atlas

Advancing Health Equity for Cancer Patients: A Hospital & Health System Perspective

A WHITE PAPER BY ATLAS HEALTH

Abstract

Providing opportunities for all individuals to achieve their full health and wellness potential is a top organizational goal for many hospitals and health systems, with significant commitments from leadership and finance.

Unfortunately, hospitals and health systems struggle broadly to measure and manage patients' financial distress. Furthermore, they have difficulty delivering financial assistance services to cancer patients in a way that's integrated and coordinated across the care continuum. NCI-Designated Comprehensive Cancer Centers offer a range of financial services implemented by a broad group of staff and providers. These include separate teams by treatment modality, inpatient and outpatient social workers, insurance treatment authorization, financial counselors, financial navigators, nurse navigators, physicians, advanced practice providers and care teams.

Clinical operations and cancer physician leaders need multifaceted, multidisciplinary approaches. Collaboration with community not-for-profit foundations and adoption of technology to augment the Electronic Medical Record are required to create comprehensive, scalable patient assistance programs that will reduce cancer patients' financial burden across the care continuum and increase equitable access to care.

Contents

Advancing Health Equity by Addressing Cancer Disparities

Health equity is the opportunity for all individuals to achieve their full potential in all aspects of health and wellness. The CDC defines cancer health equity as "every person's equal opportunity to prevent cancer, find it early, get proper treatment and follow up after treatment is completed."

CANCER DISPARITIES

Cancer Disparities: A Chartbook[1] illustrates the cancer disparities in the US, saying, "Despite the fact that US cancer death rates have decreased by 26% from 1991 to 2015, **not all Americans have benefited equally from the advances in prevention, early detection, and treatments that have helped achieve these lower rates**. Significant differences persist in cancer incidence, survival, morbidity and mortality among specific populations in the US. Research shows that racial/ethnic minorities and other medically underserved groups continue to have higher cancer rates and are less likely to be diagnosed early or receive optimal treatment compared to other groups. Individuals of lower socioeconomic status also suffer disproportionately from cancer and other disease burdens compared to individuals with higher socioeconomic status, regardless of demographic factors such as race/ethnicity".[2]

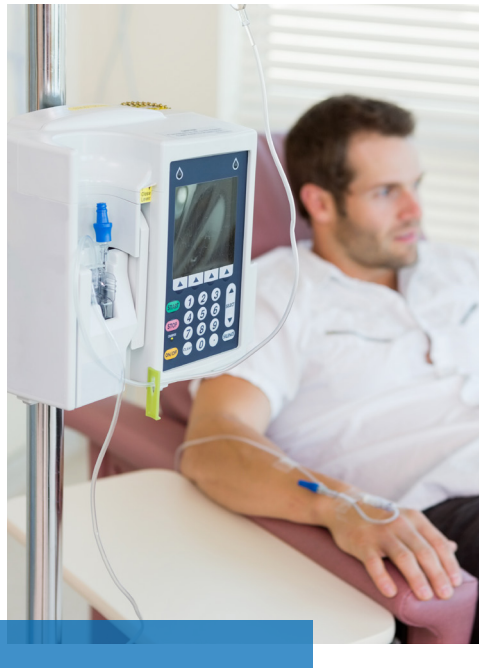
Social determinants of health (SDOH) refer to the circumstances in which people are born, grow up, live, work and age, the systems in place to deal with illnesses, and the distribution of money, power and resources they experience on global, national and local levels. Addressing social determinants of health reduces cancer-related health disparities and advances health equity. Eradication of inequalities among these determinants is the goal, but in the interim, individual-focused interventions that improve equitable access to cancer prevention, detection and treatment resources are beneficial.

Standard assessments of social factors can be integrated into the EMR or reported using evidence-based validated surveys.[2] Still, screening for non-medical, health-related social needs such as housing instability, food insecurity and transportation is not yet standard clinical practice. Health systems frequently struggle to collect the relevant data, review patient needs, identify referral options and track community referrals surrounding social determinants of health.[3] However, as providers adopt and integrate tools that gather and connect patient data captured via registration, claims and visits, the more they can leverage tools like Atlas Navigator to match and enroll eligible patients with available programs.

