Insights from the Minority Health Committee

Incorporating OMM Into Your Practice

February 2021

Black History Month: Celebrating ACOI Pioneers

ACOI Heroes: Facing COVID-19

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Michael A. Adornetto, DO, MBA, FACOI
President
Michael.Adornetto@UHhospitals.org
Robert L. DiGiovanni, DO, FACOI
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robert.digiovanni27@gmail.com
Joanne Kaiser-Smith, DO, FACOI
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kaiserjo@rowan.edu
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Immediate Past President
snydersam@att.net
Annette T. Carron, DO, FACOI
Past President
carronannette@gmail.com

BOARD of DIRECTORS
Damon L. Baker, DO, FACOI
damonbaker@okstate.edu
Robert A. Cain, DO, FACOI
rcain@aacom.org
Watson Ducatel, DO, MPH, FACOI
drwd@healthybodiesmdc.com
Susan M. Enright, DO, FACOI
susan.enright@hc.msu.edu
Charlene A. LePane, DO, FACOI
clepane@hotmail.com
Robert T. Hasty, DO, FACOI
rhasty@me.com
C. Clark Milton, DO, FACOI
cmilton@wheelinghospital.org
Laura Rosch, DO, FACOI
LRosch@kcumb.edu
Amila Vasoya, DO, FACOI
vasoya.909@gmail.com
Valentina Stevanovich Lassalle, DO
Resident Rep
vsllassalle@gmail.com

STAFF
Karen C. Caruth, MBA
Executive Director
karen@acoi.org
Timothy W. McNichol, JD
Deputy Executive Director
tmcmichol@acoi.org
Donald S. Nelinson, PhD
Chief Science & Education Officer
don@acoi.org
Susan B. Stacy, FACOI
Director of Administration and Meetings
susan@acoi.org
Keisha L. Oglesby
Director of Finance and Member Services
keisha@acoi.org
Kara Kerns
Post-Doctoral Training Specialist
kara@acoi.org
Claudette Jones
Membership Services Specialist
claudette@acoi.org
Katie Allen
Digital Media Manager
katie@acoi.org
Meg O’Rourke
CME Specialist
meg@acoi.org
Neena J. Kuruvilla
Administrative Assistant
neena@acoi.org

Leadership
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Health & Wellness
We lead you to discover the spirit of wellness
February is the heart of winter, when most of us in northern climates have had enough of cold temperatures and gray skies. Even though the days begin to show light in the mornings and a little more light in the evenings, it is a challenging month all the same.

As we emerge from winter and begin to leave February behind, we take time to honor those colleagues who have struggled to find their way in medicine against a system that was not always welcoming, through the celebration of Black History Month. Throughout this edition of ACOI Information, you will find stories that remind us of these achievements that have paved the way for others and have helped improve healthcare for those who have historically had limited access to care.

Although minority representation was sparse when I began medical school, Barbara Ross-Lee, DO was named the first female Dean of an American Medical School shortly after I graduated from the Ohio University (Heritage) College of Osteopathic Medicine, creating a path for improved access to underserved populations.

William G. Anderson, DO, the first Black American to lead the American Osteopathic Association, worked alongside Dr. Martin Luther King, and eventually earned his right to provide the care that he was trained to provide.

Judith A. Lightfoot, DO, MACOI, became the first Black President of the ACOI in 2014. She is an infectious disease specialist and continues to serve the ACOI in many capacities. I have been very fortunate to have worked alongside her during my tenure on the board and I appreciate her mentoring and wisdom.

Watson Ducatel, DO, MPH, FACOI, Chair of the Minority Health Committee, will present an op-ed in this edition written by Timothy J. Barreiro, DO, FACOI entitled “A House Divided.” The Committee will provide us with a monthly update, highlighting issues around health care disparities and ways to reach neglected or underserved populations, as well as addressing minority health issues.

The ACOI asks you to Stay True to Why You Pursued Medicine through Principle-Centered Medicine™. We continue to serve osteopathic internists and promote improved patient care through education and advocacy. It gives us great pleasure to recognize and celebrate the diversity of our members and their achievements. We celebrate all of our members who worked tirelessly and inspired us to continue the work of ACOI. We will strive to find a common path to improve the lives of those with limited access to healthcare, and resolve healthcare disparities in our communities.

Michael A. Adornetto, DO, MBA, FACOI
President
president@acoi.org
Abraham Lincoln’s famous speech, *House Divided*, more than century old oratory, still has context in today’s medical and political landscape. Lincoln’s remarks depicted the danger of disunity: a passage of the speech reads, “A house divided against itself, cannot stand.” Antecedent references to a house divided can be found in the synoptic gospels, patristic writes, and, more contemporaneously, in Hobbes’ *Leviathan* and Paine’s *Common Sense*. Scholars argue that this idea was a clarion call to the populace, that only unity can overcome the social ills. The current pandemic, political climate, and practice restrictions placed on health care have challenged and changed us all. Today, the landscape of medicine-fractured pre-pandemic and perhaps weakened by the pandemic—needs a similar call for unity.

There is little debate that the torrid history of medicine is an example of a house divided. In medicine, physicians are continuously inspired by breakthroughs and scientific technologic advancements, as new discoveries change current care and beliefs. Learning about medicine’s past can help us prepare for rapid changes in the future. Physicians, nurses, and other health care workers preparing for the next infectious onslaught should be inspired by the courage and self-sacrifice of their predecessors. But, like Lincoln’s speech notes, physicians must learn that the privilege of practice needs advocacy in order to promote a free and just system equitable for all.

