

From President Bulger Two Epidemics - One Sudden, One Stealthy



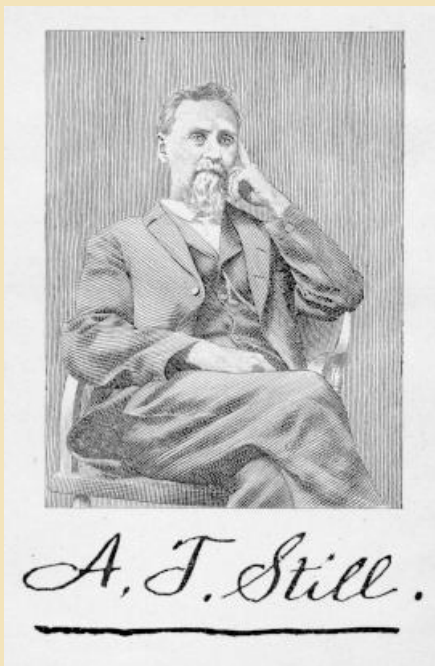
We tend to get caught up in the day-to-day routine and do not always think about our important role in the communities that we serve. Current events have a way of offering

perspective. The latest loss of life in Orlando is one example. The suddenness and the scale bring instant recognition. For me, it highlighted two significant public health issues facing our nation: the ability for one person to inflict harm on many of their community members; and the epidemic of prescription opioid abuse. One of these is an immediate flash point, the other more covert.

As physicians, we are charged with improving the health of the people and populations that we serve. To accomplish this, we need valid and

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ACOI Planning Process Focuses On Osteopathic Distinctiveness



As the ACOI celebrates its 75th year of existence, external events are playing a prominent role in how the future will unfold. For most of its past, the College has focused on the education of internists from residency throughout the years of practice. A concerted effort initiated by the College leaders in the early part of this century resulted in dramatic growth of the number and quality of osteopathic internal medicine and graduate medical education programs. There are now four times as many trainees in osteopathic programs as there were 15 years ago.

The decision by the American Osteopathic Association to give up its authority to approve GME programs in favor of a single accredita-

tion system means that the ability of the ACOI to influence the postdoctoral training of DO internists will be sharply curtailed, if not eliminated. During this period of rapid growth in GME, the ACOI has continued to focus on the continuing medical education (CME) that is so vital to its members' ability to keep abreast of the rapid advances in medical knowledge.

Over the same 15-year period, the number of credits offered have doubled and learners reached per year have increased from approximately 500 to more than 2000. Member satisfaction with the CME offerings has been strongly favorable.

Even without the GME accreditation evolution that will be completed by 2020, the ACOI Board of Directors would be engaged in regular strategic planning discussions to move the College forward. The impact of the single accreditation system has pushed these discussions into a higher gear. Beginning in June, 2015, the Board embarked on a process known as continuous planning. This means that facilitated planning discussions are taking place at least twice a year and will continue for the foreseeable future. The focus of these discussions has been on identifying a vision of the ACOI beyond

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**ACOI Annual Convention
& Scientific Sessions
October 27-31 • Palm Desert, CA
Registration available in July!**



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

2015-2016 OFFICERS

John B. Bulger, DO, MBA, FACOI.....President
jbulger@geisinger.edu

John R. Sutton, DO, FACOI.....President-Elect
suttonendo@msn.com

Martin C. Burke, DO, FACOI.....Secretary-Treasurer
mburke@medicine.bsd.uchicago.edu

