Insights from the Minority Health Committee

ACOI Heroes: Facing COVID-19

Feed Your Brain While Feeding Your Soul

World Kidney Day: Living Well with Kidney Disease
inside:
ACOI info March 2021

Letter From Our President 3-4
ACOI Offers Something for Everyone
Read

ACOI’s 2021 Spring Meetings 5
Up to 40 1A credits available! Read

Insights From the Minority Health Committee 6
“I Treat Everyone the Same.” Should I? Read

ACOI Heroes: Facing COVID-19 7-8
From Childhood Dream to Worldwide Health Influencer, Nosakhare Obanor, DO, FACOI Makes Impact in Africa and Beyond Read

World Kidney Day 9
Insights on living well with kidney disease from nephrologist Mark Baldwin, DO, FACOI Read

Membership Appreciation 10
Seeking nominations for ACOI Membership Appreciation Month.
Read

Hints from Hermann 11
Incorporating OMM into your practice Read

Government Relations 12-13
• Washington in Brief
• American Rescue Plan Act of 2021 Signed into Law
• Gender Policy Council Established
• … and more! Read

Talking Science & Education 14-15
• Motivation and Resident Well-Being
• Diabetes Dialogues Read

Coding Corner 16
Identifying and Documenting Risk
Read

Certification Information 17
Exam dates and updates from the NBOME.
Read

75th Anniversary Circle Members 19
Thank you for your support! Read

2020-2021 OFFICERS
Michael A. Adornetto, DO, MBA, FACOI
President
Michael.Adornetto@UHhospitals.org
Robert L. DiGiovanni, DO, FACOI
President-Elect
robert.digiovanni27@gmail.com
Joanne Kaiser-Smith, DO, FACOI
Secretary-Treasurer
kaiserjo@rowan.edu
Samuel K. Snyder, DO, FACOI
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
drwds@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
Amita Vasoya, DO, FACOI
vasoya.909@gmail.com
Valentina Stevanovich Lassalle, DO
Resident Rep
vsllassalle@gmail.com

2020-2021 OFFICERS
Michael A. Adornetto, DO, MBA, FACOI
President
Michael.Adornetto@UHhospitals.org
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President-Elect
robert.digiovanni27@gmail.com
Joanne Kaiser-Smith, DO, FACOI
Secretary-Treasurer
kaiserjo@rowan.edu
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Immediate Past President
snydersam@att.net
Annette T. Carron, DO, FACOI
Past President
carronannette@gmail.com

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rcain@aacom.org
Watson Ducatel, DO, MPH, FACOI
drwds@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
Amita 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 Kems
Post-Doctoral Training Specialist
kara@acoi.org
Caudette Jones
Membership Services Specialist
caudette@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

Connect with us:
A letter from our President

Michael A. Adornetto, DO, MBA, FACOI
president@acoi.org

It is a great pleasure to welcome spring and emerge from our long winter, made more challenging with limited travel and activities. Although the pandemic has not ended, the increased availability of vaccines and in many places a decrease in severe infections gives hope that we are starting to regain some normal rhythm to our lives. The work of the ACOI continues to move forward to reach you in many different ways.

Heartened by our exceptional Annual Convention held virtually last year, we are offering our spring meetings on this now familiar platform. Our Hospitalist review will bring together exceptional speakers and focus on topics important to the care of hospitalized patients and the lessons learned from the COVID pandemic. We will follow that up with our newly designed subspecialist conference featuring cardiology, pulmonology, and infectious disease subspecialties this year. Our Internal Medicine Board Review has also been retooled to provide content that allows participants to prepare for both ABIM and AOBIM exams.

These conferences are open for registration and there is more information in this newsletter and on our website.

While planning engaging and timely educational events for you, we are also actively trying to meet the needs of current and future members. One area of growth for ACOI this year has been through the Student Osteopathic Leadership in Internal Medicine and Dialogue (SOLID) Program, which has flourished under the leadership of Robert Good, DO, MACOI. The SOLID Program meets monthly with internal medicine clubs and leadership through this program. ACOI has paired more than 200 students with mentors, and provided interactive educational sessions on applying to residency, practice management, and finances. If you are interested in becoming a mentor for osteopathic medical students or internal medicine residents, please email Susan Stacy at susan@acoi.org.

