The process of integrating oncology nurse navigators into joint (hospital-community) local teams

by Lise Fillion, Michèle Aubin, Marie de Serres, Danielle Robitaille, Anne-Marie Veillette, and François Rainville

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Abstract

Implementing oncology nurse navigators or IPOs (which stands for "infirmière pivot en oncologie") is a key element of the Quebec Cancer Control Program in order to improve the continuity of care. This qualitative study describes the process of implementing IPOs in teams working both in hospitals and in the community. Several groups of stakeholders (IPOs, physicians, nurses, various health workers, administrators, people with cancer and their families) described how they perceive the functions and effects related to this implementation. After putting results into perspective, we recommend developing measures promoting the dissemination of the role and integration of IPOs in formally defined health teams. We strongly advocate for the continuation of joint efforts in order to define and clarify this complex role.

Background

The fragmentation of health care, the delays in accessing it, and the lack of information and continuity all contribute to creating a feeling of dissatisfaction in people living with cancer (Turgeon, Dumont, St-Pierre, Sévigny, & Vézina, 2004). With the increased complexity and variability of treatment options, people with cancer and their families experience a feeling of isolation and powerlessness when facing a fragmented health system they describe as a "maze". They express the need to benefit from better communication between care providers, support in their decision-making, personalized information and emotional support throughout the care trajectory (Turgeon et al., 2004). To meet these needs, various programs aiming

to improve the continuity of care emerged. This is a concept that takes into account the continuity within the information, the approaches and the care relation (Haggerty, Reid, McGrail, & McKendry, 2001).

Among the initiatives phased in to foster continuity of care, three types of navigation models have been put forward in Canada: professional, community and virtual (Canadian Partnership Against Cancer, 2008).

Most of the work on navigation completed in Canada dealt with professional navigation and improving continuity of care, from diagnosis to palliative care (Cancer Care Nova Scotia, 2004; BC Cancer Agency, 2005; Fillion et al., 2006; Skrutkowski et al., 2008).

In the early 2000s, two models of professional navigation were implemented in Canada. After consulting with individuals living with cancer and health care professionals, Nova Scotia introduced its Cancer Patient Navigator (CPN) model (Cancer Care Nova Scotia, 2004). In Quebec, the Quebec Cancer Control Program (PQLC, as per its official French acronym) developed the Oncology Nurse Navigator (IPO, its official French acronym) model (PQLC, 1998). These roles performed by nurses include four main functions: support, education, symptom assessment and management, and coordination. The Nova Scotia model was implemented in the community setting while the Quebec model was created within local oncology teams in the hospital setting. In Nova Scotia, the role is starting to be implemented within specialized teams in hospital centres (HC). In Quebec, the role was recently introduced within teams with a stronger community connection, in the health and social services centres (CSSS, the official French acronym). In this study, we'll focus on a joint role integrated in both hospitals and CSSSs.

The introduction of IPOs within local teams is an integral part of implementing the PQLC (1998). Local teams are required to serve patients with various types of cancers. In the Quebec City area, an original model called "Joint HC-CSSS Local Team" was implemented. These teams are different in the sense that they have been developed in

Processus d'implantation d'infirmières pivots en oncologie au sein d'équipes locales conjointes (Centre hospitalier-Communauté)

Abrégé

L'implantation d'infirmières pivots en oncologie (IPO) est un élément clé du Programme québécois de lutte contre le cancer pour améliorer la continuité des soins. Cette étude qualitative décrit le processus d'implantation d'IPO au sein d'équipes basées à la fois en centre hospitalier et dans la communauté. Plusieurs groupes d'acteurs (IPO, médecins, infirmières, divers intervenants, administrateurs, personnes atteintes du cancer et leurs proches) ont décrit leur perception des fonctions et des effets associés à cette implantation. La mise en perspective des résultats permet de recommander l'élaboration de mesures visant à favoriser la diffusion du rôle et l'intégration des IPO au sein d'équipes de travail formellement définies. La poursuite d'efforts concertés visant à définir et préciser la complexité de ce rôle est fortement recommandée.

Lise Fillion, RN, PhD, Full Professor, Faculty of Nursing, Laval University. Address all correspondence to: Dr. Lise Fillion, Centre de recherche clinique et évaluative en oncologie (CRCEO), Hôtel-Dieu de Québec, 9 rue McMahon, Québec, QC G1R 2J6. Tel.: 418-525-4444 ext. 15754, Fax: 418-691-2920, E-mail: lise.fillion@fsi.ulaval.ca

Michèle Aubin, MD, MSc, FCFP, CCFP, Chairholder of the Canada Research Chair in Palliative Care, Laval University, Department of Family and Emergency Medicine, UMF-Laval, CSSS, Québec, QC.

