

MAOFP NEWS

A Publication from the Michigan Association of Osteopathic Family Physicians, Inc.

Summer 2011

President's Message



Jeffrey Stevens, D.O.

Good evening from Grand Rapids. It seems that summer is finally making its entrance, a welcome sight I must say. It seemed it would never get warm this year. My golf clubs were starting to feel neglected.

It's hard to believe my year as president is almost over. It seems only yesterday I was taking over at Crystal Mountain. It has been a fabulous year so far. At the ACOFP conference, one of our former MAOFP Presidents, George Sawabini, was installed as ACOFP President. What an incredible honor for an extremely

hard working ambassador for Osteopathic Family Medicine. I was fortunate to present an award to another MAOFP past-president, Kurt Anderson, DO as he took over as President of the Michigan Osteopathic Association. Congratulations to both of you. It shows that our organization truly does train strong leaders in the Osteopathic profession.

I am happy to report that our association once again brought home hardware at the ACOFP annual conference. Michigan was awarded the Educational Society of the Year. Our education committee deserves the credit. I would like to personally thank the committee chair, David Best DO, and MAOFP staff Sara Carson, for all the hours of hard work. We could not have done it without you.

The board is quite engaged and motivated to move forward into the new era of health care. I am happy to lead such an active group of physicians. We have a strategic board retreat this September where we hope to finalize our short/medium and long term goals

for the association. Our board is very well aware of the challenges our members face every day in practice. We want to be a strong voice for every osteopathic family physician in Michigan, and to do that we need to truly understand what our members want and need in this incredibly important time. I have confidence that our board will be up to the task at hand and put this organization on the path to great things.

It has truly been an honor to serve as your president, and I know the incoming President, Andrew Adair, DO will do an excellent job taking us into the future.

Thanks for your confidence,

Jeffrey Stevens, D.O.
President

Board of Directors

President – Jeffrey Stevens, D.O. **President-Elect** – Andrew Adair, D.O.

Secretary/Treasurer – William Morrone, D.O. **Past President** – Steven Dupuis, D.O.

Executive Director – Myral Robbins, D.O. **Directors** – Lawrence Abramson, D.O., David Best, D.O., Patrick Botz, D.O., Glenn Gradis, D.O., Algirdas Juocys, D.O., Frank Komara, D.O., Thomas Reeths, D.O., Kathleen Rollinger, D.O., Kristopher Brenner, D.O., R. Taylor Scott, D.O.

Resident Director – Leah Cecil, D.O. **Student Director** – Ryan Spencer

Michigan Leadership – In The News

The MAOFP would like to congratulate our Past President and MOA Past President, **George Sawabini, D.O., FACOFP, dist.** for being elected as the 58th President of the American College of Osteopathic Family Physicians in March 2011 in San Antonio, Texas. **Mark Sikorski, D.O., FACOFP,** MAOFP Past President was again elected as the ACOFP Speaker of the Congress of Delegates.

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Kurt Anderson, D.O., MAOFP Past President, was elected President of the Michigan Osteopathic Association at MOA's House of Delegates May 13, 2011. A member of the MOA Board of Trustees since 2006, Dr. Anderson hopes to spend his year as the association's leader to promote member engagement with legislators to help foster an environment that is more conducive to quality health care for all of Michigan's citizens.

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Congratulations to MAOFP President Elect, **Andrew Adair, D.O., FACOFP,** practicing in Chesterfield, Michigan for being named a Fellow of the American College of Osteopathic Family Physicians (ACOFP) on March 19, 2011 in San Antonio, Texas.

The designation "Fellow of the American College of Osteopathic Family Physicians (FACOFP)" is conferred upon members of ACOFP in recognition of individual experience, dedication, and contributions of the highest order to the profession of osteopathic family medicine. Presented annually since 1976, it is awarded following stringent criteria and careful consideration by the ACOFP Awards Committee followed by a majority vote of the ACOFP Board of Governors.

For more information on fellowship criteria and to download an application visit the ACOFP website at <http://www.acofp.org/leadership/fellows.aspx>.

MSUCOM SAACOFPP Student Report

By Ryan Spencer, SAACOFPP Chapter President

Summer is finally here and there has been a lot going on at MSUCOM!

On April 15th MSUCOM hosted the annual open house. There was a huge turnout with high school students, undergraduate students, and even members of the public who had an interest in osteopathic medicine showing up! Our SAACOFPP chapter set up a table at the organization fair and I was able to talk with many students who were interested in osteopathic medicine and their parents about what osteopathic family medicine is. It was a very rewarding experience and there was a lot of interest from the guests.

On May 27th the Class of 2013 took their last exams of their preclerkship years. To celebrate we hosted our annual SAACOFPP pancake breakfast for them. Our eboard members cooked pancakes and waffles all morning and fed about 100 hungry students. We wish the Class of 2013 all the best as they head off to their base hospitals and begin clerkship rotations this summer!

Currently everyone here at MSUCOM is preparing for the arrival of the new first year students in the Class of 2015, whose first day of orientation will be June 22nd. We will be planning our recruiting efforts for the organization fair this fall and try to get as many new SAACOFPP members as possible!

