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CMA™ Today

Cause for Concern

Prevent alcohol misuse with open dialogues

Bittersweet memories

It's hard to believe my presidency, which began two years ago, is coming to an end. It has been a roller coaster ride from day one. So, in my final message to AAMA members, there are so many people I want to thank.

First and foremost, I want to thank AAMA members for electing me to serve as your president during the 2019 AAMA Annual Conference in Greensboro, North Carolina, and then voting to keep the same officers and trustees for another year. I am grateful for the confidence and trust in the AAMA Board of Trustees (BOT) and our ability to carry on AAMA business for another year.

The BOT has been a significant part of my life—not just professionally but personally as well. They have become like a second family to me. We have laughed, cried, and developed such a great friendship over these past two years. I experienced an outpouring of love and support from the BOT when my husband, Sam, passed away in May 2020. I will always treasure all that they have done for me during such a difficult time.

I couldn't be prouder of this team and our achievements during our term—including working during a pandemic. Our time in office has been both challenging and rewarding, and I feel we have accomplished a great deal for this organization. We have all learned more about Zoom and GoToMeeting than anyone would expect. These virtual meetings have been a new experience but also a wonderful way to connect when it wasn't possible to meet in person.

In closing, it's been a great honor to serve as your president, and I thank you all for that privilege. The AAMA means so much to me, the people mean so much to me, and I have been glad to serve our organization and its members in this capacity.

I offer two small words that mean so much: thank you.

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

AAMA® Mission

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

CMA (AAMA)® Certification

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

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CMA Today

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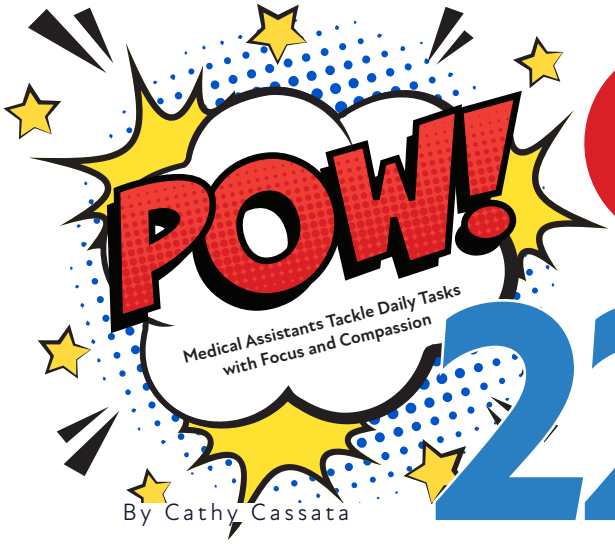

MARWeek special feature

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AAMA update

Make the grade without breaking the bank

Embrace your inner student this fall with discounts on the ABC-AHE and Topics in Telemedicine*!*

In the spirit of lifelong learning and new beginnings, the Continuing Education Board presents a back-to-school special on two certificate-level programs in the AAMA e-Learning Center. Use these discounts to branch out into or strengthen existing skills in telemedicine topics as well as allied health education.

- **Save 20% on *Topics in Telemedicine: Go the Distance with Remote Patient Care.*** Show employers that you have an understanding of important aspects of—and medical assistants' role within—telemedicine.
- **Save 25% on the Assessment-Based Certificate Program in Allied Health Education (ABC-AHE).** Whether you're thinking about, just starting, or continuing a longtime career in medical assisting education, completing the ABC-AHE is the right choice to strengthen your ability to teach a diverse population.

Looking for bite-size continuing education courses? You can take the individual courses of the ABC-AHE and save 10% on each:

- *The Principles of Adult Learning*
- *Effective Classroom Instruction*
- *Assessment, Evaluation, and Other Aspects of Allied Health Education*

This sale lasts Sept. 1, 2021, through Nov. 30, 2021 (midnight).

CEUs for self-care

Since the onset of the COVID-19 pandemic, health care professionals are at an increased risk for developing compassion fatigue as they attend to the needs of patients. In their role, medical assistants promote and model healthy coping behaviors. However, health care professionals often ignore their own needs and warning signs associated with compassion fatigue in the workforce.

Join Sandra Gonzalez, PhD, LCSW, in *Compassion Fatigue and Self-Care for Medical Assistants*, a two-part webinar series in which she breaks down compassion fatigue and discusses how to recognize warning signs, like risky alcohol use, and how to cope with compassion fatigue.

Worth 2 AAMA-approved CEUs (gen/clin), this course is free for all via the AAMA e-Learning Center until Aug. 4, 2022.

This webinar is brought to you by the Center for the Application of Substance Abuse Technologies (CASAT) and the Medical Assistant Fetal Alcohol Spectrum Disorders Practice Improvement Collaborative (Medical Assistant FASD PIC). ✦

New AAMA blog on certification!

The AAMA is pleased to introduce *CMA (AAMA) In Sight: For Medical Assistants with an Eye for Excellence*! The AAMA's second blog, *CMA (AAMA) In Sight*, will focus on pertinent topics related to CMA (AAMA)® certification.

Subscribe today: go to www.CMAAAMAInSight.wordpress.com, enter your email address in the top-right field, and then click "Subscribe." Once subscribed, you'll receive a notification for each new post. ✦

MARWeek power packs

It's a bird! It's a plane! No, it's all medical assistants, saving the day *every* day with their super patient care! Every year, we celebrate these heroes with Medical Assistants Recognition Week (MARWeek) during the third full week in October:

MARWeek: Oct. 18–22, 2021

MARDay: Oct. 20, 2021

While these pros don't need capes, the AAMA provides other tools (i.e., promotional MARWeek packets, products, and downloads) to help you celebrate the professionals who are true partners in health care. Visit the AAMA online store to order* complimentary MARWeek packets or individual posters and window clings or purchase t-shirts.

**Orders of complimentary items will be sent out through early October while supplies last. You may also download the MARWeek logo and materials, such as sample messaging, from the "MARWeek" webpage, which is found within the "News & Events" tab.* ✦

Scholarship road

In honor of last year's recipients of the esteemed Maxine Williams Scholarship, we checked in to see how they are doing on their journeys as medical assistants:

Cari Daul, CMA (AAMA), graduated from Muskegon Community College in Michigan and passed the CMA (AAMA) Certification Exam in August 2020. She currently works for Mercy Health Urgent Care in Muskegon, Michigan.

Daul loves her position as a medical assistant in urgent care, where she has been able to use many of the skills that she learned at Muskegon Community College. She also values continuing to learn from colleagues and firsthand experiences. Daul embraces the fast-paced, varied nature of the urgent care setting, which allows her to see and learn something new every day.

"Helping patients is so rewarding," says Daul. "I have absolutely fallen in love with the medical field and love helping patients every day!" Her passion for helping others inspired Daul to pursue further education. She is currently working on completing the nursing program prerequisites at Muskegon Community College.

Mindy Swain, CMA (AAMA), graduated from the medical assisting program at Salt Lake Community College in Utah in December 2020 and passed the CMA (AAMA) Certification Exam the same month. She also passed the Limited Radiology Practical Technician (LRPT) licensing exam. In January 2021, she began a new job as a medical assistant at Lone Peak Internal Medicine in Draper, Utah.

Swain finds her new role and ability to improve patients' lives incredibly rewarding. She enjoys working as a team with her coworkers to help each patient receive care. Her favorite aspect of internal medicine is seeing the same patients often and getting to know them better, allowing her to watch patients' growth and improvement.

Swain is grateful for her teachers at Salt Lake Community College and the in-depth education she received. "Their knowledge and preparation ... helped to prepare me to be the best medical assistant I can be," says Swain. She adds, "It has been such an honor to receive the Maxine Williams Scholarship. It helped alleviate some of the financial burden for my education." ✦

Early bird membership specials

Discounted dues for online sign-ups! If you sign up for AAMA membership between July 1, 2021, and Oct. 31, 2021 (before midnight), you will receive an $8 discount! *(Discount does not apply to student members.)*

Renew instantly on the AAMA website. Sign in and click "My Account" above the search bar at the top-right. Then click the "Renew My Membership" link from the left-side menu on the page.

On the web

Digital badges
Under CMA (AAMA) Exam
Get answers to frequently asked questions about your CMA (AAMA) digital badge and how to get one.

Request a rep
Under Volunteers/Guidelines and Forms
State presidents, see instructions for submitting your request for a member of the Representatives Bureau to attend your 2022 meeting.

Support the profession
In the Store
Help deserving medical assisting students and safeguard the quality of medical assisting education. Donate to the Maxine Williams Scholarship and Ivy Reade Relkin Surveyor Training Fund.

BOT highlights
Under News and Events
Sign in and find all the decisions made by the AAMA Board of Trustees at the June 2021 meeting. *(Must be a member for access.)* ✦

Eligibility pathway for the CMA (AAMA) Certification Exam!

Do you have medical assisting coworkers, colleagues, or friends who aren't CMAs (AAMA) because they were ineligible to take the CMA (AAMA) Certification Exam?

A four-year pilot program, launched in August 2019, expands the education pathway for graduates of medical assisting programs to take the CMA (AAMA) Certification Exam!

Share the eligibility and application requirements, which are on the "Certification Exam Eligibility Pilot Program" page of the AAMA website. ✦

The AAMA launches Order Entry Competence outreach to payers

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

The Medicaid Promoting Interoperability Program (formerly the Medicaid Electronic Health Record [EHR] Incentive Program) will be ending December 31, 2021. In furtherance of its Mission Statement goal of advocating for quality patient-centered health care and its Core Value of promoting patient safety and well-being and as authorized by the Board of Trustees of the American Association of Medical Assistants® (AAMA), the AAMA launched its national Order Entry Competence (OEC) initiative on July 11, 2021. The purpose of the OEC outreach is to persuade third-party payers to incorporate into their agreements with licensed providers the requirement that their orders be entered into the computerized provider order entry (CPOE) system by either credentialed medical assistants or licensed health care professionals who are competent in order entry.

The OEC initiative is anticipated to create several effects:

- A decrease in the number of incorrect orders
- An improvement in health outcomes
- An avoidance of the monetary and pain-and-suffering costs resulting from inaccurate order entry

The following history of the Promoting Interoperability Programs provides justification for the need for the OEC outreach.

The HITECH Act

In 2009 the U.S. Congress enacted into law the Health Information Technology for Economic and Clinical Health (HITECH) Act. Although not as well-known as the Patient Protection and Affordable Care Act, the HITECH Act has also had a profound and far-reaching impact on American health care.

