for each, which will facilitate the participant's completion of each item. They will also guide the participants through the patient management simulation module. Internet access will be provided to allow completion of the entire SAM such that when the participants leave this session, they will have completed their yearly ABFM requirement and will have received a total of 22 CME credits!

Asthma SAM

Saturday, April 21, 2007 8:00 a.m. - 1:00 p.m.
University of Virginia-Wise
Wise, VA

Saturday, April 28, 2007 8:00 a.m. - 1:00 p.m.
J. Sargeant Reynolds Community College - Parham Road
Richmond, VA

Saturday, September 15, 2007 8:00 a.m. - 1:00 p.m.
Northern Virginia Community College
Annandale, VA

Diabetes SAM

Sunday, June 17, 2007 1:30 p.m. - 5:30 p.m.
Eastern Virginia Medical School - Brickell Library
Norfolk, VA

Saturday, August 11, 2007 1:30 p.m. - 5:30 p.m.
Valley Elementary School
Hot Springs, VA * Note - The August 11th session will be held in conjunction with the Annual Meeting at The Homestead.

Saturday, October 27, 2007 8:00 a.m. - 1:00 p.m.
Carilion TSG Building
Roanoke, VA

THE VAFP WELCOMES NEW MEMBERS

New Members

Active

Theodore Aldhizer, MD - Mechanicsville
Charles Cho, MD - Ashburn
Tasha Dickerson, MD - Glen Allen
Benjamin Ernst, DO - Roanoke
Erin Harris, MD - Glade Spring
Henry Ivey, MD - Vinton
Vonetta Lee, MD - Grafton
Ellen Palen, MD - Richmond
Trupti Patel, MD - Manassas
Tejas Shah, MD - Woodbridge
Elizabeth Weaver, MD - Falls Church

Resident

Elizabeth D'Amore, MD - Midlothian
Sharron Daggett, MD - Midlothian
Kerry Eley, MD - Midlothian
David Frate, MD - Chesapeake
Vishal Gohil, MD - Charlottesville
Kanika Govil, MBBS - Fairfax
Lisa Jenkins, MD - Newport News
Martin Kosciuk, MD - Winchester
Amritpal Manes, MD - Charlottesville
Raoul Muse, MD - Midlothian
Michelle Paulsen, DO - Virginia Beach
Molly Vorster, MD, PhD - Winchester

Student

Jeffrey Burket - Charlottesville
William Dameron - Richmond
Stephen Hunter - Louisville
Stephen Kirshenbaum - Norfolk
Lauren Kostelnik - Norfolk
Joanna Lim - Norfolk
Lin Lu - Germantown
Crystal Shrestha - Gaithersburg
Stephanie Wilson - Elwood

Virginia Academy of Family Physicians
Board of Directors Meeting

Wintergreen Resort • Wintergreen, VA

Approved a motion to accept the minutes from the November 4, 2006 VAFP Board of Directors meeting held in New Kent, Virginia.

Heard informational report from Drs. Danny Felty and Neal Carl and Mr. Tom Blue from Vital Data, LLC.

Approved a motion to approve the VAFP 2007 Budget and the VAFP revised President's Funding Policy.

Heard report from VAFP CME Chair, Mitch Miller, MD, on the 2007 VAFP Winter Family Medicine Weekend held February 2-4, 2007 at Wintergreen Resort. Dr. Miller also reported on the plans and programming for the VAFP Summer Meeting Scheduled August 9-12, 2007 at The Homestead Resort.

Heard report from VAFP Practice Redesign and Quality Task Force Co-Chair, Kurt Elward, MD, MPH, on the plans and programming of the 2007 VAFP Self Assessment Module Group Learning sessions. Dr. Elward also reported that a schedule of events will be mailed to all VAFP active members in March 2007.

Heard report from VAFP Legislative Committee Chair, Sterling Ransone, MD and VAFP Lobbyist Mr. Seth Ginther on the activities at the 2007 Virginia General Assembly. Mr. Ginther reported that the Academy is focusing on grassroots efforts at the 2007 GA including introductions of the family physician of the day to his/her legislator to build relationships. These efforts include developing a database of members and their legislators for future communications. Mr. Ginther reported that he attends all healthcare related committee meetings and will update the Academy on issues as they arise.

Heard report from the VAFP Practice Redesign and Quality Task Co-Chair Tony Kuzel, MD, on the feedback from the Learning Better Together! session at the 2007 Winter Family Medicine Weekend.

Heard membership report from VAFP President Wayne Reynolds, DO, noting that the VAFP tied for 2nd place with the Florida AFP for having the largest percentage increase in the active member category for chapters with over 1,000 active members.

Heard report from VAFP Secretary, Roger Hofford, MD on the approval of a new medical school in Roanoke. He noted it will be a five year program for 40 students per year with a priority of focusing on academic research.

Heard reports from VAFP Members serving on AAFP Commissions: Dr. Kurt Elward – Commission on Science and Dr. Wayne Reynolds – Commission on Continuing Professional Development.

Heard report from Mitch Miller, MD on his national meeting with Anthem.

Approved a motion to request dialogue with Anthem on behalf of the Academy to provide grave concern over their new P4P product.

Heard reports from VAFP Student and Resident Board members.

DMAS IS IN THE FINAL PHASE OF NPI RE-ENROLLMENT

The Department of Medical Assistance Services (DMAS) is in the final phase of National Provider Identifier (NPI) Re-Enrollment. Most providers have responded and are ready to begin using their NPI on all transactions. However, there are still a significant number of providers who have not responded to requests for their NPI. Beginning on May 23, 2007, DMAS will DENY all claims received from providers who have not re-enrolled with their NPI!

If providers need assistance, or need a replacement NPI Re-Enrollment packet, don't wait! Call the Provider Enrollment Unit today at 1-888-829-5373 (In-state toll free) or 1-804-270-5105 (Outside Virginia).

There are new documents outlining several helpful DMAS NPI Scenarios as well as the DMAS position on Healthcare Provider Subparts and Taxonomy Codes available on the DMAS NPI Web Page. To view these documents, go to http://www.dmas.virginia.gov/npi-home_page.htm and select "What's New".

Please visit http://www.dmas.virginia.gov/LN-upcoming_events.htm for upcoming DMAS Training Sessions and interactive "WebEx" Webcast Question and Answer sessions.

Getting an NPI is Free – Not sharing it with DMAS can be Costly!

2007 HEALTH CARE LEGISLATION

BY M. SETH GINTHER, HF CONSULTING, LLC

The 2007 General Assembly adjourned on February 24. While the big issues keeping legislators busy during this Session related mainly to transportation and the budget, there still was a fair amount of legislative activity in health care. This summary describes many of the bills that passed both houses of the General Assembly and are before the Governor for his signature, budget issues, some notable health care legislation that was not reported from committee, and identifies several hot button issues for the 2008 Session. It's important that all 140 members of the General Assembly are up for re-election this November. Many face primary challenges as well as tough races in the general election. Accordingly, the makeup of the General Assembly likely will change next year.

VAFP President Wayne J. Reynolds, DO, and VAFP Past President Cynthia C. Romero, MD greet Virginia Governor Timothy Kaine at the 2007 MSV Legislative Reception.

LEGISLATION THAT PASSED

HPV vaccine (HB 2035). HB 2035 may have significant impact on family medicine. This bill requires females to receive three doses of properly spaced human papillomavirus (HPV) vaccine. The first dose shall be administered before the child enters the sixth grade. After having reviewed materials describing the link between the human papillomavirus and cervical cancer approved for such use by the Board of Health, a parent or guardian may elect for his daughter not to receive this vaccine.

Notably, this bill contains a delayed effective date of October 1, 2008, which means that it will not effect sixth grade females until the fall of 2009. This timeline also allows the 2008 and 2009 legislative sessions to make changes if issues arise concerning the legislation. If Governor Kaine signs the bill, the VAFP will actively monitor the state mandated procedures for implementation of this vaccine and voice concerns over how that implementation may negatively impact family medicine. This legislation was sponsored in the House of Delegates by Delegate Phil Hamilton, R-Newport News, who chairs the Health, Welfare and Institutions Committee.

Similar measures are in the process of working their way through the legislative process in other states. Texas was the first with an HPV vaccine mandate based on an Executive Order signed by Texas Governor Rick Perry earlier this year.

Board of Medicine disciplinary procedure (HB 2157). This bill requires the Board of Medicine to make available via any department website information regarding any final orders together with any associated notices that impose disciplinary action against a licensee of the Board. It prohibits the Board from posting notices that have not been adjudicated and provides that notices and orders that do not result in disciplinary action may be removed upon written request of the licensee. It also limits information regarding claims provided to consumers to medical malpractice judgments and settlements of more than $10,000 within the most recent 10 year period. Finally, it changes the requirement that the Board assess competency of a person on whose behalf three medical malpractice claims are paid within a 10 year period to a requirement that the Board assess the competency of a person on whose behalf three medical malpractice settlements of more than $10,000 are paid within the most recent 10 year period. The legislation was patroned by Delegate John O'Bannon, R-Henrico.

Authority to send laboratory test results directly to patients (HB 3061). This bill allows any health care practitioner licensed pursuant to Title 54.1 who orders a laboratory test or other examination of the physical condition of any person, if so requested by the patient or his legal guardian, to inform the laboratory or other facility conducting the test or examination to provide a copy of the report of the results directly to the patient or his legal guardian. The legislation was carried by Delegate Jeff Frederick, R Prince William.

