Home Health Services

Petition – Personal Home Care of NC, LLC
Regarding the Proposed 2009 State Medical Facilities Plan

*Agency Report on the Petition

*Petition

*Comments from Petitioner

AGENCY Report:

Proposed 2009 Plan

Notes related to Home Health Petition from Personal Home Care of NC, LLC

Request

Personal Home Care of NC, LLC submitted a Petition requesting: *"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."*

Background Information

The home health need methodology projects future need based on trends in historical data, including the "Average Annual Rate of Change in Number of Home Health Patients" over the previous three years and the "Average Annual Rate of Change in Use Rates per 1000 Population" over the previous three years. Average annual rates of change are compiled based on "Council of Governments (COG)" regions.

Patient origin data used in the Plan is compiled from Home Health Agency Annual Data Supplements to License Applications as submitted to the Division of Health Service Regulation. The data supplements request data for a twelve month period using a start date of either July, August, September or October. The methodology aggregates patient origin data by four age groups, under age 18, 18-64, 65-74 and over 75.

The methodology utilized in development of the State Medical Facilities Plan does not project future need based on the number of home health agencies in any given county or on the capacity of existing agencies. Rather, it projects need based on the number of patients served during the reporting years indicated in the plan. In essence, if existing agencies keep pace with the projected number of persons who may need home health services, there would not be a need determination. However, if they do not keep pace, there may be a need determination allowing an opportunity for a new home health agency or office.

The State Health Coordinating Council authorized the formation of a Home Health Task Force to make recommendations for the 2009 State Medical Facilities Plan. The task force made three recommendations to the Council's Long-Term and Behavioral Health Committee. The Committee accepted the following Task Force recommendations which were subsequently approved by the Council for inclusion in the Proposed 2009 Plan.

1. Revise the methodology to lower the deficit threshold for a need determination and the "placeholder" adjustment for a new agency from 400 patients to 275; and,
2. add an item "d" to item 8 of the Basic Assumptions of the Method to read, "address special needs populations."

The Task Force's third recommendation was that the need determination threshold be reviewed again in five years. The Committee recommended and the Council approved that the threshold be reviewed again in three years rather than five years.

The petitioner has petitioned over the past few years for the following: Proposed 2008 Plan - requested an increase in the planning horizon to three years rather than one year; Proposed 2007 Plan (March) – requested changes in the methodology to allow for a need determination based on a defined deficit in a region and a county within the region and restricted access by virtue of a language barrier and a new policy related to a significant underserved population who speak a language other than English or Spanish; Proposed 2007 Plan (Summer) - requested inclusion of an adjusted need determination for one home health agency in HSA III, Home Health Region F, for the counties of Mecklenburg, Union, and Cabarrus for persons facing ethnic and cultural barriers, particularly for Russian-speaking persons.

It should be noted that any person may submit a certificate of need (CON) application for approval for a need determination in the Plan. Therefore, should there be a need determination in the 2009 Plan, the CON review could be competitive and there is no guarantee that the petitioner would be the approved applicant.

The petition was posted on the Division of Health Service Regulation's web site. Written comments were received by the September 9, 2008 date that was identified for submission of comments on petitions and comments to the Division's Medical Facility Planning Section. The comments were from the Association for Home & Hospice Care of North Carolina, physicians and others. The comments are attached.

There was a need determination for Mecklenburg County in the 2005 Plan. Eight applications were received for the need determination. The petitioner was not one of the applicants.

ANALYSIS OF PETITION

The Proposed 2009 Plan indicates a projected surplus of 356 patients in Mecklenburg County. Contributing to this projected surplus is the inclusion of 275 patients in the calculation of potential total people served to adjust for one new agency that has received a Certificate of Need but has yet to be certified. This new agency was approved as a result of a need determination in the 2005 Plan. As indicated in the Home Health Services Basic Assumptions of the Method, a placeholder is maintained during the time when new agencies or offices are being established and are developing their services. Based on the standard methodology, a place-holder will be applied for Mecklenburg County through the three annual plans following certification of the agency. It is noted that even if there were no adjustment for an agency in Mecklenburg County, there would not be a need determination in Mecklenburg County because there would still be a projected surplus of 81 patients.