The HITECH Act created the Medicare and Medicaid Promoting Interoperability Programs and directed the Centers for Medicare & Medicaid Services (CMS) to issue rules for these new programs. The two Promoting Interoperability Programs provided annual payments to licensed providers and health care institutions who demonstrated—in addition to other requirements—meaningful use of their EHR systems by meeting or exceeding various quantitative measures established by the CMS. Specifically, for each reporting year, a certain percentage of medication orders, a certain percentage of laboratory orders, and a certain percentage of diagnostic imaging (initially just radiology) orders had to be entered into the CPOE system.

Who should be allowed to enter orders?

A point of major debate during the early years of the Medicare and Medicaid Promoting Interoperability Programs was who should be permitted to enter orders into the CPOE system for meaningful use calculation purposes. Early versions of the CMS rules stated that orders had to be entered by licensed health care professionals. The CMS "invited public comment on whether the stipulation that the CPOE function be used only by licensed health care professionals remains necessary or if CPOE can be expanded to include non-licensed health care professionals."[1] Comments received by the CMS included opinions that "any individual

(licensed or not) who receives the order from the ordering provider [should] be permitted to perform CPOE."[2]

After evaluating these comments, the CMS tentatively concluded that CPOE for Promoting Interoperability Programs' purposes may be done by "any licensed health care professional [who] can enter orders into the medical record per state, local, and professional guidelines."[2] Before incorporating this language into the final Promoting Interoperability Programs rule, the CMS gave the public another opportunity to comment.

The AAMA submits comments to the CMS

On April 24, 2012, the AAMA submitted comments[3] to the CMS regarding the proposed final rule.

The comments outlined the reasons competent and knowledgeable medical assistants who are credentialed by a third-party entity—such as an independent certifying body—should be incorporated into the CMS rule. The AAMA requested that the wording be amended to allow "any licensed or *appropriately credentialed* health care professional [emphasis added]"[3] to enter medication, laboratory, and diagnostic imaging orders into the CPOE system for meaningful use calculation purposes under both the Medicare and Medicaid Promoting Interoperability Programs.

The CMS accepts AAMA recommendations

After reviewing the second round of comments, on August 23, 2012, the CMS promulgated its final rule for Stage 2 of the Promoting Interoperability Programs. In a major victory for the AAMA and the medical assisting profession, the CMS tacitly agreed with the AAMA's comments and decided that credentialed medical assistants, in addition to licensed health care professionals, would be allowed to enter orders into the CPOE system for meaningful use calculation purposes. The CMS articulated its reasons in the August 23, 2012, *Federal Register*:

> We are particularly concerned with CPOE usage by [eligible professionals (EPs) such as physicians, osteopaths, and podiatrists] in this regard. Many EPs practice without the assistance of other licensed health care professionals. These EPs in their comments urged the expansion [to any licensed, certified, or appropriately credentialed health care professional who can enter orders into the medical record per state, local, and professional guidelines]. *We believe this expansion is warranted and protects the concept that the [clinical decision support (CDS)] interventions will be presented to someone with medical knowledge as opposed to a layperson* [emphasis added]. The concept of credentialed health care professionals is over broad and could include an untold number of people with varying qualifications. Therefore, we finalize the more limited description of including credentialed medical assistants. *The credentialing would have to be obtained from an organization other than the employing organization* [emphasis added].[1]

Reasons for the OEC initiative

Why is there a need for a private sector campaign to ensure competence in order entry? The simple answer is that patient welfare is dependent on not only accurate order entry but also clinically correct responses by allied health professionals to CDS messages and proposed interventions. The CMS emphasized this in additional rationale for its August 23, 2012, final rule:

> Based on public comments received, questions submitted by the public … and demonstrations of [certified EHR technology (CEHRT)] we have participated in, it is apparent that the prevalent time when CDS interventions are presented is when the order is entered into CEHRT, and that not all EHRs also present CDS when the order is authorized [by the licensed provider] (assuming such a multiple step ordering process is in place). *This means that the person entering the order could be required to enter the order correctly, evaluate CDS either using their own judgment or through accurate relay of the information to the ordering provider, and then either make a change to the order based on the CDS intervention or bypass the intervention. We do not believe that a layperson is qualified to do this* [emphasis added].[1]

In light of what competent and safe clinical order entry entails, the AAMA holds the position that the OEC outreach is needed to remind third-party payers and licensed providers that clinical knowledge is necessary when a clinical order is entered, not just when the licensed provider subsequently authorizes the order.

Assistance requested

It is both imperative and appropriate that the AAMA—as the voice of the medical assisting profession and a tireless advocate for high quality and readily accessible health care—create and lead the OEC initiative. However, for the OEC outreach to be successful, the AAMA needs help from medical assisting practitioners, managers, educators, and representatives of our other communities of interest. Please provide the contact information for any executives and board members of health insurance carriers by emailing me at DBalasa@aama-ntl.org.

Thank you in advance for helping the AAMA protect the health and safety of patients throughout the United States! ✦

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

References

1. Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2; Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology; Final Rules. *Fed Regist.* 2012;77(171):53967-54162. To be codified at 42 CFR §412, 413, 495.
2. Medicare and Medicaid Programs; Electronic Health Record Incentive Program. *Fed Regist.* 2010:75(144):44314-44588. To be codified at 42 CFR §412, 413, 422, et al.
3. Balasa D. AAMA comments on the proposed CMS rule. *CMA Today*. 2012;45(3):6-7. Accessed August 25, 2021. https://www.aama-ntl.org/cma-today/archives/article?id=907fcf4a-4840-6a90-a81c-ff00003b2c18

Not in Vein

Treatments for varicose veins worth the legwork

By John McCormack

When seeking treatment, people with varicose veins—swollen, twisted veins that lie just under the skin, typically occurring in the legs[1]—are apt to encounter many businesses promising to quickly cure the condition with solutions such as apple cider vinegar, witch hazel, and miracle creams.

Unfortunately, these promises are largely empty. "As the old saying goes: if it seems too good to be true, it probably is," says Ellen Dillavou, MD, FACS, associate professor of surgery at Duke University School of Medicine in Durham, North Carolina. "No creams or pills can make varicose veins immediately go away."

The condition is fairly common, affecting approximately 40 million Americans.[2] Further, the treatment market is expected to grow to $558.7 million by 2027.[3]

As a result, health care professionals, including medical assistants, need to know the ins and outs of varicose veins so they can help patients get much-needed relief.

Out for blood

Increased blood pressure causes varicose veins.[4] Basically, when one-way valves that move blood to the heart become weakened or damaged, blood collects in the veins, causing them to become enlarged.[4]

In some cases, the condition may be inherited.[4] "If [a patient has] one parent who has varicose veins, [the patient is] about 50% likely to have varicose veins," explains Dr. Dillavou. "If [a patient has] two parents [with varicose veins, the patient has] more than a 90% chance of having varicose veins."

While heredity is a significant factor, other influences affect risk as well. "The hormonal fluctuations of puberty, pregnancy, and menopause can also play a role in the progression of this condition for [some] patients," says Jeffery P. Schoonover, MD, RPVI, DABVLM, the chief medical officer at Indiana Vein Specialists in Carmel, Indiana, and a board member of the Foundation for Venous and Lymphatic Disease in Chicago. "Obesity can play a role …, but it is not as strong [a factor] as genetics."

Another factor is an excess in the same type of leg position for long stretches of time. Standing for lengthy periods can increase the risk for those with jobs in factories, retail, hospitality, and health care. In the same vein, sitting for extended periods also can affect varicose vein progression. In fact, "the changing job responsibilities throughout the COVID-19 pandemic have forced multiple patients to be sitting much more than previously," says Dr. Schoonover. "We are seeing a significant number of patients who have had their lower extremity swelling worsen due to multiple hours of videoconferencing."

Step on it

Twisted, bulging, dark purple or blue veins are often an initial sign of varicose veins. Other common symptoms form the acronym *HASTI*, according to Dr. Dillavou:

- Heaviness
- Aching
- Swelling
- Throbbing
- Itching

Patients presenting with these concerns range from "being minimally symptomatic to being seriously impacted in their activities of daily living and sleep," says Dr. Schoonover.

Obtaining a complete medical history

is the first step toward diagnosing varicose veins. Clinicians then need to conduct a physical examination, which requires the patient to be in a standing position, preferably without shoes and socks on.

"Besides recognizing the dilated varicosities, take time to evaluate for swelling," says Dr. Schoonover. "A classic indentation at the sock line can be suggestive of the type of swelling that accompanies venous insufficiency." Dry skin is another telltale sign.

When varicose veins are suspected, clinicians may use duplex ultrasound to confirm the diagnosis. These ultrasounds provide a noninvasive evaluation of blood flow through the arteries and veins.[5]

Back in circulation

Fortunately, once a diagnosis is confirmed, patients have multiple treatments available. "We have much better treatment options than we did 20 years ago, when clinicians used to do vein strippings—procedures that basically pulled veins out of the body. These strippings caused a lot of bruising and were pretty uncomfortable," says Dr. Dillavou. "Now we have catheter-based treatments in which clinicians put a catheter up inside the vein and close that vein off with a variety of different technologies. These treatments are pretty fast and painless, and people have no downtime after the procedure."

Clinicians may also recommend other therapies depending on the severity of the condition:

- **Sclerotherapy.** The clinician injects small- and medium-sized varicose veins with a solution or foam that scars and closes those veins.[6]
- **Thermal ablation treatment.** Lasers or radiofrequency energy destroy the walls of varicose veins by delivering heat via a tiny fiber inserted into the vein.[4]
- **Ambulatory phlebectomy.** Clinicians remove smaller varicose veins through a series of tiny skin punctures.[6]

In addition to medical treatments, some home remedies may offer relief. Compression stockings will not prevent or cure varicose veins but can help relieve symptoms. "They are kind of like eyeglasses in that [glasses] help when you have them on, but they don't change your vision," says Dr. Dillavou. "Patients report that compression stockings make their legs feel better while they're wearing them. [The stockings] give you more energy, and your legs [won't feel] as heavy feeling or achy—and that's terrific."

Additionally, "exercise and weight loss are your friends," says Dr. Dillavou. "And that holds true with varicose veins. They won't prevent [varicose] veins from developing, but they may make the symptoms decrease."

Patients can also take self-care measures to slow or prevent the development of varicose veins[6]:

- Avoid high heels and clothes that are tight around the waist, legs, or groin
- Elevate legs above the heart during short breaks
- Change sitting or standing position regularly

Treatment and continued monitoring are essential; as the diseased veins become larger and progress with swelling and skin changes, chronic venous insufficiency can set in. "As this condition worsens, patients can also be at a higher risk for superficial thrombophlebitis or even deep venous thrombosis," warns Dr. Schoonover. "Both of these conditions are serious and can result in a life-threatening pulmonary embolism if left untreated."

