Mar/Apr 2022

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CMA™ Today

Rules of Substance

The DEA Enforces Prescription Drug Rules and Regulations

Planting for the Future

On my behalf and on the behalf of the Board of Trustees (BOT), thank you for your hard work during these times, especially with the staff shortages, long hours, the loss of family members and friends, or positive COVID-19 tests.

With spring approaching, it is time for new or renewed growth. The American Association of Medical Assistants® (AAMA) offers our members different ways to branch out in their professional development and leadership. Many state societies within our organization are hosting state conferences this time of year, whether in person or virtually, and offering opportunities for earning CEUs, meeting other members, and running for leadership positions. Several states also have local chapters that meet monthly to offer CEU opportunities.

The AAMA has also recently developed a new professional development program, the Population Health Module. By completing the courses and passing the final test, you will earn a digital badge that can be displayed within your email signature.

Another popular event for education and professional development—and my personal favorite—is the AAMA Annual Conference. Hundreds of medical assistants from all over the country come together in the fall to receive quality education, network with other medical assistants, conduct AAMA business during the House of Delegates, celebrate the winners of the Excel Awards, and just have fun. This October, the AAMA Annual Conference will be in Myrtle Beach, South Carolina—my home state! The South Carolina Society of Medical Assistants is very excited to be hosting this year and is ready to welcome you to our beautiful state.

Another way to cultivate your career is through leadership within the AAMA. The best place to start is by joining a committee, becoming a committee chair, or running for a chapter or state office. If you have done this already, the next step could be filling out the AAMA Volunteer Leadership Application, which can be found on the "Guidelines and Forms" webpage of the AAMA website, by Aug. 1. If you are ready to run for office or a trustee position, fill out the AAMA Officer and Trustee Nomination Form and submit it by May 1. Find detailed descriptions of committees as well as officer and trustee positions in *AAMA Volunteer Leadership Position Descriptions*, available via the "Members-Only Downloads" section of the website.

Being a part of leadership within the organization is a great way to not only support the organization but also grow your professional development and learn more about yourself. We would love to have you join our team!

If the BOT can be of any assistance to you or your state society, please reach out to us. We are here for you, the members of our wonderful organization. Let's all work together to grow the AAMA to be a stronger organization than it already is.

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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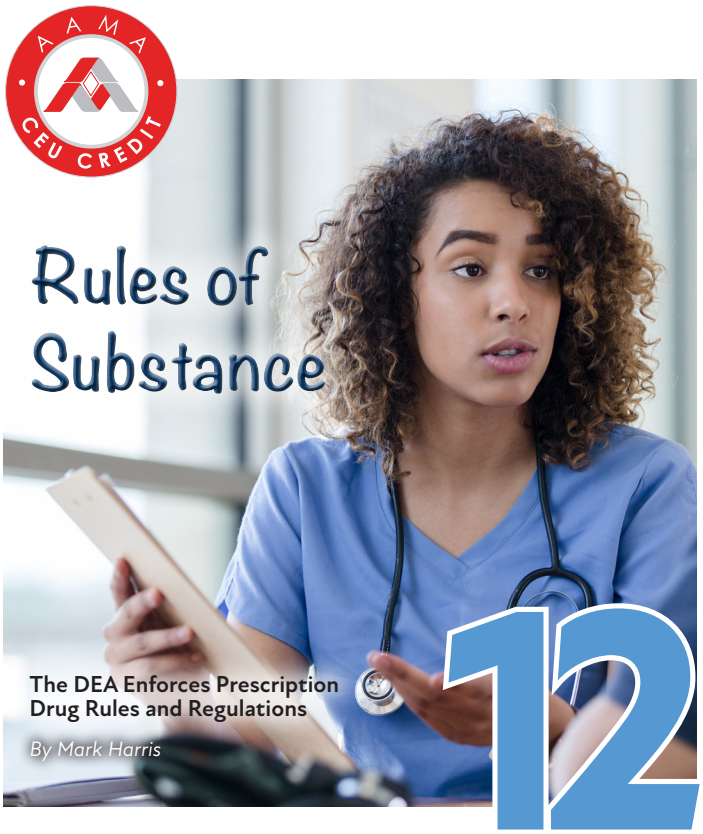
CMA Today



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A Brighter Future in South Carolina

The registration brochure for the 2022 AAMA Annual Conference will be posted to the website soon. Download the brochure to access a wealth of resources:

- **Good tidings: discounts and details.** Check out conference hotel discounts and see if any information about the Palmetto State catches your eye.
- **Soak up some skills.** Pore over more than 20 continuing education opportunities.
- **Share sunny expressions.** Come face-to-face with fellow members of the AAMA from all over the country!

Plan now to attend conference by adding this year's dates to your calendar:

Myrtle Beach, South Carolina—Oct. 21–24, 2022

Official Call for HOD Representation

State societies are entitled to the following representation in the House of Delegates at the 2022 AAMA Annual Conference in Myrtle Beach, South Carolina. The HOD convenes at 8 AM Saturday, Oct. 22, 2022, at the Marriott Myrtle Beach Resort & Spa at Grande Dunes.

AK	3	IL	5	ND	2	SD	3
AL	3	IN	7	NE	4	SC	5
AR	2	KY	4	NH	3	TN	3
CA	4	MA	4	NJ	4	TX	4
CO	3	MD	3	NM	3	UT	3
CT	3	ME	4	NV	2	VA	3
FL	5	MI	7	NY	3	WA	7
GA	5	MN	6	OH	7	WI	8
HI	2	MO	3	OK	3		
IA	6	MT	3	OR	5		
ID	3	NC	11	PA	4		

The submission window for the 2022 Excel Awards will be open soon. Start gathering your submission materials to enter the competition honoring the achievement of excellence:

- **AAMA members.** Nominate a medical institution—big or small—that employs CMAs (AAMA)® and is a strong supporter of professional growth, particularly in the areas of certification and recertification, continuing education, and membership.
- **State leaders.** Enter your state publication, website, marketing campaign, or community service effort for recognition. And remember to nominate exemplary national leaders for one of the three Awards of Distinction.
- **Medical assisting students.** Craft an essay responding to this prompt: "As health care continues to have increasing demands and staffing shortages, providers are looking for medical assistants to fill important roles and provide excellent quality care to their patients. What opportunities do you think this offers to the medical assisting profession, and how will you utilize those opportunities?" Enter for a chance to win $1,000.

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

2022 State Conferences

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

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

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

1. Make sure your state conference information is posted on the AAMA website. You can email the AAMA at MarCom@aama-ntl.org with questions and updated information, including links to registration information for your state conference.
2. If you would like AAMA staff to share the event via the AAMA's Facebook page to broadcast the information to its 51,000+ followers, submit a Save-the-Date online form, accessible via the My Account section of the AAMA website *(must be signed in for access)*.

Show employers that you have the know-how to be a practice manager with the Assessment-Based Certificate Program in Practice Management (ABC-PM).

This program will expand and advance your knowledge of essential aspects of practice management, including leading and managing employees, understanding practice structure, and measuring and providing quality health care.

The ABC-PM is available to CMAs (AAMA), medical assistants, and all other health care professionals. The program, worth 8.5 general/administrative CEUs, is now available through the AAMA e-Learning Center.

Hot tip! Use AAMA membership to get a discount on the ABC-PM. Become an AAMA member or renew your membership today. ✦

On the Web

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

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

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

Who's Who?
Within the "About" Section/ Executive Office Staff
The AAMA has supported medical assistants for more than six decades, and in that time, we've had the privilege to know some outstanding individuals. In the spirit of strengthening connections, the "Executive Office Staff" webpage provides a breakdown of all staff.

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

Utilizing Medical Assistants to the Top of Their Training

How Recent Law Changes Have Expanded Their Scope of Service

The following is a summary of a presentation I gave to the Medical Group Management Association (MGMA) Medical Practice Excellence: Leaders Conference on October 25, 2021.

The scope of practice and service of medical assistants has expanded dramatically during the last 18 months because of changes in federal and state law. The purpose of this presentation is to highlight some of the major changes in medical assistants' scope of practice and service so clinicians and managers will be able to utilize medical assistants to the top of their education or training and credentialing.

Telemedicine/Telehealth

My legal opinion is that, under the laws of all states, knowledgeable and competent medical assistants are permitted to (1) receive information by electronic means for licensed providers and (2) convey information by electronic means as authorized by overseeing/delegating providers. Providers should specify in writing what information may be received and transmitted by medical assistants. When receiving and conveying information, medical assistants must avoid making independent clinical judgments and assessments.

In its *Telehealth Implementation Playbook*,[1] the American Medical Association recognizes the roles that medical assistants are able to assume in telemedicine/telehealth. Note the following excerpt from this publication:

> **MEDICAL ASSISTANT …**
>
> - Be familiar with the conditions and situations that are appropriate for a telehealth visit
> - Educate patients on telehealth expectations
> - Support patient troubleshooting related to platform pre-visit and during visit
> - Let [the] doctor know when a patient has "checked in" for a telehealth appointment[1]

Because of favorable laws and growing recognition of their unique capabilities, medical assistants are being assigned roles as telemedicine communicators in clinics and medical practices.

Remote Physiologic Monitoring

In their publications and policies, both the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services have acknowledged the expanding role of medical assistants in remote physiologic monitoring (RPM). The following is from the Centers for Disease Control and Prevention website:

> In some cases, peripheral medical equipment (e.g., digital stethoscopes, otoscopes, ultrasounds) can be used by another [health care professional] (e.g., nurse, *medical assistant* [emphasis added]) physically with the patient, while the consulting medical provider conducts a remote evaluation.[2]

From the Centers for Medicare & Medicaid Services perspective, a new code descriptor (*Current Procedural Terminology* [*CPT*] code 99457) for Medicare Part B went into effect January 1, 2020. The code description is as follows:

> [RPM] treatment management services, *clinical staff*/physician/other qualified health care professional [emphasis added] time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes[3]

RPM services reported with *CPT* code 99457 may be furnished under general supervision—rather than direct supervision—and may be billed incident to the services of the licensed provider.