If this petition were to be approved, it is not known to what extent others may propose similar petitions in the future to address specific population groups.

In response to the petition filed in March 2006, the Agency presented alternatives that may be considered:

1. Purchase an existing Medicare-Certified home health agency. The petitioner indicates that there are no agencies for purchase in Mecklenburg County at a rate they can afford. However, it is not known whether or not an agency may become available in the future. The Proposed 2009 Plan indicates that there were 15 separate agencies located in Mecklenburg and contiguous counties that reported serving patients Mecklenburg County.
2. Apply for a certificate of need when a need determination is identified in the State Medical Facilities Plan. It is noted that there was a projected deficit in Union County of 159 patients. Union County is contiguous to Mecklenburg County.
3. Explore sub-contracting with an existing Medicare-Certified agency to provide services to the target population. The petitioner indicates that they have not found an existing agency interested in a joint venture.

Agency Recommendation

The Agency supports the home health standard methodology as presented in the Proposed 2009 Plan. A question is if the petitioner has presented a compelling case sufficient to warrant an adjusted need determination to address a special needs population.

If the Committee determines that a compelling case has been presented sufficient to warrant a need determination in Mecklenburg County, the Agency encourages the Committee to consider the following. If there is a need determination and if a CON is issued and an agency is developed, unless there are requirements on who the agency must serve, there is no guarantee that the non-English speaking, non-Hispanic population would be served. The agency could be sold after it is developed and the new owner may not serve the target population absent strict requirements thereby defeating the intention of the need determination. Also, what if it was determined that in spite of best intentions; it was not feasible to serve the target populations?

If there is to be a need determination in the 2009 Plan, the Agency recommends that the following conditions be placed on the Certificate of Need.
1. The approved applicant shall actively market to and serve non-English speaking, non-Hispanic persons in Mecklenburg County.
2. The approved applicant shall accept all referrals for non-English speaking, non-Hispanic persons in Mecklenburg County from home health agencies and others.
3. Following certification, the approved applicant shall annually provide a notarized affidavit indicating the number of non-English speaking, non-Hispanic persons served in Mecklenburg County and that all qualified referrals of such persons were served. Absent demonstration to the satisfaction of the Certificate of Need Section that the approved applicant has materially complied with representations made in the Certificate of Need application regarding the non-English speaking, non-Hispanic persons served in Mecklenburg County, the applicant agrees to surrender the Certificate of Need and cease to be a Medicare-Certified Home Health Agency.
4. In the event of a change of agency ownership, the conditions of the Certificate of Need shall apply to any and all future agency owners.

If the petition was to be approved and there was a need determination, it is presumed that there would not be a placeholder created for the new agency since the need determination was not determined by the standard methodology or policy.

ssociation for
Home & Hospice Care
of North Carolina

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Suite 204
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North Carolina
27609

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toll free (nc) 800.999.2357
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info@homeandhospicecare.org
www.homeandhospicecare.org

September 9, 2008

State Health Coordinating Council
c/o Floyd Cogley
Division of Facility Services
2714 Mail Service Center
Raleigh, North Carolina 27699-2714

RE: Special Needs Petition from Personal Home Care of North Carolina, Inc regarding special need for home health agency in Mecklenburg County

Dear Committee:

The Association for Home & Hospice Care of NC is a thirty-seven year old non-profit association representing more than 700 of North Carolina's certified home health agencies, certified hospices and non-certified licensed home care agencies. AHHC has reviewed the "special needs" petition submitted by Personal Home Care of North Carolina, Inc.

