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How to Hire Great Medical Assistants

This article was originally published in Medical Economics and is written by Julie Miller.

Many practices are adopting an all-hands-on-deck approach to deliver the suite of services required to achieve comprehensive patient care. Experts say medical assistants (MAs) can be cost-effective contributors to these emerging care models.

Emerging Roles for MAs

MAs are equipped to manage some of the new practice responsibilities that have emerged under value-based care initiatives. Patient-centered medical homes are especially well suited to make use of MAs, who can carry out a number of health management strategies, he says.

Emerging roles for MAs include:

- ▶ Prevention outreach specialist or panel manager—identifies patients with care gaps and communicates with them to encourage adherence to recommended care;
- ▶ Patient navigator or patient advocate—acts as a liaison between the patient and the healthcare system in an effort to reduce barriers to care;
- ▶ Clinician—qualified to deliver certain services under Medicare's Chronic Care Management and Transitional Care Management programs.

As a patient navigator, the MA also takes on a communications role, advocating for the patient with sensitivity to cultural, socioeconomic, age, gender, or other personal characteristics. It's a valuable asset for practices that are eligible for bonus payments based on patient satisfaction scores.

Medicare Reimbursement

Under Medicare's Chronic Care Management and Transitional Care Management programs, certain services performed by MAs can be billed as "incident to" the services of the overseeing physician or advanced practice provider (chronic care, non-face-to-face service code CPT 99490 and transitional care management codes CPT 99495 and CPT 99496). In other words, practices participating in the two programs can get paid for work performed by MAs.

Some examples of chronic care management duties for MAs include recording patient health information and keeping comprehensive care plans up to date electronically. Transitional care management services include providing education about available community resources.

Paula Lozano, MD, MPH, a pediatrician and researcher with the Kaiser Permanente Washington Health Research Institute in Seattle, recommends an approach that allows MAs to take ownership of care-management tasks. Practices should also consider enhanced compensation packages for MAs—not just in terms of wages, but also training and career advancement opportunities—to recruit and retain the best assistants. ■

To read the unabridged version, visit www.medicaleconomics.com.

Comparing Treatments in Early-Stage Pediatric Hodgkin Lymphoma



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When managing early-stage pediatric Hodgkin lymphoma, combining modality therapy with chemotherapy and radiotherapy appears to correlate with better survival than using chemotherapy alone.

Presently, there is no well-defined standard of care for managing pediatric patients with early-stage Hodgkin lymphoma (HL). "Current treatments include chemotherapy alone or combined modality therapy (CMT) with chemotherapy and radiotherapy," explains Rahul R. Parikh, MD. "CMT has been shown to be manageable for these patients but this treatment can result in toxic side effects. More recently, there has been an increased emphasis on reducing radiotherapy in this patient population. This strategy, however, remains controversial."

With disease control becoming more common for early-stage pediatric HL, greater attention is being paid to identifying the most appropriate patients for CMT versus chemotherapy alone and the subsequent effects on survival. "CMT has demonstrated efficacy, with event-free survival rates of 80% and higher and with overall survival (OS) rates that are greater than 95%," says Dr. Parikh. "However, questions remain as to whether CMT benefits outweigh risks of long-term side effects."

A Closer Look

For a study published in *JAMA Oncology*, Dr. Parikh and colleagues examined use of CMT in early-stage pediatric HL and its association with improved OS using data from the National Cancer Database. Study patients received definitive treatment with chemotherapy or CMT. Clinical features and survival outcomes were assessed in 5,657 pediatric patients (≤21 years) with a diagnosis of stage I or II HL between 2004 and 2015. "Our work is the largest retrospective study to date involving this patient population," Dr. Parikh says. The primary goal was to determine the association between use of CMT and OS. The authors also explored links between pathologic factors and OS.

"CMT was associated with improved OS at 5 years (97.3%) when compared with chemotherapy alone (94.5%)," says Dr. Parikh (Figure). "Our study also found that use of CMT was preferential in younger patients, male patients, those with stage II disease, and those with

private insurance." Several factors were significantly associated with OS in the study, including age, use of transplant procedure, and type of health insurance. These OS findings remained significant in an intention-to-treat analysis and multivariate analysis.

In a sensitivity analysis, the low-risk cohort—those with stage I to stage IIA disease—and adolescent and young adult patients benefited the most from CMT. "Adolescents and young adult patients had the most impressive benefit with combined modality therapy versus chemotherapy alone," Dr. Parikh says. "Conversely, the youngest patients—those aged 1 to 13 years—appeared to benefit the least from this combined form of treatment. This is an important finding because these patients are most vulnerable to the potential long-term effects of radiotherapy."

The study also identified changes in national practice patterns. Use of CMT decreased by 24.8% from 2004 to 2015, dropping from 59.7% to 34.9% during this period. The most common physician-reported rationale for not using consolidation radiotherapy as part of the CMT

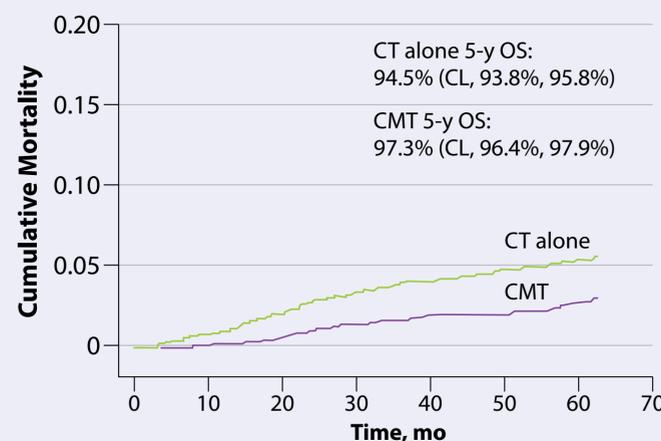
program was that it was not part of the planned initial treatment strategy, accounting for more than 90% of cases. This finding may be due, in part, to chemotherapy alone being used as standard therapy in clinical trials. It could also reflect clinician bias against the use of radiotherapy, perhaps due to a lack of access to modern radiation treatment options (eg, proton therapy).

