

## From President Sutton Palliative Care is Comfort Care



Celebrate Summer! This is the current welcome sign on my front lawn in Carson City, NV. June can be hot, even in northern Nevada, but air conditioning and the lack of high humidity make it comfortable. Summer is not a place of comfort outside in my

Alabama homeland. This year I am traveling a great deal of the time as a representative of the ACOI. Sometimes I get a special seat on my preferred airline due to my miles status. It is called a comfort seat. More leg room, drinks, snacks are nice. I fondly call it comfort care seating.

In the years of my residency training, comfort care was something else. For most patients, we did everything. When it was clear that

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## Elections Set for October 15

# Nominations for ACOI Leadership Positions Announced



*Martin C. Burke, DO*

**Susan Enright, DO** and **Amita Vasoya, DO**, complete the slate. Under the College's Bylaws, this year's President-Elect, **Martin C. Burke, DO**, will be inaugurated as President for the 2017-2018 year at the conclusion of the elections.



The ACOI Nominating Committee has announced the slate of candidates for election at the Annual Meeting of Members scheduled for Sunday, October 15 in Washington National Harbor, MD. The Committee has nominated **Annette T. Carron, DO**, for President-Elect and **Samuel K. Snyder, DO**, for Secretary-Treasurer. The Nominating Committee also approved five candidates for election to the Board of Directors. Incumbents **Damon Baker, DO**, **Robert DiGiovanni, DO**, and **Joanne Kaiser-Smith, DO** are nominated for new three-year terms.

**Annette T. Carron, DO, FACOI**, of Troy, MI, is board-certified in internal medicine, geriatric medicine and hospice and palliative care medicine. She is a geriatrician at Henry Ford Memorial Hospital in Clinton Township, MI. She also is a clinical lecturer at Michigan State University College of Osteopathic Medicine and has an active hospice practice. Dr. Carron completed her internal medicine training at Botsford Hospital and a geriatric medicine

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## A Vision for ACOI Post-2020 Is Emerging

When the AOA announced in February 2014 that it would stop approving graduate medical education programs, the ACOI immediately understood that major challenges would lie ahead for osteopathic internal medicine.

The development and nurturing of high quality internal medicine residency training has been a major focus of the College for all of its 75-year history. Of equal importance, these training programs have been the source of the new members that are the lifeblood of any successful organization.

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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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aggressive care would

not be curative and life was near its end, we discussed comfort care with the family and patient. Keep the patient comfortable, pain free. All of that usually came at the very end. Early on, we did not even have the terminal wean. At that time, I understood that once the patient was hooked up to the ventilator, it could not be stopped. I remember one patient who came in at the apparent end of life. He had been intubated, but had not been hooked up to the ventilator. I asked the technician to manually ventilate the patient while I talked to the family. They agreed to comfort care. The patient was placed on a T-piece and later expired.

Hospice has been a choice for many patients over the years of my career. Terminal cancer has been the usual diagnosis for hospice. In recent years, hospice and palliative care have taken new meaning. Skillful physicians in this area of expertise now include diagnoses other than cancer. A few years ago, I had one such patient with congestive heart failure. It was apparently terminal in that all avenues of care had been expended. This was a surprise to me, as he was fairly well on routine clinical exam in my office. He was placed on hospice and expired shortly after.

[Getpalliativecare.org](http://Getpalliativecare.org) reports of palliative care, “This type of care is focused on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.” Palliative care can be provided along with curative care. This is the new comfort care. As osteopathic internists, we are the champions of the care of serious illness. I am an old school osteopathic internist. Do everything. Get to the bottom of it. Aggressive care is the only way. That does not set well with every patient. Some patients indicate to me and my staff that my aggressive approach is unwanted. To other patients, I am just what they desire in healthcare.

Aggressive care of diabetes can be in some ways palliative. Painful neuropathy, for example, can be greatly improved by control of glucose values. Wounds, sometimes painful, are more easily healed with better glucose values. Vision complications get better, and cardiac status can improve.

We are trained as osteopathic internists to consider body and spirit in the healthcare of our patients. We understand that one tenet of osteopathic medicine is rational therapy. The definition of rational therapy takes on new meaning with modern hospice and palliative care. Sometimes rational therapy in my office means an insulin pump in a 75-year old patient for better diabetes control. Sometimes rational therapy means to stop all insulin and diabetes medication. That is a hard one for me, but I am willing to work with the hospice and palliative care team for the good of the patient in the best standard of care. We must individualize care. We must stand up for the life, comfort and peaceful death of any given patient.

At the ACOI, we are here to support the osteopathic internist. We are working hard to represent our members. We are here to lead osteopathic internal medicine into the future. Let us know how we can help you.

God bless Osteopathic Internists.

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# government RELATIONS

Timothy McNichol, JD

## Showdown in the Senate Looms

Senate Republican leadership released a discussion draft of legislation to repeal the Affordable Care Act (ACA) on June 22. The draft legislation follows approval of the “American Health Care Act” (H.R. 1628) by the House entirely along party lines on May 4.

