Articles

Increasing HIPAA Compliance Home Health Care
Celia McDonald, RMA (AMT)
CE #31-304-17
(1.5 CE credits)

Which Test to Choose
By T.J. Weatherly, MT (AMT)
CE #31-305-17
(1.0 CE credit)

The Good Bacteria
By Lauren Ehle
CE #31-306-17
(0.5 CE credit)

Did You Know...
Peppermint Essential Oil
By Jill Gandy, MT (AMT)

Features
Calendar of Events .................... 19
Photos ................................. 12-13
TxSSAMT CE Questions ...... 18-19
Conference Schedule ............... 21
Fall Registration ........................ 22

Departments
Officer’s Page ......................... 3
Message from the President ..... 4
District Councillor’s Message ... 5
Treasurer’s Message ................. 5

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The Editor reserves the right to edit all articles where necessary.

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The Fall TxSSAMT Conference will be hosted by TJ Weatherly and I on November 10-11, 2017 at The Stella Hotel in Bryan, Texas. The room rate is $110 per night for double or king rooms for Thursday and Friday night. It is a football weekend, so the rates will increase to $159 on Saturday night. The Hotel cut off date is October 10, 2017 at 5pm with the block code is TxSSAMT. We have online credit card registration available with some additional features! Please let us know your professional specialty and food preferences when you register online.

Don’t forget to attend the Dinner and Famous Auction! It is included with your registration. Our theme for this conference is “1960’s Las Vegas with the Rat Pack.” Good ‘ol “Blue Eyes” himself, Frank Sinatra with Dean Martin & Sammy Davis Jr. Our menu will be Italian with some 1960’s favorites included. Convention Coordinator Michelle Hege is working hard to make it a fun and inviting atmosphere!

Please do not forget to bring an item to place in our auction. The funds raised from Friday night will be put toward student scholarships.

The luxurious hotel is brand new to the area. There is an onsite lake with paddle-board and bikes available for use onsite at no charge to the guests. There is an full restaurant, whisky/wine bar, exercise room, pool, and hot tub. There are complementary water bottles and robes in each of the rooms.

Our convention coordinator, Michelle Hege, is working on the exciting meal plans for the business meeting and an Italian food Rat Pack theme for our Famous Social and Auction! Remember, the auction raises money for scholarships and writing awards for our members.

We plan to have technical lectures on vaccines, pathology, instrumentation and clinical lab. If you are interested in giving a lecture (you would receive comped registration and CME for creating/presenting a lecture), please email me!

More details will be posted to the website as they become available!

For continuing education credits, don’t forget to fill out the free CEU article questions in the journals and send them to Alfonso Clemmings.

Our state is in need of a new pin! So, we are offering a pin design competition! A TxSSAMT member can design a state pin and email their work to me, Katrina Fryar. The designs will be voted on by the board and the winner is awarded a lifetime of free conference registrations. The winner will be announced at the Fall 2017 Conference. So, have fun and let the imaginations flourish!! Can’t wait to see what you think represents our great state!

Lastly, I would like to invite each of you to write a technical article with questions that we could publish in our journals. You would be able to claim CME for authoring a written work that is approved and published in the journal!

We would love to see you at one of the conferences!

Thank you,
Kat Fryar, MT (AMT)
President

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**Calendar of Events**

**November 10-11, 2017** - TxSSAMT Fall Meeting and Conference in Bryan, Texas

**Spring 2018** - TxSSAMT Fall Meeting and Conference in McKinney, Texas

**July 1-5, 2018** - National Convention in Washington, D.C.

**Fall 2018** - TxSSAMT Fall Meeting and Conference in TBD

**March 28 - April 1, 2019** - Spring 2019 Carnival Conference Cruise to Cozumel
District Councillor’s Message

What an awesome week we just spent in Kansas City, Mo. At the AMT National convention, I had a great time renewing old acquaintances and meeting the first timers.

There were 332 registered members with 22 first timers. If you were a first timer your job now is to be a 2nd timer. At the business meeting; the two MT-MLT members elected to the board are Ken Hawker incumbent, a new board of director’s Sherry-Ann Dacosta- from New York. The two RMA BOD elected are incumbent, Debra Westervelt and newly elected Lisa Bromley, Kentucky.

We are now at 100% participation of AMT banking. Thirty-two of 38 societies have had their by-laws reviewed and approved. Only 3 SOPS have been reviewed and approved, so we need to get the SOP’S done before the end of the year.

With the 2017 national convention behind us, it is time to look forward to 2018. The Convention will be held in Washington DC over the 4th of July. Fireworks will be flying in the sky and on the Capitol grounds. The 2019 convention will be held in the Great Lakes District, location and dates TBD. Make sure you attend your state meetings this fall.

Now the one task that I thoroughly enjoy, acknowledging the Central District National award winners. I counted 20 different awards for our district. There are individual, writing, student, and editing awards. Look in your June AMT events to view each one of them. But I must highlight one, I was so proud when it was announced that Mary Burden- OK was the recipient of the OGM. This is the highest award offered by AMT. Mary you are so deserving. Congratulations.

With this I will close message, this will be my last one. You will have a new Councillor next year. I have had nine awesome years serving you. Every one of you are very special to me. Make me proud and keep pushing forward, you are all the greatest.

Respectfully
Randy Swopes MT (AMT)
Central District Councillor
AMT IS THE CHOICE FOR ALL ALLIED HEALTH PROFESSIONAL CERTIFICATION

A Message from Continuing Education Chair

Greetings to All! It has been an interesting few months since I assumed the Continuing Education Chair. I applaud all of you that are taking advantage of the free CEs offered in THE NEW TEXAN journal. Remember, you can also submit CEs from previous issues of the journal. If the articles have the former CE Chair’s name on them, please send them to me anyway to avoid delays. Here are a few things that I noticed when grading your papers:

1. Write legibly on all your papers – print, if possible. If I cannot read a letter or number on one page, the other page usually resolves the issue. This is especially important for your email address. Your passing results are emailed to you. The same is also true for the envelope, in case I have to mail something back to you.
2. Remember to write your AMT member ID number on all pages submitted. Check or circle your AMT certification(s).
3. Check your answers before mailing your answer sheets. Do not leave questions unanswered. You must get 80% to get a passing score. Re-read the question, ask your co-workers for their interpretation, and/or try to eliminate each incorrect answer. Guess if you must! Also, do not put multiple answers if the question is not asking for it.
4. The AMT STEP CEs should be done online or sent to the AMT home office. Remember, you will have to pay for those CEs. Please do not send them to me – I will return them to you. If you accidently sent your NEW TEXAN CEs to the AMT home office, they will usually scan the pages and email them to me. I will grade them.
5. If you log onto the AMT website, you can access the issues of THE NEW TEXAN. You can print the answer sheets. It will save you from having to tear the pages from your journal, in case you wish to review that particular article at a later date.

