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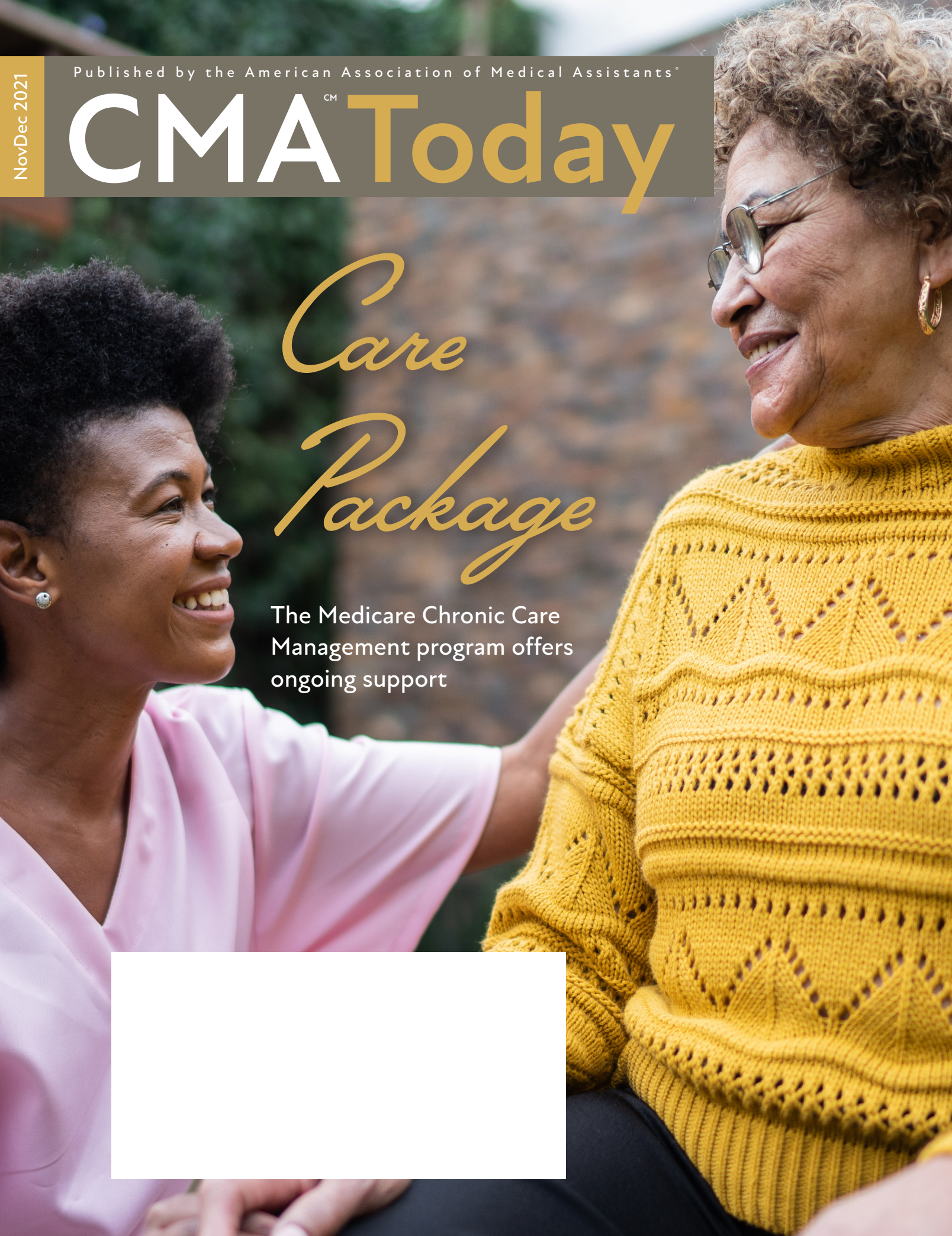

Care Package

The Medicare Chronic Care Management program offers ongoing support

Career Professional Development • Series I

POPULATION HEALTH

Developed by the Career Professional Development Committee of the American Association of Medical Assistants®

Career enhancement meets convenience.

Professional development at your pace.

The program includes six modules on population health topics:

- Population health overview
- Health coaching
- Care management programs
- Patient navigation
- Behavioral health
- Motivational interviewing

Each module is worth AAMA CEUs. Complete all modules and pass a final test to earn the Series I digital badge.

For details and pricing, visit the AAMA e-Learning Center https://learning.aama-ntl.org/

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

12 The Medicare Chronic Care Management program offers ongoing support

By Mark Harris

26 2021 CMA (AAMA)® Compensation and Benefits Report

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AAMA update

Earn a digital badge in population health!

The AAMA has launched Career Professional Development Series I: Population Health to empower medical assisting professionals with refined skills and knowledge so they can enhance their ability to improve health outcomes for patients in their community.

This budget-friendly online program is available to CMAs (AAMA)®, other medical assistants, and all other health care professionals. Use the Series I: Population Health digital badge as a declaration that you're qualified for that promotion, salary bump, or job opportunity!

To earn the digital badge, individuals must complete the following six courses and pass a final assessment:

- *Population Health Overview*
- *The Impact of Behavioral Health on Population Health*
- *Creating Care Management Programs*
- *The Expanding Field of Health Coaching: An Ideal Role for Credentialed Medical Assistants*
- *Patient Navigators: An Ideal Role for Credentialed Medical Assistants*
- *Motivational Interviewing: Understanding the How, What, When, and Why*

The courses can be taken together as part of the Series I: Population Health program or individually for AAMA CEU credit. Only those who pass all six courses will receive a digital badge upon completion. The program, worth 11 administrative/general/clinical CEUs, will be available via the AAMA e-Learning Center.

Online submission of featured AAMA-approved CE programs

Ready to submit AAMA-approved CEUs like a CPR card? You can instantly submit documentation for AAMA-approved CEUs via the AAMA website! This feature is the preferred method for uploading CPR cards as well as courses from the free, online FASDs and Smiles for Life programs.

Visit the "AAMA Approved CE Programs" webpage to learn more about those CEU opportunities. Then log on to your AAMA website account and select "Web Uploads" from the left-side menu to quickly and conveniently submit your program completion documentation to receive CEU credit. Simply select the appropriate course from the drop-down menu, upload a file, and submit!

You can see the status of your submitted documentation on that same webpage. Allow 2–3 business days for processing. ✦

On the web

Survey says ...
Under Medical Assisting/ Compensation and Benefits
See how your earnings and benefits stack up against the rest in the *2021 CMA (AAMA) Compensation and Benefits Report*, featured in this issue. The website version includes an extended report on compensation and benefits for medical assisting educators.

CMA Today *indexed*
Under CMA Today/Archives
Need to find an article, but can't remember the issue? Use the 2003–2021 *CMA Today* title/author indexes. Then, search by volume and issue on the "Archives" webpage. Or use the search field (upper-right corner of each webpage).

Take the CMA (AAMA) Certification Practice Exam
Under CMA (AAMA) Exam/Study for the Exam
Students and medical assistants preparing for the CMA (AAMA) Certification Exam can enhance their readiness by taking the CMA (AAMA) Certification Practice Exam. The practice exam contains 10 practice modules, each with 20 questions, which users can go through twice. Read the CMA (AAMA) Certification Practice Exam FAQs for more information. ✦

Managers meet up

The AAMA was present and accounted for at the American Academy of Family Physicians Family Medicine Experience and the Medical Group Management Association annual meetings in September and October.

At the AAMA exhibit booths, your Board of Trustees leaders, the AAMA public relations and marketing manager, and the AAMA CEO and legal counsel vigorously promoted the hiring of CMAs (AAMA) and provided innovative insight on how medical practices can utilize staff to the top of their certification or licensure. ✦

Standout students

Congratulations to the latest recipients of the Maxine Williams Scholarship:

Petrea Ashmore, CMA (AAMA), graduated in August from University of Alaska Southeast in Sitka, Alaska, and earned her CMA (AAMA) credential in September. Ashmore was drawn to medical assisting for several reasons, including wanting to help people, looking for a stable career to support her family, and enjoying diverse settings. "I feel that this profession, although may be difficult at times, will be very rewarding," she shares.

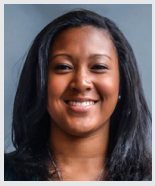
Meanwhile Ashmore's colleagues share reasons *patients* would enjoy a rewarding experience working with Ashmore. Ashmore is known for being an attentive, thorough, highly qualified individual with excellent communication skills and a generous spirit. A professor eloquently summarizes Ashmore's contribution to patient care: "She embraces professionalism consistent with the spirit of medical assisting."

Amy Baron graduated from Eastern Maine Community College in Bangor, Maine, in August. Her desire to pursue a career as a medical assistant stems from her background in biology and human anatomy education. Baron wants to "make [herself] useful in health care in the community."

Indeed, Baron is community driven, volunteering much of her time to events that benefit children and nature, despite long commutes. She is characterized by others as dedicated, responsible, intelligent, friendly, and a lifelong learner. Her educator summarizes, "I strongly believe that she will make lasting contributions to the medical assisting field."

Tara Ramon, CMA (AAMA), graduated from Apollo Adult Education in June and earned her credential in July. She found her calling in medical assisting by taking care of her grandfather, which sparked her passion for serving others.

As a student, Ramon is praised for being bright, professional, engaged, and driven; she "possesses good leadership qualities that will surely benefit her in her career path," according to one of Ramon's educators. Another colleague shares how Ramon has promise as a medical assistant who can withstand the chaotic, unpredictable health care environment that exists today: "Tara has always been hardworking and resilient. She puts forth her best effort no matter how many obstacles she may encounter."



Tamaragail Tarrant, CMA (AAMA), graduated from Greenville Technical College in August and earned her CMA (AAMA) credential in September. Tarrant's passion for medical assisting is driven by her desire to improve the lives of patients, particularly women of color and their children. "I want to make an impact that will improve the overall quality of life within an underserved community in an innovative and compassionate way," she says.

As a student, Tarrant earned high praise from her program director: "I cannot speak highly enough of Tamaragail's professionalism and her commitment to serve others with dignity and respect. She … navigates stressful situations with empathy and poise." As an employee, Tarrant is called an integral part of the team in both tangible and intangible ways. "What she does for the patients," says her supervisor, "is far more than I can measure."

Milena Thao graduated from Century College in May. Thao's interest in medical assisting sprouted from her love of helping others and two, poignant personal experiences with medical assistants. "I want patients to be heard and to feel as though they really do matter," she says.

During her academic career, Thao's work ethic and passion for the profession has seen her through obstacles like earning her degree as a first-time mother of a young child. As a student, Thao is praised for being hard working, driven, a helpful classmate, and a local volunteer. "Melina is one of the most professional, conscientious students I know," writes one educator. "She has a strong commitment to the field of medical assisting."

AAMA Board of Trustees creates the Advisory Program

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

"How can we utilize medical assistants to the top of their education and credentialing in our large health system? We employ over 60 medical assistants across all our campuses and plan to hire more in the next six months."

"What is the optimal staffing structure for our multispecialty clinic? We employ many medical assistants and are transitioning to a patient-centered medical home model. We want to hire health professionals whose knowledge and skills complement those of our medical assistants."

"How do the recent changes in state and federal law affect our medical assistants' scope of practice? We are reading and hearing different things from various 'experts.' We would really appreciate definitive answers to our questions."

The above are typical questions we frequently receive at the American Association of Medical Assistants® (AAMA) Executive Office. To provide accurate answers to these sorts of questions and to facilitate the effective deployment of medical assistants and CMAs (AAMA)® in the rapidly changing American health care delivery system, the AAMA Board of Trustees (BOT) has created the Advisory Task Force Advisory Program. The Advisory Program was unveiled at the AAMA Annual Conference in Houston, Texas, in September 2021.