Marie de Serres, MSc, RN, CSIO(C), Oncology Nurse Specialist at CHUQ, L'Hôtel-Dieu de Québec, QC.

Danielle Robitaille, MSc, RN, Function Manager, Nursing Care Development and Evaluation, Oncology Program, Centre hospitalier affilié (CHA).

Anne-Marie Veillette, Anth, MA, Research Professional, Member of the CRCEO Research Team at HDQ.

François Rainville, BA, Research Assistant, Member of the CRCEO Research Team at HDQ.

light of a close partnership between the hospital setting and community health services. In Quebec, these community services are provided in the local community service centres (CLSCs, according to their French acronym), which are now fully integrated with the CSSSs. It means that the IPO on a joint HC-CSSS local team is a nurse who belongs to the CSSS (CLSC component). She is familiar with community services. However, her office is located in the HC where oncology care is provided. She spends most of her working time there with oncology care professionals for the cancer population in her catchment area who are receiving oncology care in this HC and do not have access to the services of another IPO. It is expected that the implementation of joint HC-CSSS IPOs will contribute to the establishment of integrated networks of services and promote sharing of expertise between specialized teams, local teams and community services always with a view to meeting the needs of individuals affected by cancer and their loved ones. This clinical and administrative innovation poses challenges that are both specific and poorly understood. Identifying the factors that both facilitate and hinder the implementation of these IPOs would give us a better understanding of the whole process.

Literature review

To date, not a single study has documented the implementation process for HC-CSSS IPOs. Some studies documented the implementation of CPNs in the community (Cancer Care Nova Scotia, 2004), of IPOs within specialized teams (Fillion et al., 2006, 2009) and within regional or local teams in HCs (Roberge et al., 2004). These studies documented the impact of contextual factors such as the reluctance of some physicians to refer people living with cancer to IPOs (Cancer Care Nova Scotia, 2004; Farber, Deschamps, & Cameron, 2002), functional problems or the conflicts occurring within interdisciplinary teams (Farber et al., 2002; Roberge et al., 2004), the ambiguity of the role with regards to its clinical and organizational functions (Tremblay, 2008) and the lack of resources at the time of implementation (Roberge et al., 2004; Fillion et al., 2006). These studies described certain implementation-facilitating conditions: paving the way, clarifying the role within the interdisciplinary team, respecting local dynamics, having the IPOs supported by clinical experts, getting the support of managers and having the clinical leadership that facilitates role integration (Cancer Care Nova Scotia, 2004; Fillion et al., 2006; Roberge et al., 2004). In her study, Tremblay (2008) documented the implementation process over the long term and stressed the importance of the following conditions to facilitate the integration and consolidation of the role within oncology teams: long-term commitment of clinical leaders with a recognized expertise and credibility, support to IPOs in the form of time and training, and the existence of feedback mechanisms in the field demonstrating the role's positive effects on clients. The particularities of implementing this innovative HC-CSSS IPOs role, which marries the HC's and the community's resources (CSSS), a unique concept in the metropolitan area of the provincial capital on the one hand, and the absence of information on its deployment on the other, it seemed necessary to document the implementation process for these IPOs.

Goal of the research

This study aims to use a qualitative approach to assess the implementation process of Oncology Nurse Navigators within two local joint teams, situated in HC and CSSS contexts. The overall objective of the assessment procedure is to describe the implementation process from the perspective of the various stakeholders involved.

Method

Paving the way for the implementation of Oncology Nurse Navigators (IPOs)

A ground preparation phase was completed first. The research team partners (the Provincial Capital Health and Social Services Agency [ASSS-03, as per its official French acronym] and joint local teams

HC-CSSS: team A and team B), had to set up an implementation committee and clinical committees, define these committees' mandates, prepare a presentation on the role of HC-CSSS IPOs and pave the way by organizing consultation and role presentation meetings to the groups of stakeholders involved in the cancer patients follow-up both at the HC and the CSSS. The implementation of HC-CSSS IPOs took place from the spring to the fall of 2007, during which time the research team acted in a consultative role. This preliminary phase helped complete a feasibility analysis and determine the goals for the evaluation, i.e., a better understanding of the implementation process rather than a study of the effects and impacts, as the latter appeared to be premature at this stage of the implementation.