If you have not received your results within 14 days, please email me so that I can resolve the issue. My email address is alfoclem@gvec.net.

There were two errors in the Spring/Summer 2017 issue of the NEW TEXAN. Two CE articles had the incorrect CE hours. The correct CEs are as follows: “Middle East Respiratory Syndrome, CE#31-302-17 (1.0 CE)” and “The Kidney, CE#31-303-17 (0.5 CE)”.

See you and your co-workers at the Fall meeting in Bryan!
Alfonso Clemmings, MT (AMT)
TXSSAMT Continuing Education Chair
ABSTRACT
As more elderly patients are getting to the point of needing home health care, the need for maintaining patient confidentiality and HIPAA compliance grows with it. Home health care practices come in various forms, from family owned to franchise practices. Regardless of the size and type of home health care practice, HIPAA compliance and patient confidentiality must remain a priority. The need for quality patient care is always the utmost in thought but when a careless act costs a patient identity theft or worse, then it is too late to think about what could have been done. When caregivers are taking patient charts, whether hard copy or electronic, with them to patient's homes then there arises the opportunity for HIPAA violations abound. There have already been some practices investigated for the careless actions of its staff in regards to HIPAA violations. Some of these home health care practices may make the argument that there is a lack of funding to truly safeguard protected health information; the costs and legal fees alone from a HIPAA violation would be considerable higher. HIPAA compliance is a known necessity within the health care industry, in order to provide the type of professional service and care that is warranted when it comes to home health care, it should include more stringent protections to ensure patients' information is not at risk.

The home health care industry is one of the toughest medical fields to regulate and enforce when it comes to quality of patient care and HIPAA compliance involving protected health information and patient confidentiality. They have several governing and licensing agencies across federal, state and local levels that can convolute how to exactly maintain compliance for patient care and confidentiality. While we hear about violations within the quality of care given to elderly patients, it is often neglected the violations of HIPAA that occur on almost a staggeringly regular basis. According to "How Private is Your Health Information?"(2012),"Over the past three years, almost 21 million patients have had their medical records exposed in data security breaches, according to the Department of Health and Human Services."(para.1). Elderly patients that are sometimes incapacitated may not be able to report HIPAA violations that may be happening within the home health care fields and so as professionals we should be able to provide solutions to prevent these violations from occurring. By requiring and enforcing (through documentation and logging) the simple solutions based on the type of storage of PHI and patient data; the probability for HIPAA violations would dramatically decrease.

UNDERSTANDING CURRENT REGULATIONS
Most home health care agencies are providing services to the elderly which would fall under the demographic that is covered by Medicare. The Medicare Conditions of Participation regulate the qualifications for home health agencies and explain patients’ rights. (McWay, 2010)

McWay (2010) stated, “The regulations also specify that all clinical records maintained by the home health agency are confidential and that the agency must advise the patient of its policies and procedures regarding the disclosure of records.” Along with Medicare regulations, state regulations would also apply when it comes to HIPAA and patient confidentiality. How realistic is the enforcement of HIPAA compliance and patient confidentiality in a facility in which the caregivers are transporting PHI in the form of hard copy paper charts or electronic devices, visit notes, etc. from the main office and medical records storage area to patient’s homes? Other than the caregiver’s credentials and expertise, what other safeguards of patient confidentiality and HIPAA compliance can be verified on this professional?

OPPORTUNITIES FOR PHI EXPOSURE
Ms. Smith is a CNA working for ABC Home Healthcare. She goes to the office prepared to see her scheduled four patients for the day. Ms. Smith picks up the charts from the medical records shelf for all four patients and proceeds to leave the office to go see her patients in their homes. She gets in her car and receives a personal call on her cell phone while on her way to see a patient. The patients’ charts sitting on the passenger seat next to her. Ms. Smith lets the caller know that she’s on her way to see a patient and will call them...
back when she’s done. Ms. Smith gets to the patient’s home and the patient’s daughter is there wanting to overview care to ensure that she does her job correctly. The patient’s chart is left on the table while Ms. Smith takes the patient’s vitals.

This is a scenario that happens daily with various health care professionals in the home health industry, and as you can imagine the opportunities for patient confidentiality to be broken are abundant. Some of the easiest ways to violate patient confidentiality as outlined by Community Caregivers Notice of Privacy Practices (2011, p.1 para.1-4), “Client-related information is left, exposed where visitors or unauthorized individuals can see it. Client information is discussed in a public place or inappropriate, unauthorized individuals. Client records are accessed for the wrong reasons or by inappropriate individuals.” Many home health care agencies still use paper charts that have different risks associated with them than EMR (electric medical records). Gungor (2013) stated, “As such, it is not inconceivable that a confidential medical document would be mistakenly filed in another patient’s health record. It is also possible for a sheet of paper with private patient information to be accidentally grouped with another pile of papers to be mailed to an unauthorized person, or improperly disposed of without shredding.” How easy could it be for Ms. Smith, CNA for ABC Home Health, to accidentally file visit notes in the wrong patient chart while out in the field? The demand for home health services is growing exponentially, the patient load given to one caregiver is high enough to add to potential liability of charting mistakes and HIPAA violations.

Another area of field work with home health care to consider is mobile device use. How can the home health care management be confident that Ms. Smith is not divulging patient information through the use of her cell phone? The use of the cell phone has gotten to be more prevalent along with the use of such applications like Twitter, Facebook, and Linked In and the preferred use of public WIFI, which is completely insecure. Using GPS to map out the route to a patient’s home, or texting another caregiver questions about the patient’s care, are all easily done without being in the confines of working strictly within an office setting. The article “Text Message Use Among Providers Raise HIPAA Concerns (McLaughlin, 2011, page 1, para.5), “The National Institute of Standards and Technology, in “Guidelines for Cell Phone and PDA Security,” has stated that special risks apply to mobile devices, which includes cell phones. The risk level is deemed high for loss, theft, or disposal and for unauthorized access. NIST cites that most cell phone users seldom employ security mechanisms built into a device or often apply settings that can be easily determined or bypassed. HHS cites data storage and transmission as potential risk areas. Text messaging appears to be particularly vulnerable, as text messages are not automatically encrypted when they go from cell phone to cell phone, and the messages may be stored either on a smart phone computer or on the SIM card in the cell phone, unlike a voice conversation.” Another article sites, “The most common form of security breach is the theft of mobile devices. A recent survey of 600 U.S. hospital executives, physician organizations, health insurers, and pharmaceutical/life sciences companies found that theft accounted for 66 percent of reported data breaches over the past two years.8 Mobile devices are typically small, light and highly visible to would-be thieves looking for an opportunity to take a phone left behind in a public space, such as at a restaurant.