The pandemic exposed in our health care system disparities in care. Health care providers have sought to reduce, if not try to eliminate, social determinants of health. Poverty, malnutrition, substance abuse, and homelessness have always impacted hospitals and the populations they serve. The current pandemic echoes this intersection between health and disparities. Time and time again, physicians continue to struggle with diseases that could be prevented by adequate housing, clean water, basic nutrition, education, and sanitation systems. In fact, the shift from infectious etiologies to chronic disease as causes of mortality occurs in the pre-antibiotic era and the rectification of the survival curve in the 20th century is attributable to these basic improvements in standards of living. However, payor structures have physicians treat individuals, not communities. This disconnect and lack of unity and medicine’s checkered past parallels the current disunity that Lincoln and others feared.

During this pandemic, we have observed the modern health care system’s inability to handle the capacity and needs of the US population; older, sicker, minority Americans have been particularly impacted. Care of the US population is as diverse as its people. Care teams, such as those in health care systems where international medical graduates and midlevel providers bridge gaps in care, exhibit diversity. In *Bellevue*, David Oshinsky outlines how ethnic populations long favored hospitals and care where their native tongue was spoken. Care was understood and beliefs, in addition to science, helped drive care decisions. The early 20th century immigrant experience and the rise of religious sponsored health care systems and hospitals is also an example of this phenomena.

What does the modern medical hospital need to do in order to reduce disparities of care and promote health? Firstly, it needs to recognize the historically fractured health care system and learn from the experience. In the not so recent past, hospital privileges were restricted to those affiliated with allopathic medical schools or those doing clinical research. Osteopaths were unable to work, perform surgery or provide care in allopathic centers. State licensure for allopaths and osteopaths was different. Hospitals pushed patients out to community hospitals to care for uninsured or difficult patients. Hospital systems continue in their inability to provide care for diverse populations; financial stresses for hospitals with largely government payors continues to foment disadvantages and disparities. The need for a diverse work force remains a major issue, especially for patients with diverse needs.

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For decades, doctors were fee-based and only cared for those who could pay. In addition, elite medical schools often accepted doctors via nepotism, not merit. Very few medical schools survived the Carnegie funded report, *Medical Education United States and Canada*, published in 1910, which revealed deficiencies in physician education and lack of diversity in medical school recruitment. One key problem noted within the report was a lack of coordination between the fund of available medical and scientific knowledge and a foundational mechanism to hold doctors accountable for clinical training in patient care, the clinical application of that knowledge. There is no doubt that the Flexner report changed the course of medical education. Unfortunately, since the report’s issuance, continued strides are still needed. Recently the combination of GME programs, with allopathic and osteopathic, resulted in heated debate. However, similar training regardless of educational background will only raise the bar for patient care. Remaining is the continued need for clinical educators, with dedicated time for education and mentorship, given the complex structure of health care systems where residents are working harder than ever before.

Ethnic and minority populations have cultural differences that affect health and wellness. Studies have long demonstrated that patients and providers with similar backgrounds have better outcomes. Medicine has yet to find a way to improve and provide diversity in this regard. Sometime between 1915 and 1922, the first women were accepted into a New York medical school; yet, Johns Hopkins medical school has been coed since its founding in 1893. However, the ability to graduate and find meaningful employment for female physicians was virtually nonexistent, forcing Blackwell and others to seek opportunities including Europe.

While there have been pioneers breaching racial divides, little is talked about or discussed in health education. People of color and other racial backgrounds have serious problems of access to education and academic mentorship. James McCune Smith (1811-1865) was the first Black American to obtain a medical degree, but not from a US medical school. He earned his medical degree in Glasgow, Scotland, in 1837. He wrote about the plight of race in medicine and the “need for practionaires of medicine to battle against the deadly quackery” of nonscientific medicine. He lived an active life, dedicated to civil rights and the intellectual effort of minorities to practice medicine. Despite newer programs, the pace of ethnic and minority entry into medical schools is still slower than most of us want to admit. Today, lack of provider diversity remains an issue. Medical school systems exhibit admission designs to ensure stability and student body balance. However, the application process is still utilized as a way to weed out applicants before entry into medical training.

The ACOI continues in its open legacy and commitment to establish a right and just system, evidenced by providing this platform to express concerns and need for improved awareness among those currently shaping the future of health care. The ACOI hopes that you will join with us to help improve health to all, not just the few. Only in unity can we overcome.


February is Black History Month:
We Celebrate Two Distinguished ACOI Pioneers in Osteopathic Medicine

ACOI is proud to celebrate members, Arthur Bouier, DO, MACOI, and Sonnora Johnson-Reed, DO, FACOI—the first Black American physicians to be board certified in internal osteopathic medicine in the Nation!

Interview by Gina Kilker.

Sonnora Johnson-Reed, DO, FACOI

How did you get interested in osteopathic medicine?

I’ve always wanted to be a physician. That was my childhood dream! As I grew older and focused on my career aspirations my initial area of interest was pediatrics. It wasn’t until after having conversations with our family doctor did my interest begin to shift toward osteopathic medicine. He became a valuable resource for me as I navigated through the first phase of becoming a physician. He had children, all of which became physicians as well. I remember he also directed me to Michigan State for school. He played an influential role for me in choosing osteopathic medicine.

How were you supported in your quest to enter osteopathic Medicine?

