Core areas of practice and associated competencies for nurses working as professional cancer navigators

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Abstract

Fillion et al. (2012) recently designed a conceptual framework for professional cancer navigators describing key functions of professional cancer navigation.

Purpose: Building on this framework, this study defines the core areas of practice and associated competencies for professional cancer navigators.

Methods: The methods used in this study included: literature review, mapping of navigation functions against practice standards and competencies, and validation of this mapping process with professional navigators, their managers and nursing experts and comparison of roles in similar navigation programs.

Findings: Associated competencies were linked to the three identified core areas of practice, which are: 1) providing information and education, 2) providing emotional and supportive care, and 3) facilitating coordination and continuity of care.

Conclusion: Cancer navigators are in a key position to improve patient and family empowerment and continuity of care.

Implications: This is an important step for advancing the role of oncology nurses in navigator positions and identifying areas for further research.

Key words: patient navigation, professional navigators, cancer patient navigator, pivot nurse in oncology, competency standards, empowerment, continuity of care, coordination of care, supportive care, collaborative care, specialized nurses, domains of practice, core areas of practice

Introduction

The role of patient navigator has been introduced widely as a means to improve coordination and continuity of care and enhance patient and family empowerment (Cancer Care Nova Scotia, 2004; Fillion et al., 2006, 2009; Doll et al., 2005; Melnyshyn & Wintonic, 2006). However, the role of patient navigator has lacked clarity and has been implemented broadly depending on the setting of care and resources available. Recently, Fillion et al. (2012) designed a conceptual framework for professional cancer navigation and described key functions and processes to improve continuity of care and patient and family empowerment. As a further step in building upon this framework, two well established models of professional nursing navigation, in Quebec and Nova Scotia, were studied to identify the core areas of practice and associated competencies associated with ensuring continuity of care and patient empowerment. In both programs, cancer navigation is provided by specialized oncology nurses who screen, assess, intervene and evaluate patients’ clinical and supportive care needs throughout the cancer journey in collaboration with an interdisciplinary team.

For the purposes of this study, navigation is defined as a proactive, intentional process of collaboration between a person, his or her family and the interdisciplinary care team to provide clinical interventions, education, emotional support and logistical assistance, as they negotiate the maze of treatments, services and potential barriers throughout the cancer journey (Canadian Partnership Against Cancer Corporation, 2010).
Background

The concept of patient navigation in cancer emerged from identification of the challenges patients and families face in a complex system. Most cancer care and treatments are delivered in ambulatory settings requiring that patients and their families make the daily adjustments to deal with cancer in their own homes and communities. Many will have difficulty finding their way through the system and obtaining the support to deal with the physical, social, emotional, psychological, informational, spiritual and practical challenges associated with a cancer diagnosis (Fitch, 2008). The cancer system itself is also complex and it is not uncommon for patients to be seen by many health professionals within and across multiple health services and sectors. In addition, contemporary combined modality cancer treatment involves multiple treatments over an extended period of time. These experiences place cancer patients at risk for increased psychosocial morbidity, as well as fragmented care (Bultz & Carlson, 2005).

The complexity of cancer patients needs requires health care responses that are carefully planned and coordinated to ensure the cancer system does not add to the burden and distress already experienced by individuals facing cancer. In this context, facilitating coordination and continuity of care, as well as providing emotional support and education, become significant components of person-centred care. One objective of the Canadian Partnership Against Cancer Corporation (CPACC) is to move the cancer system toward person-centred care with a coordinated process that responds to the full range of needs of all Canadians and their families, through all stages of the cancer experience. CPACC’s Cancer Journey Action Group has promoted patient navigation initiatives as an innovative approach to improve continuity of care and to provide the support needed through the cancer journey (Canadian Partnership Against Cancer Corporation, 2010).

Early developments

During the early 2000s, the implementation of oncology nurse-led clinical case management and navigator models were proposed both nationally (Farber, Deschamps, & Cameron, 2002) and internationally (Freeman, 2006; Corner, 2003), as a standard of care and a potential solution for improving access to supportive care. One of the first professional models of cancer navigation in Canada was implemented in Nova Scotia in 2001 as a client-centred, outcome-focused care management approach put in place to help patients, their families, health professionals, and health leaders deal more effectively with cancer and the cancer system. Key findings from the evaluation of this program identified that patient navigation was seen as an important source of support for patients and families in dealing with the emotional turmoil, informational needs and logistical challenges associated with a cancer diagnosis. A key finding of the evaluation was that cancer patient navigation had improved the quality and consistency of cancer care, as well as fostered collaboration and communication among health professionals, reducing duplication of services and resulting in more efficient care (Cancer Care Nova Scotia, 2004).

