

# AOSW 2026



## Annual Conference

**June 10-12, 2026**

Portland Marriott Downtown Waterfront  
Portland, Oregon USA

**Pre-Conferences: June 9, 2026**

#AOSW2026





# The Journey of Care for Rural Esophageal Cancer Patients

Neeka Goodwin, LCSW, OSW-C  
Estin Yang, MD, MPH

# Overview

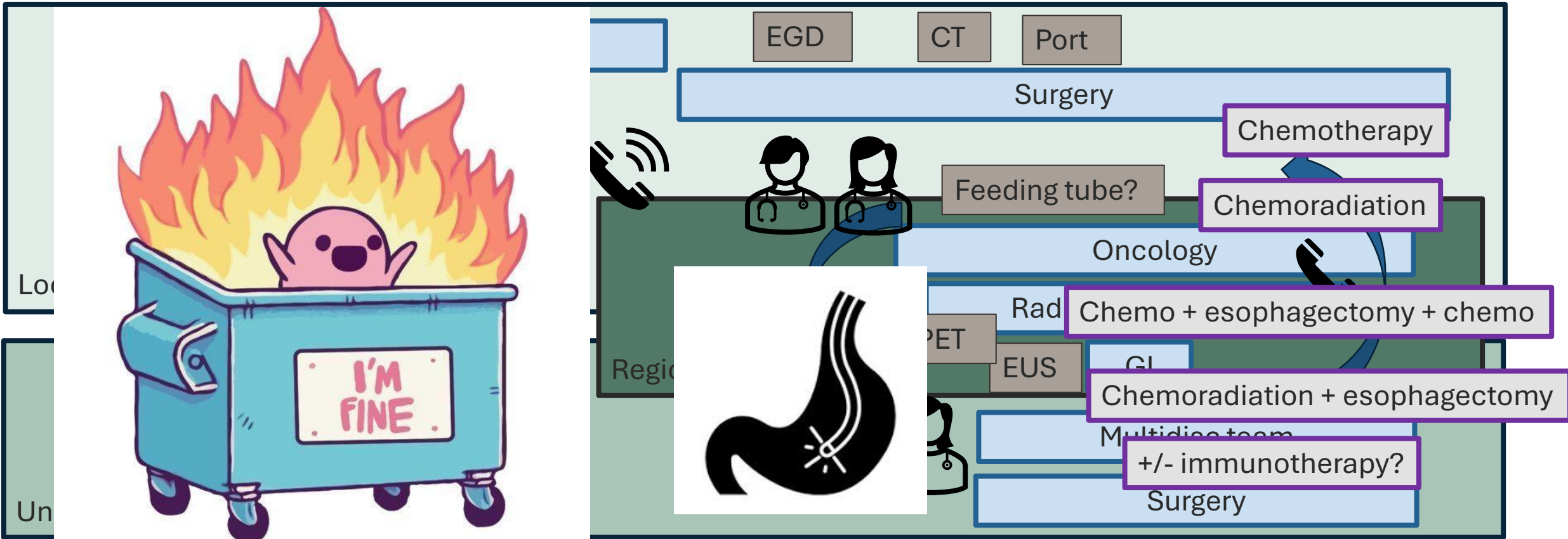
- Intro 11 AM
- Rural ECA Journey 11:05 AM
- Medical & SW Framework 11:20 AM
- Workshop 11:30 AM
- Discussion & Close 11:40 AM

# Rural Esophageal Cancer Care

- Worse outcomes than urban patients
- More healthcare disparities – education, \$, insurance
- More travel, fewer local resources
- Fragmented care, disjointed care coordination

