ACOI information

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From President Burke

Mission Critical: Continue to Innovate Osteopathic IM Education and Certification

The ACOI is looking forward to an innovative and creative 2018 that results in substantial transformation into a physician services organization. As I have previously mentioned, a primary ACOI service strategy is to expand our Osteopathic Internal Medicine education activities beyond the traditional destination CME and case-based Osteopathic Continuing Certification (OCC) modules. This expansion is already taking place under the direction of the ACOI Board and our able staff. New initiatives in online learning will soon be unveiled. Programs that provide educational content for our Cardiologists, Hospitalists and Residency Program Directors will be offered in Chicago in April concurrently with our usual high-value Internal Medicine Board Review Course. The April meeting is shaping up to be an osteopathic internal medicine *tour de force* so please consider joining us.

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In This Issue...

April 27-29, 2018 in Chicago, IL

Advanced CME Course for Cardiologists Planned for April

Whether a general cardiologist, interventionalist, or electrophysiologist, the place to be on April 27-29, 2018 is at ACOI's New Science in Cardiovascular Medicine, which will be held at the Marriott Chicago Downtown Magnificent Mile Hotel. An internationally recognized faculty will bring the very latest in evidence-based advances using a highly interactive, case-centric approach. This activity is the first in a series of new CME offerings the ACOI plans to offer for subspecialists.

A number of important topics will be featured. Risk management and treatment, including a frank discussion on diabetic heart disease and conflicting blood pressure targets contained in recent guidelines (ACC vs ADA), will be presented by Robert J. Chilton, DO, FACOI, FACC and George Bakris, MD.

The course will focus on several new and timely topic areas, including cardio-oncology, women and heart disease, and the state-of-the-art in DVT assessment and treatment: science vs. pseudoscience. A full complement of presentations will deliver value to the interventional cardiologist, such as TAVR and the patient with low gradient severe aortic stenosis, the latest thinking on the treatment for STEMI and non-STEMI with program chair Asif Serajian, DO, and a panel discussion on the readiness of the mitral clip for use in day-day practice.

Heart failure will be well-represented on the agenda with talks on differential diagnosis of heart failure in patients with preserved ejection fraction, the use of biomarkers in heart failure management, and best practice use of echocardiography in heart failure and cardiomyopathies.

Finally, a section on arrhythmias and electrophysiology will feature presentations on when to order a wearable defibrillator, with Martin C. Burke, DO, FACOI, FACC; atrial fibrillation: ablation vs medical intervention; stroke risk reduction with NOACs vs LA Appendage Devices, and cardiac resynchronization.

This program has been designed specifically for clinical cardiologists. Registration and additional information on this program can be found on the ACOI website here.

2018 Board Review Course Registration Open

Registration is open for the 2018 ACOI Internal Medicine Board Review Course, which will take place April 25-29 at the Marriott Chicago Downtown Magnificent Mile. This 5-day course is a comprehensive review of general medicine and each of the subspecialties. It is an excellent way for practicing physicians to update their medical knowledge, and it provides an intensive and comprehensive overview of most of the major areas of importance to physicians preparing for the American Osteopathic Board of Internal Medicine Certifying Examination (September 12, 2018) and Recertifying Examination (September 12, 2018).

Special emphasis is placed on recent advances in various subspecialty areas in internal medicine and clinical skills management as they pertain to clinical practice and the examinations. In addition, several "board-type" questions are included during each lecture to improve registrants' readiness to respond to examination questions.

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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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The ACOI is looking to position our College strategically as a leading provider of online IM education products, using our brand of patient-centric, clinically-relevant, cutting-edge content. We are investing resources to create an online platform that provides smooth access to higher-level new content that is web and video-based no matter what type of device it is accessed from. The content and delivery are a critical piece of innovation designed to ensure that our members, both current and future, have the tools necessary to easily keep up-to-date and maintain private time for ourselves and our families.

American Osteopathic Board of Internal Medicine Update

Brian Donadio and I had the pleasure of meeting this month with the members of the American Osteopathic Board of Internal Medicine (AOBIM). It is important to recognize this board for its superb leadership and volunteer effort in determining what it means to be an osteopathic IM-certified physician, and for delivering the highest quality metrics to insure an outstanding physician class for patient care worldwide. The history and high-end output of this board situates it for a bright future. Our shared vision is to maintain the continuum of osteopathic education and certification, while expanding opportunities to like-minded, qualified internists, both osteopathic and allopathic. As I mentioned last month, the ACOI is a devoted partner with the AOBIM and, as our face-to-face meeting supports, we are committed to making this work for our members and all diplomates. The AOBIM wants to innovate two-steps ahead. Consequently, the two groups have agreed to remain in constant communication. As the AOBIM (and the AOA) settles on the evolving criteria for OCC, we will relay details and progress to you.

Professional Stewardship and Wellness

Physician wellness and life are key components considered today in every initiative created by the ACOI and the Board of Directors. In this light, internists need to build or further their leadership "mojo" back into the clinical setting in order to preserve the profession. Physicians lead naturally as the stewards of health and well-being on behalf of humankind, and we, together, need to protect this very aspect while not killing ourselves in doing so. Our Osteopathic oath dictates such patient-oriented stewardship and leadership. Patient care operationally needs to be rationalized to allow for more organizational time for us to lead (whether employed, or independent) our clinical infrastructure into more equitable, patient-focused models that are traditionally osteopathic (In other words, an administrator should never be allowed to utter that "you spend too much time with patients."). Historically, A.T. Still's frustrations have created a sustained and important movement in American Medicine through his vision and leadership. Let's pick up that banner for the entire medical profession, which is currently meandering.

