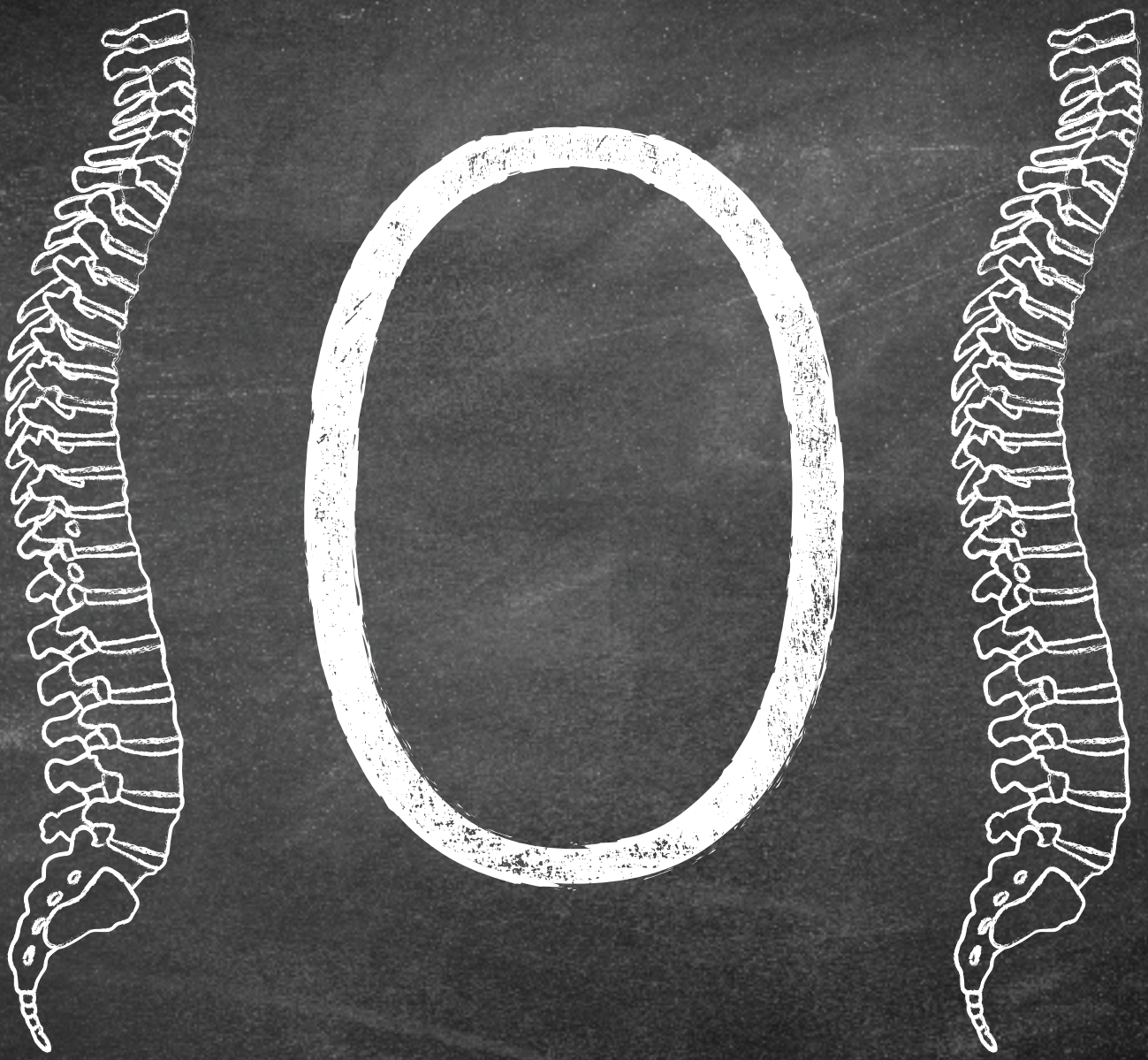
The Magazine for Professional Medical Assistants

Medical Assisting Today

JanFeb 2024

Volume 57 | Issue 1



Back to Basics

Straighten Up Your Knowledge of Spine Health

Published by the American Association of Medical Assistants®

Ringing in the New Year

As I look forward to the year ahead, I am humbled to be the 2023–2024 AAMA President. The new year is filled with many resolutions in our personal and professional lives, which we make with ambitions and good intentions for the future.

One of the CMAs (AAMA)® Core Values is to actively participate in the delivery of quality health care and promote patient safety and well-being. How can we achieve this in the new year?

Listening to patients' problems and encouraging them to interact with me and their providers gives patients a greater sense of trust in our team. This approach prompts more open communication about the patient's health care concerns and needs, leading to better health outcomes. I communicate with patients to ensure they understand the provider's health care plan, their medications, and any necessary follow-up care. Following all practice procedures and protocols reduces errors and promotes better patient safety. Gaining the trust of patients and receiving their kind words has made my medical assisting career more rewarding.

As medical assistants, we are in a fast-paced and highly demanding profession. While we do a wonderful job of taking care of patients, we should remember to take care of ourselves. We should have realistic New Year's resolutions for our own health and well-being. You can take better care of yourself by setting healthier lifestyle goals, including getting more rest and having more stress relievers.

Using SMART goals as a guide for our New Year's resolutions provides a path to greater success. SMART goals are specific, measurable, achievable, realistic, and time-bound objectives, and they will help us meet short- and long-term personal and professional goals.

The Board of Trustees (BOT) is working diligently to formulate and carry out our SMART goals this year. Big things are coming for the medical assisting industry, and we have initiatives and expertise to enhance our position in the field.

The Strategic Issues Plan has been approved and is the map for the BOT's decision-making. As the BOT formulates our initiatives and projects, these goals are the focus for building a stronger membership organization. This year's focus will embrace change and move the AAMA and the medical assisting profession toward greater recognition while strengthening the market share. We want to educate the public about who we are and our profession while informing decision-makers of the value of medical assistants and the CMA (AAMA) credential.

As medical assistants, we are crucial as part of the health care team. I am excited to work on the growth, promotion, and recognition of the AAMA and our profession this year. I look forward to the year ahead and where it will lead us.

Again, I thank you for this opportunity to serve you.

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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Back to Basics 101

14 Straighten Up Your Knowledge of Spine Health

By Mark Harris

4 aama update

Coming Soon! Assessment-Based Recognition in Medical Office Basics; House Highlights; Community + Connection

6 public affairs

USDE Issues Final Regulations for Title IV of the HEA

By Donald A. Balasa, JD, MBA

10 quick clinic

Soft Tissues, Tough Battles

Learn How to Support Patients with Rhabdomyosarcoma and Their Families

By Brian Justice

12 news to use

Racial Gaps in Childhood Cancer; More Free Home COVID-19 Tests Are Available

24 for your health

Act Your Age; A Clear Head; The Magical Power of Self-Compassion; Protein Machine

26 practice manager

Plan the Path Forward

Help Patients Map Out Living Wills and Other Advance Directives

By Pamela Schumacher, MS, CCMP

28 educators forum

Go for Gold

Achieve Grant-Writing Victories by Employing Top Strategies

By Cathy Cassata

30 spotlight

Social Medium

Medical Assistant Uses YouTube to Spread the Word on Medical Assisting

By Cathy Cassata

Medical Assisting Today (ISSN 1543-2998) is published bimonthly by the American Association of Medical Assistants, 20 N. Wacker Dr., Ste. 3720, Chicago, IL 60606. Periodicals postage paid at Chicago, Illinois, and at additional mailing offices.

Subscriptions for members are included as part of annual association dues. Nonmember subscriptions are $60 per year.

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Postmaster: Send address changes to AAMA Membership Department, 20 N. Wacker Dr., Ste. 3720, Chicago, IL 60606.

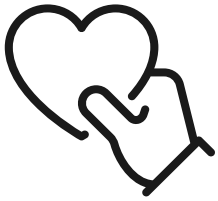
Coming Soon! Assessment-Based Recognition in Medical Office Basics

The Assessment-Based Recognition in Medical Office Basics (ABR-MOB) is designed to provide introductory education to non-medically educated individuals so that they can be better prepared to be a part of the medical practice team. Share the news of its upcoming launch with employers, managers, and anyone potentially interested in this new opportunity for self-paced education.

This new education program will meet employers' needs and nudge these new-to-the-health-care-profession individuals into the AAMA community.

Learners must complete all eight modules to be granted the ABR-MOB.

Many Thanks for Supporting the Profession



Conference attendees gave generously to these important medical assisting–centered funds:

Maxine Williams Scholarship Fund

$2,611

Ivy Reade Relkin Surveyor Training Fund

$1,248 ✦

Join us next year in Grand Rapids, Michigan:

September 20–23, 2024 ✦

Common Knowledge: This Event Rocks!

Volunteers from the North and South Carolina state societies once again delighted the conference crowd with the 2023 CMA (AAMA)® Knowledge Bowl. Attendees competed in teams to test their medical assisting knowledge in one of the most popular events of the conference. ✦

A Guiding Light

At the Presidents Banquet, 2022–2023 AAMA President Deborah Novak, CMA (AAMA), congratulated incoming AAMA President Monica Case, CMA (AAMA). The AAMA extends its appreciation to Immediate Past President Novak for her excellent leadership and wishes the best to President Case as she leads the association through the coming year! ✦

House Highlights

The House of Delegates elected officers and trustees. Meet your 2023–2024 Board of Trustees:

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Shannon Thomas, AAS, CMA (AAMA)

Sandra Williams, CMA (AAMA) ✦

Going Hall Out

Visitors to the Exhibitors Hall discovered the latest in educational materials, technology, and more. The AAMA thanks all the 2023 exhibitors:

- Cengage Group
- CenterWell Senior Primary Care
- Cielo
- Dean Vaughn
- Elsevier
- F.A. Davis
- Intermountain Healthcare
- Goodheart-Willcox Publisher
- Jones & Bartlett Learning
- Labcorp
- McGraw Hill
- Medical Assistant Partnership for Healthy Pregnancies and Families/ University of Nevada, Reno
- Pediatrix Medical Group
- Platinum Educational Group
- PSI Services
- Trajecsys Corporation
- University of Wisconsin Extended Campus ✦

Saluting our Sponsors

A hearty thank you to this year's sponsors:

- CenterWell Senior Primary Care
- Intermountain Healthcare
- McGraw Hill
- PAHCOM
- Platinum Educational Group
- PSI Services
- Wisconsin Society of Medical Assistants ✦

Bylaws Amendments

The House adopted six bylaws amendments. For details on the adopted amendments, including their rationale, review *AAMA Bylaws* and the 2023 Delegates Packet available via the "Member Downloads" webpage of the AAMA website (*sign in required*).

Community + Connection

Hundreds of medical assistants from near and far enjoyed new educational possibilities at the 67th AAMA Annual Conference in Lake Buena Vista, Florida. Almost 700 people connected with their peers and furthered their knowledge as medical assistants.

Many thanks to the Annual Conference Education Committee, the members of the Florida Society of Medical Assistants, and the 2022–2023 Annual Conference Committee for a fun and informative event dedicated to medical assisting professionals.

