RECRUITMENT AND RETENTION STRATEGIES OF CANCER PATIENTS AND THEIR CAREGIVERS IN FAMILY-BASED INTERVENTION STUDIES

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Family-based psychosocial behavioral interventions (PBIs) that target both the cancer patients and their caregivers may more effectively help them with self-care and improve quality of life; however, family-based PBIs often face unique challenges during study implementation. This systematic review aimed to a) examine the recruitment and retention rates of cancer patients and their caregivers in clinical trials testing family-based PBIs; and b) explore the recruitment and retention strategies. We systematically searched five electronic databases to identify randomized controlled trials that tested family-based psychosocial or behavioral interventions among adult patients with cancer and their adult family caregivers. Our searches yielded 48 studies. The average recruitment rates of patients and caregivers were 56.8% (SD=31.8%; range=8-100%) and 54.5% (SD=32.4%; range=8-100%), respectively. The majority of the studies have focused on white and female patients and caregivers. The average retention rate at end of follow-up times was 69.1%. Only 13 studies reported retention strategies, including providing money/gift cards upon returning of each follow-up survey or study completion, and excluding advanced cancer patients. Reasons for attrition, i.e., dropping out of studies, were classified as: health-related (e.g., death, illness, psychological distress), intervention-related (e.g., intervention does not meet expectation, frustration with group allocation, intervention burden) and other reasons (e.g. lack of time, unable to establish contact). Recruitment and retention of patients and caregivers in family-based PBI are integral to the success of interventions. Researchers need to incorporate effective strategies for optimizing recruitment and retention at the planning stage of their studies.

USING MEDICARE DATA TO INFORM INTERVENTION AND CARE DELIVERY FOR THE MOST EXPENSIVE PATIENTS

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Older adults with high medical spend require tailored interventions and care delivery models to meet their complex needs. Segmenting high-spend patients is a promising approach to designing such interventions. In this study we explored patient spend across 4 years (2016-2019) using claims from 799,205 patients continuously enrolled in UnitedHealth Group Medicare Advantage (mean age=73.7; S.E.=0.01). Patients with healthcare spend in the top decile were segmented into three subgroups: catastrophic, persistent, and semi-persistent. Catastrophic patients had more acute events (acute myocardial infarction and hip/pelvic fracture) driving their cost. Persistent patients were younger (mean age=67.8; S.E.=0.06) and had significantly more medications. Semi-persistent patients were older (mean age=76.6; S.E.=0.04) and had significantly more chronic conditions and frailty, indicating their cost was driven by medical complexity. These subgroups displayed different temporal stability in their healthcare costs over time. Each year, 79-81% of the catastrophic group dropped out of the top decile. In contrast, nearly 72% of the persistent group remained in the top decile whereas only 37% of the semi-persistent group remained year over year. As the global population continues to age, it will be necessary to design interventions and care delivery models that address the complex needs of older adults in the high-spend patient population. Our study suggests that segmenting high-spend patients into potentially actionable subgroups is an important first step in achieving these goals.

SESSION 10290 (LATE BREAKING POSTER)

HEALTH CARE

1-YEAR REHOSPITALIZATION AND MORTALITY RATES IN GERIATRIC PATIENTS AFTER ACUTE HOSPITALIZATION

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Hospitalization for an acute illness often leads to accelerated sarcopenia, debility, and loss of independence in geriatric patients. These post-hospitalization effects can further deteriorate health and lead to rehospitalizations and sometimes death. To improve health outcomes in these patients, it is important to determine predictive factors for increased readmission and mortality rates. Data regarding readmission and mortality within 1 year post-discharge were collected from the PACE and GRAMS studies (NCT02203656, NCT02990533) conducted at UTMB Galveston (Jan 2014 - Mar 2019). Readmission and mortality rates were analyzed to find associations with total days hospitalized and total number of readmissions within 1 year, demographics (age, highest education level, BMI, percent fat, baseline SPPB score), and interventions (exercise with protein supplementation, exercise with placebo, protein supplementation, placebo supplementation, and testosterone injection). Of the 175 subjects, 63.4% were rehospitalized and 9.7% died within 1 year. We found that patients who were rehospitalized within a year of their initial hospitalization were over 4 times more likely to die that year than patients who were not rehospitalized. Patients who died within one year had twice the amount of hospitalization within the year and spent three times the number of days hospitalized. Of the interventions studied, a single testosterone injection at discharge from the index admission appeared the most effective to reduce rehospitalizations.