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SUMMER • 2006
family physician

**2006-2007
VAFP PRESIDENT
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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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WELCOME 2006-2007 VAFP BOARD

DIRECTORS

Chris Lupold, MD, Charlottesville - Dr.

Lupold attended medical school at Jefferson Medical College in Philadelphia, PA and completed his residency at Lancaster General Family Medicine Residency Program in Lancaster, PA. Dr. Lupold is Board Certified by the American Board of Family Medicine. Dr. Lupold is in private practice in Charlottesville and specializes in a full spectrum of family medicine including maternity care.

Albert Francis, Jr., MD, Hampton -

Dr. Francis graduated from Eastern Virginia School of Medicine and completed his family medicine residency at East Tennessee State University's Bristol Family Medicine Residency Program in Bristol, TN. Dr. Francis is in private practice in Hampton, Virginia.

Kent Willyard, MD, Newport News - Dr.

Willyard received his undergraduate degree from East Tennessee State University and earned his Doctor of Medicine at Eastern Virginia Medical School. He completed an internship and residency in family medicine at Riverside Regional Medical Center. Dr. Willyard is Board Certified in Family Medicine, a Fellow of the American Academy of Family Physicians, and an Assistant Professor of Family and Community Medicine at Eastern Virginia Medical School. He has been practicing in Newport News since 2001.

RESIDENT DIRECTORS

Sharon Diamond-Myrsten, MD,

Lynchburg - Dr. Diamond-Myrsten is a third-year resident at Lynchburg Family Medicine Residency in Lynchburg, VA, and a graduate of Eastern Virginia Medical School. During her

undergraduate medical education, she became involved with the Virginia Academy by serving as Student representative to the Board of Directors. Since that time, she has become active in the AAFP as well, and last year served as Resident representative on the Committee on Special Constituencies. This year, she was also the Virginia Resident Delegate to the AAFP Resident Congress, and looks forward to sharing ideas with other residents in the state.

Wayne A. Stoutenger, MD, Newport

News - Dr. Stoutenger is a 2nd year Family Medicine Resident at Riverside's VCU affiliated program in Newport News, Virginia. Dr. Stoutenger comes to Riverside after serving as a Primary Care physician for the US Army in the Republic of Panama and at Fort Eustis, Virginia while on Active Duty and as a civilian for 15 years. In the 1980's Dr. Stoutenger spent 5 years as a Neurosurgery Resident at The Medical College of Pennsylvania and Northwestern University following a Surgical Internship at Cooper Hospital in Camden, New Jersey as a graduate of St. Louis University School of Medicine. Dr. Stoutenger and Amy, his wife of 34 years, currently reside in Yorktown, Virginia.

Feroz Tamana, MD, Norfolk - Dr.

Tamana has completed his medical education in Kabul, Afghanistan. He graduated from Avicenna State Medical College of Kabul in 1988. Before coming to the United States Dr. Tamana has been to many Asian and European countries and has an extensive work experience as a physician with multiple international organizations in different countries. Prior to beginning his residency at EVMS in June, 2004, he worked as a teaching assistant in the department of Pathology at George Washington University. He has been a teacher and instructor in

different institutions throughout his life and has a keen interest in teaching. Beside his medical profession, he has been serving as a language specialist for Farsi, Dari and Pashto languages with the department of Justice. He is currently the chief resident in his residency program and is expected to complete his residency in June, 2007. Dr. Tamana is happily married to his wife Egleema and they have two sons, Wally Tamana and Zachary Tamana. They enjoy traveling, watching TV, Swimming and family gathering.

STUDENT DIRECTOR

Ronna D. Compton, Blacksburg - Ms.

Compton is a student in the Class of 2007 at the Virginia College of Osteopathic Medicine (VCOM) in Blacksburg, VA. Ronna is from Grundy, VA; a 1999 graduate of Council High School; and attended the University of Virginia in Charlottesville where she graduated in 2003 receiving her BA in English Language & Literature and Government. Ronna has been integral to the establishment of the family medicine interest group at VCOM. She served as the inaugural president of the VCOM student chapter of the American College of Osteopathic Family Physicians (ACOFP), served as the 2005-2006 Student Academic Member on the ACOFP Board of Governors, and presently serves as the National ACOFP Student President. Ronna also serves as the VCOM Student Director on the VAFP Board of Directors and served as the Virginia Student Voting Delegate at the AAFP Student Congress of Delegates in August 2006. After graduating from VCOM and completing residency in family medicine, Ronna plans to return to her hometown of Grundy to practice family medicine.

PRESIDENT'S MESSAGE

WAYNE J. REYNOLDS, DO



As the Virginia Academy of Family Physicians enters our 58th year, it is with tremendous PRIDE and honor I assume the position of President for the 2006-2007 term. I am truly humbled and have appreciated all the good wishes and support that I have received thus far. I look forward to a productive year with the very talented and dedicated Board of Directors of the VAFP who are committed wholeheartedly to improving the health care system for all the citizens of Virginia in keeping with the VAFP's Vision and Mission Statements.

My comments at the Annual Meeting, which again was very successful and during which we all enjoyed a beautiful weekend in Virginia Beach with family and friends, indicated my theme for this year would be taking PRIDE in being a family physician.

During the 2006 VAFP Annual Meeting, a survey was completed by the attendees asking for their opinions on what should be the Academy's highest priorities and focus for the next three years. This survey came about out of the last two VAFP Board meetings strategic planning discussions under the guidance of Dr. Kurt Elward with the discussion facilitated by Dr. Mark Greenwald. The discussion centered around about

to make comments. I am happy to report that both the board and those members returning surveys were in complete agreement on the top four priorities for the Academy.

As a result of this agreement, four working groups were set up at the last board meeting. They include 1) CME/MOC to be co-chaired by Dr. Mitch Miller and Dr. Kurt Elward, 2) Legislative Affairs to be chaired by Dr. Sterling Ransone, 3) Practice Redesign to be co-chaired by Dr. Tony Kuzel and Dr. Kurt Elward, and 4) Reimbursement Issues to be chaired by Dr. Marlene Capps. Each Board member has agreed to work within one of these groups, and each group has chosen a chairperson to lead the group and report each group's progress at each full board meeting. While the VAFP leadership recognizes the dedication and leadership of our current board members, we also recognize our membership has many, many extremely talented, experienced members who may not officially be on our board and would like to invite them to consider becoming involved and offering and sharing some of their experience and expertise to the Academy and fellow members by working with any of the above four groups to advance family medicine in the great Commonwealth of

...it is with tremendous PRIDE and honor I assume the position of President for the 2006-2007 term.



twenty topics and ideas, but understanding focus and targeted objectives were key, the top four priorities were voted on by the board first and then the meeting attendees were surveyed for what they felt should be the priorities with an opportunity



Virginia. By getting involved we can truly make a difference in our patient's lives, our family's lives and our own lives. So take PRIDE and be proud of family medicine. Innovation and Evolution can move us all in the direction we truly desire for

CONTINUED ON PAGE 9

our patients and families for which we are so Devoted and Dedicated to.

Once again, thank you for the trust, honor and privilege to serve as your President this coming year. Please feel free to

contact me with any comments, ideas, suggestions you may have to help us build a better and stronger Virginia Academy. Our Headquarters' number remains 804-968-5200 or 1-800-THE-VAFP.

picture 1:

James King, MD, AAFP Director, installs Wayne J. Reynolds, DO 2006-2007 VAFP President. Following the installation, Dr. Reynolds addressed the audience outlining his priorities during his year as VAFP President.

picture 2:

2006-2007 VAFP Officers and Directors were installed at the 2006 Annual Meeting & Exposition on Saturday, July 22nd in Virginia Beach. Pictured front row left to right are: Mitch Miller, MD, Virginia Beach; Kent Willyard, MD, Newport News; Wayne Stoutenger, MD, Newport News; Roger Hoffer, MD, Salem; Alber Francis, Jr., MD, Hampton; Sharon Diamond-Myrsten, MD, Lynchburg; Larry Kagan, MD, Virginia Beach; Janice Ragland, MD, Herndon; Sterling Ransone, Jr., MD, Deltaville. Pictured back row left to right are: Feroz Tamana, MD, Norfolk; James King, MD, AAFP Installing Officer; Wayne Reynolds, DO, Gloucester Point.

BOARD OF DIRECTORS MEETING

HILTON HOTEL, VIRGINIA BEACH, VA

JULY 20, 2006

- Approved minutes from the May 13, 2006 VAFP Board of Directors meeting held in Charlottesville, Virginia.
- Participated in Leadership Focus Session follow-up targeted on VAFP strategic planning.
- Heard report from VAFP CME Chair, Mitch Miller, MD on the VAFP Annual Meeting & Exposition held July 20-23, 2006 at the Hilton Oceanfront Hotel in Virginia Beach.
- Heard report from VAFP Quality Task Force Chair, Kurt Elward, MD, MPH on the Asthma SAMs programs scheduled across the state.
- Approved the 2005 VAFP Audit.
- Heard report from Terry Schulte, VAFP Executive Vice President on plans and programming for the AAFP National Conference of Family Medicine Residents and Medical Students held August 2-5, 2006 in Kansas City, Missouri.
- Approved a motion to establish a "Doctors Lounge" form of communication via an electronic bulletin board.
- Heard report from Kurt Elward, MD,

MPH on the AAFP's Vote for American Health Rally scheduled for Wednesday, September 27 in Washington, DC.

- Heard report from VAFP Ex Officio Member, Tony Kuzel, MD on the proposal to integrate the practice re-design seminars into the Wintergreen meeting. He also noted that Dr. John Bachman, a physician at the Mayo Clinic in Rochester, MN, has accepted an invitation to speak on practice re-design in Richmond on November 4, 2006.
- Heard request from VAFP Director, Mark Watts, MD to generate a list of family physicians willing to serve as defense expert witnesses. The Board recommended that a workshop be held at a future CME meeting to be conducted by a defense attorney.

Legislative Affairs and Practice Redesign.

- Assigned leaders to each area of focus with the goal of facilitating the work group priorities to be reported at the fall VAFP Board meeting.
- Approved a motion to generate resolutions for the AAFP Congress of Delegates regarding a Uniform Prescription Medication Authorization/Appeals Process and Reform and Simplification of Medicare Part D.
- Approved next step efforts regarding AAFP "Vote for America's Health" Rally. The Board decided to pursue the following 5 priorities for the rally:
 - Set meetings/PR opportunities with VA legislators
 - Invite Senator Allen's personal family physician to attend
 - VAFP staff to coordinate a room to meet with legislators and or legislative aides
 - VAFP staff to obtain the list of VA members attending the AAFP meeting
 - VAFP staff to send an all member e-mail apprising the membership of the rally
- Heard report from VAFP Student and Resident representatives on activities at their medical schools/residency programs.

