THE PROCESS OF ONCOLOGY NURSE PRACTITIONER PATIENT NAVIGATION: A GROUNDED THEORY APPROACH

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BY

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DEDICATION

For all of the dedicated NP navigators that participated in this study and their interest in furthering new nursing knowledge by sharing their journey as to how they are carving this new and vitally essential nursing role.

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ABSTRACT

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AUGUST 2016

Nurse practitioner (NP) navigation, in general, has been shown to achieve cost effective quality care, while saving millions of dollars (ANA, 2012). Research, though scant, has shown that oncology nurse practitioner navigators improve clinical outcomes (Johnson, 2015). For purposes of this dissertation, oncology NP navigators are nurse practitioners with a certification in oncology who utilize navigation processes to care for cancer patients along any aspect of the cancer care continuum. Navigation process is defined as "a series of actions or steps taken in order to achieve a particular end" (Process, 2014).

To date there are no standard me asures of the process of oncology patient navigation or related clinical outcomes. Development of process and outcome measures is critically important in that the development of these measures is necessary for navigator program evaluation. The purpose of the study is to answer the question: What processes do oncology NP navigators use in caring for cancer patients? Twenty oncology nurse practitioner navigators were interviewed through the use a semi-structured interview utilizing grounded theory methodology. This resulted in a well-defined set of concepts and theoretical framework for the process of ONP navigation that lays the groundwork for program evaluation and role delineation.

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CHAPTER I

INTRODUCTION

Focus of Inquiry

The Institute of Medicine Committee (IOM, 2013) has concluded that the cancer care delivery system is in crises due to a growing demand for cancer care and a shrinking workforce. Oncology care has become increasingly complex and the cost is rising. By 2022, it is projected that there will be 18 million cancer survivors. Incidence is expected to rise to 2.3 million new diagnoses per year by 2030. The IOM maintains that care is uncoordinated and not patient centered. Due to the complexities of cancer care, coupled with the rising need within the context of a dwindling workforce, novel solutions have been proposed. The Affordable Care Act (ACA) addresses these issues, and proposes patient navigation programs as one solution (Obama, 2010). Patient navigation in cancer care refers to "individualized assistance offered to patients, families, and caregivers to help overcome healthcare system barriers and facilitate timely access to quality health and psychosocial care from prediagnosis through all phases of the cancer experience" (ONS, AOSW, & NASW, 2010, para. 1). The IOM executive summary indicates that the ACA is in alignment with the principles of patient navigation which have a focus on minorities and the medically underserved; patient centered health care models; integration of a fragmented health care system; and the elimination of barriers to timely and appropriate care (IOM, 2013).

Likewise the American Nurses Association (ANA) stresses the need for navigation programs to address the current fragmented health care system. As corroborated by the ANA (2012), navigators are needed at all levels of the organization. Studies indicate that nurse practitioners (NPs) have drastically reduced costs and improved the care-coordination process. NP navigators, in general, have been shown to achieve cost effective quality care, while saving millions of dollars (ANA, 2012). Oncology NP navigators are nurse practitioners with a certification in oncology who utilize navigation processes to care for cancer patients along any aspect of the cancer care continuum. Navigation processes are defined as "a systematic series of actions directed to some end" (Process, 2014). The process of oncology nurse practitioner navigation is understudied, but the studies that exist have demonstrated favorable outcomes (Johnson, 2015).

Therefore the purpose of this study is to answer the following research question: What processes do oncology nurse practitioners use in caring for cancer patients? Grounded theory has been chosen as the theoretical framework in this study. The crux of the theory is that groups have shared social interpretations that are not always well defined. The research process of grounded theory has well defined guidelines that link theory with practical application resulting in the discovery of a theoretical explanation (Maz, 2013). According to Evans (2013), the use of classical grounded theory is an excellent guide to the study of people and leadership processes. Thus this framework is a good fit for the emergence of theory relating to oncology nurse practitioner patient navigation. Grounded theory has its philosophical underpinnings in the teachings of

George Herbert Mead, and his theory of symbolic interactionism (Corbin & Strauss, 2008). The goal is either a coded set of propositions or a set of conceptual categories embedded within a theory (Glaser & Strauss, 2010), thus resulting in an emerging definition of the NP oncology navigation process.

Problem of the Study/Statement of Purpose

The purpose of this study is to answer the following research question: What processes do oncology nurse practitioners use in caring for cancer patients?

Rationale of the Study

To address the disparities in cancer care the American College of Surgeons Commission on Cancer issued Accreditation Standard 3.1 (American College of Surgeons Commission on Cancer, 2014). This requires that a navigation process be in place in order for cancer programs to receive accreditation. Few systematic studies exist that describe navigation processes. Jean-Pierre et al. (2011) in a qualitative study explored 21 transcripts of interviews with 3 community navigators who talked about their experiences with patients. It was found that outcomes were influenced by patients, navigators, navigation processes, and external factors. A preliminary framework emerged; it was recommended that future studies look at ways to tailor navigation approaches within different contexts. The core of the navigation process was identified as relationship building and instrumental assistance.

Models for quality assurance such as the Donabedian model have stressed the critical linkage between the role that processes have in determining outcomes, and the

challenges involved in determining cause and effects of these organizational components. According to the Donabedian (1966) construct of structure, process, and outcome, each organizational factor is influenced by the previous. Utilizing this model, Smitz Naranjo and Viswanatha Kaimal (2011) found that care processes had the most influence on quality outcomes. In a study by Gardner, Gardner, and O'Connell (2013), the Donabedian framework was shown to be useful in evaluating structure, process, and outcomes of nurse practitioner services. Data were collected on structure, process, and outcome evaluation of NP services using a mixed method design. Stakeholder surveys (n=36), in-depth interviews (11 patients and 13 nurse practitioners), and medical records on service process were analyzed, showing that the framework provided a useful model for planning, putting together, and evaluating a health service evaluation. They concluded that an understanding of the structure and process requirements for planning a care innovation is the basis for safe and effective patient care.

Research has indicated a need to define the value of the NP role in terms of delivering patient outcomes (Grainne, Plummer, O'Brien, & Boyd, 2011). However, a recent literature review indicated a paucity of studies that define standardized outcome measurements for nurse practitioners in the oncology setting (Johnson, 2015), though consortiums are in place that are serving to define these metrics on a global basis (Battaglia, Burhansstipanov, Murrell, Dwyer, & Caron, 2011; Guadagnolo, Dohan, & Raich, 2011). Monitoring the quality of clinical care is in fact the responsibility of oncology nurse practitioners, as written in the Oncology Nurse Certification Corporation

(ONCC, 2014) role delineation statement. The processes of oncology NP navigation are not well defined and researched, yet processes can be gleaned from the information defined in oncology NP studies that currently exist. Research, though scant, has shown that ONP navigators improve clinical outcomes (Campbell, Craig, Eggert, & Bailey-Dorton, 2010; Rosales et al., 2014).

To date there are no standard measures of the process of oncology patient navigation or related outcomes. Development of the process and outcomes is critically important for program evaluation. Through program evaluation, nurses can demonstrate their impact on patient care outcomes. Nurse practitioners practicing oncology by virtue of their education and training are ethically responsible for ensuring quality patient care. Defining the process of patient navigation that oncology nurse practitioners use in caring for their patients is the initial step towards achieving standardized outcome measures and ensuring high level quality care.

According to Grainne, Plummer, O'Brien, and Boyd (2011), defining what NPs do professionally promotes nursing in the global context, and helps raise the profile of nursing as a profession. Once the initial step of defining the process of ONP navigation is determined, further research involving well controlled interventional studies can be designed that determine the impact on patient outcomes. Definition of standardized outcome measures will serve to promote interprofessional collaboration on a global basis. Definition of navigation processes can serve to promote clarification of the navigation role, and serve as the basis for nurse practitioner training and development.

Demonstration of the effects of the navigation process as utilized in programs can serve as the basis for policy development as standards of care are better defined.

Researcher's Relationship to the Topic

This researcher formerly took part in a pilot telemedicine research study at the Michael E. DeBakey VA in Houston, Texas. As the ONP for the study which involved caring for oncology patients across the state of Texas, she realized the need for navigation programs to address the Veterans' barriers to care. With this goal in mind, the researcher decided to investigate what is entailed in the ONP navigation process.

Study Assumptions

Ontological assumptions refer to the nature of reality or the study of being (Crotty, 2011). Grounded theory, the methodology used for this study, has its philosophical underpinnings in the teachings of George Herbert Mead, and is guided through the lens or theoretical perspective of symbolic interactionism (Corbin & Straus, 2008). Grounded theory and symbolic interactionism share mutual ontological assumptions. Central to symbolism interactionism and representative of Mead's view of reality is his view of self and social interaction. According to Mead (1965), "The self to which we have been referring arises when the conversation of gestures is taken over into the conduct of the original form" (p. 167). A gesture represents part of a social act, and serves as the stimulus to other forms in the social act. The form can be an individual, social situation, or abstract idea (Mead, 1965). The social process involved in forming the self occurs through interaction between these forms, and results in the formation of

the self-concept. The self-concept is derived by one's communication with self and is formed by continuous interaction between the "I" and the "me" (Mead, 1965). According to Mead (1965), the "I" acts, but the "me" evaluates and interprets. Mead refers to the "generalized other" which can be individuals, social groups, or communities. According to Mead (1965), "The organized community or social group which gives to the individual this unity of self may be called the 'generalized other' " (p. 154).

In order for an individual to fully develop, one must not only take on the attitude of others, but must assimilate the attitudes of others towards oneself and other people, taking into consideration their attitudes towards the social activity or group in which they are engaged. The attitudes are then generalized, and the person acts towards the bigger phase of the social process which according to Mead (1965) "… constitutes its life and of which these projects are specific manifestations" (p. 155). In summary, main ontological assumptions within symbolic interactionism are that humans act according to the meaning they internalize from the situation, meanings are formed from social interaction, and the social construct is formed through this social interaction (Blumer, 1969).

Philosophical Underpinnings

Grounded theory has been chosen for the method of investigation for this study due to its shared ontological assumptions with symbolic interactionism. In grounded theory the researcher does field work to discover the meaning of the concepts being explored, and how these meanings are impacted within the social setting. The crux of the theory is that groups have shared social interpretations that are not always well defined.

