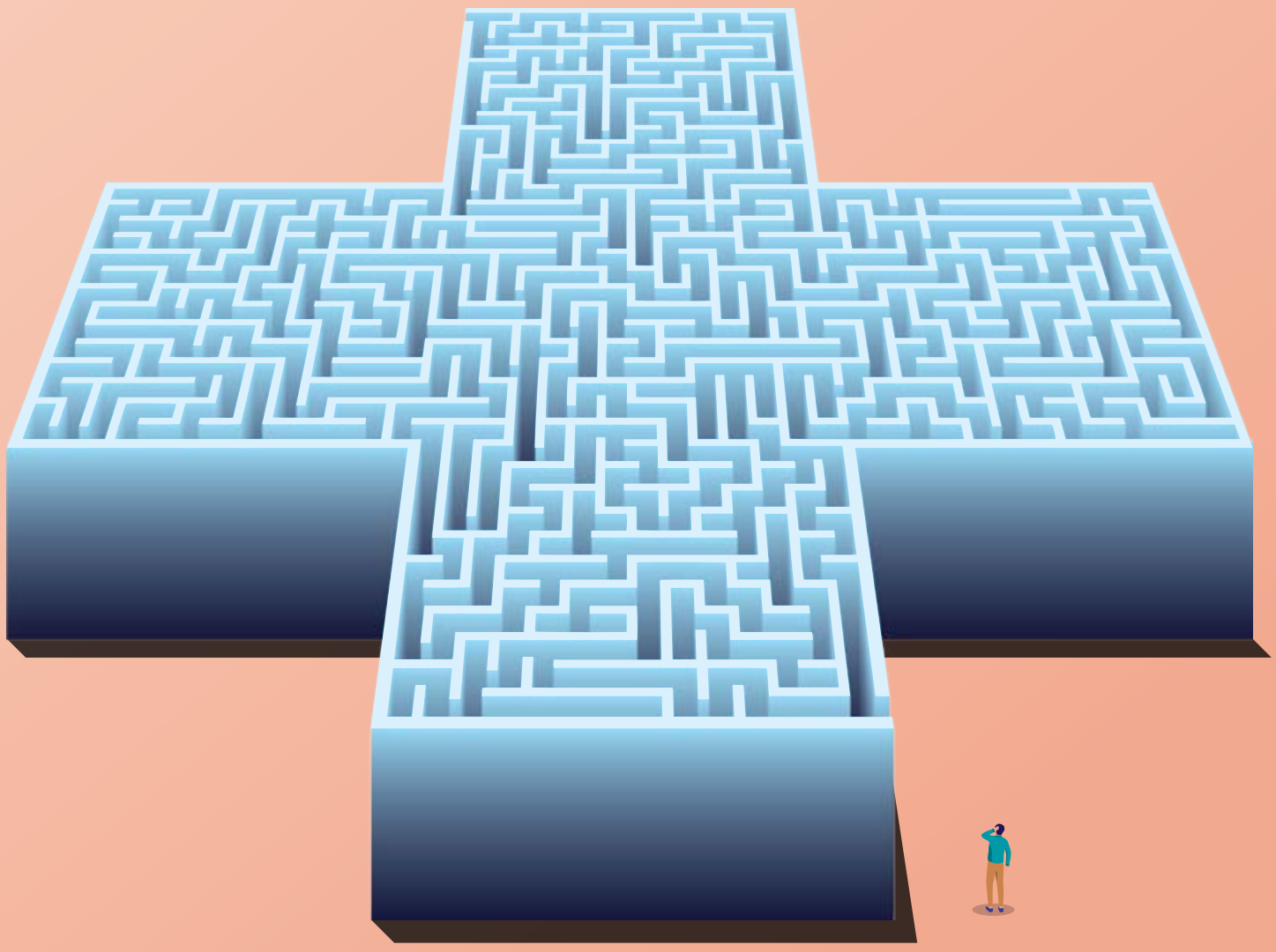
MarApr 2024

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS.

Volume 57 | Issue 2

Medical Assisting Today

The Magazine for Professional Medical Assistants



A MEDICAL MAZE

Biologic Coordinators Guide Patients around Medication Access Barriers

Published by the American Association of Medical Assistants®

Spring into Action

As your AAMA President, I am pleased to share that the AAMA Board of Trustees (BOT) has continued our dedication and work for the association during these winter months. In our productive winter BOT meeting, we discussed initiatives and strategies to bring recognition to our profession and credentialed medical assistants in 2024.

As we approach spring, we all look forward to new growth as blooms emerge. Consider growing not only in your personal life but also in your professional life. What better way to grow than by enhancing your medical assisting education via the vast opportunities available from the AAMA at the national, state, and local levels?

It is hard to believe state conferences are just around the corner with so many great educational and networking opportunities. Support your state, attend your conference, and get those continuing education units (CEUs). As a medical assistant, staying up to date with industry trends and developments is crucial, and obtaining CEUs helps keep your credential current.

Many states have requested a BOT representative. The BOT members are excited to attend state conferences and share updates from the AAMA while getting to know state and local chapter leaders and attendees. Take the opportunity to get to know your BOT representative, learn more about the national office, and share ideas.

A wonderful way to grow in your professional life is by volunteering. Consider volunteering not only within your state but on the national level. Nothing has been more rewarding than the times I have served on numerous national committees. Being able to contribute to an organization for medical assistants has been my greatest achievement. Spread your wings, dive in, and fill out that AAMA Volunteer Leadership Application. The application provides more information and descriptions about committees. The application is due on August 1, 2024, and is available on the "Guidelines and Forms" page of the AAMA website. I look forward to seeing many new faces as we work together.

My fondest memories of education and networking are from attending AAMA annual conferences. I still remember my first House of Delegates and Welcome and Awards Ceremony, the outstanding education I received, and the lifelong friendships I made. Come join us for the 68th AAMA Annual Conference "Strength in Learning" September 20–23, 2024, in Grand Rapids, Michigan.

If any of the BOT or I can be of assistance, please reach out. Remember, we are here for you. Thank you for the opportunity to serve.

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.

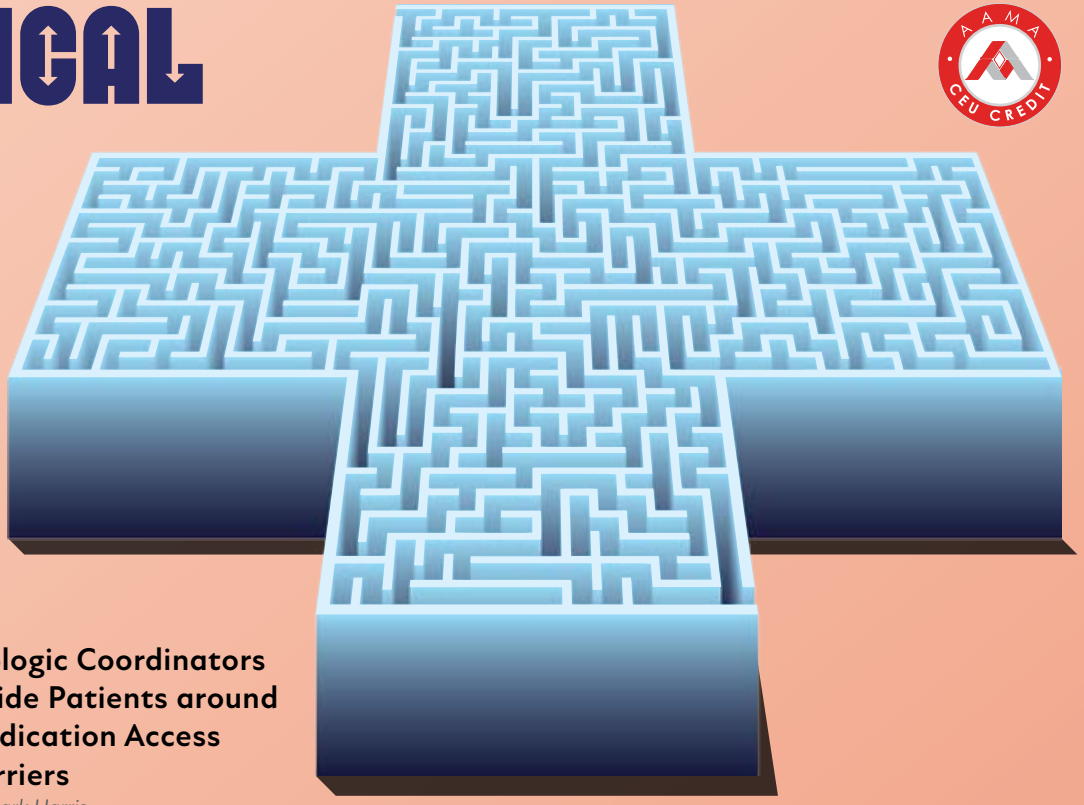
CMA (AAMA)® Certification

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.

This publication printed on paper that contains 10% recycled content.

PRINTED WITH SOY INK

A MEDICAL MAZE



12 Biologic Coordinators Guide Patients around Medication Access Barriers

By Mark Harris

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.

Contact us at MarCom@aama-ntl.org or 800/228-2262.

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

Gear Up for a Grand Time in Michigan

Online registration via CVENT for the 2024 AAMA Annual Conference is live. Visit the CVENT website to access a wealth of resources:

- **Dive into discounts and details.** Find conference hotel discounts and see whether any information about the Great Lakes State catches your eye.
- **Dip your toes into the opportunities.** Pore over an abundance of continuing education opportunities.
- **Build bridges.** Come face-to-face with fellow members of the AAMA from all over the country!

Keep an eye on your inbox for further conference information. Plan now to attend conference by adding this year's dates to your calendar:

Grand Rapids, Michigan—Sept. 20–23, 2024

2024 State Society Conferences

The AAMA shares available information on state society conferences via the "State Society Conferences" webpage (under the Continuing Education tab of the AAMA website) and via the AAMA Facebook page's events section.

AAMA members and other interested medical assistants—if your state is not listed, contact your state president for details. You can find your state president on the "State and Chapter Listings" webpage. *(Updates will be posted to the AAMA website and Facebook page as received.)*

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

1. Make sure your state conference information is posted on the AAMA website. You can email the AAMA at MarCom@aama-ntl.org with questions and updated information, including links to registration information for your state meeting.
2. If you would like AAMA staff to share the event via the AAMA's Facebook page to broadcast the information to its 52,000+ followers, submit a Save-the-Date online form, accessible via the My Account section of the AAMA website *(must be signed in for access)*. ✦

On the Web

Conference Advertising

Under the News & Events/Conference

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

Who's Who?

Within the "About" Section/Executive Office Staff

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

State Scope of Practice Laws

Under Employers or Home Page/State Scope of Practice Laws Section

Access updated documents detailing key state scope of practice laws for medical assistants. Find out everything you need to know about the duties medical assisting staff can perform.

Check Certification Expiration

Under My Account/My Certification Information

Time flies. Make sure it doesn't pass your recertification by! CMAs (AAMA)® can double-check their certification expiration dates on the AAMA website. Sign in or create an account to stay ahead of the curve. ✦

Official Call for HOD Representation

State societies are entitled to the following representation in the House of Delegates at the 2024 AAMA Annual Conference in Grand Rapids, Michigan. The HOD convenes at 9 AM Saturday, Sept. 21, 2024.

AK	3	ND	2
AL	3	NE	3
AR	2	NH	3
CA	3	NJ	3
CO	3	NM	2
CT	3	NV	2
FL	4	NY	3
GA	4	OH	6
HI	2	OK	3
IA	5	OR	4
ID	3	PA	4
IL	5	SC	5
IN	6	SD	3
KY	3	TN	3
MA	3	TX	3
ME	3	UT	3
MI	6	VA	3
MN	5	WA	6
MO	3	WI	7
MT	3		
NC	9		

Enter the Excel Awards!

The submission window for the 2024 Excel Awards is open! Start gathering your submission materials to enter the competition honoring the achievement of excellence:

- **AAMA members.** Nominate someone deserving of recognition!
  - Nominate a medical institution—big or small—that employs medical assistants and is a strong supporter of professional growth, particularly in the areas of certification and recertification, continuing education, and membership.
  - Nominate exemplary national leaders for one of the three Awards of Distinction.
- **State leaders.** Enter your state publication, website, marketing campaign, or community service effort for recognition.
- **Medical assisting students.** Craft an essay responding to this prompt: "What are your goals and aspirations as a medical assistant to stand out to your employer and patients and in your career?" Enter for a chance to win $1,000.
- **Anyone.** Nominate influential new leaders for the AAMA Rising Star Awards.

Visit the "Excel Awards" webpage to read the details on required submission materials. Entries must be postmarked or emailed by July 15.

