Canadian Oncology Nursing Journal

Revue canadienne de soins infirmiers en oncologie

Volume 27, Issue 1 • Winter 2017
eISSN: 2368-8076

CANO
ACIO

Canadian Association of Nurses in Oncology
Association canadienne des infirmières en oncologie

The role of oncology nurse navigators in facilitating continuity of care within the diagnostic phase for adult patients with lung cancer

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ABSTRACT

Objective: The objective of this study was to explore the role of oncology nurse navigators (ONN) in facilitating continuity of care for adult lung cancer patients during the diagnostic phase of cancer care.

Design: A phenomenological approach was used and involved semi-structured patient interviews and an oncology nurse navigators' focus group.

Results: Eight individuals participated, including four adult patients with lung cancer and four oncology nurse navigators. Themes regarding the organizational functions of the ONN role in facilitating continuity of care were identified: patient-focused care, needs assessments, shared decision-making, accessibility, and eliminating barriers.

Conclusion: Awareness of the organizational functions of the ONN role could be used to create core areas of practice within nursing training modules to provide consistent and patient-centred continuity of care.

Key words: nurse navigators, continuity of care, cancer, diagnostic phase

INTRODUCTION

Cancer is a process, a chain of events that begins at the molecular level in the human body and persists through changes that patients and their families undergo to deal with the personal and medical effects of this disease. The diagnostic phase of cancer, from suspicion to diagnosis, is characterized by numerous tests and treatments, high levels of uncertainty, and patient anxiety (Psooy, Schreuer, Borgaonkar, & Caines, 2004). Lengthy wait times create anxiety among patients, delay

treatment, and increase the possibility of disease progression, which, in turn, lead to poor patient outcomes (Christensen, Harvald, Jendresen, Aggestrup, & Petterson, 1997). Navigating through the healthcare system and not knowing what services are accessible can be very challenging and stressful, as patients are making major life decisions.

Patients have often emphasized the complexity of navigating through the healthcare system and expressed a significant need for continuity of care (Trussler, 2002). Continuity of care is described as the level to which healthcare services are experienced as coherent, connected, and consistent with a patient's health needs and personal situation (Haggerty et al., 2003). The concept of nurse navigation in cancer has occurred as a result of challenges patients and their families faced in a complex healthcare system. Cancer navigation programs have emerged as a model of care within North America to enhance continuity of care and services for patients diagnosed with cancer (Fillion et al., 2012). Thus, current and emerging roles have emerged to guide and improve a patient's journey through the cancer care continuum.

Although nurse navigation is recognized by many provinces as a key element of an integrated system of cancer care, this process is not yet delivered in a standardized way across Canada (Cancer Care Ontario, 2010). Little evidence exists pertaining to the effectiveness of the role of the nurse navigator on patients' experience in supporting the implementation of a nurse navigator position for patients with cancer (Cantril & Haylock, 2013; Fillion et al., 2012; Pedersen & Hack, 2011). Additionally, continuity of care is acknowledged differently across health disciplines (Haggerty, Roberge, Freeman, & Beaulieu, 2013), and there is limited evidence, within Canadian studies that shows how oncology nurse navigators (ONNs) have facilitated patient continuity of care during the diagnostic phase of cancer care (McMullen, 2013). The purpose of the study was to examine the lived experiences of lung cancer patients and ONNs, so as to explore the role of ONNs in facilitating continuity of care for adult lung cancer patients during the diagnostic phase of cancer care.

CONCEPTUAL FRAMEWORK

The Bi-Dimensional Framework (Fillion et al., 2012) was used to guide the study methodologically and to examine the lived experience of patients and ONNs. This framework acknowledged the qualitative aspect in determining how the role of ONNs affected patients' experience by focusing on the bi-dimensional nature of the role: organizational and clinical. It was established in early 2012 to bring clarity to the roles

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DOI: 10.5737/236880762717480

and functions of professional nurse navigators in a Canadian context (Fillion et al., 2012). The framework consists of two theoretical dimensions: a) facilitating continuity of care, and b) promoting patient empowerment. This paper focuses on the first dimension: facilitating continuity of care, which is composed of three related concepts—informational, management, and relational continuity. These three concepts together created a coherent and connected experience of care for patients with cancer.

