Report on California's Nursing Homes, Home Health Agencies, and Hospice Programs

Prepared for the California HealthCare Foundation

for

California Nursing Home Search

www.calnhs.org

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INTRODUCTION

Nursing homes, home health care agencies and hospice programs provide vital services to many individuals with who need nursing care, therapy, and assistance with activities of daily living. A large number of individuals depend upon these facilities, agencies, and programs and yet little is known about them. This report examines these three types of long term care providers in California and provides background information about a consumer information system developed by the California HealthCare Foundation.

Admission to a nursing home is usually a last resort for individuals who are too sick to care for themselves or have someone care for them at home, or for individuals who do not have anyone to care for them. Admission may be for short-term care, to recover from an acute illness, or long term for a more debilitating illness or help with activities of daily living. Unfortunately, some expected short stays can turn into longer stays because residents do not receive the care they need to recover or because an individual's condition or situation prevents them going home. Good quality of care is important for both long and short stay residents and quality of care varies widely across facilities.

Most individuals with illnesses and disabilities prefer to remain at home with where they can receive services and support from family members and friends. Home health care agencies provide services from trained workers who visit the home to help with personal and medical care needs. Services range from basic care from home health aides and homemakers to professional services from registered nurses and therapists who help with care and therapeutic needs. Home health care agencies emphasize post-acute rehabilitative services, not long term and custodial home care.

Home care and personal care services (also called personal attendant care) are often needed. Home care services are provided paid or unpaid caregivers who help with a variety of tasks, including: meal preparation, errands, housekeeping and shopping, as well as feeding, toileting assistance, walking, bathing and companionship. Caregivers can be hired through home care organizations, referral agencies, or they can be privately hired.

Hospice care is an approach to caring for terminally ill clients that stresses palliative care (relief of pain and uncomfortable symptoms), as opposed to care that attempts to cure illness. The goal of hospice care is to minimize pain and suffering. Hospice clients are cared for by a team of professionals and volunteers who specialize in different types of care. In addition to meeting the client's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the client as well as the psychosocial needs of the family or caregiver. Hospice programs provide care in a variety of settings including: the client's home, skilled nursing facilities, special units in hospitals, or stand-alone hospice programs. Hospice services include nursing care, physical and occupational therapy, speech language therapy, medical social services, home health aides, medical

supplies and equipment, medications, physician services, short term inpatient care, and psychological, spiritual and nutritional counseling.

These three programs are valuable long-term care services and are the focus for the development of a consumer information website in California. This paper describes the initial development of the website, the most recent changes in the website, and the research that was undertaken for the website. In addition, the paper presents a summary of current information about nursing homes, home health agencies, and hospices in California, along with some recent trend data.

California Nursing Home Search

In response to public concerns about nursing home quality of care and costs, California Nursing Home Search (calnhs.org) was launched by the California HealthCare Foundation in October 2002 to meet the need for free comprehensive information that can be used by consumers, providers and other stakeholders to find objective data about the state's nursing homes. The website has proven to be a useful tool for consumers, family members and friends, discharge planners, social workers, nurses, physicians, researchers, policy makers and others.

In December 2004, this website was revised to make the website easier for consumers to use. In addition, information about specific home health agencies and hospice programs were added to the website to inform individuals about their options for care at home and in the community. Information is available on approximately 1,400 nursing homes, 834 home health agencies, and 172 hospice programs in the state.

The website presents information from multiple state and federal data sources in an easy-to-use format. It includes data on long term care for one stop shopping. Consumers will no longer have to rely solely on a phone book to find long term care. They will have comparative data available to help them make choices and will have help deciding what kind of care they need. The website offers the following features:

- Basic information on facilities, agencies, and program characteristics as well as information on clients.

- A search tool for seeking and comparing nursing homes, home health agencies, and hospice programs within the state on key features.

- Objective ratings of quality on key indicators such as staffing, deficiencies and complaints, quality measures, and financial and cost information.

- Important supplemental information on guidelines to other care options such as home care, in-home supportive services, adult day care, and other long term care services and information.

- Substantial content to educate and inform all users about their rights and what to look for when selecting a provider.

- State level data not found anywhere else and a detailed description of data sources.

- Links and resources within the state to go to for more information.

The Need for a Consumer Information Resource

Selecting a nursing home or finding appropriate long term care services to allow individuals to live at home is one of life's most challenging situations. The decision to do so is usually made under the pressure of time and emotional stress associated with the illness or disability of a loved one. Complicating the decision enormously is the difficulty in choosing between available options. Consumers have had little or no objective information with which to evaluate the quality of providers and have had to base their decisions on other factors such as location or price, a visit to the facility, or the recommendation of friends.

Consumers are highly concerned about the quality of nursing home care. Quality varies considerably between facilities, and the demand for nursing home quality information is significant.[1-3] In addition, quality variations also occur between home health agencies and hospice programs and these data are generally not available for consumers.

Other important stakeholders also want information about nursing homes, home health and hospice. The lack of objective, accurate, comparative information on long term care quality has stymied those who refer patients to these facilities, namely, hospital discharge planners, physicians, nurses, and social workers. Managers of the facilities and programs have been hindered in their quality improvement efforts because of the absence of quality benchmarks. Insurance companies and health maintenance organizations who purchase long term care also want information on quality to help in contract decisions. Researchers and members of the press also have difficulty obtaining information about facilities and programs. Policymakers and advocates alike have had no consistent, reliable way of: (1) grasping the scope and magnitude of quality issues in long term care and their relationship to staffing and funding; or (2) monitoring changes over time.

In response to these concerns, in February 2000 the California HealthCare Foundation (CHCF) initial funded a $2 million two-year program to evaluate the quality of the state's nursing homes and distribute the findings to the public via an interactive Website. The creation of *California Nursing Home Search* and the extensive research needed to analyze, compile, and validate the quality data was carried out by researchers at the University of California, San Francisco, Department of Social and Behavioral Sciences; the University of California, Los Angeles, Borun Center for Gerontological Research at the Los Angeles Jewish Home for the Aging; RAND; and the University of Wisconsin, Madison, Center for Health Systems Research and Analysis**.** [2,4-6] On-going funding has been available to update the information system on a quarterly basis.