My family was my support system throughout my journey, and I know they’re proud of my career and accomplishments just as much as I am. My sister was a special education teacher, who also became a minister later in life; she supported me a lot. My aunt was a high school principal in Westbury, NY and was behind me along the way, as well as my other aunts and uncles. My parents separated, but they both poured into who I am today naturally. The support of a family is something to truly be treasured.

What kind of obstacles did you face?

I was one of the first female physicians where I did my residency at the Michigan Health Center, which later became the Michigan Osteopathic Medical Center. I remember the first day I got off the elevator there was a code blue, and the elevator doors opened and there was this little nurse standing there. I introduced myself as the new resident and she just simply said, ‘Oh, hell, a woman?’

So, we proceeded to go with the code, and we worked on this patient for, I don’t know how long, and we did revive him. But after that, the nurse said to me, ‘Well, welcome to the unit! I will never doubt another female again. I will like you much better.’

Obstacles were a regular occurrence. Some racial, some financial. My family was not rich. I had student loans to pay back. I worked while going to school. I was an out-of-state student and didn’t know anyone.

My transportation was a bus at 5am. Peanut butter and jelly sandwiches and ramen noodles were my meals. There was the old boys’ club where resentment was not withheld for being a woman in a male-dominated profession.

Pew Research statistics show that just 42% of Black Americans said they will get a COVID-19 vaccine. The hesitancy stems from years of mistrust in the medical community. Is that something you have personally seen yourself in your patients?

Yes, I have. There is certainly a history of reluctance and hesitation in accepting medical treatments and of course vaccinations within the African American community. My approach is to reach my patients with care, finesse, and facts. I encourage them to do what I would recommend as being the best option of care and protection for each of them.

Continued
I make myself available to discuss any areas of concern, so that they’re comfortable with the care provided.

Having those open conversations, showing research, and providing resources have a huge impact on how you care for patients. Building trust is a key factor in the physician-to-patient relationship. Without that trust the care will be impacted.

Do you have any words of encouragement for young Black women going into medicine today?

I think it’s fantastic, definitely not something I thought would be the case. My intention was to do this work because I love it, I enjoy the people, helping people, healing people. If I can make a difference in the industry, then that’s just icing on the cake!

Looking back on your career, including your private practice and everything that you’ve achieved and overcome, what would you say is one of your most memorable moments?

When I graduated from medical school—that was the most memorable part. Then when I opened my own practice, and the fact that I was able to be blessed to have a solo practice. I mean, nowadays it is extremely hard and extremely rare. Nobody is doing it. I was just blessed to have some beautiful patients to take care of. You know, that’s the most rewarding thing! Plus, my family is well, so, I can’t ask for anything more than that! I have had a good life and a very good practice.

What are you doing now?

I loved being in private practice. I absolutely loved it! I just closed my office three years ago and I’m doing hospital medicine part-time right now and I don’t want to stop. I still enjoy it!

Every once in a while, I get asked ‘where’s your practice?’ And I tell patients that I’m just strictly here in the hospital and that I don’t have a private practice which is strange to say after having a practice for 40 years. And they will say ‘well, if you change your mind, let me know!’

Arthur Bouier, DO, MACOI

What was your childhood like?

I grew up in Detroit, on the east side, in an area known as Black Bottom, which was a very poor area. I was raised by my mother and grandmother and I always wanted to be a physician. But people told me that I couldn’t do it because I was Black, and I was poor. But I had a grandmother who was very faithful to God and she always told me that if I prayed that God would always answer my prayer.

How influential were your mother and grandmother in your quest to become a physician?
My mother was the first Black nurse at Henry Ford Hospital in the oncology department in the 1940s. The only place where Black people worked during that time in the hospital was in the kitchen as cooks or they ran the elevators.

But my mother was a very aggressive lady, and she went to nursing school. She was the type of person who did not accept that you couldn’t do anything you set your mind to. She always encouraged me to go to medical school ever since I can remember. She was always telling me, ‘If you get it into your head, they can never take it away from you.’ And that always stuck with me. And then, of course, my grandmother was a praying woman. She gave me my spiritual side. So, between those two women, that is why I am where I’m at today.

**What did you do after high school?**

When I was in school, I was in the ROTC and then I got drafted to Vietnam. I joined the Air Force and became a combat medic. I did air rescue.

I went to school for aerospace medicine. They said I couldn’t do that either, but I did. It’s funny, most of my stories are about what they told me I couldn’t do! I ended up getting awarded the Air Medal, which is the third highest medal in the military for rescue. It is awarded to soldiers that are in combat who do over 100 missions into battle on planes and helicopters to get the wounded out. Once you do 100 missions, you are awarded the Air Medal for valor and courage.

When I got out of the service, I went to Wayne State University enrolled in pre-med and was accepted at Michigan State University College of Osteopathic Medicine. You have to remember in those days, there were very few Black people who were going into medicine. When I graduated from Michigan State University, they went into general practice. There were no Black specialists at all. And I was fortunate enough to go to Detroit Osteopathic Hospital, which was a premier hospital during that period.

I was there for four years. I was a Chief Intern. I was the Chief Resident. And at that time, of course, being Black, that was not heard of. I finished my program. I took my boards the first time around, and at that time there were no Black individuals that were boarded. I was the first Black man to be boarded in internal medicine in the college; most went into primary and general practice.

