ASSOCIATION OF CANCER EXECUTIVES UPDATE

AUGUST 2023 | www.cancerexecutives.org

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 VIENNA 2023

Summer registration is now open until August 31st. Please visit the IOLC website for more information.

ACE NASHVILLE 2024

Early-bird registration opening soon! The 30th ACE Annual Meeting will be held at the Grand Hyatt Nashville from February 4-6, 2024!

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.

Financial Navigation: Assisting Cancer Patients Today, Building a Strong Future for Tomorrow

BY KEN ENDO MHA, BS RTT, CLINICAL DIRECTOR, CANCER PROGRAM, PIH HEALTH

BACKGROUND

Cancer treatment often involves high-cost medical expenses, including hospital stays, surgeries, chemotherapy, radiation therapy, medications, laboratory tests, imaging, and follow-up appointments. Additionally, there may be indirect costs such as transportation, childcare, and time off work or reduced work hours for both the patient and their caregivers. These expenses can quickly accumulate and cause significant financial stress. High cost of cancer treatments, particularly newer therapies, and targeted drugs can lead to substantial out-of-pocket expenses. Co-pays, deductibles, and co-insurance for medical services and medications can place a significant financial burden on patients, especially if they have limited insurance coverage. Cancer patients and their families may experience anxiety, worry, and distress related to the financial implications of the disease. The financial burden can lead to difficulties in meeting everyday living expenses, paying bills, and managing debt. It can also result in financial insecurity and a negative impact on overall quality of life. Financial considerations may influence treatment decisions. Patients may opt for less effective or less expensive treatments due to concerns about the affordability of certain therapies. Financial toxicity can potentially compromise the optimal care and outcomes for patients. To cope with the financial burden, patients and their families may be forced to make difficult choices, such as cutting back on basic necessities, depleting savings, borrowing money, or delaying or forgoing necessary treatments. These sacrifices can have long-term consequences on the financial well-being and health of patients and their families affected through cancer care and treatment.

METHODS

A community needs assessment determined that cost/paying for cancer care was one of the top priorities for patients and the community at large. In response, PIH Health hired an oncology financial navigator, who advocates/assists cancer patients and their families in managing the financial aspects of cancer care. The oncology financial navigator plays a crucial role in helping PIH Health patients understand and navigate the complex landscape of healthcare costs, insurance coverage, and financial resources available to them.

The primary goal of the oncology financial navigator is to alleviate the financial burden associated with cancer treatment and ensure that patients have access to the necessary care without excessive financial stress. They work closely with patients, healthcare providers, and insurance companies to identify and explore all available financial resources and options.

Some key responsibilities and functions of the oncology financial navigator:

1. Insurance and Benefits Education: The Navigator educates patients about their insurance coverage, including deductibles, copayments, and coverage limitations. They help patients understand their benefits, rights, and responsibilities regarding cancer treatment. They assist patients in choosing plans that are going to be best suited for their needs. For instance, the navigator received a referral to assist a patient that lost her coverage due to layoffs during the pandemic but needed coverage to continue with her treatments. They met and weighed the different options and determined that COBRA would be a better choice than an Affordable Care Act exchange plan. The cost of COBRA, while high, was still less expensive than the premium and deductible the patient would have to pay if she chose the ACA plan. We had a patient that was lured away from a long-established insurance plan by cheaper coverage. The patient discovered that the plan did not cover the needs of her care and even removed her from her established oncologist. The navigator was able to use her knowledge and experience to reinstate the prior coverage and made it retroactive so there was no lapse in coverage.
2. Financial Counseling: Oncology financial navigators assess patients' financial situations, including income, expenses, and available resources. They provide personalized financial counseling to help patients develop strategies for managing medical bills and explore financial assistance programs.
3. Billing and Claims Assistance: They review medical bills for accuracy, identify billing errors or discrepancies, and work with insurance companies to resolve any issues.
4. Patient Advocacy: Oncology financial navigators act as advocates for patients, ensuring their financial concerns are addressed and helping them access the necessary care. They collaborate with social workers, patient advocates, and healthcare teams to provide comprehensive support.
5. Resource Identification: They identify potential sources of financial assistance, such as government programs, charitable foundations, and pharmaceutical patient assistance programs. They assist patients in completing applications for financial aid and help them navigate the often-complex eligibility requirements. The navigator searches for different programs to best suit each patient's individual needs.
    - Charitable Foundations: There are numerous charitable foundations and organizations that provide financial assistance to cancer patients. These foundations often offer grants or financial aid to help cover treatment-related expenses such as medications, transportation, and lodging. Oncology financial navigators are knowledgeable about these

foundations and can help patients identify and apply for relevant programs.

- Pharmaceutical Patient Assistance Programs: Many pharmaceutical companies offer patient assistance programs that provide free or discounted medications for cancer treatment. These programs are designed to assist patients who may not have adequate insurance coverage or cannot afford the high cost of cancer medications. Navigators help patients navigate the application process and connect them with the appropriate programs.
- Nonprofit Organizations: There are nonprofit organizations dedicated to assisting cancer patients with financial support. These organizations may provide grants, financial aid, or scholarships to help cover treatment expenses, including medical bills, co-pays, and other related costs. Navigators can help patients identify and apply for such programs.
- PIH Health has their own charity program to assist those that do not meet criteria for other programs.

If the patient does not qualify for any of these types of funding, PIH Health has developed the microfund program. Designed as a stop gap for those patients that do not qualify for traditional funding.

This patient population was identified when we began tracking the program for our commission on cancer accreditation project and found that approximately five percent of patients referred to the navigator did not qualify for any of the traditional funding opportunities. We were challenged with finding other ways to assist these individuals. We developed and put the micro fund in place to help with basic needs such as gas and groceries. The micro fund helps offset some of the cost patients would have to use for treatment, instead of family needs. The program is funded through philanthropic donations to the cancer program through PIH Health Foundation.

