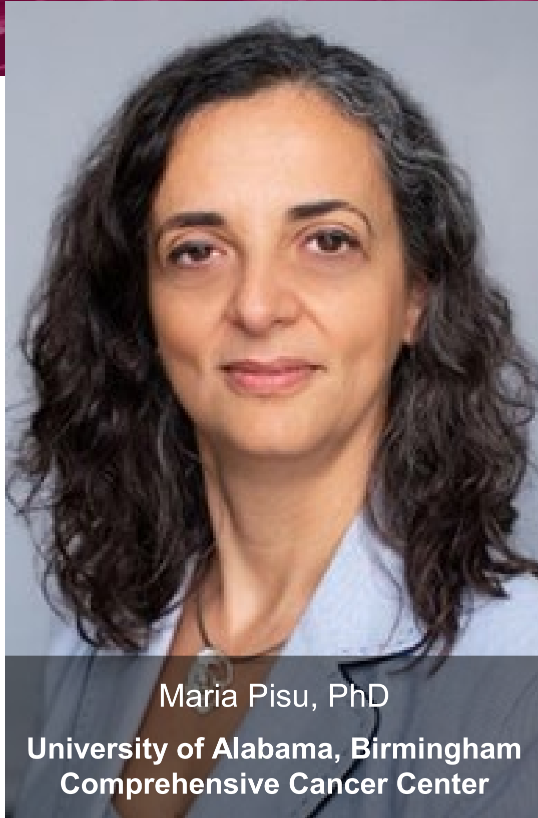
Session 2: Integrating Financial Hardship Screening and Service Delivery into Cancer Care

Moderator: Michael T. Halpern, MD, PhD, MPH



Session 2 Speakers

Expanding Distress Screening To Optimize Identification Of Cancer Patients Experiencing Financial Hardship To Enhance Delivery Of Financial Navigation

Maria Pisu, PhD, Margaret Liang, MD

O'NEAL COMPREHENSIVE CANCER CENTER

UAB THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

Acknowledgements

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- Gynecologic oncology clinic staff
  - Monesia Mock: lay navigator
  - Lindsey Murphy: social worker
  - Jill Hyde, Kevin Wallace, Jennah Moore: research assistants
  - Jhalak Dholakia, MD: gyn-onc fellow
  - Tavonna Kako, MD: ob/gyn resident
- Fania Thomas: financial counselor
- Lingling Wang: statistical analyst
- O'Neal's Participant Recruitment and Assessment Shared Facility team

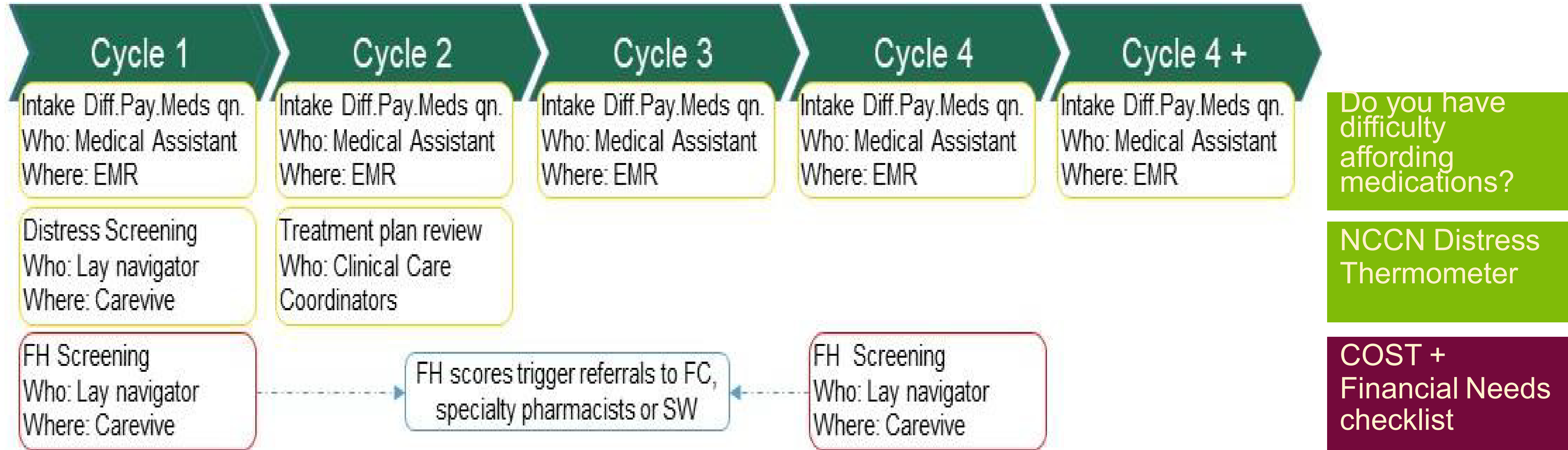
Rationale and Objective

- One in 2 gynecologic oncology patients had financial hardship
- Patients needs for addressing financial concerns about cancer care
  - Upfront information
  - Linkage to resources
- No systematic way to meet these needs and reduce financial hardship
- One solution: universal financial hardship screening

