ASSOCIATION OF CANCER EXECUTIVES UPDATE

JANUARY 2021 | www.cancerexecutives.org | SPECIAL 2021 ANNUAL MEETING ISSUE

WHAT'S INSIDE

association of cancer executives
Connecting All Oncology Leaders

Announcements

2021 IOLC

IOLC 2021 will be held in Rome, Italy in-person from November 14-16, 2021. To learn more, please visit us here.

2022 ANNUAL MEETING – SAVE THE DATE

The ACE 2022 Annual Meeting will be held in Charleston, SC at the Charleston Place Hotel from January 23-25, 2022.

Upcoming Webinars

DATA-DRIVEN PROCESS IMPROVEMENTS THAT IMPROVE WORKFLOW EFFICIENCY IN CANCER CARE

March 3, 2021 | 2:00PM EST

Speaker: Brenda Farnham, MBA, BSN, RN, OCN, Associate Vice President, Oncology Services, Northern Light Cancer Care

How do oncology care teams align to improve patient throughput and care efficiencies? Learn how Lafayette Family Cancer Institute, part of Northern Light Cancer Care, manages continuous improvement efforts by using data to fuel change. Hear practical advice for gaining buy in from staff, tips for mitigating exposure risks and optimizing patient safety, using data to assess performance, and sustaining patient flow improvements.

To register, please visit us here.

Member News

Joel Helmke Joins Fox Chase Cancer Center as New Chief Operating Officer, PHILADELPHIA (January 7, 2021) – Fox Chase Cancer Center is pleased to announce the addition of Joel Helmke, MHA, FACHE, to its senior leadership team as chief operating officer (COO). Helmke's tenure will begin on February 1, 2021.

HAVE SOME NEWS TO SHARE?

