Self-Reported Financial Burden and Satisfaction With Care Among Patients With Cancer

FUMIKO CHINO,^a JEFFREY PEPPERCORN,^b DONALD H. TAYLOR, JR.,^c YING LU,^d GREGORY SAMSA,^d AMY P. ABERNETHY,^{b,e} S. YOUSUF ZAFAR^{b,e}

^aSchool of Medicine, ^bDuke Cancer Institute, ^cSanford School of Public Policy, ^dDepartment of Bioinformatics and Biostatistics, and ^eCenter for Learning Health Care, Duke Clinical Research Institute, Duke University, Durham, North Carolina, USA

Disclosures of potential conflicts of interest may be found at the end of this article.

Key Words. Patient satisfaction • Neoplasms • Cost of illness • Economics • Health insurance

ABSTRACT

Background. Health care-related costs and satisfaction are compelling targets for quality improvement in cancer care delivery; however, little is known about how financial burden affects patient satisfaction.

Methods. This was an observational, cross-sectional, survey-based study assessing patient-reported financial burden (FB). Eligible patients were ≥ 21 years with solid tumor malignancy and were receiving chemotherapy or hormonal therapy for ≥ 1 month. The Patient Satisfaction Questionnaire Short-Form assessed patient satisfaction with health care. Subjective FB related to cancer treatment was measured on a 5-point Likert scale.

Results. Of 174 participants (32% response rate), 47% reported significant/catastrophic FB. Participants reported highest satisfaction with interpersonal manner and lowest satisfaction with financial aspects of care. In adjusted analysis, high FB was negatively associated with general satisfaction

(coefficient: $-.29$), satisfaction with technical quality (coefficient: $-.26$), and satisfaction with financial aspects of care (coefficient: $-.62$). Older age was associated with higher scores in all satisfaction subscales except patient-physician communication and financial aspects. Annual household income of $< \$20,000$ was associated with lower satisfaction scores in all subscales except time spent with doctor. High FB was not associated with patient satisfaction scores for accessibility and convenience, communication, interpersonal manner, or time spent with doctor.

Conclusion. FB is a potentially modifiable correlate of poor satisfaction with cancer care including general satisfaction and satisfaction with the technical quality of care. Addressing cancer-associated FB may lead to improved satisfaction, which in turn can influence adherence, outcomes, and quality of life. *The Oncologist* 2014;19:414–420

Implications for Practice: Cancer treatment often leads to significant financial burden (FB), which can affect patient satisfaction. Dissatisfaction with health care has been linked with poor outcomes including decreased adherence, utilization, and safety. This study investigates how FB may mediate how patients view their health care. The key finding was that high FB was associated with dissatisfaction with general aspects of health care, the technical quality of cancer care delivery, and the financial aspects of health care. These results imply that high FB may negatively affect downstream targets of patient satisfaction and may be tied to distrust of health care quality and delivery.

INTRODUCTION

As health care costs rise, third-party payers have shifted a portion of the cost burden to patients in the form of coinsurance, higher deductibles, copayments, and tiered drug formularies. As a result, even insured patients face a financial burden from their health care bills; in a national survey of more than 100,000 participants, the Centers for Disease Control and Prevention found that 32% of respondents reported family financial burdens due to medical care [1]. Similarly, in 2010, 16% of adults in the U.S. were estimated to be underinsured, defined as spending at least 10% of income on out-of-pocket medical expenses [2].

Financial burden negatively affects patient well-being and quality of health care, especially in the setting of a

cancer diagnosis. Despite insurance coverage, cancer patients are concerned about paying for their care [3]. Health care costs contribute to higher risk of bankruptcy among patients with cancer compared with individuals without cancer [4]. Some patients report nonadherence to therapy as a result of higher out-of-pocket costs [5, 6]. Those patients facing the greatest financial distress report spending their savings, working more hours, and selling property to defray expenses [7].