- Implementation challenges
  - Extensive screening ongoing
    - Is financial hardship screening really needed?
  - Disclosing finances sensitive
    - Is such financial hardship screening acceptable to patients?
- **Objective:** Implement universal financial hardship screening and evaluate if:
  - It added value to current screening
  - It was acceptable to patients

Methods, Population, Interventions, Time Frame

- **Setting**: Gynecologic oncology clinic
- Staff interviews on barriers
  - Unclear clinic flow, Lack of staff training, No method for case tracking
- **Target**: Women starting a new line of chemotherapy
  - 364 women screened, 10/2020 - 01/2022



Methods, Population, Interventions, Time Frame

Financial Needs Checklist	Lay Navigator (LN) refers to
Difficulty in affording:	
Basic needs (food, shelter) Utilities Transportation or lodging Medical supplies Child/elder care	LN or Social Worker (SW)
Medications	Financial Counselor (if infusion drug), Specialty Pharmacist (if oral cancer drug), SW (if non-cancer treatment)
Upfront payments for visits, tests, imaging, labs Insurance	Financial Counselor
Medical bills	SW , Financial Services/Business Office, Charity Care office
Foreseeing or having problems related to:	
Employment or Disability	SW
No financial need but COST <26	Financial Counselor

Results: Successes and Challenges of Implementation

- Easy incorporation of financial hardship screening into routine screening for distress by lay navigators
  - Most women completed screening
  - More women identified with financial needs than through existing screening
  - 79 completed brief surveys ❼ screening acceptable and found important/helpful
- COVID – in person vs. phone screen
  - Phone screening feasible
- Lay navigation outsourced
  - High turnover
  - Lack of communication of tracking systems
- Information on follow-up hard to obtain, not measurable
  - Of 115 with at least 1 financial need, 103 were helped by navigator or referred to others, mainly social worker
    - Few referred to financial counselor or patient financial services
- What interventions do patient need?
  - Complex, may come from a number of different team members
- Ownership at clinical operations level needed

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Conclusions

- Dedicated financial hardship screening is needed and feasible
  - Patients find it acceptable, helpful and important
- Integration into workflow requires to be strategic about:
  - Staff roles
  - Oversight
  - Integrated tracking systems

Optimizing the Implementation of Systematic Financial Screening by Leveraging Technology

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Rationale and Objectives

RATIONALE

- Implementation of routine financial screening is a critical step toward mitigating financial toxicity
- Screening facilitates identification and intervention delivery
- Technology (electronic health record, patient portal) may facilitate screening among some patients

OBJECTIVES

- Develop a financial screening process using stakeholder input
- Evaluate the feasibility and acceptability of the first year of systematic financial screening in a large, urban, outpatient cancer center
- Describe the process of incorporating financial screening into the electronic health record

Methods

- **Process developed through key stakeholder input**
- **Screening tool:** 2-items adapted from *Comprehensive Score for Financial Toxicity (COST)*
  - Q1: “I worry about the financial problems I will have in the future as a result of my illness or treatment”
  - Q2: “I know that I have enough money in savings, retirement, or assets to cover the costs of my treatment”
- **Cohort:** English or Spanish-speaking, 18+ yrs, in breast oncology clinic at CUIMC (3/2021- 2/2022).
- **Survey data Collection:** 1) completion via patient portal before clinic; OR 2) paper form manually entered into EHR
- **Perception of Screening:** structured interviews assessing acceptability & appropriateness of screening process

eCheck-In

Personal Info | Insurance | Medications | Allergies | Health Issues | Question-naires

Financial Hardship Questionnaire

For an upcoming appointment with **Family Medicine, Physician, MD** on 1/26/2021

We know that having cancer (a child with cancer) is distressing. We want to understand how the financial costs of cancer care may add to your distress so we might help you connect to available resources and hopefully, reduce distress. We understand that giving this information may make you uncomfortable, and we greatly appreciate the information you give us, and your time.

*Indicates a required field.

*I know that I have enough money in savings, retirement, or assets to cover the costs of my treatment.

1 - Strongly Disagree | 2 - Disagree | 3 - Neutral | 4 - Agree | 5 - Strongly Agree

*I worry about the financial problems I will have in the future as a result of my illness or treatment.

1 - Strongly Disagree | 2 - Disagree | 3 - Neutral | 4 - Agree | 5 - Strongly Agree

Continue | Cancel

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Results

- **Number of patients seen in oncology clinic: N = 3,500; 39% response rate (N = 1,349)**
- **Total responses using patient portal: 79%**
- **36% (n=499) endorsed financial worry**
- **52% (n=703) endorsed financial hardship**
- **Patient perception of screening:**
  - Transparency to patients about purpose of the screening and resources available
  - Ensure non-English access is optimized
  - Patient engagement with the portal
- **Staff perceptions:**
  - During times of limited resources (staffing, busy clinic), paper form distribution is challenging
  - Kiosks or other patient-directed support may help improve technology engagement

