ASSOCIATION OF CANCER EXECUTIVES UPDATE

FEBRUARY 2024 | www.cancerexecutives.org | ANNUAL MEETING SPECIAL EDITION

WHAT'S INSIDE

HAVE SOME NEWS TO SHARE?

Please send to Brian Mandrier at **brian@mandriergroup.com**

association of cancer executives
Connecting All Oncology Leaders

Upcoming Events

IOLC PARIS 2024

We are very excited to announce registration for IOLC Paris 2024, which will be opening in March. The meeting will be held November 10-12, 2024.

ACE NEW ORLEANS 2025

The 31st ACE Annual Meeting will be held in New Orleans from January 26-28, 2025! Registration and details coming soon.

Announcements & Reminders

ACCEPTING NOMINATIONS!

Accepting nominations for the 6th Annual Marsha Fountain Award for Excellence in Oncology Administration. The award is reserved for nominees currently working in the oncology administration field. Learn more here.

Navigating Hypofractionation: Revolutionizing Radiotherapy with Efficiency

BY CARLOS CASTILLEJA, ELEKTA'S EXECUTIVE VICE PRESIDENT - REGION AMERICAS

In the dynamic landscape of cancer treatment, the paradigm of radiotherapy is undergoing a significant transformation, with hypofractionation emerging as a leading driver of change. Hypofractionation challenges the traditional approach to radiotherapy by delivering higher doses of radiation in fewer treatment sessions compared to standard radiation therapy. This departure is grounded in clinical evidence and technology advancements, offering not only enhanced treatment outcomes but greater convenience for patients and less demand on staff.

DISPARITIES IN CANCER CARE

It's a common misconception that only patients in developing countries struggle with receiving appropriate cancer care, but in reality, this challenge can occur anywhere outside of major metropolitan centers. Despite the high-quality cancer treatment services available in the U.S., individuals in countless rural communities face a range of problems as described in a 2020 JCO Oncology Practice article. The authors cite how long travel distances, and the length of a treatment course can be hardships for rural patients. However, amidst the challenges, hypofractionation has emerged as a silver lining, narrowing the care gap for rural patients. For example, once a site in Oklahoma was able to start offering breast cancer patients a 20 fraction treatment, they didn't have to spend as much time and money traveling to the clinic, as well as experienced fewer side effects.

DUAL THERAPY PROTOCOL SHOWS PROMISE

As is common in medicine, combining two or three different treatments can provide a synergistic effect that is highly therapeutic. Advances in medical oncology, particularly immunotherapy, contribute to the growing importance of hypofractionation in cancer treatment. This synergy between medical oncology and hypofractionation is opening up new avenues for purchasing hardware and the overall efficacy of cancer treatments.

HYPOFRACTIONATION AND U.S. REIMBURSEMENT: CHALLENGES AND OPPORTUNITIES

Reimbursement is a critical factor limiting the purchase of hardware and utilization of hypofractionation, especially in community hospitals and independent radiotherapy centers. The lack of higher reimbursement for advanced hardware may restrain the adoption of new technology, with academic medical centers often being the primary beneficiaries of these advancements. However, there is resilience within the field. While economic challenges exist, the potential benefits of hypofractionation are compelling enough to outweigh financial concerns since centers that do not embrace hypofractionation may face financial risks under the new reimbursement model, especially if commercial payers follow suit.

Elekta remains steadfast in its commitment to making advanced technology accessible and available to healthcare institutions striving to embrace hypofractionation. At the forefront of this transformative journey is Elekta Unity MR-Linac, an innovative MR-guided Radiation Therapy (MRgRT) system. The capabilities of Elekta Unity go beyond mere technological advancements; it is a testament to our commitment to revolutionizing cancer treatment. With online plan adaptation and Comprehensive Motion Management (CMM), our users are reducing not only margins but also patient side effects with precision and accuracy, making it a cornerstone for the successful implementation of ultra-hypofractionation.

