

The Impact and Importance of a Care Coordinator in Community Oncology

BY WENDY COLLINS



When a patient is diagnosed with cancer, the ensuing treatment plan becomes the highest priority. However, care coordination is just as important as the treatment a patient receives during their cancer journey. Care coordination comes in many forms:

- Improving access to care
- Ensuring continuity of care
- Transitioning patients between care settings
- Planning for discharge
- Connecting patients to supportive care services.

Care coordination is crucial for managing the adverse effects of cancer treatment and navigating patient challenges such as emotional distress, isolation, financial toxicity, and lower quality of life. The care coordinator at an oncology clinic assists patients in identifying barriers to care and then works to remove those barriers and ensure the patient achieves the best health outcome possible. In doing so, care coordinators promote health equity, and contribute to patients receiving comprehensive cancer care. That is the goal I am focused on achieving.

My Story

I am the care coordinator at the Beacon Clinic, a boutique cancer center in Coeur d'Alene, Idaho. The Beacon Clinic is committed to providing holistic patient care. I created the care coordinator role at the cancer center when I saw the stress caused by a cancer diagnosis in our patients' lives. My degree in crisis counseling has prepared me to walk alongside patients with cancer in a difficult season

of their lives. People present to the clinic from different walks of life. When they meet with their physician, they are focused on their overall outcome and treatment options. Often, the ability to discuss the issues that keep them awake at night does not happen in the exam room. That is where I come in.

I discover the psychosocial challenges a patient is experiencing by creating a space they are comfortable in. We also discuss the financial impact of cancer treatment on them and their families. This is a crucial step, as most patients underestimate or are underinformed about the impact of financial toxicity. As many as 51% of patients with cancer in the United States report catastrophic levels of financial hardship and are carrying medical debt due to their cancer treatment.¹ Therefore, a greater commitment to establishing health equity across the cancer care continuum is more important than ever.

Identifying a patient's needs is not enough. These issues must be addressed by actionable resources and community relationships to assist that patient. Because I understand this, I have been committed to creating partnerships in the community for referrals that our patients can utilize in their time of need. I apply for grants that ensure patients have access to medication when they cannot afford it. This helps reduce the financial burden that uninsured and underinsured patients bear. In addition, I refer patients to mental health professionals in the community when their needs are more than I can address. At the Beacon Clinic, we have community meal delivery services, as well as lodging and transportation assistance, to make life easier for patients experiencing a challenging situation.

Effective Tools

In my experience, the most useful tool in my arsenal to help improve health equity is the National Comprehensive Cancer Network (NCCN) Distress Thermometer. This tool has been invaluable in helping me identify the needs of our patients. It is a 10-point scale; 0 represents no distress, 10 represents severe distress, and a score of 5 or 6 indicates moderate distress. Patients who score a 5 or higher may benefit from immediate intervention to address the factors contributing to their distress. As a result, the front desk staff report all distress thermometer forms where patients have self-reported a 5 or higher, which allows me to identify patients who are feeling stressed. Once their challenges are addressed, these patients are asked to complete a new distress form a few weeks later. Then the care team and I address any other issues they may have and tackle those. We observe the results and impact of the interventions we have implemented.

On average, there is a 4-point reduction on the NCCN Distress Thermometer once we implement an intervention. Some of the tangible items patients require based on their self-report are easier to accommodate. Our local nonprofit organization provides volunteer drives to assist patients with cancer in getting to and from appointments. I have secured reduced lodging at some area hotels for our patients who are undergoing treatment. Through community partnerships such as this, we have found creative ways to address the unique needs of our patients.

Bridging Communication Gaps

The care coordinator is an integral part of the care team and often serves as a medical interpreter between their colleagues and patients. The relationship I have with patients and their families allows me to have conversations that patients—by their own admission—are uncomfortable having with their provider. Patients often overstate their wellness to their providers, and it takes an attentive and deliberate staff member to inquire about how patients are really doing—both mentally and physically. The level of attention a care coordinator pays to a patient is essential today, as many health care professionals are consumed with trying to obtain treatment reimbursement from insurance companies. Additionally, the care coordinator role can provide a “lift” to the clinic by taking on patient-centered administrative duties and supporting other departments.

Cancer does not wait for a convenient time to come into a person's life. A patient may be grieving a loved one before being blindsided by a cancer diagnosis. One of our patients poignantly stated, “It is impossible to plan for cancer financially.” At the Beacon Clinic, the care coordinator has positively affected patient treatment adherence by removing barriers to care that may have otherwise gone

unnoticed. Committing to the health equity of our patients allows us to treat patients holistically and will enable them to experience the best health outcomes possible.

In Closing

To comprehensively treat a cancer patient, a cancer program or practice must intentionally assess their patient's needs. Because of the relationships care coordinators build with their patients, they can help improve treatment adherence and can minimize treatment disruptions. I deliberately create the necessary space to identify how patients' needs relate to their roles in their families and communities. Being intentional in forming community partnerships also is imperative for the patient's success. Ultimately, a cancer program or practice must be able to do more than simply identify a patient's needs—they must deliver actionable strategies to rectify those deficiencies. 

Wendy Collins lives with her husband of 25 years in beautiful North Idaho where they have raised 4 children. Wendy has a natural love for walking with people through difficult seasons. She has been a care coordinator at the Beacon Clinic for 3 years. This role allows her to share her compassion with others and relieve some of the burden experienced by patients with cancer.

References

1. American Cancer Society Cancer Action Network. Survivor views: cancer & medical debt. Published March 17, 2022. Accessed November 10, 2023. <https://www.fightcancer.org/policy-resources/survivor-views-cancer-medical-debt#:~:text=Mirroring%20recent%20national%20reports%2C%2051%25%20of%20cancer%20patients,16%25%20who%20have%20since%20paid%20off%20their%20debt>