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

USDE Issues Final Regulations for Title IV of the HEA

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

The U.S. Department of Education (USDE) promulgated a set of final regulations for Title IV of the Higher Education Act (HEA) in the Oct. 31, 2023, *Federal Register*. These regulations address financial responsibility, administrative capability, certification procedures, and ability to benefit, and they reflect changes to the wording of the proposed regulations in the USDE May 19, 2023, Notice of Proposed Rulemaking (NPRM). These final regulations will go into effect July 1, 2024.

The Oct. 31, 2023, *Federal Register* includes comments from the public about its May 19, 2023, NPRM, as well as the USDE responses to these comments. The final regulations reflect changes prompted by the comments. The following will point out changes in the wording of the regulations that are relevant to the allied health community.

GE Programs Must Meet Licensure or Certification Requirements

I.

One of the most controversial elements of the USDE May 19, 2023, NPRM was the requirement that graduates of gainful employment (GE) programs be eligible for licensure or certification requirements in the profession/occupation. GE programs must meet this requirement to receive Title IV funding. The following public comment was published in the Oct. 31, 2023, *Federal Register*:

> *Comments*: Several commenters observed that the proposed regulation for institutions to satisfy the educational prerequisites for State licensure or certification requirements would impose an infeasible burden for both schools and State licensing boards.
>
> Many commenters reported that in previous determinations of licensure compliance, such investigations were time-consuming and costly and often yielded no definitive answer. According to these commenters, inquiries to State bodies frequently resulted in no reply. The commenters further explained that State rules vary widely and are subject to frequent changes. … The commenters asked how the [USDE] could impose this requirement given that we cannot guarantee the necessary State cooperation.[1]

In response to the above comment, the USDE made it clear that it would not compromise on this fundamental element of the GE regulations. Here is the USDE response:

> *Discussion*: When a student enters a program that prepares them for an occupation that requires licensure or certification, they should have the expectation that finishing that program will allow them to fulfill the educational requirements necessary for getting the necessary approval to work in that field. We are concerned that students attending programs that do not have those necessary approvals will not only fail to achieve their educational goals but may also end up with earnings far below what they expected. Such programs also represent a waste of taxpayer money, as the Federal Government is supporting credits that cannot be redeemed for their stated purpose. The [USDE] agrees that complying with this requirement will create costs for institutions, but we also believe those costs are worthwhile to protect student and taxpayer investments. Institutions are not required to participate in the title IV programs, both overall and on a programmatic basis. If they do not want to take the necessary steps to protect against wasted investments, then they can choose to make these programs not eligible for Federal aid.[1]

After weighing all the comments, the USDE decided on the following wording for this section of the final rule:

> **§ 668.14 Program participation agreement.**
>
> …
>
> (32) … [for] each student who enrolls in a program on or after July 1, 2024, and attests that they intend to seek employment, the institution must determine that each program eligible for title IV, HEA program funds—
>
> (i) Is programmatically accredited if the State or a Federal agency requires such accreditation, including as a condition for employment in the occupation for which the program prepares the student, or is programmatically pre-accredited when programmatic pre-accreditation is sufficient according to the State or Federal agency; [and]
>
> (ii) Satisfies the applicable educational requirements for professional licensure or certification requirements in the State so that a student who enrolls in the program, and seeks employment in that State after completing the program, qualifies to take any licensure or certification exam that is needed for the student to practice or find

employment in an occupation that the program prepares students to enter[1]

II.

Another debated provision of the USDE May 19, 2023, NPRM was the state laws with which schools and their GE programs had to comply. The USDE included the following comment in the Oct. 31, 2023, *Federal Register*:

> *Comments*: Many commenters noted that it is not reasonable to presume that students will necessarily pursue their career in the State in which they initially enroll in their program. For example, several commenters offered that the students might be members of the military or family thereof and only be temporarily located in that State, or they might live near a State border and intend to find employment in a neighboring State or move to a State where jobs are more available.[1]

The USDE saw merit in the above comment:

> *Discussion*: … We do agree that there are instances in which a student, such as a military-connected student, might plan to leave the State they reside in and intend to seek employment in another State. Therefore, we have added language to § 668.14(b)(32) to say that an institution can consider the State a student is in at their time of initial enrollment, or the State identified in an attestation from a student where they intend to seek employment in another State. We would note that the student must identify a specific State and the institution's program must meet the requirements of that State.[1]

The USDE settled on the following language for the final rule to consider the reality that graduates may want to (or have to) work in their occupation/profession in a state other than the state of the GE program. The new language is italicized:

> **§ 668.14 Program participation agreement.**
>
> …
>
> (32) In each State in which: the institution is located; *[and] students enrolled by the institution in distance education or correspondence courses are located, as determined at the time of initial enrollment* … [for] each student who enrolls in a program on or after July 1, 2024, and attests that they intend to seek employment, the institution must determine that each program eligible for title IV, HEA program funds[1]

See the above language in Section 668.14(32) of the final regulations.

GE Programs Must Not Exceed Minimum Program Length

Section 668.14, Program participation agreement, (32), seeks to ensure that GE programs *do not omit* education requirements that a state requires for admission into an occupation/profession through licensure or certification. Section 668.14, Program participation agreement, (26), in contrast, seeks to ensure that GE programs *do not add* education requirements that exceed the state's minimum requirement for admission into an occupation/profession. The USDE has used the phrase "course stretching"[1] to describe this practice.

I.

Commenters urged the USDE not to penalize students who will already be enrolled in GE programs that exceed the state's minimum requirement when the final regulations go into effect on July 1, 2024. Note the following comment in the Oct. 31, 2023, *Federal Register*:

> *Comments*: … Commenters that supported the NPRM's proposal stated that they understand our concerns with excessive length and the wide variation among States' requirements for the same professions, but that the Department's original proposal during negotiated rulemaking would place undue hardship on institutions and students in States with much longer requirements. The commenters also raised a concern that, if the new rule went into effect immediately, it could place undue hardship on students currently enrolled in a program that could lose title IV, HEA eligibility before they complete their program due to circumstances outside their control.[1]

The USDE acknowledged the wisdom of this comment and proposed a solution:

> *Discussion*: … While we think it is important to protect students through this provision, we also agree with the commenters who said that it would not be appropriate for this new requirement to affect students who are already enrolled in eligible programs, as we do not want to disrupt those students' educational plans if their program were to lose eligibility for title IV, HEA funds due to being too long. Therefore, when these regulations are implemented, we will permit institutions to continue offering a program after the implementation date of the regulations that exceeds the

applicable minimum length for students who were enrolled prior to the regulatory change taking effect [July 1, 2024]. This will mean that some institutions may temporarily offer two versions of the same program concurrently but will not be able to enroll new students in the version of the program that exceeds the minimum length. In these cases, the institution is not required to report both programs to the [USDE] but must internally document the existence of two separate versions of the program and indicate which students are enrolled in each program.[1]

II.

The initial draft of the regulations in the May 19, 2023, NPRM apparently overlooked professions that offer a degree option that exceeds the minimum requirements for practicing the profession. Nurse education was used as an example in the following comment:

> *Comments*: One commenter stated the proposed rule would curtail title IV, HEA eligibility in ways that would sharply reduce nursing graduates, worsening the severe shortage of nurses. The commenter argued that many institutions may no longer be permitted to offer Bachelor of Science in Nursing (BSN) programs with title IV, HEA eligibility because such programs would include more credits than necessary to practice as a nurse, which in many States only requires a diploma or associate degree.[1]

Once again, the USDE was persuaded by the logic of this comment. The USDE offered the following:

> *Discussion*: We agree with the concerns raised by the commenter about how degree programs subject to State hours requirements could be affected and have made a change to address this issue. We are clarifying that this provision does not apply to situations where a State has a requirement for a student to obtain a degree in order to be licensed in the profession for which the program prepares the student. Minimum length requirements typically operate differently for non-degree and degree programs. For a non-degree program, the hours required by a State typically represent all, or the vast majority of, the curriculum offered in a program. By contrast, State educational requirements for licensure or certification within a degree program may only represent a portion of that credential and likely will not include other components of a degree, such as general education requirements. As such, minimum length requirements for degree programs may understate the potential length of the program and inadvertently exclude programs that are otherwise abiding by the minimum time related to the component of the program that fulfills specific State licensure requirements. For instance, a State may establish requirements for the component of a bachelor's degree in registered nursing related to the nursing instruction, but not speak to the rest of the degree program.[1]

III.

The next comment and USDE response demonstrate the difficulty of wording regulations that account adequately for distance education:

> *Comments*: One commenter suggested the rule should be amended to allow programs to meet title IV, HEA eligibility by allowing for the longer of two measures: The program length can be no longer than the longest number of credit hours required for licensure in a State in which the institution is permitted to enroll students in compliance with §600.9; or the program length is in compliance with the standards of one of the institution's accreditors. The commenter argued that this approach would allow distance education programs to continue to participate in the title IV, HEA programs while recognizing the licensure variances amongst States.
>
> *Discussion*: The Department recognizes that § 668.14(b)(26)(ii) as written in the NPRM created the potential for confusion for programs offered entirely online or through correspondence. … For fully online programs, there may be situations when the length of a program required in the institution's State differs from State requirements for the length of a program in the student's State. To address this issue, we have clarified that this provision does not apply to fully online programs or programs offered completely through correspondence, since these are the only situations where this disparity might occur.[1]

IV.

After taking into account the three comments discussed above (and other comments), the USDE decided on the following language for Section 668.14(b)(26):

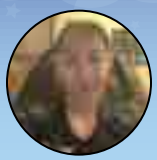
> (26) If an educational program offered by the institution on or after July 1, 2024, is required to prepare a student for gainful employment in a recognized occupation, the institution must—
>
> …
>
> (ii) Demonstrate a reasonable relationship between the length of the program and the entry level requirements for the recognized occupation for which the program prepares the student by limiting the number of hours in the program to the greater of—
>
> (A) The required minimum number of clock hours, credit hours, or the equivalent required for training in the recognized occupation for which the program prepares the student, as established by the State in which the institution is located [or a state that meets the criteria in the final rule], if the State has established such a requirement or as established by any Federal agency; …
>
> (iii) Notwithstanding paragraph (a)(26)(ii) of this section, the program length limitation does not apply for occupations where the State entry level requirements include the completion of an associate or higher-level degree; or where the program is delivered entirely through distance education or correspondence courses.[1] ✦

Questions about this article may be directed to the author at DBalasa@aama-ntl.org.

Reference

1. Financial Responsibility, Administrative Capability, Certification Procedures, Ability to Benefit (ATB). *Fed Regist*. 2023;88(209):74568-74710. 34 CFR §668.

2023 AAMA Rising Star Award Winners



Norma Gonzalez, CMA (AAMA)

CMA (AAMA) Certified Since: 2019
First Became an AAMA Member: 2020

Gonzalez "embodies the CMA (AAMA) standards and exemplifies hard working and exceptional medical assistants," according to one of her colleagues.

As an active member of her state society, Gonzalez has quickly become a strong leader, rising through the ranks from state society member to secretary. She has also served the AAMA on the national level as a page for the House of Delegates.

A colleague applauds her commitment to caring for underserved communities in health care, stating that Gonzalez "is uniquely suited to facilitate accurate flow of information between [a] provider and patient, [educating] patients from the Latinx community in a way that is sensitive to their personal needs and expectations and serving as a bridge between English and Spanish speakers within her [practice]."

