

From President Burke Principle-Centered Medicine™



Over these past months, my message has pointed out the ACOI's transformation from a Graduate Medical Education and Continuing Medical Education organization to a

Professional Services Organization. Our response to challenges continues to define us. The single accreditation construct of internal medicine residencies and fellowships made this a true necessity. The advent of single accreditation has led the ACOI and its Board of Directors to look inward as to why we exist, whom we serve and what our value is. We have made progress the past three years in understanding these questions, with substantial answers arising during much soul searching and planning for the future. Osteopathic Internal Medicine is steeped in principles and philosophy which, frankly any physician, but especially internists, may find gravitational pulls. For 75 years we have protected this philosophy in our GME standards. At the same time, we painstakingly have developed holistic CME events that embrace our members' style of clinical care and learning.

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October 17-21, 2018 in Orlando

2018 Convention Will Introduce New Hospital Medicine Interest Group



The 2018 ACOI Annual Convention and Scientific Sessions will take place Oct. 17-21 in Orlando, FL. The Orlando World Center Marriott will be the host hotel for the meeting. Following up on the recent

conclusion of the ACOI's 75th Anniversary celebration, the Convention theme this year is: "Osteopathic Internal Medicine: the Next 75 Years."

Program Chair Robert L. DiGiovanni, DO, and the CME Committee have designed an educational activity that will appeal to general internists, hospitalists and subspecialists. The agenda will include a high-level cardiology symposium, plenary sessions geared toward the problems that internists are dealing with in each subspecialty area, and a number of special sessions aimed at specific audiences, including hospitalists, residency program trainers, residents and students.

For those practicing as hospitalists, the ACOI is creating a new special interest group that will organize during the Convention. The purpose of the group will be to provide guidance to the College on education and other services that would enhance hospitalists' ability to serve their patients. The organizational meeting will take place on Thursday, Oct. 18. Scott Girard, DO, a hospitalist and member of the Board of Directors, will moderate the session. Two additional sessions specifically for hospitalists will be offered on Friday and Saturday mornings.

In keeping with the ACOI's commitment to addressing all aspects of osteopathic internal medicine care, a limited attendance session will be offered for those who are interested in learning more about how OPP/OMM is relevant to their patient care. The half-day session, "Exploring the Role of OPP in Daily Patient Care," will be offered on Saturday, Oct. 20, and will be limited to 24 participants. It will include a mix of discussion and case examples that seek to distinguish between thinking osteopathically and treating osteopathically. Robert A. Cain, DO, and Annette T. Carron, DO, will facilitate this session.

There also will be a day-long series of presentations on Florida and other state law requirements for maintaining licensure. Daily keynote sessions will include a presentation by Christian T. Cable, MD, who is chair of the ACGME Internal Medicine Residency Review Committee. Dr. Cable, who recently became the first MD accepted for full Active membership in the ACOI, will speak on: "Osteopathic Medicine from the Outside In."



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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mburke@corvitahealth.org

Annette T. Carron, DO, FACOI.....President-Elect
annette.carron@beaumont.edu

Samuel K. Snyder, DO, FACOI.....Secretary-Treasurer
snyderdo@nova.edu

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

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

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

Damon L. Baker, DO, FACOI.....damonbaker@okstate.edu

Robert A. Cain, DO, FACOI.....cainr@ohio.edu

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

Susan M. Enright, DO, FACOI.....susan.enright@hc.msu.edu

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

Robert T. Hasty, DO, FACOI.....Rhasty@idahocom.org

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

Amita Vasoya, DO, FACOI.....vasoya.909@gmail.com

Sara E. Ancello, DO, Resident Rep.....sara.ancello@gmail.com

STAFF

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

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

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

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

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

Kara Kerns.....Post-Doctoral Training Specialist
kara@acoi.org

Claudette Jones.....Membership Services Specialist
claudette@acoi.org

Katie E. Allen.....Member Services Specialist - OCC/CME Development
katie@acoi.org

Meg O'Rourke.....CME Specialist
meg@acoi.org

Neena J. Kuruvilla.....Administrative Assistant
neena@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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Over time, we have come to realize that the ACOI exists to define and protect the philosophy and practice of Principle-Centered Medicine™. In this existence, ACOI welcomes all physicians and others who practice Principle-Centered Medicine™. Our value proposition is to help you “stay true to why you pursued medicine.” Our members - you - do this every day by faithfully practicing principle-centered care; by appreciating what is profound in medicine; by learning exactly what you need to know for your patients; by mastering your craft; and by belonging to a community of like-minded people. There is nothing more professional than medicine that is principle-centered, where the main principle finds life in the doctor-patient relationship. It's time to double down and spark this movement that finds wellness using our six senses and tools, such as OMT, that have been improving exponentially year over year.