One potential consequence of financial distress that has been little studied is the impact of costs of care on patient satisfaction. Patient satisfaction is both an elusive and subjective component of care that embodies the patient's

Correspondence: S. Yousuf Zafar, M.D., Duke Cancer Institute, DUMC 3505, Durham, North Carolina 27710, USA. Telephone: 919-684-0138; E-Mail: yousuf.zafar@duke.edu Received September 26, 2013; accepted for publication January 9, 2014; first published online in *The Oncologist* Express on March 25, 2014. ©AlphaMed Press 1083-7159/2014/\$20.00/0 <http://dx.doi.org/10.1634/theoncologist.2013-0374>

expectations and perceptions, including patients' judgment of the quality of health care [8]. In an era of personalized medicine and patient-centered care, patient satisfaction is becoming an important topic for investigation.

Although studies have been inconsistent, a focus on patient satisfaction may improve adherence, resource utilization, and patient safety [9]. Understanding the connection between financial burden and patient satisfaction may help identify the extent to which modification of burden can improve this important metric of quality patient-centered care and improve the downstream results of an enhanced patient experience. We explored the relationship between personal financial burden and patient satisfaction with health care. We hypothesized that patients with higher financial burden will express less satisfaction not only with their financial interactions with the health care system but also with the overall quality of health care delivery.

MATERIALS AND METHODS

Study Design

This was an observational, cross-sectional survey study assessing patient-reported financial distress [7]. Participants completed the survey at the time of enrollment. The survey was developed and pilot tested at the Duke Cancer Institute and was self-administered either online or on paper.

Participants

Study participants were identified from the HealthWell Foundation, a 501(c)(3) nonprofit organization that assists patients with copayments, coinsurance, and premium payments. When potential participants requested financial assistance from the HealthWell Foundation, they were asked if they had an interest in participating in research. Participants were informed that enrollment in the study would have no bearing on their application to receive assistance through HealthWell. Interested participants were referred to the Duke research team, who contacted them by phone or e-mail. Eligible patients were 21 years or older, had a solid tumor malignancy, and were receiving chemotherapy or hormonal therapy for at least 1 month. Enrollment occurred between June 2010 and May 2011. The institutional review board of the Duke University Health System approved this study.

Outcomes

The Patient Satisfaction Questionnaire Short-Form (PSQ-18) [10] was used to assess patient satisfaction with health care. The outcome variable was patient satisfaction with health care based on scaled responses to the PSQ-18. Seven subscale scores included general satisfaction with health care (two questions), perceived technical quality of care (four questions), interpersonal manner (two questions), patient-physician communication (two questions), financial aspects of care (two questions), time spent with doctor (two questions), and accessibility and convenience (four questions). Analysis was performed on subscale scores only; aggregate score (across all subscales) was not considered. The complete PSQ-18 with subscale breakdown and scoring notes is shown in the supplemental online data.

Covariates

Subjective financial burden due to cancer treatment was measured on a survey-specific 5-point Likert scale ranging from "not a financial burden at all" to "catastrophic financial burden." This question was developed as a subjective measure of personal financial burden and was pilot tested for comprehension before implementation in the survey. Covariates included age, race, education level, marital status, employment status, insurance status, prescription drug coverage, household size, annual household income, metastatic disease, and primary tumor site.

Statistical Analyses

Descriptive statistics summarized demographic, socioeconomic, and disease-related characteristics. Subjective financial burden scores were dichotomized into high (significant/catastrophic) and low (moderate/minor/no) burden. Comparisons of patient satisfaction scores between groups were made using the two-sample Student's *t* test. To examine the unadjusted and adjusted effect of financial burden on patient satisfaction scores, univariate linear regression and multivariate linear regression were performed respectively for each subscale score. For multivariate linear regression, forward variable selection was used with entry requiring a *p* value $\leq .1$ for all patient characteristics except financial burden, which was anchored in the model. We then determined the final model with the subset of predictor variables according to the Akaike information criterion and the Bayesian information criterion for model selection.

