Women's History Month

A Time to Celebrate, Appreciate, and Elevate

Special Features:

#DOsDoingGood: Joanne Kaiser-Smith, DO, FACOI

Committee on Health Equity and Inclusion on Medicine: Members Nicola McLean, DO, FACOI, and Timothy J. Barreiro, DO, MPH, FACOI, FCCP, FACP

ACOInfo
American College of Osteopathic Internists

March
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2022-2023

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A Letter From Our President

What is March known for?

- National Women's History Month
- Yellowstone becoming the first US National Park in 1872
- The invention of silly putty in 1943
- The least productive month of the year due to betting pools for March Madness! Think St. Peter's University last year and Fairleigh Dickinson University this year—Go New Jersey!

Perhaps the most important to many who are reading this letter is March 30—Doctor's Day.

Doctor's Day is celebrated every year during National Physicians Week, which is March 25-31 this year. It was established to recognize the work of physicians providing patient care and their contributions to the communities they live or work in.

The holiday was first started in Winder, Georgia in 1933 by the Barrow County Alliance. Initial celebrations involved mailing greeting cards to physicians and placing flowers on deceased doctors' graves. In 1990, the US Senate and the House of Representatives passed SJ 366 which President Bush signed into law, making it a national holiday.

Doctors deal with years of school, grueling residency training, and often making life changing and emotionally difficult decisions and conversations, yet we manage to do so with kindness and empathy. We do our best to use cutting edge science to care for others.

Let us all take a moment to celebrate *us*—highly qualified and compassionate physicians who may be your family members, friends, and colleagues.

Even the smallest sign of gratitude can be extremely rewarding. You are acknowledging the time and energy spent mastering and maintaining their field of expertise. Use #NationalDoctorsDay to post on social media.

I want to take this opportunity along with the ACOI Board of Directors to thank you all for your commitment, sacrifice, and hard work. Thank you for putting your talents forward to reassure patients, save lives, and expand your services beyond patient care to your community and professional organizations.

To help you keep current in your field of expertise and participate in your medical community, the ACOI offers education, mentorship, and fellowship. This year our Spring Meetings are virtual and will be held in May.

They include:

- ACOI Internal Medicine Board Review Course
  May 9-13
- ACOI Clinical Challenges in Hospital Medicine
  May 10-13
- ACOI Subspeciality Focused Meeting
  May 11-13

Since they are all virtual and will be available on-demand through August 15, consider registering for more than one meeting. **You can register for one meeting at the original price and get the second meeting 50% off.** Email claudette@acoi.org for assistance. For more information, visit our website here.

Eligibility for the degree of Fellow is now available to qualified members. Fellowship qualifications include active membership for at least two years (dues paid and in good standing for two years) and board certification in internal medicine or subspeciality by the AOBIM or ABIM is required.

In order to become a fellow your primary sponsor needs to be an ACOI Fellow and member of the organization. Your secondary sponsor does not need to be an ACOI member or Fellow. For our members who may not have appropriate sponsors in their area, the ACOI Board of Directors will help you find someone.

Once your application is completed, it will be reviewed by the Honors and Awards Committee. Successful candidates will take part in the Convocation of Fellows which is held as part of the 2023 Annual Convention in October in Tampa, Florida, and will receive the honorary degree of Fellow of the American College of Osteopathic Internists (FACOI).

Joanne Kaiser-Smith, DO, FACOI
president@acoi.org

Women's History Month: A Time to Celebrate, Appreciate, and Elevate

by Nicola McLean, DO, FACOI
Member of the Committee on Health Equity and Inclusion in Medicine

While I was deep in my thoughts typing a note about a complicated patient, a nurse walked up with a beaming smile on her face wishing me "Happy Women Physicians Day." I couldn't help but smile back touched by her enthusiasm and energized by her excitement. The interaction made me wonder. How did National Women Physician Day come about? Little did I know, the very same group whose notifications I read with curiosity and intrigue while I scroll Facebook (more frequently than I'd like to admit), are responsible for this day. Physician Moms Group led by Hala Sabry, DO. Feb 3 was declared National Women Physician Day in 2016. This was the birthday of the first woman who received a medical degree in the US in 1849, Dr. Elizabeth Blackwell. But before there was a NWPD, there was a National Women's History Week. In February 1980, President Carter declared the week of March 8, as National Women's History Week. In 1987, Congress declared March as Women's History Month in perpetuity. As a result women like Dr Blackwell, Amelia Earhart, Rosa Parks, and so many more have garnered awareness and recognition for their accomplishments and helped pave the road.

As a female physician I understand the struggles and sacrifices that were made so that I could be here today and be able to fulfill my purpose in my career. Yet, there still remain barriers that prevent women from achieving their full potential and from being fully recognized for their contributions.

According to one study, for over 25 years, women have made up at least 40% of U.S. medical students. Yet overall women make up only 34% of physicians in the U.S., and account for only 18% of hospital CEOs and 16% of all deans and department chairs in the U.S. Why this discrepancy? Lack of mentorship, diversity, work life balance, and the presence of inherent biases are a few factors.

