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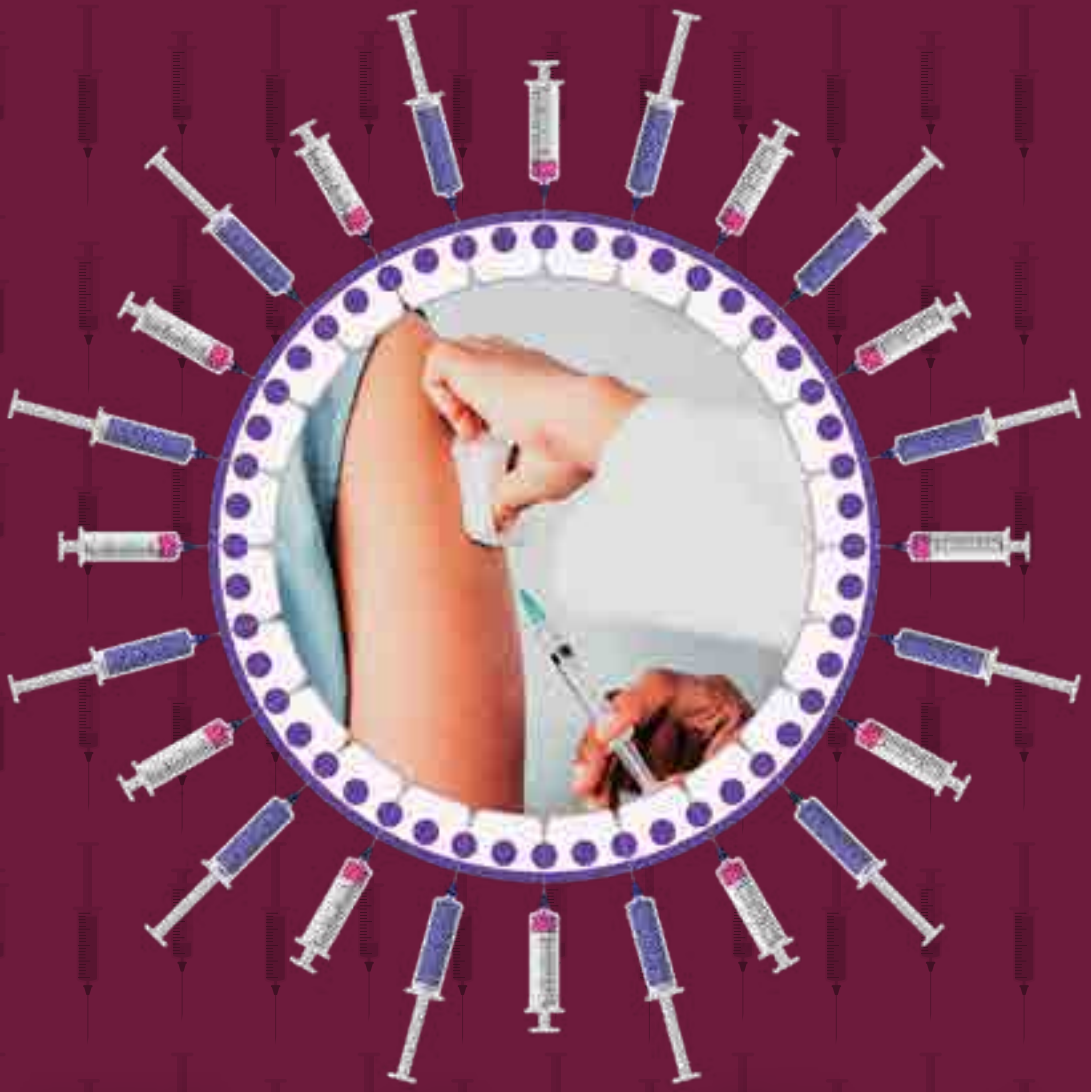

Worth a Shot

New Preventive Options Available for Respiratory Syncytial Virus

75% more CEUs; 0% more fees

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Rooted in Gratitude

Adapted from the inaugural address of 2024–2025 AAMA President Virginia Thomas, CMA (AAMA), at the 2024 AAMA Annual Conference.

The AAMA and its members mean so much to me, and I thank you all for your vote of confidence in electing me as your 2024–2025 AAMA President.

There are many that I would like to thank who have made this journey possible. First, I must thank God for guiding me. Next, I would not be a medical assistant or a part of the AAMA without my grandpa and his support. Thank you, Grandpa, for looking out for my future and teaching me about hard work and a good work ethic.

I thank my mom, who was my biggest cheerleader, for teaching me kindness and compassion toward others. I thank my dad, my other big cheerleader, for teaching me to always complete a job at hand.

I am grateful to my mentors: Kathy McNamara got me involved in the local AAMA chapter and supported me as I began my journey as a leader. Deb Benson, Charlene Couch, Joyce Hardee, and Debby Houston saw a spark in me and began to nourish the flame as I continued to grow within my state society.

Many past AAMA presidents and state leaders have also guided me as a leader. There is no single way to lead, and we can all continue to grow and learn from one another.

I have worked with many amazing board and committee members over my nine years as an AAMA trustee and secretary. The Board of Trustees (BOT) works as a team for all of our members. We have seen Career Professional Development Committee items come out to further education and membership initiatives to increase our numbers. The Advisory Service has beneficial resources for those who hire medical assistants and provides advisory support to employers on the use of medical assistants in outpatient settings. The newly created Educators Collaborative Task Force educates and encourages educators regarding the benefits of association with the AAMA, determines resource needs of educators, and provides tools to establish state society educator groups and reach out to current or recent graduates. The BOT has collaborated with AAMA staff to develop an improved website, an updated logo, membership recognition pins, and more.

Looking toward the future, the AAMA must continue to be inclusive of all credentialed medical assistants. We need to continue to work to find those members with a tiny spark and fan their flame to show them the type of leader they can be. The creed of the AAMA is not just something that we say at the end of our meetings but our driving force every day.

Thank you. I look forward to working for you all this year with an amazing team by my side.

Virginia Thomas, CMA (AAMA)

Virginia Thomas, CMA (AAMA)
2024–2025 President

AAMA® Mission

The mission of the American Association of Medical Assistants® is to provide the medical assistant professional with education, certification, credential acknowledgment, networking opportunities, scope-of-practice protection, and advocacy for quality patient-centered health care.

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The CMA (AAMA) is awarded to candidates who pass the CMA (AAMA) Certification Exam. PSI Services LLC constructs and administers the exam. The CMA (AAMA) credential must be recertified every 60 months by the continuing education or exam method.

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Worth a Shot

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AAMA update

Strength in Learning and Community

Hundreds of medical assistants from near and far enjoyed new educational possibilities at the 68th AAMA Annual Conference in Grand Rapids, Michigan. More than 580 people connected with their peers and furthered their knowledge as medical assistants.

Many thanks to the Annual Conference Education Committee, the members of the Michigan Society of Medical Assistants, and the 2023–2024 Annual Conference Committee for a fun and informative event dedicated to medical assisting professionals.

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

Many Thanks for Supporting the Profession

Conference attendees gave generously to the Maxine Williams Scholarship Fund: $4,099. ✦

Generous Contributions

Many thanks to the state societies who gave so liberally to the educational programming of the 2024 AAMA Annual Conference:

- Alaska
- Illinois
- Montana
- North Carolina
- South Carolina
- Texas
- Washington

Your generosity benefits us all!

Powering Up

At the Presidents Banquet, 2023–2024 AAMA President Monica Case, CMA (AAMA), congratulated incoming AAMA President Virginia Thomas, CMA (AAMA). The AAMA extends its appreciation to Immediate Past President Case for her excellent leadership and wishes the best to President Thomas as she leads the association through the coming year! ✦

Common Knowledge: This Event Rocks

Volunteers from the North and South Carolina societies once again delighted the conference crowd with the 2024 CMA (AAMA)® Knowledge Bowl. Attendees competed in teams to test their medical assisting expertise in one of the most popular events of the conference. ✦

Saluting Our Sponsors

A hearty thanks to 2024's sponsors:

- McGraw Hill
- North Carolina Society of Medical Assistants
- Ohio State Society of Medical Assistants
- PAHCOM
- Pediatrix Medical Group
- Wisconsin Society of Medical Assistants ✦

House Highlights

The House of Delegates elected and reelected officers and trustees. Meet your 2024–2025 Board of Trustees:

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Shannon Thomas, AAS, CMA (AAMA)

Going Hall Out

Visitors to the Exhibitors Hall discovered the latest in educational materials, technology, and more. The AAMA thanks all the 2024 exhibitors:

- AstraZeneca
- Cengage Group
- F.A. Davis
- Goodheart-Willcox Publisher
- Henry Ford Health
- Jones & Bartlett Learning
- McGraw Hill
- Medical Assistant Partnership for Healthy Pregnancies and Families/ University of Nevada, Reno
- Pediatrix Medical Group
- Platinum Educational Group
- Total Medical Supply
- Trajecsys Corporation ✦

Join us next year in Arlington, Virginia, for the 69th AAMA Annual Conference on September 19–22, 2025.

South Carolina Legislature Amends Medical Assisting Law

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

The 2024 South Carolina General Assembly enacted legislation amending the statutory language delineating the scope of practice for medical assistants. The provisions of the new law went into effect May 21, 2024, and establish definitions of "certified medical assistants" and "unlicensed assistive personnel" and specify different scopes of practices for these two categories of personnel. The following is an explanation of the key provisions of the new law.

Definition of *Certified Medical Assistant*

The legislation defines *certified medical assistant* as follows:

> "Certified medical assistant" or "CMA" means a person who:
>
> (1) has completed:
>
> (a) a medical assisting education program accredited by the Commission on Accreditation of Allied Health Education Programs or its successor, by the Accrediting Bureau of Health Education Schools or its successor, or by any accrediting agency recognized by the United States Department of Education, and which must include courses or components in anatomy and physiology, medical terminology, pharmacology, medical laboratory techniques, and clinical experience, provided the clinical experience component may be satisfied through an individual's work experience with a health care employer;
>
> (b) a Career and Technical Education Health Sciences Program approved by the South Carolina Department of Education;
>
> (c) a medical assisting program provided by a branch of the United States military;
>
> (d) a medical assisting United States Department of Labor-approved Registered Apprenticeship program; or
>
> (e) a training program that is delivered, in whole or in part, by a health care employer that aligns to a nationally accredited certification exam; and
>
> (2) a person who … maintains current certification from a certifying body offering a certification program that is:
>
> (a) approved by the [South Carolina] Board of Medical Examiners and the [South Carolina] Board of Nursing; and
>
> (b) is accredited by the National Commission for Certifying Agencies or other accreditation body recognized by the [South Carolina] Board of Medical Examiners and the [South Carolina] Board of Nursing.[1]

Grandfathering and Grace Period Provisions

The legislation establishes a grandfathering provision for medical assistants who, since January 1, 2020, were certified by an approved and accredited certification program. Note that the following language does not require these grandfathered certified medical assistants to have completed medical assisting education. The law also provides that medical assistants employed as of May 21, 2024, who do not meet the requirements of the new law have until July 15, 2026, to do so. This may be characterized as a grace period. The following is the language from the law:

> The term "certified medical assistant" or "CMA" also includes medical assistants who have maintained certification from one of the certifying entities in item (2) of this section since January 1, 2020, and individuals employed as certified medical assistants as of the effective date of this act who do not meet the education or training requirements required in this item, but who meet those requirements no later than July 15, 2026.[1]