JULY 23, 2006

- Participated in Leadership Presentation lead by Mr. Mark Towers, Speak-Out Seminars.
- Reviewed responses from VAFP Annual Meeting attendees regarding areas of focus for the VAFP in the next two years - High Quality CME/Maintenance of Certification Activities, Reimbursement,

Increasing Immunization Coverage May Reverse Rising Reports of Pertussis

Many people are unaware that reports of pertussis, commonly called whooping cough, have been rising in the United States (US) and pose serious consequences for infants who are too young to be fully immunized. Until recently, pertussis immunization was limited to infants and young children 6 weeks through 6 years of age. Fortunately, in 2005 the Food and Drug Administration licensed 2 combination tetanus/diphtheria/acellular pertussis (Tdap) booster vaccines; one for adolescents and one, ADACEL® (Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine Adsorbed), for both adolescents and adults.²

To provide further protection against pertussis,

has steadily increased, reaching 25,827 in 2004, the largest number since 1959.³ Because of underreporting and misdiagnosis, the true number of pertussis cases is most likely even higher, estimated at 600,000 adults annually.²

In recent years, pertussis has had a significant impact on particular age groups. For example, between 2003 and 2004 reported pertussis cases increased 73% in children 4 years of age or younger⁴ and 122% overall.⁵ Adolescents 10-19 years of age and adults over 20 years of age still accounted for a clear majority (approximately 66%) of the reported cases.⁵

The implications of these rising case numbers are alarming. Most young infants with pertussis still must

be hospitalized, and some cases can be fatal.⁶ From 2001-2003, 91% of the deaths from pertussis were among infants younger than 6 months of age and 75% were among infants younger than 2 months of age.³

Why are reports of pertussis on the rise?

One reason for the increase in pertussis cases may be that immunity to pertussis “wears off” over time—approximately 5-10 years after completing the childhood vaccination series¹—which means adolescents and adults who think they have immunity can

be susceptible to the disease and may transmit pertussis to infants.

Adolescents and adults also 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. In families, this is often the case.

In a study to determine the source of infant pertussis, family members, especially new mothers, were found to be an important source among identifiable cases. The study 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.⁶ Therefore, immunization with ADACEL vaccine for parents and family members may help reduce the spread of pertussis to infants.

ADACEL vaccine recommended for adolescents, adults, and HCP

The ACIP has voted to recommend vaccination with ADACEL vaccine for new mothers and those family members who are in close contact with infants younger than 12 months of age.² 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 booster¹
- A single dose of Tdap vaccine (ADACEL vaccine) for adults 19-64 years of age instead of a Td booster; the booster dose is recommended if it has been more than 10 years since the last Td booster, but shorter intervals after Td vaccine are acceptable.²

The role of health-care personnel

With the availability of ADACEL vaccine for adolescents and adults, HCP need to redefine the standard of care for infant pertussis by immunizing not only the child but all close contacts as well. HCP will play a major role in increasing Tdap immunization.

HCP can help reduce the increasing rates of pertussis infection by first making sure that, if they work in hospitals or ambulatory-care settings, they have received immunization with ADACEL vaccine to protect themselves, their patients, and family members. This is especially important for those in direct contact with infants less than 12 months of age.

HCP also need to make sure that family members in contact with infants are up-to-date with their pertussis vaccinations and that infants and young children have completed their DTaP childhood vaccination series.

Raising awareness among new mothers and their families

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. Providers can use existing office visits as an opportunity to increase Tdap vaccinations among adolescents and adults. 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.

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. 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 March 10, 2006.
3. 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.
4. CDC. Summary of notifiable diseases—United States, 2003. *MMWR*. 2003;52:1-85.
5. CDC. Pertussis Surveillance Report?8/12/05. MKT11970.
6. Bigard KM, Pascual FB, Ehresmann KR, et al. Infant pertussis: who was the source? *Pediatr Infect Dis J*. 2004;23:985-989.

Pertussis Transmission at Home

* In a Centers for Disease Control and Prevention study of 774 reported cases of infant pertussis, interviews were conducted with 418 of the families to determine the source of the disease.

— A source was defined as a person with an acute cough illness who had contact with the case infant 7 to 20 days before the infant's onset of cough.

* The source was identified for 43% (264) of the infants with pertussis. Within this subgroup of infants, the known or suspected source of pertussis was:

— The mother in 32% of these infant cases

— A grandparent in nearly 50% of these infant cases

— A family member in 70% of these infant cases

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



the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) 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. ADACEL vaccine provides adolescents and adults with protection against pertussis and may help reduce the spread of pertussis to vulnerable infants. Physicians like knowing that ADACEL vaccine can be used concomitantly with hepatitis B or 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 receive a single dose of Tdap booster vaccine as soon as feasible (if they have not previously done so), especially those who have direct contact with infants less than 12 months of age.

The ACIP recommendation redefines the standard of care for preventing pertussis, a vaccine-preventable disease reported at its highest rates in decades.

Reports of pertussis on the rise

The number of pertussis case reports in the US

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

R 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 $\geq 40.5^{\circ}\text{C}$ (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 (VIS) 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/AM 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 neurologic 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 neurologic 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 Td. 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 be precisely 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 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 immune competence. 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
MKT10383

Manufactured by:
Aventis Pasteur Limited
Toronto Ontario Canada

Printed in USA

Distributed by:
Aventis Pasteur Inc.
Swiftwater PA 18370 USA
2021114/2021543

FAMILY PHYSICIAN OF THE DAY

VIRGINIA GENERAL ASSEMBLY

Volunteers are needed to serve as Family Physicians of the Day during the 2007 Virginia General Assembly. As the Family Physician of the Day, you will be responsible for staffing the courtesy medical station for 9:00 a.m.-3:30 p.m. on your chosen day. Directors and more specific information will be provided with confirmation of your assigned date. Reimbursement for participation as family physician of the day includes \$100.00 per day per diem and mileage.

Name: _____
 Address: _____
 City/State/Zip: _____
 Phone: _____
 Fax: _____
 Email: _____

MON	TUES	WED	THU	FRI
		10	11	12
15	16	17	18	19
22	23	24	25	26
29	30	31		

JANUARY

MON	TUES	WED	THU	FRI
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23

FEBRUARY

I have chosen the following three dates from the calendar that I will be able to participate. I have listed the dates in order of preference. NOTE: Every effort will be made to provide your first choice.

1. _____
2. _____
3. _____

PLEASE RETURN FORM TO:

VAFP • 2301 North Parham Road • Suite 4 • Richmond, VA 23229
 Phone: 800-843-8237 • Fax: 804-968-4418
 Email: mschulte@vafp.org



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

Physician Assistants:
 Partners
in medicine

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)



- 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

MEDICARE PARTICIPATION OPTIONS FOR PHYSICIANS

Please note: This document was originally developed by the AMA and contains excerpts from the AMA-published Medicare RBRVS: The Physicians' Guide 2002.

To help ensure that physicians are making informed decisions about their contractual relationships with the Medicare program, the AMA has developed the following brief overview of the various participation options that are available to physicians. **The AAFP is not advising or recommending any one of the three options described in this document. The purpose of the document is merely to ensure that physician decisions about Medicare participation are made with complete information about the available options.**

The Three Options

There are basically three Medicare contractual options for physicians. Physicians may sign a participating (PAR) agreement and accept Medicare's allowed charge as payment in full for all of their Medicare patients. They may elect to be a non-PAR physician, which permits them to make assignment decisions on a case-by-case basis and to bill patients for more than the Medicare allowance for unassigned claims. Or they may become a private contracting physician, agreeing to bill patients directly and forego any payments from Medicare to their patients or themselves.

Physicians who wish to change their status from PAR to non-PAR or vice versa may do so annually. Once made, the decision is binding until the next annual contracting cycle except where the physician's practice situation has changed significantly, such as relocation to a different geographic area or a different group practice. To become a private contractor, physicians must give 30 days notice before the first day of the quarter the contract takes effect. **Those considering a change in status should first determine that they are not bound by any contractual arrangements with hospitals, health plans or other entities that require them to be PAR physicians. In addition, some states have enacted laws that prohibit physicians from balance billing their patients.**

Participation

PAR physicians agree to take assignment on all Medicare claims, which means that they must accept Medicare's approved amount (which is the 80% that Medicare pays plus the 20% patient copayment) as payment in full for all covered services for the duration of the calendar year. The patient or the patient's secondary insurer is still responsible for the 20% copayment but the physician cannot bill the patient for amounts in excess of the Medicare allowance. While PAR physicians must accept assignment on all Medicare claims, however, Medicare participation agreements do not require physician practices to accept every Medicare patient who seeks treatment from them.

Medicare provides a number of incentives for physicians to participate:

- The Medicare payment amount for PAR physicians is 5% higher than the rate for non-PAR physicians.
- Directories of PAR physicians are provided to senior citizen groups and individuals who request them.
- Carriers provide toll-free claims processing lines to PAR physicians and process their claims more quickly.

Non-Participation

Medicare approved amounts for services provided by non-PAR physicians (including the 80% from Medicare plus the 20% copayment) are set at 95% of Medicare approved amounts for PAR physicians, although non-PAR physicians can charge more than the Medicare approved amount.

Limiting charges for non-PAR physicians are set at 115% of the Medicare approved amount for non-PAR physicians. However, because Medicare approved amounts for non-PAR physicians are 95% of the rates for PAR physicians, the 15% limiting charge is effectively only 9.25% above the PAR approved amounts for the services. Therefore, when considering whether to be non-PAR, physicians must determine whether their total revenues from Medicare, patient copayments and balance billing would

exceed their total revenues as PAR physicians, particularly in light of collection costs, bad debts, and claims for which they do accept assignment. The 95% payment rate is not based on whether physicians accept assignment on the claim, but whether they are PAR physicians; when non-PAR physicians accept assignment for their low-income or other patients, they still receive only 95% of the amount PAR physicians receive for the same service. Non-PAR physicians would need to collect the full limiting charge amount roughly 35% of the time they provided a given service in order for the revenues from the service to equal those of PAR physicians for the same service.

Assignment acceptance, for either PAR or non-PAR physicians, also means that the Medicare carrier pays the physician the 80% Medicare payment. For unassigned claims, even though the physician is required to submit the claim to Medicare, the program pays the patient, and the physician must then collect the entire amount for the service from the patient.

