Primary Care & Cancer: Opportunities for Integration

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Overview

• Goals & approaches
  – 2015-2020 NH Cancer Plan
  – Primary care (including a few snapshots)
  – Primary care and public health

• Reflection on your experience

• Opportunities for working with/in primary care
2015-2020 NH Cancer Plan Goals

1. Foster communities and systems that support and reinforce healthy lifestyles.

2. Detect cancer at its earliest stage.

3. Optimize quality of life for those affected by cancer.
Goal 1: Foster communities & systems that support & reinforce healthy lifestyles

- Link between health status and where people live
  - Poverty
  - Access to healthy food
  - Opportunities for physical activity
  - Access to healthcare
  - Transportation
  - Child care
  - Employment
  - Receiving information in a person’s own language

- Communities that support and reinforce healthy lifestyles will have better health outcomes.

- Focus efforts on public policy as well as community and organizational systems change.
Goal 2: Prevent and detect cancer at its earliest stage

• Screening at appropriate intervals can help to prevent and detect some types of cancer (e.g., breast, cervical, colorectal and lung) at early stage
• Finding cancer at the earliest stage provides opportunities for early treatment & reduced cancer morbidity and mortality
• Screening rate disparities exist in NH - despite increased access to health insurance and coverage for preventive screenings
• Focused on addressing health equity & improving health systems to navigate patients and improve community-clinical linkages
Goal 3: Optimize quality of life for those affected by cancer

- Improving the health and well-being of cancer patients, their families and caregivers
  - Begins at the time of diagnosis
  - Continues across the natural trajectory of the disease
  - Extends beyond disease status *(palliative care, psycho-social, spiritual...)*

- Focus on improving access to high quality health services through policy, system & environmental strategies that promote access to comprehensive and cutting-edge treatments & services

- Strategies need to be data-driven
  - Identify and utilize existing data
  - Develop new data
  - Identify disparites
THE CANCER CONTROL CONTINUUM

PREVENTION
Tobacco control
Diet
Physical activity
Sun exposure
Virus exposure
Alcohol use
Chemoprevention

DETECTION
Pap test
Mammography
FOBT
Sigmoidoscopy
PSA

FOCUS
DIAGNOSIS
Informed decision-making

TREATMENT
Health services and outcomes research

SURVIVORSHIP
Coping
Health promotion for survivors

CROSSCUTTING ISSUES

Communications
Surveillance
Social Determinants of Health Disparities
Genetic Testing
Decision-Making
Dissemination of Evidence-Based Interventions
Quality of Cancer Care
Epidemiology
Measurement

Adapted from David B. Abrams, Brown University School of Medicine.
Multilevel influences on the cancer care continuum.

Fig. Results of a reanalysis of the monthly prevalence of illness in the community and the roles of various sources of health care. (Green LA et al., *N Engl J Med* 2001, 344:2021-2024)
Principles of Primary Care

- **Accessibility** as 1st contact with health care
- **Accountability** for large majority of healthcare needs (comprehensiveness)
- **Coordination & integration** of care across settings, acute & chronic illnesses, mental health & prevention
- **Sustained partnership** – relationships over time in a family & community context


The Promise of Primary Care

• Primary care characterized by
  – supply of primary care physicians
  – a relationship with a source of primary care
  – receipt of important features of primary care

• Associated with
  – Healthier populations
  – Less health care spending
  – Less inequality in health care and health

A bit of data from direct observation of primary care
Visits to Family Physicians

- Variety of patients, problems and complexity
  - Top 25 diagnostic clusters account for <50% of visits

- 10 minute average duration

- Reason for visit
  - 58% acute illness
  - 24% chronic illness
  - 12% well care

- Average patient paid 4.3 visits in the past year

Multiple Problems Per Visit

• **Average of 3 problems per visit**
  – 37% >3 problems
  – 18% 4 problems
  – 2 problems per visit on bill

• **Special groups**
  – Patients >65 - 4 problems per visit
  – Diabetics - 5 problems per visit