Concurrently, the Quebec government’s cancer control strategy supported the “infirmières pivots en oncologie” (Pivot Nurses in Oncology, 2006). Both provinces provide the navigators with orientation, ongoing education and support.

Professional cancer navigators

In Canada, professional navigation is carried out by paid health care providers, usually nurses or social workers, located in a variety of settings (Pedersen & Hack, 2010). Professional navigators work with patients and families at many points along the cancer journey, providing a single point of contact and bridging patients and families to the interdisciplinary team, the cancer centre, and community agencies. The navigation programs in Nova Scotia and Quebec employ specialized oncology nurses, registered nurses with enhanced knowledge and skills in oncology. Specialized oncology nurses complete a formal training program and hold nationally recognized oncology nursing qualifications (Canadian Association of Nurses in Oncology, 2006). Both provinces provide the navigators with orientation, ongoing education and support.

In Australia, cancer care coordinators fulfill a very similar role, working with people and their families to assess the range of needs, develop and oversee the care plan, coordinate care and services, and provide psychosocial support throughout the cancer journey. This role is also filled by registered nurses with a post graduate degree and at least five years of experience in cancer nursing (Cancer Nurses Society of Australia, 2008). Similar to the Canadian models of professional navigation, the role includes an emphasis on patient education, assessment, psychosocial support, and coordination of care in collaboration with an interdisciplinary team.

To date, in Canada, the core areas of practice for professional navigators have not been described. Determining the competency standards and educational support needed to develop and maintain the skills to practise in this field are important steps in developing the role to its full potential that will optimize patient outcomes. As Corner (2003) has pointed out, it is not the designation of a specialized oncology nurse that makes the difference, but the interventions and skills they have developed that translate into better patient outcomes.

The conceptual framework for cancer navigation

A bi-dimensional conceptual framework for cancer navigation designed by Fillion et al. (2012) describes the professional navigator’s role as facilitating continuity of care and promoting patient and family empowerment. The first dimension, facilitating continuity of care, includes three health system concepts: informational, management, and relational continuity. Continuity of care is achieved when the experience of care appears as coherent and connected for the patient, the family, and care providers. The second dimension, patient and family empowerment, also includes three key concepts: active coping, self-management and supportive care. This dimension describes interventions that would place the patient and their family at the centre of care. The framework also identifies a set of clinical functions within each of the six concepts. These descriptions enabled the authors to map the functions to various competency documents for specialized oncology nurses.

The purpose of this study was to identify the core areas of practice and associated competencies for professional cancer navigators that are considered integral to optimizing patient and family empowerment and facilitating continuity of care. These core areas of practice and competency standards are intended for cancer navigators who work within a model of care that reflects ongoing support to patients and families across the entire cancer journey.


Methods

The methods used in this study included a literature review, mapping navigation framework concepts and functions against practice standards and competencies, comparison of roles in two well documented programs in Australia and a validation process.

The study design consisted of five steps:
1. Identifying a broad set of domains of practice and competencies that would reflect the ability of a cancer navigator to improve continuity of care and patient and family empowerment
2. Mapping the concepts and functions described in Fillion et al. (2012)'s patient navigation framework to a Canadian standards of practice and competencies document for specialized oncology nurses
3. Validating the findings with Canadian professional navigators, their managers and nursing and psychosocial oncology experts
4. Refining the identified practice standards and competencies into core areas of practice
5. Comparing results with two well implemented Australian models.

A review of the literature was first conducted to identify existing domains of practice and competency standards for professional navigators. PubMed, CINAHL, EMBASE and PsycINFO databases were searched to obtain relevant studies published in English up to and including December 2009. Roles with comparable scope of practice were included (e.g., cancer patient navigators, case coordinator, specialized breast navigator/educator). This was followed by searches of reference lists of relevant articles, reviewing the authors’ library of articles on patient navigation programs and web searches for professional oncology organizations. This process identified four key documents describing competencies for health professional roles that apply to the navigation functions as described in Fillion et al.’s (2012) navigation framework (National Breast Cancer Centre, 2005; Canadian Association of Nurses in Oncology, 2006; Oncology Nursing Society, 2007; Affara, 2009).

