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CMA™ Today

Spotlight on Prevention

VACCINATIONS ARE A SHOWSTOPPER IN MEASLES MANAGEMENT

Welcome Change

Adapted from the inaugural address of AAMA President Deborah Novak, CMA (AAMA), at the 2022 AAMA Annual Conference.

Thank you for allowing me this privilege to serve as your president. Standing before you as the leader of this prestigious group has been my goal and dream, and it is my honor to do so.

In 1982, I lived in Mount Pleasant, South Carolina, working as a medical assistant and office manager for a family practice physician. At that time, I was six months pregnant with my second child. I also had a 13-month-old daughter known to many AAMA friends as Ms. Kelly, who had recently been diagnosed with multiple congenital disabilities. Feeling worried, I found myself up at midnight one evening watching a local March of Dimes telethon.

The telethon's celebrity hosts approached the volunteers answering the phones and asked them to talk about their group and organization. Libby Perkins, who was a CMA (AAMA) at the time, stood up and said they were the Charleston Chapter of Medical Assistants, an affiliate of the AAMA. To my amazement, I had never heard of this organization, and the next day I called information to find out how to reach the AAMA. I learned about the AAMA and soon became an active member who was mentored and encouraged by many past presidents.

Things have changed; however, we still must find ways to make the medical assisting profession recognized by the public. I have spent the last 40 years learning from fellow medical assistants and members, and the AAMA has provided me with many networking and learning opportunities. I have been in a leadership role with large health care systems for the last 27 years and continue to advocate for our profession and credential. I have watched the medical profession evolve dramatically.

Medical assistants are critical to the future of the medical profession. The AAMA provides current knowledge and critical thinking skills to ensure that we achieve metrics, close care gaps, and provide quality and safe care to all patients.

As an organization, we must overcome obstacles to serve our members' needs. We must focus on gaining membership and market share. We must embrace change and think outside the box to advance our profession, credential, and organization, including by reaching out to current nonmembers. We must build solid partnerships. We must ask employers to support their staff so those staff can provide quality care. We must educate the public on the value of medical assistants!

I want to thank my family, friends, fellow Board of Trustees members, past presidents, and the AAMA membership for their support and trust. I promise not to disappoint you. I also want to thank Donald Balasa and the AAMA office staff for all their hard work.

I want to close with this quote from Winston Churchill: "We make a living by what we get, but we make a life by what we give."

Deborah Novak, CMA (AAMA)
2022–2023 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.

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The CMA (AAMA) is awarded to candidates who pass the CMA (AAMA) Certification Exam. PSI Services LLC 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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12 Vaccinations Are A Showstopper in Measles Management
By Mark Harris

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AAMA update

Passing the Torch

At the 66th AAMA Annual Conference Presidents Banquet, 2021–2022 AAMA President Patty Licurs, CMA (AAMA), CPC, congratulated incoming AAMA President Deborah Novak, CMA (AAMA). The AAMA extends its appreciation to Past President Licurs for her excellent leadership and wishes the best to President Novak as she leads the association through the coming year!

Recertification Policy Change for First-Time Certificants

CMAs (AAMA)® recertifying for the ***first time*** may apply a maximum of 20 recertification points (AAMA-approved points or non-AAMA-approved points) earned in the three months prior to *initial* certification toward recertification.

Reference the CMA (AAMA) Recertification by Continuing Education Application for the requirements that points must follow to qualify for non-AAMA-approved points.

This policy change applies to only CMAs (AAMA) recertifying for the *first time*. It does not apply to those CMAs (AAMA) who have recertified previously.

Other recertification policies—such as 30 of the 60 recertification points being from AAMA CEUs and at least 10 certification points being from each of the general, administrative, and clinical categories—remain in effect.

Bylaws Amendment

The House adopted one bylaws amendment: 22-01. For details on this adopted amendment, including its rationale, review the 2022 Delegates Packet available via the "Member Downloads" webpage of the AAMA website *(sign in required)*.

On the Web

Reports from the CEO
Under News & Events/Reports from the CEO

Access excerpts from past reports of AAMA CEO and Legal Counsel Donald A. Balasa, JD, MBA, to the House of Delegates.

Save the Dates
Under Calendar

Find dates for upcoming board meetings, annual conferences, and MARWeek in the AAMA calendar. ✦

Ready, Set, Go! Free CEU Course Available

Do your New Year's resolutions include recertifying via continuing education? Start the year strong by visiting the AAMA e-Learning Center to take a free new course, *Research Ready*—worth 1 general CEU.

Developed by the Louisiana Public Health Institute, this course covers the basic tenets of research, research integrity, the research process, and more! *Research Ready* is available and free online until November 30, 2023. ✦

Cheers!

Volunteers from the North and South Carolina societies once again delighted the conference crowd with the 2022 CMA (AAMA)® Knowledge Bowl. Attendees competed in teams to test their medical assisting expertise in one of the most popular events of the conference. ✦

House Highlights

The House of Delegates elected and reelected officers and trustees. Meet your 2022–2023 Board of Trustees:

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Deborah Novak, CMA (AAMA)

Vice President
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Jane Seelig, CMA-A (AAMA)

Sandra Williams, CMA (AAMA)

Supporting the Profession

Conference attendees gave generously to the Endowment funds:

Maxine Williams Scholarship Fund
$3,663

Ivy Reade Relkin Surveyor Training Fund
$1,822 ✦

A Sunny Success

Hundreds of medical assistants from coast to coast dove into new educational possibilities at the 66th AAMA Annual Conference in Myrtle Beach, South Carolina. Almost 800 people connected with their peers and furthered their knowledge as medical assistants.

Many thanks to the Annual Conference Education Committee, the members of the South Carolina Society of Medical Assistants, and the 2021–2022 Annual Conference Committee for creating an event with everything under the sun for medical assisting professionals.

The AAMA congratulates all the Excel Award winners who took home awards from the conference. You go above and beyond to positively represent the AAMA and the medical assisting profession, and your recognition is well-earned! ✦

Going Hall Out

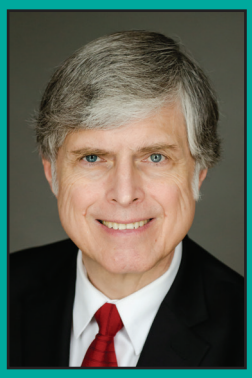
Visitors to the Exhibitors Hall discovered the latest in educational materials, technology, and more. The AAMA thanks all the 2022 exhibitors:

- Accrediting Bureau of Health Education Schools
- Ameenah's Bath Boutique
- Cengage Group
- Center for Phlebotomy Education
- dōTERRA Essential Oils
- Elite Integrated Therapy Centers
- Elsevier
- Everside Health
- Excelsior University
- F.A. Davis
- Intermountain Healthcare
- Jones & Bartlett Learning
- Jordan Essentials
- Lacey Llama Creations
- Mary Kay
- McGraw Hill
- Nadine's Collectibles
- Platinum Educational Group
- Optum
- Trajecsys
- UNC Health
- University of Nevada, Reno/ Medical Assistant FASD Practice Improvement Collaborative

AAMA Conference 2023

Join us next year in Lake Buena Vista, Florida: September 22–25, 2023

Why Professional Regulation Laws Vary from State to State



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

I am often asked why medical assisting laws vary—sometimes greatly—from state to state. Certainly, this question can be asked about laws regulating most professions. Would it not make more sense—and be better public policy—for the U.S. Congress to enact laws for each regulated profession that are nationally applicable and consistently interpreted in all American jurisdictions?

National regulation of the professions has great intuitive appeal. For example, in this era of technological advancements and expanding telehealth, uniform federal standards for the health professions may be in the best interests of patients and health professionals. Even though national regulation of the professions would seem to be a no-brainer, the plain language of the U.S. Constitution would render broad federal regulation of the professions unconstitutional.

Federalism

The United States has a federalist system of government, meaning that the federal government has certain powers and other powers are vested in the states. Therefore, understanding which level of government has the primary authority to regulate the professions—and why—is essential.

The Legislative Authority of Congress Is Limited

The legislative authority of the U.S. Congress is addressed in Article 1 of the Constitution. Article 1 lists the legislative powers given to Congress. These powers do not include the authority to pass laws governing professions. Moreover, the Tenth Amendment of the Constitution reinforces the limits of the legislative authority of Congress:

> **Tenth Amendment**
>
> The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.[1]

Because the authority to regulate the professions is not assigned to Congress by Article 1 of the Constitution, the Tenth Amendment ensures that the regulation of professions rests primarily with the states. Consequently, an effort by Congress to dictate educational and testing requirements, scope of practice, disciplinary standards, and similar basic elements for the practice of a profession would be summarily struck down by the courts as a violation of the Tenth Amendment and an unconstitutional usurpation of the states' power to protect their citizens by overseeing and regulating the professions.

EHR Incentive Programs

The above constitutional analysis begs the following question: If the primary legal power to govern the professions is reserved for the states, what was the source of authority for the Centers for Medicare & Medicaid Services (CMS) to establish credentialing requirements for medical assistants entering orders into the computerized provider order entry (CPOE) system for meaningful use calculation purposes under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs? To answer this question, we must examine Article 1 of the Constitution.

The following clause in Article 1 (the spending clause) has been interpreted by the courts to give Congress broad authority to collect revenue and spend money for the well-being of the United States and its people:

> **Section 8**
>
> The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States[2]

In 2009 Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act. One of the main purposes of this statute was to incentivize and hasten the conversion from paper medical records to EHRs. Congress charged CMS with creating the Medicare and Medicaid EHR Incentive Programs. An objective of these programs was to encourage the meaningful use of the EHR.

The Medicare and Medicaid EHR Incentive Programs authorized incentive payments to eligible professionals (EPs) who could demonstrate that they were using the EHR in the manner required by CMS. Many aspects were involved in these Medicare and

Medicaid EHR Incentive Programs. The one of greatest relevance for the medical assisting profession was the requirement that a certain percentage of medication, laboratory, and diagnostic imaging orders be entered by licensed health professionals or credentialed medical assistants. If these meaningful use thresholds were not met, the EP would not receive the annual incentive payment(s).

Why the Medicare and Medicaid EHR Incentive Programs Were Constitutional

It may seem that the CMS infringed on states' authority by promulgating regulations requiring credentialing for medical assistants entering orders for meaningful use. However, this was not the case. The CMS regulations did not override state law and did not require all medical assistants to be credentialed. Rather, ensuring that a certain percentage of orders be entered by credentialed medical assistants or licensed health professionals was a condition for receiving incentive payments under these federal programs. The CMS regulations did not attempt to establish a federal credentialing requirement for medical assistants. Eligible professionals who chose not to participate in the Medicare and Medicaid EHR Incentive Programs were not required by law to employ credentialed medical assistants.

Are There Constitutional Means of Making the State Licensing Laws More Uniform?

