Petition to the State Health Coordinating Council
Regarding the Home Health Methodology and Policies
For the 2009 State Medical Facilities Plan

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PETITION

STATEMENT OF REQUESTED CHANGE

Personal Home Care (PHC) of NC, LLC requests the following changes in the methodology and policies for the 2009 State Medical Facilities Plan.

> Inclusion of an adjusted need determination for one home health agency in Mecklenburg County to address the special needs of the non-English speaking, non-Hispanic population. Qualified applicants should show evidence of fluency in multiple languages other than Spanish, including Russian, and should have a track record of successfully serving the County.

REASONS FOR THE PROPOSED CHANGES

Existence of an Underserved Special Needs Population

In 2007, deficits in the 2008 Home Health Services assumptions and methodology triggered the formation of a Home Health Task Force to make recommendations on the 2009 State Medical Facilities Plan (SMFP). Among the recommendations was a statement added by the North Carolina State Health Coordinating Council encouraging home health applicants to "address special needs population".

This statement to applicants pertains to all the service areas in North Carolina. It is clearly intended to support the SMFP's basic governing principle of expanding health care services to the medically underserved. However, what may not be apparent is just how urgent the situation is in the greater Mecklenburg area.

Mecklenburg County has had no home health agencies added since 2005. Yet, it is the second fastest growing county in the state.

Mecklenburg County has a large and growing population of foreign-born citizens. According to the most recent U.S. Census Bureau estimates, 13 percent of the county's population is foreign born. This population segment has grown dramatically in the last several years. The 2000 census reported only 9.8 percent of the population or 68,349 people as foreign born. For 2006 estimates, this number has risen to 104,789 people. The largest non-American ancestry groups reported for Mecklenburg include (listed alphabetically): Arab, Czech, Danish, Dutch, English, French (except Basque), French Canadian, German, Greek, Hungarian, Irish, Italian, Lithuanian, Norwegian, Polish, Portuguese, Russian, Scotch-Irish, Scottish, Slovak, Sub-Saharan African, Swedish, Swiss, Ukrainian, Welsh, West Indian (excluding Hispanic origin groups)[1]. As one might expect with such a diverse population, language is often a barrier to receiving adequate health care.

Mecklenburg County Demographics

	Total population	Foreign-born population*	Foreign-born as % of total	Speak English "less than very well"	"less than very well" as % of total
2000	695,454	68,349	10%	43,326	6%
2006	827,445	104,789	13%	62,531	8%

Source: U.S. Census Bureau, 2000 American Community Survey and U.S. Census Bureau, 2006 American Community Survey

*Excluding population born at sea

Fifteen percent of the population of Mecklenburg County report that they speak a language other than English at home. Eight percent of the population report that they speak English "less than very well". Notwithstanding media focus on the growing Hispanic population, this population is not all Hispanic people. Only about half are Spanish speaking. The other half speaks a variety of

[1] American Community Survey 2000 & 2006, *U.S. Census Bureau,* http://factfinder.census.gov/servlet/ACSSAFFFacts?_event=Search&_lang=en&_sse=on&geo_id=05000US37119&_county=Mecklenburg+County. Retrieved July 11, 2008.

languages. North Carolina's most commonly spoken other languages include Arabic, Chinese, French, German, Italian, Japanese, Korean, Greek, Russian, and Vietnamese[2].

Imagine what it means to have 62,531 people in the service area who struggle to get their daily needs met because of a language barrier. This is approximately one in every 13 citizens of Mecklenburg County. These people are neighbors, fellow church members and participants in community events. Now, imagine what it means to have 62,531 people using the local health care system and struggling to communicate in English.

Translation services do not accurately convey meanings, because they translate literally. For example, the question "Have you had a bowel movement today" literally translates in Russian to "Have your bowels moved around in your body today" or "Did you use the restaurant restroom?" Pronunciation difficulties compound the problem.

