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## PUBLIC HEALTH & PRIMARY CARE | CASE REPORT

# Bilingual patient navigator or healthcare interpreter: What's the difference and why does it matter?

Ineke H. M. Crezee<sup>1\*</sup> and Cynthia E. Roat<sup>2</sup>

**Abstract:** This study describes the Bilingual Patient Navigator Program at Seattle Children's Hospital, comparing the Navigator's role to that of the professional interpreters also provided by the hospital. The study uses individual and group interviews to investigate why the bilingual patient navigators have been more effective than interpreters alone in impacting no-show rates, number of unplanned hospitalizations, average length of stay, and staff/family confidence in the family's ability to care for the patient at home among families who were previously experiencing difficulty navigating the healthcare system. Critical differences were found to be the navigator's freedom to build trust with a patient's family over time, to point out missed inferences, to restate physician speech into plain language, to alert providers to barriers to implementation of treatment plans, and to teach families basic skills such as preparing for a medical appointment and how to talk with doctors. Implications for healthcare systems serving LEP patients are discussed and further research suggested.

**Subjects:** Intercultural Communication; Health Communication; Language & Linguistics; Translation & Interpretation; Community Health; Health Communication; Health Education and Promotion



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### ABOUT THE AUTHOR

Ineke H. M. Crezee and Cynthia E. Roat both have long careers training healthcare interpreters and share an interest in bilingual patient navigation. Since the early 1990s, Ms. Roat has been a force for language access in the United States, where she is now a national consultant in the field. From 2012-2015, she supervised a unique Bilingual Patient Navigator program conceived and developed by Sarah Rafton at Seattle Children's Hospital. Dr. Crezee has been involved in developing healthcare interpreter education in New Zealand since 1991. In 2014 she was a Fulbright New Zealand Scholar (Public Health) at the program Ms. Roat supervised at Seattle Children's Hospital, exploring the role differences between healthcare interpreters and bilingual patient navigators. Both Dr. Crezee and Ms. Roat are advocates for patient navigation programs that help patients and families learn to manage their own care in the increasingly complicated healthcare systems of New Zealand and the U.S.

### PUBLIC INTEREST STATEMENT

Interpreters are becoming a more common sight in our health care systems, as our understanding grows of how important it is to have clear communication between patients who don't speak English and the providers who serve them. Interpreters, however, focus specifically on facilitating understanding within a given healthcare encounter. As our healthcare systems become increasingly complex, a growing number of patients seem to be dropping through the cracks, not getting the care they need. This is especially true for limited English proficient (LEP) patients who are not familiar with the healthcare systems of their adoptive countries. A new healthcare worker, the Bilingual Patient Navigator, is being found in some hospitals, to help LEP patients and families learn to negotiate their care. This article describes such a program at Seattle Children's Hospital and looks at the fundamental differences between the roles of the interpreter and the patient navigator.

**Keywords:** healthcare interpreters; bilingual patient navigators; healthcare; cross-cultural health communication; Seattle Children’s Hospital

## 1. Introduction

Health outcomes are affected by a wide range of non-clinical factors, including socio-economic indicators, the patient’s educational background, and the quality of the communication between patients and providers. Lack of shared medical knowledge and the complexity of healthcare systems are both common causes for misunderstanding, even when patients and providers share the same cultural and linguistic context. Diverging cultural and linguistic backgrounds, linked with differing health beliefs and priorities, constitute additional barriers to understanding that play a major role in compromising health outcomes.

In order to ameliorate the impact of language differences on quality of care, healthcare systems in many countries over the past three decades have increasingly utilised the services of professional medical interpreters (Jacobs, Shepard, Suaya, & Stone, 2004; Karliner, Jacobs, Chen, & Mutha, 2007), and the benefits of interpreting services have been clearly demonstrated (Hsieh, 2015; Tsuruta, Karim, Sawada, & Mori, 2013; VanderWielen et al., 2014). Qualified healthcare interpreters erase the language barrier and allow patients and providers to “hear” each other as if they spoke the same language.

But is erasing the language barrier enough? Even among English-speaking populations, diverging levels of health literacy are known to play a major role in patient compliance with prescribed treatment, as well as in patients’ ability to recognize danger signs and take appropriate action. Because of this, in 1990 some health services in the United States turned to patient navigator programs to help English-speaking patients manage the complexities of western medicine and the confusing healthcare system (Freeman, 2012, 2006a; Freeman & Rodriguez, 2011; Genoff et al., 2016; Meade et al., 2014). Soon after, experiments began with *bilingual* navigator programs in an attempt to lower both the linguistic and health literacy barriers to good health outcomes (Wells et al., 2016).

The aim of this study is to compare the roles of healthcare interpreters and bilingual patient navigators in healthcare settings. We examined the role and training of bilingual navigators and compare it to those of healthcare interpreters. We chose Seattle Children’s Hospital because its successful bilingual navigator service was one of the few that has collected data to document the impact of its program (Pacific Hospital Preservation & Development Authority, 2013). The paper will discuss our findings and use them as a basis to discuss and compare interpreter and navigator roles and provide some general recommendations.

## 2. Background

### 2.1. The role of the interpreter and the patient navigator

The role of the healthcare interpreter has been defined differently in different countries. In general, however, a healthcare interpreter’s purpose is to facilitate understanding of what is being said in a communication between two or more people who do not speak the same language. The emphasis is placed on recreating accurately in the target language—without omission, addition, or change—the meaning of the source-language message. In the archetypal interpretation, the interpreter “fades” into the background, and the interlocutors get the sense that they are actually interacting directly with each other. Interpreters are exhorted to be impartial and to maintain strict professional boundaries in order to encourage patients to bond, not with their interpreters, but with their healthcare providers. If the interpreter senses that there are other issues preventing patients from understanding or complying with treatment, the interpreter in countries such as Australia and New Zealand is largely prevented by

codes of practice/ethics from intervening in this situation (Australian Institute of Interpreters and Translators, 2012; New Zealand Society of Translators and Interpreters, 2013).

