



# Population Health Navigators

## An Innovative Approach for Supporting Underserved Patients

**T**he patient navigation world has a new kid on the block. Just when we thought we knew everything there was to know about navigators, the role has been reinvented by a concept so intuitive, it is difficult to believe that these navigators are not standard practice in oncology. By now, most cancer programs and practices across the United States have introduced at least one type of navigator into their ecosystem—whether as nurse, lay, patient, clinical, disease-specific, or financial—navigators have become an integral component of comprehensive, high-quality patient care. Yet the trailblazing team at the Office of Cancer Health Equity at Atrium Health Wake Forest Baptist’s comprehensive cancer center in Winston-Salem, N.C., introduced an approach that has the potential to reshape the navigation landscape.

Meet population health navigators—individuals who are dedicated to supporting a specific underserved population, including rural, Black (African American), and Hispanic populations, through culturally and linguistically competent navigation services for patients with cancer, their families, and their caregivers. These navigators share a cultural connection and language with their patients and are non-clinical professionals—legal specialists, social workers, advocacy experts—who bring valuable, real-world skills and experiences to patients’ cancer journey and help break down barriers more effectively by understanding the nuances of a patient’s culture, language, and identity.

### Making the Case for Population Health Navigators

Far too often, underserved populations face inequities during their cancer care journey and encounter unique barriers. Atrium Health Wake Forest Baptist’s novel approach addresses these health disparities by designating population health navigators who assist patients with cancer in overcoming healthcare system- and social-related barriers, facilitate timely access to quality medical and supportive care, and educate our underserved and

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underrepresented patients with critical information about the role of research and clinical trials in cancer care. While other cancer programs and practices may have bilingual navigators, Atrium Health Wake Forest Baptist is the only comprehensive cancer program in the U.S. with population health navigation—support services focused on the specific patient population being served, rather than focusing on a specific disease and attuning navigation services with all the linguistic, cultural, and societal implications that impact a patient’s cancer experience. A Black patient being helped by a Black navigator will have a different impact because of their shared culture and community; there is a higher level of initial trust that can be bridged between these two. If we really want to address underserved populations and health equity, instead of expecting patients to meet us at the level that we operate, even with basic things like the language and word choices we make, we need to meet patients where they are at.

And that, we have done. Our latest comprehensive review of underserved patients navigated by Atrium Health Wake Forest Baptist’s population health navigators between September 2019 and August 2022 revealed that 773 patients (231 Hispanic, 239

**Table 1. Underserved Patients Navigated, Sept. 1, 2019 to Aug. 31, 2022 (n=773)**

CATEGORY	Rural Patients n=303		Black Patients n=239		Hispanic Patients n=231	
	Number	Percentage	Number	Percentage	Number	Percentage
<b>GENDER</b>						
Female	148	49%	143	61%	142	61%
Male	155	51%	96	39%	89	39%
<b>AGE</b>						
0-17	1	<1%	1	<1%	5	2%
18-34	11	4%	17	7%	19	8%
35-59	95	31%	98	41%	150	65%
60+	196	65%	123	51%	57	25%w
<b>TYPE OF CANCER</b>						
Brain	13	4%	7	3%	7	3%
Breast	30	10%	53	22%	46	20%
Gastrointestinal	38	13%	15	6%	41	18%
Genitourinary	16	5%	4	2%	12	5%
Gynecologic	15	5%	17	7%	30	13%
Head & Neck	23	8%	13	5%	10	4%
Hematologic	69	23%	43	18%	54	23%
Thoracic	92	30%	53	22%	16	7%
Other	7	2%	34	14%	15	6%

Black, and 303 rural) were successfully navigated (Table 1, above). Our population health navigators have assisted patients across a broad spectrum of issues specific to their needs. While the most common barriers were related to treatment logistics, including transportation and financial and/or insurance issues for all patients, communication was the next most significant barrier for Hispanic patients, practical needs for Black patients, and information and education for rural patients (Figure 1, page 36).

Furthermore, the rates of participation in clinical trials for navigated patients are higher than for unnavigated patients with cancer prior to program implementation: 36 percent of rural patients, 32 percent of Black patients, and 31 percent of Hispanic patients with population health navigators are participating in clinical trials (Figure 2, page 36)—a tremendous achievement among patient populations that are underrepresented in clinical research in general.

