ACOI Heroes: Facing COVID-19

Together Again at ACOI 2021 in Orlando, FL!

Membership Appreciation Month Spotlight: Using Creativity to Educate

Insights from the Wellness Task Force
inside:
ACOI info May 2021

2020 Convention Now Online! 10
The 2020 Annual Convention is now available for purchase on our Online Learning Center. Read

Government Relations 11-12
• Washington in Brief
• ACOI Supports Efforts to Protect Health Care Providers in the Workplace
• ACOI Supports Efforts to Examine Race and Ethnicity in Clinical Algorithms
• ... and more! Read

Coding Corner 13-14
COVID Vaccines in the Office
Read

Talking Science & Education 15-16
• Appreciative Inquiry and Medical Education
• Diabetes Dialogues Read

Hints from Hermann 17
Incorporating OMM into your practice Read

Certification Information 18
2020 examination dates. Read

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

Letter From Our President 3-4
Together Again Read

ACOI 2021 Convention 5
Join us for our first hybrid live/virtual event! Read

Insights from the Wellness Task Force  6
“Why We Pursued Medicine” Read

Membership Appreciation 7
Spotlight on MarkAlain Dery, DO, FACOI and his new animated educational series. Read

ACOI Heroes: Facing COVID-19 8-9
Communication & Community helped Dr. Menolasino weather the COVID-19 storm. Read

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Leadership
We help you realize your full potential

Community
We create and welcome you to a home where you belong

Education
We help you learn exactly what you need to know

Health & Wellness
We lead you to discover the spirit of wellness

Connect with us:
Together Again

I am extremely excited to begin to see the United States of America experience life again. The opportunity to return to some sense of normalcy also provides an opportunity to reconnect with old friends, to go to the ballgame, and to dine in the company of others. I am most appreciative to have the vaccine, and hope this continues to be offered to all throughout the community. I applaud those who received their COVID vaccine to protect themselves and others, and believe this is a great step towards minimizing the burden of COVID in our communities.

In keeping with this return, we have news to share with you about the 2021 ACOI Annual Convention & Scientific Sessions! After much consideration and planning, ACOI is moving forward with a hybrid Convention to be held in October 2021 in Orlando, Florida. With this, we are offering a live in-person convention and a virtual component for those still not wanting to travel, but looking for outstanding CME.

We have worked very hard to find the best place that offers easy travel, nearby activities, and ample space to gather safely together.

To accommodate as many members as possible who want to join us for Convention, we have moved the location from San Francisco to Orlando, Florida. Features of this year’s convention include:

- The Gaylord Palms Resort and Convention Center, Orlando Florida
- Condensed Format, Wednesday-Saturday, October 27-30.
- Hybrid meeting allowing for virtual attendance.

This will be the first time ACOI has held a meeting at the Gaylord Palms, which has fun activities for attendees and family members. Due to the tumultuous year we have all experienced, ACOI has gone to a slightly shorter conference format, meeting Wednesday-Saturday, October 27-30. We realize many physicians are still working patients into their schedules and hope the shortened format and virtual option help accommodate these needs.

We hope to see as many of you as possible with your friends and families to reconnect.

As many of you know, the ACOI has a long history of in-person gatherings that have created an important connection between our members. I remember the first time I attended the ACOI meeting in Orlando and reconnected with residents I trained and enjoyed dinner with friends I trained with. But most of all I really hold dear the memory of meeting my family at the Magic Kingdom after a great session of meetings. Even though they are all grown up, I remember their excitement like it was yesterday.

Over the years, we have gotten to know each other’s families. We still look forward to the convocation of fellows, where we have welcomed new members, celebrated each other’s accomplishments, and created lifelong bonds with each other—many of these started at a Convention.
After the challenges of 2020, a year that was difficult and isolating for many of us, we sincerely hope you can make plans to reconvene in person to rekindle those relationships with old friends and make new ones.

