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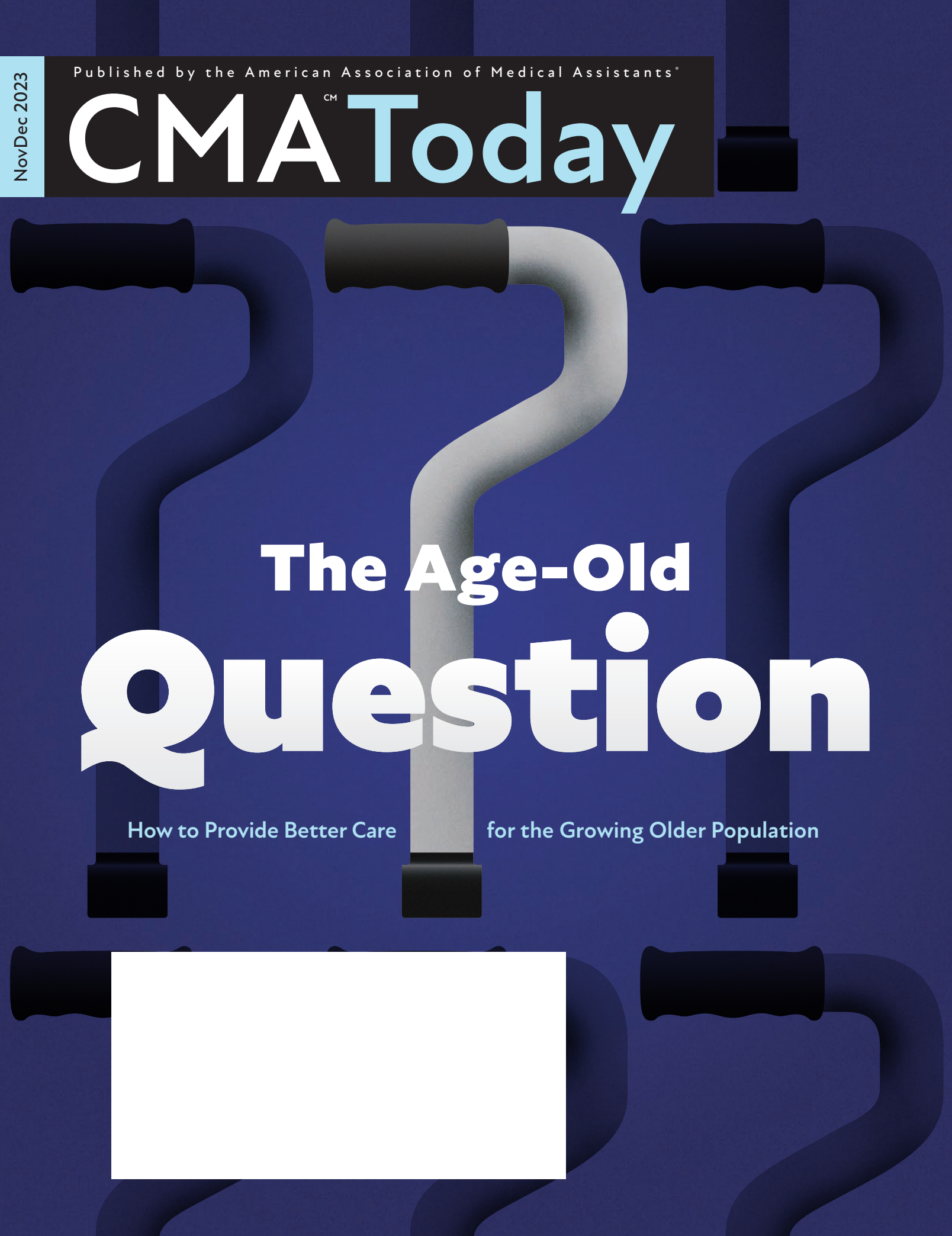

The Age-Old Question

How to Provide Better Care for the Growing Older Population

Let's Get to Work!

Adapted from the inaugural address of AAMA President Monica Case, CMA (AAMA), at the 2023 AAMA Annual Conference.

Thank you for allowing me to share my medical assisting passion and serve as your 2023–2024 AAMA President; it is truly an honor.

In 1986, I started classes at a local college for a brand-new medical assisting program. My educator required us to attend the Chattanooga Chapter of Medical Assistants meeting. I was amazed at how passionate the attendees were about the profession. That started the tugging and burning in my heart. I was hooked and wanted to know more.

I started in the local chapter and was mentored and inspired. I worked my way to the state level and served in all positions. I attended my first AAMA conference in 1998, representing Tennessee as an alternate delegate, and I have missed only one conference since then. The House of Delegates inspired me as I observed the same passion I had for medical assisting.

I stood before the House of Delegates in 2016 and asked for member support as I ran for AAMA Trustee. I vowed to work hard for the members, our profession, and the CMA (AAMA)® credential, and I will continue this as your AAMA President.

The medical assisting profession has motivated and empowered me to excel professionally and personally. Medical assisting is about providing the safest and best care for all patients, and I wish for the AAMA to continue promoting this stance.

My presidency is not about me; it is about the work of the AAMA and Board of Trustees (BOT). But more importantly, it is about you, the members, and our future. When we change nothing, nothing changes. We must be proactive and keep the AAMA ahead of the game. The AAMA must embrace change and bring more recognition to the profession. We must educate the public and promote the value of medical assistants and the CMA (AAMA) credential.

Reaching out to nonmembers and showing the value of membership will increase our numbers. With greater numbers come greater achievements.

Each member has a voice in this organization and its future. We all need to step up, as we have the same passion.

I want to thank my family, friends, employer, the BOT, and the AAMA past presidents for your support and trust. You inspire me to be the best, and I thank the members for your support.

Monica Case, CMA (AAMA)

Monica Case, CMA (AAMA)
2023–2024 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. 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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CMA Today

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Submit Your Recertification Application Materials Any Time Before Your Expiration Date

CMA (AAMA)® recertificants do not need to wait until six months before their expiration date to submit their completed CMA (AAMA) Recertification by Continuing Education Applications.

Applications can be submitted any time before recertificants' certification expiration date.

Even better news: recertificants can keep their original expiration date or choose to recertify early!

Keeping Your Certification Expiration Date

If all continuing education requirements are met and the application fee is submitted, the application will be processed, and the new certification period will not begin until the original certification period has ended.

Recertifying Early

Applicants wishing to have their certification period begin immediately upon submitting their application must select "Early Recertification" on the application or notify the Continuing Education Department in writing. If "Early Recertification" is selected, the new certification period will begin the month in which the recertification application is received by the AAMA Executive Office.

Reference the CMA (AAMA) Recertification by Continuing Education Application for details and the overall process.

On the Web

CMA Today *Indexed*

Under CMA Today/Archives

Need to find an article but can't remember the issue? Use the 2003–2023 *CMA Today* title/author indexes. Then, search by volume and issue on the "Archives" webpage. Or use the search field (upper-right corner of each webpage) to find what you're looking for. ✦

Turning the Page on *CMA Today*: New Magazine Title!

Starting with the Jan/Feb 2024 issue of the magazine, *CMA Today* is becoming *Medical Assisting Today: The Magazine for Professional Medical Assistants*. ✦

Boost Your Recertification Points Total with This Policy for Recertifying by CE!

Are you recertifying for the **first time**? A policy from the Certifying Board of the American Association of Medical Assistants® allows you to apply a limited number of recertification points earned prior to your initial certification toward your first time recertifying!

If you are an initial certificant, you 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.

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. Course credits earned and required for graduation from a medical assisting program ***cannot*** be used toward initial recertification.

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

Standout Students

Congratulations to this year's recipients of the Maxine Williams Scholarship:

Darrylinn Tafoya graduated in July 2023 from Santa Fe Community College in New Mexico. Tafoya's passion for helping people with health care needs in her community (San Ildefonso Pueblo) fueled her career in medical assisting. In the future, she hopes to help meet the needs of others who need assistance. "I enjoy giving back to the community and surrounding areas that have helped me along my health care career and school needs."

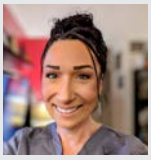
As a student, Tafoya is described by a professor as an exemplary student and team player. "[Darrylinn] is a very kind and caring person, [as well as] very strong and determined—great qualities for a medical assistant."

Michaela Reed graduated in May 2023 from SUNY Erie Community College in Williamsville, New York. Reed hopes to channel her love of children and desire to help families through difficult times into work as a pediatric cardiac sonographer. She feels the CMA (AAMA) credential will equip her with the skills to be a multifaceted health care worker. "I am so glad I chose medical assisting because no other program offers the combination of clinical and administrative curriculum like this field," she says.

Reed is known for her adaptability and positive attitude. Her employer emphasizes their confidence in Reed's career: "[Michaela] thinks of better ways to do things and isn't afraid to volunteer her excellent ideas. I am confident that Michaela will be the best medical assistant she can be. Her warm, welcome, and positive attitude will brighten the days of many people."

Millaray Lopez graduated in August 2023 from Bates Technical College in Tacoma, Washington. After graduation, she hopes to work as a CMA (AAMA) in a hospital setting, helping a variety of patients. She eventually hopes to pursue higher education.

Lopez's educators praise her as a focused, organized, and skillful student. A professor notes, "Millaray distinguishes herself in the program with her professionalism and accomplishments. … She continues to show exceptional maturity and reliability in her performance."



Terreva Zipp will graduate in May 2024 from Ivy Tech Community College in Sellersburg, Indiana, with two certifications and an associate degree. After graduation from the medical assisting program, she will continue studying at Ivy Tech for certification in addiction studies. She hopes to eventually work in a private practice.

During her academic career, Zipp has persevered to achieve and maintain academic success. Despite her numerous responsibilities, she is dedicated to her assignments and enjoys supporting other students. Her professor notes, "[Terreva] takes pride in her work and performs her absolutely finest in all that is asked of her."

Want to Submit Your Membership Dues Renewal via Mail?

Keep an eye on your mailbox in November for the mailed 2024 Membership Dues Remittance Form for you to renew your membership by mail for the 2024 membership term. ✦

States That Require Medical Assistants to Meet Education and Testing Requirements

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

The U.S. Department of Education's issuance of its final rule "Financial Value Transparency and Gainful Employment" (see "A Department of Education Proposed Rule Could Impact Career and Technical (Including Allied Health) Education"[1] in the September/October 2023 issue of *CMA Today*) has prompted renewed interest in the scope of practice of medical assistants under state law. The following article summarizes the laws of states that require medical assistants to meet education and/or testing requirements for the performance of certain duties. More detailed descriptions of state medical assisting laws can be found on the AAMA website on the "State Scope of Practice Laws" webpage.