Expert Witness Certification, Medical Malpractice (HB 2415). This bill clarifies that, when the plaintiff in a medical malpractice case requests service of process or requests the defendant to accept service of process, he certifies that he has obtained an expert opinion that the defendant physician deviated from the applicable standard of care. However, the certifying expert's identity or qualifications are not discoverable. The legislation was sponsored by Delegate Athey, R-Front Royal.

Restaurants; smoking prohibited; penalties (HB 2422). This bill prohibits smoking in restaurants in Virginia unless a restaurant posts signs stating "Smoking Permitted". The sign must be conspicuous to ordinary public view at each public entrance. This legislation was sponsored by House of Delegates Majority Leader Morgan Griffith, R-Salem. He claims the bill would encourage more restaurants to go smoke-free while also respecting private-property rights. Public health groups opposed the bill because it eliminates the requirement that restaurants with more than 50 seats have nonsmoking sections.

Privileged communications; physician peer review and physician accreditation entities (HB 3090). This bill clarifies that privilege attaches to the proceedings, minutes, records, and reports of a quality assurance, quality of care, or peer review committee of a national or state physician peer review entity or physician accreditation entity. The legislation was sponsored by Delegate Albo, R-Springfield.

The legislation summarized above now is before Governor Kaine for his consideration to be vetoed

CONTINUED ON PAGE 10

Jenny Sharp-Warthan, MD
Chair, VAFP Insurance & Managed Care Committee

United Healthcare

United Healthcare has made the AAFP aware of the following policies for its health plans effective 1/1/2007 - all laboratory services are to be performed at Labcorp laboratories. This includes clinical labs as well as pathology specimens. Quest Diagnostics which used to have a relationship with United is no longer a participating laboratory. If you are unaware of a Labcorp facility in your area, please contact United Healthcare.

You should also be aware that after March 1st, any physicians using laboratory services from anyone other than Labcorp may receive anything from a fine to termination from the plan. You will also be contacted soon if not already for United Healthcare's move towards Electronic Claims and Payment Submission. Virginia is slated to have live sessions in March to communicate how this will be implemented. According to what they have provided us, this would be put in place by October 2007.

Finally, if you have a facility you use or have ownership, the American College of Radiology has issued a bulletin stating that effective 3/1/2008 United Healthcare will mandate that facilities that do CT, MRI, and other imaging modalities will have to have some type of accreditation. If the facility does not, the procedure will be denied for payment.

Physician Quality Reporting Initiative

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2007 Physician Quality Reporting Initiative (PQRI) webpage is now available.

On December 20, 2006 the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by CMS. CMS has titled the statutory program the 2007 Physician Quality Reporting Initiative.

PQRI establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. Eligible professionals who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for covered Medicare physician fee schedule services.

This newly established webpage will be updated regularly, so check it often for timely and reliable information from CMS.

For more information on 2007 PQRI, visit http://www.cms.hhs.gov/pqri/ on the CMS website.

Anthem – HEDIS Measures

Physician offices will be contacted on behalf of Anthem between 3/1/07 and 5/31/07 by an independent group to gather information for HEDIS measurements. Offices will be given the patient's name prior to their visit so charts can be pulled. Those physicians who have 5 or fewer charts will submit the patient information by way of fax. The measurements are as follows.

HEDIS® information will be requested for HealthKeepers, Inc., Peninsula Health Care, Inc., or Priority Health Care, Inc. patients. According to the HIPAA Privacy Rule (CFR 160, 164) amended August 14, 2002, health care providers can disclose protected health information (PHI) to health plans for the purpose of quality assurance, quality improvement, and accreditation activities. HEDIS® data collection is included as a quality improvement and accreditation initiative. ***Providers are permitted to disclose PHI to health plans for HEDIS® data collection without authorization from the patient when both the provider and health plan had a relationship with the patient and the information relates to that relationship*** **(45 C.F.R. 164.506(c) (4)). The following table outlines the information being requested for each HEDIS® measure.**

continued on page 18

Thank You…

to the Family Physician of the Day Volunteers

A special thank you goes out to all the physicians that participated in the Family Physician of the Day program during the 2007 Virginia General Assembly. The Academy also appreciates VCU Medical Center's help with nursing staff in the clinic. The Academy encourages all physicians to become involved legislatively in state and national issues.

Margaret Adeniji, MD
Margaret Baumgarten, MD
Craig C. Clark, MD
David Anthony Clark, MD
David Clevenson, MD
Frank Dennehy, MD
B. Kent Diduch, MD
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Terence McCormally, MD
Susan Miller, MD
Thomas Powers, MD
James Rodman, MD
Mark Ryan, MD
James Thompson, MD
Walter Scott Waugh, MD
John Witman, MD

continued from page 8

or amended. If the Governor does sign these bills, they become effective on July 1, 2007 (with the exception of the HPV vaccine bill, which would become law October 1, 2008).

BUDGET AMENDMENTS

The Commonwealth of Virginia operates on a biennial budget. The first year of the current biennium began on July 1, 2006 and ends June 30, 2007. The second year of the current biennium begins July 1, 2007 and ends June 30, 2008. The Governor's budget amendments considered in the 2007 Session, as well as any amendments made to them by the General Assembly, will take effect July 1, 2007 for the second year of the current biennium.

Governor Kaine's budget amendments introduced in the 2007 General Assembly Session included a $5.2 million allocation from the General Fund for a seven percent increase for pediatric services during the second year of the current biennium. The General Assembly amended that budget allocation, reducing $1.5 million in the second year from the General Fund and $1.8 million from matching funds for the rate increase for pediatric services. By doing so, the General Assembly amendment provides an increase for Medicaid and FAMIS physician payment rates of two percent beginning July 1, 2007, including pediatric services.

The net effect of the General Assembly amendment is a two percent increase in pediatric services reimbursements (for a net increase of ten percent) and the rates for all other physician services (except OB/GYN) will increase by two percent (from three percent to five percent) beginning July 1, 2007.

LEGISLATION THAT FAILED

Although defeated in the 2007 Session, the bills described below have the potential to be issues again next year.

Payment for health care costs of prisoners (HB 2034). This legislation would have required that payment by local and state correctional facilities for costs incurred for health care for prisoners not exceed the lesser of the amount that would be paid under Medicare or Medicaid. Currently, physicians and hospitals negotiate directly with local and state correctional facilities on rates. This bill was sponsored by Delegate Hamilton, R-Newport News.

Joint payment of health insurance claims (HB 2562). This legislation would have required every health insurer, health services plan, or health maintenance organization, when paying a claim for services rendered by a health care provider that does not participate in the provider panel, to pay the claim by sending a check made payable to both the insured, subscriber, or member and to the nonparticipating health services provider. It was defeated in the House Commerce and Labor Committee on a 12-9 vote and sponsored by Delegate Ware, R-Powhatan.

ON THE HORIZON

Two issues have the potential to be at the center of debate in the health care arena during the 2008 General Assembly Session. Virginia's medical malpractice cap is set to reach its legal maximum of $2 million in 2008. Accordingly, there is speculation that legislation will be introduced in the 2008 session that would seek either elimination of the cap, or at a minimum, further increase in the cap. In addition, the Virginia Birth-Related Neurological Injury Program stakeholders group will continue its facilitated discussions throughout the 2007 calendar year with an objective of developing recommendations for legislation for the 2008 session to address issues now faced by the Program. The VAFP will keep members posted as these two issues continue to develop throughout the year and the possible impacts of both issues on family medicine.

FYI...

UNCLAIMED PROPERTY REPORT REQUIRED BY STATE LAW

Although it's not a new law, you may have overlooked it. And, if you did overlook it, it may cost you. It's the Uniform Disposition of Unclaimed Property Act. This law requires holders of "unclaimed property" to file annual reports with, and deliver the property to, the State Treasurer. "Unclaimed property" is defined by Virginia law as property for which the owner, as shown by the records of the holder of the property, has ceased, failed, or neglected within a specified period of time to make presentment or demand for payment and satisfaction, or to do any other act in relation to or concerning such property.

Unclaimed property includes without limitation savings and checking accounts, wages or commissions, underlying shares, dividends, customer deposits, refund checks, insurance proceeds, and the like. Types of unclaimed property that commonly are found in medical offices and hospitals include:

- patient and insurance outstanding refund checks
- patient account credit balances
- credit balance write-offs
- outstanding payroll checks
- employee benefits
- outstanding accounts payable checks
- unapplied or unidentified receipts

The length of time that property may remain on the books or in possession of the holder before it is declared "unclaimed property" is the dormancy period. After the passage of the dormancy period with no activity, the property is presumed to be abandoned and is reportable to the State Treasurer. The dormancy period ranges from one to fifteen years, depending on the type of property. For instance, the dormancy period for unnegotiated payroll checks is one year. The dormancy period for credit balances is five years.

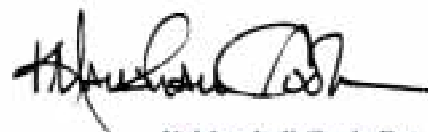
Reporting of unclaimed property to the State Treasurer is required every year by November 1 for the immediately preceding annual reporting period ending on June 30. There is no amount of unclaimed property that is too small to include in the annual report. The reporting process is fairly complex, and there are significant penalties for the failure to file annual unclaimed property reports.

