ACOI information

A PUBLICATION OF THE AMERICAN COLLEGE OF OSTEOPATHIC INTERNISTS
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From President Carron

Connection Leads To Protection

Empathy—it's that ability to understand the feelings of others because we share something in common. At the most basic level, we all have something in common. Just living as humans gives us a primal knowledge of what it's like to endure. From birth to death, certain physiological functions are sure to occur that cause us pain, fear, confusion, joy and peace. Falling as we take our first steps, that first trip to the doctor, meeting the love of your life, having a baby, losing 20/20 vision, the excitement of learning, a scary diagnosis, growing old. If you live long enough, you experience every facet of the human condition.

While we may not be able to relate to everyone who comes into our offices, it isn't too much of a stretch to find something we have in common. Once we do that, the person before us isn't just a patient anymore, but a fellow human being going through a

continued on page 2

In This Issue...

2019 ACOI Membership Survey Results

The ACOI conducts a survey of the membership every two years in order to find out more about members, their practices and their involvement with and evaluation of ACOI. The names used for this year's survey, which was conducted by ResearchUSA, were all ACOI members with known e-mail addresses. The data in this report are based on computer tabulation of the 882 (24.1%) completed questionnaires that were returned.

About Members

Males comprised 65.8% of those responding, with the average age of all respondents being 48.5 years, both slightly lower than the 2017 survey. Members' practices are located in most states throughout the United States, with the largest percentage practicing in Michigan, Pennsylvania, Florida, Ohio, and New Jersey. An average of 74% of member's time is spent in patient care. Approximately 98% of all members are board certified; with 96.9% of this group being certified by an AOA recognized osteopathic board. Fifty-five percent of respondents are currently an ACOI Fellow. Subspecialists (63.4%) and members who practice in both office and hospital medicine (60%) are most likely to be Fellows, compared to 56% of those in office-based general medicine, and 37% of hospitalists. A majority of members who are not currently an ACOI Fellow plans to seek the FACOI title.

ACOI Member Benefits & Services

Many ACOI activities studied are rated "very" or "somewhat important" by a majority of members in all primary practice areas. The activities rated "very" or "somewhat important" are as follows:

continued on page 10

June 30 Deadline

ACOI Board of Directors Nominations Sought

Active members of the ACOI who are interested in serving on the Board of Directors are invited to contact the College's office and request a nominating packet. The members of the ACOI will elect three individuals to three-year terms on the Board at the Annual Meeting of Members November 3 in Phoenix, AZ.

As part of an ongoing self-assessment process, the Board has developed a position description for Board members, and a list of competencies that should be possessed by the Board as a whole. Potential candidates must complete an application form that allows them to describe how their experience and expertise match up with the desired competencies. In order to be considered by the Nominating Committee, the completed nomination packet must be returned to the ACOI office no later than June 30, 2019. The slate of candidates will be announced in the July issue of the newsletter.

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

continued from page 1

situation that we know something about. There really isn't a lot to be gained by putting ourselves on pedestals, above the normal challenges of living. But there is much to be gained by empathizing and letting our patients know that we know what it's like. Not just from books, but because we've been there ourselves. Empathy builds trust and a trusting patient is much more likely to take our advice and follow our directions. This, for me, is the true essence of the practice of an Osteopathic physician

Even if we have never experienced the exact same condition as our patient, we understand the feelings associated with a diagnosis, or uncertainty. We may even draw upon knowledge of a family member, friend or colleague who went through something similar. The degrees of separation between all humans aren't really such a stretch.

Now, I am not by any means suggesting that we go into great detail about our circumstances or those of people we know. We don't need to minimize a patient's concerns or make the visit all about us. Instead, I'm suggesting that perhaps we can find a thread of empathy and show that we, in fact, do understand and relate. Giving comfort this way takes us off the pedestal and sets us squarely in the role of healer as human. Being empathetic allows us to step out of the restrictions imposed by a massive healthcare system, insurance regulations and medical lingo and lets us do what we became doctors to do—treat people.

Relational therapy and instruction work. Remember your favorite professor? If you're like me, it's the one who'd been there, done that. It was someone who told first-hand stories of therapies that worked, or how they walked a patient through a serious disease, crisis or end-of-life experience. Self-help and 12-step groups save countless lives based solely on sharing. The greatest friendships are based on shared experiences, tears and laughter. The most effective spiritual leaders aren't afraid to share their own failings and how they found their way out of the darkness.

As we strive to live up to our ACOI values, to a practice of principled-centered medicine, an ingredient we can't overlook is the power of empathy and how it can so seamlessly be woven into the way we deliver our services. Human to human, perhaps we can overcome the stigma of the doctor/patient relationship that too many people hold as us vs. them, causing patients too often to approach our relationship with negative expectations and fear. Steven Covey said, "When you show deep empathy toward others, their defensive energy goes down, and positive energy replaces it. That's when you can get more creative in solving problems."