Then there is the issue of wage gap. In a report from the AAMC, women were paid between $0.72 and $0.96 per $1 paid to men across different departments and specialties. Additionally, one Harvard article noted that research on competitive business negotiation has found that women are generally less assertive and less successful than men. These findings were especially true in salary negotiations, where women agreed to lower outcomes, widening the gender wage gap.

And like in many facets of our lives, implicit bias finds a way of making itself known. Almost every female physician can relate to being mistaken for a nurse or tech at some point in their career. This is despite wearing the very same white coat our male counterparts wear.

Even though expectations have shifted, women are still seen as the primary parent to manage household duties, child and elder care.

JAMA Internal Medicine published a study that looked at dual-physician couples without children and found that men worked 57 hours while women worked 52.4 hours. However, the disparities in hours worked grew when children entered the picture with female physicians working 10.9 hours less (41.5 hours) than women without children. Men with children worked 55.3 hours, which was 1.7 hours less than men without children. Work life integration tends to be worse compared to that of our male physicians as a result. In the aftermath of COVID, these pressures have been magnified. Female physician burnout has also increased in greater proportions compared to male physicians.

In order to make change and one day level the playing field, we must educate our colleagues and patients about implicit bias. This can be accomplished by firstly acknowledging the presence of biases and then try to consciously use existing information to make decisions. We should strive for equity in leadership positions. We can achieve this by being more assertive and making our goals known when opportunities arise. If we are already in leadership positions, mentorship and sponsorship is a great way to implement change. As a mentor, one can offer advice, support, and insight for career advancement. As a sponsor, one can use their own connections and influence to facilitate promotions and increase visibility at a higher level.

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Women's History Month
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We should seek to equalize compensation packages. Start by knowing our value. Research average salaries for similar positions of interest. Learn the art of negotiation. There are workshops and summits geared towards women and negotiation. In order to encourage work life balance, perhaps employers can provide on-site day care for children or flexibility with schedules or allotted time for parental leave. We already see flexibility in some practices via the ability to chart at home, telemedicine, onsite child care.

The good news is there is room for growth and positive change. Even better news is that both female and male physicians can be a part of it. Women's History Month is just a gentle reminder to be thankful and hopeful all at once.

References:

New report finds wide pay disparities for physicians by gender, race, and ethnicity | AAMC

https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2649262

What's Holding Women in Medicine Back from Leadership by Christina Mangurian, Eleni Linos, Urmimala Sarkar, Carolyn Rodriguez, and Reshma Jagsi. June 19, 2018, Updated November 07, 2018

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Women in Medicine: A Prescription

by Timothy J. Barreiro, DO, MPH, FACOI, FCCP, FACP
Member of the Committee on Health Equity and Inclusion in Medicine

As of 2015, more than one third of the active physician workforce in the United States is female. For over 25 years, women have comprised at least 40% of US medical students. Although women have made progress and substantial contributions in the advancement of science and promotion of health, much remains to be done to improve equity and parity. Additionally, improved opportunities for promotion and leadership roles in health care are needed.

Women account for only 1% of hospital CEOs and 16% of all deans and department chairs in the US, positions that typically direct the strategy, mission, and control of resources at most medical centers. Women are in the minority in authorship. Female editors-in-chief at prestigious medical journals are under-represented. The female physician workforce differs widely by discipline.

Why the gender disparities? Women do not achieve promotion to leadership positions at the same rate as men. Highly qualified women do not attain independent grants, publications, and leadership positions. Evidence shows that in academics, women experience greater challenges finding mentor and sponsors. Women in all positions get paid less than men with the same position, even if women exhibit similar productivity. In recent data from a 2017 survey, the gender gap in compensation was 16%.

Even educational bias during instruction—calling on male students for math and sciences questions and calling on female students for language and English questions—can impact educational advancement and attainment from an early age, creating gender-specific assumptions around educational success and achievement. Unfortunately, gender assumptions about occupational roles and attainment can be internalized.

What is holding women back? Certainly, implicit and explicit gender and maternal bias, such as the unconscious bias that women in medicine are inferior leaders, that women are disrespected by peers, and that in some cases, women are treated less formally than men, contributes to disparity. This phenomenon remains as prominent today as it was when *Walking Out on the Boys* was published in the 1970s, a stirring account of a Stanford neurosurgeon subjected to macho medicine. Adding to gender disparities is the double jeopardy hypothesis that woman of color and lower social class, in addition to being female, may compound and exponentiate bias, gaps, and frustrations.

The medical system is not conducive to women. System wide barriers contribute to women leaving medicine and therefore, not achieving higher goals. Multiple issues compound burnout, retention, and productivity.

In fields of science, engineering, and medicine, historically male dominated hierarchical domains, gender has had a structural effect, leading to workplace harassment for women. Women face sexual harassment from colleagues. Women physicians are also more likely to experience harassment from patients. In addition, due to fear of retaliation or stigmatization, underreporting is common. Inadequate primary care reimbursement and a greater proportion of women in primary care also create structural economic disparity. Even the physical workplace environment contributes to structural gender inequality. It was not until the mid-1980s at a local state university that female bathroom facilities were added to the engineering building and male bathroom facilities were added to the nursing department.