ACOI has been very intentional about the in-person Convention, weighing as we did in 2020. We learned a lot from that experience, but we also learned one key takeaway: how valuable our time in-person together is—both for an organization and for individuals. We are working hard to make the most of the in-person experience. We are very cognizant of the privilege that gathering in person affords, and we will focus on cultivating connections in Orlando.

We realize that not every member will be able to get away and, to accommodate everyone, we offer the virtual Convention option which will be held simultaneously for those who are unable to attend. But it is my sincere hope that if it is at all within your power to attend in person, that you please join us to reconvene in Orlando!

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

Physicians meeting for lively discussion at the Women in Medicine panel.
2021 Annual Convention and Scientific Sessions
October 27 - 30, 2021
Gaylord Palms Resort & Convention Center
Orlando, FL

Join us for our first hybrid live/virtual event!
Registration coming June 1st.

Together Again

Education
Insights From the Wellness Task Force

“Why We Pursued Medicine”
Martin C. Burke, DO, FACOI,
Chair, ACOI Wellness Task Force

A prominent pillar woven into the very fabric of the ACOI is Wellness. Our daily philosophies seek wellness for our families, friends, and patients with drive and determination. The toil of such a life can sometimes become overwhelming. For us and the ACOI to be true to why we pursued medicine, we need to also look in the mirror and gauge our own wellness and have support systems in place that are professional and flexible.

The ACOI is committed to examining the status of our members health as well as the work environment that daily undermines such health. As first responders (those who accelerate towards problems) we often place others ahead of ourselves and in many circumstances this soul is taken for granted and exploited by so-called leaders in the system.

A simple question that you can ask yourself is, “Do I feel overburdened and underappreciated?” Our professional health is suffering. Our ability to lead, teach, and drive an individual’s care through Principle Centered Medicine™ seems to be used poorly by a corrupted system. As you can see, this is a menagerie so complex that it periodically feels hopeless. The system is pushing us away from our true pursuits.

The ACOI Wellness Task Force is undaunted in using our “Principles” to provide health and wellness to our members, our patients, and team members to combat the anger, grief, and emotional distress that most of the US heath industry is creating. The Task Force wants to focus on our first responders, especially physicians. The ACOI, through the recommendations of the Board and Task Force, is setting up a Wellness Retreat for select members to decompress in a safe place and engage in peer-to-peer counseling. The pandemic has limited in-person meetings, but we have had video conferencing peer-to-peer events that have been well-received, and more are planned with discussions surrounding ways to regain leadership in the healthcare system, time management, addiction, and debt management.

These events need our members to share their raw emotions and stories so that together we can find a place to allow our Principles to regain the day. So please reach out to the ACOI office with your needs.

The ACOI is pedestaled by four pillars: Leadership, Community, Education, and Wellness. Our ability to provide health and wellness to osteopathic physicians committed to others is steeped in these four pillars because they are YOU. My brothers and sisters, you are the Task Force and we can and will right this ship.
Membership Appreciation Month Spotlight: MarkAlain Dery, DO, FACOI
Using Creativity to Educate the Public about COVID-19

At the beginning of the pandemic, MarkAlain Dery, DO, FACOI and Eric Griggs, MD, a community health specialist, sought to combat misinformation about COVID-19 through a daily podcast and livestream. In addition to the weekly video blog Dr. Dery produces for the ACOI, he also produces the federally-funded COVID NoiseFilter Podcast and NoiseFilter Live Show which focus on analyzing data, dispelling myths, and sharing expert knowledge about COVID-19.

At the end of 2020, Dr. Dery and Dr. Griggs began working with Gigantic Fantastic, an educational production company, to conceptualize a series of animated videos using compelling imagery and entertaining storytelling to turn complex scientific matters into digestible lessons intended for viewers without a background in infectious disease. In January 2021, they teamed up with FableVision Studios, a multi-media production company, and their first episode recently debuted. In Episode 1 of the animated series, Dr. Dery and Dr. Griggs help the public understand how mRNA vaccines work by stimulating the human body's immune system.