Definition of *Unlicensed Assistive Personnel*

The law defines *unlicensed assistive personnel* (UAP), distinguishes this category of personnel from certified medical assistants, and specifies that UAP are not to administer medications:

> "Unlicensed assistive personnel" or "UAP" means persons not currently licensed by the Board of Nursing as nurses, or persons who are not certified medical assistants as defined [above], who perform routine nursing tasks that do not require a specialized knowledge base or the judgment and skill of a licensed nurse. Nursing tasks performed by a [UAP] must be performed under the supervision of a physician, physician assistant, [advanced practice registered nurse], registered nurse, or selected licensed practical nurse. *[UAP] must not administer medications.* [Emphasis added.][1]

Conditions for Delegating Tasks to Certified Medical Assistants

Note the following section of the new law:

> (B) A physician, physician assistant, or advanced practice registered nurse may delegate specified tasks to a CMA pursuant to the following requirements:
>
> (1) the task must be delegated directly to the CMA by the physician, physician assistant, or advanced practice registered nurse, and not through another licensed practitioner;

(2) the task must be performed when the physician, physician assistant, or advanced practice registered nurse delegating the task is in such close proximity as to be immediately available to the CMA if needed;

(3) the physician, physician assistant, or advanced practice registered nurse delegating the task must determine that the task is within the training and competency of the CMA and will not pose a significant risk to the patient if improperly performed;

(4) the task must not involve the verbal transmission of an order or prescription to a licensed person if the licensed person requires the order or prescription to be in writing; and

(5) the CMA must wear an appropriate badge identifying the CMA's status, which must be clearly visible to the patient at all times.[1]

Tasks Not Delegable to Certified Medical Assistants

The new statute lists tasks not delegable to these certified medical assistants:

> Specific tasks may be delegated to a CMA by a physician, physician assistant if authorized to do so in [their] scope of practice guidelines, or advanced practice registered nurse if authorized to do so in [their] practice agreement … The following tasks must not be delegated to a CMA … :
>
> (1) administering controlled medications, intravenous medications, contrast agents, or chemotherapy agents;
>
> (2) injecting neurotoxin products, neuromodulatory agents, or tissue fillers;
>
> (3) using lasers or instruments that result in tissue destruction;
>
> (4) placing sutures;
>
> (5) taking radiographs or using any ionizing radiation unless the CMA is also a certified limited practice radiographer;
>
> (6) analyzing, interpreting, or diagnosing symptoms or tests;
>
> (7) triaging patients; and
>
> (8) performing a clinical decision-making task by means of telemedicine.[1]

Tasks Delegable to UAP

The law also contains a list of tasks delegable to UAP:

> A physician, physician assistant, [or advanced practice registered nurse] may delegate nursing tasks to UAP under the supervision of the physician, physician assistant, [or advanced practice registered nurse]. Such nursing tasks include, but are not limited to, the following:
>
> (a) meeting patients' needs for personal hygiene;
>
> (b) meeting patients' needs relating to nutrition;
>
> (c) meeting patients' needs relating to ambulation;
>
> (d) meeting patients' needs relating to elimination;
>
> (e) taking vital signs;
>
> (f) maintaining asepsis;
>
> (g) collecting specimens (urine, stool, sputum);
>
> (h) point of care testing and screening tests;
>
> (i) recording information;
>
> (j) performing non-clinical tasks via telemedicine; and
>
> (k) observing, recording, or reporting any of the nursing tasks enumerated in this subsection.[1]

Certified Medical Assistants May Be Delegated Medication Administration

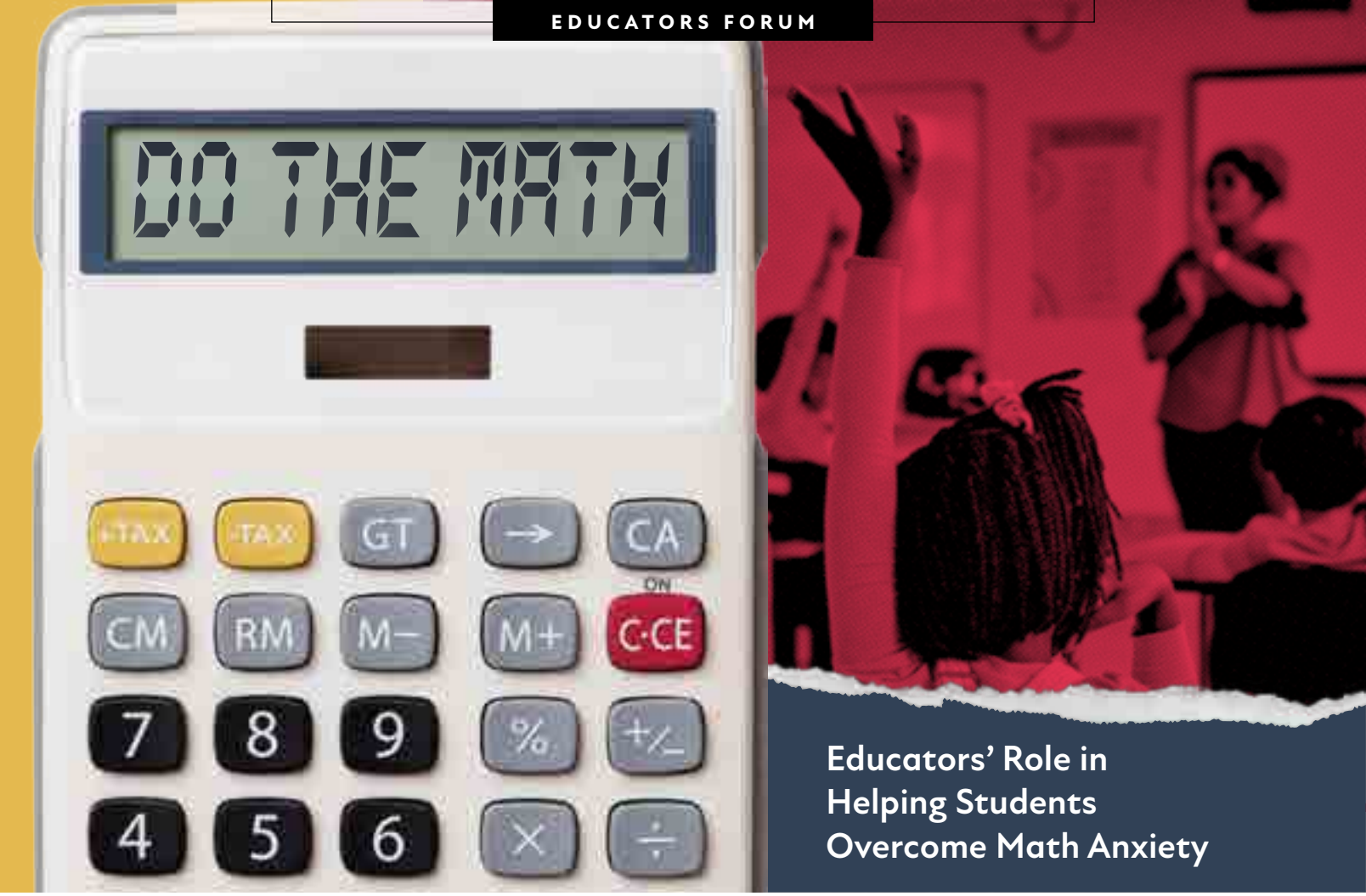
The following language from the law allows certified medical assistants to be delegated the administration of medication:

> Nurse Practice Act, delegation of tasks
>
> SECTION 3. Section 40-33-42(C) of the 1976 Code is amended to read:
>
> "(C) Subject to the rights of licensed physicians and dentists under state law, and except as provided [above] regarding the delegation of tasks to certified medical assistants, the administration of medications is the responsibility of a licensed nurse as prescribed by the licensed physician, dentist, other authorized licensed provider or as authorized in an approved written protocol or guidelines. Unlicensed assistive personnel must not administer medications, except as otherwise provided by law."[2] ✦

Questions may be directed to CEO and Legal Counsel Donald A. Balasa, JD, MBA, at DBalasa@aama-ntl.org.

References

1. SC Code of Laws ch 47, §40 (2023). https://www.scstatehouse.gov/code/t40c047.php#40-47-20
2. *South Carolina Statutes as of July 2024.* American Association of Medical Assistants. Accessed December 15, 2024. https://www.aama-ntl.org/docs/default-source/state-sop-laws/south-carolina-statutes-(july-2024).pdf



Educators' Role in Helping Students Overcome Math Anxiety

by Brian Justice

Anxiety can make life—including education—all the more challenging. In fact, anxiety disorders are some of the most common mental health problems worldwide, and one of the most intense in education is math anxiety.[1]

"Learning math is both emotional and cognitive, and anyone who feels limited by math anxiety needs to work through those emotions before they can successfully solve math problems," says Geillan Aly, PhD, CEO of Compassionate Math in Glastonbury, Connecticut, a professional development organization specializing in math.

Dr. Aly's advice is sound and highly relevant. About 93% of adults in the United States have experienced some level of math anxiety, and around 17% experience it at high levels. Its effects include test and performance anxiety, which can have detrimental lifelong effects, not only in academics but also in a person's career path.[1]

"Math anxiety is quite common among students, especially for those receiving on-the-job training," says Melody Gibson, BS, CMA (AAMA), CPT(ASPT), RPSGT, medical assisting and phlebotomy program director at Gaston College in Dallas, North Carolina. "For some students, math anxiety often stems from being away from a classroom or educational environment for an extended period of time."

THE PRESSURE ADDS UP

Some students feel stressed when taking timed tests. The pressure to complete tests within the given time frame can cause anxiety, sometimes even causing students to forget material that they knew thoroughly before sitting for the exam. Additionally, students may feel a sense of failure when they do not perform as well as expected. When this stress is associated with math, it can spark a fear of that subject, which then becomes an endless cycle of ever-increasing anxiety that can be hard to overcome.[2]

Embarrassment is a factor too. Being scolded or publicly corrected for a wrong answer can easily establish a strongly negative association with math. This leads to apprehension about participating in class or even attempting challenging problems because of the fear of making mistakes in front of others. When tension around math increases, it causes confidence to deteriorate even further.[2]

"The thing that I run into with students is they automatically say, 'I'm not good at math,' or 'I can't do math.' It just shuts them down right away," says Carmen Monk, BS, CMA (AAMA), a medical assisting educator, program director, and practicum coordinator at Western Iowa Tech Community College in Sioux City, Iowa. "They haven't had a good experience with math, and that perpetuates their anxiety."

In theory, a little bit of nervousness can motivate people to study harder and perform better. However, for people with math anxiety, dealing with numbers is not just difficult; it can be emotionally upsetting. Research has shown that for people with elevated levels of math anxiety, merely

LONG-HELD DIVISION

Women consistently report higher rates of math anxiety than men, even though research suggests that this stems more from stereotypes than actual math ability. Men and women are equally proficient in math, but cultural beliefs can create math anxiety. The unsupported assumption that math is a masculine subject can be internalized in women, making them believe they are not naturally capable in that subject, and this generally false belief can build anxiety.[5]

This is a real concern in medical assisting, which is 90% female.[6] Despite math proficiency levels comparable to their male counterparts, female students report higher levels of math anxiety throughout all stages of their education.[5] Frustratingly, studies on gender and math anxiety reveal that the gender difference often increases with age. Women not only report more negative feelings about math but are also more likely to avoid math-related studies and professions, which has a significant impact on their career choices.[7] The connection between math anxiety, gender stereotypes, and performance in mathematics may vary depending on the type of math-associated task at hand, but it is consistently shown that women's math anxiety is fueled more by society than actual ability.