A holder who does not file an annual report may be subject to penalties and interest. The failure to perform due diligence required by the Act (that is, attempt to locate the owner of the property) could result in a civil penalty of up to $50 for each account on which due diligence was not performed. A holder who fails to report, pay or deliver property within the time prescribed by the Act may be subject to a civil penalty of $100 for each day the report, payment or delivery is withheld, up to a maximum of the lesser of $10,000 or twenty-five percent of the value of the property that should have been reported. If the failure to report is determined to be willful, the maximum civil penalty increases to the lesser of $50,000 or one-hundred percent of the value of the property that should have been reported.

The State Treasurer also may require the holder to pay interest on the property or value of property that should have been delivered to the Department of the Treasury, which currently is at a rate of eight percent. If a holder fails to file an annual report, the State Treasurer has ten years following the date on which such property first became reportable to maintain an action or proceeding against the holder. If a holder never has filed a report, however, the Treasurer may examine property presumed abandoned for report year 1985 and subsequent years.

Filing an unclaimed property report each year is something that easily could escape the attention of a medical group administrator or practice manager. The penalties for failure to file the report, however, are significant. Family physicians and their medical groups should contact their accountants or attorneys for advice concerning the statutory requirements for filing unclaimed property reports. A detailed summary of the Act's requirements, including reporting forms and instructions, may be found on the VAFP's web site at www.vafp.org.

FYI... is a summary of health care market information that will appear regularly in the Virginia Family Physician. Although it is written by the Academy's General Counsel, it is not legal advice. The Academy and I hope its contents will be informative and helpful in your medical practice.



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Increased Vaccination Coverage May Counteract Rising Reports of Pertussis

Did you know that reports of pertussis, commonly called *whooping cough*, have been rising in the United States (US) for years,[1] reaching a 45-year high of more than 25,000 reported cases in 2004?[2] These statistics show that, although pertussis is a vaccine-preventable disease, it remains a highly contagious health threat—one that poses serious consequences for infants who are too young to be fully immunized.[2]

Until recently, there were only pertussis vaccines for infants and young children. Fortunately, in 2005 the Food and Drug Administration licensed 2 combination tetanus/diphtheria/acellular pertussis (**Tdap**) booster vaccines to provide *adolescents and adults* with protection against pertussis.[3] Only one of these, **ADACEL®** (Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine), is licensed for *both* adolescents and adults.

To provide further protection against pertussis, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention has voted to recommend that adolescents 11-18 years of age and adults 19-64 years of age receive a single dose of **Tdap** vaccine in place of a single dose of tetanus/diphtheria (Td) booster vaccine.[3] When there are multiple cases of pertussis in a household, older persons are often found to have the initial case; **ADACEL** vaccine provides adolescents and adults with protection against pertussis, which may help reduce the spread of the disease to vulnerable infants.

Physicians like knowing that **ADACEL** vaccine can be used concomitantly with hepatitis B and influenza vaccines and that it has a safety profile comparable to Td vaccine in both adolescents and adults.

ACIP also has voted to recommend that health-care personnel (HCP) who have direct patient contact should receive a single dose of **Tdap** booster (if they have not previously done so) as soon as feasible, especially those who have direct contact with infants less than 12 months of age. Pertussis infection has a greater impact on infants than other age groups. Most young infants with pertussis still must be hospitalized, and some cases can be fatal.[4] From 2001-2003, 91% of the reported deaths in the US from pertussis were among infants younger than 6 months of age and 75% were among infants younger than 2 months of age.[2]

Why are reports of pertussis increasing?

There are a few factors contributing to the increase in reported pertussis cases:

- Immunity to pertussis "wears off" over time, approximately 5-10 years after completing the childhood vaccination series, so adolescents and adults who think they have immunity can still be susceptible to pertussis and may transmit pertussis to infants[1]
- Adolescents and adults tend to have milder forms of pertussis, or even be asymptomatic; but those who develop even mild pertussis disease may still transmit the organism to unimmunized or underimmunized infants

One study to determine the source of infant pertussis found that, among 264 cases of infant pertussis infection with a known or suspected source, *75% of the sources were family members and 32% were mothers.**[4] These results demonstrate the need to reduce infant pertussis infection by emphasizing immunization of adolescents and adults.

*It is unknown whether immunizing adolescents and adults against pertussis will reduce the risk of transmission to infants.

ADACEL recommendations for adolescents, adults, and HCP

ACIP has voted to recommend **ADACEL** vaccine for new mothers and those adolescents and adults who are in close contact with infants less than 12 months of age.[3] Specific finalized or provisional recommendations for immunization beyond the completed diphtheria/tetanus/pertussis (DTP) or diphtheria/tetanus/acellular pertussis (DTaP) childhood vaccination series include:

- A single dose of **Tdap** vaccine for *adolescents* 11-18 years of age instead of Td for those who have yet to receive a Td booster[1]
- A single dose of **Tdap** vaccine for *adults* 19-64 years of age instead of a Td booster; the **Tdap** dose is recommended if it has been more than 10 years since the last Td booster, but shorter intervals after Td vaccine are acceptable[3]

ACIP also recommends that HCP make sure that their *own* vaccinations are up-to-date, as are those of any family members in contact with infants (especially new mothers) and that all infants have completed their childhood vaccination series. Remember to immunize not only the child but all close contacts as well.

To help reduce the spread of pertussis to vulnerable infants, HCP and their organizations should develop campaigns to raise awareness among new mothers and their families about the importance of **Tdap** vaccine. Through the commitment of HCP, plus the availability of **Tdap** vaccines, the standard of care for providing protection against pertussis in the US is being redefined.

ADACEL

Safety Information

ADACEL vaccine is indicated for active booster immunization for the prevention of tetanus, diphtheria, and pertussis as a single dose in persons 11 through 64 years of age.

As with any vaccine, ADACEL vaccine may not protect 100% of vaccinated individuals. There are risks associated with all vaccines. The most common local adverse events include injection site pain, erythema, and injection site swelling. The most common systemic adverse events include headache, body ache, tiredness, and fever. ADACEL vaccine is contraindicated in persons with known systemic hypersensitivity to any component of the vaccine or a life-threatening reaction after previous administration of the vaccine or a vaccine containing the same substances. Because of uncertainty as to which component of the vaccine may be responsible, no further vaccination with the diphtheria, tetanus, or pertussis components found in ADACEL vaccine should be carried out. Because intramuscular injection can cause injection site hematoma, ADACEL vaccine should not be given to persons with any bleeding disorder, such as hemophilia or thrombocytopenia, or to persons on anticoagulant therapy unless the potential benefits clearly outweigh the risk of administration. If the decision is made to administer ADACEL vaccine to such persons, it should be given with caution, with steps taken to avoid the risk of hematoma formation following injection.

Before administering ADACEL vaccine, please see accompanying full Prescribing Information.

References: 1. Centers for Disease Control and Prevention (CDC). Preventing tetanus, diphtheria, and pertussis among adolescents: use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR*. 2006;55(RR-3):1-44. **2.** CDC. Pertussis. In: Atkinson W, Hamborsky J, McIntyre L, Wolfe C, eds. *Epidemiology and Prevention of Vaccine-Preventable Diseases. The Pink Book*. 9th ed. Washington, DC: Public Health Foundation; 2006:79-96. **3.** CDC. National Immunization Program. ACIP votes to recommend use of combined tetanus, diphtheria and pertussis (Tdap) vaccine for adults (Advisory Committee on Immunization Practices): March 2, 2006. Available at: http://www.cdc.gov/nip/vaccine/tdap/tdap_adult_recs.pdf. Accessed August 23, 2006. **4.** Bisgard KM, Pascual FB, Ehresmann KR, et al. Infant pertussis: who was the source? *Pediatr Infect Dis J*. 2004;23:985-989.

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Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine Adsorbed ADACEL™

℞ only

Brief Summary: Please see package insert for full prescribing information

INDICATIONS AND USAGE ADACEL vaccine is indicated for active booster immunization for the prevention of tetanus, diphtheria and pertussis as a single dose in persons 11 through 64 years of age. The use of ADACEL vaccine as a primary series, or to complete the primary series, has not been studied. See DOSAGE AND ADMINISTRATION for use in tetanus prophylaxis in wound management. ADACEL vaccine is not indicated for the treatment of *B pertussis, C diphtheriae* or *C tetani* infections. As with any vaccine, ADACEL vaccine may not protect 100% of vaccinated individuals.

CONTRAINDICATIONS Known systemic hypersensitivity to any component of ADACEL vaccine or a life-threatening reaction after previous administration of the vaccine or a vaccine containing the same substances are contraindications to vaccination with ADACEL vaccine. Because of uncertainty as to which component of the vaccine may be responsible, additional vaccinations with the diphtheria, tetanus or pertussis components should not be administered. Alternatively, such individuals may be referred to an allergist for evaluation if further immunizations are to be considered. The following events are contraindications to administration of any pertussis containing vaccine: (1)

- Encephalopathy not attributable to another identifiable cause within 7 days of administration of a previous dose.
- Progressive neurological disorder, uncontrolled epilepsy, or progressive encephalopathy. Pertussis vaccine should not be administered to individuals with these conditions until a treatment regimen has been established, the condition has stabilized, and the benefit clearly outweighs the risk.

