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A REVIEW OF FACTORS ASSOCIATED WITH ACCESS TO CARE IN BREAST CANCER PATIENTS

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OBJECTIVES: Health disparities in breast cancer (BC) management are well documented and can affect different points in the cancer care continuum including timeliness of diagnosis, receipt of treatment, and long-term health outcomes. The study's objective was to review current knowledge on factors associated with access to care in BC patients. **METHODS:** A literature search was conducted using six databases: PubMed, CINAHL, PsycINFO, Embase, Cochrane Library, and Web of Science. Included studies were published in English between January 1, 2005 and September 30, 2017 and assessed access to care in patients with a confirmed diagnosis of BC. Search terms included a combination of the following words using Boolean operators: breast cancer, access, barriers, disparity, care, treatment, health services. Factors associated with access were organized according to the Theoretical Model of Cancer Health Disparities (TMCHD). **RESULTS:** Ninety-one studies were included in the review. Facets of BC care identified comprise standard BC treatment, breast reconstruction, social work services, specialist consultation, palliative services, psychosocial/mental health services, lymph node biopsy (dissection), complementary and alternative medicine, social support services, follow-up care, and rehabilitative services. Factors across the four main TMCHD domains – patient characteristics (age, race, marital status), patient factors (treatment costs, insurance coverage, patient beliefs/attitudes), provider factors (cultural incompetence, non-referral for services), and practice organization factors (waitlists, lack of patient assistance programs) – were identified. However, their prominence in affecting access differed based on facet of BC care. **CONCLUSIONS:** A variety of patient, provider, and organization factors influence BC patients' access to care, depending on the aspect of BC care examined. Future strategies aimed at improving BC patients' access to care should target the identified factors and customize strategies based on factors relevant to the type of BC care of focus.

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DETERMINANTS AND IMPACT OF CONTINUITY OF CARE IN INDIVIDUALS NEWLY DIAGNOSED WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE

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OBJECTIVES: Continuity of care is important for individuals with chronic obstructive pulmonary disease (COPD), as coordinated and comprehensive care is critical for COPD disease management. Suboptimal and duplicate care can lead to deteriorating conditions and increasing medical costs. Therefore, this study aimed to identify factors associated with continuity of care in the early phase of disease management, and examine the impact of continuity of care on risk of emergency room visit or hospital admission, and medical costs in individuals newly diagnosed with COPD. **METHODS:** Adult subjects who were newly diagnosed with COPD and had at least four outpatient visits for COPD were selected from the National Health Insurance claims database. Continuity of care index was calculated based on their outpatient visit patterns during the first year after the initial COPD diagnosis. Their use and costs of health services during the second year were measured according to their emergency room visit, hospital admissions, and medical costs of this period. Logistic regression model and generalized linear model were adopted for analyses. **RESULTS:** Of those newly diagnosed with COPD, the mean age was 56 years old, and the majority was male. Older age, male, living in rural area, and poverty were associated with lower continuity of care. Those with better continuity of care were less likely to be admitted to emergency room or hospital, and incurred lower medical costs. **CONCLUSIONS:** This study identified factors associated with patterns of continuity of care in individuals newly diagnosed with COPD. The information is of importance for planning interventions to improve continuity of care, as it was demonstrated that better continuity of care contributed to a lower risk of emergency room visit or hospital admission, and lower medical costs.

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DO MEDICAL HOMES AFFECT HEALTHCARE UTILIZATION RATES? A LONGITUDINAL EVALUATION ON MEDICAL HOME IMPLEMENTATION IN ITALY

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OBJECTIVES: This study compares healthcare utilization rates between patient populations served by general practitioners (GPs) affiliated with newly established medical homes (MHs) and those not affiliated with MHs. **METHODS:** This longitudinal study of administrative healthcare data from the Local Health Authority of Parma, Emilia-Romagna, Italy included residents ≥ 14 years residing in Parma ≥ 1 year prior to entry in the study. During the study period (1/1/2010-12/31/2016), 16 MHs were established at various times, with the first one opening in December 2011. The exposure of interest for any patient at any time was assignment to a GP affiliated with an MH. Utilization measures evaluated were Emergency Department (ED) visits and hospital admissions, including ambulatory care sensitive conditions (ACSCs). The association between MH healthcare and each outcome was evaluated through a series of Cox proportional hazards models with a time-dependent MH status. To adjust for the strong influence on healthcare utilization rates of patients treated by a GP with a disposition to join an MH, the models were adjusted for GP type (i.e., GP who joined an MH during the study period vs. GP who had not). **RESULTS:** 412,394 patients contributed exposure time to non-MH healthcare and 124,801 contributed to a MH healthcare (median follow-up time 4.5 years and 3.9 years, respectively). Most patients (65.4%) were followed for the entire 6-year period. Compared to patients not exposed to MH healthcare, those exposed had a lower risk (HR; 95% CI) of ED visits (0.96; 0.95-0.97) and ordinary

hospital admissions (0.98; 0.96-0.99). No difference was observed among admissions for ACSCs. **CONCLUSIONS:** These findings suggest MH healthcare is associated with improvements in healthcare utilization rates. Additional healthcare utilization outcomes should be evaluated and further longitudinal analyses, including adjustments for other potential confounders, should be conducted as more MHs are implemented and additional years' data become available.