Judith A. Lightfoot, DO, FACOI.....Immediate Past-President
jlightfoot@gsida.org

Rick A. Greco, DO, FACOI.....Past-President
donotsmoke@msn.com

2015-2016 BOARD of DIRECTORS

Michael A. Adornetto, DO, MBA, FACOI...maadornetto@aol.com

Robert A. Cain, DO, FACOI.....robert.cain62@icloud.com

Annette T. Carron, DO, FACOI.....acarron@bostford.org

Robert L. DiGiovanni, DO, FACOI...robdsimc@tampabay.rr.com

Scott L. Girard, DO, FACOI.....grrdscet@yahoo.com

Robert T. Hastly, DO, FACOIrhastly@campbell.edu

Mitchell D. Forman, DO, FACOI...mitchell.forman@tun.touro.edu

Joanne Kaiser-Smith, DO, FACOI.....kaiserjo@rowan.edu

Samuel K. Snyder, DO, FACOI.....snyderdo@nova.edu

Christopher Sciamanna, DO, Resident Rep...csciamanna@gmail.com

STAFF

Brian J. Donadio, FACOI.....Executive Director
bjd@acoi.org

Timothy W. McNichol, JD.....Deputy Executive Director
tmnichol@acoi.org

Donald S. Nelinson, PhD.....Chief Science & Education Officer
don@acoi.org

Susan B. Stacy, FACOI.....Finance/Administration Director
susan@acoi.org

Christina A. (Smith) Perando.....Postdoctoral Training Specialist
christy@acoi.org

Keisha L. Oglesby.....Senior Member Services Specialist
keisha@acoi.org

Katie E. Allen.....Member Services Specialist
katie@acoi.org

Claudette Jones.....Executive Assistant
claudette@acoi.org

Melissa R. McConnell...Member Services/Development Program
melissa@acoi.org

Ellen J. Donadio.....Website/Graphic Design
ellen@acoi.org

11400 Rockville Pike

Suite 801 • Rockville MD 20852

301 231-8877 • 800 327-5183 • Fax 301 231-6099

acoi@acoi.org • www.acoi.org

Letter from the President

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reliable data about the status of the community. Our ability to have this information regarding gun violence is blunted by the inability to robustly study the problem. What we know is that some members of our community will think or act irrationally for biologic, psychologic, and sociologic reasons. Those people have readily available means to harm themselves and others. Whether the risk of that availability outweighs the benefit of the availability is a public health question. Said another way, whether the risk of the availability of semi-automatic weapons and large capacity magazines outweighs the benefits to our society is a public health issue. As physicians, it is our duty to engage in this discussion.

The other issue, which we sometimes are not as focused on since its upswing has been more insidious, is the rise in deaths from overdoses of prescription drugs. The latest CDC data suggest that more than 50 people die every day from prescription opioid overdoses. Think about that number. These deaths are from drugs that need a physician or other healthcare provider's prescription. That is not to say that there aren't a host of other ways that these drugs are procured, but we control the majority of the pipeline. Physicians need to lead the solution. As with any improvement endeavor, hard work, education, and diligence play a role; but we need to hardwire solutions if we expect meaningful change. This will include placing limits on our prescribing, using alternatives that will require us to educate our patients, and diligently checking all prescriber databases prior to prescribing.

When we received our degrees, we were granted all of the privileges and responsibilities that come with them. The greatest of these responsibilities is doing no harm to the patients and populations that we serve. Speaking with one voice to combat these two epidemics--- one sudden, one stealthy--- is imperative.



government RELATIONS

Timothy McNichol, JD

Supreme Court Sends ACA Challenges Back to Lower Courts

Without expressing any “view on the merits the case,” the Supreme Court sent cases challenging the contraceptive coverage requirement of the Affordable Care Act (ACA) back to the lower courts for additional consideration. The Court signaled to the federal appeals courts that the parties may be able to achieve a compromise that would make the Court’s involvement unnecessary. Religious nonprofit organizations contend that the requirement to submit notice to their insurers or the government of their objection to provide contraceptive coverage in essence triggers the very coverage they object to in violation of their sincerely held beliefs protected by the Religious Freedom Restoration Act (RFRA). The Court heard oral arguments in March encompassing seven separate cases. It is likely the Court took this action to avoid a 4-4 split that would result in different rules depending on the jurisdiction in which the parties are located.

Zika Funding Measures Approved in the House and Senate

The House and Senate approved separate measures to provide emergency funding for Zika virus response and preparation. The Senate measure includes \$1.1 billion in funding, almost double the amount provided for in the House package. In a statement of Administrative Policy, the Administration announced its opposition to the House bill, calling it “woefully inadequate.” House and Senate negotiations are ongoing. With the summer months approaching, it is likely some form of compromise will be reached.