Multiple access points were established for referrals to be submitted to the Financial Navigator. Establishing multiple entry points may seem inefficient but when a gap analysis was completed, we found that not all PIH Health departments use the same Electronic Medical Records (EMR) system.

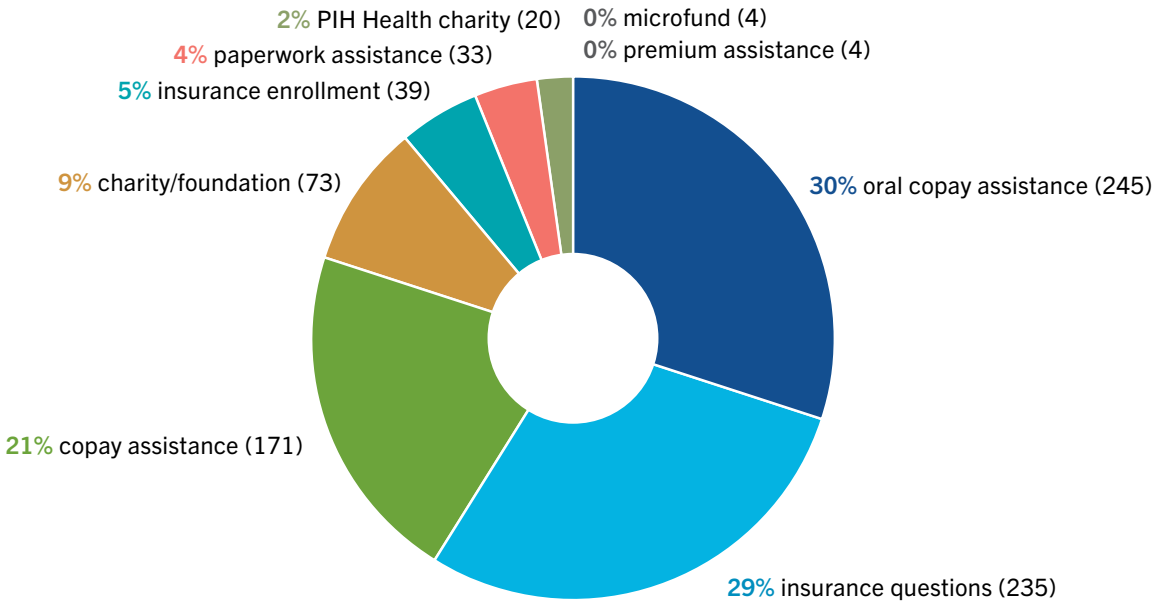
Outpatient clinics and hospital-based departments use different EMR systems. Radiation Oncology uses another EMR system entirely. The outpatient EMR has the ability to send tasks and progress can be tracked. The hospital system did not have that feature. Additionally, clinicians are busy and may not have time to go into their EMR to send a task. The hospital-based departments would have to send either an email or voice mail. While that was perfectly acceptable, it was very hard to track and manage. To manage all the patients, a stand-alone website for the cancer program was developed. Staff are now able to refer patients by filling out an online form. We retain all other methods, however once patients are entered into the website, we can track them more efficiently and pull data from one location. Once the referral is placed, the navigator will review the patient's hospital records and then reach out to them to get more information, so they are able to advise them on the best course of action.

Metrics and data collected includes number of patients served by the navigator, the services provided, and savings, if foundation money was obtained. The data is analyzed and reported at our Oncology Service Line meeting as well as at our cancer committee meeting.

RESULTS

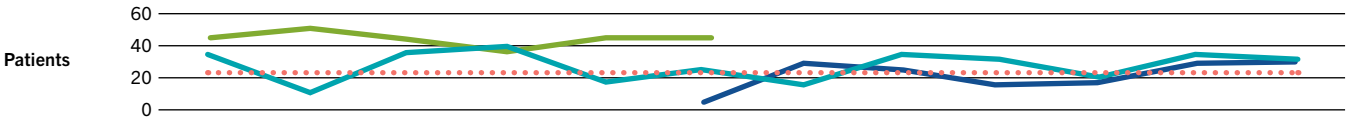
Since going live in March 2021, we have received the most referrals from the Hematology Oncology office at 470 referrals, followed by nurse navigators at 109. The infusion center and the oncology social worker both made 87 referrals. Oral drug copay assistance tops the needs at 30 percent of referrals followed by insurance questions at 29 percent.

Figure 1.



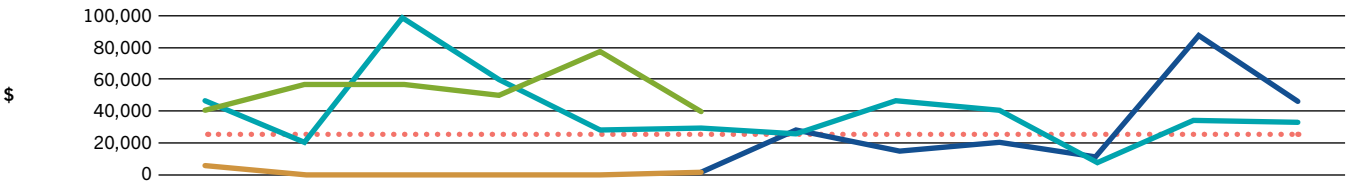
The navigation program has assisted more than 824 individuals spanning two hospital facilities. We averaged 24.8 patients a month for 2021. In 2022, our average increased to 27.4 patients/month. This met our goal of 25 patients/month served with a current average of 45.5 patients/month. A 45 percent increase.
The total dollar amount patients saved out of pocket averaged at $34,445 per month in 2021, $38,799 per month in 2022, and to date in 2023, $52,465 per month. As of Mid-May 2023, we have saved $1,144,891 in total payments patients would have incurred.

