The Infirmière Pivot en Oncologie (IPO) was implemented in 2005 in Québec, however many questions remain around how many IPOs are required to meet patient needs. This presentation describes milestones in provincial human resources (HR) planning for IPO services. The adequate caseload for an IPO to appropriately intervene with cancer patients has been a recurrent question from the nurses themselves and the Quebec Ministry of Health. A provincial study conducted in 2012 examined IPO interventions and the time required for each intervention at different phases along a typical patient trajectory. The time requirements were determined by an expert panel and confirmed using a Delphi method to obtain consensus among all IPOs working in the province. This professional consensus was compared to how IPOs currently spend their time using a time-and-motion technique. The 2 sets of study data, professional consensus on time requirements, and time-and-motion studies provided the basis to estimate the number of IPOs required at the local, regional and provincial levels. The inevitable next question in a context of limited human and financial resources regarded how to prioritize patients for IPO services. The Direction québecoise de cancérologie mandated a subgroup to appropriately identify the patients who would benefit the most from the interventions of the IPO. This workgroup is currently reviewing the evidence and consulting with different partners.

In Quebec, the Infirmière Pivot en Oncologie (IPO) was established in 2005, and over 250 oncology nurses currently fulfill the navigator role for the 49,100 newly diagnosed cancer patients in the province each year. This presentation by Biron and Saucier offered highlights of 3 phases of an ongoing study aimed at adding specificity to the IPO role. These include HR planning to determine how many IPOs are needed to meet the Quebec provincial target of 70% of people with a diagnosis of cancer having access to a IPO (2012–2017); identification of criteria for prioritization of patients and families who need to be followed by an IPO; and development and testing of risk assessment tools to identify patients and families requiring care by an IPO.

**SIGNIFICANCE**

This study adds to our knowledge about how best to align patient needs, from basic to complex, with IPO resources across the cancer trajectory. Moving beyond Dr. Freeman’s original conceptualization of implementing navigator roles to remove barriers and improve equal access to care, this study is laying the foundation for a systematic process of identifying the most vulnerable patients to ensure they have priority access to IPO care. Further, in a fiscally constrained environment, it is important to clarify how many IPO resources are needed to meet priority patient needs, rather than determine numbers solely through ideologies of scarcity and efficiency that can further marginalize vulnerable groups.

**VALIDATE, CALCULATE, PRIORITIZE**

This study builds upon the foundational work by Skrutkowski et al. to validate the IPO role dimensions (i.e. care coordination, symptom management, teaching and support) and quantify the time it takes to deliver priority interventions within these role dimensions.

Using a nominal group technique and consensus-building Delphi process across local, regional and supraregional sites, in the first phase of this study the investigators identified 29 interventions that were prioritized across different phases of the cancer trajectory (i.e. diagnosis, surgical treatment, chemotherapy treatment, radiotherapy treatment, posttreatment followup, and transition to palliative care). The estimated time required for each intervention was also considered within this consensus-building process. For example, during the diagnostic period, participants estimated it takes 120 minutes (spread over 1 month) to assess patients’ biopsychosocial needs and provide information.
and education about the diagnosis, treatment, exams, next steps and available resources.

A time-and-motion study was then undertaken to directly observe time spent on IPO interventions, as well as other duties, including administrative meetings and elements of non-value-added care, such as waiting for someone or searching for something. Two experts spent 213 hours observing 26 IPOs delivering care to patients across the cancer trajectory. The investigators used this information to calculate average times for IPOs to deliver each of the 29 interventions. Sixty-eight percent of the IPO time was spent on clinical interventions, such as assessment, teaching, support and documentation. Of these interventions, 63.4% were face to face and 36.6% were over the phone. Coordination of care took 21.8% of IPO time. An additional 19% of time was spent on organizational activities (waiting, searching, travel, team meetings, breaks, other). The information gathered, along with time requirements identified through the professional consensus for each phase of the illness trajectory, could then be used to build the manpower plan. Total time requirements are multiplied by the number of patients going through each phase of the cancer trajectory.

The second phase of this study sought to determine which patients need an IPO most. Using a nominal group technique, 5 criteria were identified to initiate IPO care: 1. Complex psychosocial situation (e.g. inadequate social support); 2. Presence of comorbidities (e.g. multiple and disabling); 3. Severity of the illness (e.g. poor prognosis); 4. Treatment complexity (e.g. several modalities); 5. Management of symptoms (frequent, multiple and complex). Criteria to end IPO care were identified as: transfer to another centre, IPO or to palliative care; patient choice to end care by IPO; and death.

Phase 3 of the study is ongoing and is seeking to develop a risk assessment tool to be used by IPOs to prioritize care according to patient needs. A prioritization tool was developed based on literature review to include indicators of overall risk for complications, including age, functional status, support, emotional distress, treatment-related symptoms and comorbidity. This tool will now be tested in two clinical settings to determine how accurately it identifies the patients who need to be seen by the IPO more urgently. This triage tool will be compared to the triage/assessment process currently used by the IPOs.

**OUTCOMES AND ROLES**

Helpful next steps may include determining the impact of this triage/risk stratification system on patient outcomes, such as quality of life, symptom burden and other patient reported outcomes. An assessment of resource utilization patterns and outcomes that includes patients who do not receive IPO care will also be helpful to determine the impact of IPOs on other healthcare providers, including those in primary care. It is likely that better utilization of IPO roles to address complex patient needs may have an impact on Clinical Nurse Specialist and Nurse Practitioner roles; role delineation and areas of overlap may need to be clarified in the process of evolving the IPO role. Interface with primary-care and chronic-care systems should also be explored, as older cancer survivors may have long-term treatment sequelae and comorbid conditions.

**Tools to identify priority groups/individuals in this study will also benefit provinces and care settings where specific navigator roles are not currently implemented. Navigation is a standard of care and core competency of all specialized oncology nursing care.**

**What this study showed**

- A 3-phased research process validated the IPO role dimensions, articulated criteria for prioritizing complex patient and family needs, and quantified the time to deliver priority interventions to patients and families with cancer.
- This new knowledge will assist in building the provincial HR plan necessary to optimize alignment for IPO resources to priority patient and family needs in Quebec.

**Next steps**

- Plans are underway to test a draft risk assessment tool in 2 clinical settings to determine feasibility and efficacy in identifying those patients and families who are most at risk and require priority care by an IPO.
- Helpful next steps may include determining the impact of this triage/risk stratification system on patient and family outcomes.
LANDMARKS

References