

Montérégie Comprehensive Cancer Care Centre

Integrating nurse navigators in Montérégie's oncology teams: One aspect of implementing the Cancer Control Program—Part 1

by Anne Plante and Sonia Joannette

Abstract

The oncology patient navigator role was developed to ensure both continuity and consultation in the delivery of care to cancer patients and their families. In Québec, this role is filled by a nurse. This first article in a series of two, aims to explain why nurses were selected as patient navigators and to describe how this new role has been integrated in the Montérégie Region. The Québec Cancer Control Program, the definition established for the oncology nurse navigator role and the implementation of an integrated care network based on the Montérégie experience will be discussed.

Introduction

Oncology is, in itself, a very special intervention area, which derives its character from the all-out struggle fought by thousands of Canadian men and women against a disease that can sometimes be life threatening and a constant menace to their quality of life. In spite of modern scientific and technological advances, the diagnosis is all too often equated with suffering and death, and the mere mention of the disease causes stress and fear. Cancer affects not just the patients, but also upsets their whole family circle. The number of new cancer cases and deaths continues to increase for some types of cancer. The population is aging across Canada, and this process appears to be particularly rapid in the province of Québec. The growing number of available treatments and the complexity of care are putting extra pressure on health professionals wanting to deliver optimal specialized cancer care.

Geographic inequities, fragmentation of services and the desire to better meet the needs of the population motivated the initiators of the Québec Cancer Control Program ("PQLC" after its official French acronym) (Ministère de la Santé et des Services sociaux, 1998) to redefine oncology care. The Québec Ministry of Health established a committee to analyze client dissatisfactions and identify the improvements most wanted by patients and health care professionals alike. Putting in place patient navigators as reference practitioners is one of the concepts advocated in this program. The Canadian Strategy for Cancer Control (CSCC) also recommends this type of stakeholder to help cancer patients navigate the health care system throughout the continuum of care (Urquhart & Grunfeld, 2007). This

first article of two articles aims at explaining why nurses were selected as patient navigators and describing the integration of the role in Montérégie. The Québec Cancer Control Program, the Oncology Nurse Navigator role and the Montérégie experience will be discussed.

The Québec Cancer Control Program: Centred on oncology patients' needs

The Québec Cancer Control Program (Ministère de la Santé et des Services sociaux, 1998) is the fundamental discussion document recommending the choice of an oncology nurse for the navigator role. In 1995, the province wanted to develop a program that could combine the efforts of professionals and decision-makers in all areas of cancer control: health promotion and cancer prevention, early detection, investigation, treatment and adaptation, and palliative care, as well as research and education. The Minister of Health asked the Advisory Committee on Cancer to formulate a new structural pattern for oncology. The goal was to improve the organization of services in order to deliver more individualized care to people with cancer and their families while factoring in resource limitations. Experienced professionals, managers and individuals with cancer collaborated closely in order to create an exact picture of reality for cancer patients and their loved ones and for care and services. The PQLC's overall objective is to organize oncology services with a view to fostering their humanization, quality, efficiency and accessibility. The clients appreciate it when services are delivered as close as possible to their region (Ministère de la Santé et des Services sociaux, 1995). The cancer care and treatments are both numerous and complex. A great deal of clinical follow-up is required to ensure proper quality of life for the patients and their families, and attainment of therapeutic goals. The importance of integrated services is stressed in the PQLC.

The provision and maintenance of quality services depend on three main conditions. First, the implementation of interdisciplinary teams is seen as a foolproof and a recognized way to meet the clients' biopsychosocial needs in order to increase efficiency, on the part of the professionals (consistent communication), quality of services, accessibility, and satisfaction on the part of patients, families and care providers (Haggerty, Reid, McGrail & McKendry, 2001; Blitzer & Kutscher, 1990). Several authors list the positive attributes of interdisciplinary work both in inpatient and outpatient facilities (Moulin & Fraval, 2004; Frank & Cramer, 1998; Conley & Kelly, 1997). However, the mere gathering of health care professionals from various disciplines within an oncology team was not sufficient to characterize it as an interdisciplinary team. Openness, sharing of knowledge and cooperation are required between team members if they are to have real exchanges around the complex situations experienced by patients and families. The members of the interdisciplinary team must be given time and space to formulate individualized interdisciplinary care plans. If the team is unable to develop this ability to share perspectives and link interventions, such care plans will not be possible.