What is Principle-Centered Medicine™?

ACOI Board member Bob Cain, DO, FACOI, has helped identify the epitome of what is at the heart of the ACOI and its belief system through gestation, discussion with members, retreats and listening, and I quote:

- *Principle-centered Medicine is patient care based upon a guiding framework (principles) that is intended to help the patient (or patient's family) and physician(s) as they work collaboratively to realize the patient's fullest health potential, with or without the presence of disease.*
- *Regular application of this guiding framework allows for meaningful orientation or re-orientation to what is important when navigating the volatile, uncertain, complex, and ambiguous environment that often characterizes a patient's health journey.*
- *Principle-centered Medicine's guiding framework centers us on the importance of the patient-physician relationship, reminds us to 'see what matters' through the eyes of each patient, and recognizes the physician's central role in helping individuals and populations to determine and achieve desired health outcomes.*

This spring, the ACOI Board has further defined the concepts and principles of medicine that have been a hallmark of our training programs and are critical to continue at the training level. The ACGME realizes these values and has enlisted programs, both traditionally osteopathic and likewise allopathic, to adopt these concepts through Osteopathic Recognition (OR). We have seen steady progress in programs gaining osteopathic recognition, but we need more IM programs to adopt Principle Centered Medicine tenets to complete our mission and preservation projects. Please support OR at your local training programs and if you have questions contact the ACOI office and Don Nelinson, PhD, to learn how we can help.

ACOI Annual Convention

Family fun and CME in Orlando at the World Center!! We will be addressing our usual topics in medicine and osteopathic principles in more depth at this year's October CME convention. We will be rolling out a new branding message to help define our value, a value that starts with you, our members, and your participation in our programs. Packets for the meeting go out this month. Please join us for an outstanding and unique brand of medicine and continuing education.

Finally enjoy the summer and all it offers for relaxation and family fun!

Respectfully submitted,

Martin C. Burke, DO, FACOI
President



government RELATIONS

Timothy McNichol, JD

Right-to-Try Legislation Signed into Law

The President signed legislation into law to give patients with life-threatening diseases access to experimental treatments. Under the new law, with certification by a physician, certain patients will potentially have access to drugs and biological products that are not yet approved for commercial use by the Food and Drug Administration (FDA). The law potentially benefits those with life-threatening diseases who are not otherwise eligible to participate in a clinical trial. While the FDA's current Expanded Access Program allows patients to use unapproved experimental drugs if certain conditions are met, this law expands potential access to drugs and biological products by not requiring the FDA to sign off on a treatment, among other things. Opponents of the new law have expressed concern that it undermines patient protections and adversely impacts the FDA's safety and effectiveness oversight activities. The law expands access to drugs and biologics that have successfully completed phase one clinical trials, but have yet to be approved for sale.

New Court Challenge to ACA

The Department of Justice (DOJ) recently announced that it will not defend the Affordable Care Act (ACA) in a suit brought by 20 Republican-led states. The states filed a lawsuit stating that the ACA is unconstitutional as a result of the recent enactment of tax-reform legislation that contained a provision repealing the individual mandate originally established under the ACA.

In June 2012, the Supreme Court found that the individual mandate was a tax and a valid exercise of congressional authority. This finding prevented the ACA from being struck down and allowed its implementation to continue. Following the recent enactment of tax-reform legislation that contained a repeal of the individual mandate, 20 states filed suit contending that without the individual mandate, the ACA is unconstitutional in its entirety. The matter is further complicated by the ACA's reliance on this provision as its backbone. As an example, it appears that the pre-existing condition protections provided in the ACA, as well as the prohibition against discriminatory premium rates, will not be able to survive absent the individual mandate because of the expected change in the composition of the insurance pool. In response to the DOJ's inaction, 17 states are working to defend and protect the ACA and its provisions. In addition, a bipartisan group of governors has called on the DOJ to rescind its decision not to defend the ACA because of the potential negative impact on patients. The ACOI will continue to monitor this matter closely.

