Development of a national position statement on cancer patient navigation in Canada

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ABSTRACT

As the landscape of cancer care in Canada evolves, oncology nursing roles are developed to enhance the patient experience and address the changing needs of patients and families. Cancer Patient Navigation (CPN), an oncology nursing role focusing primarily on person-centred care coordination and system navigation, has become integral to providing high-quality cancer care in many Canadian jurisdictions. Since 2016, a national group of oncology nursing leaders have been engaged in convening and catalyzing our understanding of the role of patient navigation in the Canadian cancer context with the purpose of developing a national position statement on CPN. In this paper, we provide a historical analysis of the development of the forthcoming Canadian Association of Nurses in Oncology (CANO) position statement on CPN. We present an analysis of participant feedback from workshops at the 2016, 2017, and 2018 conferences, and meeting minutes from the National working group over this same time period. This paper serves as a concise historical summary of the evolution of CPN in Canada while providing a template for other groups looking to develop a consensus-based position statement.

The introduction of Cancer Patient Navigation (CPN) into the oncology nursing landscape over the last two decades has marked a change in how oncology nurses manage and coordinate patient care (Pedersen & Hack, 2010). Although navigation is operationalized differently across the Canadian oncology landscape, a shared purpose is to guide patients through the healthcare system. Patient navigation in cancer has been defined as, "a proactive, intentional process of collaborating with a person and his or her family to provide guidance, as they negotiate the maze of treatments, services and potential barriers throughout the cancer journey" (Canadian Partnership Against Cancer, 2010, p.5). Past research demonstrates that navigation carried out by a nurse with oncology expertise has positive outcomes for patients, families, caregivers, the interdisciplinary healthcare team, healthcare organizations and healthcare systems (Campbell, Craig, Eggert, & Bailey-Dorton, 2010; Cantril & Haylock, 2013; Case, 2011; McMullan, 2006; Pedersen, Hack, McClement, & Taylor-Brown, 2014; Seek & Hogle, 2007). For example, Campbell and colleagues (2010) found increased satisfaction with care and decreased barriers to care in an American community cancer centre setting, with similar findings demonstrated in a provincial evaluation of the implementation of oncology navigators in Alberta (Watson, Vimy, Anderson, Champ, & DeIure, 2016).

In 2016, work towards developing a national position statement about CPN was initiated. The effort was directed toward gaining a better understanding of the multiple definitions of the CPN role in Canada, as a cohesive understanding could guide practice in the *Canadian Association of Nurses in Oncology* (CANO). We wanted to convene and catalyze voices regarding CPN across Canada to build a position statement locating navigation within the practice of oncology nursing. In this paper, we describe the multi-year process of consultation across the country to create a national position statement that would guide CPN in Canada.

BACKGROUND—EVOLUTION OF NAVIGATION IN CANADA

Within cancer care, patient navigation has emerged as an important role for connecting patients with appropriate healthcare services in a timely streamlined fashion (Freund, 2011; Pratt-Chapman, Simon, Patterson, Risendal, & Patierno, 2011). The *Canadian Partnership Against Cancer* (CPAC) report on patient navigation outlines three types of navigation that may be used alone or as complementary to one another, depending on patients' needs (Canadian Partnership Against Cancer, 2010). Professional navigation, led by a nurse or social worker, is often entrenched within the hospital or institutional hierarchy and positions navigators to work with physicians and allied professionals in coordinating and managing care. Peer navigation is led by volunteers who can provide insight and guidance to others with cancer, drawing on their personal or family experience with the illness. Finally, the CPAC report outlines that virtual navigation encompasses tenets of both professional and peer navigation, facilitated by technology-enabled means.

In Canada, CPN programs were introduced nearly 20 years ago. The first CPN program was implemented in Nova Scotia in 2001 by Cancer Care Nova Scotia. In 2005, Quebec initiated their l'infirmière pivot en oncologie (IPO)/Pivot Nurse

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in Oncology (PNO) program (Ministère de la Santé et des Services sociaux (MSSS), 2005). Subsequently, many provinces implemented cancer navigation programs with variable designs across the country. These early programs have continued to grow since their first implementation, as a result of the evolution of navigation, in general, and in response to changes in patient care across the country.