In addition, unlike laptops and PCs, clinicians are far more likely to use their own personal mobile devices, rather than employer-issued mobile devices, to access and exchange ePHI. An estimated 81 percent of 2,041 physicians surveyed use personal mobile devices, whether a BlackBerry, Android or iPhone, to access ePHI, such as patient records.” (Barrett, 2011, page 1, para.4)

The opportunities for caregivers in the home health care industry to violate HIPAA and/or patient confidentiality are numerous; for example: cell phone use through personal conversation (verbally or electronically), exposure to patient information while out in the field, or through theft of PHI, etc. There has to be ways to ensure that the caregiver is remaining vigilant about maintaining patient confidentiality and compliance with HIPAA.

RECENT HIPAA VIOLATION CASES.

“Howard University Hospital in Washington, D.C., notified 34,503 patients of a potential breach of their PHI that occurred in January. An unencrypted laptop was stolen from a contractor’s vehicle. The records stolen did contain patient names, addresses, Social Security numbers and diagnoses for many affected. Moreover, the hospital reported that the contractor had stopped working at Howard University Hospital in 2011 but violated policy and continued to download patient data.” McCann (2013). Another incident involving a home health care service involved the PHI of over sixty-four thousand patients. “Apria Healthcare, a Lake Forest, Calif.-based home health care services company, reported that in June an unencrypted laptop containing the PHI of some 64,846 patients was stolen from an employee’s locked car in Phoenix. Patient names, phone numbers, Social Security numbers and possibly clinical data were contained on the laptop.” McCann (2013). There is not enough safety precautions being taken while caregivers are out in the field when it comes to patient charts or devices containing PHI. Another example is reported on by Tortolano & Company Blog (2013, p.1 para 2) stated, “The agency reports through its letter sent to patients that a netbook, which is a smaller version of a laptop, was stolen during a robbery at a staff member’s house on July 20. The netbook contained HealthWyse’s home health clinical software PalmWyse along with the associated database. Contained
within the database was patient data for the entire agency. Although the netbook and patient database had two levels of password protection, an experienced and determined hacker could potentially obtain access.”

More home health agencies are becoming established and some may be less prominent professionally than others. There are some home health care businesses that are run by families or out of the owner’s homes. This brings up the question of patient record storage and access to those records. One story by the Los Angeles Times (Terhune, 2013, page 1, para.3) reported about a health care facility contracting someone else to do their document storage. “Until this week, the Deans also had emails from Kaiser and other files listing thousands of patients’ names, Social Security numbers, dates of birth and treatment information stored on their home computers.” “In court filings, Kaiser said the Deans put patient data at risk by leaving two computer hard drives in their garage with the door open. In response, Stephan Dean moved them to a spare room.” (Terhune, 2013, page 1, para. 13)

The correct home health care scenario should go like this: Ms. Smith, CNA for ABC Home Health care arrives at the office to start her day of seeing patients. She checks out her tablet and mobile hot spot device from the office by scanning it out this logs her as the user along with the date and time that the devices are “checked out”. Ms. Smith has both devices placed in her tool bag or in her glove compartment in which they are secured. Ms. Smith has her personal cell phone placed on silent with instructions that any personal calls be made to the home office in the event of an emergency, they will contact her while out in the field. Ms. Smith arrives at the patient’s home with the patient’s daughter there to check on the patient’s care. Ms. Smith has the tablet password locked sitting on the table while she’s taking the patient’s vitals.

Although there are a couple of technological aids that can be costly in this scenario, the focus is still on maintaining patient privacy and compliance with HIPAA while out in the field performing home healthcare services.

EASY SOLUTIONS
There are certain solutions that can be found within the realm of affordability and within the current framework of any home health care agency servicing its patients today. For those with paper charts, implementing a scanning system of barcodes on each chart. This way when a chart is “checked out” if needed for a client, it can easily be tracked within the system. Obviously, there has to be training within the scope of security practices when transporting PHI whether in the chart itself or in the visit notes that accompany caregivers. When changing over to EMR, the main idea is encryption and security passcodes for any and all electronic devices. This would be an additional cost but it is a necessity when it comes to already transferring over to electronic devices anyway. In regards to patient information storage both electronically and hard copy, there should be a site or facility audit required every six months or so to verify that storage is being done securely both with electronic and physical safeguards. There has to be policies and procedures in place when it comes to mobile device use while out in the field, whether it is verbal or electronic use. Simple solutions that can be implemented with little to no additional cost depending on the how the practice is already working.

**Regulation and Enforcing HIPAA compliance and Patient Privacy**
Making these small but simple changes within the scope of the Home Health Care agencies can easily prevent any type of distress to patients, the practice, its staff, and related persons by implementing simple provisions whether you are EMR or still working off of hard copies. HIPAA violations hurt everyone involved and patient confidentiality is just as important as patient care.

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References


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About the author:
Celia McDonald is a graduate from the North American University RMA program. She currently serves on the TxSSAMT Board of Directors as Secretary.
Over the years, laboratorians often get the same related to choosing an appropriate test or the best test (known as the “Gold Standard”) for one's patient. Providers must navigate a multitude of mnemonics, letters, numbers, cost-to-benefit analysis, time, and judgement of clinical significance in order to choose appropriate tests for their patients. In this article, we will review several testing methodologies along with common diseases such as Chicken Pox, Helicobacter Pylori, and non-healing wounds to determine what testing strategy to use for accurate diagnosis.

IMMUNOGLOBULIN TESTS (ANTIBODY)

One common question is “Should I order the IgG or the IgM antibody, or the antigen?” To answer this, one needs some understanding of immunology. In general, a person is exposed to an antigenic substance, often a foreign protein. The body’s immune system mounts an attack, and creates antibodies to that substance (bacteria, virus, plants, food, venom, etc.). The antigen is the foreign substance, and the antibody is the body’s response.

While there are several types of antibodies, we will only discuss immunoglobulins M and G here. IgM is the body’s first response to an antigen. This antibody is quickly produced by the immune system, primarily in blood and lymphatic fluid, but does not persist in circulation for a long time (1). An antibody switch occurs at about 2 weeks for many diseases, where IgM decreases, and IgG begins to be produced. IgG then persists for a long time (a lifetime in many instances). IgG is the most abundantly found immunoglobulin within the body because of its persistence, and the fact that it is found in all body fluids (1). While the IgG antibody for a particular antigen will decrease over time if no more antigens are present, once the antigen is recognized again, IgG will be produced quickly instead of an IgM response.

An example of these points would be a child with Chicken Pox. The child contracts the virus, and begins to develop symptoms and lesions. Initially, IgM is produced to fight the active infection. After some time, the disease resolved, and the body produces its IgG antibodies. These antibodies remain in circulation, and can look for other Chicken Pox viral antigen to attack so that the child (or the now-adult) does not get the virus again.