They journey through the human body to explain how mRNA vaccines stimulate the immune system to fight COVID-19. In the upcoming episode set to be released next month, Dr. Dery and Dr. Griggs explore COVID-19 variants through fairytale analogies.

According to Dr. Dery, “Using animation to explain immunizations seemed like the perfect direction for me and Doc Griggs. We have a long history of using humor and stories to explain dense medical concepts. Whimsical animations rooted in scientific data is the next step in our mission to reduce vaccine hesitancy.”

Dr. Griggs emphasizes the need for more diversity in medicine. “Hopefully these videos spark the interest of students of color to explore STEM when they see a black doctor on screen,” he shares.

“The impact of these videos can be tremendous—not only in promoting vaccinations, but also in empowering younger generations to study medicine and public health.”

Thank you to ACOI member Dr. MarkAlain Dery and Dr. Griggs for helping share information about the COVID-19 vaccine! Check out the video and recommend it to your patients to learn more about how the vaccine works: Valiant Vaccine Versus the Vicious Virus.

MarkAlain Dery, DO, FACOI, recipient of the 2020 ACOI Internist of the Year Award
ACOI Heroes: Facing COVID-19

Communication & Community Came Together to Weather the COVID-19 Storm in Northeastern Ohio

by Gina Kilker

As New York City became the pandemic epicenter in March 2020, Michael Menolasino, DO, FACOI, Medical Director for the Lake Health System in Northeastern Ohio, watched with anticipation of what was to come. He quickly came to the realization that his health system was ill-equipped for the magnitude of the impending health emergency.

Expecting an influx of infected patients, he worried that they likely would not have enough PPE or life-saving equipment such as Bilevel Positive Airway Pressure machines or ventilators. That concern, as it turned out, was about to be tested. Just after Dr. Menolasino walked out from a meeting with hospital administrators in which he proposed a proactive measure to slow PPE shortages, he discovered that three new hospital admissions were the first confirmed COVID-19 patients to be admitted to his hospital. The first wave was underway.

To handle the expected incursion of COVID patients, Dr. Menolasino and his team decided that a staffing plan was needed. The hospitalist team, headed by Dr. Menolasino, was assigned to be the official COVID response team since the hospital only had three part-time pulmonary critical care physicians on staff. As very sick COVID patients flooded the hospital, they realized that many of the patients deteriorated rapidly and needed ICU level care.

“For the first time in our hospital system’s recorded history, we actually closed the intensive care units. Patients could only be admitted to the ICU if they were admitted by the official COVID team.” The anesthesiology department also segmented to create a series of intubation teams.

This method of limiting who could admit patients to the ICU helped the staff clearly understand their roles and be selective when it came to assigning the precious few ICU beds. Non-COVID patients were managed by the non-hospitalist services, with Dr. Menolasino’s team taking care of the sickest patients. To further prepare, elective surgeries were canceled and ambulatory outpatient physicians were on standby to be mobilized to assist should they need extra manpower.

Immediately following the Fourth of July holiday, the second wave hit northeast Ohio with an average of 10-15 COVID patients daily. It was when the third wave hit at the end of October, with an average of 20-30 COVID patients daily, that Dr. Menolasino felt confident that they finally had some effective treatments. With both the organized team structure working well and adequate supplies of Remdesivir on hand, the hospital was ready to handle the sickest patients.

“We knew exactly what to do and into that third wave, our mortality numbers were actually surprisingly better than the national averages. Our senior leadership suggested that our results were due to our preparation and the great care that we gave. I agreed with them—to a point.

I also think some of it was just dumb luck and being fortunate that patients were starting to come in early enough so that we were able to get medications started sooner.”

