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Primary Care-Led Transition Clinics Hold Promise in Improving Care Transitions for Cancer Patients Facing Social Disparities: A Commentary

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Abstract

Transitions in care are key junctions during which care coordination, communication, and individualized support are required to ensure optimal health outcomes for patients. This is particularly true for patients who face social disparities, such as poverty, limited health literacy, or belonging to a racial or ethnic minority, who are particularly at risk for experiencing poor care transitions. Interdisciplinary primary care-led transition clinics are an intervention that have shown promise in improving care transitions for diverse patient populations, including those that face social disparities, but their role in improving transitions in cancer care remains largely untapped. In this commentary we highlight why the time-limited support of an interdisciplinary primary care-led transition clinic that targets socially vulnerable cancer patients holds the promise of achieving more equitable healthcare access, healthcare quality, and ultimately more equitable health outcomes for cancer patients.

Keywords

access to care, primary care, managed care, patient centeredness, underserved communities

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Transitions in care are key junctures in which care coordination, communication and individualized support are imperative to ensuring optimal health outcomes for patients.[1,2] Care transitions are common throughout patients' engagement with the healthcare system and can include transitioning from pediatric to adult care, inpatient to outpatient care, and specialist to primary care. Regardless of the context, care transitions are recognized as high-risk scenarios for low-quality care and adverse medical events.[2] This is because when done poorly care transitions can lead to loss of critical information between care providers and create confusion for patients contributing to preventable readmissions, unnecessary healthcare visits, poor adherence to follow-up, and low patient satisfaction.[1-4]

Transition Clinics as a Step Toward Equitable Care Transitions

Equitable healthcare is care that is accessible and of equal quality for all patients regardless of ethnicity, age, gender, geographic location or socioeconomic status in order to achieve optimal health for all.[5] This often means providing care that differs from person to person and group to group to account for the inequities in access to care and quality of healthcare experienced by some individuals or groups due to social disparities they face such as poverty, limited health literacy, low education or belonging to an ethnic or racial minority.[3,6-9] Therefore, to achieve equitable healthcare during care transitions some patients, such as those facing social disparities, require more support than others to ensure optimal health outcomes.

One promising intervention to improve care transitions for medically complex and socially vulnerable patients is interdisciplinary primary care-led transition clinics.[8,10,11]

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The transition clinic (TC) team's composition can take many forms depending on the context but often includes a primary care physician and/or advanced practice nurse, social worker or community health worker, and psychologist.[10,12,13] Together they form an interdiscipinary team that provides time-limited, patient-centered support to individuals of a target population during a specified care transition. The transition clinics main objectives are to address and stabilize unmet medical and psychosocial needs, empower patients toward improved health, and facilitate care coordination between care providers during the identified care transition.

Examples of the potential benefits of transition clinics are growing in the literature. For example, Wang and colleagues in the United States have demonstrated the benefits of using transition clinics to support inmates with chronic medical conditions as they move from prison to community healthcare settings.[10,14] Demonstrated benefits include increased engagement in primary care and reduced emergency department visits within the first year following release leading Wang and colleagues to conclude that interventions focused on supporting medically and socially vulnerable patient populations during critical care transitions may offer a novel way to reduce social disparities, including socioeconomic and racial disparities, in chronic conditions.[10,14] There is also increasing evidence demonstrating the benefit of transition clinics in reducing hospital readmissions following discharge of at-risk patient populations with diverse disease conditions.[11,13] For example, one prospective randomized controlled trial comparing a transition clinic intervention with usual care upon hospital discharge amongst a large cohort of adults in the United States (of whom over half were homesless or living in a high-poverty area) found that those attending the transition clinic had a 37% lower probability of any inpatient re-admission at 90 days and had 42% fewer inpatient admissions at 180 days.[13]

According to Chin and colleagues who developed a roadmap to reduce disparities in healthcare organizations, the more levels of healthcare delivery an intervention targets the more likely it is to address the identified disparity.[9] This is arguably a key strength of the transition clinic model—it influences change across 4 levels of healthcare: (1) at the level of the patient, by providing patient-centered care with a focus on self-management, goal setting, and culturally-competent health education, (2) the provider, by facilitating communication between relevant healthcare providers to improve patient care and related health outcomes, (3) the microsystem (ie, the immediate clinical environment), by integrating new members into the patient's care team such as an advanced practice nurse and/or community health worker, and (4) the broader community, by integrating community- and healthcare-based resources related to housing, social, and cultural supports to achieve optimal patient-centered outcomes. Further, transition clinics are inherently team-based and interdisciplinary which Chin and colleagues describe as a "pillar of successful equity interventions."[9]

