Interventions for Financial Toxicity: More Crucial Than Ever in the Time of COVID-19

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As the science of cancer treatment in the United States continues to exponentially accelerate and treatment becomes more personalized (and expensive), the impact of the financial aspects of cancer care has increasingly been recognized as a major determinant of outcomes.^{1,2} Previous research in this area has well-described the problem and shown that financial distress, or “financial toxicity,” is associated with nonadherence to treatment that extends not only to medications but also to all aspects of medical care, which can lead to worsened outcomes.^{3–6} Therefore, it is imperative that work in the field moves from a descriptive to an interventional paradigm.⁷ Although true change can only come from a policy perspective, currently, effecting real change on patient circumstances falls to institutions.

This is an especially important consideration in the current global environment. The COVID-19 pandemic represents an unprecedented health and economic crisis that will have far-reaching implications on patient care. Patients with cancer are a particularly vulnerable population for the virus, with increased risk of severe illness and mortality that will potentially increase healthcare utilization.⁸ At the same time, the economic impacts of the response to the disease may be equally impactful, with more than 21 million Americans filing for unemployment in the week ending May 16, 2020.⁹ This will impact both household income and insurance coverage. Therefore, evaluating current practices and attempting to identify areas of improvement have great value, because these systems will probably be needed even more in the times ahead.

In this issue of *JNCCN*, Khera et al¹⁰ present the results of their survey of NCCN Member Institutions regarding the current state of financial distress management practices, perceived barriers and leadership attitudes regarding implementation of these practices, and the impact of incremental financial burden associated with clinical trial participation at these centers. This is important work and gives us a glimpse of the “real world” implementation of financial screening and assistance, which is so often understudied and reported on in the literature.

The major takeaway from the study is that although it is encouraging that most of the centers are screening for financial distress (76% of the centers screened regularly and an additional 18% screened occasionally), large variations remain in all aspects of care. This includes variation in the extent of screening, the populations screened, the screening tools used, and the services offered to those in need. For example, only half of the centers screened patients multiple times during their treatment course, and 25% only screened targeted groups of patients (eg, elderly, those with multiple comorbidities, those with certain types of insurance) or patients receiving certain types of treatment. This is concerning because we know patients’ circumstances are likely to change through their treatment course, from both disease-related and external factors. This means that a significant portion of patients is probably being missed if not screened regularly. We also know from previous studies that targeted screening is likely to miss a significant number of younger and underinsured patients, which leads to disproportionate outcomes.¹¹

These variations were also seen in the screening tools and services offered. In terms of screening tools, Khera et al¹⁰ found that 50% of the centers used the NCCN Distress Thermometer and 19% used a dedicated financial distress questionnaire. This lack of

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standardization is unfortunately a reoccurring issue in this type of research and leads to difficulties when comparing different approaches and results. Finally, all of the programs surveyed provided basic financial assistance, such as help with drug costs, meal or gas vouchers, and payment plans, but other services, especially higher-level or more-intensive services, were not offered uniformly. Although the needs of each center's patient population obviously vary, there are several well-described approaches, such as financial navigation, that will hopefully begin to be implemented as standard of care.¹²

So, what can be done to improve these issues? As has been extensively documented, the current healthcare policies in the United States are complex and too often lead to significant financial hardships. Although we should continue to strive and work for systemic change, these issues are unfortunately likely to persist in the short term. Therefore, in the setting of the current health and economic crisis, efforts will need to be concentrated on helping individual patients at an institutional and provider level. We can think of these areas of improvement as falling into 3 categories: standardization, evaluation, and cooperation.

Standardization in screening and services offered is critical to moving forward and improving outcomes. Particularly needed are short-form screening modalities that can be applied in a busy clinical environment. Although the COMprehensive Score for financial Toxicity (COST) measure is valuable and the only validated tool in evaluation and quantification of the degree of financial toxicity,¹³ we need a more rapid process if we hope for greater implementation. In terms of services, as discussed previously, several well-described interventions exist that could potentially impact diverse patient populations if implemented, such as financial navigation. These types of services also have the potential to be offered remotely, which is more important than ever with the current need for social distancing.

Evaluations of interventions and defined metrics for improvement have also been somewhat lacking. Preintervention

and postintervention surveys and patient satisfaction are important metrics, but there is a definite need for a shift to evaluating hard outcomes, such as disease-free and overall survival, which will demonstrate the incredible value of this work. This will also help to identify the highest-impact interventions, which will be important when incorporating this type of research into best practices and quality initiatives.

The last area of important evaluation is defining costs to the system and patient with these interventions. In almost all published data, these interventions lead to net savings from a system perspective, which can help build enthusiasm for widespread implementation.

Cooperation is the final essential area of improvement. Financial toxicity/distress research has thus far been primarily institution-specific, with almost no multi-institutional trials performed. Although local variations in care delivery are expected, we know from all other areas of cancer care that cooperation is the key to advances for the greatest number of patients. It is past time for conducting financial toxicity/distress research in large cooperative trials, as is done for all other high-impact interventions. Devising interventions and solutions for issues faced by community practices—where the needs are sometimes greater and resources less abundant than at the traditional academic hospital environment—also needs greater emphasis.

Overall, the excellent work by Khera et al¹⁰ in this issue could not be more timely or relevant. By defining the current practice, we are better able to identify urgent areas of need and move forward with greatly needed interventions. Hopefully, this will lead to continued refinement of our processes, and ultimately to real improvements in patient outcomes.

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