To start small with a few hinge points, the wellness of our profession and colleagues depends on addressing some of the following:

1. We can no longer accept the metric that physician salaries have been flat for the last 10 years when it is completely untrue!! A critical shift of the "Affordable Care Act" (tongue in cheek emoji here) has been volume, despite the introduction of electronic access to test results, order sets and catching up on notes 24/7. Our 12-hour work day has doubled and the salaries have remained flat while hospital networks and insurance companies have seen colossal gains at the expense of our profession and wellness. This is unsustainable and we must stop staring at it. Physicians manage risk with fewer and fewer resources, which in a capitalist market is unsustainable. Historically, physicians are more likely to direct resources to limit the risk to patients through systems and techniques in a progressive way, because we feel the risk (that's how medicine progresses). It is not easy to be well when being taken advantage of consistently.

2. We have to balance access points to continuity of care while rewarding all forms of care by valuing Osteopathic tenets of human care. There can be a happy medium here where value and expertise are valued equally to quality of life. If we do not take charge to lead us out of this market reality, then patient care will eventually be managed only by the ER, urgent care centers and hospitalists because there will be too few physician-

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government RELATIONS

Timothy McNichol, JD

CMS Announces New Bundled Payment Model

The Centers for Medicare and Medicaid Services (CMS) recently announced a new voluntary bundled payment model called Bundled Payments for Care Improvement Advanced (BPCI Advanced). The new payment model allows participants to earn bonus payments if all expenditures for an episode of care for a beneficiary are under a spending target. Quality is factored in as well. Under the BPCI Advanced model, participants may receive payment for 32 different clinical episodes. BPCI Advanced qualifies as an Advanced Alternative Payment Model (APM). According to CMS Administrator Seema Verma, "BCPI Advanced builds on the earlier success of payment models and is an important step in the move away from fee-for-service and towards paying for value." The model is intended to incentivize efficient, quality care. You can learn more by visiting https://innovation.cms.gov/initiatives/bpcis-advanced. Applications to participate in the BCPI Advanced model are due by 11:59 Eastern Time on March 12, 2018.

Medicaid Work Requirements Allowed for the First Time

CMS announced approval of Kentucky's Medicaid waiver request to allow for the addition of a "community engagement" requirement. Approval of the waiver allows Kentucky to implement a five-year demonstration program that will include establishing a Medicaid eligibility work requirement for adults 19 - 64 years of age. The Kentucky demonstration program exempts from the requirement pregnant women, primary care givers of dependents, the "medically frail," and students. There are nine other states that have applied to CMS for a similar waiver. These waiver requests follow an announcement by the Administration last year to promote more flexibility in an effort to advance innovation of the Medicaid program.

ACOI Joins Medical Society Consortium on Climate and Health

The ACOI became the first osteopathic organization to become a member of the Medical Society Consortium on Climate and Health. The Consortium is a group of American medical societies representing over 550,000 physicians who have joined together to inform the public and policy makers about the harmful health effects of climate change and the immediate and long-term health benefits associated with decreasing heat-trapping pollution, among other things. The ACOI will be represented by ACOI Board of Directors member Samuel Snyder, DO, FACOI. You can learn more about the Consortium by visiting https://medsocietiesforclimatehealth.org/.

CMS Affirms Prohibition of Texting Physician Orders

According to a memorandum recently released by CMS, texting of orders by physicians does not comply with Medical Conditions of Participation (COPs) or Conditions for Coverage (CfCs). The document sent to State Survey Agency Directors stated that Computerized Provider Order Entry (CPOE) is the preferred method of order entry by a provider. While CMS recognizes the role of texting as a means of communication, the memo states, "All providers must utilize and maintain systems/platforms that are secure, encrypted, and minimize the risks to patient privacy and confidentiality."

More Than $3.7 Billion in False Claims Recovered

The Department of Justice (DOJ) announced the recovery of more than $3.7 billion in settlements and judgements from civil cases involving fraud and false claims in Fiscal Year 2017. Of the total recovered, $2.4 billion involved health care. The largest part of the health care recoveries came from drug and device companies. According to the DOJ, the majority of recoveries were the result of actions brought by whistleblowers.

Washington Tidbits

Funding Gaps

One of Congress' primary obligations is to fund the operations of the federal government through the approval of appropriations that must be signed into law by the President. In fact, Article I, Section 9 of the Constitution provides, "No money shall be drawn from the Treasury but in consequence of appropriations made by law…." Expiration of funding, absent new appropriations, results in a partial shutdown of the government due to legal requirements surrounding the expenditure of federal funds.

The obligation to fund the government is ideally done through a year-long appropriations process with the fiscal year beginning on October 1. When agreement on year-long funding cannot be reached, Congress has the option to advance to the President for enactment interim appropriation agreements known as continuing resolutions (CRs). CRs have been used four times since October 2017 to keep the lights on. The current CR will expire on February 8th. Should agreement not be reached, the government will be shut down again. Will we see another funding gap that will result in another partial shutdown? Only time will tell!

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 and by contacting Ms. Young at 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.

2018 Coding Update

As a new year begins, it is a good time to take a look at some of the coding and billing updates that may impact your practice. Following are a few highlights for your consideration.