Mecklenburg County is unique in many ways. Charlotte is ranked by the State Demographer as the largest municipality in the state. Charlotte is almost twice as big as Raleigh, the second largest municipality. Mecklenburg County is also a locality that attracts diverse immigrant populations.

Currently, Mecklenburg County has 8 Medicare certified home health agencies (with CON's) that are physically located in Mecklenburg County and an additional 17 Medicare certified home health agencies who are allowed to serve Mecklenburg citizens from contiguous and surrounding counties.

Our many home health agency members in Mecklenburg County do an excellent job of serving patients and provide quality home health care. However, this county now has almost one million people, and it is growing at the rate of 3 percent every year. This rapid growth makes it difficult to keep up with the special needs of significant but small groups of residents who have special language problems. Area hospitals and others have made remarkable strides with regard to serving the emerging Spanish-speaking population. Yet, the growing Eastern European and Russian languages present a unique challenge because the alphabet, culture and language structures differ so drastically from English and the Romance languages.

We have worked with our association member, Mr. Ivans Belovs and Personal Home Care of North Carolina, for many years and have listened to Mr. Belovs's concerns regarding the need for a new type of Certified home health agency in Mecklenburg County that offers services to the emerging Russian population, etc. We have convened meetings between home health agencies and Mr. Belovs and have encouraged cooperation. At this time, due to the recent recognition of special

needs populations by both the Long-Term & Behavioral Committee and the SHCC, we do feel a compelling case can be made for an attempt at a new Special Needs Home Health Agency located physically in Mecklenburg County with emphasis on non-English speaking patients, particularly Russian and Eastern European populations. If approved, this Special Needs Agency should be held to the same standards as dictated by the SMFP and other appropriate regulatory entities. AHHC supports this concept in Mecklenburg County only.

Thank you for your time and attention.

Respectfully,

Jim Rogers

Timothy R. Rogers
CEO
Association for Home & Hospice Care of NC
3101 Industrial Drive, Suite 204,
Raleigh, NC, 27609

September 4, 2008

State Health Coordinating Council
c/o Floyd Cogley
Division of Facility Services
2714 Mail Service Center
Raleigh, North Carolina 27699-2714

Dear Committee Members,

I am writing in support of the petition filed by Personal Home Care of NC for a home health agency in Mecklenburg County that focuses on the special problems of people who speak languages other than English and Spanish.

Personal Home Care of NC plays an important and unusual role in the Charlotte area. This personal home care agency emerged in response to a unique problem. They patiently provide responsive services to a large community. Russian speaking immigrants from the former USSR, Ukraine, Byelorussia, Turkey and other related countries now represent a large part of Mecklenburg County's population. We estimate about 60,000 are here now, and their numbers are growing. The communities began forming in the late 1990's and are now attracting a second wave of newcomers. The first group came because of favorable immigration policies; now word of mouth to friends and relatives is drawing more. Several churches and congregations of multiple faiths have formed. Extended families are appearing in the area. Parents, grandparents and older relatives come with the younger working members of the family.

The older people do not speak English, or if they do, their vocabulary is limited. They are legal immigrants; many are citizens. Many are entitled to Medicare and Medicaid services, but the language and cultural barriers make it difficult for most agencies to serve them. Personal Home Care of NC is the only agency that crosses the language barrier, because its staff speaks Russian and understand this culture. However, Personal Care is not a home health agency, hence cannot get licensed to offer Medicare or Medicaid nursing care. Family members in this community assign a person to stay with the older and infirm, but lay people cannot provide clinical services, and are not always able to act as clinical interpreters.

I believe that there are enough people whose primary language is neither English nor Spanish to keep a home health agency very busy. Please approve their petition.

Please do not hesitate to call me should you have questions.

Regards

L. Bridges MD. 704-384-9920

September 4, 2008

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c/o Floyd Cogley
Division of Facility Services
2714 Mail Service Center
Raleigh, North Carolina 27699-2714

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Regards

Walter Jordan MD 704-575-9508.

