SeptOct 2025

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS®

Volume 58 | Issue 5

Medical Assisting Today

The Magazine for Professional Medical Assistants

Check Your Vitals

Monitoring and Managing Workforce Burnout in Health Care

Published by the American Association of Medical Assistants®

Back to Connection, Celebration, and Community

As summer gradually transitions to autumn, we will soon find ourselves back to brisk mornings and cozy evenings. For medical assistants, this season marks a return to something profoundly meaningful: our annual gathering at the AAMA Annual Conference.

There is excitement in the air as we prepare to reconvene—not just to further our knowledge, but to rekindle friendships that span coast to coast. It's a time for sharing stories, laughter, and ideas with colleagues who have become family over the years. The anticipation builds for what promises to be a great experience. There is so much to do—continuing education sessions, the CMA (AAMA) Knowledge Bowl, the House of Delegates, and much more.

The Gatsby gala–themed Welcome and Awards Celebration on Friday night calls for our finest attire—shimmering gowns, pressed suits—an evening to honor the dedication of individuals, local chapters, and state societies. On Sunday evening, during the Presidents Banquet, we celebrate our state presidents, recognize those who have shaped our legacy, thank the outgoing Board of Trustees members, and welcome the newly elected leaders who will guide us into the 2025–2026 year.

And the excitement does not end there! October brings Medical Assistants Recognition Week (MARWeek), October 20–24, 2025, a time to spotlight the invaluable contributions of medical assistants nationwide. This year's theme, "Medical Assistants: Valued Champions of Health Care," is a fitting tribute to our role on the front lines of patient care. The poster created by the AAMA Marketing Department captures our spirit and dedication, and we hope it graces practices across the country, inspiring pride and gratitude.

Does your workplace celebrate MARWeek? If not, perhaps it's time to spark a new tradition. Whether it's cookies, cupcakes, or a card, simple gestures can go a long way. Let's not wait for someone else to start the festivities—sometimes, the best celebrations begin with one enthusiastic champion. Share your plans, your surprises, and your stories. What are you doing to honor your team? How does your clinic or hospital show appreciation for you and your colleagues? Your ideas might inspire others and turn small moments into cherished memories.

As we look ahead to the 69th AAMA Annual Conference in Arlington, Virginia, and the celebrations that follow, let's carry this spirit with us. Come ready to learn, lead, honor, and be honored.

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.

CMA (AAMA)® Certification

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

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

PRINTED WITH SOY INK

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

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

The opinions and information contained in *Medical Assisting Today* do not necessarily represent AAMA official policies or recommendations. Authors are solely responsible for their accuracy.

Publication of advertisements does not constitute an endorsement or guarantee by the AAMA of the quality or value of the advertised services or products.

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

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

AAMA update

Medical Assistants Matter

Get ready to cheer for medical assistants during Medical Assistants Recognition Week (MARWeek)! This year—and every year—we celebrate medical assistants as champions in health care.

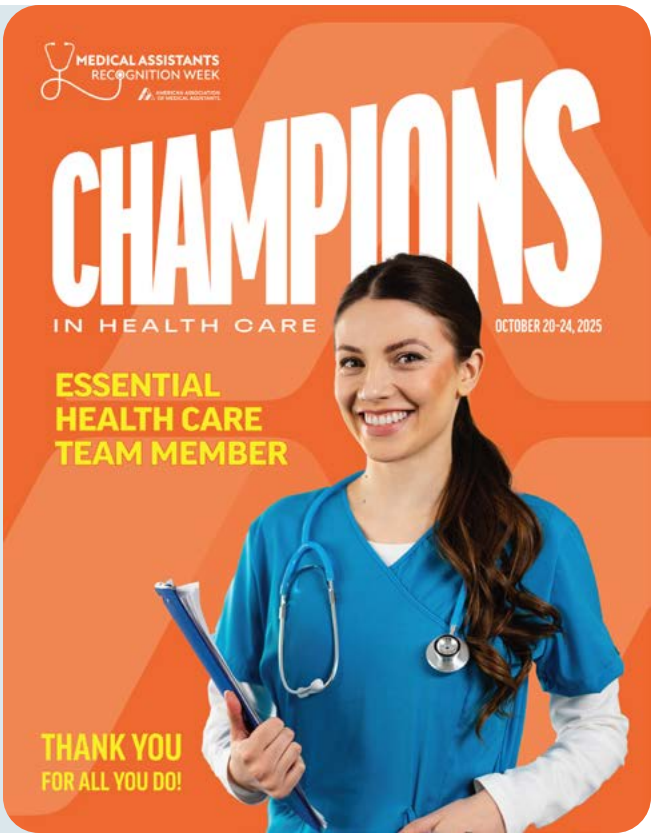
That is why we observe MARWeek during the third full week in October:

MARWeek: Oct. 20–24, 2025

MARDay: Oct. 22, 2025

The AAMA provides tools (i.e., promotional MARWeek packets, products, and downloads) to help you celebrate the professionals who are true partners in health care. Visit the AAMA online store to order* complimentary MARWeek packets. You can also order individual posters and magnets.

**Orders of complimentary items will be sent out through early October while supplies last. You may also download the MARWeek logo and materials, such as sample messaging, from the "Medical Assistants Recognition Week" webpage, which is found within the "Education and Events" tab.*



Earn Free AAMA CEUs While Learning about FASDs

Want to expand your knowledge of addressing substance misuse in clinical settings in honor of FASDs Awareness Month? Check out these free CEU courses provided by the Medical Assistant Partnership for Healthy Pregnancies and in the AAMA e-Learning Center:

- *FASD Awareness: OBGYNs and Medical Assistants Collaborating to Make a Difference* (1 gen/clin CEU)
- *What Medical Assistants Need to Know about Opioid Use Disorders and Pregnancy in 2024* (1 gen/clin CEU)
- *Women and Alcohol: Prevalence, Trends, and Preventing Alcohol-Related Harm* (1 gen/clin CEU) ✦

AAMA Membership Reminder

Be on top of your dues—if you are hoping to serve as a delegate or alternate for your state society to the 2026 AAMA House of Delegates, be sure to pay your dues well ahead of the Dec. 31 deadline so that the AAMA is able to report your active status to your state. ✦

Scholarship Road

In honor of last year's recipients of the esteemed Maxine Williams Scholarship, we checked in to see how they are doing on their journeys as medical assistants:

Shalimar Guillermo, CMA (AAMA), graduated from Central Penn College in Pennsylvania in December 2024. Since then, she has been working as a credentialed medical assistant at the Penn State Health Cancer Institute.

Despite the intensity of the oncological setting, Guillermo loves every moment she spends with patients. "This experience has transformed my understanding of patient care—while clinical skills are essential, human connection is just as important," she says. "Caring for individuals during one of the most difficult times in their lives has deepened my ability to listen, empathize, and provide compassionate care."

Guillermo shares her gratitude for the Maxine Williams Scholarship: "Receiving the Maxine Williams Scholarship has been a tremendous help—not only financially, but also in boosting my confidence to pursue a new career path," she shares. "It reminded me that it is never too late to start over, especially when you're chasing a dream you're passionate about."

Jaclyn Pullum graduated with honors from Hartford Community College in May. Since graduation, she has been studying to take the CMA (AAMA) Certification Exam while working as a medical assistant in a fast-paced urology practice. At work, she takes on a range of clinical duties and channels her passion for working with patients.

"I find gratification in being able to support patients through their most vulnerable moments," she says. "Many don't have emotional or physical support at home, and I do my best to provide not just clinical care but compassion, patience, and a sense of comfort. Helping them feel seen, heard, and cared for is what makes this work so meaningful to me."

Pullum shares her gratitude for the Maxine Williams Scholarship and its contribution to her growth and transformation: "The scholarship did more than just help financially; it gave me confidence at a time when I was still finding my footing in this new career path. It reminded me that I was capable and worthy of investing in myself and my future. That encouragement pushed me through some of the more overwhelming moments."

Kenadee Weigel, CMA (AAMA), started working as a medical assistant at a fast-paced family medicine practice in the past year.

While the pace of the practice and the myriad responsibilities can be difficult to navigate at times, Weigel is grateful for the new experience and the opportunity to connect with and support patients. "It keeps me learning and growing," she says.

Weigel reflects on how the Maxine Williams Scholarship assisted her education: "The Maxine Williams Scholarship helped ease the financial burden of my education and allowed me to stay focused and committed to my goals. I'm so thankful for that support, and it has truly helped set the foundation for where I am today."

While Weigel's eventual goal is to continue her education and pursue a career in nursing, her role as a medical assistant has only deepened her passion for patient care and reaffirmed her love for health care. ✦

Put Safety First in September

The Medical Assistant Partnership for Healthy Pregnancies and Families (MAP) strives to reduce and prevent FASD by introducing and sustaining medical assistants' knowledge and practice behaviors.

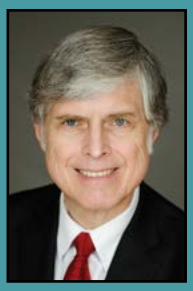
September is FASDs Awareness Month, a great time to explore the MAP website and its resources, including the Walk and Talk products, which medical assistants can use—even during brief moments with patients—while walking from the waiting room to the examination room. Choose from scripts, posters, index cards, and more to help you and fellow medical assistants improve your interactions with patients. Visit the MAP website (FASDMAP.org) for resources on these topics and more:

- Alcohol and Cancer Risk
- Pregnancy and Fentanyl
- Opioids and Naloxone
- Things to Avoid During Pregnancy
- Compassion Fatigue/Self-Care

The partnership between the AAMA and MAP acknowledges the unique role medical assistants have in forming communication links between patients and providers and motivating patients to avoid or stop dangerous alcohol consumption. Take action this FASDs Awareness Month and learn more about promoting alcohol- and substance-free pregnancies through these great, free resources! ✦

Protecting Medical Assistants' Right to Practice

A Retrospective: Part II



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

In Part I, I presented some of the successes of the American Association of Medical Assistants® (AAMA) in protecting medical assistants' right to practice under state law. In this article, I will discuss the AAMA's crucial role in ensuring that credentialed medical assistants were permitted to enter orders into the computerized provider order entry (CPOE) system for meaningful use calculation purposes under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

Medicare and Medicaid EHR Incentive Programs

As authorized by the United States Congress in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009, the Centers for Medicare & Medicaid Services (CMS) began establishing the Medicare and Medicaid EHR Incentive Programs (Incentive Programs) shortly after the HITECH Act was signed into law by President Barack Obama.

A key element of the Incentive Programs was that a certain percentage (respectively) of a licensed provider's (1) medication/prescription orders; (2) diagnostic imaging orders; and (3) laboratory orders had to be submitted electronically, and not by hard copy, to demonstrate the "meaningful use" of EHRs. Providers who did not meet these "meaningful use" percentage requirements in one or more of the three categories of orders would not receive incentive payments from CMS.

Who was allowed to enter orders into a CPOE system for meaningful use?

Medication, diagnostic imaging, and laboratory orders were entered into an EHR via CPOE systems. Early versions of the proposed CMS regulations stated that only "licensed health care providers" or "licensed health care professionals" would be permitted to enter orders into the CPOE system to determine whether the meaningful use percentages had been met. In other words, orders entered into the CPOE system by *unlicensed* staff could *not* be counted toward meeting the meaningful use percentage requirements.

As is still the case in 2025, very few states licensed medical assistants when the initial CMS rules were proposed in 2011 and 2012. This limiting language in the proposed CMS rules, consequently, was of great concern to the AAMA because many medical assistants were routinely entering orders into the CPOE system at that time. Indeed, entering orders into the CPOE system was the primary job task for some medical assistants. Forbidding medical assistants from entering orders into the CPOE system would have been catastrophic for the medical assisting profession and would have likely caused countless medical assistants to lose their jobs.