Because medical assistants may be classified as clinical staff under *CPT* definitions,

code 99457 has provided additional opportunities for providers to delegate RPM to medical assistants and receive incident-to reimbursement for their medical assistants' services.

Chronic Care Management and Transitional Care Management

The Chronic Care Management (CCM) and Transitional Care Management (TCM) programs were created to provide reimbursement for services for Medicare recipients who have health needs not included within standard Medicare coverage. As noted above, medical assistants fall within the *CPT* definition of clinical staff. Medical assistants also are auxiliary personnel according to chapter 15, section 60.1, "Incident to Physician's Professional Services," of the *Medicare Benefit Policy Manual*.[4] Medical assistants may be delegated tasks that are billable incident to the provider's services under *CPT* code 99490 (CCM) or *CPT* codes 99495 and 99496 (TCM).

The CCM and TCM programs have provided new opportunities for medical assistants to fill care coordinator roles in a variety of health care delivery settings. Care coordinators provide general coaching and guidance to the patient as authorized by care providers such as physicians, advanced practice registered nurses (APRNs), physician assistants, physical therapists, and occupational therapists. Coordinators also transmit information to care providers, such as patients' vital signs, adherence to treatment plans, and questions.

Post-Discharge Medication Reconciliation

Medical assistants are not mentioned specifically in the following quality measure of the National Committee for Quality Assurance (NCQA):

> **Quality ID #46 (NQF 0097): Medication Reconciliation Post-Discharge**
>
> …
>
> **2019 Collection Type:**
>
> …
>
> **NUMERATOR (SUBMISSION CRITERIA 1 & 2 & 3)**
>
> Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge[5]

Because of this lack of specific mention in the above measure, health systems were reluctant to delegate to medical assistants post-discharge medication reconciliation.

At the direction of the AAMA Board of Trustees, I contacted NCQA staff. I received the following response:

> NCQA recognizes the supervising physician as providing the service when they have signed off on the medical record/documentation. It is our understanding many licensed practical nurses (LPNs) and medical assistants work with physicians and registered nurses (RNs). With this in mind, medication reconciliation provided by the medical assistant and signed off by a physician, [nurse practitioner, physician assistant, or clinical pharmacist with prescribing privileges] or RN may be counted toward NCQA Medication Reconciliation indicators as the signature indicates additional clinical oversight for this work.

Nurse Practitioner Delegation under Maryland Law

Maryland nursing law was ambiguous about whether APRNs, especially nurse practitioners, were permitted to delegate to unlicensed allied health professionals such as medical assistants the administration of certain types of injections. The AAMA worked with nurse leaders in Maryland to draft a bill that would eliminate this ambiguity. The legislation was enacted into law and requires the Maryland Board of Nursing to promulgate regulations authorizing APRN delegation of injections to unlicensed assistants (such as medical assistants).

Revised Supervision Requirement under Washington Law

The COVID-19 pandemic has necessitated less stringent supervision requirements for knowledgeable and competent medical assistants. In April 2021, the Washington legislature codified into statute the following revised supervision requirement previously included in an executive order by Washington Governor Jay Inslee:

> (b) The health care practitioner does not need to be present during procedures to withdraw blood [by a medical assistant], but must be immediately available [by telephone].
>
> (c) During a telemedicine visit, supervision over a medical assistant assisting a health care practitioner with the telemedicine visit may be provided through interactive audio and video telemedicine technology.[6] ✦

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Sweet Tooth

Bite-Sized Tips for Cutting Sugar Consumption

By John McCormack

Sandra Weaver, CMA (AAMA), has tried and tried again to decrease her sugar consumption. "Stopping cold turkey. [Limiting] intake of all sugar. Counting grams of sugar," lists Weaver. "They would work in the short term, and then something in my life would come up and cause stress. Then, out the window everything [went]."

Weaver, a medical assistant at UNC Family Medicine at Wakefield in Raleigh, North Carolina, is not alone. Despite the widely acknowledged fact that sugar can negatively affect health, many people still struggle to decrease sugar consumption. Americans consumed about 11 million metric tons of sugar in 2020–2021, up from about 10 million metric tons in 2009–2010.[1]

Eating too much sugar can kill you. People who get 17% to 21% of their calories from added sugar have a 38% higher risk of dying from cardiovascular disease than those who get 8% of their calories from sugar, according to a study published in *JAMA Internal Medicine*.[2]

While sugar is linked to a variety of conditions such as acne, diabetes, depression, stroke, and cancer, sugar is not necessarily the single cause of these diseases. "However, we see strong correlations of higher rates of these chronic conditions in diets that are high in processed food and added sugar," says Wesley McWhorter, DrPH, MS, RDN, LD, CSCS, assistant professor of health promotion and behavioral sciences at the University of Texas Health Science Center at Houston School of Public Health.

"Most people know that added sugars are not great for your health. So, awareness is not our challenge at this point," says Colleen Tewksbury, PhD, MPH, RD, CSOWM, LDN, senior research investigator at the Perelman School of Medicine at the University of Pennsylvania and bariatric program manager at the university's health system. "Yet, only about 2 out of every 5 adults actually meet the goal of limiting added sugars. The vast majority of adults eat more added sugars than what's recommended."

Health care professionals and consumers need to move beyond simple awareness and develop a more sophisticated understanding of sugar's effects on health. The following eight insights could help medical assistants control their own sugar intake and educate patients on how to do so as well.

#1: Identify Different Types of Sugar

To better protect from adverse health effects, avoid lumping all sugar into one category, advises Dr. Tewksbury. "We need to distinguish between naturally occurring sugars and additive sugars. [Additive sugars] are the sugars that are added to different products rather than those that are naturally occurring, like in fruit or dairy. Regular consumption of additive sugars has been … strongly linked to developing cardiovascular disease and early mortality."

Natural sugars, on the other hand, are not as harmful—and they come with health benefits. "Naturally occurring sugars are what our brains run on. Our brains need glucose; they need sugar to be able to function properly. So naturally occurring sugars are an essential macronutrient," says Dr. Tewksbury.

#2: March to Your Own Beat

To reduce sugar intake, people can set boundaries around portion control, reduce the frequency of sugar intake, or substitute other products in lieu of sugar. "If someone is having a 20-ounce bottle of soda per day, [they] would be cutting that down to a 12-ounce can, … limiting it to one every other day, or [finding] a substitute … such as seltzer water," explains Dr. Tewksbury. "All three of these approaches can be effective. It just comes down to what works for each individual."

#3: Get the Facts

"Don't pay attention to the front side of the packaging where all the marketing information is. Flip it over and look at the label," advises Dr. McWhorter. "The important point we want to look at is the amount of added sugar. Look at fiber too. Fiber helps to slow the absorption of sugar into the bloodstream, and typically if there is fiber in the food, it is less likely to have high amounts of added sugar."

#4: Don't Go Cold Turkey

"Sugar has been in people's diets for a long time," says Dr. McWhorter. "Simply saying 'don't eat it anymore' doesn't work. The literature is very clear. That approach is not sustainable. We should remember that small steps can make a huge and sustainable change in someone's diet."

#5: Know Your Options

Many nonnutritive sweeteners such as aspartame, stevia, and sucralose are available on the market.[3] Consumers should understand when these substitutes should and should not be used.

"If someone was recently diagnosed with diabetes, and they're consuming two-to-three sugar-sweetened beverages; lots of sweets; processed foods; and no vegetables, whole grains, or other healthy foods, then a nonnutritive sweetener could serve as a good stairstep down for them. If somebody is having a sweetened beverage only on occasion, it's not necessary that [they] use a nonnutritive sweetener as an alternative," advises Dr. McWhorter.

#6: Leverage Reliable Information

The *Dietary Guidelines for Americans, 2020-2025*, published by the U.S. Department of Agriculture and the U.S. Department of Health and Human Services, offers a summary of the most recent research and is updated every five years.[4]

This publication contains useful information for everyone. "The guidelines provide advice on how someone can improve their nutrition to overall improve their health and reduce the risk of chronic diseases," says Dr. Tewksbury. "So, medical assistants can confidently point people to the dietary guidelines."

#7: Seek the Right Help

Health care professionals can provide general dietary guidance, but when patients present with chronic diseases, bringing a registered dietician into the mix is warranted. "Let's say that you're talking to a patient who has cardiovascular disease, diabetes, cancer, or even obesity. These are conditions that really require subspecialized nutrition treatment. So, it's best to refer to a specialist," says Dr. Tewksbury.

Health care providers should make sure that patients do not consider these referrals as punishment for a perceived failure. "To ensure that a patient considers a referral as a good thing, health care providers, including medical assistants, need to communicate the referral in positive terms or as a way to help that person get to where they want to be [nutritionally]," notes Dr. McWhorter.

#8: Indulge in Moderation

"In nutrition, we often forget about our humanity," concludes Dr. McWhorter. "We eat food for more than survival. We like sugar because the flavor is delicious. We want to have an enjoyable diet. We know that [abstaining] doesn't work. So, the goal should be to enjoy a balanced and sustainable dietary pattern. … Oftentimes, we think that a diagnosis of diabetes means you can never eat any of those foods again. It's better to realize that if you eat a balanced meal, you can occasionally have a sweet treat." ✦

Sugar Bites Back

While many of sugar's harmful effects take a long time to materialize, indulgence in the sweet stuff can bring on the dreaded sugar hangover in just a couple of hours.