The competencies described in these documents were then mapped to the six concepts outlined in the professional patient navigator framework by Fillion et al. (2012). The mapping process identified congruent competencies, as well as gaps where competencies would be specific to professional cancer navigators.

Because the professional navigation framework was designed in a Canadian context involving Canadian Professional Navigators (CPNs) in Nova Scotia and Pivot Nurses in Oncology (PNOs) in Quebec who both use an advance nurse model and receive a major component of their initial training through the Canadian Association of Nurses in Oncology (CANO), a second detailed mapping process was completed using the CANO’s practice standards and competencies for the specialized oncology nurse (Canadian Association of Nurses in Oncology, 2006). This was performed by a team of two experts from Quebec and two experts from Nova Scotia. As a result, for each of the six concepts and functions within the patient navigation framework, the key CANO domains of practice and competencies were identified and described.

Third, the domains of practice and competency standards identified from this mapping process were presented for review and debate during a day-long workshop. The participants included navigators (n=14) from three eastern provinces of Canada, and experts (n=3) working with navigation programs in Canada (one expert from the CPACC, one manager from Cancer Care Nova Scotia, and one Clinical Nurse Specialist). The end result was a broad set of articulated major domains of practice for professional cancer navigators used to guide the development of the core areas of practice through the next steps.

Fourth, the identified set of CANO domains of practice and competencies were then reviewed and regrouped under three core areas of practice, during the same day-long workshop. The refined definition of the core areas of practice was then associated with the CANO standards and competencies previously identified. To further validate this process, the expert (Clinical Nurse Specialist) familiar with both the navigation role and the CANO competencies reviewed the patient navigation framework and indicated which functions were addressed by the CANO competencies and standards (Canadian Association of Nurses in Oncology, 2006).

As a final step, to further validate the navigator’s core areas of practice and associated competencies, a comparison was conducted with two similar programs in Australia that incorporated navigation functions. The competencies of the specialist breast cancer nurses (National Breast Cancer Centre, 2005) and the role and scope of practice of cancer care coordinators (Cancer Nurses Society of Australia, 2008) were compared and contrasted to the Canadian patient navigation model.

Results

The review of multiple sources of evidence allowed the authors to generate a comprehensive collection of domains of practice and competency standards that would be applicable to oncology nurses working as professional cancer navigators.

The domains of practice and competency standards identified through the mapping process of the navigation framework (Fillion et al., 2012) and the Canadian Association of Nurses in Oncology Practice standards and competencies for specialized oncology nurses (Canadian Association of Nurses in Oncology, 2006) were condensed into major CANO domains of practice. While each concept within the framework may be associated with several CANO practice standards, one major CANO domain of practice was chosen for each concept. These domains of practice are based on the current practice standards for specialized oncology nurses in Canada and reflect the consensus of individuals involved in the study.

Table 1 shows how the professional navigation framework defined by Fillion et al. (2012), with its six concepts and key functions, corresponds to a domain of practice for oncology nurses, as outlined by CANO (Canadian Association of Nurses in Oncology, 2006). Associated competencies were identified in the practice standards; these competencies reflected the ability to perform the identified functions in the six concepts.

The synthesis of these findings resulted in the identification of a set of three core areas of practice for professional nurse navigators: (a) providing information and education, (b) providing emotional and supportive care, and (c) facilitating coordination of services and continuity of care within the context of an interdisciplinary team approach.

Core areas of practice

Providing information and education

One of the central areas of practice of the professional cancer navigator is the ability to provide and explain information that is being given or handed to the patient by other health care providers, in order to help the patient and his family to make

continued on page 49...
Table 1: Cancer navigation framework, CANO domains of practice and associated competencies