The research process has well defined guidelines that link theory with practical application resulting in the discovery of a theoretical explanation (Maz, 2013). Thus the framework is a good fit for the emergence of new knowledge and theory relating to patient navigation. According to Aldiabat and Navenec (2011), the definition of situation in symbolic interactionism is taken from Thomas (1978). Humans respond to a situation through how they see it. To understand why they are defining it as such helps in understanding the behavior. According to Corbin and Strauss (2008), a basic assumption of grounded theory cited in Mead (1934) is:

> Actions are embedded in interactions, past, present, and imagined future. Thus, actions also carry meanings and are locatable within systems of meanings. Actions may generate further meanings, both with regard to further actions and the iterations in which they are embedded (Mead, 1934; Corbin & Strauss, 2008, p. 6).

Thus much like symbolic interactionism, the ontological assumptions of grounded theory are that humans act according to the meaning they internalize from the situation; meanings are formed from social interaction; and, the social construct is formed through this social interaction (Blumer, 1969).

Epistemology is the theory of knowledge within the theoretical perspective and methodology that explains how we know what we know (Crotty, 2011). Constructivism is the epistemology chosen for this study; according to Crotty (2011), it is embedded within many theoretical perspectives including symbolic interactionism. Constructivism

also is at the core of the grounded theory methodology. Corbin and Strauss (2008) maintain, “I agree with the constructivist viewpoint that concepts and theories are constructed by researchers out of stories that are constructed by research participants who are trying to explain and make sense out of their experiences and/or lives, both to the researcher and themselves” (p. 10). Researchers using constructivist grounded theory place a priority on the phenomenon of study, as the data and analysis are derived from the shared relationship with the participants. They explore how and why the research participants construct meaning in different instances in different cases. Researchers also explore how, when, and to what depth the experience described is embedded in the greater and often not so obvious relationships with individuals, situations, and networks (Charmaz, 2012). The actors or navigators have a story to tell that will unfold through the interview process involving this researcher. The goal of the research is to work towards identifying the formation of the social process of navigation that is consistent amongst the participants. The major research method involves in depth analysis of interviews.

The research question is designed with this philosophical stance in mind. Initial interview questions are centered on the nurse navigator role as experienced by the nurse navigator. Ongoing questions are tailored at defining the actual process of navigation. The goal is either a coded set of propositions or a set of conceptual categories embedded within a theory (Glaser & Strauss, 2010), as relates to oncology nurse practitioner patient navigation. Key questions are tailored towards identifying the novel aspects of the navigation process in respect to the traditional oncology nurse practitioner processes.

Summary

In summary, the cancer care system is in crisis due to the growing demand for cancer care and shrinking workforce. This is compounded by uncoordinated patient care, coupled with system barriers to care that impede timely access. Novel approaches to care, such as patient navigation, have been proposed by chief governing bodies. A stipulation for cancer accreditation is that hospitals have well defined navigation processes. The process of oncology nurse practitioner navigation is understudied. Thus utilizing a grounded theory approach within the framework of symbolic interactionism, this researcher proposes the following research question: What processes do oncology nurse practitioners use in caring for cancer patients? Chapter 2 provides a review of the literature as relates to oncology nurse practitioner patient navigation. Chapter 3 defines the methodology used in this research. Chapter 4 provides an analysis of the data. Chapter 5 concludes with a summary of the study.

CHAPTER II

SYSTEMATIC REVIEW OF ONCOLOGY NURSE PRACTITIONER NAVIGATION METRICS

Abstract

American Nurses Association (ANA) has petitioned the nurse practitioner (NP) to become active in patient navigation and care-coordination, as research has shown favorable outcomes. In a white paper, the ANA (2012) has recognized the care coordination role, a component of patient navigation, as highly influential in improving patient care at every level of organization. For purposes of this study a nurse practitioner (NP) is defined as a nurse with a state license and certification to practice as an advanced practice nurse. Oncology nurse practitioners (ONP) are advanced practice nurses caring for oncology patients. ONP navigators are nurse practitioners that are in oncology navigation roles. Research has shown that the inclusion of an NP to staff has resulted in improved outcomes (Robles et al., 2011; Naylor et al., 2004). Through the use of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) technique this study sought to: 1. Analyze the quantitative research studies pertaining to ONP navigation for quality and level of research. 2. Describe the most frequent metrics that ONP navigators utilize in their research. 3. Contrast these metrics to published standards for oncology patient care. Seven studies met research criteria. It was found that

research is emerging that shows that ONP navigators make a difference in ensuring timely care, as well as patient and staff satisfaction. This is in line with recommendations of expert consensus. The need for more research utilizing identified sound research tools that have been rigorously tested has been identified by this systematic review. The article can be accessed on the following link: https://cjon.ons.org/cjon/19/3/systematic-review-oncology-nurse-practitioner-navigation-metrics

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CHAPTER III

METHODS

Procedure for Collection and Treatment of Data

This study used a grounded theory approach to answer the question: What processes do oncology nurse practitioner (NP) navigators use in caring for cancer patients?

It has been detailed previously that symbolic interactionism and grounded theory share ontological assumptions. They are: humans act according to the meaning they internalize from the situation; meanings are formed from social interaction; and, the social construct is formed through this social interaction (Blumer, 1969). This chapter details the methodology for this study specifically as it relates to these ontological assumptions.

Setting

The settings for the study included telephone interviews in a location convenient to the participant in any area of the United States. For the most part, the researcher conducted the telephone interviews from her private study behind closed doors located at 17744 Kings Park Lane, Houston, Texas, 77058. Telephone interviews were also conducted by the researcher behind closed doors in a motel and an office setting.

Participants

The study criteria for the participants was formulated keeping in mind that a seasoned oncology nurse with a fair amount of experience who has been professionally recognized through an oncology certification process would be the best fit. An expert opinion of those practicing in the field was sought to define the oncology nurse practitioner navigation process. This was in line with the basic underlying assumption of the grounded theory methodology based on George H. Mead's theory of symbolic interactionism. In summary, it proposes that humans respond to a situation through how they see it; to explore why they define the situation as such facilitates understanding of the behavior (Mead, 1934; Thomas, 1978; Corbin & Strauss, 2008; Aldiabat & Navenec, 2011). The semi-structured interview was designed to learn the goals, interactions, and challenges of navigation, as well as any unique responsibilities that distinguished this novel process from traditional nurse practitioner processes. Though navigation is practiced in other areas of the world, this researcher was interested in understanding the navigation process within the framework of oncology nurse practitioners practicing within the United States.

The study participants were recruited from all areas of the United States. To be eligible for the study, the nurse practitioners were required to be working as navigators and meet the following criteria: 1) license to practice as an NP in their respective state; 2) certification to practice as an oncology nurse; 3) minimum of 5 years full time experience in oncology nursing; and 4) English speaking. These criteria were used in order to recruit

a sample of experienced NPs that would provide a detailed description of the navigation process.

A convenience sampling framework was utilized to recruit 20 oncology NPs who worked in in-patient and/or out-patient settings. The interviews were conducted until theoretical saturation occurred. The recruitment strategies were diverse and included: 1. word of mouth networking with peers – nurse practitioners were asked if they knew of any oncology NPs in the area that meet the study criteria; 2. soliciting volunteers through public announcements at professional nursing conferences; 3. contacting authors of oncology NP navigation articles appearing in newsletters or convention pamphlets via telephone or e-mail; 4. posting information soliciting oncology NP volunteers on blogs or websites of professional organizations with organizational director approval; and, 5. recruiting by snowball sampling, i.e., asking oncology nurse practitioner (ONP) navigators and other nurses to volunteer names of ONP navigators who may be interested in the study. Appendix A includes wording for recruitment communications. Appendix B includes wording for recruitment flyer.

Protection of Human Subjects

Four major risks for participants were: 1. loss of confidentiality; 2. coercion; 3. fatigue; and 4. discomfort and/or embarrassment with any of the questions asked during the interview. Steps to minimize these risks were taken and are delineated below.

Loss of Confidentiality

A log of participant names and contact information was kept separate from transcribed interviews. Only code numbers were used on transcripts. All study materials were kept in the PI's secure and locked office. Interviews were conducted via telephone behind closed and locked doors. Only the PI and the dissertation committee had access to the interviews. Tapes were destroyed utilizing a degaussing process.

Coercion

Participant could withdraw consent at any time and was reminded of this right at the beginning of the telephone contact.

Fatigue

Participant was informed of the right to stop the interview at any time and not to finish the interview or finish at a later time.

Discomfort and/or Embarrassment with any Questions Asked During the Interview

Participant was informed of right to refuse to answer any question that created discomfort or embarrassment. The PI continually monitored the participant's verbal cues for potential discomfort/embarrassment. The PI was willing to stop the interview if a participant was distressed, in which case the participant would be encouraged to contact her personal health care provider, if needed.

Data Collection

The research protocol involved an interview script, and interviews were conducted until theoretical saturation occurred. Theoretical saturation is defined as "the

point in analysis when all categories are well developed in terms of properties, dimensions, and variations. Further data gathering and analysis add little new to the conceptualization, though variations can always be discovered" (Corbin & Strauss, 2008, p. 263). Likewise, researchers using constructivist grounded theory place a priority on the phenomenon of study, as the data and analysis are derived from the shared relationship with the participants. They explore how and why the research participants construct meaning in different instances. Researchers also explore how, when, and to what depth the experience described is embedded in the greater and often not so obvious relationships with individuals, situations, and networks (Charmaz, 2012).

Accordingly, this researcher through an evolving interview process sought to learn how the NPs navigate a patient through the cancer continuum. The interviewer sought to identify the social processes that were consistent amongst the participants, and conducted the interviews until the information was repetitive and no further new knowledge derived. The research was conducted until the goal was achieved, which was the identification of either a coded set of propositions or a set of conceptual categories embedded within a theory (Glaser & Strauss, 2010) that related to nurse practitioner oncology patient navigation.

The steps for data collection were as follows:

1. Potential participants were contacted via phone, e-mail, or in person, and the Recruitment Script was provided (Appendix A). If potential participant met eligibility

criteria and wanted to participate, a date, time, and location of meeting was arranged for interview.

2. If participant agreed to a telephone interview and would not meet in-person for interview, the informed consent (Appendix C) was emailed or faxed to the participant. The participant reviewed, signed, and returned consent to PI prior to telephone interview.