This postindulgence hyperglycemia—or excess of glucose in the bloodstream—results in various symptoms[5]:

- Fatigue
- Fogginess
- Blurred vision
- Increased thirst
- Headaches

Of course, the best way to avoid a sugar hangover is to steer clear of the sweets. Fortunately, a sugar hangover is merely a nuisance for most people. However, the blood sugar spikes associated with these hangovers could affect overall health if they occur frequently enough.[5]

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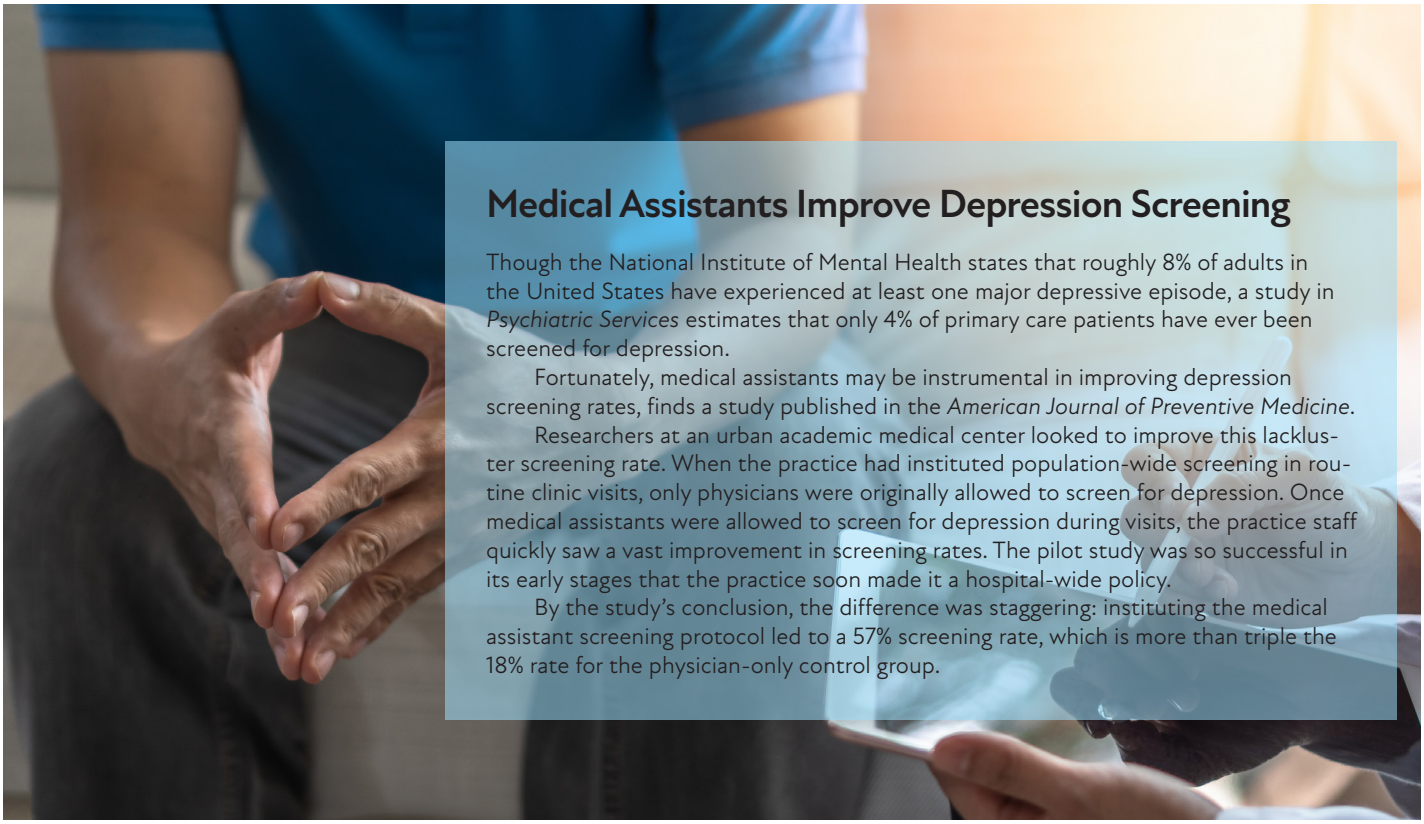


Medical Assistants Improve Depression Screening

Though the National Institute of Mental Health states that roughly 8% of adults in the United States have experienced at least one major depressive episode, a study in *Psychiatric Services* estimates that only 4% of primary care patients have ever been screened for depression.

Fortunately, medical assistants may be instrumental in improving depression screening rates, finds a study published in the *American Journal of Preventive Medicine*.

Researchers at an urban academic medical center looked to improve this lackluster screening rate. When the practice had instituted population-wide screening in routine clinic visits, only physicians were originally allowed to screen for depression. Once medical assistants were allowed to screen for depression during visits, the practice staff quickly saw a vast improvement in screening rates. The pilot study was so successful in its early stages that the practice soon made it a hospital-wide policy.

By the study's conclusion, the difference was staggering: instituting the medical assistant screening protocol led to a 57% screening rate, which is more than triple the 18% rate for the physician-only control group.

Education Improves
Lung Cancer Screening Rates

Lung cancer screening (LCS) education for providers and medical assistants can result in greater knowledge and better care for high-risk patients, reports a study in *Clinical Lung Cancer*.

The study, which took place at two federally qualified health centers, aimed to increase provider and medical assistant knowledge regarding LCS and, in turn, evaluate the change in low-dose computed tomography (LDCT) scans after increased education. This training covered topics such as LCS eligibility criteria, smoking cessation, and shared decision-making.

Participants showed higher confidence in their abilities to accurately identify LCS candidates after the training. This increased confidence led to a massive increase in LDCT orders. The combined clinics went from nine orders in the year before the training to 336 orders in the year and a half after training.

A little bit of LCS education can go a long way in protecting our most vulnerable populations. ✦

Inadequate Blood Pressure Practices

Blood pressure (BP) readings are widely regarded as a crucial piece of health information. Surprisingly, their importance often does not translate into accurate assessments, according to a recent study in the *American Journal of Preventive Cardiology*.

The study surveyed health care professionals to determine whether they were accurately assessing BP, which was defined by the following:

- Routinely checking BP in both arms
- Checking BP two or more times per visit
- Waiting five minutes after patients sit before checking BP

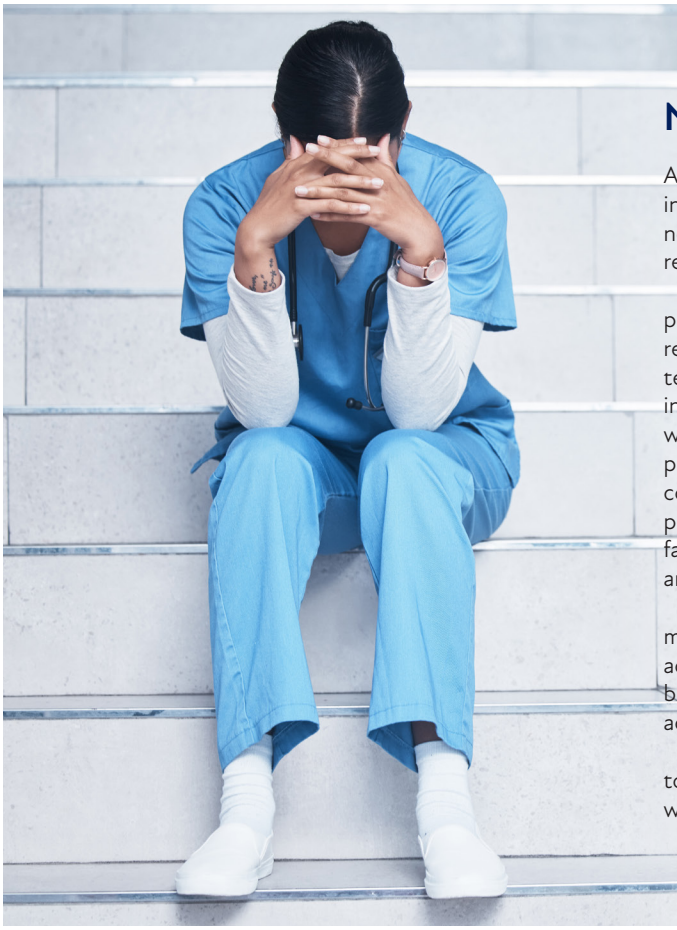
The results were less than ideal. Of the 571 health care professionals who responded, 51% checked BP only once per visit, and 55% checked BP in only one arm. Most did wait at least five minutes before checking BP, but nearly 36% reported waiting fewer than five minutes or not knowing how long they waited.

Increase in HPV Vaccine Hesitation

The human papillomavirus (HPV) vaccine is proven safe and effective, but distrust in its safety has increased in recent years, according to research published in *JAMA Pediatrics*.

Data from the National Immunization Survey–Teen showed that from 2008 to 2019, self-reported safety concerns and adverse effects increased as the primary motive for vaccine refusal. In 2008, safety concerns were the primary reason for refusal in only 5% of respondents. By 2019, this number exploded to 26%, a near fivefold increase.

While misinformation campaigns regarding vaccination safety continue to grow and cast misplaced doubt, medical assistants are well positioned to help educate patients about the HPV vaccine and its abilities to safely reduce preventable illness.



New Tool Targets Burnout in Health Care

As health care organizations work to combat burnout, identifying and employing impactful interventions is crucial. To that aim, a new tool called the Reducing Burnout Driver Diagram (RBDD) was recently presented in the journal *Healthcare*.