California

The following are excerpts from the website of the Medical Board of California:

> Prior to a medical assistant performing technical supportive services, a medical assistant shall receive training, as necessary, in the judgment of the supervising physician, podiatrist, or instructor to ensure the medical assistant is competent in performing that service.
>
> Medical assistants shall be trained [in a formal academic setting or] by a licensed physician, podiatrist, registered nurse, licensed vocational nurse, a physician assistant, or a *qualified medical assistant* [emphasis added].
>
> …
>
> For medical assistants to administer medications by intramuscular, subcutaneous, and intradermal injections, to perform skin tests, or to perform venipuncture or skin puncture for the purposes of withdrawing blood, a medical assistant shall complete the minimum training prescribed in the regulations.
>
> Training shall be for the duration required by the medical assistant to demonstrate competence to the supervising physician, podiatrist, or instructor. Where applicable, training shall include no less than:
>
> - 10 clock hours of training in administering injections and performing skin tests;
> - 10 hours of training in venipuncture and skin puncture for the purpose of withdrawing blood;
> - at least 10 of each intramuscular, subcutaneous, and intradermal injections and 10 skin tests, and/or at least 10 venipuncture and 10 skin punctures;
> - 10 hours of training in administering medication by inhalation; and
> - training in the above shall include instruction and demonstration in:
>   - pertinent anatomy and physiology appropriate to the procedures;
>   - choice of equipment;
>   - proper technique including sterile technique;
>   - hazards and complications;
>   - patient care following treatment or tests;
>   - emergency procedures; and
>   - California law and regulations for medical assistants
>
> In every instance, prior to administration of medicine by a medical assistant, a licensed physician or podiatrist, or another [appropriately] licensed person shall verify the correct medication and dosage. The supervising physician or podiatrist must authorize any technical supportive services performed by the medical assistant and that supervising physician or podiatrist must be physically present in the treatment facility when procedures are administered, except as provided in section 2069(a) of the Business and Professions Code.
>
> …
>
> Medical assistants are not required to be licensed or certified by the State of California. … If medical assistants will be training other medical assistants [outside of a formal academic setting], they must be certified by one of the [Medical Board of California]-approved certifying organizations listed on the Board's Medical Assistants page.[2]

Connecticut

Connecticut law allows medical assistants who (1) have met specified education requirements and (2) are certified in medical assisting by a recognized certification body to administer vaccines in a nonhospital setting under the authority, control, and supervision of a physician, nurse practitioner, or physician assistant.

Delaware

Delaware law authorizes advanced practice registered nurses (APRNs)—including nurse practitioners—to assign medication administration to a medical assistant if the medical assistant (1) has successfully completed a medical assistant training program and (2) possesses current national medical assistant certification.

The APRN must be present in the building when the medical assistant is administering medications and will assume liability for the actions of the medical assistant.

Massachusetts

Massachusetts law is as follows:

> A PCP [primary care provider] may delegate the administration of immunizations

to a certified medical assistant who:

(1) has graduated from a post-secondary medical assisting education program accredited by the [Commission on Accreditation of Allied Health Education Programs (CAAHEP)], the Accrediting Bureau of Health Education Schools, or another certificate program that the commissioner of public health may approve; and

(2) is employed in the clinical practice of a licensed primary care provider[3]

Nebraska

Nebraska law requires medical assistants—regardless of their education and credentialing—to register with the state Department of Health and Human Services as medication aides to be delegated certain types of administration of medication. Medical assistants who work in medical practices and clinics need to pass a competency assessment that is administered by a licensed provider or a licensed health care professional.

New Jersey

New Jersey law permits medical assistants who have met specified education requirements and hold a current medical assisting credential to be delegated (1) venipuncture and (2) the administration of certain types of injections under the authority of a physician who is on the premises and immediately available.

North Dakota

North Dakota nursing law requires medical assistants to meet education and certification requirements and to register with the Board of Nursing as a Medication Assistant III to be delegated certain types of administration of medication.

South Carolina

South Carolina law permits medical assistants who (1) have completed specific education requirements and (2) hold a current, recognized medical assisting certification to be delegated certain nonbasic tasks by physicians, nurse practitioners, and physician assistants who are on the premises and immediately available. These tasks include certain types of administration of medication. There is a grace period extending to July 2024 for medical assistants working as of July 2022 to become certified and, therefore, be legally eligible to be delegated nonbasic tasks.

South Dakota

Note the following excerpt from the May 11, 2022, policy statement of the South Dakota Board of Nursing:

Guidelines

A registered nurse may assign nursing tasks and supervise a medical assistant provided:

…

- The medical assistant is certified with the American Association of Medical Assistants (AAMA) or American Medical Technologists (AMT);
- Assigned nursing tasks are consistent with Commission on Accreditation of Allied Health Education Programs (CAAHEP) standards, with the exclusion of IV therapy;
- The medical assistant has demonstrated competency to perform the assigned nursing tasks;
- The supervising registered nurse is readily available either in person or via electronic communication.[4]

Tennessee

The following are excerpts from the Tennessee law:

(1) "Ambulatory outpatient hospital clinic" means a clinic or physician office that is owned and operated by a hospital licensed under this title and that provides treatment to patients who are not admitted as inpatients to the hospital;

(2) "Certified medical assistant" means personnel with training to function in an assistive role to a licensed physician or licensed nurse in the provision of patient care activities in a facility used as an ambulatory outpatient hospital clinic as delegated by the physician or licensed nurse;[5]

A "certified medical assistant" must be certified in medical assisting by a body recognized (in the 2021 Tennessee statute).

(A) A certified medical assistant may administer approved, standardized dosage vaccines to the patients of an ambulatory outpatient hospital clinic that uses certified medical assistants pursuant to this section. A certified medical assistant shall administer other medications only pursuant to delegation by a licensed nurse or physician.

…

(k) This section does not apply to personnel employed by a physician performing duties in settings other than in an ambulatory outpatient hospital clinic.[5]

Washington

Washington law has established four categories of medical assistants, with different requirements for each category. (These requirements are in the process of being modified by the Washington State Department of Health pursuant to legislation enacted in February 2022.) Medical assistants who perform clinical tasks are required by law to register with the Washington State Department of Health in one of the four categories. ✦

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

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SMOKE & MIRRORS

Poor Air Quality Is an Invisible Threat

By Brian Justice

The extraordinary reach of smoke from the 2023 Canadian wildfires made the news and raised collective awareness about poor air quality and its dangers. Many health issues are caused or aggravated by air pollutants, and the negative effects are on the rise. In fact, poor air quality causes 6.5 million deaths around the world every year, and the rate has increased over the past two decades.[1]

Air pollution's causes are both natural and human made[1]:

- Smoke
- Volcanic ash
- Gases from decomposing matter
- Vehicle emissions
- Fuel oils
- Natural gas
- Manufacturing byproducts

However, other, more systematic dangers exist too, cautions Adrian M. Pristas, MD, the corporate medical sleep director at Hackensack Meridian Health Monmouth Sleep and Pulmonary Associates in Hazlet, New Jersey.

"Certainly, people with respiratory compromise are going to be more susceptible to the effects on their underlying lung disease," he says. "There's plenty of data to show that there are downstream consequences, including overwhelming the medical system, especially [because] these vulnerable people cannot accommodate these stresses on short notice without some kind of plan to stay free and clear of air pollution."

Air Apparent

Common pollutants can have serious consequences:

Ammonia is a pungent, colorless gas originating from agricultural processes, cigarette smoke, and cleaning products. Even small amounts can irritate the eyes, nose, throat, and respiratory tract, and larger quantities are poisonous.[2]

Carbon monoxide is an odorless, colorless, and tasteless toxic gas emitted from vehicles, propane heaters, fireplaces, ovens, forest fires, and power plants. It interferes with a body's ability to deliver oxygen to organs and, in high concentrations, can be deadly.[2]

Nitrogen dioxide is formed via the oxidation of nitric oxide and can take the form of acid rain, which damages soil and water. Nitrogen dioxide negatively affects the respiratory system, increasing risks of stroke.[2]

Ground-level ozone forms in reaction to other pollutants. It reduces lung function, damages vegetation, and is a major component of smog.[2]

Particulate matter is airborne liquid and solid particles from traffic, construction, power plants, heaters, and more. It is linked to cardiovascular and respiratory diseases, and ultrafine particles pose even greater health risks because they can penetrate the respiratory and circulatory systems, damaging the lungs, heart, and brain.[2] Fine particular matter (PM 2.5) is 30 times finer than human hair and causes most air pollution health effects in the United States.[1]

Many may think poor air quality is a danger only outdoors, but significant dangers exist inside too.

Americans typically spend 90% of their time indoors, where concentrations of pollutants can be 2–5 times higher than those outdoors.[3] More vulnerable populations, including infants, older people, and individuals with cardiovascular or respiratory conditions, tend to spend even more time inside. Indoor pollutant levels are also rising because of the increased use of synthetic building materials, furnishings, personal care items, pesticides, household cleaners, and even energy-efficient building designs, which may lack proper ventilation.[3]

Air on the Safe Side

The U.S. Environmental Protection Agency (EPA) established the Air Quality Index (AQI) to inform people about daily air quality. It assesses the concentration of ground-level ozone, particulates, carbon monoxide, nitrogen dioxide, and sulfur dioxide via over 1,000 pollution monitors nationwide. The index ranges from 0 to 500. Below 100, the air quality is generally safe. However, when the index is higher, outdoor air poses risks to older adults, children, and people with heart or lung conditions, and an index exceeding 200 is deemed very unhealthy.[6]

Access to this data—and more—is readily available through the AirNow website, a comprehensive overview of local, state, national, and global air quality information. An interactive map allows users to access air quality data for specific areas. It uses the AQI and—in collaboration with the EPA, the National Oceanic and Atmospheric Administration, the National Park Service, NASA, the Centers for Disease Control and Prevention, and other air quality agencies—delivers air quality information for over 500 U.S. cities, American embassies and consulates around the world, Canada, and Mexico.[7]

As I Live and Breathe

Certain populations may be more vulnerable to the effects of air pollution:

Children. The Children's Health Study at the University of Southern California found that elevated air pollution levels contribute to increased short-term respiratory infections and thus more school absences. Children engaged in multiple outdoor sports in high ozone areas and those who live near busy roads are more likely to develop asthma. Children with asthma exposed to high air pollutant levels are also more prone to bronchitis.[1]

Older Adults. Researchers at the University of Washington have established a compelling connection between air pollution and dementia. Conversely, another multiyear investigation demonstrated that *improved* air quality is associated with a decreased risk of dementia in older women.

Air pollution has also been implicated in various neurological disorders, including Parkinson disease, Alzheimer disease, and osteoporosis. Long-term exposure to traffic-related air pollution significantly accelerates the onset of physical disabilities among older adults, especially among racial minorities and those in medically underserved communities.[1]

This discrepancy concerns Curtis Brown, a visiting senior practitioner in residence at the Virginia Commonwealth University L. Douglas Wilder School of Government and Public Affairs. "Health care professionals may be seeing patients who come from communities that have been historically marginalized," he says. "Understanding why they are suffering promotes trying to find solutions and developing a sense of empathy."

