

Table A. Winnipeg Workshop (Dec 7/07): Barriers and Solutions to Implementing a Navigation Program

BARRIERS – GROUP 1	SOLUTIONS
<ul style="list-style-type: none"> ▪ Change and resistance to change ▪ Multiple levels of government ▪ Defining roles ▪ Navigator needs authority to implement change 	<ul style="list-style-type: none"> ▪ Education with resources for the centre ▪ Communicate “clear mandate – everyone buys in” ▪ Clear definition of role • Leadership
BARRIERS – GROUP 2	SOLUTIONS
<ul style="list-style-type: none"> ▪ Resistance from other health professionals to this new role. ▪ Funding 	<ul style="list-style-type: none"> ▪ Careful discussion of the new role and how it will benefit others. We can learn from the midwife – labour nurse or NP–FP challenges as these new roles were introduced. ▪ Start with “high risk groups” where the “financial” benefit may be easier to demonstrate. Possible high risk group: <ul style="list-style-type: none"> – Head & Neck cancer – Aboriginal – Young people – Low income/literacy – Remote geography ▪ ReBalance Focus AG can help by sharing info that would help provinces make the case dollar-wise
BARRIERS – GROUP 3	SOLUTIONS
<p><u>Patient</u></p> <ul style="list-style-type: none"> ▪ No prior knowledge ▪ No support from the beginning ▪ No designated referral ▪ No awareness of silo activities ▪ No clear standards of care ▪ Recognizing the need for navigation <p><u>To start Navigation</u></p> <ul style="list-style-type: none"> ▪ Getting staff ▪ Money to pay Navigator 	<p>Information package handed to patient during first contact with health professionals.</p> <ul style="list-style-type: none"> ▪ Communication to stakeholder ▪ Acknowledgement ▪ Implemented successful navigator systems and use this info as the base for a new “standard of care” communication strategy
BARRIERS – GROUP 4	SOLUTIONS
<ul style="list-style-type: none"> ▪ Recognizing the need for a navigation system 	<ul style="list-style-type: none"> ▪ Communication of results of success/cost and time effectiveness to all stakeholders.
BARRIERS – GROUP 5	SOLUTIONS
<ul style="list-style-type: none"> ▪ What model – who offers ▪ Sense of community in urban areas not as strong as rural areas ▪ In rural area may not be a cancer expert to consult with 	<ul style="list-style-type: none"> ▪ Ensure network for Navigators ▪ Share best practice model with us (emphasis for new immigrants/Aboriginals and various cultural groups) ▪ Central one-stop shopping for resources available, web-site for downloading materials

BARRIERS – GROUP 5 (Cont'd.)	SOLUTIONS
<ul style="list-style-type: none"> ▪ May not be any other survivors in area ▪ Rural – isolated community <ul style="list-style-type: none"> ○ Lack of human resources ○ Transportation ○ Accommodation ○ Limited finances ▪ Job description is huge for navigator ▪ Lack of trust in Western Medicine ▪ English is not first language ▪ Isolated rural community <ul style="list-style-type: none"> ○ No cancer care near ○ Transportation ○ Financial ▪ Cultural issues <ul style="list-style-type: none"> ○ No eye contact ○ Spiritual aspect ▪ Financial implications (no permanent funding) 	<ul style="list-style-type: none"> ▪ Proactive contact for newly diagnosed ▪ Standards for cancer care across Canada ▪ Communication with doctors – RHAs, nursing staff to share information, resources ▪ Telehealth available to rural areas ▪ Navigator can facilitate communication with family and involvement and transportation ▪ Navigator can facilitate interpreter for language – help with patient understanding diagnosis and treatment ▪ Navigator does initial assessment ▪ Navigator facilitates incorporation of traditional cultural medicine for Roland and hospital staff ▪ Education on what a patient educator is for province
BARRIERS – GROUP 6	SOLUTIONS
<ul style="list-style-type: none"> ▪ Lack of communication ▪ Team accepting navigator role ▪ Education/involving team ▪ Lack of respect – respecting credibility ▪ Power/control/egos ▪ Management ▪ Job satisfaction ▪ Staff shortages ▪ Workload ▪ Boundaries – who does what? ▪ Shared team vision ▪ Evidence based practice models ▪ Research audit/comparative proof for funding 	<ul style="list-style-type: none"> ▪ Quality indicators ▪ Resources to hold community information meetings ▪ Providing ongoing evidence-based programs ▪ Updates on each region
BARRIERS – GROUP 7	SOLUTIONS
<ul style="list-style-type: none"> ▪ Team acceptance – feel threatened ▪ Lack respect ▪ Power/control/egos ▪ Management ▪ Financial ▪ Job satisfaction ▪ Staff shortages ▪ Workload ▪ Boundaries ▪ Evidence-based (lack of) practice/ model 	<ul style="list-style-type: none"> ▪ Credibility of navigator/team ▪ Education ▪ Team involvement ▪ Shared vision ▪ Audit/indicators/comparatives ▪ Research