Final Rule Implements Nondiscrimination Provisions of the ACA

A final rule was published by the Department of Health and Human Services Office for Civil Rights implementing a provision of the ACA which prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs or activities. The nondiscrimination protections are extended to individuals participating in: any health program or activity which receives funding from HHS; any health program or activity that HHS itself administers; and Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces. You can learn more about the final rule and nondiscrimination provisions of the ACA by visiting <http://www.hhs.gov/civil-rights/for-individuals/section-1557>.

New Medicare Physician Payment Data Made Available

The Centers for Medicare and Medicaid Services (CMS) posted updated data on Medicare payment for Part B services and procedures provided to beneficiaries by physicians and other healthcare providers. This is the third release of the Physician and Other Supplier Utilization Payment Public Use data set. The data includes payments and submitted charges by over 986,000 distinct health care providers. According to CMS, the data represents \$91 billion in Medicare payouts. You can access additional information on this program at www.cms.gov.

Alternative to ACA Legislation Introduced

In a lead-up to the political season, Republicans in the House and Senate announced legislation to serve as an alternative to the ACA. Under the proposal, every individual would be eligible for a tax benefit of up to \$2,500 and an additional \$1,500 tax benefit per dependent minor. While it is unlikely that this legislation will be considered and sent to the President for signature, it is a benchmark for additional discussion as the 2016 election season heats up.

Uninsured Rate Drops in 2015

According to a recently released report by the Centers for Disease Control (CDC), 7.4 million fewer people were uninsured in 2015 than in 2014. The uninsured number fell to 28.6 million, or 9.1 percent. This is down from 36 million, or 11.5 percent in 2014.

The report also found that adults 25-34 years of age were more than twice as likely to lack insurance coverage as those who are 45-64 years of age. You can view the report in its entirety by visiting www.CDC.gov.

FTC Releases Web-Based Tool to Assist with Mobile Health App Development

The Federal Trade Commission (FTC) released an interactive web-based tool to assist developers of health care-related apps obtain guidance on the applicability of certain federal laws. While the tool is not intended to constitute legal advice about all compliance obligations, it will give a developer a snapshot of a few important laws and regulations from three federal agencies. Specifically, the tool walks the user through a series of high-level question to consider the applicability of the Health Insurance Portability and Accountability Act, the Federal Food, Drug, and Cosmetic Act, the FTC Act, and the FTC’s Health Breach Notification rule. You can access the tool at <https://www.ftc.gov/tips-advice/business-center/guidance/mobile-health-apps-interactive-tool>.

Washington Tidbits Political Symbolism

As the race for the White House continues to march toward the Republican and Democratic nominating conventions, which will take place later this summer in Cleveland, Ohio and Philadelphia, Pennsylvania, the symbolism of the elephant and donkey are as strong as ever. Where exactly did the symbols come from?

The symbol of the donkey dates back to 1828 when opponents of Andrew Jackson called him a jackass. Jackson, amused by the label, began using an image of a donkey in his campaign posters and went on to defeat incumbent John Quincy Adams, thus becoming the first Democratic president. The Republican Party was formed in 1854 with its first candidate, Abraham Lincoln, ascending to the White House in 1861. An image of an elephant was used in a political cartoon during the Civil War when “seeing the elephant”

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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 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.

Prepare for the End of “Close Enough” Coding

I have been asked several times in the past couple of weeks what will happen on October 1 with ICD-10 coding. Prior to the implementation of ICD-10 coding in 2015, the Centers for Medicare and Medicaid Services (CMS) issued a two-page document indicating that for the first 12 months of ICD-10 implementation, claims billed under the Part B physician fee schedule through either the automated medical review or complex medical review processes would be evaluated based on whether the physician/practitioner used a valid code from the correct family of codes. This process was to be adopted by the Medicare Administrative Contractors, the Recovery Audit Contractors, the Zone Program Integrity Contractors and the Supplemental Medical Review Contractors. As a result, there has been some leeway in the selection of diagnosis codes.