Generally speaking, when choosing between Antibody type and Antigen, we can make some conclusions. If one is looking for active infection, testing for the antigen is of primary concern (if a test is available). Secondly one would want to check an IgM level to look for active disease, as it would indicate that the disease process was acute/current or within the last few weeks. If a provider is looking to see if a person had a disease already, or has immunity, generally IgG antibodies are the most appropriate test. In the case of Helicobacter Pylori infections, one would want to know if the infection was causing the patient’s current symptoms. The American College of Gastroenterology recommends that if H. pylori is suspected, clinicians check for active infection first with a stool antigen for H. pylori or Urea Breath Test. While IgG is commonly tested, it cannot help providers distinguish between current and long-term infection. Some patients are loathe to collect a stool sample however, and it is recommended that H. pylori Antibody testing be done when a patient refuses antigen testing, or it is not possible. For Herpes Simplex Virus, culture is preferred if there are open lesions indicating acute infection. However, if there are no lesions, then IgG/IgM testing is recommended to look for current or long term infection. Knowing about the clinical picture, and the purpose of testing will help healthcare providers choose the best test in many situations.

BLOOD BANK TESTING

Immunohematology, Transfusion Medicine, and Blood Bank are similar terms related to the laboratory field that determines a patient’s blood type, screens for antibodies or other
incompatibilities, and prepares blood products for transfusion to patients. Tests such as Blood Type and Rh, Antibody Screen, Crossmatch, and transfusion reaction investigation are routinely performed by Blood Bank staff. Choosing the right laboratory test is important in order to have appropriate blood products available to the patient and provider at the time it is needed. There are also some time constraints that must be considered in choosing the right test.

Blood Type and Rh is the most frequently ordered test within the Immunohematology discipline. During this test, a laboratory will collect a blood sample, and test it for antigen/antibody interactions to determine A/B/O and Rh types. Combined, these tests yield a blood type such as A Positive or O Negative. Blood Type and Rh testing is necessary to have other Blood Bank tests performed or to receive most blood products. It is also useful in determining if ABO and Rh incompatibility is possible between a mother and child. This can cause Hemolytic Disease of the Newborn, when the mother is exposed to fetal cells that differ from her own blood type. This can be through fetal-maternal hemorrhage, abortion, trauma, obstetrical procedures, or even normal delivery. The mother’s cells then interact with the fetal cells and produce antibodies to the fetal RBC antigens. The majority of these cases involve a type O mother because they produce more IgG antibodies to target the fetal cells and cause hemolysis (destruction). Blood Typing is a basic Blood Bank test, and can take from 2-30 minutes depending on methods used.

A screen is just that, and many antibodies will look the same in an Antibody screen, so they are only positive or negative.

Many blood banks also perform Antibody Screening. This test analyzes a patient’s blood plasma for antibodies to known antigens (from several different blood typing systems other than ABO) present on Reagent Red Blood Cells. Also known as an Indirect Coombs, an antibody screen is necessary to make sure that the blood a patient receives is compatible with their own, and that antibodies within the patient will not destroy the red blood cells they are given causing transfusion reactions. A screen is just that, and many antibodies will look the same in an Antibody screen, so they are only positive or negative. If an antibody screen is positive, an antibody panel is performed to determine the correct antibody. For example, an antibody panel might be positive, the antibody panel shows positive for ANTI-D, meaning that the patient needs D (Rh) negative blood. If a patient has ever had an antibody, more intensive testing is needed to be sure that the blood products for the patient are compatible, even with a current negative Antibody Screen. Antibody Screening takes about 30 minutes, and further testing can take 2-24 hours or more.

Once a patient’s blood type is determined, and screening has been done for antibodies, a crossmatch is performed to assure the blood products, such as Red Blood Cells are compatible with the patient. Crossmatching is also known as compatibility testing. Because it is often an extra charge to the patient, and reserves the products for that particular patient (effectively taking them out of stock), crossmatching should only be performed if there is a reasonable expectation that the patient may need to be transfused with the blood product. There are several methods used by different laboratories that take varying amounts of time. When an antibody screen is negative with no clinically significant alloantibody history, some labs elect to do either an Immediate Spin Crossmatch, or Electronic Crossmatches are done by a computer system. These types of crossmatches only verify that the product and the patient are of compatible ABO types that react at room temperature. Prior to 1977 antiglobulin (Coombs) crossmatches were performed on all patients. However, it has since been proven that performing this labor intensive type of crossmatch isn’t always necessary. In the absence of history, and with a current negative antibody screen, only leaves a 0.005% chance of missing a clinically significant antibody. Electronic crossmatches take almost no time, while immediate spin crossmatches take a few minutes. If antibodies or a history is present, the crossmatch is typically performed to the antiglobulin (AHG or IgG) phase, and can take an additional 30 minutes after the rest of the workup has been performed.

Choosing wisely among blood bank tests helps to properly identify potential incompatibility between patient and product, save time by not performing unnecessary tests, and reserve our very limited blood product supply for those patients that need it the most. Antibody Screens, Antibody Panels, and Coombs crossmatches take more time than the rest of blood bank testing discussed here, but is necessary to reduce the likelihood of transfusion errors and reactions. Many reasons for testing can be satisfied by choosing the simplest appropriate test. For instance, if it is anticipated that a patient will need blood products in the distant future, a type and screen would be appropriate to determine if antibodies are present, but a crossmatch would not be appropriate.

NON-HEALING WOUNDS AND NUTRITIONAL STATUS

While most wounds eventually heal on their own regardless of a patient’s nutrition, some wounds persist and do not heal. These are termed Non-Healing wounds, with an ICD-10 classification of T81.89XA, and healing is connected to a patient’s co-conditions, nutritional status, and inflammation present. Albumin and Prealbumin are both proteins within the body used to assess a patient’s nutritional (protein)
state of being. While they sound similar, there are many differences. Prealbumin is named because it migrates faster on protein gel electrophoresis testing than albumin (5). They are not structurally related, or even all that similar, but it is important to pick the right test for one’s patient. 

Albumin accounts for over half of all serum proteins (7) after it is synthesized in the liver, and indicates the protein status of the organs and blood. Albumin also has a long half-life of nearly 20 days (7). This means that it takes a longer period of time for serum levels to decrease once a patient stops taking in adequate nutrition. Once the albumin levels have dropped, a significant amount of the protein is gone from the serum pool, and can take a long time to build back up. While albumin is a routinely performed lab test on most metabolic panels, and has its place, it is not the best test to assess acute nutritional status.

Knowing that a patient is getting text-book perfect care, but not seeing improvement can impact the morale of both providers and patients.

Prealbumin has long been confused with albumin because of their similar name. Because of this, it is now commonly known as transthyretin because it TRANSPORTS THYroxine and RETINol within the body (5). Prealbumin has a relatively short half-life of 2 days (7). This means that as a patient’s nutritional intake changes, it doesn’t take as long to see that change in the laboratory blood workup. There is also a smaller serum pool than albumin, which helps make changes more quickly apparent to the healthcare provider.