ADACEL vaccine is not contraindicated for use in individuals with HIV infection. (1)

WARNINGS Because intramuscular injection can cause injection site hematoma, ADACEL vaccine should not be given to persons with any bleeding disorder, such as hemophilia or thrombocytopenia, or to persons on anticoagulant therapy unless the potential benefits clearly outweigh the risk of administration. If the decision is made to administer ADACEL vaccine in such persons, it should be given with caution, with steps taken to avoid the risk of hematoma formation following injection. (1) If any of the following events occurred in temporal relation to previous receipt of a vaccine containing a whole-cell pertussis (eg. DTP) or an acellular pertussis component, the decision to give ADACEL vaccine should be based on careful consideration of the potential benefits and possible risks: (2) (3)

- Temperature of ≥40.5°C (105°F) within 48 hours not due to another identifiable cause;
- Collapse or shock-like state (hypotonic-hyporesponsive episode) within 48 hours;
- Persistent, inconsolable crying lasting ≥3 hours, occurring within 48 hours;
- Seizures with or without fever occurring within 3 days.

When a decision is made to withhold pertussis vaccine, Td vaccine should be given. Persons who experienced Arthus-type hypersensitivity reactions (eg., severe local reactions associated with systemic symptoms) (4) following a prior dose of tetanus toxoid usually have high serum tetanus antitoxin levels and should not be given emergency doses of tetanus toxoid-containing vaccines more frequently than every 10 years, even if the wound is neither clean nor minor. (4) (5) If Guillain-Barré Syndrome occurred within 6 weeks of receipt of prior vaccine containing tetanus toxoid, the decision to give subsequent doses of ADACEL vaccine or any vaccine containing tetanus toxoid should be based on careful consideration of the potential benefits and possible risks. (1) The decision to administer a pertussis-containing vaccine to individuals with stable central nervous system (CNS) disorders must be made by the health-care provider on an individual basis, with consideration of all relevant factors and assessment of potential risks and benefits for that individual. The ACIP has issued guidelines for immunizing such individuals. (2) A family history of seizures or other CNS disorders is not a contraindication to pertussis vaccine. (2) The ACIP has published guidelines for vaccination of persons with recent or acute illness. (1)

PRECAUTIONS General Do not administer by intravascular injection: ensure that the needle does not penetrate a blood vessel. ADACEL vaccine should not be administered into the buttocks nor by the intradermal route, since these methods of administration have not been studied; a weaker immune response has been observed when these routes of administration have been used with other vaccines. (1) The possibility of allergic reactions in persons sensitive to components of the vaccine should be evaluated. Epinephrine Hydrochloride Solution (1:1,000) and other appropriate agents and equipment should be available for immediate use in case an anaphylactic or acute hypersensitivity reaction occurs. Prior to administration of any dose of ADACEL vaccine, the vaccine recipient and/or the parent or guardian must be asked about personal health history, including immunization history, current health status and any adverse event after previous immunizations. In persons who have a history of serious or severe reaction within 48 hours of a previous injection with a vaccine containing similar components, administration of ADACEL vaccine must be carefully considered. The ACIP has published guidelines for the immunization of immunocompromised individuals. (6) Immune responses to inactivated vaccines and toxoids when given to immunocompromised persons may be suboptimal. (1) The immune response to ADACEL vaccine administered to immunocompromised persons (whether from disease or treatment) has not been studied. A separate, sterile syringe and needle, or a sterile disposable unit, must be used for each person to prevent transmission of blood borne infectious agents. Needles should not be recapped but should be disposed of according to biohazard waste guidelines.

Information for Vaccine Recipients and/or Parent or Guardian Before administration of ADACEL vaccine, health-care providers should inform the vaccine recipient and/or parent or guardian of the benefits and risks. The health-care provider should inform the vaccine recipient and/or parent or guardian about the potential for adverse reactions that have been temporally associated with ADACEL vaccine or other vaccines containing similar components. The vaccine recipient and/or parent or guardian should be instructed to report any serious adverse reactions to their health-care provider. Females of childbearing potential should be informed that Aventis Pasteur Inc. maintains a pregnancy registry to monitor fetal outcomes of pregnant women exposed to ADACEL vaccine. If they are pregnant or become aware they were pregnant at the time of ADACEL vaccine immunization, they should contact their health-care professional or Aventis Pasteur Inc. at 1-800-822-2463 (1-800-VACCINE). The health-care provider should provide the Vaccine Information Statements (VISs) that are required by the National Childhood Vaccine Injury Act of 1986 to be given with each immunization. The US Department of Health and Human Services has established a Vaccine Adverse Event Reporting System (VAERS) to accept all reports of suspected adverse events after the administration of any vaccine, including but not limited to the reporting of events required by the National Childhood Vaccine Injury Act of 1986. (7) The toll-free number for VAERS forms and information is 1-800-822-7967 or visit the VAERS website at http://www.fda.gov/cber/vaers/vaers.htm.

Drug Interactions Immunosuppressive therapies, including irradiation, antimetabolites, alkylating agents, cytotoxic drugs and corticosteroids (used in greater than physiologic doses), may reduce the immune response to vaccines. (See PRECAUTIONS, General.) For information regarding simultaneous administration with other vaccines refer to the ADVERSE REACTIONS and DOSAGE AND ADMINISTRATION sections.

Carcinogenesis, Mutagenesis, Impairment of Fertility No studies have been performed with ADACEL vaccine to evaluate carcinogenicity, mutagenic potential, or impairment of fertility.

Pregnancy Category C Animal reproduction studies have not been conducted with ADACEL vaccine. It is also not known whether ADACEL vaccine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. ADACEL vaccine should be given to a pregnant woman only if clearly needed. Animal fertility studies have not been conducted with ADACEL vaccine. The effect of ADACEL vaccine on embryo-fetal and pre-weaning development was evaluated in two developmental toxicity studies using pregnant rabbits. Animals were administered ADACEL vaccine twice prior to gestation, during the period of organogenesis (gestation day 6) and later during pregnancy on gestation day 29, 0.5 mL/rabbit/occasion (a 17-fold increase compared to the human dose of ADACEL vaccine on a body weight basis), by intramuscular injection. No adverse effects on pregnancy, parturition, lactation, embryo-fetal or pre-weaning development were observed. There were no vaccine related fetal malformations or other evidence of teratogenesis noted in this study. (8)

Pregnancy Registry Health-care providers are encouraged to register pregnant women who receive ADACEL vaccine in Aventis Pasteur Inc.'s vaccination pregnancy registry by calling 1-800-822-2463 (1-800-VACCINE).

Nursing Mothers It is not known whether ADACEL vaccine is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when ADACEL vaccine is given to a nursing woman.

Pediatric Use ADACEL vaccine is not indicated for individuals less than 11 years of age. (See INDICATIONS AND USAGE.) For immunization of persons 6 weeks through 6 years of age against diphtheria, tetanus and pertussis, a Diphtheria and Tetanus Toxoids and Acellular Pertussis Vaccine Adsorbed (DTaP) may be used, unless otherwise contraindicated.

Geriatric Use ADACEL vaccine is not indicated for individuals 65 years of age and older. No data are available regarding the safety and effectiveness of ADACEL vaccine in individuals 65 years of age and older as clinical studies of ADACEL vaccine did not include subjects in the geriatric population.

ADVERSE REACTIONS The safety of ADACEL vaccine was evaluated in 4 clinical studies. A total of 5,841 individuals 11-64 years of age inclusive (3,393 adolescents 11-17 years of age and 2,448 adults 18-64 years) received a single booster dose of ADACEL vaccine. The principal safety study was a randomized, observer blind, active controlled trial that enrolled participants 11-17 years of age (ADACEL vaccine N = 1,184; Td vaccine N = 792) and 18-64 years of age (ADACEL vaccine N = 1,752; Td vaccine N = 573). Study participants had not received tetanus or diphtheria containing vaccines within the previous 5 years. Observer blind design, ie, study personnel collecting the safety data differed from personnel administering the vaccines, was used due to different vaccine packaging (ADACEL vaccine supplied in single dose vials; Td vaccine supplied in multi-dose vials). Solicited local and systemic reactions were monitored daily for 14 days post-vaccination using a diary card. Participants were monitored for 28 days for adverse events which were not specifically queried on the diary card, ie, unsolicited adverse events, and for 6 months post-vaccination for visits to an emergency room, unexpected visits to an office physician, hospitalization and serious adverse events. Unsolicited adverse event information was obtained either by telephone interview or at an interim clinic visit. Information regarding adverse events that occurred in the 6 month post-vaccination time period was obtained via a scripted telephone interview. Approximately 96% of participants completed the 6-month follow-up evaluation. In the concomitant vaccination study with ADACEL and Hepatitis B vaccines, local and systemic adverse events were monitored daily for 14 days post vaccination using a diary card. Local adverse events were only monitored at site/arm of ADACEL vaccine administration. Unsolicited reactions (including immediate reactions, serious adverse events and events that elicited seeking medical attention) were collected at a clinic visit or via telephone interview for the duration of the trial, ie, up to six months post-vaccination. In the concomitant vaccination study with ADACEL vaccine and trivalent inactivated influenza vaccines (see Clinical Studies for description of study design and number of participants), local and systemic adverse events were monitored for 14 days post vaccination using a diary card. All unsolicited reactions occurring through day 14 were collected. From day 14 to the end of the trial, ie, up to 84 days, only events that elicited seeking medical attention were collected. Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a vaccine cannot be directly compared to rates in the clinical trials of another vaccine and may not reflect the rates observed in practice. The adverse reaction information from clinical trials does, however, provide a basis for identifying the adverse events that appear to be related to vaccine use and for approximating rates of those events.