The 2010 CPAC *Guide to Patient Navigation Implementation* report was an important document for cancer navigation in Canada. While the CPAC report characterized several types of navigation models, it also presented strategies for how navigation could be implemented and illustrated the potential positive impacts on healthcare systems. From that point, existing nurse navigation programs in oncology were refined and new programs were initiated in several jurisdictions across the country. Oncology nurses were seen as particularly well positioned to be navigators because they were already doing much of the system navigation work described in the CPAC definition. Oncology nurses are required to have an evidence-informed understanding of the physiological impacts of treatment and diagnosis, the psychosocial impacts of the illness, and an understanding of cancer care services across the cancer trajectory (Canadian Association of Nurses in Oncology, 2001; Ferrell, McCabe, & Levit, 2013; Ministère de la santé et des services sociaux (MSSS), 2008). These attributes, along with the competencies of oncology nursing more generally, the definition of navigation, and the shared goal of patient-centred care, position oncology nurses as well suited to the navigator role.

Seminal work in oncology nurse navigation has been conducted by Fillion and colleagues since the early 2000s. In this early work, Fillion described the navigator role as a person who assists with coordinating the complexity of medical care and treatments, identifying patient needs, and facilitating access to community resources using a holistic and person-centred approach (Doll et al., 2007; Fillion et al., 2009; Fillion et al., 2006). Subsequent qualitative research with oncology nurse navigators in Quebec described their work as encompassing interventions related to practical, informational, emotional, psychosocial, physical, and spiritual needs (Hébert & Fillion, 2011). Further work by Fillion and colleagues generated a professional navigation framework for oncology nursing in Canada (Fillion et al., 2012). The framework has two core domains, and multiple sub-domains, which are: (1) facilitating continuity of care, including informational continuity, management continuity, and relational continuity; and (2) promoting patient and family empowerment, including active coping, cancer self-management, and supportive care. In subsequent research, core competencies of professional navigation were linked to core areas of oncology nursing practice, including: (1) providing information, (2) emotional support and supportive care, and (3) facilitating coordination and continuity of care (Cook et al., 2013). This foundational work informed the background for how CPN was framed within the Canadian context leading up to 2016.

Positioning Navigation within CANO/ACIO

With the evolution and dissemination of CPN programs across the country, there were growing numbers of voices within the CANO/ACIO membership interested in understanding the CPN landscape, and where this role fits within broader oncology nursing roles. Furthermore, the majority of CPN roles were being filled by specialized oncology nurses, and the mission of CANO/ACIO is to advance oncology nursing excellence through practice, education, research and leadership for the benefit of all Canadians. Therefore, CANO/ACIO leadership felt it was important to understand the experience of specialized oncology nurses in CPN roles and examine if any further structures or supports were required from CANO/ACIO to support these roles.

Formal discussions began at the 2016 CANO/ACIO conference in Calgary where nurses from across the country participated in a workshop to discuss the Canadian situation regarding CPN. Workshop attendees articulated a clear need for a position statement to guide the development of CPN roles across the country. The results of the workshop discussion led to the creation of a national working group to draft the CANO/ACIO position statement on CPN. Subsequent workshops were held at the 2017, and 2018 CANO/ACIO conferences where the position statement was iteratively presented, refined, and finalized.

Below we present the genesis of how this cross-country initiative originated and how it has evolved over time. We incorporate an in-depth analysis of our work, which presents the evolution of how the Navigation Position Statement was developed (Figure 1).

2016: Initial Meeting at CANO Conference

In October 2016, a call was issued to CANO/ACIO members and representatives in oncology nursing across the country to join a national conversation on CPN at the annual CANO/ACIO conference. The purpose of this conversation was to discuss and understand the role of CPN across the country and the nursing role in CPN. An initial email invitation for this event was sent to 39 leaders in oncology nursing representing each province and territory. Invitees were encouraged to attend and, if unable, were encouraged to send someone on their behalf from their jurisdiction. The abstract for the event was available in the CANO/ACIO conference program, making it an event open to all members of CANO/ACIO and conference attendees. Thirty-nine individuals attended this first roundtable event.

