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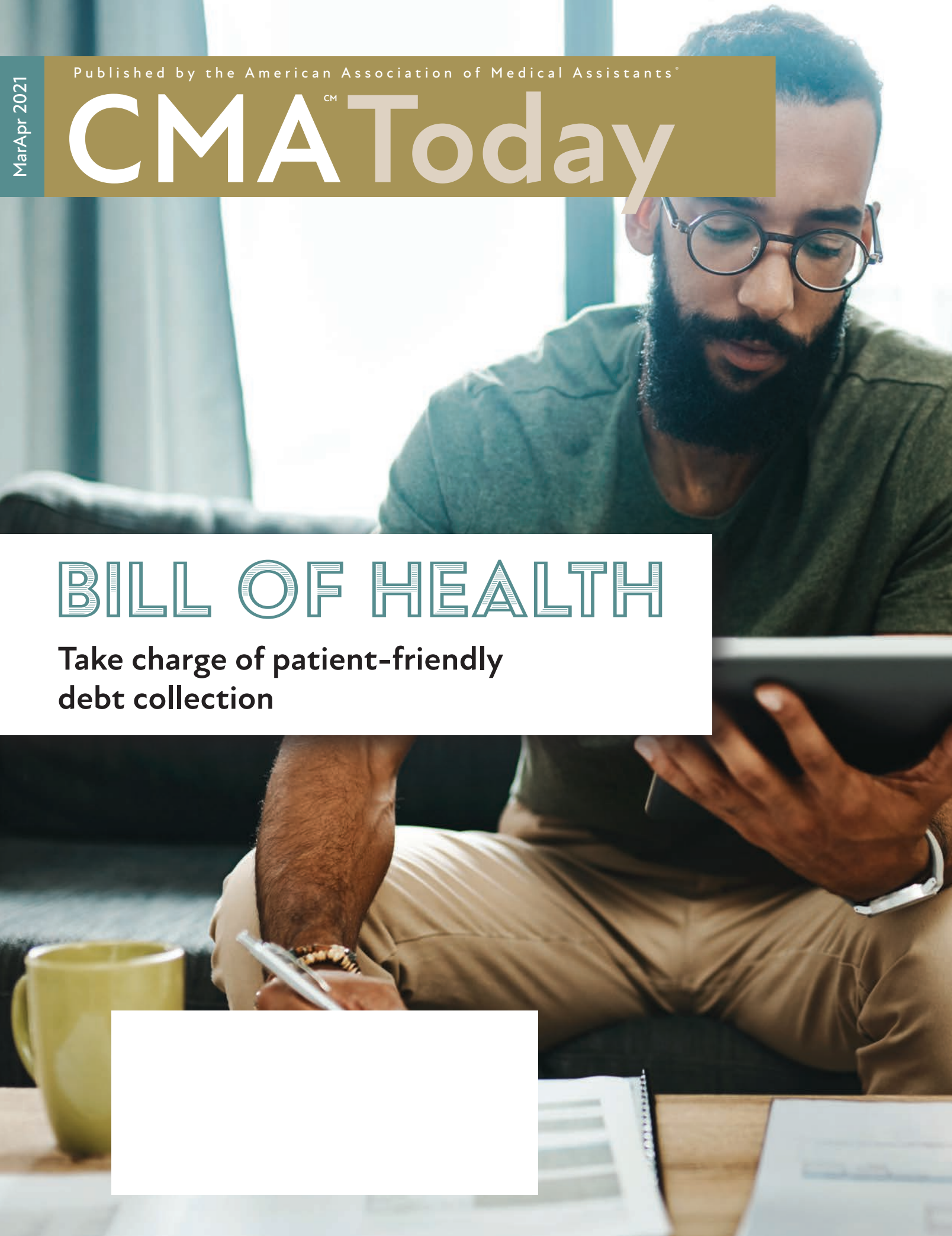


BILL OF HEALTH

Take charge of patient-friendly debt collection

A new season for growth

I would like to start with a great big *thank you* to all of you working during the COVID-19 pandemic, whether on the front lines, from home, or with reduced hours. My heart goes out to those taking care of their families, those whose families have lost someone due to COVID-19, and those dealing with COVID-19 complications. Know that your Board of Trustees has your back, and together we will grow stronger. The past year has been difficult, but we look to the future with hope.

Now we are approaching spring, a season for new beginnings—and the American Association of Medical Assistants® (AAMA) and its leaders welcome this time for continued growth. In that spirit, we want to share opportunities for professional development with all our members!

Many options are available for continuing education. The AAMA has recently published new certificate programs for education and telemedicine in the e-Learning Center. And, although the pandemic has prevented many meetings and conferences, state societies and local chapters have made continuing education events available virtually. These programs are shared on the AAMA's Facebook Events page, where they can be easily found by followers.

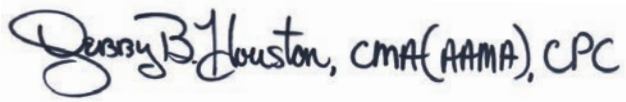
And we cannot forget one of my favorite professional development events: the AAMA Annual Conference! I am so looking forward to Houston, Texas, not only for the conference and CEUs but also to see longtime and new friends and our great family of AAMA staff and members. Renewing our friendships and reconnecting with one another is so important.

This year's conference slogan is "Over the Moon," which is what we all will be when we see one another again. I hope to see you all there!

With all this professional and personal growth within the AAMA, medical assistants are truly blossoming and ready to take on new roles—so don't forget to fill out the AAMA Volunteer Leadership Application. Review the application—which is available on the Guidelines and Forms webpage—for position descriptions and requirements. A lot of you are already serving on either the chapter or state levels or both; this is the year for you to step out of your comfort zone and join us on the national level. We know that you will make a great addition to the team, and we would love to have you join us.

You have so much to offer: consider what you can do for your fellow medical assistants at the national level of the AAMA. For ideas, visit the AAMA website to check out what the AAMA has been doing to support medical assistants.

Thank you again for your vote of confidence in the Board of Trustees by allowing us to serve for another year. The members of my team have been awesome, and we have developed such a great comradery with one another during this past year. We are looking forward to the rest of 2021 and all opportunities to grow as an association.



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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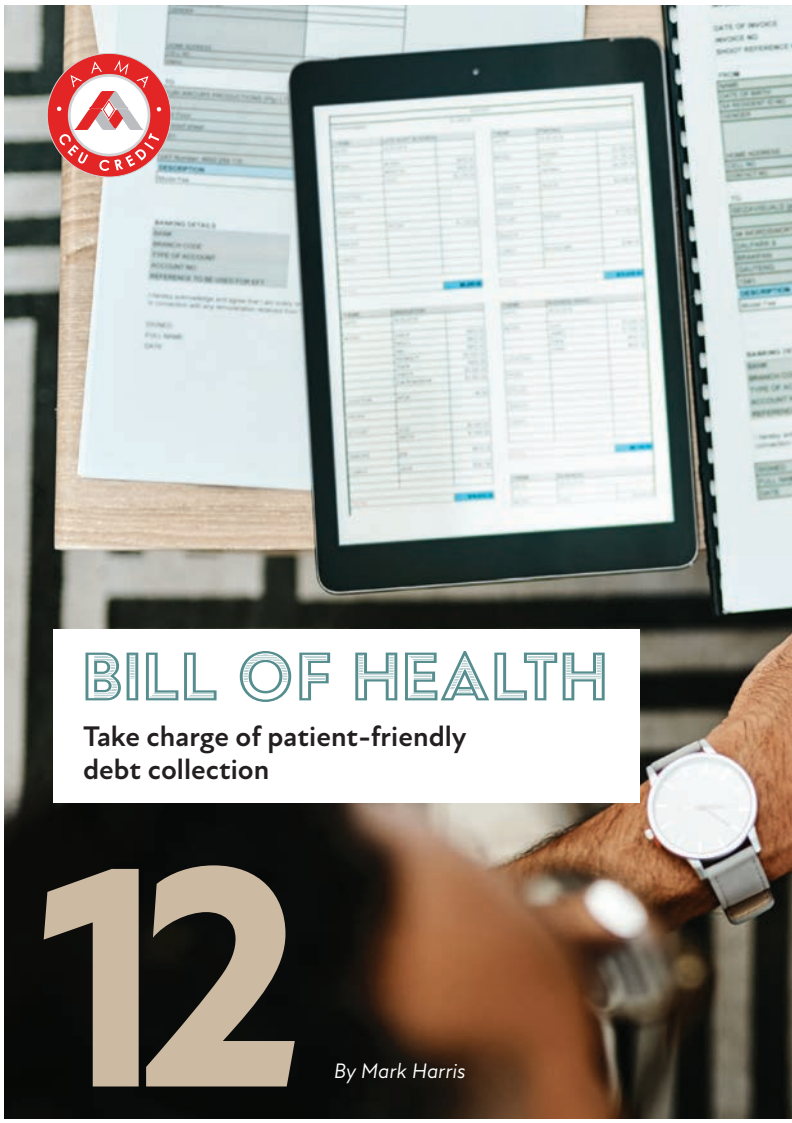

BILL OF HEALTH
Take charge of patient-friendly debt collection

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By Mark Harris

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AAMA update

Houston: We are a go!

The AAMA has been over the moon about medical assisting for 65 years! Celebrate with us at the 2021 AAMA Annual Conference. *(The conference will be held in person unless the AAMA determines that it is not in the best interest of the AAMA and its attendees to do so. See the AAMA's statement on the Conference webpage of the AAMA website.)*

The registration brochure for the 2021 AAMA Annual Conference will be posted to the website soon. Download the brochure to access a wealth of resources:

- **Stellar findings.** Check out conference hotel discounts and see if any information about the Lone Star State catches your eye.
- **Everything under the sun.** Pore over more than 20 continuing education opportunities.
- **Out-of-this-world opportunities.** Meet fellow members of the AAMA from all over the country; touch base with both new and familiar faces!

Plan now to attend conference this year and next:
Houston, Texas—Sept. 24–27, 2021
Minneapolis, Minnesota—Sept. 16–19, 2022

Official call for HOD representation

State societies are entitled to the following representation in the House of Delegates at the 2021 AAMA Annual Conference in Houston, Texas. The HOD convenes at 8 AM Saturday, Sept. 25, 2021, at the Westin Galleria Houston.