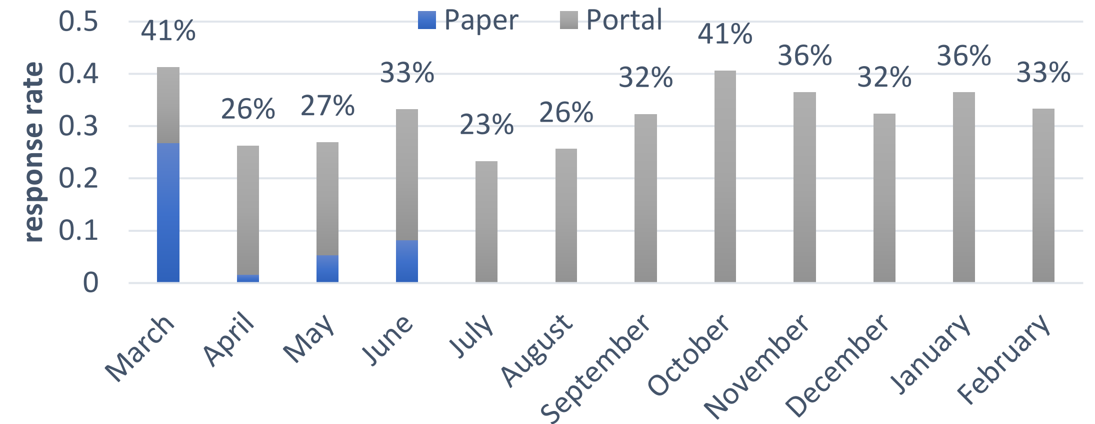

Figure 1: Response rate and mode by month

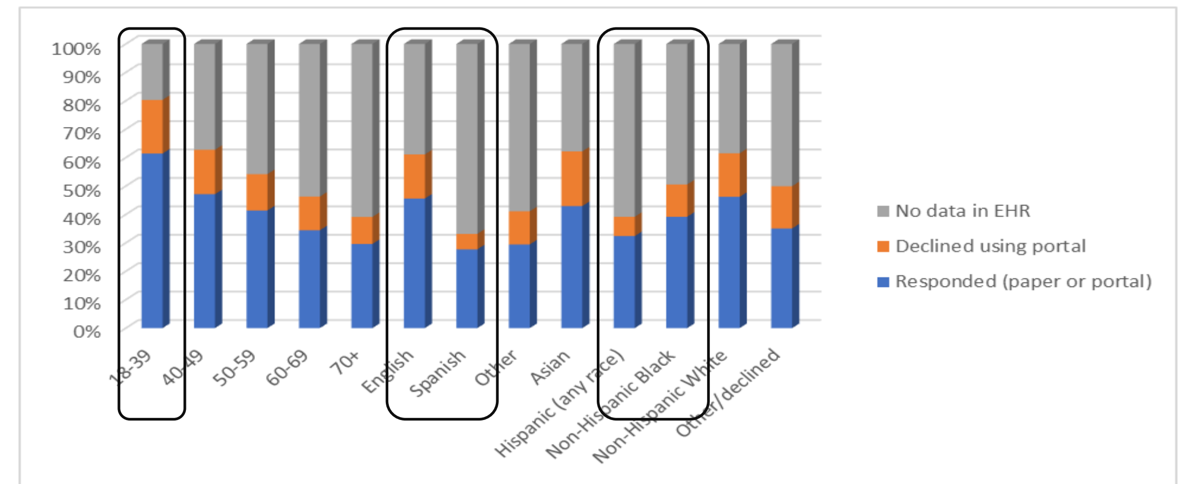

Figure 2: Response rates by patient characteristics

Conclusion

- Systematic financial screening is feasible
- Requires engagement with clinical staff, providers, and patients
- Need to offer low-tech screening completion options
- Accessible options, including language and cultural adaptation, are necessary for screening implementation success

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Challenges and Opportunities for Addressing Financial Hardship

Kate Glaser, PhD

Increasing capacity for systematic financial hardship screening and enhanced patient navigation at Roswell Park

- **Kathryn (Kate) Glaser, PhD**
  - Program Co-Director for Cancer Screening and Survivorship at Roswell Park Comprehensive Cancer Center in Buffalo, NY
  - Medical Anthropologist and Implementation Scientist; focus on cancer health disparities and health systems barriers that are often a source of inequity
- **Goal: Roswell recognizes that financial effects of cancer treatment are a major concern and problem for many patients, particularly in our region given high rates of poverty**
  - Numerous processes to help reduce the negative financial impact of cancer treatment
  - We piloted a process to:
    - Proactively screen for financial hardship
    - Navigate to financial services
    - Evaluate the efficacy and reach of programs to reduce financial hardship

