ASSOCIATION OF COMMUNITY CANCER CENTERS

FINANCIAL ADVOCACY NETWORK

Financial Advocacy Services Guidelines Virtual Town Hall

Wednesday, April 25, 2018

Question & Answer Summary

Association of Community Cancer Centers

The Association of Community Cancer Centers (ACCC) Financial Advocacy Services Guidelines Town Hall on Wednesday, April 25, 2018, prompted dynamic discussion and Q&A. This document summarizes the questions that were addressed during the Town Hall. Over 60 questions on the topic of Financial Advocacy Services were submitted.

FINANCIAL ADVOCACY SERVICES GUIDELINES TOWN HALL PANELISTS

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Access the ACCC Financial Advocacy Services Guidelines Virtual Town Hall on-demand at
accc-cancer.org/home/learn/financial-advocacy

Note: The following Q&A summary has been lightly edited for clarity.

What is the delineation between financial advocacy and social worker?

Clara Lambert: In my practice we have financial navigators and a social worker, and we try to make sure we are not overlapping and doing the same work. Primarily the social worker does counseling and also assists with resources. Once she does get to the point of sharing resources, she gets involved in making sure she is communicating with the financial navigation team. We (the financial navigators) do the main portion of insurance education with the patients, insurance optimization, basically anything to do with their treatments. When it comes to resources for living expenses, travel, transportation, and lodging – that's where overlap occurs, and we just work together.

How would you describe the organization of the cancer care team and how they collaborate with the advocates/counselors?

Lori Schneider: From what I have seen across the U.S., there are a lot of different models out there. We see social workers doing authorizations or having these conversations, but we also see places where the financial advocates are doing that work – and none of those models are wrong. It's just important that the patient is being taken care of in some form or format. As we continue to get this education out, hopefully these financial advocate roles will continue to grow to help our patients across the United States.

Clara Lambert: Most of this ongoing training can be accessed through ACCC.

What are the most important topics for a person to start with for training and education?

Eric Dallara: Everyone has a different view on how they do it. The ACCC Financial Advocacy Boot Camp is the best thing for new people to do. We have used the ACCC Boot Camp with our new advocates. We also do a two-to-three month job shadow with our current advisors and financial advocates—learning how to apply the NCCN Compendium, which can be difficult, and also learning how to deal with insurance companies on the phone – understanding the lingo and how to get through to an insurance specialist. Having experience is nice to have, but it's hard to find someone with all the experience.

Clara Lambert: It can be hard to find someone with experience when needed. I second Eric on the ACCC Financial Advocacy Boot Camp. We are a regional medical center, so we have two financial advocates here and some at regional centers. All of us have taken the Boot Camp. There are also consultants you can hire to come on site and do training. It is expensive, but it can be worth it. Finding other resources that pertain to financial advocacy or patient navigation are really great. They may not be as in depth as the Boot Camp, but you also need to know how to navigate a patient. You can see that from our [financial advocates] past lives. We have people with education in pharmacy, clinical education as nurses, pharmacists, social workers, and people like me who have a business degree. We are all able to put it all together.

Do you have examples of tools you have created?

Lori Schneider: Something our team has done is create what we call "benefits sheets." The benefits sheet explains what a deductible is, what a co-pay is, what co-insurance is, and what out-of-pocket (OOP) is. We also use it to research and find out what of the [required] amount the patient has met, and to get the most up-to-date information before we go talk with the patient so that we can explain what those are and where they are at. Explaining what out-of-pocket maximum is versus what treatment cost is, is way better. Treatment cost is too overwhelming for patients, so we want to focus on what their out-of-pocket cost is. This is our initial meeting with a new patient about foundation assistance, patient assistance from pharmaceutical companies or what other resources are available to financially help the patient during this difficult time.

Is it recommended more to discuss estimated cost of treatment or rather what the out-of-pocket expense is for that patient, based on their plan coverage?