Opioid Bills Advance in the House and Senate

The House recently approved more than 20 bills to address the expanding opioid epidemic. The legislation approved by the House responds to the crisis by expanding treatment and recovery efforts, supporting prevention activities, and advancing education efforts. Included in the legislation approved by the House is language to provide the National Institutes of Health (NIH) with enhanced flexibility to conduct research on non-addictive pain medications. In addition, language was included to ensure physicians have access to a patient's complete medical record before making prescribing decisions.

The Senate is continuing to work to address the opioid epidemic, as well. Most recently, the Senate Finance Committee approved legislation to reform the Medicare and Medicaid programs in support of more efficient treatment. While it remains uncertain what final legislation sent to the President's desk for signature

will look like, the consideration of opioid-related legislation continues to be a bi-partisan effort transcending geographic and partisan lines. The ACOI will continue to closely monitor congressional activity on this important issue.

Number of Hospital Acquired Conditions Continues to Decline

According to a recently-released report by the Agency for Healthcare Research and Quality (AHRQ), hospital acquired conditions dropped an estimated eight percent from 2014 to 2016. The report found that the reduction in things such as adverse drug events, catheter-associated urinary tract infections, and injuries from falls resulted in roughly 8,000 fewer deaths and a savings of approximately \$2.9 billion. The report estimates that there were 3,500 fewer hospital acquired conditions during the reviewed time period. This comes on the heels of an estimated 17 percent reduction between 2010 and 2014, resulting in an estimated 2.1 million fewer hospital acquired conditions, a savings of \$19.9 billion and 87,000 fewer deaths. The Centers for Medicare and Medicaid has set a goal of reducing hospital acquired conditions by 20 percent from 2014 to 2019. You can review the full report at <https://www.ahrq.gov/>.

Washington Tidbits Representation by the Representatives

Civics 101 teaches us that there are 435 representatives and 100 senators in the US Congress. This is correct, but how did we get here? The Constitution clearly states, "The Senate of the United States shall be composed of two Senators from each state...." The manner in which the House reached 435 members is not as clear cut.

There were approximately five million Americans in 1800 represented by 106 representatives and 32 senators. These numbers grew to 20

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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.

Split/Share Billing

In my last article, I addressed the many misconceptions surrounding incident to billing for services provided by non-physician practitioners (NPPs) (most often nurse practitioners and physician assistants). In fact, there are actually three ways by which services provided by an NPP can be billed: direct billing under their own provider number (paid at 85 percent of fee schedule); incident to billing, which we talked about last time; and split/shared billing where both the physician and NPP are paid under the physician fee schedule for the service provided.

Split/shared billing is exactly what it sounds like. Each provider performs part of the care and is reimbursed accordingly. Documentation is looked at closely to determine the level of service provided to the patient on that day. Split/shared services occur when the place of service from a billing perspective is in an inpatient hospital setting, an outpatient hospital setting, or an emergency department. The most common scenario is in the inpatient hospital setting. The NPP rounds and sees patients in the morning and the attending physician comes in later in the day to do their evaluation and write their note. According to the Medicare Carriers Manual, Chapter 12, Section 30.6.1B, "E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed."

In practice, however, Medicare regional carriers indicate that a substantive portion of the E&M visit must be performed by the physician. This represents a significant difference in the amount of work expected of the physician for his or her portion of the split/shared billing visit. Amazingly, this part of the definition is found in the Skilled Nursing and Nursing Facilities section of the Manual after stating that it cannot be performed in the skilled nursing or nursing facility setting. Again, from the Medicare Carrier's Manual Chapter 12, Section 30.6.13.H, which states, "a split/shared E/M visit cannot be reported in the SNF/NF setting. A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some

portion of the history, exam or medical decision making key components of an E/M service."