The draft legislation released by Senate leadership differs from the House-approved legislation in its details, but contains many of the same general policy provisions impacting Medicaid, coverage requirements, and health-related tax provisions, among other things. Of continued concern for many is the potential impact on Medicaid beneficiaries, the rolls of which were greatly expanded by the ACA. In addition, while the Senate version of the legislation does not allow states to request waivers from protection for preexisting conditions, the draft bill would allow states to seek waivers from other insurance coverage requirements, such as essential health benefits.

Within hours of the release of the draft legislation, four Republicans announced their opposition to the draft bill. Additional Republicans have expressed strong reservations. With a very narrow pathway through the Senate, it is expected that the draft legislation will be amended prior to consideration. Senate leadership indicated that they hope to have a vote on the legislation prior to Congress’ July 4th recess. Should the legislation be approved in the Senate, it would go back to the House where it would have to be approved in its current form. If the House does not accept the Senate version of the legislation as approved, a conference committee would be appointed and assigned to combine the competing legislation into one bill that would have to be approved by both chambers. Numerous hurdles remain for the approval and enactment of legislation to repeal the ACA. The path forward in both the House and the Senate remains very narrow allowing for only a few Republican defectors. The ACOI is continuing to closely monitor this dynamic situation.

## Improper EHR Incentive Payments Made

According to a report released by the Health and Human Services (HHS) Office of Inspector General (OIG), an estimated \$729 million in payments under the Medicare and Medicaid electronic health record (EHR) incentive programs were made to providers who did not meet meaningful use requirements. According to HHS, as of June 2014, approximately \$6 billion in Medicare incentive payments were made. Deficiencies were found to include insufficient attestation support, incorrect reporting periods, or insufficient use of certified electronic health record technology. Incorrect payments were also made in instances where a provider switched between the Medicare and Medicaid incentive programs. As a result of its findings, the OIG has made recommendations to CMS for additional action to reduce the number of improper payments.

## CMS Report Shows Slowed Spending Growth

A new report released by the Centers for Medicare and Medicaid (CMS) showed every state had a slower growth in per capita personal healthcare spending from

2010 - 2013. According to the report, healthcare spending slowed to a 2.8 percent growth rate compared to an average of 5.2 percent from 2004 - 2009. The report also found that Medicaid spending increased 12.3 percent from 2013 to 2014 for states that expanded their coverage under the ACA compared to just 6.2 percent for states that did not expand their coverage. However, per enrollee spending grew by 5.1 percent in non-expansion states whereas expansion states saw a 5.1 percent reduction in per-enrollee spending. To review the report in its entirety, visit [www.CMS.gov](http://www.CMS.gov).

## Some Physicians to See Cuts in Medicare Payments

According to a report recently released by CMS, about 500,000 physicians will see a 2 percent reduction in 2017 Medicare payments as a result of not meeting quality reporting requirements in 2015. About 16 percent of those seeing a reduction are primary care physicians. Nearly two-thirds of doctors and other medical professionals will be unaffected. There were approximately 1.36 million eligible professionals under the Physician Quality Reporting System (PQRS). The PQRS is the precursor to the Merit-based Incentive Payment System (MIPS) now in place. To learn more about the incentive payment program visit <https://qpp.cms.gov/>.

## HHS OIG Continues Recoveries in 2017

According to a report released by the HHS OIG, investigative recoveries for the first half of fiscal year 2017 are expected to exceed \$2.04 billion from October 1, 2016 through March 31, 2017. During this time, the OIG has instituted 468 criminal actions and 461 civil actions. As a result of the OIG’s activities, 1,422 individuals and entities have been excluded from federal health care programs during this time.

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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.*

### **Documentation of a Proper E&M History**

Does the visit really need a chief complaint in the documentation? I get asked this all the time. The resounding answer is yes. Both the 1995 and 1997 Evaluation and Management (E&M) guidelines state, "The medical record should clearly reflect the chief complaint." The term "chief complaint" was defined in the 1995 E&M Guidelines as, "a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter." The definition was expanded by the 1997 E&M Guidelines with the addition that the chief complaint (CC) be, "usually stated in the patient's own words." Documentation starts with the "why" of the office visit, or the initial visit in the hospital. The CC and subsequent History of Present Illness (HPI) set the stage for subsequent exams and workups of a patient and his or her illness.

These two critical areas of documentation state the patient's view. It is from this point that the rest of the note evolves. It is not hard to see the significance of documentation that reflects a rash on a patient's hand versus a rash that has been on their hand for two weeks, now spreading up their arm with increasing redness and tenderness. The Review of Systems (ROS) and Physician Exam (PE) may be significantly different in intensity based on the additional information contained in the record.

Another example I frequently see of documentation listed under CC and HPI is "needs refills." The 1997 Guidelines state the CC is usually in the patient's own words. Note the word "usually." In this instance, the patient is most likely in for follow-up related to their chronic illness. As a result, their chief complaint would be that treatment and management of the existing illness. The HPI which is "a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present," would document any changes in the chronic illness since the patient's last visit. The story of the patient's problem is being told.

With only two levels of HPI scored for documentation, the difference in the amount of "detail needed to accurately characterize the clinical problem(s)" varies. A brief HPI is warranted with only one or two elements documented if the patient's illness is stable. However, if the patient is having problems or has multiple stable illnesses then answers to a number of questions may be needed.