ACOI’s other committees have been working hard to expand the advocacy and educational efforts of the College. Notably, the Minority Health Committee continues to address healthcare inequities and has begun writing monthly features in the newsletter. This month, a piece entitled, “I treat everyone the same.” Should I? by Christina Stasiuk, DO, FACOI, addresses how to think differently about the definition of equity and equal treatment, and challenges our current thinking. The Information Technology Committee met this week and is addressing technology challenges faced by practicing physicians, particularly considering the changes to primary care catalyzed by the effects of the pandemic.

Committees are a great way to become more involved with ACOI and influence the future of the organization. I would like to thank all Committee Chairs and ACOI members supporting the ACOI.

Continued
From an advocacy perspective, ACOI has been working closely with NBOME as they determine how to evaluate clinical skills for osteopathic medical students with the indefinite suspension of the COMLEX-USA Level 2-PE. Additionally, ACOI helped create the OCC longitudinal assessments that transitioned the AOBIM recertification from a high-stakes assessment to an online recertification pathway. ACOI recognizes the importance of certification to the osteopathic medical community and has been actively engaged in supporting representation and viewpoints on these important certification changes facing practicing and future DOs.

Finally, ACOI is in the process of developing education to accompany our Principle-Centered Medicine™ philosophy. These Principles can help strengthen the physician-patient relationship and provide tools for wellness and balance. In “normal” times, these Principles are important, but the pandemic has heightened the need for the tenets espoused in the Principles. Stay tuned for ACOI to share additional information about these Principles in the coming months.

In closing, I hope that the increased daylight and sunshine is accompanied by increased hope and opportunity to return to spending time with extended family and friends. Your ACOI friends and family wish you a healthy and happy spring.

Michael A. Adornetto, DO, MBA, FACOI
President
president@acoi.org
Feed Your Brain Without Forgetting About Your Soul.

ACOI Spring Meetings May 11-15 are a Chance to Do Both! Register today!

Too many times we think about our education in one sense only—to feed our brain. ACOI is bringing another dimension to CME meetings with the 2021 ACOI Spring Meetings. This year we are making it even more convenient and credit-rich! The Spring Meetings will be held virtually for the first time, May 11-15, and offer up to 40 AOA Category 1A / AMA PRA Category 1 Credits™.

Juggling your education needs with all the demands of our profession during this time just got easier! The following three meetings are available for immediate enrollment. Take a sneak peek by clicking the links below so you can get a taste of what will be covered:

**2021 Internal Medicine Board Review Course, May 11-15** - now for both AOBIM and ABIM exams!

- Approximately 40 AOA Category 1A / AMA PRA Category 1 Credits™

This meeting is intended for those studying to take the AOBIM and/or ABIM Internal Medicine Board exams to gain first-time certification in internal medicine.

It also serves as a refresher course for general internists and internal medicine subspecialists who are looking to stay up to date on their day-to-day knowledge of osteopathic internal medicine.

**2021 Clinical Challenges in Hospital Medicine, May 12-15**

- Approximately 24 AOA Category 1A / AMA PRA Category 1 Credits™

This meeting is intended to help hospital-based internists stay up to date on all the medical advances and structural initiatives related to the myriad of clinical cases they are required to manage in the inpatient setting.

As all ACOI meetings do, this meeting features an amazing faculty with presentations that offer the latest in all topic areas, especially those that pertain to COVID-19.

**2021 Subspecialty Focused Review, May 13-15**

- Approximately 16 AOA Category 1A / AMA PRA Category 1 Credits™

This meeting is for subspecialists in the areas of cardiology, pulmonology, critical care, and infectious disease particularly in the rapidly moving landscape of treating patients with COVID-19. The meeting will address practice approaches in the management of COVID-19 and focus on the best available data for the current standards of care.

**BONUS!**

Individuals who register before [April 20](#) will enjoy an early bird discount of $50 off the Spring Meetings, and an additional $100 off the ACOI Annual Convention and Scientific Sessions to be held September 29-October 3, 2021. Register now!
Let’s not waste a good crisis. Last month, Timothy Barreiro, DO, FACOI, laid out how this pandemic has shined a light on health disparities, factors leading to disparities, and the need for a diverse workforce. This COVID-19 pandemic also provides each of us an opportunity to reflect on our own behaviors in an environment shaped by systemic racism. Let’s pause to think with kindness and a desire to seek understanding, rather than react to that perspective.

Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. Invariably, when meeting with health care professionals to discuss gaps in care due to health disparities, someone declares that “I treat everyone the same.” Frankly, I don’t know what that means. I love my children to the same degree, but each one is different, and requires different love and support at different times of their lives.