Pregnant People. Smoke poses particular risks to pregnant people, many of whom have reduced lung capacity. Research also suggests that exposure to air pollution during the first two trimesters might be linked to gestational diabetes. The dangers extend to the developing fetus, with an increased chance of low birth weight, miscarriage, and stillbirth. A worldwide assessment revealed that air pollution may have played a role in nearly 6 million premature births in 2019.[4]

Slow Burn

A recent review in *BJPsych Open* highlights the impact of poor air quality on mental health, noting links to depression, anxiety, psychosis, and other neurocognitive disorders. Notably, children and adolescents may face exposure to these pollutants during critical stages of their mental development, increasing their vulnerability to severe and lasting mental health issues. While poor air quality is already associated with adverse physical health outcomes and diseases, the connection between air pollutants and mental health has previously received comparatively limited attention.[5]

Increasingly poor air quality creates cascading effects of ongoing issues, notes Matty McElwain, CMA (AAMA), who works at Methodist HealthWest Sports Medicine in Omaha, Nebraska.

"I've noticed that with the decreased air quality, people with asthma have increased pain levels," she says. "When the body is stressed and you can't breathe, you start noticing more pain, and the higher the stress level, the higher the pain levels too. More patients are having to get intercostal nerve blocks to help with their breathing."

Paula Schubert, CMA (AAMA), who works at Hancock Health in Greenfield, Indiana, organizes referrals for a consortium of health care providers and has seen an uptick in those she makes to pulmonologists. "It's gone from five or six a year to 15," she says.

With the continual increase in adverse health effects from poor air quality, continuing to raise awareness about its effects can help protect high-risk populations and inspire advocating for decreasing and regulating pollutants in the future. ✦

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The Dangers of Medical Diagnosis Errors

In the United States, medical misdiagnoses cause hundreds of thousands of deaths and permanent disabilities each year, according to a recent report in *BMJ Quality & Safety*.

Researchers from Johns Hopkins Medicine used past studies to determine how certain conditions were missed and harmed patients, scaling the risk by the incidence rate of new cases in the total U.S. population. They found that about 371,000 people die and 424,000 sustain permanent disabilities—including brain damage, blindness, loss of limbs or organs, or metastasized cancer—yearly as a result.

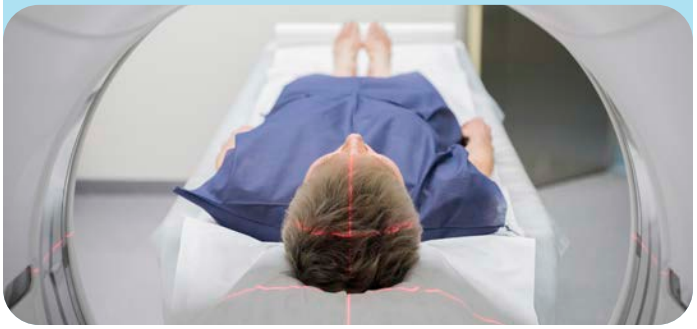
Researchers found that nearly 40% of severe outcomes like death and permanent disability were linked to erroneous diagnoses of five conditions—sepsis, pneumonia, stroke, venous thromboembolism, and lung cancer. These conditions were not the most frequently misdiagnosed but rather had the most significant impact.

Stroke is the top cause of serious harm. Nearly one million people in the United States have a stroke each year, and about 18% of cases are missed, which annually causes about 94,000 serious harms.

Medical diagnosis errors are typically caused by the attribution of nonspecific symptoms to a more common and mild condition than the true cause, according to CNN Health. Symptoms like dizziness, fatigue, and headaches can be symptoms of numerous conditions, making it harder to pinpoint a diagnosis.

Additionally, the fragmented nature of health care, with patients having multiple providers with different systems and understandings of their medical histories, makes it easy for information to get scattered.

Improving diagnoses in health care is crucial for the future of public health. Patients should keep track of their personal medical histories and stay informed about conditions, tests, and medications to help take charge of their own diagnostic journey, according to the National Academies of Sciences, Engineering, and Medicine.



Climate Disaster Cited as Cause for Blood Shortage Crisis

The American Red Cross declared a national blood shortage in September 2023 due to critically low blood supply levels that have dropped by nearly 25% since August. They urgently called for donors of all blood types, particularly platelet and type O blood donors, to ensure patients nationwide receive the medical care they need.

The Red Cross speculates that the critically low levels are partially attributable to ongoing climate disasters, including Hurricane Idalia, which hit Florida in August and caused over 700 units of blood and platelets to go uncollected. They also cite a busy travel season and back-to-school activities as potential causes of the drop in donor turnout.

The donor drop-off caused a shortfall of 30,000 donations, as 2,500 hospitals and transfusion centers rely on the Red Cross to collect 12,500 blood donations daily, according to the *New York Times*.

Low blood supply can take weeks to rebound to normal levels. The Red Cross estimated that they must collect 10,000 additional blood products weekly for a month for the blood supply to meet the needs of hospitals and patients.

The need for blood is constant, as someone in the United States needs blood every two seconds. This demand requires the Red Cross to constantly work with hospitals to meet patients' needs, as those with conditions like sickle cell anemia or those undergoing chemotherapy for cancer need frequent blood and platelet transfusions. Nearly half of all platelet donations go to patients undergoing cancer treatment.

The Red Cross urges individuals who can give blood to help them return to normal supply levels and aid those with medical needs.

New Ozempic Side Effects Uncovered in Epidemiological Study

Diabetes drugs like Ozempic and Wegovy have exploded in popularity as weight loss tools but have been found to pose a risk of severe gastrointestinal problems.

Researchers from the University of British Columbia conducted the first large, population-level study to examine the adverse gastrointestinal events in non-diabetic patients using glucagon-like peptide-1 (GLP-1) agonists such as Ozempic, Wegovy, Rybelsus, and Saxenda for weight loss. The results, published in *JAMA*, found that these GLP-1 medications are associated with an increased risk of serious medical conditions like pancreatitis, bowel obstruction, and stomach paralysis.

The researchers examined health insurance claim records for 16 million patients with a recent history of obesity in the United States, looking at those prescribed one of two main GLP-1 agonists between 2006 and 2020, excluding patients with a history of diabetes. They found that patients had about 9 times higher risk of pancreatitis, over 4 times higher risk of bowel obstruction, and nearly 4 times higher risk of gastroparesis.

The off-label weight loss tool became approved for obesity treatment in 2021 and climbed to about 40 million prescriptions in the United States in 2022. However, studies that investigated the drug's efficacy for weight loss did not examine gastrointestinal effects due to the small sample sizes and lack of follow-up periods.

With millions of people using these drugs globally, patients should be well-informed on the potential risks. Researchers hope drug manufacturers and regulatory agencies add warning labels to their products.

Patients taking these drugs for weight loss should monitor their symptoms and seek medical care if they notice side effects to avoid serious consequences.

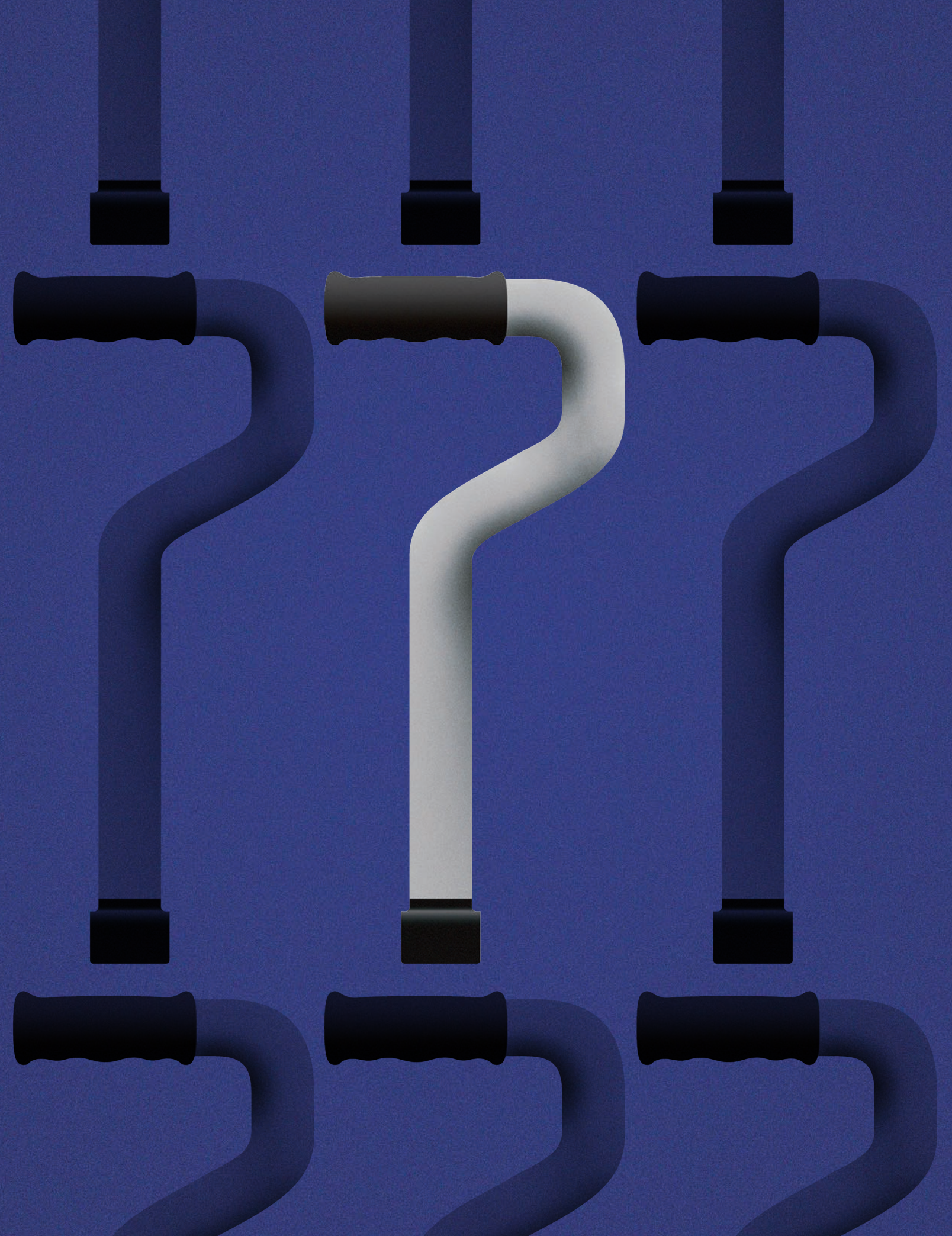
Kaiser Permanente Workers Strike for Better Wages and Patient Care

Health care worker unions reached a tentative agreement with Kaiser Permanente following the biggest health care strike in U.S. history in October. The three-day strike involved over 75,000 workers across California, Colorado, Washington, Oregon, Virginia, and Washington D.C., according to NPR. The strike included nurses, medical technicians, and support staff.

