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Care Coordination in Oncology Social Work

Section 1: Introduction

References: 1, 11, 12, 16, 32, 45, 78, 88, 89

The History of Oncology Social Work

Oncology social work has been a specialty within medical social work for over 40 years. Several historical events led to its development and recognition as a distinct profession.

First, in the 18th and 19th centuries, hospitals became established in large American cities, including Philadelphia, New York, Boston, and Baltimore. Next, in the 20th century, more hospitals were being built throughout the country, mainly to address the growing need to manage infectious diseases. Between 1905 and 1915, social workers were hired into more than 100 hospitals across America, including Ida Cannon, one of the most noteworthy medical social workers in history (Fobair et al., 2009).

Cannon spent 40 years of her career at Massachusetts General Hospital (Mass General), establishing the first hospital-based social work program in America and advancing the profession nationwide in immeasurable ways (Massachusetts General Hospital, n.d.). She worked to promote “the expansion of the social work role in the hospital and the inclusion of the social perspective as a regular part of the medical treatment plan” (Massachusetts General Hospital, n.d., para. 9). Some of the highlights of Cannon’s career include:

- Developing a psycho-physiological approach to illness, which includes medical, social, and psychological aspects of patient care.
- Initiating group work for patients with certain diseases.
- Participating in clinical research and incorporating it into practice.

- Developing and implementing systems to measure social work interventions and document them in medical charts.
- Hiring and working alongside Harriett Bartlett, the department's first education director, to create programs that helped medical social workers further define their role and the quality of their work, while also broadening their professional growth. Over time, Bartlett became well known for her research and contributions to medical social work.
- Creating several national health care and social services programs, as well as a standardized training program for medical social workers at the Boston School of Social Work.
- Becoming a founding member of the American Association of Hospital Social Workers.

Cannon was a true pioneer in the field from the time she entered it, and she remains a role model for oncology social workers today (Fobair et al., 2009; Massachusetts General Hospital, n.d.).

Around the time of Cannon's retirement in 1945, innovations in cancer care began, with significant advancements in surgery, chemotherapy, and radiation in the 1950s. Around the same time, social work expanded as a profession, and the American Hospital Association determined that social work services were important for accreditation. Social workers were also encouraged to pursue graduate-level education to obtain employment in hospital settings.

Also in the 1950s, the psychosocial issues that cancer patients experience started to gain recognition when health care professionals, including oncology social workers, started writing about the psychological aspects related to a cancer diagnosis in medical journals. Shortly thereafter, cancer centers began increasing their social work staff to meet the needs of cancer patients in clinical and research settings. In the early 1970s, the National Cancer Act broadened the National Cancer Institute's scope and established the National Cancer Program Plan, signaling federal interest in the psychosocial issues of cancer patients. As interest in psychosocial oncology increased, hospitals added positions for medical social workers who became specialized in cancer care. Cancer treatments have also become more effective over time, leading to more cancer survivors and greater attention to psychosocial needs, which, in turn, have created more opportunities for research and clinical social work practice.

In the 1980s, the American Cancer Society began to spotlight oncology social work, which at that time became a subspecialty of medical social work. Professional psychosocial oncology groups also began to form. The National Association of Oncology Social Workers was established in 1984, and ten years later, it became the Association of Oncology Social Work (AOSW) (Fobair et al., 2009). Today, AOSW is a “non-profit international organization dedicated to the enhancement of psychosocial services to people with cancer, their families, and caregivers” (AOSW, n.d.a, para. 1).

Oncology Social Work Practice

AOSW has established standards of practice for oncology social workers. Within the scope of practice is delivering “services to cancer survivors, families, and caregivers through clinical practice providing comprehensive psychosocial services and programs through all phases of the cancer experience” (AOSW, n.d.b, para. 1).

Some of the functions of clinical practice beyond screening and assessment are to:

- Develop multidisciplinary care plans, with input from patients, survivors, and their loved ones, that are aligned with mutual goals.

- Use of a range of therapeutic techniques and other interventions, including supportive counseling, group work, and education, to address issues in each phase of the illness (AOSW, n.d.b, para. 5).

Oncology social workers also practice in alignment with the values of the social work profession and the guidelines published in the National Association of Social Work's Code of Ethics (AOSW, n.d.b).

Oncology social workers can be found in various settings, including comprehensive cancer centers and large health systems, smaller community hospitals, community organizations, and private practice (Zebrack et al., 2025). Oncology social workers are often integrated into a larger interdisciplinary team or agency staff, and "engage in specific practice behaviors throughout the continuum of care and across multiple practice settings" (Zebrack et al., 2025, p. 2). While the role of an oncology social worker may vary by the setting, care coordination is often a core practice behavior. According to Zebrack et al. (2025),

> *"The social workers' role on the multidisciplinary team is dynamic and includes patient care coordination through letters, phone calls, or electronic health record messages, or referrals to other ancillary care services, including psychiatry or behavioral medicine, mental health counseling, chaplaincy and spiritual support, or financial resources" (p. 3).*

Services provided to cancer patients and their loved ones by oncology social workers must reflect the following principles:

- Interventions should be based on an understanding of the patient's diagnosis and treatment plan, as well as their social and emotional circumstances.

- Interventions are designed to help people feel more in control of a situation (the cancer diagnosis) that likely causes them to feel helpless and out of control.
- Oncology social workers should focus their interventions on helping people cope with the physical, emotional, and social problems they encounter throughout the cancer experience (Blum et al., 2001).

According to Blum et al. (2001), interventions depend on the specific needs and issues that are identified through screening and assessment. Some interventions may occur only once, while others may be ongoing. For example, a referral to a community resource may be needed only once, whereas supportive counseling may continue throughout the disease trajectory. Interventions are most likely to be effective when health care professionals, including oncology social workers, have an understanding of the vast needs that may arise after a cancer diagnosis and when they are flexible and skilled in using various clinical strategies (Fawzy, Fawzy, Arndt, & Pasnau, 1996, as cited in Blum et al., 2001).

This course will expand on the first three Oncology Social Work Practice courses, reviewing core competencies of care coordination in the following aspects of oncology social work:

- Demonstrate an understanding of culturally-competent, equitable access to care for people living with cancer, including for vulnerable populations (e.g., persons of color, LGBTIQA+, young adults, elderly, disabled, Veterans, and low-income individuals).
- Describe certain aspects of care coordination, including navigating the health care system, addressing barriers to care, facilitating family meetings, and advocating for patients’ rights.

- Recognize social and practical needs that may arise for patients and families after a cancer diagnosis, and identify ways to address them.
- Explain how to arrange, facilitate, and support transitions of care throughout the disease trajectory.
- Interpret oncology case management practices and guidelines.

Section 1 Key Terms

Medical social work - "a field that focuses on meeting the various needs of individuals, families, and communities navigating challenges in health and wellness. When people are sick, in addition to physical care, they may also need support with the emotional, financial, and social complications that can arise. They may feel overwhelmed by the health care system, need assistance planning their aftercare transition, or seek counseling support to process changes in their lives. Medical social workers address all of these needs in a variety of settings" (University of Southern California Suzanne Dworak-Peck School of Social Work, 2019).

Oncology social work - "the primary professional discipline that provides psychosocial services to patients, families, and significant others facing the impact of a potential or actual diagnosis of cancer. The scope of oncology social work includes clinical practice, education, advocacy, administration, policy, and research" (AOSW, n.d.b, para. 11).

Interdisciplinary care - an approach in health care that allows each team member to operate within their discipline and scope of expertise, while encouraging collaboration through communication, interaction, and knowledge integration. Professionals collaborate to develop a shared understanding of the problem or patient's situation, share information, and create a comprehensive care plan to meet the patient’s needs. This approach can foster a “deeper understanding of complex health care issues by drawing on diverse knowledge bases and promoting coordinated care delivery” (Zimmerman, 2024, para. 3).