(see chart below)

Private Contracting

Private contracts must meet specific requirements:

- THE PHYSICIAN MUST SIGN AND FILE AN AFFIDAVIT AGREEING TO FORGO RECEIVING ANY PAYMENT FROM MEDICARE FOR ITEMS OR SERVICES PROVIDED TO ANY MEDICARE BENEFICIARY FOR THE FOLLOWING 2-YEAR PERIOD (either directly, on a capitated basis, or from an organization that received Medicare reimbursement directly or on a capitated basis);
- Medicare does not pay for the services provided or contracted for;
- the contract must be in writing and must be signed by the beneficiary before any item or service is provided;
- the contract cannot be entered into at a time when the beneficiary is facing an emergency or an urgent health situation.

In addition, the contract must state unambiguously that by signing the private contract, the beneficiary:

- gives up all Medicare payment for services furnished by the “opt out” physician;
- agrees not to bill Medicare or ask the physician to bill Medicare;
- is liable for all of the physician's charges, without any Medicare balance billing

limits;

- acknowledges that Medigap or any other supplemental insurance will not pay toward the services; and
- acknowledges that he or she has the right to receive services from physicians for whom Medicare coverage and payment would be available.

To opt out, a physician must file an

affidavit that meets the above criteria and is received by the carrier at least 30 days before the first day of the next calendar quarter.

There is a 90-day period after the effective date of the first opt-out affidavit during which physicians may revoke the opt-out and return to Medicare as if they had never opted out.

EXAMPLE: A SERVICE FOR WHICH MEDICARE FEE SCHEDULE AMOUNT IS \$100

PAYMENT ARRANGEMENT	TOTAL PAYMENT RATE	PAYMENT AMOUNT FROM MEDICARE	PAYMENT AMOUNT FROM PATIENT
PAR PHYSICIAN	100% MEDICARE FEE SCHEDULE = \$100	\$80 (80%) CARRIER DIRECT TO PHYSICIAN	\$20 (20%) PAID BY PATIENT OR SUPPLEMENTAL INSURANCE (I.E., MEDIGAP)
NON-PAR/ASSIGNED CLAIM	95% MEDICARE FEE SCHEDULE = \$95	\$76 (80%) CARRIER DIRECT TO PHYSICIAN	\$19 (20%) PAID BY PATIENT OR SUPPLEMENTAL INSURANCE (I.E., MEDIGAP)
NON-PAR/UNASSIGNED CLAIM	LIMITING CHARGE/109.25% MEDICARE FEE SCHEDULE = \$109.25	\$0	\$76 (80% PAID BY CARRIER PATIENT + \$19 (20%) PAID BY PATIENT OR SUPPLEMENTAL INSURANCE + \$14.25 BALANCE BILL PAID BY PATIENT

GUBERNATORIAL HEALTH CARE COMMISSIONS CREATED. VIRGINIA GOVERNOR TIM KAINE HAS CREATED TWO SIGNIFICANT STATE HEALTH CARE ENTITIES BY EXECUTIVE ORDER, AND (AT THE TIME THIS ARTICLE IS WRITTEN) APPOINTED MEMBERS TO ONE OF THEM. KAINE’S COMMISSION ON HEALTH REFORM WILL “CONVENE LEADING VOICES FROM ALL FACETS OF BOTH THE PUBLIC AND PRIVATE SECTORS TO RECOMMEND EFFECTIVE WAYS TO REFORM AND STRENGTHEN HEALTHCARE IN VIRGINIA,” ACCORDING TO THE GOVERNOR’S AUGUST 8 PRESS RELEASE ANNOUNCING THE COMMISSION.

THE SECOND ENTITY, VIRGINIA’S HEALTH INFORMATION TECHNOLOGY COUNCIL, IS CHARGED WITH RECOMMENDING THE MOST INNOVATIVE AND EFFECTIVE INVESTMENTS FOR THE \$1.5 MILLION APPROPRIATED BY THE GENERAL ASSEMBLY TO ENCOURAGE THE ADOPTION OF ELECTRONIC HEALTH RECORDS THROUGHOUT VIRGINIA.

THE HEALTHCARE REFORM COMMISSION. THIS COMMISSION SEEMS TO BE DESIGNED TO IMPROVE THE DELIVERY OF HEALTH CARE IN VIRGINIA. WHEN HE CREATED THE COMMISSION, GOVERNOR KAINE NOTED THAT “[W]ITH MORE THAN ONE MILLION VIRGINIANS LACKING HEALTH CARE COVERAGE, AND GROWING SHORTAGES OF HEALTH PROFESSIONALS IN ALL DISCIPLINES ACROSS THE COMMONWEALTH AND THE NATION, WE MUST LOOK FOR CREATIVE WAYS TO FURTHER IMPROVE THE DELIVERY OF HEALTHCARE TO VIRGINIANS.”

THE COMMISSION HAS BEEN TASKED

WITH IDENTIFYING AND IMPLEMENTING NATIONAL BEST PRACTICES AT THE STATE LEVEL WITH EMPHASIS ON ACCESS, QUALITY, AND SAFETY OF CARE, AS WELL AS ADDRESSING LONG-TERM CARE AND AFFORDABILITY. IT WILL WORK CLOSELY WITH THE GENERAL ASSEMBLY’S JOINT COMMISSION ON HEALTH CARE AND THE JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION AND FOSTER COOPERATION BETWEEN THE EXECUTIVE AND LEGISLATIVE BRANCHES OF STATE GOVERNMENT ON THESE ISSUES.

ALTHOUGH THE MEMBERS OF THE COMMISSION HAVE NOT BEEN APPOINTED AT THE TIME THIS ARTICLE IS WRITTEN, THE GOVERNOR HAS INDICATED THAT IT WILL BE CHAIRED BY VIRGINIA’S SECRETARY OF HEALTH AND HUMAN RESOURCES AND WILL HAVE DIVERSE MEMBERSHIP INCLUDING STATE LEGISLATORS, MEMBERS OF THE GOVERNOR’S CABINET, CONSUMER AND PATIENT ADVOCATES, HEALTH CARE LEADERS AND CITIZENS.

HEALTH INFORMATION TECHNOLOGY COUNCIL. THIS COUNCIL CONTINUES THE WORK OF GOVERNOR WARNER’S ELECTRONIC HEALTH RECORDS TASK FORCE. GOVERNOR KAINE SUGGESTED IN THE AUGUST 3 PRESS RELEASE ANNOUNCING THE COUNCIL THAT A REQUEST FOR INFORMATION WILL BE ISSUED THAT SOLICITS PROPOSALS FOR PUBLIC-PRIVATE PARTNERSHIPS TO ENCOURAGE THE ADOPTION OF ELECTRONIC HEALTH RECORDS.

THE GOVERNOR’S SECRETARIES OF HEALTH AND HUMAN RESOURCES MARILYN

TAVENNER AND TECHNOLOGY ANEESH CHOPRA WILL CO-CHAIR THE COUNCIL. THE GOVERNOR APPOINTED THE REMAINING 22 MEMBERS OF THE COUNCIL ON AUGUST 30. THESE APPOINTEES INCLUDE FOUR PHYSICIANS: DR. GOPINATH JADHAV, A COLONIAL HEIGHTS GASTROENTEROLOGIST, KEITH NEWBY, SR., A NORFOLK CARDIOLOGIST, JOHN O’BANNON, A RICHMOND NEUROLOGIST AND THE ONLY PHYSICIAN MEMBER OF THE VIRGINIA HOUSE OF DELEGATES, AND LARRY T. WILSON, A WEBER CITY FAMILY PHYSICIAN.

OTHER GUBERNATORIAL APPOINTEES TO THE COUNCIL INCLUDE THE CHIEF INFORMATION OFFICER FOR THE UNIVERSITY OF VIRGINIA HEALTH SYSTEMS, THE EXECUTIVE VICE PRESIDENT AND ADMINISTRATOR OF RIVERSIDE REGIONAL MEDICAL CENTER, THE CEO OF OWENS AND MINOR, THE CHIEF INFORMATION OFFICER AT AOL, AND THE DIRECTOR OF TELECOMMUNICATIONS STANDARDS FOR THE NATIONAL ASSOCIATION OF CHAIN DRUG STORES.

GUBERNATORIAL APPOINTMENTS TO THE VIRGINIA BOARD OF MEDICINE.

GOVERNOR KAINE ALSO HAS MADE APPOINTMENTS TO THE BOARD OF MEDICINE. SERVING AN ADDITIONAL TERM WILL BE DR. MALCOLM COTHRAN, JR., A LEXINGTON INTERNIST AND BOARD MEMBER AT STONEWALL JACKSON HOSPITAL IN LEXINGTON. APPOINTED TO A NEW TERM IS DR. ELLEN SHAPIRO, A RICHMOND PODIATRIST.

2006 VAFP ANNUAL MEETING HIGHLIGHTS

Over 250 Family Physicians and their families enjoyed the premier CME offerings and fabulous Hilton Oceanfront Hotel at the 2006 Annual Meeting and Exposition held July 20-23, 2006 at the Hilton Oceanfront Hotel in Virginia Beach. Comments from attendees capture the Annual Meeting:

"This conference was excellent - the topics were great - schedule of events was great - I look forward to future conferences by the VAFP."

"A Great Job Again!"

"Kudos once again to the CME Program Committee!"

"A perfect mid-summer break for my family."

"VAFP presented an excellent comprehensive program with compelling evidence appropriate for primary care."



SPECIAL RECOGNITION MUST BE GIVEN TO **"VAFP PARTNERS."** THESE ORGANIZATIONS ARE DESERVING OF OUR HIGHEST LEVEL OF APPRECIATION FOR SUPPORT DURING THE 2006 ANNUAL MEETING & EXPOSITION.

3M
AMERICAN ACADEMY OF FAMILY PHYSICIANS
LEADERSHIP ROAD SHOW
CARILION HEALTH SYSTEM

CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS
ECR PHARMACEUTICALS
ELLMAN INTERNATIONAL
GENZYME BIOSURGERY
GLAXOSMITHKLINE
KOS PHARMACEUTICALS
MERCK & Co., INC.
NOVARTIS
P&G PHARMACEUTICALS
PFIZER

PHILLIPSCOX INSURANCE AND FINANCIAL SERVICES
PROFESSIONALS ADVOCATE
SANOFI-AVENTIS
SANOFI-PASTEUR
SENTARA MEDICAL GROUP
SOUTHEAST UNITED DAIRY INDUSTRY ASSOCIATION (SUDIA)
VIRGINIA DEPARTMENT OF HEALTH
WYETH PHARMACEUTICALS



THE ACADEMY GRATEFULLY ACKNOWLEDGES THE PARTICIPATION AND SUPPORT OF THE FOLLOWING ORGANIZATIONS THAT CHOSE THE 2006 VAFP ANNUAL MEETING & EXPOSITION TO DISPLAY THEIR PRODUCTS AND SERVICES.