Although progress has been made toward gender diversity in the workforce, disparities in compensation, rank, and leadership positions remain, creating inequality and disparities in medicine. The medical profession, and healthcare in general, benefit greatly from a diverse workforce. A concerted effort must be made to eliminate imbalance in compensation and career advancement. Opportunities and a more inclusive environment remain an elusive goal.

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Women in Medicine: A Prescription
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Certainly, to address gender disparities in medicine, multiple approaches need to be employed. The first physician to receive a medical degree in the US in 1849, Elizabeth Blackwell, said: "A blank wall of social and professional antagonism faces the woman physician that forms a situation of singular and painful loneliness, leaving her without support, respect, or professional counsel." There is a need for female physician mentors in underrepresented medical specialties for medical students. Additionally, there is a need for female scientists and physicians as role models at the undergraduate level. Each of us needs to express a willingness or pledge that all forms of sexual harassment will be reported and investigated. Finally, extramural support for the women's health research agenda, led by female physician-scientists, is worthy of consideration. As a profession, we can tear down Blackwell's wall, and remove any remaining impediments.

Wellness Corner

ACOI members identify dealing with stressors as the most critical issue facing them today. Each month we'll share an idea a member shared with us on how they work to promote their own wellness.

"As a Hospitalist, my hours are long (12 hour shifts per day for 2 weeks a month.) On the days I am off to decompress, I spend time with my family, exercise more, (since I can't do so when I am working), play music, and read pleasant books. "

"Believe it or not, having the ability to attend a Virtual CME meeting— [it] helps with reducing stress"

Have a suggestion of your own? Email us at katie@acoi.org.

#DOsDoingGood: Featuring ACOI President, Dr. Kaiser-Smith for National Women's History Month

by Gina Kilker

In October 2021, when ACOI President, Joanne Kaiser-Smith, DO, FACOI, FACP, was named Mentor of the Year by the American Osteopathic Association, she found her thoughts drifting to those men and women who mentored her as she was rising in her career. In the ACOI history book, *A History of Osteopathic Internal Medicine: Celebrating the ACOI's First 75 Years*, Dr. Kaiser-Smith is featured in a section, "The Rise of Women in Osteopathic Internal Medicine." Within the chapter about her journey, the intro page does not feature her solo portrait like the intro pages of the other members featured in the book. Instead, her chapter begins with a photograph of Dr. Kaiser-Smith standing alongside someone she considers as one of her most treasured mentors, James C. Giudice, DO, MACOI (shown above).

Outside of her being awarded as the AOA Mentor of the Year, the photo's prominence in her chapter may be the most obvious sign that she perceives mentorship as vitally important to where she is today. "I could not do what I do, I could not be who I am without all those people who touched me along the way and who were there to hold me up, kept me going, and supported me," she says.

Today as the Associate Dean for Graduate Medical Education at the Rowan-Virtua School of Osteopathic Medicine, Dr. Kaiser-Smith is unlike a lot of women in medicine. For one, female physicians are less likely to have mentors[1], and secondly, she is in the minority as a woman in academia who has reached leadership ranks. Research has found that while women have accounted for over 50% of those who matriculate to medical school, they are underrepresented in academic medicine with only 39% of them representing full-time faculty and 22% as full professors. Also, even fewer women find themselves in leadership roles within their institution with 16% being department chairs and only 17% are medical school deans.[2] Even more reason female physicians in academia need to be recognized and celebrated, especially during Women's History Month.

However, breaking the mold is something Dr. Kaiser-Smith is accustomed to doing. Looking back on her glass-ceiling-shattering career, the number six has come to represent her career ascension. Consider she was just the sixth woman in her residency class, and this past fall, she took over the reins as only the sixth woman to become the President of the ACOI.

She is quick to point out that her career trajectory was guided along by her mentor, Dr. Giudice, whom she affectionately refers to as "The Chief." As the first female Chief Resident in the residency program at the Kennedy Hospital System in Stratford, New Jersey, Dr. Kaiser-Smith eventually rose to serve as the Associate Program Director of the internal medicine residency program. Dr. Giudice, then the Program Director, recognized her leadership potential and asked her to fill the position, while encouraging her along the way to grow and to become his successor someday. Naturally, when he stepped down to pursue other interests, Dr. Kaiser-Smith was well prepared for her promotion to Program Director. She went from being one of the first female faculty members at the former UMDNJ-SOM, which is now known as the Rowan-Virtua School of Osteopathic Medicine, to becoming the first woman Program Director in the residency program. Today she looks back and is proud to announce that she has mentored nearly 500 residents (and counting).

Dr. Kaiser-Smith's History of ACOI Involvement

Dr. Kaiser-Smith's tenure with the ACOI was encouraged early on while she was still a resident. At that time, Dr. Giudice sent her to ACOI's Annual Congress on Medical Education.

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#DOsDoingGood: Dr. Kaiser-Smith

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It was a pivotal moment for her to attend representing her residents, and one she took seriously. "I loved the idea of creating education for residents and bridging the gap between what the organization was doing and what I was bringing back to the residents. I came back so enthusiastic about the meeting that Dr. Giudice started letting me attend in place of him on occasion." After staying involved and getting to know the ACOI staff and leaders, she admits that she was "hooked."