In short, women are not worse at math than men. By recognizing and addressing the impact of stereotypes, educators and mentors can help reduce anxiety caused by stereotypes and create a more supportive environment for women.

anticipating an encounter with math agitates the regions in their brains associated with threats and pain.[3]

CALCULATING CONFIDENCE

"It can be easy to assume that students are coming in with a mastery of basic math," says Aaron Emmel, PharmD, MHA, BCPS, founder and program director of Pharmacy Tech Scholar in St. Augustine, Florida. "But dedicating time to working with fractions and decimals, rounding, and fundamental units of measure is needed to set the foundation for more difficult health care–related calculations."

Research supports Dr. Emmel's opinion. Managing math anxiety should not only include finding ways to decrease that anxiety but also support everyone's learning processes, which drives improvement in their math proficiency and their confidence.[4]

A basic technique for alleviating math anxiety is celebrating success.

"Confidence comes from within," says Patricia Boutilier, MBA, MS, BS, EDS, CMA (AAMA), RMA(AMT). "Acknowledge efforts and progress, however minor. Positive reinforcement can motivate students to keep trying and boost confidence and motivation."

"I do my best to make it fun," adds Monk. "I've used [an online education program] to reinforce elementary math to build their confidence. Then, they're like, 'Oh, yeah. I remember how to do this,' which reinforces what they already know, and they can build on that."

Helping students cultivate positive behaviors can also reduce anxiety. For example, encourage them to set aside the proper amount of study time to avoid last-minute jitters and reduce stress.

"[Students should] do homework in lots of short bursts rather than sitting for hours feeling frustrated," advises Dr. Aly. "Students get more out of doing a few problems over the course of a day or two, without frustration or berating themselves, and practice, practice, practice!"

Some basic relaxation techniques can help too. Positive self-talk and deep breathing exercises can alleviate stress and promote calm.

"I encourage students to join support groups or study groups where they can share experiences and learn from each other. That can provide a supportive community and reduce feelings of isolation," says Boutilier. "Practicing mindfulness and meditation can also help reduce anxiety, improve focus, and reduce the stress associated with math, leading to improved performance and greater confidence."

SUBTRACTING THE STRESS

Relieving math anxiety is more than just mastering formulas. It requires fostering positive and supportive learning environments that build confidence and skills. Starting with rudimentary knowledge that students already have, celebrating even the smallest measures of progress, and using intentionally low-pressure study habits and basic mindfulness practices can make math more approachable and diminish the fear around it. Thoughtful educators can help students break a cycle of fear and failure that often starts in childhood, transforming math from an emotional minefield into a solid foundation of confidence and competence. ✦

References

1. Luttenberger S, Wimmer S, Paechter M. Spotlight on math anxiety. *Psychol Res Behav Manage*. 2018;11:311-322. https://doi.org/10.2147/PRBM.S141421
2. What is math anxiety? Oxford Learning. September 20, 2024. Accessed December 15, 2024. https://www.oxfordlearning.com/what-is-math-anxiety/
3. Weir K. How to solve for math anxiety? Studying the causes, consequences, and prevention methods needed. American Psychological Association. October 1, 2023. Accessed December 15, 2024. https://www.apa.org/monitor/2023/10/preventing-math-anxiety
4. Lockett E. Tackling math anxiety: from diagnosis to treatment and more. November 16, 2022. Accessed December 15, 2024. https://www.healthline.com/health/anxiety/math-anxiety
5. Justicia-Galiano MJ, Martín-Puga ME, Linares R, Pelegrina S. Gender stereotypes about math anxiety: ability and emotional components. *Learning Individual Differences*. 2023;105. https://doi.org/10.1016/j.lindif.2023.102316
6. Medical assistant demographics in the United States. CareerExplorer. Accessed December 15, 2024. https://www.careerexplorer.com/careers/medical-assistant/demographics/
7. Vos H, Marinova M, De Léon SC, Sasanguie D, Reynvoet B. Gender differences in young adults' mathematical performance: examining the contribution of working memory, math anxiety and gender-related stereotypes. *Learning Individual Differences*. 2023;102. https://doi.org/10.1016/j.lindif.2022.102255

News to Use By Kelli Smith

Walking Linked to Increased Longevity

For Americans over the age of 40, walking as much as the most physically active members of the population could lengthen their lives by at least five years, according to a new study published in the *British Journal of Sports Medicine*.

The study's authors found that the top 25% of the population in terms of physical activity spend the equivalent of 160 minutes of walking daily at nearly 3 miles per hour. If the least active members of the population brought their activity up to this same level, they could add 11 years to their life expectancy.

The study uses observational data from a life table of the 2019 United States population, mortality information from 2017, and physical activity data from the 2003–2006 National Health and Nutritional Examination Survey.

While the study does not imply cause and effect, the general health benefits of daily physical activity are well established, and a lack of activity can cause a variety of mental and physical health problems.

The authors further speculate that changes in infrastructure, such as more walkable neighborhoods and green spaces that promote activities like biking and walking, could lead to greater longevity within the general population, according to Healthline.

Consistent exercise can decrease your resting heart rate, manage cholesterol, and reduce your chances of heart attack or stroke. And thankfully, walking is often accessible, making it a simple and powerful tool for a healthier life.

Injuries Threaten Health Care Workers' Well-Being

Health care workers face increasing risks of injury while caring for others and are nearly twice as likely to experience work-related injuries compared with other industries, according to the U.S. Department of Labor. These injuries can lead to missed work, reduced quality of life, and sometimes career-ending disabilities. Note risk factors for common injuries:

Moving and lifting patients. Health care workers often lift loads exceeding recommended safety limits, creating significant risk for back injuries. In fact, the prevalence of back pain is high among health care personnel, find multiple studies. Many facilities still need more adequate lifting equipment or proper staffing levels for safe patient handling. The physical toll of repeated lifting can accumulate over time, leading to chronic conditions that affect health care workers' work performance and quality of life.

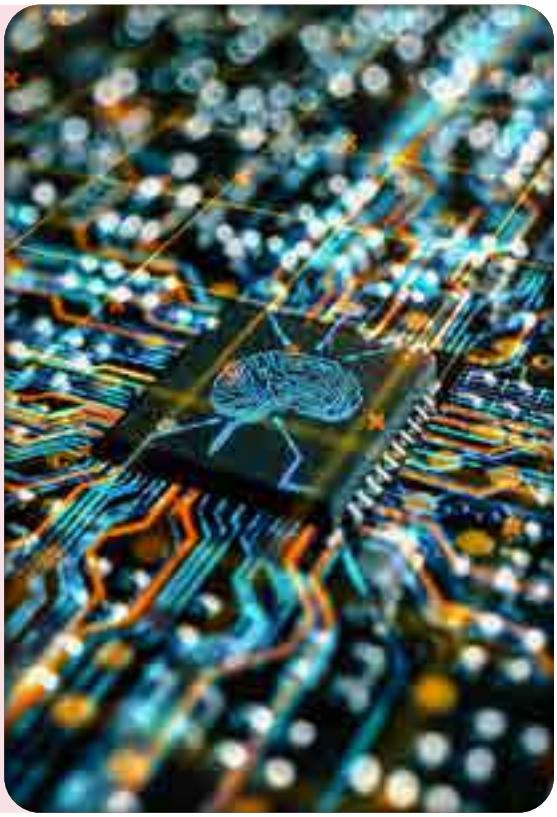
A fast-paced environment. Accidents resulting from circumstances such as wet floors and cramped spaces pose constant risks, especially when workers move quickly during emergencies. Recent data show that slip and fall accidents account for nearly one-quarter of worker compensation claims in health care settings.

Exposure to infectious diseases and harmful substances. The Occupational Safety and Health Administration estimates that thousands of health care workers experience serious infectious exposures yearly.

Physical and mental exhaustion. Long hours and high-stress environments create dangerous levels of tiredness. Studies show tired health care workers are 3.4 times more likely to experience workplace injuries.

Reducing health care worker injuries requires systemic changes, such as providing proper equipment, staffing levels, and frequent safety training. Workers require support systems that enable them to prioritize their own safety while upholding patient care.

AI Cost-Efficiency in Health Care



Hospitals and health systems generate tons of data every day. Artificial intelligence (AI) can offer ways to automate and streamline workflows by assisting with a variety of tasks. However, continuously running AI models is very costly, creating a barrier to widespread use.

A study published in *npj Digital Medicine* by the Icahn School of Medicine at Mount Sinai has identified strategies for using large language models—a type of AI—in health systems while maintaining cost efficiency and performance.

The study involved testing 10 AI models with real patient data and observing how each model responded to a variety of clinical questions. The team ran over 300,000 experiments to evaluate completed tasks' accuracy and the models' ability to follow clinical instructions, incrementally increasing task loads to see how the models managed rising demands, according to ScienceDaily.

By grouping up to 50 tasks (e.g., structuring research cohorts, reviewing medication safety, and matching patients for clinical trials) together, the AI models could handle them simultaneously without a major drop in accuracy. This approach could mean that hospitals can optimize workflow and reduce costs.

The research team plans to explore how these models perform in real-time clinical environments, managing real patient workloads and interacting directly with health care teams.

Health Disparities Cause Varied Life Expectancy

Americans' average lifespans vary dramatically depending on race, ethnicity, income, and location, and these gaps continue to widen. A new report says that health inequalities have created 10 Americas based on specific groups. Notably, life expectancy is considered a crucial measure of a population's health.

While life expectancy rose in six groups between 2010 and 2019, it plummeted in all 10 in 2021, during the pandemic. Across all groups, the life expectancy gap rose from 12.6 years in 2000 to 20.4 years in 2021, again largely due to the pandemic, according to the report.

The population with the longest life expectancy in 2021 was Asian Americans at 84 years, two decades longer than the group with the lowest life expectancy: American Indians and Alaska Natives living in the West, who were expected to live 63.6 years. Meanwhile, progress to improve life expectancy among Black Americans has largely stalled, the report shows.

Researchers call for federal, state, and local governments to work together to close the gaps. They conclude that prioritizing health care, educational, and job development resources to address the root causes is crucial.

Worth a Shot

New Preventive Options Available for Respiratory Syncytial Virus

By Mark Harris

Every year, many people experience illness from infectious diseases. Whether caused by viruses, bacteria, or other harmful pathogens, the burden of infectious disease on society is significant.

Viral infections are certainly a major cause of infectious diseases. They include influenza (flu), COVID-19, and the rhinoviruses that cause the common cold. For instance, the United States had 31 million flu-related illnesses during the 2022–2023 season, resulting in 21,000 deaths, according to the Centers for Disease Control and Prevention (CDC).[1] Yet, compared with the flu, the public is probably less familiar with another common viral condition called respiratory syncytial virus, or RSV.