However, with proper treatment and management, patients can obtain symptom relief, improve veins' appearance, and prevent serious complications.[1] ✦

Untwist the myths on treatment

Many people take one look at their bulging, purple veins and immediately rush to get them treated. "They might go to a strip mall–based location, walk in for a free evaluation, and be told that they need all kinds of treatments for their varicose veins," Ellen Dillavou, MD, FACS. "Then, they go ahead and spend a lot of money on these treatments, which are often unneeded."

To receive *reliable* diagnoses and treatments, patients should go to vein centers that have been accredited by Intersocietal Accreditation Commission or to dedicated vein clinics.

Patients should also consider seeking treatment from physicians who are board-certified through the American Board of Venous and Lymphatic Medicine because such physicians have passed the most comprehensive examination of knowledge in venous disease available.[7]

References

1. Varicose veins. National Heart, Lung, and Blood Institute. Accessed August 14, 2021. https://www.nhlbi.nih.gov/health-topics/varicose-veins
2. Varicose veins. Society for Vascular Surgery. Accessed August 14, 2021. https://vascular.org/sites/default/files/VV_Flyer_English_Link.pdf
3. Global varicose vein treatment industry. ReportLinker. April 2021. Accessed August 14, 2021. https://www.reportlinker.com/p06043982/Global-Varicose-Vein-Treatment-Industry.html?utm_source=GNW
4. Varicose veins. Johns Hopkins Medicine. Accessed August 14, 2021. https://www.hopkinsmedicine.org/health/conditions-and-diseases/varicose-veins
5. Leers SA. Duplex ultrasound. Society for Vascular Surgery. Accessed August 14, 2021. https://vascular.org/patient-resources/vascular-tests/duplex-ultrasound
6. Mayo Clinic Staff. Varicose veins. Mayo Clinic. January 30, 2021. Accessed August 14, 2021. https://www.mayoclinic.org/diseases-conditions/varicose-veins/diagnosis-treatment/drc-20350649
7. What is venous and lymphatic medicine? The American Board of Venous & Lymphatic Medicine. Accessed August 14, 2021. https://www.abvlm.org/what_is_venous_and_lymphatic_medicine.php

Take care of health care workers

As the U.S deals with COVID-19, employers must not forget the immense physical and mental struggles health care workers face on the front lines of this global health crisis. Managers should use this time to put measures in place that will better protect health care workers, a position thoughtfully argued by researchers in *Frontiers in Public Health*.

Burnout, depression, and trauma are just a few of the challenges that can plague health care workers. While the researchers note that self-care is an important factor, they also offer numerous policy recommendations:

- Create tools and resources for improving employee well-being and resilience
- Distribute information on wellness interventions and programs
- Maintain sufficient staffing and fair wages
- Destigmatize seeking mental health treatment while ensuring such resources are available
- Allow front line workers to have a say in policies that affect them

By engaging in these discussions now, employers will be doing a great service to health care workers for years to come.

A call for contraceptive care

In 2019, the World Health Organization issued a recommendation that self-administered injectable contraceptives, such as subcutaneous depot medroxyprogesterone acetate (DMPA-SC), should be made available. In 2021, the Centers for Disease Control and Prevention (CDC) has adopted this guidance and added it to the U.S. Selected Practice Recommendations for Contraceptive Use.

The CDC reviewed the evidence and determined that self-administered DMPA-SC increased contraceptive continuation and, when compared with provider-administered DMPA-SC, did not result in increased rates of pregnancies, side effects, or adverse events.

The CDC notes that it should be considered an additional approach to provider-administered DMPA-SC that could reduce barriers to access and empower individuals. ✦

Hospital penalties for HACs

Hospital-acquired conditions (HACs) and readmissions are two major concerns for patient safety and can seriously cut into Medicare payments. Infections, bedsores, and blood clots are just a few of the complications that factor into HAC rates. Hospitals with the highest HAC rates are penalized 1% of their Medicare payments for the fiscal year, according to Kaiser Health News. Hospitals can also face an up to 3% payment reduction for readmission penalties.

In 2019, 800 hospitals were paid less because of high rates of infections and patient injuries, the highest number of penalties since the creation of the Hospital Acquired Conditions Reduction Program. However, the number of HACs has decreased about 8% from 2014 to 2016—with the exception of bedsore and urinary tract infection cases, which have increased.

Curious how your local hospitals stack up? Try the search tool from Kaiser Health News: https://khn.org/news/hospital-penalties.

Gender bias in *pain perception*

Health care has come a long way from diagnosing female patients with hysteria in lieu of real treatment, but more work needs to be done. People perceive women as having less intense pain than their male counterparts, according to two recent studies in the *Journal of Pain*.

In the first study, participants watched videos of men and women experiencing shoulder pain. Participants more often underestimated women's pain when compared to their evaluations of men's pain. The second study repeated a similar experiment and asked participants to recommend either medication or psychotherapy to treat the pain. Results showed that participants were more likely to say that women rather than men would benefit from psychotherapy.

While the study tested participants from outside the medical community, the lesson is valuable for health care workers too. Awareness of potential biases can help ensure that patients are treated with the respect and care they deserve. ✦

Subsequent care needed after alcohol use screening

While identifying patients with alcohol use disorders (AUD) is critical, the health care system is falling short on the next steps, according to a study in *Alcoholism: Clinical and Experimental Research*.

Data from over 200,000 respondents to the 2015–2019 National Survey on Drug Use and Health showed that roughly 8% of individuals have an AUD. Though 70% of those with AUD had been screened for alcohol use in the past 12 months, intervention rates were drastically lower. Only 12% received a brief intervention, and an even smaller proportion (5%) were referred to treatment.

Discouraging as these figures may be, awareness of this gap between screening and treatment can help health care workers better serve their populations.

Dance dance neurocognition

Exergaming (i.e., physical activity that involves video games) isn't just a fun way to break a sweat; it also has numerous health benefits for those with major neurocognitive disorders (MNCD), notes a recent study in *Alzheimer's Research and Therapy*.

The study had individuals in long-term care facilities with diagnosed MNCD use an exergame platform that instructs participants to step on directional arrows in a sequence. As a result of the study, participants improved cognitive and lower-extremity functions, increased step reaction time, and even showed a reduction in depressive symptoms.

There were no adverse events reported from the study, and, moreover, 83% of participants completed the program. That crucial mix of health benefits and strong participation rates makes exergaming an exciting workout option for those with MNCD.

Cause for Concern

Prevent alcohol misuse with open dialogues

By Sandra J. Gonzalez, PhD, LCSW

The U.S. has a drinking problem. Enter "alcohol use in America" into any search engine, and the results tell an alarming story. The pervasiveness of excessive drinking is well documented, and the number of people drinking has continued to rise over the past two decades. Recent prevalence rates indicate that approximately 38 million adults in the U.S. drink too much, whereas only about 1 in 6 has talked about their drinking with a health professional.[1] And more than 95,000 people in the U.S. die from alcohol-related causes each year.[2] Alcohol misuse has been associated with a host of health problems, including certain cancers, liver disease, heart disease, and, for people who are pregnant, fetal alcohol spectrum disorders (FASDs) for their developing children.

Because many people whose assigned sex at birth is female can become pregnant, intend to become pregnant, or both, a 2017-published study's findings that alcohol use, high-risk drinking, and alcohol use disorders (AUDs) in female participants have all increased[3] indicate an increased risk for FASDs among children. In particular, the findings indicated that more female adults are drinking (a 16% increase from 2002–2013) and significantly more are drinking at risky levels (an 83% increase).[3] Such indicated trends in risky drinking, specifically binge drinking, are reinforced by 2011–2018 Centers for Disease Control and Prevention (CDC) data.[4]

Defining the problem

For alcohol use to be considered *low risk*, consumption must stay within the recommended daily and weekly limits, which is broken down by birth-assigned sex (i.e., *male* and *female*) and age. The National Institute on Alcohol Abuse and Alcoholism recommends that both male individuals over the age of 65 and female individuals consume no more than three drinks per day and no more than seven drinks per week. Meanwhile, male individuals under the age of 65 should consume no more than four drinks per day and no more than 14 drinks per week. *Binge drinking* is when a male individual has more than four drinks or a female individual has more than three drinks in about two hours—the time it typically takes to bring a person's blood alcohol concentration to 0.08 or above. Female individuals who consume eight or more drinks per week or male individuals who consume 15 or more drinks per week are considered heavy drinkers.[5]

In the U.S., one standard drink contains 14 grams of pure alcohol. This same amount is found in 12 ounces of regular beer, 8–9 ounces of malt liquor, 5 ounces of wine, and 1.5 ounces of 80 proof liquor.[6] Therefore, pattern of consumption may be a more important variable to consider than type of alcohol where health is concerned.

People are often surprised to know the exact definition of a standard drink. Many

times, they receive alcoholic beverages that exceed standard drink measures (quantity or alcohol by volume percentage) at restaurants or bars or, if at home, they do not consider the amount of alcohol in their drink. For example, a large pour of wine, a mixed drink containing more than one liquor, or a high gravity beer may be served in one container but can equal more than one drink. In turn, if people do not measure out wine or spirits at home, they could be exceeding the recommended amounts.

Low risk does not mean there is no risk at all. Numerous factors, including health, age, genetics, and drinking patterns, are worth consideration when deciding how much to drink or whether to drink at all. The mechanisms by which alcohol affects cardiovascular risk factors are associated with alcohol's ability to impact inflammation, the hardening and narrowing of the arteries, and the formation of blood clots—all factors associated with coronary artery disease. Anyone under the age of 21, individuals who are pregnant or may be pregnant, and those driving or operating machinery should not consume alcohol at all. Other considerations include taking a prescription or over-the-counter medication that may interact with alcohol, having one or more medical conditions that may be worsened by alcohol (e.g., liver disease and pancreatitis), and being unable to control the amount of alcohol consumed.

Lifestyle, diet, and developmental factors play a crucial and unique role for each individual. And yet, ultimately, no safe level of drinking is known, and alcohol causes 10 times as many deaths as it potentially prevents for certain conditions via low-level usage.[7] Therefore, if a patient is not currently drinking alcohol, beginning to drink alcohol is inadvisable because of *potential* health benefits.

