



Jeffrey Stevens, D.O.
MAOFP President

How do you replace a legend? For those who have not heard the news, it is with great sadness that I inform all of you on the passing of our long time Executive Director, Samson Inwald, DO. Samson passed away on November 21st, 2010, and the osteopathic profession lost an incredible advocate and colleague. The face of MAOFP for decades, Sam was instrumental in moving the organization to where it is today. His passion and drive kept him on the path, constantly pushing to keep osteopathic family physicians at the forefront of every conversation he had, regardless of the audience he was speaking to. On behalf of the board, our sincerest condolences to his widow Susan and her lovely family. Sam received his well deserved Lifetime Service award with his family present at our summer

conference at Crystal this summer, and it proved to be the crowning achievement in his illustrious career. It was made even sweeter, because I think for the first time in a long time, he was truly surprised. Thanks again Sam for all you have done for this organization. Our board will truly miss your insight and wisdom.

Plans for the winter conference are well underway for Shanty Creek Resort in late January 2011 (not quite ready to start writing that yet), and we hope to see you all there. The educational committee has been finishing up a very solid lecture schedule that should include a mix of topics requested by attendees from previous conferences. We listen to feedback from you and try to coordinate a variety of topics while keeping an overall theme. We try to balance demand for topics and yet, be aware of the cost of putting together a conference. Your evaluations help drive future conferences and are crucial in helping us to deliver excellent quality CME.

The board is very engaged, and is looking at opportunities to be more visible and involved. Recent redesign of our logo is the first step in that process. We anxiously await the arrival of new members into our state legislature, and look forward to building strong relationships that will benefit the lives of our patients. It is crucial that you get involved in whatever capacity you can in your local community. With constant turnover due to term limits

at the state and local levels, we need to be a voice of clarity/reason to our representatives. If we don't speak for our patients who will??? Your MAOFP will continue to inform/educate, and when needed motivate you to become involved. The time for advocacy is now. Recent challenges to the smoking ban are just one example of that. If you value what we have in our current health care system, start showing it. Don't wait for state/federal legislators to tell us what's wrong with health care, start telling them what's right in health care. We all have an obligation to our patients to "do no harm", by being silent, we do that very thing. You can start at your local hospital department, PHO/PO, county association, or state/national committee by simply showing up and getting engaged. If you permit apathy, you promote it. We all have incredibly busy schedules and are constantly stressed to get everything done, and still make a living. I implore you to go that one extra step. Our committees are always looking for members, and would welcome your help. The volunteer board can't do it alone, we need your help. Your MAOFP will be there with the information/insight you need to make a difference.

Thanks for your help, and continued confidence in me. It is truly an honor to serve as your president.

Board of Directors

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Al Juocys, D.O., Recognized for Efforts with MNO's Community Care Travel Team, Targeted to Individuals with Chronic Conditions



Medical Network One, a Rochester, Michigan-based physician's organization and provider of comprehensive health management support programs and interventions offered through physicians, clinicians, health plans, employers, community groups and directly to individuals, is pleased to announce that Al Juocys, D.O., Medical Network One's founding physician and Chief Medical Officer, has received a Crain's Detroit Business 2010 Healthcare Heroes honorable mention award for his leadership with the Community Care Travel Team. Dr. Juocys was recognized in the *Advancement in Health Care* category and was featured in the August 9th issue of Crain's Detroit Business.

Under Dr. Juocys' direction, Medical Network One introduced the Community

Care Travel Team (CCTT) in 2007. The CCTT, a complement to the Patient Centered Medical Home, is a multi-disciplinary health care team comprised of a registered nurse, certified diabetes educator, registered dietitian, lifestyle coach, behavioral health specialist and exercise specialist, that brings its combined expertise to individuals at their primary care physician's office, the worksite and educational/community centers. The CCTT evaluates, provides coaching, and helps reduce the risk of complications from chronic conditions, including diabetes, asthma, heart disease and pediatric, adolescent and adult obesity. Because of Michigan's high obesity and type II diabetes rates, more than 70% of the CCTT's current efforts focus on patients with diabetes.

Dr. Juocys first piloted the Community Care Travel Team concept (then called the Chronic Care Travel Team) in 2006 in his own primary care practice, Rochester-based Country Creek Family Practice, and then in select Medical Network One physician's offices. About 70 primary care physicians are now offering the CCTT to their patients. Ultimately, the goal of the partnership of patient, physician, and Community Care Travel Team is to improve a patient's overall health and attitude with measurable

clinical results that reflect decreased nephropathy, lower BMI, HbA_{1c}, blood pressure and lipids; and, in general, increased patient engagement in self-managing their diabetes and/or other chronic conditions. Patient outcomes to date reflect that the CCTT program is working.

The Community Care Travel Team is a portable program that has broader implications at the community level. In 2009, the CCTT expanded beyond the physician's office and was introduced to individuals at community centers, senior centers and at the workplace. The workplace in particular has tremendous potential to reach significant numbers of people for health education. Last year, Medical Network One launched a Diabetes Self Management Education (DSME) program in conjunction with the Greater Detroit Area Health Council at the Southeast Michigan sites of General Dynamics, MGM Grand and Trinity Health. About 80 employees have been involved with the CCTT's DSME program thus far.

Dr. Juocys and other award recipients were honored at the Crain's Detroit Business Health Care Heroes Luncheon on Thursday, October 14th at the Rock Financial Showplace in Novi.

“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.

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WHITHER OR WITHER ARE WE GOING?

As I write this article the midterm elections are just completed; the reprieve from the madness of political advertisements has ended. The real work now begins. The lame ducks will unlikely enact many new initiatives – at least not in Michigan. So, in concert with my mantra, I invite you to become engaged in advocacy for your patients and for your practice of osteopathic medicine. The challenges and threats to your autonomy and professional stature remain unchanged.

I like quotes – they crystallize concepts in ways that help define the moment. For those who are old enough to remember the great comedian Jack Benny (or for those who are not – he was an icon of his era), he quipped:

“If you don’t mind, it doesn’t matter”.

One of the features of a great comedian is the uncanny ability to see the world a bit out of kilter – say 90 degrees off; so if you don’t mind that your professional stature is under siege, if you don’t mind that less qualified mid-level practitioner will supplant you through expanded scope of practice; if you don’t mind that you will have to adhere to unfunded mandates; if you don’t mind that others will decide how you will practice; if you don’t mind that your practice will not generate sufficient income to support you or your family; if you don’t mind.....