- ABBOTT LABORATORIES
- AMERICAN HOME PATIENT
- AMGEN
- AMILYN PHARMACEUTICALS
- ASTRAZENECA
- ATLANTIC ORTHOPAEDIC SPECIALISTS
- AUGUSTA MEDICAL CENTER
- BENCHMARK SYSTEMS
- BOEHRINGER INGELHEIM
- BON SECOURS SURGICAL WEIGHT LOSS CENTER
- CENTRA HEALTH MENTAL HEALTH SERVICES
- CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS
- CODE BLUE CODING
- DOMINION PATHOLOGY LABORATORIES
- DORAL DENTAL USA/SMILES FOR CHILDREN
- E-MDS
- ECR PHARMACEUTICALS
- ELLMAN INTERNATIONAL
- ENDO PHARMACEUTICALS
- GENWORTH FINANCIAL -LONG TERM CARE
- GLAXOSMITHKLINE
- GUDIANT CORPORATION
- HCA VIRGINIA
- KOS PHARMACEUTICALS
- MAG MUTUAL INSURANCE
- MED VIRGINIA, LCC
- MEDICAL SOCIETY OF VIRGINIA INSURANCE CENTER
- MEDICUS STAFFING
- MERCK
- MERETEK DIAGNOSTICS, INC.
- MISYS HEALTHCARE SYSTEMS
- MORGAN KEEGAN AND COMPANY, INC.
- NOVARTIS
- OSCIENT PHARMACEUTICALS
- PFIZER
- PHILLIPSCOX INSURANCE & FINANCIAL SERVICES
- PRI-MED
- PRICARA
- PROFESSIONALS ADVOCATE INSURANCE COMPANY
- ROCHE
- SANOFI-AVENTIS
- SANOFI-PASTEUR
- SCHERING PLOUGH
- SCHERING PLOUGH RESPIRATORY
- SENTARA
- SEPRACOR PHARMACEUTICALS
- SOURCE ONE MOBILITY
- TAKEDA PHARMACEUTICALS
- TAP PHARMACEUTICALS
- TEVA SPECIALTY BRANDS
- TRAILBLAZER HEALTH, MEDICARE PART B
- U.S. ARMY HEALTHCARE RECRUITING TEAM
- UCB
- UNITED STATES AIR FORCE
- VIRGINIA ACADEMY OF PHYSICIAN ASSISTANTS
- VIRGINIA ARMY NATIONAL GUARD
- VIRGINIA DEPARTMENT OF HEALTH, CENTER FOR INJURY AND VIOLENCE PREVENTION
- VIRGINIA DEPARTMENT OF HEALTH, OFFICE OF HEALTH POLICY AND PLANNING
- VIRGINIA HEALTH QUALITY CENTER
- VIRGINIA SEARCH
- WILLIAMSBURG PLACE & THE WILLIAM J. FARLEY CENTER
- WYETH
- WYETH WOMEN'S DIVISION
- WYTHE COUNTY COMMUNITY HOSPITAL

MITCHELL B. MILLER, M.D., RECEIVES F. ELLIOT OGLESBY, MD, VOLUNTEER OF THE YEAR AWARD



Mitchell B. Miller, M.D., Virginia Beach, was selected by the Virginia Academy of Family Physicians as the 2006 recipient of the F. Elliott Oglesby, MD, Volunteer of the Year Award. The award is presented annually to an Academy member whose outstanding service to his or her profession and community exemplifies the true nature of volunteerism. Recipients must also possess those unique and special qualities that are indicative of a truly outstanding family physician.

His award reads, "In recognition of your genuine concern and your immediate response to the victims of Hurricane Katrina. Your decision to travel to Mississippi and volunteer your time, energy and expertise reflects great credit on you and the Specialty of Family Medicine."



DR. MILLER ADDRESSES THE AUDIENCE DURING THE AWARDS CEREMONY AND ACKNOWLEDGES THE ACTS OF VOLUNTEERISM BY FAMILY PHYSICIANS THROUGHOUT THE STATE OF VIRGINIA.

DR. MITCHELL B. MILLER GRACIOUSLY ACCEPTS THE AWARD FROM 2005-2006 VAFP PRESIDENT KURTIS S. ELWARD, M.D., MPH. ACCOMPANYING THE AWARD IS A CONTRIBUTION TO THE ORGANIZATION OF DR. MILLER'S CHOICE.

FAMILY PHYSICIANS OF CHESTER, P.C., RECEIVES THE 2006 JAMES P. CHARLTON, M.D. TEACHER OF THE YEAR IN FAMILY MEDICINE AWARD

Family Physicians of Chester, P.C., was named the 2006 recipient of the James P. Charlton, M.D., Teacher of the Year in Family Medicine Award. Dr. G. Val Puster accepted the award on behalf of his practice at the VAFP 2006 Annual Meeting and Exposition's Awards Ceremony held at the Hilton Oceanfront Hotel in Virginia Beach. The award is presented annually to a family physician or family physician practice that exemplifies excellence in the teaching of family medicine to family medicine residents and medical students.

Family Physicians of Chester's award reads, "In recognition of your collective and long-term commitment to the education of VCU medical students and in deep appreciation for your exemplary service to these students as mentors, role models and preceptors. Your unparalleled dedication has contributed immeasurably to the continuing success of the VCU Department of Family medicine Predoctoral programs."

The Family Physicians of Chester have been teaching VCU School of Medicine students since the early 1980's. The physician members of Family Physicians of Chester include: Brian G. Burijon, M.D., Donn S. Cobaugh, M.D., Brian Port, M.D., G. Val Puster, Jr., M.D. and Thomas R. Stennett, III, M.D.



DR. G. VAL PUSTER ACCEPTS THE AWARD FROM 2005-2006 VAFP PRESIDENT KURTIS S. ELWARD, M.D., MPH.

A NEW PROVIDER EDUCATION PRODUCT

Quick Reference Information: Medicare Immunization Billing - This two-sided job aid gives Medicare fee-for-service physicians, providers, suppliers, and other health care professional's quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. This product is available to view, download, and print from the CMS Medicare Learning Network Preventive Services Educational Products web page located at

[http://www.cms.hhs.gov/MLNProducts/35 PreventiveServices.asp](http://www.cms.hhs.gov/MLNProducts/35%20PreventiveServices.asp)

on the CMS website. Print copies will be available in early Fall 2006.

NATIONAL PROVIDER IDENTIFIER (NPI): GET IT. SHARE IT. USE IT.

As the industry transitions to NPI compliance, remember that there is no charge to get an NPI. Providers can apply online for their NPI, free of charge, by visiting

<https://nppes.cms.hhs.gov> or by calling 1-800-465-3203

to request a paper application. The CMS NPI page, located at

www.cms.hhs.gov/NationalProvIdentStand/,

is the only source for official CMS education and information on the NPI initiative; all products located on this site are free of charge.

CMS continues to urge providers to include identifiers on their NPI applications, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated State names. If providers have already applied for their NPI, CMS asks them to go back to the NPPES and update their information with their legal identifiers. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI. Getting a NPI is free - not having one can be costly.

FAMILY PHYSICIANS INTERESTED IN PASSING PRACTICE ON TO SOMEONE WHO IS INTERESTED IN A SOLO FAMILY PRACTICE OFFICE. PHYSICIANS WILL STAY FOR TRANSITION. ALL OF OFFICE INCLUDED, EMR ALREADY IN PLACE. NO PRICE FOR GOODWILL, WOULD LIKE REIMBURSEMENT FOR EQUIPMENT, ASSUME LEASE. PLEASE E-MAIL IF INTERESTED IN A PLEASANT BUSY FAMILY PRACTICE IN A UNIVERSITY TOWN THAT IS A GREAT PLACE TO RAISE A FAMILY. FOR MORE INFORMATION CONTACT
ADMIN@VAFP.ORG.

DR. JOHN BACHMAN

Thinking of getting an electronic medical record, but feeling "damned if you do, damned if you don't?" Already have one, but wishing it worked better for your office?



Then you need to come to hear fellow family physician, John Bachman, as he tells us about "The Hero's Journey: Crossing the Digital Divide." Dr. Bachman, who works in the Mayo Clinic in Minnesota, is inspiring thousands of US family physicians to bring IT into their clinical practice, and showing them numerous practical ways to minimize the costs and maximize the impact of the technology. Now you and your colleagues can hear and learn from Dr. Bachman at a special presentation on Saturday, November 4, 2006, 10 am – 2 pm at the beautiful headquarters of the Virginia Farm Bureau in Goochland County, just west of Richmond and near two lovely outdoor malls for shopping and dining (for map and directions, see <http://www.vafb.com/location.htm>). Because lunch is part of the program and we need an accurate headcount of those who will actually attend, we ask that you send a check for \$20 for each member of your practice that will attend, payable to the VCU Department of Family Medicine, Attention: Clarisse Harton, PO Box 980251, Richmond, VA, 23298, by October 27, 2006, and that you contact Clarisse Harton by phone (804-827-4160), fax (804-828-5856), or e-mail (ctharton@vcu.edu) with the names of those planning to attend. Dr. Bachman's past talks have received standing ovations and superb evaluations – don't miss this opportunity to learn with your colleagues how to make IT work for you and your patients. (Brought to you by the Departments of Family Medicine at Virginia Commonwealth University, the University of Virginia, Eastern Virginia Medical School, the Edward Via College of Osteopathic Medicine, and the VAFP; 3 hours CME credit applied for).

INCOMING PRESIDENT'S SPEECH

Wayne J. Reynolds, DO

WAYNE J. REYNOLDS, DO 2006-2007 VAFP PRESIDENT

NOTE: Dr. Reynolds presented this speech during the VAFP Installation Ceremony held in conjunction with the VAFP Annual Meeting.

Thank you to the members of the Board for agreeing to serve the Academy this next year; for without your devotion and commitment, the Academy could not continue to move forward in its mission to promote and advance family medicine in the great Commonwealth of Virginia. I would like to thank one and all for this tremendous honor and privilege to serve as your President this next year and hope to promote, to my utmost abilities, the vision and mission of the Virginia Academy of Family Physicians. With this in mind, I have chosen the theme of **PRIDE** in Family Medicine, with each letter representing an individual goal.