Why a *Strategic* (not *Traditional*) Occupational Analysis Is Essential for Medical Assisting Curriculum and Exam Development

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

My Public Affairs article "Occupational Analyses: Why Such Studies Are Important for Examination *and* Curriculum Development"[1] was published in the July/August 2015 issue of *CMA Today* (now titled *Medical Assisting Today*). As the sciences of (1) curriculum development and (2) testing and measurement have progressed this past decade, I have come to the realization that *traditional* occupational analyses are no longer adequate for rapidly evolving professions such as medical assisting. (*Note: The term* occupational analysis *will be used in lieu of* job analysis *in this article.*)

The thesis of *this* article, therefore, is that a *strategic* occupational analysis is indispensable for (1) accurate updating of the "Core Curriculum" of the Commission on Accreditation of Allied Health Education Programs *Standards and Guidelines for the Accreditation of Educational Programs in Medical Assisting* and (2) the *Content Outline of the CMA (AAMA) Certification Exam*. Most importantly, my conviction is that a strategic occupational analysis is essential for the optimal positioning of the medical assisting profession in the allied health labor market. (*Note: The terms* occupation *and* profession *are used interchangeably in this article.*)

Traditional Occupational Analysis

According to a seminal article on strategic (occupational) analysis, traditional occupational analysis (TOA) techniques make "the implicit assumption that information about a job as it *presently* exists may be used to develop programs to recruit, select, train, and appraise people for the job as it will exist in the *future* [emphases in original]."[2] The obvious weakness of this assumption and approach is that future changes in the occupation may result in different elements of knowledge, skills, and professional attributes and behaviors (KSAs) being required for the occupation. Consequently, the philosophy and methodology of TOA may be classified as a *static* approach to arriving at the cognitive and psychomotor requisites of an occupation.

Strategic Occupational Analysis

Unlike traditional occupational analysis, strategic occupational analysis (SOA) "focuses on jobs as they will exist in the future."[3] Thus, SOA is especially appropriate for professions that are in transition.[3] According to a 2023 study about transitioning from TOA to SOA, conducting a gap analysis between the KSAs of the current profession and the projected KSAs needed for the profession in the future is an important element of an SOA.[4] Strategic occupational analysis, in contrast with TOA, may be considered a *dynamic* approach to determining the cognitive objectives and psychomotor competencies of a profession.

Medical Assisting in 2024 and Beyond: Observations and Questions of Importance for SOA

Nontraditional Medical Assisting Education Is Being Substituted for Traditional Postsecondary Medical Assisting Education.

In the United States, the number of accredited medical assisting programs in formal postsecondary academic institutions (primarily community colleges and vocational-technical schools) has been decreasing since 2011. The total number of students in these programs has also been declining. (These decreases have not occurred in every state and every region of every state.)

There have been many conjectures and debates about why these decreases have occurred. Research initiatives to pinpoint the causes of these declines should be an important part of a 2024 strategic occupational analysis of medical assisting.

A way to state this decrease is that the demand for alternative forms of medical assisting training is replacing the demand for traditional, postsecondary medical assisting education. Some of the nontraditional, alternative forms are in-house training programs in health systems and clinics; apprenticeship programs that include classroom instruction and hands-on work; truncated programs by training providers that only include certain medical assisting tasks and less classroom instruction; medical assisting programs being taught at the secondary (i.e., high school) level; and medical assistants being trained on the job.

It is uncertain whether this decrease in formal postsecondary medical assisting programs will continue. Indeed, there may be ways to lessen these declines and even

reverse them. Therefore, devising realistic strategies to reverse the decreases should be a key component of SOA for medical assisting.

Are Alternatively Educated Medical Assistants Performing Less Advanced Tasks than Traditionally Educated Medical Assistants?

A corollary of the above observation about nontraditional training replacing formal, postsecondary medical assisting education is that two general categories of medical assistants have emerged based on their education and training. Another key 2024 strategic occupational analysis question should be whether the tasks performed by alternatively educated medical assistants are the same as, or different from, those done by formally educated medical assistants.

If alternatively educated medical assistants are doing less advanced duties, how does this fact affect the efficiency of ambulatory health care delivery settings? Is this altering the staffing configuration of outpatient settings and increasing the hiring of additional health professionals—such as registered nurses, licensed practical/vocational nurses, radiologic technologists, and registered dietitians? Are these new staffing patterns increasing the cost of delivering ambulatory care?

On the other hand, if alternatively educated medical assistants perform the same tasks as formally educated medical assistants, are these tasks performed at the same level of competence? If not, is patient safety being jeopardized by medical assistants with less knowledge and fewer skills?

Should Formally Educated Medical Assistants Be Taught and Delegated More Advanced Tasks?

If alternatively educated medical assistants are being delegated fewer and less advanced duties, would a viable SOA strategy be to include in the curriculum of accredited, postsecondary medical assisting programs more advanced tasks—perhaps tasks that previously have not been a part of the medical assisting scope of practice? There is a school of thought within SOA theory that—in times of change and disruption in a market for a profession—a curriculum should be redesigned to revitalize a profession by expanding its curriculum requirements to include duties that in the future *should be delegated* to members of a profession. The profession can be repositioned by including such duties to assume a different niche in the larger labor market.

(Adding tasks to a health profession is feasible only if relevant laws allow for such an expansion of scope.)

Should There Be Pathways for Entry into Medical Assisting by Other Health Personnel?

During this period of change, the medical assisting profession could be enriched by encouraging other allied health professionals to enter medical assisting by pursuing postsecondary, accredited medical assisting education. Certified nursing assistants, emergency medical technicians, dental assistants, military-trained health personnel, phlebotomists, and pharmacy technicians should be allowed to have their prior education, credentialing, and experience serve as entry points into medical assisting education, the CMA (AAMA)® credential, and the medical assisting profession.

Final Thoughts

My position is that traditional occupational analysis is no longer adequate for formulating a curriculum and constructing an exam blueprint for the medical assisting profession in 2024. Rather, strategic occupational analysis is essential for charting a correct course into the future. ✦

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

References

1. Balasa DA. Occupational analyses: why such studies are important for examination and curriculum development. *CMA Today*. 2015;48(4):6. Accessed February 15, 2024. https://www.aama-ntl.org/docs/default-source/default-document-library/default-document-library/ja-pa-occup.pdf?sfvrsn=2
2. Schneider B, Konz AM. Strategic job analysis. *Hum Resource Manage*. 1989;28(1):51-63. doi:10.1002/hrm.3930280104
3. Gast I, Vaughn K. *Strategic Job Analysis: Predicting Future Job Requirements*. US Customs and Border Protection. Accessed February 15, 2024. https://www.ipacweb.org/Resources/Documents/conf12/gast.pdf
4. Ahmad S, Alqaarni S. Job analysis in organizations: transition from traditional to strategic. *Int J Professional Business Rev*. 2023;8(5):1-18. https://doi.org/10.26668/businessreview/2023.v8i5.1424

By Brian Justice

BOTTLED UP

Opening the Truth about Daily Aspirin Use

A low daily dose of aspirin has been common practice for over 40 years. The Food and Drug Administration approved it in 1980 for preventing strokes in those who had already experienced one and, five years later, for preventing heart attacks in those who had experienced a heart attack. By the early 1990s, aspirin was recommended for preventing a first heart attack or stroke in people over the age of 50, and a study published in 1995 found that low-dose aspirin decreased the risk of a first heart attack.[1]

As a result, the public began to assume that daily aspirin was a safe and reliable way to prevent stroke and heart attacks. While that can be true for patients who meet specific criteria, a surprising amount of confusion exists around who should and should not take aspirin for these purposes.

A survey analysis found that in high-income countries, about 65% of people who experience a cardiovascular event take aspirin.[2] At the same time, 29 million Americans who have not been diagnosed with cardiovascular disease take aspirin daily, and nearly 7 million of people do so without their physician's recommendation.[3]

"The biggest challenge is that aspirin is an over-the-counter medicine. So, patients hear 'low dose' and automatically think it's safe to take," says Laura Shultz, CCMA, who works in cardiology at Tower Health Medical Group in Royersford, Pennsylvania. "Also, low-dose aspirin has been something that many people have taken for years, but it may do more harm than good, especially in terms of interacting with other medicines."

Aspirin the Right Questions

Aspirin has long been a standby for pain relief and anti-inflammation. It can help prevent blood clots, the primary contributor to heart attacks and strokes.[4]

Blood clots occur when plaque—which results from cholesterol and other substances accumulating on the walls of arteries—ruptures. The body makes the blood clot in an attempt to contain the damage. However, clots can obstruct blood flow to the brain or heart. Aspirin taken regularly reduces the odds of the blood cells forming clots by targeting platelets, mitigating the risk of cardiovascular events.[4]

However, the benefits of daily, low-dose aspirin can be outweighed by potential risks. The stomach lining can become irritated, leading to gastrointestinal issues and ulcers. Its blood-thinning properties pose a threat to people at elevated risk for bleeding, such as those taking other blood-thinning medications or with kidney failure, liver disease, or bleeding or clotting disorders. Understanding these nuances is crucial to making informed decisions about preventively using aspirin.[4]

"Patients typically ask about their medications during check-in, and I notice that they will verify taking a particular medication, which often triggers them to ask if other options are available," says James Kelly, CMA (AAMA), a medical assistant at University Health Lakewood Medical Center in Kansas City, Missouri. "I recommend discussing any medication changes with the [physician], or I make a note and follow up with questions about why they are asking. Is it cost, a commercial they saw, [or] side effects?"

A Medication Myth

A common misperception about low-dose aspirin therapy is that it is always permanent.

"I've had patients say, 'Well, I'm going to be taking this for the rest of my life,' " recounts James Kelly, CMA (AAMA). "That could be true, as heart attacks and stroke risk increase with age. However, bleeding risks, falls, injuries, and bruising could be seen as risks that don't outweigh the benefits. So, aspirin therapy is not necessarily ongoing."

"I'll give an example," adds Majid Basit, MD. "I have a patient who had bariatric surgery and lost 100 pounds. Their diabetes is basically cured, their blood pressure is normal, and their cholesterol level is well controlled. There's absolutely zero need for them to be on aspirin. We stopped aspirin treatment for that patient because the risk-benefit ratio favored risk over benefit. The aspirin now increased the risk for irritation of the stomach and bleeding, so there's no reason to take that risk."

Recommendation Revisions

The United States Preventive Services Task Force recently updated its recommendations on using aspirin to prevent cardiovascular disease. It now advises *against* using aspirin for preventing a first heart attack or stroke in people 60 or older with no clinical evidence or history of vascular disease.[5]

The new recommendations have also changed for healthy people aged 40 to 59 without risks of bleeding. Low-dose aspirin may be considered for people in this group with an elevated risk for cardiovascular disease. However, current studies indicate that aspirin's marginal benefits may not outweigh its potential for adverse effects for this population. In fact, more holistic approaches, including not smoking and managing hypertension and cholesterol, seem to offer greater protection.[5]

"Aspirin therapy has undergone a paradigm shift from being a universal preventative intervention to a selective one based on individual cardiovascular risk," says Kelvin Fernandez, MD, an internal medicine physician at Newark Beth Israel Medical Center in Newark, New Jersey, and tutor and medical residency advisor with Ace Med Boards. "The latest guidelines are influenced by recent studies examining the risk-benefit trade-off. We now appreciate that a one-size-fits-all approach is not ideal, and a recent trend is aspirin therapy based on more personalized risk assessments. When substantial evidence emerges, I review it critically and discuss it with colleagues to determine how it can be integrated into our clinical practices."

Doses Dos and Don'ts

Daily aspirin therapy can spark potentially negative drug interactions. Combining low-dose aspirin with prescription blood thinners (e.g., apixaban, dabigatran, enoxaparin, heparin, rivaroxaban, or warfarin) may increase the risk of major bleeding. Other medications that can similarly interact with aspirin include clopidogrel, corticosteroids, ibuprofen, and certain antidepressants such as clomipramine and paroxetine. Additionally, herbal and dietary supplements that are generally considered safe (e.g., bilberry, capsaicin, evening primrose oil, ginkgo, and omega-3 fatty acids) can elevate bleeding risk when combined with aspirin.[6]

Now, the general recommendation for lowering the risk of cardiovascular events is to embrace healthy habits such as regular exercise, not smoking, and good nutrition. Scientific evidence consistently supports the idea that maintaining a healthy lifestyle and effectively managing blood pressure and cholesterol are the primary methods for preventing heart attack or stroke in the first place, rather than relying on low-dose aspirin.[7]

"Every organ system is interconnected. If you affect one, you are going to affect the others. So, we don't look at one system like the heart by itself," says Majid Basit, MD, a cardiologist at Memorial Hermann Health System in Houston, Texas. "There are plenty of medications to treat diabetes, high blood pressure, [and] high cholesterol, and once someone is healthy, the role of aspirin is minimal."

