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AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

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Medical Assisting Today

The Magazine for Professional Medical Assistants



CURING CONFLICT

Find Remedies for Workplace Conflict

A Message from the Outgoing President

As my second term as President draws to a close, I find myself reflecting with a full heart on the people, friendships, partnerships, and shared purpose that have made this journey so meaningful. Together, we have strengthened our organization, welcomed new opportunities, and continued serving our members and communities.

Everything we accomplished was made possible by the generosity and dedication of our officers, trustees, delegates, committee leaders, volunteers, partners, and members. Thank you for sharing your ideas, giving your time, and stepping forward whenever help was needed. You reminded me again and again that leadership is not a solo endeavor—it is something we build together.

Serving as your President for the past two years has been one of the greatest honors of my life. I leave deeply proud of what we have achieved and excited for all that lies ahead. As new leadership takes the helm, I hope you will stay involved, share your voice, encourage one another, and build on our momentum. Thank you for your trust, service, kindness, and friendship. I look forward to remaining by your side and cheering on our continued success as Immediate Past President.

If you could not join us for the 70th AAMA Annual Conference in Reno, Nevada, please know you were missed. We hope to see you in 2027 in Kansas City, Missouri.



Virginia Thomas, CMA (AAMA)
2024–2026 President

A Message from the Incoming President

As I step into this role, my primary focus for the upcoming year is simple: honoring the greatest strength of our organization—our people. From our dedicated Board of Trustees to the incredible volunteer leaders stepping into committee roles, our success relies on your passion and commitment.

This year, our leadership team will collaborate intentionally on key projects, stewarding our resources with wisdom and care. As we chart our path forward, we must also lean into a critical principle: supporting the evolving needs of the medical assisting profession requires equal focus on supporting the people who sustain it every day.

A strong bridge into the future is built on trust, teamwork, and resilience. The success of this Board depends on our ability to support one another, communicate openly, and work together with mutual respect. Members look to the Board as examples of professionalism, integrity, and service, and we must always be mindful of the trust placed in us.

During this season of change, we must be truly open to one another—listening with our hearts and minds. When we listen with understanding and respect, we create a collaborative environment where bold ideas flourish, challenges are addressed constructively, and sound decisions are made.

When we are educated, equipped, and empowered, our collective resilience will help us navigate uncertainty, stay focused on our purpose, and build a stronger AAMA.



Sherry Bogar, CMA (AAMA), CN-BC
2026–2027 President

AAMA® Mission

The mission of the AAMA is to empower medical assistants by advancing education, certification, advocacy, and scope-of-practice protection.

CMA (AAMA)® Certification

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

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AAMA update

2026 Conference Highlights

Nearly 500 people from near and far enjoyed new educational possibilities at the 70th AAMA Annual Conference in Reno, Nevada. Thank you for making this event a success!

Many thanks to the Conference Education Committee, the Southwest region members, and the 2025–2026 Annual Conference Committee for a fun and informative weekend.

The AAMA congratulates all the Excel Award winners who took home awards and Mary Dey, BAS, CMA-AC (AAMA), for receiving the 2026 AAMA Life Member Award.



Want to Submit Your Membership Dues Renewal via Mail?

Keep an eye on your mailbox in November for the 2027 Membership Dues Remittance Form so you can renew your membership by mail for the 2027 membership term. ✦

Introducing *Inside the AAMA with Annie*

Get an inside look at what's happening across the AAMA community with *Inside the AAMA with Annie*, a new monthly series. AAMA Executive Director Annie Storey, MS, CAE, will share updates from across the association, discuss developments in the profession, and offer a look at what's ahead.

Whether you're a longtime AAMA member or new to the association, *Inside the AAMA with Annie* allows you to stay connected, informed, and engaged with the work happening throughout the medical assisting profession. Check your inbox for updates on new episodes, and watch previous episodes on the AAMA YouTube channel. ✦

Standout Students

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



Name: Bliaal Alvi

Expected Graduation: September 2026

Institution: Hunter Business School

In Their Own Words: "[Medical assistants] are always the ones that left an impression. I want to be part of that. I want to help people feel better and more comfortable."



Name: Sandra Coker

Expected Graduation: April 2026

Institution: Bryant & Stratton College

In Their Own Words: "More than anything, I want to be someone who makes a real difference in people's lives. I know I cannot change everything, but if I can ease someone's pain, support them through a difficult moment, or help them feel cared for, then I know I am fulfilling my purpose."



Name: Sharon Finco

Expected Graduation: May 2026

Institution: College of Southern Idaho

In Their Own Words: "I want to be the kind of medical assistant that lights up the faces of providers and patients alike, building those long-term professional

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relationships [in which] patients feel seen and providers know they have a [medical assistant] they can trust and rely upon."



Name: Corey Finelli

Expected Graduation: May 2026

Institution: Sussex County Community College

In Their Own Words: "I realized I am most fulfilled when I am helping others in meaningful, tangible ways. Health care provides that opportunity every day. … I am drawn to the hands-on nature of the profession and the ability to make patients feel comfortable, heard, and cared for during what can often be stressful experiences."



Name: Jordan Harris

Expected Graduation: August 2026

Institution: Gaston College

In Their Own Words: "Early in life, I knew I wanted to work in the health care field! … In five years, I believe serving as a [CMA (AAMA)] in a local doctor's office would be a great career for me and allow me to help others feel better in my local community!"



Name: Shania Harrison

Expected Graduation: August 2026

Institution: ECPI University

In Their Own Words: "I chose medical assisting because helping others has always been important to me, especially through my experience taking care of my relatives. Being there for them showed me how much of a difference it makes when someone is patient, understanding, and truly cares."



Name: Crystal Parsons

Expected Graduation: July 2026

Institution: College of the Albemarle

In Their Own Words: "Medical assisting is the perfect fit for me because it allows me to combine both clinical and administrative skills. I enjoy working directly with patients, but I also thrive in multitasking and handling front-office responsibilities. This career gives me the best of both worlds."



Name: Ashley Robles

Expected Graduation: December 2026

Institution: Cape Fear Community College

In Their Own Words: "Wanting someone to live their best life comes naturally for me. Now, I am learning how to help them get there. Medical assisting is a heavily team-based career, and I look forward to growing my capability to work with others and problem solve as a team."

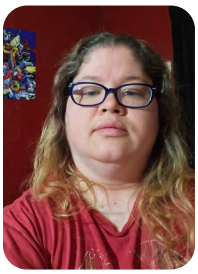


Name: Natalie Rodriguez Garcia

Expected Graduation: August 2026

Institution: Tarrant County College

In Their Own Words: "I've learned that everyone starts somewhere, and I chose to begin with the foundation or backbone of the medical field so I can continue opening doors to future opportunities."



Name: Briana White

Expected Graduation: May 2026

Institution: College of Western Idaho

In Their Own Words: "I thrive on helping people, because I know what it is to need help, and this career graciously gives me the tools I need to do just that." ✦

Catch Up with Scholarship Winners!

Learn more about the recipients of the the Maxine Williams Scholarship in Honor of Crystal Coleman, CMA (AAMA), and this award on the AAMA website. ✦

CMS Reimbursement for Patient Navigation



Donald A. Balasa, JD, MBA, ICE-CCP
AAMA Legal Counsel

The Centers for Medicare & Medicaid Services (CMS) issued a final rule (effective January 1, 2024) authorizing Medicare reimbursement for patient navigator services billed incident to the services of a licensed provider. Such services may be provided for patients with "serious high-risk disease" expected to last at least three months.[1] Medical assistants are permitted to provide such patient navigator services incident to the services of the delegating/overseeing licensed provider (e.g., MD, DO, nurse practitioner, physician associate/assistant), and CMS will reimburse the provider for these services.

Here are some answers to frequently asked questions about CMS reimbursement:

What is "incident to" billing?

CMS provides the following definition:

> The term "incident to" refers to the services or supplies that are a key part of the physician's [or other licensed provider's] personal professional services in the course of diagnosis or treatment of an illness or injury. In plain language: under the "incident to" provision of Medicare, services are submitted under the physician's NPI [National Provider Identifier number] but are performed by someone else.[2]

Who are auxiliary personnel?

The Code of Federal Regulations offers this definition:

> **Section 410.26. Services and supplies incident to a physician's professional services: Conditions.**
>
> (a) Definitions …
>
> (1) Auxiliary personnel means any individual who is acting under the supervision of a physician (or other practitioner) … and meets any applicable requirements to provide incident-to services, including licensure, imposed by the State in which the services are being furnished.[3]

What are PIN services?

Principal illness navigation (PIN) services are frequently delegated to auxiliary personnel such as medical assistants. Note the following description of PIN from the American Cancer Society:

> PIN services include navigation provided by certified or trained personnel as part of the treatment plan for one serious, high-risk disease expected to last at least 3 months, which places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death. The condition should require development, monitoring, or revision of a disease-specific care plan, and may require frequent adjustment in the medication or treatment regimen or substantial assistance from a caregiver.[4]

CMS lists the following categories of PIN services:

> CMS provides 8 categories of PIN services: person-centered assessment; practitioner, home-, and community-based care coordination; health education; building patient self-advocacy skills; health care access/health system navigation; facilitating behavioral change; facilitating and providing social and emotional support; and leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.[4]

Who can provide PIN services?

Auxiliary personnel provide PIN services delegated by the overseeing/delegating provider as long as the auxiliary is knowledgeable and competent in the delegated PIN services.

Who verifies that the auxiliary providing PIN services is knowledgeable and competent in the delegated PIN services?

The billing/delegating provider is responsible for verifying the competence of the auxiliary.

Must a minimum duration of PIN services be provided each month to be reimbursable?

Yes, 60 minutes of navigation time must be provided each calendar month.

Must PIN services be provided by a clinical health professional or a licensed health professional?

No. A non-clinical or a non-licensed health professional (such as a medical assistant) is permitted to perform PIN services if the auxiliary is knowledgeable and competent in the PIN services assigned by the delegating provider.

What competencies must a patient navigator have to be delegated PIN services?

Note the following from the American Cancer Society:

> Training required to provide PIN services must include the competencies of patient and family communication, interpersonal and relationship-building, patient and family capacity-building, service coordination and system navigation, patient advocacy, facilitation, individual and community

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assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base, including specific certification or training on the serious, high-risk condition/illness/disease addressed in the initiating visit.[4]

Must a patient navigator be a community health worker to be delegated PIN services?

No. The community health worker (CHW) is a distinct profession that has mandatory education and testing requirements in some states. Many CHWs function as patient navigators. However, state laws regarding physician, nurse practitioner, and physician associate/assistant practice do not require providers to delegate patient navigation tasks only to CHWs. ✦

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

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SYSTEM UPDATE

Keep Knowledge of Health Care Technology Current



By Brian Justice

Medical assistants are often the first people patients see, and their first job is to inspire trust. Now that nearly every patient interaction incorporates technology from the get-go, a medical assistant's digital literacy is more crucial than ever. And educators are well-positioned to help students succeed in this area.

