Jul/Aug 2022

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CMA™ Today

Racism in Health Care

Address This Public Health Threat with Awareness and Strategy

You Can Do It!

Summer is here, and everyone is thinking about vacations, children out of school, pool days, and hot summer nights. Summer also means it is time to decide which AAMA committee you would like to volunteer to serve on for the upcoming AAMA year. The deadline is right around the corner to turn in AAMA Volunteer Leadership Applications: **August 1**.

I know some of you may feel you do not have the knowledge to serve on a national committee, feel intimidated, or feel it will take a lot of your time to serve on a national committee. Before ever serving on the AAMA Board of Trustees, I felt the same way. I thought there was no way I would be able to contribute anything to a national committee. Yes, I served the South Carolina Society of Medical Assistants by participating as an officer and chairing several committees, but to serve on a national committee was a totally different level in my mind.

I was encouraged to fill out the application and was chosen to serve on the Leadership Development and Mentoring Strategy Team (the name has since been changed). I was a little intimidated at first, but I got through it. I ended up enjoying that team, so I decided to serve on the strategy team again the next year.

Betty Springer, CMA-C (AAMA), was the leader of this team at that time and became a new mentor for me. Under her direction, I found the courage to speak with confidence. I have since served on several AAMA committees and have worked with wonderful people, most of whom I have become friends with. This is the best part of serving on a committee: getting to know other members and forming friendships that last longer than serving on the committee. You are also serving your organization and showing your employer you care about your profession.

Most committee work is done by email or Zoom meetings. Travel is not required. Serving on a national committee is very rewarding. You will be contributing to new ideas that will make the AAMA a better organization, and that experience also looks good on a résumé.

You can find *Volunteer Leadership Position Descriptions* on the AAMA website on the "Members-Only Downloads" webpage after you sign in to your account. This document gives descriptions of AAMA committees, strategy teams, and task forces and will help guide you to the group you feel would best suit you.

Please consider applying to one of the national committees; we would love to have you join us in serving the AAMA and the profession. If you have any questions about a certain committee, strategy team, or task force, please contact the chair of that group. They will be more than happy to help.

Patty Licurs, CMA(AAMA), CPC

Patty Licurs, CMA (AAMA), CPC
2021–2022 AAMA President

AAMA® Mission

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

CMA (AAMA)® Certification

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

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AAMA CEU CREDIT

Address This Public Health Threat with Awareness and Strategy

By Mark Harris

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Candidates for the AAMA Board of Trustees

Vice President

Monica Case, CMA (AAMA)

My vision: enhanced promoting of the profession, organization, and value of the CMA (AAMA)®. The AAMA is recognized as a valued partner in health care, will provide opportunities for medical assistants, and improve respect and wages. Increasing membership is vital. I am committed to lead, formulate strategic decisions, and work for the members.

Vital Stats

Member: 1987; Certified: 1989

National Volunteer Teams

Chaired: Ad Hoc to Revise BOT Policies and Procedures; Awards; Leadership Development; Marketing; Partnership; Strategic Issues Planning

Served: Trustee; Speaker of the House; Vice Speaker of the House; Ad Hoc on Higher Education; Advisory; Annual Conference; Assessment-Based Certificate; Board of Trustees Observer to Occupational Analysis Workshop; Bylaws and Resolutions; Career Professional Development; Constituent Societies; Documents; Endowment; HOD Minutes; Maxine Williams Scholarship; Membership Development; Nominating; Research and Development

Secretary-Treasurer

Virginia Thomas, CMA (AAMA)

I plan to offer advice to leaders regarding the decrease in membership. I plan to encourage potential leaders to invest in taking an active leadership role. I plan to enhance the transition to leadership positions for future leadership candidates.

Vital Stats

Member: 2001; Certified: 2002

National Volunteer Teams

Chaired: Bylaws and Resolutions; Leadership Development; Membership Development; Social Media; Strategic Issues Planning

Served: Trustee; Awards; Annual Conference; Conference CE Sessions; Documents; Endowment; HOD Minutes; Marketing; Maxine Williams Scholarship; Nominating; Partnership

Vice Speaker of the House

Sherry Bogar, CN-BC, CMA (AAMA)

Through change and transformation, I believe that the CMA (AAMA) credential and the AAMA can emerge as leaders in health care. With our continued dedication to higher education standards and providing safe, quality patient care, we can change the profession and perception of medical assistants and show why we are partners in health care.

Vital Stats

Member: 2004; Certified: 2004

National Volunteer Teams

Chaired: Ad Hoc on Higher Education; Marketing; Social Media

Served: Trustee; Annual Conference; Awards; Bylaws and Resolutions; Career Professional Development; Conference CE Sessions; Endowment; Leadership Development; Membership Development; Nominating; Partnership

AAMA Award of Distinction: Medical Assistant of the Year (2018)

Trustee

Shelley Gingrich, CMA (AAMA)

Medical assisting is an ever-changing field. During my first term as Trustee, the board worked on changes to keep the AAMA current and at the forefront of the medical assisting profession. I want to continue to serve the AAMA as we move forward to maintain our gold-standard status.

Vital Stats

Member: 2003; Certified: 2004

National Volunteer Teams

Chaired: Editorial Advisory

Served: Trustee; Awards; Annual Conference; Bylaws and Resolutions; Documents; Leadership Development; Nominating; Social Media; Strategic Issues Planning; Test Construction

Claire Houghton, CMA (AAMA)

Growth: As the AAMA continues to grow and increase its membership, we continue to look to the future but won't forget our history or the growth and need for CMAs (AAMA) in allied health positions. I would like to help this organization to grow and flourish. Thank you for your support.

Vital Stats

Member: 2002; Certified: 2003

National Volunteer Teams

Chaired: Editorial Advisory

Served: Trustee; Ad Hoc on Higher Education; Bylaws and Resolutions; Endowment; HOD Minutes; Leadership Development; Marketing; Maxine Williams Scholarship; Membership Development; Strategic Issues Planning; Test Construction

Pamela Neu, MBA, CMA (AAMA)

My experiences in the Indiana Society of Medical Assistants and the AAMA have been instrumental to my professional development. The strengths of our organization are the education, leadership, and current forms of communication for the AAMA. My goal for the AAMA is to enhance these strengths for all medical assistants.

Vital Stats

Member: 1976; Certified: 1975

National Volunteer Team

Served: Test Construction

BOT Qualifications

Thinking of running for the AAMA Board of Trustees? Check the *AAMA Bylaws* on our website (within the "Members-Only Downloads" section) to make sure you meet the requirements for nominations. Nominees have already been announced, but candidates may put forth nominations from the floor at the AAMA Annual Conference. ✦

You Can Make a Difference!

Reminder: AAMA Volunteer Leadership Applications are due by **August 1**. ✦

On the Web

Follow the AAMA on TikTok

Username @TheAAMAOfficial

The AAMA is on TikTok! Follow us at @TheAAMAOfficial for fun and informative videos about pertinent medical assisting–related topics. And go a step further—duet with us in your own TikTok videos!

Make a Difference for Medical Assistants:

Join the CEB!

The Continuing Education Board (CEB) is looking for experienced volunteers to continue its mission of developing and administering quality continuing education opportunities for medical assistants.

Overview: Responsibilities will include remotely assisting with CEB projects as needed throughout the year, as well as travel to three annual meetings in late winter or early spring, summer, and fall.*

Experience (preferred): The ideal candidate is a CMA (AAMA) who has worked in the medical assisting field for the past three years and has experience as both a state or chapter officer and a program planner.

For more information, download the AAMA Volunteer Leadership Application via the "Guidelines and Forms" webpage of the AAMA website (under the "Volunteers" tab).

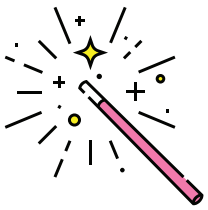
**CEB members are reimbursed for travel to their annual meetings and are provided free lodging at the host hotels.*

CEUs Benefit All

You don't have to be a CMA (AAMA) to reap the benefits of continuing education!

All AAMA continuing education products enhance the professional skills of any medical assistant and show employers a commitment to keeping up with the changing world of health care. A full transcript means a well-rounded medical assistant! Also, the AAMA offers multiple assessment-based certificates for learners who want to round out their résumés. ✦

MARWeek Magic Is Coming!



Every year, we celebrate Medical Assistants Recognition Week (MARWeek) during the third full week in October:

MARWeek: October 17–21, 2022

MARDay: October 19, 2022

The AAMA provides tools (i.e., promotional MARWeek packets and products) to help you celebrate medical assistants as true partners in health care. Visit the AAMA Store online in August to order.*

**Orders 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.* ✦

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

Key Scope of Practice Legislation Is Enacted in Connecticut and South Carolina

For many decades Connecticut law forbade medical assistants from administering injections. Ambiguity arose during the last five years over whether South Carolina law permitted nurse practitioners and physician assistants to delegate to medical assistants the administration of injections. Thanks to bills passed by the Connecticut and South Carolina legislatures during the latter half of May 2022, medical assistants will soon be able to administer vaccinations in Connecticut and be delegated injections in South Carolina by not only physicians but also advanced practice registered nurses (including nurse practitioners) and physician assistants.

