



Why Member Navigation in Cancer Care is a Health Equity Issue

How can payers deliver better and more appropriate oncology treatments to the populations who need them most? It starts with conversation, connection and compassionate care.



Contents



Introduction

Cancer care is evolving fast and furious, driven by breakthroughs in everything from diagnostic tools and DNA sequencing to biosimilars, immunotherapies and treatment approaches.

Last year alone, the U.S. Food and Drug Administration (FDA) issued 43 drug approvals for oncology, including 12 that were first-in-human molecules.¹ Such relentless innovation has been a boon to patient outcomes. The American Cancer Society estimates that the U.S. cancer death rate has dropped 33% since 1991, which translates to 3.8 million deaths averted.²

But there's no question that the fast-expanding oncology landscape has meant more complexity – and more cost. Cancer is now the top driver of health care costs for large U.S. employers, the Business Group on Health found.³ And globally, cancer drug spend is expected to nearly double over the next 5 years, reaching \$377 billion in 2027.⁴

The rising costs and complexity of cancer care often exacerbate the long-standing inequities that disproportionately impact patients of color, as well as LGBTQ+ patients and those living in rural areas and with lower incomes. Push past the banner-worthy decline in overall cancer mortality, for instance, and one finds a landscape dotted with disparities.



\$209+ savings

per member with cancer, per month when patient navigation services were used, compared to treatment costs without such services.⁵

Robust member navigation won't level those inequities entirely. But navigation does present a powerful tool for payers to address those inequities, to better ensure that all members feel empowered in their cancer journey and are guided toward the right treatment at the right time.



In the pages to come, we explore how member navigation has the potential to break down barriers to access, strengthen patient medical adherence, reduce cancer spend for payers and save member lives. Consider this a roadmap to equity-driven cancer treatment.

The many dimensions of cancer disparities

From clinical research to oncologist proximity, guideline adherence to financial burden, health inequities can be an invisible force in every stage and at every touchpoint of a patient's cancer journey.

17% higher mortality rate across all cancers are faced by rural Americans, compared with their urban counterparts.⁶ Though roughly 1 in 5 Americans reside in rural areas, only 3% of medical oncologists practice in rural communities.⁷

2x to 4x increase in mortality for Black men with prostate cancer, compared with all other racial and ethnic groups.⁸ Black men have the highest cancer incidence rate of any racial or ethnic group in the United States.⁹

95% of medical oncologists report they're comfortable treating lesbian, gay and bisexual patients, yet only 53% report they're confident in their knowledge of the health needs of these cancer patients.¹⁰

Never-smoking Chinese American women have **2x** the age-adjusted rate of lung cancer incidence compared to white women. Though Asian individuals have the lowest rate of developing any type of cancer, compared with other racial or ethnic groups, cancer is the leading cause of death for Asian Americans.¹¹

The odds of women with cervical cancer in the lowest socioeconomic quintile receiving guideline-adherent care is **32% less** than those in the highest socioeconomic group.¹²

The median additional delay for radiotherapy for Black women with breast cancer experience is **66 days more** (204 days total) compared with white women (138 days). Black women also face longer time to initiation of endocrine therapy and longer delays for chemotherapy and surgery.¹³

Less than 3% of clinical trial participants are Black and Hispanic.¹⁴ Yet research shows that, when offered the opportunity, Black patients participate at similar rates to white patients.¹⁵

There's an **18% higher likelihood** that liver cancer patients living in socially vulnerable areas (lower socioeconomic status, higher language barriers, housing challenges) did not receive surgical interventions shown to potentially improve cancer outcomes.¹⁶ The difference was particularly marked for Black and Hispanic patients.¹⁷

A closer look at cancer care's complexity

Eradicating health inequities in a static ecosystem would be challenging enough. But given how swiftly and substantially cancer care is evolving, health payers must adopt dynamic strategies that take into account cancer care's many dimensions. Here are some of the factors upending business as usual for oncology.

More diagnoses

Even as cancer mortality rates decline, the number of Americans facing a cancer diagnosis is inching upward.¹⁸ The American Cancer Society projects there will be 1,958,310 new cancer cases in the U.S. this year, about 40,000 more than last year.^{19,20}

Increased life spans, stronger screening promotion, and improvements in detection and diagnostics all contribute toward better odds of survival following a cancer diagnosis.