As members of ACOI, we connect with each other through this newsletter, our get-togethers, dinners and meetings. As your President, I get great joy from the relationships that come from my involvement, from sharing experiences with you and creating a safe, positive environment in which we all can grow to be the best doctors that we are capable of being, effective at making a difference in the lives of others. We all fell down when we first started walking and we all got up. There's no greater joy than touching the hand that reaches down to help us up as our benefactor says, "It's going to be okay, I've been there too."

government RELATIONS

Timothy McNichol, JD

ACOI Member Appointed to CMS Committee
ACOI member Seger S. Morris, DO, MBA, was recently appointed to the Centers for Medicare and Medicaid Services' (CMS) Episode-Based Cost Measure Hospital Medicare Clinical Subcommittee. The subcommittee is tasked with helping to develop episode-based cost measures in hospital medicine suitable for potential use in the Quality Payment Program. Dr. Morris is a member of the ACOI Government Affairs Committee.

Federal Court to Hear Arguments in Case Striking Down the ACA
The Fifth Circuit Court is scheduled to hear oral arguments beginning in July in a case challenging the constitutionality of the Affordable Care Act (ACA). An earlier court decision in the US District Court for the Northern District of Texas (Texas v. US) found the ACA to be unconstitutional as a result of a change in federal law zeroing out the individual mandate penalty created by the ACA. The lower court found, absent the individual mandate penalty, the law cannot stand. The Department of Justice (DOJ) announced a change in its previous position and has notified the courts that it supports the ACA being struck down in its entirety. It is likely the US Supreme Court will have the final word in this complex litigation. The ACOI will continue to monitor this case closely as its final adjudication could significantly impact the healthcare delivery system.

Final Conscience Rule Issued
The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) recently issued a final rule providing protection for healthcare providers who refuse to provide medical services on religious or moral grounds. The final rule extends conscience protections to abortion, sterilization, and assisted suicide. The final rule also applies to advance directives. According to OCR Director Roger Serna, "This rule ensures that healthcare entities and professionals won't be bullied out of the healthcare field because they declined to participate in actions that violate their conscience, including the taking of human life. Protecting conscience and religious freedom not only fosters greater diversity in healthcare, it is the law." A lawsuit has been filed in federal court challenging the final rule arguing that it is too broad and could allow healthcare providers to refuse to provide care in emergencies. The rule takes effect later this summer.

House Approves Bill to Repeal Administrative Guidance
The House approved legislation requiring the Trump Administration to rescind guidance granting states greater flexibility to waive certain requirements created under the Affordable Care Act (ACA). Specifically, the guidance permits states to apply for waivers to pursue strategies for providing residents with access to health insurance by altering existing ACA guidelines. The concern is that the broad use of waivers granted under the Administration's guidance could result in the removal of protections for pre-existing conditions created through the ACA. Similar legislation has been introduced in the Senate where it is not expected to be considered.

House Approves Package to Lower Drug Costs, Protect ACA
The House recently approved a package of bills crafted to lower the cost of prescription medication by promoting generic competition. The legislation included four bills added to counter efforts by the Administration to repeal the ACA through administrative maneuvers. The addition of the ACA language resulted in a final bill being approved along party lines. It is unlikely that the Senate will consider the final bill approved by the House. It is, however, likely the prescription drug pricing reforms supported on both sides of the aisle will reappear at a later time in a different bill.

Prescription Drug Pricing Required in Ads
The Department of Health and Human Services (HHS) recently released a final rule requiring pharmaceutical manufacturers to include a drug's list price in direct-to-consumer television ads. Under the final rule, television ads will be required to include the wholesale acquisition costs for prescription drugs and biological products covered by Medicare and Medicaid if their list price is more than $35 for a one-month supply, or the usual course of therapy. The final rule exempts radio, magazine, newspaper, website, and social networking ads. The final rule does not include enforcement mechanisms, leaving this to competitors to bring suit for unfair competition. HHS will maintain and post a listing of companies in violation of the rule on CMS' website. The rule takes effect on July 9.

Washington Tidbits
Birth of a Nation…Birth of a Leader
The town was a powder keg waiting to explode. The fuse was lit; shots were fired. At the end of the day, five Bostonians lay dead in the street and another six were wounded. Charged with murder were British Captain Thomas Preston and his men. It was 1770 and the young nation would never be the same.

With the rule of law being the guiding hand, the defendants were unable to secure legal representation until a 35-year-old local attorney agreed to lead the defense. The attorney was not a sympathizer, and in fact did not care for his clients. However, he thought it imperative that they receive a fair trial since their lives were at stake. The attorney argued that confusion ruled the cold wintery night in Boston. There was no way to clearly discern what had happened and who was to blame. He argued the existence of "reasonable doubt." Captain Preston was found not guilty. A few months later, the attorney was elected to the Massachusetts' House of Representatives due in part to his efforts in the trial. A few years after that he went on to become the second President of the United States. John Adams launched his career

coding CORNER

Jill M. Young, CPC, CEDC, CIMC

Jill Young, CPC, CEDC, CIMC, is the principal of Young Medical Consulting, LLC, a company founded to meet the education and compliance needs of physicians and their staff. Jill has over 30 years of medical experience working in all areas of the medical practice. You can reach Jill by emailing her at youngmedconsult@gmail.com.

Increasing the Efficiency of Your Coding...99213 Office Visits

A common trend I see in the audits I conduct is the inclusion of copious amounts of unnecessary information for the documentation of 99213 office visits. This often occurs when a physician resorts to the use of pre-populated templates that then need to be reviewed and edited. Rather than searching for the appropriate template and then editing it, perhaps the use of free-form text would be a more efficient use of your time.