Study framework and design

This study is based on a framework that incorporates three models (for more details, see Fillion et al., 2006). The first model is inspired by the classical principles for program assessment put forward by Donabedian (1980, 1985). The second one (Robert, 2000) takes into account the organizational change context. The third, based on emerging action theory (Patton, 1990, 1997) provides an operational grounding for assessing the innovation according to the following seven levels of questioning: 1) origins, 2) activities, 3) participation, 4) reactions, 5) effects on people living with cancer, 6) effects on health care system, and 7) long-term effects and impacts. This qualitative study was based on a descriptive, evaluative design of two cases: two joint HC-CSSS local teams in oncology located at two sites (team A and team B) (Yin, 1994).

Sample and accrual of participant

The sample, which was of a purposive type, is composed of eight groups of participants: 1) IPOs from the two HC-CSSS joint local teams; 2) IPOs from HC supraregional teams; 3) specialist physicians; 4) other oncologic stakeholders interacting with HC-CSSS IPOs; 5) managers and administrators; 6) family physicians; 7) people living with cancer and receiving the services of a HC-CSSS IPO; and 8) significant others of people living with cancer. These stakeholders came from various health organizations and facilities in the Provincial Capital Region (03). HC-CSSS IPOs and managers provided lists of names to the research team so that it could contact participants via telephone. The "snowball" sampling technique was also used. All participants were informed of the study's goals and signed a consent form. The research project was approved by each participating facility's research ethics board.

Data collection

A multimodal data collection was completed: 1) documents related to the preliminary stages of the research (literature search, tool and documentation compilation); 2) individual interviews (n = 44); and 3) group interviews (n = 8). Interview guides included a sociodemographic section and a section with semi-open questions developed from the above-described framework. Data triangulation was used to factor in the diversity of experiences and targeted stakeholder groups.

Analysis strategy

Individual and group interviews, lasting on average from 90 to 120 minutes, were conducted by a research professional (with graduate training in anthropology) and two students under her supervision. Qualitative data were recorded and transcribed in their entirety. The *verbatim* were subdivided into units of meaning and coded into analysis categories using the NVivo7® program. A thorough reading of the *verbatim* was completed in order to determine the presence of analysis categories connected to the seven dimensions of the selected operational framework. A systematic categorization process (Strauss & Corbin, 1990) was performed individually first, then collectively in order to achieve consensus. Intragroup analysis was completed for each group of participants, followed by intergroup analysis with a comparison of data for teams A and B.

Results and interpretation

Description of the sample

A total of 90 participants voluntarily took part in this study. The group of HC-CSSS joint local team IPOs ($n = 8$) and specialized team IPOs ($n = 13$) was composed of women (100%), with a mean age of 42 years and university education. The group of specialist physicians (pneumologist, oncohematologist, urologist, radiation oncologist, psychiatrist) ($n = 5$) and family physicians ($n = 11$) comprised equal numbers of men (50%) and women (50%), with a mean age of 46. The group of other oncology health workers interacting with HC-CSSS IPOs ($n = 27$) and managers and administrators ($n = 8$) was primarily composed of women (89%), with a mean age of 47, and a university (74%) or college (26%) education. The group of people living with cancer and receiving the services of a HC-CSSS IPO ($n = 13$) and their loved ones ($n = 5$) was mostly made up of women (61%), mean age, 61 years, whose education was at the CEGEP (Québec pre-university/vocational colleges) level or better (43%).

Main results

Data analysis revealed that the implementation process is taking place in a similar fashion for both HC-CSSS teams under study. However, one notes that team A appears to be meeting some challenges with more intensity than team B. Based on this finding, the article results are disseminated as a whole. Similarly, they are being presented without any systematic distinction among the eight groups of participants. The results, organized according to Patton's seven dimensions, are grouped and presented in accordance with the following four categories: 1) stakeholders' perceptions on the origins of the role and initial resources (dimension one); 2) activities of HC-CSSS IPOs (dimension two); 3) participation of the various stakeholders in facilitating integration of the role and their reactions to its pertinence (dimensions three and four); 4) effects of role implementation on the clients and the health care system in both the short and longer term (dimensions five, six and seven). Table One uses *verbatim*s to illustrate each of these dimensions.

