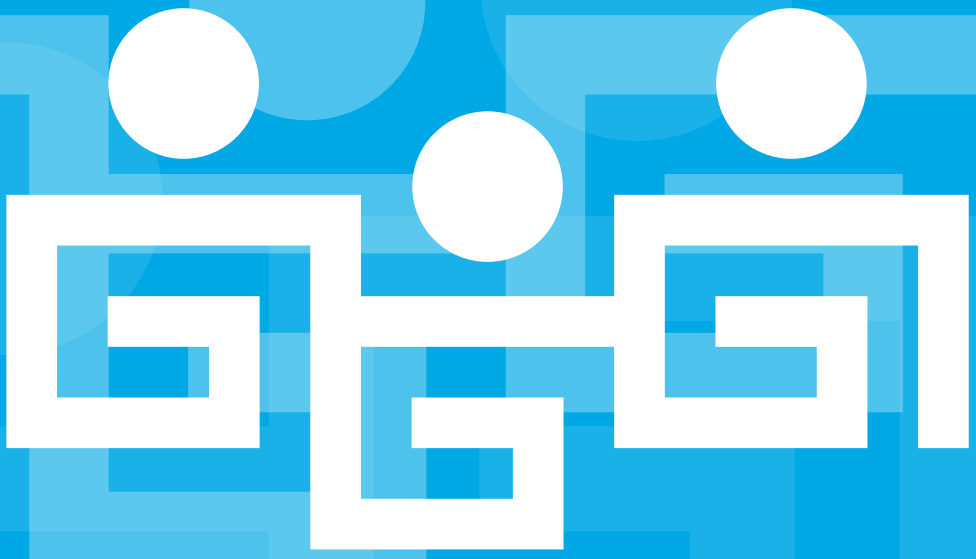
KOREAN NEEDS ASSESSMENT OF THE BAY AREA 2014-2015

POLICY BRIEF

IMPROVING HEALTH LITERACY FOR BAY AREA KOREANS



Korean Community Center of the East Bay

HEALTH RESEARCH FOR Action
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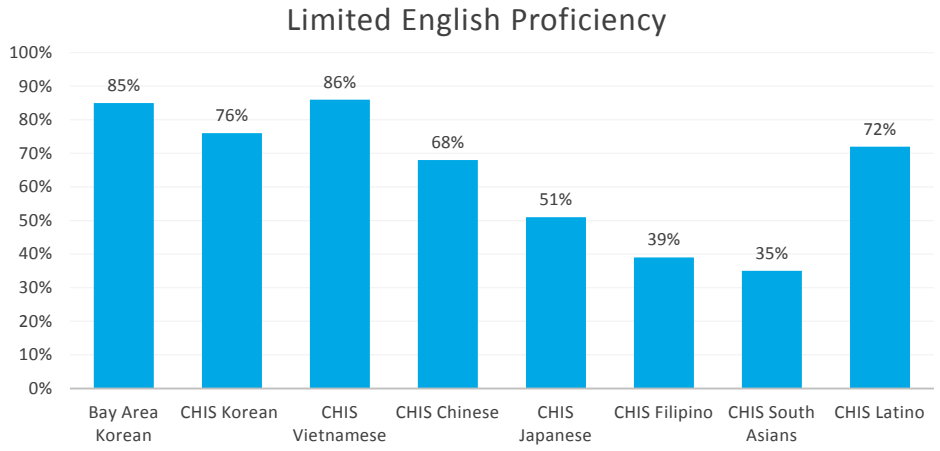
Significance

The demographics of the United States are increasingly diversified. The Asian American population is perhaps the most illustrative of this growing diversity, as the fastest-growing racial group in the country, with dozens of different cultures and languages. Approximately 71% of Asian Americans speak a language other than English at home, and 32% of Asian Americans have limited English proficiency (LEP) and experience some difficulty communicating in English. In 2010, 25.2 million LEP individuals were living in United States, accounting for 9% of the total U.S. population ages 5 and older (Pandya, McHugh, & Batalova, 2011). Among all the states, California has the greatest proportion of people with LEP, with 19% of the total state population identifying themselves as having LEP (Zong & Batalova, 2015). The 2011–2012 California Health Interview Survey (CHIS) reported that although Asians have the second highest LEP rate (60%) compared to other racial groups, Koreans have a LEP rate of 76%, which is higher than other major Asian subgroups and Latinos. This comparison shows that language access is an obstacle faced by a majority of Koreans living in the U.S.