As always, I want to thank the MAOFP for all of your support, both financially and otherwise. I am appreciative of the close relationship that we have with our state association and it is that relationship that makes our SAACOFPP chapter so great. If anyone has any questions or would like to work with SAACOFPP to have an event feel free to contact me at spenc194@msu.edu



Michigan State University Open House, students pictured left to right, Jennifer Hanna, Ryan Spencer and David Pohl

“As physicians, we have so many unknowns coming our way...

One thing I am certain about is my malpractice protection.”

Medicine is feeling the effects of regulatory and legislative changes, increasing risk, and profitability demands—all contributing to an atmosphere of uncertainty and lack of control.

What we do control as physicians:
our choice of a liability partner.

I selected ProAssurance because they stand behind my good medicine and understand my business decisions. In spite of the maelstrom of change, I am protected, respected, and heard.

**I believe in fair treatment—
and I get it.**



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Professional Liability Insurance & Risk Management Services

ProAssurance Group is rated **A (Excellent)** by A.M. Best.

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A Primer on Healthcare Policy in Michigan 2011-13

- Larry Abramson, D.O.

By the time this article reaches you the State of Michigan budget for the next fiscal year should be old news. Whatever the end results occur will be significant impact on the delivery of healthcare in the state. Governor Snyder has identified his public health foci and included them in his public MIDashboard (on the web); yet, beyond these foci lies many of the integral changes planned – many of which impact you in your daily practice. Snyder appointed Olga Dazzo as Director of the Department of Community Health, the agency responsible for implementation his healthcare vision. In private conversations and in public presentations, Ms. Dazzo has provided descriptions of the vision and how the administration will implement it.

From the 60,000 foot level the vision incorporates three fundamental aims:

- Provide every citizen access to affordable, high quality health care
- Emphasize prevention, wellness and personal responsibility
- Transform Michigan to a more patient-centered model to achieve major cost savings, promote wellness, and improve overall service quality

If the 60,000 foot level provides overall aims, moving to the 30,000 foot level provides the objectives:

1. Promote wellness programs to reduce costs, improve quality of life, and increase detection of health conditions before they become chronic.

2. Create Patient-Centered Medical Homes for Medicaid populations not enrolled in coordinated care programs.
3. Increase Medicaid reimbursement rates to broaden access.
4. Leverage use of Federally Qualified Health Centers to increase access and reduce costs.
5. Leverage community solutions to provide immediate support for high-risk populations.
6. Implement Health IT initiatives to reduce administrative costs, enhance fraud protection, and eliminate avoidable redundant testing.
7. Create a catastrophic event coverage policy to help Michigan's citizens.



● Top 10 States ↑ Performance improving
● Middle 30 States ↔ Performance staying about the same
● Bottom 10 States ↓ Performance declining

Economic Strength				
	Prior	Current	Rank	Progress
Unemployment	12.4%	11.7%	●	↑
Gross Domestic Product (GDP)	(2.7)%	(5.2)%	●	↓
Real personal income per capita	\$28,250	\$27,558	●	↓
Number of structurally deficient bridges	2,732	2,726	●	↑
Children living in poverty	19%	23%	●	↓

Health and Education				
	Prior	Current	Rank	Progress
Infant mortality (Per 1,000 births)	7.6	7.7	●	↓
Obesity in the population	29.5%	30.3%	●	↓
3rd graders reading at grade level	87%	90%	●	↑
College ready (Average ACT score)	19.6	19.7	●	↑
Population with bachelor's degree or higher (25+ years old)	24.7 %	24.6%	●	↓

Value for Government				
	Prior	Current	Rank	Progress
Bond rating (Standard & Poor's)	AA-	AA-		↔
Debt burden per capita	\$766	\$748	●	↑
Access to state government – number of online services	325	357		↑
State government operating cost as a percent of GDP	11.9%	12.5%		↓
State and local government operating cost as a percent of GDP	21.9%	22.9%		↓

Quality of Life				
	Prior	Current	Rank	Progress
State park popularity – annual visits per citizen	2.1	2.1		↔
Clean and safe water resources – water quality index	83	88		↑
Population growth (Ages 25 – 34)	(1.9) %	(1.6)%	●	↑

Public Safety				
	Prior	Current	Rank	Progress
Violent crimes per 100,000	501	497	●	↑
Property crimes per 100,000	2,935	2,838	●	↑
Individuals fatally or seriously injured in traffic accidents	7,705	7,382		↑

www.michigan.gov/MiDashboard

Figure 1: Governor Snyder's public MI Dashboard.

As the altitude continues to descend, the goals become more specific within objectives. Expressing the example from the equation of public health and wellness the MIDashboard expresses the goal and achievements over time. It's the overall concept of improve health, improve care, and the results is lower costs; when combined with competitive and collaborative organized systems of care the effect is magnified. The two crucial concerns the governor identified to improve the health status of our citizens that will maximize overall benefit to the state:

- **Reducing obesity.**
- **Reducing infant mortality.**

The strategy to accomplish this involves building alliances with charitable foundations, employers, health systems, local public health systems, and other stakeholders to leverage and channel dollars already being spent in these and other areas of wellness. The goals are evident as seen in Figure 1.