**Dimension 1: Facilitating continuity of care**
The patient appraises the experience of care as coherent and connected

| CONCEPTS               | KEY FUNCTIONS                                                                                                                                                                                                 | CANO Domains of practice*                                                                 | Associated competencies                                                                                                                                                                                                                                                                                                                                 |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **Informational continuity** | Use of information, disease- or person-focused, to make current care appropriate for each individual. Information is relevant to link care from one provider to another and from one health care event to another (Haggerty et al., 2003). | • Having access to, and understand, a high level of information on the patients with cancer and their care  
• Providing timely and tailored information and advice to the interdisciplinary team(s) and patients with cancer (patient-centred information)  
• Working closely with the interdisciplinary team(s) to improve continuity of the information and knowledge of family and patients' needs and changes  
• Using communication tools and strategies to increase continuity of information | Practice Domain 5 Facilitating continuity of care and navigating the system  
Providing information on the patients with cancer and their needs and changes  
Using communication tools and strategies to increase continuity of information  
Facilitating coordination and organization of care and navigating the system | To facilitate a collaborative approach by helping the patient/family and the health professionals to work as a team  
• To serve as the conduit of information between patient and health care team  
• To provide linkage between the cancer system and community resources  
• Utilize information beyond the medical conditions to include patient values, preferences, and social context  
• Share information about the changing needs of patients as they move across the cancer continuum  
• Provide information to patients and families across the cancer continuum, through transitions and changes in goals of care |
| **Management continuity** | A consistent and coherent approach to the management of cancer that is responsive to a patient’s changing needs. Providing a sense of predictability and security in future care for both patients and providers (Haggerty et al., 2003). | • Conducting comprehensive screening and needs and resources assessment (initial and ongoing)  
• Matching unmet needs with services, resources available, and support systems within the cancer care organization and the community  
• Identifying lack of resources, finding temporary solutions and reporting the system gaps  
• Mapping continuum of care, explaining treatment and care plans, minimizing uncertainty (patient orientation), and decreasing barriers to cancer care adherence  
• Referring to and communicating with hospital and community teams  
• Doing prompt liaison  
• Facilitating coordination and organization of medical and psychosocial care (using care pathways)  
• Contributing to the elaboration and application of the interdisciplinary care plan and nursing care plan  
• Contributing to interprofessional collaboration (hospital and community settings) | Practice Domain 1 Comprehensive Health Assessment  
Conducting timely and comprehensive assessments of the health and supportive care needs of the individual with cancer and their families across the cancer continuum using a systematic approach that is sensitive to language and culture | To facilitate a coordinated approach by using assessment skills to identify and address changing health and supportive care needs throughout the cancer continuum  
• Conducts a comprehensive assessment, using a systematic approach of the health and supportive care needs that include individuals’ response to cancer, individuals’ main concerns, goals and understanding of prognosis  
• The assessment considers the situational context and needs and responses of the individual and family in determining the scope and depth of the assessment |
| **Relational continuity** | A therapeutic relationship between a patient and at least one provider, who develops accumulated knowledge of the patient as a person and bridges the past to current and future care (Haggerty et al., 2003). | • Initiating and maintaining an ongoing relationship with the patient with cancer  
• Being easily accessible through the cancer continuum  
• Mapping on the cancer trajectory how the professional navigator is involved and until when  
• Being part of an oncology team  
• Being trusted by health providers and team members | Practice Domain 2 Supportive and Therapeutic Relationships  
Engaging in caring and therapeutic relationships with individual patients and their families. Relationships are supportive and sensitive to changing physical and psychosocial-spiritual responses | To establish a therapeutic relationship with patients/families by being a consistent link between the patient, the health team, the hospital, and community services throughout the cancer continuum  
• To build a therapeutic relationship through the use of communication skills and engaging in conversations that explore fears and concerns related to living with cancer disease progression, mortality, dying and sexual health issues  
• Making referrals to other health professionals as appropriate  
• Serves as a key contact for patients and families at different phases of the patient journey |

