

*From President Bulger*

## The Conundrum of Measuring Quality in Healthcare



The proliferation of measurement in healthcare recently has been on the minds of many. Societies, quality leaders, and pundits have written extensively on the topic.

The concern over measurement culminated last week with the Centers for Medicare and Medicaid Services (CMS) delaying the publication of hospital ratings (<http://khn.org/news/medicare-delays-plans-for-new-star-ratings-on-hospitals-after-congressional-pressure/>), or Hospital Star Scores.

Let me first say that I do believe that measurement is necessary to improve. One cannot know the

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May 5-7, 2016

## Annual Trainers Congress Set for Savannah, GA



More than 200 residency program directors, trainers, rising chief residents and medical education coordinators will gather May 5-7 in Savannah, GA, for the 2016 ACOI Congress on Medical Education for Residency Trainers. The agenda for the meetings will focus heavily on assisting the programs with understanding and meeting the requirements for accreditation from the

Accreditation Council for Graduate Medical Education (ACGME).

The Congress will kick off on Thursday, May 5 with a keynote lecture by Robert Flora, MD, MBA, MPH, on Crucial Conversations. The lecture is based on a course that teaches skills for creating alignment and agreement by fostering open dialogue around high-stakes, emotional, or risky topics. The Thursday program will also feature a report from the ACGME Residency Review Committee for Internal Medicine. The Review Committee is the approval body for programs seeking accreditation from the ACGME.

In addition to the program for trainers, there will be separate sessions for rising chief residents and emerging leaders, as well as for medical education coordinators. The Congress will take place at the Westin Savannah Harbor Golf Resort and Spa. Registration materials are available at [www.acoi.org](http://www.acoi.org).

## Board of Directors Nominations Sought

Active members of the ACOI who are interested in serving on the Board of Directors are invited to contact the College's office and request a nominating packet. The members of the ACOI will elect three individuals to three-year terms on the Board at the Annual Meeting of Members, October 31 in Palm Desert, CA.

As part of an ongoing self-assessment process, the Board has developed a position description for Board members, and a list of competencies that should be possessed by the Board as a whole. Potential candidates must complete an application form that allows them to describe how their experience and expertise match up with the desired competencies.

In order to be considered by the Nominating Committee, the completed nomination packet must be returned to the ACOI office no later than June 17, 2016. The slate of candidates will be announced in the July issue of the newsletter.



## American College of Osteopathic Internists

*In Service to All Members; All Members in Service*

### MISSION

*The mission of the ACOI is to promote high quality, distinctive osteopathic care of the adult.*

### VISION

*The ACOI seeks to be the organization that osteopathic internists think of first for education, information, representation and service to the profession.*

### VALUES

*To accomplish its vision and mission, the ACOI will base its decisions and actions on the following core values:*

*LEADERSHIP for the advancement of osteopathic medicine*

*EXCELLENCE in programs and services*

*INTEGRITY in decision-making and actions*

*PROFESSIONALISM in all interactions*

*SERVICE to meet member needs*

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## Letter from the President

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success of improvement work without an assessment of process and outcomes related to the change. There are problems, however, that create a measurement conundrum. The first is that while there are many measures that reliably and accurately assess improvement, they are not intended to be used to discriminate good from bad, or compare dissimilar institutions. The National Quality Forum (NQF) (<http://www.qualityforum.org/Home.aspx>) is the premier body for healthcare measurement endorsement. I have had the honor to serve in the NQF process. The hallmarks of the endorsement process are validity and reliability. Use is not explicitly considered in the process. A measure may validly and reliably discriminate the top and bottom quintiles on a given process or outcome, but it is not powered to separate institutions in the middle of the curve. Using this type of measure to assess better or worse than average, as the readmission measures are used by CMS, is not within the spirit of the NQF endorsement.

The second problem is the sheer volume of measures. A recent report from the Healthcare Association of New York State (HANYs), *Measures that Matter*, ([http://www.hanys.org/quality/clinical\\_operational\\_oversight/measures\\_that\\_matter/?utm\\_source=homepage&utm\\_medium=hanys.org&utm\\_campaign=Measures-That-Matter](http://www.hanys.org/quality/clinical_operational_oversight/measures_that_matter/?utm_source=homepage&utm_medium=hanys.org&utm_campaign=Measures-That-Matter)) commented on the number of measures that hospitals and physicians must collate. As part of their study, HANYs noted that there is a total cost to physician offices of over \$15 billion and 785 hours of staff time per year to track the metrics. Nothing is more important than quality and safety in healthcare. That much staff time, however, could go a long way toward improvement. If physicians are expending this much money and effort on mandated measurement, there is far less time for actual improvement.