The strike focused on workers' demands for better pay and methods for reducing chronic staff shortages and high turnover that have negatively impacted working conditions and the quality of patient care at Kaiser Permanente. One of the largest nonprofit health care providers in the United States, Kaiser Permanente serves nearly 13 million patients nationwide, according to NPR.

Represented by the Coalition of Kaiser Permanente Unions, workers demanded nearly 25% wage increases and improvements for the severe understaffing that was spurred by the COVID-19 pandemic, highlighting Kaiser's recent profits of $3 billion in the first half of 2023 and the inflated salaries of executives, according to Guardian US.

The positive outcomes of this strike could show a way forward for other health care workers who hope for better working conditions and more resources to ultimately provide quality patient care.



The Age-Old Question

How to Provide Better Care for the Growing Older Population

By Mark Harris

Many older Americans lead vital and active lives. As a group, older Americans represent a large and fast-growing sector of the population. In fact, Americans aged 65 and older will comprise 21% of the population by 2030, a 6% increase from 2018, according to the U.S. Census Bureau.[1] Nearly 25% will be 65 years or older by 2060, while the 85-plus population will triple.[1] The aging of society is also a worldwide trend—the global population aged 60 and over is expected to nearly double from 12% to 22% between 2015 and 2050, according to the World Health Organization.[2]

People are more likely to develop a range of age-related health conditions as they age and live longer. These conditions can include hearing and vision issues, neck and back pain, osteoarthritis, chronic obstructive pulmonary disease, depression, dementia, diabetes, and other conditions. Further, half of cancer diagnoses affect people 66 years and older.[3]

As people age, they are also more likely to be diagnosed with multiple health conditions or to develop what are known as *geriatric syndromes*. Geriatric syndromes result from other health issues, including frailty, falls, urinary incontinence, delirium, and other symptoms. They may also face challenging adjustments in living and social circumstances.[2]

Prescription for Care

In health care, no firm definition exists for *old age*. However, for practical reasons, age 65 is commonly used as a marker for the transition from middle age to the status as an older person. After all, this is when many people retire and Medicare eligibility may begin.

Geriatric medicine is the branch of medicine concerned with the health of older adults. About 30% of patients 65 years and older need geriatric medical care, according to the American Geriatrics Society.[4] Just as no precise number defines old age, no strict rule dictates when an older adult should see a geriatric physician for medical care.

"In the ambulatory setting, there are different ways in which a referral can happen," says Rebecca Boxer, MD, MS, chief of geriatrics for the newly formed Division of Geriatrics, Hospice and Palliative Medicine at UC Davis Health in Sacramento,

California. "In our institution, the primary care [physician] will make a referral to geriatric medicine for consultation when they've identified the need for additional specialty assistance due to the patient's condition. This could be for a variety of reasons, including a cross section of mobility and morbidity issues, cognitive decline, or a complicated social situation. Usually, [a] referral is for a mix of these reasons.

"There are other models where patients can choose a geriatrician as their primary care [physician]," notes Dr. Boxer. "The patient and perhaps their family are making that choice. Usually, patients [choose] to see a geriatrician because they've already identified themselves as declining due to what they perceive as age-related issues. Or they go by their age and say, 'Well, I'm healthy, but I'm 80 years old, so I'll see a geriatrician.' There is not necessarily any industry standard."

Some clinics have an age cutoff for referral to geriatric care. "There are a lot of healthy people in the 65 to 75 age group who don't need a geriatrician, so some clinics will make the cutoff 75 or older," explains Dr. Boxer. "That's also because so many people are aging now; there's just not enough geriatric specialty care, so health systems will push the age up."

Accordingly, a geriatrician may be the patient's primary care physician or work as a specialty provider in conjunction with their primary care provider. Typically, older adults begin seeing a geriatric specialist at age 75 or older. These are often patients with chronic or complex illnesses, signs of impaired physical or cognitive function, or other health issues. They may be frail, at risk for falls, or experiencing symptoms such as urinary incontinence, unusual weight loss, and other signs of functional decline.[5]

A geriatric referral is often made when an older adult's medical condition creates significant new challenges for patients and their family or caregivers. Other motivations might include concerns about how to safely manage the patient's growing list of prescription medications or the patient's family finding increasing difficulty coping with their caregiving responsibilities.[5]

Advanced Care

An integrative approach can be particularly useful in managing the health care of older adults. Geriatric medicine encompasses a range of interdisciplinary practitioners, from geriatricians and primary care physicians to pharmacists, physician assistants, nurse practitioners, social workers, mental health counselors, dietitians, and others. Geriatric medicine also frequently overlaps with palliative and hospice care services.[6]

In 2019, UC Davis Health launched the Healthy Aging Initiative, a project designed to promote more seamless, integrated health care delivery for older adults across the medical campus. The initiative reflects many leading health systems' growing recognition of the challenges posed by a rapid increase in older populations.

"Our mission is to promote age-friendly, person-centered care across the lifespan in all care settings," says Dr. Boxer. "The goal is to optimize quality of life, function, and autonomy for our patients, support family caregivers, and develop tools for independent living. We also hope to support in-depth, cutting-edge research across collaborative disciplines and prepare the next generation of clinicians in degree programs and fellowships."

Today, a cornerstone of geriatric resources at UC Davis Health is the Healthy Aging Clinic, which opened in Sacramento in 2021 as a one-stop multispecialty care facility for adults aged 65 and older. The clinic features a mobility clinic, a dementia care program, a California Alzheimer's Disease Center, and other health services. Services include cognitive neurology, neuropsychology, dietary planning, pharmacy, nursing, and social work patient care resources.

Notably, the Healthy Aging Clinic, UC Davis Medical Center, and the Department of Emergency Medicine have all earned the "Age-Friendly Health System" designation from the Institute for Healthcare Improvement (IHI) and the John A. Hartford Foundation, in partnership with the American Hospital Association and the Catholic Health Association of the United States. The designation recognizes health care facilities that meet a series of criteria for high-quality, evidence-based care for older adults.[7]

The Age-Friendly Health System criteria are based on four key components of high-quality care for older adults known as the *4Ms*, which provide an overall framework or approach to health care for older adults rather than a prescriptive lens tailored to any specific medical diagnosis.

The 4Ms address the following parameters of care, according to the IHI:

- **What Matters:** Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care and across settings of care.
- **Medication:** If medication is necessary, use age-friendly medication that does not interfere with what matters to the older adult, mobility, or mental function across settings of care.
- **Mentation:** Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.
- **Mobility:** Ensure that older adults move safely every day in order to maintain function and do what matters.[8]

Additionally, UC Davis Medical Center participates in Nurses Improving Care for Healthsystem Elders (NICHE), a patient-centered geriatrics nursing program developed at New York University Rory Meyers College of Nursing.[9]

Evergreen Ethics

Age-Friendly Health Systems have several goals[7]:

- Follow evidence-based practices
- Cause no harm
- Align health care goals to reflect what matters to older patients and their family caregivers

The two programs represent complementary initiatives to improve the care of older adults in the hospital medical center, explains Anna Satake, PhD, MSN, GCNS, RN, a geriatric clinical nurse specialist and coordinator of the NICHE program at UC Davis Health. The NICHE program qualifies geriatric resource nurses through a three-month, 35-hour training program.

"The basics of NICHE have to do with increasing knowledge, competence, and confidence in [the] care of older adults at the bedside for nurses," says Dr. Satake. The concept of the 4Ms is embedded into NICHE training and adapted to the medical center setting, she adds.

"We now have 57 nurses trained across 17 units, including three [intensive care units]," reports Dr. Satake. "The programs help our nurses be experts or champions of geriatrics in their units. They might help troubleshoot a case in a unit, for example, or help with staff education, initiatives, or quality improvement projects regarding older adults."

Health care facilities meet the 4M criteria in several ways. "For What Matters, it's expected that our nurses write on the patient whiteboards their daily care plan goals," says Dr. Satake. "They're also encouraged to have conversations with the patients on the goals of care. Under Mobility, nurses use a tool called the Bedside Mobility Assessment Tool to assess every shift in the patient's mobility level as part of their work toward getting the patient out of bed. For Mentation, we do a delirium screening every shift as part of a protocol for prevention and management. For Medication, our pharmacy [technicians] have a screening tool for reviewing high-risk medications and [reducing] risk. If they screen positive, a pharmacist will do a best practice medication review to look further at the patient's medications."

How does the age-friendly approach to care translate in the emergency department? "In addition to the Age-Friendly Health System designation, we are also a Level 1 accredited geriatric emergency department," says Katren R. Tyler, MD, UC Davis Health vice chair for geriatric emergency medicine and wellness in the emergency medicine department. Dr. Tyler reports only five Level 1 geriatric emergency departments in California and 27 nationally. "These emergency departments are really focused on the 4Ms. We've built processes that work parallel to a standard emergency medical consultation."

The emergency department also has geriatric-focused resources. "We have a lot of physical therapy coverage in our emergency department that allows us to make sure somebody is safe to go home," says Dr. Tyler. "Or if they're unable to ambulate unassisted, they have appropriate discharge medical equipment before they're discharged. We also have excellent occupational therapy exposure to help manage whatever limitations the patient might have. We have excellent medication reconciliation pharmacy technicians, so we can be sure the medication lists we're working with are accurate and safe for the patient. We also have upstanding case management coverage so the intersection with the patient's home life and medical concerns can be addressed in the emergency department."

Opportunities for Improved Care

In health care, quality improvement represents an ongoing challenge for health systems. To meet this challenge, UC Davis Health seeks ways to fine-tune the care and resources available to older adults in its health system.

For example, one issue that can arise for hospitalized older patients is unrecognized hearing loss. "We often have older patients who are hard of hearing and have never gotten fitted for a hearing aid," says Dr. Satake. "Sometimes they deny that they're having hearing trouble. But if it appears … that they might have a hearing issue, we will provide them with a hearing enhancer. We have these [devices] available now in all our units. When patients use a hearing enhancer, they don't seem as confused; they have the opportunity to benefit from the education we provide and are thus more likely to follow discharge instructions. They're more engaged in their care. A very simple thing like this can make a huge difference."

Another age-friendly improvement has involved creating an icon within the electronic health record (EHR) to flag patient hearing or vision impairments. "The icon shows an eye or ear next to the patient's name," explains Dr. Satake. "You can hover over the icon to see [whether] they use hearing aids or a hearing amplifier or if they wear glasses or are blind." The EHR also provides staff access to tools available from the American Geriatrics Society, such as the Geriatrics At Your Fingertips app and the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.