Transitions in Cancer Care

In the context of cancer care, the transition from active cancer treatment to follow-up care is well-known to be a critical care transition, serving as the focus of the 2006 Institute of Medicine (IOM) report, *From Cancer Patient to Cancer Survivor: Lost in Transition.* The report made clear that "*If care is not planned and coordinated, cancer survivors are left without knowledge of their heightened risks and a follow-up plan of action.*"[15] However, due to a multitude of medical or social factors, not all cancer patients face the same risk for getting lost during care transitions. Those at particular risk include elderly and multi-morbid patients.[3,16] They also include patients who face inequities in access to care and quality of healthcare created by social disparities including poverty, limited health literacy, low education or belonging to an ethnic or racial minority.[2,3,6-8,17,18] Since the 2006 IOM report, some important advances have been made to reduce inequities and improve care transitions for sub-groups of at-risk cancer patients who face social disparities, including the advent of patient navigation programs.[19] Yet there has been little exploration of using interdisciplinary primary care-led transition clinics to achieve these goals despite growing evidence of their merit in non-cancer, primary care-based research.

Primary Care-Led Transition Clinics in Cancer Care

Though the use of primary care-led transition clinics has been explored to some extent in cancer care,[20] there has been little focus on using them to achieve equitable healthcare transitions in sub-groups of at-risk cancer patients who face social disparities. This is despite widespread recognition that disparities exist within cancer care that run along socioeconomic, racial, ethnic, and geographic gradients.[21,22]

For example, one patient sub-group evidence has shown is particularly impacted by disparities in access to care and related health outcomes is women who develop cervical cancer. In high-income countries where cervical cancer screening and prevention programs are widely available, women who develop cervical cancer disproportionately represent an underserved group who often do not receive primary care due to barriers they face in accessing and receiving timely, high-quality care. Factors that contribute to these barriers include poverty, low education, being of immigrant background, and being HIV positive.[23-25] Given that many risk factors for the development of cervical cancer are driven by social factors that create health-related

inequities, a significant proportion of women who undergo treatment for cervical cancer might therefore benefit from enhanced support provided by a dedicated transition clinic during their transition from active cancer treatment to follow-up care. Screening for particular medical and social vulnerabilities using a validated conceptual vulnerability framework at the outset of cancer treatment could be one way to facilitate the identification of particularly at-risk women for whom the transition clinic model of care would be of most benefit.[26] Further, offering the intervention to those without an identified or stable primary care provider could be another effective strategy to identify those at highest risk for poor care transitions following active cancer treatment.

Once deemed an appropriate candidate for the transition clinic intervention, the transition clinic's primary care-led team would create an individually-tailored transitional care plan based on the medical and social needs of the individual, aimed at addressing root causes for their poor health outcomes. Specific transition clinic interventions might include: motivational interviewing to improve self-management of chronic health conditions, simplification of medication regimens, needs-based health education to improve health literacy, transportation coordination, speciality care coordination, ensuring caregiver supports are in place, and creating connections with relevant social services and cultural supports.[13] Further, patients who screen positive for depression or anxiety or who have identified mental health concerns could be offered therapy with the transition clinic's psychologist.

This sub-group of women with cervical cancer whom face social disparities that impact their access to high-quality, timely healthcare represent just one cancer population for whom primary care-led transition clinics might prove beneficial. In fact, the transition clinic model of care has the potential to benefit a wide array of cancer patients. In high-income countries, social disparities render all cancer screening programs (including colonoscopy, mammography, and lung cancer screening using computed tomography, or CT scans) less accessible and less often offered and performed in certain subsets of the population. Further, some cancer types are inherently characterized by a higher prevalence in socially vulnerable populations. These include head and neck cancers, hepatocarcinomas, and HIV/AIDS-related cancers. Much like many women with cervical cancer, a significant proportion of patients diagnosed with these forms of cancer may benefit from enhanced support as they transition from active cancer treatment to follow-up care.

Conclusion

Primary care-led transition clinics have shown promise in improving care transitions for diverse patient populations but their role in improving transitions in cancer care remains largely untapped. Through the time-limited support of an interdisciplinary team which targets socially at-risk cancer patients, primary care-led transition clinics have the potential to become an integral component of the evolving paradigm of healthcare for cancer survivors by improving access to care, quality of life, and supporting those most in need as they re-integrate into life and work post-cancer treatment. In this way, primary care-led transition clinics hold the promise of achieving more equitable healthcare access, healthcare quality, and ultimately more equitable health outcomes for cancer patients. To move from potential to reality, research that formally evaluates the efficacy of interdisciplinary primary care-led transition clinics in supporting socially at-risk patients based on outcomes such as patient satisfaction, quality of life, and access to care, as we have seen done in other sectors of health research, are needed in cancer care. It is our hope that this commentary will catalyze innovative research initiatives with this focus.

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