The Association of Oncology Social Work (AOSW) - a “non-profit international organization dedicated to the enhancement of psychosocial services to people with cancer, their families, and caregivers. Founded in 1984 by social workers interested in oncology, AOSW has become the world’s largest professional organization dedicated entirely to the psychosocial care of people affected by cancer. AOSW membership is comprised of an international set of professionals and students who practice in hospitals, cancer centers, home care agencies, hospice, community-based oncology practices, community programs, patient advocacy organizations, educational institutions, and other settings” (AOSW, n.d.a, para. 1).

Care coordination - described by the Agency for Healthcare Research and Quality (2024) as “the primary care practice that involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care, which means that the patient's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate, and effective care” (para. 2 & 3).

Section 1 Reflection Question

How does care coordination look in your practice?

Section 2: Vulnerable Populations and Equitable Access to Care

References: 2, 3, 5, 6, 9, 14, 17, 18, 34, 38, 39, 43, 44, 47, 49, 51, 52, 54, 56, 57, 58, 60, 61, 63, 65, 67, 68, 69, 70, 71, 72, 74, 75, 79, 80, 81, 83, 87

Vulnerability in the context of health refers to "the degree to which a population or individual is susceptible to harm or neglect influenced by both inherent (e.g., age, sex, race) and acquired (e.g., health behaviors, environment, sociocultural behaviors) risk factors" (Texas Epidemic Public Health Institute, n.d., para. 1).

Vulnerable populations are:

> *"Groups and communities at a higher risk for poor physical, psychological, or social health. These barriers are further intensified due to social, economic, political, and environmental components. Limitations due to illness or disability can also influence the vulnerability of a population" (Texas Epidemic Public Health Institute, n.d., para. 2).*

Minority groups, economically disadvantaged individuals, chronically ill or groups living with disabilities, older adults, children, mothers, immigrants, and rural residents are all considered vulnerable populations. They are considered vulnerable in the health care setting due to barriers and limitations that impede their access to care.

Health care access is defined as:

> *"The ability of individuals to obtain necessary health services in a timely, convenient, and affordable manner. This concept encompasses not only the availability of services but also factors such as the quality, affordability, and acceptability of care provided to diverse populations" (Regassa Senbato et al., 2025, para. 2).*

To build on this definition, equitable health care access “ensures that all individuals, regardless of their socioeconomic status, geographic location, or cultural background, can access the healthcare they need to achieve optimal health outcomes” (Regassa Senbato et al., 2025, para. 2).

Equitable access to health care is a public health concern for a few reasons. First, people can improve and maintain their well-being by accessing health care, which can have a ripple effect across communities and, at a broader level, enable them to participate fully in society. Equitable access also fosters social justice and reduces health disparities in disease prevention, early detection, and treatment, thereby decreasing health care costs and preventing complications.

While equitable access to health care is crucial, several barriers impede individuals' ability to receive the care they need. Barriers can be:

- Geographical: rural or remote areas have limited access to facilities and providers.
- Financial: high insurance premiums and other out-of-pocket medical costs can pose significant challenges, especially for low-income individuals and families.
- Cultural: language differences, mistrust of health care providers, and health beliefs that are not aligned with the majority of care given in America can hinder access to care.
- Systemic: fragmented health care systems and inadequate infrastructure exacerbate the challenges outlined above, making it difficult for vulnerable populations to receive the care they need (Regassa Senbato et al., 2025).

Oncology social workers are healthcare professionals who often address these barriers and others in collaboration with their interdisciplinary teams. As stated by Roberts (2019),

> *“Social workers are a viable resource and can provide a practical remedy to the challenge of delivering an equitable health care system. Due to the unique skill set held by social workers, they are able to facilitate the patient assessment process, pinpoint health concerns that may be considered atypical, and provide a continuum of care across the lifespan” (para. 7).*

This section will discuss some of the ways oncology social workers provide culturally-competent, equitable access to care for people living with cancer, including for vulnerable populations (e.g., persons of color, LGBTIQA+, young adults, elderly, disabled, Veterans, and low-income individuals).

Vulnerable Populations

Vulnerabilities typically arise from complex relationships among social, economic, cultural, and systemic factors. Specific individuals are considered vulnerable in the health care system based on characteristics, conditions, or circumstances that place them at elevated risk of disparities in access to and quality of services (Cleveland State University, 2024). This sub-section will provide an overview of vulnerable populations and identify interventions to promote equitable access to care.

Persons of Color

The National Institutes of Health (2025) defines a person of color as “someone who is not White or of European origin” (para. 29). This can include African American and Black people, Asian American, Native Hawaiian, and other Pacific Islander people, and Hispanic/Latino people, among different groups. Cancer in these populations will be reviewed next.

African American & Black People

Cancer was the second-leading cause of death in Black men and women, after heart disease, in 2022 (the most recent data available). Survival is lower in Black people than in White people for most types and stages of cancer. Data also show there has been a slower return to cancer screening after the COVID-19 pandemic in Black people when compared to White people, ultimately leading to later-stage diagnoses, delays in treatment, and increased cancer-related mortality (Saka et al., 2025).

These disparities are due to a variety of factors. First, they are "driven in part by lower socioeconomic status (SES), resulting in a higher prevalence of risk factors for cancer and other diseases as well as less access to high-quality care" (Saka et al., 2025, p. 2). In connection with lower SES, data from the most recent U.S. Census Bureau survey (in 2023) showed that 18% of Black people lived below the federal poverty level (FPL), and 8% were uninsured, which is higher when compared to 8% of White people living below the FPL and 5% being uninsured (Saka et al., 2025). Another social and economic factor is residential segregation. A large portion of black people live in urban areas that have fewer resources to support health and more things that expose them to health risks. As stated by Artiga et al. (2024),

> *"Black people are more likely to live in areas that have more limited educational and employment opportunities, more limited access to healthy food options, less access to green space, and more limited transportation options, which in turn make it more difficult to access health coverage and care and pursue healthy activities. Moreover, many of these areas pose increased environmental and climate-related health risks, including increased exposure to extreme heat, lead, pollution, and toxic or hazardous materials" (para. 9).*

Asian American, Native Hawaiian, and other Pacific Islander (AANHPI) People

According to the American Cancer Society (2024a), cancer is the leading cause of death in Chinese, Filipino, Korean, and Vietnamese individuals. In Asian Indian, Native Hawaiian, and Japanese individuals, it is the second leading cause of death. In the Samoan people, it is the third leading cause of death.

While there is an overall lower cancer mortality in these groups when compared to White people, the death rate is higher for some cancers. Asian American individuals are 40% more likely to die from liver cancer and twice as likely to die from stomach cancer when compared to White people. For Native Hawaiian and other Pacific Islander people, the death rate is 30% higher for breast cancer, 75% higher for liver cancer, and 2 to 3 times as high for cervical, stomach, and uterine cancers, when compared to White people.

Some reasons for these disparities may include lower screening rates, lower SES, language barriers, stereotypes, and discrimination. Additionally, variation in immigration history, combined with policies that limit health care access, can influence the prevalence of risk factors and people’s ability to receive medical care (American Cancer Society, 2024a; Massachusetts General Hospital, 2025).

Hispanic/Latino People

According to the American Cancer Society (2024b), cancer was the leading cause of death in the Hispanic population for ten years, from 2009 to 2019. It became the second leading cause of death in 2022, after heart disease (the most recent data available). These trends are similar to those of White people. Hispanic people are less likely than White people to have a localized-stage cancer, with the most considerable disparity in melanoma diagnoses.