I came through during the time when Black people were just starting to break barriers and when Affirmative Action was just starting. I spent many years teaching and training other residents and interns. I eventually became the Director of Medical Education and a Residency Program Director. That was unheard of for a Black man to be in either of those positions. But I achieved both of those. I eventually became a Master Fellow in the ACOI about three years ago. I became the first Black Fellow in the College! I was kind of a quiet guy. Nobody, except the College, knew much about me.

As a Black osteopathic internist, you have achieved many firsts. Let’s review all those firsts again…what are all your firsts?

I was the first Black Chief Resident Intern. I was the first Black to be fellowed in American College of Osteopathic Internists and the first Black Master Fellow of ACOI. I was the first Black Program Director for Internal Medicine. I was the first Black Director of Medical Education. I was the first Black man to be board certified in osteopathic internal medicine in the nation. All of these were firsts in the nation.

**What has being an osteopathic physician meant to you?**

The osteopathic profession has given me the opportunity to become a physician. Without the osteopathic profession, I am not sure I would be who I am now. I have been the first in everything because they gave me the opportunity. I think it’s the greatest profession. I think osteopathic physicians have much broader training and better overall training. When I was interviewing to get into medical school and went to the allopathic interviews, the people were very arrogant; they acted like they were doing me a favor by even interviewing me.

*Continued*
But when I went to Michigan State (College of Osteopathic Medicine) and I got my interview, the people were so warm and open. The Dean and everyone came out and they encouraged us; they wanted us to become part of their family. All the osteopathic physicians were so nice and friendly.

The osteopathic profession has taught me to have a holistic approach in how you see a patient. And that has been a joy to me because I can treat people at any level. I think the most important thing as a doctor is that you must have a good spiritual side. You can heal people physically, but a lot of times they are spiritually dead. They’re not physically dead, but they’re spiritually dead. And someone has to be there for them.

What is your take on some of the lessons of the current pandemic?

I look at it from a spiritual standpoint. I look at it as God trying to tell us that we all need to slow down and enjoy the things that are around us. I have learned during this pandemic to sit in my backyard and look at the birds and their different colors, and to look at the groundhogs and at the trees. I have learned to enjoy my family. Sometimes we get so busy, especially in the medical profession. My children grew up before I knew it because I was trying to achieve so much. However, I think people are learning now that your family is the most important thing. You have to spend time with your family and those who love you. I think that God is trying to show us that love is more important than all this busy work that we do.

What are you doing now?

I got ordained in the ministry. And I’m still practicing medicine, but I’m also teaching and training preachers in the ministry. I still practice medicine and religion is a part of my practice and I am always praying for my patients and encouraging them spiritually. I have been in practice for 43 years now. I wouldn’t stop practicing if you paid me. You can’t stop me from practicing!

My patients would have a fit if I quit! I love what I do. The people need me. That’s the osteopathic way. That’s why I like it. We really care! We care about the patients physically. We care about the patients socially. We care about the patients spiritually. They are my family. I have four to five generations in my practice now—the great grandmother, a grandmother, the mother, and the kids and now the kids’ kids are coming. It’s special.
ACOI Heroes: Facing COVID-19
Dr. Sciamanna and his team encounter challenges in protecting cardiac patients
by Gina Kilker

As a specialist in advanced heart failure, mechanical circulatory support, transplant cardiology, and pulmonary hypertension, Chris Sciamanna, DO, FACOI, works with seriously ill patients. They are usually in stages of early or advanced heart failure, suffering from coronary artery disease, valvular disease, angina, or atrial fibrillation. Understandably, as a heart failure cardiologist, which he describes as a “subspecialty of a subspecialty,” Dr. Sciamanna was gravely concerned when he first heard about the novel coronavirus a year ago. He knew that his patients were at risk of potentially fatal complications if they contracted COVID-19, and he and his team went to great lengths to create detailed protocols and contingency plans to protect patients in their care.

The biggest fear, he said, was the thought of asymptomatic transmission from provider to patient. With a relatively small number of specialized heart failure and heart transplant cardiologists in the country, Dr. Sciamanna and his team felt an extra burden of responsibility to stay healthy. “What happens if all of us get sick? Who’s going to take care of these people?” Those fears prompted the team to conduct telehealth visits as much as possible. They also created procedures to decrease physical contact during in-room patient visits and reduced the number of specialty providers and medical staff that would be permitted to enter hospital rooms.

Patients who received transplants, or are being considered for transplants, are typically evaluated by multiple teams in a hospital setting, which would include Dr. Sciamanna’s team or groups of independent consultants. While teams are specialized depending upon the condition being treated, Dr. Sciamanna would typically need to see each patient. “I would stand outside their door, and unless I really needed to be there physically, I wouldn’t go into the room. If I had to talk to the patient, I would do so from outside the room, or call them on their phone,” Dr. Sciamanna said.

Little did he know at the time that those careful plans would soon come in handy when he did unfortunately contract COVID-19 last April. It was during one of his weekend rounds in the hospital that he was exposed by a patient. The patient had suffered with a persistent cough and while COVID-19 was suspected, the patient had tested negative twice. It wasn’t until a troubling chest x-ray indicated an issue that a third test was ordered. That one was positive.

It was too late for Dr. Sciamanna who, realizing he had been exposed, quarantined at home and defaulted to the team’s plan of doing telehealth visits with his patients. It wasn’t until a week later that his symptoms appeared. As a person living with type 1 diabetes, he was concerned.