The AAMA Submitted Comments to CMS

In March 2012, CMS issued a *Notice of Proposed Rulemaking* regarding the order entry personnel requirements for the Incentive Programs. The AAMA was quick to express its vehement opposition to the exclusionary language of the proposed rule:

> There are a number of allied health professionals who are not licensed but who are formally educated in their disciplines, have a current [accredited] certification awarded by [a] national credentialing body, and have the [knowledge and competence] to be able to enter orders into the CPOE system as directed by an overseeing health care provider, such as a physician, nurse practitioner, or physician assistant.
>
> A good example of such allied health professionals is medical assistants who have graduated from a programmatically accredited postsecondary medical assisting program and who hold a current medical assisting credential that is accredited by the National Commission for Certifying Agencies [or under International Organization for Standardization (ISO) *Standard 17024*].
>
> Given the reality that a significant number of allied health professionals are not licensed by state law but are capable of entering orders into the CPOE [system] … without endangering the health and safety of patients, the AAMA respectfully requests that CMS alter the wording in its existing and proposed regulations to read as follows:
>
> > Use [CPOE] for medication[, diagnostic imaging, and laboratory] orders directly entered by any licensed ***or appropriately credentialed*** health care professional who can enter orders into the medical record per state, local, and professional guidelines.
>
> Allowing appropriately credentialed, as well as licensed, health care professionals to enter orders into the CPOE system as directed by a health care provider would not increase the risk of inaccurate information being entered into the [EHR] but would allow for enhanced patient care resulting from increased attention to patient needs and greater communication among the health care team. It would also lessen the disruption of the current division of labor within the health care [delivery] system.[1]

CMS Changed Its Rule

CMS amended its regulations to allow "credentialed medical assistants"—in addition to licensed health care professionals—to enter orders into the CPOE system for meaningful use calculation purposes. In the November/December 2012 issue of *Medical Assisting Today* (then *CMA Today*), the following was announced:

> Due, in part, to the advocacy efforts of the [AAMA], CMS decided that credentialed medical assistants—including CMAs (AAMA)—would be permitted to enter medication, [laboratory, and diagnostic imaging] orders into the [CPOE] system for meaningful use purposes. This is a major victory for the medical assisting profession, credentialed medical assistants, and the AAMA.[2]

Enforcement of the Meaningful Use Requirements

As the CMS order entry requirements became widely known, a question arose regarding the strictness of CMS enforcement of this rule. I addressed this in my December 19, 2013, *Legal Eye* post:

> When the [CMS] order entry rule went into effect, there was some speculation that CMS auditors would not have the authority to inquire about the credential status of medical assistants entering orders into the CPOE system.
>
> This speculation has no basis in fact. To qualify for payments under the [EHR] Incentive Programs, providers will be required to present documentation of all entries, many of which are automatically kept by the EHR system. CMS auditors have the authority to determine whether entry of medication, laboratory, and diagnostic imaging orders has been made by licensed health care professionals or credentialed medical assistants. If it is discovered that order entry was done by individuals other than licensed professionals or credentialed medical assistants, the auditors could cite this violation, and it is possible that the order entry by these individuals would not be counted toward meeting the meaningful use thresholds. As a result, the eligible professional may not meet all the core objectives and consequently would not receive incentive payments.
>
> The reality of these audits only serves to emphasize the importance of employing credentialed professionals in the health care setting.[3]

To reinforce the importance of abiding by the meaningful use rule, the Department of Health and Human Services—the cabinet-level executive branch agency of which CMS is a part—announced the following audit plan:

> Any eligible professionals (EPs) who received incentive payments from Jan. 1, 2011, to June 30, 2014, are eligible to be randomly selected for auditing. The OIG will review certain meaningful use measures to determine whether selected EPs incorrectly received any incentive payments, and whether those EPs have adequately protected patients' health information created or maintained by the EHR. As part of the auditing process, the agency will request specific information and documentation of compliance with the meaningful use measures under review.[4]

Expiration of the Incentive Programs

As planned by CMS prior to the start of the Incentive Programs, both the Medicare and Medicaid EHR Incentive Programs ceased functioning by December 31, 2021. Nevertheless, the residual benefits of the Incentive Programs for the medical assisting profession and credentialed medical assistants continue to this day. ✦

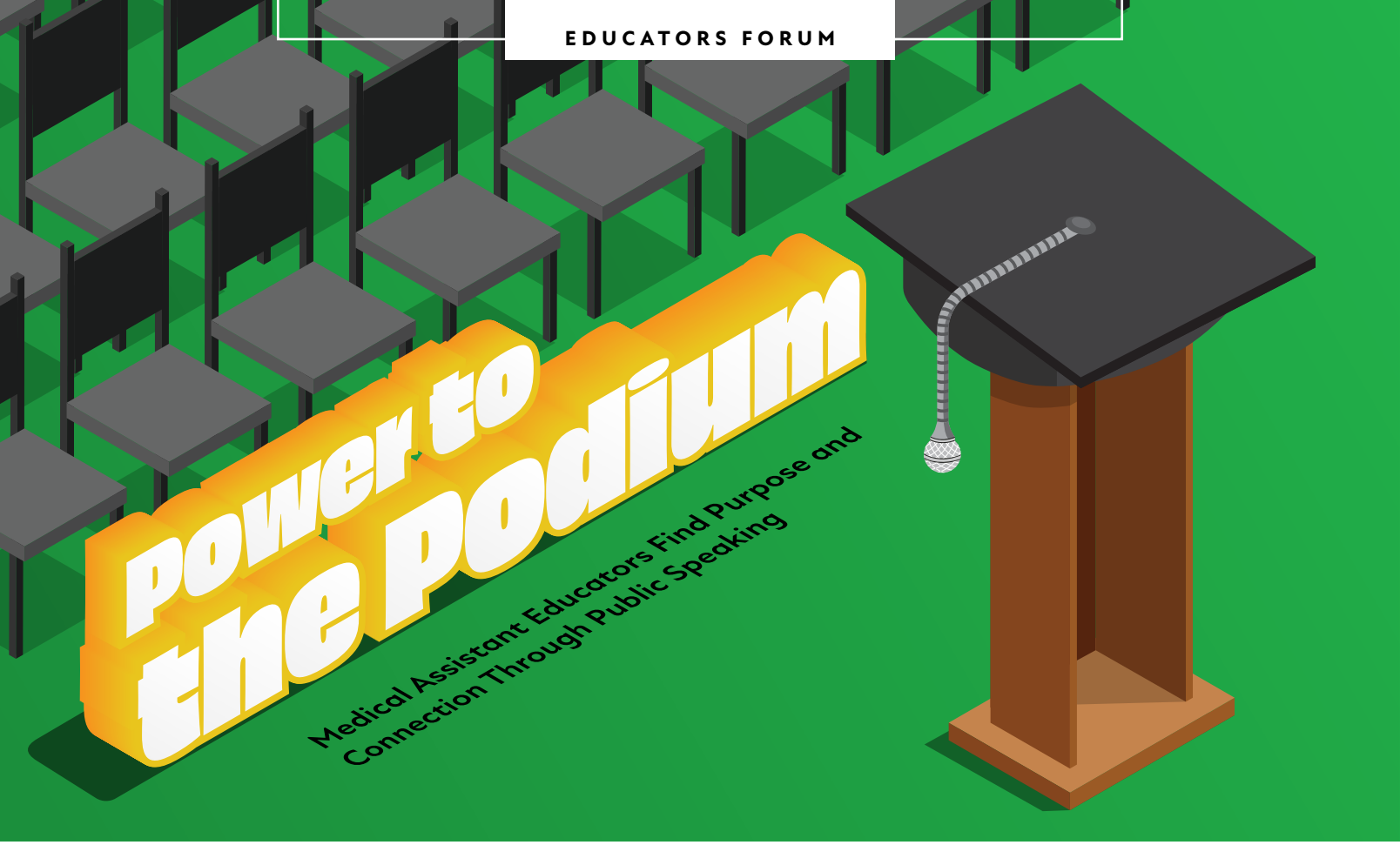
Questions may be directed to CEO and Legal Counsel Donald A. Balasa, JD, MBA, at DBalasa@aama-ntl.org.

References

1. Balasa D. AAMA comments on the proposed CMS rule. *CMA Today*. 2012;45(3):6-7.
2. Balasa D. AAMA triumphs in CMS order entry rule. *CMA Today*. 2012;45(6):6-8.
3. Balasa D. Audits and the importance of credentialing for order entry. *Legal Eye* blog. December 19, 2021. Accessed August 15, 2025. https://aamalegaleye.wordpress.com/2013/12/19/audits-and-the-importance-of-credentialing-for-order-entry/
4. Balasa D. OIG Initiates Audit Program of the Medicare EHR Incentive Program. *Legal Eye* blog. April 21, 2015. Accessed August 15, 2025. https://aamalegaleye.wordpress.com/2015/04/
5. The CMS rule for meaningful use order entry, question and answer session (11/1/2013). AAMA. November 20, 2013. Accessed August 15, 2025. https://www.youtube.com/watch?v=yQiy6bmwEII

Joint CMS and AAMA Presentation

Learn more about this success via a presentation and question-and-answer session presented at the 57th AAMA Annual Conference[5]:



Power to the Podium

Medical Assistant Educators Find Purpose and Connection Through Public Speaking

by Pamela Schumacher, MS, CCMP

"There are only two types of speakers in the world: the nervous and the liar."

—Mark Twain

Medical assistant educators who speak at conferences and on panels tap into a powerful platform they can use to share their expertise, elevate their professional profile, and expand their network. Additionally, presenting at conferences allows educators to not only contribute to the advancement of best practices and training standards but also position themselves as thought leaders in their field.[1]

Amplify Your Impact

"As educators, we should never stop learning or networking. All educators should consider speaking at conferences to share their knowledge with as many people as possible," says Melody Gibson, MHRD, CMA (AAMA), CPT (ASPT), RPSGT, associate dean of allied health and director of the medical assisting program at Gaston College in Dallas, North Carolina. "Being a conference speaker allows us to step out of our comfort zone and practice what we preach in our classes. We are training medical assistants to be patient advocates and leaders in health care. We should be a shining example for them."

"Speaking is a wonderful opportunity for education—your audience's education and your own. I learn something new every time I give a presentation," notes Teresa L. Schraeder, MD, author of *Physician Communication: Connecting with Patients, Peers, and the Public.* "It also promotes your ideas and provides recognition for you and your work, and you might even connect with others for new projects. I've had people come up to me after a speech, saying they're working on a project, and they invite me to collaborate with them. You'd never get these opportunities if you didn't put yourself out there."

"A conference is the perfect audience, so why not take advantage of the opportunity?" says Cyndi Maxey, MA, CSP, a speaker, consultant, and author of *Present Like a Pro: The Field Guide to Mastering the Art of Business, Professional, and Public Speaking.* "A conference audience consists of people who do what you do, people who might hire you, and even meeting planners for other events. There's a nice variety of people that you don't find in other places."

Manners of Speaking

In addition to educational sessions, panels, and workshops, associations host various events, such as meals, receptions, community gatherings, and even specialty groups, where you can connect and collaborate.

"Make yourself available to learn and interact," says Gibson. "Volunteer to join an AAMA committee and committees on your campus. This can give you exposure and [connections to] other professionals. Doing this has brought me out of my building and day-to-day activities into the larger community."

Dr. Schraeder, who teaches the Physician as Communicator scholarly concentration at the Warren Alpert Medical School of Brown University in Providence, Rhode Island, urges educators to seek speaking opportunities in their local communities.

"If you are ever asked to speak by a superior or a colleague, you should definitely take the opportunity," she says. "Even if it's an in-service or an educational meeting, just

say, 'Yes!' because the more often you speak, the better you'll get at it. You can also create your own opportunities by thinking outside the box. Would senior centers, park districts, or libraries benefit from your information? Talk to your colleagues and your superiors about opportunities that might be available. Does your medical [practice] need someone to go to the local school to give a presentation? Always be thinking, 'Is there an audience that would benefit from my work and information?' and then find a way to get in front of them."

"I can't say this enough: it's imperative to join your national and local associations," says Maxey. "Speaking at a local event to a small group of colleagues will give you the confidence to speak at a national conference, but don't just stop at medical assisting conferences. … One day, I got a flyer about an organization that did telemarketing, and I wasn't into telemarketing, but I was interested in the topic. I sat at the table next to a woman, and we started talking. She was an executive in a customer service group in a hospital, and I have a background in telephone customer service. She became a client for the next 10 years, so attending other professional meetings can be a way to easily expand your network."

Heard Mentality

You may want to speak at a conference or on a panel, but you are terrified of speaking in front of an audience beyond your students. You are not alone. The fear of public speaking is the most common phobia, ahead of death, spiders, or heights. The National Institute of Mental Health reports that public speaking anxiety, or glossophobia, affects about 40% of the population.[2]

You can calm your fears and give an effective and engaging presentation by following these tips[1]:

- Know your subject well.
- Know your audience, their expectations, and potential questions they may have.
- Start with an impactful opening statement.
- Share a relatable story or case study.
- Practice.
- Take deep breaths, slow down, and appear confident, even if you do not feel it.

"Give your speech to your colleagues or even your dog. Memorize your opening lines and be very familiar with your slides," advises Maxey. "And if working with notes—which I recommend—keep them simple. Do not read every word of your notes—that's not a presentation, that's manuscript delivery. … My slide presentation is usually available on the conference portal, but I often also provide a one-sided handout with no more than four to five bullet points. If there's a longer article, I'll provide a link to that. People don't want to be overwhelmed with 20 things to remember from your presentation."

"The most important thing in public speaking is to be yourself," notes Dr. Schraeder. "You may watch other speakers, teachers, or presenters and notice what you like about them, but you don't have to look or sound like anyone but yourself. Even if you are an introvert, you can still give a great public speech.

"Think of yourself in a one-on-one conversation with the audience. If you make a mistake, it's perfectly okay to correct yourself," says Dr. Schraeder. "And make eye contact. Find one friendly face and talk to them for a minute, and then find another friendly face, and that way you move around the room. I am convinced that most people have all the tools they need to be a great communicator; they just need to practice beforehand to bring out their best." ✦

Gift of the Gab

Teresa L. Schraeder, MD, suggests using her MACY Method when preparing a presentation[3]:

- **M**ission: Why are you speaking, and what is your purpose?
- **A**udience: Who is your audience, and what do they need from you?
- **C**ontent: Make it organized and informative. Be concise, relevant, and engaging. Tell a story. Make sure there is a clear beginning, middle, and end. Have specific points, but be prepared to improvise.
- **Y**ou: Be prepared, organized, and rested. Rehearse at least twice in the week leading up to the talk. Visualize giving a great speech and practice breathing exercises beforehand.

Prep Talk

Cyndi Maxey, MA, CSP, offers tips for preparing to be on a panel:

- Be very clear with the moderator about what they want from you.
- Prepare your key points in advance and practice them.
- Don't waste time; when it's your turn to talk, state your point and thank the moderators and other participants afterward.
- Take the stage. Don't apologize for being asked to participate.
- Watch your nonverbals, distracting postures, or movements.
- Avoid being too academic, and state your point briefly.