He also emphasizes that truly effective patient care is a team effort. "The [physician] may be the captain of the ship, but the ship doesn't run without everyone working together," says Dr. Basit. "Everybody on that team has a say, and their voices must be heard. I tell [medical assistants] and nurses, 'If you notice something or the patient tells you something, bring it to my attention.' Full communication between team members is so important because that's how we are able to provide the best care for our patients." ✦

References

1. Craven J. What's going on with the new aspirin recommendations? Slate. October 21, 2021. Accessed February 15, 2024. https://slate.com/technology/2021/10/aspirin-advice-heart-attack-bleeding.html
2. Bever L. Aspirin lowers risk after a heart attack or stroke. Most don't use it. *Washington Post*. August 30, 2023. Accessed February 15, 2024. https://www.washingtonpost.com/wellness/2023/08/30/aspirin-heart-attack-stroke-prevention/
3. Daignault M. Why you should reconsider taking daily aspirin. *USA TODAY*. August 29, 2022. Accessed February 15, 2024. https://www.usatoday.com/story/life/health-wellness/2022/08/25/daily-aspirin-use-danger-outweighs-benefits-most-americans/10355817002/
4. Michos ED. Is taking aspirin good for your heart? Johns Hopkins Medicine. Accessed February 15, 2024. https://www.hopkinsmedicine.org/health/wellness-and-prevention/is-taking-aspirin-good-for-your-heart
5. Amsterdam A. Who should – and who shouldn't – take daily aspirin. UC Davis Health. August 22, 2022. Accessed February 15, 2024. https://health.ucdavis.edu/news/headlines/who-should--and-who-shouldnt--take-daily-aspirin/2022/08
6. Daily aspirin therapy: understand the benefits and risks. Mayo Clinic. April 20, 2023. Accessed February 15, 2024. https://www.mayoclinic.org/diseases-conditions/heart-disease/in-depth/daily-aspirin-therapy/art-20046797
7. Nania R. Don't start aspirin regimen to prevent heart attack, stroke after turning 60. AARP. October 12, 2021. Updated July 27, 2023. Accessed February 15, 2024. https://www.aarp.org/health/drugs-supplements/info-2021/aspirin-recommendations.html

Behavioral Activation Therapy for People with Heart Disease

Behavioral activation therapy is as effective as antidepressants for treating depression in heart failure patients, according to a new study published in *JAMA Network Open*.

More than 6 million adults have heart failure in the United States, according to the Centers for Disease Control and Prevention. Depression is a common comorbidity with heart failure, with about half of heart failure patients experiencing symptoms of depression. People who have both heart failure and depression have more visits to the emergency room, more hospital admissions, lower cardiac function, and a lower quality of life compared to people with heart failure but not depression.

Behavioral activation therapy is an evidence-based therapy that uses enjoyable activities to treat depression. The patient discusses meaningful activities with the therapist—such as going for a walk, meeting with friends, or volunteering—and then starts actively engaging with them on a regular basis.

Researchers followed more than 400 people for a year to determine whether behavioral activation therapy or antidepressants more effectively treated depression in those with heart failure. At the end of the year, researchers found no statistically significant difference in the effectiveness between the two groups. Both had more than a 50% reduction in the severity of their depressive symptoms.

Participants who received the behavioral therapy showed improvement in their physical and mental health. They also had fewer emergency room visits and spent less time in the hospital than those who received antidepressants, according to Science Daily.

The study illustrates that depression can potentially be well-treated without medication, which can avoid medication interaction risks for patients on several medications. Providing more options for mental health treatment is essential for those experiencing mental health problems alongside or as a result of chronic conditions. ✦

Asthma Drug Shows Promise for Treating Food Allergies

New research reveals a potential breakthrough in protecting children against severe food allergies, including peanuts, eggs, and milk. A recent clinical trial backed by the National Institute of Allergy and Infectious Diseases shows that the asthma and chronic hives drug Xolair may shield against severe allergic reactions, according to NBC News.

Notably, 165 children and adolescents who received Xolair injections could tolerate higher food doses without triggering reactions compared to those on placebos. The U.S. Food and Drug Administration (FDA) is fast-tracking approval for using Xolair against accidental food exposure, reports Allergic Living.

Since the drug is approved to treat asthma, it can be prescribed off-label to patients with allergies, but it can be difficult to clear with medical centers and get insurance coverage. Additionally, the cost is a barrier, with Xolair's off-label use costing around $3,663 monthly. Full FDA approval for food allergies could ease insurance hurdles.

Approximately 2% of adults and between 4% and 8% of children in the United States have food allergies, according to the U.S. Department of Agriculture. Anaphylactic shock caused by consuming allergens contributes to 30,000 emergency room visits, 2,000 hospitalizations, and 150 deaths annually, making this advancement crucial. The FDA's priority review for Xolair is underway, and if approved, it could revolutionize food allergy management this year.

Vaccine May Prevent the Recurrence of Certain Cancers

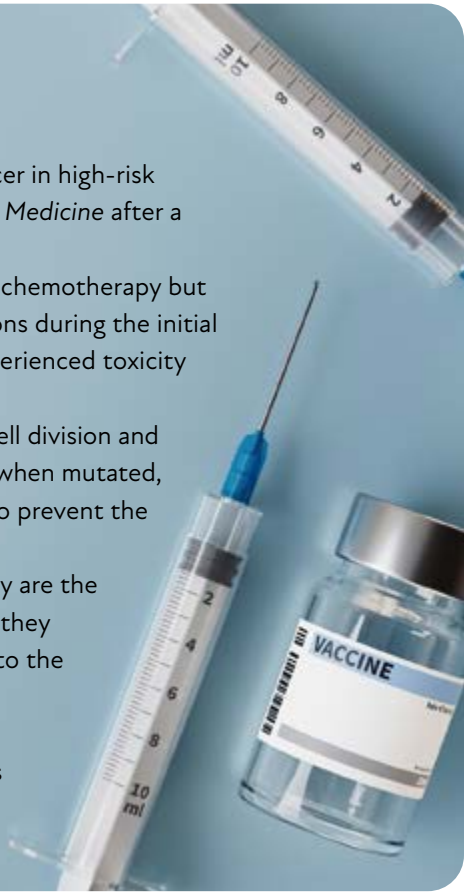
A new vaccine could help prevent the recurrence of colorectal and pancreatic cancer in high-risk individuals who have had cancer treatment. The findings were published in *Nature Medicine* after a successful phase 1 trial for the drug ELI-002.

Researchers recruited 25 people who had successfully undergone surgery and chemotherapy but were considered at high risk for the recurrence of cancer. They received six injections during the initial trial phase, followed by four follow-up booster shots. None of the participants experienced toxicity related to the dose or serious adverse outcomes.

This vaccine targets two genetic mutations of KRAS genes that help regulate cell division and growth. While these genes are not inherently harmful, they can become cancerous when mutated, causing more aggressive tumor growth and lower survival rates. The vaccine aims to prevent the cancer from returning by teaching the immune system to stop KRAS mutations.

Colorectal and pancreatic cancer are two of the deadliest forms of cancer. They are the second and third leading causes of cancer deaths in the United States. Combined, they were responsible for over 100,000 deaths in the United States in 2023, according to the National Cancer Institute.

The vaccine is still in early development, but the trial's promising results have spurred a phase 2 trial that will further test the safety and efficacy of ELI-002. This is a crucial step forward in the protection of patients who have experienced colorectal and pancreatic cancer.



New Sickle Cell Disease Treatments Approved

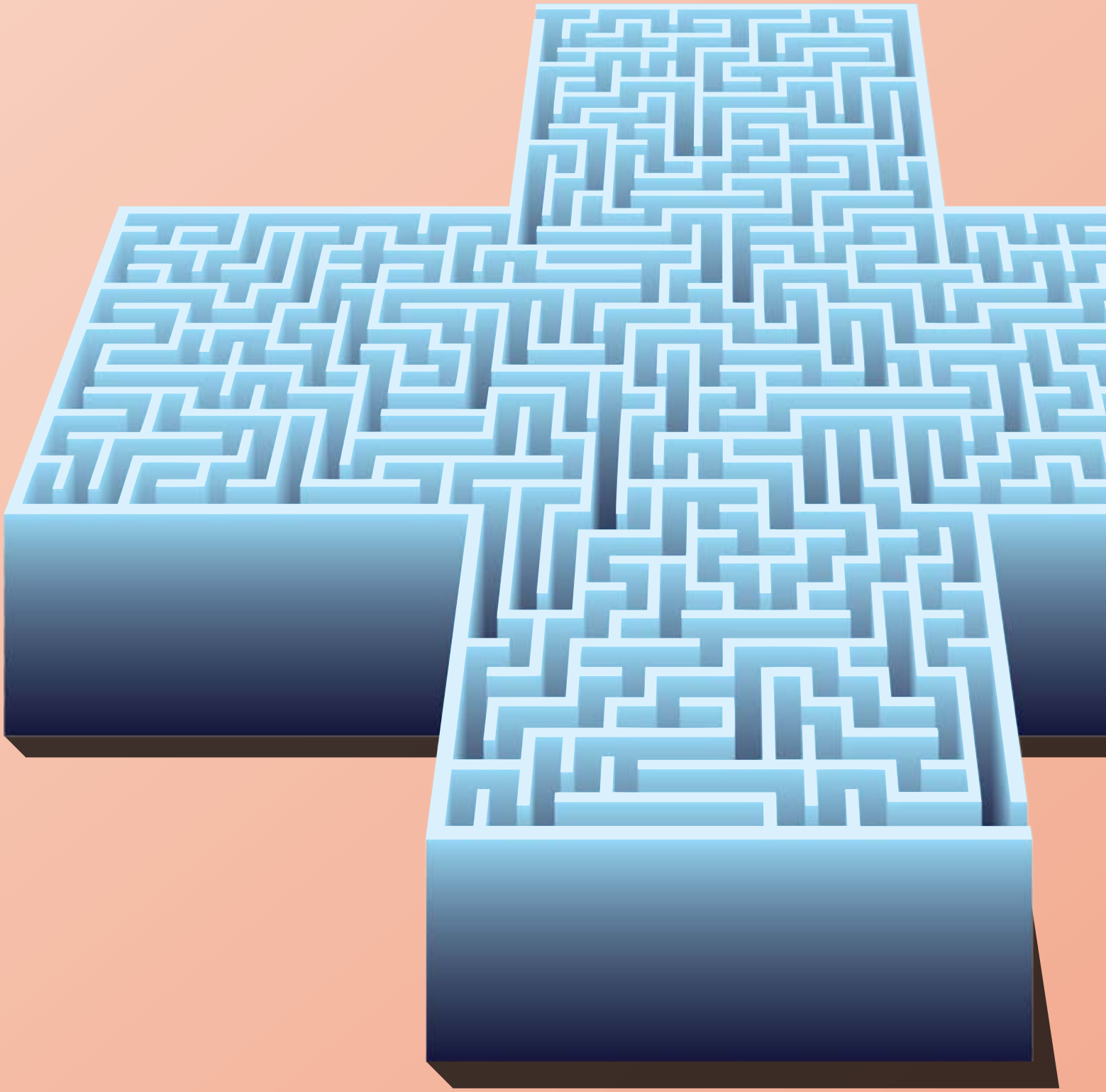
The FDA recently approved Casgevy and Lyfgenia, two groundbreaking cell-based gene therapy treatments for sickle cell disease (SCD) in patients 12 and older.

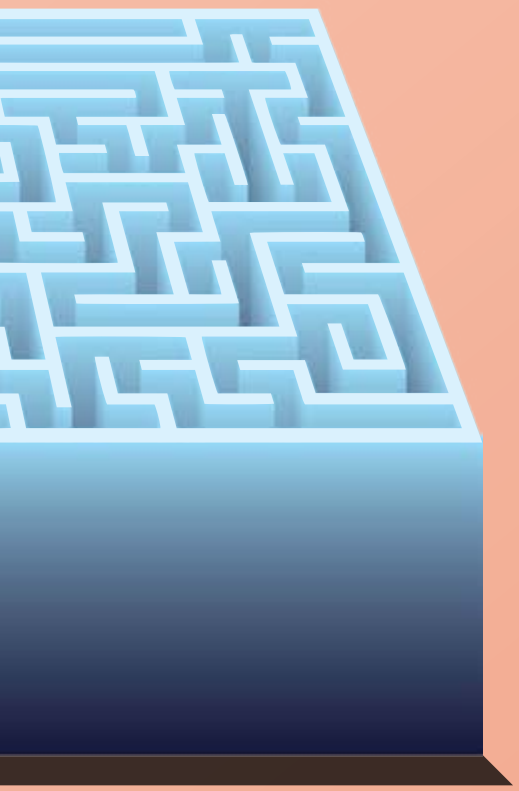
A group of inherited blood disorders, SCD affects approximately 100,000 people in the United States, most often African Americans, reports the FDA. The disease causes a mutation in hemoglobin, making red blood cells develop a crescent shape. The crescent shape restricts the flow in blood vessels and limits oxygen delivery to the body's tissues. This can lead to severe pain, organ damage, strokes, and early death.

Casgevy is the first FDA-approved treatment to use CRISPR, a novel genome editing technology, marking a significant advancement in treating SCD. To treat SCD, Casgevy uses genome editing to modify patients' blood stem cells to produce high levels of fetal hemoglobin. Lyfgenia genetically modifies the patient's blood cells to produce gene-therapy-derived hemoglobin that functions similarly to hemoglobin A, which is the normal adult hemoglobin produced in persons not affected by SCD.

Unfortunately, both gene therapies are costly, intensive, and lengthy processes, taking about a year to complete, reports Yale Medicine. Further, the therapies will require patients to receive high doses of chemotherapy to kill faulty stem cells before being replaced with modified stem cells. Insurance companies have yet to determine how they will approach the cost of treatment, which currently costs $2 to $3 million.

Previously, the only possible cure for SCD was a bone marrow transplant, according to Yale Medicine. Casgevy and Lyfgenia are intended to be a one-time cure, but it will take years to confirm their efficacy. These therapies are groundbreaking for people living with SCD, representing the first-ever gene therapies to potentially cure the painful hereditary condition. ✦





A MEDICAL MAZE

Biologic Coordinators Guide Patients around Medication Access Barriers

By Mark Harris

The use of prescription medications to prevent and treat illness and disease is a crucial component of modern medicine.