CONCLUSION: HYPOFRACTIONATION'S UNCHARTED COURSE

Hypofractionation is steering radiotherapy into uncharted territory, redefining treatment protocols, and challenging established norms. With key drivers such as reimbursement challenges, bundled payments, and medical oncology advances shaping its trajectory, hypofractionation is becoming increasingly integral to the future of cancer treatment. Navigating the challenges and capitalizing on the treatment technique is essential for realizing its potential to elevate care standards and provide efficient and effective treatment options. I believe Elekta's commitment to advancing technology and the transformative power of hypofractionation stand out as beacons of hope.

AI in Healthcare: The Effect on Current and Future Care

BY RON DIGIAIMO, MBA, FACHE, OREST BOYKO, MD, PHD, JOHN MONTVILLE, MBA, FACHE, FACMPE, FACCC, COA, AND BRI DRIGGERS

INTRODUCTION

"AI" is the hottest buzzword for 2023 – and maybe all of the 2020s. Some discussions of Artificial Intelligence (AI) have included additional wording at the start of the phrase such as "Assistive", "Augmented", "Autonomous", or "Adoption". Regardless of the viewpoint, AI is on everyone's mind, and it's got many people divided on their perception of it. As with many technological innovations and advancements, the healthcare community is excited by innovation if they are early adopters, or reticent on this innovation and willing to be late adopters who tend to be in the majority of providers.

Some comments made in AI adoption discussions include "Is a robot going to take my job?" This tends to be the first question that late adopters ask when the topic of AI comes up in conversation.

Surely an industry full of highly skilled and specialized providers wouldn't need to worry about their job security… right?

RCCS CEO Ron DiGiaimo and marketing manager Bri Driggers had a chance to talk with two industry experts about the development of AI in healthcare and what it means for our futures.

Dr. Orest Boyko has a background as a clinical radiologist and served as a residency and fellowship director for neuroradiology for several years. Almost a decade ago, Dr. Boyko decided to step back from the clinical side of things and go part-time as a radiologist for an industry AI research group in San Jose, California. The last ten or so years have opened his eyes to the possibilities of AI in healthcare, and he assures the non-believers and hesitant adopters that, in his opinion, "AI will always be a tool that is overseen by humans."

Another expert we interviewed, John Montville, Executive Director of the Oncology Service Line at Bon Secours Mercy Health-Lourdes Hospital, also observed, "Medicine has always been an art." Certain specialties may be more objective and less 'artistic,' which puts them at the top of the list of those believing AI is here to assist. However, John assures providers that even the more cut-and-dry specialties like pathology can benefit from AI without anyone worrying about becoming expendable.

Ron echoed these sentiments stating, "The only ones who are truly at risk for being replaced by AI are those who refuse to learn, utilize, and optimize this rapidly emerging tool."

THE CURRENT LANDSCAPE OF HEALTHCARE AND AI

Ultimately, healthcare is an industry where AI lends itself far more to being "assistive," meaning it is primarily used with human supervision. With Dr. Orest's radiology background, he identifies existing AI tools as "a radiology fellow in a box." he paraphrases the statement by Dr. Nick Bryan, retired Chairman of Radiology at the University of Pennsylvania, who, during his 2022 keynote speech at the 60th American Society of Neuroradiology (ASNR) meeting, referred to the performance of his neuroradiology clinical decision tool, Galileo CDS, as a "radiology fellow in a box". AI serves as a resource for the provider to offer better patient care via improved AUC (Area Under the Curve) performance and faster turnaround times. Additionally, mammographers who have adopted AI in their practice have recently commented on how their Mammography Quality Standards Act (MQSA) scores improved.

"Interacting with the AI tool used in my radiology practice has made me a far better radiologist," Orest commented when asked about his opinion on the developing technology. Given his tenure in the field, he notes that many tools he now uses in his radiology practice were not taught during his residency and fellowship. Radiologists are always in a constant mode of learning and adopting innovation for their patients. For example, the tool he has been using most recently assists with the detection of lung nodules. This tool helps him to more quickly locate nodules that may have taken more time on his own to ultimately observe. Over time and with consistent use of the tool, Dr. Boyko has gathered more subtle findings that assist his pattern recognition skills for future cases.