Indeed, one recent multicountry survey found that 60% of adults over the age of 50 were unaware of RSV.[2] Yet, RSV has a major impact on public health. In the United States, approximately 2.1 million outpatient visits for RSV occur yearly. This includes 58,000 to 80,000 hospitalizations. Another 100,000 to 160,000 hospitalizations for RSV-related illness are also reported among adults 60 years of age and older.[3]

It's Nothing to Sneeze At

As a viral condition, RSV is a highly contagious respiratory virus that infects the nose, throat, and lungs. Since most cases of RSV are mild and self-limiting, clearing up in a week or so, its potential health risks might be easy to underestimate.

"RSV is a common respiratory virus that usually circulates in the fall and winter in the United States," says Robert H. Hopkins Jr., MD, medical director of the National Foundation for Infectious Diseases. "While it usually causes cold-like symptoms, in small children, older adults, and those with chronic medical conditions or other risk factors, RSV can cause serious infections—most commonly pneumonia. Unfortunately, there are currently no approved antiviral medications for RSV, so treatment is supportive in nature."

Fortunately, RSV preventive medicine is advancing. "RSV vaccines are now available to prevent severe infections in adults and can also be used in pregnant [people] to prevent disease in infants," Dr. Hopkins explains. "There is also a monoclonal antibody that can be given to newborn infants and older babies at high risk to prevent severe outcomes. By vaccinating our patients, we can [now] help prevent older adults and infants from being hospitalized due to RSV."

These new therapies represent an exciting breakthrough in preventive treatment, observe experts. "What has frustrated us for many years is that we have not had any way to prevent RSV," says Kelly L. Moore, MD, MPH, president and CEO of Immunize.org, a national nonprofit advocacy organization for vaccines and immunization services. "Discoveries in how to design vaccines allowed us to develop all at once numerous RSV vaccines that became available this past year. Until the fall of 2023, we had no tools to use to prevent RSV, other than an extremely expensive antibody treatment that was used for only a few very high-risk infants."

Considering the burden of RSV disease in society, the significance of these new tools in prevention is apparent. "We know that somewhere between 6,000 and 10,000 adults die of RSV disease each year in the United States," remarks Dr. Moore. "RSV illness is also the No. 1 cause of the hospitalization of infants in the United States. Until the introduction of [an] RSV vaccine during pregnancy or the RSV antibody last year, we could expect that about 1 in 50 infants would be admitted to the hospital with RSV disease in their first year of life."

The impact of infant hospitalizations for RSV on families can be particularly distressing, adds Dr. Moore. "While thankfully only a small number of infants die from RSV disease—maybe between 100 and 300 hundred infants across the United States every year—many thousands of infants are hospitalized and their families are traumatized by severe illness in their young child," she says. "When you think about the impact on families, the hospitalization of an infant is incredibly expensive, families lose work time, and it's also incredibly stressful for the family. This usually [happens] with an infant under 6 months of age. So, it's not just hospitalization, but the cost and the trauma to the family that we can—now, for the first time—prevent."

On Pins and Needles

Notably, injectable antibody therapy for newborns and young children differs from RSV vaccines for older adults and pregnant people.

"The monoclonal antibody is not a vaccination per se," explains Donna L. Tyungu, MD, a pediatric infectious disease specialist with Oklahoma Children's Hospital OU Health in Oklahoma City. "However, it is considered an immunization as it will protect the patient against [RSV] for a period. It provides months of antibody protection to help infants come through their first winter seasons. ... Most children will be able to better tolerate RSV in later seasons of life due to having larger facial anatomy and an improved ability to control the clinical response, which consists of a large amount of nasal and respiratory secretions. It is the first season that can be the most detrimental. Those infants under 8 months old whose mothers did not receive an RSV vaccine are eligible for this protection. Traditionally, vaccination teaches our immune systems how to fight pathogens by forming new antibodies. Monoclonal antibodies provide direct and immediate antibody protection to the patient."

Note that a monoclonal antibody is a type of laboratory-made protein that attaches to the virus and can help block it from infecting healthy cells.[4]

For Dr. Tyungu, getting the word out to parents and families about these new therapies is a priority. "Families should be aware of these new protective options for newborns," she says. "At our hospital this year, we are offering the monoclonal antibody to our sickest neonates—those who have spent time in neonatal, pediatric, or cardiac intensive care units. Others will be offered the immunization at outpatient pediatric offices."

Only one of the three RSV vaccines is authorized for use in pregnant individuals.

"RSV vaccination of pregnant [people] between 32 and 36 weeks of pregnancy helps stimulate maternal antibody production against RSV, which is passed on to the infant to protect against severe infection in their first RSV season. For infants whose mothers did not receive an RSV vaccine, the monoclonal antibody nirsevimab is an injection given to newborns within the first week of life to provide antibody protection against severe RSV infection for the first RSV season. This antibody can also be given in the second RSV season to certain infants who are at increased risk. Both are safe and effective strategies to help protect infants from severe RSV."

—Robert H. Hopkins Jr., MD

This is Pfizer's Abrysvo vaccine, which has been found safe and effective for use during pregnancy, reports Dr. Moore. In most of the United States, the vaccine is authorized for use during pregnancy from September through January. Providers are advised not to administer the maternal RSV vaccine outside of this seasonal framework unless evidence shows that RSV is circulating regionally in a less predictable pattern, according to the CDC.[5]

"The maternal RSV vaccine is a traditional vaccination intended to protect newborns via passive immunization through their mother's immune system," adds Dr. Tyungu. "The idea is to vaccinate pregnant [people], and their newborns will retain that immunity typically through the first 18 months of life. Infants will have maternal immunity against many different pathogens if their mother has previously been exposed to or vaccinated against that pathogen. The level of protection is significant. Infants born to vaccinated mothers have a reduced risk of hospitalization at 3 months of age—reduced by 67%—and still a decrease at 6 months of life—reduced risk of 57%. It also reduced the risk of severe disease by 82% in 3-month-old infants."

The Ill at Ease

Many parents might ask when a symptomatic child should be seen by a pediatrician or get tested for RSV.

"Infants who have rapid breathing, are unable to feed well, or have irritability with a respiratory illness should be assessed by a health care professional as soon as possible," advises Dr. Hopkins. "In addition, any infant younger than 2 months old with a fever should be assessed by a health care professional."

While most cases of RSV cause mild symptoms, in some individuals, the virus can develop into bronchiolitis or pneumonia, which are infections of the lower airways in the chest or lungs. Generally, RSV symptoms last an average of seven to 14 days, with symptoms peaking on days three through five.[6]

"Most children will be able to stay home to manage their RSV symptoms," says Dr. Tyungu. "Unfortunately, some of our youngest children cannot tolerate the amount of secretions produced by their bodies due to infection. These younger infants or immunocompromised children can present with signs and symptoms of pneumonia, persistent cough and congestion, hypoxia, or decreased oxygenation. Testing for RSV is relatively simple, and patients with cough or fever can typically receive point-of-care testing with their pediatrician. Infants who experience cyanosis—turning blue, poor appetite leading to a decrease in the number of wet diapers, and persistent cough with fever should be brought in for care. They may benefit from nasal suctioning, oxygen, or antibiotic therapy, as viral infections can predispose patients to secondary bacterial infections."

A Turning Point

The CDC recommends that everyone age 75 and older get an RSV vaccine. Vaccination may be recommended for adults ages 60–74 with chronic conditions that increase their risk for severe disease. The vaccination may be also be recommended for individuals with chronic heart or lung disease, with weakened immune systems, and who are nursing home residents.[7]

"These vaccines work best at preventing severe disease that results in [emergency room] visits and hospitalizations," explains Dr. Moore. "That's our primary goal with vaccination: to prevent serious outcomes in adults. The RSV vaccines are reducing the risk of severe disease and hospitalization by around 75% or 80% in the first season, based on the information from last season. This was consistent with what we saw in the clinical trials of tens of thousands of older adults who received these vaccines. This is important especially when you look at adults who are frail and fragile, who are 75 and older, for whom the hospitalization rate can be quite high."

The first two vaccines released in fall 2023, Pfizer's Abrysvo and GSK's Arexvy, are traditional protein-based vaccines, whereas the new Moderna vaccine mResvia is an mRNA-based platform.[7] "We think the mRNA-based vaccine will work as well as the other two vaccines, but we're awaiting more information because it's a newer product," reports Dr. Moore. "We expect the protection to be a little bit less significant in the second year, but people who got vaccinated last year won't need another dose this year. With [COVID-19 and the flu], people are getting vaccinated each year, or sometimes more than once a year, but with the RSV vaccine, we believe significant protection will last at least two years and perhaps longer."

As Dr. Moore clarifies, a more complete assessment of the RSV vaccines is forthcoming. "One of the challenges when a new vaccine comes out is that we don't necessarily know how long it's going to last until we have some time to watch how it works. We're monitoring these vaccines closely now to determine when people are going to need another dose in the future. It may be two or three or more years, but we still don't know."

Disease Defenses

The best ways to help prevent the spread of RSV include the following:

- Cover coughs and sneezes.
- Wash hands often with soap and water for at least 20 seconds.
- Avoid close contact with others who are sick.
- Avoid touching the face, particularly the eyes, nose, and mouth.
- Clean frequently touched surfaces (such as doorknobs).
- Consult a health care professional if you have cold-like symptoms that linger or worsen.
- Get immunized to protect against severe RSV, if recommended.[3]

Why is the vaccine recommendation more qualified for the age 60–74 population? "We know that the risk of getting serious RSV disease goes way up as you age," remarks Dr. Moore. "The real change is around age 75 and older. If you're otherwise completely healthy and you're 65 or 70 years old, it's very unlikely that you're going to end up in the hospital with RSV. But if [patients] have serious heart, lung, or kidney disease, if [patients] have diabetes but it's not well controlled and [they] have end-organ damage, or if [patients are] particularly frail and fragile, those patients can benefit from RSV vaccination when they're younger."

Understandably, some older adults in the 60–74 age group might be unsure whether they should receive the RSV vaccine. "I would encourage anyone aged 60–74 years who has questions about their eligibility for RSV vaccination to talk with a trusted health care professional," suggests Dr. Hopkins. "It is important to note that RSV vaccination is currently recommended as a one-time single dose, and those adults who have already been vaccinated should not get another dose."

While the RSV vaccine is available year-round, the CDC recommends eligible older adults get the vaccine in late summer or early fall (August through October) before the usual seasonal spread of the virus in the community.[7]

Viral News

Many health experts recognize the need for more engaged public discussion of RSV's potential health risks and how to prevent them. Generally, public awareness of RSV tends to lag behind other viral infections, such as the flu.[8] This awareness can also vary depending on the population demographic.

"The people who know the most about RSV are parents of young families," observes Dr. Moore. "This is because almost every child is going to get infected with RSV by the time they are 2 or 3 years old. And parents remember that illness. Many will also have a friend who had a baby who was hospitalized, because it's so common in that age group. These families are very well aware of RSV. The good news is that many of them are demanding either vaccines during pregnancy or the antibody for the infant. They understand that RSV is scary, and they want to do everything they can to protect babies."

Conversely, awareness of RSV's health risks among older adults is more likely to fall short. "A recent National Foundation for Infectious Diseases survey found that many U.S. adults are not as concerned about RSV as they should be, which is concerning because RSV can be serious and can cause life-threatening complications, hospitalizations, and death," reports Dr. Hopkins. "According to the [National Foundation for Infectious Diseases] survey, only 16% of U.S. adults are concerned about RSV, and only 21% of older adults say they will get vaccinated."[9]

Dr. Moore's explanation for why RSV awareness and its risks have been comparatively low among older adults is simple: "Until now, we couldn't do anything about it," remarks Dr. Moore. "We didn't have a vaccine. We didn't have a treatment. If they got RSV and were hospitalized, we simply did the best we could to take care of them until they got better. But because there was nothing we could do to prevent or treat it, we didn't talk about RSV much, which kind of makes sense. We didn't talk about what we couldn't do anything about."