*You get the picture. If **YOU** don’t mind, it doesn’t matter. If you decide that you don’t need to be involved, engaged, and active then it doesn’t matter. If you decide that you don’t want to be support your professional organizations, then it doesn’t matter.*

If you decide that others have to do the work, spend their money, meet with policy makers (including legislators AND others), then it doesn’t matter.

*Okay, I’m a zealot. I have this underlying belief that **YOU** can make a difference and that **WE** working*

cohesively can restore the luster to the profession. That together we can prevent the transformation of our great profession to an algorithm-driven technocracy. We should absolve our anger, our fear, and our apathy and supplant that with energy, vision, and wisdom. We must understand the changing environment, and use that knowledge to forge our future with a design that makes sense.

Healthcare is a service – and it is an industry, and it is a sector of the economy. The costs are high – too high to sustain; you’ve been sold that line; the public has been sold that line. That it is an ever-increasing proportion of the Gross Domestic Product is an on-going assault line strategy; yet, in some circles I have heard we’re actually not spending enough to reverse healthcare inflation – it’s just that the allocation has been distorted. Yes, there will have to be some pain before the restoration of sanity to the expense; it’s really not different from surgery: there’s pain following excision of the “bad body” part, there’s analgesics provided during recovery, and then there is resolution. So it might be with the healthcare expense dilemma. How that “surgery” is done, that’s where our opportunity lies.

That leads my next quote, from Abraham Lincoln:

“If we could first know where we are, and whither we are tending, we could then better judge what to do, and how to do it.”

Healthcare, being a service, is not immune from the vagaries of economic reality. In the US, and particularly in Michigan, we have witnessed the malady associated outsourcing and eventually off-shoring of manufacturing (heavy and light). We now understand better than most the need for understanding the shifting winds. Those same underlying forces impact the service sector. Oh, not healthcare you say. I caution you that healthcare is not immune to the “globalization” engendered by the market. What began as service off-

shoring in “call centers” for major corporations (you know them when you reach them don’t you?), has spread to many smaller agencies. Healthcare services have followed. Consider medical transcription. 80% is now performed in India because of the cost advantage – and now think about how the drivers on the payor side are requiring increased “documentation” to support billing practices. Think about the expansion of services – particularly in the digital environment. You’ve likely heard about Nighthawk – the radiology service firm that interprets medical imaging procedures during the “off-shift” because they are located on the side of the time zones (their day is our night); they are staffed in places like Australia by Board -certified, US residency trained physicians. And they are less expensive than having US-based radiologists. In the digital-era, you don’t need to be onsite for services. There now exist in thirty four US hospitals ICUs in which patient management has been “off-shored”. In my hospital the Emergency Department has a robot that examines ischemic stroke patients for off-site neurosurgeons to determine if the patient “qualifies” for the “roto-roter” intervention at a tertiary facility. This is not algorithmic medicine; it is patient-specific clinical care. So it has become essential for you as a physician to understand the changed landscape.

My intent here is NOT to alarm or enrage but rather to engage. I understand the competition for your time and energy. I understand the multiple challenges placed before you to see patients, respond to payor or regulator initiatives, the ongoing requirements to be more efficient, effective, appropriate, safety and the never ending expansion of clinical and non-clinical knowledge that stresses you along with the economic drivers. Yet, you cannot flourish unless **WE** begin to exert the necessary influence.

Here’s the opportunity so that as family physicians we don’t wither; it is the whither where we need to go.

In 2009 Atul Gwande showcased Grand Junction Colorado in a *New Yorker* magazine article (yes, even in the digital age some magazines still exist). What was described was a low-cost mecca with a rating of number one in quality in that state (yes, I know how statistics can “prove” what you want). It’s the analysis of the why that intrigued me: It was the cooperation between physicians, hospitals, and health plans working together to serve the population. The most salient inference however, despite the political battles, was the history of the assumption of LEADERSHIP by family physicians. – dating back to the 1970s. Certainly they used some of the familiar tactics – withholds, performance profiles, and the like, but they made them available to all physicians. The family physician remained at the center of the fray – they directed to whom (specialist, facility, etc.) their patients were referred for care that exceeded their own scope of practice. They envisioned a different kind of risk-sharing. When hospitalists began to

assume care for inpatients, the health plans continued to pay primary care physicians for visiting their patients in the hospital – improving the continuity of care and facilitating coordination of care at the time of discharge thus reducing likelihood of readmission. In Michigan there are now “projects” to address these issues (MiSTAAR, BCBSM PGIP BOOST) – a more complex, less robust approach than just paying for ongoing care by a family physicians. There is one additional aspect that has been aggressively addressed in the Grand Junction model: low-cost end-of-life care that has been encouraged by the family practitioners.

This is a difficult journey to say the least, but as in any situation, the first step is usually the most difficult (overcoming the status quo). In this instance, the first step is for primary care physicians to come together to explore ways to adopt this to local realities. That is a role for our organization, but without your active engagement – and the active

engagement of our fellow family physician s (many of whom are not members) we will have limited ability to influence the policy outcomes.

So, the elections are over and now it’s time to get to the real work. It’s time for each of us to get to know our elected officials; it’s time for each of us to get a fundamental understanding of the changes necessary to make healthcare accessible for our patients, affordable for our communities, and satisfying professionally for family physicians.

And the final quote, from the great football coach Don Shula:

I don’t know any other way to lead but by example.”

It is both my blessing and my curse. I’m fully engaged in this quest. I hope you will actively join as well.

Larry Abramson, DO

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

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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.

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The Fight to Eradicate Polio

In 1985 350,000 cases of polio were reported in 125 countries. Currently polio is endemic in only four countries, Afghanistan, India, Pakistan and Nigeria. Periodically cases are found in neighboring countries. The last indigenous case of polio in the Americas was reported in 1991.

Rotary International through the Rotary Foundation is spearheading the largest non-governmental effort to eradicate polio worldwide. The effort to eradicate polio has been a major focus of Rotary since 1985. Rotary has donated nearly one billion dollars to the eradication effort as well as providing expertise, providing volunteers in all facets of the eradication effort, as well as lobbying politically with governments and international agencies and educating about polio.

Currently Rotary is trying to raise 200 million dollars as a match to 355 million dollars pledged by the Bill and Melinda Gates Foundation. The Gates Foundation has in fact already provided the money in the expectation that Rotary will raise the match money. As an Osteopathic physician I fully support this effort. Rotary International's PolioPlus campaign provides everyone a rare opportunity to help eradicate a horrendous disease. More information on this worthy program can be found at www.rotary.org.