Please send to Brian Mandrier at brian@mandriergroup.com

Exercise Is Medicine in Oncology: A Call to Action

BY KATHYN SCHMITZ, PHD, MPH, FACSM, FTOS, FNAK & KAREN WONDERS, PHD, FACSM

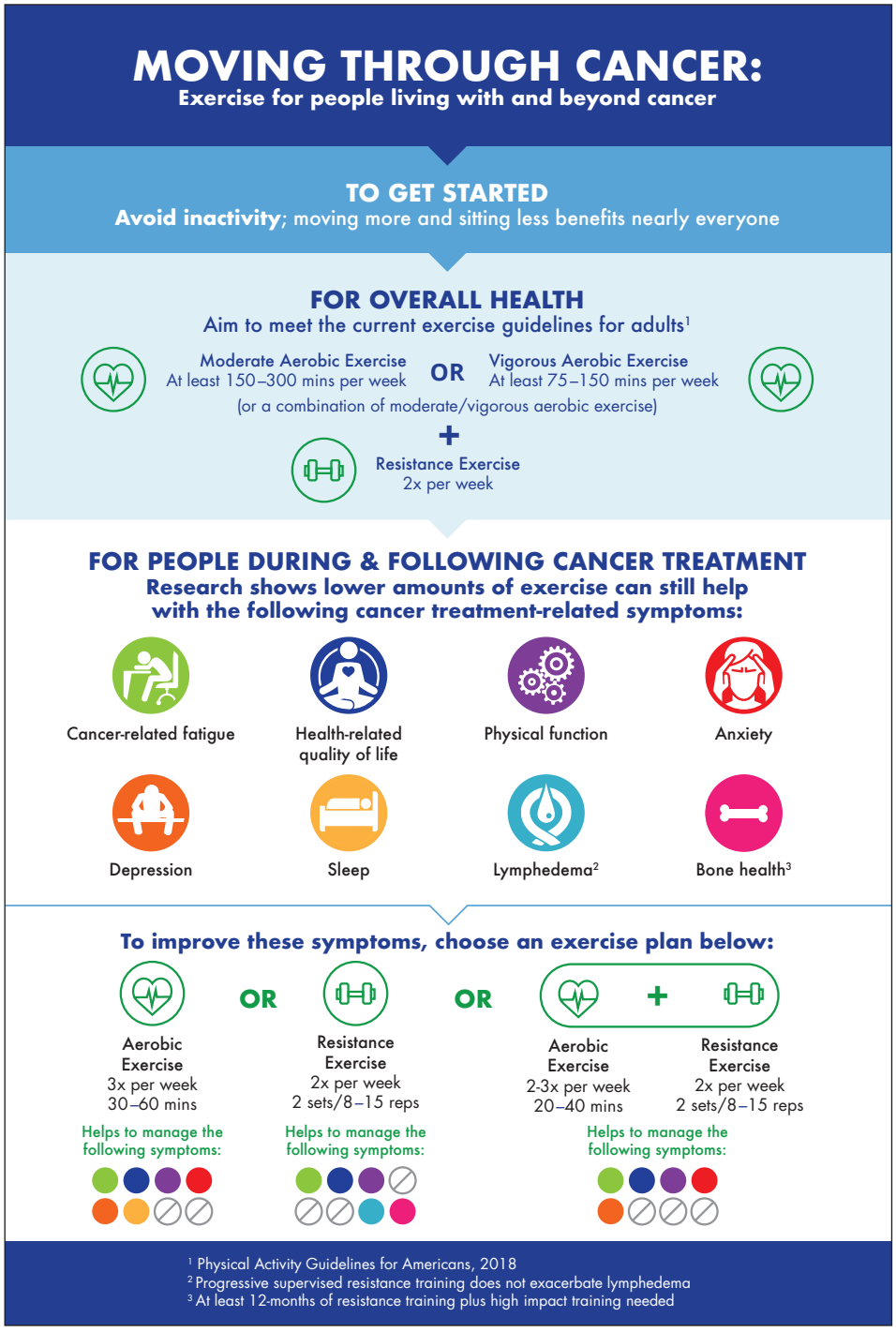
THE EVIDENCE

In 1955, Dr. Rusch of the famed Wistar Institute in Philadelphia, PA ran an experiment to show that the 'stress' of forced swimming would result in an increased rate of cancer death. His results paradoxically showed that the exercised animals lived longer than the sedentary animals. In the late 1980's nursing researchers Winningham and MacVicar undertook the first human clinical trials of exercise therapy among breast cancer patients receiving chemotherapy. Women randomized to bicycle ergometry improved symptoms, fitness, and body composition. By 2005, there had been 22 high quality randomized controlled trials of exercise among cancer patients and survivors. A review of PubMed as of December 20, 2020 revealed 1979 randomized controlled trials, in English, with the keywords 'exercise' and 'cancer'. This exponential growth in the evidence base for exercise oncology has led multiple international organizations to review the evidence and develop guidelines.

Among these are the American College of Sport Medicine (ACSM) guidelines for cancer prevention and control, published in 2019, and endorsed by the National Comprehensive Cancer Network, the National Cancer Institute, the American Cancer Society, the American Physical Therapy Association, the American Association for Physical Medicine and Rehabilitation, the American College of Lifestyle Medicine, the Commission on Accreditation of Rehabilitation Facilities, and the Society of Behavioral Medicine, among others. The review of the evidence resulted in conclusions that are summarized in the nearby infographic. For primary and secondary prevention of cancer, the recommended dose of exercise is 150-300 min/week of moderate intensity aerobic exercise. The expert panel observed that the amount of exercise needed to improve symptoms during cancer treatment was far less: 90 min/week of aerobic exercise and twice weekly strength training are recommended. The symptoms and side effects for which exercise was shown to be an effective treatment included fatigue, quality of life, anxiety, depression, physical function, sleep, and bone health. Further, there was evidence of no harm from being more active with regard to breast cancer related lymphedema.