The workshop discussion centred on the current state of oncology nurses' contributions to CPN and enhancing patient access to navigational supports across Canada (see Table 1 for a summary of the 2016 state of navigation across Canada, as reported by workshop attendees). A rich discussion occurred where nurses at the meeting emphasized how the cancer system is currently under stress related to increased patient volumes and budget constraints, and that patients are often left in need; often staff nurses do not have the necessary knowledge, time, or scope within their role to assist with the complex needs of the patients. Participants highlighted that many

Figure 1: Growing the Navigation Position Statement 2016–present (created with presentationgo.com)

provinces in Canada recognize navigation is a key component of an integrated system of cancer care and that enhancing navigation supports improves the delivery of person-centred care. However, participants emphasized that the organization and development of navigation roles and programs within provinces and across Canada is somewhat informal. That is, programs seemed to have emerged in relation to specific local needs, rather than in a coordinated and organized fashion. As an example, some provinces described CPN programs that provided care for particular types of cancer patients (e.g., breast or GI) while others emphasized their programs focused on providing care at particular points in the cancer journey (e.g., pre-diagnostic or pre-surgical); still others described their program's commitment as providing open access to navigation support across the patient's disease trajectory. Participants also highlighted that these structural differences between programs have impacted how the navigation role is enacted and the system outcomes that are achieved.

Participants stressed that although the scope and focus of navigation programs differed from region to region, and variations in the design of the navigation program impacted the outcomes that could be expected, there was a solid foundation of similarity in the CPN roles. Regardless of this similarity, further articulation and clarification of the role was needed. Generally, participants agreed that navigators enhance patient-centred care by targeting their nursing interventions on the unique context and needs of the patient.

Eight key recommendations emerged from the group discussion and are summarized in Table 2. The primary recommendation from the workshop was about the importance of positioning navigation as one dimension of the specialized oncology nurse role alongside comprehensive health assessment, therapeutic relationships, symptom management, teaching and coaching, decision making and advocacy, professional practice, and leadership (Canadian Association of Nurses in Oncology, 2001). The specialized oncology nurse was described as foregrounding and backgrounding aspects of the CPN role dimensions, depending on the relevant patient needs, with varying levels of distribution and interaction. Additional suggestions from the group included a need for more research on patient experiences and outcomes of navigation in Canada, the need for a CANO/ACIO position statement on navigation, and a strong interest in developing a CPN Special Interest Group (SIG).

2017: Workshop at CANO Conference

As recommended at the 2016 workshop, another workshop was held in 2017. During the 2017 CANO/ACIO workshop, we

