

Transforming Practices Through the Oncology Care Model: Financial Toxicity and Counseling

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In the last 5 to 7 years, a significant amount of research has been performed on the experience of financial toxicity in the oncology setting. Studies by such researchers as Yousuf Zafar,¹ Scott Ramsey,² and Jonas A. de Souza,³ to mention a few, have successfully shed light on this growing problem; however, to date, little work has been done to find effective solutions for this financially vulnerable patient population.⁴ We could argue that the problem at hand is multidimensional. Responsibility should fall on providers, patients, pharmaceutical companies, politicians, and payors alike. This article will focus on the provider responsibilities that seem to play a part in the growth of financial toxicity for the oncology patient.

Financial toxicity often results in decreased treatment adherence⁵ as well as a decrease in overall sense of wellbeing.⁶ This should not be surprising, as we understand that a person's financial stability or instability has significant ramifications on their physiologic and emotional wellbeing. From a psychosocial standpoint, Maslow's theory of the hierarchy of needs plainly established that if a person's basic needs and his or her sense of security is threatened, the person will likely be unable to experience wellness. When a person is diagnosed with cancer, the provider focus is on the medical needs of the patient and less expert attention is provided to the basic and security needs of the patient. Yet consideration should be given to provide expert guidance on both the medical

and financial concerns of the patient on the basis of a survey conducted by the Community Oncology Alliance that found that Americans fear the costs of cancer care as much as they fear dying from the disease.⁷ Patients often experience difficulty in maintaining employment; decreased income; loss of employer-based health insurance; increased expenses, such as transportation and caregiver assistance; and the increasing out-of-pocket responsibilities that are likely to be incurred with pending treatments. Financial toxicity often takes hold as a result of a lack of expert guidance on these issues. In addition, many Americans do not have a cushion of savings to cover unexpected expenses. A study by Bankrate.com⁸ found that 57% of Americans would not be able to cover an unexpected bill of \$500. When considering these factors, it is easy to understand why so many oncology patients experience some level of financial toxicity.

The following are four opportunities that will help alleviate financial toxicity in the oncology setting:

1. Increase the commitment to the role of financial advocacy. Although oncology programs across the United States have demonstrated the financial and practical value of having a financial advocate in place,⁹ providers continue to be slow in investing in the role¹⁰ (Fig 1). The responsibilities of the job often fall to low-paid staff members who do not see the role

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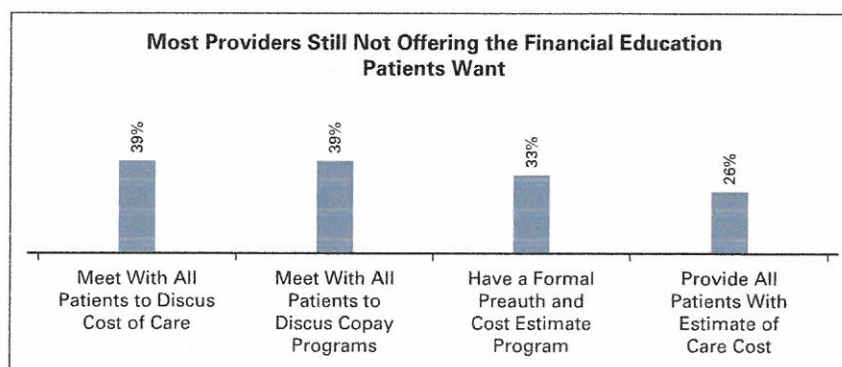


Fig 1. 2016 Association of Community Cancer Centers trends in cancer programs.¹⁰

as a favorable career path, or it falls in the laps of social workers or front office staff who have had no specific training to provide such a service to patients. Furthermore, the role will often focus on benefit and prior authorization processes that result in the neglect of the patient who needs help navigating our complex health insurance systems.

2. Establish certification and education requirements for the financial advocate role. All disciplines within the medical field—physicians, nurses, dietitians, social workers, physical therapists, etc—have standard education and certification processes in place before they are allowed to practice their skill on patients. In fact, the provider can incur huge liabilities if these requirements have not been fulfilled; however, to date, there are no standards or certification requirements in place for financial advocates that are employed within the health care system. Research completed by the Oncology Roundtable¹¹ has found that 45% of financial advocates in the oncology setting have only a high school diploma, 37% have an associate's degree, 26% a bachelor's degree, and only 14% a master's degree