What is wrong? How long has it been a problem? How bad is it and what makes it better or worse? Answers to these and other questions will give you the four HPI elements needed in documenting an extended history of the present illness or problem.

After documentation of the HPI, the ROS is next. Asking questions about systems directly related to the problem identified by the HPI and more are needed. Clear documentation of the patient's problem, its history and severity will flow easily in to the documentation. Each section of documentation is based on information gathered from the prior section.

This completes the discovery aspect of your verbal interaction with the patient. Your documentation should reflect what is wrong with the patient and other items that you deem necessary to your clinical assessment based on your conversation with the patient. The "story" of this patient's history section is complete.

One note of caution: using pre-populated templates for your chart documentation can be problematic. Documentation in a patient's chart should reflect what is needed for that patient, for that day, and for their set of complaints. Entering an entire completed section of information by cutting and pasting or by pulling information forward does not show the unique nature of that patient. I cannot tell you how many charts I audit where the ROS is contradicted by other parts of the chart. My assumption is a cloned ROS was entered into that record. Who knows if the questions were actually asked, but it is an incorrect and inaccurate section of documentation with potentially a significant financial impact. Documentation must be specific to each patient encounter.



Welcome to the June edition of Talking Science and Education. For many of us it seemed as if spring would never come. Well, for those of us in the East, Mother Nature has leapfrogged into summer! Last month's trivia on the state of health in the US yielded several answers, but unfortunately no correct responses. Our question last month asked in which state did the prevalence of smoking decrease most significantly in 2016. Illinois saw an average decrease in smoking of -1.37% per year. Now members, come on and try! Continuing with our trivia series on the state of health in the US, this week's question is:

Compared to the 35 countries which make up the Organization for Economic Co-operation and Development (OECD), where does the US rank in infant mortality?

- 5th
- 10th
- 18th
- 29th

Please email your response to me at [don@acoi.org](mailto:don@acoi.org). Remember: we do give VALUABLE prizes, and if you're thinking of going to Google for the answer.....DON'T!!

## Talking Graduate Medical Education

As the deadline approaches for three-year residencies and fellowships to submit applications to ACGME (12/31/17), we strongly urge you to move forward with these applications as soon as possible. We at ACOI also urge our internal medicine residencies to seek Osteopathic Recognition (OR). Programs that achieve OR ensure the unique principles and practices of the osteopathic medical profession continue to benefit the entire medical community and, most importantly, patients for generations to come.

In answer to the question, "Why should my program apply for OR?" we offer three responses:

1. Students want osteopathically-focused training;
2. GME programs want qualified applicants;
3. Hospitals want residents who provide patient-centered care.

To assist internal medicine programs in securing OR, we have an OR Toolbox on our website with useful resources which are regularly updated and augmented. You can find the toolbox at [http://www.acoi.org/education/gme/general-information/OR\\_Toolbox.html](http://www.acoi.org/education/gme/general-information/OR_Toolbox.html). Finally, I am available to assist you in this process in a number of ways. Reach out to me at [don@acoi.org](mailto:don@acoi.org) for more information.

## Diabetes Dialogues

### Overtreatment of Frail and Elderly People with T2DM Appears to be Common

Overtreatment with insulin and sulphonylureas appears to be common in elderly people with type 2 diabetes, including those with chronic kidney dis-

ease or dementia. These data out of the UK, published in the journal Diabetic Medicine last month are consistent with the clinical impressions shared by several diabetologists I've talked with. As we know, insulin and sulphonylureas are medications which aggressively lower blood sugar levels, and therefore overtreatment can lead to hypoglycemia.

The study was carried out by researchers at Leicester Diabetes Centre and the University of Leicester. Data was drawn from a database of 24,661 people from 16 primary care clinics across the county of Norfolk in England.

Of these, 1,379 met the criteria of being 70 years old or older, having type 2 diabetes and being prescribed either a sulphonylurea drug or insulin. 644 participants had chronic kidney disease (CKD) and 60 had dementia.

The analysis showed that 30 per cent of the participants had HbA1c values below 53 mmol/mol (7%). The researchers defined this to be 'potential overtreatment' of diabetes. While the American Association for Clinical Endocrinology (AACE) recommend a target A1c of  $\leq 6.5\%$ , they indicate that this target is "less stringent for patients with additional health problems. The current American Diabetes Association Guidelines suggest 7% as a target, they qualify this by indicating:

"Less stringent A1C goals (such as  $<8\%$ ) may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, extensive comorbid conditions, or long-standing diabetes in whom the general goal is difficult to attain despite diabetes self-management education, appropriate

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## 75th Anniversary Campaign Update – Halfway to \$750,000 Goal (Outright Gifts and Multi-Year Commitments as of June 14, 2017)

If you would like to support the 75th Anniversary Campaign and be recognized on this special Honor Roll of Donors, please email [Barbara@acoi.org](mailto:Barbara@acoi.org) or [click here](#) to print the campaign pledge card.

Donors who contribute \$1,000 or more will be recognized in ACOI print/electronic materials, on the ACOI website, with an autographed copy of the 75th Anniversary History Book, and be honored on the 75th Anniversary Circle Tree or Donor Wall of Honor in the ACOI office, depending on level of commitment. Campaign donors will receive special invitations and be honored at key events during the 2017 ACOI Convention in the Washington, DC area.

