UNC Health Cancer Navigation Case Study

Navigation at UNC has evolved over more than 15 years in response to what we have learned from our patients, our teams, and the increasing complexity of cancer care. At its core, the work has always been about helping patients get where they need to go and making a complicated healthcare system a little easier to navigate.

Clinical nurse navigation began at our flagship academic medical center in 2010, with disease-specific navigators providing clinical expertise, education, coordination, triage, and continuity. For many years, those same nurses also addressed the broad range of psychosocial and practical barriers experienced by their patients. As volumes and complexity grew, this became increasingly difficult. Nurse navigators were balancing significant clinical responsibilities while also trying to address transportation, financial concerns, caregiver needs, health literacy, social determinants of health, and connection to community resources. All of the work was important, but there were simply too many competing priorities for one role.

In 2021, Central Navigation was developed as a complementary model, beginning with three nurse navigators and three Oncology Patient Navigators (OPNs). The OPN role was specifically designed to focus on non-medical barriers to care, creating additional capacity around clinical navigation and allowing each discipline to work more consistently within its area of expertise.

The timing of that development mattered. Much of the early work occurred during and immediately following COVID, when communication, staffing, and clinical workflows looked very different. Central and clinical navigation continued to evolve, but often in parallel. Both programs developed important strengths, but the relationships and workflows connecting them did not always develop at the same pace.

Over the next several years, Central Navigation expanded across medical oncology disease groups and Rapid Access programs. Standardized risk and barrier assessments, social determinants of health screening, Epic documentation, and pre-consult outreach helped move navigation from primarily reactive referrals toward earlier identification of patient needs. At our academic medical center, the OPN team has grown from three to 14 FTEs, while clinical navigation has expanded to approximately 57 FTEs across medical, surgical, and hematologic oncology.

That growth has taught us an important lesson: building programs may be easier than integrating them. Our biggest challenge now is creating the relationships, workflows, and shared understanding that allow those resources to function as one navigation system. We are intentionally moving away from thinking about “Central” versus “Clinical” Navigation

and toward UNC Health Cancer Navigation. This does not mean everyone does the same work. In fact, successful integration depends on preserving different areas of expertise while becoming much better at handing work back and forth. A clinical navigator needs to trust that an OPN can take ownership of an appropriate non-medical barrier; an OPN needs to recognize when a concern requires clinical assessment and confidently bring the nurse navigator back in. Those handoffs sound straightforward on paper but require role clarity, communication, relationships, and trust to work consistently.

The next phase takes this work beyond the academic medical center and across the Cancer Service Line. Our intent is not to replicate one staffing model at every UNC Health entity. There are already navigators, nurses, care managers, social workers, financial navigators, and other care coordination teammates doing important work locally. Our opportunity is to understand and leverage those existing resources while creating enough shared language, expectations, tools, and connectivity to function as a larger system.

This makes planning and communication inseparable from implementation. Planning must include the people closest to the work and begin with what the patient needs rather than an org chart. Communication must create shared understanding across teams with different histories, reporting structures, terminology, and established ways of working. “We have always done it this way” is a very real implementation challenge, but it also represents experience and relationships we do not want to lose.

For that reason, implementation cannot be a single launch. Our approach will need to remain iterative: plan, communicate, implement, listen, adjust, and try again. Some longstanding practices will need to change; others should be preserved. The work is determining the difference together.

Ultimately, patients should not need to understand our org charts, reporting structures, or which team employs the person helping them. They should experience a connected system that recognizes what they need and gets them to the right person at the right time.

That is the longer-term vision for UNC Health Cancer Navigation.