However, health care technology is developing at a fast pace. Advances in telehealth, artificial intelligence (AI), and digital health are driving hybrid workflows, remote monitoring, virtual care, and the management of patient data. Because these technologies evolve so rapidly, health care workers' competencies should be reviewed regularly and brought up to date as needed.[1]

This acceleration makes it increasingly crucial for medical assistants to adapt to new technologies and, given how quickly they evolve, be ready for newer ones.

"Digital literacy for a medical assistant today means having the skills to use modern health technology with confidence, accuracy, and efficiency in a clinical setting," says Rebecca Gayheart, DNP, MSN, APRN, FNP-C, CNL, a medical assisting adjunct professor with the U.S. Career Institute in Fort Collins, Colorado.

A Stanford University study found that the expanding capabilities of digital tools have also expanded medical assistants' responsibilities, particularly in helping patients and providers use technology in virtual care.[2] As health care becomes even more dependent on technology, medical assistants will collect and manage more health information and share that data throughout the larger health care system.[3]

"That means digital tools must be used in service of excellent patient care, which is the ultimate goal," says Melba Militante, CEO of Phoenix Virtual Solutions in Orange, California. "The real skills are not in just using those tools, but knowing how to use them effectively."

KEYS TO SUCCESS

Medical assistants must be familiar with technology such as telehealth, health apps, remote monitoring, wearables, and more. These tools not only gather and manage data, but they are increasingly used to help patients manage their own health.[4]

"Medical assistants do not necessarily need to know specific software, but they need to understand how to work with the software at hand," says Janet Perry Quintana, a commissioner with the Distance Education Accrediting Commission. "The need to access patient demographics, insurance, visit records, medical reports, prescriptions, [and] test results, not to mention knowing how to use billing and coding software, means that technological skills are among the most important ones today's medical assistant needs."

Students must also understand how AI can improve the patient experience and outcomes.[4] Just as importantly, they need to know its limitations. While it can be used for studying, summarizing information, and organizing notes, ease of use can easily lead to overreliance. AI is not reliably accurate, so it is not only wise but crucial for students to

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SOFT SKILLS, HARDWIRED

Whatever the technology and its capabilities, some basic touchstones of effective professional service remain the same. Communication skills, critical thinking, and adaptability will always empower medical assistants to understand and use technology to best serve patients.

"Digital etiquette is among the most valuable skills that a medical assistant needs to perform effectively," says Marjorie Van Duyne, CMA (AAMA), an adjunct medical assisting educator at Wayne Community College in Goldsboro, North Carolina. "The written word is still a valuable and insightful tool to communicate [effectively]. Bad grammar can be seen as the inability to pay attention to detail, and shorthand, like LOL or OMG, can be read as immature or unprofessional." Her students participate in weekly discussion boards about sentence structure, spelling, and grammar.

"Today's medical assistants still struggle with communication," says Karen McIntyre-Pearson, a medical assisting educator at Miller-Motte College in North Carolina. "Being a professional team member with good judgment and critical thinking [is a major concern] for many health care providers. It's very important to be trained in using electronic health record software, medical office systems, organizational dynamics, and clinical settings [and] procedures before graduating."

Graduation cannot be the end of digital learning, and McIntyre-Pearson has felt the need for continued training herself. "To do my job effectively, I attend in-service classes," she says. "I would also advise medical assistant educators to make sure the students are familiar with AI in researching articles and interpersonal communication."

As platforms and technologies continue to change, the most durable goal is to develop the communication skills, judgment, critical thinking, and adaptability medical assistants will need to move from one digital environment to the next.

understand its capabilities and limitations.[5]

"Treat AI output like an unverified chart entry," says Militante. "Useful, but not fully usable until a human checks it. Verification, privacy, and data integrity depend on how responsibly a tool, in this case AI, is used." This approach should be the foundation of AI instruction. Learning how to compare AI-generated output with clinical guidelines, existing literature, and other credible sources helps identify errors, determine what is relevant to the situation, identify missing information, and decide whether to accept the AI output, modify it, or reject it altogether.[5]

TECH CHECK

Security is a primary concern with virtually every developing technology, especially in health care. Learning to use digital tools responsibly includes appreciating the importance of cybersecurity, patient data protection, and the ethical, legal, and regulatory requirements governing digital tools in health care.[4]

"Documentation integrity matters," states Militante. "Understanding when a message needs to be secure and how patient data flows through a practice are skills that are needed to protect and serve the patient."

To that end, the Department of Health and Human Services declared that education about new and emerging social engineering threats should be incorporated into security awareness and training programs related to the Health Insurance Portability and Accountability Act. Medical assistants must learn to recognize phishing, follow appropriate information access practices, and recognize how their own use of digital tools can protect, or inadvertently expose, patient information.[6]

"Students must understand their scope of practice," says Perry Quintana. "As more patient information becomes available through technology, a solid education requires that a medical assistant knows what they can do with it in their role. For instance, while they may see a diagnosis in a patient record, it is often out of their scope of practice to discuss it with the patient."

THE NEXT UPGRADE

As digital technology changes how health care is delivered and expands how medical assistants support patients and providers, digital literacy must be hardwired into new medical assistants as they enter the workforce.

What medical assistants learn today may be replaced or updated tomorrow, making the ability to adapt just as important as knowing how to use any particular tool. For educators, the challenge is to prepare students not just for the digital workplace they will enter after graduation but to continue learning as that workplace evolves.

Educators can future-proof digital literacy by teaching foundational, tool-agnostic principles instead of specific software interfaces. In other words, educators should make sure that students are trained to use any technology they encounter. When educators focus on critical thinking and concepts, the skills remain relevant no matter how fast technology changes. ✦

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Local Anesthesia Can Reduce IUD Insertion Pain

Intrauterine devices (IUDs) are a long-lasting and effective form of birth control that many women opt for over other forms of birth control. However, many women have painful IUD insertion experiences, and until recently, providers did not commonly offer pain management.

A recent Swedish trial found that local anesthetic delivered through a thin catheter just before IUD placement could reduce pain. The trial, published in *JAMA*, involved 370 women ages 18 to 31 and took place at several health clinics in Sweden. Researchers randomly assigned the women to either receive a saline placebo or the local anesthetic via a thin catheter inserted into the uterus two minutes before IUD placement. Neither the participants nor the health care providers knew which option they were receiving.

Participants then rated their pain on a visual scale of 0 to 100. The local anesthesia group reported an average pain score of about 44 during IUD placement, compared with 59 for the placebo group. Fewer women in the local anesthesia group (17%) reported severe pain (70 or higher) than in the placebo group (35%). More people in the anesthesia group said they would opt for an IUD again (93%) than in the placebo group (82%).

Pain management during IUD placement is crucial because many women forgo this form of contraception because they fear the pain.





FDA Approved Four 2026–2027 Updated COVID-19 Vaccines

The U.S. Food and Drug Administration has approved updated COVID-19 vaccines for many Americans. The four vaccines are from Moderna, Novavax-Sanofi, and Pfizer-BioNTech for the 2026–2027 season.

These vaccines target the JN.1-lineage XFG variant, which is currently the most prevalent throughout the world. The updated vaccines are approved for all adults 65 and older, as well as younger individuals with underlying conditions that put them at a higher risk of severe COVID-19.

Though all four of these updated vaccines target the same variant, their eligibility varies by age and underlying health conditions, reports Healthline:

- **COMIRNATY (Pfizer-BioNTech):**
  - Ages 5 years and older with underlying conditions
  - All adults 65 and older
- **SPIKEVAX (Moderna):**
  - Ages 6 months and older with underlying conditions
  - All adults 65 and older
- **MNEXSPIKE (Moderna):**
  - Ages 12 years and older with underlying conditions
  - All adults 65 and older
- **NUVAXOVID (Novavax):**
  - Ages 12 years and older with underlying conditions
  - All adults 65 and older

Updated COVID-19 vaccines are crucial because they target new viral strains. As COVID-19 continues to evolve, an annual vaccine update helps ensure protection against circulating strains.

The Best Carbs for Weight Loss



Many people believe they have to cut out carbohydrates to lose weight. And while some people may feel better when they reduce their carb intake, that is not the only way to lose weight. In fact, some types of carbs may even support a weight loss journey.

If you love carbs and are trying to lose weight, here are some carbs worth including in your diet, according to Healthline:

- **Beans, lentils, chickpeas, and other legumes** provide a combination of fiber and protein that can help promote fullness. Add them to salads, grain bowls, or tacos!
- **Potatoes** provide substantial fullness for relatively few calories. They are also inexpensive, accessible, and versatile.
- **Oats** are high in fiber, making it easy to build a satisfying meal around them. For a balanced breakfast, combine them with Greek yogurt, nuts, seeds, or fruit.
- **Brown rice, quinoa, barley, and other whole grains** provide carbohydrates, fiber, and crucial micronutrients.
- **Air-popped popcorn** can be a great high-volume snack. Because popcorn contains a lot of air, relatively few calories can provide a substantial serving.
- **Sweet potatoes** offer carbohydrates while also contributing vitamins and minerals. Try them alongside fish, chicken, or beans.

Rest Assured

If you feel tired all the time, you are certainly not the only one. The majority of adults (72%) experienced fatigue at least some days over the past three months, according to a recent report from the National Center for Health Statistics.

Feeling tired sometimes is normal, but fatigue is severe tiredness that persists, even when you get sleep. Fatigue can make it difficult for you to get through daily activities or focus at work. While it can be temporary and caused by lifestyle habits, it can also stem from an underlying medical condition.

Here are some reasons why you're always tired, according to Everyday Health and Health:

Sleep deprivation: Most adults need seven or more hours of sleep each night. You can improve your sleep quality and quantity by having a strict bedtime routine; avoiding screens, meals, and alcohol close to bedtime; and staying active during the day.

Sleep disorder: Sleep disorders are health conditions that directly affect your sleep quality and duration. Common sleep disorders include sleep apnea, narcolepsy, and restless leg syndrome. Consult a physician if you think you may have a sleep disorder.

Stress and mental health conditions: Stress from work, school, or other aspects of life can make it hard to fall asleep. Mental health conditions such as anxiety and depression can also make it hard to get proper sleep.

Nutrient deficiencies: Not getting enough essential nutrients from your diet can cause fatigue. Fatigue can be linked to deficiencies in folate, iron, magnesium, and more.

Certain medications: Medications that may be connected to your sleep quality include antihistamines, some antidepressants, antipsychotics, and more.

Dehydration: Dehydration can cause fatigue because water supports so many of your body's daily functions.

If fatigue is interfering with your daily life or your tiredness may be due to an underlying health condition, talk with your physician about treatment options.