CMS stated, “for all quality reporting completed for the Program Year 2015 Medicare clinical data review contractors will not subject physicians to... penalty during primary source verification or auditing related to the additional specificity of the ICD-10 diagnosis code, as long as the eligible professional (EP) used a code from the correct family of codes. Furthermore, an EP will not be subject to a penalty if CMS experiences difficulty calculating the quality scores for Physician Quality Reporting System (PQRS), Value-Based Modifier (VBM) or Meaningful Use due to the transition to ICD-10 codes.” The only exception noted was if there was a specific CMS policy listing a specific payable diagnosis.

As discussed in prior columns, “close enough” meant “good enough.” As long as you identified that the patient had a muscle strain, which arm did not need to be part of the code selected. If your code showed that a patient had abdominal pain, it did not matter where the pain was located. If you coded that a patient had asthma, coding for unspecified asthma was sufficient. This general coding will be changing and preparation is essential.

Many of the electronic health record (EHR) software uses General Equivalence Mapping (GEMS) or other cross-walking programs to aid you in the transition to ICD-10. CMS indicated that the GEMS are a tool for converting ICD-9 data to ICD-10. Confidence in the use of GEMS is evidenced by CMS stating that GEMS are, “a comprehensive translation dictionary that can be used to accurately and effectively translate any ICD-9 data, including data for tracking quality, calculating reimbursement and convert-

ing to ICD-10 codes for use with payment systems.” However, caution must be used when cross-walking. Software is limited if the provider knows more about a patient's illness and does not use the information. The data is lost if the ICD-9 code previously selected was non-specific when using cross-walking software. Perfect software would include the choices in the “family” of codes to show the provider what he or she might not have realized could be reflected in the code selection. For example, in ICD-9 codes for asthma, there is intrinsic, extrinsic, chronic obstructive and unspecified asthma. Converting intrinsic or extrinsic asthma from ICD-9 to ICD-10, may result in a code for Mild Intermittent Asthma. But there are five different “severity levels” of asthma in ICD-10-CM. In checking with pulmonologists, they indicate that patients with intrinsic or extrinsic asthma, may have a more severe form of asthma, such as severe persistent and not the mild intermittent. Using the cross-walking software, you are lulled into a false sense of security that you have an “equivalent” code. Some software I have used will crosswalk intrinsic asthma to the unspecified asthma code in ICD-10, which creates additional problems. The other two diagnoses I used above as examples also code to either unspecified codes, or ones with a specificity that may not be what you intended.

So what to do? First, have a list of your most frequently utilized ICD-10 diagnosis codes created for your review. Look at it and compare it with your ICD-9 list from before the transition. You should be able to spot the incon-

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talking science & education

Donald S. Nelinson, PhD

Welcome to this month's edition of Talking Science and Education. I've certainly enjoyed working with many of our residency programs on your Osteopathic Recognition (OR) applications with ACGME. I will try to use this column to address issues or clarify some confusion regarding the OR applications. I have learned that some program directors are under the impression that the OR applications are under the same timeline as the ACGME application. This is not the case. Programs may apply for OR at any time during the transition to the single accreditation system (deadline July 1, 2020), or at any time after that date. There is no specific deadline for OR. However, programs are encouraged to apply at the same time as their Pre-accreditation application due to the overlap and synergies in the two applications. As always, if you have questions or need help, please don't hesitate to contact me at ACOI.

Revisiting the Mechanisms of Neuropathic Pain

Neuropathic pain presents itself in many forms in both general internal medicine practices, as well as in subspecialty practices. Considering this, I thought in this month's Talking Science and Education we could revisit the underlying mechanisms of neuropathic pain as nicely described in a recent review article published in *Neuron* by the groups of Yves de Koninck, PhD and Steven Prescott, MD, PhD at the Laval University, Quebec, Canada and the Hospital for Sick Children, Toronto, Canada, respectively. The article highlights the need to better target treatments for chronic neuropathic pain. Individuals experiencing chronic pain with neuropathic characteristics account for 7-8% of adults and report higher pain levels than patients with non-neuropathic chronic pain.

Altered potassium-chloride co-transporter (KCC2) function leads to dysregulation of intracellular chloride (Cl⁻) levels, which severely affects inhibitory signals normally blocking pain transmission. This results in hyperexcitability of spinal neurons transmitting pain signals, causing neuropathic pain. A recent study from the Prescott laboratory shows that alterations in KCC2 function, although impacting inhibition of both excitatory pain-producing and inhibitory pain-reducing neurons, results in low levels of excitation, which, through spatial summation results in supra-threshold excitation, thus producing allodynia.