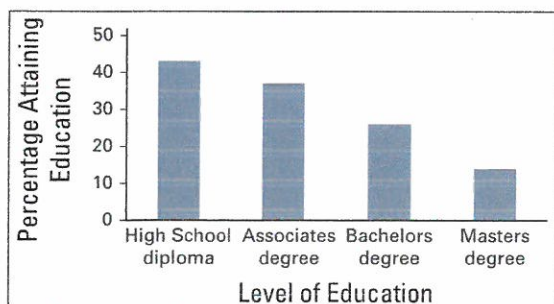


Fig 2. Financial counselor level of education.¹¹

(Fig 2). We ask undereducated staff to deal with the number one concern of oncology patients. We ask them to solve multifaceted problems within a health insurance system that is the most complex system on the planet. The United States health care system has changed dramatically in the last 10 years, with the creation of Medicare Part C and D and the Affordable Care Act. These massive systems have complex enrollment and entitlement guidelines that few financial advocates understand on an expert level.

3. Increase physician engagement in understanding the dynamics of financial toxicity. Oncologists have proven themselves effective in dealing with the many adverse effects of chemotoxicity; however, research¹² suggests that few oncologists feel comfortable broaching the topic of financial distress with their patients. Financial toxicity is a true adverse effect of treatment; therefore, oncologists should be prepared to have discussions with patients and the financial navigation team to identify the best treatment options in the context of the pending financial toxicity the patient will experience.
4. Improve processes to identify patients in need. In most hospital oncology programs across the United States, financial advocacy services are located outside of the oncology department. Patients are referred to these services rather than the services coming to the patient. As a result of this, little to no communication occurs between providers regarding the details of the patient's diagnosis, prognosis, and treatment plan. The financial advocate is then treating the patient blindly and offers the same conveyor belt solutions to all patients who are referred. Our current process of intervention also tends to follow a reactive approach. We treat, bill, and then

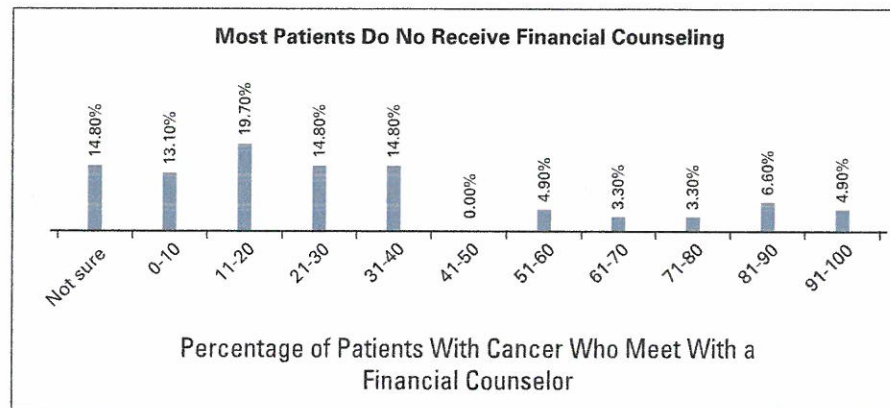


Fig 3. Most patients do not receive financial counseling.¹¹

deal with the financial toxicity experienced by the patient (Fig 3). This should be reversed. We should anticipate and prevent financial toxicity, then treat the patient. In other words, we should provide competent financial navigation services before incurring medical debt for the patient.

It is important for providers to understand that financial navigation is complex and that it impacts the patient from both a practical and psychological standpoint. As a result of the complexity of financial toxicity, there is increased potential for providers to underestimate the psychological damage that occurs once financial toxicity takes hold. When we read the work of Zafar, Ramsey, and de Souza, as well as reports provided by national organizations, such as Kaiser Family Foundation,¹³ The Community Oncology Alliance,⁷ Association of Community Cancer Centers,¹⁴ and Cancer Care,¹⁵ we can acknowledge that, as a whole, the oncology community has failed to effectively deal with the experience of financial toxicity for a significant portion of the oncology patient population. A pertinent question, therefore, is what level of responsibility should the provider have in addressing these issues, and at what level of expertise should they be intervening?

The following is a case scenario that illustrates the point:

D.T., a 71-year-old married male is diagnosed with stage IV colon cancer. His monthly household gross income is \$1,590 and he has \$10,000 in assets. He has Medicare Parts A, B, and D only. His treatment regimen includes surgery followed by bevacizumab, oxaliplatin, and oral capecitabine for 12 months, along with anti-nausea and pain medications. He will also need palliative radiation treatments. His total treatment cost for 1 year is estimated to be approximately \$350,000, and the patient responsibility is estimated to be approximately \$40,000.