Documentation for an established patient requires the inclusion of two of three elements. I prefer to use Medical Decision Making (MDM) as one of the two because it helps to show medical necessity. Documentation requirements for a 99213 office visit follows:

1995 Evaluation & Management Guidelines – (E&M)

-History at an Expanded Problem Focused (EPF) level
  1 HPI element
  1 ROS element, pertinent to the problem
-Exam at an Expanded Problem Focused (EPF) level
  1 affected body area or organ system
  1 other related system
-Medical Decision Making (MDM) at a Low (L) level (1 from each column)

Number of Diagnoses and Treatment Options	Table of Risk/Review Data
1 stable chronic problem with 1 co-morbidity	Prescription management
1 unstable chronic problem	1 or more stable chronic illnesses
2 stable chronic problems	Order or reading of labs plus an EKG or PFT

As an example of how minimal documentation for the 99213 visit can be (with apologies for writing a note as a non-clinician), I have written the following notes, which would be acceptable documentation in these simplified examples:

EXAMPLE 1:

Mary returns today for a recheck of her hypertension and COPD. She has not had any problems with either since her last visit. Exam today reveals her heart with RRR and lungs are clear with mild crackles at the base. She will continue on her medications (see medication sheet) and return in 6 months. DX: Hypertension; COPD

EXAMPLE 2:

Fred returns today for follow up of his high cholesterol and diabetes. Since his visit last year, his sugars have been stable and he has been eating and sleeping better. A&P: He will continue on the medication regimen as previously prescribed by me DX: Diabetes, Hyperlipidemia

EXAMPLE 3:

Susie has been having difficulty maintaining her sugars in the desired range this past month. They have been running XXX. She is trying to eat a better diet but struggles with snacking when her moods are affected by her family stressors. I have encouraged her to continue with improving her eating quality and quantity and to perhaps only keep healthy snacks available to her for those stressful times. She will continue with her insulin protocol as prescribed by me. DX: Diabetes in poor control, family stressors

In fact, at least one of these examples has MORE items than the documentation guidelines require for a 99213 visit! You can you see how quickly you could document this note by free-texting it. You do not need to identify which exam template to use, nor do you need to verify and uncheck half a page of history and ROS items in search of proper documentation. There is no need to have a two- or three-page note when 50 to 70 words as shown in the examples above would meet documentation requirements.

The same logic applies to your hospital patients. A 99232 hospital subsequent care day requires the same level of history (EPF) and exam (EPF) as the 99213 does. The difference is in the level of MCM which must be at a moderate level which brings that documentation to a higher level.

-Medical Decision Making (MDM) at a MODERATE (M) level
(1 from each column)

Number of Diagnoses and Treatment Options
1 unstable chronic problem with 1 co-morbidity
Prescription management
2 unstable chronic problems

Table of Risk/Review Data
2 stable illnesses
2 stable chronic problems with 1 co-morbidity
Acute illness w/systemic problems
Order or reading of (need 3)
  Labs
  X-Rays
  EKG/ PFT

Save time where you can! Simplify your documentation when appropriate. Forget the pre-filled information you are dumping into the record, which can result in conflicting documentation and become a compliance issue. Consider free texting your notes for expediency and accuracy.

talking science&education

Donald S. Nelinson, PhD

Greetings colleagues and welcome to the June issue of Talking Science and Education. Spring has sprung and I am back to the self-torture of pursuing my new passion: golf! Those of you who are golfers know of what I speak.

In last month's population health quiz, we asked you to identify the percent decrease of children in poverty between the years 2013 and 2018. The percentage of children in poverty decreased 19 percent from 22.6 percent in 2013 to 18.4 percent in 2018. It decreased 6 percent since 2017 from 19.5 percent of children aged 0 to 17. Unfortunately, there was no winner, but take a chance at this month's question.

Last month's question featured a population health success. This month we look at an area that remains a major healthcare challenge. In the past year, obesity in American adults has increased by what percent?

A. 15%
B. 5%
C. 10%
D. 3%

Become a Talking Science and Education winner but remember: no Googling!!!

Send your answer to don@acoi.org and win valuable prizes!

TALKING EDUCATION

The Physician as Adult eLearner

As the trends and preferences for online---or eLearning---in undergraduate, graduate and continuing medical education rapidly advance, this month I want to revisit some of the seminal thinking regarding adult learning and how it is relevant to eLearning activities. Malcolm Knowles put forward a theory in 1968 that distinguished adult learning (andragogy) from childhood learning (pedagogy). He expounded his ideas using five main assumptions. From these, he extrapolated four principles to make adult learning education more effective. His theory still holds water and is closely referenced in the development of most quality eLearning materials. For online learners and medical educators, here are seven notable facts and tips about adult learning theory that you may want to consider before creating or selecting your next eLearning activity:

1. Adult learners (physician learners) have a well-established sense of self.
In childhood, we model ourselves off our parents and siblings. As teenagers, we pull away from family to mimic our friends and peer groups. It isn't until adulthood that we pick-and-choose from these two stages. We form a complete entity we call our 'self' and can be very attached to it. Even if we're not emphatic about identity politics, we do have a clear sense of self. We know we're distinct and separate from those around us. This affects our decisions and actions. In a training context, this means we want a say in our eLearning activities. We require a healthy sense of autonomy in learning. Otherwise, we soon lose interest. Needs assessment, self-directed learning, and relevant case-centric approaches all help accomplish this.