3. Demographic questionnaire (Appendix D) was e-mailed or faxed.

4. Tape recorder was turned on and the interview was carried out guided by the interview script (Appendix E).

5. At the conclusion of the interview, the researcher thanked the participant for participating, and obtained an address where gift card could be mailed.

6. A code number was assigned to each transcription and PI (F. Johnson) or transcriptionist Leslie Hopkins transcribed the interview verbatim.

7. PI analyzed data via open, selective, and theoretical coding and constant comparison methods, and this was reviewed by committee chair.

8. Data collection was continued until theoretical saturation occurred; concepts were generated and connected to generate a navigation theory.

Data Collection Procedures

Data collection procedures were generated by the emerging theory and mutually agreed upon by student and committee chair. Data collection was in the form of interviews using an initial interview script (see Appendix E) via the telephone. As the theory emerged the interview questions were revised on an ongoing basis. The researcher

utilized memoing during the interview process which was included as part of the data for analysis. All data were kept in a locked file.

Data Analysis

In grounded theory, data collection and analysis occur simultaneously (Corbin & Strauss, 2008). The goal of data collection in accordance with Social Interaction Theory was to learn the meaning that the NP navigators ascribe and internalize from the situation, and to determine the social construct of navigation formulated through this social interaction (Blumer, 1969). Basic analytic techniques used in grounded theory include sampling, memoing, constant comparison, and coding (Corbin & Strauss, 2008).

Sampling Types

In the beginning of the research open sampling was used. The researcher began the interviews and viewed the information through a lens open to all possibilities. The script was examined for events that explained the emerging concepts. In the later phase, the researcher went back to the next interviewee and delved deeper to find answers to the questions to which the previous data alluded (Corbin & Strauss, 2008). This is theoretical sampling, the process of selecting "incidents, slices of life, time periods, or people on the basis of their potential manifestation or representation of important theoretical constructs" (Patton, 2001, p. 238).

Memoing

Memos were recorded beginning with the first interview and continuing throughout the data analysis. The purpose of memos was to explore data, identify

properties of the concepts, make comparisons, determine relationships between conditions, and develop the story (Corbin & Strauss, 2008). These memos were included in the data analysis process.

Constant Comparison

As an incident was noted in the research process, it was constantly compared for ways in which it was the same or different from previous incidents. The concepts were labeled and grouped according to the noted variations (Corbin & Strauss, 1990) through the use of NVivo for Windows and regular review with committee chair.

Line by Line Coding

Data analysis used line by line coding; each line of the manuscript was coded for concepts, using NVivo for Windows software. Line by line coding is a technique developed by Glaser (1978). This method works well with detailed data involving processes as in this case. Line by line coding allowed the researcher to remain open about the data and its individual parts, defining the actions of the process, identifying the tacit assumptions, and comparing the data amongst the participants (Charmaz, 2012). This led to the development of categories and processes (Charmaz, 2012).

Open Coding

The data was next analyzed by "breaking data apart and delineating concepts to stand for blocks of raw data" (Corbin & Strauss, 2008, p.195). It involved "…the process of breaking down, examining, comparing, conceptualizing, and categorizing data"

(Corbin & Strauss, 1990, p. 61). This was done for each question through the use of NVivo for Windows software. Seventy-two concepts emerged from coding 16 interviews.

Axial Coding

The next step involved axial coding, the development and linking of concepts into conceptual families (Corbin & Strauss, 2015). After interview ten, the concepts were separated into eleven thematic categories, and it was believed that theoretical saturation had been achieved. Appendix F shows these categories.

Axial coding specifies the properties and dimensions of a category (Corbin & Strauss, 2008). The goal is to link categories with subcategories, and to define interrelationships (Corbin & Strauss, 2015). Though this is listed separately from open coding, the two go hand in hand as they occur simultaneously. As this researcher worked with the data, relationships between concepts and their overall connectedness to each other was sought. Interview questions were tailored to elaborate on the concepts and interrelationships. Questions such as who, why, when, how, and with what consequences were proposed prior to the next interview (Corbin & Strauss, 2008).

Selective and Theoretical Coding

The outcome of **s**elective coding was the formalization of the relationships between concepts into theoretical frameworks (Corbin & Strauss, 2015). All categories were explained around a core category or central phenomenon. An explanation surrounding the variations of the categories was sought (Corbin & Strauss, 1990). Selective coding uses constant comparison and memoing, and results in further refined

categories. The categories were described, theorized, and cross-referenced with the literature (see Appendix G). This resulted in a description of the basic social process, as well as processes that were occurring within the codes. Data collection continued through 19 interviews. The theoretical model below (see Figure 3.1) is derived (Jones & Alony, 2011)

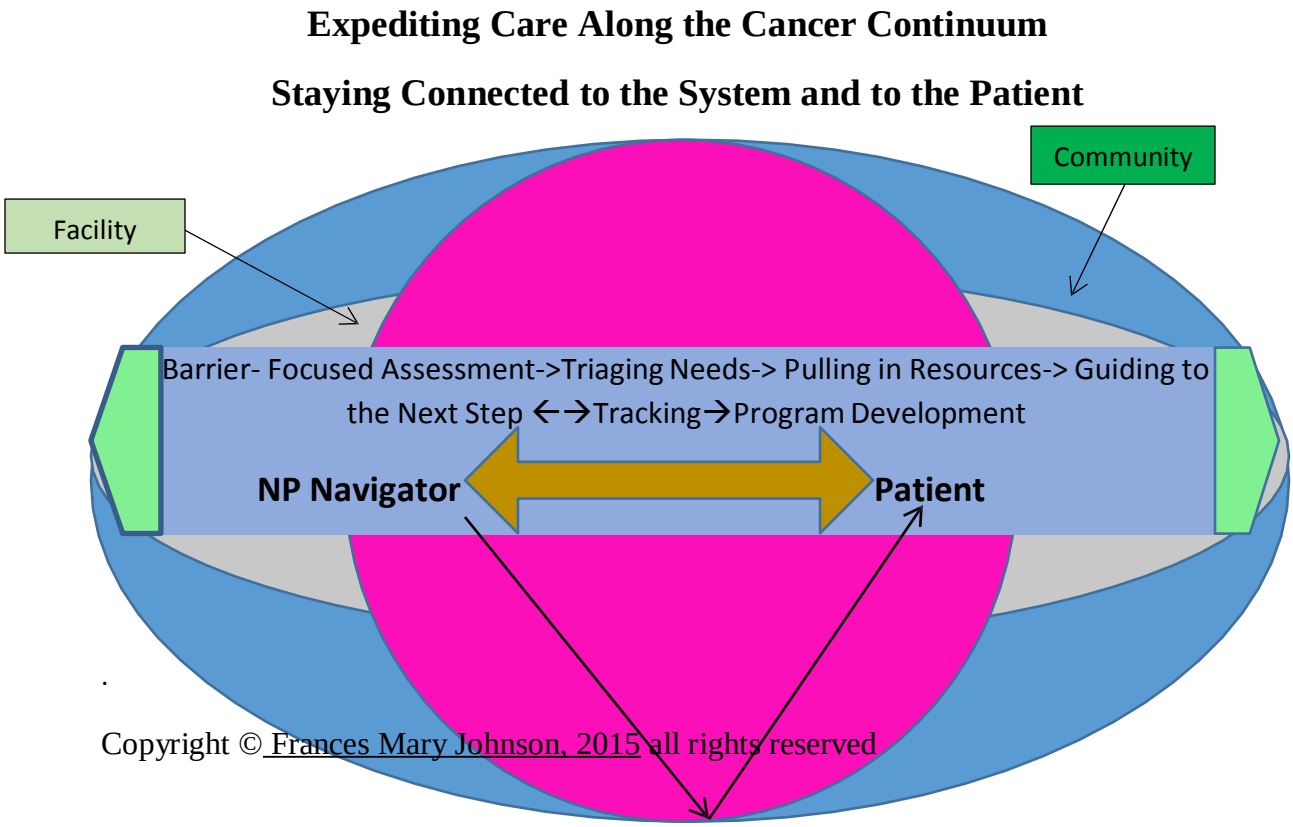

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Figure 3.1 The Process of Oncology Nurse Practitioner Navigation Model.

Interview twenty, the only survivorship navigator, confirmed the process.

Integration of Data Collection and Analysis

The method of sampling used was theoretical sampling. In this process 1-2 initial interviews were conducted utilizing an interview script. During this taped interview, the researcher collected the data and memoed any pertinent information. Early memos were written notes that recorded what the researcher observed in the data. Advanced memoing occurred later in the research process, and was used to make comparisons, describe how categories emerged, and identify beliefs, as well as support assumptions based on the data (Charmaz, 2012). The interview was transcribed, analyzed, and coded by the researcher.

The coding was reviewed by the committee chair as well. Interview questions were adjusted accordingly. The goal of this process was to collect data for the generation of theory (Glaser & Strauss, 2010). Guided by the emerging theory, the researcher utilized the principles of open, relational, and discriminate sampling as the next 1-2 participants were interviewed.

In open sampling, the researcher begins the interviews and views the program through a lens that is open to all possibilities. The data is then examined for relationships between concepts. As the process evolves, the researcher searches for events that explain the concepts. In the last phase, the researcher goes back to the site, and delves deeper to find answers to questions to which previous data alluded (Corbin & Strauss, 2008). Constant comparison (Glaser & Strauss, 2010) was started early in the sampling process and occurred during the data collection process. Comparisons were made of data

collected from incident to incident. As the theory evolved concepts were generated from additional data collection.

In the final stages of comparisons between concepts, sampling assumed a more deliberate form as determined by review between researcher and committee chair (Jones & Alony, 2011). The goal was to gather data through various sampling methods. The sampling process continued until theoretical saturation was reached. Three criteria used to determine saturation were the researcher's understanding of the empirical limits of the data, synthesis of the density of the theory, and the researcher's theoretical sensitivity (Glaser & Strauss, 2010).

Integration of Relevant Theory into the Literature

Literature search was done to compare the model to other models that support the process. This was integrated in the discussion of the model and implications for research and practice.

