Technical Guide to the CalQualityCare.org Ratings:

Hospice

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INTRODUCTION

Since 2002 the California HealthCare Foundation (CHCF) has partnered with the Department of Social and Behavioral Sciences at the University of California, San Francisco (UCSF-SBS) to develop a resource for consumers on long-term care providers throughout the State. CHCF sponsors the project and manages the website www.CalQualityCare.org on which data about long-term care facilities are displayed to improve quality and inform consumer decision-making. The UCSF-SBS team provides the data content for the website, including developing the ratings methods and scoring the facilities. The data are obtained from California and United States federal government sources, as well as from recognized accrediting organizations.

CalQualityCare.org provides “Performance Ratings” on important measures of the quality of long term care provided by nursing homes, home health care agencies, and hospice programs. The goal of these ratings is to provide clear, directional information to consumers about facilities (e.g., individuals in need of long-term care, family members, friends of individuals in need of long-term care, health care professionals needing to find long-term care resources for clients). The provider ratings are based on the most recent data from California and U.S. government sources. The data are updated quarterly with the most current information available.

The methodological foundation used to calculate the CalQualityCare.org provider ratings are based on existing algorithms, such as the procedures used by the Centers for Medicare and Medicaid Services (CMS) used for nursing homes; research literature; and expertise and knowledge in long-term care, research design, and program evaluation. In order to provide a common metric across all facility types rated, CalQualityCare.org has adopted the following five-level rating system CMS uses for nursing homes: Superior, Above Average, Average, Below Average, Poor, or not rated.

The number of ratings presented for each provider type is dependent on the available information. For example, nursing facilities have a significant amount of California state and U.S. government data available and receive performance ratings in four areas: Overall, Quality of Facility, Staffing, and Quality of Care. Intermediate care facilities for the developmentally disabled (ICF/DD) receive performance ratings in three domains: Overall, Quality of Facility, and Staffing. However, Home Health Care agencies have less data available and receive performance ratings in only two areas: Quality of Agency and Quality of Care. Hospice programs have information to provide a performance rating in only a single area: the Quality of Program. The website does not give performance ratings for assisted living, congregate living health facilities, continuing care retirement communities, adult day health care, or adult day care because these providers are subject to different standards that do not allow for collecting similar performance data. As data on these facilities become available, ratings will be developed and assigned to those providers.

OVERVIEW OF HOSPICE RATINGS

As noted above, CalQualityCare.org provides Performance Ratings for hospice programs in a single area: the Quality of Program. The Quality of Program rating is comprised of several
components: (1) the number and type of deficiencies the program receives during routine inspections or from complaint investigations for the most recent survey; (2) substantiated complaints; (3) the submission of the Office of Statewide Health Planning and Development Annual Utilization Report (OSHPD AUR); and (4) accreditation. Hospices that participate in the Medicare or Medicaid programs are required to meet minimum federal quality and life safety standards. The California state Licensing and Certification (L&C) program conducts surveys (inspections) of hospices about once every eight years. The surveys evaluate hospice quality based on specific regulations regarding: quality of care, patient rights, administration, and other areas. This information is obtained from the most recent federal CMS Certification and Survey Provider Enhanced Reporting (CMS CASPER) database.

Deficiencies

Deficiencies for violating federal standards fall under two categories: condition-level or standard-level. Each condition of participation represents a performance area that could have a serious impact on the quality of care given to patients if not met. Standards are the specific points that must be met within the conditions of participation.

**Condition Level (Condition Not Met)**

If a surveyor believes there is a significant problem that “adversely affects or has the potential to adversely affect clients,” the surveyor assigns a condition-level deficiency, which is the most serious kind. There are 24 federal conditions for hospice programs. These are the most serious deficiencies and are given for problems that cause harm to clients or have the potential to harm clients. A program is in danger of losing its certification to receive Medicare or Medi-Cal payments if it does not correct this kind of deficiency. The program has either 28 or 90 days to correct the deficiency, depending on its severity.

**Standard Level (Standard Not Met)**

Standard-level deficiencies are less severe than condition-level deficiencies. Programs that receive several standard-level deficiencies in one area may also receive a condition-level deficiency, indicating that clients have been harmed or could be harmed. If a program receives a standard-level deficiency, the program must submit a plan to correct the problem. The state L&C office does not re-survey the program to follow-up on standard-level deficiencies, but the program is expected to correct the problem.
Substantiated Complaints

A complaint is a formal grievance against a facility that is filed with the state L&C Program. Patients, family members, local ombudsmen or other individuals may file complaints about poor care or safety.

The L&C program should investigate serious complaints and incidents within a two-day period, but most complaints are investigated within 10 days. Some complaints and incidents that are not serious may not be investigated because of limited L&C resources. When complaints are investigated by L&C, they are deemed either substantiated (if the inspector found the claim to be true) or unsubstantiated (if there was no proof to support the complaint). If a complaint is substantiated, a deficiency may be given to the program.

About 85% of hospice programs had no complaints over an eight-year period. Just under 7% of programs received more than one complaint. Therefore, the threshold for complaints to effect the program quality rating was set at two or more.

OSHPD Annual Utilization Report

The OSHPD AURs are submitted yearly and report data from the previous calendar year. The OSHPD AUR database is updated semi-annually and includes data for the two most recent years. While the OSHPD AUR is a component of licensure, there is no repercussion if a program does not submit a report. We consider that complying with the licensure requirements and disclosure are proxy measures for program quality.