C-reactive protein or Erythrocyte Sedimentation Rate (ESR/SED Rate) blood tests are the most often ordered test to check for inflammation. Monitoring these indicators of inflammation is important to wound healing. While they are non-specific indicators of inflammation, they can be a good indication of the clinical picture of the patient.

Caring for non-healing wounds can be frustrating for patient care providers. Knowing that a patient is getting text-book perfect care, but not seeing improvement can impact the morale of both providers and patients. Knowing the appropriate lab tests to order can help the situation. Firstly, a baseline check of the nutritional and inflammatory indicators discussed above is appropriate. For difficult wounds, many will never heal until the inflammation has subsided, and providers should address the elevation of inflammatory markers. When the body does finally start to repair the wound, it takes a lot of energy. Patient’s with wounds that are healing can need “up to three times the normal daily requirement of protein" and additional calorie intake to provide the energy for healing (6). While one could use albumin to monitor the patient’s nutritional status, it really won’t indicate much of a change, and clinicians should wait at least 3 weeks to see reliable proof of improvement. Use of Prealbumin/transthyretin is a better indicator, as it can be monitored as often as 1-2 times a week with meaningful results. Using the tests described above can remove some of the frustrations associated with non-healing wounds.

CONCLUSION

As laboratory testing makes technological advances, and more laboratory tests become available, it can be confusing for Health Care Providers. Providers only want what is best for their patient, but can often fall into the habit of ordering the same tests repeatedly. Ordering the most appropriate test can sometimes take multiple attempts. Diagnostic Laboratory Consulting is a growing field, and some colleges are now offering degrees or certifications in this field. These consultants are available at many large laboratories, and can be a benefit to providers by providing valuable guidance about patient testing to clinicians. Confusion about laboratory testing even became an ASCP priority with the “Choose Wisely” campaign to help spread education about the importance of laboratory test choices. Providers have many resources to help choose laboratory tests, but knowledge is paramount in choosing the best test for the situation.

Citations and Resources

About the author:
T.J. Weatherly graduated in 2004 from Texas A&M University with a Bachelor of Science in Biology. He first certified with AMT in 2009 as an MLT and later as an MT. After years on the front lines as a bench technologist, he is currently the Team Leader of a rural hospital laboratory and focuses on generalist laboratory work and Molecular Microbiology testing. He also has a background in laboratory education for both laborsitians and clinicians.
1. First Timers Spring 2017
2. Canine Assistants Representative along with Lecturers from Cook Children's
3. Celia McDonald reading the minutes at the Spring 2017 Meeting
4. Kim Derschuck, member and Astou Lou
5. Michelle Hege and Taffy Durfee
6. Taffy Durfee and Distinguished Achievement Award Recipient, TJ Weatherly
7. Board of Directors 2017-2018
8. Roz Alhaddad enjoying the Paris themed social
9. Texas Basket - President Katrina Fryar with Winner Susan Jack from PA
10. Conference Chair Michelle Hege and Host Ron White celebrate a job well done
11. First time attendees receiving a TxSSAMT Pin
12. 2017 National Delegates at the social
13. 2017 National Delegates with Randy Swopes, District Councillor
14. First Timer Arnold Rodriguez stopping to pose
15. Celebration with Vernell Boyd
16. Rocella Carllysle, Katrina Fryar and Naomi Durfee at Nationals
17. Stopping to read a book
18. TJ Weatherly receiving the AMT Distinguished Achievement Award
19. Jean Palmer and attendees before a lecture
In recent years, researchers are viewing intestinal microbiota as a microbial human organ due to the important roles it plays in homeostasis through aiding in the body’s immune functions and energy metabolism. If the normal functioning levels of the microbiota are so important, what happens when the levels are disrupted? This raises the possibility that microbiota-related dysfunction can result in diseases. Within the past 5 decades, intestinal microbiome has been under constant antibiotic assault from medical therapies and the use of antibiotics in farming practices. Researchers believe this has led to unanticipated health consequences, and many common diseases that are associated with Western lifestyles have been causally linked to alterations in the gut microbiota. Diseases such as constipation, IBS, IBD, obesity, the metabolic syndrome, autoimmunity, and asthma are linked to gut dysfunction and have reached epidemic proportions in the past years.

Elie Metchnikof, a Russian immunologist in the 1800s, noted the large consumption of fermented milk in certain Eastern European rural populations well-known for their longevity. He introduced it into his own diet, and noticed a subsequent improvement in his health. This formed the foundation for probiotics (Borody, 2001). However, oral probiotic doses are typically 3–4 orders of magnitude lower than the 100 trillion native micro-organisms contained within the colon (Borody, 2001). This number is likely to be reduced further from the loss of adaptation to the harsh environments of the stomach and the small bowel during ex vivo cultivation and subsequent passage through them. The search for a better solution for probiotics led to the formation of the Human Microbiome Project in the USA and the MetaHIT project in Europe (Borody, 2001). These projects aimed at characterizing the microbial communities of the human body to determine their role in both human health and disease. To the dismay of all the microbiologists, the vast majority of dominant anaerobic species are unculturable by traditional microbiological techniques and therefore rendering their study difficult.

The first time Fecal Microbiota Transplant (FMT) was performed, was in the 1950s. A team of surgeons in Colorado successfully treated four patients using fecal enemas. Three of the patients were critically ill with fulminant pseudomembranous colitis, which at the time had a 75% mortality rate (Borody, 2001). Antibiotics, hydration, vasopressors, hydrocortisone and Lactobacillus acidophilus probiotic gave no success, so in desperation, the physicians resorted to fecal retention enemas. This resulted in prompt recovery of all patients, facilitating their hospital discharge within days of treatment (Borody, 2001). FMT has been employed numerous times since then and showed similar positive results.

Currently, the biggest use of fecal microbiota transplant is for the treatment of recurrent Clostridium difficile infection (CDI). This infection is as a result of a major disruption of normal gut microbiota; this can occur after antibiotic treatment and ingestion of environmental spores or gastrointestinal surgery. Its mechanism of infection is through toxins that disrupt the colonic epithelium leading to an inflammatory response. The clinical symptoms vary from mild diarrhea to life-threatening pseudomembranous colitis. Between 1996 and 2003, there was a two-fold increase in CDI to 0.6 per 1,000 patients (Borody, 2001). In 2009, the CDI prevalence rate among inpatients rose to 13.1 per 1,000 patients (Borody,
Biopsy of pseudomembranous plaques reveals an inflammatory exudate composed of mucinous debris, fibrin, necrotic epithelial cells and polymorphonuclear cells.