Figure 2. Financial Navigator: Patients Navigted



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Total
FY 21						6	29	24	18	19	33	26	155
FY 22	33	13	35	38	20	26	16	33	31	23	29	32	329
FY 23	47	52	44	39	46	45							273
Target	25	25	25	25	25	25	25	25	25	25	25	25	300
Δ to target	22	27	19	14	21	20							123

Figure 3. Financial Navigator: Copay + Chemo Drug Assistance



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Total
FY 21						$3,310	$26,505	$17,002	$21,175	$11,097	$85,208	$45,686	$209,982
FY 22	$45,882	$23,004	$97,678	$55,575	$29,810	$28,874	$27,664	$43,912	$40,550	$8,756	$32,491	$31,390	$465,585
FY 23	$42,792	$54,200	$52,224	$51,499	$78,351	$35,724							$314,790
Target	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$300,000
Δ to target	$17,792	$29,200	$27,224	$26,499	$53,351	$10,724							$164,790
FY 23 Charity	$3,783	$0	$0	$0	$0	$251							$4,034

Additionally, satisfaction of those patients that completed their primary course of treatment is tracked to determine if we are meeting their needs.

Question 1: Did you experience financial hardship while on treatment? For 2021, seven percent of those surveyed reported experiencing financial hardship, and in 2022 that number increased to 23 percent. So far as of December 2022 we were at 10%. The goal is to keep financial hardship below 15 percent by ensuring patients are aware of our services.

Question 2: Were you offered a referral to the financial navigator if you experienced financial concerns? For 2021, when we began the program, 11 percent a had been offered a referral, and in 2022 it was 73 percent. As of December 2022, we were at 100 percent. In 2021 we promoted the program heavily through our cancer program newsletter, handouts, flyers in patient packets and presented information on the program at staff meetings for medical oncology, radiation oncology, infusion, and the in-patient floor. Providers were educated as well.

Question 3: Do you feel your needs were addressed/met by the financial navigator? In 2021, 50 percent responding "yes", and in 2022 that number increased to 75 percent. No responses were recorded for the Oct through December 2022 for this question.

Table 1.

Nurse Navigation Patient Satisfaction Survey	FYQ1-23 (Oct-Dec)	FYQ2-23 (Jan-Mar)	FYQ3-23 (Apr-Jun)	FYQ4-23 (Jul-Sep)	Quarter goal	Quarter stretch	FY-21	FY-22
1 Did you experience financial hardship while on treatment?	100%				<15%	<10%	7%	23%
2 Were you offered a referral to the financial navigator if you experienced financial concerns?	100%				75%	90%	11%	73%
3 Do you feel your needs were addressed/met by the financial navigator?					63%	73%	50%	75%

One future goal of the oncology financial navigator is to expand the assistance to all infusion/oral chemotherapy cases regardless of if they were referred to the navigator. Using the ATLAS software, we will be able to identify qualifying patients in our infusion center regardless of the patient expressing financial distress or getting a referral. This will broaden the total number of patients that can be assisted. We are currently in the implementation phase. We plan to implement a six-month trial period to track efficiency. Data we will be tracking will include the number of patients reviewed and number of patients that qualified for funding. Other data include how much funding was received. Additional area of expansion includes supporting the infusion center by offering to find assistance for non-cancer related infusion treatments, like rheumatoid arthritis. Non-cancer related assistance makes up approximately 25 percent of the infusion center's volume.

CONCLUSION

Building the oncology workforce of tomorrow at PIH Health included adding an Oncology Financial Navigator to assist with patients' cancer care finances. Having a dedicated navigator to address financial toxicity provided patients with one contact to aid them in reducing financial toxicity that often comes with the diagnosis of cancer. The oncology financial navigator plays a vital role in supporting cancer patients and their families by minimizing financial stress, maximizing access to care, and providing guidance throughout the financial aspects of cancer treatment. With cost of care and living expenses rising, having an oncology financial navigator is a win for both patients and hospitals.

How Annexus Health is Championing Health Equity through Financial Assistance and Patient Access Services

AND HOW HEALTHCARE PROVIDER ORGANIZATIONS, LIFE SCIENCE COMPANIES, FOUNDATIONS, AND SPECIALTY PHARMACIES CAN LEVERAGE OUR SOLUTIONS TO DO THE SAME

BY NICOLE CHAMBERS, VICE PRESIDENT OF STRATEGIC INITIATIVES AT ANNEXUS HEALTH

HEALTH EQUITY AND WHY IT MATTERS

Should a person's circumstances in life determine how deserving they are of medical care?

The answer in my heart—and, I imagine, most hearts—is no. From the physician's office to the pharmaceutical manufacturer and everywhere in between, when we see a person facing a life-changing diagnosis, we want them to get the care they need regardless of who they are, where they live, or how much money they have. In fact, a 2022 report from Accenture and HIMSS Market Insights reveals that 93% of US healthcare executives believe in the importance of initiatives that promote health equity,[1] or making sure everyone gets the high-quality care they deserve according to their specific needs.

But despite widespread support for the idea of health equity, it is far from our current reality. In the complex web of private and public entities that comprise the United States healthcare system—such as healthcare provider organizations, life science companies, pharmacies, insurance companies, and government agencies—access to quality health care is often dependent on a person's ability to afford it. Many Americans lack adequate insurance coverage or are unable to pay out of pocket for necessary medical treatment, and this inequitable access to care contributes to an alarming disparity in health status and life expectancy: research shows that Americans in the bottom third of household wealth can expect to live 7 to 9 years fewer without disability (in terms of difficulty performing activities of daily living) than those in the top third.[2]

Because of statistics like this and the people behind them, advancing health equity has long been a passion of mine. It's what led me to join the team at Annexus Health, a company on a mission to improve patient access to care by reducing the financial and administrative burdens that often stand in the way. But before we explore how Annexus Health's solutions promote health equity, let's take a closer look at the current state of affairs.