Visits by Diabetic Patients in a CHC

- Mean of 25 problems (range 13 to 32)
- Multiple acute & chronic illnesses, prevention
- Variety of issues
  - Biomedical
  - Behavioral
  - Social
  - System
  - Environmental health

Competing Demands and Tobacco Counseling

• Hierarchy of taken & missed opportunities
  – Good (5As) counseling: 21%
  – Competing demands: 24%
  – Failure in a non-smoking related visit 27%
  – Failure in a smoking-related visit 25%
  – Failure in a health maintenance visit 2%

• Guidelines to counsel every visit unrealistic

• Systems & individual approaches are needed

Opportunistic Preventive Service Delivery

- 32% of outpatient visits for illness
  - Health habit advice (28%)
  - Immunization (5%)
  - Screening (4%)
- No difference in patient satisfaction
- Visits longer by 2.1 minutes

Opportunistic Preventive Service Delivery

• More common during visits by:
  • Patients who smoke, drink or are overweight
  • Patients with high risk diseases
  • New patients
  • Patients with fewer visits in the past year
  • Patients requesting preventive services

• Less common during visits involving:
  • Another family member
  • Acute illness
  • Prescription of a drug


The “Secondary Patient”

- Family members other than the identified patient
- 18% of outpatient visits
- Care of secondary patient
  - Advice, information, explanation
  - Prescription
  - Follow-up of a previous episode of care
  - Visits longer by 1.3 minutes
- No difference in primary patient’s
  - Preventive service delivery
  - Satisfaction
  - Billing


Preventive Service Delivery to African Americans & Whites

• Similar rates of screening & immunization

• Higher rates of health habit counseling

Healing

• Cure when possible
• Transcendence of suffering


Healing Relationships Model

Healing Relationships

Processes

Valuing
- Nonjudgmental Stance
- Connecting
- Presence
- Full Attention in Encounter
- Paying attention to Illness Experience
- Suffering with Patient

Appreciating Power
- Partnering
- Education
- Pushing

Abiding
- Accessibility
- Presence for Major Health Events
- Commitment to Not Give Up
- Caring Actions

Clinician Competencies

Relational Outcomes

Hope
- Trust
- Being Known

Self Confidence
- Emotional Self-Management
- Mindfulness
- Knowledge

Holarchy of Health Care

- **Healing and Transcendence**
  - Abiding even when healing cannot be fostered
  - Fostering healing

- **Prioritized Care**
  - Integrating biotechnical & biographical care based on deep knowledge of both & connections to others
  - Balancing individual, family, community & system needs & opportunities

- **Integrated Care**
  - Integrating care across acute & chronic illness, prevention & mental health
  - Management of multimorbidity

- **Fundamental Healthcare**
  - Psychosocial care
  - Proactive management of prevention & chronic illness
    - Care of acute illness
    - Management of patient concerns

**Relationship-centered Care**

**Goal-oriented Care**

**Patient-centered Care**

**Clinician-centered Care**

Community-Oriented Primary Care

• Takes responsibility for the health of a defined population

• Steps
  – **Define** the population.
  – **Assess** the defined population's health needs.
  – **Organize** an effective intervention strategy.
  – **Evaluate** the success of the intervention.


Principles of Public Health

• Three core functions
  – Assessment
  – Policy Development
  – Assurance

• 10 essential services
  • Monitor health status
  • Diagnose and investigate
  • Inform, educate, empower
  • Mobilize community partnerships
  • Develop policies & plans
  • Enforce laws & regulations
  • Link people to needed services / assure care
  • Assure a competent workforce
  • Evaluate health services
  • Research

IOM (1988); Core Functions of Public Health Functions Steering Committee (1994).
The Public Health Approach

1. Surveillance
   What is the problem?
   Define the violence problem through systematic data collection.

2. Identify risk and protective factors
   What are the causes?
   Conduct research to find out why violence occurs and who it affects.

3. Develop and evaluate interventions
   What works and for whom?
   Design, implement and evaluate interventions to see what works.