2. Past experiences play a pivotal role in physician learning.
Kids go to school with a good deal of knowledge, but it's not necessarily academic. By pre-school, they vaguely know how to share and speak. But there's lots of space for fresh data. On the other hand, adults in general and physicians, specifically, have a world of both academic and social experience behind them. To advance physician learning effectively, educators must feed into what learners already know, piggy-back off that and launch new concepts. This is crucial because if new data clashes with the learners' existing knowledge base, they're not likely to accept it. As an educator, you must skillfully integrate into the learner's lived experience, becoming an active part of their thought process. If a physician feels he or she doesn't need to change how to manage a patient with T2DM, telling them how to change makes no sense. The first step is to bring them from pre-contemplation to contemplation (Prochaska).

3. Physician learning is purpose driven.
Kids go to school because they're supposed to. Physicians learn because they see the relevance. If they don't train, it could cost them a non-compliance penalty or a "ding" on QA measures. They consciously decide to pick up a new skill or consider a different standard of care. It's a choice, not a duty. So, their learning must be goal oriented. They have to see measurable learning objectives and have a clear system of gauging their progress. Otherwise, they will neither see nor glean any value. An eLearning course for physician learners must be tied to real-world applications. For example, they should incorporate simulations or real-world examples that allow the learners to see how the skill optimizes patient care or will help them overcome a challenge that is hindering their work performance.

4. Physician learning relies on a readiness to learn.
Whether learners have paid for an eLearning activity, or were sponsored by an employer, they are keenly aware they're in the session by choice. So, they're open to learning. They see the value in it and can comprehend the big picture. This makes them more receptive to study the online training material. It also makes them more discerning. They can recognize quality and are more vocal in demanding it. They relate to online instructors and eLearning activity designers as peers, since they're fellow healthcare professionals. They rarely hold them in awe or derision like kids do with their teachers. The "thought leader"

continued on page 6

continued from page 5

aura is diminished in the eLearning environment. Online training material must be relevant and task-based to tap into the learner's openness and interest.

5. Physician learners are driven by internal motivation.
Kids can be trained with carrots and sticks. They want their teachers to like them, and they're eager for those gold stars. They're scared of disapproval. These polar emotions can keep them working hard, at least for a while. Physicians and all adult learners develop their own methods of motivation. Online training should focus on problem-solving. Rote learning doesn't do physician learners much good. There's no stage in their workday when they'll need to recite their lessons. Instead, simulations and contextual, case-based role play, showing how to translate online training into real life, can be very effective.

6. Mistakes are often the most valuable teacher.
Adult learning theory hinges on experiential learning. Which means that adults are encouraged to explore the subject matter firsthand and learn from their mistakes. For example, clinical pathway scenarios show how actions or behaviors lead to real outcomes. As a result, learners are less likely to make those mistakes in the clinical setting and continually develop their experiential knowledge.

7. Physician learners must play an active role in the eLearning activity design.
A core principle of the adult learning theory is that online learners must be actively involved in the process so that they're empowered, motivated and are assured of content relevance. They should play a part in developing eLearning content, evaluating performance, and creating training criteria. They should also be able to personalize their learning paths and choose eLearning activities that are relevant to them and their job duties. The goal is to provide resources that allow learners to immediately apply what they've learned and address individual pain points.

Some of Knowles' concepts of andragogy are generally accepted. Others are disputed because they overlap with pedagogy. Further research has shown that childhood to adult learning is a spectrum. Some kids are precocious, and some adults are immature where online training is concerned. That said, Knowles' adult learning theory states that adults have a developed sense of self, prior experience, and practical reasons for learning; they're ready to learn and internally motivated. As a result, their online training programs should be self-directed, relevant, contextual, and task-based. They should be less theoretical and more hands-on.

For those of you who are involved in eLearning as an educator, I hope this revisit to some basic concepts in adult learning has been helpful. For those of you seeking quality online or other eLearning activities, I hope this article will help you make informed choices.

DIABETES DIALOGUES

Abnormal Sleep Patterns Raise HbA1c in Patients with Pre-Diabetes and Untreated T2DM

Adults with prediabetes or untreated type 2 diabetes who sleep fewer than 5 hours or more than 8 hours per night tend to have higher blood glucose levels than those who sleep between 7 and 8 hours, according to findings published in Diabetes Care this month[1].

There have been many studies over the last two to three decades showing relationships between sleep quality, sleep duration and either risk of developing diabetes or prediabetes or, once you have diabetes, putting your diabetes more out of control. Babak Mokhlesi, MD, MSc and his colleagues at the University of Chicago attempted to add to that literature with a more robust methodology.

Mokhlesi and colleagues conducted a cross-sectional study with 962 participants (mean age, 52.2 years; 45.4% women) in the RISE consortium (Restoring Insulin Secretion). All participants were aged 20 to 65 years and had prediabetes (n = 704) or newly diagnosed, untreated type 2 diabetes (n = 258). The study took place between 2013 and 2017 at four centers in Illinois, Indiana, Washington and California.

Blood samples were taken to measure HbA1c and plasma glucose, and participants also took a 75-g oral glucose tolerance test (OGTT). Participants were categorized as having prediabetes (n = 704; mean age, 51.8 years; 46.6% women; mean BMI, 34.5 kg/2; mean HbA1c, 5.7%) or recent, untreated type 2 diabetes (n = 258; mean age, 53.2 years; 42.2% women; mean BMI, 35.3 kg/2; mean HbA1c, 6.1%). Sleep duration and quality were assessed via questionnaire. Sleep durations were similar for those with prediabetes and type 2 diabetes, and about one-third of each group reported sleeping 6 hours or less per night. Mean sleep duration for the entire cohort was 6.6 ± 1.3 hours per night. Shift work was reported by 23% of those with prediabetes and 28% of those with diabetes.