Connecticut

The Connecticut legislation defines *clinical medical assistants* as those who (1) hold a medical assisting credential and (2) have graduated from a medical assisting program. The following is the language from the enacted bill "An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes":

> Sec. 47. (NEW) (*Effective October 1, 2022*) (a) For purposes of this section, "clinical medical assistant" means a person who (1) (A) is certified by the American Association of Medical Assistants, the National Healthcareer Association, the National Center for Competency Testing or the American Medical Technologists, and (B) has graduated from a postsecondary medical assisting program … that is accredited by the Commission on Accreditation of Allied Health Education Programs, the Accrediting Bureau of Health Education Schools or another accrediting organization recognized by the United States Department of Education, or (ii) offered by an institution of higher education accredited by an accrediting organization recognized by the United States Department of Education and that includes a total of seven hundred twenty hours, including one hundred sixty hours of clinical practice skills, including, but not limited to, administering injections, or (2) has completed relevant medical assistant training provided by any branch of the armed forces of the United States.[1]

The Connecticut bill specifies that clinical medical assistants may administer vaccines when they are under the "supervision, control, and responsibility"[1] of a physician, physician assistant, or advanced practice registered nurse (including a nurse practitioner). Clinical medical assistants are allowed to administer vaccines "in any setting other than a hospital setting."[1] In addition to the medical assisting education specified above, clinical medical assistants must have specific training regarding administering a vaccine:

> (b) A clinical medical assistant may administer a vaccine under the supervision, control and responsibility of a physician licensed pursuant to chapter 370 of the general statutes, a physician assistant licensed pursuant to chapter 370 of the general statutes or an advanced practice registered nurse licensed pursuant to chapter 378 of the general statutes to any person in any setting other than a hospital setting. Prior to administering a vaccine, a clinical medical assistant shall complete not less than twenty-four hours of classroom training and not less than eight hours of training in a clinical setting regarding the administration of vaccines.[1]

South Carolina

The newly enacted South Carolina legislation[2] will go into effect July 15, 2022. It defines a *certified medical assistant* as a person who has graduated from an accredited, postsecondary medical assisting education program and who is currently certified.[2] The program must include courses in "anatomy and physiology, medical terminology, pharmacology, medical laboratory techniques, and clinical experience."[2] A certified medical assistant "must maintain current certification from the certifying board of the American Association of Medical Assistants, the National Center for Competency Testing, the National Certification Medical Association, American Medical Technologists, or any other recognized certifying body approved by the Board of Medical Examiners."[2]

The South Carolina bill contains a grace period for medical assistants who are "cur-

rently employed … as of the effective date of this act who do not have the certification required by this SECTION but who achieve such certification no later than two years after the effective date of this act."[2]

Certified medical assistants are differentiated from unlicensed assistive personnel in the South Carolina legislation:

> 'Unlicensed assistive personnel' or 'UAP' are persons not currently licensed by the board as nurses, or persons who are not certified medical assistants as defined in Section 40-33-20( ) [*sic*], who perform routine nursing tasks that do not require a specialized knowledge base or the judgment and skill of a licensed nurse. Nursing tasks performed by a UAP must be performed under the supervision of a physician, physician assistant, an advanced practice registered nurse, registered nurse, or selected licensed practical nurse. Unlicensed assistive personnel must not administer medications except as otherwise provided by law.[2]

The South Carolina legislation authorizes physicians, physician assistants, and advanced practice registered nurses to delegate to certified medical assistants the administration of medication. The following tasks may not be delegated to certified medical assistants:

> (1) administering controlled medications, intravenous medications, contrast agents, or chemotherapy agents;
>
> (2) injecting neurotoxin products, neuro modulatory agents, or tissue fillers;
>
> (3) using lasers or instruments that results in tissue destruction;
>
> (4) placing sutures;
>
> (5) taking radiographs or using any ionizing radiation unless the [certified medical assistant] is also a certified limited practice radiographer;
>
> (6) analyzing, interpreting, or diagnosing symptoms or tests;
>
> (7) triaging patients; and
>
> (8) performing a clinical decision-making task by means of telemedicine.[2]

Physicians, physician assistants, and advanced practice registered nurses "may delegate specified tasks to a [certified medical assistant] pursuant to the following requirements," according to the South Carolina legislation:

> (1) the task must be delegated directly to the [certified medical assistant] by the physician, physician assistant, or advanced practice registered nurse, and not through another licensed practitioner;
>
> (2) the task must be performed when the physician, physician assistant, or advanced practice registered nurse delegating the task is in such close proximity as to be immediately available to the [certified medical assistant] if needed;
>
> (3) the physician, physician assistant, or advanced practice registered nurse delegating the task must determine that the task is within the training and competency of the [certified medical assistant] and will not pose a significant risk to the patient if improperly performed[2]

The Significance of These Laws

The new Connecticut and South Carolina laws are highly significant because they empower medical assistants in these states to perform tasks for which they are educated, credentialed, and competent. Moreover, these statutes establish another state law precedent for differentiating the legal scope of practice for educated and credentialed medical assistants from that of other medical assistants.

I commend the Connecticut Society of Medical Assistants and the South Carolina Society of Medical Assistants for these noteworthy legislative victories. They portend greater recognition of and appreciation for educated and credentialed medical assistants. ✦

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1. An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes, Pub Act 22-58, HR 5500, 2022 Session (Conn 2022). Accessed June 15, 2022. https://www.cga.ct.gov/2022/ACT/PA/PDF/2022PA-00058-R00HB-05500-PA.PDF
2. S 613. 124th Leg, 2021-2022 Session (SC 2022). Accessed June 15, 2022. https://www.scstatehouse.gov/sess124_2021-2022/bills/613.htm

Red Flags

Hemophilia Requires Considerate Care for Affected Patients

By John McCormack

"He would have to be so careful … with sharp objects. If he got even the slightest injury such as a paper cut, he had to immediately go down to the nurse's office. He also always had to have a vial of his medicine on hand just in case he was to have an accidental injury. He would need to inject himself with the medication to help his blood clot."

—Kiersten Templeton, CMA (AAMA)

That is how Templeton remembers what one of her friends had to go through in middle and high school. Listening to him describe his experience with hemophilia helped her gain deeper understanding of the condition. As a result, she is now better prepared to help patients with hemophilia as a medical assistant at University Hospitals in Berea, Ohio.

"Knowing someone personally with hemophilia has changed my mindset," says Templeton. "The advice I have for medical professionals working with [patients with hemophilia] is to always listen to patients."

Such guidance is spot-on, according to Leonard A. Valentino, MD, CEO at the National Hemophilia Foundation (NHF) in New York City.

"Health care professionals and, in particular, medical assistants can work optimally with hemophilia patients by listening to them frequently, as [these patients] have lived experience of their disease and are subject matter experts," says Dr. Valentino. "Oftentimes, patients are discounted and not taken seriously [when they] opine on their disease and its treatment."

Hemophilia patients typically have a good understanding of this life-threatening disease because they are diagnosed at a young age and actively manage their health daily.

Nevertheless, the treatment journey is a difficult one, making it imperative that clinicians work closely with hemophilia patients. As such, all health care professionals need to understand hemophilia causes, symptoms, diagnosis, and treatment.

Hemophilia patients bleed uncontrollably because their blood does not have enough blood-clotting factors. Hemophilia typically causes bleeding for a long time after an injury and, in severe cases, internal bleeding.[1]

Usually a genetic disorder, hemophilia is carried on the X chromosome. Patients are often diagnosed shortly after birth or in early childhood in severe cases, but mild cases may not be diagnosed until adulthood.[1] "Then they'll have a sports injury or dental surgery, and they get diagnosed because they don't stop bleeding," explains Michelle L. Witkop, DNP, FNP-BC, vice president and head of research at NHF. The disease manifests as mild, moderate, or severe, adds Witkop.

Clot Off Guard

Family history plays a key role in diagnosis. Evidence of hemophilia in previous generations combined with excessive bleeding during childhood medical procedures (e.g., heel sticks or circumcisions) often prompts health care professionals to suspect hemophilia.

"Even if [patients] don't get diagnosed right after they are born, then they'll generally get diagnosed when they start walking and have some issues with falling and bruising. Or, they'll experience a joint bleed early in life," says Witkop. A blood test is used to confirm the diagnosis and the severity of the blood factor deficiency.

"In addition, there's about a 30% mutation rate, meaning that there's a spontaneous

mutation in either the mom's gene or the baby's gene," adds Witkop. "So, it can just show up in families that have no history of hemophilia."

As such, clinicians should always look for potential blood disorder symptoms. "A patent might have joint pain because they are frequently bleeding into that joint. Bruising, heavy menstrual bleeding, and nosebleeds are also red flags that could indicate a bleeding disorder," says Witkop.

Blood Work

Hemophilia can be downright dangerous if not managed. About 30% of hemophilia patients will die from a bleeding-related incident.[2] A simple bump on the head can cause bleeding into the brain for some people who have severe hemophilia.[1]

Additionally, when hemophilia goes untreated, patients are more likely to have complications such as deep internal bleeding and joint damage.

Fortunately, hemophilia treatment now focuses on using prophylactic medicines, which are designed to prevent issues from occurring.

