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CMA℠ Today

Eating disorders

Biopsychosocial conditions with a bite

Endless gratitude

"Thank you": two small words that mean so much. Thank you for your confidence and trust in the AAMA board's ability to carry on the business of the AAMA for another year. We were amazed that all states voted to keep the same officers and trustees as last year, and for that we are grateful.

We all know what this past year has been like due to COVID-19. To each medical assistant working on the front line, balancing work and family, keeping a smile on your face behind a mask for hours at a time, and maintaining your faith in this board, we thank you.

Moving forward to this new year, we will continue to work for our members and plan for all to meet in Houston, Texas, for the 2021 AAMA Annual Conference. I am sure there will be a lot of happy people and joy at seeing our fellow medical assistants once it's safe to do so again.

Never once in Greensboro, North Carolina, when I was sworn in as AAMA president at the 2019 AAMA Annual Conference, did I think I would be a president during a pandemic. But knowing your confidence in me and the rest of the AAMA Board of Trustees, we will gladly serve our members again for another year. We will be making history for the AAMA, as this is the first time that an AAMA president and the AAMA Board of Trustees will be serving an additional year. Again, thank you.

Debby B. Houston, CMA (AAMA), CPC

Debby B. Houston, CMA (AAMA), CPC
AAMA President, 2019–2021

AAMA® Mission

The mission of the American Association of Medical Assistants® is to provide the medical assistant professional with education, certification, credential acknowledgment, networking opportunities, scope-of-practice protection, and advocacy for quality patient-centered health care.

CMA (AAMA)® Certification

The CMA (AAMA) is awarded to candidates who pass the CMA (AAMA) Certification Exam. The National Board of Medical Examiners constructs and administers the exam. The CMA (AAMA) credential must be recertified every 60 months by the continuing education or exam method.

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AAMA update

Earn an assessment-based certificate in education!

Medical assisting educators help shape the next generation of medical assistants. And to provide quality education to students, educators must be prepared with an understanding of learning fundamentals, knowledge of best practices and methods, and the ability to teach a diverse population.

Whether you're exploring an interest in medical assisting education or allied health education, beginning a career in teaching, or looking for new ways to improve as a longtime educator, completing the Assessment-Based Certificate in Education (ABC-E) Program is right for you! The ABC-E Program provides comprehensive education in three key topics:

- Principles of adult learning
- Effective classroom instruction
- Assessment, evaluation, and other aspects of allied health education

The ABC-E courses are available to CMAs (AAMA)®, medical assistants, and all other health care professionals. The courses can be taken together as part of the ABC-E Program or individually for AAMA CEU credit. Altogether, the program is worth 27 general CEUs. The program is now available through the AAMA e-Learning Center at https://learning.aama-ntl.org.

Increase your knowledge and your marketable skills! Save 10% by purchasing the courses or program on or before Jan. 31, 2021.

Moreover, use AAMA membership to get additional discounts on the ABC-E Program. Become an AAMA member or renew your membership today!

On the web

Follow your leaders
Under Volunteers/National Volunteer Leaders
See the roster of committed members leading this association!

Reports from the CEO
Under News & Events/Reports from the CEO
Access excerpts from past reports of AAMA CEO and Legal Counsel Donald A. Balasa, JD, MBA, to the House of Delegates.

Save the dates
Via Calendar
Find dates for upcoming board meetings, annual conferences, and MARWeek in the AAMA calendar. ✦

The 2020 AAMA Life Membership winner

We are pleased to announce that Ann Naegele, CMA (AAMA), was awarded life membership with the AAMA! This award recognizes an exemplary medical assistant who has achieved a lifetime of service to the association, medical assisting profession, and CMA (AAMA) credential. ✦

President's message

The AAMA Board of Trustees will continue to serve until the next election at the 2021 AAMA Annual Conference. To begin her second term, AAMA President Debby Houston, CMA (AAMA), CPC, has shared some words of hope with all AAMA members. The message looks ahead to the future and reflects on the past by summarizing the Board of Trustees' activities from the past year and highlighting key accomplishments.

The message portion appears in this issue of *CMA Today*. The full president's report is available on the AAMA website. ✦

Recognizing EXCEL-lence

Congratulations to the winners of the 2020 Excel Awards! Although the AAMA Annual Conference was canceled to mitigate the spread of COVID-19, the AAMA recognizes the incredible medical assisting groups and individuals who participated in the 2020 Excel Awards.

In lieu of the Awards Ceremony typically held at the AAMA Annual Conference, the AAMA Awards Committee hosted a Facebook Live event with AAMA President Houston to announce the 2020 winners of the Awards of Distinction, the CMA (AAMA) Employer of the Year Award, and the student essay competition. All winners will still be celebrated in person during the 2021 conference, during which AAMA President Houston will give trophies and the like to the appropriate winners. Furthermore, all 2020 winners will receive their certificates in the mail soon.

See the list of 2020 Excel Award winners at the end of this issue. Go to News & Events/Conference on the AAMA website to download the full list, which includes Achievement Award winners, and read the winning student essay.

Bylaws amendments

The House adopted amendments to AAMA bylaws that create changes to office terms due to the COVID-19 pandemic. These amendments allow the officers and trustees in office at the end of the 2019–2020 AAMA year to remain in office for the 2020–2021 AAMA year.

The speaker and the vice speaker shall now be elected in odd-numbered years, and the secretary-treasurer will be elected in even-numbered years. Furthermore, four trustees will be elected in odd-numbered years, and three trustees will be elected in even-numbered years.

Read the amendments under Article IX and Article X in the 2020–2021 *AAMA Bylaws* on the Member Downloads page of the AAMA website. ✦

Find AAMA-approved CEU programs via Facebook!

An easier way to find state society and local chapter programs worth AAMA-approved CEUs is now available! Visit the AAMA's Facebook page and navigate to the "Events" section to see all upcoming events. Many of these events are virtual, so no matter where you live, you have the chance to register and earn CEUs!

Are you a state society or local chapter officer who would like to share an upcoming program? Submit a Save-the-Date submission form via the AAMA website within the My Account section of the website (must be signed in for access). ✦

What tasks are delegable to—and performable by—medical assistants?

Part II

Donald A. Balasa, JD, MBA
AAMA CEO and Legal Counsel

The following is adapted from the handout for my presentation of the same title for the 2020 American Academy of Ambulatory Care Nursing Annual (Virtual) Conference.

Part I discussed four legal axioms and their applications in determining tasks delegable to—and performable by—medical assistants. It also debunked three pervasive myths about medical assistants' scope of practice and proffered diagnostic questions for ascertaining the legality of a specific task. This article will address state laws about medical assistants (1) performing injections and venipuncture, (2) executing verbal and standing orders from licensed providers, and (3) entering orders under the Medicaid Promoting Interoperability Program (formerly the Medicaid Electronic Health Record [EHR] Incentive Program) and its meaningful use provisions for electronic order entry.

Injections delegated by physicians

Under the laws of all states except New York and Connecticut, physicians are permitted to delegate to knowledgeable and competent unlicensed allied health professionals such as medical assistants working under their authority and supervision the administration of intramuscular, intradermal, and subcutaneous injections—including vaccinations and immunizations. Medical assistants must meet certain requirements to administer physician-delegated injections according to the laws of South Dakota, Washington, North Dakota, Nebraska, Massachusetts, New Jersey, Arizona, and California.

My legal opinion is that—based on common law principles—if there is a likelihood of significant harm to a patient if a medication or other substance is selected or prepared improperly, the delegating physician must verify the identity and dosage of the injectable substance before the medical assistant administers it. Verification of all injections' identity and dosage before administration by medical assistants is required by the laws of some states. Depending on the specific state law, this verification of dosage and identity may be done by a licensed provider other than a physician or by a licensed health care professional, such as a registered nurse.

Injections delegated by nurse practitioners or physician assistants

In some states, the laws governing the delegation to medical assistants of injection administration vary depending on whether the delegating provider is a physician, nurse practitioner, or physician assistant. To complicate the legal analysis, the laws of some states permit a licensed provider to supervise a medical assistant who is performing injections delegated by a licensed provider of a different category. For example, in some states, a nurse practitioner is not permitted to delegate to medical assistants injection administration. However, in some of these states, a nurse practitioner may be allowed to supervise a medical assistant who is administering an injection delegated to the medical assistant by a physician.

Venipuncture

As is the case with injections, venipuncture may be delegated to medical assistants under state law, and some states have requirements that medical assistants must meet to be delegated this task. For example, California law has different requirements for medical assistants performing phlebotomy under licensed provider authority in outpatient settings and for medical assistants working as phlebotomists in clinical laboratories without physician, nurse practitioner, or physician assistant supervision.