BARRIERS – GROUP 8	SOLUTIONS
<ul style="list-style-type: none"> ▪ ↓ \$ to hire adequate staff to deliver adequate navigation ▪ Geography ▪ Lack of medical care ▪ Multidisciplinary still working in silos ▪ Care is “disease-focused 	<ul style="list-style-type: none"> ▪ ↑ \$ ▪ ↑ teamwork/communication (cancer care team PLUS general medical system) ▪ Move to TRUE “patient-centered” care
BARRIERS – GROUP 9	SOLUTIONS
<ul style="list-style-type: none"> ▪ Lack of awareness of continuity supports, lack of human resources to continue supports especially in smaller communities, communication ▪ Establishing good relationships with many partners to ensure good data collection and awareness of interrelated services i. e. diagnostic services, cancer centre, medical/hospital centres ▪ Getting initial “buy in” from government (federal, provincial), the regional administration, local admin, physicians, nurses, allied health, public 	<ul style="list-style-type: none"> ▪ Navigator could be a conduit for communication ▪ Various tools for communication i.e. newsletter ▪ Have MB Health take lead and set minimum mandatory data sets, navigators to work out of a variety of settings so they can be a neutral person, but a conduit ▪ National focus groups, conferences to develop general national consensus, outline/determine standard/baseline outcome measurements (national)
BARRIERS – GROUP 10	SOLUTIONS
<ul style="list-style-type: none"> ▪ Who should be navigators – nurses, social workers – yields barrier to making this happen right away ▪ Agree to model i.e. nurses, social worker ▪ Transportation/distance ▪ Jurisdictional issues (federal/ provincial) ▪ Where to place navigators (rural/ urban) ▪ Funding support to reallocate funding ▪ Roles of navigator ▪ Support from management ▪ Distorted communication b/w programs, services rural/urban 	<ul style="list-style-type: none"> ▪ Talking ▪ Diverse community ▪ Creative solutions ▪ Funding, resources ▪ Flexibility ▪ Community assessment ▪ More \$ ▪ Reallocate \$/redesign the process ▪ Matching model/role to needs you are trying to address ▪ Education about model & role ▪ Team building

Table B. Fredericton Workshop (Jan. 18/08): Barriers and Solutions to Implementing a Navigation Program