CMAs (AAMA) like Gonzalez set the bar for excellence through professionalism, intellect, and dedication to inclusive patient care.

Alyssa Shackelford, CMA (AAMA)

CMA (AAMA) Certified Since: 2018
First Became an AAMA Member: 2020

Shackelford "is truly a rising star," says her state society president.

Since becoming a CMA (AAMA), Shackelford has become a strong leader for her local chapter and state society, serving as chapter president and state society treasurer in recent years. She has continually developed her career and continued her education, even while enduring personal hardships and expanding her family.

A former educator applauds Shackelford's dedication to reaching her goals, saying she "has a great vision, and I look forward to watching her passion grow in medical assisting."

Her former state society president praises her trajectory in the field, saying, "I am so proud and in awe of what she has accomplished in the fledgling years of her career. I look forward to seeing where her vision and compassion lead her."

CMAs (AAMA) like Shackelford inspire others through their commitment to being the best medical assistant they can be and serving as a role model to other medical assisting professionals. We look forward to seeing what she accomplishes next!

Cameron Smith, CMA (AAMA), PBT(ASCP)

CMA (AAMA) Certified Since: 2016
First Became an AAMA Member: 2018

Smith "is dedicated to the profession of medical assisting and is passionate about the AAMA," says an AAMA colleague. They feel that he has grown in his years of membership but "still has new heights to [achieve]."

Smith is an active member of the AAMA at the local, state, and national levels, showing incredible initiative as a leader. He has risen the ranks of the AAMA, serving as president for his local chapter and state society and working on several national committees.

He is known by colleagues as positive, dependable, dedicated, and professional. He is a proponent of the AAMA membership and goes above and beyond to continually learn and volunteer wherever needed.

A former educator sings Smith's praises: "I have great confidence in his abilities and compassion to help others. I don't think you will find anyone more dedicated to the profession of medical assisting."

Medical assistants like Smith never cease to reach new heights and honor this great profession. For this reason, we applaud Smith for his numerous commitments and contributions to the profession and wonderful work as a leader in the early years of his career.

This is the first time that the AAMA Rising Star Awards have been presented.

Soft Tissues, Tough Battles

Learn How to Support Patients with Rhabdomyosarcoma and Their Families

By Brian Justice

Rhabdomyosarcoma (RMS) is an extremely rare type of cancer. Up to 500 new cases are reported every year in the United States,[1] making RMS the most common soft-tissue cancer in children,[2] accounting for approximately 3% of all childhood cancers.[1]

Most cases occur in children under the age of 10, and boys are at slightly higher risk than girls. While RMS is primarily a childhood cancer, it can also affect teenagers and adults. In those age groups, survival rates are considerably lower.[1]

"Rhabdomyosarcoma, or sarcomas in general, are cancers of the soft and connective tissues in the body," explains Michael Ferguson, MD, associate professor of pediatrics and medical director of the Solid Tumor Program at Riley Hospital for Children in Indianapolis, Indiana. "These are specific muscle-related tumors. There are muscles, such as in the arms and legs, but also smooth muscles in the bowels and gut associated with blood vessels and other parts of the body. So, this is a cancer of a muscle origin."

RMS presents in two primary forms[2]:

- **Embryonal RMS**, which commonly occurs in the head and neck area, genitals, or urinary tract, often affects children under the age of 6. Embryonal RMS generally responds well to treatment.
- **Alveolar RMS** is more prevalent in teenagers and frequently found in the arms, legs, chest, or abdomen. Alveolar RMS is harder to treat and requires more intensive therapy.

Causes

Researchers are still trying to determine what causes RMS. The simplest explanation is that while the human body includes tumor suppressor genes that stop cells from growing too fast and turning into tumors, RMS may hinder those suppressors, causing cells to grow and form tumors.[3] People with certain inherited gene mutations, like Noonan syndrome, which affects one out of every 1,000 to 2,500 people,[4] and neurofibromatosis type-1, which occurs in one out of every 3,000 to 4,000 people,[5] seem somewhat more likely to develop RMS.

A gene called p53 stops cells from dividing too much. However, cells continue dividing and create a tumor if a mutation occurs. This inherited gene is specific to embryonal RMS, notes Dr. Ferguson. Meanwhile, Dr. Ferguson adds, the PAX/FOX01 fusion gene (i.e., when portions of an individual's DNA switch between chromosomes), which leads to uncontrolled cell division and tumor formation,[3] is specific to alveolar RMS.

Symptoms

RMS symptoms vary depending on the tumor's location. In the urinary tract, RMS may cause difficulties with urination, blood in the urine, or a vaginal, testicular, or abdominal mass. In the head or neck, it causes problems in the sinuses or nasal

passages, headaches, bleeding or growth in the ear canal, or a painful bulging eye if behind the eye socket. In an extremity, it may present as a mass that may or may not be painful. If the cancer is within the trunk, individuals may experience abdominal pain, constipation, and vomiting.[3]

"Cancers of the muscles, or that affect skeletal muscle, are very painful," explains Danielle Leonardo, MD, a medical oncology consultant at the Medical City Ortigas in Pasig City, Philippines. "These patients also tend to have disfigurements because of large tumors, and that can be devastating."

Treatment

Various factors determine the prognosis and treatment strategies, such as the type of RMS, the tumor's location and size, surgical outcomes, and whether the cancer has metastasized. Children between the ages of 1 and 9 generally have a more favorable outlook than infants, older children, or adults.[1]

The primary methods for treating RMS are chemotherapy, surgery, and radiotherapy, often in combination. Chemotherapy is used to shrink the tumor before surgery or remove remaining cancer cells.[3] The type and stage of the disease determine the specific drugs administered and the duration of treatment.[2] If surgery is unfeasible, a combination of chemotherapy and radiotherapy is used, with high-energy rays directed to the area of origin to destroy cancer cells while minimizing harm to the surrounding healthy ones.[2]

Up to 90% of children with low-risk RMS survive five years or more after diagnosis. For those with intermediate risk, that drops to about 50% to 70%. Among children with high risk, only up to 30% survive five years or longer. These statistics emphasize the need for early diagnosis and treatment.[3]

"It's not always fatal—especially in younger kids, because they tend to get the embryonal subtype, and we are able to achieve a cure around 70% of the time," explains Dr. Ferguson. "And when the tumor occurs in other locations, like behind the eye, we see cure rates of almost 90%."

Notably, adults with RMS have a five-year survival rate of 47%, according to Dr. Ferguson. Factors contributing to this disparity include the cancer's rapid growth and the fact that it can manifest in challenging-to-treat anatomical locations.[3]

Residual Effects of Childhood Cancer

The effects of childhood cancer are long-lasting and extend beyond full recovery. In a recent review[7] of 73 studies, researchers discovered that childhood cancer survivors remain at risk for other long-term health challenges. The vast majority (95%) develop issues related to their cancer or treatment by age 45, including hormone issues, reproductive health challenges, musculoskeletal problems, and cognitive impairment.

Approximately one-third of childhood cancer survivors experience severe or potentially life-threatening chronic issues, with endocrine disorders, neoplasms, and cardiovascular disease being the most common. Radiation fields on the chest, brain, neck, abdomen, or pelvis pose other specific risks, possibly leading to other cancers, especially after treatment with higher radiation doses. Mental health is also impacted, with depression rates ranging from 2% to 41%, far exceeding the national average of 10% of adults who report experiencing depression.

Given these ongoing risks, researchers advocate for survivors to receive lifelong care focused on awareness of potential health issues—physical and mental. Health care providers are encouraged to inform patients about the potential long-term effects of treatment, emphasizing the need for regular physicals and an elevated level of preventive care for adult survivors of childhood cancer.

Parents and Families

Any serious childhood illness profoundly affects families, and cancer presents unique challenges.

Research shows that parents of children with cancer face multiple unmet needs. The chronic nature of childhood cancer necessitates continuous care that impacts the family's personal, social, and professional lives and makes them more vulnerable to emotional and physical stresses. Recognizing and addressing their needs helps them focus on their child's care.[6]

Families require clear, understandable information to fully participate in health care decisions. Robust collaboration between health care providers and parents is vital to providing the support and assistance they need to deal with their family's new levels of responsibility and stress.[6]

"The best way to interact with children and their families is to give them the utmost compassion," says Jessica Blessinger, CMA (AAMA), clinical preceptor lead for Hancock Health in Greenfield, Indiana. "Remember that there are no questions that should not be asked." ✦

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Racial Gaps in Childhood Cancer

Strides in childhood cancer treatment in recent decades have been remarkable, but a new report highlights that despite overall progress, improvements have stalled for Black and Hispanic youth, causing a gap in death rates.

In 2001, the childhood cancer death rates were nearly equal between Black, Hispanic, and white children. However, the report by the CDC reveals that treatment advancements made in the past decade have primarily benefited white children, as only their death rates have dipped lower. The 2021 rates per 10,000 are 2.38 for Black youth, 2.36 for Hispanic youth, and 1.99 for white youth. The overall cancer death rate for children and teenagers in the United States declined by 24% over the past two decades, according to the CDC, but this racial disparity is still striking.

Families face numerous challenges when navigating childhood cancer treatment, especially with complex treatments like gene therapy. Many parents cannot afford to quit their jobs and be with their children throughout treatment. Additionally, families may need more guidance from social workers in navigating paperwork, job-protected leave, and health insurance coverage for their children.

The National Cancer Institute aims to collect data from every childhood cancer patient to link each child to state-of-the-art care, fostering equity and furthering the improvement in survival rates.

While this study highlights a discouraging reality, the health care industry must strive for greater equity and work to ensure that every child receives the best care possible, regardless of their background.

More Free Home COVID-19 Tests Are Available

Each U.S. household is eligible to order free COVID-19 home tests through the government. Households can order four rapid antigen COVID-19 tests by submitting a request form via COVIDTests.gov.

The U.S. government is offering the tests ahead of the typical surge in cases during winter, as cold and flu season surges. Winter 2023–2024 is the first winter since the pandemic began during which insurers are no longer required to cover the cost of COVID-19 tests, which now cost about $11 out of pocket.

COVID-19 rapid tests can be used at home regardless of whether someone has symptoms, reports CNN Digital. However, the Centers for Disease Control and Prevention (CDC) recommends testing if you have any common COVID-19 symptoms (e.g., a sore throat, runny nose, loss of smell or taste, or fever). People should also use tests before attending large events, particularly if they are not current on vaccines. Testing can help determine which antiviral medication is necessary for each case.

Though the tests may have upcoming or past expiration dates, the Food and Drug Administration has extended some of those dates.

The Food and Drug Administration also approved updated COVID-19 boosters in September 2023. The shots target XBB.1.5 and replace older vaccines that target the original coronavirus strain and an earlier version of omicron, according to the Associated Press.

Updated Lung Cancer Screening Guidelines Expand Eligibility for Millions

Lung cancer claims more lives in the United States than breast, colorectal, and prostate cancer combined. In 2023, the American Cancer Society (ACS) estimated 238,340 new cases of lung cancer would be diagnosed, with over 127,000 deaths from the disease. Despite this, only a fraction of those at high risk get screened, according to NBC News.