Ala.	3	Maine	3	N.M.	3
Alaska	3	Mass.	4	N.Y.	3
Ark.	2	Md.	3	Ohio	7
Calif.	4	Mich.	6	Okla.	3
Colo.	3	Minn.	6	Ore.	5
Conn.	3	Miss.	2	Pa.	4
Fla.	5	Mo.	3	S.C.	4
Ga.	5	Mont.	3	S.D.	3
Hawaii	2	N.C.	9	Tenn.	3
Idaho	3	N.D.	2	Texas	3
Ill.	5	Neb.	3	Utah	3
Ind.	6	Nev.	2	Va.	3
Iowa	5	N.H.	3	Wash.	6
Ky.	3	N.J.	3	Wis.	8

Free 1-CEU course

The Center for the Application of Substance Abuse Technologies (CASAT) and the Medical Assistant Fetal Alcohol Spectrum Disorders Practice Improvement Collaborative (Medical Assistant FASD PIC) have created a new course worth an AAMA-approved CEU!

This recorded webinar, now an online course—*Alcohol and the Immune System: Another COVID-19 Risk Factor?*—examines the effect of alcohol on the immune system, particularly in the context of the COVID-19 pandemic. Take the course to learn how to identify excessive alcohol use and improve the delivery of messaging and intervention.

For a one-year period, this course is free! Worth 1 clinical/general CEU, the course is available online in the AAMA e-Learning Center. ✦

On the web

Legal perspectives on COVID-19 topics

Under News & Events/COVID-19 Updates

Read a collection of legal perspectives on COVID-19 topics from AAMA CEO and Legal Counsel Donald A. Balasa, JD, MBA, that were published on his blog *Legal Eye: On Medical Assisting* and in *CMA Today* as Public Affairs articles.

Shout out to employers

Under Employers/Employer Spotlight

Medical assistants are invaluable parts of the health care team; employers who recognize that fact deserve to be recognized in turn. Read the latest Employer Spotlight, then submit an Employer Spotlight suggestion for a worthy employer or institution via the Call for Employer Spotlights link in the sidebar.

Who's who?

Within the About section/Executive Office Staff

The AAMA has supported medical assistants for 65 years, and in that time, we've had the privilege to know some outstanding individuals. Now, in the spirit of strengthening connections, the newly published Executive Office Staff webpage puts names to the organization with a breakdown of all staff. ✦

2021 state conferences

Due to safety concerns associated with the COVID-19 pandemic for large in-person meetings, details about state society conferences are ever-changing. The AAMA will share available information on the State Society Conferences webpage (under the Continuing Education tab of the AAMA website) and via the AAMA Facebook page's events section.

AAMA members and other interested medical assistants—if your state is not listed, contact your state president for details. *(Updates will be posted to the AAMA website and Facebook page as received.)*

State society leaders—two ways to reach potential attendees are available:

1. Make sure we have your state conference information posted on the AAMA website. You can email us at MarCom@aama-ntl.org with questions and updated information, including links to registration information for your state meeting.
2. If you would like AAMA staff to share the event via the AAMA's Facebook page to broadcast the information to its 50,000+ followers, submit a Save-the-Date online form, accessible via the My Account section of the AAMA website *(must be signed in for access)*. ✦

Earn a program-level certificate in telemedicine!

The AAMA has launched *Topics in Telemedicine: Go the Distance with Remote Patient Care* to expand and advance the health care professional's knowledge and understanding of important aspects of—and medical assistants' role within—telemedicine.

To earn the certificate, individuals must complete the following three courses and pass a final assessment:

- Introduction to Telemedicine
- Telemedicine: Care Delivery and Patient Management
- Telemedicine: Documentation

The telemedicine courses are available to CMAs (AAMA)®, other medical assistants, and all other health care professionals. The courses can be taken together as part of the telemedicine program or individually for AAMA CEU credit. Only those who pass all three courses will receive a program-level certificate upon completion. The program, worth 4.5 administrative/general CEUs, is now available in the AAMA e-Learning Center. ✦

The 2021 Excel Awards!

The submission window for the 2021 Excel Awards will be open soon. Start gathering your submission materials to enter the competition honoring the achievement of excellence:

- **AAMA members.** Nominate a medical institution—big or small—that employs CMAs (AAMA) and is a strong supporter of professional growth, particularly in the areas of certification and recertification, continuing education, and membership.
- **State leaders.** Enter your state publication, website, marketing campaign, or community service effort for recognition. And remember to nominate exemplary national leaders for one of the three Awards of Distinction.
- **Students from CAAHEP-accredited programs.** Craft an essay answering this question: "After obtaining your CMA (AAMA) credential, how will you promote the credential and the medical assisting profession and how will you help patients navigate through telehealth and new technology?" Enter for a chance to win $1,000.

Visit the Excel Awards webpage to read the details on required submission materials. Entry forms will be available for download soon. Entries must be postmarked or emailed by July 1. ✦

Federal policy and the pandemic

How the pandemic and changes in federal policy have expanded medical assistants' scope of practice

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

The COVID-19 pandemic has proven to be a catastrophic public health crisis. Medical assistants, as well as all other health professionals, have been impacted in unanticipated and unprecedented ways. In the early days of the pandemic, pronouncements by federal agencies and executive orders by state governors expanded medical assistants' legal scope of practice. When the long-awaited vaccines were made available, legal barriers to medical assistants administering vaccinations were largely removed. This article will discuss these government actions and how they have changed—perhaps permanently—the knowledge, skills, and professional attributes and behaviors medical assistants are now expected to have and to demonstrate.

Telehealth

Centers for Disease Control and Prevention

In a June 10, 2020, guidance[1] on how to expand access to health care during the COVID-19 pandemic, the Centers for Disease Control and Prevention (CDC) affirmed that medical assistants and other health care professionals are permitted to interact with patients by several means. Note the following from this CDC guidance:

> **Telehealth Modalities**
>
> Several telehealth modalities allow HCP [health care personnel] and patients to connect using technology to deliver health care:
>
> - **Synchronous:** This includes real-time telephone or live audio-video interaction typically with a patient using a smartphone, tablet, or computer.
> - In some cases, peripheral medical equipment (e.g., digital stethoscopes, otoscopes, ultrasounds) can be used by another HCP (e.g., nurse, *medical assistant* [italics added]) physically with the patient, while the consulting medical provider conducts a remote evaluation.[1]

Nasopharyngeal swabbing

Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) published an interim final rule with comment period in the April 6, 2020, *Federal Register*.[2] Its language supports the legal position that medical assistants are permitted to perform nasopharyngeal swabbing to test for COVID-19. Note the following excerpts from this CMS rule:

> Even if the patient is confined to the home because of a suspected diagnosis of an infectious disease as part of a pandemic event … a nasal or throat culture … could be obtained by an appropriately-trained [*sic*] *medical assistant* or laboratory technician. …
>
> Services furnished by auxiliary personnel (such as nurses, *medical assistants*, or other clinical personnel acting under the supervision of the [rural health clinic] or [federally qualified health center] practitioner) are considered to be incident to the visit and are included in the per-visit payment. [Italics added.][2]

New York

The New York State Board for Medicine has taken the position that physicians may not delegate certain invasive procedures to unlicensed allied health professionals such as medical assistants. In response to the early crisis period of the COVID-19 pandemic, New York Governor Andrew Cuomo declared a state disaster emergency that included the following provision:

> I hereby temporarily suspend or modify … the following: …
>
> Sections 6521 and 6902 of the Education Law, to the extent necessary to permit unlicensed individuals, upon completion of training deemed adequate by the Commissioner of Health, to collect throat or nasopharyngeal swab specimens from individuals suspected of being infected by COVID-19, for purposes of testing; and to the extent necessary to permit non-nursing staff, upon completion of training deemed adequate by the Commissioner of Health, to perform tasks, under the supervision of a nurse, otherwise limited to the scope of practice of a licensed or registered nurse;[3]

Administration of COVID-19 vaccinations

CDC

When the administration of COVID-19 vaccinations was beginning in the United States, the CDC published *COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations*.[4] The purpose of this publication is to assist state and local public health programs "to plan and operationalize a vaccination response to COVID-19 within their jurisdictions."[4] Note the reference to medical assistants as "vaccinators":

> Verify COVID-19 vaccination providers have active, valid licensure/credentials to possess and administer vaccine. This licensure verification is needed only for those with prescribing authority (e.g., [doctor of medicine (MD), doctor of osteopathic medi-

cine (DO), registered pharmacist (RPh), nurse practitioner (NP), physician assistant (PA)]) who will oversee COVID-19 vaccine administration. Credential verification is not required for *vaccinators* who work under the authority of someone with a higher level of licensure (i.e., not required for pharmacy [technicians]/interns, RNs [registered nurses], LPNs [licensed practical nurses], *medical assistants*, etc.) [italics added].[4]

National Council of State Boards of Nursing

In its December 15, 2020, policy brief, the National Council of State Boards of Nursing (NCSBN) stated that knowledgeable and competent certified medical assistants may be delegated COVID-19 vaccine administration:

> Waivers by the [state or territorial] governor or [board of nursing] may be necessary to authorize an RN or LPN/VN [licensed practical nurse and licensed vocational nurse] to delegate vaccine administration to *certified medical assistants*, medication aides, and emergency medical technicians/paramedics that have been trained in COVID-19 informed consent, vaccine administration, COVID-19 vaccine side effects, emergency management of adverse reactions and the principles of reconstitution and proper storage [italics added].[5]

Tennessee

As demand for allied health professionals to administer the COVID-19 vaccines increased rapidly, state governors issued executive orders waiving certain elements of their state law to enable knowledgeable and competent medical assistants to be delegated, and to administer, COVID-19 vaccinations. For example, on December 4, 2020, Tennessee governor Bill Lee issued Executive Order No. 68.[6]

In part, this order authorizes "medical assistants certified by the American Association of Medical Assistants [to be delegated] tasks that would normally be within the practical nurse scope of practice, including, but not limited to, administration of COVID-19 vaccinations."[6] Tasks delegable to certified medical assistants "are required to have been ordered and authorized by a Tennessee licensed practitioner with prescriptive authority" and "performed under the supervision of the delegating registered nurse."[6]

The authority of physicians to delegate directly to medical assistants the administration of COVID-19 vaccinations is addressed in other provisions of Tennessee law.