... longer journeys, poorer quality, worse outcomes

# Rural Esophageal Cancer Journey



# Rural Esophageal Cancer Care

6/2024

6/2025

6/2026



## 1. To understand

- Journey of care milestones
- Quality of care

## 2. To transform

- To shorten care
- To improve care

*Funding support from the Knight Cancer Institute Community Partnership Program*



**KNIGHT  
CANCER**  
Institute

# OREGON

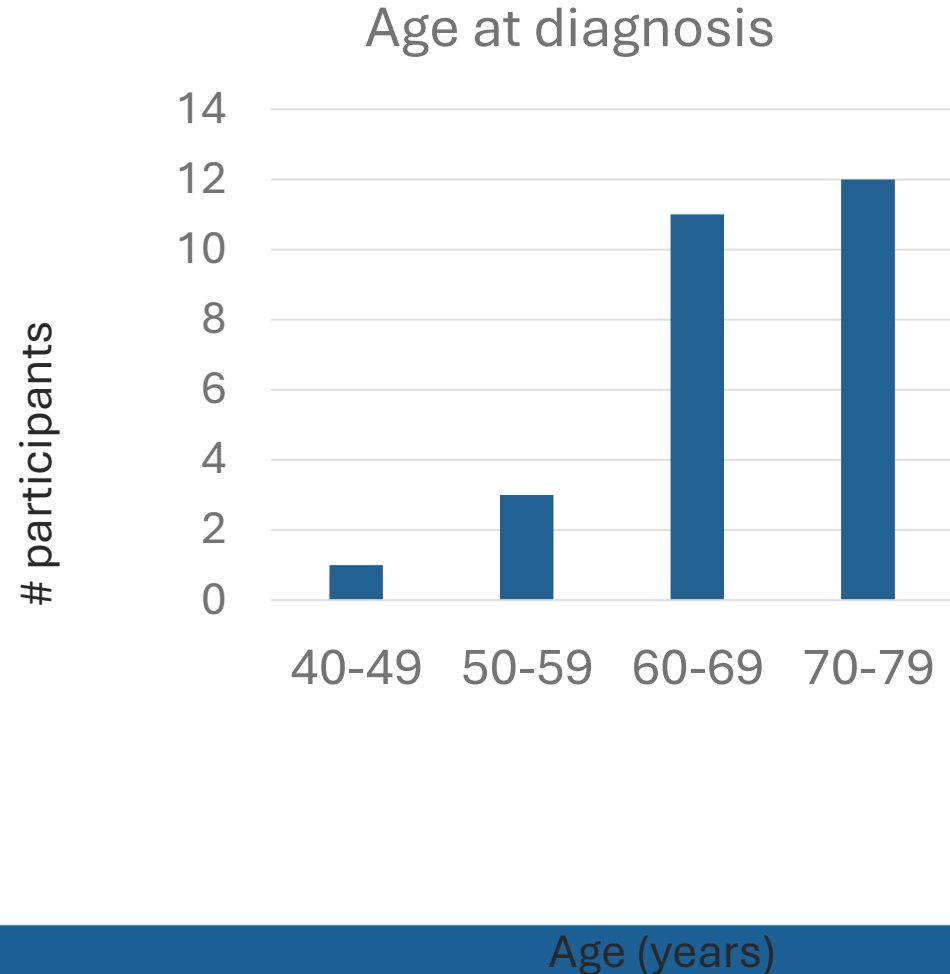
elevation model



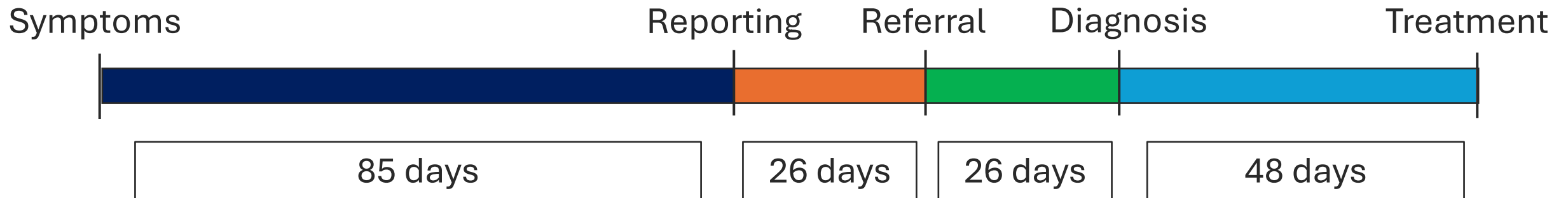
Map prepared using 1 arc second digital elevation data and hydrography.