Financial Toxicity

Financial toxicity describes problems cancer patients experience related to the cost of treatment. Financial toxicity impacts people with all types of conditions, but oncology patients are among the most common sufferers. Many cancer survivors report difficulty paying medical bills, high financial distress and delaying or forgoing care altogether because of cost. Cancer care spending has increased in recent years due in part to targeted therapies, immunotherapies, advanced imaging, supportive care, longer treatment durations and more treatment combinations.[4] **National patient economic burden, including out-of-pocket and time costs associated with cancer care, was estimated to be $21.1 billion in 2019 across all cancer diagnoses, cancer stages and phases of care.** The economic burden is highest for patients in the first 12 months after diagnosis and the 12 months before death. Out-of-pocket costs were generally higher for younger patients and patients diagnosed with later-stage disease.[5]

Patients receiving radiation therapy as a stand-alone treatment or as part of a multimodal regimen received the Comprehensive Score for Financial Toxicity questionnaire, a patient-reported outcome tool, three months post-final radiation treatment. As a result of radiation therapy, **40% of patients faced financial distress, and 10% had a loss or decrease in income** as an indirect consequence.[6] In another study, **22% of patients experienced financial toxicity** related to radiation treatment. Of those, **28% attributed financial distress to loss of job, 24% to a loss of income, 20% to difficulty paying their rent or mortgage, 15% to difficulty paying for transportation and 13% to difficulty paying for meals.**[7]



The number of global patients receiving chemotherapy is expected to increase from 9.8 million to 15 million over the next two decades.[8] Patients receiving systemic chemotherapy are more likely to experience financial toxicity than those receiving only radiation therapy or surgery due to the greater duration of treatment and high drug costs.[9] Compared to a decade ago, cancer patients receive more expensive chemotherapy and biologics, both alone and in combination. Infused chemotherapy and supportive drugs covered under patients' primary medical benefits entail high out-of-pocket costs that are growing as infusion care continues to shift from community-based infusion centers to hospital-based outpatient departments. Oral cancer drug-based treatment regimens, covered under patients' pharmacy benefits, include expensive oral specialty drugs that likely have the highest tier cost sharing.[10]

Clinical trials are vital to developing novel therapies for patients with cancer, yet less than 7% of eligible patients participate, with the elderly, uninsured and minorities among the most underrepresented. Although the Affordable Care Act requires coverage of routine costs for patients participating in clinical trials, patients experience additional financial burdens due to more frequent clinical visits, testing, travel and missed work.[11] These challenges can rapidly compound, resulting in financially toxic situations that only introduce more stress into patients' lives and reduce the likelihood they'll discuss their financial situation or seek and continue care altogether.

Financial toxicity has been linked with several clinically relevant patient outcomes, including quality of life, symptom burden, compliance and survival.[12] Given the relationship between financial toxicity and poor clinical outcomes, it's clear that all cancer patients would benefit from early and continued financial distress assessments and access to interventions that reduce financial burdens.

While validated screening tools to assess financial toxicity exist, they're not uniformly deployed. **37% of NCI-Designated Comprehensive Cancer Centers could not estimate the number of patients who experience cancer-related financial hardship**, and **50% of the centers reported that patients were reluctant to ask for financial help when needed**. While most NCI-Designated Comprehensive Cancer Centers offer a range of patient financial assistance programs, not all hospitals leveraged their full potential[13]:

40% reported a lack of staff awareness around available programs

46% reported unclear workflows to match patients and programs

76% of respondents screened patients routinely for financial distress

18% screened occasionally

6% did not screen at all

The American Association of Community-Based Cancer Centers (ACCC) has also established Financial Advocacy Service Guidelines that recommend screening and monitoring patients regularly for risk of financial toxicity.[14] Unfortunately, many community-based cancer practices don't have the resources to implement patient distress screening, have concerns about integration complications and lack expanded patient support services such as outpatient financial counselors, navigators and social workers.