CURING CONFLICT

Find Remedies for Workplace Conflict



By Mark Harris

The ability of health care teams to provide quality patient care depends largely on having an organizational culture shaped by effective communication, respectful relationships, and a shared dedication to the patient care mission. A positive, cooperative work environment where staff work well together is integral to health system performance.[1]

As a large and complex industry, health care is also a demanding and often stressful environment. Whether the demands involve clinical or administrative responsibilities, the health care system undoubtedly asks a lot of its workforce. In this challenging environment, conflict is unavoidable. From workforce and organizational pressures to patient care issues and more, health care professionals must invariably contend with differing perspectives, disagreements, tensions, and other stressors.

But while conflict may be an inevitable part of the medical system, its negative impact or outcomes are not. Conflict management skills can help leaders and managers, clinicians, and staff navigate these challenges in ways that promote staff well-being, organizational improvement, and quality patient care.

Why Conflict Matters

While the terms *conflict management* or *conflict resolution* might imply that all conflict is negative or harmful, this is not the case.

"It's important to understand that conflict itself is not bad," says Kimberly Best, RN, MA, a St. Louis–based conflict management expert and former emergency room and intensive care unit nurse. "Conflict is important; conflict is natural. It means there's a problem to solve or a misunderstanding that can be smoothed over. It means there's room for improvement. So, conflict in itself is not the enemy. Conflict escalation becomes the problem. That happens when we have a conflict that maybe we should be able to solve between us, but we don't have the tools to do it. And so, the conflict gets buried until it gets so big that catastrophic things happen, like a big staff turnover or patient

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accidents. Or it gets mishandled and comes out in aggression."

Accordingly, when ongoing conflict is left unaddressed or poorly handled, it can corrode not only staff satisfaction and performance, but also patient safety and care. "Conflict matters in health care because it does affect patient outcomes," says Best. "There is research where we see mortality and infection rates in hospital units [go] up with unresolved conflict. When we're in conflict, we don't hear one another as well. We're holding grudges we don't even know we're holding, which makes us unable to bring our best [selves] all the time. From job satisfaction to patient safety, there are just a lot of reasons why conflict matters."

Whether conflict in health systems is resolved in a timely and productive way will depend largely on how the team, practice, or organization responds. Do they have the competency and resources to resolve tensions and disagreements in ways that lead to desired outcomes?

"I have a slide that I use for every health care training that I give," remarks Best. "It's a quote from Michelle Gelfand, a Stanford psychologist and professor of organizational behavior. She writes, 'Learning the appropriate way to handle conflict in a hospital, if you're a doctor or a nurse, is just as important as any medical training.' "[2]

This observation extends to every member of the health care team, adds Best. The message is to consider conflict management skills an essential, staff-wide resource.

"Medical assistants in particular sit at the intersection of nearly every single relationship in a clinic," says Best. "They're between the patients, the providers, the nurses, and the office staff. They're often the first one who sees a patient when they come in upset or the last if they leave upset. They sit in a place where there are a lot of dynamics occurring, and sometimes they have great voice and their input matters. And sometimes, because health care can be a hierarchy, it doesn't. What I try to do, especially in practices or ambulatory care centers where medical assistants are used more, is to help develop a team that realizes that every single person's input is just as important as the others."

> "While patient care is what drives health care services, it's important to understand how much quality care relies on the state of the work culture. I worked with a practice whose primary goal was a great patient experience, and that's honorable. But what they forgot is [that] they can also have a great workplace experience. They were committed to treating their clients and patients well but had forgotten about treating one another well. They never had that conversation even after years in business. Our goal was to help them design a system where they could define respect. We want to be respectful to each other. So what does that look like? When things get escalated, how can we sit down and talk about it? It's about rehumanizing the people we're working with."
>
> —Kimberly Best, RN, MA

From an organizational or systems perspective, Best offers a more encompassing or holistic view of the conflict management challenge. "I am big on systems design, and your office is a system," she observes. "The whole health care system we are in is also a system, but each office is its own system. The people within that system need to be part of the voice that decides how that system is going to operate. Everyone first needs to be educated in how to manage conflict, why we have different capacities or do things differently, and how to understand the roots and causes of conflict."

In turn, the goal of organizations should be to move beyond conflict management per se, responding or reacting to conflict as it occurs, toward what Best describes as a more enduring "conflict ecosystem" in the organization.[3] This means building an organizational environment or culture where the sources of conflict can be addressed by those directly affected, using practical skills and shared agreements developed within the department, team, or organization.

The idea is to build conflict competency organically throughout the organization, explains Best, forging a skilled workforce culture versed in conversation skills that understands the norms for disagreement and can offer solution-oriented organizational responses. Critically, a conflict ecosystem should respond in a timely, proactive way to minor conflicts or tensions before they escalate into larger problems or crises.[4]

Under Pressure

In today's workforce, the idea of a conflict ecosystem is perhaps more relevant than ever, given the pressures many health systems face. In fact, as health care has evolved over recent decades, the potential for conflict has further intensified. Experts point to several reasons for this.

"Health care has evolved significantly over time from a business that once was run primarily by medical professionals who didn't necessarily have business acumen to one that has elevated the role of business professionals as partners," says Richard Birke, chief architect and lead facilitator for JAMS Pathways, a conflict resolution and training organization based in Irvine, California. "This marriage or integration has resulted in different kinds of cultural expectations of how business ought to be run. That's been one source of conflict in health care. In addition, with an aging population [and] increasing complexity in the practice, economics, and regulation of the modern workforce generally, there are more pressures on medical organizations and the people who work there than decades ago. Even though it was always a high-pressure profession, I think there is higher stress now."

Unfortunately, health care professionals may not always be well-versed in conflict management skills, adds Birke, nor recognize the need for education or training in this area. "A lot of folks who work in all aspects of the health care profession, including front-line service providers, doctors, and their staff, generally haven't been allowed the luxury of time to stop and upskill in conflict resolution," says Birke. "There's also perhaps a kind of Dunning-Kruger effect, where

people think, 'well, I learned to negotiate with my siblings, I learned to negotiate with my parents, [and] I negotiate with my kids, so I have conflict resolution skills.' "

The Dunning-Kruger effect is a term from academic psychology that describes a cognitive bias in which people overestimate their knowledge or ability in a specific area.[5]

In modern health systems, Birke believes conflict resolution skills are also relevant across a wider spectrum of operations than in years past. Gone are the days when conflict management might have centered primarily on the physician-patient relationship. "These are skills that involve mediating between colleagues everywhere in conflict, negotiating with team members, and negotiating between departments and for resources," says Birke. "We have remote workforces as well, so there are also some tensions there. I would say that medical professionals—and I'd say this broadly to include not just service providers but [also] the people who help around the organizations—would be well-served by either more training or partnering with conflict resolution professionals."

Further, the body of knowledge informing conflict resolution studies continues to expand. "As someone who has been out of law school for 40 years and working in conflict resolution for 35 years, my reading list is growing longer than ever," says Birke, who is also senior vice president and executive director of the JAMS Institute.

Resources

Best Conflict Solutions

https://www.bestconflictsolutions.com

Cairn Consulting Solutions

https://cairncs.com

JAMS Pathways

https://www.jamspathways.com

Agree to Disagree

Like other experts, Birke also reminds us that productive workplace relationships do not have to be calm and harmonious at all times. He suggests thinking of the historical example of President Lincoln's famous cabinet comprised of former political foes who worked to save the Union during the Civil War. In fact, the clash of opinions, differing perspectives, and tensions and disagreements that erupt at times may actually drive creative problem-solving.

"Sometimes different people with different approaches in a healthy dialogue can result in more thorough conversations and more creative outcomes," notes Birke. "If people disagree about how to approach a problem they share—whether that is a patient diagnosis and treatment or how to deal with something like a collective bargaining agreement—if they're collaborating and having disagreements about how to approach these issues, those conversations can sometimes be heated. People can feel strongly about their viewpoint and their approach, but as long as they can disagree without being disagreeable, that kind of conflict is productive."

Of course, disagreements can become disagreeable. "For whatever reasons, relationship conflict [can occur] because a past conflict has either not been managed effectively or because it's become personal, and often there are a wide variety of ways that things become personal, [which] can then result in hard feelings," remarks Birke. "This can lead to diminution in psychological safety, workplace unrest, lowered morale, and a reluctance to participate fully."

For example, Birke describes a workplace that experienced conflict because of a particular individual in a position of authority. "When that person was stressed, they would sometimes take things out on subordinates in a semi-public setting in front of other colleagues," he reports. "There were ripples that occurred from that where people didn't want to communicate with this individual. People also started [forming] camps. Generally, in conflicts, we see people who support one side, people who support the other, and people who want to be neutral and do their job. When you have a medical organization splitting into groups, what you see again is more sick days, less communication, stress, higher turnover, and lowered morale, all of which negatively impact patient outcomes."

For practice managers, a people-oriented leadership approach can go a long way toward creating a more cooperative, high-functioning work culture. "If leadership can lead also as peers," says Birke, "if they can learn to separate out past conflict and relationship conflict and learn to manage past conflict effectively, like how to run a good meeting, how to think in terms of effective brainstorming, how to take input and just manage that dialogue in a constructive way, that side of conflict is terrific. Otherwise, the alternative is groupthink and false consensus, and that results in impoverished conversations and diminished outcomes."

A Unique Challenge

With a background as a physical therapist in hospital acute care settings, Amy Lafko, MSPT, MBA, founder of Cairn Consulting Solutions, is particularly aware of the impact and dynamics of conflict in health systems.

As a business consultant, Lafko remarks that in other industries, executives might joke about how it's not as if they're doing brain surgery. But health care *is* the profession where brain surgery is actually done. The weight of decisions, professionalism, and performance always matters in the high-stakes world of medicine.

"Conflict resolution skills matter so much in health care," says Lafko, author of *People First: A Proven Method for an Exceptional Healthcare Practice*. "In health care, we're dealing with high-stress, often difficult environments. Patients come in because they're concerned about their health or are already having a problem. That's the unfortunate reality of health care. They're already often under stress and strain, and we're in systems that are under stress and strain. When we either brush conflict under the table, ignore it, or resolve it poorly, that can create an even more stressful environment."

As Lafko observes, when the health care environment is layered with conflict, which at times involves life-and-death medical

issues, it can be harder for people to have good self-regulation of their emotions all the time. "This is why it's so important that we raise those concerns in a productive way," she says.

Like other industry experts, Lafko also agrees that conflict management is not about viewing all conflict as negative. "Conflict can be beneficial," says Lafko. "It's when we have unproductive conflict that it's a problem. It's like two ends of a pendulum swing: On one end, there is a conflict, but people are avoiding it, and that's very unproductive because the underlying issues don't get resolved. Or people have conflict and blow up instead of having a conversation, and that blow-up leads to hurt feelings, leads to people shutting down, and decreases psychological safety in the practice. When you've got one of those extremes, either we don't talk about conflict, or we shout out our conflict. Neither one of those [is] helpful to our practice."

