

**Technical Guide to the
CalQualityCare.org Ratings:**

Home Health Care

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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 HOME HEALTH CARE RATINGS

As noted above, CalQualityCare.org provides Performance Ratings for home health care programs in two areas: the Quality of Agency and the Quality of Care.

The Quality of Agency rating is comprised of two components: (1) the number and type of deficiencies the program receives during routine inspections or from complaint investigations for the most recent survey and (2) substantiated complaints. Home health agencies that participate in the Medicare or Medicaid programs are required to meet minimum federal quality and life safety standards. The California Licensing and Certification program conducts surveys (inspections) of home health agencies about every three years. The surveys evaluate agency quality based on specific regulations regarding: quality of care, patient rights, administration, and other areas. This information is obtained from the most recent CMS Online Survey Certification and Reporting/Certification and Survey Provider Enhanced Reporting (OSCAR/CASPER) database.

The Quality of Care rating is based on the quality of care measures developed by CMS from the Outcome and Assessment Information Set (OASIS) assessment tool to describe the quality of care provided by home health agencies. The OASIS assessment must be completed for all patients who receive Medicare or Medicaid payments. The assessments are conducted by home health agency staff and are submitted to CMS on a quarterly basis.

The quality measures (QM) were selected to address a broad range of functioning and health status in multiple care areas. The Quality of Care rating is based on performance on QMs currently posted on the Medicare Home Health Compare web site. All measures have been validated. The measures were selected based on their validity and reliability, the extent to which the measure is under the agencies' control, statistical performance, and importance.

QUALITY OF AGENCY Rating Methods

Agency quality is based on a combination of deficiencies and complaints from state agency inspection reports. Home health agencies that participate in the Medicare or Medicaid programs are required to meet federal standards for quality and life safety requirements. The California Licensing and Certification program conducts surveys (inspections) of home health agencies about every three years. The surveys evaluate agency quality based on specific regulations regarding: quality of care, patient rights, administration, and other areas.

Deficiencies

The number and type of deficiencies an agency receives is an indication of the quality of care provided by an agency because they reflect the violations of federal regulations found by trained inspectors during visits to the agency.

The State Licensing and Certification Program (L&C) surveys home health agencies at least every three years to ensure that minimum standards of care and safety are being met. When a

surveyor finds that a standard is not met, the agency receives a deficiency. Home health agencies may also receive a deficiency in response to a substantiated complaint.

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)

There are 15 federal conditions of participation that agencies must meet to be certified to receive Medicare and Medi-Cal payments. Deficiencies received because a condition is not met are the most serious deficiencies that cause harm or have the potential to harm clients. 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 of deficiency. An agency is in danger of losing its certification if it does not correct this kind of deficiency. The agency 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 they actually help determine if a condition has not been met. If enough standards within a condition have not been met, an agency may receive a condition-level deficiency. If an agency receives a standard-level deficiency only, the agency must submit a plan of correction to correct the problem. The state L&C office does not re-survey the agency in response to standard-level deficiencies, but the agency is expected to correct the problems.

Substantiated Complaints

A complaint is a formal grievance against a facility that is filed with the state Licensing and Certification (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 2-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 or citation may be given to the agency.

Of the home health agencies in California, 86% did not have complaints over a three-year period. Only 5% of agencies had two or more complaints. Therefore, the threshold used in the rating algorithm for complaints was set at two or more.

Agency Quality Rating for Deficiencies and Complaints

Agencies with no deficiencies over five years are rated as superior. Any agency that has one or more condition-level deficiency is rated as very poor. For the remaining agencies, the number of standard-level deficiencies is divided equally into thirds. Agencies with the fewest number of standard-level deficiencies are rated above average, agencies in the middle third are rated average and agencies in the bottom third are rated below average. If an agency received two or more complaints the rating was lowered one level.

QUALITY OF CARE Rating Methods

The Centers for Medicare and Medicaid Services (CMS) developed a set of quality measures from the OASIS assessment tool to describe the quality of care provided by home health agencies. These are based on the assessment that must be completed for all patients who receive Medicare or Medicaid payments. The assessments are conducted by home health agency staff and are submitted to CMS on a quarterly basis.

The quality measures were selected to address a broad range of functioning and health status in multiple care areas. The facility rating for the QM domain is based on performance on QMs currently posted on the Medicare Home Health Compare website. All measures have been validated. The measures were selected based on their validity and reliability, the extent to which the measure is under the agencies' control, statistical performance, and importance.

Quality of Care Rating

The quality of care rating is constructed by dividing the scores for each quality measure into fifths for the most recent reporting period. For all quality measures, except the measure for clients who "Had to be admitted to the hospital," a high percentage is better than a low percentage. Agencies with scores in the top 20% receive the highest rating; those in the 61-80% range receive an above average rating; those in the 41-60% range receive an average rating; those in the 21-40% range receive a below average rating and those in the bottom 20% receive a poor rating.

For the measure of clients who "Had to be admitted to the hospital," the opposite is true. Agencies with scores in the top 20% receive the poor rating; those in the 61-80% range receive a below average rating; those in the 41-60% range receive an average rating; those in the 21-40% range receive an above average rating and those in the bottom 20% receive the superior rating.

Each quality measure is given an equal weighting. The summary score for all the quality of care measures is created by adding the scores for each of the quality measures and dividing by the number of quality measures having non-missing values. If an agency has some missing scores, the summary rating is calculated based on the quality measure scores that are available.

COMPOSITE HOME HEALTH AGENCY RATING

No composite home health agency rating was presented because we did not determine there was adequate data available for the rating.