These disparities are due to various factors. First, Hispanic people have more limited access to care when compared to White people, as 28% of Hispanic people are uninsured, and fewer Hispanic people report ease with getting to a location that provides medical care. They often lack access to primary care providers and rely on community health centers and emergency departments for care. Next, Hispanic people have lower SES and higher rates of poverty when compared to White people. Additionally, some individuals face challenges communicating with physicians, including language barriers (American Cancer Society, 2024b; Artiga et al., 2021).

Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual (LGBTQIA+) Individuals

Approximately 160,000 cancer diagnoses could occur in LGBTQIA+ individuals. This estimate is based on the percentage of people in the U.S. who identify as LGBTQIA+ and the number of new cancers diagnosed each year.

LGBTQIA+ people are considered vulnerable in health care based on specific risk factors, social/economic inequities that limit access to care, and a lack of gender affirming care. First, some LGBTQIA+ people engage in behaviors that increase cancer risk, including tobacco use, alcohol use, and having excess body weight. Of note, anxiety and depression may contribute to some of these behaviors. Next, LGBTQIA+ individuals are also more likely to be uninsured or underinsured, be unhoused, and to be living in poverty, all of which impact access to care. Another issue exists in cancer screening, which could be attributed to limited access to care, in general, and gender affirming care, more specifically, as well as people not knowing about screening for various reasons, including that their health care provider did not discuss it. For example, transgender and gender-nonconforming people are less likely to be offered screening tests (American Cancer Society, 2025b). In addition, there may be fear of negative responses and/or discrimination from health care providers that make LGBTQIA+ individuals more vulnerable when receiving medical care (National LGBT Cancer Network, n.d.).

Young Adults

Nearly 5% of cancer diagnoses in the U.S. in 2025 will occur in adolescents and young adults (AYAs) between the ages of 15 and 39 (National Cancer Institute, 2025). AYAs frequently experience a delay in their diagnosis, misdiagnoses, and barriers that make them a vulnerable population in cancer care. A delayed diagnosis can happen if symptoms are ignored, either by the individual experiencing them or by health care providers. Health care providers may also think symptoms are something else, as there is a belief that AYAs are too young to get cancer, ultimately leading to misdiagnoses and/or delays. Additionally, some AYAs experience financial instability, low income, and/or lack of health insurance, which limits their ability to access necessary medical care (Scott, 2025).

Older Adults

Different organizations define an older adult beginning at ages 60 or 65. In this section, data will be shared on adults aged 65 and over. In a report by Siegel et al. (2025), adults aged 65 and over accounted for 61% of cancer diagnoses in the U.S. in 1995. Still, in 2021, this percentage decreased to 59%, despite the number of older adults in the U.S. increasing. This means that in 2021, just over 1.2 million people diagnosed with cancer in the U.S. were aged 65 and over, accounting for a significant number of this population (U.S. Centers for Disease Control and Prevention, 2025b).

Older adults are considered vulnerable in the medical system because they may be frail and have compounding medical problems in addition to challenges with their cognition and mobility. The medical system often operates on a specialist model, resulting in fragmented care and a difficult-to-navigate system, which is especially challenging for older adults. Older adults are also more susceptible to preventable injuries, such as falls, infections, pressure wounds, malnutrition, and abuse or exploitation. Additionally, they may be socially isolated, lack available caregivers, have limited financial resources, and face barriers to accessing care for various reasons (Cleveland State University, 2024; Khan et al., 2024).

Disabled Adults

According to the U.S. Centers for Disease Control and Prevention (2024), over 70 million adults in the U.S., or 1 in 4 people, reported having a disability in 2022 (the most recent data available). While there are varying definitions of disability, the U.S. Centers for Disease Control and Prevention (2025a) defines it as “any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions)” (para. 1). Though the term disability is sometimes used to describe a single group of people, disabilities vary greatly and can impact a person’s vision, movement, thinking, remembering, learning, communicating, hearing, mental health, and social relationships (U.S. Centers for Disease Control and Prevention, 2025a).

As said by Hughes et al. (2022), there is no systematic documentation on the incidence of cancer in disabled people before their cancer diagnosis. However, we do know that over 2 million people in the U.S. are estimated to be diagnosed with cancer in 2025, and over 8 million individuals in the U.S. are receiving social security disability benefits (American Cancer Society, 2025a; Social Security Administration, 2025). Between 2015 and 2019 (the most recent data available), the Social Security Administration awarded disability benefits to nearly 2 million people each year, with about 6% (over 100,000) of those awards due to a primary cancer diagnosis. This number does not include individuals who were already disabled, then diagnosed with cancer. Social Security tends to focus on awarding benefits to people with the most severe terminal and metastatic cancers, such as lung, breast, and colorectal, making it difficult to estimate the number of people who have cancer and are disabled (National Academies of Sciences, Engineering, and Medicine, 2021).

Studies have shown that disabled adults are more vulnerable to cancer-related risk factors, face barriers to accessing health care, and deal with disparities in cancer screening, diagnosis, and treatment. More commonly than healthy adults, disabled adults are socially excluded, have higher levels of poverty, lower educational attainment, more unemployment, lack health insurance, have limited financial resources, lack reliable transportation, experience anxiety due to functional limitations, receive inadequate patient-provider communication, and face challenges with inaccessible medical equipment and health care facilities (Hughes et al., 2022; Yang, 2025). Disabled adults also have a high prevalence of chronic health conditions in addition to their disability, which may be the focus of medical visits, and there may be a delay in acknowledging cancer-related symptoms and receiving the appropriate work-up (Hughes et al., 2022).

Veterans

As stated by Martin et al. (2021), the U.S. Veteran population is “considered vulnerable in terms of health status, psychological functioning, and social context” (p. S28). Veterans tend to experience the following specific medical and psychosocial issues at disproportionate rates when compared to non-Veterans:

- Mental health or behavioral adjustment disorders
- Substance use disorders
- Post-traumatic stress
- Suicide

- Traumatic brain injury
- Chronic pain
- Amputations
- Hazardous exposures
- Homelessness (Olenick et al., 2015)
- Mobility issues
- Lack of cancer care due to living in rural areas
- Unreliable transportation (Greer, 2023)

Any of these issues alone, but especially in addition to a cancer diagnosis, makes Veterans vulnerable in the health care setting.

Low-income Individuals

According to the U.S. Census Bureau, close to 36 million people, or about 10% of the population, were living in poverty in 2024 (Shrider & Bijou, 2025). Low-income individuals are those who are "facing significant economic hardships, often lacking stable housing and financial resources" (Cleveland State University, 2024, para. 30). Economic hardship and instability are linked to higher rates of chronic illness, mental health issues, and substance use. Low-income individuals are a vulnerable population in health care because they experience poorer health outcomes, a higher disease burden, greater difficulty accessing care, and lack health insurance and the resources they need, such as food, housing, transportation, and a stable support system (Cleveland State University, 2024).

Equitable Access to Care

As noted above, vulnerable populations face multiple barriers to accessing health care, which lead to disparities and inequities. Historically marginalized populations can also experience a heightened vulnerability when they become ill because of stigmas and discrimination that already exist. They may already face barriers to having their needs met. Then, when a diagnosis is made, the illness can exacerbate these issues.

With core values of service, social justice, the dignity and worth of the person, the importance of human relationships, integrity, and competence, social workers are strong advocates for vulnerable populations. In cancer care, oncology social workers are often members of interdisciplinary teams who work with vulnerable populations to promote equitable access to care. Social workers are trained to view each person as an individual within their environment, and they have the following knowledge and abilities to:

- Screen, assess, and identify each patient and family's unique psychosocial needs.
- Enhance an individual's already existing strengths, resources, and coping skills.
- Develop a psychosocial plan of care with interventions that evolve in response to psychosocial needs and the recommended treatment plan.
- Evaluate the efficacy of interventions (Bullock et al., 2021; Mesca & Storace, 2025).

