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Ability to Deliver Services in Spanish: A Survey of Michigan Home Health Agencies, 2012

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Summary

The capacity of home health agencies to serve children from families with low English proficiency is not well understood. We conducted an exploratory survey of home health agencies in Michigan in 2012 to document whether they can provide services in Spanish, serve children, and accept Medicaid.

Keywords

Home health agencies; language; communication barriers; health services accessibility; health care disparities; Michigan

Numerous studies have shown that inadequate communication between health care providers and patients with limited English proficiency (LEP) is associated with adverse outcomes in a variety of clinical settings and patient populations.[1–5] These adverse outcomes include delayed diagnosis, misunderstanding the plan of care, decreased compliance, and disparities in utilization such as longer emergency department stays, increased hospitalization rates, and lower rates of preventive care.[1–3,5] In a study of children requiring long-term antibiotics, LEP in the children’s primary caregivers (e.g., parents) was associated with an increased risk for longer hospital stays and fewer home health referrals.[6]

A conceptual framework was recently proposed to guide research into the myriad of factors that may contribute to racial and ethnic disparities in home health care, including language barriers.[7] Of particular interest to us is access to home health care for patients with LEP, including the capacity of home health agencies to serve these patients. To our knowledge, the ability of home health agencies to deliver services to patients with LEP and the methods they use to provide services in the native language of these patients have not been documented.

Survey of Michigan Home Health Agencies

To add to the knowledge base regarding home health services for our state’s largest LEP population, we were interested in documenting the ability of home health agencies in Michigan to provide services in Spanish, as well as whether they serve children and accept Medicaid. To do so, we performed a cross- sectional telephone survey of a sample of home health care agencies operating in Michigan. As the information was obtained from home health agency staff regarding agency policies and characteristics, the study did not involve

human subjects and was categorized as a non-regulated study by our medical school Institutional Review Board.

Based on 2010 U.S. Census data, we identified the 12 Michigan counties with the highest proportion of Hispanic/Latino population (range 5.2%–13.7%): Allegan, Gratiot, Ingham, Kent, Lenawee, Newaygo, Oceana, Ottawa, Saginaw, St. Joseph, Van Buren, and Wayne. These 12 counties were selected because they account for over half (57%, n=248,010) of the Hispanic population in Michigan, and therefore are most likely to have demand for home health services in Spanish. It is not possible to estimate the magnitude of this potential demand based on available data on home health utilization.[8,9]

To identify home health agencies (HHAs) in these counties, we used publicly available telephone directories on the internet. Our target was to have at least 10 HHAs per county. For the eight counties that had fewer than 10 HHAs, the sample was supplemented with HHAs from adjacent counties (i.e., Jackson, Kalamazoo, Monroe, Muskegon); internet directory searches in the original counties consistently turned up agencies in these adjacent, higher-population counties, implying overlap in their service areas. If different sites from the same agency were identified in multiple study counties, only one site was included and an additional agency was selected as a replacement, if available. The total sample was 148 HHAs.

The study team developed a brief, five-question telephone survey instrument. The initial question was to verify that the agency provides in-home health care services. Follow-up questions asked whether the agency is able to deliver home health care services to Spanish-speaking patients in Spanish, and what methods they use, or might use, to provide services in Spanish. Additional questions explored whether the agency accepts Medicaid payment, whether it serves children younger than 18 years of age, and, if so, whether any children were served in the past year.

Telephone calls were made from November 2011 through February 2012. Questions were typically answered by the agency staff member answering the telephone; in a few cases, questions were referred to a site manager or an intake nurse. Non-working numbers were double-checked via the internet and re-tried. Responses were coded and entered into an Excel database, and frequencies were calculated for each survey item.

Results

Out of the 148 total sites that we attempted to contact, there were 23 for which no working telephone number could be found. Of the remaining 125 sites, 113 were successfully contacted (90% overall response rate). Twenty-three of the 113 sites were not eligible for our survey because they do not provide in-home health care services, yielding 90 eligible HHAs that provided survey responses (88% eligible response rate).

Ability to provide services in Spanish and methods used

Fifty-eight percent of the 90 HHAs (n=52) reported being able to deliver home health services in Spanish to Spanish-speaking clients. The methods they reported using to deliver

services in Spanish are summarized in Table 1. The majority reported using their own Spanish-speaking staff members (60%); the next most common methods were using telephone interpreter services (29%) or other interpreter services (12%), such as through a hospital.

About one-third of the 90 HHAs (37%, n=33) said they were not currently able to deliver home health services in Spanish to their Spanish-speaking clients, while 5% (n=5) were unsure. Among these 38 HHAs, the most frequently mentioned methods that they might use if they were contacted to provide services to a Spanish-speaking client were hiring Spanish-speaking staff (26%), using a family member/friend of the patient (21%), or referring the patient to another agency (21%).