### Honor Roll of Donors

*Thanks to the generous donors listed below we now have gifts and commitments totaling \$376,000!*

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## Vision for ACOI

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The ACOI leadership adopted a strategy of continuous planning to address the challenges ahead. Previously, the Board of Directors undertook professionally-facilitated strategic planning every two years. The Board Executive Committee conducted planning sessions in the off years. Since 2015, both the Board and Executive Committee have participated in facilitated planning annually.

As they have done so, a vision of ACOI's future has begun to emerge. Early in the process, the ACOI Mission statement was revised to put the focus on how the College can support members in the provision of high-quality, osteopathic care to patients. This led to such actions as the decision to seek recognition from the Accreditation Council for Continuing Medical Education (ACCME) as a provider of CME. This step will not only enhance the quality of ACOI's educational activities, it also will allow the College to offer CME that qualifies for both AOA and AMA credit, and meet the recertification requirements of both the AOBIM and the ABIM. Accreditation by the ACCME is expected to be achieved by the end of 2017.

Another strategy has been to work collaboratively with any other organizations that would further the ACOI's promotion of high-quality patient care. This effort has resulted in ACOI securing an *ex officio* seat on the ACGME Residency Review Committee for Internal Medicine, as well full participation in the Internal Medicine Education Advisory Board, which comprises all of the major academic internal medicine organizations, plus the American College of Physicians, the American Medical Association, the Society for General Internal Medicine, the Society for Hospital Medicine and the American Board of Internal Medicine.

These interactions provide the ACOI with powerful new partners and allies and afford the opportunity for the College to continue to influence internal medicine residency training beyond the transition.

The underlying theme of ACOI's strategic efforts is the desire to create a home for those who believe in the patient-centered, osteopathic approach to healthcare. One element of this effort is to provide hands-on assistance to residency programs as they seek allopathic accreditation, and to encourage them to secure Osteopathic Recognition as they make the transition. This will assure that the distinctive osteopathic philosophy imbued in students during their medical school years will continue during residency. It is gratifying that 100 percent of the ACOI internal medicine programs that have been reviewed by the ACGME have been granted initial accreditation.

Additionally, ACOI is committed to emphasizing the osteopathic approach in all of its educational activities. At the Board's most recent planning session in June, a task force was created to develop and communicate a plan for integrating osteopathic principles and practices into the College's programs, products and services. The recently-completed 2017 ACOI Membership Survey revealed that 47 percent of members use OMT at least some of the time in their practices. The Board recognizes that manual medicine, while not defining osteopathic care, should be a meaningful part of the discussion about osteopathic distinctiveness. The task force will begin by developing a consensus statement on the importance of incorporating osteopathic manipulative medicine into the care of the adult patient. It is also charged with developing practical mechanisms for integrating osteopathic principles and practices into the continuum of education.

Recognizing that the members of ACOI want high-quality, easily accessible, inexpensive CME, the Board created a second work group to modernize ACOI's existing CME offerings and develop new activities that take advantage of advances in technology. These efforts will focus on activities that assist members in obtaining and retaining board certification, as well as keeping their medical knowledge current. The new work group will build on activities undertaken by the CME Committee in 2016 to completely revamp ACOI's policies and procedures for its CME activities. The Com-

mittee has developed a rigorous needs assessment process that is based on identifying knowledge gaps between clinical research and practice. ACOI's educational activities are designed to address these gaps.

Another outcome of the planning sessions conducted this year by the Board and Executive Committee is the creation of a task force on physician wellbeing. This group will address the growing problems of stress, burnout and suicide that are the result of systemic issues affecting physicians, including paperwork burdens, pressure to see too many patients and work too many hours, and a general loss of control. Its charge will be to identify the problem and its sources, refer members to appropriate resources, and focus on fixing the causes of the problem in collaboration with other groups. The task force will include representatives from the membership at large, including residents and students.

Finally, the Board agreed on the importance of strengthening the AOBIM and assuring that its credentials remain viable for all who already have them, as well as those completing training. The AOBIM is a separate organization from the ACOI. It has always operated under the authority of the American Osteopathic Association, but until recently it operated autonomously. The AOA in 2015-16 brought all of the certifying boards under its own management. The transition has not gone completely smoothly. The ACOI Board of Directors will continue to monitor the situation and take whatever steps it can to protect those who have AOBIM credentials.

The past two years have been a period of rapid change with many challenges, almost all of which have been created by forces outside of the ACOI's control. An organization's success is determined by how it turns challenges into opportunities. Members of the ACOI should be confident that the leadership of the College is taking the steps needed for the organization--and osteopathic internal medicine--to emerge stronger than before.

## Nominations

*continued from page 1*

fellowship at George Washington University in Washington, DC. She is Chair of the ACOI Ethics Committee, a member of the Development Committee and is active in the Geriatrics and Palliative Medicine Subspecialty Sections of the College. Dr. Carron has been an Active member of the ACOI since 1995. She achieved the degree of Fellow in 2002. She was first elected to the Board of Directors in 2008.