Another breakthrough was the implementation of a monoclonal antibody infusion practice in the outpatient setting. When asymptomatic patients tested positive but were at risk due to comorbidities, they could come into the hospital to get an infusion of monoclonal antibodies (now they are doing dual monoclonal antibodies) to prevent them from deteriorating. “That treatment and seeing patients earlier in the course of the infection has made a significant impact into the severity of illness.”

Dr. Menolasino and a member of his team of hospitalists, Dr. Sabahat Iqbal.

Continued
ACOI Heroes: Facing COVID-19

(Continued)

Open-forum style weekly senior physician leader meetings helped Dr. Menolasino’s team to confer about what responses and treatments were working. “Literally any source of information that could be found was being brought forward in that meeting to have a discussion regarding what was occurring in and around us, as well as nationally. No idea was considered dumb, which was probably the most important thing.”

**From ponchos to protective gear**

An all-out community effort to support the Lake Health System proved to be an invaluable contributor to managing the stress of equipment shortages. Dr. Menolasino believes that the long 100+ year history of the Lake Health System within the community played a major part in helping he and his team feel supported. He also credits the long tenure of the health care administration staff to creating a sense of family along with long-standing personal connections—all of which went a long way.

“Local industry reached out to us and asked how they could help—and that was huge! We have a company near us that makes plastic ponchos; they supplied much of our PPE. We had another organization that did all of our processing of N-95s and we had many of our companies around us move their manufacturing operations to making face shields and isolation gear.”

In addition, the resourcefulness of their senior hospital administration leaders helped in obtaining ventilators.

“It’s a small enough county that everybody knows each other. I think that historic perspective and mindset of taking care of each other contributes to the interconnectedness of the community and the hospital, which helped bring people together to come up with creative ideas on how to keep our system functioning.”

Education was also a top priority in helping the community understand the importance of masking. That relationship with community leaders, which included churches, businesses, and local government, helped them to set the example for others to mask up.

“Our staff helped educate the community by putting on their social media pages the importance of masking for everyday activities and being good examples. Since everybody in the community knows who the nurses, the housekeepers, and the paramedics are, that went a long way in providing an example. The same is true for our fire department and the police department. There was a real spirit of ‘we’re all in this together’ and much more of a sense of a doing it for your neighbor, not just for yourself.”

Dr. Menolasino believes that although there is enough vaccine to vaccinate everybody, the struggle now will be focused on getting younger people to get the vaccine. He said his patient population with COVID has shifted from older at-risk individuals to patients in their 40s.

**Being okay in saying you’re not okay**

“I think probably the biggest challenge for me was admitting when I was tired, when I was frustrated, or angry—when I was feeling ‘emotionally empty.’ Sure, I could do the job and deliver health care, but there were times when I was just emotionally exhausted—when there was nothing left in that bucket.”

As one of the hospital’s leaders, Dr. Menolosino found it difficult to identify opportunities to take a break and do something to rebuild his emotional reserves.

“I was doing death certificates—several a day for a few weeks—and I finally had to stop! I actually said to my boss at that point: ‘I am just done. I’m turning off my computer and I’m taking the day off. The death certificates will wait. I just I needed to go do something else.’ Having a group of people that you can say that to is important. It is even more important to hear them say to you—‘It’s okay, we got this, you go and take care of yourself.’”

Dr. Menolosino emphasized that it is important for leaders to admit to the need to take a break, and just as important to give permission to others to admit the same. “As leaders it is important to let people feel that they need to heal themselves so they can come back and do the job again.”
ACOI Online Learning Center

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 (OLC) is your one-stop shop for the latest information in internal medicine and its subspecialties. You can find educational content available for both credit and non-credit. The OLC makes these resources available at your fingertips at a time and place most convenient to you. The OLC was recently updated to include lectures from the 2020 Annual Meeting and Scientific Sessions with more than 50 AOA 1-A credits available. The lectures are available à la carte or as a complete package saving your more than 50 percent! We understand the many challenges you face each day, staying abreast of your continuing medical education does not need to be one of them. You can access the OLC and all of its content here.