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Second, the establishment of an integrated network appears to be the critical structure to let professionals share their expertise and standardize their practice in all disciplines and jurisdictions (Rycroft-Malone, Harvey, Seers, Kitson, McCormack, & Titchen, 2004; Morin & Leblanc, 2002; FCRSS, 2000). Sharing resources and using evidence-based knowledge help reduce variations in services between the different hospitals in the province. The program describes the issues and focuses on the efforts needed to produce standardized practices and foster partnerships between existing services. According to the PQLC, oncology services must be organized according to the following levels: local, regional and supraregional. Access to specialized services is guaranteed to all by the hierarchization of services. Local oncology teams regularly insure continuity of services as close as possible to the clients' homes. They are entrusted with the screening and treatment of the most common types of cancer. These local teams combine local hospitals, home care services and community organizations. Regional teams deliver more specialized treatments (e.g., radiation therapy). They collaborate closely with the hospitals in their region (local teams) to foster a constant exchange of information (e.g., establishing standardized chemotherapy protocols, tumour board via teleconferencing). Supraregional teams are located in university hospitals. They deliver ultra-specialized care and services (e.g., osteosarcoma surgeries, bone marrow transplants). Thanks to this organization of services, each centre is able to define the services it offers and to always have sufficient case volume for each tumour site for maintaining its expertise. Service corridors must be set up between these levels to facilitate patient transfers and successful interprofessional exchanges regarding continuity of care.

Third, the fluidity and speed of information exchanges between teams guarantee appropriate follow-up for the clients. The idea of creating a front-line patient navigator role in each oncology clinic was also a winning solution. The goal is to allow each individual newly diagnosed with cancer and his or her loved ones to promptly meet with the team so that they understand the situation, receive information and support, establish and maintain contact between them and the stakeholders for all service levels and to develop from the very beginning an individualized care plan adapted to both their needs and resources. A Canadian survey (Ashbury, Findlay, Reynolds, & McKerracher, 1998) and a British survey (Cox, Jenkins, Catt, Langridge, & Fallowfield, 2006) came to the same conclusions. Information, support, the presence of a contact person and the desire to actively participate in decisions regarding therapeutic choices clearly stand out as an essential package for each individual with cancer.

Main needs as expressed by individuals with cancer

- Humanizing the communication of diagnosis and contacts during treatment and follow-up.
- Stakeholders using language that is both simple and understandable by the individuals with cancer and their families.
- Participation in the decisions affecting them and a desire to maintain control over their therapeutic choices.
- More time with specialists at communication of diagnosis and subsequent meetings.
- Information as well as psychosocial and existential support from the time the diagnosis has been announced.
- Complete information on the whole range of public, community and private resources so that they know the full extent of available services.
- The opportunity to contact a person on the oncology team who is designated to do the follow-up and answer questions from the affected individual/family.

(Ministère de la Santé et des Services sociaux, 1998)

Patient navigator: Oncology nurse navigator

In Québec, the nurse was selected as the professional with the best fit for the navigator functions. Because of her training and comprehensive vision, the nurse can analyze and address the various biopsychosocial areas with the patient and their family. According to De Serres and Beauchesne (2000), the patient navigator must possess certain essential characteristics and be selected in light of their skills: Thorough (biopsychosocial) knowledge of oncology, attitudes, skills in communication and helping relationships, advocacy, holistic approach to patient care and capacity to work both within a team and independently are major attributes of a good patient navigator. The patient navigator must be accessible and to the extent possible, be readily available. She provides clinical follow-up to oncology patients from diagnosis to treatment to remission, recurrence and sometimes to the palliative phase if end-of-life care teams are not available. The CEPIO (French acronym of "Evolution of Oncology Nursing Practice Committee") (Bélanger, Bergeron, de Serres, & Saucier, 2005) underlines that the ability to assess the clients' physical and mental states and to provide clinical monitoring of their condition is an integral part of the nurse's scope of professional practice.