BARRIERS – GROUP 1	SOLUTIONS
<ul style="list-style-type: none"> ▪ Lack of support from administration (management) ▪ Misunderstanding of role and what it can include ▪ Learning curve for navigator ▪ Time investment up front before starting role ▪ Tracking of patient satisfaction and outcomes (how they relate) ▪ Diversity within population (language, beliefs, culture, religion) ▪ Trying to be everything to everyone ▪ Needs to be “patient centered” focus ▪ Resource availability (right person, right job, right time) ▪ Isolation in small communities “need central 	<ul style="list-style-type: none"> ▪ Case presentations/data collection & base ▪ Track outcomes ▪ Seek funding ▪ Education to stakeholders ▪ Patient champion ▪ Develop orientation program/CE ▪ Needs assessment ▪ IT system ▪ Network with community ▪ Provincial coordination
BARRIERS – GROUP 2	SOLUTIONS
<ul style="list-style-type: none"> ▪ Marketing ▪ Finance ▪ Turf protection ▪ Space ▪ Lack of human resources/staff ▪ Lack of time ▪ Communication ▪ Resistance to change ▪ Geographic location 	<ul style="list-style-type: none"> ▪ Forming groups to rally in support of navigation program ▪ Education and awareness ▪ Opportunistic ▪ Communication/informing ▪ Include and value people responsible in the solution ▪ “Just do it!”
BARRIERS – GROUP 3	SOLUTIONS
<ul style="list-style-type: none"> ▪ Nurses’ MD’s resistance ▪ Acceptance • Silos • MDs crowd out discussion with tumor boards 	<ul style="list-style-type: none"> ▪ Educate about role – benefits to patient, costs, timesaving ▪ Interprofessional participation in selecting navigators ▪ Formalize role, get introduced to team; have a project manager ▪ Participatory planning with all stakeholders ▪ Nurse leadership educate MDs about role of RN ▪ Physician champions ▪ Develop alliances ▪

BARRIERS – GROUP 3 (Cont'd.)	SOLUTIONS
<ul style="list-style-type: none"> ▪ Nurses overburdened to take on new roles (nursing shortage) ▪ Resentment among other nurses ▪ Lack of oncology expertise ▪ Getting territorial ▪ Record keeping ▪ Difficulty with RN retention 	<ul style="list-style-type: none"> ▪ More \$, time, education, train more RNs ▪ Mentorship, experience ▪ Work as teams e.g., with social workers ▪ Share responsibility ▪ Electronic!! Shared charting ▪ Work within scope of practice
BARRIERS – GROUP 4	SOLUTIONS
<ul style="list-style-type: none"> ▪ Funding ▪ Human Resources/Organization goal ▪ Who fills the role? ▪ Geographic distance/urban vs rural ▪ Acceptance of the role by family doctors 	<ul style="list-style-type: none"> ▪ Identify the need for navigator role and present to appropriate stakeholders ▪ Pro-active – not reactive ▪ Partnering with non-profit disease site organization ▪ Efficient use of resources ▪ Dialogue about the role ▪ Nurses, other HCPs (SW etc.) ▪ Define the role and the characteristics essential for the role ▪ Telephone consultation ▪ Collaborating with community nurse ▪ Virtual clinics ▪ Education about the role ▪ Ongoing feedback

Table C. Edmonton Workshop (Feb 12/08): Barriers and Solutions to Implementing a Navigation Program

BARRIERS – GROUP 1	SOLUTIONS
<ul style="list-style-type: none"> ▪ Lack of definition of patient navigation role ▪ Current training models that exist may not: <ul style="list-style-type: none"> ○ Readily communicated & available ○ Support a hospital-based navigator ▪ Political culture of hospitals and relationships with cancer centres/other stakeholders ▪ Hospitals not connected pre and post cancer centre treatments ▪ Inter-provincial coordination of cancer care ▪ Health care team not communicating well ▪ Sustained funding to support initiatives, successful pilot projects ▪ Not enough trained navigators (especially disease specific) 	<ul style="list-style-type: none"> ▪ ReBalance Focus Action Group to define patient navigation and identify existing models ▪ Evaluation of existing patient navigation models <ul style="list-style-type: none"> ○ Mega analysis ○ Making recommendations ▪ Canadian-based navigation training and certification program ▪ Clarification of cancer navigation models and how they could link, build on successes of current models ▪ Define how collaboration without <ul style="list-style-type: none"> ○ Tools needed for successful collaboration ○ How to “manage up” and diffuse political barriers ▪ Provincial committees ID common areas for collaboration
BARRIERS – GROUP 2	SOLUTIONS
<ul style="list-style-type: none"> ▪ Current role of nurses ▪ Financial barriers ▪ Size of caseloads ▪ Prioritizing ▪ Role definition (lack of role clarity) ▪ Geography in some areas ▪ Support for whole team ▪ Limited/unclear connections with other organizations ▪ Who are the players/stakeholders? 	<ul style="list-style-type: none"> ▪ Financial plan ▪ Government funding ▪ Pursue private funding ▪ Tool kit – navigation training program ▪ Standard of Practice ▪ Team building /coping ▪ Create databases; other linked info with other groups ▪ Solve system issue