"Over the last 30 years, there has been an evolution in the treatment paradigm focusing more on prevention rather than intervention at the time of bleeding. So-called episodic treatment or treatment at the time of a bleeding event has been shown to result in poor health outcomes, especially in terms of long-term joint damage," says Dr. Valentino.

Since treatments need to be administered on a regular basis—typically two to three times per week in the case of factor replacement therapy—adherence to a regimen is vital to ensure optimal outcomes, notes Dr. Valentino.

Band-Aid and Abet

Patients should manage their disease with the help of a comprehensive hemophilia treatment center (HTC). An HTC provides patients with the care and education to address all issues related to the disorder. Teams at these centers usually consist of physicians (hematologists or blood specialists), nurses, social workers, physical therapists, and other health care providers who specialize in bleeding disorders.[3]

When patients work with both an HTC and primary care provider, they can better clear the hurdles associated with managing hemophilia.

For example, professionals can teach parents to administer medicine to a child with hemophilia through ports, devices that include a small, round reservoir covered with a plastic membrane and a catheter. Patients receive treatment through the port rather than enduring multiple needle sticks. As soon as patients are old enough, clinicians can teach them how to self-administer medications.

Heart to Heart

Whether in HTCs, primary care, or other clinical settings, medical assistants can play a crucial part in hemophilia care:

Provide useful information. Medical assistants can help patients by referring them to educational resources such as Steps for Living, a NHF program that provides guidance on how patients can meet challenges at various life stages. Such guidance includes how to communicate with teachers and school nurses.

Refer to summer camps. "CMAs (AAMA)® can let patients know about bleeding disorder camps where kids can interact—sometimes for the first time—with other kids who have a bleeding disorder," says Witkop. "Because they are surrounded by people who are very knowledgeable at these camps, they can learn about their disorder and [how to manage it]."

Discuss movement. "Certainly, physical therapists want hemophilia patients to exercise and keep their muscles strong so that they can support their joints," says Witkop. And yet, caution is still warranted. "People with hemophilia can participate in virtually all sporting and physical activities aside from … collision sports such as American football and boxing," says Dr. Valentino.

Navigate finances. The average annual cost of medication to treat hemophilia is more than $270,000 per patient and can soar to more than $1 million if complications arise.[4] Medical assistants can help patients by referring them to financial assistance programs that are available through associations such as NHF. Additionally, CMAs (AAMA) can work with patients to ensure that their medications are covered by insurance, adds Witkop.

While medical assistants can help patients with hemophilia better manage the disease, all health care professionals should stay up to date on emerging treatments. "Over the next couple of years," Dr. Valentino concludes, "I'm confident that … the next generation of hemophilia gene therapy products will meet the expectations and needs of the patient community." ✦

State of the Art-ery

On average, patients with mild hemophilia are diagnosed at 36 months old, those with moderate hemophilia at 8 months old, and those with serve hemophilia at 1 month old.[5]

An accurate total of people who have hemophilia in the U.S. is unknown. But some data indicates that about 400 babies are born with hemophilia A (also called *classic hemophilia*) each year.[5]

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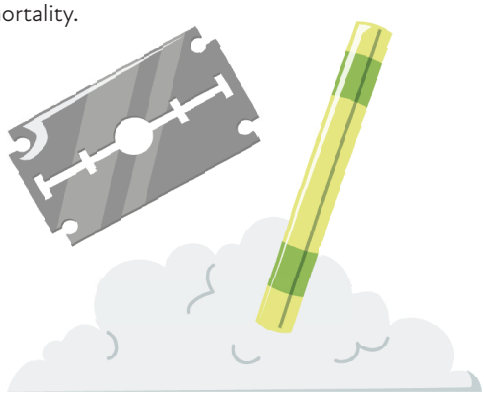
Teen Cocaine Use as a Red Flag

Can a positive urine drug screen (UDS) in teens predict an increased risk of external mortality? Researchers explore this difficult topic in *Focus on Childhood and Adolescent Mental Health*.

The study found that of the 2,772 participants ages 13–18 who took a UDS, 1,126 (41%) were UDS-positive. With an average follow up of 11.8 years, results showed that a positive UDS for any illicit substance was not linked to a significant increase in mortality. While there was some overlap in those who tested positive for tetrahydrocannabinol (THC) and cocaine, those who tested positive for THC but not cocaine did not have a statistically significant increase in mortality. However, a cocaine-positive USD was tied to a significant increase in external mortality.

The researchers suggest that cocaine use should be considered when determining the risk of a lethal overdose and could be seen as a warning sign for a future opioid-related death. ✦



Hearing Awareness and Care Gaps

Did you hear that? It's a new study about people's inability to identify a "normal" range of hearing, courtesy of *Otology & Neurotology*.

The survey tested adults between the ages of 50 and 80 on their knowledge of common health metrics. While the majority of respondents could identify the "normal" ranges for vision, blood pressure, and cholesterol, only 9% understood the "normal" range for hearing.

These results are concerning as many also were unaware of the link between hearing loss and a wide range of conditions such as depression, dementia, and type 2 diabetes. Furthermore, estimates show that roughly 21% of those with measurable hearing loss use hearing aids, leaving millions in the lurch.

Screening and patient education can help fight this untreated sensory epidemic and get people the care they need. ✦

Telemedicine Insights for Pediatric Practices

A recent rapid increase in pediatric telemedicine has taught several vital lessons, according to *Advances in Pediatrics*:

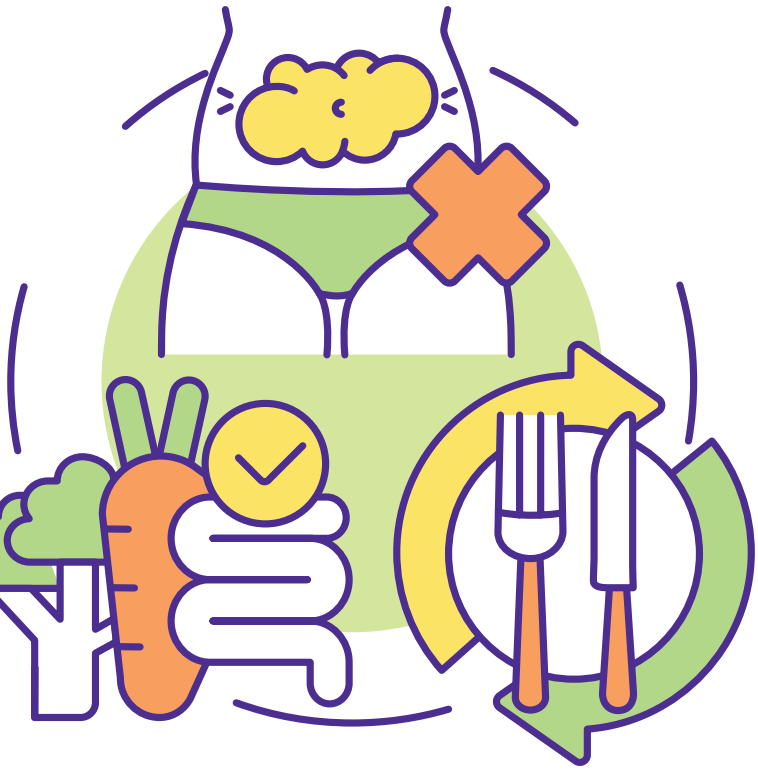
Education and training. Give staff the proper training to take on telemedicine through learning resources such as webinars, learning modules, and tool kits. Distribute tip sheets that address common questions and concerns, and establish a telemedicine "champion" to provide answers and resources.

Clinical workflows. Take a thoughtful approach to the practice workflow and how telemedicine can be integrated effectively into it. To avoid missed follow-up visits, which may occur without the reminder of a physical front desk, build scheduling into the clinical workflow. Maintain a team-based care approach so the usual team members can still be involved in the visit, and try a practice run.

Assessment and treatment. Reduce common pediatric telemedicine assessment issues with some preplanning. Give the child (and caregivers) a sense of what to expect. Advise the caregivers to make sure the child is wearing comfortable clothes, noise and distractions are at a minimum, and objects for displaying fine motor skills are at the ready.

Family-centered care. Use telemedicine as an opportunity to bolster family involvement with the provider in decision-making. Telemedicine can improve the quality of care, reduce costs for children with complex medical needs, increase communication, and minimize parental anxiety during palliative and post-surgical care.

Though COVID-19 accelerated its use, pediatric telemedicine as a supplementary care modality is here to stay. By continuing to evaluate and fine-tune telemedicine practices, health care professionals can contribute to children getting the best care possible.



Best Practices for Managing IBS

Diet can play an important part in mitigating the symptoms of irritable bowel syndrome (IBS). The American Gastroenterological Association's recent Clinical Practice Update on diet and IBS is the product of expert opinion and literature reviews and offers guidance through a series of best practice advice statements.

The advice highlights soluble fiber and a low-FODMAP diet as two dietary interventions to reduce IBS symptoms. (FODMAP is an acronym for fermentable, oligosaccharides, disaccharides, monosaccharides, and polyols.) Further, they recommend the referral to a registered dietitian nutritionist for patients who are willing and require additional assistance to meet their dietary modification goals. For any dietary intervention, proper implementation requires a predetermined end date. This allows for the opportunity to assess for effects and try something new if necessary.