Online Learning Center Spotlight: Pixar Alum Discusses the Value of Story Telling

Matthew Luhn, a 20-year storytelling veteran, has spent his career evoking the emotions of his audience. Firmly believing that stories serve as much more than entertainment, Mr. Luhn said they can invoke emotion and, most importantly, stories can help a patient feel comfortable and open to listening to another’s viewpoint. For physicians, using metaphors and storytelling provide the ability to frame a procedure or a health goal in a way that transforms it from a sterile and, perhaps, frightening clinical scenario, to one that is not only more easily understood, but also relieves patients’ fears. Storytelling aligns with the goals of Principle-Centered Medicine™ and allows osteopathic internists to have better connections with patients and fosters relationship building while putting the heart back into medicine. Whether in business or in patient care, stories have proven to be an influential communications tool. This lecture is available for free on the Online Learning Center!

ACOI National Meetings

2021 Virtual Spring Meetings
These virtual meetings have been archived and can still be accessed through December 31, 2021.
Register now!

2021 Annual Convention & Scientific Sessions
October 27-30
Gaylord Palms & Convention Center, Orlando, FL
Hybrid Live/Virtual Meeting - registration coming soon

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

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

Information on any meeting listed here may be obtained from ACOI Headquarters at 800 327-5183, or from our website at acoi.org.
The legislation would, among other things, do the following: direct the Occupational Safety and Health Administration (OSHA) to issue a federal workplace violence prevention standard to protect workers in health care and social services from injury and death; require employers in the health care and social service sectors to develop and implement a workplace violence prevention plan, tailored to specific workplaces and worker populations; require hospitals and skilled nursing facilities to comply with the new standard as a condition of a Medicare provider agreement; and require intergovernmental and private-sector mandates through facility compliance with the OSHA standard. You can read the full letter on the ACOI’s website here.

ACOI Supports Efforts to Examine Race and Ethnicity in Clinical Algorithms

The ACOI and AOA called on AHRQ to engage in an extensive review of the evidence available, identify research gaps, and evaluate the tools in real-world settings. In addition, the letter calls on AHRQ to disseminate the results of the review to help improve clinicians’ awareness when tools have a high likelihood of exacerbating health disparities and negatively impact the quality of care provided. The full comments are available on the ACOI’s website here.

ACOI Joins in Comments Addressing Scope of Practice Concerns in New York

The ACOI joined with the AOA and the New York State Osteopathic Medical Association to express strong concern with legislation that would eliminate the requirement that nurse practitioners (NPs) must complete 3,600 hours of collaborative practice with a physician before they become eligible to independently treat patients, and instead would allow the collaborative practice requirement to be fulfilled by another NP.
The letter expresses the concern that such a large increase in scope of practice for NPs, without any mandatory increases in education, training, or certification competency requirements, may put the health and safety of New York patients at risk. You can read the full letter here.

Efforts to Increase Access to Opioid Use Disorder Treatment Expanded

The Department of Health and Human Services (HHS) recently released new practice guidelines to increase access to opioid use disorder treatment by removing potential hurdles to the prescription of buprenorphine. Under the new guidelines published in the Federal Register, eligible practitioners are exempt from federal certification requirements related to training, counseling, and other ancillary services for obtaining a waiver to treat up to 30 patients with buprenorphine for opioid use disorder. Physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives must be supervised or work with a DEA-registered physician if required by state law. The exemption does not apply to Schedule II medications such as methadone. In the 12-month period that ended in September 2020, the US experienced its highest reported 12-month period of overdose deaths, surpassing more than 90,000.

You can view the full practice guidelines here.