WHERE WE ARE NOW: HEALTH DISPARITIES IN THE UNITED STATES

While health equity is the goal, health disparities are the unfortunate status quo. Findings from the American Association for Cancer Research Cancer Disparities Progress Report 2022 help illustrate what health disparity looks like today, including:

- A 12% higher cancer death rate in people living in poverty compared with those who are not,[3]
- A 17% higher cancer death rate in people living in rural areas compared with those in urban areas,[3]

- And a 12% higher cancer death rate in Black women compared with White women (despite an 8% lower cancer incidence in the former group compared with the latter, likely due in part to fewer cancers being diagnosed at an early stage in Black women)[3,4]

The CDC defines health disparities as preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.[5] The encouraging key word there is "preventable"—we can level the playing field to ensure optimal health care for everyone, but doing so is a big job, as health disparities are multifaceted, interrelated, and often deeply rooted in our socioeconomic system.

Indeed, socioeconomic status (including income, education, employment, and overall economic stability) is one of the primary drivers of health inequity in the United States.[5,6] People with higher incomes and more resources are far more likely to have access to quality health care than those in poverty.[7] Today, one in every 10 Americans is living in poverty, leaving even those with insurance unable to afford healthcare services—and avoiding care as a result.[6,8] Moreover, many people affected by poverty struggle to afford other necessities of a healthy lifestyle, such as nutritious food and housing.[6]

Other significant areas of health inequity include race, ethnicity, gender, sexual orientation, geographic location, age, and disability status, with many of these factors often interlinked with socioeconomic status.[9-13]

SOCIAL DETERMINANTS OF HEALTH AND HOW TO EFFECT POSITIVE CHANGE

As we look for ways to address disparities and move toward equity in health care, focusing on social determinants of health (SDOH) can provide a framework. SDOH refer to the environmental conditions that affect health, functioning, and quality of life outcomes and risks, and they are grouped into 5 domains[14]:

Economic stability

Interventions aimed at improving economic stability include employment programs, career counseling, and childcare opportunities. The goal is to help people find and keep jobs and earn steady incomes so they can afford basic health care. Programs and policies that help people pay for food, housing, health care, and education fall into this domain as well.[6]

Education access and quality

Because people with higher levels of education are more likely to live longer, healthier lives, increasing educational opportunities and investing in student success is critical to achieving health equity.[15]

Neighborhood and built environment

Improving the health and safety of communities can include policy changes at the local, state, and federal levels, such as those that improve air or water quality, address violence, or even add sidewalks and bike lanes.[16]

Social and community context

A person's health and well-being can be significantly influenced by the quality of their relationships and interactions with family, friends, coworkers, and others in their community. Examples of interventions in this domain include efforts to provide social support to victims of bullying and children whose parents are incarcerated.[17]

Healthcare access and quality

Helping people get timely, comprehensive, and high-quality healthcare services is essential to health equity. This means overcoming barriers to care such as high healthcare costs, administrative hurdles, lack of adequate insurance, and transportation issues.[18]

THE ROLE OF FINANCIAL ASSISTANCE AND PATIENT ACCESS SERVICES

Financial assistance and other patient access services offered by life science companies and charitable foundations play an important role in counteracting inequity in health care. They can dramatically reduce out-of-pocket treatment costs and other expenses (travel, lodging, physical therapy, psychosocial help, wigs, etc) for eligible patients, providing them with the opportunity to receive care that would otherwise be inaccessible to all but the wealthiest Americans.

In most cases, healthcare provider organizations (typically financial counselors or other administrative staff) are the gatekeepers for these critical resources. They are responsible for seeking out financial assistance and other access services for their patients, enrolling them into available programs, and tracking the status of the awards. For patients with serious health conditions requiring complex treatments, specialty pharmacies are often involved in the process as well.

But while these resources can make all the difference in a patient's ability to get the care they need, they are often underutilized. And when available funds are left on the table, patients are left struggling unnecessarily to afford treatment. Many delay or simply go without needed care, their conditions worsening as a result; others take on medical debt that impedes their ability to pay for basic necessities like food, rent, and heat.[19-21] In this way, the cycle of health disparity is perpetuated.

So, if financial assistance and other patient access services are out there, what keeps eligible patients from getting them? The answer is administrative toxicity across the patient access journey, including limited human resources within the provider organization, a reactive approach to managing patient access (that is, only seeking out financial assistance for those patients who state they cannot pay a medical bill), and cumbersome manual enrollment processes.

This is where Annexus Health comes in.

ANNEXUS HEALTH: WE *ARE* HEALTH EQUITY

On the provider and specialty pharmacy end, our software platform, AssistPoint®, simplifies, streamlines, and speeds up the process for managing financial assistance and other access services. This makes it possible for these organizations to take a proactive approach and work up all patients for assistance so no one misses out on available resources—or needed

care. AssistPoint users can search a comprehensive library of assistance options at the click of a button, quickly apply and enroll eligible patients into individual assistance opportunities, and actively monitor award fulfillment to ensure utilization and adherence. Moreover, a comprehensive suite of AP Analytics® reports available within AssistPoint helps organizations stay on top of all activities related to patient assistance.

For provider organizations that lack the human resources or infrastructure to proactively manage patient access, or those simply looking to improve efficiency and free up their administrative staff for other important work, our Adparo® services division empowers them to do so. Adparo minimizes the administrative burden on provider organizations by providing trained, experienced staff to utilize AssistPoint to perform an array of tasks related to patient access.

As part of our Adparo team's commitment to health equity, we proactively work up every patient for financial assistance and other access services, dramatically increasing the number of patients who actually receive assistance. In a recent analysis of customer data, Adparo amplified financial assistance searches by a median of 323%, leading to a median boost in financial assistance awards secured of 158%.

On the life science and foundation end, Annexus Health is helping to improve the delivery of the actual patient support programs through which financial assistance and other access services are offered. Our technology-driven solution, AP Connect®, digitally integrates these programs with AssistPoint, bringing them directly into the provider workflow in connection with the practice management system to streamline and speed up the application, enrollment, and fulfillment processes so more eligible patients can benefit from these valuable resources.

MOVING FORWARD WITH OPTIMISM—AND THE RIGHT TOOLS

As a society, we have a long way to go before we achieve true health equity, but I do believe we'll get there. I believe it because health equity is finally a part of the cultural conversation, and a growing number of stakeholders across the spectrum of health care are actively seeking ways to advance it. Healthcare provider organizations, life science companies, foundations, and specialty pharmacies looking to address health disparities can leverage Annexus Health's solutions to improve access to care for *all* patients.