In some countries, the interpreter role is a bit more expansive. The National Code of Ethics for Interpreters in Health Care from the United States provides some flexibility for the interpreter to intervene if he or she perceives that health literacy or cultural differences are creating a barrier to understanding (National Council on Interpreting in Health Care, 2005). The intervention, however, is limited to pointing out the potential misunderstanding and does not empower the interpreter to solve the problem. This Code also recognizes the role of healthcare interpreters, like every other healthcare worker, in advocating for patients if the patient's "health, well-being, or dignity is at risk." This intervention is seen as an unusual step to be taken only in emergency situations, "after careful and thoughtful analysis of the situation and if other less intrusive actions have not resolved the problem" (National Council on Interpreting in Health Care, 2004, p. 3). Overall, the role of the interpreter is still limited to facilitating understanding within the specific conversation which the interpreter is interpreting.

The role of the patient navigator has been defined differently. Navigators are focused on helping patients wend their way through a complicated medical system, assisting them in understanding their health problems, their recommended treatment plan, and their options within the system. They help health professionals become aware of issues impacting on follow-up rates, re-admission, lack of health literacy, and culture-specific health- and diet-related beliefs. In addition, they have a role in engendering trust, which enables health professionals to work more effectively with patients and their families. Trust, in turn, encourages compliance, or makes it possible for factors affecting compliance to be discussed and addressed.

In this light, patient navigators can be seen principally as case managers. However, in some programs their role is defined as more of a teacher, focused on helping patients to understand and "navigate" the healthcare system independently. While they may provide case management services at the beginning of the relationship with patients, as they teach the patients to self-manage, they slowly withdraw their support, until the patients are able to handle their healthcare interactions on their own.

## **2.2. Patient navigators**

A recognition of the value of trusted intermediaries to help facilitate access to healthcare is not new. In the United States, Byers (2012) discusses working with Community Health Representatives (or CHRs) as far back as the mid-1970s when he joined the U.S. Indian Health Service after graduating from medical school. He describes the CHRs as "lay health workers navigating Native Americans and Alaska Natives through the health care system." He writes: "[w]ithout the many efforts of CHRs at the often-complex interface between providers and patients, I am sure our health outcomes would have fallen far short for many patients" (Byers, 2012, p. 1618).

In 1989, an American Cancer Society (ACS) report (Freeman & Wasfie, 1989) indicated that poor individuals faced significant financial, logistical and sociocultural barriers to accessing the cancer care they needed (Freeman, 2006a). In response, in 1990, Dr Freeman pioneered the first navigation service in Harlem, New York City, in collaboration with the ACS. This patient navigation service aimed to reduce barriers to breast-cancer screening for poor black women, many of whom had been presenting with advanced stage breast cancer; the five-year survival of this group had been only 39% (Freeman, 2006b). Freeman reports an increase to 70% in 5-year survival rate in a separate study conducted between 1995 and 2000, crediting this huge improvement to three factors, including free or low-cost mammograms, "increased outreach and culturally sensitive education" (Freeman, 2006b, p. 140), and the fact that patient navigators were helping to reduce barriers to screening.

Dr. Freeman's ground-breaking efforts resulted in a growing interest in patient navigation services around the United States, as well as the establishment of related services (Ethnomed,

2017). The role was enshrined in U.S. law in 2005 through the introduction of the Patient Navigator, Outreach, and Chronic Disease Prevention Act (United States Government, 2005). A special Patient Navigator Research Program (PNRP) was established (Freeman, 2012; Vargas, Ryan, Jackson, Rodriguez, & Freeman, 2008; Wells et al., 2008).

Due to its origins in cancer prevention and care, the navigator role originally focused on reducing barriers specifically to cancer screening, diagnosis and treatment for patients with low socio-economic status (Freeman, 2006a). Today much of the literature around patient navigators still focuses on work in oncology (Wells et al., 2016). However, the focus of navigator programs in the U.S. has gradually expanded to include the needs of patients experiencing barriers to care for other than merely socio-economic reasons. In 1994, Harborview Medical Center in Seattle introduced the Community House Calls program providing caseworkers/cultural mediators for patients from specific cultural and linguistic backgrounds (Ethnomed, 2017), while elsewhere similar programs were established (Burhansstipanov et al., 1998). In the words of Dr Freeman himself: “[f]rom its origin in Harlem about 2 decades ago, patient navigation has rapidly expanded and has become a nationally recognized health care service delivery model” (Freeman, 2012, p. 1616).

Wells et al. (2008) carried out a comprehensive study of the literature on patient navigation programs in the United States and Canada in the field of cancer prevention, screening, and treatment, focusing especially on those studies that attempted to measure the efficacy of such programs. Based on their review of the literature, Wells described the role of the patient navigator as one that focuses principally on overcoming health system barriers, secondly on providing health education, thirdly on addressing patient barriers to care, and lastly on providing psycho-social support (Wells et al., 2008).

Patient navigators have become an integral part of the U.S. healthcare system. However, the literature on bilingual navigators shows that there is no “one size fits all” model (Dohan & Schrag, 2005; Wilson-Stronks, Lee, Cordero, Kopp, & Galvez, 2008). Patient navigator programs share certain features such as being patient-centric and aimed at navigating patients through complex systems, while also making providers aware of barriers to care. However, role descriptions and training requirements vary across hospitals or areas of healthcare. In general, the role of patient navigators today still revolves around reducing barriers to care, where such barriers may be related to:

- Cultural and linguistic divergences;
- Financial issues;
- Time issues (walk-in, flexi-hours);
- Transportation issues (not having car, public transport, time off from work);
- Health literacy;
- Literacy/numeracy.