The Path to Equity and Access

Reducing financial toxicity requires a multifaceted, multidisciplinary approach. The COVID-19 pandemic has created additional challenges for patients and families due to unemployment, loss of insurance, expenses associated with hospital and intensive care unit admissions and expensive medications.[15]

The Levine Cancer Institute (LCI) provides all oncologic services for Atrium Health with more than 40 hospitals and 900 offices, delivering care to 18,000 new patients over 200,000 annual visits in North Carolina, South Carolina and Georgia. As a proof-of-principal study, they created a Financial Toxicity Tumor Board (FTTB), bringing together over 40 physicians, nurses, financial counselors, nurse navigators, social workers, pharmacists, pharmacy technicians and administrators every month to review patient cases. Cases were triaged based on acuity and severity. The board developed a systematic approach involving review of need for new infusion patients and existing patients with drug regimen changes. Pharmacy technicians were virtually embedded in clinical practices to track and coordinate oral oncology drugs and verify prior authorizations. Patients were referred to the FTTB for management by staff and physicians, as well as patients who screened positive for financial toxicity using an electronic self-assessment tool. In 2020, LCI secured over $60 million in drug credits for 749 patients and $1.4 million in copay assistance for 1,000 patients.

The Cleveland Clinic Cancer Center developed a proactive, multidisciplinary approach to reducing patients' financial burden with impressive results. In 2018, 10,939 patients were scheduled for consultation, with a 6–7-day median time to appointment. Of the patients seen, 7,960 proceeded with treatment, and 35% (2,754) needed financial assistance. **The Financial Navigation Program secured copay assistance for 464 patients ($1,121,849), free medication for 1,048 patients ($11,171,779) and $188,000 of philanthropic funds. Time-to-treat was also reduced from 39 days to 26 days.**[16]

Increasingly, hospitals and health systems seek to collaborate with entities outside of healthcare for additional support and solutions to reduce financial toxicity. One example is Housing for Health, a Los Angeles County Department of Health Services program that provides housing to patients who are homeless and experiencing complex health issues. An evaluation of the program found that inpatient services decreased by approximately 75% among participants and, after accounting for housing costs, participants' total social service and health care costs decreased by approximately 20%. Another example is the American Cancer Society (ACS) which partners with health systems, private transportation vendors and lodging partners to help cancer patients minimize barriers to care during treatment. To help increase equitable access to care for patients with cancer, establishing funding sources and increasing collaboration needs be a high priority.[2]

While there are thousands of patient assistance and social support programs offering billions in funding every year, connecting cancer patients to philanthropic medical aid is challenging. Providers lack visibility into which patients need support, the specific programs that will help and automated program enrollment and re-enrollment processes. Programs vary dramatically, with different eligibility rules, enrollment requirements and reimbursement processes. Available funds from programs fluctuate frequently and require real-time monitoring. Many organizations attempt to navigate this complexity manually but often lack the dedicated resources, efficient logistics and a comprehensive database to access aid programs effectively at scale. Collaborating with philanthropic organizations through technology solutions can help to bridge these gaps, expanding access and improving outcomes.

Conclusion

There are approximately 17 million cancer survivors in the US. Those who experience financial distress have an increased mortality risk and often experience lasting adverse effects from their cancer and associated treatment. Compared to those without a history of cancer, survivors are at greater risk for new cancers, disease progression, chronic conditions, out-of-pocket health care expenditures and work limitations.[17] These challenges amplify the need for provider and policy solutions to protect cancer patients from financial harm.

At Atlas Health, we see the state of health equity among cancer patients as a critical opportunity for providers to connect patients and philanthropic aid programs that ensure they get the essential treatment and post-treatment support they desperately need.

Atlas Navigator matches patients with more than **20,000 philanthropic medical financial aid programs** and helps distribute more than $30 billion in annual funding to make healthcare more affordable and accessible to every American.

Want to learn more about how we can help you and your patients?
Visit us at Atlas.Health.