Origins of the role and initial resources

Comprehension of the role varies from one group of stakeholders to another. To IPOs and for other groups, the role must first help in meeting the needs of people with cancer. Generally speaking, perceptions of HC-CSSS IPOs and specialized teams' IPOs are closely related and they will be examined globally. A subsequent article will present a thorough comparison of different applications for the role (Fillion et al., in progress). Besides, several family physicians and specialists insist that the role must meet a coordination need at the organizational level in order to relieve physicians and other care providers of some tasks. At the time the data were collected, the role still remained imprecise and the role dissemination process was still in progress. Moreover, management tools that would allow for a systematic follow-up of clients were either lacking or being developed, so that some of the IPOs had to design their own follow-up system. Lastly, mechanisms to refer people living with cancer to IPOs were poorly understood.

Activities of HC-CSSS IPOs

The main functions of IPO are assessment, support, information and coordination. While all four functions are mentioned by the majority of participants, the support and coordination functions are described more precisely. An article dealing specifically with secondary analyses and the description of the support function will permit in-depth examination of this function (Hébert & Fillion, in progress). Various types of support are reported as being offered by IPOs to individuals with cancer and their families (emotional/psychological, informational and instrumental). People with cancer and their families believe that IPOs take the necessary amount of time to meet their needs while establishing a meaningful relationship with them. In their co-ordination function, IPOs are transmitting information between care providers and

performing concrete actions to facilitate the care trajectory. They coordinate certain medical interventions and appointment settings. Their collaboration with CSSS teams and a few family physicians helps to bridge some service gaps.

Overall, it is reported that not one of the four main functions of IPOs predominates the others. These intersect throughout the continuum. For specialists, the support function seems dominant. Moreover, family physicians were hard-pressed to define IPO's functions and activities, as they do not know this role very well and only have a theoretical definition.

With regards to activity constraining factors, IPOs state that the request for and performance of numerous clerical tasks interrupts or interferes with the performance of their functions. They stress the difficulty they have in deciding whether these tasks relate to their role, but that they need to complete them in order to foster their integration within the new work teams. They also lament the lack of resources. For example, the special context of belonging to two different organizations (HC/CSSS) leads to poorly streamlined communication systems and some problems with access to medical and psychosocial information. The information transfer mechanisms they use are essentially the result of individual initiatives. HC-CSSS IPOs must adapt some of the resources available to them or create new ones. The lack of concerted and systematic mechanisms to refer people living with cancer to IPOs was also regretted. Nonexistent or late referrals force IPOs to use their time identifying the individuals with cancer who should be referred to them.

The other function-limiting factor reported by participants was that HC-CSSS IPOs are not integrated within a well-established team. The local oncology team is still working to define itself and each member's role is yet to be clarified. Several stakeholders have difficulty identifying the IPO's scope of practice in comparison to that of liaison nurses and social workers. Given this context, the difficulty of achieving interdisciplinarity is brought up even though the IPO's coordination functions have them working with various partners in hospitals, CSSSs and the community.

The IPOs appreciate the flexibility and independence they have. They stress the importance of the support and recognition they receive from some of their partners with whom they have developed a fruitful collaboration.

Stakeholders' participation and reaction

Each group of stakeholders interviewed thinks that the first meeting between the patient and the IPO should take place soon after the diagnosis but, in reality, it occurs at different points in the trajectory. Some of the people living with cancer do not have access to the services of IPOs. Besides, few stakeholders, particularly among the family physicians and specialists, report having developed the habit of contacting IPOs.

Despite the lack of awareness about the operationalization of the role among certain stakeholders who have not had to interact with IPOs, all stakeholders agree on its theoretical relevance for people with cancer and their families. Described as a "safety net", the IPO acts as a resource person who provides a human contact, and has an important trusting relationship with them. Furthermore, various tools help guide IPO's practice such as assessment, referral and information transfer tools. When faced with a problem in the performance of their functions, IPOs state that they turn to other HC-CSSS IPOs and managers. In order to define and reinforce their role, IPOs emphasize they appreciate having access to various on-the-job training opportunities. They would appreciate more training regarding their emotional/psychological support function and information transfer (e.g., services provided by community organizations).

Effects of implementation

IPOs are expected to be present at all steps of the care trajectory. IPOs feel that they are and that they help people with cancer and their