**Samuel K. Snyder, DO, FACOI** is Associate Professor and Chair of the Department of Medicine at Nova Southeastern University-College of Osteopathic Medicine in Fort Lauderdale, FL. He recently completed service as the program director of the internal medicine residency at Mount Sinai Medical Center there. He was appointed in 2015 to represent the ACOI and AOA on the ACGME Internal Medicine Residency Review Committee. Dr.

Snyder is board-certified in internal medicine and nephrology. He has been an Active ACOI member since 1986 and received the degree of Fellow in 1995. He has been a member of the Research Committee, which he chairs, and has lectured numerous times on nephrology topics for the College. Dr. Snyder chaired the annual convention program in 2015. He was first elected to the Board of Directors in 2009.



**Damon L. Baker, DO, FACOI** is a board certified general internist practicing in Tulsa, OK. He is Professor and Chair of the Department of Internal Medicine at Oklahoma State University Center for Health Sciences, College of Osteopathic Medicine (OSU-COM), and Chief Medical Officer at Oklahoma State University Medical Center. Dr. Baker is also program and medical director of the Internal Medicine Specialty Services HIV/AIDS program at the OSU Center for Health Sciences. A 1993 graduate of

OSU-COM, Dr. Baker completed his internal medicine residency at Tulsa Regional Medical Center. He has served on numerous boards and committees at the local level, and served on the ACOI Council on Education and Evaluation. An Active ACOI member since 1997, Dr. Baker received his FACOI degree in 2001.



**Robert L. DiGiovanni, DO, FACOI** is a board-certified internist and rheumatologist practicing in Largo, FL. He completed his internal medicine training at Suncoast Hospital (now Largo Medical Center) in Largo, and a fellowship in rheumatology at the University of Arizona Health Sciences Center in Tucson. He is the current president of Suncoast Internal Medicine Consultants and the program director of the rheumatology fellowship program at Largo Medical Center. Dr. DiGiovanni has been active in the

ACOI Subspecialty Section of Rheumatology, including serving as chairman and education coordinator of the section. He has provided numerous lectures for the College at the board review course, annual convention and other meetings. Dr. DiGiovanni has been an Active member of the ACOI since 1987 and achieved the degree of Fellow in 1994. He was first elected to the Board of Directors in 2013.



**Susan M. Enright, DO, FACOI** of Rochester Hills, MI, is board certified in internal medicine and emergency

medicine. She recently joined the Michigan State University College of Osteopathic Medicine as director of the clinical clerkship curriculum. Previously, Dr. Enright was at Genesys Regional Medical Center in Grand Blanc, MI, where she served as community faculty coordinator for MSUCOM's primary care ambulatory clerkship and core clinical concepts clerkship programs, traditional internship program director, interim director of medical education/designated institutional officer and as program director of the internal medicine residency. She has served several terms on the ACOI Council on Education and Evaluation, including the past two years as Chair. Dr. Enright has been an ACOI Active member since 1998 and earned the degree of Fellow in 2002. She was appointed earlier this year to fill a Board position available due to the resignation of Mitchell D. Forman, DO, FACOI. The Bylaws provide that Board positions filled by appointment expire at the next election. Dr. Enright is nominated to fill the two year's remaining in Dr. Snyder's term.



**Joanne Kaiser-Smith, DO, FACOI** is board-certified in internal medicine and geriatric medicine with a practice in

Stratford, NJ. She is Assistant Dean and Director of Medical Edu-

*continued on next page*



## Nominations

*continued from page 1*

cation at Rowan University- School of Osteopathic Medicine, and also serves as the chief of the Division of General Internal Medicine in the Department of Medicine there. Dr. Kaiser-Smith is a graduate of UMDNJ-SOM (now Rowan University) and completed her residency training at Kennedy Memorial Hospitals-University Medical Center in Stratford. She has served several terms on the Council on Education and Evaluation and is chair of the Governance Committee. She also was chair of the Women's Health Task Force. Dr. Kaiser-Smith has been an Active member of the ACOI since 1988 and was awarded the degree of Fellow in 1994. She was first elected to the Board of Directors in 2012.



**Amita Vasoya, DO, FACOI**, is board certified in internal medicine, pulmonary diseases, critical care medicine and sleep medicine, with a practice in Stratford, NJ. She is clinical assistant professor for internal medicine training at Christiana Care Health System, and director of the sleep medicine fellowship at Rowan University School of Osteopathic Medicine. Dr. Vasoya has served on the ACOI Committee on Minority Health and Cultural Competency since 2009, including one year as Chair. She has lectured

extensively for the ACOI and served as subspecialty section chair and education coordinator for both the Pulmonary and Sleep Medicine sections. An ACOI Active member since 2001, Dr. Vasoya achieved the degree of Fellow in 2005. She is nominated to fill the one year remaining in Dr. Forman's term.