Notably, conflict management is not just a leadership concern. "We want our frontline staff to be able to have productive, healthy conflict as well," emphasizes Lafko. "I love this idea of being conflict competent, which involves a couple different pieces. No. 1 is self-awareness and self-regulation. You should know when you're in conflict, even if it's just in your own head. Be aware that something is problematic and then know how to regulate it. Now, I'm not perfect at this; none of us are. We might have a day where we're frustrated by something and that leaks out to the rest of the group. One of the conflict competencies we should have is the ability to state what our issues are objectively. It's not just about 'you as a person did this to me,' but what are the objective issues, and can we separate the objective data from our feelings?"

Lafko spends a lot of time helping practice leaders separate the objective data from feelings or assumptions. "For instance, think about when someone is late for work," she says. "Are you frustrated that they're late for work because this is someone who has been frustrating you in other ways, or is it just because a person was late to work? That takes us to a second, [vital] conflict competency: being able to let go of our assumptions. We all [make] a lot of assumptions about others. We might assume that everyone is stressed for the same reasons we are or is in a similar life situation. And then third is knowing how to not only bring up your concerns in a productive way, but to listen to the other person so we can find that middle ground.

Lafko cites an illustrative example to make her point: "For instance, when I ran urgent care operations, one of my practice managers once said, 'We're going have to let someone go; she's been late to her shift.' I asked if this involved the position where we had changed the operating hours. She said, 'Yes, and now this person is late all the time.' The practice manager's assumption was [that] this employee just didn't want to come in 15 minutes earlier. In response, I suggested we have a conversation with the employee first. When we sat down and talked, we discovered the employee was late was because, with the new hours, she was not able to drop her child off at school in time. Where she lived did not have school buses, so there was no other way to get her child there but to drop her off herself. We asked her, 'Well, what if we moved you to a different location in our system that's closer to the school and also has different operating hours?' She replied that she could make that work. And so now we didn't have to lose a really good employee."

For Lafko, this situation also raised another concern: "My question then became what got in the way of this employee coming to us with that information? A practice manager's job is to create an environment where, if there are issues, people can confidently and safely bring them to the manager. I realized that was an issue we also needed to work on."

Finally, managers should stay alert for early or emerging signs of conflict in the practice. "The first thing for the practice manager is to be willing to acknowledge that something is happening," says Lafko. "Maybe we're having subtle disagreement or noticing passive-aggressive behavior. Maybe we're hearing more concerns and issues from people, or there just seem to be some underlying issues happening. The skill then becomes: How do we sort this out? And can we do something about it?"

The Team Approach

Undoubtedly, every member of the health care team has an essential role in creating a healthy, cooperative workplace culture. The medical assistant can play a pivotal role as a workplace influencer, experts acknowledge.

"When you have a medical assistant who is skilled at understanding how to set the visit up so that the patient feels safe [and] who is skilled at recognizing the stressors the patient is feeling, that can change the whole trajectory of the visit," observes Lafko. "When we dismiss the medical assistant's role in the process, we're not helping the patient. I also want to say my bigger message for health care leaders is to help their physicians learn how

> "I believe the leadership has to model the behavior they wish to inculcate in the organization. That means they need to be available, non-defensive, and [reward] people who offer critiques they don't want to hear but [that] are valid. If you come to me and say something that's a critique of me or the organization and I shut you down, well, you're not coming back. And other people are going to see that. [Instead, I may] say, 'That was hard to hear; thank you for having the courage to come to me' [or,] at a meeting, 'This idea was brought to me; it was hard for me to hear, but I'm really grateful. I'm making the following changes, and we are going to get into a dialogue about X, Y, Z.' Now, all of a sudden, people feel like they can contribute. That's hard to do. But I think everybody in a position of leadership, when they hear a critique, needs to be able to step back and say maybe there's some validity to it. Rather than being defensive, I should model the kind of behavior that I want other people in my organization to aspire to."
>
> —Richard Birke

> "I think the most important thing to understand is that conflict resolution is a skill and we can all develop it, and that's hugely important. You can become really successful at resolving all types of conflict with some understanding of the process, some reflection on your own assumptions, and skills and strategies [for] how to have the conversation. I want people to recognize that whether you're that person ... who gets angry and blows up or you're that person who does everything they can to avoid conflict, you can develop a skillset to become someone who can have productive conflict conversations."
>
> —Amy Lafko, MSPT, MBA

to have productive conflict with the rest of the team and not just rely on position or authority. There is still such a sense of hierarchy in the health system. I want to have leaders who know how to create a safe space for staff to raise their concerns."

"I believe the medical assistant is such a vital role in health care," agrees Michelle Potter, CMA (AAMA), who works in the vascular and vein surgery department at Providence Medical Group in Everett, Washington. "We set the tone in the room sometimes. What I mean is that we can either let the patient vent out their concerns first, so when the provider arrives, they can get down to business, or we can listen and ease their way. Either way, the way I have always done my job, the patient always comes first."

When a patient is upset or in conflict over issues concerning their health care, Potter's advice is straightforward. "Listen; really listen," she says. "Treat them as you would want to be treated by a staff member or caregiver. Real life can be messy and hard for anyone. Take a moment to read the room, listen to the patient's needs, and be honest with them. If you do not know an answer, tell them, but also try [to] find one and [be] willing to do so. And also follow through with that patient."

Potter shares concerns about current staff shortages and other system pressures fueling more workplace strain and conflict. "In my experience, communication and having patience with each other would go a long way to avoid conflict," she suggests. "Listening to the needs of others may also be very helpful. Also, don't be so put off by someone's response. If you don't agree or feel it was unnecessary, then take a minute and do a peer-to-peer check-up. Often, if someone snaps at you, they may not realize it, and most likely it was not intentional. Be kinder to each other and ourselves; we are all human and deal with stressors differently."

Check the Blame Game

In a sense, the underlying challenge of conflict management is to recognize and honor the humanity of others while working together to achieve shared goals.

"With medical assistants, I recognize that they carry a lot on the job," observes Best. "On an individual level, we know everybody has challenges, but I would encourage all of us to try to have generous assumptions about others. We're right now in a bit of a culture of blame. My advice is to check the blame; check the story you're telling yourself about someone else. Ask questions. Maybe that story I'm telling myself about why someone looked at me a certain way is that they don't like me. But it might be the other person really was thinking about their uncle who was dying. It had nothing to do with you. I would try to check those assumptions and live more in the space of curiosity."

Generosity toward others also translates into showing kindness toward yourself, adds Best: "I would also say be good to yourself. Most of the time we're harder on ourselves than we are on other people. And we leak that onto other people. So, practice gratitude; go in with gratitude. For every problem we see, we should also try to offer a solution. It's easy to be critical or to criticize, but in the absence of a solution, without offering something that might fix it, we're just tearing something down without rebuilding it."

This is an insightful perspective. The challenge of conflict management—the ability to resolve issues productively—is, at heart, largely a matter of cultivating awareness, not only of ourselves as individuals and professionals but also of the broader dynamics of our workplace interactions and relationships. This self-awareness translates into emotional intelligence, active listening skills, and the capacity to treat others with insight, generosity, and empathy.

A health care professional skilled in this awareness views workplace tensions or issues through a more objective lens, works amicably and collaboratively with others, and derives satisfaction from a job well done. This ability also ensures more consistent delivery of quality patient care. ✦

The CE test for this article can be found on page 24.



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Blockbuster Reviews

Help every employee deliver a five-star performance

By Cathy Cassata

Giving staff evaluations can be stressful, especially when they happen only once a year.

"A practice manager sits down in November and tries to remember what happened in February," says Julianne Prizant, president and founder of the human resources consulting company OptiPeople Resources. Inevitably, she observes, this leads to the evaluation being influenced only by the last several weeks. "The employee can walk away feeling like an entire year of work was reduced to whatever was freshest in their manager's mind," says Prizant.

Perceptions of performance evaluation effectiveness are higher when reviews happen more frequently than annually and are associated with 11% more engagement, 8% more favorable views of fairness, and a 5% greater likelihood that employees say their performance has improved.[1]

"Employees should consistently know what they are doing well, where they need to improve, and what is expected of them," says Prizant. "Feedback also has much more impact when it is given close to the moment, when the situation is still fresh and the employee can connect the feedback to what actually happened."

To make the most of employee evaluations, consider the following advice:

Set Clear Expectations from the Start

Beverly L. Parnell, CMA (AAMA), has been the practice manager at Family Physicians of Evans in Georgia for 30 years. Her evaluations are divided into two parts: code of conduct and job-specific standards. "When we have a new hire, I give them a copy of their job description and a copy of the evaluation so that there is a clear understanding of what's expected," she says.

The evaluation system uses a simple 1–3 scale. A score of 1 signals an employee needs improvement, a 2 is the minimum that the company expects from everyone, and a 3 is reserved for those considered exceptional.

Prioritize Evaluations and Feedback

While managers are often pulled in multiple directions, Prizant notes that evaluations and regular feedback should not continually get pushed aside because something else feels more urgent. "When that happens, employees notice," she says. "Prioritizing your team means creating time for those conversations throughout the year, not rushing through an evaluation at year-end because the form is due."

Provide Detail

Telling an employee they did a good job is encouraging but not specific. Prizant suggests saying something like, "Great job with how you helped de-escalate that situation in the waiting room. You remained calm, listened to the patient's concerns, and found a solution."

Specific examples of challenges and areas for development are also insightful. "And if you have been providing regular feedback, this should not be the first time the employee is hearing about either the things they are doing well or the areas where they need to improve," says Prizant.

Discuss Issues

When Brittany Henning-Wolfe, CMA

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Tips for Delivering Difficult Evaluations

Giving a staff member a bad evaluation is never easy. However, Julianne Prizant offers the following tips:

Do not make it a surprise. If there are performance concerns, the employee should have heard about them before the formal evaluation. "[We] would be doing the employee a disservice if we soft-pedaled the feedback or skimmed over the difficult parts simply because they make us uncomfortable," says Prizant.

Be direct, respectful, and specific. Avoid vague statements like, "You need to have a better attitude" or "You aren't a team player." Instead, Prizant suggests using the SBI (Situation, Behavior, Impact) method. "Describe the specific situation, identify the behavior you observed, and explain the impact that behavior had. Then be clear about the expectations going forward," she says.

For example, consider saying, "Over the past month, there have been three occasions when you arrived after the first patient was scheduled. When that happens, another team member has to step away from their responsibilities to cover yours, which affects the rest of the team and potentially the patient experience. Going forward, I need you here and ready to work before the first scheduled patient."

Give the employee an opportunity to respond. There may be information or circumstances you are not aware of. "That does not mean the expectation automatically changes, but it may change how you approach the solution," says Prizant.

Ultimately, the goal of difficult feedback is not to make someone feel bad about what happened. "It is to make sure they understand what needs to change and give them a fair opportunity to make that change," says Prizant.