Various legal approaches facilitate greater uniformity of state licensing laws without running afoul of constitutional prohibitions. The following is a brief overview of some of these approaches:

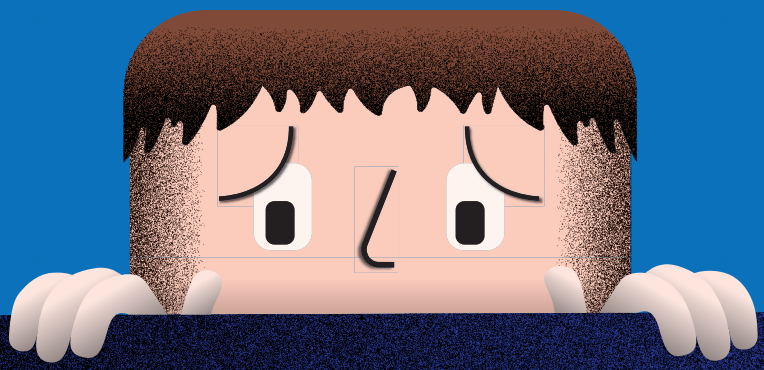
- **Reciprocity agreements between states.** Reciprocity agreements are profession by profession. They consist of legislation involving two or more states stipulating that individuals licensed in one state in a particular profession can become licensed in the other state in the same profession without additional education or testing. The professional may have to pay a fee to the licensing board of the destination state, but they usually can begin practicing without a long waiting period.
- **Interstate licensing compacts.** Interstate compacts are also profession by profession. They require each state participating in the compact to enact identical legislation for the profession. Compacts are similar to reciprocity agreements but usually involve several states.
- **Expedited licensing for military spouses and veterans.** Because service personnel are frequently reassigned geographically, expedited licensing for military spouses has been established to reduce the hardship on military spouses licensed in a profession. Expedited licensing usually does not involve exemptions from education and testing requirements but shortens waiting periods.
- **Universal license recognition.** This is a relatively new development in professional regulation. Unlike reciprocity agreements and interstate compacts, universal license recognition applies to all licensed professions. The 2019 Arizona statute is one of the first universal license recognition laws. The following is a description of this law:

> Arizona's licensing boards will recognize out-of-state occupational licenses for people who have been licensed in their profession for at least one year, are in good standing in all states where they are licensed, pay applicable Arizona fees, and meet all residency, testing, and background check requirements.[3] ✦

Questions? Contact Donald A. Balasa, JD, MBA, at DBalasa@aama-ntl.org or 800/228-2262.

References

1. U.S. Const. amend X.
2. U.S. Const. art. I, § 8, cl. I.
3. Office of the Governor Doug Ducey. *Universal Licensing Recognition*. Accessed December 15, 2022. https://azgovernor.gov/sites/default/files/universal licensingrecognition1_0.pdf



STAY SHARP

Wield Empathy and Knowledge Against Vaccine Hesitancy

By Cathy Cassata

With their broad scope of practice, medical assistants may be called on to provide vaccine education and administration, sometimes encountering patients with vaccine hesitancy. Even before the COVID-19 pandemic, the World Health Organization (WHO) named vaccine hesitancy as one of the top 10 threats to global health in 2019 and noted that vaccination prevents 2 to 3 million deaths a year and could save more lives if the global coverage of vaccines improves.[1]

Additionally, a 2018–2019 survey of more than 7,500 parents in the United States with children aged 19 to 35 months found that about 25% were hesitant to get their child vaccinated.[2]

"Vaccinations are [a critical] part of preventive medical care," says Steven Abelowitz, MD, FAAP, a pediatrician at Coastal Kids, a pediatric medical group. "[Open] communication between the patient and the pediatrician will enhance adherence to children receiving the appropriate vaccines and in a timely manner."

On Pins and Needles

People avoid or hesitate to get vaccines for various and complex reasons, including complacency, difficulty accessing vaccines, and lack of confidence.[1] Dr. Abelowitz adds that people might be unsure about vaccines for the following reasons:

- Religious beliefs
- Personal beliefs
- Philosophical reasons
- Distrust in science

And yet, safety concerns is the reason Dr. Abelowitz hears most often. "In other words, parents are worried that the side effects could be riskier than the benefits of preventing the illness," he explains. "We believe that most of these valid concerns are enhanced by misinformation, and the [physician should address] appropriate concerns."

Jilianne Sperling, CMA (AAMA), agrees. She works at Ascension Standish Family Medicine in Michigan, which is part of two vaccine programs: a federally funded vaccine program that vaccinates children from infancy to 18 years old who are uninsured, underinsured, or have private insurance and a private vaccine program for those older than 19 years. Sperling oversees vaccine ordering, stocking, administration, and education. She lists the most common vaccine questions she gets from patients:

- Is it safe?
- Is it necessary?
- Does it work?
- Why do we need it?
- What are the vaccine's side effects?
- What is in it?

Sperling stays informed about the vaccine information sheets she gives patients and synchronizes with the vaccine information she receives from her provider. She also learns about vaccines in her free time by reading reputable websites like the Centers for Disease Control and Prevention website. "I'm very passionate about vaccines and learning about them," she says.

Sperling also attends an annual vaccine conference held in Michigan. "I get a lot of current information from that every year," she notes.

Straight to the Point

In Sperling's workplace, the human papillomavirus (HPV) vaccine receives the most resistance from parents concerned about vaccinating their children.

"There's so much negative press around [the HPV vaccine]," says Sperling. To ease their concerns in a relatable way, she tells patients that the HPV vaccine has been around longer than the iPhone. "Then I'll explain the statistics, how the HPV vaccine works, how it's the most effective … cancer-preventing vaccine available, and how science is now linking HPV to cancers like colorectal, stomach, and oral," she says.

For older patients, the influenza, shingles, and COVID-19 immunizations are most critical, according to Lisa Smith, CMA (AAMA), a medical assistant at Cleveland Clinic in Cleveland, Ohio. Smith primarily works with patients who are older than 65 years. After the physician speaks to patients, Smith's role involves answering questions regarding vaccinations. "I go over the worst-case scenarios that can happen if you get the flu, shingles, or [COVID-19] and the best-case scenario that the vaccine can help give you," she says.

She also addresses their age and the vulnerability that comes with aging. "Unfortunately, as we get older, our bodies aren't where they were when we were 20 [years old]. [Older patients] have to realize their limitations, and once they understand that we want to help them live safer, it resonates," says Smith.

Building trust with patients is Smith's focus, which she has accomplished by working with the same provider for 20 years. "If you can build trust with patients, they're more likely to listen to vaccine education from you than [believe] some [unfounded] stuff they see on TV," she says.

Because the older population may rely more on TV than the internet for information, Smith's provider often suggests movies and documentaries that educate on health-related issues. "They come back for a two-month follow-up and tell me they saw the documentary or read the additional literature I suggested and feel comfortable with the decision they made," says Smith.

Another challenge with older patients is that they may have a caregiver or family member making decisions for them if they cannot. In these cases, she must advocate for the patient's best interests regarding vaccinations. "It's my job to stay calm, help the family understand that their loved one is in a population who is at risk for complications if they get a virus like COVID-19, and reiterate that [that risk is] why the [physician] recommends they receive the vaccine," says Smith.

Calling on the physician to debunk misinformation helps, adds Dr. Abelowitz, noting that it makes patients and their loved ones "more aware that the benefits outweigh the risks, thereby feeling more comfortable with the decision of going forward with the vaccines." ✦

References

1. Ten threats to global health in 2019. World Health Organization. January 10, 2019. Accessed December 14, 2022. https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019
2. Nguyen KH, Srivastav A, Lindley MC, et al. Parental vaccine hesitancy and association with childhood diphtheria, tetanus toxoid, and ace llular pertussis; measles, mumps, and rubella; rotavirus; and combined 7-series vaccination. *Am J Prev Med*. 2022;62(3):367-376. doi:10.1016/j.amepre.2021.08.015
3. Public. Michigan Care Improvement Registry. Accessed December 14, 2022. https://mcir.org/public/

Call the Shots

In addition to providing patients with education and informational handouts regarding vaccine benefits and safety, medical practices can use the following strategies to improve vaccine adherence:

Encourage patients to schedule annual wellness visits. "It is key to have follow-up appointments and especially encourage the scheduling of these appointments at the end of the [current] visit," says Steven Abelowitz, MD, FAAP.

Practices can encourage follow-up appointments by having a medical assistant walk the patient to the front desk and explain their follow-up needs or give them a paper with that information to give the front-desk staff.

Standardize record keeping. Electronic health records can track missed visits and log accurate immunization records. In some systems, a patient's file will get marked with a red notification that informs medical staff when patients are overdue for vaccines. Looking for these notifications when patients come in for appointments can prompt staff to tell patients what they have missed.

Jilianne Sperling, CMA (AAMA), regularly looks at the Michigan Care Improvement Registry, which collects reliable immunization information for children.[3] "I go in there and run a list at the beginning of every month and then call the patients and tell them they are overdue for so-and-so vaccines," she says.

Send reminder messages. Sending patients messages via text, email, or patient portal notifications can help ensure they stay up to date with immunizations. Knowing the patient population is also essential, notes Lisa Smith, CMA (AAMA).

"With [older adults], we have to make a lot of phone calls, but about 80% of our population is signed up for MyChart, where they can message or chat with staff online," she says.

Loneliness and Type 2 Diabetes

Loneliness can contribute to the risk of type 2 diabetes, according to new research from *Diabetologia*.

The study examined self-reported loneliness levels and found that, in a 20-year follow-up, those with the highest reported loneliness had twice the risk of developing type 2 diabetes than those who did not report loneliness. Researchers also found this relationship between loneliness and type 2 diabetes existed when controlling for depression.

In practice, the study authors suggest health care providers should consider loneliness during type 2 diabetes consultations and interventions. They also recommend open communication with patients regarding their loneliness concerns.

Loneliness can have serious health effects on patients, but an empathetic and mindful approach from the patient care team can be the first step in connecting patients with the help they need.

Allergic Redaction

Did you know that more than 30 million people in the U.S. have a penicillin (PCN) allergy documented in their medical records, but 90% of them may not actually be allergic to PCN and other beta-lactam antibiotics? An article in *The Joint Commission Journal on Quality and Patient Safety* explored this concern and possible long-term solutions.

Many patients have an incorrect PCN allergy label in their electronic health records, which causes a flood of safety alerts. While these alerts are intended to promote patient safety, the authors suggest that these warnings often have adverse effects by ruling out an effective medication for millions of patients. Incorrect PCN allergy labels may result from unverified entries from childhood, and documented tolerance to PCN often does not prompt a record correction. Medication reconciliation can also cause relabeling of PCN allergies, even if the most recent documentation shows a tolerance. Meanwhile, prescribers understandably avoid overriding the alert in case doing so compromises patient safety.

The authors insist that safety alerts are critical for patient care but must be more effectively implemented. They suggest that the software be improved so the alerts trigger data reconciliation that can find evidence of tolerance through prior use or testing and prompt a record correction. Separately, health care institutions can do their part through education on inaccurate PCN allergy labels.