Disrupted inhibition of excitatory vs inhibitory spinal neurons causes much more dramatic effects, as the former neurons themselves receive excitatory signals, which are unmasked in the absence of inhibition. This phenomenon underlies nociceptive sensations elicited by normally painless touch.

A number of other ion channels have also been implicated in hyperexcitability of pain-producing neurons. Current pharmacologic interventions for neuropathic pain aim at reducing hyperexcitability of pain-producing neurons. However, these target single ion channels, and have therefore proved largely ineffective. Studies like those conducted in the laboratories of Drs Prescott and De Koninck, investigating precise mechanisms of spinal neuronal excitability, will contribute to designing adequate treatments for neuropathic pain

targeting all implicated ion channels, dysregulation of which affects pain signal transmission. The neuroscience geek in me really enjoys this stuff!

Diabetes Dialogues

An interesting study out of Sweden examining the varying safety of add-on, second line treatments for type 2 diabetes (T2DM) was published on June 10th in *Diabetes, Obesity and Metabolism*. The researchers found that patients with T2DM who are taking metformin, the risk of cardiovascular events and mortality varies with the addition of different second-line therapies.

Nils Ekström, M.D., Ph.D., from the University of Gothenburg in Sweden, and colleagues examined the relative safety of glucose-lowering agents as add-on medication to metformin in T2DM. Patients on metformin therapy who started another agent were eligible for inclusion; data were obtained for 20,422 patients during the period of 2005 to 2012.

The researchers found that 43, 21, 12, 11, 10, 1, and 1 percent of patients started on second-line treatment with sulfonylurea (SU), basal insulin, thiazolidinedione (TZD), meglitinide, dipeptidyl peptidase-4 inhibitor (DPP-4i), glucagon-like peptide-1 receptor agonist (GLP-1), and acarbose, respectively. The risk of mortality was higher for basal insulin and lower for TZD compared with SU (hazard ratios, 1.18 and 0.76, respectively). Significantly lower risks of cardiovascular disease, fatal cardiovascular disease, coronary heart disease, fatal coronary heart disease, and congestive heart failure were seen for DPP-4i.

The investigators state: "This nationwide observational study showed that second-line treatment

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Talking Science

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with TZD and DPP-4i as add-on medication to metformin were associated with significantly lower risks of mortality and cardiovascular events compared with SU, whereas basal insulin was associated with a higher risk of mortality.”

Ekström N, Svensson AM, Miftaraj M, Franzén S, Zethelius B, Eliasson B, Gudbjörnsdóttir S. Cardiovascular Safety of Glucose-Lowering Agents as Add-on

Medication to Metformin Treatment in Type 2 Diabetes: Report from the Swedish

National Diabetes Register (NDR). *Diabetes Obes Metab*. 2016 Jun 10. doi: 10.1111/dom.12704. [Epub ahead of print] PubMed PMID: 27282621.



New Members Welcomed

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

Active Membership

Alex W. Armour, DO
Kyle M. Bennett, DO
Joseph T. Candelore, DO
Julia A. Cherkasova, DO
Braden F. DeLoach, DO
Charles O. Duncan, DO
Valena N. Fiscus, DO
Ashley L. Gabbard, DO
Brandon D. Greene, DO
Sherry Penland Ismatov, DO
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Erlin J. Marte, DO
Wilbur N. Montana, DO
Rajan Narula, DO
Chelsea A. Nickolson, DO

April L. Nofzinger, DO
Richard R. Rattin, DO
Jason B. Reese, DO
Rachel Hughes Schwartz, DO
Kelly S. Sprawls, DO
Anthony Tran, DO
Harpreet K. Tsui, DO
Cynthia M. Vakhariya, DO
Tyler D. Warner, DO
Lily W. Wong, DO

Associate Membership:

Faheem Ahmad, MD
Eugenio Angueira, MD
Camelia Chirculescu, MD
John T. Dedousis, MD
Khaled M. Ismail, MD
Herbert Patrick, MD

Government Relations

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was an expression used by soldiers in reference to having seen combat. It was not until the 1870s that political cartoonist Thomas Nast used both the donkey and the elephant to symbolize the Democratic and Republican parties. Other cartoonists followed suit shortly thereafter cementing the images of the two parties. Not only is Thomas Nast credited with establishing these party symbols and bringing them into the mainstream, the German-born artist is also credited with creating the image of the modern-day Santa Clause.