As the governor indicated, he intends to use classic business principles in his approach to Michigan government. Whether that can be fully actualized in government is an unknown; however, the tenant of classic business approaches are reflected in the "strategic plan" outlined for the Michigan Department of Public Health. Using that model and extending the aeronautics example, moving to the 5,000 foot level we find the strategies expounded and as landing is approached, we find the tactics. The governor has established the deadline for completion of this healthcare "strategic plan" as 2013. In keeping with the strategic planning model, the Governor Snyder and Director Dazzo established strategy and tactics with assignment of responsibility and accountability for implementation to senior staff. A summary of priorities, tactics and responsible staff:

1. Improve the health of Michigan's population:

- a. Implement statewide stakeholder plan for obesity. (Chabut)
- b. Implement statewide stakeholder plan for infant mortality. (Chabut)
- 2. Improve health care provided to Michigan's population:**
 - a. Implement CMS patient-centered medical home demonstration grant. (Fitton)
 - b. Facilitate creation of OB services access in northeast Michigan. (Chabut)
 - c. Develop state plan to promote Federally Qualified Healthcare Centers (FQHCs). (Brim)
 - d. Implement plan to promote integration of behavioral and physical health, including health homes (ACA Section 2703). (Kelly)
- 3. Lower the health care costs per person in Michigan**
 - a. Obtain grants from foundations for statewide planning: obesity, infant mortality, health system reform, FQHCs. (Brim)
 - b. Implement Office of Health Inspector General to reduce fraud, waste, abuse. (Dazzo)
 - c. Develop and implement internal audit plan with links to federal programs. (Lyon)
 - d. Move fee for service programs into managed care.
 - e. Children with special health care needs. (Fitton)
 - f. Medicare and Medicaid Dual Eligible. (Fitton)
- 4. Plan and implement health care reform requirements, as feasible:**
 - a. Implement multidisciplinary bureau that focuses on planning and implementing health reform. (Priest)
 - b. Plan expansion of Medicaid to 133% of FPL. (Priest)
 - c. Complete health insurance exchange plan design and consider conclusions for implementation. (Priest)
 - d. Obtain planning grant for integration of dual eligibles

- e. Implement 2013 and 2014 physician fee schedule increase to 100% of Medicare. (Fitton)
- f. Expand Aging and Disability Resource Centers. (Brey)
- g. Expand long term care option counseling through Community Living Program. (Brey)
- h. Identify other health reform opportunities that meet Gov. Snyder's reform goals. (Priest)

That's the capsule view from 60,000 feet to landing – those are the aims, vision, strategy, tactics and responsibility matrix of the Snyder Administration for healthcare services in Michigan for the next two years. These emanate from the Executive Branch; some elements are codified in federal and state statutes or other regulatory requirement; others are initiatives that are within the purview of the "management" of government. It's a flight plan – and like all flight plans subject to the verities of the environment in which it exists; we have all experienced flight delays, cancellations, and re-routings. And, like the airline ticket pricing, the cost depends on some irrational black box logic. These are all evident in our healthcare system as well as the non-permanence of the political process.

I provide this snapshot so you have an understanding of the start point. In this era of digitalization, you know that a snapshot is only as good as the moment viewed; the ability to easily crop, cut and paste, or otherwise modify an image is true in these strategic plans as well. Internet exchanges will extol, vilify, inflame, disparage, or any myriad of permutations change what we believe is actually occurring with this "plan". Be alert to the changing environment. As an organization representing the you and your patients, we will be monitoring the "plan" and alert you if concerns arise or inform you if the results emerge beneficial for all.



I recently had a superb experience with two MSUCOM students during the struggle to maintain Medicaid Graduate Medical Education funding in Michigan. For those of you who were not following this issue, the governor's budget proposed eliminating funding entirely and in conference in the legislature nearly doing the same. A full court press by the Partnership for Health, among other constituencies, prevailed in minimizing the cuts and sustaining this essential funding to train residents in Michigan hospitals. In a call-to-arms to my colleagues requesting that they contact members of the legislative committees dealing with these budget items, these students answered the call. Not just answered, but set up an appointment with a legislator to discuss it. Not having prior experience in meeting with a legislator they asked for guidance – could someone with knowledge of the approach to a legislator assist, or better yet, accompany them to their meeting. I joined them in Lansing the afternoon of their appointment, discussed with them what they planned to say, and went with them as “coach” to their meeting. The discussion with the legislator went extremely well; they presented their concern, some facts to back up their position, and left a succinct, bullet point support document. This legislator listened to their position, asked some questions, acknowledged the need for the continued support, and invited them to participate further in discussions as they emerge during this session of the legislature. Indeed, a teachable

moment. They understood the impact on their lives, their careers, and their communities. These young men represent what is going to be needed for the success of our profession addresses the trials of change that will continue over the next several decades to address the myriad of challenges the healthcare delivery system will have to answer. Policy advocacy represents one of the pillars on which our profession and our organization must nourish and support.

Now that this temporary budget “crisis” has ended we can begin to focus on other concerns. For family practice the workforce deficit represents a paramount issue. We learn daily that an impending critical shortage has either arrived or will arrive in the short term (the rural community will tell you that it already exists in their communities – and there does not appear an easy solution to recruit replacements as the physician population ages and retires). In family practice our bench strength has declined for decades – a lament for us and a critical danger for patients in terms of access to care or effective coordination of care. Many of us have heard the lament – no one wants to be a family physician anymore; the reasons myriad. In a recent discussion with students they expressed some of those reasons succinctly. When asked how to improve interest, they did not offer Twitter or Facebook as the answer. They offered three concrete barriers that we will have to overcome if we want to increase the number of highly qualified physicians entering osteopathic family medicine:

1. **Debt.** Students want income “assurances” – sufficient to cover the cost of their education loans. Using current interest rate it translates into approximately \$36,000 annually for 10 years to retire average debt. With increasing frequency students entering primary care have access to debt retirement through service

commitments (such as the National Health Service Corps). However, current practitioners must improve communication related to the financial implications of a career in primary care and how to leverage desire into less debt.