BARRIERS – GROUP 2 (Cont'd.)	SOLUTIONS
<ul style="list-style-type: none"> ▪ Moving teams toward patient focus ▪ Space (offices, privacy) ▪ Lack of technology 	<ul style="list-style-type: none"> ▪ Team building/coping ▪ Patient centered care ▪ Identify potential leaders ▪ Technology • Close the loop to problems
BARRIERS – GROUP 3	SOLUTIONS
<ul style="list-style-type: none"> ▪ Language/culture ▪ Resources ▪ Fragmentation/people working in isolation 	<ul style="list-style-type: none"> ▪ 1-800-interpreter (existing paid service) ▪ Advocating ▪ Demonstrate need & benefits ▪ Using least costly resources i.e. volunteers ▪ Interdisciplinary advisory committee ▪ Collaboration (with Home Care) with Palliative Care)
BARRIERS – GROUP 4	SOLUTIONS
<ul style="list-style-type: none"> ▪ Funding – finding sufficient ▪ Organizational cultural ▪ Human Resources – finding enough (communities lacking GPs/specialists) ▪ Lack of space ▪ Legal/jurisdictions e.g., FOIP etc. ▪ Resistance to change • Knowledge/Definition of Navigation (by patients, health care professionals) 	<ul style="list-style-type: none"> ▪ Find funders e.g., individuals, companies, cultural organizations, fund raising volunteer ▪ Need buy-in of the leaders ▪ Convince agencies/institution to see need ▪ Provide education, presentations ▪ Present benefits ▪ Find a champion ▪ Recruit trained professionals and volunteers of diverse cultures ▪ Enable people to work in variety of settings e.g., laptop, cell phone ▪ Works within the limits of the relevant legislation ▪ Increase awareness of program ▪ Develop partnership agreements and protocol agreement ▪ Generational diversity • Increase awareness and understanding of professionals; knowledge of roles

BARRIERS – GROUP 5	SOLUTIONS
<ul style="list-style-type: none"> ▪ Lack of trust in the medical system ▪ Language ▪ Transportation ▪ Belief system ▪ Financial and human resources ▪ Respect for elders and impact on decision making ▪ Environment space issues ▪ Knowledge transfer about aboriginal culture 	<ul style="list-style-type: none"> ▪ Identify and engage decision makers ▪ Spokesperson for family ▪ Build a trusting relation with Roland and his family/support system ▪ Ensure profession language is clear ▪ Navigator to identify his understanding of this experience ▪ Paid translations ▪ Ensure resources are available ▪ Identify who are the decision makers ▪ Mobilize resources in own community ▪ Peer within same community to help grandmother understand ▪ Provide education for staff ▪ Contact health/band nurse
BARRIERS – GROUP 6	
<ul style="list-style-type: none"> ▪ Funding ▪ Human Resources ▪ Invisibility of role ▪ Lack of evidence with efficacy or need of role ▪ Unclear role 	<ul style="list-style-type: none"> ▪ Lobbying (government action) ▪ Fundraising ▪ ↑ awareness ▪ Undergrad programs for oncology recruitment ▪ Understanding skill set required ▪ Clarifying model ▪ Flexibility to needs of community ▪ Standardized screening tool/pretest/post test) ▪ Evidence from other navigation sit ▪ Listen to the patient needs ▪ Developing mandate based on evidence ▪ Be reflective ▪ Identifying needs (in all settings)
BARRIERS – GROUP 7	SOLUTIONS
<ul style="list-style-type: none"> ▪ Money (funding) ▪ Human resources expertise ▪ Buy-in from administrator, physician, patients, other providers ▪ Coordination → pt focus (lack of holistic approach) ▪ Sharing information ▪ Technology ▪ Regional boundaries 	<ul style="list-style-type: none"> ▪ Partnerships ▪ Partnerships ▪ Communication plan ▪ Early involvement ▪ Change management plan ▪ Project sponsors ▪ Evidence based ▪ Multidisciplinary team meetings ▪ IT support/tracking system