IBS is a chronic condition that requires lifelong management. By drawing from expert opinions and the latest scientific research, health professionals can better serve those with IBS and further patients' treatment goals. ✦

Extreme Heat Affects Mental Health

With the change in seasons comes the potential for extreme heat. Though the physical tolls of high temperatures are well-documented, new research published in *JAMA Psychiatry* shows that high temperatures can also put a severe strain on people's mental health.

The study found that emergency department visits for mental health issues increased on days with extreme heat, particularly for conditions such as substance use disorders, schizophrenia, and mood disorders.

Researchers note that mental health and emergency department practitioners may want to prepare for increased demand by increasing capacity and proactively touching base with patients who are at high-risk. They added that individuals should also look out for themselves and the people in their lives who may be at risk.


AAMA
CEU CREDIT

Racism in Health Care

Address This Public Health Threat with Awareness and Strategy

By Mark Harris

In many ways, 2020 was a watershed year for public health concerns. In the United States, the impact of the COVID-19 pandemic created unprecedented pressures on health system resources.

The public health crisis also exacts a disproportionate cost on racial and ethnic minority populations. In fact, Hispanic, Black, American Indian, and Alaska Native people have been approximately twice as likely to die from COVID-19 as White Americans and one and a half times more likely to be infected.[1]

Simultaneously, the year 2020 was also witness to a strong public focus on racism, as the murder of George Floyd and other highly publicized incidents of police violence against Black people led to historic antiracism protests in cities across the nation. These events have led to "heightened awareness of racism as a public health crisis," according to an *American Family Physician* editorial.[2]

A Social Determinant of Health

With a renewed interest in racism's impact on health and society, many leading health care organizations are developing programs and initiatives to promote racial justice and health equity.

A starting point for antiracist education and activity in health care is the understanding that racism is a significant social determinant of health. In other words, structural or systemic racism is a contributing factor in poorer health outcomes for many medical conditions, including cardiovascular disease, diabetes, hypertension, infant mortality, obesity, and psychological conditions such as depression and anxiety.[3]

The issue of racial health disparities is also shaped by both current and historic

concerns. For example, a 2003 Institute of Medicine report found that African Americans have higher mortality rates from heart disease, cancer, cerebrovascular disease, and HIV than any other racial or ethnic group.[4] Hispanic Americans are nearly twice as likely as non-Hispanic White people to die from diabetes.[4] Health disparities were also found to disproportionately impact Native American and Asian American populations.[4]

Significantly, the Institute of Medicine also found racial and ethnic minorities experience a lower quality of health services and are less likely to receive routine medical procedures.

"The Institute of Medicine report from 2003 showed the quality of health care received is different for people of different races and ethnicities," remarks Bram P. Wispelwey, MD, MPH, an associate physician in the division of global health equity at Brigham and Women's Hospital in Boston. "That was a landmark assertion based on really extensive evidence at the time of … institutional racism. But what is striking is that they did a follow-up ten years later documenting that not much had changed. And now when we look at a lot of the studies currently being published, we still see that not much has changed."

Undoubtedly, the roots of enduring racial and ethnic health disparities need to be understood in a larger historical and societal context, as acknowledged by a 2021 statement by the Centers for Disease Control and Prevention (CDC):

> A growing body of research shows that centuries of racism in this country [have] had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships, and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. These conditions—often referred to as *social determinants of health* [italics added]—are key drivers of health inequities within communities of color, placing those within these populations at greater risk for poor outcomes.
>
> The data show that racial and ethnic minority groups, throughout the United States, experience higher rates of illness and death … when compared to their White counterparts. Additionally, the life expectancy of non-Hispanic/Black Americans is four years lower than that of White Americans. The COVID-19 pandemic, and its disproportionate impact among racial and ethnic minority populations is another stark example of these enduring health disparities.[5]

With this perspective in mind, the CDC and other leading health care organizations have declared systemic racism an urgent public health threat, calling for expanded efforts by health care leaders to promote racial and health equity in medicine and society. Toward this end, the American Medical Association (AMA) adopted a new strategic plan in 2021 to advance a broad, antiracist health care initiative. The *Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021–2023* represents a far-reaching initiative by the AMA to promote equity-centered practices in every aspect of patient care, medical education, and health system operations.[6]

Led by the AMA Center for Health Equity, the strategic plan proposes establishing new national health care equity and racial justice standards, benchmarks, and other measures.[6] The plan is further committed to eliminating all forms of discrimination in medical school admissions, medical education and training, and hiring and promotion.[6]

From Silence to New Dialogues

The AMA's strategic plan is part of a national conversation on racism in medicine and society—one that seeks to stimulate education, awareness, and action for meaningful improvements in the health care system's ability to provide equitable care. It attempts to not only effect change but also to deepen understanding of the ways racism undermines health equity.

One physician who is involved in the AMA's antiracist work is Emily Cleveland Manchanda, MD, MPH, director for social justice education and implementation at the AMA Center for Health Equity. She explains that the AMA's antiracism agenda hopes to foster within the medical profession a new, more nuanced level of awareness of racism as a public health issue.

"As an emergency room physician at Boston Medical Center, which is New England's largest safety net hospital, and in my work with the AMA, I have the opportunity to see the impact that racism has on the health of individuals and communities," says Dr. Cleveland Manchanda. "The challenges can differ at the individual, community, and national levels, but there are also some similarities in the challenges. One of those is the historical silence on the topic of racism, certainly within health care but also in society at large. Before 2020, there was not a lot of conversation about the impact of racism on health. We talked about racial disparities, but we didn't talk about race as a proxy for the experience of racism. That's a nuance that's important for people to understand as they start to address racial inequities in health care."

Notably, AMA policy now recognizes that race is a social, not a biological, construct.[7] This means that traditional medical practices that use race as a proxy for biology in medical education, research, and clinical practice should be ended. Additionally, descriptions of risk factors for disease should focus on genetics and biology, the experience of racism, and social determinants of health. Finally, physicians and clinical practitioners should be educated on how racism and forms of systemic oppression can contribute to racial and health disparities.[7]

The AMA strategic plan recommends mandatory antiracism, structural competency, and equity-explicit training and competencies for all trainees and staff.[6] To support its strategic objectives, the AMA developed the *Racial and Health Equity: Concrete STEPS for Health Systems* tool kit.[8]

While the AMA is a physician-led organization, the group recognizes that every member of the health care team, including medical practice managers and staff, has a role to play in facilitating transformative change in support of racial and health equity, notes Dr. Cleveland Manchanda.

"Any time you are looking to embed racial justice within an organization [or]

organizational practices, you really need everyone to come along for the ride," says Dr. Cleveland Manchanda. "You need everybody to be on board, in particular those who are in leadership positions. The *Racial and Health Equity* tool kit is meant to outline practical steps that can be taken by managers, including office managers and people managers, to begin to address racial justice within clinical practices."

As an implementation guide, the tool kit is designed to help medical practices navigate a series of steps toward improvement, explains Dr. Cleveland Manchanda: "The steps include committing as a group—as a health system or a practice—to doing the work, then looking into your organizational norms and figuring out what you don't know. This involves getting a handle on your data [and] understanding where racial inequities are emerging in your setting. Once you have an understanding of where you are, the group can then develop a shared, compelling vision and goals for that health care system or practice. Of course, this is followed by actually doing the work, which is launching your targeted improvements. I'll add that whether the work is being led or championed by [practice] managers or by physician leadership, as long as there is buy-in from all decision-makers, the work can be undertaken by anyone in a practice leadership position."

The AMA Center for Health Equity models its *Racial and Health Equity* tool kit on several successful interventions that led to improvements in care. One is the Accountability for Cancer Care through Undoing Racism and Equity (ACCURE) clinical trial, which sought to improve racial equity at two cancer treatment centers in the United States. The ACCURE trial involved early-stage lung and breast cancer patients. Prior to the intervention, the study found only 80% of Black patients completed treatment compared to 87% of White patients.[9]

Researchers reported multiple reasons for the disparity; one was implicit bias on the part of some clinicians who were less inclined to recommend the same treatment to minority patients. To address these disparities, a real-time warning system was derived from electronic health records, race-specific feedback on completion rates was provided to clinical teams, and staff training sessions on health equity were held.[9]

Notably, specially trained nurse navigators were also assigned to engage with patients during treatment, building

Resources

AMA Center for Health Equity
https://www.ama-assn.org/topics/ama-center-health-equity

The Centers for Disease Control and Prevention
https://www.cdc.gov/healthequity/racism-disparities/index.html

trust and communication. As a result, the trial intervention led to near elimination of inequities in treatment and outcomes.[9]

"Essentially, they were working with Black women who had worse outcomes than White women with breast cancer and got them involved in redesigning the cancer care system," explains Dr. Cleveland Manchanda. "In so doing, they not only eliminated racial inequities in cancer care but also improved the outcomes for all groups—for White women as well as Black women. It's a really nice example of how when you target your interventions to address inequities, the care for everyone gets better."