No quick and easy solution exists for the millions of inaccurate PCN allergy labels. However, the health care system can develop a more accurate and effective approach to PCN allergies that better serves all patients. ✦

Patient Problems

What upsets patients most? A new study on negative health care experiences in *Healthcare* explores the roots of unsatisfactory encounters.

The study interviewed 373 patients and found 27% to be memorably upset patients. Researchers explored whether the upset patients' concerns stemmed from systems issues (e.g., inefficiencies, access barriers, and facilities problems) or care team issues (e.g., poor communication, neglect, coldness, and incompetence). The most reported issue from the memorably upset group was inefficiencies (70%) related to scheduling problems and poor care flow. The second was miscommunication (38%), which includes poor messaging and patient education. The third most common issue was access barriers (33%), encompassing inconvenience as well as cost and insurance concerns.

Notably, care team members often underestimated the number of complaints about care team issues. Instead, they assumed patients were more concerned with systems issues and discounted the care team's role in the patient experience.

Researchers pointed to the 27% of memorably upset patients as a sign that health care delivery can improve. Additionally, they proposed that patient surveys can better screen for care-team experiences by asking about specific, single instances of incompetence or other negative interpersonal experiences (e.g., What aspect of your visit felt the most unsatisfying?) rather than asking general questions about overall care (e.g., How would you rate your visit?). Clinics can also make concerted efforts to survey for upsetting experiences rather than relying on average ratings.

Care team members profoundly impact the patient experience, and recognizing this can improve patient experiences and outcomes. ✦

Breaking through Language Barriers

Despite the significance of family history collection, many primary care settings are inadequately gathering this information from Spanish-speaking patients, according to researchers in *PEC Innovation*.

Researchers found multiple barriers that affected family history collection for Spanish-speaking patients. Providers and other staff sometimes made broad, biased assumptions that their Spanish-speaking patients had limited family history knowledge and health literacy. Communication barriers compromised the history-taking, because providers and medical assistants who spoke Spanish were not always fluent enough for a detailed and nuanced discussion. The history-taking also varied by team member, causing documentation disparities. Health care providers can miss various dialects and Spanish language medical terms without an interpreter's assistance. Meanwhile, practices often underuse interpreters due to time concerns.

Going forward, researchers suggest standardizing interpreter use in the clinical setting to improve family history-taking. Clinics can also support the use of electronic health record patient portals while considering access issues.

All patients deserve the same level of care. Primary care settings can do their part by working toward gathering complete and accurate family medical histories for these patients. ✦


Spotlight
on
Prevention
VACCINATIONS ARE A SHOWSTOPPER IN MEASLES MANAGEMENT

By Mark Harris

Measles, an acute viral respiratory illness, is one of the oldest diseases to afflict the human population. While a Persian physician provided one of the earliest written accounts of measles in the ninth century,[1] evidence suggests the disease may have been present in humans as early as the fourth century.

For centuries, measles was considered endemic in Europe, the Middle East, and other world regions. As Europeans migrated to the Americas in the late 15th century, the introduction of measles and smallpox often devastated indigenous populations by infiltrating their communities.[2]

In the 18th century, Scottish physician Francis Home, a president of the Royal College of Physicians of Edinburgh, proved that an infectious agent in the blood caused measles.[1] In 1758, Dr. Home made the first attempt to vaccinate against measles.[3]

The United States did not classify measles as a nationally notifiable disease until 1912. Public health authorities then required health care providers and laboratories to report all diagnosed measles cases.[1] In the first decade of mandatory reporting, an average of 6,000 measles-related deaths occurred annually, according to the Centers for Disease Control and Prevention (CDC).[1]

Mandatory reporting was an essential touchstone in the history of the U.S. response to measles, as was the introduction of the first modern measles vaccine in 1963. In the decade before the availability of an effective vaccine, measles infected almost all children in the United States by age 15. In that same decade, an estimated 3 to 4 million people in the United States contracted measles each year, 48,000 were hospitalized, and 400 to 500 people died.[1]

Due to effective public vaccination campaigns, measles' widespread global impact has considerably improved over the past six decades. Measles was eliminated in the United States, declared the World Health Organization (WHO) in 2000. Nonetheless, sporadic outbreaks occur in the United States, largely in settings or groups with low vaccination rates. In 2019, more than 1,200 measles cases were reported across 31 U.S. states, the largest number of cases reported in 25 years.[4]

Meanwhile, global measles deaths declined by 73% between 2000 and 2018, according to WHO. Yet the disease remains persistent in certain regions, particularly in some areas of Africa and Asia. In 2018, more than 140,000 deaths from measles were reported worldwide. WHO reports that the disease remains a significant cause of death globally among young children.[5]

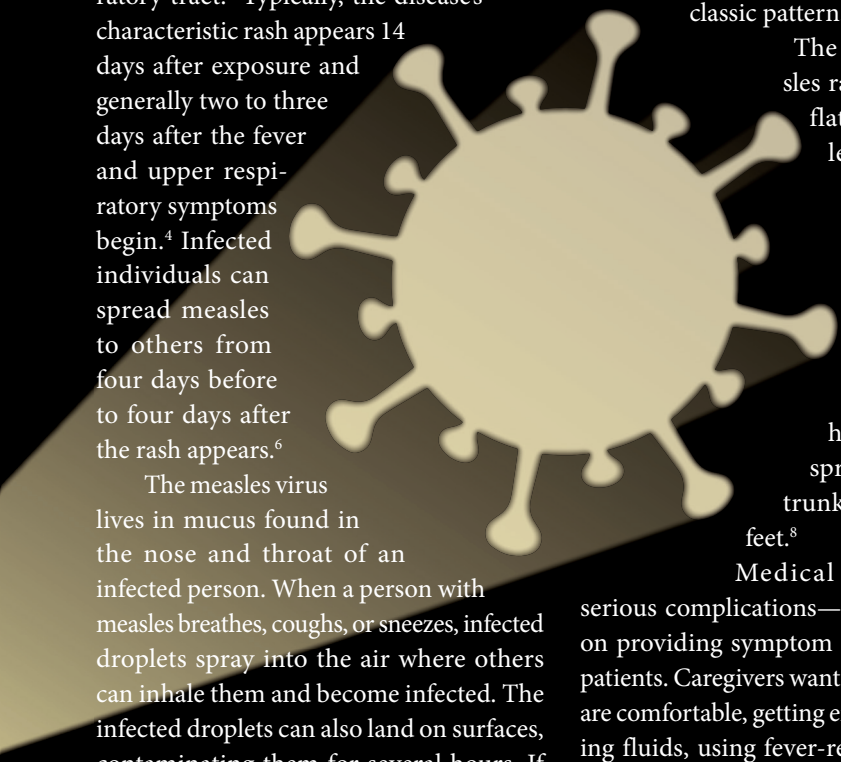
VIRAL RISKS

"Measles is a highly contagious infection caused by a virus," says Dawn Nolt, MD, MPH, professor of pediatrics (special focus in infectious diseases) at the Oregon Health & Science University School of Medicine in Portland, Oregon. "The disease can be as mild as a fever and rash but can be serious, particularly in unvaccinated children younger than five years old. The serious issues include pneumonia and [brain] swelling. There is no medication to treat and kill the measles virus, so the best way to manage this infection is through vaccination, which can reduce [the] risk of death and serious consequences. We have a safe and effective vaccine against this infection, [which] has been used [worldwide] for almost 60 years."

Measles is the most contagious infectious disease known to affect human beings,

according to the National Foundation for Infectious Diseases (NFID).[4] The widespread public health impact of measles in the pre-vaccination era speaks to its contagiousness. A person with measles may infect up to 90% of nonimmune individuals upon exposure.[4]

As a disease, measles is known as a paramyxovirus, meaning it belongs to a category of RNA viruses. Measles infects epithelial structures in the human body (e.g., eyes, oropharynx, lungs, and intestines) and almost always impacts the respiratory tract.[4] Typically, the disease's characteristic rash appears 14 days after exposure and generally two to three days after the fever and upper respiratory symptoms begin.[4] Infected individuals can spread measles to others from four days before to four days after the rash appears.[6]



The measles virus lives in mucus found in the nose and throat of an infected person. When a person with measles breathes, coughs, or sneezes, infected droplets spray into the air where others can inhale them and become infected. The infected droplets can also land on surfaces, contaminating them for several hours. If someone touches a contaminated surface and then touches their nose, eyes, or mouth, they risk infection.[6]

DIAGNOSIS AND TREATMENT

A measles diagnosis may be suspected in individuals with a fever, cough, rash, conjunctivitis, and runny nose, especially following a known exposure or outbreak. Fatigue or a sense of malaise commonly precedes measles. Laboratory testing can confirm a measles diagnosis in patients with partial vaccinations or weakened immune systems because their symptoms may stray from the classic pattern.[7]

The trademark measles rash involves both flat and raised skin lesions. The discolored areas and small raised bumps are known as a *maculopapular rash*. They usually begin on the head and face and spread to the neck, trunk, arms, legs, and feet.[8]

Medical care—barring serious complications—generally focuses on providing symptom relief for measles patients. Caregivers want to ensure patients are comfortable, getting enough rest, drinking fluids, using fever-relieving over-the-counter medications as necessary, and taking other measures to speed recovery. While patients are contagious, they are cautioned to remain isolated. Patients may receive antibiotics if pneumonia or a bacterial ear infection develops.[5]

Beyond managing symptoms, experts recommend a few additional treatment options for an active measles infection or exposure.

"There are three interventions we would consider if someone has measles or has been exposed to measles," says Patricia A. Stinchfield, MS, RN, CPNP-PC, president of the National Foundation for Infectious Diseases. "First, if someone … is within the first 72 hours after [measles] exposure, you can give them the measles, mumps, and rubella (MMR) vaccine as a prophylactic. That [intervention] works well, although … by the time we find out they're exposed, that 72-hour window is often closed. After that, we've got another window [to] give intramuscular immune globulin. This [antibody] helps mop up any virus in its percolated stage. From the time of exposure to before they break out in a rash … you can use immune globulin."