**Martin C. Burke, DO, FACOI** is a board-certified cardiologist and electrophysiologist practicing in Chicago. He is the Chief Scientific Officer for the Corvitas Science Foundation there. Dr. Burke completed an electrophysiology fellowship at the University of Chicago, following his internal medicine and cardiology training at the Chicago College of Osteopathic Medicine. Dr. Burke is chairman of the ACOI Development Committee and is President-elect this year. He chaired the annual convention program in 2014 and has chaired and served as education coordinator of the Cardiology Subspecialty Section. Dr. Burke is involved in clinical research and has served as an editorial consultant for the Journal of the American College of Cardiology and other peer-reviewed journals. He has been an Active member of the ACOI since 1995 and achieved the degree of Fellow in 2001. Dr. Burke was first elected to the Board of Directors in 2008.

The Nominating Committee this year is chaired by **Robert G. Good, DO**. Also serving are **Michael Adornetto, DO**, and **Robert Cain, DO**. Any Active member of the ACOI may nominate other qualified candidates by submitting the nomination to the Executive Director. Such nominations must be supported by the signatures of 30 Active members of the College; they also must include a brief statement of qualifications and must be received no later than 30 days prior to the date of the election. Further information is available from the Executive Director.

## Member Milestones



**Pamela S.N. Goldman, DO, MHA., FACOI**, of Yardley, PA, was elected in April as vice president of the Pennsylvania Osteopathic Medical Association (POMA). Board certified in internal medicine, Dr. Goldman is the interim chair and associate chair of the Division of Hospital Medicine and an academic hospitalist with Einstein Medical Center in Philadelphia.

Dr. Goldman is a 2006 graduate of the Lake Erie College of Osteopathic Medicine, where she also received a master's degree in health services administration. She completed an internship and internal medicine residency at Aria Health System in Philadelphia.

## In Memoriam

Word has been received of the death of **Edward W. Foster, DO, PhD, FACOI**, of Elmira, NY. Dr. Foster died on January 26 at the age of 65. A graduate of Des Moines University College of Osteopathic Medicine, he completed his internal medicine residency at the University of Buffalo. He also earned a PhD in microbial physiology at the University of New Mexico. Dr. Foster was an Active member of the ACOI since 2007 and received the degree of Fellow in 2011.

## Government Relations

*continued from page 3*

### Washington Tidbits

#### Repeal and Replace...

#### Overcoming Regular Order

House and Senate legislative activities are guided by complex rules that set forth procedures to consider and approve legislation. From the committee structure, to where certain types of legislation must originate, legislation that makes it to the President's desk for enactment must overcome a number of procedural obstacles that go well beyond those created by the politics of the policy under consideration.

As an example, legislation in the Senate traditionally needs 60 votes to overcome procedural barriers (filibuster) intended to protect the minority. However, the Congressional Budget Act of 1974 created a process called reconciliation. Under reconciliation, certain legislation impacting spending, revenues, and the federal debt limit can be considered without being subject to filibuster. Legislation considered under these rules can be approved by a simple majority. Reconciliation limits debate to 20 hours without limiting the number of amendments that can be offered as long as they are not determined to be "extraneous." Any amendments remaining at the end of the 20 hours of debate are voted upon without further discussion. While the reconciliation process is seldom used, it is being used for consideration of the legislation to repeal and replace the ACA. As divisions in the Senate continue to percolate, do not be surprised to hear of this process being used more frequently in the near future.

## Letter from the President

*continued from page 2*



### Osteopathic Internist in the Trenches

**Reuben Eliuk, DO**, is a classic Osteopathic Internist born in Alberta, Canada. After completing high school to get off the farm, he moved far away to train in physical therapy in California. Dr. Eliuk graduated with a Bachelor's degree from Loma Linda University, College of Allied Health Professions. He took a job in Bay City, MI, and later advanced to head of PT at Saginaw Osteopathic Hospital. That was his first exposure to Osteopathy. He learned some spinal manipulation from the Interns, which was helpful in PT.

In Saginaw, Dr. Eliuk began completing pre-med requirements and was introduced to schools of Osteopathic Medicine. His father-in-law, who was CEO of Garden City Osteopathic Hospital, was of great influence. Dr. Eliuk completed his Osteopathic Medicine degree in 1977 at MSU-COM in a pilot program that allowed him to complete his degree in 36 consecutive months.

He completed an internship at Garden City Osteopathic Hospital in 1978. He then went directly into general practice in Caro, MI for four years. Realizing that residency training was a must, Dr. Eliuk proceeded to the Internal Medicine residency program at Garden City Hospital. He completed the program in 1986. As Dr. Eliuk reports, he worked as a hospitalist "...back when being a hospitalist was not cool, especially as a DO. People would always ask me 'Where is your office?'"

Dr. Eliuk was board certified in 1987, which was the "...first year that there was no oral portion to the boards!!!" For over 20 years, he worked at Garden City Hospital as IM program director, IM Department Chief, Chief of Staff and on the Board of Trustees. He has been awarded the well-deserved Intern Trainer of the Year, Resident Trainer of the Year, and Humanitarian of the Year recognitions.

Dr. Eliuk chose to limit his professional responsibilities in December 2012, when he became employed by the Bronson Healthcare Group in Kalamazoo, MI. His plan is "never" to retire, as he thoroughly enjoys caring for hospitalized patients and the challenges that this provides in today's health care environment. Dr. Eliuk's group is now associated with the relatively new Western Michigan University School of Medicine, and he reports that it is refreshing to see the young medical students with their short jackets and loads of enthusiasm.