*continued on page 48...*
### Dimension 2: Patient and family empowerment

The patient perceives the care providers as supportive partners in care

| CONCEPTS                          | KEY FUNCTIONS                                                                 | CANO Domains of practice* | Associated competencies                                                                                                                                 |
|------------------------------------|-------------------------------------------------------------------------------|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| **Active coping**                  | • Assisting the patient and family to actively obtain information, support, and referral they need | Practice Domain 4          | To provide individualized information and education, based on their need, education level and situation using evidence based strategies to help patients and families cope |
| Process of taking active steps to try to remove or circumvent the stressor or to ameliorate its effects (Carver et al., 1989) | • Enhancing or reinforcing the patient’s and family’s senses of autonomy (self-care) and self-determination through education and support to maintain their sense of control and quality of life | Teaching and coaching      | • Access individuals’ readiness to learn, learning styles, preferred depth of, and role in, decision-making |
|                                    | • Enhancing recognition of the patient’s and family’s inner resources.         |                           | • Be aware of different aspects of the cancer experience and provide relevant “just in time” education as well as reinforcing education given by others |
|                                    | • Reinforcing active coping                                                  |                           | • Possess sufficient knowledge to discuss in depth aspects of treatment options and side effects, disease process, and management within various clinical and social contexts |
|                                    | • Facilitating problem solving                                               |                           | • Possess negotiation and collaboration skills to enable appropriate advocacy on behalf of patient/family |
|                                    | • Facilitating decision making                                               |                           | • Help patient mobilize their own resources and explore new ones |
|                                    | • Setting and prioritizing goals                                             |                           | • Mobilize resources and services within cancer organizations and communities to address needs |
| **Cancer self-management**         | • Assessing and monitoring symptoms                                          | Practice Domain 3          | To work with the patient and family to understand and manage the care plan and associated side-effects, symptoms and complications |
| Supporting the person and family and reinforcing his or her ability to accept the illness and regain control, regardless of prognosis (Bulsara et al., 2006) | • Providing or facilitating symptom management                               | Management of cancer       | • To understand the cancer experience and to engage in conversations comfortably about different needs, feelings, fears, concerns, losses that the individual and family may encounter throughout the cancer journey |
|                                    | • Assisting and reinforcing the patient in adjusting to and managing his or her altered health state and symptoms proactively, not reactively, through timely and tailored information and self-care instructions | symptoms and treatment     | • Prepares the patient/family to self manage problems and issues associated with treatment side effects and symptoms of standard treatments |
|                                    | • Reinforcing self-care behaviours                                          | side effects               | • Uses best practice/evidence based interventions to prevent or minimize problems/symptoms as they occur |
|                                    | • Assisting in following individualized treatment and care plans             |                           | • To anticipate problems and issues associated with treatment side effects and symptoms of standard treatments |
|                                    | • Supporting the patient and family in decision making and cancer transition (palliative care) |                           | • To understand the cancer experience and to engage in conversations comfortably about different needs, feelings, fears, concerns, losses that the individual and family may encounter throughout the cancer journey |
|                                    | • Supporting the patient and family on how to negotiate care (advocacy role)  |                           | • Prepares the patient/family to self manage and anticipate problems and issues associated with treatment side effects and symptoms of standard treatments |
|                                    | • Optimizing self-care capabilities and skills                              |                           | • Uses best practice/evidence based interventions to prevent or minimize problems/symptoms as they occur |
|                                    | • Educating, modelling and coaching to facilitate the patient’s, family’s and team members’ behavioural changes toward patient-centred care (hospital and community resources) |                           | • To anticipate problems and issues associated with treatment side effects and symptoms of standard treatments |
| **Supportive care**                | • Providing access to supportive care through screening, assessment, direct care and intervention, and referral | Practice Domain 2          | To identify multiple physical, psychological, social, sexual and spiritual needs of clients throughout the cancer continuum and provide supportive care interventions and referrals in a collaborative multidisciplinary approach to care |
| Providing the necessary services as defined by those living with or affected by cancer to meet their physical, informational, practical, emotional, psychological, social, and spiritual needs (Fitch, 2008) | • Identifying unmet supportive care needs                                   | Supportive and therapeutic relationships | • To identify, validate and prioritize potential and actual physical, psychological, social, sexual and spiritual needs through routine screening and assessment of clients |
|                                    | • Educating on distress and distress management                              |                           | • Collaborate with all members of the health care team to facilitate the provision of physical and emotional care/support to patients and families |
|                                    | • Assessing available support and reinforcing it                             |                           | • Utilize communication skills and applying knowledge of family dynamics and disease progression during interactions with patient and family |
|                                    | • Supporting patient and family to mobilize their own resources and to explore new ones |                           | • Apply knowledge of family dynamics and disease progression during interactions with patient and family |
|                                    | • Providing transitional support                                            |                           | • To anticipate problems and issues associated with treatment side effects and symptoms of standard treatments |
|                                    | • Identifying policies or structural barriers limiting access to supportive care and suggesting ways to address it |                           | • To anticipate problems and issues associated with treatment side effects and symptoms of standard treatments |
|                                    | • Assisting and facilitating the development of community and health care resources (leadership) |                           | • To anticipate problems and issues associated with treatment side effects and symptoms of standard treatments |
|                                    | • Referring (mobilizing resources and services within the cancer care organization and the community to address unmet supportive care needs) |                           | • To anticipate problems and issues associated with treatment side effects and symptoms of standard treatments |

*Note: Domains of practice from the Canadian Association of Nurses in Oncology (CANO) Practice Standards and Competencies for the Specialized Oncology Nurse*
decisions and understand the treatment plan. Translating medical information on an ongoing basis is a vital function. This area of practice incorporates competencies reflecting the ability of the cancer navigator to provide individualized information and education to help patients and families cope with the diagnosis and treatment based on individual need, educational level and situation. In order to facilitate educational discussion, the navigator must be able to integrate and apply knowledge of cancer pathophysiology, disease process and treatments, as well as the effects of treatments in certain clinical and social contexts (Table 1 [CANO Practice Domains 3 & 4]).