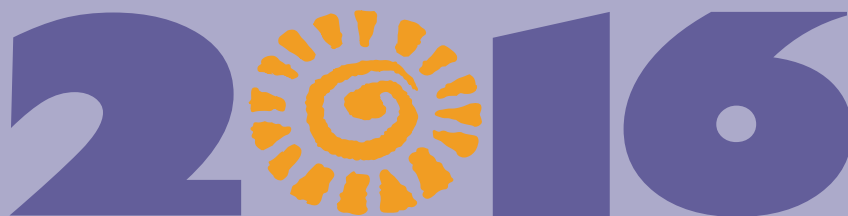


Coding Corner

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sistencies mentioned above. Next, have your staff generate a list of your top 100 utilized codes. From this list, look at those that say unspecified and take just a moment to ask yourself if you knew more than was reflected by the code used. If so, look at an ICD-10 book so you can see the choices. While this analysis may take a bit of time, we have no guidance from CMS as to what they will be doing differently. Will they allow only “unspecified” codes for three consecutive encounters with a patient? Will they deny unspecified codes all together? We simply do not know at this point in time, yet we must still try to prepare.

The language of the one-year moratorium states that it applies to “either automated medical review or complex medical review” processes. That seems to indicate that your claims will be paid no matter what the diagnosis specificity, but it matters later when reviews/audits are done and the need for specificity is enforced. As such, you may not know that there is a problem until a review is done. So be proactive and be specific!



ACOI Annual Convention & Scientific Sessions
October 27-31 • Palm Desert, CA • Registration available in July!

Member Milestones



Mia Taormina, DO, FACOI, an infectious disease and travel medicine specialist,

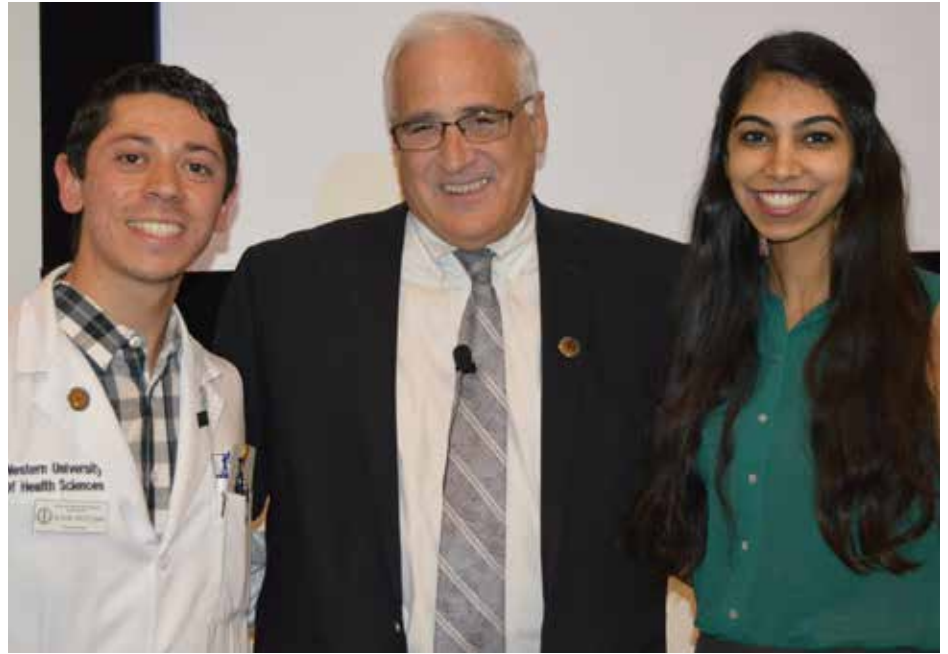
and the Chair of the Department of Infectious Diseases at DuPage Medical Group in Illinois, was featured in an ABC news story on the Zika virus. Dr. Taormina is a member of the ACOI CME Committee and education chair for the Infectious Diseases subspecialty section of the College. On the ACOI's recommendation, she was selected by the AOA for media outreach on Zika and other issues. You can view the ABC News feature at the following link: <http://abcnews.go.com/Travel/threat-zika-virus-forces-shift-summer-travel-plans/story?id=39332404>.