Freeman and Rodriguez (2011, p. 3539–3542) define the principles of patient navigation as follows (italics ours):

- (1) Navigation is a *patient-centric* health care service delivery model.
- (2) Patient navigation serves to virtually integrate a fragmented healthcare system for the individual patient.
- (3) The core function of patient navigation is the *elimination of barriers to timely care* across all segments of the healthcare continuum.
- (4) Patient navigation should be defined with a *clear scope of practice that distinguishes the role and responsibilities of the navigator from that of other providers*.
- (5) Delivery of patient navigation services *should be cost-effective* and commensurate with the training and skills necessary to navigate an individual through a particular phase of the care continuum.

- (6) The determination of who should navigate should be determined by the level of skills required at a given phase of navigation.
- (7) In a given system of care there is the need to *define the point at which navigation ends*.
- (8) There is a need to navigate patient across disconnected systems of care, such as primary care sites and tertiary care sites.
- (9) Patient Navigation systems *require coordination*.

Navigators differ in terms of role, training, and selection process. In 2008, Seattle Children’s Hospital decided to develop its own unique version of a patient navigation system, in an effort to impact the barriers that Spanish-speaking and Somali patients were encountering in trying to navigate this world-class speciality hospital. Following is a short history and description of the program.

### 2.3. The bilingual patient navigator program at Seattle Children’s Hospital

#### 2.3.1. Seattle Children’s Hospital

Seattle Children’s Hospital (SCH) is one of the United States’ highest-ranked paediatric specialty hospitals, providing primary to quaternary care to patients and families from a range of ethnic groups, originating both within and outside of Seattle and Washington State. About 15% of the patient population or their families are Limited English Proficient (LEP; self-identifying as needing an interpreter in order to communicate with healthcare staff).

The hospital demographic is changing continually, shifting towards new migrants speaking languages such as Somali, Ukrainian, and Mandarin Chinese.

The language needs of patients and families seen at SCH are also highly diverse, with 15% of the patient population in 2013 preferring a language other than English. Table 1 shows a breakdown of the preferred language of medical care for LEP patients at SCH in 2013.

#### 2.3.2. Language access services at SCH

Prior to commencing the patient navigator trial in 2008, Seattle Children’s Hospital already had systems in place to try to achieve health equity for a very diverse patient population, in particular focusing on limited-English-proficient patients. Such systems included:

- *Interpreter services*—The hospital provided 12 staff interpreters speaking Spanish, Vietnamese, Cantonese, Mandarin, Russian, Ukrainian and American Sign Language; four agency contracts to cover overflow and other languages; one-touch telephonic interpreting available at the bedside in all clinic locations; easily accessible video remote interpreting services provided by

**Table 1. Preferred language of care for Limited English Proficient (LEP) patients FY2013, Seattle Children’s Hospital**

Spanish	58%
Somali	8%
Vietnamese	6%
Cantonese	4%
Russian	3%
Amharic	3%
Mandarin	2%
Korean	1%
Unknown	1%
Range of 20+ other languages	14%

an external language company; and a Family Interpreter Line accessible by families outside the hospital trying to contact SCH staff.

- *Translation services*—The hospital employed two full-time translators so that procedure preparation and discharge instructions were routinely translated for LEP families.
- *Health information in a range of languages*—The hospital had a wide range of health and health procedure related information in a variety of patient languages.
- *Community Outreach Health Equity Liaisons*—The hospital had Health Equity Liaisons working with different communities to obtain feedback on the quality of patient care and what could be done to improve patient experience and outcomes.

Even with all this support, such systems did not prove sufficient to prevent health disparities and costs due to re-admission, duration of in-hospital stay and high rates of missed appointments (no-show rates) among LEP patients and families. Hospital staff were keen to address health disparities.

### 2.3.3. *Historical background of SCH's navigator program*

The principal and immediate impetus for the patient navigator trial was feedback received from the medical staff at a nearby public hospital that many LEP families were feeling lost and unable to navigate services at Seattle Children's Hospital. These families felt unable to make appointments, organize transportation to and from the hospital, or understand what their children's problems were or how to care for them. It was suggested that SCH should initiate a patient navigator program, similar to the interpreter/case manager (ICM) program in place at Harborview Public Hospital in Seattle (Ethnomed, 2017).

The initial navigator trial commenced in 2008, with the aid of a 2-year grant of US\$277,832 from the Pacific Hospital Preservation & Development Authority (PHPDA) (2013). Three patient navigators (two Spanish-speaking and one Somali) were recruited and trained by a multi-disciplinary team at SCH of social workers, paediatricians, and nurses. These mentors were available to the navigators for consultation throughout the program. Key data were tracked from the very initiation of the navigator program throughout the two-year grant cycle.

### 2.3.4. *Criteria for selection of families*

Families were referred to the navigator program by anybody at SCH who provided services for patients: including physicians, nurses, social workers, and even interpreters. Every effort was made to select families for whom navigators could make a significant difference: that is, families who would be seen regularly over a long period of time in the hospital and who seemed to be experiencing difficulty in getting the care they needed. In practice, this meant that families had to meet the following criteria to be referred for navigation:

- The child had a medically complex and/or chronic condition for which the child was being seen by specialists from at least three areas of care and for which the child was likely to be seen for an extended period of time. Unlike other navigator programs which focused on cancer care, patients with any constellation of serious health problems were accepted into this program.
- The family spoke Spanish, Somali, or an indigenous language from Southern Mexico or Central America.
- The family demonstrated difficulty in managing the child's healthcare, either having a history of no-shows, demonstrating a lack of understanding of the child's condition, or demonstrating an inability to comply with treatment protocols. Recent immigration status, or the presence of cultural or religious issues could also trigger referral to a navigator, as would arrival of the patient from outside of King County.