By not recognizing the differences that patients bring to our conversations, we miss the opportunity to understand the richness of their experiences, the forces that shape their lives, and the resources they have available to optimize their health.

Do you provide the same treatment plan to a single, white mom, who works three jobs and is dependent on mass transportation, the same way as a stressed, African-American dad executive, who can set his own hours, can afford a driver, and has an assistant to manage his calendar? These differences are social constructs (or social determinants of health) that we do recognize and incorporate into our care management.

Equal treatment is not necessarily equitable treatment. To end disparities we must champion equity instead. Equity requires taking an individual approach to our care. Caring for each person based on their individual needs and circumstances. Recognizing these differences, and the impact that our implicit biases have on the clinical outcomes, are key to taking actions to modify care plans and close these preventable gaps in health disparities.

Equally important, is the need to question race as a factor in interpreting clinical data. As Richard Cooper, et. al. noted in his 2003 New England Journal of Medicine “Race and Genomics” when addressing genome analysis in relation to race: “The central observations remain: variation is continuous and discordant with race, ....and there is no evidence that the units of interest for medical genetics correspond to what we call races.”
ACOI Heroes: Facing COVID-19

From Childhood Dream to Worldwide Health Influencer, Dr. Obanor Makes Impact in Africa and Beyond

by Gina Kilker

The American dream means different things to different people. For some, it means monetary success or fame. For others, like ACOI member, Nosakhare Obanor, DO, FACOI, it has meant being empowered to create a life defined by giving back. At just 17 years old, Dr. Obanor uprooted his life from a continent 8,000 miles away, leaving his home and family to follow his dream—to move to the United States, earn his medical degree, and become a doctor.

Dr. Obanor’s mother, a fabric trader, and his father, an auto mechanic, in Edo State, Nigeria, raised their son with strong values about helping others. “It is a good feeling to be able to give back. My father always taught me something—that you not only receive in life, but you also learn to live a life to give back,” Dr. Obanor said. “And I think those are the things that I have taught my kids.”

Today, Dr. Obanor is a gastroenterologist living in Sacramento, who has never forgotten his roots or why he chose to become a doctor. He finds ways to give back no matter where the need exists—whether it is volunteering at medical clinics for the homeless in neighboring Stockton, California, working in orphanages in Mexico and Jamaica, returning to his homeland to set up HIV Clinics in Nigeria, or creating opportunities for his former countrymen to learn about the dangers of COVID-19.

As a teenager, Dr. Obanor witnessed firsthand how a lack of access to quality medical care, especially for complicated health conditions such as diabetes, affected his community. Within his own home, his beloved “Auntie Esther” suffered from diabetes and, with medical help over 5 hours away, her inability to get consistent, quality care for her condition made a lasting impression on him. As a high schooler, he watched her condition consistently deteriorate. He was continually plagued by the thought that her health outcome could be very different if she only had a doctor nearby who could help. That was when the seed to pursue a future as a physician was planted.

That motivation to help those who are most lacking access is still a driving force for him all these years later and, with the help of technology, it has manifested into a larger effort that is resonating around the world. In January 2021, Dr. Obanor began a series of informational YouTube broadcasts intended to educate the citizens of Edo State that now has grown beyond the region’s borders. He initiated the series of lectures for the general public to help citizens learn more about various health conditions. “My feeling is that if you are able to empower people when they go to their physician, they are able to ask better questions and get better.”

Every other Saturday Dr. Obanor presents a 30-minute online interactive presentation that he leads with a group of rotating guests who share their expertise on various topics. He has done lectures on urinary tract infections, diabetes, the benefits of aspirin, and more.

A few weeks ago, he discussed the myths and facts of another timely topic—the current pandemic.

He said a prevalent belief in Nigeria is that COVID-19 is a disease that only exists in countries that have cold weather. The perception that Nigeria is exempt from COVID-19 has created an environment where individuals aren’t following proven standards of COVID-safe behavior such as wearing masks, staying socially distant, or quarantining when feeling ill. He and his panelists discussed that the SARS-CoV-2 virus is indeed in Nigeria, as it is in every country on the African continent, regardless of the warm climate. During the broadcast, they provided tips on what citizens must do to protect themselves to prevent the spread. They told listeners that wearing masks is essential, as is hand washing, and that gatherings need to be avoided. They also encouraged the audience to get a vaccine when they become available.