Training and Management of INR

The Centers for Medicare and Medicaid Services (CMS) added a new code for the training and initiation of home INR monitoring (93792). In addition, code 93793 has been added for the payment of ongoing warfarin management. The prior management codes (99363-99364), which were not payable by most insurance carriers and were bundled into an E&M service for Medicare, have been deleted for 2018. Unlike 93793, training for initiating INR monitoring is payable on the same day as a separately identifiable E&M service. Neither 93792 nor 93793 can be reported during the time periods assigned to the chronic care management or transitional care management codes. Codes G0248-G0250, codes that are used when providing INR monitoring services for patients with mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism, are still listed as payable on the 2018 Medicare Fee Schedule.

Cognitive Assessment and Care Plan Services

Prior to 2018 there were no specific codes to report cognitive assessments and care planning. The addition of 99483 enables these services to be described, addresses the gaps in providing care, and promotes quality of care by listing required elements. Code 99483 lists 10 elements required for the code to be payable. The guidelines state that if all the requirements are not met, the provider should bill the services with an E&M code. The service is provided when a comprehensive evaluation of a new or existing patient exhibits signs and symptoms of cognitive impairment. The evaluation is required to establish or confirm a diagnosis, and to identify the etiology and severity of the condition. It includes a thorough evaluation of medical and psychosocial factors that potentially contribute to increased morbidity. The creation of a care plan is a service to the patient. Medical decision making includes current and likely progression of the disease; assessing the need of referral for rehabilitative, social, legal, financial or community based services; and, meal, transportation and other personal assistance services. This is a code that can only be billed once every 180 days.

Pulmonary Diagnostic Testing

Codes 94617 and 94618 have been added to report dyspnea. The previously used code 94620 has been deleted. Code 94617 is used to report exercise testing. Its descriptor reads, "Exercise test for bronchospasm, including pre- and post-spirometry electrocardiographic recording(s) and pulse oximetry." It includes a number of pulmonary tests and electrocardiographic recordings. Code 94618, is used for pulmonary stress testing (e.g. six minute walk test) and includes the measurement of heart rate, oximetry and oxygen titration, when performed. This code is used to report pulmonary stress testing including measurements of heart rate, oxygen levels (when performed), oximetry and oxygen titration.

Chest X-Rays

All nine previously used codes for chest x-rays have been deleted for 2018. The new codes, 71045-71048, no longer reflect specific views of a chest x-ray, but rather differentiate simply by the number of views. The new codes reflect common practice and allow for greater flexibility. Medicare will continue to penalize those who are using old fashioned hard films when taking x-rays instead of newer computer radiology technology. A modifier "FY" is required for claims using old technology. These claims will be reduced by seven percent in 2018 on the technical component of the service.

Psychiatric Collaborative Care Management Services

Psychiatric Collaborative Care Management Services were released in 2017 as "G" codes. These were deleted in 2018 and replaced by codes 99482-99494. These codes for initial and subsequent care management mirror the "G" codes. CPT chapter guideline are very helpful in use of these codes.

Diabetes Prevention

CMS implemented a Medicare Diabetes Prevention Program (MDPP) expanded model for 2018. The model has been tested and allows Medicare beneficiaries to access evidence-based diabetes prevention services. The goal is to lower the rate of progression of Type 2 diabetes. There are also several policy updates to MDPP. Additional supplier enrollment requirements and compliance standards have also been adopted to enhance program integrity.

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talking science & education

Donald S. Nelinson, PhD

Happy New Year colleagues. We wish you, your families, and your communities a very healthy 2018. To quote (modified!) the iconic line from the movie Poltergeist, "It's back!" Yes the monthly population health trivia question is back. Last year I began this series of questions about health in America based on the United Health Foundation's annual report. The report derives its definition of health from the World Health Organization: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." This year's questions are based on 2017 data. So once again I invite you to send your answers to don@acoi.org. The first person to respond with the right answer will receive a valuable prize. BUT in the spirit of good sportsmanship, no Googling allowed. Here's the first question for 2018. Good luck!

Over the past year, the premature death rate (the number of years of potential life lost before age 75) in the United States has_____.

A. Decreased

B. Increased

C. Remained the same

Send your answer to don@acoi.org.

Talking Education

Use of the EHR is rapidly increasing in academic institutions and private practice settings used for undergraduate medical education. However, as the transition from physical patient records to the EHR has occurred, access to the clinical chart by medical students has become highly variable, as has the opportunity for student learning in the use of the EHR as an important clinical skill in preparation for graduate medical training. In many, if not most, educational settings for students, current policies restrict student access to the EHR and this equates to their being poorly prepared for clinical practice upon graduation.

Barriers to student access to the EHR take many forms, including technical complexities for providing access, medicolegal concerns associated with student documentation, and issues associated with confidentiality related to Health Insurance Portability and Accountability Act (HIPAA) regulations. Additionally, guidelines from the Centers for Medicare and Medicaid Services (CMS) and other federal agencies that limit the use of student documentation for billing purposes raise potential compliance issues and create the need for duplicate documentation. These also encourage restricted student use of the EHR.