The project's initial goals were to:

1. Independently analyze and validate through on-site observational study, the publicly reported clinical quality information about nursing homes in California.
2. Define nursing home quality for consumers in a new and more comprehensive way than in the past and create a one-stop-shopping information resource.
3. Educate consumers about the relevance and relative importance of each type of quality information.
4. Present the findings in an easy-to-use web-based format that allows consumers to manage the level of complexity of information they need.
5. Provide facilities, policymakers, regulators, and advocates with a more complete picture of quality of care in nursing homes in order to spur quality improvement efforts in California.

Content

The website defines nursing home quality for consumers in an expanded way. The website goes beyond listing of deficiency and complaint information to include additional information that extensive research has shown can have an impact on the quality of care delivered.

Nursing Homes
For each nursing home listed, the following information is available:

Facility characteristics: These include size, payment accepted, type of services, facility type, accreditation status, specialized services, and resident involvement. Facility characteristics show whether facilities have the capacity to meet the needs and preferences of residents. Included are the current licensee/owner and the type of ownership.

Resident characteristics: These include demographics, age, gender, race/ethnicity, care needs, length of residency, special care needs, and resident need for assistance. Resident characteristics are useful in understanding the types of residents living in a facility and the care they need.

Nurse Staffing: Staffing information includes the amount of staff time available and the types of staff based on their level of training as well as amount of staff changes (turnover) each year. The website shows whether each facility meets the California minimum staffing requirement and whether the facility meets the federal staffing level goal (taking into account the needs of residents in the facility). Our independent research confirmed previous reports indicating that residents respond better to care and treatment at facilities with a high number of well trained staff.

Quality Measures: Quality measures help measure the quality of life and the clinical care in nursing home and home care agencies. These measures show how well a facility or agency is able to prevent residents from developing problems or to treat individuals so

that they can maintain or improve his or her health. The website shows ratings as better than average, average, or worse than average.

Quality of the Facility or Agency: Information provided under deficiencies shows the total state and federal deficiency levels, state and federal deficiency ratings based on compliance with the regulations, types of deficiencies, a listing of specifics deficiencies. Deficiencies show quality of care problems found by trained inspectors during visits and are valuable guides for consumers.

The number and types of complaints are shown and a rating of complaints as average, above average, or below average for nursing homes. Only complaints that have been substantiated by the state Licensing and Certification Program are included. Complaints show the degree of consumer satisfaction or dissatisfaction with the facility.

Financial and Cost Indicators: Included are charges, average charges per day, percent paid by funding source, wages per hour, benefits per hour, types of expenditures per resident per day, net operating income, and operating margin. Reimbursement rates affect quality of care because they affect the number and type of staff a facility is able to hire. Financial indicators also show how much of the money that a facility receives is actually spent on resident care.

Summaries: An overall summary page of ratings is shown. These ratings are on: staffing, quality of the facility, quality of care, and financial or cost indicators.

Home Health and Hospice

Additional work on adding home health and hospice programs to the website was undertaken in 2004. The purpose of this work was to use existing public databases to provide information and quality ratings for home health services and hospice programs. Efforts were made to provide information similar to what is available for nursing homes. Available data for home health agencies and hospice programs, however, are considerably more limited than for nursing homes.

Although data on home health and hospice are less available for consumer information, we have collected and organized the existing information in a similar format to the information for nursing homes. Information available on home health agencies includes:

- **Agency Characteristics:** Type of program, availability of the six basic services, and 11 special services (AIDS/HIV; blood transfusions; enterostomal, intravenous or respiratory/pulmonary therapy; mental health counseling; pediatric; psychiatric nursing; nurse assistants, home health aides or homemakers; and continuous care nursing) and ownership.

- **Client Profile:** Number of clients, diagnosis (such as cancer or heart and lung disease), care intensive diseases (HIV or Alzheimer's), and age characteristics.

- **Quality of Agency:** Ratings based on the number of state and federal deficiencies, a 2000 – 2004 year-by-year summary of state and federal deficiencies compared to state averages for eight specific measures (quality of care, mistreatment, resident assessment, resident rights, environment, nutrition, pharmacy and administration), agency complaints, and accreditation (JCAHO or CHAP).

- **Quality of Care:** Ratings on quality of life (e.g. walking around and bathing) and clinical care (e.g. taking medicines correctly, admitted to hospital) measures compared to state averages.

- **Staffing:** Visits per patient, compared to state averages, by either skilled nurses, aides, or seven other specialists: nutritionists, social workers, speech pathologists, occupational or physical therapists, physicians or spiritual advisors.

- **Finances:** Payment sources compared to state averages: Medi-Cal, Medicare, self-pay, or other sources.

Information available on hospice programs includes:

- **Program Characteristics:** One of five (or other) program types; six specialized services; days spent in the home, hospital, skilled nursing facility, congregate living health facility, or residential care facility – compared to state averages; and ownership;

- **Client Profile:** Diagnosis (cancers and blood disorders; brain nervous system and mental disorders; heart and lung diseases; digestive and urinary system diseases), length of treatment compared to state averages; and age, gender, race/ethnicity characteristics.

- **Quality of Program:** Ratings based on the number of state and federal deficiencies and a 2000 – 2004 year-by-year summary of state and federal deficiencies compared to state averages for nine specific measures (quality of care, mistreatment, client assessment, client rights, environment, nutrition, pharmacy, administration and life safety), agency complaints, and accreditation (JCAHO or CHAP).

- **Staffing:** Visits per client, compared to state averages, by a registered nurse, LVN, hospice physician, social worker, home health aide and homemaker, spiritual advisor, or "other" clinical service provider.

- **Finances and Cost:** Comparisons to state averages for: average expenses per client (inpatient care, nursing home care, visiting services, other program and administrative costs), average charges per client by payment source (Medi-Cal, Medicare, self-pay, or other sources), client days by payment source, visits by payment source, and financial status. (This information will be available for the next update of the programs.)

Website Functionality: The Website allows consumers to search for and find detailed information for nursing facilities, home health agencies, and hospice programs in the state. The site also allows consumers to search and compare facilities on the basis of certain features. Information is also available to help consumers choose a nursing home, home health agency or hospice program and look at other care options and access other resources.

