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Continuous primary care is central to comprehensive cancer care: are we ready to meet growing needs?

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Abstract

Primary care engagement is essential to meet the need for high quality, comprehensive, long-term cancer care. Primary care currently serves an integral role as the point of care for preventive and surveillance cancer screenings. As cancer prevalence rises, primary care will increasingly serve a growing need for care continuity as patients transition between screening, active treatment and continued follow-up care.

Commentary

Continuity of care and access to care are central issues for all patients. For patients dealing with cancer they can be critical. In this issue of the Journal of the American Board of Family Medicine (JABFM) articles by Maly et al and Roetzheim et al address the centrality of primary care engagement in screening for cancer and continued follow-up after cancer treatment.

Roetzheim and colleagues studied cancer screening for melanoma in a Medicare population who reported visits with both a dermatologist and primary care physician (PCP). They found that patients who visited either both a dermatologist and PCP or a PCP alone were more likely to be diagnosed at an earlier stage, with thinner melanomas thereby improving melanoma mortality among these patients. These findings point to care continuity in primary care as being a central factor that influences whether patients are seen often enough to provide adequate opportunities to screen. Similarly, Maly et al studied PCP directed management of follow-up cancer preventive screening care after a breast cancer diagnosis. They also report that primary care is integral to receipt of screening for breast cancer surveillance and preventive colorectal and cervical cancer screening, particularly among a low income population. Indeed, they find that women who saw only a PCP and not a cancer specialist for their follow-up care had the highest odds of receiving each clinical care service. Together, these studies' findings highlight the necessity and centrality of primary care in the management of cancer care through providing both preventive and surveillance cancer screening.

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These two studies bring to the fore a new and growing challenge for primary care—how can PCPs manage the increasing numbers of cancer survivors in their patient panels and meet their complex ongoing needs for screening and surveillance? There are approximately 13.7 million cancer survivors in the US and by January 1, 2022, that number is projected to increase to nearly 18 million.[1] Most of the current cancer survivors were diagnosed more than 5 years ago (64%) with approximately 15% diagnosed more than 20 years ago. [1] The current data suggest that these trends will continue. Breast and melanoma cancers are among the most prevalent cancers and have some of the highest rates of cure. [1] Over 60% of breast cancers and 3 out of 4 melanoma cancers are diagnosed and treated at localized stages.[1] As far these patients and their doctors know, they have been "cured" which means they are highly unlikely to continue making regular trips to see their specialists and cancer treatment teams for follow-up.

We know from previous research that the further away patients get from their active or curative cancer treatment, the more likely they are to be cared for exclusively in a primary care setting. A population based study using Surveillance, Epidemiology, and End Results data linked to Medicare claims found that only one-third of long term cancer survivors continued to seek care from physicians whose specialties are related to their original cancer after 5 years of survival.[2] Approximately 46% of long term breast cancer survivors were followed by their oncologists at year 5; yet, their rates fell to 11% in their 12th year of survival. They also found that patients with localized disease were significantly more likely to be followed by their primary care providers. In contrast, only 20% of survivors report receiving the majority of their health care from a cancer specialist.[3] Results from Maly and colleagues in this issue of JABFM underscore this reality and suggest that for low income populations, regardless of patient preference, that it may not be feasible to continue follow-up care in an oncology setting.

It is, therefore, imperative for primary care to continue to remain engaged and to play an active role in the coordinated care of cancer survivors. This is a population that is at increased risk for additional co-morbidities and complications resulting from their prior cancer treatments as well as accelerated aging if their co-morbid health risks are not appropriately managed.[4] Moreover, primary care is well positioned for intervention with those cancer survivors who do not engage protective health behaviors, including those who continue to smoke (15%), do not participate in adequate physical activity (32%), and are obese (28%).[3] Cancer survivors are also at increased risk for both recurrence as well as new second primary cancers. Therefore, it is paramount that they continue to receive preventive and surveillance screening. However, we know that many are not receiving recommended preventive care, not only for cancer screening but for influenza and pneumococcal vaccinations.[3] In our own study of cancer survivors[5] in community practice settings we found that although cancer survivors' rates of preventive cancer screening were higher than those of patients without a history of cancer, they were lower than optimal given cancer survivors' increased risk of cancer recurrence and/or second primary cancer. [5] Further, their self-reports of screening were higher than testing documented in their medical records suggesting that there may be some confusion about what constitutes cancer screening. For these reasons, they need for primary care to be engaged in actively monitoring their health through use of health maintenance and prevention visits.

While there is increased need for cancer survivor follow-up monitoring in primary care, there is some concern about the quality of monitoring provided. There are a number of articles that point to limited PCP information and expertise to deal with cancer treatment related late effects or unknown long term effects of treatment. Maly et al describe this as a potential barrier. However, what much of the existing literature fails to take into account that both Maly and Roetzheim and their colleagues address is that in many health care markets throughout the country where there is low specialty penetration or where access to specialists are constricted by limited resources that primary care is already dealing with these issues without the benefit of an extensive safety net. Roetzheim and colleagues raise this issue when they suggest that even though dermatologists may provide more accurate skin examinations in contrast with PCPs, their impact may be more limited because they have fewer contacts with patients and, therefore, fewer opportunities to diagnose melanoma at earlier stages. Roetzheim and colleagues present data consistent with this argument as over half of the patients diagnosed with melanoma in the study had had contact with their PCP, not a dermatologist in the 2 years leading to their diagnosis. Seizing opportunities for diagnosing cancer at earlier stages has important implications for cancer survival which in turn shapes the needs of the long term cancer survivor population.

The studies by Maly et al and Roetzheim et al remind us of the centrality of primary care engagement in providing effective and timely screening for prevention and as part of continued follow-up after cancer treatment. Both raise important questions about what next steps should be taken to further enhance uptake of cancer and other types of preventive screening in primary care. These studies focus on the ends of the screening continuum from prevention before a cancer diagnosis to surveillance afterwards in survivorship care and underscore the need for primary care to play a continuous role as part of comprehensive cancer care. Given the projected growth in both baby boomers and cancer survivors in the next decade who will have increasing need of these services, we must make certain that we in primary care are ready to meet their growing needs.

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