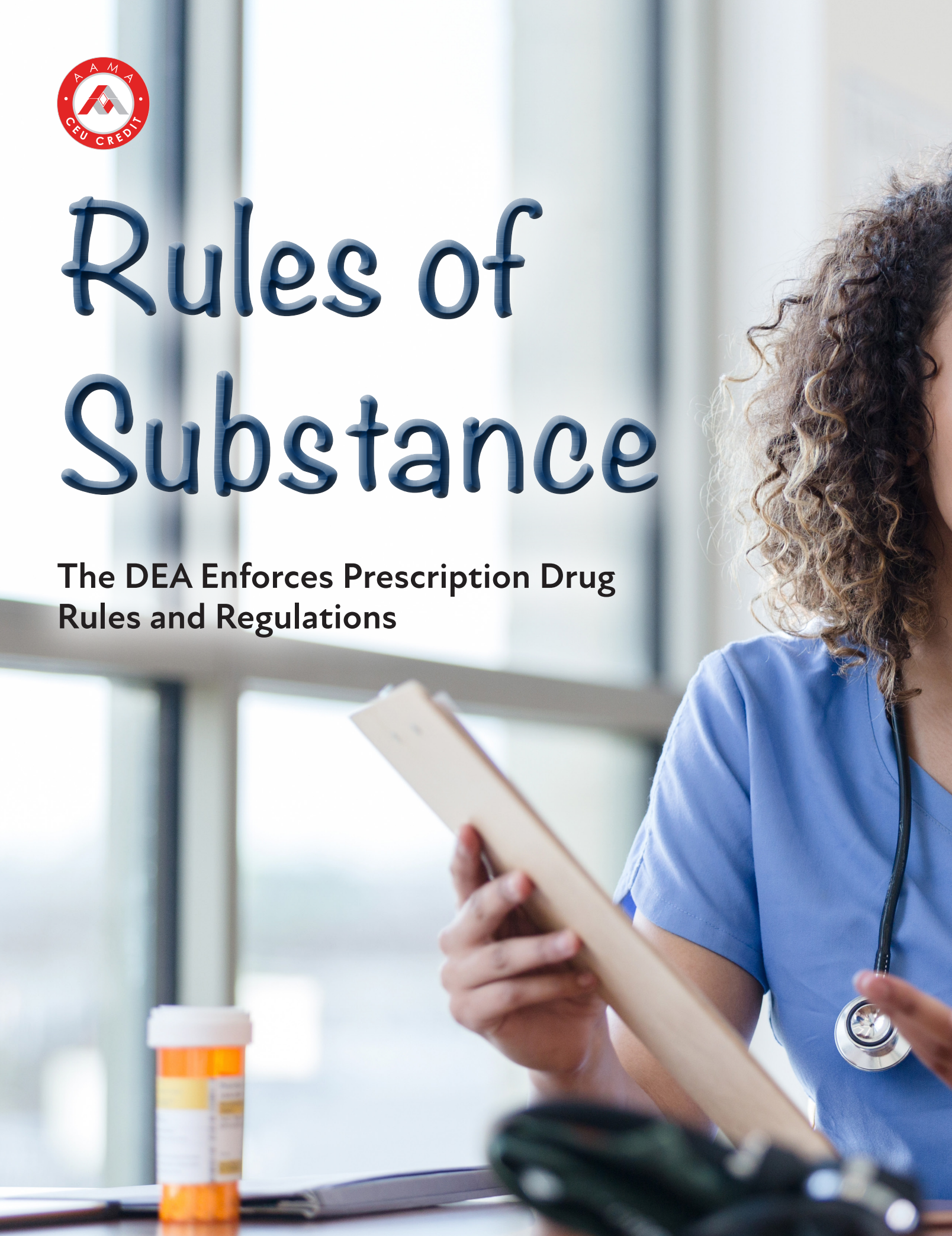
This tool was introduced to 14 primary care teams and used a primary and secondary drivers system to identify areas that would reduce staff burnout. Seven primary drivers were offered to the teams, including engaging and activating leadership, strengthening the team and building camaraderie, and promoting a culture of wellness. Each had its own set of secondary drivers that identified processes and norms that help move primary drivers. For example, connecting to meaning and purpose—a primary driver—was supported by secondary drivers such as engaging patients and their families in improvement efforts, connecting staff to work outcomes, and using team documentation.

Practices chose the primary drivers they thought would be most impactful and worked on quality improvement projects to achieve their goals. Participants found that the RBDD reduced burnout by building teamwork and giving staff more control over addressing workplace concerns.

While there remains no simple solution for addressing burnout, tools such as the RBDD can help practices by providing a framework for a better future.

Rules of Substance

The DEA Enforces Prescription Drug Rules and Regulations



By Mark Harris

The practice of medicine is a complex activity that can involve many professional responsibilities. For physicians and other licensed medical practitioners, one major area of clinical practice involves medication prescription.

The ability to prescribe medications, including controlled substances, is subject to an array of federal and state regulatory controls. The regulatory process includes federal oversight from the U.S. Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, the Drug Enforcement Administration (DEA), and state agencies. The goal of this multifaceted regulatory system is to ensure prescription drugs that enter the market are safe, effective, and appropriately managed and dispensed.[1]

In the United States, the DEA is primarily responsible for regulating the use of controlled substances. By definition, a controlled substance includes any drug, substance, or chemical for which legal access is restricted due to its potential to be abused or cause addiction. The DEA's regulatory authority covers the manufacture, handling, storage, use, and distribution of all controlled substances. Notably, controlled substances can include both legal prescription drugs used for medical purposes (e.g., diazepam [Valium] and methylphenidate [Ritalin]) and illegal substances (e.g., heroin and LSD) with no known medical use.[2]

Classifications

The DEA's regulatory authority originates in the Controlled Substances Act, which took effect in 1971 as part of broader drug abuse, prevention, and control legislation. Under the Controlled Substances Act, the DEA classifies drugs, substances, and certain chemicals according to five main categories,

Prescription Drug Monitoring Programs

A prescription drug monitoring program (PDMP) is an electronic database that tracks controlled substance prescriptions. A PDMP can help identify patients who may be misusing prescription opioids or other prescription drugs and who may be at risk for overdose. Clinical practice guidelines encourage the use of a PDMP before prescribing to assess a patient's history of controlled substance use.[17]

which are also called *schedules*. The schedule a drug, substance, or chemical falls into is determined by various qualifying factors including—and most importantly—its accepted medical uses and potential for abuse or dependency in humans.[3]

The classification system the DEA uses for controlled substances is summarized into five parts:

- **Schedule I.** These drugs, substances, or chemicals have no accepted medical use and the highest potential for abuse and psychological or physical dependence. Heroin, LSD, and methylenedioxymethamphetamine (ecstasy) are examples.[4]
- **Schedule II.** These drugs, substances, or chemicals are dangerous with a high potential for abuse or severe psychological or physical dependency. This classification includes cocaine, oxycodone (Oxycontin), methamphetamine (Desoxyn), fentanyl (Duragesic), amphetamine and dextroamphetamine (Adderall), and methylphenidate (Ritalin). Schedule II also includes combination products with less than 15 milligrams of hydrocodone per dosage unit (Vicodin).[4]
- **Schedule III.** These drugs, substances, or chemicals pose a moderate-to-low potential for physical and psychological dependence. Examples include products that contain less than 90 milligrams of codeine per dosage unit, such as Tylenol with codeine, as well as anabolic steroids, ketamine, and testosterone.[4]
- **Schedule IV.** These drugs, substances, or chemicals have a low potential for abuse or dependency. Examples include products used for anxiety or as sleep aids, such as alprazolam (Xanax), diazepam (Valium), and zolpidem (Ambien).[4]
- **Schedule V.** These drugs, substances, or chemicals have the least potential for abuse. This classification includes antidiarrheal, antitussive, and analgesic products with limited quantities of narcotics in the preparations. For example, some cough preparations with less than 200 milligrams of codeine, such as Robitussin AC, are classified under Schedule V.[4]

For the purposes of criminal prosecution, under DEA rules, a drug or substance does not have to be listed as a controlled substance to be classified as a Schedule I or Schedule II product. As such, a controlled substance analogue is a substance considered pharmacologically or structurally similar to a Schedule I or Schedule II product but is not approved for sale in the U.S. market.

DEA Registration

Controlled substances constitute about 10% of all prescriptions written in the United States. In 2017, 88% of physicians were reported to be prescribing controlled substances.[5]

Under the Controlled Substances Act, a closed system of drug distribution is established for managing controlled substances by qualified medical practitioners. The federal statutory provisions are designed to create a legal distribution chain for controlled substances based on both the registration of licensed prescribers and documentation of prescribing and dispensing activity.[6]

To prescribe controlled substances for medical uses, physicians, dentists, nurse practitioners, optometrists, veterinarians, physician assistants, and other licensed practitioners must apply for a DEA registration number. Such registration is granted by the DEA based on the applicant's medical license and ability to meet various certification requirements.

With DEA registration, a physician or other practitioner is assigned a DEA number that allows them to write prescriptions for legal controlled substances. This registration system also provides the DEA with the means to track and monitor prescribing activities, including tracking who is prescribing the substances and the quantities prescribed. Notably, a DEA number follows a specific informational format comprised of two letters, six numbers, and one check digit. The format is designed to identify the prescriber and verify their registration status. Accordingly, pharmacies, health clinics, HMOs, and health insurers are required to use a provider's DEA number to verify their eligibility to prescribe controlled substances.[7]

To clarify, a physician or other qualified clinician requires a DEA number to prescribe controlled substances for medical use. But, of course, not all prescription medications are considered controlled substances. Antibiotics and blood pressure, cholesterol, and diabetes medications, for example, are categorized as noncontrolled substances. For this reason, a prescribing practitioner who does not prescribe controlled substances can legally practice without a DEA number. And yet, because most pharmacies and insurance companies use the DEA number to identify health care providers, working without one could be very difficult for a prescribing practitioner.[8]

Furthermore, in some instances, state pharmacy regulations might be interpreted to require a DEA number for all prescriptions. Thus, while the use of the DEA number for identification purposes is not a DEA-approved practice, it has become a practical reality in the pharmacy corner of the health care system.

Additionally, individual health care providers use the National Provider Identifier as a unique health identifier. The National Provider Identifier is a standard identifier issued by the Centers for Medicare & Medicaid Services for transactions or services covered under the Health Insurance Portability and Accountability Act of 1996. When it comes to processing claims or fill-

ing prescriptions, medical staff should not confuse the DEA number with the National Provider Identifier when identifying prescribing physicians.[9]

Compliance Is Key

The management of prescription medications generally is a carefully regulated area of health care. With controlled substances especially, DEA rules combine with state requirements to create a rigorous regulatory tapestry that health care providers need to understand and comply with.