Serious Adverse Events in All Safety Studies Throughout the 6-month follow-up period in the principal safety study, serious adverse events were reported in 1.5% of ADACEL vaccine recipients and 1.4% in Td vaccine recipients. Two serious adverse events in adults were neuropathic events that occurred within 28 days of ADACEL vaccine administration; one severe migraine with unilateral facial paralysis and one diagnosis of nerve compression in neck and left arm. Similar or lower rates of serious adverse events were reported in the other trials and there were no additional neuropathic events reported.

Solicited Adverse Events in the Principal Safety Study The frequency of selected solicited adverse events (erythema, swelling, pain and fever) occurring during Days 0-14 following one dose of ADACEL vaccine or Td vaccine were reported at a similar frequency in both groups. Few participants (<1%) sought medical attention for these reactions. Pain at the injection site was the most common adverse reaction occurring in 62-78% of all vaccines. In addition, overall rates of pain were higher in adolescent recipients of ADACEL vaccine compared to Td vaccine recipients. Rates of moderate and severe pain in adolescents did not significantly differ between the two groups. Rates of pain did not significantly differ for adults. Fever of 38°C and higher was uncommon, although in the adolescent age group, it occurred significantly more frequently in ADACEL vaccine recipients than Td vaccine recipients. (8) The rates of other local and systemic solicited reactions occurred at similar rates in ADACEL vaccine and Td vaccine recipients in the 3 day post-vaccination period. Most local reactions occurred within the first 3 days after vaccination (with a mean duration of less than 3 days). Headache was the most frequent systemic reaction and was usually of mild to moderate intensity.

Adverse Events in the Concomitant Vaccine Studies

Local and Systemic Reactions when Given with Hepatitis B Vaccine The rates reported for fever and injection site pain (at the ADACEL vaccine administration site) were similar when ADACEL and Hep B vaccines were given concurrently or separately. However, the rates of injection site erythema (23.4% for concomitant vaccination and 21.4% for separate administration) and swelling (23.9% for concomitant vaccination and 17.9% for separate administration) at the ADACEL vaccine administration site were increased when co-administered. Swollen and/or sore joints were reported by 22.5% for concomitant vaccination and 17.9% for separate administration. The rates of generalized body aches in the individuals who reported swollen and/or sore joints were 86.7% for concomitant vaccination and 72.2% for separate administration. Most joint complaints were mild in intensity with a mean duration of 1.8 days. The incidence of other solicited and unsolicited adverse events were not different between the 2 study groups. (8)

Local and Systemic Reactions when Given with Trivalent Inactivated Influenza Vaccine The rates of fever and injection site erythema and swelling were similar for recipients of concurrent and separate administration of ADACEL vaccine and TIV. However, pain at the ADACEL vaccine injection site occurred at statistically higher rates following concurrent administration (66.6%) versus separate administration (60.8%). The rates of sore and/or swollen joints were 13% for concurrent administration and 9% for separate administration. Most joint complaints were mild in intensity with a mean duration of 2.0 days. The incidence of other solicited and unsolicited adverse events were similar between the 2 study groups. (8)

Additional Studies An additional 1,806 adolescents received ADACEL vaccine as part of the lot consistency study used to support ADACEL vaccine licensure. This study was a randomized, double-blind, multi-center trial designed to assess lot consistency as measured by the safety and immunogenicity of 3 lots of ADACEL vaccine when given as a booster dose to adolescents 11-17 years of age inclusive. Local and systemic adverse events were monitored for 14 days post vaccination using a diary card. Unsolicited adverse events and serious adverse events were collected for 28 days post vaccination. Pain was the most frequently reported local adverse event occurring in approximately 80% of all subjects. Headache was the most frequently reported systemic event occurring in approximately 44% of all subjects. Sore and/or swollen joints were reported by approximately 14% of participants. Most joint complaints were mild in intensity with a mean duration of 2.0 days. (8) An additional 962 adolescents and adults received ADACEL vaccine in three supportive Canadian studies used as the basis for licensure in other countries. Within these clinical trials, the rates of local and systemic reactions following ADACEL vaccine were similar to those reported in the four principal trials in the US with the exception of a higher rate (86%) of adults experiencing 'any' local injection site pain. The rate of severe pain (0.8%), however, was comparable to the rates reported in the four principal trials. (8)

Postmarketing Reports In addition to the data from clinical trials, the following adverse events have spontaneously been reported during the commercial use of ADACEL vaccine in other countries. These adverse events have been very rarely reported (<0.01%), however, incidence rates cannot precisely be calculated. The reported rate is based on the number of adverse event reports per estimated number of vaccinated patients. General disorders and administration site conditions: injection site bruising, sterile abscess; skin and subcutaneous tissue disorders: pruritus, urticaria.

Reporting of Adverse Events The National Vaccine Injury Compensation Program, established by the National Childhood Vaccine Injury Act of 1986, requires physicians and other health-care providers who administer vaccines to maintain permanent vaccination records of the manufacturer and lot number of the vaccine administered in the vaccine recipient's permanent medical record along with the date of administration of the vaccine and the name, address and title of the person administering the vaccine. The Act further requires the health-care professional to report to the US Department of Health and Human Services the occurrence following immunization of any event set forth in the Vaccine Injury Table. These include anaphylaxis or anaphylactic shock within 7 days; brachial neuritis within 28 days; an acute complication or sequelae (including death) of an illness, disability, injury, or condition referred to above, or any events that would contraindicate further doses of vaccine, according to this ADACEL vaccine package insert. (7) (9) (10) The US Department of Health and Human Services has established the Vaccine Adverse Event Reporting System (VAERS) to accept all reports of suspected adverse events after the administration of any vaccine. Reporting of all adverse events occurring after vaccine administration is encouraged from vaccine recipients, parents/guardians and the health-care provider. Adverse events following immunization should be reported to VAERS. Reporting forms and information about reporting requirements or completion of the form can be obtained from VAERS through a toll-free number 1-800-822-7967 or visit the VAERS website at http://www.fda.gov/cber/vaers/vaers.htm. (7) (9) (10) Health-care providers should also report these events to Pharmacovigilance Department, Aventis Pasteur Inc., Discovery Drive, Swiftwater, PA 18370 or call 1-800-822-2463 (1-800-VACCINE).

DOSAGE AND ADMINISTRATION ADACEL vaccine should be administered as a single injection of one dose (0.5 mL) by the **intramuscular route.** SHAKE THE VIAL WELL to distribute the suspension uniformly before withdrawing the 0.5 mL dose for administration. Five years should have elapsed since the recipient's last dose of tetanus toxoid, diphtheria toxoid and/or pertussis containing vaccine. For individuals planning to travel to developing countries, a one-time booster dose of ADACEL vaccine may be considered if more than 5 years has lapsed since receipt of the previous dose of diphtheria toxoids, tetanus toxoids or pertussis-containing vaccine. Do NOT administer this product intravenously or subcutaneously.

STORAGE Store between 2° - 8°C (35° - 46°F). DO NOT FREEZE. Discard product if exposed to freezing. Do not use after expiration date.

REFERENCES 1. CDC. General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Family Physicians (AAFP). MMWR 2002;51(RR-2):1-35. **2.** CDC. Pertussis vaccination: Use of acellular pertussis vaccines among infants and young children. Recommendations of the ACIP. MMWR 1997;46(RR-7):1-25. **3.** CDC Update. Vaccine side effects, adverse reactions, contraindications and precautions - recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1996;45(RR-12):1-35. **4.** CDC. Update on adult immunization recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1991;40(RR-12):1-52. **5.** CDC. Diphtheria, tetanus and pertussis: recommendations for vaccine use and other preventive measures. Recommendations of the Immunization Practices Advisory Committee (ACIP). MMWR 1991;40(RR-10):1-28. **6.** CDC. Use of vaccines and immune globulins in persons with altered immunocompetence. Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1993;42(RR-4):1-18. **7.** CDC. Current trends - Vaccine Adverse Event Reporting System (VAERS) United States. MMWR 1990;39(41):730-3. **8.** Data on file at Aventis Pasteur Limited. **9.** CDC. Current trends - national vaccine injury act: requirements for permanent vaccination records and for reporting of selected events after vaccination. MMWR 1988;37(13):197-200. **10.** FDA. New reporting requirements for vaccine adverse events. FDA Drug Bull 1988;18(2):16-8.

Product information as of June 2005
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Notice to Readers: Improved Supply of Meningococcal Conjugate Vaccine, Recommendation to Resume Vaccination of Children Aged 11--12 Years

In January 2005, a tetravalent meningococcal polysaccharide-protein conjugate vaccine (MCV4) (Menactra™, Sanofi Pasteur, Inc., Swiftwater, Pennsylvania) was licensed for use among persons aged 11--55 years. The Advisory Committee on Immunization Practices (ACIP) recommends routine vaccination with MCV4 for children aged 11--12 years at their regular health-care visit and, if not previously vaccinated with MCV4, of adolescents at high-school entry (at approximately age 15 years), of college freshmen living in dormitories, and of other persons at increased risk for meningococcal disease (i.e., military recruits, travelers to areas in which meningococcal disease is hyperendemic or epidemic, microbiologists who are routinely exposed to isolates of Neisseria meningitidis, persons with anatomic or functional asplenia, and persons with terminal complement deficiency) (*1*).