Lori Schneider: If I were a patient, I would only want to know what I have to pay. I would run scared the other way if I really knew that it was hundreds of thousands of dollars being charged to the insurance company. We focus strictly on what does that patient have to pay. And we can educate the patients up front as well, to let them know you are going to see what the cost is but please know that that is not what the insurance is going to pay, nor what will be your out-of-pocket cost. It's important that a patient understands that.

Eric Dallara: Eventually they will get the statement in the mail; so they will know how much it costs after the fact.

What are the tools you utilize to ensure insurance optimization?

Clara Lambert: A lot of what I use from the past is the knowledge I have gained. Understanding how Medicare Works – to include Parts A, B, D, and Advantage plans. Understanding when a Medigap plan vs. an Advantage plan would be best for a patient. I personally have financial navigation software that we have been starting to test and pilot. There are people out there creating tools to help us find resources for our patients as well.

What is your process in searching financial assistance and what is your first step once you have the diagnosis code?

Clara Lambert: Once I have the diagnosis code, in my practice here, I just do financial navigation because the insurance verification is already completed. So, I know that the treatment the patient is going to have is already covered by insurance, and we are looking at what their out of pocket is. Not only is the diagnosis code important but what the insurance is, in determining the path for getting patient assistance. One of the first things I do with the medications is look at NeedyMeds, and it will tell you what the programs are – that's usually my first step. Then, we also have two financial advocates, and so we split it up by diagnosis. My partner works on certain diagnosis and I work on certain diagnosis, too. You get to know the assistance programs after a while, knowing what's open and what's closed.

How do you coordinate face-to-face meetings as opposed to the phone? We have trouble ensuring we meet with patients in person given the volume of patients we have.

Clara Lambert: We try to coordinate this through our group chemo education class and the oral chemo education class, so we try to coordinate meetings around the classes because the patients are already here. We do talk over the phone with patients but if we are going to do an application many times, we need the patient to be here because we have additional documents to submit like tax returns and those kinds of things. I really encourage an in-person meeting if you are going to be applying for any assistance.

Lori Schneider: Our patients have their own individual "chemo teach" appointments, and we have our financial advocates meet with the patients after that appointment. To ensure that we get notified, we put a note on their appointment line, to "call Susie at this number" when the patient is ready so that we are catching that patient before they leave.

How do you go about putting together the payment plan?

Clara Lambert: I try to find all of the assistance available first. Then we look at the payment plan, after we have estimated how much assistance they will have and what their true cost should be. And the plan is a written agreement signed by the patient.

Eric Dallara: We have an activity built into our EMR that the business office has to sign off on, so they make sure the drug is authorized and there is not a huge out of pocket for the patient. On the oral side, we are lucky enough to have our pharmacy in-house dispensing. All three of our sites send all their prescriptions to our pharmacy first, and then we do the benefits investigation. If it needs

prior authorization, we do all of that, which can save days. We do it; it takes us 10-20 minutes: we send it out; it could take three days before all of that is done. When we send something out, the financial assistance has been figured out. It's a lot easier to keep control.

What services are offered for tracking, if any? Do they integrate with electronic medical records (EMRs)?

Clara Lambert: A lot of places use spreadsheets. There are two navigation software tools that are being developed that include tracking. It is very important to track your work. We have foundations opening and closing, and when you are working with a patient, their foundation might be closed. Also, you need a way to track which patients these are, because when the program opens again, you will want to get a hold of the patients to help them apply as quickly as you can. The two programs I know of are TailorMed and Vivor. Vivor is working on integrating with Epic and TailorMed is looking at integrating with Aria, but they are not totally integrated yet.

Eric Dallara: It is especially important nowadays—when foundations are opening and closing all of the time and we need to know how much money is in the account for new applications. It has been a challenge for us.

What services are offered for pre-authorization, if any?

Lori Schneider: We use the benefits sheet to talk to the patient up front. Our team gets the treatment information needed to get the authorization needed before patients start treatment. We use Epic so we put in an authorization expiration date, then there is a trigger built in the EMR that lets us know two weeks before that date to get another authorization if needed.

What steps can you take to show very basic impact of this kind of role?