Comparison to Other Websites: The federal government (Centers for Medicare and Medicaid Services has an national website that presents information on all nursing homes in the United States including California (www.Medicare.gov/nhcompare/home.asp). This website allows for comparisons across facilities and is provided in Spanish. The website, however, does not provide ratings of facilities or agencies on key quality indicators as are provided at www.calnhs.org nor does it provide consumer guidelines to help with understanding the information. The federal website does not rate staffing and adjust for resident care needs and does not include changes in staffing (turnover). The federal website does not include data on state deficiencies and complaints, state and federal enforcement actions, cost information (e.g. wages and benefits, and bankruptcy status), and ownership information. Overall, the www.calnhs.org website provides comprehensive information in a format that is easy for consumers to understand and use.

Since 2003, Medicare has also provided basic information on home health agency quality measures on Medicare Home Care Compare (www.Medicare.gov/hhcompare/home). This website allows individuals to search by geographic location and by six services. It provides information on the agency, owners, ownership type, and certification, as well as information on 11 quality measures. This information does not rate agencies or show the agencies that are in the highest and lowest categories on the measures. It als does not have hospice data.

ANALYSIS AND RESEARCH

Although all of the data that appear on *California Nursing Home Search* come from publicly reported sources, it required considerable analysis to develop ratings that could be considered reliable for consumer use. In order to create *California Nursing Home Search*, three major activities were undertaken: (1) building a comprehensive database on California nursing homes; (2) analyzing the data on California nursing homes, home health agencies and hospice program; and (3) conducting a validation study of selected quality performance indicators in nursing homes.

Building a Comprehensive Database

A number of state and federal databases were used and combined to create a comprehensive database on each long term care provider in California. These databases included:

- Two databases (for hospital-based and freestanding nursing facilities) from cost reports that nursing facilities are required to submit to the Office of Statewide Health Planning and Development (OSHPD) annually for all payers. The cost

report information include: facility characteristics, staffing levels, turnover rates, and financial indicators.[7,8]

- Two utilization databases created from information reported to OSHPD by all nursing facilities on an annual basis (for hospital-based and freestanding nursing facilities). This utilization information include: resident demographics (age, gender, and race/ethnicity) and resident length of stay; type of services offered; and special care units. [9,10,11]

- OSHPD utilization databases for home health and hospice from information reported to OSHPD by agencies and programs on an annual basis. This utilization information include: client demographics (age, gender, and race/ethnicity) and resident length of care; type of services provided; number of visits provided; and other information.[12,13]

- The state Licensing and Certification Program collects extensive data on nursing facility licensees during the survey process, called the Automated Certification and Licensing Administrative Information and Management Systems (ACLAIMS). ACLAIMS data for freestanding vs. hospital-based nursing homes, home health agencies, and hospices are used to provide information on certification type, ownership, complaints, and deficiencies. [14]

- Accreditation for nursing homes, home health, and hospice programs came from the Joint Commission on Accreditation for Healthcare Organizations (JCAHO) and the Community Health Accreditation Program (CHAP) websites. [15,16]

- The federal On-Line Survey Certification and Reporting (OSCAR) system for nursing homes is an administrative database maintained by the Centers for Medicaid and Medicare Services (CMS) for data collected during the federal survey and certification process. OSCAR data report on special beds, resident and family councils, chain organizations, and resident need for assistance.[17]

- The federal Minimum Data Set (MDS) contains information from the nursing facility resident assessment form completed for each resident and submitted to CMS. Resource Utilization Groups (RUGs), a resident classification system, are created by CMS using the MDS data, and these are used to determine resident care needs categories and resident need scores.[18]

- The quality measures (QMs) for nursing homes are from the Minimum Data Set (MDS) forms for all nursing home residents and sent to CMS. [19] The quality measures (QMs) for certified home health agencies are collected from agency assessments of clients using the Outcome and Assessment Information Set (OASIS) forms.[20] The information for each facility and agency are used to calculate the top quartile, the middle two quartiles, and the lowest quartile for each indicator for rating quality.

All of these data are collected, organized, and compiled to create a comprehensive set of information for each facility. Each data set has different reporting periods which are shown on the website. The information for each facility is updated on the website every quarter so that the information is the most current data available. Although the financial information is generally one year old, these data are updated as soon as they become available. In contrast, the information on complaints and deficiencies are available every quarter, although data for 2004 were delayed because of changes in the state computer system.

Analyzing Data on California Nursing Homes

Using California data from many different public sources, the project team analyzed a wide range of indicators for inclusion on the website. For example, we examined the relationship between facility cost and quality, patterns of federal and state deficiencies, and complaints. Many other analyses were conducted and the findings were prepared for research publication.

In particular, the quality measures for nursing homes were examined by a research team for the website project. The quality measures were originally developed for CMS by the University of Wisconsin Center for Health Systems Research and Analysis and are calculated using information from resident assessments that are submitted by each facility to the federal government.[21]

As originally developed, the quality performance indicators were not tested to identify problem levels above or below which quality of care would be affected in order to rate the quality of care in a facility for consumers. The accuracy of this self-reported information was also unknown. Therefore, because the quality performance indicators appeared to point to issues of such great importance to consumers in evaluating quality, the team pursued an independent validation study to resolve these concerns.

A field test of 30 nursing facilities in California was conducted to better answer the following: (1) whether homes that score in the upper and lower 25th percentile of selected quality indicators and a staffing indicator (nursing staff hours per resident day) provide different processes of care that reflect quality; and (2) what information about each indicator might be useful for consumers.[22]

Observational, interview, and behavioral assessment protocols were developed to assess the accuracy of nursing facility reported staffing statistics and MDS QPI rates. The protocols were in part developed from work that identified care processes related to quality indicators in nursing homes.[23] The protocols measured care processes that should differentiate between nursing facilities that are providing good care versus those providing poor quality of care (for example, how many times a resident was taken to the toilet or walked during the day). The approaches were designed to be specific and standardized, so that they could be replicated. [22]

The findings from the validation study were used to make decisions about which quality measures would be rated for consumer decisions about quality and what information would be presented on each indicator.[22] The findings were used to develop consumer guidelines. A number of articles from these studies have been published on the different quality measures including: staffing, bedfast, physical restraints, pressure ulcers, incontinence, pain, and depression.[24-40]