After assessing for psychosocial needs, oncology social workers can employ the following interventions to promote equitable access to care:

- Providing emotional support to patients and their families during times of crisis, stress, and difficulty related to the cancer diagnosis and treatment. Active listening, empathetic understanding of concerns, and creating a non-judgmental space for patients help them feel safe, understood, and accepted, ultimately promoting overall emotional well-being.
- Coordinating services both inside and outside of the hospital.
    - Within the hospital, this means working with the interdisciplinary team to take an integrated, collaborative approach to patient care. It also means helping patients navigate a complex health care system by providing informational support on the system itself, available services, and their rights as patients, including explanations of informed consent, treatment options, and how to access specialty services.
    - Outside the hospital, this entails addressing social determinants of health, building collaborative relationships with community agencies, and making appropriate referrals to services, including housing, food assistance, and transportation.
- Securing health insurance for eligible individuals and/or applying for financial assistance programs.
- Practicing with a trauma-informed lens.
- Providing culturally-competent communication that builds trust and engages the patient in their health care experience.
- Arranging and coordinating the use of medical translators for patients and families who speak languages other than English or are hearing-impaired.

- Educating and advocating for patients' rights, including "the right to privacy and confidentiality of medical information, the right to receive appropriate and respectful care, the right to make informed decisions about their treatment, and the right to receive non-discriminatory or prejudiced care" (Mesca & Storace, 2025, p. 3 & 4).
- Advocating with local government agencies for the needs of patients with serious illnesses (Bullock et al., 2021; Mesca & Storace, 2025).

As said by Roberts (2019), "since the inception of the profession, social workers have focused on public needs and helping underserved populations access health care. Factoring complete social, economic, and physical contexts into patient assessments and treatment plans is paramount if we are to produce an optimal health care system" (para. 5). Because oncology social workers take all aspects of a person's situation into consideration when implementing the above interventions, they are promoting equitable access to care and working towards better health outcomes for patients.

Cultural Awareness, Competence, Humility, and Self-Reflection

As a part of promoting equitable access to care, oncology social workers practice in a culturally competent manner, drawing on their knowledge and skills in cultural awareness, self-reflection, and humility. They can also serve as leaders in these areas by modeling and encouraging others to practice these approaches.

Culture

According to the National Center for Cultural Competence (n.d.a), culture is defined as:

> *“The learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world. It comprises beliefs about reality, how people should interact with each other, what they “know” about the world, and how they should respond to the social and material environments in which they find themselves. It is reflected in their religions, morals, customs, technologies, and survival strategies. It affects how they work, parent, love, marry, and understand health, mental health, wellness, illness, disability, and death ” (para. 1).*

Cultural Awareness

One way to think of cultural awareness is the mindful recognition of similarities and differences among groups. It includes understanding what culture is and what it is not, how people become part of a culture, and the role of culture in their lives. It also entails awareness of power, privilege, and oppression.

To apply cultural awareness in practice, social workers must recognize their own cultural influences on their values, worldviews, beliefs, traditions, norms, and perceptions, which constitutes self-reflection, and they must also understand these influences among the people they serve. Without this self-awareness, social workers could impose their own culture on their clients (Barsky, 2018; National Center for Cultural Competence, n.d.a).

Some strategies for practicing cultural awareness include:

- Acknowledging where understanding is lacking and being open to learning.
- Being open to others' characteristics and empathizing with their life experiences.
- Recognizing that the patient is the most knowledgeable person about themself and what is best for them.

- Learning from other people who have different beliefs, values, and worldviews (U.S. Department of Health and Human Services, Office of Minority Health, n.d.).

Cultural Competence

Cultural competence in social work extends beyond awareness and self-reflection by building on knowledge and values, while emphasizing effective practices and actions. While there are several different definitions of cultural competence, the U.S. Department of Health and Human Services (as cited in the National Center for Cultural Competence, n.d.b), defines it as:

“A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities” (para. 23).

Regarding social work practice, the National Association of Social Workers (NASW) has published ‘Standards and Indicators for Cultural Competence’ (2015), which states the following:

> *“Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, spiritual traditions, immigration status, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each. Cultural competence is a set of congruent behaviors, attitudes,*

> *and policies that come together in a system or agency or amongst professionals and enable the system, agency, or those professions to work effectively in cross-cultural situations. Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes. Competence in cross-cultural functioning means learning new patterns of behavior and effectively applying them in appropriate settings" (p. 13-14).*

The NASW also notes that cultural competence is a lifelong process for social workers who will continue to encounter diverse clients and new situations in their practice.

Some strategies for practicing cultural competency include:

- Learning about cultural identities, including one's own and others', and recognizing the strengths inherent in all cultures.
- Maintaining a knowledge base of cultures and demonstrating competence in the provision of services.
- Respecting the beliefs, values, and communication preferences of others.
- Communicating effectively and in a culturally-sensitive manner.
- Adapting services to each patient's unique needs.
- Experiencing new cultures.
- Combating stereotypes.
- Advocating for policies and practices that promote cultural competence (National Association of Social Workers, 2015; U.S. Department of Health and Human Services, Office of Minority Health, n.d.).

Cultural Humility

Cultural humility builds on cultural awareness and competence. As noted above, cultural awareness entails recognizing and understanding how culture shapes individuals. Cultural competence is the ability to view culture at both the individual and broader levels and to communicate, respond, and practice appropriately.

In social work practice, cultural humility is the:

> *"Attitude and practice of working with clients at the micro, mezzo, and macro levels with a presence of humility while learning, communicating, offering help, and making decisions in professional practice and settings" (National Association of Social Workers, 2015, p. 16).*

The NASW also notes that cultural humility is a lifelong commitment to learning and self-evaluation. Additionally, because social workers are often oriented toward others, they are well positioned to address power imbalances and to develop mutually beneficial partnerships, both of which are components of cultural humility.

Cultural humility is also viewed as a person's ability "to remain open to another person's identity" (Caba & Colón, 2022, para. 2). It entails presenting oneself as a learner rather than an expert and treating others with respect and empathy. In cancer care, it helps providers recognize that an individual's cultural background, beliefs, values, and traditions can influence decision-making. It can also involve acknowledging power imbalances that may exist in health care provider-patient relationships and holding institutions accountable to ensure that the best options for care are available to every patient.

Cultural humility in cancer care includes considering family dynamics, gender roles, shame related to the cancer diagnosis, body autonomy, end-of-life issues, and grief and loss. For example, cancer can change roles within the family, which may cause conflict or interrupt the way a household functions. Some belief systems may also credit a cancer diagnosis to past actions or karma, which can lead a patient to feel shameful or stigmatized. Some groups also hold specific views related to what happens to their bodies, which may lead a patient to decline certain treatment options. Additionally, some cultures are uncomfortable with end-of-life planning, whereas others may be open to it. Culture may also define how people grieve, with some weeping openly, while others do so in private. Therefore, being open, asking questions, and showing interest in a patient's culture as standard clinical practice can help build trusting relationships and engage patients in a shared, collaborative experience, thereby improving quality of life (Caba & Colón, 2022).