Providing emotional and supportive care

The ability to identify problems and issues causing distress and offering clinical interventions to help the patient manage these issues is another critical area of practice for the cancer navigator. This requires engaging in conversations and using specific tools that may explore fears and anxieties about disease progression, mortality, dying, body image or sexual health. Professional cancer navigators need a high level of skill in assessing and responding to concerns and feelings, assisting with problem solving and decision making, discussing active coping strategies, ways to relax and providing reassurance. This area of practice incorporates competencies reflecting the ability of the cancer navigator to identify multiple physical, psychological, social, sexual and spiritual needs of clients throughout the cancer journey and to provide supportive care interventions and referrals in a collaborative interdisciplinary approach (Table 1 [CANO Practice Domains 1 & 2]).

Facilitating coordination of services and continuity of care within the context of an interdisciplinary team approach

Screening, diagnosis, treatment and supportive care are all provided by different health care professionals, often located in multiple settings. Lack of coordination can lead to fragmented care. The professional navigator is uniquely positioned to support cancer patients and their families throughout the continuum and influence continuity at key points, from the time of diagnosis, and transitioning into active treatment, as well as transitioning to survivorship or palliative care. The professional cancer navigator can provide a link between the patient and the health care team and between the hospital and community services. Proactive interventions by navigators improve patient outcomes by providing early contact with resources and education. Establishing a single person to work consistently with a patient throughout their cancer journey provides relational continuity and allows for a deeper and more therapeutic relationship.

Professional navigators need to demonstrate a comprehensive understanding of the role of other colleagues; broad knowledge of all resources available for patients; initiate referrals in a timely consistent manner; share information about the patient’s clinical, practical, supportive care needs, preferences and goals; liaise and collaborate with care providers in

| Table 2: Comparing core areas/scope of practice in three well defined nurse models of navigation |
|-------------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| **Canadian Cancer Navigator**                  | **Australian Specialist Breast Nurse**        | **Australian Community Care Coordinator**     |
| Core Areas of Practice                         | Core Domains of Practice                      | Scope of Practice                              |
| Navigation is mainly provided by specialized  | The SBN is a registered nurse who applies      | Care Coordinator position involves direct      |
| oncology nurses who screen, assess, intervene | advanced knowledge of the health needs,       | patient care and incorporates critical        |
| and evaluate patient’s clinical and supportive | preferences and circumstances of women with   | functions of assessment, management and      |
| care needs throughout the cancer journey       | breast cancer to optimize the individual’s    | evaluation of clinical and supportive         |
| in the context of an interdisciplinary team    | health and well-being at various phases across| care needs throughout the cancer journey. Care |
|                                                 | the continuum of care including diagnosis,    | coordinators function within the context of a |
|                                                 | treatment, rehabilitation, follow up and      | multidisciplinary team approach               |
|                                                 | palliative care                               |                                               |
|                                                 |                                               | • Providing timely and consistent              |
| • Providing information and education          | • Information provision and education         | education and information                      |
| • Providing emotional and supportive care     | • Supportive care                             | • Providing clinical and supportive care      |
| • Facilitating coordination of services and    | • Collaborative care                          | • Collaborating with all members of the team  |
| continuity of care                             | • Coordinated care                            | to facilitate the provision of physical and    |
| • Clinical leadership                          | • Clinical leadership                         | emotional support to patients and families    |

(1. National Breast Cancer Centre, 2005; 2. Cancer Nurses Society of Australia, 2008)
different episodes of care and health care settings. The professional navigator can initiate, advocate and mobilize agency and community resources needed by patients and their family at different points in time and care settings (Table 1 [CANO Practice Domains 5 & 6]).