METHODS

Study Design

The phenomenological approach was used to examine the lived experience of patients with cancer and ONNs within the diagnostic assessment of patients at the Durham Regional Cancer Centre (DRCC) in Ontario. This research design assisted the researchers in understanding participants' lived experiences (Flood, 2010; Groenewald, 2004). It involved putting aside personal attitudes and beliefs and allowed researchers to view the phenomenon from the perspectives of persons who experienced it (Flood, 2010; Groenewald, 2004). This study received ethical approval from the Lakeridge Health and the University of Ontario, Institute of Technology Research Ethics Boards. All participants provided informed consent prior to the interview and focus group.

Recruitment

Convenience sampling was used to recruit participants. The ONNs identified patients based on the eligibility criteria using patient records and preliminary telephone screening. Eligibility criteria of patients were: adult men and women 18 years or older; referred to the diagnostic assessment program within the agency with a suspicion of lung cancer; fluent in English; and had at least two contacts with their nurse navigator prior to data collection. The receptionist at the agency provided the letter of invitation and consent form to those patients who met the eligibility criteria. Interested persons were asked to give verbal consent to provide the principal investigator (PI) with their contact information. Interested persons were then contacted by the PI via telephone to inform them about the study. Patient participants were invited to participate in individual interviews at the agency at a scheduled time suitable to them.

The PI emailed the letter of invitation to participate in the study to the ONNs working within the diagnostic assessment program at the agency. Interested ONNs were invited to participate in a scheduled focus group. Eligibility criteria of ONNs were: working in the diagnostic assessment program within the lung cancer department at the DRCC; provided health-care to patients; and completed lung-specific courses, as well as held the designation of Certified in Oncology Nursing (Canada, CON(C)). Recruitment of participants occurred between January 2013 and March 2013, and concluded when successive interviews became repetitive and no new responses or themes emerged (Creswell, Plano Clark, Gutmann, & Hanson, 2003).

Data Collection

Patient participants took part in a semi-structured interview with open-ended questions, which lasted approximately 15–20 minutes. ONN participants engaged in a focus group and answered open-ended questions, which lasted approximately 35 minutes. The interview guides for both the patient interviews and ONN focus group were based on the concepts within the Bi-Dimensional Framework (Fillion et al., 2012). The interview questions were developed using the Patient Continuity of Care Questionnaire (Sisler, n.d.), a standardized questionnaire that included: (1) informational continuity (i.e., how the ONNs provided timely information); (2) management continuity (i.e., how the ONNs manage patient care; and (3) relational continuity (i.e., how the ONNs maintain an ongoing relationship with patients and their families). Interview and focus group data were audio-recorded, then transcribed verbatim.

Data Analysis

Data collection and analysis were carried out in an iterative manner. The accuracy of the transcripts was verified by the PI. Themes were generated from participants' narratives through the iterative process of thematic analysis process (Graneheim & Lundman, 2004). A subset of interview transcripts was initially coded by the PI. The other two researchers also reviewed the transcripts to identify themes from the data; compared accuracy of findings and interpretation of the data, answered questions, explored and resolved (through consensus) any inconsistencies in coding between the PI and themselves. This ensured rigour and enhanced reflexivity. Segments of data, an idea or word conveying an idea, were identified before they were subsumed under a theme. A theme included configuration of segments of data. The codes were finally clustered into categories and predominant themes were identified. A coding framework was then developed by the PI to the remaining transcripts. 'Outsider' checks of the developing analysis occurred through conversations with the members of the research team to maximize credibility and trustworthiness (Toma, 2011). Together, the researchers explored several thematic maps until consensus was reached and themes were agreed upon.

FINDINGS

Eight individuals participated in this study (four adult patients with lung cancer and four oncology nurse navigators). Patient participants reported that they had lung cancer and their "right-lobes were removed". Characteristics of the participants are reported in Table 1.