### 2.3.5. *Guidelines for navigation*

Patient navigators worked with families to help them learn to:

- Understand their child's diagnosis and treatment plans;
- Ask questions of medical staff;
- Advocate for their child, so as to be able to truly partner with the medical team in caring for their child;
- Understand the healthcare system and any barriers to accessing the same;
- Connect with resources they needed to make informed decisions about their child's care, treatment and recovery after discharge;
- Schedule appointments and arrange transport;
- Work with interpreters and use the Family Interpreter Line.

Navigators helped patients and families reach these goals by first doing tasks for the family. As trust was built, the navigator then started showing the caregiver how the task was done. The navigator would then start accompanying the caregiver, but standing by and coaching as the parent did the task. Next the navigator would start encouraging the caregiver to do the task independently and checking in afterward to hear how it went. When it was clear that the caregiver could complete the task on their own, the navigator would withdraw.

Navigators also helped medical, nursing, and social work staff to understand personal or cultural issues that families brought to interactions. These were often culturally-based, sometimes family-based, and often shared with the navigator before the family had sufficient trust to share with the provider. Other times, it was the cultural insight of the navigator that helped the provider to ask the right questions to learn what the family was really thinking and doing.

In 2012, an additional duty was added for the navigators: that of interpreting for appointments at which they were present to navigate anyway. Prior to this, hospital interpreters and navigators worked together in patient encounters, despite the fact that all the navigators were themselves certified medical interpreters. Allowing navigators to handle the interpretation for their encounters themselves maximized use of linguistic resources, provided navigators with an additional tool to help build understanding of diagnosis and treatment, and minimized conflict between navigators and interpreters serving the same family.

#### 2.3.6. *Graduation criteria*

Navigators worked with families until these were ready to graduate, i.e. until families had concretely demonstrated the ability to successfully complete all the actions listed under the Guidelines for Navigation. The most important criteria for graduation involved families understanding their child's diagnosis and treatment plan and being able to advocate for their child. Time to graduation varied, depending on families' unique circumstances and abilities.

#### 2.3.7. *Program evaluation*

In 2011, at the end of the initial two-year grant period, the Pacific Hospital Preservation and Development Authority contracted with an independent management consulting company to carry out a formal external program evaluation. This evaluation study showed significant improvement in the following areas (Pacific Hospital Preservation & Development Authority, 2013):

- The no-show rate for navigated patients dropped from 16.8% to 10.3% for navigated Spanish-speaking patients, and 8.5% to 3.5% for Somali patients, representing savings of about US\$35,000.
- The number of encounters for which interpretation was provided increased at discharge and during inpatient stays.
- Unscheduled hospitalizations for navigated patients dropped from an average of 3.68 days per year to 1.01 days per year.
- Average length of stay dropped from 14.8 days per stay to 6.5 days per stay.

- A total cost saving of approximately US\$1.2 million was identified in return for direct annual personnel costs of about \$210,000, representing a return on investment (ROI) of 6:1 (US\$6 saved for every US\$1 invested).

Patient families and healthcare professionals were also asked for feedback. There were statistically significant improvements in satisfaction rates for both navigated families and healthcare providers. After the 2-year trial, a majority of the latter said that the quality of care for the navigated LEP patients was now better, or about the same as it was for English-speaking patients; hence linguistic barriers to care delivery seemed to have been dissolved.

The evaluation also showed that patient navigators played a significant role in teaching families how to deliver correct home care and prevent emergency and hospital readmissions. They also helped families make and keep the appointments from physician referrals. At the end of the grant, families with patient navigators were more likely to complete referrals than families in the same language groups without patient navigators. No-show rates (missed appointments) reduced by 32% for Somali families and by 21% for Spanish-speaking families. Finally, in the last quarter reported before the evaluation was conducted, more than 20% of families receiving navigator services during the quarter graduated from the program—a remarkable success.

### **3. Study of the patient navigator role**

#### **3.1. Rationale**

By July of 2014, SCH's bilingual patient navigator program was in its fifth year, still operating with three bilingual navigators and showing significant impacts on patient no-show rates, hospitalization rates, length of stay, and the confidence among families and providers that families knew how to care for chronically-ill children at home. It seemed that this same program might be effective in New Zealand, where social, linguistic, and cultural differences were creating major barriers to effective healthcare in many limited-English-speaking communities. It was not clear, however, how patient navigators differed from the interpreters currently being employed in healthcare settings in New Zealand. With funding from a Fulbright Award, we set out to explore this question.

#### **3.2. Methodology**

We obtained Institutional Review Board (IRB)<sup>1</sup> approval from Seattle Children's Hospital and ethics approval from the Auckland University of Technology to interview a series of stakeholders in the SCH Patient Navigation Program: including patient navigators (n = 4, including one relief navigator), a small number of providers working with them (n = 6), the hospital medical administrator, interpreting services staff, as well as staff from a comparable program at the neighbouring Harborview Medical Center involving bilingual caseworkers/cultural mediators (CCMs). The author used a semi-structured interview format and digitally recorded and transcribed all interviews; interviews lasted between 25 and 50 minutes. Interview transcripts were thematic analysed and salient findings coded. A member check was carried out: all physicians were MDs and all other interviewees were professionally qualified in fulltime employment.<sup>2</sup> Thus the credibility and dependability of interview data was ensured.

In the semi-guided interviews, interviewees provided fairly static views<sup>3</sup> when asked what they thought constituted the main difference between the role of health interpreters as opposed to patient navigators. They were also asked to give examples. For reasons of patient confidentiality, only general replies have been provided here. Many of the examples given related to end-of-life experiences or to children with very complex medical conditions, leading to possible identification of patients and their families.