"I liked the idea of creating the future for our residents with our involvement in GME at the time, so after a couple of meetings I was asked to join the ACOI's Council on Graduate Medical Education, a committee of nine physicians and some of the ACOI staff who created policy and oversight for every internal medicine residency and fellowship in the country in the osteopathic profession."

Soon she was attending every ACOI Annual Convention and delighting in the "instant friendships" that she made. "It became the family that I don't have any blood relatives with." Yet ACOI Annual Conventions were something that Dr. Kaiser-Smith also attended with her own "blood family," including her husband and son, who recently graduated from the same internal medicine residency program as she did.

At #ACOI2022 she was surrounded by all her families: her ACOI family and friends, her colleagues, her relatives, and even some of those she has mentored as her rise to the office of President for the ACOI was celebrated.

While she acknowledges that her career has helped her create a legacy built on mentorship, she acknowledges each of the five previous female office holders who came before her as pivotal to her own leadership path.

The Ultimate Balancing Act: Family, Career, and Mentorship

Perhaps one of Dr. Kaiser-Smith's most admirable accomplishments has been her ability to build her career and still be a mentor for residents without sacrificing family time. For her, balancing the demands that many professional women struggle with – being an involved mother and a connected professional —meant creating clear boundaries. She carefully managed participating in activities outside her career as her son was growing up. When he was young, attending his games was a family affair that she did not intend to miss, especially since she volunteered to be the team physician for his baseball team while her husband coached.

When the ACOI history book was published in 2016, she discussed her views of balancing a life as a physician and a mother. "You have to figure out how to balance being successful in medicine and being successful in your role as mother and wife…I think one of the things that is different now from when I graduated was that there was an expectation then that you had to work full-time if you were to be perceived as dedicated to medicine. There was less flexibility. Times have changed however."

They have indeed since Dr. Kaiser-Smith was one of just six women in her class of 36. Her message and her example are resonating to more women who are increasingly choosing to become DOs. AACOM published a report recently that in the 2021-2022 academic year, 54% of first-year osteopathic students were female.[3] According to the admissions page on the Rowan-Virtua website[4], women are no longer in the minority. Today the ratio of male to female to non-binary physicians is 46:53:1.

Her passion for being a woman leader in a field primarily dominated by men is something she recognizes as her way to create a path for other women. Beyond the professional mentorship inside the hospital, years ago she even created the Women in Medicine Club that quickly became a personal endeavor for her. As the faculty representative, she organized and hosted meetings, sometimes at her home, for the residents as a way for female residents to support one another and to help foster professional friendships and bonds that last a lifetime. "We had very few women role models, so I took it upon myself to help women rise with me."

1. Why Mentorship Opportunities For Women In Healthcare Matters (forbes.com)

2. Mentorship of Women in Academic Medicine: a Systematic Review - PMC (nih.gov)

3. The DO: AT Still's First Osteopathic Medical School Class Included 6 Women

4. Rowan-Virtua SOM | School of Medicine | Rowan University

Government RELATIONS

Timothy W. McNichol, JD, and Camille Bonta

President Sends Budget to Congress

On March 9, the Biden-Harris Administration released the President's Budget for Fiscal Year 2024. The budget is a blueprint that reflects the Administration's priorities with most of it dead on arrival in a divided Congress. The release of the budget officially kicks off the appropriations process on Capitol Hill and starts consideration of the 12 spending bills that fund the federal government.

The proposed budget for the Department of Health and Human Services (HHS) includes $144.3 billion in discretionary funding and $1.7 trillion in mandatory funding.

Building off the Inflation Reduction Act passed in 2022, the budget allows Medicare to negotiate prices for more drugs and bring drugs into negotiation sooner after they launch. It also strengthens the requirement that drug companies pay rebates to Medicare when they increase prices faster than inflation by extending this rule to commercial health insurance. Neither proposal is likely to gain much traction in the Republican-controlled House.

The budget proposal renews the expired funding appropriation to generate new measures for use in the transition to the Medicare Merit-based Incentive Payment System (MIPS) Value Pathways and to expand the types of measures that may be developed to include cost performance measures. The budget proposal also seeks to fulfill several aims of the White House National Strategy on Hunger, Nutrition and Health by expanding and enhancing Medicare coverage of nutrition and obesity counseling through a demonstration project that would cover medically-tailored meals for beneficiaries with diet-impacted diseases such as diabetes.

To address health care workforce shortages, the FY 2024 budget invests $28 million for a new program to stimulate and develop innovative approaches to recruiting, supporting, and training new providers, with an emphasis on meeting the needs of underserved communities.

To learn more about what is included in the HHS budget, including funding for medical research, maternal and behavioral health, public health preparedness, and much more, visit the HHS website.

Medical Societies Ask Congress for Inflation-Based Payment Update

For the first time, the Medicare Payment Advisory Commission (MedPAC) has called for a physician payment update tied to the Medicare Economic Index (MEI).

