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# Mixed methods health policy Analysis of Cancer Survivorship within Primary Care: Insights and Perspectives for Improving Care

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# MIXED METHODS HEALTH POLICY ANALYSIS OF CANCER SURVIVORSHIP WITHIN PRIMARY CARE: INSIGHTS AND PERSPECTIVES FOR IMPROVING CARE

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# Background:

- Over 14 million cancer survivors in the United States and the number is rapidly growing
- Unclear role for Primary Care in cancer survivorship care
- Conflicting definitions of survivors, survivorship care, guidelines

# Objective:

- To determine contextual, environmental and policy features that may be hindering or improving the provision of high-quality cancer survivorship care nationally

# Design

- **Mixed Methods – Concurrent Triangulation**
- **Comparative Case Study**
- **Health Policy Analysis**

* Embedded NCI funded supplement within larger NCI funded R01 national case comparative study of cancer survivorship within Patient-Centered Medical Homes

# Socio-ecologic Framework

- Evaluating Contextual/Environmental Features of Cancer Survivorship from Three Levels:

- **1) Community Neighborhood**
  - Social demographics of community, access to community health resources, cancer resources, support groups
- **2) Medical Neighborhood**
  - Primary care clinicians, oncology providers, health systems, lab/radiology services, cancer centers, referral patterns, survivorship clinical sites
- **3) Policy Neighborhood**
  - ACO or provider regional networks, insurance market and regulations, financial metrics in region, DOH input

# Mixed Methods Design

- **Quantitative Geospatial Mapping**
  - Key Variables of interest for social determinants of health
  - Mapping for Primary Care clinicians, oncologists, mental health providers and health facilities

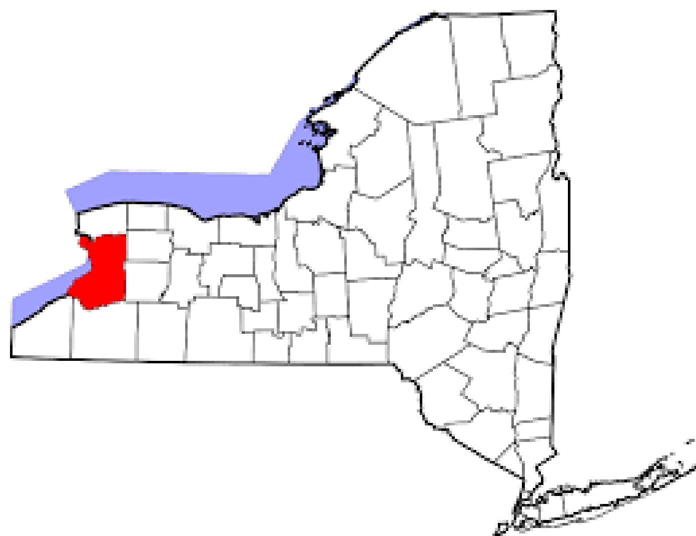
- **Qualitative Analysis**
  - Analysis of field notes, patient pathways, practice interviews from R01 parent study
  - Key informant Interviews, 45 min telephone depth interviews
  - Cross Comparative Analysis between informants at different layers and across informants of same layer from different regions

# Key Informant Interviews

- **Community Informant**
  - Examples: Community resource CEO, community researcher, AHEC representative, community board member specific to health)
- **Medical Informant**
  - Examples: Medical Director of health system, administrative and clinical leaders of health provider network, key oncologists from referral network, director of cancer center
- **Policy Informant**
  - Examples: Insurance company leaders, local or state department government officials, regulatory board members

# Descriptive Case Study – P3

- Practice #3 from NCI R01 Parent Grant is located in Erie County, NY
- Mixed methods health policy analysis for supplement was undertaken for Erie County



# New York State Counties by Percent Insured, 2015

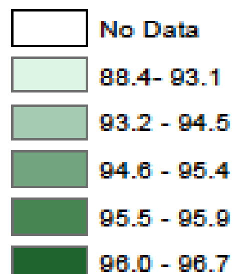
Erie County (highlighted)

| | |
|---|---|
| All Cause Cancer Mortality per 100,000 | 183.3 |
| Population per Mental Health Provider | 1,860:1 |