### 3.3. Findings

#### 3.3.1. The importance of a patient navigator

Stakeholder views are summarised in Table 2.

**3.3.1.1. Medical staff.** Medical staff felt that navigators added value to interactions when compared to interpreters because they were able to point out any missed inferences, and were able to suggest alternative and culturally-appropriate ways of explaining complex medical matters to families. For example, in a case in which the pre-literate parents of a child with a genetically-linked developmental delay had no knowledge of even basic genetics, the navigator suggested that this be explained using a story about the mother and father making a stew together, and each adding their own ingredients. This metaphor helped the parents better understand the fundamental concept of reproductive genetics, why their children had similarities and differences (“every stew comes out a little bit different”) and why the delay could not be “cured” (“you can’t unmake the stew once it’s made”).

**3.3.1.2. Social workers.** Social workers felt that navigators added value to interactions when compared to interpreters because they were able to build trust with families more quickly than a social worker or an interpreter. This then enabled the social worker to gain the family’s trust (by extension) more rapidly than they would have been able to do alone or with an interpreter.

**3.3.1.3. Interpreters and interpreting services.** Interpreting services staff felt that families appeared to prefer having a navigator assigned to them, because the navigator would assist them in finding their way around the hospital, understanding the diagnosis and the health system, as well as interpreting for them. In addition, navigators would interpret into simpler language, so families could understand, whereas interpreters would interpret using the appropriate medical terms, without changing the wording or the register.

**3.3.1.4. Program supervisor.** The program supervisor emphasised the importance of providing ongoing support for navigators. Some navigators had very high caseloads, including complex cases, emotionally-draining end-of-life scenarios, and ethical dilemmas. They often came to discuss cases with the supervisor and reported that the ongoing support and the opportunity to seek feedback were invaluable.

Table 2. Aspects of navigator role emphasised most by various interviewees				
	Pointing out missed inferences	Teaching role: Suggesting alternative ways of explaining complex medical matters; explaining how the healthcare system works	Trust	Lowering register (rephrasing in “plain language”)
Physicians’ views (n = 3)	√	√	√	
Navigators’ views (n = 4)	√	√	√	√
Social workers’ views (n = 3)	√		√	
Interpreting service staff views (n = 2)	√			√
Supervisor/director views (n = 2)	√	√	√	√

3.3.1.5. *Program manager.* The program manager echoed the program supervisor's comments about the value of ongoing supervision, adding that selection of the right supervisor was of the utmost importance.

Both the program manager (who had helped set up the program through its early trial years and who had been key to its success) and the program supervisor had built up a wealth of experience in establishing and running navigator services.

3.3.1.6. *Navigators.* Interestingly the navigators themselves emphasised their "teaching role". They felt that the most important thing that they brought to an encounter was the freedom to intervene to identify whether families were really understanding the provider, and to suggest alternative ways of explaining complex medical information that would be more easily understood by patients and families.

### 3.3.2. *The importance of careful selection of navigators*

The hospital medical director and the program manager both emphasised that careful selection of the navigator is of the utmost importance; in fact, they saw selecting the right candidate (in terms of personal attributes, knowledge and experience of the health system) as more important than training in predicting that navigator's success. The selection processes they described were preceded by extensive consultation with representatives from the ethnic communities that the navigator was to serve. This was easier in case of the smaller, close-knit Somali community but more difficult for larger and more diverse Spanish-speaking communities.

Selected navigators all had extensive knowledge of healthcare through their previous training, qualifications, and extensive experience as certified healthcare interpreters. They were modest people, who were able to bridge the gap between cultures by sensitively reflecting views and approaches of families and health professionals. They also lacked any tendency to take over the communication: instead they listened with respect (even when they did not agree with what was said) and were thus able to help prevent escalation of potential conflict situations, and to help build bridges. They had realistic expectations of the immigrant and refugee families with whom they worked, perceiving them neither with a paternalistic romanticism nor with disdain, but with a grounded view of each family as unique and capable of learning to become more independent.

The selection panel included key stakeholders from the community, the medical profession, and the SCH hospital social work department.

### 3.3.3. *The training and supervision of navigators*

Following the careful recruitment of appropriate navigator candidates, the program manager identified careful training and supervision of navigators as critical to their success. After the initial training carried out by a bilingual hospital social worker, a paediatrician, and various hospital administrators, the navigators received bi-monthly support from key medical and nursing personnel. They were familiarized with the hospital's strategic plan, procedures, and priorities.

In addition to training the navigators about their role, every effort was made to ensure that staff within the hospital was also familiar with the navigator role. In particular, it was critical that staff understood the difference between the work of the navigators and that of the interpreters.

Navigators had immediate access to their supervisor, which enabled them to discuss any potentially problematic situations, issues, and dilemmas. Having the supervisor as a sounding board helped the navigators to adhere to their professional role boundaries, and helped avoid situations where navigators became "a law unto themselves", which might have potentially harmed families or created unnecessary conflict.

### 3.3.4. *Role comparison of navigators and healthcare interpreters at SCH*

The difference in the role of the navigators and healthcare interpreters was a central focus of inquiry in this study. A limitation of the study was that the voice of health interpreters was

represented by a member of the Interpreting Service who was in a supervisory role. However, most navigators at SCH had been healthcare interpreters before taking on a navigator role and appeared to be very aware of the role differences. Table 3 shows a comparison of navigator and healthcare interpreter role at SCH as ascertained during this small study.