References

1. Vogel WH, Viale PH. Presenting with confidence. *J Adv Pract Oncol.* 2018;9(5):545-548. Accessed August 14, 2025. https://doi.org/10.6004/jadpro.2018.9.5.9
2. Public speaking anxiety. National Social Anxiety Center. Accessed August 14, 2025. https://nationalsocialanxietycenter.com/social-anxiety/public-speaking-anxiety/
3. Schraeder TL. Public speaking and presentation skills. In: Schraeder TL. *Physician Communication: Connecting with Patients, Peers, and the Public.* Oxford Academic; 2019. Accessed August 14, 2025. https://doi.org/10.1093/med/9780190882440.003.0003

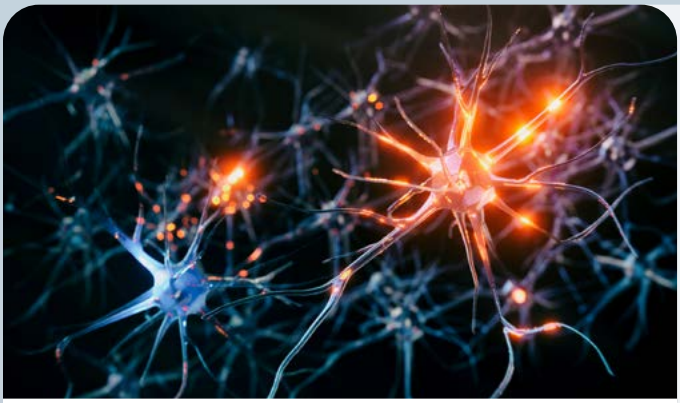
Parents, Plus One

A new in vitro fertilization (IVF) procedure pioneered in the United Kingdom shows promise for reducing the threat of mitochondrial DNA diseases transmitted from mother to child.

Published in the *New England Journal of Medicine*, the study highlights the innovative IVF technique, pronuclear transfer, which includes DNA from three individuals—two parents and a female donor. The procedure, performed after the egg is fertilized, "involves transplanting the nuclear genome (which contains all the genes essential for our individual characteristics, for example, hair color and height) from an egg carrying a mitochondrial DNA mutation to an egg donated by an unaffected woman that has had its nuclear genome removed," as described in Science Daily. "The resulting embryo inherits its parents' nuclear DNA, but the mitochondrial DNA is inherited predominantly from the donated egg."

Thus far, eight babies (four girls and four boys) have been born through the technique to seven women at high risk of transmitting serious diseases to their children. All eight babies show no sign of having the disease-causing mitochondrial DNA mutations.

"After years of uncertainty this treatment gave us hope—and then it gave us our baby," says the mother of one of the baby girls from the study. "We look at them now, full of life and possibility, and we're overwhelmed with gratitude. Science gave us a chance."



Water Quality Not Up to Par

Many people enjoy golf courses' idyllic, pastoral nature. Indeed, homes built near golf courses command top dollar. A new study suggests, however, that those wide, weed-free swaths of green (the result of regular applications of pesticides), may come at a significant public health cost—increased incidence of Parkinson disease (PD).

The study, published in *JAMA Network Open*, examined 139 golf courses in Minnesota and Wisconsin and analyzed 419 cases of PD. The researchers found an association between living near a golf course and a higher risk of PD: "Living within 1 mile of a golf course was associated with 126% increased odds of developing PD compared with individuals living more than 6 miles away from a golf course." They also note that the largest effect sizes were found "in water service areas with a golf course and in vulnerable ground-water regions."

The American Parkinson Disease Association acknowledges that people who live near golf courses or share a golf course's water system "may reasonably be concerned about their increased risk of PD" and suggests that these individuals consider a home water filtration system as one step to allay such concerns.

Emerging Trends for Emergency Departments

Even if George Clooney is your attending physician, a visit to the emergency department (ED) is no picnic, much less a panacea—especially for older adults, who are susceptible to delirium, functional decline, and mortality induced by an excessively long ED stay.

An article in *JAMA Network* discusses this troubling trend, which has accelerated in recent years despite such efforts, such as the Age-Friendly Hospital Measure developed by the Centers for Medicare & Medicaid Services (CMS), to enhance the care of older patients in various hospital settings.

The article covers a study in *JAMA Internal Medicine*, "Prolonged Emergency Department Stays for Older U.S. Adults," which reviews the growing practice of boarding, in which patients are held in the ED awaiting a hospital bed. As of this year, CMS requires hospitals to attest to their procedures for keeping ED length of stay to fewer than eight hours and boarding time to three hours for a percentage of older adults. As the study illustrates, however, "20% of ED patient encounters had a length of stay of more than 8 hours at the end of 2024, an 8-percentage-point increase from the start of 2017."

The authors state that the causes for this unfortunate increase are numerous, ranging from health care workforce shortages and the aging population to a lack of hospital bed capacity. Analysts agree that the issue will require a multipronged effort to fully address "a system-wide approach that moves beyond hospital walls," concludes the article's author, Virginia Hunt.

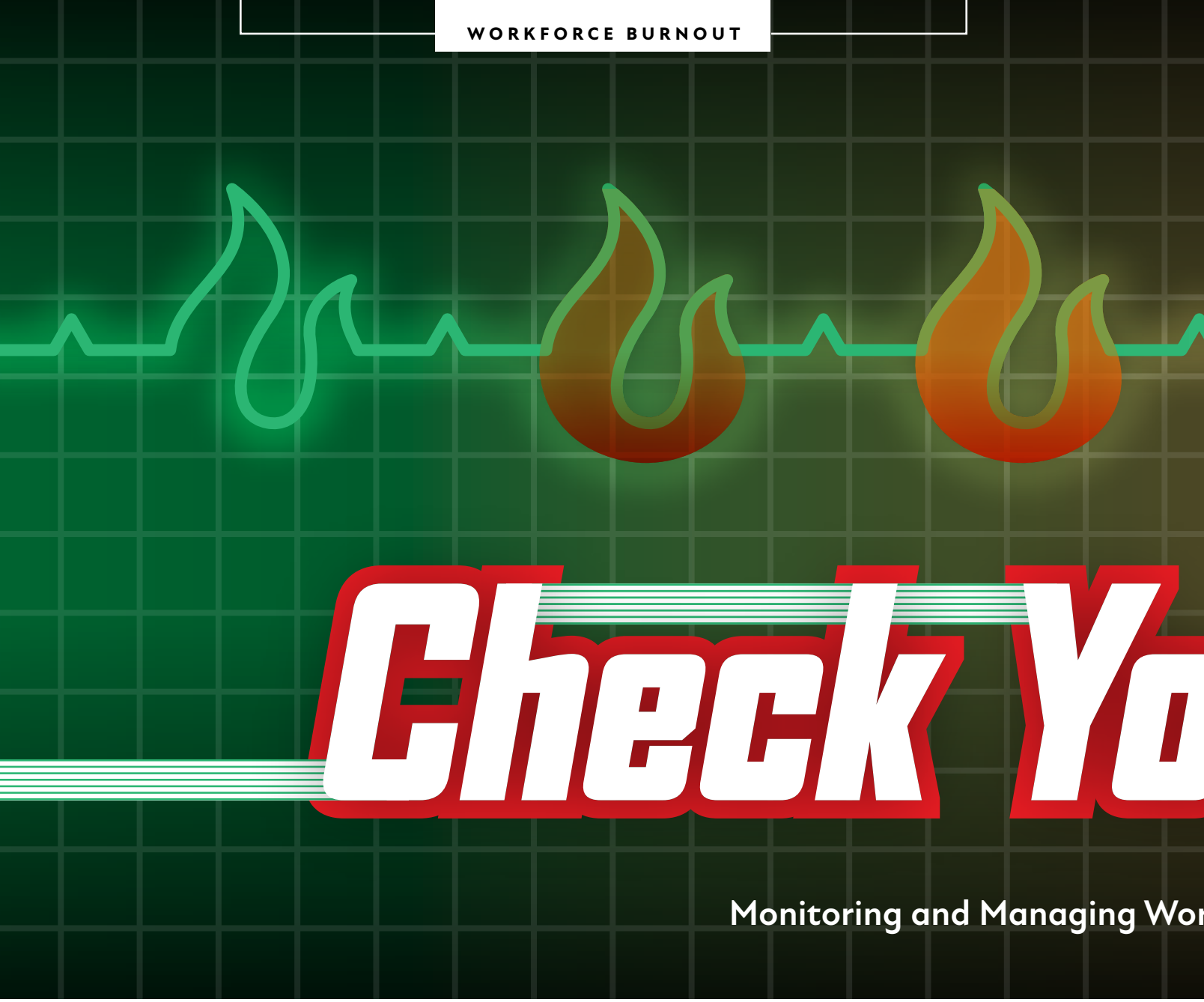
ACA Health Care Premiums to Rise Dramatically

In 2026, anyone with Affordable Care Act insurance might decide their insurance has outgrown its name. A recent analysis by health policy research group KFF predicts a rise of 75%—the largest increase in more than five years—in premium costs for individuals who buy their insurance via Healthcare.gov or state-based marketplaces.

The cause? The expiration of enhanced premium tax credits in the ACA markets. These credits, which started during the COVID-19 pandemic, greatly reduced the cost of federal and state coverage but are set to expire in 2026.

KFF predicts that in 2026 millions of Americans will forgo the expanded cost of health care coverage and choose to be uninsured. Many of these individuals will be relatively healthy, leaving behind a pool of insured people who are sicker, have chronic conditions, and require pricy medications. With this market of higher-need individuals, insurers are planning their 2026 premium increases to account for this higher-cost contingent of insured individuals.

The impact of the recently adopted One Big Beautiful Bill Act and tariffs will also contribute to the rising premiums, notes KFF. Hospitals, especially those in rural areas and safety-net institutions serving Medicaid patients, will face growing financial pressures, as detailed in an analysis by PwC. The perpetual rise in health care costs is another contributing factor; these are predicted to continue as well, similar to last year's reported 8% increase.



Check Yo

Monitoring and Managing Wor

By Mark Harris

The health care system is remarkably complex and is built upon the training, skills, and dedication of the many people who comprise the system's diverse workforce. From physicians and licensed practitioners to administrators, medical assistants, technicians, and numerous other professionals, the health professions encompass a diverse range of occupations, skill sets, and responsibilities.

The modern health care system also represents one of the nation's largest workforce sectors, constituting 9% of total employment in the United States as of 2022.[1] As a service-oriented industry devoted to human health, the stakes are invariably high that the medical system functions at an optimal level of quality, efficiency, and performance.

For many health care professionals, working in the medical field can involve years of education and training, adherence to licensure and professional standards and guidelines, and the ability to meet the numerous daily responsibilities and demands of patient care.

While there are unique pressures associated with work in the health care field, a number of modern stressors also weigh on today's workforce. These include poor work conditions exacerbated by staffing shortages, excessive workloads, salary and contract issues, and other operational challenges. The impact of the COVID-19 pandemic further complicates these challenges.

When left unaddressed, chronic workplace stressors in health care can impair the well-being and performance of both individuals and organizations. For staff, these stressors can eventually lead to job burnout, which the American Psychological Association (APA) characterizes as involving ongoing emotional exhaustion and other negative symptoms.[2] The APA warns that these stressors go beyond the usual or expected pressures of most workplaces. For health care providers and organizations, unmanaged workforce stress can lead to high rates of absenteeism, staff turnover,

and declines in job performance. Meanwhile, workforce burnout can also increase the risk of medical errors.[3]

Chief Concerns

Workforce burnout is not a medical condition. The concept of burnout is classified in the *International Classification of Diseases, 11th Revision* (*ICD-11*) as an "occupational phenomenon," according to the World Health Organization.[4]

The inclusion of burnout in *ICD-11* reflects the significance of the phenomenon. The *ICD-11* describes occupational burnout as follows:

> Burnout is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions:
>
> - feelings of energy depletion or exhaustion;
> - increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and
> - reduced professional efficacy.[4]

Undoubtedly, the COVID-19 global pandemic placed an enormous strain on the health care system's workforce. Nearly half (46%) of health care workers reported often feeling burned out in 2022, according to the Centers for Disease Control and Prevention. Nearly as many also expressed interest in finding a new job at that time.[5]

While the acute stressors associated with the pandemic have lessened since the height of the public health emergency, symptoms of workforce burnout remain higher than pre-pandemic levels.[6] Several factors may explain these persistent stressors, according to industry experts.

"While we don't face the same burden of acute and life-threatening illness that we saw during surges in the pandemic, what has not returned to pre-pandemic levels is the total volume of care that is occurring in American health care facilities, both ambulatory and inpatient," says Jeff Salvon-Harman, MD, CPE, CPPS, vice president of safety at the Institute for Healthcare

Improvement (IHI). "And not only the sheer number of those patients, but the complexity of those patients. Thirty years ago, we would typically see one or two chronic conditions in the same patient when they would present for care. Now, we tend to see four or more chronic conditions in patients who are presenting for acute care."