IV tasks

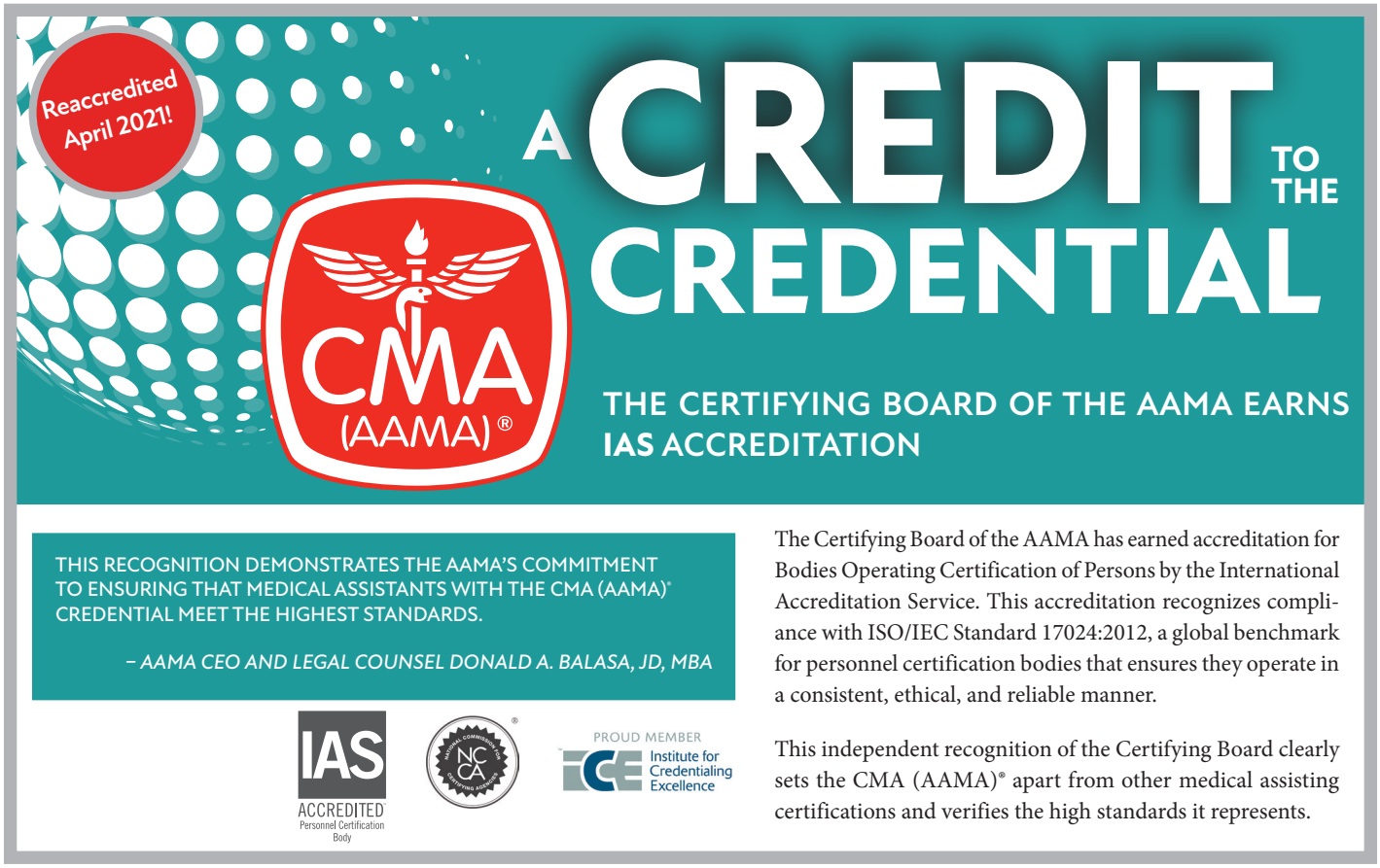
According to the laws of some states, licensed providers are neither specifically authorized nor forbidden from delegating to unlicensed allied health professionals such as medical assistants the performing of intravenous (IV) tasks. Some states' laws permit providers to delegate to medical assistants certain IV tasks such as initiating IVs, performing IV infusion, and (in Washington and Maryland) performing IV injections. For example, Florida law permits physicians to delegate to knowledgeable and competent medical assistants the performing of IV infusion under the physician's direct or on-site supervision. In some of these states, medical assistants must meet education and credentialing requirements to be delegated certain IV tasks.

Employer policy and state law

Employers of and delegators to medical assistants must abide by state law regarding the legally allowable scope of practice for medical assistants. An employer, however, is permitted to establish a delegation policy for medical assistants *stricter than* what state law allows. In other words, an employer may choose to not allow medical assistants to perform certain duties that are within the medical assistant's legal scope of practice. Not allowing competent medical assistants to work to the top of their education and credentialing under the law may not seem to make economic sense for the employer. However, such policy is legally permissible and does not violate any state or federal laws (e.g., anti-discrimination laws).

Verbal orders

My legal opinion is that—unless state laws



indicate otherwise—medical assistants are permitted to receive and execute verbal orders from an overseeing or delegating provider if the following conditions are met:

1. The medical assistant understands the verbal order.
2. The task to be performed is within the medical assisting scope of performable tasks under the laws of the state, and the delegating physician (or another provider) is exercising the degree of supervision required under state law for the delegated task.
3. The medical assistant is knowledgeable and competent in the delegated task.
4. Executing the order does not require the exercise of independent clinical judgment or the making of clinical assessments, evaluations, or interpretations.

Standing orders

My legal opinion is that medical assistants are permitted to receive and execute standing orders from an overseeing or delegating provider if the following conditions are met:

1. The medical assistant understands the standing order.
2. The standing order is for a task that is delegable to medical assistants under the laws of the state, and the delegating provider is exercising the degree of supervision required by the laws of the state.
3. The standing order is either patient-specific or applicable to all patients without exception.
4. The standing order does not require the medical assistant to exercise independent clinical judgment or make clinical assessments, evaluations, or interpretations.

Medicaid Promoting Interoperability order entry requirements

Despite the phasing out of the Medicare EHR Incentive Program by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), this Centers for Medicare & Medicaid Services (CMS) rule remains in effect: only licensed health care professionals or credentialed medical assistants are permitted to enter medication, laboratory, and diagnostic imaging orders into the computerized provider order entry (CPOE) system for meaningful use calculation purposes under the Medicaid Promoting Interoperability Program (formerly the Medicaid EHR Incentive Program).[1]

Consequently, CMAs (AAMA)® must keep their credential current to remain within the CMS definition of *credentialed medical assistants*. Similarly, medical assistants must have a current Assessment-Based Recognition in Order Entry (ABR-OE) to be classified as credentialed medical assistants under the CMS rule. ✦

Questions about this adapted presentation may be directed to AAMA CEO and Legal Counsel Donald A. Balasa, JD, MBA, at dbalasa@aama-ntl.org.

Reference

1. Centers for Medicare & Medicaid Services. *Medicaid Promoting Interoperability Program Eligible Professionals Objectives and Measures for 2020 and 2021: Objective 4 of 8.* Accessed December 14, 2020. https://www.cms.gov/files/document/medicaid-ep-2020-cpoe-objective-4.pdf

PILING UP

Unpack ideas about hoarding disorder

By Kathryn S. Taylor

The famous reality show *Hoarders* spans more than 120 episodes and showcases people's struggles with and treatment for hoarding disorder. Generally, the show selects people to profile based on how extreme the hoarding is, with a crisis (e.g., the threat of eviction) prompting the televised intervention—all of which contribute to the heightened drama typical to reality TV. Meanwhile, increasingly sophisticated targeted-marketing tactics and the commonplace status of superstores that sell products in bulk—with the promise of saving more by buying more—normalize desiring, acquiring, and keeping more stuff.

With such a range of attitudes about accumulation, health care professionals need to sharpen their awareness of hoarding disorder to help those in need.

Know your stuff

Hoarding disorder entered the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) in 2013 and affects approximately 2% to 6% of the population.[1] Mild signs of hoarding typically start around age 13 and worsen over time, with these behaviors potentially becoming a severe problem for adults in their 50s.[1]

While most disorders occur before the age of 25, hoarding disorder is difficult to recognize at such an early stage, according to Fugen Neziroglu, PhD, ABBP, ABPP, cofounder and executive director of the Bio-Behavioral Institute in Great Neck, New York, and professor at the Donald and Barbara Zucker School of Medicine.

People with hoarding disorder have three indicators[2]:

- They gather and keep numerous items, even those that seem worthless to others.
- They allow items to clutter their housing so that rooms cannot be used.
- Their daily lives are negatively impacted by their items.

They also tend to have unique emotional symptoms[3]:

- Suspicion of others touching their possessions
- Embarrassment over their belongings
- Indecision regarding where to put objects
- Anxiety about discarding items

Not everyone who displays hoarding behaviors has hoarding disorder, and various degrees of hoarding disorder exist. Some patients contain their hoarding to one room so that visitors never suspect the person is a hoarder, explains Dr. Neziroglu. Others are organized hoarders, who keep their possessions in labeled and stacked boxes.

Law and hoarder

The first step toward overcoming hoarding disorder is often difficult and uncomfortable for patients.

"[In my experience,] it's so unusual to have a … hoarder be the one to initiate the treatment," says Karen Cassiday, PhD, ACT, managing director and clinical psychologist at the Anxiety Treatment Center in Deerfield, Illinois. "Oftentimes, their family or partners are strong-arming them. That's usually what gets people into treatment—that or they're in trouble with the law."

"While hoarders likely recognize [they have] a problem, the fear that once they're discovered they're going to be asked to let go is *incredibly* anxiety provoking," says Dr. Neziroglu. She notes that the emotional attachment to objects is a chief indication of hoarding disorder.

Those with hoarding disorder have difficulty ridding themselves of excess objects for numerous reasons[2]:

- Difficulty organizing their possessions
- Guilt or anger when considering the disposal of items
- Belief that their items have feelings
- Sense of responsibility for the perceived feelings of inanimate objects

They may also acquire excessive amounts of objects because they are incapable of passing up bargains or free items.[2] Sometimes, a traumatic event will exacerbate hoarding.[2]

Hoarding can lead to health and safety issues, evictions, and conflicts with family and friends.[2]

Outside the box

Children of hoarders suffer on various levels.

Dr. Neziroglu, coauthor of *Children of Hoarders: How to Minimize Conflict, Reduce the Clutter, and Improve Your Relationship*, notes that most children feel sadness over their parents' situation. "It's a feeling that the parent has chosen the possessions over them," she says. As adults, they often become either hoarders or minimalists. While Dr. Neziroglu believes there is a biological predisposition to hoarding, she also knows the total impact is larger still: "If you grew up in a hoarder's home, you … [often] don't learn how to organize, prioritize, or make decisions."