RESULTS

Cohort Characteristics

Among 546 eligible patients, 174 insured patients agreed to participate and completed the PSQ-18 survey (32% response rate). Reasons for nonparticipation are shown in Figure 1. Of the 174 formally enrolled, 168 completed all components of the survey and were included in statistical analysis. Participant characteristics for the full cohort, as well as characteristics broken down among participants endorsing low and high financial burden, are presented in Table 1. All patients applied for copay assistance, and all patients were insured. Participants came from 39 of 50 states (Fig. 2); Florida had the most participants, with 16 formally enrolled in the study.

Financial Burden and Patient Satisfaction

Overall, 47% of participants reported significant or catastrophic financial burden (Fig. 3). Patient satisfaction was reported on a 5-point Likert scale with a higher score signifying greater satisfaction. Overall score for the full cohort was 3.73, with participants with low financial burden scoring 3.89 and participants with high financial burden scoring 3.55 ($p < .01$) (Table 2).

Across subscales, health care satisfaction scores for the full cohort ranged from 2.59 to 4.19. Participants reported highest satisfaction with the interpersonal manner of the care delivery team and lowest satisfaction with the financial aspects of care. This general distribution held true regardless of the degree of financial burden; that is, participants with

Figure 1. CONSORT diagram.

low burden still felt the least satisfied with the financial aspects of their care.

In adjusted analysis, high financial burden was negatively associated with the “general satisfaction with health care” subscale score (coefficient: $-.29$; lower to upper bound: $-.57$ to $-.01$; $p = .04$) and the “satisfaction with technical quality of care” subscale score (coefficient: $-.26$; lower to upper bound: $-.48$ to $-.03$; $p = .03$) (Table 3). High financial burden was negatively associated with the “satisfaction with financial aspects of care” subscale (coefficient: $-.62$; lower to upper bound: $-.94$ to $-.31$; $p < .01$), suggesting both measures consistently measured financial distress. Participant responses for the financial aspects of care PSQ-18 subscale (broken down by low and high financial burden categories) are shown in Figure 4.

High financial burden was not associated with patient satisfaction subscale scores for accessibility and convenience, communication, interpersonal manner, or time spent with the doctor.

Patient Sociodemographics and Patient Satisfaction

In adjusted analyses, older age was associated with higher scores in all satisfaction subscales except patient-physician communication and financial aspects (Table 3). Annual household income of less than \$20,000 was associated with lower

satisfaction scores in all subscales except time spent with doctor. Having a prescription drug plan was associated with higher subscale scores for accessibility and convenience of care (coefficient: $.44$; lower to upper bound: $.12$ to $.76$; $p = .01$), but larger household size was associated with lower satisfaction in this subscale (coefficient: $-.36$; lower to upper bound: $-.59$ to $-.12$; $p < .01$). Receiving chemotherapy for more than 1 year was associated with greater satisfaction with financial aspects of care (coefficient: $.32$; lower to upper bound: $>-.01$ to $.64$; $p = .05$). White race was associated with less satisfaction with financial aspects of care (coefficient: $-.66$; lower to upper bound: -1.07 to $-.25$; $p < .01$).

DISCUSSION

Costs related to cancer treatment can affect the cancer patient’s experience; however, little is known about the relationship between financial burden and patient satisfaction with care. Our study assesses this relationship among a cohort of insured patients seeking financial assistance for cancer care, using a well-validated measure of patient satisfaction [10]. Our key finding was that high financial burden was associated with dissatisfaction with general aspects of health care, the technical quality of cancer care delivery, and the financial aspects of health care.

Cancer patients experiencing financial burden are often faced with difficult decisions regarding their health care. Because of costs, they are at risk for skipping chemotherapy appointments, declining tests, and being nonadherent with oral chemotherapy or hormonal therapy [5–7]. In addition, our data suggest that cancer patients with financial burden perceive a lower overall quality of care. Patient satisfaction with health care is an important measure to track for three reasons. First, patient satisfaction remains a core component of providing patient-centric care [8]. Second, patients can provide insight into the health care delivery process that is not captured by other means [11]. Third, dissatisfaction with health care has been associated with medication nonadherence and other negative health outcomes [9]. If patient satisfaction is a potential moderator of cancer treatment adherence and health outcomes, factors associated with lower satisfaction (e.g., financial distress) should be addressed.