Clinicians' input costs—as measured by the MEI— grew by 2.6 percent in 2021 and are estimated to have grown 4.7 percent in 2022, substantially higher than the recent historical norm of 1 to 2 percent per year. Growth in clinicians' input costs is projected to remain high in 2023 (3.9 percent) and 2024 (2.9 percent).

Despite the significant growth of clinicians' input costs, MedPAC is recommending that Congress update physician payments next year at half of MEI, which would be 1.45 percent based on current projections. MedPAC justifies its recommendation because clinicians' practice expenses account for about half of the MEI. MedPAC is recommending the update be permanent and built into subsequent years' payment rates, which contrasts with temporary updates provided by Congress in recent years.

While ACOI appreciates MedPAC's acknowledgement that clinicians may be unable to absorb cost increases at current payment levels, its recommendation falls short. According to MedPAC, between 2010 and 2022, the MEI increased cumulatively by 23 percent, exceeding the 6 percent cumulative increase in annual physician payment updates. ACOI has joined more than 130 other health care organizations in a letter asking Congress to adopt a 2024 Medicare payment update that recognizes the full inflationary growth in health care costs.

As a result of congressional intervention last year, physician payment rates will increase 1.24 percent next year — less than what will likely be needed to offset anticipated cuts due to budget neutrality requirements.

Continued

Government RELATIONS *(Continued)*

Needed MVP Improvements Outlined in Letter to CMS

Some specialties have a new voluntary way to meet Merit-based Incentive Payment System (MIPS) reporting requirements—MIPS Value Pathways (MVPs). Each MVP includes a subset of measures and activities that are related to a specialty or medical condition and is intended to offer more meaningful and less burdensome participation in MIPS. For 2023, there are 12 MVPs. The physician community is concerned MVPs are repeating many of the problems with traditional MIPS—notably a lack of clinical relevance to physicians and administrative burden. In a letter to CMS, ACOI and other societies have made recommendations on the transition to MVPs and are encouraging they remain a voluntary reporting option.

ACOI Endorses Step Therapy Legislation

ACOI has endorsed legislation that would require group health plans governed by ERISA to provide an exception process for any medication step therapy protocol, including when a patient is stable on his/her current medication. The *Safe Step Act* (S. 652) has been reintroduced in the Senate by a bipartisan group of lawmakers led by Sens. Lisa Murkowski (R-AK) and Margaret Hassan (D-NH). Introduction of companion legislation in the House is expected.

In a press release issued by Sen. Murkowski, ACOI President Dr. Joanne Kaiser-Smith was quoted as saying, "Patients are caught between the high cost of prescription drugs and the use of step therapy protocols by insurance companies. The Safe Step Act creates clear exceptions to step therapy protocols to ensure that medical decisions made by physicians in consultation with their patients are respected, and the health and safety of patients are a priority. ACOI is pleased to offer its strong endorsement of the legislation and calls for its passage by Congress."

In the previous Congress, the legislation had the cosponsorship support of 197 House members and 36 senators but failed to receive formal consideration.

In related news, in February ACOI joined a letter led by the American Academy of Ophthalmology that asked CMS to reinstate the step therapy prohibition in Medicare Advantage plans for Part B drugs.

Osteopathic Community Supports Proposed Electronic Prior Auth Requirements

ACOI recently joined the osteopathic community in a letter to the Centers for Medicare and Medicaid Services (CMS) in support of proposed policy changes that would streamline and improve transparency of prior authorization (PA) processes across health plans, including Medicare Advantage, Medicaid, CHIP and Qualified Health Plans on the Federally-Facilitated Exchanges. The groups expressed support for CMS' proposal to require plans to support electronic PA via a standards-based application programming interface (API), although the requirement would exclude drugs from the electronic PA requirements.

The groups supported CMS' proposal to shorten the timeline for PA decisions, although requested that CMS finalize a timeline of 72 hours for standard requests and 24 hours for urgent requests, rather than one week for standard requests and 72 hours for urgent requests as proposed.

The groups also asked CMS to finalize rules for transparency that would require the reporting of more granular information about plan approvals and denials based on specialty or service rather than just in aggregate and gave support to a proposed requirement for health plans to provide a specific reason for a PA denial.

Washington Tidbit

President John Adams signed legislation moving the federal government from Philadelphia, PA, to Washington, DC, and appropriated $5,000 to establish the Library of Congress on April 24, 1800. The library was to serve as a reference library for the legislative body and was housed within the Capitol. British troops torched the Capitol and destroyed the contents of the library in 1814. Within one month retired President Thomas Jefferson offered his private collection of 6,487 books to replace the library. Congress purchased his collection for $23,950. Today, the Library of Congress is the largest library in the world with more than 173 million items in its collections. The library receives more than 15,000 items and adds more than 10,000 items each day!