To begin with, “**P**”, which not only stands for *Pride*, but also *Proud*. I know with these trying times in medicine today it is hard to take Pride and be Proud in the work we do, but I would ask for each of us to reflect on that work, and realize that we can and should take Pride and be Proud of the work that we do, even though others may not realize and appreciate that work on a day to day basis. For example, the status of our health system would be in complete disarray without the family physician. This is exemplified by the fact that when a specialist gets into trouble, who many times are they calling upon to coordinate the care of a complex patient, but that patient’s family physician who has an in depth relationship with not only the patient, but also their families. So take Pride and be Proud in the work we do on a day-to-day basis even though the thank-yous and compensation we receive may not always be compensatory with the work we do.

Next, “**R**” stands for *Research* and the importance of getting more family physicians involved in the trenches doing clinical research. While I believe and support the majority of Phase I and Phase II research being completed at the academic and institutional level, I believe and support the majority of Phase III and IV research being done at the family physician level across the country in diverse clinical settings. In this way we may get a broader experience in the testing of these new therapies. By doing so would help uncover potential unseen complications of these new therapies in advance of their release as we have seen with so many new drugs and therapies that have come to the market in the past few years that have had to be removed from the market due to potential safety issues. I would like to encourage all of us in this audience to consider membership in the American Academy of Family Physicians National Research Network, which is an independent organization, which looks to support research in family medicine. The goals of the Network are fivefold:

- 1) to address questions of importance to family medicine,
- 2) to improve care by family physicians,
- 3) to improve family physician finances,
- 4) to improve the health status of our patients and their families, and finally
- 5) to improve the health status of our communities.

Without going into further details at this time I would be happy to entertain questions during the rest of this weekend individually as I have been a member for the past 10 years and have found it to be a rewarding and educational relationship. And just a quick plug, Virginia will host the next convention of the Network in March 2007 at the Founder’s Mill Inn in Virginia Beach.

Next “**I**” stands for *Innovation* in family medicine. While there have been many innovations in medicine, one of the most important, but heavily debated has been the electronic medical record. This has been set as a priority in the American

Academy of Family Physicians Future of Family Medicine

Report and while many of our membership have embraced the concept, I truly appreciate the reality of the investment and cost of every member adopting an EMR. I would still like to encourage those with a time line of 5 or more years before retiring to consider the adoption of this innovation in medicine. The efficiency over the long run truly exceeds the investment involved in the investment, and improves the quality of patient care we may bring to our aging patient population. The ability to track and monitor our patients with diabetes, HTN, Hyperlipidemia by following their HgA1c's, Micro albumins, lipids and blood pressures truly improves their overall care and helps prevent the long-term complications we see these diseases. And this does not even include the benefit for our pediatric patients, with their need for so many immunizations, and the ability to closely monitor prescription refills which I have found personally to be the biggest and most efficient time saver, particularly related to controlled substances. There is clearly no fooling the computer, because each prescription is time and dated in the medical record.

“**D**”, stands for *Devotion* to our patients and our families. Medicine is a demanding career, but one must never lose sight of why we chose family medicine as our career. The services we provide are to be applauded. The continued devotion to our patients is truly appreciated by so many. But I would also like to remind us of the importance of our devotion to our families as I truly understand the commitments that family medicine takes in the day to day care of our patients and that this many times takes us away from the commitments of our families such as missed soccer games and recitals. While I know our families are understanding of these commitments these are cherished times that cannot be relived.

“**D**” also stands for *Diversity* and recognizing that in 2006 we have entered a global economy and that more and more of the patients we are seeing in family medicine hail from all over the world. I know in my practice I am seeing many more Japanese, Russians, Bosnians, and African refugees that have come with many unique and fascinating language barriers and medical issues. Sensitivity to these issues has created an opportunity for new experiences and the beginning of life long friendships. Appreciating this concept and fully taking the extra time to explore and ask about the cultural differences, I have found to be extremely rewarding.

And finally, “**E**”, stands for *Evolution*, and very briefly, evolution in life is inevitable and the evolution we have seen in just the last 100 years of technology, I don't believe anybody could have predicted except maybe HG Wells. We have moved very rapidly into the 21st century and I would ask everybody to keep in mind that without evolution, a species would over time lead to its own extinction.

In closing, take **PRIDE** and be *proud* to be a family physician. Consider *research* in your individual practices, consider *innovation* for your future and growth of your practice, embrace *devotion* to your patients and your families, and finally remember without *evolution* leads to extinction.

Again, thank you for this honor and I look forward to serving you this year and hope if you have any issues or concerns for the VAFP you will contact myself or our central office in Richmond at 804-968-5200.



MEDICAL MALPRACTICE INSURANCE:

Thomas P. Cox, ARM

President

PhillipsCox Insurance

The Physician Division of RCM&D Healthcare

WHAT'S NEXT?

Between 1992 and 2001 physicians enjoyed one of the longest, softest medical professional liability (“malpractice”) insurance markets since the tort system in this country changed in the 1970’s. Malpractice insurance rates increased dramatically in recent years, however, and several malpractice insurance companies went out of business. This “hard” market only abated in 2006 with most physicians seeing little or no premium increase and some seeing a premium decrease.

So, what is next? Will the soft market continue? Will it harden again? In either case, what will be the determining factors?

First of all, hard markets and soft markets both always return. Presently it appears as if the soft market will continue, at least in Virginia, for the next few years. While there remain isolated “hot spots” for malpractice insurance in different areas around the United States, according to most experts Virginia has the most competitive marketplace in the country. This is the only state with seven standard market companies fighting for business. This means that market forces alone will help continue the

soft market.

In addition to competition, the insurance companies are being told by their actuaries that rates appear to be sufficient. This information was included in the Risk Management Committee report that came out of the ongoing Virginia General Assembly study. Remember that one challenge to being a successful malpractice insurance company is that you will not know if your rates are sufficient until three to five years later, as it takes that long for claims to mature and close. One reason rates increased during the last five years is because losses trended upwards very rapidly between 1996 and 2001, actually doubling on a national basis. The average jury verdict in medical malpractice cases in 1996 was just over \$500,000, according to Jury Verdict Research; in 2001 the average jury verdict had increased to over \$1 million. Most malpractice insurance companies in Virginia saw an increase in indemnity payments of around 50% subsequent to August 1, 2001 when the cap on damages increased from \$1 million to \$1.5 million. These rapid increases placed the insurance companies in a position of constantly playing catch

up to the losses they were incurring.

So, if the rates appear to be sufficient and there is good competition in Virginia, what might happen to turn the market hard again? The first thing that comes to mind is the elimination of the cap on damages in Virginia. The cap will increase each of the next two years, reaching \$2 million per claim on July 1, 2008. Rates may have to increase slightly to keep pace with these increases, as well as losses incurred due to past increases in the cap. What no one is quite sure about right now is what happens to the cap after July 1, 2008. Does it stay or go? Will it be indexed for inflation, perhaps dating back to 1976? This step could increase the cap to around \$2.8 million. Make sure you keep the ear of your state senator and delegate on this matter.

The last hard market was also heavily influenced by increased losses in the reinsurance market, reinsurance being what insurance companies purchase to protect themselves from large losses. The events of September 11, 2001 certainly had an impact, but back then the reinsurance market was already hardening, something we told

our customers about in January 2001. In the years leading up to 09/11/01 the reinsurance industry was dealing with a slowly eroding financial situation due to property (natural disaster) and asbestos losses, plus medical malpractice losses. The September 11th attacks exacerbated the situation because, while actuaries include natural

Casualty reinsurance industry, but not so severe as to trickle over to the casualty side and impact malpractice rates. However, another bad year (as this is written, so far, so good) and all bets are off.

The soft market in Virginia would also be hardened by increased losses. As a few recent studies have shown, as losses go up, rates go up.

writes coverage at 15% to 50% below the established market. The rates, of course, are not sustainable when the claims start to come in, so in about three years the carrier must quickly raise rates up to where the established carriers rates are or higher, or go out of business or pull out of the state. This is what happened with many carriers in



disaster modeling when calculating rates, it is impossible to predict a man-made disaster such as a terrorist attack. In addition, the losses associated with the September 11th attacks were so large and cut across virtually every line of insurance, including life, disability, property, worker's compensation, business interruption, etc.

The natural disaster losses in 2005 were severe enough to impact the property side of the Property &

Sounds pretty simple, but during the recent hard market there were plenty of people trying to lay the blame elsewhere.

Finally, the soft market may disappear if we return to some of the practices of the 1990's, where companies were writing business at rates that were not sustainable. Called "market share underwriting" by the insurance industry, this means that a company enters a market or line of insurance and

Virginia in the late 1990's, carriers that are no longer with us today. While physicians originally loved the low rates they received, this behavior forced down all rates to artificially low levels. When the companies writing at these low rates disappeared, the start of the hard market ensued.

The old rule still applies: if something looks too good to be true it probably is.

FAMILY PHYSICIANS SELECTED FOR CLAUDE MOORE PHYSICIAN LEADERSHIP INSTITUTE

Kurtis S. Elward, MD, Thomas W. Eppes, Jr., MD, Patricia A. Pletke, MD, Sterling N. Ransone, Jr., MD, Diane L. Reynolds-Cane, MD and Cynthia C. Romero, MD, FAAFP have been selected to participate in the inaugural class of the Medical Society of Virginia Foundation's (MSVF) Claude Moore Physician Leadership Institute. They will join 14 other physicians from across the Commonwealth to strengthen their leadership abilities and gain the skills necessary to improve health care in Virginia.

"While medical school and residency prepare physicians to provide the best care for their patients, these educational venues do not typically provide the training necessary to serve as adept community, organizational or business leaders," said Beth Bortz, executive director of MSVF. "Thanks to a generous grant from the Claude Moore Charitable Foundation, MSVF has been able to launch an innovative initiative to better prepare physicians for the challenges of the current health care environment."

Participants have shared their views on the importance of this learning opportunity. "As a rural physician practicing outpatient medicine, I have relatively little contact with other doctors," said Ransone. "The networking opportunities provided through the Physician Leadership Institute will give me a sounding board for ideas I have for improving the delivery of health care for my patients and for all Virginians."