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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Improving Performance in Practice (IPIP) update, 10/15/2010 [note project ended June 2010]

Respectfully submitted by Mary Goldman, D.O., your MAOFP Representative in IPIP

Brief History of IPIP:

IPIP began as an attempt to support physicians who were frustrated by being asked to do more with less. Automotive Industry process engineers volunteered their time to support development of more effective processes in delivery of outpatient medical care. Through their work in IPIP, these quality coaches have performed a nationally followed demonstration of how industrial quality process development can support quality improvement in medical offices. Funding for the project was obtained from Robert Wood Johnson Foundation, American Board of Medical Specialists (ABMS), Pharmaceutical companies, and other donors.

The story:

In 2007, the development of a successful strategy to improve processes in primary care practices began. Michigan was one of three states to participate in a second wave of process transformation demonstrations. Automotive Industry

Action Group (AIAG) Quality coaches volunteered to enter focus groups and then medical practices to work on process improvement in individual practices. Each was screened and trained for the project, with efforts supplemented by in kind participation of a Michigan Department of Public Health Diabetes Educator and Six Sigma Black Belts from the automotive industry. (Black Belt denotes the top training level in Six Sigma process improvement).

The first data about populations of patients with chronic problems focused on diabetes and was uploaded into the National IPIP computers in 2008. Two coaches were partnered into every practice: one was technically strong in quality tools, the other coach chosen for stronger ability with facilitation and change management. Coaches met with the practice on a weekly to bimonthly basis. Practices with more frequent interaction with their coaches performed better than the less interactive practices.

Three waves of recruitment of teams ended in summer 2008. Thirty-three practices were involved. The process included a two day speaker centered preparatory learning collaborative and a follow up learning collaborative to discuss process change in diabetics in the family practice and internal medicine practices and asthma in the pediatric practices. Quality improvements were shared; most participants noted that the process change was challenging and painful during the onset. Data uploading allowed evaluation for the National IPIP, but the Michigan IPIP and AIAG had difficulty accessing the raw data, limiting interpretation at the state level. [Author note: some concern about local access to information occurred as practitioners were concerned about punishment for perceived poor performance on metrics and its effect on veracity of reporting] A major hurdle to the project was the slow development of interacting technology that would allow functional registries to collect the metrics (measurable

information about outcomes). Such electronic patient registry is vital to the application of outcomes measurement, which is crucial to driving the change that makes practices more efficient. Hospitals and other parent organizations for the practices are still developing their electronic ability to allow integration of data with data from their associated practices. For the process to be fully effective, registry commonality is necessary. Otherwise, measurement of hospital and emergency room visits, and the like, cannot be reliably obtained.

Michigan Public Health Institute (MPHI) sent an initial and a one year follow up survey to the practices. Sometimes a full year did not elapse before the follow up survey was received and problems with insufficient time to demonstrate the transformation, or lack of raw data available at the time of the post test resulted in inaccurate conclusions. Never the less, results were showing positive output from the project.

Project details:

Thirty-three practices actively shared data. All practices engaged in diabetic protocols reporting data, actively sharing information and driving process change. Sixty one coaches became involved at some time, some leaving due to employment change. Some practices went through as many as five coaches due to the loss of coaches during the economy change. The range of practice size was from two or less physicians (fourteen "small practices") to practices with ten or more physicians (two "large practices"). . . . 276,000 patients were impacted. Many practices did not have registries in place, but twenty-four practices had registries at the finish of the project. Some registries required excel spreadsheets due to problems with electronic registries integrating with the allowed systems. Twelve practices started with Patient Centered Medical Home (PCMH) designation, but twenty-seven had PCHM designation by the end of the project. The time coaches needed to spend with the practices was at first estimated at four hours per week, but at the end of the project, an average of ten hours per week was advised during the training process.

Successes included more practices engaged, more measurement and monitoring of patient populations, improvement in measured outcomes, and tracking of more clinical information

specific to the goals which were specified. The transition occurred from markedly uncontrolled findings on the metrics to recognition of poor data collection, and then to improved control of the measured outcomes. Everybody is getting the data in on all of the desired metric components now, even the practices just beginning the process. Smoking cessation was a metric that was already being performed well, but improvement occurred in better tracking. Laboratory metrics, on the other hand, reflected improved identification of individual patient control, with hemoglobin A1C over 9 improved by 40% and hemoglobin A1C over seven improved by 2.4%. The further identification of individual patient or physician performance, important to driving change, was thwarted by the difficulty of lack of raw data access from the National IPIP site, as mentioned above.

Only the three Pediatric practices performed Asthma metrics. Two of those practices are successfully tracking changes, the third still experiencing registry problems. All protocols are being monitored at the end of the project. Data collection on emergency room visits and hospital visits relied on recall of the patient because electronic systems do not integrate well between parts of the health care system, i.e. health system (hospital) electronics do not communicate with practice electronic systems. There was a reduction in the number of emergency room visits in the practices. Smoking cessation and vaccine administration were improved as a result of the tracking process increasing awareness of need to attend to these issues.

Learning Collaborative meetings involved two days of most staff removed from their offices with no reimbursement. MPHI reported that this was very straining on the system and the individual practices. Half of the practices felt that the value was worth the attendance, half felt that there was not enough value added above the value received from meeting with their coaches.

Practice call in sessions on a monthly basis allowed staff to listen to dialogue about the improvement process or phone presentations about process improvement during their lunch time or before their clinic opened. There were problems with attendance until adjustment in the times and day of the

week was made to suit the needs of the participants. After this attendance averaged ten practices per call, with good sharing of information.

Monthly Coach meetings involved an average of thirty-four coaches per meeting. Meetings discussed sharing of tools, problems in coaching, demonstration of efforts with tools being utilized in practices and how these tools could be utilized in a different problem. On an average of two times a week, "just in time assistance" by coaches was provided.

Conclusions:

All engaged practices were able to eliminate waste, start measuring and monitoring metrics. Small successes drove momentum, but the measurement needed to encompass a longer time period than was initially expected. The program provided increased in knowledge of the Plan-Do-Study-Act (PDSA) cycle, increased satisfaction of care, increased quality efforts, proof that industry engineers can assist in transformation, and provided showed value added to the program being utilized. Clearly, measurement of outcomes will result in process improvement once it is successfully implemented.