In addition to Dr. Boyko's insights, John pointed out that "AI is both a fellow and a mentor in some cases." With John's oncology background, he looks at AI through a slightly different lens.

Ron notes, "Right now, we have a radiologist shortage in rural US that is leading to multi-hour delays in some Emergency Rooms. Without a full staff of radiologists, the turnaround time for routine imaging services like CTs and MRIs is exceeding industry standards and patient expectations. If AI is adopted in cases like this with routine and normal findings, it can speed up the process to make ERs efficient while simultaneously assisting with the radiologist shortage that is projected to increase over the next decade."

John highlights the benefits of using AI as a "second set of eyes" in breast cancer screenings, as well as further developing risk assessment tools. Could AI offer a way to assess patients and provide higher or lower probabilities of breast cancer? The short answer is yes.

Are we ready to rely on that and recommend some patients get mammograms every 10 years instead of three due to lower probability? That answer is not so clear.

While the adoption of AI in radiology has moved along a little more quickly, mammography has been slower to lean into this new technology. This is, in part, due to a lack of targeting by AI software companies. The other part of slow adoption is due to the fear of new technology, lack of adequate reimbursement, and unknown legal risks.

Healthcare is a business and one of the largest economic drivers in the US. Some providers and hospitals may be hesitant to adopt an AI tool that cuts down on revenue from procedures, office visits, and the need for more frequent routine assessments. The implications of risk assessment also involve

the application of medical ethics standards and can get very complicated very quickly.

CONSIDERING AI IN VALUE-BASED HEALTHCARE

AI already has a history within radiology and medical imaging, acting as a "second set of eyes," working alongside radiologists to identify areas of interest during the screening of mammograms. However, its potential extends far beyond Computer-Aided Diagnosis (CAD). Medical imaging is exceptionally well-suited for AI to play the various roles mentioned earlier:

- **Mentor:** AI can aid in training new healthcare providers by offering guidance and practice in reviewing images and identifying changes through simulated cases and data.
- **Fellow:** It can act as a fellow radiologist, providing valuable second opinions and clinical insights.
- **Provider:** AI can handle the initial review and manage the less complex cases, allowing healthcare providers to focus on more challenging cases.

Additionally, AI can play a crucial role in "combination" medicine, where it integrates imaging with other diagnostic tests that were previously conducted separately. For example, it can add coronary artery calcium scoring to lung nodule imaging to detect clinically unsuspected cardiovascular disease. These extensions can enhance disease detection, improve patient health outcomes, and reduce healthcare costs by streamlining care and testing.
This approach extends to other imaging areas, such as interpreting Low Dose CT lung screening images and detecting pancreatic cancer at an earlier stage due to its higher specificity in identifying changes and abnormalities. When combined with genetic and family history data, AI has the potential to revolutionize early cancer detection, making treatment far more effective.

This is where the concept of value-based care comes into play. Value-based care primarily focuses on improving patient health outcomes. This supports investing in AI tools and other developing technology across all specialties to continue down the path to achieving value-based care.

SO, WHAT DOES THE NEXT DECADE OF HEALTHCARE LOOK LIKE WITH AI?

John notes that "AI can create far better clinical pathways and extremely precise treatment recommendations, and that's something worth investing in. It will create revolutionary change in the creation of true precision medicine, allowing the clinician to better organize all aspects of the patient's health state and all data on the cancer type and makeup to create a treatment plan that is built for that patient and their cancer care."

AI and the digitization of pathology departments have a similar path as we've seen in AI and radiology. Both have strong focuses on the concepts of "Assistive" and "Augmentative" and are well suited to more "black and white" or binary evaluations. In pathology, the stain either turns red or it doesn't, and counting cells per specimen is as objective as a result can be. In imaging, the spot in the lung (for example) has either increased in size, decreased in size, or remains the same. These are all observations that have little room for subjectivity.

CONCLUSION

The integration of Artificial Intelligence (AI) into healthcare is currently a topic of intense interest and debate. While concerns about AI replacing healthcare professionals exist, experts in the field emphasize that AI is designed to complement human expertise rather than replace it. The current landscape in healthcare sees AI serving primarily as an "assistive" tool, enhancing patient care and speeding up diagnostic processes.