Staffing was found to be the best predictor of good processes of nursing home care.[36] Nursing homes in the top 10 percentile on staffing (4.1 hrpd or higher) performed significantly better on 13 of 16 care processes implemented by nursing assistants (NAs), compared to all other remaining homes combined.[36] Residents in the highest staffed homes were significantly more likely to be out of bed and engaged in activities during the day and to receive more feeding assistance and incontinence care. The study concluded that there is a relationship between total staffing levels and the quality of care process implementation, but only in facilities in the top 10 percentile on staffing.[36] Comparing the results of the staffing study findings with studies of 8 separate quality indicators, Schnelle and colleagues concluded that staffing levels were a better predictor of high quality care processes than the eight quality indicators that were examined.[36]

Widespread problems were found in most nursing homes: inadequate assistance with eating (only a few minutes of assistance; verbal interactions during mealtime only 28 percent of the time; and false charting (inaccurate documentation of feeding assistance, toileting, and repositioning); toileting assistance on average once about every 6 hours; residents not turned every 2-3 hours; over half of residents left in bed most of the day; walking assistance only 1 time a day on average; and widespread untreated pain and untreated depression.[24-40]

A 2001 CMS report found that staffing levels for long stay residents that are below 4.1 hours per resident day could result in negative consequences for residents (1.3 hprd for licensed nurses and 2.8 hprd of NA time).[41] When actual staffing levels were compared with the target goals recommended by CMS, 97 percent of all facilities were found to be operating below the desired level in 2001.[41]

The project also conducted a number of studies on the nursing home market in California. Research showed there is an adequate supply of beds in most areas of the state, indicating that facilities are in competition for consumers.[42] The information on *California Nursing Home Search* may drive consumers to the top-performing facilities thereby forcing underachievers to improve their quality scores in order to maintain competitive.

The complex relationships between staffing levels and nursing turnover rates were examined.[41,43] Nurse turnover rates in NFs averaged 71percent in the US, and were over 100 percent in 20 states in 2002.[41] A study of 1,100 nursing homes in California showed that turnover rates range from 4 to 300 percent per year.[43] High turnover was directly related to low staffing and low staffing is related to high turnover rates.[43] High turnover may result in poor staff morale and shortages of staff and poor continuity and quality of

care.[43] Turnover is directly related to heavy workloads, low wages and benefits, poor working conditions, and other factors.[41,43]

Nursing home reimbursement methods and per diem reimbursement rates are of great importance to facilities because they influence the costs of providing care. Medicaid paid for about 50 percent of the nation's total of $100 billion for nursing home expenditures, while Medicare paid for 12 percent, consumers paid for 27 percent, and private insurance and other payers paid for 11 percent in 2001.[44] Medicaid nursing home payments were an average of $115 per day across the nation,[41] while Medicare rates for freestanding facilities were $269 in 2000.[45]

The average nursing home made a 19 percent profit on Medicare while Medicaid rates fell short of costs by about $3.5 billion for the US. [46] Low Medicaid reimbursement rates can result in facilities discriminating against Medicaid residents.[47] Higher Medicaid rates have been found to be associated with higher staffing and quality in markets without excess demand.[48,49]

Congress passed prospective payment system (PPS) reimbursement for implementation in 1998 to reduce overall payment rates to skilled nursing homes.[57,58] By 2000, five of the nation's top 10 nursing home chains declared bankruptcy, impacting about 1,900 facilities across the country. [45,46,50] Provider organizations warned of widespread facility closure and campaigned for increases in Medicare and Medicaid reimbursement rates, but there was little evidence that the bankruptcies led to closures. [51] The GAO attributed the bankruptcy of five of the largest multi-facility operators (chains) to poor business decisions.[46] By 2002, four of the five large chains had emerged from bankruptcy.[47]

Research on California nursing homes found that those with very high profits appeared to be taking profits at the expense of quality. California nursing homes with net income profit margins greater the 9 percent had higher deficiencies and poorer quality of care.[52] CMS could place limits on profits for all Medicare and Medicaid certified facilities.

Overall these studies provide greater about both quality of care measures and market factors that have an impact on quality of care. Nursing home report cards are a relatively new phenomenon, so it is impossible to predict to what degree, if any, the new tools will affect the market.

KEY FINDINGS

This report on California nursing homes was designed to examine changes since the website was launched, and provide a follow-up to two previous reports.[53-55] The new information on home health agencies and hospices describes available programs and services in California and examines some trends. These findings use the most currently available data, generally comparing data from 2000 to 2003. In this report, data on freestanding nursing homes are reported separately from those in hospital-based facilities because of the differences in the two types of facilities and different reporting periods for

each type. Data on nursing homes, home health, and hospice are reported separately below.

Nursing Homes

There are about 1,400 nursing homes in California (17 percent are hospital-based facilities and 83 percent are freestanding facilities). In 2003 there were about 99,000 nursing home residents located in 101,005 licensed free-standing nursing home beds and 16,811 hospital-based beds.[9,10]

California spent $5.7 billion on freestanding nursing homes and $1.5 billion for hospital based facilities for a total of $7.2 billion in 2003.[7,8]

The free-standing nursing homes reported a 88 percent occupancy rate in 2003 while the hospital based facilities reported a 66 percent occupancy rate in 2002 (hospital data are one year later than free-standing facility data).[9-11] The overall occupancy rate was 84 percent showing that there is adequate capacity for nursing home care in most areas of the state.

Staffing

Almost one-third (31 percent) of freestanding nursing facilities did not meet the state minimum staffing standard of 3.2 hours per resident per day of care in 2003.[7] This had changed since 2002 when 37 percent of freestanding facilities did not meet the standard, compared with 50 percent of facilities that did not met the standard in 2001.[7] Facilities that do not meet the minimum staffing law are more likely to cause harm or jeopardy to residents.

In freestanding nursing homes, the average total nursing hours per resident day increased from 3.15 hours in 2000 to 3.41 in 2003.[7] Although the total average nursing hours improved, facilities decreased the hours of registered nurse care by 8 percent, by substituting licensed practical nurse (LPN) hours (nurses with 1 year of training) for RNs. LPN hours increased by 12 percent, and nursing assistant (NA) hours increased by 11 percent.[7] Research shows that RN hours have the highest relationship to good quality of care, so this decrease in hours can have a serious negative effect on the quality of nursing home care.