Organizational Functions of Oncology Nurse Navigators

Synthesis of the findings resulted in the identification of organizational functions of the ONN role in facilitating patient continuity of care. Table 2 presents themes with selected participants' quotes. The core organizational functions of the ONN roles were determined based on patients' perceptions of how their nurse navigators impacted their experience during the diagnostic phase, ONNs' perceptions of how their roles impacted the patients and their families, and what the ONNs felt was important in providing a positive patient experience. The organizational functions of the ONN role in facilitating

continuity of care were classified under: informational, management, and relational continuity. Subsumed under informational continuity was patient-focused care. Management continuity composed of needs assessment and shared decision-making. Relational continuity consisted of accessibility and eliminating barriers.

Informational continuity

The ONNs appropriately used information such as disease process or patient-centred care for each patient. For example, nurse navigators needed access to patients' records to understand their level of functioning and the type of care given. With this acquisition of information, the ONNs were able to provide patient-focused cancer care.

Patient-focused care

Participants across both groups noted the significant role that ONNs played in terms of providing timely and personalized information to patients and their families. Timely and personalized information was described as the process of efficiently and effectively transferring information to patients and their acquired knowledge in order to ensure current and appropriate care. Patients recognized the importance of ONNs providing valuable information to them, such as describing the process, symptoms, and procedures within the diagnostic assessment program. One participant mentioned, "...she went over a few common side effects to make sure I understood them and made sure that I knew them and their meanings." The ONNs reported that having access to and understanding patients' information helped with enhancing continuum of care, such as offering the right type of health services at the right time. ONNs also said, "directing patients' care based on their symptoms or what they were telling us also eliminated unnecessary tests or duplication of tests during the diagnostic assessment period".

Management continuity

A core attribute to the ONN role involves following a consistent and coherent method to the management of cancer that was responsive to a patient's changing needs. By managing the patient's care, it allowed the ONNs to conduct needs assessment of the patients, and ensured shared decision-making between the patients and other healthcare providers.

Needs assessment

Patients recognized the significant roles of the ONN as successfully coordinating and organizing their cancer care. The majority of patients confirmed that the ONNs conducted telephone assessments prior to patient visits to the cancer centre in order to retrieve any medical or symptom-related history of the patients before the first consult with the physician. All ONN participants reported that they conducted routine needs assessment, which included medical and cultural assessments of patients in order to ensure a consistent and comprehensive approach to management of cancer. The ONNs also targeted unmet needs of the patients. They further added that by conducting a needs assessment, they determined patients' needs for information, supportive care, and medical needs, as well as their social and medical history.

Shared decision-making

The ONNs gave high importance to involving the patients in planning their care, as "it decreased the anxiety of the unknown." They recognized that the patients felt a sense of loss of power during the diagnostic assessment phase. In order to include the patients in their care planning, the ONNs reported that a shared-decision making approach was followed. Since the patients were not aware of what was happening and what will happen in the future, the ONNs "empowered them to help make a decision that's appropriate for them by involving them in the care..." Additionally, the patients claimed their ONNs shared maximum information with them about their health status and care.

Relational continuity

The ONNs took initiative to maintain a therapeutic relationship with their patients and their families to ensure continuity of care. The ONNs maintained an ongoing relationship with their patients by being accessible and accumulated knowledge about them, which led to identifying and eliminating barriers to care.

Accessibility

Along with providing coordinated care, there was consensus among ONNs that they maintained a therapeutic relationship with patients and their families. One of the participants stated there was a "professional-personal touch." Most patient participants reported that the ONNs provided a strong support system for them, which increased a feeling of confidence for them and their families. A key element to building a trusting relationship with patients was accessibility. For example, the ONNs made themselves accessible both in person and over the telephone during business hours (from Monday through Friday). Moreover, patient participants reported that the ONNs were very efficient in returning phone calls, which showed their compassion and empathy towards the patients' needs.

