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CMA℠ Today

A Hard Pill to Swallow

Prescription overuse is a recipe for antibiotic resistance

Aim high

Spring has long sprung into action: take the beautiful flowers everywhere as proof. And just like the flowers that grew despite tough conditions, we too have to face challenges head on and do what we need to do to grow—and move forward—in 2021.

I'm certainly looking forward to the 65th AAMA Annual Conference in Houston, Texas. Yes, they named the city after my husband, Sam Houston—just kidding! I can hardly wait to see all of you, whether you're attending to represent your states as delegates or to earn CEUs. Nor can I hardly wait to experience your smiling faces, hugs, and the joy of attending our national conference.

This year's conference slogan, "Over the Moon," can do so much more than express our excitement over celebrating the AAMA's 65 years of dedication to the medical assisting profession. I think it can serve as inspiration for what each of us can do. Let's go *big* and *better* for 2021.

Shoot for the stars by submitting an entry to the 2021 Excel Awards. Find the entry forms and details on the Excel Awards webpage of the AAMA website. The deadline for submissions is July 1.

We have such awesome state leaders. You deserve recognition in the 2021 Excel Awards, and we can use you on the national level. Go above and beyond as a member of the AAMA community by applying to be a national-level volunteer leader. Find the Volunteer Leadership Application on the Downloads webpage under "Membership." The deadline for applications is August 1.

Discover which committee, task force, strategy team, or board you'd be most interested in joining by perusing *Volunteer Leadership Position Descriptions*. This document is available on the Members-Only Downloads page. As the spokesperson for the Board of Trustees, I can assure you wholeheartedly that we'd love to have you join us.

Serving at the national level is important, but that doesn't diminish the vital work members are doing at the state level. For instance, during this pandemic, most of our state societies have shared their online CEU events with other states via Facebook. So, as pieces of the AAMA community, we can all win. I'm proud of you all!

Speaking of winning, congratulations to the AAMA for earning the professional association 2021 80% in Every Community National Achievement Award from the National Colorectal Cancer Roundtable (NCCRT). We couldn't have won without the medical assistants who went the extra mile to make patients aware of the need for colorectal cancer screening. We were recognized nationally, including during an NCCRT webcast. What an honor!

And all our members are winners because they too have committed to supporting the profession and dedicating themselves to lifelong learning and professional development.

So, let's join together to move forward, think big, and make 2021 our year.

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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CMA Today

A Hard Pill to Swallow

12 **Prescription overuse is a recipe for antibiotic resistance**

By Mark Harris

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AAMA update

Updated *Content Outline* will go into effect soon

The Certifying Board of the AAMA released a *Content Outline for the CMA (AAMA) Certification Exam* that goes into effect **July 15, 2021**.

This document, also called *Content Outline* for short, acts as a road map for tracking the topics exam candidates should study to prepare for the CMA (AAMA)® Certification Exam.

Note: If you plan to take the CMA (AAMA) Certification Exam *before* July 15, 2021, you should continue to use the previous *Content Outline* to study for the exam. If you will take the exam *on or after* July 15, 2021, use the updated *Content Outline*.

View both versions on the AAMA website under CMA (AAMA) Exam/Study for the Exam/Content Outline:

- *Content Outline for the CMA (AAMA) Certification Exam* (effective **through** 7/14/21)
- *Content Outline for the CMA (AAMA) Certification Exam* (effective **on and after** 7/15/21)

The ABC-P program has earned I.C.E. accreditation!

The Assessment-Based Certificate in Pediatrics (ABC-P) Program of the AAMA has been awarded accreditation under *ICE 1100:2019 – Standard for Assessment-Based Certificate Programs*. The ABC-P is the only medical assisting continuing education vehicle that has received this prestigious accreditation.

ICE 1100:2019 is a publication of the Institute for Credentialing Excellence (or *I.C.E.*) that has been recognized by the American National Standards Institute (ANSI) as an American National Standard for assessment-based certificates.

The ABC-P courses are available to all medical assistants, including CMAs (AAMA), and all other health care professionals. The courses can be taken together as part of the ABC-P Program or individually for AAMA CEU credit. Altogether, the program is worth 16 CEUs (gen, admin, clin).

Increase your knowledge and your marketable skills! Begin the program today via the AAMA e-Learning Center: https://learning.aama-ntl.org.

Also, use AAMA membership to get discounts on the ABC-P Program. Join or renew today! ✦

AAMA Calendar

Events

AAMA annual conferences

65th—Houston, TX. . . . . Sept. 24–27, 2021
66th—Minneapolis, MN . . . . . Sept. 16–19, 2022

Medical Assistants

Recognition Week . . . . . Oct. 18–22, 2021
Recognition Day. . . . . Oct. 20, 2021

2021 deadlines

Life Membership nominations . . . . . June 1
State officer election notification submissions. . . . . June 1
State delegates and alternates submissions . . . . . June 1
Excel Awards submissions. . . . . July 1
Conference program advertising . . . . . July 1
National volunteer leadership applications. . . . . Aug. 1

See under Volunteers/Guidelines and Forms to access the information hub for deadlines and forms. ✦

The future is now!

Register for the 2021 conference online

Take one small step today for one giant leap this fall. Register online for the 65th AAMA Annual Conference via the AAMA website! Registrants may securely pay their registration fees online, select the continuing education sessions they wish to attend, and choose their ribbons.

Access the conference registration page by clicking on News & Events/Conference, and on the left-side menu, you will see an option to register for the conference. Sign in (or create a new account) to be redirected to the registration page. You also may register by mail or fax.

Conference registration deadline: Aug. 24, 2021

Hotel registration deadline: Sept. 1, 2021
Conference dates: Sept. 24–27, 2021 ✦

Claim your space

Reserve your spot among the stars—your fellow medical assistants—in the AAMA room block at the host hotel by **Sept. 1, 2021**, to take advantage of the conference registration discount. When registering for the AAMA Annual Conference, you must provide a reservation confirmation number from the Westin Galleria Houston to get the discount. ✦

Recertify by June 30, 2021!

To help mitigate the challenges brought on by the COVID-19 pandemic, the Certifying Board extended expiration dates until **June 30, 2021**, for the following categories:

- CMAs (AAMA) whose certifications were set to expire Dec. 31, 2020, through May 31, 2021
- Those with expired credentials who were no longer able to recertify by continuing education (CE) after March 30, 2020, through Dec. 31, 2020

No further extensions of certifications, expired certifications, or the 90-day credential expiration policy will be available past June 30, 2021. Thus, visit the "My Account" section of the AAMA website, and double-check your certification expiration date via the "My Certification Information" tab of the left-side menu.

- **If your certification expires June 30, 2021,** you have 90 days after your expiration date to recertify by CE or exam. After those 90 days, you must sit for and pass the CMA (AAMA) Certification Exam to recertify.
- **If your credential previously expired and you had until March 31, 2020, to recertify by continuing education**, you now have until June 30, 2021, to recertify by CE. After June 30, 2021, you must sit for and pass the CMA (AAMA) Certification Exam to recertify.

The AAMA will be contacting those with certifications expiring in the above time frames with updated certification information. ✦

Digital badges: Coming soon!

The Certifying Board is now offering digital badging to CMAs (AAMA)! This cutting-edge technology allows CMAs (AAMA) to securely—and quickly—share their credential across the web, on résumés, in email signatures, and via social media outlets to celebrate and validate their achievement.

CMAs (AAMA) who certify or recertify **on or after June 1, 2021**, will receive a digital badge instead of a paper certificate. Anyone who recertifies before June 1, 2021, will receive a paper certificate.

More info coming soon to the AAMA website. ✦

Leadership forms deadlines

Delegate and Alternate Submission Form. AAMA members and state presidents have a deadline to note:

- *Members*—talk to your state president about serving as a delegate or alternate in the AAMA House of Delegates. If you are attending but not serving in the House, consider volunteering to serve on a House committee.
- *State presidents*—complete and submit these forms (under News & Events/Conference on the AAMA website) to the AAMA by June 1.

State and Chapter Officer Election Notification Form. *State and chapter officers*—don't miss important mailings! Complete and submit this form (under Volunteers/Guidelines and Forms) to the AAMA by June 1. ✦

On the web

Conference advertising

Under News & Events/Conference

Looking to honor one of your leaders or voice your support of a candidate for the AAMA Board of Trustees? Place your order for an ad in the AAMA Annual Conference on-site program by completing the Ad Insertion Order. *(Space is limited.)*

BOT highlights

Under News & Events/BOT Highlights

Discover the latest decisions of the Board of Trustees and highlights of the February 2021 meeting. *(Must be signed in for access.)*

Check certification expiration

Within the My Account section/My Certification Information

Time flies—make sure it doesn't pass your recertification by! CMAs (AAMA) can double-check their certification expiration dates on the AAMA website. Sign in or create an account to stay ahead of the curve.

Recertify online

Under Continuing Education/Apply to Recertify by CE

Current CMAs (AAMA) can recertify online—regardless of having all 60 or as few as 30 recertification points from AAMA continuing education sources. Recertification is just a few clicks away! ✦

Basics of not-for-profit and tax-exempt law

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

The following article was adapted from telephone presentations I gave to AAMA state societies and local chapters. Although not all not-for-profit (NFP) and tax-exempt entities are corporations, the following article will address only NFP and tax-exempt entities that are incorporated.