Sign of the times

The COVID-19 pandemic places an inordinate amount of stress on communities worldwide. By mid-August 2021, over 600,000 people in the U.S. have died from COVID-19.[8] In order to curtail the spread of the virus, several polices were implemented throughout the country. In early March 2020, a state of emergency was declared by the federal government. Soon after the declaration, 44 states and the District of Columbia instituted stay-at-home orders, closed bars, and restricted dine-in service at restaurants.[9] These policies were intended to promote social distancing and eliminate the gathering of people from different immediate households. However, they also limited access to alcohol normally consumed in bars and restaurants. In response, many states loosened restrictions on how alcohol could be purchased. Specifically, many states allowed curbside to-go alcoholic beverages and home-delivery services, creating greater access to alcohol while at home. Alcohol sales were up 21% in April 2020 compared with the previous year, and online sales were up 234%.[10]

Additionally, COVID-19's deleterious effect on the mental health and well-being of individuals has been widely reported. The Household Pulse Survey conducted by the National Center for Health Statistics and the U.S. Census Bureau showed that the number of U.S. adults reporting symptoms of anxiety or depression increased from 11% in January–June 2019 to 42% in December 2020.[11] Substance use has also increased. Previous research has shown that alcohol use can increase during tragedies such as natural disasters and pandemics. Alcohol is commonly used to cope with stress, and the increase in stress is thought to have contributed to a rise in alcohol consumption. In one pandemic study, participants reported consuming an average of 26.8 drinks containing alcohol on 12.2 days of the past 30 days.[12] Another study, which compared data from February 2020 and April 2020, showed increases in the average drinks per day, percentage of people exceeding drinking guidelines, and percentage of people binge drinking.[13]

What influences the recent increases in alcohol consumption? Researchers in Australia found several predictors[14]:

- Pre-pandemic heavy drinking
- Being a woman
- Being between the ages of 25 and 64
- Belonging to a higher income bracket
- Having a history of mental illness

Notably, pandemic-related stress can exacerbate female individuals' greater risk of developing alcohol-related problems: Many have faced unique challenges and have absorbed the greater burden of combined caregiving along with work responsibilities during the pandemic. And, even though women are more likely to discuss mental health concerns or marital discord with their primary care providers, they are less likely to disclose alcohol consumption.[15]

Fortunately, medical assistants have been on the front lines, providing care to patients during these unprecedented and stressful times. Patients likely share their health struggles, their anxiety about the virus, and maybe even their use of alcohol as a coping strategy. People struggling with the effects of social isolation participate in happy hours with family and friends through video conferencing platforms. They also may make end-of-the-day martinis called *quarantinis*, a nod to the homemade cocktail that quickly became a viral hashtag when many were quarantining. The drink was seen by many as a way of creating a sense of universality.

While comradery in any form is often an essential balm during difficult times, previous research has indicated that postdisaster rates of alcohol consumption may not change over time and that they may endure if not adequately addressed. Primary care practices are in an ideal position to identify misuse and provide timely intervention to reduce the health and social consequences of alcohol consumption.

Medical assistants can do much to help provide timely intervention:

- Work as a team member to implement universal alcohol screening in the practice
- Collaborate with providers to identify science-based messages regarding alcohol and stress
- Share patient education materials that include information about standard drink amounts and excessive drinking limits

- Provide patients with recipe cards for mocktails

Handle with care

As a positive influence and motivator for many patients, medical assistants are well-positioned to also help prevent alcohol-exposed pregnancies. All individuals of reproductive age with a uterus are at risk of having an AEP—a term that describes when a fetus is exposed to alcohol in utero—if they drink alcohol and are at risk of pregnancy. AEPs occur in every demographic group. For that reason, universal screening is paramount to prevention.

During screening, health care professionals must abstain from making assumptions about which populations are less likely to engage in problematic drinking. Although most individuals quit drinking once they become aware of their pregnancy, most may not realize they are pregnant for several weeks after conception. During this time, they may not change their drinking patterns. Non-pregnant individuals capable of pregnancy who drink excessively, including those who binge drink, may be at higher risk than others for an AEP if they become pregnant. Using 2015–2017 data from the Behavioral Risk Factor Surveillance System, CDC researchers found that among female individuals aged 18–44 years, around 1 in 9 pregnant individuals reported drinking alcohol in the past 30 days. About one-third of pregnant individuals who reported consuming alcohol engaged in binge drinking.[16]

In-utero alcohol exposure is the only cause of fetal alcohol spectrum disorders (FASDs), an umbrella term used to describe the various conditions responsible for a myriad of physical, behavioral, and intellectual disabilities. FASDs are the leading cause of preventable birth defects and developmental disabilities.[17] Fetal alcohol syndrome (FAS) is the most complex condition along the FASD spectrum and is characterized by three diagnostic criteria[17]:

- Dysmorphic facial features
  - Short palpebral fissures (i.e., short distance between the inner and outer corner of the eyes)
  - Smooth philtrum (i.e., area between the upper lip and nose)
  - Thin upper lip
- Growth deficits, which may occur at any point—prenatally or postnatally—and may affect weight, height, and head circumference (at or below the 10th percentile adjusted for age and sex)
- Central nervous system abnormalities
  - Structural (e.g., size and shape of the corpus callosum, basal ganglia, or cerebellum)
  - Functional (e.g., cognitive, intellectual, or developmental delays)
  - Neurological (e.g., motor problems)

Diagnosis by a qualified health care professional requires documentation of all three of the main criteria, with or without confirmed fetal exposure to alcohol.[18]

Individuals who are pregnant or who may be pregnant should be told that during pregnancy there is no known safe amount, no safe time, and no safe type of alcohol use. Any type of alcohol consumed can negatively affect the development of a fetus. Because roughly 45% of pregnancies are unintended,[19] clinicians who work with pregnant-capable patients should include messages related to alcohol use during preconception counseling.

Time to intervene

Alcohol screening and brief intervention (SBI) is a simple, concise, and effective evidence-based practice to reduce excessive and risky alcohol use and is intended to meet the public health goal of reducing harms and societal costs associated with excessive drinking.[20] The brief interventions are intended for drinkers who do not have an AUD but drink excessively.

Despite years of federal funding being allocated to SBI programs, widespread adoption of the practice has not yet been reached. Studies point to numerous barriers associated with implementation and, ultimately, sustainability of alcohol SBI in the primary care setting.[21-23] Health care professionals have reported time constraints, lack of training, lack of confidence, and inadequate staff resources as potential barriers. Providers have expressed concern about addressing alcohol use in their practice, fearing that they will offend the patient. Others feel that they do not have the needed knowledge and skills to provide an effective intervention.[23]

One method for addressing these barriers is to include all members of the health care team in the preparation and implementation of alcohol SBI. Successful implementation begins with garnering support and buy-in from all staff that will be involved in the process. Another key element is establishing a screening plan in advance. Doing so provides an opportunity to identify and address potential barriers and facilitators among the entire team.

Alcohol SBI creates an opportunity to present clear and consistent, science-based messaging around alcohol use, and—for pregnant-capable patients—preconception education about how alcohol affects pregnancy.

Evidence demonstrates that patients expect their providers to ask questions about lifestyle choices, including alcohol use. Establishing a universal system for screening will normalize these conversations and reduce stigma and bias. In addition to alcohol SBI for those drinking above low-risk limits, health care providers should also screen, motivate, and refer patients who might have an AUD.

From draft to done

Primary care practices are in an ideal position to identify patients who may be drinking excessively. Ensuring that all health care professionals understand how alcohol affects patients' health is fundamental to the process of alcohol SBI implementation. As is the case with other preventive services, each member of the interprofessional team has a role in the adoption and sustainability of alcohol SBI.

Many resources are available to assist practices in adapting alcohol SBI to their setting. In some practices, convening a planning team to work together to identify the best way to implement the alcohol SBI program may be necessary. And to improve the likelihood of buy-in from all staff, identify members of the team who can serve as alcohol SBI practice champions.

Champions are front-line health care professionals (physicians, advanced practice professionals, medical assistants, nurses, behavioral health providers) who work directly with patients and are essential to establishing and maintaining the use of alcohol SBI within the clinical environment.

The first step in developing a screening plan is to identify how the screening will be conducted: choose between paper or electronic means, determine whether screening will be held in the waiting room or examination room, and establish who will conduct the screening.

Next, the team should determine which patients will be screened and how often. Many practices opt to screen during patients' wellness visits, alongside other screenings such as blood pressure, glucose, or cholesterol, or during new patients' initial consultation. In any case, because a person's drinking patterns might change over time, following up annually or more often, as needed, is essential.

Alcohol SBI implementation checklist[26]

1. **Clinic Readiness to Implement Alcohol SBI**
   - ☐ Confirm that administration and staff are committed.
   - ☐ Identify alcohol SBI champion(s).
2. **Screening**
   - ☐ Determine screening tool format (paper forms or integrated into the electronic health record).
   - ☐ Determine screening tool administration method (by staff or by patient [i.e., self-administered]).
   - ☐ Score screening tool and communicate results to the clinician.
3. **Brief Intervention**
   - ☐ Share screening results with licensed provider and discuss with patient.
   - ☐ Provide patient education materials.
4. **Referral Plan**
   - ☐ Identify community resources for additional follow-up and treatment.
5. **Training**
   - ☐ Determine preferred time for staff trainings.
   - ☐ Choose training time frame (e.g., a single 2–3-hour session or multiple 1-hour sessions).
   - ☐ Select training format (e.g., in-person or self-paced).
6. **Ongoing Support**
   - ☐ Schedule regular staff meetings and alcohol SBI training booster sessions to ensure ongoing quality improvement and sustainability of the program.

The USAUDIT-C

This three-question U.S. Alcohol Use Disorders Identification Test-Concise (USAUDIT-C)[27] in an easy, swift way to screen patients for risky alcohol use:

Questions	0	1	2	3	4	5	6	Score
1. How often do you have a drink containing alcohol?	Never	Less than monthly	Monthly	Weekly	2–3 times a week	4–6 times a week	Daily	
2. How many drinks containing alcohol do have on a typical day you are drinking?	1	2	3	4	5–6	7–9	10 or more	
3. How often do you have X (five for male patients aged 65 and under; four for female patients and male patients over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	2–3 times a week	4–6 times a week	Daily	
							Total	

The U.S. Preventive Services Task Force reviewed the research literature on screening for unhealthy alcohol use and brief counseling and recommended that primary care settings routinely provide screening to those aged 18 and older.[24] The use of alcohol SBI with teenagers is an emerging area of practice, and the research is pointing to promising results.[25]

Finally, a validated alcohol screening instrument should be chosen to identify whether a patient is drinking too much. While many screening tools are available, time constraints may prohibit the use of screening methods that are too lengthy. For this reason, two screening instruments have been validated for use in the primary care setting: the Single Question Alcohol Screen and the U.S. Alcohol Use Disorders Identification Test-Concise (USAUDIT-C).