From antibiotics to treat bacterial infections to vaccines for infectious diseases and medications for countless health conditions, prescription medications play a vital role in the U.S. health care system.

In fact, nearly half of Americans have used at least one prescription drug in a given month in recent years, according to the Centers for Disease Control and Prevention. In 2019, about 80% of physician practice visits involved drug therapy, with one billion drugs provided or prescribed.[1]

The effectiveness of medications, whether prescribed or over the counter, requires that they be used safely and responsibly—particularly with prescription medications, which can only be prescribed by a licensed health care provider to a designated individual to minimize their potential for harm.

AHEAD OF THE CURVE

Federal and state laws closely regulate the distribution and use of prescription medicines. Clinical and pharmacy guidelines help ensure their safe and appropriate use. These rules can vary according to how the Food and Drug Administration (FDA) categorizes prescription drug products. For instance, specialty pharmacy products often require more rigorous clinical monitoring, with stricter controls and handling requirements, due to their potential for more severe side effects and other reasons.[2]

One important category of specialty

pharmacy products is biologic medicines, which encompass a range of medications, products, and therapies. These include vaccines, gene therapy, somatic cells, tissues, treatments involving blood components, and recombinant therapeutic proteins. Biologics are distinguished by their use of living systems—such as microorganisms, plants, or animal cells—in their production.[3]

Biologics often refer to protein molecules that target immunological processes and inflammatory disease responses.[4] A relatively newer group of medicines, biologics are typically administered as injections or infusions.

As specialty pharmaceuticals, much of the growth in biologics—or related biosimilar products—has occurred over the past 20 years. Today, biologics are increasingly used in dermatology, rheumatology, allergy, asthma, immunology, orthopedics, and oncology. And the selection of biologic medications to choose from is growing. For example, at least 11 FDA-approved biologics are now available to treat psoriasis,[5] and over 25 new biologics are being developed to treat eczema.[6] In 2022, 40% of all new drugs approved by the FDA were biologics.[7]

FIRST STEPS

Acquiring access to prescription biologics can often be complicated for patients. Insurance health plans typically require patients to meet prior authorization rules to receive them. These requirements can involve meeting what are known as *step therapy rules* that require the patient to have first tried and failed other treatments before a biologic prescription can be approved. For some patients, a high co-pay or lack of insurance can also be barriers to access.[8]

Accordingly, medical practices may assign staff to manage prior authorizations and other tasks related to the approval process. Especially in dermatology, rheumatology, allergy, asthma, and immunology, they may assist providers and patients as biologic coordinators. These employees are often essential in helping navigate insurance and coverage issues to secure patient access to prescribed biologics or other specialty medications.

Who can be a biologic coordinator? "The coordinator position can be filled by a medical assistant, licensed practical nurse, physician assistant, practice manager, physician, or other health care professional," says Lacey Varnon, ADN, PACS, BCPA, founder of the National Society of Biologic Coordinators.

Whatever their background, the biologic coordinator should possess strong communication skills, basic familiarity with the biologic medications used in the practice, and knowledge of the insurance rules relevant to obtaining prescription benefits coverage.

Notably, practice staff and others responsible for managing prescription access responsibilities may function under different job titles, reflecting the newness of the biologic coordinator position in health care. "The biologic coordinator role can go by so many different names," explains Varnon. "It's not always necessarily called a biologic coordinator. Sometimes, it is called a medication access specialist. Sometimes, it's a physician or a nurse who is in this role. It doesn't necessarily have to have a specific title; it's just that medication access position, whoever is in the [practice] getting that work done."

Those who work as biologic coordinators know that securing biologics and similar drugs can be time-consuming, notes Heather Sawrey, cofounder and president of Biologic Coordinators of Dermatology. "There are several challenges that patients face when it comes to their medications," says Sawrey, a biologic coordinator at the George Washington University Department of Dermatology in Washington, D.C. "Most patients have no idea [what a biologic is], how to obtain it, or how expensive they can be. … As biologic coordinators, we are an extension of the provider and are [needed] in the office for many reasons. First, once the biologic … is prescribed, we, the biologic coordinators, are the ones who get the approvals for the medications, and we usually know what each insurance needs to approve the medication. Knowing that information helps the providers complete the office visit note in its entirety, including everything that patient has tried and failed, or why they could not take a preferred medication."

PROBLEM SOLVERS

Affordability can often be a serious patient concern with biologics, explains Sawrey. "Once we get the medication approved, the next challenge is [whether] the patient [can] afford the medication," she notes. "These medicines are usually expensive, and the normal co-pay for a commercially insured patient can be hundreds of dollars. For the Medicare patient, the co-pays are usually over $1,000. As biologic coordinators, we help commercially insured patients enroll in the co-pay card programs [manufacturer cost-savings programs], and we can help Medicare or uninsured patients get directed to the patient assistance programs for their situation. Once we get them signed up for the respective co-pay assistance, we get the prescription sent to the specialty pharmacy for the patient."

Sawrey adds that many patients may be unaware of what a specialty pharmacy is. "We take the time to explain why the prescription cannot go to their normal neighborhood pharmacy," she remarks. "We also explain how the pharmacy will call and set up a delivery once their new patient enrollment has been taken care of. As a biologic coordinator, we also make sure they know how [and when] to inject their medication if it is an injectable.

RESOURCES

Biologic Coordinators of Dermatology
https://www.bcofdermatology.com

National Society of Biologic Coordinators, an affiliate of the National Association of Medication Access & Patient Advocacy
https://www.namapa.org

"[There] are so many different avenues now for us; there should not be many reasons why we cannot get a patient started on the product the physician prefers. We all know [insurance] appeals and denials are a huge issue in health care. But a successful biologic coordinator will understand how to get around these issues."

—Lacey Varnon, ADN, PACS, BCPA

We also set up the training appointments and make a dosing chart for the patient. In addition, we help make sure that the patient has follow-up appointments, which can help us with future approvals when we have current notes for the patient. We also can send in refills and do prescription clarifications when the pharmacy may need them."

A biologic coordinator should be extremely detail-oriented with good time-management skills, adds Varnon, a Tennessee-based program manager for Allergy Partners, a national allergy and asthma practice. "As a manager, my goal is for the [physician] to prescribe the drug they want, and the coordinator works to obtain that drug. … But it's not as simple as sending out an authorization request and moving forward with whatever happens. It's about diving down and getting to the bottom of what's happening in the process—being that detailed investigator who can ensure the patient gets the drug that's been prescribed."

Notably, the biologic coordinator's job will partially depend on how practices manage pharmacy requests. Varnon explains that some hospital clinics and physician practices use the buy-and-bill reimbursement model, managing their own inventory of medications that they purchase and sell directly to patients. The buy-and-bill model makes it possible for practices to maintain greater inventory control and access to many medications they prescribe.[9]

"Our role as biologic coordinators is going to depend on how the drugs are acquired," says Varnon. "The benefits investigation is the very first thing we always do, which is going to be that deep dive into the insurance and the coverage value. Then we submit the authorization request, based on how we need to acquire the drug, whether it's buy and bill or specialty pharmacy."

Like Sawrey, Varnon takes a methodical approach to fulfilling the prescription request. "We could have a severe asthma patient, for example, that the [physician] decides to put on TEZSPIRE [tezepelumab-ekko]. First, we will have the enrollment form filled out by the patient in the office. Then, our team will do our own [internal] benefits investigation, which involves several steps. We'll ask whether this prescription is covered under medical insurance or pharmacy benefits. In my benefits investigation, I also look at the patient's responsibility: Is the drug going to be affordable for them? [Some] co-pay assistance programs exist, but they'll need to be eligible. Then, after we get all this information back, we will submit a medical benefit prior authorization to the medical insurance or the payer."

How does Varnon handle claims denials? "When you get a denial, it's a matter of pleading your case," she says. "You want the insurance payer [to] understand why the patient needs this drug and its benefits. One thing I find helpful is to use my own fill-in-the-blank templates for different types of appeals. This can make the process a little faster.

"Another thing I find helpful is to quote the insurance company's own words in my appeal letter. So, whatever their policy states, use their language and make sure to include the [insurance] policy number in the appeal. It helps if the payer realizes that you're doing the work behind the request and are looking at this closely."

Mapping Out the Details

While biologics constitute an important sector of drugs requiring prior authorization, approval rules are not limited to specialty biologics. One recent study found 600 unique medications among four types of insurance plans (commercial, marketplace, Medicaid, and Medicare) that required prior authorization before they could be dispensed. Prior authorization rules can apply to a wide range of medications, including antihyperlipidemics, narcotic analgesics, hypnotics, antidepressants, and diabetes medications.[10]

A challenge with prior authorization rules for any drug is that they can vary among insurance plans. For this reason, medical practice staff who handle these requests need to pay close attention to the fine print of the approval process, cautions Pamela Evans, CMA (AAMA), a staff member in the internal medicine department at South Shore Medical Center in Norwell, Massachusetts. This includes understanding why a drug is being prescribed.

"You should have a basic knowledge of what the medication is used to treat," says Evans, who handles prior authorization requests for South Shore Medical Center's primary care patients. "It's almost like you're doing a school research paper. If the patient is prescribed a medication, why are they given it? What is the diagnosis? Why are they given this medication versus something else? What drugs has the patient already tried and failed in the past?

"I would say the step therapy requirements are probably the first roadblock to approval," emphasizes Evans. "Usually, the medications that require prior authorization are not the most cost-effective for the insurance companies or pharmacies. These

"Biologic Coordinators of Dermatology—BCoD—is an association of over 2,000 members aimed at enhancing the patient journey by educating and empowering the biologic coordinator, medical assistant, or office staff overseeing drug fulfillment.

"Our annual conference brings together members and industry partners who share in the relentless pursuit of patient access.

"Last year's meeting unveiled the BCoD certificate program that offers the most relevant and meaningful patient access content available in the industry. We are steadfast in providing our members with a deep network of resources. In 2024, BCoD will unveil additional resources suited for seasoned and newer access staff so they can efficiently and confidently move the patient through their therapeutic journey."

—Craig Schuette, Executive Director of Biologic Coordinators of Dermatology

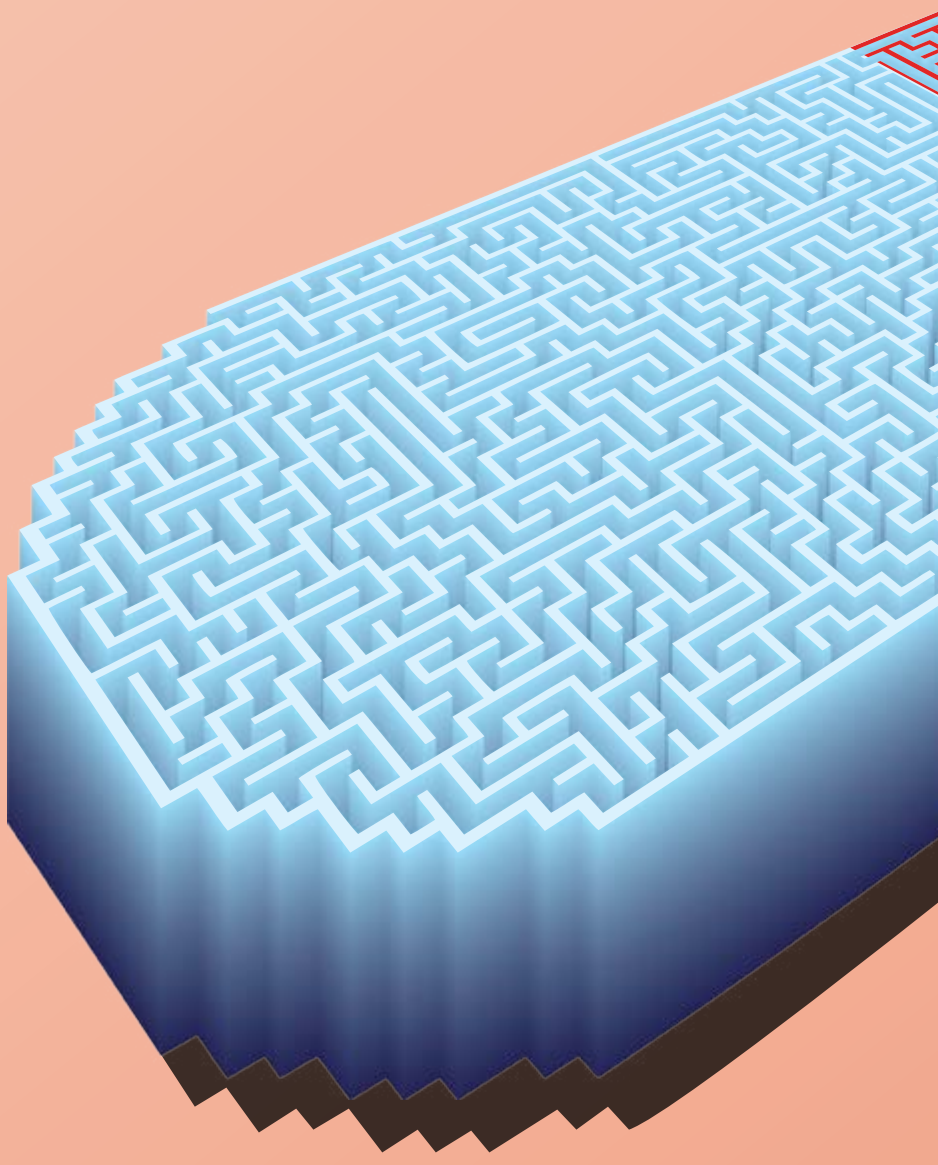
medications are generally not tier 1 [medications] but the higher 3-, 4-, or 5-tier medications."