Our team is making the business case for population health navigation and proving that there is a place for this unique comprehensive cancer care service at the navigation table.

### The Evolution of Population Health Navigators

The program started out as a single position. When I joined the cancer center almost 11 years ago, one of my tasks was to do outreach in the Hispanic community and address the challenges and barriers to cancer care this community faced. What came up—repeatedly—were challenges around language and culture, as well as barriers in the clinic when trying to get treatment and work through the health system. When there are immigration status or insurance-related issues, patients experience even more barriers to care. Thus, the first population health navigator position was our Hispanic patient navigator.

The early days of the population health navigator program looked vastly different from what it has become today. The first population health navigator, grant-funded and working primarily independently, was focused simply on connecting with each Hispanic patient that came through the cancer center to determine if they had needs or potential barriers to care; there were no other models or programs from which our first navigator could draw direct experience. In fact, at the time, the concept of “navigators” in the local area was limited to clinical navigators, primarily for

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Figure 1. Patient Barriers to Care by Underserved Population

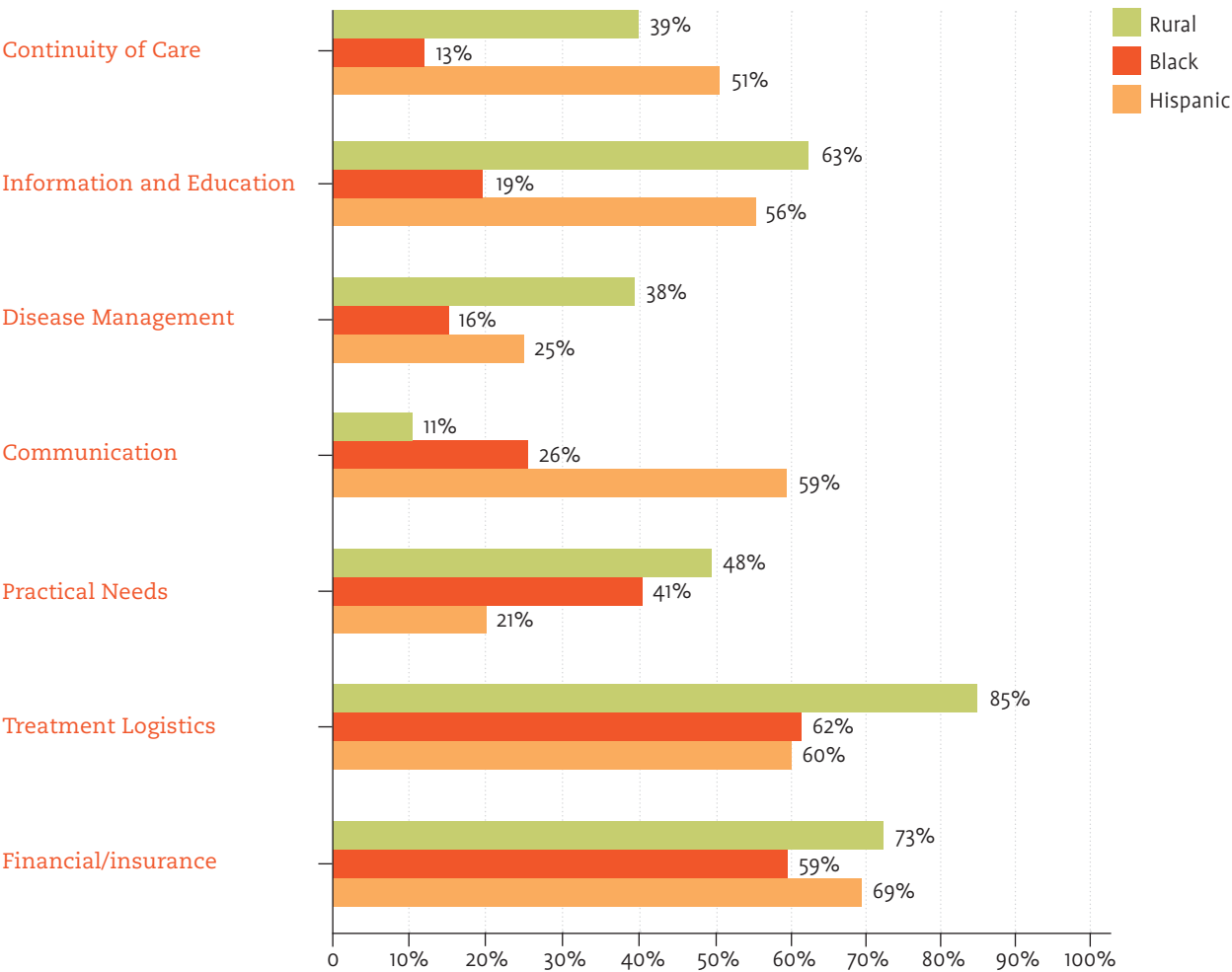
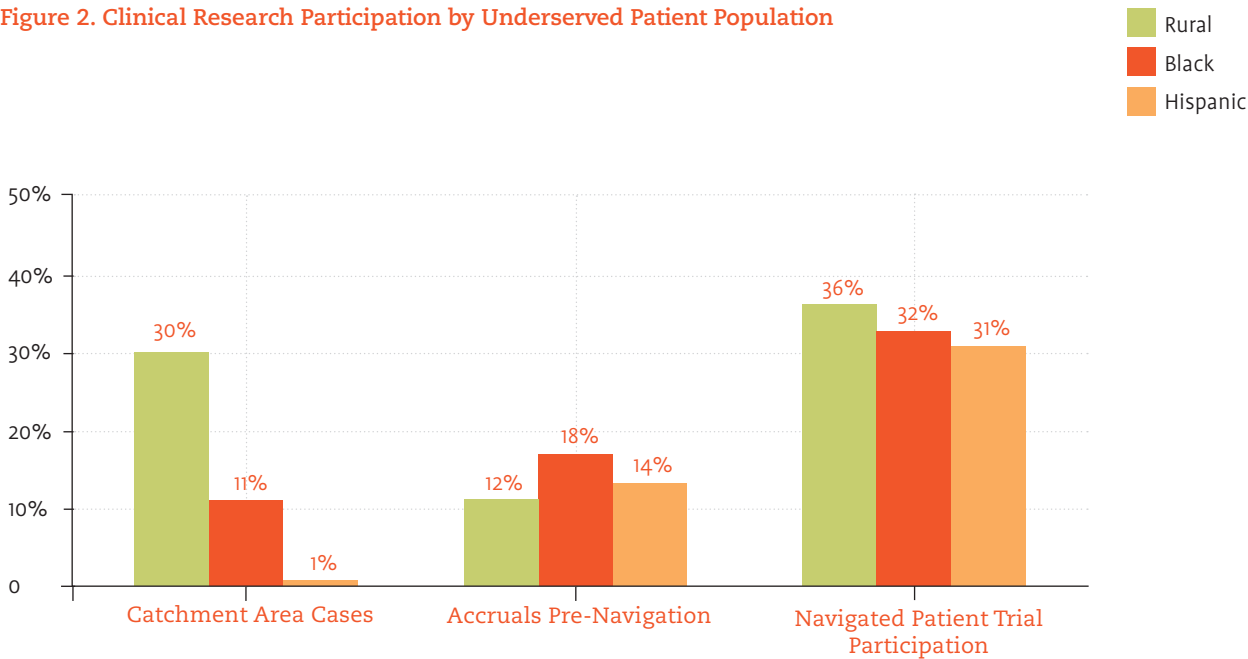


Figure 2. Clinical Research Participation by Underserved Patient Population





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breast health. Most providers had no idea what a population health navigator was or what exactly they could do. Even now, because population health navigation may not be easily understood, we sometimes refer to it as underserved patient navigation.

Yet by 2018, under the tutelage of our previous leader—Karen Winkfield, MD, PhD, professor in the Department of Radiation Oncology at Vanderbilt University Medical Center, Vanderbilt-Ingram Cancer Center—who served as the director of the Office of Cancer Health Equity at the time, the program flourished. Building on the initial success of the inaugural Hispanic population health navigator and by obtaining grants to fund additional full-time equivalents, Dr. Winkfield advocated for the development and growth of our program.