Some strategies for practicing cultural humility include:

- Asking about identity first to understand how patients define themselves, their values, their strengths and priorities, and their barriers.
- Asking about a patient's cultural background, traditions, practices, and preferences.
- Avoiding stereotypes and minimizing power imbalances.
- Considering that a disease is not the only issue that is present at any given time. Patients may be worried about cultural considerations or other issues related to their care.
- Listening more than speaking and providing opportunities for patients to express themselves in the conversation. Using respectful language. Observing non-verbal cues.
- Taking each opportunity to build trust and follow through on promises.

- Reflecting on one’s cultural identity, beliefs, and biases, to better understand how they inform interactions with patients.
- Learn about biases, discrimination, historical and structural inequities, microaggressions, and trauma, to inform practice (McGee-Avila, 2018; National Center on Advancing Person-Centered Practices and Systems, 2024).

Section 2 Key Terms

Vulnerable populations - “groups and communities at a higher risk for poor physical, psychological, or social health. These barriers are further intensified due to social, economic, political, and environmental components. Limitations due to illness or disability can also influence the vulnerability of a population.” Minority groups, economically disadvantaged individuals, chronically ill or groups living with disabilities, older adults, children, mothers, immigrants, and rural residents are all considered vulnerable populations. They are considered vulnerable in the health care setting due to barriers and limitations that impede their access to care (Texas Epidemic Public Health Institute, n.d., para. 2).

Health care access - “the ability of individuals to obtain necessary health services in a timely, convenient, and affordable manner. This concept encompasses not only the availability of services but also factors such as the quality, affordability, and acceptability of care provided to diverse populations” (Regassa Senbato et al., 2025, para. 2).

Equitable health care access - ensuring that “all individuals, regardless of their socioeconomic status, geographic location, or cultural background, can access the healthcare they need to achieve optimal health outcomes” (Regassa Senbato et al., 2025, para. 2).

Cultural awareness - being “cognizant, observant, and conscious of similarities and differences among and between cultural groups” (National Center for Cultural Competence, n.d.a, para. 2).

Cultural competence - the process of learning about other cultures to adapt services and make them more responsive to communities.

Cultural humility - the acknowledgment that culture is unique to each individual and that learning is a lifelong process (National Center on Advancing Person-Centered Practices and Systems, 2024).

Section 2 Reflection Questions

What is your experience working with vulnerable populations?

What interventions have you found effective in working with them?

How do you promote equitable access to care?

How do you practice cultural awareness, competence, and humility?

Section 3: Care Coordination

References: 1, 12, 15, 21, 23, 24, 29, 30, 33, 35, 40, 42, 46, 48, 62, 76, 82, 85, 86, 88

Care coordination is described by the Agency for Healthcare Research and Quality (2024) as “the primary care practice that involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care, which means that the patient's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate, and effective care” (para. 2 & 3). Ultimately, care coordination supports patients in managing chronic conditions and receiving care aligned with their goals (Centers for Medicare & Medicaid Services, 2023).

Care coordination is a practice behavior that oncology social workers engage in throughout the continuum of care and across multiple practice settings (Zebrack et al., 2025). According to Bires (2023), oncology social workers often “act as care coordinators, collaborating with healthcare teams to ensure seamless delivery of services, and they help patients navigate complex healthcare systems, access financial resources, and coordinate multidisciplinary care” (para. 7).

It has been established that cancer places significant physical, emotional, and financial burdens on patients and their families. These burdens can be more difficult when patients are already facing social barriers, such as economic instability, limited literacy, lack of access to health care, living in an under-resourced community, and/or an unsafe neighborhood. For example, a patient with low socioeconomic status may have limited access to health care. Needing medical care because of symptoms can exacerbate this issue and cause the patient to have a later-stage cancer diagnosis or receive inadequate treatment, leading to a higher likelihood of death (Bires, 2023; U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, n.d.).

Oncology social workers can assess the factors affecting patients’ lives and coordinate care to support them through their cancer diagnosis. This section will describe certain aspects of care coordination, including navigating the health care system, addressing barriers to care, facilitating family meetings, and advocating for patients’ rights.

Navigating the Health Care System

The current health care system is fragmented and disjointed, with processes across primary care and specialist care varying for patients, often leaving them confused and frustrated. Providers may not receive the information they need from other providers to give patients adequate care, and patients may be unclear about the reasons they are seeing certain providers and the next steps in their care (Agency for Healthcare Research and Quality, 2024).

A cancer diagnosis is often overwhelming and complex. After a diagnosis, patients and their families are placed within a challenging health care system that they are trying to navigate while also feeling overwhelmed with information about the diagnosis, treatment options, side effects, insurance coverage, and much more. They may also be struggling with the physical, mental, and emotional impact of the disease (Sharpe & Scheid, 2018).

Oncology social workers play a unique role within the health care system and within their teams because of their knowledge of cancer and its effects, their skill in conducting assessments, and their training in providing evidence-based interventions. Patients, caregivers, interdisciplinary teams, and institutions/ organizations often rely on oncology social workers to integrate these aspects of their role into patient care (Costello, 2025).

Oncology navigation is a core practice in psychosocial care. It is defined as “individualized assistance offered to patients, families, and caregivers to help overcome healthcare system barriers and facilitate timely access to quality health and psychosocial care from prediagnosis through all phases of the cancer experience” (The Professional Oncology Navigation Task Force, 2022, para. 13).

Within AOSW’s Standards of Practice (n.d.b), oncology social workers are expected to provide services to cancer survivors, families, and caregivers that foster their adaptation to the diagnosis, improve their quality of life, direct them through the health care system to achieve high-quality care, and mobilize supportive resources, all of which involve aspects of navigation.

The Professional Oncology Navigation Task Force (2022) has also established standards of practice for patient navigators, including those serving as clinical navigators/oncology social work navigators. These standards of practice address the following areas:

- Ethics
- Qualifications
- Knowledge
- Cultural and linguistic humility
- Interdisciplinary and interorganizational collaboration
- Communication
- Professional development
- Supervision
- Mentorship and leadership
- Self-care
- Prevention, screening, and assessment
- Treatment, care planning, and intervention
- Psychosocial assessment and interventions
- Survivorship
- End of life

- Advocacy
- Operational management
- Practice evaluation and quality improvement
- Evidence-based care

In cancer care, research has shown that patients enrolled in navigation programs had significant improvements in access to care and in optimizing treatment outcomes. Patients also reported greater satisfaction with their care, particularly related to its quality (Chen et al., 2024).

Some ways that oncology social workers help facilitate patients and families' ability to navigate the medical system include:

- Conducting a comprehensive assessment of strengths and needs, which includes learning about any services that are already established.
- Considering the diagnosis and prognosis, personal characteristics, financial concerns, emotional state, and physical, social, and spiritual environment.
- Identifying gaps in services and barriers to care.
- Responding to patients’ preferences for receiving care and support, communication, disclosure, and decision-making.
- Engaging them in shared decision-making by encouraging them to be informed and active partners with all involved in their care, emphasizing the patient’s importance throughout the process.
- Respecting autonomy.

- Assessing whether information is understood by all involved in the patient's care, identifying knowledge gaps, providing education, and exploring any ambivalence.
- Developing a plan to address any needs.
- Identifying, providing, and referring to appropriate resources that will address barriers to care.
- Reassessing throughout the continuum of care (Konrad, 2016).

Care Coordination for Patients with Underlying Mental Health Issues

Patients with underlying mental health issues may face their own set of health challenges that go beyond the effects of their psychiatric symptoms and negatively impact their physical health. Various affective, psychological, and cognitive symptoms may interfere with healthy lifestyle decisions, motivation to seek care, and the ability to trust and engage with health care providers. In addition, symptoms of depression, such as fatigue, despair, and hopelessness, as well as conditions with reality distortions, including hallucinations and delusions, can increase already existing challenges, including those related to accessing medical care.