Prescription drug formularies often have tiers or groups of drugs categorized by cost. Accordingly, the patient's co-payment or cost-share is based on which tier the drug is in. "The insurance company usually wants to start with the least expensive tier drug—[for example,] 1, 2, 3, or 4—and work up to tier 5," says Evans. "The prior authorization process is a way for them to justify why the patient needs the prescription."

Evans makes another crucial point about the approval process. "There are two parts to a prior authorization," she explains. "For most people with health insurance, there is almost always a prescription coverage benefit plan within that health insurance. I might have Blue Cross Blue Shield, but my prescription coverage is CVS Caremark, Express Scripts, or Optum Rx. The patient's insurance company [does not usually approve or decline] the request. This is done by the prescription benefit plan. So, your first step with a prior authorization request will be to know where to go for the approval."

Evans notes that the patient's insurance card will usually have a BIN, PCN, and group number, as well as a member ID, which can help identify the company responsible for the prescription drug coverage. For those working in primary care or internal medicine, Evans also suggests staff avoid overlooking supporting documentation from other providers. "In many cases, the supporting documentation for prior authorizations is important," she states. "For example, obtaining notes from the patient's rheumatologist or dermatologist is often helpful to include. This is because sometimes medications are prescribed in primary care in conjunction with other specialties."

With any prior authorization request, documentation is key. "In terms of step therapy rules, you want to make sure you're diligent with your chart review [to] document failed treatment alternatives," remarks



Evans. "Maybe the patient didn't fail a treatment last year, but they could have failed something five years ago. You might have to dig deep for that information."

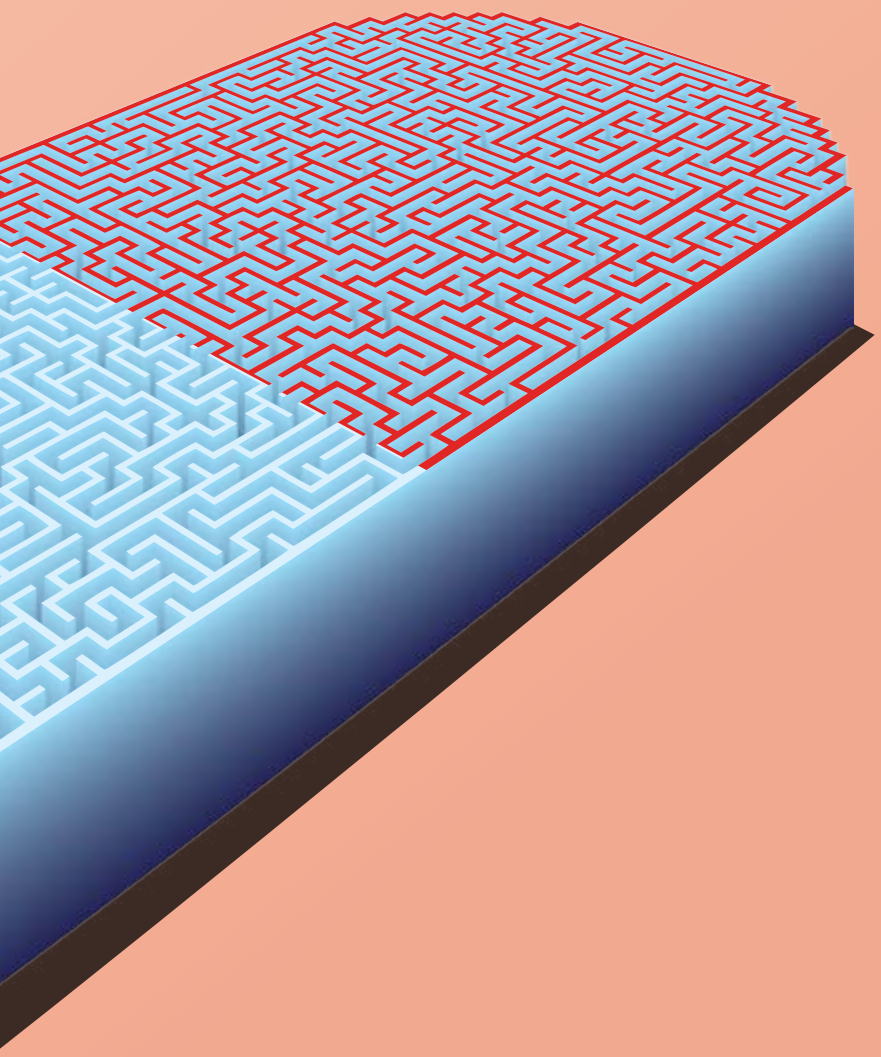
> "Somewhere in the neighborhood of 65% of all new drugs in development are biologics. That's some big job security for a biologic coordinator. It's important for medical assistants, nurses, or others to understand that there is a career pathway [to] being a biologic coordinator. But it adds not just a monetary value but also the satisfaction that comes when you are helping patients directly in getting the specialty medications they need."
>
> —Marc Del Bono, PACS

TWISTS AND TURNS

Managing prior authorization requests can sometimes be complicated by whether the insurer's request is improper. The Office of the Inspector General reported that 13% of prior authorization denials by Medicare Advantage in 2019 were for covered benefits.[11]

For staff, countering improper prior authorization requests without access to the patient's insurance policy can be difficult, according to experts. "Whether it involves biologics or something else, any medical treatment that requires prior authorization is first a matter of understanding what the patient's insurance policy states," says David J. Zetter, president of Zetter Healthcare Management Consultants in Mechanicsburg, Pennsylvania.

Unfortunately, Zetter says many medical practices do not access patients' insurance policies. He explains payers may inappropriately require unnecessary prior authorizations for certain services or treatments.



BIOLOGIC LOGIC

Practices can help address prior authorization requirements through the use of their electronic health records (EHRs). By delegating prior authorization to dedicated staff such as biologic coordinators, others are free to focus on care. Use EHR to improve practice workflows[15]:

- Create master lists of medications and procedures that require prior authorization, broken down by insurer, and alternatives that do not require it. Set up alerts for orders that typically require prior authorization.
- Take especially thorough documentation when ordering treatments or services that do not follow the standard guidelines.
- Create prepopulated forms listing codes, diagnoses, and other required information for processing a prior authorization.
- Submit requests electronically and use a portal or EHR to upload supporting documentation rather than faxing it.
- Assign prior authorizations to a dedicated employee.

"Most practices just assume the insurance company is the expert requiring a prior authorization," remarks Zetter, a past president of the National Society of Certified Healthcare Business Consultants. "Unfortunately, if they request a prior authorization that is not legal, the practice is often not going to know this."

Most private retirement and employer-based health plans are governed by the Employee Retirement Income Security Act of 1974, the federal law that sets minimum consumer protection standards for the plans.[12] Zetter cautions that many medical practices are unversed in the act's benefits protections.

Notably, the American Medical Association and other groups are critical of insurance industry rules on prior authorization, describing them as often "costly, inefficient, and responsible for patient care delays."[13] In 2022, an American Medical Association physician survey found that about 94% of physicians reported delays in care because of prior authorization requirements. Further, approximately 80% of physicians say patients abandoned recommended treatments because of prior authorization roadblocks. In turn, many surveyed physicians report negative impacts on clinical care and patient outcomes because of these barriers.[14]

As a result, efforts to legislate reforms in prior authorization practices are now under consideration in many states.

"Prior authorizations are a cost-saving measure for insurance companies," observes Marc Del Bono, PACS, the former manager of member education with the Biologic Coordinators of Dermatology. "Biologic coordinators are aware of this. We also know there are initiatives for prior authorization reform and discussions looking toward streamlining prior authorizations." For Del Bono, these challenges only underscore the critical role of biologic coordinators in navigating solutions to access barriers.

"A biologic coordinator is someone who sees through the problem," he says. "They will go to the Blue Cross Blue Shield portal, for example, and look at the policy to see if a prior authorization is required. If so, what step edits [do] they need to inform the prescriber about? As biologic coordinators, we're the ones who let the prescriber know what medications need to be tried and failed so we can prevail with the authorization. When practices don't have biologic coordinators, the insurance companies win. We are advocating not only for the patient but also for the practice."

A PATH FORWARD

Biologic coordinators are an emerging professional resource in health care. With increased prescription biologics and other specialty medications, the need for trained staff with expertise in facilitating patient access to specialty pharmacy products is more important than ever.

Medical assistants interested in working as biologic coordinators can find numerous opportunities. "Finding people who can fill the role of a biologic coordinator is a big need now in health care," concludes Varnon. "I think more providers at the executive level are starting to understand the value behind having someone who is specifically trained as a biologic coordinator, with the knowledge base necessary to do the best work."

While biologic coordinators manage the prescription enrollment and approval process, they also support and educate patients, answering their questions or concerns regarding benefits or treatments. For instance, a biologic coordinator might provide patients with educational videos on home injections, dosing schedules, or other treatment issues. They also educate prescribers on access issues.

In this sense, biologic coordinators play a unique role as patient advocates, working closely with providers, patients, and insurers to navigate often dense pathways to medication access. Their skills make them a potentially instrumental resource in the patient's journey to health and healing. ✦

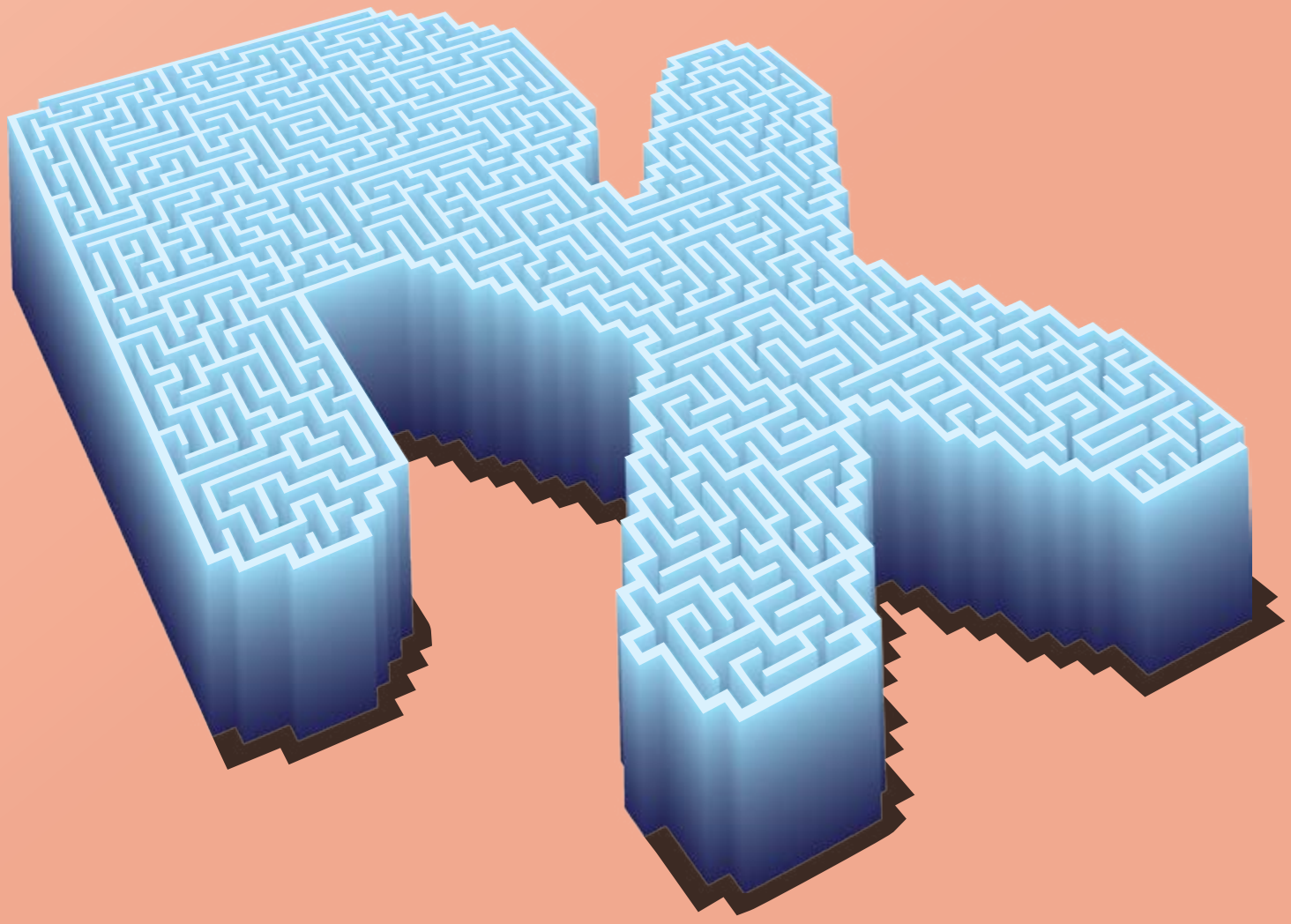
ASKING FOR DIRECTIONS

Biological drugs, referred to as biologics, are made by reproducing—or growing—copies of a specially engineered living cell, a process that begins by growing the cells in a carefully controlled facility. The proteins that comprise the drug are developed by these cells.