The U.S. Department of Health and Human Services (2015) defines persons with limited English proficiency (LEP) as those "who are unable to communicate effectively in English because their primary language is not English and they have not developed fluency in the English language". Language assistance services are necessary for LEP individuals to access federally-funded and privately-offered programs and activities in the health care system. Without language assistance services that ensure meaningful access to the Patient Protection and Affordable Care Act's (ACA's) new insurance programs or existing programs, communities with a large number of LEP individuals will be systematically excluded from opportunities to achieve better health. Thus, LEP serves as a significant hindrance to healthy living because it also strongly affects health literacy, which is the degree to which individuals have the capacity to obtain, process, and understand basic



(CHIS. 2010-2012)

health information and services needed to make appropriate health decisions (Nielsen-Bohlman, Panzer, & Kindig, 2004).

Due to the complexity of issues affecting health literacy, no reliable studies of its full impact on costs for health care services have been completed. One study estimated the cost of limited health literacy to the nation's economy to be between $106 and $236 billion in U.S. dollars annually. When future costs that result from current actions (or lack of action) are included, the real present-day cost of limited health literacy might be closer to $1.6–3.6 trillion annually (Vernon, Trujillo, Rosenbaum, & DeBuono, 2007). Limited health literacy also has psychological costs. Adults with limited health literacy skills report feeling a sense of shame about their skill level (Parikh, Parker, Nurss, Baker, & Williams, 1996; Wolf et al., 2007). They may hide their struggles with reading or vocabulary (Baker et al., 1996). Further, limited health literacy is often invisible to health care providers and other public health professionals (Barrett, Puryear, & Westpheling , 2008; Parker, 2000; Rogers, Wallace, & Weiss, 2006).

Individuals with both LEP and low health literacy compose a particularly vulnerable group, with high rates of poor health status (Sentell & Braun, 2012). Given the high LEP rates among Koreans, in combination with poor self-reported health and low health literacy, it is critical to address this health disparity issue for this group.

Korean Community Center of the East Bay (KCCEB) and Health Research for Action at UC Berkley School of Public Health conducted a survey in the San Francisco Bay Area, which corroborates the serious problems associated with high levels of LEP and low health literacy rates among Koreans living in the region. 342 Korean American adults participated via phone, in-person interviews, and online between July 2014 and February 2015 in the San Francisco Bay Area. The following are results of the survey and recommendations to improve access to health care coverage and services.

Discussions

Bay Area Koreans show a very high rate of limited English proficiency. LEP is reported to be one of two key risk factors that affect health-related quality of life among six Asian ethnic groups: Chinese, Filipino, Japanese, Korean, Vietnamese, and South Asian (Gee & Ponce, 2010). In our Bay Area survey, eighty-five percent (85%) of Korean participants reported LEP, which is higher than the 76% LEP rate for the California Korean population reported by the 2011–2012 CHIS. A majority of our survey participants was an immigrant population born in Korea, and our rate is consistent with the state data on high LEP rate among Koreans. This indicates the importance of exploring the language service capacity gaps and communication preferences to support Koreans in accessing, understanding and making appropriate health decisions.

A majority of Bay Area Koreans has difficulty understanding communications by their physicians. A third of our participants (33%) reported difficulty in communicating with their health care provider due to language barriers. Of that group, 87% reported that they needed help to understand the doctor, 78% said they would prefer to have a doctor who speaks Korean, and 46% would prefer to see a Korean doctor even if they had to pay more for health care. Clearly, a provider network with Korean-speaking physicians and other ancillary providers would be important to improve health care access and quality care in this population.