Romero and Reynolds-Cane are seeking effective ways to improve health care in their communities. Romero said, "I am eager to participate in the Institute with other physicians who are committed to enhancing their personal skills to benefit other physicians, physician organizations, communities and ultimately, all Virginia patients. I intend to use what I learn through the Institute to help ensure that efforts within the community, in hospitals, in physician communities and in medical organizations are focused on and pertinent to improving health and the delivery of health care in the Commonwealth."

"My participation in the Institute will benefit my community by equipping me with the tools required to develop innovative health policy that will enable improvements in health care locally and throughout the Commonwealth," Dr. Reynolds-Cane said.

Elward believes the coursework and the interaction with fellow physicians will enable him to be a better advocate for improved health care.

"We have a tradition and certain transcendent health care values that cannot be replicated or replaced. However, our way of delivering this care is undergoing a dramatic change. We must also change and realize the future will be based on what our patients want and need,

and also some honest market facts," he said. "I believe that physicians must present better solutions for the health care needs of our country and our individual patients – and it will take our collective efforts to achieve it. The Institute offers the opportunity for me to develop skills both through the course work and through contact with colleagues and mentors that will enable me to be part of finding solutions."

"Expanding our horizons is critical to forward growth. Every opportunity to learn from peers statewide and from experts can only benefit one who wishes to be a leader in organized medicine," Eppes said.

By participating in the Institute, Dr. Pletke hopes gain the skills to more effectively promote care for the uninsured.

"I am especially passionate about meeting the health care needs of the underserved and am excited by the opportunity to share with and learn from other physicians with similar passion. I will use skills learned through the Institute to increase collaboration among colleagues who are also interested in similar issues as well as to inspire new physicians to take an active role in organized medicine," she said.

The Physician Leadership Institute has assembled a cadre of experienced professionals to guide participants through the following four tracks:

- Public Policy
- Community Health
- Clinical Care
- Executive Management

After a joint meeting in September, each physician will select one of these areas to focus on throughout the eight-month program. Some of the distinguished speakers include Marilyn Tavenner, Virginia Secretary of Health and Human Resources; Del. Phillip Hamilton; Charles Dwyer, PhD; Edward F. X. Hughes, MD; Hugh Gouldthorpe; and Wally Stettinius.

Participants were chosen from a competitive pool of applicants by a selection committee comprised of members of the Physician Leadership Institute Advisory Board. Participation in the program required membership within the MSV, nomination by a local or specialty medical society and good standing in the physician community.

The Claude Moore Charitable Foundation awarded MSVF a \$467,000 grant to fund the Physician Leadership Institute over the next five years. In addition, HCA Virginia is a Presidential sponsor of the Institute.

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

FAMILY PRACTICE FLIGHT SURGEON



WE HELD IT UP TO AN ENTIRE INDUSTRY,
AND THIS IS WHAT WE HEARD.

There are too many malpractice claims, office management responsibilities and pesky HMOs. If you are a doctor and want to return to practicing medicine, call **1-800-423-USAF** or find out more by logging on to our Web site at **airforce.com**.



U.S. AIR FORCE
CROSS INTO THE BLUE

THE VAFP WELCOMES NEW MEMBERS

New Members

ACTIVE

Adam Brett Cook, MD-Midlothian
Alan Edward Noble, MD-Roanoke
Alice Eusebio Ordonez, MD-Virginia Beach
Alison Prestia Guptill, MD-Raleigh
Alysia C Ogburia, MD-Alexandria
Aman Gill, MD-Herndon
Bao-Dan Tran Nguyen, DO-Fairfax
Bernard Anthony Stupski, DO-
Charlottesville
Beverly Bernice Brown, MD-Roanoke
Chelsea Coffey Hamman, MD-Marion
Cheryl Taitano, MD-Aldie
Chi-Feng Lucy Hsieh, MD-Fairfax
Christine Hyunsook Lee, MD-Fairfax
Cristina Mai Covert, MD-Roanoke
Cuong Tan Doan, MD-Midlothian
Denise Ann Way, MD-Charlottesville
Dudley Allen Raine Jr, MD-Amherst
Eveline Biyoga Ane, MD-Silver Spring
Francis Valerian Javier, MD-Roanoke
Garry Wai Keung Ho, MD-Annandale
Hannah E Miedel, MD-Vinton
Himabindu Chinnepalli, MD-Maggotty
Ian Wilson Bushell, MD-Charlottesville
Jessica Leah Ormsmith, MD-Midlothian
Joseph Ryan Teel, MD-Lynchburg
Kabaye Berhanu, MD-Chesapeake
Kafui Vida Tsikata, MD-Midlothian
Karissa Lynn Hackelton, MD-Richmond
Kevin Jamil Sahli, MD-Richmond
Lee Coleman Hinnant, MD-Virginia Beach
Lisa Elana Allen, DO-Chapel Hill
Lisa Marie Knust, MD-Newport News
Lorren Michael Donmoyer, MD-
Portsmouth
Malinda A Brooks-Williams, MD-Richmond
Mark Alan Clarkson, DO-Roanoke
Mark D Erhardt, DO-Bartlesville

Marsha Lynn Taylor, MD-North Garden
Martin R Bohnenkamp, MD-Williamsburg
Maura Eileen Redington, MD-
Charlottesville
Meenal G Dandekar, MD-Newport News
Naeem Khan, MD-Springfield
Nicole Rene Scanlon, MD-Altavista
Olumuyiwa Gisanrin, MD-Newport News
Omar Iqbal Khan, MD-Hanover
Pamela Gray Herbert, MD-Lynchburg
Patricia Cecilia Richardson, MD-Centreville
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William Flinn Ball Sr, MD-Roanoke

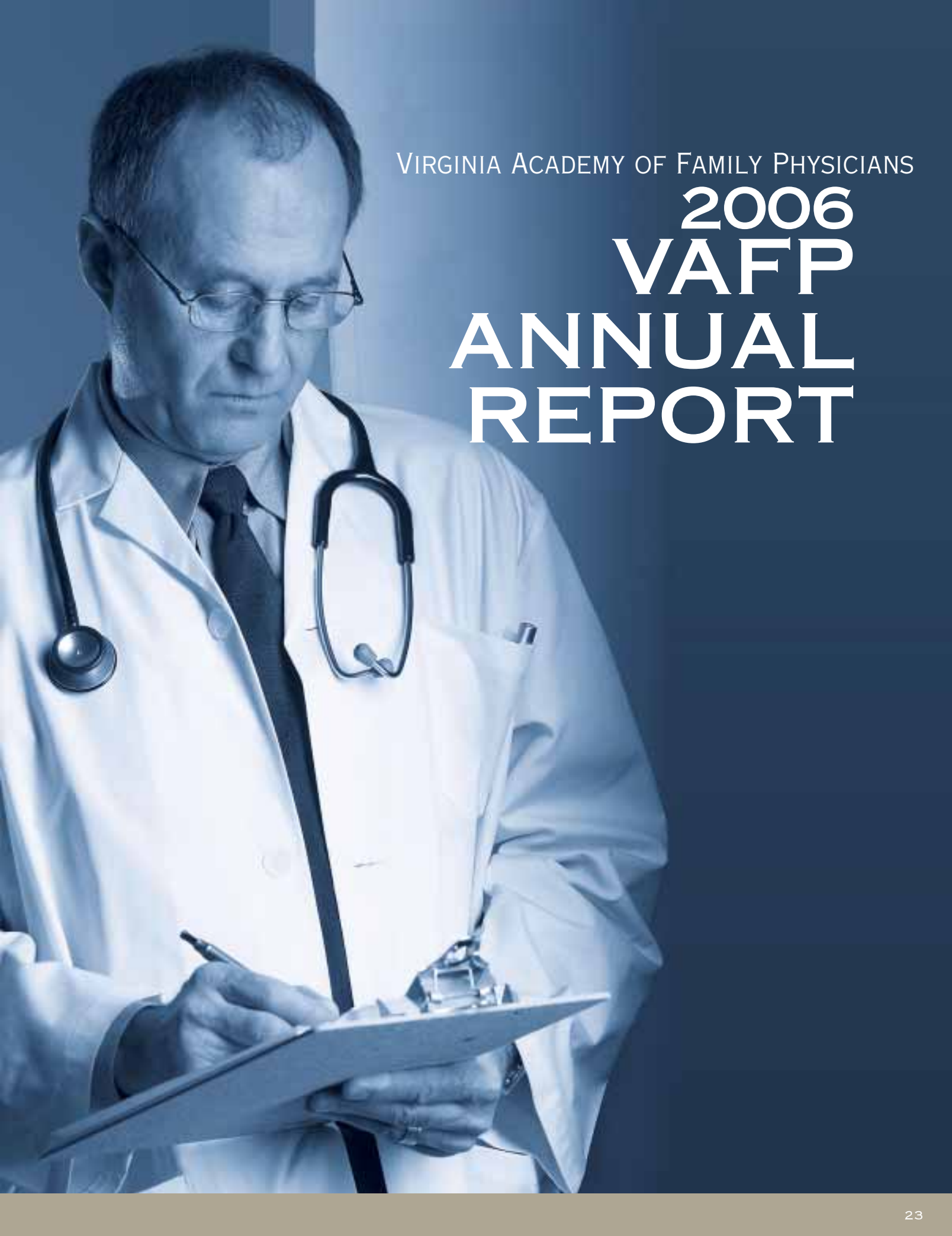
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Shagufta Maududi, MD-Roanoke
Sireesha Dasari, MD-Roanoke
Tara Glennon, MD-Charlottesville
Winston Liaw, MD-Houston
Yuhee Kim, MD-Roanoke

STUDENT

Mr Mark Wayne Jankowske-Troutdale
Ms Biljana Simikic-Fall Branch
Ms Catherine Rogers Rainbow-Norfolk
Ms Rebecca Anna Brooks-Charlottesville
Ms Ronna Denise Compton-Grundy



VIRGINIA ACADEMY OF FAMILY PHYSICIANS

2006
VAFP
ANNUAL
REPORT

2006 VAFP ANNUAL REPORT

Annual Report



OUTGOING PRESIDENT'S MESSAGE KURTIS S. ELWARD, MD, MPH, FAAFP CHARLOTTESVILLE

Dear Colleagues,

This has been an exciting and humbling year as your President. I continue to be incredibly impressed by the dedication you all have to outstanding patient care and the consistent focus on the ideals of Family Medicine. I am also impressed with the commitment and incredible talents currently present on the Board. These outstanding physicians represent you extremely well in so many of the areas of tremendous importance to your practice. Several hold national leadership positions and one of our former presidents, Dr. David Ellington, will be a candidate for the AAFP Board of Directors in 2007.