Remember this level of documentation when documenting notes to be billed as split/shared visit. Your note needs to contain "all or some portion of the history, exam or medical decision making." A signature alone will not suffice. As an example, the documentation used as a teaching physician is insufficient. "I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the (resident's) note" is a statement that does not show what work was done. It does not document "all or some portion of the history, exam or medical decision making."

One final note, if your practice location is owned by the hospital and is considered a "provider-based" office (patients get a bill from both the facility and the provider) that location is considered an outpatient hospital. As such, incident to billing, which allows the NPP to see the patient alone based on the plan of care previously written by the physician, would not be the concept used, split/shared billing would be appropriate. In other words, if you want to bill under the physician's numbers and collect 100 percent of the allowed amount, the physician must perform a "substantive" portion of the E&M service. Changes in location classification change the billing and documentation requirements. Do not get caught in an audit with insufficient documentation (substantive), or using incident to concepts that do not apply.



talking science & education

Donald S. Nelinson, PhD

Greetings colleagues and welcome to the June, 2018 issue of Talking Science and Education. From winter to summer almost overnight! I hope you are all taking some time to enjoy the beautiful weather and the great outdoors.

In last month's population health quiz, we asked which state has more than 200 primary care physicians per 100,000 population. The distribution of primary care physicians varies by approximately two-to-one across the nation. From our quiz, Connecticut is one of the states with more than 200 primary care physicians per 100,000 population. Now c'mon folks, we had no entries last month. So I'm hoping this month will draw in some players. Don't forget, the first respondent with the correct response will receive valuable prizes.

Keeping with the PCP theme, here's your population health trivia quiz for June. Remember, in the spirit of good sportsmanship, no Googling allowed. Good luck!

This month we want to know which of the following states has fewer than 100 primary care physicians per 100,000 population?

- A. Idaho
- B. Delaware
- C. Louisiana
- D. Tennessee

Send your answer to don@acoi.org.

This month in our section on education, I'd like to share an interesting study focused on the training of primary care physicians. I think we all would agree that geriatrics training is essential for future primary care providers. The Extension for Community Healthcare Outcomes (ECHO) model improves access to specialty care via case-based videoconferencing, but Project ECHO has not previously been designed to target residents.

Reported last week in the Journal of Graduate Medical Education (JGME), the investigators discussed how they designed Project ECHO-Geriatrics to deliver geriatrics education to primary care trainees. They utilized the ECHO model and evaluated self-rated geriatrics competency of trainees from the University of Washington Family Medicine Residency Network programs who participated between January 2016 and March 2017.

Outcomes of Project ECHO-Geriatrics were assessed through anonymous surveys. Participants rated didactics, case discussions, and geriatrics-specific knowledge before and after sessions on a 5-point Likert-type scale (1, low, to 5, high). Participants were asked whether they planned to do anything differently in their practice and, if yes, to describe this change. This intent-to-change is commonly used to assess Moore's level(s) 3/4 in CME.

Fifteen sessions were held with 204 unique participants from 12 sites, with an average of 28 (range, 13–41) participants per session. From the nine of 29 (31%) Family Medicine Residency Network programs that enrolled, 63% percent (116 of 184) of eligible residents attended. Sessions were highly rated (89% of responses were 4 or 5). Self-reported geriatrics-specific knowledge increased significantly (before 3.3 [SD = 0.89] versus after 4.0 [SD = 0.60], $P < .001$). Sixty-five percent (118 of 181) of participants reported plans to change their practice.

Project ECHO-Geriatrics is an innovative, feasible way to train the future primary care workforce in geriatrics and grow the capacity to provide high-quality care to older adults. Perhaps a replication of this study with internal resident trainees might improve how we are approaching our training of residents in primary care geriatrics.

Diabetes Dialogues

Lifestyle advice alone fails to reduce type 2 diabetes risk

Among Norwegian adults at high risk for developing type 2 diabetes, twice-yearly group sessions designed to teach lifestyle modifications did not decrease disease risk over two years, according to study results. Anne Jølle, MD, a specialist in family medicine and research fellow in the department of public health and general practice at the Norwegian University of Science and Technology, and colleagues enrolled 2,380 adults (identified through the 2006-2008 Nord-Trøndelag Health Study (HUNT3) of adults living in Nord-Trøndelag County, Norway without type 2 diabetes but at increased risk for the disease in the InnvaDiab-DE-PLAN study.

