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July 1-5, 2018

80th Educational Program and National Meeting

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AMT — A National Certification Agency

American Medical Technologists (AMT), established in 1939, is a national, non-profit certification agency for: Medical Technologist, MT®; Medical Laboratory Technician, MLT®; Registered Medical Assistant, RMA; Registered Dental Assistant, RDA; Certified Medical Laboratory Assistant, CMLA; Registered Phlebotomy Technician, RPT; Certified Laboratory Consultant, CLC; Certified Allied Health Instructor, CAHI; Certified Medical Administrative Specialist, CMAS

For information on qualifications necessary for each certification, contact:
AMT, 10700 Higgins Rd., Suite 150, Rosemont, IL 60018—Phone: 847/823-5169.

MEMBER:
Institute for Credentialing Excellence/National Commission for Certifying Agencies
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Use your professional credential plus “(AMT)” to share your AMT pride and achievement!

Why not showcase your certification from AMT every day? Members should start sharing AMT’s well earned reputation by adding the suffix “(AMT)” after your discipline-specific credential. This addition to your credential shows your AMT pride and helps distinguish your prestigious AMT certification from other organizations’ credentials with confusingly similar names.

FOR EXAMPLE:

Mary Jones, RMA (AMT)       Tom Tech, RPT (AMT)
Joe Smith, MT (AMT)           Jane Doe, MLT (AMT)

As a member of AMT, you know that AMT is a nationally and internationally recognized certification agency and membership society for allied health professionals. AMT’s goals are to promote and maintain a high standard of excellence for allied health professionals, support their role as part of the patient healthcare team, and provide continuing education and membership programs to enhance members’ professional and personal growth.

- Medical Technologist MT (AMT)
- Medical Laboratory Technician MLT (AMT)
- Registered Phlebotomy Technician RPT (AMT)
- Certified Medical Laboratory Assistant CMLA (AMT)
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Thank you all for your donations
Greetings to you, my AMT Family:

Wow! Another great national meeting in Kansas City! Were you there? If not, you really missed out. Post-meeting surveys said that 76% of attendees will be back next year; and 92% would recommend this meeting to others. Count me in that 92%, because I definitely recommend that you attend next year. Your Board is already hard at work making the next one even better.

Next year we are in Washington, DC, over the week of the 4th of July. We’ll be staying near the National Mall, and you’ll have plenty of time to attend the festivities. And, you could be a delegate from your state, and get some financial assistance to attend the meeting, too. Start by attending your next AMT State Society meeting, and ask the leadership about attending the national meeting as a delegate.

In Kansas City, the delegates elected two new members to the Board of Directors. The Nominating Committee did an outstanding job of bringing eight very highly qualified candidates to the membership. In the end, four were elected. Cherry-Ann Da Costa-Carter is an MT and RPT from New York. Cherry has extensive experience in AMT leadership, most recently serving as the New York State Society President. Lisa Marie Bromley is an RMA from Kentucky. Lisa also has extensive experience in AMT leadership, serving as the Kentucky State Society Secretary and the National Student Activities Chair. I welcome both of these bright ladies to the Board, and I look forward to working with them to keep AMT strong and growing.

Incumbents Ken Hawker (MT) and Deborah Westervelt (RMA) were both reelected to a second 3-year term. Both are very valued Board members and I was very happy to have them continue serving on the Board. In the end, the membership of AMT is very fortunate to have a very diverse, cohesive, strong Board of Directors.

So, who went off the Board, you ask? Well, no one. Cherry will fill the MT/MLT class seat formerly held by our Past-President Everett Bloodworth, while he stays on the Board as the Immediate Past-President to help keep me straight. And Lisa fills a brand-new RMA/RPT/COLT class seat on the Board that was added in a bylaws amendment last year.

The two bylaw amendments brought to the delegates this year were both passed unanimously. The first repeals the Proctoring Committee, which is no longer needed since all our exams are now electronic. The second allows the Resolutions Committee, held annually at the national meeting, to cancel the committee meeting if there are no resolutions submitted in advance.

One of our primary goals here at AMT is that we want our members to be proud of their professional organization. One way you can show that is to always use your AMT initials after your name on all professional documents (memos, letters, emails, etc). For example, I am certified as an MT with AMT, so I always put “MT (AMT)” after my name. Showing pride in your organization helps boost the greater organization. Please join me in showing your AMT pride!

In other news from your Board of Directors:
- Began work to create a Point-of-Care Certificate.
- Continued work on the Molecular Diagnostics Certification. This should be rolling out in 2018.
• The ECG Certificate is very popular. If you do ECGs, I recommend you take a look at this.
• AMT remains very strong financially, and continues to grow in this area.
• Received the State Society System Assessment report from Mariner Management. The Board will be reviewing their recommendations and begin to implement measures to make our state societies stronger and more relevant to our membership.

Do you work in Molecular Diagnostics? We need help rolling out our new certification exam. We need members to take the 200 question, 3-hour pilot exam at a local Pearson Vue Testing Center this fall. You’ll even be paid an honorarium. If you are interested in the opportunity to help AMT and the laboratory field by assisting in this important project, please contact Gina Neuhalfen in the AMT Testing Department at: gneuhalfen@americanmedtech.org, OR (847) 823-5169 x 239. Gina will be able to provide additional details to interested MT practitioners.

The next Laboratory Legislative Symposium will be held in Alexandria, VA, March 19-20, 2018. AMT co-sponsors this event with ASCLS and other lab groups. It is a fun and exciting experience. You’ll be coached on lobbying and presentation techniques to prepare you for your meetings with your Congressional representatives. You are always well received in the Congressional offices. You’ll return home from Washington with first-hand knowledge of the political system in action and confidence that you made a difference. If you are an MT or MLT member of AMT and are interested in going on behalf of AMT, let your state society president know. There is an application process. If approved to attend the meeting, some financial assistance may be available.

As of January 1, 2017, the AMT Board of Directors also assumed the duties as the AMTIE Board of Trustees. The same officers and members will serve on both boards. Here are some things we are working on for AMTIE:
• Revised the bylaws (some housekeeping and keeping the same officers as the AMT Board)

As you can see, AMT is very busy providing high quality credentialing and membership services to you, the AMT members, and to prospective members. As we continue to grow membership, we also continue to provide more services and opportunities. Please ask yourself, what have you done for your professional organization and for your profession lately? Within AMT you have ample opportunity to learn and grow, to develop leadership potential, and to make a difference in your profession.

It is always a great day to be an allied health professional. Together, let’s go out and make a difference!

Respectfully,
Jeff Lavender, MT (AMT)
We have to learn to walk a fine line between empathy and apathy. Because there are times when what you think you see in front of you, in fact doesn’t really exist, based in part as a direct result of the patient strategically, deliberately and purposefully giving misleading patient cues.

Then on the other hand, there are times when you choose not to see what is directly in front of you, as a result of being chronically misled by previous patients. You become jaded with preconceived notions and judgments based on previous patient actions and/or scenarios. Some patients are “professional-patients” in their own right, and have the ability to make you think something is very wrong when in fact it is not. What happens now going forward is that the very next legitimate patient who presents with similar symptoms and mannerisms may cause you to think nothing is wrong, when in fact, something very much is. It’s a catch 22 of treat the patient, and not the scenario.