Karen J. Nichols, DO, MACOI, was installed earlier this month as the President of the Insti-

tute of Medicine of Chicago. Dr. Nichols, who is Dean of the Midwestern University College of Osteopathic Medicine, is the first DO to be elected to the IOM of Chicago Board of Governors. She is a past president of both the AOA and ACOI.

Our Visiting Professor Program in Action



David F. Hitzeman, DO, MACOI conducted a visiting professor program at Western University COM-Pomona this spring for COMP students and internal medicine faculty. Special thanks to SOIMA co-Presidents **Priya Patel** and **Byron Rastegari** and to **Dr. Airani Sathananthan**.



PROFESSIONAL OPPORTUNITIES

PRIMARY CARE PHYSICIAN, SILICON VALLEY, CA - Santa Clara Valley Medical Center, a public teaching hospital, affiliated with the Stanford University School of Medicine, located in the heart of Silicon Valley, CA is seeking a BC/BE Internal Medicine-primary care physician to join our dynamic, growing, nurturing Department. Please submit a letter of intent and CV to roya.rousta@hhs.sccgov.org. Equal Opportunity Employer.

Have You Moved?

Keep us updated.

If you have recently made any changes in your address, phone number or email, please notify the ACOI.

www.acoi.org

Cardiologist Finds Value to Patients in ACOI Education Programs

(This is one in a series of interviews with ACOI members who are strongly committed to the College and why they believe it has made a difference in their lives. This series is presented by Barbara L. Ciconte, CFRE, Development Counsel to ACOI.)



Please meet **Pamela Gardner, DO, FACOI, FACC**. Dr. Gardner, is a board-certified cardiologist at Lima Memorial Heart Institute of Northwest Ohio and Lima Memorial Hospital. She serves as the division chief of Cardiology, the director of Lima Memorial's Congestive Heart Failure Clinic, and the Chief of Lima Memorial's Structural Heart program. In addition, she is an associate professor at the University of Toledo. Dr. Gardner is a member of the 75th Anniversary Circle and regularly attends ACOI Annual Conventions and other educational programs.

Ms. Ciconte: Tell me why you value your ACOI membership.

Dr. Gardner: I especially value the high quality of ACOI's educational meetings because the speakers offer good and timely information that I find very helpful to my work. Given my responsibilities to my patients, I must be certain that the time I take away from them is worthwhile. Unlike some other medical

educational meetings I have attended in the past, I always feel that my patients will benefit from my attending ACOI educational meetings.

Ms. Ciconte: How can ACOI continue to serve its members in the future?

Dr. Gardner: With the new single accreditation program, I would like to see the ACOI marry allopathic and osteopathic information as best they can in order to make the transition more seamless and painless. I had a personal experience when trying to become certified in heart failure by the Heart Failure Society. Because osteopathic internal medicine did not have an exam in this area and I had not done any allopathic rotations, I was not allowed to take the allopathic boards to be certified in this cardiac area. I believe with this merger, it will be very important that ACOI has strong leaders on staff and the Board representing us.

Ms. Ciconte: In addition to participating in ACOI educational programs over the years, you have made financial contributions to ACOI over and above your dues. Tell me what motivates you to give and what motivated you to join the 75th Anniversary Circle at last year's Annual Convention.

Dr. Gardner: I believe it is very important to give back to the College. I was a nurse for 27 years before I went to an osteopathic medical school. I am here today because of the others who mentored and supported me in my pursuit to become a DO. As a mentor to pre-med students, I help them understand the time commitment they will need to make to become a doctor. However, I also tell them that there is no greater feeling than seeing a patient you have helped get better.