2. **Insufficient POSITIVE role models.** Students seek mentors. Smart people who can choose any specialty they want select fields based on advice from mentors and peers. When their peers are all saying “take the money” they need strong mentors to reassure them that it is good to do the right thing for the right reason. Unfortunately, seasoned family physicians often do not realize the impact of verbalized frustrations. To quote from a previous generation, “Loose lips sink ships” and make anesthesiologists.
3. **Disrespect.** Students need for us to sell family medicine to the public as an esteemed discipline so that they know they have committed to what they believe is a great specialty. They need some bragging rights. While not demonstrating the excitement of impending brain surgery, they need to experience pride and acknowledgement that they are a bona fide specialist - not at risk of being replaced by a mid-level provider. We must really sell our specialty both in the social media and more importantly in the mass media.

If these students represent our emerging generation of physicians, I have confidence that our profession will retain the necessary strength and commitment to thrive. It's the lack of vitality of our stewardship that causes me to lose sleep at night.

Board of Directors Self-Evaluation / Leadership / Mentorship

The MAOFP Board made a decision this year that each member complete a Self-Assessment Questionnaire. This tool was intended to provide an opportunity for self-reflection on the role played by each individual Board member, as well as validation for the MAOFP's current direction. In subsequent years, the assessment will be completed prior to re-nomination for a Board position. As an enhancement for leadership development, each new nominee elected to the Board will be assigned a Mentor by the MAOFP President to guide that individual toward achieving both personal and Board goals.

Board of Directors Regional Representatives

A resolution has been proposed to address expansion of the Board to groom future leaders. The intent of an ex-officio appointment is two-fold: to provide the individual an opportunity for leadership mentoring as well as to provide the Board of Directors with regional or specialized expertise. The resolution is posted in this issue of the MAOFP Newsletter and will be voted upon at the Stakeholder's luncheon, August 6, 2011. Let us know your interest in this new opportunity to be an active leader with MAOFP.

Strategic Planning Retreat

Plans are underway for the MAOFP Board to hold a strategic planning retreat this September. Long-term planning set a 3-year cycle for the Board to brainstorm its mission, vision and ability to serve the needs of its membership. Our contracted facilitator, having worked with us during two previous retreats, clearly

understands the challenges our organization is facing and is articulate in framing the areas of focus needing solutions. These challenges include: recruitment of a younger and often employed physician membership; better engaging membership; scope of primary care practice; and reimbursement issues.

Resident Awards

Recently, the Board added the Resident of the Year Award in recognition of an outstanding trainee in a Family Medicine Residency program. In the past, recognition of a Family Medicine Resident was through submission of a written scholarly paper for the Resident Paper Award. Given changes in the presentation of scholarly activity, MAOFP is considering amending criteria to include poster submission.

ACOFP State Society Award – Education

Congratulations to MAOFP for a THREEPEAT, winning the ACOFP state society award for Education. Thanks Rhonda Ballard, our Staff Liaison, for putting together an exemplary packet of MAOFP achievements to provide our membership with the highest quality CME.

ACOFP Convention

Congratulations to two MAOFP members:

- George Sawabini, DO FACOFP *dist* our newly installed ACOFP President and a past MAOFP President.
- Andrew Adair, DO, FACOFP newly awarded recognized ACOFP Fellow designation

ACOFP / COD

MAOFP representation to the ACOFP/COD included 15 physician

members, a resident member, and three student members for a credentialed delegation of 17 members. This was a larger turnout than usual, however we are still under represented in comparison to other delegations, more conspicuously so because of our large number of allotted delegates. Thanks to: MAOFP physician members serving as delegates; Lynn Miller, resident delegate; Kim Oberski, student delegate; Ryan Spencer, the incoming student Board member, as well as Shannon Murphy (alternate student delegates). The Board is addressing the issue of attendance at the ACOFP/COD. Consider allowing your voice to be heard at the national policy making body by registering with the MAOFP delegation when you attend the March 2012 ACOFP convention.

ACOFP Fellowship

"The Fellow of the American College of Osteopathic Family Physicians (FACOFP) Award recognizes experience, dedication, and contributions of the highest order to the advancement of osteopathic family practice.... The Award is conferred only on persons in the osteopathic profession and seeks to demonstrate the importance of professional career and family practice service in the community." All opportunities to advance within the national organization are predicated upon the designation of *Fellow*. I urge all members of MAOFP to seriously consider working toward this award. Not only will you as an individual be recognized for your professional dedication, the rewards flow to your state society, as well.