What can happen next is a misinterpretation, a misdiagnosis, or a mistreatment of the patient in front of you. All these “misses” lead to patient care mistakes, and mistakes lead to harm. “Do no harm” is at the core of our care. Chronic drama patients, “dramatic offenders” or pain medication seekers may distract and mislead you from the legitimate sick simply through attrition. Sometimes the legitimate acutely ill and injured patient may be erroneously thought of as another drama patient, or another chronic drug seeker, thereby ultimately leading you to acquire a false sense of the patient’s true history, injury, pain, or disease. In other words you don’t believe them.

Any and all health care professionals will eventually be susceptible over time, either through pure repetition of care, or being bombarded by inappropriate patient behaviors. This can lead to an induced routine of complacency, or apathy, or cynicism, or a combination of all three, turning a profession into a job, just another day at work, and dishing out the IOC—in illusion of care. Over time, this becomes the perfect trifecta for the possibility of substandard care stemming from a false sense of patient cues, or professional ideologies.

Let’s face it, realistically, how can any healthcare worker honestly gauge a patient’s pain level? You certainly may have a general idea utilizing the well known 1 thru 10 pain scale, but after a while, how do you know what to believe? How do you know when to believe them? We often say, “don’t treat patients like numbers,” but unfortunately,
medicine is numbers-based. Patients are a number, how many patients did we see today? Patients are always asked, "What is your pain level right now, on a scale of 1 to 10, where 10 is the worst pain in your life?" Now in their eyes, we are setting forth a notion that a higher number will yield a more prompt result in care. If the patient states, "my pain is a 10" all the while eating potato chips, drinking a beverage or excessively talking or texting, this forces your thoughts of a “here we go again” attitude mindset.

Pay close attention to patient body language and mannerisms. Some patients can manipulate and play the system like a finely tuned violin, manipulating prescriptions for pain, or notes to be off from work. Sunday is the new Saturday, patients looking for a three day weekend. I have witnessed countless patients upon entering a room say “I'm a 10” even before the word hello is expressed. I think patients are programmed to react a certain way to obtain a certain result. In the mind of some patients, they typically believe the number 10 equates to quicker service with instant pain medication relief.

Patient mannerisms and body language can absolutely affect your clinical judgments. What do you think? What do you do? How do you react? Do we morally, ethically, and mentally judge patients? Or do we clinically treat patients based on patient input, symptomology, and clinical findings? This is a very difficult question, because realistically, we have to learn to balance between a little bit of both, like walking a proverbial tightrope, simultaneously observing the patients’ symptoms, mannerisms, and attitude, all the while actively listening to the patient.

We have to be able to differentiate as accurately as possible between true acute or chronic pain and legitimate injury against the proverbial “bad-back” or illegitimate related injuries and claims of chronic unbearable crippling limitations without prejudice. We have to learn to overcome being judgmental or to have the feeling of “they are trying to trick me” into giving pain meds or a note off from work or school.

We can’t possess an unhealthy and unprofessional mindset of, here is another attention seeker, another hypochondriac, another drug addicted person hooked on pain medication. All this does is put into motion a scenario that gets you stuck in ineffective paradigms, and quells your ability to deliver proper patient care throughout the day.

When any patient comes into a facility, they absolutely want to be treated properly. Patients expect you to actively listen. Patients want you to acknowledge them, to look at them, make eye contact, and have the ability to relate, respond and react appropriately as needed. For most patients, the smallest injury, or the smallest pain is huge to them at the time, and they just want to be told what is wrong with them, and that they are going to be OK. Some people just like to chronically whine and complain about nothing for the attention, and keep coming back. Some people are chronic worriers and keep coming back. Some people are loneliest when they are a little sick and need to be comforted, and keep coming back. Others are looking for drugs, and keep coming back. Some patients just want a medical “hug” and feel like someone cares, so they keep coming back.

The trouble is, how can you differentiate between counterfeit pain, and injury from legitimate pain and injury? Realistically you can’t, certainly never with 100 percent accuracy. I firmly believe, over time, most patients get treated based on the previous patient with similar symptoms. For example, the child with non-descript belly pain eating candy and drinking soda in the ER waiting room gets the standard abdominal X-ray, and diagnosed as mildly constipated. The next day the same patient returns to the ER now more emergent with a positive appendicitis.

So what happens now is, the next kid with non-descript belly pain automatically gets a CT scan of the abdomen, to rule out a possible appendicitis based in part as a direct result from the previous patient with similar symptoms.

There is almost a symbionic relationship
between patients and healthcare professionals. Our patient experiences influence our decisions and choices down the line for the next patient with similar mannerisms and circumstances. A previous inappropriately or problematic patient may also subconsciously set the tone for the next patient you encounter. Say, for example, your next patient happened to vocalize a simple phrase or word as did the problematic previous patient. This may lead to an unintentional triggering of a response, changing your mood, yielding emotional negativity, and a bad experience for no apparent reason other than spoken words. The way patients act and look will absolutely influence the care they receive.

How do you tell legitimate from illegitimate? It is difficult to impossible; however, experience is the key. Typically, patients experiencing true/acute pain are noticeably withdrawn. Many patient statements include, "I have been in pain for weeks... my back, my back, my back is killing me... I can't move... My stomach hurts... I am nauseated and can't eat... My chest hurts when I take a breath... I can't raise my arm, my shoulder hurts... I can't turn or move my head, my neck hurts." These are all perfectly normal and legitimate issues that happen to people every day.

Now ask yourself these questions. How did the patient get here today? How did they get in and out of their vehicle? How did they get from their vehicle to the building? How did they get their clothes on to come here? Do they smell? Body odor, or like soap? How did they shower? How did they tie their shoes? Are they acting loud and inappropriate? Are they actively eating, drinking or have been smoking?

Regardless of what you may be thinking at the time, be advised that any form of health care provider "eye rolling" is always quickly noticed by the patient and is always counter-productive. This ultimately causes the line of communication and trust between the patient and health care provider to immediately degrade. Ideally, you should always be cognizant of the patient's mannerisms and body language, and simultaneously be acutely aware that most patients are very observant and sensitive to your own “feedback” mannerisms and body language as well.

While engaging any patient, always be especially mindful of your words, and your voice. Be aware of your voice inflections, the tone of voice, and your facial expressions, and, of course, your body language can speak volumes. If the patient interprets that there is a seemingly lack of empathy on your part, it can cause a patient’s attitude to escalate into anger and frustration even without your speaking a single word. Your lack of eye contact, the lack of care in your voice, a sarcastic tone, a disinterested demeanor, a rushed and hurried demeanor, or any means of temporality disengaging a patient by using your cell phone, excusing yourself from the room in the middle of a conversation, excessive reading and writing in the patient chart, or failure to ask relevant questions will be seen as a lack of care.

I have been an X-ray technologist for over 25 years, worked in many places, worked in many emergency rooms on weekends and overnights, and I still continue to do so. I thoroughly enjoy my profession and the patients that I serve. There are a million reasons to wind up in an emergency room, and there are thousands of funny and sad stories that go with them.

A 27-year-old woman who drove herself to the hospital, and walked into the ER to be seen at approximately 1:30 am was all dressed up from being at a party. Her initial complaint was mild chest pain, with shortness of breath occurring shortly after an argument with her boyfriend at that party. She did have slurred speech, she did have alcohol on her breath, and she did openly admit to drinking a lot of alcohol that night. Simultaneously she was angrily texting back and forth with her boyfriend. Because of her actions, because of her claim to drinking and fighting with her boyfriend, because of the story, her situation, her scenario, the patient’s complaint was noted, and she was put on the proverbial “back burner” as some kind of relationship/boyfriend drama, and was told "we will get to you as soon as we can."