Scientific Rigor

Credibility, transferability, dependability, and confirmability are four established criteria for evaluating qualitative research (Lincoln & Guba, 1985). Credibility refers to the veritability of the findings (Lincoln & Guba, 1985). One method of achieving this is through triangulation. Triangulation is taken into consideration in the data collection process and refers to using more than two data sources and methods. This study utilized data collected from researcher memoing and published studies, as well as taped interviews. Additionally, when indicated, various sampling strategies were used. For

example, parallel sampling involves two or more cases, pairwise sampling involves comparing one case to others in the sample, and multilevel sampling involves the comparison of two or more subgroups taken from different levels (Leech & Onwuegbuzie, 2007). These sampling techniques were implemented. This ensured data triangulation which involves data collection through different sampling methods to represent data from different time periods and social situations as well as different people (Denzin, 1970).

To address reflexivity, the researcher examined her own feelings regarding navigation prior to entering the field to prevent bias in interpretation (Bowen, 2009). Transferability refers to applicability of the findings in other contexts (Lincoln & Guba, 1985). To ensure transferability, the researcher strove to look at navigation in both inpatient and outpatient settings until the thematic categories were saturated with a rich description of the phenomenon of navigation. Dependability refers to showing that the findings can be replicated and consistent. The researcher tracked the research process by documentation of an audit trail, which was reviewed by the committee chair. Additionally, a reflexive journal detailing the researcher's self-appraisal as well as ethical, social, and political views (Nelson, 2008) was included as part of the data collection.

Summary

In summary, this chapter detailed a description of the sample, methods used for human subject protection, data collection, and data analysis for conduction of this study

utilizing a grounded theory approach to answer the research question: What processes do oncology NP navigators use in caring for cancer patients? The rationale for use of a constructivist approach within the framework of symbolic interactionism as a natural blend for the design has been presented.

CHAPTER IV

THE PROCESS OF ONCOLOGY NURSE PRACTITIONER PATIENT NAVIGATION: A GROUNDED THEORY APPROACH

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Abstract

Objective: Nurse practitioner (NP) navigation, in general, has been shown to achieve cost effective quality care, while saving millions of dollars (ANA, 2012). Research though scant has shown that oncology nurse practitioner navigators improve clinical outcomes (Johnson, 2015). For purposes of this research, oncology NP (ONP) navigators are nurse practitioners with a certification in oncology who utilize navigation processes to care for cancer patients along any aspect of the cancer care continuum. Navigation process is defined as "a systematic series of actions directed to some end" (Process, 2014).

To date there are no standard measures of the process of ONP patient navigation or related clinical outcomes. Development of process and outcome measures is critically important for navigator program evaluation. The purpose of this study is to answer the question: What processes do oncology NP navigators use in caring for cancer patients?

Methods: Twenty ONP navigators were interviewed though the use of semi-structured interviews utilizing grounded theory methodology.

Conclusion: This resulted in a well-defined set of concepts and theoretical framework for the process of ONP navigation which lays the groundwork for program evaluation and role delineation.

Introduction

NP navigation, in general, has been shown to achieve cost effective quality care, while saving millions of dollars (ANA, 2012). Patient navigation in the cancer arena is defined as "individualized assistance offered to patients, families, and caregivers to help overcome healthcare system barriers and facilitate timely access to quality health and psychosocial care from prediagnosis through all phases of the cancer experience" (ONS, AOSW, & NASW, 2010, p. 1). A recent literature search showed that the process of ONP patient navigation and the related outcomes are not well defined; however, emerging data has shown their benefit in ensuring timely access to care and patient satisfaction (Johnson, 2015). Thus this researcher proposed the following research question: What processes do ONP navigators use in caring for cancer patients?

Grounded theory methodology was chosen because it has well defined guidelines that link theory with practical application resulting in the discovery of a theoretical explanation (Maz, 2013).

Methods

Population

To be eligible for this study, an NP must work as a navigator in the United States, be English-speaking, and have: 1) a license to practice as an NP in the state where he or

she is employed; 2) a certification to practice oncology nursing; and 3) a minimum of 5 years full time experience in oncology nursing.

Sample Strategy Process

Institutional Review Board (IRB) approval was obtained. Convenience sampling was utilized to recruit 20 NPs who worked in in-patient and/or out-patient settings by: 1) word of mouth networking with peers; 2) soliciting volunteers through public announcements at professional nursing conferences; 3) contacting authors of oncology NP navigation articles; 4) posting information soliciting oncology NP volunteers on blogs or websites of professional organizations with organizational director approval; and, 5) recruiting by snowball sampling. A recruitment letter and flyer was given to the potential interested participant. Informed consent was then obtained.

Interview Guide

A fourteen question interview script was used, with lead prompt of: describe your role as an NP navigator when caring for a cancer patient.

Sample

The sample was all female certified as nurse practitioners with a mean age 52 years (see Tables 1-4 for sample details).

Data Collection Procedures

Interviews were conducted over the phone. The interview script was modified as indicated by the emerging theory.

Sampling Types

Sampling and data collection occurred simultaneously (see Table 5).

Trustworthiness

Steps to ensure trustworthiness were followed (Guba, 1981; Shenton, 2004); see Table 6.

Findings

The core category that emerged from this research was "expediting care along the cancer continuum." This was the NP navigation goal, as failure to expedite the care along the cancer continuum would result in treatment delays, and patients being "stuck in the system." Care was expedited through a barrier-focused assessment, triaging needs, pulling in resources, guiding to the next step, tracking, and program development. The navigator is a center for care not only for the patient, but within the facility and community. In grounded theory, the basic social process (BSP) centers on the core category (Glaser, 2005). In this research, the BSP was connectivity, defined as "staying connected to the patient and system." Through interfacing with the system, the navigator was a pivot point for care for all those involved in the patient's cancer journey. One participant stated "we're the glue that holds things together."

Barrier-focused Assessment

This ONP navigation process began with a barrier-focused assessment addressing factors on an individual, facility, and community level.

Patient Assessment

The patient assessment was global in nature.

> …Nurses are taught to think holistically… I have a note template…covers everything from what their diagnosis is to their treatment plan…dietary, psychosocial and all those specialties so that I am…covering all of those issues…and then their follow-up.

Facility Assessment

The facility assessment included not only knowledge of the facility resources but finding ways to expedite and coordinate care. This was done through the development of key connections. A widely used means of implementing facility assessment was through multidisciplinary team collaboration.

> It's called a multi-disciplinary neuro oncology clinic where I work with the neuro surgeon, the radiation oncologist, and the medical oncologist. We also meet with the neuro radiologist and the pathologist along with social work other mid-level practitioners from the neuro surgery…discuss the best course of action to treat somebody's tumor…

Community Assessment

A major focus of the ONP navigation process was the assessment of community resources related to patient utilization, especially barriers to care. All navigators noted that knowledge of community resources and interconnectedness with the community was important. Marketing the role to the community and public educational assessments for

program development both within the hospital and in the community were widely employed to meet the community needs as a whole.

> You have to know your community…to be able to assess your community and know what their needs are…I am responsible for community education…Your navigation process is dictated by your community…there were two new thoracic surgeons that I am having to go out and meet…and being a provider, I am not used to being a marketing person…and I am not really good at that…felt awkward…

Triaging Needs

There is an order to cancer care due to the correlation between untimely diagnostic workup, treatment initiation, and disease progression. The triage process is an expedited and timely order for processing patient care through a diagnostic work-up and initiation of treatment. Knowledge of the natural course of the disease guides the initial triage process. Oncology NP prescriptive authority expedites this process by alleviating the need for physician orders. The triage process is applied to patient, facility, and community, addressing barriers to care in a systematic manner.

Patient Triaging

Patient triaging flows from the initial comprehensive assessment. It is part of the patient program, intertwined within the context of the facility and community programs. Triaging involves expert knowledge of all of the factors that are influencing the patient's

care, as well as utilization of the navigator's connectivity to contacts within the facility and community to assist the patient in overcoming barriers to care.

> To try to help them with their fears, show them how to learn about what's going to be happening, and then giving them a timeframe on you're going to see your surgeon first, and then, you're going to see the medical oncologist before your surgery, and this is what's going to happen next for you.

Facility Triaging

The barrier to the navigation process cited as problematic for all of the navigators was lack of time, particularly for navigators who had clientele with heavy navigational needs. To offset the barriers, navigators often utilized a triage process that identified and gave priority to patients who were at high risk for stagnating within the system secondary to navigation needs. Insurance barriers were often the cause of difficulties in the navigation process.

> I am usually up around 6…and I review all of the patients sometimes; there can be as few as 20, and sometimes 40-50…every day I am going through all of the patients…tracking them…is there anyone that has had a referral?…I triage…and see which patients need more help…and this is the hospital go to…and I prioritize throughout the day…
>
> …to identify people that maybe don't have any resources, as far as they don't have any family help or they have a very limited help. If they have barriers like they don't drive, or, they're in a financial mess. So at least some of those rise

to the top, and they will get more help than someone that is very squared away, and can sort of self-navigate.

Community Triage

The triage process was also evident as the navigator considered the make-up of the community, which they triaged as a target population for enhanced navigation intervention.

> …less than 5% of outpatient that came in for screening mammography were Hispanic, and less than 5% were Asian. So we actually wrote a grant to the Coleman Foundation and were able to hire a –she's a lay outreach coordinator…she actually goes out in the community…teaches about, the importance of –screening mammography, checking your breast. She's from Mexico…taught Spanish in the public schools here for years…So we've been able to reach…a considerably more, larger group of our Hispanic population.

> I also function as a liaison with the health Department in that I actually have slots available to me from the Health Department of … to get patients in so that they're covered for biopsy.

Pulling in Resources

Pulling in resources involved care co-ordination, a central process by which navigators sought resources for the patient. Navigators facilitated care-coordination among departments and specialists, appointment setters, family systems, research teams, insurance companies, state health departments, community resources, care providers in

other states, and any other resources that would be helpful to the patient. Facility and community resources were intertwined, and therefore addressed synergistically. Good communication skills and well-defined flow processes were critical in accessing appropriate resources for the patient at every level.

Pulling in Resources in a Patient Context

Pulling in resources in a patient context is done after determination of the patient's needs in the barrier-focused assessment. Skill in advanced practice oncology nursing is essential. The educational component of the navigation process is a key factor. The ONP must have the necessary key contacts and processes in place to expedite obtaining necessary resources for the patient.

> …I really; really stress… the fact that you need to look at all actions for that patient. You need to look at all of your resources that you can draw from, and that's sometimes difficult for people who aren't accustomed to being able to do that work. I get NPs or NP students who have worked in family practice offices and …they want to start doing something like this. They just don't know how many things are involved in getting the patient from point A to point B.

