Implementation of a Multisite Financial Reimbursement Program in Cancer Clinical Trials Integrated With Patient Navigation: A Pilot Randomized Clinical Trial

Hala T. Borno, MD1,2; Li Zhang, PhD1,2,3; Sylvia Zhang, MS2; Tracy K. Lin, PhD2,4; Andrea Skafel, MSc2; Elena Nieves, MEd2; Dana Domsife, BS5; Robert Johnson, MD, PhD6; Kim Rhoads, MPH, MD1,2; Eric Small, MD1,2; and Darcy Spicer, MD5

QUESTION ASKED: Does additional telephone-based outreach as part of a financial reimbursement program (FRP) offered during therapeutic cancer trial discussions enhance enrollment in clinical trials?

SUMMARY ANSWER: The IMproving Patient Access to Cancer clinical Trials pilot feasibility trial observed that implementation of a FRP at two comprehensive cancer centers is feasible and can serve a diverse patient population. No difference in enrollment in clinical trials between the two study arms was observed; the proportion of enrollment was 70% for both study arms. The most common reason for not enrolling in a clinical trial was due to ineligibility determined through screening procedures (75%).

WHAT WE DID: Study participants were recruited at two National Cancer Institute–designated comprehensive cancer centers. Participants were randomly assigned 1:1 to receive no follow-up (usual care and brochure) or a follow-up telephone call to facilitate FRP utilization stratified by study site. The brochures were available in English, Spanish, and Chinese (traditional and simplified). A language-concordant researcher or telephone translator was provided for non–English-speaking participants.

BIAS, CONFOUNDING FACTORS: Given this study was performed at two comprehensive cancer centers, there is inherent selection bias in offering these services to patients already seeking care at our sites.

REAL-LIFE IMPLICATIONS: We found that offering a FRP as part of therapeutic cancer clinical trial participation is feasible and serves a diverse patient population. It is associated with high therapeutic clinical trial enrollment overall, and a follow-up outreach telephone call does not appear to enhance enrollment.

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CARE DELIVERY

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PURPOSE Cancer clinical trial participants face considerable indirect costs associated with participation, such as travel and lodging, which may contribute to poor enrollment. Here, we report the findings in IMproving Patient Access to Cancer clinical Trials, a pilot feasibility study investigating the efficacy of offering a financial reimbursement program (FRP) during a therapeutic clinical trial discussion with or without additional outreach in improving patient enrollment.

METHODS Study participants for this study were recruited at two National Cancer Institute–designated comprehensive cancer centers (CCCs) from April 8, 2019, to September 19, 2019. Eligible participants were adults with a cancer diagnosis being approached to consider enrollment in a clinical trial. Participants were randomly assigned 1:1 to receive no follow-up (usual care) or a follow-up telephone call to facilitate FRP utilization stratified by study site. The target enrollment was 132 patients, with 66 patients in each study arm. The primary outcome was the consent rate to the multisite interventional study on the FRP among participants enrolling in clinical trials.

RESULTS The study had a 78% consent rate and enrolled a total of 132 participants, of whom 51% were non-White compared with 28% of CCC treatment clinical trial participants in 2019. No difference in enrollment in clinical trials between the two study arms was observed as the proportion of enrollment was 70% for both study arms. The most common reason for not enrolling in a clinical trial was due to ineligibility determined through screening procedures (75%).

CONCLUSION The current study observed that implementation of FRP at CCCs is feasible and serves a diverse patient population. Future studies will measure the impact of programs on overall clinical trial accrual and among racial/ethnic minorities.

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BACKGROUND

A lack of racial/ethnic diversity among cancer clinical trial participants remains a critical problem. According to the National Cancer Institute (NCI), the majority of participants in publicly funded phase I-III clinical trials are considered ethnically White.1 Specifically, middle-class White patients have traditionally had the highest participation rates in cancer treatment clinical trials.2 While the National Institutes of Health (NIH) promoted greater inclusion of women and racial/ethnic minorities in publicly funded clinical trials through the 1993 Revitalization Act,3 it remains estimated that < 5% of cancer studies adequately represent minority groups currently.2,7,8 These observed disparities are influenced by social factors such as insurance status, neighborhood, and household income.3,9-14