The third and final problem is focus. I am fond of Albert Einstein's quote, "Not everything that can be counted counts, and not everything that counts can be counted." The current state of measurement, and the choice of metrics by CMS, defines the "test" by which physicians and hospitals are judged. What is tested does not always match with what matters to patients and what needs to improve. Nonetheless, providers can be tempted to concentrate on the noted metrics, or study for the test. When this happens, patient care suffers and resources that could be placed in areas such as teamwork, inter-professional collaboration, professionalism, and mindfulness are shunted aside to improve the measures on the test.

One cannot manage what one cannot measure. That statement has been attributed to many and holds some truth. But one cannot measure everything that is important in healthcare; and all measures are not created equal. It is important that we strike a balance. Currently, that balance is too heavily weighted on measuring what we can measure, rather than on what is important. Measurement needs to improve and I'm confident it will. In the meantime, we must be prudent about how we use the current measures that are available.



# government RELATIONS

Timothy McNichol, JD

## **CMS Announces Initiative to Expand Primary Care Model**

The Centers for Medicare and Medicaid Services (CMS) announced a new five-year initiative to expand a primary care model that rewards value and quality. The new Comprehensive Primary Care Plan (CPC+) initiative will offer two different tracks in up to 20 regions of the country. Up to 5,000 practices will be able to participate under the program. It is estimated that as many as 25 million individuals will receive care under the initiative. Medicare will partner with commercial and state health insurance plans to support the delivery of advanced primary care services that consists of the following key components: access and continuity; care management; comprehensiveness and coordination; patient and caregiver engagement; and planned care and population health. Monthly care management fees will be based on beneficiary risk tiers within two tracks. Participation is contingent upon practices being able to document multi-payer support, use of certified electronic health record technology and other capabilities. Practices interested in participating can submit applications between July 15 and September 1. Additional information is available at <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>.

## **House Committee Cannot Consider Medical Liability Reform Legislation**

The House Judiciary Committee recently was unable to consider and advance medical malpractice reform legislation due to the lack of a quorum. The lack of a quorum was caused in-part by the majority party's in-fighting over medical liability reform legislation and the role of states in the process. The bill that would have been considered by the Committee is similar to legislation previously approved by the full House in a previous session of Congress. Specifically, the legislation would cap noneconomic damages at \$250,000 and limit attorney contingency fees, among other things. There is no clear path forward for the legislation at this time. As a result, it is unlikely that meaningful medical liability reform legislation will be advanced in either the House or Senate this year.

## **FDA Proposes Ban on Powdered Medical Gloves**

The Food and Drug Administration (FDA) recently announced a proposed ban of powdered medical gloves because of an "unreasonable and substantial risk of illness or injury" to healthcare providers and patients. The ban would apply to powdered surgeons gloves, powdered patient examination gloves and absorbable powder for lubricating a surgeons gloves. Comments on the proposed ban are due by June 20.

## **Department of Justice Announces Regional Elder Justice Task Forces**

The Department of Justice (DOJ) announced the launch of 10 regional Elder Justice Task Forces. The task forces are designed to bring together federal, state and local prosecutors, law enforcement, and other agencies that provide services to the elderly, to coordinate efforts to pursue nursing homes that provide substandard care to their residents. The Elder Justice Task Forces will be launched initially in the following districts: Northern District of California; Northern District of Georgia; District of Kansas; Western District of Kentucky; Northern District of Iowa; District of Maryland; Southern District of Ohio; Eastern District of Pennsylvania; Middle District of Tennessee; and, the Western District of Washington. According to a statement released by the DOJ, "Creating the task forces sends a message to those in charge of care for these beneficiaries that grossly substandard care will not be tolerated." Additional information is available at [www.justice.gov/elderjustice](http://www.justice.gov/elderjustice).

## **Supreme Court Hears Challenge to the ACA**

That Supreme Court heard oral arguments examining the contraceptive coverage mandate created under the Affordable Care Act (ACA). In total, eight federal appeals courts have considered whether the accommodations for religious nonprofits violates the Religious Freedom Restoration Act. Of the eight courts that have considered whether the mandate created a substantial burden on religious exercises, only one has found that it does and that the accommodation process is not the least restrictive means possible. The argument is that the process in place triggers contraceptive coverage for employees contrary to their sincerely held religious beliefs. It appears that much like the appellate courts, the Supreme Court is divided. The ruling, which is expected later this year, could result in a 4 to 4 split because of the death of Justice Antonin Scalia. In the event of a 4 to 4 split, the lower court decisions would stand for the time being, leaving conflicting rulings in place.