Washington

Also, state departments of health have clarified (as necessary) the fact that COVID-19 vaccinations may be delegated to, and may be administered by, knowledgeable and competent medical assistants. For example, the Washington State Department of Health published a list of health professionals permitted to administer the COVID-19 vaccine under licensed provider authority and supervision. Note the following:

> Medical assistant-certified
>
> Can administer vaccine(s)? Yes
>
> Requires supervision? Yes
>
> Task must be delegated by a provider with the activity in their scope of practice: MD/DO, RN, ARNP [advanced registered nurse practitioner], Naturopathic Physician, PA/DOPA [osteopathic physician assistant]. The requirements for the supervising health care practitioner to be physically present and immediately available in the facility are waived under Governor Inslee's Proclamation 20-32. The supervisor only has to be immediately available, which may be by remote means.[7] ✦

Questions may be directed to AAMA CEO and Legal Counsel Donald A. Balasa, JD, MBA, at DBalasa@aama-ntl.org.

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Into the unknown

Demystify fibromyalgia

By Kathryn Taylor

Fibromyalgia is a chronic, nonfatal pain disorder[1] that most often causes pain in muscles, ligaments, and tendons. Affecting 2% to 4% percent of the U.S. population,[2] fibromyalgia is often accompanied by fatigue, sleep issues, and *fibro fog*, a term that encompasses difficulties with focus, memory, judgment, and performance of straightforward mental tasks.[1] Memory and thinking symptoms may fluctuate but are more common with increased stress and fatigue levels.[1]

Researchers hypothesize that people with fibromyalgia have stronger reactions than others to pressure, heat, sound, and light because their central nervous systems experience pain signals more acutely,[1] resulting in amplified pain.

The pain event

The cause of fibromyalgia is unknown, but researchers speculate that certain events may contribute to the disorder[3]:

- Stressful or traumatic events
- Repetitive injuries
- Illness
- Certain diseases

Researchers are also exploring potential connections to sleep issues; stress; and immune, endocrine, and biochemical problems.[2] Those with autoimmune diseases are predisposed to developing fibromyalgia,[1] which also seems to run in families.[3]

Symptoms usually become evident in adults between the ages of 30 and 55, although they can appear in children, particularly adolescent girls.[1] Women are more likely than men to develop fibromyalgia.[3]

The phantom menace

"There's no single laboratory test or diagnostic test that will confirm that [fibromyalgia is] what people have," says Charles Kodner, MD, a physician in Louisville, Kentucky, and author of a review on fibromyalgia published in *American Family Physician*. "One of the biggest frustrations that people might have … is that there's never any way to be absolutely sure that someone has fibromyalgia. It's a constellation of symptoms."

In the past, the tender point examination was typically used to diagnose fibromyalgia. For this test, physicians would press firmly on 18 particular points[1] on a person's body to see which were painful.[4]

More recently, the American College of Rheumatology updated its diagnostic criteria for fibromyalgia to include widespread pain for a minimum of three months in at least four of five areas of the body[4]:

- Left upper region
- Right upper region
- Left lower region
- Right lower region
- Axial region

The upper regions include the shoulders, arms, and jaw, while the lower regions include the hips, buttocks, and legs. The axial region entails the neck, back, chest, and abdomen.[4]

Additionally, the widespread pain index (WPI) lists 19 areas of the body where those with fibromyalgia are likely to experience pain or tenderness.[1] The symptom severity (SS) score uses a scale of zero to 3 to rate symptoms[1]:

- Fatigue
- Sleep patterns
- Problems with memory, thinking, focusing, and problem-solving
- Physical symptoms (e.g., headache, numbness, and bowel issues)

"I separate tolerance and perception when I talk to people," says Brett Smith, DO, a rheumatologist at Blount Memorial Hospital in Alcoa, Tennessee. "Tolerance is your psychological [ability to cope] with any degree of pain, whether you smash your hand with a hammer or you stub your toe. … [Increased] pain perception means that you *do* feel more pain than somebody [else with] a lower stimuli level."

Much of a fibromyalgia diagnosis involves ruling out other conditions first, many of which are metabolic and autoimmune issues, according to Dr. Smith.

For example, X-rays or blood tests (e.g., complete blood count or thyroid function

tests) can help rule out other conditions with similar symptoms.[1,4]

Growing pains

Whether a causal relationship exists between fibromyalgia and certain comorbidities is unclear, but several documented concurrent issues are possible[1]:

- **Restless legs syndrome,** which may be related to sleep difficulties.
- **Depression or chronic anxiety,** which can worsen pain and fatigue associated with fibromyalgia. Patients with fibromyalgia are 20% more likely to have depression or chronic anxiety.
- **Migraines and headaches,** including tension headaches and pain in the face and jaw.
- **Pelvic pain,** particularly endometriosis (a condition in which endometrial tissue grows outside of the uterus, potentially causing painful and irregular menstrual cycles).
- **Somatization syndrome,** which involves extreme anxiety about a physical symptom and may lead to emotional distress and difficulties functioning.
- **Overactive bladder,** a condition that causes frequent urination.
- **Irritable bowel syndrome,** a greater risk for people with fibromyalgia that may cause bloating, stomach pain, and cramping.

Painstaking care

No cure is currently available for fibromyalgia.[1] Still, patients can find relief through treatment. Managing the pain and accompanying symptoms typically involves a mix of medications and self-care.[4] Understanding triggers and learning to manage them can be a helpful first step.[1]

Dr. Smith treats both adult and pediatric patients with fibromyalgia. One morning a week, he teams up with a pediatric psychologist who specializes in pain to address both physical and mental aspects of pain management. They hope to add a physical therapist to their team so that they can offer desensitization treatment—which Dr. Smith finds particularly effective in treating fibromyalgia—to their therapeutic arsenal.

Useful medications include over-the-counter pain relievers, such as acetaminophen (Tylenol), ibuprofen (Advil), or naproxen sodium (Aleve).[4] Three medications approved specifically to ease fibromyalgia symptoms include pregabalin (Lyrica), which targets the brain chemicals regulating the degree of pain one feels, and duloxetine (Cymbalta) and milnacipran (Savella), which control the quantities of pain-controlling chemicals in the brain.[1] Overall, certain antidepressants, anti-seizure medicines,[4] anti-inflammatories, and sleep medicines can help with the pain, sleep, and mood disorders associated with fibromyalgia.[1]

Additionally, therapy can be an effective tool for managing symptoms. Physical therapy can help improve strength, flexibility, and stamina, while occupational therapy helps to reduce stress to the body. Counseling can help patients deal with the stress and other effects of fibromyalgia.[4]

Stress-management is also key, as is eating well, maintaining good sleep habits, and exercising regularly.[4]

"One of the most beneficial things that [fibromyalgia patients] can do is get some form of regular exercise," says Dr. Kodner. Still, patients' fatigue and pain may make them resistant to following through. "I try to get them to recognize that even though it hurts [to move more], there's nothing that's broken in their body." Patients should add exercises to their lifestyles gradually—and pace themselves—to decrease fibromyalgia symptoms.[4]

"Fibromyalgia is a real biological illness," affirms Dr. Kodner. "We can't measure it, [and] we can't point to an imaging study, but it clearly is a biological abnormality. I think reassuring patients that they really do have an illness … is very important." ✦

Inside story

Rebecca Belt, CMA (AAMA), was diagnosed with fibromyalgia more than 20 years ago. As a medical assistant, Belt had suspicions that she had fibromyalgia when she started to experience fatigue and widespread pain.

Belt's fibromyalgia presents as a constant dull, aching pain in the joints and muscles all over her body. Her other chief concern is fatigue. "I often wake up tired, even after getting a good night's rest," she says. "However, my sleep is often disrupted by pain."

Belt observes that symptoms are inconsistent: "My fibromyalgia pain comes and goes, and the intensity varies." She notes that the weather seems to affect her symptoms.

"In the beginning, I struggled to find a rheumatologist that I could trust, who was empathetic, skilled, respectful, and knowledgeable," she recalls.

Support has also come from a familiar source. "Medical assistants have been very helpful to me as a patient with fibromyalgia," she says. "They have been my direct line of communication with my rheumatologist."

After trial and error, Belt has discovered that the best treatments for her are celecoxib (Celebrex), tramadol (Ultram), or both, in addition to stress management and lifestyle changes. Belt embraces a multifaceted approach: "Other ways I cope with my diagnosis include exercising regularly, eating healthy, and having a sense of humor."

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U.S. dietary guidelines updates

Every five years, the U.S. Department of Agriculture and the U.S. Department of Health and Human Services release guidelines targeted toward improving the health of the U.S. population. In the most recent version, *Dietary Guidelines for Americans, 2020-2025*, many recommendations remain unchanged, with several notable exceptions, notes Everyday Health:

- Promotes the idea that anyone can benefit from healthy dietary changes, regardless of health status
- Emphasizes building long-term patterns of healthy eating rather than focusing on individual foods
- Identifies targeted health strategies across all age groups, including toddlers and infants

Read *Dietary Guidelines for Americans 2020–2025* for details. Ultimately, the guidelines are meant to provide a framework for making healthy choices rather than create a strict set of rules. The organizations behind the guidebook emphasize that it is meant to be customized and adapted to individuals' preferences, cultures, and budgets. ✦

Knowledge gaps in migraine management

Of the 39 million U.S. citizens who have migraines, more than 70% are women, according to the Migraine Research Foundation. Despite that, a recent study published in *Headache* has identified significant knowledge gaps regarding migraine management among women's health providers.

A survey of 115 women's health care providers found that while 82% of participants felt at least somewhat comfortable diagnosing a migraine, only 58% routinely asked patients about headaches and just 38% had received headache and migraine education. Nevertheless, nearly all respondents indicated interest in further education about migraine prevention, treatment, migraine-associated disability, and diagnostic testing.

Authors of the study infer that women's health care providers generally recognize migraine prevalence but would benefit from headache-specific education. ✦

Prioritize the care of health care professionals

Throughout the COVID-19 pandemic, professionals on the front line of health care are working in new ways and adapting to a constantly evolving situation, all while maintaining their own physical and mental health. Thus, health systems and organizations must ensure health care team members are receiving the support they need.