Research has shown that people with mental health issues and chronic medical conditions are less likely to receive medical care and adhere to treatment plans than people without. Studies have also shown that patients with mental health conditions have a higher mortality rate than people in the general population, and one study has shown higher cancer-related mortality in this group. However, their incidence of cancer is not greater than that of the general population. One explanation for these differences is that patients with mental health issues may have less access to screening, causing a delay in making the diagnosis and a more advanced stage of disease. Additionally, they generally have limited access to cancer care. They are less likely to receive specialized interventions, such as surgery, chemotherapy, or radiation, due to the complex nature of these treatments (Lyckholm & Aburizik, 2017).

In care coordination for patients with underlying mental health issues, autonomy should be respected and decision-making capacity presumed; however, mental illness can “cloud one’s judgment, making it difficult to reach decisions about one’s cancer care that are in harmony with one’s beliefs and values” (Lyckholm & Aburizik, 2017, p. 446). Concerns about a patient’s decision-making capacity may warrant further evaluation. It is important to note that decision-making capacity is on a spectrum, and patients with mental illness should not be deemed to lack this capacity until a formal evaluation has taken place. If capacity is compromised, a surrogate decision-maker should be involved in the patient’s care. Ideally, this decision-maker would be someone who knows and cares about the patient and has been or could be involved in their care (Lyckholm & Aburizik, 2017).

In addition to navigating the medical system, oncology social workers may also facilitate the evaluation of the patient's decision-making capacity. In many cases, these assessments are done by physicians or advanced practice professionals. They are “best when made and documented by the clinicians who will perform a procedure or treatment” (McFarland et al., 2020, para. 21). Bioethicists and mental health professionals, such as a psychiatrist, may also be involved in making determinations about decision-making capacity (McFarland et al., 2020).

Oncology social workers may communicate with individuals in the patient’s support system and collaborate with the interdisciplinary team to support the process of identifying a surrogate decision-maker. Notably, the individuals who can serve in this role vary by jurisdiction (McFarland et al., 2020). Oncology social workers may also coordinate care with any other mental health professionals involved in the patient's care, which can help optimize treatment of the mental illness. Furthermore, they may be involved in connecting patients with mental health concerns to resources that address barriers to care and provide them with comprehensible cancer-related education.

Coordinating Neuropsychological Evaluations

In addition to working with patients with underlying mental health issues, oncology social workers may also work with patients who have experienced cognitive changes as a result of the cancer itself, such as a brain tumor, or from the effects of specific cancer treatments, such as chemotherapy, radiation therapy, and hormone therapies. Cognitive changes may include difficulty concentrating, processing thoughts, multitasking, learning and recalling new information, and finding words or remembering things (Memorial Sloan Kettering Cancer Center, n.d.). Based on their role and patients' situation and needs, oncology social workers may facilitate referrals for neuropsychological evaluations.

Clinical neuropsychologists are experts in "identifying, diagnosing, and treating changes in a person's cognitive function (ability to think), personality, behavior, and mood (Wefel, 2013, para. 1). Their evaluations typically consist of a clinical history and interview, including obtaining information from the patient and sometimes family members and friends, about symptoms, medical history, and other factors, and cognitive testing.

After the evaluation, neuropsychologists will draft a report that may include cognitive strengths and weaknesses, diagnoses, recommendations, and the treatment plan. The results are shared with the patient and health care providers involved in their care (Wefel, 2013). It is helpful if oncology social workers receive this report so they can support the patient in adhering to the recommended treatment plan and coordinate any identified care needs. For example, if a patient requires transportation to neuropsychological appointments or cognitive rehabilitation, an oncology social worker can assist them in securing these services.

The interventions that neuropsychologists provide include:

- Education
- Memory aid training
- Adaptation and problem-solving skills
- Behavior and environmental modifications
- Strategies to manage daily life
- Recommendations for work or school accommodations
- Medication
- Referrals to cognitive rehabilitation and/or psychiatry (Memorial Sloan Kettering Cancer Center, n.d.; Noll et al., 2018; Wefel, 2013)

Studies have shown that these interventions, including cognitive rehabilitation, can improve cognitive dysfunction in cancer survivors (Von Ah & Crouch, 2021).

Coordinating and Facilitating Family Meetings

In cancer care, family meetings are typically held under specific circumstances. The first is close to the time of the diagnosis, when patients and their families are learning about the disease, its treatment options, and available support. The second occurs when a patient is admitted to the hospital and treatment options or goals of care require review. In this instance, there is likely a change in the patient’s medical condition that warrants discussion. The third occurs during the transition from active treatment to palliative care or hospice care, when family support and planning for the patient’s ongoing needs are essential. The fourth occurs when there is conflict in a patient’s care among the various people involved (Coyle & Kissane, 2010).

Once the need for a family meeting is identified, the oncology social worker can work with the patient (if they can participate), their family, and the interdisciplinary team to coordinate the meeting. It is crucial to schedule a time that works for the patient, their family, and the patient’s primary oncologist. If the patient is admitted to the hospital, a different physician may be responsible for the inpatient care. In this case, the oncology social worker can consult both physicians to determine which one will attend the family meeting.

After the physician’s availability is determined, the oncology social worker can meet with the patient and their family to arrange the family meeting. If the patient is not able to participate in the meeting, the oncology social worker can work directly with the patient’s health care power of attorney or point of contact. If the oncology social worker has not met this person or the family before this time, it is helpful for them to learn some information about the family, including its composition, living arrangements, relationships, lifestyle, culture, values, and spiritual beliefs. This information will enable the interdisciplinary team to understand the family system, its coping mechanisms, any expectations they may have, and their potential resilience in facing the situation.

In this encounter, the oncology social worker can also discuss the need for a family meeting, evaluate who should be invited on behalf of the patient and their family members, and finalize the meeting time. The oncology social worker will also want to identify a private space for the meeting and communicate the location to all participants. In addition to communicating the reason for the meeting, it is helpful for the oncology social worker to inform the family in advance which members of the interdisciplinary team will attend. All this information will help the patient and their family understand what to expect (Gritti, 2015). Lastly, the oncology social worker may wish to convene a pre-meeting with the interdisciplinary team to clarify goals, share information, and develop a plan for the meeting.

When the family meeting takes place, an oncology social worker may lead it, or it may be led by a physician, advanced practice provider, or nurse. As stated by Glajchen (2022),

> *"Social workers are well-trained in family communication, psychosocial support, patient- and family-centered care, and managing family and team conflict, which can greatly assist the oncologist. In addition, social workers are skilled in accessing community resources and entitlements which promote coping for patients and caregivers, alleviate burden, and encourage follow-through for treatment recommendations" (p. 663).*

There are several components to facilitating a family meeting, including:

- Starting with introductions, establishing the meeting goal, and setting ground rules, such as the time available.
- Assessing the patient and/or family's understanding of the medical situation.
- Asking the patient and/or family how much information they want.
- Discussing the patient's illness, treatments, course, and prognosis.
- Exploring what could be done next with a focus on learning about the patient, what is important to them, what they would want for their care, and any beliefs that may be influencing it.

- Providing recommendations and identifying the decisions that need to be made.
- Summarizing what was discussed and developing a clear plan for next steps.

A medical provider may wish to lead certain parts of the meeting, with support from the oncology social worker, including discussion of the illness and prognosis, treatment options, and recommendations. Throughout the meeting, opportunities for questions, exploring thoughts and feelings (check-ins), and assessments of understanding should be incorporated. Empathetic statements should also be offered (Cerceo, n.d.). Gritti (2015) also recommends using clear, practical, and straightforward language; asking open-ended questions; repeating and rephrasing; active listening; offering helpful comments; and being attuned to nonverbal communication as additional essential strategies for family meetings.