The Healing ARC

A growing number of antiracist initiatives and activities are currently underway in U.S. health systems. One is a pilot project championed by Dr. Wispelwey and colleagues at Brigham and Women's Hospital to address inequities in care for heart failure patients. The project began after a review of 10 years of hospital records found evidence that Black and Latinx patients with heart failure were less likely to be admitted to the hospital's specialized cardiology unit than White patients. This was a critical concern to address, asserts Dr. Wispelwey, as patients receiving specialized cardiology care services have better recovery rates, including lower readmission rates and mortality, than those in the general medicine service.

Under the pilot program, changes to facilitate more equitable care were made in the hospital's admissions and electronic health record system. "We've designed our medical records system now so that if a Black or Latinx patient with heart failure is selected to be admitted to the general medicine service, the physician will get an [electronic] pop-up stating that this patient is from a racial and ethnic group with historically inequitable access to cardiology and [asking them] to consider admitting them to cardiology," explains Dr. Wispelwey. "We're studying this process now to see how it is working."

The heart failure project is part of a new Brigham program called the Healing ARC, a hospital initiative that seeks to identify and root out racial inequities in their system. The "ARC" of the program is based on three components: acknowledgement, redress, and closure. First, health care providers should

acknowledge the role of racism in contributing to health inequities. Then, they need to redress the harms linked to unequal treatment by creating new pathways to equity. Finally, providers should seek closure by reconciling with the communities that have suffered inequities in care.[10]

Dr. Wispelwey and other antiracist advocates have expressed concerns that "color-blind solutions" in health care have failed to adequately address existing racial health inequities. While diversity and inclusion efforts, implicit bias training, objective checklists for clinical criteria, and other solutions are certainly helpful, he says, more needs to be done to truly embed racial and health equity in medicine. The Healing ARC is thus built on the notion of building a deeper, more robust awareness of race-conscious solutions to health inequities.[11]

"We like to say in medicine when you have a problem, you have to go after the underlying cause of the problem," remarks Dr. Wispelwey. "The key problem in a heart attack, for example, is an obstructed artery. So, you've got to break up that clot in the artery. You go right after it. Now, if we're documenting examples of institutional racism, our view is we have to address the racism directly, and that requires being race conscious as opposed to being race blind."

In this spirit, the Brigham initiative also emphasizes the critical importance of including input from the local community. "The idea of the Healing ARC is to try to say, How do we actually develop that institutional accountability?" explains Dr. Wispelwey. "How do we develop a mechanism to address and redress these racial inequities that we find in health care? This isn't just a theoretical problem. We know we've been treating our heart failure patients differently. This is an example of documented institutional racism. Since we want to do right by our patients, we also created a wisdom council of Black and Latinx community members to discuss what each of these components should look like—acknowledgement, redress, and closure. I believe it's very important that we bring in the voices of impacted communities."

Equal to the Task

The Ohio State University Wexner Medical Center and College of Medicine in Columbus have taken the lead in supporting antiracist initiatives. "As an institution, we denounce

racism in all forms," says Demicha Rankin, MD, associate dean for admissions for the College of Medicine. "We believe that racism, specifically … discriminating against a person because of their race or ethnicity, is a social determinant of health that is damaging to our community. We believe it damages our patients in how they're treated, our faculty in terms of promotion or opportunities, and our faculty and trainees in terms of encountering bias. It impacts all levels in its damage to our community."

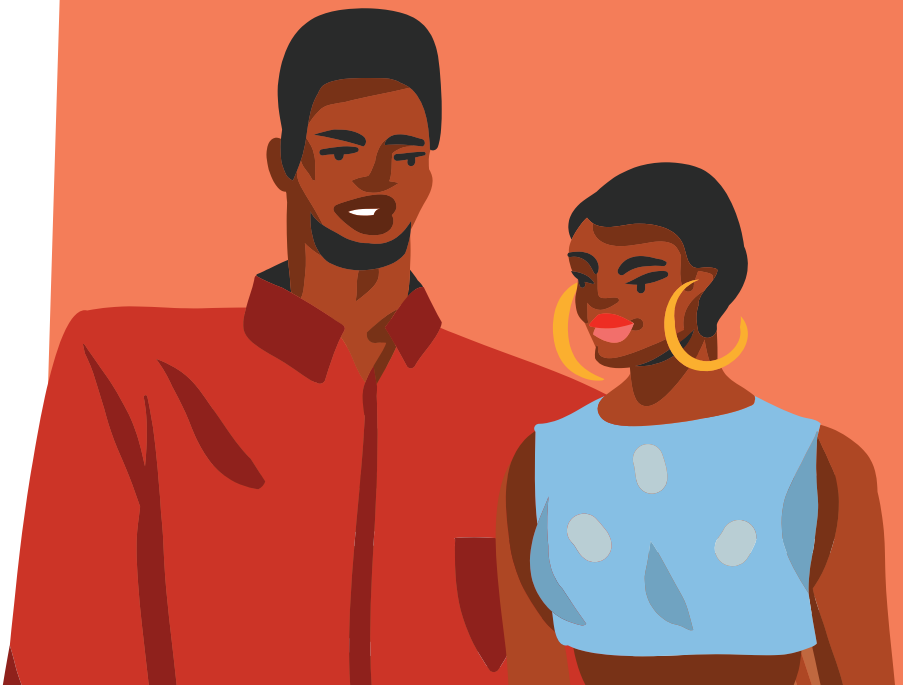
In 2020, a university-wide task force of faculty, staff, and students at Ohio State University was created to provide recommendations on ways to foster an equitable, antiracist campus community. This included establishing an initial $1 million seed fund for interdisciplinary research on racism and creative solutions for the campus and community. The result was the adoption of their campus-wide Anti-Racism Action Plan.[12]

As institutions that provide comprehensive patient care services, medical education, and research, academic medical centers can play an especially important role in leading antiracist work. "I do think we have a responsibility to be leaders in this area," says Dr. Rankin. "We have a long history of existence and of solving problems creatively. As an academic medical center, we have to be cognizant of creating a culture that fully embraces and respects inclusion in all aspects of the learning, research, and clinical environments. It starts with education and training—creating a workplace culture and environment where everyone can be their full authentic selves and be valued for their skills and perspectives. Whether it's in research, teaching, or interactions with staff—all of the different spaces we occupy—we want to foster a community that prioritizes and celebrates diversity, equity, and inclusion in every area."

The Anti-Racism Action Plan represents a coordinated series of initiatives designed to create a culture of equity, fairness, and inclusion in every facet of Wexner Medical Center and the College of Medicine, explains Dr. Rankin. As such, a task force of medical students, faculty, and staff set out to identify key areas requiring action

"We have adopted the idea that we have to educate with intent. We believe medical education of new physicians should include learning about racism, health, and health care delivery from an African American perspective, as well as [the perspectives of] other marginalized groups. **A failure to do so … is a disservice to the education of all medical students."**

–Demicha Rankin, MD



and attention.

"We came away with three pillars that we wanted to focus on," says Dr. Rankin. "The first pillar was the *curriculum*—looking at how we teach, who's teaching, what's in the content, what's in the materials? Is there bias? Is the curriculum dynamic? Is the curriculum antiracist? We also looked at *culture*—ensuring that the culture allows for representation of everyone's full authentic selves unapologetically. The third pillar was *commitment*—affirming our commitment to providing resources, access, and opportunities to ensure student success."

As a result, several new curriculum offerings have been introduced into the medical education program, reports Dr. Rankin. "For instance, we now have a four-week advanced elective in medical ethics for our [fourth-year] students that addresses the African American experience. In addition, we also offer a new curriculum for [first- and second-year] medical students where we discuss racism, health, and health care delivery, as well as a first-year module on issues with race-based medical misinformation and history's impact on today's medical practices."

Other changes have been relatively easy to make. For example, the College of Medicine has introduced the use of Black manikins in the simulated education center where students learn responses to mock emergency room codes.[13] "This is an example of something we were able to identify—the low-hanging fruit in our curriculum, so to speak—where we realized we can do better," says Dr. Rankin.

Multiple components are involved in antiracism activity at Ohio State University, such as the 21-Day Anti-Racism Challenge, an educational activity inviting individuals and groups to learn more about systemic racism, privilege, and equity. Another, older Ohio State University program that addresses racial health disparities is the Moms2B program. Led by a multidisciplinary team of health professionals, Moms2B is a community-based program to help people deliver healthy, full-term babies. The program provides access to a variety of pregnancy-related health necessities, including prenatal education and other family and health resources.[14]

The Moms2B program addresses a significant public health issue by working to reduce adverse pregnancy outcomes. Nationally, infant mortality for Black infants is 11.4 per 1,000 live births, which is more than double the 4.9-per-1,000 rate for White infants. In Ohio, Black infants die at nearly three times the rate of White infants.[14] The state's fetal mortality rates also show Black women are more than twice as likely as White women to experience fetal death during pregnancy.[14]

Since its inception in 2010, Moms2B has helped thousands of women. From 2011 to 2017, Moms2B babies were 55% less likely to die in their first year of life. Program participants also had fewer premature or low-birthweight babies.[14] Notably, the program's success has also led to the creation of a Dads2B program to provide additional support and education for new fathers.[14]

Help Wanted in the Workplace

The issue of racial and health equity in medicine is an issue not limited to patient care. Those who *work* in health care settings also have the right to be treated with respect and dignity and not be subject to racial or ethnic bias or other forms of discrimination or abuse by employers, colleagues, or patients.