## **Costs Estimates of ACA Increased**

According to a report released by the non-partisan Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT), the net cost of the ACA's insurance coverage premiums increased by \$136 billion over last year's estimate. The report found that the largest difference is in the projected increase in Medicaid spending. By 2025 it is estimated that 24 million more people will have coverage under the ACA. Further, it is estimated that from 2017 to 2026 the number of people with coverage is expected to grow from 246 million to 253 million. Interestingly, the report also estimates that the total number of uninsured people will grow from 26 million to 28 million. You can view the report in its entirety at [www.CBO.gov](http://www.CBO.gov).

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# coding CORNER

Jill M. Young, CPC, CEDC, CIMC

*The ACOI Coding Corner is a column written by Jill M. Young, CPC, CEDC, CIMC. Ms. Young is the Principal of Young Medical Consulting, LLC. She has over 30 years of experience in all areas of medical practice, including coding and billing. Additional information on these and other topics are available at [www.acoi.org](http://www.acoi.org) and by contacting Ms. Young at [YoungMedConsult@aol.com](mailto:YoungMedConsult@aol.com).*

*The information provided here applies to Medicare coding. Be sure to check with local insurance carriers to determine if private insurers follow Medicare's lead in all coding matters.*

## Coding with Specificity Has Its Benefits

ICD-10 Coding has garnered a great deal of attention in both this column and throughout the lectures that I have given over the last two years. One area of focus that continually emerges is the importance of specificity in selecting a code. I would estimate that I have presented on this topic to over 1,000 physicians representing most specialties. The majority of physicians want to know why it matters. Physicians argue that it does not affect the treatment of the patient. Why should they waste time trying to find just the right code when the time could be better spent caring for patients? Good question.

Continuity of care is one reason. In this electronic age sometimes the only information available to another physician providing care is a code number and its accompanying words. The diagnostic code you assign helps other physicians understand the patient's condition and the severity of the illness. Many times, care is based on the history of care that other physicians have access to.

Medical necessity is another reason. Documentation and use of properly specific codes lends support to the level of service you are selecting for an Evaluation & Management (E&M) code. In addition, it provides support for any procedure that is provided. A properly specific code tells the WHY for a patient's course of treatment.

All too often physicians are choosing "unspecified" in a diagnosis family. While payments are still being made, the Centers for Medicare and Medicaid Services (CMS) has indicated that effective October 1, 2016 "close-enough" coding will no longer be accepted in most instances. This will become a problem for physicians using unspecified codes after this date where other more specific codes are necessitated. It is important that you start planning now for this transition.

It is not that for every patient seen there is always a diagnosis code with the specificity that the family of codes offers. It is important to note, however, unspecified coding might be an appropriate code. A patient with unspecified pneumonia as a diagnosis is a great example of the challenges presented. You may know very little about the pneumonia and as a result treat the patient empirically and correctly code an unspecified pneumonia. There are more coding options that you can use. Is it a bronchopneumonia, lobar pneumonia, hypostatic pneumonia or some other type of pneumonia? These are the other choices in the "Unspecified organism for pneumonia" family of codes as seen below:

In other diagnostic areas where an unspecified code would be less likely to be a representation of what the physician truly knows, I see it being selected. An example is "unspecified abdominal pain" (R10.9) where the chart clearly indicates a location and whether it is a localized pain or one that is with rebound or just an abdominal tenderness. Another common "unspecified" code selected is for patients with asthma. Because of crosswalks, GEMS and often a lack of time, the quick easy code

of Unspecified, asthma: J45.909 is selected. There are 18 codes in the asthma family; four sections based on severity of the asthma within each section and three codes which reflect the status of that type of asthma.