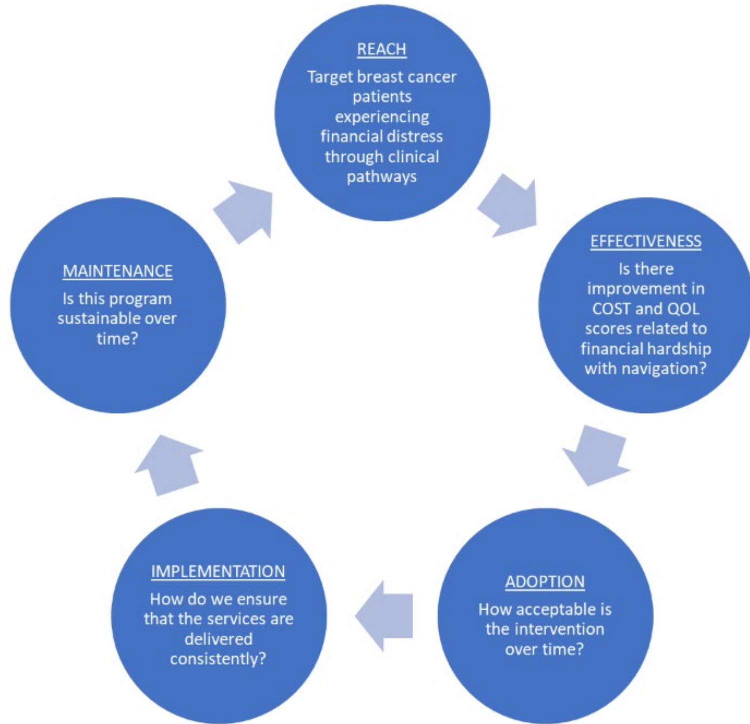
Acknowledgements – Study Team

- Title: Increasing capacity for systematic financial hardship screening and enhanced patient navigation at Roswell Park
- Funding: P30 Supplement (NCI)
- Project Lead:
  - Kate Glaser, PhD — Co-Director Cancer Screening and Survivorship
- Project Co-Leads:
  - Elizabeth Gage-Bouchard, PhD — SVP and AD Community Outreach & Engagement
  - Tessa Faye Flores, MD — Medical Director of Screening & Survivorship
  - Elisa Rodriguez, PhD — Director of Community Engagement Resource
  - Mishellene McKinney, RN/MHA — VP, Cancer Care Services at Kaiser Permanente
  - Susan LaValley, PhD — Research Scientist, Community Outreach and Engagement

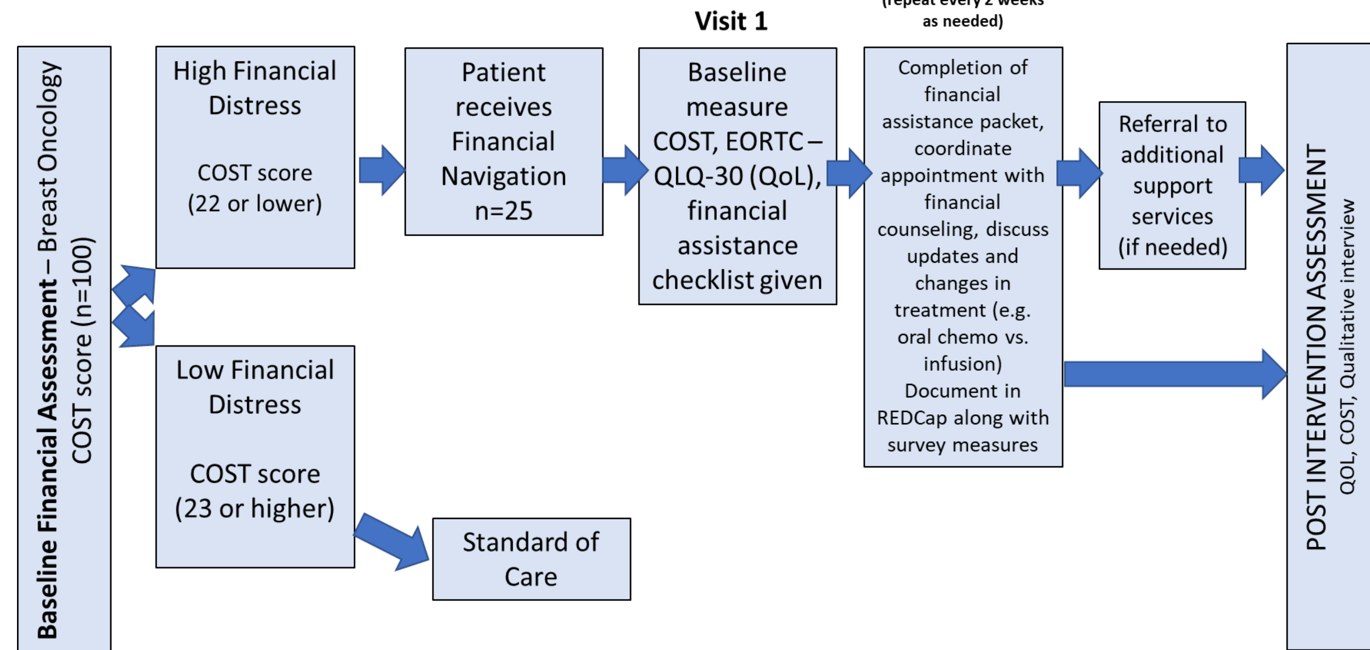
Objectives, Rationale

- **Roswell is the only NCI-designated comprehensive cancer center in Upstate NY**
- **Roswell is dedicated to the reduction of cancer disparities, including those related to financial burden of cancer care**
    - Location: Buffalo/Niagara metropolitan area
    - Catchment area: 8 counties of Western New York
- **Specific Aims**
    - **Aim 1:** Use implementation strategies to convene stakeholders to develop standardized workflows to enhance financial hardship identification and navigation (environmental scan).
    - **Aim 2:** Pilot test a new process for proactively identifying patients concerned about or experiencing financial hardship in the EHR.
    - **Aim 3:** Pilot test an intervention to navigate patients to financial services.