The Single Question Alcohol Screen asks, "How many times in the past year have you had X or more drinks in a day?"—X is replaced with "five or more" for male patients and "four or more" for female patients. For pregnant patients, the Single Question Alcohol Screen is, "Have you had a drink since you found out you were pregnant?" The USAUDIT-C is a three-item screen that is used to measure a patient's consumption and how often they are engaging in excessive drinking.

If a patient screens positive on either the Single Question Alcohol Screen or the USAUDIT-C, the appropriate health care professional administers the full USAUDIT. The USAUDIT is a 10-question alcohol screening instrument that can provide additional information about how alcohol use has affected patients and whether they might have an AUD and need of specialized treatment.

Patients who screen positive for at-risk drinking are provided with a brief intervention. A brief intervention is a short conversation between the health care professional and the patient that focuses on motivating the patient to cut down or stop drinking to reduce their risk of alcohol-related consequences.[26]

If a pregnant-capable patient is having sex, wants to avoid becoming pregnant, and drinks alcohol, the clinician should share birth control options. If a pregnant-capable patient intends to or is planning to become pregnant or not using birth control with sex, the best advice is to stop drinking alcohol. In some cases, health care professionals may encounter patients who are having difficulty quitting excessive alcohol consumption on their own. In those cases, a referral for additional services such as substance use disorder treatment might be necessary.

Cheers to the champions

Once the implementation plan is in place, alcohol SBI champions should apply these crucial elements of an effective brief intervention[26]:

Normalize the brief intervention process. Stating that alcohol SBI is conducted with all patients conveys that it is a normal part of good health care practice. For example, say, "We like to talk to all of our patients about issues that may affect their health. Would it be OK if we take a few minutes to do that now?"

Use nonjudgmental language. Being more thoughtful about the words used with patients reduces patients' resistance to talking about their alcohol use. For example, say something like "consuming alcohol at an unhealthy level" instead of "you drink too much."

Employ core skills for conducting a successful brief intervention. Improving on and using these skills will lead to more effective brief interventions:

- Use reflective listening: respond with

empathic statements that reflect what the patient says

- Provide feedback: ask permission, review results, and express concern related to specific risks
- Roll with resistance: do not argue; instead, provide information for consideration
- Explore change: learn about the patient's pros and cons, and assess readiness
- Explore options: ask what options might be useful in making a change

Ultimately, the monitoring of excessive alcohol use allows health care professionals to develop and implement universal interventions that can improve patient outcomes. Every member of the patient's health care team can play a vital role in reducing the harms associated with at-risk drinking for both patients and patients' children. And medical assistants, in particular, are excellent candidates for championing alcohol SBI and reducing stigma by increasing the normalcy of these conversations. ✦

What medical assistants can do

In the alcohol screening and brief intervention process, medical assistants can play a huge role[26]:

- Perform an initial vital signs assessment after taking the patient to the examination room
- Score the USAUDIT-C, and if the patient screens positive, administer USAUDIT
- Document the USAUDIT-C score
- Review the score with a clinician or perform brief intervention per standing orders
  - Positive screen: discuss the patient's alcohol use, health impact, willingness to change drinking pattern, and offer educational materials
  - Negative screen: acknowledge the patient's healthy behaviors and offer educational materials
- Document the conversation and update the clinician

References

1. McKnight-Eily LR, Okoro CA, Turay K, Acero C, Hungerford D. Screening for alcohol use and brief counseling of adults—13 states and the District of Columbia, 2017. *MMWR Morb Mortal Wkly Rep*. 2020;69(10):265-270. doi:10.15585/mmwr.mm6910a3
2. Esser MB, Sherk A, Liu Y, et al. Deaths and years of potential life lost from excessive alcohol use - United States, 2011–2015. *MMWR Morb Mortal Wkly Rep*. 2020;69(39):1428-1433. doi:10.15585/mmwr.mm6939a6
3. Grant BF, Chou S, Saha TD, et al. Prevalence of 12-month alcohol use, high-risk drinking, and *DSM-IV* alcohol use disorder in the United States, 2001-2002 to 2012-2013: results from the national epidemiologic survey on alcohol and related conditions. JAMA Psychiatry. 2017;74(9):911-923. doi:10.1001/jamapsychiatry.2017.2161
4. Denny CH, Acero CS, Terplan M, Kim SY. Trends in alcohol use among pregnant women in the U.S., 2011–2018. *Am J Prev Med*. 2020;59(5):768-769. doi:10.1016/j.amepre.2020.05.017
5. Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. Excessive alcohol use is a risk to women's health. Centers for Disease Control and Prevention. Reviewed October 23, 2020. Accessed August 20, 2021. https://www.cdc.gov/alcohol/fact-sheets/womens-health.htm
6. Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. Alcohol use and your health. Centers for Disease Control and Prevention. Reviewed May 11, 2021. Accessed August 20, 2021. https://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm
7. Nelson DE, Jarman DW, Rehm J, et al. Alcohol-attributable cancer deaths and years of potential life lost in the United States. *Am J of Public Health*. 2013;103(4):641-648. doi:10.2105/AJPH.2012.301199
8. COVID data tracker. Centers for Disease Control and Prevention. Accessed August 20, 2021. https://covid.cdc.gov/covid-data-tracker/#datatracker-home
9. State COVID-19 data and policy actions. Kaiser Family Foundation. August 2, 2021. Accessed August 20, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/state-covid-19-data-and-policy-actions/
10. Rebalancing the 'COVID-19 effect' on alcohol sales. NielsenIQ. May 7, 2020. Accessed August 20, 2021. https://nielseniq.com/global/en/insights/2020/rebalancing-the-covid-19-effect-on-alcohol-sales/
11. National Center for Health Statistics. Anxiety and depression. Centers for Disease Control and Prevention. Reveiwed July 14, 2021. Accessed August 20, 2021. https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm
12. Grossman ER, Benjamin-Neelon SE, Sonnenschein S. Alcohol consumption during the COVID-19 pandemic: a cross-sectional survey of US adults. *Int J Environ Res Public Health*. 2020;17(24):9189. doi:10.3390/ijerph17249189
13. Barbosa C, Cowell AJ, Dowd WN. Alcohol consumption in response to the COVID-19 pandemic in the United States. *J Addict Med*. 2021;15(4):341-344. doi:10.1097/ADM.0000000000000767
14. Neill E, Meyer D, Toh WL, et al. (2020). Alcohol use in Australia during the early days of the COVID-19 pandemic: initial results from the COLLATE project. *Psychiatry Clin Neurosc*. 2020;74(10):542-549. doi:10.1111/pcn.13099
15. Gender and women's mental health. World Health Organization. Accessed August 20, 2021. https://www.who.int/teams/mental-health-and-substance-use/gender-and-women-s-mental-health

More information

For additional information, visit the Medical Assistant FASD Practice Improvement Collaborative website, which includes many trainings and resources to assist with the implementation of alcohol screening and brief intervention: https://fasdmapic.org/

16. Denny CH, Acero CS, Naimi TS, Kim SY. Consumption of alcohol beverages and binge drinking among pregnant women aged 18–44 years—United States, 2015–2017. *MMWR Morb Mortal Wkly Rep*. 2019;68(16):365-368. doi:10.15585/mmwr.mm6816a1
17. Williams JF, Smith VC; Committee on Substance Abuse. Fetal alcohol spectrum disorders. *Pediatrics*. 2015;136(5):e1395-e1406. doi:10.1542/peds.2015-3113
18. Riley EP, Infante MA, Warren KR. Fetal alcohol spectrum disorders: an overview. *Neuropsychol Rev*. 2011;21(2):73-80. doi:10.1007/s11065-011-9166-x
19. Finer LB, Zolna MR. Declines in unintended pregnancy in the United States, 2008–2011. N Engl J Med. 2016;374(9):843-852. doi:10.1056/NEJMsa1506575
20. Babor TF, McRee BG, Kassebaum PA, Grimaldi PL, Ahmed K, Bray J. Screening, brief intervention, and referral to treatment (SBIRT): toward a public health approach to the management of substance abuse. *Subst Abus*. 2007;28(3):7-30. doi:10.1300/J465v28n03_03
21. Johnson M, Jackson R, Guillaume L, Meier P, Goyder E. Barriers and facilitators to implementing screening and brief intervention for alcohol misuse: a systematic review of qualitative evidence. *Journal Public Health*. 2011;33(3):412-421. doi:10.1093/pubmed/fdq095
22. Williams EC, Johnson ML, Lapham GT, et al. Strategies to implement alcohol screening and brief intervention in primary care settings: a structured literature review. *Psychol Addict Behav*. 2011;25(2):206-214. doi:10.1037/a0022102
23. Nilsen P, Aalto M, Bendtsen P, Seppä K. Effectiveness of strategies to implement brief alcohol intervention in primary healthcare: a systematic review. *Scand J Prim Health Care*. 2006;24(1):5-15. doi:10.1080/02813430500475282
24. Curry SJ, Krist AH, Owens DK, et al.; US Preventive Services Task Force. Screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: US Preventive Services Task Force recommendation statement. *JAMA*. 2018;320(18):1899-1909. doi:10.1001/jama.2018.16789
25. Levy SJL, Williams JF; Committee on Substance Use and Prevention. Substance use screening, brief intervention, and referral to treatment. *Pediatrics*. 2016;138:1-3. doi:10.1542/peds.2016-1211
26. Hartje J, Prokosch K, Roget N, Clampit M. *Enhancing the Role of Medical Assistants: A Toolkit to Increase the Capacity of Primary Care Practices to Reduce Risky Alcohol Use and Prevent Alcohol-Exposed Pregnancies*. Mountain Plains Fetal Alcohol Spectrum Disorders Practice and Implementation Center, University of Nevada, Reno; 2019. Accessed August 20, 2021. https://www.fasdmapic.org/wp-content/uploads/2019/10/FINAL-FASD_Enhancing_Toolkit_.pdf
27. National Center on Birth Defects and Developmental Disabilities. *Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use: A Step-by-Step Guide for Primary Care Practices*. Centers for Disease Control and Prevention; 2014. Accessed August 14, 2020. http://www.cdc.gov/ncbddd/fasd/documents/alcoholsbiimplementationguide.pdf

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T F

☐ ☐ 1. Statistics indicate that today—compared with 2002—more female adults in the United States are consuming alcohol at risky levels.