The origin of the Advisory Program

The BOT, through their contacts with AAMA members and their knowledge of the current health care delivery environment, came to the realization that questions such as the above were being asked frequently throughout the United States. The BOT commissioned the Advisory Task Force, consisting of some members of the BOT and other AAMA leaders, to evaluate the challenges medical assistants were facing in their professional lives. The Advisory Task Force recommended to the BOT that an Advisory Program be established to provide the most up-to-date information about effective utilization of medical assistants, preferred staffing configurations, and the parameters and limitations of medical assisting scope of practice in the shifting legal landscape.

Advisory Program expertise and target audiences

The BOT accepted the Advisory Task Force's recommendation, appointed the members of the Advisory Task Force, and selected AAMA staff to serve as subject-matter experts for the Advisory Program. Advisory Task Force members have considerable expertise in medical practice staffing issues; management of small, medium, and large practices and clinics; patient-centered medical home formation and operation; clinical and administrative medical assisting; National Committee for Quality Assurance compliance; third-party reimbursement; and federal and state laws and their scope of practice impacts.

The Advisory Program's target audiences will include, but will not be limited to, the following professionals:

- Licensed providers and other clinical staff
- Medical managers and administrators in the areas of human resources, risk management, and compliance
- Managed and accountable care specialists
- Coding and reimbursement professionals

Unlocking the potential of the medical assisting profession

The primary charge of the Advisory Program (as determined by the BOT) is providing concrete and reliable information that will remove barriers to the full utilization of medical assistants. Dispelling misconceptions

and imparting trustworthy knowledge will be a key step in unlocking the untapped potential of medical assisting professionals.

It is indeed fitting that the AAMA, the national professional society representing over 80,000 medical assistants and CMAs (AAMA), has developed this much-needed Advisory Program. In initiating this and other strategic programs, the BOT is guiding the AAMA in fulfilling its purpose to "enable medical assisting professionals to enhance and demonstrate the knowledge, skills, and professionalism required by employers and patients; protect medical assistants' right to practice; and promote effective, efficient health care delivery through optimal use of multiskilled CMAs (AAMA)."[1]

Additional information about the Advisory Program will be available on the AAMA website. Questions and requests for further information may be directed to AAMA Public Relations and Marketing Manager Francesca Llanos, liaison to the Advisory Task Force, via AdvisoryTaskForce@aama-ntl.org. ✦

Reference

1. *AAMA Bylaws, 2020-2021*. American Association of Medical Assistants; 2020. Accessed October 15, 2021. https://www.aama-ntl.org/docs/default-source/members-only/aama-bylaws.pdf

THE GRASSROOTS OF CANNABIDIOL

Weed out the doubtful details on CBD

By Kathryn S. Taylor

Cannabidiol is an unusual word that is about to become a lot more familiar. Cannabidiol (CBD) is the second-largest active component in marijuana and an important ingredient in medical marijuana.[1]

Cannabis refers to all products derived from the *Cannabis sativa* plant.[2] And *marijuana* refers to the plant's parts and products that contain significant amounts of tetrahydrocannabinol (THC).[2] Cannabis plants that have little THC are called *industrial hemp*. The cannabis plant includes approximately 540 chemicals,[2] with 140 of those being cannabinoids.[3] THC and cannabidiol (CBD) are the main cannabinoids present.[2] While THC is psychoactive, CBD is not.[4]

The body produces its own cannabinoids, known as endocannabinoids, which are neurotransmitters that bind to cannabinoid receptors in the nervous system.[4] The endocannabinoid system regulates sleep, appetite, pain, immune system responses,[4] learning, memory, and inflammation.[3]

Highs and lows

One of the main benefits that CBD is believed to have is pain reduction.[4] CBD is also believed to act on serotonin receptors in the brain. Therefore, CBD is being investigated to combat anxiety and depression without the addictive qualities of medications such as benzodiazepines, as well as insomnia and anxiety in children who have post-traumatic stress disorder.[4]

Other conditions CBD may improve are acne, neurodegeneration associated with Alzheimer disease, heart and circulatory issues (including high blood pressure), psychosis, substance use disorder, and diabetes, among others.[4]

Animal and test-tube studies have even shown promise for CBD as a weapon against breast cancer cells.[4]

The mighty combination of CBD and THC is being evaluated to treat pain related to multiple sclerosis and rheumatoid arthritis, cancer symptoms, and chemotherapy side effects.[4]

But while there are high hopes for CBD, its actual proven benefits are few. Numerous studies have been or are being conducted on other, potential benefits of CBD. And yet most have been inconclusive because the studies lack a control group, have been done on too small of a group, are animal studies that are not necessarily applicable to humans, or are unreliable for other reasons.[2]

In June 2018,[5] Epidiolex, an oral medication,[2] became the only CBD product approved by the Food and Drug Administration (FDA).[6] This is a prescription oil[6] containing purified CBD[2] that is used to treat seizures associated with two types of rare and severe[2] childhood epilepsy syndromes—Dravet syndrome and Lennox-Gastaut syndrome—against which antiseizure medications are usually ineffective.[1]

Hemp and haw

As with cannabis, the legality of CBD is forever changing.[1] While CBD is legal in all 50 states, CBD is subject to restrictions and is classified along with marijuana by the federal government.[1] The regulation of the use of medical hemp and marijuana products varies across states, and production and distribution are unregulated.[5] CBD products that are derived from hemp and contain less than 0.3% THC are legal under federal law, but those derived from marijuana are not.[4] Laws concerning both of these vary by state.[4]

CBD products are readily available for anyone to purchase, which brings its own set of issues. Because CBD is sold as a supplement rather than as a medication, the FDA does not regulate its safety and purity.[1] Therefore, these products may have misleading labels as far as types and levels of ingredients.[1] In fact, in one study, of 84 CBD products bought online, more than 25% had less CBD than advertised, and 18 of them contained THC.[6]

"I don't know where [patients] get their CBD oil," says Kathy Hansen, CMA (AAMA), who works in prior authorizations with Dartmouth-Hitchcock Neurology

in Manchester, New Hampshire, "which I think is the problem. You don't know the quality and can't verify the concentration."

To find reputable sources of CBD, Alan Carter, PharmD, an independent consultant in the Kansas City area and an adjunct faculty member of the University of Missouri–Kansas City School of Pharmacy advises, "Look for products from companies that only use hemp grown in the U.S. and provide proof of independent third-party testing by an ISO 17025–compliant laboratory. Broad-spectrum CBD products should contain no THC, but full-spectrum products may contain up to 0.3% THC according to the certificate of analysis provided by the laboratory. Also, the [certificate of analysis] must indicate the product passed testing for heavy metals, pesticides, and mold contamination."

Because CBD is not officially approved for most uses, the dosage can be hit or miss. "Start low and go slow with dose increases," says Dr. Carter. "The lowest dose that provides relief is the goal."

It's only natural

"I think we should treat all natural products with respect," says Brent A. Bauer, MD, FACP, research director at Mayo Clinic Integrative Medicine and Health in Rochester, Minnesota.

"Remember, anything that is strong enough to help address a symptom or disease is also strong enough to have negative effects," he notes. Side effects of CBD include diarrhea, appetite and weight fluctuations, and fatigue.[4]

Patients need to discuss their use of CBD with their health care providers because CBD can interact with some medications.[1] For example, CBD can increase the level of the blood thinner warfarin (Coumadin) in the bloodstream.[1]

"Especially with higher doses," Dr. Bauer adds, "there have been a few reports of elevated liver enzymes in some users."

At her previous job in obstetrics and gynecology, Hansen learned that many of her practice's patients used CBD through the medication list they fill out. She has found that some patients undergoing chemotherapy use CBD to battle nausea. "A lot of them don't have a specific condition. [While] some of them say they use it for anxiety," shares Hansen.

"The data is not so strong that I recommend these things routinely," says Dr. Bauer. "I also do not recommend CBD—or any dietary supplement—without having the patient first focus on a high-quality lifestyle approach—emphasizing good nutrition, daily aerobic exercise, at least 30 minutes of mind-body practice on a daily basis, structured social support, good sleep hygiene, and regular spiritual practice. At that point," he says, "if they are still having symptoms that might be addressed by CBD, we explore that on an individual basis." ✦

Plant a seed

While animal studies have shown therapeutic promise for some of the other cannabinoids, research on humans has yet to be done. Until then, safety issues and definitive answers about their ability to provide relief for certain conditions remain up in the air.[3]

Animal studies have shown **tetrahydrocannabivarin** lowers fasting insulin levels, aids weight loss, and increases glycemic control.[3,4]

While there are trace amounts of **cannabinol** (CBN) in cannabis plants, for the most part, it results from the degradation of tetrahydrocannabinol (THC). Although CBN is being marketed as a sleep aid, no evidence backs this benefit. Animal studies do, however, support its use as an appetite stimulant and anti-inflammatory. A study on humans done in Israel showed better attention-deficit/hyperactivity disorder symptom control in strains of cannabis with higher levels of CBN.[3,4]

Delta-9-THC has lower amounts of THC and may serve as medical cannabis that offers a lower high and its accompanying anxiety and paranoia. Cannabis contains trace amounts of Delta-9-THC, and it can be distilled and synthesized from hemp.[3,4]

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Improving predictions of cardiovascular health

While cardiovascular risk scores are already common in primary care, predictive power can be bolstered by evaluating changes in the scores over time, as detailed in *The Lancet Digital Health*.

In a longitudinal study of adults aged 40–75, researchers measured cardiovascular risk scores—using European Society of Cardiology Systematic Coronary Risk Evaluation (SCORE) and American College of Cardiology/American Heart Association atherosclerotic cardiovascular disease algorithms—over five-year intervals and integrated these findings into their risk model. In doing so, they improved predictive insight into both the likelihood of cardiovascular disease events and years free of such events when compared to single cardiovascular score readings.

The researchers suggest that this may be a powerful first step that could ultimately better inform treatment interventions and risk communication in the clinical setting.

Oral health as a frailty indicator

Poor-oral-health indicators in the older adult population can offer a window into potential frailty, according to *Lancet Healthy Longevity*.

Through a literature review on the subject, researchers identified 12 oral health factors, which they grouped into four categories:

- Oral health status deterioration
- Deterioration of oral motor skills
- Chewing, swallowing, and saliva disorders
- Oral pain

They found that oral health status deterioration was the category most associated with frailty. More specifically, frailty was most closely associated with factors such as few remaining teeth, poor oral health, and impaired masticatory (i.e., chewing) function.

By taking oral health factors into account, clinicians may be able to better predict the onset of frailty. While researchers note the difficulty in conducting a full oral health assessment in most clinical settings, they suggest using a tooth count could be a useful measure to track for general health purposes. Relatedly, a focus on improving oral health in older adults could also mitigate adverse health outcomes by improving nutrition and oral function. ✦

Satisfaction survey solutions

While asking patients to complete a survey that uses rating scales is one way to elicit feedback, this method may not provide a full picture, according to research published in *Health Policy OPEN*.

The study looked at patient satisfaction ratings of nurse care, physician care, and hospitalization conditions through a series of Likert-scale questions and found high levels of satisfaction in all three realms with low variability. To better interrogate these findings, the survey also included an open-ended question: "Do you have any further comments or suggestions for improvement?"

Of the 11,098 individuals surveyed, nearly 44% gave additional verbal comments with only 14% expressing a positive opinion. These comments highlighted numerous complaints regarding hospital cleanliness, interpersonal conduct of caregivers, poor communication, and other issues.