ABOUT ATLAS

Atlas Health automates philanthropic aid to improve access, affordability, outcomes and health equity for vulnerable populations. Through intelligent matching and enrollment to 20,000 philanthropic aid programs, healthcare organizations can improve patient outcomes and reputation, increase cash and reduce staff administrative burden. Learn more at Atlas.Health.

REFERENCES:

1. Cancer Disparities: A Chartbook https://www.fightcancer.org/policy-resources/cancer-disparities-chartbook
2. Understanding and addressing social determinants to advance Cancer Health Equity in the US: A Blueprint for Practice, Research, and Policy Kassandra I Alcaraz, PhD, MPH, Tracy L. Weidt, MPH et al doi.org/10.3322/caac.21586
3. Developing electronic heath record (EHR) strategies related to health center patients' social determinants of health Rachel Gold, PhD, Erika Cottrell, PhD, MPP et al J AM Board Fam Med. 2017 doi:10.3122/jabfm.2017.04.170046
4. Medical Hardships among cancer survivors in the United States Zheng Z, Jemal A Hanx et al 2019:125(10):17371747 doi.org/10.1002/cncr.31913
5. Annual Report to the Nation on Status of Cancer, Part 2: Patient Economic burden associated with Cancer Care K.Robin Yabroff PhD et al JNCI J Natl Cancer Inst 2021 doi:10.1093/jnci/djab192
6. Financial Toxicity: A side effect of Radiation Therapy for Cancer? Tjash T. Patel, MBA, Joshua D Palmer, MD et al digitalcommons.pcom.edu
7. Patients undergoing Radiation Therapy are at risk of Financial Toxicity: A patient based prospective survey study Joshua D Palmer, MD, Tajesh T. Patel MD et al https://pubmed.ncbi.nlm.nih.gov/29726359/
8. Estimates of global chemotherapy demands and corresponding physician workforce requirements for 2018 and 2040: a population based study Lancet Oncology 2019; 20(6):769-780 doi.org/10.1016/S1470-2045(19)30163-9
9. Breaking the bank: Financial Toxicity in Cancer https://www.pharmacytimes.com/view/breaking-the-bank-financial-toxicity-in-cancer-care
10. NIH National Cancer Institute Financial Toxicity and Cancer Treatment www.cancer.gov/about-cancer/managing-care/track-care-costs/financial-toxicity-hp-pdq
11. Recognizing the Financial Burden of Cancer Patients in Clinical Trials Ryan D. Nipp, Elizabeth Powell, et al NThe Oncologist 2015:20:572-575 doi.org/10.1634/theoncologist.2015-0068
12. Financial insolvency as a risk factor for early mortality among patients with cancer Ramsey SD, Bansal A, Fedorenko et al J Clin Oncology 2016;34:980-986 doi.org/10.1200/jco.2015.64.6620
13. Current Practices for screening and management of Financial Distress at NCCN Member Institutions Nadita Khara MD, MPH, Jessica Sugalski MPPA et al J Nat Comp Care Netw 2020:18(7) doi.org/10.6004/jnccn.2020.7538
14. Association of Community Cancer Centers Financial Advocacy Network, Financial Services Guidelines www.accc-cancer.org/docs/documents/publications/financialadvocacyservicesguidelines.pdf
15. Levine Cancer Institute Financial Toxicity Tumor Board: A Potential Solution to an Emerging Problem Derek Raghavan, MD, PhD, Nicole A. Keith, BS et al JCO Oncology Practice DOI doi.org/10.1200/OP.21.00124
16. Patient Financial Burden: Considerations for Oncology Care and Access. One Organizations approach to addressing financial Toxicity Kimberly Bell, BSN, MBA Melisa Monak, CPC, CHONC, ROCC et al Managed Care Volume 28, No 7 July/August 2019 lsc-pagepro.mydigitalpublication.com/publication/?i=610934&article_id=3454299
17. Financial Toxicity Can Be Deadly for Patients with Cancer https://www.valuebasedcancer.com/issues/2020/december-2020-vol-11-no-6/2841-financial-toxicity-can-be-deadly-for-patients-with-cancer