MOA

Kevin McKinney continues to maintain the MOA/MAOFP legislative

agenda before members of the Michigan state legislature including:

- repeal of the helmet law may which may become a reality as a result of a strong single issue lobbying campaign mounted by the state's motorcycle interests.
- the nurse practitioners and FM scope of practice issues
- MOA initiative to maintain a database of its member's relationship with state legislators
- no physician tax

Medicare CMS-CAC

The Medicare Carrier Advisory Committee meets February, May, and September. There is no contract update and WPS is hoping for resolve by the end of June. CMS is reducing the number of jurisdictions from 15 to 10.

ICD-10 Codes

Implementation is for an effective date of October 1, 2013 with no extensions. Once accepted, these will replace ICD-9 codes. There will be no merge as the codes are not similar and thus there is no crosswalk available. Once the ICD-10 codes are implemented, no ICD-9 codes will be accepted. Providers are reminded that they need to be using the CPT Code Book from 2011.

Comprehensive Error Rate Testing (CERT) Program Update

Errors are broken down by type of error: e.g. E &M down-coding and up-coding. The CERT contractor is a separate entity contracted with CMS. The CERT contractors determine their own definitions of errors, by which Medicare contractors must abide. The need is to be compliant with the CERT contractor to help reduce the CERT error rate. The need to legibly sign all documentation

remains as there continues to be a high volume of errors for this issue. If the issue is a lack of signature or an illegible signature, the provider will be hard pressed for an appeal. If the provider feels that something is medically necessary, additional documentation may be required/ requested. There is a real need to eliminate waste so the public and government consider any reported CERT error to be fraud and/or waste. CERTS can be disputed by appeal. Unfortunately, although the CERT report in fact may be in error, reflect minor signature problems, difference in opinion or other legitimate issues, this gets interpreted by the media and by Congress as "Fraud and Abuse." The majority of the denials are on electronic submissions.

"Welcome to Medicare Visits"

If a beneficiary has had their welcome to Medicare visit they can receive their annual wellness visit 12 months later and each following year. The annual wellness visit is other than an E&M visit. Beneficiaries should still get their "Welcome to Medicare visits" within their first year of Medicare eligibility as the new services (effective 01/14/2011) do not replace this benefit. Providers do not have a choice which service to bill. During the first year the "Welcome to Medicare" must be used and in subsequent years, the Annual wellness codes must be used. Providers may not pick and choose.

HiPAA II: ASC x12 Version

This is the only way an ICD-10 can be accommodated as an electronic format. Compliance date is 01/01/2012. WPS Electronic Data Interchange (EDI) Hotline: 877-567-7261 has a list of compliant vendors available by calling the hotline. Know

your vendor, billing service or clearing house transition plan.

Timely Filing Requirements

Service Dates	Claim must be filed by
10/1/2007 – 9/30/2008	12/31/2009
10/1/2008 – 12/31/2009	12/31/2010
01/01/2010 and after	1 year from date of service

- Dates of service beginning January 1, 2010 will be denied outright, if filed more than 1 year after the date of service
- ALL claims must be filed within 1 year of date of service
- Waiver of late filing due to change in status is only waiver provision. MUST be filed in writing and mailed.

Electronic Funds Transfer: Medicare sends payments directly to your financial institution in an attempt to go green.

- Deposits payments electronically on the next business day.
- To be set up, please download the EFT Authorization Agreement from the CMS website: http://www.wpsic.com/edi/pdf/cms588_ele_funds.pdf
- For EFT assistance, you may also call 866-380-4742.

Medicare Remit East Print (MREP)

- Software is free, allowing provider to print remittance, saving time and money.
- Enables physicians/suppliers to view and print 835 files.
- For assistance, call Electronic Data Interchange (EDI) at 877-567-7261.

Professional / Business Affairs Committee

The committee convened via email to judge and award The Student of the Year Award. The winner is Eric Leikert who will be attending Botsford's Family Medicine Program and completing a one year OMM fellowship. Dr. Leikert is a strong advocate for family medicine and will represent our profession well.

The Family Physician of the Year Award was voted upon, in assistance with the MAOFP Board of Directors, and will be awarded to George Sawabini, DO, FACOFP, dist. His tireless efforts both locally and nationally earned him this honor which will be presented at the MAOFP summer conference. The Distinguished Service Award, also presented this summer, will be presented to Otto Graesser, DO of Mt. Hope, Lansing. Dr. Graesser has been a long standing supporter of osteopathic family medicine in Michigan, teaching and encouraging young DO's.

New business that will be discussed at the next meeting will include the new section for the MAOFP by-laws. As the profession grows, as does the Board, mentoring and fostering future leaders in osteopathic family medicine becomes vital. This new addition will allow those who

want to be involved to do so in the hopes of future great leaders to move our association forward.

Sincerely,
Andrew Adair, D.O.

The proposed addition to the MAOFP Bylaws is printed below. The proposal will be voted on at the MAOFP Stakeholder's Membership Meeting on August 6, 2011 at 12:45 p.m. at the Grand Traverse Resort in Acme, Michigan.

Article VIII: Board of Directors
Section I

D. Annually the MAOFP Board of Directors shall have the discretionary authority to appoint one or more association member(s) in good standing to serve as an ex-officio Director-At-Large, without vote. The intent of the appointment is two-fold: to provide the individual an opportunity for leadership mentoring as well as to provide the Board of Directors with regional or specialized expertise. The duration of this discretionary appointment shall not exceed one year.

We proudly announce that American Physicians and The Doctors Company have united.