Cost to Provide Services to the Underserved

Local health care facilities, such as Carolinas Medical Center (CMC), long ago recognized the challenges and the risk of medical errors when treating patients with a language barrier. As a result of this service need, CMC offers interpreter services, telephone prompts in Spanish, translated patient education materials and prescriptions filled in Spanish. For every CMC location where greater than five percent of the population speaks Spanish, the hospital provides bilingual staff and on-site interpreters. However, a home health care provider has fewer resources at her disposal; she is one-on-one with her patient. Interpretation could be handled via the language line. Yet, the language line currently costs $3.95 per minute. For a typical 50 minute home care visit, the translation expense alone would exceed Medicare reimbursement for the visit.

Carolinas Medical Center has done some research on the strain that language barriers put on its health care system. CMC has determined that it takes 17.6 percent longer to care for a Spanish speaking patient than for an English speaking patient[3]. Given that CMC has invested significant resources in providing for the Spanish speaking population, that percentage of time can be assumed to be higher for a patient who speaks a language other than Spanish. Moreover, CMC has also discovered that hiring bilingual staff is more cost effective than translation. CMC determined that paying a bilingual staff member is nine times more cost effective than paying an internal interpreter, and 30 times more cost effective than contracting with an agency interpreter.

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[2] Detailed List of Languages Spoken at Home for the Population 5 Years and Over by State, *U.S. Census Bureau,* http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=DEC&_submenuId=datasets_2&_lang=en&_ts=. Retrieved July 11, 2008.

[3] Mayor's Immigration Study Commission: Healthcare, *Immigration: Legal and Illegal, Local Perspective – Charlotte, North Carolina* (2007, January), http://www.charmeck.org/Departments/Mayor/ImmigrationStudy/Healthcare.htm. Retrieved July 11, 2008.

Problems with the Proposed SMFP 2009 Methodology

The methodology used in the Proposed 2009 State Medical Facilities Plan for calculating need for home health agencies combines historic three-year averaged age-adjusted use rates by county for 2005-2007, population forecasts by age for 2010 and the actual number of patients served by existing agencies for 2007. It assumes that it will take 275 patients to support a new agency. It calculates need for each of 17 Council of Governments Regions by aggregating the need for counties in each Region. It anticipates that existing agencies will continue to grow at the county's three-year adjusted age rate. Need for a new agency thus occurs only when population outstrips average growth by 275 patients. The methodology has no provision for maximum annual growth in an agency. This means that as existing agencies expand and provide service to more patients, it is less likely that any additional agencies will be approved. Though it shields existing agencies, it also suppresses competition and favors the status quo.

The difference in ratio of home health agencies to population in Mecklenburg, Wake and Guilford Counties emphasizes the access disparity in Mecklenburg County. In Mecklenburg, the average agency serves 60 percent more patients than the average agency in Guilford County. Moreover, the Mecklenburg ratio is inflated by the non-functional placeholder. Without the placeholder, the Mecklenburg ratio of patients per agency would be twice that of Guilford County.

Home Health Patients Per Agency in 2010

County	Agencies	Patients per Agency
Mecklenburg	* 9	104,782
Wake	11	75,837
Guilford	7	65,826

Source: Proposed 2009 SMFP, Table 12A, pages 262-263 and Proposed 2009 SMFP, Table 12C, page 277

* One additional agency has been added to account for the placeholder agency not listed amongst existing 2007 agencies. This agency was approved in 2005, but is not anticipated to begin providing service until sometime in 2008, because of CMS delays.

Part of the problem lies in the long stay of a placeholder in Mecklenburg County. For the past three years, a 400-patient placeholder has remained in the Plan. The actual need is masked by this placeholder. Over time, as patients could not be accommodated by existing agencies, the use rates fell unnaturally. In 2009, the threshold of need for a new agency has been dropped to 275 un-served patients. Yet, because of low use rates, Mecklenburg still shows a surplus of 356 patients and no need for an additional home health agency.