(AAMA), a practice manager at Dermatology and Skin Surgery Associates in Tinley Park, Illinois, had a new employee who was dealing with personal issues that were affecting her performance at work, Henning-Wolfe sat down with her to talk about how it was impacting her work. "She did not realize how much it was affecting her and thought she was doing well," says Henning-Wolfe. "After talking through her performance and looking at some specific areas, she was able to see where she was struggling and how the situation was holding her back."

The conversation led to more frequent weekly check-ins. "The additional check-ins seemed to help, and we saw some improvement in her work performance," says Henning-Wolfe.

Be Careful with Others' Feedback

Although soliciting feedback from others who work with an employee can give perspective, Prizant cautions it can also introduce subjectivity. "Some people naturally grade harder than others," she says. "One person's 'meets expectations' may be another person's 'exceeds expectations.'"

If you ask others for input, she suggests giving them clear criteria and asking for specific examples rather than simply asking: How is this person doing? "The goal is to evaluate the employee against the expectations of the role, not against each reviewer's personal definition of *good*," says Prizant.

Embrace a Two-Way Conversation

Henning-Wolfe asks staff to complete the same evaluation form as their manager to make the process more collaborative and give employees a chance to share their perspective.

Prizant suggests asking employees for their perspective with engaging questions:

- What are you most proud of?
- Where do you feel you have grown?
- What has been challenging?
- What would help you be more successful?

"Their answers may give you a perspective you would never get by simply going line-by-line through an evaluation form," she says.

Set Clear Goals

During a review, Henning-Wolfe helps employees set goals that focus on improving performance while also creating opportunities to learn new skills and take on new responsibilities. For instance, if an employee is struggling, she helps identify the reason, such as a need for additional training, an unclear process, or personal circumstances. Then she provides appropriate support. "Continue to track progress and revisit goals and evaluations regularly to make sure the employee is moving in the right direction," says Henning-Wolfe.

Understanding what motivates the employee can help set realistic, achievable goals. "Make sure rewards and recognition are connected to the goals and the effort the employee is putting in," says Henning-Wolfe.

Conducting quarterly goals can give work context, adds Prizant. "Particularly when an employee's goals can connect to a larger goal of the practice," she says. "Employees can see what they are working toward and how their contribution supports what the practice is trying to accomplish."

For example, a medical assistant who wants to take on more responsibility might lead an effort to improve a workflow that is creating delays. Checking in on this after a quarter can evaluate how the practice benefits from the process while the employee develops skills in problem-solving, communication, and leadership.

Quarterly goals can also make progress more manageable and relevant. "A goal that made perfect sense in January may no longer make sense in March because priorities, staffing, systems, or the needs of the practice have changed," says Prizant.

Lastly, help staff identify what it will take to achieve the goal by answering: What specific actions will lead to the result? What does the employee need to do differently or consistently? What support or resources do they need? "If you cannot identify the actions that should lead to the outcome, you probably do not yet have a well-defined goal," says Prizant. ✦

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A Chilling Situation

How to Recognize and Respond to Cold Weather Injuries

By Pamela Schumacher, MS, Prosci, RYT

From cold exposure to hypothermia, cold weather injuries (CWIs) are among the oldest documented forms of trauma and can cause severe, potentially life-altering damage.[1] Although outdoor workers are at risk, CWIs can affect anyone, particularly people participating in recreational activities, individuals with certain medical conditions, infants, older adults, and people experiencing homelessness. Prompt recognition, careful assessment, and appropriate treatment are essential to reduce the risk of serious complications, including loss of limbs and death.

The Cold, Hard Facts

Cold weather injuries are divided into nonfreezing injuries, which occur when the ambient temperature is above freezing, and freezing injuries. They include everything from cold stress and frostnip to the three stages of hypothermia.[2]

"Cold stress is when your body temperature is still in the normal range, but you're shivering. Your body is telling you that you're cold, and you're trying to generate more heat," Nadia Kimmel, MS, RN, WEMT, CEO of Desert Mountain Medicine, which provides wilderness medical training with an emphasis on risk assessment and prevention. "The big difference between cold stress and hypothermia is that [with cold stress,] you still have your mental faculties and can make good decisions. You have the ability for self-care such as telling yourself, 'I'm cold—I'll put on a jacket or start a fire.' Once you hit mild hypothermia, self-care starts to diminish. As you go through the stages of hypothermia, self-care goes to zero. One test is to ask somebody to zip their jacket. If they're having difficulty, their fine motor skills are diminishing and hypothermia has progressed."

"Hypothermia occurs when the external temperature and environment exceed the body's ability to maintain a minimum core temperature," says Molly O'Shea, MD,

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CWI Symptoms

Here are key symptoms of commons CWIs[9]:

- **Frostnip**
  - Usually affects the face, ears, or fingertips
  - May cause numbness or blue-white skin color
  - Normal feeling and color return quickly when warmed with no permanent tissue damage
- **Frostbite**
  - Feeling of pins and needles
  - Freezing of the skin and the tissues beneath it because of temperatures below freezing
  - Skin feels cold, numb, and stiff or rubbery to the touch and may blister
  - Potentially unable to tell extent of injuries until skin has been rewarmed
- **Mild hypothermia**
  - The person is cold, shivering, and shows signs of impaired physical ability like stumbling and inability to care for themselves.
  - Their core body temperature is likely to be 91 to 95 F.
  - They may show some signs of altered mental state, like slurred speech.
  - Their pulse may be quite rapid, although it will slow as they cool.
- **Moderate hypothermia**
  - The person feels cold, but their shivering is weak or has stopped.
  - They cannot care for themselves and may be confused, make odd decisions, show excessive hunger, and have irregular or slow heartbeat and breathing (less than 12 breaths per minute).
  - Their core body temperature is likely to be 83 to 90 F.
- **Severe hypothermia**
  - The person is likely unconscious, experiencing decreasing strength, decreasing pace and regularity of heartbeat, slow and irregular breathing, no nervous reflexes, and no pain responses.
  - Their core body temperature is likely to be 75 to 82 F.
  - Below a core body temperature of 74 F, signs of life continue to decline. This includes eyes not responding to light, a decreasing heartbeat, and eventually a loss of brain activity or heartbeat.

FAAP, an American Academy of Pediatrics media spokesperson. "In other words, the body can't keep up with the demands of generating enough heat to keep the body warm due to the harsh external environment, and as a result the body's core temperature falls. Cold exposure on the other hand is when the core temperature is maintained, but exposed parts of the body are injured due to the harsh environment."

"The risk in cold weather is most likely to be frostbite," says Gordon Giesbrecht, PhD, professor emeritus at the University of Manitoba. "You can get frostbite in a short amount of time in a lot of different conditions."

Chill Factors

Infants and older adults are especially vulnerable to problems with cold exposure, often because they have a harder time regulating their body temperature. Even a small drop in the surrounding temperature or a short time spent outside in the cold can cause a large drop in body temperature in infants and older adults. Additionally, living in a poorly heated home can also cause hypothermia.[3]

"Hypothermia can happen acutely, such as in an accident, or it can happen over several days," says Kimmel. "One of the more common situations in an urban setting would be someone who doesn't have sufficient heat in their house, so over the course of several days they have been exposed to a cold environment. This can drop their body temperature too low. It could also be people who are homeless and living in and out of a shelter or in their car."

Risk factors for CWIs include[4]:

- Winter season
- No or inadequate shelter from the cold
- High wind chill factor
- Exposure at a high altitude
- Prolonged duration of exposure
- Prolonged exposure to a wet condition
- Altered mental status
- Unhealthy alcohol or drug use
- Malnutrition
- Immobilization
- Extremes of age
- Homelessness
- Presence of medical disorders like diabetes, hypothyroidism, peripheral vascular disease, stroke, or arthritis
- Being a smoker

"Children have a high surface area-to-body mass ratio so they will radiate heat," says Dr. O'Shea. "When placed in a cold environment, their bodies will radiate even more heat to raise their temperature. Frail, older people often have problems because responding to extreme cold requires a robust metabolism and the ability to mobilize several pathways, including shivering, movement, and others. Fat layers also insulate the body. Older people often have more sluggish metabolisms, peripheral artery disease, or other chronic illnesses, and therefore cannot generate heat very well."

Cold Cues

When exposed to the cold, the body can lose heat faster than it produces it. Over time, the body uses up its stored energy and body temperature begins to drop. Long-term exposure to the cold—especially if the body's core temperature falls below 95 degrees Fahrenheit—can lead to hypothermia, frostbite, and other problems. Determining stages of cold exposure is based on observing a person's behavior, sensations, and external symptoms:

- The sensation of cold
- The onset and progression of a shivering response, which is one of the ways a body rewarms itself
- The loss of ability to do normal physical activities like [zipping] zippers [and] walking without stumbling
- Impairment of mental ability as the brain cools, like slurred speech, disorientation, [and] sleepiness
- Degree of consciousness
- The decrease or absence of signs of life like breathing or heartbeat[5]

The most important warning sign of frostbite is numbness, says Giesbrecht: "When you get cold, you generally feel cold. If your skin and receptors get colder, you'll feel pain, and then you'll feel numbness because the receptors and nerves that bring signals to the spinal cord and brain are getting cold or not working. When you feel nothing, that means you're so cold that you can't even get poor signals. You're at imminent risk of freezing that tissue, and that means you can have tissue damage or loss."

"You can get frostbite and not have hypothermia. You can have hypothermia and not frostbite, or you could have both," says Kimmel. "Frostbite is freezing. Crystals form within your tissue layers. You could have superficial frostbite or deep frostbite. … You can only tell severity after the thaw.

"A patient's vitals, such [as] blood pressure, heart rate, and respiration, should be assessed, but taking a patient's temperature with an oral thermometer will not tell you if they are suffering from hypothermia because it doesn't get the core temperature," says Kimmel. "Instead, you assess hypothermia by level of responsiveness and shivering. Are they alert and oriented? Is confusion setting in? Are they unresponsive? Shivering can be mild, uncontrollable, or none."

"As you get progressively colder, you get what we call the 'umbles.' You gradually lose the ability to speak, think, and move; you grumble, mumble, fumble, stumble, and finally tumble," says Giesbrecht. "And shivering, of course, is the first sign that there's anything wrong. Shivering is a defense mechanism to produce heat so that you don't lose core temperature. You can be shivering for hours and still have a normal temperature. Shivering is not a sign of hypothermia, but it's a sign that you're losing more heat than you're gaining, and you need to do something about it."

Kimmel notes that the symptoms of hypothermia can mimic other conditions. "The cognitive issues of hypothermia might look like a stroke. Shivering might look like alcohol withdrawal. It could also look like seizure activity or essential tremors."

"If I saw a patient who was cold and shivering, and if the context were right, such as if it's winter, then I would suspect hypothermia and notify the care team and the physician," says Terrie Clark, CMA (AAMA), a medical assistant in Colorado Springs, Colorado. "I once had a patient who came in with frostbite, an older farmer who was recently diagnosed with type 2 diabetes. He said he didn't even notice his feet getting colder, so it's important to warn folks that it can sneak up on you, especially if you have certain medical conditions."