"In a medical practice, there can be both DEA rules and specific state rules for how to handle any kind of prescription controlled substance," says David J. Zetter, lead consultant at Zetter HealthCare in Mechanicsburg, Pennsylvania. "If a physician is still using prescription pads, for example, there have always been rules on where those have to be kept or locked up, and not just left out on someone's desk. Of course, it's different today with electronic health records and so much being done electronically, via fax into a pharmacy, and so on. But if you're dispensing any prescription products from within your organization, there are certain rules and requirements the practice should be complying with."

Indeed, when health care providers violate DEA rules, however inadvertently, problems can ensue. A cautionary tale is offered by Zetter of the consequences when even what can be considered a minor rule is violated. "A medical practice I worked with got in trouble with the DEA for not maintaining the original copies of the DEA registration certificates for each provider with a DEA number," he reports. "This was a [medical] practice with a large number of providers and multiple tax IDs. The practice paid the DEA registration fees for each of their providers."

When a health care provider successfully applies for a DEA number, the certificate from the DEA is mailed to the provider, says Zetter, who is also a past president of the National Society of Certified Healthcare Business Consultants. "The original document from the DEA has to be maintained on-site at the practice," he explains. "In this case, the practice wasn't. … They were unaware of the requirement. Instead, they had duplicate copies of the DEA certificates downloaded from the DEA website. As a result, they ended up coming under a memorandum from the DEA that they were now being monitored."

Consequently, every time the practice applies for a new DEA certificate, it must first communicate in writing their intention to do so to the regional DEA office in their state. The practice then has to wait 10 days before formally submitting the application for a new DEA registration number. This requirement will be maintained until a date determined by the DEA, says Zetter.

Insight on On-Site Storage

For clinics such as urgent care or other facilities that store controlled substances on-site, ensuring drugs are kept secure is a top priority. For example, Zetter describes an urgent care practice he visited at a newly built Florida facility. "All the drugs they prescribe are kept in a locked room," he reports. "Every bin [identifies] exactly which drug is in it. All the drugs are logged, with lot numbers and other identifying information so the practice can track every bottle or drug that enters the facility. This is important because they're always rotating their supplies, making sure nothing is getting old or out of date, and tracking things of that nature. They are also monitoring access to the room, documenting who enters the room and at what time. No one can just go in and pull some drugs out. The practice is always making sure that the inventory is safe and secure."

Practice procedures and protocols for managing on-site controlled medications should be formally documented in the procedure manual, advises Freda Miller, CMA (AAMA), a former administrator for an urgent care practice in Juneau, Alaska. "If and when things do change regarding any class of medication of drugs," says Miller, "you can then change whatever you need to in your procedures manual to keep up with the compliance requirements."

Miller describes the practice protocol she used to securely manage controlled substances: "We had a locked cabinet, and there were only two keys," she says. "When the shift started in the morning, two people were assigned the keys to the locked cabinet where drugs were kept. It might be two different people the next day, but only two people ever had the keys so there was limited access. I also had a key because I would do a count of the drugs every week to make sure the counts I was receiving were accurate."

As an experienced administrator, Miller emphasizes the importance of up-to-date record keeping. "Don't ever let the paper-

DEA Office Inspection Tips

The Drug Enforcement Administration (DEA) is authorized to inspect any physicians who met the requirements of the Drug Addiction Treatment Act of 2000 (DATA)[15] to obtain waivers.

The DEA will inspect a DATA-waivered physician every 15 years from when they are approved to prescribe buprenorphine, with the first inspection usually taking place within the first three years after they are initially waivered. If a physician applies for a higher patient limit, then that 15-year inspection period renews from the date their higher limit is approved, and they will likely be inspected again within the first three years after their patient increase.[18]

The DEA inspector may ask the DATA-waivered physician to provide the following details18:

- Current DEA registration denoting waivered status
- Patient prescription log
- Patient dispensing log (if dispensing)
- Safe and secure area where buprenorphine-naloxone combination and buprenorphine stock bottles are stored
- A list of patients receiving buprenorphine-naloxone or buprenorphine prescriptions (the list may identify patients by codes or numbers to protect patient privacy)
- Physician's access to behavioral health professionals

National Prescription Drug Take Back Day

The Drug Enforcement Administration's annual National Prescription Drug Take Back Day (April 30, 2022) aims to provide a safe, convenient, and responsible means of prescription drug disposal across the nation while also educating the public about the potential for medication abuse.[19]

work on the drugs you manage get behind or be inaccurate," she says. "If the paperwork is behind or something doesn't seem right, stop right then and go back and get it figured out before you let any time pass. You have to be able to show exactly what has happened to the drugs you manage for a two-year period. You don't want to get into a situation where there might be a breach in your protocol that you didn't discover right away just because you didn't keep up with your end of the paperwork."

Managing the Opioid Crisis

In recent decades, another area of concern for the DEA involves the rising incidence of opioid overdose deaths. From 1999 to 2019, nearly 500,000 people died from opioid overdoses. In 2019, more than 70% of the 70,630 drug overdose deaths that occurred in the United States involved an opioid drug.[10]

This epidemic of opioid overdose deaths began in the 1990s with increased legal prescribing of opioid medications. In the past decade or more, however, there has been a shift toward an increase in deaths attributed to illegal heroin use. Since 2013, overdose deaths due to the use of fentanyl, an illicitly manufactured synthetic opioid, have significantly increased.[10]

"The misuse of opioids is a public health crisis," says Shawn A. Ryan, MD, MBA, a member of the American Society of Addiction Medicine (ASAM) board of directors. Recognizing the scope of the opioid crisis in society, ASAM works to support an improved understanding of opioid addiction and access to effective treatments for patients with opioid use disorder (OUD).

"Our organization is a physician and other clinician membership group of over 6,000 members that's focused on increasing access to evidence-based addiction treatment and education around all facets of addiction medicine for medical staff and the public," remarks Dr. Ryan. "We're also involved in furthering improvement in the quality standards in addiction medicine, not just improving access to care."

ASAM and other medical groups also advocate at the policy level for the medical needs of patients with OUD and substance use disorder. This includes addressing the impact of DEA rules and regulations on the management, availability, and dispensing of prescription medications used in treatment.

"The DEA and regulation of controlled substance prescribing and distribution is necessary," says Dr. Ryan. "Of course, it's not an exact science because humans and medicine and patient care are so complicated. It's a little tough to write rules that address all patients at all times in all scenarios. That being said, part of the opioid crisis is present because of underregulation and limited oversight of opioid distribution from the 1980s to the 2000s. For this reason, regulation and oversight is a necessary component of controlled substance and prescribing distribution."

Indeed, the regulatory role of the DEA in health care is a complex one—and not always without criticism or varying assessments of its effectiveness. For this reason, Dr. Ryan says health care providers should not overlook opportunities to share their input and perspectives with health care regulators involved in setting health care policy.

"It is important for health care providers to share their expertise and experiences working with drug addiction issues related to controlled substances with the DEA and other state boards," says Dr. Ryan. "I've worked with them, and I have a lot of respect for the challenges in front of the DEA. Of course, some folks are very binary on the DEA—that it's good or bad or whatever they may feel about it—but … its role is multidimensional. It's complicated. I think what we need is to advocate for medical providers in every setting, including medical staff, to communicate as much as they can, within reason, the practice realities."

As Dr. Ryan notes, invitations for public comment on regulatory rule changes are often part of the federal and state policymaking process. "Medical practitioners should not ignore notices or invitations from the DEA or a state board of pharmacy medicine for public comment on issues related to how controlled substances will be prescribed or regulated, including concerns with telehealth policies," he says. "We need to take the time to comment and not let that email from the DEA fly by. Whether it's a single practitioner, a practice group manager, or a health system administrator involved in the pharmacy supply chain with responsibilities related to controlled substances, they need to speak up and be heard."

In its oversight capacity, the DEA—in collaboration with the FDA—establishes production quotas regulating the available supply of prescription opioid medications. In recent years, these production quotas have been steadily reduced for such medications. In fact, the production of widely used opioid pain medications such as oxycodone and hydrocodone has declined by more than half over the most recent five-year period. Concurrently, opioid prescriptions have also declined.[11]

Notably, the American Medical Association (AMA)[12] and other medical leaders have expressed concerns that DEA efforts to contain misuse of opioids unfairly stigmatize the legitimate use of prescription opioid medications. In turn, these concerns spill over into related criticisms regarding opioid prescribing guidelines[13] adopted by the Centers for Disease Control and Prevention in 2016. The AMA fears that arbitrary limits and other restrictions on opioid prescribing hurt patients who have legitimate needs for opioid medications.[12]

"The nation no longer has a prescription-opioid-driven epidemic," writes James L. Madara, MD, executive vice president and CEO of the AMA, in a 2020 commentary[12] on

the "CDC Guideline for Prescribing Opioids for Chronic Pain, 2016."[13] "We are now facing an unprecedented, multifactorial and much more dangerous overdose and drug epidemic driven by heroin and illicitly manufactured fentanyl, fentanyl analogs, and stimulants. We can no longer afford to view increasing drug-related mortality through a prescription opioid-myopic lens."[12]

Regulating Medication Assistance

Health care leaders will continue to assess these complex issues. The AMA, ASAM, and other advocates for addiction medicine support a comprehensive public health approach to effectively address the harms caused by the misuse of opioids. The urgency of this advocacy is apparent in the social costs of controlled-substances misuse evident in the epidemic of opioid overdoses, emergency room visits, deaths, and untreated substance use disorders.

One important treatment tool in the campaign against opioid addiction involves prescription buprenorphine. Approved by the FDA in 2002, buprenorphine relieves withdrawal symptoms and pain while also helping patients who have OUD to normalize brain function. With methadone and naltrexone, buprenorphine is one of three FDA-approved medicines for treating opioid dependence.[14]

The use of buprenorphine is considered a medication-assisted treatment and medication for opioid use disorder. As such, buprenorphine is prescribed as part of a comprehensive treatment plan that typically includes counseling or other behavioral health services.