The *Cancer Care Navigator* role is usually rendered in French as "intervenant pivot", but it is not quite the equivalent. Besides helping to navigate the system, the Oncology Nurse Navigator or IPO (which stands for "infirmière pivot en oncologie") plays a similar role to that of the *Cancer Care Navigator* in offering and facilitating access to social support, decision support, active coping and fostering self-efficacy as described in the conceptual framework by Doll and collaborators (2007). The IPO goes a step further in her holistic approach to both the patient **and** their family, via the concept of empowerment she promotes, the prevention/management of symptoms and the development of an individualized care plan in partnership with the interdisciplinary team. The nurse navigator acts as a catalyst within the oncology team to influence medical practice and the practices of all the other health professionals towards a care philosophy centred on the patients and their families. Patient navigators are present in several areas of Canada, and their existence yields results much appreciated by the patients and organizations (Saucier, 2007; Urquhart & Grunfeld, 2007; Fillion et al., 2006; B.C. Cancer Agency, 2005; Cancer Care Nova Scotia, 2004; Roberge et al., 2004).

Following is the definition of the Oncology Nurse Navigator role as formulated in our health region to meet the guidelines of the PQLC (Comité consultatif des infirmières en oncologie, 2008; Bélanger et coll., 2005; de Serres et Beauchesne, 2000) and to better respond to patients' expectations (Ponte & Nies, 2003; Deber, Kraetschmer, & Irvine, 1996):

The experience in Montérégie

The Montérégie is Québec's second largest administrative region. It covers a 10,000 km² geographic area and serves 1,371,000 inhabitants with a regional hospital centre affiliated with Université de Sherbrooke, as well as 11 health and social services centres ("CSSS" according to their French acronym) delivering inpatient care, home care and long-term care (Ministère de la Santé et des Services sociaux, 2008).

Implementation of the PQLC in Montérégie was achieved by mobilizing predetermined teams. When the PQLC was published, oncology program administrators and health professionals in the region saw the document as being very innovative, but felt its setting up seemed unrealistic in the short term given the lack of resources. However, the *Agence de la santé et des services sociaux de la Montérégie* [Health and Social Services Agency of Montérégie] (the Agency) decided to make a priority out of the

establishment of the PQLC in its area. The Agency's mission is to lead the region's health care and social services system to improve its performance towards excellence and, thus, contribute to enhancing the population's health and welfare (Ministère de la Santé et des Services sociaux, 2008).

The Agency's management facilitated the shared task of defining the steps required to implement the PQLC, a program deemed advantageous to the wellness of the population. All institution executive directors were informed about the project, and were all invited to take an active role in its establishment. The CICM [Montérégie Comprehensive Cancer Care Centre] was designated as the regional oncology team based at Hôpital Charles Lemoyne, the regional hospital centre of Montérégie affiliated with the Université de Sherbrooke. The 11 CSSS, eight of which are offering ambulatory oncology services, were invited to collaborate with the Agency and the CICM on the implementation of the PQLC. The coordinating committee of the *Réseau Cancer Montérégie* [Montérégie Cancer Network] (RCM) aims to bring together representatives from all institutional levels to form a steering committee. This committee bestows the power of convergence and harmonization on regional oncology practices, both organizational and clinical (Appendix 1). When administrators are engaged in the thinking and decision process, they deploy the necessary energies to support the professionals at their own

institutions and encourage them to become involved in the desired practice changes (Barter, 2002; Colling & Wilcox, 1994; Shortell, Zimmerman, & Rousseau, 1994).

To initiate change, the regional leadership is built on administrative stakeholders such as head nurses and health care professionals such as nurse advisors. Various strategies (e.g., communication, establishment of regional committees of professionals) were used to entice individuals to cooperate and highlight the added value to such collaboration (Roberge et al., 2004). The Agency granted a specific budget allowance to implementing the PQLC in its jurisdiction. CSSS executive directors and directors of nursing discussed the proposed changes. The patient- and family-centred interdisciplinary care model was selected (Jassak, 1992).