Yet, multiple medical education organizations have emphasized the importance of developing communication skills by medical students that relate to the ability to effectively use the EHR. The Liaison Committee on Medical Education (LCME) states that curricula must "prepare medical students for entry into graduate medical education," and "include specific instruction in communication skills as they relate to physician responsibilities, including communication with patients and their families, colleagues, and other health professionals."[1] The recently published Core Entrustable Professional Activities for Entering Residency by the Association of American Medical Colleges (AAMC) include multiple expected competencies for undergraduate medical students related to use of the EHR, including entering and discussing orders (EPA 4), documenting a clinical encounter in the patient record (EPA 5), and giving or receiving a patient handover to transition care responsibly (EPA 8).[2] The United States Medical Licensing Examination (USMLE) also evaluates a student's ability to write notes in electronic form as part of the USMLE Step 2 Clinical Skills Examination.[3] Additionally, the Accreditation Council for Graduate Medical Education (ACGME) core program requirements state that residents are expected to "maintain comprehensive, timely, and legible medical records,"[4] and the Program Requirements for Graduate Medical Education in Internal Medicine state specifically that the sponsoring institution and participating sites must provide access to an electronic health record or show commitment to its development and implementation (I.A.2.g).[5] Finally, several internal medicine residency training milestones (utilization and completion of medical records, interprofessional team communication, and patient care transitions) relate to the need to effectively use the EHR.[6]

Impaired medical student access to, or limitations on, their use of the EHR threatens development of these important competencies needed for continued training, licensure, and the lifelong practice of medicine.

ACOI, as a member of the Alliance for Academic Internal Medicine's (AAIM) Internal Medicine Education Advisory Board (IMEAB) has worked with ACP and other IMEAB members to field a survey to all osteopathic and allopathic medical schools to determine the actual extent and range of training on the meaningful use of HER during medical school. These data will be used to support efforts ensuring medical

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Clinical Challenges Program Offers 26 CME Credits

Clinical Challenges in Inpatient Care, the popular ACOI CME program for hospitalists and others who treat patients in the hospital, will take place April 26-29 in Chicago. The ACOI Continuing Medical Education Committee and activity Chair Rick A. Greco, DO, have designed an appealing program that will provide up to 26.75 1A credits in internal medicine.

Internists have very busy practices and it can be difficult to keep updated on the medical advances and structural initiatives related to the myriad of clinical cases presented to them. Clinical Challenges in Inpatient Care will address key gaps that have been found to exist in hospital-based internists' practices. These gaps were determined through literature reviews, population health data reported by the CDC, quality measurement sources (e.g., AHRQ, NCQA), and ongoing survey activities within ACOI.

This activity is designed for internists, subspecialists and other health professionals who are hospital-based clinicians. At the completion of the program, attendees will be able to:

- Define optimal management approaches for various presentations of atrial fibrillation, utilizing both medical treatments and with devices;
- Identify the appropriate population for referral for TAVR, and describe its complications and limitations;
- Describe the most recent developments in management of Systolic Heart Failure, including medications and new devices;
- Demonstrate ability to interpret ECG accurately in the hospitalized population;
- Identify the appropriate use of newer oral anticoagulants and Metformin in the chronic kidney disease patient;
- Describe the effective use of OMM in the hospital;
- Articulate the principles of pulmonary management in the hospitalized patient, including infection, respiratory support and proper approach to pulmonary fibrosis;
- Recognize common misuse of laboratory testing and procedures in the hospitalized patient;
- Describe the proper use and management of nutrition in critical illness;
- Relate best practices in efficient transition of care and optimization of length of stay;
- Describe evolving changes to MACRA/MIPS and their impact on current hospital practice.

This activity will provide internists and subspecialists updates in the areas of healthcare administration, cardiology, pulmonary disease, critical care medicine, infectious diseases, gastroenterology, hematology/oncology, and internal medicine, empowering them to provide improved care to their patients. Outcomes will be assessed via immediate and time-delayed post-tests assessing intent to change practice behavior, and self-report of changes.

The host hotel is the Marriott Chicago Downtown Magnificent Mile, located at 540 N. Michigan Avenue, Chicago, IL 60611. For hotel information, call 1-877-303-0104. A room rate of $199/per night has been arranged for this meeting. Reservations must be made by April 3, 2018 in order to receive this special ACOI discounted rate. Reservations also may be made online here.

Coping With Coding

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ICD-10 Codes

There are changes to Section I50 on Heart Failure for 2018. Classifications are based on the American College of Cardiology and American Heart Association stages of heart failure. They complement and should not be confused with the New York Heart Association Classification of Heart Failure. There are inclusion terms that have been added related to ejection fraction, systolic heart failure, diastolic heart failure, and combined systolic and diastolic heart failure subcategories. Codes now distinguish right ventricular failure from end stage heart disease, and chronic and acute (or decompensated) heart disease in the adult. Cases of right heart failure and left heart failure are now differentiated.

The other significant coding update is under the Section I21 classification of Types of Myocardial Infarction (MI). The following types of MI's are now categorized:

- MI Type 1 - Spontaneous myocardial infarction
- MI Type 2 - Myocardial infarction secondary to ischemic imbalance
- MI Type 3 - Patients who present with death from a presumed cardiac etiology but without confirmatory cardiac biomarkers being available
- MI Type 4 - Myocardial infarction associated with revascularization procedures
- MI Type 5 - MI - Associated with coronary artery bypass graft surgery (CABG)

Flu Vaccine Reminder

As a reminder, the Fluzone High-Dose (Influenza Virus Vaccine) is covered under Medicare Part B (code 90662). The code ONLY applies to patients ages 65 and older. Be sure a patient meets this requirement or your claim for the vaccine will be rejected.