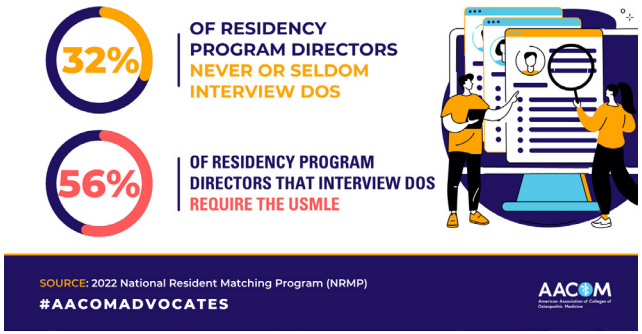
Government RELATIONS *(Continued)*

Guest Column

Fairness in Residency Starts with the FAIR Act

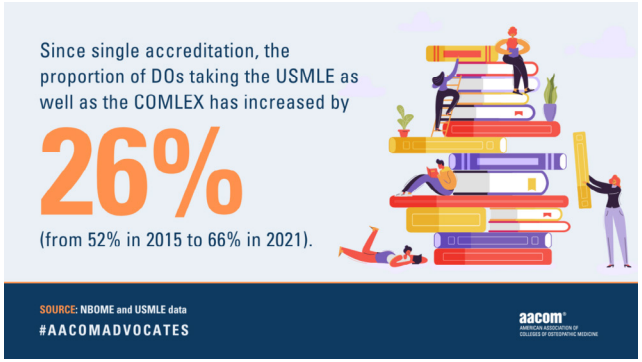
Robert A. Cain, DO, FACOI, AACOM President and CEO

It's no secret to the osteopathic community that our students face unfair barriers to residency compared with their MD counterparts. According to National Resident Matching Program data, **32 percent** of residency program directors never or seldom interview DO candidates. Of those who do, at least **56 percent** require the MD licensing exam. It costs DO students more than **$6 million** a year to take the MD exam, which is an additional **$2,235** and **33 hours** of exam time per student.



Since single accreditation, which was designed to increase access to residency programs for both DOs and MDs, the proportion of DOs taking both licensing exams has increased by **26 percent—totaling 66 percent of all DO students.**

Further, the percent of DOs matching to their preferred surgical specialties has declined, and in other specialties, DOs are substantially underrepresented.



As osteopathic medical educators and internists, we must take steps to advance fairness in residency access for our future osteopathic physicians. That's why the American Association of Colleges of Osteopathic Medicine (AACOM) worked with Congress to craft the *Fair Access In Residency (FAIR) Act*, H.R. 751. This bipartisan legislation, reintroduced by U.S. Representatives Diana Harshbarger (R-TN), Chellie Pingree (D-ME), Sam Graves (R-MO) and Jared Golden (D-ME), requires Medicare-funded graduate medical education (GME) programs, as a condition of participation, to report annually on the number of DO and MD applicants and accepted residents and affirm that the DO and MD licensing exams will be equally accepted if an exam score is required.

Medicare accounts for **71 percent** of all GME funding. If passed, the *FAIR Act* stands to benefit not only DO students, who currently represent **25 percent** of our country's future physicians, but patients everywhere, especially those in rural and medically underserved communities where many DO students go to practice.

ACOI has been one of our strongest supporters of the *FAIR Act*. Now, we're calling on all its members to join us in taking action. You can do this by sending a message to your Members of Congress in support of the legislation, or using our toolkit to share your message on social media. For more information about the *FAIR Act* and its more than 60 organizational supporters, please view our coalition letter and one pager, and learn from our advocates about how the *FAIR Act* helps osteopathic medical students continue to Choose DO into residency and makes for a fairer Match process.

Take action today and help create a fairer tomorrow.

CODING CORNER

Prolonged Care Codes – When Does the Clock Start?

Jill M. Young, CPC, CEDC, CIMC

Last month, I wrote about critical care coding and the discrepancies that exist between Current Procedural Terminology (CPT) and the Center for Medicare and Medicaid Services' (CMS) determination of when an additional time starts. In the example of critical care, it is a question of when the clock starts for the additional 30 minutes add-on reflected in code 99292. For prolonged care codes, the answer to when the clock starts depends on whether you use CPT or CMS guidelines.

In 2021, the codes for Office and Other Outpatient Services underwent multiple changes. One of those changes was the time periods identified in the assignment of codes 99202-99205 and 99212-99215. These codes and all remaining Evaluation & Management (E&M) service codes in 2023 have seen an increase in minutes assigned with the newly defined duties allowed when assigning a level of service based on time. Be sure any tools you use in selecting an E&M code based on time have current time periods. Prolonged care codes can only be added to the highest-level code in the set (i.e., for OOOS services 99205 or 99215). The following is a chart of the time allowances when looking to possibly assign a prolonged care code to the OOOS code set.

CPT CODE	2023 Time in Minutes	Threshold Minutes to Bill 99417	Threshold Minutes to Bill G2212
99205	60-74	75	89
99215	40-54	55	69

CMS's position is that the prolonged care clock does not start ticking until the 75th minute for code 99205. If you are required to provide the full 15 minutes of service to satisfy the G2212 modifier, then you must provide care for 89 minutes to bill for prolonged care in this example. CPT's position is that that clock starts at the 60-minute threshold for the code. The effect of this policy difference is in this case 15 minutes. As a result, billing for an 80-minute office visit where documentation supports medical necessity for the visit would be billed as follows:

- Insurer that follows CPT rules: Codes 99205 and 99417
- Insurer that follows Medicare rules: Only code 99205

The differences in these two policies may result in inability to bill for a 15-minute increment. The value of this time increment from Medicare's perspective is approximately $32.