Another crucial intervention involves the use of vitamin A, says Stinchfield. This intervention involves administering therapeutic doses of supplemental vitamin A, which has been found to lessen the disease's severity and hasten recovery. Notably, some hospital studies show measles patients frequently have low serum vitamin A levels correlating with the severity of their symptoms. In one study, children with no known prior vitamin A deficiency experienced a significant decline in their serum retinol levels dur-

MMR VACCINATION RECOMMENDATION SNAPSHOT

The CDC recommends everyone gets the measles, mumps, and rubella (MMR) vaccine to safeguard themselves. Children should get two doses of the MMR vaccine, starting with the first dose at 12 to 15 months of age and the second dose at 4 to 6 years of age. Teens and adults should also stay current on their MMR vaccination. Children may also get the MMRV vaccine, which protects against varicella (chicken pox) in addition to measles, mumps, and rubella. This vaccine is licensed only for children 12 months to 12 years old.[9]

MEASLES COMPLICATIONS

Young children most commonly experience diarrhea as a complication of measles, which occurs in 8% of cases. Ear infections occur in 7% of reported cases. Pneumonia occurs in 6% of reported cases and accounts for 60% of measles-related deaths. Approximately 1 out of 1,000 cases will develop acute encephalitis, an inflammation of the brain. Encephalitis can cause permanent brain damage.[16]

Having measles during a pregnancy increases the potential for premature labor, miscarriage, and low-birth-weight infants, although congenital disabilities have not been linked to measles exposure.[16]

Measles can be especially severe in individuals with compromised immune systems and in malnourished children, particularly those with vitamin A deficiency. In developing nations, the fatality rate may be as high as 25%.[16]

ing the acute phase of measles. The decline in plasma retinol levels returned to normal as patients recovered.[4]

Notably, WHO recommends vitamin A therapy for all children with an acute measles infection. For children over 1 year old, the standard dosage treatment is 200,000 international units (IU) of vitamin A administered once daily for two days. For infants 6 months to 11 months old, the recommended dose is 100,000 IU for two days and 50,000 IU for those younger than 6 months. A third age-specific dose may also be given two to four weeks later to children who show signs of vitamin A deficiency.[4]

And yet, vitamin A tends to be underused as a therapeutic intervention in the United States. In 2020, NFID published "Call to Action: Vitamin A for the Management of Measles in the United States" to promote greater understanding among medical providers of the science, recommendations, and benefits of vitamin A therapy in managing measles.[4]

PANDEMIC IMPACT

The CDC recommends that children receive two doses of the MMR vaccine, with the first dose at 12 to 15 months of age and the second dose at 4 to 6 years of age. Receiving the measles, mumps, rubella, and varicella (MMRV) vaccine also protects against varicella, commonly known as *chicken pox*. The MMRV vaccine is given only to children from 12 months to 12 years of age.[9]

Unfortunately, the COVID-19 pandemic caused an international decline in routine childhood vaccinations. Since 2019, global childhood vaccination rates have experienced their largest sustained decline in about 30 years, according to a July 2022 report by WHO and UNICEF.[10] In 2021, measles coverage in children fell internationally to 81%, the lowest level since 2008. This number translates into 24.7 million children who missed their first dose of the measles vaccine. Another 14.7 million did not receive the second measles dose. Similar declines in vaccine coverage were reported for other diseases.[10]

Catherine Russell, UNICEF executive director, describes the decline in vaccination rates as a red alert for child health, and she warns that this decline will lead to more infectious disease outbreaks unless health systems catch up on immunizations.[10]

The pandemic interrupted many pediatric well-child visits in the United States, including participation in routine childhood vaccinations. The CDC reports a 14% drop in public-sector vaccine ordering data for 2020–2021 compared with 2019. This includes a reported decline of more than 20% in measles vaccinations.[11]

"The pandemic has disrupted the ability of many families to seek out or continue routine medical visits for children," observes Dr. Nolt. "This may be because of a fear of contracting COVID-19 in the community or clinic, stay-at-home orders, or schools not enforcing vaccine requirements due to virtual learning. Children then [cannot] receive the vaccines, or [they have] delayed vaccinations, [which] are usually given at these routine check-ups. Because of this lag in childhood vaccinations, experts warn of a rise in outbreaks of infections … that normally would be prevented."

Dr. Nolt says pediatricians should be cognizant of these challenges. "I would encourage families to bring their children in for medical check-ups to make sure kids stay healthy," she suggests. "This is a great opportunity to get updated on vaccines. Providers should also be reviewing [their patients'] medical records to remind them to come in and get vaccinated."

SEVERE CONSEQUENCES

These four statistics illustrate how measles can be serious[6]:

- About 1 in 5 people in the United States who get measles will be hospitalized.
- 1 out of every 1,000 people with measles will develop brain swelling, which could lead to brain damage.
- As many as 1 in 20 children with measles get pneumonia.
- 1 to 3 out of 1,000 people with measles will die, even with the best care.

VACCINE EDUCATION

Beyond the catch-up work on immunizations, health systems face a related concern. How should practitioners approach vaccine hesitancy from patients or families? Experts agree that providers must respond to such concerns respectfully.

"There are many reasons families may not be confident about vaccines in general or a specific vaccine," says Dr. Nolt. "It's important to allow families to bring their concerns to their child's health care provider, and although not every conversation will result in a vaccination, [providers can establish] trust for ongoing care."

To facilitate constructive dialogue with patients, the health care team involved in administering vaccinations must be educated and up to date on essential vaccine information.

"For [health care professionals], I think there has to be some knowledge and understanding of the vaccines themselves," says L.J. Tan, PhD, MS, chief strategy officer for Immunize.org (formerly the Immunization Action Coalition) in Saint Paul, Minnesota. "For medical assistants, I would strongly encourage going through and making sure you're reading valid, scientifically accurate information about the vaccines you're giving. I'm not saying you have to become an expert, but you should [be competent] in your knowledge base. This [knowledge] will allow you to talk with some confidence about a vaccine."

Jennifer Baranski, CMA (AAMA), office manager for Avance Care Matthews, a family practice clinic in Matthews, North Carolina, echoes this advice: "In my experience, the single most important thing, especially [when] working with a pediatric population, is to know your vaccines. You should know what they are for, the minor side effects, and the issues that could arise from not having the vaccine. You should also [understand] what a catch-up [immunization] schedule is."

To note, the CDC publishes a catch-up immunization schedule designed to guide vaccination recommendations for children and adolescents who start late or are behind on their recommended vaccinations.[12]

As legally required, patients and families are always provided with the appropriate Vaccine Information Statement (VIS) before clinic immunizations, reports Baranski. "As an office, we try to head off any questions about the vaccines by providing that information up-front," she says. "We want patients to [know] what the vaccine protects [against]. We also want new parents to know why it's important to stay on schedule with their vaccinations."

The clinic's medical assistants administer many scheduled vaccinations, notes Baranski. In her experience, interactions with physicians, clinicians, and other staff build patient trust in vaccines.

"If you're talking to a new parent or someone who has concerns, you need to be able to answer [their] basic questions," says Baranski. "What is this vaccine for? What is it going to do to my 6-month-old infant? What's going to happen? You need to be able to answer their questions, or patients [will] feel uncomfortable. Patients want to know that the people helping their children with their vaccinations are [also] knowledgeable."

"I think when staff [is] reasonably informed about the vaccines they're giving, patients are more likely to trust us as a team," adds Baranski. "[Patients will] be more comfortable [discussing] any hesitations or problems they have with vaccines. Hopefully, we can overcome those hesitations in the clinic before it becomes an issue and they don't vaccinate at all."

Motivational interviewing is a technique that helps practitioners learn how to approach patient conversations about vaccines, says Dr. Tan. Motivational inter-

viewing uses various tools, practices, and strategies to help patients clarify ambiguities or resolve issues in their personal health care decisions.[13]

"The key to motivational interviewing is the idea of listening, not to respond, but listening to understand," explains Dr. Tan. "Instead of just talking at the patient, motivational interviewing allows you to converse with [them] to understand [and address] their concerns."

Motivational interviewing cautions against immediately correcting patient misinformation, says Dr. Tan. For example, some patients may incorrectly believe that the MMR vaccine causes autism. "The moment you try to correct the patient off the bat, you create a barrier in that conversation," says Dr. Tan. "Your immediate response might be to say, 'No, you're wrong. The data now is very clear; 35 publications show [otherwise].' And then you go into your explanation. Instead, you might respond, 'I understand your concern.' "

As Dr. Tan explains, motivational interviewing keeps the patient-provider dialogue open and constructive. It encourages listening with empathy and facilitating communication and understanding, instead of scolding patients or dismissing their concerns. As such, the health care team strives to provide reliable medical information while accepting the patient's—or the patient's caregivers'—beliefs. The larger intention aims to empower patients, caregivers, and families to make informed health care choices.

Additionally, Dr. Tan suggests health care professionals avoid describing vaccines in comparative terms, such as ranking the MMR vaccine as among the best. "We try to say the measles vaccine is one of the most *effective* vaccines," explains Dr. Tan. "We avoid using the term *best* because it's subjective. A patient might think if a vaccine doesn't offer 95% effectiveness, the vaccine is not good. And that's not true. For example, with COVID-19, we know vaccines don't have to be 95% effective [at preventing infection], but they can do a lot of good at preventing death and hospitalization."

Many resources exist to help health care professionals learn about vaccine topics, including brief courses on motivational interviewing. The Immunize.org website is an excellent resource for clinics, providers, and staff, offering a wide range of information on vaccines and immunization-related issues, says Dr. Tan.

"On our website, we have tools [for learning to administer] vaccines, properly [documenting] vaccinations, and [scheduling] vaccines in the operational flow of your clinic and practice," says Dr. Tan. "We also have tools to help you screen for potential contraindications in patients. We have tools that define the [vaccine's] entire storage and handling path. This includes everything from [when] the vaccine leaves a distributor to [when] it ends up in a patient's arm. We also offer translation in more than 27 languages of the Vaccine Information Statements that providers are required by law to give patients before [vaccinating] them."

LESSONS FROM THE GLOBAL CHALLENGE

Despite the United States' measles-eliminated status with WHO since 2000,[4] periodic outbreaks have continued, occurring in California in 2008 and 2015, Minnesota in 2017, and New York in 2019. Unfortunately, measles remains endemic to certain parts of the world. As such, infected travelers can reintroduce the virus when traveling to the United States. Overall, 3,874 cases of measles were reported in the United States between 2001 and 2019.[14]

What can people do to reduce or eliminate the likelihood of future outbreaks? "Vaccination, vaccination, vaccination,"

"Medical assistants can be a frontline defense against measles. They can be vaccine champions in primary care, looking to identify gaps in coverage, such as with the child who's 2 years old and has not had their first MMR vaccine or the six-year-old who has not had their second MMR. [Medical assistants] can be that front door of the clinic, checking every single child's immunization record and whether they have a vaccine that's due. At a visit, you might take care of a sprained thumb, but you can also look at the patient's immunizations and take care of that during the visit. It's about reducing missed opportunities to vaccinate. Medical assistants can also be verbal champions to patients. They can tell patients, 'I'm vaccinated; my children are vaccinated.' They can be role models in that way."

—Patricia A. Stinchfield, MS, RN, CPNP-PC

emphasizes Dr. Tan. "[The] most recent outbreaks all started in what we call 'pockets of need.' These are [communities] in which people have refused to get vaccinated. [Their refusal] could be for religious reasons [or] because of misinformation in the community that has led to [a] distrust of the vaccine. … When that large coverage drops, the community can no longer protect itself because immunity is down."

Measles requires a 95% vaccination coverage rate for community immunity to be achieved.[15] "If we can get these resistant populations vaccinated, we would reduce or eliminate the ability of measles to transmit in those communities," explains Dr. Tan. "We would prevent outbreaks."