Ms. Ciconte: What can ACOI do to encourage other ACOI members to give?

Dr. Gardner: I believe it is every member's responsibility to support the College in some way. It is important to show members where their contributions are being used. ACOI won't be able to grow and address the issues it faces in the future if it doesn't have the additional resources needed.

Ms. Ciconte: Dr. Gardner, ACOI thanks you for your generous support as a member of the 75th Anniversary Circle that helps the College educate and train both the current and next generation of osteopathic medicine internists.

Giving ACOI Your IRA Can Avoid Taxes

Q. I have an IRA and have been told that I should plan to leave it to charity rather than to my family. Why is that?

A. If you have other assets that you can leave to your family, it would be better to give your IRA to ACOI because that way it will not be reduced by taxes.

Q. Why is an IRA reduced by taxes?

A. When you make payments into your IRA, they are tax-sheltered and the fund grows tax free. When payments are made to you when you retire, they are taxed as ordinary income. At your death, there is a special tax on what is left in your IRA to "recover" what would have been paid to you. This is called a tax on Income in Respect to a Decedent (IRD) and it imposed on what remains in your IRA account. But by leaving your IRA to a charity like ACOI, this tax is not imposed. As a result, everything that's left in your IRA will go on to help keep ACOI strong for future generations of Osteopathic Internists.

Q. How can I learn more?

A. Call Tim McNichol at ACOI or ask for free literature that explains IRA gifts and others.

Financial Planning Materials Available

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

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

Email Katie Allen at Katie@acoi.org to request the new pamphlets or any of the following titles:

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



CME CALENDAR

Future ACOI Education Meeting Dates & Locations

NATIONAL MEETINGS

- 2016 Annual Convention & Scientific Sessions
Oct 27-31 JW Marriott Desert Springs Resort and Spa, Palm Desert, CA
- 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
- 2019 Annual Convention & Scientific Sessions
Oct 30- Nov 3 JW Marriott Desert Ridge Resort & Spa, Phoenix, AZ
- 2020 Annual Convention & Scientific Sessions
Oct 21-25 Marco Island Marriott Beach Resort, Marco Island, FL

Please note: It is an ACOI membership requirement that Active Members attend the Annual Convention or an ACOI-sponsored continuing education program at least once every three years.

Information on any meeting listed here may be obtained from ACOI Headquarters at 800 327-5183 or from our website at www.acoi.org.

2016 Certifying Examination Dates & Deadlines

Internal Medicine Certifying Examination

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

Subspecialty & Certification of Added Qualifications:

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

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

Internal Medicine Recertifying Examination

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

Focused Hospital Medicine Recertification

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

Subspecialty and Added Qualifications Recertifying Examinations:

Aug. 20, 2016 • Lombard, IL

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

Application Deadline: Expired

Late Registration Deadline: Expired

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

ACOI Planning

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2020. The Board has spent much of this time trying to identify what is distinctive about osteopathic internal medicine.

The ACOI believes that DO internists share a common approach to health and healthcare that: begins with compassion, listening and a deep desire to understand; focuses on health first (not disease first); embraces the whole patient; views and considers each patient individually; emphasizes empathy; includes a 21st century way of incorporating the four tenets of osteopathic medicine, and recognizes and honors the inter-relatedness of structure and function at both the micro and macro levels.

It is recognized that other physicians and healthcare providers embrace many of these approaches, but the ACOI believes that the combination of these traits is what distinguishes osteopathic internists from all others.

Because of the AOA transition away from GME accreditation, the ACOI will focus in the future on incorporating these elements into our continuing education programs. The content of the programs will continue to include the latest advances in the art and science of medicine provided by the most qualified faculty. All presenters will be asked to keep in mind the distinctive concepts above and incorporate them into their presentations.

As the College embarks on its next 75 years, the Board sees an opportunity to return to the roots and traditions of osteopathic medicine in a thoroughly 21st Century way. Internists have long been the leaders in osteopathic education and the ACOI is ready to meet this challenge. More information about the ACOI's vision for the future will be shared as the planning process continues. Member views on these issues are welcome and should be addressed to Executive Director Brian J. Donadio (bjd@acoi.org).