The CICM team was initially (i.e., 1999) made up of four hemato-oncologists, two pharmacists, several chemotherapy clinic nurses, one psychologist, one social worker, one pastoral counsellor, one nutritionist, one research nurse and one representative from the administrative support staff. In each of the 11 CSSS, eight of which have an oncology clinic, the teams were composed of an oncologist or hemato-oncologist, a pharmacist and a nurse dispensing oncology treatments. The nurse navigator was the selected professional to enact the role of achieving the care philosophy and structure changes put forward in the PQLC. Oncology clinic administrators were required to familiarize themselves with this new concept of working

Table: Oncology nurse navigator role in Montérégie Region

Evaluate	Meet with each newly diagnosed patient and assess from the very start their biopsychosocial needs, coping strategies, capacity to use available resources, and bring to light the skills of the patients and their families.
	Assess the clients' comprehension of information received in order to facilitate informed decision-making regarding therapeutic choices across the continuum of care, while respecting their values.
	Assess the needs brought forward by the patients and their families, along the care trajectory, according to the PQRST assessment model, apply the associated nursing interventions.
Coordinate	Be the referral person for the clients (Monday to Friday).
	Coordinate clients' follow-up with affected partners in the hospital and community contexts for full-circle communication (Laurice, 1991).
	Present complex cases at the interdisciplinary meeting to develop an individualized care plan in consultation with all team members who can all have a better understanding of the patient and better adjust their therapeutic interventions following hypothesis generation.
	Refer the patients and their families to required resources and/or professionals according to specific referral criteria.
	Guide therapeutic interventions towards relaxing of systems (both family and organizational) to create space for change and promote adaptation to current reality.
Teach/ Inform	Assess and teach required knowledge to patients and their families in order to enhance self-care and their decision-making ability across the continuum.
	Reinforce the teachings already provided by attending physician, pharmacist, nurses delivering the treatments, and other professionals.
	Inform clients about available resources (professionals on the team, <i>Info-onco</i> web service, team of volunteers, printed material, validated web sites, community organizations, complementary and alternative practices, etc.).
	Teach health promotion and personal health practices while being sensitive to the clients' realities and act as an agent of change.
Support	Support through active listening and open avenues of hope for patients and their families to facilitate their process of adaptation and to offer a human and comforting perspective in the cancer care experience (Sharpe, 2005).
	Support the patients and their families in the management of symptoms through telephone communications (triage) and/or during follow-up at the oncology clinic in order to reduce emergencies and optimize wellness at home (Cancer Care Ontario, 2004).
	Support the patients and their families in their requests to health professionals.
Indicate in the patients' medical records all assessments and interventions performed with them and their significant others.	

within an integrated network, to understand the nurse navigator role and to make sure that the proposed changes would be taken into account by the other professionals on oncology teams. The directors of nursing agreed to meet with the Regional Nurse Consultant in Oncology Care at the CICM to develop a proper understanding of the nurse navigator role, stipulated changes and PQLC objectives. Following this meeting, nine directors of nursing (that of the CICM and those of eight local hospitals) approved integrating the nurse navigator role into the oncology care teams. These nurse navigators were to introduce a new intervention philosophy in their respective workplaces and impress the legitimacy of their role on the other health professionals, particularly the oncologists. In Montérégie, a new era began for oncology by introducing nurse navigators in ambulatory oncology clinics in the region's hospital centres and developing interdisciplinary teams in these contexts.

According to Roberge and colleagues (2004), the Montérégie initiative shows that it is easier to mobilize professionals around an integration project when the latter has an institutional base. Likewise, the implementation of a network requires the participation of diverse stakeholders spread among various organizations and practice settings. Tremblay (2008a) recently studied the IPO role as an organizational innovation. She mentions that this role requires mobilizing a network of players from different levels (political, clinical, tactical and operational) in support of its deployment. The necessity to unite all these players around a joint project increases the investments to be made in terms of awareness and training.