Table 1: State of Navigation across the country in 2016, as reported by participants at the 2016 conference workshop	
British Columbia	No coordinated system of specific navigation roles for nurses; goal is to empower all oncology nurses to navigate, regardless of roles. Looking at models of care to position nurses in the cancer care system relative to patient needs, support to practise to full scope; rather than limit to another layer of "navigator" nursing roles. NPs attached to tumour groups; some in primary care; may bridge gaps in care; some breast nurse navigators in the past.
Alberta	3 Models (1) Generalist – from diagnosis to end of life care; any site – located in rural or isolated communities that have cancer care facilities. Provincially managed/organized; (2) One indigenous navigator located at the CCI, but funded by Indigenous health, works closely with the Community oncology navigation program referenced above; (3) Breast cancer – from suspicion to first surgical consult – three similar breast health programs in urban centres. Some ad hoc programs in other centres including breast navigators at Misericordia, ovarian navigator at the Royal Alex in Edmonton, and inpatient navigators in hematology.
Saskatchewan	Screening focused navigators for colorectal, breast, and prostate cancer. Social worker Navigators are the first point of contact for cancer agency and connect patients to resources as needed. The primary focus is on patients newly referred to the cancer centre - do not follow patient forward. Peer navigation – in development.
Manitoba	Navigators see the patient before starting treatment and support as needed. Provincial system transformation to embrace navigation teams; establish "hubs"; work with primary care. Initially roles were implemented in rural settings but are now being utilized in urban settings. In urban centres, focus is on reducing ER visits, also for patients with advanced disease who are awaiting clinic appointments; navigators can visit in person or contact by phone. Work closely with palliative care, rapid diagnostic clinic, family doctors (good network in the province).
Ontario	Many types of navigators situated in a variety of settings, populations, point in trajectory, etc. across the province (no overarching provincial structure or standards). Diagnostic assessment program (DAP) – roles across program vary; some are clerical navigators. Clerical navigation models are also being tested. Peer navigation also available. The role is primarily organizationally based; different roles and responsibilities as a result; every region/DAP is different; there is no overarching provincial model.
Quebec	Infirmière Pivot en Oncologie (IPO) with 4 functions (assessment, teaching, coordination, support). Nurses only (no lay navigators); ~250 in province, supported by provincial government. Access to IPO varies across province; each centre has criteria for who can see an IPO. More than 50% of care is delivered by telephone. Variation in models depending on size of centre – Large centre: IPOs are site specific; smaller centre: IPOs are generalists. Evaluation being done to determine impact of IPO on patient outcomes; also challenge to know when it is the optimal time to "end" the IPO relationship.
New Brunswick	Pediatric navigation services but no other coordinated navigation programs.
PEI	All nurses are navigators within the context of being an oncology nurse. There is one nurse who specifically is designated as a navigator; mental health background; located in main centre in Charlottetown but travels to Summerside 1 day a week. Main gap in patient care is the interval before connection to cancer centre. Navigator role is not well known yet at that point/evolving. After care (survivor follow up) is evolving.
Nova Scotia	Navigators are RNs: 9 navigators in adult oncology and 8 in pediatric oncology, "generalist"; community-based tend to follow the patient throughout the continuum of care; follow patient through entire experience, if patient in active treatment navigator steps back. Navigators at the cancer centre in Halifax focus on head and neck cancer, 2 for breast. Clinical Nurse Specialists take over once the patient is at the centre.
Newfoundland	The Cancer Patient Navigation team members are located throughout Newfoundland and Labrador. Cancer Patient Navigators, are culturally sensitive and highly trained registered nurses in oncology, available at point of suspicion to help patients and their families, health care providers, and community partners, ensuring they have information and knowledge to make the best decisions about their care.

Table 2: Recommendations from 2016 Roundtable

1. Centre conversations about navigation within the specialized oncology nurse role, that include navigation/care coordination as one dimension alongside comprehensive health assessment, therapeutic relationships, symptom management, teaching and coaching, decision making and advocacy, professional practice and leadership.
2. Look at navigation from the public perspective
   a. Concerned about gap between patient expectation and experience of care; navigation to close the gap?
   b. What is the public/patient perception of navigation?
3. Measure patient and system outcomes from navigation roles.
4. Acknowledge that navigator roles are not taking anything away from the specialized oncology nurse role, but rather are roles designed to have a primary focus on navigation and care coordination, where other RN roles have a more diverse focus across the role dimensions.
5. Reduce barriers to optimally placing specialized oncology nurses within the cancer care system to address patient needs. Consider the structural, contextual, and other factors shaping the fragmented cancer care system in addition to navigator roles (otherwise navigator roles are 'band-aids' for broken system).
6. CANO should have another session at the conference next year to pull apart the layers of navigation and determine CANO's role in setting the direction for oncology nurse navigation in Canada.
7. CANO should have a policy or position statement on nurse navigation.
8. Develop a Navigation SIG to further this discussion.