HHS to Enforce Anti-Discrimination Regulations

The Department of Health and Human Services (HHS) recently announced its Office for Civil Rights (OCR) will enforce protections against discrimination toward transgender and LGBTQ individuals established by the Affordable Care Act (ACA). In June 2020, the US Supreme Court found that Title VII of the Civil Rights Act of 1964’s prohibition on employment discrimination based on sex encompasses discrimination based on sexual orientation and gender identity. As a result of the Court decision and provisions of the ACA, HHS’ OCR will interpret the prohibition on discrimination on the basis of sex to include: discrimination on the basis of sexual orientation; and discrimination on the basis of gender identity. According to a release by HHS, “The mission of our Department is to enhance the health and well-being of all Americans, no matter their gender identity or sexual orientation.” You can view the full statement by HHS here.

Washington Tidbits

I Do Solemnly Swear…With Amendment

When one thinks of Congress, it may conjure up an image of the thousands of bills introduced in the House and Senate each year. Of the thousands of bills, only a few are considered by the full House and Senate, and even fewer make it to the President’s desk for enactment. The first bill to make it through this process was the Oath Act in 1789 which provided, “I _____ do solemnly swear (or affirm) that I will support the Constitution of the United States.” The oath was intended for members and civil servants, and was first administered to senators by Vice President John Adams. It was amended four times during the Civil War to reflect the times, challenges, and concerns, but remains intact since its last amendment in 1884 to read, “I do solemnly swear (or affirm) that I will support and defend the Constitution of the United States; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter: So help me God.” The first legislation approved by Congress and signed into law by George Washington has survived to this day—with amendment.
CODING CORNER

COVID Vaccines in the Office
Jill M. Young, CPC, CEDC, CIMC

With the recent announcement by the Food and Drug Administration (FDA) that paves the way for the Pfizer COVID-19 vaccine to be administered through emergency use authorization to individuals 12 years of age and older, the practice considerations of offering the vaccine in the office setting are worth taking a closer look at.

Information released by the Centers for Medicare and Medicaid Services (CMS) suggest a long-term goal for COVID-19 vaccines to be provided primarily through physicians’ offices. CMS has provided a wealth of information about this subject on its website. The current model still sees the government as the central supplier for vaccines and that results in no pass-through costs. Reimbursement for the administration of the vaccine, and the work involved in giving patients their shots, is approximately $40.00 per patient with some geographical variation.

CMS announced programs for coverage of the administration of the vaccine in physician offices through local Medicare contractors. There are two programs that will cover the administration of the vaccine: one for patients with Medicare and one for patients without insurance. The billing for these two types of patients is different and explained in detail on the CMS website.

CMS encourages offices that administer vaccines to take all patients who present for one, regardless of insurance status. In the available literature, Medicare states the hope other insurers will follow suit with their reimbursement model for the administration of the COVID-19 vaccine at or about the same level.

Administration codes have been established for the Pfizer vaccines (separate codes indicate first or second dose). Codes also exist for all other currently approved COVID-19 vaccines.

The reimbursement amount for administering a COVID-19 vaccine was increased in late March to approximately $40.00 per vaccination given.

It allows you to vaccinate your patients within the confines of your office where you can perhaps build upon the physician-patient relationship should additional conversation around the value of the vaccine be needed.

Unfortunately, the Pfizer vaccine, as you know, has significant storage requirements. You have five days after it is thawed to use it, and six hours once it is reconstituted. The Moderna vaccine also has temperature and expiration requirements that must be considered and accounted for. Careful planning and tracking will be needed to make sure any doses given by your office have been properly stored and prepared. Careful management of your supply will be essential to eliminate wasted vaccines.

While not impossible, having worked at a mass vaccination site, it is clear to me that an efficient and effective vaccine process requires someone with specific skills who is able to focus on the task at hand. Where I worked, the medications were prepared for those who were actually drawing up the syringes with the initial process handled by a pharmacist. The pharmacist had access to an appointment log to allow for effective management of the vaccine supply.
Perhaps a retired nurse or pharmacist could work a day or two per week to help your office administer vaccines. Appointments could be made at times when your office is not as busy or on off patient days to not detract from the normal operations of your practice. Hopefully, we will be talking about this someday soon with regard to booster shots should they become necessary.