While under-representation in clinical research is well described in the literature, to date, little research attention has been directed at mitigating factors driving these observed disparities.15 Efforts to dismantle barriers to enrollment have largely focused on addressing attitudes, knowledge, and beliefs around clinical trials, with implementation of initiatives to improve patient awareness and access to trials.15-20 Currently, the significance of costs, both direct and indirect, associated with cancer clinical trial participation are increasingly understood. The indirect costs, such as travel, may be considerable for patients in the context of a therapeutic clinical trial...
Interventions aimed to reduce disparities seldom address these added financial burdens. Most studies avoid engaging with financial models to address clinical trial disparities for fear of being perceived as inducement rather than reimbursement.19

Here, we report the findings observed in IMproving Patient Access to Cancer clinical Trials (IMPACT), a pilot study investigating the feasibility of a multisite interventional study offering a financial reimbursement program (FRP) during a TCT discussion with or without additional outreach in improving therapeutic cancer clinical trial (TCT) enrollment (ClinicalTrials.gov identifier: NCT03943082). The objectives of this study were to assess the feasibility of this study design, to test the efficacy of performing follow-up for a sliding scale FRP to improve accrual to cancer TCTs, and to evaluate if a sliding scale FRP improves accrual among racial/ethnic minorities to cancer TCTs by comparing with historical control.

**METHODS**

**Recruitment Methods**

Participants for this study were recruited at two NCI-designated comprehensive cancer centers (CCCs)—the University of California San Francisco and the University of Southern California—from April 8, 2019, to September 19, 2019. Eligible participants for the IMPACT study were adults with a cancer diagnosis being approached to consider enrollment in a TCT. Participants were introduced to the IMPACT study at the time of TCT discussion and were identified by their clinicians. All clinicians at the CCC were made aware of the IMPACT study presentations conducted at clinical research meetings. The researcher then obtained informed consent for follow-up and data collection through the IMPACT study. Participants were randomly assigned in a 1:1 fashion to receive a brochure about a FRP at the time of consent for a TCT (usual care) or receive brochure and additional telephone call by the IMPACT study outreach coordinators after a semistructured script regarding the FRP (usual care plus intervention). The brochures were available in English, Spanish, and Chinese (traditional and simplified). A language-concordant researcher or telephone translator was provided for non–English-speaking participants.

**Sliding Scale FRP**

Before IMPACT, the FRP has been available to patients enrolling in a TCT at the CCC regardless of participation in the IMPACT study. FRP may be offered if patients seek financial support either as a brochure from a provider, clinical trial coordinator, or social worker; however, communication was not standardized before IMPACT. For all patients who receive FRP either through IMPACT or outside of IMPACT, reimbursement receipts are submitted through e-mail, post mail, or fax directly to a centralized reimbursement processor at the Lazarex Cancer Foundation in Danville, California. Representatives from the Lazarex Cancer Foundation contacted the patient to resolve discrepancies and process all claims. The IMPACT study research coordinator served as an onsite integrated navigator for FRP utilization and assisted patients with claim submissions at the patients’ request. Expenses eligible for reimbursement included ground transportation, gas mileage, taxi/rideshare, parking, tolls, lodging, air travel, and a companion’s travel cost.

**Eligibility for FRP**

Participants were eligible for FRP if they submitted an application to the Lazarex Cancer Foundation and provided proof of having a household income ≤ 700% per the 2018 Health and Human Services Poverty Guidelines. Acceptable proof-of-income documents included a copy of income tax return, a copy of the most recent pay stub, unemployment check, and supplemental security income, social security disability, or public assistance benefit notification. If a patient was not employed or could not provide the aforementioned documents, they could submit a signed letter stating their current financial situation.

**Baseline and Follow-Up Measures**

Disease characteristics of study participants including stage of disease and tumor type were collected. Clinical trial characteristics such as phase of study and funding type (eg, internal, governmental, or private) were recorded for each participant. IMPACT study participants completed questionnaires at baseline (time of consent) and follow-up (time of TCT completion as defined by the TCT protocol). At baseline, the following items were collected: sociodemographic details including race/ethnicity, household income, wealth/assets, Comprehensive Score for financial Toxicity Patient-Reported Outcome Measure,20 NIH Patient-Reported Outcomes Measurement Information System (PROMIS) Global Health,21 National Comprehensive Cancer Network Distress Thermometer (DT), 3-item health literacy assessment,22 and Brief Resilience Scale.23 At follow-up, NIH PROMIS Global Health and National Comprehensive Cancer Network DT were collected.