Higher financial burden was also associated with dissatisfaction with the technical quality of health care. Survey questions related to the technical quality of care included, “Sometimes doctors make me wonder if their diagnosis is correct,” and “I have some doubts about the ability of the doctors who treat me.” To the best of our knowledge, no prior study has described a relationship between financial burden and dissatisfaction with the technical aspects of care. Not surprisingly, lower household income (less than \$20,000 per year) was also associated with lower satisfaction with technical aspects of care. The relationship between financial burden and dissatisfaction might partially explain why patients with lower socioeconomic status are more likely than patients with higher socioeconomic status to distrust physicians [12].

After adjusting for income, the relationship between high financial burden and lower satisfaction with technical aspects of care still persists. This finding suggests a change

Table 1. Patient characteristics

Demographic		Low Financial Burden <i>n</i> = 87 (%)	High Financial Burden <i>n</i> = 81 (%)	Full Cohort <i>n</i> = 174 (%) ^a
Mean age		70 Range: 45–88	63 Range: 41–80	67 Range: 41–88
Gender	Female	87 (100)	74 (91)	167 (96)
Race	White	73 (86)	65 (80)	143 (82)
	Black	8 (9)	11 (14)	19 (11)
	Asian	1 (1)	1 (1)	2 (1)
	Other/unknown	5 (6)	4 (5)	10 (6)
Primary cancer site	Breast	80 (92)	63 (78)	148 (85)
	Colorectal	1 (1)	6 (7)	7 (4)
	Lung	1 (1)	1 (1)	2 (1)
	Other solid tumors	5 (6)	11 (13)	17 (10)
Marital status	Married	39 (45)	37 (46)	78 (45)
Annual household income	<\$20,000	23 (27)	33 (41)	57 (33)
	\$20,000–39,999	47 (56)	29 (36)	79 (45)
	\$40,000–59,999	8 (10)	9 (11)	17 (10)
	≥\$60,000	0 (0)	2 (2)	2 (1)
	Prefer not to say/unknown	9 (11)	8 (10)	19 (11)
Employment status	Employed full time	6 (7)	11 (14)	17 (10)
	Employed part time	8 (10)	5 (7)	15 (9)
	Not working outside the home	8 (10)	19 (25)	27 (16)
	Retired	62 (74)	40 (53)	106 (61)
	Self-employed	0	0	0 (0)
	Unknown	3 (3)	6 (6)	9 (5)
Level of education	High school or lower	58 (67)	41 (51)	103 (59)
	Associate degree	1 (1)	2 (2)	3 (2)
	College	22 (25)	31 (38)	55 (32)
	Postgraduate	3 (3)	5 (6)	8 (5)
	Prefer not to say	3 (3)	2 (2)	5 (3)
Insurance	Medicare	70 (80)	46 (57)	120 (69)
	Medicaid	1 (1)	4 (5)	5 (3)
	Employer-provided insurance	10 (11)	18 (22)	28 (16)
	Personally purchased insurance	17 (20)	17 (21)	35 (20)
	Veterans Administration	0	0	0 (0)
	Personally purchased supplemental	32 (37)	24 (30)	61 (35)
	Other	13 (15)	18 (22)	34 (20)
Prescription drug coverage	No	11 (13)	11 (14)	23 (13)
	Yes	70 (80)	62 (77)	136 (78)
	Unknown/missing	5 (6)	8 (10)	15 (9)
Household size	1	43 (49)	22 (27)	69 (40)
	≥2	42 (48)	58 (72)	102 (59)
	Unknown/missing	2 (2)	1 (1)	3 (2)
Duration of chemotherapy	1–6 months	7 (8)	16 (20)	24 (14)
	6–12 months	9 (10)	12 (15)	23 (13)
	≥12 months	71 (82)	53 (65)	127 (73)
Metastatic disease	No	68 (78)	47 (58)	120 (69)
	Yes	12 (14)	27 (33)	39 (22)
	Unknown	7 (8)	7 (9)	15 (9)

^aFull cohort: *n* = 174; 6 did not fill out the “financial distress” question.