MAKING EXERCISE STANDARD OF CARE: EXERCISE IS MEDICINE IN ONCOLOGY

Given the broad ranging benefits of being more active during and after cancer treatment, the ACSM panel recommended that all cancer clinics adopt the Exercise Is Medicine Solution. This approach, originally developed by the ACSM for primary care settings, suggests that an oncology care professional assess physical activity, advise the patient regarding the above noted benefits, and then refer the patient appropriate programming. When considering whether a given patient is able



to exercise, the expert panel recommends using the standard physical function assessments used clinically, such as the ECOG or Karnofsky scales. But to simplify further: if the patient walked into the treatment room, the patient can do some exercise. The process of assess, advise, refer can be done by the same person who already does the psychosocial distress screening in your clinics.

REFER WHERE?

Many communities now have Livestrong at the Y programs, and these can be an excellent partner in making exercise standard practice. In addition, there is a registry of over 1600 cancer exercise and rehabilitation programs across the U.S. and beyond that have all been vetted to be run by qualified personnel. Navigate to www.exerciseismedicine.org/movingthroughcancer to find this registry. Note that some of the programs on the registry are virtual and can partner with cancer programs anywhere in the United States. One such program is Maple Tree Cancer Alliance www.mapletreecanceralliance.org. Maple Tree Cancer Alliance partners with clinical providers to offer supervised, individualized exercise programming to patients at any point in their cancer trajectory, on-site and/or virtually. Their evidence-based approach and robust research program has produced promising results indicating decreased health care costs and improved symptom severity for patients. At present, they have 43 clinical partnerships across the country, and are looking to expand rapidly in the coming years.

WHO WILL PAY FOR IT?

Recent evidence suggests that the costs of these programs is low on a 'per patient' basis (for example, the ENACT program at Penn State Cancer Institute cost $191/patient). We have also analyzed whether the ENACT program is at least cost neutral. What we observe, based on 160 patients in the program, as compared to 80 matched comparisons, is that the costs of emergency room visits and hospitalizations were $5288.54 lower among the patients who did the ENACT exercise program, even after accounting for the cost of the intervention. The benefits of an exercise program may, indeed, extend beyond improvement of symptoms for your patients.

MEMBER SPOTLIGHT

PROFILE

Melissa Childress, MBA

Title, Organization:
Vice President of Cancer Services, Winship Cancer Institute of Emory University

Years in the field:
25 (OMG! I cannot believe it!)

TELL US A LITTLE ABOUT YOUR PROGRAM? SIZE, SERVICE AREA, ANY OTHER INTERESTING FACTS

Winship Cancer Institute is the only NCI-Comprehensive Cancer Center in the state of Georgia. As such, our mission is to lessen the burden of cancer for the citizens of Georgia through aligning our outstanding cancer research and education initiatives with our significant cancer prevention and cancer care efforts. Of the more than 10M citizens of Georgia, more than 6M live in Atlanta metro area, making Georgia more of a city state in its approach to healthcare. Winship sees more than 21k new cancer cases per year, and we have grown exponentially over the past 5 years. Winship has dedicated facilities on 8 of the 10 Emory owned campuses in our Winship at- model, and our faculty also serve Grady and the Atlanta VA. We opened our new proton center in 2018, and will complete our 1,000th treatment on our 2 year anniversary in December. Looking to the future, Winship is building a 17 story innovative cancer facility on the Emory Midtown campus which will open in the Spring of 2023. On top of it all, we are excited that Emory Healthcare is implementing EPIC over the next two years to enable all of our great work.

WHAT PART OF YOUR WORK ARE YOU MOST PASSIONATE ABOUT?

Our cancer patients are my "Why". Our staff are truly embracing this why in their daily work, and our mission is to treat the patients differently. Cancer Patients face so much adversity in their daily lives and treatment. They deserve to the treated like family and to have access to the latest, cutting edge research and treatments available delivered in the most compassionate environment. I am passionate and bullish about the patient experience from end-to-end. In fact, we are in the process of completing a completely reimagined care model called the Winship Way. We are bringing care to the patient, and focusing on implementing a Lean operating system to support our new care model. Our goal is for patients to feel that they are in the arms of Winship at every moment, and to envelope them with the care, dignity and consideration they deserve.

WHAT IS A KEY CHALLENGE THAT YOU SEE FACING THE FIELD OF CANCER CARE?