To back this goal, the American Medical Association has published suggestions and strategies for leadership:

- Conduct surveys to assess the impact of the COVID-19 pandemic on health care professionals and use results to develop solutions.
- Redistribute workloads as needed.
- Instate helpful institutional policies (e.g., eliminate out-of-pocket expenses for COVID-19 related illness and provide access to health services).
- Connect employees with resources to make sure they are able to meet their childcare and pet care needs.
- Provide staff with appropriate personal protective equipment.
- Attend to mental health needs (e.g., create a system for providing emotional support and make health resources readily available).

Look ahead for mental health

Lockdowns or periods of isolation can negatively affect emotional well-being. To learn how to best improve mental health, the University of Surrey recently conducted a study to determine which strategies are most effective at combatting the emotional burden of lockdown during the COVID-19 pandemic.

Results published in the *Journal of Positive Psychology* found that participants who focused on the present (with gratitude) or future reported stronger feelings of social connectedness. Furthermore, those in the best-possible-self group (i.e., those who pictured themselves after the lockdowns) reported the most positive feelings after the exercise. ✦

Behavioral strategies for reducing blood pressure

The Mindfulness Center at Brown University is tackling hypertension head-on with a new program aimed at blending traditional blood pressure reduction strategies with behavioral science techniques, according to *Continuum*, a magazine of the Brown University School of Public Health.

In the study, participants underwent a nine-week Mindfulness-Based Blood Pressure Reduction program to determine if increased mindfulness would minimize the risk factors for high blood pressure. This was paired with antihypertensive medication as well as education about healthy habits to provide the subjects with a well-rounded approach to lowering blood pressure.

After one year, the participants showed both a reduction in blood pressure and, crucially, a significant improvement in self-regulation skills. Researchers also found that participants more closely followed the American Heart Association guidelines on salt and alcohol intake and exercise after the program. ✦

Disparities in telehealth use

Use of telehealth has increased during the COVID-19 pandemic. However, a study published in *JAMA Otolaryngology–Head & Neck Surgery* draws attention to noteworthy gaps in patient use. The study used self-reported and U.S. 2010 Census data from more than 1,000 patients receiving care from the otolaryngology department of an urban, tertiary care center.

Findings of the study highlight certain disparities that may help health care providers identify vulnerable patient populations that require focus:

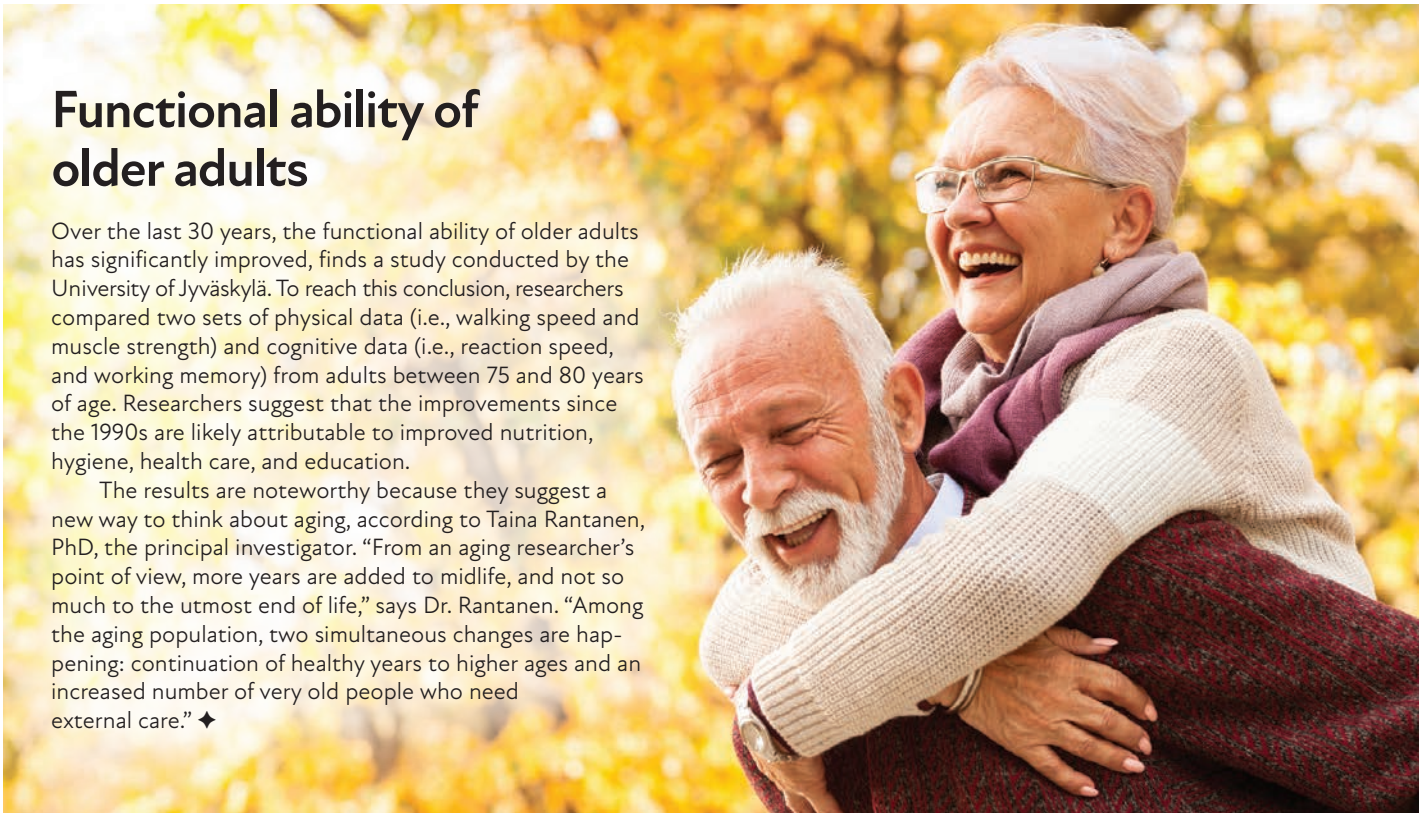
- Women and patients with preferred provider organization insurance were more likely to use telehealth.
- Increasing age and being in the lowest median household income quartile (i.e., one subset of a group of four subsets) were associated with a decreased likelihood of completing a virtual visit.
- Patients with Medicaid, other public insurance, or no insurance were more likely to complete a telephone visit.

The study's authors recommend that telehealth initiatives include patient education and training to foster patient access and acceptance.

Functional ability of older adults

Over the last 30 years, the functional ability of older adults has significantly improved, finds a study conducted by the University of Jyväskylä. To reach this conclusion, researchers compared two sets of physical data (i.e., walking speed and muscle strength) and cognitive data (i.e., reaction speed, and working memory) from adults between 75 and 80 years of age. Researchers suggest that the improvements since the 1990s are likely attributable to improved nutrition, hygiene, health care, and education.

The results are noteworthy because they suggest a new way to think about aging, according to Taina Rantanen, PhD, the principal investigator. "From an aging researcher's point of view, more years are added to midlife, and not so much to the utmost end of life," says Dr. Rantanen. "Among the aging population, two simultaneous changes are happening: continuation of healthy years to higher ages and an increased number of very old people who need external care." ✦

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BILL OF HEALTH

Take charge of patient-friendly debt collection

By Mark Harris

The U.S. health care system delivers some of the most modern medical care in the world. But health care in the United States is also expensive, and how people pay for health care is based on a complex payment and reimbursement system. Indeed, Americans pay for health care using a wide array of individual and employer-based commercial health plans; Medicare, Medicaid, and Veterans Affairs benefits; and direct out-of-pocket payments.

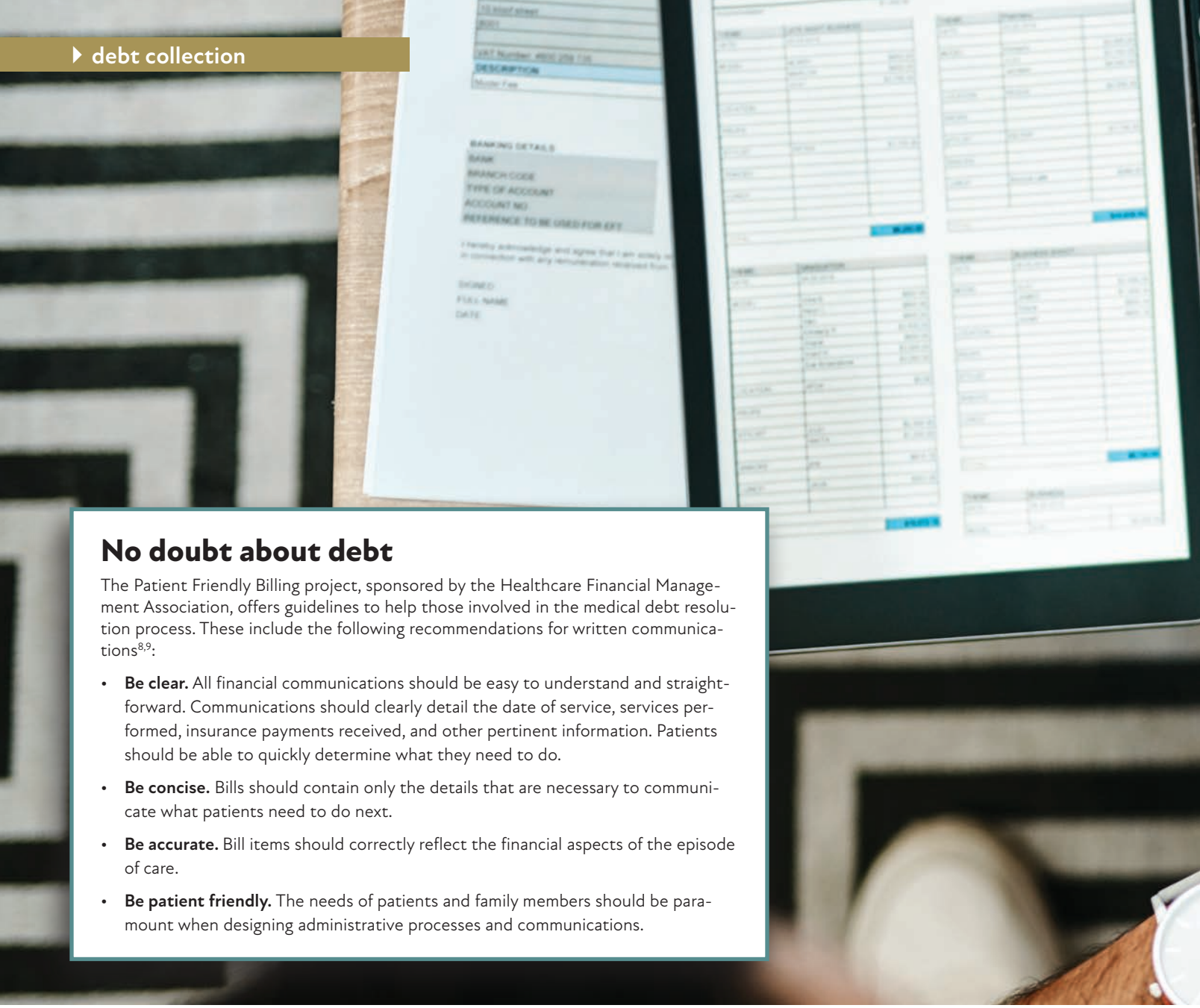
Insurance deductibles, coinsurance, and other out-of-pocket payments are rising, which makes paying for medical bills increasingly difficult for many patients. For instance, high-deductible health plans can require patients to pay thousands of dollars in deductibles before insurance even begins to cover many of their medical costs.[1] Coupled with steadily rising medical costs, many insured hospital patients are finding it difficult to pay their bills in full.[2]