If you have a short list of common codes tacked up on the wall or printed on a sheet, you might not be coding with enough specificity. Now that the hurdles and hysteria of implementing ICD-10 have passed, it is time to continue the learning process to do it right when it comes to diagnosis documentation and code selection. As an added benefit, this will also have a positive effect on your

As I previously suggested during the conversion process, look at your top 25 utilized diagnosis codes. Ask your biller/coder to run the list again looking specifically at the past three months so you are looking at your ICD-10 codes after you had a while to use them. Look to see how many codes have the word "unspecified" in the descriptor or end in a digit of "9." Have your biller/coder look up in a book or online ([www.ICD10data.com](http://www.ICD10data.com)) the words of the code and print out for you the choices associated with that illness or disease process. While there may be a large number of choices, I have found that for most physicians seeing the options will allow them to understand what code choices exist. Many times the list can be significantly reduced just by examining it and comparing the diagnoses to the types of patient's they see. Do just two codes per week. If you have the proper data it should not take you more than 5-10 minutes to look over. With the next patient seen, you will probably remember to stage the asthma (mild intermittent; mild persistent; moderate persistent; severe persistent) and indicate its status at this appointment (with exacerbation, with status asthmaticus or uncomplicated). The time spent now will avoid hours of consternation and stress when "close-enough" will longer be accepted by CMS.



# talking science & education

*Donald S. Nelinson, PhD*

Welcome to this month's edition of Talking Science and Education. It was a pleasure seeing many of you at the Board Review Course and Hospital Medicine meeting last month.

While on the topic of education, **are you aware that the ACOI has committed significant resources to support programs with ACGME Osteopathic Recognition applications?** The Board of Directors has determined that this is the most important priority for the College right now. The ACOI staff is prepared to provide a number of support services including, but not limited to:

1. Assisting programs in developing clear statements on:
  - a. Integrating OPP into residency curricula
  - b. Defining and supporting scholarly activity within training programs
  - c. Identifying references and resource materials to support osteopathically-focused education;
2. Networking program directors who are in the process of preparing their applications with other program directors who have successfully secured ACGME Initial Accreditation and Osteopathic Recognition;
3. Developing strategies for discussing at the C-suite level the benefits for programs, patients and institutions to pursue osteopathic recognition.

These are just a few topline services that ACOI is ready to offer, whether through phone calls, onsite collaborations, or other methods. In addition, we are working to set up a series of interactive webinars with ACGME to offer ongoing guidance and consultation for our programs.

**Finally, the agenda for the annual Trainer's Congress (May 5-7, Savannah, GA) will focus almost exclusively on ACGME accreditation and osteopathic recognition.**

For further information, please contact me at don@acoi.org (201-323-5327).

## ***Afib and Oral Anticoagulants***

Looking at some important newly-published data, a recent study found that nearly 50% of patients with atrial fibrillation (AF) are at increased risk for stroke because they are not being treated with oral anticoagulant medications (OAC).

Forty-eight percent of AF patients, who are at the highest risk of stroke, were not prescribed OAC medication. This despite the incidence of stroke being seven times greater in these patients than in those without the condition. The findings come from a new study by researchers at the University of California and published in JAMA Cardiology. They analyzed a cross-section of 429,417 outpatients with AF who were enrolled in the PINNACLE (Practice Innovation and Clinical Excellence) Registry between January 2008, and December 2012. The mean age of the participants was 71.3 years.

A total of 192,600 patients (44.9%) with AF were prescribed an OAC, with warfarin being the most-commonly prescribed therapy (173,832 [90.3%]),

followed by dabigatran (14,896 [7.7%]) and rivaroxaban (3,872 [2.0%]). It is noteworthy that these data were collected prior to the approval of apixiban and edoxaban. Using the CHADS2 and CHA2DS2-VASc score, researchers found that each one-point increase in either score was associated with increased odds of OAC prescription (approximately 15% greater adjusted odds). However, when CHADS2 scores exceeded three or CHA2DS2-VASc scores exceeded four, the patients more often were not prescribed an OAC, even when compared with lower-risk counterparts.

The authors hypothesized that reluctance on the part of healthcare professionals to prescribe OACs to sicker patients may be due to concerns surrounding bleeding risks. Despite the heightened bleeding risk with higher HAS-BLED scores, the authors note that the benefits of anticoagulation continue to outweigh the risk as all of these scores increase.

The authors conclude that "these findings draw attention to important gaps in appropriate treatment of patients with AF at the highest risk of stroke and highlight opportunities to understand the reasons behind these gaps and insights to improve them."

While the debate on the ultimate risk/benefit ratio continues, this study adds valuable fuel to this important discussion.

## ***Diabetes Dialogues***

While the controversy around intensive glucose control fueled by the ADVANCE and ACCORD trials continues, it appears that for patients with type 2 diabetes, intensive glucose control has long-term benefits for preventing end-stage kidney disease (ESKD), according to a study published online March 22 in Diabetes Care.