Table One. Quotes from interviews illustrating the study results

Dimensions	Sample quotes (verbatim)
1. Origins of the role and initial resources	<p>“The first few months, they needed to clarify their role, define it and make it known. That is specific, really. It brought about a problem because they had to define themselves, as professionals, in relation to other professionals. It is a huge challenge.” (<i>Manager/Administrator</i>)</p> <p>“Physicians, oncologists, some of them will use us and understand our role in pivotal moments and others, not at all. (...) I was surprised to see how people are working solo in a hospital.” (<i>HC-CSSS IPO</i>)</p>
2. Activities of HC-CSSS IPO	<p>“Being able to blend both the biological and the psychosocial dimensions of the cancer experience. That’s what’s so very particular with these professionals. They are almost the only ones who are required to possess an excellent mastery of the two aspects at the same time! This wholeness is one of their strengths.” (<i>Specialist</i>)</p> <p>“The first three weeks, I needed her often. I had so many questions. She answered our questions. She is very reassuring to us. It plays the situation down. She has been a great, great help.” (<i>Individual living with cancer</i>)</p> <p>“Our functions are rather broad! It is as if we did not set any limits for ourselves. At times, we do a lot of things we should not be doing, which are not mentioned in theories, but that we do a lot. It’s true! There are clerical tasks we should not be performing. I think it is much broader than the so-called theoretical definition.” (<i>HC-CSSS IPO</i>)</p> <p>“My CSSS colleagues who use my patient records at the CSSS will find them quite empty, because all the information is entered at the hospital. It’s certainly not the best of all worlds, but at this point in time, I can’t see how we can work adequately in two physical places at a time in terms of record management.” (<i>HC-CSSS IPO</i>)</p> <p>“It’s been a bit of trial and error. It’s details such as where to place them in the hospital? There has been no instruction. (...) We notice the efficiency based on proximity. (...) If we were starting anew tomorrow, we would not make the same decisions. We would demand certain things.” (<i>Manager/Administrator</i>)</p> <p>“There’s no office. It’s a question of privacy basically. (...) She asks us if we have needs! Of course I have needs! But I am not going to tell her in front of 20 people! (...) We lack a small physical space, somewhere. Doesn’t need to be big. She just needs to get us, so that we can go there.” (<i>Family member of individual with cancer</i>)</p> <p>“In my organization, there’s not one team that’s dedicated to me. I look at the supraregional team and they have a real team, complete with physicians and everything. Me, I have to sort of “juggle” with several specialists. (...) Everybody feels one is needed, but it is in the administrative area that a lot needs to be accomplished.” (<i>HC-CSSS IPO</i>)</p>
3. Stakeholders’ participation and reactions	<p>“I have patients who call them their guardian angels and, for me, it is an image that’s very telling. (...) I have seen patients that had been utterly disorganized and disoriented regain confidence and feel totally reassured from the moment they had a navigator. (...) The feedback I get from the patients, since the role has been implemented, is that it can be an extremely meaningful connection, which makes all the difference in the cancer experience.” (<i>Specialist</i>)</p> <p>“At present, as the number of navigators is still limited, they’ve identified target sub-populations. Unfortunately, I will tell you that sometimes I still come across patients—even in these sub-populations—who don’t have access to their navigator in a timely manner.” (<i>Specialist</i>)</p> <p>“In real life, they do a lot of screening because referrals do not come... They do screening and they try to find systematic ways to obtain referrals. (...) We go at it with the means and the good will of the team.” (<i>Manager/Administrator</i>)</p> <p>“It is called initial assessment, but it is too broad to be simply initial. It’s too demanding, so it’s rare that I perform it. (...) If I achieve it in part, I do not include it in the record because it’s incomplete. I feel bad including anything that is incomplete. (...) If it was more succinct, it would be more useful.” (<i>HC-CSSS IPO</i>)</p> <p>“If the individuals, physicians, surgeons don’t believe in it, especially the ones issuing referrals, there’s nothing you can do. (...) Nurses are disheartened. Physicians don’t believe in it. There is no credibility. (...) We are the ones who have to spend a lot of energy to go and find our clients.” (<i>HC-CSSS IPO</i>)</p>
4. Effects of implementation	<p>“It can provide them with empowerment, to be able to make informed choices and to take charge in all this. (...) Better equipped because they have information, because they know where to call...” (<i>HC-CSSS IPO</i>)</p> <p>“Maybe in a year’s time, as soon as auntie Georgette announces to auntie Annette that she has cancer, she’ll hear back: ‘Have you met with your IPO?’ (...) In the long term, having a nurse navigator is going to become common place in the health system, it’s going to be a must.” (<i>HC-CSSS IPO</i>)</p> <p>“Realizing that it is not just the system that’s going to be delivering care to everybody according to very narrowly defined protocols, but that the care needs to be personalized. Because taking time to sit down and look at their needs, that’s the basis for humanizing the care.” (<i>Family physician</i>)</p> <p>“Better collaboration between hospital centres. Dissemination of information, working less competitively, more collaboratively, working less in silos. Opening barriers a bit ... Our old system was fostering a lot of competition between the regions, even within each of the regions, between certain hospitals such as CHA and CHUQ.” (<i>Supraregional IPO</i>)</p> <p>“Service consumption will, ultimately, be optimized and streamlined: better use in more precise circumstances with improved timeframes and improved response to patients’ needs. (...) It is going to help improve our quality and follow-up indicators and our health indicators in oncology.” (<i>Specialist</i>)</p>