Furthermore, as pandemic restrictions ease, more people are traveling internationally. The global decline in routine vaccinations raises the risk of future measles outbreaks. Thus, ensuring global access and participation in routine measles vaccination for all children and eligible adults is critical.

"I believe we have to have a sense of global public health here," concludes Stinchfield. "If there are measles [cases] anywhere, then people everywhere are potentially at risk. Just as we're learning [about] COVID-19, we need to have a [broader] mind-set about infectious disease prevention and caring about and getting vaccines to parts of the world that need [them]. … I think we can eradicate measles, but we won't be able to unless we see [a worldwide] reduction in disease."

Similarly, measles prevention also benefits from broad clinic and health system engagement. "One of my goals is to emphasize interdisciplinary collaboration," says Stinchfield, NFID's first nurse practitioner president. "It does take all of us—physicians, nurse practitioners, nurses, medical assistants, emergency room personnel; everyone [must work] together to promote health and communicate clearly about measles prevention."

Despite the many public health challenges measles prevention poses, most families welcome the efforts of clinic providers to stay current with vaccination coverage. "We talk so much about vaccine hesitancy, but the vast majority of parents still vaccinate their children, and they vaccinate them on time," says Stinchfield. "They appreciate the assistance when a clinic says they're due for a vaccine."

As the infectious disease community recognizes, vaccination remains a key component of current global public health efforts to reduce the risk of periodic measles outbreaks. Even more, vaccination drives the attainable, long-term vision of a world free from measles. ✦

RESOURCES

Immunize.org

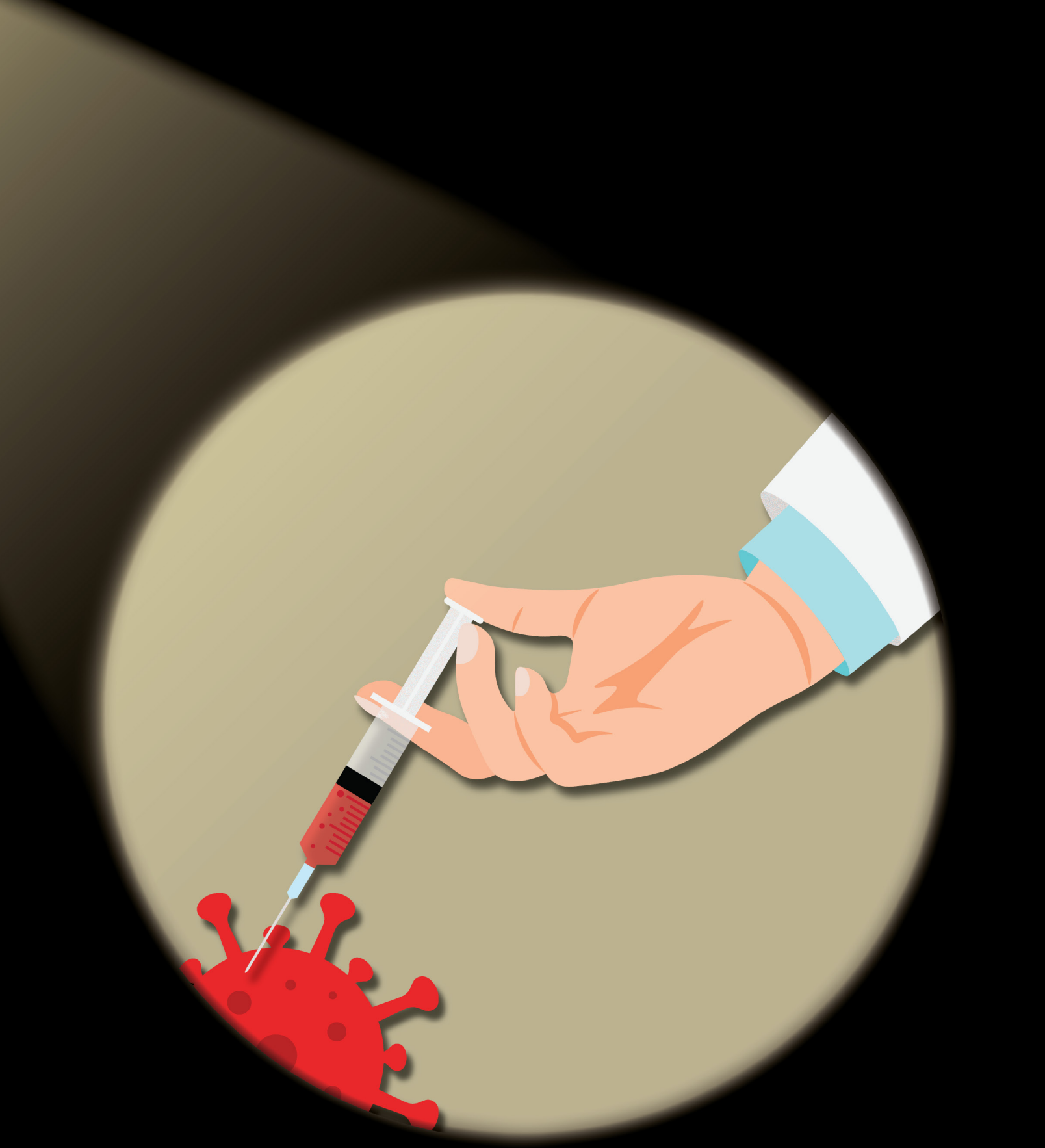
Immunize.org works to increase immunization rates and prevent disease by creating and distributing educational materials for health care professionals and the public that enhance the delivery of safe and effective immunization services. The website also facilitates communication about the safety, efficacy, and use of vaccines within the broad immunization community of patients, parents, health care organizations, and government health agencies.

https://www.immunize.org

National Foundation for Infectious Diseases

The National Foundation for Infectious Diseases is dedicated to educating the public and health care professionals about the burden, causes, prevention, diagnosis, and treatment of infectious diseases.

https://www.nfid.org



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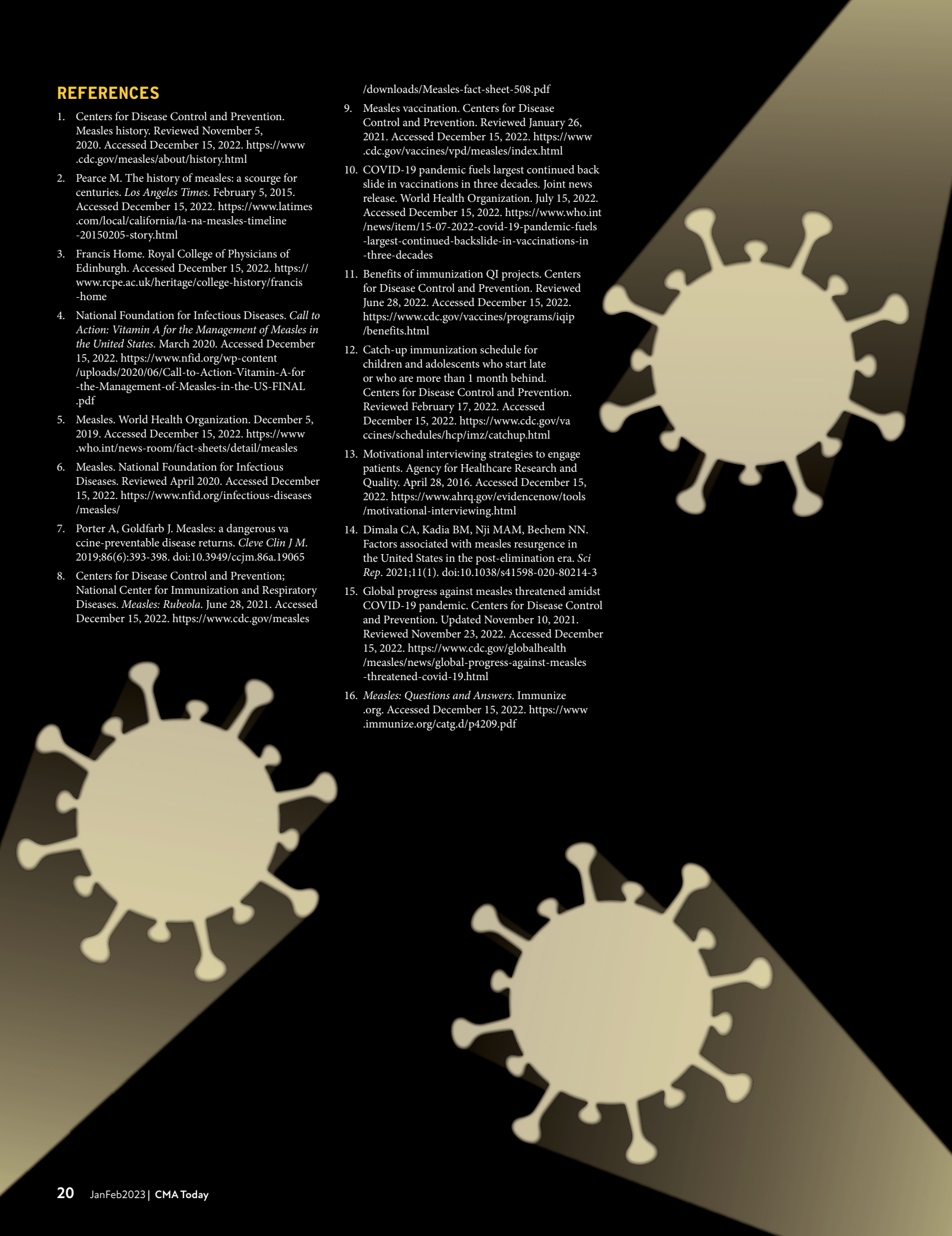

Measles Prevention

Deadline: Postmarked no later than **March 15, 2023**

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T F

☐ ☐ 1. While the World Health Organization declared in 2000 that measles was eliminated in the United States, periodic outbreaks of measles continue to occur in the United States.

☐ ☐ 2. The law requires that parents (or caregivers) receive a Vaccine Information Statement before a vaccine is administered to their child.

☐ ☐ 3. Measles is no longer a significant cause of death for children throughout the world.

☐ ☐ 4. Administering vitamin A to a person infected with measles lessens the severity of the illness and speeds up their recovery.

☐ ☐ 5. Measles is especially dangerous for children 5 years of age and older and less dangerous for children under 5 years old.

☐ ☐ 6. Vaccination rates of 95% are necessary for community immunity to be reached.

☐ ☐ 7. The discovery of a medication to kill the measles virus in infected people was an important breakthrough in the fight against this disease.

☐ ☐ 8. The COVID-19 pandemic caused an increase in vaccination rates for children because their parents or guardians became aware of the danger of highly infectious diseases such as COVID-19.

☐ ☐ 9. People infected with measles can infect others four days before and four days after the appearance of the measles rash.