The Regional Nurse Consultant in Oncology Care is responsible for integrating the nurse navigator role within the eight oncology centres and the CICM. Her role includes several components: consensus building, development of evidence-based work instruments, education, supervision and support. She is the concrete link between the RCM and oncology nurse navigators around Montérégie. Her consensus-building role is to standardize practices to achieve one common goal: evidence-based care centred on the patients and their families. She endeavours to build a communication network open to all stakeholders involved in the implementation of the PQLC and encourages collaboration by all. In times of uncertainty, she reminds the various partners of the goals of the PQLC and clinical objectives to be attained in nursing. The Regional Nurse Consultant forwards to the partners documentation and numerous scientific references so that they can keep abreast of what is being taught to oncology nurse navigators and support them in their role. The need to maintain and improve quality of services is recognized by all health professionals, particularly in oncology. Nevertheless, each professional tends to routinely carry out his or her professional responsibilities, and openness to change does not readily exist among care teams. Interprofessional collaboration varies from one context to another depending on team composition and individual behaviours (Tremblay, 2008b).

Engaging head nurses to encourage reflection by their team members on the needs of patients and the issues within their setting was an element of success. Pauchant (1996) stresses the importance of having a mentor on the management side. Without the involvement of head nurses, the change of paradigm focused on individualized and collaborative care would not have taken place in such a short time (Udod & Care, 2004; Sullivan, 1998; Warren, Houston, & Luguire, 1998). However, even with all of the discussions with head nurses, written messages from the Agency and training evenings, the task of integrating the nurse navigator role and patient and family focused interdisciplinary care required patience and perseverance.

The Regional Nurse Consultant developed tools to foster reception of this new role by Montérégie's health care teams. She provided them to the directors of nursing and head nurses so they could support nurse navigators in their new role. The various tools aim to promote the nurse navigator work with the clients and the work of all the other members on the oncology interdisciplinary team:

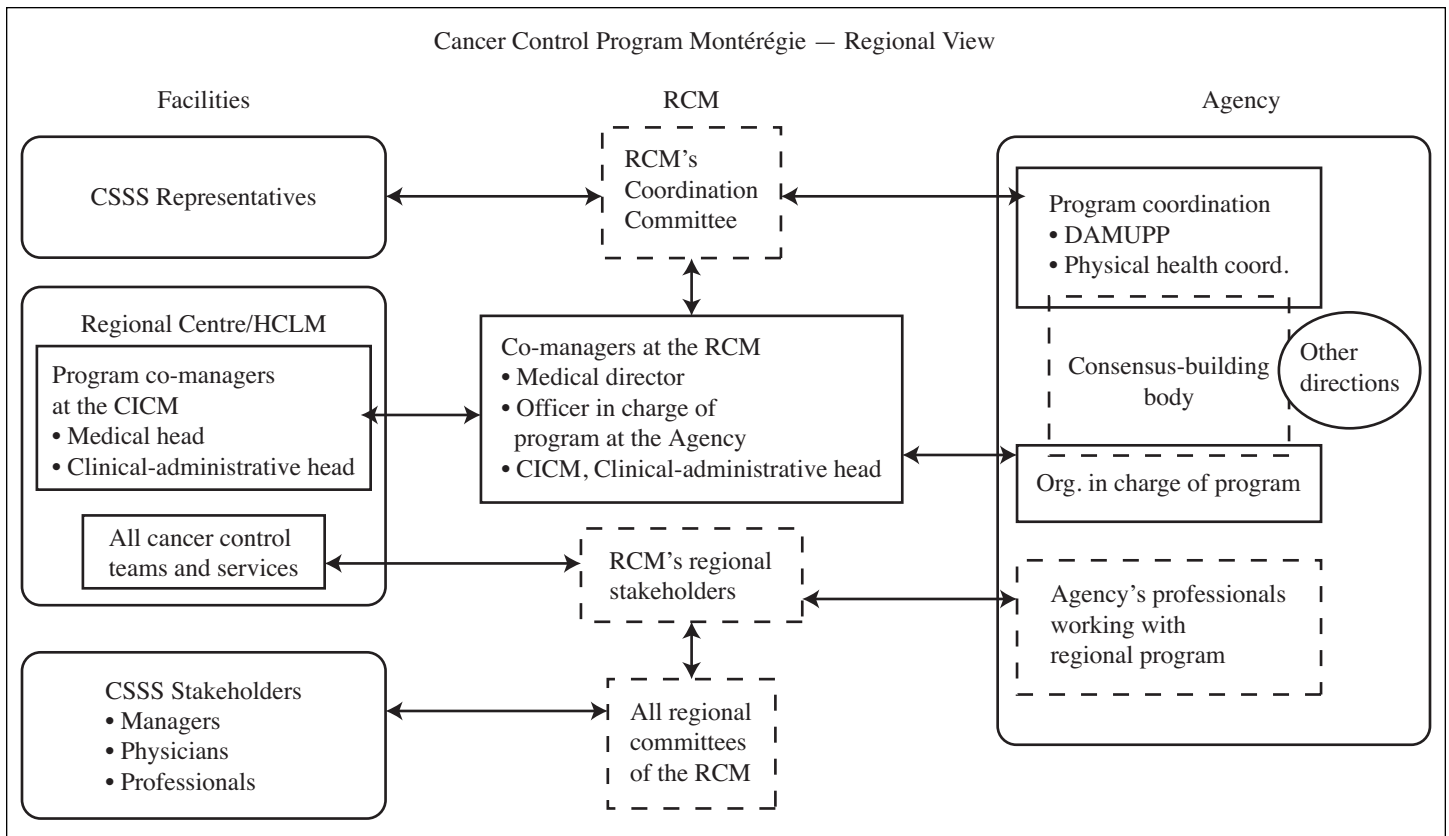
- explanatory card about the oncology nurse navigator role;
- criteria and selection grid for oncology nurse navigators;
- training program for oncology nurse navigators;
- basic training program in oncology for nurses and other professionals;
- training program regarding interdisciplinarity;
- data collection based on the client- and family-focused care model including a genogram and an eco-map (Wright & Leahy, 2001);
- telephone screening;
- care plan produced after the interdisciplinary meeting (Appendix 2);
- screening criteria for reference by professionals (nutritionist, pharmacist, pastoral animator, psychosocial services, etc.).