The sessions are interactive and the panelists address questions that viewers send in. Since the online sessions are available to anyone with an internet connection, viewership extends beyond Nigeria and reaches thousands around the world. “We even get questions from people in Japan and Australia,” Dr. Obanor said. To broaden distribution of the presentations, especially for Nigerians who do not have access to a computer or an internet connection, Dr. Obanor regularly purchases airtime on a local television station to ensure all Nigerians have the opportunity to hear the messages.

Continued
Dr. Obanor understands the impact his efforts have had on his hometown. Beginning in 2005, he spent a month in Edo State each year setting up HIV clinics, training physicians, and getting medicine to the clinics to treat patients. The gratitude the locals felt for his work surfaced one day in a very unexpected way. When his father passed away, more than 3,000 people showed up to support Dr. Obanor and his family at the funeral. There were so many in attendance that the crowd spilled outside of the packed church.

Ironically, most of those who attended didn’t even know Dr. Obanor’s father. “I had the support of people that I never knew. When we were in need, they were there,” he recalls. He was overwhelmed by the community’s desire to repay him for his many years of help by showing their support. “That was a touching moment for me. You do, and you don’t expect anything in return! But sometimes you get a reward that you don’t even expect. It was if they were saying, we can’t do much to thank you for what you have done, but our presence will support you.”

What’s next? In his usual fashion, Dr. Obanor continues to find ways to honor his passion and live a legacy of giving back. He is now working to set up subspeciality-focused Zoom clinics to provide free telemedicine services to the citizens of Edo State who are in need of specialized care from physicians such as gastroenterologists, endocrinologists, and rheumatologists. The hope is to be able to provide for the people in Edo State opportunities for care that his Auntie Esther did not have all those years ago.
Tuesday, March 11, 2021 marked the 15th annual World Kidney Day (WKD) which is celebrated in 88 countries worldwide. This annual event was established by the International Society of Nephrology and International Federations of Kidney Foundations to raise awareness of the impact of chronic kidney disease (CKD) and end stage kidney disease (ESKD) on society. Although the past year has been a “stress test” to healthcare systems worldwide that has been felt especially in nephrology community, we still have much to celebrate. This year’s theme of “Living Well With Kidney Disease” focuses on the goal of kidney care throughout the patient’s course of renal disease, from diagnosis through interventions, ongoing follow up, transplant, end stage kidney disease (ESKD), and palliative care.

The incidence of kidney disease is increasing worldwide; driven by increasing rates of obesity leading to diabetes and hypertension related kidney diseases. Climate change and pollution have been newly recognized contributors to increasing rates, especially in agricultural and factory workers where extreme heat and environmental toxins influence disease.

With the systemic effects of CKD and ESRD, nephrology was an early pioneer in the team-based approach and has served as a model in the care of complex illness. Our physicians, nurses, educators, technicians, renal social workers, and dieticians help our patients and their families navigate the daily challenges of renal disease.

The past decade has brought forth a number of advances in research, understanding, and improved care for our patients. For many years we have recognized that certain patients have a higher incidence of kidney diseases with more rapid progression. We now realize that alleles of the Apolipoprotein 1 gene (APOL-1) are the genetic link causing damage to the podocytes. While this genetic adaptation of one or both alleles provide immunity to Trypanosomiasis, African sleeping sickness, the detrimental effects are now recognized as well. This discovery has started a journey toward prevention and treatment advances.

Since the 1990s we have been in the “ACE/ARB era” where inhibition of the renin angiotensin aldosterone system has slowed the progression of many forms of CKD and improved cardiovascular outcomes. Newer treatments for diabetes such as the SGLT-2 inhibitors and GLP-1 agonists have proven to slow the progression of CKD have also shown improved cardiovascular outcomes, heralding a new era.

Recently released data published by the United Network for Organ Sharing (UNOS) covering 2019, showed that almost 40,000 renal transplants were performed, an 8.7% increase from 2018, yet almost 100,000 patients remain on the waiting list. The U.S. still has considerable work to improve our outcomes for patients with CKD and end stage kidney disease (ESKD).

Education for increased awareness, improving access to healthcare and state and national policy changes remain a key challenge to improving the transplant opportunities for our patients.

The Tenets of Osteopathic Medicine, namely that the whole body is a functioning unit of mind, body, and spirit, the interrelationship of form and function, and the body’s capacity to heal and regulate itself mirror the basis of care for patients with CKD. Sadly, only 30-40% of nephrology fellowship positions are filled every year through the match. 90% are filled after the match, yet our demands for nephrologists and skilled nurses continue to rise, especially in underserved and rural communities.