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## Talking Science

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Muh Geot Wong, M.D., Ph.D., from the University of Sydney, and colleagues examined the long-term effects of intensive glucose control on the risk of ESKD and other outcomes in survivors of the Action in Diabetes and Vascular Disease: Preterax and Diamicon Modified Released Controlled Evaluation (ADVANCE) trial. A total of 8,494 ADVANCE participants, who had previously been randomized to intensive or standard glucose control, participated in a post-trial follow-up.

The researchers found that by the first post-trial visit, in-trial HbA1c differences disappeared. After 9.9 years of overall follow-up, the in-trial reduction in the risk of ESKD (seven versus 20 events; hazard ratio, 0.35;  $P = 0.02$ ) persisted (29 versus 53 events; hazard ratio, 0.54;  $P < 0.01$ ). Greater effects were seen in earlier-stage chronic kidney disease ( $P = 0.04$ ) and at lower levels of baseline systolic blood pressure ( $P = 0.01$ ). The glucose lowering effects on death, cardiovascular death, or major cardiovascular event risks did not vary according to levels of kidney function ( $P > 0.26$ ).

“Intensive glucose control was associated with a long-term reduction in ESKD, without evidence of any increased risk of cardiovascular events or death,” the authors write. “These benefits were greater with preserved kidney function and with well-controlled blood pressure.”

ADVANCE and ADVANCE-ON are industry-sponsored trials.

As always, if you’ve read this far, thanks! Feel free to reach out to me at [don@acoi.org](mailto:don@acoi.org).



## New Members Welcomed

*The ACOI Board of Directors and staff welcome the following members whose membership applications or changes in membership status have been approved by the Credentials Committee and Board of Directors.*

### Active Membership

*Bridget M. Akel, DO*

*Jennifer M. Auxier, DO*

*Shadi M. Bashour, DO*

*Joel M. Blackburn, DO*

*Gwendolyn E. Bowers, DO*

*Andrew S. Brown, DO*

*Emily A. Burk, DO*

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*Kristen K. Sanford, DO*

*Cyril A. Varughese, DO*

*Shailee Viroja, DO*

*Justin D. Wilberding, DO*

*Alireza Zadsalamat, DO*

### Associate Membership

*Stephen A Hermes, MD*

*Gregory J. Hicks, MD*

## Government Relations

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### Final Rule Extends Mental Health Parity to Medicaid and CHIP

CMS announced a final rule extending provisions of the Mental Health Parity and Addiction Equity Act to Medicaid managed care arrangements and the Children’s Health Insurance Program (CHIP). As a result of the final rule, plans are required to disclose information on mental health and substance use disorder benefits upon request, including medical necessity criteria. States are also required to disclose the reason for denying reimbursement on payment for mental health and substance use disorder services. According to CMS, the rule will benefit 22.3 million Medicaid beneficiaries and 880,000 CHIP enrollees. The final rule was promulgated as a result of language contained in the ACA.

### Washington Tidbits New Renovation Project Underway

As the Capitol sits shrouded in scaffolding, a new addition to the Capitol skyline has emerged over the Cannon House Office Building signaling the beginning of a new project.

The Cannon House Office Building, completed in 1908, last saw a major renovation in the 1930s. The oldest office building on the Capitol campus, Cannon has fallen into a state of disrepair that presents serious safety and health issues. The top-to-bottom renovation underway is estimated to take 10 years and cost \$752.7 million. The scope of the project is immense. The building consist of nine acres of marble, 800 city blocks of conduit, 510 lighting fixtures in 170 rooms and 740 windows that total 2.5 million square feet of glass. The renovation process underway is certain to present a number of challenges for the Architect of the Capitol as entire portions of the building will have to be closed for extended periods of time. You can learn more about the project and the role of the Architect of the Capitol by visiting [www.aoc.gov/cannon](http://www.aoc.gov/cannon).



# PROFESSIONAL OPPORTUNITIES

## FACULTY MEMBER/DEPARTMENT OF PRIMARY CARE -Texas.

The University of the Incarnate Word School of Osteopathic Medicine plans to matriculate its first class of osteopathic medical students in July 2017. Located in beautiful San Antonio, UIWSOM will educate aspiring physicians to be justice-minded, global citizens using a community-based, distributed model of education, which fosters inclusion, discovery and innovation. The UIWSOM invites applications for an Internal Medicine faculty member.

