ASCO’s Quality Training Program

Project Title: Decreasing the Risk of Financial Toxicity in an Ambulatory Oncology Practice

Presenters: Thomas Hensing, Tyler Bauer, George Carro, Anna Palafox, Margaret Whalen

Institution: NorthShore University HealthSystem, Kellogg Cancer Center

Date: 1/26/2017
Problem Statement

0% of NorthShore University HealthSystem Kellogg Cancer Center patients routinely receive information on financial risks of high cost cancer therapies, as well as available financial support services, resulting in significant financial and overall distress and compromised informed decision making.
Institutional Overview

NorthShore University HealthSystem (NSUHS)

• 4 hospital integrated health care system in northern suburbs of Chicago
• 3 outpatient Kellogg Cancer Centers (KCC)
• Academic affiliation with University of Chicago
• Total employees: ~55 MDs and 200 staff
• ~4000 new cancer patients per year
• QOPI certified in 2012 and 2015
# Team Members

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Role</th>
<th>Discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theodore Mazzone, MD</td>
<td>Project Sponsor</td>
<td>Department of Medicine Chair</td>
</tr>
<tr>
<td>Thomas Hensing, MD</td>
<td>Team Leader</td>
<td>Medical Oncology</td>
</tr>
<tr>
<td>Tyler Bauer, MBA</td>
<td>Core Team Member</td>
<td>Assistant Vice President, NSUHS</td>
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<tr>
<td>George Carro, RPh</td>
<td>Core Team Member</td>
<td>Director, KCC Pharmacy</td>
</tr>
<tr>
<td>Margaret Whalen, RN</td>
<td>Core Team Member</td>
<td>Navigator, GI Oncology</td>
</tr>
<tr>
<td>Anna Palafox, PharmD</td>
<td>Core Team Member</td>
<td>KCC Pharmacy</td>
</tr>
<tr>
<td>Kendall Chaney</td>
<td>Team Member</td>
<td>Patient Financial Advocate</td>
</tr>
<tr>
<td>Laura Lenski, RN</td>
<td>Team Member</td>
<td>Collaborative RN, Thoracic Oncology</td>
</tr>
<tr>
<td>Cindy Geaslin</td>
<td>Team Member</td>
<td>Director, Patient Financial Services</td>
</tr>
<tr>
<td>Yousuf Azhar</td>
<td>Team Member</td>
<td>Health Information Technology</td>
</tr>
<tr>
<td>Bruce Brockstein, MD</td>
<td>Team Member</td>
<td>KCC Director, Co-Sponsor</td>
</tr>
<tr>
<td>Oncology Patient Advisory Board</td>
<td>Project Oversight</td>
<td>--</td>
</tr>
<tr>
<td>Holley Stallings, RN, MPH, CPH, CPHQ</td>
<td>QTP Improvement Coach</td>
<td></td>
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</tbody>
</table>
Patients not receiving information regarding financial risks of cost of treatment

Vague information (i.e., "expensive treatment")

Need for consistent information regarding treatment costs

Providers unsure of cost of treatment

Insurance Value information

P.O.C.

Time

Uncomfortable discussing financial risks with patients

Need for consistent communication to collaborative team

Expectation that providers will fix the issues (i.e., always succeed in appeals)

Uncertain of prior authorization work flow

Time to approval for compassionate use drug

Providers

Time from treatment recommendation to financial advocate's review

Financial advocate not made aware of treatment

Financial advocate challenges (work load, late notifications, etc.)

Inconsistent means to document/consent (conversation, understanding, agreement)

Patient-specific information (labs, pathology, genetics, etc.) not available

Inconsistent means to document/consent (conversation, understanding, agreement)

Process

Time limitation in informed consent process

Long approval process/checking on status of P.A.

Time to approval for compassionate use drug

Expectations for quick start to treatment

Need for consistent consent methodology re: cost of treatment

Limited teaching tools re: financial risks/costs

Lack of cost transparency

Value information

P.O.C.

Insurance

Providers

Patient anxiety/focus on need to start treatment ASAP

Patient embarrassment re: financial status

Provider difficulty communicating with insurance company

Confusion re: insurance coverage

Changes in insurance policies - Who is informed?