In most hospital settings across the United States, financial advocates would assist this patient in applying for both Medicaid and charity; however, in most states, these interventions would do more harm to the patient than help. He would likely qualify for Medicaid, but not without some spend-down responsibilities. He would be required to spend down his \$10,000 in assets to below \$3,000. This intervention, which occurs daily across the United States, harms the patient's financial security needs as the \$10,000 in assets provides a significant security blanket. This patient will be a classic statistic of financial toxicity; however, a financial navigator with an expert knowledge of Medicare would lead this patient down a completely different pathway. He qualifies for several entitlement programs that would not only optimize his health insurance but increase his monthly income. By navigating the Medicare Savings Program as well as the Low-Income Subsidy program, this patient can be moved from a \$40,000 responsibility down to as little as \$0 out-of-pocket responsibility, and his income would increase by more than \$200 a month. This becomes a win for the patient and the provider.

The Oncology Care Model is putting in place the 13 components of the Institute of Medicine's Care Management Plan requirements, most of which will influence the patient's sense of financial wellbeing. Informing the patient of his or her diagnosis, prognosis, length of treatment, and treatment benefits and harms, as well as providing an estimate of the total and out-of-pocket costs of treatment all heavily impact the patient's financial sense of security or wellbeing. Asking an untrained and noncertified financial advocate to address these complex circumstances is unfair to both the financial advocate and the patient. With the implementation of the Oncology

Care Model, physicians and financial advocates need to be better prepared to deal with the many ramifications of financial toxicity. Unfortunately, personnel in most health care systems do not have the skill level to do this, and as long as that continues, financial toxicity will continue to plague the oncology patient population. Oncology providers across the United States should invest in improving the skill level of their financial advocates and navigators, which would result in improved patient experience, revenue capture, and reduced financial toxicity. **JOP**

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References

1. Zafar SY, Peppercorn JM, Schrag D, et al: The financial toxicity of cancer treatment: A pilot study assessing out-of-pocket expenses and the insured cancer patient's experience. *Oncologist* 18:381-390, 2013
2. Ramsey S, Blough D, Kirchhoff A, et al: Washington State cancer patients found to be at greater risk for bankruptcy than people without a cancer diagnosis. *Health Aff (Millwood)* 32:1143-1152, 2013
3. De Souza J. A., Yap B. J., Wroblewski K, et al: Measuring financial toxicity as a clinically relevant patient-reported outcome: The validation of the COmprehensive Score for financial Toxicity (COST). *Cancer* 123:476-484, 2017
4. Zafar SY: Financial toxicity of cancer care: It's time to intervene. *J Natl Cancer Inst* 108:djv370, 2015
5. Kaisaeng N, Harpe SE, Carroll NV: Out-of-pocket costs and oral cancer medication discontinuation in the elderly. *J Manag Care Spec Pharm* 20:669-675, 2014
6. Fenn KM, Evans SB, McCorkle R, et al: Impact of financial burden of cancer on survivors' quality of life. *J Oncol Pract* 10:332-338, 2014
7. Community Oncology Alliance: Americans fear paying for cancer treatments as much as dying of the disease. *Oncol Times* 31:16-17, 2009
8. Steiner S: Bankrate.com: Survey: How Americans contend with unexpected expenses. <http://www.bankrate.com/finance/consumer-index/money-pulse-1215.aspx>
9. The Advisory Board Company: Cancer patient financial navigation: Helping patients manage their costs while protecting program margins. <https://www.advisory.com/research/oncology-roundtable/studies/2014/cancer-patient-financial-navigation>
10. Association of Community Cancer Centers. 2016 Trends in Cancer Programs Survey. <https://www.accc-cancer.org/surveys/CancerProgramTrends-2016-Overview.asp>
11. The Advisory Board Company: The results are in: The 2014 cancer financial navigation survey. <https://www.advisory.com/research/oncology-roundtable/resources/2014/the-results-are-in-the-2014-cancer-financial-navigation-survey>
12. Schrag D, Hanger M: Medical oncologists' views on communicating with patients about chemotherapy costs: A pilot survey. *J Clin Oncol* 25:233-237, 2007
13. Pollitz K, Cox C, Lucia K, et al: Medical debt among people with health insurance. <http://kff.org/private-insurance/report/medical-debt-among-people-with-health-insurance>
14. Association of Community Cancer Centers: Financial advocacy network (FAN). <http://www.accc-cancer.org/resources/FinancialAdvocacy-Overview.asp>
15. CancerCare: CancerCare patient access and engagement report. <http://www.cancercare.org/accessengagementreport>

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