

From President Bulger Collaboration In a New Age



Teamwork has been an essential part of medicine in the 21st century. Atul Gawande has noted that the “volume of knowledge and skill has exceeded our

individual capabilities.” This is why it is important for physicians to understand the dynamics of teamwork and collaboration.

In the same vein, the ACOI’s success depends more and more on our ability to partner with other organizations. Some of these are traditional collaborators like the American Osteopathic Association and other osteopathic specialty organizations. Some examples of this are our participation in OMED and work in committees that strengthen the

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Certificate Program in Healthcare Leadership And Management Registration Now Open

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

Registration is now open for the eight-month long Health Care Leadership and Management Program (HCLMP). Sessions begin in July, 2016, and are built on an asynchronous learning model. Participants will access online modules utilizing the most advanced distance learning tools available. This allows participation when it is most convenient for a busy practicing physician. The learning experience is expanded through ongoing peer-to-peer interaction utilizing a threaded online

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Resources to Assist Training Programs With ACGME Osteopathic Recognition

The ACOI Board of Directors has determined that the most important priority for the College right now is to assist its training programs with achieving ACGME accreditation and osteopathic recognition. Staff has been hired and is ready to provide a number of support services including, but not limited to:

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

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

In addition, the agenda for the Annual Trainer’s Congress (May 5-7, Savannah, GA) will focus almost exclusively on ACGME accreditation and osteopathic recognition.

The ACOI welcomes the opportunity to assist programs in the weeks ahead. For further information, please contact ACOI’s Chief Science and Education Officer, Don Nelinson, PhD (don@acoi.org; 201-323-5327).

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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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continuum of osteopathic education. Our 2017 Annual Convention will be co-hosted with the American College of Osteopathic Surgeons.

The ACOI has had a wonderful collaborative relationship with the American Osteopathic Board of Internal Medicine that has manifested itself in educational programs for our members and improved care for the patients and populations that we serve. As times change, and the practice of medicine becomes more complex for our members, the ACOI's partners evolve as well.

For several years, the ACOI has sustained a relationship with the American College of Physicians while maintaining a dialogue on topics of mutual interest. This partnership includes reduced dues for those who are members of both organizations. With the advent of the Single Accreditation System for graduate medical education, the ACOI and the American Association of Colleges of Osteopathic Medicine (AACOM) have been exploring ways to work together to improve education for osteopathic residency trainers and prepare MDs for potential entry into osteopathic residencies. The ACOI is also working to ensure that every one of our current programs becomes ACGME accredited and has the opportunity to gain osteopathic recognition. This offers further avenues for collaboration with AACOM and with the Association of Osteopathic Directors and Medical Educators.

Additionally, we are reaching out to other academic resources such as the Alliance for Academic Internal Medicine (AAIM). Over the years, many of our members have interacted with AAIM, but this is new ground for the ACOI. The relationship already has begun to bear fruit as we have been invited to participate in the Education Advisory Board for Internal Medicine. This important body includes representatives from all of the major internal medicine players, such as ACP, ABIM, ACGME, AMA, the Society for Hospital Medicine and others. Furthermore, we are looking to find ways to partner with members of the Council of Medical Specialty Societies for joint education of our collective members.

Teamwork is important when we are directly caring for our patients. Increasingly, it is important as we look to find ways to provide the services that our members need to care for the patients and populations that they serve. Along the way, we will continue to partner with old friends and pursue exciting, new, valuable partnerships.



government RELATIONS

Timothy McNichol, JD

House Fails to Override ACA Repeal Legislation

Following the President's veto of legislation to repeal provisions of the Affordable Care Act (ACA), the House failed to secure enough votes to override the veto. The House fell well short of the necessary two-thirds majority vote needed to override. As the race for the White House and House and Senate seats heats up, it is certain that the ACA and a potential repeal will remain a central topic on the campaign trail.

FDA Commissioner Confirmed

The Senate confirmed the nomination of cardiologist Robert Califf, MD, to serve as Commissioner of the Food and Drug Administration (FDA) by a bi-partisan vote of 89 to 4. Dr. Califf is a researcher who joined the FDA in January of 2015. Prior to his confirmation as Commissioner, he served as Deputy Commissioner for Medical Products and Tobacco. His confirmation was delayed as a result of "holds" placed on his nomination by Senators looking to make political and policy statements. The reasons stated for the holds included Dr. Califf's prior ties to the pharmaceutical industry, as well as the FDA's approval process for opioid painkillers. Dr. Califf's successful nomination fills a position that was vacant since February 2015, when Dr. Margaret A. Hamburg resigned.

CBO Projects Increased Federal Spending for Major Healthcare Programs

According to a report released by the non-partisan Congressional Budget Office (CBO), healthcare outlays will increase by 11.1 percent (\$104 billion) in 2016. As a result, federal outlays for Medicare, Medicaid and other major federal health programs will total \$1.1 trillion in 2016. This represents an increase from \$1 trillion (5.8 percent of Gross Domestic Product (GDP)) in 2015. The report estimates that federal spending on major healthcare programs will see an average growth of nearly six percent per-year between 2016 and 2026, with spending reaching \$2 trillion, or 7.4 percent of GDP, by the end of this period. Medicare spending, alone, is estimated to reach \$1.3 trillion or 4.7 percent of GDP by 2026. You can view the entire report at www.CBO.gov.