75th Anniversary Campaign Honor Roll

Outright Gifts and Multi-Year Commitments as of January 9, 2018

$75,000
Lawrence U. Haspel, DO, MACOI

$45,000
Martin C. Burke, DO, FACOI

$25,000 - $44,999
Rick A. Greco, DO, FACOI and Carol A. Greco, DO
Robert J. Stomel, DO, MACOI
William D. Strampel, DO, MACOI

$15,000 - $24,999
John B. Bulger, DO, MBA, FACOI and Michele Neff Bulger, DO
Robert G. Good, DO, FACOI
David F. Hitzeman, DO, MACOI
Judith A. Lightfoot, DO, FACOI and Alvin Banks

$10,000 - $14,999
Jack D. Bragg, DO, MACOI and Jocelyn Bragg
Michael B. Clearfield, DO, MACOI
Robert L. DiGiovanni, DO, FACOI and Monica DiGiovanni
Kevin P. Hubbard, DO, MACOI and Roxanne Hubbard
Susan O'Neal, DO, FACOI
Michael I. Opipari, DO, MACOI
Anthony N. Ottaviani, DO, MPH, MACOI
and Catherine Ottaviani
Frederick A. Schaller, DO, MACOI and Amy Schaller
James C. Wells, DO, PhD, FACOI
Larry A. Wickless, DO, MACOI

$7,500 - $9,999
Robert A. Cain, DO, FACOI and Gina Eversole-Cain
C. Clark Milton, DO

$5,000 - $7,499
Damon L. Baker, DO, FACOI
Lee Peter Bee, DO, FACOI
Brian J. Donadio, FACOI and Ellen Donadio
Scott L. Girard, DO, FACOI and Laura J. Girard
James C. Giudice, DO, MACOI
Karen J. Nichols, DO, MA, CS, MACOI
Eugene A. Oliveri, DO, MACOI
Ruben Tenorio, DO, FACOI

$2,500 - $4,999
Michael A. Adornetto, DO, MBA, FACOI
Steven B. Calkin, DO, FACOI
Annette T. Carron, DO, FACOI
Janet E. Cheek, DO, FACOI
Pamela R. Gardner, DO, FACOI
Bonita J. Krempel-Portier, DO, FACOI and Bill Portier, PhD
Sara Liter-Kuester, DO
Daniel J. Peasley, DO and Marti Peasley
Keith A. Reich, DO, FACOI
Morvarid Rezaie, DO, FACOI
Samuel K. Snyder, DO, FACOI and Pamela Snyder
Scott Spradlin, DO, FACOI
John F. Uslick, DO, MACOI
Winter Wilson, DO, FACOI and Tina Wilson
Randall Worth, DO, FACOI

$1,000 - $2,499
Gary A. Agia, DO, FACOI
Barbara Atkinson, DO, FACOI
Mark D. Baldwin, DO, FACOI
Jay Beckwith, DO, MACOI and Beth Beckwith
Robert Biggs, DO, FACOI
Gerald W. Blackburn, DO, MACOI
Francis X. Blais, DO, MACOI
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Boyd Buser, DO
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Ira Epstein, DO, FACOI
Mitchell D. Forman, DO, FACOI
Eric D. Good, DO, FACOI
Debora Goodrich DO, FACOI and John Goodrich
David J. Greathouse, DO, FACOI
Robert T. Hasty, DO, FACOI
Dory Jarzabkowski, DO, FACOI
G. Michael Johnston, DO, MACOI
Robert Juhasz, DO, FACOI
Joanne Kaiser-Smith, DO, FACOI and Kevin Smith
Michael Keefe, DO, MACOI
Marc M. Kesselman, DO, FACOI, FACC
Teresa M. Kilgore, DO, FACOI
Andrew Kotis, DO, FACOI
Cheryl Kovalski, DO, FACOI
Paul Kudelko, DO, MACOI
Nathan J. Landesman, DO, FACOI
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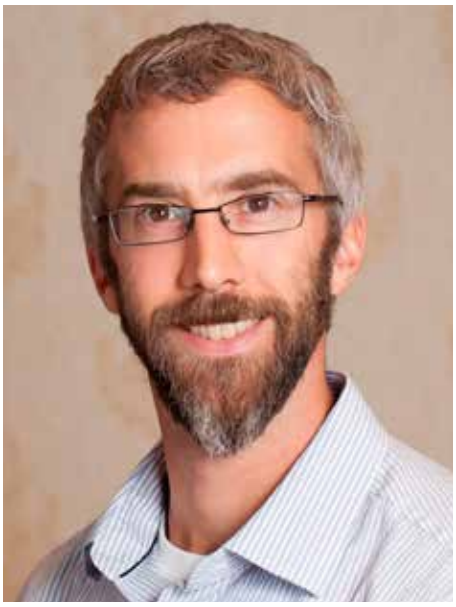
Donald S. Nelinson, PhD
V. Kim Newsome, DO, FACOI and Tim Stainbrook, RN, BSN
Herbert Pasternak, DO, FACOI
Joanna Pease, DO, MACOI
William Peppo, DO, FACOI
Daniel K. Peshka, DO
John Prior, DO, FACOI
Bennett Radford, DO, FACOI
Jeffrey A. Ranalli, DO and Trina A. Poretta, DO
Laura Rosch, DO, FACOI
for her mentor George Caleel, DO, MACOI
Christine M. Samsa, DO, FACOI
and Nathan P. Samsa, DO, FACOI
Roy J. Sartori, DO, FACOI and Christine Sartori
Thomas Schneider, DO, FACOI
Suzanne Shenk, DO, FACOI and Scott Siegal, DO, FACOI
Martin W. Schwarze, DO, MACOI
Laura Smith, DO, FACOI
Duane Sossong, DO
David G. Stainbrook, Jr., DO, FACOI
Christina A. Stasiuk, DO, FACOI and George Farian, Esq.
W. W. Stoever, DO, MACOI
Brad Suprenant, DO, FACOI
David Susser, DO, MACOI
John R. Sutton, DO, FACOI
Richard R. Thacker, DO, FACOI
Kenneth Trinidad, DO
Gordon P. Tussing, Jr., DO
Amita Vasoya, DO, FACOI
William H. Voss, DO, MACOI
Thomas Waltz, DO, FACOI
R. Colin Wetz, DO, FACOI
Mark L. Woodard, DO, FACOI
Mark L. Woodard, DO, FACOI
William Zipperer, Jr., DO, FACOI