As a final step in the validation process, the Canadian core areas of practice identified in this study were compared to two Australian models of care that incorporate navigation functions. The three core areas of practice were coherent with competency standards in Australia. The core set of competency standards identified for the Specialist Breast Nurse (SBN) in Australia covers five areas: supportive care, collaborative care, coordinated care, information provision and education, and clinical leadership (National Breast Cancer Centre, 2005). These SBN competencies correspond closely to the CANO’s practice standards and competencies for oncology nurses (Canadian Association of Nurses in Oncology, 2006), and the concepts of patient navigation defined earlier. Additionally, the examination of the scope of practice between the Australian cancer care coordinators (Cancer Nurses Society of Australia, 2008) and the core areas of practice of the Quebec and Nova Scotia models also showed similarities (Table 2). Finally, participants involved in the management and delivery of navigation in Canada with the CPACC initiatives also agreed with the observation of the programs’ similarities. Both programs address the continuum of care and not only focus on medical needs, but also address the emotional, psychological, informational, social, spiritual, and practical needs of cancer patients within an interdisciplinary team.

Discussion

The navigator role was created to ensure that clinical and supportive care needs are assessed and addressed throughout the cancer journey, so that patients experience less distress, are able to more fully engage in the management of their care, and their cancer experience is a coordinated one. The purpose of this work was to define the core areas of practice and associated competencies for professional nurse navigators and to identify the skills and educational training that would develop the role to its full potential. In essence, the comparison of existing navigator role functions embodied within the Patient Navigation Framework against the CANO Specialized Oncology Nurse Role and two similar roles in Australia, facilitated the identification of the core navigator areas of practice. The competencies incorporated in these core areas of practice will position the patient navigator role to be a key factor in the achievement of patient-centred care, and improved continuity of care.

Evidence highlights that navigational models of care that support early, systematic, purposeful screening and assessment with periodic review of needs, facilitates early intervention and referral to appropriate levels of care, and reduces distress and fragmented care (Fitch 2008). In this context, the coordination of care and services, emotional support, and education become significant components of patient-centred care.

Wolfe (1993) and Wagner (1998) observed that the key to successful cancer treatment is an adequately prepared patient and family with access to ongoing support, education and someone to coordinate services in order to meet individual needs. Walker and Avant (2005), identified five critical attributes of a Patient Navigator as an individual who (1) facilitates access to care, (2) is a skilled communicator and listener, (3) is knowledgeable of the cancer system and resources in which he works, (4) acts as an empathic patient advocate, and (5) provides information and education.

Education

The first core area of practice, education, provided in a concise and efficient manner, tailored to patient needs (e.g.,

| Organization | Educational support | Location |
|--------------|---------------------|----------|
| Canadian Partnership Against Cancer | Navigation implementation manual | http://www.partnershipagainstcancer.ca/wp-content/uploads/2.4.0.1.4.7-Guide_Implementation_Navigation.pdf |
| | Person-Centred Care Toolkit resources | http://www.partnershipagainstcancer.ca/priorities/cancer-journey/strategic-initiatives/integrated-person-centred-cancer-care/person-centred-care-toolkit/ |
| The Canadian Association of Psychosocial Oncology | Interprofessional psychosocial oncology distant education (IPODE) programs | http://www.ipode.ca |
| Cancer View | Psychosocial Education Directory Guideline for Psychosocial Assessment of Adult Patients Symptom Management Guidelines Psychosocial Oncology Education Framework—identifies many additional opportunities to develop psychosocial skills | www.cancerview.ca |
| Alberta Health Services | Patient Navigation Curriculum - for nurses in navigational roles | http://www.albertahealthservices.ca/2301.asp |
the complexity of cancer care. How complex care is coordi-

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Emotional and supportive care

The second core area of practice is related to psychological
distress, which is a natural or expected response to a life-threat-
ening illness. Approximately 35% to 45% of cancer patients have
significant emotional distress and ongoing difficulties coping
with the illness (Zabora, BrintzenhofeSzoc, Curbow, Hooker &
Piantadosi, 2001). Professional navigators need to have com-
prehensive assessment skills to ensure early recognition of
psychosocial issues and supportive care needs, and referral to
appropriate health professionals. The use of a systematic tool
to screen for distress in patients has proven to be an effective
way in identifying cancer patients with unmet needs. The imple-
mentation of a validated distress screening tool with the patient
 navigators in Quebec and Nova Scotia demonstrated that screen-
ing for unmet needs is a relevant process to a patient naviga-
tor’s practice and an effective mechanism for identifying the
emotional and supportive care needs for cancer patients (Fillion
et al., 2011).