Overall, only 7 percent of California free-standing nursing homes met the total 4.1 hours of care per resident day recommended in a staffing report prepared for the Centers for Medicare and Medicaid Services (2001), and this level was the same as in 2002.[7] The average free-standing nursing home had only 44 percent of the recommended registered nursing hours of care and 65 percent of the nursing assistant hours in 2003.[7,41]

Hospital based nursing homes have more than double the average staffing levels that free-standing facilities (8.3 hours per resident day).[8] Almost 93 percent of hospital based

facilities meet the minimum of 3.2 hours per resident day and 74 percent met the 4.1 hours per resident day standard that is recommended for nursing staffing.[8]

Turnover Rates. On average, about two-thirds of nursing assistants employed in nursing homes leave employment each year. The average California free-standing nursing home turnover rates for nursing assistants declined from 84 percent in 2000 to 73 percent in 2002, and this further declined to 64 percent in 2003.[7] These improvements are probably related to the economic down turn that encouraged more workers to stay in existing positions.

In spite of improvements, the turnover rate ranged from a low of 8 percent to a high of over 258 percent in 2003.[7] Nursing homes with turnover rates of 46 percent or less (33 percent) were rated as the best on turnover and nursing homes with rates of 72 percent or higher were rated as the worst (33 percent of facilities).[7]

The current average turnover rates are too high to ensure quality of care. High turnover rates result in low staffing levels, low morale, and poor continuity of care. Facilities that have low nurse turnover rates tend to pay higher wages and to have better working conditions.

Wage Rates. The average wage rates for nursing assistants was $10.56 in free-standing nursing homes in California in 2003.[7] Net patient revenues increased by 5 percent between 2002 and 2003 but nursing assistant wage rates only increased by 1 percent during the period.[7]

Wages are low compared with other jobs. The average wages for nursing assistants in free-standing nursing homes were 15 percent lower than the wages in hospital-based facilities in 2003.[7,8] Wages for licensed nurses were 6 percent lower in free-standing facilities than in hospital-based facilities in 2003.[7,8] Low wages encourage high turnover rates and threaten the stability of staff in nursing facilities.

Compliance with Regulations

Deficiencies are violations of federal (for Medicare and Medi-Cal standards) and state nursing home regulations found by the state survey agency during complaint visits and regular surveys. These deficiencies are critical indicators of nursing home quality. The state survey agency reports show when regulations were violated and the seriousness of the violations.

Federal Compliance. Federal regulations are required for facilities that want to be certified for Medicare and Medi-Cal.

- The average nursing facility in California received 10 federal deficiencies per survey in 2003. Only 9 percent of nursing facilities were in compliance or substantial compliance with federal standards.[14] Eighty percent of facilities had serious

deficiencies and 11 percent of facilities had very serious deficiencies or were rated as offering substandard care.[14]

The following table shows the distribution of compliance with federal regulations among California freestanding nursing homes, using the federal categories of compliance, for 2000-2003.[14]

	2000 (1099 surveys)	**2001 (1135 surveys)**	**2002 (1197 surveys)**	**2003 (857 surveys)***	**Percent Change from 00-03**
Average number of deficiencies	13.2	12.0	10.3	9.7	-27%
In Compliance	5%	3%	3%	2%	-60%
In Substantial Compliance	5%	5%	7%	7%	+40%
Noncompliance (Serious)	62%	73%	78%	80%	+29%
Noncompliance (Very Serious)	23%	17%	11%	10%	-57%
Substandard Care	5%	3%	1%	1%	-80%

*All data for 2003 may not be included because of a lag in data entry

- There was a 27 percent decrease in the average number of federal deficiencies given to California freestanding nursing homes between 2000 (13.2 deficiencies) and 2003 (9.7 deficiencies).[14] It is unknown whether the reduction in the number of deficiencies is related to changes in state agency survey procedures or to improvements in the quality of care.

- Over the past two years, there was a substantial decrease in the percent of facilities in federal noncompliance with "very serious" deficiencies and those with substandard care, and an increase in facilities rated as noncompliant for "serious" deficiencies.[14] The reduction in very serious deficiencies may be related to a change in the way that deficiencies are classified by the state agency rather than an improvement in quality (based on a study by the US General Accounting Office in 2003).[54]

State Compliance. The state also sets its own standards for nursing homes. If facilities violate federal standards, the deficiencies are generally shown as federal deficiencies, but those facilities that are not participating in Medicare and Medi-Cal are licensed using only state standards.

- The average number of state citations and deficiencies given to facilities remained the same between 2000 and 2003 (about 2 per facility). [14]

- Of the state regulatory standards, 47 percent of California nursing homes received no state citations or deficiencies, 35 percent received deficiencies only (state deficiencies serve as a warning to fix a problem, they do not warrant a penalty), 14 percent received citations for minor violations and 5 percent received citations for major or severe violations in 2003. [14]

	2000	2001	2002	2003	Percent Change 2000-2003
No Citations or Deficiencies	33%	29%	31%	47%	+42%
Deficiencies Only	44%	48%	43%	35%	-20%
Minor Citations	15%	17%	20%	14%	-7%
Major Citations	7%	5%	6%	4%	-43%
Severe Citations	1%	1%	.33%	1%	0%

*All data for 2003 may not be included because of a lag in data entry

- The percent of facilities receiving state citations and deficiencies declined between 2000 and 2003.[14] The reduction in very serious deficiencies may be related to a change in the way that deficiencies are classified by the state agency rather than an improvement in quality (based on a study by the US General Accounting Office in 2003).[54]

Complaints. The average nursing home received over one complaint per year in 2003. The range of complaints was from 1 to 237 complaints in the 2000-04 time period, with a state average of 7 per facility.[14]

	2000	2001	2002	2003*	% Change 2000-2003
Total Complaints	8,161	8,766	11,102	8,302	2%
Substantiated Complaints	3,292 (40%)	3,366 (38%)	3,318 (30%)	2,210 (27%)	-33%
Unsubstantiated Complaints	4,869 (60%)	5,400 (62%)	7,784 (70%)	6,092 (73%)	25%
Average Number Substantiated Complaints	1.8	1.9	1.7	1.3	-28%

*All data for 2003 may not be included because of a lag in data entry

- Although the number of complaints filed against nursing facilities in California increased by 2 percent between 2000 and 2003, there were missing data for 2003 so the total number of complaints files were incomplete.[14] Of those complaints reported in 2003, the percent of complaints substantiated by the state survey agency decreased to only 27 percent substantiated and 73 percent unsubstantiated.[14] The reduction in unsubstantiated complaints does not necessarily indicate an improvement in quality,

it may be a change in the survey process or the problem of less timely follow-up of complaint inspections because of the reduction in state survey agency staff.

