Access to Health Care for Vulnerable Populations

Korean American Seniors in Metropolitan Chicago

Prepared for the Asian American Institute
by the South Asian American Policy and Research Institute

The study aims to contribute to the information available on the needs of Korean Americans with limited English proficiency in the Chicago area, in furtherance of the broader goal of increasing the availability and quality of interpretation services provided by health care providers in metropolitan Chicago. It documents the experiences of Korean American patients at different hospitals and clinics in Chicago, as well as the northern and near northwestern suburbs.

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I. Acknowledgments

Asian American Institute (AAI) was established in 1992 as a pan-Asian not-for-profit 501(c)(3) organization. Its mission is to empower the Asian American community through advocacy, research, education, and coalition-building.

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II. Background and Goals

The need for health care is a basic human need that affects the daily lives and well-being of all people. Patients' ability to communicate with government and private-sector health care providers is the first step toward receiving health care, and this ability to communicate depends greatly on language proficiency. According to the most recent three-year American Community Survey (ACS)[1], there are millions of Americans who are limited English proficient (LEP), including citizens and legal permanent residents.[2] Language access is a crucial aspect of the provision of effective health care in the United States.

Language access is a serious concern for Asian Americans. The most recent three-year American Community Survey shows that, among the 280 million people in the United States age five and older, over 19% (55 million people) speak a language other than English at home.[3] Of those who speak a language other than English at home, 44% (24 million people) speak English less than "very well."[4] The majority of those who speak a language other than English at home speak Spanish or Spanish Creole.[5] However, a substantial portion of the LEP population is Asian American -- 8.2 million people speak Asian or Pacific Island languages instead of English at home, and nearly 49% of them speak English less than "very well."[6] More significantly, there are nearly 1.5 million "linguistically isolated" households speaking Asian and Pacific Island languages (meaning that no one over age 14 in a given household speaks English "very well"), making up nearly 28% of all linguistically isolated households in the United States.[7]

The federal government and courts have recognized that language minorities are legally entitled to meaningful access to federally-funded programs. There are several laws –

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[1] The American Community Survey is a continuously ongoing survey conducted by the United States Census Bureau that asks in-depth questions to three million housing units annually from across every county in the nation.

[2] U.S. Census Bureau, 2006-2008 American Community Survey, Characteristics of People by Language Spoken at Home, *available at* http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=01000US&-qr_name=ACS_2008_3YR_G00_S1603&-ds_name=ACS_2008_3YR_G00_&-_lang=en&-_caller=geoselect&-state=st&-format=.

[3] U.S. Census Bureau, 2006-2008 American Community Survey, Language Spoken at Home, *available at* http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=01000US&-qr_name=ACS_2008_3YR_G00_S1601&-ds_name=ACS_2008_3YR_G00_&-_lang=en&-_caller=geoselect&-state=st&-format=.

[4] *Id*.

[5] *Id*.

[6] *Id*.

[7] U.S. Census Bureau, 2006-2008 American Community Survey, Linguistic Isolation, *available at* http://factfinder.census.gov/servlet/STTable?_bm=y&-state=st&-qr_name=ACS_2008_3YR_G00_S1602&-ds_name=ACS_2008_3YR_G00_&-redoLog=true&-_caller=geoselect&-geo_id=01000US&-format=&-_lang=en; U.S. Census Bureau, 2006-2008 American Community Survey, Households and Families, *available at* http://factfinder.census.gov/servlet/STTable?_bm=y&-state=st&-qr_name=ACS_2008_3YR_G00_S1101&-ds_name=ACS_2008_3YR_G00_&-redoLog=true&-_caller=geoselect&-geo_id=01000US&-format=&-_lang=en.

including significant federal legislation, orders, and regulations – that protect LEP individuals in the health care context. Title VI of the federal Civil Rights Act of 1964 and its corresponding regulations require recipients of federal money to take reasonable steps to provide “meaningful access” for LEP individuals to participate in its programs and activities.[8] Virtually all health care institutions -- including hospitals, nursing homes, home health agencies, managed care organizations, entities with health or social service research programs (including universities), state, county, and local health agencies, and state Medicaid agencies -- receive some form of federal financial assistance and are thereby governed by the United States Department of Health and Human Services (HHS) regulations and guidelines. Though there are federal and state requirements that protect LEP persons, many of these language assistance mandates are unfunded. The burden of complying with these requirements falls on the agencies themselves – 85% of them supply interpretation and translation services, but only 44% are funded to do so.[9] This lack of funding strains limited community resources and is a significant obstacle to the provision of appropriate language services to those who need it. As a result, LEP patients often are obliged to bring relatives, friends, neighbors, and other untrained individuals to provide ad hoc interpretation during health care visits. The use of untrained individuals can result in a number of problems, including:

- Breach of confidentiality which may have safety implications;
- Accidental omission of key information;
- Misinterpretation of health care terminology; and
- Lack of true, informed consent from the patient.