One IPIP member stated that many more practices are ready to participate in this type of project.

Next steps:

Output from IPIP will be a fixed written story and a data supported version of the story to be published within the next few months. Project officially ended in June 2010, although AIAG, the automotive group is still financing some summation and information storage. Final reports are being created and will be sent within the next few months. National IPIP will contact the Michigan Primary Care Consortium (MPCC) and Aligning Forces for Quality (AF4Q, a Robert Wood Johnson Foundation sponsored organization) to discuss ways in which to utilize information on how to walk through an individual case problem and how to set up a data measurement system. MPHI is also utilizing information on a confidential basis, but leaving autonomy of the practices intact. The Blue Cross project Physician Group Incentive Program (PGIP) will be discussing the transformation and engagement in a short article. Refer to the MPCC website, www.mipcc.org to obtain more information.



2011 Mid-Winter Family Medicine Update

Conference Agenda

Thursday, January 20, 2011 4 credits

- 1:00 p.m. - 7:00 p.m. Registration & Sign-In - Parlor C
Exhibits Open - Parlor B&C
Lectures - Parlor A
- 1:45 p.m. - 2:45 p.m. Pharmacological Update, Parlor B&C
Visit Exhibits
- 2:45 p.m. - 3:00 p.m. Opening Remarks, David Best, D.O., MAOFP Education Chair
Jeffrey Stevens, D.O., MAOFP President
- 3:00 p.m. - 4:00 p.m. How Can Primary Care Practices Adopt EHR Technology and Prosper Under Meaningful Use?
Paul Ponstein, D.O.
- 4:00 p.m. - 5:00 p.m. EHR Implementation at a Federally Qualified Health Center; David Best, D.O.
- 5:00 p.m. - 6:00 p.m. Comprehensive Breast Cancer Update; Jamie Caughran, M.D.
- 6:00 p.m. - 7:00 p.m. Family Medicine Immunization Update;
Hugh Gunner Deery II, M.D., F.A.C.P., F.I.D.S.A.
Supported by Michigan State University Physician Peer Education Project on Immunization Project & the Michigan Department of Community Health
- 7:00 p.m. - 9:00 p.m. Wine & Cheese Welcome Reception - *hosted by* MAOFP
Summit D

Friday, January 21, 2011 5 credits

- 8:00 a.m. - 1:30 p.m. Registration & Sign-In - Parlor C
Exhibits Open - Parlor B&C
Lectures - Parlor A
- 8:00 a.m. - 9:00 a.m. Continental Breakfast, Parlor B&C
Supported in part by the Michigan Osteopathic Association
- 8:00 a.m. - 9:00 a.m. Pediatric Health & Wellness; Chris Pohlod, D.O.
- 9:00 a.m. - 10:00 a.m. Diagnosis & Treatment of the most Common Sports Injuries; Greg Cibor, D.O.
- 10:00 a.m. - 10:15 a.m. Pharmacological Update/Break, Parlor B&C
Visit Exhibits
- 10:15 a.m. - 11:15 a.m. Diagnosis & Treatment of the most Common Sports Injuries; Sean Bak, M.D.
- 11:15 a.m. - 11:30 a.m. Pharmacological Update/Break, Parlor B&C
Visit Exhibits
- 11:30 a.m. - 12:30 p.m. Nutritional Evaluation: Understanding Your Patients' Nutrition and Supplement Needs; Patrick Hanaway, M.D.
- 12:30 p.m. - 1:30 p.m. Dementia Update; Frank Komara, D.O.

Lecture Materials

Lecture materials will be placed on USB Flash Drives. You will receive your USB Flash Drive when you sign in at the conference, January 20 – 23, 2011. (1) One per attendee. (2) Not necessary to bring your laptop (PowerPoint Presentations will be displayed in the lecture rooms for viewing). (3) You may download and print the presentations ahead of time at www.mafp.org if you prefer to have hard copies. They will be available online Monday, January 17th. (4) PowerPoint Presentations not included on the Flash Drives will be made available on our website after the conference.



2011 Mid-Winter Family Medicine Update

Conference Agenda

Saturday, January 22, 2011 6 credits

- 8:00 a.m. - 3:30 p.m. Registration & Sign-In - Parlor C
Exhibits Open - Parlor B&C
Lectures - Parlor A
(exhibit hall closes at 3:30 p.m. and will NOT be open on Sunday)
- 8:00 a.m. - 9:00 a.m. Continental Breakfast, Parlor B&C
- 8:00 a.m. - 9:00 a.m. Overactive Bladder & Incontinence
Amy Brode, D.O.
- 9:00 a.m. - 10:00 a.m. P.L.A.Y. Therapy; Adam Brode, M.A., CCC-SLP
- 10:00 a.m. - 10:15 a.m. Pharmacological Update/Break, Parlor B&C
Visit Exhibits
- 10:15 a.m. - 11:15 a.m. Psychopharmacology in Children & Adolescents; Jed Magen, D.O.
- 11:15 a.m. - 11:30 a.m. Pharmacological Update/Break, Parlor B&C
Visit Exhibits
- 11:30 a.m. - 12:30 p.m. Health Care Update; Doug Paterson, M.P.A.
- 12:30 p.m. - 1:30 p.m. "Stakeholders Round Table"- Semi-Annual Membership Meeting
Lunch served – conference registrants only please
Parlor D
- 1:30 p.m. - 3:30 p.m. OMT Workshop: How to Perform Ligamentous Articular Strain Technique (LAST)
on the Foot; Mary Goldman, D.O.
- 8:00 p.m. - 10:00 p.m. *MSUCOM Indoor Tailgate, Bellaire Ballroom
Sponsored by MSUCOM

**The Michigan State University College of Osteopathic Medicine will be celebrating the MSU/Purdue basketball game with an indoor tailgate from 8 to 10 p.m. Both good food and the televised game will be available, and you're welcome to attend!*

Sunday, January 23, 2011 5 credits

- 8:00 a.m. - 1:00 p.m. Registration & Sign-In - Parlor C
Lectures - Parlor A
- 8:00 a.m. - 9:00 a.m. Continental Breakfast, Parlor A
- 8:00 a.m. - 9:00 a.m. Personality Disorder Update; Lauren Oxholm & Luis Oxholm, D.O.
- 9:00 a.m. - 10:00 a.m. Women's Health Update; Jason Bennett, M.D.
- 10:00 a.m. - 11:00 a.m. The Art and Science of Communicating Decline, Patricia Schmidt, D.O., F.A.C.O.I.
Supported by In-House Hospice & Palliative Care
- 11:00 a.m. - 1:00 p.m. Risk Management
Mark Hakim, M.A., M.B.A., C.P.H.R.M.
Supported by ProAssurance Casualty Company

CME Accreditation and Certificates

The Michigan Osteopathic Association has approved this program for 20 hours of AOA Category 1-A CME credit. Your CME certificate will be mailed to you after the conference and hours will be sent to the American Osteopathic Association for recording. Please keep your certificate as proof of attendance. Risk Management Certificates will be handed out immediately following the Risk Management session on Sunday.