☐ ☐ 10. Measles is contracted only by inhaling droplets in the air, not by touching a surface on which droplets have landed.

☐ ☐ 11. The introduction of mandatory measles reporting was an important, positive step in the fight against measles.

☐ ☐ 12. A person may be given the measles, mumps, and rubella (MMR) vaccine within 72 hours of being exposed to measles.

T F

☐ ☐ 13. Measles is the most contagious infectious disease, with an estimated infection rate as high as 90% for nonimmune individuals who are exposed to measles.

☐ ☐ 14. Measles did not have a significant impact on indigenous populations in North and South America because they were generally immune to this disease.

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The Grass Is Always Greener

By 2050, nearly 70% of the global population could reside in urban areas, according to the World Health Organization. A study in *Cities & Health* found psychophysiological benefits associated with walking in urban green settings.

To note, urban gray settings are heavily trafficked, with wide road systems and sidewalks, and largely populated with shops and restaurants. Urban green settings have narrower road systems, more trees, residential gardens, and small parks.

Green settings offer various health perks:

- Improved participant moods
- Greater effect on psychophysiological stress reduction
- Higher heart rate variability, indicating a lower physiological stress level

Additionally, if you work or live in urban areas, using green areas can yield better psychophysiological rewards. Walking is a beneficial and joint-friendly activity with low injury risk. Next time you go for a walk, run through your options for locations. The setting matters! Find a local park or walkable residential area to brighten your mood and get the most out of your walk.

Living and Longevity

What are the keys to living a long life? A study published in *eBioMedicine* looked at 186 factors and found the best predictors for this age-old question.

If you're ready to level up your longevity, check out three significant factors that impact life expectancy and see how you can address them in your lifestyle choices:

- **High-density lipoprotein (HDL).** These particles are often referred to as "good cholesterol" and reduce bad forms of cholesterol. Your everyday food choices affect your HDL levels. Adding avocados, olive oil, and various nuts and fish to your diet can help boost your HDL levels, and avoiding excessive refined carbohydrates and fried foods can decrease HDL levels, according to Livestrong.
- **Pack years of smoking.** Pack years are the product of a person's number of daily cigarette packs smoked and the years they have smoked. As your pack years increase, your risk of lung cancer and heart disease increases. Crucially, even if you have a smoking history, you can improve your longevity by quitting.
- **Instrumental activities of daily living.** The ability to complete tasks related to shopping, housekeeping, accounting, food preparation, and travel indicates increased longevity. No need to hit the squat rack at the gym; maintaining even a small amount of consistent physical activity can increase longevity.

Ultra-Processed Pitfalls

Reducing your risk of colorectal cancer can start when you get that gut feeling: a rumbly tummy. When it's time to eat, limit your consumption of ultra-processed foods, advises research in *BMJ*.

The researchers define ultra-processed foods as "industrial ready-to-eat or ready-to-heat formulations made of little or no whole foods." These foods often contain excess sugar and fat, few vitamins and nutrients, and potentially damaging food additives. Consuming an excess of ultra-processed foods and ultra-processed food subgroups increases the risk of developing colorectal cancer.

Reduce your risk by consuming fewer ultra-processed foods, particularly meat and seafood-based ready-to-eat products and dishes as well as sugary beverages. If you need a ready-to-eat snack that's a good source of protein and can satisfy a sweet tooth, reach for a yogurt.

Remember that increasing whole foods consumption can reduce colorectal cancer risk and provide a better all-around nutritional punch.

Sleep Like a Baby

New or expecting parents might want to take note. A recent study in *Sleep Health* confirmed what many sleep-deprived parents already know; sleep is critical for their mental health in early parenthood.

Unsurprisingly, parents are, on average, less likely to meet the recommended sleep guidelines than people with no children. The study also showed that, on average, new parents slept roughly six hours a night, short of the minimum seven hours recommended. Those with sleep deficits scored lower on mental health ratings at six and 12 months.

Of course, getting more sleep is never as easy as it sounds, especially with a newborn in the house. But it never hurts to try. Researchers suggest consulting a practitioner to discuss feasible postpartum sleep strategies. They may suggest strategies for improving the baby's sleep as well as caffeine reduction and other good sleep habits for adults.

Owning Up

Possess the Skills and Grace to Make an Impactful Apology

By Pamela M. Schmacher, MS, CCMP

In a physician's practice, patients want an apology when something goes wrong. However, physicians and medical assistants may be hesitant to apologize to patients because they are uncomfortable admitting mistakes, fear being sued,[1] or do not know how or when to apologize.

Research shows these fears may be unfounded because a sincere apology—when delivered correctly—can prevent legal action, strengthen the patient-physician bond, and improve practice credibility.[2]

A Sorry State

Even health care workers who have never needed to apologize to a patient before may need to in the future. In 2013, more than 922 million physician practice visits occurred in the United States,[3] and the high volume of outpatient care increases the potential for error. An analysis of paid medical malpractice claims from 2005 to 2009 found that of the 11,000 paid claims, 43% were for outpatient setting events.[3] About 4 out of 10 patients are harmed in the primary or ambulatory setting worldwide.[4]

"It's [essential] to have an established apology policy so that everyone in the office knows how to apologize and when to do it," says Benjamin McMichael, PhD, JD, associate professor of law at the University of Alabama School of Law in Tuscaloosa, Alabama. "While you can't foresee every possible event, you can outline a protocol to fall back on when something occurs."

"An apology program is beneficial in that it shows patients that the practice is honest, transparent, and willing to learn," says Haley Stephens, CMA (AAMA), AEMT, a medical assistant at Athens Family Practice in Athens, Tennessee. "But it is beneficial only when used in conjunction with change. An apology without action to fix the problem is empty, and change without an apology or explanation looks like you're trying to hide something. Both [action and an apology] need to be used to avoid litigation and facilitate patient-provider trust and respect."

Dr. McMichael agrees: "When patients sue, often they're just trying to get information about what went wrong, and it's not [an] effective way to communicate. It's better to be up front about what has occurred."

Many patients say that a lack of an apology caused them to pursue a malpractice suit.[2]

I Beg Your Pardon

"Physicians and staff tend to think an apology is only about saying, 'I'm sorry,' but it's more complex than that," says Dr. McMichael. "In a successful apology program, it's important to train ahead of time on how and when to [apologize] effectively."

"Our apology policy is Always Honesty," says Stephens. "We let each physician and their CMA (AAMA) handle any apologies on a case-by-case basis with their provider, practice manager, and medical director."

An effective apology should acknowledge harm, explain what occurred, show remorse, promise behavioral change, and offer to repair any damages. The goals should be to do the following for the patient[5]:

- **Give back dignity and power.** Patients and their families may experience humiliation or disrespect if they believe the physician is withholding critical information, lying, speaking condescendingly, not listening, or avoiding them.
- **Regain their trust.** A sincere apology assures patients that they can trust the practice to make things right.
- **Make them feel they are in good hands.** Patients should be treated respectfully and not as a problem that needs to be fixed.

- **Provide empathy and understanding.** Patients want to know that staff understand how they feel.
- **Release negativity.** Receiving an apology can help patients let go of hostile feelings.

Apologies that do not meet these goals are likely to fail and could cause more harm than no apology. Apologies perceived as inadequate can be met with anger, hurt, and criticism.[2]

Dr. McMichael emphasizes that everyone in the practice must be on the same page. "Medical assistants are an important part of the care team," he says. "If something goes wrong, the entire team should coordinate the apology. You don't want someone going rogue and apologizing without telling [other team members]. That's why it's [crucial] to have a policy in place, so you know what steps to take."

Righting Wrongs

Many states have passed apology laws that make physicians' apologetic statements inadmissible if the patient chooses to sue.[2] Many believe that by providing legal protection, physicians are more inclined to apologize and effectively communicate with patients. Currently, 39 states and the District of Columbia have apology laws.[2] Some physicians incorrectly believe these laws shield them from everything conveyed during an apology, but that is not the case.[2]

"Sometimes [physicians] consider these laws a free pass, but [the effect] depends on [whether] you're practicing in a state with full or partial apology laws," says Dr. McMichael. "Full apology laws protect expressions of regret, error, and statements of fault. Partial apology laws protect expressions of regret only, without any protection for admissions of liability.

"As a rule, it's not a good idea to blurt out 'I'm sorry' without understanding all the facts of the case," he explains. "Patients [usually] don't have medical training and often can't identify when something happened due to bad luck or bad practice. You don't want to apologize in such a way that signals you or the practice may have been at fault. Also, remember that apology laws apply only to statements made by a physician; they don't apply to the rest of the staff."

Contrite as Rain

The benefits of apologies are well established, as patients value honesty from their physicians. A well-formulated apology can help overcome communication barriers between physicians and patients and disarm emotional responses that prompt patients to sue.[6]

"My understanding is that using apologies appropriately can reduce litigation," says Dr. McMichael. "When [physicians] apologize to patients, the patients are willing to forgive them, [improving] the relationship going forward."

Stephens notes that not apologizing can affect the practice's culture: "The impact of not apologizing and owning your mistakes is that patient trust is broken, and it fosters a culture of covering things up instead of [one of] honesty. You don't want your practice to have a reputation for dishonesty." ✦

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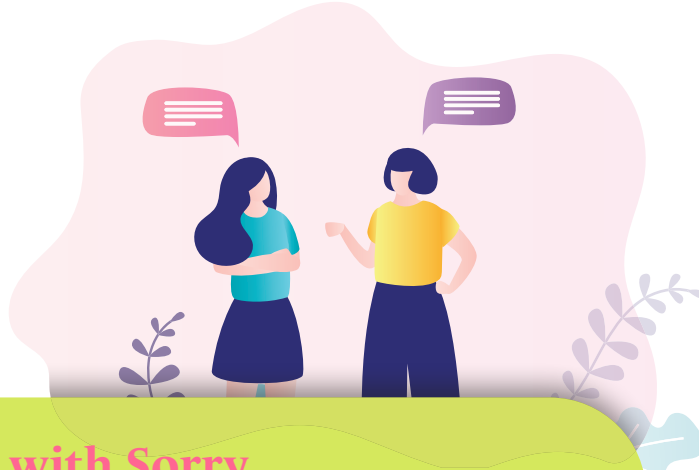