If you have not already done so, changes need to be made in your code assignment process when working with prolonged care codes. I recommend your staff select codes for these services. You can look at last month's Coding Corner on critical care codes for my recommendations on how to make these needed changes. As I noted, critical care code selection was based on when to bill the additional code. When using prolonged care codes, it is about when to bill the additional code AND which code to use on the claim form.

If you use the wrong code combination, you will not likely be paid for the extra time spent with the patient.

The same problem exists when looking at prolonged care codes for the remaining E&M service codes that changed in 2023. CPT uses code 99418, while Medicare rules indicate use of codes G0316, G0317 and G0318. Following is a list the prolonged care codes and how they match up:

Office and other outpatient service

– CPT code 99417

- HCPCS/Medicare code G2212

Inpatient or observation visits

- CPT code 99418
- HCPCS/Medicare code G0316

Continued

CODING CORNER

Prolonged Care Codes – When Does the Clock Start?

Jill M. Young, CPC, CEDC, CIMC

(Continued)

Nursing facility

- CPT 99418
- HCPCS/Medicare G3017

Patient's home or residence (assisted living)

- No CPT specific code
- HCPCS/Medicare G3018

You need to check with the insurances you accept to see which rules they follow. Do your Medicare Advantage insurers follow Medicare rules, or do they follow CPT guidelines? In addition, some states Medicaid plans follow Medicare rules. It is important to know which rules your state follows.

Whenever you use time as the basis for selecting a code, the documentation should include the time spent by the physician or other qualified health care provider to provide the elements defined in the service code. It is not sufficient for the provider to log information in to the patient's chart or their computer. Time should be documented in the note, along with proof of medical necessity to show the time requirements were met as defined by the applicable code. There is no clear guidance on how to document time, but it is recommended that one simply documents the minutes spent.

While preparing this column, I found at least one Medicare regional contractor (Novitas), that has direction on its website. It states that start and stop times need to be in the provider's documentation when using time as the determining factor for the level of service for an E&M service that is also using prolonged care codes. I have not yet found this information on the main CMS.gov website.

Climate Change and Health

by Mary Schaefer Badger, DO, FACOI, FAWM
Chair of the Committee on Climate and Health

Earth Day 2023 will be celebrated on Saturday, April 22. It presents an opportunity to explore and consider the impact of our ailing planet on the health of our patients. The *2022 Intergovernmental Panel on Climate Change Impacts Report* stated that climate and health care are inseparable. 78 percent of known diseases can by adversely affected by climactic changes. *(Mora, et al. Nat. Clim. Chang. 2022).* Climate change is putting increased pressure on vulnerable systems, populations, and regions, compounding already existing medical conditions and health disparities. *(Source).*

Principle-Centered Medicine is aligned with patient-centered, high-value care, and the needs of our nation's healthcare system. It is a logical outgrowth of the osteopathic tenets. The recent pandemic upended many of our assumptions about how to practice these principles in an ever-changing world. It has made the need to find an approach to the existing climate crisis even more urgent.

What can we do as individual physicians?

1. **Educate Ourselves:** 60 percent of physicians cite lack of knowledge about climate change as the reason they do not address climate related health concerns with patients. To address this knowledge gap, you may want to check out the following:

- My free lecture, Climate Change and Health: An Introduction and Physician Call to Action, available on the ACOI's Online Learning Center
- Dr. MarkAlain Déry's blog post, Climate Change as a Public Health Crisis
- The presentation from Samuel Snyder, DO, FACOI, that explores Climate Change and Kidney Disease
- Free webinars from The Medical Consortium on Climate and Health
- The Department of Health and Human Services' (HHS) Office of Climate Change and Health Equity (OCCHE)
- *Global Climate Change and Human Health-from Science to Practice* by Jay Lemery, MD, et al.

2. **Educate our Trainees:** Many medical schools have begun to implement either required or voluntary lectures on climate and health. Residency programs are also planning for ways to add patient-specific climate discussions during rotations. These are important steps in recognizing climate impact on patients' health.

3. **Educate our Patients:** 40 percent of physicians report lack of time as another reason they do not discuss the environment and health. Annals of Global Health reports patients trust their physicians more than anyone else when it comes to discussions on climate change. You can briefly review a patient's individual risks as part of disease prevention strategies. To save time, you can give them printed information. These include brochures from My Green Doctor. These materials can be set up with your practice information and emailed or printed for patients in English or Spanish.

There are also posters from the Public Health Institute that you can put up in your office to help your patients, their families, and your communities understand the health impacts of climate change and what can be done to protect oneself and the planet. You can also give patients additional information on emergency preparedness and air quality.

4. **Serve as an Example:** Use the "7th generation" principle taught by Native Americans which says that in every decision, be it personal, governmental, or corporate, we must consider how it will affect our descendants seven generations into the future.

Addressing Climate Change will help our patient's and our own health and the health of our planet. We must all do our part. Please start now!