- The lack of timely complaint investigations in California is one reason that the number of substantiated complaints may be lower than in the past. According to the state ACLAIMS data in 2003, of the total complaints in California, 38 percent of investigations were completed after their completion due date.[14] On average the complaint investigations were not completed until more than three months (89 days) after the due date.[14]

Time Requirement & % of Complaints	Percent of Complaints Past Due Date	Average Number of Days Past Due Date
24 Hours (14%)	27%	90
2 Days (4%)	35%	89
10 Days (72%)	41%	94
70 Days (10%)	40%	145

- In 2003, the investigation time requirements were only met for 73 percent of the serious complaints classified as having the potential to immediately jeopardize the safety of residents.[14] Less serious complaints were more likely even more likely not to be investigated within the necessary time limit. Deadlines were not met on 41 percent of complaints that needed to be investigated within ten days and 40 percent of those that needed to be investigated within 70 days.[14] According to the GAO, the major reasons for the timeliness problems are due to increases in the number of complaints and state agency staff shortages.[54]

Quality of Care

Quality Measures (QMs) provide an indication of nursing care in all nursing facilities. They are based on resident assessment reports that facilities send to the Centers for Medicare and Medicaid Services on a quarterly basis. The table below shows the average Quality Measures for California compared with the US average.[19]

	California	**US**	**Range**	**Poor Quality**
Quality of Life				
Activities of daily living got worse	9%	16%	0-51%	14-51%
Spend most of time in bed or chair	4%	4%	0-66%	6-66%
Ability to move around got worse	6%	13%	0-47%	11-47%
Physical restraints	12%	8%	0-63%	19-63%

	California	US	Range	Poor Quality
Clinical Care				
Low risk incontinence of bowel and bladder	31%	47%	0-89%	60-89%
High risk pressure sores	8%	14%	0-62%	15-62%
Urinary tract infection	5%	8%	0-37%	8-37%
Weight loss	9%	NA	0-100%	12-100%
Short stay pressure sores	13%	21%	0-90%	24-80%

In terms of measures related to quality of life, in 2003, the average California nursing home reported slightly better percentages than the US except for physical restraints, which was 50% percent higher than the national average.[19]

In terms of clinical quality, the average California nursing home reported better rates than the national average except for weight loss where national averages were not available. Although these are areas where good nursing care processes can be targeted to reduce poor outcomes. In spite of these reports, the frequency of restraint use, physical decline, weight loss, incontinence, pressure ulcers, and infections are all of serious concern and are indicators of poor quality of care in nursing homes. The above table shows the wide variations in the quality of care and shows the range for the worse facilities.

Facility Characteristics

- California's hospital-based nursing facilities had 218 percent higher staffing levels (8.3 nursing hours per resident day on average) than freestanding nursing facilities (3.8 nursing hours per resident day) in 2003.[7,8] Thirty-one percent of freestanding nursing facilities did not meet the state minimum staffing standard of 3.2 hours per resident per day of care compared to 93 percent of hospital-based nursing homes that met the standard in 2003.[7] Overall, only 7 percent of California free-standing nursing homes met the total 4.1 hours of care per resident day recommended by the CMS report compared to 74 percent of the hospital based facilities.[7,8]

- Hospital based facilities had 50 percent fewer deficiencies and citations (5.5) per year than freestanding nursing facilities (11) in 2003.[14] Hospital-based facilities generally have more Medicare residents, higher resident acuity, and receive higher reimbursement rates.

- Non-profit free-standing nursing facilities had 15 percent higher staffing levels (3.8 hours per resident day) than for-profit facilities (3.3 hours per resident day) in 2003.[7] Of the for-profit nursing homes, 65 percent met the 3.2 hours per resident day state minimum staffing level compared with 86 percent of non-profit nursing homes in 2003.[7] Only 3 percent of for-profit nursing homes met the 4.1 hours per resident day staffing goal compared with 24 percent of non-profit nursing homes.[7]

- Non-profit nursing facilities have fewer total deficiencies and citations (36 per facility) and fewer serious deficiencies per facility than for-profit nursing facilities (from January 2000 through February 2004). For-profit facilities had 31 percent more total deficiencies and citations (47 per facility) in the same period and more serious deficiencies than non-profit facilities.[14]

- Nursing facilities that are part of a multi-facility chain (with two or more facilities) generally had the same average staffing hours as non-chain facilities in 2003 (3.4 hours per resident day).[7] Chain facilities also had 10.5 total deficiencies and citations compared with 10 for non-chain facilities in 2003.[14]

Financial Information

Resident Days

- In California, 63 percent of all resident days of care in free-standing nursing homes were paid for by Medi-Cal in 2003. Only 9 percent of resident days were paid by Medicare, 22 percent of days were paid by individuals themselves, and 6 percent were paid by other payers such as private insurance and health maintenance organizations.[7] The percent of care paid for by Medi-Cal in free-standing nursing homes remained stable during the 2000-2003 period, but Medicare patient days increased (from 6 to 9 percent) and the amount of self-pay declined at the same rate.[7]

- In hospital-based nursing homes, 45 percent of resident days were paid by Medicare, 39 percent by Medi-Cal, and 16 percent by other payers such as private insurance and health maintenance organizations.[8]

Average Net Revenues

- The average freestanding nursing home in California charged $115 per day for Medi-Cal residents, $408 per day for Medicare, and $151 for private pay, with overall average charges of $151 per day in 2003 (based on net patient revenues after deductions).[7] The average cost was about $55,000 per year for nursing home care in free-standing facilities.