In the UC Davis Medical Center, geriatric resource nurses are also trained to use an assessment tool called SPICES—an acronym for sleep disorders, problems with eating or feeding, incontinence, confusion, evidence of falls, and skin breakdown—to identify common syndromes that affect older adults.[10]

Life Lessons

"As we age, no one gives us a textbook of what normal aging is. One thing I would love to see—like in the fifth or sixth grade when we have to watch videos about our changing bodies—is more public education about what is normal and not normal aging and when to be concerned and get checked out by a provider. This can especially be an issue with dementia. People think [some symptoms are] normal, and then they never get a medical work-up because they think dementia is just part of aging. That's really concerning. A person can be declining, and it could be for something reversible that was never worked up."

—Anna Satake, PhD, MSN, GCNS, RN

Priorities for the Ages

For medical assistants working with older patients, being cognizant of their unique circumstances is crucial. "I think patience and compassion for the people you're working with is so important," says Dr. Boxer. "Understanding that things that are easy for younger folks, such as moving around comfortably [or] not being at risk for a fall, may not be easy for older adults. When older patients come to the clinic, they need to be able to take all the time they need to get from the waiting room into the [examination] room. They should also know what's going to happen, so you want to be sure to explain to them what to expect from their appointments."

Indeed, treating older patients with respect and not as less capable is essential. "There's something called *elder speak* where people talk to older adults in ways that you would speak to a child," observes Dr. Boxer. "It can be pretty offensive to an older adult. You do not want to [speak] to older patients like they're children or to the caregiver or others with the older adult [instead of] talking directly to the older adult. It's very easy for this to happen. You also want to make sure patients are safe. It may not be easy for someone to climb onto a high examination table or to make a long walk in the office that could become taxing."

Just as in the hospital setting, older patients with hearing issues may also benefit from access to a hearing enhancer or amplifier during clinic appointments. "To make sure they get the most out of their visit, prior to appointments staff should make sure patients with hearing aids wear them at the visit, or if there are vision issues, they have their glasses with them," advises Dr. Boxer.

Ensuring that older patients and their caregivers understand any instructions they receive during their appointments is also critical. "I will ask the patient what they understood about the instructions or directions we've provided during the visit," says Dr. Boxer. "This is called the *teach-back method*. We also provide written patient instructions, which are also available in the electronic patient portal.

"I always ask patients for their communication preferences," explains Dr. Boxer. "How do they prefer to receive information? If they have follow-up information or [laboratory] results, for example, I'll ask if they want a phone call or if they're going to look at their results in the patient portal. Some people will ask us to communicate with a caregiver or family member. That is not uncommon. But I never assume that they're going to want it one way or another."

Living and Learning

Some older patients may not be well-versed with modern communication tools, such as electronic patient portals, email, text messages, or other tools. They might also face added challenges navigating their insurance benefits and related issues. If older patients struggle with such responsibilities, providers in turn may need to address those issues.

"Technically, knowing what [is] and what is not covered by their insurance is the responsibility of the patient, but we know many patients do not always understand their coverage as well as they should," says David J. Zetter, PHR, CHCC, CHCO, CPC, president of Zetter Healthcare in Mechanicsburg, Pennsylvania. "They may

Resources

American Geriatrics Society

https://www.americangeriatrics.org

Institute for Healthcare Improvement: Age-Friendly Health Systems

https://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx

UC Davis Health: Healthy Aging Initiative

https://health.ucdavis.edu/healthy-aging/

Medication Advice for Caregivers

"My advice for older adults is to make sure that anyone who might be called to answer questions about you when you're ill—or because you can't speak—knows what medications you take, why you take them, and how you take them. You want to have all these things written down. In terms of your medical history, [the public assumes] that because we have electronic health records, we always know what's happening. But we want to be sure you're given safe care [and] that you're getting the medications you're supposed to. As a patient, you and your family or whoever advocates for you want to have this information."

—Anna Satake, PhD, MSN, GCNS, RN

not have read their summary plan description or policy when it was issued to them or always keep up with Medicare or other insurance communications."

To address such concerns, Zetter recommends that practices assign a staff member as a patient advocate or patient financial—or registration—counselor. "Some patients need someone who can [guide them] and be the patient advocate in the practice for them," explains Zetter. "This should be the first person the patient meets in the practice, [who can] help them understand their responsibilities as a patient. This person can educate patients on how to communicate with the practice and contact [them] for prescriptions, what to do if they have medical record requests, and so on. All of this should be done up front with each patient once they initially register as a patient in the practice."

In her experience working with older adults, Abbahgail Russell, CMA (AAMA), of Duncan, South Carolina, says communication skills are essential to quality patient care. As a team leader for a chronic care management service, Russell works with chronic care coordinators to provide remote health care and patient monitoring services for Medicare patients. Medicare patients are enrolled with the service's contracted primary care providers.

The chronic care coordinators conduct regular phone visits with patients to review and discuss their ongoing medical care. The care coordinators can remotely access the patient's EHR and upload notes about the visit to the provider. "We make sure that the gaps in our patients' health care are closed, like vaccinations or colorectal and other screenings they may be coming up on due to their age or condition," says Russell.

The chronic care coordinators typically speak to patients in monthly calls that last about 20 minutes. "We review their medications [and] clinic appointments and go over other issues or concerns," explains Russell. "We answer questions, educate, and explain some of the services or care the patients need."

Russell asserts the key to having a productive visit is building rapport with patients. "It's important to make sure you … relate to people where they're at," she says. "You don't want to approach patients like you're nagging them or wanting to push them to do something. If somebody doesn't want to get a flu vaccine, for example, they have the right to decline it. It's important to allow people to speak their minds, but we also try to educate them and then respect their decision, no matter what it is."

For example, Russell notes some patients may be disinclined to do colorectal screening. "In that instance, I might ask them [whether] they know what the test is for," she says. "I'll take the time to explain why the test is important. I find they'll almost always decide they want to do it."

Another way to improve encounters is to look at the visit more broadly than a strictly medical standpoint, concludes Russell: "You want to have that personal relationship with patients where they can open up to you. But you also want to keep it professional. It's just about being open and honest with people and using the visit to educate."

Ageism and Other Challenges

Ageism refers to the expression of stereotypes, prejudice, and discrimination toward others based on their age, according to the World Health Organization.[11] While ageism is not limited to older adults, they are often its target. Health care workers can perpetrate ageism in myriad ways, including by treating older adults condescendingly, as if their age-related conditions are not a treatment priority, or in other ways that diminish the quality of the care they receive.[12]

"We often think about ageism in health care in a discriminatory sense," remarks Dr. Tyler. "But what can also happen is that providers are reluctant to have difficult conversations with older adults, so sometimes we don't offer patients a truthful appraisal of where they are. … For example, the patient is on [many] medications, and somebody else will add two medications to that list without thinking about the consequences of medication interactions. Or we assume that somebody wants full and active care for a malignancy, even though the person may choose a different path. Ageism manifests in a lot of different ways. At its heart, it is about

Patient (Age)ncy

"The age-friendly approach to care of older adults focuses on the 4Ms as the main parameters of care. It's very much a patient-centered approach to driving care, rather than the typical medical model, which has the physician in charge and everybody else doing what the physician says. That's a hierarchical system, whereas the patient-centered approach has the patient in charge and making decisions about their own life and what's important to them."

—Katren R. Tyler, MD

not addressing what the patient wants and helping [them] think through that process."

Indeed, age-friendly health care is invariably patient-centered. However, high-quality care also requires that health care facilities have adequate resources for their older patient population. While many leading health care facilities are champions of strong, integrated services for older patients, a national shortage of geriatricians is also a challenge for many health systems.

With a rapidly growing older population, the demand for geriatricians in the United States currently outpaces the available supply. In fact, the U.S. Department of Health and Human Services anticipates an expected national shortage of 26,980 geriatricians by 2025.[13] Accordingly, experts in geriatrics recognize the broader leadership challenges posed by the shortage of trained geriatricians in the health system.

"As geriatric specialists, part of our job is to make sure that we are training and teaching everyone who cares for older adults," remarks Dr. Boxer. "We know there's a shortage of geriatricians, but this does not mean that other providers can't take excellent care of older adults. We have several new initiatives at UC Davis Health to help the hospital teams better care for older adults. We're going to be doing more education for medical residents and medical students [about] caring for older adults, advancing older adult education throughout our system. We want to make sure everybody comes up to the same level of knowledge and ability."

Caring for older adults frequently raises collaborative challenges, requiring expertise from across the professional health spectrum.

"The care of older people requires a team approach to health care that goes across traditional medical silos," concludes Dr. Tyler. "If we are to be successful in fully integrating the care of complex older adults, we want the best practice care focusing on the patient as an individual and using an evidence-based approach based on large bodies of research. One issue is that older people are often excluded from standard research studies, so we may lack information about what is specifically tailored to them in certain circumstances. There's still a lot of unknowns that medical science has to spend some time on, but at heart, it's a team-based practice."

Today, many older adults are proving that advanced age does not have to be a barrier to a healthy and active life. Whether geriatric patient concerns are addressed in primary care, the hospital, long-term care, or other health settings, the dedicated health professionals who care for older adults have an essential role in supporting their health and well-being over their lifetimes. ✦

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T F

☐☐ 1. *Elder speak* describes when health professionals speak to older patients more sophisticatedly than they would to younger patients.

☐☐ 2. One of the four key components of high-quality care for older adults is mentation, which includes preventing and managing issues such as depression and dementia.

☐☐ 3. *Ageism* is defined as discrimination against patients due to their age, such as by treating them condescendingly and deprioritizing their health care needs.

☐☐ 4. Inpatient hospital settings incorporate principles of geriatric care but emergency department settings do not.

☐☐ 5. The generally accepted consensus in the medical community is that patients aged 70 and older should start seeing a geriatric specialist for all or part of their medical care.

☐☐ 6. The number of geriatricians in the United States is not keeping up with the demand due to the increasing number of older people.

☐☐ 7. Unrecognized hearing loss is a common problem for older patients.

☐☐ 8. Examples of geriatric syndromes include frailty, falls, urinary incontinence, and delirium.

☐☐ 9. Geriatric care involves only geriatricians and not social workers, dietitians, or mental health counselors with expertise in care for older people.

☐☐ 10. The fact that older patients are frequently excluded from research studies makes it difficult to develop evidence-based treatment approaches for them.

☐☐ 11. Having a staff member serve as a patient advocate or care coordinator can enhance the older patients' experiences.

T F

☐☐ 12. Health care professionals should prioritize their own judgment regarding older patients' health care and disregard patients' opinions if the patients exhibit poor judgment in medical matters.

☐☐ 13. The teach-back method has the patient or their representative restate the instructions given to the patient back to the provider.

☐☐ 14. In the United States, the number of people who are 65 and older is decreasing and becoming a smaller percentage of the total population.

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AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS®

Under the Weather

With winter fast approaching, you may be gearing up for illness prevention by masking up, drinking plenty of water, and even staying in on rainy days. But despite what many were told growing up—that you will catch a cold if you go outside in the rain—this old wisdom has only *some* truth to it.