With new preventive resources now available, older adults must be informed about their options. "Now, the tables have turned on this virus, and we can do a lot to prevent the damage it's causing in older adults," says Dr. Moore. "So, we need to start educating our patients who are 75 and older and our patients with serious health complications who are younger that now we can do something. We have to make sure they understand this virus is commonplace. They've probably had it a few times in their lives already, and if they don't get vaccinated, they're going to get it again. But now they are at an age when it could put them in the hospital, and we want to prevent that."

The Ill, Advised

Immunize.org provides a weekly newsletter, *IZ Express*, to help readers stay informed on new CDC vaccine recommendations, U.S. Food and Drug Administration vaccine approvals, newly released Vaccine Information Statements, immunization resources, notable publications, vaccine news, upcoming events, and more.[14]

Resources

Immunize.org
https://www.immunize.org

National Foundation for Infectious Diseases
https://www.nfid.org

Staff Perspectives

"We're starting to see an uptick in our office of more pregnant [people] getting the RSV vaccine," says Alex Szymanski, CMA (AAMA), practice manager for Advocare Medford Pediatrics in Medford, New Jersey. "We get newborn records from the hospital that will indicate [whether] the mother has had [the vaccine]. If the mom didn't get the RSV vaccine during pregnancy, we offer [antibody] immunization to newborns and patients under the age of 19 months. If they have anything like a compromised immune system, a risk of respiratory infections, or an issue with asthma, we can give another dose the following year."

"Quite honestly, we've seen a lack of immunizations [generally] since COVID-19," adds Szymanski. "We know some parents don't want to get their children immunized. But we've had a lot of interest in parents wanting the RSV antibody injection for their children. Frankly, when it came out last year, I thought nobody was going to want this. But the number of patients we had was phenomenal, and again this year. Parents want it for their children. I think it's because RSV is very scary for a lot of parents with the complications it can lead to, especially in infants."

Dosages for the antibody immunization are based on the age and weight of the newborn, infant, or toddler.[10] "In our office, the medical assistants give the injections," says Szymanski. "It's usually an intramuscular injection into the baby's thigh. There are usually no major side effects other than a little soreness at the injection site. But otherwise, the babies are tolerating it well."

As a mother of a 4-year-old and a new baby, Szymanski also has personal experience with RSV in her family. "My 4-year-old son had RSV when he was 2," she says. "My newborn was immunized when he was 8 weeks old. I found with RSV that it kind of hits fast. With my son, it started with what I thought was a normal cold. He was fine that morning, and by midnight, he was having very labored breathing [and] retractions in his ribs. I could tell something was off, so I took him to the [emergency room]. They did a respiratory panel, and that came back positive for RSV. We were there for several hours. They put him on a steroid and nebulizer treatment for his breathing because his oxygen level was low. He was having some respiratory stress, but once we started the nebulizer treatments every four hours with steroids we saw some improvement. It took about a week for him to recover."

While her son was not hospitalized, Szymanski believes that if he was younger he probably would have been admitted to the hospital. "I want medical assistants and everyone to know RSV is serious," says Szymanski. "Obviously, with your own children, you should follow your … gut if you think something is wrong. You should especially watch out for your child's breathing. If you know what their breathing pattern is normally versus a breathing pattern when they're sick, that can make a huge difference. If something's off and there are signs of respiratory distress, you would be able to identify that right away."

Most parents are interested in the new antibody immunization for infants, agrees Jennifer Zeher, CMA (AAMA), a clinical medical assistant for a pediatrics clinic in Wake Forest, North Carolina. "In our [practice], we've had few parents decline it when it's offered," she says. "With a lot of parents worried about their children getting sick, in the wintertime especially, we're seeing a lot of families opting for it."

While RSV season typically starts in fall and peaks in winter, with some regional variations in timing and severity, the overall seasonal timing of the virus was disrupted during the COVID-19 pandemic.[11] "Our [physicians] tell us that ever since COVID-19, RSV season is all over the place," says Zeher. "We've had kids coming in for RSV in June and July, which prior to COVID-19 was unheard of. It's showing up any time of year, although we're allowed to order the immunization for only the RSV season." The CDC expects, however, RSV's traditional seasonal pattern will gradually return.[11]

Medical assistants must be informed and up to date on RSV, says Zeher. Working in pediatrics, she observes her learning has grown considerably since the introduction of the new vaccine and antibody therapies, but also by her own experience as a parent.

"As someone who has been a parent for only three years, my child got RSV three times in one year," she reports. "He's in daycare, and it just goes through there like wildfire. As far as symptoms go, he was not immunocompromised and is healthy otherwise, so he just looked miserable with a cold for a week or so. But for kids that have health issues, like lung or heart disease or other problems, they can very easily end up in the hospital. I think RSV should be everyone's concern."

High Points to Come

Primary care providers, pediatricians, infectious disease specialists, medical staff, and other health care professionals all have a vital role to play in educating and raising awareness about RSV with patients, families, and communities.

"It is important for families with new babies to understand the risks of RSV and know of the preventive agents at our disposal," concludes Dr. Tyungu. "Pediatricians are generally very good at disclosing age-appropriate risks as children grow. This is only the second year we have had these tools in our immunization toolbelt, and we should be excited about assisting families in avoiding some of the outcomes that can result from infection with this virus. Practical tools that may help spur conversations would be flyers in the [practice], mentions on clinic social media pages, emails, or informative text messages to families with young babies."

For example, the American Academy of Pediatrics sponsors an RSV Campaign Toolkit that pediatricians can use to educate parents and families. The tool kit includes information on how to identify warning signs of RSV in babies, immunization resources, the importance of handwashing, and preventive tips to reduce the spread of RSV.[12] The American Lung Association has also recently launched an RSV public awareness campaign, prioritizing outreach to high-risk groups such as adults 60 or older with chronic lung disease.[13]

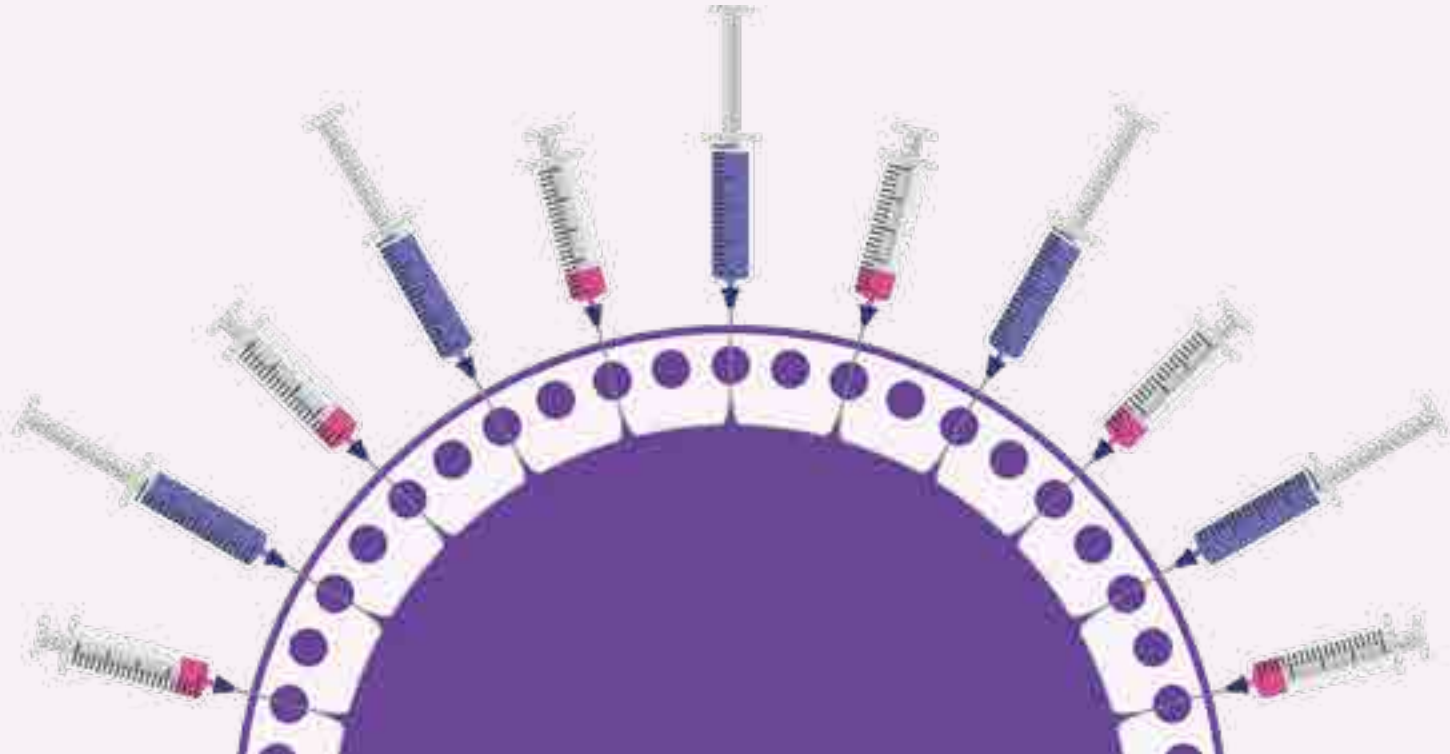
"We are all in this together—health care professionals, advocacy organizations, and the media," concludes Dr. Hopkins. "We need to provide timely and accurate information about RSV, especially its impact on older adults and young children; the fact that there are no approved antiviral medications as treatment; and that safe and effective preventive tools are available! We want to ensure that everyone eligible is protected against RSV."

The current juncture in medicine's response to RSV is a promising one. With new preventive tools now available, health care professionals are poised to better support and empower patients, families, and communities to prevent severe RSV. ✦

The CE test for this article can be found on page 26.