While many still reported favorable overall experiences, the open-ended call for feedback provided a more nuanced perspective of the patient experience and revealed underlying places for improvement that otherwise would have been missed. ✦

Social media influences adolescent diets

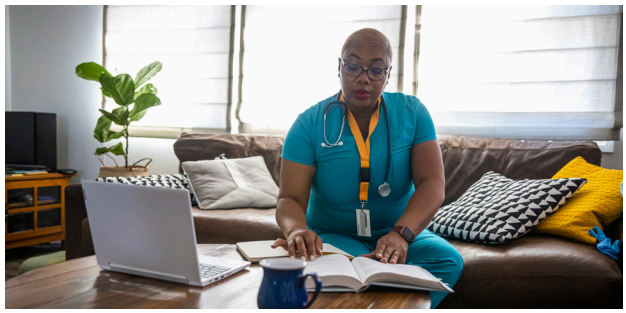
Researchers in the journal *Appetite* are recognizing a new frontier of social media food marketing (SMFM) targeted to adolescents.

Their study convened experts on SMFM and adolescent behaviors to investigate the relationship between marketing and dietary behaviors. The experts noted that unhealthy foods, particularly snacks, are advertised on social media far more often than healthy foods. Additionally, they identified a few ways in which SMFM can blur the lines of advertising and entertainment through interactivity. For example, if an adolescent is being encouraged to share the SMFM content, participate in contests or giveaways, or even take part in a campaign through their own contributions, the adolescent may not even realize they are being advertised to.

To make matters more complicated, digital marketing has advanced to a degree that adolescents can be targeted based off data collected on their values and preferences. Further, adolescents as a group can also be more susceptible to the influence of online role models who normalize food patterns and influence dietary choices.

While research on SMFM is still in its infancy, more needs to be done to better inform the public and encourage appropriate public policies. ✦

Student preferences for multimedia in education



Students seek out multimedia technology; however, many still prefer traditional teaching methods, according to a study in *Health Professions Education*.

The study surveyed 153 medical and health care students and found that about 85% would look for videos, animations, and images online to aid in their studies. Additionally, 71% had used 3D educational tools, and 55% had used educational games to supplement their learning. Although students had a clear interest in multimedia technology, only 36% of respondents felt their university had adequate multimedia available to support their learning.

Despite these statistics, 59% of students still preferred lectures over multimedia content, though 70% would prefer more multimedia to be involved in the learning process.

All in all, this study reflects the value of blending traditional teaching methods with multimedia educational tools to give students a well-rounded learning experience.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Care Package

The Medicare Chronic Care Management program offers ongoing support

By Mark Harris

Chronic care management is an essential aspect of the primary care system. This is especially true for older individuals who qualify for Medicare benefits.

In 2015, the Centers for Medicare & Medicaid Services (CMS) began offering health care providers separate billing codes to improve patient access to and reimbursement for Chronic Care Management (CCM) services.[1] As such, the Medicare CCM program is built on the pivotal need for chronic care services for many older Americans.

In fact, an estimated 117 million adults in the United States today have one or more chronic health conditions, according to the CMS.[2] Among Medicare-eligible individuals, more than half are reported to have three or more chronic conditions.[3] As the population ages, the number of people with multiple chronic conditions is also likely to increase significantly.[3]

Parcel out the details

Understandably, many patients with chronic medical conditions require access to ongoing care, resources, and services. Medicare's CCM services are designed to enhance preventive care, encourage the patient-caregiver relationship, and promote timely communication and sharing of health information. With this program, the CMS hopes to promote a more cost-effective, preventive, and community-based approach to health care for older adults. The goal is to reduce emergency room visits, hospital admissions, and other costly acute care needs while simultaneously improving patient well-being and medical outcomes.[4]

Early reports from the Medical Group Management Association show that patients enrolled in the CCM program under Medicare Part B had reduced hospital, emergency room, and nursing home costs and lower admission rates for individuals

Medicare's Chronic Care Management program

One of the Chronic Care Management program's main goals is to provide access to care and continuity, as described by the Centers for Medicare & Medicaid Services and the Medicare Learning Network:

- Provide ... 24/7 access to physicians or other qualified health care professionals or clinical staff, including providing patients (and caregivers as appropriate) with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of [the] week.
- Ensure continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care by telephone and also through secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods (for example, email or secure electronic patient portal).[4]

with a wide range of conditions, including diabetes, chronic obstructive pulmonary disease, congestive heart failure, urinary tract infection, pneumonia, and dehydration.[3]

The CMS provides the following definition of CCM under Medicare:

> Chronic care management is care coordination services done outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. These services are typically non-face-to-face and [allow] eligible practitioners to bill for at least 20 minutes or more of care coordination services per month.[5]

Under the Medicare CCM program, physicians, certified nurse midwives, clinical nurse specialists, nurse practitioners, and physician assistants may bill for CCM services.[5] A flat-fee reimbursement for basic or non-complex CCM services is offered, usually around $42 per billing, depending on the locale and specific Current Procedural Terminology (CPT) code used.[6] The activities that fall under the purview of the CCM program's definition of non-face-to-face services include telephone communication, reviews of medical records and test results, and consultations and exchanges of health information with other providers.[7] As a Medicare Part B benefit, patients are responsible for a 20% co-pay.[7]

Notably, Medicare allows only one practitioner to bill CCM services in any given month.[4] "The billing provider should be the one who is managing and monitoring the chronic conditions," says David J. Zetter, PHR, SHRM-CP, CHCC, a nationally recognized Medicare expert and president of Zetter HealthCare in Mechanicsburg, Pennsylvania. "Normally, that would be someone such as a primary care provider or an internal medicine [physician]—or maybe a cardiologist or another type of specialist such as a nephrologist. … Once an initial provider documents and bills for those Chronic Care Management services, if they're billing for it first, then no one else can bill for those services for the patient during that month."

To bill for Medicare CCM services, health care providers are required to use CPT code 99490. This covers non-complex CCM services and involves the minimum 20-minute requirement of monthly clinical staff time under the direction of a physician or other qualified health care professional. Additionally, if the service involves at least 30 minutes provided personally by the physician or other qualified health care professional, CPT code 99491 should be used.[4]

For complex CCM services, CPT code 99487 is applied. Complex care involves 60 minutes of clinical staff time directed by a physician, with moderate- or high-complexity medical decision-making involved. For every additional 30 minutes of clinical staff time, billing practitioners are asked to use CPT code 99489. Both non-complex and complex CCM services share many essential elements. However, they differ in the amount of clinical staff time involved, the degree of work done by the billing practitioner, and how much care planning is involved.[4]

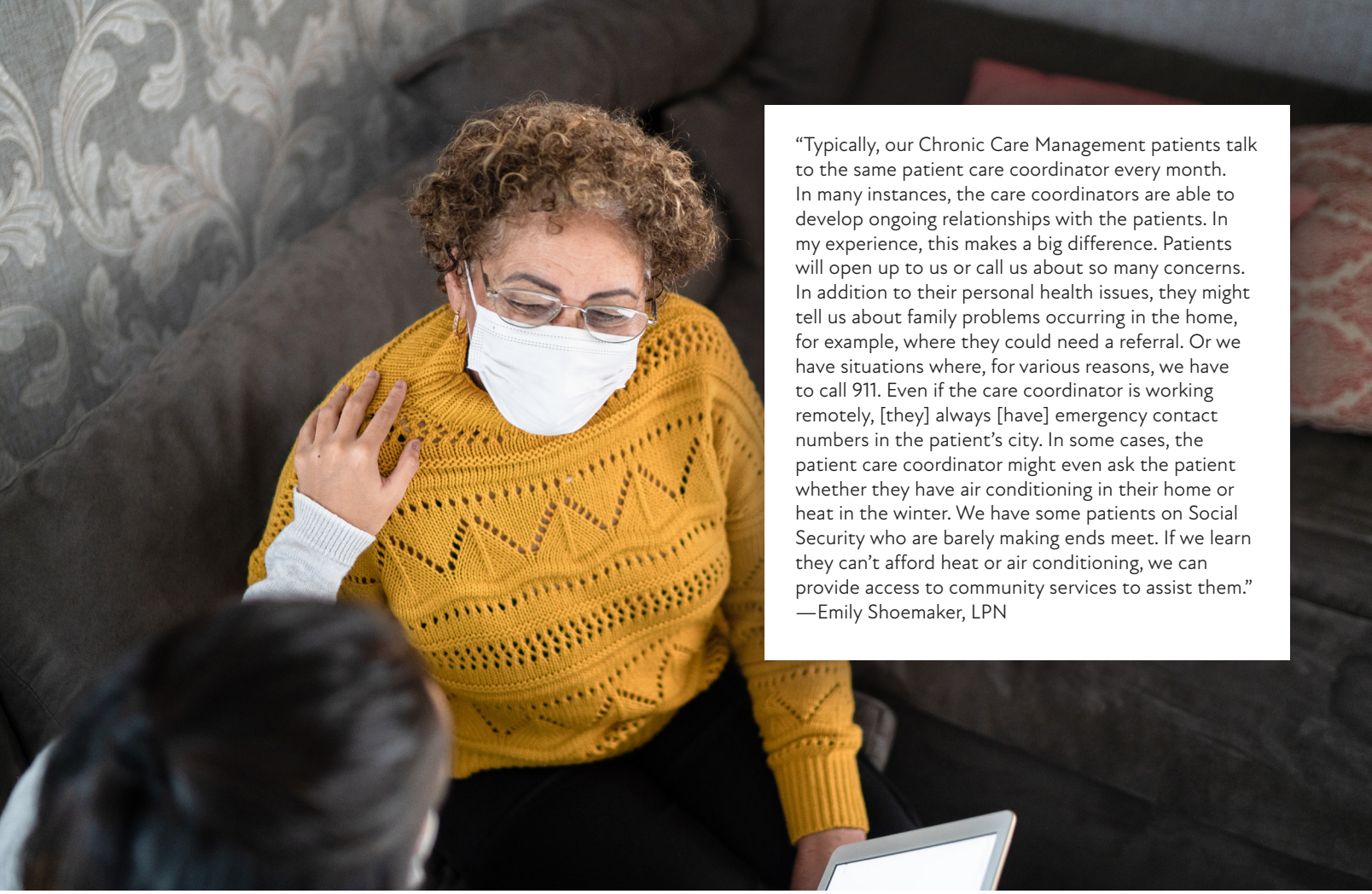
To the letter

What is the process to enroll patients in the Medicare CCM program? First, a health care provider must verify that the patient qualifies for the CCM program. This might occur during the Medicare Annual Wellness Visit, for example. The provider is required to have an initial in-person conversation with the patient about enrolling for CCM services. The patient's express verbal agreement allows the provider to begin submitting billing claims for CCM services.[4]

Significantly, current enrollment requirements have been modified since the Medicare program was first launched in 2015. "Prior to January 1, 2017, a practitioner could not bill for Chronic Care Management unless and until the beneficiary had signed a written consent form," explains Zetter, who is also a past president of the National Society of Certified Healthcare Business Consultants. "Now, that consent form is no longer required."