Hours had passed; later on that morning X-rays revealed that she had an approximate 50 percent collapse of her left lung, a pneumothorax. Now a thoracic surgeon was called stat, a chest tube was soon inserted and the patient was immediately admitted.

A 30-something year old man came in for chest pain at 11:30 pm with an unkempt appearance, long hair pulled back in a man bun, scraggly facial hair, faded ripped jeans, and an old washed out football jersey. Comments were made behind his back like
"he’s here for drugs, looks like he smokes too much weed, he probably does not even have a job, oh great, another uninsured patient, you know who is paying for this." Interestingly enough, he did have a job, he was an undercover police officer in the narcotics division with stress related chest pain.

A female patient complained of chest pain across her nipples; there were some comments, some eye rolling. The patient died six hours later of an aortic dissection.

What you think you see, you typically don’t, and what you don’t see gets you in trouble. Never judge a patient or look at the scenarios, just focus on treatment based on symptoms, patient complaints, and patient history. Whether you want to admit it or not, patients are treated based on our judgments. How a patient looks, acts and dresses definitely influences their initial care. Treat the patient and not the scenario. Treat patients individually and not categorically. Patient social habits should not influence your standard of care. Never judge a patient, although we certainly often do.

Michael Shymko, AS, RT, ARRT, Staff Radiologic Technologist, Hackensack Meridian Ocean Medical Center; Clinical Liaison-Clinical Instructor, Middlesex County College Program in Radiography; Brookdale Community College Medical Assistant Program-Health Care Instructor Clinical Instructor, Lincroft, NJ.

2018 AMTIE Scholarships

April 1, 2018, is the filing deadline for applications and supporting documents in the AMTIE 2018 undergraduate/graduate scholarship program and for grants to high school graduates pursuing medical technology, medical assisting, dental assisting, or phlebotomy studies. Don’t wait, apply now!

Up to three $1,500 AMT Member Scholarships may be awarded annually. Applicants must be members in good standing with AMT and enrolled in a college or university accredited by a regional accrediting commission. The course of study should be concerned with the disciplines certified by AMT. Scholarship recipients will be selected by the AMT Institute of Excellence and scholarship committee based on financial need, career goals, and previous scholastic record.

Up to five $500 Student Scholarships are awarded annually and available to high school graduates interested in pursuing medical technology, medical assisting, dental assisting, or phlebotomy studies. Applicants must be enrolled or planning to enroll in a school accredited by an accrediting agency recognized by the U.S. Dept. of Education, or enrolled or planning to enroll in college, university, or junior college medical technology, medical assisting, dental assisting, or phlebotomy studies. Scholarship recipients will be selected based primarily on need; taken into consideration are individual goals and motivation, school grades, participation in extracurricular activities, work experience, and personal references.

All scholarships will be awarded during the AMT National Convention.

For information and to receive an application, visit www.americanmedtech.org

Application deadline is April 1, 2018. Any applications received after April 1, 2018, will be held until next April, 2019.
Congress Focuses on Market Stabilization After Failing to Repeal ACA

Following the stunning defeat of Republican efforts to repeal the Affordable Care Act, Congress turned its attention in September to seeking at least short-term bipartisan solutions to shore up the health insurance markets for 2018.

Lawmakers on both sides of the aisle signaled that they were willing to approve so-called “cost share reduction” (CSR) payments for the 2018 plan year to prevent huge spikes in next year’s individual market premiums. CSRs are government subsidies that help reduce the amount of deductibles and co-payments lower-income policy holders are required to pay under health exchange plans. But prospects for a longer-term, bipartisan market stabilization package seemed elusive. After campaigning for years on promises to get rid of Obamacare – and despite polls showing that a clear majority of Americans opposed the House and Senate ACA repeal/replace measures earlier this year – GOP members remained unlikely to engage in bipartisan efforts to “fix” Obamacare on a long-term basis.

Sen. Lamar Alexander (R-Tenn.), chairman of the Senate Health Committee, told The Tennessean in late August that any stabilization bill is likely to be short-term and narrow. “Congress doesn’t do comprehensive well, and I think it makes much more sense to go step-by-step especially since the last seven years have been so partisan,” Alexander said.

The Health Committee held several days of hearings in early September to receive input on market stabilization measures. On the eve of those hearings a powerful coalition of health industry and business groups urged Congress to finance CSR subsidies for at least two years. In a joint letter to the committee leaders, the coalition said that “persistent uncertainty” over whether the Administration would block CSR payments “is a significant driver of current market instability.” Failure to assure the subsidies for at least two years, they said, will lead to higher premiums and some insurers withdrawing from the state exchanges.

The groups signing onto the statement included the American Medical Association, American Hospital Association, America’s Health Insurance Plans, and the U.S. Chamber of Commerce. They were among the nearly 100 consumer, patient and provider organizations asking lawmakers to quickly pass a bipartisan bill to stabilize the ObamaCare insurance markets.

At the Sept. 6 hearing, state insurance commissioners echoed the need to fund the ACA’s cost-sharing reduction payments, but preferably for more than two years. The commissioners also asked for more control over individual state insurance markets and a more streamlined process for seeking waivers of some of the ACA’s mandates.

Sen. Alexander said he hoped to bring a negotiated stabilization package to the floor for a Senate vote before the end of September. At press time, however, it appeared unlikely that a stabilization package could be brought to a floor vote before the Sept. 27 deadline.
by which insurers must sign agreements (and list rates) to offer coverage through the federal Health Insurance Exchange in 2018.

Clash Between Detective and Nurse Over Blood Draw Spurs Changes in Hospital Policies

Hospitals are likely to upgrade their security policies after a video showing a July 26 altercation between a burn unit nurse and a police detective in Salt Lake City went viral. The detective became irate when the nurse, following legal and hospital policies, declined to allow him to draw blood from an unconscious patient.

The patient had been involved earlier that day in a serious truck accident, but was not suspected of any wrongdoing. The truck he was driving had been front-ended by a pickup truck that crossed a median while evading a police chase. The patient was admitted to the University of Utah Hospital unconscious and with severe burns.

Detective Jeff Payne, who followed the patient to the hospital, insisted that nurse Alex Wubbels allow him to perform a blood test on the crash victim. Wubbels repeatedly informed the detective that hospital policy prohibited drawing blood from a patient who was unconscious, had not consented to the procedure, and was not under arrest.

Despite nurse Wubbels being backed-up by her supervisor via phone conference, Detective Payne reportedly “snapped,” manhandled the nurse, handcuffed her and strapped her into the front seat of a police car for allegedly obstructing justice. Although charges against Wubbels were not pursued after the hospital's COO intervened, she subsequently obtained videos of the incident taken by the officer's body camera and uploaded them to social media, where they quickly went viral and were featured on national news programs.

Both hospital protocols and legal precedents support the nurse’s refusal to allow police to draw the unconscious patient’s blood. Hospital policy requires that police have either a warrant or the patient’s consent to obtain a blood sample. Last year the U.S. Supreme Court ruled that police must obtain a warrant to test the blood of motorists suspected of drunken driving. (In that case the court drew a distinction between a blood test a breathalyzer test, which is less invasive and does not require a warrant.)