In May 2006, CDC, in consultation with ACIP, the American Academy of Pediatrics, American Academy of Family Physicians, American College Health Association, and Society for Adolescent Medicine, recommended deferral of MCV4 vaccination of children aged 11--12 years in response to vaccine supply limitations (*2*). Currently, Sanofi Pasteur reports that limitations in the MCV4 supply have resolved. Therefore, CDC recommends resuming routine vaccination for all recommended groups according to ACIP recommendations, including children aged 11--12 years and, if not previously vaccinated with MCV4, of adolescents at high-school entry (at approximately age 15 years), of college freshmen living in dormitories, and of other persons at increased risk for meningococcal disease. Where possible, providers who deferred vaccination of children aged 11--12 years should recall those patients for vaccination. Providers who have questions about ordering vaccine may contact Sanofi Pasteur at 1-800-VACCINE or at http://www.vaccineshoppe.com/.

References

1. CDC. Prevention and control of meningococcal disease: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2005;54(No. RR-7):1--21.
2. CDC. Limited supply of meningococcal conjugate vaccine, recommendation to defer vaccination of persons aged 11--12 years. MMWR 2006;55;567--8.

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**Questions or messages regarding errors in formatting should be addressed to mmwrq@cdc.gov.

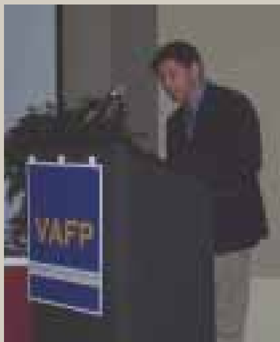
Winter Family Medicine Weekend

Congratulations to the winners of the Exhibit Booth Visitation Prizes awarded at the 2007 Winter Family Medicine Weekend.

Grand Prize – Anke Hacker, MD, Norfolk
(Three night's hotel at The Homestead Resort during the VAFP Annual Meeting scheduled August 9-12, 2007)

First Prize – Michael Cunningham, MD, Lexington
(Complimentary green fees for four players at The Homestead Resort)

Second Prize – James Barton, MD, Williamsburg
(Apple NANO Ipod)



The following organizations provided support of the outstanding continuing medical education program at the 2007 Winter Family medicine Weekend. The VAFP is pleased to acknowledge our "partners" in CME.

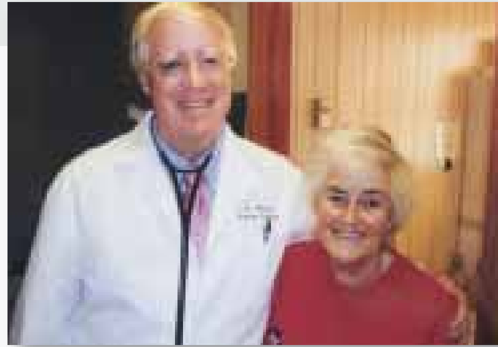
AstraZeneca
Bristol-Myers Squibb
Carilion Health System
Eli Lilly and Company
Forest Pharmaceuticals
GlaxoSmithKline
Pfizer
PhillipsCox Insurance
Sanofi-pasteur
TEVA Neuroscience

The VAFP extends a special thank you to the exhibiting organizations that participated in the 2007 Winter Family Medicine Weekend.

Abbott
AstraZeneca
Boehringer Ingelheim
Centra Health Mental Health Services
e-MDs
Forest Pharmaceuticals
GlaxoSmithKline
KOS Pharmaceuticals
Mag Mutual Insurance
Merck
Novartis
Novo Nordisk
Oscient Pharmaceuticals
Pfizer
PhillipsCox Insurance
PriCara
Pulse Systems, Inc.
Roche
sanofi-aventis
Schering
Schering-Plough Respiratory
Sepracor Pharmaceuticals
Source One Mobility
Takeda Pharmaceuticals
TAP Pharmaceutical
TEVA Specialty Products
UCB Pharma
US Army Healthcare Recruiting
Virginia Health Quality Center
Williamsburg Place & The William J. Farley Center
Wyeth

VAFP Member David Nichols, MD, White Stone

NAMED 2006 COUNTRY DOCTOR OF THE YEAR



Almost 30 years ago, VAFP Member David Nichols, M.D. made a promise to the 600 residents of tiny Tangier Island, an isolated community located in the middle of the Chesapeake Bay. He would visit them once a week, stitching up the lacerations that result from hard work on the water and treating the symptoms of "Tangier Disease," a rare genetic condition found on the island that causes high cholesterol and heart attacks. True to his word, Dr. Nichols has been flying to the island ever since, providing care to descendants of English settlers.

Dr. Nichols was honored by Staff Care as the 2006 Country Doctor of the Year in part for the extraordinary commitment he has shown to an isolated population with a high incidence of medical issues. An airplane and helicopter pilot, Dr. Nichols has flown the 25 miles to Tangier Island once a week for almost 30 years, becoming part of the fabric of life in this unique community where the majority of residents are the descendants of five or six founding families. During his always busy day on the island, Dr. Nichols treats everything from cuts and bruises to respiratory failure. He is literally a life-saver to the islanders, who have embraced him as a care-giver, confidant and friend.

When not flying to the island in his own helicopter, Dr. Nichols runs a thriving family practice in White Stone, Virginia. Before building his practice, Dr. Nichols was the only physician in town, and he continues to serve as the mainstay of primary care in the community. The site of his helicopter rising from the parking lot of his clinic has become a familiar one to residents of White Stone. The 58-year-old physician with "DR COPTR" on the license plate of his car is not about to curtail his visits to Tangier Island, even though weather conditions sometimes make flight a risk.

"I promised to visit the island come hell or high water," Dr. Nichols observes, "and if I can't get there by flight I'll go by boat. I like to go and the islanders have come to depend on me. Besides, who else is going to do it?"

The Tangier Island Health Foundation has been established to raise money for a new clinic on Tangier. In exchange for 2 weeks off with coverage, Dr. Nichols convinced Staff Care to donate the money to the new clinic. Staff Care donated $5,000 to the Tangier Island Health Foundation. If you would like to make a donation to the Tangier Island Health Foundation, please send your check to Tangier Island Health Foundation, P.O. Box 788, Irvington, VA 22480.

Congratulations to Dr. Nichols!

NETWORKING OPPORTUNITIES

- 3rd year FP resident finishing residency program at the University of Minnesota in August 2007. Completed medical school in Bangladesh and has green card. Special interests include women's health, adult health and preventive medicine. Prefers outpatient setting but will also do inpatient. Looking for a medium size practice, employed position close to a metro area. If interested, please contact Aziza Shireen at 651-486-4914 or via e-mail at shafiq_1961@yahoo.com.
- Graduating Family Medicine resident seeking primary care opportunity starting in August 07. Interested in staying in the Northern Virginia/Washington D.C. area. Looking for outpatient practice without OB. Please call 202-494-5424 if interested.
- Graduating third year Family Medicine resident seeking group practice for October 2007 start date. Interests include women's health (excluding OB) and pediatrics, but would like to practice broad scope of medicine. Open to both outpatient and inpatient full-time work in Loudoun County or surrounding areas. If interested, please call Rhodaline Tootell, MD at 610-497-9365 or email rtootell@yahoo.com.
- Hampton Family Practice, Hampton Virginia seeking a family physician to join the group. Independent practice serving Hampton, Newport News, York County and Williamsburg. Seven physicians, three nurse practitioners. New 15,000 sq ft facility. Minor surgery room, BMD machine, in-house lab. No hospital rounds. Excellent compensation and benefits plan. If interested, please contact the practice via e-mail at SallyRyan@cox.net or fax 757-838-6335.

VAFP MEMBERS RECEIVE AAFP DEGREE OF FELLOW

The VAFP congratulates the following members who have achieved the Degree of Fellow of the American Academy of Family Physicians (AAFP). Established in 1971, the AAFP Degree of Fellow recognizes family physicians who have distinguished themselves through service to family medicine and ongoing professional development. This year's fellowship class brings the total number of AAFP Fellows to more than 29,000 nationwide. AAFP Fellowship entitles the Physician to use the honorary designation, "Fellow of the American Academy of Family Physicians," or "FAAFP."

Criteria for receiving the AAFP Degree of Fellow consist of a minimum of six years of membership in the organization, extensive continuing medical education, participation in public service programs outside medical practice, conducting original research and serving as a teacher in family medicine.

James Barton MD
Gregory Bentz MD
John Brady MD
Cesar Caballero MD
Thomas Conage MD
Rebecca Davison MD
Barry Diduch MD
Augustine Dolcich MD
Danny Felty MD
Kevin Fergusson MD
Julie Floyd MD
David Gregory MD
David Harden DO
Cynthia Horner MD
Paul Jackson MD
David Lee MD
Jesus Lizarzaburu MD
Laurie Markin MD
Sheri Marshall MD
Christopher Ryan MD
Donald Soles MD
Alger Southall MD
Bradley Ware MD

Letter of Introduction

Dear Colleagues,

Resource Partners Referral Network would like to introduce to the Virginia Academy of Family Physicians a revolutionary means of generating substantial revenue with little to no out of pocket expenses.

RPRN has partnered with eCast Corporation, which has been providing medical software for nearly 20 years, to jointly develop the technology and methodology to supply clinical research organizations and pharmaceutical companies with large volumes of de-identified, highly accurate and pre-consented clinical trials data. This in turn generates significant revenues for the provider organizations and physician investigators participating in the clinical trials.

As a result, RPRN would like to invite Networks of 30-50 physicians to work with us to equip their medical practices with our turn-key trials program. If interested, you will be entitled to participate in the RPRN eCast Trials System. As a participant in RPRN's electronic clinical trials program, physicians can expect to receive an average payment of $3,000 - $6,500 per patient. Because our trials process is virtually paperless and highly efficient, a typical physician investigator can expect to oversee a minimum of 30 clinical trial patients per year.