You may be more likely to get sick after spending time in the rain, but the rain itself is not the cause. The cold may affect your immune system, which puts you at greater risk of contracting a cold or flu virus, according to Health.com. Being cold and wet for a sustained period makes it difficult to regulate your body temperature, decreasing your immune response and making it harder for you to fight off a virus.

People often get sick during cold and rainy seasons, partially because they are spending more time indoors, where people spread viruses through the air and close physical contact. In fact, cold and flu viruses tend to thrive in dry and cold conditions rather than in rainy, humid ones.

However, you can lower your risk of contracting a cold virus by frequently washing your hands, eating a balanced diet, avoiding sharing food and beverages, exercising regularly, refraining from touching your eyes and mouth, and getting enough sleep, according to Healthline.

If you opt to spend time outdoors on cold, rainy days, make sure to wear waterproof clothing, change into dry clothing as soon as possible, and drink warm beverages to maintain a healthy body temperature.

And if you do get a cold this season, don't fret! Make sure to rest, stay hydrated, use a humidifier, and consider taking over-the-counter medications to shorten the severity and duration of your symptoms as much as possible.

The Underlying Causes of High Cholesterol

Nearly 40% of American adults have high cholesterol, according to the Centers for Disease Control and Prevention. While prevention advice includes regular exercise, abstaining from smoking, maintaining a healthy weight, and eating a balanced diet, these lifestyle changes are not enough for everyone. Some less obvious causes may be keeping your cholesterol high, according to WebMD and Everyday Health:

- **Genetics:** Familial hypercholesterolemia is an inherited condition that leads to cholesterol accumulating in the bloodstream. Physicians may prescribe these patients a statin to block a substance the body uses to make cholesterol.
- **Stress:** Chronic stress can raise your risk for bad cholesterol because stress hormones, like cortisol and adrenaline, trigger changes that cause higher blood sugar and inflammation.
- **Medications:** Medications such as birth control pills, retinoids, corticosteroids, diuretics, and antivirals can unexpectedly raise cholesterol.
- **Alcohol:** Too much alcohol can raise cholesterol and triglycerides and contribute to weight gain.
- **Thyroid Problems:** An underactive thyroid, or hypothyroidism, can allow high cholesterol levels.
- **Liver Problems:** The liver makes, processes, and breaks down cholesterol, so liver problems such as nonalcoholic fatty liver disease can affect cholesterol levels.
- **Kidney Problems:** Conditions like nephrotic syndrome and chronic kidney disease may increase or decrease cholesterol levels.
- **Inactivity:** Being inactive can decrease an enzyme that turns harmful cholesterol into good cholesterol. If you tend to sit or be still throughout the day, try to stand frequently or take brief exercise breaks when possible.
- **Menopause:** Cholesterol levels raise when menopause causes estrogen to drop.
- **Pregnancy:** The body uses cholesterol to help the fetus grow and develop during pregnancy, increasing cholesterol levels up to 50% during the second and third trimesters. This spike is not harmful, but your physician should keep track of your levels if you already have high cholesterol.

The Link Between Caffeine and Anxiety

Making a cup of coffee is a soothing ritual for many and perhaps even a catalyst for getting out of bed in the morning. But consuming too much of this stimulant can cause or worsen symptoms of anxiety, including rapid heartbeat, restlessness, and feelings of uneasiness, according to *Medical News Today*.

About 70% of Americans drink coffee weekly, and more than 60% drink coffee daily. The average American coffee drinker has more than three cups per day, according to the National Coffee Association.

The *Diagnostic and Statistical Manual of Mental Disorders* recognizes caffeine-induced anxiety disorder, a condition in which caffeine interferes with one's daily functioning. Caffeine anxiety symptoms replicate standard anxiety symptoms, including feelings of dread, excessive worry, sweating, restlessness, and rapid heartbeat.

If you experience these symptoms after consuming caffeine, several things can help you reduce caffeine-induced anxiety, such as limiting intake to one cup a day, trying alternatives with less caffeine like decaf coffee or green tea, or maintaining a healthy lifestyle through hydration and exercise, according to Psych Central.

Moderate coffee consumption is unlikely to produce harmful effects in many people, and even those with preexisting anxiety may not see their symptoms worsen with caffeine consumption. However, it is important to be aware of the potential link between caffeine and anxiety so you can manage symptoms if they arise.

Weekend Warriors Fight for Heart Health

Many people have busy weeks that include long workdays, tending to families, cooking, and more. These packed schedules may prevent consistent exercise regimes. However, a recent Harvard University study published in *JAMA* found that weekend warriors—people who fit one week's worth of exercise into one or two workout sessions during the weekend—can reap the similar heart health benefits as those who work out throughout the week.

This research debunked the common-held belief that weekend warriors may have ineffective and unsafe exercise routines that are unlikely to yield many health benefits. Notably, significantly lowering the risk of premature death only requires meeting the exercise guideline of 150 minutes of exercise a week. The frequency of exercise per week is less relevant than meeting the minute goal.

Researchers analyzed the health data and physical activity of about 90,000 people for about six years, finding that weekend warriors had a 27% lower risk for heart attacks, 38% lower risk of heart failure, and a 21% lower risk of stroke than people who didn't exercise. Additionally, weekend warriors did not face more injuries than those who worked out more often, according to the *Washington Post*.

Ready to start weekend workouts? If you are not used to much activity, work up to longer workouts gradually to help avoid injury and develop a more sustainable routine.

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS®

2023 CMA (AAMA)® Compensation and Benefits Report

The CMA (AAMA)

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

Medical assistants and medical assisting educators across the country enthusiastically participated in the 2023 Compensation and Benefits Survey conducted by the American Association of Medical Assistants® (AAMA). More than 11,000 medical assistants completed the survey.

The AAMA emailed an electronic questionnaire to nearly 250,000 individuals—including almost 75,000 CMAs (AAMA)—and announced the survey via the AAMA Facebook page (about 52,000 followers). The majority of respondents (77%) were medical assistants, while about 4% identified themselves as medical assisting educators. Approximately 3% of respondents identified themselves as medical practice managers, while about 8% identified as both medical assistants and medical assisting educators. Most of the participants had earned the CMA (AAMA) credential (81%) and were members of the AAMA (62%).

Statistical Significance and Terms Used

The large number of participants ensures that the results have a high degree of statistical significance. The overall margin of error for the 11,803 responses is ±0.9% at the 95% confidence level. Margin of error describes the statistical significance of the sample as an estimate of the population. The margin of error should be treated only as an approximation, since margin of error calculations are based on pure random selection, which is not achievable in traditional survey settings where response is voluntary. The ±0.9% margin of error applies to overall statistics based on the total respondents to the survey; smaller breakout groups presented throughout the report have higher margins of error. Judgments based on statistics with very low sample sizes should be made with caution. Statistics are rounded to the nearest whole number.

Employee Pay Rate and Status

Both hourly pay rates and annual gross salaries were collected from the survey. Approximately 98% of full-time medical assistants are paid hourly, while roughly 2% are paid by annual salary. Of the 7,905 respondents who are practicing medical assistants, approximately 90% work full time while nearly 10% work part time. For the purposes of this report, results represent compensation and benefits for the full-time employee population.

Compensation

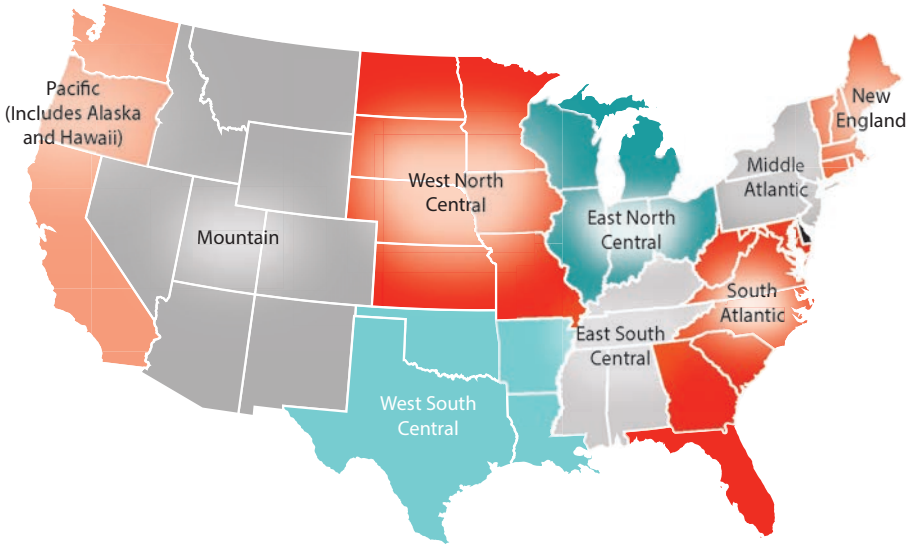
Overall, of those surveyed, full-time medical assistants holding a current CMA (AAMA) certification earn an average of $21.64 per hour or an average annual salary of $40,658.22. Non-CMA (AAMA)-certified medical assistants earn an average of $20.84 per hour or an average annual salary of $39,053.95. Average hourly wages and salary varied for CMAs (AAMA) according to years of experience and other factors, which are broken down as follows.

By Geographic Region

The average annual earnings and hourly wages were computed for geographic regions of the United States (Figure 1). The Pacific region showed the highest earnings for full-

CMA (AAMA) overall average earnings
Hourly: $21.64
Salary: $40,658.22

Figure 1. Regions Based on the United States Census Divisions



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

Table 1.

Geographic Region	Average Full-Time CMA (AAMA) Pay by Years of Experience ($)					
Northeast	0–2 years	3–5 years	6–9 years	10–15 years	16 years+	Overall
New England	17.84 32,091	20.83 41,040	23.02 44,388	24.13 46,910	24.99 48,848	22.29 42,637
Middle Atlantic	18.08 33,292	19.52 37,798	21.12 41,417	22.39 43,296	23.11 47,500	20.82 40,369
Midwest						
East North Central	18.79 35,230	20.03 36,445	21.00 38,202	21.91 40,809	23.27 43,329	21.15 39,029
West North Central	19.58 35,577	21.00 37,147	22.90 40,766	23.67 43,784	25.18 47,023	22.91 41,768
South						
South Atlantic	18.36 34,117	18.83 34,938	20.25 38,294	21.15 39,727	22.68 43,155	20.49 38,442
East South Central	17.42 33,663	18.31 34,029	19.59 37,857	20.68 38,895	21.52 40,398	19.46 36,715
West South Central	17.33 31,487	18.42 38,078	18.38 34,071	20.36 37,743	21.81 43,645	19.56 37,538
West						
Mountain	19.70 34,622	19.95 37,157	21.83 41,255	23.92 44,606	24.35 48,055	22.06 41,346
Pacific	23.51 43,705	24.48 47,704	25.83 50,348	26.66 53,056	26.91 56,467	25.41 50,010

time current CMAs (AAMA), with averages of $50,009.76 annually and $25.41 hourly. Across the country, the New England region turned in the second-highest annual earnings ($42,637.43), while the West North Central region had the second-highest hourly wages ($22.91). The full comparison is shown in Table 1.