Salt Lake City Mayor Jackie Biskupski and Police Chief Mike Brown apologized Sept. 1 for the conduct of Payne. It took the police department a full month, however, to place Payne and a fellow officer who accompanied Payne to the scene, on administrative leave.

The altercation and resulting national publicity have led the Utah university hospital to impose new restrictions on law enforcement, including barring officers from patient-care areas and from direct contact with nurses. Under an agreement formed with the Salt Lake City police, law enforcement personnel henceforth will register at the hospital’s front desk and make their requests through hospital administrators rather than asking front-line providers directly.

The incident is also likely to spur hospital administrators elsewhere to evaluate their policies surrounding police access to patients. An Arizona nursing consultant told Modern Healthcare that police requests to draw blood from patients without an arrest, a warrant, or consent are common around the country. Nurses and emergency department staff often comply because they are busy or don’t know their hospital's policy. That level of complicity is destined to change following nurse Hubbel’s heroic actions to protect her patient’s legal rights.

CMS On Track to Implement PAMA 1/1/2018 Despite Limited Price Data

Officials with the Centers for Medicare and Medicaid Services told attendees at the annual Clinical Laboratory Fee Schedule (CLFS) public meeting in Baltimore Aug. 31-Sept. 1 that the agency is moving ahead to implement Section 216 of the Protecting Access to Medicare Act (PAMA) on January 1, 2018. Despite persistent objections from the lab community, CMS plans to issue preliminary prices for each test on the Clinical Laboratory Fee Schedule (CLFS) by mid-to-late September, followed by a 30 day public comment period, then publication of final 2018 CLFS prices in November.

The lab industry continues to urge CMS to delay PAMA implementation for at least 6 months and to broaden the definition of “applicable laboratories” – i.e., labs that are authorized (and required)
to report price and volume data to the agency. The current regulatory definition effectively omits almost all hospital outreach labs and a great majority of physician office labs. In fact, the HHS Office of Inspector General has estimated that only 5% of all clinical laboratories will submit all of the data used by CMS to compute the new CLFS rates.

PAMA requires the agency to set new prices for each test on the fee schedule based on prices paid by private payors to applicable labs. With only a limited number of the largest independent labs reporting data, the new rates are guaranteed to be skewed toward heavily discounted pricing. As such, the updated CLFS is certain to have a major adverse impact on smaller local and regional labs and hospital outreach labs, especially in rural and underserved areas. Many of those labs are the only ones that serve nursing home populations.

Although the PAMA statute limits the degree by which the price for any given test can be lowered during the first six years of PAMA's implementation – no more than a 10% reduction in each of the first three years, and a 15% reduction each of the next three years – the cumulative impact of the maximum reductions will make many labs unprofitable. Even with the limitations, the price of a test could be reduced by nearly 55% over the next six years.

AMT will continue to support the lab providers in their efforts to delay PAMA's effective date and to enhance the sources of data from which the new fee schedule will be calculated.

State Legislative Highlights –

- California AB 387 – Would have required allied health program clinical interns to be paid minimum wage. Passed two Assembly committees despite strong opposition from hospitals, colleges, universities, trade schools, professional organizations (including AMT and CaSSAMT), and many others. Bill died last day before Assembly deadline for passage.

- Connecticut HB 6025 – As passed by the Public Health Committee, the bill would have allowed medical assistants to administer vaccines under supervision of physician, APRN, or PA. Bill was amended (significantly watered-down) and passed by House to require a study and recommendation by the state Dept. of Public Health on vaccine administration by MAs. Bill Died in Senate.

- Florida HB 1195 – Would have repealed the entire subchapter of the Florida Statutes that provides for State licensing of clinical laboratory facilities, and instead would require clinical labs to be CLIA certified (or accredited by a CLIA-deemed accrediting organization, such as TJC, CAP, or COLA). The legislation would not affect Fla. personnel licensure. Bill died in committee in early May.

- Florida HB 209 – After having removed references to medical assistant certifications in 2016 legislation, the Florida Legislature in 2017 reenacted a subsection of the medical assistant law to add new references to MA certification. Subsection (3) of Fla. Stats. section 458.3485 now provides:

  (3) CERTIFICATION.—To obtain the designation of a certified medical assistant, the medical assistant must receive certification from a certification program accredited by the National Commission for Certifying Agencies, a national or state medical association, or an entity approved by the board [of medicine].

Despite imposing limits on who may be titled as a “certified medical assistant,” it should be noted that Florida law does not require medical assistants to be certified to perform the tasks within the extensive scope of practice for MA's listed in the first two subsections of the above-cited law.
Hematopoiesis
by Sally Wharton

Life begins
BLOOD CELLS kick in
Not a thesis
Just some fun
With HEMATOPOIESIS

God makes the STEM cell
A good place to start
Designs all cells that follow
Creates a work of art

Conception to two months
The yolk sac - extraordinary
Beginns the process
Extraduillary

The first to form
In this colorful cast
A primitive cell
The ERYTHROBLAST

Six weeks to seven months
Support from a new team
The liver gets keen
Along with the spleen

Seven months to birth
From child to adult
The bone marrow we know
Is the star of the show

The spleen becomes a catcher
Of platelets and RBCs
Primary function
Filtraion junction

Must mention the thymus
Its role is clear
Helps T cells
Develop and mature

Interferons, interleukins
Help keep cells in line
Proteins for growth control
They’re called cytokines

HEMATOPOIETIC STEM cells
PLURI/MULTI potent
Replication, self perpetuation
Differentiation, proliferation

PROGENITOR cells
Must decide
Have to make up their minds
Must differentiate
What type of cell? Which kind?

As PRECURSOR cells commit
They start to multiply fast
You can be sure
They will have a BLAST

Let’s start with ERTHROCYTES
Also known as RBCs
Hemoglobin / oxygen carriers
Floating through the bloodstream

From RUBRIBLAST to PRO
Then a RUBRICYTE
Next the NUCLEATED RED

Gets spotted as a RETICULOCYTE
Shapes up - forms a biconcave disc
Morphs into an ERTHROCYTE

GRANULOCYTES are next
Known for phagocytosis
When fighting infections
These WBCs are ferocious

MYELOBLAST - first to form
Round nucleus, fine chromatin
No granules - the norm
Blue cytoplasm, nucleioli too
Auer rods might give you a clue
As Azurophilic granules alight
It becomes a PROMYELOCYTE

The MYELOCYTE must choose
Its destiny to fulfill
BASOPHIL, EOSINOPHIL
Or SEGMENTED NEUTROPHIL

BASOPHILS though few seen
Pack lots of histamine
Those large granules - purple-black
Keep hypersensitivity on track
A cousin of the BASOPHIL
Relaxes histamine fast
Throughout body tissues
It’s called a MAST

EOSINOPHILS - increased upon inspection
Allergies or parasitic infections
With orange-red granules for cover
Vibrant colored cells like no other

Round / oval, eccentric nucleus
Flat on one side
Pink, secondary granules no longer hide
Sit by the nucleus looking familiar
You’re seeing the ‘dawn of neutrophilia’
You’re right - NEUTROPHILIC MYELOCYTE

With pink cytoplasm peeking through
A METAMYELOCYTE ‘ts true
Pink, secondary granules abound
Indented nucleus - no longer round

A left shift we might see
Curvy BAND cells there will be
Upon detection - inflammation / infection
Wait - just give them some time
NEUTROPHILS are next in line