Implementation Strategy, Intervention and Timeline



RE-AIM framework



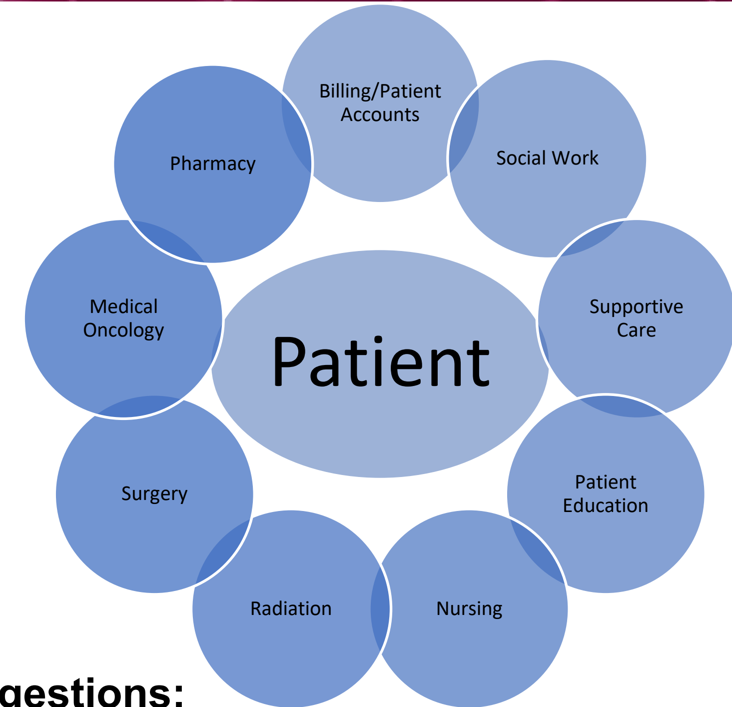
Environmental Scan

Aim 1: Environmental Scan

16 Stakeholder conversations held between October 2020 and January 2021

Findings:

1) Financial hardship can be caused by multiple factors
2) Patients often receive financial assistance/information when they themselves initiate the process (referrals to counseling not proactively offered across the institute)
3) Patients are not systematically screened for financial hardship
4) Physicians may not know actual costs of treatment or understand insurance coverage



Suggestions:

- Refer patients to Financial Counseling early in their time at Roswell
- Review benefits with patients prior to treatment
- Provide patients with tip sheet/assistance understanding their insurance coverage

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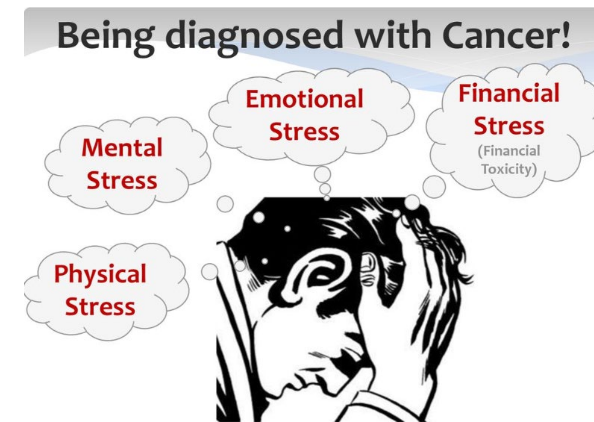
Implementation and Intervetion Results

- Financial Hardship (COST)[1] and EORTC QLQ-30[2] data collection:

  March - October 2021 (n=428)

- 267 COST and QLQ-30 completed in Survivorship (including Adolescent and Young Adult Survivors)
  - **15% of patients** indicated extreme financial distress
- 161 COST and QLQ-30 completed in Breast Medicine
  - **20% of patients** indicated extreme financial distress and were navigated to financial counseling
  - Only 6.5% eligible for financial aid application



1. De Souz et al. Cancer 123.3 (2017): 476-484.
2. Fayers P, Bottomley AE, EORTC et al. European Journal of Cancer. 2002 Mar 1;38:125-33.

Conclusions

- What works?
  - Having embedded financial navigators in each clinical area (e.g. radiation) and enhancing navigation across the cancer care continuum
- Challenges
  - Implementing new assessments and follow-up on financial distress
    - Staffing shortages and workflow since COVID pandemic
    - Calculating survey threshold scores and automating referrals to financial counseling
  - Improving of the coordination, navigation, and delivery of financial services
- Opportunities
  - Enhance patient navigation including Financial Empowerment Coach
  - Leverage patient reported outcomes
  - Reduce number of questions related to financial distress
  - Implement simple assessment (use “worry about money” to refer patients to financial services)

Tameka Brooks
Financial Empowerment Coach

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A Multi-Dimensional Assessment of Financial Hardship Using Existing Health System Data

Wen You, PhD

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Acknowledgements

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- **Postdoctoral fellows**:
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- **Collaborative Teams**:
  - Supportive Care Services Team
  - Research & Clinical Trial Analytics Team
  - Patient Financial Service Management Team