AI has potential applications in value-based care via developing precise treatment recommendations, creating more effective clinical pathways, and enabling the customization of treatment plans for individual patients. Overall, the next decade in healthcare with AI promises revolutionary changes that align with the value-based care approach, enhancing patient health outcomes and the quality of care across various medical specialties.

SOURCES:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7185050/

Nurturing Patient Navigation Programs: A Blueprint for Optimal Oncology Care

BY AMY WARE, MHA, MED, FACHE, ASSOCIATE REGIONAL VICE PRESIDENT AT SARAH CANNON CANCER INSTITUTE AT TRISTAR HEALTH; HEATHER BLOOMFIELD, MSNED, RN, OCN, DIVISION DIRECTOR OF ONCOLOGY NAVIGATION OPERATIONS AT SARAH CANNON CANCER INSTITUTE AT TRISTAR HEALTH

As a pivotal component in the modern healthcare landscape, patient navigation programs serve as an effective tool to mitigate the prevalent issue of healthcare disparities. By transcending the confines of individual care, these programs foster a more inclusive and equitable healthcare system. Emphasizing a comprehensive strategy, they not only focus on patients' medical conditions but also navigate the intricate socioeconomic factors that may impede access to adequate care.

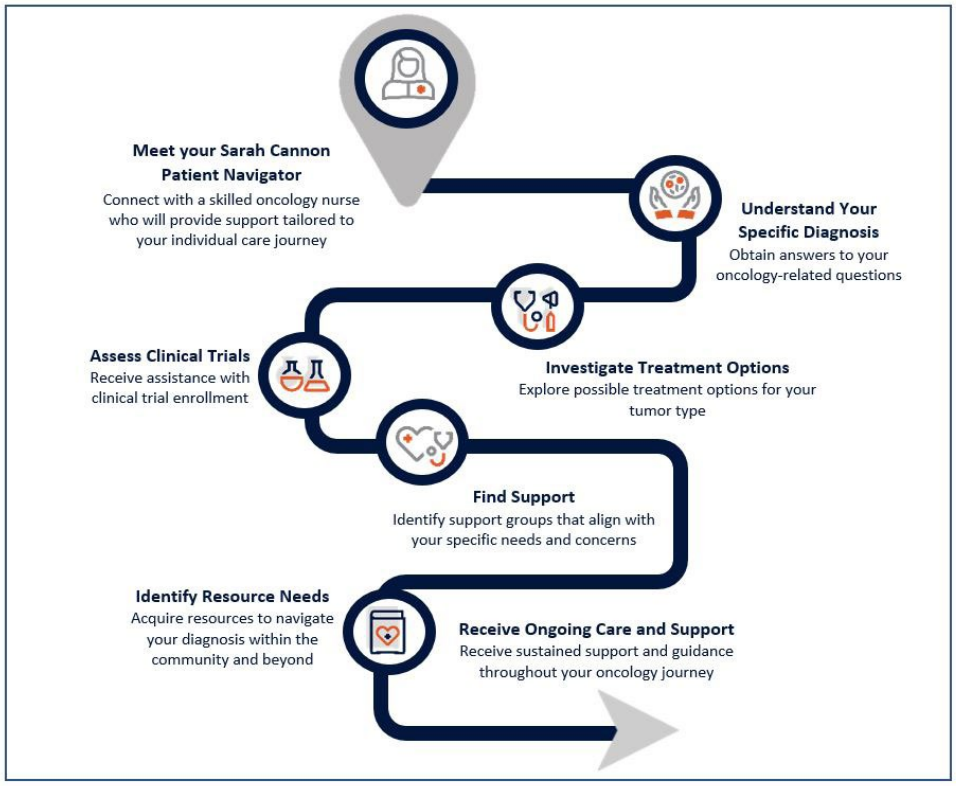
Specifically, in the field of oncology, patient navigation becomes exceptionally important. Cancer treatment is multifaceted and often lengthy, making the healthcare journey complex and overwhelming for patients. Navigators, in this context, assist cancer patients in understanding their diagnosis, treatment options and potential side effects. Navigators also streamline communication with healthcare providers and organize appointments, reducing the burden on patients. Moreover, they help patients overcome barriers such as transportation, financial constraints and language or cultural differences, ensuring that every patient receives timely and appropriate cancer care regardless of their socioeconomic status.