September 4, 2008

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Raleigh, North Carolina 27699-2714

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Regards

Vasiliy Rugnitskiy (704)644-7365
Vasiliy Eremyk (pastor) (980)721-7541

FIRST SLAVIC BAPTIST CHURCH
VASILY RUDNITSKY, CHAIRMAN

September 4, 2008

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c/o Floyd Cogley
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Vlad Koshkarev (704)421-1111

September 4, 2008

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Regards

Olga Syrnichenko (704) 345-8121

September 4, 2008

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Sergiy Derkach (realtor) (704) 975-0188

September 4, 2008

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Regards

Ruzanna Kakachyan - CA (clinical assistant)
Cotswold Family Medicine (704) 446-2360

MD

September 4, 2008

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Regards

Marina Svecharnia - MD
Cotswold Family Medicine (704)446-2360

M/Vee MD

September 4, 2008

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2714 Mail Service Center
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Regards

Lynda Teutter (Dental Assistant)
(704) 246-6399

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

August 1, 2008

RECEIVED
By Kelli Fisk at 4:30 pm, Aug 01, 2008

Petitioner:

Personal Home Care of NC, LLC
1515 Mockingbird Lane, Suite 801
Charlotte, North Carolina 28209

Contact:

Ivans Belovs
Personal Home Care of NC, LLC
(704) 522-6144, telephone
(704) 522-6145, facsimile

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.

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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

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Presentation to North Carolina State Health Coordinating Council

Charlotte, NC

July 30, 2008

Good afternoon and thank you. My name is Ivans Belovs. As many of you know, I am a co-owner of Personal Home Care of North Carolina, a licensed North Carolina home care provider. For the past two years, we have submitted formal petitions asking for a change in the home health agency methodology and policy to make it more internally consistent and to make it possible for new home health agencies to be available when the people need them. Today I am again submitting a petition. I am requesting an adjusted need determination that would allow the development of one home health agency to address the special needs of the non-English speaking population in the Mecklenburg County area.

I settled in Charlotte after emigrating from Latvia in 1997, joining thousands of other Russian speaking people who were settling there. I became active in the Russian community, and started the Russian language newspaper, Panorama Charlotte. When my father-in-law became ill, I saw first hand the struggle of someone who spoke little English trying to communicate with his caregivers. I looked around for resources that could help him and found only that there were many others like him and little resources to assist. Two years ago, Personal Care of North Carolina was

founded with the intent to serve people like my father-in-law, those with language barriers who were not being well-served by existing agencies.

The Mecklenburg area has a large and growing population of foreign born citizens. According to the most recent U.S. Census Bureau estimates, 13 percent of the population is foreign born. In addition, eight percent of the Mecklenburg population report that they speak English "less than very well." Only about half of that group, speaks Spanish. The remainder speaks a wide variety of other languages, including: Arabic, Chinese, French, German, Italian, Japanese, Korean, Greek, Russian, and Vietnamese.

Recent media focus has drawn attention to the growing Hispanic population. Numerous changes in schools and health care facilities have been made to accommodate the needs of the Spanish speaking population. Out of necessity, Carolinas Medical Center (CMC) offers interpreter services, telephone prompts in Spanish, translated patient education materials and prescriptions filled in Spanish. For every location where more than five percent of the population speaks Spanish, they provide bilingual staff and on-site interpreters. CMC has incorporated these changes because of the challenges and risk of medical errors when treating patients with a language barrier. Yet, no one is addressing the remainder of Mecklenburg's diverse, foreign born population who struggle to communicate in English.

Home health care is a particularly challenging environment when caregiver and patient do not speak the same language. A home health care provider has fewer resources at her disposal; she is one-on-one in a patient's home. . What if I said to you, "Keep the bandage loose." But you heard, "Держите повязку свободно" or I said " Have you had a bowel movement today?" and you heard "Вы ходили сегодня в

туалет по большому?" or worse, what if I tried to translate and said "Did your bowel change its location in your body today?" This is the literal translation that would come through an interpreter service.