Registration Form January 20 – 23, 2011

Please Print

AOA Number _____ Name _____

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City _____ State _____ Zip Code _____

Phone # _____ Fax # _____ Email _____

We accept Visa, MasterCard and Discover. Please complete the following:

Card # _____ Exp. Date _____ CVV #(3 digit code on back) _____

Authorized Signature _____

Register online at www.maofp.org. Or if paying by *Check*, please make it payable to: MAOFP

Deadline to Pre-Register is Tuesday, January 18, 2010

Please mark your registration status and fees:

Pre-Registration Fees by Tuesday, January 18, 2011

- MAOFP Member \$350 Non-Member \$450 Retired \$200
Nurses, P.A.'s, Med Techs: (Member) \$350 (Non-Member) \$450
 Residents, Interns & Students \$0 (circle status) *Pre-registration is required.
 Past President of MAOFP \$0 *Pre-registration is required.

Registration Fees after January 18, 2011

- MAOFP Member \$400 Non-Member \$500 Retired \$250
Nurses, P.A.'s, Med Techs: (Member) \$400 (Non-Member) \$500

Have you paid your 2011 dues?

Pay them now and receive the reduced member registration rate.

Yes, pay my dues now (\$100 annually)

Yes, pay my dues now First Year in Practice \$50

Refund Policy: A \$75 processing fee will be assessed to any cancellations made after January 18, 2011.

Please register online at www.maofp.org or send this page with your payment made payable to:

Michigan Association of Osteopathic Family Physicians or MAOFP

2445 Woodlake Circle, Okemos, MI 48864 or fax with credit card number to (517) 347-1566

For additional questions regarding the conference, please contact the MAOFP office at (800) 657-1556 or (517) 347-1555 or scarson@mi-osteopathic.org

Interested in presenting at any of our upcoming conferences?

Please contact Sara Carson at scarson@mi-osteopathic.org or (800) 657-1556.

- Yes, I am interested in presenting at a future MAOFP conference.

Name: _____ Topic/Specialty: _____

- No, I am not interested in presenting; however, I would recommend the following person to present.

Name: _____ Topic/Specialty: _____



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Michigan Association of Osteopathic Family Physicians
January 19-23, 2011
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Check-in begins at 6pm, Check-Out is 12pm

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Confirmation Email: _____ Fax: _____

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LODGING ONLY ROOM TYPES:	1Adult	2 Adults	3 Adults	4 Adults
_____ Guest Room (2 Beds)	\$165	\$165	\$180	\$195
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The above rates are Per Room, Per Day, plus 6% state tax, 8% resort fee and 2% local tax.

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_____ Parlor Studio (King Bed)	\$788.91	\$449.96		
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_____ Two Bedroom Condo	\$1337.53	\$724.27	\$519.84	\$417.63

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THIS FORM MUST BE MAILED OR FAXED IN TO RECEIVE THE GROUP DISCOUNTED RATES.

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(If Mailing a Check, Please Note on the Line Above.) Reservation will be held for 10 days pending receipt of the check. If credit card deposit is made and organization pays in full by check refunds of credit card are subject to a \$10.00 handling fee.

Signature (Required): _____

Do you have any special lodging requests?

Barrier Free: _____ Other (Please Indicate): _____

On-Campus Occurrences

MSUCOM AACOFP Student Report

By Kimberly Oberski, SA-ACOFPP Chapter President

With the start of the new school year, we have found ourselves very busy with classes, meetings, exams, and, of course, football games here at MSUCOM! We gained a large amount of first years that joined our group at the student organization fair in September, and have also had a few conferences and speakers throughout these first few months of the fall semester. We have definitely been busy and are happy to share some of our recent events:

From August 5-8, 2010 we had a handful of MSUCOM SAACOFPP students attend the Michigan Association for Osteopathic Family Practice Summer Family Medicine Update. This free conference (thanks to our generous MAOFP!) was a great opportunity for students to network with Michigan family practice doctors, learn about topics ranging from kidney disease, to dermatology, to the importance of Vitamin D in the elderly, and spend some time at a beautiful northern Michigan golf resort! We received nothing but great feedback from those who attended, saying the doctors were great and that they learned so much. We all cannot wait for the even bigger winter MAOFP conference in January, and as always are so thankful for this wonderful opportunity being provided to our students free of charge.

The MSUCOM student organization fair was held on Monday, September 13 at all three of our school's campuses. The five members of our eboard spread out between sites and recruited as many members as we could convince with pretty posters, candy, and a raffle drawing for a Biggby card, with one winner at each site. We told all the curious first years that came out for the event about all the fun things we have planned for the year and have really enjoyed the new faces at our monthly activities and meetings. It was a successful start to the school year and we are excited to see what this class has to offer as the year progresses!

In celebration of Primary Care Week we decided to hand out baked goods to our fellow classmates. The three East Lansing eboard members and our liaisons at the DMC and MUC campuses took time out of our busy class schedule to get our culinary skills a big test in making mass quantities of everything from muffins, to cookies, to brownies, to bread. On Tuesday, October 19 we stood out in the hallway in front of the computer labs and handed out our baked goods for free to any student wishing to take them! We wished each of them a happy primary care week and even got a chance to tell a few interested students about how to get more involved in ACOFP and also about our upcoming events. Everyone was so shocked that the desserts were free and the fruit of our long hours of hard work were gone in less than 10 minutes! We got a chance to spread the word about Primary Care Week in a way that touched so many classmates, and we feel our little "celebration" was a huge success!