Participants (mean age, 62.7 years; 60.8% women) underwent a baseline physical examination and then attended four 2.5-hour group education sessions at two, six, 12 and 24 months after baseline. Sessions covered general information about diabetes and diabetes risk/prevention, nutrition and dietary recommendations, advice on moderate physical activity, and information on physical activity opportunities. HbA1c and fasting two-hour oral glucose tolerance test measurements were recorded at each session.

Among the cohort, 50.9% attended at least three of the sessions, with attendance similar between men and women; participants younger than 50 years had moderately higher atten-

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Interview with Frederick A. Schaller, DO, MACOI



Meet Rick Schaller, DO, MACOI, a practicing clinical cardiologist in Henderson, Nevada. An ACOI member since 1985, he served on the ACOI Board of Directors for many years and was the College's President in 2005-2006. Dr. Schaller currently chairs ACOI's Continuing Medical Education Committee.

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

Dr. Schaller: My whole career has focused on medical education. After completing my fellowship, I was asked to serve on the Council on Education and Evaluation. For many years I developed educational programming for Program Directors at institutions across the country. I was fortunate to have a special mentor, Andy Pecora, to guide me.

Ms. Cicone: Regarding your efforts and involvement with the College, what are you most proud of ACOI accomplishing?

Dr. Schaller: I believe the College's most recent and impressive accomplishment is the shift from a focus of medical education residency training to the new venture of continuing medical education for our members and the broader medical profession. This sea change, led by the ACOI Board of Directors, required the College to readjust and realign our vision for the future.

I am very appreciative of ACOI's role over the years in developing sound residency training, creating the best training programs in internal medicine. There was phenomenal growth in residency programs.

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 a generous contribution to the 75th Anniversary Campaign. Why did you choose to make a gift? What do you think ACOI should do and say to encourage members to support the College financially?

Dr. Schaller: From when I was President, I felt strongly that the College needed to have resources to do new initiatives beyond dues and convention registrations. We did attempt to raise funds from our members but did not have success until the launch of the 75th Anniversary Campaign. I am very pleased to see that our members responded so positively to the urgent need to support the College through its paradigm shift.

There will be a need for increased resources in order for the College to successfully accomplish its vision for the future. I would recommend that ACOI continue to inform its members about the initiatives supported by current campaign funds as well as any new efforts and initiatives that are created as part of the College's strategic planning process. Financial support from the members is critical.

Ms. Cicone: You and your wife are Charter Members of ACOI's Legacy Society that recognizes individuals who have included the College in their estate plans. Why did you choose to make this ultimate contribution? What would you say to others about becoming a member of the Legacy Society?

Dr. Schaller: When I was President, I saw that many other organizations had programs that allowed people to include those organizations in their wills. For that reason, I decided to help establish the ACOI's bequest program and, of course, I wanted to participate.

The Legacy Society recognizes those of us who have included the College in their wills or estate plans. I would encourage others who have been involved with ACOI and feel that they have benefited from their ACOI membership over the years to give serious consideration to joining the Legacy Society members. For many of us it is a way to give back to the College and to the osteopathic internal medicine profession.

Ms. Cicone: Given the challenges facing osteopathic internal medicine, what does ACOI need to do to continue to serve its members in the future?

Dr. Schaller: I know we are facing a number of challenges but I do believe ACOI has a future. The College must continue to be a driving force for our profession. Thousands of members will benefit if ACOI remains current, active, flexible, and relevant. We will keep our members and add new members because we still need each other!

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

75th Anniversary Campaign Honor Roll of Donors

(Outright Gifts and Multi-Year Commitments of \$1,000 or more as of June 30, 2018)

The ACOI Board of Directors wishes to thank all ACOI members for their annual support for the College. The generous support of our 75th Anniversary Campaign donors is of the utmost importance as we seek to maintain an osteopathic approach to internal medicine for future generations of patients.