Table 3: 2017 CANO/ACIO Conference Workshop

Representation: 29 participants from 7 provinces

Question	Responses
What is the collective understanding about navigation?	Transitions occur at various points along the cancer journey/trajectory. The key message from patients is having that one contact – and it being a nurse – is important; having one individual who can cover all needs and be seen at each visit is important. There are some clerical folks who are excellent 'navigators' regarding appointment scheduling. Navigator roles seem to be expanding and evolving to other parts of the cancer trajectory; is success breeding success? Or is it simply 'scope creep'? DAP (Diagnostic Assessment Program) navigators are embedded within cancer clinic so takes patient through diagnosis to surgery or treatment. CPN roles are often linked to volume and higher volume has more specific roles (tumour group or trajectory specific). Community-based roles are typically broader in their scope. When nurses fill navigation roles, they may do it differently because of their knowledge of the disease, treatments, symptoms, side effects, and system awareness. Definition and boundaries of the role are dependent on how the organization defines navigation.
What added benefits come from the navigator being a registered nurse?	Provide more comprehensive service access, reduce waiting times, and provide psychosocial support. Especially important for complex cases (i.e., head and neck patients), as CPN can ensure they don't fall through cracks, and are seen in a timely manner. The primary nurse is often tied to a location, while the navigator is (often) going through the trajectory - diagnosis through survivorship - being there in transitions and between spots. Step forward during transition. Not tied to a location, so can see a patient when they are discharged from hospital. Stepping forward, stepping back, being in the background throughout the trajectory. There are differences in big versus small centres, where the role of navigator is clearer - being the one point of contact, being the link, tying all the pieces together. Described as the life-saver person - not actually tapped into as much as one might think (there is a fear that if role is open access to patients, the workload will be too big). However, patients just want to know and feel reassured that there is someone there if needed.
What competencies do navigators need?	Complexity - Nurse CPNs have both generalist and specialist knowledge. Navigation is not one thing, it is defined by how it's situated and how the scope of role is defined in each organization. Scope of focus is dependent upon the population served, tumour group, time points, and primary area of focus.

revisited questions about navigation that dominated discussion in the 2016 workshop. We explored the collective understanding of CPN across the country, the added benefits of CPN, and the competencies nurse navigators needed to enact their role (discussion summarized in Table 3). The collective understanding was that oncology nurses were ideally situated as cancer patient navigators to guide patients through the cancer trajectory. Participants articulated that CPN is not only delivered by nurses and that navigation programs in Canada are also led by social workers and volunteers. Participants also emphasized the added value that nurses can bring to the navigation role because of their comprehensive knowledge of the physical, psychosocial, and system challenges facing people with cancer. The requisite competencies for CPN identified by the participants include the capacity to manage complex and changing health states and the ability to understand and address the specific needs of the target population at key time points. Most agreed that navigation is difficult to concretely define, and how it is operationalized and defined within an organization will impact the required competencies of each navigator.

2017: Development of a National Working Group

In 2017, a national working group was formed in response to the workshop discussion and the recommendation to develop a position statement. An email to join the *National Working Group on Oncology Nurse Navigation* was sent to 85 people who either attended the conference workshop(s), expressed interest, or were on the original mailing list. This initial invitation garnered a response from 12 individuals across the country representing the following jurisdictions: Newfoundland, Ontario, Manitoba, Nova Scotia, Saskatchewan, Alberta, British Columbia, and Quebec. The working group met on four occasions via teleconference in 2018 and had numerous contact points by email. The group communication and conference calls were led and coordinated by the senior author (LW) and facilitated by CANO/ACIO staff.

During the first meeting in April 2018, callers from east to west were invited to discuss critical components of CPN, to share their definitions of navigation, and to share challenges with the actualization and implementation of navigation in their local jurisdictions. Meeting notes summarizing the robust discussion were analyzed using a thematic analytic approach and four key themes were identified (Braun & Clarke, 2008). The key themes from this meeting included: (1) meeting the demands of complex and diverse patients with variable needs; (2) a need for continuity throughout the trajectory from pre-treatment into survivorship; (3) addressing demands due to ill-defined boundaries, and tensions regarding role overlaps with other disciplines; and (4) the need for a clear definition to clarify boundaries. Table 4 contains a full accounting of themes and definitions.

This initial working group meeting formed a shared understanding amongst working group members regarding perspectives of navigation and the landscape of navigation across the country. Minutes capturing the themes were circulated to members in advance of the subsequent meeting. As we moved forward into the development of the draft position statement, these themes served as a guiding structure for the position statement.