Key Implications

Current radiotherapy techniques minimize the long-term effects of CMT, but researchers are continuing to establish which patients will truly benefit from CMT and seeking to determine if some patients can be identified as better candidates for consolidation radiotherapy. "Our study demonstrated an improvement in survival benefit for patients with early-stage pediatric HL," says Dr. Parikh. "Clinicians should discuss CMT as a treatment option with these patients and their family and caregivers. Investigators should consider designing future clinical trials for this patient group to include CMT as a standard arm. In addition, research is needed on ways to improve access to care for all pediatric patients with this disease." ■

Figure Cumulative Mortality & Survival

The figure below depicts cumulative mortality and overall survival (OS) for patients aged 21 years or younger who received combined modality therapy (CMT) as compared with those who received chemotherapy (CT) alone. Patients had a median follow-up of 61.8 months.



Sources: Adapted from: Jhawar SR, et al. *JAMA Oncol*. 2019;5(5):689-695.

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Docsplaining. An Unfair Generalization of Physicians



Written by
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Doctor bashing as social media's latest spectator sport | I found the piece insulting but somehow not surprising. Bashing doctors, after all, is the social web's latest spectator sport.

Twitter's own physician community includes some who seem to take pleasure in reminding us of just how broken we are as physicians and humans. Dramatic displays of faux humility suggesting 'we must do better' serve more as a trite reflection on the users own facade of enlightenment than anything truly constructive. Public self-flagellation and the exaggerated disclosure of our professional failures serve to counter the guilt of perceived privilege.

So, concerning docsplaining, Twitter's groupthink would suggest that we concede and retreat Dr. Launer's new term to support just how universally disrespectful doctors are. But you won't find me on this sorry bandwagon.

Physicians have room for improvement | There are many things that doctors could do better as individuals and as a profession. There are those who would benefit from insight into their own attitude, tone, and approach with patients. Continuing education, patient/peer feedback should be part of our professional development. And like Dr. Launer, I have at times been critical of the trajectory of our profession and the trends adopted by some of my peers.

Many doctors defy the docsplaining stereotype | Despite these generalizations, I can speak only to the dedication and compassion of my co-workers. As a mentor to many of them, I see their efforts to defy the perverse stereotype perpetuated in Dr. Launer's viewpoint. I can point you to colleagues who have built careers out of the kind of human connection that he perhaps has never seen.

In the kangaroo court of public dialog, the predictable response to my criticism will be to position me as a perpetrator of docsplaining. But if you spend time on my blog, you'll find situations, stories, and solutions carefully documented that counter the suggestion that docsplaining is every physician's modus operandi.

If you're prone to doctor bashing, it may be time to take stock. Many of us are doing a better job than some want you to believe. ■

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Antibiotics and Colorectal Cancer Risk

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Antibiotic overuse, a driver of antimicrobial resistance, is a global public health problem. In 2010, estimated global antibiotic consumption was at least 10 doses per person. Multiple studies indicate that antibiotic use, even with narrow-spectrum antibiotics, changes the gut microbiota.

Along with our colleagues from Johns Hopkins University School of Medicine and University of East Anglia Norwich (UK), we sought to investigate the long-term health outcomes from oral antibiotic use, focusing on colorectal cancer (CRC). For a paper published in *Gut*, we conducted a matched case control study in the United Kingdom Clinical Practice Research Datalink (CPRD). A total of 166,057 participants were analyzed. With a median follow up of 8 years, 70% of participants received oral antibiotics, with most prescribed more than one type during the study period.

After controlling for potential confounding factors (factors that increase CRC risk such as weight, smoking, and alcohol intake), we found colon cancer risk increased with even one antibiotic course, with maximal increased risk (15%) after 30 days of antibiotic exposure. This association of antibiotic exposure and increased colon cancer risk was observed only in the proximal colon. Antibiotics that kill anaerobic bacteria—in particular penicillins—appeared to drive the risk. Further, increased risk for colon cancer after antibiotic exposure was linked to antibiotic use more than 10 years before the cancer diagnosis, suggesting a long-term impact of antibiotics on the gut microbiota and also consistent with the usual slow growth of colon tumors.

With our colleagues, we observed that antibiotic exposure, particularly to tetracyclines, was associated with decreased rectal cancer risk, but only after 60 days of exposure. The differences observed in the associations between antibiotic exposure and colon versus rectal cancer are consistent with the differing biology of these two cancer types.

Our findings support, but do not prove, the potential causal link between disrupted microbiota and CRC. More clinical and translational studies are needed to confirm and extend this work to determine how the colonic microbiota contributes to CRC disease. Regardless, this study highlights the importance of judicious antibiotic use by physicians, even beyond concerns for antimicrobial resistance and *Clostridioides difficile* infection. ■

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