Medicare Tries to Reduce Readmissions for Minorities

The Centers for Medicare and Medicaid Services (CMS) Office of Minority Health recently released a guide to help hospitals reduce preventable readmissions among racially diverse Medicare populations. The guide addresses discharge planning, limited English proficiency and other key areas affecting readmissions for minority populations. The publication is available at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf.

12.7 Million Enrolled in ACA Marketplace Coverage

According to a report released by the Department of Health and Human Services (HHS), approximately 12.7 million individuals enrolled in ACA marketplace plans for 2016. In releasing the report, HHS Secretary Burwell stated, "The marketplace is growing and getting stronger and the ACA has become a crucial part of healthcare in America." According to HHS, the released enrollment numbers included more than four million new enrollees. As previously noted, the ACA and its provisions will continue to be part of the political dialogue for much of 2016 and beyond. The increasing number of Americans covered under various provisions of the ACA continues to grow, complicating the efforts of those interested in repealing the legislation in its entirety. The ACOI will continue to monitor this matter closely.

Legislation Impacting E-Cigarette Packaging Signed into Law

Legislation was signed into law requiring packaging of liquid nicotine containers to be subject to the Consumer Product Safety Commission's standards and testing procedures. The standards require special packaging that is difficult for children under five years of age to open or access harmful content. Under the recently-enacted law, the packaging requirement must be treated as a standard for the special packaging of household substances under the Poison Prevention Packaging Act of 1970. The law applies to any form of chemical nicotine. The legislation was approved by both the House and Senate on a bipartisan basis with no objections.

Washington Tidbits Home to Congress the Supreme Court and Much More....

The history of the U.S. Capitol Building is one of construction, destruction, repair and expansion. The building, with the cornerstone laid by President George Washington on September 18, 1793, is traditionally viewed as home only to Congress. However, its long history has seen it serve many roles. In its early years, the building housed the Supreme Court, the Library of Congress and even courts for the District of Columbia. It also played a unique roll during the Civil War of which few are aware.

The Capitol was set ablaze by British forces on August 24, 1814. It would have been completely destroyed but for a heavy rainstorm that moved through the area dowsing the fire. Repairs and expansion followed until construction was placed largely on hold in 1861 due to the war raging between the North and South. It was at this time that the Capitol building was put to use as a hospital, military barracks and bakery. In fact, 20 ovens were constructed in the basement of the building to provide bread for thousands of soldiers housed at the Capitol and throughout the city. The Capitol Building has played a critical role in the history of our Nation, well beyond being home to the House and Senate.



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.

Crosswalking and Unspecified Codes in ICD-10 Are Worthy of Extra Attention

Although many of the coding software packages that work with electronic health records (EHRs) crosswalk your ICD-9 diagnosis codes over to ICD-10 diagnosis codes, please do not trust the computer software. The process of “crosswalking” codes is good in theory, but you as the clinician still need to verify that the diagnosis codes are correct based on the patient’s condition and treatment.

As an example, many providers used ICD-9 code 311, depressive disorder, not elsewhere classified. Although this was an unspecified code, it was widely used by primary care providers and insurances paid for services with 311 as a co-morbidity or secondary diagnosis. The crosswalked code for 311 in ICD-10 is F32.9 – major depressive disorder, single episode, unspecified. Many providers I have worked with are not comfortable with coding these patients with having a major depressive disorder. Upon review, many are selecting F32.8 – other depressive disorders.

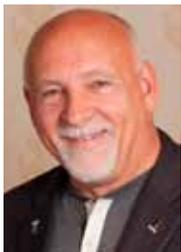
Another diagnosis frequently used is hypertension, unspecified, coded as 401.9 in ICD-9. In July and August, I had several calls from offices that were getting documentation requests for office visits (levels 4 and 5) that had 401.9 as a primary or secondary diagnosis. It appeared multiple payers were looking at the medical necessity of physicians billing higher level care codes with an unspecified hypertension diagnosis. If you crosswalk 401.9 to ICD-10 your code is I10 Essential (primary) hypertension. The question I would ask is would I11.0 or I11.9, hypertensive heart disease with or without heart failure, be a more appropriate code for some of these patients? Only you as the clinician would know.

Coding for asthma is another example. ICD-10 includes four new sub-classifications of asthma: mild intermittent; mild persistent; moderate persistent; severe persistent; and of course, unspecified. Each sub-classification has sub-codes for uncomplicated, exacerbation and status asthmatics. Crosswalking the most utilized asthma code from ICD-9, 493.90-asthma, unspecified type, would give you the choice of codes for unspecified asthma, uncomplicated or other asthma. Did you know there was that much specificity just for asthma?

The old adage, “You do not know what you do not know,” is true with many physicians when it comes to ICD-10 coding. If you have not looked at a coding book to see what codes exist in the areas that you most commonly code to and that your EHR system crosswalks to, you may be under-coding the diagnosis and treatment of the patient. As you know, specificity and severity of the patient’s illness is very important for proper reimbursement. While there have been requests for documentation on unspecified codes (usually those ending with the number 9), Medicare’s revised ICD-10 payment policies, National Coverage Decisions (NCD) and Local Coverage Decisions (LCD) frequently do not include unspecified codes.

I am not suggesting that you read an ICD-10 code book cover-to-cover. That would be impractical. I do encourage you to run a report of your top 25 most utilized diagnosis codes and then copy the section pages for one or two of them to review each week. As a clinician, you will be able to peruse the listings and understand what specificity that section is looking for. Pay particular attention to any of your top codes that end in the number 9. Take an extra moment with these and see if there might be a more specific code that would be more appropriate to use.