There have been a number of accomplishments this year that directly pertain to those of you in practice. We have successfully initiated a program for group completion of an asthma self-assessment module which has received extremely positive feedback and has made the recertification process much more positive and efficient. Please see the Quality Task Force Report for details.

As also described in the Quality Task Force Report, we have partnered with our academic colleagues and the National TransforMED Program to showcase outstanding innovations in practice enhancement and allow the active interchange of ideas among our membership. We are also developing innovative approaches to completion of the Part 4 requirement of the ABFM (performance in practice modules), which we believe will place Virginia Family Physicians as leaders in patient care and practice innovation.

Your leadership recently had a very productive meeting with Marilyn Tavenner, the Governor's Secretary of Health and Human Resources. The VAFP has been invited to provide representation on the Governor's Strategic Planning Task Force, as well as its next iteration of work on electronic health records and information technology.

The challenges of Family Medicine continue to increase. Thirty percent rises in malpractice costs continue to impair the scope of practice that Family Physicians can offer. Certain managed care contracts inappropriately restrict access and reduce appropriate reimbursement for Primary Care; and efficiency and costs are further compromised by heavy regulatory burdens. To this end, your VAFP leadership realizes the importance of strategic planning for the tasks ahead, and more important, strategic action and advocacy for you, our membership. Your Board will be engaging in a series of strategic action and practical leadership development activities that are intended to supply the skills and focus needed to address the many important areas you will be facing over the coming years. You will be receiving a member survey asking your input into both priority areas and specific strategies to meet these challenges. I strongly encourage you to take time in considering this request for input and providing counsel and suggestions to us, both from your head and from your gut, as a family physician.

I want to urge your strong support for our new president, Dr. Wayne Reynolds. I am pleased to pass the leadership role to his capable hands and strongly endorse his emphasis on the pride, power and purpose of Family Medicine. I also applaud the efforts of our upcoming President-elect, Dr. Sterling Ransone. You can look forward to strong leadership and consistent advocacy for you and your patients as they take the helm.

Finally, I want to especially mention the outstanding staff headed by Terry Schulte and assisted so superbly by Mary Lindsay White. As I have visited other states this year and engaged presidents from other academies, it has been remarkable what a truly outstanding staff we have. Please take time during this meeting to thank them for their efforts and the tremendous dedication they consistently show on your behalf.

Thank you again for the privilege of serving you as your President. It is truly an honor being able to serve Virginia's Family Physicians.

INCOMING PRESIDENT'S MESSAGE
WAYNE J. REYNOLDS, DO, GLOUCESTER POINT



With a new year upon us, I would first like to congratulate and thank our outgoing President Dr. Kurt Elward for his fine leadership and support of the Virginia Academy over this past year. Our Academy has continued to move forward on several fronts with the challenges facing each of us as family physicians and Dr. Elward has led the charge with thoughtful insight and enthusiasm. The Board of Directors has been there each step of the way and continues to work on many of the bigger issues facing each of us that we sometimes take for granted on a day-to-day basis. Some of the issues include various legislative and insurance issues, practice management challenges and our ever-growing need for concise, up to date, evidenced based continuing medical education.

We are truly fortunate to have such a strong state Academy with so many dedicated family physicians willing to volunteer their time and energy to help us move forward with our various missions. It will be with great honor and respect that I will be assuming the roll as President this coming year, and I look forward to serving to the best of my ability to promote the Virginia Academy's goals and objectives for 2006-2007.

Taking PRIDE in being a family physician is what I would ask each of our members to consider and promote this coming year as we move forward with our goals for it is something very simple that each of us can do. Whether talking with our patients, our staff, insurance companies, and particularly our medical students, taking PRIDE in being a first class citizen of medicine, a family physician is something all to often forgotten during the busy encounter. I would hope we all chose the specialty of family medicine to take the very best care of the whole patient and the whole family like no other specialty can.

The Virginia Academy is dedicated to supporting this goal and with your help, we will continue to help every patient in the Commonwealth of Virginia find a medical home with a dedicated, caring family physician.

Again, I look forward and am honored to serve as your President over the next year. If the Academy or I can assist you in any way please do not hesitate to contact the Academy office at 1-800-THE-VAFP.

HONORS AND AWARDS

The Honors and Awards task force coordinates promotion of the importance and availability of the various VAFP Awards to Academy members. The Award applications were promoted in several issues of the VAFP Newsletter, via all member email and were also promoted on site during the VAFP Winter Family Medicine Weekend held at Wintergreen, Virginia in February, 2006.

Regrettably, the VAFP did not receive any nominations for Family Physician of the Year but did receive several nominations for the Teacher of the Year Award and the Volunteer of the Year Award. Included in each registrants packet are nomination forms for all 2007 VAFP Awards and the task force respectfully requests members to nominate a fellow family physician for one of these outstanding awards this year.

Those selected will be presented the Awards during the VAFP Installation & Awards Dinner scheduled Saturday evening July 22.

Virginia Academy of Family Physicians - 2006 Award Recipients:

Legislator of the Year
The Honorable Phillip Hamilton
Newport News

James P. Charlton, MD
Teacher of the Year Award
Family Physicians of Chester
Chester

F. Elliott Oglesby, MD
Volunteer of the Year Award
Mitchell B. Miller, MD
Virginia Beach

FINANCES

The Virginia Academy of Family Physicians continues its tradition of operating under sound financial management. This effort is led by VAFP Treasurer David A. Ellington, MD.

The VAFP is the only constituent chapter of the American Academy of Family Physicians that has not had a dues increase in the previous sixteen (16) years. The VAFP's last dues increase was in 1990. For AAFP Chapters with an active membership of 1,000 members or more, VAFP dues are the second lowest. Only the Uniformed Services chapter's dues are lower.

The percentages of dues revenue versus non-dues revenue are "water mark" numbers that reflect the financial acumen of associations. Statistics from the American Society of Association Executives indicate that on average most individual membership associations have dues revenue in the 60-70% of total revenue and non-dues revenue in the 30-40% range. For fiscal year 2005, the Academy's dues revenue was 49% of total revenue and non-dues revenue stood at 51% of total revenue. Successful associations in today's environment must become less reliant on dues revenue and increase their focus on non-dues revenue. The VAFP is committed to that philosophy.

Physicians spent a lot of energy in the 2006 Regular Session trying to restore what they lost in a Virginia Supreme Court decision (*Oraee v. Breeding*) in November 2005. The new statute provides that a physician (now defined in this statute to include MDs, DOs, chiropractors and podiatrists) is not liable for failure to review or act on results of laboratory tests or examinations that s/he did not request or authorize, unless the physician is provided the report with a request for consultation, the physician assumes responsibility for the report, or the physician has reason to know the report result is needed. The physician also must prove one of the following: (1) no physician-patient relationship existed, (2) the physician received the results without a request for consultation, (3) the results were not part of the physician's management of the patient, or (4) interpreting the results would exceed the physician's scope of practice.

The Virginia Birth Injury Program will require significant additional funding to become actuarially sound. A report submitted by the Program to the Assembly (House Document 11) outlines the reasons and possible sources for this additional funding. Next year inevitably will see legislation that provides this funding. The 2006 Regular Session enacted legislation (Senate Bill 632) that may increase the Program's financial difficulties rather than reduce them. The groups who benefit from this Program - whether claimant families, physicians, insurers, or hospitals - need to agree on a solution that is palatable for them all and will ensure future financial stability to the Program.

Two other bills require special comment, the first because it wasn't defeated outright during the 2006 Assembly and the other because it adds some clarity to an issue that constantly has remained obscure to physicians and other providers.

House Bill 253 would have required health plans to recognize an assignment of benefits made by a patient to a physician. This bill was continued to the 2007 Session. Heavy lobbying by Anthem and other health plans in this and prior sessions of the legislature normally has resulted in this bill's counterparts being defeated. It's unclear whether the fact that House Bill 323 was continued until 2007 means the door may be open for its consideration.

LEGISLATIVE

The 2006 Session of the General Assembly saw physicians trying hard to keep from losing advantages earned in prior years. As this summary is being written in mid-June, there's still no state budget. The budget bill that was discussed during the regular and special sessions of the legislature contained overall increases for physician Medicaid payment rates, with additional increases for physicians providing pediatric services, but those earlier results could change with the enactment of a final budget bill.

The second bill, House Bill 323, now requires that any health plan that rents its provider network to unaffiliated plans make a list of those plans available to its providers upon request. This is important legislation. Many health plans rent their provider networks, usually without the knowledge or the agreement of its contracted providers. If this information does not appear on a health plan's web site after July 1, 2006, providers should request the information directly from the plan.

A detailed summary of health care legislation enacted in the 2006 Session of the General Assembly is posted on the Virginia Academy of Family Physicians web site at www.vafp.org.

MEMBERSHIP

The Virginia Academy of Family Physicians membership continues to increase annually. As of May 31, 2006, active membership in the VAFP stood at 1,656 active members which is the largest number of active members in the association's history. Total VAFP membership is 2,493 which includes 1,656 active members, 437 students members, 198 resident members, 157 life members, 38 inactive members and 7 supporting members.

The Virginia Academy of Family Physicians is the thirteenth largest chapter of the American Academy of Family Physicians. The VAFP is also the largest medical specialty society in the Commonwealth.

The Virginia Academy of Family Physicians is delighted to report that during the time period of May 31, 2005 to May 31, 2006, the increase in the VAFP active membership was the third highest nationally. Only California and Florida, which are significantly larger AAFP Chapters, recruited more active members.

NECROLOGY REPORT

Robert L. Cassidy, MD
(VAFP Past President)
Culpeper, VA

Raymond D. Dyer, Jr., MD
Blacksburg, VA

Keith C. Edmunds, MD
Roanoke, VA

Melvin L. Horne, MD
Virginia Beach, VA

Gustavus V. Jackson, Jr., MD
Richmond, VA

Howard Kruger, MD
(VAFP Past President)
Norfolk, VA

Monica C. Lobo, MD
Charlottesville, VA

Robert L. McCorkle, MD
Tappahannock, VA

Saeed K. Nassiri, MD
Richmond, VA

Samuel A. Royola, MD
Roswell, NM

Robert J. Stewart, MD
Mathews, VA

ST. FRANCIS FAMILY MEDICINE RESIDENCY PROGRAM

DONALD E. YEATTS, D.D.S., M.D.
ASSOCIATE DIRECTOR

The new St. Francis Family Medicine Residency began on July 1, 2005. The convergence of a series of unique opportunities led to its creation.