Figure 2. Location of participants by state. No participants from Alaska or Hawaii.

Overall, to what degree have the costs of your cancer care been a financial burden for you or your family?

Figure 3. Patient-reported financial burden ($n = 174$): 46.6% reported catastrophic or significant financial burden; 50.0% reported moderate, minor, or no financial burden.

in trust when patients are financially stressed. It may be that the same fears and concerns that patients of lower socioeconomic status feel are manifest when pushed beyond one's resources, regardless of one's background and baseline financial stability. Patients' negative feelings concerning the technical acuity of their medical care highlight how financial strain has larger effects within the psychology of health care delivery [13].

Perhaps the most interesting findings from our analysis are the aspects of patient satisfaction that are not affected by financial burden. Scores in satisfaction with interpersonal manner, communication, time spent with the doctor, and accessibility and convenience had no association with degree of financial burden. These subscales are more direct measures of how a patient views his or her physician rather than health care as a whole. As such, these negative findings suggest that patients continue to view their doctors favorably despite being burdened by health care-related financial stress.

Although the stability of the doctor-patient relationship is reassuring, it also highlights that oncologists may be insulated from patient dissatisfaction with health care, particularly in the setting of financial distress.

Our study is subject to limitations. We present results from cancer patients who have applied to a copay assistance program and are inclined to have some degree of financial stress. Although this skews our cohort toward a higher proportion of underinsured patients, this bias presents a unique opportunity to focus on underinsured cancer patients, an incompletely described but substantial population [2]. Our patient sample is mostly white, female, and diagnosed with breast cancer; although this may limit the generalizability of our study, the financial burden of care is similar in other chronic disease states and may warrant further research. Our financial distress measure was not externally validated, but it was thoroughly piloted; furthermore, we found a strong correlation between our dichotomized measure of financial distress and the financial satisfaction subscale of the PSQ-18, a well-validated measure. Although the financial distress responses were dichotomized for analysis (with low burden including moderate financial burden based on natural cut lines), if anything, this would underestimate the effects of financial burden in this sample. The survey response rate was 32%, but this exploratory study focused on elderly cancer patients facing financial hardship. Surveying low-income or financially distressed populations is challenging, as shown by low response rates in other survey studies focused on these populations [14–16].

CONCLUSION

Our study investigates how financial distress may be a mediator in how patients view their health care, and our results imply that high financial distress may negatively affect downstream targets of patient satisfaction. Our results also reinforce known associations between satisfaction and sociodemographics, including age and socioeconomic status [17]. Because patient

Table 2. Patient Satisfaction Questionnaire Short-Form patient satisfaction subscale scores

Satisfaction Category	Full Cohort n = 168 ^a (SD)	Low Financial Burden n = 87 (SD)	High Financial Burden n = 81 (SD)	p ^b
General satisfaction	4.03 (0.83)	4.29 (0.60)	3.77 (1.02)	<.01
Technical quality	4.08 (0.70)	4.29 (0.47)	3.84 (0.89)	<.01
Interpersonal manner	4.19 (0.75)	4.27 (0.60)	4.12 (0.89)	.20
Communication	3.99 (0.76)	4.16 (0.59)	3.81 (0.91)	<.01
Financial aspects	2.59 (0.89)	3.02 (0.90)	2.21 (0.88)	<.01
Time spent with doctor	3.80 (0.93)	3.88 (0.89)	3.72 (0.98)	.26
Accessibility and convenience	3.85 (0.69)	3.95 (0.61)	3.75 (0.76)	.33
Overall	3.73 (0.55)	3.89 (0.43)	3.55 (0.62)	<.01

^an = 168 because not all 174 participants completed the “financial burden” question.

Likert scale 1–5, 3 is neutral.