But other factors may be putting more people in the crosshairs – and earlier. Though advancing age remains the most important risk factor for cancer overall – with the median age of diagnosis being 66 years old²¹ – research shows a dramatic increase, since the 1990s, in early-onset cancer diagnosis among people younger than 50.²² No lone factor is responsible the trend, with researchers pointing to a complicated interplay of potential factors, from diet and the microbiome to environmental exposures.

More gaps in provider knowledge

Considering most cancers are discovered in primary care settings,²³ helping providers keep pace with the rapidly changing cancer landscape should be a clear imperative. Yet research suggests many non-specialists may be working with information still rooted in their medical school days. When asked to estimate survival rates for the 12 most common forms of cancer, most non-oncologists made accurate estimates for only 2 of the types.²⁴ They were also far more pessimistic than their oncology counterparts when weighing in on specific clinical scenarios.

While general practitioners may not quarterback a patient's cancer treatment, those early interactions do set the tone for how a patient approaches their cancer journey, as well as how swiftly they move from diagnosis to treatment. And even after treatment is underway, the importance of that relationship typically endures. One-fourth of patients looking to

mitigate negative side effects from cancer treatment said their primary care physician was the only information source they consulted.²⁵





66%

of oncologists expect “technology-driven recommendations based on data” will shape treatment decisions a decade from now, putting data-fueled tech at the top of list, ahead of discussions with scientific communities or discussions with peers.²⁶

More patient choices – and confusion

A cancer diagnosis has always been fraught with high emotions and high stakes. But the flood of recent medical breakthroughs means cancer patients can face a dizzying number of treatment options and new terminology. That confusion may persist well through treatment, too. When asked how immunotherapy works in a multiple-choice format, for instance, almost half of cancer patients responded that they didn’t know or weren’t sure, and only 32% selected the correct explanation.²⁷

Barriers are even higher for those with lower health literacy. Without tailored education and guidance, they may be effectively forced into the backseat of managing their care. That’s a missed opportunity considering the well-established truism that patient participation has the potential to improve cancer outcomes.²⁸

More costs for cancer care

It’s hard to overstate how dramatically costs for cancer care have risen in the U.S. in recent years. National costs for cancer-related medical services and oral prescription drugs hit an estimated \$183 billion in 2015.²⁹ By 2030, it’s projected to exceed \$245 billion – an increase of roughly 34%.³⁰

The uptick in incidence rates plays a part, but the largest driver is per-capita treatment costs.³¹ While a six-figure cancer drug might have raised eyebrows in the early 2010s, such launch prices are now routine. One study of Medicare beneficiaries found that, while the proportion of people receiving cancer care was unchanged between 2016 and 2020, drug costs roughly doubled, jumping from \$9,325 to \$18,761 per person in just 4 years.³² If trends continue, some estimate that by 2026 launch prices could hit \$325,000 (for pills) and \$525,000 (for biologics).

In response, payers are doubling down on cost control tactics, such as shifting infusions to lower-cost settings, requiring drug sourcing from specialty pharmacies and increasing prior authorization requirements. Meanwhile, employers are demonstrating renewed interest in narrow networks and centers of excellence. But both stakeholders understand such measures must be implemented in concert with health equity goals.

5 pillars of equity-driven member navigation

As cancer care evolves, payers must address its complexities head-on. One powerful approach to improving health outcomes, health care utilization and health equity: strengthening member navigation.

The classic example of the power of patient navigation is The Harlem-based pilot program Harold Freeman, MD, launched to improve survival rates for low-income Black women with breast cancer. By pairing each patient with personalized support, the program boosted the five-year survival rate to 70% from a dismal 39% at the program's inception.^{33,34}

Further study has made clear the benefits of navigation support ripple far beyond patient health. In the CDC's Project ECHO rural cancer pilot, 92% of providers reported that they benefited from the navigation program.³⁵ And in a large-scale study of patients with cancer, researchers found navigation support meant costs \$429 less per member, per month compared with patients without access to such programs.³⁶

Still, not all navigation programs are created equal. For health plans looking to bolster health equity, not simply through ad hoc initiatives but as part of a holistic and expansive strategy, here are the 5 pillars that set the best programs apart.