Civil rights laws have been in place for some time to protect employees from employer discrimination. Unfortunately, encounters with racism or other forms of bigotry from patients still occur, acknowledges an American Association of Medical Colleges report.[15] In such instances, institutions have an obligation to provide guidance and support for employees who are subject to racial prejudice or abuse. This includes encouraging staff to report discriminatory incidents and even at times informing patients they may be asked to leave the provider's care.[15]

"Being Hispanic, racism is an issue [for me]," says Liliana Nava, CMA (AAMA), a staff member at UNC Primary Care at Chatham and UNC Endocrinology in Siler City, North Carolina. "I've been working in family practice for four years and unfortunately have witnessed racism toward me and others."

In one instance, Nava describes working with a White physician assistant whose last name is commonly associated with a Hispanic background: "We actually had a patient contact our front desk and say they didn't want to see 'them' again, meaning me and the other staff member. When the front desk asked why—if they had been treated wrongly—the person replied, no, they just wanted to see someone 'normal,' which for them meant a 'White person who would understand me.' "

Incidents of racial prejudice should be reported to a clinical manager or provider, stresses Nava: "You should bring it up with your manager. I would also say it's important in these situations to stay professional at all times. Stay calm. Even if at the end of the day you don't feel that much was done, at least the incident is on record."

Nava encourages providers to recognize how critical it is for minority staff to feel supported when racism appears. "We need that support from our employers," she emphasizes. "We want to know our voices will be heard. Some people might think they're superior to you, but they're not. Of course, there is going to be a mix of people in our work, and we need to understand and respect all of them. I believe everybody's equal. We all need to remember our value and the fact that we all need each other."

The goal of racial and health equity is invariably rooted in a holistic vision of fairness and justice, one that extends from patient care to medical education and the organizational cultures of health systems. While the challenges are certainly daunting, the goals of the antiracism movement in medicine herald the possibility of improved health and health care services for all communities. ✦

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Racism Is a Public Health Threat

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T F

☐☐ 1. In the United States, the infant mortality rate for Black infants is half the rate for White infants.

☐☐ 2. On average, the quality of health services received by ethnic and racial minorities is of a lower quality than the services received by White Americans.

☐☐ 3. Clinicians have been proven to *not* show bias when recommending treatment options to racial and ethnic minority patients.

☐☐ 4. Educators should ensure that curricula in medical school and education programs for other health care professions are not biased or racist.

☐☐ 5. Involving members of local minority communities can help lessen health inequities.

☐☐ 6. Wealth, education, employment, and housing are several social determinants of health.

☐☐ 7. Empirical evidence that Hispanic and African American people had higher death rates than White Americans for certain conditions and diseases did not emerge until 2015.

☐☐ 8. Interventions by specially trained nurse navigators have been shown to reduce inequities in treatments and outcomes.

☐☐ 9. No evidence of racial discrimination is present in medical school admissions and the hiring and promotion of physicians.

☐☐ 10. Reducing inequities in cancer treatment results in the increased quality of care for *all* patients.

☐☐ 11. Hispanic, Black, American Indian, and Alaska Native people are just as likely to be infected by COVID-19 as White Americans.

T F

☐☐ 12. No evidence suggests bias and differential treatment in regard to the admission to specialty cardiology units.

☐☐ 13. Systemic racism can result in poorer health outcomes for some medical conditions, such as hypertension and diabetes.

☐☐ 14. All members of the health care delivery team have an important role to play in reducing racial disparities in health care.

☐☐ 15. Simply adopting color-blind policies and practices is a sufficient strategy for lessening health disparities.

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Taste, Not Waste

Quit feeling guilty about food waste by following these food-saving tips from NC State News to get more mileage out of your groceries:

- A massive cause of food waste is the misunderstanding of food labels. Pay particular attention to the "best if used by" labels, which are tied to the food's peak quality rather than its safety. With the notable exception of infant formula, which is devoid of nutritional value after its "best if used by" date, many foods that are stored properly can still be consumed after their date labels.
- Many fruits, vegetables, meats, and other kitchen staples can be safely frozen or dried and consumed at a high quality for up to a year. A little bit of research can go a long way; check out the National Center for Home Food Preservation website (nchfp.uga.edu) for tips on safely freezing or drying a wide variety of foods.
- Turn a delicious dinner into lunch later in the week by splitting leftovers into small food containers and putting them in the refrigerator quickly. Some refrigerated leftovers that are stored properly can be eaten for up to seven days.

With some planning and a bit of time, you can minimize food waste and maximize the potential of your pantry. ✦

Oil Change

Concerned about cooking oils? Harvard Health Publishing provides some simple advice to navigate these murky waters.

Oils are part of a balanced diet and provide fatty acids, such as omega-3s and omega-6s, that are critical for nutrition and help decrease inflammation, bad cholesterol, and blood pressure. To choose the right oils, seek out liquid- and plant-based oils. Olive, corn, canola, sunflower, and soybean oils are all considered to be healthy oils. Try to limit the use of lard, butter, palm oil, and coconut oil, which are packed with saturated fat and can increase your risk of cardiovascular disease and diabetes.

While it's easier to control oil type and amount when cooking at home, eating out poses challenges. A restaurant may be using unhealthy oils to fry foods and reusing oils for too long. The repeated reheating of an oil can create trans fats, which trigger inflammation and are linked to heart disease and type 2 diabetes.

By primarily using liquid and plant-based oils, you can improve your meals while contributing to a balanced diet.

Activity Positivity

An active lifestyle can benefit older adults in significant ways, according to the National Institute on Aging. Benefits can include a decreased risk of dementia and heart disease, longer life-spans, and improved resiliency and cognition.

Older adults should engage in varied activities to maintain their health:

- Spend time with family and friends through activities such as games, shared hobbies, or travel.
- Take on new learning opportunities and explore your interest in cooking, art, or music.
- Embrace your community in ways that suit your skills and interests (e.g., volunteering at a local food bank or library, teaching, or participating in community theater).
- Remain physically active in whatever ways work best for you (e.g., bowling, biking, or tending your garden).

Pursuing an active lifestyle as an older adult doesn't have to mean ultramarathons and scaling mountains. It's really about exploring your interests and engaging with your friends, family, and community. ✦

Guided by Choices

Exercise has countless benefits for physical and mental health, but how *much* physical activity should be the goal? At least 150 minutes of moderate-intensity physical activity combined with two days of muscle-strengthening activity every week is just what the doctor ordered, according to the U.S. Department of Health and Human Services' *Physical Activity Guidelines for Americans*.

Because people have hectic schedules, these guidelines say that flexibility is the name of the game. Setting a weekly 150-minute minimum means that you can break it into workable chunks of time that best fit your schedule.

Short on time but itching to maximize your periods of activity? Try 75 minutes of weekly vigorous-intensity physical activities or an equivalent combination of moderate and vigorous activity instead.

No time for traditional forms of exercise? Think about the daily activities and chores you already engage with (e.g., walking the dog or mowing the lawn) that could boost your weekly activity.

While 150 minutes of moderate-intensity physical activity is the weekly goal, it's not all or nothing. Every bit counts. Find the activities that are right for your schedule and get moving! ✦

Where There's a Pill,

There's a Way

Getting a child to take their medication can be a harrowing experience, and it can be especially tricky if the medication is in pill form. However, you can teach children how to take pills and minimize the stress for everyone involved with seven steps from *Michigan Medicine*:

1. **Keep practices short.** Start early, when the child is still on liquid medications, and try to practice for only five-minute sessions during low-stress times so as not to hurry the child.
2. **Reward learning.** Offer the child encouragement via stickers or other small rewards so that they learn with positive reinforcement.
3. **Offer tips for taking pills.** Have them sit up straight in a chair and take a sip of water. Use metaphors (e.g., a waterslide) to make it more relatable to the child.
4. **Start small.** Place a small candy sprinkle in the middle of the tongue and wash it down with water.
5. **Increase pill size slowly.** Once successful, try a slightly bigger candy. Don't rush to larger size candies; make sure the child is successful on multiple attempts before scaling up.
6. **Set a goal.** Once successful with the slightly larger candy, move up to the size of the pill they need to take. Keep progression gradual, and try to end on a success to keep the child engaged and confident for future practice.
7. **Go back a step if needed.** If a child is unable to take a larger pill, go back to the size they're comfortable with. Remember that there may be setbacks, and that's OK.

This may seem like a lot of steps, but taking a proactive approach to teaching a child how to swallow pills can reduce their anxiety around doing so and have them mastering this new skill in no time.

Tell Me about Yourself

Behavioral-Based Interviewing Helps Employees Choose the Right Candidate

By Pamela M. Schumacher, MS

Interviewing can be a blessing or a curse. Done correctly, employers pick the perfect candidate for the job. Done incorrectly, it can cost practices time and money. In fact, the U.S. Department of Labor estimates the average cost of a bad hiring decision is at least 30% of the individual's first-year expected earnings, and some argue the cost is actually greater.[1]

A proven method of reducing the likelihood of hiring the wrong candidate is using behavioral interviewing questions, says Vicki Hoevemeyer, author of *High-Impact Interview Questions* and a human resources consultant. "There are two parts to every job. First there's … the requirements of the job. You can check to see if, on paper, the candidate is a match. Next is the 'how' of performing the job. This is when you define the behaviors and actions—or *competencies*—required to perform it. Competency-based behavioral interviewing [CBBI] is an interviewing approach that focuses on 'how' a candidate approaches the 'what' aspect of the job."