Segmented, purple nucleus
Two to five lobes will do
Lilac granules, Döhle bodies of blue
Cytoplasm pink and pure
NEUTROPHILs - MATURE

PLATELETS start coagulation
Adhering and aggregating fast
First formed in the bone marrow
As MEGAKARYOBLASTS

Super large, MEGAKARYOCYTES
Follow from the PROs
Release thousands of PLATELETS
Into the blood flow
Getting activated when bleeding begins
Receptors for vWf and fibrinogen

LYMPHOBLASTs
After going PRO
T LYMPHOCYTES / B LYMPHOCYTES
Put our immune system in the know

Dense clumped chromatin
Antibodies / lymphokines
Some aggressive / lethal
The NATURAL KILLER kind

Against disease - defenders brave and bold
Sharing a home we’re told
Designed especially for immunity
The LYMPH NODES

DENDRITIC cells process antigens
Present info to the Ts / Bs
Again for immunity
One of the keys

A PLASMACYTOID B LYMPH
Then oval PLASMACYTE
Eccentric nucleus - Golgi complex in sight
Cytoplasm deep blue
For Multiple Myeloma - an important clue

Finally the last of the bunch
Largest peripheral cell
Should give you a hunch
Gray cytoplasm, vacuoles, granules few
Indented, folded nucleus
Lacy chromatin too

HISTIOCYTE, PHAGOCYTE
It goes by many names
In blood circles is the same

MACROPHAGES are MONOCYTES too
For tissue phagocytosis
A ribbon of blue
Go on scavenger hunts
Ingest foreign debris
Help inflammatory response
Be the best it can be

For bone marrow / peripheral differential
Each cell unique, essential
Viewed through the microscope
An ever changing kaleidoscope

Now our blood tale is spun
Though never completely done
Just a small chapter
Not always happily ever after

Sometimes the cells get confused
Sometimes they lose their way
ANEMIAS / LEUKEMIAS
Another story, another day

BLOOD CELLS
Production, formation
Destruction, reproduction
HEMATOPOIESIS

CIRCLE OF LIFE

Sally Whorton, MT (ASCP)
Hematology-Coagulation
Baptist Medical Center South
Montgomery, AL

| AMT Events September 2017 | 101 |
The Caribbean Association of Medical Technologists (CASMET)

FOR LABORATORY PROFESSIONALS

AFFILIATE OF AMERICAN MEDICAL TECHNOLOGISTS (AMT)

Presents its
Biennial General Meeting &
Scientific Symposium 2017
“Championing Quality Health Care Behind the Scenes in the 21st Century”
Hosted by
The Guyana Association
In our capital city Georgetown, Guyana

For more information and registration forms check out our website @ www.casmet.org

Service Charges
♦ Bellmen $ 3.00 US per guest room
♦ House Keeping $ 2.00 US per guest room

More information & reservation please check:
Website: guyanamariott.com

Conference dates: 21st - 22nd October, 2017
Regional Council Meeting, Biennial General Meeting and Scientific Symposium
23rd - 27th October, 2017

Room Rates VAT Inclusive
Venue: Marriott Georgetown, Guyana

Single Occupancy: US$ 185.60 per Night
Double occupancy: US$ 214.60 per Night
Triple occupancy: US$ 243.60 per Night
Quad occupancy: US$ 272.60 per Night

For more information you can contact:
Mr. Nolan Hawke @ noocgy@gmail.com
Tel: +1-592-642-3060
+1-592-649-6770

Mr. Khalil Lucky @ Khalillucky@hotmail.com
Tel: 1-868-682-6949

Mr. Harry Narine @ dharr64@hotmail.com
Tel: 1-868-755-6191

FOR LABORATORY PROFESSIONALS

AFFILIATE OF AMERICAN MEDICAL TECHNOLOGISTS (AMT)
BIENNIAL GENERAL MEETING AND SCIENTIFIC SYMPOSIUM

October 22nd to 26th, 2017

Marriott

Georgetown, Guyana

NAME ____________________________

ADDRESS ________________________________

EMAIL ____________________________

CASMET ID # ________________________________

COUNTRY ____________________________

STATUS □ MT □ MLT □ RPT □ STUDENT □ ASSOCIATE □ OTHER

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** Full package includes: Admission to all Lectures, Exhibitions, Guyana Night, Awards Banquet, & BGM

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HOTEL ACCOMMODATION

Venue: Marriott Georgetown, Guyana (Room rates Vat Inclusive)

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Additional Service Charges

Bellmen US$ 3.00 per guest room
Housekeeping US$ 2.00 per room night

Bank information for registration fee payment:
Citizens Bank Guyana Inc. Account number: 218943197
Account Name: Medical Technologists Association of Guyana

For our online registration form go to: www.casmet.org

Hotel Reservations can be made at http://www.marriott.com/geomc

Email forms to casmet53@gmail.com
Outstanding Health Professionals

Are you an outstanding health professional? That should be an easy question to answer. If you are part of a health care team, your answer should be “absolutely yes.” I truly believe there is no room in the health care workplace for employees who are minimally competent or mediocre (neither very good nor very bad). American Medical Technologists celebrates Medical Assistant Recognition Week, October 16-20. The slogan this year is “Medical Assistants, Outstanding Skills, Outstanding Care.”

We need to ensure that we always live up to the meaning of this slogan. Why do you think I put the word “always” in that statement? It is because our patients and co-workers are watching us even when we are not in the workplace at our medical facilities. We might encounter these folks while standing in line at the local grocery store, at the shopping mall on a Saturday morning, or even at the movie theater. Although we are not providing health care outside the office, patients see us as a health professional whether we are dressed in our scrubs or in our jeans and a T-shirt.

If someone is outstanding in his or her field of work, they are distinguished, set apart from others. “Outstanding Skills” we acquire through formal education. We maintain that status by participating in continuing education.

In order for us to be outstanding, we need to examine the service we provide our patients, as well as reflect on how we interact and treat our co-workers. There is always room for improvement in our delivery of service.

I believe that outstanding care begins with basic qualities such as:

- Patience
- Tolerance
- Quality Communication

When providing service to our patients, we need to have a lot of patience, calm endurance. Some patients are elderly and may need more time to move around or process information. Others may be scared or fearful about their future. We need to have patience and focus on the care we deliver all patients, especially these. Take time with each patient. Do not rush through patient education and instructions. Take time to make sure there is understanding. Carefully listen to your patients. People do not want to feel like they are a bother or are in the way. We cannot forget that this might be the first time a patient has experienced this health problem or faced a specific situation. Remember these people are your customers and contribute to the fact that you have an important job as a medical assistant or health care provider.

Showing tolerance with patients and co-workers involves respecting their beliefs and practices. Tolerance starts with open-mindedness. Be willing to understand others and the way they may differ from you. Cultural awareness is critical when caring for the various types of patients that may seek our help.

Quality Communication is the process of giving or exchanging information by talking or writing. It also includes non-verbal communication in the form of body language. Much of our communication takes place face-to-face with our patients and our co-workers. Keep in mind that each patient is different but our message may be the same to several patients. Individualize the information specific to
each patient. When providing patient education or instructions, the same delivery method may not work equally with everyone. Patients are not a number and want individual care and attention. Confirm information or education provided to patients. Take time to talk with the patient questioning them about instructions and critical directions provided about their health care.

Be mindful of verbal and written messages. The abbreviated methods used to construct texts or e-mails are easily misinterpreted. Re-read all messages before you send so you will not be embarrassed later having to explain what you really meant in the message.