The use of minor children as interpreters poses additional problems because this places an undue burden on children who do not have the vocabulary or maturity to adequately interpret, while also damaging the parent-child relationship dynamic. Finally, adult LEP patients are unlikely to disclose sensitive health care information in front of their children, which can result in misdiagnosis and a failure to treat the underlying health condition.

The overarching goal of the Language Access project is to increase the availability and quality of interpretation services provided by key health care providers in metropolitan Chicago. It is generally accepted that language minorities face barriers when seeking health care, but there is insufficient research on the specific unmet language access needs of Asian Americans. This study aims to contribute to the information available on the needs of LEP Korean Americans in the Chicago area, with the broader goal of increasing the availability and quality of interpretation services provided by key health care providers in metropolitan Chicago. It documents the experiences of Korean

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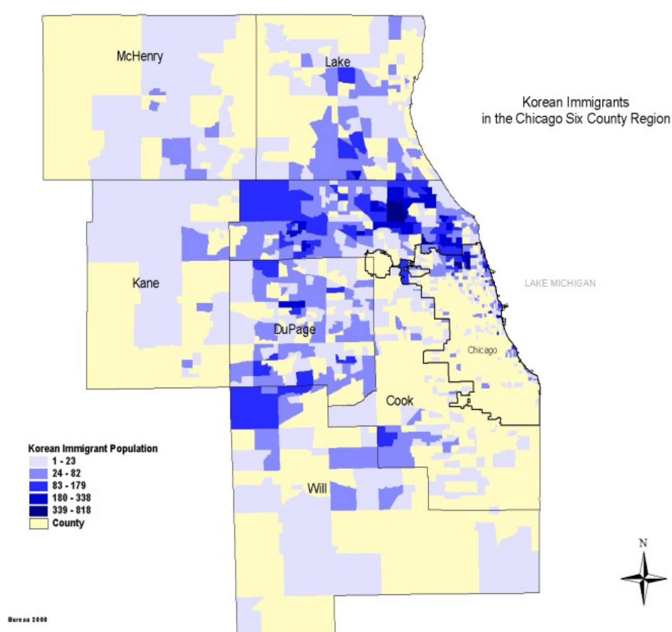
[8] *Id.*; Enforcement of Title VI of the Civil Rights Act of 1964 – National Origin Discrimination Against Persons With Limited English Proficiency, 65 Fed. Reg. 50,123 (Dep’t of Justice Aug. 16, 2000), *available at* http://www.justice.gov/crt/cor/Pubs/eolep.pdf (“DOJ Guideline”).

[9] Paul Igasaki and Max Niedzwiecki, *Aging Among Southeast Asian Americans in California: Assessing Strengths and Challenges, Strategizing for the Future* (2004), at 4, *available at* http://www.searac.org/aging-seaamer-fin.pdf (“SEARAC Report”).

American patients in Chicago, as well as the northern and the near northwestern suburbs, at a variety of hospitals and clinics.

Korean Americans

During the 2000 Census, Koreans were 11% of the Asian American population in the United States, and the fifth largest Asian American subgroup[10]. This represented an almost 35% increase over the previous decade[11]. The United States is home to the second largest overseas Korean community in the world after China. As of 2000, there were approximately 1.1 million Korean Americans,[12] with the largest populations in the states of California, New York, New Jersey, Illinois, Washington, Texas, Virginia, Maryland, Pennsylvania, and Georgia. As a recent immigrant community, a vast majority of Korean Americans are limited English proficient (LEP) and about 41% are linguistically isolated.



Illinois counted 50,646 in the 2000 Census (60,709 Korean Americans in the 2006-2008 ACS data) with 45,607(53,524 in 2006-2008 ACS data) in the Consolidated Metropolitan Census Area with 33,953 in Cook County alone (34,915 in 2006-2008 ACS data)[13]. According to the data from the 2000 Census, 11,489 Korean Americans lived in Chicago with the others living outside the city. Most seem to live in the northern and near northwest suburbs of Chicago in places such as Glenview and Northbrook, among others. The six-county map based on the 2000 Census illustrates this[14].