Read the original article here.

SOURCES:

1. Nine out of ten healthcare executives say that health equity initiatives are a top business priority, according to Accenture and HIMSS Insights: yet only 36% have a dedicated health equity agenda budget. Accenture. March 15, 2022. Accessed April 12, 2023. https://newsroom.accenture.com/news/nine-out-of-ten-healthcare-executives-say-that-health-equity-initiatives-are-a-top-business-priority-according-to-accenture-and-himss-insights.htm
2. Zaninotto P, Batty GD, Stenholm S, et al. Socioeconomic inequalities in disability-free life expectancy in older people from England and the United States: a cross-national population-based study. J Gerontol *A Biol Sci Med Sci*. 2020;75(5):906-913. doi:10.1093/gerona/glz266
3. *AACR Cancer Disparities Progress Report 2022: Achieving the Bold Vision of Health Equity for Racial and Ethnic Minorities and Other Underserved Populations*. Philadelphia: American Association for Cancer Research; 2022. https://cancerprogressreport.aacr.org/wp-content/uploads/sites/2/2022/06/AACR_CDPR_2022.pdf
4. More Black women die from breast cancer than any other cancer. American Cancer Society. February 14, 2022. Accessed April 12, 2023. https://www.cancer.org/latest-news/facts-and-figures-african-american-black-people-2022-2024.html
5. Health disparities. Centers for Disease Control and Prevention. Updated November 24, 2020. Accessed April 12, 2023. https://www.cdc.gov/healthyyouth/disparities/index.htm
6. Economic stability. Healthy People 2030. Accessed April 12, 2023. https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability
7. Khullar D, Chokshi DA. Health, income, and poverty: where we are and what could help. Health Affairs. October 4, 2018. Accessed April 12, 2023. https://www.healthaffairs.org/do/10.1377/hpb20180817.901935/
8. Weinick RM, Byron SC, Bierman AS. Who can't pay for health care? *J Gen Intern Med*. 2005;20(6):504-509. doi:10.1111/j.1525-1497.2005.0087.x
9. The state of health disparities in the United States. National Library of Medicine. 2017. Accessed April 12, 2023. https://www.ncbi.nlm.nih.gov/books/NBK425844/
10. Creamer J. Inequalities persist despite decline in poverty for all major race and Hispanic origin groups. United States Census Bureau. September 15, 2020. Accessed April 12, 2023 . https://www.census.gov/library/stories/2020/09/poverty-rates-for-blacks-and-hispanics-reached-historic-lows-in-2019.html
11. Kochhar R. The enduring grip of the gender pay gap. Pew Research Center. March 1, 2023. Accessed April 12, 2023. https://www.pewresearch.org/social-trends/2023/03/01/the-enduring-grip-of-the-gender-pay-gap/
12. The complexity of LGBT poverty in the United States. Institute for Research on Poverty. June 2021. Accessed April 12, 2023. https://www.irp.wisc.edu/resource/the-complexity-of-lgbt-poverty-in-the-united-states/
13. Last Census Bureau data shows Americans 65+ only group to experience increase in poverty. National Council on Aging. September 13, 2022. Accessed April 12, 2023. https://ncoa.org/article/latest-census-bureau-data-shows-americans-65-only-group-to-experience-increase-in-poverty
14. Social determinants of health. Healthy People 2030. Accessed April 12, 2023. https://health.gov/healthypeople/priority-areas/social-determinants-health
15. Education access and quality. Healthy People 2030. Accessed April 12, 2023. https://health.gov/healthypeople/objectives-and-data/browse-objectives/education-access-and-quality
16. Neighborhood and built environment. Healthy People 2030. Accessed April 12, 2023. https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment
17. Social and community context. Healthy People 2030. Accessed April 12, 2023. https://health.gov/healthypeople/objectives-and-data/browse-objectives/social-and-community-context
18. Health care access and quality. Healthy People 2030. Accessed April 12, 2023. https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality
19. Poll: nearly 1 in 4 Americans taking prescription drugs say it's difficult to afford their medicines, including larger shares among those with health issues, with low incomes and nearing Medicare age. Kaiser Family Foundation. March 1, 2019. Accessed April 12, 2023. https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/
20. Perez SL, Weissman A, Read S, et al. U.S. internists' perspectives on discussing cost of care with patients: structured interviews and a survey. *Ann Intern Med.* 2019;170(9)(suppl):S39-S45. doi:10.7326/M18-2136
21. Collins SR, Gunja MZ, Aboulafia GN. U.S. health insurance coverage in 2020: a looming crisis in affordability: findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020. The Commonwealth Fund. August 19, 2020. Accessed April 12, 2023. https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial

Welcome to our new members & renewal members since May 9, 2023. We are thrilled to have you be a part of the ACE!

Megan Aiello
Ginger Araujo
Wendy Austin
Donna Boehm
Susan Brown
Will Callans
Amber Campbell
Kimberly Carli
Cindy Chavira
Lori Drew
Kristi Gafford
Cheryl Gates
Denise Gerlach
David Gosky
Niesha Griffith
Mosie Hackett
Robert Houlihan
Nick Jaidar
Lisa Jordan
Shreya Kanodia
William Laffey
Julie Lux
Christopher Loertscher
Christina Longnecker
Joy Martin
Gina Myracle
Ollieta Nicholas
Matthew Novak
Michael Peters
Steve Price
Tatianna Robles
Maryann Roefaro
Tricia White-Rhemtulla
Scott Schlesner
Drew Snyder
Brian Springer
Susan Stokley
Richard Thompson
Michelle Vislovsky
Jason Wilson
Stan Whitbey
Connie Wood
Susan Yackzan

Member updates:

Megan Aiello joined the Stony Brook Medicine team as the new Assistant Vice President at Stony Brook Cancer Center.

Melissa Childress was named Principal with Chartis Oncology Solutions.