Hoarding disorder may also be a comorbidity of obsessive-compulsive disorder (OCD), obsessive-compulsive personality disorder (OCPD), attention-deficit/hyperactivity disorder (ADHD), and depression.[3]

"I don't call [those with OCD, ADHD, or depression who have issues with hoarding] true hoarders," says Dr. Neziroglu, since they have no emotional attachment to the objects. Instead, these people may just become distracted due to ADHD, be too exhausted or apathetic to clean as a result of depression, or avoid objects that they feel are contaminated because of OCD.

Less frequently, hoarding may accompany psychosis, dementia, Prader-Willi syndrome (a genetic disorder), or pica (i.e., eating non-food substances).[3]

Divide and conquer

Treatments for hoarding disorder run the gamut[1]:

- Self-help books
- Support groups
- Individual talk therapy
- Medications
- Group therapy

Internet-based treatments are being studied, and peer-facilitated group treatments may also be effective.[1]

Patient buy-in is paramount.[2] Clearing out a hoarder's home without permission can cause extreme distress and actually make the problem worse.[2]

Motivational interviewing is a great way for patients' treatment to begin, according to Dr. Cassiday: "Get the patient to clarify what is it they really want out of life. Because usually they have great ambitions, and you [can] try to help them see how the way they're living is preventing [those ambitions] from happening."

Cognitive behavior therapy is a cornerstone of hoarding disorder treatment. Dr. Neziroglu says that cognitive behavior therapy teaches patients to disengage the attachment from the object.

Additionally, trained professionals can teach patients to prioritize and make decisions by helping patients sort their items into various boxes (e.g., useful items, donations, garbage, and important documents). A therapist (or another mental health professional or both) should help with this process at first, and then the patient can transition to working independently.[2]

Another strategy is to challenge the hoarder's beliefs about needing to keep things or acquire new ones.[2] For example, Dr. Cassiday reminds patients that books and magazines are available online. Also, "giving away clothes to charities, rather than throwing them away, helps," says Dr. Neziroglu.

Government agencies can connect hoarders with therapy and help with treatment. "There are task forces for those who are being evicted [that work] … with therapists," says Dr. Neziroglu.

Additionally, "you have to address the acquisition behaviors," says Dr. Cassiday. "You practice going to the areas where you would normally acquire things and don't do anything—let the urge pass. So you just do straightforward exposure therapy. Usually fairly quickly, people can get to where they can resist that urge and stop bringing new stuff in."

But treatment for hoarding disorder does not end with a purge.

"[Patients] need to keep working at it; they need to do an ongoing relapse prevention program," says Dr. Neziroglu. "If someone doesn't get treatment or doesn't get the *right* treatment," confirms Dr. Cassiday, "they relapse." ✦

More than just pet peeves

Animal hoarding is defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* as accumulating numerous animals but failing to provide minimal standards of care[1]:

- Unmet nutrition, veterinary care, and sanitation needs
- Lack of response to animals' declining health
- An overcrowded or unsanitary environment

"[Animal hoarding] usually starts off with very good intentions to help the animals, but, unfortunately often, it ends up hurting the animals, because [the hoarders] can't take care of them," says Fugen Neziroglu, PhD, ABBP, ABPP.

The hoarder may initially be able to care for their pets, but they lose the ability due to illness, lowered income, or loss of a spouse.[1]

"Most people who hoard animals also hoard objects," says Karen Cassiday, PhD, ACT. She notes that those who hoard animals are more likely to have experienced interpersonal traumas, such as physical or sexual assault, the death of a parent as a child, or a negative relationship with their partner or spouse.

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Influenza vaccination remains essential

Every year, influenza vaccination remains a vital part of a person's routine health care. Despite that, many patients avoid getting vaccinated for various reasons. To combat misinformation, the American Medical Association provides answers to common concerns about vaccination to help health care professionals prepare how to respond to and inform patients with concerns:

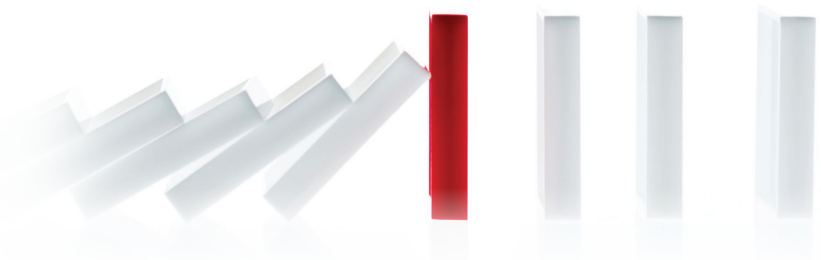
- Even healthy people should be vaccinated because influenza is highly contagious and can lead to serious illness in otherwise healthy individuals.
- Vaccinations are proven to be safe through more than 50 years of research and do not cause people to contract influenza.
- Patients should not wait until their local area is affected by influenza, as it can take two weeks to develop antibodies after receiving a vaccination.
- Vaccinations should be repeated every year because the influenza virus strains can change from year to year, and the effectiveness of a vaccine from a previous year may wane over time.
- An influenza vaccine may produce some common side effects; however, influenza itself can cause much more severe problems for those infected, including hospitalization and death. And even when an individual has a mild case, they risk spreading it to someone who may experience a worse case. Thus, receiving the vaccination is better than risking illness.

Global prevalence of GI disorders

Gastrointestinal (GI) disorders are common worldwide, particularly for women, according to findings published in *Gastroenterology*. Researchers examined data collected via questionnaires and interviews from more than 73,000 people across 33 countries.

Overall, 40% of adults reported GI symptoms (e.g., heartburn, acid reflux, and indigestion), with severity ranging from mild discomfort to high impact on a person's quality of life. Furthermore, 37% of men and 49% of women met the criteria for one or more functional GI disorders.

These results are significant as this report is one of the first to study the global prevalence of GI disorders with a consistent diagnostic questionnaire and research methodology. "The results may influence substantially future planning of health care resources and clinical trials," say study authors. ✦



Engagement reduces fall risk for inpatients

To prevent the risk of falls and fall-related injuries for patients staying in hospitals, the Fall Tailoring Interventions for Patient Safety toolkit was created and implemented at 14 medical units. A recent study to test its effectiveness included 37,231 adult patients.

A previous study found the toolkit reduced falls by 25% but did not reduce fall-related injuries caused by patient nonadherence, according to *ACP Hospitalist*. However, the current study, published in *JAMA Network Open*, focused on a more patient-centered approach with greater family and patient engagement. This resulted in 15% fewer inpatient falls overall and 34% fewer falls that resulted in injury. ✦

Telemedicine can positively influence weight loss

Because of health concerns related to COVID-19, an estimated 32% of U.S. adults delayed or avoided routine care visits, according to the Centers for Disease Control and Prevention. While people who experience medical emergencies should seek care without delay, telemedicine may provide a viable alternative to in-person visits for certain health concerns, such as weight loss.

A study presented at the virtual ObesityWeek 2020 Interactive meeting (which was hosted by The Obesity Society, an organization headquartered in Maryland) examined data from participants who had reported treatments for obesity (e.g., bariatric surgery, counseling, or medication) at Sheba Medical Center in Israel.

Of the 139 patients, those who used telemedicine services to speak with a physician, dietician, or mental health professional during the survey period—which took place during a lockdown—achieved an average weight loss of about 4.5 pounds. In contrast, those who did not use the medical center's telemedicine services experienced less weight loss (about 1 pound.) Furthermore, about a third of patients who used telemedicine services indicated they would use them again in the future. ✦

Self-compassion bolsters lifestyle changes

Despite how well documented the benefits of certain healthy habits (e.g., quitting smoking, increasing exercise, and eating healthier) are, making significant lifestyle changes can remain difficult for many. But that difficultly could be lessened by increased self-compassion, suggests research published in *Harvard Review of Psychiatry*.

Researchers found that mindfulness-based interventions (MBIs) can be a valuable tool for improving a person's ability to make changes. Essentially, MBIs aim to help patients increase their ability to focus their attention and regulate their emotions, thus allowing them to acknowledge and deal with internal body signals.

Previous research has often promoted a "cool" approach to MBIs, which encourages patients to acknowledge and accept unpleasant sensations (e.g., cravings). However, the study authors suggest that a "warm" approach, which integrates self-compassion, may be even more effective. "Self-compassion involves responding with a warm, kind, and understanding orientation toward oneself," write the researchers. "Interventions and programs that focus explicitly on cultivating inner compassion, which includes and extends beyond self-kindness, may help facilitate behavior change, particularly for individuals who are prone to excess self-criticism, shame, or unworthiness." ✦

Sleep and expectation affect appetite

Many factors influence appetite, including the amount a person sleeps and their assumptions about their hunger, reports Nutrition Action.

A study published in *Nutrients* examined the effect of sleep on a person's food consumption the following day. Adult women were directed to either sleep their typical seven to nine hours at night or reduce their sleeping time by a third. Participants who decreased their sleep time reported increased hunger, food cravings, and portion sizes.

Similarly, research presented in *Appetite* detailed findings on how expectation affects hunger. In this study, participants were given the same serving sizes on two separate mornings. But the study administrators told participants that one portion was larger than the other. On the day participants ate the portion perceived as smaller, they consumed approximately 70 more calories during their next meal.

Thus, hunger should be considered a part of overall health and not necessarily an isolated feeling. If trying to monitor appetite, people (and patient education) should factor in other aspects of their health to identify the root cause.


AAMA
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Eating disorders

Biopsychosocial conditions with a bite

By Mark Harris

While the term *eating disorders* is familiar to most people, the group of conditions that fall under this diagnostic label are often misunderstood by the general public and often underrepresented in popular culture.