New York State

| | |
|---|---|
| All Cause Cancer Mortality per 100,000 | 160.1 |
| Population per Mental Health Provider | 1,068:1 |

**Percent Insured by Quintile, ACS 2015**



- No Data
- 88.4- 93.1
- 93.2 - 94.5
- 94.6 - 95.4
- 95.5 - 95.9
- 96.0 - 96.7

Source: American Community Survey Table S2701, 2015

# Mapping of Oncologists in Erie County

Oncology Provider Locations

HealthLandscape

CANADA
UNITED STATES

**Gynecological Oncology; Hematology/Oncology; Medical Oncology; Musculoskeletal Oncology; Pediatric Hematology/ Oncology; Surgical Oncology**

20 mi

HealthLandscape

**Population per Provider**

**Providers**

Oncology

# Qualitative Analysis

- Identification of first three key informants to interview:

- **1) Community Neighborhood**– Community Health Disparities Researcher
- **2) Medical Neighborhood** – Administrative Leader of IPA
- **3) Policy Neighborhood** – CEO of Insurance Company serving region

# Interview Transcript Analysis: Medical Neighborhood

## Financial viability is a strong driver in new initiatives

As the leader of the IPA, his viewpoint is based on the healthcare market and he chooses what the IPA focuses on based on its ability to control cost while improving care, i.e. the triple aim framework. The bottom line is that since cancer survivorship care hasn't been shown to reduce costs, it is unlikely to gain traction as an initiative in this IPA.

# The oncology-primary care relationship needs to be strengthened for cancer survivorship care to be implemented.

**The adult oncology-primary care relationship is weak. Incentives for better collaboration through the ACO and PCMH give reason to be hopeful that there may be improved collaboration in the future. As a pediatrician, he feels that "childhood cancers" are an anomaly; for a variety of reasons, pediatric primary care doctors and specialists provide better cancer survivorship care.**

# Cross Comparison of Themes

| | P3#1 | P3#2 | P3#3 |
|---|---|---|---|
| Data/guidelines are important, lack of guidelines, hard to implement existing guidelines given pressures on PCPs | X | X | X |
| Financial metrics drive what gets done | | X | X |
| Need improved PCP-oncology relationship/coordination | X | X | X |
| EMR changes may enhance cancer survivorship | | X | X |
| Focusing on diverse communities and their survivorship needs | X | | |
| Advocacy with community cancer groups | X | | |
| Involving Survivors in Research | X | | |
| Lack of National Survivorship Focus, Advancing the Agenda | X | X | X |
| Survivorship in Online Tools | | | X |

# Three Take-Aways

**1) Guidelines and Metrics are Important, Currently there is a lack of guidelines for cancer survivorship and there are challenges to implement guidelines available**

**2) Need improved PCP-Oncology Relationship and Coordination**

**3) Lack of National Survivorship Care Focus, Ways to Advance the Agenda**

# Acknowledgments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- Sub-group Analysis Co-Members – Dr. Jenna Howard, Dr. Jennifer Tsui
- Robert Graham Center/Health Landscape, Dr. Jennifer Rankin for contribution with mapping components of study



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# Extra Slide – Tabular Data Erie County

| | New York State | Erie County |
|---|---|---|
| **Educational Attainment % GED** | 26.9% | 28.4% |
| **Educational Attainment % College** | 19.1% | 17.2% |
| **Poverty <100% FPL** | 15.6% | 14.7% |
| **Poverty < 138% FPL** | 22.4% | 21.1% |
| **Poverty < 200% FPL** | 32.6% | 31.2% |
| **Poverty < 400% FPL** | 60.0% | 62.5% |
| **Race/Ethnicity: American Indian** | 0.4% | 0.5% |
| **Race/Ethnicity: Asian** | 7.8% | 2.9% |
| **Race/Ethnicity: Hispanic** | 15.6% | 13.2% |
| **Race/Ethnicity: Black** | 18.2% | 4.8% |
| **Race/Ethnicity: White** | 65.0% | 79.1% |
| **Uninsured %** | 10.6% | 6.4% |
| **Insured %** | 89.4% | 93.6% |
| **Medicaid %** | 22.5% | 19.9% |
| **Medicare %** | 15.4% | 18.2% |
| **Private Insurance %** | 65.7% | 72.4% |
| **All-cause Cancer Mortality (per 100,000)** | 160.1 | 183.3 |
| **Population per Mental Health Provider (includes psychiatrist and psychologist)** | 1068:1 | 1860:1 |