With the next round of quality and value-based incentives and disincentives just around the corner, your choice of the most appropriate and specific code may make a difference in your scores, and ultimately, your reimbursement. Take that five minutes for review. It may be an invaluable use of your time.



talking science & education

Donald S. Nelinson, PhD

This month in Talking Science and Education, I am introducing a new feature: Diabetes Dialogues. As a neuroendocrinologist this is a personal passion. But of even greater importance is the fact that diabetes and cardiometabolic disease present to virtually all ACOI members in your clinical practices. In this segment I plan to share recent research or discussions that have relevance to all of our members; whether general internists or subspecialists.

Diabetes Dialogues: Fat But Fit?

This is not a new mantra, rather one that has been debated for quite some time. Many overweight and obese Americans might be perfectly healthy when it comes to blood pressure, cholesterol and blood sugar levels -- while many thin folks may not be the picture of good health, a new study contends.

In a study published last week in the International Journal of Obesity (February 4, 2016), the results of a researchers found that nearly half of overweight U.S. adults were “metabolically healthy.” That meant they had no more than one risk factor for type 2 diabetes and heart disease -- including high blood pressure, unhealthy cholesterol or triglyceride levels, elevated blood sugar, or high concentrations of C-reactive protein (CRP).

Among obese adults, 29 percent were deemed healthy -- as were 16 percent of those who were severely obese based on body mass index (BMI).

On the other hand, more than 30 percent of normal-weight Americans were metabolically unhealthy. The researchers estimate that nearly 75 million Americans would be “misclassified” as heart-healthy if BMI is the only yardstick. One might assume that no practicing physician would use a single parameter to assess cardiometabolic status, however overreliance on well-established markers may be misleading.

“The bigger picture we want to draw from our findings is that the dominant way of thinking about weight -- that higher-weight individuals will always be unhealthy -- is flawed,” said Jeffrey Hunger, one of the researchers on the study.

The study is far from the first to find that obese adults can be in good shape as far as heart health. Researchers have debated the “fat but fit” theory for years.

By the same token, studies have shown, being thin is no guarantee of good health.

But, Hunger said, the new findings also help “solidify” the number of Americans who could be mistakenly deemed unhealthy based solely on BMI.

That has potential “real-world consequences,” Hunger said. Many larger U.S. businesses offer employee wellness programs, which can include discounts on health insurance premiums for meeting certain goals, such as weight loss. Some employers penalize employees for not participating.

Hunger’s team says the U.S. Equal Employment Opportunity Commission has proposed rules that would allow employers to charge workers up to 30 percent of their health insurance costs if they fail to meet certain health criteria, including a specified BMI.

The new study’s findings are based on more than 40,000 U.S. adults who took part in a nationally representative federal health study between 2005 and 2012.

Obese men and women were, in fact, the most likely to fall into the unhealthy category: Depending on the severity of their obesity, 71 percent to 84 percent had risk factors for heart disease and diabetes. That compared with 24 percent of underweight and 31 percent of normal-weight adults.

Still, the authors assert, weight is not the be-all and end-all.

“Right now, we have this laser focus on weight when we should be talking about health,” he said. “The general public should try to focus on improving their health behaviors -- eating well, staying active and getting enough sleep -- and forget about the number on the scale.”

But Dr. Gregg Fonarow, a professor of cardiovascular medicine at the University of California, Los Angeles, cautioned that weight does still matter.

He noted that some recent studies have been challenging that idea of “metabolically healthy obesity.”

Last year, researchers reported on a long-term study of more than 1 million Swedish men showing that those who were obese but fit -- based on a cycling test -- were 30 percent more likely to die prematurely than men who were out of shape but thin.

But another study, published in the Journal of the American College of Cardiology, followed 2,500 British adults for 20 years. It found that among those who were obese but healthy at the outset, more than half eventually developed high blood pressure, diabetes and other risk factors for heart disease -- often within five years.

It’s true, Fonarow said, that at any point in time, obese people may be metabolically healthy. But over the years, obesity takes its toll.

“So individuals who are classified as obese by BMI are at increased risk for a variety of obesity-related ills,” he said.

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Talking Science

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Still, Hunger and his colleagues warn against “obsessing” about weight, which may only worsen heavier people’s well-being. Instead, healthy eating and regular exercise should be the focus, rather than BM. “Practically speaking, the conversation needs to shift.”

New Lyme Disease Pathogen Identified

The Centers for Disease Control and Prevention (CDC) announced the discovery of a new species of *Borrelia mayonii* that causes Lyme disease. Prior to now, *Borrelia burgdorferi* was the only species of bacteria believed to cause Lyme disease in North America.

The findings, published in *Lancet Infectious Diseases*, showed unusual lab test results from 6 out of 9,000 people infected with suspected Lyme disease between 2012-2014. Analysis of the bacteria’s DNA sequences revealed a previously unrecognized *Borrelia* species. Researchers at the Mayo Clinic in Rochester, MN, reported that additional genetic testing showed that the new bacteria *B. mayonii* was closely related to *B. burgdorferi*.

B. mayonii causes fever, headache, rash, and neck pain in the early stages of infection, and arthritis in later stages of infection like the illness caused by *B. burgdorferi*. However, *B. mayonii* also causes nausea, vomiting, diffuse rashes (instead of the single “bull’s-eye” rash), and a higher concentration of bacteria in the blood.