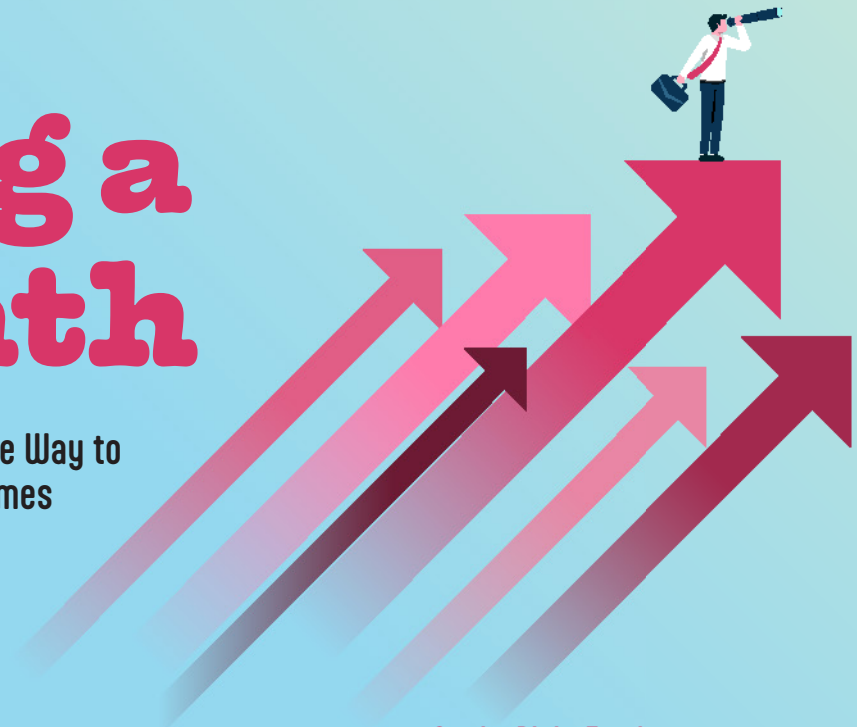
Better Safe with Sorry

Improve your apologies with these tips[1]:

- Get the facts from the involved staff and review the medical record.
- Make the apology in a comfortable and private place. Consider who should be present (e.g., the physician, nurse, CMA (AAMA), patient, and the patient's family).
- Ask the patient what happened to gain insight into their perspective and knowledge of the situation. They should explain how the mistake impacted them and list their concerns, questions, and ongoing needs.
- Provide a simple, chronological timeline of the facts and reasons behind the interventions used.
- Avoid angry rebuttals or defensive statements.
- Outline the action taken so that the error is corrected and prevented from happening again.
- Discuss fair compensation with injured patients.

Forging a New Path

Patient Navigators Show Patients the Way to Improved Access, Health, and Outcomes



By Brian Justice

As the health care landscape evolves and grows more complex, patient navigators become integral in care delivery. An empathetic, generous, and understanding guide can ensure that patients who encounter barriers get efficient and effective help.

Notably, the patient navigator role's definition is still being determined, according to the *Journal of Nursing and Patient Care*:

> As an emerging industry, there is no clear definition or standard training to call oneself a navigator or advocate. There is [no] specific education or background requirement to work as a patient navigator. Different facilities will have different requirements to work in this position. The title of patient navigator does not yet have a universal definition or standardized certification requirements.[1]

While no formal definition for the patient navigator's role exists, workers agree on the role's basic functions.

"A patient navigator improves the patient experience by helping individuals overcome barriers and access the services they need," says Sheila Busheri, MT, CLS, CCL, founder and CEO of Universal Diagnostic Laboratories in Van Nuys, California. "Most navigator programs help patients through the entire process to varying degrees. The patient's individualized program often includes affordable care options, therapies, and more, which can take time and require expertise from someone like a patient navigator. Most programs provide patients the attention they need to fully assess their condition and access better treatment options."

Evidence supports the positive effect patient navigators have on patients. Patient navigators can increase access to health care, improve cancer screening rates, and address social determinants of health—especially in rural areas—by increasing care coordination and connecting populations to health care and other social services.[2]

Experts project the field to grow considerably in the coming years. From 2014 to 2024, the demand for patient navigators by health care systems, insurance companies, and physicians' practices is expected to increase by 50%.[1] The Bureau of Labor Statistics considers patient navigation a "bright outlook" occupation because it "is projected to have many job openings and is a new and emerging occupation,"[1] especially as governmental requirements include higher levels of patient satisfaction.[1]

As such, medical assisting students would benefit from learning about—and what to expect from—this career opportunity, particularly by having it incorporated into their program's curriculum.

On the Right Track

The patient navigator role was created to help cancer patients. However, patient navigators are increasingly helping broader populations manage issues related to health care access, health literacy, and poverty.

"A patient navigator needs to be aware of any barriers the patient may face—mental, emotional, cultural, religious, and financial," says Sherry Bogar, CMA (AAMA), CN-BC, a breast health patient navigator in Clover Ridge League City, Texas. "If a patient is [paying for themselves], a conversation about their financial situation helps me guide them to resources [offered] through Medicaid, Medicare, or the [health insurance] marketplace. Being considerate of the situation and assuring them they have adequate means to cover their treatment eliminates additional stressors throughout their journey."

"We [use the term] *scaling trust*," says Tom Ferry, president and CEO of Engooden Health in Farmington, Massachusetts. "That means talking with patients about their clinical condition [and] everyday challenges. Those [challenges] may include finances, food or shelter insecurity, and perhaps having to choose [daily] between putting food on the table and buying medication. Helping them [create] a plan that eliminates some barriers builds trust with the [patient]."

Those needs may include addressing

why certain patients regularly visit emergency departments (EDs), often because of access limitations in their area, says Brandy Martin, CMA (AAMA), a patient care navigator at MyMichigan Health in Midland, Michigan.

"We focus on patients who have been in the ED more than three times within 60 days," she says. "We try to connect with them and figure out what barriers they face that [make] them use the ED so often. We work with their primary care physicians [to get] them to appointments [and] educate them on proper ED usage and where to go for nonemergency care. That can also include assisting with transportation, food, [and] housing and connecting them with a [physician] if they do not have one. That's just a handful of the many situations we come across and help assist with every day."

Are We There Yet?

Certification is currently unavailable for patient navigators. However, patient navigator groups seek to determine certification criteria.[3] The Colorado Department of Public Health and Environment has a workforce development initiative to create a credentialing exam for health navigators,[4] and other states are following suit. A pilot program in Pennsylvania found that patient navigators improve patient outcomes. Their results prompted the establishment of training programs in 35 locations throughout the country.[1]

As health care transitions to increasingly complex value-based criteria, providers may ask clinical staff to help with patient navigation, which risks compromising patient satisfaction and overall quality of care.[5] Patient navigation tasks undertaken by professionals who are trained in and familiar with the patient journey create an environment of care, and these professionals reap the rewards.

"Like any job, it has difficult moments," admits Martin. "Sometimes, it takes a long time and a lot of trial and error to connect with a patient. However, the feeling you get when you successfully help a patient is the best reward."

Bogar agrees, noting that "being a patient navigator has helped me develop better communication skills, become more empathetic, and provide better and more comprehensive care."

Further, health care facilities are becoming increasingly aware of the financial benefits of using patient navigators, including reducing readmissions and avoiding cuts to Medicare payments.[1]

"People ask how using patient navigators benefits the health care system overall," says Ferry. "Clinical issues are only about 20% of what impacts patient health. The other 80% is outside of clinical interaction. Eliminating some of the obstacles people face, with the help of navigators, improves health care because patients can focus more on their care plans and other things that impact their overall health. Plus, their feedback helps providers better understand patients' challenges."

Still, the patient navigator role must grow further, observes Bogar. And that growth can start in the classroom. By introducing students to patient navigation during their education, educators set future medical assistants up for success in an increasingly necessary role. ✦

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Make Your Move

Staff at the Oregon Health & Science University created the Student Navigator Project—a teaching program focused on patient navigation and health systems science—and observed its progress between 2016 and 2019.[6] These observations were published via a study[6] in *Medical Science Educator* in June 2022.

Overall, the preclinical students gained several short-term outcomes through the program[6]:

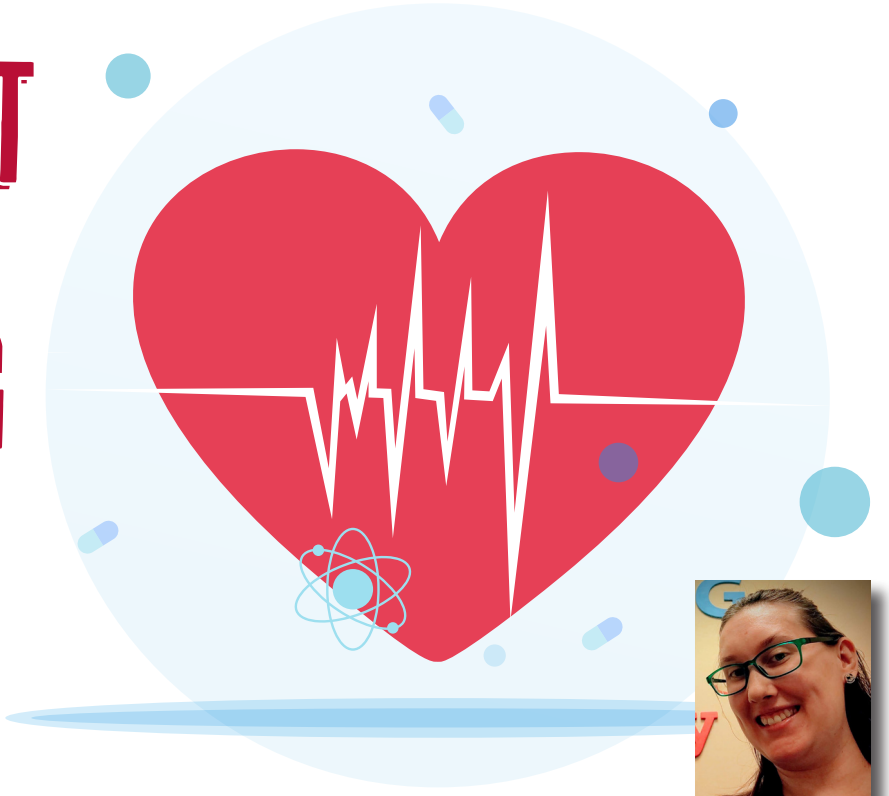
- Interprofessional skills from training and working as medical assistants
- Value-added, longitudinal relationships with medically and socially complex patients while they navigate the health care system together
- An understanding of patients' perspectives of health care
- Insight into the biopsychosocial challenges of the health care system
- Immersion in a systems-based practice approach early in their education and career
- Satisfaction in the program and their knowledge of program focus areas
- The opportunity to contribute meaningfully to patients' care

The study is available to read for free online. Read it to learn what training the students received and the educational activities timeline for inspiration on establishing a similar program between your medical assisting program and practicum sites.[6]

A HEART SET ON CAREGIVING

CMA (AAMA) Shows Strength and Kindness as a Medical Assistant and Patient

By Cathy Cassata



Siara Wallace, CMA (AAMA), knows firsthand the reality of being a patient. The 32-year-old underwent open heart surgery in high school due to a familial connective tissue disorder that causes multiple aortic abnormalities.

"My mom and her brothers passed away from [the condition], and two of my cousins have it, plus one of their sons. Unfortunately, [physicians] don't know what it is. They thought it was Marfan syndrome or [hereditary hemorrhagic telangiectasia], but it's neither," says Wallace.