Accreditation

Accreditation is an evaluation process that requires a hospice organization to meet standards of care. A hospice program pays an accrediting organization to inspect all aspects of its program. Accreditation is not required, but being accredited may indicate a program’s commitment to providing high-quality care. However, obtaining accreditation can be expensive, which may prevent organizations from applying to become accredited.

Since 2007, when survey mandates were revised, new providers may choose to pay for accreditation in order to receive payments from the Medicare or Medi-Cal programs. In the past, the initial survey to participate in the Medicare or Medi-Cal programs was conducted at no cost by the state or by the Center for Medicare and Medicaid Services (CMS). Because of resource limitations and a change in survey priorities, the number of initial certification surveys that can be conducted has been severely limited. Many provider applicants may conclude that the benefits of becoming accredited, being certified to receive payments from the Medicare or Medi-Cal programs, through one of the accrediting organizations is worth the expense.

After an organization is accredited, it is monitored by the accrediting organization to make sure it continues to meet the standards.
QUALITY OF PROGRAM Rating Methods

The program ratings are based on the total number and type of deficiencies and substantiated complaints received over the most recent eight-year period, submission status of the OSHPD AUR, and accreditation.

Because hospice surveys are so infrequent, no hospice program can receive a superior rating.

Table 1 summarizes the procedures for determining the Hospice Program Rating. The rating algorithm involves three steps.

Step 1: The first step is to calculate an unweighted rating for programs. The distribution of standard-level deficiencies are based on surveyed facilities and grouped into three categories: (1) deficiencies falling within the 0% - 20% distribution range (a lower percentage indicating fewer deficiencies); (2) deficiencies within the >20% - <50% range; and (3) deficiencies equal to or above the 50% range. For the May 2011 data these standard-level deficiency distributions corresponded to 0-3, 4-8, and 9+ deficiencies, respectively. Programs with no deficiencies, no substantiated complaints, and current OSHPD data receive a rating of above average. Because of the seriousness of condition-level deficiencies, any program that has one or more condition-level deficiency receives a rating of poor. Similarly, any program having standard deficiencies at or above the 50% level receives a rating of poor.

Step 2: Step two involves applying the weighting factors to all facilities that have an average or below, average rating. The weighting factors for this step are substantiated complaints and/or OSHPD data status. For example, if a facility had an unweighted rating of average and more than one substantiated complaint, the rating of the facility would be lowered to below average.

Step 3: The final step applies an additional weighting factor to facilities whose poor rating is due to an old survey. An old survey is one that was conducted four years or more from the current year. Due to infrequent surveys, facilities that were surveyed four or more years ago, may have corrected these deficiencies, but because they have not subsequently been surveyed, there is no documentation of these improvements. A decision was made that would acknowledge accreditation, no substantiated complaints, and submission of OSHPD AUR as evidence of a facility making improvements and the rating would increase by one level. Therefore, if a facility with a poor rating, stemming from an old survey, is accredited, does not have any substantiated complaints, has OSHPD data, then the rating is increased to below average.

This rating methodology resulted in the following ratings distribution:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Percentage of Hospice Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above Average</td>
<td>about 49%</td>
</tr>
<tr>
<td>Average</td>
<td>about 24%</td>
</tr>
<tr>
<td>Below Average</td>
<td>about 17%</td>
</tr>
<tr>
<td>Poor</td>
<td>about 10%</td>
</tr>
</tbody>
</table>
### Table 1. Hospice Program Rating Methodology

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Deficiencies</th>
<th>Standard Deficiency Categorization*</th>
<th>OSHPD AUR</th>
<th>Substantiated Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superior</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Above Average</td>
<td>None</td>
<td>None</td>
<td>current*</td>
<td>none</td>
</tr>
<tr>
<td>Average</td>
<td>None</td>
<td>0 - 20%</td>
<td>Newly licensed facility* - no OSHPD data or not current data</td>
<td>See “Weighting Factors”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>current*</td>
<td>See “Weighting Factors”</td>
</tr>
<tr>
<td>Below Average</td>
<td>None</td>
<td>0 - 20%</td>
<td>no OSHPD data or not current data</td>
<td>See “Weighting Factors”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;=20 - &lt;50%</td>
<td>See “Weighting Factors”</td>
</tr>
<tr>
<td>Poor</td>
<td>1 or more -OR-</td>
<td>&gt;=50%</td>
<td>See “Weighting Factors”</td>
<td>See “Weighting Factors”</td>
</tr>
</tbody>
</table>

**WEIGHTING FACTORS**

- **Applied to ALL facilities with an AVERAGE or BELOW AVERAGE rating** -
  - **Complaints**: If a facility has more than 1 substantiated complaint, lower the rating by 1 level
  - **OSHPD**: If there is no OSHPD data, lower the rating by 1 level

**Additional WEIGHTING FACTOR for facilities with a survey conducted 4 years or later from the current year** and having a POOR Rating

- If the facility is accredited, does not have any substantiated complaints and the OSHPD data is current or not more than 1 year behind the most recently available data – increase the rating by one level

**Notes:**
The categorization of the standard deficiencies is based on the distribution of standard deficiencies for surveyed facilities.
The “Current OSHPD” data is defined as the most recent year of available data.
A “Newly licensed facility” is defined as a facility whose license date is greater than or equal to the date of the most recently available OSHPD data.
The “current year” is the year in which the data is being processed for inclusion on the website.