Ana Ignat was named Senior Vice President for the Topper Cancer Institute at Lehigh Valley Hospital Network.

Amy Ware was named the Associate Regional Vice President of Oncology for the HCA/Sarah Cannon Cancer Institute.

Care Guidance Advances Health Equity for Cancer Survivors, Supports Hospitals with Quality Performance Goals

BY EDWARD PARTRIDGE, MD, CHIEF MEDICAL OFFICER, GUIDEWAY CARE AND WARREN SMEDLEY, DSC, MSHA, MSHQS, VICE PRESIDENT, THE KINETIX GROUP

For cancer hospital administrators, considering the addition of a patient care navigation program to their portfolio of services, this article provides insight and a better understanding of the non-clinical factors that influence health disparities and challenge patients. It explores the role of care navigators in helping to meet health equity objectives and achieve optimal operational and financial performance in value-based care and quality payment programs.

The rapid transition from traditional fee-for-service to value-based care (VBC) largely results from policymakers and payers increasingly working to align the efficacy of health equity initiatives with quality payment strategies. A growing number of cancer hospitals and their providers are electing to participate in arrangements that link payments to measured health equity improvements and overall quality performance indicators.

HEALTH EQUITY IS A QUALITY INITIATIVE OF VALUE-BASED CARE

A CMS initiative that is helping advance health equity is the introduction of the Quality Payment Program (QPP) as a value component to the Accountable Care Organization (ACO) model. QPPs offer rewards and shared savings to provider groups that deliver coordinated, high-quality patient-centric care to Medicare and Medicaid beneficiaries. QPPs include Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS).

For cancer hospitals that are exploring options to participate in VBC-aligned programs that reward for achieving better outcomes by supplementing their clinical protocols with social determinants efforts, there are a number of choices. No matter which program a hospital is considering, the common element is the need to better identify, document, address and resolve barriers embedded in social determinants of health (SDoH) and drivers of health disparities. Research recognizes SDoH as socioeconomic, education, cultural and environmental factors that can be complex and perpetuate cancer health disparities. In fact, nearly 80 percent of patient risk is tied to these non-clinical factors, which are not directly related to a person's clinical condition. SDoH affect a wide range of practical, everyday functions, and typically fall outside of a hospital's visibility and control.

SOCIAL DETERMINANTS IMPACT CARE ACCESS AND TREATMENT ADHERENCE

Cancer is a complicated and physically demanding disease to treat that places a wide variety of stresses and burdens on the patient and their family, including physical burdens, coordination of care burdens, and financial burdens, along with meeting all of the normal concerns of daily living. Professor Carl May (2014) described these stresses to the patient as a "Burden of Treatment", which is added to the burden of the disease itself, potentially overwhelming patients with a variety of distresses. The presence of non-clinical factors in a patient's life that have

been associated with poorer outcomes, such as race, socioeconomic status, education, and environmental issues, may significantly compound the already excessive burdens of a cancer diagnosis.

There is growing recognition of the struggles that cancer patients face to overcome non-clinical barriers attributed to SDoH and related disparities that impede access to care and adherence to treatment. Patients at-risk of SDoH often require amplified levels of attention and monitoring that cannot be addressed through a typical hospital's resource capacity and scope limitations. Attempting to allocate clinical resources to address nonclinical patient needs is both inefficient and costly.

Oncologists acknowledge the far-reaching impact of SDoH on patient outcomes. The American Cancer Society suggests that a prognosis for cancer is correlated with the quality of care received based on health equity. ACS strongly links the presence of SDoH to higher cancer risk, greater cancer prevalence, poorer outcomes, and worse rates of morbidity, mortality and survivorship, which in turn impact cancer treatment decisions and patient compliance.

Furthermore, the National Cancer Institute's (NCI) National Cancer Plan prioritizes addressing health disparities and advancing health equity objectives. One of the eight goals is the elimination of disparities in cancer risk factors, incidence, treatment side effects and mortality through equitable access to prevention, screening, treatment and survivorship care.

CARE NAVIGATION PROACTIVELY WORKS TO RESOLVE SDOH-RELATED DISPARITIES

To support an equitable path forward for all cancer survivors, the American Association for Cancer Research (AACR) recommends cancer hospitals and oncology providers consider employing patient advocates and navigators whose scope is focused on proactively activating patients to identify, understand and resolve their SDoH-related disparities–before the issues become problematic and costly.

Vigilance in eliminating cancer health disparities remains one of the hallmarks of the O'Neal Comprehensive Cancer Center at the University of Alabama at Birmingham (UAB). As one of the original eight NCI-Designated Comprehensive Cancer Centers, the Office of Community Outreach & Engagement at O'Neal is dedicated to reaching minority, medically underserved, and vulnerable populations throughout the entire state. Using the Community Health Advisors model, the Center has trained more than 2,000 "natural helpers" from within their own communities to actively provide cancer education through evidence-based interventions.

HOW CARE GUIDANCE WORKS

Care guidance is becoming a "must have" addition to the service line portfolio of health systems. Success of a care guidance program rests largely upon the shoulders of specially selected and tech enabled "care guides" who work to establish a peer-to-patient connection with patients and their families. This human-led approach builds trust, enhances a patient's ability to communicate, and helps to uncover potential barriers they encounter during their care journey.

The core principle of a comprehensive care guidance program is empowering patients to be more engaged and supported in achieving improved personal health. Patients are encouraged to become more proactive in shared decision making and self-managing many aspects of their care. Care guides are empowered to directly help patients overcome the nonclinical barriers to appropriate care. This allows clinical teams to work at higher levels within the scope of their professional training. The combined effects are better patient outcomes, more efficient care and use of fewer resources.

Integrating care guides into the clinical care team also empowers the team to be more intentional in enhancing health equity. Comprehensive care guidance programs may additionally serve in some ways as a surrogate patient-centered oncology medical home model, which can provide a way to empower patients to more effectively participate in their treatment and survivorship journey. Care guidance programs also provide a foundation for disparate provider groups to join forces and provide a more integrated care delivery system, which is attractive to insurance networks, accountable care organizations and other value-based contracting entities.