Ability to serve low- income children

Among the 90 HHAs, 55% (n=48) accept Medicaid payment for home care services; 59% (n=53) stated that they provide services to children less than 18 years of age, of which seven agencies noted restrictions on ages served (e.g., no infants) or type of services delivered (e.g., only respiratory therapy). About one-third of the 90 HHAs (36%, n=32) both accept Medicaid payment and provide services to children.

Ability to provide services in Spanish to low- income children

Among the 52 HHAs who reported being able to provide services to Spanish- speaking patients in Spanish, 33 HHAs also accept Medicaid payment and 34 HHAs provide services to children. Only 23 HHAs reported that they accept Medicaid, serve children, and are currently able to provide services to Spanish-speaking patients in Spanish, corresponding to 26% of the 90 responding HHAs.

Discussion

Overall, the majority of HHAs responding to our survey identified themselves as being able to provide services to Spanish-speaking clients in Spanish. The most common method for providing these services was using Spanish-speaking staff members. It is unclear how fluent these staff members are in Spanish and whether they have received any medical interpreter training. It is also unknown whether these staff persons are clinical staff (e.g., nurses) directly conversing with patients or other staff members (e.g., administrative staff) serving as third- party translators. Use of professional interpreters, either by phone or in person, and bilingual clinical staff have been shown to be equally effective.[10] However, *ad hoc* interpreters—those who are not bilingual, including clinical and non-clinical personnel, and who have not received medical interpreter training—have a much higher likelihood of translation errors.[11] Areas for future research include assessing the level of fluency of Spanish-speaking HHA staff and measuring outcomes such as errors and readmissions.

Home health agencies not currently able to provide services in Spanish showed a greater reliance on family or community members as third-party translators. These HHAs may be unfamiliar with the data showing that the use of professional interpreters results in a significantly lower risk of errors and greater patient satisfaction compared with *ad hoc* interpreters, including family members.[11–14] In addition, barriers to using professional

interpreters, such as perceived cost, that have been demonstrated in other areas of the health care delivery system (e.g., emergency departments)[14,15] are likely to be barriers for home health agencies as well. Additionally, one quarter of HHAs not currently able to provide services in Spanish would consider hiring Spanish-speaking staff if contacted to provide care to a Spanish-speaking patient. It is unknown whether this hiring process could happen quickly enough to provide timely care for the patient being referred to the agency.

Only about half of HHAs studied in Michigan accept Medicaid or serve children, with only one quarter able to provide services to Spanish-speaking, low-income children. In addition, among agencies that do have the capacity to serve Spanish-speaking, low-income children, demand for services is likely infrequent due to the small size of this population, which may make it difficult for these HHAs to sustain this capacity. This limited access could be a significant barrier to these children receiving adequate home health care following a hospitalization. To further explore the ability of Medicaid-enrolled children to access home health care, additional attention should be given to documenting the number of HHAs accepting Medicaid that have pediatric capability, relative to the number of Medicaid-enrolled children in that service area.

Being able to address the language needs of patients will become increasingly important in all areas of health care. The number of LEP individuals the United States grew by 80% between 1990 and 2010, with Spanish the most common language spoken by these individuals.[16] Currently, 37 million people speak Spanish in the United States and almost half of them speak English “less than very well,”[17] and it is expected that the Hispanic population will double by or before the year 2050.[18]

The main limitation of this study is that it was conducted in a subset of counties in one state, and therefore the results are not generalizable to other states or for other languages besides Spanish. In addition, the data collected from HHA staff were not verified. This study was an initial exploratory study designed to identify some of the issues related to access to home health care for patients with LEP. Other important areas for future study related to access to home health care for patients with LEP include the factors considered in the referral decision-making process by hospital personnel (e.g., perceived ability of home health agencies to serve patients with LEP) and the factors that influence families with LEP to follow through with these referrals (e.g., level of understanding of referral instructions, health literacy level).

Conclusions

Although most HHAs report being able to deliver services in Spanish, only a quarter could provide services in Spanish for a Medicaid-enrolled child. The use of professional interpreters to provide services in Spanish is limited. Important areas for further study include the level of fluency of Spanish-speaking HHA staff, the accuracy of the interpreters, and other factors that contribute to home health care access for patients with limited English proficiency.

Notes

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Table 1

Methods for Delivering Home Health Services in Spanish Among HHAs Currently Able To Provide These Services (N=52)^a

Methods	N (%)
Spanish-speaking staff	31 (60%)
Telephone interpreter service	15 (29%)
Other interpreter service	6 (12%)
Family member/friend	3 (6%)
Community member	1 (2%)
Other method	3 (6%)

^a Respondents could provide multiple responses, so percentages add up to greater than 100%.