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[10] U.S. Census Bureau, Race Alone or in Combination for American Indian, Alaska Native, and for Selected Categories of Asian and of Native Hawaiian and Other Pacific Islander: 2000, *available at* http://factfinder.census.gov/servlet/QTTable?_bm=y&-geo_id=01000US&-qr_name=DEC_2000_SF1_U_QTP7&-ds_name=DEC_2000_SF1_U&-_lang=en&-_caller=geoselect&-state=qt&-format=.

[11] *Id.*; U.S. Census Bureau, 1990 Census, Detailed Race, *available at* http://factfinder.census.gov/servlet/DTTable?_bm=y&-state=dt&-ds_name=DEC_1990_STF1_&-mt_name=DEC_1990_STF1_P007&-redoLog=true&-_caller=geoselect&-geo_id=01000US&-geo_id=NBSP&-format=&-_lang=en.

[12] *Id.*

[13] United States Census Bureau, http://factfinder.census.gov/servlet/DTTable?_bm=y&-context=dt&-reg=DEC_2000_SF2_U_PCT032:001|023;&-ds_name=DEC_2000_SF2_U&-CONTEXT=dt&-mt_name=DEC_2000_SF2_U_PCT032&-tree_id=402&-redoLog=true&-all_geo_types=N&-_caller=geoselect&-geo_id=04000US17&-geo_id=05000US17031&-geo_id=16000US1714000&-search_results=16000US1714000&-format=&-_lang=en

[14] Korean Americans in the Chicago Metropolitan Region, Egan Urban Center, DePaul University, 2005.

According to the National Korean American Service and Education Consortium (NAKASEC)[15]:

- Nationally, 26% of Korean Americans do not receive regular care (the number climbs to 48% among those uninsured), with only 26% of Korean Americans reporting visiting a regular doctor.
- Though breast, cervical and colon rectal cancer is common among Korean American women, screening practices are greatly underused.

Among the top factors cited for the underuse of preventive and early diagnostic medical services is the lack of health services that are culturally competent or linguistically appropriate.

[15] National Korean American Service & Education Consortium, *Why Korean Americans Need Responsible Health Care Reform* (2009), 1, *available at* http://nakasec.org/blog/wp-content/files/2009/10/Health-Reform-Community-Ed-redesign.pdf

III. Methods

With input from Korean American Community Services (KACS), AAI developed a 22-item questionnaire that collected respondents' demographic information, utilization of selected public benefits programs, and information relating to their most recent medical visit, including access to language services. A copy of the survey instrument, which was translated into Korean, is included in the Appendix.

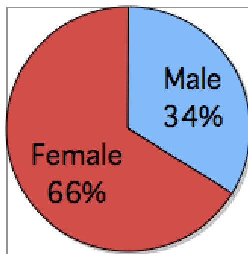
Bilingual volunteers from KACS conducted the survey with community members in 2010. Respondents included those living in Chicago and the suburbs, and those who received health services in the city and the suburbs.

KACS staff indicated that they reached out primarily to their constituents to participate in this survey, which means that the respondents mirror their agency's client demographics and may not be representative of the larger Korean American community in greater Chicago. Presumably, these constituents are also more likely to need interpretation services and less likely to have a high level of English proficiency. Many of the respondents are tenants of the organization's senior housing programs.

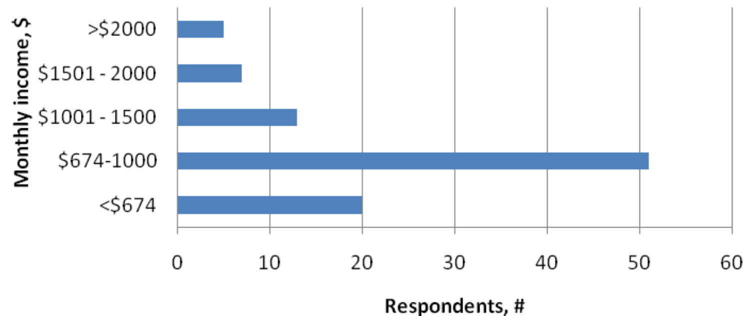
The survey was designed in order to examine the experience of Korean American seniors in "mainstream" or non-Korean health care provider settings, rather than the experience of seniors who saw Korean providers. This survey design was done with the assumption that seniors with Korean providers would not experience language barriers. However, this survey design did not take into account that younger Korean American physicians may not be fluent in speaking Korean and may present a language barrier to their limited English speaking patients.

