

Provider Communication: The Key to Care Coordination Between Tribal Primary Care and Community Oncology Providers

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PURPOSE: To explore tribal primary care providers' and community oncology providers' experiences of caring for individuals with cancer to inform intervention development and improve cancer care coordination in this high-need population.

PARTICIPANTS & SETTING: 33 tribal primary care providers and 22 nontribal, community-based oncology providers.

METHODOLOGIC APPROACH: A qualitative, descriptive design was used, and 55 semistructured individual interviews were completed. Data were analyzed using conventional inductive content analysis to identify major themes.

FINDINGS: Effective care coordination for individuals with cancer was characterized by timely communication. Providers in both settings identified unhindered communication between providers as a key element of care coordination. Identification of points of contact in each setting enhanced information exchange. As patient needs related to cancer care intensified, care coordination increased in complexity.

IMPLICATIONS FOR NURSING: Evaluating strategies to enhance communication between tribal primary care providers and community oncology providers is an important next step in enhancing the coordination of care for tribal individuals with cancer.

KEYWORDS care coordination; communication; primary care; tribal health care; providers

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Cancer is the second most common cause of death in the United States and Oklahoma (Centers for Disease Control and Prevention, 2021; Heron, 2021). In 2019, about 13% of Oklahoma's population was American Indian/Alaskan Native (AI/AN) race alone or in combination with one or more other races (U.S. Census Bureau, 2019). The patterns of cancer occurrence among AI/AN populations are distinctive because of their unique history, culture, geographic location, and access to health care (Cobb et al., 2008; Koh, 2009; Levine et al., 2014). Among the major risk factors for cancer, commercial tobacco use and alcohol misuse, lower physical activity levels, and high levels of obesity have been observed at greater rates in AI/AN populations (Cobb et al., 2008; Fine et al., 2004; Kagawa-Singer et al., 2010). Cancer outcomes are influenced by access to care (Yabroff et al., 2020). Reduced screening among AI/AN populations has also been attributed to the lack of AI/AN healthcare providers, culturally relevant education, and ancillary support services (Daley et al., 2012). AI/AN cultural and spiritual beliefs have been shown to influence perceptions of screening, specifically related to privacy and fear (Filippi et al., 2013). In some cases, AI/AN individuals believe that talking and thinking about cancer may result in its manifestation (Watson-Johnson et al., 2011).

Racial disparities in cancer exist (Chu et al., 2007; Li et al., 2003; Siegel et al., 2013). AI/AN populations often bear higher rates of cancer incidence and mortality; this disparity varies by geographic region and cancer site (Becker et al., 2008; Bliss et al., 2008; Espey et al., 2005; Henderson et al., 2008; Jim et al., 2008; Lemrow et al., 2008; Perdue et al., 2008; Reichman et al., 2008; Sugarman et al., 1994; Swan