> "The features of a thriving health care workforce are well understood: the most joyful, engaged, productive staff feel both physically and psychologically safe, perceive belonging, appreciate the meaning and purpose of their work, have some choice and control over their time, experience camaraderie with others at work, and perceive their work life to be fair and equitable."[12]
>
> —Institute for Healthcare Improvement

Business-related factors are further contributing to workforce pressures. "We see many more challenges in the payer structures that support the economics of health care," says Dr. Salvon-Harman. "We continue to see the health care workforce and workplace being asked to lean down in the sense of getting very lean and eliminating waste and inefficiencies. But also, it is resulting in leaning down of the size of the workforce—the continued [expectation] of doing more with less. That's a large part of what's driving burnout for many in our workforce."

As Dr. Salvon-Harman notes, the topic of workforce well-being encompasses themes such as burnout, moral injury, the sense of belonging or disconnection at work, and the physical safety of the workforce. Notably, the concept of moral injury involves a sense of ethical or moral disconnection that occurs when a care provider believes regulatory or payer influencers, or other limiting factors, are barriers to what they believe is the right or more caring course of action for a patient.

"Within the different professions in the workforce, we see slightly different influences, but in general, the workforce is still experiencing significant stressors and a combination of both burnout and moral injury in their day-to-day work," remarks Dr. Salvon-Harman. "We know, particularly among medical assistants and in the acute care setting, … that they have among the highest turnover of any of the health professions. In the ambulatory setting, we've seen a [shift] away from professional nurses and [toward] medical assistants. So, there is an increasing number of that workforce segment, while we see [a decrease] in nursing to support them. This contributes [to the burnout in] the medical assistant community."

As Dr. Salvon-Harman explains, health care organizations must address these rates of staff turnover, especially because direct care workers are among those who encounter and interact most with patients.

How Are You Feeling?

In response to these workplace challenges, IHI provides collaborative support to health care groups interested in enhancing workforce well-being within their organizations. As part of a strategic approach, IHI's Improving Joy in Work initiative offers health care leaders and organizations a range of professional development tools, trainings, and resources that can help create a more positive and well-functioning work environment.[7]

In recent decades, patient-centered care has emerged as a guiding framework in the medical field. It is a care philosophy in which the patient-provider relationship is fundamentally viewed as a partnership, one informed by open communication, close listening, and valued regard for the patient's concerns.

Accordingly, as Dr. Salvon-Harman explains, the merits of this patient-centered approach are now finding application in many workforce improvement initiatives. Just as clinicians must listen to patients to learn what matters to them, health system leaders and managers should also listen to staff, recognizing, acknowledging, and addressing their workplace needs and concerns as necessary and appropriate.

"I think the hallmark of the Joy in Work framework is the question, 'What matters to you?' " says Dr. Salvon-Harman. "We often make assumptions, or we just don't have those conversations with staff. We might fear that we'll get drawn into a lengthy discussion or hear about concerns that we don't have any control over and can't address. And so, we avoid the conversation altogether. I think it can be a missed opportunity to explore and understand [the] staff's concerns. Are they all outside our control, or are there concerns we could [address] that would dramatically change workforce well-being, not only for [a single] workforce member but potentially others with similar perspectives?"

As Dr. Salvon-Harman notes, the "What matters to you?" movement was originally focused on asking patients what matters to them to understand the levels of care they would desire and how their life goals align with their medical care and interventions. In other words, what do they desire from their health care experience, and how does that tie into their life outside of health care?

"It's a somewhat logical step to think about how we would apply that type of thinking to our workforce and to ask them what matters," explains Dr. Salvon-Harman. "What would remove barriers and increase your connection to work, your connection to patients, and your engagement in your role and with the organization? That's really what the Joy in Work framework centers around: getting past those misperceptions and barriers to asking the question and being prepared to receive this information. It's much like we try to prepare health care leaders for 'intentional rounding,' as it's known: not just visiting as a blank slate outside of your [practice] to where the care is occurring, but also being prepared with questions for the staff. And then being prepared for how to receive the answers to those questions."

To note, the term *intentional rounding* originally refers to a hospital nursing practice that involves a timed, planned intervention to address key elements in the patient's care.[8]

For managers, IHI's framework also provides practical guidance on how to prepare, engage in, and follow through on the "What matters to you?" conversations. IHI also recognizes that these workforce challenges must be consistently addressed at every level of leadership and of the organization. Dr. Salvon-Harman advises that there should be

a senior leader champion, someone who can model the organization's values, priorities, and commitment to the staff's well-being. A strong leadership commitment will also help ensure the group's improvement efforts prove durable and lasting.

Pulse Checks

Even without an organization-wide leadership initiative, medical practices can take steps to foster a more positive work environment. For instance, managers and supervisors can strive to cultivate strong, ongoing communication channels in the practice, conveying their interest in staff concerns, perspectives, and feedback.

"A lot of medical practices, and businesses in general, do annual reviews with employees," says David J. Zetter, PHR, SHRM-CP, CHCC, president of Zetter Healthcare Management Consultants in Mechanicsburg, Pennsylvania. "As a [human resources] person, I've never supported that. I've always said you should manage as you move. What I mean is that managers should be [communicating with] their employees on a regular basis. A manager should not be in their office too much. They should be out walking around, talking to staff, and observing what they go through each day. Understanding what the challenges are, supporting the staff, and providing solutions to the challenges they face [is] the manager's job."

In practical terms, Zetter suggests managers have a conversation with each employee about once a month. "Even if it's only for five minutes, it can help," he says. "This should be a serious conversation in which you're not interrupted, you're taking notes, and you then act on whatever the employees tell you."

Likewise, managers should convey to staff that they are approachable, says Zetter: "As a manager, you should have an open-door policy, so staff feel comfortable coming to you. They need to know that [regardless of what] is happening, if they tell you something, no matter how bad it is or how big an emergency, they are in a safe place. You're going to listen intently, take notes, and then you're going to provide action. Once staff feel that you're listening, [they] will tell you anything. Just give them the opportunity."

Continuing staff education and training should be another priority, suggests Zetter. "One of the biggest challenges for most medical practices is [that] they don't train and educate their employees in an ongoing fashion to become better at their jobs," he remarks. "I would encourage practices to invest in staff training and education. I have known practices with coders [who] have not been to a training class or coding update in years. How [can] they do a good job if the practice is not willing to pay for their continuing education? The same is true for billing and front-desk staff. The risks [of] burnout increase when staff aren't educated [on] how to do their jobs [more effectively] and with the management support they need. You don't want staff to feel like they're alone on an island, trying to take care of all their responsibilities. If the practices are not willing to invest in their education, that is also telling the employees something."

Taking Notes

While workforce stress in the health care system is pervasive, individual health systems and organizations will weather these challenges differently and to varying degrees of success.

An informative 2021 study in the *Journal of Healthcare Management* offers valuable insights into the nature of workforce resilience among medical assistants at a large academic medical center. The study surveyed the large medical assisting workforce at Stanford Health Care in Palo Alto, California, on factors influencing well-being and burnout. These measures included the impact of control, organizational culture, team knowledge, self-efficacy (a person's belief or confidence in their ability to perform a job successfully), and professional fulfillment and meaningfulness in the work experience.[9]

The organizational culture, professional fulfillment, and self-efficacy were identified as key factors in assessing the potential for burnout. Notably, a negative perception of the organizational culture was identified as the strongest predictor of burnout.

The Stanford study reported that burnout among its large medical assisting workforce was low, while professional fulfillment and meaningfulness ranked high. The study first surveyed Stanford's medical assisting staff in 2018 with a follow-up survey in 2022. Significantly, the latter survey found levels of burnout had not worsened for this workforce, despite the new stressors associated with the COVID-19 pandemic.[10]

For study coauthor Timothy Seay-Morrison, EdD, LCSW, senior vice president and chief administrative officer of ambulatory care operations and service lines at Stanford Health Care, the results were both revealing and encouraging. "The balance to that burnout measure is professional fulfillment, and medical assistants find a lot of fulfillment in the work that they do," says Dr. Seay-Morrison. "They feel like they're contributing to the mission, and they impact people's lives. They enjoy being on teams and understand how to communicate on teams. They also have good coping skills and boundaries."

Notably, medical assistants at Stanford Health Care are classified as patient care coordinators (PCC), with commensurate responsibilities and opportunities for career advancement. The medical center uses a tiered

> "In most cases, when something goes wrong in health care, it's [despite] valiant efforts and desire to do the right thing. It's driven more by complexity or insufficient system design, where parts are not appropriately connected, the dots aren't connected, [or communication doesn't] occur. Time and volume pressures, productivity, revenue generation—all of these outside influences intersect with the health care workforce. And so, we have to recognize and address the vast contribution of system factors that are driving burnout. Otherwise, it's like trying to put a bandage on an arterial bleed but not actually addressing the source of that arterial bleeding."
>
> —Jeff Salvon-Harman, MD, CPE, CPPS

system for the PCC role, with PCC I, II, and III levels to categorize the position.

"The medical assistants we attract and retain are those [who] are looking to work in a complex environment," reports Dr. Seay-Morrison. "The reason we call the job *patient care coordinator*—and they're very attached to that title—is because their job [goes] beyond the basics of what is in a medical assistant's scope of practice. In physician practices across the country, medical assistants are people of many attributes. They do so much work that keeps the practice moving and the patients well cared for. But here at least it's built into the job description and to their progression ladder."

Dr. Seay-Morrison elaborates on what it means for medical assistants to join the Stanford Health Care team. "At Stanford, you would join us as an entry-level medical assistant/patient care coordinator and have very typical medical assistant tasks like rooming and [taking] vitals, responding to the physician's requests, front-desk operations, and more," he says. "But then we add in other responsibilities like care coordination that might sometimes fall to nursing, social work, or other disciplines, even though it doesn't require a license or expertise in that field. [However,] it is an area in which a medical assistant can certainly [perform tasks such as] complex scheduling and [guiding] a patient through their treatment journey. They can pass on medical education. They can relay important messages and provide guidance within protocols. And they can participate in resource finding and performance improvement."

Regarding the latter, Dr. Seay-Morrison describes an improvement philosophy that seeks to empower the medical assisting workforce. "In our world, because we want all of our staff engaged in performance improvement, they write their own problem statements, and we train them to work on fixing problems and empower them to help us solve problems and make the workplace better," he explains.

Resources

Centers for Disease Control and Prevention: The National Institute for Occupational Safety and Health
https://www.cdc.gov/niosh/healthcare/risk-factors/stress-burnout.html

Institute for Healthcare Improvement
https://www.ihi.org

Stanford Health Care
https://stanfordhealthcare.org

As nonexempt employees, medical assistants follow defined shift hours, breaks, and workplace responsibilities. In California, a state historically known for strong labor regulations, these boundaries may provide a layer of protection from the workforce pressures associated with burnout. However, like other health care professionals, medical assistants are also affected by the many modern system pressures that are affecting health systems.

"We know medical assistants have also been plagued by many random changes in what they're asked to do—to take on new population health measures and new ways of communicating with patients and families and more," notes Dr. Seay-Morrison. "They've experienced these impacts too. But for many reasons, their capability to remain [within boundaries] is perhaps one of the learnings we can take from medical assistants for other disciplines."

Indeed, one enduring impact of the COVID-19 public health emergency may be a shift in perspectives among health care leaders and the workforce itself toward how to approach the work environment.

"Is work really different from [before the] pandemic?" asks Dr. Seay-Morrison. "No, but perhaps the pandemic gave us some perspectives that change the way we approach work, especially in health care. These are demanding and highly regulated [jobs,] and the American health care system is not [very] efficient. The work burdens and what we expect of the people in this environment are emotionally [and] physically taxing. All of the different complexities of the job weigh on people [as well as] the amount or pace at which individual workers have to adapt to change, [whether] through new regulatory requirements, new documentation methodologies, [or] the ever-changing landscape of what payers or the government expect in terms of [performance]. It's super dynamic."

Indeed, one consequence of the pandemic may be a shift toward more awareness of how well health systems, including staff, are coping and functioning, observes Dr. Seay-Morrison. In turn, this awareness could lead to updated or improved assessments of how health care organizations approach workforce issues, including monitoring, measurement, and improvement activities.

"How are we taking responsibility for our workforce?" asks Dr. Seay-Morrison. "I think [that while] health care has been more rigid than other industries, the pandemic has challenged us to think about how we can be more flexible [and] about what is possible. The pandemic has also changed our perspective on what individuals need to feel good about the work they're doing and what is most important in life—how much of the work can be done flexibly or remotely, for example, as well as our understanding and ability to talk about these concerns."

As an executive leader, Dr. Seay-Morrison has a great appreciation for the contributions the medical assistant workforce brings to Stanford Health Care. "We've learned this population has a lot of strengths and understands how to take care of themselves and balance work and fulfillment well," he concludes. "We try to lean on what those strengths are. In a highly technical and professionalized world, … our practice environments [rely on individuals] who choose to [pursue] medical assistant–level work. They are our core workforce in the ambulatory practice environment. They are so impactful. You can ask any physician when their medical assistant position turns over, it's almost like a crisis because they know so much."

Accordingly, the Stanford Health Care vice president is a strong advocate for health

system investment in individual and collective growth and development of the medical assisting workforce. "I believe it's an investment that will pay off for everybody," concludes Dr. Seay-Morrison.

Checking All the Boxes

Investment in workforce development and well-being is foundational to the health care system's ability to consistently deliver high-quality patient care. In the current industry climate, this challenge remains a pressing concern and responsibility.