Together, we set a higher standard. We aggressively defend your name. We protect good medicine. We reward doctors for their loyalty. We ensure members benefit from our combined strength. We are not just any insurer. We are a company founded and led by doctors for doctors. We are the largest national insurer of physician and surgeon medical liability.

On October 22, 2010, The Doctors Company and American Physicians officially joined forces. With the addition of American Physicians, we have grown in numbers, talent, and perspective—strengthening our ability to relentlessly defend, protect, and reward our nearly 55,000 members nationwide. To learn more about how we can protect your livelihood and reputation with our medical professional liability program, call (800) 748-0465, or visit us at www.thedoctors.com.

We relentlessly defend, protect, and reward the practice of good medicine.



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What Do Our Cannabis Friendly Neighbors Know That Michiganders Just Do Not Understand? - William Morrone, D.O.

Where is Michigan two years after a marijuana law allows use without arrest. To understand Michigan you need to look at other parts of the world. *The Dutch government will start banning tourists from buying cannabis from "coffee shops" (code word: coffee shop means cannabis shop) and impose restrictions on Dutch customers by the end of the year.* I recently lectured to more than 300 physicians in Columbus and Sandusky, Ohio. Their patients are buzzing about going to Michigan "to buy dope." The Netherlands is well known for having one of Europe's most liberal soft drug policies that has made its cannabis shops a popular tourist attraction, particularly in Amsterdam. Cannabis is certainly on the street as a Michigan tourist attraction. Where are the jobs? What happened to the sick and the dying?

Physicians and the public needed to be reminded about the origins of the marijuana law; being sold as a needed option for "the sick and dying." There is an on-line blogosphere butchering that hits any physician speakers that is full of acid and directed from a twenty-somethings between jobs screaming about their right to smoke pot because the Chinese did it 5,000 years ago. What happened to the sick and the dying?

Michigan Prosecuting Attorneys in every county and physicians wait for meaningful guidelines from the State of Michigan. **Guidelines will never come.** Prove to the citizens that Emergency Room visits and all drug related crime from 2009-2010 are down, since Proposition One.

A direct narrative from a "Brooklyn Boys Pizza" in the restaurant district in the Tri-Cities is "There is more dope on the street than I have ever seen." Michigan has more dope on the streets and the Dutch government plans to curb drug tourism as part of a nationwide program to promote health and fight crime. Medical marijuana passed a vote and street marijuana is exploding in our Michigan cities. What went wrong? HIV and glaucoma are not in the top five diagnoses certified.

Marijuana regulation in Michigan is castrated by the law itself and common sense has been lost. The official policy of the state is "we are not for or against" they just carry out the law and the people

voted. The people were lied to about the law. It is a bad law. Michigan now has an insane **open-door policy** that originally was stated to be "for the sick and dying."

"In order to tackle the nuisance and criminality associated with coffee shops and drug trafficking, the open-door policy of coffee shops will end," the Dutch health and justice ministers wrote in a letter to the country's parliament. Data from the Michigan Medical Marijuana program is not an honest forum or sincere registry. Data mining in marijuana hits a brick wall. Data requests go unanswered. If you wanted to search COPD, breast cancer, cardiac disease or prostate cancer, there is a way to explore data by county or zip code. This is done for the sake of public health and that data surveillance is at the core of the study of public health.

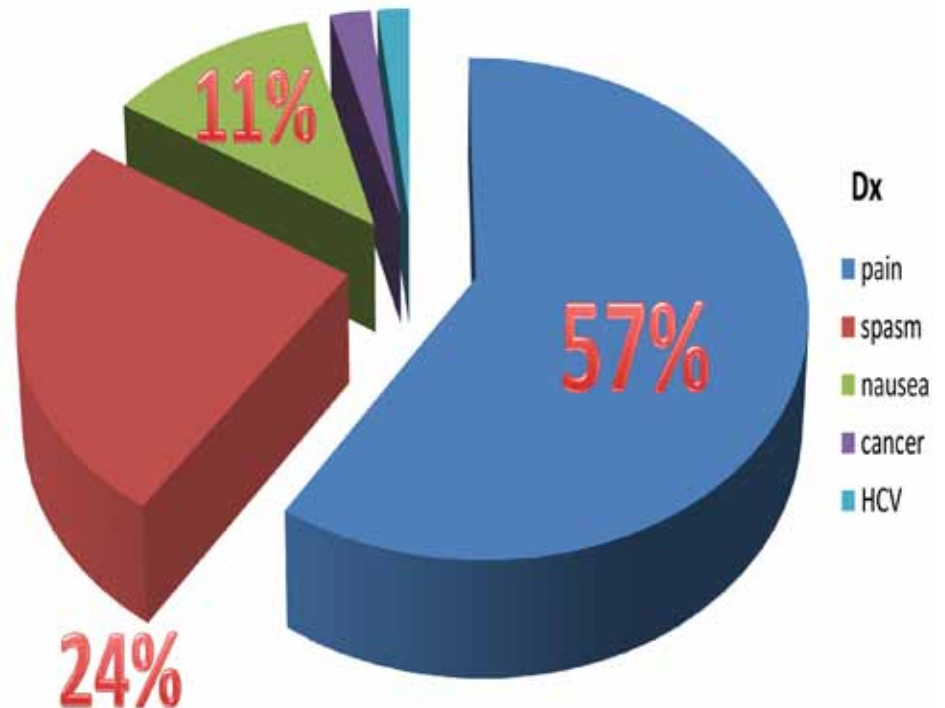
The focus of public health intervention is to improve health and quality of life through the prevention and treatment of disease

and other physical and mental health conditions, through surveillance of cases and the promotion of healthy behaviors. It is a model example established at "The Chicago School of Public Health." Michigan marijuana law *blocks access or the state has no interest in participating or both.*