I am super excited about our impending ACE Annual meeting this December. We have a wonderful slate of presentations on the agenda and tons of best practices that are being developed to address the challenges all of us are seeing in the field of cancer care. We also have an outstanding networking platform to add value to the time at the conference. Call it "speed networking". We all must continue to work together to tackle the challenges in cancer care, and the best way to do so is by learning from each other and innovating on our collective work. Please do not shy away from the virtual environment. The conference planning team has been working overtime to ensure that your experience will be fabulous!

Ok, now to the question. A key challenge I see facing the field of cancer care is succession planning in our work force both in the administrative and clinical sectors. Call it understanding each other, meeting folks where they are, or embracing diversity, these are all key elements to us sustaining the momentum of beating cancer (I call beating cancer cure and longevity of high quality life). Cancer is a formidable foe, and we need to work together as a collective whole to bring forward the future of discovery and care. The generations we are raising (as parents) and mentoring (as staff) are truly our future in this arena, and we must figure out how to tap into their innovative ideas and to make them real. This is one of our thematic elements in 2021 annual meeting (along with many others), and I hope you are able to tune in and collaborate to help us with this challenge!

If NDC Units Are the New J-Codes — Are You Ready?

BY JIM MUSSLEWHITE, MBA MSF, *Chief Executive Officer Oncology Convergence, Inc.*

Of the many forces affecting the oncology revenue cycle, the move away from traditional billing units (J-codes) toward the NDC billing unit methodology by payors may be the most impactful of the last several years.

In its role providing revenue cycle services to its clients, Oncology Convergence, Inc. has first-hand experience with NDC codes and the impact they can have on a practice. We have seen payors moving away from the standard billing methodology of J codes and billing units to a reimbursement model that uses the information specific to each NDC as a basis for reimbursement, rather than the number of billing units.

For example we recently initiated a relationship with a client where the inability to bill correctly under the NDC code methodology created a $ multi-million shortfall. The OCI team was able to quickly identify and solve the billing issues, submit past claims to correct this issue and also provide a path to profitability. It Is our wish that we can inform and help you before you find yourself in a similar situation. Recently, the use of NDC codes has expanded beyond a reporting metric and is being used as the method of reimbursement. While the infusion industry has dealt with NDC codes for years as numerous payers required the specific NDC code on the claim, using the code as a basis for reimbursement represents a fundamental change. The benefits of NDC codes are that the additional information provides full transparency related to the manufacturer, drug name, dosage, strength, package size and quantity of a medication. As a result, payors are able to more effectively track utilization, and improve management of drug costs. In both the freestanding and hospital environments, OCI has clients where the payers are moving beyond the simple inclusion of the NDC number on the claim toward reimbursement that is based on the exact NDC administered to the patient. In other words, the J code, and the corresponding number of billing units, does not indicate the dose of the drug administered and the corresponding reimbursement. Instead, 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.

The potential issues with this reimbursement methodology become clear

when you consider some of the current challenges many hospital pharmacy systems encounter with providing the exact NDC code for the actual vial administered to the patient, or when multiple/different vial sizes are utilized for the same patient. In the J code environment, the lack of NDC transparency is a mere reporting error. Under an NDC Units of measure reimbursement methodology, a reporting error quickly becomes a billing error with real dollars at risk.

We have listed key information to help your oncology billing team identify and implement an NDC based billing process in the sections below.

We have found that there are four areas of focus for successful NDC based billing:

A) NDC Billing Process Requirements

- N4 qualifier
- 11-digit NDC number
- NDC Unit of Measure
- NDC Units administered/used

B) NDC Specific Contract Review

- Conduct a comprehensive contract review to identify which payors require NDC billing.
- Identify which payors allow – but do not require NDC billing.
- Determine if NDC based billing would be advantageous to your revenue on a per payor basis.
- Identify the specific NDC requirements for each payor.
- Identify which lines of payer types the requirement applies to.