The American Society of Nephrology (ASN) has recognized a rising number of U.S. medical school graduates entering fellowship programs are coming from an osteopathic medical school. ASN initiated an osteopathic outreach program led by Laura Maursetter DO, fellowship director of the Nephrology Fellowship Program at the University of Wisconsin in Madison. Dr. Maursetter spoke at ACOI’s virtual conference in October 2020 and discussed her work with ASN. ACOI has established an ongoing relationship with ASN which may serve as a model for future subspecialty relationships.

1 Organ Donation Again Sets Record in 2019.
May is Membership Appreciation Month

Nominations Open through April 16!

Seeking nominations for ACOI Membership Appreciation Month

The ACOI is recognizing members who deserve recognition for their contributions to osteopathic internal medicine in leadership, education, community, and health & wellness.

In May, the ACOI will be kicking off its inaugural Membership Appreciation Month. Do you or someone you know deserve recognition for commitment to osteopathic internal medicine? We’d like to recognize you or a colleague you recommend. Nominations are open now!

Throughout the month of May we will highlight members for the work they have done and continue to do that aligns with ACOI’S foundational pillars of leadership, education, community, and health and wellness.

ACOI members do amazing things every day. As part of Membership Appreciation Month, ACOI would like to highlight these accomplishments and share member stories. These stories, shared with others, will help elevate the ACOI community and strengthen ties among our professional community.

To nominate an individual, please submit the form found online by April 16.

Gratitude is like a magnet; the more grateful you are, the more you will receive to be grateful for.

— Iyanla Vanzant

Welcome New Members!

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

Vlad Apostol, DO
Cyrus Asadi, DO
Sevag Boyadjian, DO
Conrad Braaten, DO
Justin Buchholz, DO
Tricia Charles-Cowan, DO
Danielle Chimento, DO
Kristel Cronin, DO
David Cullen, DO
Charles Defendorf, DO
Shamik Dwivedi, DO, MPH
Adam Esmail-Rawji, DO
Marcy Fitz-Randolph, DO
Peter Fox, DO
Farooq Ghouri, DO
George Ghuneim, DO
Teresa Hardesty, DO
Kelly Heidle, DO
Michael Ianniello, DO
Allan Jeffery, DO
Carrie Jones, DO
Lisa Kernic, DO
Puneet Khandelwal, DO
Edward Kirsch, DO
Parshawn Lahiji, DO
Sandrine Lee, DO
Marty LeJeune, DO
Meredith Lindner, DO
Gregory Loewen, DO
Jed Lowe, DO
Ashley McBrearty-Hindson, DO
Ryan Melvin, DO
Joel Mensing, DO
Christabel Moy, DO
Innocent Nzana, DO
Michael Nekoranik, DO
Frances Norton, DO
Erika Olson, DO
Elizabeth Oommen, DO
Taryn Parks, DO
Kristin Parks Lee
Kishan Patel, DO
Karnik Patel, DO
Dhaval Patel, DO
Stephanie Perez, DO
Kimberly Persaud, DO
Paul Poidomani, DO
Shawn Potteiger, DO
Sera Ramadan, DO
Yameen Rashid, DO
Allison Roe, DO
Patrick Rutka, DO
Saw San, DO
Jason Schend, DO
Savannah Schultz, DO
Cale Sebald, DO
Savitik Shah, DO
Oluwafemi Showole, DO
Dena Snead, DO
Matthew Snead, DO
Kristi Taylor, DO
Kardie Tobb, DO
Christopher Tonthat, DO
Kelvin Tran, DO
Patrick Tyrrell, DO
Andrew Van Boening, DO
Shaista Walji, DO
Frank Zhang, DO
The essence of spring is dawning. With this turn of the season we are able to reflect on our introspection during winter. What did we learn, what have we recognized, where were some of our greatest restrictions?

Spring is the time to begin to release those restrictions and bring our life more into balance. It’s up to us, as we are the stewards of our lives.

As DOs we have the ability to assist others back into balance, their optimal point of balance for that moment in front of us. This ability begins with assessing TART, restrictions in their system, and then treating for the restrictions.

Balanced ligamentous tension (BLT) is one of my favorites as it is easily applicable to any patient at any age with a restriction acute, chronic or anything in between with a light touch or a pressure that will create balance at that ligamentous site.