Prior to the subsequent meeting, notes were circulated to group members, alongside a draft version of the position statement written by the senior author (LW). A list of questions to clarify the content and direction of the position statement was also circulated to working group members, with a request to comment on the position statement prior to the subsequent meeting. The following questions were posed to working group members:

1. What are the common themes/elements about navigation that run through the draft position statement?
2. What are the elements that differ about navigation in each province/program?
3. Are there elements in the position statement that are missing that would help a reader understand what cancer patient navigation is? and,
4. What is your definition of cancer patient navigation?

Responses from team members are themes in Table 5.

Based on these responses, the position statement was revised to include attention to the themes and experiences of the cross-country participants. Changes to the position statement made as a result of this meeting included: strengthening the linkage between CPN care and person-centred care; clarification that although the role of a CPN is defined by the program's focus, the competencies and skills required to enact the role are similar; and clarification that outcomes of CPN programs are directly affected by the scope of the program. After each participant had reviewed the position statement and offered feedback, we met again to review the position statement and plan for the 2018 roundtable at the national conference.

2018: Round Table at CANO/ACIO Conference

At the October 2018 conference, the progress toward developing the Navigation position statement and the work of the *National Working Group* was shared with a national audience through a roundtable at the conference in Prince Edward Island. The abstract was listed in the program, thereby providing an open invitation to all oncology nurses at the conference interested in CPN to join the session. The purpose of this roundtable was to share the work done to date in developing the current position statement and to review the position statement with participants.

Twenty-five individuals from across Canada were present and participated in the discussion. The meeting was facilitated by LW, who started by taking the group through a discussion of CPN in Canada, the current roles, and the progress of the working group. This discussion recapped many of the themes, reaffirming to our team that there was a high level of concordance between the position statement and the voices of diverse CANO members. We also observed evolution in navigation roles from across the country, with an increase in CPN roles since 2016.

The group participants were then asked to review the position statement with others seated at their table. Each table group

Table 4: Themes from initial working group meeting April 2017				
Theme	Meeting the demands of complex and diverse patients with variable needs	A need for continuity throughout the trajectory: From pre-treatment, treatment, and into survivorship	Addressing demands due to ill-defined boundaries, and tensions regarding 'turf' with other disciplines	The need for a clear definition to clarify boundaries
Definition	Patients are complex and have variable needs. This challenges the role of navigators. Navigators must be flexible and responsive to this diversity.	There is wide variance in how navigation is implemented across the country. The consensus amongst participants is that this would ideally be implemented from pre-diagnosis to survivorship.	The navigator role is maturing across the country but there are still tensions due to concerns around overlapping roles, and tensions about conflicting roles of the clinic nurse, navigator nurse, care coordinator, clinical nurse specialists, and oncologists.	The working group struggled with the absence of a collective definition of navigation and its fleeting, comprehensive, but unique essence. Collectively, members felt that a definition created through a position statement would support their role and their ability to work within some set of boundaries.
Examples	Less schedule-driven, more able to be patient-driven. Capacity to manage emerging / unpredictable vs predictable needs of patients. Not all patients need navigation, but it is important that they are aware that it's available and that they have access to it. Enacted in various ways in different jurisdictions. Job is complex, diverse and hard to specify.	Most patients use CPN up front and then lose contact with navigator after treatment is completed (follow up and survivorship issues/concerns) The commonalities between navigation roles seems mostly related to specific times across the cancer trajectory. Early referral is key: Ideally at high point of clinical suspicion. Patients referred right at diagnosis, had most clarity of navigator role and is easier for patients and others to understand. Participants questioned when patients finish active treatment, what is the role of the navigator post treatment, when do navigation supports end? These concerns are especially relevant considering the chronicity of treatment and side effects. Navigators could also specifically target the gaps in care and pick up again at transition out of treatment (survivorship, palliative, etc). Pre/post-treatment are key time points when people need CPN. The 'in between' is more grey: Referring patients into centre, who do they talk to when in "in between" of diagnosed but not appointment?	Struggling with navigation practice- other healthcare professionals just bring patients to navigator. A more formal referral system with parameters around when/ whom to refer to navigators is needed. Emerging work in patient self-management, pushing care to home and transitions- how does that link to navigation role? Overlap with other disciplines. Need to articulate that there is a uniqueness that comes from nurse navigation. Each type of oncology nursing role uses certain CANO standards more often than others, but all oncology nursing roles require all standards as a foundation. Other clinic nurses feel protective of their work and their patients and fear that the navigator will take away elements of their role that are meaningful. Navigation has made big strides, but is a moving target. There is a lot of messaging that is top down.	Navigation is difficult to define: What do we really mean by navigation? Need more clarity around role-language: Defining the boundaries is complex. Staff/colleagues have general idea of navigator role but don't understand the full scope of the role How the role is contextualized is dependent on how program is structured (time points vs across journey). Need to clearly define what is meant by navigation and trajectory so everyone is clear around the definitions and assumptions are not made. Majority of competencies within and outside of navigation are the same. How an organization conceptualizes navigation impacts boundaries of role. Defining navigation is the most important thing and we need to clearly spell that out at the very beginning of the document. Clearly define what is meant by "navigation" and "trajectory"