BARRIERS – GROUP 7 (Cont’d.)	
<ul style="list-style-type: none"> ▪ Public/private partnerships ▪ Scope ▪ Time ▪ Space ▪ Increasing demand ▪ Capacity – surgeon/diagnostics 	<ul style="list-style-type: none"> ▪ Provincial/federal ▪ Sharing of information ▪ Yearly workshops ▪ Joint projects ▪ Defined scope ▪ Standard of practice ▪ Partnerships ▪ Triage/workload measure ▪ Right person/right job/right time/right test
BARRIERS – GROUP 8	SOLUTIONS
<ul style="list-style-type: none"> ▪ Politics ▪ Lack of practicalities ▪ Lack of funding ▪ Lack of human resources ▪ Lack of leadership (champions) ▪ Geography ▪ Resistance to change 	<ul style="list-style-type: none"> ▪ Public relations ▪ Conferences ▪ Lobbying ▪ Community partners ▪ Mobilizing voters ▪ Incentives ▪ Partner programs ▪ Technology ▪ Access community resources ▪ Public relations strategy (ongoing)
BARRIERS – GROUP 9	SOLUTIONS
<ul style="list-style-type: none"> ▪ Funding (financial, human resources) ▪ JOB SATISFACTION ▪ “buy-in” (physicians, other staff) ▪ Workload ▪ Role clarification ▪ Not knowing available resources ▪ Geography ▪ Model disagreement 	<ul style="list-style-type: none"> ▪ Funding in place, positions filled ▪ Data collection ▪ Portfolio manageable ▪ Education/communication ▪ Leadership ▪ Successes/wins ▪ Data collection ▪ Policy & procedures ▪ Education/orientation ▪ Forms ▪ Define parameters ▪ Community/hospital links ▪ Inventory of resources ▪ Technology ▪ Education needs assessment
BARRIERS – GROUP 10	SOLUTIONS
<ul style="list-style-type: none"> ▪ Buy-in from local doctors, hospital facility, nurses, SW ▪ Minimal resources available 	<ul style="list-style-type: none"> ▪ Communication ▪ Planning ▪ Quick win