The clinical trials program includes a powerful web-based EMR (eCast EMR) for every provider participating in clinical trials. This system is available to you to use within your whole practice and includes as an added value the following features:

- Disease risk management,
- Clinical protocols,
- Pay for performance (P4P),
- Patient health records, and
- Access to RPRN's proprietary web-based Telemed-Video application.

Also, physicians with an existing EMR can participate in the clinical trials program via the RPRN eCast Clinical Data Repository (CDR) interface. RPRN has developed programs for all practices with or without an existing EMR system to benefit their practice and their patients.

Please contact us to schedule a presentation so we may discuss this opportunity further. To contact Resource Partners, please call (843) 572-3525 or visit www.rprn.net.

Sincerely,

Gordon Jones, DHA
RPRN CEO

2007 VAFP AWARDS – SUBMIT YOUR NOMINATION ON-LINE NOW

Nominate your peers for a 2007 VAFP Award! Annually, the VAFP presents the Virginia Family Physician of the Year Award, the F. Elliott Oglesby, M.D., Volunteer of the Year Award and the James P. Charlton, M.D., Teacher of the Year Award in Family Medicine. The criterion for each award is listed below. Submitting a nomination is easy. Visit http://www.vafp.org and click on the Award Nomination Link at the top of the page. If you have questions, please e-mail awards@vafp.org or call 1-800-THE-VAFP. Nomination materials must be received no later than May 31, 2007.

Virginia Family Physician of the Year Award

The physician nominated should have the following qualities.

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.

F. Elliott Oglesby, M.D. Volunteer of the Year Award

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.

James P. Charlton, M.D. Teacher of the Year Award in Family Medicine

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.

CONTINUED FROM PAGE 9

Measure	*Required HEDIS Information*
Childhood Immunization CIS	Evidence of immunization: 4 DtaP/DT, 3 IPV, 1 MMR, 3 HiB, 3 Hepatitis B, 1 VZV and 4 Pneumococcal conjugate OR documented history of the illness OR a seropostive test result
Adolescent Immunization AIS	Evidence of immunization: 2nd dose of MMR, 3 Hepatitis B or completion of 2-dose regimen, and 1 VZV) OR documented history of the illness OR a seropostive test result
Cervical Cancer Screening CCS	Pap smear during 2006, 2005 or 2004 OR documentation of a complete/total hysterectomy (no residual cervix) at any time in the patient's history.
Controlling High Blood Pressure CBP	Last recorded BP during 2006 where the member was not undergoing a significant surgical or diagnostic test AND oldest documentation of hypertensive diagnosis
Cholesterol Management for Cardiovascular Conditions CMC	LDL-C screening dates and results in 2006.
Comprehensive Diabetes Care CDC	• Most recent HbA1c test date and result in 2006 • Most recent LDL-C screening date and result during 2006 • Documentation of a dilated retinal eye exam with result performed by either an optometrist or ophthalmologist during 2006 or 2005 • Documentation in 2006 of a visit with a nephrologist, treatment for nephropathy, a urine microalbumin, a positive macroalbumin, ACE inhibitor/ARB therapy OR diagnosis of ESRD, CRF, ARF, renal insufficiency, dialysis, hemodialysis or peritoneal dialysis. • Most recent blood pressure reading in 2006 AND documentation confirming the diagnosis of diabetes, gestational diabetes, steroid induced diabetes or polycystic ovary disease)
Colorectal Cancer Screening COL	• Fecal Occult Blood Test (FOBT) screening with results during 2006 • Flexible sigmoidoscopy during 2006, 2005, 2004, 2003 or 2002 • Double contrast barium enema (DCBE) or air contrast enema during 2006, 2005, 2004, 2003 or 2002 • Colonoscopy during 2006, 2005, 2004, 2003, 2002, 2001, 2000, 1999, 1998, 1997 OR diagnosis of malignant neoplasm of colon/large intestine or total colectomy
Prenatal and Post Partum Care PPC	Prenatal Care: • Documentation of basic physical exam that includes auscultation for fetal heart tones OR pelvic exam with ob observations OR measurement of fundus height by an OB practitioner, Family Practitioner or midwife • Documentation of a prenatal care procedure: uterine ultrasound, prenatal labs (e.g., obstetric panel, Torch, rubella titer, ABO/Rh incompatibility) • Documentation of LMP or EDD with either evidence of prenatal risk assessment and counseling/education OR complete obstetric history Post Partum Care: • Documentation of a visit on or between 21-56 days after delivery that included any of the following: pelvic exam OR notation of post partum check-up OR evaluation of weight, blood pressure, breasts and abdomen. (Requires documentation that confirms delivery of a live birth between 11/6/2005 and 11/5/2006)

VIRGINIA ACADEMY OF PHYSICIAN ASSISTANTS

Physician Assistants (PAs) are licensed health professionals who

- Practice medicine with physician supervision
- Provide a broad range of diagnostic and therapeutic services
- May also perform educational, research, and administrative activities

THINKING OF HIRING A PA CONTACT THE VAPA AT :

VAPA
950 NORTH WASHINGTON STREET
ALEXANDRIA, VIRGINIA 22314-1552
OR
1-866-VAPA-ORG
E-MAIL: VAPA@VAPA.ORG
WWW.VAPA.ORG(SEE PA JOB LINK)

Physician Assistants:

PArtners *in medicine*

- Perform physical exams and take patient histories
- Diagnose and treat illnesses
- Order and interpret laboratory tests
- Assist in surgery
- Write prescriptions (in nearly all states)
- Provide patient education and counseling

QUIT NOW *Virginia*

Want to help your patients stop smoking or using tobacco, but don't have the resources or enough time? Referring your patients to a toll-free quitline can double their chances of successfully quitting. Quitlines are easy, free and they work.

for patients: www.smokefreevirginia.org
for healthcare providers: www.aptna.org
for nurses: www.tobaccofreenurses.org
free quit kits: 1-877-856-5177 (toll-free)

1-800-QUIT NOW

Urge your patients who smoke or use tobacco to call the Virginia quitline and speak to a trained counselor today!

*Funded by the Virginia Department of Health Tobacco Use Control Project www.vahealth.org/cdpc/tobaccouse

New MSVF Program Helps Physicians Navigate Prescription Programs

Submitted by: Medical Society of Virginia

Each day, thousands of uninsured Virginians have to choose between feeding their families and filling their prescriptions. Those who live in a community with a free clinic or a community health center with a licensed pharmacy are able to obtain much-needed prescription medications through RxPartnership. But for the considerable number of low-income Virginians who receive their care in a private physician's office, this option is not available. Instead, these patients have had to navigate the difficult Patient Assistance Programs (PAPs) offered by individual pharmaceutical companies.

To address this issue and facilitate more effective distribution of medications to those in need, the Medical Society of Virginia Foundation (MSVF) is implementing a program that will assist patients and their physicians in accessing the medications offered through the PAPs without the administrative difficulty. The program, DOC RxRelief: Doctors Optimizing Care through Prescription Relief, is funded by grants from The Virginia Health Care Foundation (VHCF) and the Richard Gwathmey and Caroline T. Gwathmey Memorial Trust. The grant funding enabled MSVF to hire a new full-time staff person, Rebecca L. Bird-Eichelberger, who will serve as the program's caseworker.

Bird-Eichelberger, who is extensively trained in prescription access efforts, will assist physician practices in utilizing pharmaceutical company PAPs to provide patients at or below 200 percent of the federal poverty level with free prescription medications. She will train administrative and clinical staff to identify patients who might be eligible for prescription assistance, assist practice staff in obtaining the necessary financial and clinical documentation, apply for prescription assistance for each patient using the VHCF's The Pharmacy Connection (TPC) software, and ensure that the patient has received the prescribed medication.

The goal of DOC RxRelief is to improve the health status of patients by ensuring compliance with prescribed treatment protocols through the provision of prescription medications. In the first year, the program will offer services to five physician practices. MSVF plans to grow the program in subsequent years so that it is available to all physicians in private practices who are MSV members.

"This program is a grand slam for Virginia's medical community," said Mitchell B. Miller, MD, board member of Virginia Health Quality Center and a former MSV president.

Miller and the MSVF leadership recognize that private-practice physicians provide pro bono and reduced-fee health care to uninsured patients and are a key component of Virginia's health care safety net. While they are able to make arrangements for the actual care, the outcome is greatly impacted by the patient's ability or inability to afford any prescribed medications. Patient compliance with the physician's prescribed treatment plan is the key to improving the health of patients.

Some physicians are able to dedicate staff to help patients complete the complicated paperwork required to apply for free medication from PAPs. However, many solo practitioners and physicians practicing in underserved areas are unable to afford such support. Consequently, their patients are left without access to the medications they need to become healthy. MSVF recognizes the overwhelming burden that the required paperwork places on physicians to comply with federal, state and insurer regulations, resulting in a lack of time to complete the applications for prescriptions via PAPs.

DOC RxRelief is not MSVF's first venture into prescription assistance for the uninsured. Three years ago, MSVF partnered with VHCF to develop and implement the concept of a public-private partnership that solicits bulk pharmaceuticals from drug manufacturers for distribution in licensed non-profit pharmacies.