Dr. Eliuk is in a loving marriage with his wife Janice for 45 years. They have three grown children and four grandchildren, whom they enjoy greatly. His son, Brett, is also a graduate of MSU-COM and is a cardiologist in the Bronson Hospital System. The senior Dr. Eliuk reports that it has been rewarding to see his son progress through the same professional roles that he had the privilege of filling.

Dr. Eliuk says that: "Osteopathic Internal Medicine has been extremely rewarding to me personally, and I still say the best all-around physician is a DO-trained Internist!" Please, Join me in celebrating Dr. Reuben Eliuk as the June 2017 Osteopathic Internist in the Trenches.

John Sutton, DO, FACOI, FACE, CCD  
President

# A Living Trust Makes Sense

Many ACOI members have established healthcare directives that clearly spell out how they want certain end-of-life decisions to be made if they are incapacitated and not able to articulate them.



Many today also establish a Living Trust that appoints a trustee who can handle your affairs on your behalf if you become incapacitated without resorting to court appointed “guardians.” If your assets (your home, other property, stocks, etc.) are in a living trust, your estate will avoid the delays, expenses and restrictions of probate. To learn more, click anywhere on the image of an informative electronic brochure, A Legacy in Trust, <http://rrnew.com/aco/> which contains helpful graphics to show how it works. It will open in a separate page, where you’ll have the opportunity to request that more information be sent to you.

## 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 Members:

Francis Ampadu, DO  
Soheil Assar, DO  
Vincenzo Barbato, DO  
Jared Benz, DO  
Brian Blair, DO  
Richard Bourjaily, DO  
Zachri Buzzinotti, DO  
Christopher Chum, DO  
Donna Cota, DO  
Matthew Day, DO  
Caressa Eckley, DO  
Jennifer Fitzgerald, DO  
Tristan Flack, DO  
C. Johnathan Foster, DO  
Amanda Frugoli, DO  
Armita Ghoddousi, DO  
Nathan Gibb, DO  
Gregory Greene, DO  
Matthew Griffin, DO

Gregory Harris, DO  
Stuart Harris, DO  
Zeinab Hashem, DO  
William Hoskinson, DO  
Perri Huitt, DO  
Cindy Huynh, DO  
Julie Jones, DO  
Stephen Kehres, DO  
Bryan Kelly, DO  
Kevin Kwolek, DO  
Birrilla Maddox, DO  
Hazem Malas, DO  
Patrick Malie, DO  
Joshua Menefee, DO  
Thomas Morris, DO  
Mehjabeen Nasser, DO  
Steven Nemirov, DO  
Sarah Oberste, DO  
Ignatius Ohamadike, DO  
Mary Parrott, DO

Eric Peterson, DO  
Lee Riddle, DO  
Hilda Riderer, DO  
Hannah Robinson, DO  
Zaid Saffo, DO  
Kiren Sahni, DO  
David Santini, DO  
Douglas Sata, DO  
Gurinder Singh, DO  
Manjeet Singh, DO  
Anton Sisante, DO  
Katie Sumnicht, DO  
Jessica Tyler, DO  
Jamie Whitt, DO  
Justine Young, DO  
Kayleigh Zerr, DO  
**Associate Membership:**  
Kasim Kazbay, MD

# AOBIM Seeks General Internist Board Member

The AOBIM has an open Board member position for a general internist. Responsibilities of AOBIM board members include duties ascribed by the AOA in the certification processes of osteopathic physicians, including and setting and testing a standard of excellence. AOBIM board members participate in exam development, item writing and reviewing, and appeals. Participation on the Board requires attendance at in-person meetings (travel expenses are reimbursed by the AOA) and conference calls as needed. Board members receive CME credit for writing items, attending exam-related meetings and administering exams, and honoraria for attending in-person Board meetings. The time commitment is approximately 10 hours per month. Please contact Dan Hart, AOBIM Certification Director, at [aobim@osteopathic.org](mailto:aobim@osteopathic.org) for more information.

**Have You Moved?**  
Keep us updated. If you have recently made any changes in your address, phone number or email, please notify theACOI at [www.acoi.org](http://www.acoi.org).

## An Interview With Robert J. Stomel, DO, MACOI



**Meet Bob Stomel, DO, MACOI**, a Past President of the ACOI and a highly-respected cardiologist for more than 30 years. A graduate of Michigan State University-College of Osteopathic Medicine, Dr. Stomel was a member of a 17-person cardiology group in metropolitan Detroit. He cites ACOI leaders Larry Wickless, DO, David Susser, DO and Gene Oliveri, DO as important mentors to him. In 2008, Dr. Stomel and his wife, Elaine, who is a Cardiac Nurse Practitioner, moved to Prescott, AZ and started the only private cardiology practice in Northern Arizona.

**Ms. Ciconte:** Tell me why you have dedicated your time and

talents to ACOI.

**Dr. Stomel:** I was President of the Michigan Osteopathic Association when I was first invited to serve on ACOI's Council on Education and Evaluation. That experience led me to join the ACOI Board of Directors and serve in 2002-2003 as the College's President. I had the best experience being involved with ACOI because of the great people I worked with on the board and staff. Brian Donadio had just joined the ACOI staff and working with Brian over the years and Susan Stacy made me feel that my time and efforts were valued and appreciated in fulfilling the College's mission.