Eliminating barriers

The ONNs reported that a trusting relationship with patients led to identifying and eliminating barriers to care. Barriers may be something totally unrelated to the disease itself. They may be a social or a mental health issue that prevented the patient from coming to an appointment or following through with investigations that were required to make a diagnosis. Having a good rapport with the patient or family was really important for ONNs to provide that care. Furthermore, by maintaining a relationship with their patients and ensuring their needs were met, the ONNs were able to collaborate with the physicians by allowing them to make more efficient use of their time, such as developing a treatment plan.

DISCUSSION

The current study aimed to explore how the roles of ONNs impacted patients' experiences, focusing on continuity of care of adult lung cancer patients during the diagnostic phase of cancer care. Using a phenomenological approach, five core organizational functions of the ONN role in facilitating patient continuity of care were identified. They were patient-focused

care, needs assessment, shared decision-making, accessibility and eliminating barriers. In combination, these functions profiled a comprehensible and interconnected model and experience of care for patients with lung cancer, specifically related to the diagnostic phase of the disease continuum. This is the first qualitative study to add a broader understanding of the ONN roles in facilitating continuity of care within the diagnostic phase of cancer care from the perspectives of lung cancer patients and ONNs.

This study demonstrated a significant role that ONNs played in providing patients with patient-focused cancer care. Patient-focused care was described as putting patients at the centre of their care, helping them make informed decisions and using information to provide coordinated and tailored care based on their values and needs. Based on nurses' knowledge of oncology and exposure to a broad range of symptoms experienced by patients, the nursing team can synthesize patients' information in order to provide patient-focused symptom management. Additionally, the ONNs found that by having access to new information about the patient, they were able to discriminate and identify appropriate testing sequences to better focus on the diagnosis or treatment plan according to patient's needs.

Although a vast amount of health-related information was found in information technology, in this study, booklets and brochures played an important role by assisting patients in gaining knowledge during a stressful period. The ONNs explained the information within the booklets to patients, as well as medical terms mentioned by their physicians. An anecdotal statement from one patient applauded ONNs as the resource for cancer information and its interpretation, confirming the Cook et al. study (2013), which found that ONNs served as a "conduit of information" between the patient and the other healthcare providers. Findings from Cook et al.'s study reinforced the role ONNs performed in relaying and decoding information provided by the physician in "simpler terms", so that the patient gained comprehension of the process.

The findings from this study emphasized the importance of the ONNs' role in conducting a needs assessment, including medical and cultural assessment of the patient. Although medical assessment was common within any healthcare setting, cultural assessment was a distinctive concept. According to the Registered Nurses' Association of Ontario (RNAO) (2007), the basic premise of the cultural assessment was that patients had a right to their cultural beliefs, practices and values, and these factors should be comprehended, respected, and considered when providing culturally competent care. The initial phase in conducting a cultural assessment involved a comprehension of the definition of the disease with respect to the patient's unique culture (Saha, Beach, & Cooper, 2008), so the ONNs provided culturally competent cancer care during the patient-nurse navigator encounter (RNAO, 2007). Data gathered from these assessments assisted the patient and nurse navigator to develop a mutually acceptable, culturally responsive treatment plan. The ONNs retrieved cultural information from assessments, and indicated how it benefited the patients

Table 1: Characteristics of the Participants	
Characteristics of Patients	n=4; n, Range
Sex	
Male	2
Female	2
Age	58–71
Symptoms experienced	
Shortness of breath	2
Weight loss	2
Fatigue	2
Swollen joints	2
No symptoms	2
Education	
High School	3
Undergraduate/College	1
Relationship status	
Married	3
Divorced	1
Employment status	
Retired	3
Employed	1
Characteristics of Oncology Nurse Navigators	n=4; n, Range
Sex	
Male	0
Female	4
Age	39–50
Years working in oncology	4.5–20
Education	
Undergraduate/College	3
Post-graduate	1
Employment status	
Part-time	2
Full-time	2

in managing their care. Although this study provided evidence about the importance of collecting health information pertaining to the cultural diversity of patients, there was limited detail on how the ONNs conducted cultural assessments. Thus, further research is warranted to determine how ONNs addressed cultural barriers and achieved cultural competency within the cancer centre, given that there were many culturally diverse patients receiving cancer care in Canada.