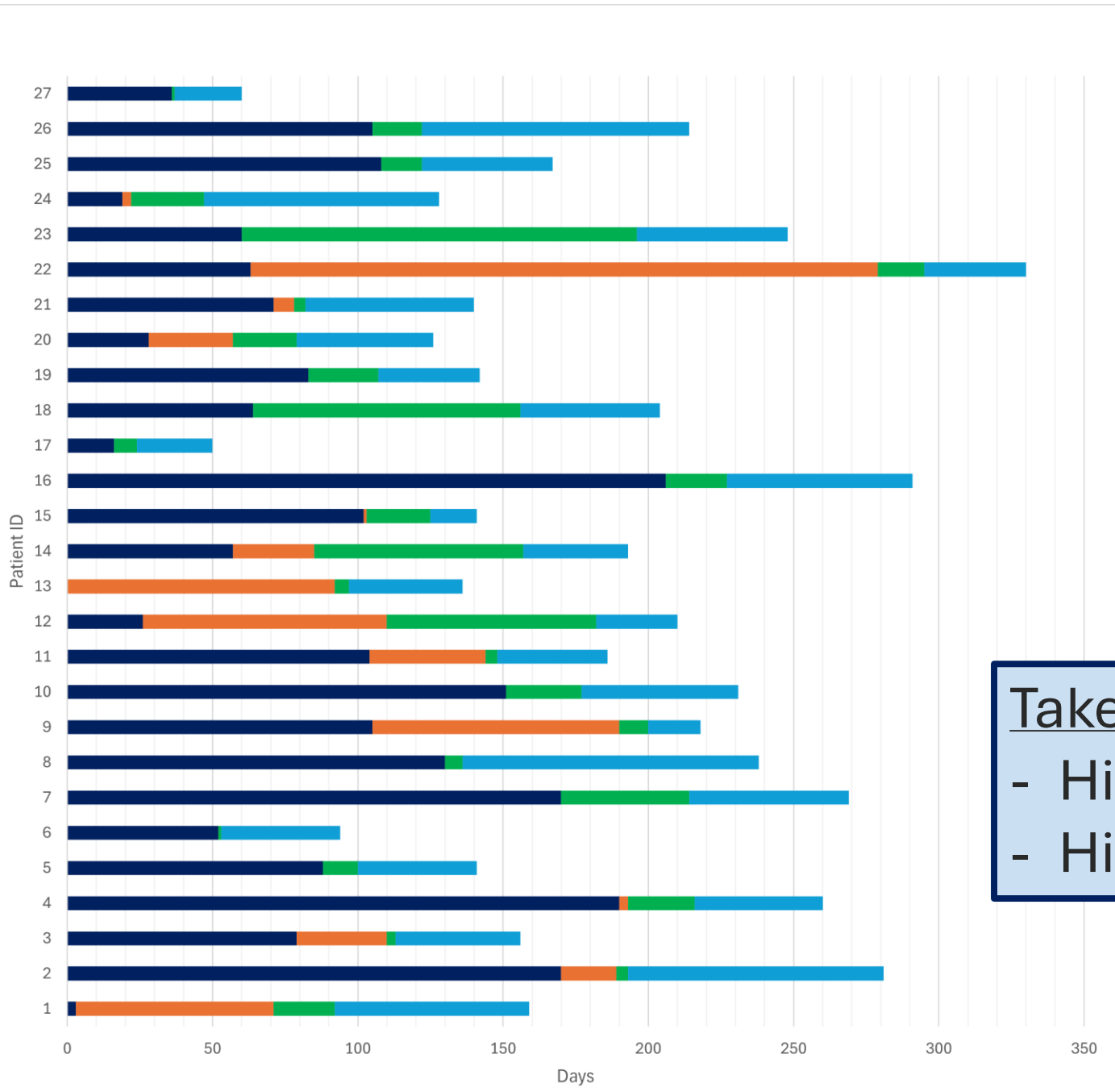
# Demographics

- Average age 67 (range 45-78)
- 81% men
- Lives with...
  - Spouse / SO (59%)
  - Alone (25%)
  - Other (16%)
- \$\$
  - Retired (79%)
  - Social security (33%)
  - Disability (11%)
  - Financially responsible for others (46%)
- Live median 12.5 miles to cancer center (range 1.9-103 miles)



# Rural care journey – all patients





Takeaways