Notably, buprenorphine is the first medication for patients with OUD that can be legally prescribed or dispensed in medical practices, outside of opioid treatment programs. Buprenorphine's availability in medical practices has increased access to treatment for many patients.[15]

Qualified practitioners who wish to administer, prescribe, and dispense buprenorphine in a practice setting are required to file an application for a

Medical Assistants' Role in Opioid-Related Care

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buprenorphine waiver certification with the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration. In turn, prescribing practitioners are subject to regulatory limits, depending on their level of training and how many patients they may treat with buprenorphine at any one time. Without a granted exemption, many practitioners are limited to treating no more than 30 patients at a time.[15]

Unfortunately, 1 in 5 pharmacies refuse to dispense buprenorphine to patients.[14] Some pharmacies reportedly are reluctant to dispense buprenorphine due to fears over the DEA's reputation for what some consider overzealous enforcement of controlled substance rules. Unfortunately, despite buprenorphine's reputation as a valued medication for OUD, many patients encounter barriers in accessing this medication.[16]

"Regulation and oversight are necessary parts of the system for prescribing and dispensing controlled substances," says Dr. Ryan. "But it is also important that we recognize the different controlled substances and how they need to be controlled and managed. For example buprenorphine—the most popular brand name is Suboxone—should not be as restricted as the rest of the opioid controlled-substance family. Yet what we see at the patient level are challenges for patients when they go to the pharmacy to get their medications for their opioid addiction. These are patients who need to stay on their medication-assisted treatment for OUD. This is because buprenorphine, which is a partial agonist opioid but an opioid nonetheless, gets caught up in the attempt to find the right regulatory framework in the management of opioids."

All-Out Outreach

Obviously, opioid misuse constitutes a significant public health issue. As the AMA, ASAM, and other health leaders acknowledge, the goal of public health policy should be to ensure every patient in need has access to the full array of appropriate treatment options. In this context, the discussion of DEA rules and regulations for controlled substances invariably touches upon many larger public and community health issues.

Thanks to medical advocacy, for example, community access to the overdose-reversal drug naloxone (Narcan) has become an important component of the public health response to the opioid crisis. Medical and safety first responders, community health activists, and others are helping to bring this life-saving medication, which quickly and safely reverses an opioid overdose, into communities at risk for heroin and opioid addiction and misuse. Additionally, physicians are able to co-prescribe naloxone, along with their regular opioid prescriptions, to patients in treatment for OUD.

One individual with experience addressing the challenge of community drug addiction is Lee Rusch, director of the West Side Heroin/Opioid Task Force in Chicago. The task force works in partnership with community leaders, the Chicago Department of Public Health, area hospitals, and others to improve direct access to health care services for people who use addictive drugs. This work includes training volunteers and distributing naxolone in communities hard-hit by opioid overdose and opioid-related deaths.

"About 40% of all opioid overdose deaths in Chicago occur in a group of neighborhoods on the city's west side," says Rusch. "Our response to opioid overdoses

in these neighborhoods has been to get naloxone, or its [brand-name] nasal spray version, Narcan, out into the community. The goal is to make its use ubiquitous in the community—to make the presence of naloxone almost like having smoke detectors in homes."

Community outreach initiatives such as this complement the work of health care providers who offer in-office clinical care for OUD and substance use disorder. As such, Rusch encourages health care providers, including staff who he notes often live in the same communities in which they work, to take the time to better understand the reality of drug addiction issues in their local community.

"I would encourage people working in health care to get out and see what's happening in their community, meet the providers who are closest to the issue, and continually look at ways to improve care in the system," he says. "It's estimated that 60% of people who have OUD or substance use disorder have co-occurring disorders, and so it's important to understand that we're dealing with something much more complex than somebody who has a choice to 'get high' today. This is often part of a larger health challenge of trauma-informed care."

While exploring the role of the DEA in the regulation of controlled substances, health care professionals should not lose sight of these larger medical and societal challenges. "In a sense, we are trying to tilt the system in a certain direction—to align community outreach more closely with those in health care who are already doing great work in harm reduction and destigmatizing addiction issues," notes Rusch.

In the health care system, issues of regulatory responsibility for prescription controlled substances similarly intersect with the many patient care challenges involved in addiction medicine, pain management, and related clinical and treatment issues. In this sense, oversight of prescription medications classified as controlled substances requires an ongoing assessment of a complex balance of regulatory, policy, and medical concerns.

In the end, the management of prescription controlled substances in ways that are safe and benefit patients and society requires cooperation and engagement from everyone—regulators, clinicians, community leaders, and patients—to prevail in this vital part of health care. ✦

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Drug Enforcement Administration

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T F

☐ ☐ 1. Federal statutes limit the oversight and regulation of medications (including controlled substances) to federal agencies, such as the Drug Enforcement Administration (DEA) and excludes state agencies.

☐ ☐ 2. The pharmacy laws of some states require that prescribing providers have a DEA number for prescribing any medication—both controlled substances and noncontrolled substances.

☐ ☐ 3. A controlled substance is defined as a chemical, drug, or other substance for which there are legal restrictions on access because of the potential threats to individuals for addiction or abuse.

☐ ☐ 4. Photocopies of each licensed provider's DEA certificate that includes each provider's DEA number, rather than the original certificate, may be kept in the practice setting.

☐ ☐ 5. The authority of the DEA is limited to illegal substances that have no known medical use or benefit.

☐ ☐ 6. Fentanyl and heroin abuse have become a more dangerous threat to Americans' health than prescription-opioid abuse, according to the CEO of the American Medical Association.

☐ ☐ 7. Naloxone is an effective drug for reversing an opioid overdose.

☐ ☐ 8. Health clinics, pharmacies, and managed care organizations use their own DEA number when one of their licensed providers orders a controlled substance, not each provider's DEA number.

☐ ☐ 9. A licensed provider with prescriptive authority is required by federal law to have a DEA number to issue prescriptions for any medications.

☐ ☐ 10. Prescribing providers are permitted to use either the National Provider Identifier number or DEA number when prescribing a controlled substance.

T F

☐ ☐ 11. Best practices incluce putting all policies and procedures for handling controlled substances in the procedure manual, strictly enforcing the procedures, and limiting access to the room in which the controlled substances are kept.

☐ ☐ 12. Although scientific evidence indicates that buprenorphine is effective in treating opioid use disorder, licensed providers cannot yet legally prescribe or dispense buprenorphine.

☐ ☐ 13. A DEA registration number is issued to providers if they have the necessary license and (for providers who have been in practice) if the history of their prescribing and dispensing of controlled substances does not give evidence of misuse or overprescribing.

☐ ☐ 14. Drugs that have some medical benefit and a low likelihood of addiction or abuse are classified as Schedule IV substances.

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Vitamin D

Vital for Health

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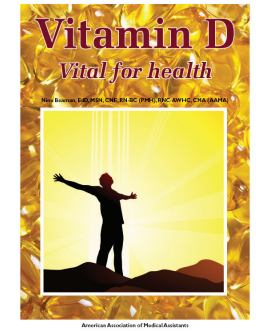

When acquired in the correct dosages, vitamin D offers many benefits for the human body. Discover how to promote vitality by studying the positives—and negatives—that come with this substance.

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Subtracting Additives

Carboxymethylcellulose (CMC) may not roll off the tongue, but it can be a wrecking ball for your gut's microbiome, according to a recent study in *Gastroenterology*.

The study looked at how CMC—a common food additive used as an emulsifier in many processed foods, such as ice cream, bread, and chewing gums—affected study participants. Participants who were given foods with CMC experienced a short-term negative impact on their gut microbiome. This included a reduction in short-chain fatty acids and free amino acids that promote good health. This disruption to the gut microbiome may be linked to an increased rate of inflammatory disease.

To maintain health by avoiding unhealthy food additives, Children's Health of Orange County offers several tips:

- **A matter of fact.** Read food labels and compare products, opting for those that use fewer additives.
- **The cutting board.** Chop processed foods from your diet when you can, and replace them with minimally processed products.
- **Local time.** Farmer's markets and other sources of local produce often offer fruits and vegetables with fewer additives.
- **Tricks for a trade.** Reduce additives with easy swaps (e.g., air-popped popcorn instead of microwaved or blocked cheese instead of shredded).
- **House rules.** Control what goes into your food by making meals at home. ✦

Live the Dream

Time to brew up some chamomile and find your sleep mask. Improved sleep quality can also boost your mental health, according to a meta-analysis from *Sleep Medicine Reviews*.

Researchers analyzed the results of 72 sleep improvement interventions across 65 studies and found that an increase in sleep quality reduced depression, anxiety, stress, and other conditions. Additionally, the more sleep quality improved, the greater the mental health outcomes improved along with it.

Ready for curtain call? Set the stage for the best sleep performance with simple suggestions from Healthline:

- Increase bright light exposure during the day and reduce blue light exposure in the evening to preserve your circadian rhythm.
- Avoid snacks, caffeine, and alcohol late in the day.
- Upgrade your sheets, mattress, and pillow to optimize your sleep time.
- Find your optimal sleep temperature—about 70 F is ideal for most people.
- Time your sleep right: sleep and wake at consistent times, and avoid long or irregular naps during the day.

A Toast to Breakfast

Do you find yourself putting breakfast on the back burner on a regular basis? Your nutrition may be getting burned, suggests *Proceedings of the Nutrition Society*.

The study found that those who skipped breakfast showed higher calorie, carbohydrate, and saturated fat intake than those who ate breakfast. Despite these increases, breakfast skippers were also less likely to reach their recommended amounts of vital nutrients such as folate, calcium, and vitamin C.

Kick *your* nutrition into high gear with a balanced breakfast. Chewing over the details? The American Heart Association suggests planning ahead so time is never an issue. Fill your fridge with easy grab-and-go options, such as muffins, hard-boiled eggs, or mason jars of fat-free yogurt and frozen fruit. Or, fill a thermos with easy-to-assemble foods, such as smoothies or instant oatmeal. ✦

Finding Your Footing

Don't forget to treat your feet right, even when you're at home, argues orthopedic foot and ankle specialist Sean Peden, MD, in *Yale Medicine*.

Dr. Peden recommends supportive footwear for at-home use, as walking barefoot can cause additional stress on your plantar fascia, tendons, arches, and joints. By choosing slip-on footwear with a hard sole for home use, you can reduce the chance of injury.