“Because it was still so early on and we’d been seeing the data that the virus would likely affect those with diabetes with more gravity, it was stressful,” he said. “Some people get it and don’t have symptoms or just get mild symptoms. Some people are young and healthy, and they end up dying. So that is always in the back of your head. It was just like this struggle of wondering where you fall on the spectrum. My wife, my parents, and my colleagues were worried and wondered if I should be doing rounds at all.”

Suffering from fatigue, achiness, headaches, and congestion, he stayed in his guest bedroom away from his wife, leaving her with the duties of caring for their dog and two cats and preparing his meals and leaving them for him at the bedroom door. He stayed isolated from her for two weeks, and luckily, with no shortness of breath, he never needed to go to the hospital. He lost his sense of smell and, as of this newsletter, it still has not returned. He does not expect that it will ever return.

Prior to his contracting COVID-19, he and his team had researched as much as they could when the news about the virus came out, since there was only sparse information from the CDC. They joined webinars and teleconferences with physicians in China who were providing their insights.

The concern for the team was that patients in their care faced a multitude of risk factors, more so than the general public, especially for heart transplant patients who were on immunosuppressive therapy.

Continued
ACOI Heroes: Facing COVID-19

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But as he discovered in the hospital that one fateful weekend, some patients invariably contracted COVID-19, including his most vulnerable transplant patients. “Some patients did okay, and for some patients it was shocking how sick these people got and how quick it was. Some of these people would come in one day and by the next day they’re on ventilators or, on ECMO, which is basically a heart/lung machine. Some perished quickly.”

Dr. Sciamanna is the only provider in his group that has contracted COVID-19, but with the pandemic still a concern, their safety protocols remain. He eventually returned to practice once he recovered and two weeks passed from his last positive test. Testing positive for COVID-19 antibodies, Dr. Sciamanna began donating plasma weekly. He’s now fully vaccinated with both doses of the Pfizer vaccine.

His practice is now seeing a new set of patients—individuals who have developed cardiomyopathy due to COVID-19. “We still don’t completely understand how it happens. We have seen that it’s definitely associated with the virus. We don’t know if it’s the virus itself that makes the heart weak, or if it is the inflammatory response the body has that makes the heart weak. Some of these people get really, really, sick and they end up on life support and they end up on ECMO. It’s been a big challenge. We see it happen in young people too. We’ve seen teenagers end up with cardiac implications.”

“Some people are having heart attacks and developing clots within their coronary arteries. Even some time after the heart recovers, we still see patients coming in with significant symptoms. This is not something that just affects the lungs. There is an inflammatory response that affects the kidneys and the heart. The severity of it is very often unpredictable.”

With all the potential complexities of COVID-19 during and after infection, and with many of the unknowns that still persist, what is his recommendation for his ACOI colleagues? “Don’t be afraid to reach out to other colleagues or centers for questions or for help. We’re still writing the guidelines. This is still evolving. I think most providers are doing everything that they can, obviously getting the vaccine and encouraging others to do so as well.”

He said the real risk he sees now is COVID fatigue, which doesn’t just apply to patients. “The medical community feels it too. Sometimes I think it’s easy for us to get a little tired living in this COVID world, even in the hospitals. And I think we just have to remind ourselves to not develop COVID fatigue, to keep yourself safe, wear PPE at all times, wash your hands, get your vaccine. If you’re working with medical students and other trainees in your ancillary staff, make sure that you’re protecting them. When I round, even though I typically have a bunch of people with me, and I want my fellows and my residents to learn, if there’s a COVID patient that I have to see, there’s no reason why everybody should be coming into the room. We’ve got to protect each other still.”
Member Profiles

Get to know your fellow ACOI members!

Monica Carter, DO, FACOI has been a member of the Committee on Health Equity and Inclusion in Medicine since its inception in 2006. She completed her residency at RowanSOM and now practices in North Carolina, specializing in geriatric medicine.

“Doctoring is an humbling experience. I learn something new from those around me every day and am thankful to be able to serve those to whom I provide care.”
– Monica S. Carter, DO, FACOI

Member Achievements

Congratulations to David F. Hitzeman, DO, MACOI on receiving a Special Recognition award from the AOA for his years of service and dedication to the osteopathic profession! Dr. Hitzeman is a past ACOI board member and was the ACOI 2012 Internist of the Year.

Congratulations Berry Pierre, DO, FACOI on his appointment to the ACOI Minority Health Committee. Dr. Pierre a board certified internist, an author, podcast host, and a national speaker. Check out his website!

Community
Welcome to February, the month of love! I hope your month is marked by stability, self-care, and filling your reserve tank. Winter is always a time to pause, be stable, look inward, assess, and bring the insights outwards.

Remember TART? Tenderness, Asymmetry, Restriction and Tissue texture changes. These are the basics of your osteopathic diagnostic skills. They are used for any physical exam for any chief complaint, but they also assist us with an osteopathic structural assessment. You may not remember the details about how unrestricted anatomy moves, but I’m sure you know innately.

For example, ribs all move out and in. Osteopathically there are 3 motions:

- Upper Ribs 1-6—pump handle motion, A/P motion on a transverse axis.
- Middle ribs—bucket handle motion, Lateral motion on an anterior axis.
- Lower ribs 11, 12—caliper motion, inhalation moves ribs out and exhalation moves ribs in.