# Interview Transcript Analysis: Medical Neighborhood

| **II. Financial viability is a strong driver in new initiatives**<br>• **As the leader of the IPA, his viewpoint is based on the healthcare market and he chooses what the IPA focuses on based on its ability to control cost while improving care, i.e. the triple aim framework. The bottom line is that since cancer survivorship care hasn't been shown to reduce costs, it is unlikely to gain traction as an initiative in this IPA.** | |
|---|---|
| He thinks in terms of a "market" area for cancer survivorship care. | p. 3 |
| Another major driver for development of initiatives is whether they "meet the triple aim," i.e. have a "positive impact on cost of care" or "improve the outcomes" or "patient experiences." He doesn't outright reject that cancer survivorship could meet these objectives. | p. 7 |
| He feels that the IPA and ACO can incentivize the priority conditions focused on in the PCMH through "reward[ing] positive behaviors" and giving "resources to help them adopt" new care plans. | p. 6 |
| He is only interested in initiatives that are very "pragmatic" with data that can be measured over the short term (less than "three years"). | p. 7 |
| Controlling costs over the short-term is the priority, and the inability to "measure it either accurately or in a timely manner" will undermine any initiative. | p. 8 |
| He makes a point to mention that they sometimes do initiatives that are mission-driven and not necessarily cost-effective, but cancer survivorship has not been one of them. | p. 9 |
| He thinks that initiatives usually are put forth if they have financial drivers, but he thinks cancer survivorship lacks financial drivers at this time. | p. 9 |

| The oncology-primary care relationship needs to be strengthened for cancer survivorship care to be implemented.<br>• The adult oncology-primary care relationship is weak. Incentives for better collaboration through the ACO and PCMH give reason to be hopeful that there may be improved collaboration in the future. As a pediatrician, he feels that "childhood cancers" are an anomaly; for a variety of reasons, pediatric primary care doctors and specialists provide better cancer survivorship care. | |
|---|---|
| He feels that there is a relationship between oncology and primary care partly driven by the "need that that has to occur" [perhaps due to the ACO?] | p. 3 |
| He is interested in "tools and processes" that will enhance collaboration between primary care and oncology. | p. 3 |
| He feels that there is a good "collegial" relationship between providers partly because of some oncologists working hard to ensure good communication. | p. 4 |
| He feels that the relationship between PCPs and oncologists is not as strong in the adult population. | p. 5 |
| He is explaining that part of the difference between children and adult populations in Buffalo is that pediatric oncology is only offered at Roswell Park and the Children's Hospital, but in the adults, they have community oncologists and the academic oncologists and he feels that there is a "historical" divide between those "in the ivory tower" and those in "private practice." [could this be referencing tensions re: Roswell's history as per fieldnotes?] | p. 5 |
| He feels that this positive relationship between providers and oncologists in pediatrics in partly due to the fact that people are willing to go the "extra mile" because of the "emotional aspect" of cancer in children. | p. 4 |
| He describes how primary care feels that cancer patients get lost to oncology, "going into the black box," and the providers don't know what is happening with their patients anymore. | p. 5 |
| He indicates optimism that we are at a time where collaboration needs to improve. [possible reference to market changes?] | p. 6 |
| In response to the interviewer's question about EMR, he explains that they have 20+ outpatient EMRs and a different inpatient EMR which don't talk to each other and make transmitting information "cumbersome and time-consuming." | p. 4 |
| He thinks oncology is changing and becoming more "collaborative" across the health system. | p. 10 |
| He can imagine the possibility of cancer survivorship fitting into this model nicely. | p. 10 |