### From a Person to a Program

To understand the direction the population health navigation program took next, it is important to understand the geographic and historical identity of Winston-Salem. As a gateway city, Winston-Salem connects the mountainous, Appalachian region of North Carolina and predominantly homogenous rural communities with the more urban northwest Piedmont region of the state. In contrast, Winston-Salem and its surrounding county, according to 2021 U.S. Census Bureau estimates, are home to a diverse population of nearly a quarter of a million people that identify as Black or African American (34.2 percent), Hispanic or Latino (15.1 percent), or as two or more races (5 percent).<sup>1</sup> Moreover, 17.5 percent of the population speak languages other than English at home.<sup>1</sup> Additionally, the area is a historical hub for tobacco production and cigarette manufacturing, one of several elevated cancer risk factors, which, along with limited access to healthcare and other social determinants of health, contribute to significant racial, ethnic, and geographic disparities in the region.

Recognizing the diversity of our catchment area and understanding how these specific populations intersect with cancer (e.g., significantly higher rates of cancer, including colon cancer mortality, exist among the Black community), our team tailored their population health navigation strategy around these diverse characteristics.

As the boots on the ground office for our Community Outreach and Engagement program, the population health navigation program is charged with making sure that the work of the cancer center is reflective of and responsive to the needs of our catchment area. After staffing the Hispanic patient navigator, we prioritized an expansion to include a rural patient navigator to address the unique needs of our very large, geographically rural catchment area. In contrast, Winston-Salem is a majority-minority city with a long, southern-based history that includes the Black community and their role in building the area, so we also added a navigator dedicated to serving this population.

As the program developed, we worked with our informatics experts to create a daily data pull that compiled all new patients from Hispanic, Black, and rural backgrounds, who had appointments scheduled in the next two weeks. Our population health navigators would then methodically filter through this list of patients and reach out to conduct an initial assessment—a tailored acuity scale created for the program around identified patient characteristics and potential barriers to care that indicate the expected level of navigation intensity required (i.e., no navigation, low level of support, medium level of support, and high level of support needed) to best assist patients. These levels provide a structure for our proactive navigation services and their respective timelines needed to guide the work of the navigators. Historically, our rural patients have needed lower levels of support, while most of our Black patients have needed medium levels support and our Hispanic population has had the largest percentage of high levels of support needed (see Table 2, page 38).

In just a short span of time, the popularity of the population health navigation program soared. Emily Copus, MSW, OPN-CG, manager of the Office of Cancer Health Equity's population health navigation program at Atrium Health Wake Forest Baptist, described this evolution. "Originally, we were proactively going through those lists and looking to see who was coming within the next week, who [we] could call and reach out to offer an initial assessment. But now people know who we are, [so] we don't have to utilize it anymore. Now we get referrals from





everyone—physicians, ambulatory nurses, PAs [physician assistants], our nurse navigators, front desk folks. For the most part, it is providers calling us saying ‘Hey, we met this person in clinic, and they had to scrape together two pennies to get here today. Can you reach out and do an assessment?’”

Today, our population-focused program has grown to include five navigators, and they are busier than ever. With a dedicated Hispanic navigator, African American navigator, rural navigator, adolescent and young adult navigator (an underserved population with very unique age-related barriers), and a financial navigator (for patients in lower socio-economic populations), we have effectively built a dream team of navigators who serve very specific patient populations.

Our population health navigators educate every patient about the role of research in cancer care, and we are very intentional about those words. Our navigators never represent a specific study or consent a patient; they advocate for informed decision-making.

The Mechanics of the Program

So what exactly does a population health navigator do? How is this role different from a nurse navigator? Because our navigators are population specific, rather than disease specific, every workday looks different. Population health navigators may begin their day in clinic, and, while they are part of the multidisciplinary care team, they are there to address the health-related social needs of patients by focusing on social determinants of health. This allows other team members, such as nurse navigators, to focus on the clinical aspects of patient care and work to the highest level of their licensure. Below are some examples of a population health navigator’s day-to-day activities:

- Arranging a ride to and from treatment appointments
- Providing a meal voucher to address food insecurity
- Overcoming language and literacy barriers by ensuring patients’ understanding of their treatment plan
- Helping patients communicate their clinical needs to their care team.

Population health navigators spend time in multiple tumor boards, gathering vital information that will be used to better assist their patients through the duration of their care. These navigators return patient phone calls to provide much-needed resources and information, including everything from budgeting and financial assistance to logistical barriers like transportation and household management. In a few words, population health navigators support and provide solutions to address barriers to care.