Today's care guides are equipped with scalable, technology platforms that provide structured workflows and directed to use evidence-based disease and condition-specific protocols to proactively identify and resolve practical and non-clinical issues. Through this technology and support, care guides can also make certain that clinical issues are immediately escalated to proper clinical care teams. Effective collaboration between hospitals, providers and care guides supports a necessary triad of care coordination and management. This simple, cost-effective extension of the care team has positive and profound results for delivering personalized, equitable, and proactive patient-centric care.

The scope of a Care Guidance program typically includes:

- Reaching and managing more patients, especially those at higher risk for SDoH barriers to accessing care
- Making SDoH risk assessments and identifying pathways to barrier resolution
- Coordinating preventive screenings
- Supporting treatment adherence, appointment scheduling and medication management
- Reducing unnecessary service utilization and avoidable readmissions
- Maintaining continuity of care and reducing patient migration

SOLUTION TO CRITICAL NURSING SHORTAGES

As healthcare organizations experience the profound financial impact of clinical staff, nurse and resource shortages, care guidance is providing an innovative and efficient solution to these current resource constraints. The addition of a care guidance program beyond legacy navigation efforts provides organizations with truly effective support services, functioning as a lower cost extension of clinical teams and freeing up labor, time and resources so that clinicians can focus on clinical services.

CONCLUSION

Care guidance is an innovative approach to patient activation that supports 'high-value, high-quality care' required of QPP and helps meet incentivized provider goals in managed, value-based arrangements that optimize financial and operational performance. As a Solution as a Service (SAS), care guidance advances health equity aspirations and improves a cancer hospital's ability to render patient-centered care to generate the best possible outcomes.

Clinical staff receive the extended support they need to ensure the delivery of high-quality cancer care with a focus on achieving health equity, while collaborating with care guides to enhance patient experience, satisfaction and resumption of a functioning quality of life. A comprehensive care guidance program presents health systems and cancer centers with the value of a well validated, equitable, approach to high quality, cost-efficient care for all patients.

How AI Technology Supports Marginal Thinking for Optimized Infusion Scheduling

BY RICK SCHLIEPER, MANAGER OF PRODUCT IMPLEMENTATION & CUSTOMER SUCCESS, LEANTAAS

Facing frequent reductions in resources and staffing, combined with the increasing needs of their patient population, infusion centers must grow their patient volumes despite limitations and make the best use of what they do have. However, scheduling challenges quickly arise as the schedule fills in advance, becoming a barrier to clinic growth and patient access. Marrying economic theory with AI-based technology can eliminate this barrier, supporting organizational growth and also a better patient experience.

LONG-TERM INFUSION SCHEDULING IS A BLANK SLATE

Scheduling the very first patient on any given day is a relatively simple task. In fact, most infusion centers estimate the first 60-80% of the patients they schedule for the day are easy to fit in. The majority of scheduling decisions do not require overrides, shuffling appointments, or other efforts that likely come to mind when thinking about optimized infusion center scheduling.

COMPLICATIONS ARISE WHEN SCHEDULING INFUSION APPOINTMENTS FOR THE NEAR FUTURE

Roadblocks do arise and extra effort is required to schedule the final population of patients for the day, which accounts for 20-40% of appointments in total. The schedule is often full a week or two in advance of the desired treatment day. Next-day and same-day add-ons are especially difficult to fit in, even more so considering patients who must also see their provider or get labs during the same visit. Organizational goals of growing appointment volumes may seem unachievable in light of an already full schedule.

So how can infusion leaders and staff more easily schedule this last set of appointments and grow their volumes as needed? One way is to borrow a concept of economic theory commonly referred to as marginal decision making – and deploy that concept to its full extent, using AI-based technology.

DEFINING MARGINAL DECISION MAKING IN ECONOMIC TERMS

In economics, focusing a decision on the margin means thinking about the cost or benefit of the very next unit made or worked on, as opposed to the overall average cost. For example, if a person is working on doing 100 sit-ups and measuring the cost of doing them with time, and it takes five minutes to do the 100 sit-ups, then on average the cost is three seconds per sit-up. What likely happens, however, is that the person is able to do the first several sit-ups significantly faster than the last, meaning sit-ups #99 and #100 take longer than #1 and #2. Assuming the final two sit-ups ultimately take five seconds each, then even though the average time cost of each sit-up is three seconds, the marginal cost is five seconds.

APPLYING MARGINAL DECISION MAKING TO INFUSION CENTER SCHEDULING

Consider a scheduling team working on scheduling 100 infusion appointments on a given day. This is naturally a process that happens over the course of several weeks, and as mentioned, the first 60-80 appointments to schedule are relatively easy due to the sizable lead time, available chairs, and free space in the center's scheduling calendar. At this time the center does not yet feel

Figure 1.
Utilization profile of sample infusion center using open scheduling without the marginal effort required to schedule future appointments.

