The Construct of Financial Toxicity and Association with Quality of Life in Poor Populations (TH341A)

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Objectives

- Explain three predictors of quality of life for vulnerable populations diagnosed with cancer.
- Illustrate how the construct of financial toxicity may need to be operationalized differently based on the unique needs of vulnerable patient populations.

Original Research Background. There is growing recognition that patient reported outcome (PRO) measures complement traditional biomedical measures in conveying important information for cancer care decision making. With increasing cancer care costs understanding how the cost of medical care affects patient outcomes, particularly for patients in vulnerable populations, is imperative.

Research Objectives. This is a sequential mixed methods study (n=115) that aims to identify financial, psychosocial, and cancer related factors that affect patient outcomes. Our secondary aim was to explore the construct of financial toxicity among the poor and underserved populations diagnosed with cancer.

Methods. Adult (age 18+) patients diagnosed with cancer requiring drug therapy at an infusion center focused on serving uninsured, underinsured and low income patients were enrolled in the PRO study and data was collected at 2 time-points.

Standardized assessment instruments were used including: the Functional Assessment of Cancer Therapy (FACT-G), the CAHPS Cancer Care Survey, the PROMIS NIH (Anxiety, Depression, Fatigue, Pain Interference, and Physical Function), and the Comprehensive Score for Financial Toxicity (COST). Qualitative interviews were conducted to assess the relevance and utility of the COST measure for patient's financial stressors.

Results.

- 61.5% of our study population has a household income less than $25,000 (compared to 21.4% of patients in the national CanCORS II cancer cohort study).
- 20% of our study population had private insurance (compared to 80% of patients in CanCORS II).
- Depression, pain interference, and financial toxicity were found to be consistently significant predictors of quality of life in our study population, controlling for demographics and disease specific variables.

Conclusion. Financial toxicity continues to be a strong predictor of quality of life but qualitative data reveal the specific financial burdens experienced by financially vulnerable populations differ from typical cancer populations reported in the literature.

Implications for Research, Policy, or Practice. Opportunities for future research include creating a validated scale appropriate for poor population.

Caregiver-Reported Concerns and Challenges with Medications: Findings from Structured Interviews with Primary Caregivers of Patients with Cancer (TH341B)

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Objectives

- Describe caregiver-reported challenges to understanding and managing medications when caring for a family member with cancer.
- Recognize and address caregivers' difficulties with integrating and applying information about safe and efficacious medication use.

Original Research Background. For patients with cancer, family caregiver-administrated medication is often essential for high-quality care. While previous studies have focused primarily on analgesics, other medication-related issues may pose challenges for caregivers.

Research Objectives. We conducted a qualitative study to elicit caregivers' concerns about medications to inform future interventions.

Methods. From October-December 2017, we audio-recorded semi-structured phone interviews with 35 adults who were primary caregivers for a patient who died with cancer between July-December 2016. Two analysts independently coded transcripts using content analysis and summarized results as major themes.

Results. Most caregivers were white (91%), female (63%), spouses (89%) with a college education (60%). Twenty-seven (77%) had concerns about medications. We identified three major themes. First, *caregiver overload that impeded understanding*: "I am in shock… I didn't ask the questions. Looking back, there were a lot of things I should have asked." Second, *stigma/fear resulting in under-treatment of patient pain*: "I didn't want to take a chance on overdosing him." "My family is drug-resistant, we don't like to take drugs." Third, *marginalization of caregiver concerns*: "They kept giving opiates which I had objected to but was told it was not my decision…by then they had him addicted." "I did not feel like he was a good candidate… (he) had a blood clot…diabetes, was weak… I asked, 'Do you really think he's a good candidate?'(The doctor) said, 'Yes' so that's what we did, but that was my complaint."

Conclusion. Most caregivers had concerns about managing and understanding medications, and some felt their concerns were not heard by prescribers.

Implications for Research, Policy, or Practice. Family caregivers may have trouble processing information about medications. Acknowledging caregiver concerns may reduce caregiver stress and improve caregiver understanding. Future interventions should incorporate regular inquiries to assess caregivers' understanding of and concerns with medications.

Engaging Primary Care Physicians: Lessons Learned Seeking Buy-In and Patient Referrals for a Home-Based Palliative Care Program (TH341D)

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Objectives

- Describe the factors that may impede primary care physician buy-in and patient referrals for a home-based palliative care program.
- Discuss the lessons-learned and possible facilitators to better engaging primary care physicians in a home-based palliative care program and initiating patient referrals.

Original Research Background. Home-based palliative care (HBPC) is an important model originally developed for managed care. It surpasses the continuity and access barriers plaguing inpatient palliative care by providing palliative care in patients' homes in collaboration with primary care. Repeated studies have demonstrated that HBPC can improve patient outcomes while decreasing costs of care, however, replication of this model in fee-for-service has been stymied by a lack of reimbursement structure. To overcome this barrier, a large California-based health insurer (Blue Shield of California) has begun to reimburse contracting medical group providers for HBPC. However, over 12-months later, primary care physician (PCP) engagement and patient referrals for the HBPC program are dismal.

Research Objectives. The purpose of this secondary mixed-methods study was to explore the impact of PCP outreach efforts by a physician champion for the HBPC program.

Methods. PCPs were identified as practicing in the Sacramento, CA region and having a greater percentage of Blue Shield patients in their practice. The physician champion contacted PCPs to arrange one-hour in-person meetings to discuss the HBPC program. Bi-weekly field notes from the 12-month study period were analyzed using the constant comparison method.

Results. From June 2017-2018, 18 solo practitioners (66.7%) and clinicians at 9 group practices (33.3%) were contacted by the physician champion (average contacts=3). On average, practice sizes were 1,108 patients (±1,050.5; range 210-5,639) with 33% (±7.4%; range 23%-54%) comprising Blue Shield patients. Qualitative findings revealed four themes: overburdened PCPs; fear of losing patient control; facing mortality; and dilemma for mid-level providers (managing patient care in light of PCP oversight).

Conclusion. Findings highlight the specific challenges to engaging PCPs and obtaining their buy-in for a HBPC program and a set of implementation strategies have been developed.

Implications for Research, Policy, or Practice. As increased attention is directed to new payment models for palliative care, results of this study may inform widespread replication of HBPC.

3—4 pm

Education Forums

State of the Science in Pediatric Palliative Care Forum (TH351)

Katharine Brock, MD MS, Children's Healthcare of Atlanta, Atlanta, GA. Christopher Collura, MD MA, Mayo Clinic, Rochester, MN. Margaret Root, MSN RN CPNP-AC CHPPN, UCSF Benioff Children's Hospital, San Francisco, CA. Caitlin Scanlon, MSW LSW, Riley Children's Hospital, Indianapolis, IN. Megan Thorvilson, MD MDiv, Mayo Clinic, Rochester, MN. Pat Weikart, MDiv, Nemours/Alfred I. duPont Hospital for Children, Wilmington, DE.

Objectives

- Discuss with a colleague one new article relevant to the clinical practice of pediatric palliative care.
- Describe a fact, skill or attitude that you are reconsidering based on the information presented at this session.
- Identify a clinical population that your program serves that you could write about to educate the larger pediatric palliative care community.