Table 5: Responses from May 2017 Navigation working group meeting: Perspectives on the current draft of position statement			
What are the common themes/elements about navigation that run through the document?	**What are the elements that differ about navigation in each province/program. What resonates for you?**	**From your experience are there elements that are missing that would help a reader understand CPN?**	**What is your definition of cancer patient navigation?**
The goal of navigation is the patient's "experience" versus clinic where the goal is effective and organized clinical treatment. Language to support common understanding: what is meant by navigation, transitions and trajectory- different definitions depending on the practice context/location. How does having a nurse in the CPN role influence the patient experience and program "outputs" (what are the expected benefits)? Referral to navigation as early as possible (close to time of diagnosis and/or clinical suspicion) has benefits for patients (better clarity of navigator role, connections to supports, and understanding of their care pathway). Challenges with other providers (nursing and supportive care) as roles overlap and providers are protective of their work and their patients. Where do navigation supports begin and end (survivorship and chronicity of treatment)? Common theme is that nurse CPN is unique, complex, and diverse with a broad scope of care. All models of navigation across the provinces aim to be person-centred. Elements of a person-centred experience include: Care that is personalized, coordinated, enabling, and the person is treated with dignity, compassion and respect. Patients who have a person-centred care experience describe it as: (1) care was tailored to who I am and my priorities; (2) care was coordinated across time and met my changing needs; (3) care enabled self-management when possible and support for help when required; and (4) I was treated with dignity, respect and compassion. As defined by the Health Foundation, 2016 https://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf	Time points on care pathway where navigators are involved, some provinces are intervening very early- at time of clinical suspicion to post diagnosis/ pre-consult. When to refer patients on their care pathway- most provinces agree early referral is key but less clarity about CPN role once they begin treatment or when treatment ends(survivorship, palliative)/becomes chronic Who takes on the navigator role? Most provinces it is the RN but some use social worker, or community liaison. Models of navigation are heavily influenced by organizations' conceptualization of the role and the context in which a navigator works (Generalist vs population/tumour group specific, community vs acute care past, case management vs patient driven, time point specific vs continuous) One jurisdiction has a particular focus on CPN reducing wait times from point of clinical suspicion of cancer to start of treatment. Navigators should be the consistent link between the patient, the Primary Care Provider and the 'health system'. Navigators facilitate communication between family physicians, surgeons, and other community-based specialists and oncologist.	How CPN "looks" in a particular jurisdiction is heavily influenced by what needs/gaps an organization chooses to centre the CPN role around. The context in which a CPN practises, influences how their work looks and the objectives they are trying to meet. Challenges across the country are very similar (role clarity, integration within a team). Many similarities with APN roles and how they integrate within a team. Often organizations do not take the time to have a well thought out approach about how to integrate a CPN into the team and what gaps/needs the role will address and how this will be organized. Role development takes a significant amount of time- perhaps frameworks like the PEPPA framework (Participatory Evidence-based Patient-focused Process for Advanced Nursing Practice) would support other jurisdictions who are interested in a navigator role, in understanding how it will integrate within an existing time for better role clarity up front.	I personally like the CPAC definition of navigation. It feels general enough to apply to multiple models of navigation but also captures the value navigation brings. Designated person within the care team with capacity to focus on the navigation needs of the patient and their family. Which could also include supporting other systems and providers in caring for the patient. CPN programs primarily focus on meeting the needs of the patient through optimized system process rather than meeting the systems' needs first, with the patients' needs being secondary.