Pulling in Resources in a Facility Context

Pulling in resources in a facility context involves interfacing with anyone involved in the care of the patient at any level of care. The navigator must possess the ability to communicate with all levels of personnel in order to expedite and coordinate the patient's care.

> …Primary care physicians, pulmonologists, medical oncology, radiation oncology, other nurse practitioners in most groups, other nurses, especially the lung cancer patients get chemo radiation at the same time…so coordinating, making sure that we know when they are starting so that their chemotherapy is set up to be started. Social work is a big one, dietary… Coordinating between inpatient and outpatient, because oftentimes patients can get admitted

Pulling in Resources in a Community Context

Mutual interaction between the navigator and community is necessary as the navigator draws upon the community resources and develops programs of care. This is facilitated by having relationships with key contacts within the community.

> So some community outreach and community navigation as well…I kind of see that, as a community navigator. I sit on some administrative committees, there's a women's service line, an oncology service line. They have an annual oncology update and community educational presentation, and sometimes I speak at those.

> …I think that many years of experience has helped me, and I know a lot of people in the area…worked in the area my whole life, so…good references, as far as knowing where to send people.

Guiding to the Next Step

Guiding to the next step was a phrase used by many of the navigators. Once the barriers to care were identified, needs were triaged, and resources were pulled in, the

patient was given guidance describing the next part of their care. Typically the process of barrier-focused assessment, triaging needs, and pulling in resources was ongoing in that the navigators (N = 13) repeated the process along the cancer continuum, i.e., from diagnosis to survivorship; contact with the patient took place from diagnosis to death. For other navigators, contact occurred in a specific phase of the cancer continuum such as the diagnostic or survivorship phase (N = 7), followed by a transfer to a provider.

Guiding to the Next Step within a Patient Context

Most of the navigators addressed educational needs and resources for supportive care during the diagnostic process.

> Well we actually start at the very beginning when the patient finds out that they're going to be biopsied, and so our role is to talk to them, tell them what's going to happen, kind of prepare them for the next step.

Guiding to the Next Step within a Facility Context

Guiding to the next step within the facility context was done as the ONP coordinated care between the other providers in order to facilitate cancer care both within and between all phases of the cancer continuum. According to the Agency for Healthcare Research and Quality (AHRQ) (AHRQ, 2014), "care coordination is the deliberate organization of patient care activities between two or more participants (including the patient), involved in a patient's care, to facilitate the appropriate delivery of health care services" (AHRQ, 2014, para. 5).

The National Institute of Health (NIH) defines the cancer continuum as "…various points from cancer prevention, early detection, diagnosis, treatment, survivorship and end-of life" (NIH, 2011, para. 1). Placement for survivorship care was an overall patient goal. Survivorship care was provided by clinics managed by either the participant NP, by survivorship group programs, and/or by either primary care or oncology physician services.

> We are just starting…survivorship and treatment summaries. So as patients are kind of through with their active surveillance after GYN cancers we are working on summarizing their care, and letting their referring GYN or primary care doctor know the plan, or recommend follow up for their patients…sending the patient and the referring doctor a letter...letting them know…your patient is doing well. We're sending her back to you for ongoing care. This is the follow up scheduled we recommend.

Guiding to the Next Step within a Community Context

The navigators described arranging resources for patients within the community to facilitate and expedite care. This required that the navigator be closely connected to the community system through the fostering of ongoing relationships with community providers.

> I also arrange transportation, which is a big issue in our community … I am the one that makes sure that they get to where they need to be; hopefully pre-treatment, during treatment, post treatment.

> …also work with three navigators from three local offices, so that does help me out because they work with surgeon's offices, and they are the three most common offices that I use…

Tracking

The major goal for the navigation process was high outcomes measured by metrics. Metrics were tracked using navigation tools. Both patient metrics and system metrics (hospital/community) were tracked throughout any phase of the navigation process in any stage of the cancer continuum.

Patient Metrics

Metrics associated with the patient's experience included distress ratings, patient satisfaction, risk scores, referrals, lost to follow-up rates, treatment decisions, pathology report notification, out migration, insurance authorization, quality of care, and survivorship care. Patient satisfaction was a major goal, and the Press Ganey system was frequently employed. In some instances focus groups were held in the community both to determine need and to gain feedback regarding patient satisfaction with care.

> I make sure that I talk to them after the screening, what was recommended and then I follow up with them at that time to make sure that those follow-up tests are getting done.

Facility Metrics

Quality care was sought by following expert consensus guidelines, and programs were built with these guidelines serving as their backbone. These guidelines were

developed by National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO), Institute of Medicine (IOM), National Accreditation Program for Breast Centers (NAPBC), Commission on Cancer (CoC), American Congress of Obstetrics and Gynecologists (ACOG), and American Cancer Society (ACS). Patient metrics in these guidelines were not mutually exclusive with system metrics. The two are closely intertwined because the navigation process works synergistically between the patient, hospital system, and community. Thus certain metrics in these guidelines applied to program development rendering system guidelines. Diagnostic metrics were a major focus for the NP navigator, and incorporated timely care such as reporting pathology to patient and/or provider, ordering staging tests in a timely manner, and obtaining and providing treatment consults. Other institutional metrics included patient lost to follow-up percentages, STAR rehabilitation program referrals, number of patients seen, point along the cancer continuum, number of procedures/referrals, QA indefinable indicators such as sentinel node biopsies and DCIS, timely initiation of appointments, consistency of practice, face to face visits, phone calls, resource referrals, length of time the case is open, admissions, discharges, and number and types of interactions.

> I flowed out what was happening with patients coming into the radiology department to start and how they would progress through the system…what we ended up with was a span of 52 days from abnormal mammogram to diagnosis….not to surgery, but to diagnosis…when I took over …our goal was

seven to fourteen days from abnormal mammogram to diagnosis, and we met that goal…

Community Metrics

Integrated provider care systems are necessary in order to successfully manage population health across the care continuum. Overall population health management dintegrates hospitals, physicians, and community providers (American Hospital Association, 2011), promoting digital connectivity amongst care providers and patients. Care systems addressing oncology population health management use facility, community, and national cancer statistics. A glimpse of the far reaching implications of navigation is demonstrated as this survivorship NP navigator talks about her pilot program and development of a survivorship care plan which entails collecting data from the patient record and integrating the facility metrics with the community metric system.

> …it has been individualized (template) and it's a challenge to spend the time going through the medical record and gleaning this information from multiple sources, so I get to work with a department that does pull that together for the state anyways, and we have tried to develop a template so that information can cross over, but that has been our biggest challenge.
>
> **…** we were part of the …. study in the state of … which is looking at the number of breast cancer cases, and it's through the American College of Surgeons.

Navigation Tools

Navigation tools served as guides for tracking. The information from the tools is compared to standards of care and serves as a guide for process improvement.

Patient tools. Examples of patient tools included chart review, templates, Gail Model Risk Assessment, lung nodule screening criteria, triage protocols, and Press Ganey Scores. Less formal tracking tools included spreadsheets, task point, note template, sticky notes, informal face sheets, chart reviews, excel spreadsheets, PowerPoint tools, Care Coordination master schedule, Outlook alerts, and triage protocol. Navigators may create forms specific to their needs, for example:

> We have an intake and referral sheet. It's a 2 page form. Even though the hospital has an electronic medical record we're still using paper form and paper charting because the electronic health record doesn't have a navigation piece to it, and we need to be able to track when to follow-up with patients and when the patient's surgery is and when to call them back…We need to be able to see at a glance what's happening...

Facility tools. Examples included sophisticated computer systems, leadership meetings for program evaluation, process tools, pamphlets describing the navigator role with contact information, QA initiatives, and multidisciplinary meetings for consensus opinions regarding treatment planning. Computer tracking systems were utilized frequently as a means of communication between the systems. Journey Forward (n.d.) was popular for use in survivorship. This is a free tool that assists oncology professionals

to make tailored treatment plans. The CoC maintains that it meets the requirements identified by them and the IOM for important components of survivorship care (Journey Forward, n. d.). Human trackers included RN data specialists. Administrative tools for system analysis and goal formation included process maps, picture representation of program, and specific navigation guidelines such as the NCOBC navigation steps. One program used an NCCP flowchart to standardize the navigation process amongst the different navigators within the system. Other programs included Practice Partner, NURSENAV, ARIUM, EQUICARE, EPIC, ASPEN, ACTS, CORDATTA, and BEACON. One hospital system utilized a homegrown tailored computer software program designed for their system.

> I am entering every step of the way for them behind the scenes, so everything from their diagnosis, imaging, abnormal imaging, biopsy and continuation from there, has all been populated all along the way…

Community tools. These included marketing tools, group meetings, and community resource binders. Several participants described coordination of state and facility programs for cancer control through the use of a shared data base.

> **…**RN Data Specialists…who also work with the –let me see, the (National Database of Nursing Quality Indicators) NDNQI…

In summary the major goal for the navigation process was to expedite patient care. Timely care was gauged by metrics. Navigation tools were tied closely with these metrics, facilitated their tracking, and were used in all phases of the navigation process.

Tracking and tracking tools were the means by which the navigator facilitated staying connected to the patient and system.

Program Development

All of the navigators participated in the development of a navigation program. Intrinsic to this process was the development of novel and unique alliances tailored for the system and designed to expedite care. Carving the unique role involved developing a "navigation system" in lieu of one navigator assuming all responsibilities of the role.

The Patient Program

The program was related to direct intervention carried out between the nurse and patient typically involving patient education.

> I have had an intern that was a nurse that was a lay navigator…she would come in with me, and I would do the NP part and she was very good with coming up with a plan for helping them with their anxiety, pre-op fears, she would do a stress reduction session with them…maybe 10 minutes…

Facility Program

The facility program involves reorganizing navigator roles in order to provide seamless care.

> Yeah it will be a combination of ADNs with OCNs with MSNs as NP who will be…. I guess it could be called a patient navigator who can be an ADN or a BSN as long as they have on OCN…working with a NP who will be doing a lot of the follow-up care…they leave the diagnostic division…go into the cancer

division; and the navigator from diagnostics will be handing that on to the navigator from cancer; and I will be handing them off from me to the NP over in the cancer side…

Community Program

The community program involved outreach programs designed by the NP navigator that served the needs of the community.