- The low Medi-Cal reimbursement rates appear to be related to low staffing and the poor financial status of the average facilities, because most care (66 percent of the resident days) is paid for by Medi-Cal.[7]

- Overall average charges were $716 per day for hospital-based nursing home care in 2003, but most of the days of care were for short stay residents (less than 21 days) (based on net revenues after deductions).[8] The average hospital-based nursing home received $2,880 per day from Medicare, $725 from Medi-Cal, $143 per day from individuals, and $813 per day from other insurance in 2003.[8] Hospital based facilities generally have more post acute short-term residents with higher nursing care needs.

Average Expenditures

- The average freestanding nursing home spent $198 per resident per day in 2003, which was a 26 percent increase over the previous year.[7] Of the total expenditures, 54 percent ($106 per resident day) was for direct care expenses (e.g. nursing, therapy, activities), 16 percent ($32 per resident day) for other care expenses (e.g. housekeeping, dietary services, food and other), 7.5 percent ($15 per resident day) was for capital (e.g. buildings, land and other), and 22.5 percent ($45 per resident day) was for administrative expenses (e.g., personnel, insurance, legal fees and other costs).[7]

- Between 2000 and 2003, direct care expenses increased from 52 to 54 percent of total expenditures.[7] Facilities that allocate more direct care funds per day generally have higher staffing levels.

Financial Status

- The average free-standing nursing home had a 0.9 percent net income in 2002 but this decreased to a loss of 7 percent in 2003.[7]

- Almost half (47 percent) of free-standing nursing homes had a loss of net income, 12 percent had a 0 to 1 percent net income margin, 26 percent had 2-8 percent net income margin, and 15 percent had a 9 percent or higher net income margin in 2003.[7] The number of facilities with negative net income margins in 2003 was similar to that in 2001 and 2002.

- With these types of losses sustained over time, some facilities may be in serious financial jeopardy. Nursing homes with losses can be expected to try to raise charges per day and to cut costs by reducing staffing.

- Recent research shows that the 15 percent of for-profit nursing facilities with profit margins of 9 percent or more are more likely to have poor quality of care.[50] Facilities with excess profits may be reducing staffing and other services to increase profit margins.

- Hospital-based facilities had a total of one percent average net income margin. They had 45 percent of their income from Medicare, 39 percent from Medi-Cal, and 16 percent from other insurance and self-pay.[8] Net Medicare revenues per resident day for hospital-based facilities were $2,880 compared with $725 of Medi-Cal and $142 for self-pay residents. The average net patient revenue (after deductions) was $716 per day.[8]

- From 1999-2002, a total of 160 facilities in eight chains in California were in bankruptcy for all or part of the time.[51,52] Although bankruptcy does not mean a facility will close, it does indicate that the facility is more likely to be financially unstable.[48,49] The state of California was unable to report the number of facilities in bankruptcy in 2003.

Because charges and expenses vary by region in California, on California Nursing Home Search, each facility's experience is compared to the regional average for that facility.

Home Health

Home health care agencies emphasize post-acute rehabilitative services, not long term and custodial home care. Individuals who need nursing and other health care services may receive home health care from trained workers who visit the home to help with daily activities and care needs. Services include basic care from home health aides and professional services from registered nurses and therapists who help with care and therapeutic needs.

Home Health Agencies

In 2003, there were 834 home health agencies in California. The number of home health agencies declined dramatically (from 1,404 in 1997 to 834 in 2003) -- by 40.5 percent -- between 1997 and 2001,[12] primarily because of changes and reductions in the federal Medicare home health agency payment system adopted by Congress in 1997 and then implementation of a prospective payment system in 2000 based on a 60-day episode of care. The number of home visits provided by agencies also declined by 46 percent during the same period. Since 2001, the number of agencies has remained stable.[12]

Geographical Location. Home health agencies were located in 52 of the 58 counties in the state in 2003.[12] Of the total, 51 percent (423 agencies) were located in Los Angeles county, 46 agencies (5 percent) were in San Diego, 43 in San Bernardino, 33 in Orange, and 29 were in Riverside, suggesting greater competition between agencies in the southern part of the state. Twenty counties had only one or two agencies and 6 counties (Calaveras, Glenn, Modoc, Mono, Sierra, and Sutter) had none.[12]

Ownership and Agency Types. Of the agencies in 2003, only 18 percent were non-profit and 82 percent were for-profit businesses.[12] Five percent (45 agencies) also had a hospice program that provides care to individuals with terminal illness.[12] Nine home care agencies provided a home infusion program for the administration of medication, nutrients and other fluids directly into a client's body.[12]

Accreditation. Accreditation is an evaluation process that requires a health care organization to meet standards of care determined by an independent accrediting organization. Home health agencies can choose to be accredited either by the Joint Commission of Healthcare Organizations (JCAHO) or the Community Health Accreditation Program (CHAP). Accreditation standards are independent from government regulations required for Medicare or Medi-Cal certification, although in some cases an accredited home health agency does not have to go through the certification process as the accreditation inspection may serve in lieu of the certification survey. After an agency is accredited, it is monitored by the accrediting organization to make sure it continues to meet the standards. Twenty-six percent of home health

agencies in California have JCAHO accreditation and 2 percent are accredited by CHAP.[15,16]

Clients

California home health agencies served 536,000 individuals and provided over 8 million visits in 2001.[13] Of the clients served, 25 percent had heart or lung diseases, 28 percent had skin, muscle or bone disorders, 7 percent had cancer, and the remainder had a range of other disorders.[12]

Age of Clients. Home health agencies serve individuals across all age groups, but they primarily serve older individuals with chronic illness, injuries, and disabilities. About 9 percent of the clients were under 21, 16 percent were 21 to 50, 22 percent were 51-70, 25 percent were 71-80, and the remaining 28 percent were age 81 and older in 2001.[12]

Payments for Care. Of the home health agencies in the state, 64 percent were certified to take Medicare payments, 44 percent had Medi-Cal certification, and 33 percent accepted only self pay or private insurance payments in 2003.[12]

Most home care is paid for by Medicare. Medicare paid for 58 percent of all visits, only 8 percent of visits were paid by Medi-Cal, and 34 were paid directly out-of-pocket by individuals, insurance companies or health maintenance organizations.[12]

Medicare pays home health agencies a fixed rate per illness episode regardless of the number of visits made. The average Medicare payment was $4,187 per individual in California in 2002.[55] The average Medi-Cal payment per individual was $8,060 in 2001.