Tammy Berger, CMA (AAMA), a coding manager at Henry Ford Health in Detroit, Michigan, and an adjunct medical assisting educator for Ross Education agrees. "Once you know the person has the right technical know-how, then you can ask competency-based questions to see whether they're a good fit for your team," she says. "You can teach tasks, but you can't change someone's personality, ethics, or integrity. I've hired a less experienced candidate when I thought they had the right interpersonal relationship skills for my organization."

For Example

Behavioral-based interviewing focuses on a candidate's past experiences by asking them to provide specific examples of how they have demonstrated certain behaviors, knowledge, skills, and abilities. Behavioral interview questions tend to be pointed, probing, and specific.[2]

"The big difference with CBBI is that it focuses on actual behavior as opposed to traditional interview questions such as 'What are your strengths?' or 'What are your weaknesses?' People know how to answer those questions, and you don't really learn much by asking them. I've found that the best indicator of future performance is past or current performance," says Hoevemeyer.

A close cousin to behavioral interviewing is situational or scenario-based interviewing. In these interviews, candidates are asked to describe how they would deal with a particular situation.[3]

"Situational questions are good to pose to candidates right out of college or with little experience," says Hoevemeyer. "However, the drawback is that you might learn whether a candidate knows what process to follow in a certain situation, but you won't know how they will actually behave."

"A situational question for medical assisting candidates might be, 'How would you handle a difficult patient?' To ask it as part of a CBBI say, 'Tell me about a time when you dealt with a difficult patient.' This provides insight not only into how they handled this patient but also how they define *difficult*. Do they think a difficult patient is someone who gave them a funny look when they got on a scale or [a] patient [who was] rude, swearing, or belligerent? This information enables the interviewer to determine whether a candidate has the

experience of dealing with issues that might arise at the medical [practice]."

Berger likes to ask candidates what steps they would take if they had a disagreement with a colleague. "If they say, 'Oh, I never have a conflict,' never leave it at that," she says. "I drill down and ask, 'What about in your personal life?' Sometimes candidates don't want to admit they've made a mistake or had conflicts, but if you can get them to explain how they would handle something in their personal life, then you can understand how they would behave in an office setting."

On the Job

Behavioral interviewing starts with identifying the job competencies. A competency is a behavior, skill, ability, or set of behaviors that describes the expected performance in a particular work context.[3] Further, competencies are specific employee behaviors that relate to an organization's strategic goals, are correlated with job performance, and can be measured.[2]

"I like to draw questions based on a candidate's résumé," says Berger. "If they're [CMA (AAMA)] certified, I ask them about their training or externship. In addition, I often ask a candidate to describe the perfect work environment. This gives me insight into whether they will fit into my office and what they're expecting when they come to work."

To convert a traditional interview to a behavioral-based interview, employers can review existing questions and rewrite them in a way that gets at the competencies needed for the open position, such as with these examples[3]:

- **Traditional:** How would you deal with an angry, upset, or irate patient?
    - **CBBI:** Tell me about a time you had to deal with an angry, upset, or irate patient.
- **Traditional:** What would you do if someone asked you to do something unethical?
    - **CBBI:** Tell me about a time you were asked to do something you felt was unethical.
- **Traditional:** If you could change one decision you made during the past year, what would that be?
    - **CBBI:** Tell me about a work-related decision that, if you could, you would like to redo.

Hire Purpose

Once the questions have been created, the next step is to determine a rating scale or an interview rubric. A rating scale helps hiring managers to consistently ask all candidates the same questions and increases fairness in screening them.[4] The scale can be a simple 'yes' or 'no' or have multipoint scales, but it should be understood by all interviewers. For example, a scale could include the following options[2]:

- **Superior:** Demonstrates competency accurately, consistently, and independently. Provides many good examples.
- **Satisfactory:** Demonstrates competency accurately and consistently on familiar procedures and requires supervisor guidance for new skills. Provides some good examples.
- **Unsatisfactory:** Demonstrates competency inconsistently, even with repeated instructions or guidance. Provides few good examples.

The interview rubric should provide the interviewer cues about how to score each answer.[4]

Dig Deeper

A challenge for interviewers who are new to behavioral-based interviewing is they may encounter candidates who answer in generalities, warns Hoevemeyer. "If that happens, ask follow-up questions such as, 'Can you give me a specific example in which you dealt with this situation?' People who give general answers are often trying to fake their experience," she explains. "Also, be wary of candidates who say 'we' a lot because the candidate may be trying to hide what their actual role was. Again, ask a follow-up question such as, 'Specifically, what did you do in that situation or on that project?' "

Finally, not knowing something is not necessarily a drawback, adds Hoevemeyer: "I give candidates a lot of credit if they're willing to be honest and say, 'I've never had to do that specific thing, but I did do this other thing that is similar.' That would provide enough information for the interviewer to judge whether the candidate could handle a situation and be a good fit for the organization." ✦

Interviewing Tips

- Ask a person who has been in the position before to identify the most important competencies for the job.
- Identify six to 10 competencies or behaviors needed to be successful. Do not include more than 10 because the interview will get too long.
- Determine what questions will allow you to assess these behaviors. What story do you want to hear that would show you that this person has necessary competencies to succeed in the organization?
- Create a rating scale or interview rubric. Train interviewers so they understand and agree on what each rating means.
- If a candidate answers in generalities, ask for specific examples.

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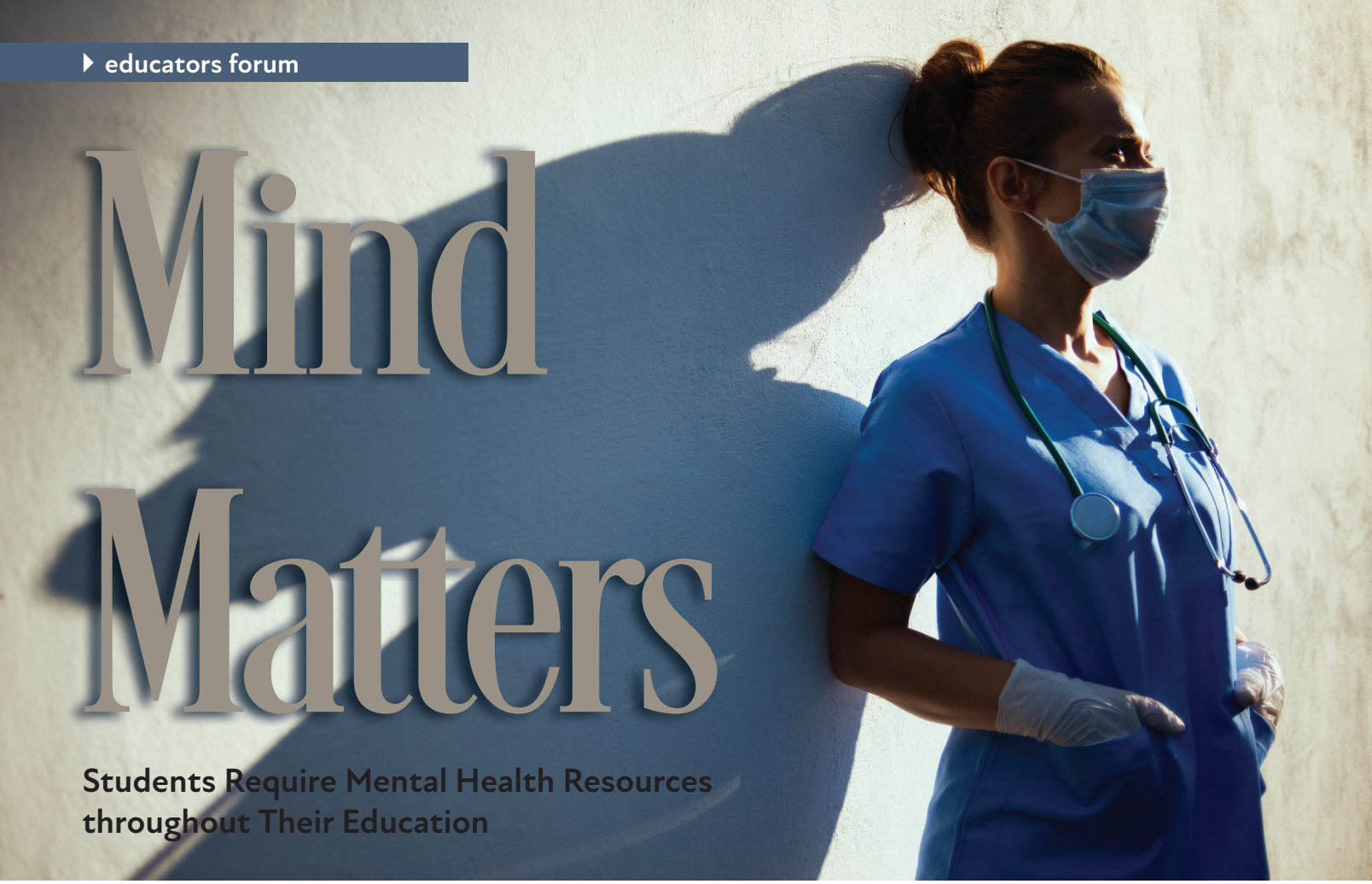

Mind Matters

Students Require Mental Health Resources throughout Their Education

By Brian Justice

Young people across the country are facing large amounts of stress. Social, educational, and economic issues—not to mention COVID-19—are impacting them in such a way that they can experience setbacks in most areas of their lives, including their mental health. Those dealing with stress on a daily basis may see it affect their academic performance and, later, how they move through the world as employees.