Living with the condition drew Wallace to the medical field. She first got her bachelor's degree in sports science with a minor in psychology. After college, she considered going to graduate school for cardiac nursing, but in South Carolina, where she lives, few job opportunities in the field are available.

"My mom's health declined at that time, and I wanted to stay near her, so I ended up taking care of an elderly woman who had Alzheimer disease for three years and really enjoyed it," explains Wallace.

Wallace decided to enroll in a medical assisting program and completed her practicum at a nursing home. When she graduated in 2017, she got a job with an independent contractor of nursing homes and rehabilitation centers that hires nurse practitioners and physicians to treat patients at various facilities. She traveled across South Carolina to work at their different locations.

"As the medical coordinator, I was the liaison between the floor nurses, patients, and practitioners," she explains. "If a patient got a cold, wasn't feeling well, or needed new medication, that's where my job came in. I made sure everybody was seen in the facility."

She also managed medical charts, handled scheduling, and trained other medical assistants on staff. Her favorite role was conducting telehealth visits with residents and off-site physicians.

"I'd go into the patient's room, and if the [physician] needed to see a bed sore, the nurse and I would roll them over and show the [physician] the bed sore via the app. Then we'd hold the device so the [physician] and patient could talk," she says. "That was the highlight of my day because I got to see the patients. I know what it's like to lay in that bed. I've been there."

She also excelled at talking to older patients' family members.

"When a patient [is] sitting in a nursing home or hospital, it can be frustrating when [they're] waiting and just want somebody to listen. I always try to be that person who gives somebody a few moments," says Wallace.

After working in this role for seven years, she had to step back from medical coordinating in January 2022 due to severe complications from a surgery she underwent the previous December to correct an arteriovenous malfunction. After recovering from surgery, she began experiencing neurological difficulties, including bouts of blanking out.

"I would log in to the computer at work and couldn't remember my password, and so that's when I knew I couldn't work anymore," says Wallace.

The decision to stop was heartbreaking because Wallace was at a great place in her career and loved her role as a medical assistant.

"I really didn't want to stop working, but going under anesthesia so many times in the last couple years has really slowed me down, unfortunately," she says.

Wallace hopes neurobehavioral counseling will help restore her brain functioning to full capacity and that she can get back to medical assisting. "I'll do what it takes so I can be there for patients and their families again," she says. ✦

2022 EXCEL AWARDS

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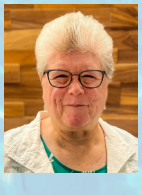

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Student Essay Award

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Tasha Siaosi, CMA (AAMA)
Community Care College, Tulsa, Oklahoma

Medical Assistant Employer of the Year Awards

Sections by Employee Totals

Section A = 1–50 employees
Section B = 51–100 employees
Section C = 101–500 employees
Section D = 501 employees or more

Fairview Hospital's "Westown Physician Center" Lakewood Teams (A), represented by Alexandria Boyadia and Nancy Richards

Nationwide Children's Hospital School-Based Health Services (B), represented by Mary Kay Irwin

Avera Health (D), represented by Pam Hilbur

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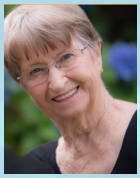

Johnny Adamson, CMA-AC (AAMA)

Sections by State Society Member Totals

Section A = 200 members or fewer
Section B = 201–500 members
Section C = 501–800 members
Section D = 801 members or more

Publishing

Excel
SDSMA Messenger, published by **South Dakota** (A), Maggie Olson, BS, CMA (AAMA), editor
Texas Tidbits, published by **Texas** (B), Donna Gibbins, CMA (AAMA), and Dina Harrett, CMA (AAMA), editors
PSMA WAVE, published by **Pennsylvania** (C), Diana Rogers, CMA (AAMA), editor
Helping Hands, published by **Ohio** (D), Diana Rogers, CMA (AAMA), editor
The Michigan Medical Assistant Journal, published by Michigan (D), Tracy Hardy, CMA (AAMA), editor

Achievement
CTSMA e-Magazine, published by **Connecticut** (B), Rebecca V. Parry, CMA (AAMA), editor
NYSSMA Today, published by **New York** (B), Heather Kazmierczak, BFA, CMA (AAMA), editor
TEMPO, published by **North Carolina** (D), Amber Greer, BS, CMA (AAMA), PBT(ASCP), editor
Med-A-Scoop, published by **Indiana** (D), Pam Neu, MBA, CMA (AAMA), editor

Website Development

Excel
South Dakota (A), Maggie Olson, BS, CMA (AAMA), web chair
Nebraska (B), Debra Potratz, CMA (AAMA), web chair
Michigan (D), Mistie Atkins, CMA (AAMA), web chair

Achievement
Arkansas (A), Misty Ross, CPPM, CMA (AAMA), web chair
Connecticut (B), Rebecca V. Parry, CMA (AAMA), web chair
Florida (D), Mary Lou Allison, CMA-C (AAMA), web chair
Indiana (D), Pam Neu, MBA, CMA (AAMA), web chair
North Carolina (D), Amber Greer, BS, CMA (AAMA), PBT(ASCP), web chair
Ohio (D), Jennifer Dietz, MS, CMA (AAMA), web chair

Marketing, Promotion, and Recruitment

Excel
"2022 State Convention and Online CEU Opportunities," conducted by **South Dakota** (A), Erica Arends, CMA (AAMA), and Maggie Olson, BS, CMA (AAMA), campaign directors
"Medical Assistants in Pink," conducted by **Texas** (B), Lisa Connelley, CMA (AAMA), Donna Gibbins, CMA (AAMA), and Dina Harrett, CMA (AAMA), campaign directors
"WE Are the Future of FSMA: Let's Make a Positive Influence," conducted by **Florida** (D), Deniece Jozefiak, CMA (AAMA), and Kathryn Panagiotacos, CMA (AAMA), campaign directors

Achievement
"Where Are My People?" conducted by **Arkansas** (A), Melinda Rhynes, MEd, CMA (AAMA), campaign director
"CTSMA 62nd Conference," conducted by **Connecticut** (B), Jen Amaral, CMA (AAMA), campaign director

Community Service

Excel
"Red Cross Blood Drive 62nd Conference," conducted by **Connecticut** (B), Rebecca V. Parry, CMA (AAMA), campaign director
"Fostering the Fosters," conducted by **South Carolina** (D), Stephanie Pruitt, CMA (AAMA), campaign director

Achievement
"2021 Year of Giving Back," conducted by **New Hampshire** (B), NHSMA Board, campaign directors
"Sprays for the Rescue Mission of the Mahoning Valley," conducted by **Ohio** (D), Laura Mizicko, CMA (AAMA), campaign director

Membership Retention

Montana (A); **Colorado** (B); **Maine** (C); **Iowa** (D)

Membership Recruitment

Hawaii (A); **Missouri** (B); **Kentucky** (C); **Illinois** (D)

Student Membership Recruitment

Oklahoma (A); **Alabama** (B); **California** (C); **Minnesota** (D)

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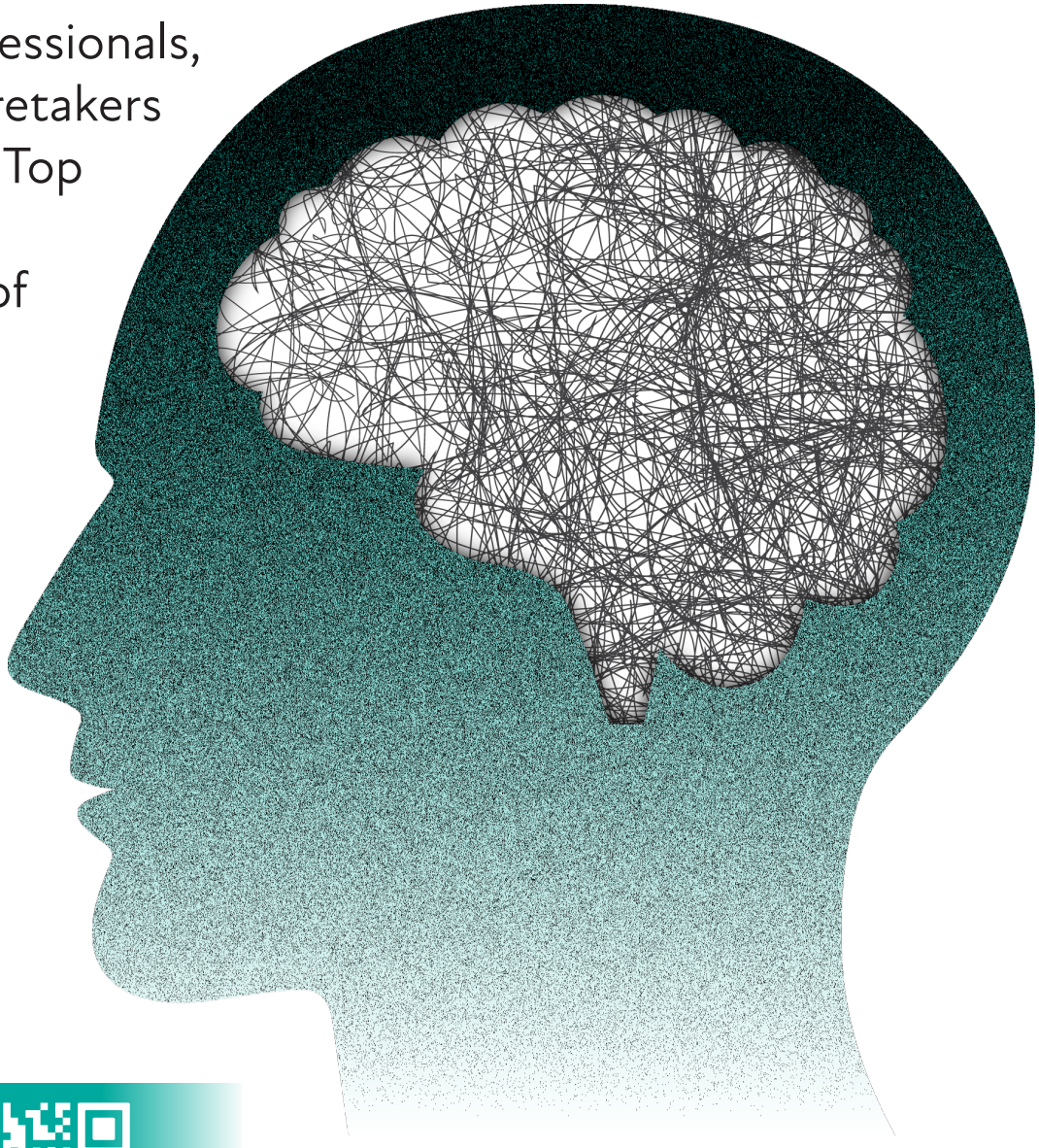
Attention-Deficit/ Hyperactivity Disorder

Health Care Professionals, Patients, and Caretakers Need to Stay on Top of a Continually Evolving Canon of Knowledge

By John McCormack



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