- High variability between patients
- High variability within each phase

# Appointments & procedures from diagnosis to treatment start

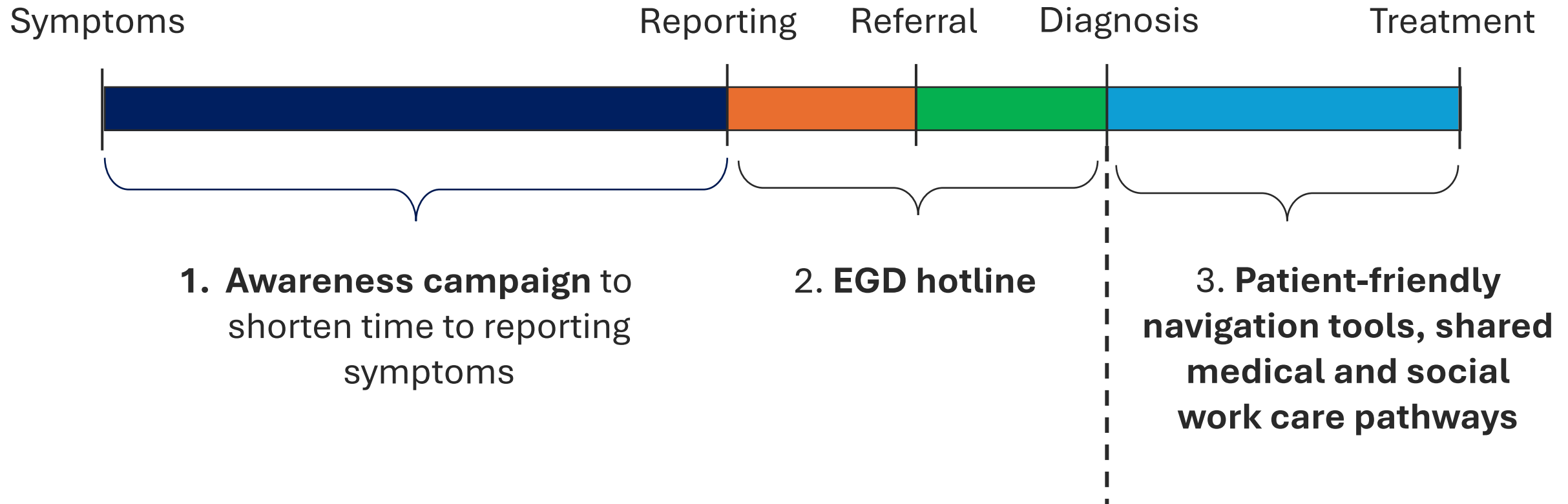
	All	Metastatic	Non-metastatic	p
Procedures	3.1	2.8	3.5	0.193
Imaging studies	2.8	3.1	2.5	0.097
ER visits & unplanned admissions	1.2	1.1	1.4	0.571
Clinic appointments	5.5	4.8	6.3	0.048
Total Encounters	12.6	11.8	13.7	

