

Peer Review File

Article information: <https://dx.doi.org/10.21037/pcm-21-16>

Review Comments

Reviewer A

Comment 1: The rationale for a health insurance program for CCS is well justified.

Comment 2: A clearer explanation is needed about the role of health insurance in CCS' transition to adult care.

Reply: Thank you for this comment. In the transition to adult care, one typically becomes both responsible for their own medical decision making, and the financial means to do so. As CCS will likely require more frequent medical care and visits than a non-CCS counterpart, an inability to develop and retain the financial means to manage medical care as an adult may substantially limit the health and / or the financial stability of CCS. The ability for young adult CCS to acquire and use medical insurance independently is vital to maintain the ideal medical access.

Changes in the text: We have added additional text to highlight the role of health insurance in CCS transition to adult care in lines 61-69.

Comment 3: Age definition of CCS is needed

Reply: The age definition used in this study is any patient treated by a childhood cancer provider and diagnosed before age 25.

Changes in the text: We have included this definition in lines 73-74 of the text.

Comment 4: What is in the psychosocial assessment?

Reply: This is a series of questions to gather information on a patient's social and psychological well-being. It is a standard practice tool for social workers practicing in healthcare settings.

Changes in the text: Psychosocial assessment has been explained in line 130-131.

Comment 5: Clarify, is this for the pediatric or survivor clinic and what the annual survivor visit structure is. In the text it is mentioned that the health insurance education is also delivered over the phone. The length and structure of this program is unclear.

Reply: The outlined program includes both pediatric and adult childhood cancer survivor clinics. Each annual visit includes time with a medical provider, social worker, and research assistant. If time does not permit completion of discussions during the in-person

appointment, each of the three different persons of the medical team may follow up as needed with the patient by phone.

Changes in the text: In lines 134-135, we have clarified that this program will begin during the patient visits to the pediatric CCS clinic and will continue into their visits to the adult CCS clinic. In lines 194-195, we have modified the verbiage as to how telephone calls are incorporated into the visit structure.

Comment 6: The model is straightforward, but are the topics repeated within each age block? What if patients are diagnosed before age 13?

Reply: Topics may be repeated in each age block depending on the provider's assessment of the patient's comprehension of the topic. As many CCS are diagnosed before the age of 13, many will have completed their therapy course and be referred to the CCS clinic before the age of 13. During their initial visits to the pediatric CCS clinic, most of the initial conversations will be directed towards the patient's parents or caregivers. Once a CCS reaches their teenaged years, conversations will gradually become directed towards the patient, concurrent with the anticipated transition towards independence. An important component of our program is the personalization of the discussions and information delivery, which can be modified to suit the learning style and rate of comprehension of the material of the patient.

Changes in the text: We have modified the manuscript text in lines 150-154 to answer the reviewer's questions.

Comment 7: Conclusions are that they have successfully integrated the health insurance program into their survivorship clinic visits, but no data on this are presented.

Reply: Thank you for this excellent point. We do not intend to relay a message that is perceived as our program instituting an evidence-based practice change. We do not have data yet to support the successful integration of this educational program into our clinical care. The success is based on the ability to change our local institutional practices and successfully incorporate the social work visit into our routine survivor-focused model of care. This was a clinic patient-flow challenge as this change ultimately prolongs the visit time significantly and takes up clinic room availability. We also needed protected time from a social work provider to deliver the educational messages. The manuscript is intended to report on the end product of this journey and our single institution experience successfully operationalizing this practice change that has now become standard clinical practice for our program.

Changes in the text: The "Conclusions" section (lines 178-186) has been rewritten to describe our current perspective on this health insurance literacy program within our CCSP, and to provide some insight into future work that could provide evidence to support the efficacy of this program.

Comment 8: The Recommendations and future directions section is interesting, but unfocused. What recommendations are being made specifically based on lessons learned from this program? Details of the HOWs, e.g. for collaborative learning and standardized workflows, are needed.

Reply: Thank you again for this excellent point, which will result in the reader more easily identifying our lessons-learned. A primary lesson learned is the importance of incorporating this program into routine clinic visits and has found the most value in individual visits with a social worker during a multidisciplinary visit. As medical health insurance is on an ever-changing landscape, we have tried to focus our recommendations broadly, recognizing that too much detail based on current health insurance programs in the United States may limit the applicability of our commentary in the future. We also now discuss considerations for multicentered collaboration, as future areas of program development.

Changes in the text: The *Recommendations and future opportunities* section has been reorganized and additional text added to provide more concrete examples of recommendations in each of the four components of this section. This section is found in lines 184-221 of the body of the manuscript.

Reviewer B

Thank you for the opportunity to review this manuscript. The authors endeavor to provide an overview of why health insurance education and navigation is important for childhood cancer survivors, and they go on to describe the features of their health insurance navigation program. This is such a critical area of study that warrants attention, and I appreciate the authors' efforts to address this important area of need. With that said, there are some minor concerns/comments that I encourage the authors to consider to further strengthen this work.

Comment 1. I appreciate the authors' summary of their program and efforts to improve health insurance knowledge and awareness among childhood survivors. However, it would be helpful to know a bit more about how this program was developed. What did the authors use to inform the content covered at each survivorship visit, and how did they determine the appropriate timing of these conversations? Also, to what extent is support offered beyond age 25? As the authors describe, there is evidence that long term survivors continue to experience concerns about health insurance and financial toxicity along with job lock. How are these long-term concerns addressed or how does the program prepare survivors for these potential concerns?