After this cell growth, the protein is extracted and purified until the final biologic drug is obtained. The final product illustrates the complexity of biologics. Small molecule drugs (e.g., aspirin) can consist of as few as 21 atoms. On the other hand, biologics can be made of over 25,000 atoms.[16]

References

1. Therapeutic drug use. Centers for Disease Control and Prevention. Reviewed November 3, 2023. Accessed February 15, 2024. https://www.cdc.gov/nchs/fastats/drug-use-therapeutic.htm
2. Specialty pharmaceuticals. AMCP. July 18, 2019. Accessed February 15, 2024. https://www.amcp.org/about/managed-care-pharmacy-101/concepts-managed-care-pharmacy/specialty-pharmaceuticals
3. What are "biologics" questions and answers. US Food and Drug Administration. Reviewed February 6, 2018. Accessed February 15, 2024. https://www.fda.gov/about-fda/center-biologics-evaluation-and-research-cber/what-are-biologics-questions-and-answers
4. Coondoo A. Biologics in dermatologic therapy - an update. *Indian J Dermatol*. 2009;54(3):211-220. doi:10.4103/0019-5154.55627
5. Brownstone ND, Hong J, Mosca M, et al. Biologic treatments of psoriasis: an update for the clinician. *Biologics*. 2021;15:39-51. doi:10.2147/BTT.S252578
6. Johnson JL. Biologics are changing the landscape of eczema treatment. National Eczema Association. April 5, 2021. Updated March 15, 2022. Accessed February 15, 2024. https://nationaleczema.org/blog/biologics-eczema-treatment/
7. de la Torre BG, Albericio F. The pharmaceutical industry in 2022: an analysis of FDA drug approvals from the perspective of molecules. *Molecules*. 2023;28(3):1038. doi:10.3390/molecules28031038
8. Onorati H. National Psoriasis Foundation. Getting the care you need and deserve. September 29, 2021. Accessed February 15, 2024. https://www.psoriasis.org/advance/getting-the-care -you-need-and-deserve
9. DeMarzo A. What is buy and bill? ACMA. March 22, 2021. Accessed February 15, 2024. https://www.priorauthtraining.org/what-is -buy-and-bill/
10. Jones LK, Ladd IG, Gionfriddo MR, Gregor C, Evans MA, Graham J. Medications requiring prior authorization across health insurance plans. *Am J Health-Syst Pharmacy*. 2020;77(8):644–648. doi:10.1093/ajhp/zxaa031
11. Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care. US Department of Health and Human Services. April 27, 2022. Accessed February 15, 2024. https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp?hero=mao-report-04-28-2022
12. ERISA. US Department of Labor. Accessed February 15, 2024. https://www.dol.gov/general/topic/health-plans/erisa
13. O'Reilly KB. Bills in 30 states show momentum to fix prior authorization. American Medical Association. May 10, 2023. Accessed February 15, 2024. https://www.ama-assn.org/practice-management/prior-authorization/bills-30-states-show-momentum-fix-prior-authorization
14. American Medical Association. *2022 AMA prior authorization (PA) physician survey*. Accessed February 15, 2024. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
15. Techniques to reduce prior authorization burden. American Academy of Family Physicians. Accessed February 15, 2024. https://www.aafp.org/family-physician/practice-and-career/administrative-simplification/prior-authorization/techniques-prior-auth.html#2
16. Understanding biologic and biosimilar drugs. American Cancer Society. July 27, 2018. Accessed February 15, 2024. https://www.fightcancer.org/policy-resources/understanding-biologic-and-biosimilar-drugs



Certificate in Practice Management

Spring into Success with our Practice Management Program!

Seize the season with our exclusive **25% off** spring sale on our Assessment-Based Certificate Program in Practice Management (ABC-PM).

Unlock the knowledge you need to thrive in the fast-paced world of health care administration. The three courses included in this program cover topics such as managing employees, understanding practice structures, risk management, and more!

Enroll now and enjoy special spring savings! Don't miss this opportunity to invest in your future and bloom into a successful practice manager.

Members: **$170** ➡ **$127.50**

Nonmembers: **$255** ➡ **$191.25**

Sale ends May 31st

Enroll now and watch your career blossom!

Biologic Coordinators

Deadline: Postmarked no later than **May 1, 2024**

Credit: 2.5 AAMA CEUs (gen/clin/admin) **Code: 142488**

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

Electronic bonus! This test is available on the e-Learning Center at learning.aama-ntl.org. Miss the postmark deadline? Take the test online instead!

T F

☐☐ 1. Step therapy rules require patients to try and fail other therapies before being prescribed biologics.

☐☐ 2. The Employee Retirement Income Security Act of 1974 is the federal statute that protects patients against medical malpractice by health care providers.

☐☐ 3. The American Medical Association and other groups are critical of rules in the prior authorization system.

☐☐ 4. Biologics are less costly than other medications because of generous government subsidies that considerably reduce their price.

☐☐ 5. Medical assistants and practice managers cannot be biologic coordinators.

☐☐ 6. The patient's health insurance policy is important to review when determining whether a prior authorization request is legitimate.

☐☐ 7. Biologics prescriptions are sent to specialty pharmacies rather than typical pharmacies.

☐☐ 8. Health care practices and clinics cannot legally purchase and sell biologics to patients.

☐☐ 9. Biologic coordinators assist providers and patients with their knowledge of insurance plans' requirements for medication approval.

☐☐ 10. Biologics are therapies, products, and medications that use living systems in their production.

☐☐ 11. Biologics are usually administered orally or by inhalation.

☐☐ 12. Citing language from the insurance company's policy can help persuade them to pay for the prescribed medication.

T F

☐☐ 13. Only licensed health care providers are legally permitted to prescribe prescription medications.

☐☐ 14. Specialty pharmacy products have less potential for severe side effects, so they are less closely regulated by the Food and Drug Administration.

☐☐ 15. Within health insurance coverage, there is usually a separate prescription coverage benefit plan, sometimes offered by another company.

☐☐ 16. Prior authorization rules are consistent from one insurance carrier to another.

☐☐ 17. The medications that require prior authorization are usually more expensive.

☐☐ 18. Prior authorization is limited to specialty biologics and does not apply to other categories of medications.

Donate online and SUPPORT EDUCATION!

Donate through the AAMA Store online, and help foster the growth of the next generation of medical assistants.

The Maxine Williams Scholarship Fund

provides educational assistance for deserving medical assisting students.

The Ivy Reade Relkin Surveyor Training Fund

helps ensure the quality of accredited medical assisting programs by training skilled surveyors. This fund is part of the Medical Assisting Education Review Board. Contribution checks should be made payable to the Medical Assisting Education Review Board, with a notation on the memo line that the funds are for the Ivy Reade Relkin Surveyors Training Fund. Checks may be mailed to:

MAERB
2020 N. California Ave., #213, Suite 7
Chicago, IL 60647

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS®

For more information, visit About/Endowment on the AAMA website.

www.aama-ntl.org

Continuing Education Application

AAMA CEU Credit: You have two options for testing.

Option 1: Go to www.aama-ntl.org and click on e-Learning Center under Continuing Education. Pay for and take the test online.

Option 2: Complete the test and application on this page, and mail it to the address below. Enclose a check or money order payable to the AAMA.

The nonrefundable testing fee is $20 (members) or $30 (nonmembers). Credit will be awarded to those who achieve a score of at least 80%.

Last Name

First Name & Middle Initial

Street Address

City/State/ZIP

AAMA Membership Status: ☐ Member ($20) ☐ Nonmember ($30)

Members—AAMA ID Number *(Required)*

Nonmembers—Last Four Digits of Social Security Number *(Required)*

Date Completed

Day Phone Fax

Email

Retain a photocopy of your payment and test for your files.
The AAMA does not keep copies on file after grading.
Send completed test application and fee to:

AAMA *Medical Assisting Today* CE Test
20 N. Wacker Dr., Ste. 3720
Chicago, IL 60606

Continuing education units (CEUs) are awarded based upon content, depth of article, learning outcomes, and length of time for completion per IACET (International Association for Continuing Education and Training) guidelines and criteria. IACET created the CEU for the purpose of providing a standard unit of measure to quantify continuing adult education. CEU value is awarded based upon the projected contact hours needed to complete the continuing education activity (e.g., 1 CEU equals 1 hour, or 1.5 CEUs equal 1.5 hours). *Medical Assisting Today* articles follow this standard for awarding CEU value. The $20 or $30 is a test processing fee. A $25 administrative fee will be assessed for returned checks.

**Mail-in test deadlines are maintained for administrative purposes. Electronic test deadlines on the e-Learning Center will vary. The AAMA reserves the right to remove any course at any time.*

Refreshed and Revised!

Earn a certificate in Geriatrics

Increase Your Marketable Skills

The older patient population is growing, and employers need professionals with skills and knowledge in geriatric care. Demonstrate your capabilities with the newly updated Assessment-Based Certificate (ABC) in Geriatrics.

Visit the AAMA e-Learning Center to find out more:

College of DuPage

Full Time Faculty - Medical Assistant Program (Fall 2024, Tenure Track)

The College of DuPage is a comprehensive community college located 27 miles west of downtown Chicago, vitally connected to our local area for over 50 years. We prepare students for a lifelong passion for learning on our 273-acre campus which is home to nine associate degrees and a wide variety of professional and technical certificates. Many of these credentials prepare students to seamlessly articulate into the baccalaureate programs of our higher education partner institutions.

College of DuPage is committed to student success and values an inclusive and welcoming community environment. We are an equal opportunity employer committed to diversity in the workforce. Our connection to the larger metropolitan area is essential to our success and provides a wealth of diverse cultural and recreational opportunities.

Primary Duties and Responsibilities:

College of DuPage seeks a **full-time, tenure track faculty member** to teach **Medical Assistant Program courses** starting in August 2024.

This position requires knowledge of CAAHEP accreditation guidelines with respect to teaching in the Medical Assistant Program. The position also requires oversight of lecture, labs and clinical.

We are actively seeking innovative, collaborative colleagues who regularly examine their pedagogy and practices in order to foster more equitable, accessible, and inclusive student learning.

Faculty duties include classroom instruction, assessment, curriculum development, advising students, professional inquiry, committee work and engaging with instructional technology.

Teaching assignments may include various delivery modes, such as face-to-face, on-line, hybrid and/or blended formats during days, evenings and weekends. Faculty positions may not be fully remote.

Qualifications:

- Bachelor's degree in the content area required. Masters degree preferred.
- Certified Medical Assistant CMA(AAMA) with physician office experience.
- Teaching experience in an accredited medical assistant program required.
- Experience with CAAHEP accreditation preferred.

Competitive starting salaries are dependent on education and experience. College of DuPage also offers a generous benefits plan. Positions are contingent upon ongoing budget availability and Board approval.

To apply please submit your electronic application, unofficial transcripts, current curriculum vita, a cover letter including a list of three references, and a Teaching Statement. Applications accepted until 11:59 p.m. CST, April 28th, 2024.

The Teaching Statement must include the candidate's anticipated contributions to College of DuPage related to academic quality and student success and meet a 2-page limit.

A teaching demonstration will be required at interview.

This position requires a pre-employment background and drug screen. The College of DuPage does not sponsor employment.

Foreign Transcripts: Transcripts issued outside the United States require a course-by-course analysis with an equivalency statement from a certified transcript evaluation service verifying the degree equivalency to that of an accredited institution within the USA.

College of DuPage is an equal opportunity employer. We are committed to diversity and creating an inclusive environment for all employees.

College of DuPage does not discriminate against individuals in employment opportunities, programs and/or activities on the basis of race, color, religion, gender, sexual orientation, age, national origin, ancestry, veterans' status, marital status, disability, military status, unfavorable discharge from military service, or on any other basis protected by law.

To apply, visit: https://apptrkr.com/4977167

Carbohydrates and Long-Term Weight Gain

Many people cut carbohydrates to lose weight quickly, but have you ever wondered how this affects long-term weight gain?

A recent study conducted by the Harvard T. H. Chan School of Public Health found that people whose low-carbohydrate diets emphasized plant-based proteins and fats and quality carbohydrates from whole grains had slower long-term weight gain than people who ate more animal proteins and fats as well as refined carbohydrates.

Looking to improve your low-carbohydrate diet? Verywell Fit suggests opting for high-quality carbohydrates:

- Whole grains
- Beans and legumes
- Fruits
- Vegetables
- Nuts and seeds

Meanwhile, avoid low-quality carbohydrates:

- Refined flour products
- Sugary drinks and juices
- Processed snacks

While numerous studies have previously shown the benefits of cutting carbohydrates to achieve short-term weight loss, this study illustrates a bigger picture: not all low-carbohydrate diets offer the same assurance of managing weight long-term.