The Nurse Consultant carries out her supervisory role by being available for telephone consultation for nurse navigators facing complex situations. She organizes and leads monthly continuing education sessions for Montérégie nurse navigators. The dynamics of exchanges and challenges developed among the RCM's health professionals, managers and executives are described by the Nurse Consultant to nurse navigators during their monthly meetings. This progress report on meetings helps nurse navigators feel supported in their daily actions. Through all these meetings, the Nurse Consultant helps each and every one of them to keep their focus on clinical objectives, the expertise still to be put in place and to remain optimistic throughout the realistic evolution of events. Her support role with her partners (oncology nurse navigators, RCM, directors of nursing and head nurses) helps give prominence to the strengths of each and all as a central focus.

Conclusion

The engagement and involvement of all partners, the clinical and administrative leadership, strong clinical managers, collaboration, interdisciplinary work, training and support to stakeholders, the clear definition of roles and integration of nine oncology nurse navigators in oncology care teams of Montérégie facilitated changes and continuing progress toward attaining the objectives of the PQLC. This program was the catalyst for change, and nurse navigators successfully fulfill their role as agents of change. They are anchor points for the patients and their families. The objective of integrating care within a network in which interdisciplinary care is focused on the patients and their families and the practice is based on scientific evidence, appears to be well anchored in Montérégie. Success relies on the will of the stakeholders and organizations to cooperate and make it into a priority.

The arrival of IPOs brings together oncology teams by encouraging reflection on interdisciplinary work. Numerous challenges remain because increases in the volume of clients and limited resources call for new solutions. Nevertheless, implementation of the PQLC—with the integration of nurse navigators as front-line staff—constitutes a constructive and uniting model. "The ultimate in life is the harmony between all elements. It's action too. It is feeling surrounded by kindness and hope" (Menuhin, 2001).



Appendix 1. RCM [Montréalégie Cancer Network] Organization chart

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Appendix 2. Interdisciplinary intervention plan
Hôpital Charles LeMoigne
Montréalégie Regional and University Affiliated Centre

Presentation to the CICM's Interdisciplinary Team

Patient Name: _____
 File: _____
 Diagnosis: _____ Age: _____
 Physician: _____ Nurse Nav.: _____ Date: _____

History: _____

Current situation: _____

Symptoms: _____

Hypotheses: _____

Reason for this presentation: _____

Intervention Plan: _____

Signature: _____

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