In 2008, before the vote on marijuana, our Lansing State Journal ran an unopposed pro marijuana Op-Ed and never balanced the information from a politician with information from a physician. The Detroit Free Press established that only 55 physicians may account for greater than 70 % of the marijuana applicants (currently 137,000). That would be almost 96,000 marijuana certificates from those 55 physicians, for people who do the math. By a conservative account in Michigan there are 37,000-40,000 physicians. The good news is the State of Michigan should have collected \$ 13.2 million from marijuana fees. I hope they

What are the top 5@MMMP?

<http://www.westport-news.com/default/article/report-details-medical-marijuana-certifications-1346653.php>



April 21, 2011

are saving some of that money at MDCH to treat addiction at a later date. After observing changes in society, a major London newspaper published an apology for supporting cannabis 10 years earlier.

One of Bay City's marijuana doctors comes up from Detroit and works with the "Liquid Ladybug" man seeing patients in a pesticide store. If the Detroit doctor rented from Bay Regional Medical Center or the Allen Medical Building he would work by the light of day. In Saginaw marijuana doctors were working out of a motel and warehouse. Before working out of a motel this doctor had problems with the DEA on how Xanax and Vicodin prescriptions were handled. Clinton Township authorities found a conspiracy to sell pre-signed medical marijuana certificates from a clinic in the back of a Warren appliance store and that doctor has had her license suspended by the state. **These are certainly not "bona fide" doctor-patient relationships required by the law.** Regulation has been lost and so has truth. The answer is not to take marijuana away. Correct the system with an open door for abuse.

If you have a real brick and mortar practice in neurology, pain medicine or primary care and a small portion of your patients have been certified for medical marijuana then you are more than likely legitimate. But 55 physicians where the bulk or exclusive focus of your practice is to certify marijuana is unreasonable. That is not the way medicine is done, or it is not real medicine.

If it's not medicine what is it? The average fees collected by marijuana doctors are \$200-400 to certify. Physicians are hard hit with tough economic times also. Marijuana doctors may have collected between \$ 50 to \$100 million cash in the last 24 months including re-certifications. Can you blame them?

When the state is questioned about the marijuana scam, their answer is, "We leave it up to the doctors." "The doctors don't police themselves." When the discussion about the lack of double blind placebo controlled evidence with cannabis is initiated, the MSWs and MPHs in the state bureaucracy roll their eyes and mumble how unenlightened physicians are about pain. Psychiatric co-morbidities later in life linked to young brains exposed to cannabis published in Sweden (a cannabis friendly nation) are laughed off as government fear based propaganda.

What is the answer? People are misinformed. Cities are broke. The state is bankrupt. Police are frustrated. Medical societies do not have cash, people or policies for corrective advocacy. If you want to follow the age old model, follow the money. Marijuana certification has infused \$ 50 to \$100 million dollars into the hands of physicians. The Department of Treasury needs to look very close at those business and personal tax returns of 55 doctors to verify there is no skimming of the register in a cash business like this. If you are seeing 200 patients a day and your annual income goes from \$ 150,000 a year to \$ 6 million, you may need review. Money collected should be ear marked for addiction treatment and honest regulation and evidenced based certification of marijuana for pain (teaching, licenses, fees and audits).

We have treatment, teaching, licenses and grants for alcohol, tobacco and opiate addiction and abuse. Now is the time to collect money, taxes, fees and capital from providers to restructure marijuana certification to plan for treatment, teaching, licenses and honesty.

In the Netherlands, under the new rules, only Dutch residents will be able to sign up as members of cannabis shops. Dutch customers will have to sign up for at least a year's membership. Michigan marijuana registration cards are confidential and now being issued with **no photograph**. Dispensaries (not covered in the law) could sell to anybody. Does anybody really think marijuana sellers are looking at customer's cards? Selling marijuana was not really allowed in the law. What happened to the sick and the dying? The answer is not to take marijuana away. Correct it. Correct the process that is flawed or it is not medicine. It's beer.

The Global Commission on Drug Policy, this year, will publish a report in New York calling for a "paradigm shift" in the way we deal with drugs. It will advocate not just decriminalization, but also experiments with legalization and regulation. Regulation means **regulation**, real honest regulation. **Oakland County District Court** has noted, about regulation and the Michigan Medical Marijuana Act (MMMA),

[the MMMA "is probably one of the worst pieces of legislation I've ever seen in my life,"]

Before he was President, Obama called the war on drugs an "utter failure" and said we should think about decriminalizing

cannabis. Before he was Prime Minister, Cameron said Britain's drug policy was an "abject failure" and called for a debate on legalization of all drugs. Now that they're in power, though, both men have had an utter and abject failure of nerve. They agree with the former Prime Minister of Luxembourg, Jean-Claude Juncker, who once said, in this context: **"We know what to do, but we don't know how to get re-elected once we have done it."**

Amsterdam, home to about 220 coffee shops, is already in the process of closing some in its red light district. In Michigan, marijuana on the streets is exploding, young people are getting the wrong message. Honest data analysis for public health is forbidden in the law. When truth is a victim we all lose. The Danish experience is transparent. For all of its problems and faux pas, you can always say the Danish are and have been honest and transparent with cannabis. Michigan is struggling to find the light.