Navigators saw the teaching role as the main point of difference between their role and that of healthcare interpreters at the hospital. They reported meeting with families prior to healthcare appointments, asking them to prepare “three good questions” to ask the provider. During the appointment, they might intervene to make sure a family was understanding a complex term or concept. They did this to check family understanding of their child’s condition, the aim being to get families to a point where they were able to advocate for their children. They also *demonstrated* how to advocate in a polite way and helped parents practice before going in to see a provider. They taught families how to identify which of the child’s many specialists they should call for a particular problem, how to use the Family Interpreter Line, how to leave messages, how to consolidate multiple appointments within the same day, how to arrange transportation to the hospital, how to connect with their social worker or their financial worker, what assistance the hospital support programs could render and how to access those programs. At first, navigators might “do for” the families, transitioning quickly to “doing with”, and finally to “watching them do” for themselves.

It is not surprising that, according to interpreting service staff, patients preferred having a navigator assigned to them. Healthcare interpreters reportedly felt that families preferred navigators because their role allowed them to be “more helpful”. One navigator felt that some families in her community expressed a preference for navigators because they “did more for them”.

The navigator’s freedom to identify and alert providers to barriers to follow-up care and treatment was another point of difference between navigators and interpreters that emerged from the interviews. For example, one Somali father responded aggressively to having an appointment scheduled for 8:30 a.m. He had raised his voice and staff had felt obliged to put through a “Code Purple”, calling security officers in to assist. The interpreter with him could do no more than interpret staff’s requests and his angry responses. When the navigator arrived, however, he was able to sit with the father and calm him down, to inquire as to what was upsetting him, at which point he found that the family was living in a two-bedroom apartment with nine children. The father had to take his other children to school between 8:00 and 9:00 a.m.; in addition he did not see anything amiss with the child (who had been diagnosed with autism spectrum disorder), so he did not appreciate the importance of taking him to the specialist clinic. When the navigator alerted providers to this, arrangements were made for the family to move into larger accommodation. Providers also spent time explaining to the father why it was important for his little boy to be seen at the Autism Clinic.

Table 3. Role comparison of navigators and healthcare interpreters		
	Healthcare interpreters	Navigators
Pointing out missed inferences	No	Yes
Teaching Role: e.g. suggesting alternative ways of explaining complex medical matters	No	Yes
Trust	Not known	Yes
Interpreting into plain language	No	Yes
Interpreting while maintaining same register/level of formality etc.	Yes	No
Alerting providers to barriers to treatment and follow-up care	No	Yes

Another navigator related how a small child needed to be bathed in a special solution for a skin infection. The mother was too embarrassed to tell providers that she had just become homeless; however, she did tell the navigator. She was desperate to follow the instructions, but did not know how to, as she had no access to facilities where she could bathe her child. The navigator discussed this with the providers, and the mother was given a plastic tub so she could follow treatment while a permanent housing solution was sought.

A third navigator related an instance in which a provider was talking to the mother of a child who had been diagnosed with an autoimmune disease. The child was being discharged and the provider told the mother that normally children's medication was tapered down, but in her daughter's case, medication was to be kept the same. The mother then told the doctor that she had not received much education and that he was obviously a well-educated man. She repeated this statement several times. The interpreter accurately interpreted the mother's statements, leaving the provider at a loss as to how to respond. The navigator, however, had the impression that the mother was unsure why the doctor was discharging her child while leaving her medication the same, when he had just stated that medication was normally tapered down. With the doctor's permission, she checked this out with the mother. The mother confirmed that this was what she had wanted to ask. This was an example of the navigator identifying and alerting the provider to a possible missed inference based on cross-cultural differences in what is considered a polite form of questioning. Hale (28) describes such cross-cultural issues in court interpreting. The navigator was also able to provide a pragmatically-equivalent rendition. Most interpreter codes of ethics, and guidelines for practice limit how much an interpreter can intervene in this way, and in the authors' experience, many interpreters feel conflicted as to how far they can go in providing a pragmatically-equivalent rendition.

If we look at the role differences between interpreters (focused on facilitating understanding in discrete communicative encounters), and navigators (focused on facilitating understanding of how to interact with the healthcare setting), we can see the assignment of one or the other depends on the patient and/or family's level of health literacy. SCH's criteria for assigning a navigator, then, correctly takes into account a family's level of understanding, the complexity of the child's health condition and the length of time that the family has been exposed to U.S. culture. When patients have even a moderate level of health literacy, and some years of exposure to U.S. culture, a healthcare interpreter may be the best choice to facilitate effective care, simply by bridging the language gap. However, when low health literacy combines with a lack of familiarity with the dominant healthcare system and the dominant culture, patient navigators may be a better choice in order to maximize good patient outcomes and cost-effective care.

#### **4. Discussion**

All the language access measures in place at Seattle Children's Hospital prior to 2008 were not sufficient to prevent health disparities and costs due to re-admission, duration of in-hospital stay, and high no-show rates among the patients in some LEP communities. The implementation of a patient navigator program, however—in which navigators could teach families how to manage their child's healthcare effectively and from which families graduated when ready—made a significant difference in all these variables.

As this paper has described, there were a number of characteristics that set SCH's bilingual patient navigator program apart from other such programs. Strict family selection criteria were in place so that families assigned to the program had a high possibility of benefitting from the program. The work of the navigators was clearly specified and focused on teaching the families to manage their child's care independently, not on simply providing case management services. The navigators provided amplified interpreter services when they were present in an encounter to navigate, guaranteeing increased understanding, and demonstrating to families how to intervene and advocate for their children. Finally, when the families were ready, they graduated from the program.