The newly discovered bacteria is thought to be transmitted to humans by the bite of an infected blacklegged “deer” tick. *B. mayonii* has been detected in blacklegged ticks in at least 2 counties in northwestern Wisconsin with likely patient exposure sites in north central Minnesota and western Wisconsin. Currently available evidence suggests that *B. mayonii* is limited to the upper mid-western U.S.; it was not identified in any of the >25,000 samples from residents of 43 other states with suspected tickborne diseases taken during the same study period. The CDC informed that specific identification of *B. mayonii* can be done by using polymerase chain reaction (PCR) assays. The bacteria may also be seen on a blood smear in some cases.

The infected patients included in the report were successfully treated with common antibiotics for Lyme disease caused by *B. burgdorferi*. Healthcare providers are recommended to follow the regimen described by the Infectious Diseases Society of America (IDSA) when treating patients infected with *B. mayonii*.

In general, the CDC recommends the following guidance to reduce the risk of tick bites and tickborne diseases:

- Avoid wooded and brushy areas with high grass and leaf litter
- Use insect repellent when outdoors
- Use products that contain permethrin on clothing
- Bathe or shower as soon as possible after coming indoors to wash off and more easily find ticks
- Conduct a full-body tick check after spending time outdoors
- Examine gear and pets, as ticks can come into the home on these and later attach to people

Thanks for reading. As always, I welcome any feedback or requests. Feel free to contact me at don@acoi.org.

Larry Wickless, DO, Begins Term as 2016 AOF Board President



Larry A. Wickless, DO, MACOI, recently began a term as President of the American Osteopathic Foundation Board for 2016. Dr. Wickless is a past president of both the ACOI and the American Osteopathic Association. He has served on the AOF Board of Directors since 2011.

“Dr. Wickless is a change agent who has held many leadership roles in the osteopathic profession. We are honored to tap his expertise to help grow our donor base and our impact,” said AOF Executive Director Stephen Downey.

Dr. Wickless hopes to increase awareness about the service projects AOF sponsors, especially in the United States. “It’s interesting to go to other countries to volunteer, but here at home, there are so many things you can do, so many people you can help,” said the sponsor of the AOF Caring for Communities Award, established in 2014.

During his tenure as AOA president in 2009-10, Dr. Wickless’ theme was “Managing Change.” He feels it’s better to give anonymously and says of the Caring for Communities Award, “It’s not important to have my name attached to it. It allows the award to be supported by other individuals who want to support this cause, and they can take part.”

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

Wassim Chehour, DO

Henry A. Chen, DO

Amy Chung, DO

Romi M. Coolidge, DO

Brendan F. Curley, DO

Nathaniel J. Drexler, DO

Svetlana O. Enman, DO

Lee S. Epstein, DO

Brian M. Fishman, DO

Jarett A. Gregory, DO

Yan Lin L. He, DO

Steven W. Krause, DO

Howard Y. Lee, DO

Erick C. Lu, DO

Drew T. Lupton, DO

Rajeev Marreddy, DO

Marisa E. McNeal, DO

Donald J. Neal, DO

Desmond Paul-Coker, DO

Ngoc B. Phan, DO

Naveen T. Raj, DO

Keriake Semertzides, DO

Ana Carolina C. Silva, DO

Omesh S. Singh, DO

Justin L. Sullivan, DO

Tanya Tang, DO

Paul R. Wucka, DO

Mary Zhitnikova, DO

Certificate Program

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discussion format that encourages the open exchange of ideas among learners with diverse experiences. The Program culminates with an in-person capstone session offered in March, 2017. Fifty AOA CME credits are anticipated.

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

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

To register or learn more about the program, visit www.acoi.org. Additional information is available by contacting Tim McNichol at 1-800-327-5183 or at tmcnichol@acoi.org.

AOA Extends Deadline to Meet Three-Year CME Cycle Requirements

The AOA Board of Trustees announced late in December that it has extended the deadline for physician members to meet the CME requirements for the three-year CME cycle that closed on December 31, 2015. During each cycle, members are required to complete 120 CME credits, 30 of which must be in category 1A. In addition, certified physicians must complete a minimum of 50 credits in internal medicine or a subspecialty. The deadline to meet the requirements was extended until May 31, 2016. During this period, members will have the option to apply their CME credits to either the 2013-15 cycle or the 2016-18 cycle.

This provides ACOI members and others the opportunity to meet the CME requirements by attending either the Internal Medicine Board Review Course, or the Clinical Challenges in Inpatient Care program, both of which will be offered in late March in Orlando, FL. Further information about those programs appears inside this newsletter.

For those who don't wish to travel, the ACOI's online medical knowledge self-assessment modules are another CME option. The modules can provide up to 75 AOA internal medicine specialty CME credits. The modules test your acumen in a case-centric format on the 30 most common acute, chronic and other presentations seen by practicing internists. They use the latest in brain science and game theory to help you acquire information quickly, remember it long-term and accurately recall it in the clinical setting. There are 15 modules available and each provides five internal medicine, hospitalist and/or subspecialty credits. Modules may be purchased individually or in packages. They are designed to be completed in one sitting, but can be paused at any point for later completion. The modules also meet one of the AOBIM's requirements for participation in Osteopathic Continuous Certification. You may access the modules via the OCC Education Center for Internal Medicine at www.acoi.org.

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

Eric Langer, DO, Represents ACOI at AACE/ACE Consensus Conference on Expanding CGM Technology

As emissary of the American College of Osteopathic Internists, Eric S. Langer, DO, FACOI, FACE, CCD, (Endocrine Fellowship Program Director, McLaren Medical Center-Macomb, Michigan) participated in February in a consensus conference convened by the American Association of Clinical Endocrinologists for the purpose of acquiring expanded use of continuous glucose monitoring (CGM) in the management of diabetes. He has provided the following report of the Consensus Panels findings.