Facilitating coordination of
services and continuity of care

The third area of practice addresses how to better handle
the complexity of cancer care. How complex care is coordi-
nated may affect a patient’s chance of receiving the full com-
pement of care provided by multiple professionals. Two valued
mechanisms to improve continuity of care include: regularly
scheduled meetings with a patient management focus, and the
systematic use of patient centred programs such as patient
educators and patient navigators (Bickell & Young, 2001). By
providing improved coordination and continuity of care, pro-
fessional navigators are fostering a cohesive approach to the
team and continuity of care for patients (Cancer Care Nova
Scotia, 2004). Fillion et al. (2006) described the impact of PNOs
on continuity of care and improved interdisciplinary collabora-
tion in the health care setting.

Finally, the comparison of the three core areas of practice with
two similar roles in Australia provides some coherence and con-
tent validation. The independent development of the Australian
and Canadian programs to address the needs of cancer patients
resulted in very similar programs, which can be seen as a form
of convergent construct validity. The evaluation of the care coor-
dination role (Stowers & Williams, 2008) and the Cancer Patient
Navigation program in Nova Scotia (Cancer Care Nova Scotia,
2004) and in Quebec (Fillion et al., 2006; 2009) also support the
effectiveness of this approach to address the needs of patients
and families dealing with cancer.

Implications

Patient navigation is an evolving arena in Canada. The
development of the professional navigation framework, func-
tions, as well as the core areas of practice and associated
competencies has laid a foundation for consistency in role
development and implementation. Education and training pro-
grams for professional navigators are key aspects to achieving
consistency in the implementation of this role. Clearly defined
standardized education and orientation to prepare professional
navigators with core knowledge, skills and competencies is nec-
essary for the role to reach its full potential. Training programs
that develop therapeutic communication and assessment skills
are needed, as well as programs that incorporate multiple teach-
ing strategies and principles of adult learning. It is important
that the professional navigator’s role is supported through-
out the provision of professional development opportunities
and, organizational and health care team support. The cost
and efforts to design, deliver and evaluate training are signifi-
cant. Collaboration and leadership from national cancer orga-
nizations and oncology professional organizations are needed
to ensure access for professional navigators to the required
knowledge and skills, and to have continuing education oppor-
tunities available. Table 3 identifies several current education
and tools available for development of navigators and naviga-
tion programs.

Conclusion

This paper has defined three core areas of practice for profes-
sional navigators, essential for the achievement of continuity of
care and patient empowerment. Key components of continuity
of care are comprehensiveness, accessibility and patients receiving
the appropriate range of services at the right time in their can-
cer journey. Professional cancer navigators are in a key position
to enable continuity because their practice incorporates advanced
knowledge and skills in assessment, coordination of services,
provision of supportive care (including psychosocial support),
distress management, provision of information and coaching,
and clinical care. They adapt their practice to the multiple health
and supportive care needs of individuals at various points in the
continuum. Navigators facilitate effective interdisciplinary team
functioning and continuity of care between different phases of
the cancer journey, multiple care settings and care providers,
and they demonstrate leadership by providing advice and support to
other health professionals.

A cancer nursing background enhances the capacity of a can-
cer navigator to provide the physical, educational and psychoso-
cial areas of the role. Cancer nurses have the essential knowledge
regarding diagnostic investigation of cancer treatment modal-
ities, side effects, and evidence-based interventions. They work
collaboratively in relationship with medical and allied health
colleagues and they are familiar with the importance of advo-
cacy and fostering patient self-care. Cancer navigators require a
combination of specialized skills and knowledge, as they have
to respond to the unique health and support needs of people
affected by cancer as they transition through the many points
along the cancer continuum.

Optimal navigator practice is highly dependent on effective
relationships with other professionals especially physicians, other
nurses and social workers. Professional cancer navigators must
also have demonstrated competencies in team building, conflict
management, and interpersonal effectiveness to be an integral part
of, and an active participant in the interdisciplinary team and to
advocate for their patients.

Navigation is an emerging trend in cancer care. Cancer nav-
giators are playing a significant role in assisting patients and
families with coordination of services across the continuum of
care and continued research is essential in advancing the role of
oncology nurses as patient navigators. As development of sur-
vivorship programs are becoming more standard in cancer care
settings, a more coordinated approach to the patient’s follow up
care after treatment is required. Consideration should be given
to the value of the navigator role in these programs, especially as
their core areas of practice, ability to provide education, offering
psychosocial support and coordinate services, make them ideal
candidates.
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