As I close the article, I would like to send a message to all those affected by the recent hurricanes in Texas and Florida. I trust that all AMT members, including me, are keeping you and your families in their thoughts and prayers for your safety and a speedy recovery from the devastating damage sustained during these events.

Janet Sesser, RMA (AMT), MS Health Education, Faculty Medical Assistant and Medical Billing and Coding Programs, The Allen School of Health Science, Phoenix, AZ

state societies

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In Memoriam

Bobby S. Chambers, MT, Union City, TN, certified in 1954, DOD unknown


Correction: In the June issue of AMT Events – Awards section, Chantal Jordan, RPT of the Year, was listed incorrectly as the Secretary on the Florida State Society Board. She is actually Secretary on the Georgia State Society Board. We apologize for this error.
Recovering from a Stroke: A personal experience with the Military Health Care System and Medicare

Health care in itself is challenging. Requirements, regulations and constant changing and updating of laws make it all that much more of a puzzle. Most of us try to stay in the best health that we can. Exercise, eat right most of the time, keep our stressors to a minimum, get the rest we need and try to keep a positive outlook—but our bodies can still have issues beyond our control. Doing what the science book says is not always right for everyone. Most of us try to get our medical check-ups regularly, depending on your age and/or gender. Sometimes insurance will not pay for wellness even though you may have some risk factors. Convincing the insurance companies and sometimes even family medicine doctors can take up much of your energy, and you just want to give up. Don’t, sometimes the only advocate you have is yourself.

Medicare is a whole other arena. Maneuvering through that system is frustrating especially if you are acting on behalf of a loved one. If your loved one agrees, get a Medical Power of Attorney and make sure that all of the HIPPA paperwork is signed. If you don’t, you cannot speak up on behalf of your loved one and they will not tell you anything of their condition. If you are dealing with an elderly parent who may still want to be independent, they may not share with you all that is needed to keep them safe and healthy.

I am going to share with my AMT family something very personal. My mother had a stroke in the summer of 2015. She was overseas at the time. She received excellent healthcare while she was recovering. Because she was alone there, she had to depend on the kindness of her friends and the government to negotiate the medical system. I convinced her to move back to the United States and come live with me and my family. If something happens again, at least she will have the support of her family. When she moved back, she brought back her medical records from the facilities that took care of her. Even though she is a US citizen and English is her primary language, they were not translated. I don’t know if she could have requested this, but I know that where I work, there are translators available in almost every language. They will find someone to help no matter what language is spoken. This is the advocate part. I am sure when my mom decided to return to the US and wanted the records, there were issues. I am sure that even if the service were available, she would not have asked. It should have been offered.

After she was released from rehabilitation, in her mind she was fully recovered. I have my doubts. Now that she is with me, we have a doctor, (who accepted Medicare, a whole different story), trying to get her healthy, body and mind again. So I inquired about maybe having an MRI
or some cognitive studies done, and we were shut down. Unless she has another stroke, she will be maintained with medication and regular visits to her provider. Just because you are on Medicare and receive Social Security, you should not get substandard health care.

I am sure by now you are wondering where I am going with this. I got up on January 22, 2017. I had the worst headache ever. I couldn’t walk straight, was speaking nonsense and I couldn’t do simple tasks. I told my husband I just want to go back to bed. He looked at me and asked me to stick out my tongue. His response was we are going to the ER. He said, "You are going to let me take you or I am calling an ambulance." We get to the ER and I am triaged. I get put in a bed. One of the doctors believes it is just a migraine and wants to send me home. My husband said no, you did not see her before. This was about 2-3 hours after initial onset and it looked like I had recovered from whatever it was. They ordered a CT scan on my head. We have one in the ED, so all I had to do is wait for it to be open. It was decided to keep me overnight for observation. The CT scan showed nothing abnormal. It was decided to do an MRI with and without contrast on my brain and neck. This happened about 10 o’clock at night. I had had one some months before so they had something to compare to. So when I came back, I got all wired up and went to sleep. The next morning, the docs came in for rounds. I call them the “puppies” as there is usually one attending physician (the big dog) and his residents and interns (puppies). Yes, I am on the Telemetry unit at the Flagship of Military Medicine also known as San Antonio Military Medical Center. It’s BAMC to those of us who have been around awhile. So he says it looks like you had a stroke. My response was “WHAT?” A small one, but a stroke is a stroke.

I became an interesting case. How many 53-year-old nonsmoking females have a stroke? I am not hypertensive and the MRI showed my arteries in my neck were clean. But because it was a stroke, I am here two more days. Everyone wanted to come and give me a neurological exam. I let them, it’s how they learn and it doesn’t hurt. I also had an ECHO. So now cardiology is involved. That popped up something abnormal. I had more tests and there was still not a definitive answer of what caused it, besides a clot. Where it came from is the big question. My case is still discussed by the residents and staff regularly. I have staff doctors going back and forth on what my treatment should be. I am not forgotten when I leave the hospital. All members of my healthcare team including my primary care are involved. This is military medicine.

The reason that I want to tell this story is I see some of my patients who have been referred to the “outside” civilian medical care. We can do all of the labs, radiology and prescriptions at little or no cost to the patient. Because of this, many patients come to us for these ancillary services. Some do not want to be seen by a primary care here because we do change doctors on a regular basis. I was lucky as I had my last one for four years. This is why the Team approach was instituted in the Family Medicine. TRICARE has treated me and my family well, as long as we are seen in the military system. Yes, as a retiree, I do pay for my health insurance, but not nearly as much as civilians pay. My experience with civilian doctors is not all that positive, even when I was referred by TRICARE. I will wait to be seen in the military system if I can, rather than go on the outside.

I want to tie this all together. I am sure Mommy got great care while she was overseas. Unfortunately, we have to start over as her records are not in English. Next, I am sure she is not all aware of the medical issues that she has, either because the doctors didn’t tell her or she just didn’t understand. She hates taking pills and in her mind, she is perfectly healthy.

Here are two people who had strokes, different causes, but still strokes. I will be followed for years to come, even when I change doctors. With mom, however, it seems to be forgotten that she had the stroke, as she is on Medicare. More MRIs will not be ordered to see if her brain has recovered; I’m not even sure she had one before. She has never had some of the routine testing that we in the military system may take for granted.

"When people talk negatively about the military health care system, I have to say something."
When people talk negatively about the military health care system, I have to say something. No, it’s not perfect, but we have many passionate people working and the all mighty dollar is not the driving force. Yes, dollars and cents are looked at but not at the expense of the patients themselves. Our research has saved lives on the battlefield and right here in San Antonio. Our Emergency Department sees Civilian Level One Traumas. Our police officers and firefighters are taken to SAMMC/BAMC for critical care. We share these responsibilities with University Hospital here in San Antonio. These two are the only Level One trauma centers in the city. We are inspected and certified by all the same agencies that inspect civilian hospitals.

I will continue to be my mom’s advocate as well as one for myself.

Yvonne A. Spade, MT (AMT), HHS (CLT), MLT (ASCP), SSG USA (Ret), San Antonio Military Med Center

Stroke is the third leading cause of death in the United States. More than 140,000 people die each year from stroke in the United States.

Stroke is the leading cause of serious, long-term disability in the United States.

Each year, approximately 795,000 people suffer a stroke. About 600,000 of these are first attacks, and 185,000 are recurrent attacks.