Two of our eboard members, Kim Oberski and Kristen Strehl, got the incredible opportunity to attend the AOA conference in San Francisco, CA from October 23-28. With help from our student government association and our wonderful MAOFP, most of the expenses of our trip were paid for and we were able to enjoy a great trip and learn so much at the conference! We attended meetings including the International Seminar, the DO Care board meeting, a talk about atherosclerosis, one regarding HIV/AIDS, and of course the residency fair to name a few! We got opportunities to network with other students and physicians and will have a lot to teach the other eboard members at our November meeting. We are so thankful for the opportunity to attend our first AOA conference and had an amazing time visiting California!

On November 4th we invited our associate dean Dr. Donald Sefcik to speak to a very large group of student about his journey throughout many aspects of osteopathic medicine. We

had the biggest turnout for an event thus far, and for the first time, we actually ran out of food! Dr. Sefcik was so engaging and gave us great tips about how to "strategically move our chess pieces" to get the residency we want, how to save money and resources effectively, and how time plays an important role in everything we do and every decision we make. The first and second years who attended loved it, and he was being asked questions from curious students long after his allotted time to speak with us! We are proud to be the student organization on campus to have hosted his presentation and are very happy with how our first speaker event of the school year went.

Finally, on November 6, we held our second annual ACOFP Chili Cook-Off during the tailgate for the MSU vs. Minnesota football game. The weather turned out to be beautiful for football and chili, with not a cloud in the sky but temperatures in the low forties. We started out a little slow, but as the cold got to everyone, we watched as cups and cups of chili disappeared! Most of the eight chilis entered in the contest were gone by the start of the football game and the winner, one of our classmates, walked away with a \$20 gift card to our medical bookstore downstairs in Fee. We were very happy with how everything turned out, and were proud to host such a successful event for our classmates!

As always, we would like to thank the MAOFP for playing such a large role in making all of these events and opportunities available to the students at MSUCOM. We appreciate your support and guidance and cannot thank you enough!! We will hopefully be bringing a very large group to the winter conference and will be able to personally thank you for all you do for our group. Thank you so much, and GO GREEN!!

WHAT IF ...

Times change and we change with the times. Issues come and go and our reactions to them vary with our personal state of mind and the influences of our society as viewpoints and culture evolve. During certain eras we experience relative quiet and comparatively little change; other eras are marked with tumult. Sometimes we're lulled into a sense of being safe when in reality a cataclysm is about to be released. Think about the events in ancient Pompeii, Italy when in the year 79 A.D. the volcano Mt. Vesuvius erupted without warning and simply entombed the city with its ash. Those who lived in Pompeii were aware of the danger yet still chose to live there. They had the "facts" for their decision-making. What they could not do was envision the disaster. How we as a profession decide to act to define our future as osteopathic family physicians is not that different. Our destiny, like most, revolves around our interpretation and reaction to a lot of "what ifs".

What if ... Primary care (in our case the osteopathic family physician) is NOT the salvation that policy makers and payers opine will rein in the runaway health-care cost debacle.

Consider this: *We work in the twenty-first century using a twentieth or perhaps even a nineteenth century delivery model struggling with a status quo that serves neither physician nor patient adequately. Many other "industries" have experienced disruptive innovations and morphed dramatically. Our current model of primary care relies on physicians to assume responsibility for basic tasks defined under that rubric - much of the mainstay of our practice such as routine checkups, wellness advice, disease prevention or mitigation, managing chronic diseases, arranging or directing patients through the ever-increasing complexity of healthcare*

services, and more recently smoothing end of life care.

At minimum three questions emanate from this presumption: Does it require a physician to serve as navigator and advocate for the patient; can a primary care physician performing in this system maintain current comprehension of the proliferating medical knowledge and related evidence-based best practices; and, given the reimbursement model, does the harried schedule of the primary care physician (volume needed to support a practice) allow sufficient time to gain substantive insights in the patient's well-being when seen only briefly (estimates range from average of 45 minutes to 90 minutes during the course of a year for a patient with chronic diseases)?

What if ... Primary care (again, in our situation, the osteopathic family physician) demonstrates the capability of effectively bending the health-care cost curve while improving patient outcomes but lacks workforce capacity to deliver to a significant segment of the population.

Consider this: *We know that over the past several decades as a nation we have experienced a migration of physicians from primary care to secondary, tertiary and even quaternary care. The myriad of reasons posited by researchers and other public policy experts include economic disincentives (exemplified by how to make an adequate living compounded by those entering the field harboring excessive education debt requiring financially crippling loan repayments), lack of "glamour" or intellectual excitement associated with specialty practice (how often have you heard this response*

to the question what kind of doctor are you? - "I'm JUST a family practitioner"), and lifestyle choices by newly minted physicians entering the physician supply chain. The attraction to primary care usually encompasses individuals with a keen desire to connect with patients; yet, this is almost a poetic yearning for the halcyon days associated with the early to mid twentieth century. What is recognized: the graying of the primary care work force; it reflects the aging of the US population as well. As that population age distortion accelerates, there will emerge greater need for primary care management; then consider that fewer than fewer than 300 fellowships in geriatric medicine fill annually in a country that now hosts forty million individual of retirement age. Consider the estimated nationwide shortfall of primary care physicians anticipated at 46,000 by 2025.

This primary care physician workforce issue raises public policy challenges particularly on the access side of the supply-demand equation confounded by costs of care. The science and the economics of practice in the twenty-first century have morphed dramatically from what was acceptable in the past century. Does the creation of 500 more residencies for primary care, as the recent healthcare reform act has provided, resolve that deficit? Does it address the cost side? An illuminating look inside the Patient Protection and Affordable Care Act reveals the direction of public policy with funding for pilot projects involving nurse-lead patient-center medical clinics. The policy implies that more predictable work can be off-

Continued on page 14

loaded to non-physicians (e.g. nurse practitioners or physician assistants) who require less training, who can be brought online sooner at a lower cost, and who can be employed with lower overall expense. It's certainly been the mantra in other industries in their response to changing dynamics including global competition and excision of cost from the operating structure.

What if ... The assumptions that have fostered Patient-Centered Medical Home development (I still prefer Patient-Centric Delivery Model rather than "Home") fail to validate.

Consider this: The economic picture of success as envisioned by policy makers has not as yet been confirmed on a large scale; many of the reports of improvement are practice efficiency based. Beyond the economic model postulated to bend the healthcare cost curve, another feature has been potentially overlooked. In the world of business, including services, the voice of the customer must be heard. When you come to understand the undoing of some of our largest corporations because they deemed, as in the old General Motors' attitude that "the public will buy what we decide we will build", the voice of the patient requesting this change is unverified.