So anyway, we developed a program; I worked together with a cardiac pulmonary nurse…a perfect marriage…She develops the cardiac pulmonary end which is very much smoking related…and I do the cancer end, so we work together with classes, support groups…

Discussion/Implications for Practice and Research

A navigation process has been identified for ONP navigators. This is important because research has indicated that process and outcomes are intrinsically linked (Gardner, Gardner, & O'Connell, 2013). Donabedian framework was shown to be useful in evaluating structure, process, and outcomes of nurse practitioner services. Data was collected for outcome evaluation of NP services using a mixed method design. Stakeholder surveys (n = 36), in-depth interviews (11 patients and 13 nurse practitioners), and medical records on service process were utilized. Researchers concluded that an understanding of the structure and process requirements for planning a care innovation is the basis for safe and effective patient care. Implications for further research would center upon further defining the categories of this navigation process for program

development including developing standardized metrics for patient, facility, and community components of the process. For example, in reference to assessment barriers to research recruitment, the National Cancer Institute Community Cancer Centers Program (NCCCP) addressed barriers to recruitment of patients for research studies through the use of an information technology system, a web-based tool used to collect groups of screening data entered by sites for NCI trials (Dimond et al., 2015). Web based assessment tools such as this could be used as screening tools to assess barriers to care across the three realms of this navigation process. Additionally, this type of tool could be used as a triage mechanism that would identify those at risk of not receiving and/or completing care, and barriers could be addressed accordingly within a systems context. Oncology related triage tools are of crucial importance as the best of care plans can be thwarted by an inept triage process. Furthermore, research has indicated a need to define the value of the NP role in terms of delivering patient outcomes (Grainne, Plummer, O'Brien, & Boyd, 2011). Finally, identification of standardized outcome measures will serve to promote interprofessional collaboration on a global basis.

The participants in this study had an official institutional title of navigator. The findings indicate that not all of the participants guided the patient entirely through the cancer continuum. Some guided patients only through either the diagnostic or the survivorship phase, or only up until survivorship. This indicates that not all institutions strictly adhere to the term navigator in accordance with the definition of patient navigation (ONS, AOSW, & NASW, 2010). According to Grainne, Plummer, O'Brien,

and Boyd (2011), defining what NPs do professionally promotes nursing in the global context, and helps raise the profile of nursing as a profession. This definition of navigation processes can serve to promote clarification of the navigation role, and serve as the basis for nurse practitioner training and development. Finally, the basic social process that centered on the core category was "staying connected to the patient and to the system." Factors identifying barriers to navigation care and system connectivity are in need of further definition.

Strengths and Weaknesses

The strength of this study is that it is the first of its kind to document a patient navigation process for ONPs. Since it is at level VI (I-VII) of the evidence hierarchy of research designs (Polit & Beck, 2012), further research perhaps utilizing a correlation design would be the next step.

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Table 1

Oncology Nurse Practitioner Nursing Experience

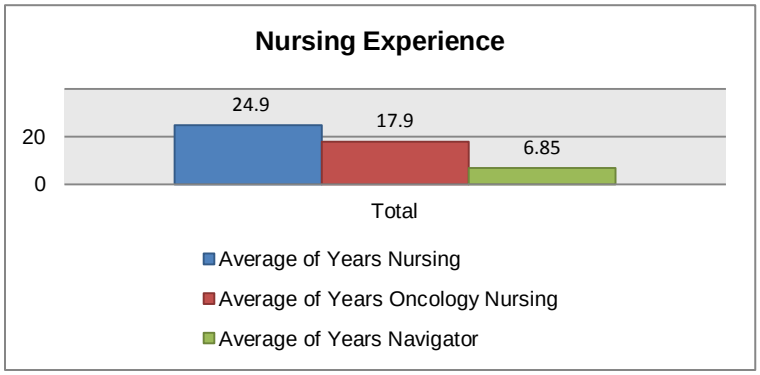

Table 2

Ethnicity

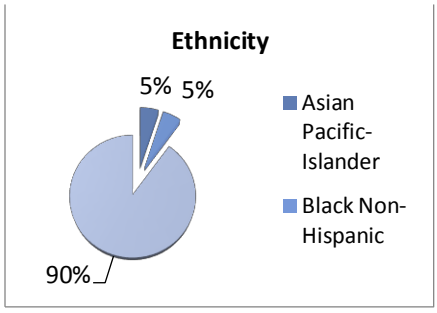

Table 3
Oncology Certifications

Certifications	Count
Certified Breast Patient Navigator CBPN-IC	1
Advanced Oncology Certified Nurse practitioner AOCNP®	4
Advanced Oncology Certified Nurse AOCN®	5
Oncology Certified Nurse OCN®	3
Survivorship Training and Rehabilitation STAR	1
Certified Navigator Breast Provider CN-BP	3
Certified Breast Care Nurse CBCN®…	2
Certified Navigator Breast RN CN-BN	3
Association of Pediatric Oncology Certified Nurses APHON®	1
Clinical Breast Examination Certification CBEC	1

Table 4

Work Setting by Certification

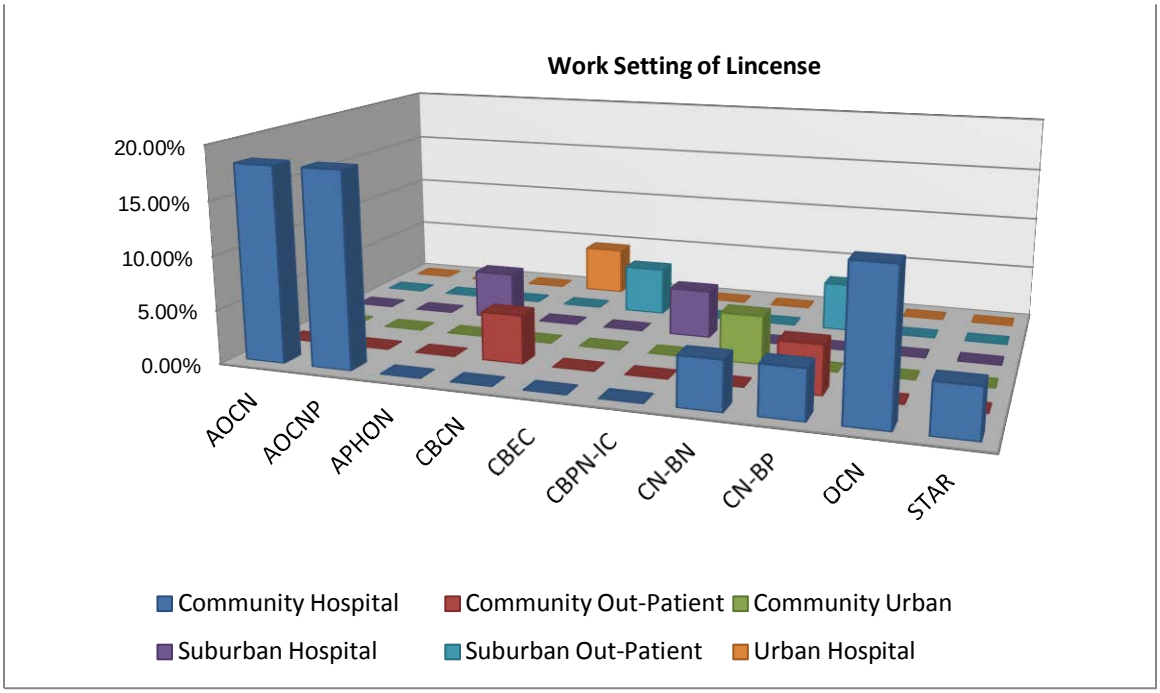

Table 5

Sampling and Data Analysis Techniques

Techniques	Process	Results
Open **Sampling**	Script reviewed for events that explained concepts	Line by line concept coding(Glaser, 1978) with NVivo software Memoing used in data analysis Returned to site to find answers to questions (Corbin & Strauss, 2008)
Constant **Comparison**	Constantly compared incidents in the research process Noted ways in which the data was the same or different from previous incidents	Variations classified using NVivo (Corbin & Strauss, 1990)
Open Coding	"breaking data apart and delineating concepts to stand for blocks of raw data" (Corbin & Strauss, 2008, p.195	Interview #7 Seventy-two concepts emerged
Axial Coding	Concepts linked into conceptual families (Corbin & Strauss, 2015	Interview #10 Theoretical saturation; eleven thematic categories
Selective **Coding**	Formulation of relationships between concepts into theoretical frameworks	Core category identified Collapsed into seven categories Cross-referenced with literature Basic Social Process identified (Corbin & Strauss, 2015) Interview nineteen: diagram (figure 3.1) Interview twenty: process confirmed with only NP to navigate to survivor stage

(Glaser, 1978); (Corbin & Strauss, 1990; 2008; 2015)

Table 6

Steps for Trustworthiness

Credibility	Information congruent with reality	Well established research technique of grounded theory Trusting relationship with participants stressing confidentiality
Transferability	Findings can be applied to other studies	Core process explaining navigation Demographic questionnaire and participant inclusion criteria designed to recruit highly experienced ONPs from various settings
Dependability	Detailed reporting of processes	Accuracy of taped transcriptions rechecked Use of NVivo software
Confirmability	Data is true to participant experience	Data reviewed with research chair Audit trail

(Guba, 1981; Shenton, 2004)

CHAPTER V SUMMARY OF THE STUDY

The purpose of this descriptive grounded theory study was to describe the process that ONP navigators use in caring for cancer patients. This chapter presents a summary of the study, conclusions, implications for practice, and recommendations for further research.

Summary

In this grounded theory study the focus was to understand the process that ONP navigators use in their clinical practice in caring for cancer patients. A semi-structured interview guide was used to collect information about this process from 20 participants. Theoretical saturation was reached with interview 10. To ensure validity of the process, the interview process continued for 9 more interviews. The last participant was the only participant that solely navigated cancer survivors. The navigation process was confirmed during this interview.

The navigation process is a patient centered process that begins in a nurse-patient relationship. It is carried out synergistically within the context of the patient, facility, and community. The components of the process are barrier-focused assessment, triaging needs, pulling in resources, and guiding to the next step. Tracking and program development are done throughout each of the components of the process.