At the Sarah Cannon Cancer Institute, our extensive nurse navigation program is committed to offering comprehensive support to patients along their cancer journey. With a team of over 170 nurse navigators, we guide nearly 30,000 patients each year. From managing appointments and treatment plans to linking patients with additional resources and support services, our navigation program strives to empower both patients and their families, while also serving as the gold standard in patient-centered oncology care.

Having a robust oncology program with patient navigation support leads to:

- **Improvements in patient satisfaction and experience:** At the Sarah Cannon Cancer Institute, our trained nurse navigators are a constant point of contact for patients, addressing their concerns and providing emotional support. This improved communication and personalized care contribute to higher patient satisfaction rates.
- **Decreased healthcare costs:** Beyond the logistical aspects of care, our nurse navigators are attuned to the financial challenges that often accompany a cancer diagnosis. They actively engage with patients to identify and address potential financial barriers, offering guidance on available resources, financial assistance programs, and helping to navigate insurance complexities. By providing this comprehensive support, our nurse navigators empower patients to focus on their treatment and well-being, alleviating the burdens associated with the administrative and financial aspects of their healthcare journey.
- **Improved outcomes:** Our nurse navigators ensure that patients adhere to their treatment plans and follow-up appointments, improving treatment compliance and ultimately leading to better outcomes. Moreover, our nurse navigators proactively work to minimize delays in diagnosis or treatment, ensuring that patients receive the critical interventions they need promptly. This proactive approach not only contributes to the effectiveness of the treatment but also plays a pivotal role in enhancing overall patient well-being.

Despite the evident benefits provided by patient navigation, a concerning reality persists in the field of oncology—numerous programs lack the implementation of these vital systems of support. Moreover, the absence of patient navigation exacerbates



healthcare disparities, particularly affecting individuals from underserved communities or those with limited access to healthcare resources.

Although services within the oncology field may differ, for the establishment of a thorough patient navigation program in your cancer center, we recommend the following:

Needs assessment	Conduct a thorough assessment to identify the distinct needs and challenges encountered by oncology patients in your program. This involves a detailed examination of various aspects of patient care, encompassing medical, emotional, and logistical considerations.
Program design	Establish a well-structured plan to target identified needs, with a specific focus on areas such as emotional support, education, navigation, and care coordination.
Navigation structure	Determine the organizational structure for patient navigation and explicitly outline the goals of the program, with a primary emphasis on enhancing patient outcomes, minimizing disparities, and elevating satisfaction.
Training and education	Provide comprehensive training for nurse navigators, encompassing medical knowledge, communication skills, cultural competency and familiarity with community resources.
Collaboration and strategic partnerships	Cultivate partnerships with healthcare providers, community organizations, and stakeholders to fortify the program's influence and extend its reach. This collaborative approach enhances the program's effectiveness, fostering a network that amplifies its impact within the community.
Patient empowerment and collaboration	Facilitate patient education, shared decision-making and self-management strategies, empowering patients to actively engage in their healthcare journey.
Continuous evaluation	Consistently evaluate the program's effectiveness by incorporating patient feedback, outcome measures, and benchmarking against industry standards. Implement essential adjustments and improvements based on the results of this ongoing evaluation, ensuring the program remains responsive and aligned with the evolving needs and expectations of those it serves.

In the realm of cancer care, patient navigation emerges as a game-changer, significantly enhancing the patient experience and promoting equitable access to care. By proactively incorporating these key initiatives, cancer programs can strategically construct a robust patient navigation program, supporting patients through complex healthcare systems and ultimately improving healthcare experiences and outcomes with a patient navigator by their side.

To learn more about patient navigation at the Sarah Cannon Cancer Institute, visit Nurse Navigators | Sarah Cannon.