If insured patients have trouble paying medical expenses, the issue is compounded for those without insurance. A 2019 report in the *American Journal of Public Health* says 29 million U.S. Americans were uninsured, despite efforts to lower the number of uninsured people with the Patient Protection and Affordable Care Act.[3] Further, more than 250,000 private GoFundMe medical campaigns were recorded in 2018, one potential indicator of the significant impact of medical debt.[3] Another indicator is that medical debts are often cited as a major reason for bankruptcy filings.[3]

To make matters worse, the COVID-19 pandemic is likely adding to these financial burdens, as the impact of lost or furloughed jobs with accompanying health benefit losses is now felt by many individuals and families.[4]

A consequence of these financial trends and pressures is that many medical practices must devote more time and resources to collecting outstanding patient balances. For this reason, health care providers must maintain efficient billing and collections systems, including practice policies and procedures to mitigate the financial impact of uncollected patient debts.

While staff members need to be well versed in collections policies and procedures, they should also know how to work with patients to resolve debt issues. Ideally, the goal of collections should be to find solutions for issues with uncollected patient debts in a manner that is fair to both patients and



No doubt about debt

The Patient Friendly Billing project, sponsored by the Healthcare Financial Management Association, offers guidelines to help those involved in the medical debt resolution process. These include the following recommendations for written communications[8,9]:

- **Be clear.** All financial communications should be easy to understand and straightforward. Communications should clearly detail the date of service, services performed, insurance payments received, and other pertinent information. Patients should be able to quickly determine what they need to do.
- **Be concise.** Bills should contain only the details that are necessary to communicate what patients need to do next.
- **Be accurate.** Bill items should correctly reflect the financial aspects of the episode of care.
- **Be patient friendly.** The needs of patients and family members should be paramount when designing administrative processes and communications.

practices and conducive to the core patient care mission.

Dollars and sense

How should medical practices approach the many challenges involved in managing debt collection? First of all, health care providers must communicate clearly with patients about their practice's financial policies. When patients register with a provider, they should have a basic understanding of the financial policies and responsibilities associated with their care. The better informed that patients are about the costs of care, the better equipped they can be to resolve debts or billing issues that may arise with their accounts.

"In my view, practices always need to be very up-front with patients about their billing practices," says Lorraine Coughlin, CEO of LMC Medical Claims Management in West Palm Beach, Florida. "They need to always verify the patient's insurance and make sure the patient understands and is comfortable with what the front desk is telling them. To avoid any surprises, for example, the provider should have it posted that the co-pay or any out-of-pocket expense is collected up front. Tell the patients when you call to verify their appointment that you will be collecting their co-pay at the appointment."

Indeed, as Coughlin suggests, when it comes to reducing the impact of unpaid balances, collecting co-pays at the time of service should be considered a key best practice. Many experts share this view. "In my opinion, [when] practices don't collect co-pays up front and just wait to send the patient a statement, frankly, it's just unwise," says David J. Zetter, PHR, CPC, founder and senior consultant with Zetter HealthCare in Mechanicsburg, Pennsylvania. "That is all old school; it's you constantly chasing your revenue. ... Unfortunately, once the patient

leaves the office, the chances of collecting money owed can decline dramatically."

Instead, Zetter recommends that medical practices update their approach to avoid—or reduce as much as possible—the need to pursue out-of-pocket charges for services already rendered. As he explains, "Typically, the practice will collect the patient's demographics during their appointment; [staff members are] verifying insurance, eligibility of benefits, and so on—and then billing [patients'] insurance. Now, all of a sudden, [the medical practice has] also got a patient balance. The billing staff or a billing company now has to follow up with that patient and try to collect that money."

This can involve spending time and resources sending repeated billing statements or making other attempts to contact patients. "Now you've got staff members phoning patients during business hours, when patients are probably not home, and leaving messages that are often not returned," notes Zetter, who is also president of the National Society of Certified Healthcare Business Consultants. "Some patients will call you back and pay on an invoice or statement, but most do not. And so, you keep having to follow up."

To avoid time spent later chasing revenue, experts agree the collections process should begin with the practice's first interaction with the patient. "You should start your collections process when you're scheduling the patient," says Doral Jacobsen, MBA, FACMPE, a managing consultant with the Medical Group Management Association. "That means when you're on the phone making the appointment. Successful practices understand the insurance; they verify the insurance. They understand if the person has a high deductible. They're having a financial discussion with the patient at the time they're scheduling."

Jacobsen notes that one barrier to

"There are a variety of time-of-service collections webinars, collecting patient liability webinars, and other helpful resources available for staff training. My recommendation is not to just put out an edict for everyone on staff to watch a training video but to do [training] together so you can ask questions and have a discussion. Maybe you can even dive into some role-playing to broaden the discussion. In my view, practices that do very well have an ongoing dialogue on these issues. They're understanding what's getting in the way of doing a good job collecting. These discussions can be a catalyst for some very critical conversations that can help position a practice to do well."
—Doral Jacobsen, MBA, FACMPE

collecting account balances post-visit is that insurance carriers send explanations of benefits to patients that are complex. "Many patients don't really understand what to pay," says Jacobsen, a founding partner of Prosper Beyond, a health care consulting group in Asheville, North Carolina. "When the patient's in front of you, you have a chance to explain what the balance is for. We find that most patients are willing to pay; they just want to know why."

Notably, the American Medical Association also recommends that medical practices try to collect whatever amounts are due from patients at the time of service (or point of care). The American Medical Association explains that the benefits of doing so include

> reducing accounts receivable, increasing cash flow, reducing medical billing and back-end collection costs, decreasing the administrative burdens of tracking and writing off bad patient debt, and managing the growing portion of practice revenue generated from patient payments. All of these factors can help a practice maintain or improve its financial viability.[5]

A credit to the practice

For medical practices, modernizing debt collections involves taking a more preemptive approach to managing out-of-pocket costs. This might include asking patients to establish payment accounts with the practice, for example. "Instead of a staff member calling people about their account balances, make that staff person what I would call a *patient financial counselor*," says Zetter. "This should be the first person the patient talks to after they've made their appointment, either on the phone or before their appointment. The financial counselor can make sure the patient understands what the policies are at the practice. They can also talk to the patient about setting up an account with authorizations for payments, either with an active credit card on file or an ACH [Automated Clearing House] draft from their checking account."

An ACH is a financial network used for electronic funds transfers, or *direct payments* as they are also known. With credit or bank authorizations, medical practices must follow any applicable legal compliance requirements to protect patient financial security.[6]

"You shouldn't document the patient's entire credit card number, for example—only the last four digits to identify which card the patient is using," cautions Zetter. "The full number will go into the merchant services system. You don't want a piece of paper filed away in a filing cabinet where the patient's information and identity could be stolen. You want only the bank holding on to that information."

Jacobsen is also enthusiastic about the idea of having an assigned patient financial counselor in the medical practice. "If you're big enough as a practice, you can have someone in that role," she says. She notes that a patient financial counselor can be especially helpful when patients need counseling on paying large balances.

"A patient financial counselor can help the patient understand what's creating a financial liability and work with them to find the solution," says Jacobsen. "There are medical credit cards available, for example. There are payment plans that can be established. There are a lot of things that can be done."

Calm, cool, and collected

In a sense, the concept of an assigned patient financial counselor speaks to the challenge of finding ways to resolve uncollected debts without diminishing patient satisfaction with the provider. In Jacobsen's view, the key to success comes from understanding the patient's needs and working toward solutions together. In turn, this means encouraging communication and engagement with patients on all aspects of their care.

At times this might involve turning to creative or flexible financial solutions. But solutions always start with communication. "If a patient is not paying their balance, I think it's important to ask the right questions," advises Jacobsen. "Sometimes there are catastrophic things that happen to people—[such as a] divorce or perhaps enormous medical bills—that have put them in a situation that's unusual. Maybe they've been your patient for 10 years. And now, all of a sudden, they're not paying the bill. In those cases, it's helpful to have a financial plan through which you could provide some sort of discount, forgiveness, or other solution based on some defined criteria. That's a best practice that I think is very reasonable. It can also help the collections staff to know you can work with patients in this way, to really help serve your population as you would want for yourself or a [loved one]."

To enhance collection at the time of service, Jacobsen recommends ensuring administrative or collections staff have the proper training. "I think a lot of times we overlook this issue," she says. "The check-in and check-out staff don't always have the right words or phrasing to do a good job collecting at the time of service. If a person has a balance of $500, for example, what staff will often do is ask, 'What can you pay?' [In my opinion,] that is not how it should go. What they should be saying is, 'Your responsibility today is $500.' If the patient says they can't pay that much, then

the conversation should shift to something like, 'Well, how much are you short today?' Unfortunately, if staff get intimidated by a patient and don't really understand why there's a balance, [they may] just let that patient walk out of the practice."