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ARMED CONFLICT AND INFANT MORTALITY DUE TO DIARRHEA IN COLOMBIAN CHILDREN

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OBJECTIVES: We aimed to explore infant mortality due to Acute Diarrheal Disease (ADD), and its relationship with the armed conflict in Colombia. **METHODS:** We extracted mortality data from death certificates of the National Administrative Department of Statistics (DANE, in Spanish) using the codes A00-A09 from ICD-10. We excluded deaths with missing data. We used population projections from 2005 DANE census. We estimated municipality mortality rates related to ADD (MR-ADD) by sex in children under-five. Then, we calculated for 1998-2003, 2004-2009 and 2010-2015 the average annual mortality rate by quintiles of armed conflict intensity (ACI) at municipal level, following the ACI index built by the National Institute of Health of Colombia. Rate ratios were estimated to evaluate relative inequalities, such as the ratio between the quintile mortality rate of the higher ACI (more conflict intensity) and the lowest one. **RESULTS:** MR-ADD in children under-five were higher in boys than in girls, for all the periods studied. There was a decrease in the MR-ADD during the three periods for all ACI quintiles. A gradient pattern was evident according to the intensity of the conflict in all periods and for both sexes, with higher mortality rates in the quintile with the greatest impact due to the conflict. These inequality gaps showed that in children, for 1998-2003, the MR-ADD related to the quintile with the highest ACI was 1.64 times greater than the rate of quintile 1. For 2004-2009, this gap increased to 2.67 times and in 2010-2015, this relative difference was 2.78. In girls, rate ratios among the extreme quintiles were 1.75, 2.56 and 3.13, respectively. **CONCLUSIONS:** Our results showed a close relationship between armed conflict and MR-ADD in children under-five, with a clear gradient pattern according to the ACI and bigger inequalities during the period analyzed, in spite of the decreasing in the mortality rates.

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DIFFERENCES IN HPV VACCINE UPTAKE BY NATIVITY STATUS AMONG AMERICAN MEN AGED 18-32

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OBJECTIVES: About 16,500 HPV-associated cancers occur in the United States annually among men. HPV is thought to be responsible for more than 90% of anal, 70% of oropharynx and 60% of penile cancers. HPV vaccination reduces the risk of infection from the most common HPV types that cause HPV-associated cancers. There is limited research on vaccination uptake among men based on nativity status (i.e., U.S.- versus foreign-born). We examined whether there were significant differences in HPV vaccination uptake between U.S.-born and foreign-born men. **METHODS:** The National Health Interview Survey 2014-2016 was examined for men, aged 18-32 years (n = 6598). HPV vaccine initiation was defined as receipt of at least one dose of the vaccine and completion as receipt of the three doses. Weighted, multivariable binary logistic regression models were used to assess the association between nativity status and HPV vaccine uptake, adjusting for demographic, socioeconomic, and healthcare factors. **RESULTS:** Approximately 16% of men self-identified as foreign-born, 8% had initiated the HPV vaccine, and 3% had completed the HPV vaccine. After adjusting for covariates, compared to U.S.-born men, foreign-born men were 47% ([adjusted odds ratio] 0.53; [95% confidence interval] 0.36-0.78) less likely to initiate the HPV vaccine but there were no difference between the two groups in terms of vaccine completion. Men were more likely to initiate and complete the HPV vaccine if they had visited the doctor's office 6+ times (3.13; 2.16-4.53), and 1-5 times (1.84; 1.42-2.39) vs. no doctor's office within the last 12 months. The results held for HPV vaccine completion. **CONCLUSIONS:** We found that HPV vaccine uptake among men was very low overall, and foreign-born men had lower initiation compared to US born men. Public health interventions to improve HPV vaccination need to be developed for all men irrespective of nativity status.

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RACIAL/ETHNIC DISPARITY IN HRQOL: IMPLICATIONS OF SOCIAL SUPPORT AND SOCIAL CONNECTEDNESS IN THYROID CANCER CARE

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OBJECTIVES: To assess disparities in HRQoL between non-Hispanic Whites and Minorities with TC. **METHODS:** Data from the 2005 to 2014 Medical Expenditure Panel Survey was utilized. Dependent variables were the Short Form-12 physical (PCS) and mental (MCS) component summary scores. Race/ethnicity was categorized as Minorities (Hispanics and non-Hispanic Blacks) and non-Hispanic Whites (NHWs). Propensity score matching was conducted on covariates: age, sex, education level, marital status, region of residence, and number of comorbidities. Associations between race/ethnicity and PCS and MCS scores were evaluated using two weighted linear regression models, adjusting for poverty level, health insurance status, and employment status. Analyses were performed in the R software and an alpha level of 0.05 signified statistical significance. **RESULTS:** Race/ethnicity was not significantly associated with PCS [β : 1.14; 95% CI (-2.93, 5.21)] but was significantly associated with MCS—minorities had a MCS score 7.79 points higher than NHWs [95% CI (4.02, 11.57)]. **CONCLUSIONS:** Among thyroid cancer survivors,