The core category that connects this theory to practice is “expediting care along the cancer continuum.” This was the goal of the process, in that failure to carry this out would result in treatment delays. The basic social process upon which this core category was centered was staying connected to the patient and to the system. Through interfacing with the patient, facility, and community, the navigator was a center for care for all those involved in the patient’s cancer journey. Program development was an ongoing process, as these navigators paved the way for quality cancer care.

Discussion

The process of navigation for the 20 navigators interviewed included participation in processes that were part of the nurse practitioner role and navigator role. Though the nurse practitioner process includes assessment, diagnosis, planning, and evaluation, these navigators all utilized an expanded version of the nursing process during the initial assessment, which was global and focused on patient, hospital, and community barriers. The triage process focused on expediting cancer care along the continuum, with the longer term goal of getting the patient to survivorship care. The goal of expediting care was intertwined with the supportive process of staying connected to the patient and system. Navigators walked a tight rope because they had to negotiate their role within the system while being careful not to “step on physician toes.”

These navigators grappled with the fact that at times they were no longer the “provider” and thus viewed their responsibility to the patient as more supportive; they furnished all of the information patients needed to guide them along their paths, thus

empowering patients to make informed choices. If the system was set up so that the navigator had structured clinic time, the traditional NP role was more evident. All in all the navigators walked a tightrope as they fluctuated between the typical NP role and supportive care. Billing was a challenge, and several mentioned the lack of a billing system for the navigation process.

The process of navigation was far reaching in that the navigator system included the patient, institution, and community. ONPs developed a process of navigation that was uniquely defined for their organization; they utilized many unique processes to connect patient care within the community and even state programs in a few instances. Metrics were employed to gauge the timeliness and quality of care. As these NPs forged ahead to individually carve this role for the patient, system, and community, they indicated unanimously that lack of time, and in some cases lack of support for the role by physicians, were major barriers in caring for patients. These barriers were eased in some instances by collecting data and justifying more help to create subsystems for navigation, as well as negotiating role functions with the physicians and institutions.

These navigators were frontiers women who carved out processes for their institution that included, but were not limited to, creating novel approaches to patient care. Examples were creation of new roles such as using a primary care oncologist for survivorship, working alongside an RN navigator to assess and intervene with anxiety management, hiring additional specialist NP navigators, and hiring an RN navigator to work in the team.

The navigators indicated that the navigation needs were heavier during the diagnostic phase of cancer and for disadvantaged patients with few resources. Scarcity of resources, lack of time, and lack of support from key players involved in patient care were challenges faced by navigators.

This study adds support to the social interaction theory as proposed by Mead. The social process involved in forming the self occurs through interaction between these forms and results in the formation of the self-concept. The self-concept is derived by one's communication with self and is formed by continuous interaction between the "I" and the "Me" (Mead, 1965). According to Mead (1965), the "I" acts, but the "me" evaluates and interprets. Mead refers to the "generalized other" which can be individuals, social groups, or communities. According to Mead (1965), "The organized community or social group which gives to the individual this unity of self may be called the 'generalized other' " (p. 154). In order to develop in the fullest, an individual must not only take on the attitude of others, but must assimilate the attitudes of others towards oneself and other people, taking into consideration their attitudes towards the social activity or group in which they are engaged. The attitudes are then generalized, and the person acts towards the bigger phase of the social process which according to Mead (1965) "… constitutes its life and of which these projects are specific manifestations" (p. 155).

The navigators in this study developed the social process of navigation by negotiating with key people who participated in oncology patient care. The meaning of

navigation was formed through the everyday social interaction between patient, ONP, facility, and community. Through this process, the navigator uniquely carved the role for the institution. All navigators participated in some type of program development designed to expedite care. This involved carving the NP navigator role, the goal of which was to utilize knowledge and skills of the navigators so that they could practice to the highest levels of their licensure. In some cases this was possible; in other cases, it was a sought after goal.

Novel roles and partnerships were developed based on perceived patient need. These ranged from RN and social worker partnerships as well as partnerships with non-licensed personnel. Key ties within the community, such as with lay navigators or other systems, were other avenues. In some instances, multidisciplinary group rounds were used to accommodate a large volume of patients with heavy navigation needs. In other cases, navigation infrasystems were developed within the facility, with well-defined processes. One navigator fluctuated between the roles of “administrator” and “provider” so that patients without a provider would not stagnate within the system. Generally, the navigation process was molded around the needs of the patient, and adjusted to expedite patient care.

Metrics and Navigation Tools

The major goal for the navigation process was high outcomes. Outcomes were measured by metrics. Closely intertwined with the metrics were navigation tools that facilitated the tracking of these metrics. Metrics fell within two categories, patient metrics

and system metrics. System metrics included both the hospital system and in some instances the community. Tracking tools were used to gauge these metrics for the patients.

Conclusions

Conclusions derived from this study include:

1. The ONP navigation process is a process that is carried out synergistically within the context of the patient, facility, and community, and consists of a barrier-focused assessment, triaging, pulling in resources, guiding to the next step, tracking, and program development.
2. The overall goal of the ONP navigation process is to expedite care along the cancer continuum.
3. The core category for the process is staying connected to the patient and to the system.
4. Patient, facility, and community metrics are used to gauge the progress of the navigation process, which is tracked through the use of tracking tools.
5. The goal of the process overall is guiding the patient through the system to survivorship care.
6. Not all navigators care for patients through the survivorship phase of the cancer continuum. A common placement for the ONP navigator is in the diagnostic phase of the continuum; the advantage of prescriptive authority expedites care by bypassing the step of obtaining a physician order.

7. ONP navigators throughout the process continually develop unique navigation programs for the patient, the facility, and the community.
8. Novel approaches to patient care are created that include the patient, the facility, and the community.
9. The goal of expediting care is intertwined with the supportive process of staying connected to patient and system; novel approaches to care are negotiated between the patient, the facility, and the community.
10. In carving the ONP navigation process, navigators seek to practice to the highest level of their licensure, possible in some cases and not in others. Key contacts are instrumental in facilitating the definition of the ONP navigator role.
11. Program development is evident and ongoing in all steps of the navigation process and in all partnerships, evolving to manifest a navigation system.

Implications for Practice

Based on the findings of this study, the following recommendations for nursing practice are included:

- Strategically designed process mapping is essential in defining a navigation program that involves each step of the ONP navigation process within the context of patient, facility, and community.
- ONP navigation goals should incorporate well defined metrics and tracking systems that incorporate the patient, the facility, and the community across all phases of the cancer continuum.

- Administrative support is essential for identifying committees involving patient, facility, and community that can include ONP navigators and their input in reference to evaluating care utilizing benchmark standards of care.
- Regular meetings with administration are essential in order to identify barriers that ONPs encounter to "staying connected to the patient and to the system."
- A well-defined job description entailing ONP scope of practice that incorporates utilizing the ONP to the highest level of licensure is essential prior to initiating the role.

Implications for Research

- Regular review of success of metrics in reference to care transitions between phases of the cancer continuum is of paramount importance.
- ONP input in reference to matching evaluation processes of facility metrics with community, state, and other universal metrics is essential for evaluation of cancer control.
- Ongoing development of standardized tools that measure key metrics on a patient, facility, and community level, and evaluation of their impact on expediting care on patient, facility, and community levels is critical in further defining the process.
- The cost effectiveness of utilizing an ONP patient navigator is in need of further exploration.

- Further exploration of variations in the ONP role in hospital versus community settings, as well as rural versus urban settings is needed.

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APPENDIX A

Recruitment Script

Hello,

My name is Frances Mary Johnson. I am a doctoral student at Texas Woman's University. I am doing a study pertaining to how Oncology Nurse Practitioner Navigators perform their job. I would like to know if you would like to participate in this study.

To be eligible for this study you must:

1) Have a license to practice as an NP in your respective state, 2) Have a certification to practice as an oncology nurse, 3) Have at least 5 full time years' experience, practicing in oncology nursing, and 4) Be English speaking.

If you meet these criteria and would like to participate in the study, the time commitment is no more than 75 minutes. You will receive a $25 gift card for your time. The interview can be conducted over the telephone or in person. The study includes an audiotaped interview. You will be asked questions in reference to how you perform your job. The results are strictly confidential.

If you would like to participate, please contact me at email FJohnson1@twu.edu or telephone/text at 281-300-2635.

Thank-you very much for your interest.

Sincerely,

Frances Mary Johnson, MSN, AOCN, Oncology NP

APPENDIX B

Recruitment Flyer

NOW RECRUITING

Nurse Practitioner Navigators Caring for Oncology Patients

Purpose of the study:
A study with Oncology Nurse Practitioner Navigators to identify how they go about performing their job.

This study is 100% confidential

Time Involvement:
About 75 minutes

Date of Interview:
According to your schedule & convenience
Can be done over telephone or in-person

$25 Gift Card Provided

Contact:
Frances Mary Johnson, MSN
TWU Doctoral Nursing Student
FJohnson1@twu.edu

281-XXX-XXXX (call or text)

APPENDIX C

Informed Consent

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: The Process of Oncology Nurse Practitioner Patient Navigation

Investigator: Frances Mary Johnson, MSN 281-xxx-xxxx
Advisor: Peggy Landrum, PhD 713-xxx-xxxx

Explanation and Purpose of the Research
You are being asked to participate in a research study for Ms. Frances Johnson's dissertation at Texas Woman's University. The purpose of this research is to gain a better understanding of the processes that oncology nurse practitioner navigators use in caring for cancer patients.

Research Procedures
If you agree to participate and sign the consent form, you will then complete a demographic questionnaire that will ask you questions about your gender, years of experience in nursing and as a nurse navigator, year graduated from nursing school, and setting in which you practice. There will be an interview during which you are asked questions in reference to how you perform your job as an oncology nurse practitioner navigator. The interview will be conducted either on the telephone or at a location convenient to you. The interview is audiotaped. At the end of the interview you will receive a $25 gift card. The entire process will last no longer than 75 minutes.

You have the liberty to decline participation in the study without any type of consequences or penalty. Your participation in the study is completely voluntary, and should you agree to participate, you may leave the study at any time.

Potential Risks
Potential risks related to your participation in the study are minimal, and include loss of confidentiality, discomfort and/or embarrassment, and fatigue during the interview. ***Confidentiality will be protected to the extent that it is required by law.*** To avoid loss of confidentiality, a code name rather than the participants' real names will be used on the transcription. Audiotapes, data, and data analysis files will be retained in a locked file cabinet in the principle investigator's office. Only the investigator and dissertation committee will have access to the data. If you feel discomfort and/or embarrassment regarding the interview questions, you may refuse to answer the questions. The PI will stop the interview if the participant is distressed, and will refer the participant to their health care provider if necessary.