Accordingly, staff members should be supported by clear financial policies and procedures, which they can use to comfortably manage any patient encounter. "You have to give the staff the script and the tools," says Jacobsen. For example, she suggests providing instructions on making payment arrangements and referring the patient to the front office lead, administrator, or clinical supervisor. "Staff should feel comfortable that they have the support of the practice. I find that [the process] falls apart when they don't. What can happen then is they'll default to 'we'll send you a bill,' which is not helpful."

While patient financial counselors or other staff members need to be knowledgeable in explaining practice financial policies, they must also have the right set of interpersonal skills for the position. "You need to have somebody in this role who can be empathetic and sympathetic with the patient," says Zetter. "They need to know how to communicate with people. Of course, you've also got to fully train that person. They need to know the rules, policies, and procedures, and they need to be organized. But the main thing is they need to have the soft skills to be able to communicate with patients."

Asking price

As noted, many industry experts consider the issue of collecting co-pays central to reducing the uncollected patient debt burden on medical practices. This viewpoint is shared by Tammy Newman, CMA (AAMA), PMAC, practice manager for the Medical Foot Center and Spokane Surgery Center in Spokane Valley, Washington. Notably, the Spokane area medical center has found one way to further incentivize time-of-service collection. "We always verify every patient's insurance, and if we see a co-pay, we will collect it at the time of the visit," says Newman. "That's first and foremost. If the patient won't pay the co-pay at the appointment, we will also charge another $15 in order to bill them for the co-pay."

The co-pay billing charge was a response to how many co-pays were not being paid at appointments, explains Newman. In effect for almost two years now, the surcharge policy has significantly reduced the number of unpaid co-pays. "I would say about 90% of the people who owe co-pays now pay them at the visit," Newman reports. "Before, we were probably sending out 100 statements a month just for co-pays. Now, we're down to about 150 billing statements a month, instead of 250."

Newman says the clinic will sometimes waive the $15 surcharge if the person calls in a timely fashion to pay the co-pay. She also notes the co-pay charge policy has become standard among many medical practices in the Spokane region.

Of course, because surgical procedures often involve larger bills than most practice visits, surgery centers will often offer extended payment plan options that allow patients to pay off charges within a few months. Newman reports many surgery centers in the Spokane region will estimate what a surgical procedure is going to cost and collect 100% of the out-of-pocket estimate. Then, if the final cost is more or less than the estimate, the patient will either get a bill or a refund.

"Our surgery policy is to collect 50% of the [estimated] amount for a surgical procedure," says Newman. "Ideally, it would be nice if patients could pay off their bill in full within four months. That's what we try to do. But if somebody has also been coming in for weekly appointments, sometimes their balance can get up to $10,000 fairly quickly. We will still ask them what would be a comfortable amount to pay every month. Our doctors have gone five years on an account. We don't like to do that, but they're more concerned about the patient's care than what they can pay at any given time. We'll actually take as little as $5 per month just to keep their account current." Monthly payment plans are set up as automatic payments with the patient's bank, explains Newman.

As practice manager, Newman says patient education on the financial aspects of their care is a practice priority. "We do a lot of educating from our front office," she says. "Our patient education starts with the person who does the scheduling. The staff person who does reminder calls for appointments will also inform patients about any co-pays they may have at the upcoming appointment. Our front desk person and I will also talk to patients about their finances. Generally, we find younger patients don't always understand co-pays or deductibles. Our front office will explain all this to them. Older people who are switching to Medicare Advantage plans may not understand when they go to a specialist they do have a co-pay, although they may not at their primary care clinic."

Checks and balances

As medical practice staff manage collections and debt responsibilities, managers

Money talks

The American Medical Association shares several tips on how to sharpen the payment management process[9]:

- **Offer multiple options.** Accommodate most patient preferences by offering flexibility in the method and delivery of payment. For example, online patient portals and waiting room kiosks can facilitate payment.
- **Practice kindness and courtesy.** Make sure staff members are trained in proper telephone etiquette, and remind them to treat others as they would want to be treated.
- **Be mindful of timing.** Avoid discussing financial issues when patients are in pain, anxious, or stressed—for example, the moments before a procedure.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and billing staff must stay informed and up to date on the health plans with which the practice contracts.

"Medical practices should fully understand their contracting and credentialing with insurers," says Coughlin. "This is a big concern. I think a lot of health care providers, especially the smaller providers, are not always aware of what their contracts state. Who are they credentialed with? What are their contracted rates? When posting payments, are they posting the proper payment? Are they being underpaid? Are insurers not paying in a timely way? Unfortunately, many providers don't always understand their contracts."

When patients have scheduled procedures, Coughlin recommends that medical practice staff be aware of any issues that could potentially affect the patient's out-of-pocket costs. For example, is a procedure scheduled at a free-standing facility or a facility affiliated with a hospital? The former usually costs less. Is the facility or the specialist referral in-network for the patient? Is the laboratory work in-network? How these questions are answered can affect the patient's co-pay and coinsurance costs.

While patients are ultimately responsible for understanding their health plan benefits, staff members' awareness of any plan rules associated with scheduling tests and procedures could help patients avoid potentially higher costs.

"If someone is going to have a surgical procedure, it can be nerve-racking for the patient," remarks Coughlin. "Understandably, they may not be thinking about all these other billing issues. Maybe there's an assistant surgeon or anesthesiologist involved in the procedure who is not in their network, which could mean they end up with surprise medical bills. This can seem so unfair to the patient. If staff members are educated about the health plan contracts—what the rules and requirements are—they can really help patients better understand how everything is going to [be paid]."

In turn, staff members should also ensure authorization requirements for tests, procedures, and referrals are met. "You don't want to end up having your claim denied because you didn't get the proper authorization," cautions Coughlin. "You really want to watch your claims and payments. ... Knowledge is power."

Wealth of info

Medical Group Management Association
https://www.mgma.com

National Society of Certified Healthcare Business Consultants
https://www.nschbc.org

Alliance of Claims Assistance Professionals
https://www.claims.org

Debt's all, folks!

A proactive approach toward managing debt collections can greatly reduce the need for medical practices to turn bad debts over to outside collection agencies. Unfortunately, that process can take perhaps 25% or 50% of the revenue owed, notes Zetter. "In my opinion, this is usually a waste of time and money. The agencies will often cherry-pick the really easy debts to collect and avoid the harder cases." These agencies are a resource of last resort and also largely unnecessary when an effective collections system is in place, concludes Zetter.

If a practice chooses to use an outside collection agency, selecting an agency with a reputation for fair treatment and adherence to legal guidelines is important. In fact, the Fair Debt Collection Practices Act protects consumers from abusive, unfair, and deceptive practices by debt collection companies.[7] "I would recommend a smaller, local collection agency rather than a big name-brand agency," says Newman. "We have found that our local area agency performs much better than some of the larger collection agencies. They also seem to be more caring with our patients."

To sum up, the most vital steps in the collections process usually occur less when debts are outstanding than at the very outset of the patient encounter. "With collections, the early bird gets the worm," concludes Jacobsen. "If you start early in your process, everything else should go a little better. If

> "We don't have a lot of patients who are dissatisfied with our financial policies. First, our doctors choose not to charge interest. When we're setting up a payment plan schedule with somebody that has a balance, we never say, 'We need you to pay $5 or $250 a month. Instead, we always try to work with our patients. We'll ask, 'What can you do?' Usually, it's a higher amount than what we might have suggested. I think the patients feel more in control this way."
> —Tammy Newman, CMA (AAMA), PMAC

you invest more time to understand what the potential liability could be and you're proactive and have discussions with patients in person as much as possible, as close to the visit or procedure as possible, your chances of collecting that patient liability will increase exponentially."

With strategies such as up-to-date practice management software systems, informed attention to contracted insurance requirements, payment plan options, and staff training in billing and payment rules, much can be done to minimize the impact of uncollected debt on medical practices.

For practice managers and staff members, knowing how to work tactfully with patients to address issues with uncollected medical debts can contribute greatly to the practice's overall financial fitness, while also maintaining a high level of patient satisfaction with the medical practice. ✦

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Debt collection

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T F

☐ ☐ 1. Providers setting up extended payment plans for patients violates federal and state credit laws.

☐ ☐ 2. Health insurance plans with high deductibles require patients to pay a large amount out of pocket before the insurance carrier begins to pay for the care.

☐ ☐ 3. Providers should offer patients various options for how they may pay for services received.

☐ ☐ 4. The Fair Debt Collection Practices Act forbids debt collection companies from engaging in deceptive or harassing behaviors when attempting to persuade patients to pay outstanding medical debts.

☐ ☐ 5. Collecting co-pays at the time that medical services are provided to patients is illegal.

☐ ☐ 6. To reduce the risk of a patient's credit card number being stolen, medical practices should keep only the first four digits of a credit card number on file.

☐ ☐ 7. Explanations of benefits sent to patients by health insurance carriers sometimes confuse patients, and that lack of understanding makes it more difficult for providers to collect amounts owed to them by patients.

☐ ☐ 8. Debt incurred to pay for health care is an uncommon cause of filing for bankruptcy because unpaid medical expenses are paid for under the Patient Protection and Affordable Care Act.

☐ ☐ 9. Electronic funds transfers are a means of sending direct payments from a patient's checking account to the provider's account.

☐ ☐ 10. When dealing with patients, collections staff in a provider's practice should prioritize being insistent and uncompromising rather than empathetic and willing to listen.

T F

☐ ☐ 11. Scheduling staff can sometimes save patients money by scheduling procedures at in-network facilities rather than out-of-network facilities.

☐ ☐ 12. The cost of medical care in the United States has decreased in recent years because of greater efficiencies in the health care market.

☐ ☐ 13. Charging patients a surcharge if they are unable to pay the co-pay amount at the time of service is an acceptable practice that may reduce unpaid co-pays.

☐ ☐ 14. Clear and honest communication with patients about payment policies, beginning when the initial appointment is made, is an essential element of good collection practices.

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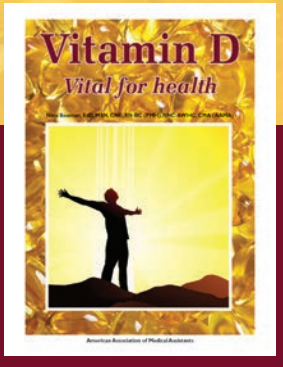

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Play today

Sometimes the research tells you exactly what you want to hear. That's the case for a recent article on the benefits of play in the *American Journal of Health Promotion*.