☐ ☐ 2. Alcohol use by pregnant individuals is one of several causes of fetal alcohol spectrum disorders.

☐ ☐ 3. Medical assistants are permitted to score the results of the alcohol screening mechanism and report the findings to the overseeing or delegating provider.

☐ ☐ 4. Even though there are physiological differences between female and male individuals, the amount of alcohol consumption that constitutes binge drinking is the same for both sexes.

☐ ☐ 5. Because alcohol-exposed pregnancies (AEPs) occur more frequently in low-income and ethnic minority groups, universal screening for AEPs is inefficient and unnecessary.

☐ ☐ 6. Individuals should consider genetics, age, and health conditions when determining how much alcohol to consume or whether to drink alcohol at all.

☐ ☐ 7. *Fetal alcohol syndrome* is the umbrella term that describes the full range of conditions resulting from AEPs—from the most to the least serious.

☐ ☐ 8. Individuals who are operating machinery or driving a vehicle and individuals who are pregnant or may be pregnant should not consume any alcohol.

☐ ☐ 9. A person who drinks excessively, by definition, has an alcohol use disorder.

☐ ☐ 10. The number of deaths prevented by low-level consumption of alcohol is about the same as the number of deaths caused by drinking alcohol.

☐ ☐ 11. Policies to reduce COVID-19 cases (e.g., restrictions on dine-in services and the closing of bars), resulted in a marked decrease in alcohol sales in 2021 compared with 2020.

T F

☐ ☐ 12. There is no safe amount, no safe time, and no safe type of alcohol to consume during pregnancy.

☐ ☐ 13. Although women tend to be more transparent in sharing mental health concerns in a primary care visit, they tend to be less likely to disclose a problem with alcohol consumption.

☐ ☐ 14. A thin upper lip and a smooth philtrum are physiologic characteristics manifested by some individuals exposed to alcohol in utero.

☐ ☐ 15. *Low-risk* or *high-risk* drinking is determined by the number of alcoholic drinks per day, not the number of alcoholic drinks per week.

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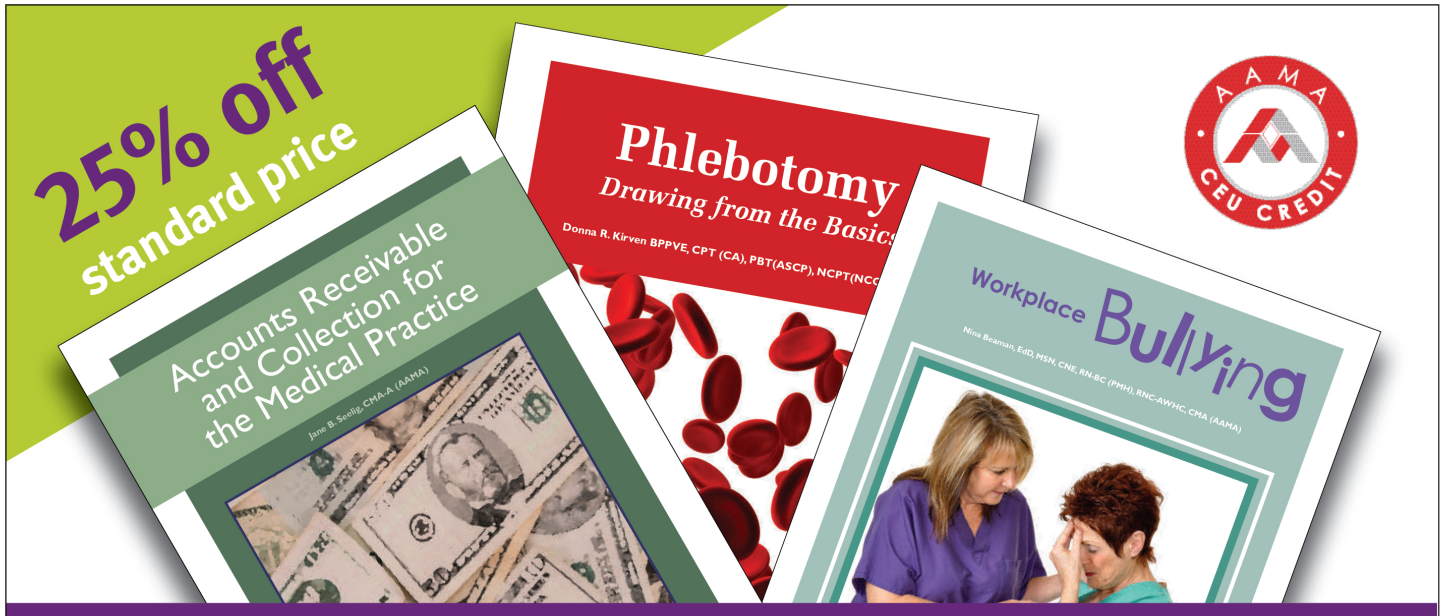

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POW!

Medical Assistants Tackle Daily Tasks with Focus and Compassion

By Cathy Cassata

From the moment patients walk into their physician's practice, medical assistants have patients' best interests in mind while performing a wide array of tasks. Their hard work and dedication help make patients' visits run smoothly and the provider's day run efficiently. Truly, they are the superheroes of the practice! In celebration of Medical Assistants Recognition Week, patients and providers share these personal stories about the medical assistants in their lives to express gratitude for medical assistants' incredible work.

Patients give thanks

I have a close yet professional bond with the medical assistant at my doctor's office. Anytime that I have concerns or need refills or forms filled out for medication or referrals, I am able to get in touch with her without waiting days or weeks for a response. Plus, she never makes me feel like a burden. Back in October, I had a severe case of COVID-19 and was hospitalized for a week. After I returned home and had to visit my doctor for routine laboratory work and a checkup, the medical assistant showed me the utmost compassion and empathy. She always takes time to talk to me and genuinely empathize with me instead of making me feel like just another patient. I have told her numerous times how grateful I am. ... She truly represents all wonderful CMAs (AAMA)® who care about patients.

Rachel Hogan
Asheboro, North Carolina

I had a mole on my back that was painful and worrisome. The medical assistant at my doctor's office got me in right away. ... The medical assistant was compassionate throughout the whole process. At the time, I had been seeing a different family doctor for about 10 years, but after this incident, I switched to this office and have stayed there for seven years. Their medical assistants make it apparent that they care about me as an individual every step of the way. They personalize every interaction and always answer my questions with a caring tone rather than a robotic response. As someone who works behind the counter at a postal office, I understand how challenging it can be to serve the public, and I appreciate how well medical assistants work with patients.

Craig Schwabe
Traverse City, Michigan

The medical assistant at my doctor's office ... makes me feel like I'm the only patient at the time of my visit. She asks questions with sincerity about my day and how I'm feeling. If there's something I need or questions I have, she makes it a point to relay everything to the doctor and to problem-solve until my needs are met. She is my advocate, always making sure everything involved in my care is addressed, even if that means going back to the doctor multiple times.

Tammy Rushbrook
Asheboro, North Carolina

I've been going to my primary care physician's clinic for a long time. The medical assistants there know [that] I experience physician anxiety every time I visit, and they are so kind about it. I get particularly anxious about getting my blood pressure taken because I am treated for high blood pressure. To calm me down, the medical assistants always make it a point to engage in small talk with me, and after we chat for a bit, they give me a few minutes to take deep breaths. ... They also follow up quickly with my requests. During my last visit, after the doctor left the examination room, I told the medical assistant that I forgot to ask for a handicapped parking application. She jumped right on it and brought back the paperwork before checking me out.

Grace Delia
Clinton Township, Michigan

Providers sing praises

Medical assistants have excellent, broad training that can be utilized in multiple areas to support the ambulatory health care team. Working alongside me, my medical assistants apply their clinical training and versatility to ensure efficiency and quality care for patients. Their greatest skill is direct interaction with patients. The medical assistants I work with have a knack for getting to know patients and understanding the best way to interact with them so we can maximize their health care. This skill is incredibly valuable, and I'm thankful for their hard work, dedication, and commitment to serving our patients and our community. There is no doubt that medical assistants are valuable members of the health care team.

Joseph Rawlin, DO
Family practice physician in Traverse City, Michigan

The medical practice is definitely a team sport [environment], and it is unlikely that a medical provider could render health care in a high-quality, efficient, productive, cost-effective fashion without the support of well-trained, motivated medical assistants. ... Their connection with patients enhances the therapeutic relationship, which is crucial to the delivery of effective and personalized health care. ... Their motivation to make a difference in the lives of patients and to help me perform the best job I can is essential. Medical assistants are valued colleagues, and my work would not be nearly as enjoyable or as effective without their partnership.

Howard Eisenson, MD
Family practice physician in Durham, North Carolina

Medical assistants make my job easier—not to mention faster. Their strong communication skills in addition to their clinical knowledge make this possible. For instance, if my medical assistant hears a patient complaining of abdominal pain, by asking the right questions, she is likely to uncover that the patient is also [experiencing] urinary frequency. ... Without her as part of my clinical team, there is no way I could see the same volume of patients I do. Providing health care is a stressful and sometimes thankless job, but I hope all medical assistants know that we appreciate them working beside us.

Greta O'Buch, PA-C
Physician assistant in Asheboro, North Carolina

I have six medical assistants working with me, and each of them is a critical component to making sure patients receive high-quality care. In this day and age, there are so many moving parts to caring for dermatology patients, and doctors can't do it all. Scheduling tests, making sure results are back, and processing prescriptions would be impossible to keep track of without my medical assistants. ... I rely on my well-trained medical assistants to make sure everything falls into place. Every day I work, I'm grateful they are there assisting me because I so highly depend on them to make the day go smoothly.

Brent Schillinger, MD
Dermatologist in Delray Beach, Florida

Medical assistants make the world go round in my opinion. For one thing, they are crucially important to helping patients get their cancer screenings. Our medical assistants help prompt both me and the patient when it's time for a patient's mammogram, colon cancer screening, or Pap smear. They are also 100% responsible for getting our entire community their influenza shots each year. Over the past two years, our medical assistants administered over 22,000 flu shots!

Holly Biola, MD
Family practice physician in Durham, North Carolina

Best in shoe

What type of shoe should you wear when experiencing knee pain? Stable and supportive is the way to go, according to research published in *Annals of Internal Medicine*.

The study's researchers had participants, who had moderate to severe medial knee osteoarthritis, wear either flat, flexible shoes (think flats with no arch support and minimal-to-no cushioning) or stable, supportive shoes (think arch support, thick heel, and a rigid sole).