ACOI Member News

Dr. Bee Accepts New Positions

Earlier this month Lee Peter Bee, DO, DC, MS, FACOI, began new positions as Advisor/Ambassador at Medmo and Associate Medical Director with the Home and Community Division of Optum Health. Congratulations, Dr. Bee!

Dr. Keith Named Chief Resident

Dr. Brysen Keith, DO, MS, has been offered the position of Chief Medical Resident at Jackson Memorial Health System in Florida. Congratulations, Dr. Keith! Check out our profile of Dr. Keith featured in last month's newsletter.

In Memoriam

Pedro A. Espat, DO, FACOI, of Sebastian, Florida, passed away in January 2023. He had been an ACOI member since 1987. Dr. Espat left behind his wife, Roberta Rose, DO, and two daughters, Marissa and Stephanie.

Originally from Belize, Dr. Espat always wanted to be a physician. He excelled at Botsford Hospital and was named Chief Resident. He and his wife opened a practice in Sebastian, FL. He was a great chef and loved to entertain friends and family. If you were his friend, you were a friend for life and was always there for you.

In Memoriam

Dorothy E. Carnegie-Shillinglaw, DO, MACOI, of Lansing, Michigan, passed away in February 2023. She had been an ACOI member since 1959. She is survived by her daughter, Susan Shelander, RN, and her son, Dr. William Shillinglaw.

Dr. Carnegie-Shillinglaw had a distinguished career as a clinician, leader, and educator in Osteopathic Medicine. She was appointed to the National Advisory Council on Health Professionals Education from 1972-1975. Along with her husband, Richard Shillinglaw, DO, she established the Carnegie Shillinglaw Endowed Award for Academic Excellence in Internal Medicine. In 2016, she became the first recipient of ACOI's Distinguished Service Award.

2023 Certifying Examination

Dates & Deadlines

AOBIM Initial Certification Exam

Remote Online Proctoring
September 20-22, 2023
First Application Deadline: July 20, 2023
Final Application Deadline: August 20, 2023

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

Share Your News With Us!

If you've recently received an award or accepted a new position, let us know so we can give you a shout out! Send an email to katie@acoi.org with your news, or news about your fellow members.

Upcoming ACOI Events

Register Now!

ACOI 2023 Virtual Spring Meetings

2023 Internal Medicine Board Review Course
May 9-13, 2023 | Virtual
Register Now!
Add to Outlook | Add to Apple Calendar | Add to Google Calendar

2023 Clinical Challenges in Hospital Medicine
May 10-13, 2023 | Virtual
Register Now!
Add to Outlook | Add to Apple Calendar | Add to Google Calendar

2023 Subspecialty Focused Meeting
May 11-13, 2023 | Virtual
Register Now!
Add to Outlook | Add to Apple Calendar | Add to Google Calendar

Which Meeting is Right for You?

ACOI 2023 Virtual Spring Meetings	Internal Medicine Board Review Course	Clinical Challenges in Hospital Medicine	Subspecialty Focused Review
Who Will Benefit	Internists and subspecialists	Hospital-based internists and subspecialists	Internists and subspecialists
What You'll Learn	An internal medicine refresh	The latest in hospital-based care	A knowledge update in cardiology, pulmonology, critical care, infectious diseases, and gastroenterology.
CME Available	~42 hrs of CME	~23 hrs of CME MOC points also available	~18 hrs of CME MOC points also available

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

Upcoming ACOI Events

(Continued)

ACOi 2023 October 11-14 Tampa • Hybrid

2023 Annual Convention & Scientific Sessions
October 11-14
Tampa Marriott Waterside Hotel, Tampa, FL | Hybrid
Add to Outlook | Add to Apple Calendar | Add to Google Calendar

2024 Annual Convention & Scientific Sessions
October 30-November 3
Kierland Resort, Scottsdale, AZ
Add to Outlook | Add to Apple Calendar | Add to Google Calendar

2025 Annual Convention & Scientific Sessions
October 8-12
JW Marriott Marco Island Resort, Marco Island, FL
Add to Outlook | Add to Apple Calendar | Add to Google Calendar

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

Share Your Work at #ACOI2023

Submissions are now open for ACOI's Annual Poster Contests and Presentations. Submit before **July 31** to qualify!

Annual Poster Contest

Residents and students can submit abstracts in the categories of original research or case presentations. Cash prizes will be awarded to the top winners in each category, and convention registration is free for residents and students.

Resident Application **Student Application**

Faculty Poster Presentations

Faculty are welcome to share their knowledge with the ACOI community in a number of categories. Poster presentations will qualify for scholarly activity. Learn more.

Faculty Application

Donor Club

The ACOI wishes to thank all Members for their annual support for the College. Their generous support is of the utmost importance as we seek to maintain an osteopathic approach to internal medicine for future generations of patients.

$75,000+

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$50,000+

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Robert J. Stomel, DO, MACOI

$15,000 - $24,999

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Mission

As the premier community for osteopathic internists, ACOI provides leadership, networking, and education to help our members be successful and stay true to why they pursued medicine.

Visit our website to learn more.

4250 North Fairfax Drive

Suite 600 • Arlington, VA 22202

301 231-8877 • 800 327-5183 • Fax 301 231-6099

acoi@acoi.org • www.acoi.org