**Primary and Secondary Objective**

The primary objective was to assess the feasibility of a multisite interventional study on FRP among participants enrolling in TCTs. The primary end point was measured as the percentage of patients who signed consent to the IMPACT study out of all patients who are offered enrollment. The secondary objective was to evaluate how FRP may improve cancer TCT accrual through the mechanism of performing intensive follow-up—defined as a follow-up scripted phone call within 3 days of IMPACT study consent. The secondary end point was the percentage of participants who signed consent for a cancer TCT at day 30 by arm out of the total number of patients in each arm, respectively.
Statistical Analysis
Demographic and clinical characteristics were summarized by descriptive statistics. In general, frequency distribution and percentage were used to summarize categorical variables, and mean with standard deviation (SD) was used to describe continuous variables. If the normality assumption did not hold, median with interquartile range was used to describe continuous variables. Comparison of the continuous variables among groups was assessed using the two-sample t-test and analysis of variance for two groups and more than two groups, respectively. If the assumptions did not hold, the corresponding nonparametric tests were applied. The chi-square test was applied to test if there was a statistical association between two categorical variables. The statistical significance was declared at $\alpha < .05$.

Power and Sample Size Calculation
The target enrollment is 132 participants across all sites, 66 participants per site. We estimated an 80% consent rate among patients approached for participation in this study and therefore intended to approach a minimum of 166 patients, which would provide 95% CI (74 to 86) for consent rate. A stratified random assignment was applied, stratified by site (University of California, San Francisco [UCSF] v University of Southern California). With a type I error of 0.1, there was at least an 80% power to detect an increase of 0.2 (eg, 0.30-0.50) in the proportion of patients who consent to participate in a TCT and receive an additional follow-up call compared with those who do not by a directional two-sample proportion test with 66 participants in each arm. Hence, this study had adequate power to detect clinically meaningful improvements in TCT consent rate because of this intervention.

All study procedures were reviewed and approved by the Institutional Review Boards at participating sites.

RESULTS
As shown in Figure 1, 170 patients were approached for the IMPACT study (UCSF = 87, University of Southern California = 83) and 132 provided consent to participate with a study consent rate of 78%. Among approached patients, a subset declined to participate (n = 38), of whom 16 (42%) indicated that they were not interested in receiving assistance or knew they would not qualify for the program. Among patients who signed consent for the IMPACT study (n = 132), 67 patients did not proceed on study with the most common reasons being deemed ineligible for TCT (51%) and not qualifying for FRP (11%). We observed no difference in enrollment in TCT between the two study arms as the percentage of enrollment was 70% and 70% for the usual care and usual care plus intervention arms, respectively. Among 170 patients approached for the study, nine (5.2%) patients were ineligible for FRP before providing consent and 10 (5.8%) participants withdrew because of FRP ineligibility.

The characteristics of patients who signed consent for the IMPACT study are reported in Table 1. We observed a mean age of 57 years (SD = 14 years). Among participants, 57% were male. Overall, the majority (49%) of participants were non-Hispanic White. The other major racial groups were Black (5%), Asian (12%), and Hispanic (26%). Among respondents, 24% reported a household income <$25,000 US dollars (USD), 14% reported a household income from $25,001 to $56,000 USD, 4% reported a household income from $56,000 to $99,000 USD, and 8% reported a household income of $100,000 USD or more. In this study, 31% of respondents reported a high school degree or less as highest education attained. Household income and education level were not collected in 50% of the study population. The insurance types included private (32%), Medicaid (33%), Medicare (26%), and Veterans Affairs (< 1%). The most common cancer types were breast (24%), gastrointestinal (36%), and genitourinary (17%). The majority of patients had metastatic disease (73%). At baseline, the PROMIS Global Physical Health score was 38.9 (SD = 7.9) and the PROMIS Global Mental Health score was 43.1 (SD = 8.0). The mean DT score for participants was 4.7 out of 10. All patient characteristics were balanced between study arms.

As shown in Table 2, 72% of patients reported using private vehicle to travel to clinical trial visits. The time spent to receive care was considerable, with the majority (75%) of study participants reporting > 3 hours to travel and receive care for a cancer care visit; most patients (72%) did not require overnight lodging. The reported out of pocket costs varied across the study population, with 32% reporting <$50 USD per month, 57% reporting between $50 USD and $1,000 USD, and 11% reporting more than $1,000 USD per month. Most patients reported moderate (38%) or significant (30%) financial burden associated with costs of cancer care. Among respondents, 25% reported feeling uncomfortable with discussing finances with their doctor, 35% reported feeling somewhat comfortable, and 40% reported feeling very comfortable.

DISCUSSION
Cancer clinical trials have largely failed to engage and enroll racial/ethnic minorities calling into question the generalizability of these results. In the United States, Black and Hispanic/Latinx patients comprise about 12% and 16% of the US population, respectively; however, these groups each account for < 5% of trial participants. In the IMPACT study overall, 5% of FRP recipients were Black and 26% were Hispanic/Latinx which reflect the demographics of the population cared for at the CCCs. Overall, this study demonstrated that the IMPACT study oversampled racial/ethnic minorities given that only 28% of TCT participants across the CCC have a non-White race/ethnicity. These data suggest that implementing an FRP for ancillary costs of clinical trial participation is feasible at

A Randomized Clinical Trial
CCCs. FRP was observed to be used among a diverse patient population. Future research will examine the effect of an FRP on minority clinical trial accrual.

While telephone-based interventions have been shown to promote healthy behaviors in previous research and are frequently practiced in clinical settings, we did not observe a difference in TCT enrollment between groups on the basis of receipt of an additional telephone call to discuss the FRP. However, we did find a strikingly high proportion of TCT enrollment in both study arms during the RCT, well above the accepted standard consent rate among patients with cancer. Unger et al evaluated 35 studies that offered trial participation to 9,759 patients and observed a consent of 55% overall. Our study observed a TCT enrollment of 70% in both study arms, suggesting that adding a telephone call does not have utility in accelerating recruitment; however, the availability of an FRP in general may accelerate TCT recruitment. We will separately evaluate and report the impact of FRP availability on trial accrual.

As exploratory measures, this study assessed patient burdens, especially as it relates to travel and cost, that may contribute to a lack of diversity in clinical research. Among study participants, the majority of participants (75%) required more than 3 hours to attend cancer treatment appointments, a subset (17%) of who traveled more than 8 hours. This study also observed that one fourth of patients required overnight lodging to receive care in the context of a clinical trial; however, this observation was driven largely by a single study site (UCSF). These data add to the growing body of literature revealing that conventional clinical trials place a high degree of burden on patients. Previous research has shown that the
### TABLE 1. Patient Characteristics

| Characteristic                                      | Overall (N = 132) | Usual Care (n = 66) | Usual Care Plus Intervention (n = 66) | P  |
|-----------------------------------------------------|-------------------|---------------------|--------------------------------------|----|
|                                                     | No.    | %     | No.    | %     | No.    | %     |        |
| Age, mean (SD), years                              | 57 (14) | 55 (15) | 59 (13) | .178 |
| Sex                                                 |        |       |        | .725 |
| Male                                                | 57     | 43    | 27     | 41    | 30     | 46    |
| Female                                              | 75     | 57    | 39     | 59    | 36     | 55    |
| Race                                                |        |       |        | .325 |
| NH White                                            | 65     | 49    | 30     | 46    | 35     | 53    |
| Black                                               | 6      | 5     | 2      | 3     | 4      | 6     |
| Asian                                               | 16     | 12    | 8      | 12    | 8      | 12    |
| Native Hawaiian or Other Pacific Islander           | 1      | 1     | 0      | 0     | 1      | 2     |
| Hispanic or Latino                                  | 34     | 26    | 21     | 32    | 13     | 20    |
| Others                                              | 8      | 6     | 3      | 5     | 5      | 8     |
| Unknown                                             | 2      | 3     | 2      | 3     | 0      | 0     |
| Household income, USD                               |        |       |        | .56  |
| $24,999 or less                                     | 32     | 24    | 15     | 23    | 17     | 26    |
| $25,000-$55,999                                     | 18     | 14    | 9      | 14    | 9      | 14    |
| $56,000-$99,999                                     | 5      | 4     | 3      | 5     | 2      | 3     |
| $100,000 or more                                    | 11     | 8     | 3      | 5     | 8      | 12    |
| Unknown                                             | 66     | 50    | 36     | 55    | 30     | 46    |
| Highest education attained                          |        |       |        | .11  |
| High school degree or less                          | 41     | 31    | 20     | 30    | 21     | 32    |
| College degree or equivalent                        | 18     | 14    | 5      | 8     | 13     | 20    |
| Graduate degree or equivalent                       | 7      | 5     | 5      | 8     | 2      | 3     |
| Prefer not to answer/unknown                        | 66     | 50    | 36     | 55    | 30     | 46    |
| Insurance type                                      |        |       |        | .52  |
| Private                                             | 42     | 32    | 19     | 29    | 23     | 35    |
| Medicaid                                            | 43     | 33    | 21     | 32    | 22     | 33    |
| Medicare                                            | 35     | 27    | 21     | 32    | 14     | 21    |
| Veterans affairs/military                           | 1      | 1     | 0      | 0.0   | 1      | 2     |
| Not insured                                         | 1      | 1     | 1      | 2     | 0      | 0.0   |
| Others                                              | 10     | 7.6   | 4      | 6.1   | 6      | 9.1   |
| Cancer type                                         |        |       |        | .51  |
| Breast                                              | 32     | 24    | 17     | 26    | 15     | 23    |
| Cutaneous                                           | 10     | 8     | 7      | 11    | 3      | 5     |
| GI                                                  | 47     | 36    | 20     | 30    | 27     | 41    |
| Genitourinary                                       | 22     | 17    | 11     | 17    | 11     | 17    |
| Gynecologic                                         | 5      | 4     | 4      | 6     | 1      | 2     |
| Head/neck                                           | 4      | 3     | 2      | 3     | 2      | 3     |
| Hematologic                                         | 4      | 3     | 1      | 2     | 3      | 5     |
| CNS                                                 | 1      | 1     | 1      | 2     | 0      | 0     |
| Sarcoma                                             | 1      | 1     | 1      | 2     | 0      | 0     |
| Thoracic                                            | 6      | 5     | 2      | 3     | 4      | 6     |

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The burden of travel associated with clinical trial participation is shouldered by patients traveling from low-income neighborhoods. Therefore, mitigating the costs associated with travel is an opportunity to enhance access to trials for patients of low socioeconomic status (SES).

In this study, participants reported out-of-pocket costs associated with cancer care. About half of participants reported a household income < $56,000 USD. Despite being of low SES, 25% of study participants reported feeling uncomfortable bringing up health care cost-related issues with their cancer doctor. Additionally, this study observed that the monthly out-of-pocket costs associated with cancer treatment varied with about one third of participants paying < $50 USD per month; however, 11% had out-of-pocket costs > $1,000 USD. Previous research has described the relationship between financial hardship, patient income, and clinical trial participation. Goldman et al observed that 932 patients with cancer enrolled in NCI-sponsored clinical trials experienced 6.5% higher adjusted costs compared with nonparticipants. A study examining factors that affected patient accrual found that among 276 assessed patients, 13% did not participate in a clinical trial because of travel distance and 8% because of insurance coverage concerns, highlighting the role of indirect costs in informing patient decision making.

### TABLE 1. Patient Characteristics (continued)

| Characteristic                        | Overall (N = 132) | Usual Care (n = 66) | Usual Care Plus Intervention (n = 66) | P  |
|---------------------------------------|-------------------|--------------------|--------------------------------------|----|
|                                       | No.   | %    | No.   | %    | No.   | %    |        |
| Clinical trial phase                 |       |      |       |      |       |      | .27    |
| I                                     | 33    | 25   | 11    | 17   | 22    | 33   |        |
| I/II                                  | 27    | 21   | 16    | 24   | 11    | 17   |        |
| II                                    | 39    | 30   | 21    | 32   | 18    | 27   |        |
| II/III                                | 1     | 1    | 0     | 0    | 1     | 2    |        |
| III                                   | 27    | 21   | 15    | 23   | 12    | 18   |        |
| NA                                    | 5     | 4    | 3     | 5    | 2     | 3    |        |
| Clinical trial funding type           |       |      |       |      |       |      | .01    |
| Internal funding                      | 15    | 11   | 6     | 9    | 9     | 14   |        |
| Government                            | 15    | 1    | 11    | 17   | 4     | 6    |        |
| Private for profit                    | 75    | 57   | 42    | 64   | 33    | 50   |        |
| Private not for profit                | 27    | 21   | 7     | 11   | 20    | 30   |        |
| Stage of disease at enrollment        |       |      |       |      |       |      | .59    |
| I                                     | 1     | 1    | 1     | 2    | 0     | 0    |        |
| II                                    | 9     | 7    | 6     | 9    | 3     | 5    |        |
| III                                   | 8     | 6    | 5     | 8    | 3     | 5    |        |
| IV                                    | 112   | 85   | 53    | 80   | 59    | 89   |        |
| NA                                    | 2     | 2    | 1     | 2    | 1     | 2    |        |
| Metastatic                            | 96    | 73   | 45    | 68   | 51    | 77   |        |
| Mean Health Literacy Score, 3 low—15 high (SD) | 11.3 (3.0) | 11.4 (3.0) | 11.3 (3.0) | .84 |
| Mean Brief Resilience Score, 1 low—5 high (SD) | 3.5 (0.6) | 3.5 (0.7) | 3.6 (0.5) | .65 |
| Mean Financial Toxicity Score, 0 worst—44 best (SD) | 14.8 (8.8) | 14.1 (8.6) | 15.5 (9.0) | .56 |
| Mean PROMIS overall QoL, 1 poor—5 excellent (SD) | 2.5 (0.9) | 2.6 (1.0) | 2.5 (0.9) | .93 |
| Mean PROMIS overall health (SD)       | 2.2 (1.0) | 2.1 (1.1) | 2.3 (0.9) | .36 |
| Mean PROMIS global physical health (SD) | 11.6 (2.9) | 11.2 (3.0) | 11.9 (2.9) | .32 |
| Mean PROMIS global mental health (SD) | 11.8 (3.2) | 12.0 (3.1) | 11.6 (3.3) | .61 |

NOTE. Percentages do not add up to 100% because of rounding.

Abbreviations: NA, not applicable; NH, non-Hispanic; PROMIS, Patient-Reported Outcomes Measurement Information System; QoL, quality of life; SD, standard deviation; USD, US dollars.
While financial toxicity and out-of-pocket costs assumed by patients are increasingly acknowledged as contributors to cancer disparities, to date, an effective, scalable model for mitigating these risks has not been developed. Previous research from the Cancer Care Equity Program at Massachusetts General Hospital highlighted that addressing indirect costs associated with clinical trials may improve accrual of patients from diverse socioeconomic backgrounds. Despite this evidence to support strategies to mitigate the added costs that may be endured by patients enrolled in therapeutic cancer clinical trials, no model has been developed in cancer clinical research. This study provides evidence that FRPs can be implemented at CCCs. Future research is required to further

**TABLE 2. Direct and Indirect Costs of Cancer Care**

| Survey Question                                                                 | No. | %   |
|-------------------------------------------------------------------------------|-----|-----|
| Primary mode(s) of travel to appointments (select all)                        |     |     |
| Private vehicle                                                               | 54  | 72.0|
| Public transportation                                                          | 8   | 10.7|
| Taxi                                                                          | 4   | 5.3 |
| Airplane                                                                      | 3   | 4.0 |
| Others                                                                        | 6   | 8.0 |
| How many hours out of your day did your last appointment for cancer care/treatment take (including travel time)? |     |     |
| < 1                                                                           | 2   | 3.1 |
| 1-3                                                                           | 14  | 21.5|
| 3-5                                                                           | 24  | 36.9|
| 5-8                                                                           | 14  | 21.5|
| More than 8                                                                   | 11  | 16.9|
| About how much out-of-pocket costs did you have related to cancer care/treatment in the last month? This includes hotel/lodging costs, tests, medications, copays, etc, USD |     |     |
| < $50                                                                         | 21  | 32.3|
| $50-$100                                                                     | 11  | 16.9|
| $100-$300                                                                    | 12  | 18.5|
| $300-$500                                                                    | 7   | 10.8|
| $500-$700                                                                    | 5   | 7.7 |
| $700-$1,000                                                                  | 2   | 3.1 |
| More than $1,000                                                              | 7   | 10.8|
| Do you usually need to arrange overnight lodging?                             |     |     |
| Yes                                                                           | 17  | 26.2|
| No                                                                            | 47  | 72.3|
| Missing                                                                       | 1   | 1.5 |
| To what degree has the cost of your cancer care been a financial burden for you/your family? |     |     |
| Not a financial burden at all                                                  | 7   | 10.8|
| Minor financial burden                                                        | 12  | 18.5|
| Moderate financial burden                                                     | 24  | 36.9|
| Significant financial burden                                                  | 19  | 29.2|
| Catastrophic financial burden                                                 | 1   | 1.5 |
| Missing                                                                       | 2   | 3.1 |
| How comfortable do you feel bringing up health care cost-related issues with your cancer doctor? |     |     |
| Uncomfortable                                                                 | 16  | 25.4|
| Somewhat comfortable                                                           | 22  | 34.9|
| Very comfortable                                                               | 25  | 39.7|
| Missing                                                                       | 2   | 3.2 |

Abbreviation: USD, US dollars.
explore if these programs adequately address financial concerns among under-represented populations.

This study has several limitations worth noting. Cost estimations over the past month among participants were subject to recall bias, therefore introducing error in measurement of financial burdens. Most notably, availability of the FRP was for patients who previously established care and were currently being evaluated at the CCCs. Therefore, there is inherent selection bias in offering these services to patients already seeking care at our sites. Further studies will need to measure the impact of expansion of FRP to patients receiving cancer treatment in other community health centers to understand its universal uptake. In general, we also observed that patients self-screened when completing the application to determine if financial reimbursement was of potential benefit to them. Future research will need to incorporate an FRP on a population level to better assess the impact on clinical trial enrollment. Another serious limitation of this study is that we were unable to collect the number of patients for whom clinical trials discussions occur; therefore, we are unable to report the total number of potentially eligible patients during the study period. Finally, the ability to scale the FRP intervention will require more universal sponsor or payer coverage of indirect costs associated with TCT participation.

Despite these limitations, this study has several strengths. This study operationalized access to an FRP across disease programs at two CCCs. Patients at the CCC had access to the financial assistance program through the Lazarex Cancer Foundation before the launch of the IMPACT study. However, patients were previously only introduced to the resources after referral to social work or if their clinician or research coordinator happened to be aware of the resource. The collaboration between Lazarex and the CCC is a novel initiative that attempted to more systematically address out-of-pocket costs of clinical trial participation. IMPACT formalized informing patients about the Lazarex FRP to evaluate whether operationalizing follow-up improves recruitment to cancer TCTs. Given that cancer clinical research is conventionally siloed by disease indication, a research study that offers FRP to all patients with cancer demonstrates that the availability of an FRP can serve all patients with cancer considering clinical trials, regardless of tumor type.

In conclusion, this study observed that offering an FRP as part of therapeutic cancer clinical trial participation is feasible, associated with high TCT enrollment overall, and a follow-up outreach telephone call does not appear to enhance enrollment. Patients who received financial reimbursement were racially/ethnically diverse and of low SES. Future research will need to expand the FRP to other sites to examine variation in FRP utilization by geography and clinical setting.

**REFERENCES**

1. The Society of Women’s Health Research: Successful Strategies for Engaging Women and Minorities in Clinical Trials Dialogues on Diversifying Clinical Trials; September 22-23, 2011. Washington, DC, Food and Drug Administration, 2011
2. Burke N: Rethinking the therapeutic misconception: Social justice, patient advocacy, and cancer clinical trial recruitment in the US safety net. BMC Med Ethics 15:68, 2014
3. Murthy VH, Krumholz HM, Gross CP: Participation in cancer clinical trials: Race-, sex-, and age-based disparities. JAMA 291:2720-2726, 2004
4. Probstfield JL, Frye RL: Strategies for recruitment and retention of participants in clinical trials. JAMA 306:1798-1799, 2011
5. Symonds R, Lord K, Mitchell A, et al: Recruitment of ethnic minorities into cancer clinical trials: Experience from the front lines. Br J Cancer 107:1017-1021, 2012
6. Timmermans S, McKay T: Clinical trials as treatment option: Bioethics and health care disparities in substance dependency. Soc Sci Med 69:1784-1790, 2009

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7. Epstein S: The rise of "recruitmentology" clinical research, racial knowledge, and the politics of inclusion and difference. Soc Stud Sci 38:801-832, 2008
8. Joseph G, Dohan D: Recruitment practices and the politics of inclusion in cancer clinical trials. Med Anthropol Q 26:338-360, 2012
9. Borno HT, Small EJ, Zhang L, et al: How current reporting practices may mask differences: A call for examining cancer-specific demographic enrollment patterns in cancer treatment clinical trials. Contemp Clin Trials Commun 16:100476, 2019
10. Borno HT, Zhang L, Siegel A, et al: At what cost to clinical trial enrollment? A retrospective study of patient travel burden in cancer clinical trials. Oncologist 23:1242-1249, 2018
11. Albain KS, Unger JM, Crowley JJ, et al: Racial disparities in cancer survival among randomized clinical trials patients of the Southwest Oncology Group. J Natl Cancer Inst 101:984-992, 2009
12. Bhatnagar V, Wu Y, Goloubeva OG, et al: Disparities in black and white patients with multiple myeloma referred for autologous hematopoietic transplantation: A single center study. Cancer 121:1064-1070, 2015
13. Boyd KD, Ross FM, Chiocchio L, et al: Gender disparities in the tumor genetics and clinical outcome of multiple myeloma. Cancer Epidemiol Biomarkers Prev 20:1703-1707, 2011
14. Brown SD, Partee PN, Feng J, et al: Outreach to diversify clinical trial participation: A randomized recruitment study. Clin Trials 12:205-211, 2015
15. Borno H, Siegel A, Ryan C: The problem of representativeness of clinical trial participants: Understanding the role of hidden costs. J Health Serv Res Policy 21:145-146, 2016
16. Ford ME, Siminoff LA, Pickelsimer E, et al: Unequal burden of disease, unequal participation in clinical trials: Solutions from African American and Latino community members. Health Soc Work 38:29-38, 2013
17. Nipp RD, Lee H, Powell E, et al: Financial burden of cancer clinical trial participation and the impact of a cancer care equity program. Oncologist 21:467-474, 2016
18. Kwiatkowski K, Coe K, Bailar JC, et al: Inclusion of minorities and women in cancer clinical trials, a decade later: Have we improved? Cancer 119:2956-2963, 2013
19. de Souza JA, Yap BJ, Hlubocky FJ, et al: The development of a financial toxicity patient-reported outcome in cancer: The COST measure. Cancer 120:3245-3253, 2014
20. Hays RD, Bjorner JB, Revicki DA, et al: Development of physical and mental health summary scores from the patient-reported outcomes measurement information system (PROMIS) global items. Qual Life Res 18:873-880, 2009
21. Sarkar U, Schillinger D, Lopez A, et al: Validation of self-reported health literacy questions among diverse English and Spanish-speaking populations. J Gen Intern Med 26:265-271, 2011
22. Smith BW, Dalen J, Wiggins K, et al: The brief resilience scale: Assessing the ability to bounce back. Int J Behav Med 15:194-200, 2008
23. Loree JM, Anand S, Dasari A, et al: Disability of race reporting and representation in clinical trials leading to cancer drug approvals from 2008 to 2018. JAMA Oncol 5:e191870, 2019
24. California Cancer Registry 2020. https://www.ccrcal.org/retrieve-data/data-for-the-public/
25. Hurst AJ, Breckon JD: A review of telephone coaching services for people with long-term conditions. J Telemed Telecare 17:451-458, 2011
26. Nielson CM, Rivelli JS, Fuoco MJ, et al: Effectiveness of automated and live phone reminders after mailed-FIT outreach in a pilot randomized trial. Prev Med Rep 12:210-213, 2018
27. Dunagan WC, Littenberg B, Ewald GA, et al: Randomized trial of a nurse-administered, telephone-based disease management program for patients with heart failure. J Card Fail 11:358-365, 2005
28. Goldman DP, Berry SH, McCabe MS, et al: Incremental treatment costs in National Cancer Institute-sponsored clinical trials. JAMA 289:2970-2977, 2003
29. Lara PN, Higdon R, Lim N, et al: Prospective evaluation of cancer clinical trial accrual patterns: Identifying potential barriers to enrollment. J Clin Oncol 19:1728-1733, 2001
30. Goossens ME, Rutten-van Molken MP, Vlaeyen JW, et al: The cost diary: A method to measure direct and indirect costs in cost-effectiveness research. J Clin Epidemiol 53:688-695, 2000
31. Unger JM, Hershman DL, Albain KS, et al: Patient income level and cancer clinical trial participation. J Clin Oncol 31:536-542, 2013
Implementation of a Multisite Financial Reimbursement Program in Cancer Clinical Trials Integrated With Patient Navigation: A Pilot Randomized Clinical Trial

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