Participants with the stable, supportive shoes reported less knee and ipsilateral hip pain than those with flat, flexible shoes. Additionally, wearing stable, supportive shoes resulted in fewer adverse events.

The takeaway: if you're dealing with knee pain, don't drag your feet on getting some extra support! ✦

Restroom realities

It's not conversation for the dinner table, but public restrooms are primed for aerosolized droplet transmission of infectious diseases, reports *Physics of Fluids*. Droplets created by flushing toilets persist at heights of up to five feet for more than 20 seconds. Droplet dispersion is reduced—but not eliminated—when a lid is placed over the toilet before flushing.

These findings further support the need for proper ventilation in public restrooms. Meanwhile, individuals may want to keep these results in mind the next time nature calls. The American Association of Retired Persons (AARP) offers several recommendations for reducing risk in public restrooms:

- Wear a mask.
- Spray the air and toilet seat with a disinfectant.
- Limit your time within the stall.
- Exit the stall immediately after flushing.
- Wash your hands and apply hand sanitizer.
- Avoid hot-air hand dryers. ✦

No hard feelings

Don't go to bed angry—or with an unresolved argument. The University of Oregon has a body of evidence on their side: researchers conducted surveys about the feelings and experiences of more than 2,000 people for eight straight days. They found resolving an argument either significantly reduced or totally eliminated the stress response associated with an argument.

Chronic stress can impact health, causing mental health issues, heart disease, a weakened immune system, and more. But even daily stressors can affect mortality by influencing inflammation and cognitive function.

Handling an argument well is a key step toward conflict resolution. The University of Texas at Austin offers some tips for managing conflict:

- Stay calm and avoid overreacting.
- Take breaks (e.g., walking or journaling) if you need them.
- Avoid accusations and generalizations.
- Know your own goals.
- Communicate clearly.
- Invite other points of view.
- Identify solutions and be willing to compromise.

The friendly fungus

Mushrooms on pizza may be up for debate, but consuming more mushrooms could help reduce cancer risk, according to a study from *Current Developments in Nutrition*.

Researchers looked at 17 published studies spanning over 50 years and found that increasing mushroom consumption by 10 grams a day was linked to a 17% reduction in cancer risk. Breast cancer was most strongly associated with the reduction in cancer risk.

One potential explanation for the inverse relationship between mushroom intake and cancer risk is their abundance of ergothioneine, an antioxidant that could ward off oxidative stress, reports Penn State. Further, mushrooms are rich in nutrients and vitamins.

Explore the wonderful world of mushrooms by adding any safe variety to salads, soups, pizza, and more!

Not-so-sweet news

No surprises here—more bad news regarding sugar consumption and its negative health effects has surfaced. Sugar-sweetened beverages (SSBs) are inversely correlated with bone mass density, according to meta-analysis findings published in *Nutritional Journal*. Significantly, those who consume excessive SSBs are more likely to have bone fractures.

A primary contributing factor for this relationship is that sugar can spur urinary calcium loss, and calcium is commonly seen as vital for bone metabolism and health.

It's easier said than done, but ditching the sugary drinks is a step in the right direction for your future bone health. Need some alternatives? Nutrition Action recommends sipping these refreshing—and health-conscious—drinks:

- Naturally flavored seltzer
- Unsweetened iced tea
- Soda sweetened with stevia
- Sparkling water with fruit juice
- Cold brew coffee ✦

Food label follies

Think you know what "Use By" and "Best If Used By" mean on your food labels? The average consumer does not, according to research in *Journal of Nutrition Education and Behavior*.

This voluntary two-date labeling system was started by Food Marketplace Inc. and Consumer Brands Association in 2017. The "Use By" label is tied to food safety risk, signaling that items such as deli meats, prepared foods, and soft cheeses can become unsafe over time. *Listeria*, the most worrisome foodborne pathogen, can propagate in these foods without discernible differences in look, taste, or smell.

Most foods use the "Best If Used By" label, which instead focuses on food quality and notes that foods past that date may start to decline in look, taste, and smell. Barring contamination or storage issues, they will typically degrade in quality before they would become unsafe to eat.

Reexamine your foods labels to make sure you're making accurate assessments of your foods at home!

Give It a Shot

The VFC program enables higher vaccination rates in children

By Brian Justice

The number of children vaccinated in the United States annually is both impressive in its scope and meaningful when considering the amount of disease such efforts prevent.

The percentages of children who receive various vaccinations by the age of 24 months are noteworthy[1]:

- 81% for diphtheria, tetanus, and pertussis
- 93% for polio
- 91% for measles, mumps, and rubella
- 80% for *Haemophilus influenzae* type b
- 90% for varicella (i.e., chicken pox)
- 81% for pneumococcal conjugate vaccine
- 91% for hepatitis B
- 68% for the combined seven-vaccine series

A significant public achievement that helps make these impressive statistics possible is the Vaccines for Children (VFC) program, which provides free vaccines to children whose families or caretakers cannot afford them.

Mitigating strains

The VFC program benefits children, their families, and society as a whole by providing cost-effective health care interventions that have helped reduce morbidity and mortality. The program has also helped increase the use of common vaccinations and reduce disparities in vaccinations among racial, ethnic, and socioeconomic groups.[2]

Tiffany Heath, LPN, CMA (AAMA), CS, a medical assistant educator at the National Institute for Medical Assistant Advancement, has significant experience with the program. Her participation is hands-on, including picking up vaccines and delivering them to providers' practices, administering vaccines, and tracking and reporting vaccinations to the local department of public health.

"There are many that benefit from this program," she says. "The financial burdens are eliminated, and the general public benefits because, as the children are vaccinated, the amount of active disease—and its potential to infect others—is reduced."

Bethany Hodges, MD, a pediatrician and assistant professor of pediatrics at the University of Chicago Medicine, frequently works with traditionally underserved communities.

"As a pediatrician, I always tell people there are three major public health initiatives that probably save more lives than any others: clean drinking water, antibiotics, and vaccines," she says. "I have a lot of patients who would not be able to get the vaccines

Dose to-dos

Any health care provider that is authorized to prescribe vaccines can be a Vaccines for Children (VFC) provider. Providers can begin the process by contacting the state, local, or territory VFC coordinator to request enrollment in the VFC program.[3]

that are recommended without the VFC program. And that's been true everywhere I've practiced, not just here in Chicago. The program makes these routine vaccinations—critical elements in pediatric care—available to every family."

Spread the news

Eligibility is fairly straightforward. Any child younger than 19 years old qualifies for the VFC program if they are Medicaid eligible, uninsured, or Native American or Alaskan.[3] Those who are underinsured (i.e., their insurance does not cover certain vaccines, does not cover any vaccines, or has a fixed financial cap for vaccines) can receive help too.[3]

More than 44,000 physicians at nearly 40,000 sites are enrolled in the VFC program, and every state's VFC coordinator can provide contact information for people to reach physicians enrolled in the program.[3]

Vaccinations are also provided at public health clinics, Federally Qualified Health Centers (i.e., health centers that provide care to medically underserved populations), and rural health clinics (i.e., clinics located in medically underserved areas as designated by states' governors).

Generally, a proactive staff is key to fully implementing the program in the communities that a practice serves.

"Practice managers can drive participation and compliance with the program," says Heath. "They can incorporate information into regular staff meetings and allow everyone to share experiences and identify potential problems. Attending training themselves to stay in the know about any changes at the state or federal levels will help [practice managers] communicate that information to those who interact with patients and ensure full compliance with program requirements."

Ultimately, the program is effective only if the community knows about—and makes use of—it. Heath provides fact sheets to parents and guardians and makes effective use of technology to help users access the program at any time.

"Communication with the family or guardian about what to expect and the importance of sticking to the vaccination schedule is a requirement," she says. "I give them a handout or a code that they can scan to their smartphone. I have seen a reduction in phone calls and side effect reporting, because there is something to check against to see if a child is experiencing a typical side effect or something expected."

Running the program effectively also requires time to attend to all details and requirements associated with state and federal programs, notes Angie Haley, a medical assistant who works with UK HealthCare Internal Medicine in Lexington, Kentucky.

"The best thing my practice manager did to help with the success of the VFC program in our area was allowing me time during the week between patients to work on placing orders," she says. "I would be happy to come in early or on weekends to do my count and make sure that we have the vaccines needed on hand, but making those activities part of my regular workday is extremely helpful."

A viral program

The VFC program is also useful for educating people about children's other health care concerns, suggests Dr. Hodges.

For instance, Dr. Hodges recommends making caregivers aware of the full range of pediatric care available to children. "We may have families worried that they're going to get a bill that they can't pay," she says, "but we work with them so that they are confident that there are measures in place to give them the care that they need. Being able to say that there are no costs for the vaccines makes it easy to let them know what their options are for their child's pediatric care in general, so they don't have to worry."

The prevention of communicable childhood diseases has been among the most beneficial health care initiatives worldwide. In the United States alone, childhood vaccinations are estimated to prevent more than 322 million incidents of illness and over 730,000 deaths in the lifetimes of children born between 1994—one year after the VFC program was launched—and 2013.[2]

But, for the VFC program to help those who need it, medical professionals must have awareness and training in how to use the program. By equipping staff with knowledge about the VFC program, practice managers can help ensure the VFC program's success and improve the lives of children and the community as a whole. ✦

Boosted immunity

In 1991, the United States faced low immunization coverage, and a measles resurgence two years prior resulted in 55,000 cases, more than 11,000 hospitalizations, and 123 deaths—most among children who had not been immunized.[4]

As a result of that epidemic, the Vaccines for Children (VFC) program was created on August 10, 1993, and became operational on October 1, 1994.[3] This program is instrumental in preventing an array of diseases.[5]

"We have to continue to educate people about the strength and complexity of the immunization system," says Larry Pickering, MD, FAAP, who was on the American Academy of Pediatrics Committee on Infectious Diseases when the VFC launched. "We must be persistent."[4]

References

1. National Center for Health Statistics. Immunization. Centers for Disease Control and Prevention. Reviewed March 29, 2021. Accessed August 14, 2021. https://www.cdc.gov/nchs/fastats/immunize.htm
2. Walsh B, Doherty E, O'Neill C. Since the start of the Vaccines for Children program, uptake has increased, and most disparities have decreased. *Health Aff*. 2016;35(2). https://doi.org/10.1377/hlthaff.2015.1019
3. National Center for Immunization and Respiratory Diseases. About VFC. Centers for Disease Control and Prevention. Reviewed February 18, 2016. Accessed August 14, 2021. https://www.cdc.gov/vaccines/programs/vfc/about/index.html
4. Korioth T. AAP reflects on VFC anniversary marketing the right for all kids to receive vaccines. AAP News & Journals Gateway. July 1, 2019. Accessed August 14, 2021. https://www.aappublications.org/news/2019/07/01/vfc070119
5. Cole M. The Vaccines for Children program (VFC). National Center for Health Research. Accessed August 14, 2021. https://www.center4research.org/vaccines-children-program-vfc/

Morale Support

Medical assisting educators boost pandemic morale

By Sheri Reda

Medical assisting programs—which involve interpersonal skills *and* clinical and administrative expertise—can be stressful in the best of times. The COVID-19 pandemic produces a lot of additional strain because of the uncertainty it causes, observes Nikki Marhefka, EdM, MT(ASCP), CMA (AAMA), a medical assisting program director at Central Penn College in Summerdale, Pennsylvania.