# Patient interviews

- How could they have been better prepared?
  - *Patient education, more nimble referrals, felt disempowered*
- What are things you wish you had known earlier?
  - *Cancer awareness, more details & effects on day to day life*
- What barriers to care did you experience?
  - *Insurance, travel/distance, coordination, scheduling difficulties*
- How did this cancer affect work, relationships, finances?
  - *Mixed (isolation, felt like a burden, strengthened), devastating financial impact*

# Step 2 – to transform

- Targeted interventions to shorten and improve care journeys



# From diagnosis to treatment

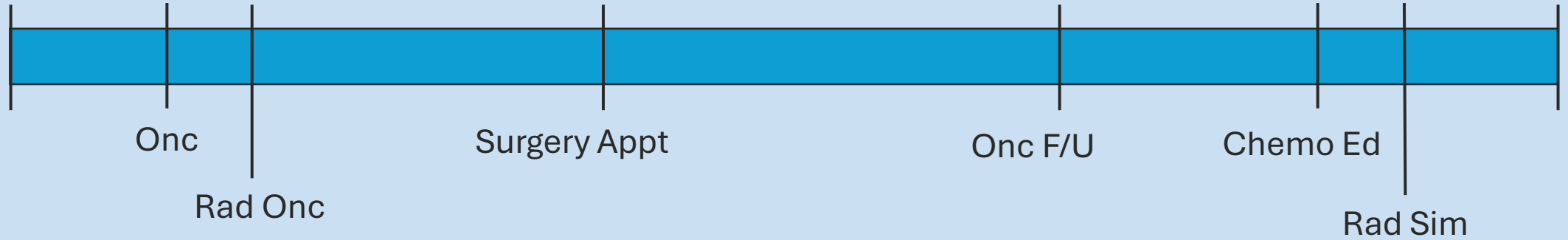
- How can we shorten and improve the journey from diagnosis to treatment?
- How can clinicians and social workers create a coordinated care pathway to holistically meet a patient's needs?