Sarah Cannon, the Cancer Institute of HCA Healthcare, offers integrated cancer services with convenient access to cutting-edge therapies for those facing cancer in communities across the United States and United Kingdom. Through its services, Sarah Cannon is providing state-of-the-art cancer care close to home for hundreds of thousands of patients, a number unmatched by any single cancer center.

Navigation Is a Critical Component in a Comprehensive Approach to Dismantling Health Inequities

THIS DOCUMENT IS A CALL TO ACTION FROM THE ACADEMY OF ONCOLOGY NURSE & PATIENT NAVIGATORS (AONN+) LEADERSHIP COUNCIL FOR THE INTEGRATION AND SUSTAINABILITY OF NAVIGATION WITHIN THE HEALTHCARE TEAM

There has never been a more optimal time to embrace and move toward widespread implementation and sustainability of the patient navigation role to address individual health equities.[1,2]

DEFINITIONS:

Health equity is the attainment of the highest level of health for all people[3] and the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality.[4] Health inequities are unfair, unjust, avoidable, or unnecessary. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.[5]

CANCER DISPARITIES:

- The root causes of racial disparities in cancer care are complex, including implicit bias, poor communication and potential language barriers in care delivery, lack of representation in the oncology community, mistrust of the healthcare system and clinical trials, and social drivers of health.
- Disparities in cancer care persist, with marginalized communities facing significant barriers to accessing and receiving quality oncology screening and treatments, which lead to more advanced stage presentation and worse oncologic outcomes.
- Despite recent progress toward reducing disparities in the burden of cancer, ethnic or communities of color, which make up 40% of the US population, continue to experience cancer inequities. Below are just a few examples:
  - Compared to Caucasian men, cancer incidence in African American men is 6% higher and cancer mortality is 19% higher. This disparity is even more notable in African American women, who have 8% lower cancer incidence than Caucasian women but 12% higher cancer mortality.[6]
  - American Indian/Alaskan Native people also have higher incidence rates for kidney (80% higher), liver (2 times higher), and lung cancers (5 times higher for those living in the Northern Plains), as well as increased mortality from these diseases, when compared to Caucasian patients.[6]
- Cancer disparities are not limited to racial disparities, but also are present in rural communities.
  - Compared to those individuals living in urban areas, rural communities show 17% higher death rates from all cancers combined.[7]
- Numerous studies highlight socioeconomic and racial/ethnic disparities present in oncologic care, and further implicate access to timely cancer screening and treatment, as opposed to biologic differences, as a major driver of health inequities.

PATIENT NAVIGATION (PN):

- One of the only evidence-based interventions that has effectively been able to address disparities in cancer care is PN.[8,9]
- PN is an evidence-based solution to dismantle health inequities, helping patients overcome healthcare system barriers and providing them with timely access to quality medical, logistical, and psychosocial care from before cancer diagnosis through all phases of their cancer experience.
- Navigation encompasses both clinical and nonclinical navigators who are critical members of the multidisciplinary team and provide important perspectives on logistical, structural, and social needs of the patient as well as cultural considerations, patient values, and care preferences.
- Patient navigators:
  - Promote health equity and its benefits in improving oncologic screening and treatment, especially for traditionally marginalized communities.
  - Improve the lives of those in greatest need, specifically those who have experienced systemic and institutional injustices/inequities.
  - Impact health literacy through patient education and the value of trusted relationships between patients and patient navigators.
  - Demonstrate sensitivity and responsiveness to a diverse patient population, including, but not limited to, race, ethnicity, gender and gender identity, age, culture, religion, abilities, and sexual orientation.
  - Expose health inequities and find solutions to ensure that all people have the opportunity to live healthy, fulfilling lives.
  - Can expose and increase awareness of bias against underrepresented populations in cancer care, particularly as it applies to their unequal representation in clinical trials.
  - Identify solutions appropriate for communities that lack resources and/or infrastructure.
  - Exhibit cultural humility with diverse communities, cultural norms, beliefs, or practices.
- Effectiveness and scope were studied in relation to cancer screening, diagnosis, treatment, clinical trial enrollment, survivorship, and palliative care.
  - The Patient Navigation Research Program, a multisite, randomized controlled trial conducted in heterogeneous settings, compared PN to usual care with outcomes that included time to diagnosis and

treatment, patient satisfaction, and cost-effectiveness.[10]