Many Bay Area Koreans have trouble navigating the health care system and are unfamiliar with patients' health rights as well as the other benefits that their medical insurance offers. Although language is one obvious obstacle, the complexity of the U.S. health care system, in contrast to Korea's single-payer system, is another very likely cause. Like many Americans, Korean Americans face challenges with evaluating various health plans, choosing primary care providers, and utilizing services within a provider network. The fact that a huge portion of the community does not have a usual source of care (28%) despite having health insurance indicates a limited understanding of the health system; in combination with LEP, this puts Koreans at a higher risk for poor health outcomes. Less than half of survey participants (46%) reported being familiar with the patients' rights assured by the Affordable Care Act (ACA), and 77% said they were unfamiliar with its provisions specific to women's health. Clearly, designing health information materials about patient rights and health care benefits as well as generating health promotion efforts that are culturally appropriate to the Korean community are vital in addressing their current challenges in navigating the complex American healthcare system.

Table 6. Korean Physician Preferences

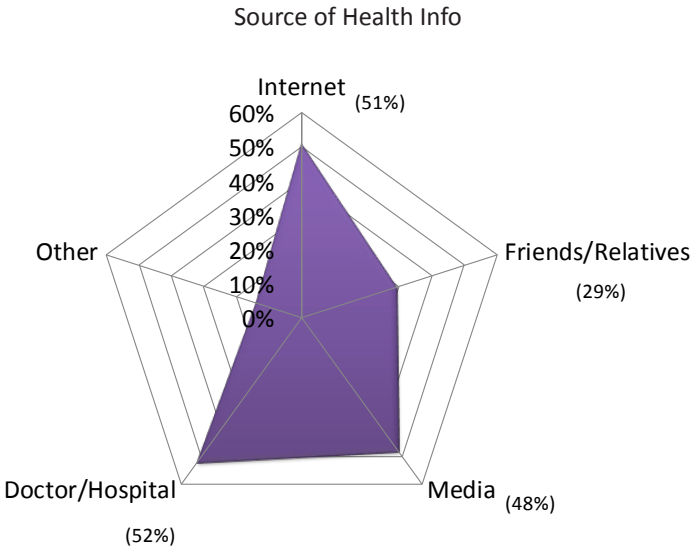
	Valid %
Have a doctor that speaks Korean (**yes, n=324**)	53
Of those who have doctors who speak Korean…	
Korean doctor is competent (**yes, n=174**)	83
Prefer a doctor who speaks Korean (**yes, n=321**)	78
Of those who prefer doctors who speak Korean:	
Prefer to pay out of pocket for a Korean Doctor (**yes, n=253**)	46
Prefer to receive care from a Korean Doctor even if it would prevent you from enrolling in a health plan (**yes, n=245**)	30
Difficulty communicating due to language (**yes, n=312**)	33
Of those who had difficulty communicating:	
Needed help to understand doctors (**yes, n=104**)	87

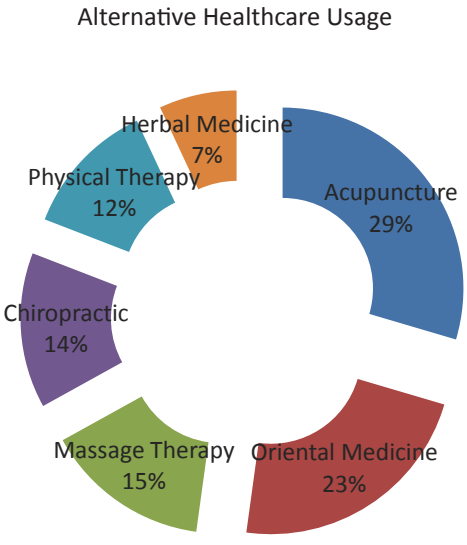
Koreans do not have a usual source of care, they experience delays in seeking medical care, and they do not often utilize preventive services such as cancer screening. Cancer is the leading cause of death (32%) for Koreans, yet one-third of Bay Area Korean participants (33%) responded that they do not have a usual place to go for healthcare. Even among those who have insurance, 28% reported that they do not have a usual place for care when they are sick. Almost one-tenth of participants (9%) visited the emergency department in the past year, and a third of the participants (31%) experienced delayed care. 30% of female participants responded that they never received a Pap smear, and 24% of participants who were above age 50 had reported that they had not received colorectal cancer screening. To better understand these low cancer screening rates, we tested the association between LEP and familiarity with each of the two cancer screenings and found a significant negative association between LEP and familiarity with the Pap smear ($p = 0.010$). This result implies that Korean women living in the Bay Area may not have received a Pap smear because of unfamiliarity with its benefits due to language barriers. A comprehensive community assessment of barriers and facilitators to cancer screenings for Koreans is needed to understand the gaps and provide recommendations on effective strategies and messages to increase the awareness about the value of cancer screenings in the Korean community.