Patients are often elderly and frail and cannot muster the sign language to discuss bowel and bladder problems, eating patterns, skin care and express their pain. They become trapped in the isolation of their language barrier and suffer unnecessarily because of it

Our staff is too often called upon to provide volunteer translation services, when there is no one else available. We also provide nursing services to language-challenged patients who are covered by Medicare. Personal Home Care is not paid for these services, but provides them because these patients and families are desperate and have no where else to turn. We respond because it would be inhumane to ignore their cries for help.

Today, Personal Home Care of North Carolina serves over 200 patients. Most of our patients speak little or no English. We understand the challenges they face on a daily basis. We can identify with them. We have learned how to recruit, train and hire professionals from other countries certified to practice in North Carolina. Presently, we are the only home care provider in the area that can provide services that overcome language barriers. We are willing to take the challenge to serve more than one language. We are the best prepared to provide these services, because we are already providing them. We now have staff who speak Latvian, Ukranian, Polish, Czech, Spanish and Russian. We have also managed to train aides who

speak only Vietnamese. We are becoming the agency that people call when they have patients who do not speak English.

The methodology used to calculate the need for additional agencies is complex. Yet clearly, Mecklenburg needs more home health agency capacity and needs a multi-lingual agency that can well serve this special needs population. The average home health agency in Mecklenburg serves 60 percent more patients than the average agency in Guilford. This region has not had a new agency added since 2005. Moreover, when looking across the state, the extreme variability in age adjusted use rates prove the methodology needs to be reevaluating.

In summary, our company is a licensed North Carolina home care provider that specializes in serving this language challenged, special needs population. In order to provide our patients a full range of services, we must have a home health care agency license. Yet, year after year, despite a wave of immigration and a rapidly growing population, Region F continues to show no need in the State Medical Facilities Plan. There is evidence of insufficient home health agency capacity and a significant under-served special needs population.

Personal Home Care of North Carolina is willing, ready and able to serve this population if given the opportunity. We ask that you reconsider the need determinations and add another home health agency to the 2009 plan, so that the State of North Carolina may stay true to its basic principle of ensuring equitable access to all of our citizens.

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By Kelli Fisk at 11:03 am, Aug 01, 2008

Presentation to North Carolina State Health Coordinating Council
Charlotte, North Carolina
August 1, 2008

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looked around for resources that could help him and found only that there were many others like him and little resources to assist. Two years ago, Personal Care of North Carolina was founded with the intent to serve people like my father-in-law, those with language barriers who were not being well-served by existing agencies.

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aides who speak only Vietnamese. We are becoming the agency that people call when they have patients who do not speak English.

The methodology used to calculate the need for additional agencies is complex. Yet clearly, Mecklenburg needs more home health agency capacity and needs a multi-lingual agency that can well serve this special needs population. The average home health agency in Mecklenburg serves 60 percent more patients than the average agency in Guilford. This region has not had a new agency added since 2005. Moreover, when looking across the state, the extreme variability in age adjusted use rates prove the methodology needs to be reevaluated.

In summary, our company is a licensed North Carolina home care provider that specializes in serving this language challenged, special needs population. In order to provide our patients a full range of services, we must have a home health care agency license. Yet, year after year, despite a wave of immigration and a rapidly growing population, Region F continues to show no need in the State Medical Facilities Plan. There is evidence of insufficient home health agency capacity and a significant under-served special needs population.

Personal Home Care of North Carolina is willing, ready and able to serve this population if given the opportunity. We ask that you reconsider the need determinations and add another home health agency to the 2009 Plan, so that the State of North Carolina may stay true to its basic principle of ensuring equitable access to all of our citizens.

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