The ACS recently updated its guidelines to help reduce the number of people dying from the disease due to their smoking history. The new guidelines encourage annual lung cancer screenings for people aged 50 to 80 years old who smoke or formerly smoked and have a 20-year or greater pack-year history. Even smokers who quit 15 or more years ago should get these annual scans, which is an update from previous guidance.

The belief that the risk of lung cancer decreases over the years after quitting has been disproven. In fact, the risk rises with age, even for those who quit smoking more than 15 years ago. While quitting smoking may initially improve lung health for former smokers, the effects do not tend to last.

The new guidelines make 5 million more patients eligible for regular scans that can detect tumors early enough to save lives. They recommend a low-dose computed tomography scan for an annual screening test.

Only about 6% of Americans have received lung cancer screenings, and rates were as low as 1% in some states, according to a 2022 report from the American Lung Association. These low screening rates may explain the high fatality rate of lung cancer, as most people are not diagnosed until a late stage. Over 80% of people whose lung cancer was caught early through screening were still alive after 20 years.

Life Expectancy Gap Widens between Men and Women

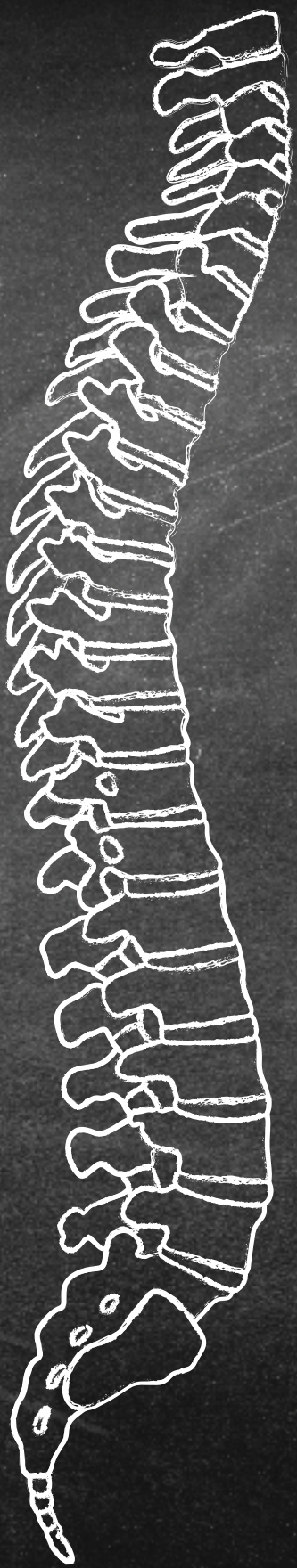
For over a century, women have had a longer life expectancy than men, largely due to heart disease and lung cancer related to smoking behavior.

However, the gap between the life expectancy of men and women has reached its widest point in decades. Women in the United States are now outliving men by an average of six years, which is largely the result of COVID-19 and drug overdoses, according to a study published in *JAMA Internal Medicine*.

In 2021, the life expectancy gap between men and women was 5.8 years—79.3 years for women and 73.5 years for men—the largest difference since 1996. The gap previously reached a low of 4.8 years in 2010. However, the gap grew by 0.2 years over the next decade and 0.7 years in the first two years of the COVID-19 pandemic, reports CNN Digital.

Since the pandemic began, life expectancy in the United States fell by more than two years. But while life expectancy dropped for both men and women, the drop was not equal. Men were more likely to die from COVID-19, but the reasoning is unclear.

COVID-19 is not the sole cause of the gap, and numerous factors help explain the disparity. Men are more likely to engage in risky behaviors such as smoking, drinking, and participating in dangerous sports or occupations. They are also less likely to seek medical intervention, according to Medical News Today. This less proactive approach to health can contribute to the late detection of diseases and poorer management of health conditions.



Back to Basics

Straighten Up Your Knowledge of Spine Health

By Mark Harris

The spine is a pivotal component of human anatomy. As an anatomic structure, the spine makes it possible for human beings to move, stand upright, sleep, and otherwise physically function in a coordinated way.

When the spine is unhealthy, the consequences can be far-reaching. From limited mobility to chronic or acute pain, an impaired or damaged spine can significantly impact a person's health and quality of life. Some types of spinal cord injuries can even result in paralysis. As the body's central support structure or scaffolding, the spine is at the core of physical beings.[1]

Spinal Sense

In terms of anatomy, the spine is a complex structure comprised of small bones, disks, nerves, joints, ligaments, and muscles. The spine extends from the base of the skull to the tailbone.[2]

The spine forms a natural S-shaped curve that is observable when viewed from the side. This natural curvature allows for flexible movements and even weight distribution in the body. Three distinct curves in the spine correspond to the cervical (neck), thoracic (middle back), and lumbar (lower back) regions. Together, these curves work like natural shock absorbers to prevent injury and promote stability in the body.[2]

A major feature of the spine is the 33 stacked vertebrae that form the spinal canal. This canal houses and protects the spinal cord and its column of nerves. Most of the vertebrae move, which allows for a range of motion in the body. The exceptions are the vertebrae in the lower sacrum and coccyx areas of the spine, which are fused together

Put Your Back into It

"If I was going to give someone general advice on how to stay healthy—how they can keep pain in check—it is to just move. Exercise. Walking is one of the best forms of exercise on the planet. Why? First, you're moving. Second, you increase blood flow. It's good not only for your tissues but also for your cardiovascular system. When we increase our cardiac output, we [increase] blood to all our muscular, joint, brain, and nervous system tissues. So, the most important thing is that people keep moving. Don't sit too long. Especially as we age, we do not bounce back as quickly as we used to. We just don't have that elasticity. And the less you move, the more stiff you get and the more you set yourself up for injury."

—Colleen Louw, MPT, MED, CSMT

and do not move.[2]

The spine also plays a vital role in our central nervous system. As part of the neuromuscular system, the nerves in the spinal cord transmit messages between the brain and muscles. This makes it possible to feel sensations in the skin, muscles, joints, and elsewhere. Thus, the ability to feel cold, warmth, and pain and acquire sensory information from touch originates in the spine.[3]

The spine includes three other essential components[2]:

- The **facet joints** include cartilage that allows the vertebrae to slide against one another. These joints allow the body to twist, turn, and bend in a stable but flexible way.
- The **intervertebral disks** are found between the vertebrae. With their soft, gel-like center, these flat, round disks also enhance flexibility while cushioning the body's movements.
- The **soft tissues** include the ligaments that connect the vertebrae, muscles to support the spine, and tendons that connect the muscles to the bones.

Nerve-Wracking Issues

Many health conditions can affect or involve the spine. These can range from degenerative conditions caused by age-related wear and tear or injury to spinal deformities, infections, tumors, and other medical concerns. For example, osteoarthritis is a degenerative joint disease involving the gradual thinning of spinal cartilage. Spinal stenosis is characterized by a narrowing of the spinal column that can put pressure on the spinal cord and compress or pinch the nerves. A herniated disk occurs when the nucleus of one of the disks between the vertebrae pushes out through a tear or rupture in its outer layer.[4]

Accordingly, the field of spinal health care is invariably multidisciplinary, ranging from primary care and physical therapy to orthopedics, neurosurgery, physiatry (physical medicine and rehabilitation), orthopedics, pain management, sports medicine, and alternative or complementary medicine.[5]

A health issue broadly associated with spine health is back pain, which constitutes one of the most common health concerns in the United States. In fact, 39% of Americans reported back pain during a three-month period in 2019, found the Centers for Disease Control and Prevention. Adults over age 65, women, non-Hispanic white adults, and people with a low-income were most likely to report back pain.[6]

In many cases, chronic back pain is caused by muscle strain or is nonspecific in origin, meaning an exact cause or diagnosis cannot be identified. Back pain is often focused in the lower back area. In terms of the spine, this involves the region known as the lumbar spine, which is the main structural support for the upper body.

When a patient presents with acute or chronic low back pain, clinicians will take a thorough, stepwise approach to try to determine the cause of the patient's symptoms and whether it involves a spine-related diagnosis.

"Making a solid diagnosis regarding lumbar spine pain can be challenging, as the pain generator may be from a nerve, muscle, bone, connective tissue etiology, or a combination thereof," says Julie Muché, MD, CPE, medical director of the Lovelace UNM Rehabilitation Hospital Pain Clinic in Albuquerque, New Mexico.

"A thoughtful approach to [reaching] a diagnosis starts with a thorough history to delineate influences on pain etiology, such as [the] mechanism of injury, or chronic disease pathology, such as rheumatoid arthritis. Then, a directed physical examination to include palpation, range of motion, muscle strength testing, neurological examination, and special musculoskeletal tests can guide further workup. [Laboratory] work, imaging with radiographs—including lumbar spine flexion/extension views to evaluate structural stability—advanced imaging, diagnostic intervention—[or] selective nerve blocks—and electrodiagnostic studies can aid in supporting an accurate diagnosis."

More than a Skeleton Crew

A primary care provider may refer patients with chronic lower back pain to physical therapy for treatment. This is often recommended even if the source of the pain remains indeterminate. For many patients, a tailored exercise program under the direction of a physical therapist can help resolve or relieve back pain and improve function. The therapy might involve stretching, core strengthening, posture retraining, aerobic exercises, and other aspects of care.[7]

Physical therapists typically see several spine-related concerns among patients. "The wear and tear associated with osteoarthritis is very common for our general patient population," says Colleen Louw, MPT, MED, CSMT, a media spokesperson for the American Physical Therapy Association. "There are also disk issues that can occur with our spine patients. Disks wear out as well. They bulge on nerves, although it's often more of an inflammatory condition occurring

around the nerve because of the chemical properties that exist in and around the disk. Less frequently, we also see patients who have scoliosis and ankylosing spondylitis. The latter is a tough genetic condition in which the spine starts to fuse to itself and becomes very stiff."

In physical therapy, patient education is especially integral to recovery and healing, emphasizes Louw, the program director for the Therapeutic Pain Specialist Certification program at Evidence in Motion, a post-professional health care education service based in San Antonio, Texas. "I spend a lot of time educating people about disk health and what happens when a disk starts to go through the wear-and-tear process. I believe the more a patient understands, the less they're going to fear. The unknown creates a lot of fear [in] people. But [when] we explain to someone why they hurt and how they're going to heal, I find it's a huge benefit. Educating our patients can definitely help in the recovery process."

In turn, patients might fear the worst when they hear terms like *herniated* or *bulging* to describe their spinal disk problems, remarks Louw. "You can see on an MRI that disks will show what looks like a herniation," she observes. "It's usually just a disk that has a lot of wear and tear. Sometimes, [a] traumatic injury can happen, … but I think we should try to get away from using provocative language such as *bulging* or *herniated*. Sometimes, we show patients spine models with these terrible bulges, and it makes them feel worse. It doesn't help them to feel any better about their condition."

In her conversations with patients, Louw prefers to use the phrase *disk issues* and reassure patients about their recovery potential, emphasizing that disks will usually heal. "We just have to give them the optimum environment for that to occur," she adds.

They Got Patients' Backs

Since the management of spinal disorders can involve complex medical issues, patients often find optimal treatment in large, integrated care settings, such as major academic medical centers.