As Copus described, “We are multi-disease site navigators, so one of the puzzle pieces we must put together when looking at our day and our week is which patients are coming to which clinic on which day. [For example,] I just left a new patient visit, and, while the physician is explaining what kind of cancer [the patient] has and what the treatment protocols look like, I know I have voicemails that I need to return for patients asking about food pantries or transportation for next week.”

The number of patients the program supports is also as variable as the navigators’ scope of work. “Just yesterday, I had 11 patients that I somehow talked to, whether they were in clinic or on the phone. But today, I’ve worked with just 3 patients and spent over 2 hours with a single patient,” Copus explained.

With the popularity of the program and referrals growing each day, our acuity scale has become more important than ever in helping guide our population health navigators in triaging patients’ needs and services, allocating their time, and balancing their caseload. A rural patient with a cancer type who has a standard treatment protocol and who also has stable insurance, great family support, and lives an hour away may not require as much support as a patient who is uninsured, undocumented, and lives in West Virginia with no caregiver.

And the population health navigation program works. As an example, a Black patient who needed a feeding tube was vehemently refusing it despite appeals by several members of the clinical team. “He kept saying over and over, ‘No way, no way.

Table 2. Intensity Level by Underserved Population				
Intensity Level	Total (n=434)	Rural (n=170)	Black (n=122)	Hispanic (n=142)
No navigation	28 (6%)	10 (6%)	6 (5%)	12 (8%)
Low	177 (41%)	95 (56%)	38 (31%)	44 (31%)
Medium	183 (44%)	62 (36%)	66 (54%)	65 (46%)
High	36 (8%)	3 (2%)	12 (10%)	21 (15%)

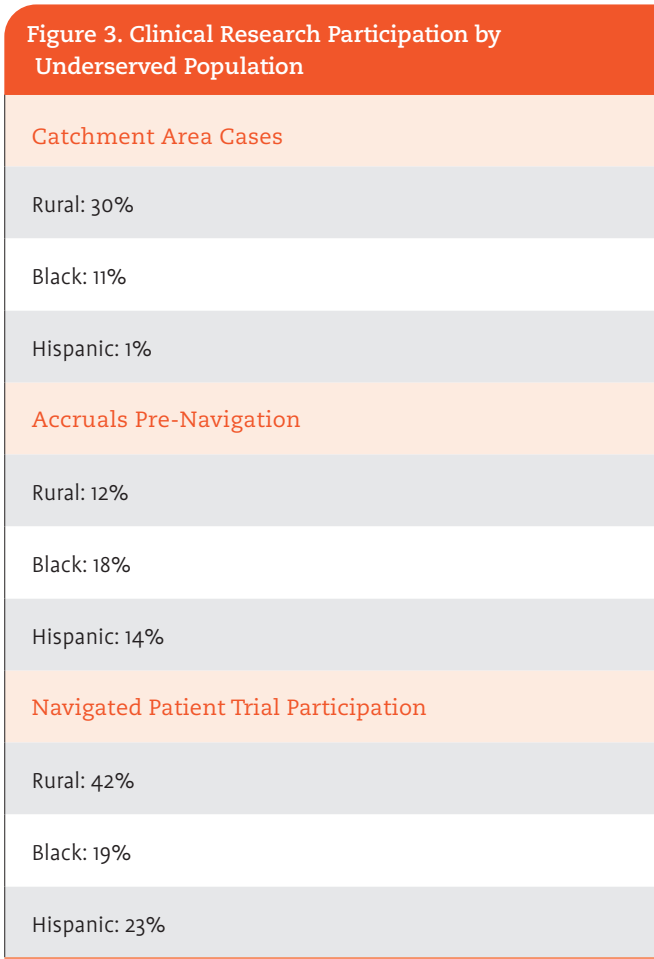
I don't want this feeding tube.' So they asked Alexis, our Black navigator, to talk with him. She went up to the clinic and said, 'Give me a minute, I got this.' She went in and spoke to the patient, addressing his concerns and explaining what he needed to understand about it that he wasn't getting from the clinical team. She had her conversation and then less than 15 minutes later she walked out and said, 'He's ready for his tube.'" While it is not always as simple as this, Alexis' story truly paints a picture of why it matters who is talking to patients, who patients trust, and who is helping them understand with the words and language that resonate best with them.