What is the difference between not-for-profit and for-profit corporations?

A primary difference is that not-for-profit (NFP) corporations do not have stockholders. This is because the law does not give NFP corporations the authority to issue shares of stock. Not-for-profit corporations must use their resources to further their tax-exempt purposes, not to provide economic benefit to any individual or other legal entity.

In contrast, for-profit corporations are authorized by law to issue shares of stock. The stockholders may be paid dividends from the profits of the corporation. They also benefit from any increase in the value of the stock.

What are the typical governance documents of an NFP corporation?

The primary governance documents of an NFP corporation are its articles of incorporation and its bylaws. The articles of incorporation are typically given greater legal weight than the bylaws. Consequently, if the bylaws contain language inconsistent with the articles of incorporation, the provisions of the articles will usually prevail over the language of the bylaws.

An NFP corporation may also have secondary governance documents, such as standing rules, policies, and procedures. The language of the articles of incorporation and the bylaws prevail over the provisions of these secondary documents.

What must an NFP do in order to incorporate?

Not-for-profit incorporation is granted by a state executive-branch agency, such as the offices of the secretary of state, attorney general, or department of revenue. An entity must be organized and must operate in accordance with its state's NFP act in order to incorporate. For example, the NFP must have a purpose permitted by the relevant NFP statute. The NFP's purpose is usually specified in its articles of incorporation, its bylaws, or both. Also, the primary governance documents must specify that, if the NFP corporation is dissolved, any remaining assets (after debts and obligations have been paid) must not be given to any individual members or leaders of the NFP corporation. Rather, remaining assets must be distributed to an entity such as another NFP corporation.

The NFP must complete the form for NFP incorporation; include its articles of incorporation, bylaws, and the required fee; and submit these documents to the appropriate state agency. If everything is deemed to be in order, the NFP will be sent a certificate of incorporation. Most states require a short and simple annual report (along with a small fee) to be submitted by each NFP corporation.

How does an NFP corporation obtain an income tax exemption?

First, individuals and for-profit corporations are not the only entities required to pay federal income tax. Some limited liability companies, partnerships, estates, trusts, and NFP corporations are required to file federal returns and pay federal income tax.

Although state law governs the incorporation of NFPs, federal law sets forth the requirements for income tax exemptions. For an NFP corporation to obtain an income tax exemption, it must fall into one of the tax-exempt categories established by the United States Congress in the Internal Revenue Code. The NFP corporation must then complete and submit the appropriate form for tax exemption, with the necessary documentation and the required fee, to the Internal Revenue Service (IRS). An NFP corporation granted income tax exemption will receive an exemption letter from the IRS.

What are examples of tax-exempt categories in the Internal Revenue Code?

The Internal Revenue Code has two tax-exempt categories that are of particular interest to NFP associations. The first category is found in section 501(c)(6) of the Internal Revenue Code. This section authorizes income tax exemptions for professional societies, business leagues, and

trade associations. The second category is found in section 501(c)(3) of the Internal Revenue Code. This section includes charitable, philanthropic, scientific, religious, and educational entities.

Most professional societies, such as the American Association of Medical Assistants® (AAMA), are NFP corporations exempt under section 501(c)(6) of the Internal Revenue Code. Many associations have established an affiliated 501(c)(3) entity. An example is the AAMA Endowment (AAMAE).

The AAMAE is an NFP that is separately incorporated and is exempt from income tax under section 501(c)(3) of the Internal Revenue Code. The AAMAE houses the Medical Assisting Education Review Board (MAERB) and its activities as an accreditation-recommending committee on accreditation of the Commission on Accreditation of Allied Health Education Programs (CAAHEP). The Medical Assisting Education Review Fund includes the Ivy Reade Relkin Surveyor Training Fund, whose purpose is to provide financial assistance for individuals to attend surveyor training workshops held by MAERB. These individuals become accreditation site surveyors of medical assisting programs seeking initial or continuing accreditation by CAAHEP. The AAMAE also houses the Maxine Williams Scholarship Fund, whose purpose is to provide scholarships to worthy medical assisting students in CAAHEP-accredited medical assisting programs.

Is an NFP association exempt from paying sales tax on its purchases?

This question has been a source of much confusion in the NFP and association worlds. The primary reason is that 501(c)(6) associations are treated differently from 501(c)(3) entities in regard to paying sales tax on items purchased to carry out their tax-exempt purposes.

All states do not have a sales tax. States that have a sales tax require the seller of goods to charge the buyer the required sales tax and remit that amount to the state department of revenue. This applies to all buyers unless a buyer has been granted an exemption.

State laws do not exempt 501(c)(6) entities (including professional associations) from paying sales tax on items they purchase for consumption by attendees at a state annual meeting or education conference. However, some state sales tax laws exempt 501(c)(3) entities—or a subset of 501(c)(3) entities—from paying sales tax on items they buy for consumption by attendees at fund-raising or charitable events.

State laws do not exempt 501(c)(6) entities (including professional associations) from paying sales tax on items they purchase for consumption by attendees at a state annual meeting or education conference. However, some state sales tax laws exempt 501(c)(3) entities—or a subset of 501(c)(3) entities—from paying sales tax on items they buy for consumption by attendees at fund-raising or charitable events.

Eligible 501(c)(3) entities can submit their certificate of NFP incorporation from the state and their 501(c)(3) tax exemption letter from the IRS to the state department of revenue. The department, in turn, will issue the 501(c)(3) entity a letter verifying its exemption from sales tax. The 501(c)(3) entity may show a copy of its sales tax exemption letter to a vendor. The vendor is then not permitted to charge the 501(c)(3) entity sales tax on purchases related to its tax-exempt purpose.

Are association dues and amounts paid for continuing education deductible by the members?

Dues and continuing education costs paid by members are deductible as professional expenses in calculating federal income tax. Membership dues and continuing education costs are not deductible as charitable expenses.

Are contributions to 501(c)(3) bodies, such as scholarship funds established by an association, deductible for income tax purposes?

Donations to a 501(c)(3) association foundation are deductible as charitable contributions. Such donations are not deductible as professional expenses. ✦

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

Talk the talk

Use narrative medicine to enhance patient outcomes

By Mark Harris

Narrative medicine is a term used with increasing frequency in the recent medical lexicon. It refers to a unique approach to medical care that emphasizes the use of narrative skills (e.g., writing, respectful listening, and storytelling) to relieve patient stress, encourage stronger bonds between patients and providers, and promote healing.

A growing list of academic health centers, hospitals, and other facilities sponsor programs and trainings in narrative medicine. A master's degree or other certification in narrative medicine is even available at institutions such as Columbia University and the University of Southern California.

A group of health care professionals at Advocate Children's Hospital in Park Ridge, Illinois, have been incorporating narrative medicine concepts into patient care for several years now.

"Narrative medicine is already part of the medical system, under what we call *history of present illness*," remarks David G. Thoele, MD, a pediatric cardiologist and founder of the hospital's narrative medicine program. "But with our program's expressive writing approach, we're bringing out more of the stories that patients have. As clinicians, we're also learning how to be better listeners to our patients. Our goal is to reduce stress for everyone and create a more healing environment for our patients."

With colleague Marjorie Getz, PhD, a learning and behavior specialist, Dr. Thoele is a codirector of the narrative medicine program at Advocate Children's Hospital. The group meets twice monthly via Zoom with participants, who include physicians, therapists, nurses, other staff members, patients, and community volunteers. The meetings and events the group sponsors feature a mix of writing, meditation, music, poetry, and topic presentations.

Three-Minute Mental Makeover

When Dr. Thoele first learned about narrative medicine, he was intrigued and felt challenged to find a practical way to introduce some of the concepts into his busy clinical practice. Consequently, he developed a short exercise called the Three-Minute Mental Makeover, or 3MMM. The exercise asks both the patient and practitioner to compose written responses to three prompts:

- Write three things you are grateful for, and be specific.
- Write the story of your life in six words.
- Write three wishes that you have.

The participants write concurrently and then share what they have written. Dr. Thoele has learned from experience that some patients may be reluctant to do a writing exercise on their own, but when done in conjunction with the practitioner, the exercise can be revelatory.

"Most patients respond well to this brief writing exercise," says Dr. Thoele. "I've found it helps create a connection between us. For myself, as a doctor, I also get an insight into what makes a patient tick when they share what they've written."

A peer-reviewed study in *The Permanente Journal* shows the benefits of the 3MMM. The study looked at survey responses from eight health care practitioners and 96 patients and family members at a children's hospital over eight months in 2016–2017.[1]

Notably, 88% of the patients and family members found the 3MMM helpful, and participants reported noteworthy reductions in stress after the 3MMM activity. Practitioners also reported improved communication with patients after the shared exercise. In the neonatal ICU particularly, families noted a significant improvement in communication.

Storied past, present, and future

"I've often found the most stressful situations occur when families or patients are asking good questions, but I don't have the answers," observes Dr. Thoele. Using the 3MMM, he finds that even a brief foray into expressive writing can introduce a sense of reflection into uncertain moments, dampening the stress the patient or family may be experiencing.

Even when sharing his story during 3MMMs with patients, Dr. Thoele is careful to keep the focus on each patient. "First, I will make one of the things I'm grateful for

Members of the narrative medicine program at Advocate Children's Hospital; *top right*, David Thoele, MD

Write on!

Health care practitioners can improve their narrative medicine practices by employing key strategies[2]:

- Avoid interrupting patients.
- Make time for patients to write about their conditions and discuss concerns.
- Be mindful of body language and convey receptiveness when listening.
- Examine assumptions about patients and existing stereotypes.
- Ask open-ended questions.
- Listen to patients' stories and identify key words.

be about the patient," he explains. "I might say, 'I'm grateful that your daughter has a mother who shows up every day and really loves her.' I also share a little bit about myself, such as 'I'm grateful that I got to ride my bike to work today.' I share something they might not know about me. I also make one of the wishes about the patient. For instance, [I might say] 'I hope I provide compassionate, competent care to your daughter, so she has a good chance of getting off the ventilator as soon as possible.' As a brief exercise, the 3MMM allows me to express my compassion and care for the patient."

Sigrun Hallmeyer, MD, an Advocate Health Care oncologist, has also found the 3MMM beneficial. She recalls an early experience using the exercise with a young patient who was in her 20s with metastatic breast cancer. The circumstance required breaking the news to the patient that her disease had progressed despite significant treatment.

"I was dreading the appointment, as I had known since the evening before that the scans didn't look good," recalls Dr. Hallmeyer. "There was a lot of tension in the room that day, and I sensed the patient was ready to give up. She told me she didn't even want to hear the results of the scans—that she knew it was bad."

At that time, Dr. Hallmeyer had just completed her first meeting of the hospital's narrative medicine group. On the spot, she asked the patient whether she would give the 3MMM a try. Dr. Hallmeyer shared how she was grateful for her teenage daughter, who, despite challenges, remained close to her. She shared how she had moved from East Germany as a young woman, hoping to become a physician.

But initially there was not much the patient was grateful for. Her six-word story was also bleak. "It was basically, 'Born. Raised. Suffering. Suffering. Suffering. Death,' " says Dr. Hallmeyer. "This was the moment in the room when her mom started crying. I had to take a deep breath as well—so how do we disassemble that?"

The patient's despair prompted Dr. Hallmeyer to speak to the patient about how the patient was born into a wonderful family and has parents who could not love her more and a brother who adores her. Dr. Hallmeyer mentioned her patient's love of dancing, an activity she continued during her illness. In short, Dr. Hallmeyer counseled the young woman that "born, raised, and suffering" did not represent her complete story and that there was much more to her life. The few minutes for a different, more personal conversation made a difference.

"As an oncologist, there's often little room for this kind of personal conversation with your patients," observes Dr. Hallmeyer. "But I felt by opening up to her maybe she would also [open up more about her feelings]. I also had good news for her about qualifying for a promising new clinical trial. Ultimately, we were able to turn the moment around to her six-word story being, 'Born. Raised. Fighting a lot. Hope.'

"It was extremely helpful to get from that devastation we both felt to putting a much larger frame around the moment," concludes Dr. Hallmeyer. "Without this tool, I think the appointment would have ended in such a way that she would have left crying."

In the busy health system, patients benefit from a wide array of clinical resources. But the system often operates as if on warp speed, strained by financial pressures, time constraints, and other pressures.

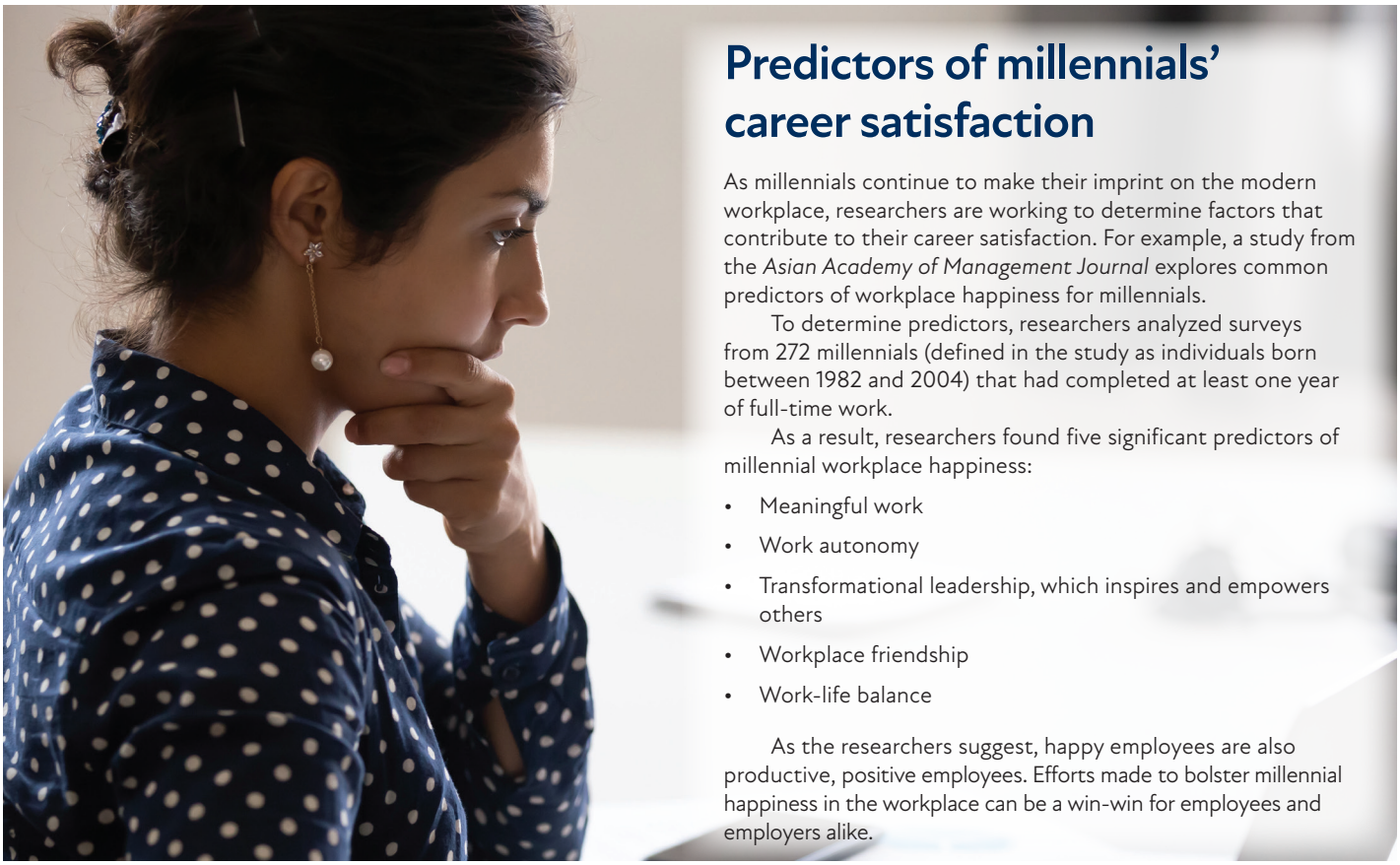
As a tool, narrative medicine helps patients and practitioners reflect, connect, and heal. It offers a simple antidote for often complex clinical moments and a way to ease the stress that comes with illness and medical care. ✦

References

1. Thoele DG, Gunalp C, Baran D, et al. Health care practitioners and families writing together: the Three-Minute Mental Makeover. *Perm J.* 2020;24(1):47-53. doi:10.7812/TPP/19.056
2. Peterkin A. Practical strategies for practising narrative-based medicine. *Can Fam Physician.* 2012;58(1):63-64. Accessed April 14, 2021. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3264015/

About News You Can Use

From now on, News You Can Use will feature short news stories that not only impart the latest health industry news but also suggest ways to improve the workplace for medical assisting professionals. ✦



Predictors of millennials' career satisfaction

As millennials continue to make their imprint on the modern workplace, researchers are working to determine factors that contribute to their career satisfaction. For example, a study from the *Asian Academy of Management Journal* explores common predictors of workplace happiness for millennials.

To determine predictors, researchers analyzed surveys from 272 millennials (defined in the study as individuals born between 1982 and 2004) that had completed at least one year of full-time work.

As a result, researchers found five significant predictors of millennial workplace happiness:

- Meaningful work
- Work autonomy
- Transformational leadership, which inspires and empowers others
- Workplace friendship
- Work-life balance

As the researchers suggest, happy employees are also productive, positive employees. Efforts made to bolster millennial happiness in the workplace can be a win-win for employees and employers alike.

Learning over multiple sessions improves retention

For medical assistants, learning is a vital and continuous part of the job—whether that entails learning new treatments, medications, or electronic health record systems.

But what is the best way to absorb new information? To find the answer, researchers analyzed the study habits and quiz results of 747 online students and reported their findings in *npj Science of Learning*.

Their results were clear: the more learners spaced out their study sessions, the better they scored on the end-of-unit quizzes. Overall, spacing out content, rather than cramming everything into one or two sessions, produced better retention for students across the study.

Notably, students with a higher ability or increased likelihood of completing course activities were more likely to space out studying, but the benefits of spaced learning were greater for students with a lower ability or decreased likelihood of completing course activities. Moreover, the researchers suggest this learning method can be beneficial whether participants follow imposed spacing or self-regulate spacing. ✦

Flawed self-evaluation of

phishing risks

Many studies show that most Americans consider themselves to be good drivers. But they may be overestimating their abilities. This disconnect between perception and reality also applies to cybersecurity, suggests a study in *Comprehensive Results in Social Psychology*.

The study found that individuals assess their own risk of falling for phishing schemes differently than they would for other people. Specifically, participants thought they could *better* spot phishing attempts than the average person. This effect may be at least partly due to how participants used data: while they often overlooked data that could help them recognize a potential scam, participants often used data to predict other people's behaviors.

As the researchers warn, this overconfidence can be damaging, both at home and at the workplace, because it leaves people more susceptible to online attacks. ✦

Employer interventions for

heart health

Much focus is put on individual choices for cardiovascular health, but employers can also play an active role. After all, many people's workdays can compose roughly half of their waking hours, and many jobs involve physical inactivity and exposure to unhealthy foods.

With that reality in mind, researchers conducted a review, which is published in the American Journal of Preventive Cardiology, to determine specific interventions employers can use to improve their workers' heart health:

- Provide step counters for employees
- Create walkable spaces
- Make mineral water and affordable, healthy snacks readily available
- Offer standing workstations and hands-free devices
- Involve employees in health promotion initiatives

Regardless of the strategies used, employers can create a happy and healthy workplace by taking actions that facilitate healthier lifestyles. ✦

Reducing air pollution has fast results

Air pollution has been linked to numerous health risks, but the good news is that the American Thoracic Society suggests that people exposed to air pollution may see significant—and swift—improvements when that exposure is reduced by citywide, nationwide, and at-home interventions.

A study published in *Annals of the American Thoracic Society* reviewed several cases in which targeted interventions were used to decrease air pollution and found significant positive outcomes:

- When Atlanta, Georgia, closed parts of the city for 17 days during the 1996 Olympic Games, hospitalizations for asthma decreased by 19%.
- A 13-month closure of a steel mill in Utah decreased hospitalization for pneumonia, pleurisy, bronchitis, and asthma by 50%.
- After smoking was banned in Ireland, the country experienced a 13% decrease in all-cause mortality, a 32% reduction in stroke, and a 38% reduction in chronic obstructive pulmonary disease.
- Families in Nigeria who, during nine-month pregnancies, had clean cookstoves that decreased air pollution reaped the benefits of higher birthweights, greater gestational age at delivery, and less perinatal mortality.


AAMA
CEU CREDIT

A Hard Pill to Swallow

Prescription overuse is a recipe for antibiotic resistance

By Mark Harris

The development of antibiotics to treat infectious diseases is one of the wonders of modern medicine.

From the discovery of penicillin in 1928 to its first widespread drug application in World War II to treat infections in soldiers, the dawning age of antibiotics heralded remarkable advances in medicine's efforts to control bacterial infections in humans.[1]

Thanks to the growing availability of many new pharmaceutical antibiotics following World War II and through the 1970s, a host of once-difficult-to-treat diseases, such as bacterial pneumonia and strep throat, can now be successfully treated. Antibiotics have also enabled other medical advances, including practices that involve management of complex surgeries, organ transplantation, cancer chemotherapy, care for premature infants, and the intensive care unit.[2]

From wonder to worry

Yet, the wonders of antibiotics come with a caveat. These potent drugs must be used judiciously to preserve their value as a medical treatment. When antibiotics are overused or used inappropriately, the risk that they will lose their effectiveness as disease-fighting agents increases. This is because the germs that cause bacterial infections can adapt to antibiotic medicines used against them.

The phenomenon of antibiotic resistance is a naturally occurring one. When exposed to antibiotics, the germs that cause bacterial infections can develop resistance mechanisms using instructions in their DNA. In turn, this resistance can spread as the bacteria multiply and share these genetic instructions with other germs. While the defense strategies used by disease-causing bacteria work in different ways, the end result is an adaptive response that can render antibiotics less effective in destroying harmful bacteria.[3]

In a sense, the very power of antibiotics to work so effectively against many infectious diseases requires a proportional responsibility to respect and preserve that power. Sir Alexander Fleming, who shared the win of the 1945 Nobel Prize in Physiology or Medicine with Ernst Chain and Sir Howard Florey for their work in developing penicillin,[4] understood this. Fleming issued a warning in his Nobel lecture:

> The time may come when penicillin can be bought by anyone in the shops. Then there is the danger that the ignorant man may easily underdose himself and, by exposing his microbes to nonlethal quantities of the drug, make them resistant.[5]

To some extent, that time has come. Today, antibiotic resistance is a significant global health issue. At least 700,000 people die each year globally due to drug-resistant diseases, according to the United Nations (UN) Interagency Coordination Group on Antimicrobial Resistance.[6] Without future action, this figure could increase to as many as 10 million deaths each year by 2050.[6]

Dose don'ts

Health experts from the Pew Charitable Trusts, the Centers for Disease Control and Prevention, and elsewhere teamed up in 2018 to evaluate antibiotic use and set national prescribing targets. Several findings from the analysis showed ample room for improvement[17]:

- 56% of the examined prescriptions were inappropriate in terms of the specific antibiotic prescribed, the duration of treatment, or the illnesses for which they were given.
- 79% of all antibiotic prescriptions for community-acquired pneumonia and 77% of those for urinary tract infections were inappropriate. The expert panel determined that the national target should be to reduce 90% of the inappropriate use for each condition.
- 47% of all fluoroquinolone and 27% of all vancomycin prescriptions were inappropriate. The panel recommends a 95% reduction in the use of each of these antibiotics as a national target.

How does this growing global-health peril impact Americans? While patterns of antibiotic use vary among nations, the threats from growing antibiotic resistance in one geographic region or nation invariably create risks in other parts of the world.

"As we have learned through the COVID-19 pandemic, microbes don't really respect political boundaries, and [they] travel the world," says Lance Price, PhD, codirector of the Antibiotic Resistance Action Center at the Milken Institute School of Public Health at George Washington University. "Globally, antibiotic resistance is a big problem. In some countries where environmental controls are not as good, and where they have no regulations in terms of use, we see a really ugly picture that contributes to antibiotic resistance spreading around the world. This is partly to blame for some of the bad superbugs we are dealing with today in the United States, like CRE—carbapenem-resistant *Enterobacteriaceae*—which is one of the nightmare superbugs."

Indeed, U.S. data reveal the locally felt perils of antibiotic resistance. "In the United States, the CDC [Centers for Disease Control and Prevention] estimates there are about 2.8 million infections caused by antibiotic-resistant bacteria and approximately 35,000 deaths every year," says David Hyun, MD, senior officer of the Antibiotic Resistance Project for the Pew Charitable Trusts. "This is widely viewed as somewhat of a conservative estimate—that the true number may actually be even higher. It's a very significant issue. We're starting to see higher numbers of patients in the community who are getting infections that used to be easily treated with antibiotics. There's some difficulty now in treating these infections, such as urinary tract infections that have become more resistant, [because] the traditional oral antibiotics are just not effective anymore in curing the disease."

Surprisingly, most antibiotics used in the United States are in food production. Around 80% of antimicrobials purchased in the United States in 2014 were for use in animal agriculture.[7] This widespread use of antibiotics in livestock raises its own set of public health concerns, say experts.

"The issue is that the antibiotics they're using as growth promoters in animals are the same as—or they can be very similar to—those used in human health," says Marnie L. Peterson, PharmD, PhD, outreach coordinator for the Antimicrobial Stewardship Project at the University of Minnesota's Center for Infectious Disease Research and Policy. "This creates resistance to bacteria. Like *E. coli* bacteria, they are bacteria that can become pathogenic in humans, and they have a resistance mechanism that can be class resistant to an antibiotic that might be used in humans. Even if it's a different antibiotic, it can be in the same class, so it's therefore still resistant."

As Dr. Peterson notes, the use of antimicrobial agents in agriculture raises the matter of the mechanisms that link these industry practices to humans and their environment. "It's the consumption of the antibiotics that drives the resistance, which then drives the potential risk," explains Dr. Peterson. "But there's the connectivity issue of how this resistance gets transferred. Does it get transferred throughout the system by contamination? Is the food not properly sterilized? Does the drainage water system runoff have these bacteria, and somehow it contaminates a water source? How do we get exposed to these things in different fashions throughout the environment?"

The use of antibiotics in animal agriculture is also an international concern. "In the United States, the large majority of antibiotics on a per-pound basis is going into animals," notes Dr. Price. "The threat here is directly relevant to the drugs, both the quantity and the types of drugs that people use in animals. It's been a painfully slow process, but the FDA [U.S. Food and Drug Administration] has over the years limited the different types of antibiotic drugs that can be used in animals. That moderates the potential impact on human health. However, if you think about it globally, we've also exported this industrialized model of animal production with the concentrated animal feeding operations [CAFOs] that use many different antibiotic drugs. In developing countries, they are using all the different antibiotic drugs, both first-line and last-line antibiotics, as a sort of shortcut to try to make animals grow faster and prevent diseases that may or may not occur."

Rx restraint

To clarify, bacteria are considered a type of microbe, which is why antibiotics are also known as *antimicrobials*. Another type of microbe is fungi, which cause illnesses such as yeast infections and athlete's foot. These conditions may be treated with antifungals.[3] Further, basic differences exist between bacteria and viruses.

Bacteria are living, single-celled microorganisms found in a variety of environments. Most bacteria are either harmless or otherwise beneficial, such as the good bacteria in the gastrointestinal system that aid in digestion.[8]

Where are the new antibiotics?

The development of new antibiotic drugs is a crucial component of the long-term solution to growing antibiotic resistance. Unfortunately, the pharmaceutical industry, due to financial and market factors, has been slow to prioritize developing new antibiotic products. However, as the scope of the antibiotic-resistance issue has become more urgent, new legislative and industry initiatives have emerged. Advocates of antibiotic development hope such initiatives will begin to remedy the current shortage of new antibiotic products.[16]

By contrast, viruses are much smaller than bacteria. A virus is a small collection of genetic code (DNA or RNA) surrounded by a protein coat. Unlike bacteria, viruses are not alive but require a host cell to replicate. They are also much more common than bacteria, outnumbering the latter by 10 to 1.[9]

A starting point for antibiotic awareness is to know that these drugs will not work against infections caused by viruses or fungi. Unfortunately, some of the more common infectious illnesses will often share similar symptoms. Therefore, physicians should make a careful clinical assessment, which includes the use of diagnostic testing, to determine whether an antibiotic is the right choice for a serious presenting illness.

The CDC identifies the appropriateness of antibiotics' use for the following common illnesses[10]:

- **Chest cold (acute bronchitis).** Symptoms include cough and mucus; antibiotics will not help recovery.
- **Common cold.** Symptoms include sneezing, runny or stuffy nose, sore throat, and cough; antibiotics do not work against viruses that cause colds.
- **Ear infection.** Symptoms include ear pain and fever; some ear infections, such as middle ear infections, need antibiotic treatment, but many can improve without antibiotics.
- **Flu (influenza).** Symptoms include fever, cough, sore throat, runny or stuffy nose, and body aches; antibiotics do not ease symptoms, and their side effects could cause harm.
- **Sinus infection (sinusitis).** Symptoms include headache, stuffy or runny nose, and face pain or pressure; antibiotics are not necessary for many sinus infections, so a physician should decide whether an antibiotic is needed.
- **Skin infections.** Symptoms include skin redness and swelling of the affected area; a physician may decide whether an antibiotic is needed.
- **Sore throat.** Symptoms include throat pain and hoarseness; most sore

Resources

Antimicrobial Stewardship Project
Center for Infectious Disease Research and Policy, University of Minnesota
https://www.cidrap.umn.edu/asp

Antibiotic Resistance Action Center
Milken Institute School of Public Health, George Washington University
http://battlesuperbugs.com

Antibiotic Resistance Project
The Pew Charitable Trusts
https://www.pewtrusts.org/en/projects/antibiotic-resistance-project

throats, except for strep throat, do not need antibiotics.

- **Urinary tract infection.** Symptoms include pain or burning while urinating as well as frequent urination; antibiotics are needed, with a physician's diagnosis and prescription.

Notably, most antibiotic prescriptions are written in outpatient health care settings. In fact, approximately 13% of all outpatient medical practice visits result in an antibiotic prescription. Yet, as many as 30% of these prescriptions may be unnecessary, according to a panel of experts convened in 2015 by the Pew Charitable Trusts, the CDC, and other groups.[11] While 44% of outpatient antibiotic prescriptions were used to treat acute respiratory conditions (e.g., middle ear infections, bronchitis, influenza, and pneumonia), about half of these prescriptions were unnecessary because many of those conditions are not responsive to antibiotics.[11]

Why is there such a high percentage of unnecessary outpatient antibiotic prescriptions? The reasons are many and complex. A 2020 *BMJ Open* article's findings indicate that 94% of primary care physicians agree that antibiotic resistance is a problem in the United States.[12] Yet only 55% of the physicians surveyed saw improper prescribing as an issue in their own practice.[12]

"We observed somewhat of ... a disconnect in the study," notes Dr. Hyun, one of the study's coauthors. "As a larger issue, antibiotic resistance and inappropriate prescribing were recognized as a problem when they were looking at it at a macrolevel or the national level. But when you narrow it down to their practice at the provider level, the recognition diminishes quite significantly."

Dr. Hyun offers some clarity on the significance of the disconnect among physicians seen in the study: "When it comes to improving antibiotic use, what this [disconnect] tells us first is the importance of data—showing providers what their prescribing patterns are and comparing them to their peers so that everybody has a clear understanding of where their prescribing patterns stand—[and] in terms of not only just the volume but also at the appropriateness level."

The restrain game

Dr. Hyun and other experts agree: the value of data is integral to antibiotic stewardship strategies designed to reduce the overuse of antibiotics. In the hospital setting, antibiotic stewardship programs over the past two decades have used data on prescribing patterns and other measures to promote better use of antibiotics.

"Antibiotic stewardship programs and activities are basically systemic applications of policy efforts to ensure that antibiotics are used only when they are truly needed—when there's a true bacterial infection," explains Dr. Hyun. "And when they are needed, [antibiotic stewardship is used] to make sure that the right type of antibiotics is being selected—the most effective and the safest choice—and then used in the most appropriate dosing and length of therapy."

The value of such hospital-based stewardship programs has more recently led to new Joint Commission and Medicare standards and rules supportive of a methodical organizational approach to antibiotic stewardship. Notably, the U.S. government also sponsors the National Action Plan for Combating Antibiotic-Resistant Bacteria, 2020-2025. This federal task force plan represents an update of government initiatives in place for several years now to promote evidence-based strategies to optimize the appropriate use of antibiotics.[13]

Efforts are also underway to expand evidence-based stewardship strategies in outpatient settings. "Time and time again, we've seen how important being able to measure antibiotic use at the provider level [is] and then providing that data back, with feedback, to the provider on how to improve their antibiotic prescribing," says Dr. Hyun. "That is the tried-and-true method in hospital settings, but there's also been more recent data that show it's equally effective in outpatient settings."

Notably, the 2020 *BMJ Open* article's study[12] indicates that to effectively get involved in stewardship activities to improve prescribing patterns, physicians need assistance from their health systems and organizations. "Nearly half of the physicians we surveyed responded that they needed a lot of help in doing so," reports Dr. Hyun. "This is because a lot of primary care physicians are inundated with many competing priorities when it comes to quality improvement across many different public health issues. As such, they have a finite level of resources and time to allocate to these issues."

A related aspect of antibiotic stewardship, especially in outpatient care, involves finding ways to improve public and patient awareness of what constitutes appropriate antibiotic use. Indeed, this issue touches on concerns about the overall health literacy in

Critical conditions

The Centers for Disease Control and Prevention divides 18 antibiotic-resistant bacteria and fungi into three categories based on level of concern to human health: urgent, serious, and concerning.[15]

One urgent threat involves *Clostridioides difficile*, or *C. diff*, a bacterium that is a cause of life-threatening diarrhea and colitis. In 2017, there were 223,900 cases of *C. diff* and at least 12,800 deaths. *C. diff* occurs in people who have had recent medical care that included antibiotic treatment.[15]

Drug-resistant gonorrhea is another urgent health threat. The *Neisseria gonorrhoeae* bacterium, or *N. gonorrhoeae*, causes this sexually transmitted disease. The disease is associated with life-threatening ectopic pregnancy, infertility, and other risks. There are about 550,000 drug-resistant gonorrhea infections annually. Only one class of antibiotics is still considered an effective treatment for gonorrhea.[15]

Another well-known infectious disease threat is methicillin-resistant *Staphylococcus aureus*, or MRSA. In 2017, MRSA was associated with an estimated 323,700 hospital infections and 10,600 deaths. The Centers for Disease Control and Prevention categorizes MRSA as a serious health threat.[15]

the community, say experts, including gaps in the public's knowledge of antibiotics.

"Public awareness of the impact of antimicrobial resistance is getting better, but there is still a big gap in true understanding of the topic," says Elizabeth D. Hermsen, PharmD, MBA, BCPS-ID, head of Global Antimicrobial Stewardship at Merck. "I think that's where the issue of health literacy really comes into play. There have been different surveys done in different countries, not just in the United States, evaluating the public's understanding of antimicrobial resistance and stewardship. Most people recognize that antimicrobial resistance is a problem, but many people incorrectly think that it's the body developing resistance to the antibiotic rather than the bacteria becoming resistant to the antibiotic. They don't understand that antibiotic overuse is a key driver of antibiotic resistance. There's also still the common misbelief that viral illnesses, like the common cold, for example, can be treated with antibiotics."

All this underscores how important antibiotic literacy is to addressing overuse of these medicines, especially in outpatient care, where most antibiotic use occurs, says Dr. Hermsen. To note, Dr. Hermsen is a coauthor of a 2020 *Advances in Therapy* report.[14] In the report, the authors make a critical point about the role of both patients and providers in improving antibiotic literacy and practices in outpatient settings:

> Increased awareness and education are not only needed for patients. Providers overprescribe antibiotics for many reasons. Factors influencing prescribing decisions include, but are not limited to, time constraints, diagnostic uncertainty, 'decision fatigue,' perception that the risk of not treating is greater than the risk of overprescribing, perceived or explicit patient/caregiver demands, and patient satisfaction concerns. Both patient and provider behaviors need to be considered in order to improve AMS [antimicrobial stewardship]. These points reinforce the importance of the two-sided nature of health literacy.[14]

Path of least resistance

While experts agree more work remains to be done to improve antibiotic literacy throughout the health system, signs indicate that public awareness is slowly shifting in the right direction.

"I think with the shift toward educating patients more about which [conditions] are appropriate to treat with an antibiotic, people are becoming more aware that they don't always need an antibiotic," says Iris Peltier, CMA (AAMA), who works at Cradle thru College Care in Kansas City, Missouri. "However, it's still not unusual for parents to assume their child needs an antibiotic. Sometimes parents feel that if they're coming in for an appointment, then they need to leave with a prescription. But, of course, that's not always necessary."

In fact, one of the most common phone calls the clinic receives is from someone asking whether one of the physicians can just call in an antibiotic prescription, observes Peltier. "It might be for what they assume is an ear infection, for example," she says. "Our response is to explain that if it's a true ear infection, the doctor will be happy to prescribe an antibiotic. But the ear could hurt for a number of reasons. So, [I say,] 'Let's [have a pediatrician] take a look and see if we can get to the bottom of why the ear is feeling this way.' "

The clinic physicians are careful to follow established antibiotic-prescribing guidelines, such as those from the American Academy of Pediatrics, says Peltier. "A confirming test of some kind or clinical history—gathering history information on the current illness—is necessary for our physicians to know how they are going to treat an illness. Whether it's supportive care for the symptoms or more diagnostic testing, there are steps they'll recommend before they reach the point of saying this needs an antibiotic."

Peltier and others agree that health care providers need to find engaging ways to improve patient literacy about antibiotics. Medical practice staff can take simple steps to convey to patients their commitment to appropriate antibiotic use, such as through communication tools like commitment letters as well as waiting and examination room informational posters on antibiotics. Another helpful strategy is to sponsor staff

Plan for action

The National Strategy for Combating Antibiotic-Resistant Bacteria defines five goals to reduce the incidence and impact of antibiotic-resistant infections[13]:

1. Slow the emergence of antibiotic-resistant bacteria and prevent the spread of antibiotic-resistant infections.
2. Strengthen national One Health surveillance efforts to combat antibiotic resistance.
3. Advance the development and use of rapid and innovative diagnostic tests for the identification and characterization of antibiotic-resistant bacteria.
4. Accelerate the research and development for new antibiotics, other therapeutics, and vaccines.
5. Improve international collaboration and capacities for antibiotic-resistance prevention, surveillance, control, and antibiotic research and development.

training on how to talk to patients about appropriate antibiotic practices.

With its mix of professional information, commentaries, news reports, podcasts, and other materials, the Center for Infectious Disease Research and Policy website, for example, is a great online resource useful to both clinicians and interested individuals who want to learn more about antibiotics. For instance, the podcast series *Superbugs and You: True Stories from Scientists and Patients Around the Globe* provides up-to-date information about antibiotic stewardship and related insights to a wide target audience. "It's not just news for a policy maker or health care provider," says Dr. Peterson. "It's news that anyone would be able to understand and digest."

Another helpful online resource is the Antibiotics and You website, which is sponsored by the Antibiotic Resistance Action Center at the Milken Institute of Public Health. The site provides easy-to-understand explanations of key issues involving the use of antibiotics.

"For individuals, the value of staying informed about antibiotics, knowing they do have the power to use this information to affect their health, … is so important [to recognize]," concludes Dr. Peterson. "But there's another point worth repeating. We know we can't prevent antibiotic resistance 100%, but we certainly can affect it. That's what antibiotic stewardship is about. The stewardship is in using these antibiotics appropriately when they're needed and knowing when not to use them at all when they're not needed."

Dr. Peterson voices a critical point. As a global public health challenge, the campaign to protect antibiotic medicine is one built on a recognition of the issue's profound societal and global interconnectivity. From the physician's examination room to the patient's medicine cabinet and beyond, when it comes to antibiotics, the choices we all make matter. ✦

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Antibiotic resistance

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T F

☐ ☐ 1. *Clostridioides difficile* (*C. diff*) is a bacterium that causes life-threatening gastrointestinal diseases such as colitis and diarrhea.

☐ ☐ 2. Bacteria are smaller than viruses, unalive, and require a host cell to reproduce.

☐ ☐ 3. Germs can develop resistance mechanisms that render antibiotics less effective in combating bacterial infections.

☐ ☐ 4. Overprescribing and improper prescribing of antibiotics are more common in inpatient settings than outpatient settings.

☐ ☐ 5. Unlike other diseases, antibiotic-resistant diseases are usually limited to one nation or region.

☐ ☐ 6. Increasing public awareness of the dangers of antibiotic overuse is an important component of antibiotic stewardship programs.

☐ ☐ 7. Methicillin-resistant *Staphylococcus aureus* is an example of a disease that is categorized as a serious health threat by the Centers for Disease Control and Prevention.

☐ ☐ 8. In the United States, most antibiotics are used to treat sexually transmitted diseases in humans.

☐ ☐ 9. Antibiotics are not an appropriate treatment for influenza.

☐ ☐ 10. The antibiotics used on animals to increase growth are similar to those given to humans to treat certain diseases.

☐ ☐ 11. Viral pneumonia is one of several diseases that can be treated with antibiotics.

☐ ☐ 12. Strep throat, unlike most types of sore throats, can benefit from antibiotic treatments.

T F

☐ ☐ 13. The U.S. Food and Drug Administration has limited which antibiotic drugs may be used in animals.

☐ ☐ 14. Penicillin was used extensively during World War I to treat soldiers who had various types of infections.

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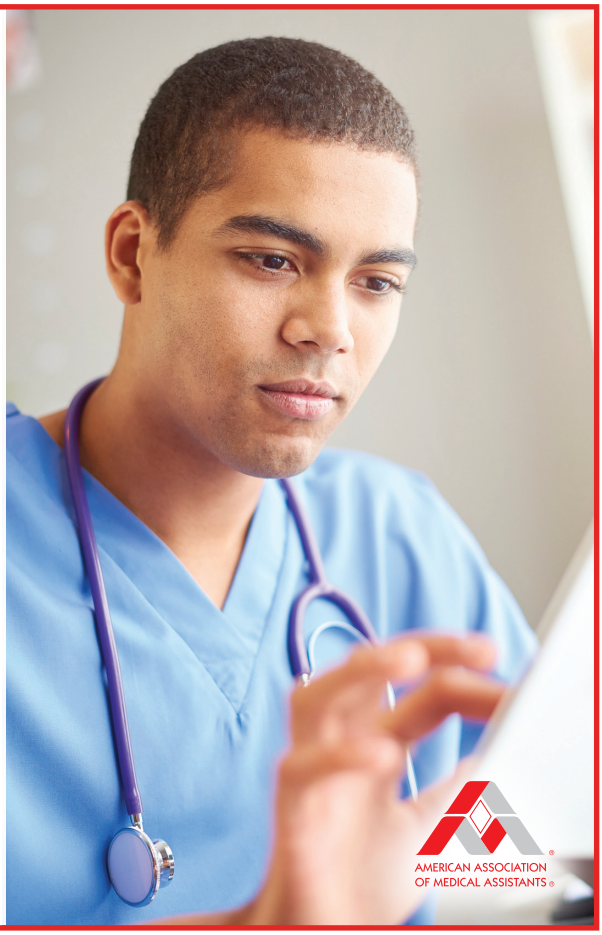

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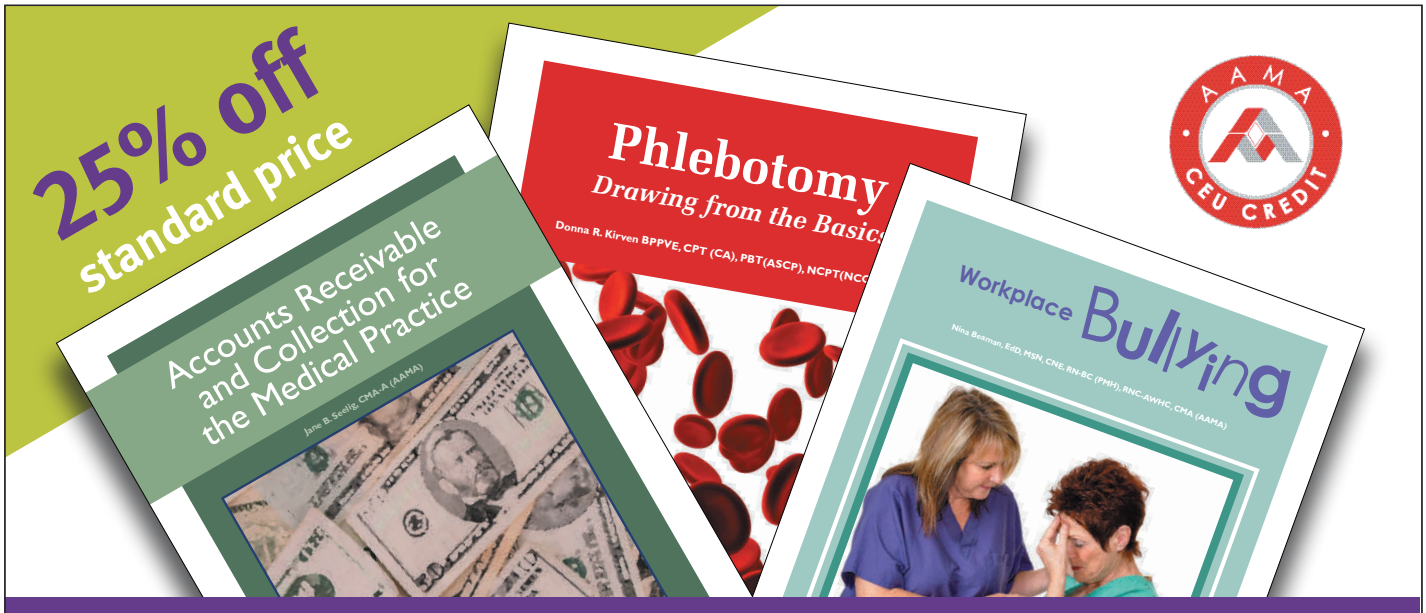

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Whether they're roasted in the oven or tossed into a salad for an extra nutritional kick, this root vegetable can't be beat. ✦

Goal-getters

How do you approach your goals? Do yourself a favor by asking the right questions, suggest three studies in the *Proceedings of the National Academy of Sciences of the United States of America*.

The studies looked at the value of using a strategic mindset for tackling goals, which involves asking questions such as, What can I do to help myself, and is there a way to do this even better? Study participants who employed greater strategic thinking showed more progress in their life's goals, whether those goals were educational, professional, or health and fitness related.

The researchers also created an un-egg-spected experiment that asked participants to crack eggs and collect as many egg whites as possible for two minutes. The results showed that those who had been primed with an article on the benefits of a strategic mindset approached the task with a more strategic mindset and performed better in the experiment.

Whatever goals you may have—big or small—remember that a little strategy can go a long way.

Canines for cardio

If you're looking for another reason that dogs are a gift to humankind, you're barking up the right tree. New dog owners showed a short-term increase in physical activity in a study from *BMJ Open Sport & Exercise Medicine*.

The study measured the number of walking minutes per week for individuals before and after becoming dog owners. Participants showed a 93-minute-per-week increase in walking three months after getting a dog and a 50-minute-per-week increase after eight months. While researchers acknowledge that more studies need to be done concerning long-term effects on physical activity, the short-term boost to physical activity is reason enough to give—and consider getting a pet with—paws.

And proud dog owners rejoice: your dog's endless energy is a perfect motivation fur physical activity!

Middle-age momentum

You can never start planning for older age too early or too late. Healthy habits at age 50 can reduce frailty 20 years later, according to a longitudinal study published in *PLOS Medicine*.

Researchers assessed four healthy behaviors (i.e., nonsmoking, moderate alcohol consumption, moderate-to-vigorous exercise, and daily fruit and vegetable intake) for study participants around age 50. Those who engaged in all four healthy behaviors were 70% less likely to show frailty at an older age than those who practiced none of them. Plus, those who increased their number of healthy behaviors between roughly ages 45 and 55 successfully decreased their frailty risk.

Take time to analyze your own activities and note healthy and unhealthy behaviors. Make a plan on how to cut the bad habits while supporting the positive ones, and reap the benefits for decades to come. ✦

Break it up

Is staying in your seat putting a cramp in your workday? Taking periodic breaks from sitting can ease the discomfort of prolonged sitting, according to a study from *Safety and Health at Work*. Furthermore, certain activities and lengths of breaks may stand up to muscle pain better than other interventions.

Researchers measured discomfort for participants tasked with two-hour periods of desk-bound work and found a high likelihood of muscle fatigue after just 40 minutes of sitting. From there, researchers tested multiple interventions to help relieve muscle fatigue.

On the edge of your seat? The researchers make a clear recommendation: after 40 minutes of sitting, stand and stretch for five minutes for the greatest reduction of muscle discomfort. This intervention typically provides 30–45 minutes of a recovery-level state. ✦

At face value

Using vaccinations to combat a global pandemic translates to a whole lot of injections. But researchers at the University of California, Irvine, found an easy way to make those shots a bit less painful, as detailed in *Emotion*.

The study evaluated the effects of four different facial expressions on reported pain levels from a 25-gauge-needle injection. Those who maintained a Duchenne smile (i.e., a smile that reaches the eyes, typically associated with sincerity) or even a grimace during the injection experienced up to 40% reductions in reported pain, compared with the neutral expression baseline group. Those who were in the Duchenne smile group also showed reduced heart rates.

The next time you find yourself staring down a vaccine or other injection, give smiling or even grimacing a shot! ✦

Perk alert

Improve employees' access to FMLA benefits

By Brian Justice

In 1993, the U.S. Congress passed the Family and Medical Leave Act (FMLA) with bipartisan support, and President Bill Clinton signed it into law. In 2000, almost half (47%) of private-sector employees in the United States were covered and eligible for FMLA leave,[1] and as of January 2021, workers have used the FMLA more than 300 million times[2] to take time to care for their own or their family's health without the fear of losing their job or insurance coverage while doing so.

Almost 15 million people take FMLA leaves every year.[2] That is impressive considering that the benefits apply only to employers and employees that meet certain criteria. Employers must provide FMLA benefits if they fall into one of several categories[1]:

- Private-sector employers with 50 or more employees working 20 or more workweeks in the current or most recent calendar year
- Local, state, and federal public agencies
- Public and private elementary and secondary schools

Employees are considered eligible for FMLA leave when they meet all requirements[1]:

- Work for a covered employer
- Have worked for that employer for at least one year
- Have worked at least 1,250 hours for that employer in the preceding year
- Work at a U.S. location where their employer has at least 50 employees within 75 miles

The FMLA at work

Under the FMLA, eligible employees can take up to 12 weeks of unpaid, job-protected leave to care for themselves or their immediate family (i.e., a spouse, parent, or child). In 2008, the FMLA was amended to expand the leave period to 26 weeks for employees to care for military family members.[3]

Overall, the FMLA was conceived as a means for people to prioritize personal and family health needs, a purpose illustrated by Viki Van Sickle, MSM, CMA (AAMA), medical assisting department chair at Ivy Tech Community College in Valparaiso, Indiana.

"I used it in the past when my mother had open heart surgery," she says. "So, if I needed to go to appointments with her or take her to therapy sessions or anything like that, I had the ability to do those things and not have it affect me at work."

And the FMLA extends to self-care. More than half of the FMLA leaves taken are used to address a personal health condition.[2] A CMA (AAMA) employed at a large health care system who asked to remain anonymous used FMLA benefits to address both her own health issues and those of her child.

"Once [I used FMLA benefits] for ongoing medical problems after surgery, when I needed to make appointments on very short notice because of sudden flare-ups," she says. "Another time [I took leave] for my child, and because of the FMLA, I was able to put my family first and not worry about losing my job."

Get your act together

However beneficial the policy, the FMLA cannot be used unless its benefits are accessible and employees are fully informed. Conscientious organizations, managers, and human resource professionals take that responsibility very seriously.

"Our mission is to preserve and improve human life, and that extends not just to our patient community but obviously our team members and their families as well," says Joyce Milewski, assistant vice president of employee relations and human resources at NorthShore University HealthSystem in Evanston, Illinois. "Ensuring that our employees understand what their rights are as they relate to leave and the FMLA, specifically, is important to us."

Supervisors should encourage employees to use the FMLA when needed and take time to explain that FMLA will protect their jobs while they are away. That open dialogue between staff members and supervisors is key. "That work relationship you have with your employees has a big effect," Van Sickle agrees. "The process for us is fairly easy. We

just have to reach out and get the necessary paperwork or the links. I've seen the FMLA work to everyone's benefit, even if you're not being paid for that time off."

Making an effort to provide employer education on FMLA early on is a worthwhile step. NorthShore University HealthSystem includes FMLA awareness in new employee orientation. "There's also a portal that our employees can access for information about policies and forms anytime they need it," says Milewski.

Love to leave

The FMLA has generally proven to be successful all round. In a survey on the effects of the FMLA, 90% of responding workplaces indicated no difficulty with complying with the FMLA. Additionally, less than 2% of workplaces reported misuse of FMLA leave, and more than one-third reported that their workplace experienced positive effects.[2]

"In some situations, such as maternity leave or surgery, notice can be given in advance, and using FMLA leave is fairly straightforward," says Nicole Stice, CMA (AAMA), CCMA, medical assistant facilitator for the HSHS Medical Group in Springfield, Illinois, and president of the Lincolnland Chapter of Medical Assistants. "However, in cases of unexpected sickness or intermittent absences, [FMLA leave] can be harder to manage, affecting the workload and causing some stress on other employees." The most common solution seems to be temporarily assigning tasks to other workers. Only 6% of worksites that participated in the aforementioned survey needed to hire a temporary replacement.[2]

"We do have cases in which we will utilize reduced work schedules and flexible work arrangements," explains Milewski. "Those work-arounds are always a win-win because we have the benefit of the employee providing care to patients, and at the same time, the employee has a schedule that's modified so they can care for their needs as per the FMLA."

The real payoff

Employees' ultimate benefits through the FMLA are intangible: work-life balance, stability, productivity, overall job satisfaction, and peace of mind.

"One of my employees needed to use FMLA leave when her daughter was ill," remembers Van Sickle. "So, for her, with no family and no other help around, we were able to all work together to figure out a schedule so that altogether her time off would not be more than a month. She was still able to help and I covered for her, and that turned out to be a safe harbor for her—knowing that her job was safe and there for her to come back to." ✦

The paid-leave push

The success of the Family and Medical Leave Act has helped people keep jobs and insurance coverage, but going without pay for even a short time can be a real hardship for many people.

Only 13% of private-sector workers have paid family leave, and 41% have medical or short-term disability leave.[4] But several states, cities, and municipalities have mandated employer-provided paid leave.[5]

Proactive business owners, practice managers, and human resource professionals may need to be prepared for others to follow suit.

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PANDEMIC PIVOT

How COVID-19 changed medical assisting program curricula

By Pamela M. Schumacher, MS

The onset of the COVID-19 pandemic and the public health response needed to minimize the spread of COVID-19 required an immediate change to the traditional approach to medical assisting education. Responses from programs across the country included moving classes online, rethinking in-person training and testing, and completely retooling curricula.[1] The impact of these changes will be felt even after the vaccine is fully distributed.

Playing defense

"In March 2020, accredited medical assisting programs pivoted swiftly and efficiently to online education for the didactic portion of their curricula because of the dictates of their institutions and states," says Sarah R. Marino, PhD, executive director of the Medical Assisting Education Review Board (MAERB). "Program directors and instructional staff demonstrated flexibility and creativity in making new uses of existing learning management systems or creating new learning environments within an online modality."

Dana Woods, MAEd, CMA (AAMA), program director of the medical assisting program at Southwestern Illinois College in Belleville, Illinois, says her team made changes almost overnight. "When the college closed, we transitioned theory classes to an online format," she says. "We backloaded those sessions with hands-on skills so students could have the same experience as previous classes. This also kept our students close to the standard timeline for finishing the program.

"When restrictions were eased, we adjusted how we conducted in-person classes by breaking students into smaller groups, sanitizing classrooms more frequently and more thoroughly, socially distancing as much as possible, wearing masks, taking temperatures, and limiting access to the building," says Woods. "All these precautions were to keep students and instructors safe. The instructors did an excellent job working as a team, scheduling students, and helping each other with laboratory activities so students were able to practice skills with limited time on campus."

Dr. Marino notes that some educators also conducted two-to-three-day boot camps for focused sessions to help students achieve clinical competencies. "Other programs set up individual sessions for students, training students on the clinical and administrative competencies on a one-on-one basis," she explains.

Practicum practicalities

"During the early days of the pandemic, the first concern was how to offer practicums, because ambulatory health care sites were shut down," says Dr. Marino. To best support program directors and students, MAERB adjusted its policies to expand the implementation of the required 160-hour practicum, a standard listed in the Commission on Accreditation of Allied Health Education Programs (CAAHEP) publication *Standards and Guidelines for the Accreditation of Educational Programs in Medical Assisting*. MAERB published a COVID-19 statement that—for a limited time—allows programs to use alternative health care sites, simulation, case studies, and other problem-based learning scenarios as substitutes for the traditional on-site practicum.[2]

"We asked programs to consult with their communities of interest—employers, practicum sites, institutions, and students—to ensure that the students received the full experience of a CAAHEP-accredited medical assisting program and that graduates of that program were well-trained within their scope of practice to ensure patient safety," says Dr. Marino.

The Southwestern Illinois College program used the options in the MAERB COVID-19 statement to meet the needs of its students and successfully offer a practi-

cum experience. "Creating a safe pandemic practicum experience was a little more difficult than switching to online teaching," says Woods. "We employed a combination of on-site experience and simulated hours. All students had time in an ambulatory health care setting for a practicum, supplemented by online simulations. These included mostly administrative skills like additional scheduling exercises, payroll, and conducting inventories.

"This turned out to be beneficial because students seldom experience those tasks during a practicum," she says. "Some practicum sites required students to bring their own personal protective equipment, such as N95 masks and gloves. The school provided those items for the students, although supplies were limited and hard to find."

Dr. Marino notes that many programs were able to retain their traditional practicums by deferring them to a later time or by adapting the practicum length —for example, from 240 hours to 160 hours. "When considering any changes, programs should refer to the MAERB COVID-19 statement, which provides a helpful checklist to guide CAAHEP-accredited programs in making adaptations to their existing curriculum or practicum [made necessary by the pandemic]."

On the rebound

COVID-19 may not be the last public health emergency that medical assisting educators encounter in their careers; however, the response to COVID-19 shows how health care education may continue to evolve in the coming years.[1]

"We learned a lot from this experience," says Woods. "Some of the positives include adding simulations, finding alternative ways to teach, and adding *more* telemedicine to our standard curriculum. When online learning was implemented, we required some recorded and live presentations to be submitted by the students. Oral presentations, role-playing with family members, and other assessments are some examples."

While adapting to changes, educators and institutions should not neglect the needs of students who have a low income, have caregiving duties, or lost their jobs.[3] "The emergency pivot to online courses proved especially stressful for disadvantaged students who need more counseling and advising to stay on track," says Linda L. García, PhD, executive director of the Center for Community College Student Engagement in Austin, Texas.

"In 2020, many community college students struggled with adapting to the online environment and not having the structure of in-person education. To make matters worse, many [lack] access to a dependable computer, have inadequate and unreliable internet, or may be dealing with food and housing insecurity," says Dr. García. "There's been a 10% decline in community college enrollment during the pandemic because students have more pressing priorities than getting an education. Relationships matter with community college students, so anything an institution can do to foster relationships will help keep students engaged and enrolled."

Woods agrees educators should always maintain an active connection with students but especially during the pandemic. "Most of our instructors made themselves available to students by email, phone, or Microsoft Teams for much more [time] than just when classes ran," she says. "I am really proud of the people I work with and how they are handling the challenges we are facing. Going forward, I can see some of the newly acquired technology skills remaining in the way we teach classes." ✦

Show and tell

Focus on these areas to help students stay connected during and after the pandemic[3–5]:

- Technology and connectivity
  - Establish Wi-Fi hotspots on campuses to enable students to work in their cars.
  - Distribute laptops—or allow students to use financial aid or take out an additional loan to purchase a computer—so students can continue learning during campus closures.
- Advising
  - Enable chat or instant messaging for students and advisors to communicate in real time.
  - Create an early alert system that flags when students' grades slip or when they have not logged on for a while.
  - Steer students toward emergency financial aid when needed.
- Basic assistance
  - Be flexible and acknowledge what everybody is going through.
  - Connect students to resources (e.g., help applying for federal housing or food assistance or emergency gift cards to a local grocery store).

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Comfort in crisis

Medical assistant prioritizes mental health during pandemic

By Cathy Cassata

When Bailey Nissen, CMA (AAMA), graduated from a medical assisting program in 2018, she kept her options open while job hunting.

"I was looking for jobs in my area, and I came across a medical assisting role that was the only one I had seen in psychiatry," says Nissen. "It sparked my interest."

To her delight, Nissen was hired by Broadlawns Medical Center in Des Moines, Iowa, to work at their outpatient behavioral health clinic soon after she applied.

Nissen's days are filled with caring for patients who have various mental health disorders, such as anxiety, depression, bipolar disorder, and substance use disorder. When she first took the position, she traveled back and forth between the clinic and its affiliated psychiatric urgent care unit.

"It was great to help patients in need [during a crisis]," she says. "I never knew what [situation] was coming through the door."

However, her time in urgent care was limited, and before the COVID-19 pandemic began, Nissen mainly worked in the clinic, assisting physicians who met with 10 to 15 patients per day. She roomed patients, took their vital signs, and recorded medical histories.

"I would ask questions that pertain to mental health—such as whether they had symptoms of depression, suicidal thoughts, or changes in eating habits for those with an eating disorder—as well as other general questions medical assistants would ask about medications the patients take and allergies they have," says Nissen.

At the start of the COVID-19 pandemic, the clinic turned to telemedicine. Nissen calls patients the day before their appointments to ask whether they have any changes to their medications or pharmacy location and gathers information related to their medical history.

"I really miss seeing the patients," says Nissen. "But we have noticed that we have a lot more patients showing up for their appointments—whether over the phone or via [computer]—since they don't have to come in."

Overall, patients are displaying increased anxiety and depression symptoms, notes Nissen. "A lot of people can't get out of the house like they could before, and a lot of people have anxiety about contracting the coronavirus. We definitely notice an increase with our substance use disorder patients, and more people are asking to get help," says Nissen.

Unlike typical primary care or specialty practices, Nissen's work involves the unique challenge of being unable to immediately see patients' symptoms.

While stigma and preconceptions about who might have a mental illness abound, *anyone* can be affected. "With mental health, you can't really see it, so being able to talk with patients and find out what's going on in their head is crucial to understanding their struggles," says Nissen.

Nissen finds that working with substance use disorder patients is most gratifying. The clinic offers a medication-assisted treatment program in which patients visit with their health care provider once or twice a month. Some patients are referred to Broadlawns Medical Center after being discharged from a residential treatment program. Others are seeking care for withdrawal from opioids or methamphetamine.

"A patient might come in initially not doing well," says Nissen. "As their recovery journey progresses, it is rewarding seeing them staying sober, attending their appointments with the provider, going to therapy, and taking medication as prescribed."

While Nissen plans to stay in mental health for the long term, she believes the skills she has gained will benefit any practice.

"No matter where I work, there will be patients with mental health issues, so everything I've learned in this setting will help end the [associated] stigma no matter where I go," says Nissen. ✦

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Medical assistants, thank you!

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