Nearly three-quarters of all strokes occur in people over the age of 65. The risk of having a stroke more than doubles each decade after the age of 55.

Strokes can and do occur at ANY age. Nearly one fourth of strokes occur in people under the age of 65.

Stroke death rates are higher for African-Americans than for Caucasian, even at younger ages.

On average, someone in the United States has a stroke every 40 seconds.

Stroke accounted for about one of every 17 deaths in the United States in 2006. Stroke mortality for 2005 was 137,000.

The risk of ischemic stroke in current smokers is about double that of nonsmokers after adjustment for other risk factors.

Atrial fibrillation (AF) is an independent risk factor for stroke, increasing risk about five-fold.

High blood pressure is the most important risk factor for stroke.

**Signs of a stroke**

**Think** **FAST**

**FACE**
Face Drooping (Stick out tongue)

**ARMS**
Arm Weakness

**SPEECH**
Speech Difficulty

**TIME**
Call 911 or Emergency Services
AMENDMENTS TO AMT NATIONAL BYLAWS
ADOPTED BY DELEGATES TO THE 2017 ANNUAL BUSINESS MEETING

The delegates to the 2017 Annual Business Meeting in Kansas City, Missouri, unanimously adopted the following amendments to the AMT National Bylaws.

The first revision is a “housekeeping” amendment that repealed the provision for a Proctoring Committee. Because all domestic certification exams are now administered by computer at Pearson VUE testing centers – which provide their own proctors and test security measures – there is no longer any need for a proctoring committee.

The second set of revisions made changes to the way the Resolutions Committee functions. The Resolutions Committee convenes once a year, at the annual convention. In the past, any member or state society could bring a proposed resolution (written or oral) before the committee at any time prior to the committee’s adjournment. In many years, no resolutions have been presented. In other years, resolutions were introduced at the last moment, without the committee members having had any chance to consider the matter raised in the proposal or to discuss the resolution with their state leaders.

The adopted amendments require that proposed resolutions must be submitted in writing to the AMT Office by May 15th of the year they are to be considered. This will give committee members adequate time to consider a resolution before voting on it. If no resolution is submitted by May 15th, the Resolutions Committee will not be convened at that year’s convention, thereby preserving valuable time in an increasingly congested conference schedule.

The text of the adopted amendments follows. New language is in bold underlining; deleted text is stricken through.

ARTICLE IX
COMMITTEES, DEPARTMENTS AND COUNCILS

AMENDMENT #1: Delete Article IX, Section 6 – Proctoring Committee

Section 6. Proctoring Committee – [Repealed.] This Committee shall be composed of a Chair appointed by the Board of Directors and Chair of the Proctoring Committee of each chartered State Society. It shall address procedural and field-related issues associated with the administration of non-electronically administered certification examinations.

AMENDMENT #2: Amend Article IX, Section 10 – Resolutions Committee – as follows:

Section 10. Resolutions Committee – This Committee shall be composed of the presidents of all active state and international societies, or in the absence of a president, a substitute from such society, and one member in good standing from the United States Uniformed Services (active, reserve or retired). The Chair and secretary shall be elected by the Committee from among their number. It shall meet at a time and date certain, prior to the annual business meeting. At that time, any member or active state or international society may submit, in the prescribed manner, written resolutions on any matter pertinent to the affairs of the Registry; provided, that no such resolution shall be presented to the committee unless it has been submitted in writing, by regular or electronic mail, to the Registry office by May 15 of the year it is to be considered. The Committee shall thereupon consider these properly presented proposals, may call witnesses to testify concerning them, if the Committee so desires, and revise, amend, and adopt those worthy of consideration. Such resolutions so adopted shall thereupon be referred to the Board of Directors, the annual business meeting, or other appropriate body of the Registry, as the Committee shall determine. This meeting shall be open to all members of the Registry, and they may participate in discussion on properly presented proposals. The committee shall not be convened in any year in which no resolutions have been received at the Registry office by May 15.
The 2017-2018 AMT Board of Directors

AMT Board Election

At the election held during the Business Meeting that took place on July 13, 2017, at the InterContinental Hotel in Kansas City, MO, elected to a three-year term were Cherry-Ann Da Costa-Carter, MT, RPT; and Lisa Bromley, RMA. Re-elected to a three-year term were Deborah Westervelt, RMA, COLT; and Ken Hawker, MT.

Cherry-Ann Da Costa-Carter, MT, RPT, Brooklyn, NY, has been a member of AMT for 17 years. She was the president of the New York State Society (past secretary). Honors include Distinguished Achievement, and President’s Award.

Lisa Bromley, RMA, from Cadiz, KY, has been a member of AMT for 14 years. She was the president of the Kentucky State Society, and Chair of the Student Activities Committee.

Deborah Westervelt, RMA, COLT, from Arnold, MO, has been a member of AMT for 20 years. She is the current AMT national secretary, and past secretary of the Missouri State Society. Honors include Distinguished Achievement, RMA of the Year, Pillar Award, and Medallion of Merit.

Ken Hawker, MT, from West Jordan, UT, has been a member of AMT for 41 years. He is the current national treasurer, and a past Western District Councillor. Honors include Distinguished Achievement, Exceptional Merit, Becky Award, and Editor of the Year.

Board Elects Officers

Officers were elected by the AMT Board of Directors at its organizational meeting held in Kansas City, MO, during the AMT convention. Elected were Jeff Lavender, MT, President; Jeannie Hobson, AHI, CMAS, RMA, RPT, Vice President; Ken Hawker, MT, Treasurer; and Deb Westervelt, RMA, COLT, Secretary.
“HELP WANTED”
Seeking New Perspectives!

The AMT Board of Directors, committed to ensuring that AMT programs meet the needs of all AMT members, wants to make sure we have the best information possible to understand what those needs are. A growing percentage of AMT’s nearly 70,000 members are new members, younger professionals near the start of their careers. Accordingly, the Board is going to invite two non-voting observers from the newer and younger ranks of AMT membership to sit at the Board table, to listen to the discussions and decision-making, and have the opportunity to provide appropriate and relevant comment and input.

- Any member in good standing of AMT with current certification who is under the age of 40 is eligible to be selected.
- There will be two non-voting observer positions: one position for clinical laboratory practitioners (MT/MLT/CMLA/COLT) and one for RMA/CMAS/RPT and RDA classes of membership.
- The observers will be appointed to a one-year term.
- Nominations have already been invited from our state societies, but nominations are also invited directly from any of our members. Members may self-nominate.

To obtain an application form for “Under-40 Non-Voting Observer,” please send an e-mail to mail@americanmedtech.org with the subject line “Under 40 Application Form” and we will e-mail the form to you.

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*Add additional $15 for international shipping
The 79th Educational Program and National Meeting was held at the InterContinental Hotel at the Plaza in Kansas City, MO, July 10-13, 2017. Following is a photographic review of this convention.

A U.S. Army Color Guard from Ft. Leavenworth, KS, presented the flag at the opening ceremony of the convention.

Keynote speaker Michael Wigge presented “How to Travel the World for Free: A Keynote on Goal Setting for Incredible Results.”

AMT President Jeff Lavender and Executive Director Chris Damon presented opening remarks.
AMT staff members welcomed attendees to the convention. L-r: Diane Powell, Dr. Jim Fidler, Sheryl Junius, Executive Director Chris Damon, Kathy Cilia, Mark Garcia, Camille Murray, Janet Rosenberg

AMT and the American Kidney Fund hosted a one-mile walk to raise awareness.