Improper footwear could potentially cause Achilles tendonitis—inflammation of the Achilles tendon that spans the calf to heel—or plantar fasciitis, which is caused by inflamed tissue at the bottom of the foot and can cause extreme heel pain, especially in the morning.

While proper footwear is a great start, exercise and physical therapy can also mitigate potential injury risk. Most importantly, don't be afraid to speak with a physician if you have persistent foot pain; it's better to intervene early when treatment options are more numerous and less invasive.

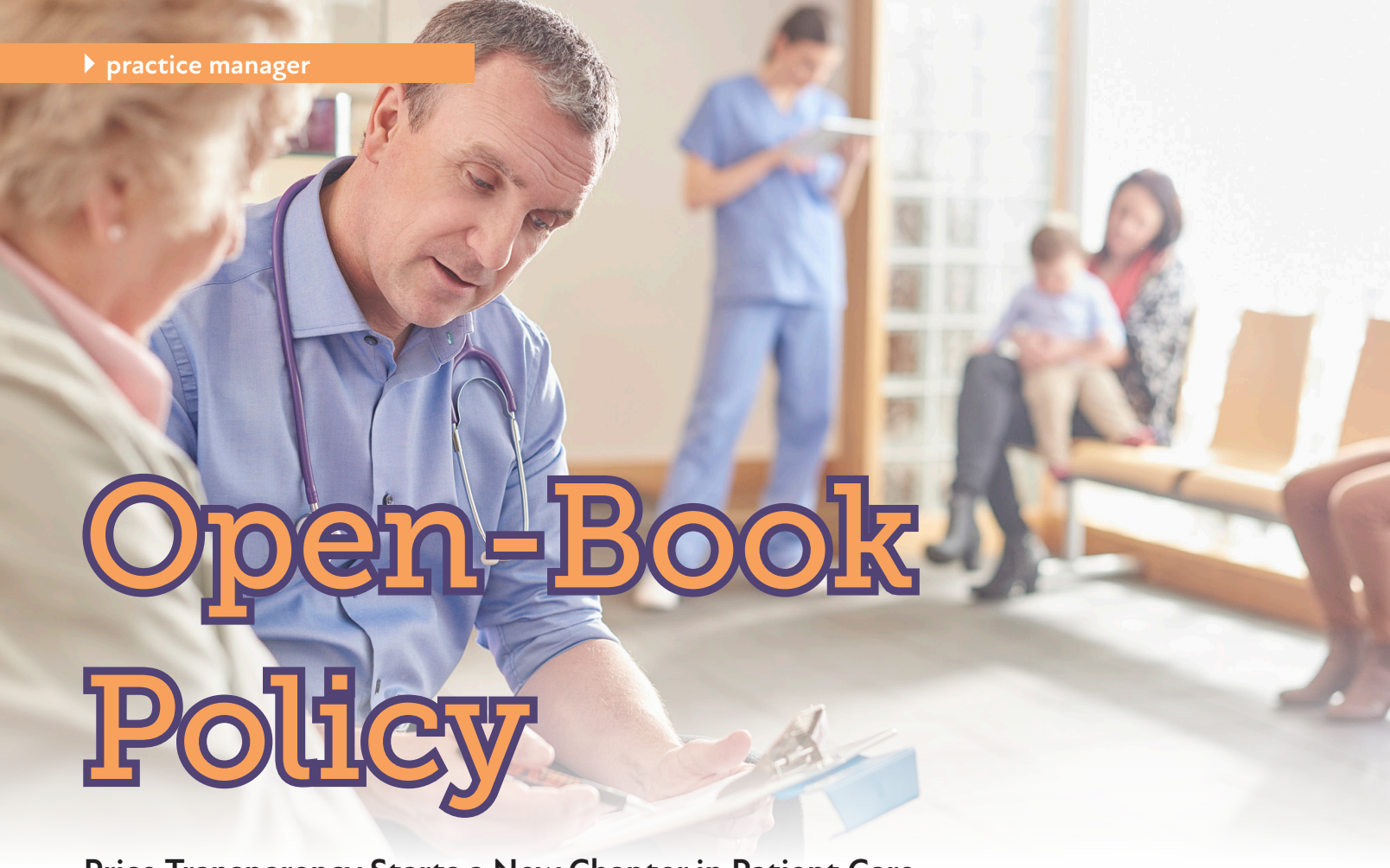
Siri, Look at This Mole

As smartphone use has become commonplace, so too have voice assistants. While they may be great at baking conversions and detailing the local weather forecast, medical questions are a different story, warns one study in the *Annals of Family Medicine*.

This study's researchers assessed the accuracy of four voice assistants when asked, "Should I get screened for [X type of] cancer?" for 11 cancer types. The researchers documented the voice assistants' abilities to understand the questions and provide accurate information through web searches and verbal responses. The researchers used U.S. Preventive Services Task Force's cancer screening guidelines to determine accuracy.

Apple Siri, Google Assistant, and Microsoft Cortana all understood 100% of the queries. However, their handling of the questions was less impressive. Siri had the highest rate of accuracy (70%) for producing correct information from web searches, while Cortana (68%) and Google Assistant (67%) had similarly underwhelming rates. Worse yet were the verbal replies wherein Google Assistant and Cortana had 64% and 45% accuracy rates, respectively, and Siri did not work. Amazon Alexa had no accuracy rate for either, as it consistently gave a generic response conveying that it did not understand the question.

As amazing as the technology may be, voice assistants have a long way to go before users can trust them with providing vital health information accurately. And using voice assistants is no match for voicing your health concerns to your primary care physician or a specialist. ✦



Open-Book Policy

Price Transparency Starts a New Chapter in Patient Care

By Brian Justice

In late 2021, the Centers for Medicare & Medicaid Services (CMS) issued new rules regarding increased price transparency for patients, making hospitals responsible for ensuring that health care consumers have the information they need to make informed decisions. Further, beginning in 2022, CMS has increased the penalty for hospitals that do not comply with those rules.[1]

"CMS is committed to promoting and driving price transparency, and we take seriously concerns [that] we have heard from consumers that hospitals are not making clear, accessible price information available online," says Chiquita Brooks-LaSure, the administrator for CMS. "We are also taking action to enhance patient safety and quality care."[1]

First, Do No (Financial) Harm

All stakeholders are on board when it comes to the new emphasis on price transparency.

"It's needed to let true market forces work on price and quality control, like every other service industry," said Jeffrey S. Gold, MD, a family medicine physician in Massachusetts. "Care can't happen if people can't afford it, and [the oath] 'Do no harm' includes doing no financial harm."

"How many places do you go and get items or services without knowing the price?" asks J. Robin Atkins, CMA (AAMA), who works at Augusta University Student Health Services in Augusta, Georgia. "Health care services should be no different [than other services]. Letting patients know up front what the price is helps them decide between what types of treatment they would like to pursue."

This new transparency is being driven by a mindset about health care that has been changing for some time now. Health care organizations have been treating patients more like consumers, and recent events have accelerated that development even more.

"Health care consumerism is growing, perhaps in part due to the economic and financial challenges resulting from the COVID-19 pandemic," comments David Wojczynski, president of TransUnion Healthcare.[2] A survey conducted by TransUnion Healthcare showed that as many as 6 in 10 patients put off seeking medical care and treatment during the pandemic.[2] "Our survey illustrates to providers just how important it is to offer flexible care delivery options and payment experiences for their patients during this period of uncertainty, as well as understand and address individual payment needs."[2]

Benefit$

The importance of price transparency is driven home by the fact that most adults are unaware that the new requirements even

exist. One poll showed that almost 70% did not know whether hospitals are required to make pricing available, and 22% thought that hospitals were not required to.[3]

The benefits of price transparency to patients are obvious.

"Patient care is improved when patients are informed [and] feel confident in their ability to advocate for themselves when it's time to make health care decisions," said Benjamin Fenton of the Fenton Law Group, which specializes in health care law, in Los Angeles, California. "Providing price information is … helping create informed patients and, ultimately, improving patient care. Becoming better educated and informed can help demystify health care and guide the patient's decision-making."

Sharon Smith, CMPE, CPPM, CMA (AAMA), CPC, COC, MBS, a practice manager at Virginia Beach Surgery in Virginia Beach, Virginia, foresees price transparency driving more engaged behaviors in patients.

"It is anticipated that shopping for the best pricing will drive competition and lower prices," she says. "This model would work best for uninsured patients who have to pay out-of-pocket for services."

Fenton is also quick to point out the unexpected benefits of transparency.

"Medical practices that embrace price transparency may find that it yields unexpected benefits," he notes. "A practice with transparent pricing may be able to negotiate better deals with insurance payers and third-party administrators."

"People have high deductibles and copays," adds Rhys Davies, CMA (AAMA), a clinical team lead at Union Medical Group in Terre Haute, Indiana. "Knowing what charges to expect can help patients get better care, and they are more likely to pay the bill when it comes."

An elevated sense of trust in providers correspondingly improves the patient experience and the providers' reputations.

"We believe that price transparency increases patients' confidence in our physicians," says Melanie Robinson, CMA (AAMA), who works at a plastic surgery specialist practice in Louisville, Kentucky. "The practice benefits from having a reputation of being forthright, honest, and trustworthy."

As with all things related to health care, it all comes back to the patient.

"I believe that the fear of not knowing what the final cost will be prohibits patients from receiving much-needed tests and procedures," suggests Smith. "Price transparency helps build trust between the patient and the provider, and patients are more likely to be more compliant with treatment if they know the fees associated with them."

Transparency Pays Off

Still, both patients and practices must come to grips with some issues around health care consumerism.

"Showing costs doesn't always point to improved patient care," says Tom Kennedy, CMA (AAMA), who works with the Broadway Medical Clinic in Portland, Oregon. "But providing clarity does give the patient some reassurance as to what to expect during and after care."