While the types of play can vary greatly—from creative writing to throwing a frisbee to attending a virtual social event with friends and coworkers—play has proven to have numerous cognitive benefits. Even for adults, play can aid in prefrontal cortex development, a region of the brain charged with higher-level thinking processes such as decision-making and tackling abstract concepts. Additionally, play spurs on nerve growth and encourages new neuron connections between areas of the brain. Play can also build skills such as adaptability, teamwork, creativity, and resiliency.

Take this as your reminder to play; do it for your health!

Snack to the future

After a night (or a few) of minimal sleep, reaching for a sugary snack to get an energizing sugar rush seems and feels right. But you'd be better off eating healthier alternatives for the energy you need, according to a study published in the *American Journal of Lifestyle Medicine* and reported by Stanford Medicine.

Researchers found that healthy diets (high in plant-based foods, low in saturated fat and added sugars) reduce the side effects of sleep deprivation. Additional research has found a similar tie between better nutrition and an improvement in cognitive function and sleep quality. By preventing adverse effects of poor sleep like brain fogginess, difficulty concentrating, and irritability, health care professionals who eat healthily could improve patient care, suggest researchers.

While forgoing the brief bout of energy that a sugary snack can provide is especially difficult while sleep deprived—after all, sleep deprivation impairs decision-making skills—you can make things easier for yourself by being proactive. Stock your pantry with healthy snacks and reduce the readily available snacks loaded with salt, sugar, and fat to not only push yourself toward the fuel you need but improve your sleep quality for days to come.

Pomegranate PUNCH

Orange you tired of the eating bananas and apples to meet your fruit goals? Try expanding your fruit repertoire with pomegranates. Beyond the traditional health benefits of fruits, pomegranates have plenty of advantages, according to *Foods*.

Below are just a few properties found from years of pomegranate research:

- Antioxidative
- Anti-inflammatory
- Antihypertensive
- Prebiotic
- Antimicrobial

Additional studies show promising research that pomegranate consumption may help with specific conditions, such as diabetes, osteoporosis, and Alzheimer disease. While the research continues, pomegranates can be a healthy and tasty addition to anyone's diet.

Golden-years goings-on

Tending to our brain health as we age involves more than a morning crossword puzzle. Social engagement may help older adults in the fight against dementia, according to one study from the University of Pittsburgh Graduate School of Public Health.

Researchers surveyed participants, who averaged 83 years in age, on their social activities such as volunteering, playing board games, and hanging out with friends and family. They then took brain scans of the participants to measure microstructural integrity in gray-matter areas linked to dementia. Results showed that those with higher social engagement scores also had greater gray-matter microstructural integrity, a sign of better brain health.

Even moderate social engagement can aid brain health. While this study was conducted before the COVID-19 pandemic, safe social engagement is possible and encouraged. Whether playing cards online with a friend, taking an online class, or hosting a family video chat, any day is a good day to buddy up for brain health. ✦

Minds matter

Many at-home strategies exist for maintaining mental health, but professional help can be a useful tool as well. While seeking help can be difficult, the National Institute of Mental Health provides suggestions for beginning a conversation about mental health with your physician:

- If you are unsure *whom* to talk to, start with your primary care provider. In addition to putting your mental health into context with your overall health, they can refer you to a specialist as needed.
- Before your visit, prepare by thinking of—and even writing down—family history, medications you're taking, and any questions you have. Consider bringing a family member or friend to provide emotional support and note-taking.
- During the appointment, make sure you ask all the questions you have about your diagnosis and treatment. If necessary, ask about other treatment options or seek a second medical opinion.
- Finally, make sure to be as honest as possible during your appointment. Accurate details about the type, severity, and onset of symptoms can help your physician make a more precise diagnosis.

Walk this way

Trudge past the same oak tree every day for the last month? Luckily, many paths are open for pepping up your steps routine, courtesy of *Harvard Health Letter*:

- **Shuffle play.** Blend other exercises into your walking. For example, start interval-training by adding in bursts of higher intensity to boost cardio. If strength training is more your speed, bring a resistance band along for the ride.
- **Step off the beaten path.** Nordic walking, which uses specialized walking poles, promotes a full-body workout and gives you the increased stability to vary your terrain. Hiking is another avenue for those who want to take in the great outdoors.
- **Slow down to find your stride.** Focus on your breathing to help quiet the mind. Take in the surrounding sights and sounds to help stay in the moment.
- **Walk and talk.** Bring a friend along and catch up while getting your steps in for the day. ✦

'Appy Medium

Mobile health solutions save time and improve care

By Pamela M. Schumacher, MS

Looking to streamline processes and improve efficiency in a medical practice? There are mobile health apps for that! An app is a piece of software that can run on not only smartphones but also other electronic devices, like computers and tablets. Mobile health or *mHealth* solutions are certain apps designed to improve patient care by helping practice managers prepare more accurate documents, complete records, improve productivity, access information, and communicate findings and treatments.

Patients, too, are increasingly turning to apps on their phones and tablets to access medical records, review clinical laboratory test results, manage chronic conditions, schedule appointments, and refill prescriptions. Many apps are free or offer free trials that provide a basic level of service. The U.S. Food and Drug Administration (FDA) defines these medical apps as mobile device software that functions as an accessory to a regulated medical device software or transforms a mobile platform into a regulated medical device.[1]

Practical app-lications

Many apps are available to make medical practice administrative procedures more efficient, such as scheduling and communication apps. The most useful ones reduce waiting time for patients, bridge the gap between practitioners and patients, and deliver services beyond appointment booking.

"Health-related apps can absolutely improve efficiencies," says William J. Gordon, MD, a physician at Brigham and Women's Hospital in Boston, Massachusetts. "For example, apps can help patients fill out previsit questionnaires, schedule a visit through a patient portal, or use secure messaging to alert them when it's time to enter the office during COVID-related restrictions."

Rebecca Diann Vermaat, CMA (AAMA), a practice manager at Riverwood Family Medicine in Grand Rapids, Michigan, agrees. "My practice uses Healow, which allows users to make appointments, view laboratory results, and manage medications," she says. "The convenience of using the apps is unmatched, and I don't feel that there is any difference in the level of care that is received by using the app versus an in-person interaction. In fact, using the app makes our practice more responsive to patient needs because patients can send us a message any time and they don't have to wait to call during office hours."

Scheduling and communication apps for practices often have free versions available with limited features[2]:

- **Acuity Schedule** automates bookings, cancellations, reminders, and payments. Although not designed specifically for medical practices, the app simplifies scheduling new and existing patients.
- **PracticeSuite** offers patient scheduling with an integrated billing and practice management system. Features include authorization utilization tracking, productivity reports, and a look-up function for *International Classification of Diseases, Tenth Revision* (*ICD-10*) and *Current Procedural Terminology* (*CPT*) codes.
- **SuperSaaS** integrates with existing websites to allow online appointment booking.

Tech talks

The most beneficial laboratory apps for a medical practice provide relevant, up-to-date information on reference values and inter-

pretation, causes for abnormal values, and laboratory unit conversions. Notably, laboratory apps *cannot* replace clinical judgment or patient interaction; they can, however, support clinical decision-making.

When selecting laboratory apps, practice managers should choose apps with significant informational and technical capabilites[3]:

- **Lab Values Medical Reference** contains three medical reference tools, including laboratory reference values, medical abbreviations, and medical prefixes and suffixes.
- **iLabsDDx** is an advanced laboratory interpretation tool designed to help guide clinicians with every step of abnormal laboratory results management.
- **Pocket Lab Values** can be used to look up clinical data and medical information and contains in-depth information for more than 320 common normal and abnormal laboratory values for a broad range of medical conditions.

Laboratory apps can provide instant access to laboratory results, which can be a double-edged sword. "One issue we've encountered is when patients use an app with a laboratory or an imaging facility and the results are released to the patient's health portal at the same time as [they are released to] our office," says Vermaat. "This can result in a lot of anxiety on the part of the patient until we're able to contact them."

'Appy campers and wallets

Medication costs can be a concern for patients, but some apps may provide solutions. *Consumer Reports* staff tested several such apps and recommends GoodRx and WeRx, which are both free and can be used with iOS. GoodRx is also compatible with Android.[4]

To provide assistance with other aspects of medication adherence, many national pharmacy chains have apps that allow providers to send prescriptions directly to the store location to fill or refill a prescription. For example, Walgreens, Walmart, CVS, and Rite Aid are easy to navigate and provide convenient features such as the ability to request refills or find nearby stores.[5]

Additionally, most insurance companies offer free apps that patients can download. Typically, these apps provide patients with benefits that make aspects of their health care easier to manage:

- Quick access to information (e.g., service coverage, coverage amounts, and in-network providers) through a single interface
- Online consultations
- Detailed instructions for what patients should do in the case of an incident
- Instructions for submitting a claim

Gotta hand it to 'em

Patients are seeking more control over how they access and track their health, and apps and other mobile health solutions help them achieve that goal.

Not only can health apps improve patients' visits and records, they can assist with care management for certain health issues. "Health apps are commonly used to assist patients in managing their chronic conditions," says Dr. Gordon. "For example, a patient with inflammatory bowel disease may track their daily symptoms using an app so that they have a reliable log of how they are feeling. If the patient agrees, this information can be shared with their health care provider. In addition, apps can track medication usage—whether a medication was tolerated and whether the patient responded to it."

Additionally, apps can provide much-needed support for telehealth. "During the COVID-19 pandemic, patient access to our patient portal and app enhances our ability to care for patients," says Vermaat. "We deployed the stand-alone service Doxy.me, which we implemented for televisits. While many services had to go virtual earlier in the year, we were able to stay connected with those patients who did not want to or couldn't come into the office, and our service level remained consistent." ✦

The lowdown on downloads

Mobile apps are worth investigating. "Apps can help patients take more responsibility for their health and enhance engagement with the practice," says Rebecca Diann Vermaat, CMA (AAMA).