Among the entire cohort, participants who slept between 7 and 8 hours per night had statistically significantly lower HbA1c than those with shorter or longer sleep durations, according to researchers. Mean HbA1c levels of 5.74% (95% CI, 5.67-5.8) compared with 5.84% (95% CI, 5.74-5.93) for those who averaged fewer than 5 hours of sleep per night and 5.85% (95% CI, 5.78-5.93) for those who slept more than 8 hours per night

Sleep duration also was associated with fasting plasma glucose and BMI measures; the addition of 1 hour of sleep was associated with an increase in FPG of 0.79 mg/dL (95% CI, 0.15-1.42) and decrease in BMI of 0.3 kg/m2 (95% CI, –0.56 to –0.03). Participants who performed shift work had a mean BMI 1.32 kg/m2 higher than those who did not. Participants with higher BMI were more likely to report excessive sleepiness during the day (P = .0024) and worse sleep quality (P = .048) compared with those with lower BMI.

The findings seem to say that people should strive to have more normal sleep duration of anywhere between 6 and a half to 7 and a half hours on average, understanding that there may be fluctuations from day to day. This type of sleep stabilization might be healthier than either sleeping excessively or sleeping less than 5 hours. It seems that the next question is, if you do an intervention to help improve sleep can you make an impact?

[1] Mokhlesi B, et al. Diabetes Care. 2019 May 2. pii: dc190298. doi: 10.2337/dc19-0298. [Epub ahead of print]

PMID: 31048411

75th Anniversary Campaign Honor Roll of Donors

(Outright Gifts and Multi-Year Commitments of $1,000 or more as of May 15, 2019)

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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Andrew Kotis, DO, FACOI
Cheryl Kovalski, DO, FACOI
Paul Kudelko, DO, MACOI
Nathan J. Landesman, DO, FACOI
Alexander "Sandy" Macnab
Daniel L. Maxwell, DO, FACOI
Timothy W. McNichol, JD
Michael J. Menolasino, III, DO, FACOI
Nathan Miller, DO, FACOI
Jo Ann Mitchell, DO, FACOI
Rizwan K. Moinuddin, DO and Mahnaz Ali, DO
Joseph Namey, Jr., DO, MACOI
Donald S. Nelinson, PhD
V. Kim Newsome, DO, FACOI and Tim Stainbrook, RN, BSN
Herbert Pasternak, DO, FACOI
Joanna Pease, DO, MACOI
William Peppo, DO, FACOI
Daniel K. Peshka, DO
John Prior, DO, FACOI
Bennet Radford, DO, FACOI
Jeffrey A. Ranalli, DO and Trina A. Poretta, DO
Laura Rosch, DO, FACOI for her mentor George Caleel, DO, MACOI
Christine M. Samsa, DO, FACOI and Nathan P. Samsa, DO, FACOI
Roy J. Sartori, DO, FACOI and Christine Sartori
Thomas Schneider, DO, FACOI
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 M. Farion, Esq.
W. W. Stoever, DO, MACOI
Brad Suprenant, DO, FACOI
David Susser, DO, MACOI
John R. Sutton, DO, FACOI
Richard R. Thacker, DO, FACOI
Kenneth Trinidad, DO
Gordon P. Tussing, Jr., DO
Amita Vasoya, DO, FACOI
William H. Voss, DO, MACOI
Ronald L. Walsh, DO, MACOI
Thomas Waltz, DO, FACOI
R. Colin Wetz, DO, FACOI
Mark L. Woodard, DO, FACOI
William Zipperer, Jr., DO, FACOI

ACOI Online Learning Center

With the launch of the ACOI Online Learning Center, continuing medical education is now available at your fingertips 24/7.

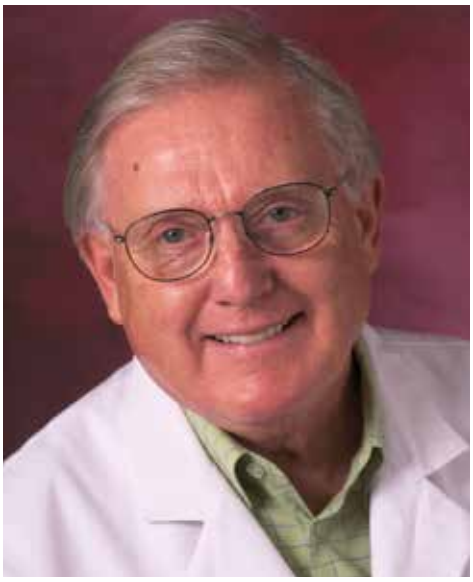
Convenient. Affordable.

Visit *www.learning.acoi.org.* to get started!