Position: UIW SOM is seeking a full-time Internal Medicine faculty member for the Department of Primary Care. This faculty member will have tripartite responsibility: teaching, clinical work and service. It is also strongly preferred that some research or other scholarly activity be undertaken. Faculty members assume the shared responsibility of developing, recommending, and executing all approved policies of instruction. UIWSOM is looking for an internist with a passion for teaching at all levels, including pre-clinical, clinical, and postgraduate trainees and who is comfortable with new and innovative teaching methods. The faculty member will operate within the UIWSOM framework of lifelong learning through collaborative scholarship, innovative educational excellence and learner-centered curricula. For a complete position description and on-line application, please see the following link: <https://jobs.uiw.edu/postings/6634> or contact Thomas Mohr, DO, FACOI at [tjmohr@uiwtx.edu](mailto:tjmohr@uiwtx.edu).

## Member Milestones



*Judith A. Lightfoot, DO*



*Steven Blake, DO*

## Dean, College of Osteopathic Medicine

Des Moines University is conducting a national search for Dean of the College of Osteopathic Medicine. The Search Committee invites letters of nomination, applications (letter of interest, full resume/CV, and contact information for at least five professional references), or expressions of interest to be submitted to the search firm assisting the University. Review of materials will begin immediately and continue until the appointment is made. It is preferred, however, that all nominations and applications be submitted prior to March 15, 2016. For a complete position description, please visit the Current Opportunities page at [www.parkersearch.com](http://www.parkersearch.com).

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Two ACOI members were honored recently at the annual I Am the Dream awards ceremony sponsored by the Office of Diversity and Compliance at the Philadelphia College of Osteopathic Medicine. **Judith A. Lightfoot, DO, FACOI**, an infectious diseases specialist in Stratford, NJ, was the winner of the Dr. Martin Luther King, Jr. Legacy Award. **J. Steven Blake, DO, FACOI**, a gastroenterologist in Philadelphia, won the William M. King, DO, Award.

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# How ACOI's Generational Advancement Fund is Making a Difference For A Student Leader



Meet **Jacob I. Nelson** – Ohio University Heritage College of Osteopathic Medicine (OU-HCOM), Student Osteopathic Internal Medicine Association (SOIMA) Immediate Past President

Jacob, a second year medical student, grew up in Ohio and graduated from Brigham Young University in 2013. He was first introduced to osteopathic medicine as a child because he and his family went to a family medicine practice that had two MDs and one DO. Jacob's family knew well the benefits of manipulation because his mother was a massage therapist with a chiropractic practice. When he decided to pursue a medical career as a DO, Jacob was able to visit his brother, who is nine years older, while he was a student at OU -HCOM. His brother became a very special mentor offering pros and cons on the paths Jacob might consider in his medical education. Jacob's brother, Kenneth, is currently a Cardiology fellow in Corvallis, Oregon.

**Ms. Ciconte:** As the IM Club President, have you been able to schedule a Visiting Professor program at your school?

**Mr. Nelson:** Yes, as a SOIMA member at OU-HCOM, I have had the wonderful opportunity to take part in the Visiting Professor Program for the past two years. This year, as President, I was pleased to have Dr. (Marianne) Holler come to speak with us about code status. Dr. Holler is a wonderful speaker with many years of experience working with the elderly. Her presentation was clear and engaging. It discussed the importance of communication with patients and family about end-of-life care. I won't let "I want everything done," be the end of the conversation, but rather a starting point to discuss with patients and families, feelings behind that statement and other concerns they may be having.

I hope that the ACOI continues to sponsor the Visiting Professor Program so that future medical students at OU-HCOM can benefit from this invaluable learning experience.

**Ms. Ciconte:** What are some of the challenges facing medical students today?

**Mr. Nelson:** Certainly academics and the rigorous courses we take are always challenging. But looking ahead, I believe that undergraduate and graduate medical education need to collaborate more. There has been a dramatic increase in the number of osteopathic medical schools, but not in the number of residencies that are available. We know that enrolling more students in each class is good for the physician shortage, but measures need to be put in place to address insufficient residencies.

**Ms. Ciconte:** How can the ACOI help?

**Mr. Nelson:** The ACOI can continue to do what it's already doing. The ACOI advocates for current members and the patients those members serve. The ACOI can remain current on important issues that may have impact on the healthcare community and help organize us, the members, to aide in passing positive legislation, and fight legislation that may have a negative impact. Recently the Ohio Osteopathic Association (OOA) sent out a series of emails about a bill in the Ohio legislature that was going to increase the duties of nurse practitioners in working with patients. Some of those duties were previously only assigned to doctors. The email alerts were useful for informing OOA members about the bill and the possible actions we could take. I would welcome similar correspondence with the ACOI, especially in regards to topics that directly impact medical students.