The donor is at minimum screened for infectious agents, but much more rigorous donor screening is recommended. Given the important roles gut microbiota have in the digestive system, donors with any gastrointestinal complaints, the metabolic syndrome, autoimmune diseases or allergic diseases should be excluded. The method of transplantation through an enema or colonoscopy is the more common route (80% of reported patients). With the remaining 20% receiving the feces through a nasogastric or nasoduodenal/jejunal tube. There were no specific side effects reported related to installation of feces in the upper or lower tract and the limited numbers of studies make it impossible to predict which route of installation is more successful in curing patients from CDI. There are, however, advantages and disadvantages with the different methods of administration that need to be presented and talked through with the patient. Colonoscopy is considered more difficult and strenuous, whereas (slow) infusion through a nasoduodenal tube seems safe and time-efficient. Donor feces may be difficult to install via nasoduodenal/jejunal tube if patients have signs of diminished passage of fluids through their intestines. On the other hand, infusing feces using this route has the advantage that the infused flora reaches the whole bowel.

WHAT ROLE DO LAB TECHNICIANS PLAY IN FMT?
Pathology assistants will see the intestines of some of the patients with CDI in the lab to be analyzed histologically. In patients with severe recurrent CDI or fulminant disease, surgical intervention might be considered before FMT, and grossly, yellowish plaques with pseudomembranous colitis will be notable. Biopsy of pseudomembranous plaques reveals an inflammatory exudate composed of mucinous debris, fibrin, necrotic epithelial cells and polymorphonuclear cells. The underlying crypts show disruption by mucous and inflammatory debris. Microbiology will receive the fecal matter to aid in the diagnosis of CDI and the screening of the donors. Stool cultures are the most sensitive studies for determining CDI, and before a patient can undergo FMT, stool tests to rule out other treatable causes like fecal Giardia antigen, Cryptosporidium antigen, acid-fast stain for Cyclospora, Isospora, Dientamoeba fragilis, Blastocystis hominis, norovirus and rotavirus, and Helicobacter pylori fecal antigen. Light microscopy examination of stool samples is carried out for ova and parasites. Stool cultures are the most sensitive studies for determining CDI, and before a patient can undergo FMT, stool tests to rule out other treatable causes like fecal Giardia antigen, Cryptosporidium antigen, acid-fast stain for Cyclospora, Isospora, Dientamoeba fragilis, Blastocystis hominis, norovirus and rotavirus, and Helicobacter pylori fecal antigen. In addition, the notable lab value that will show up in patients with CDI is leukocytosis. The send-outs area will play an integral role in contacting the facilities that provide the donor material and mediating the reception of the feces for administration. In addition, send-outs will aid in performing screening tests that are not in-house but have to be run on the patient prior to FMT to have a complete work-up. It is notable for the technicians in the chemistry department to know that patients with C diff are prone to acute kidney injuries, so the creatinine and BUN levels may be elevated and an indicator of severe C diff infection would be electrolyte imbalances and hypoaalbuminemia, in which case more drastic measures would need to be taken.

The current challenges for FMT therapy is the need for standardized methods for collecting from donors and storing transplant material. This is crucial so the material can be rapidly accessed and deployed for patients with severe CDI and early signs of fulminant disease needing immediate treatment. The current thought for solving this issue is establishing a few centralized facilities that are capable of processing the donor material and shipping it to individual providers in frozen, lyophilized or encapsulated forms.
As for the future of fecal microbiota transplant, a double-blind, randomized, controlled trial of FMT in 18 men with the metabolic syndrome was performed to study the effects of FMT on triglyceride levels. Nine patients received fecal material from lean male donors and nine were implanted with their own feces as controls. After transplantation of fecal flora from lean donors, fasting triglyceride levels in patients with the metabolic syndrome were markedly reduced; no effect was observed in the control group re-instilled with their own feces (Borody, 2001). As you can see, more studies are needed to be performed to assess the full potential of FMT in the treatment of the many diseases that are thought to result from the disruption of the intestinal microbiota, but the future of this therapy is promising and worth exploring considering the overwhelming success that has been showed with the treatment of recurrent Clostridium difficile infections. As more and more hospitals begin to employ this potentially life-saving therapy, the medical community will begin to hear about the relief this therapy provides to patients on a regular basis.

References

About the author: Lauren Ehle is a second year medical student attending Texas A&M University Health Science Center College of Medicine. She completed a four week program in the laboratory where she learned the many aspects of laboratory medicine and roles of pathology in treating patients.
PEPPERMINT ESSENTIAL OIL is produced from the plant *Mentha piperita*. Since the oil is harvested from the leaves instead of a flower like lavender, it is relatively easy to come by and less expensive. Peppermint as a plant is easy to grow at home, either indoors or out. Like the plant, the essential oil is ingestible as well as topical. Here are 6 reasons with a bonus feature to include this oil’s use from head-to-toe.

**Did You Know...**

By Jill Gandy, MT(AMT)

1. **Headaches** – Headaches can disrupt anyone’s day from the change in the weather to body dehydration. Simply place a few drops on your fingers and massage into the temples and across the forehead. It may even clear the sinuses as an extra bonus.

2. **Bad Breath** – Eoil containers are easy to carry with you. For a fast refresher before greeting friends, family, and co-workers, invert the bottle so a small amount is on your finger tip then slide your finger from front to back on the tongue. You are now ready for your close up.

3. **Congestion** – This oil is one of the main ingredients in all the famous chest rubs for cold and flu symptoms. Create your own rub with a jar of petroleum jelly and 1ml of peppermint oil, then stir with spoon to an even mixture. Apply to chest and cheeks for relief.

4. **Indigestion (such as nausea and gas)** – It can also be used for its anti-nausea benefits and soothing effects on the gastric lining and colon because of its ability to reduce muscle spasms. Placing a few drops on a cotton ball for inhalation or a few drops in the belly button (yes, the belly button) for digestive relief.

5. **Joint Pain** – Does pipetting tend to flare up the old wrists? Place a few drops on the wrists and wrap with a warm towel for about 10 minutes. The warming of the skin with the towel opens the skin pores, and the oil can be absorbed and soothe the inflammation of the tendons.

6. **Menopause** – Night and day sweats due to hormone changes soaking your clothes and hair. Try this oil on the back of the neck, wrists, and sternum for a quick cool down.

**Bonus: Insect Repellant** – Just as effective as citronella, this oil can be used neat on the back of the neck, on wrists, and the back of the knees to keep common summer pests from spoiling your fun. A roll-on applicator is great for an on-the-go usefulness.

**Note:** When purchasing any essential oils, you should look for lot numbers and expiration dates. Just like reagents, Eoils are quality controlled for potency and batch troubleshooting in case of a contamination incident. Also, make sure oils are packed in amber glass containers. Anything in plastic bottles may be diluted or lab manufactured which could produce a negative result for your symptoms.

**Caution:** Peppermint oil can be used neat topically, but it can cause irritation to the skin. It is best to use a carrier oil like olive, jojoba, or coconut. Do not use this oil if you are pregnant or have epilepsy.