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

Interview With James C. Clouse, DO, MACOI



Meet James C. Clouse, DO, MACOI, FACNM, FACNP, Chair, Department of Nuclear Medicine and Molecular Imaging at Golden Valley Memorial Hospital in Clinton, Missouri, a post he has held since 1972. A 1962 graduate of the Kansas City University of Medicine and Bioscience, Dr. Clouse continued his medical training with an internship and radiology residency at Wetzel Hospital, followed by a fellowship in nuclear medicine at Golden Valley Memorial Hospital. He has held a number of leadership positions in medical organizations, including being a Founding Member of the American Society of Nuclear Cardiology. Jim has served for many years as ACOI's Nuclear Medicine Education Chair and as such is a regular attendee at the College's annual conventions. Jim also served as preceptor for senior Osteopathic medical students from KCUMB for over 25 years, which earned him the distinguished title of Clinical Professor of Medicine.

Ms. Ciconte: What prompted your decision to become a DO? Why did you become an ACOI member and how have you benefited from your membership over the years?

Dr. Clouse: Our family physician was a DO and when I expressed interest in medicine, he encouraged me to become a DO. As for joining the ACOI, I felt it was important to become a member in order to meet other DOs and to be able to discuss cases with fellow DOs and learn what to do. I did know some people who were involved in the College and I must say from the start that the leadership welcomed me into the group, made me feel a part of the organization. In my opinion, the ACOI has had great leaders these past 10 years. The values of the early leaders who welcomed me into the membership decades ago remain strong today.

Ms. Ciconte: Tell me why you have dedicated your time, talents, and treasure to ACOI.

Dr. Clouse: I have enjoyed being ACOI's Nuclear Medicine Education Chair. As a past chairman of the manpower committee of the Society of Nuclear Medicine and Molecular Imaging (SNMI), I knew leaders in our field who were excellent speakers. I was able to invite them, most are MDs, to speak at the annual ACOI convention, which also provided opportunities for them to better understand our osteopathic thought processes.

Years ago, medical societies like the ACOI received financial support from pharmaceutical companies to cover some of the expenses of annual conventions. When that source of revenue was no longer available, I decided that I would "just do it myself," and personally cover the speakers honorarium and related expenses for my speakers.

Ms. Ciconte: Given your long tenure as an ACOI member, what changes have you seen in the College?

Dr. Clouse: In my opinion, the College continues to experience positive changes – such as increasing membership, larger attendances at the annual conventions, and most importantly, the quality of its educational programs continues to be excellent.

Ms. Ciconte: How do you see the single GME accreditation transition that will be completed in 2020 affecting the osteopathic internal medicine profession and the ACOI?

Dr. Clouse: I think it will be good. Many of us trained in allopathic hospitals. Barnes Hospital in St. Louis 30 years ago had a preceptor program. I have both DO and MD boards and they seem to work well. I cannot see any of the privileges which one has over the other degree.

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

Dr. Clouse: I think the College needs to continue to do what they are doing – offering high-quality postgraduate programs, keeping members informed on government regulations, and insuring strong leadership for ACOI's future.

Ms. Ciconte: Any closing comment or thought?

Dr. Clouse: I have spent much of my career speaking and teaching, thanks in part to the ACOI. One of my fondest memories is when I was President of the American Heart Association Missouri Affiliate and on the lecture circuit years ago. I owned my own airplane, only sold it two years ago, and could fly to anywhere in Missouri on a speaking engagement and return home within a few hours. I enjoy going to ACOI meetings and seeing my previous students and listening to their success stories. It gives me a warm feeling to see that so many of them have made such great achievements in their medical careers.

However, I must say, in all honesty, that a highlight of my life is indeed being a member of the ACOI!

Ms. Ciconte: Dr. Clouse, ACOI is indeed grateful to you for your generosity,

Add Your Name to Leave a Legacy

Members of the ACOI Legacy Society have done their part to ensure the future of the College. A special thank you to our Charter Members!

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 will 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 with a bequest of $10,000 or more, 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 2019 ACOI Convention in Phoenix. Be among those who will receive a certificate and a unique crystal memento that shows 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 lifetime income, please contact Brian Donadio via email at bjd@acoi.org or call 301-231-8877 to let us know how and when to contact you.

Legacy Society Charter Members

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

75th Anniversary Fundraising Campaign

How Your Contributions Have Been Put to Use

The ACOI has used the funds raised in the successful 75th Anniversary Campaign to create a home for those who believe in the patient-centered, osteopathic approach to healthcare that we call Principle-Centered Medicine. More information about this will be forthcoming soon.

Meanwhile, in the past three years, we have hired staff and accomplished the following:

- Achieved accreditation from the Accreditation Council for Continuing Medical Education (ACCME) as a CME provider. Our CME now can provide AOA and AMA credit and meets the recertification requirements of both the AOBIM and the ABIM.
- Upgraded our technology to allow ACOI to offer CME in a variety of new, mobile-friendly formats that our members need. The new ACOI Online Learning Center now houses more than 100 CME credit opportunities that can be accessed anywhere, anytime.
- Provided hands-on assistance to residency programs as they seek allopathic accreditation while encouraging them to secure Osteopathic Recognition as they make the transition. This assures that the distinctive osteopathic philosophy imbued in students during their medical school years will continue during residency. The overwhelming majority of both internal medicine and subspecialty programs have been approved by the ACGME.
- Became the first osteopathic specialty to be granted an ex officio seat on an ACGME Residency Review Committee.