AMT and the American Kidney Fund hosted a one-mile walk to raise awareness.
Welcome Party

View of Kansas City from the welcome party

Happy recipients of the state society door prizes
AMT attendees love to dance, dance dance!
Representatives of Honor Roll state societies accepted the Award of Superior Achievement on behalf of their states: Alabama, Arizona, Arkansas, California, CASMET, Central Plains, Florida, Georgia, Illinois, Iowa, Kentucky, Louisiana, Maine/New Hampshire, Minnesota, Mississippi, Missouri, Nevada, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rocky Mountain, South Carolina, Tennessee, Virginia, West Virginia.

State Society publication awards were presented to 1st Place Journal: Khalil Lucky/CASMET; 2nd Place Journal: Nettie Norphleet/Alabama; 3rd Place Journal: Sherry Blevins/Tennessee; 1st Place Newsletter: Nicole Weiss/California; 2nd Place Newsletter: Emmanuel Eko Biney/New York; 3rd Place Journal: Kathleen Hardy; Most Improved Publication: Alicia Martin.

Roxann Clifton of SWOSU accepted MLT Student of the Year award on behalf of Kylee Jo Cahoy. (not pictured are Angela Ranonis, Medical Assistant Student of the Year; and Drita Martini, Medical Administrative Specialist Student of the Year).

Khalil Lucky of CASMET was named Editor of the Year.
Lisa Maness of Winston-Salem State University accepted Student Technical Writing Awards on behalf of winners Jude Okoyeh and Victoria Gibson. (not pictured is fellow winner Jacob Fernando from San Joaquin Valley College)

Dr. Georgia McCauley received the Medical Technologist of the Year Award.

The Becky Award was presented to Kaye Tschop.

The Order of the Golden Microscope (OGM) was presented to Mary Burden by President Jeff Lavender.

Accepting the Silver Service Award were Dr. Paul Brown, Lavern Hein, Louise Isbell, Donna Mae Nelson, and Fred Witt.

Dr. Naomi Melvin was the recipient of the Pride of the Profession Award.

The Friend of AMT Award was presented to Dave Rounsvill and Peter Toledo. (Sheryl Rounsvill accepted on behalf of husband Dave.)

The GEM Award was presented to Clara Boykin, John Sherer (missing in photo is Judith Dry).
Alice Macomber was presented with the President’s Award.

Distinguished Achievement Awards were presented to: Sandra Biggar, Jemm Fos, Jasmin Hanley, Leslie Hasegawa, Colleen Hutchins, Cynthia Kukenberger, Sarah Kuzera, Debra Marshall, Jacquetta McFarland, Cindy Meyer, Melissa Smith, Deborah Virgil, Michael Waide, and Tommy Weatherly.

Recipients of the Exceptional Merit Award were Ketlaid Boursiquot, Anna Catron, Susan Constable, Alice Macomber, Francine Oran, and Ernest Silva, Jr.

Solomon Goldenberg received the Medical Assistant of the Year award.

Alice Macomber was presented with the President’s Award.
Melissa Bishop was presented the Medallion of Merit (MOM) by her daughter; President Jeff Lavendar congratulates Melissa.

Anita M. Ott was presented the O.C. “Skip” Skinner Armed Services Award.

The Pillar Award was presented to Kellard Boursiquot, Celeste Grande, Josephine Harden, Kathleene Hardy, Patricia Hite, Beatriz Montoya, Ivette Rivera, and Loretta Sweet.

Chantal Jordan was the recipient of the Phlebotomist of the Year award.

Dr. Kimberly Cheuvront was presented with the Cuviello Commitment to Excellence Award.

Melissa Bishop was presented the Medallion of Merit (MOM) by her daughter; President Jeff Lavendar congratulates Melissa.
Educational Sessions

Over 30 educational sessions were presented during the convention week for which attendees could earn continuing education credits. Among these were:

Lynn Maedel of Sysmex American presented Those Bodacious Body Fluids – A Hematology Perspective.

Representatives from the Missouri Dept. of Health and Senior Services presented Bioterrorism: Risk, Recognition, and Response.

Lynn Maedel of Sysmex American presented Those Bodacious Body Fluids – A Hematology Perspective.
Arlene Clancy of the College of American Pathologists presented Top Ten Deficiencies in Lab Inspections.

Katherine Whelchel of Diagnostica Stago presented Heparin: How Monitoring Choices Impact Patient Care and Hospital Costs.


Arlene Clancy of the College of American Pathologists presented Top Ten Deficiencies in Lab Inspections.
Business Meeting / Town Hall

At the Town Hall and Business Meeting, delegates and other members have the opportunity for open dialogue with the Board of Directors. Board elections are also held at the Business Meeting.
Linda Jones Sotak and Kaye Tschop were awarded the Dusty Rhodes LIFE Award from the Virginia State Society at the Business Meeting.

Attorney Michael McCarty tallied the election votes.
District Councillors l-r: Central District - Randall Swopes; Western District - Sheryl Rounsivill; Executive Councillor Edna Anderson; Eastern District - Ivette Rivera; Southern District – Kaye Tschop; Great Lakes District – Beverly Christiansen

Executive Director Chris Damon and President Jeff Lavender congratulate MOM recipient Melissa Bishop at the OGM/MOM honors dinner.

Past and current recipients of AMT’s highest honor for MTs, the Order of the Golden Microscope (OGM) gather at the OGM/MOM honors dinner. (l-r): Roxann Clifton, Dr. Paul Brown, Walter Parsons, Dave McCullough, Dorothy Roush, Barbara Ware, Judith Smith, George Cook, Edna Anderson, Mary Burden, Nancy Barrow, Joyce Lybrand, Mary Midkiff, Linda Jones Sotak, Andy Longoria, John Sherer

AMT welcomed CASMET members from many Caribbean nations gathered at the AMT convention.
Past and current recipients of AMT’s highest honor for RMAs, the Medallion of Merit (MOM) gather at the OGM/MOM honors dinner. (l-r) Nicole Weiss, Sheryl Rounsivill, Deborah Westervelt, Melissa Bishop, Louise Isbell, Kathleene Hardy, Jeannie Hobson.

AMT’s Book of Memories honors members who have passed away.

Executive Director Chris Damon and President Jeff Lavender congratulate OGM recipient Mary Burden at the OGM/MOM honors dinner.

Zenaida Maraggun, president of the Louisiana State Society (third from left), welcomed fellow Philippine attendees.
Delegates from State Societies...

...at the Business Meeting
**Medical Assistant Student Challenge Bowl**

Participants in the Bowl

Winners of the Medical Assistant Student Challenge Bowl Jennifer Kieffler and Ashlyn Malmstrom of Pima Medical Institute, Renton, WA

Staff member Janet Rosenberg handing out AMT souvenirs of the Bowl to student participants
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SECRETARY: Deborah Westervelt, RMA, COLT, Arnold, MO dwestervelt.dw@gmail.com (2017-2020)

TREASURER: Kenneth Hawker, MT, West Jordon, UT khawker@q.com (2017-2020)

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Jerry Hudgins, MT, Hendersonville, TN jerryhudgins340@yahoo.com (2015-2018)

Dr. Naomi Melvin, MT, Chipley, FL nnawaisjo@aol.com (2016-2019)

Christopher Seay, MT, Memphis, TN cseayamt1@bellsouth.net (2013-2019)

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