Keep Your Cool

Knowing how to treat CWIs is crucial for medical assistants.

To treat frostnip you can do the following[2]:

- Rewarm by immersing the affected part in a water bath of 105–110 F for 25–40 minutes.
- Monitor the temperature carefully with a thermometer, as higher temperatures can cause damage.
- Remove constricting clothing. Place the appendage in the water and maintain the water temperature by adding additional warm water. Do not add this warm water directly to the injury.
- Thawing is complete when the part is pliable and color and sensation have returned.
- Once the area is rewarmed, pain may be significant. Discontinue the warm water bath when thawing is complete.
- Do not use dry heat to rewarm. It cannot be effectively maintained at 105–110 F and can cause burns, further damaging the tissues.

Frostbite can damage tissue in two ways. First, ice crystals form inside the tissue, causing direct mechanical damage and reduced blood flow (ischemia). Second, rewarming the frozen tissue triggers reperfusion, creating an inflammatory and prothrombotic state that leads to further secondary injury.[4] To treat frostbite, take these actions[6]:

- Raise the patient's body temperature in lukewarm water or by applying warm, wet packs to their skin for up to 30 minutes.
- Apply wound dressings to frostbitten skin with sterile bandages, keeping fingers and toes separated to avoid rubbing.
- Test blood flow in the affected area of the body. If they have Stage 3 frostbite, you may need to connect the patient to a bag of warm IV fluid to improve circulation.
- Give antibiotics and pain relievers.
- Rehydrate by giving warm (not hot) water. (Frostbite dehydrates tissues.)
- Tell them not to walk on frostbitten feet or toes.

Cold Plunges

Heat loss can occur through several mechanisms[10]:

- Conduction: Physical contact with a cold object
- Convection: Air or water on the skin moves heat away from the body
- Evaporation: Water (e.g., sweat) vaporizes from the skin
- Radiation: Environment decreases heat

- Do not rub the frostbitten area.
- Avoid touching hot surfaces with the frostbitten area.

To rewarm a hypothermic patient, conserve the heat they have and replace the fuel they are burning. Everything should be done gently[7]:

- Dry the patient's skin.
- Change them into warm, dry clothing.
- Cover them with warm blankets.
- If the hypothermia is mild, have them drink hot beverages.
- Heat the core, the armpits, and trunk. Do not place heat sources directly on the skin; separate them with cloth or another insulator to avoid burns.
- If the hypothermia has progressed past mild, keep the patient horizontal and do not let them move. The movement will send cold blood from the limbs to the heart and could result in cardiac arrest.

Gentle handling is key because of the risk of complications:

- **Afterdrop** is the continued cooling of the deep core body temperature after getting out of the cold. It happens because blood vessels dilate and allow cold blood from chilled arms and legs to flow back into the body's core.
- **Rescue collapse (also called circum-rescue collapse)** is a sudden and dangerous drop in arterial blood pressure that can cause fainting, heart failure, or death right before, during, or after a rescue. It is triggered by the loss of water pressure (hydrostatic pressure) surrounding the body once a person is lifted out of cold water, combined with cardiovascular instability and moving from a horizontal to a vertical position.

"A patient's condition deteriorates even though they're no longer in the cold. It can range from simply falling down to fainting to sudden death. By the time a patient gets to a medical assistant, they should always look at that patient as a candidate for rescue collapse," says Giesbrecht. "Take care of them, but keep the patient horizontal."

Freeze Frame

Advise your patients to follow these steps to avoid problems with cold exposure[3]:

- Dress in layers.
- Wear warm clothing and waterproof shoes to protect the hands, feet, neck, and face.
- If going outside for any length of time, bring plenty of fluids and food high in protein and fat.
- For short trips outside, bring carbohydrates for quick energy boosts.
- Avoid alcoholic drinks because they make the body lose heat faster.
- Keep moving to stay warm, but avoid exhaustion.
- To avoid developing hypothermia indoors, place a rolled towel in front of doors to block drafts, make sure windows are weather-stripped or caulked if they have gaps, and keep indoor temperatures above 68 F. Get to a warm location if a home heating system fails.

"Get out of the cold if you can. It makes sense, but people get sucked into thinking, 'I'll be fine,' and they stay out there, and then they die. You can increase your physical activity to produce more heat, put on more clothing, or add more thermal protection. That's basically how you prevent cold weather injuries," says Giesbrecht.

"Clothing layers are key to preventing injury due to extreme weather," says Dr. O'Shea. "When working or exercising outside in the extreme cold, take breaks often and change clothes to keep the area near the skin dry. Wear sweat-wicking fabrics next to the skin and plan to change layers frequently to avoid dampness near the body during extreme cold. Wearing a hat and gloves, as well as insulated boots, can also help prevent heat loss. Children should always wear one more layer than adults since they radiate so much more heat."

To help patients avoid CWIs, medical assistants can ask them about home heating, water in the home, permanent living status, substance use, and access to warm clothes to ascertain the social and economic pressures facing their families, says Dr. O'Shea: "Understanding this and [offering support to] families in a compassionate way can make a big difference in reducing morbidity."

"If … I can tell [patients] need some help, I take out my little black book of community resources," says Clark. "I'll also advise the nurse and the physician that this is a case that maybe we should take a closer look at. If we can connect patients to resources available in the community, we can make a big difference in improving their lives." ✦

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



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Conflict Resolution

Deadline: Postmarked no later than **January 1, 2027**

Credit: 2.5 AAMA CEUs (gen/admin) **Code: 146017**

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(s) to each of the following, based on information derived from the article.

1. **Which relationships commonly place medical assistants at the center of clinic dynamics?**
   - ☐ A. Patients
   - ☐ B. Providers
   - ☐ C. Nurses
   - ☐ D. All of the above

2. **Which description best reflects a healthy conflict ecosystem?**
   - ☐ A. Only managers are permitted to address disagreements.
   - ☐ B. Minor tensions are addressed proactively using shared skills and agreements.
   - ☐ C. Conflict is ignored until a formal grievance is filed.
   - ☐ D. Team members avoid expressing different perspectives.

3. **Which situation is the best example of productive conflict?**
   - ☐ A. Team members compare different approaches and collaborate on a solution.
   - ☐ B. Staff members form camps and stop sharing information.
   - ☐ C. A leader criticizes an employee in front of colleagues.
   - ☐ D. A concern is buried to preserve harmony.
   - ☐ E. One person ends debate by relying on title or authority.

4. **The Dunning-Kruger effect refers to what tendency?**
   - ☐ A. Underestimating the impact of hierarchy
   - ☐ B. Overestimating one's knowledge or ability in a specific area
   - ☐ C. Avoiding all disagreement with leaders
   - ☐ D. Preferring remote work over on-site work

5. **Which outcomes may follow when relationship conflict becomes personal? *(Select the four that apply.)***
   - ☐ A. Lower psychological safety
   - ☐ B. Reduced morale
   - ☐ C. Reluctance to participate
   - ☐ D. Stronger communication across camps
   - ☐ E. Higher turnover

6. **Which abilities are part of conflict competency?**
   - ☐ A. Self-awareness
   - ☐ B. Self-regulation
   - ☐ C. Stating issues objectively
   - ☐ D. Testing assumptions
   - ☐ E. All of the above

7. **A supervisor says a staff member is late because they do not care about the team. What is the best first step?**
   - ☐ A. Treat the statement as objective data.
   - ☐ B. Separate the observed lateness from the assumption about motive.
   - ☐ C. Immediately recommend termination.
   - ☐ D. Share the conclusion with the full team.

8. **After clinic hours change, a reliable employee begins arriving 15 minutes late. What is the best manager response?**
   - ☐ A. Ask open questions to understand the cause and explore workable options.
   - ☐ B. Assume the employee is resisting change.
   - ☐ C. Publicly warn the employee during the next huddle.
   - ☐ D. Reduce the employee's duties without discussion.

9. **A practice manager notices passive-aggressive comments and more staff complaints. What should happen first?**
   - ☐ A. Acknowledge that an emerging conflict may be present and begin sorting out the issue.
   - ☐ B. Wait until patient care is disrupted.
   - ☐ C. Prohibit staff from discussing concerns.
   - ☐ D. Assume the behavior will resolve without attention.

10. **A staff member gives a leader difficult but valid feedback. Which response best models psychological safety?**
    - ☐ A. Thank the staff member, consider the feedback without defensiveness, and explain next steps.
    - ☐ B. Dismiss the feedback to protect authority.
    - ☐ C. Ask the staff member not to raise concerns in meetings.
    - ☐ D. Delay any response until the concern is forgotten.

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11. An upset patient tells a medical assistant that no one has explained a delay. What is the best response?

- ☐ A. Listen carefully, be honest about what is known, seek the answer, and follow through.
- ☐ B. Tell the patient delays are unavoidable.
- ☐ C. Promise a specific outcome without checking.
- ☐ D. End the conversation and refer every concern elsewhere.

12. A respectful peer-to-peer check-up can clarify a tense interaction that may not have been intentional.

- ☐ True
- ☐ False

13. What practice best supports solution-oriented conflict management?

- ☐ A. Offer a possible solution when identifying a problem.
- ☐ B. Avoid raising concerns unless a complete plan is guaranteed.
- ☐ C. Focus discussion on who caused the problem.
- ☐ D. Use criticism to establish authority.

14. Why is unresolved conflict a patient-care concern?

- ☐ A. It can reduce communication and contribute to safety and quality problems.
- ☐ B. It guarantees that every disagreement becomes a formal complaint.
- ☐ C. It affects morale but not clinical outcomes.
- ☐ D. It eliminates differing viewpoints.

15. During a care-process meeting, everyone quickly agrees with the senior clinician despite unspoken concerns. What should the facilitator do?

- ☐ A. Invite differing viewpoints and manage the dialogue constructively.
- ☐ B. Record the agreement as proof that no conflict exists.
- ☐ C. End the meeting before disagreement begins.
- ☐ D. Ask only leaders for input.

16. A medical assistant notices repeated tension between two team members that is beginning to affect patient care. Which sequence is most appropriate?

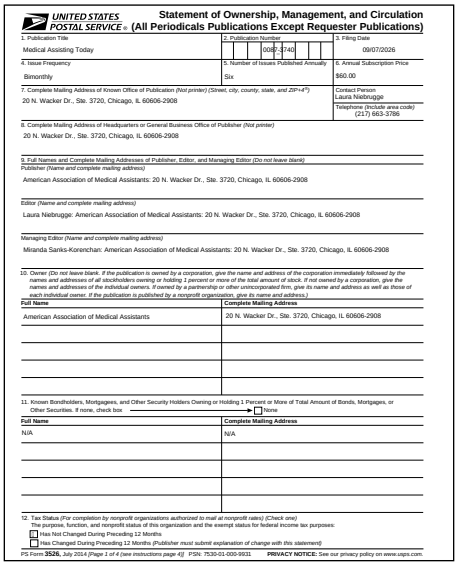
- ☐ A. Ignore the issue until a patient complains.
- ☐ B. Choose a side and gather supporters.
- ☐ C. State the observed problem objectively, ask questions, listen to both perspectives, and help escalate through the appropriate channel if needed.
- ☐ D. Send a department-wide message naming both employees.
- ☐ E. Reduce communication between the employees without discussion.