Finally, the oncology social worker may wish to follow up with the family after the meeting to continue providing support to the patient and their family and to assist with communicating questions and concerns to the interdisciplinary team.

Section 3 Key Terms

Oncology navigation - “individualized assistance offered to patients, families, and caregivers to help overcome healthcare system barriers and facilitate timely access to quality health and psychosocial care from prediagnosis through all phases of the cancer experience” (The Professional Oncology Navigation Task Force, 2022, para. 13).

Standards of practice - guidelines that define clinical activities. AOSW has developed standards of practice. The Professional Oncology Navigation Task Force has also created them for individuals serving in oncology navigation roles.

Standards of practice should be referenced and adhered to according to an individual's professional role.

Section 3 Reflection Question

What types of care coordination do you perform in your role?

Are there specific aspects of care coordination that are more challenging than others? If so, what are some reasons?

Section 4: Identifying and Addressing Social and Practical Needs

References: 4, 12, 15, 19, 20, 22, 25, 31, 36, 37, 41, 53, 55, 59, 77, 84

Health-related social needs (HRSN) are factors that affect individuals. Although this term is often used interchangeably with social determinants of health (SDOH), there is an essential distinction between the two.

> *"HRSN are defined as an individual's unmet, adverse social conditions (e.g, housing instability, homelessness, nutrition insecurity) that contribute to poor health and are a result of underlying social determinants of health (conditions in which people are born, grow, work, and age)" (Hinton, 2023, para. 1).*

Because of HRSN's impact on health outcomes, the National Comprehensive Cancer Network (NCCN) established a working group to identify measures for HRSN screening and to develop practice recommendations.

As a result of this group's work, the NCCN recommends screening in four core areas, including:

- Transportation access

- Housing security
- Access to food
- Financial security

The NCCN also recommends that, based on the patient's specific needs, secondary screening topics should include:

- Social support and caregiver support
- Utility assistance
- Work support
- Neighborhood and community safety
- Health insurance needs
- Health literacy and health insurance literacy
- Digital connectivity

The recommendations also include screening cancer patients at least once a year for HRSN and during significant care transitions, such as moving from one treatment to another or during survivorship care planning. The reasoning is that patients' needs can change over time and affect their ability to access care, so it is essential to remain aware of these concerns throughout the disease trajectory. Therefore, the working group emphasized that screening for these concerns should be a routine component of cancer care and an ongoing conversation. In addition to screening, institutions should have referral processes and staff, such as oncology social workers, to assess and intervene appropriately (National Comprehensive Cancer Network, 2023).

Financial Toxicity

The National Cancer Institute (n.d.) defines financial toxicity (also called financial distress) as:

> *"A term used to describe problems a patient has related to the cost of medical care. Not having health insurance or having a lot of costs for medical care not covered by health insurance can cause financial problems and may lead to debt and bankruptcy. Financial toxicity can also affect a patient's quality of life and access to medical care" (para. 1).*

A report from the National Cancer Institute (n.d.) notes that cancer patients have a higher chance of experiencing financial toxicity when compared to people without cancer. Several studies have examined this topic and have shown that cancer survivors have higher out-of-pocket costs related to their insurance and health care (direct medical costs), incurred non-medical costs (transportation, childcare), gained medical debt, depleted assets, and experienced loss of income, more so than people without cancer.

- One study of a nationally representative sample showed cancer survivors spent around $1100 annually on out-of-pocket costs, compared to just over $600 for people without a cancer history.
- Other studies have shown that between 33% and 80% of cancer survivors used their savings to pay for medical expenses, and between 2% and 34% have borrowed money to pay for their care or have medical debt.
- Cancer survivors report decreasing their spending on food, clothing, utilities, and leisure activities, as well as selling stocks, investments, property, and possessions to deal with their experiences.

- Another study showed that people with a cancer history were less likely to be employed three years after their diagnosis and that their family income dropped by about 20%.
- Adult survivors of adolescent and young adult cancers also lost about twice as much income due to productivity loss.
- Lastly, cancer survivors are 2.7 times more likely to file for bankruptcy than people without cancer (National Cancer Institute, 2024).

As noted above, financial toxicity also includes not having health insurance. One analysis by the American Cancer Society (2024c) examined the insurance status of approximately 6.4 million cancer cases among people aged 18-64. They found that 4.4%, or just over 48,000 people with cancer, were uninsured. Another national analysis found that approximately 25 million Americans are uninsured, with most reporting that insurance costs were too high. Other people lack access to employer-sponsored insurance, or, if they reside in a state that has not expanded Medicaid coverage, they may remain ineligible for insurance (Tolbert et al., 2024). Even with health insurance, individuals may still encounter difficulties navigating their plan or appealing insurance denials (Lawrence, 2023).

Financial distress as a whole leads to delayed or interrupted care, chronic stress, emotional distress, decreased health-related quality of life, and higher mortality (Chowdhary et al., 2019).

One way to proactively identify financial toxicity is through screening. Two validated tools in cancer care are the Comprehensive Score for Financial Toxicity (COST) and the NCCN Distress Thermometer. Although the NCCN Distress Thermometer is not a financial-toxicity-focused tool, it assesses financial hardship, including insurance and transportation, among other factors (Falconer, 2023).

Screening tools can be administered during an initial consultation or admission and should be repeated at different time points throughout the disease trajectory.

Once financial toxicity is identified through screening, an oncology social worker can meet with the patient to assess their concerns, discuss financial assistance programs, and make appropriate referrals. They can also engage in ongoing assessment and collaboration with the patient and the interdisciplinary team (Chowdhary et al., 2019).

If the patient has not been screened for financial toxicity, questions about financial concerns should be included in a psychosocial evaluation as early in the disease process as possible to identify these needs and intervene proactively. Ongoing psychosocial assessment and collaboration with the interdisciplinary team are also beneficial to the patient in this instance.

Additional Barriers to Care

In addition to financial and health insurance barriers, some other obstacles to patient care include:

- Living in a rural or medically underserved area
- Lack of transportation or lodging
- Needing childcare or eldercare
- Employment-related concerns or issues navigating disability benefits
- Limited social support
- Emotional distress or mental health concerns, including fear, anxiety, or depression
- Low health literacy can lead to difficulties in health care communication

- Accessing appropriate resources (Hendren et al., 2011; Lawrence, 2023)

Oncology social workers are critical to addressing barriers to care. They are often knowledgeable about local, regional, and national resources that can support patients' needs and can assist with referrals and service arrangements. For example, if a patient lives in a rural area and is temporarily relocating closer to a cancer center for a specific treatment, such as daily radiation therapy or a bone marrow transplant, an oncology social worker can assist in arranging lodging for the patient and their caregiver. Oncology social workers can connect patients with transportation resources based on their residence and the available services. They can also refer patients to financial assistance programs or community programs that support childcare or eldercare needs. To address employment-related concerns or to navigate disability benefits, oncology social workers can provide education on the Family and Medical Leave Act (FMLA), Social Security (including disability and Supplemental Security Income), short- and long-term disability benefits, and reasonable accommodations.

If patients have limited social support, oncology social workers can provide education about available support services, such as those offered at the cancer center (e.g., art or music therapy), support groups, or peer-mentoring programs. To address emotional distress, oncology social workers can provide supportive counseling and other therapeutic interventions or refer patients to a mental health provider. Lastly, to support patients with low health literacy, they can provide education and facilitate communication between patients and the health care team (Association of Oncology Social Workers, n.d.b; Bires, 2023; CANCERcare, 2025; Cancer Support Community, 2023; Virgil, 2023).