As I look forward to the new normal, I hope this article gives you something to think about as it relates to the administration of the COVID-19 vaccine. I hope not to dissuade you from doing it, but rather to provide you some things to think about and how providing the COVID-19 vaccine can maybe fit into the day-to-day operations of your practice. One thing is clear, providing the COVID-19 vaccine in your office is unlike providing the flu vaccine or other shots. The COVID-19 vaccinations need special consideration and care—just like your patients!
Greetings colleagues, and welcome to the May 2021 issue of Talking Science and Education. Spring has sprung in Vermont and the four “Ss” (snow, skiing, shoveling, snow) have turned to the three “Gs” (golf, gardening, and more golf). Watching the Green Mountains reanimate is an experience of which I never grow tired.

In last month’s population health quiz, we asked by what percent did exercise among adults in the US increase between 2017-2019? Unfortunately, we had no correct responses last month. Between 2017 and 2019, exercise increased 13% nationally from 20.3% to 23.0%, an increase of nearly 4.9 million adults. During this two-year period, exercise increased:

- 14% among females (18.2% to 20.8%) and 11% among males (22.7% to 25.2%).
- 31% among adults ages 65 and older (17.6% to 23.1%) and 19% among ages 45-64 (17.8% to 21.2%).
- 14% among white (20.6% to 23.5%) and 13% among Black (20.3% to 23.0%) as well as Latinx (18.4% to 20.8%) adults.
- 33% among adults ages 25 and older who have less than high school education (9.8% to 13.0%), 28% among those who are high school graduates (14.5% to 18.5%), 18% among those with some college (19.7% to 23.3%) and 7% among those who are college graduates (26.5% to 28.3%).

During this two-year period, exercise increased:

The AI approach can be used for the development and enhancement of the potential of both individuals and organizations. An essential aspect of the AI approach is the generative process, in which a new situation is envisioned and both individual and collective strengths are mobilized to make changes to achieve the hoped for future outcome. The AI approach has been widely used in the world of business and general education, but has an exciting potential for medical education, including curriculum development, faculty development, supporting learners through academic advising and mentoring, and for enhancing the teaching and learning of both individuals and groups.

Talking Science and Education: Diabetes Dialogues

Interventions Needed to Improve Quality of Life for Underserved African American Adults with Diabetes

Patient-centered interventions may help African American adults with type 2 diabetes living in inner cities overcome various cultural and environmental barriers to care.
African American patients with type 2 diabetes living within distressed inner cities experience multidimensional adversity across levels of influence that have significant impact on quality of life and clinical outcomes. A major clinical implication of these findings is the importance of patient-centered care and communication on quality of life and finding ways of enhancing them during patient conversations.

Leonard Egede, MD and colleagues at the University of Wisconsin conducted a cross-sectional study examining the association of individual, community, and health system factors with physical and mental quality of life for African American adults with type 2 diabetes who lived in inner cities. Researchers recruited 241 African American adults aged 21 years and older living in Milwaukee in 2017 and 2018 (62% women; mean age, 57 years). All participants had a clinical diabetes diagnosis or an HbA1c of 6.5% or higher and completed a paper-based SF-12 survey with physical and mental components to measure quality of life. The study cohort answered questions about sociodemographics, physical and psychosocial behavior, and barriers to health service and in the community. Due to the large number of covariates, researchers used four modeling strategies to identify significant factors: a sequential regression model with variables entered in blocks, a stepwise regression model with backward selection, stepwise regression with forward selection, and all possible subsets regression.

Of the study population, 82% said they were unemployed and about two-thirds reported having between four and nine comorbidities.