CGM is an FDA-approved device that provides a visual graphic display of interstitial glucose readings throughout the 24-hour day, to equip the diabetic patient with a personal anticipatory assessment of glycemic behavior thereby allowing for any preemptive modification of their therapeutic requirements. Continuous glucose monitors offer the potential to predict hyperglycemic and hypoglycemic events before they occur (information pertaining to direction, magnitude, duration and frequency of glycemic trends) and monitor for glucose variations that may not be detectable through isolated Glucometer assessments (whole blood interpretation). As such, CGM data does not serve to specifically reflect the “real-time” numerical depiction of blood sugar, but rather an invaluable “real-time perspective” on “glycemic trending” for anticipatory intercession.^{1,2,3}

As it stands today, CGM technology is the primary advance that in combination with continuous insulin infusion pump systems will allow for the long-awaited “artificial pancreas”, a concept which will soon be reality and based upon instrumentation requiring three essential components:

- CGM system
- Insulin delivery system
- Computer algorithm that "closes the loop" by adjusting insulin delivery based upon changes in glucose levels

Despite the powerful interventional influences offered by CGM availability, continuous glucose monitoring has not been widely adopted in the management of diabetes. In light of advances in CGM technology and a growing body of evidence supporting CGM benefits, the American Association of Clinical Endocrinologists (AACE) and the American College of Endocrinology (ACE) convened a public consensus conference to review all available CGM-related literature and develop strategies for overcoming barriers to CGM use and access. Representatives from medical and scientific societies, patient advocacy organizations, government, health insurance providers, and device and pharmaceutical manufacturers (five “Pillar” factions) met to discuss the complete spectrum of CGM-related concerns during the summit congress. Among the issues rigorously examined⁴:

- Identification of patient populations who may benefit from personal and/or professional CGM use
- Standardization of CGM reporting to facilitate consistent interpretation in clinical practice
- Definition of a protocol for effective analysis of CGM data for clinical utilization
- Impact of using CGM to reduce healthcare costs associated with diabetes (e.g., severe hypoglycemic events)
- Strategies to remove barriers for successful use of CGMs by patients and healthcare providers for improved diabetes management
- Use of CGM in a rapidly evolving healthcare environment
- Use of CGM in the evolving healthcare environment, (e.g., the Patient-Centered Medical Home model, alternative payment)

The program itinerary was highlighted by Dr. Bruce Buckingham’s (Stanford School of Medicine – Pediatric Endocrinology) introductory perspective on insulin pump therapy and its eventual evolution to incorporate the use and guidance of CGM support in the effort to safely and effectively achieve dependable glycemic stability in the diabetic patient, and setting the stage for the

collaborative reconciliation of contemporary evidenced-based literature by the participating delegates of each “Pillar Coalition”.

Preliminary “pre-conference” requisites encouraged the participating delegates of each “Pillar” to prepare a comprehensive survey of the medical research germane to five primary themes of inquiry in an effort to highlight the clinical, social, economic and informational benefits associated with the utilization of CGM Technology. A final 33-page appraisal of the existing evidence-based literature was drafted and subsequently condensed into a power point summary coupled with the unique opportunity of offering a formal presentation and overview specific to Medtronic-acquired statistical data underscoring the “real-life” value of Personal CGM Technology.

As my General Endocrine Practice was a part of Medtronic’s evolving “Practice Level Aggregate CareLink Study,” I was, with the technology company’s assistance, able to render a statistical analysis portraying the myriad advantages and care-related yields associated with the implementation and use of Personal CGM-Low Threshold-Suspend technology, both on a national and personal practice-comparative basis. The data as documented clearly authenticated the intended use and aspirations of the personal CGM concept and served not only to accentuate in broad fashion this summit’s intended goal and task at hand, but was embraced as an integral component of the information that would ultimately be utilized toward crafting a final AACE/ACE position statement with their key conclusions (February 23, 2016).

The key conclusions concerning CGM use in diabetes included the following 4:

- Robust data support benefits in many people with diabetes, particularly those with type 1 diabetes
- Technological advances have improved reliability and accuracy
- Use has reduced hypoglycemia while improving control of blood glucose, ensuring patient safety
- Data suggest benefits in other patient populations, such as patients with type 2 diabetes on intensive insulin therapy

continued on page 9

Dr. Langer

continued from page 8

- Studies are needed to demonstrate the value of CGM technology in other patient populations
- Access should be expanded to all patient populations with proven benefits

“This conference was a necessary and critical step to help ensure that persons with diabetes who can benefit from CGM technology gain access to the best clinical care possible,” said Dr. Vivian Fonseca, FACE and Chair of the Consensus Conference. “By incorporating the practical knowledge and insights of experts across the diabetes care spectrum, we are in a position to advance this cause considerably.”⁴

“It’s crucial that we embrace the technological advances in diabetes management that enhance our capacity to provide the highest level of care to people with diabetes,” added AACE President Dr. George Grunberger, FACP, FACE. “Our Conference participants’ examination of the clinical and economic issues affecting expanded use of CGM was invaluable.”⁴

A comprehensive formal publication describing the necessary steps toward a concerted, collaborative effort necessary to address and overcome current barriers to optimal diabetes care will be published in a future issue of Endocrine Practice, AACE’s monthly, peer-reviewed medical journal.⁴

A complete summary of the conference conclusions can be found online at the American Association of Clinical Endocrinologists⁴: <https://aace.newshq.businesswire.com/press-kit/2016-continuous-glucose-monitoring-consensus-conference-summary-statement>.