In patients with pneumonia, trauma, empyema, SARS-CoV-2, pneumothorax, or pleuritis, restriction in movement will be found on TART assessment because the pathophysiology of the patient’s condition will inhibit movement of the tissue in its area. For example, bacterial pneumonia usually presents itself as an infiltrate in a subsection of the lung tissue. With the growth of the bacterial colony in that region of the lung parenchyma, the overall parenchymal elasticity will decrease, leading to restriction of the tissue. In cases of SARS-CoV-2 and viral pneumonia all lung parenchyma will be affected. As seen in CXR and CT thorax, the restriction is felt throughout the thorax. All of the ribs have decreased motion, therefore greater restriction throughout.

Increasing your patient’s overall anatomical movement and fluid flow will assist with clearing the infection. It is easy and quick to apply osteopathic treatment by focusing on thoracic movement, lung parenchyma, and the lymphatic system. This can be done with rib raising and lymphatic pedal pump.

The rib raising technique has the physician standing at the side of the patient’s bed, sliding hands under the supine patient’s thorax, placing fingertips on the rib angles (on the same side of the thorax that you are standing on), directing your fingertips toward the ceiling, and holding this position until you feel the tissue soften. Once that occurs, move the angle of the rib slightly lateral with your fingertips—almost just a suggestion. Hold until you feel the tissue soften. It takes about 30-60 seconds for the tissue to release. Move your hands to the next section of ribs until you have done superior, middle, and lower bilaterally.

The pedal pump technique is simple and takes about 30-60 seconds. Stand at the feet of the supine patient. Place your hands on the dorsal surface of the foot at the mid transverse arch. Push inferiorly with a pulsatile motion. Feel the tissue restriction. Pump the feet for about 30-60 seconds until you feel the tissue soften and the movement become less restricted.

Now, go help your patients! See you soon!

Jodie Hermann, DO, FACOI is Chair of the Osteopathic Manipulative Medicine Department and Assistant Professor at the University of New England College of Osteopathic Medicine.

jhermann@une.edu
Recognizing the severe financial strain created by the pandemic for physician practices, Congress first provided a temporary reprieve from the two percent Medicare payment sequester through the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Congress then extended the moratorium through approval of the Consolidated Appropriations Act of 2021. Absent additional congressional activity, the current moratorium will expire on March 31, 2021. The call for Congress to act recognizes the ongoing financial challenges and pressures faced by physicians as a direct result of the pandemic. You may review the letter to congressional leaders here.

ACOI Supports Continued Efforts to Expand Physician Workforce

As a member of the Graduate Medical Education (GME) Advocacy Coalition, the ACOI joined to thank Congress for the establishment of 1,000 new Medicare-supported GME training positions. These newly funded training positions were included as part of the recently enacted Consolidated Appropriations Act of 2021. The funded training positions are an important step to help address the projected physician shortage that could reach between 54,000 and 139,000 by 2033. The ACOI will continue to work to advance efforts to expand the availability of training opportunities for the future physician workforce. You may review the letter to congressional leaders here.

Regulatory Actions Frozen Pending Review

A memorandum was issued by the White House Chief of Staff to direct a pause of regulatory activity pending review by the new administration. The memorandum allows agency heads to postpone for 60 days the effective dates of rules that have been published but have not yet taken effect. In addition, agencies may open a 30-day comment period. Rules may take effect if they do not raise any substantial questions of fact, law, or policy. This is a common procedure when one administration transfers to another. As a result of the directive, the Department of Health and Human Services (HHS) recently provided notice to delay the effective date of a final rule that requires health centers that purchase drugs through the 340B Drug Discount Program to provide low-income patients insulin and injectable epinephrine at the 340B price. The ACOI will continue to carefully monitor these and other regulatory actions that impact physicians and their patients.

Continued
CMS Take Steps to Streamline Prior Authorizations

The Centers for Medicare and Medicaid Services (CMS) issued a final rule that requires Medicare Advantage, Medicaid, Children’s Health Insurance Program (CHIP), and Qualified Health Plan (QHP) payers to streamline the documentation process and enable providers to send prior authorization requests and receive responses electronically. The rule (CMS-9115-F) allots a maximum of 72 hours for payers to issue prior authorization decisions on urgent requests, and seven calendar days for non-urgent requests. In an effort to further promote transparency, the final rule requires payers to include a specific reason for denying a request. Also included in the rule is a provision that requires Medicaid, CHIP, and Qualified Health Plan QHP payers to implement and maintain application programming interfaces (APIs) using the Health Level 7 Fast Healthcare Interoperability Resources (FHIR) standard to support data exchange and prior authorization. Additional information on the final rule and its provisions is available here.

White House Announces $1.6 Billion to Fight COVID-19

The White House announced $1.6 billion to increase COVID-19 test and genomic sequencing efforts.

Washington Tidbits

An American First

Following the end of the Civil War, the nation entered the Reconstruction Era. For obvious reasons, Congress played an important role in the readmission process of southern states. One of the first orders of business was to fill congressional seats left vacant during the war. One such vacancy was for the Mississippi Senate seat. It was filled by the first African American to serve in Congress, Senator Hiram Revels (R-MS). He took the oath of office on February 25, 1870 and served the remainder of a term that ended on March 3 of the following year. In 1874, Senator Blanche K. Bruce, also of Mississippi, was elected to serve a full term. Amazingly, it would be more than 80 years until the next African American was elected to the Senate—Edward Brook of Massachusetts in 1967. You can learn more about Senate trailblazers here.
Greetings colleagues, and welcome to the February 2021 issue of Talking Science and Education. We in Vermont are experiencing record snow falls to the delight of those of us who enjoy snow shoeing and other outside sports. Unfortunately, the mountain to which I have a season’s pass is not following CDC and state health department guidelines, so I am regrettably not able to enjoy the stellar skiing conditions.