1 One-on-one support

A cancer diagnosis typically kicks off a flurry of appointments and procedures – each a potential hurdle for patients with limited resources, restrictive work schedules or low health literacy. Connecting members with a single point of contact, such as an experienced oncology nurse advocate, can streamline the cancer care landscape dramatically.

This dedicated resource can help coordinate care, collaborate with providers and bridge any health literacy gaps that might otherwise threaten their treatment plan. One-on-one support – rather than an impersonal hotline, for instance – also means that, as the treatment plan unfolds and the patient's health and circumstances change, the case manager is best poised to continuously assess and proactively address social determinants of health (SDOH) barriers to care.

This kind of high-touch, one-on-one support can be incredibly effective at guiding patients to the right care, at the right time. Imagine, for instance, a patient is experiencing a great deal of pain following a

particular procedure. Rather than head to the ER for help, that patient reaches out to their case manager, who is able to swiftly collaborate with providers on a new pain management plan, delivering an update to the patient while they rest at home. The patient not only gets help with their acute pain, they're able to avoid a costly and draining hospital visit, while receiving swifter resolution.



94% satisfaction with nurse

among patients who have taken part in the Optum Cancer Resource Services (CRS) program – with 88% reporting "very satisfied"

2 Personalized communication that reaches members where they're at

A twenty-something gay man living in the city juggling a full-time job and a chronic health condition. An octogenarian living in a rural area who hasn't had a health issue since he quit his pack-a-day smoking habit in the 1970s. Let's face it: Beyond a shared cancer diagnosis, cancer patients may not have much in common. That means if health plans want navigation messaging to actually hit the mark, they must prioritize personalization.

Digital tools are a clear win for many, but maybe not the 42 million Americans who don't have reliable access to internet.³⁷ At the same time, LGBTQ+ individuals may gravitate more than others toward telehealth, as a means of connecting with providers who are registered with the Gay and Lesbian Medical Association or who have a strong reputation among fellow LGBTQ+ patients with cancer.³⁸ Another example: People with lower health literacy may benefit from simple text and illustrations, which research shows can boost informed decision-making and understanding among this group.³⁹

Personalized support also enables a more nuanced assessment of language proficiency. Consider that more than 1 in 5 Americans speak a language other than English at home.⁴⁰ Even if a patient is comfortable handling a doctor's appointment without help, that doesn't necessarily mean they have the proficiency to absorb complex oncology terms and treatment details. Research shows that

cancer patients with limited English are less likely to understand treatment effects, have poorer symptom management and experience higher symptom-related distress.^{41,42}

Equity-centered member navigation replaces the usual one-size-fits-most messaging with more expansive options that are tailored to the patient.

3 Provider partnership

When it comes to successful member navigation programs, integration is the name of the game. By collaborating closely with the care team, case managers can support and reinforce the doctor's treatment plan to drive more seamless coordination of care, provide services the care team may not, such as referrals to behavioral health and EAP programs, while strengthening treatment adherence.

Behind the scenes, provider tools that combine up-to-date information on clinical treatments with personalized information about member coverage mean doctors can determine treatment plans with far less risk of care-plan shifts. That's far more efficient for providers, and means members are presented with a unified plan that's far simpler to navigate.

Here's an example of the power of plan-provider symbiosis. Say a patient experiences unpleasant side effects from her oral chemotherapy and, failing to understand the importance of med compliance, elects to stop taking her medication. When the case manager unearths that update during a routine



touchpoint, coordinating between the provider (to gauge whether an alternate medication may be just as effective) and the payer (to make sure that alternate drug is authorized) is built right into the program.

4 SDOH-related support

Many patients are unprepared for the challenges of cancer treatment and, particularly for underserved and vulnerable communities, need active support navigating the SDOH-related barriers that may interfere with their cancer treatment.

Even when such resources exist, expecting resource-strapped patients facing cancer to seek out these supports is a losing proposition. Instead, equity-driven navigation programs are designed to assess patient needs on an ongoing basis, then proactively connect them with the community-based organizations, health system programs, local resources and other avenues to mitigate those challenges.

Here are a few common barriers to care, along with proactive solutions member navigation programs may take to address them.