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Objectives & Rationale

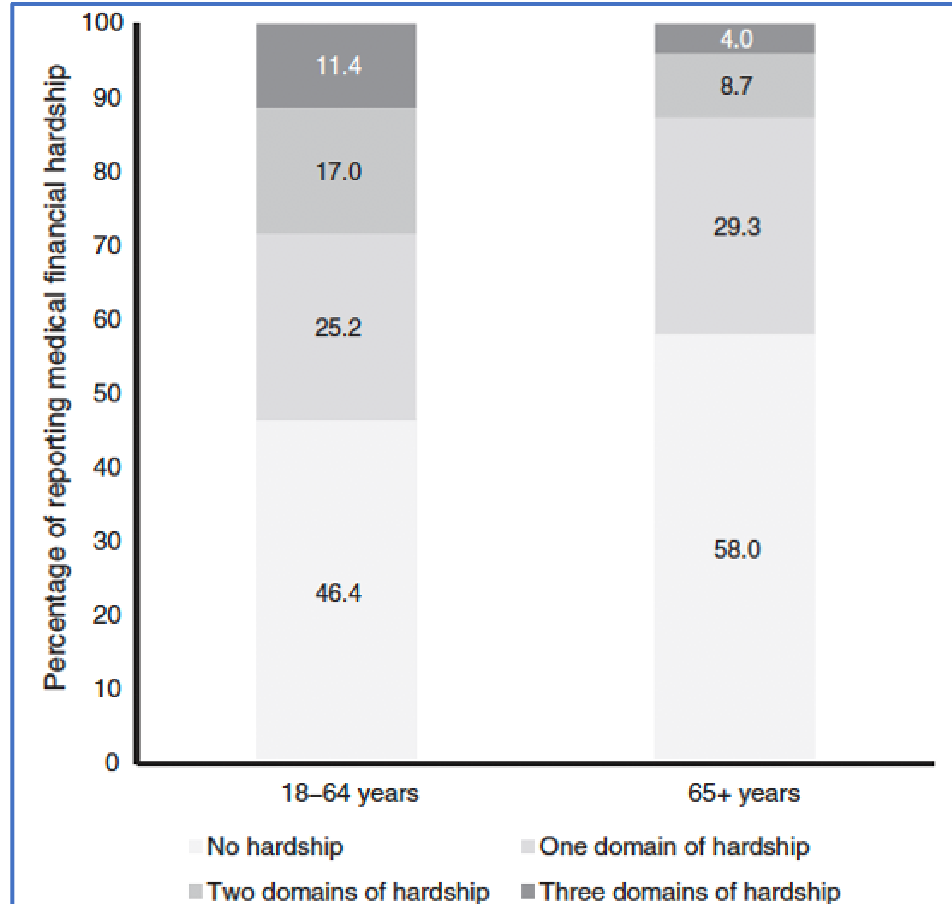


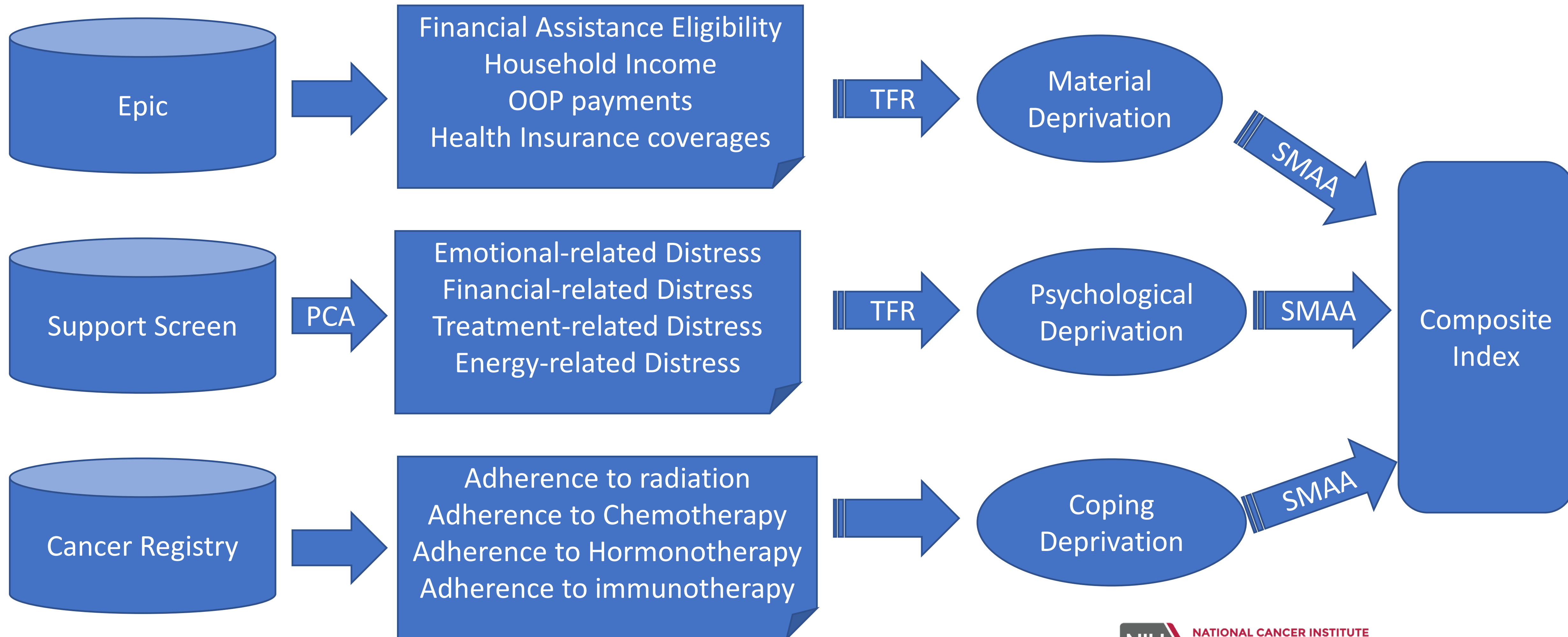
Figure 1.
Medical financial hardship associated with cancer by age group, unadjusted ($N = 963$). Weighted percentages of reporting none, one, two, and all three domains of material, psychological, and behavioral medical financial hardship in cancer survivors, by age group. Data are from the MEPS 2016.