Indeed, health care workers continue to leave the industry for a variety of reasons. Evidence suggests "substantial and persistent" turnover in the health care workforce both during and after the height of the pandemic, according to a 2024 *JAMA* report.[11]

"In countering burnout, I think workforce development is a big deal," agrees Taylor Roemer, a medical assisting supervisor at the Native American Health Center in Oakland, California. "For instance, I would love to have medical assistants take more advantage of their education benefits and see what avenues they can grow into in their careers. I understand [that] many unionized health systems [offer] good educational benefits, for example, but they're [often] underutilized. Medical assistants should [be aware of the] educational benefits [available to them at] their place of employment. In terms of career growth, management has opportunities to speak on these issues and do more to encourage their employees to move forward and grow. But they're not always doing that. The risk is that staff can become stagnant in their careers. Medical assistants should be aware of opportunities to further their professional development."

One enduring result of the pandemic may be a greater emphasis on work-life balance, adds Roemer, whose career also includes experience as a medical assisting educator. "During the pandemic, medical assisting and frontline staff had to become a lot more flexible," she explains. "And in that, we learned we can do some of the administrative tasks we have at home. This gave us more flexibility with some of the work we do. However, since coming back into the workplace, I think some people are finding it more stressful to be in the office now, doing tasks they feel they could easily do at home and still be productive."

In turn, Roemer also expresses concern about current management pressures to incentivize overworking. "It's leading to people [who] are not able to move forward in their careers [to consider changing] careers [or going] into different sectors," she reports. A positive work environment also should respect staff in everyday ways, she believes. "In terms of overall job satisfaction, I think not being made to feel guilty if you [desire] to take a vacation, for example, is important," says Roemer. "[No one should] be made to feel like they are responsible for getting their shifts covered. Everyone should know how to work with each other."

Health care leaders, providers, and staff are currently more willing to think critically about established expectations surrounding work. In terms of hours, schedules, and other parameters, what are reasonable expectations for the workforce before a job becomes overburdening? In terms of the impact on a person's life, what should it mean to be employed as a health care professional? These questions will continue to deserve examination and discussion.

Certainly, a fully engaged and thriving work environment, where job satisfaction and personal fulfillment are nurtured and supported by fair compensation, benefits, and clear work parameters, is a prerequisite for the health system's ability to deliver quality patient care. With fresh leadership perspectives, vital input from every employment sector, and the resolve of health care organizations committed to improvement, the long-term goal of creating a healthy, well-managed, and positive workforce environment is achievable. ✦

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

References

1. Smith S, Blank A. Healthcare occupations: characteristics of the employed. US Bureau of Labor Statistics. June 2023. Accessed August 15, 2025. https://www.bls.gov/spotlight/2023/healthcare-occupations-in-2022/home.htm
2. Employers need to focus on workplace burnout: here's why. American Psychological Association. May 12, 2023. Accessed August 15, 2025. https://www.apa.org/topics/healthy-workplaces/workplace-burnout
3. Garcia CdL, Abreu LCd, Ramos JLS, et al. Influence of burnout on patient safety: systematic review and meta-analysis. *Medicina*. 2019;55(9):553. doi:10.3390/medicina55090553
4. Burn-out an "occupational phenomenon": International Classification of Diseases. World Health Organization. May 28, 2019. Accessed August 15, 2025. https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases
5. Health workers face a mental health crisis. Centers for Disease Control and Prevention. Updated October 24, 2023. Accessed August 15, 2025. https://www.cdc.gov/vitalsigns/health-worker-mental-health/index.html
6. McCormick B. Burnout among health care workers drops post pandemic but remains elevated. AJMC. April 21, 2025. Accessed August 15, 2025. https://www.ajmc.com/view/burnout-among-health-care-workers-drops-post-pandemic-but-remains-elevated
7. IHI framework for improving joy in work. Institute for Healthcare Improvement. Accessed August 15, 2025. https://www.ihi.org/resources/white-papers/ihi-framework-improving-joy-work
8. Harris R, Sims S, Leamy M, et al. Intentional rounding in hospital wards to improve regular interaction and engagement between nurses and patients: a realist evaluation. *Health Serv Deliv Res*. 2019;7(35). https://www.ncbi.nlm.nih.gov/books/NBK547458/
9. Seay-Morrison TP, Hirabayshi K, Malloy CL, Brown-Johnson C. Factors affecting burnout among medical assistants. *J Healthcare Manage*. 2021;66(2):111-121. doi:10.1097/JHM-D-19-00265
10. Tackling burnout rates: medical assistants, patient care coordinators. Healthcare Experience Foundation YouTube page. February 20, 2025. Accessed August 15, 2025. https://www.youtube.com/watch?v=pSxuSDTkLa0
11. Shen K, Eddelbuettel JCP, Eisenberg MD. Job flows into and out of health care before and after the COVID-19 pandemic. *JAMA Health Forum*. 2024;5(1):e234964. doi:10.1001/jamahealthforum.2023.4964
12. Workforce well-being and joy in work. Institute for Healthcare Improvement. Accessed August 15, 2025. https://www.ihi.org/library/topics/workforce-well-being-and-joy-work

MEDICAL ASSISTANTS RECOGNITION WEEK
AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

CHAMPIONS IN HEALTH CARE

OCTOBER 20–24, 2025

ESSENTIAL HEALTH CARE TEAM MEMBER

By Cathy Cassata

The ever-changing landscape of health care can leave providers overwhelmed and patients confused. However, the presence of medical assistants on staff can help ease the burden for providers and enhance patient care.

As an extension of physicians, medical assistants use their administrative and clinical skills to keep practices running efficiently and demonstrate their invaluable role on the health care team. This Medical Assistants Recognition Week, providers and patients express their deep gratitude for all medical assistants do to enhance health care.

Providers Filled with Pride

Medical assistants are crucial to the work that we do every day in our clinic. They are fantastic team players and truly the backbone of the medical field. Their ability to help with patient flow, patient care, and administrative work is impressive. Our clinic functions so well because of their dedication, skills, and expertise. I thank medical assistants for being amazing. They are a critical part of the health care team, and I am grateful for all that they do.

Nick DeBlasio, MD, MEd
Pediatrician in Cincinnati, Ohio

My medical assistant extends my reach by handling clinical and administrative tasks that enable me to focus on diagnosis, treatment, and meaningful patient interaction. At our organization, medical assistants are embedded in workflows and team huddles. They are often the first and last clinical contact for patients, making them vital for reinforcing care plans, identifying social needs, and flagging clinical concerns early. We rely on them to enhance continuity and close care gaps in real time. As we redesign primary care around team-based models, medical assistants are central to that evolution. In fact, we have started our own medical assistant training program to teach the next generation the complex skills needed to be successful members of our advanced care teams.

James DomDera, MD
Family medicine physician in Uniontown, Ohio

Medical assistants decrease the workload for our nurses and reduce the burden on our providers. Their clinical skills allow them to take vital signs, administer medications, and assist with examinations. Their versatility with clinical and administrative duties helps improve patient flow in the clinic. Thank you to our medical assistants for taking great care of our patients every day and for always going the extra mile to make patients feel better.

Jared Veurink, CRNA
Director of clinical operations in Platte, South Dakota

I have hired medical assistants since I started my practice 25 years ago. We are located in a community that faces a lot of challenges. The health of our community is less than average, and the poverty in our community is high—at least 30% of our patients are on Medicaid. Despite these circumstances, my medical assistants ensure the [practice] runs efficiently. They are critical in improving patient care by managing prior authorizations and relaying information to patients in a timely manner, so their care is not delayed. I'm immensely thankful for their hard work and their dedication to the health and satisfaction of my patients. I'll be honest; the reason I have a 4.5 Google star rating is more because of my medical assistants than me.

Bobby Mukkamala, MD
2025–2026 President of the American Medical Association and otolaryngologist in Flint, Michigan

Patients Left with Positive Impressions

I have pain caused by complications from a spinal injury I endured during a kidney stone removal procedure. After seeing different specialists, I finally saw a physician who diagnosed me with severe spinal cord nerve damage and helped me find relief. The medical assistant at his [practice] is incredible. When I met her, she immediately knew the pain I was in and was so empathetic and reassuring. She made me feel seen, heard, and cared for. The day before my surgeries, she called to tell me she was sending positive thoughts my way, and after my surgeries, she called to see how I was doing and if my medication was filled. She makes me feel like I'm the most important patient that she has seen and addresses all my family's concerns. I've never experienced feeling that way with any medical assistant before.

Eunice Esparza
Chula Vista, California

My husband and I moved into an independent living facility seven years ago. At that time, I was able-bodied and could help with his care. He is paraplegic. I have a progressive muscle disease, and now I use a wheelchair and walker, so we both need help. In the medical center here, we were lucky to see a medical assistant for years. She cared for us both with such compassion and cheer, and she had a way of making us laugh too. Her uncanny ability to create a good rapport with everyone she saw stood out. She took the time to get to know us despite our age, disabilities, and needs. I'm grateful for the time we were under her care.

Karen Spielman
Lincolnshire, Illinois

I'll always remember the medical assistant who cared for my husband at our independent living facility. He was so comfortable seeing her, and she was the only person he would let draw his blood. She would talk during the process, so he didn't even know he was getting poked. When my husband passed away three years ago, I stopped going to the clinic, but just recently I started [going] back there. I'm so happy to see the medical assistant again. She has exceptional bedside manner and works well [with] the physicians. I won't go anywhere else now.

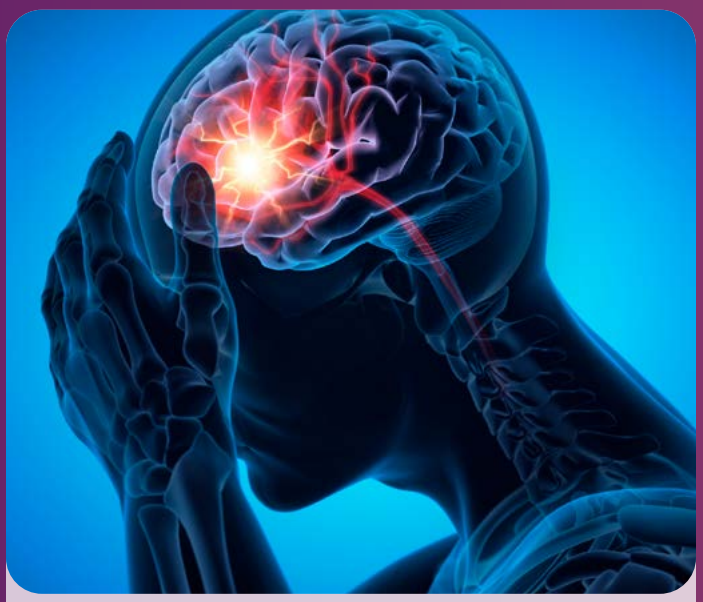
Karen Kay Lavris
Libertyville, Illinois

The medical assistant at my general practitioner's [practice] is full of sunshine. Two years ago, I was hit by a truck while I was directing traffic as a deputy sheriff. It's a miracle I'm alive. After spending three months recovering in the hospital, I left legally blind and unable to walk well. About three months after the accident, I had an appointment with my physician. When his medical assistant saw me, she burst into tears and told me she was grateful I was OK. This moved me to tears. She is a genuine, caring person. There is no false pretense with her. Plus, she is always thorough, follows up when she says she will, makes sure she answers my questions, and puts me at ease when I see the physician.

Arvin Clar
Akron, Ohio

The medical assistants at my son's pediatric dermatology practice are the bomb. They've truly eased the glide path throughout his alopecia journey and provided both counsel and understanding with insurance frustrations when we needed their help the most. We are grateful for their care as we navigated his diagnosis, treatment, and life with this condition.

Lynne Smith Obiala
Chicago, Illinois



A Head for Stroke Preparedness

Protect and preserve your brain with these crucial tips from the Center for Science in the Public Interest (CSPI), published in Nutrition*Action*, to avert the growing threat of stroke among Americans:

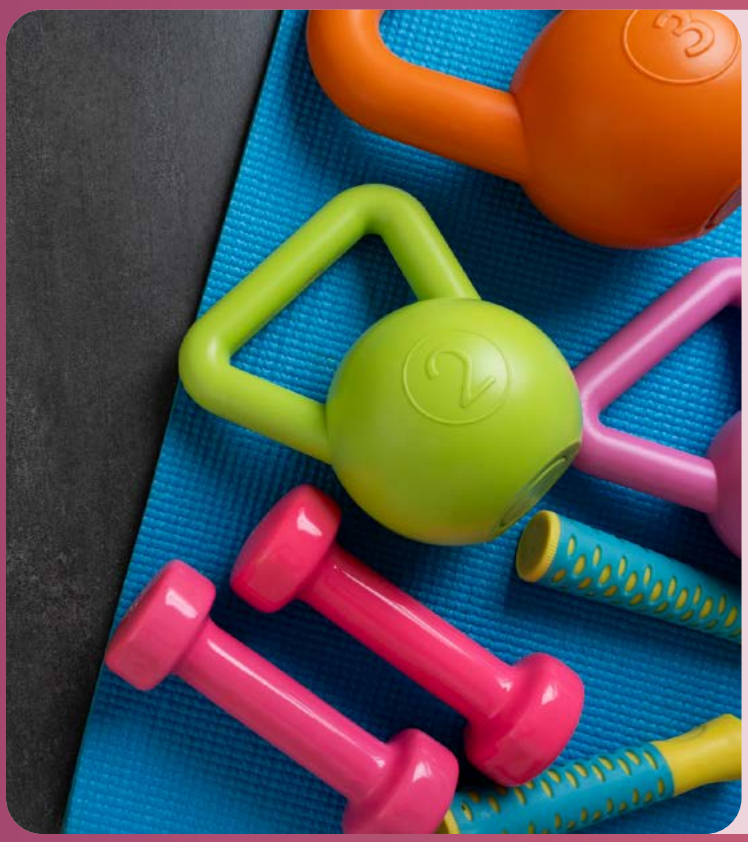
- **Call 911.** If you suspect a stroke, don't drive yourself or get a ride to the emergency room. Stay put so emergency responders can come to you. Remember, "Time saved is brain saved." The longer the brain is starved of blood and oxygen, the more grievous the damage.
- **BE FAST.** Use this acronym to recognize stroke symptoms and respond:
  - **B**alance (loss of balance, headache, dizziness)
  - **E**ye or vision problems
  - **F**acial droop
  - **A**rm or leg weakness
  - **S**peech difficulty
  - **T**ime to call 911
- **Note women's additional risk factors.** Although men have a higher risk of stroke in youth and middle age, women are more likely to die of stroke—not just because they live longer than men, but because of conditions that put them at greater risk, including atrial fibrillation, early-onset menopause, endometriosis, and migraine headaches.
- **Go low.** A key risk factor for stroke is high blood pressure. Dietary approaches to curtailing stroke risk have proven effective. Reduce sodium intake and adopt the DASH (Dietary Approaches to Stop Hypertension) diet to help prevent stroke and maintain a healthy brain.