Barrier to care

Mitigation strategy



Transportation difficulties

From physical mobility issues to financial constraints, simply getting to an appointment can be a challenge. Every year, 3.6 million people do not access health care services due to lack of transportation.⁴³ Case managers may steer members toward mobile care units or satellite clinics, connect them to medical transport services, or advocate on the member's behalf for telehealth appointments and increased at-home care.



Lack of childcare

A 2020 survey revealed the number one reason women fail to access health care services is difficulty obtaining childcare, outpacing even a lack of health insurance.⁴⁴ Case managers may coordinate emergency drop-in daycare services for treatment days or coordinate telehealth appointments.



Food insecurity

Food insecurity (particularly prevalent for Black, Hispanic and lower-income cancer patients⁴⁵) is associated with lower medication compliance, higher rates of depression and lower quality of life, when compared with food-secure cancer patients.⁴⁶ Case managers may connect patients with community-based organizations, hospital programs or other local resources to directly address this pernicious threat.



Bias or stigma

Eight percent of LGBTQ+ patients report being refused an appointment in the past year due to their sexuality.⁴⁷ Meanwhile, 23% of transgender patients report having been misgendered or referred to by the wrong name.⁴⁸ Case managers may assist in location LGBTQ+-affirming providers or join patients at their appointments for support.⁴⁹

5 Access to the best possible care

Proximity shouldn't be the defining factor in cancer care. This is particularly true of rural members, for whom the very lack of proximity to health care makes care options limited. But this adage is equally true of members of lower socioeconomic status who are more likely to live in areas with underfunded or poorly performing hospitals.

Traveling is one way to expand one's treatment options, of course. But if picking a local provider feels daunting, expanding the geographic search can make the process intimidating to the point of paralysis. For a patient, trying to coordinate insurance approvals, provider appointments and travel logistics adds a potentially insurmountable layer of complexity.

To help open the aperture on oncology access for more members – of any socioeconomic status, in any region of the country – health plans are incorporating Centers of Excellence (COE) into their member navigation efforts. COEs are highly vetted networks of preapproved providers and resources, all centered on evidence-based best practices and patient-centric care. They make seeking a second opinion for a cancer diagnosis or treatment plan far easier than many patients might anticipate, which in turn can help manage care costs and improve outcomes and equitable quality of care.

COE oncology services have been shown to increase diagnostic accuracy, reduce complications, better match types of cancer with pertinent specialists, shorten hospital stays and increase survival rates. And these outcomes aren't limited to those who happen to live within driving distance or have the means to manage their own travel and the health literacy to find and request an appointment. They're available to all.



25% to 42% saved

for health plans that used a COE,
according to Optum internal research

Conclusion

Much like oncologists need a full quiver of treatment options, Optum understands that payers need tailored solutions that fit their needs. Our trio of navigation programs are designed to deliver impact on their own. But when deployed together, the upsides of these programs are amplified – from lower costs and better outcomes to more equitable access and higher member satisfaction.

More than 17 million members actively participate in the Optum® Cancer Support Program, which provides deeply personalized assistance and guides members toward the best possible care for their particular oncology needs. A dedicated oncology nurse is the linchpin of this program, ensuring seamless care coordination while easing barriers that might otherwise threaten a patient's treatment outcomes. The net result? A 10% reduction in medical spend per participant per year and a 6% reduction in hospitalizations.

5-10:1 ROI
for the Optum Cancer
Guidance Program

The Optum® Cancer Guidance Program enables providers to leverage powerful data analytics to cut through the deluge of recent cancer research and identify the most effective treatment options that are also covered by a patient's health plan. Because providers are able to sidestep the usual prior authorization and approvals process, there's less risk of delay or disruption to the treatment plan – a benefit that's made this program particularly popular, with more than 29 million members supported by the Cancer Guidance Program.

Finally, the Optum® Cancer Resource Services program, which has served more than 50,000 members since 2001, connects patients to top-notch cancer care, regardless of where in the country they live or which barriers they may face. And payers that use the COE model save more than 25%, on average, Optum analysis shows.

While cancer affects millions of Americans each year, forward-thinking member navigation services like these can ease the burden on both patients and payers – and foster equity in a system that has long left vulnerable populations in the lurch.

Learn more about [Oncology Management Programs for Health Plans](#).

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