4. Implementation
   Scaling up effective policy & programmes
   Scale-up effective and promising interventions and evaluate their impact and cost-effectiveness.

# Primary Care & Public Health

## Very Different

### Primary Care
- Underfunded
- Misaligned mission & incentives
- Misunderstood
- Broad scope, fragmented approach
- Increasingly about chronic illness
- Mission more about promoting health than delivering commodities
- About partnerships

### Public Health
- Underfunded
- Misaligned mission & incentives
- Misunderstood
- Broad scope, fragmented approach
- Increasingly about chronic illness
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## Efforts to Reform Primary Care & Public Health - Very Similar

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Public Health</th>
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<tbody>
<tr>
<td>• More funding</td>
<td>• More funding</td>
</tr>
<tr>
<td>• Different funding</td>
<td>• Different funding</td>
</tr>
<tr>
<td>• More information support</td>
<td>• More information support</td>
</tr>
<tr>
<td>• Greater integration within</td>
<td>• Greater integration within</td>
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<tr>
<td>• Greater integration across sectors</td>
<td>• Greater integration across sectors</td>
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<tr>
<td>• More targeting and incentives</td>
<td>• More targeting and incentives</td>
</tr>
<tr>
<td>• Greater focus on population health</td>
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Integrating Primary Care and Public Health

• “The interactions between the two sectors are so varied that it is not possible to prescribe a specific model or template for how integration should look.”

• General principles
Principles of Integration

• Shared goal of population health improvement

• Community engagement in defining and addressing population health needs

• Aligned leadership
  – Bridges disciplines, programs, and jurisdictions
  – Clarifies roles and ensures accountability,
  – Develops and supports appropriate incentives
  – Has the capacity to manage change

• Shared infrastructure

• Collaborative use of data & analysis

Affordable Care Act Opportunities

- Community Transformation Grants
- Community Health Needs Assessments
- Medicaid Preventive Services
- Community Health Centers
- National Prevention, Health Promotion & Public Health Council & the National Prevention Strategy
- CMS Innovation Center
- Accountable Care Organizations
- Patient-Centered Medical Homes
- Primary Care Extension Program
- National Health Service Corps
- Teaching Health Centers

A few more opportunities

- Integrating social determinants of health into the electronic health record
- Community health needs assessments & community health assessments
- Maintenance of certification requirements
- Multilevel interventions
- Abundance emerging from collaborations stimulated by a shared sense of shortage

IOM. Recommended Social and Behavioral Domains and Measures for Electronic Health Records. www.iom.edu/Activities/PublicHealth/SocialDeterminantsEHR.aspx


Imagine…

• A specific instance when you felt most effective in working in cancer control or prevention.

• When your best attributes were brought to bear, perhaps working with others, perhaps even working with or in primary care, that made a difference in the life of an individual, family or community.
Partnerships that Integrate Primary Care with Other Sectors for Cancer Control

• Synergy in each doing what we’re good at

• Questions
  – What are you good at?
  – Who do you have access to, and when?
  – What data do you have / need?
  – What work is value-congruent?
  – How can we come to the table around mutual need?
  – How can we partner for complementary effect?
Ways of Knowing
### 4 Ways of Knowing

<table>
<thead>
<tr>
<th></th>
<th>Inner Reality</th>
<th>Outer Reality</th>
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</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>“I”</td>
<td>“It”</td>
</tr>
<tr>
<td><strong>Collective</strong></td>
<td>“We”</td>
<td>“Its”</td>
</tr>
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</table>

Adapted from:
# 4 Ways of Knowing About Health & Health Care

<table>
<thead>
<tr>
<th>“I”</th>
<th>“It”</th>
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</thead>
<tbody>
<tr>
<td>Patient, Clinician, Worker, Policymaker</td>
<td>Disease, Treatment</td>
</tr>
<tr>
<td>“We”</td>
<td>“Its”</td>
</tr>
<tr>
<td>Family, Practice, Team, Community</td>
<td>Systems, Organization</td>
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Adapted from:
Ways of Knowing, Learning & Developing