A 60-Second Hack to Health and Happiness

Improve self-connection, build consistency for achieving your goals, mitigate decision fatigue, and prevent burnout—all possible through a simple one-minute, daily check-in routine!

Follow this abbreviated recipe to cook up success and healthiness—physically, mentally, and emotionally, from Healthline:

1. **Identify your goal(s).** Clarify what you're trying to achieve through this check-in.
2. **Set a time.** Use mornings to set the tone for the day, afternoons for a midday check-in, or evenings to wind down before bed. Choose what works for you and your goals.
3. **Choose your metrics.** In other words, what are you tracking? This could be your energy levels, whether you've moved today, mental or emotional needs, and so on. Choose what's relevant to your goal(s) and what's easiest to get quick feedback on your progress.
4. **Pick a check-in process.** Whether pen and paper or tech (notes app or voice memo), by tallying a checklist, logging an emoji for the day, or speaking aloud, try different methods to see what suits you best.
5. **Be gentle with yourself.** This daily check-in isn't a pass-fail test; treat it like a conversation with a friend. Listen, notice, and respond to your needs with kindness and without judgment.



Misleading and Myth-Busting

Don't myth out! Bust these common misconceptions related to working out, courtesy of the Mayo Clinic Speaking of Health blog:

"Stick solely to cardio for weight loss." Remember, if you have more muscle, you burn more calories. Pair cardio with strength training.

"Heavy weights will bulk me up too much." Women lack the requisite amount of testosterone to bulk up the way men do, so there's no need to fear *accidentally* looking like a bodybuilder.

"If the number on the scale isn't going down, I'm not losing weight." The number may actually go up if you're building muscle in place of fat. Muscle is denser and heavier than fat. Measurements of arms, waist, and thighs can provide a more accurate picture of actual progress.

"No pain, no gain." Although this saying has some truth, there's pain, and then there's *pain*. When discomfort shifts to anguish, something is wrong, and you should stop immediately. "Pushing through it" could lead to serious injury.

Mitigating Menopause's Impacts

Menopause represents a major change in many lives. Everyone has a different experience, with symptoms and their severity differing from one person to the next. These often include hot flashes and night sweats, sleep disturbances, and mood changes.

The good news? As with many medical conditions, a balanced diet can help minimize these symptoms and support overall physical and mental health. Incorporate healthy options from these food groups into your diet, recommends the Academy of Nutrition and Dietetics:

- **Protein** helps maintain muscle mass and increase satiety (feeling full), which may help minimize weight changes that often come with menopause.
- **Whole grains, fruits, and vegetables** provide essential nutrients and minerals, as well as dietary fiber, for maintaining bone and gut health and keeping blood sugar at healthy levels.
- The nutrients in **dairy and dairy alternatives** can help mitigate the increased risk of bone loss during menopause, which can lead to osteoporosis.
- **Healthy fats** (like omega-3 fatty acids) help ameliorate some symptoms related to inflammation, such as joint pain.

Along with these "pro" recommendations, just say "no" (or at least, "maybe, but minimize") to added sugars, saturated fats, sodium, and alcohol.

In addition to dietary modification, stay active, manage stress levels, and get your z's. And remember, always hydrate. A few sips of cold water before bed may even help reduce hot flashes during sleep.

The Night Shift

Exploring the Causes, Treatment, and Emotional Toll of Noctural Enuresis

By Brian Justice

Although generally not a serious health issue, nocturnal enuresis (NE), also known as *bedwetting*, can be upsetting for children who experience it after a certain age. In the United States, approximately 5 to 7 million children experience bedwetting.[1] However, NE can have a disproportionate and disruptive impact on a child and their family. Ongoing bedwetting ranks among the most distressing experiences in childhood.[1] That makes understanding NE and how to deal with it crucial for health care professionals at every level.

Most children stop wetting the bed by the time they are 5 years old, but reliably dry nights come later for over 10% of 6-year-olds and 5% of 10-year-olds. Up to 1% of teenagers and young adults even experience NE.[2] And, for reasons that people do not fully understand, boys are affected at roughly twice the rate of girls.[3]

Wake-Up Call

Causes of NE may include underdeveloped bladder capacity, overproduction of urine at night, genetic predisposition, sleep disorders, and hormonal imbalances such as low nighttime production of antidiuretic hormone, which normally reduces urine output during sleep, or a family history of enuresis.[1,2]

NE is categorized into two types:

- **Primary nocturnal enuresis** occurs in children who have never experienced consistently dry nights since potty training.
- **Secondary nocturnal enuresis** occurs when a child who has been dry for six months or more starts bedwetting again, often due to triggers like constipation, neurological conditions, or emotional distress.[2]

"I see it most often in children between the ages of 5 and 10," says Latasha Ladd, MEd, BHCM, CMA (AAMA), the medical assistant program director at South University in Columbia, South Carolina. "Caregivers often worry that the bedwetting is their fault or that something is seriously wrong with their child. They also ask how long it will last and what they can do at home."

In the Dark

"We consider whether there's any structural, neurologic, or physiologic contributor to the child's bedwetting," says Ryan Egan, PhD, a clinical psychologist in Durham, North Carolina. "That might involve a urinalysis or even bladder imaging, depending on the symptoms."

A clinician exploring the underlying causes of NE will generally do the following[3]:

- Conduct a physical examination.
- Discuss symptoms, fluid intake, family history, bowel and bladder habits, and problems associated with the child's bedwetting.
- Perform urine tests to detect signs of infection or diabetes.

- Order imaging tests of the kidneys or bladder.

Mental health tends to be an issue among children with NE, with 20% to 30% of them having at least one mental health condition, twice the rate of their peers. Other conditions, such as attention-deficit/hyperactivity disorder, autism spectrum disorder, and mood disorders, are frequently linked. These are not believed to cause NE; they simply accompany it. However, the emotional responses to bedwetting, primarily shame and frustration, can contribute to anxiety and depression, which in turn can make NE even more persistent.[4]

"Psychological factors, like family and social stress, contribute to enuresis," agrees Sadi Fox, PhD, a licensed psychologist and CEO of Flourish Psychology in Brooklyn, New York. "Developmental disorders are also common comorbidities that exacerbate it."

Dream Up a Plan

"We often refer patients to behavioral health if stress, anxiety, or trauma might be contributing to the bedwetting," says Ladd.

Behavioral strategies include moisture alarms, which are widely considered the most effective treatment option and can condition the child to wake up before urinating. It may take up to three months to see results, but they can offer a better long-term solution than pharmaceuticals.[3]

"Moisture alarms are the most effective first-line treatment. They're safe, drug-free, and help a child build the brain-bladder connection," says Dr. Egan, who also emphasizes that biological factors play a role. "Underdeveloped musculature and reflexes in the groin that help control the flow of urine are often associated with bedwetting, and the maturity of those muscles is highly heritable."

Medication may be considered if alarms and behavioral changes fail to help. Desmopressin is a common option that works by reducing the amount of urine produced at night. When it works, it works well, can be used privately, boosts confidence, and is also covered by most health plans.[2]

"Desmopressin can be effective for some children," says Dr. Egan, "but we use it judiciously. It's not a cure."

Other medications, such as oxybutynin, are helpful if daytime wetting also occurs; however, physicians generally only recommend them when other treatments have failed.[3]

Lifestyle changes can help too. Limiting fluids in the evening, avoiding caffeine, and encouraging children to use the toilet right before bed can help.[3] Engaging the child in their own treatment is also a good tactic. Decide on a date with them to begin, keep a calendar to monitor progress, and offer rewards for even the smallest gains.[2]

"Behavioral approaches are the best practice for young children," says Dr. Fox. "Education, normalization of feelings, and being open with communication between the child and parents [are] helpful."

Doze It Affect Adults?

An estimated 5 million adults in the United States experience nocturnal enuresis, also known as *adult bedwetting*.[4] It is a sensitive topic, so understanding that it is a medical condition is crucial. "It can be more emotionally difficult for adults," says Ladd. "So, we approach it with extra sensitivity and privacy and often look for the underlying medical causes."

Adult bedwetting differs from childhood enuresis in both cause and complexity. Genetics can play a role. Just as in children, those with a family history of bedwetting are at greater risk, but adult-onset enuresis is more often associated with health issues.[5]

Hormonal imbalance is one common cause. The antidiuretic hormone regulates urine production at night; however, if the body does not produce enough or if the kidneys do not properly respond, excess urine may accumulate, leading to nighttime accidents. This condition, known as *nocturnal polyuria*, may also be associated with type 1 diabetes.[5]

Bladder-related issues are another contributing factor. These include a reduced functional bladder capacity or overactive detrusor muscles that cause the bladder to contract prematurely. Such overactivity is observed in up to 80% of adults who experience bedwetting. Common bladder irritants, such as caffeine, alcohol, and spicy or acidic foods, can exacerbate symptoms.[5]

Other causes include urinary tract infections, side effects from medications (especially psychiatric or sleep aids), stress, and serious conditions such as prostate enlargement, pelvic organ prolapse, or obstructive sleep apnea.[5]

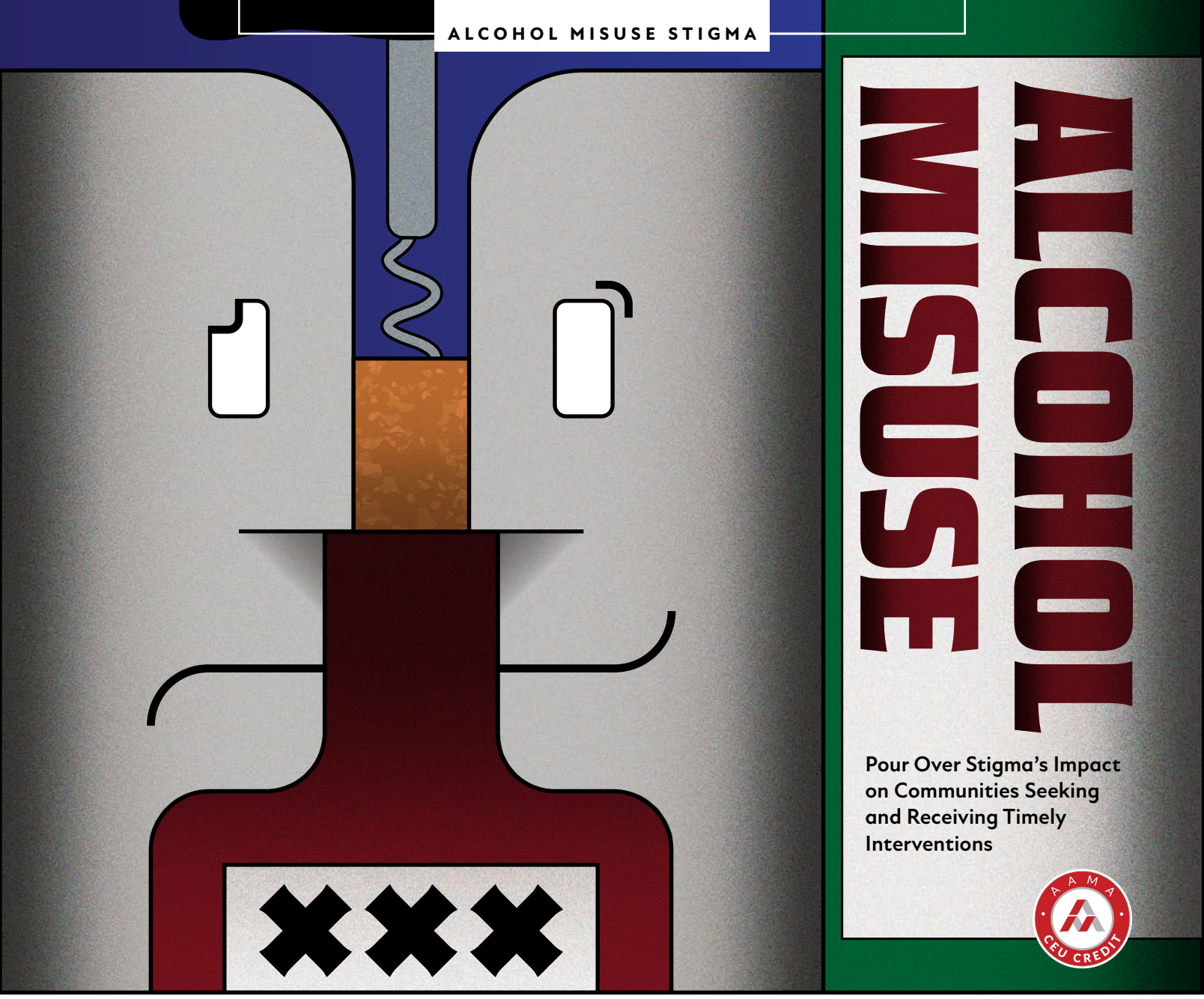
Fortunately, adult bedwetting is treatable. Depending on the cause, treatment options may include fluid management, bladder training, pelvic floor exercises, medication, or addressing related health issues. Keeping a bladder diary can help track symptoms and identify triggers.[5]