Researchers involved with the American Academy of Family Physicians (AAFP) Transformed practices reported that the vast majority of physician offices could successfully incorporate most changes; early signs suggest quality of care and preventive health ratings demonstrated small improvements. Office staff became more streamlined,

efficient and satisfied. Most notably, physicians were more content than ever before with their work, despite still having to deal with an unchanged fee-for-service or managed care reimbursement system. Yet despite these successes, there was also one unexpected early finding: the patients were unhappy.

Yes, patients were seen quicker and followed closer than ever before, but many patients reported feeling disoriented. Some felt displaced as they saw the traditional one-to-one physician-patient interactions replaced with one-to-three or one-to-four relationships involving not only the physician but also a whole cadre of other providers. The switch to electronic medical records augmented the disaffection with patients reacting to distracted clinicians more focused on learning new computer systems rather than listening to them. Satisfaction fell because in working so hard to adopt changes on their patients' behalf, clinicians temporarily lost their focus on the patients themselves.

What if ... The current and future incentives result in the transformation from patient-physician relationship based care to a "corporate" practice of medicine.

Consider this: In a 2009 editorial in the *Annals of Internal Medicine* Carolyn Clancy, MD, the Director of the federal government's Agency for Healthcare Quality and Research opined that primary care is too important to fail. She cited a survey some 2000 primary care physicians that determined a typical primary care physician coordinates the care of their Medicare patients with 229 other physicians working in 117 different practices – and this

does not include other types of coordination such as with non-physician therapists, educators, psychologists, or community partners. Place the primary care physician at the center of this essential function, then add the requirements imposed by payers, regulators, and other third party intrusion; combine that with the requirements of implementing electronic health informatics; and confound that with the necessity to provide the aspects of delivery associated with the patient-centric model {home} of care; finally, add the fatal blow – pay for this transformation.

The reality: most primary care practices (75% in 2006) have five or fewer physicians. They lack both the human and economic capital to make this required transformation. Combined with emerging payment models (e.g., Accountable Care Organizations) that defines a patient encounter as multiple episodes of care extending across the continuum and the need for hospital or health systems to manage and control costs and publically reported outcomes (value-based purchasing and transparency), has resulted in the current frenzy by those entities to either employ physicians or acquire physician practices (and other providers of healthcare services). The employed physician obviously has less autonomy and perhaps less discretion in patient advocacy.

What if ... Financial drivers or personal ego corrupt the evidence-based practice science that supports best clinical practices, or worse case scenario faulty science becomes systemically embedded in our delivery algorithms.

Consider this: The focus on public reporting (i.e., physician, hospital or health system "report cards") posits that the

underpinnings of these “ratings” reflect direct compliance with evidence-based clinical guidelines or best practices. In theory this remains consistent with the intent of physicians to deliver the best and most appropriate care for their patients – and particularly in a one-to-one patient-physician relationship. Part of where theory and practice diverge occurs when the patient does not fit the best practice or evidence-based guidelines (a situation in which statistical significance inappropriately trumps clinical significance on the reporting side of the equation); this reflects the “art” of practice – or customization to meet the patient condition, need, values, or cultural difference. Other situations impact this schema as well.

At times guidelines or recommended best practices are later deemed in error. A recent effort to tightly control blood glucose in the ICU patient, an incentivized element of some payment systems to produce higher quality patient outcomes, was challenged by some physicians and eventually the premise was proven to represent dangerous and discarded. Despite faulty science, including defective study design and poor guideline vetting prior to implementation, the guideline became a driver in reimbursement incentives in an environment sensitive to pay for performance programs. During the past decade significant concern related to falsified data, non-conducted clinical studies published as research from prestigious institutions in reputable peer reviewed journals, and financial influences in the research have added to the conundrum of what constitutes best clinical practice. More disconcerting: the promulgation of multiple guidelines containing conflicting recommendations published

by recognized authorities (e.g., intervals for screening mammograms) – leaving the physician accountable and responsible for conformance without the ability to influence those decisions.

What if ... Individual patient lifestyle or behavior choices supersede a physician’s ability to intervene to protect a patient’s personal health status?

Consider this: *A famous comedian once said, “I’ve been rich, and I’ve been poor, and believe me, rich is better.” As an analogy a patient might say, “I’ve been a good patient, and I’ve been a bad patient, and believe me, being a good patient helps to get me out of the hospital, but being a bad patient helps to get me back to real life”. We’ve all been there: You’ve figured out what’s ailing your patient; however, you have the challenge to persuade the patient to comply with your advice. Overcoming social and cultural hurdles often constitute unfair expectations: many patients refuse to make recommended lifestyle changes; compound this with the realization that only half of all chronically ill patients take medicines as directed, and many fail to even get prescriptions filled.*

Noncompliance is dangerous for the patient and frustrating for the physician. As more payers promote pay-for-performance programs, physician accountability and economic risk increase. Patient outcomes and physician performance metrics will be adversely impacted by the non-compliant behaviors that remain beyond physician control. Think about a comment by former US Surgeon General C. Everett Koop: “Drugs don’t work in patients who don’t take them.” Some things haven’t changed!

The incidence of non-compliance becomes more germane when realizing the economic drivers external to the practice of medicine that increases non-compliance: job loss, lack of or inadequate insurance benefit coverage for the necessary services or products. This represents the hidden burden of disease.

What if ... we as physicians, individually and collectively, engage in shaping our future?

I present this to you as the open-ended question. Contained within each of the “what if’s” are a multitude of public policy issues and personal decisions. I hope they might serve as a framework for discussions and deliberations both within our organization and hopefully in other venues in which you travel. We need to develop cogent answers to resolve the issues facing the healthcare system and particularly to physicians. We must preserve the sacrosanct individual patient-physician relationship with modifications in the delivery model to reflect the current era in which we live and work. These are enormous challenges that will not be solved by hyperbole, inciting anger, or posturing.

Carpe Diem,

Larry Abramson, DO

MAOFP Hosts Summer Family Medicine Update at the Crystal Mountain Resort in Thompsonville, Michigan



The Michigan Association of Osteopathic Family Physician's (MAOFP) Summer Family Medicine Update was held at the beautiful Crystal Mountain Resort in Thompsonville, Michigan from August 5-8, 2010.

The lectures included a wide variety of topics applicable to the Michigan family physician. Twenty-one hours of AOA category 1-A CME credits were available. Excellent feedback from the attendees was received as a result of informative, up-to-date lectures and topics.

