

Conclusion. Although there is some consistency in POLST forms, significant variation exists in treatment categories and choices.

Implications for Research, Policy, or Practice. Varied POLST forms create differences in life-sustaining treatment options given to patients and/or surrogates based on their state of residence. Greater discussion is needed among healthcare providers, policymakers, and researchers to reconcile this variation.

Impact of Palliative Care Interventions on Health-Related Quality of Life (HRQOL): A Secondary Analysis of the Promoting Resilience in Stress Management (PRISM) Randomized Controlled Trial (RCT) (S870)



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Objectives

1. Review the concept of health-related quality of life as a study outcome.
2. Evaluate the effectiveness of an intervention using patient-reported health-related quality of life as an outcome.

Original Research Background. PRISM is a novel resilience-building intervention for adolescents and young adults (AYAs). Primary analysis of the RCT in AYAs with cancer showed PRISM improved HRQOL.

Research Objectives. Secondary analysis explored changes in HRQOL domains and differences between patient groups.

Methods. English-speaking AYAs (12-25 years) were randomized to PRISM or usual care (UC) from 1/2015 – 10/2016. Surveys were completed at enrollment and six months later, using the Pediatric Quality of Life Inventory (PedsQL) Generic Short Form (SF-15) and Cancer Module to assess HRQOL. We compared change scores (PRISM vs UC) by domain (PedsQL SF-15: physical, emotional, social, school; Cancer: pain, nausea, procedure anxiety, treatment anxiety, worry, cognition, perceived appearance, communication). Participants were stratified by age (12-17 years vs 18-25 years) and advanced cancer status (yes/no).

Results. 74 patients (36 PRISM, 38 UC) completed 6-month assessments. 72% were 12-17 years old. 23% had advanced cancer at enrollment. PRISM improved patient-reported communication (UC: median [interquartile range, IQR] 0 [-17, 8]; PRISM: 8 [0, 25]). Younger patients benefited more, especially in PedsQL SF-15 school (12-17: UC 0 [-8, 0], PRISM 13 [0, 17]; 18-25: UC 0 [-33, 17], PRISM 0 [-25, 17]) and social domains (12-17: UC 0 [-33, 0], PRISM 0 [0, 8]; 18-25: UC 0 [-25, 4], PRISM -17 [-25, 8]), and cancer-specific perceived appearance (12-17: UC -4 [-25, 0], PRISM 8 [-8, 25]; 18-25: UC 0 [-21, 0], PRISM -8 [-25, 17]). Patients with advanced cancer benefited more in cancer-specific domains nausea (no: UC 0 [-10, 15], PRISM 10 [-10, 40]; yes: UC 6 [-15, 25], PRISM 35 [25, 50]) and pain (no: UC 13 [-13, 25], PRISM 6 [-13, 25]; yes: UC -13 [-25, 0], PRISM 6 [-13, 25]).

Conclusion. With PRISM, younger AYAs coped better with age-appropriate challenges and AYAs with advanced cancer improved physical symptom HRQOL.

Implications for Research, Policy, or Practice. Efficacious psychosocial intervention for AYAs.

Recruitment Outcomes Among African-American and Rural Populations with Heart Failure to an Early Palliative Care Clinical Trial (S871)



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Objectives

1. Examine relationships between sociodemographic factors and enrollment status in an early palliative care interventional clinical trial in the Deep South.
2. Describe baseline patient-reported outcome measures of quality of life, symptom burden, mood [anxiety/depression], activation, coping style, social support, self-reported health, health literacy, and spiritual/religious coping.

Original Research Background. Improving minority and underserved rural patient recruitment to palliative care (PC) clinical trials is a high clinical research priority area. We conducted a randomized trial of ENABLE CHF-PC (**E**ducate, **N**urture, **A**dvice, **B**efore **L**ife **E**nds **C**omprehensive **H**earthcare for **P**atients and **C**aregivers) early PC telehealth intervention for persons with heart failure.

Research Objectives. To explore racial (Black vs White) and rural (vs. urban/suburban dwellers) ENABLE CHF-PC participant enrollment rates and differences.

Methods. Using bivariate tests and measures of association, we compared consented and non-consented patients by race and residency status. Among randomized participants we examined baseline differences in sociodemographic/clinical characteristics and baseline patient-reported outcomes (PROs) (quality of life [QOL], symptom burden, mood, resource use, activation, coping style, social support, health literacy, and spiritual/religious coping).

Results. Of 564 eligible patients, 82% (n=461) consented and 90% (n=415) of those were randomized. Of 103 eligible participants who declined, 73.5% (n=75) were White compared to only 25% (n=26) who were Black (d-equivalent =0.57; p<0.01). Of those randomized, 26 % (n=108) resided in a rural area (by RUCA criteria). Among rural residents there was a higher portion of White 58.3% (n_w=63) compared to Black participants 40.7% (n_B=44) (d-equivalent=0.34; p=0.124). Baseline PROs were not statistically different based on rural/urban location.

Conclusion. Higher proportions of Black and rural patients were recruited, relative to the Alabama population (26% African American; 23% Rural). At baseline, patients reported a fair QOL, low anxiety/depression and average pain. Minority and rural patient recruitment is possible despite documented PC disparities.

Implications for research, policy or practice. High recruitment rates of Black patients may be attributable to racial congruence between

recruiters and patients. We found no PRO differences based on racial or rural status; lack of disparities may be due to similar access to care and socioeconomic status.

An Opportunity for Palliative Care: Symptom Burden in Patients with Amyloidosis (S872)



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Objectives

1. Evaluate symptom burden of patients undergoing treatment for amyloidosis.
2. Justify the need for palliative specialists to be a part of standard of care for patients with amyloid.
3. Propose a model for palliative care to be integrated with standard of care for patients with amyloidosis.

Original Research Background. Although significant symptom burden has been described in patients with amyloidosis, few studies have used a validated tool to assess symptom burden or severity. Amyloidosis has many similarities to cancer; prognosis is poor, multiple organs may be involved, and treatment toxicities are common.

Research Objectives. To evaluate baseline symptom severity using the Edmonton Symptom Assessment System (ESAS), and the change in total symptom burden between outpatient hematology-oncology clinic visits in patients with amyloidosis.

Methods. Retrospective chart review of 48 consecutive patients with amyloidosis presenting to a cancer center outpatient clinic. ESAS and Total Symptom Distress Scores (TSDS) representing the combined physical, emotional, and well-being intensities were reported at each visit. Individual ESAS scores ≥ 4 were considered moderate to severe intensity. The minimal clinically important difference (MCID) was calculated for TSDS between first and second visits. Based on past research cutoffs used were $\geq +3/90$ for improvement and $\leq -4/90$ for deterioration. Patients being co-managed with at least one appointment with palliative care (PC) during the study period, were noted.

Results. Baseline ESAS scores were collected on 48 patients with 31 also receiving a second. At baseline 34 (71%) had at least one or more moderate-severe symptoms. Fatigue in 23 (48 %) and insomnia 42% were most common. The MCID for TSDS showed 35% of patients improved while 35% showed deterioration. Only 6 (13%) of patients received palliative care.