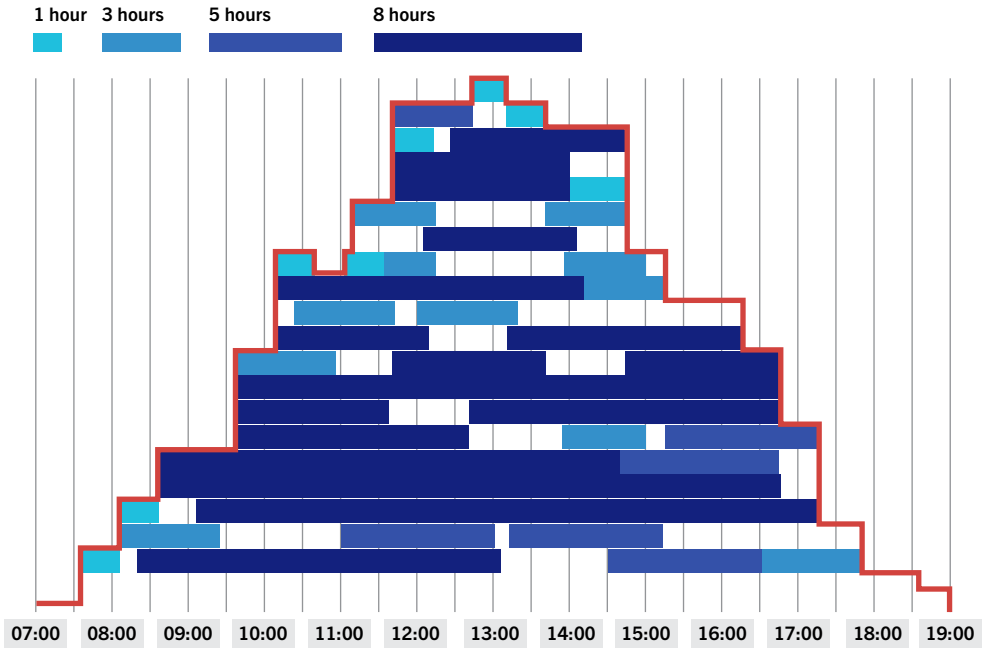
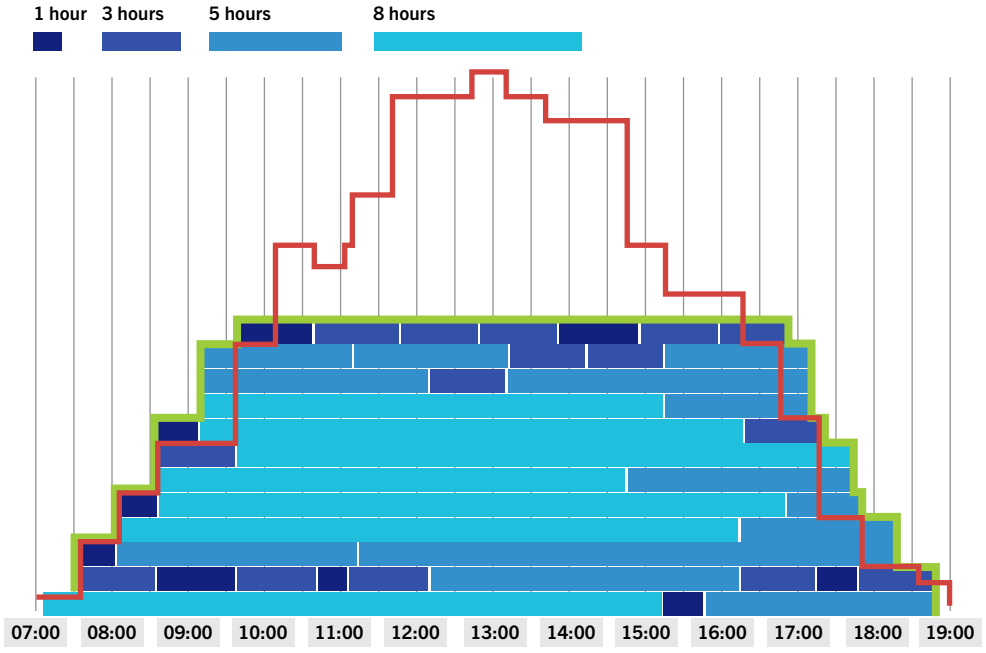


Figure 2.
Utilization profile of infusion center using pre-calculated optimized scheduling factoring in the need for future anticipated volume.



constrained, and most centers end up having a chair utilization profile with gaps of free space within. Then, as more and more appointments are scheduled, the schedule feels increasingly full. While the scheduling team does its best, the level of effort needed to place each additional patient appointment increases. The result is some combination of the following:

- More and more people-power is dedicated to the situation. There are escalations to leadership, calls made to patients to ask if they can move their appointments, revision of infusion center schedules (plus related provider and lab schedules), and overrides to the schedule, creating situations where the center is scheduled beyond its chair capacity.
- All patients are not scheduled, because there doesn't seem to be enough room. Patient lead times are extended, delaying treatment and creating a worse patient experience. Patient appointment volume may also be decanted to other units in the geographical area, resulting in loss of revenue.
- The center feels unable to grow. It may have demand to increase volume, but it seems unable to accommodate this growth due to ongoing struggles to handle the current volume demands.

While a number of factors can contribute to solving these challenges, marginal decision making can help fill the gaps and improve infusion scheduling through a variety of methods. Infusion leaders, managers, and decision makers will likely find this too intensive to apply manually. Here a smart scheduling solution that is able to take into account past, present, and future schedule data to optimally support marginal decision making through AI, is an invaluable tool.

MARGINAL DECISION MAKING PROVIDES SCHEDULING SOLUTIONS

The right technology can utilize a number of best practices and scheduling tactics to reduce the severity of this scheduling crunch and even allow centers to increase the volume of patients treated. These focus on minimizing problems that will eventually increase the marginal effort of those last several appointments that must be scheduled.

There are three main approaches scheduling teams can take into consideration when trying to solve these issues:

- Where possible, focus on protecting peak demand times for patients who truly need them, and more fully utilize less desirable times of the day.
- "Pre-play" the Tetris game of appointment time combinations to avoid gaps in the schedule, then offer those available appointment times to patients when scheduling.
- Empower schedulers with tools that show the impact of their scheduling decisions as it relates to the utilization within the infusion center.

Technology can help infusion users easily follow the first approach by making the center's common peak demand times clearly visible. It can implement and hone the latter two approaches by providing access to the center's unique predictive scheduling information. Infusion centers who have thus pivoted to marginal decision making have achieved proven results including reduced patient scheduling lead times, increased appointment volumes, and fewer scheduling escalations and leadership interventions on scheduling decisions. These outcomes in turn result in improved access for patients, and increased infusion scheduler autonomy, independence, and job satisfaction.

Read on to learn more on how leading infusion centers have adopted marginal decision making and achieve these outcomes of optimized scheduling.