One of the most common types of health apps used specifically by patients are healthy-living apps, which focus primarily on encouraging healthy behaviors, such as physical activity, smoking prevention, mental well-being, and healthy diets.[6] But health care professionals should take certain steps before recommending a healthy living app to patients[6]:

- Research the app ahead of time, paying attention to the description, user ratings, and reviews.
- Assess the app to make sure it is clear, simple, interesting, and engaging.
- Verify whether the information provided by the app is evidence-based and whether its sources are reliable.
- Test the app personally, focusing on the features, functionality, usability, and content accuracy.
- Ask patients about their experiences with the app after they have used it and seek feedback about the app's usefulness to inform future recommendations.

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ASSESS TO *impress*

Think critically about first impressions

By Brian Justice

A mere tenth of a second is all it takes to form an impression of someone based solely on their face, and that first impression is hard to shake.[1]

Making a strong first impression matters in education, when an educator must inspire confidence, excite expectations, and take the first step in establishing the culture of the classroom.

And while first impressions are often made in a moment, educators can set their classroom up for success by taking time to set the tone and establish expectations throughout the students' first day—and first week—of classes.

Hooked on a feeling

"Teaching can be hard. Creating a supportive and engaging learning environment can be even harder, but it doesn't have to be," says Tricia Nolfi, EdD, assistant professor and program director at Rider University in Lawrenceville, New Jersey. To create such environments, educators take certain steps on the first day. Dr. Nolfi suggests that establishing rapport is a good start.

"Before diving into the syllabus or discussing assignments, teachers need to ensure that there is clear understanding and connection with their students," Dr. Nolfi says. "Through rapport building, the teacher creates an environment in which students become intrinsically motivated to flourish and succeed."

The first step is simple: learn and use students' names as quickly as possible. After educators introduce themselves, students should have the opportunity to do the same.[2] Educators can write down and repeat names aloud to improve name recollection.[2]

Educators should also establish commonalities, recommends Nadine Larson, CMA (AAMA), who taught aspiring medical assistants at Somerset County Vocational and Technical Schools in Bridgewater, New Jersey.

"On the very first day, I liked to ask students why they were there and why they wanted to do this," she says. "Then, I would tell them about my journey to medical assisting and how I came to be where I am." She also finds value in sharing personal information about herself. For example, Larson would tell students that she established a successful career while raising two children.

Making personal connections right away can create better long-term understanding. "I want to know what makes my students tick. I frequently discuss my family and ask my students about their families and their friends," says Jennifer Pike, CMA (AAMA), a medical assisting clinical education coordinator at Forsyth Technical Community College in Kernersville, North Carolina. "My classroom is also multicultural, so I like to ask them about food and holiday traditions."

Teaching at first sight

Students may make assumptions about the course based on their initial impression of their educator. Learning those beliefs at the beginning of the course can help educators succeed.

Pike has students write a blog entry or post on a discussion board about their

expectations of her as an educator. "This has proven to be a powerful tool in helping me understand my students' needs and clarify my role," she says. "Often, what I thought would be a quick chat turned into an enlightening conversation. It has helped establish rules for [communicating with students] and a list of classroom expectations." Doing this assignment during the first week helps to quickly establish class principles, build rapport, and open a dialogue.

Ultimately, the syllabus is the most straightforward way to set expectations at the beginning of each course and serves as a valuable resource for students. "A class without boundaries creates chaos and confusion. When students' expectations for each class, laboratory, procedure, and task are clearly defined, everyone knows how they will be assessed," says Pike. "This promotes an environment of transparency and makes students less anxious," particularly when this information is shared up front.

Preparedness is key. "Students want and need structure," says Barbara Snyder, MEd, CMA (AAMA), medical assisting program director and practicum coordinator at Miller-Motte College in Wilmington, North Carolina. "When students are aware of what is expected, they are able to create their own plan for how to be successful."

Meeting of the minds

"I'm here to share my collective knowledge and experience, but I respect that my students have their own life experiences and knowledge in areas that I do not," says Aaron Emmel, PharmD, MHA, BCPS, founder and program director of Pharmacy Tech Scholar. "This helps build mutual respect and strengthen the student-teacher relationship." Vocalizing that principle—and encouraging students to contribute—on the first day of class can foster better relationships throughout the course.

Pike found a unique way to relate to her students' experience. "The landscape of medicine has changed so much in the 21 years since I first certified, and so has the [CMA (AAMA)®] Certification Exam," she says. When Pike transitioned from being a clinical medical assistant to an educator, she found that she was unable to answer students' questions about the exam because of those changes. So, she decided to experience the current process when she next recertified. "Sitting for the exam again allowed me to supply my students with credible information about what the experience is like now."

For Mary Murphy, CMA (AAMA), AHI(AMT), CPT, medical program coordinator at the College for Technical Education in Lexington, Kentucky, free-flowing communication and availability have been instrumental in establishing and maintaining a successful learning environment. While students are still developing their perception of the classroom, educators need to explicitly state their office hours and discussion policies.

"I have an open-floor policy in my classroom," Murphy says. "I don't believe in just lecturing, because students quickly become uninterested. I solicit my students' opinions, and when I incorporate my own clinical experience, it enhances their learning and excites them about their own futures." By emphasizing the classroom as a place for this type of dialogue during the first week, educators set the tone and create a model for discussions that students can emulate for the rest of the course.

First and lasting

While students may use first impressions to assess the course overall, educators can use those impressions to their advantage. By following best practices, educators can effectively model during the course's first week what students can expect in the days to come.

And, when educators define their classroom culture early on, students can attain better outcomes. "An engaging and supportive classroom creates a community by building connections while [students learn] how to be successful," says Dr. Nolfi. "When learners feel comfortable, they develop a sense of trust, making them willing to take risks that result in deeper engagement." ✦

First things first

Every situation that involves meeting people for the first time has its own particulars. But a few guidelines for creating a good first impression hold true for just about anyone, anytime, and anywhere[3]:

- **Game plan.** Educators can establish the classroom climate from the start, so decide what that climate is going to be and walk in ready to achieve it.
- **Dress for success.** Think about your attire down to the last detail—shoes, jewelry, watches, etc.—and the conclusions students will draw from them.
- **Say a lot without saying a word.** Consider your posture, gestures, handshake, and even walk. Though possibly uncomfortable, watching videos of yourself can be instructive on how you present yourself to others.
- **Fake it until you make it.** You cannot control the causes of a bad mood, but you can control how you move forward and act toward others. Improve your state of mind with upbeat music, entertaining podcasts, or funny videos.
- **Be interesting by being interested.** People can spot insincerity, even unconsciously. Find something relevant to ask people about and be genuinely interested in their answers.

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Go the extra mile

Medical assistant connects isolated patients with their families

By Cathy Cassata

After graduating from a medical assisting program and obtaining his CMA (AAMA)® certification in February 2020, Josh Lehrer, CMA (AAMA), got hired at Hunterdon Healthcare and began training at his practice site, Hunterdon Family Medicine at Philips-Barber.

"While externing, I knew the medical field was for me," says Lehrer.

And yet, at the end of March, he was furloughed due to the COVID-19 pandemic. Nearly a week later, he received an offer at the clinic's affiliated flagship hospital, Hunterdon Medical Center, to support patients during the COVID-19 pandemic. He accepted and immediately went to work. Dressed in personal protective equipment (PPE) and with a tablet computer in hand, Lehrer visited patients at their bedsides and facilitated virtual meetings with their families.

"Everything was up in the air because this [is] an evolving [situation]," says Lehrer. "We [have] to improvise a lot and be flexible."

He estimates that 80% of the patients he visited had contracted COVID-19.

"A significant number were intubated, on respirators, or receiving assistance through other life-support medical devices," states Lehrer. "A small minority did not have COVID-19. [Nevertheless], restrictions on visitors were still in place, so we wanted to do the best we could in connecting patients with their loved ones."

During his month at the hospital, he also trained two other CMAs (AAMA) in the role. His diligence, compassion, and tireless efforts earned him a Hunterdon Healthcare Hero Award, which included a gift card and chocolate treat.

"It was an honor to receive the award, and the experience is something I'll never forget. Getting to help people in any way possible during such a difficult and important time was rewarding," says Lehrer.

Even before getting the role at the hospital, he tried to use his medical assisting skills to help patients dealing with the pandemic by joining the Hunterdon County Medical Reserve Corps.

"I felt I could use my medical assisting skills in some capacity," explains Lehrer. "By the time they called, I was working at the hospital, but I was able to help once on one of my days off with a phone bank." When residents called to get tested or follow up about results, he helped direct them. He is also signed up to administer COVID-19 vaccinations.

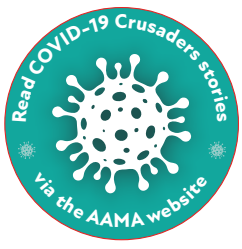
Additionally, Lehrer joined the Philadelphia Medical Reserve Corps. "On a Saturday in early October [2020], they held an influenza immunization drive-through clinic for first responders and families," recalls Lehrer. "I volunteered and was selected as a vaccinator to administer the shots."

His passion to help others goes deep. After obtaining a bachelor's degree in psychology in 2016, he volunteered with the organization City Year as an AmeriCorps academic coach to help students in an underserved community in San Antonio, Texas. He has also worked at a foster care community, a children's hospital, a residential treatment lodge for youth, and the lodge's affiliated psychiatric hospital.

Lehrer believes that the medical field is his true calling and plans to become a nurse practitioner (NP). In fact, before becoming a medical assistant, he was enrolled in an NP program at Vanderbilt University. "I felt I hadn't developed the right skills yet to pursue that further, so I left and decided to get my CMA (AAMA) [certification] first," says Lehrer. "I'm glad I did because I've learned so much and gained so much confidence in my clinical skills. I genuinely believe that what I've gained will help me as a nurse practitioner."

Lehrer is planning to enroll in an NP program at Emory University in Atlanta, Georgia, and is set to start in May 2021. Until then, he continues to work for Hunterdon Family Medicine and per diem for a pediatric urgent care network.

"I love kids, and we don't get to see as many children at Hunterdon Family Medicine. Working as a medical assistant in pediatric urgent care a few times a month is great," says Lehrer. "When I'm an NP, I hope to be able to work with kids as well as [other age groups]." ✦



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✓ **This form.** Number in order of preference *(1 being the highest)* the position(s) you seek to fill.

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✓ **Statement.** Include a brief assessment of your reasons for requesting the position(s) and your qualifications.

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(Note: Résumé not required for same position reappointments.)

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Preferred mailing address: _____

_____

City/State/ZIP: _____

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