# CURRENT STATE

## Medical

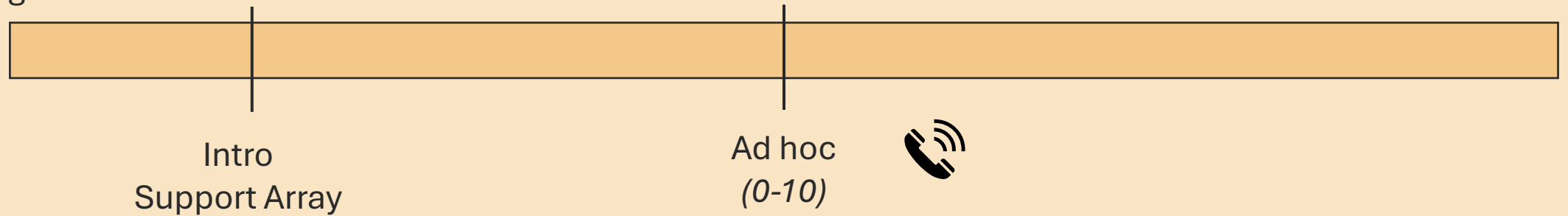
Diagnosis

Treatment



Diagnosis

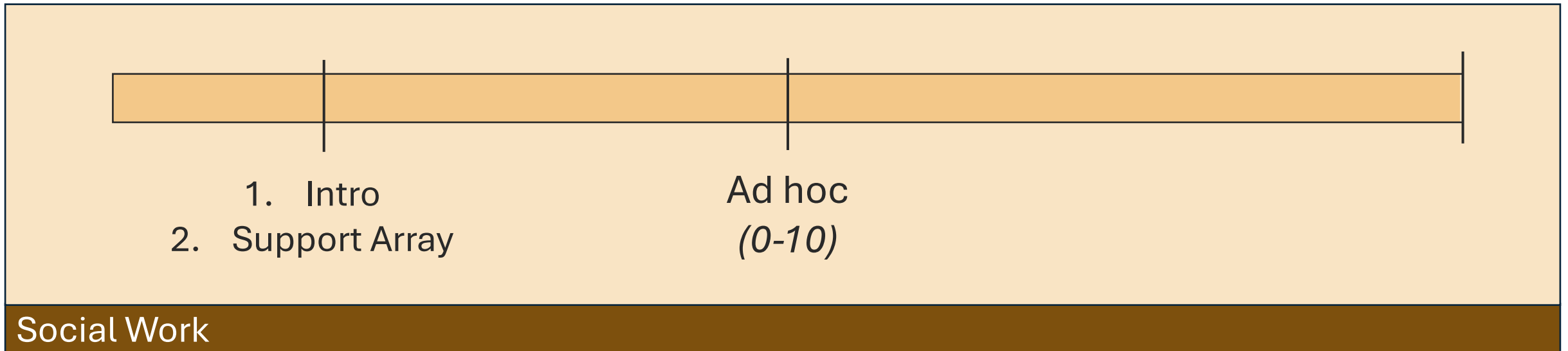
Treatment



## Social Work

## CURRENT STATE

- Introductory visit
- Support array
- Ad hoc needs



# Support Schedule - New Proposal

- Earlier introduction at diagnosis – “black hole of anxiety”
- Proactive, not reactive
- Schedule
  - Introductory visit
  - Needs assessment
  - Support services array
  - Overview of potential journey of care pathways

# Introductory Visit

- Social worker introduction at diagnosis (within 24 hours)
- Overview of coordinated care pathway

# Needs Assessment

## Needs Assessment

- To identify which additional services will be necessary

## Social Services Array

- Providing information about internal and external support services

Finances / insurance  
Transport / lodging  
In-home care needs  
Care coordination  
Mental / emotional support

# Financial / FMLA

## Needs Assessment

- Insurance
- Employment
- Financial status

## Social Services Array

- FMLA
- Social security
- Paid Leave Oregon (PLO)
- Charity support

Need to start early due to long delays  
in application process

# Transport / lodging

## Needs Assessment

- Vehicle
- Driver
- Gas money
- Distance from facility (long-distance vs local)
- If distant, lodging needs

## Social Services Array

- Gas card
- Taxi voucher
- Insurance reimbursement / transport
- Medical transport
- Family house
- Insurance lodging reimbursement

# Mental / emotional support

## Needs Assessment

- Need related to diagnosis
- Preexisting mental health need
- Family member/caregiver need

## Social Services Array

- Short term, one on one mental health support – for patient, family member and/or caregiver
- Referral for long term mental health support for preexisting mental health need
- Referral for support group for patient, family member/caregiver

# In home care needs

## Needs Assessment

- Current ability to care for oneself
- Current support system – spouse, family, friends, neighbors
- Eligibility through insurance for specialized care

## Social Services Array

- Home health service referral
- Durable medical equipment providers
- Directions for needs assessment through state agency and process for application to become a paid caregiver
- List of private pay caregiving agencies

# Care coordination

## Needs Assessment

- Understanding of medical processes to begin treatment
- Stalled referrals, delays in scheduling
- Barriers to attending necessary appointments
- Barriers that veterans are experiencing with VA service

## Social Services Array

- Social worker contact for any delays, unexpected needs, unanswered questions
- Barrier resolution, transport, scheduling conflict, insurance/financial changes
- Advocacy with VA for veterans regarding service-related disability and access to support