For example, Lovelace University of New Mexico (UNM) Rehabilitation Hospital Pain Clinic is affiliated with the UNM Health Sciences Center. Together with spine care specialists at Sandoval Regional Medical Center, UNM Health is a full-service provider throughout New Mexico for all spine-related medical issues.

Another leading provider of comprehensive specialty care is the Spine Center at Oregon Health & Science University (OHSU) in Portland. "The OHSU Spine Center represents a joint, multidisciplinary partnership between orthopedics and neurosurgery," says Josiah Orina, MD, a neurosurgeon who directs the spine division in the OHSU neurological surgery department. "We care for the full spectrum of our patients' spine health needs, ranging from diagnosis and evaluation to nonsurgical treatments, recommendations with modalities like injections, physical therapy, pain medication, all the way up to and including surgery. Because we are multidisciplinary, we're able to see patients' problems from multiple perspectives. … We have a full range of tools at our disposal that allow us to put the patient at the center of our decision-making."

A variety of issues bring patients to the OHSU Spine Center. "We're seeing patients who have chronic pain, whether that be back pain or neck pain from disk herniations or bulges from osteoarthritis," reports Dr. Orina. "That's probably the [largest] share of our population—patients who are dealing with degenerative spine diseases. But we also have quite a few patients who have more complex issues, such as spine tumors, scoliosis, spinal deformity, infections, and … traumatic spinal cord injuries."

Not everyone who has back pain needs to be seen by a back pain specialist such as a physiatrist, orthopedic physician, or neurosurgeon, notes Dr. Orina, but several reasons might warrant the need. "One reason to refer somebody to a spine center like ours is if … a course of nonsurgical management [has been unsuccessful]," explains Dr. Orina. "But if the patient is having back pain and they don't have any red flags in their presentation—like motor weakness, bowel-bladder incontinence, or numbness—then we encourage primary care providers to initiate a course of nonsurgical management: physical therapy,

Spinal Support

"A multidisciplinary approach is usually more effective [in] maintaining spine health as there are a variety of issues surrounding these disorders. A physiatrist can be a leader coordinating rehabilitation care with a variety of team members, which may include physical therapy, occupational therapy, psychology, nursing, social work, occupational medicine, and specialists, including rheumatology, integrative medicine, osteoporosis specialists, and spine surgeons, depending on the needs of the patient. It is optimal to treat all factors that influence spine health."

—Julie Muché, MD, CPE

Spine Health Education and Resources

American Physical Therapy Association
https://www.apta.org

Oregon Health & Science University Spine Center
https://www.ohsu.edu/spine-center

Lovelace UNM Rehabilitation Hospital Pain Clinic
https://lovelace.com/location/lovelace-unm-rehabilitation-hospital-pain-clinic

Evidence in Motion
https://evidenceinmotion.com

pain medication, and activity modification for about six weeks.

"If that doesn't help, then the primary care [physician] can feel confident and comfortable ordering an MRI of that area of the spine to see whether there's any [spinal] stenosis or pinching of nerves," continues Dr. Orina. "If there is, that's a great reason to refer the patient to a spine center. Or if they feel that the nonsurgical treatments initiated aren't helping or working, that's another reason to refer out. But I think the collaboration works best if the primary care [physicians] feel empowered to initiate some of these therapies at the beginning."

A similar approach guides specialty referrals at UNM Health, says Dr. Muché: "Referrals for chronic pain to a specialist at the Lovelace UNM Rehabilitation Hospital Pain Clinic are warranted after a basic workup—X-ray [and laboratories]—and basic treatment—physical therapy [and] medications—has been tried for at least four to six weeks without resolution. If the patient is experiencing acute pain, especially from an acute disk herniation or shingles, it is recommended that the primary care physician call our service so we can evaluate and treat the patient promptly."

All in Alignment

With many spine-related health conditions, pain management is often a key concern. Certainly, both prescription and nonprescription medications may play a role in pain management. These can involve analgesics, anti-inflammatory drugs, muscle relaxants, and other medications. In terms of long-term use, prescription medications should be used with caution to avoid potential complications or side effects. This is particularly a concern with opioid medications, which are potentially addictive.[7]

The larger goals of treatment for spine-related pain should address not only the root cause of the pain but also its potential impact on the whole person. Chronic spine-related pain can sometimes incur a high emotional cost for patients. For this reason, providers may refer patients for psychological counseling or other support resources.

"The psychological burden of pain can have a tremendous effect on a patient's treatment outcomes," observes Dr. Muché. "Stress, depression, and anxiety are prevalent issues in chronic spine pain disorders. Cognitive behavioral therapy is extremely beneficial for the patient's emotional support. … Instead of catastrophizing, patients learn acceptance, life control, and functional restoration as they embark on their ability to manage their pain. Other behavioral health approaches may include biofeedback, mindfulness, meditation, and support groups."

A variety of complementary health resources can help patients relieve or better manage their pain, including their psychological responses. These include yoga, tai chi, and other gentle exercises that promote physical recovery while helping a person feel more relaxed and emotionally centered. Additional treatment options may include an anti-inflammatory diet or other dietary modifications and losing weight to help reduce pressure on the spine. Acupuncture, massage, and other nonsurgical therapies can also be beneficial.[7]

Experts agree the psychological impact of chronic pain and disability in patients should not be ignored or downplayed. "In our practice at OHSU, we never rush to surgery," says Dr. Orina. "We focus on how we can rehabilitate the patient with the least invasive options possible, … with a focus on the interplay between physical and mental status. So, when patients are catastrophizing their pain, how can we help them retrain their minds in terms of how they respond to pain? How do we help them to reframe or change their perspectives so they have the emotional and mental resources they need to cope better with their pain? This can have a profound impact on patients."

Accordingly, patients struggling with chronic pain may be referred to the OHSU Comprehensive Pain Center for treatment with physical and psychological therapies, including cognitive behavioral therapy, massage, chiropractic, acupuncture, and other resources. "If they eventually do need surgery, [it can be beneficial] that they've gone through that process of better understanding their pain," remarks Dr. Orina. "There's data that shows it leads to better postoperative outcomes … compared with patients who don't go through a more holistic approach to their pain."

Bone Up on Surgical Options

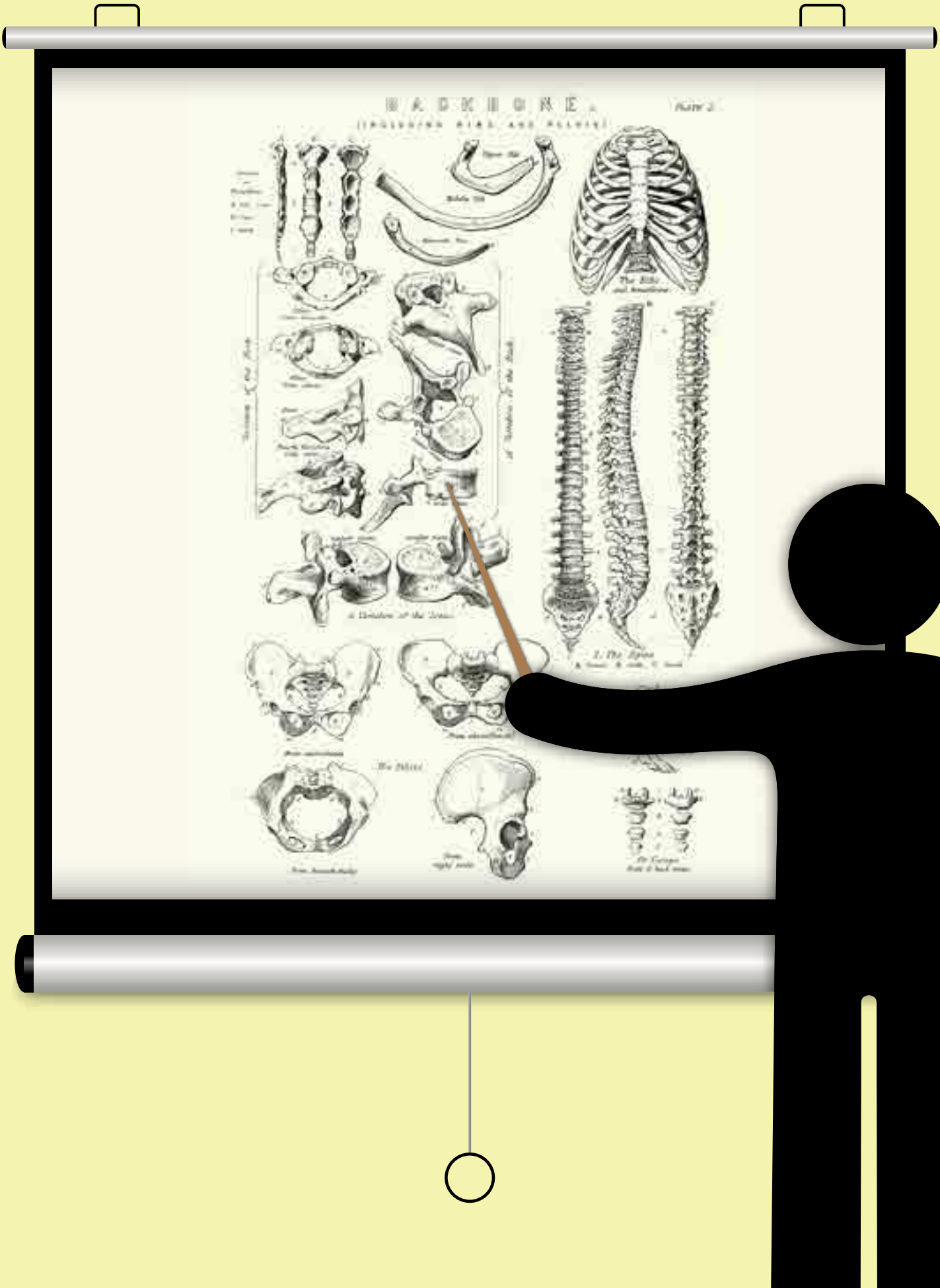
Surgery can be a viable treatment option for many serious spinal disorders and injuries. These can include medical issues involving spinal deformity, infections, trauma, tumors, stenosis, disk herniation, and other conditions.

"Lumbar stenosis is a very common condition," observes Dr. Orina. "It's also

Herniated Disk Treatment

"After proper assessment with history, physical examination, and imaging workup for disk herniation, a pain specialist could treat the patient in a variety of ways. It is a collaborative effort [between] the provider and the patient to determine appropriate treatment goals for the patient, as pain is a very individualized experience, and treatment for it should be tailored accordingly. Initial conservative treatment may include anti-inflammatories, muscle relaxers if spasm is present, nerve agents if radicular in nature, and physical therapy. Lifestyle modifications such as smoking cessation, weight loss, and following an anti-inflammatory diet are excellent adjunctive recommendations for treatment. A patient may be interested in complementary alternative medicine treatment to complement the above standard of care measures. If acute or severe pain is unresponsive to the above measures, an epidural steroid injection is an option with interventional treatment. In recalcitrant cases, a spine surgery consult may be warranted."

—Julie Muché, MD, CPE


BACKBONE
(INCLUDING RIBS AND PELVIS)
Plate 2

A Bone to Pick

The Cleveland Clinic shares common cause of back pain[4]:

Strains and sprains: The most common causes of back pain are injured muscles, tendons, or ligaments, often caused by lifting something too heavy or not lifting safely.