Eating disorders constitute a category of serious, even life-threatening, mental health disorders including but not limited to the following[1]:

- Anorexia nervosa
- Bulimia nervosa
- Binge-eating disorder
- Other specified feeding or eating disorder (OSFED)
- Avoidant/restrictive food intake disorder (ARFID)

And various unspecified or subclinical eating disorder behaviors fall into the eating disorder category too.[1]

Altogether, the impacts of eating disorders are widely felt throughout society. Of the U.S. population in 2018–2019, an estimated 28.8 million will have an eating disorder at some point in their lifetimes, according to a 2020 Deloitte Access Economics report.[2]

This report, published in conjunction with the Strategic Training Initiative for the Prevention of Eating Disorders (STRIPED) and the Academy for Eating Disorders, found the overall lifetime prevalence of eating disorders was estimated to be 8.6% among females and 4.1% among males. Notably, eating disorders are linked to "substantial excess premature mortality," with approximately 10,200 deaths in 2018–2019 linked to anorexia nervosa, bulimia nervosa, binge-eating disorder, and OSFED.[2]

Undoubtedly, eating disorders impact a diverse cross section of the U.S. population because they exist among individuals of any age, gender, ethnicity, body weight, and socioeconomic group. While eating disorders primarily constitute a serious mental health or psychiatric illness, they are influenced by a mix of psychological, biological, and genetic factors.[3]

"We talk about eating disorders as biopsychosocial illnesses," says Claire Mysko, MA, CEO of the National Eating Disorders Association. "As such, treatment for eating disorders is multidisciplinary. It's a multifaceted treatment approach. With eating disorders, there are underlying psychological issues, but there's also a high rate of co-occurring conditions. Most people who have an eating disorder diagnosis are also dealing with other issues, including anxiety and depression. There is also a strong link with past trauma. There may also be a significant crossover with other substance use disorders. We also know that eating disorders can have very serious medical consequences. Typically, the overall treatment plan includes both psychological counseling and a medical consultation."

Apititude in appetites

How are eating disorders defined? The following criteria describe some of the main features that are characteristic of the major eating disorders.

Anorexia nervosa. Individuals with anorexia nervosa have significantly low body weight and are very fearful of gaining weight. The disease is essentially a form of self-starvation. Notably, these individuals often have trouble recognizing their low body weight or related health consequences as a health risk. The diagnostic criteria is that the person weighs less than what is considered normal for their age, sex, height, and other health measures.[4]

The eating behaviors of those with anorexia nervosa may vary and may be comparable to other eating disorders:

> Some individuals with anorexia nervosa engage in binge eating (i.e., eating large amounts of food while feeling out of control) and/or purging (i.e., trying to compensate

Here to serve

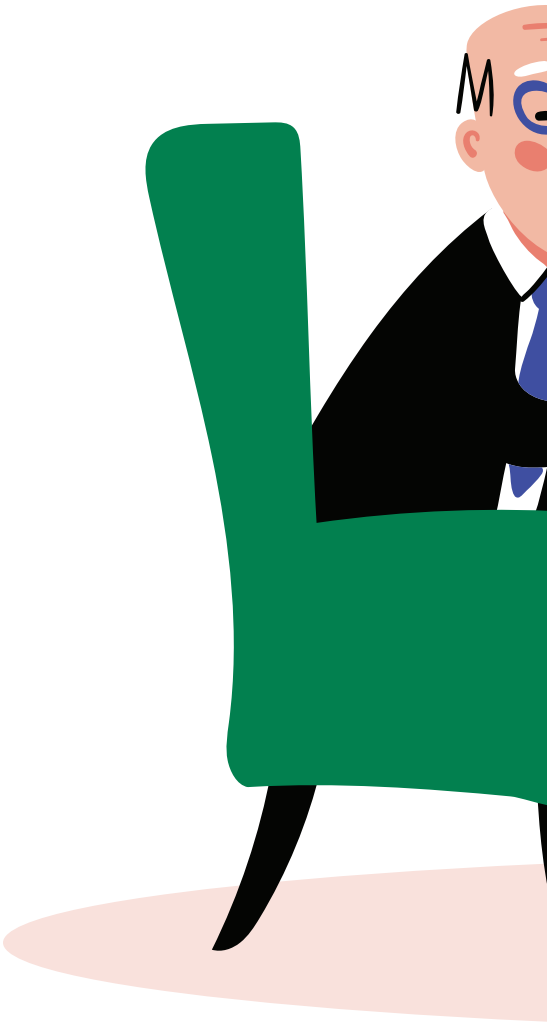
Many education and treatment resources are available, including the following:

Academy for Eating Disorders
The Academy for Eating Disorders (AED) is a global professional association committed to leadership in eating disorders research, education, treatment, and prevention.

National Eating Disorders Association
The National Eating Disorders Association (NEDA) is the largest nonprofit organization dedicated to supporting individuals and families affected by eating disorders.

The Eating Disorders Clinical and Research Program at Massachusetts General Hospital
The Eating Disorders Clinical and Research Program (EDCRP) at Massachusetts General Hospital provides outpatient evaluation and treatment for adults, adolescents, and children ages 10 and up with feeding and eating disorders.

University of California San Francisco Eating Disorders Program
A comprehensive, evidence-based program that provides outstanding clinical care for individuals with eating disorders (up to age 25) and their families, including family-based and individual treatments.



for calories consumed through self-induced vomiting or inappropriate use of laxatives, diuretics, or other medications). Others do not binge or purge but consume a very limited diet that does not adequately support their nutritional needs.[5]

Bulimia nervosa. Individuals with bulimia nervosa experience recurring cycles of binge eating, accompanied by compensatory behavior such as self-induced vomiting, using laxatives or diuretics, fasting, or exercising excessively. Typically, bulimic behavior includes eating large amounts of food within a certain time frame (e.g., two hours). Often, the person feels out of control during these episodes. The diagnostic criteria includes that the behaviors associated with bulimia nervosa occur—on average—at least once a week for three months.[6]

Binge-eating disorder. Some people engage in binge eating without the harmful compensatory behaviors that are characteristic of bulimia nervosa. Like bulimia nervosa, binge-eating disorder is characterized by recurrent episodes in which a person eats excessive quantities of food within a partiular time frame. The individual may eat food alone, quickly, and usually to the point of physical discomfort. Notably, binge-eating disorder can occur even if the person is not physically hungry. As with bulimia nervosa, the person often feels out of control while binging. The disorder is also frequently associated with feelings of shame and distress. The frequency of the behavior required for a diagnosis is the same as for bulimia nervosa: an average of at least once a week for three months.[7]

Other specified feeding or eating disorder (OSFED). This category represents eating disorder behaviors that do not meet strict diagnostic criteria for anorexia nervosa, bulimia nervosa, or binge-eating disorder. Even if sometimes considered a catch-all category, an OSFED diagnosis is no less serious than any other eating disorder. In 2013, OSFED replaced *eating disorder not otherwise specified* (EDNOS) in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*).[8] And the increased mortality rate for individuals diagnosed with OSFED compared with the general population (1.92 times higher) is close to that for bulimia nervosa (1.93 times higher).[2]

Avoidant/restrictive food intake disorder (ARFID). This eating disorder is like anorexia nervosa, with people severely limiting the amount or types of food they eat. Unlike anorexia nervosa, ARFID patients tend to not share the same distress about body shape or size. Notably, ARFID is more than being a picky eater. In fact, children with this condition do not consume enough calories for healthy developmental growth. Similarly, adults with ARFID do not eat enough to maintain basic body function.[9]

Miscellaneous. The *DSM-5* covers several additional feeding and eating disorders, including rumination disorder. A defining feature of rumination disorder is that a person repeatedly regurgitates food after eating.[10] The regurgitation is considered voluntary and often accompanied by re-chewing, re-swallowing, or spitting out the ingested food.[10] All in all, "unhealthy eating behaviors exist on a continuum,"[3] as the Academy for Eating Disorders describes, and these behaviors can have a serious impact on a person's health, even if the behaviors do not meet the formal criteria for a diagnosis.[3]

Made to order

Certainly, eating disorders are complex conditions. For this reason, as Mysko notes,

eating disorders typically require a comprehensive, multifaceted treatment approach. The pillars of treatment are mental health care, nutritional care, and medical management of the physical consequences of the eating disorder or disorders.

The Eating Disorders Program at the University of California San Francisco (UCSF), which treats minors, adolescents, and young adults up to age 25, exemplifies the range of patient care resources now available. "The UCSF Eating Disorders Program, like many programs, is interdisciplinary," says Jason Nagata, MD, MSc, an assistant professor of pediatrics in the Division of Adolescent and Young Adult Medicine at UCSF. "Our team members include people from adolescent medicine, pediatrics, family medicine, and internal medicine who help with the medical management. We also have a mental health team that includes psychologists and psychiatrists, a nutrition team with registered dieticians, social workers, occupational therapists, nurses, and medical assistants. Most patients will have, at a minimum, medical, mental health, and nutrition follow-up integrated into our program."

With its family-based treatment model, UCSF also offers the Intensive Family Treatment program for adolescents with eating disorders. This five-day, all-day program invites patients and their families or caregivers to participate in various therapeutic interventions and activities designed to address a young person's eating disorder. Up to six families at a time participate in the week-long program.

To note, most eating disorder patients are treated on an outpatient basis. Mental health providers use a variety of treatment approaches, including cognitive behavior therapy, interpersonal psychotherapy, family therapy, and behavioral therapy.[2] For some patients, therapy is relatively short-term, lasting an average of four months or so. Others, however, may be in treatment on a long-term basis. Resources such as group therapy and guided self-help are also options for some patients.[5]

Because many patients with an eating disorder may also have a diagnosis of depression, an anxiety disorder, or a substance use disorder, these issues are usually addressed in conjunction with therapy for the eating disorder. In more severe cases, patients with anorexia nervosa or bulimia nervosa,

Open 24/7

The National Eating Disorders Association offers a short online screening tool[13]—appropriate for ages 13 and up—to help individuals determine whether it is time to seek professional help.