In a 2021 survey, 87% of faculty reported that the mental health of their students worsened over the previous year.[1] Educators are also affected—about 30% report having two or more symptoms of depression, and 20% indicate that providing support to students has affected their own mental health.[2]

As a result, keeping up morale is essential for both faculty and students—not only to meet course expectations but also to help both groups thrive in the current climate and excel in their careers.

High morale in short order

People with high morale tend to create a positive influence on others.[3] Notably, high morale among educators can improve the quality of their work,[3] meaning that focusing on educator morale ultimately benefits students as well. Conversely, low morale can increase conflict and incivility, prevent the exchange of ideas, and dampen interest.[3]

Educator morale is influenced by various factors[3]:

- Workload
- Supportive resources
- Relationships with colleagues
- Perceptions of their leaders' abilities and actions
- Shared purpose, respect, and loyalty among peers
- Sense of personal value and pride
- Enthusiasm toward daily activities
- Ability to overcome challenges

To improve classroom attitudes, educators have developed strategies to boost their own morale and that of their students. Even as the pandemic drags on and stress levels rise, educators are finding ways to reinforce their effectiveness as educators and promote resiliency in students so that they can continue to pursue excellence.

Now you're talking

In response to COVID-19, many institutions turned to distance learning, making the assessment and maintenance of morale more challenging—but not impossible. Communication is an essential element of this process, especially because educators sometimes serve as a student resource for mental health. About 80% of educators report conversations with students regarding mental health and wellness.[2]

Clearly defined availability[4] and accessible resources are key. Central Penn College promotes professional counseling by highlighting resources on their website, reports Marhefka.

Elisa Correia-Dasalla, CMA (AAMA), an educator at Castro Valley Adult & Career Education in California, begins each session with a check-in, a practice in which students and educators alike take a moment to be present and to express the hopes, fears, and victories they are bringing into the classroom. Recognition of achievements plays a significant role in morale, so educators should not only celebrate students' accomplishments in sessions such as these but also have systems in place to recognize

their own successes and those of their peers.[3]

This time for recognition and discussion within the classroom also prompts class participants to bond. "Managing your emotions is a huge part of being able to work as a team," explains Correia-Dasalla. So, she gives them practice and space to talk openly. "We get a lot of feedback through evaluations, and a lot of our students tell us they feel safe in the classroom. We're positive, optimistic, and enthusiastic. That translates to the students …: 'They care. I have support.' "

Marianne Van Deursen, EdD, the medical assisting program director at Warren County Community College in New Jersey, agrees that communication is paramount and made herself available 24/7 to other faculty. "Once the pandemic hit," she says, "I took any phone call at any time because I felt as though faculty needed that connection."

Dr. Van Deursen asserts that the increased availability brought extra rewards. "Knowing that the people I worked with had peace of mind gave *me* peace of mind," she says. Nevertheless, educators should be mindful of setting a schedule that preserves their own mental health while still clearly outlining when other faculty and students can reach them.[4]

Likewise, students can also be encouraged to use one another for support. Correia-Dasalla encourages her students to stay in touch with her and one another. The resulting community can be strong enough to continue past graduation; Correia-Dasallla takes calls from graduates under pressure. "Most of the time, they just need somebody to listen—someone who understands what they are going through," she says. In turn, being a person who can help others eases stress for Correia-Dasalla.

DIY project

Though medical assisting educators do get fulfillment from their students and vice versa, morale also stems from self-care[4]:

- Setting realistic expectations
- Reducing workloads for students and educators
- Being self-aware and identifying strategies for staying calm and focused
- Practicing optimism by showing gratitude, demonstrating compassion, and finding opportunities in challenges
- Taking physical and mental breaks

For Correia-Dasalla, self-care comes from classic practices such as meditation, yoga, and simple activities like walking her dog. Educators can pass along techniques they find successful to their students, centering the discussion around healthy behaviors and the connection between academic performance and mental health.[2] Moreover, Correia-Dasalla takes the time to frame self-care activities to her students not as a treat, which is easily foregone by her selfless students, but as a form of protection for their health.

Dr. Van Deursen sees the pandemic as an opportunity to reestablish healthy habits. "I always [see] the light at the end of the tunnel," she says. So, she makes sure she eats well, sleeps more, and takes care of herself to reinforce her well-being. She encourages her faculty and students to do the same, and she finds them open to making changes.

Hooked on a feeling

Marhefka notes that another way to boost morale is to be active in the world. Though engagement is complicated with distancing mandates in place, Marhefka and the student club she supervises improved *their* morale by using club funds to create self-care baskets with toiletries and other items, which they passed along to the counseling department for distribution. The club also bought movies and snacks for shelters in town. Acts such as these improve morale while also following health guidelines.

For educators, mentoring and teaching students can similarly provide satisfaction.[3] Helping is, after all, what medical assistants do. Giving care and receiving care are inextricably linked to one another, and both play a vital role in morale. Medical assisting educators have found that protecting their own health and supporting students help educators themselves remain positive, focused, and effective. In turn, giving students self-care strategies and ways to help others empowers them and reinforces their own mental health. ✦

Tackle burnout before it begins

To maintain and improve morale, employ these tips for combatting burnout in students—as well as employees, coworkers, and yourself[5]:

1. **Share the remote (and in-person) control.** Allow students to meet in small groups with flexible time frames or offer flexible deadlines for small projects.
2. **Connect the dots.** Help students find meaning in their work by making connections between the tasks they are learning and the results they will achieve.
3. **Make it personal.** Check in with students about their academic progress *and* their individual goals.
4. **Keep the lines open.** Create mechanisms for ongoing feedback that offer opportunities to improve. Encourage students to come to you—not so that you solve their problems but to be a sounding board and mentor.

Resources

1. Carapezza K. Survey: nearly 9 in 10 professors say student mental health has worsened during pandemic. GBH. April 13, 2021. Accessed August 14, 2021. https://www.wgbh.org/news/education/2021/04/13/survey-nearly-9-in-10-professors-say-student-mental-health-has-worsened-during-pandemic
2. Flaherty C. Faculty: 'gatekeepers' of student mental health? Inside Higher Ed. April 8, 2021. Accessed August 14, 2021. https://www.insidehighered.com/news/2021/04/08/faculty-gatekeepers-student-mental-health
3. Herbert EP. Faculty morale: a perspective for academic leaders. *Kinesiology Rev*. 2019;8(2):305-311. https://doi.org/10.1123/kr.2019-0040
4. Pate C. Self-care strategies for educators during the coronavirus crisis: supporting personal social and emotional well-being. WestEd. May 2020. Accessed August 14, 2021. https://files.eric.ed.gov/fulltext/ED605940.pdf
5. Emily Paulsen. Nine ways to fight burnout in overworked medical staff. Wolters Kluwer. February 7, 2020. Accessed August 14, 2021. https://www.wolterskluwer.com/en/expert-insights/9-ways-to-fight-burnout-in-overworked-medical-staff

Back to school

Medical assistant achieves her dream of working in education

By Cathy Cassata

When Heidi McLean, CMA (AAMA), graduated with an associate degree and medical assisting certificate from Anne Arundel Community College in Arnold, Maryland, she was the second person in her family to pursue higher education.

"My parents and generations of my family lineage graduated from secondary school only to begin working in the family businesses, join the military, or become professional farmers," says McLean. "I appreciate their paths but also the opportunities that higher education brings."

After graduating in 2000, she worked full time as a CMA (AAMA)® and was quickly promoted to area supervisor. During this time, she floated between primary care, dermatology, endocrinology, neurology, and cardiology—training all the newly hired medical assistants. Additionally, she worked from 6 p.m. to midnight every Friday at an urgent care facility. When the opportunity to teach students at her alma mater came up, she jumped at it.

"The coordinator at the school was looking for laboratory assistance, so two nights a week after work, I worked in the laboratory helping new students with their clinical skills," states McLean. "It was so much fun."

Her love of education thrived on a personal level during this time as well. On the weekends, she attended the University of Baltimore in Maryland.

"I got my [Associate of Arts] degree in general studies on purpose so I could transfer, and I liked University of Baltimore because they have a health systems management program," she explains.

When McLean graduated in December 2002, the medical assisting coordinator she assisted in the Anne Arundel Community College laboratory retired and encouraged McLean to apply for her position. McLean was hired in January 2003 and worked in that role for three years. While in the position, McLean got married, had children, and began graduate school. However, she had to pause her studies when her family moved to Pennsylvania due to her husband's work transfer.

In Pennsylvania, she followed her love of teaching and took a job at a technical training school. During summer breaks, she worked on an as-needed basis as a medical assistant.

"For the next 15 years, I kept trying to get back into the community college setting," explains McLean. "But we moved every 3 to 5 years for my husband's career, and every time we moved, I'd work as a CMA (AAMA) in different roles, including as a practice manager and assistant practice administrator."

In March 2020, after teaching at Fortis College in Smyrna, Georgia, she landed her dream job as the medical assisting program director for Cleveland State Community College in Tennessee—about a 90-minute commute from her Georgia home.

"It's worth the drive," asserts McLean. "I enjoy being in the community college environment, providing education and encouragement to students, many who are like I once was—first-generation college students."

Her varied medical assisting background brings a unique perspective to her students.

"I love that I floated around," says McLean. "I think my students benefit from it because some want to work in specialties and I can often share my experience with them."

Her greatest passion as an educator is helping the profession grow and gain recognition.

"It's important to show that medical assistants are educated and trained properly. I can do my part to make sure my students prove this when they leave [college] and begin working in the field," she says. "Part of preparing them is the experience they get in school, but it's also about encouraging students to continue on with certification and to take pride in what their CMA (AAMA) credential represents." ✦

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