Member Survey

continued from page 1

Assurance that members' osteopathic education, training and board certification are recognized by hospitals, government and third-party payer	95%
Sponsorship of CME programs and providing AOA Category 1A CME credit	94%
Support of internal medicine training programs in their efforts to achieve ACGME accreditation and osteopathic recognition	91%
Representation in Washington, DC	90%
Assistance in meeting the requirements of Osteopathic Continuous Certification (OCC)	87%
Board review opportunities	79%
Hosting lectures, presentations and other resources online	79%
Offering CME activities that provide AMA Category 1 PRA credits	72%
Honoring members for their accomplishments	70%
Information/consultation on management of practice	57%
Professional opportunities listings	57%
Assistance in meeting the requirements of ABIM's Maintenance of Certification (MOC)	53%

When members were asked how they feel about their personal involvement with ACOI, 73% responded that their current level of involvement is optimal and 23% desire more involvement.

More than half of members (66%) have had contact with the ACOI office in the past two years. Most of this group (75%) rated the quality of the staff's responses to them as "excellent" and 19% more rated it as "good."

The factors which motivated the largest number of respondents to join ACOI were educational programs/CME (71%), training and knowledge (53%), belonging to a professional association (46%), and personal satisfaction and development as a professional (335%). About 11% responded that they believed they are required to be members. There is no requirement for ACOI membership.

Eighty percent of members rated the value of ACOI membership as very or somewhat valuable.

Educational Opportunities

Nearly four-fifths of members (79.5%) rated ACOI's national convention and other live educational meetings as "very" or "somewhat valuable," including 89% of those in office-based general medicine, 84% in both office and hospital medicine, 82% of hospitalists, and 67% of subspecialists.

About Their Practice

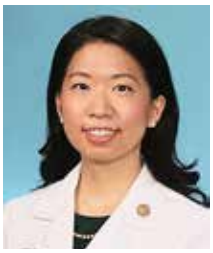
Thirty-one percent of respondents describe their employment setting as a hospital and 25% are in a group practice of 2–9 physicians. Many others are in a group practice with 10 or more physicians (19%), or a solo practice (10%). Members have been in practice for an average of 17 years and interact with an average of 91 patients in a typical week. Nearly two-thirds of respondents (65%) indicated that their patient volume is trending up. One out of four members (25%) indicated that the net income from their practice is trending up, 19.5% indicated that net income is trending down, and 34% stated it is trending flat.

The largest percentage of members (34%) describes their primary practice focus as a subspecialty, 26% are hospitalists, 25% practice office-based general medicine, and 15.5% are in both office and hospital medicine. Among subspecialists responding, an average of 10.4% of their practice is spent in primary care.

On average, respondents use Osteopathic Manipulative Treatment on their patients eight percent of the time. Forty-seven percent of members report using Osteopathic Manipulative Treatment on patients in their practice.

The ACOI is most grateful to all who completed the survey. Three members who did so were selected at random to receive a $100 gift card. They are: Elizabeth Hirney of Grand Pass, OR; Tammy Holloway of Houston, TX; and Ray Geyer of Great Falls, MT.

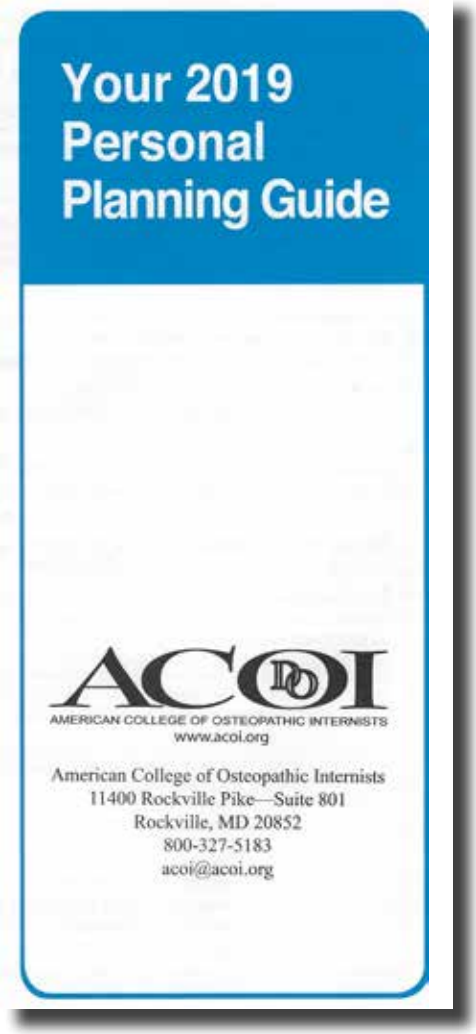
Member Milestones



Jennie H. Kwon, DO, assistant professor of medicine at Washington University School of Medicine in St. Louis, has been named a member of the National Academy of Medicine's Health Policy Fellowships and Leadership Programs (HPFLP) Advisory Committee.

As a committee member, she will provide perspective and insight to the HPFLP director and staff on current fellowship and leadership programs, and assist in the exploration of new programs and strategic initiatives.

Reduce Taxable Income and Avoid Taxes



The IRS allows all taxpayers who have an IRA and who are at least 70 ½ years old to reduce their taxable income by paying some of their required minimum distribution directly to a qualified tax-exempt organization like ACOI reducing dollar-for-dollar their taxable income.

You can reduce your taxable income by any amount to up to $100,000.

If you've already taken your 2019 distribution it's too late for the current tax year, but it's not too early to plan for next year.