References:

1. Cengiz E. and Tamborlane WV; A Tale of Two Compartments: Interstitial Versus Blood Glucose Monitoring. Diabetes Technology and Therapeutics; Volume 11, Supplement 1, 2009.
2. Garg SK, Kelly WC, Voelml MK et al. Continuous Home Monitoring of Glucose: Improved Glycemic Control with Real-Life use of Continuous Glucose Sensors in Adult Subjects with Type 1 Diabetes Diabetes Care; 2007;30(12): 3023-5.
3. Tanenberg R, Bode B, Lane W et al. Use of the Continuous Glucose Monitoring System to Guide Therapy in Patients with Insulin-Treated Diabetes: A Randomized Controlled Trial. Mayo Clin Proc. 2004;79(12):1521-6.
4. Sebold, G. AACE Press-Release: Expert Assembly Spearheaded by American Association of Clinical Endocrinologists Calls for Expanded Use of Continuous Glucose Monitoring Technology in the Care of People With Diabetes. February 23, 2016; gsebold@aace.com.

PROFESSIONAL OPPORTUNITIES

FACULTY MEMBER/DEPARTMENT OF PRIMARY CARE

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

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



Dean, College of Osteopathic Medicine

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

Laurie C. Wilder, President Porsha L. Williams, Vice President Jacob C. Anderson, Associate
770-804-1996 ext: 111
pwilliams@parkersearch.com janderson@parkersearch.com

Des Moines University is an Equal Opportunity Employer. We evaluate qualified applicants without regard to race, color, national origin, ethnicity, creed, religion, age, disability, sex, gender identity, sexual orientation, pregnancy, veteran status, genetic information and other characteristics protected by law (“protected class”).



Five Concourse Parkway | Suite 2900
Atlanta, GA 30328
770.804.1996 | parkersearch.com

Why Supporting the ACOI is Important

(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. Cicone, CFRE, Development Counsel to ACOI.)



Meet Amita Vasoya, DO, FACOI, a pulmonologist, critical care and sleep medicine specialist and the Sleep Medicine Program Director at Rowan/Kennedy Health in New Jersey. A dedicated ACOI member since her days as a resident more than 23 years ago, Dr. Vasoya has served on a number of ACOI committees, including the Minority Health Committee and the Convention Program Committee. She also is a speaker for ACOI's Board Review Course.

Ms. Cicone: Tell me why you have dedicated your time and talents to ACOI.

Dr. Vasoya: I like the fact that since ACOI is not a large organization I have been able to get to know many people and be active in the College. Being active is my way of giving back to the people who taught me and fulfills one of my personal goals to teach the next generation of osteopathic internists. The ACOI community includes many people who are so very willing to

help fellow members, residents, and students.

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

Dr. Vasoya: The College should continue to focus on providing the best in educational programs throughout the year and at the Annual Convention. I know they are currently working to address the ACGME single accreditation issue and how it impacts future ACOI members.

Ms. Cicone: In addition to sharing your time and talents with ACOI, you have made financial contributions to ACOI over and above your dues, including donating the speaker honoraria you receive. Tell me what motivates you to give.

Dr. Vasoya: I contribute to the ACOI because I want to give back. As for donating my speaker honoraria, it is because I so enjoy speaking and teaching that I don't see my honoraria as my compensation, but as another way to give back and help the ACOI do what it needs to do.

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

Dr. Vasoya: I find the check box on the dues renewal too impersonal to motivate members to give and to give larger contributions. It would be good for the College to publicize where member gifts are used such as residency programs, Visiting Professor sessions, internal medicine student clubs, etc. and allow members to select where their gift should be directed. I would also recommend that the College continue to raise awareness of those who gave and recognize the donors appropriately in ACOI publications and materials.

In closing, I encourage ACOI members to get involved in the College because I think everyone can make a difference at the ACOI.

Ms. Cicone: Dr. Vasoya, ACOI thanks you for the many contributions you have made and continue to make to help the College educate and train both the current and next generation of osteopathic medicine internists.

Help Yourself Now And ACOI Later

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

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

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

Our staff and gift consultants can provide you with confidential information about this special arrangement or other ways you can help yourself, your family, and ACOI. For more information, call Brian Donadio, FACOI, Executive Director, at 301-231-8877 or email him at bjd@acoi.org.

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 various gift planning pamphlets now available. Email Melissa McConnell at Melissa@acoi.org to request 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



New 75th Anniversary Circle Launched at Annual Convention

Members of the ACOI 75th Anniversary Circle have agreed to contribute \$1000 or more over the next two years to support the ACOI initiative to assist all residency and fellowship programs to maintain their osteopathic focus under the ACGME. Each supporter will be recognized with a leaf on the ACOI 75th Anniversary Circle Tree to be located permanently in the ACOI office.