The proposed 2010 SMFP Anticipated Use Rates per 1,000 illustrate the effect of the long stay of the placeholder approved in 2005. Because of the placeholder, the use rates in Mecklenburg County have been artificially depressed. In nearly every age group, Mecklenburg's use rates have been declining steadily since 2005. Comparing use rates with Guilford and Wake Counties calls attention to the disparity in home health access; Mecklenburg's over-75 rates are anticipated to be 68 percent of Wake County's.

2010 Anticipated Use Rates per 1000

	65-74	**Over 75**
Mecklenburg	53.48	154.43
Wake	63.46	226.50
Guilford	54.12	174.87

Mecklenburg 2010 Difference

As a % of Guilford	99%	88%
As a % of Wake	84%	68%

Source: Proposed 2009 SMFP, Table 12C, pages 277-283

As long as the use rates are suppressed by agencies that remain undeveloped for years, and forecasts of patients in existing agencies continue to grow unchecked, a need determination for Mecklenburg County is unlikely.

The argument that patients are served by agencies outside the county is countered by the home health use rates cited earlier. Age-adjusted, Mecklenburg County patients get less home health care than residents of the state's other two large urban areas.

Something is not right with the current system. We know because every day, we come into contact with patients who are not being adequately served. Personal Home Care of NC is a licensed North Carolina home care provider. Yet, because Mecklenburg continues to show no need for an additional agency, Personal Home Care of NC cannot apply for the home health agency license that would allow us to serve Medicare patients.

Need for Home Health Agencies

Personal Home Care of NC serves 200 Mecklenburg County Medicaid residents today. Our license permits us to bill Medicaid for aide services. We also provide nursing services to about 30 patients who are covered by Medicare. We are not paid for that service, because we do not have a home health agency license. We subsidize that service for our patients because these patients do not speak English; they have tried to use existing home health agency services, but at

this very direct and personal level of care, the language barrier is insurmountable. They are frail and ill and cannot muster the sign language necessary to discuss bowel and bladder problems, eating patterns, and skin care – to give a few examples. However, providing free care is not sustainable in any economy; it is more difficult when reimbursement is under pressure. Some we cannot serve at all because they are eligible only for Medicare.

In the future, existing home health agencies will be less able to address the language-challenged, because home health agency payments are also under pressure.

In January, the President proposed a federal budget that froze Medicare payment rates for home health agencies through 2013[4]. Home health agency workers, particularly in rural areas, often drive long distances to provide care in the patient's home. The combination of low wages and the expense of gas have left many agencies facing a shortage of home aides. According to a recent *New York Times* story, the National Association for Home Care and Hospice reported that "rising fuel prices has become a significant burden for the 7,000 agencies represented by the group, with some forced to close and others compelled to shrink their service areas or reduce face-to-face visits"[5]. Moreover, as gas prices soar, homebound elderly patients are seeing volunteer services and community agencies cut back on programs such as meal delivery and transportation assistance. Currently, the need for home health care agencies is greater than ever. Without adequate home care, many elderly patients who want to remain independent will be forced into institutions, at a cost far greater to the state of North Carolina. Fewer will come across the line into Mecklenburg County.

Since 2006, we have been petitioning for additional home health agency resources to serve the Russian speaking community in Mecklenburg County. The 2009 SMFP again shows no need in this area and reports declining use rates inconsistent with patterns in other North Carolina metro areas. We continue to see a growing unserved immigrant population with special needs, yet without a home health agency license we cannot provide a full continuum of care for these patients.

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[4] Pear, R., Bush Seeks Surplus via Medicare Cuts, *The New York Times* (2008, January 31), http://www.nytimes.com/2008/01/31/washington/31budget.html?scp=1&sq=bush+seeks+surplus+via+medicare+cuts&st=nyt. Retrieved July 11, 2008.