References

1. Preliminary estimated flu disease burden 2022–2023 flu season. Centers for Disease Control and Prevention. November 22, 2023. Accessed December 15, 2024. https://www.cdc.gov/flu-burden/php/data-vis/2022-2023.html
2. Steinzor P. Sixty percent of adults over 50 unaware of RSV risks, survey reveals. *Am J Managed Care*. August 30, 2024. Accessed December 15, 2024. https://www.ajmc.com/view/sixty-percent-of-adults-over-50-unaware-of-rsv-risks-survey-reveals
3. Respiratory syncytial virus (RSV). National Foundation for Infectious Diseases. Updated September 2024. Accessed December 15, 2024. https://www.nfid.org/infectious-disease/rsv/
4. Respiratory syncytial virus (RSV) monoclonal antibody. The Sydney Children's Hospital. Updated June 17, 2024. Accessed December 15, 2024. https://www.schn.health.nsw.gov.au/respiratory-syncytial-virus-rsv-monoclonal-antibody-factsheet
5. RSV vaccine guidance for pregnant people. Centers for Disease Control and Prevention. August 30, 2024. Accessed December 15, 2024. https://www.cdc.gov/rsv/hcp/vaccine-clinical-guidance/pregnant-people.html
6. Caserta M, Jones A. RSV: when it's more than just a cold. HealthyChildren.org. Updated October 25, 2024. Accessed December 15, 2024. https://www.healthychildren.org/English/health-issues/conditions/chest-lungs/Pages/RSV-When-Its-More-Than-Just-a-Cold.aspx
7. Vaccines for older adults. Centers for Disease Control and Prevention. August 30, 2024. Accessed December 15, 2024. https://www.cdc.gov/rsv/vaccines/older-adults.html
8. O'Bryan C, Bigham J. RSV season debrief: what should family physicians know? *AAFP Voices* blog. March 20, 2024. Accessed December 15, 2024. https://www.aafp.org/news/blogs/aafp-voices/rsv-season-debrief.html
9. As concerns about respiratory diseases among public drop to new lows, US health officials urge vaccination. National Foundation for Infectious Diseases. September 25, 2024. https://www.nfid.org/as-concerns-about-respiratory-diseases-among-public-drop-to-new-lows-us-health-officials-urge-vaccination/
10. RSV immunization guidance for infants and young children. Centers for Disease Control and Prevention. August 30, 2024. Accessed December 15, 2024. https://www.cdc.gov/rsv/hcp/vaccine-clinical-guidance/infants-young-children.html
11. Seasonality of respiratory syncytial virus — United States, 2017–2023. *MMWR*. 2023;72(14):355-361. April 7, 2023. Accessed December 15, 2024. http://dx.doi .org/10.15585/mmwr.mm7214a1
12. RSV (respiratory syncytial virus) campaign toolkit. American Academy of Pediatrics. Accessed December 15, 2024. https://www.aap.org/en/news-room/campaigns-and-toolkits/rsv-respiratory-syncytial-virus-campaign-toolkit/?srsltid=AfmBOopHfmsVno16gZGWENt7aaBx3PHdD48zVxa2F9FK0cVzB4_z6hDB
13. New American Lung Association RSV campaign targets high-risk groups amid low vaccination rates. American Lung Association. September 25, 2024. Accessed December 15, 2024. https://www.lung.org/media/press-releases/fy25-rsv-in-adults-campaign
14. About *IZ Express*. Immunize.org. Accessed December 15, 2024. https://www.immunize.org/news/iz-express/about/



FULL DISCLOSURE

Thorough and Quality Communication Improves Care for Patients with Gonorrhea

By Cathy Cassata

A health care visit often comes with a certain amount of unease, especially for patients who are seeking gynecological care. Add in concerns about a sexually transmitted infection (STI), and the level of anxiety, worry, and embarrassment is compounded. However, medical assistants can help patients feel comfortable and understood before they see the physician.

"Sometimes the patient is more open with me about why they are here," says Heather Hudgins, CMA (AAMA), who works at Atrium Health Wake Forest Baptist Obstetrics and Gynecology in High Point, North Carolina. "When this happens, I'll tell the provider, 'I was talking with the patient and she says she is here for vaginal discharge, but she told me her partner told her that he tested positive for gonorrhea.' " This allows the provider to enter the examination room prepared to address the situation.

Tell Me More

Gonorrhea is a bacterial infection that is spread through sexual fluids and can cause infection in the genitals, rectum, and throat. In 2022, more than 2.5 million cases of chlamydia, gonorrhea, and syphilis were reported in the United States, with gonorrhea making up almost 650,000 of those cases.[1]

"[There] is a concern that an equal number may have it, but without symptoms they have not been diagnosed," says Estrelita Dixon, MD, division chief of general internal medicine at UC Health and professor at the University of Cincinnati.

While gonorrhea is very common in people between the ages of 15 and 24, the STI can affect anyone at any age.[2]

"Sexually active people of any age can contract gonorrhea and transmit it to their partners. It can also be passed on to children during childbirth," says Tochi Iroku-Malize, MD, 2021–2022 president of the American Academy of Family Physicians.

The majority of people who have gonorrhea do not have symptoms. When present, symptoms most likely occur within two weeks of infection. Further, symptoms usually occur in men, with a large amount of penile discharge and painful urination, notes Dixon. "Sometimes there can be testicular pain," she adds.

For women and people with vaginas, symptoms can present as white, green, yellow, or bloody discharge from the vagina, pain when urinating, bleeding between periods, heavy bleeding during a period, or a fever, explains Dr. Iroku-Malize. "Additionally,

Prevention Pointers

The following can help people prevent STIs and lower their risk for gonorrhea[4]:

- Using condoms consistently and correctly
- Practicing open and honest communication with partners about each other's history of STIs and previous testing for STIs
- Applying antibiotic eye ointment on newborns to prevent gonococcal eye infection

both women and men can get sore throats if they've had oral contact with an infected person," she says.

Men and women who have rectal infections and show symptoms might experience the following[2]:

- Discharge
- Anal itching
- Soreness
- Bleeding

What's Next

Testing for gonorrhea can be done with a urine sample; by using a swab to take cell samples from the throat, genitals, or rectum; or by swabbing discharge from any infected area. Some types of gonorrhea tests can be done with an at-home STI test kit. "The kit includes a container for collecting a urine sample to send to a laboratory for testing," says Dr. Iroku-Malize.

When patients, concerned that they have been exposed to an STI, go to the clinic where Hudgins works, the physician will run the test to confirm whether they were exposed, "but [the physician] will also go ahead and treat them while we are waiting for results, to be on the safe side," she says.

Gonorrhea is curable with antibiotics. Depending on the strain, one pill might be prescribed, or a patient may need to take medication for seven days. Because an increased rate of antibiotic resistance is occurring worldwide and some strains of gonorrhea are resistant to antibiotics, the physician may prescribe two kinds of antibiotics in shot and pill form.[3]

"While it might be nerve-wracking or scary to get diagnosed with gonorrhea, it is easily treated with antibiotics," says Dr. Iroku-Malize. "However, I encourage patients to get it treated immediately, because if it's left untreated, it could cause some serious health problems."

Complications from untreated gonorrhea include the following[4]:

- Pelvic inflammatory disease
- Chronic pain
- Infertility
- Ectopic pregnancy
- Increased risk of getting or spreading HIV

In severe instances, untreated gonorrhea can spread to the blood, skin, heart, or joints, causing major complications and death.

Know What to Say

Receiving a diagnosis of an STI like gonorrhea can make people feel hurt or betrayed by their partner, or ashamed of themself. "These feelings are completely normal," says Dr. Iroku-Malize. Medical staff can help patients navigate emotions, in addition to treatment options, in a safe place, she adds.

When a patient tests positive for an STI, Hudgins calls them to inform them of the diagnosis and to relay the physician's treatment plan. "Some of the patients are repeat, so they already know they are positive, and some aren't surprised because they did question the possible exposure. But others are really taken back and not sure how they were exposed," she says.

For those patients, Hudgins examines their chart and tells them the date they last tested negative. Then she explains that from that date to now, any partner they engaged in sexual relations with could be who they contracted the STI from.

With 22 years of experience in OB-GYN, she trains new medical assistants on various practices of the office. When it comes to training them on STIs, she teaches them how to talk to patients.

"I tell them to remind patients, 'it's important that you and your partner treat this and make sure you are not having intercourse until you come back in so you do not spread infection. Also, if the infection is left untreated, it could cause other issues like pelvic inflammatory disease or infertility,' " Hudgins says. "We can make sure the physician's message gets across in an informative and compassionate way."

While STIs can be a difficult topic, medical assistants are well positioned to offer a safe space for patients to openly discuss their fears and concerns. Equipped with a knowledge of gonorrhea and unwavering compassion, each medical assistant can improve patients' experiences by making sure their medical visits go smoothly and helping patients receive necessary follow-up treatments as prescribed by the patient's physician. ✦

References

1. CDC's 2022 STI Surveillance Report underscores that STIs must be a public health priority. Centers for Disease Control and Prevention. Reviewed January 30, 2024. Accessed December 15, 2024. https://www.cdc.gov/std/statistics/2022/default.htm
2. About gonorrhea. Centers for Disease Control and Prevention. February 15, 2024. Accessed December 15, 2024. https://www.cdc.gov/gonorrhea/about/index.html
3. How do I get treated for gonorrhea? Planned Parenthood. Accessed December 15, 2024. https://www.plannedparenthood.org/learn/stds-hiv-safer-sex/gonorrhea/how-do-i-get-treated-gonorrhea
4. Gonorrhoea (Neisseria gonorrhoeae infection). World Health Organization. July 4, 2024. Accessed December 15, 2024. https://www.who.int/news-room/fact-sheets/detail/gonorrhoea-(neisseria-gonorrhoeae-infection)

For Your Health

By Kelli Smith

Avo-lutely Amazing

Avocados are a trendy kitchen staple for good reason. They are an extremely nutrient-dense and versatile food that can be the base of a tasty breakfast, lunch, or dinner.

Next time you're at the grocery store, consider some of the many health benefits of avocados, according to Cleveland Clinic and Healthline:

- **Great source of vitamins:** Avocados are high in many crucial nutrients, including vitamin B_6, vitamin E, vitamin C, and folate.
- **Beneficial for gut health:** Avocados' high fiber content provides nearly half of the current daily value in each avocado, helping promote the growth of healthy bacteria.
- **Full of antioxidant and anti-inflammatory compounds:** Avocados are packed with bioactive compounds such as carotenoids, vitamin C, vitamin E, and phenolic compounds, which have been shown to have significant antioxidant, neuroprotective, and cardioprotective activities.
- **Can help achieve a healthy body weight:** Though avocados are high in calories, their nutrients promote fullness due to their high fiber and fat content. Additionally, research shows that following a diet high in fiber may help support weight loss.
- **Could help reduce heart disease risk factors:** The minerals, vitamins, fiber, and healthy fats found in avocados can help keep the cardiovascular system healthy.

All You *Can* Eat

Canned foods are affordable, have a long shelf life, and are convenient for quick meals. But which canned foods stand out?

Let's explore the best canned foods to keep in your pantry, according to Health and EatingWell:

- **Beans and legumes** are perfect for adding plant-based protein to salads, soups, stews, and curries.
- **Tomatoes** are rich in vitamin C, fiber, and lycopene, which is a powerful antioxidant known to promote heart health.
- **Tinned fish and seafood** are a convenient and inexpensive way to boost your protein, vitamin B, and other nutrient intake.
- **Soup** in a can may be convenient and easy when you don't feel like making it from scratch.
- **Fruit** such as peaches, pears, and pineapple are inexpensive ways to increase your produce intake.
- **Pumpkin** is low in calories and nutrient dense.
- **Chicken**, which has high protein and low calories, can be added to pasta, soups, or casseroles.
- **Beets** offer fiber, potassium, iron, and vitamin C.
- **Peas** are a solid source of plant-based protein and fiber.
- **Artichoke hearts** provide fiber and are a tasty addition to salads, pasta, or pizza.
- **Green beans** are a great vegetable to add to your meals, as they are a good source of fiber and vitamin K.
- **Olives** are a rich source of antioxidants and healthy monounsaturated fats that support heart health.

Have It Queasy

Usually, nausea goes away on its own, and you quickly feel better. But for some people, the feeling is persistent.

Consider several causes of chronic nausea, which might help determine strategies for feeling better:

Diet. Food allergies, intolerances, and eating too much or too little food can upset your stomach. Spicy or fried foods can also cause problems if you eat them too frequently.