Three main themes emerged in the research interviews. Firstly, patients with low health literacy may not benefit as much from health interpreters as those with better health literacy, because interpreters cannot follow up when understanding is lacking or incomplete, possibly compromising compliance with treatment. Secondly, navigators can help uncover barriers to healthcare which patients may not reveal to providers. This can only happen when a relationship of trust has developed between patients and navigators. Navigators can then help ensure that barriers to care are addressed, by making relevant services within the hospital or healthcare system aware of such barriers. Thirdly, navigators were knowledgeable about both healthcare and the cultural communities they served. While not trained clinicians, they had a solid basic knowledge about the conditions of the patients they served, and they had access to clinical resources when they had questions. They were also very familiar with how the health system worked and with the barriers and concerns common in the cultural communities of their patients. This enabled them to be quite sensitive to the points at which families could potentially fall through the cracks of the system and therefore to pre-emptively check for understanding.

One strength of the study is the fact that the authors were able to attend numerous meetings related to navigation, involving ongoing discussion of the navigator role from different perspectives. Most relevant to hospital or health authorities wishing to set up similar navigation services were meetings using Continuous Progress Planning© (CPP) to map out who was involved at any stage of a patient admission-investigation-treatment-discharge journey (including navigators), what their roles were, and where these overlapped with the roles of other actors in the process. This showed that the hospital was continuously re-evaluating the navigator role and where it fitted in with the roles of other providers and professionals. In other words, CPP was used to ensure a very effective utilisation of navigator services without role overlap or role conflict, thanks to the input from all hospital-based stakeholders.

The principle value of this study is its suggestion that language access alone, in the form of professional interpreting, may not be enough to assure clear communication, understanding and good health outcomes for LEP patients with low health literacy. Patient navigators, however, in the broader and more assertive role defined by SCH's model, may be more effective in helping these patients overcome barriers to accessing services. More research is needed about the circumstances under which interpreters are sufficient to assure equal access and clear communication, and the circumstances under which the additional support of a navigator is needed. Research would also be helpful to identify exactly which parts of the bilingual patient navigator's role, as defined at Seattle Children's Hospital, are most responsible for the improvements experienced by LEP patients in the program there.

#### **4.1. Limitations of the study**

The principle limitations of this study are the small sample size and the inability of researchers to actually observe and record interpreted and navigated healthcare encounters. The former was due to the nature of the program under study, while the latter was due to the difficulty in obtaining ethics and Institutional Review Board approval for any study involving observation of the interaction between families, navigators, and interpreters. Such observations would have added a great deal of insight into the actual interactions. This limitation was partly mitigated by interpreters and providers recounting interpreter- or navigator-mediated interactions in some detail.

#### **5. Conclusion**

This paper describes the role and scope of practice of the bilingual patient navigators at Seattle Children's Hospital. It is clear that these navigators have a much broader purview than the professional interpreters provided by the hospital, allowing them to build trust with families, to teach families how to make their way in the healthcare system, to slow down the pace of communication and care and to assure understanding.

In our title we ask why the difference between bilingual patient navigators and healthcare interpreters matters. We argue on the basis of this small study that while healthcare interpreters alone should be assigned to patients who have a significant level of health literacy, bilingual navigators who have a broader focus on teaching patients and families to manage the health care

system may be more beneficial for patients who have limited health literacy, who are unfamiliar with the hospital or with the healthcare system overall, and who have unaddressed barriers to care. The benefits of such an approach were evident at SCH, where the cost of implementing such a program was repaid many times over by lower no-show rates, shorter hospital stays, and fewer unnecessary hospitalizations. In any healthcare setting, the benefits from families' increased ability to manage their own or family members' healthcare are incalculable.

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#### Notes

1. IRB approval did not extend to observing navigator-mediated interactions or interviewing parents. The opportunity to participate in interviews was communicated via the internal communications system and also within the Center for Diversity and Health Equity where the navigators were based, and respondents self-selected. The authors developed indicative questions for interviews. The Institutional Review Board at Seattle Children's Hospital did not grant permission for the lead author to observe navigator-mediated interactions, nor to interview parents.
2. All physicians were MDs and one was in fact the Medical Administrator of the hospital at the time the program was established. All social workers interviewed held a master degree in Social Work, as did the navigator program manager. The navigator program supervisor held a master degree in Public health, while all Navigators had met the very stringent requirements of the job profile and had impressive medical and general knowledge. Prolonged engagement with interviewees became less relevant because we were dealing with fairly static opinions of interviewees.
3. All interviewees were asked the following two questions: 1. What do you perceive to be the added benefits of having bilingual Patient Navigators working as part of the care team, as opposed to working with health interpreters? (Interviewees were asked to provide examples); 2. What important aspects of Patient Navigation programmes should I include in my report to the New Zealand Ministry of Health from your perspective, and why?