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George Caleel, DO, MACOI

Christine M. Samsa, DO, FACOI

and Nathan P. Samsa, DO, FACOI

Roy J. Sartori, DO, FACOI

and Christine Sartori

Thomas Schneider, DO, FACOI

Martin W. Schwarze, DO, MACOI

Suzanne Shenk, DO, FACOI

and Scott Siegal, DO, FACOI

Laura Smith, DO, FACOI

Duane Sossong, DO

David G. Stainbrook, Jr., DO, FACOI

Christina A. Stasiuk, DO

and George Farian, Esq.

W. W. Stoeber, DO, MACOI

Brad Suprenant, DO, FACOI

David Susser, DO, MACOI

John R. Sutton, DO, FACOI

Richard R. Thacker, DO, FACOI

Kenneth Trinidad, DO

Gordon P. Tussing, Jr., DO

Amita Vasoya, DO, FACOI

William H. Voss, DO, MACOI

Thomas Waltz, DO, FACOI

R. Colin Wetz, DO, FACOI

Mark L. Woodard, DO, FACOI

William Zipperer, Jr., DO, FACOI

2018-2019 ACOI Development Committee Begins Its Work

The College wishes to thank Rob DiGiovanni, DO, FACOI, who served on the 75th Anniversary Campaign Committee, for agreeing to serve as chair of the Development Committee. He is joined by several other Campaign Committee members including Larry Haspel, DO, MACOI, Campaign Chair; Marty Burke, DO, FACOI, Campaign Vice Chair and Current ACOI President; Kevin Hubbard, DO, MACOI; and Rick Schaller, DO, MACOI. We give a warm welcome to our new members, Pamela Gardner, DO, FACOI; Laura Rosch, DO, FACOI, and Ron Walsh, DO, FACOI.

Building on the success of the 75th Anniversary Campaign to build a culture of philanthropy among ACOI members, the Development Committee plays a critical role in stewarding ongoing donor relationships and helping to build stronger relationships with current and prospective supporters. If you are interested in joining this vital committee for ACOI's future, please contact Brian Donadio at bjd@acoi.org or 301-231-8877.

Have You Moved?

Keep us updated.

If you have recently made any changes in your address, phone number or email,

please notify the ACOI at acoi@acoi.org

Add Your Name to Leave a Legacy

Members of the ACOI Legacy Society have done their part to ensure the future of the College. If you are a member, thank you!

If you are not a member, please look at the names listed and consider adding yours to those who have made a provision in their estate plans, typically with a bequest provision, that will provide support in the future.

It will bring you peace of mind knowing that you have done your part to ensure that those who enter the profession in the future will have access to the same education, support, and mentoring that you have received. Think of it as paying your dues forward, leaving a legacy and mentoring those you will never know, but who will provide future generations with the kind of patient-centered care that you have built a career providing.

New members will be recognized at the 2018 ACOI Convention in Orlando. Be among those who will receive a certificate and a unique crystal membership emblem that can grace your office or den, showing that you have proudly made an investment in the future of the profession.

If you would like to have the ACOI planned giving consultant talk with you about creative ways you can join the Legacy Society now and receive a life-time income, [click here](#) and let us know how and when to contact you, or call Brian Donadio at 301-231-8877.

Legacy Society

(As of June 15, 2018)

Dr. Jack and Jocelyn Bragg

**Dr. John and
Dr. Michelle Bulger**

**Dr. Mathew and
Marbree Hardee**

**Dr. David and
Rita Hitzeman**

**Dr. Robert and
Donna Juhasz**

**Dr. Karen and
Jim Nichols**

Dr. Eugene and Elena Oliveri

**Dr. Frederick and
Amy Schaller**

In Memoriam

Word has been received of the following deaths:

Robert D. Wall, DO, FACOI, on May 25, 2017. He was 47. Dr. Wall was a practicing electrophysiologist in North Chili, NY. He completed his internal medicine and cardiology training at McLaren Medical Center-Macomb in Mount Clemens, MI, and his electrophysiology fellowship at the University of Rochester. He was an ACOI Active member beginning in 2011 and achieved the degree of Fellow in 2015.