"Informed patients are more likely to understand outcomes from not only a clinical perspective but a financial one too," Smith adds, but with a note of caution: "Higher costs do not equate to better care and neither do lower costs. Systems with a high market share of providers may command higher negotiated rates, and some carrier contracts have clauses that prohibit providers from releasing or publishing negotiated rates. It will be interesting to see how things evolve as the rules affecting insurance carriers requiring their transparency regarding payments for services go into effect."

Every person and entity involved in health care has a stake in the impact of price transparency, and those concerns are driven by the wants and needs of the most important stakeholders of all—patients.

"Price transparency … verifies the working agreement," said Dr. Gold. "I want to work for patients. All doctors do, and patients should want us working for them."

That new understanding of the patient-provider relationship is good for both.

"Price transparency increases trust between patients, providers, and staff," says Atkins. "And word-of-mouth from a happy patient goes a long way." ✦

By the Numbers

Statistics, facts, and figures from various polls support the need and desire that health care consumers have for price transparency:

- 47% of employees select providers based on price alone.[2]
- Only 9% of adults know that hospitals are required to disclose pricing.[3]
- 67% of registered voters do not feel they are given enough detail and transparency about health care costs.[4]
- 88% support government initiatives mandating price transparency.[4]
- 46% expect such initiatives to lower costs.[4]
- 65% support such initiatives, even if it leads to increased costs in the short term.[4]

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Practicums Make Perfect

Top-Tier Strategies for Practicum Management and Oversight

By Pamela Schumacher, MS, CCMP

Practicums are experiential learning opportunities that benefit students, employers, and medical assisting programs. "It's a win-win for all parties," says Kim Holman, MSN-Ed, RN, a medical assisting practicum coordinator at Bryant & Stratton College in Virginia Beach, Virginia. "Students apply their knowledge in a professional setting, employers get a chance to evaluate up-and-coming talent, and, if the student does well, [the practicum] showcases our education program to these employers and makes them eager to hire our graduates."

For medical assisting students to receive credit for these experiences, the practicum coordinator must stay on top of the documentation requirements included in the Commission on Accreditation of Allied of Health Education Programs (CAAHEP) *Standards and Guidelines for the Accreditation of Educational Programs in Medical Assisting* (*Standards*).[1] This benefits the program's accreditation, and research shows students who graduate with these real-life experiences are more likely to find employment upon graduation and be happier and more successful in their careers.[2]

Get with the Program

One way to ensure good outcomes for the student, practicum site, and program is to set clear expectations from the beginning.

For Holman this means talking about the practicum even before classes start. "We start preparing students at new student orientation by telling them, 'You will be expected to participate in a practicum if you want to complete this program.' We want them to understand the time commitment of 160 hours so they can plan for it. A lot of our students have jobs or family caregiving commitments they need to juggle. We are CAAHEP-accredited and overseen by the Medical Assisting Education Review Board, and there are very specific requirements that must be adhered to. So, we're explicit from the start and then reinforce the message in every class."

Karen Piette, MHS, CHES, CMA (AAMA), a medical assisting program coordinator at Whatcom Community College in Bellingham, Washington, holds a two-hour orientation session before the practicum. "We start with the paperwork they will be expected to complete," she explains. "We hand out time sheets and clearly outline what we need from them every week. We go into detail about how to do the time sheets properly. For instance, it's often a surprise that they can't count a lunch break in their hours. We also emphasize the importance of starting on the specific day that is agreed upon and being punctual. This orientation has prevented a lot of problems we used to see."

Holman also holds a meeting with all students approximately one month before the beginning of their practicum semester. "We discuss the documentation required before I even start to look for a site for them," she says. "This includes making sure they know and understand HIPAA [Health Insurance Portability and Accountability Act of 1996] requirements and have an updated and approved résumé and CPR certifica-

tion. In addition, we verify they have had a background screening, urine drug test, tuberculosis test, physical examination, and vaccinations—[the COVID-19] vaccine is now required. We discuss the time commitment and the CAAHEP requirements. Additionally, we conduct a skills review where students are checked again on basic skills before they are allowed in a clinical setting."

If the Site Fits ...

Getting the right student to the right practicum is both an art and a science. To be successful, a practicum should offer students certain features[3]:

- Practical work experience that includes both clinical and administrative practice
- An opportunity to observe, contribute, and rotate through different parts of the organization
- Career connections, mentorship, and networking opportunities
- Hands-on training, along with constructive, ongoing feedback for personal and professional development

The program at Highland Community College in Freeport, Illinois, sends students to visit different specialty locations before they select a practicum site, explains Alicia Michel Kepner, CMA (AAMA), AAS, a nursing and allied health educator. "Sometimes students come into class with preconceived ideas about where they would like to do a practicum, so we urge them to keep an open mind," she says. "They visit sites while we're covering different parts of the curriculum, and this really gives them a chance to see what different specialties require."

Piette visits all the practicum sites to get a feel for how each practice runs: "This is a partnership, so we carefully go over the requirements to ensure everyone is on the same page. I talk to the preceptor about the tasks the students will perform—it should be a mix of administrative and clinical duties." She has found it helpful to provide all the practicum sites with packets that include key information:

- A list of the Medical Assisting Education Review Board competencies
- A list of duties within the students' scope of skills
- A sample of the log the preceptors will need to sign each week
- Proof of students' insurance
- A list of students' vaccinations
- Contracts to be signed

Holman also visits each site to determine appropriateness. "I have found that communication of expectations, of both the site and the student, is extremely important," she says. "We have students interview with sites and earn their [practicum]. Not every student is a fit for every [practice], and we want them to have a good experience. That won't happen if there are personality conflicts."

Catch Site of Success

The *Standards* require that the practicum coordinator "provide oversight of the practicum experience" and "ensure appropriate and sufficient evaluation of student achievement."[1]

"We meet once a week during the practicum so that students can debrief and ask questions," says Kepner. "It's important to see the students in person for this class, so you can read their body language. I've picked up on things just from hearing how they describe their experience. I had one student who confessed, 'I'm not getting to do a whole lot; they're not including me.' I talked to her after class and said, 'You're a quiet person. If you want to try things, tell them.' She went the next day and said, 'I'd like to do these things,' and from that point on they included her in everything, and she had a great experience."

Holman provides her mobile phone number to students and the preceptor so they can contact her immediately if anything is wrong. She also schedules both informal and formal evaluations. "Unless there is a problem, I do an informal check-in at 40 and 120 hours and a formal evaluation at 80 and 160 hours. Because students are completing hours at different paces, I find the completed hour check-ins at 80 and 160 hours more productive. One caution, though: because of HIPAA privacy rules, I make sure the office knows when I will be visiting, and [I] don't show up unannounced."

This strategy may seem like a lot of following up with and tracking of the students and their progress, but the effort is worth it for Holman. "It is my absolute joy to assist students in becoming successful in the health care field," she explains. "We hold pinning ceremonies at the end of each semester, and I always cry because I am so proud of their hard work and what they have accomplished." ✦

Learning Experiences

- Hold an orientation before the practicum starts, which emphasizes preparation and professionalism.
- Meet with students weekly to debrief on what they are experiencing during the practicum. Ask them to share what did and did not go well.
- Tie the logging of student hours to their grades—if they do not log the hours correctly with the required signature, they do not get the credit.
- Establish good communication with the preceptor office. Let them know they can contact you if any issues arise.

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WELCOME CHANGE

CMA (AAMA) Embraces New Role to Aid PCMH Transformations

By Cathy Cassata

When Kathleen Dalton, CMA (AAMA), started her medical assisting career 25 years ago, she never imagined it would lead her to where she is today.

"I have enjoyed every role I have played as a CMA (AAMA)®—clinical, front desk, biller, educator—but my favorite is what I am doing currently," she says.

As a practice facilitator in the network ambulatory quality and patient safety department at Hackensack Meridian Health in New Jersey, Dalton works with practice teams to use best-practice guidelines. Her goal is to help the teams create workflows and policies, so they can transform their practice into a patient-centered medical home (PCMH) recognized by the National Committee for Quality Assurance (NCQA).

Although she no longer works one-on-one with patients, she feels she is making a significant impact on their lives. "While I used to take care of a panel of 1,000 patients in a [physician's practice], now I'm taking care of tens of thousands of patients in over 500 [physician's practices] by working with care teams to improve the way [the care teams] operate, so they are providing the best quality care they can for their patients," explains Dalton.

Before this role, she worked in family practice and in ear, nose, and throat for Hackensack Meridian Health. However, in 2015, she saw an opening for a population health coach in the quality and outcomes department.

"I didn't know what either the department or the position was, but since being a CMA (AAMA) was one of the qualifications, I applied on Wednesday and got an interview on Friday," she recalls.

After learning that the role involved getting practices running as PCMHs and NCQA recognized, she took the job.

"Closing gaps—reaching out to patients and asking, for example, if they got their mammogram—and chronic care management all sounded so interesting to me," she says.

Over time, the role transitioned from being a population health coach to a practice transformation facilitator.

"I'm [assigned] mainly primary care practices, and we work with their teams to make sure that they're meeting quality incentives," says Dalton. "For example, we may be looking at a [Centers for Medicare & Medicaid Services] measure. We look at how well they're doing, and if they're not performing well, we work with the teams to adjust their workflows."

Because the NCQA recognizes all the primary care practices she works with as PCMHs, she helps them maintain recognition.

"My role now is the most amazing role I've ever had, and it's a role that many CMAs (AAMA) are not aware of," says Dalton.

She believes her medical assisting training and experience gave her the skills and the knowledge to branch out from the practice realm into a corporate career.

"Looking outside of the box that we put ourselves in as medical assistants is important," asserts Dalton. "Medicine is changing, and there are different roles that are being created and developed within larger health care systems and sometimes smaller practices too."

With the hope of opening more doors, she is pursuing a bachelor's degree in health care administration with a concentration in patient safety and quality. Still, she plans to stay in the quality and safety world.

"I feel like I've found my niche in this environment," concludes Dalton. "True to being a medical assistant, I'm very passionate about quality and patient safety both from a patient and team member standpoint." ✦

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