IV. Results

Respondent Demographics



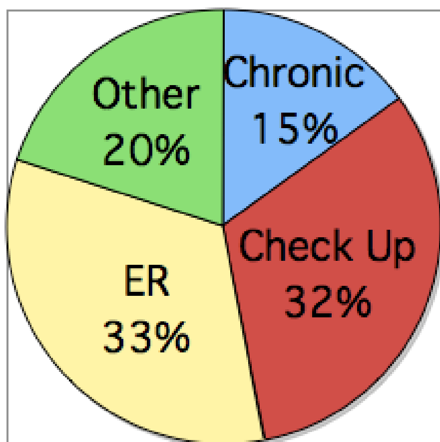
One hundred (100) respondents completed the survey. The difference in the percentage of men and women respondents is representative of the participants in KACS' programs, which tends to be mainly women. The average age of the respondents was 73 with the oldest being 93 and the youngest 55 years old. The majority of the respondents lived in the city (76%) with the remainder from the suburbs. 53% indicated that they lived alone, while the others indicated that they lived with family (including spouse and children). 64% of the respondents indicated that they had lived in the United States for 20 years or more. The primary language spoken inside the home was Korean for 92% of the survey respondents.



71% of the respondents had a monthly income of less than $1000.

88% of the respondents indicated that they had access to Medicare or Medicaid. Only two indicated that they had no health insurance.

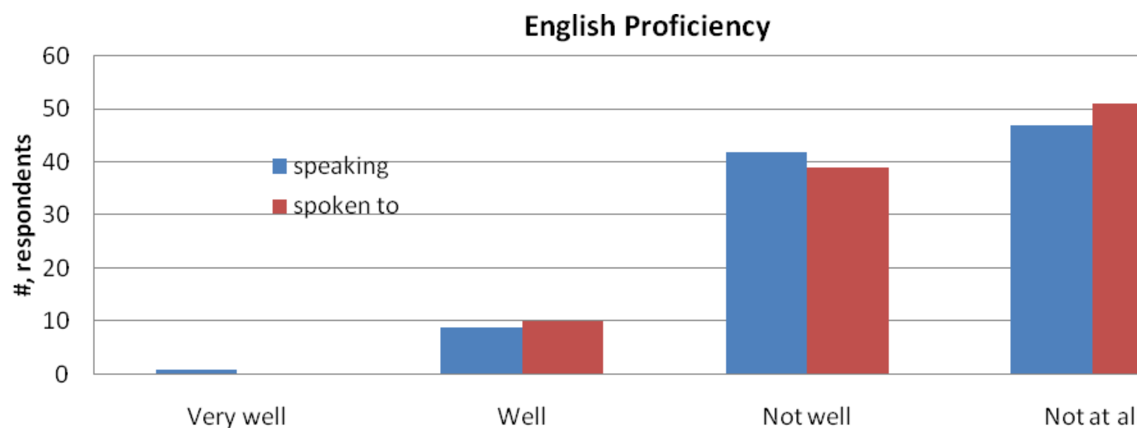
Health Access



The Korean Americans who responded to the survey had sought treatment with 'non-Korean' health care providers at a variety of locations, including a number of area hospitals and private clinics. The reasons for seeking treatment were also varied, ranging from chronic conditions, emergency services, routine checkups (which may include laboratory services), and eye exams. The accompanying chart shows the distribution of reasons for respondents' visits to the hospital or doctor.

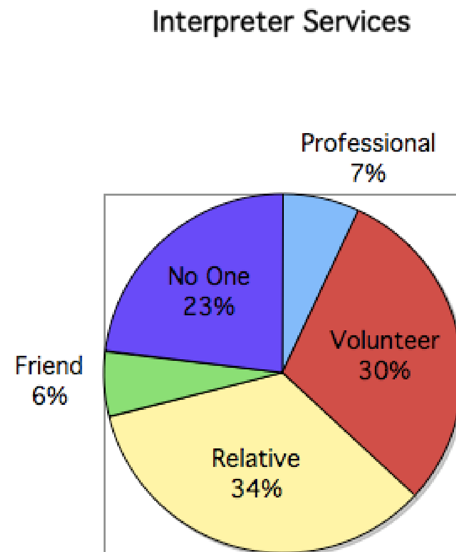
The survey also included questions about the satisfaction with the quality of healthcare provided. 88% indicated that they were very satisfied or somewhat satisfied with the services with only 11% indicating that they were somewhat or very dissatisfied with the services.