Fractures: Accidents can cause spinal bones to break. The risk is higher for patients with certain conditions such as spondylolysis or osteoporosis.

Disk problems: The disks that cushion the vertebrae can bulge from their position in the spine and press on a nerve or tear, which is known as a herniated disk. Disks can get flatter and offer less protection with age, which is called *degenerative disk disease*.

Structural problems: Spinal stenosis occurs when the spinal column is too narrow for the spinal cord. A pinched spinal cord can cause severe sciatic nerve pain and lower back pain. Scoliosis, or curvature of the spine, can create pain, stiffness, and difficulty moving.

Arthritis: The most common type of arthritis that causes back pain is osteoarthritis. Additionally, ankylosing spondylitis causes lower back pain, inflammation, and spinal stiffness.

Disease: Certain tumors, infections, and several types of cancer cause back pain.

Spondylolisthesis: Vertebrae slip out of place, causing lower back and leg pain.

the most common condition that spine surgeons will treat [in which] there's compression of the nerves. It also happens to be the condition that surgery is most effective for. If we can decompress the nerves that are being pinched, the patient's symptoms almost always get better. It's a very effective and reliable treatment for spinal stenosis."

Notably, the field of spine surgery has advanced considerably in recent years to emphasize safer, less invasive procedures. "Minimally invasive spine surgery is a newer way of doing surgery," says Dr. Orina. "The traditional ways of doing spine surgery, going back to 20 or 30 years ago, involved opening up people's backs in the middle, dissecting the muscles off of the spine, and causing a lot of local trauma to the spinal muscles as we tried to get down to the nerves. We're finding that patients who underwent those types of surgeries ended up having prolonged lengths of stay in the hospital, having to be on pain medications for longer periods of time, and having a rockier recovery. Minimally invasive spine surgery allows us to accomplish the same goals as traditional surgery but through smaller incisions that cause less local tissue damage."

Dr. Orina elaborates on the advantages of this surgical approach. "I do quite a lot minimally invasive spine surgery myself," he explains. "It involves making small incisions, dilating through the muscles rather than disconnecting them from the spine, and then working through tubes using microscopes and small instruments, sometimes even endoscopes, to decompress the nerves and treat the patient's symptoms. The main benefits are that many of the procedures can be performed as a day surgery, so they don't require overnight stays. Patients can return home sooner and get back to their quality of life much quicker."

Other, newer advances in spine surgery are also on the horizon, says Dr. Orina: "An area of spine surgery that's still relatively new that I'm excited about is motion preservation spine surgery. A lot of spine surgeries, unfortunately, involve spinal fusion operations during which we treat the patient's condition by having to fuse a joint in the back with screws and rods. Those are very effective surgeries, but they can have long-term consequences in the sense that sometimes they lead to issues with the hardware [and] problems with the levels above a fusion wearing out because they're under more stress.

"One of the hotter topics now in spine surgery is how [we can] treat patients' conditions and get good outcomes without [fusing] their spines," Dr Orina adds. "There are newer technologies available now called lumbar disk replacements and cervical disk replacements that appear very promising in allowing us to do just that—to restore motion or to preserve motion rather than to take it away from patients' backs."

Central Support

As an experienced medical assistant, Melody Malphrus, CMA (AAMA), notes the value of critical listening skills. They can be particularly essential with patients experiencing chronic back pain or related symptoms, which can sometimes pose diagnostic challenges.

"The primary care and urgent care settings are a frequent entry point for many back and neck pain issues," says Malphrus, a

Diagnostic Testing

If pain persists longer than two weeks without improvement, a physician may order diagnostic tests[9]:

- X-ray
- MRI
- CT scan with 3-D reconstruction
- Electromyography or nerve conduction velocity testing

This course of action is also recommended when a patient's pain radiates into the extremities or around the chest beyond the spinal epicenter of the pain focus, as it can help rule out other underlying causes.

staff member who works in both clinic settings for Cooley Dickinson Hospital at Mass General Brigham in western Massachusetts. "In my experience, … the important thing during patient intake is to listen carefully to patients. You want to make sure patients feel like they are heard and not rushed."

In a sense, the goal is to help the patient tell their story, explains Malphrus: "In urgent care, we mostly rely on X-rays and the patient's description of the pain. Is it sharp? Is it stabbing? Is the pain referring from anywhere? How long has the pain been bothering them? Have they had any recent [injuries]? Is there anything that's felt off in the last few days or hours? Sometimes, a patient will say, 'Well, I've had this symptom for several days.' If I ask whether they have hurt themselves, they might say, 'No, but I was taking the trash out and bent over to pick something up.' Your questions might help to jog their memory. I always try to put the focus back on them, to make them the storyteller."

In doing so, medical assistants can help fill in important details in the patient's story before they meet with the provider. "I work very closely with our providers in primary care and urgent care," says Malphrus. "We're trying to figure out what's happening with the patient, why they're here, and what their symptoms are, and then we can share that information with the provider."

As patients describe their symptoms or health concerns, staff should recognize that their interactions with patients can impact their overall satisfaction with the visit. "As the first person who sees the patient and the last they see before they leave, it's very important for me that our patients feel like they're being listened to and understood," concludes Malphrus.

As many observers note, spine health constitutes the literal backbone of human health.[8] From sleep to mobility and the normal functions of everyday life, a healthy spine is a prerequisite for every aspect of human activity and movement.

In taking care of patients'—and our own—spines by encouraging and embracing the advice to stay active, avoid injury, follow a healthy lifestyle, and access necessary medical spine care, we can ensure that we all have the ability to live life to our fullest potential. ✦

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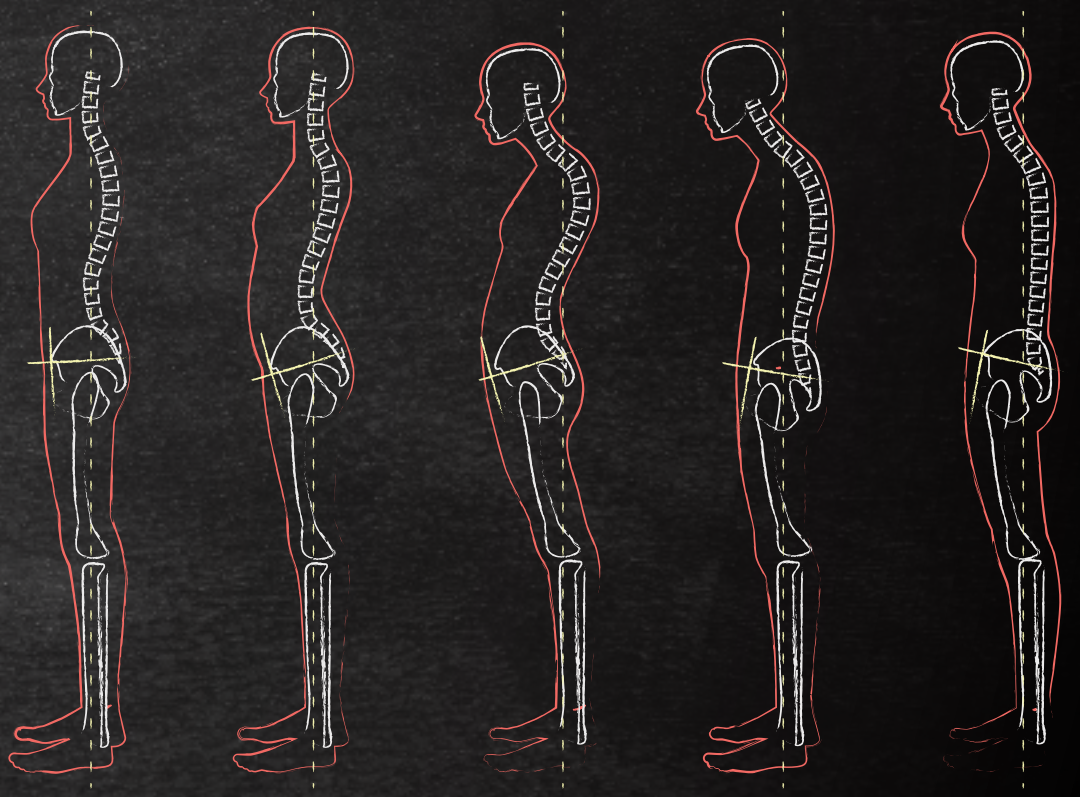

Spine Health

Deadline: Postmarked no later than **March 31, 2024**

Credit: 2.5 AAMA CEUs (gen/clin) **Code: 142346**

Directions: Determine the correct answer to each of the following, based on information derived from the article.

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T F

☐☐ 1. The spine consists of joints, bones, and nerves but not ligaments.

☐☐ 2. Minimally invasive spine surgery causes less trauma to the spine muscles and shortens the recovery time for patients.

☐☐ 3. No effective treatment currently exists for back pain that is nonspecific in origin.

☐☐ 4. Diagnosing lumbar spine pain can be difficult because such pain can be caused by one or several spine components.

☐☐ 5. Spinal stenosis is a disease that causes the gradual thinning of spinal cartilage.

☐☐ 6. Decompressing pinched nerves has not proven to be an effective treatment for spinal stenosis.

☐☐ 7. The ability to feel pain and temperature from touch originates in the spine.

☐☐ 8. Spinal disorders are often best treated in large, integrated care settings because of the complexity of medical issues that patients face.

☐☐ 9. All the 33 vertebrae of the spine can move independently.

☐☐ 10. Patients with lower back pain should not be referred to a physical therapist until a definitive diagnosis of the pain's cause has been determined.

☐☐ 11. If a patient has back pain but does not have symptoms such as numbness or motor weakness, the primary care provider should initiate a course of nonsurgical management.

☐☐ 12. Because chronic, severe back pain can result in emotional suffering, patient referrals to counseling professionals—such as clinical psychologists—can help them cope.

T F

☐☐ 13. Scoliosis causes the spine to fuse to itself and become very stiff.

☐☐ 14. The three main regions of the spine are the lumbar, thoracic, and cervical regions.

☐☐ 15. Patients with back pain must see a back pain specialist for effective treatment.

☐☐ 16. Back pain is among the most common health complaints in the United States.

☐☐ 17. Complementary health resources for spinal pain can include yoga, dietary modifications, acupuncture, and massage.

☐☐ 18. Educating patients on the cause of their back pain and the healing process can make them more fearful throughout treatment.

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Act Your Age

Biological age can vastly differ from your actual age, depending on many factors including how you care for your body. Notably, someone who works to maintain good cardiovascular health may have a lower biological age than chronological age. Meanwhile, those who smoke or follow a poor diet may have a biological age far above their chronological age, according to Medical News Today.

Thankfully, a new study by researchers at Columbia University found that biological aging—which can be determined by evaluating one's cardiovascular health—may be significantly slowed down by following the American Heart Association "Life's Essential 8" checklist. Slowing biological aging can lengthen life and lower one's risk of health issues and age-related health conditions.