Section 4 Key Terms

Health-related social needs (HRSN) - “social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse health outcomes and increased health care use” (Centers for Medicare and Medicaid Services, 2025, para. 1). HRSN refers to individual-level factors such as financial instability and limited access to healthy food, affordable and stable housing and utilities, health care, and transportation (Centers for Medicare and Medicaid Services, 2025). HRSN are different from social drivers of health, which are “the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH refers to community-level factors. They are sometimes referred to as ‘social determinants of health’” (Centers for Medicare and Medicaid Services, 2025, para. 2).

Financial toxicity (also called financial distress) - “a term used to describe problems related to the cost of medical care. Lack of health insurance or high out-of-pocket medical expenses not covered by insurance can cause financial problems and may lead to debt and bankruptcy. Financial toxicity can also affect a patient’s quality of life and access to medical care” (National Cancer Institute, n.d., para. 1).

Section 4 Reflection Questions

How do you identify social and practical needs in your practice?

What barriers to care do you see in your practice, and how do you address them?

Section 5: Transitions of Care

References: 7, 13, 28, 64, 66, 73, 88

Transitions of care are common in the cancer experience. They can be overwhelming for patients and their caregivers for various reasons. Patients may be transitioning from one setting to another (e.g., from the hospital to home) or from one type of care to another (e.g., from inpatient chemotherapy to outpatient chemotherapy), which can lead to biopsychosocial needs that vary with the patient's circumstances. Care may also be transitioned from one provider to another, which requires coordination and communication that patients and caregivers may not have the bandwidth to do. Additionally, more services may become involved in a patient's care (e.g., home care or other community resources), which can be overwhelming and challenging to track and coordinate.

Transitions of care typically go well when there is open communication, mutual trust, and shared decision-making between patients and their health care providers. Factors that contribute to poor transitions of care include limited awareness among patients and caregivers, inadequate planning by the health care team, insufficient education for patients and caregivers, and insufficient resources and services available to them. These factors can worsen when financial resources are limited, insurance coverage is inadequate, and social support is lacking. Poor transitions of care can lead to disjointed care, patient dissatisfaction, more medical errors, and adverse health outcomes (Rezaei et al., 2025).

Poor transitions of care at hospital discharge also increase the risk of readmission, particularly among older adults. Studies have shown that more than 30% of patients with any medical condition undergo more than one post-hospital transfer of care after discharge, and that 1 in 7 patients discharged from the hospital have 4 to 6 transitions of care within three months (Barber et al., 2017).

According to Barber et al. (2017), social workers are better equipped than some other disciplines to provide transition-of-care interventions in hospitals. Social workers, including those working in oncology, are trained to address medical and psychosocial needs, connect patients with community resources and home-based services, and reduce health care fragmentation through care coordination. They not only focus on patients' needs but also on caregivers' needs. Additionally, their emphasis on providing emotional support and connecting people with resources contributes to better health outcomes.

A recent study of practice behaviors among AOSW members showed that oncology social workers spent about 70% of their time on direct practice, including psychosocial assessment, treatment planning, counseling, discharge planning, end-of-life services, and resource referrals (Perlmutter et al., 2022). Some of these aspects of direct practice involve transitions of care.

For cancer patients, some examples of transitions of care include from inpatient hospital care to skilled nursing care or extended care; from an acute care or post-acute care setting to community-based care; from active treatment to survivorship with more care being given by their primary care provider; and from active treatment to hospice care (Snively, 2023).

Oncology social workers can arrange, facilitate, and support transitions of care by first conducting psychosocial assessments to identify the needs of patients and caregivers. If they are working in an inpatient hospital setting and engage in discharge planning, they can also perform a home safety assessment and/or a high-risk assessment to determine post-hospital care needs. Oncology social workers work with their interdisciplinary team members, as well as patients and caregivers, to obtain their perspectives and develop a plan to transition a patient to the appropriate level of care. In the inpatient hospital setting, patients may transition to a long-term acute care hospital (LTACH), an inpatient rehabilitation hospital, a skilled nursing facility, assisted living, or home with services such as home health care, palliative care, or hospice care (American Cancer Society, 2025c).

If the oncology social worker is working in the outpatient clinic, they can develop the psychosocial plan of care based on the initial evaluation. They can work with patients and caregivers throughout the disease trajectory, engaging in ongoing assessment, emotional support, and transitions of care, including preparing patients for inpatient admissions and supporting transitions to survivorship or end-of-life care.

- Some cancer treatment plans require an inpatient hospital stay, so oncology social workers can provide education to help patients and caregivers prepare for admission, explain what to expect afterward, and address potential discharge needs.
- For the transition to survivorship, oncology social workers can begin preparing patients and caregivers for this adjustment by providing education on common psychosocial concerns that may arise during survivorship and supporting them as these concerns emerge. These concerns may be emotional, psychological, social, and financial as people are processing their cancer experience and navigating what life looks like as they move forward (Compass Oncology, n.d.).
- During the transition to end-of-life care, oncology social workers provide education about this care and a safe space for patients and caregivers to process their concerns. They also offer support to ensure that patients' comfort and dignity at the end of life are preserved as much as possible and that medical decisions align with the patient's wishes. They may make referrals to hospice agencies and assist with coordinating this care.

Additionally, they may help patients and families with legacy work (Zebrack et al., 2025).

Section 5 Key Term

Transitions of care - "a process of transferring a patient's care from one setting or level of care to another, such as from hospital to home or hospital to skilled nursing facility. These transitions are particularly vulnerable points in the healthcare continuum" (American Case Management Association, n.d., para. 3).

Section 5 Reflection Questions

What transitions of care do you facilitate in your practice?

What interventions have you found to be effective in these instances?

Section 6: Case Management Practices and Guidelines

References: 27, 50, 64

The Commission for Case Manager Certification (n.d.) defines case management as:

> *"A dynamic process that assesses, plans, implements, coordinates, monitors, and evaluates to improve outcomes, experiences, and value. The practice of case management is professional and collaborative, occurring in a variety of settings where medical care, mental health care, and social supports are delivered. Services are facilitated by diverse disciplines in conjunction with the care recipient and their support system. In pursuit of health equity, priorities*

> *include identifying needs, ensuring appropriate access to resources/services, addressing social determinants of health, and facilitating safe care transitions. Professional case managers help navigate complex systems to achieve mutual goals, advocate for those they serve, and recognize personal dignity, autonomy, and the right to self-determination" (para. 1-3).*

A recent study of practice behaviors among AOSW members found that 93% of oncology social workers provide direct social work services, including case management, resource referrals, counseling, and related services (Perlmutter et al., 2022). Case management may take place in the inpatient or outpatient setting. It serves patients, their support systems, health care systems, employers, and some payor sources.

There are a few organizations that have published case management practices and guidelines, including:

- The National Association of Social Workers (NASW)
    - NASW Standards for Social Work Case Management
- The American Case Management Association (ACMA)
    - Case Management Standards or Practice & Scope of Services
    - Transitions of Care: Standards of Practice & Implementation
- Commission for Case Manager Certification (CCMC)
    - Code of Professional Conduct for Case Managers with Standards, Rules, Procedures, and Penalties

As noted above, AOSW has established the scope and standards of practice for oncology social workers. The Professional Oncology Navigation Task Force has also developed standards for oncology navigation practice.

Regardless of professional role, it is crucial to stay up to date on standards of practice, as they improve the quality of patient care and minimize practice variation among clinicians (Moawad, 2020).

Section 6 Key Term

Case management - a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates care provided to patients and their loved ones. The goal of case management is to improve outcomes, experiences, and value. It takes place in a variety of settings across diverse disciplines.

Section 6 Reflection Question

Which standards of practice do you reference and follow based on your professional role in cancer care?

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