A common question we are asked is how we fund the program since navigation services are not reimbursable. In the early years, our navigators were primarily grant-funded, and, at our cancer center, we accomplished this by linking our population health navigators to research and clinical trials. As a National Cancer Institute-designated comprehensive cancer center and academic medical center, research is a big part of what we do at Atrium Health Wake Forest Baptist's comprehensive cancer center. Rather than trying to keep things separate, we were very intentional about bringing research and navigation together.

One of the pieces that we built into the role of our navigators was education; our population health navigators educate every patient about the role of research in cancer care, and we are very intentional about those words. Our navigators never represent a specific study or consent a patient; they advocate for informed decision-making. This way, whether patients participate in a clinical trial as part of their initial treatment or years later in survivorship, if they are asked to participate in a study, the concept and conversations around research and trials in cancer care are normalized and patients have an increased likelihood to participate. The first time patients learn about research studies or clinical trials should not be when they're being asked to participate in one.

As a result, the clinical research participation rates at Atrium Health Wake Forest Baptist are significantly higher than the general oncology patient population as our data have shown (Figure 3, page 8). Moreover, these increased rates of participation are among underserved populations, which traditionally have been underrepresented in clinical research.

Over time, we have moved beyond clinical trial participation and have been successful in making the business case for popu-



lation health navigation through the lens of a value-added service. Thus, we seed fund each population health navigator position with a grant, show the success of the position and what it has accomplished, and, in turn, the cost of the position is absorbed by the cancer center. Thanks to ongoing support, today we have a full complement of nurse navigators, financial navigators, student navigators, and population health navigators, who work collaboratively side-by-side in a sustainable model.



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We are also looking ahead at other underserved populations with unique needs where we can take the program next. We have identified a clear need for support and care for patients within the prison population, which in Winston-Salem represents more than 240,000 people across five jails and prisons.

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### Looking Ahead—the Future of Population Health Navigation


What we have built at Atrium Health Wake Forest Baptist is strong and thriving. Our program has been largely successful due to the hard work and vision of everyone involved in the Office of Cancer Health Equity and from support by key stakeholders, including Dr. Winkfield, our former director, and A. William Blackstock, MD, chair of Radiation Oncology and interim director of the comprehensive cancer center at Atrium Health Wake Forest Baptist, as well as our local community partners, such as our regional chapter of the American Cancer Society, who have been instrumental in providing key resources and support to our program.

The potential to grow this innovative population health navigation program is great and well within our reach. In fact, Atrium Health Wake Forest Baptist recently integrated with Atrium Health Levine Cancer Institute in Charlotte, N.C. With this integration, we have the potential to impact more than twice as many patients, and our team in the Office of Cancer Health Equity is working closely with our colleagues in Charlotte to expand the program.

We are also looking ahead at other underserved populations with unique needs where we can take the program next. We have identified a clear need for support and care for patients within the prison population, which in Winston-Salem represents more than 240,000 people across five jails and prisons. We see many patients with an additional health factor that complicates their cancer experience, such as blindness or deafness. We have worked with patients suffering from a significant psychiatric illness, which requires a different set of skills and increased collaboration with psychiatry. And with the growing recognition that we should be asking about and recognizing sexual orientation and gender identity to serve the whole patient, we are also exploring the needs of LGBTQ+ patients with cancer.

In the Office of Cancer Health Equity at Atrium Health Wake Forest Baptist, we believe everyone, regardless of age, gender, race, religion, financial status, or geography, should have an equal chance of surviving cancer and surviving it well. This belief is why our navigation program is truly a game-changer. Our novel approach for population-specific navigation—culturally and linguistically concordant support for patients, families, and care-



givers that is not disease specific but tailored to the diverse needs of our patient populations—breaks down barriers to care and helps achieve health equity in oncology. As a two-time bilingual, bicultural cancer survivor, I am especially proud to be part of a team of incredible professionals and the guardian of this unique program, and I look forward to the endless possibilities, as we move our population health navigation forward into its next stage of evolution. 

*Carla Strom, MLA, is assistant director, Office of Cancer Health Equity, Atrium Health Wake Forest Baptist, Winston-Salem, N.C.*

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