families to be better able to meet their own needs by providing them with customized information and directing them to appropriate resources. Several individuals with cancer indicated that “their” IPO had enabled them to do some procedures and activities on their own and stated they felt more capable of dealing with their cancer thanks to their IPO’s support.

In the short term, participants think that the presence of IPOs should lead to a better coordination of the health care system (system being used more effectively, developing a systematic referral process, better understanding of system needs through the study of IPO’s statistical data). They consider that the presence of IPOs will improve information continuity between the different stakeholders both intra- and inter-facility (HC and CSSS). In the longer term, it is estimated that the presence of IPOs will help foster the satisfaction of individuals with cancer and their families regarding the services and care they receive. Moreover, several IPOs were eager to underscore how anxious they feel about a progressive increase in their caseload, which augurs the advent of several challenges.

Discussion

Establishing a new application of the navigation model: HC-CSSS IPOs

While the role is being implemented, one can state that certain aspects of the role and objectives pursued in implementing it with people living with cancer appear to be quite well known by the stakeholders collaborating with HC-CSSS IPO. However, few participants mentioned the families of individuals with cancer as a target population for IPOs while the PQLC refers to both individuals with cancer and their families (PQLC, 1998).

Results show that the use of the available tools is having a structuring effect even though this use varies from one IPO to the next and is yet to be standardized. In order to optimize this complex role, which is essential to the implementation of the PQLC, the Quebec Cancer Control Branch (DLCC according to its French acronym) suggested using such tools as telehealth, videoconferencing, electronic patient records, patient diaries, standardized summary sheets or request forms, all in order to facilitate patient follow-up, effectiveness and efficiency of information exchanges and, finally, training of stakeholders (DLCC, 2006; 2007). Several of these resources were lacking at the time HC-CSSS IPOs were implemented.

Perceptions relating to activities and interprofessional collaboration of HC-CSSS IPOs

The four planned functions of IPOs (DLCC, 2008) are properly recognized and described by the stakeholders. However, the understanding of the role and the objectives associated with its implementation vary among the disciplines and their level of interprofessional collaboration. Specialists and family physicians experience more difficulty in this area. As they still have few connections with IPOs, their understanding of the role seems to be theoretical and limited to that stated by the PQLC, while the operational definition for the role and functions remains poorly known and understood.

Furthermore, this ignorance of the role and the lack of credibility that derives from it are impeding the development of referral mechanisms. These appear to be improving gradually and in parallel with interprofessional collaboration, the latter occurring in accordance with the satisfaction experienced by the stakeholders in reaction to interventions by IPOs, as was reported in two previous implementation studies (Roberge et al., 2004; Fillion et al., 2006). Results demonstrate that inter/multidisciplinary work and consolidation of a well-defined oncology team appear to be important implementation facilitating conditions, despite some built-in difficulties. Working in “silos” is deplored, as it makes integrating IPOs more difficult. The challenge of mobilizing different stakeholders so that they work in an interdisciplinary fashion was

mentioned as that of understanding how much IPOs contribute to the work of their team without being perceived as “threats”. The professional collaboration model by D’Amour, Beaulieu, San Martin Rodriguez and Ferrada-Videla (2004) clearly describes the problems associated with recognizing the contribution of each member and developing a trusting relationship between all members in a context of interprofessional collaboration and team building. Updating the definition of role boundaries for IPOs remains a necessity for some stakeholders—including the IPO—so that everyone can identify the tasks required of them and complementarity to their partners. This issue was also raised in another Quebec health region (Roberge et al., 2004).

The interprofessional collaboration model also requires clinical leadership that supports the initiative (carried out, for example, by an oncology clinical nurse specialist who facilitates role integration within the team), administrative support on the part of managers and formalizing certain procedures in order to establish this collaboration (D’Amour et al., 2004). Our results support these dimensions of the model and are consistent with those of the long-term implementation study by Tremblay (2008), which stresses the importance of credible leaders supporting the integration of IPOs by strengthening the vision based on values focusing on quality of care where consideration is given to the concerns of individuals and the capabilities of each context.