Candace B. Flaughner, DO, on May 9, 2018. She was 46 years old. Dr. Flaughner was a board-certified rheumatologist practicing in Richmond, IN. She completed her internal medicine residency at St. Vincent Mercy Medical Center in Toledo, OH, and rheumatology fellowship at Osteopathic Medical Center of Texas in Fort Worth. She was an ACOI Active member since 2009.

Kevin Lee Rhodes, DO, FACOI, on June 18, 2018. He was 45 years old. Dr. Rhodes was a board-certified general internist practicing in Kirksville, MO. He completed his medicine residency at Genesys Regional Medical Center in Grand Blanc, MI. In addition to his practice, Dr. Rhodes served as the program director of the combined internal medicine-neuromusculoskeletal medicine residency program at Northeast Regional Medical Center in Kirksville. He was an Active ACOI member since 2003 and achieved the degree of Fellow in 2010.

ACOI's 75th Anniversary Campaign Surpasses Goal – Raising \$841,195.95!



PROFESSIONAL OPPORTUNITIES

July 2018 Pulmonary Fellowship Positions Available

Two PGY IV Pulmonary Medicine Fellowship positions are available beginning July 1, 2018 at Bay Area Medical Center in Corpus Christi, Texas. The ideal candidate must have completed an ACGME or AOA-approved Internal Medicine residency and meet requirements for board-eligibility before June 30, 2018.

Our Graduate Medical Education Programs include:

- Pulmonary Fellowship
- Cardiology Fellowship
- Internal Medicine Residency
- Dermatology Residency
- Pharmacy Residency

Our team is dedicated to delivering top patient care and advancing medical knowledge. With over 50 resident physicians and fellows currently practicing in our programs, we are continuing to grow.

Each fellow will have the opportunity to give numerous case presentations and participate in monthly journal clubs. Our programs are designed to equip each of our graduates with the tools they need flourish and succeed in their field.

If you have questions about our program or the application process, please contact the fellowship coordinator, Cheyenne Silva at 361-761-3436 or email Cheyenne.oneill@hcahealthcare.com.

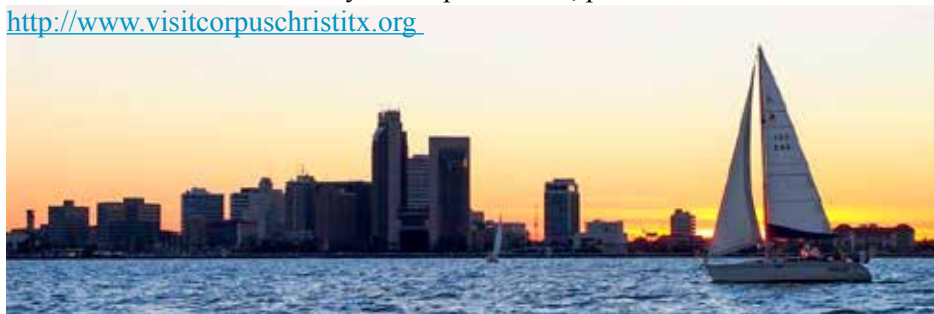
Corpus Christi Medical Center

Bay Area Hospital and Doctor's Regional Hospital are two of six hospitals that make up Corpus Christi Medical Center, an HCA affiliate bringing the best in medical care to South Texas. Corpus Christi Medical Center has been a growing part of South Texas since 1962, what began as a 26 bed facility in the early 60s has grown into a 631 bed system offering a full range of health care services. For more information, please visit <http://ccmedicalcenter.com>.

The City of Corpus Christi

Corpus Christi is a growing city of over 320,000 residents. With everything from Fiesta del Flor to the Jaz Festival, to Buccaneer Days, Corpus Christi is rich in culture and diversity. Come downtown and visit the Texas State Aquarium, the Art Museum, or the historical U.S.S. Lexington then relax and eat dinner at a restaurant overlooking the Marina. Padre Island is a mere 20 minutes away, its beautiful beaches offer everything from surfing to horseback riding to volleyball, and yes, you can drive on them. Our warm South Texas weather makes it an ideal location year round.