Resources Available for ACGME Osteopathic Recognition

As part of the College's ongoing effort to assist all internal medicine residency programs complete the transition to ACGME accreditation and achieve Osteopathic Recognition, ACOI is pleased to announce the development of an Osteopathic Recognition (OR) Tool Box.

The toolbox includes numerous resources that will help programs through the process. The resources in the tool box may be accessed by here.

Interview with Scott L. Girard, DO, FACOI



Meet **Scott L. Girard, DO, FACOI**, an internal medicine board-certified Hospitalist at Carolinas Health Care System North East in Concord, NC. Dr. Girard graduated from PCOM and did his residency at Geisinger Medical Center in Danville, Pennsylvania. He started his service on the ACOI Board of Directors as the Resident Representative and continues to be an active member of the College's Board. Dr. Girard is married and lives in Charlotte, NC.

Ms. Ciconte: Tell me why you have been involved with the ACOI.

Dr. Girard: I first got involved in 2004 by doing a poster presentation at the ACOI Annual Convention. After that I submitted posters and attended conventions because I liked the programs, the education, and people I met. Since then, I have been responsible for planning special sessions and activities for medical students and residents at the Annual Convention over the years. I am glad to hear that our students and residents continue to enjoy and find value in the sessions we are able to provide.

***Ms. Ciconte*:** In addition to sharing your time and talents with ACOI, you have made financial contributions to ACOI over and above your dues, including a generous contribution to the 75th Anniversary Campaign. Why did you choose to make a gift? What do you think ACOI should do and say to encourage members to make a special contribution to this campaign?

Dr. Girard: I am proud to be a member of the ACOI Board, Convention Planning Committee and be able to participate in the Visiting Professor Program. I see the value in each of these programs and see giving back with either my time or with a monetary gift valuable, because the ACOI has used my contributions to benefit me as a physician and the profession as a whole.

My wife and I were pleased to make a major gift to the 75th Anniversary Campaign. The campaign was a great way to celebrate our important history and bring our members together. Looking ahead, the ACOI Board is charting a new course of member services that requires increased financial support. I am pleased to see how generous our membership has been.

Ms. Ciconte: How do you see the single accreditation program that goes into effect in 2020 affecting the osteopathic internal medicine profession and ACOI?

***Dr. Girard*:** There will be changes in many membership organizations due to the single accreditation change. I know that the ACOI Board is addressing the necessary changes as opportunities for the College and internal medicine profession. The ACOI is exploring many options, including promoting the new technologies used for CME training for members, providing new types of educational/CME content, as well as helping shape what Osteopathic Medicine looks like in the future..

Ms. Ciconte: Given the challenges facing osteopathic internal medicine, how can ACOI continue to serve its members in the future?

***Dr. Girard*:** We are entering a new era in member services. The ACOI needs to continue to work on member benefits by listening to what members want and how they want their benefits.

Ms. Ciconte: Dr. Girard, ACOI is indeed grateful to you for your generosity, leadership and dedication to the College and the principles of osteopathic internal medicine.

PROFESSIONAL OPPORTUNITIES

INTERNAL MEDICINE ASSOCIATE POSITION AVAILABLE - Florida. Busy solo IM practice seeking a new graduate who is excited about learning how to remain profitable in private practice. Office hours only and no hospital rounds. Plenty of cultural events, theater, shopping, fantastic dining and outdoor activities year round are a plus for this area. Must be BC/BE and have FL licensure. Relocation stipend included in package as well as health insurance and 401K program. Interested applicants may send resume to drb@drbnaples.com. More information can be provided by Denise Maclean, practice manager at Denise@DrbNaples.com.

PRIMARY CARE PHYSICIANS - New York. Catholic Health Services of Long Island (CHSLI) currently has full time opportunities for Board Certified/Board Eligible Internal or Family Medicine Physicians to join community-based practices within Nassau County, New York. Some locations may require a measure of nursing home and hospital coverage.

Catholic Health Services of Long Island is a fully integrated health system serving the communities of Long Island, NY. Comprised of 6 hospitals, 3 long term care facilities, a Home Care and Hospice agency, and a program for developmentally disabled individuals, CHSLI has over 17,000 employees and an operating budget in excess of $2B.

Requirements include:

- Board Certification/Board Eligible Internal or Family Medicine
- NYS MD/DO License
- Strong Interpersonal and communication skills with the ability to engage at all levels of the organization to promote a culture of patient safety and participate in performance improvement

We offer a competitive salary, dynamic work atmosphere, and a comprehensive benefits package. For immediate consideration, please email your CV to: gail.still@chsli.org. Equal Opportunity Employer M/F/D/V

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

*Meet **Drew Phillips** – 2nd Year medical student at West Virginia School of Osteopathic Medicine (WVSOM) and President of the Student Osteopathic Internal Medicine Association (SOIMA)*

Drew is a native of St. Marys, West Virginia and did his undergraduate degree at West Virginia University. After graduating from WVU, Drew worked for six years at his grandfather's independent pharmacy in West Virginia. He talked to customers about their experiences with their doctors and found that there was a strong connection between patients and their DOs. Customers often remarked that their MDs did not know them. Drew felt that osteopathic medicine was the direction to go based on his personality.