**References**
Essential Oils Natural Remedies: The Complete A-Z Reference of Eoils for Health and Healing; Fall River Press; Pages 384-385.
1. Define HIPAA:
   a. Health Information Privacy and Accountability Act
   b. Health Information Privacy and Affordability Act
   c. Health Information Portability and Accountability Act
   d. Health Insurance Portability and Accountability Act

2. According to one of the article’s sources, how many patients in the course of 2 years were affected by HIPAA breach?
   a. 21 thousand
   b. 3 million
   c. 21 million
   d. The answer is not listed

3. The Medicare Conditions of Participation:
   a. Regulate the conditions of qualifications for home health agencies
   b. Explain patients’ rights
   c. Specify that all clinical records maintained are confidential
   d. All of the above

4. PHI includes all of the following EXCEPT:
   a. Patient Demographics
   b. Medical information
   c. Home Health Agency Address
   d. None of the above

5. According to one source in the article, what was responsible for 66% of PHI breach?
   a. Mobile device theft
   b. Personal conversations by the medical staff
   c. Charts left in view
   d. EMR left unencrypted

6. What is the most common mistake made with paper charts?
   a. Patient information left in view
   b. Notes misfiled in charts
   c. Charts not filed
   d. Charts left in vehicles

7. What type of storage is required for HIPAA related material?
   a. Encrypted/locked
   b. Cloud storage
   c. File cabinets
   d. EMR

8. How many patients were affected in one incidence of theft from a vehicle?
   a. 21 million
   b. 64,846
   c. 34,503
   d. 45,000

9. HIPAA violations can include which of the following:
   a. B, C, and D
   b. Leaving a company laptop in a vehicle
   c. Discussing a difficult patient on social media with a co-worker
   d. Walking away from your computer with desktop in view

10. What is the most common method of exposing patient information?
    a. Casual conversation
    b. Mobile devices
    c. Misfiling in patient charts
    d. Social media

   1 Which Antibody is produced first in an immunologic response:
      a. A
      b. B
      c. M
      d. G

   2. When looking for active Helicobacter infection, one should test:
      a. H. Pylori IgG
      b. H. Pylori Antigen
      c. H. Pylori IgM
      d. H. Pylori IgA

   3. Which Blood Bank Test gives a Patient’s Blood Type?
      a. Antibody Screen
      b. Antibody Panel
      c. Blood Type and RH
      d. Blood Type and Screen

   4. Antibody Screening takes approximately ___ Minutes?
      a. 2
      b. 15
      c. 30
      d. 60

   5. With a Negative Antibody Screen, what is the chance of missing a clinically significant antibody when using Immediate Spin Crossmatches?
      a. 100%
      b. 1%
      c. 0.005%
      d. 25%

   6. Which protein migrates faster on Gel Electrophoresis
      a. Albumin
      b. Prealbumin

   7. Which test is indicative of inflammation?
      a. Albumin
      b. Prealbumin
      c. C Reactive Protein
      d. Crossmatch

   8. Prealbumin (transthyretin) transports what compounds?
      a. Thyroxine
      b. Retinol
      c. A and B
      d. None of the above

   9. Albumin and Prealbumin have half-life’s of ___ and ___ days respectively
      a. 5, 15
      b. 20, 2
      c. 2, 20
      d. 15, 5

   10. How many times per week can prealbumin be tested?
       a. 2
       b. 3
       c. 5
       d. 7

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   AMT I.D. Number ____________________________
   (Do not put social security number on form)
1. Elie Metchnikof noticed an increased health improvement when he introduced what type of product into his diet?
   a. fermented yogurt  
   b. fecal microbiota  
   c. fermented milk  
   d. fermented vegetables

2. What was the Human Microbiome Project and the MetaHIT main purpose in determining human health and disease?
   a. characterizing what people ate  
   b. characterizing the microbial communities  
   c. characterizing why people got sick  
   d. culture the anaerobic species

3. When was the first time fecal transplant performed?
   a. 1800s  
   b. 1965  
   c. 2009  
   d. 1950

4. What organism is fecal transplant targeted to treat?
   a. Clostridium difficile  
   b. Lactobacillus acidophilus  
   c. Pseudomonas aeruginosa  
   d. Escherichia coli

5. What is the mechanism of Clostridium difficile infection?
   a. over colonization  
   b. release of toxins  
   c. immune compromised  
   d. infectious agents

6. What are some of the clinical symptoms?
   a. mild diarrhea  
   b. pseudomembranous colitis  
   c. headache  
   d. both a and b

7. What is the standard Clostridium difficile antibiotic treatment?
   a. vancomycin and metronidazole  
   b. fluoroquinolones  
   c. amoxicillin and Cefoxadine  
   d. Ampicillin and Carbenicillin

8. What is the method of transplantation?
   a. enema  
   b. colonoscope  
   c. nasoduodenal/jejunal tube  
   d. all the above

9. What is most notable in the lab results for a patient that has Clostridium difficile?
   a. increased glucose  
   b. increased leukocytosis  
   c. decreased serology  
   d. asymptomatic

10. What is the percentage of patient’s risk of relapse without the fecal microbiota transplant?
    a. 20-25%  
    b. 81-94%  
    c. 80%  
    d. 20%
MEDICAL TECHNOLOGY TERMS A

looking for a 19-letter word

ACID
AROMA
CANCER
CHLORIDE
CLEAR
COOPER
DONOR
FALCIPARUM
FAT
FEVER
FUNGUS
GAS
GENE
GIARDIA
GLOBULIN
LYSOSOMES
MICROSCOPE
MOBILE
NEEDLE
NODE
OVULE
REAGENT
SEROLOGY
SOLUBILITY
SPUTUM
TACROLIMUS
TAF
THROMBOCYTES
THYROID
TREPONEMA
TUMOR
WAX
YEAST

MEDICAL TECHNOLOGY TERMS B

looking for a 12-letter word

ACID
ACUTE
AIDS
ALBUMIN
ANEMIA
BACILLUS
BILE
BLAST
BLOOD
CELL
CHEMISTRY
COCICI
CRYSTAL
CUT
CYST
DISEASE
FOLATE
GLANDS
GRAVITY
ION
LEAD
MEAN
MEDIA
MELT
MYCOBACTERIUM
PIPET
PLASMA
PROTHROMBIN
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RATE
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RIM
RIST

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Maria Rachelle M. Luna MT(AMT)
Bachelor of Science in Medical Technology from Centro Escolar University Manila, Philippines
Currently working at The Medical Center of Southeast Texas in Port Arthur, Texas

National American University’s Austin campus is seeking applications for adjunct faculty positions to teach Medical Laboratory courses, Anatomy & Physiology, and other Medical Assisting courses

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• Applicants invited to interview will need to prepare a 15 minute teaching demonstration to a small panel of staff/faculty
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Fall/Winter 2017 / TxSSAMT

Our state is in need of a NEW PIN!! So we are offering a pin design COMPETITION! A TxSSAMT member can design a state pin and email their work to TxSSAMT President, Katrina Fryar. The designs will be voted on by the board and the winner is awarded a lifetime of FREE conference registrations.