Clara Lambert: Tracking is huge, but I also saw in the poll [live polling conducted during the virtual Town Hall] that was tracking was noted as one of the hardest challenges. Starting with a basic spreadsheet is a good start, and even tracking how many patients you have met with and the total amount of the grant you got for the patient. It might not be the true cost you have saved the patient, but it gives you an idea of how you helped the patient. I have a spreadsheet that has about 10 tabs.

Eric Dallara: One way we track free drug is through a dummy code that goes to our billing department so that we can have an idea of how much free drug we have gotten for people pretty quickly and easily.

Lori Schneider: There are different ways to get information for all of the things that we track – some are spreadsheets, some are reports that we get out of Epic. There is no easy way, right now, for us to track everything that we need. We are feeling the same pain as everybody else right now – it's a lot of manual figuring out to have the information you need in hopes that one day we will have a system that integrates all of it for us.

What is the most effective way to work collaboratively with specialty pharmacies who in a sense also work as financial advocates to get patients in need onto any patient assistance, co-pay assistance, or foundation financial assistance programs?

Eric Dallara: The biggest piece of advice is to try and deal with as few of them as you possibly can. With some, you don't have a choice; you have to deal with them. Try to push the envelope and get a point person you can talk to – your nurses will love you for it. If you have a contact person, that's great. If you have an in-house pharmacy, that's even better because all of the Medicare prescriptions you will be able to fill. Making sure that prior authorization is done, and all of the pieces of the puzzle are managed before you send it off, that can really save a lot of time.

Lori Schneider: We do the same thing as well. We go ahead and get the authorization in place before the prescription is sent. We talk to the patient and [get] the co-pay assistance application started. Then we reach out to the contact at the specialty pharmacy and say, "Hi. Here is the prescription along with the enrollment into the foundation and other required documentation." We request that our pharmacy contact person let us know when dispensing. We will then know when the patient will be receiving their medication and we can get the patient in the clinic for a toxicity check which will help with their medication adherence. Having a key contact person in each of the specialty pharmacies is huge in expediting these prescriptions.

What are tips to get approval for this position?

Eric Dallara: I was fortunate enough that we already had these positions when I started, but the bottom line is they pay for themselves – financial advocates pay for themselves. The amount of co-pay assistance they get, increased access to care for the patient, is great. Another big piece of it is, it's hard to give someone your financial story; it's hard enough for the patients to give us their financial story – including how much they make, how much they get, everything. It's even harder to give it to someone over the phone who they have never met before. They are already trusting us with their care, so it's a huge service to have for patients to have that security and comfort.

What is the most effective way to stay current on all the changes constantly going on in the world of healthcare laws and coverage?

Eric Dallara: If someone knows, please tell me. I think you have to have a lot of different tools to keep a good eye on it. The ACCCExchange and the Financial Advocacy Forum on My Network have been great. COA (Community Oncology Alliance) has a good website and a good blog to keep up with. OBR (Oncology Business Review) is one of the big ones I like to use – every day, they send a couple of updates and usually there will be some changes there. All of our financial advocates also joined the local insurance company providers' newsletters. If there are any changes to the plans, they will get an update for that. With that information they can plan for the change and see what patients it will affect.

Clara Lambert: We try to keep in contact with our healthcare system's Advocacy Department. ACCC has a newsletter as well as newsletters from insurance companies, your state hospital association, your state hematology and oncology association, national associations … I get a lot in my email. The Leukemia and Lymphoma Society (LLS) is pretty active as far as advocating for health insurance policy.

What is the best way to ensure the financial navigator is received as part of the team (inside and outside of oncology)?

Lori Schneider: Some of what we do, in order to help others outside of our team to understand the role we play, are slide presentations. These are just short presentations at other department meetings and staff meetings to say, "Hey, we are one big team, and we are behind the scenes and we do all of this stuff to help patients as well." This really helps the rest of the staff be brought in, that as soon as a patient states any concern about insurance or financial [issues] — it's like red, flashing lights — "get somebody from Financial and quick!" They know we can talk about it. It's important to talk to our providers as well. We do touch base with them regularly, as far as what patients need. New providers coming in, specifically, need some one-on-one education about the role we play, because it's such a big part of the team that's behind the scenes helping the patient.