After a rich 32 year history of training hundreds of Family Medicine physicians in the art and science of rural medicine, Blackstone Family Medicine Residency was closing its doors in June, 2005. Concurrently, the Bon Secours Health System, which owned Blackstone Family Medicine, was opening a new hospital in Chesterfield County, St. Francis Medical Center. Bon Secours also owned Harbour Pointe Family Practice, a two-physician practice, which was about 10 minutes away from this new hospital. The decision was made to bring these entities together to create a new Family Medicine residency in the rapidly growing area of Western Chesterfield County.

Greater than a year of discussion and planning took place involving representatives from Bon Secours, the VCU Department of Family Medicine including Dr. Tony Kuzel and Dr. Paul Munsen, Blackstone Family Medicine, and Harbour Pointe Family Practice. Through those tireless efforts, the residency opened its doors with 7 new residents in July, 2005.

The newly constructed Family Medicine Center is a beautiful building constructed specifically to fit the needs of a residency program. The primary hospital, St. Francis Medical Center, a state-of-the-art facility in which most of the rotations will occur, opened in September 2005. This program, affiliated with the VCU Department of Family Medicine, has received accreditation from the ACGME for eighteen total residents, six for each class. With the PGY-1 and PGY-2 classes now settled in, the residency has filled all available positions.

During its beginning stages, St. Francis Family Medicine residency was privileged to have Dr. Steve Spence serve as interim director. Dr. Spence, the former Blackstone Family Medicine Residency Director, has 26 years of experience in resident education and provided invaluable expertise in the planning and implementation of this program. On July 1, 2006, Dr. Spence passed the mantle of leadership to Dr. Paul Jackson.

The faculty brings a wealth of experience and knowledge to the residency. Dr. Jackson, the residency director, has over a decade of private practice experience. He has been a preceptor with VCU's Fundamentals of Clinical Medicine course and has worked as associate director of the residency during the time Dr. Spence served as interim director. Dr. Donald Yeatts is also a dentist. He has served as a reviewer and has written for the American Family Physician. He was the founder of Harbour Pointe Family Practice and also started a free medical clinic in Chesterfield County to provide care to the uninsured. Dr. Yeatts is a Fellow of the American Academy of Family Physicians. Both Drs. Jackson and Yeatts completed their residency at Chesterfield Family Medicine. Dr. Glenna Hendricks brings nursing experience from the VCU Medical Center emergency department and ICU. She completed her residencies in Obstetrics and Gynecology and Family Medicine at Riverside Regional Medical Center in June 2005. Dr. Hendricks has published in the American Family Physician. Dr. Phil Sherod has many years of experience of rural medical practice. He completed his residency at Blackstone Family Practice and a Faculty Development Fellowship at the University of North Carolina-Chapel Hill. He is a Fellow of the AAFP and holds a Certificate of Added Qualification in

Sports Medicine. Among his publications are articles in the American Family Physician and the Journal of Family Practice. Dr. Peter Pyatak is an Ob-Gyn specialist who has a special interest in urinary problems of women. Dr. Charles Miller is an Ob-Gyn specialist with years of experience as a faculty in the Riverside Regional Medical Center Ob-Gyn residency. Leslie Fehan is a Certified Nurse Midwife with experience at VCU Medical Center and experience in alternative birthing options for women.

The educational experience of the residents will be unique and have several focuses, all of which will enhance their training. The Bon Secours system has scores of specialist physicians who eagerly precept our residents during their off-service rotations. The residency will have a special focus on women's health. Dr. Hendricks along with the rest of the Ob-Gyn specialists see patients and precept residents in the Family Medicine Center as well as a new satellite office which St. Francis Family Medicine operates as "The Woman's Center" on the hospital campus. The residency will provide a rural health experience with scheduled rotations in the 2nd and 3rd year, under the supervision of Dr. Steve Spence, at Blackstone Family Practice.

The residents report a great satisfaction with their experience so far. Dr. Farhan Malik, a second year resident, comments that the faculty support has been "tremendous." The women's health experience and outpatient medicine are mentioned as strengths by the residents. They feel that their educational experience is making them fully prepared to be excellent Family Physicians.

Building on the decades of experience with the Blackstone Family Practice Residency, a wonderful faculty and staff, as well as the excitement of being involved in a new residency, new family medicine center, and a new hospital, St. Francis Family Medicine plans to provide superior preparation for the next generation of Family Physician.



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NETWORKING OPPORTUNITIES

Networking Opportunities

Third year resident in Family Medicine at the University of Minnesota St. Joseph's Hospital, St. Paul, MN seeking a position in Virginia. Will complete training in July 2007, and will be available for employment at that time. Looking for a traditional FP practice with hospital and clinical work - preferably with OB. If interested, please contact Patrick Moche at moche_p@hotmail.com.

Texas Tech Family Medicine PGY III Resident exploring practice opportunity in Henrico County or Richmond or suburb starting JULY, 2007. Looking for group practice opportunity in a Family Medicine clinic (group with hospital privileges to admit). Also interested in short-term locum opportunity. If interested, please contact Rumki.Banerjee@ttuhsc.edu or call cell phone 469-233-3414. Will be happy to forward CV. Dr. Rumki (Roma) Banerjee, MD Texas Tech University Health Science Center

1400 Wallace Amarillo, TX 79106.

Family Practice Physician - An established Family Practice (19 years) located in Mechanicsville, Virginia is seeking a full time Board Certified/Board Eligible Family Practice Physician. Our practice includes an electronic medical records system and on site x-ray. Enjoy a great combination of a suburban/rural lifestyle with a call schedule of 1:7 (no OB). Starting salary dependent upon experience and qualifications. Benefits include:

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For immediate consideration, please contact: Charles Thomas, Practice Administrator, 9376 Atlee Station Road, Mechanicsville, VA 23116; telephone (804) 427-7031; cell

(804) 347-9494; fax (804) 730-3375; e-mail: thomasc@hanoverfp.org.

InoMedic Inc is looking for a board certified family practice physician to provide outpatient services for the 1st Medical Group Hospital, Langley AFB, Hampton Virginia. The physician will be assigned a panel of eligible beneficiaries (military personnel and their families) as their primary care provider. A Virginia license is required and pay and benefits are competitive. Interested parties are requested to submit a resume (electronically or fax) and or call Verba Moore, MD or Leroy Gross, MD for additional information.

InoMedic Inc
2 Eaton Street, Suite 708
Hampton, Virginia 23669
757-722-7575
757-722-2233 fax
lpgross@inomedic.com

2007 CME CALENDAR

Meet us in the Mountains . . .

VAFP Winter Family Medicine Weekend

February 2-4, 2007

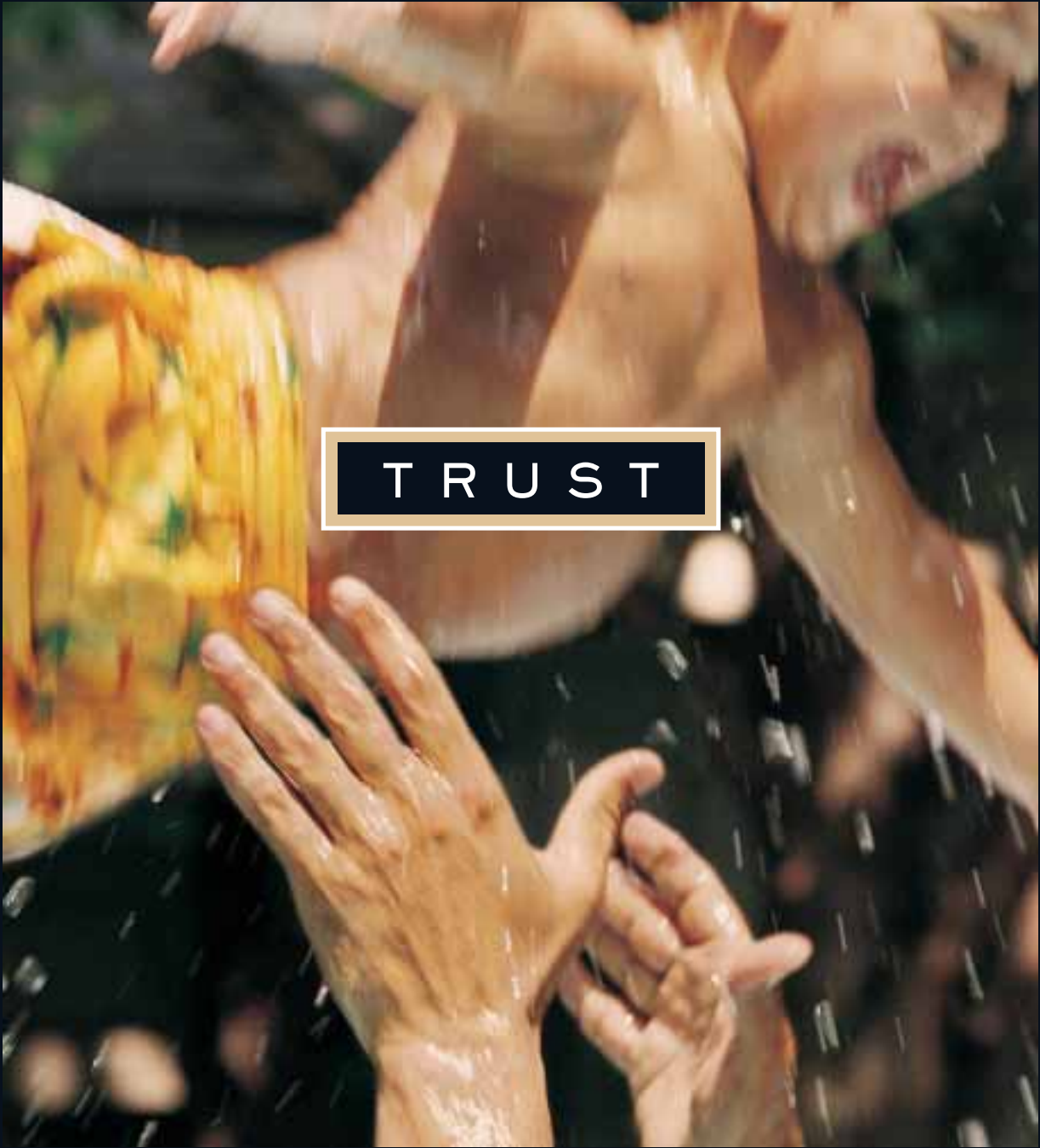
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