Our thanks to the following 75th Anniversary Circle members as of 3/11/16:

- Michael A. Adornetto, DO, MBA, FACOI
- Lee Peter Bee, DO, FACOI
- John B. Bulger, DO, MBA, FACOI
- Martin C. Burke, DO, FACOI
- Robert A. Cain, DO, FACOI
- Annette T. Carron, DO, FACOI
- Michael Clearfield, DO, FACOI
- Robert L. DiGiovanni, DO, FACOI
- Brian J. Donadio, FACOI and Ellen Donadio
- Bruce D. Dubin, DO, MACOI
- Mitchell D. Forman, DO, FACOI
- Pamela R. Gardner, DO, FACOI
- Scott L. Girard, DO, FACOI
- Robert G. Good, DO, FACOI
- Rick A. Greco, DO, FACOI and Carol A. Greco, DO
- Lawrence U. Haspel, DO, MACOI
- Robert T. Hasty, DO, FACOI
- Kevin P. Hubbard, DO, MACOI and Roxanne Hubbard
- G. Michael Johnston, DO, MACOI
- Joanne Kaiser-Smith, DO, FACOI
- Judith A. Lightfoot, DO, FACOI
- Donald S. Nelinson, PhD
- Eugene A. Oliveri, DO, MACOI
- Susan O'Neal, DO, FACOI
- Anthony N. Ottaviani, DO, MPH, MACOI
- Morvarid Rezaie, DO, FACOI
- Christine M. Samsa, DO, FACOI and Nathan P. Samsa, DO, FACOI
- Samuel K. Snyder, DO, FACOI
- William D. Strampel, DO, FACOI
- John R. Sutton, DO, FACOI
- Richard R. Thacker, DO, FACOI
- Larry A. Wickless, DO, MACOI

Information on how to join the 75th Anniversary Circle can be found by visiting <http://www.acoi.org/about-acoi/make-a-gift-to-acoi.html>.

Touro University - California Internal Medicine Club President Thanks ACOI for Support



*Kenneth Yun
Touro Univ. Osteopathic
Medical Student
Class of 2018*

“The ACOI’s support of our internal medicine club at Touro University - California has been crucial to bridging the gap between undergraduate and graduate medical education. Funding resources enrich our campus events, and providing guest physicians to come to lecture at our school play a crucial role in informing and attracting students to the specialty of osteopathic internal medicine. This past February, Dr. Baldwin provided a fascinating case presentation on Uremia at the Battle of Gettysburg. Drawing from his experience as a program director, his insight into pathways to residencies and present opportunities in the medical field gave my fellow classmates the clarity we so often seek in the daunting process of choosing the future pathway of our careers. Thank you so much for your support of our internal medicine club here in California!”

(The ACOI Visiting Professor Program is supported by member contributions to the Generational Advancement Fund.)



In Memoriam



Word has been received of the death of **Lionel J. Gatien, DO, FACOI**, on February 7, 2016. Dr. Gatien was board certified in internal medicine and practiced geriatric medicine in Orange Park, Fl. He became an Active Member of the ACOI in 1974 and received the degree of Fellow in 1991. Dr. Gatien was 76 at the time of his death.



The ACOI also has learned of the death of **Frederick G. Uberti, DO, FACOI** on February 20, 2016. A board-certified general internist, Dr. Uberti was an Emeritus Member of the College following 44 years as an Active Member, beginning in 1971. He achieved the degree of Fellow in 1983. Dr. Uberti served for many years as the program director of the internal medicine residency program at Shenango Valley Medical Center (now UPMC-Horizon Shenango Campus) in Farrell, PA. He was 76 at the time of his death.

BOARD REVIEW COURSE
March 30-April 3, 2016

REGISTRATION FORM ON PAGE 12
OF THIS NEWSLETTER

Orlando

2016 ACOI INTERNAL MEDICINE REVIEW COURSE REGISTRATION FORM

Renaissance Resort at SeaWorld, Orlando, FL • March 30-April 3, 2016
Registration available online at www.acoi.org/education/cme/board-review-course.html

Full Name			
AOA Number			
Mailing Address			
City		State	Zip
Work Phone	()	Fax Number	()
Home Phone	()	Cell	()
Email Address			
Preferred Name on Badge			
Emergency Contact		Telephone	()
Fees	<input type="checkbox"/> ACOI Member (Registering ON/BEFORE 3/9/2016...\$850)	<input type="checkbox"/> ACOI Member (Registering AFTER 3/9/2016...\$900)	
	<input type="checkbox"/> Non-Member (Registering ON/BEFORE 3/9/2016...\$1025)	<input type="checkbox"/> Non-Member (Registering AFTER 3/9/2016...\$1075)	
	<input type="checkbox"/> Resident/Fellow (Registering ON/BEFORE 3/9/2016...\$750)	<input type="checkbox"/> Resident/Fellow (Registering AFTER 3/9/2016...\$800)	
	<input type="checkbox"/> Printed Syllabus \$80 (Electronic copy provided with registration)	<input type="checkbox"/> *ACOI Generational Advancement Fund \$ _____	<input type="checkbox"/> TOTAL \$ _____
Payment Method	<input type="checkbox"/> Check to ACOI	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Visa
Name on Card			
<input type="checkbox"/> Check here if billing address is same as mailing address listed above. If not, please provide below			
Billing Street			
Billing City		State	Zip
Credit Card Number		Security Code	
Credit Card Exp. Date			
Signature			

Send this form & payment to: ACOI, 11400 Rockville Pike, #801, Rockville, MD 20852 or Fax to 301 231-6099, or register at www.acoi.org.

NOTE: All registrations must be accompanied by a check for payment in full or appropriate credit card information. A processing fee of \$50 will be charged for cancellations received at any time. In order to obtain a refund, written cancellations must be received by March 9, 2016. No refunds will be made after that date, but registration fees (less \$50 cancellation fee) may be applied to a future ACOI meeting registration.