# Minimizing Additional Appointments

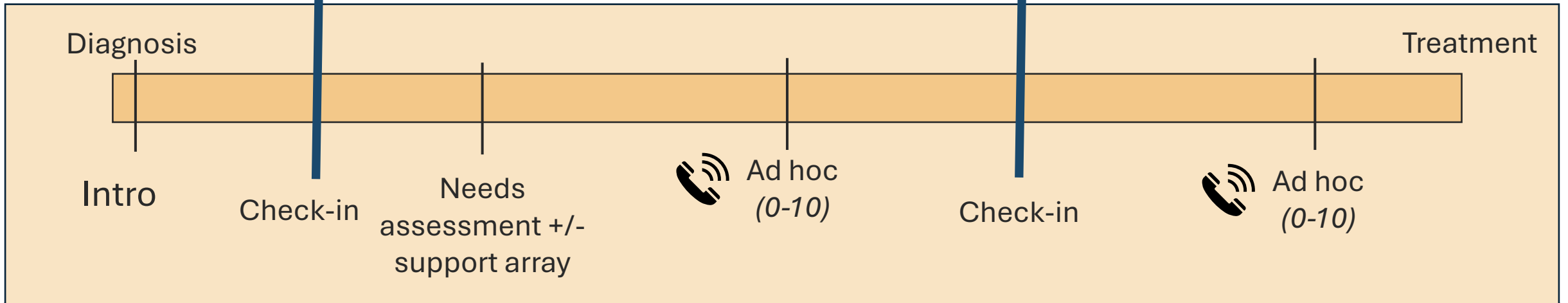
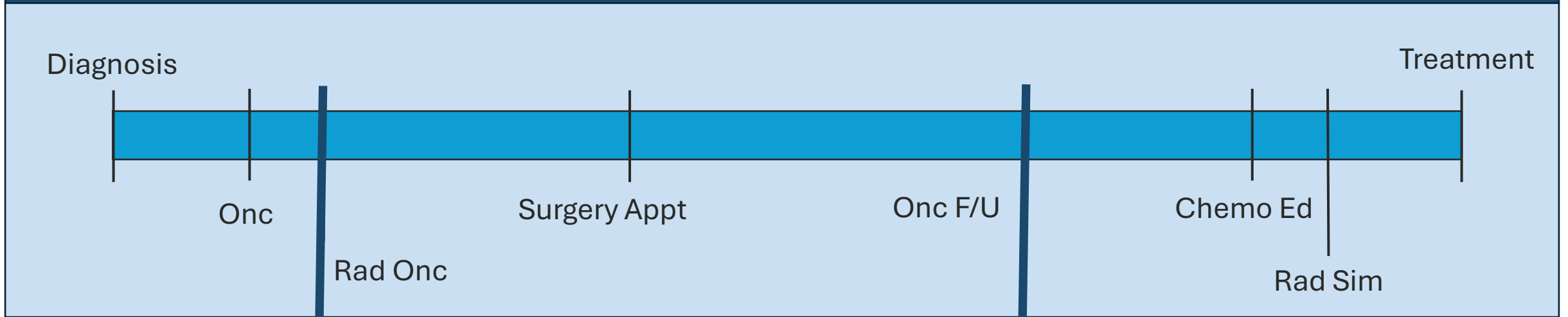
- Patient will be given the opportunity to attend these appointments in person, over the phone, or via telehealth.
- Each appointment is optional, and not all of them may be necessary depending on the individual circumstances of the patient.

# Proposed changes

- OSW introduction within 24 hours of diagnosis
  - *Referral from surgeon / GI, not onc*
- Structured needs assessment & SW array
- Coordinated medical and social work handouts / patient education

# FUTURE STATE

## Medical



## Social Work

# Small Group Discussion

**1. Do you have a structured SW framework for your cancer patients?**

*If so, describe. If not, how do you ensure consistent SW support?*

**2. What are the major barriers and challenges your patients encounter in navigating complex cancer care?**

**3. What are the available resources that you utilize to help overcome these barriers?**

*E.g. transportation / lodging resources, in-home care, durable medical equipment*

**4. What suggestions do you have to improve the proposed rural ECA social work / clinical navigation framework?**

# Next Steps

- Finalize our care pathway / handouts
- Pilot the program
- Research benefit, report
- Expand

- Contact / FU

[neeka.goodwin@asante.org](mailto:neeka.goodwin@asante.org)

[yange@ohsu.edu](mailto:yange@ohsu.edu)