[5] Leland, J., As Gas Prices Soar, Elderly Face Cuts in Aid, *The New York Times* (2008, July 5), http://www.nytimes.com/2008/07/05/us/05elderly.html?sq=as%20gas%20prices%20soar%20elderly%20face%20cuts%20in%20aid&st=cse&adxnnl=1&scp=1&adxnnlx=1216411389-h4aBsA8ynR9gBWnLG9aM9A. Retrieved July 11, 2008.

ADVERSE EFFECTS ON PROVIDERS AND CONSUMERS OF NOT MAKING THE REQUESTED CHANGE

Carolinas Medical Center has made significant changes to their services to accommodate the growing Spanish-speaking population. Out of necessity, they have added bilingual staff, interpreter services and translated literature to serve the Spanish-speaking population. Recent literature has documented well that ignoring language barriers results in delayed care, misdiagnoses and unnecessary procedures; these are risks too great for CMC's patients' health and for the facility's reputation. However, these address only half of the non-English speaking needs and few examples of problems.

The case of a Chinese patient in California, Lian Zhen Li, illustrates how frightening it is to be sick and unable to communicate with health care providers.[6] Li is a naturalized U.S. citizen, but does not speak English. When her abdomen swelled and she experienced excruciating pain, she went to her local hospital but was unable to communicate with doctors. Li said, "I was petrified by my inability to communicate, I thought I was going to die." She wondered, "Who is going to help me?" The hospital staff told her to return with someone who could interpret for her. Li was later diagnosed with ovarian cancer.

The consequence of communication errors can also be financial. In Florida, a Hispanic teenager collapsed after a baseball game.[7] Doctors spent 36 hours treating the boy for a drug overdose after his complaints of being *intoxicado* were misunderstood. In Spanish, the word *intoxicado* can mean nauseated. The boy was later diagnosed with blood clots in his brain and lost the use of both arms and legs as a result of the treatment delay. After he sued the hospital for malpractice, the facility settled out of court for $71 million.

At Personal Home Care of NC, the cases we see have bowel obstructions, incontinence, and need catheter care. All of these require the staff to talk with patients to understand where they have pain. We have cases where patients' wounds were healing, then reversed, because the provider could not understand the patient's description of pain.

We have learned how to recruit, train and get professionals who do not speak English comfortably certified to practice in North Carolina. We are willing to take the challenge for more than one language. We struggle with the language issue ourselves; so we can identify with these patients. In America, eventually, we all melt together under one Constitution and one language. However, until the next generation assimilates the language, we need a bridge.

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[6] Watanabe, T., Study Highlights Language Barriers Faced in Healthcare, (2008, March 21). *The Los Angeles Times,* http://articles.latimes.com/2008/mar/21/local/me-language21. Retrieved July 18, 2008.

[7] Weise, E., Language Barriers Plague Hospitals, (2006, July 20). *USA Today,* http://www.usatoday.com/news/health/2006-07-20-hospital-language_x.htm. Retrieved July 18, 2008.

The consequence of inaction, for both patients and caregivers, is too great to be ignored. In home health care, the premise of the service is to instruct the patient and family to maintain the care regimen after the home health care services have expired. Without adequate communication, home care agency service is doomed to fail on that measure. When caregiver and patient don't speak the same language, families cannot implement caregiver instructions on medication administration and wound care or be taught how to recognize warning signs of complications. More importantly, patients cannot relay symptoms or communicate pain to the caregiver. Without intervention, many patients become increasingly frustrated, give up and drop out of home health care services. They re-appear as emergency room patients, later and sicker. These patients have worked in the American economy, often doing very difficult jobs, like driving trucks. These are services to which they are entitled and are integral to successful recovery. Ignoring the problem and leaving an eligible special needs population without service is unjust and inhumane.

ALTERNATIVES TO THE REQUESTED CHANGE CONSIDERED AND REJECTED

Personal Home Care of NC, LLC considered several alternatives, including: 1) maintaining the status quo; 2) purchasing a home health agency; 3) subcontracting with an existing home health agency to specialize in provision of home health services to non-English-speakers; and 4) this petition. This petition is the result of four years of unsuccessfully trying the other three alternatives.