Because the primary language of most of the respondents was Korean, the respondents were asked about their proficiency in English. The answers are illustrated in the chart below. As the chart illustrates, most of the respondents indicate that their proficiency in comprehending or speaking English is limited. In spite of this, 50 respondents (50%) indicated that they were not offered any interpreter services by the hospital or clinic. 39 respondents (39%) indicated that they were offered these services and 11% of respondents did not respond to the question.



Respondents were asked how well they understood the information offered by the provider during the visit. Only 37% indicated that they understood the information very well and 32% indicated not well or not at all.

As stated above, the respondents sought a variety of treatments in a number of different hospitals. There is no clear pattern among the hospitals for offering interpretation services. There was only one hospital that seemed to consistently offer these services and one that did not offer them at all. For the other hospitals, some offered interpreter services sometimes and not at other times. There was no consistent approach to providing interpretation services within the same hospital. For instance, at one hospital which saw visits by 31 respondents, 54% were offered an interpreter while the remaining respondents were not.



According to staff at KACS, it is possible that in some cases the hospitals may have offered interpretation services in some limited manner, but not necessarily at a time that was feasible for the patient; the patient may have refused the services because of long waits in getting the assistance. Some of the respondents may have therefore tagged the answer as ‘no one’ provided the service. KACS does not consider this to be a meaningful approach to providing interpreter services.

Interpretation was provided most often by a relative, and professional interpretation services were seldom offered. Almost a quarter of the respondents indicated that they did not have the services of an interpreter. The chart above shows the distribution of who provided the interpreter services. In response to the question regarding the level of satisfaction with the quality of interpretation provided, 71% indicated that they were very satisfied with the quality of interpretation. However, no real conclusions can be drawn from this response, since it is not clear which group of interpreters could be included in this response (i.e. there has been no comparison of the reported satisfaction with the type of interpreter). Also, this response conflicts with the lower findings for understanding of the information from the healthcare provider and the quality of healthcare.

V. Discussion

To put the above research results into context, language access issues in the health care realm are critically important because language access services affect access to care; quality of care; health outcomes and health status; patient satisfaction; and cost of care.[16] Research has shown that language barriers create significant problems with access to health care. For example, non-English speaking patients are less likely to use primary and preventive care services and are more likely to use emergency rooms.[17] Additionally, language barriers lead to fewer physician visits and reduced receipt of preventive serves by LEP patients, even after controlling for factors such as literacy, health status, health insurance, regular source of care, and economic indicators.[18] Research has also shown that language barriers impair LEP patients' communication with health care providers and affect how LEP persons perceive their health care encounters.[19] Health care providers frequently identify language or cultural barriers as elements that hinder the quality of patient education for diabetes care.[20] In short, there is voluminous research documenting the relationship between language access services and racial and ethnic disparities in health care, and it shows that language access affects nearly all aspects of the health care system.

According to Title VI of the U.S. Civil Rights Act of 1964, health care institutions that receive federal funds are required to "take reasonable steps to ensure meaningful access to their programs and activities by LEP [limited English proficient] persons." Additionally, in 2000, the HHS Office of Minority Health issued standards (including mandates, guidelines, and recommendations) called the National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care.[21] The CLAS standards, independent of the Department of Justice guidance, impose four significant mandates on recipients of federal funds. Health care organizations must: (1) offer and provide language assistance services at no cost to patients; (2) provide patients verbal offers and written notices informing them of their right to receive language assistance services; (3) assure the competence of language assistance provided to limited English proficient patients by interpreters and bilingual staff, with the rule that family and friends should not be used to provide interpretation services except by patient request; and (4)

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[16] American Institutes for Research, *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations* (Sept, 2005), at 2, *available at* http://minorityhealth.hhs.gov/Assets/pdf/Checked/HC-LSIG.pdf.

[17] Jane Perkins, The Kaiser Commission on Medicaid and the Uninsured, *Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities* (Aug. 2003), at 3-4, *available at* http://www.kff.org/uninsured/upload/Ensuring-Linguistic-Access-in-Health-Care-Settings-An-Overview-of-Current-Legal-Rights-and-Responsibilities-PDF.pdf.

[18] American Institutes of Research, *supra* note 16, at 2.

[19] Perkins, *supra* note 17, at 4.