Rest Assured

While nocturnal enuresis can be a source of stress for families, it is both a common and manageable condition. A compassionate and open-minded approach will help most children overcome bedwetting and regain confidence. Open communication, proper evaluation, and consistent support from caregivers and health care providers are key to helping children feel confident and stay dry through the night. ✦

References

1. Septak M. The psychological causes of bedwetting. April 8, 2025. Accessed August 15, 2025. https://aeroflowurology.com/blog/the-psychological-causes-of-bedwetting
2. What is nocturnal enuresis (bedwetting)? Urology Care Foundation. Updated September 2022. Accessed August 15, 2025. https://www.urologyhealth.org/urologic-conditions/bed-wetting-(enuresis)
3. Bed-wetting. Mayo Clinic. August 24, 2023. Accessed August 15, 2025. https://www.mayoclinic.org/diseases-conditions/bed-wetting/diagnosis-treatment/drc-20366711
4. Daley SF, Gomez Rincon M, Leslie S. Enuresis. National Library of Medicine. December 11, 2024. Accessed August 15, 2025. https://www.ncbi.nlm.nih.gov/books/NBK545181
5. Adult bedwetting (sleep enuresis). National Association for Continence. Accessed August 15, 2025. https://nafc.org/adult-bedwetting/?utm



ALCOHOL MISUSE

Pour Over Stigma's Impact on Communities Seeking and Receiving Timely Interventions

By Sandra J. Gonzalez, PhD, LCSW

Alcohol use is prevalent worldwide and within the United States. While women are advised to consume no more than one alcoholic drink per day and men no more than two per day, nearly 1 in 6 adults in the United States are considered binge drinkers.[1]

Excessive drinking is a major contributor to preventable disease and death. The harms associated with excessive alcohol use can affect anyone, regardless of sex, racial or ethnic background, or geographic area. In the United States, approximately 178,000 people die each year due to excessive alcohol use.[2]

To ensure that people who drink at harmful levels receive the appropriate support, alcohol misuse must be addressed early. Primary care and other health care settings are ideal for screening and providing brief intervention, an evidence-based practice that may involve all members of the interprofessional health care team. Unfortunately, opportunities are often missed due to a lack of familiarity with sociodemographic, behavioral, and psychosocial factors that influence how alcohol use is perceived and addressed. Ethical concerns such as stigma, cultural sensitivity, and nonjudgmental care are essential to maximize the role of medical assistants in substance misuse prevention.

Stigma and Intersecting Identities

Gender Bias

Alcohol use among women has increased significantly in recent years,[3] narrowing the gender gap in alcohol consumption and related disorders. Meanwhile, women are disproportionately affected by stigma when they experience alcohol-related problems. Unlike men, whose alcohol use may be minimized, excused, or expected, women who misuse alcohol often face moral judgment. Such stigma deters patients from seeking help.[4]

Stigma against women with alcohol use disorders is rooted in gender stereotypes that define women as caregivers, mothers,

and nurturers. These roles are often seen as incompatible with substance use, leading to perceptions of irresponsibility. Women and pregnant persons may avoid disclosing their alcohol use for fear of being judged by health care providers or of having their parenting questioned. In some cases, they may fear losing custody of their children.[5] This fear contributes to a treatment gap. Although women often experience more severe, faster-acting health consequences from alcohol at lower levels of consumption than men,[6] they are less likely to receive timely interventions.[5-7]

Stigma is further magnified for women who belong to marginalized groups, including women of color, LGBTQ+ individuals,[8] and those with low socioeconomic status.[9] These intersecting identities can result in compounded discrimination, limited access to culturally competent care, additional barriers to recovery, and disparities in alcohol-related harms.[10]

Racial Bias

White Americans tend to report the highest prevalence of alcohol use,[1,10] while American Indian and Alaska Native communities experience the highest rates of alcohol-related harm.[10] Black and Hispanic individuals often have lower consumption rates but may encounter greater stigma or health care disparities, leading to worse outcomes.[11]

Cultural attitudes toward alcohol, religious practices, and community norms significantly influence drinking behavior. Structural issues such as racism, poverty, and health care inequities also contribute to disparities in both alcohol use and outcomes.[11] For instance, the marketing of alcohol in low-income and minority communities has been linked to increased consumption and harm.

Understanding these differences—while avoiding stereotyping or making assumptions—is necessary for developing targeted prevention and intervention strategies that are culturally appropriate and equitable. Medical assistants can enhance the quality of care for all patients by recognizing cultural and community-specific patterns, using culturally appropriate screening tools, and connecting patients with targeted support services.

> There is no known safe time—and no known safe amount—to drink alcohol during pregnancy or when trying to get pregnant.

Challenges Unique to Rural Communities

Data from the Centers for Disease Control and Prevention reveal that alcohol-related death rates have increased more rapidly in rural areas compared to urban areas. Notably, by 2018, the rates of alcohol-related deaths in rural areas were 18% higher for males and 23% higher for females compared to their urban counterparts.[12]

Several factors contribute to these trends in rural communities:

- **Cultural norms:** In some rural communities, alcohol consumption is deeply embedded in social traditions and gatherings. Activities like county fairs, hunting and fishing trips, cookouts, and sports events often involve drinking as a customary part of the experience. This normalization can make heavy or frequent drinking seem acceptable.
- **Limited recreational activities:** Fewer entertainment options may lead individuals to engage in alcohol use as a primary form of leisure.
- **Mental health challenges:** Higher rates of depression and anxiety, coupled with limited access to mental health services, can lead to alcohol use as a coping method.
- **Stigma and privacy concerns:** The close-knit nature of many rural communities may deter individuals from seeking help due to fears about confidentiality and social repercussions.

Moreover, the health care infrastructure in rural areas is often under-resourced. Fewer providers, longer travel distances, and a shortage of behavioral health clinicians result in missed opportunities for early screening and intervention. Additionally, public transportation limitations and a lack of anonymity further discourage seeking treatment.

Patterns of Alcohol Use

Patterns of alcohol use differ among racial and ethnic populations, according to the 2023 National Survey on Drug Use and Health[15]:

- **White Americans** tend to report the highest rates of alcohol use, with about 52% of people aged 12 or older reporting alcohol consumption in the past month.[15]
- **Black adults** report lower current drinking rates (43%)[15] but may face disproportionate harm from alcohol, such as higher rates of alcohol-related liver disease.[10] They have higher rates of alcohol-related chronic diseases despite lower consumption rates,[10] likely due to differences in health care access, comorbid conditions, and social determinants of health.
- **Hispanic adults** have lower drinking rates (approximately 41%)[15] but have the highest rates of death from liver cirrhosis.[10] There are also disparities in alcohol treatment use among Hispanic adults.[11]
- **Asian Americans** generally have lower rates of alcohol use (33%),[15] though subgroups such as Korean and Japanese Americans may have higher rates of alcohol use within this population category.[10]
- **American Indian and Alaska Native (AIAN) populations** have the lowest overall rates of past-month use (30%)[15] but experience significantly higher rates of heavy drinking and alcohol-related mortality. AIAN people have the highest rates of alcohol-attributable deaths per capita.[6]

Alcohol Misuse Prevention Strategies

Medical assistants are uniquely

positioned to help address excessive alcohol use through ethical, compassionate, and practical interventions. As trusted health care professionals who have unparalleled rapport with patients, medical assistants can contribute meaningfully to early identification and support individuals at risk of alcohol misuse.

Binge drinking is the most common form of excessive drinking and is defined as consuming four or more drinks on a single occasion for women and five or more drinks on a single occasion for men.[13]

Heavy drinking is consuming eight or more drinks in one week for women or 15 or more drinks per week for men. This term also includes any alcohol use by pregnant people or those under the age of 21.[13]

Several strategies can help medical assistants increase their knowledge, skills, and confidence:

1. **Engage in continuing education:** Stay informed about the latest guidelines on alcohol misuse prevention and treatment. Participating in regular training ensures competence and confidence in addressing alcohol-related issues.
2. **Reflect and improve:** Engage in regular self-reflection and seek feedback to enhance your communication skills, cultural awareness, and ability to recognize biases. Reflect on your attitudes and beliefs toward substance use, which are shaped by cultural, personal, and societal factors. Strive to separate these beliefs from your clinical interactions. Personal development enriches professional impact.
3. **Incorporate routine, universal screening:** Use validated screening tools such as the Alcohol Use Disorders Identification Test, Adapted for Use in the United States (USAUDIT) questionnaire[13] during routine patient intake. Embedding alcohol screening and brief interventions into routine primary care visits can help identify excessive drinking behaviors early and normalize conversations about alcohol use in a confidential setting.
4. **Practice nonjudgmental communication:** Foster a respectful and stigma-free environment by using empathetic language. This approach promotes trust and encourages patients to discuss sensitive issues more openly, without fear of criticism or moral judgment. This method helps individuals feel respected and heard, which is crucial in encouraging honest disclosure about alcohol use. Avoiding assumptions based on appearance, background, or behavior is vital. Individuals from all walks of life can experience challenges with alcohol, and each case should be approached with empathy and openness.
5. **Listen actively:** Demonstrate active listening by reflecting on the patient's concerns and summarizing their statements to demonstrate understanding.
6. **Provide messages to motivate behavior change:** Engage patients in short, motivational conversations[14] that raise awareness of harmful drinking patterns and support behavior change.
7. **Respect patient autonomy:** Recognize the patient's right to make decisions about their health. Provide information without pressure and support patients regardless of their readiness to change.
8. **Collaborate with the care team:** Work closely with nurses, physicians, behavioral health clinicians, and social workers to ensure comprehensive care. Share observations and inform patients of referrals authorized by the treating provider while maintaining confidentiality.
9. **Advocate for a supportive environment:** Encourage clinics and health care settings to prioritize reducing stigma, promoting cultural competency, and implementing inclusive practices. This can be achieved through policy development, team training, and quality improvement initiatives.

Additionally, health care providers and personnel can target rural communities through these strategies:

- **Expand telehealth and mobile services:** Mobile health units and digital platforms offer innovative ways to provide medically underserved populations with counseling and treatment.
- **Tailor education and outreach to the community:** Public health campaigns that resonate with rural values can help reduce stigma and encourage help-seeking behavior. Partnerships with local organizations, such as schools, churches, and businesses, can enhance outreach

efforts. Likewise, peer support groups and women-focused recovery programs provide safe spaces in which women can share their experiences without fear of judgment.

- **Increase funding for training and workforce development in rural areas:** Investing in the education and training of rural health care staff on substance use disorders is crucial for enhancing early detection and referral systems.

Nonjudgmental Care

Reducing stigma requires a multifaceted approach. Health care professionals must adopt a trauma-informed, nonjudgmental approach to screening and intervention. Public health campaigns that portray women with alcohol use disorders as individuals deserving of empathy and support, rather than blame, can also help shift societal perceptions.

Creating a clinical culture that prioritizes respect, dignity, and inclusivity reinforces the nonjudgmental approach. Staff-wide policies and training that emphasize stigma reduction can ensure that all health care professionals, including medical assistants, contribute to a welcoming and supportive environment. Medical assistants should emphasize that seeking help is a sign of strength and that support systems are in place to assist patients and to be used.

By integrating ethical principles with practical skills, medical assistants can play a critical role in addressing alcohol misuse. Through education, compassion, and collaboration, medical assistants can contribute significantly to reducing the prevalence and consequences of excessive alcohol use across a variety of patient populations. ✦

The CE test for this article can be found on page 29.

Vocab to Voice

Language plays a key role in creating a nonjudgmental environment. Medical assistants should use person-first and strength-based language—for example, saying "a person with an alcohol use disorder" or "individual in recovery" rather than "alcoholic." This subtle shift in terminology reinforces the view that individuals are not defined by their condition and are capable of recovery.