Financial risk not spelled out in current consent form

Insurance pre-authorization delays/insurance turnaround time

Incomplete or inaccurate registration

Knowledge & access to insurance requirements (need for tool to collect critical information)

Process

Patients

Patients not receiving information regarding financial risks of cost of treatment

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Diagnostic Data – Survey Results

- Lack of cost/value information
- Patient anxiety
- Uncertain/inefficient prior auth process

50%
Increase to 65% the proportion of oncology patients receiving information regarding financial risks of and available resources for high cost treatments (immune checkpoint inhibitors (ICI)) as part of the informed consent process by January 2017.
## Measures (Primary & Secondary)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Primary: Proportion of patients receiving information regarding risk of financial toxicity of immune checkpoint inhibitors (ICI) at time of informed consent</th>
<th>Secondary: Proportion of patients starting treatment with an ICI after prior authorization decision</th>
<th>Secondary: Time from treatment plan placement to prior authorization decision</th>
<th>Secondary: Proportion of patients starting treatment with an ICI who have a documented pre-treatment RN teaching visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient population</td>
<td>Medical oncology patients starting treatment with an on-label ICI</td>
<td>Medical oncology patients starting treatment with an on-label ICI</td>
<td>Medical oncology patients starting treatment with an on-label ICI</td>
<td>Medical oncology patients starting treatment with an on-label ICI</td>
</tr>
</tbody>
</table>
| Calculation Methodology | **Numerator:** Number of patients with documentation of financial risk discussion at the time of informed consent prior to starting treatment with an ICI  
**Denominator:** Number of patients starting treatment with an ICI | **Numerator:** Number of patients starting treatment with an ICI after prior authorization obtained  
**Denominator:** Number of patients starting treatment with an ICI | Time from treatment plan placement to confirmation of prior authorization decision by Patient Financial Advocate | **Numerator:** Number of patients starting treatment with an ICI who have a documented pre-treatment RN teaching visit before cycle 1 day 1 of therapy.  
**Denominator:** Number of patients starting treatment with an ICI |
| Data Source | EMR (EPIC) | EMR (EPIC) | EMR (EPIC) | EMR (EPIC) |
| Data Collection Frequency | Weekly | Weekly | Weekly | Weekly |
| Data Quality | Very accurate, no limitations, discreet data | Very accurate, no limitations, discreet data | Very accurate, no limitations, discreet data | Good, not discreet |
## Baseline Data

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-intervention (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of patients receiving information regarding risk of financial toxicity</td>
<td>0% (0/20)</td>
</tr>
<tr>
<td>Proportion of patients beginning treatment after prior authorization decision</td>
<td>50% (10/20)</td>
</tr>
<tr>
<td>Time from treatment plan placement to prior authorization decision (days)</td>
<td>Mean 7 (range 0.03 – 45)</td>
</tr>
<tr>
<td>Proportion of patients who received RN teaching visit prior to cycle 1</td>
<td>25% (5/20)</td>
</tr>
</tbody>
</table>
## Prioritized List of Changes
(Priority/Pay – Off Matrix)

<table>
<thead>
<tr>
<th>High Impact</th>
<th>Easy</th>
<th>Difficult</th>
</tr>
</thead>
</table>
| • Develop patient financial education tool to be delivered and discussed at the time of informed consent *(PDSA #1)* | • Revise prior-authorization work flow *(PDSA #2)*  
• Hire additional Patient Financial Advocates | |
| Low Impact | • Develop functionality to measure and monitor patient financial toxicity using the COST quality-of-life tool *(PDSA#3)* | • Incorporate ASCO Value tool (or similar tool) into the informed consent process *(PDSA #4)* |
# PDSA Plan (Test of Change)

<table>
<thead>
<tr>
<th>Date of PDSA Cycle</th>
<th>Description of Intervention</th>
<th>Results</th>
<th>Action Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 8/1/16 – ongoing</td>
<td>Develop OPAB(^1)-approved education tool to be provided to the patients regarding financial risks and available support services</td>
<td>Good improvement. By week 12, 53% of patients with documentation that financial risk addressed at the time of informed consent</td>
<td>Expand utilization of the financial educational tool to all high-cost infusional and oral medications</td>
</tr>
<tr>
<td>2. 8/1/16 – ongoing</td>
<td>Revise the process for prior authorization of infusional therapies in the cancer center</td>
<td>Excellent improvement. Prior authorization obtained in 94% of patients in intervention cohort prior to cycle 1. Third patient financial advocate hired by cancer center.</td>
<td>Revise prior authorization work flow to include oral cancer therapies</td>
</tr>
<tr>
<td>3. 10/1/16 – ongoing</td>
<td>Develop functionality to measure financial toxicity using the COST QOL tool</td>
<td>Survey of intervention cohort initiated January, 2017 using paper forms and validated SOP.</td>
<td>Build capability to administer through EHR portal</td>
</tr>
</tbody>
</table>