[20] American Institutes of Research, *supra* note 16, at 3.

[21] U.S. Department of Health and Human Services Office of Minority Health, *National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care Final Report* (March 2001), *available at* http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf ("CLAS Report").

make available easily-understood patient-related materials and post signage in the languages of the commonly encountered groups represented in the service area.[22] The CLAS standards are specific to the health care setting and provide clear mandates to health care providers and significant protections to LEP persons.

Asian Americans face particular challenges to accessing health care because they are culturally, linguistically, and socioeconomically diverse and are historically understudied. One significant barrier to effective language assistance for LEP Asian Americans stems from the linguistic diversity of the population – Asian Americans speak several different Asian languages, making it more difficult to provide language access assistance for all LEP Asian Americans.[23] As a result of this difficulty in obtaining language assistance, many LEP Asian Americans often rely on family members or friends to interpret for them in a medical setting. However, HHS discourages the use of family members or friends, in order to ensure complete, accurate, impartial, and confidential communication.[24] These health mandates also state that minor children should never be used as interpreters, nor should they be allowed to interpret for their parents when the children themselves are the patients.[25]

According to the HHS Office of Civil Rights' guidance, health care institutions should "consider special circumstances that may affect whether a family member or friend should serve as an interpreter, such as whether the situation is an emergency, and whether there are concerns over competency, confidentiality, privacy, or conflict of interest. Recipients cannot require LEP persons to use family members or friends as interpreters."

A variety of problems can arise when an <u>untrained</u> interpreter is used, including:

- Loss of confidentiality
- Omissions
- Additions
- Mistranslations
- Misdiagnosis
- Wrong treatment

Although most survey respondents in this study reported not speaking English well, almost 60% were not offered an interpreter, and most relied upon their children, relatives, or friends to serve as interpreters for their health care encounters. This leads to the following concerns:

- Is there an undue burden placed on LEP Korean American patients to identify and obtain their own interpreters?
- Is the interpretation accurate? There do not seem to be mechanisms in place to assure that Korean interpreters are qualified, meaning that they are fully

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[22] *Id* at 3, 10-13.
[23] SEARAC Report, *supra* note 9, at 4.
[24] CLAS Report, *supra* note 21, at 12.
[25] *Id*.

bilingual, are familiar with medical terminology, will maintain patient confidentiality, and can effectively manage the sensitive issues that often arise in health care encounters.

- What is the potential impact on quality of care received by Korean American patients, if patients are relying upon untested and untrained interpreters?

VI. Recommendations

As they age, Korean American seniors become more vulnerable in terms of their health status, and for many of them, limited English proficiency provides a significant barrier to care. For this population, it is especially critical to have effective linguistic access to health care.

Recommendations for hospitals

We recommend that metropolitan Chicago area hospitals utilize the below framework, provided by the federal government, for developing collaborative partnerships with the local Korean American community, and for training and deploying qualified health interpreters[26]:

1. Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

[26] CLAS Report, *supra* note 21, at 4.

7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Recommendations for community-based organizations that serve Korean American clients

- Use the data from these studies.
- Gain deeper understanding of when language access is legally required.

- Engage community members in the process.

    - Arm seniors and other LEP clients with information about their rights.

    - Connect community members with interpretation training opportunities, such as through Cross-Cultural Interpreting Services, a program of Heartland Alliance.

- Build a cooperative relationship with key hospital staff and be a key resource for hospital.

    - Provide periodic feedback to the hospitals, which might include both positive and negative feedback.

    - Offer assistance that includes data as well as shared understanding of cultural competency.

    - Provide community resources and help hospitals conduct outreach to community members, including potential interpreters.

    - Encourage hospitals to engage outside consultants to assist them with improving the effectiveness of pre-existing language access systems.

- Build a cooperative relationship with the HHS Office of Civil Rights and other agencies.

    - Report non-compliance to HHS: http://www.hhs.gov/ocr/office/file/index.html

    - Report non-compliance to state and local agencies that implement the Illinois Language Assistance Service Act.

    - Keep abreast of applicable laws, regulations, and enforcement.

- Create and implement an advocacy plan with goals, strategies, and benchmarks that will lead to better outcomes for their constituents.

    - Articulate reasonable commitments to seek from health care providers and government agencies.

    - Strategize how to help them achieve these commitments.

    - Join forces with other communities facing similar barriers, such as the Laotian community.

Recommendations for mainstream health advocacy organizations

- Include language access for Asian Americans as a priority advocacy issue.
- Develop cooperative relationships with Korean American community-based organizations to help them build advocacy capacity.