"[The percentage of] young adults [ages] 18 to 25 experiencing mental illness has been on the rise, from 18% in 2008 to nearly 30% in 2019," writes Lauren Drake, a licensed clinical social worker. "Of these, [those who] experienced mental illness that was severe in nature, meaning an illness that substantially interferes with or limits major life activities, [nearly doubled] from 3.8% in 2008 to 8.6% in 2019. Young, college-aged adults have become the most vulnerable population in terms of mental well-being, with rates of mental illness rising higher than that of any other age group."[1]

Tired and Tested

About 75% of all lifelong mental illnesses begin by age 24,[1] so young people in any kind of post–high school educational program are at risk.

"The most common psychological problems are forms of depression and anxiety, and this is especially true for adolescents and young adults," says Carol Landau, PhD, clinical professor of psychiatry and human behavior at Brown University in Providence, Rhode Island. "Mental health problems in young people were an [issue] before the pandemic, and the situation has only gotten worse. The second area of concern is family conflict—divorce, stress on couples, [or] caretaking needs for children or aging parents. Students don't need to [have] clinical anxiety or depression to be upset, but all this affects their academic work."

"Other common stressors include issues about relationships, family, academic demands, and finances," adds Larry Marks, PhD, a licensed psychologist working in counseling and psychological services at the University of Central Florida in Orlando. "A lot of students are struggling with readjusting to normal, in-person, on-campus routines after having been isolated and taking classes online since the start of the pandemic."

Safety Net

Educators can recognize indicators that students are having trouble outside of the classroom.

"If a student is suffering from either mental or behavioral health issues, the signs are similar," says Christine Cusano, EdD, CMA (AAMA), director of product development at Lincoln Technical Institute in

Bellingham, Massachusetts. "[The signs] could include a student coming into class late or not at all, not doing their work, talking back, or not participating in class discussions or laboratories."

However, sometimes problems are not easy to spot right away, cautions Stephanie Miller, CMA (AAMA), lead medical assistant in family medicine at Cheshire Medical Center in Keene, New Hampshire. "I find the first clues that a student is struggling are often subtle, sometimes just a feeling that something is off," she says. "Those [clues] can include a decrease in empathy, a decline in performance, or a general lack of engagement."

Student Brain Easers

So, how should a sensitive educator respond?

"Checking in with the student about your concerns is important," says Dr. Marks. "Educators should not underestimate how much impact expressing genuine concern, understanding, and encouragement can have on a student. Many times, a student just needs to be heard."

Creating an atmosphere of confidence, privacy, and safety is crucial.

"As an educator, it's important to build a relationship that is based on trust, respect, and open communication," says Dr. Cusano. "When you recognize signs that a student is suffering, … address them quickly and talk to the student privately. If you build a trusting relationship early on, it will be easier for the student to open up and discuss what is happening in their life."

A complicating factor is that mental health still carries a stigma, so educators must be conscientious about being open-minded, using inclusive language, and encouraging open discussion about mental health in the classroom.

"If a student does not respond to your outreach, … remember that you still have an ongoing relationship," says Dr. Landau. "So, you can respond with something like, 'Okay, that's fine. Feel free to reach out to me anytime, because I am concerned about you.' It's also important for them to know that, if they have a conversation with you, it will remain private and have no impact on their grades."

Feedback is one of the most valuable tools that educators can use.

"Listen to your students. … Show students that feedback is taken seriously by implementing changes to classroom dynamics," writes Drake. "These efforts go a long way in securing student trust and setting the stage for success."[1]

Educators should also respect students' autonomy in seeking out help.

"The roles that educators play in the mental health of their students are observational and through communication. [An educator's] job isn't to solve the issue themself. That could exacerbate [the issue] or create unnecessary tension in the student's already challenging life," says Tasha Holland-Kornegay, PhD, founder of WIRL, a free, online service that connects health care professionals with various wellness support services. "Educators should have strong enough relationships with their students to have an open-door policy that allows for private conversations and emotional support. However, seeking support should be the student's choice."

Educators should be prepared to respond once a student decides to accept help.

"I always try to be my student's advocate, and together we come up with a plan to work through their struggle and put that plan into action," says Jessica Blessinger, CMA (AAMA), a medical assistant clinical educator for Hancock Health in Greenfield, Indiana. "I help them in any way I can, whether it's [providing] words of encouragement or affirmation or giving them tools to better understand what they're going through, such as handouts, visual aids, videos, etc. The biggest thing, though, is to be there and listen, even if the struggles are not applicable to class itself or even health care. Sometimes they just need to vent, get advice, or simply be comforted in a time of need."

Many educators can speak from a place of genuine empathy.

"Some educators stand out as not just teachers but role models and life guides. I had a few of those people in my own life," says Dr. Holland-Kornegay. "I struggled with burnout and mental health issues, and during those trying times, my kindest teachers offered a hand. My challenges never rose to the level of requiring treatment, but their understanding and willingness to work with me put me on a much brighter path. A great [educator] can have such a positive influence on students' lives and maybe encourage those students to begin helping others too." ✦

Stressing the Impact of COVID-19

Approximately 80% of students report that COVID-19 has negatively impacted their mental health through increased stress, isolation, and depression.[2] One year into the pandemic, a survey of more than 2,000 higher education students found several notable statistics[3]:

- 65% of students reported having fair or poor mental health
- 62% of those with poor mental health graded their institution's response to student mental health as a C or lower
- 47% said that they could have used more support from their institution
- Only 15% engaged in any kind of counseling offered by their institution

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Connect the Dots

CMA (AAMA) Creates Bridges Between Students and Future Employers

By Cathy Cassata

Christine Dzoga, CMA (AAMA), is answering Chicago's call for more medical assistants. After working as a medical assistant for more than a decade and teaching medical assisting courses part time, she took a full-time role as health science director at Malcolm X College—a part of City Colleges of Chicago—in 2016.

"When I got here, they were in the midst of a transition in which all their health care programs were going to be held at Malcolm X College in the medical district," says Dzoga.

She took the lead on revamping the curriculum and obtaining accreditation from the Commission on Accreditation of Allied Health Education Programs upon recommendation by the Medical Assisting Education Review Board in 2019. The program had 30 enrolled students at the time and has since grown to over 200 students. In 2021, Dzoga helped establish a medical assisting program at a satellite campus called West Side Learning Center. She is in the process of getting a third program off the ground at a South Side location in Chicago.

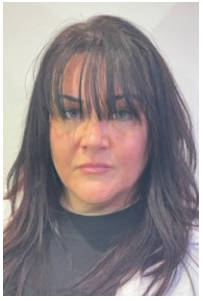
"One of our missions is to provide diversity in health care, so we are proud to be expanding our program to satellite locations throughout the city of Chicago. We want to bring the program to students in their neighborhood," says Dzoga.

In addition to providing educational opportunities, she is passionate about creating job prospects for students. During her time with City Colleges of Chicago, she developed strong partnerships with local employers. For instance, she helped arrange the Medical Assistant Pathway Program (MAPP), which is sponsored by West Side United, Ann & Robert H. Lurie Children's Hospital of Chicago, Rush University Medical Center, University of Chicago Medicine, Sinai Chicago, and Northshore University HealthSystem.

"If you're halfway through [one of] the medical assisting programs, you can apply for the scholarship, and if you are accepted, you are matched with one of the sponsoring organizations," explains Dzoga. "Plus, the rest of the program costs are paid for, including books and uniforms. You are placed at one of the organizations for the clinical rotation, and then you are guaranteed an interview after you graduate."

The arrangement helps the organizations fill staffing needs too, notes Dzoga. She based the model on her first partnership with Northwestern Medicine in 2018, which took much persistence on her part.

"They didn't place many medical assistants as externs then, but after me calling and calling, they finally agreed to have two students go through orientation with Northwestern and then placed them on clinical," Dzoga says. "It's been so successful that just last week they called and asked for 25 students!"



Northwestern makes use of the program to hire medical assistants too. The organization shared a recent report with Dzoga that indicated that 85% of their new medical assistants are hired via the program.

"I was proud of that. Students have gone out and done so well all over the city that we're constantly asked for more and more of them," she says.

Common feedback she gets about students is that they know how to communicate with patients. This sits well with Dzoga because her goal is to provide Chicago with medical assistants who can relate to all patients.

"We believe medical assistants can reach patients who wouldn't want to seek health care for various reasons," says Dzoga. "It makes a big impact when someone can go into a [physician's practice] and see themselves there, specifically [via] a medical assistant who can relate to them because patients spend the most face-to-face time with medical assistants; they set the tone for the rest of the visit and beyond, cementing their role on the health care team." ✦

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