9 truths about eating disorders

The Academy for Eating Disorders shares myth-busting facts[11]:

1. Many people with an eating disorder look healthy yet may be extremely ill.
2. The families of those with an eating disorder are not to blame for the eating disorder and can be the patients' and providers' best allies in treatment.
3. An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.
4. Eating disorders are not choices but serious biologically influenced illnesses.
5. Eating disorders affect people of all ages, genders, sexual orientations, ethnicities, body shapes and weights, and socioeconomic statuses.
6. Eating disorders carry an increased risk for medical complications and suicide.
7. An individual's genes and environment play important roles in the development of eating disorders.
8. An individual's genes alone do not predict the development of any eating disorder.
9. Full recovery from an eating disorder is possible. Early detection and intervention are important.

for example, may require more intensive treatment, such as a day-hospitalization program or inpatient hospitalization. Many treatment programs offer a step-up and step-down approach to care, adjusting the appropriate level of care depending on the patient's progress or ongoing clinical needs.[2]

When a patient is first referred to an eating disorders program, the assessment begins with a comprehensive review of the patient's history and symptoms. "We usually give the person a structured clinical interview," says Jennifer Thomas, PhD, codirector of the Eating Disorders Clinical and Research Program at Massachusetts General Hospital in Boston. "We ask about all the different diagnostic criteria to rule in or rule out whatever the diagnosis might be. If somebody comes in and their primary concern is binge eating, it's possible they could have an eating disorder. But if they're also underweight, it's possible they could have anorexia nervosa. If they're also vomiting, they could have bulimia nervosa. If they're binge eating but not very often, they might have OSFED. Just knowing one or two symptoms wouldn't usually be enough information for a diagnosis."

Further, the patient is asked to fill out self-report questionnaires before the visit; then their responses can be followed up on during the clinical interview. A consultation with a physician accompanies the interview, says Dr. Thomas, a psychologist in the psychiatry department at Harvard Medical School. "We'll take the person's weight at our visit on the mental health side, but we would also want the patient to be screened by a medical provider for any kind of medical complications. This might include blood tests for nutrition deficiencies or an electrocardiogram for bradycardia, for example. The medical evaluation follow-up is to determine whether the person is safe for outpatient care or whether they might need a higher level of care."

Fine (detail) dining

What other concerns or focuses might guide the medical evaluation? "From the physician's side, we like to do a complete medical evaluation to make sure there's not another underlying medical cause that could mimic eating disorders," says Dr. Nagata. "Based on the complete history, we might decide then to do additional testing. So, we might consider any kind of endocrine problem, for example, like thyroid issues that can lead to weight loss. Or there could be issues with the gastrointestinal tract, like inflammatory bowel disease, celiac disease, Crohn disease, or ulcerative colitis. Sometimes autoimmune diseases can also lead to weight loss. Depending on the clinical picture, we'll usually run additional laboratory tests or other testing to make sure there's not another issue involved."

For patients with eating disorders, Dr. Thomas agrees that providers must clarify any differential or co-occurring diagnoses responsible for or contributing to the patient's symptoms. "You don't want to be doing too many invasive tests," she says, "but the medical evaluation can be helpful. The challenge here is that even if a patient has a gastrointestinal condition, like celiac disease or gastroparesis, it wouldn't necessarily rule out an eating disorder. Sometimes the patient's primary complaint or presentation will have to do with physical symptoms, but they still really do have an eating disorder."

Dr. Thomas describes one scenario in which a patient's symptom presentation requires this differential diagnosis. "A patient with [ARFID] might have a bona fide food allergy, such as being allergic to tree nuts. But then they're also avoiding eating other foods they are not allergic to, like maybe peanuts, dairy, meat, or other foods. If the change in their eating is above and beyond what is needed to manage a bona fide medical condition, they could still have an eating disorder in addition to that medical condition."

One special concern with eating disorders is the risk of malnutrition, especially to the heart and brain, explains Dr. Nagata. "Being in a state of malnutrition can basically affect the entire body, including the gut, kidneys, liver, skin, and circulation. From a medical standpoint, the first question we have to answer is, Is the person medically stable? That is usually guided by vital signs such as heart rate and blood pressure. Are they in a place where their blood pressure and heart rate, or other vital signs, are dangerously low? Weight is also considered a vital sign—to see how much the weight and amount of weight change have been. This assessment will dictate the level of care. Do they need to be hospitalized or to go into a more intensive program?"

Notably, the medical assessment can include an orthostatic examination. This involves checking the patient's blood pressure and heart rate while lying down and then standing. "Sometimes when you're in a state of malnutrition, your body can't accommodate changes in position, so people who are malnourished may be at higher risk of fainting and passing out," explains Dr. Nagata.

Accordingly, getting accurate blood pressure and heart rate readings when recording vital signs is essential. For this reason, medical assistants at UCSF play a key role in the eating disorder clinic's front lines of care, says Dr. Nagata: "There are national criteria that dictate, for example, if [a patient's] blood pressure or heart rate is below a certain threshold, then [they] need to be hospitalized. The vital signs help providers determine whether [the patient] can be managed as an outpatient in a clinic, needs to go to a more intensive program, or needs to be hospitalized in an inpatient setting. This [taking vitals] is actually one of the most important tasks because getting accurate vital signs does really dictate the patient's [health care] management."

Notably, getting accurate vital signs among some younger patients is not always as straightforward as might be assumed, adds Dr. Nagata. "For some of our young people with eating disorders who have had the disease for a long time, they can become kind of savvy as to what numbers they need to avoid being hospitalized," he says. "There are actually ways they can try to manipulate their vitals to artificially inflate them. Our medical assistants have a really crucial role

"There's every reason to be optimistic about the identification and treatment of eating disorders. We have many very helpful treatments available, and we're working hard to disseminate them and make them more easily accessible with self-help versions and via mobile apps. Through the COVID-19 pandemic, teletherapy has increased access. There's research now on how to make treatment shorter, so instead of 20 or 40 sessions, we can make it 10 sessions so that we can then offer treatment to more people with the same amount of resources. There is also ongoing research about the neurobiology of eating disorders that points toward directions for future treatments, in addition to the behavioral treatments we already have."

—Jennifer Thomas, PhD

[in intervention for] eating disorders [by recording] accurate vital signs."

Going off-menu

While data suggests that eating disorders are generally more common in women, this can also depend on the specific diagnosis. For example, the Academy for Eating Disorders reports rates of binge-eating disorder are similar in females and males. Concurrently, some social groups may be more vulnerable to eating disorders. For example, female athletes such as gymnasts, ice skaters, dancers, and swimmers have higher rates of eating disorders. In one study of NCAA Division I athletes, over one-third of female athletes was at risk for anorexia nervosa, based on reported attitudes and symptoms. Similarly, male athletes in sports such as wrestling, bodybuilding, crew, running, cycling, climbing, and football have also been at greater risk for eating disorders.[3]

Of course, women historically have faced unique body image issues related to cultural pressures to stay thin, lose weight, or otherwise adhere to various ideals of feminine appearance. But men can also feel pressured to lose weight. Notably, another category of males want to bulk up, aspiring to a masculine body type that involves putting on pounds or acquiring added muscle mass and doing so in ways that involve unhealthy eating or other behaviors.

"The history of eating disorder disease has traditionally been focused on more female-centric criteria, but I do think more and more men are dealing with body image concerns," says Dr. Nagata. "We miss some of these men because a lot of the screening questions have typically been more about weight loss and don't really get at some of the muscularity concerns."

Interestingly, what accounts for the stereotype of eating disorders as a woman's issue is linked to the history of how professional eating disorders treatment has evolved within medicine. "I think the stereotype of an eating disorder patient being a young, white woman comes from the fact that many years ago, when people first started researching and treating the illness, those were the patients [who could] show up for treatment," observes Dr. Thomas, referring to both economic factors and gender expectations. "As a result, they started being the group studied. Everybody then got the idea that this is who gets eating disorders. … People would recognize eating disorders in this group and ignore the symptoms in other groups or [ignore how] the symptoms might look different in other groups."

While female patients are still more likely to be diagnosed with anorexia nervosa, Dr. Thomas notes this gender disparity is less likely with some of the newer eating disorder categories. "With newer disorders that we've recently discovered in the field, like ARFID, it's more 50-50 boys and girls [and] men and women," she says. "I think now that we know more about the diversity of symptoms, we see that eating disorders are [closer to] equal in terms of the gender distribution [as well as among] different ethnicities."

Dr. Nagata remarks that a related misconception is that a person must be very skinny to have an eating disorder. "In fact, we know that people who are at higher weights or are considered to have high body mass indexes actually have the highest rate of disordered eating behaviors, like vomiting or taking laxatives or diuretics to try to control their weight," he notes.

With concerns for the obesity epidemic prevalent in U.S. society, Dr. Nagata raises a word of caution for providers. "If primary care providers have patients who are considered obese by body mass index, they may counsel their patients about weight loss. But we have sometimes seen in our clinic that some patients will be told by their primary care doctor, or by teachers or parents, that they need to lose weight, and so then they start doing unhealthy behaviors to try to lose the weight, like vomiting or using laxatives or diuretics, taking nonprescribed weight-loss pills, just skipping a lot of meals, or fasting for really long periods."

This behavior can then become an eating disorder, cautions Dr. Nagata. "Unfortunately, if their physician or family don't really know how the patient is losing weight, [the patient] can actually get some positive reinforcement for their unhealthy behavior. They hear, 'Oh, great, you're losing all this weight! Keep up the hard work,' and so on. The behavior can then spiral out of control. If providers are going to counsel about weight loss, I would also recommend they counsel about specific behaviors for healthy weight loss."