^bp values are unadjusted.**Table 3.** Multivariate linear regression model

Variable	Coefficient	Lower to Upper Bound	p
General Satisfaction			
Financial burden (low vs. high)	−.29	−.57 to −.01	.04
Age (increasing)	.02	<.01 to .03	.02
Annual household income <\$20,000	−.36	−.63 to −.09	.01
Receiving chemo/hormone therapy >12 months	.19	−.1 to .48	.2
Accessibility and Convenience			
Financial burden (low vs. high)	.03	−.21 to .27	.79
Age (increasing)	.02	.01 to .03	<.01
Annual household income <\$20,000	−.46	−.7 to −.22	<.01
Prescription drug coverage	.44	.12 to .76	.01
Household size (2 or more)	−.36	−.59 to −.12	<.01
Communication			
Financial burden (low vs. high)	−.23	−.49 to .02	.07
Age (increasing)	.01	>−.01 to .02	.2
Annual household income <\$20,000	−.3	−.55 to −.06	.02
Financial Aspects			
Financial burden (low vs. high)	−.62	−.94 to −.31	<.01
Age (increasing)	.01	−.01 to .02	.5
Annual household income <\$20,000	−.36	−.66 to −.06	.02
White race	−.66	−1.07 to −.25	<.01
Metastatic disease	−.23	−.58 to .11	.18
Receiving chemo/hormone therapy >12 months	.32	>−.01 to .64	.05
Time Spent with Doctor			
Financial burden (low vs. high)	−.03	−.33 to .28	.87
Age (increasing)	.02	<.01 to .03	.02
Interpersonal Manner			
Financial burden (low vs. high)	<.01	−.26 to .26	.98
Age (increasing)	.01	<.01 to .03	.03
Annual household income <\$20,000	−.23	−.53 to −.03	.03
Prescription drug coverage	.27	−.08 to .62	.14
Technical Quality			
Financial burden (low vs. high)	−.26	−.48 to −.03	.03
Age (increasing)	.01	<.01 to .02	.02
Annual household income <\$20,000	−.31	−.54 to −.08	.01
Household size (2 or more)	−.19	−.42 to .03	.09

Negative coefficient is associated with lower satisfaction. Positive coefficient is associated with higher satisfaction.

Figure 4. Satisfaction with the Financial Aspects of Care subscale of the Patient Satisfaction Questionnaire Short-Form, by level of financial distress, Likert scale 1–5 (coefficient: $-.62$; lower to upper bound: $-.94$ to $-.31$; $p < .01$).

satisfaction has been linked to important aspects of care, like adherence and outcomes, future studies should investigate how to best evaluate financial burden before it affects cancer care. Patient satisfaction with health care is a compelling target for intervention within cancer care, and understanding

the interactions of financial burden with satisfaction adds clarity to this complex issue.

ACKNOWLEDGMENT

S.Y.Z. was supported by the American Cancer Society Mentored Research Scholar Grant, the Duke Cancer Institute Cancer Control Pilot Studies Award, and the HealthWell Foundation Career Development Award.

AUTHOR CONTRIBUTIONS

Conception/Design: Jeffrey Peppercorn, Donald H. Taylor, Jr., Amy P. Abernethy, S. Yousuf Zafar

Provision of study material or patients: Jeffrey Peppercorn, S. Yousuf Zafar

Collection and/or assembly of data: Fumiko Chino, S. Yousuf Zafar

Data analysis and interpretation: Fumiko Chino, Jeffrey Peppercorn, Donald H. Taylor, Jr., Ying Lu, Gregory Samsa, Amy P. Abernethy, S. Yousuf Zafar

Manuscript writing: Fumiko Chino, Jeffrey Peppercorn, Donald H. Taylor, Jr., Ying Lu, Gregory Samsa, Amy P. Abernethy, S. Yousuf Zafar

Final approval of manuscript: Fumiko Chino, Jeffrey Peppercorn, Donald H. Taylor, Jr., Ying Lu, Gregory Samsa, Amy P. Abernethy, S. Yousuf Zafar

DISCLOSURES

Jeffrey Peppercorn: Novartis (RF); GlaxosmithKline (OI; through spouse); **Amy P. Abernethy:** Employment/Leadership Position: American Academy of Hospice and Palliative Medicine, Advoset, Orange Leaf Associates (E); Novartis, Pfizer, Bristol-Myers Squibb (C/A); DARA, Celgene, Helsinn, Dendreon, Pfizer (RF); **S. Yousuf Zafar:** Genentech (C/A). The other authors indicated no financial relationships.