Effects of implementation on clients and the health care system

IPOs believe they help foster empowerment among people with cancer and their families. As described in a previous study (Fillion et al., 2006), this effect seems to be linked to giving clients the right information at the right time and in the right terms, something that would be considerably optimized if referrals occurred more rapidly after diagnosis. Armed with personalized information about available resources to meet particular needs, individuals are more able to meet their needs and to satisfactorily progress along the complex care trajectory. Furthermore, many people living with cancer and their families confirmed they felt more confident to face their illness with their IPOs acting as a “safety net”. The fact that the relationship between IPOs and people affected by cancer all along the care trajectory is being appreciated and valued, in itself, supports the relevance of the role. The unfulfilled need of relational continuity was a meaningful result of the study carried out prior to designing the PQLC (Fraser, 1995).

In addition to the empowerment effect on the clients and the improvement to relational continuity, the results of this study show that by their presence, IPOs can potentially improve care coordination (better understanding of the health care system and the care trajectory of individuals with cancer and their families, better access to care and services resulting from the high availability of IPOs, and greater satisfaction with the quality of care and services received thanks to the existence of IPOs). These results are consistent with those of an impact study on IPO implementation with regards to several indicators of client empowerment and continuity of care (Fillion et al., 2009).

To sum up, the results support the added value this role has in terms of empowerment of individuals living with cancer and continuity of care while highlighting several organizational factors that need to be taken into account to facilitate integrating the role and ensure its continuous integrity.

Recommendations

At this stage of the implementation process, it is recommended to increase dissemination of the role among the main partners of HC-CSSS IPOs and to delineate its grey areas so that interprofessional collaboration is fostered. Efforts aimed at consolidating oncology teams and integrating HC-CSSS IPOs within interdisciplinary teams are also encouraged to promote communication and information

transfer. It would be useful to design or strengthen mechanisms supporting the linking of efforts (client referral mechanisms and indicators soon after diagnosis; screening, assessment, referral and client follow-up tools; computer-based data collection, entry, analysis and management tools; allocation of consultation offices located near where care teams operate; tools to evaluate the economic and organizational impact of IPO on the health care system).

To our knowledge, there does not appear to exist any consensus on a theoretical definition of a professional navigation role (IPO or oncology nurse navigators, cancer patient navigators). The lack of a conceptual model grounded in theories putting forward specific concepts contributes to limiting the operational definition of functions required in the field, as well as the resources to be put into place for their deployment. This ambiguity does not facilitate interprofessional collaboration, nor working within oncology teams while inappropriate expectations of the IPOs still exist in these areas.

Conclusion

The collected data paint a favourable picture of HC-CSSS IPO implementation, which is still in its early stages. As mentioned in other studies (Cancer Care Nova Scotia, 2004; Roberge et al., 2004; Fillion et al., 2006; Tremblay, 2008), the success of implementation depends on the support IPOs give each other, training, managers' support and presence of clinical leaders with a long-term commitment. This support will have to be maintained as HC-CSSS IPOs are still faced with the challenge of integrating in interdisciplinary oncology teams, which, themselves, are under construction. Fortunately, the majority of the stakeholders we interviewed are still motivated to help consolidate these teams and improve care quality. In order to promote interprofessional collaboration and oncology team operation, it is strongly recommended that concerted efforts to define and clarify the complexity of the role be pursued—both from a conceptual and an operational perspective. 🌱