- Within this cohort of over 7500 patients, African American patients experienced the greatest reduction in time from abnormal cancer screening to resolution, suggesting that navigation has the most profound impact on historically marginalized communities.[11]
- Interventions, such as the 2019 Accountability for Cancer Care through Undoing Racism and Equity trial, demonstrated the impact of PN in reducing racial disparities and improving care for all cancer patients. The trial used a multifaceted, system-based intervention to improve treatment completion for both African American and Caucasian patients and reduce racial disparities.[12]
    - The 5-year observed survival for Caucasian and African American breast cancer patients increased from 91% and 89%, respectively, to 94% for both races, and from 43% and 37% to 56% and 54% for Caucasian and African American lung cancer patients, respectively, after the navigation intervention.

CALL TO ACTION

Efforts should be made to integrate sustainable PN services into standard oncology care, expand their reach to underserved populations, and strengthen collaboration among healthcare providers, community organizations, and policymakers. Future reimbursement models, including value-based and alternative payment models, for oncology should prioritize access to navigation services specifically for marginalized communities to ensure that these oncologic outcome disparities do not continue to persist or worsen. Only through a collective effort can we work towards achieving health equity for all individuals affected by cancer along the care continuum.

SOURCES:

1. Dwyer AJ, Wender RC, Staples ES, et al; the National Navigation Roundtable. Collective pursuit for equity in cancer care: The National Navigation Roundtable. *Cancer*. 2022 June 14. https://doi.org/10.1002/cncr.34162.
2. Patel MI, Lopez AM, Blackstock W, et al. Cancer disparities and health equity: a policy statement from the American Society of Clinical Oncology. *J Clin Oncol*. 2020;38(29):3439-3448.
3. US Department of Health and Human Services. Healthy People 2030 questions & answers. https://health.gov/our-work/healthy-people/healthy- people-2030/questions-answers. Accessed March 3, 2021.
4. HRSA. Office of Health Equity. https://www.hrsa.gov/about/organization/bureaus/ohe. Accessed June 19, 2023.
5. Halfon N, Larson K, Lu M, et al. Life course health development: past, present, and future. *Matern Child Health J*. 2014;18(2):344-365.
6. Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer statistics, 2022. *CA Cancer J Clin*. 2022;72:7-33.
7. Centers for Disease Control and Prevention. An update on cancer deaths in the United States. Updated February 28, 2023. Accessed June 18, 2023.
8. Dixit N, Rugo H, Burke NJ. Navigating a path to equity in cancer care: the role of patient navigation. *Am Soc Clin Oncol Educ Book*. 2021;41:1-8. doi:10.1200/EDBK_100026.
9. Nelson HD, Cantor A, Wagner J, et a. Effectiveness of patient navigation to increase cancer screening in populations adversely affected by health disparities: a meta-analysis. *J Gen Intern Med*. 2020;35:3026-3035. doi:10.1007/s11606-020-06020-9.
10. Freund KM, Battaglia TA, Calhoun E, et al; Patient Navigation Research Program Group. National Cancer Institute Patient Navigation Research Program: methods, protocol, and measures. *Cancer*. 2008;113:3391-3399.
11. Ko NY, Snyder FR, Raich PC, et al. Racial and ethnic differences in patient navigation: results from the Patient Navigation Research Program. *Cancer*. 2016;122(17):2715-2722. doi: 10.1002/cncr.30109.
12. Cykert S, Eng E, Manning MA, et al. A multi-faceted intervention aimed at black-white disparities in the treatment of early-stage cancers: the ACCURE pragmatic quality improvement trial. *J Natl Med Assoc*. 2020;112:468-477.

AONN+ acknowledges Jennifer Bires, LICSW, OSW-C; Linda Burhansstipanov, MSPH, DrPH; Vikas Mehta, MD, MPH, FACS; and Robert Winn, MD, in a combined team effort to lead the AONN+ Leadership Council in the formation of this statement.