Psychological factors. Sometimes, when nervous or upset, you can begin to feel sick to your stomach. Stress can emphasize the relationship between your gut and your mental health.

Hormonal changes. Fluctuating hormone levels can cause various symptoms, such as nausea.

Environmental factors. Certain toxins or chemicals can irritate your stomach and cause nausea.

Medical conditions. Neurological conditions, like migraines, can cause chronic nausea. Also, some medications may have nausea as a side effect.

Common conditions associated with nausea can be treated in a variety of ways, according to Verywell Health. However, strategies like eating ginger and deep breathing may help you cope with nausea in the short term.

What Bugs Me about Travel ...

No one wants to get back from vacation with an illness as a souvenir. Unfortunately, going to and from your destination usually involves situations where germs tend to spread: enclosed spaces, crowds, and surfaces that many people are touching. Additionally, travel-related disruptions to sleeping, eating, and fitness schedules can cause a weaker immune response and leave us more vulnerable to new pathogens.

But getting an illness caused by travel can be avoided. Pack up on these pre-trip tips from Everyday Health:

Know where germs congregate. You are likely to pick up germs on anything that strangers tend to touch frequently: airplane tray tables, restaurant menus, and surfaces and objects in hotel rooms. Frequently touched hotel room surfaces can contain pathogens such as fecal material, which can cause illnesses like the stomach flu. Exercise caution and good judgment to avoid contact with pathogens.

Wash hands frequently. The best way to protect yourself from the germs while traveling is to regularly wash your hands very well. Further, avoid touching your eyes, nose, and mouth with unwashed or unsanitized hands to reduce germs transmission.

Get vaccinated. Vaccines are usually the most effective protection against viral and bacterial illness. Make sure to plan ahead, because it typically takes approximately two weeks for shots to be fully protective. Depending on the season, your age, or health conditions, you may need a flu, pneumonia, COVID-19, or RSV vaccine.

Other ways you can protect yourself from illness while traveling are staying hydrated, nourishing your body, sleeping well, and taking immune-boosting supplements, according to Forbes. If you do end up getting sick during or after travel, make sure to prioritize rest, hydration, and nourishing foods.

Playing Fa

By Cathy Cassata

Liking certain people more than others is natural. However, as a manager, avoiding favoritism toward staff members is crucial. Unfortunately, not every manager abides by this rule. A study conducted at Central Michigan University found that 47% of American employees reported that their supervisor had favorites, and 21% admitted that their supervisor treated them better than their peers at work.[1]

Karen Michael, an employment attorney specializing in workplace training and investigations, notes that everyone has biases toward people due to life experiences and what they see in media. "Studies show that we immediately judge people, evaluate them, and make opinions. It takes a minute for our unconscious brain to process and evaluate [those thoughts]," she says. "The risk is that managers make decisions based on that unconscious brain instead of thinking through whether a decision is based on bias."

Researchers of the Central Michigan University study developed the following list of behaviors connected to favoritism[1]:

- Praising, supporting, and socializing with certain employees more than others
- Providing better opportunities, more desired tasks, and more frequent and timely feedback to certain employees
- Considering the suggestions of only certain employees and not others
- Giving important work-related information to certain people
- Excusing unproductive behavior and allowing individuals to get away with actions that other employees would be reprimanded for

Having favorite staff members is something Debbie Siclari, CMA (AAMA), works hard to avoid. As a medical assistant for 37 years and practice manager for 25, she has learned ways to ensure all staff feel like they are treated equally. "I'm friendly, but I try [to] keep my relationship with staff strictly professional because I have to be able to separate myself from them," she says.

While Siclari engages in small talk with staff and checks in on them when they return to work after being sick or addressing a personal issue, she sets boundaries. "I'm not connected to them on social media or anything outside the [practice] except attending work holiday parties," says Siclari.

Early in her career as a manager, she used to buy a birthday cake and balloons for staff members, but over time, it became time-consuming, and she feared favoritism. "I liked making each person feel special, but it became hard to keep up with because, if I did it for one person, I'd have to do it for everyone," she explains. The physicians at her practice decided that instead of cake and balloons, each staff member would get a small birthday bonus in their paycheck.

If Siclari gives an end-of-year holiday gift, she gives each staff member something small. "Everyone gets the same exact thing; no one is getting anything more or different," says Siclari.

She practices the same mentality regarding performance reviews, ensuring no one gets more or less time for the review. When it comes to complaints from staff about other staff members using work time for personal things like talking on the phone or brows-

Avoid Favoritism in the Workplace by Treating All Employees Equally

ing the internet, she addresses the issues with the whole group. "I don't name names, and I put it out as a general request to the staff to watch their cell phone and internet usage," says Siclari. "This keeps them from feeling targeted." If the situation escalates, she addresses it with them one-on-one.

Breaking Down Bias

While giving a staff member more praise or more desired work tasks because of favoritism is unethical, it is not illegal. The United States does not have laws specifically addressing workplace favoritism. However, regulations exist to protect workers when favoritism progresses to the following illegal behaviors, according to the Vaughn Law Firm in Decatur, Georgia[2]:

- Discriminating against employees for their gender, race, national origin, color, age, disability, or religion
- Chastising staff for not tolerating verbal, physical, emotional, or sexual harassment
- Retaliating against employees when they file complaints or organize a union drive
- Violating company policies or employment contract terms

A 2023 workplace discrimination poll conducted by the online recruiting company Monster found that 91% of respondents reported that they have faced workplace discrimination.[3]

Siclari has had to address concerns for a staff member who lives with a disability. "They had 30 years of experience of being a medical assistant and are qualified for the job. However, the [other] staff had a hard time adjusting to them," she says.

Siclari engaged in private conversations with the other staff about accommodating the staff member and being tolerant. She also referred to the human resources department regarding how to legally and appropriately address the employee's work performance. "I would have conversations about their shortfalls or not performing at an expected level when it comes to certain tasks, never pointing to the disability," she says. "We are continuing to work together to iron out performance."

She became familiar with the Americans with Disabilities Act, which prohibits discrimination against people with disabilities and guarantees equal opportunities for them in employment, transportation, public accommodations, state and local government services, and telecommunications.[4]

Four other federal laws protect individuals with disabilities from discrimination in employment and the job application process:

- **The Rehabilitation Act** authorizes funding for various disability-related purposes and activities, including state vocational rehabilitation programs, independent living programs, training and research, and the work of the National Council on Disability.

…

- **The Workforce Innovation and Opportunity Act** consolidates federal job training and employment programs, including employment and training services for adults, dislocated workers, and youth and Wagner-Peyser employment services administered by the Department of Labor; and adult education and literacy

programs and Vocational Rehabilitation programs for individuals with disabilities administered by the Department of Education.

…

- **The Vietnam Era Veterans' Readjustment Assistance Act** requires employers that have federal contracts or subcontracts entered into before December 1, 2003, of $25,000 or more and/or federal contracts or subcontracts entered into on or after December 1, 2003, of $100,000 or more to provide equal employment opportunities for certain veterans with disabilities.

…

- **The Civil Service Reform Act**, which covers most federal agencies, contains several rules designed to promote fairness in federal personnel actions and prohibit discrimination against applicants and employees with disabilities.[4]

Consequences of Favoritism

A study from Central Michigan University found that employees believe favoritism in the workplace has the following negative consequences[1]:

- Displays workplace injustice and unfairness
- Brings about negative feelings about the organization and inspires less loyalty to the company
- Increases emotional exhaustion
- Encourages less job satisfaction, stronger intentions to quit the job, and less work motivation
- Weakens work relationships with leaders
- Results in unfavored staff receiving less support, recognition, and professional help (e.g., mentoring and coaching from their supervisor)
- Decreases trust in supervisors

Righting Wrongdoings

Title VII of the Civil Rights Act of 1964 protects individuals against employment discrimination based on race, as well as national origin, color, sex, or religion. It covers the full spectrum of employment decisions, including recruitment, selections, terminations, and other decisions concerning terms and conditions of employment.[5]

Siclari says attending training and workshops over the years has helped her stay in tune with the topic and enhance her skills as a practice manager. "I also complete continuing education through the AAMA, which covers a lot and keeps me up to date on issues related to clinical and administrative responsibilities in the office and personnel issues related specifically to managing staff," she says.

The U.S. Equal Employment Opportunity Commission (EEOC) offers information on discrimination and harassment on its website: www.eeoc.gov. It also recommends the following ways to prevent racial discrimination in the workplace:

- Respect cultural and racial differences in the workplace.
- Be professional in conduct and speech.
- Refuse to initiate, participate, or condone discrimination and harassment.
- Avoid race-based or culturally offensive humor or pranks. When in doubt, leave it outside the workplace.
- Familiarize yourself with the company's workplace policies and act responsibly.
- Attend training on [equal employment opportunity] principles and learn about your legal rights and responsibilities under the anti-discrimination laws.

…

- Report incidents of inappropriate, discriminatory, harassing, or abusive behavior to your supervisor, human resources department, union, or management.
- If you experience or witness discrimination or harassment, contact EEOC or your local human rights commission.[6]

Evening the Scales

Stop workplace discrimination and favoritism by employing strategies that practice managers can use:

Foster an environment that encourages responsible bystanders. A majority (77%) of workers stated that they have witnessed an act of workplace discrimination, but 28% felt uncomfortable reporting the incident, according to the Monster poll.[3]

The Office of Congressional Workplace Rights (OCWR) suggests giving employees the tools they need to be responsible bystanders. This includes developing practice standards of conduct and policies that outline clear expectations for behavior and potential disciplinary actions for violating those standards. Moreover, workplaces must apply the policies consistently and immediately act when problems are reported. By having a fair process available to address workplace incidents, OCWR states that employees will be more likely to intervene.[7]

Instill a monthly culture check-in that encourages staff to submit feedback or observations anonymously, creating an early alert system for any concerns around favoritism or bias within the team.

"This kind of open channel shows that managers take staff input seriously and builds a stronger, more trusting workplace," says Connie Kurczewski, a medical practice management consultant and founder of Elevated Practice Consulting.

Conduct quarterly self-checks. Managers wanting to ensure fairness and spot unintentional biases within themselves can start with a quarterly self-check that involves setting aside time to review decisions, such as who is getting key assignments, how feedback is given, and any patterns in scheduling, advises Kurczewski. "Adding peer feedback or anonymous input from team members also gives them valuable outside perspective to make adjustments where needed," she says.

Ask employees for specific input on equity and inclusion. Through his own experience as a Black man, Henry Lukenge, president and CEO at Nexim Healthcare Consultants, has witnessed how systems of oppression and exclusion, such as discrimination and favoritism, undermine talent and progress. "It is important for managers to center the needs and voices of the marginalized by providing the opportunity for

What to Do

If you are a bystander to workplace discrimination that does not involve someone you manage and you are unsure what to do, the Office of Congressional Workplace Rights (OCWR) suggests taking the following actions[7]:

- Write down notes about the behavior you witnessed with details like the date and what you saw and heard.
- If you feel comfortable, tell the victim you are willing to describe the incident if there is an investigation.
- If you see the behavior continue, stay near the victim in hopes of preventing it from escalating.
- If you do not feel comfortable addressing the situation with the victim or culprit, follow your employer's internal procedures for reporting incidents. If there is not a procedure, speak with a neutral supervisor.
- Contact OCWR for help at 202/724-9250.

those staff to provide feedback on the issue of equity and inclusion," he says.