Alternatively, shared decision-making was recognized as a significant area of practice for the ONNs. This study showed that when patients were diagnosed with cancer they often sensed a loss of power. To help patients be involved in their care planning, the ONNs empowered them by incorporating their input (needs, preferences, beliefs and values) into the decision-making. Although sharing decision-making was

Table 2: Themes & Representative Quotes of Participants	
Themes	Source of Representative Quotes
Patient-Focused Care	<p>Patients said:</p> <p>“She stayed in after he (doctor) left. She said we’re going to go through this again and there were a few questions, but she was more than capable of answering.”</p> <p>“She explained everything that was going to happen with the surgery. She went through the booklets and explained the type of surgery and what was going to be involved with it and answered my questions.”</p> <p>“She was providing information on a timely basis.”</p> <p>ONNs said:</p> <p>“Directing patients’ care based on their symptoms or what they were telling us.”</p> <p>“Zone in on what’s more important to that patient.”</p>
Needs Assessment	<p>ONN said:</p> <p>“Phone assessment prior to the visit, the first visit for the patient, and based on their information needs, their social history, medical history, we target their care plan.”</p>
Shared Decision-Making	<p>ONN said:</p> <p>“It’s more of a working together arrangement than us telling them what they have to do.”</p> <p>“Empower them to help make a decision that’s appropriate for them and involving them in the care also will kind of help them to follow through with the plan of care, rather than us giving the plan of care and they just have to follow it.”</p>
Accessibility	<p>Patients said:</p> <p>“She gave me her phone number. I’ve written it in this little book, and she told me to feel quite free to call her anytime if I had any questions or if something was even bothering me.”</p> <p>“She was very helpful over the phone. She explained symptoms that might occur after I had my surgery.”</p>
Eliminating Barriers	<p>ONN said:</p> <p>“I think it helps us to be a little more proactive in identifying the barriers and helping patients and families work through them. It may be something totally unrelated to the disease itself or it may be a social or a mental health issue that prevented the patient from coming to an appointment or following through with investigations that were required for a diagnosis.”</p>

shown as a key role in ensuring management continuity, there was also emphasis on the importance of sharing information with patients. It was important to note that sharing information and decisions were not synonymous, but they were separate goals within the consultations process (Elwyn, Edwards, Kinnersley, & Grol, 2000). The ONNs sharing information with their patients ensured ‘informed consent’ where the patients were aware of all the risks and benefits of a particular cancer care service and agreed to going forward with the healthcare provider’s decisions. Whereas, shared-decision making involved the patient in all the stages of the decision-making process and ensured that with the advice of the ONN, the patients made a decision on the care options they received. This study provided some evidence on the components of shared decision-making. However, additional research is warranted to determine how the ONNs involved their patients in decision-making. Shared decision-making models should be designed for ONNs in their clinical and organizational roles, to ensure effective management and continuity of care.

Another dimension of ONNs’ roles was relational continuity. ONNs were the key point of contact for patients by being available, accessible, and a source of information and support to their patients. The patients explained that their ONNs were

easily accessible via telephone in the comfort of their homes, when they needed advice on symptom management, which reduced unwanted tension and fear. These findings were supported by previous studies (Bunn, Byrne, & Kendall, 2005; Gallagher, Huddart, & Henderson, 1998). They found that a telephone triage by ONNs was effective in increasing patients’ satisfaction and decreasing patient uncertainty.

Several barriers to cancer care for patients during the diagnostic phase were identified in the literature (Artherholt & Fann, 2012; Zabalegui, Sanchez, Sanchez, & Juando, 2005; Utsa, 2012) such as barriers to information, health literacy, and mental health issues. However, results from this study showed that eliminating the barriers to information allowed the patients to gain knowledge about their diagnosis so they were better prepared for their treatment. Similarly, most of the patients reported that the ONNs took initiative to explain medical terminologies from test results, physician consultation, health websites/booklets to them and their families to increase their awareness and understanding of the disease. The ONNs reported that they were aware of the different psychological conditions patients experienced in order to direct the patients towards social support services or provided counselling in cases, where social support services were insufficient.