**Ms. Ciconte:** You are a member of the 75th Anniversary Campaign Committee and have made a generous contribution to the campaign. Why did you agree to serve?

**Dr. Stomel:** Actually, I heard something about a campaign and decided I wanted to make a gift so I called Susan Stacy to find out more about how I could help. That's when I got a call from Larry Haspel about serving on the campaign committee. It's hard to say no to Larry Haspel! It is an honor to serve the College once again.

**Ms. Ciconte:** What do you think ACOI should do and say to encourage members to make a special contribution to this campaign?

**Dr. Stomel:** Without a family of osteopathic medicine, I remember the prejudices DOs faced years ago such as wearing a nametag at a meeting of the American College of Cardiology (ACC) that read "non-physician," or not being able to get on hospital staff. We owe a great deal to Gary Slick and Mike Oipari for their efforts that helped change things.

Now with the single accreditation program going into effect in 2020, I believe ACOI needs to continue to remind members that we are a different group and will be doomed to repeat history if the College does not have the financial resources to continue osteopathic recognition for internal medicine. Younger

DOs may not fully understand the challenges we face since their career experiences have been different from those of us who have been in the field for many decades. I wonder just how many of the younger DOs would have become doctors without the osteopathic profession?

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

**Dr. Stomel:** The College needs to maintain its leadership role in the AOA and other organizations focused on education and training. The ACOI is the only specialty association that has a plan to address the new single accreditation process and its impact on the continuation of osteopathic internal medicine. ACOI must advocate for its members concerning reimbursement and other issues that are important to members.

**Ms. Ciconte:** Dr. Stomel, ACOI is indeed grateful to you for your generosity and leadership for the 75th Anniversary Campaign. Do you have any closing comment you would like to share our readers?

**Dr. Stomel:** The ACOI has always been here for osteopathic internists. As we celebrate our 75th Anniversary, the College should share inspiring stories of who we are, where we've been, and what the future holds to remind members that we are part of a special family. The aftermath of the single accreditation process is not a done deal yet. The possibilities and opportunities that may occur will result from our action on ACOI's initiatives and programs. For that reason, it is important for all of us to pay it forward by making as generous a gift as possible to the 75th Anniversary Campaign now.

# CME CALENDAR

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

### **NATIONAL MEETINGS**

- 2017 Annual Convention & Scientific Sessions  
Oct 11-15 Gaylord National Resort and Convention Center, Washington, DC
- 2018 Annual Convention & Scientific Sessions  
Oct 17-21 Orlando World Center Marriott, Orlando, FL
- 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
- 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](http://www.acoi.org).*

## **2017 Certifying Examination Dates & Deadlines**

### **Internal Medicine Certifying Examination**

Computerized Examination 200 Sites Nationwide  
September 14, 2017 - *Application Deadline: Expired*  
*Late Application Deadline: Expired*

### **Internal Medicine Recertifying Examination**

Computerized Examination 200 Sites Nationwide  
September 15, 2017 - *Application Deadline: Expired*  
*Late Application Deadline: Expired*

### **Subspecialty Certifying Examinations**

Computerized Examination 200 Sites Nationwide  
August 29, 2017 - *Application Deadline: Expired*  
*Late Application Deadline: Expired*

- Cardiology • Clinical Cardiac Electrophysiology • Endocrinology • Gastroenterology
- Geriatric Medicine • Hematology • Hospice and Palliative Medicine • Infectious Disease
- Oncology • Pulmonary Diseases • Rheumatology • Sleep Medicine

### **Subspecialty Recertifying Examinations**

Computerized Examination 200 Sites Nationwide  
August 29, 2017 - *Application Deadline: Expired*  
*Late Application Deadline: Expired*

- 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](mailto:admin@aobim.org); 312 202-8274.*

*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.*

## **Science & Education**

*continued from page 5*

glucose monitoring, and effective doses of multiple glucose-lowering agents including insulin.”<sup>1</sup>

When the researchers stratified the results by prescription, they found the following proportions of people that potentially were being over treated:

- On sulphonylureas: 35% of participants
- On insulin: 24% of participants
- On a combination of sulphonylureas and insulin: 16%

The researchers concluded that overtreatment of type 2 diabetes in elderly people was common, even within people with CKD and dementia. The researchers have noted in the study that it is ‘potential overtreatment.’

It should also be noted that some people with type 2 diabetes may lose the ability to produce sufficient insulin as a result of having uncontrolled type 2 diabetes for many years. In these people, insulin therapy may be necessary.

In terms of sulphonylureas, there are questions whether their usage, or the dose being used, is appropriate as these drugs can lead to hypoglycemia. This can be particularly problematic in people that have conditions such as CKD and dementia

I hope you’ve found this month’s Talking Science and Education interesting and useful. As always, feel free to write me with topics of Interest at [don@acoi.org](mailto:don@acoi.org).

1. *American Diabetes Association Diabetes Care* 2015 Jan; 38(Supplement 1): S33-S40.

<https://doi.org/10.2337/dc15-S009>