Recommendations for funders

- Provide funding support to assist Korean American and other Asian American organizations to build capacity for advocating on language access issues and building relationships with health care providers.

Appendix: Survey Instruments

Language Access to Health Care Questionnaire (English)

Language Access to Health Care Questionnaire (Korean) –

의료서비스 이용시 통역 서비스에 관한 설문조사

Language Access to Health Care Questionnaire

Korean American Community Services is conducting an anonymous survey of Korean seniors (age 55+) to learn more about their recent experiences with health care and language access. Please take about 5-10 minutes to complete this anonymous and confidential survey.

Today's Date: ___/___/___ (Month/Date/Year)

I. Demographic Information

A. Zip Code:__________ **B. Gender:** Male / Female **C. Age:** ______ years

D. Which language(s) do you speak at home? __(1) Korean __(2) English __(3) Other

E. How well do you speak English:

__(1) Very well __(2) Well __(3) Not well __(4) Not at all

F. How well do you understand English when it is spoken to you:

__(1) Very well __(2) Well __(3) Not well __(4) Not at all

G. Please describe your living situation:

__(1) Alone __(2) With spouse __(3) With Children (4) With other relatives

(4) Other:______________

H. How long have you lived in the United States?

__(1) 5 years or less __(2) 6-10 years __(3) 11-20 years __(4) More than 20 years

II. Health Care Visit Information

For the following questions, please refer to the most recent time that you visited a non-Korean doctor or other non-Korean health care provider (nurse practitioner, specialist, etc.).

A. Approximate date of most recent health care visit: ___/___/___ (Month/Date/Year)

B. Name of hospital or clinic visited: ___________________________________

C. Reason for visit:

__ (1) Chronic condition: __________ __(2) Check-up __(3) Emergency__(4) Other:____________

D. How long did you wait before seeing the doctor or other health care provider? ______ minutes

E. Did the hospital or clinic offer to provide an interpreter for your visit? __(1) Yes __(2) No

F. Who provided interpretation for you during this visit?

__(1) Professional interpreter __(2) Volunteer __(3) Relative __(4) Friend __(5) No one

G. If a relative provided interpretation, what was the relationship of this person to you?

__(1) Daughter/son __(2) Niece/nephew __ (3) Brother/sister __(4) Other __(5) Not applicable

H. About how old was the person who provided interpretation for you? ___ years old

I. How satisfied were you with the quality of the interpretation provided by this person?

__(1) Very satisfied __(2) Somewhat satisfied __(3) Somewhat dissatisfied __(4) Very dissatisfied

J. How well did you understand the information from your doctor or other health care provider during this visit?

__(1) Very well __(2) Well __(3) Not well __(4) Not at all

K. How satisfied were you with the quality of health care that you received during this visit?

__(1) Very satisfied __(2) Somewhat satisfied __(3) Somewhat dissatisfied __(4) Very dissatisfied

L. ***If you experienced any difficulties during your visit, please tell us more about what happened.*** (Please use an additional piece of paper and staple it to this survey.)

III. Income and health insurance information

A. What kind of health insurance coverage do you have?

__(1) Medicaid __(2) Medicare __ (3) Health Insurance from current or previous employers (4) Private health insurance __(5) No insurance

B. Approximately how much is your gross monthly income?

__(1) $674 or less __(2) $675–$1000 __ (3) $1,001–$1,500 __(4) $1501-$2,000 __(5) $2,001 or more

Thank you very much for completing this survey! Your answers will be kept confidential. For more information about this project, please contact Youn Hee Harm at KACS, (773) 583-5501 x164.

의료서비스 이용시 통역 서비스에 관한 설문조사

한인사회복지회에서는 55세 이상의 한국분들을 대상으로 의료서비스와 그와 관련된 통역서비스에 있어서 최근에 어떤 경험들을 하셨는지에 대해 설문조사를 실시하고 있습니다. 본 설문조사를 작성하기 위해서는 약 5-10분 정도의 시간이 소요될 것이며, 이 설문조사에 제공되는 모든 정보는 비밀이 철저히 보장되어지며, 본 조사는 익명으로 진행됩니다.