References

- BC Cancer Agency. (2005). **Patient navigation in cancer care: Final report**. Retrieved from www.bccancer.bc.ca/RES/SBR
- Canadian Partnership Against Cancer. (2008). Retrieved from www.partnershipagaincancer.ca
- Cancer Care Nova Scotia. (2004, March). **Cancer patient navigation evaluation findings. Final report**. Nova Scotia: Author.
- D'Amour, D., Beaulieu, M.D., San Martin Rodriguez, L., & Ferrada-Videla, M. (2004). Key elements of collaborative practice & frameworks: Conceptual basis for interdisciplinary practice. In I. Oandasan (Ed.), **Interdisciplinary education for collaborative, patient-centred practice. Research report**. Ottawa: Santé Canada.
- Direction de la lutte contre le cancer. (2006). **Rapport d'activité 2005–2006** (p. 30). Québec : Ministère de la Santé et des Services sociaux.
- Direction de la lutte contre le cancer. (2007). **Orientations prioritaires du Programme québécois de lutte contre le cancer 2007–2012** (43 p.). Québec : Ministère de la Santé et des Services sociaux.
- Direction de la lutte contre le cancer. (2008). **Rôle de l'infirmière pivot en oncologie** (p. 15). Québec : Comité consultatif des infirmières en oncologie, Ministère de la Santé et des Services sociaux.
- Donabedian, A. (1980). **The definition of quality and approaches to its assessment. Explorations in quality assessment and monitoring: Volume I**. Ann Arbor, MI: Health Administration Press.
- Donabedian, A. (1985). **The methods and findings of quality assessment and monitoring: An illustrated analysis. Explorations in quality assessment and monitoring: Volume III**. Ann Arbor, MI: Health Administration Press.
- Farber, J., Deschamps, M., & Cameron, R. (2002). **Analyse et évaluation de la fonction d'intervenant pivot en réponse aux besoins qu'éprouvent les Canadiennes atteintes d'un cancer du sein sur les plans de l'information, de l'éducation et de l'aide à la prise de décision. Rapport de recherche**. Québec: Initiative sur le cancer du sein, Santé Canada.
- Fillion, L., de Serres, M., Cook, S., Goupil, R.L., Bairati, I., & Doll, R. (2009). Professional patient navigation in head and neck cancer. **Seminars in Oncology Nursing**, 25(3), 212–221.
- Fillion, L., De Serres, M., Lapointe-Goupil, R., Bairati, I., Gagnon, P., Deschamps, M., et al. (2006). Implementing the role of patient-navigator nurse at a university hospital centre. **Canadian Oncology Nursing Journal**, 16(1), 11–17.
- Fillion, L., Cook, S., Veillette, A.-M., De Serres, M., Aubin, M., Rainville, F., et al. (in progress). **Professional navigation framework: Empirical validation with Canadian models**.
- Fraser, A. (1995). **Pour une meilleure compréhension des besoins des personnes atteintes de cancer** (89 p.). Québec : Document produit dans le cadre des travaux du Comité consultatif sur le cancer, Ministère de la Santé et des Services sociaux.
- Haggerty, J., Reid, R.J., McGrail, K., & McKendry, R. (2001, June). **Here, there and all over the place: Defining and measuring continuity of health care** (p. 59). Vancouver, BC: Centre for Health Services and Policy Research.
- Hébert, J., & Fillion, L. (soumis). **Mieux comprendre la fonction de soutien de l'infirmière pivot en oncologie (IPO) selon la perspective d'IPO et de personnes atteintes de cancer**.
- Patton, M.Q. (1990). **Qualitative evaluation and research methods** (2nd ed., p. 532). Newbury Park, CA: Sage Publications.
- Patton, M.Q. (1997). **Utilization-focused evaluation: the new century text** (3rd ed., p. 431). Thousand Oaks, CA: Sage Publications.
- Programme québécois de lutte contre le cancer (PQLC). (1998). **Pour lutter efficacement contre le cancer, formons équipe** (p. 166). Québec : Comité consultatif sur le cancer, Ministère de la Santé et des Services sociaux.
- Roberge, D., Denis, J.L., Cazale, L., Comtois, E., Pineault, R., Touati, N., et coll. (2004). **Évaluation du réseau intégré de soins et de services en oncologie : l'expérience de la Montérégie. Rapport final de recherche** (p. 36). FCRSS. Ottawa.
- Robert, G. (2000). Bien préparer les changements organisationnels. **Revue québécoise de psychologie**, 21, 37–51.
- Strauss A.L., & Corbin, J.M. (1990). **Basics in qualitative research: Grounded theory procedures and techniques** (p. 312). Newbury Park: Sage Publications.
- Skrutkowski, M., Saucier, A., Eades, M., Swidzinski, M., Ritchie, J., Marchionni, C., & Ladouceur, M. (2008). Impact of a pivot nurse in oncology on patients with lung or breast cancer: Symptom distress, fatigue, quality of life, and use of healthcare resources. **Oncology Nursing Forum**, 35(6), 948–954.
- Tremblay, D. (2008). **La traduction d'une innovation organisationnelle dans les pratiques professionnelles de réseau : l'infirmière pivot en oncologie** (369 p.). Thèse de doctorat. Université de Montréal.
- Turgeon, J., Dumont, S., St-Pierre, M., Sévigny, A., & Vézina, L. (2004). **La problématique de la continuité des soins en oncologie. Rapport de recherche soumis à la Fondation canadienne de recherche sur les services de santé**. Québec: QC : Université Laval.
- Yin, R.K. (1994). **Case study research. Design and methods** (2nd ed., p. 232). London: Sage Publications.