Another possible risk to you as a result of your participation in this study is fatigue. If this occurs, the participant will be able to take a break and/or stop the interview at any time. The taped and transcription jump drives will be erased and the hard copies of the transcriptions will be destroyed by July 2019. It is anticipated that the results of the study will be published in the investigator's dissertation as well as in other research publications. However, no names or other identifying information will be included in any publication.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Initials

Participation and Benefits
Your involvement in this research study is completely voluntary, and you may discontinue your participation in the study at any time without penalty. The only direct benefit of this study to you is that at the completion of the study a summary of the results will be mailed to you upon request.*

Questions Regarding the Study
If you have any questions about the research study you may ask the researchers; their phone numbers are at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research at 713-794-2840 or via e-mail at IRB@twu.edu. You will be given a copy of this signed and dated consent form to keep.

_____ _____
Signature of Participant Date

The above consent form was read, discussed, and signed in my presence. In my opinion, the person signing said consent form did so freely and with full knowledge of its contents.

_____ _____
Signature of Investigator Date

* If you would like to receive a summary of the results of this study, please provide an e-mail or physical address to which this summary should be sent:

E-mail: _____
OR
Address: _____
_____
_____

Participation and Benefits

Your involvement in this research study is completely voluntary, and you may discontinue your participation in the study at any time without penalty. The only direct benefit of this study to you is that at the completion of the study a summary of the results will be mailed to you upon request.•

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_____ _____

Signature of Participant Date

The above consent fonn was read, discussed, and signed in my presence. In my opinion, the person signing said consent fonn did so freely and with full knowledge of its contents.

_____ _____

Signature of Investigator Date

• If you would like to receive a summary of the results of this study, please provide an e-mail or physical address to which this summary should be sent:

E-mail: _____

OR

Address: _____

_____

_____

APPENDIX D

Demographic Questionnaire

1. Age in years _____

2. Gender: ____ Female___ Male

3. Race/Ethnicity:_____

4. What year did you graduate from basic nursing program? _____

5. Highest nursing degree? _____

6. How many years have you worked as a nurse? _____

7. What state(s) are you licensed to practice in as a NP? _____

8. What nursing certifications do you have? _____

9. How many years have you been practicing oncology nursing? _____

10. How many year have you worked in this facility as a navigator? _____

11. Describe your practice setting_____

For the following questions, check one answer:
If you work in a hospital please answer questions #12 and #13

12. Your hospital is a:

____Community hospital _____Rural hospital _____Urban hospital _____Suburban hospital

Other_____(please explain)

13. Your hospital is a:_____Teaching facility _____Non-teaching facility

If you work in an out-patient setting please answer questions #14 and #15

14. Your outpatient setting is a:

___ Community out-patient setting ____ Rural out-patient setting ___ Urban out-patient setting ____ Suburban out-patient setting_____
Other _____ (please explain)

15. Your out-patient setting is a:___Teaching facility_____Non-teaching facility

APPENDIX E

Interview Questionnaire

What processes do Nurse Practitioner navigators use in caring for cancer patients?

1. Tell me about a typical day in your role as a NP navigator when caring for a cancer patient.
   1.1 What are your different role functions?
      1.1.1 Tell me about an example of X? Of Y?
2. How do you know your job as navigator was done?
3. What do you find challenging about the role?
   3.1.Tell me about an example of a challenging time.
4. How would you mentor an NP to become a nurse navigator?
5. What characteristics or skills do you possess that help you to do your job well?
6. What are the important things for the new NP nurse navigator to learn?
   6.1. Give me an example of how that works in your role.
7. How has your education and training prepared you for this role?
8. What else will help me to understand how you do your job?
   8.1. Probe: You mentioned --- can you give me more specifics……..?
9. What are your overall goals for navigating an oncology patient in your health care facility?
10. What kind of a structure do you use when outlining your navigation plan of care?
11. What are some of the differences between your nurse practitioner duties versus your navigator duties?
12. Tell me about a patient that you have successfully navigated from start to finish?
13. What does you hospital do to monitor the navigation process in respect to process improvement?
14. What gets in the way of you performing your jobs as a navigator?
15. Describe some of your most challenging navigation processes…and what you did to overcome the barriers to patient care?

APPENDIX F

Axial Coding

-Comprehensive Assessment and Plan Focusing on Barriers to Care
- Cancer Risk Assessment
- Global Assessment
  - -Needs Assessment
- Barrier Removal
  - -Addressing Insurance and Funding Issues
  - -Transportation
- Initial Contact
- Consults

-Staying Connected
- Nutrition Counseling
- Key Contacts (fosters relationships) (1)
  - Relationship with Boss
- Passion for the job
- Multidisciplinary Conference
- Completion of Job

-Supportive Care
- Accompanies Patient to Appointments
- Counseling
- Patient Education
  - -Initial Patient Education Binder
- Support Group Patient
- Confidante Patient
- Empowerment
- Manage Stress Navigator
- Manage Stress Patient

-Guiding Survivorship Care
- Health Promotion
- Survivorship Connection

-Integrating Community Support
- Community Involvement

-Carving the Role
- Difference between RN Navigator Versus NP Navigator
- Differences between NP Versus Navigator Duties
  - Traditional NP Role
  - Symptom Management
  - Rehabilitation
  - Screening
  - Hospital Rounds
  - New Patient Consults
  - Pathology Report Notification
  - Administrative Meetings
  - Traditional Appointment Set

Key Contacts (Identifies) (2)
Relationship with Boss
Navigation Billing
Navigator Role
Ways Education and Training Helped with the Role
Challenges of Navigation
Novel Role

-Program Development

Process Improvement
NP Standards of Care
Co-ordination of Lung Nodule conference and Program
Teaches Nurses
Educator for Hospital Ancillary Personnel
Navigation Training
Nursing Research
Mentor New Navigator

-Tracking along the Continuum

Navigation Tools
Patient Charting
Metrics

-Working within Navigation Model

Navigation Structure
Oversees Office Personnel
Point of Entry

-Triaging Care to Ensure Timely Access

Scheduled Patient Appointments
-Appointment setting
-Timely Scheduling of Patient Appointments
Streamlines Care for Physicians
Initial Presentation of Treatment Options
Initial Breast Appointment
Initial Clinical Trial Information
Providing Referrals
-Initial Referral Provider
-Case Management
Guiding Patient to the Next Step
Triaging Navigation Care

Navigator Characteristics

APPENDIX G

Core Category with Selective Codes

Core Category- **EXPEDITING CARE ALONG THE CANCER CONTINUUM**

Basic Social Process **STAYING CONNECTED TO THE PATIENT AND TO THE SYSTEM**

Comprehensive Assessment
    Needs Assessment
Triaging Care to Ensure Timely Access
    Navigation goal
Care Coordination/Pulling in Resources
    Key Contacts
Tracking
    Tracking along the Continuum
Guiding Survivorship Care
    Survivorship Connection
Guiding the Patient to the Next Step
    Supportive Care in General
Program Development/Carving a Role
    Navigation Role

APPENDIX H

Institutional Review Board Approval Letters

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Institutional Review Board
Office of Research
6700 Fannin, Houston, TX 77030
713-794-2480
mjackson3@twu.edu
http://www.twu.edu/rb.html

DATE: September 2, 2014

TO: Ms. Frances Mary Johnson
College of Nursing - Houston

FROM: Institutional Review Board - Houston

Re: Approval for The Process of Oncology Nurse Practitioner Patient Navigation (Protocol#:17787)

The above referenced study has been reviewed and approved by the Houston Institutional Review Board (IRB) on 9/2/2014 using an expedited review procedure. This approval is valid for one year and expires on 9/2/2015. The IRB will send an email notification 45 days prior to the expiration date with instructions to extend or close the study. It is your responsibility to request an extension for the study if it is not yet complete, to close the protocol file when the study is complete, and to make certain that the study is not conducted beyond the expiration date.

If applicable, agency approval letters must be submitted to the IRB upon receipt prior to any data collection at that agency. A copy of the approved consent form with the IRB approval stamp is enclosed. Please use the consent form with the most recent approval date stamp when obtaining consent from your participants. A copy of the signed consent forms must be submitted with the request to close the study file at the completion of the study.

Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc. Dr. Brenda Binder, College of Nursing - Houston
Peggy Landrum, PhD, College of Nursing - Houston
Graduate School

TWU
TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Institutional Review Board
Office of Research
6700 Fannin, Houston, TX 77030
713-794-2480
mjackson3@twu.edu
http://www.twu.edu/irb.html

DATE: July 27, 2015

TO: Ms. Frances Mary Johnson
Nursing - Houston

FROM: Institutional Review Board - Houston

Re: Extension for The Process of Oncology Nurse Practitioner Patient Navigation (Protocol tt: 17787)

The request for an extension of your IRB approval for the above referenced study has been reviewed by the 1WU Institutional Review Board (IRB) and appears to meet our requirements for the protection of individuals' rights.

If applicable, agency approval letters must be submitted to the IRB upon receipt PRIOR to any data collection at that agency. If subject recruitment is on-going, a copy of the approved consent form with the IRB approval stamp is enclosed. Please use the consent form with the most recent approval date stamp when obtaining consent from your participants. A copy of the signed consent forms must be submitted with the request to close the study file at the completion of the study.

This extension is valid one year from September 2, 2015. Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any unanticipated incidents. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc. Dr. Brenda Binder, Nursing - Houston
Dr. Peggy Landrum, Nursing - Houston
Graduate School

APPENDIX J

Manuscript Submission Acknowledgement

On Jul 3, 2016 3:46 AM, "Editor" <editorijhm@gmail.com> wrote:

Dear Frances

We will have your article's final review feedback, soon. The initial feedback was very positive.

Many
thanks

Paulo

Paulo Moreira, PhD
Editor-in-Chief

No dia 2 de Jul de 2016, C s 01:21, Frances Johnson <fjohnson1@twu.edu> escreveu:

Dear editor

Can you please tell me when you would know if my article "The Process of Oncology Nurse Practitioner Patient Navigation: A Grounded Theory Approach " has been accepted for review?

Thank-you,

Frances Johnson, Nurse Practitioner