In last month’s population health quiz, we asked by what percent have the number of mental health professionals increased in the United States per 100,000 population between 2019-2020?

The first reader with the correct answer to the January quiz was Dr. Nicole Longo! Nicole is a regular reader of the ACOI Newsletter and an ace player of the monthly population health quiz. Dr. Longo knew that mental health providers increased 9% between 2019 and 2020 (247.4 to 268.6 per 100,000 population) and 23% since 2017 (from 218.0). In 2020 there were 72,066 more mental health providers than in 2019. The number of mental health providers increased in every state. The largest gains were in Alaska (429.9 to 523.8 per 100,000 population; +662 providers), Oregon (522.3 to 571.0; +2,192 providers) and Washington (373.3 to 413.8; +3,382 providers).

The increases did show a great deal of diversity by state. The number of mental health providers is highest in Massachusetts (666.4 providers per 100,000 population), Oregon (571.0) and Alaska (523.8). The supply is lowest in Alabama (112.7 providers per 100,000 population), Texas (123.7) and West Virginia (140.5). Congratulations Dr. Longo!

Talking Science and Education: Diabetes Dialogues

SGLT2 Inhibitors: A Narrative Review of Safety and Efficacy

Shameless self-promotion time! I am very pleased to invite you to read a review on the safety and efficacy of the SGLT2i class published in the February 2021 issue of the Journal of Osteopathic Medicine. The paper is authored by ACOI member Robert Chilton, DO, FACOI, FACC, FAHA, one of Bob’s interventional cardiology fellows Jose Sosa, MD, and ACOI’s Chief Science and Education Officer: me! The following is an abstract from the paper.

Type 2 diabetes mellitus (T2DM) is a cardio-nephrometabolic condition that is frequently associated with multiple comorbidities, including atherosclerotic cardiovascular disease (ASCVD), heart failure (HF), and chronic kidney disease (CKD).
The sodium-glucose cotransporter-2 (SGLT2) inhibitors, which lower glycated hemoglobin, fasting and postprandial plasma glucose levels, body weight, and blood pressure, as well as reduce the risk of a range of cardiovascular and renal outcomes without increasing hypoglycemic risk, have heralded a paradigm shift in the management of T2DM. These drugs are compatible with most other glucose lowering agents and can be used in patients with a wide range of comorbid conditions, including ASCVD, H, and CKD, and in those with estimated glomerular filtration rates as low as 30 mL/min/1.73 m². However, there are misunderstandings surrounding the clinical implications of SGLT2 inhibitors’ mechanism of action and concerns about the key adverse events with which this class of drugs has been associated. This narrative review summarizes the data that support the efficacy of SGLT2 inhibitors in reducing the risks of cardiovascular and renal outcomes in patients with T2DM and comorbid conditions and clarifies information relating to SGLT2 inhibitor-related adverse events.¹

I hope you find the article useful in your clinical practices. In the spirit of full disclosure, several important studies on the class were presented (ESC) or published since our paper was accepted last September. So, we acknowledge that recent data from DAPA CKD, DAPA HF and other studies are not included.


Few Older Adults with Prediabetes Show Disease Progression

Prediabetes may not be a robust diagnostic criterion for predicting diabetes progression among older adults, according to a study published online February 8, 2021 in JAMA Internal Medicine².

Dr. Mary R. Rooney and colleagues, from the Johns Hopkins Bloomberg School of Public Health used data from the Atherosclerosis Risk in Communities Study (baseline, 2011 to 2013) to identify 3,412 older adults (mean age, 75.6 years) without diabetes with follow-up through 2017. Different prediabetes definitions were assessed to characterize the risk for progression.

The researchers found that during the 6.5-year follow-up period, there were 156 incident total diabetes cases and 434 deaths. Forty-four percent of participants met prediabetes criteria using glycated hemoglobin (HbA1c) levels of 5.7 to 6.4 percent, while 59 percent met impaired fasting glucose (IFG) criteria (fasting glucose level of 100 to 125 mg/dL). Overall, nearly three-quarters (73 percent) met the HbA1c or IFG criteria, while 29 percent met both the HbA1c and IFG criteria. Among participants with HbA1c-defined prediabetes at baseline, 9 percent progressed to diabetes, 13 percent regressed to normoglycemia (HbA1c <5.7 percent), and 19 percent died. Of those with IFG-defined prediabetes at baseline, 8 percent progressed to diabetes, 44 percent regressed to normoglycemia (fasting glucose level of <100 mg/dL), and 16 percent died. Of those with HbA1c levels <5.7 percent at baseline, 17 percent progressed to HbA1c-defined prediabetes and 3 percent developed diabetes. Of those with fasting glucose levels <100 mg/dL at baseline, 8 percent progressed to IFG-defined prediabetes and 3 percent developed diabetes.

“In summary, in this community-based cohort study of older adults, the prevalence of prediabetes was high; however, during the study period, regression to normoglycemia or death was more frequent than progression to diabetes. These findings suggest that prediabetes may not be a robust diagnostic entity in older age.”
Suspension of COMLEX-USA Level 2-PE

Earlier this month, NBOME announced the decision to suspend COMLEX-USA Level 2-PE administrations indefinitely given the COVID-19 pandemic. This is designed to address some of the undue burdens and multiple stressors placed upon our osteopathic medical students during the pandemic.