C) Drug codes that may require NDC information

- Drug-related revenue codes
- J codes, including miscellaneous and unlisted drug codes
- Drug-related CPT codes, including miscellaneous and unlisted drug codes
- Drug-related Q codes, including miscellaneous and unlisted drug codes
- Drug-related S codes, including miscellaneous and unlisted drug codes
- Drug related A codes, including miscellaneous and unlisted drug codes and radiopharmaceuticals

D) Staff Education – Things to Know

- What an NDC is and where it can be found
- What a 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 electronic claim
- How to enter the required 11-digit NDC billing format for an NDC number that is less than 11 digits

In addition to the points listed above, an assessment of your pharmacy and RCM system's ability to process this data must occur and any software updates or necessary new interfaces needed must be implemented. It is critical that 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 meet your days service outstanding (DSO) benchmark.

Based upon our experience with NDC billing in Oncology, we believe that the cost savings to commercial and Medicaid advantage payors will drive the transition to this methodology sooner rather than later in order to capture not only the cost savings, but also the multitude of utilization information it provides. It is our recommendation that obtaining proficiency in NDC Billing be a priority for all oncology organizations who perform infusion billing in 2021.

How the Right Data Can Transform Care Efficiencies

BY ALLEN FOUCHT, BSN, RN, CLSSMBB,
Senior Engagement Manager, Consulting Midmark RTLS

Using technology to improve care coordination can lead to more efficient patient flow. In fact, many of the nation's leading cancer centers are finding that in-the-moment visual cues from real-time locating system (RTLS) technology reduces patient wait times and creates better patient engagement.

Yet, looking beyond making on-the-spot adjustments to wait times or resources, it is the rich aggregate data provided by RTLS that enables health systems to uncover the hows and whys of process inefficiencies.

UNLOCKING INFUSION CHAIR CAPACITY

Live polling at the 2019 ACCC National Oncology Conference revealed that inefficient infusion chair utilization is the number one pain point. RTLS data helps care teams identify trends in peak chair utilization and average length of stay.

Armed with this information, resources and scheduling templates can be adjusted to create added capacity or match the ebb and flow of patient volumes.

MANAGING CONTINUOUS IMPROVEMENT EFFORTS

Whether the objective is to add capacity, improve throughput or reduce waste, measurable data provides irrefutable evidence to support performance improvement efforts.

At Lafayette Family Cancer Institute, part of the Northern Light Cancer Care network, access to location and interaction data allows administrators to assess trends in capacity and resource utilization and use them as benchmarks to drive improvements across the organization.

Brenda Farnham, MBA, BSN, RN, OCN, associate vice president, oncology services shares, "We are using data-driven process improvements to decrease patient wait times, decrease door-to-doc times, mitigate waiting room congestion, and increase patient satisfaction."

LEARN HOW LAFAYETTE FAMILY CANCER INSTITUTE USES RTLS DATA TO IMPACT PATIENT CARE

Using RTLS data to support process improvements is one way Lafayette Family Cancer Institute creates a better care environment for patients and staff. Hear Brenda Farnham share insights on their continuous improvement efforts during a special ACE webinar on March 3, 2021: "Data-driven Process Improvements that Improve Workflow Efficiency in Cancer Care." Register here.

See how Midmark RTLS Patient Flow Optimization for Oncology helps enable oncologists, nurses and staff to focus their time where it truly matters—providing the best care experience.

SAVE THE DATE

ACE Certified Oncology Administrator™ (COA) is taking new applications for

2021 - 2022

After a successful launch of the ACE COA in 2019, ACE is now seeking candidates for the 3rd class of COA's.

Completed applications are due to by November 30th. Please contact Brian Mandrier (brian@mandriergroup.com) if you have any questions.

Recent Feedback from a COA recipient:

"In my 27 years in oncology administration, I have had the ability to gain credentials that show my background, knowledge base, and abilities in general healthcare leadership. But there has been nothing where I have been able to do this specific to my field of choice, oncology. With the Certified Oncology Administrator (COA) credential, I can finally clearly demonstrate my background and expertise that is specific to oncology with this prestigious credential."

If you are interested in learning more about the COA certification please visit **www.cancerexecutives.org/certifiedadministrator**