Recipe for success

In her experience working for a family medicine clinic in Greenville, South Carolina, Claudia Watkins, CMA (AAMA), says she has learned how staff can and why they should foster a considerate, welcoming environment for patients with eating disorders.

As she notes, patients who are too underweight or overweight often feel very self-conscious or anxious about their appearance. They may have had past experiences in school or elsewhere in which they felt ostracized or shamed for their weight or appearance. Consequently, the clinic should feel like a safe space for them.

"These patients might come to the office already with a lot of anxiety about their weight or appearance," says Watkins. "In my experience, I have always felt what these patients needed from me was just a supportive and positive person. You also want to keep your emotions in check. You do not want to show if you feel pity or sadness or negative feelings for them. If you're bringing a patient back to the examination room, and they are just skin and bones, don't show your fear for that person. Keep yourself professional and courteous, and don't be abrupt with them because they are already sensitive and afraid of what's going on. I believe compassion for patients in this situation is just so important."

This sensitivity extends to taking each patient's weight, says Watkins. For example, she might suggest to an anorexic patient to stand with their back to the scale so they do not see their weight before having the chance to discuss it with the physician. With overweight and obese patients, there should be no criticism if there is weight gain. "I wouldn't even praise them if there is a weight loss," she adds. "You want to be a safe person for them when you ask them to stand on the scale, and [you want to] not betray their confidence by commenting on

their weight in some way. Our role should always be to keep the anxiety [levels] down."

While much progress has been made in our understanding of eating disorders and how providers treat them, the treatment community—in general—recognizes that eating disorders continue to be underdiagnosed and undertreated. "We believe the majority of people with eating disorders are not currently in treatment," reports Mysko. "In the last two years, we've had over 200,000 people take the [National Eating Disorders Association] screening tool on our website. Notably, the majority of those who screened 'at risk' or had answers that would indicate that they would meet the diagnostic criteria for an eating disorder also indicated they were not currently in treatment."

Some barriers to care include costs and geography, reports Mysko. The specialized care many eating disorders patients need can be limited or unavailable outside of larger metropolitan areas. Further, insurance benefits can be insufficient for the course of recommended treatments. Other factors are also at work, such as the need for improved public health screening and the reluctance of those with eating disorders to seek care.

"We know that early intervention does make a big difference in the treatment outcomes," concludes Mysko. "I believe screening for eating disorders is critical in health care. Having frontline providers, primary care providers, and those who are in a position to screen and refer at an early point can make a difference. The sooner a person can get into treatment, the more effective and cost-effective that treatment can be." ✦

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The purple book

Often referred to as "the purple brochure," *Eating Disorders: A Guide to Medical Care*[1] from the Academy for Eating Disorders' Medical Care Standards Committee is intended as a resource to promote recognition of and risk management in the care of those with eating disorders.[12]

Eating disorders

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T F

☐☐ 1. Involving family members in the treatment of a child or adolescent with an eating disorder is not recommended because these disorders are often caused by the behaviors of nuclear family members.

☐☐ 2. Patients who are severely underweight or overweight should be treated by health care professionals with respect and support, not with judgment.

☐☐ 3. People with anorexia nervosa typically are aware of their low weight and the associated health dangers.

☐☐ 4. The rates of binge-eating disorder are significantly higher in females than in males.

☐☐ 5. There may be a significant overlap of substance use disorders and eating disorders.

☐☐ 6. Patients with severe eating disorders often require more intensive treatment such as inpatient hospitalization.

☐☐ 7. Eating disorders are primarily classified as psychiatric illnesses that are serious but not life-threatening.

☐☐ 8. Physicians should complete a medical evaluation of patients to make sure that patients' extreme weight loss is not caused by inflammatory bowel disease or an autoimmune disease.

☐☐ 9. Other specified feeding or eating disorder (OSFED) is a less serious eating disorder because it is nonspecific and patients often compensate for their disorder by having above-average sleep and exercise habits.

☐☐ 10. Individuals with bulimia nervosa typically eat large amounts of food in a short time and then attempt to purge food with behaviors such as taking laxatives, vomiting, or fasting.

T F

☐☐ 11. A patient with a food allergy or food intolerance (e.g., celiac disease) may develop an eating disorder if the change in their eating habits goes beyond what is necessary.

☐☐ 12. Avoidant/restrictive food intake disorder (ARFID) poses a significant threat to children because those affected by ARFID often do not consume enough calories to sustain normal developmental growth.

☐☐ 13. Because an eating disorder involves both physical and emotional health, full recovery is unlikely.

☐☐ 14. A low blood pressure or heart rate when lying down and then standing can be an indicator of malnutrition.

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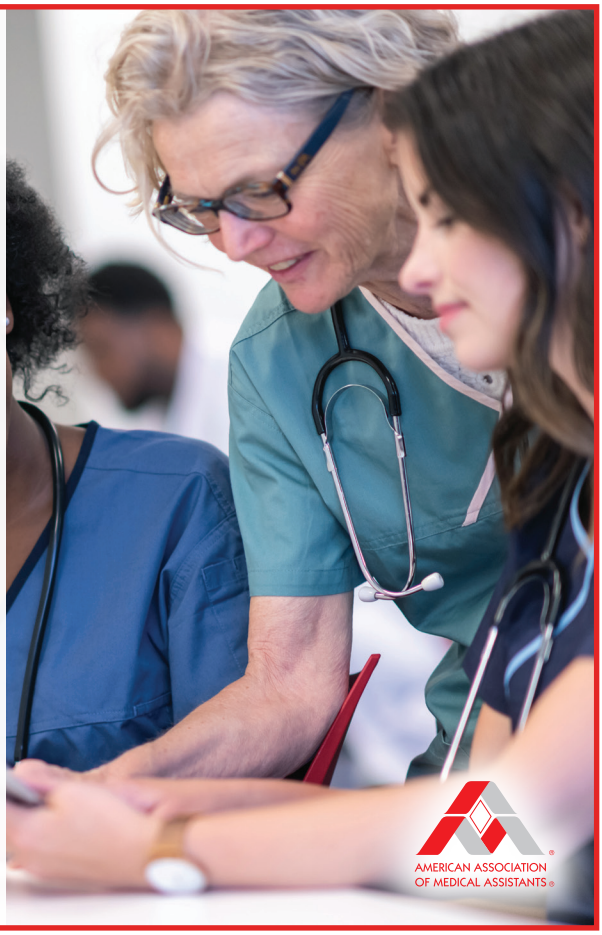

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Eye know-how

When it comes to common beliefs about ocular care, keep an open mind and a discerning eye. Separate fact from fiction with information from Harvard Health Publishing:

- Wearing glasses does *not* deteriorate eye health. Using increasingly corrective lenses may cause people to perceive their eyes as becoming weaker with time instead of recognizing that they are—in part—becoming less tolerant of blur.
- While no medical evidence supports the idea that eye exercises can correct vision or help with serious eye conditions, don't look down on eye exercises altogether—they may help reduce eye strain.
- Carrots do contribute to eye health because they provide a source of vitamin A. But you can set your sights higher. Fresh fruits and leafy greens contain vitamins C and E, which are even more beneficial.
- Computer screens and dim lighting don't actually cause eye damage, but they can strain and tire eyes, causing discomfort.

Posture perfect

Good posture can help you straighten up your health, according to Medical News Today. In addition to boosting self-confidence, improved posture can reduce back pain, minimize the risk of certain injuries, reduce muscle and joint stress, and improve circulation, digestion, respiration, and flexibility.

Maintaining better posture requires a degree of muscle strength, joint motion, and balance. Targeted exercise can train your body to practice better posture and be implemented while standing, sitting, or lying down. Generally, keeping your spine aligned is key.

The most common posture mistake is slouching, especially since 25% of U.S. adults sit for more than eight hours a day, according to *JAMA*. Get over the sitting slump with these tips:

- Change sitting positions frequently throughout the day.
- Relax shoulders by resting your forearms and elbows on a desk.
- Stand frequently and take short walks when possible.
- Avoid crossing legs and ankles and twisting at the waist. ✦

Rooting for health

You don't have to dig too deep to discover the power of root vegetables, reports the Academy of Culinary Nutrition. A staple in many pantries, these vegetables pack a nutritional punch, containing significant amounts of fiber, anti-inflammatory nutrients, antioxidants, complex carbohydrates, and vitamins A, B, and C.

Root vegetables offer a large variety of options, including carrots, onions, rutabagas, turnips, and sweet potatoes. The possibilities for cooking are similarly vast; root vegetables can be used in a range of foods such as soups, smoothies, and baked goods. Most root vegetables require cool, dark storage and should be checked regularly for sogginess and mold. ✦

Crunch time

Searching for a nutritional bite to eat? Walnuts can be enjoyed as standalone snacks, paired with dark chocolate or fruit for additional flavor, or easily incorporated into many other dishes (e.g., oatmeal, stir-fries, pesto sauces, and salads).