Reply: Our program used gottransition.com to identify insurance-related transition readiness milestones and the related timing from adolescence into adulthood. This was adapted to CCS using the institution's social work team consensus expert opinion. Additionally, social work support extends to adult-aged CCS covering the lifespan.

Changes in the text: We have included an outline of the program's development in lines 130-133 of the text.

2. The authors state that they have “successfully integrated health insurance education” into cancer survivorship care, however there is a missed opportunity to evaluate the program to determine its acceptability and efficacy. Who is served by this program? What is the percentage of patients identified vs. navigated? Is the program examining any short and long-term outcomes? What are survivors' perspectives of this program and information shared?

Reply: Childhood cancer survivors of any age are served by our CCSP. Medical providers refer almost all patients with a small number being self-referred. We do not have data yet on short and long-term outcomes. Outcomes of interest will include the prevalence of financial toxicity due to inadequate or lack of outcomes of the program's CCS who maintain or lapse in health insurance coverage. Ongoing program evaluation is necessary to improve the quality and adapt the operational delivery of these educational messages in the changing landscape of care delivery that now includes telemedicine and will prioritize eliminating disparities. Now that the program is up and running, the focus will shift to evaluation the program to determine its acceptability and efficacy including survivors' perspectives of this program and information shared.

Changes in the text: Additional text has been added in line 75-76 to show who is served by this program. Additional text has been included in lines 193-197 to discuss future outcomes of interest for program evaluation.

3. The authors describe their approach as interdisciplinary, personalized education, but there is limited information to support this statement.

Reply: Thank you for this comment. The CCSP at our institution includes medical providers as well as social work and other psychosocial support staff to provide a multidisciplinary review and visit at each annual survivorship clinic visit. By incorporating health insurance education into one-on-one visits with a patient's CCSP social worker, the opportunity is created to ensure that the material is provided to a patient in an individualized manner, such that more or less time may be allocated to specific aspects of navigating health insurance as dictated by the patient's needs.

Changes in the text: We have included additional details in lines 157-159 of how to individualize the delivery of some exemplar aspects of health insurance literacy outlined in lines 147-150. We also include discussion as to how the social worker individualizes their approach in lines 141-144.

4. I appreciate the authors' decision to offer recommendations for future direction, however it does feel slightly premature since there is no evaluation of the efficacy of this program. It may be helpful to first provide a summary of challenges and lessons learned with the program (along

with some metrics) before providing recommendations for next steps. Essentially, it is helpful to provide a basis for your recommendations.

Reply: At the present, the objective metrics asked about in this question will be better delineated by ongoing and future research directives for our CCSP. Thank you for this excellent point as we do not intend to relay a message that is perceived as our program instituting an evidence-based practice change. We do not have data yet to support the successful integration of this educational program into our clinical care. The success is based on the ability to change our local institutional practices and successfully incorporate the social work visit into our routine survivor-focused model of care. This was a clinic patient-flow challenge as this change ultimately prolongs the visit time significantly and takes up clinic room availability. We also needed protected time from a social work provider to deliver the educational messages. The manuscript is intended to report on the end product of this journey and our single institution experience successfully operationalizing this practice change as the bases for our recommendations and future opportunities.

Changes in the text: We have added text in lines 203-206 to make this more clear as well as re-written the “Conclusions” section (lines 178-186) to more accurately describe spirit of this manuscript and the information shared.

5. It would be helpful to expand on the vocational counseling that’s provided. Again, there’s evidence that long-term survivors are at risk of experiencing job lock. To what extent does your counseling address this concern?

Reply: Thank you for bringing up this excellent point regarding job lock. This is often addressed by referrals to community-based resources for career development and job counseling that exist through county or related municipalities.

Changes in the text: Additional text has been added in lines 244-249 to address this.

6. Minor comment: The manuscript itself is largely well-written, however there are some minor errors that detract from the content. For instance, there’s some repetition found on page 5, beginning with line 106.

Reply: Thank you. We have modified the manuscript to eliminate any identified grammatical errors and have removed the repetition that was described.

Changes in the text: Two lines of text were deleted around line 111, as they were repetitive with the start of the subsequent paragraph.

Reviewer C

This article provides a model for delivering health insurance education to childhood cancer survivors. The subject is important because health insurance is a key element for access to medical care in the US and financial toxicity is a documented side effect of cancer treatment.

This article provides a model and commentary only as no patients were surveyed or evaluated to assess the impact of the education provided, though the article mentions this would be an important next step. It is difficult to assess bias as there are no outcomes. Also, this program may not be applicable to all survivorship programs if they do not have integrated social work evaluations with survivorship visits. But, survivorship is a growing field and as individual programs look to improve their services and expand, this report provides a useful model for how an integrated social worker can address health insurance education and potentially decrease financial toxicity for survivors.

Reply: Thank you for the comments. We appreciate your thoughtful response to our commentary and agree with the limitations as you have outlined them. We hope that our commentary may raise awareness to this clinical need for CCS and CCSP and may help to springboard future research and national collaborative efforts.