In analysis of mental quality of life, having an education level of less than a high school graduate and having major depression were associated with a worse mental quality of life in all four modeling approaches. For physical quality of life, results were similar in all four models. Being employed and reporting trauma were associated with a better physical quality of life.

Existing evidence shows that in national studies among the general population, experiencing trauma has a dose-response relationship with physical functioning, but this has not really been studied in diabetes populations and even less has been studied among inner-city African Americans with diabetes. The investigators believe that resilience, seen in this study as well as others in individuals with diabetes, may play a role. Therefore, the observed relationship between trauma and the physical component of quality of life may be occurring indirectly through factors such as resilience, but this relationship needs to be examined specifically.

The researchers wrote that providers need to focus more on patient-centered care and create programs to allow inner-city populations to overcome the cultural and environmental barriers they face.

Much work has been done to identify barriers across levels of influence, and the medical community is at a place where they need interventions, and there needs to be a focus on implementation of evidence-based practices that accounts for the barriers identified across the evidence base.


Yet another month has presented itself upon us in this quickly moving year of 2021. I am sure that we are all busy personally and professionally as the “passing” of COVID unfolds. We are now given new freedoms, new views, new insights, and new abilities. We have learned things and lost things in the process. Along with this, we all hope and endeavor to bring new strengths forward with us whether they land in the personal or professional part of our lives.

This week I met a very bright, young, positive, calm, and determined individual whose bone marrow transplant for his B-cell ALL has caused possibly more harm than good in an overall sense. I will not know the final outcome as he has been transferred to the tertiary center where his transplant occurred in order for him to have all the resources he will need as he goes through the exploration, diagnosis, and hopefully treatment process.

On his own he brought up that if he got “bad news” about his current condition, he was already focusing on finding the solution. I hope we are all there too.

Laying hands on him to assess his overall cranial rhythm, his restrictions, his fluid movement and teasing out his vitality while helping my fellow to explore new possibilities on how to think and treat patients gave me insight to the severity of his condition with the chest tube in his right upper chest wall connected to suction to reinflate his right apical lung, which was not cooperating with our suggestion to reinflate.

Visceral manipulation, BLT, and cranial were very helpful techniques for this patient. His organs were fibrosing and increasing fluid movement along with creating ease in his system was beneficial for him. His constipation began to ease and his appetite increased as the GI tract motility increased with suggesting to his celiac, superior, and inferior mesenteric nodes to move in a clock wise direction. His thorax was extremely restricted with interstitial lung disease and fibrosing tissue, a pneumothorax on either side, a chest tube in place on the right, and a tight sided mediastinal shift.

Releasing some of the tension and torsion from the thorax allowed for improved inspiratory and expiratory movement with end resultant ability to remain on room air and intermittent supplemental oxygen via NC. Applying cranial in the cranial and sacral regions decreased the overall tissue tension running through the center of his body attaching to his SBS to assist in decreasing his migraines and allowing for improved sleep.

Treating the whole patient is always my primary goal, in whatever form they need at the moment in front of us. I hope that he continues to do well and improve, as his spirit has chosen to show me that it is always much more than the physical that takes us through our journey. I hope that you are all with me in wishing him optimal health. I always appreciate your support. As the year continues to unfold, remember to take the positives and the strengths with you in order to create more depth and breadth in self which will complement and assist others as we are osteopathic physicians at heart.
2021 Certifying Examination

Dates & Deadlines

AOBIM Initial Certification Exam
Remote Online Proctoring
September 20-24, 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
First Application Deadline: July 5, 2021
Final Application Deadline: Aug. 3, 2021

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

Advanced Heart Failure & Transplant Cardiology Initial and OCC Exams
Remote Online Proctoring
August 2-6, 2021
First Application Deadline: June 18, 2021
Final Application Deadline: July 18, 2021

Application materials are available on the AOBIM’s website. Contact the AOBIM at admin@aobim.org for additional information.
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