Ms. Ciconte: Have you ever attended an ACOI Annual Convention?

Mr. Phillips: No, I have not attended an ACOI Convention but am considering attending the 2018 Convention.

Ms. Ciconte: As the IM Club President, have you had a Visiting Professor session?

Mr. Phillips: Yes, we had Dr. Martin Burke, ACOI's new President, and Susan Stacy from the ACOI staff come to our campus in November. We had a great turnout, more than 100 students attended. ACOI helps to fill in the blanks around our medical training. Since the internet is a bottomless pit for medical students seeking information, ACOI's Visiting Professor sessions provide the focused information we need.

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

Mr. Phillips: Right now, everyone is worried about their debt. When do you start paying it back? What are the best interest rates, etc? Many medical students are type A personalities and want to be on top of these things. Decisions must be made on how to proceed after school in order to get a job that will help pay the debt. Is it possible to consider going into private practice or not?

Ms. Ciconte: How can ACOI help?

Mr. Phillips: With the upcoming single accreditation transition in 2020, it is key for ACOI to provide information to students. Students want to see information now that will help them plan for their futures. It would be good for the ACOInformation newsletter to dedicate a page or two in each publication to address those issues that are most important to students.

Ms. Ciconte: Your Visiting Professor session 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. Phillips: Contributions are a good investment in the College, an investment that helps the ACOI fulfill its vision for the future. The Visiting Professor Program at medical schools introduces the College to medical students who want to be part of a program. One hundred students filled out ACOI membership forms during Dr. Burke's visit. I believe this holds large dividends for the future for students and the ACOI.

Board Review Course

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The lectures are given by distinguished faculty who are recognized for their ability as teachers and clinicians. A detailed syllabus is provided to registrants. Immediately following each day's lectures, designated faculty from each subspecialty area are available for a question and answer period.

This postgraduate course is appropriate for physicians who provide personal care to adults: general internists; family physicians; residents and fellows-in-training; and subspecialists who want to remain current in the field of internal medicine.

The Marriott Chicago Downtown Magnificent Mile is located at 540 N. Michigan Avenue, Chicago, IL 60611. For hotel information, call 1-877-303-0104. A room rate of $199/per night has been arranged for this meeting. Reservations must be made by April 3, 2018 in order to receive this special ACOI discounted rate. Reservations also may be made online here.

Have You Moved?

Keep us updated. If you have recently made any changes in your address, phone number or email, please notify theACOI at acoi@acoi.org.

Talking Science & Education

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school curricula adequately integrate training to optimize best-practice use of EHR prior to entering residency.

Diabetes Dialogues

Is Obesity Slowing Gains in U.S, Lifespans?

In keeping with this month's population health trivia question, I wanted to report on some disturbing, yet not surprising data regarding BMI, obesity and American life spans.

The death rate in the United States isn't decreasing as it has in years past, and some experts blame the opioid epidemic. But a new study published on January 15, 2018 in the Proceedings of the National Academy of Science suggests America's increasing girth is what's really behind the slowdown.

Excess weight led to nearly 200,000 excess deaths in 2011. And overall, those extra pounds reduced life expectancy by almost one year at age 40, researchers determined.

"Rising levels of body mass index [BMI] have prevented the United States from enjoying the full benefits of factors working to improve mortality," wrote study author Samuel Preston and his colleagues. Preston is a professor of sociology at the University of Pennsylvania.

Heart disease deaths had declined consistently for nearly 40 years. These declines have slowed or stopped altogether, according to the researchers. Rates of decline in cancer deaths have also slowed, they said. At the same time, rates of obesity have been rising in the United States. From 1976 to 1980, 15 percent of Americans were obese. By 2014, 38 percent of Americans were classified as obese according to the researchers. Obesity is linked to mortality in multiple ways. It is the biggest cause of type 2 diabetes, and it promotes all of the risk factors that cause heart disease, such as high blood pressure and cholesterol. Obesity also promotes sleep apnea, which is a leading cause of sudden death and motor vehicle accidents. Obesity affects every organ system in the body. Notably, it is also linked to a number of cancers.

To get a better idea of obesity's impact on death rates, Preston and his colleagues gathered data from a national health survey from 1988 through 2010. The survey included more than 25,000 Americans between 40 and 84 years old. The researchers also looked at related death data through 2011. Using a statistical model, the researchers assessed how much of the slowing death rate trend could be explained by rising body mass index. They found that in 2011 America's increase in BMI reduced life expectancy by 0.9 years by age 40 -- almost 11 months. The statistical model also estimated that 186,000 excess deaths occurred that year due to rising BMI in the United States.[7]

Many experts believe an increase in "deaths of despair" -- such as opioid overdoses or suicides -- has slowed improvements in death rates. While opioids are definitely lowering life expectancy in younger people, obesity is a contributor across all population segments.

Preston's findings suggest the need for physicians and policymakers to deal with obesity from a public health perspective. It is noteworthy that the last time we saw a dip in life expectancy was with HIV/AIDS, and we reacted to that crisis and developed new drugs. However with obesity, there's an extreme bias because it's considered to be a behavioral condition, and insurers and Medicare and Medicaid are slow to provide coverage for obesity treatments. Coverage for obesity medications occurs only about 30 percent of the time.