By Work Setting

The overwhelming majority of CMA (AAMA)–certified medical assistants surveyed work in physicians' practices. More than 92% of medical assistant respondents are employed in that setting, with roughly 2% in ambulatory surgery and another 3% in "other." About 3% of respondents work in inpatient settings. The breakdown of wages and earnings by work setting is shown in Table 2. Figures for home health settings are not listed due to insufficient response numbers.

By Practice Specialty

About 62% of medical assistant respondents who are CMA (AAMA) certified work in a primary care practice. Another 33% work in practices with other medical and surgical specialties. The income figures for practice specialty are shown in Table 3.

By Number of Specialties

Almost 53% of CMA (AAMA) respondents work in a single-specialty practice, while

Table 2.

** = fewer than 12 responses*

Work Setting	Average Full-Time CMA (AAMA) Pay by Years of Experience ($)					
	0–2 years	3–5 years	6–9 years	10–15 years	16 years+	Overall
Physician practice	19.32 35,613	20.29 37,882	21.62 40,441	22.58 42,704	23.79 45,583	21.67 40,667
Ambulatory surgery	19.43 34,900	16.37 31,100	19.41 37,537	* 43,833	23.23 47,154	20.31 38,274
Inpatient setting	17.55 35,793	20.71 41,300	21.83 38,658	23.72 43,781	23.54 48,375	21.15 40,840
Other	19.22 35,469	21.54 38,920	22.01 42,729	22.41 40,922	24.13 48,129	22.07 41,884

Table 3.

Practice Specialty	Average Full-Time CMA (AAMA) Pay by Years of Experience ($)					
	0–2 years	3–5 years	6–9 years	10–15 years	16 years+	Overall
Primary care	19.28 35,596	20.18 37,508	21.36 39,763	22.39 41,917	23.62 45,199	21.43 39,978
All other medical and surgical specialties	19.36 35,643	20.44 38,417	21.89 41,284	23.12 44,218	24.03 46,700	22.08 41,940
Other	19.18 35,539	20.37 38,078	22.10 41,626	22.77 43,678	23.70 45,347	21.72 41,019

Table 4.

Number of Specialties	Average Full-Time CMA (AAMA) Pay by Years of Experience ($)					
	0–2 years	3–5 years	6–9 years	10–15 years	16 years+	Overall
Single specialty	19.51 36,087	20.28 37,950	21.50 40,100	22.47 42,682	23.91 45,899	21.72 40,821
Multiple specialties	19.72 36,283	20.60 38,672	21.90 41,318	23.03 43,001	23.80 45,735	21.89 41,101
Other	19.15 36,458	20.13 37,233	21.05 40,180	21.63 41,519	23.59 45,714	21.34 40,778

about 45% work in a multispecialty setting. The income figures for full-time current CMAs (AAMA) by number of specialties are listed in Table 4.

Employment Benefits

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

Insurance

About 81% of full-time CMAs (AAMA) receive paid vacation. More than 83% receive dental coverage, while nearly 70% receive major medical coverage. Approximately 78% receive vision coverage, and about 63% receive disability coverage. The full range of benefits for full-time CMAs (AAMA) is shown in Figure 3.

AAMA Membership and Conference

When asked whether employers offer to help pay for various AAMA expenses, about 13% of full-time medical assistants who are AAMA members responded that their employers pay their membership dues in full (Figure 4). In addition, approximately 6% have their annual conference registration fees paid for in full, and nearly 4% have travel and lodging paid by their employers. ✦

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

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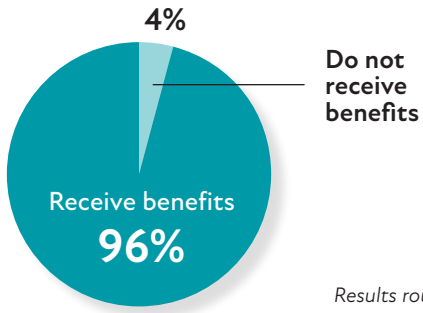
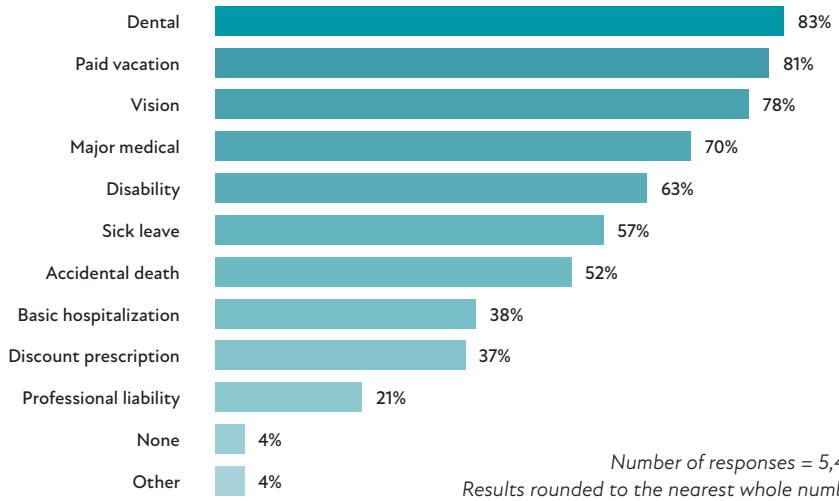
Figure 2. Benefits received by full-time CMAs (AAMA)



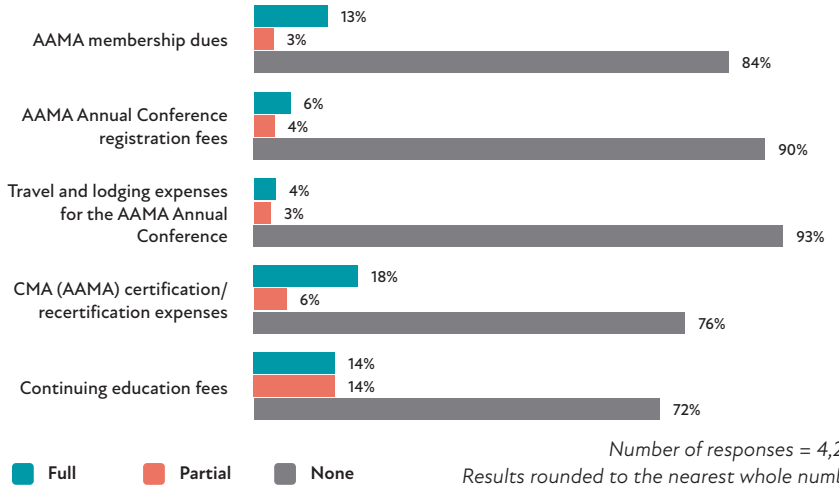
Number of responses = 5,441
Results rounded to the nearest whole number

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



Number of responses = 5,441
Results rounded to the nearest whole number

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



Number of responses = 4,257
Results rounded to the nearest whole number

SFW [SAFE FOR WORK]

Improve Workplaces with a Clear and Accessible Harassment Policy

By John McCormack

An Atlanta-based law firm reports that a medical assistant alleged that a physician at her practice told a group of people that she "looked like [she] was holding a penis" when she was eating a banana, told her she had a "really nice body," rubbed her neck without her consent, and gave her sedatives and asked if she was feeling drowsy and needed to lie down.[1] Despite the medical assistant's reports to the practice's human resources director, medical director, and nursing manager, nothing was done. So, the medical assistant eventually filed suit on claims of sexual harassment.[1]

While having harassment policies and procedures in place cannot completely prevent such situations, experts agree that they can help.

Indeed, the need for such policies and procedures is strong because harassment—whether it be patients harassing staff members, employees bullying their peers, or managers bothering staff members—is common in the health care industry. While all types of harassment can occur, sexual harassment is particularly common in health care environments.

"Health care environments have a uniquely intimate environment that may contribute to the potential for sexual harassment and other forms of harassment," says Todd Prescott, EMBA, PHR, vice president of human resources at the Medical Group Management Association in Denver, Colorado.

Susan Strauss, EdD, RN, a discrimination, harassment, and bullying consultant based in Burnsville, Minnesota, agrees. "Sexual harassment is prevalent in health care situations because we're dealing with a real difference in boundaries, [because] the work requires physical contact and nudity," she says.

In fact, health care environments are prone to sexual harassment because many organizations have "a hierarchical environment, a male-dominated environment, and a climate that tolerates transgressions—particularly when they are committed by those with power," according to a report in the *Harvard Business Review*.[2] Thus, unsurprisingly, academic medicine reports high levels of gender and sexual harassment. In fact, 30% to 70% of female physicians and as many as half of female medical students report being sexually harassed.[2]

Further, in many health care settings, employees and patients often find themselves in situations they cannot escape. Patients, nurses, medical assistants, and others typically cannot step away during a procedure being performed in an operating room, emergency department, or clinic examination room, notes Dr. Strauss.

SPELL IT OUT

Because health care organizations face so many unique challenges while trying to create safe environments, the need for harassment policies and procedures cannot be overstated. As such, practice managers should strive to create policies that include several components[3]:

- A definition of harassment
- Examples of harassment
- Potential harassment targets
- Explanations of where harassment can occur
- Harassment reporting procedures
- Investigation policies and procedures
- Supervisory responsibilities
- Legal protections and external remedies

Practice managers should also consider the following best practices when creating harassment policies:

Establish and enforce behavior expectations. Harassment policies must contain a "clear code of conduct for employees,

contractors, and patients," explains Prescott. "The code of conduct should include all the behaviors that are acceptable and unacceptable. For employees, there should be information about reporting and rights, including access to a reporting hotline if [one is] offered at the practice. Patients should be given a similar code of conduct, which should include information on how to safely report an incident, and it should be posted in the clinic."

Keep policies up to date. "These policies and procedures should be reviewed, updated, and communicated annually," advises Prescott.

Make distinctions. "While they may be similar, there should be separate procedures and policies for staff and patient harassment," says Prescott.

Offer reporting options. Secure methods (e.g., anonymous, written, and hotline) of reporting harassment should be readily available to employees. The practice manager should also ensure the reporting options are visible and familiar to the entire community.

Provide resources. Even if harassment victims choose not to pursue formal reporting processes, they should have access to counseling and support that is available outside of the institution. A location outside of the workplace can increase the comfort of harassment victims and remove potential biases of counselors that are employed by the same institution where the harassment occurred.[2]

Identify protected classes. "Policies need to list all of the people who are in a protected class," says Dr. Strauss. For example, laws protect various groups of people who share a particular characteristic (e.g., gender, race, age, disability, or sexual orientation). These laws can vary from state to state. "So, practice managers need to know who is protected. Was an employee in the military, for example? Well, in some states, they are protected," says Dr. Strauss.

Conduct training. Practice managers should ensure that all employees undergo training in harassment policies and procedures. However, getting all staff members to attend is often difficult in a busy medical practice, notes Dr. Strauss. Training should be repeated by all staff every two to three years.