#### References

- Australian Institute of Interpreters and Translators. (2012). AUSIT code of ethics and code of conduct [Internet]. Australian Institute of Interpreters and Translators. Retrieved from [http://www.ausit.org/AUSIT/Documents/Code\\_Of\\_Ethics\\_Full.pdf](http://www.ausit.org/AUSIT/Documents/Code_Of_Ethics_Full.pdf) doi:10.1094/PDIS-11-11-0999-PDN
- Burhansstipanov, L., Bad Wound, D., Capelouto, N., Goldfarb, F., Harjo, L., Hatathlie, L., ... White, M. (1998). Culturally relevant "navigator" patient support: The native sisters. *Cancer Practice*, 6(3), 191–194. doi:10.1046/j.1523-5394.1998.006003191.x
- Byers, T. (2012). Assessing the value of patient navigation for completing cancer screening. *Cancer Epidemiology Biomarkers & Prevention*, 21(10), 1618–1619. doi:10.1158/1055-9965.EPI-12-0964
- Dohan, D., & Schrag, D. (2005). Using navigators to improve care of underserved patients. *Cancer*, 104(4), 848–855. doi:10.1002/cncr.21400
- Ethnomed. (2017). Community house calls program [Internet]. Retrieved from <https://ethnomed.org/about/related-programs/community-house-calls-program>
- Freeman, H. P. (2006a). Patient navigation: A community centered approach to reducing cancer mortality. *Journal of Cancer Education : the Official Journal of the American Association for Cancer Education*, 21(1 Suppl), S11–4. doi:10.1207/s15430154jce2101s\_4
- Freeman, H. P. (2006b). Patient navigation: A community based strategy to reduce cancer disparities. *Journal of Urban Health : Bulletin of the New York Academy of Medicine*, 83(2), 139–141. doi:10.1007/s11524-006-9071-4
- Freeman, H. P. (2012). The origin, evolution, and principles of patient navigation. *Cancer Epidemiol Biomarkers Prev*, 21(10), 1614–1617. doi:10.1158/1055-9965.EPI-12-0982
- Freeman, H. P., & Rodriguez, R. L. (2011). History and principles of patient navigation. *Cancer*, 117(S15), 3537–3540. doi:10.1002/cncr.v117.15s
- Freeman, H. P., & Wasfie, T. J. (1989). Cancer of the breast in poor black women. *Cancer*, 63(12), 2562–2569.
- Genoff, M. C., Zahalla, A., Gany, F., Gonzalez, J., Ramirez, J., Jewell, S. T., & Diamond, L. C. (2016). Navigating language barriers: A systematic review of patient navigators' impact on cancer screening for limited English proficient patients. *Journal of General Internal Medicine*, 31(4), 426–434. doi:10.1007/s11606-015-3572-3
- Hsieh, E. (2015). Not just "getting by": Factors influencing providers' choice of interpreters. *Journal of General Internal Medicine*, 30(1), 75–82. doi:10.1007/s11606-015-3476-2
- Jacobs, E. A., Shepard, D. S., Suaya, J. A., & Stone, E.-L. (2004). Overcoming language barriers in health care: Costs and benefits of interpreter services. *American Journal of Public Health*, 94(5), 866–869. doi:10.2105/AJPH.94.5.866
- Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Services Research*, 42(2), 727–754. doi:10.1111/j.1475-6773.2007.00703.x
- Meade, C. D., Wells, K. J., Arevalo, M., Calcano, E. R., Rivera, M., Sarmiento, Y., Freeman, H. P. & Roetzheim, R. G. (2014). Lay navigator model for impacting cancer health disparities. *Journal of Cancer Education : the Official Journal of the American Association for Cancer Education*, 29(3), 449–457. doi:10.1007/s13187-013-0567-9
- National Council on Interpreting in Health Care. (2005, September). National standards of practice for interpreters in health care [Internet]. Retrieved from <http://www.ncihc.org/ethics-and-standards-of-practice>

- National Council on Interpreting in Health Care. (2004). A national code of ethics for interpreters in health care [Internet]. National Council on Interpreting in Health Care. Retrieved from <http://www.ncihc.org/assets/documents/publications/NCIHC%20National%20Code%20of%20Ethics.pdf>
- New Zealand Society of Translators and Interpreters. (2013). Code of ethics [Internet]. New Zealand Society of Translators and Interpreters. Retrieved from [http://www.nzsti.org/assets/uploads/files/nzsti\\_code\\_of\\_ethics\\_and\\_code\\_of\\_conduct\\_may\\_2013.pdf](http://www.nzsti.org/assets/uploads/files/nzsti_code_of_ethics_and_code_of_conduct_may_2013.pdf)
- Pacific Hospital Preservation & Development Authority. (2013). Seattle children's patient navigator pilot & evaluation [Internet]. Retrieved from <http://www.phpda.org/projects/childrens-navigator-grant-and-clegg-evaluation-of-navigator-grant>
- Tsuruta, H., Karim, D., Sawada, T., & Mori, R. (2013). Trained medical interpreters in a face-to-face clinical setting for patients with low proficiency in the local language. *Cochrane Database Systems Review* (3). doi:10.002/14651858.CD010421. Art. No.: CD010421 .
- United States Government. (2005). Patient navigator outreach and chronic disease prevention act of 2005 [Internet]. Retrieved from <https://www.govtrack.us/congress/bills/109/hr1812>
- Vander Wielen, L. M., Enurah, A. S., Rho, H. Y., Nagarkatti-Gude, D. R., Michelsen-King, P., Crossman, S. H., & Vanderbilt, A. A. (2014). Medical interpreters: Improvements to address access, equity, and quality of care for limited-English-proficient patients. *Academic Medicine : Journal of the Association of American Medical Colleges*, 89(10), 1324–1327. doi:10.1097/ACM.0000000000000296
- Vargas, R. B., Ryan, G. W., Jackson, C. A., Rodriguez, R. L., & Freeman, H. P. (2008). Characteristics of the original patient navigation programs to reduce disparities in the diagnosis and treatment of breast cancer. *Cancer*, 113(2), 426–433. doi:10.1002/cncr.23873
- Wells, K. J., Battaglia, T. A., Dudley, D. J., Garcia, R., Greene, A., Calhoun, E., & Raich, P. C. (2008). Patient navigation: State of the art or is it science?. *Cancer*, 113(8), 1999–2010. doi:10.1002/cncr.23873
- Wells, K. J., Valverde, P., Risendal, B., Esparza, A., Ustjanauskas, A., & Calhoun, E. (2016). What do different types of navigators do? Differences in the day-to-day activities of patient navigators by navigator characteristics. *Psychooncology*, 25(S2), 45–46.
- Wilson-Stronks, A., Lee, K. K., Cordero, C. L., Kopp, A. L., & Galvez, E. (2008). *One size does not fit all: Meeting the health care needs of diverse populations*. Oakbrook Terrace, IL: The Joint Commission.



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