The American Association of Colleges of Osteopathic Medicine (AACOM), American Osteopathic Association (AOA) and the National Board of Osteopathic Medical Examiners (NBOME) issued a statement in support of this decision. “Together, our organizations remain committed to developing innovative ways to assess clinical skills and other fundamental competencies for the public good and to prepare osteopathic physicians of the future.” Read the full statement [here](#).

The NBOME staff has begun cancelling all scheduled Level 2-PE examinations that were scheduled to begin on April 1, 2021 and automatic refunds are being issued. Details for the temporary alternate pathway will be announced for the Classes of 2020 and 2021 by March 11, 2021. NBOME is convening a Special Commission, which will help identify alternative pathways on the evolution of COMLEX-USA. NBOME releases [weekly updates on its webpage](#) about this decision and will release details for the Class of 2022 by April 30, 2021.

2021 Certifying Examination Dates & Deadlines

AOBIM Early Entry Initial Internal Medicine Exam
Remote Online Proctoring
March 1-6, 2021

AOBIM Initial Certification Exam
Remote Online Proctoring
September 20-24, 2021
Application Period: April 20 - Sept. 5, 2021
First Application Deadline: Aug. 6, 2021
Final Application Deadline: Sept. 5, 2021

AOBIM Initial Subspecialty Certification Exam
Remote Online Proctoring
August 18–20, 2021
Application Period: March 18 - Aug. 3, 2021
First Application Deadline: July 5, 2021
Final Application Deadline: Aug. 3, 2021

AOBIM Subspecialty OCC (Recertification) Exams
Remote Online Proctoring
August 18–20, 2021
Application Period: March 18 - Aug. 3, 2021
First Application Deadline: July 5, 2021
Final Application Deadline: Aug. 3, 2021

Application materials are available on the AOBIM’s [website](#). Contact the AOBIM at [admin@aobim.org](mailto:admin@aobim.org) for additional information.
ACOI Online Learning Center

The COVID-19 pandemic has impacted almost every aspect of your daily life. Your desire to obtain needed continuing medical education and staying abreast of the latest updates in internal medicine does not have to be one of them. We have added new content and improved navigation tools to help you quickly find the educational materials you want and need. You can access a multitude of lectures that span the many areas of internal medicine and earn CME credit when and where it is most convenient for you. We understand the many hurdles you face as a busy practicing physician, resident, or student and want to help simplify things so you can focus on what is important to you and help you stay true to why you pursued medicine. The ACOI Online Learning Center is your one-stop-shop for osteopathic online education.

Registration is Open for ACOI’s 2021 Spring Meetings!

Dates have been announced for ACOI’s 2021 Internal Medicine Board Review Course, Clinical Challenges in Hospital Medicine, and a new Integrated Subspecialty Review (focusing on Cardiology, Pulmonology, and Infectious Diseases). The Board Review Course will be held May 11-15 and will help you prepare for both the AOBIM and ABIM exams. Clinical Challenges in Hospital Medicine will be held May 12-15. The new Integrated Subspecialty Review will be held May 13-15. Each meeting will be held virtually for the continued safety of all attendees and our staff. Preliminary agendas will be out soon, so keep an eye on our website and social media platforms!

ACOI National Meetings

2021 Internal Medicine Board Review Course
May 11-15
Virtual Meeting
Register now!

2021 Clinical Challenges in Hospital Medicine
May 12-15
Virtual Meeting
Register now!

2021 Integrated Subspecialty Review (Cardiology, Pulmonology, Infectious Diseases)
May 13-15
Virtual Meeting
Register now!

2021 Annual Convention & Scientific Sessions
September 29-October 3
Marriott Marquis Hotel, San Francisco, CA

2022 Annual Convention & Scientific Sessions
October 19-23
Baltimore Marriott Waterfront Hotel, Baltimore, MD

2023 Annual Convention & Scientific Sessions
October 11-15
Tampa Marriott Waterside Hotel, Tampa, FL

2024 Annual Convention & Scientific Sessions
October 9-13
Kierland Resort, Phoenix, AZ
The ACOI Board of Director wishes to thank all ACOI members for their annual support for the College. The generous support from 75th Anniversary Circle members is of the utmost importance as we seek to maintain an osteopathic approach to internal medicine for future generations of patients.

Thank You!

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. Schwarzwe, DO, MACOI
Suzanne Shenk, DO, FACOI and Scott Segal, DO, FACOI
Laura Smith, DO, FACOI
Duane Sossong, DO
Susan B. Stacy, FACOI
David C. Stainbrook, Jr., DO, FACOI
Christina A. Stasiku, DO and George M. Faron, Esq.
W. W. Stoever, DO, MACOI
Brad Suprenant, DO, FACOI
David Susser, DO, MACOI
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Richard R. Thacker, DO, FACOI
Kenneth Trinidad, DO
Gordon P. Tussing, Jr., DO
Wilfred VanderRoest, DO, FACOI
William H. Voss, DO, MACOI
Ronald L. Walsh, DO, MACOI
Thomas Waltz, DO, FACOI
R. Colin Wetzel, DO, FACOI
Mark L. Woodward, DO, FACOI
William Zipperer, Jr., DO, FACOI
MISSION
The mission of ACOI is to promote high quality, distinctive osteopathic care of the adult.

VISION
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, 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