And if you have stock that has gone up in value and would like to make a gift, the IRS lets you do so and completely avoid the capital gains tax you would otherwise have to pay.

The tax savings possible depend on your tax bracket, but regardless of whether you think you'll have enough deductions available to exceed the standard deduction of $24,000 for couples filing jointly and half that amount for single taxpayers, reducing your taxable income and avoiding capital gains tax just makes sense.

Want to know more? Ask for your free copy of Your 2019 Personal Planning Guide and learn more about ways to save. [Insert the attached photo for the new blue 2019 Personal Planning Guide].

If you don't have an IRA, or are not yet old enough to receive your required distribution, there are other ways you can help.

- Make a gift of stock that has gone up in value. You will receive credit for the full market value of the stock and pay NO capital gains tax.
- Consider a gift of a life insurance policy you no longer need.
- If you have a vacation home you don't use much any longer, you could keep the right to use it for the rest of your life and let ACOI have it when you are gone. You can get an immediate tax deduction even though you continue using your property.
- Sell stock that has gone down in value, claim the loss against your income and have funds to help the College.

There are other suggestions we can propose.

For a free telephone planning session or to ask specific questions you may have, please email Brian Donadio at bjd@acoi.org or call 301-231-8877 to let us know how and when to contact you. Brian will ask Mr. Sandy Macnab, the ACOI planned giving consultant, to give you a free confidential call.

Join the New Sustainers Club Today

The ACOI's Sustainers Club is growing! The College is pleased to welcome and recognize the following members of our new Sustainers Club:

Lee Peter Bee, DO, FACOI

Robert A. Cain, DO, FACOI

Janet Cheek, DO, FACOI

David J. Mohlman, DO, FACOI

Jeffrey Packer, DO, FACOI

Laura Rosch, DO, FACOI

Christine and Nathan Samsa, DOs, FACOIs

Samuel Snyder, DO, FACOI

BECOME A MEMBER OF THE NEW ACOI SUSTAINERS CLUB

Help the College Better Plan for Its Future!
Sustainer Club Members contribute on a monthly basis. Benefits of being a Sustainer Club member include:

- Invitations to donor events at ACOI meetings
- Update communications from ACOI leaders twice a year
- Special recognition as Sustainers Club members in ACOI publications and the website

Sign Up Today by clicking https://www.acoi.org/make-a-gift-to-acoi/your-support-makes-difference-acoi and check the monthly gift box to make a credit card contribution.

Remember, your gift is tax-deductible to the full extent allowed by law.

CME CALENDAR

Future ACOI Education Meeting Dates & Locations

NATIONAL MEETINGS

- 2019 Annual Convention & Scientific Sessions
  Oct 30- Nov 3 JW Marriott Desert Ridge Resort & Spa, Phoenix, AZ
- 2020 Internal Medicine Board Review Course - April 29-May 3
- 2020 Clinical Challenges for Hospitalists - April 30-May 3
- 2020 Exploring New Science in Cardiovascular Medicine - May 1-3
- 2020 Congress on Medical Education for Residency Trainers - May 1-2
  Renaissance Orlando at Sea World Resort, Orlando, FL
- 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.

Tentative 2019 Certifying Examination Dates & Deadlines

Internal Medicine Certifying Examination
Computerized Examination 300 Sites Nationwide
September 3-5, 2019 - *Application Deadline: Expired- Late Deadline: July 1*

Internal Medicine Recertifying Examination
Computerized Examination 300 Sites Nationwide
September 3-5, 2019 - *Application Deadline: Expired- Late Deadline: July 1*

Internal Medicine Recertifying with a Focus in Hospital-Based Medicine Examination
Computerized Examination 300 Sites Nationwide
September 3-5, 2019 - *Application Deadline: Expired- Late Deadline: July 1*

Subspecialty Certifying Examinations
Computerized Examination 300 Sites Nationwide
August 22-24, 2019 - *Application Deadline: Expired- Late Deadline: July 1*
• 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 22-24, 2019 - *Application Deadline: Expired- Late Deadline: July 1*
• 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.*

In Memoriam

Word has been received of the following deaths in the ACOI family:

Charles L. Pritchard, DO, FACOI, 76, of Kirksville, MO, on March 27. Dr. Pritchard was a 1970 graduate of the Kirksville College of Osteopathic Medicine. He completed his internship and internal medicine residency at Doctor's Hospital in Columbus, OH, followed by a cardiology fellowship at St. Louis University Hospitals in 1975. He was board certified by the AOBIM in both internal medicine and cardiology. Dr. Pritchard practiced cardiology in Kirksville and taught at the medical school for many years. He was a long-time Active member of the ACOI and achieved the degree of Fellow in 1985.

Joseph DePetris, DO, MACOI, 96, of Dallas, TX, on April 10. Dr. DePetris was one of the early leaders in osteopathic internal medicine. A graduate of the Kirksville College of Osteopathy and Surgery, he completed his postgraduate training at Dallas Osteopathic Hospital. He served as President of the College in 1967-68, received the Distinguished Service Award in 1974, and was in the charter group inducted into the Gillum Society of Master Fellows in 1994. Dr. DePetris also was a long-time member of the AOBIM. His Memorial Lecture presented at the ACOI Convention in 1972, "Tunnel Vision Syndrome," focused on the loss of skills of diagnosis and management of general internal medicine and the fading away of the general internist.