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MAOFP Resident News

This has been an exciting year for family medicine residents in the state of Michigan and around the country. We will be faced with the challenge come July 1st of new interns joining each program across the country. Coming with them this year is the new changes in the ACGME resident duty hours regulations. This has caused many local programs, including my own at William Beaumont Hospital in Troy, to restructure with many changing to a night float system rather than traditional call system. The overall goal of the new hours restrictions is to increase patient care and safety, however those of us in the medical education system have been somewhat skeptical of changes. The new restrictions will allow first year residents to work a maximum of sixteen hours consecutively while their second and third year counterparts have only been decreased from thirty consecutive hours to twenty-eight. Also as part of the new rules all first year residents will need to have a second or third year resident supervise them in the hospital at all times. While this change has not yet been implemented by the AOA, many of the DO family medicine programs in our state are duly accredited so they too are subject to the ACGME rules. Most suspect that the AOA will quickly follow suit with new duty hours restrictions in the near future as well. It will be both interesting and challenging to see what feedback is received from residents in all specialties nation wide regarding these new changes in the coming year.

We are also excited at the ever-growing popularity of family medicine across the country. According to the National Resident Matching Program for the second year in a row the number of medical students choosing to enter family medicine has increased. This year family medicine residencies filled 94.4 percent of all positions available in 2011 which is a 3% increase from 2010 despite having 100 additional spots available. The increasing popularity of family medicine comes at a critical time, as the need for additional primary care physicians is evident. As family medicine physicians it is important for us to continue to grow our profession by reaching out to students and showing them how rewarding a career in family medicine can be. This type of support is based in organizations like the MAOFP who are committed to supporting family medicine residents and young family physicians in Michigan.

Leah Cecil, DO
MAOFP Resident Director
PGY-2 Family Medicine Resident

Education Committee Update

We are looking forward to an exciting summer conference this year at the Grand Traverse Resort in Acme on August 4-7. Up to 22 hours of CME can be obtained in a range of important primary care topics. We continue to choose topics and speakers that will give you the best CME value possible. Added this year is an orthopaedic procedures clinic for those wanting to enhance their procedural skills.

Fun activities for the family include a Wine Tour/Tasting on Old Mission Peninsula, and a Tall Ships evening sailing cruise on the Grand Traverse Bay. For those interested in some exercise, please join us for the second annual 3K fun run on Saturday August 6. For more information please go to our website at: www.maofp.org. I hope to see you up north this summer!

David Best, D.O.
Education Chair, MAOFP

Medical Opportunities in Michigan (MOM)

www.mimom.org – serves hospital employers and private practices with an online recruitment program, designed to connect Physicians, Physician Assistants, and Nurse Practitioners with jobs in Michigan. Job seekers register for FREE! Our database of Physicians spans more than 85 specialties!

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Protecting the Health of Our Communities

Preventive health remains one of the hallmarks of family practice. In an era with increased focus on this aspect of care, ensuring that the family physician understands the current recommended practices for immunization represents a core educational need. This autumn the Michigan Department of Community Health (MDCH) Division of Immunization will conduct eight 2011 Fall Regional Immunization Conferences:

- Oct. 5 - E. Lansing
- Oct. 6 - Dearborn
- Oct. 18 - Gaylord
- Oct. 20 - Marquette
- Nov. 1 - Bay City
- Nov. 2 - Troy
- Nov. 9 - Kalamazoo
- Nov. 10 - Grand Rapids



The primary goal of these one-day conferences is to update health care professionals on immunization issues that affect people across the lifespan. These conferences have annually attracted a large number of health care professionals who attend to learn about practice-management tools, techniques and information that will help ensure that patients of all ages are fully and appropriately immunized. A keynote speaker from CDC will present a Vaccine Update and also participate in a Troubleshooting Panel at each conference location. The conferences are still in the planning stages. Registration will begin in August.

- Larry Abramson, DO

Save The Date

Upcoming Events

Michigan Association of Osteopathic Family Physicians

August 4 – 7, 2011 at Grand Traverse Resort in Acme, Michigan
January 26 – 29, 2012 at Shanty Creek Resort in Bellaire, Michigan
August 2 – 5, 2012 at Grand Traverse Resort in Acme, Michigan
January 24 – 27, 2013 at Shanty Creek Resort in Bellaire, Michigan

Michigan Osteopathic Association

May 16 – 19, 2012 at the Hyatt Regency in Dearborn, Michigan
May 15 – 18, 2013 at the Hyatt Regency in Dearborn, Michigan

American College of Osteopathic Family Physicians

March 14 – 18, 2012 in Kissimmee, Florida

American Osteopathic Association Annual Convention

October 30 – November 3, 2011 in Orlando, Florida
October 7 – 11, 2012 in San Diego, California

Please visit the MAOFP website at www.maofp.org!