Data from over 6,000 adults demonstrated a potential for a difference of up to five years between chronological and biological age if you incorporate these eight recommendations into your life, according to NBC News:

- **Diet:** Eat a variety of fruits and vegetables, whole grains, healthy protein sources, and minimally processed foods.
- **Physical Activity:** Meet the goal of at least 150 minutes of moderate-intensity aerobic activity or 75 minutes of vigorous aerobic activity weekly.
- **Nicotine Exposure:** Avoid smoking, which is the most preventable cause of premature deaths in the United States.
- **Sleep Health:** Try to get seven to nine hours of sleep nightly.
- **Blood Pressure:** Control blood pressure with increased activity and a heart-healthy diet, particularly by reducing salt.
- **Blood Sugar:** Reduce blood sugar by exercising and avoiding refined sugars, carbohydrates, and sugary drinks as much as possible.
- **Weight:** Control portions, choose healthy food options, and get active to achieve and maintain a healthy weight.
- **Cholesterol:** Avoid saturated fats and carbohydrates and eat more vegetables to reduce cholesterol levels as much as possible.

A Clear Head

All types of alcohol can cause headaches due to dehydration. However, red wine is an especially common source of alcohol-induced headaches, according to the *New York Times*.

A new study in *Scientific Reports* may have found a reason why, as data suggests that headaches caused by red wine could be the result of an antioxidant present in red wine: quercetin. Though quercetin has numerous heart and brain health benefits, your body converts quercetin to quercetin glucuronide when metabolized with alcohol. And when the metabolism of alcohol is blocked by quercetin glucuronide, it can lead to a buildup of the toxin acetaldehyde, an inflammatory compound. And it does not take much—the study found that one or two glasses can trigger a headache in 30 minutes or less.

Red wine headaches can also be caused by allergies or sensitivities to other elements like sulfites, tannins, and histamines, as well as dehydration, according to Everyday Health. To minimize your risk of getting a headache from red wine, look for certain wine varieties:

- Lower tannin contents
- Lower histamine levels
- Lower alcohol content
- Minimal or no sulfites

When trying a new red wine, consider starting with less than half a glass to vet any headache symptoms that can emerge within 15 minutes.

If you opt for any red wine this winter, hydrate before, during, and after consumption, and consume meals with plenty of protein and fiber to reduce your risk of getting a headache. These practices can dilute the potentially problematic aspects of red wine that could cause a headache.

The Magical Power of Self-Compassion

Often, the way we react to our own circumstances or hardships is much harsher than the way we react to those of our loved ones. Next time you find yourself with a problem at work or school and start to think negatively, consider how you may respond to a friend in the same situation. Odds are, it is much gentler than how you think about yourself.

Ultimately, harsh self-criticism is rarely helpful. Studies have shown that those who practice self-compassion in these circumstances tend to experience less depression and more motivation, optimism, happiness, and life satisfaction, according to Psychology Today. Self-compassion is a practice that advocates for being understanding and compassionate toward yourself when negative feelings arise.

Self-compassion comprises three elements:

- **Self-kindness** urges you to shift from negative self-talk and harsh judgment to gentle warmth and acceptance.
- **Common humanity** reminds you that all humans fail, make mistakes, and suffer disappointment and loss.
- **Mindfulness** involves shifting away from judgment to being curious and observant about an experience.

These elements are important to understanding that you can counter negative thought patterns with certain strategies. With this awareness, you will have an easier time forgiving and caring for yourself, which can lead to improved health, well-being, and relationships. It may also reduce anxiety, depression, and the intensity of negative emotions you experience, according to Verywell Health.

Here are some specific ways that you can practice and monitor your self-compassion:

- Monitor your self-talk.
- Forgive yourself for mistakes and failures.
- Celebrate small accomplishments.
- Practice mindfulness.
- Be kind to yourself.
- Express gratitude.
- Seek help when needed.

Protein Machine

Getting adequate protein is crucial to a well-rounded diet and overall health. The slow-burning nutrient can help build and maintain your muscles, keep you feeling full, and improve your metabolic health. Here are a few simple ways you can get the protein you need, according to Cleveland Clinic and Healthline:

- **Snack on protein-rich foods.** Swap common snacks like tortilla chips with cheese and whole-grain crackers to increase your protein and calcium intake.
- **Enjoy more whole grains.** Whole grains contain nutrients like fiber, vitamins, and antioxidants. They can also increase the protein content of dishes when used instead of refined grains.
- **Eat protein first.** Starting your meal with protein can increase the production of peptides and keep you feeling full and satisfied. Additionally, this practice can help keep your blood sugar and insulin levels from rising too high after a meal.
- **Consider whey protein powder.** Protein shakes for post-workout recovery or breakfast can be a simple way to consume protein.
- **Try nonmeat sources.** Eating legumes, quinoa, nuts, seeds, and soy is a terrific way to add more protein and diversify your diet.
- **Be selective of meat.** Choosing leaner cuts of meat and increasing your portion can boost the amount of protein in your meal.
- **Eat eggs for breakfast.** Many breakfast foods, such as toast and cereal, are low in protein and high in carbohydrates. However, eggs can help you stay fuller longer.
- **Include protein-rich food in every meal.** Adding meat, eggs, legumes, or soy to each meal can ensure that you get the amount of protein you need.

PLAN THE HELP

By Pamela Schumacher, MS, CCMP

Help Patients Map Out Living Wills and Other Advance Directives

When a medical emergency happens—or when patients are receiving end-of-life care—patients might be unable to make their own care decisions. And those patients might incorrectly assume that their loved ones know what they would want. This disconnect between the care patients want or expect and what family or friends *think* they want can lead to emotional distress, increased suffering, and greater health care costs.[1]

Medical assistants can help patients avoid these situations by initiating conversations about advance care planning. This process involves talking with patients about end-of-life care and encouraging them to use advance directive forms in which they write down their medical wishes and name a power of attorney for health care.

"Patients are more likely to get the care they want if they have ongoing conversations about what quality of life means to them and what is important for their medical care," says Rebecca Sudore, MD, professor of medicine at the University of California, San Francisco, Division of Geriatrics, and director of the Innovation and Implementation Center in Aging and Palliative Care. "Medical assistants can play a big role in encouraging these discussions by bringing up advance care planning during regular office visits and normalizing the conversation."

"These documents are so important," says Kathy Brown, CMA (AAMA), a medical assistant at the Southern Idaho Pain Institute in Twin Falls, Idaho. "Patients who have participated in advance care planning relieve loved ones of the burden of making decisions they may not want to make or even be prepared to make, and the patient receives the end-of-life care they desire."

Glossary of Terms

Familiarizing patients with advance directives is a crucial step in the advance care planning process. Advance directives are formal legal documents authorized by state laws that individuals complete to be invoked if they become seriously ill and unable to make decisions.[2] Advance directives take three common forms[2]:

- An advance directive that combines a living will and a power of attorney for health care.
- A separate living will, which specifies preferences regarding the use of life-sustaining therapies and other medical treatments in the event of incapacity or terminal illness.
- A separate power of attorney for health care, which designates a surrogate or proxy who will make treatment decisions if a person becomes unable to make such decisions.

"There can be a lot of variety in how detailed these documents may be," says Candace J. Kim, MD, associate clinical professor of medicine at the University of California, San Francisco, Division of Geriatrics. "People can revoke or change the documents at any time, provided they have the capacity for such a revocation."

Uncharted Territory

Several barriers hinder advance care planning discussions. For physicians and other clinicians, these include lack of time, discomfort with the topic, and concerns about reimbursement[3], even though the Centers for Medicare and Medicaid Services reimburse for these conversations.[4]

"A big barrier for patients is they don't want to think about dying or becoming incapacitated," says Dr. Sudore. But patients' age or current physical health should not be the reason they wait to complete their advance care planning. "People of all ages benefit from advance care planning because a serious illness or severe injury can happen at any time," notes Dr. Sudore.

"Another barrier is that many people don't speak English, or [English] isn't their first language," continues Dr. Sudore. "And the forms and legal requirements can be confusing and vary from state to state. To address these issues, our team has put together a website, PrepareforYourCare.org, with free resources and easy-to-read forms for every state and in several languages. The online program also includes materials and scripts … that medical assistants and other health care providers can use to talk to patients about advance care planning."

Scouting Ahead

Dr. Kim recommends that medical assis-

tants introduce the concept of advance care planning and advance directives as part of ongoing medical care. "Start by assessing a patient's readiness to participate in advance care planning, [then] identify and address barriers. Once they are ready to engage in a care planning discussion, identify what is important for a person's quality of life. Then, seek to understand their health status and care options in the context of their values and goals.

"Identifying and documenting one's surrogate should be done when an individual has the cognitive capacity to make such a designation," she explains. "The documentation of the health care power of attorney must be kept in an easily accessible location. Once a surrogate is established, the patient should share their values and priorities for medical care with their surrogate. Next, the patient should communicate goals and preferences to family and friends. The details of any advance care planning conversations should be documented in the medical record and be readily accessible to surrogates and care teams."

Dr. Sudore says that simply having a conversation is a good starting point: "Yes, there are documents that can be filled out and legally recognized, but the first step starts around the kitchen table, talking with loved ones about what is important to you. Encourage patients to think about how they want to live. What does quality of life mean to them? What kind of medical intervention would or would not be acceptable? If they are near the end of their life, do they want their pets around them? Do they want to be at home? When physicians and medical assistants approach advance care planning from the aspect of living well and quality of life, patients are more likely to engage with you and tell you what matters most."

Revisiting the Map

Once created, advance directives should be revisited and updated regularly. "It's not a one-and-done process. We review health issues and insurance forms every year, so why aren't we reviewing advanced directives annually?" adds Dr. Sudore. "What if the person chosen as the health care proxy moves away or dies? … Advance care planning is a process that should change and evolve over time because we evolve and change over time."

"I've taken care of patients in the intensive care unit who haven't had a living will or health care proxy, but they've been talking with their family for years about what quality of life means to them and what would be important at the end of life," she says. "Advance directive forms help, but they're only as good as the conversations that go along with them. You can't anticipate every decision that needs to be made in the future, but if you've started the discussion, then at least the family can feel as if they're being true to the wishes of the patient." ✦

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Asking for Directions

The PREPARE for Your Care website provides a script to talk to patients about advance care planning as well as downloadable advance directive forms in multiple languages.[5]

1. **Ask about a surrogate decision-maker** (e.g., proxy, agent, or representative). For example: "Is there someone you trust to help make medical decisions for you if there ever comes a time you cannot speak for yourself?"
2. **Ask about advance directives.** For example: "Have you ever completed an advance directive? It's a legal form that identifies your medical decision-maker and wishes for medical care."
3. **Document patients' wishes** in the medical record so medical providers can find them when needed.

Go for Gold

Achieve Grant-Writing Victories by Employing Top Strategies

by Cathy Cassata

Educators prepare future medical assistants to make a difference in the medical field. However, limited resources may keep them from preparing students in ways they wish. Securing grants is one way to increase funding for classroom enrichment, supplies and equipment, field trips, professional development, and more.

Educational grants can also provide opportunities for "creative interventions and upping technologies at facilities so [students] have the best technologies," says Meredith Noble, founder of LearnGrantWriting.org.

Applying for a grant? Take these steps.

Identify Your Greatest Need

The more targeted a grant opportunity, the smaller the applicant pool will be, which improves the chances of a grant being selected for funding, says Tyler Panian, principal and cofounder of Ontogen Medtech. Panian regularly participates as a panel reviewer for applications with the National Institutes of Health (NIH).