BLT is used to find a point of greatest ease at a specific ligament or set of ligaments.

The ultimate goal is always improving fluid flow and assisting with the body’s need of supply and demand. Ligaments bridge two bones together. Musculature attach to bones via tendons. This entire unit can be affected by the ligaments’ tension balance. Proprioceptors that may be firing at a high rate secondary to increased tension may be able to decrease their firing as the stimulus to fire decreases.

For long bones, place your fingers/hands on each end and create balance by moving the bone with pressure in all directions, one direction at a time to ‘stack’ the position of the bone relative to the ligament. In a case like a vertebra or a carpel/tarsal bone, create balance between the surrounding bones. For example, if it’s the navicular (in your foot), create ligamentous balance between the first metatarsal, calcaneus, navicular and the next tarsal bone lateral. Hold the position of ease until you feel a release via a therapeutic pulse, tissue softening, warmth, tingling or decreased bogginess. Hold for about 5-10 seconds (or more if needed). Go to whichever area/region you are drawn to via your assessment of TART. Trust yourself. It doesn’t have to be complicated or thorough of the entire body.

For example, if someone comes to you with epigastric pain secondary to reflux/ulcer etc., place your hand on the epigastric area and T6-9 where the sympathetic reflex is and you will find restriction in the thoracic vertebra. Treat it, and your patient will love you.

Jodie Hermann, DO, FACOI

Hints From
HERMANN
Incorporating OMM Into Your Practice

The American College of Osteopathic Internists (ACOI) is the leading professional organization for DOs in Internal Medicine. ACOI is dedicated to providing a voice for DOs in Internal Medicine, promoting the specialty and advocating for the best interests of patients.

Jodie Hermann, DO, FACOI

Chair of the Osteopathic Manipulative Medicine Department and Assistant Professor at the University of New England College of Osteopathic Medicine.

jhermann@une.edu
American Rescue Plan Act of 2021 Signed into Law

President Biden recently signed into law the American Rescue Plan Act of 2021. The law provides additional relief to address the continued impact of COVID-19 on the economy, public health, state and local governments, individuals, and businesses. The $1.9 trillion package includes: $160 billion for COVID-19 vaccine and testing programs; funds to create a national distribution program that would offer free shots to all United States residents; $360 billion in state aid; $8.5 billion for rural hospitals; coverage for 100 percent of the costs of continuing health insurance through September for laid-off workers; $170 billion to help schools open; and an additional $7.25 billion for forgivable loans through the Paycheck Protection Program (PPP), among other things. The legislation was approved following recommendations by 23 House and Senate committees. Of note is that the law triggers mandatory sequestration, including $36 billion from Medicare, which will have to be addressed with subsequent legislation. The legislation builds on previous legislation approved in 2020 to respond to the far-reaching impact of COVID-19.

Gender Policy Council Established

The President recently signed an executive order to create the Gender Policy Council. The Council was created to advance gender equity and equality to ensure access to comprehensive health care, as well as respond to the effects COVID-19 has had on women and girls. It will be comprised of members from the Department of Health and Human Services (HHS) and other federal agencies. Within 200 days the Council will develop and submit a government-wide strategy for policies, programs, and initiatives to advance gender equity and equality. In addition, the Council is tasked to evaluate the impact that other proposed policies and legislation could have on issues of gender equity and equality.

Executive Order Signed to Secure Critical Supply Chains

The President recently signed an executive order aimed at securing the nation’s supply chain for critical and essential goods. The order calls for an immediate 100-day review across federal agencies of supply chains in the following key areas: active pharmaceutical ingredients; critical minerals needed for defense, high-tech, and other products; semiconductors and advanced packaging; and large capacity batteries.
In addition, the executive order directs a broader review of U.S. supply chains in other areas, which include the public health and biological preparedness industrial base. The executive order is in response to the shortages of personal protective equipment and medicines during the COVID-19 pandemic.

Washington Tidbits

“Baddest Town” in America

Just outside Washington, DC lies the most crime-ridden town in the world. The town includes a bank, a motel, a jewelry shop, warehouse facilities, and even single-family homes. The bank is the most often robbed bank in the world—at least twice a week. Mobsters, drug dealers, and international terrorists are around every corner. Why is this town so plagued by violence? It is the Federal Bureau of Investigation’s (FBI) training ground located in Quantico, VA—otherwise known as Hogan’s Alley.
Greetings colleagues, and welcome to the March 2021 issue of Talking Science and Education. Welcome to mud season in Vermont! This is the time of year when the big thaw begins, roads get rutted, and mud covers all ground surfaces. On March 4th, we celebrated Vermont’s 230th Birthday. On that date in 1791 Vermont was admitted as the 14th state (1st addition to the 13 colonies). Just a little New England trivia for your reading pleasure!