At its Stakeholders Membership Meeting on August 6, MAOFP members elected the 2010-2011 Board of Directors. The new MAOFP board officers are: **Jeffrey Stevens, D.O.**, of Wyoming, president; **Andrew Adair, D.O.**, of Chesterfield, president-elect; **William**



Morrone, D.O., of Bay City, secretary/treasurer. The new

Directors nominated were **Frank Komara, D.O.**, of East Lansing, **Leah Cecil, D.O.**, of Lake Orion as Resident Director; and MSUCOM student, **Kimberly Oberski** as the student director.

The MAOFP proudly bestowed its Family Physician of the Year Award to **Stephen Swetech, D.O.**, of Clinton Township. Dr. Swetech is a 1986 graduate of the Michigan State University College of Osteopathic Medicine and is board certified in family practice. He is currently medical director/president of the Stephen M. Swetech,



D.O., Medical Center, P.C., a family practice and urgent care center in Clinton Township. Dr. Swetech has held several professional leadership roles that have helped to increase visibility and understanding of the osteopathic profession including his tenure as a member of the board and as the 1999-2000 president of the Michigan Association of Osteopathic Family Physicians; board member and past president of the Macomb County Osteopathic Association; membership and service as a Michigan delegate to the American Osteopathic Association and the American College of Family Practice in Osteopathic Medicine and Surgery (ACOFP); and chairmanship of the reference

committee to the House of Delegates for the ACOFP. Dr. Swetech has been married to his



lovely wife, Grozda, for 25 years and has two children, Maria and Jonathon.

The MAOFP awarded **Samson A. Inwald, D.O., FACOFP, dist.**, a Lifetime Achievement Award to honor his dedication to the osteopathic profession, as well as his community, patients and family. Dr. Inwald was a 1956 graduate of Philadelphia College of Osteopathic Medicine and Surgery and was board certified in family practice. Over many



decades he demonstrated his exceptional lifelong commitment to promoting osteopathic family medicine nationally and particularly in Michigan. He was in private family practice in Berkley, Michigan for thirty four years. Reluctant to retire

MAOFP Hosts Summer Family Medicine Update at the Crystal Mountain Resort in Thompsonville, Michigan



he became the Director of Osteopathic Manipulative Medicine (OMM) and Assistant to the Family Practice Residency Director at Pontiac Osteopathic Hospital (now POH Regional Medical Center) in Pontiac, Michigan. Dr. Inwald's multiple professional leadership roles helped to increase visibility and understanding of the osteopathic profession including his tenure as a member our board and as our 1984-1985 president, and subsequently Executive



Director. In addition to his MAOFP activities he served as a board member and past president of the Oakland County Osteopathic Medical Association; membership and service as a Michigan delegate to the American Osteopathic Association, the American College of Osteopathic Family Physicians (ACOF) where he served on the Board of Governors and chaired a Congress of Delegates reference committee. He was

the Senior Inspector for Family Practice Residency Programs for the American Osteopathic Association until his passing on November 21, 2010. Dr. Inwald



had been married to his lovely wife, Susan, for over 58 years. He had four children and ten grandchildren. The MAOFP will hold its next

conference; MAOFP Mid-Winter Family Medicine Update at the Shanty Creek Resort in Bellaire, Michigan on January 20 – 23, 2011. Visit www.maofp.org for conference information and registration.



In Loving Memory:

Samson Inwald, D.O., FACOF, *dist.*, of Bingham Farms, Michigan passed away on November 21, 2010 at the age of 82 years. He is survived by his beloved wife of 58 years, Susan, four children and ten grandchildren.

Dr. Inwald's enthusiasm, wit, smile and compassion will be missed by all who knew him. His dedication and loyalty to the osteopathic profession and the love he gave so easily to his friends and family remains unsurpassed.

Call to Meeting

The 2011 meeting of the ACOFP Congress of Delegates will take place March 16 and 17, 2011 at the Marriott Rivercenter Hotel in beautiful San Antonio, Texas.

The Congress is scheduled to eliminate overlap with CME activities and provide all members with unrestricted time to participate in deliberations and to celebrate the inauguration of the 2011-12 ACOFP President, Michigan's own; George T. Sawabini, D.O., FACOFP.

Wednesday, March 16, 2011 ° Thursday, March 17, 2011

12:30 – 3:00 p.m. – Congress Credentialing
7:00 – 9:00 a.m. – Michigan Caucus
3:00 – 5:00 p.m. – Congress Session I
9:00 – 11:00 a.m. – Congress Session II
5:00 – 7:00 p.m. – Reference Committees
11:00 – Noon – Presidential Inauguration

To reduce printing and shipping costs, the agenda and congress information will be posted on the ACOFP website at www.acofp.org two weeks prior to the Congress. During credentialing, each delegate will receive a hard copy of the reference committee assignments, budget and resolutions.

So please plan to attend the ACOFP convention and register to be a Michigan delegate for the Congress of Delegates. You can register for the convention at www.acofp.org and for serving as a delegate by contacting the MAOFP office at (800) 657-1556. Join us in celebration as Dr. Sawabini is inaugurated as the 2011-2012 ACOFP President!

Fraternally,

Mark E. Sikorski, D.O., FACOFP
Speaker, ACOFP Congress of Delegates

FREE MAOFP CONFERENCE REGISTRATION

Receive a certificate for a complimentary conference registration to your choice of either the MAOFP 2011 summer conference at the Grand Traverse Resort in Acme, MI on August 4-7, 2011 OR the MAOFP 2012 winter conference at the Shanty Creek Resort in Bellaire, MI on January 26-29, 2012 if you serve both days as a Michigan Delegate!

Save The Date

Upcoming CME

Michigan Association of Osteopathic Family Physicians

August 5 – 8, 2010 at Crystal Mountain Resort in Thompsonville, Michigan
January 20 – 23, 2011 at Shanty Creek Resort in Bellaire, Michigan
August 4 – 7, 2011 at Grand Traverse Resort in Acme, Michigan

Michigan Osteopathic Association

May 11– 14, 2011 at the Hyatt Regency in Dearborn, Michigan

American College of Osteopathic Family Physicians

March 16 – 20, 2011 in San Antonio, Texas

American Osteopathic Association Annual Convention

October 24 – 28, 2010 in San Francisco, California
October 30 – November 3, 2011 in Orlando, Florida

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