(C/A) Consulting/advisory relationship; (RF) Research funding; (E) Employment; (ET) Expert testimony; (H) Honoraria received; (OI) Ownership interests; (IP) Intellectual property rights/inventor/patent holder; (SAB) Scientific advisory board

REFERENCES

- Cohen RA, Gindi RM, Kirzinger WK. Burden of medical care cost: Early release of estimates from the National Health Interview Survey, January–June 2011. Available at <http://www.cdc.gov/nchs/nhis/releases.htm>. Accessed July 19, 2013.
- Schoen C, Doty MM, Robertson RH et al. Affordable Care Act reforms could reduce the number of underinsured US adults by 70 percent. *Health Aff (Millwood)* 2011;30:1762–1771.
- Stump TK, Eghan N, Egleston BL et al. Cost concerns of patients with cancer. *J Oncol Pract* 2013; 9:251–257.
- Ramsey S, Blough D, Kirchhoff A et al. Washington state cancer patients found to be at greater risk for bankruptcy than people without a cancer diagnosis. *Health Aff (Millwood)* 2013;32:1143–1152.
- Neugut AI, Subar M, Wilde ET et al. Association between prescription co-payment amount and compliance with adjuvant hormonal therapy in women with early-stage breast cancer. *J Clin Oncol* 2011;29:2534–2542.
- Streeter SB, Schwartzberg L, Husain N et al. Patient and plan characteristics affecting abandonment of oral oncolytic prescriptions. *J Oncol Pract* 2011;7(suppl):46s–51s.
- Zafar SY, Peppercorn JM, Schrag D et al. The financial toxicity of cancer treatment: A pilot study assessing out-of-pocket expenses and the insured cancer patient's experience. *The Oncologist* 2013; 18:381–390.
- Donabedian A. The Lichfield Lecture. Quality assurance in health care: Consumers' role. *Qual Health Care* 1992;1:247–251.
- Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open*.
- Marshall GN, Hays RD. The Patient Satisfaction Questionnaire Short-Form (PSQ-18). Santa Monica, CA: RAND, 1994.
- Cleary PD, Edgman-Levitan S, Roberts M et al. Patients evaluate their hospital care: A national survey. *Health Aff (Millwood)* 1991;10:254–267.
- Armstrong K, Ravenell KL, McMurphy S et al. Racial/ethnic differences in physician distrust in the United States. *Am J Public Health* 2007;97: 1283–1289.
- Grande D, Barg FK, Johnson S et al. Life disruptions for midlife and older adults with high out-of-pocket health expenditures. *Ann Fam Med* 2013;11:37–42.
- Gibson PJ, Koepsell TD, Diehr P et al. Increasing response rates for mailed surveys of Medicaid clients and other low-income populations. *Am J Epidemiol* 1999;149:1057–1062.
- Kaiser Family Foundation. Spotlight on uninsured parents: How a lack of coverage affects parents and their families. Available at <http://www.kff.org/uninsured/upload/7662.pdf>. Accessed March 28, 2012.
- Markman M, Luce R. Impact of the cost of cancer treatment: An Internet-based survey. *J Oncol Pract* 2010;6:69–73.
- Sitzia J, Wood N. Patient satisfaction: A review of issues and concepts. *Soc Sci Med* 1997;45:1829–1843.

CME

This article is available for continuing medical education credit at CME.TheOncologist.com.

See <http://www.TheOncologist.com> for supplemental material available online.