In last month’s population health quiz, we asked by what did flu (excluding COVID) vaccinations increase between 2018 and 2019 in the United States? Unfortunately, we did not have anyone identify the correct answer last month. Between 2018 and 2019, flu vaccination coverage increased 25% nationally from 35.0% to 43.7% of adults. However, this remains far below Healthy People 2030’s national target to have 70% of the population vaccinated. During this time frame, vaccination coverage increased:

- 27% among males (30.8% to 39.0%) and 30% among females (35.8% to 46.6%).
- 41% among ages 18-44 (23.3% to 32.8%), 27% among ages 45-64 (33.9% to 42.9%) and 18% among ages 65 and older (53.9% to 63.7%).
- 36% among adults who identify their race as other (27.4% to 37.4%), 35% among multiracial adults (28.9% to 38.9%), 34% among Hispanic (25.2% to 33.7%), 32% among Black (27.7% to 36.7%), 29% among American Indian/Alaska Native (28.6% to 36.8%), 28% among white (36.3% to 46.6%) and 13% among Asian (38.6% to 43.5%) adults.
- 28% among adults ages 25 and older who are high school graduates (30.5% to 38.9%) and those with some college (33.6% to 42.9%), 27% among those who are college graduates (42.2% to 53.5%) and 18% among those with less than a high school education (30.4% to 35.9%).

Since 2018, significant improvements also occurred in 46 states, led by New York (28.0% to 44.9%), Wisconsin (29.9% to 46.1%) and Texas (26.4% to 40.0%).

This month’s population health quiz asks by what percent did preventable hospitalizations decrease between 2018 and 2019?

A. 5%
B. 18%
C. 3%
D. 10%
E. 15%

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

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

Talking Education

Motivation and Resident Well-Being

Despite many years of ongoing research, regulations, and initiatives to improve the well-being of physician trainees, data show we have much more work to do. A largely untapped area of study and innovation in the well-being of medical trainees is motivation. While motivation carries no consensual definition in medical education, the social cognitive approach to understanding it is widely accepted in the literature. In this approach, motivation is “why people think and behave as they do,” and is influenced by both the self and one’s constant interactions with the environment. In their brief but very practical paper published in the most recent edition of the JGME, Dr. Amber Deptola from Washington University in St. Louis summarizes the existing literature on motivation in graduate medical education (GME) and provides actionable recommendations for application of self-determination theory in the clinical setting with the goal of improving well-being. In particular, Dr. Deptola emphasizes the importance of autonomy, competence, and relatedness in the dynamic of motivation and trainee well-being. 

Continued
Talking Science and Education: Diabetes Dialogues

SGLT2 Inhibitors: Not Cost-effective for Glycemic Management Alone in Type 2 Diabetes

For those of you who read last month’s column, you know that I am very excited about the benefits of the SGLT2 class for the treatment of CKD, HF, and CV risk reduction. However, based on a newly published study, it appears that SGLT2 inhibitors provide limited glycemic management benefits and may not be cost-effective for most people with type 2 diabetes, according to a study published in the Journal of Diabetes and Its Complications.

This study led by Larry Weinrauch, MD, a clinical Researcher at the Joslin Diabetes Center, examined the prescribing trends prior to published scientific evidence of benefits in some patients with heart failure and progressive renal disease. Their study documented the changes in prescribing patterns and did not find major improvements in glycemic control associated with the availability of the newer drugs.

Weinrauch and colleagues conducted a single-center, retrospective review of all patients diagnosed with type 2 diabetes and hypertension who had at least two visits to the Joslin Diabetes Center from 2010 to 2012 and 2014 to 2016. Demographic information, BMI, HbA1c, estimated glomerular filtration rate, blood pressure, smoking status and complete medication lists were obtained. Researchers compared medication use and effects from the first period before the approval of SGLT2 inhibitors in the U.S. and the second period after the drugs were approved for treatment of type 2 diabetes.