The winner will be announced at the Fall 2017 Conference.

So HAVE FUN and let the imaginations flourish!!
Can’t wait to see what you think represents our great state!
FRIDAY, NOVEMBER 10, 2017

7:00-4:00  Meeting Registration/Sign-in
7:50-8:00  Welcome/Announcements – Katrina Fryar, MT (AMT), President
8:00-9:00  “The Past Present and Future Laboratory”
31-201-17 Nelson Way, Medical Technologist, CHI St. Joseph Health – Grimes Hospital
9:00-10:00 “Effective Communication Skills: Verbal, Non-Verbal, Written”
31-202-17 Brittany J. Miller, CDA, RDA, Dental Assisting Lead Instructor, Pima Medical Institute
10:00-11:00 “Emerging Monoclonal Antibody Therapies in the Treatment of Cancers”
31-203-17 Paul Langston MT (AMT), Lab Operations Manager, CHI St. Joseph Health Regional
11:00-12:00 “Lymphoma, Leukemia”
31-204-17 Jason Koshy, MD, Pathologist, Brazos Valley Pathology, CHI St. Joseph Health Regional
12:00-1:00 Lunch on your own/TxSSAMT Board Meeting
1:00-2:00 “Pathology, Laboratory, and Clinical Look at Pap Smears and Cervical Biopsies”
31-205-17 Marcela Jimenez, MD, Pathologist, Brazos Valley Pathology, CHI St. Joseph Health Regional
2:00-3:00 “Holiday Survival Guide - Best Practices to Maintaining a Healthy Diet”
31-206-17 Kaye Fitz, Registered Dietitian, Nutritional Counseling, CHI St. Joseph Health
3:00-4:00 “FUJIFILM Diosynth Biotechnologies U.S.A., Inc - Vaccines”
31-207-17 Presenter Name, Presenter Position, FUJIFILM Diosynth Biotechnologies U.S.A., Inc
4:00-5:00 “FUJIFILM Diosynth Biotechnologies U.S.A., Inc - Tour of Facilities”
31-208-17 Presenter Name, Presenter Position, FUJIFILM Diosynth Biotechnologies U.S.A., Inc
6:30-9:00 Wine and Cheese Social and TxSSAMT World Famous Auction (included with paid registration)

SATURDAY, NOVEMBER 11, 2017

7:00-4:00  Meeting Registration/Sign-in
7:50-8:00  Welcome/Announcements – Jean Palmer, RMA (AMT), Vice-President
8:00-9:00  “Anatomy of an Outbreak”
31-209-17 Kim Dubose MT (ASCP), Laboratory Director, CHI St. Joseph Health Regional
9:00-10:00 “Leadership Focus – The Role of Supervision, Relationships and Performance”
31-210-17 Jorge L. Lopez, MT (AMT), U.S. Army, Sergeant Major
10:00-11:00 “Pathogens and Biological Agents….. How to Protect Me”
31-211-17 Kathy Wall, TEEX WMD Instructor, Texas A&M Engineering Extension Service
11:00-1:00 TxSSAMT Semi-Annual Business Meeting – All members are encouraged to attend and lunch is provided!
1:00-2:00 “The “Far Side” of your Position Description”
31-212-17 John Rinard, TEEX WMD Instructor, Texas A&M Engineering Extension Service
2:00-3:00 “Stress Management”
31-213-17 Debbie Griffith, Trauma Coordinator, CHI St. Joseph Health – Grimes Hospital
3:00-4:00 “Blood Gas Chemistry”
31-214-17 Daniel Schorre, Respiratory Therapist, Patient Care coordinator at VieMed
4:00-5:00 “Breast Cancer Updates”
31-215-17 Heidi Arceneaux, BioMarker Testing Specialist, Genentech BioOncology

Thanks for your attendance!
Please travel home safely.
Visit us online at www.americanmedtech.org/AboutUs/StateSocieties/Texas.aspx

Note: Schedule is subject to change

All members, attendees, speakers and guests are encouraged to attend. Remember to bring items to the auction and help support the TxSSAMT Scholarship and Awards Fund.
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General Registration (All Seminars) Friday & Saturday (One Day Only) Friday or Saturday

| AMT Members | $75.00 ($85.00 at door) | $40.00 ($50.00 at door) |
| Non AMT Members | $90.00 ($100.00 at door) | $50.00 ($60.00 at door) |
| Military Personnel | $20.00 ($25.00 at door) | $10.00 ($15.00 at door) |
| Students with ID | $10.00 ($10.00 at door) | *$10.00 ($10.00 at door) |

Registration Total $ ___________

☐ RSVP if you are attending the Friday night social. No. Attending _____

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MECHANICAL REQUIREMENTS

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<tr>
<td>1/2 Page</td>
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<td>1/4 Page</td>
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</tbody>
</table>

Material requirements: Camera ready positive material.
No cancellations within 5 days of the closing date.
Agency Commission: Above rates net; any agency fees used, final fees should be adjusted so that final payment agrees with above stated rates.
Terms: No cash discount, rated due 30 days following invoice.

If I can be of assistance to you or your organization, please contact me.
Katrina Fryar, MT • 9338 FM 2549 • Bryan, Texas 77808
Cell (979) 777-7030 • ag3kat@yahoo.com

Answers to word search puzzles on page 20:
Medical Technology Terms A - 15-letter word is CRYPTOSPORIDIUM
Medical Technology Terms B - 12-letter word is CHYLOMICRONS
Join TxSSAMT for a 2019 Spring Conference Cruise!

When: March 28 - April 1, 2019
Who: Anyone interested!

Carnival Cruise Lines
Ship: Carnival Valor

Ports of Call: Cozumel Plus
Cozumel Plus: Spend more time in port, unlocking exclusive excursion that take you exploring further and adventuring more.

From $309* / person
*Interior room with bunk beds
*Taxes, fees excursions and port expenses are additional
* prices subject to change

Pay for the cruise and get amazing CE lectures at no additional cost.

Proposed Itinerary:
Day 1: Galveston depart at 4pm
Day 2: Fun Day at Sea with AMT CE lectures in the morning
Day 3: Cozumel arrive at 9am and depart at 6pm
Day 4: Fun Day at Sea with AMT CE lectures in the morning
Day 5: Galveston arrive at 8am

Please book with TxSSAMT group
Deposit due upon booking
Final Payment due by 1/27/2019

Questions:
KATRINA FRYAR
TxSSAMT President
Ag3kat@yahoo.com

Please Book with:
Mauricio “MOE” Banderas, Personal Vacation Planner
Carnival Cruise Lines
Office: 800.819.3902 Ext. 85680 mbanderas@carnival.com

Office hours
Monday – Thursday: 11:00am – 8:00pm
Friday: 9:00am – 6:00pm