*The **ACOI Generational Advancement Fund** was created to foster the growth and assure the future of osteopathic internal medicine. The Fund directs its efforts toward assisting students, residents and fellows as they begin their careers as osteopathic internists. For more information, visit https://www.acoi.org/mms/legacy_fund.cgi.

PLEASE NOTE: Check here if you plan to stay at the Renaissance Resort. Separate hotel registration is required. This does not register or guarantee a room at the hotel.

SPECIAL NEEDS: In accordance with the Americans with Disabilities Act, every effort has been made to make this conference and activities accessible to people of all capabilities. Please list specific special assistance needed or any dietary restrictions, or contact Susan Stacy at susan@acoi.org or by phone, 301 231-8877.

List special requirements here: _____

2016 ACOI Clinical Challenges in Inpatient Care REGISTRATION FORM

Renaissance Resort at SeaWorld, Orlando, FL • March 31-April 3, 2016
Registration available online at www.acoi.org/education/cme/clinical-challenges-in-inpatient-medicine.html

Full Name				
AOA Number				
Mailing Address				
City		State	Zip	
Work Phone	()	Fax Number	()	
Home Phone	()	Cell	()	
Email Address				
Preferred Name on Badge				
Emergency Contact		Telephone	()	
Fees	Registration on/before 3/9/16		Registration after 3/9/16	
	<input type="checkbox"/> ACOI Member.....	\$625	<input type="checkbox"/> ACOI Member.....	\$675
	<input type="checkbox"/> Non Member.....	\$750	<input type="checkbox"/> Non Member.....	\$800
	<input type="checkbox"/> Non Physician Provider.....	\$625	<input type="checkbox"/> Non Physician Provider.....	\$675
	<input type="checkbox"/> Residents/Fellows.....	\$525	<input type="checkbox"/> Residents/Fellows.....	\$575
	<input type="checkbox"/> *ACOI Generational Advancement Fund \$_____		TOTAL \$_____	
Payment Method	<input type="checkbox"/> Check to ACOI <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa			
Name on Card				
<input type="checkbox"/> Check here if billing address is same as mailing address listed above. If not, please provide below				
Billing Street				
Billing City		State	Zip	
Credit Card Number		Security Code		
Credit Card Exp. Date				
Signature				

Send this form & payment to: ACOI, 11400 Rockville Pike, #801, Rockville, MD 20852 or Fax to 301 231-6099, or register at www.acoi.org.

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PLEASE NOTE: Check here if you plan to stay at the Renaissance Resort. Separate hotel registration is required. This does not register or guarantee a room at the hotel.

SPECIAL NEEDS: In accordance with the Americans with Disabilities Act, every effort has been made to make this conference and activities accessible to people of all capabilities. Please list specific special assistance needed or any dietary restrictions, or contact Susan Stacy at susan@acoi.org or by phone, 301 231-8877.

List special requirements here: _____

CME CALENDAR

Future ACOI Education Meeting Dates & Locations

NATIONAL MEETINGS

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

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

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

2016 Certifying Examination Dates & Deadlines

Internal Medicine Certifying Examination

Computerized Examination 200 Sites Nationwide

September 15, 2016 - *Application Deadline: February 1, 2016*

Late Registration Deadline: April 1, 2016

Subspecialty & Certification of Added Qualifications:

Aug. 20, 2016 • Lombard, IL - *Application Deadline: April 1, 2016*

Late Registration Deadline: May 1, 2016

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

Internal Medicine Recertifying Examination

Computerized Examination 200 Sites Nationwide

September 15, 2016 - *Application Deadline: April 1, 2016*

Late Registration Deadline: May 1, 2016

Focused Hospital Medicine Recertification

Aug. 20, 2016 • Lombard, IL - *Application Deadline: April 1, 2016*

Late Registration Deadline: May 1, 2016.

Subspecialty and Added Qualifications Recertifying Examinations:

Aug. 20, 2016 • Lombard, IL

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

Application Deadline: April 1, 2016

Late Registration Deadline: May 1, 2016

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.

March 31- April 3

2016 Inpatient Clinical Challenges Program

There is still time to register for the ACOI's popular CME program for hospitalists and others: Clinical Challenges in Inpatient Care, which will take place March 31- April 3 at the Renaissance Resort at Sea World in Orlando, FL. The program will provide up to 25 AOA 1A CME credits in internal medicine. In addition, the program meets the American Osteopathic Board of Internal Medicine's (AOBIM) requirement for a board review course for those who plan to sit for the new focused hospital medicine recertification credential.

The ACOI Continuing Medical Education Committee, led by Chairman Frederick A. Schaller, DO, MACOI, has designed an agenda that will appeal to physicians who treat patients in the hospital. Among the areas to be covered are: Optimizing Transition of Care; Medical Mobil Resources to Augment Hospitalist Practice; ER-Hospitalist Relationship: Cooperative or Combative?; Acute Management of Atrial Fib; Preoperative Cardiac Risk Stratification; Acute Nephrotic Syndrome; Negotiating Payer Contracts; Care Team Assignments and more.

Guest rooms are available at the Renaissance Resort for a discounted room rate of \$199/night, plus applicable taxes. There is an optional resort fee of \$20, which includes internet, transportation to Sea World, Universal Studios and Disney, free breakfast for kids under 12, two bottles of water daily and local calls. Further information regarding the Clinical Challenges program, including meeting and hotel registration materials, are available at www.acoi.org, or by calling 1-800-327-5183.