In a nutshell, walnuts offer science-backed health benefits that are difficult to pass up. Chew on these advantages of walnuts from Healthline:

- Provide healthy fats, fiber, vitamins, and minerals, as well as significant amounts of antioxidants
- Decrease inflammation
- Promote gut health
- Reduce blood pressure
- Support brain function throughout aging
- Improve appetite regulation ✦

To the bone

Following best practices to maintain strong, healthy bones does not have tibia difficult task! Adjustments to behaviors at a younger age can potentially prevent pain and surgeries later on in life, advises Melody Hrubes, MD, a sports medicine specialist. Not sure where you kneed to start? Follow advice from *Health*:

- Pay attention to cues from your body while exercising, and see a physician if you have persistent discomfort.
- Mix up workouts with different types of exercise to prevent overuse injuries.
- Explore the option of physical therapy to reduce some musculoskeletal pain.
- Boost bone density by performing weight-bearing exercises (e.g., walking, running, or strength training) and choosing a diet with sufficient calcium and vitamin D.
- Check for weaknesses by getting a bone density test, which is typically recommended for women ages 65 and older and people who have had bone fractures or currently have a condition that prevents nutrients from reaching their bones. ✦

Scoring goals

A key part of achieving wellness is creating health goals and following through with them. However, goals without structure can hinder progress. Instead, the Mayo Clinic Health System recommends getting ahead of the game by setting SMART goals. Use each part of the acronym to shape a goal, making it achievable and tailored to your needs:

- **S**pecific. Instead of vague goals, opt for concrete plans. Rather than say you will exercise more, decide what more exercise means for you (e.g., 30 minutes twice a week).
- **M**easurable. Specific goals allow you to measure your progress. Trying one new, healthy recipe per week is something you can definitively mark as done, whereas you might not be able to measure progress for a goal like "eat healthier."
- **A**ttainable. Goals should be both challenging and achievable.
- **R**ealistic. Impossible goals can discourage effort. Aim for goals that you know are possible, which will reinforce the healthy behaviors you are trying to accomplish.
- **T**rackable. Tracking goals allows you to note your progress. Seeing your progress on a goal is not only useful information but can also be encouraging!

BACK IN BUSINESS

Hire the best medical assistants for the practice

By Pamela M. Schumacher, MS

Practice managers know the value of hiring the right medical assistant—not only can they manage customer interactions, but they perform clinical assignments and deftly juggle administrative duties. However, medical practices may have a lot of competition in hiring these versatile and in-demand paraprofessionals. Employment of medical assistants is projected to grow 19% from 2019 to 2029, much faster than the average for all occupations, according to the U.S. Bureau of Labor Statistics.[1] Having a hiring strategy will help employers successfully hire quality team members.

Hire learning

While hiring the right medical assistant is crucial to long-term success, hiring the wrong one can have lasting consequences and ultimately cost the practice time and money. A good place to start is writing an informative and compelling job description to introduce prospective employees to the company's culture and work environment. A well-written job description should set the practice apart from competing job listings.

Employment websites such as Monster provide standard medical assistant job descriptions, which should include these key areas[2]:

- **Job responsibilities.** Include the nitty-gritty, day-to-day activities the medical assistant will be performing. Give an accurate portrayal of the job. For example, if the job has a lot of administrative duties, do not underplay that.
- **Work hours and benefits.** Provide the expected work hours and employee benefits. Applicants want to know team size, staff-to-patient ratios, and shift rotations. Highlight any benefits that set the practice apart, like childcare reimbursement, commuter benefits, tuition reimbursement, and continuing education opportunities.
- **Qualifications and skill requirements and preferences.** List the skills and areas of knowledge that will make employees successful in the practice, such as supply management, ability to create a safe environment, scheduling, and teamwork.
- **Education, experience, and credential requirements.** Be as explicit as possible. Employers know the value of hiring credentialed medical assistants, such as CMAs (AAMA)®, so state it as a requirement. Also, list whether candidates should have experience in a medical practice, with specific programs, or in a specific field.
- **Call to action.** Tell candidates how to apply for the position with clear directions, such as "Email [this person] and attach [these] documents."

The Association of American Medical Assistants® (AAMA) website lists typical medical-assistant duties that can form the basis of a job description.[3]

Talk shop

Hiring the perfect medical assistant depends on the practice's specialty and needs. "I suggest starting with the standard job description and then customizing it," says Andrew Swanson, MPA, CMPE, vice president of industry insights at Medical Group Management Association in Englewood, Colorado. "Talk to the physicians and other staff who will be working with the medical assistant. Find out what they think would make someone highly effective in this position. Also determine what you *must* have in a candidate versus what is *nice* to have. This helps focus your energies on the candidates with the skills you need."

Anita Robinson Fowler, BSHA/HS, CMA (AAMA), a medical assistant for the U.S. Navy in Norfolk, Virginia, agrees a job description listing the practice's specific needs can get the right candidate in the door. But she cautions against overlook-

ing less experienced medical assistants: "If someone doesn't have the exact experience you're looking for, but they are interested in learning new skills, that is a great candidate.

"I always ask, 'Where do you see yourself in two to three years?' The answer I'm looking for is that they're interested in growth—in their skills, in their knowledge base, and even in the network of people that they know," says Fowler. "Medical assistants typically stay in a practice for only three to five years, so if you can get someone who can grow into a role, that can be an ideal situation for you and them."

Recruit for the long term

Many medical assistants stay with an employer for only a handful of years, but employers can play the long game by creating a hiring pipeline for the medical practice. The AAMA offers these tips to help hiring managers acquire a qualified pool of medical assistant candidates[5]:

- **Announce job openings directly to CMAs (AAMA).** The AAMA database has more than 80,000 CMAs (AAMA) nationwide, with the option to narrow list rental contacts according to city, state(s), and ZIP code(s).
- **Offer to serve as a practicum site.** The benefits of being a practicum site include building relationships with program directors, educators, and students who may eventually work for the practice.
- **Cultivate connections in the community.** Build a network of contacts by connecting with local accredited programs at technical schools and community colleges. Request information about their placement services. Post job listings on their job board and see whether a list of recent graduates is available.

Inquire within

After identifying several candidates, employers should ask the right questions to get a sense of candidates' core competencies. The following ranked as top interview questions to ask:

- How can you, as a medical assistant, ensure that you're protecting patient privacy and upholding [Health Insurance Portability and Accountability Act (HIPAA)] regulations?
- In your previous work or [practicum] experiences, have you been responsible for taking client histories or checking patient vitals?
- What is your experience with front-end office tasks, and are you comfortable answering phone calls and [welcoming] patients at the door?
- Have you ever received formal training with electronic health records software?[4]

While the must-haves for any medical assistant should include patient care experience, administrative skills, the ability to multitask, and certification, employers should watch out for certain warning signs, advises Swanson.

Red flags can be encountered as early as the interview. For example, a candidate who focuses significantly on listing their hard skills over their soft skills might be trying to hide their lack of soft skills. Additionally, during the interview, look for evidence of claimed—and even unmentioned—soft skills. "Hard skills, such as taking a blood pressure reading, can be verified, but soft skills, such as how they interact with patients, can be harder to judge," says Swanson. "Notice whether they are smiling, engaged in the conversation, and actively talking to you. Can they look you in the eye? These are the behaviors you want them to exhibit with patients. Medical assistants must remain calm under pressure, and the interview can approximate the stress of a patient interaction. If they are stressed talking to you in the interview, they may not be the right candidate for your practice."

Fowler recommends paying attention when an applicant shies away from a question or does not really answer it. "Then you have to dig down to understand what is making them uncomfortable," she says. "Do they really know what I'm asking? If I hire them, is this the way they'll behave on the job? Will I have to keep repeating instructions or checking their work? I don't expect any candidate to know how to do everything, but I want them to exhibit confidence in what they know and be able to speak up when they need help."

In good company

Medical assistants' certification statuses can be quickly verified by going through the credentialing body by which the medical assistant earned their certification, such as the AAMA or the American Medical Technologists (AMT). Verification can usually be performed via the organization's website or by phone by using the medical assistant's name, Social Security number, or certification identification number.

Swanson also strongly advises running a background check. "There are great companies that can verify education, certification status, professional credentials, and criminal background—things you may or may not learn from speaking to the candidate's references," she says. "It's a good investment to give you peace of mind." ✦

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One and all

Make strategies for inclusivity count

By Brian Justice

Health care professionals interact with a diverse group of people on a daily basis. And while practicing medical assistants can learn about creating inclusive environments throughout their careers, educators hold a central role[1] in promoting inclusion by modeling best practices.

"Inclusion is not just about claiming to be an open space or saying that everyone is welcome," explains Kryss Shane, MS, MSW, LSW, LMSW, author of *The Educator's Guide to LGBT+ Inclusion: A Practical Resource for K-12 Teachers, Administrators, and School Support Staff*. "It is an intentional acknowledgment of people's differences and the impact these differences have on their lives and within the context of the lesson or even the school's entire program."

Thus, to better serve diverse classrooms, educators must learn, practice, and institutionalize cultural competence (i.e., the ability to teach students who come from different cultures than their educators).[2] And medical assisting students bring many different cultures to the classroom.

"I have a unique opportunity in that I get to interact with people from all backgrounds," says Joy Shepherd, CMA (AAMA), training center coordinator for the Apollo Career Center in Lima, Ohio. For example, "some are direct from high school, have a GED [General Educational Development] diploma, [are] returning to school after years of working, or even have master's degrees."

Craft with care

Inclusivity has a place in every classroom, regardless of the subject matter. While the content itself should be diverse, many recommendations for inclusive classrooms focus specifically on teaching *methods*.[3] "I'm constantly learning new ways to share information and make it understandable for all students—to be open with them and [to build] trust [so that] they can be open with me," Shepard says.

In addition to creating inclusive spaces that build on shared values,[1] educators should integrate teaching strategies that encompass the needs of *all* students[3]:

- Organize the class structure to address all ways of learning.
- Connect with students by using their names and invite students to share their pronouns.
- Set clear expectations (e.g., set deadlines early, include objectives in the syllabus, and provide straightforward instructions).
- Combat students' self-doubt by assuring students they belong and helping them overcome challenges.
- Encourage class-wide participation by trying new approaches (e.g., anonymous participation or structured group discussion).
- Model inclusive language and avoid assumptions.