References

1. Bohm MK, Liu Y, Esser MB, et al. Binge drinking among adults, by select characteristics and state —United States, 2018. *MMWR*. 2021;70(41):1441 -1446. http://dx.doi.org/10.15585/mmwr .mm7041a2
2. Esser MB, Sherk A, Liu Y, Naimi TS. Deaths from excessive alcohol use—United States, 2016–2021. *MMWR*. 2024;73(8):154-161. http://dx.doi .org/10.15585/mmwr.mm7308a1
3. Grant BF, Chou SP, Saha TD, et al. Prevalence of 12-month alcohol use, high-risk drinking, and DSM-IV alcohol use disorder in the United States, 2001-2002 to 2012-2013: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *JAMA Psychiatry*. 2017;74(9):911-923. doi:10.1001/jamapsychiatry.2017.2161
4. Finn SW, Mejldal A, Nielsen AS. Perceived barriers to seeking treatment for alcohol use disorders among the general Danish population—a cross sectional study on the role of severity of alcohol use and gender. *Arch Public Health*. 2023;81(65). https:// doi .org/10.1186/s13690-023 -01085-4
5. Stone, R. Pregnant women and substance use: fear, stigma, and barriers to care. *Health Justice*. 2015;3(2). https://doi .org/10.1186/s40352-015-0015-5
6. Saunders H, Rudowitz R. A look at the latest alcohol death data and change over the last decade. KFF. May 23, 2024. Accessed August 15, 2025. https:// www .kff.org/other/issue-brief/a-look -at-the-latest-alcohol-death -data-and-change-over-the-last -decade/
7. Stringer KL, Baker EH. Stigma as a barrier to substance abuse treatment among those with unmet need: an analysis of parenthood and marital status. *J Fam Issues*. 2018;39(1):3-27. doi:10.1177/0192513X15581659
8. Casanova-Perez R, Apodaca C, Bascom E, et al. Broken down by bias: healthcare biases experienced by BIPOC and LGBTQ+ patients. *AMIA Annu Symp Proc Arch*. 2022;2021:275-284. https://pmc .ncbi.nlm .nih.gov/articles/PMC8861755/
9. Collins SE. Associations between socioeconomic factors and alcohol outcomes. *Alcohol Res*. 2016;38(1):83-94. https://pmc.ncbi.nlm.nih.gov /articles/PMC4872618/
10. Delker E, Brown Q, Hasin DS. Alcohol consumption in demographic subpopulations: an epidemiologic overview. *Alcohol Res*. 2016;38(1):7-15. https:// pubmed.ncbi.nlm.nih.gov/27159807/
11. Chartier K, Caetano R. Ethnicity and health disparities in alcohol research. *Alcohol Res Health*. 2010;33(1-2):152-160. https://pubmed.ncbi.nlm.nih .gov/21209793/
12. Spencer MR, Curtin SC, Hedegaard H. Rates of alcohol-induced deaths among adults aged 25 and over in rural and urban areas: United States, 2000–2018. National Center for Health Statistics. 2020. Accessed August 15, 2025. https://www.cdc .gov/nchs/prod ucts/databriefs/db383.htm
13. Babor TF, Higgins Biddle JC, Robaina K. *The Alcohol Use Disorders Identification Test, Adapted for Use in the United States: A Guide for Primary Care Practitioners*. Substance Abuse and Mental Health Services Administration. Accessed August 15, 2025. https://my.ireta.org/sites/ireta.org/files/USAUDIT -Guide_2016_final.pdf
14. Products: walk & talks. Medical Assistant Partnership for Health Pregnancies and Families. Accessed August 15, 2025. https://fasdmap.org/category/walk-talks/
15. Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health*. July 2024. Accessed August 15, 2025. https:// www.samhsa.gov/data/sites /default/files/reports/rpt47095 /National%20Report/ National%20Report/2023-nsduh -annual-national.pdf

Workforce Burnout

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

Credit: 2.5 AAMA CEUs (gen/admin) **Code: 144600**

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. Managers of health care personnel should avoid encouraging staff to work more than a reasonable and healthy number of hours each week.

☐ ☐ 2. Workforce burnout is classified as an "occupational phenomenon" and is not a medical condition.

☐ ☐ 3. Failing to educate staff on how to perform their jobs more effectively can increase the risk of burnout.

☐ ☐ 4. Medical assistants are most frequently exempt employees, meaning that they are paid a fixed salary regardless of hours worked, which are flexible and not strictly defined.

☐ ☐ 5. Substantial and persistent turnover in the health care workforce occurred during the height of the pandemic, but turnover has since returned to normal levels.

☐ ☐ 6. The importance of greater flexibility and less rigidity in delivering health care is one byproduct of the pandemic.

☐ ☐ 7. The stressors faced by individuals working in health care settings often exceed those experienced by people in other employment settings.

☐ ☐ 8. The current volume of health care services being provided in all American health care facilities is less than it was before the pandemic.

☐ ☐ 9. The fact that reduced health care staff are being asked to provide a greater amount of care is contributing to burnout.

T F

☐ ☐ 10. Providing continuing education for staff is a valuable way of showing appreciation.

☐ ☐ 11. Medical assistants have one of the lowest turnover rates of all health professionals.

☐ ☐ 12. The symptoms of burnout in the health care workforce are less prevalent than they were before the COVID-19 pandemic.

☐ ☐ 13. Managers and leaders of health systems are realizing the importance of asking staff members what matters most to them.

☐ ☐ 14. Managers should meet with each staff member once every six months.

☐ ☐ 15. There has been an increasing number of medical assistants and a decreasing number of nurses in ambulatory care settings.

☐ ☐ 16. Moral injury involves a sense of disappointment and disconnection of a health care professional resulting from not being able to provide the best quality of care because of regulatory restrictions or third-party payer limitations.

☐ ☐ 17. Only licensed professionals, not medical assistants, are eligible to become patient care coordinators.

Alcohol Misuse Stigma

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

Credit: 1 AAMA CEU (gen/admin) **Code: 144601**

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. The prevailing medical advice is that everyone should consume no more than two alcoholic drinks each day.

☐ ☐ 2. The Alcohol Use Disorders Identification Test, Adapted for Use in the United States questionnaire should be used during routine patient intake.

☐ ☐ 3. Women of color, women with low socioeconomic status, or women who are LGBTQ+ encounter a higher degree of stigma than other women.

☐ ☐ 4. White Americans experience the highest prevalence of alcohol-related harm.

☐ ☐ 5. There is a link between marketing alcohol to certain minority and low-income communities and higher rates of alcohol consumption and harm in those communities.

☐ ☐ 6. Stigma about alcohol-related problems is more of an issue for women than for men because of gender norms that stereotype women as caregivers and nurturers.

☐ ☐ 7. Scientific evidence has shown that men experience faster-acting and more severe consequences of alcohol use at lower levels of consumption than women.

T F

☐ ☐ 8. Medical assistants can enhance the quality of care for patients struggling with alcohol use because of their ability to notice community-specific and cultural patterns.

☐ ☐ 9. Using empathetic language when interacting with patients fosters trust and results in patients being more open to discussing sensitive issues such as alcohol misuse.

☐ ☐ 10. Specialty care settings, rather than primary care settings, are ideal for alcohol screening intervention.

☐ ☐ 11. Data from the Centers for Disease Control and Prevention have shown that alcohol-related deaths have increased more rapidly in urban communities as opposed to rural communities.

Donate online and SUPPORT EDUCATION!

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

The Maxine Williams Scholarship Fund

provides financial assistance for deserving medical assisting students.

For more information, visit the "About" page on the AAMA website.
www.aama-ntl.org

The Ivy Reade Relkin Surveyors Training Fund

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

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

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS®

CEU Tests Submission Form

This submission form is for both or one of the CEU articles.

How to Receive AAMA CEU Credit
Applicants can choose to complete both or either of the tests. Only one submission form is needed whether two tests are completed or one is completed.

Credit will be awarded to those who achieve a score of at least 80%.

Online Method: Go to www.aama-ntl.org and click on "e-Learning Center" under the Education and Events tab. Pay for and take the test online.

Mail Submission Method: Complete the test(s) and this submission form, and mail them to the address below. Enclose a check or money order payable to the AAMA.

40% More CEUs; 0% More Fees
As a bonus for AAMA members, you may submit CEU Test 1 and/or CEU Test 2 for $20 total.

This offer will continue through the Sept/Oct 2025 issue. The Nov/Dec 2025 issue will not have this bonus.

Fee Information
The nonrefundable testing fee is $20 (members) or $40 (nonmembers).

Last Name

First Name & Middle Initial

Street Address

City/State/ZIP

AAMA Membership Status
☐ Member (CEU Test 1 and/or CEU Test 2) ($20)
☐ Nonmember (CEU Test 1 and/or CEU Test 2) ($40)

Test Submissions
I am including the completed test pages for:
☐ Workforce Burnout (2.5 CEUs)
☐ Alcohol Misuse Stigma (1 CEU)

Members—AAMA ID Number *(Required)*

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

Date Completed

Day Phone Fax

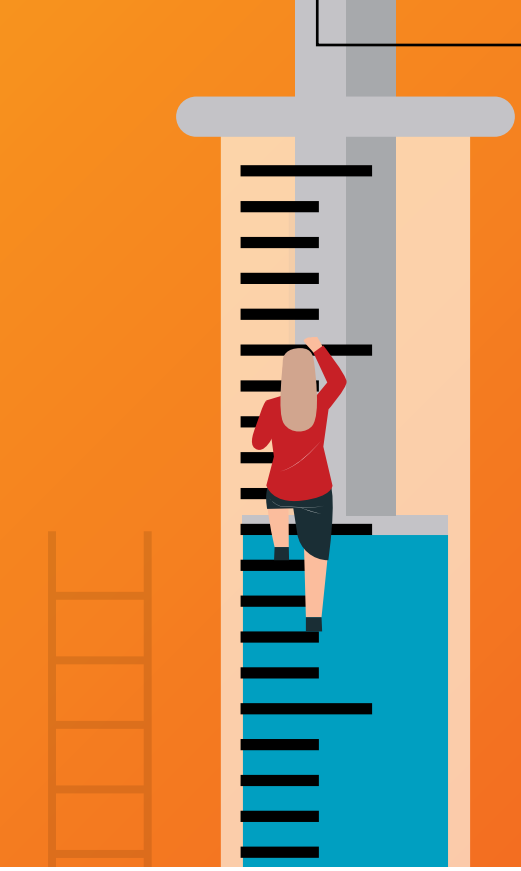
Email

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

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

Continuing education units (CEUs) are awarded based upon content, depth of article, learning outcomes, and length of time for completion per IACET (International Association for Continuing Education and Training) guidelines and criteria. IACET created the CEU for the purpose of providing a standard unit of measure to quantify continuing adult education. CEU value is awarded based upon the projected contact hours needed to complete the continuing education activity (e.g., 1 CEU equals 1 hour, or 1.5 CEUs equal 1.5 hours). *Medical Assisting Today* articles follow this standard for awarding CEU value. The $20 or $40 is a test processing fee. A $25 administrative fee will be assessed for returned checks.

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



Career Ladder

CMA (AAMA) Reaches New Heights as a Medical Assistant Coordinator

By Cathy Cassata

When Melinda Hoffman, CMA (AAMA), graduated from medical assisting school in 2012, she landed a job with a small family practice clinic in her hometown of Merrill, Wisconsin.

"It was a very busy clinic for being small, and I learned a lot," she says.

After two years, she transitioned to a pharmacy technician role at a local hospital for a few years and then took some time off to care for her young children before going back to a family practice.

In 2016, she was ready for a change and landed a job as an endoscopy technician, assisting with pre- and post-procedures in the endoscopy center at GI Associates. She then decided to work in the clinic at GI Associates, where she carried out a more traditional medical assisting position.

"The [physician] I was working for had started the practice and was getting close to retirement. I wasn't sure if I wanted to work with a new [physician], but I decided to go for it," says Hoffman. "I'm so happy that I did because we have a great working relationship."

Her day-to-day duties involve assisting the physician when he is in the clinic by rooming patients; taking vital signs; ordering medications, laboratory tests, and imaging studies; scheduling procedures; and educating patients on preparation for procedures. When the physician is performing surgeries, Hoffman is in the clinic managing his schedule, calling patients who are due for visits, processing prescription refills, preparing charts, and answering patient calls.

"We're very efficient together and in hindsight, I'm glad I decided to take on the challenge of working with a new provider," she says.

She excelled in her role so much that she was eventually promoted to medical assistant coordinator, a position that requires her to manage the schedules of six medical assistants, ensuring coverage for the providers. She also runs monthly staff meetings and weekly leadership meetings with the clinic's leadership team to discuss learning opportunities and ways to improve practice efficiency.

"It was a huge addition to my responsibilities, but I want to serve my team and make sure their needs are met each and every day," says Hoffman. "I want them to know how appreciated they are and that I'm their advocate."

She takes her role to heart. "I understand our medical assistants' workload and their frustrations because I'm right there with them. I'm not just a leader who's above them, telling them what to do. I'm still a medical assistant doing the same work that they're doing," she says.

When she began her medical assisting career, she never thought taking on a leadership role was possible without a nursing degree. "It seemed like in many clinics, nurses were the leaders, which kind of proved not to work because the nurses don't understand the medical assistant's workload, just like medical assistants don't understand the [registered nurse's] workload," says Hoffman.

The coordinator and leadership roles push her to grow and gain skills in time management and conflict resolution.

"I started at a small practice working part-time, and over time, my career blossomed. It wasn't always easy, but it's been rewarding," says Hoffman. "Anyone can do it, you just have to trust in your medical assisting skills and be willing to work hard." ✦

69TH ANNUAL
AAMA
CONFERENCE

STEP INTO A LEGACY OF GREATNESS.

Don't wait!
Register for conference today.

Join us September 19–22 for the 69th AAMA Annual Conference in Arlington, VA.