Don't let NDC Wreak Havoc on Your Collections

BY JIM MUSSLEWHITE, CEO, ONCOLOGY CONVERGENCE

For the past five years, payors have been increasingly shifting away from traditional billing units (J-Codes) toward the more complex National Drug Code (NDC) methodology giving them an upper hand on reimbursements in an already low-margin, high stakes relationship with providers.

Originally a reporting and tracking metric, NDC codes are comprehensive, giving payors new insight into drug utilization to better track performance and provide more accurate payments and improved management of drug costs based upon what is administered and billed.
As payors begin to experience more advantages from leveraging NDC codes, more have begun integrating NDC requirements into their standard billing agreements with providers in both the freestanding and hospital environments.

Today, many are using NDC codes to reimburse based on the exact NDC administered to the patient. Under this new drug reimbursement methodology, the NDC code, the NDC unit of measure, and the NDC units indicate the quantity of the drug administered to the patient and most importantly the corresponding reimbursement.

This trend, which is expected to accelerate in 2024, with UHC's announcement that they will be moving to this methodology, has outsized implications for medical oncology programs that rely on accurate and timely drug reimbursement to stay profitable. Providers must take important steps to understand the nuances of NDC billing requirements and reorganize their infusion revenue cycle to avoid over and under payments thereby ensuring proper reimbursement under this methodology.

KNOW YOUR OBLIGATIONS

Each payor and plan carries different reimbursement requirements and the fact is that many providers and organizations aren't aware which payors require NDC billing and which do not. Some allow it but don't require it. Knowing and understanding the nuances of your payor contracts is the first important step in optimizing your revenue cycle management for NDC based reimbursement. Are you aware of which payers require NDC billing? A thorough contract review will help you identify the specific NDC requirements for each payer and for which lines of business or plan types the requirement currently applies. For example, Medicare advantage facility outpatient claims may only require NDC billing for unlisted drug codes. Many payors require the inclusion of NDC information for claims payment, which is not the same as requiring the NDC units of measure for reimbursement methodology. It is important understand the difference.

RUN A FULL RCM ASSESSMENT

A thorough review of your pharmacy and revenue cycle management (RCM) system's ability to process NDC data is critical. You must ensure all the required data needed for this billing methodology is sent correctly to your RCM system and that your RCM system can format your infusion claims properly in order minimize lag time to claim submission, assure a clean claim, and get paid correctly.

In the J code environment, the lack of NDC transparency is a reporting error. Under an NDC Units of measure reimbursement methodology, a reporting error quickly becomes a billing error with real dollars at risk. Working with an experienced partner will help you optimize pharmacy information flow into your revenue cycle management systems to assure NDC billing requirements you face from your various payor contracts are in place.

A good audit partner will also help you to evaluate each payer's methodology, forecast the effect on your bottom line and successfully implement this billing process into your revenue cycle to decrease potential revenue leakage.

EDUCATE YOUR STAFF

Billing staff at all levels of your organization need to be updated about and educated on NDC billing. That means everyone from RCM leadership down to pharmacy staff, coders, billers, prior authorization, financial counselors and account receivables staff. Thorough training includes, but is not limited to, the following topics:

- What an NDC is and where it can be found
- What is an N4 qualifier and how it is used
- What the units of NDC measurement are
- Which units to submit to ensure proper reimbursement
- How to convert HCPCS units to NDC units
- Where the NDC is entered on the CMS-1500 and/or ANSI 5010 837P / 837I electronic claim
- How to enter the required 11-digit NDC billing format for an NDC number that is less than 11 digits

Unless your full staff has mastered NDC billing, you are at risk for high volumes of unnecessary denials due to incomplete or inaccurate information that will cost you time and resources to identify, correct and resubmit.

However you feel about NDC billing, it is here to stay and preparing your organization for the shift to NDC billing is imperative, especially for oncology organizations who perform infusions. By understanding the diverse and nuanced obligations of your payor contracts, optimizing your RCM system and educating your staff, you can reduce unnecessary denials and improve your net collections well into the future.

HAVE SOME NEWS TO SHARE?

Please send to Brian Mandrier at brian@mandriergroup.com or tag us on social!