**Ms. Ciconte:** Your Visiting Professor program was possible thanks to gifts to the ACOI's Generational Advancement Fund. What would you say to encourage more

ACOI members to contribute to the Fund?

**Mr. Nelson:** I would tell the ACOI members how much medical students benefit from this program that teaches us about various internal medicine practices. The Visiting Professors share their experience and advice and act as mentors to the students, some of whom might become future colleagues. I would ask ACOI members to please continue providing financial support for this program and others that help students and residents because their gifts truly make a difference for us.

## New Planning Brochures Available

In our continuing effort to provide information to ACOI members on how they can help themselves, their families, and ACOI while saving income and estate taxes, the College now has several new pamphlets available:

- Your 2016 Personal Planning Guide
- 2016 Federal Tax Pocket Guide – to share with your advisers and planners
- Charitable Gift Planning Guidelines

Email Melissa Stacy at [Melissa@acoi.org](mailto:Melissa@acoi.org) to request the new pamphlets or any of the following titles:

- Gifts of Securities
- Your Will to Help
- The Gift Annuity
- Ideas for Retirement
- A Special Beneficiary
- Art of Gift Planning
- When the Time Comes
- Your IRA Legacy
- Remarkable Unitrusts
- Bequeath Your Values
- Planning for Women







## The Charitable Gift Annuity – A Way to Help Yourself Now and ACOI Later

Would you like to have income for life, receive a generous immediate tax deduction, and also help ACOI? You can by establishing a special gift arrangement with ACOI that will pay you and one other person (usually a spouse) income for life and then go on to help ACOI programs.

The arrangement can be tailored to your individual needs and begin paying income immediately after setting it up depending on your age, or you can schedule payments to begin later as retirement approaches or as a child or grandchild approaches college age. By delaying payment, the amount of lifetime income you receive will be higher. Payments can be sent to you monthly, quarterly, semi-annually or annually.

Members who are concerned about low interest rates on bank CDs or poorly performing securities find that the special arrangement known as a Charitable Gift Annuity can be very attractive.

Our staff and gift consultants can provide you with confidential information about this special arrangement or other ways you can help yourself, your family, and ACOI. For more information, call Tim McNichol, Deputy Executive Director, at 301-231-8877 or email him at [Tmcnichol@acoi.org](mailto:Tmcnichol@acoi.org)

## Certificate Program in Healthcare Leadership And Management Registration Now Open

With the health care delivery system transitioning toward team-based care models, such as the patient-centered medical home, the ACOI has recognized the need for the development of a new skill set to meet the challenges of a team-based health care delivery environment. Physicians are confronted by a number of new challenges each day. Those who are nimble enough to adapt to these changes will be most successful in providing high-quality, cost-efficient care. In response, the ACOI has teamed with the Naveen Jindal School of Management, University of Texas at Dallas and the American College of Osteopathic Family Physicians to offer a ground-breaking program that culminates in the attainment of a Certificate in Health Care Leadership & Management.

Registration is now open for the eight-month long Health Care Leadership and Management Program (HCLMP). Sessions begin in July, 2016, and are built on an asynchronous learning model. Participants will access online modules utilizing the most advanced distance learning tools available. This allows participation when it is most convenient for a busy practicing physician. The learning experience is expanded through ongoing peer-to-peer interaction utilizing a threaded online discussion format that encourages the open exchange of ideas among learners with diverse experiences. The Program culminates with an in-person capstone session offered in March, 2017. Fifty AOA CME credits are anticipated.

This program is tailored to prepare today's busy practicing physician to become tomorrow's healthcare team leader. The participants in the HCLMP will explore the following areas:

- Personal Competencies
  - Emotional Intelligence I and II
  - Effective Communication
- Leading and Managing in an Interdependent World
  - Leaders, Managers and Followers
  - Change Management
  - Negotiation and Conflict Management
- Providing Value-Based Care for Individuals and Groups
  - Practice Improvement for Physicians and Groups
  - Clinical Informatics for the Physician's Office
  - Population Health Management
  - Team-based Care Across the Continuum
  - Creating Value for Patients and Payers
- Applying Lessons Learned to Practice Settings
  - Capstone: Integration and Consolidation of Lessons Learned

To register or learn more about the program, visit [www.acoi.org](http://www.acoi.org). Additional information is available by contacting Tim McNichol at 1-800-327-5183 or at [tmcnichol@acoi.org](mailto:tmcnichol@acoi.org).