Han et al. 2020 Cancer Epidemiology, Biomarkers & Prevention

1. Develop a multidimensional screening algorithm using existing health system data
2. Quantify the dynamics of financial hardship over time and identify risk factors
3. Quantify patients' preferences towards financial navigation services

Methods (Aim 1 & Aim 2)

Note:
PCA: principal component analysis
TFR: totally fuzzy and relative approach
SMAA: stochastic multi-criteria acceptability analysis



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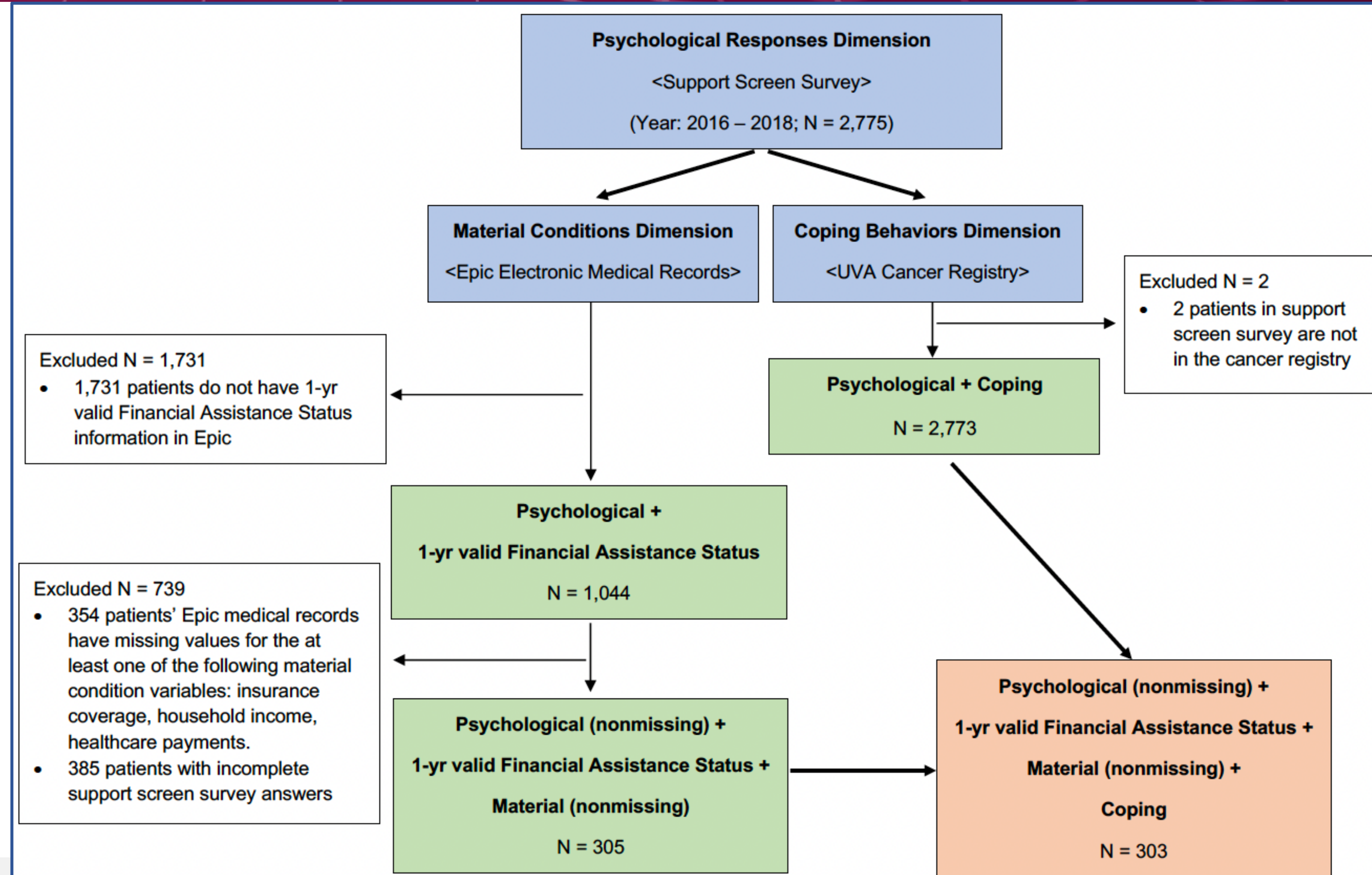
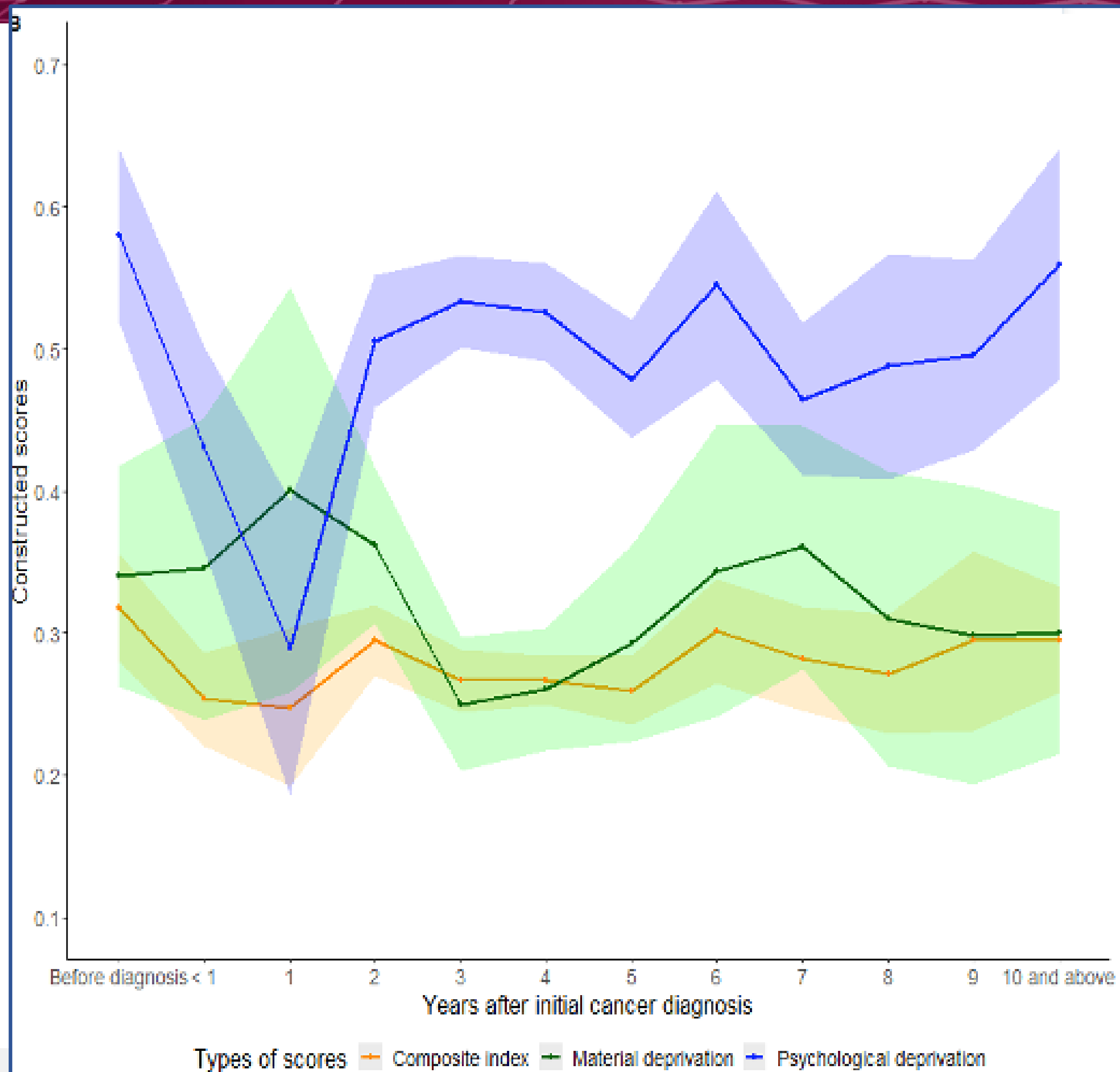
Sample (Aim 1 & Aim 2)