For information about the city of Corpus Christi, please visit <http://www.visitcorpuschristitx.org>



Government Relations

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million Americans, 226 representatives and 56 senators by 1845. As the population grew and the number of states grew, so did the number of senators and representatives. Concern with the ability of the House to function also grew in proportion to its size. To guard against an unwieldy chamber, the House approved the Permanent Apportionment Act of 1929 on June 11, 1929, capping the number of representatives at 435. The driving force behind this legislation was that following the 1920 Census, for the first and only time, the House failed to reapportion itself. The House reached 435 members following the 1910 Census and the cap was put in place. Could you imagine the effectiveness of a legislative chamber larger than this?



Outstanding Resident Of the Year Award

Nominations now being accepted via the link below. Nominations must be received by July 6.

Residents are the future leaders of the osteopathic profession, with some going on to become national and world leaders in health care or research.

The Outstanding Resident of the Year Award recognizes and honors osteopathic residents whose combination of clinical promise, leadership, dedication and commitment to osteopathic patient-centered care, separate them from others.

In partnership with the ACOI, the AOF is pleased to honor and co-recognize outstanding residents this year, to acknowledge professional excellence.

[Click here](#) to access the application.

For more information, contact the ACOI or call the AOF at (312) 202-8235.

CME CALENDAR

Future ACOI Education Meeting Dates & Locations

NATIONAL MEETINGS

- 2018 Annual Convention & Scientific Sessions
Oct 17-21 Orlando World Center Marriott, Orlando, FL
- 2019 Internal Medicine Board Review Course
- 2019 Clinical Challenges for Inpatient Care
- 2019 Exploring New Science in Cardiovascular Medicine
- 2019 Congress on Medical Education for Residency Trainers
May 7-12 Baltimore Marriott Waterfront Hotel, Baltimore, MD
- 2019 Annual Convention & Scientific Sessions
Oct 30- Nov 3 JW Marriott Desert Ridge Resort & Spa, Phoenix, AZ
- 2020 Annual Convention & Scientific Sessions
Oct 21-25 Marco Island Marriott Beach Resort, Marco Island, FL
- 2021 Annual Convention & Scientific Sessions
Sept 29-Oct 3 Marriott Marquis Hotel, San Francisco, CA

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

2018 Certifying Examination Dates & Deadlines

Internal Medicine Certifying Examination

Computerized Examination 300 Sites Nationwide
September 12-14, 2018 - *Application Deadline: Expired*

Internal Medicine Recertifying Examination

Computerized Examination 300 Sites Nationwide
September 12-14, 2018 - *Application Deadline: Expired*

Internal Medicine Recertifying with a Focus in Hospital-Based Medicine Examination

Computerized Examination 300 Sites Nationwide
September 12-14, 2018 - *Application Deadline: Expired*

Subspecialty Certifying Examinations

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

Subspecialty Recertifying Examinations

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

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

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

Talking Science & Education

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dance (58.5%) vs. those aged 50 to 69 years. Those with depressive symptoms had slightly lower rates of attendance (47.4%) vs. those without depression (52.3%).

Three and one-half percent of participants received a new diagnosis of diabetes, with 3.1% diagnosed at 12 months and four percent at 24 months, for a two-year diabetes incidence of 10.3%. From baseline to 24 months, researchers observed overall increases in mean HbA1c (0.3 percentage points), fasting blood glucose rose (0.13 mmol/L) and two-hour OGTT (0.46 mmol/L; $P < .001$ for all), as well as BMI (0.3 kg/m²; $P < .001$).

The substantial two-year diabetes incidence, the consistent increases in glycemia and BMI, the relatively low participation, and the low proportion achieving substantial weight reduction indicate that the low-grade intervention with basic lifestyle advice did not have a clinically meaningful effect on diabetes prevention, overall or in subgroups by age, sex, education level, depressive symptoms, BMI, physical activity or family history of diabetes. The prevention strategy of informing high-risk individuals about their elevated diabetes risk and providing them with basic lifestyle advice is likely of similar intensity as the preventive measures often offered to high-risk individuals in a primary care setting. However, the strategy appeared ineffective and improved population strategies or more intensive individual-level intervention seem necessary to prevent type 2 diabetes.

One might say, “Well, Don, of course utilizing such a low-grade intervention will not yield results.” To that I can only ask, “How often and for how long do we have the opportunity to do extensive lifestyle education and intervention?”