# CME CALENDAR

## ***Future ACOI Education Meeting Dates & Locations***

### **NATIONAL MEETINGS**

- 2016 Residency Trainers Congress/Chief Resident/Emerging Leaders Training Program  
May 5-7 Westin Savannah Harbor Golf Resort & Spa, Savannah, GA
- 2016 Annual Convention & Scientific Sessions  
Oct 27-31 JW Marriott Desert Springs Resort and Spa, Palm Desert, CA
- 2017 Annual Convention & Scientific Sessions  
Oct 15-19 Gaylord National Resort and Convention Center, Washington, DC
- 2018 Annual Convention & Scientific Sessions  
Oct 17-21 Orlando World Center Marriott, Orlando, FL
- 2019 Annual Convention & Scientific Sessions  
Oct 30- Nov 3 JW Marriott Desert Ridge Resort & Spa, Phoenix, AZ
- 2020 Annual Convention & Scientific Sessions  
Oct 21-25 Marco Island Marriott Beach Resort, Marco Island, FL

*Please note: It is an ACOI membership requirement that Active Members attend the Annual Convention or an ACOI-sponsored continuing education program at least once every three years. Information on any meeting listed here may be obtained from ACOI Headquarters at 800 327-5183 or from our website at [www.acoi.org](http://www.acoi.org).*

## **2016 Certifying Examination Dates & Deadlines**

### **Internal Medicine Certifying Examination**

Computerized Examination 200 Sites Nationwide  
September 15, 2016 - *Application Deadline: Expired*  
*Late Registration Deadline: Expired*

### **Subspecialty & Certification of Added Qualifications:**

Aug. 20, 2016 • Lombard, IL - *Application Deadline: Expired*  
*Late Registration Deadline: May 1, 2016*

Cardiology • Interventional Cardiology • Critical Care Medicine • Electrophysiology • Endocrinology • Gastroenterology  
Geriatric Medicine • Hematology • Infectious Disease • Nephrology • Oncology • Pulmonary Diseases • Rheumatology • Sleep Medicine

### **Internal Medicine Recertifying Examination**

Computerized Examination 200 Sites Nationwide  
September 16, 2016 - *Application Deadline: Expired*  
*Late Registration Deadline: May 1, 2016*

### **Focused Hospital Medicine Recertification**

Aug. 20, 2016 • Lombard, IL - *Application Deadline: Expired*  
*Late Registration Deadline: May 1, 2016.*

### **Subspecialty and Added Qualifications Recertifying Examinations:**

Aug. 20, 2016 • Lombard, IL

Cardiology • Interventional Cardiology • Critical Care Medicine • Electrophysiology • Endocrinology • Gastroenterology  
Geriatric Medicine • Hematology • Infectious Disease • Nephrology • Oncology • Pulmonary Diseases • Rheumatology • Sleep Medicine

*Application Deadline: Expired*

*Late Registration Deadline: May 1, 2016*

*Further information and application materials are available at [www.aobim.org](http://www.aobim.org) or by writing to: Gary L. Slick, DO, MACOI, Executive Director, American Osteopathic Board of Internal Medicine, 1111 W. 17th Street, Tulsa, OK 74107, email: [admin@aobim.org](mailto:admin@aobim.org). Contact the AOBIM at [admin@aobim.org](mailto:admin@aobim.org) for deadlines and dates for the *Hospice and Palliative Care, Pain Medicine, Undersea/Hyperbaric Medicine and Correctional Medicine* examinations.*

## **Member Milestones**

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**Mitchell D. Forman, DO, FACOI**, of Henderson, NV, was chosen by the Board of Deans of the American Association

of Colleges of Osteopathic Medicine to receive the 2016 Robert A. Kistner Award, which is presented annually to individuals who have made a significant contribution to osteopathic medical education. Dr. Forman practices rheumatology and recently retired as the Founding Dean of the Touro University-Nevada College of Osteopathic Medicine.



**David L. Broder, DO, FACOI** of Melville, NY, has been nominated to honorary membership in Omega Beta Iota,

the national Osteopathic political advocacy honor society. Dr. Broder is a general internist who is an associate dean at the New York College of Osteopathic Medicine. He also serves as vice-speaker of the AOA House of Delegates.

## **In Memoriam**

Word has been received of the death of **Sean P. Harvey, DO, FACOI** of Newtown, PA. Dr. Harvey was a 1991 graduate of the Philadelphia College of Osteopathic Medicine. He was board certified in internal medicine and nephrology, which he practiced in the Bucks County area of Pennsylvania. Dr. Harvey died on March 21, 2016. He was 52 years old.