Results



Characteristics	FA Eligible	At-Risk	*p*- value[a]
Number of patients	101	151	-
Age	63.71	60.58*	0.078
OOP/income	1.25	1.81	0.335
HH income	23,469.86	49,567.7***	<0.001
Insurance coverage	97.78	91.98**	0.001
Cancer time	1661.99	1499.08	0.526
Medicaid (%)	20	18	0.705
Received FA (%)	16	10	0.18
Late-stage cancer (%)	52	49	0.654
College (%)	48	60*	0.088
Married (%)	57	64	0.331
White (%)	94	91	0.324
Female (%)	71	77	0.332
Types of cancer			
Breast (%)	28	37	0.118
Colon (%)	6	9	0.32
Lung (%)	35	28	0.256
Other (%)	32	26	0.319

Conclusions

- Three periods of high needs for composite financial & psychological services
  - Before formal diagnosis; 2 years after diagnosis; 6 years after diagnosis
- Time periods call for targeted interventions
  - Financial services: ~1 year of diagnosis
  - Psychological services: before diagnosis; 2-6 years of diagnosis
- Current screening overlooked the following at-risk groups: younger, higher income, better educated, yet lower insurance coverage.
- Infrastructure changes needed: → Enable earlier and more effective help
  - Proactive screening
  - Better integration of existing data within the system

Session 2 Discussion