To address discrimination, he recommends managers seek feedback on the impacts of their actions and mistakes, take responsibility, and seek to correct these mistakes through learning, unlearning, and relearning. Managers should not invalidate the voices of those impacted by the manager's behavior, which would be unethical.

Implement trainings that include relatable, everyday scenarios. Real examples, like patient interactions or handling feedback with colleagues, help team members better understand how to uphold fairness. "Revisiting these training sessions twice a year keeps the message relevant and reinforces that it's a core part of the culture," says Kurczewski.

Training should also focus on inclusion and not pit people against one another, notes Michael. "We can find much more that we have in common than differences. The key is to set expectations and create an environment where people feel comfortable and confident to express ideas and be authentic," she says.

Implement a civility policy and robust code of conduct. Civility policies should require that all employees engage in conduct that is respectful, professional, and collaborative and does not tolerate demeaning, intimidating, or insensitive behavior, asserts Michael. She notes that a client of hers has a policy that prohibits conduct that undermines team cohesion, staff morale, individual self-worth, productivity, or safety.

"Too often, organizations tolerate bullying-type behaviors," she says. "The reality is that we think things in our head … [but] we can control our actions and words. Organizations should focus on [intentionally] creating policies that set expectations for workplace conduct, train them on those expectations, and then hold employees accountable for violations."

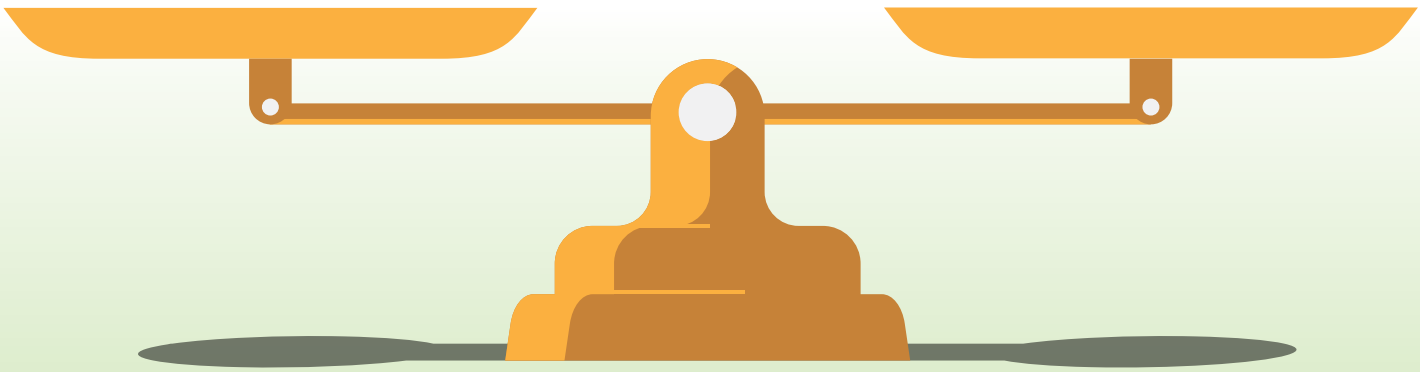
Hold an open-door review period once or twice a year that lets employees share feedback on management practices without any fear of repercussions.

"Reviewing and adjusting policies based on team input not only keeps them relevant but also shows employees that the organization is serious about creating an equitable workplace," says Kurczewski. ✦

The CE test for this article can be found on page 28.

References

1. Li M. Playing favorites: a study of perceived workplace favoritism. The Ohio State University. March 7, 2018. Accessed December 15, 2024. https://fisher.osu.edu/blogs/leadreadtoday/blog/playing-favorites-a-study-of-perceived-workplace-favoritism
2. Favoritism in the workplace. The Vaughn Law Firm. Accessed December 15, 2024. https://thevaughnlawfirm.com/favoritism-in-the-workplace/
3. Poll results: workplace discrimination. Monster. July 2023. Accessed December 15, 2024. https://view.ceros.com/monster-com/workplace-discrimination/p/1
4. Employment laws: disability & discrimination. Office of Disability Employment Policy. Accessed December 15, 2024. https://www.dol.gov/agencies/odep/publications/fact-sheets/employment-laws-disability-and-discrimination
5. Title VII of the Civil Rights Act of 1964. US Equal Employment Opportunity Commission. Accessed December 15, 2024. https://www.eeoc.gov/statutes/title-vii-civil-rights-act-1964
6. Best practices and tips for employees. US Equal Employment Opportunity Commission. Accessed December 15, 2024. https://www.eeoc.gov/initiatives/e-race/best-practices-and-tips-employees
7. YourRights@Work: a bystander's response to workplace harassment. Office of Congressional Workplace Rights. Accessed December 15, 2024. https://www.ocwr.gov/publications/your-rights-at-work/your-rights-at-work-a-bystanders-response-to-workplace-harassments/



Respiratory Syncytial Virus

Deadline: Postmarked no later than **March 1, 2025**

Credit: 2.5 AAMA CEUs (gen/clin) **Code: 143690**

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

T F

☐ ☐ 1. Influenza and COVID-19 are bacterial infections.

☐ ☐ 2. Most cases of respiratory syncytial virus (RSV) are mild and clear up in approximately one week.

☐ ☐ 3. The public is less aware of the dangers of RSV than it is of the dangers of influenza and other similar infections.

☐ ☐ 4. For certain patient groups, such as older adults and patients with chronic medical conditions, RSV can result in serious infections such as pneumonia.

☐ ☐ 5. After the start of the COVID-19 pandemic, cases of RSV are occurring more frequently at any time of year.

☐ ☐ 6. In the United States, the No. 1 cause of infants being hospitalized is RSV illness.

☐ ☐ 7. The monoclonal antibody is a vaccine that teaches the immune system how to combat pathogens by forming new antibodies.

☐ ☐ 8. The likelihood of getting a serious case of RSV decreases as a person ages.

☐ ☐ 9. A monoclonal antibody is a laboratory-made protein that attaches to a virus and helps prevent it from infecting healthy cells.

☐ ☐ 10. Any infant with a fever who is younger than 2 months old should be assessed by a health care professional.

☐ ☐ 11. The RSV vaccine is an approved medication for treating RSV.

☐ ☐ 12. The Centers for Disease Control and Prevention (CDC) recommends that anyone who is 65 years of age or older should get an RSV vaccine.

☐ ☐ 13. As is the case with COVID-19 and influenza vaccines, the RSV vaccine should be received once a year.

☐ ☐ 14. Older adults who are eligible for the vaccine should receive it in late summer or early fall, according to the CDC.

T F

☐ ☐ 15. Antibody immunizations for babies should usually be given as an intramuscular injection into the baby's arm.

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Favoritism in the Workplace

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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!

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

T F

☐ ☐ 1. Giving certain employees better opportunities than other employees with equal qualifications and performance is an example of favoritism.

☐ ☐ 2. Instead of biases driving managers' decision-making, their decision-making should be based on objective facts and impartial analysis of those facts.

☐ ☐ 3. Employers should establish a civility policy and a code of conduct and hold all employees responsible for abiding by them.

☐ ☐ 4. Favoritism in the workplace increases trust in supervisors.

☐ ☐ 5. Showing favoritism on the basis of race, color, national origin, religion, sex, disability, or age is a violation of federal law.

☐ ☐ 6. When speaking with an employee who is disabled, it is advisable, according to the Americans with Disabilities Act, to point out how deficiencies in job performance are due to the individual's disability.

☐ ☐ 7. Approximately 28% of employees indicated that they have witnessed discriminatory acts in the workplace.

☐ ☐ 8. Title VII of the Civil Rights Act of 1964 forbids employment discrimination on the basis of race, color, national origin, sex, and religion.

T F

☐ ☐ 9. The Americans with Disabilities Act forbids discrimination in transportation and public accommodations but not employment.

☐ ☐ 10. The Equal Employment Opportunity Commission recommends that all employees avoid race-based or culturally offensive humor or pranks.

☐ ☐ 11. Employees should not report incidents of discriminatory or abusive behavior to supervisors because such actions could be perceived as inappropriate interference in the enforcement of employer policies.

☐ ☐ 12. Employers should not allow employees to submit anonymous observations and feedback because doing so could encourages false accusations against employees who have done nothing wrong.

☐ ☐ 13. The Rehabilitation Act, the Workforce Innovation and Opportunity Act, the Vietnam Era Veterans' Readjustment Assistance Act, and the Civil Service Reform Act protect individuals with disabilities from discrimination in employment and the job application process.

☐ ☐ 14. Managers should ask for input about mistakes they have made, and they should seek to avoid those mistakes in the future.

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Frequently Asked Questions

CMA (AAMA) Known for Answering Patient Calls for Help

By Cathy Cassata

Anita Figueroa, CMA (AAMA), spends her days caring for older adults at a senior independent living facility in Lincolnshire, Illinois. "My mother passed away young at 58 from ovarian cancer," she says. "When I'm helping the residents, I feel like I'm helping my mother. I have a feeling of gratitude for being here."

For six years, she has worked in the facility's medical center running laboratory tests, giving electrocardiograms, providing wound care, and performing other clinical tasks. Her favorite part of the job is connecting with patients. "I walk around and talk with them and try to make them laugh. For example, one lady was eating ice cream while talking with her group of friends and I pretended like I was going to take and eat her ice cream, and they all started cracking up," says Figueroa.

She takes pride in inspiring and uplifting the residents when they need it most. For all her efforts, some of them jokingly refer to her as Ann Landers—a pen name for an advice column of the *Chicago Sun-Times* that was started by a Chicago-based nurse.

"If they're down, I talk to them. If the physician tells them they can walk but they don't believe they can, I encourage them and stand by them as they try," she says.

Helping the residents helps Figueroa too. Last year while at work, she learned she had myelofibrosis, a type of bone marrow cancer. "When I got the results, I closed the door, and I started crying and thinking 'I'm going to die,' " recalls Figueroa. "I pushed myself to walk around and talk to the residents. They got me laughing and gave me the energy to take this on. They might not know it, but they inspire me."

Her connection to older adults carries over into her second job as a caregiver. "Many of the residents request me to be their caregiver too, which is touching," says Figueroa.

She plans to work at the facility and as a caregiver for a few more years until she retires. Figueroa feels that her 36 years of medical assisting experience landed her exactly where she should be. Prior to becoming a medical assistant, when Figueroa was 17 years old, she worked as a certified nursing assistant for several years. Then she found other work to make ends meet. "When I heard about medical assisting classes, I was so interested. Going to school for this was the best choice," she says.

After graduating from a medical assisting program in 1988, she landed a job at her externship site. Over the years, she worked for physicians in family practice, ENT, and rheumatology, each sending her to Washington, D.C., for trainings to enhance her skills. She earned various titles—including office manager, wound care technician, allergy technician, Department of Transportation breath alcohol technician, and Department of Transportation urine drug specimen collector—and is certified as a biller and coder.

"My CMA (AAMA) [certification] took me further than I ever expected and allowed me to stand out and accomplish so much," she says.

Pride in the profession encouraged her to be vice president of the Chicago chapter of the Illinois Society of Medical Assistants. She is currently serving her fourth term.

"Giving back to the profession is rewarding," says Figueroa. "I hope to encourage others to take advantage of this great career." ✦

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