<ul style="list-style-type: none"> ▪ Define a navigator! ▪ Access ▪ Communication between roles of navigators ▪ Differences within province itself ▪ Convince others of focus ▪ Focus on system – not patient ▪ Cultural values ▪ Demands placed on navigator ▪ Support for navigator ▪ Expectations 	<ul style="list-style-type: none"> ▪ Specific areas in trajectory to target
BARRIERS – GROUP 11	SOLUTIONS
<ul style="list-style-type: none"> ▪ Buy-in from local physicians, hospital/community ▪ People/positions will feel threatened ▪ Confusion – define navigator ▪ Communication between/among navigators and other staff involved in care ▪ Minimal resources available ▪ Prioritize patients ▪ How to include patients who may not be diagnosed within the system ▪ Differences within & between provinces ▪ Access to services ▪ Maintaining a “person-centered” approach – an integral part of the role ▪ Expectations and demands on navigator/ emotional resources ▪ System change – from system/professional as expert instead of person with cancer as expert ▪ Mindset – to keep cultural context of person with cancer in mind 	<ul style="list-style-type: none"> ▪ Communication/marketing upfront planning ▪ Look for small projects/services you can tap into/improve to get that “quick win” – shows value added ▪ Start small ▪ Gentle consultation with communities/ reassurances ▪ Ongoing ▪ Systemic approach ▪ Target areas of continuum/transition to introduce navigator role – strategic placement of navigator ▪ Adequate support ▪ Resource allocation/support ▪ Share knowledge/successes/challenges
BARRIERS – GROUP 12	SOLUTIONS
<ul style="list-style-type: none"> ▪ GP not working with navigator or not available ▪ Committed resources to programs ▪ Referral too late/delay ▪ Communication between health care providers ▪ Compliance issues ▪ Patient’s health – may be too sick 	<ul style="list-style-type: none"> ▪ Getting buy-in from primary care networks ▪ Advocacy ▪ GP – good marketing, gain trust, ↑ referrals – make the want to refer ▪ Involve key influences ▪ ↑ communication with <u>all</u> involved ▪ Challenge care plan ▪ Put a plan in place – takes time ▪ Sharing of information – continuity of care

BARRIERS – GROUP 13	SOLUTIONS
<ul style="list-style-type: none"> ▪ Fragmentation of care b/w regional health & care agency ▪ Non-disciplinary team ▪ Money & political will ▪ Territoriality – whole team ▪ Change management ▪ Lack of professionalism ▪ Lack of communication * 	<ul style="list-style-type: none"> ▪ Leadership – someone with passion ▪ Use of Breast Model ▪ Senior leaders working in conjunction with regions ▪ Buy-in with community – improve communication relationships ▪ Lobby → be more vocal ▪ *Communication/Education re: role ▪ Marketing ▪ Need to hire the professional to assist
BARRIERS – GROUP 14	SOLUTIONS
<ul style="list-style-type: none"> ▪ Need to build trust – teams/patients/families ▪ Human resources – specialized knowledge/skill ▪ Funding ▪ “squeaky elevator” ▪ Care delivery models/settings that match needs ▪ Community resources (housing) ▪ “buy-in” from potential/actual team members – “show me!!” (ownership/pride in roles with patients/families) ▪ Existence of high-functioning care teams 	<ul style="list-style-type: none"> ▪ Communicate clear messages re role, integration, services, expectations, * multiple ways ▪ Ongoing education re above ▪ Advocate for professional CE ▪ <u>Data</u> re needs (in the language of the stakeholder group) ▪ Use info re outcomes ▪ Network – share resources! (no re-invention of wheels) ▪ Develop database of resources (people/skills) ▪ Build capacity (knowledge, skills, resources) in cancer care ▪ Triage services ▪ Screening & assessment tools & processes ▪ Clear standards of care, practice ▪ Identification of “high risk” groups/individuals – proactive ▪ Networking – partnerships ▪ Presence in the community – <u>consistently visible</u> in <u>key</u> areas (communication/education)

BARRIERS – GROUP 15	SOLUTIONS
<ul style="list-style-type: none"> ▪ Addressing needs ▪ Lack of resources ▪ Work in “silos” ▪ Communication ▪ Resistance to change ▪ Apathy ▪ Lack of empathy ▪ Time pressures in a health care system ▪ Lack of good knowledge of available resources ▪ Respect (lack of) cultural diversities 	<ul style="list-style-type: none"> ▪ Mobilize “grass roots” ▪ Education, support, team building ▪ Active listening to individual and the team ▪ Standards of Practice ▪ Standards of Practice ▪ Expectations mutual ▪ Resourcing ▪ Thinking “outside the box” ▪ Re-evaluating how we spend our time/ appropriate use of time ▪ Proper use of resources ▪ Timely access to appropriate knowledge/ support ▪ <u>Patient/family focus</u> not just patient or health care provider