17. Conflict itself is always harmful to a health care team.

- ☐ True
- ☐ False

18. A colleague gives a brief response during a busy clinic session. Which reaction is most appropriate?

- ☐ A. Pause, check the story you are telling yourself, and ask a curious question.
- ☐ B. Assume the colleague is disrespectful.
- ☐ C. Complain to others before speaking with the colleague.
- ☐ D. Respond in the same tone.
- ☐ E. Avoid the colleague permanently.



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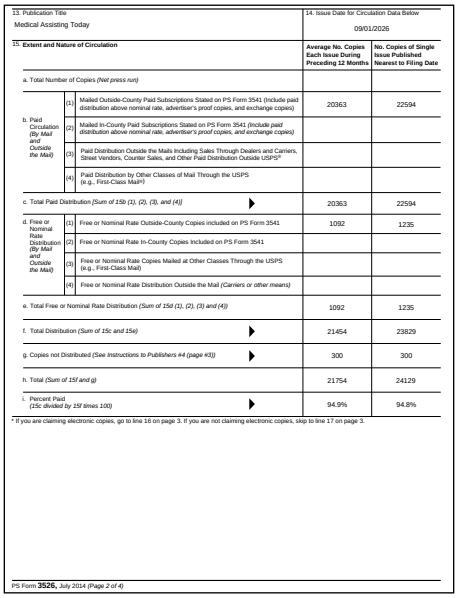
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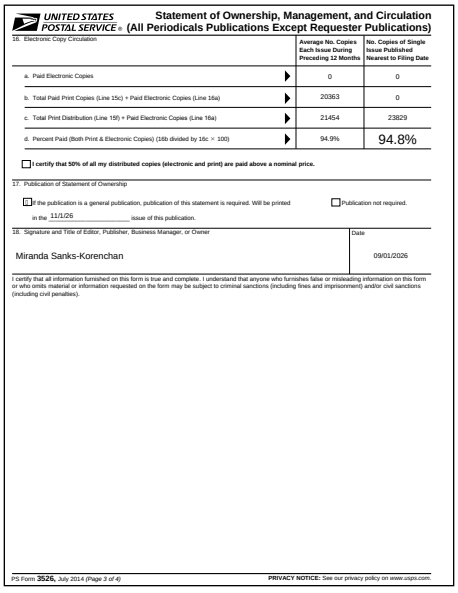


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Cold Weather Injuries

Deadline: Postmarked no later than **January 1, 2027**
Credit: 1 AAMA CEU (gen/clin) **Code: 146018**

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

1. **An older patient arrives during winter shivering and confused. An oral temperature is normal. What should the medical assistant do next?**
   - ☐ A. Rule out hypothermia because the oral temperature is normal.
   - ☐ B. Assess responsiveness and shivering, obtain vital signs, and notify the care team.
   - ☐ C. Ask the patient to walk briskly until warm.
   - ☐ D. Apply a heating pad directly to the skin.

2. **Which finding most clearly distinguishes mild hypothermia from cold stress?**
   - ☐ A. The person reports feeling cold.
   - ☐ B. The person begins shivering.
   - ☐ C. Self-care and fine motor ability begin to diminish.
   - ☐ D. The person asks for another clothing layer.

3. **Which factors increase a person's risk for cold weather injury? *(Select the four that apply.)***
   - ☐ A. Prolonged wet exposure
   - ☐ B. High wind chill
   - ☐ C. Extremes of age
   - ☐ D. Adequate heated shelter
   - ☐ E. Diabetes

4. **Numbness after cold exposure can signal imminent risk of tissue freezing and damage.**
   - ☐ True
   - ☐ False

5. **Which action is appropriate when rewarming frostnip?**
   - ☐ A. Use a 105–110 F water bath and monitor the temperature.
   - ☐ B. Rub the area vigorously.
   - ☐ C. Use dry heat from a heating pad.
   - ☐ D. Add very hot water directly onto the injured area.
   - ☐ E. Continue soaking after color and sensation return.

6. **Shivering alone confirms that a patient has hypothermia.**
   - ☐ True
   - ☐ False

7. **A patient rescued from cold water has more than mild hypothermia. Which action is most appropriate?**
   - ☐ A. Keep the patient horizontal and handle gently.
   - ☐ B. Have the patient walk to generate heat.
   - ☐ C. Massage the arms and legs.
   - ☐ D. Seat the patient upright near a heater.

8. **During intake, a patient reports that the home heating system has failed. What is the best medical assistant response?**
   - ☐ A. Document the issue only if the patient already has frostbite.
   - ☐ B. Compassionately assess access to warmth and connect the patient with the care team and community resources.
   - ☐ C. Recommend staying home under several blankets regardless of indoor temperature.
   - ☐ D. Avoid asking about housing or heating because these are not health concerns.

9. **What causes afterdrop during rewarming?**
   - ☐ A. Cold blood from the limbs returns to the core as blood vessels dilate.
   - ☐ B. The patient suddenly begins producing too much body heat.
   - ☐ C. Ice crystals form only after the patient is indoors.
   - ☐ D. A warm beverage lowers blood pressure.

10. **A patient will work outdoors in extreme cold. Which prevention strategies should the medical assistant reinforce? *(Select the four that apply.)***
    - ☐ A. Dress in layers and keep clothing near the skin dry.
    - ☐ B. Bring fluids and foods that support energy needs.

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- [ ] C. Use alcohol to create a warming sensation.
- [ ] D. Take breaks and avoid exhaustion.
- [ ] E. Wear a hat, gloves, and insulated boots.

11. Which instructions are appropriate for a patient with frostbite? *(Select the four that apply.)*

- [ ] A. Do not rub the affected area.
- [ ] B. Keep fingers or toes separated with sterile dressings.
- [ ] C. Walk on frostbitten feet to restore circulation.
- [ ] D. Avoid direct contact with hot surfaces.
- [ ] E. Rehydrate with warm—not hot—water.

12. A patient exposed to cold is mumbling, fumbling with a zipper, and stumbling. What is the best interpretation?

- [ ] A. The patient is showing progressive impairment from cooling.
- [ ] B. The patient has isolated frostnip only.
- [ ] C. The patient is demonstrating normal cold adaptation.
- [ ] D. The patient is ready for vigorous exercise.

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A Calling to Care

Family Caregiving Experience Leads to Medical Assisting Career



By Cathy Cassata

In June 2001, Patti Stowell, CMA (AAMA), found herself caring for her sister in a way she never imagined. "She was in a terrible car accident with my niece. My niece tragically passed away, and my sister was left with permanent brain trauma, having lost her short-term memory and much of her cognitive rationality," she says.

Stowell took on the role of caring for her sister around the clock. At the same time, her mother's health declined due to congestive heart failure and diabetes. While caring for both women simultaneously with no formal training, Stowell decided to enroll in a certified nursing assistant (CNA) program.

"With all the health issues my loved ones were going through, I wanted to be a better advocate for them, but I needed more experience and knowledge," she says. After getting certified, Stowell balanced caring for her mom, sister, and her own two children while working three jobs at once—driving a school bus, providing home care, and working at a foot clinic.

Despite the stress, her passion for health care grew, and in 2011 she decided to attend nursing school. That same year, her mother died. "My finals were scheduled the day of her funeral, but I took them anyway," says Stowell.

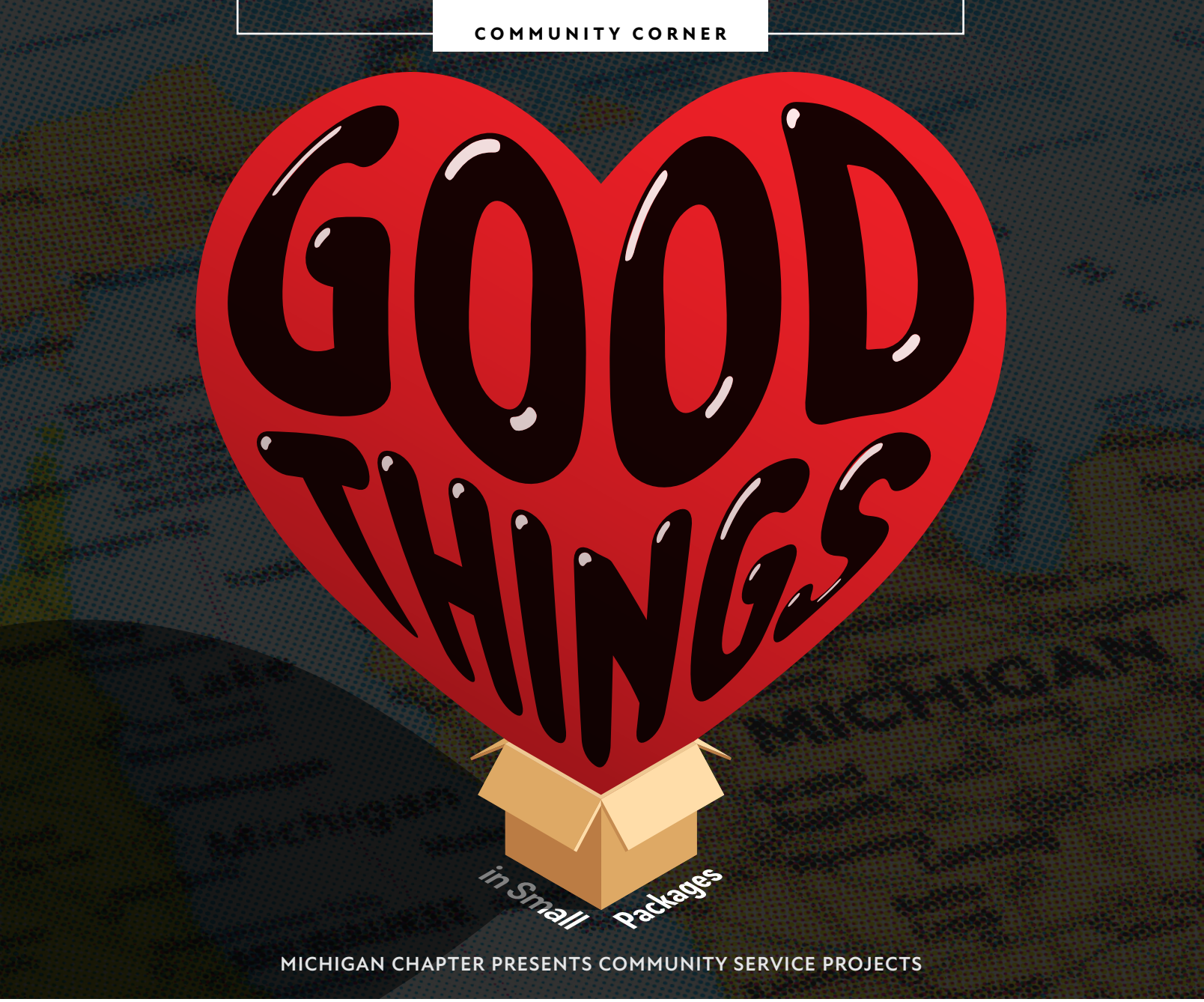
Four months later, her father's health declined from chronic obstructive pulmonary disease, and he needed constant care, so Stowell moved in with him for nine years. However, during the first year, the strain of caregiving for several family members forced her to drop out of nursing school. "I was barely getting by," she says, "And I knew that I wasn't going to make it."