We can no longer maintain the status quo. Mecklenburg's Medicaid Community Assistance Program (CAP) agency continues to refer Russian speaking patients to PHCNC, because we are the only home care service in the area that can provide services and overcome language barriers. Financial pressures will not allow us to continue to offer free nursing services to these patients much longer. We are already restricting them to what one nurse can do.

For the last four years, Personal Home Care of NC has actively pursued purchase of an existing home care agency and attempted to establish partnerships with existing agencies. After four years, there are still no agencies available for purchase in Mecklenburg County at a rate we can afford, and we have not found an existing agency interested in a joint venture. We have participated in countless meetings with potential candidates, only to have agencies refuse to follow up.

The proposed special need is the only viable avenue left.

NON-DUPLICATION OF SERVICES

Including in the 2009 State Medical Facilities Plan a need in Mecklenburg County for one home health agency specifically staffed and organized to serve non-English speaking people, whose language is other than Spanish, would not duplicate existing services:

- No such agency exists in Mecklenburg or contiguous counties.
- Mecklenburg County is underserved, as measured by age-adjusted use rates and by the ratio of patients to population.
- The number of non-Spanish speaking persons who have difficulty understanding English and who reside in Mecklenburg County is more than the population of many North Carolina counties and more than sufficient to support a 275-person home health agency.
- Language line translations are too expensive for home health agencies to use effectively in patients' homes where nursing and therapy staff must communicate with families and with English speaking referring health care providers.

As we have discussed our story in the community, we have learned that the statistics are true. The Russians are not alone. We have now hired people who speak Latvian, Ukranian, Polish, Czech, Spanish and Russian, and we have also managed to train aides who speak only Vietnamese. We are in discussions with other ethnic community groups. The community needs more home health agency capacity AND it needs a multi-lingual home health agency.

CONCLUSION

The North Carolina State Health Coordinating Council and the Medical Facilities Planning Section perform an outstanding service in developing a State Medical Facilities Plan that strives to properly and fairly address the healthcare needs of the residents of North Carolina. The healthcare needs of a significant population of non-English-speaking North Carolinians are not being met. Personal Home Care of NC, LLC, respectfully requests that the State Health Coordinating Council consider a policy that would permit development of a home health agency in HSA III to serve groups for whom language presents a significant barrier to receiving care.

Sources:

1. Leland, J., As Gas Prices Soar, Elderly Face Cuts in Aid, (2008, July 5). *The New York Times.* Retrieved July 11, 2008, from http://www.nytimes.com/2008/07/05/us/05elderly.html?sq=as%20gas%20prices%20soar%20elderly%20face%20cuts%20in%20aid&st=cse&adxnnl=1&scp=1&adxnnlx=1216411389-h4aBsA8ynR9gBWnLG9aM9A.

2. Mayor's Immigration Study Commission: Healthcare, (2007, January). *Immigration: Legal and Illegal, Local Perspective – Charlotte, North Carolina.* Retrieved July 11, 2008, from http://www.charmeck.org/Departments/Mayor/ImmigrationStudy/Healthcare.htm

3. Pear, R., Bush Seeks Surplus via Medicare Cuts, (2008, January 31). *The New York Times.* Retrieved July 11, 2008, from http://www.nytimes.com/2008/01/31/washington/31budget.html?scp=1&sq=bush+seeks+surplus+via+medicare+cuts&st=nyt .

4. Watanabe, T., Study Highlights Language Barriers Faced in Healthcare, (2008, March 21). *The Los Angeles Times.* Retrieved July 18, 2008, from http://articles.latimes.com/2008/mar/21/local/me-language21.

5. Weise, E., Language Barriers Plague Hospitals, (2006, July 20). *USA Today.* Retrieved July 18, 2008, from http://www.usatoday.com/news/health/2006-07-20-hospital-language_x.htm