Pick Up the Pace

The American Diabetes Association recommends taking 10,000 steps a day or walking for at least 30 minutes to reduce your risk of diabetes, but did you know walking faster can further improve that benefit? Walking at a brisker pace can significantly reduce your risk of type 2 diabetes, according to a study published in the *British Journal of Sports Medicine.*

Independent of distance or step count, walking about 2.5 mph was associated with a 15% lower risk of type 2 diabetes compared to strolling less than 2 mph. This speed is equal to around 87 steps per minute for men and about 100 steps per minute for women. Once you hit this pace, your risk drops further as you increase your speed. Every 0.6 mph increase in walking speed is linked to a 9% lower risk of type 2 diabetes, reports NBC News.

The analysis, which used data from 10 studies involving over 500,000 people, found that brisk walking (3–4 mph) was associated with a 24% lower risk, while striding (more than 4 mph) was linked to a 39% reduced risk.

Brisk walking not only reduces body fat but also helps lower insulin resistance. Increasing your walking pace improves insulin sensitivity, a crucial factor in preventing diabetes.

However, any movement is helpful. The Department of Health and Human Services recommends 150 to 300 minutes a week of moderate physical activity.

Walking can improve your balance, blood pressure, concentration, bone and muscle strength, cholesterol, and mental outlook, notes the American Diabetes Association. You can add more steps to your day by walking during lunch, scheduling walking dates, and parking further from your destination. Consider picking up the pace for additional protection against diabetes!

Give It a Whirl

Dancing is a great way to let loose and have fun, and new research shows that it is an effective way to lose weight and develop lean muscle. A review of 10 studies in *PLOS ONE* details the effects of dance interventions on body composition in people with obesity.

Dance was found to contribute to significant improvements in body mass, waist measurements, fat percentage, and fat mass, according to Healthline. These effects are due to dance's calorie-burning qualities and ability to engage numerous muscle groups. Additionally, dance's fun and social nature makes you more likely to stick with the habit long-term.

Dance incorporates a combination of strength training, cardiovascular exercise, and flexibility, making it a well-rounded exercise. However, you should aim for moderate to high-intensity levels to see results. A good way to make sure you are dancing intensely enough is to break a sweat and feel out of breath enough that you can talk but not sing.

If you are on a weight-loss journey and decide dancing is for you, take these steps:

- Choose a dance style that brings you joy.
- Start with short sessions and build up to longer routines.
- Make sure to warm up and cool down each time.
- Stay hydrated.
- Rest!

Finding enjoyable forms of exercise can be difficult and overwhelming, but dancing is a fun activity you can integrate into your daily life that is highly efficient for reaching or maintaining a healthy weight.

Plastic, Not Fantastic

Microscopic pieces of plastic are all around us, and now, in a groundbreaking study from *Proceedings of the National Academy of Sciences*, researchers have discovered that bottled water sold in stores can contain 10 to 100 times more plastic than previously thought, including nanoplastics so small they cannot even be viewed with a microscope.

Researchers found about 240,000 detectable plastic fragments in a typical liter of bottled water, according to CNN Health. Approximately 10% of the detected plastic particles were microplastics, and the other 90% were nanoplastics that are 1,000th the average width of a human hair.

Microplastics have previously been discovered in people's lungs, excrement, blood, placentas, and other places, according to NPR.

Nanoplastics are a concerning threat to human health, as they can migrate through the digestive tract or lungs into the bloodstream and distribute harmful synthetic chemicals throughout the body. They can be more dangerous than microplastics because their size makes them more likely to be misidentified as a natural part of the cell.

Ironically, some of the plastics in bottled water could be shed from the plastic used in water filters. This reinforces past advice from experts to drink tap water from glass or stainless-steel containers to reduce the risk of exposure to plastic.

Researchers hope this study brings light to the amount of plastic people ingest and how it can affect their bodies and health. So, if you haven't already, consider swapping your plastic water bottle for a reusable one. It can protect you from unnecessary plastic and save bottles from ending up in landfills.

SITE UNSEEN

Manage and Schedule Multisite Medical Assistants with Clear Communication

By Pamela Schumacher, MS, CCMP

Many medical practices are part of groups with locations throughout a geographic area. Traditionally, group practices employ medical assistants that are based at each location. However, depending on the practice's needs and staff availability, medical assistants may be asked to travel from site to site, or the practice may hire contract traveling medical assistants to fill short-term assignments. Either circumstance can present challenges for practice managers.

"Traveling staff have different issues than those who stay at one location," says April Jones, CMA (AAMA), a surgery scheduler at MetroPartners OBGYN, which has practice locations in Maplewood, Woodbury, and Lilydale, Minnesota. "In our practice, we have medical assistants who travel with the physician to each location. It works well because they establish a close, working relationship with the physician. These medical assistants are often more efficient because they quickly get to work and don't spend time chatting with colleagues. However, it may mean they're less likely to do things like clean up the break room or restock supplies if something runs out."

Staffing shortages have forced many practices to consider hiring contract medical assistants to fill travel positions. A Medical Group Management Association (MGMA) poll found that nearly 9 in 10 health care leaders reported difficulty recruiting medical assistants because many have left health care for fields with higher pay.[1]

A contract travel medical assistant works in clinics or hospitals for a few weeks or months at a time. When the contract ends, they can sign another contract at the same place—if offered—or look for a contract elsewhere. Travel medical assistants typically make more than the average medical assistant's salary and receive a food and lodging stipend.[2]

"Using contract travel medical assistants can be beneficial," says Cristy Good, MPH, MBA, CPC, CMPE, a senior industry advisor at MGMA in East Englewood, Colorado. "They provide the flexibility to address staffing shortages or temporary needs. This flexibility allows health care practices to adapt to changing demands and maintain continuity of care. They often have experience working in various health care settings, such as clinics, hospitals, and physicians' practices. This diverse experience enables them to quickly adapt to new environments and work efficiently with minimal training or orientation."

Go the Distance

Designating medical assistants to travel to multiple sites can minimize the administrative and financial burden of managing multiple clinics, but it can also cause issues, especially regarding scheduling and workforce management.[3]

Jones asserts that maintaining open and clear communication is key to managing traveling employees: "It starts with the interview. I let them know the expectations for the job and that they will be traveling from practice to practice with the physician. If this is an issue, then it should be addressed immediately. I also expect the medical assistant to communicate with me, particularly if they are running late or ill. I visit all the practices randomly and work side by side with each medical assistant. I bring fruit cups and bagels, and we talk about the issues they've encountered. It shows that we're all on the same team, and I'm interested and concerned about what they're experiencing."

Scheduling traveling medical assistants between sites can be complex, notes Good. "The best way to determine assignments and respond to employee requests or preferences is to establish a centralized scheduling system where all the information regarding availability, skills, and preferences is stored," she

explains. "This gives you a clear overview of the available resources across different sites. Then, develop standardized scheduling processes and guidelines to ensure consistency and fairness in assigning shifts and tasks to medical assistants. This streamlines the scheduling process and minimizes confusion.

"Next, invest in scheduling software that automates the scheduling process and provides real-time updates. This helps you efficiently manage and track the schedules of medical assistants across multiple sites," says Good.

Considering employee expertise, interests, and development goals is crucial when creating the schedule, adds Jones: "Assign tasks that align with employees' strengths and interests because this increases their motivation and productivity. Then review and adjust schedules based on feedback, workload changes, and any emerging needs and make improvements as necessary."

Nomad Is an Island

Creating a community for traveling employees helps make them feel like an integral part of the organization, says Jones: "I hold a monthly meeting where everyone calls into a group line. It's just a 15-minute check-in, and people provide a quick update. Once a quarter, I have everyone come into the practice for a lunch and learn. If a medical assistant can't make it, I stream or record [the presentation] so everyone benefits. It's important to have these get-togethers to build rapport and connection."

Good recommends maintaining open and clear communication channels with medical assistants to ensure they are aware of their schedules and any possible changes. "Utilize technology such as email, messaging apps, or scheduling software to facilitate communication," she says. "Medical assistants should feel like they can always reach someone if they have questions or need a manager's help."

Far-Reaching Strategies

Establishing consistent policies, processes, and procedures across the business helps employees move seamlessly between locations. This should include providing clear guidelines, training, and access to necessary equipment and supplies. Additionally, policies should be applied consistently across every location to prevent confusion and avoid potential legal action.[3]

"The medical practice should determine [whether] medical assistants are to be compensated for travel time between different sites. This can vary depending on local labor laws and organizational policies," says Good. "Implement a system for medical assistants to accurately record their working hours, including clocking in and out at each site. This tracks their time and ensures accurate payment for their work.

"Clearly communicate expectations regarding punctuality and arrival times. Establish policies for inclement weather or last-minute changes to locations. This may include [medical assistants] notifying their supervisor or designated contact person as soon as possible. Establish protocols for handling last-minute changes to locations," says Good. "But the best policies aren't worth anything if employees don't know about them. So, it's important to conduct regular training sessions and provide ongoing communication to ensure they are aware of the policies, procedures, and expectations related to travel, clocking in and out, reimbursement, and inclement weather situations. This minimizes confusion and ensures compliance."

Finally, the practice should consult legal and risk management departments to address liability considerations, advises Good: "Ensure medical assistants are aware of their responsibilities and any potential risks associated with their work at different sites and implement appropriate insurance coverage and risk mitigation strategies." ✦

References

1. Harrop C. Medical assistants remain elusive for practices navigating a staffing crisis. Medical Group Management Association. April 6, 2022. Accessed February 15, 2024. https://www.mgma.com/mgma-stats/medical-assistants-remain-elusive-for-practices-navigating-a-staffing-crisis
2. Holbrook J. Travel medical assistant: salary, jobs, & how to become. Stepful. Accessed February 15, 2024. https://www.stepful.com/post/travel-medical-assistant
3. Carson-Hruby A, Daniels V. Streamlining management of shared employees across multiple locations. The Journal of Urgent Care Medicine. August 28, 2017. Accessed February 15, 2024. https://www.jucm.com/streamlining-management-shared-employees-across-multiple-locations/
4. Spinoza JD. How to manage multiple teams in multiple locations. *Zoomshift* blog. February 7, 2022. Accessed February 15, 2024. https://www.zoomshift.com/blog/multiple-teams-multiple-locations/

On the Move

Managing teams in multiple locations requires careful attention and well-planned management practices[4]:

1. **Establish systems** that standardize the practice's communications, business operations, employee management, and productivity for the practice. Create a structure that outlines a clear chain of command with responsibilities, boundaries, and authority.
2. **Use employee management software** to create schedules and track team members across multiple locations. Some software has GPS time-tracking features that indicate when employees are at different locations and track their time accordingly.
3. **Spend time at each location.** A regular visit makes all team members feel valued.
4. **Encourage communication between employees and managers.** This helps identify issues and challenges that are specific to various locations.
5. **Use helpful technology.** Share documents through Google Drive, OneDrive, or Dropbox. Basecamp and Trello allow teams in different locations to collaborate on projects together.

GENERATION

by Cathy Cassata

Educators will interact with students of all ages during their careers. However, young educators and those who are new to teaching may be intimidated by having students older than them. With the average age of medical assistants at nearly 37, educators must consider that their student population could include learners older than they.[1]

"I started as a young [educator] with older students. I was 27, and they were much older. It was intimidating because those students could tell me about life, and they had children and grandchildren," says Kimberly Scott, CMA (AAMA), RMA, DBA, MPH, MBA, a medical assisting educator at Keiser University with 16 years of teaching experience.

Educators in a similar situation can employ the following tips for effectively leading a classroom with students older than them.

Put Fear and Intimidation Aside

The concept of respecting elders is deeply embedded in society for good reason. Older populations have contributed to society longer and may have more wisdom and experience than their younger counterparts. For this reason, it can be intimidating to command their attention and respect in the classroom. However, being younger does not make you less qualified, asserts Kaity Ritter, CMA (AAMA), BS, program coordinator at Illinois Valley Community College. As a 37-year-old with four years of teaching experience, exuding confidence helps Ritter gain respect from older students.

"I know what my education and background are, and my employer decided that I was qualified to do this because of those things, so I don't let it get to me," she says.

If Scott could go back in time, she would approach teaching then with her current mindset. "[When I first started,] I came across differently. I was a scared, new [educator] and even allowed some older students to influence me. From the start, I should have said I have something to offer just like they have something to offer," she says.

Avoid Emphasizing Age

Ritter received advice to tell students she was a new educator and that they would learn together. "I listened and felt I was humanizing myself, but they ate me up that year. I could never do anything right from then on," she says.

Even if you are a new educator and learning new material, she recommends you fake it until you make it. "Be human, but don't tell them you don't know what you're doing. They don't want to hear that."