"Truly, it all comes back to building those relationships," asserts Jennifer Breisacher, CEO of Student-Centered World. "From the youngest of children to the oldest of adults, if someone feels welcome and respected, they are going to try harder."

Open door policy

No single definition of inclusiveness will fit every learning environment, and much depends on the educator's personal experiences.[4] In many situations, quality communication is key.

"When I am addressing a subject, I try to stay very clinical, just state the facts, and not add any bias," says Shepherd. "But, as much as I try not to [add bias], it still happens. And when it does [while discussing something that has multiple viewpoints], I make sure that we explore all sides."

Shane cautions against falling back on being too general. "It can undermine the very personal and very specific experiences of each student," she says. "It can impede their ability to learn how to best engage with

those in marginalized groups, and that does a disservice to everyone."

Additionally, "self-reflection is integral to adult learning," says Ikemefuna Okwuwa, MD, FAAFP, program director of the family medicine residency program and associate professor at Texas Tech University Health Sciences Center in Odessa, Texas. "As educators, we all must first examine our own implicit biases and assumptions if we want to create an inclusive environment that fosters mutual respect and trust among learners."

To encourage that self-reflection and awareness in students, educators should facilitate meaningful discussions about diversity, inclusivity, and culture.

"When assumptions are made—hopefully by accident and without harmful intent—the culture of the classroom should be such that a corrective conversation is perfectly acceptable to have and learn from," says Breisacher. "When someone does not have cultural knowledge, they should be willing to find information, fill in the gaps, and do better moving forward."

All-inclusive

Educators should embrace the vast range of perspectives students bring into the classroom.[4] And because identification within groups is varied and complex, how learners respond to information or discussions can depend on context.

"An educator must always … acknowledge specific differences and the specific impacts they can have," says Shane. "When training someone how to work with others—such as with patient care, client engagement, [education], etc.—it's vital to consider the impact that race, ethnicity, gender identity [and] expression, sexual orientation, national origin, abilities, age, and more has on that individual as they navigate through the world."

To achieve an inclusive space, Ann Zeller, CMA (AAMA), medical assisting program and practicum coordinator at Northwest State Community College in Archbold, Ohio, works on building relationships. "I like to create classrooms that promote a sense of belonging for the students," she says. "Fostering an environment that ensures teamwork and even creates friendships between students helps ease the journey of their medical assisting education."

Active listening plays a vital role in producing this environment. This practice involves "not just listening with the intent to reply," Dr. Okwuwa clarifies, "but listening with the intent to understand."

All together now

The benefits of an inclusive classroom go both ways. Students are more comfortable and experience significant academic improvements[3]:

- Narrowed achievement gaps between groups of students
- Increased interest in course material
- Improved student focus

Furthermore, educators who conscientiously create such environments reap rewards too. For example, educators can immediately experience the impact of—or take comfort in sowing the seeds of—positively influencing students. "Modeling good habits that acknowledge our diverse backgrounds and experiences in a manner that respects each person's individuality promotes equitable treatment of all," explains Dr. Okwuwa.

Additionally, educators become learners themselves[1] and may be challenged to expand their own knowledge. "I have learned so much about cultures, ethnicities, and life in other social-economic statuses over the years just from having conversations with my students," says Breisacher. When she learns something new, she applies that knowledge going forward.

And any gaps in knowledge provide opportunities to seek out and amplify others' voices. "While educators may be experts in their field, they are often not experts in the experiences of every marginalized community," says Shane. "And there's nothing wrong with that, as long as they are aware of that limitation. It's vital that they reach out to experts or guest speakers for guidance so that students have the full benefit of [those professionals'] knowledge [toward] their own learning experience."

Because culture is so dynamic, no one can identify with everyone's point of view. Thus, educators should focus on allowing those varying viewpoints and experiences to coexist within the classroom.[1] When educators model inclusive practices, they pave the way for future medical assistants to demonstrate these behaviors throughout their careers and take values of inclusivity and open-mindedness from the classroom to patients. ✦

In the know

The National Education Association identifies cultural competence skills applicable to educators, schools, and educational systems[2]:

- Accept and respect different cultural backgrounds, customs, ways of communicating, traditions, and values.
- Be aware that an individual's experiences, knowledge, skills, beliefs, values, and interests shape who they are and where they fit in their family, school, community, and society.
- Know what can go wrong in cross-cultural communication and how to respond to these situations.
- Have some base knowledge of students' cultures to place their behaviors in cultural contexts.

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GO THE DISTANCE

Medical assistant uses decade to achieve her career goals

By Cathy Cassata

In 2010, Erica Odom, CMA (AAMA), decided to pursue her dream of working in the medical field. That August, she entered the medical assisting program at Everest College in Washington. A month into classes, she learned she was pregnant.

"It was a surprise, and I knew I was going to have to be a single parent," she recalls. "Still, I continued on with school and graduated with honors that April."

In May, she gave birth to her son and a few months later began working at a weight loss center.

"I was there for two-and-a-half years and really enjoyed it. I have a calling to help people, and I know how to engage with patients, always making sure they feel comfortable," she says.

Her employer quickly noticed her skills and promoted her to lead medical assistant. "They even sent me to train new hires in their California clinics," says Odom.

However, her daily commute to the weight loss clinic became difficult to manage while raising her son, and in 2013, she took a two-year break from the medical field to work as a marketer for a cleaning and restoration company. But Odom's heart stayed in health care, and she found herself back in the field in 2015 when she took a job as a financial counselor in the emergency room at Harborview Medical Center.

When a role at a fertility clinic came up in 2017, Odom jumped at the opportunity. Two years into the job, her employer asked her to obtain a certification.

"I started by getting my RMA(AMT) [credential] and then studied for the CMA (AAMA)® Certification Exam," Odom explains. "Last August, I studied hard; I went over books again and made flash cards. It felt like a long time since I had been in school studying the material."

By November 2019, she felt ready to sit for the exam.

"I failed the first time and took it again in December—and failed by just one point. Finally, on January 25, 2020, I passed my test after being out of school for 10 years," says Odom.

Odom considers the achievement one of her greatest yet. She hopes getting her certification sets an example for her son.

"I want him to know that you can do anything you put your mind to, no matter how long of a break you take. You can always go after your goal," says Odom. "I feel like I locked myself into a career that I love, and I [feel confident] that I have the mental capability to do what I want to well."

Odom obtained her certification at a useful time. In April, Odom was laid off from the fertility clinic due to the COVID-19 pandemic. Since fertility care was not considered essential, the clinic had to temporarily close.

"I'm grateful I got certified before the pandemic hit. I know it helped me land a job a week after I got laid off," says Odom.

Since May, she has been working at a family practice office just a few blocks from her home, where she performs both clinical and administrative duties, including administering COVID-19 tests.

"We put on our N95 [masks and] gear and go on. The patients swab themselves, but we give them directions on how to do it and come in to collect the sample when they are done," Odom explains.

She is proud that her medical skills allow her to help combat COVID-19 in some capacity, and she feels that every step during her 10-year career has brought her to this moment.

"Looking back, I have no regrets," she asserts. "I love where I'm at, and I love what I do." ✦

2020 Excel Awards

Congratulations to the Excel Award winners! The full list of who won both Excel and Achievement Awards is available on the AAMA website.

Awards of Distinction

Golden Apple
Jennifer Williams, MS, BHA, AAS, CMA (AAMA)

Leadership and Mentoring
Mary Gambrell, CMA (AAMA)

Medical Assistant of the Year
Ramona Charlene Driggers, CMA (AAMA)

Student Essay Award

(Sponsored by F.A. Davis)

Yolanda Estrada, from Modesto Junior College, in Modesto, California

CMA (AAMA)® Employer of the Year Award

TriHealth LLC (D), represented by Vesta Johns

Section A = 1–25 employees
Section B = 26–50 employees
Section C = 51–75 employees
Section D = 76 employees or more

Section A = 200 members or fewer
Section B = 201–500 members
Section C = 501–800 members
Section D = 801 members or more

Publishing

CTSMA eMagazine, published by **Connecticut** (B), Rebecca Rivera, CMA (AAMA), editor

The Helping Hands, published by **Ohio** (D), Melanie Shearer, CMA (AAMA), editor

Website Development

South Dakota (A), Maggie Olson, CMA (AAMA), web chair

Connecticut (B), Rebecca Rivera, CMA (AAMA), web chair

Michigan (D), Mistie Atkins, CMA (AAMA), and Cristle Weissmiller, CMA (AAMA), web chairs

Marketing, Promotion, and Recruitment

"Medical Assistants Fighting COVID-19," conducted by **Arkansas** (A), Melinda Rhynes, MEd, CMA (AAMA), campaign director

"Fantastic Fall Medical Assistants Recognition Week," conducted by **Texas** (C), Angela Hensley, CMA (AAMA), Lisa Connelley, CMA (AAMA), and Tammie Hartman, CCMA, campaign directors

"Post Card Campaign," conducted by **North Carolina** (D), Betty Jones, campaign director

Community Service

"Seton Youth Shelter," conducted by **Virginia** (B), Virginia Thomas, CMA (AAMA), campaign director

Membership Retention

South Dakota (A); **New Hampshire** (B); **Nebraska** (C); **Iowa** (D)

Membership Recruitment

Hawaii (A); **Colorado** (B); **Maine** (C); **Florida** (D)

Student Membership Recruitment

Oklahoma (A); **Idaho** (B); **Maine** (C); **Oregon** (D)

CMA (AAMA) Certification

Greatest percentage increase of member CMAs (AAMA)

Oklahoma (A); **New York** (B); **Texas** (C); **Washington** (D)

Medical assistants, thank you!

You have our eternal gratitude for the work you are doing to combat the COVID-19 crisis. Thank you for the incredible strength, kindness, and skill you demonstrate every day.