\(^1\)Oncology Patient Advisory Board
Cancer treatment is constantly evolving. Recent technological advances have made it possible to identify genetic changes, known as mutations, in the DNA of a cancer cell. Several immunotherapies (cancer treatments that use your body’s own immune system to help fight cancer) are FDA approved for treatment of cancers with specific genomic (the study of genes and their functions) profiles. Prior to initiating treatment with immunotherapy it is important to address and acknowledge several relevant issues regarding these treatment approaches.

1. Treatment recommendations are evidence-based (treatment backed by scientific evidence) and take into consideration possible benefits as well as toxicities.

2. We will need to verify your insurance information to ensure that we have the most recent data in our system. Please immediately notify us of any changes in your insurance coverage.

3. Please note that your health insurance may not cover the cost of the recommended immunotherapeutic drug, therefore we recommend that you contact your insurance provider to determine eligibility and in-network status.

4. Kellogg Cancer Center Patient Financial Advocates will contact your insurance carrier to review coverage. If this treatment is not covered by your insurance, we will review other options to help with the financial burden and appeals will be submitted when prior authorization is denied.

5. Kellogg pharmacy staff will work with industry foundations to determine available resources including free or reduced cost drug and financial support.

6. Efforts will also be made to obtain immunotherapeutic drug for compassionate use (use of an investigational product not approved by the FDA) basis.

7. Confirmation of treatment schedules will be reliant upon approval status and/or drug availability.

If you have any questions or concerns regarding this information, please contact a member of your care team or the Kellogg Patient Financial Advocates listed below.

Evanston Kellogg Cancer Center
Natalie Pawlicki
847-570-1825

Glenbrook-Highland Park Kellogg Cancer Centers
Kendall Chaney-Ward
847-503-1181 Glenbrook
847-480-4724 Highland Park
Patients Receiving Financial Information at the Time of Informed Consent

Goal = 65%

PDSA#1 – Implement Financial Risk Patient Education Form

Week

Mean  Actual Value  Lower Control Limit  Upper Control Limit

Goal = 65%

53%
PDSA 2 - Revised Process Map

NorthShore University HealthSystem
Kellogg Cancer Center
Treatment Pre-Authorization Workflow &
Revised

Patient referred for treatment
Consult appointment scheduled (in/out of network)
Insurance verified (PSA, RN, Navigator)
Consult appointment completed, treatment plan determined (MD)
Patient informed that pre-auth will be completed & that there are other options if insurance denies. Financial Information document provided to patient & documented via smarttext (RN)
InBasket to PFA (Pool for pre-auth utilizing Aspara smarttext (RN)
Treatment plan populated in PCC work queue report
Pre-auth initiated (PFA)

Patient Treated
Treatment Cycle One, Day One, consent signed (MD, RN)
Teaching session appointment, consent signed (RN)
Teaching session & treatment scheduled (Collaborative RN & PSA)

Approved?
Yes
InBasket to MD & RN (PFA)
End
No
Pre-auth pending?
Yes
InBasket to MD & RN (PFA)
Further information provided to insurance
No
Pre-auth pending?
Yes
InBasket to MD & RN (PFA)
Further information provided to insurance
No
Denied?
Yes
InBasket to MD & RN (PFA)
Conversation with patient regarding next steps (self-pay & drug replacement) (MD, RN, PSA)
Apply for drug replacement (PFA)
Approved
Yes
Free drug received
End
No
Appeal?
Yes
Further information provided to insurance (MD, RN, PSA)
No
End

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American Society of Clinical Oncology
PDSA 2 - Revised Prior Auth Process