was given a position statement and LW facilitated a discussion about the strengths and gaps in the document. Key points of emphasis included clarifying that CPN is a specialized oncology nursing role and keeping the language flexible, as the role of the cancer patient navigator varies with each position, despite the core competencies being clearly emphasized. Participants identified there was no mention of how patients transition in and out of the care of a navigator and encouraged the working group to address this gap. There was agreement amongst the group that by addressing these gaps, the statement would be ready for escalation to the CANO/ACIO Professional Practice Committee for approval and endorsement. Ultimately, it could be an important tool to guide CPN practice.

DISCUSSION

The CANO position statement on navigation required a multi-year development process through engagement and collaboration with national stakeholders. The CANO/ACIO conference provided a national platform to engage key navigation leaders and providers in discussion and gain an understanding of the current state of navigation and navigator roles in Canada. Following the initial conversation, there was a natural evolution to further the collective understanding of the CPN role in Canada and CANO's role in providing direction and support for the value of CPN roles to be enacted by specialized oncology nurses.

Through this multi-year process, the role of patient navigators across the country has become more visible. However, there are still tensions regarding the differences between care coordination and navigation. We trust that through our work, we have clarified that the role of CPN goes beyond the logistical aspects of care coordination and encompass patient complexity and holistic patient-centred care. There are also concerns that advocating for nurse navigators in CPN roles may be applying a 'band-aid' to broken and unsustainable system design, rather than seeking solutions to address what ails the system (Thorne & Truant, 2010). As the role of navigators has evolved in Canada over the last two decades, the advancement of this role has surpassed issues of system access, and grown into an important aspect of holistic, patient-centred nursing care in oncology.

The virtual working group that developed out of the 2016 and 2017 CANO workshops, provided a platform from which to build a national position statement. This virtual structure allowed for the work to progress at a more rapid pace and for continued national engagement. Through facilitation by the working group leads, members were given specific tasks and work to complete prior to meeting virtually. This supported effective and efficient conversations and provided the group with a clear direction and purpose. A final in-person meeting and facilitated discussion by the working group lead supported application of a national lens and setting the direction for next steps. These included a presentation to the CANO/ACIO Professional Practice Committee for review and approval.

A virtual working group was a key structural component that supported development of the position statement. CANO/ACIO facilitated this structure by providing a virtual meeting platform for the working group to use. Structured facilitation from the working group leader maintained the group focus and guided analysis of comments and feedback on the content and structure of the position statement. While this format supported the development of a position statement, it required a multi-year process. Engagement with multiple national stakeholders virtually can be challenging to manage because of schedules, timing and ability to use and manage virtual meeting platforms.

As a next step, a Special Interest Group for Navigation has been formed and led a workshop at the 2019 conference. This workshop focused on the development and updating of education modules to further develop and enhance the skills and competencies required for CPN roles. This work will be informed by the working group's position statement.

CONCLUSIONS

Since the work of this group started in 2016, the landscape of oncology nurse navigation has evolved across Canada. The role of oncology nurses as CPNs has crystallized in jurisdictions where it was previously absent, and the role continues to fill a critical gap for patients across the cancer trajectory. There is still work required to explore the perceptions of those who have experienced the care of CPN. In the context of this multi-year cross-country work, we are interested in supporting the various models of CPN across the country and understanding their impacts on patient-reported outcomes and experiences.

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