The authors stressed the importance of understanding that losing weight is more complicated than "eat less, exercise more." Preston recommended seeing a doctor who specializes in weight management who can help the patient successfully shed pounds and keep them off.

Rosen agreed that there's no easy answer for losing weight. "Obesity may be tougher to treat than cigarette smoking," he said. "The best strategy is not to gain weight when you're young," he said. But if you do have excess weight to take off, he added, you need to change what you're eating.

[1] Liaison Committee on Medical Education. "*Functions and Structure of a Medical School; Academic Year 2016-2017*." 2016.

[2] Association of American Medical Colleges. *"Core Entrustable Professional Activities for Entering Residency; Curriculum Developers'* Guide. 2014.

[3] United States Medical Licensing Examination. *"Step 2 Clinical Skills (CS); Content Description and General Information"*. 2015.

[4] Accreditation Council for Graduate Medical Education. *"Common Program Requirements."* 2016.

[5] Accreditation Council for Graduate Medical Education. "*ACGME Program Requirements for Graduate Medical Education in Internal Medicine*." 2015.

[6] Accreditation Council for Graduate Medical Education and the American Board of Internal Medicine. "*The Internal Medicine Milestones Project*." 2015.

[7] Preston SH et al. The role of obesity in exceptionally slow US mortality improvement. Proc Natl Acad Sci U S A. 2018 Jan 16. pii: 201716802. doi: 10.1073/pnas.1716802115. [Epub ahead of print]

2017-2018 ACOI COMMITTEE APPOINTMENTS

The ACOI Board of Directors recently approved the committee roster for the coming year. More than 200 members volunteered to fill approximately 25 vacancies on one or more of the committees. President Martin C. Burke, DO and the Board express gratitude to all who volunteered. Members who were not selected will be considered for openings that occur next year.

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CME CALENDAR

Future ACOI Education Meeting Dates & Locations

NATIONAL MEETINGS

- 2018 Internal Medicine Board Review Course - April 25-29
- 2018 Clinical Challenges in Inpatient Care - April 26-29
- 2018 Exploring New Science in Cardiovascular Medicine - April 27-29
- 2018 Congress on Medical Education for Resident Trainers - April 27-28
  Chicago Marriott Downtown Magnificent Mile, Chicago, IL
- 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
- 2021 Annual Convention & Scientific Sessions
  Sept 29-Oct 3 Marriott Marquis Hotel, San Francisco, CA

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.

2018 Certifying Examination Dates & Deadlines

Internal Medicine Certifying Examination
Computerized Examination 300 Sites Nationwide
September 12-14, 2018 - *Application Deadline: February 1, 2018*

Internal Medicine Recertifying Examination
Computerized Examination 300 Sites Nationwide
September 12-14, 2018 - *Application Deadline: April 1, 2018*

Internal Medicine Recertifying with a Focus in Hospital-Based Medicine Examination
Computerized Examination 300 Sites Nationwide
September 12-14, 2018 - *Application Deadline: April 1, 2018*

Subspecialty Certifying Examinations
Computerized Examination 300 Sites Nationwide
August 28-30, 2018 - *Application Deadline: April 1, 2018*
• Cardiology • Critical Care Medicine • Endocrinology • Gastroenterology
• Hematology • Hospice and Palliative Medicine • Interventional Cardiology
• Infectious Disease • Nephrology • Oncology • Pulmonary Diseases • Rheumatology

Subspecialty Recertifying Examinations
Computerized Examination 300 Sites Nationwide
August 28-30, 2018 - *Application Deadline: April 1, 2018*
• Cardiology • Clinical Cardiac Electrophysiology • Critical Care Medicine • Endocrinology
• Gastroenterology • Geriatric Medicine • Hematology • Hospice and Palliative Medicine
• Infectious Disease • Interventional Cardiology • Nephrology • Oncology
• Pulmonary Diseases • Rheumatology • Sleep Medicine

Further information and application materials are available by contacting Daniel Hart, AOBIM Director of Certification at admin@aobim.org*; 312 202-8274.*

Contact the AOBIM at admin@aobim.org *for deadlines and dates for the* ***Allergy, Sports Medicine, Pain Medicine, Undersea/Hyperbaric Medicine and Correctional Medicine*** *examinations.*

President's Letter

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led ambulatory systems to which to transfer care. The current clinical care resource distribution is not sustainable.

3. We need to control our clinical outcomes and care data in order to direct and re-invest resources back into local clinical care systems. The care of patients is very local. It requires physician leadership and analysis in order to protect it and advance it. This begins with systematic data collection and analysis that is regionally unique and quantified. Currently, this data is being collected without reference and used as a commodity by hospitals and insurance companies with no re-investment in patient care. In fact, the least amount of resources are returned to physician-lead care systems. A profession is defined by the health of its client list. We are losing control of our patient lists for various reasons, but we can control the data and categorize the way patients are treated in order to improve care. You already do these calculations in your practice.

The ACOI is a place where we can begin to address and craft strategies together for the initiatives or facts described above and beyond. Whether independent or employed, we need to start small and rebuild leadership into the clinical operation that is patient-focused. As an association, the ACOI can assert more collective interest in our member's well-being, as well as promote the survival of the osteopathic profession, even when the entire American medical profession is on its heels. Please share your personal or professional strtegies and examples of patient-focused leadership with me or the ACOI staff so that we may craft best practices in gaining local leadership. I cannot think of a better resource than our members, as you are most likely to find ways to lead every day.

Martin C. Burke, DO, FACOI
President