Many people forget to narrow down what they need a grant for, agrees Noble. "Most people want to skip this part and get right to the grant writing part without figuring out which grants to go after in the first place," she notes.

In her book, *How to Write a Grant: Become a Grant Writing Unicorn*, she recommends looking for up to 100 relevant grants, then narrowing the list down to the top 20. After researching those, apply for the top two to three.[1]

A free way to search for available federal grants is by registering with Grants.gov. However, Noble also suggests a paid grant database called Instrumentl (https://www.instrumentl.com/), which includes private and federal grants.

Be Clear about the Problem You Want to Solve

Having a good idea for a grant or a valid financial need is insufficient, says Noble. Rather, articulate a specific problem and how you would like to solve it. For example, the problem could be that your classroom lacks enough blood pressure monitors, which are needed to practice a vital skill for medical assisting.

When the problem expressed aligns with something the funder cares about, she says it is more likely to catch their attention.

Panian notes good grant writing is simply good storytelling that explains a problem and how you plan to solve it with specifics. "In many cases, you are not bound by the plan that you present in a grant application, but it is so critically important to have a well-developed, cohesive plan to present in your grant," he says.

"A meaningful, well defined, and specific plan for what you will accomplish and how you will use the funds" lends credibility to the person requesting funds and demonstrates that they will accomplish their aims, explains Panian.

Know Your Odds

Before applying to your top choices, Noble suggests emailing the grant funder and asking them how many applicants they received last year and what percentage were funded. Apply to grants that have at least a 15–20% chance of getting funded.[1]

Get More Detail

After identifying potential grants, Noble recommends connecting with a funding representative to determine whether your proposal is one that makes sense for them. She recommends asking the following questions[1]:

- Would your organization fund a project like ours?
- Is our project eligible?
- Why would this project not get funded?
- When is the best time to apply?
- What must be in place to apply?
- Who can you partner with to make this project a success?
- What was the average award size, and how much total funding will be awarded?
- What distinguishes successful appli-

cants?

While not always necessary, Panian says most funding representatives are willing to meet briefly to discuss overall submission strategy and introduce the ideas and proposals they can expect in the application. "More importantly, a brief meeting with the funding representatives can be helpful in [narrowing down] which funding opportunities are best suited for your particular niche area of interest," he says.

Write the Grant

While writing the grant can feel overwhelming, Noble breaks it down into the following steps:

Follow the guidelines. Most funding guidelines are available on the funding agency's website. Panian stresses reading them thoroughly. "Don't leave it up to the reviewers to interpret and figure out how your application applies to the specific funding constraints," he says.

Prepare your narrative skeleton. Panian suggests writing a grant thesis and outline before creating additional content. "This will help keep the grant focused, structured, and 'punchy,' " he says. "Sometimes grant writers … provide a laundry list of perceived benefits of their [proposal] scattered throughout the application, but this can do more harm than good in detracting from the overall message and thesis."

Host a kick-off meeting. Inform all people involved in the application (e.g., other medical assisting educators) about the grant application requirements, deadlines, and their role in the application process.[1]

Create the grant budget. Panian suggests developing a budget after you finish the outline and aims, which spells out the specific tactics of what you intend to accomplish, how you will measure success, and more. Noble recommends including the following details in your budget proposal[1]:

- Demonstrate that the funds being asked for will be used wisely.
- Be specific in its estimates.
- Be clear.
- Use outline form, listing line items under major headings and subheadings.
- Include the subtotal for each of the major components with a grand total at the end.

"Then develop your research strategy, which spells out in a broad sense what you intend to investigate and why," Panian says. "At this point, you have a very clear picture of what you are proposing to accomplish within the scope of the grant, and you can populate a well-defined budget to match those aims."

Write your narrative. A narrative is a written description of your project, the problem it solves, and why it should be funded, explains Noble. Each funding agency has different narrative requirements. Some private foundations ask for a two-page letter summarizing the proposal, and if they like it, request a full application. Other funders ask for longer grant narratives with technical attachments.[1]

"Be prepared for several rounds of editing. Many grants have discrete page limits," says Panian. "It can be tricky being succinct, being punchy, and editing out portions that may otherwise seem important."

Prepare key attachments. Attachments can take time to gather:

- **Grant budget and budget narrative,** entered online or via a spreadsheet
- **Resolution,** which shows that a higher-up at your school approves the grant application
- **Letters of support** that explain how the grant will help students

Grant Stats

Below are some insightful grant statistics:

- 61% of all grant seekers leaned on one or two people to help with the grant writing and submission process.[2]
- The top three challenges for grant seekers are lack of time or staff, competition, and difficulty researching and finding grant opportunities.[2]
- The federal government distributed about $721 billion to states and localities in fiscal year 2019.[3]
- In 2019, about 61% of government funds went to health care, 16% to income security programs, and 9% each to transportation and education, training, employment, and social services.[3]
- More than 50,000 foundations gave funds to nonprofits.[4]

Seek Independent Review and Submit

Noble recommends having an independent reviewer look at an application before submission. Panian suggests using formatting and images to emphasize key points in your grant application while keeping within the formatting rules of the grant opportunity.

"Use bold, italics, boxes, diagrams, illustrations—anything you can to make the reviewer latch onto the points you want them to grab," he says. "Even if your grant content is rock-solid, if it is simply a wall of text, it can be laborious for the reviewers to get through and can impact the perception of the application."

By taking the time to plan and draft a well-thought-out grant application, educators can boost their chances of securing necessary funds for improving their students' education. In turn, these students will be well-prepared for success in the health care field. ✦

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Social Medium

Medical Assisting Educator Uses YouTube to Spread the Word on Medical Assisting Knowledge

By Cathy Cassata

While teaching medical assisting courses at the University of the District of Columbia (UDC), Kendra Fowler, certified clinical medical assistant (CCMA) and certified medical administrative assistant, was inspired to spread her knowledge beyond the classroom and into the YouTube world.

"My students asked me to start a channel for medical assistants," she says. "I made a few videos [and] noticed they were growing in views and thought there must be a need for this."

After sharing two videos in 2020, Fowler took a break for about a year and then began posting regularly in 2021. Today, her channel, *Medical Assisting with Ms. K* (https://www .youtube.com /@MedicalAssistingwithMsK), has over 24,000 subscribers and averages about 150,000 monthly views.

However, her videos reach far beyond her subscribers. "Only 24% of my viewers are subscribers," says Fowler.

Her ability to reach many viewers is due to her teaching ability and friendly demeanor, which shine through in her videos. With an engaging and informative tone, Fowler covers topics ranging from checking manual blood pressure and administering injections to becoming a medical assistant and studying for medical assisting exams.

"I help students prepare for exams, and I noticed that videos on this topic get the most views, so I kept doing that," she says.

For her YouTube viewers who are interested in study materials for the CMA (AAMA) and Registered Medical Assistant (RMA(AMT)) exams, she directs them to study materials specific to those exams.

"A lot of what I talk about is going to be on those exams," says Fowler. "However, what is on those exams is bigger and broader than the CCMA exam, so I make sure they know where to get the most appropriate study material."

She also creates videos based on questions and comments she receives from viewers or topics she teaches in the classroom.

Fowler began intermittently teaching medical assisting courses in 2011 and now has eight years of experience under her belt. She works part-time in cardiology while teaching clinical and administrative classes in the Workforce Development and Lifelong Learning program at UDC. "The program allows D.C. residents to attend classes for free," she says. "It's exciting to be part of something that brings opportunity to more people who want to work in the medical field."

As a child, Fowler aspired to be a physician. But in her teen years, she became inspired when her sister began working as a medical assistant. "I used to admire her in her scrubs," she says. "I knew I wanted to work with patients, and it seemed like [a great] career to do that."

She enrolled in a local medical assisting program and graduated in 2004. Throughout her career, Fowler has worked in different specialties, including OB-GYN, family practice, pediatrics, podiatry, infectious diseases, and cardiology. All her experience helps her succeed in the classroom and on YouTube.

"I know I'm doing what I'm supposed to be doing because so many people have said I'm a blessing [in] their lives or that when they're taking an exam, they hear my voice," she says. "I never realized I was such a good teacher until people started telling me. It's great that my channel allows me to reach so many medical assistants outside my classroom." ✦

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Community Service

Excel

"Children's Home for Family Safety," conducted by **South Dakota** (B), Susan R. Hookie, CMA (AAMA), service program director

"Rustic Hope Baby Supply Drive," conducted by **Ohio** (D), Aimee Quinn, CMA (AAMA), service program director

AAMA Rising Star Awards

Norma Gonzalez, CMA (AAMA)

Alyssa Shackelford, CMA (AAMA)

Cameron Smith, CMA (AAMA), PBT(ASCP)

Membership Retention

North Dakota (A)
South Dakota (B)
New Hampshire (C)
Iowa (D)

Membership Recruitment

Oklahoma (A)
New Mexico (B)
Maine (C)
Iowa (D)

Student Membership Recruitment

Oklahoma (A)
New Mexico (B)
New Hampshire (C)
Iowa (D)

CMA (AAMA)® Certification

Greatest percentage increase of member CMAs (AAMA)
Arkansas (A)
Missouri (B)
Maine (C)
Iowa (D)

Student Essay Award

Jacquline Jeter, CMA (AAMA)

Medical Assistant Employer of the Year Award

Urology Specialists Clinic & Ambulatory Surgical Center (A), represented by Tiffany Weeks

In Memoriam:

Nathan J. Breen, Esq

The leadership of the American Association of Medical Assistants® (AAMA) is deeply saddened to announce that Nathan J. Breen, Esq, general counsel of the AAMA for many years, passed away Dec. 3, 2023. Mr. Breen was a partner of Howe & Hutton Ltd., one of the most prominent professional and trade association law firms in the United States.

Mr. Breen worked with AAMA boards, strategy teams, and committees and was well-respected and well-liked by AAMA volunteer leaders and staff. The following are tributes from AAMA leaders:

"Whenever I heard or saw Nathan's name mentioned, I always thought of his kind smile and calm demeanor. I always felt he had the best interest of the AAMA in mind when asked for his legal opinion on any AAMA matter. He will be greatly missed."

"I had the pleasure of working directly with Nathan the past two years as I served as President of the AAMA. Nathan always provided us with sound advice and guidance. It was apparent that Nathan always had the best interests of our organization and our members first and foremost. I enjoyed talking with Nathan when he attended the 2017 AAMA Annual Conference in my home city of Cincinnati. Nathan assisted our Board and answered many questions to help our board members understand situations and issues and to allow us to make wise and sound decisions. We greatly appreciate the contributions Nathan provided to the AAMA. I send my deepest sympathy to Nathan's family and would like them to know how kind and special he was to our organization."

"Nathan was a kind, gracious, and knowledgeable man. I was so sorry to hear about his passing."

"Nathan had a thorough mastery of association law—including antitrust, association governance (including bylaws), intellectual property (including trademarks and copyright), tax, certification, and meetings and conventions (including hotel and other contracts). His analysis of the issues was always accurate, and his wise counsel benefitted the medical assisting profession and the AAMA in countless ways."

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS