Knee osteoarthritis (KOA) is one of the most prominent causes of chronic pain, functional impairment, and disability in older adults. The current standards of care for KOA are aimed toward reducing pain and are largely comprised of analgesic medications, but existing pharmacologic approaches often produce significant adverse effects. Moreover, recent evidence suggests that KOA pain is characterized by alterations in pain-related brain mechanisms. Cranial electrical stimulation (CES), which delivers a low-amplitude alternating electric current to the brain, can facilitate the reversal of maladaptive brain function. Portable CES devices can be used at home with real-time monitoring through a secure videoconferencing platform to facilitate high adherence. Thus, the purpose of this pilot clinical study was to examine the preliminary efficacy of remotely supervised CES on clinical pain severity in older adults with KOA. Thirty participants with KOA were randomly assigned to receive 10 daily sessions of remotely supervised CES with 0.1 mA at a frequency of 0.5 Hz for 60 minutes (n=15) or sham CES (n=15). We measured clinical pain severity using the numeric rating scale (NRS; range, 0 – 100). Participants (67% female) had a mean age of 59 years. Active CES significantly reduced scores on the NRS (Cohen’s d = 1.43, P < 0.01). Participants tolerated CES well without any adverse events. Our findings demonstrate the promising clinical efficacy of remotely supervised CES for older adults with KOA. Future studies with larger-scale randomized controlled trials with follow-up assessments are needed to validate and extend our findings.

Session 2125 (Symposium)

PATIENT, CAREGIVER, AND PHYSICIAN BARRIERS TO HOME-BASED PALLIATIVE CARE: FINDINGS FROM A TERMINATED STUDY

Chair: Susan Enguidanos
Discussant: Stephanie Wladowkosi

Despite two decades of palliative care services, there remains numerous barriers to patient and caregiver use of palliative care. For many years, policymakers believed lack of funding for palliative care was the primary obstacle to accessing palliative care services. In 2017, we undertook a randomized controlled trial to test the effectiveness of a home-based palliative care (HBPC) program within accountable care organizations and in partnership with an insurance company that covered the cost of HBPC. After 20 months, we had recruited just 28 patients and 10 of their caregivers. Findings from this terminated trial may inform other researchers in development of participant recruitment methods.

TRIALS AND TRIBULATIONS: PALLIATIVE CARE TRIAL RECRUITMENT APPROACHES AND CHALLENGES

Anna Rahman, Sindy Lomeli, and Susan Enguidanos, University of Southern California, Los Angeles, California, United States

In 2017, we received funding from the Patient-Centered Outcomes Research Institute to conduct a large, state-wide, randomized controlled trial to test the effectiveness of a home-based palliative care (HBPC) program within accountable care organizations. Participants were randomized to either HBPC or enhanced usual care, where physicians were provided added training and support in core palliative care practices. Originally, we planned to obtain patient referrals to the trial from primary care physicians, however we were unable to engage primary care physicians in patient identification processes. In this session we will discuss the numerous trial modifications made to our trial recruitment methods and the success of each approach. Ultimately, after 20 months of trial recruitment, we had recruited just 28 patients and 10 of their caregivers. Findings from this terminated trial may inform other researchers in development of participant recruitment methods.

IT’S YET ANOTHER THING: BARRIERS TO AND RECOMMENDATIONS FOR PHYSICIAN REFERRALS TO HOME-BASED PALLIATIVE CARE

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To understand primary care providers’ (PCPs) experiences with referring patients to home-based palliative care (HBPC), we conducted individual, key-informant interviews with 31 PCPs. About half participants were male (54.8%), White (42.5%), US-born (58.1%), and were 57 years old (SD=9.17), on average. About one-third of participants (32.3%) indicated they refer 10+ patients annually to HBPC, while most (80.7%) reported “strong” comfort discussing palliative care with patients. Qualitative analysis revealed three prominent thematic categories, each related to barriers PCP experienced when referring patients to palliative care: (1) PCP-level (lack of knowledge and comfort); (2) perceived patient-level (culture, family disagreement, need, home-based aspect); and (3) HBPC program-level (need to close the loop with PCP, insurance coverage, program availability, and eligibility). PCP recommendations for overcoming identified barriers will be discussed. Findings hold important implications for timely patient-referrals to palliative care by PCPs and for sustaining palliative programs that rely on these referrals.