Limitations

Recognizing the challenges and limitations of this study provided good starting points for future research questions. Although the sample size was small, it enabled the PI to carry out in-depth interviews, particularly with the nurse navigators, which generated new findings about the role of the ONNs. This study also used two different methods of data collection: individual interviews with patient participants and focus group interviews with ONNs. Triangulating the data provided more insight into the topic and strengthened the validity of the study (Burns & Grove, 2009). However, a larger sample using two different methods of data collection (individual interviews and focus groups) for both patients and ONNs would have provided a more comprehensive analysis.

Another limitation was that only English-speaking participants were included in this study. This criterion excluded a large number of potential participants. By excluding those patients who could not speak English or had a minimum knowledge of spoken and written English limited the exploration of linguistic and cultural perspectives of patient-nurse navigator relationships. Additionally, the study did not reveal how ONNs addressed cultural and language barriers, as well as how they achieved cultural competency within the cancer centre, because there were many culturally diverse patients receiving cancer care. Although this did not detract from the interpretations of the study, it raised questions about language and cultural barriers in nursing care and research. These should be explored in future studies.

Implications

Ample guidelines and practice standards already exist for oncology nurses that provide expert direction for best practices. The domains of practice for the oncology nurse, as outlined by the Canadian Association of Nurses in Oncology

(CANO) Standards of Care, Roles in Oncology Nursing and Roles Competencies document (2006), validate the core organizational functions of the ONN role identified in the current study. These results supported and illustrated how continuity of care was enhanced in a community-based cancer centre. Acknowledgement of a comprehensive nurse navigation framework and core competencies/domains of practice by decision makers, managers and healthcare providers could lead to the development of similar roles with other diseases such as cardiovascular diseases and mental illness. The ONN framework described in this study may be used to guide the content of the nursing training modules to provide a consistent patient-centred care and systematic training reflecting the organizational functions/core areas of practice of patient continuity of care (Fillion et al., 2012).

CONCLUSION

Nurse navigation is an emerging trend in cancer care. ONNs play a significant role in assisting patients and their families with coordination of services across the continuum of care, and continued research is necessary in advancing the oncology nurses as ONNs. The current study has amalgamated the perspectives of both the patients and ONNs within the diagnostic assessment phase of cancer care. Overall, the current study demonstrated that ONNs were in a key position to enable continuity of care because their practice incorporated advanced knowledge and skills in patient-focused cancer care. Current evidence indicated that ONNs were integral in enhancing the standard of care and ensuring quality of life for individuals going through the cancer journey. Awareness of the organizational functions of the ONN role could be used to create core areas of practice within nursing training modules to provide consistent and patient-centred continuity of care.