This model, known as RxPartnership (RxP), increases access to prescription medications for Virginia's eligible uninsured. Housed at MSV, RxP serves as a broker, facilitating the distribution of free medications from participating pharmaceutical companies to licensed affiliate pharmacies which it credentials and monitors. RxP has delivered more than $10 million in prescriptions to more than 6,000 patients of Virginia's free clinics and community health centers.

RxP recently welcomed its newest manufacturing partner, Abbott Pharmaceuticals, who will join GlaxoSmithKline, Merck & Co. and Novartis in providing medications to the uninsured. Abbott's support will provide access to nine new medications including important treatment options for seizure disorders, hypertension, high cholesterol and various infections.

...ENSURING COMPLIANCE WITH PRESCRIBED TREATMENT PROTOCOLS...

RxP's Board President Beth Bortz also serves as executive director of MSVF. The organization has been a lead funding partner since RxP's inception. Together, RxP and Doc RxRelief will work to address one of MSVF's strategic priorities, improving access to prescription medications for Virginia's at-risk patients.

CHAGAS DISEASE:
A CLINICAL UPDATE

In the past year, cases of Chagas Disease were diagnosed in Virginia. Chagas Disease is a parasitic disease endemic in Latin and South America, which affects approximately 16 to 18 million people worldwide. Trypanosoma cruzi, the parasite that causes Chagas Disease, is transmitted by the feces of triatomine bugs, blood transfusions, organ transplants, and congenital transmission. It is not spread through casual contact between individuals.

Chagas Disease manifests itself in two stages: acute and chronic. The acute stage develops soon after exposure, and symptoms may include fever, fatigue, rashes, and vomiting. Symptoms may not be present or may go unnoticed. During the chronic phase, patients can develop cardiac damage (e.g. an enlarged heart, heart failure, altered heart rate or rhythm, and cardiac arrest) and/or intestinal damage (e.g. an enlarged esophagus or colon). Such intestinal damage can lead to difficulties with eating and/or constipation. The symptoms associated with the chronic stage of the disease typically occur years after the initial infection.

In the clinical encounter, some facts are important to keep in mind. The medical literature refers to the main vector as the reduvid or triatomine bug. However, Latin Americans may refer to it as a chinche or a chipo. Patients may also not be familiar with the term Chagas Disease. Finally, clinicians should use a variety of expressions to ask about heart irregularities since terms such as heart palpitations may be unfamiliar to patients.

If you have a patient who may have Chagas Disease, contact the Centers for Disease Control and Prevention [CDC], NCID, Division of Parasitic Diseases, Parasitic Diseases Branch Public Inquiries. The phone number is 770-488-7775 and the email address is: ncidpdbpi@cdc.gov. The CDC also has a fact sheet and other Chagas Disease resources on their website: http://www.cd-c.gov/ncidod/dpd/parasites/-chagasdisease/default.htm

A clinician must work with the CDC to diagnosis Chagas Disease and obtain the drugs needed for treatment. The main technique for diagnosing Chagas Disease is a blood screening test that is sent to the CDC for evaluation. Nifurtimox, the only available pharmaceutical in the United States for the treatment of Chagas' Disease, can be obtained through the Centers for Disease Control Drug Service. The CDC is currently working to make benznidazole, another popular treatment for the disease, available.

To respond to the recent cases of Chagas Disease in Virginia, the Virginia Department of Health, Olde Towne Medical Center, and the College of William and Mary created the Virginia Chagas Project [VCP]. VCP provides educational programs for patients and clinicians, and will offer a screening program in 2007. For further information about the Virginia Chagas Project, contact Kelly Joyce, Assistant Professor, The College of William and Mary, kajoyc@wm.edu, or Rene Cabral-Daniels, Director of the Office of Health Policy and Planning, Virginia Department of Health, Rene.CabralDaniels@vdh.virginia.gov.

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PUT ICE IN YOUR CELL PHONE –

Providing Key Information in Case of Emergency

There's a new movement gaining momentum across the country to make cell phones the source of key information for EMTs and other emergency workers. A British paramedic came up with the idea of having people make an entry in their cell phonebook under ICE, for "In Case of Emergency". Under that listing, the owner of the phone would enter the name and numbers of the person who should be called if an emergency should happen.

Paramedics, police, and firefighters responding to accidents, crimes, and disasters often deal with injured people who carry no information about their next of kin or who should be contacted in an emergency. In the case of victims who are unconscious, these contacts make it possible for EMTs to find out important information about a patient's medical history or allergies.

Emergency workers often waste valuable time trying to determine which name in a cell phone to call. They wind up looking through wallets for clues, or scrolling through cell address books and guessing. People usually enter their spouse by name in their phones, so they're indistinguishable from other entries. Even dialing the numbers for Mom and Dad might not be the best idea, especially if they're elderly or in poor health and shouldn't be confronted with potentially disturbing information.

With ICE, emergency workers can get hold of the right person in a few seconds. That's why EMTs, paramedics, police officers and firefighters in the US are encouraging people to start putting an ICE entry into their cell phones. The cellular phone industry is also getting behind the campaign. And word is spreading through the media, word of mouth, and e-mails. Women are realizing that an ICE number in their phones is better than other forms of identification, because they'll sometimes go out without a purse but nearly always bring their cell phones.

It is important to everyone to use the same listing-ICE-or else it will be confusing to those who need the number. If you would like to store more than one name as an emergency contact, you can simply enter ICE1, ICE2, ICE3, and so on.

Please share this information with every cell phone user you know and ask them to share it with all their contacts. If everybody does that, it won't take long before the whole country is using this terrific idea that can literally save lives.

National Program Taps Senior Virginia Physicians for Volunteering

-- TAP-IN.org Connects Doctors to Information and Opportunities --

TAP-IN (which stands for Third Age Professional Initiative) is an innovative new program which connects senior physicians with volunteer opportunities, is now available for all Virginia physicians ages 55 and over through a partnership with the Virginia Association of Free Clinics. Free Clinics serve a unique population--adults not old enough to qualify for Medicare and not poor enough to qualify for Medicaid. Many of these people have a job, but not enough income to cover the cost of insurance. Often referred to as the "working poor," the number of these patients is growing across America to almost 46 million.

TAP-IN was created to help meet this need by tapping into a new resource for volunteer care givers, physicians who may have some extra time available to them during their retirement years. TAP-IN will use its website (www.tap-in.org) and toll-free number (1-877-605-3250) to serve as an information hub for physicians who want to learn more about the practicalities involved in donating their time. In addition to connecting physicians with volunteer opportunities, the site provides a host of tools relevant to potential volunteers, including requirements for state medical boards and information on malpractice insurance. By facilitating volunteerism,

VIRGINIA'S IMMUNIZATION REGISTRY IS NOW HERE

§ 32.1-46.01 of the Code of VA authorized the Board of Health to establish the Virginia Immunization Information System (VIIS), a statewide immunization registry. VIIS allows users to:

- Access the complete immunization records for clients
- Lower the rates of under and/or over-immunizations
- Increase the rates of vaccination coverage
- Track and update immunization records
- View when age-appropriate vaccines are due
- Identify who should be sent reminder notices
- Manage vaccine inventories
- Produce reports (VFC, CASA, inventory lot maintenance, etc.)
- Print Official Immunization Records that are accepted by the DOE for Section III of the School Entry Form
- Perform data exchange from your existing patient care management system

From August 2006 through July 2007, geographic pilots will be underway around the state. The goal is to populate VIIS with demographic data from Vital Records and past immunization history by performing data exchange with the public health system, Health Care Plans, DMAS, hospitals, etc . Currently within VIIS, we have 2 M client records and 8 M immunizations from the data exchanges that have been performed so far.

You can support this effort by volunteering to participate as a pilot champion or as a pilot participant. There can be more than one champion for each region. These champions will: advise VDH on organizations within their area that may participate in the pilot; serve as an advisory to VDH on VIIS and be a sounding board for resolving VIIS enhancements and other issues.

At the completion of the pilot phase, VIIS will be available to all providers throughout the state at no charge. Additional information about VIIS can be found at http://www.vdh.virginia.gov/imm/. Once on the web page, click Immunization Registry (VIIS) on the left Menu Panel and select the Training Basics under Quick Links.

If you are interested in learning more about VIIS or in becoming a pilot champion, contact Dr. Archer Redmond at (804) 864-8074. The Division of Immunization's toll-free number is 1-800-568-1929.

The Division of Immunization is looking forward to the opportunity to work with your organization to help our children to stay healthy and disease-free!

the goal of TAP-IN is to enable physicians to do what they do best—serve patients.

This is a program about people, purpose and opportunity. The many retired physicians already engaged in Free Clinic work report that it gives them a sense of purpose, keeps them involved with colleagues and helps them improve the quality of life in their communities. They are contributing their medical skills to the community in ways that reminds them of why they started practicing medicine in the first place—and doing so at times that fit their schedule without being on call. Clinics need physicians with general medical experience as well as specialists to help serve patients with a wide variety of needs.

...INNOVATIVE NEW PROGRAM WHICH CONNECTS SENIOR PHYSICIANS WITH VOLUNTEER OPPORTUNITIES...

"We are excited that TAP-IN picked Virginia as one of the pilot states and that their tools will help bring more retired physicians into Free Clinics to care for our patients," said Mara Servaites, Interim Executive Director of the Virginia Association of Free Clinics. "As the number of Virginia's uninsured continues to grow, so does the demand for Free Clinic services. The valuable experiences of retired physicians will help meet these critical needs."

The TAP-IN program is run by the American Health Initiative. More information on TAP-IN and retired physician volunteerism is available at www.tap-in.org.

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