Considering the high LEP rate and low rate of health literacy, understanding how Koreans get their health information is critical - Bay Area Koreans obtain health information from sources other than their physicians and seek alternative health care services. When asked about their sources of health information, about half of the participants mentioned the doctor's office (25%) and/or hospital (27%); many responded that

they rely on Internet (51%), friends and relatives (29%), newspaper (26%), and television (22%), among other sources. One fourth of the Korean participants are getting healthcare from someone other than a physician or nurse. When asked about types of alternative healthcare services they have received, acupuncture was the number one alternative healthcare service (30%), followed by eastern medicine doctor (23%), massage therapy (15%), chiropractic (14%), physical therapy (12%), herbal medicine (7%), and mental health counseling (4%). Getting vital health information out to Koreans requires a multi-pronged approach that includes support from a variety of community information sources such as family/friends, newspaper, television, and traditional Korean medical providers together with Western health care sources such as a primary care physician or another clinical staff.

Improving health literacy requires multifaceted solutions outside the clinical setting. Given how LEP affects health literacy, addressing physician-patient language barriers is critical. However, many current approaches to this issue are based on a clinical model that views poor literacy as a risk factor that needs to be managed when providing care. This type of intervention alone is not sufficient as it fails to address the importance of social determinants of health. Community-based empowerment models view health literacy as an asset that needs to be developed. Health education and communication improve one's ability to effectively navigate the health care system, actively participate in making health care decisions, and choose healthier behaviors, thus gaining greater control over everyday events in their lives (Nutbeam, 2000). As a result of improved health literacy, individuals will be able to develop necessary skills to engage in health-enhancing actions including using services to promote better health, enabling confident interactions with health care providers, having the ability to navigate the health care system effectively, and influencing others to make healthy decisions.





Recommendations

- Lack of Korean language physicians and other healthcare providers is one of the largest barriers to healthcare access. Therefore, Covered CA should expand provider networks to include bilingual Korean healthcare professionals;
- Federal, state and local governments need to create meaningful public-private partnerships that value Korean-serving community-based organizational (CBO) partnerships. This includes contracting with Korean CBOs who can provide expertise in initial planning and development of culturally and linguistically appropriate health educational materials and ensuring proper translation from English into Korean and other languages, rather than relying on the current ad hoc system of using third party translation agencies and then requesting pro bono post-translation validation from CBOs;
- Expand collaboration beyond traditional Western health care and partner with alternative systems of healthcare (e.g., acupuncture, traditional Asian medicine) in conjunction with primary care; also expand coverage to include alternative healthcare services;
- Create federal and state funding streams to support building of a community health workers (CHW) network beyond clinical setting, based on the empowerment model to improve health literacy. CHWs are fundamentally different from support staff who provide assistance to healthcare professionals in a clinical setting. As CHWs are most effective in facilitating self-directed change, investing in them will lead to community capacity development and empowerment of Korean patients to successfully navigate the American healthcare system;
- Since Internet/smartphones are the primary source of health information for Koreans, explore easy-to-use Korean apps that provide accurate and reliable health information and instructions for accessing and utilizing the healthcare system;
- A comprehensive community assessment of barriers and facilitators to cancer screenings for Koreans is needed to understand the gaps and provide recommendations on effective strategies and messages to increase the awareness about the value of cancer screenings in the Korean community.

References

All references cited in the text are available in the on-line. [http://kcceb.org/konabayarea/]

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