REFERENCES

- Artherholt, S.B., & Fann, J.R. (2012). Psychosocial care in cancer. *Current Psychiatry Reports*, 14(1), 23–29.
- Bunn, F., Byrne, G., & Kendall, S. (2005). The effects of telephone consultation and triage on healthcare use and patient satisfaction: A systematic review. *Br J Gen Pract*, 55(521), 956–961.
- Burns, N., & Grove, S. (2009). *The practice of nursing research: Appraisal, synthesis, and generation of ideas* (6th ed.). St. Louis, MI: Saunders.
- Canadian Association of Nurses in Oncology. (2006). *Practice standards and competencies for the specialized oncology nurse*. Toronto, ON: CANO/ACIO.
- Cancer Care Ontario. (2010). *Patient Navigation Pilot Project*. Toronto, ON: Cancer Care Ontario.
- Cantril, C., & Haylock, P.J. (2013). Patient navigation in the oncology care setting. *Seminars in Oncology Nursing*, 29(2), 76–90. WB Saunders.
- Christensen, E.D., Harvald, T., Jendresen, M., Aggestrup, S., & Petterson, G. (1997). The impact of delayed diagnosis of lung cancer on the stage at the time of operation. *European Journal of Cardio-Thoracic Surgery*, 12(6), 880–884.
- Cook, S., Fillion, L., Fitch, M.I., Veillette, A.M., Matheson, T., Aubin, M., ... & Rainville, F. (2013). Core areas of practice and associated competencies for nurses working as professional cancer navigators. *Canadian Oncology Nursing Journal/Revue canadienne de soins infirmiers en oncologie*, 23(1), 44–52.
- Creswell, J.W., Plano Clark, V.L., Gutmann, M.L., & Hanson, W.E. (2003). Advanced mixed methods research designs. *Handbook of Mixed Methods in Social and Behavioral Research*, 209–240.
- Elwyn, G., Edwards, A., Kinnersley, P., & Grol, R. (2000). Shared decision making and the concept of equipoise: The competences of involving patients in healthcare choices. *Br J Gen Pract*, 50(460), 892–899.
- Fillion, L., Cook, S., Veillette, A.M., De Serres, M., Aubin, M., Rainville, F., ... & Doll, R. (2012). Professional navigation: A comparative study of two Canadian models. *Canadian Oncology Nursing Journal/Revue canadienne de soins infirmiers en oncologie*, 22(4), 257–266.
- Fillion, L., Cook, S., Veillette, A.M., Aubin, M., De Serres, M., Rainville, F., ... Doll, R. (2012, January). Professional navigation framework: Elaboration and validation in a Canadian context. *Oncology Nursing Forum*, 39(1), E58–E69.

- Flood, A. (2010). Understanding phenomenology. *Nurse Researcher*, 17(2), 7–15.
- Gallagher, M., Huddart, T., & Henderson, B. (1998). Telephone triage of acute illness by a practice nurse in general practice: Outcomes of care. *Br J Gen Pract*, 48(429), 1141–1145.
- Graneheim, U.H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24(2), 105–112.
- Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods*, 3(1), Article 4. Retrieved from http://www.ualberta.ca/iiqm/backissues/3_1pdf/groenewald.pdf
- Haggerty, J.L., Reid, R.J., Freeman, G.K., Starfield, B.H., Adair, C.E., & McKendry, R. (2003). Continuity of care: A multidisciplinary review. *BMJ*, 327(7425), 1219–1221.
- Haggerty, J.L., Roberge, D., Freeman, G.K., & Beaulieu, C. (2013). Experienced continuity of care when patients see multiple clinicians: A qualitative metasummary. *The Annals of Family Medicine*, 11(3), 262–271.
- McMullen, L. (2013). Oncology nurse navigators and the continuum of cancer care. *Seminars in Oncology Nursing*, 29(2), 105–117. WB Saunders.
- Pedersen, A.E., & Hack, T.F. (2011). The British Columbia Patient Navigation Model: A critical analysis. *Oncology Nursing Forum*, 38(2).
- Psooy, B.J., Schreuer, D., Borgaonkar, J., & Caines, J.S. (2004). Patient navigation: Improving timeliness in the diagnosis of breast abnormalities. *Canadian Association of Radiologists Journal*, 55(3), 145.
- Registered Nurses Association of Ontario. (2007). *Embracing cultural diversity in health care: Developing cultural competence*. Toronto, ON: Registered Nurses Association of Ontario.
- Saha, S., Beach, M.C., & Cooper, L.A. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association*, 100(11), 1275.
- Sisler, J. (n.d.). *Patient Continuity of Care Questionnaire*. Retrieved from http://uregina.ca/~hadjista/framework_tool.html
- Toma, J.D. (2011). Approaching rigor in applied qualitative research. *The SAGE handbook for research in education: Pursuing ideas as the keystone of exemplary inquiry*, 405–423.
- Trussler, T. (2002). *Uncovering the gaps: An inquiry of breast care in British Columbia*. Vancouver: Canadian Breast Cancer Foundation.
- Utsa, Y.Y. (2012). Importance of social support in cancer patients. *Asian Pacific Journal of Cancer Prevention*, 13(8), 3569–3572.
- Zabalegui, A., Sanchez, S., Sanchez, P.D., & Juando, C. (2005). Nursing and cancer support groups. *Journal of Advanced Nursing*, 51(4), 369–381.