What is the average number of patient referrals or the case load for a financial advocate/counselor?

Eric Dallara: For face-to-face, our counselors see about five to ten people a day. As far as authorizations and co-pay assistance and everything, that's about 15 a day for each advocate per day. It's a workload. It's a full day, that's for sure.

What are various models of financial advocacy that are being used across the nation at cancer centers?

Lori Schneider: Right now, we are seeing social workers, RNs, financial navigators, nurse navigators, authorization teams. I spoke to a cancer center that has six different teams providing these services for patients. In our area we have one team that is a one-stop-shop for patients. We do everything from checking the benefits to getting the authorizations for everything that our oncology physicians order; to getting any kind of financial assistance, foundation assistance, patient assistance; all the way to medication and appeals—if the medication gets denied—on the backside. We fill out applications for patients as well. We are kind of the one-stop-shop where everything is combined in one role. There is nothing wrong with the way everyone is doing it, as long as patients are getting what they need and getting some help. That's the key to helping and starting the program.

Any advice or examples to show how having an in-house dispensing pharmacy will benefit the clinic and the patients?

Eric Dallara: Access is obviously a big thing. I couldn't tell you how many times we have had people get medications sent out to mail-order pharmacies and come back and say, "Oh, we are not taking it. That's too expensive – what's our co-pay?" Then we find out the outside pharmacy did not apply for a grant or a co-pay card, which is a simple thing to do. To have that point person [in pharmacy] is a huge piece of it. We see people between every cycle, so we catch dose changes ahead of time and don't fill the medications. People are constantly bringing in bottles of full drugs to us that were filled at mail-order pharmacies. We [our pharmacy] would not have done this, because we have the capability to make dose changes prior to the patient getting the next cycle of medication, which is huge. Mail-order pharmacies don't often do this. Our patients love it [the in-house pharmacy]. A lot of times we also do antibiotics for people, so if they are here getting hydration they do not have to go to the pharmacy and pick up their prescription which probably won't be ready. There are a lot of benefits and also for the nurses – we are able to answer a lot of their questions. It has been great.

Have you ever developed a productivity model for your staff?

Eric Dallara: Not yet.

Clara Lambert: No, not yet.

Lori Schneider: I think we are just mastering knowing what we need to be tracking before we can figure out exact productivity. We can monitor month to month the volume of scan authorizations or medication authorizations that come through, so we have some of that, but we have not held the team to a "you have to do this much or this has to happen".

Does anyone know of financial assistance for radiation therapy costs?

Clara Lambert: That's a good question. The Leukemia and Lymphoma Society does help with treatment costs, so if radiation is part of that treatment plan and it's one of their covered diagnoses – yes. There are also some smaller foundations that I have found for breast cancer that do have assistance for medication expenses and they don't specify drug treatment. I just recently applied with a patient, I don't know if it is approved but we are trying it.

Lori Schneider: Check your local foundations. Foundations in your community may help with those bills in some way whether it be that radiation bill or another bill for the patients so that they have the ability to pay for the radiation.

Additional questions raised by Town Hall participants will be addressed in the online ACCC Financial Advocacy Network Forum. Check the forum weekly for new discussions.

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The Association of Community Cancer Centers (ACCC) is the leading advocacy and education organization for the multidisciplinary cancer care team. ACCC is a powerful network of 24,000 cancer care professionals from 2,100 hospitals and practices nationwide. ACCC is recognized as the premier provider of resources for the entire oncology care team. For more information visit accc-cancer.org or call 301.984.9496. Follow us on Facebook, Twitter, and LinkedIn, and read our blog, ACCCBuzz.

The ACCC Financial Advocacy Network is the leader in providing professional development training, tools, and resources that will empower providers to proactively integrate financial health into the cancer care continuum and help patients gain access to high quality care for a better quality of life.

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