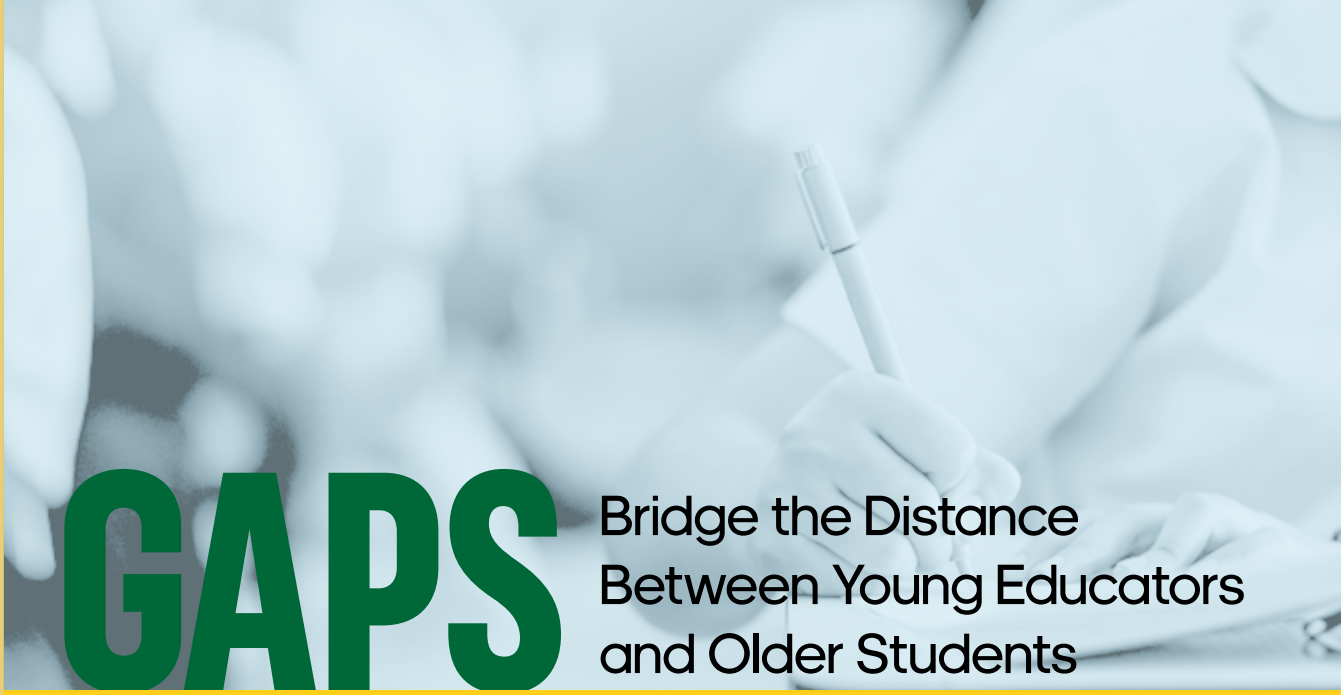
Be Yourself

Rather than being authoritative, being genuine and open with students can help them see you as more than just a younger educator.

In Ritter's first year of teaching, she thought she should be authoritative because that was *her* educator's approach. She struggled to balance being firm but not strict and quickly learned that she did not have to act a certain way to teach a class effectively and that no one-size-fits-all teaching style exists. For her, being more relaxed and open to students' input—yet in command—was the best approach, especially with older students. "The more I taught, the more I realized I could still have boundaries, limits, and expectations and gain respect. I also learned that it was OK for students to know they can laugh with me and come to me with personal things without me judging them," says Ritter.

While teaching older students, remember that learning does not have age limits attached.

"We have this idea that school is for the young, and that's not true," says Scott. "As an educator, we have to review our classroom environment and make sure it's inclusive for collaboration with everyone."



GAPS Bridge the Distance Between Young Educators and Older Students

Acknowledge Older Students' Experiences

Often, older students have work experience and knowledge to offer to the classroom. For example, Scott had a student who was a certified nursing assistant for 20 years before entering a medical assisting program. "Asking for their insight on certain topics gives them respect and lets them know that you acknowledge they have something to offer to the classroom and profession," she says.

She uses transformative learning, which focuses on the concept that adult learners can adjust their thinking based on new information. Jack Mezirow, who developed the concept, theorized that adult students have important teaching and learning opportunities that are affected by their past experiences.[2]

"These students have experience from the past and new [skills] they are learning in class, like injections and phlebotomy," says Scott. "This type of learning says by acknowledging that they have their past knowledge, they can use it with the new knowledge to enhance critical thinking." ✦

References

1. Medical Assistants. Data USA. Accessed February 15, 2024. https://datausa.io/profile/soc/medical-assistants
2. Transformative learning theory. Wichita State University. Accessed February 15, 2024. https://www.wichita.edu/services/mrc/OIR/Pedagogy/Theories/transformative.php

Opposite Perspective: Teaching Students Younger Than You

Lisa Nash, MEd, CMA (AAMA), program director and practicum coordinator at the University of Alaska Anchorage, became a medical assistant at 54 and has more than 30 years of experience as an educator. Now, at 63, she says all her medical assisting students are younger than she.

One of her biggest challenges is incorporating relevant examples in classroom material. When learning materials refer to times, places, people, or things that do not connect with students, revising them is important. For example, several chapters in the medical law textbook Nash teaches reference the O. J. Simpson trial. "I'm talking to my students about it and getting this blank stare. They had no idea who he was or about the trial," says Nash. "I brought humor to the disconnect, but it's important to improvise in those moments."

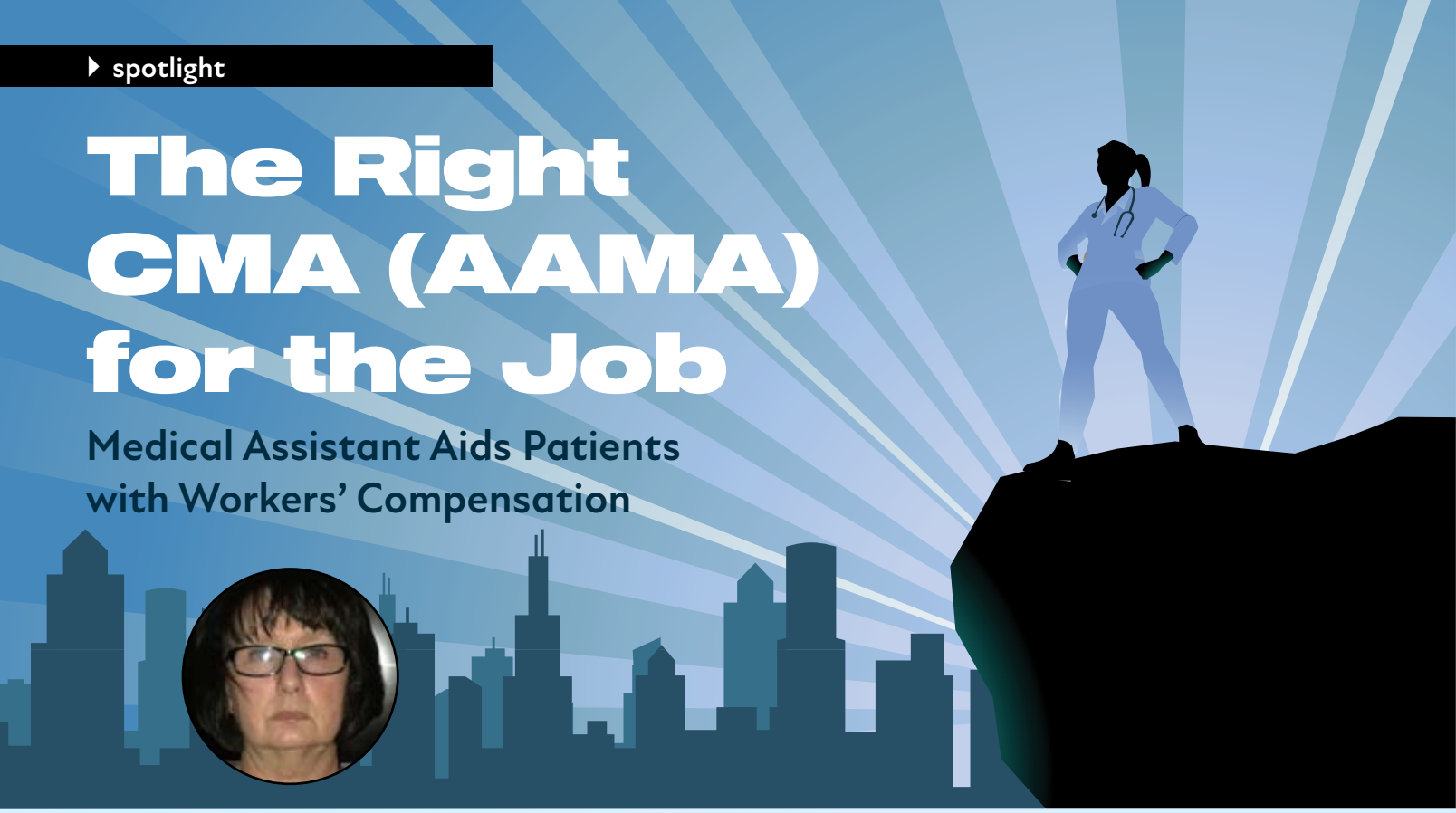
She also incorporates humor for grammar chapters by playing Schoolhouse Rock! songs. "I play 'Conjunction Junction,' and they like the unit because they've never seen it, and it makes them respond and laugh," Nash says.

On a serious note, she notes acknowledging that students often have complicated lives has been her best way to connect with them. "My generation was told to ... 'move on,' but I think we now know there is a detriment to that mentality," says Nash. "I have students who have horrific challenges, so I'm not only their educator but sometimes their mentor and lifelong cheerleader. And that's something I didn't expect."

Allowing flexibility with deadlines and directing students to resources to help them navigate life's difficulties—regardless of age—can help them thrive in class. "We have food pantries on campus, and we have a student health and counseling center where I have personally walked students when ... a conversation about school deteriorated because of life circumstances happening to them," says Nash. "You have to know when you need to switch gears from a teacher and taskmaster to a human being."

The Right CMA (AAMA) for the Job

Medical Assistant Aids Patients with Workers' Compensation



By Cathy Cassata

Tina Mamula, CMA (AAMA), always wanted to work in health care, but self-doubt kept her from pursuing her dreams until she was 49 years old.

"When I was 18, I started nursing school and stopped because I lacked [the] confidence to keep going. In the meantime, I got married and had a child and decided to stay home with him," she says.

When her son was a sophomore in high school, she enrolled in a medical assisting program and graduated in May 2013. The cardiology practice where she externed hired her, and she worked there for over five years until she came across a position in occupational and employee health. "When the person running workers' [compensation] quit, I said I'd take it on," says Mamula.

If a person is injured on the job and goes to the emergency room, they are referred to Mamula's practice, where she assists the physician in examining the patient. "Depending on the injury, the [physician] will determine what we need to document and if the patient needs to see a specialist or have further tests done," she explains.

Mamula fills out a C9 form with physician's diagnosis and treatment recommendations and submits it to the patient's bureau of workers' compensation, managed care organization, or third-party administrator for approval or denial.

"My favorite part of workers' [compensation] is comforting a patient who has been injured on the job and is distraught," she says. "I have prayed and cried with some of the people. That is what it's about to me—helping patients."

She remembers a man in his early 20s who was severely injured while driving farm equipment that flipped over. Documenting his injuries required multiple pages. "They didn't think he was going to make a full recovery, and now he is back to work with some issues. But he's gotten so much treatment, and all was taken care of the way it should be," she says. "When his care was finished [on] our part, I prayed, and we were all teary-eyed."

As part of occupational health, she also draws for laboratory tests, gives vaccinations, and performs electrocardiograms, drug screenings, pulmonary function tests, and more.

"I love employee health. I feel like I'm helping workers by getting them tests and treatment they need," says Mamula. "Every day, I learn about 10 new things."

In fact, she is always striving to learn more and help patients in new ways. When her employer asked her to become a Certified Occupational Hearing Conservationist in 2021, she did not hesitate. Obtaining the certificate allows her to conduct hearing tests as part of examinations, which are used to evaluate whether a driver is qualified to operate vehicles, such as tractor trailers, buses, and trains. Certification is required to sign off on the paperwork accompanying the hearing test.

"Many companies send employees for audio tests. I put them in the booth and run the audio tests, then print off the results for the [physician] to evaluate," says Mamula.

When she reflects on the myriad of skills she uses on the job, the self-doubt she experienced all those years ago is long gone. "There's so much that I can do with my training and still so much more that I can learn to keep building on my skills and stay challenged," says Mamula. ✦

Medical Office Basics

An Assessment-Based Recognition Program for New Hires!

Designed to bridge the gap between talent and training, these comprehensive courses equip new hires with fundamental knowledge and skills. Whether your team members have limited formal education or are transitioning to health care from other fields, our program provides a solid foundation to excel in their positions!

Scan the code to purchase and learn more:

EMPLOYERS GET $15 OFF

Employers purchasing 10 or more full courses recieve a discount!

Email Continuing Education and Membership Director Nick Mickowski for more information: **NMickowski@aama-ntl.org**

Join us for the 68th AAMA Annual Conference in Grand Rapids, Michigan, September 20–23, 2024

GEAR UP FOR A GRAND TIME

in beautiful Grand Rapids, Michigan

- Choose from continuing education sessions to earn CEUs
- Meet your peers from across the nation and share ideas
- Promote your profession
- Strengthen your leadership skills
- Educators—improve your impact in the classroom with sessions designed specifically for you
- See the latest products, publications, and services on display at the Exhibitors Hall

DON'T WAIT! REGISTER FOR CONFERENCE TODAY

68th Annual
AAMA CONFERENCE
Strength in Learning