Once the patient has agreed to participate in the program, the physician or other qualified health professional creates the patient's comprehensive care plan. The care plan addresses the patient's health problems, treatment goals, medications, overall care needs, and community services they may require and identifies the treating providers. The care plan assumes 15 minutes of work by the billing practitioner on a monthly basis.[4]

At the heart of Medicare's CCM service is the monthly 20-minute patient time with a designated patient care coordinator. The patient care coordinators are clinical staff members who have been assigned to stay in touch with patients between appointments,



"Typically, our Chronic Care Management patients talk to the same patient care coordinator every month. In many instances, the care coordinators are able to develop ongoing relationships with the patients. In my experience, this makes a big difference. Patients will open up to us or call us about so many concerns. In addition to their personal health issues, they might tell us about family problems occurring in the home, for example, where they could need a referral. Or we have situations where, for various reasons, we have to call 911. Even if the care coordinator is working remotely, [they] always [have] emergency contact numbers in the patient's city. In some cases, the patient care coordinator might even ask the patient whether they have air conditioning in their home or heat in the winter. We have some patients on Social Security who are barely making ends meet. If we learn they can't afford heat or air conditioning, we can provide access to community services to assist them."
—Emily Shoemaker, LPN

arrange services, answer questions, and otherwise coordinate patients' care on behalf of the supervising practitioner. They play a key role in Medicare's CCM program, functioning as a kind of liaison to ensure regular communication and strong relationships between patients and providers.[4]

Under Medicare's CCM program, *direct supervision* of the clinical staff who help provide chronic care services is not required of the primary care physician or other supervising practitioner. Instead, Medicare allows for g*eneral supervision* of qualified staff who are involved in providing CCM.[8]

Accordingly, the Medicare program considers appropriately educated and credentialed medical assistants to be qualified clinical staff.[8] As such, they can provide certain CCM services under the practitioner's general supervision. The practitioner is expected to provide overall direction and control of the clinical staff, but they do not have to be physically present when the services are performed. Of course, the clinical staff time spent on CCM must be incident to any applicable Medicare rules, state law, licensure, and scope of practice requirements.[8]

Furthermore, Medicare's CCM services are distinct from Medicare's Transitional Care Services (TCM) program. The latter covers eligible Medicare recipients who are being discharged from an inpatient setting and are returning to their homes or assisted living settings. Under the *Medicare Benefit Policy Manual* definition of *auxiliary personnel* and the CPT definition of *clinical staff*, appropriately educated and credentialed medical assistants can provide both CCM and TCM services under the appropriate CPT coding requirements.[8]

Stay in touch

How do patient care coordinators know what to discuss with patients during the monthly phone call? "First, we're in the patient's electronic medical record in real time," explains Emily Shoemaker, LPN, a patient care coordinator and CCM program manager for Chronic Care Staffing, a Medicare service provider in Mt. Pleasant, South Carolina. "Before we call, the care coordinator always reviews the patient's record to note anything [they] need to ask or discuss with the patient. We can see the notes for the patient's most recent [physician's] visit, when they got their medications last filled, the pharmacy they use, and any recommendations or referrals their [physician] has made."

As a nurse, Shoemaker also supervises a staff of about 10 CCM patient care coordinators, who are mostly licensed practical nurses and CMAs (AAMA)®. Together, they provide CCM services for two large regional health care providers in South Carolina with 17 small practices.

Shoemaker describes how a typical patient phone call with the patient care coordinators might proceed. "We usually start off by asking the patient how they are doing [and] if anything's changed with their health since we last spoke," she reports. "Have they seen any other providers or specialists

Who is eligible for Medicare Chronic Care Management services?

To qualify for the Chronic Care Management (CCM) program, patients must meet certain conditions:

> Patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, are eligible for CCM services.
>
> ...
>
> Examples of chronic conditions include, but are not limited to, the following:
>
> - [Alzheimer] disease and related dementia
> - Arthritis (osteoarthritis and rheumatoid)
> - Asthma
> - Atrial fibrillation
> - Autism spectrum disorders
> - Cancer
> - Cardiovascular disease
> - Chronic obstructive pulmonary disease
> - Depression
> - Diabetes
> - Hypertension
> - Infectious diseases such as HIV [or] AIDS[4]

recently? We might ask about their blood pressure or blood sugar readings. Do they have a device to check their blood pressure two or three times a week? Do they have access to their prescribed medications? Are there any barriers to accessing their medications or getting to their appointments? Do they have transportation? We'll make sure they're set up with their [physician] for future appointments, and we help with referrals if they need to see a specialist or other provider. There are all sorts of practical issues we can assist with."

A call from the patient care coordinator can also offer patients an opportunity to clarify any concerns or questions they may have had since their last in-clinic appointment, suggests Shoemaker. "You would be surprised at the number of patients who go home and forget what the [physician] told them about how to take their medications, how to give their insulin shot, or something like that," she notes. "In my experience, there are so many different types of education a care coordinator provides that can make a person's day-to-day life better and healthier."

As Shoemaker observes, CCM patient care coordinators work as a kind of communication go-between for patients and physicians. "Sometimes people won't call their [physicians] to tell them something new is going on with their health," she says. "The Medicare Chronic Care Management program gives patients access to someone they can reach out to. Some patients don't have anyone they can call. … The access we provide can sometimes keep a person out of the [emergency room]. In my opinion, this is probably the best part of the Medicare program, as it gives patients someone to interact with whom they can trust. We become a resource for them."

The physician or billing practitioner should be informed of what transpires during the 20-minute phone visit. "We record what's called a *chronic care phone visit* in the patient's chart," explains Shoemaker. "Basically, we document everything the patient tells us in their chart. If there is an issue that needs addressing, we can also send messages to their [physician] to update them. We are keeping the [physician] up to date on everything that concerns the patient."

Push the envelope

The Medicare CCM program offers both enhanced patient care benefits and a potential new revenue stream for many primary care or other qualifying medical practices. Yet Medicare's CCM program remains somewhat underused in today's health care system, suggest experts.

"I don't think enough providers are taking advantage of Medicare's Chronic Care Management program," observes Zetter. "It's a program that's especially relevant for a primary care physician or a specialist that deals with patients with multiple chronic conditions. It's no different [from] other services such as remote patient monitoring, transitional care services, or even preventive care services that can be managed and billed to Medicare. It makes sense for practices to offer these services."

Notably, a 2018 industry survey found that only 51% of primary care physicians knew about the Medicare program, and only 1 in 4 had taken steps to implement the program in their practices.[3]

"Understandably, most health care providers already have a lot on their plates, so the Medicare program was a slow rollout initially," says Patrick Dowd, a spokesperson for Chronic Care Staffing. "Medicare did not see the early enrollment among eligible providers they had hoped for. For this reason, CMS subsequently modified or eased some of its patient enrollment requirements for the program. They also changed the rules to require general supervision of clinical staff by the billing practitioner as opposed to direct supervision. These changes were designed to encourage greater participation by both patients and providers."

Admittedly, staffing, resources, and financial issues may pose challenges for some medical practices, especially smaller practices, interested in introducing the program. The formula for Medicare reimbursement can make it hard for some practices to balance the added staff workload and expenses involved to get CCM services up and running, according to a 2019 *Medical Economics* report.[6]

The program's emphasis on monthly non-face-to-face phone visits with patients might also require a shift in thinking on the part of physicians. To some degree, the monthly phone call from a patient care coordinator may be reminiscent of the house calls that some generations of physicians might have practiced but which are not necessarily a familiar part of the contemporary primary care landscape.[3] At the same time, the advent of telemedicine in recent years may be helping to make the "virtual house call" an increasingly familiar concept to both patients and practitioners. As time goes on, Medicare's CCM program with its routine monthly patient check-ins is likely to be perceived as just a normal part of modern primary care.

Medical practices that successfully implement the Medicare program strive to proactively engage and educate patients about the benefits of its services.[6] Some participating providers may also rely on assistance from membership in accountable care organizations, which can provide access to CCM service hubs and other resources that assist multiple practices. The latter can provide access to patient care coordinators (or health coaches) who work through centralized teams of care managers under the supervision of billing practitioners. Like Shoemaker, managers and coordinators in such service hubs also have direct access to the patient's electronic health record.[6]

This is a similar model to the many third-party service providers or vendors that provide contracted CCM services. To note, general supervision and incident-to billing rules allow providers to contract with third-party CCM service providers. For this reason, clinical staff who work as patient care coordinators do not have to be directly employed by the participating provider. At the same time, physician practices that contract CCM services should ensure quality patient care is consistently enforced and maintained.

"In my opinion, Chronic Care Management services should be fully integrated into the clinical practice," says Dowd. "This should make it possible to [remotely access] the practice's [electronic medical records] in real time, just like the practice staff would. This is important. The providers can then see the CCM calls and messaging in real time. Those [providing CCM services] are actually taking on the practice's identity. On our phone calls, for example, from caller ID to voice mail greeting, we are identified as the patient's practice. I think this really helps from a quality perspective."

To promote continuity of care, Dowd also believes CCM programs, whether they are run internally by the medical practice or a contracted service provider, should make every effort to link patients with the same patient care coordinator on an ongoing basis. "In our experience, we find patients start to open up to the care coordinators more when they're talking to the same person every month," he says. "For this reason, we try to keep the same nurses and medical assistants working with the same providers and practices. This helps establish that continuity of care, which leads to better communication and better quality care."

Dowd cites other benefits of the enhanced patient-provider communication that come with being on familiar terms with the patient care coordinator. "In a sense, the patient care coordinators are also holding patients accountable," he says. "[Patients] know they're going to get that monthly phone call, asking about their blood pressure, glucose levels, or other concerns. We have patients who tell their care coordinator, 'I knew you were going to call, so I wrote down my blood pressure readings for the month.' Or we might have a patient who is 78 years old and lives independently, but her daughter is her caregiver. [The patient] might ask the care coordinator if [they] could speak with her daughter about her care. If the daughter is [authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)], she can speak directly with the care coordinator about her mother's health care. She might ask why the [physician] switched her mother's medication, for example. We're able then to read the patient's record and explain it to her."

The comprehensive care plan

Under Medicare's Chronic Care Management program, a comprehensive care plan is required for enrolled patients. The care plan for all health issues typically includes the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and identification of the individuals responsible for each intervention
- Medication management
- Community/social services ordered
- A description of how services of agencies and specialists outside the practice are directed/coordinated
- Schedule for periodic review and, when applicable, revision of the care plan[4]

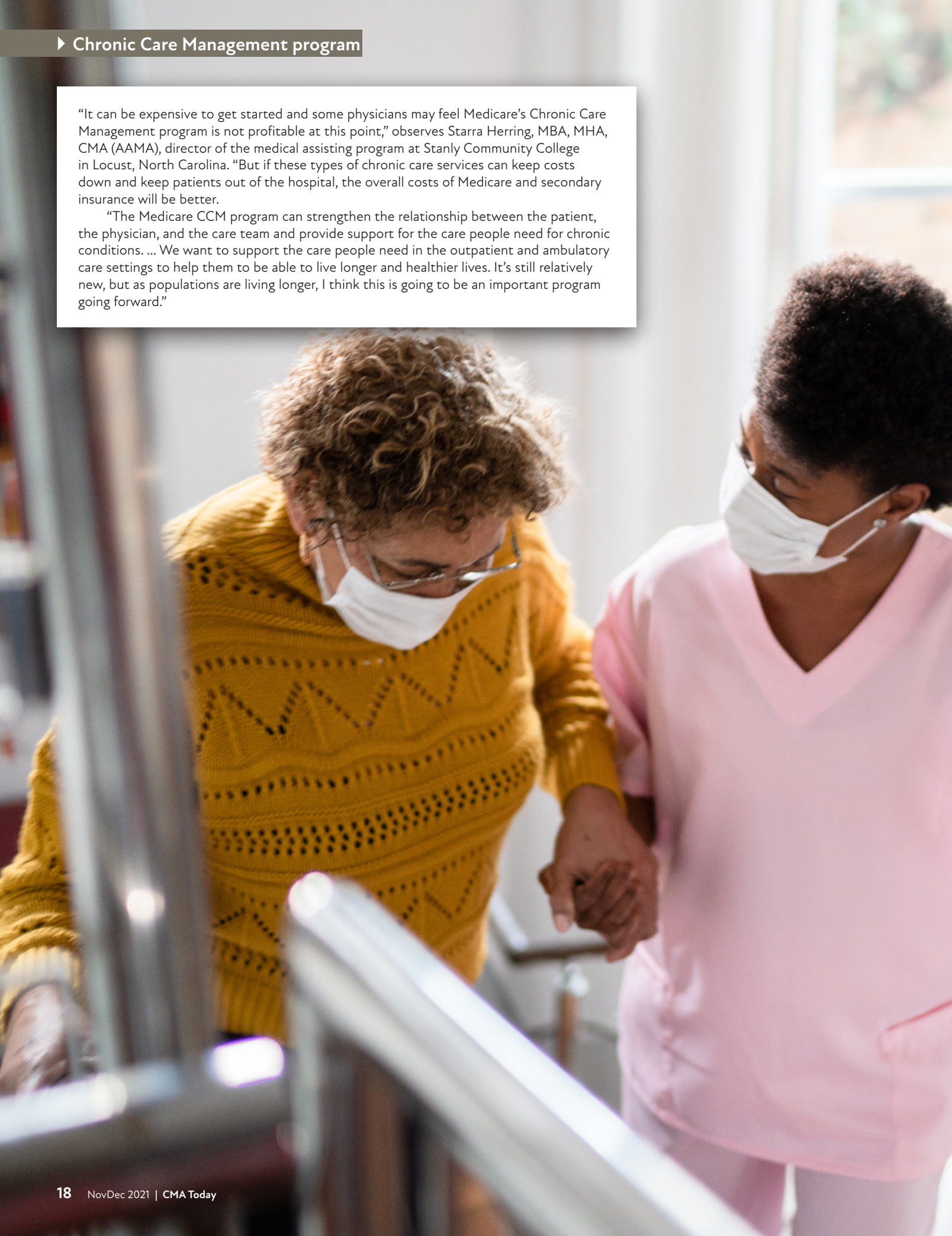
First-class care

For practices that prefer to manage their own Medicare CCM programs, a few considerations should be examined. First, if a practice has not been billing for CCM services and wants to start, Zetter suggests a manager or qualified staff member be assigned to take responsibility for overseeing the program's implementation.

"To implement Chronic Care Management successfully, you've got to have someone who is

"It can be expensive to get started and some physicians may feel Medicare's Chronic Care Management program is not profitable at this point," observes Starra Herring, MBA, MHA, CMA (AAMA), director of the medical assisting program at Stanly Community College in Locust, North Carolina. "But if these types of chronic care services can keep costs down and keep patients out of the hospital, the overall costs of Medicare and secondary insurance will be better.

"The Medicare CCM program can strengthen the relationship between the patient, the physician, and the care team and provide support for the care people need for chronic conditions. ... We want to support the care people need in the outpatient and ambulatory care settings to help them to be able to live longer and healthier lives. It's still relatively new, but as populations are living longer, I think this is going to be an important program going forward."



going to be the champion of the new Chronic Care Management service line," says Zetter. "For the most part, physicians or the owners of the practice don't have to do a lot of this work. It can be done by ancillary staff. But someone does have to manage the process, set everything up properly, and develop processes and systems to ensure everything is covered. From reviewing your patient base to determine who qualifies to validating that each patient has been monitored and the documentation [has been] done properly, someone in the [practice] needs to take overall responsibility."

Toward this end, managers should assign staff who are going to be consistently working on the CCM program, advises Zetter. "Depending upon how many patients qualify for the Chronic Care Management program, it's possible one staff person could manage all of the practice's Chronic Care Management patients, including the documentation and managing other providers under ancillary staff," he says. "Chronic Care Management should be all this staff member is responsible for. That would be my first recommendation."

Of course, the ability of any medical practice to take on added Medicare CCM staffing and resource responsibilities must be assessed individually. "In many primary care practices, the number of Medicare patients that qualify for CCM services could be potentially sizeable," cautions Zetter. "In a typical primary care practice or internal medicine practice, many—if not most—patients have a lot of chronic conditions. In fact, it's likely [that] almost every one of their Medicare patients may qualify for the CCM program. This could be true even in a very busy specialty practice."

For this reason, practice managers should give some thought to their management or staffing issues before implementing the Medicare program. "You really have to carefully assess the practice's situation and the individual staff person's capabilities," says Zetter. "Is the assigned staff person really going to be able to handle 500 CCM patients … on a monthly basis, for example? Are they fully aware of all of the Medicare rules and requirements for Chronic Care Management services? Is there a capable process and system in place for the required documentation that must be done each month before submitting the CPT code for billing? These are questions the practice will have to consider."

Opportunities for medical assistants

"The Medicare Chronic Care Management program offers new professional opportunities for qualified medical assistants. As a medical assistant participating in providing CCM services, you will need to be versed in chronic care [Current Procedural Terminology] codes and what is included in the patient's comprehensive care plan. To help manage and coordinate the care plan, medical assistants need to understand all the details and components of the plan that have to be completed. As a medical assistant, you will also be the liaison between the physician and the patient, so it's an important role.

"I believe medical assistants with their versatile clinical and administrative training can potentially play an especially important role as the Medicare program grows in popularity. There's going to be more need for coordination of care leaders [and] for staff with the training to better help manage the patient's overall care and services on an outpatient basis. … Medicare's CCM program can make [medical assisting] more marketable as a profession."

—Starra Herring, MBA, MHA, CMA (AAMA)

Yours truly

The Medicare CCM program provides many advantages to qualified beneficiaries and makes enhanced patient care services available to about 80% of the Medicare members.[9]

The Medicare program also offers expanded opportunities for qualified clinical staff such as medical assistants and others, working as patient care coordinators or in other capacities, to make a genuine differ-

ence in patients' lives. "As a patient care coordinator, you have to have a good personality and really care about the patients to go the extra mile for somebody," concludes Shoemaker. "In nursing or medical assisting, I believe someone with the right skills and a lot of compassion for patients and patient care is going to be excellent at this job."

For many patients with multiple chronic health conditions (e.g., diabetes, heart disease, arthritis, or high blood pressure), CCM is an increasingly essential aspect of the advanced primary care services often necessary to ensure quality patient care. ✦

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Chronic Care Management program

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Directions: Determine the correct answer to each of the following, based on information derived from the article.

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T F

☐☐ 1. The Chronic Care Management (CCM) program is available only to individuals who are covered by Medicare

☐☐ 2. Having the same care coordinator work with patients for a long time often results in patients being more open with care coordinators.

☐☐ 3. A verbal agreement (rather than a written agreement) from a patient is sufficient for a provider to start billing for CCM services.

☐☐ 4. On average, patients enrolled in the CCM program through Medicare Part B incur higher health care costs because the CCM program ensures that they have access to health care services that are not available under standard Medicare coverage.

☐☐ 5. CCM services are face-to-face services that may not be provided by electronic means.

☐☐ 6. Accountable care organizations are permitted to provide CCM service hubs that are available to several clinics and medical practices.

☐☐ 7. The only licensed providers permitted to bill for CCM services are physicians, nurse practitioners, and physician assistants.

☐☐ 8. A care coordinator is a clinical staff member who serves as a communication link between the licensed provider and the patient or the patient's caregiver.

☐☐ 9. The goals of the CCM program include lessening the number of emergency room visits and fostering better communication between health professionals, caregivers, and patients.

☐☐ 10. No more than two practitioners are allowed to bill for CCM services in a particular month.

☐☐ 11. Medical assistants who are appropriately educated and professionally credentialed may be classified as *clinical staff* under both the CCM and the Transitional Care Management programs.

T F

☐☐ 12. Because the CCM program is a Medicare Part B benefit, patients are responsible for a 30% co-pay for services provided.

☐☐ 13. A provider may determine that a patient qualifies for the CCM program during the Annual Wellness Visit required for Medicare patients.

☐☐ 14. CCM regulations require care coordinators to be employees of the licensed provider participating in the CCM program for Medicare reimbursement to be allowed.

☐☐ 15. The licensed provider must be exercising direct supervision of clinical staff for the staff's services to be reimbursed under the CCM program.

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Nutrition over restriction

While diets come and go with the seasons, the principles of eating well can provide a more stable dietary guidepost, according to Harvard Health Publishing.

Vegan and paleo diets both offer benefits from their focus on vegetables and high-quality protein, along with a reduction in highly processed foods. However, both have potential drawbacks. Vegan diets can leave you deficient in vitamin D, calcium, and especially vitamin B_{12} without additional supplements. Meanwhile, paleo diets exclude grains, beans, dairy, and some fruits and vegetables, which can cause deficiencies in fiber, vitamins B and D, and calcium.

Regardless of the dietary pattern, five principles have been identified for those seeking nutritional health benefits:

1. **Don't skimp on the plants.** Aim for filling half your plate with vegetables, fruits, legumes, whole grains, nuts, and seeds at each meal.
2. **Find healthy proteins.** Plant-based sources (e.g., beans and lentils) and seafood are most beneficial, but meat can be a healthy choice in limited quantities.
3. **Avoid highly processed foods.** Because food processing involves unhealthy additions (e.g., extra fats, sugars, sodium, preservatives, and additives) and strips valuable nutrients, eating a lot of processed foods can cause unhealthy effects on blood sugar, weight, and cholesterol.
4. **Limit saturated fat, sugar, and sodium intake.** Both fat and sugars should each be limited to less than 10% of your daily calories, while no more than 2,300 milligrams of sodium should be consumed per day.
5. **Balance your diet.** Your daily diet should encompass a variety of nutrient-dense foods from all the food groups.

Following these guidelines can help establish a safe, balanced diet that stresses moderation and variety over strict limitations.

A winter's tale

The coldest months can be a strain on mental health, particularly during a pandemic that reduces social contact. But social isolation and loneliness can be combatted with creativity. Brighten up winter blues with these ideas from Shots: Health News from NPR:

- Explore outdoor winter activities, particularly ones you can do with friends or family (e.g., skiing, walking, or ice skating)
- Embrace long-distance connections in new ways, such as by sending care packages, photos, or letters
- Strengthen relationships by collaborating on a shared memories project, in which friends or family members contribute memories, videos, and photos of past gatherings
- Reinvigorate video calls by adding new elements (e.g., watching a movie together, playing a virtual game, working out, or meditating) ✦

Annie get your gum

Been a while since you last chewed bubblegum? It may be time to dust off the old pack before your next walk around the block, according to research in the *Journal of Exercise Science and Fitness*.

The study compared the results of 15-minute walks taken by a gum-chewing group and a control group. The control group ingested two tablets with the same ingredients as the gum, minus the gum base. Researchers found that the gum-chewing group had a higher walking distance, speed, and heart rate. Most notably, the gum-chewing group also had a 5% increase in energy expenditure.

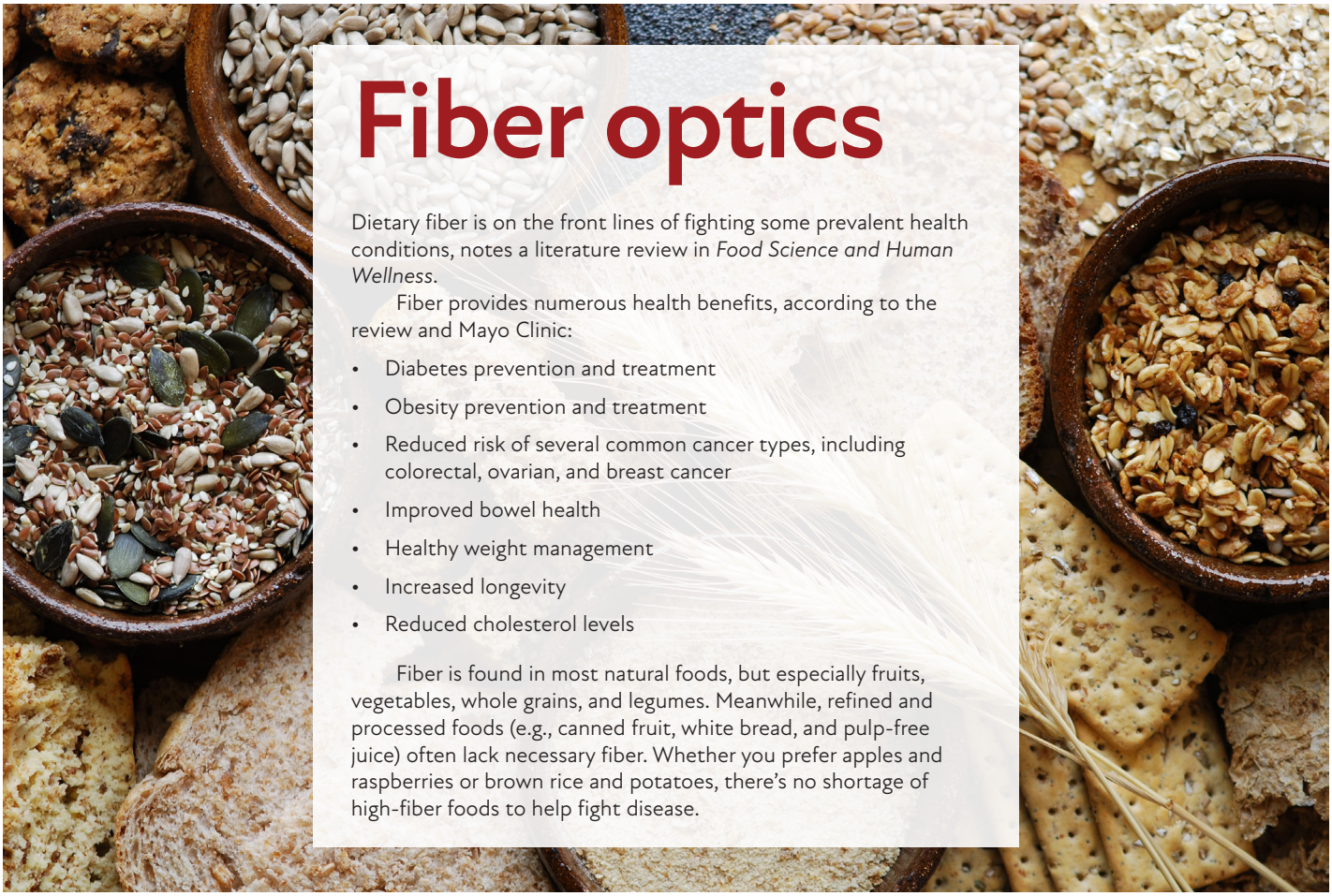
While researchers are still exploring the mechanism that makes gum-chewing increase these physical and physiological functions, it's not too early to start chewing over the checkout aisle gum options before your next walk. ✦

Kick it up a notch

Slow and steady wins the race? Not so fast. High-intensity exercise significantly increases brain-derived neurotrophic factor (BDNF), a protein associated with cognitive function, when compared to light-intensity exercise, per a new meta-analysis from the *Journal of Sport and Health Science*.

Why does BDNF matter? While high BDNF levels are linked to improved cognitive performance, people with dementia, Alzheimer disease, and major depression often have low levels of BDNF. The analysis, which focused on healthy young adults, showed that high-intensity exercise increased BDNF levels regardless of an individual's cardiovascular fitness. Moreover, even high-intensity exercise in small doses can increase BDNF, making it an efficient way to bolster brain health.

As cooler weather takes hold, it is a perfect time to break a sweat and get the BDNF flowing. ✦



Fiber optics

Dietary fiber is on the front lines of fighting some prevalent health conditions, notes a literature review in *Food Science and Human Wellness*.

Fiber provides numerous health benefits, according to the review and Mayo Clinic:

- Diabetes prevention and treatment
- Obesity prevention and treatment
- Reduced risk of several common cancer types, including colorectal, ovarian, and breast cancer
- Improved bowel health
- Healthy weight management
- Increased longevity
- Reduced cholesterol levels

Fiber is found in most natural foods, but especially fruits, vegetables, whole grains, and legumes. Meanwhile, refined and processed foods (e.g., canned fruit, white bread, and pulp-free juice) often lack necessary fiber. Whether you prefer apples and raspberries or brown rice and potatoes, there's no shortage of high-fiber foods to help fight disease.

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2021 CMA (AAMA)® Compensation and Benefits Report

The CMA (AAMA)

Employers are increasingly demanding that their medical assistants have a CMA (AAMA)® credential.[1] Every day the AAMA responds to more than 100 employer requests for CMA (AAMA) certification verification—for both current and potential employees.[2] Such demand is often due to the pressures of potential malpractice suits and the certification mandates placed on employers by managed care organizations.[3]

Medical assistants and medical assisting educators across the country enthusiastically participated in the 2021 Compensation and Benefits Survey conducted by the American Association of Medical Assistants® (AAMA). Nearly 14,000 medical assistants completed the survey.

The AAMA emailed an electronic questionnaire to more than 80,000 CMAs (AAMA) and AAMA members and announced the survey via the AAMA Facebook page (over 51,000 followers). The majority of respondents (86%) were medical assistants, while almost 2% identified themselves as medical assisting educators. Approximately 3% of respondents identified themselves as medical practice managers, while about 2% identified as both medical assistants and medical assisting educators. Most of the participants had earned the CMA (AAMA) credential (97%) and were members of the AAMA (74%).

Statistical significance and terms used

The large number of participants ensures that the results have a high degree of statistical significance. The overall margin of error for the 13,805 responses is ±0.85% at the 95% confidence level. Margin of error describes the statistical significance of the sample as an estimate of the population. The margin of error should be treated only as an approximation, since margin of error calculations are based on pure random selection, which is not achievable in traditional survey settings where response is voluntary. The ±0.85% margin of error applies to overall statistics based on the total respondents to the survey; smaller breakout groups presented throughout the report have higher margins of error. Judgments based on statistics with very low sample sizes should be made with caution. Statistics are rounded to the nearest whole number.

Employee pay rate and status

Both hourly pay rates and annual gross earnings were collected on the survey. Approximately 98% of full-time medical assistants are paid hourly, while roughly 2% are paid by annual salary. Of the 10,900 respondents who are practicing medical assistants, approximately 91% work full time while 9% work part time. For the purposes of this report, results represent compensation and benefits for the full-time employee population.

Compensation

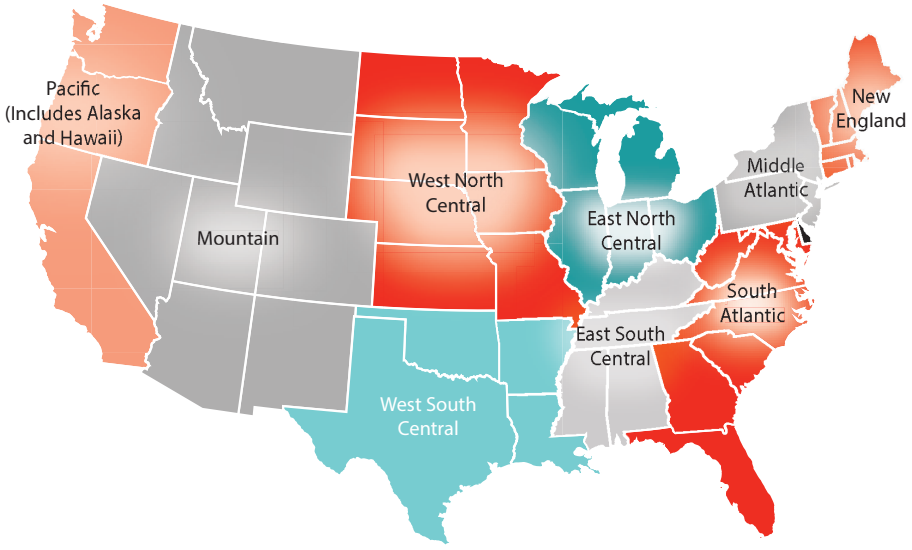
Overall, of those surveyed, full-time medical assistants holding a current CMA (AAMA) certification earn an average of $19.02 per hour or average annual earnings of $35,659.36. Average hourly wages and annual earnings varied for CMAs (AAMA) according to years of experience and other factors, which are broken down as follows.

By geographic region

The average annual earnings and hourly wages were computed for geographic regions of the United States (Figure 1). The Pacific region showed the highest earnings for full-time current CMAs (AAMA), with averages of $43,441.18 annually and $22.94 hourly. Across the country, the New England region turned in the second-highest annual earnings ($37,907.80), while West North Central region had the second-highest hourly wages ($20.20). The full comparison is shown in Table 1.

CMA (AAMA) overall average earnings
Hourly: $19.02
Salary: $35,659.36

Figure 1. Regions based on the United States Census divisions



Note: *Data presented in this report represent current-dollar values (i.e., dollar amounts are not adjusted for cost of living by region). To learn more about constant-dollar values in your region, search online to view cost-of-living adjustments for individual locations.*

Table 1.

Geographic region	Average full-time CMA (AAMA) pay by years of experience ($)					
	0–2 years	3–5 years	6–9 years	10–15 years	16 years+	Overall
Northeast						
New England	17.92 33,776	18.90 35,589	19.90 38,038	21.05 40,025	21.96 41,601	20.01 37,908
Middle Atlantic	16.94 32,766	17.77 33,672	18.90 36,305	20.17 39,151	21.44 41,779	18.89 36,122
Midwest						
East North Central	16.59 30,157	17.59 32,494	18.35 33,630	19.12 35,318	20.63 38,974	18.50 34,150
West North Central	17.06 31,387	18.96 34,160	20.25 37,363	21.00 37,866	22.14 42,329	20.20 37,253
South						
South Atlantic	15.79 29,379	16.61 31,311	17.51 33,341	18.60 35,494	19.98 38,515	17.83 33,880
East South Central	14.64 27,230	16.14 31,373	16.81 32,438	18.13 34,167	19.74 39,494	17.14 32,975
West South Central	14.75 27,667	15.90 29,433	17.28 32,270	19.18 37,658	19.60 37,014	17.42 33,063
West						
Mountain	16.48 30,049	17.49 31,791	19.06 35,563	20.48 38,155	21.45 40,765	18.92 35,042
Pacific	20.47 37,305	21.99 40,764	23.39 44,184	24.57 46,890	24.73 49,144	22.94 43,441

By work setting

The overwhelming majority of CMA (AAMA)–certified medical assistants surveyed work in physicians' offices. Nearly 94% of medical assistant respondents are employed in that setting, with roughly 1% in ambulatory surgery and another 3% in "other." Almost 2% of respondents work in inpatient settings. The breakdown of wages and earnings by work setting is shown in Table 2. Figures for home health settings are not listed due to insufficient response numbers.

By practice specialty

About 60% of medical assistant respondents who are CMA (AAMA)–certified work in a primary care practice. Another 33% work in practices with other medical and surgical specialties. The income figures for practice specialty are shown in Table 3.