Of 10,191 people included in the analysis, 7,769 had data from 2010 to 2012, and 6,576 had at least one visit from 2014 to 2016. Compared with the 2010-2012 period, 2014-2016 saw a decrease in the use of biguanides (69.5% vs. 66.3%), sulfonylurea compounds (44.7% vs. 39.4%), thiazolidinediones (13.6% vs. 3.4%), amylin analogues (2.7% vs. 1.1%), meglitinide (3.9% vs. 2.5%) and thiazide diuretics (32.4% vs. 28.9), whereas there was an increase in use of GLP-1 receptor agonists (16% vs. 23.8%), SGLT2 inhibitors (0% vs. 14%), insulin (56.1% vs. 60.5%) and statins (78.4% vs. 81.5%).

Based upon their reviews of current U.S. pricing, the monthly cost of high-dose metformin and glipizide are each less than $30 when compared to greater than $300 for liraglutide (Saxenda, Novo Nordisk) and greater than $450 for empagliflozin (Jardiance, Boehringer Ingelheim and Eli Lilly). This 10- to 15-fold increase in monthly glycemia control cost was associated with a fall of HbA1c from 7.9% to 7.8% in our study.

In his article, Weinrauch points out that guidelines for the treatment of diabetes are written by clinicians for clinicians based upon scientific evidence, by insurers for payors, but not for the working people who must pay for medical insurance, copays and medications. He goes on to note that these consumers/patients have a different value system not based on the significant differences in combined endpoints. Their question is always based on ‘what will this do for me?’ Patients in the study were already taking pills for high blood pressure and cholesterol, and 70% were taking two or more medications for control of blood sugars.

Weinrauch said longer-term data are needed to assess whether SGLT2 inhibitors or GLP-1 receptor antagonists have glycemic control advantages over less-expensive medications. He added that future research should examine cost comparisons instead of cost-effectiveness.


The Table of Risk (Table A) is part of the 1995 and 1997 Evaluation and Management (E&M) Guidelines and is used to calculate the Medical Decision Making (MDM) of services. It is one of three key components to determine an appropriate level of coding. Table A differentiates patients whose care management options are impacted by those with an increased risk.

For example, all surgeries have associated risks. This is not the “risk” intended in the Medical Decision Making (MDM) section of the E&M Guidelines. “Risk” in Table A is intended to reflect the risk that is above and beyond the normal risk factors identified for a specific surgery. The distinctive risk the patient has, and is intended to be captured in the table, is generally risk due to factors such as a disease process or other comorbidity.

A physician, when deciding whether or not to personally perform a procedure or surgery on a patient with increased risk, has as an increased level of MDM complexity. That increased complexity can result in a higher level of E&M service.

As an example, this can be seen in the Diagnostic Procedures Ordered column (with endoscopies), in addition to the Management Options Selected column in the Table of Risk from the 1995 & 1997 Guidelines that follow.

As a result of the new Office and Other Outpatient Services Guidelines for 2021, we have two methods to determine the level of service—time, and utilization of the Elements of Medical Decision Making Table (Table B). Like the language used in Table A, “patient with identified risk factors,” the 2021 guidelines now read, “with identified patient or procedure risk factors.” The meaning and intent are the same.

According to Dr. Peter Hollman, speaking on behalf of the AMA in April 2020 on the new 2021 office E&M codes, “This was something the American College of Surgeons told us is the language that they now use in their educational materials. We said again if you have been doing this for a long time that’s not going to change coding patterns. Let’s keep with that.” As a result, we have new language in 2021 that reflects prior wording and intent. When considering the MDM, if there is an elevated risk identified to a patient, or a procedure that is above and beyond normal risk, the provider should select this higher code level on Table B. As with the 1995 & 1997 E&M Guidelines, the 2021 Elements table differentiates between patients who have higher risk and those who do not.

As a best practice, if your patient possesses an increased risk, be sure to document it by saying something like, “This patient is at risk above and beyond the normal risk for this procedure because of [describe the risk]” in your medical records. This documentation may help qualify the patient in the selection of a higher level of service. This is true for both the new Office and Other Outpatient Services in 2021, and all other E&M Services that utilize the 1995 or 1997 Guidelines.

Do not miss the opportunity to compliantly qualify for a higher level of MDM, which will potentially lead to a higher level of service for the patient.

The AMA released a “Technical Corrections” document to their 2021 Office and Other Outpatient Services materials on March 9th. The updated materials are available here.
Suspension of COMLEX-USA Level 2-PE

In February, 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 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.

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.

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Thank You!
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