TAKE CARE

In addition to establishing policies, practice leaders need to take action to address harassment situations.

"If a practice manager sees signs of harassment or receives a complaint, a formal conversation should occur with anyone involved," says Prescott. "If there is an incident evolving, the practice manager should step in to de-escalate if it is safe. If the situation is not safe, the practice manager should contact the authorities."

After harassment is reported or observed, practice managers must investigate the situation. "It's critical that the practice manager or another manager within the practice knows how to conduct an investigation, because that is what's frequently missing. We don't have people—not just in medicine but in other industries as well—who have been trained to conduct an investigation," says Dr. Strauss.

As such, leaders should undergo training that illustrates how to do the following:

- Recognize harassment
- Understand the types of questions that need to be asked in the wake of a complaint
- Develop separate questions for the accuser, accused, and witnesses
- Determine how to assess credibility
- Draw objective and useful conclusions

In addition to learning these basics, carrying out investigations professionally and objectively is crucial.

"So, the first thing a practice manager needs to do when somebody comes to them is to interview those involved and start taking notes about the incident," says Dr. Strauss. "These notes should be verbatim if possible. In addition, the conclusions in the report should include only objective, observable data. So, when a leader is taking notes, [they] should not say, 'The proprietor is a jerk for grabbing the medical assistant's butt.' You can't say that because then you are labeling somebody. So, you would say, 'The medical assistant alleges that the proprietor touched her inappropriately on three occasions.' "

Additionally, Dr. Strauss says that investigators cannot label interviewees. For example, they cannot state that "Tricia is lying." Instead, they should note, "Three witnesses state the incident occurred, [which is] in direct contrast to what Tricia described."

If a medical practice does not have a leader trained in conducting investigations, Dr. Strauss advises seeking outside help.

"If they hire an attorney, they need to make sure the attorney's been trained. Not all attorneys have been trained to conduct [an investigation], even though they might claim that as one of their responsibilities as an attorney," warns Dr. Strauss.

By publishing policies and following procedures, practice managers can help to potentially prevent and address harassment before it causes irreparable harm. "It's absolutely critical that the practice manager or someone else in the practice takes responsibility," concludes Dr. Strauss. ✦

MANY TYPES OF HARASSMENT

Harassment in the workplace comes in many shapes and forms:

- Verbal harassment
- Psychological harassment
- Cyberbullying
- Sexual harassment
- Physical harassment

Perpetrators also target victims based on disability, race, religion, citizenship status, age, gender, sexuality, and other factors.[4]

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Practicum Practicalities

Help Students Prepare for Disputes, Dilemmas, and Disasters in the Workplace

By Pamela Schumacher, MS, CCMP

After all the studying, homework, projects, and tests, completing a practicum is one of the crucial requirements to graduate as a medical assisting student. A practicum, which involves at least 160 hours in a health care setting,[1] is considered essential to professional competence in most health care professions. Practicums have been described as an " 'interactive network of forces' … rich in opportunities for learners to transfer theory to practice."[2] This experience not only simulates the work environment but also introduces students to prospective employers. As such, practicums offer students a taste of the real world, and like in the real world, challenging situations can arise that will test students in numerous ways.

"The practicum is where the rubber meets the road, because it allows the student to apply skills learned in class to an actual working environment," says Karon Green Walton, MEd, CMA (AAMA), program director and practicum coordinator at Augusta Technical College in Augusta, Georgia. "It's a comprehensive assessment of the skills necessary to be a medical assistant, and we want to make sure they do well."

Work-Case Scenarios

During the on-site practicum, students may face an array of challenges[3]:

- Adapting to a high-stress work environment
- Communicating with patients and their relatives
- Having difficulty using medical equipment
- Managing sudden changes in patients' conditions
- Maintaining good relationships with clinical staff
- Making mistakes
- Dealing with the attitudes and expectations of clinical staff and educators

Medical assisting educators play a critical role in preparing students to successfully meet these challenges.

"The best way to prepare students for the practicum is to ensure they are appropriately trained for their placement. Students should have solid knowledge of and ability to perform fundamental procedures," says Shane G. Owens, PhD, ABPP, a private practice psychologist in Commack, New York, who helps people in all stages of medical education, including physicians, nurses, and medical assistants. "Educators should be open and honest about what students can expect of their practicums and provide information about available support. They might also remind students of the skills and values that helped them get this far in their education and provide appropriate reassurance that those things will continue to be helpful."

"I start with a practicum orientation and spend an extensive amount of time talking about issues that may arise," says Walton. "I share possible challenges, and we engage in role-play activities to help students navigate obstacles that may occur at the practicum site. I create role-play activities from past experiences that students have shared with me and from the practicum site evaluations.

"The most common practicum challenges will vary from semester to semester, but one I've seen frequently is when students have trouble adapting to different ways and techniques of performing tasks other than [how] they were taught," she says. "The role-playing activities help students address this challenge effectively."

Try, Try Again

Educators can also design training to address practicum challenges through drills, boot camps, and other true-to-life simulations—the more realistic, the better.

"Our program has a pre-practicum boot camp where students are given several realistic scenarios set in a physician's [practice]," says Walton. "During this phase, students are expected to complete all tasks of the scenario without instruction or guidance from the practicum coordinator. For example, I create scenarios that require the student to apply knowledge from an array of courses within the program, ranging from communication to clinical courses. In addition, I steer fast-paced drills to prepare them for the customary pace of a [physician's practice]. My students enjoy the challenge. I am not sure they appreciate it in the beginning, but they certainly see the value of the activity once they have completed the boot camp. Since I incorporated the pre-practicum boot camp, they haven't reported problems with adapting to a fast-paced work environment."

"The most powerful thing educators can do is practice and model appropriate coping strategies and self-care. They should also have frequent check-ins with practicum students not only to measure performance but to gauge the student's emotional, mental, and behavioral well-being," says Dr. Owens. "Educators should trust students to cope on their own and support those efforts but also provide access to help with emotional and behavioral problems. After every crisis—despite the outcome—educators and students should work together to discover what worked and where there are opportunities for growth."

Often, the best way to prepare students for any unforeseen event is to encourage them to be resilient and use available resources. Many students who are nervous may hesitate to ask questions or seek guidance when they meet with their supervisor because they fear appearing ignorant or vulnerable.[4] Tapping their supervisors' expertise and seeking help can avoid unnecessary stress and anxiety. "Students have the rest of their lives to be experts," notes Walton. "Now is the time when they should be open to discussion, training, and learning from mistakes."

Disaster Preparedness

Use the best strategies to prepare students for the worst:

- Create scenarios, simulations, and role-playing opportunities for students to use to prepare for problems that might arise during their practicums.
- Remind students that it takes time to get comfortable. Many start the practicum feeling anxious and nervous about their abilities, but the best way to get comfortable is to work at it.[4]
- Encourage students to think critically, ask questions, and request assistance before acting or responding to an unexpected event. The purpose of the practicum is to find ways to implement what they have learned in the classroom and apply it to workplace situations.[5]
- Tell students when things get tough, they should stick to their training. If they do their job, things will work out. They are a team member, but they are not solely responsible for how things turn out.

All in a Day's Work

In a busy medical practice, unexpected or unplanned events can throw off the most seasoned staff. Students should be aware of this and be ready for anything.

"If an unexpected event occurs, educators should remind students that they are well trained," says Dr. Owens. "Tell them, 'When things get tough, stick to your training. Do your job. Everything will work out.' Students should also be reminded that they are members of a team; they are vital, but they are not solely responsible for the outcome."

"Unexpected events will certainly occur," notes Walton. "I advise my students to be alert and focused at the practicum site to be better prepared for unexpected events. If something happens, I remind them to think critically, ask questions, and request assistance before acting or responding to an unexpected event. In addition, the practicum coordinator should be available to all students during [their] practicum, and they will provide assistance and feedback to students. I also encourage my students to call me during their lunch or immediately after the practicum if they are feeling overwhelmed or frustrated so we can discuss possible solutions to handle various encounters before returning to the site the next day.

"I'm the practicum coordinator and director for my college, and we truly value our practicum sites and want our students to do well," says Walton. "It's important for the students to have a great experience, because they're going to be our future health care providers. It's very personal to us that we get it right." ✦

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a PILLAR OF THE COMMUNITY

CMA (AAMA) Uses Compassion to Create Lasting Bonds with Local Patients

By Cathy Cassata

Kristy Rabun, CMA (AAMA), grew up caring for her mom, who had type 1 diabetes and rheumatoid arthritis.

"She was a go-getter, though," says Rabun. "She had a motorcycle and was very active in life until she got older and her health started declining."

When her mom developed ulcers at the bottom of her feet, Rabun learned to care for her wounds. After her mom experienced two strokes, she started using a wheelchair. During this time, Rabun felt a calling to the health care field.

"I had been a waitress and an office manager, and the [health care] field never crossed my mind until I felt so at home caring for my mom's declining health," she says.

In 2016, she began a medical assisting program at Augusta Technical College. She graduated in December 2017, just a few weeks before her mom passed away.

"I'm so glad she saw me through it all," says Rabun. And, her mom knew Rabun found her calling in oncology. Rabun was placed at Augusta Oncology (now known as AO Multispecialty Clinic) for her practicum and then hired full time in 2017. But at first, Rabun didn't think oncology was the right fit.

"I cried all the way to clinical my first day because I thought there was no way I could work with cancer patients who were really sick," she explains. "I thought it would be so sad, but honestly, being there is so rewarding."

She worked in the laboratory for the first four years, taking vitals and performing blood draws. Then, she moved on to her current role, assisting a physician with patients. She reviews their medical history, medication list, and any problems they are experiencing. She also processes Family and Medical Leave Act and disability paperwork.

Because patients frequent the practice up to five days a week for chemotherapy and injections, the bond Rabun creates with them is meaningful.

"The five minutes during their blood draws can impact a [patient with cancer]," explains Rabun. "Some come alone and just need a conversation with someone else. Simply asking how they feel and [whether] they have pain can get them to open up."

She exudes compassion and empathy every day on the job.

"I'm able to relate to [patients] and their caregivers … because I was in that situation so many times with my mom," she explains. "I was the one taking care of her. I was the one taking her to all her appointments."

When patients pass away, Rabun experiences heartbreak along with their loved ones. She knows some patients personally because her hometown is 30 miles away from the clinic, which is the only private practice in the area. Rabun has also waited tables at her aunt's restaurant in town since she was a teenager and continues to do so on Sundays.

"There are several people I've known since I was a young girl who come to the [practice], and it's really hard when they pass away," she says.

Sometimes, Rabun attends wakes and funeral services as an acquaintance or medical assistant. She was even listed in an obituary for the care she provided to a patient.

"When I read it, I went to pieces," she says. "I wish my mom was here so I could say, 'Thank you for letting me take care of you, because taking care of you put me in the position to take care of others.' " ✦

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