By number of specialties

Almost 53% of CMA (AAMA) respondents work in a single-specialty practice, while 44% work in a multispecialty setting. The income figures for full-time current CMAs (AAMA) by number of specialties are listed in Table 4.

Table 2.

Work setting	Average full-time CMA (AAMA) pay by years of experience ($)					
	0–2 years	3–5 years	6–9 years	10–15 years	16 years+	Overall
Physician practice	16.95 31,246	17.96 33,328	18.88 35,229	19.87 37,232	21.16 40,527	19.01 35,576
Ambulatory surgery	17.29 30,036	18.67 34,708	20.30 39,950	20.54 38,796	22.38 41,912	19.88 37,762
Inpatient setting	18.03 31,952	19.00 35,707	18.57 35,821	20.12 38,966	20.01 40,083	18.97 36,137
Other	17.59 32,121	18.24 34,093	18.64 36,145	20.60 39,696	21.33 43,056	19.29 37,017

Table 3.

Practice specialty	Average full-time CMA (AAMA) pay by years of experience ($)					
	0–2 years	3–5 years	6–9 years	10–15 years	16 years+	Overall
Primary care	16.92 31,111	17.92 32,935	18.69 34,484	19.83 36,788	21.02 40,012	18.90 35,074
All other medical and surgical specialties	17.17 31,613	18.24 34,333	19.31 36,630	20.18 38,465	21.49 41,709	19.39 36,797
Other	17.01 31,623	18.10 33,709	18.88 35,502	19.88 37,665	21.12 40,770	18.95 35,791

Table 4.

Number of specialties	Average full-time CMA (AAMA) pay by years of experience ($)					
	0–2 years	3–5 years	6–9 years	10–15 years	16 years+	Overall
Single specialty	16.91 31,267	17.83 33,207	18.72 35,186	19.81 37,324	21.01 40,502	18.92 35,613
Multiple specialties	17.14 31,511	18.26 33,800	19.22 35,851	20.22 37,772	21.58 41,269	19.31 36,071
Other	17.40 31,583	18.26 34,143	18.31 33,580	19.55 36,793	20.58 38,628	18.72 34,650

Employment benefits

Roughly 96% of all full-time CMAs (AAMA) receive some form of benefits package from their employer.

Insurance

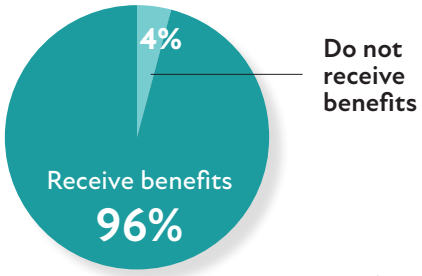
About 84% of full-time CMAs (AAMA) receive paid vacation. Nearly 84% receive dental coverage, while 72% receive major medical coverage. About 78% receive vision coverage, and 63% receive disability coverage. The full range of benefits for full-time CMAs (AAMA) is shown in Figure 3.

AAMA membership and conference

When asked if employers offer to help pay for various AAMA expenses, about 11% of full-time medical assistants who are AAMA members responded that their employers pay their membership dues in full (Figure 4). In addition, approximately 6% have their AAMA Annual Conference registration fees paid for in full, and just over 3% have travel and lodging paid by their employers. ✦

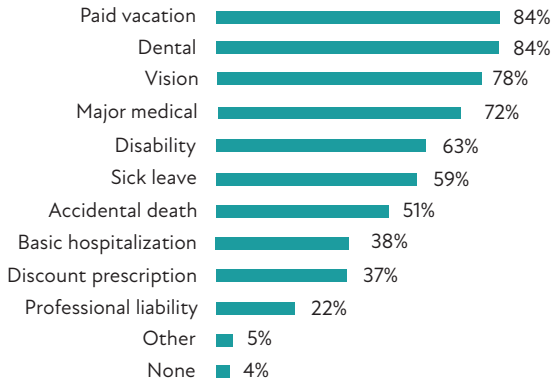
The American Association of Medical Assistants thanks all the participants who made this survey possible.

Figure 2. Benefits received by full-time CMAs (AAMA)



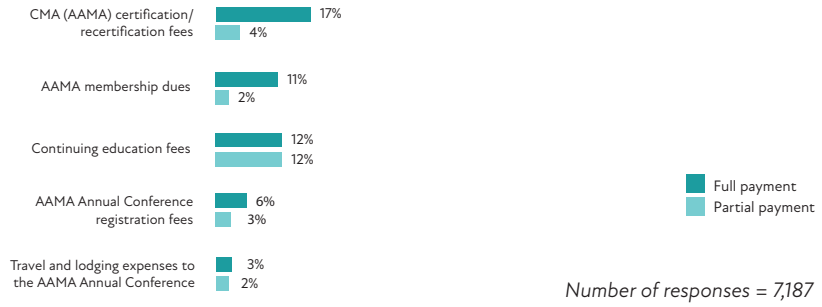
Number of responses = 9,396
Results rounded to the nearest whole number

Figure 3. Insurance benefits received by full-time CMAs (AAMA)



Number of responses = 9,396
Results rounded to the nearest whole number

Figure 4. Dues assistance received by full-time medical assistant AAMA members



Number of responses = 7,187
Results rounded to the nearest whole number

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HELP WANTED

Tie mentorship into employee training

By Brian Justice

Tell me, and I forget. Teach me, and I may remember. Involve me, and I learn."

These words express the essence of truly effective mentorship: a personal investment in someone else's career development pays off in the short-, mid-, and long-term and for all stakeholders.

A study of more than 1,000 employees concluded that mentoring has a positive impact on both mentors and mentees and fosters employees that are more highly valued by the business.[1] The study found that 25% of employees who were mentored got raises, mentors were promoted 6 times more often, and mentees were promoted 5 times more often.[1] And retention rates were higher, too: 72% for mentees and 69% for mentors.[1]

Up close and personal

Mentoring that is structured to the person, and not just the job, is crucial. In fact, when a mentorship program is perceived as an obligatory exercise assigned by the human resources department, it can generate resentment.[2] That drove Jonathan Baktari, MD, CEO and chief medical officer of e7 Health, to be sensitive while developing mentorship programs at e7 Health.

"Medical assistants are the core of our staff, so we take a big interest in … how they are educated and mentored," he said. "They benefit more from mentoring than many other health care professionals because their training period is [sometimes] short and many of them come from other types of work experiences."

Noel Montgomery, BS, CMA (AAMA), NCMA, PFT, an educator at the Healthcare Careers Academy at Mount Tahoma High School in Tacoma, Washington, took an early and keen interest in mentorship.

"Defining who you are personally and professionally—and showing it with patience and transparency—can provide you with excellent tools to lead someone," he says. He began mentoring new CMAs (AAMA)® at a supervisor's request. He recounts working with a particularly insecure and stressed new hire. "I even wondered how they landed an interview," he said, "but I was open to working with them and doing whatever I had to do to help them build up their confidence and conquer any doubts they had."

After demonstrating procedures and explaining office flow, he asked them to perform the procedures and repeat the explanations. The new hire expressed frustration and reacted with negative self-talk. Montgomery countered by praising areas in which the new hire excelled and the new skills they demonstrated when they practiced what they learned.

As the days progressed, so did the new hire. In fact, after only a week, a patient asked how long the medical assistant had been working in the clinic. When told that it had only been seven days, the surprised patient replied that they had thought it had been more like seven years.

"That spoke volumes to me," says

Montgomery, who proudly notes that the mentee is now a supervisor running an outpatient clinic with 10 physicians and multiple employees.

The personal touch is something that Torey Winn, CMA (AAMA), of Community Health Programs in Dalton, Massachusetts, believes in too.

"The most important thing is to listen and know who your mentee is [and] what their strengths are, as well as their weaknesses," she says. "Weakness is not a fault, just something that needs to be understood so that they can learn."

Listen and learn

Being upfront immediately about expectations benefits everyone and helps mentees understand that efforts are seen by the practice as investments in their personal and professional growth.

"I think that the most important thing is to listen and know who your mentee is," says Winn. After more than 40 years, she still remembers her own mentors fondly. "They were more than just educators. They were leaders who showed me the ins and outs of the work that I was doing."

Her career expanded from billing to transcription to phlebotomy, then medical assisting in private practices to practice manager at Community Health Programs, where she is now a recruiter and is often asked to mentor new practice managers.

"My company recognizes the work that I've done and my knowledge base," she says. "I can bring that to new folks. Give them pearls of wisdom that help them to not only do their job but understand it so they can excel and move up in their own careers."

How to show the ropes

A few mentoring techniques are particularly effective with millennials. One is reverse mentoring. A senior employee demonstrates and explains procedures and practices, while the younger employee teaches their colleague skill sets, such as how to use social media to communicate within the organization and with patients. The teaching goes both ways and builds mutual respect.[3]

Another is group mentoring. A specialized online platform allows a mentor to work with several mentees at the same time, sometimes in different locations. Participants share experiences, progress, and build a common experience that increases camaraderie and speeds learning.[3]

Anonymous mentoring matches mentors and mentees, but, as the name implies, one does not know the identity of the other. Sometimes they are not even in the same location. The guarantee of anonymity encourages frank exchanges, which may be especially useful for new employees who might be hesitant to ask certain questions for fear of being judged and for advisors who may fear being too harsh when they advise or correct someone in person.[3]

More than a job

Thoughtful and thorough mentorship includes more than performing tasks correctly and efficiently. It includes aspects of the profession that someone just out of school or coming from another line of work may not consider.

"Being a good mentor means taking someone who's new in whatever field and giving them insight into what I call the *art* of what they are doing," says Dr. Baktari. "You can have training manuals on how to give a shot or draw blood or run the office, but how you handle people, patients, and coworkers and how you conduct yourself is just as important."

The benefits, he says, include more than just proficiency on the job. They include inspiring confidence in the most important people of all: patients.

"When you walk in [wearing] scrubs, patients view you as part of the health care team," says Dr. Baktari. "They attribute someone in scrubs with all the attributes they give to a health care *professional*, and that is a high standard to be held to." ✦

Mentoring the millennials

By 2025, millennials will make up approximately 75% of the workforce.[4] A poll of more than 2,000 professionals from a wide range of industries showed that millennials want steady feedback,[3] and mentorship is the most effective way to provide that. They bring with them expectations that, at the core, are not really that different from employees from the previous generations. But there are some unique aspects.

What millennials want from their boss[3]:

- Help with navigating their career path
- Straight feedback
- Mentorship and coaching
- Assistance with formal development programs
- Flexible schedules

What millennials want from their company[3]:

- Development of skills for the future
- Strong values
- Customizable benefit packages
- Work-life balance
- Clear career path

Millennials place a strong emphasis on work that is personally fulfilling and allows them to make friends and learn new skills and all in the service to a larger purpose. Mentorship programs that recognize those values will drive success for both employers and employees.

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Link Up

Lock in retention rates with student-focused strategies

By Pamela M. Schumacher, MS

Chalk up another bad higher education statistic to the impact of the coronavirus pandemic. Fewer students are enrolling—spring 2021 enrollment by college students aged 18–20, who make up 40% of all undergraduates, shrunk by 7%, with the deepest declines occurring at community colleges, which were down 15%.[1] Hanging on to those students was also a challenge—community colleges tallied substantial drops in retention rates (the percentage of students who return to *the same* institution), which were down about 2 percentage points to 52%.[2]

"This is the most dramatic decline we've seen in decades," says Lynn Pasquerella, PhD, president of the Association of American Colleges and Universities in Washington, DC. "The enrollment rate decline was 7 times greater than in the past for community colleges."