오늘날짜: ____(월)_____(일)/_________(년도)

I. 인구 통계학적 정보

A. 현 거주지의 우편번호 (Zip Code):_________ B. 성별: 남성/ 여성 C. 나이: _____ (세)

D. 귀하께서는 집에서 무슨 언어를 사용하십니까? (1)한국말___ (2) 영어 _____ (3) 이외의 다른 언어________

E. 귀하께서는 얼마나 영어를 잘 말합니까?

(1) 아주 잘 말한다.___ (2) 잘 말한다.___ (3) 잘 말하지 못한다.____ (4) 전혀 못 한다. ____

F. 귀하께서는 얼마나 영어를 잘 이해합니까?

(1) 아주 잘 말한다._____ (2) 잘 말한다._____ (3) 잘 말하지 못한다._____ (4) 전혀 못 한다. ____

G. 귀하께서는 현재 누구와 함께 살고 계십니까?

(1) 혼자서 ____ (2) 배우자와 함께___ (3) 자녀들과 함께____ (4) 친척들과 함께 ____ (5)기타:________

H. 미국에서 얼마나 오래 살았습니까?

(1) 5년 미만____ (2) 6-10년 ____ (3) 11-20년____ (4) 21년 이상____

II. 최근 의료서비스 방문에 관한 정보

다음은 귀하께서 가장 최근에 <u>한국말을 하지 못하는</u> 의료서비스 제공자들 (의사, 간호사, 전문의들 등)을 방문했던 경험들에 관한 질문들입니다.

A. 가장 최근에 (한국어를 못하는) 의료서비스 제공자를 방문한 날: ____ (월)/______(일)/______(년도)

B. 방문한 병원 또는 의료기관의 이름: ________________________________

C. 방문이유:

(1) 만성질환_____ (2) 정규검진____ (3) 응급치료____ (4) 기타:_____________________________________

D. 귀하께서는 의료서비스를 받기 전까지 얼마나 오래 기다렸습니까? ______ 분

E. 귀하께서 방문한 병원 또는의료기관으로부터 통역서비스를 제공받았습니까? (1)예___ (2)아니요___

F. 귀하께서 병원 또는 의료기관을 방문하셨을 때 누가 통역을 제공해 주었습니까?

(1) 전문통역사 ____ (2) 자원봉사자 __ (3) 친척____ (4) 친구____(5) 통역사가 없었음____

G. 만일 친척이 통역서비스를 제공했다면, 이 사람과 귀하는 어떤 관계입니까?

(1) 자녀____ (2) 조카____ (3) 형제/자매_____ (4) 기타______

H. 귀하를 위해서 통역서비스를 제공해 준 사람의 나이는 대략 몇 살입니까? ___ 살

I. 귀하께서는 이 사람이 제공한 통역서비스에 대해서 얼마나 만족하십까?

(1) 매우 만족한다.___ (2) 조금 만족한다.___ (3) 조금 만족하지 않는다. ___ (4) 매우 만족하지 않는다.___

J. 귀하께서는 최근에 방문했던 한국말을 못하는 의사 또는 의료서비스 제공자들로 부터 받은 정보들을 얼마나 잘 이해했습니까?

(1) 아주 잘 이해했다.___ (2) 잘이해했다.____ (3) 잘 이해하지못했다. ___ (4) 전혀 이해하지 못했다. ____l

K. 이방문 때 귀하께서 받은 의료서비스 받은 의료서비스에 대해서 얼마나 만족하십니까?

(1) 매우 만족한다.___ (2) 조금 만족한다.___ (3) 조금 만족하지 않는다. ___ (4) 매우 만족하지 않는다.___

L. 만일 귀하께서 최근 의료서비스를 받으면서 어려움이나 불쾌한 경험을 하셨다면, 어떤 일이 있었는지 아래의 빈 공간에 자세히 적어주시기 바랍니다.

III. 소득 및 의료 보험 정보

A. 귀하께서는 다음 중 어떤 의료보험을 가지고 있습니까?

(1) 메디케이드 __(2)메디케어 __ (3)직장보험__ (4)사보험____(4) 의료보험 없음____

B.귀하의 월 소득(세금 공제 전)은 약 얼마 입니까?

(1) $650미만__ (2) $651-$1000__ (3) $1,001-$1,500__ (4) $1501–$2,000__ (5) $2,001이상___

본 설문조사에 참여해 주셔서 감사합니다.
귀하께서 제공한 모든 답변들은 비밀이 보장될 것입니다.
본 설문조사와 관련하여 더 자세한 정보를 원하시면,
한인사회복지회 노인복지부 드렉터 함윤희께 (773) 583-5501(교환:164)으로연락하시기 바랍니다.