Baseline

Revised

NorthShore University Health System

Kelloqq Cancer Center
Treatment Pre-Authorization Workflow B

Patient referred for treatment
Consult appointment scheduled PSA, RN, Navigator
Insurance verified PSA
Consult appointment completed, treatment plan determined MD
Patient informed that pre-auth will be completed & that there are other options if insurance denies RN
InBasket to PFC for pre-auth RN
Verbal communication to PFC for pre-auth RN
Added to Excel Workbook PFC
Pre-auth initiated PFC
Treatment plan created MD
Treatment plan populates in PFC work queue report

NorthShore University Health System

Kelloqq Cancer Center
Treatment Pre-Authorization Workflow A Revised

Patient referred for treatment
Consult appointment scheduled PSA, RN, Navigator
Insurance verified PSA
Consult appointment completed, treatment plan determined MD
Patient informed that pre-auth will be completed & that there are other options if insurance denies. Financial Information document provided to patient & documented via smarttext RN
InBasket to PFA Pool for pre-auth utilizing kollect smarttext RN
Treatment plan populates in PFC work queue report
Pre-auth initiated PFA

Treatment plan created MD

Teaching session

American Society of Clinical Oncology

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## Change Data

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-intervention (n=20)</th>
<th>Post-intervention (n=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of patients receiving information regarding risk of financial toxicity</td>
<td>0% (0/20)</td>
<td>53% (9/17)</td>
</tr>
<tr>
<td>Proportion of patients beginning treatment after prior authorization decision</td>
<td>50% (10/20)</td>
<td>94% (16/17)</td>
</tr>
<tr>
<td>Time from treatment plan placement to prior authorization decision (days)</td>
<td>Mean 7 (range 0.03 – 45)</td>
<td>Mean 6 (range 0.06 – 22)</td>
</tr>
<tr>
<td>Proportion of patients who received RN teaching visit prior to cycle 1</td>
<td>25% (5/20)</td>
<td>41% (7/17)</td>
</tr>
</tbody>
</table>
Change Data – PDSA 2

Proportion of Patients with Prior Authorization Before Starting Immunotherapy

Introduction of revised prior authorization workflow
Economic Impact

• Average drug cost per patient per dose: $7,363.57
  – Minimized potential risk to patient/organization
    • Total = $125,180 for post-intervention group

• Justification for additional Patient Financial Advocate
Next Steps/Plan for Sustainability

- **Continue monthly meeting of the financial toxicity working group**
  - Provide continuous feedback to medical staff and patient financial advocates to continue improvement in the prior authorization process

- **Enhance EMR (EPIC) functionality**
  - Improve communication with treating teams and patients on status of prior authorization

- **Develop educational initiatives for medical staff**
  - Prepare to use the ASCO value tool at the time of informed consent
Conclusions

• Although the primary aim was not met, the proportion of patients receiving information about financial risk and available cancer center financial support services at the time of informed consent increased from 0% to 53%.

• The revised prior authorization process increased the proportion of patients starting treatment after prior authorization from 50% to 94%.
Lessons Learned

• Importance of a multidisciplinary QI team that has representation of relevant stakeholders in order to effect change

• The involvement of patients and their caretakers at the beginning of the QI project improved acceptance of the patient financial educational tool by the medical teams
**Project Title:** Decreasing the Risk of Financial Toxicity in an Ambulatory Oncology Practice

**AIM:** Increase to 65% the proportion of oncology patients receiving information regarding financial risks of and available resources for high cost treatments (immune checkpoint inhibitors) as part of the informed consent process by December, 2016.

**INTERVENTION:** Conduct a QI project to improve patient education regarding risk of financial toxicity and available financial support services at the time of informed consent for selected high-cost therapies.

**RESULTS:**
- Although the primary aim was not met, the proportion of patients receiving information about financial risk and available cancer center financial support services at the time of informed consent increased from 0% to 53%.
- The revised prior authorization process increased the proportion of patients starting treatment after prior authorization from 50% to 94%.

**CONCLUSIONS:**
- The revised prior authorization process increased the proportion of patients starting treatment after prior authorization from 50% to 94%.

**NEXT STEPS:**
- Continue monthly meeting of the Financial Toxicity working group
- Establish ability to track patient financial toxicity through the NCCN Distress and COST tools
- Prepare medical staff for incorporation of the ASCO Value Tool into the informed consent process.