The fall 2021 numbers aren't encouraging either. Applications for federal financial aid, a key indicator of intent to enroll in college, are down across the country, and more than 40% of prospective students said they might delay starting a one- or two-year program.[3]

Assembly required

The reasons for the drop in enrollment and retention have to do with the uniqueness of the pandemic. Typically, during a recession, more people enroll in college; however, this time is different. COVID-19 raised new barriers for many postsecondary students, with heightened impacts on students of color, those with disabilities, and students who are caregivers. Many reported experiencing food insecurity, housing insecurity, or homelessness.[1]

"Because it [is] a pandemic, people were instructed to stay at home. This meant a lot of jobs disappeared or work hours were curtailed," says Dr. Pasquerella. "Although schools switched to virtual teaching, many students didn't want to or couldn't attend online classes. In addition, many high school students said no to even starting college because job prospects were so uncertain."

Bill Wright, system director of academic operations and student affairs of Bryant & Stratton College in Orchard Park, New York, says several factors influenced retention at his school. "During the pandemic, many of our students had their own health-related issues, and they may have been taking care of their families. Many did not have the ability or interest in continuing their education online.

"We made a choice to move to a remote synchronous delivery—attending a virtual class at the same time as your instructor and classmates—for our classrooms. Our students found the experience a viable option until we could return to a normal face-to-face delivery for the building-based campus students. We surveyed students after the transition to remote delivery, and approximately 85% rated the transition as either 'good' or 'great,' " says Wright.

Tools of the trade

With so many unknowns for the 2021–2022 term, being flexible, innovative, and responsive are key to recruiting and retaining students, say the educators interviewed.

"To improve retention, we suggest creating engaging classrooms that leverage different modalities of educational delivery," says Wright. "Educators should look for new and varied ways to package concepts to engage the learners at different levels of inquiry. This can be done by implementing

interactive software and systems that better capture the face-to-face experience of the classroom."

Although online classes were a lifesaver for many colleges, experts caution against over-relying on technology because many students are experiencing technology fatigue from a lack of in-person interactions.[4] To combat this, Fauna Stout, MEd, BS, AAS, CMA (AAMA), program director of and professor in the medical assisting technology program at Columbus State Community College in Columbus, Ohio, uses a personal touch in her efforts to help students be successful in college.

"Students need to believe that you genuinely care about them and want to see them succeed. My teaching philosophy is be firm, be fair, and show them that you care," says Stout. "My mentor always said, 'Show them how much you care before you show them how much you know.' Especially given our current situation, students need support and good resources. During my 35 years of teaching, my philosophy hasn't changed, and it seems to be working."

Build something better

Institutions can also step up their game when it comes to recruiting and retaining students. This can be through communication, expanded services, and marketing. Public colleges spend $14 per student on advertising compared to private, non-profits at $48 per student and for-profit colleges at $400 per student.[4] "If community colleges hope to bring students back in the fall, they will need to market themselves to students, like a business," writes National Student Clearinghouse.[4]

"Our college assists students in identifying needed resources both internally and externally," says Wright. "We offer a loaner laptop program to assist with technology needs; however, during the pandemic, it appeared access [issues were] often a result of connectivity problems due to the household volume of internet users, which was a more difficult problem to address. Colleges should consider expanding broadband access to parking lots so that students can attend online classes in their cars, if necessary."

"The best suggestion I can provide is to know what services the college provides and point them out to students because they often aren't aware of the services available," says Stout. "As an educator, you become the bridge to ensuring students get the help they need. [Columbus State Community College] provides a one-stop shop [webpage] called 'Resources for Students,' which houses a multitude of departments to assist students. I place this information prominently on the classroom Blackboard account, publish it in the course syllabus, and discuss it the first day of class. I want students to know we can help, whether it's accessing a computer or providing emergency food and shelter assistance."

Can we fix it?

Thanks to an unstable job market and economic turbulence, more students are questioning the value of a college degree, which will influence their decision to enroll or stay in college. Colleges should plan to address the needs of current and future students and ensure faculty are prepared.[4]

"Focus on continuous improvement and renewal as the classroom continues to change and evolve," says Wright. "Students may need additional guidance and support to remain focused on their educational goals. … This means looking at a student's college experience holistically. Institutions need to be aware of and address barriers to student enrollment and retention. If students need food or housing assistance, make sure you have a way to help them."

"I may be an optimist," says Stout, "but I believe good things will come out of this experience. The knowledge alone that we have gained will help us be better prepared in the future. Although a high price was paid [during the pandemic] for this knowledge, since we are in the field of medicine, we will learn something that makes the world a better, kinder place." ✦

Better by design

Educators can improve student recruitment and retention with these strategies, says Lynn Pasquerella, PhD, president at the Association of American Colleges and Universities:

- Engage students where they live by having faculty, staff, and administrators be visible within the community. Ideas include attending local sporting events and parades, giving lectures at community groups, and participating in local service opportunities, such as food banks.
- Create community within the classroom through icebreakers and other activities.
- Establish intrusive advising, which means educators proactively reach out to students to check on their progress, issues, and concerns.
- Emphasize the connection between a student's long-term goals and what they are doing in class. Have people in the medical assisting field attend class to answer questions about what the job is like in the real world.

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Education Enthusiast

Medical assistant retains, recruits, and supports medical assistants

By Cathy Cassata

More than a decade after earning her bachelor's degree in health administration, Laurie Lee Domiano, CMA (AAMA), landed her dream job.

"I started off a little backwards," she says. "After getting my bachelor's in 2008 during the recession, I found it hard to be hired where my degree could be [used]. I went back to [my] local community college to get my associate degree in medical assisting."

Domiano immediately obtained her CMA (AAMA)® certification and began working at a primary care practice while also teaching in the medical assisting program at Harford Community College in Bel Air, Maryland.

"It was very fulfilling," she says. "I loved getting to meet students and help them navigate and prepare for the field."

Her teaching experience also prepared Domiano for her most gratifying position: medical assisting training and development manager at ChristianaCare. "Teaching at the community college and having adult learners was a great experience and helped to build up my skill set for my current role," explains Domiano.

At ChristianaCare, she focuses on ways to improve medical assistant retention, recruitment, and career development. During her two years in this role, she has established a medical assistant practice council, whose primary purpose is to provide opportunities to share information, provide practice insights, improve care delivery and outcomes, and make recommendations to leadership on decisions that impact medical assistants' work across The Medical Group, which is comprised of community-based primary care physicians and specialty-care practices at ChristianaCare.

Domiano also put in place a medical assistant star award that is given to a deserving medical assistant by the counsel. Additionally, she has led career development and leadership classes for medical assistants.

Most recently, Domiano helped initiate the health system's Medical Assistant University program, which is a partnership between ChristianaCare and Delaware Technical Community College. The program encourages current employees within the health system to obtain their medical assisting education at the college, complete their practicum in an ambulatory setting within the health system, partake in a certification prep course, and then take the CMA (AAMA) Certification Exam after graduation. Once they are certified, participants are lined up with an interview for a medical assisting job opening.

"Having the certification will help you move into a role as a medical assistant," says Domiano.

She says the program offers medical assistants an immersive learning opportunity to work in one of the nation's most dynamic health care systems.

"You graduate already having a network of resources and people on your side," explains Domiano. "[Those who complete the practicum] get to understand the beliefs and values of ChristianaCare and get to know who they are going to be working with in our team-based environment. The university experience offers more than just learning medical assistant skills; it also teaches them the team dynamic and what it feels like being in a team environment."

Tuition, certification, and recertification are all paid for by ChristianaCare.

"[It's] very exciting to be part of a health system that is investing so much in medical assistants," says Domiano. "ChristianaCare believes that medical assistants are the backbone of practices and that we need to grow and get benefits out to medical assistants." About 350 medical assistants currently work for ChristianaCare clinics throughout Delaware, Maryland, Pennsylvania, and New Jersey.

In addition to the Medical Assistant University, Domiano helps recruit medical assistants by working with four local schools to place graduates with practicums and hire them if they are a good fit.

"Being a medical assistant is such an exciting role," says Domiano. "We get to perform meaningful work in people's lives. Helping medical assistants know that they are valued and helping them find a job that suits them is a big reason I love the work I do." ✦

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Qualifications? Experience in medical assisting. That's it! Practicing medical assistants, practice managers, and medical assisting educators—all are welcome!

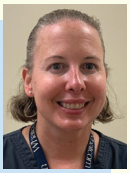
Fill out the form online under *CMA Today*/Call for Interviewees on the AAMA website.

"We have patients who come in kind of grumpy or irritated. This is because they just don't feel good. But we treat them with respect and care, and we take the time to ask the right questions and get to know them. It's important to their care that we do so."

–Cheri McPherson, CMA (AAMA)
Poulsbo, Washington

"Managers need to set a good example. Develop a good rapport with employees, and get to know them on personal and professional levels. Treat all employees equally [and] with respect, and let them know you are there to support their success."

–Berlene Farthing, CMA (AAMA)
Federal Way, Washington



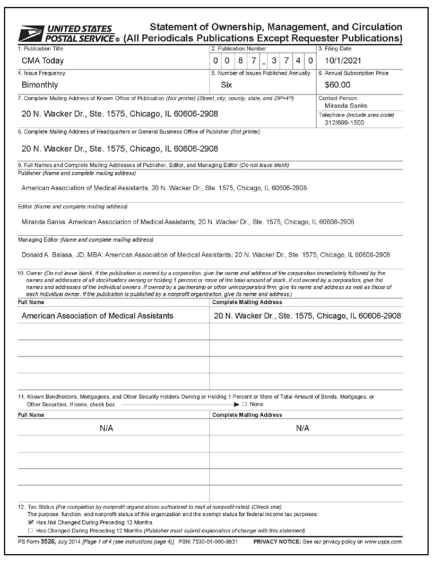
"I believe that teaching is not some stringent recipe. Some of the best class discussions occur more organically."

–Karen Piette, MHS, CHES, CMA (AAMA)
Bellingham, Washington

"Educating [patients] that there are ways to get relief from their symptoms can be the beginning of a very satisfying journey for these potential patients."

–Patti Chandler, CMA (AAMA)
Warsaw, Indiana

https://aama-ntl.org/cma-today/interviewees



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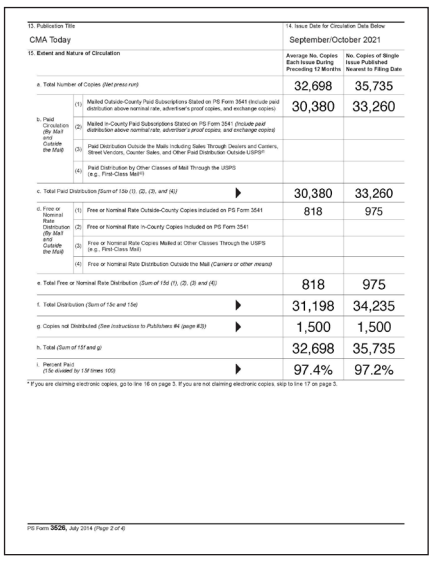

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f. Total Distribution (Sum of 15c and 15e)		31,198	34,235
g. Copies not Distributed (See Instructions to Publishers #4 (page #3))		1,500	1,500
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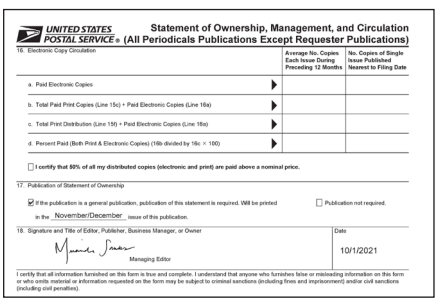

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