Her drive to work in health care persisted though, and in 2018 she found a different position as a CNA in hospice. "I really liked the job until a back injury sidelined me and I needed surgery," she says. While recovering, she had time to think about her next career move and decided to attend a medical assisting program. She graduated in 2024 and was hired by a UW Health kidney clinic. Her days are filled with anemia injections, laboratory orders, medication refills, and pre-visit planning. "I still get to have a lot of patient interaction, which I love," says Stowell.

One encounter that stays with her involves a patient who was distressed after learning that, because her chart indicated she was receiving palliative care for a terminal illness, a physician refused to prescribe her treatment to help with an unrelated chronic condition. "She told me that she wasn't able to get certain treatments to help with sleep because of this, and I passed on the information to the doctor and urged her to speak up," says Stowell. When the woman returned for a follow-up, palliative care had been removed from her chart. "When I saw her at the appointment, she said, 'I'll never forget you. You have no idea what you've done [for] me. You've made such a difference in my life,' " says Stowell.

Patient interactions like these remind her that she's exactly where she should be. While she did not know that caring for family would lead to a rewarding career, Stowell says it is a silver lining she is grateful for. "Helping people who might not have loved ones advocating for them or looking out for them brings real meaning to my medical assisting work," she says. "That's what I'm here for. It's my calling." ✦

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MICHIGAN CHAPTER PRESENTS COMMUNITY SERVICE PROJECTS

By Kelli Smith

Mistie Atkins, CMA (AAMA), president-elect and community outreach chair of Michigan's Northwest Chapter of Medical Assistants, describes her local chapter as a "small but mighty group." With about seven medical assistants who show up to every local chapter meeting and participate in their community service projects each year, she is spot-on. This tight-knit group of dedicated medical assistants does a great deal for their community, usually choosing about three community service projects per year to carry out.

"We live in a rural community, and it's really important to give back to our community that we all live [in] and serve," explains Atkins. "It's something that's really important to our chapter and the people that attend the meetings. It's a passion of mine as well. And by doing these community outreach projects, we can give back."

While the chapter has a great passion for helping others, they also enjoy informing their community about the medical assisting profession through their service. "Shockingly enough, a lot of people in the community still don't realize what medical assistants are," says Atkins. "So, it's kind of [a] dual purpose of giving back to the community but also educating the community on medical assisting in their community as well."

Last year, the chapter chose to serve Munson Manor Hospitality House, Northwest Education Services Career Tech, and Leelanau Christian Neighbors' Blessings in a Backpack program, all of which are near and dear to medical assistants of the Northwest Chapter.

Here is a breakdown of each of the Northwest Chapter's community service projects and how they made a difference to these communities this past year.

Munson Manor Hospitality House

Munson Manor Hospitality House in Traverse City, Michigan, houses out-of-town patients, family members, and caregivers who need a place to stay during a loved one's

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hospitalization at Munson Medical Center.[1] They have a Family Dinner Volunteer Program for guests in which volunteers help supply dinners for individuals staying at Munson Manor.

Once a year, the Northwest Chapter makes a meal, serves it, and sits down to eat with the residents of Munson Manor. Usually, the people staying there want to share their story.

"It's really rewarding to get to hear their [stories] and be part of that," states Atkins. "We see a lot of families there [for the Neonatal Intensive Care Unit (NICU)]. So, we had a couple [whose] baby had been in the NICU for several weeks and was going to be there for several more weeks. They were essentially living at the manor while she was still breastfeeding and had to go over [to the hospital] all the time. And so, it's always meaningful when you meet a NICU family."

They typically volunteer around the holidays to provide meals during difficult times in the residents' lives. "They're always so appreciative of a [freshly] cooked meal, because either they're eating cafeteria food or they're getting pizza. So, to be able to eat like a home-cooked meal is usually pretty impactful for them—[and] to be able to just sit down and take a minute and share their story."

Atkins enjoys how this volunteering project is people-facing, and the chapter really gets to feel the impact they are making on these residents' days.

Career Tech Center

Northwest Education Services Career Tech in Traverse City, Michigan, provides students with academic and technical skills, as well as knowledge and training in high-demand careers, such as medical assisting.[2] They have a closet dedicated to personal care items and snacks for students who are in need of food or items such as deodorant or toothbrushes.

Atkins connected to the school because of its medical assisting program and because one of the Northwest Chapter members works there. "I'm pretty involved in that program," she says. "I go and talk to the students [every year] about medical assisting so that they can make a good, informed choice. And I'm trying to sway them to get as many medical assistants as possible in that program."

Though Atkins knew there was a need for these items in her community, she did not know the need was so profound at the school. "I've been going to Career Tech center for years and years to teach [and] do some outreach through the health science class. And I didn't know until this last year that they had a need for basic things for their students," explains Atkins. "So that really surprised me. I didn't realize that there were students out there that needed deodorant and some of these basic things. So that was an eye-opener for me."

Blessings in a Backpack

Leelanau Christian Neighbors' Blessings in a Backpack program is a hands-on initiative that helps alleviate weekend hunger by providing food to children throughout Leelanau County. Each week during the school year, students in need receive a backpack full of nutritious food to get them through the weekend.[3] Students who receive assistance through this program receive their items in a backpack so it is can be given to them discreetly and other students do not have to know that they are receiving help from the organization.

When Atkins delivered cartloads of food to them before Christmas break, they were thrilled. "You couldn't fit one more thing in my car, … and I think it was three full cartloads full of food," says Atkins. "We purposely did that one last year before Christmas break because they send extra food home, because a lot of the kids only eat when they're at school. They get the free breakfast and the free lunch, and then they go home and a lot of times don't have dinner.

"There was a big need through [the] Thanksgiving holiday and Christmas holiday where they were off a week and then two weeks for Christmas," she continues. "So, they were really appreciative because that was stocking them up to be able to do the extra food for the holidays."

Small but Mighty

As a medical assistant, community service means a great deal to Atkins and the rest of her local chapter.

"[What community service means to me is] just being there and showing up for our community, educating them, teaching them, [and] helping them," she says. "We have an amazing community where we live and just want to continue to support our community." ✦

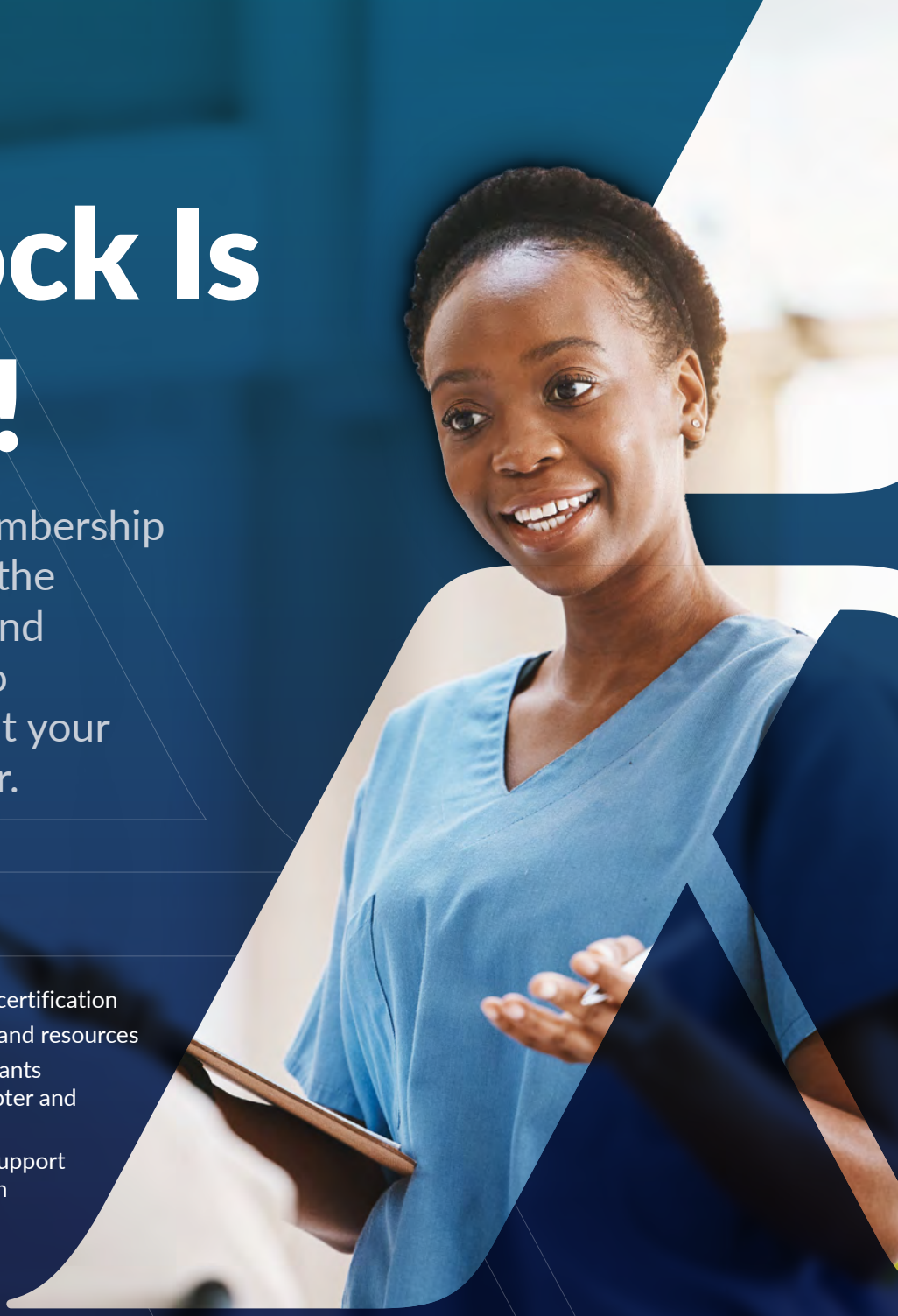
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