Average Number of Client Visits. California home health agencies made an average of 25 visits per individual client in 2001.[12] Of the visits reported, an average of 18 visits were by skilled nurses, 4 visits by home health aides, 2 visits by physical therapists, and the remaining by other types of staff. On average, Medicare paid for 15 visits per client, Medi-Cal paid for 4 visits, and insurance and health maintenance organizations paid for 6 visits per client.[12]

Compliance with Regulations

Examining deficiencies and complaints is one of the best ways to determine whether a home health agency is meeting the quality of care standards. Complaints are formal problems that were reported to and investigated and substantiated by the California Licensing and Certification program. Deficiencies are issued for violations of federal and state regulations.

Deficiencies. Deficiencies for violating federal standards fall under two categories: condition-level or standard-level. For home health agencies there are 15 conditions of participation. Each of these represents a performance area that could have a serious impact on the quality of care given to clients. Standards are the specific regulations that

must be met within the conditions of participation. If a surveyor believes there is a significant problem that "adversely affects or has the potential to adversely affect clients," the surveyor will assign a condition-level deficiency, which is the most serious kind of deficiency.

Of the home health agencies surveyed between January 2000 and February 2004, 186 certified agencies had a federal condition out on their last survey showing that they had serious violations and were not in compliance with the federal certification requirements.[14] These agencies had an average of 1.5 conditions that were not met. 491 home health agencies had an average of 15.9 of the less serious federal deficiencies and 101 agencies had state deficiencies on their last survey. [14]

In 2003, the average home health agency received 8 deficiencies for failure to meet quality standards and conditions.[14] The average number of deficiencies has declined steadily from 17 deficiencies in 2000 to 8 in 2003.[14] It is not known whether quality of agencies is improving or whether the state survey agency is giving fewer deficiencies in general.

	State Average	**Range for Best Agencies**	**Range for Average Agencies**	**Range for Worse Agencies**
Federal and state deficiencies, January 2000-February 29, 2004	18.1	1-6	7-18	19-116

Quality of care varied widely by agency because the number of deficiencies between 2000 and February 2004 ranged from 1 to 116 per agency.[14] Agencies with the highest number of deficiencies, especially those that had 19 or more deficiencies (in the top 33 percent of agencies on deficiencies) are considered to offer poorer quality of care than other agencies. Agencies that had 6 or less deficiencies (in the lowest 33 percent of agencies) are considered to have the best quality of care.[14]

Complaints. There were 339 complaints filed against agencies between 2000-February 2004. [14] The average agency had less than one complaint per year, but the number of complaints ranged from 0 to 10. Agencies with more complaints may have more quality problems.

State Inspection Surveys. The state does not inspect home health agencies on a frequent basis and inspections have been reduced because of state budget constraints. Of the total home health agencies, 38 percent (371 programs) had not been inspected in the 2000-2004 time period; [14] 199 programs were inspected in 2003, 184 programs in 2002, 103 in 2001, and 18 in 2000. [14]

Quality of Care

Quality measures show the percent of clients who have met a certain outcome while being treated by a home health agency. They were created by the federal government and are used to indicate quality of care. Eight of the measures are shown here and grouped into two summary categories: quality of life and clinical care.[20] Quality of life indicates the quality of personal care and therapeutic care received while clinical care is related to the quality of nursing care received. Comparisons for agencies are shown on the website for quality of life and clinical care in 2003.[20]

	California	US	Range in California	Poorest Quality
Quality of Life				
Better at walking or moving around	35%	33%	12-76%	12-29%
Better at getting in and out of bed	47%	47%	6-90%	6-37%
Less pain when moving around	59%	56%	17-95%	17-51%
Better at bathing	60%	56%	17-95%	17-53%
Confused less often	37%	34%	5-95%	5-33%
Clinical Care				
Better at taking medicines correctly	43%	37%	5-62%	5-29%
Need urgent, unplanned medical care	19%	23%	5-59%	24-59%
Had to be admitted to the hospital	23%	30%	0-54%	28-54%

The agencies that scored in the lowest 25 percent on the first six measures were rated as being worse than other agencies. The agencies that had the highest rates (in the highest 25 percent) on two items (need urgent unplanned medical care and had to be admitted to the hospital) were considered to be worse than other agencies. The measures have to be considered with some caution, however, because some agencies may have clients who are sicker than others so they may have lower scores.

Although the range of scores within California agencies vary greatly, California agencies did slightly better than the US average in all areas except getting in and out of bed which was the same as the US average.

Summary. The number and types of visits and the quality of care vary across home health agencies. Consumers should use available information to first select those agencies that take the type of payment an individual plans to use (Medicare, Medi-Cal or other), the types of services needed, and the age group of the client. Then consumers should make sure that the agency provides an adequate number of visits with the appropriate types of staff. Agencies with the worst ratings on deficiencies and quality measures should questioned before they are selected as a provider.

Hospice

Hospice care is an approach to caring for terminally ill clients that stresses relief of pain and uncomfortable symptoms, as opposed to care to cure the illness. Hospice care is provided by a team of professionals and volunteers, who address the physical, psychosocial, and spiritual needs of the client as well as the psychosocial needs of the family or caregiver. The care may be provided at home, in nursing homes or residential care, or in acute care hospitals.

Hospice Programs

In 2001, there were 184 licensed hospice programs in California but the number of programs declined 6 percent to 172 in 2003.[12]

Geographical Location. The programs were located in 37 counties in the state, while 21 counties did not have hospice programs (Alpine, Amador, Calaveras, Colusa, Glenn, Inyo, Kings, Lassen, Madera, Marin, Mendocino, Merced, Modoc, Mono, Plumas, San Benito, Santa Cruz, Sierra, Sutter, Tehama, and Trinity). [12] Thirty-five percent of hospice programs (60) are located in Los Angeles county, while 8 percent (13) were located in San Diego county. [12]

Agency Type and Location of Care. Of the licensed hospice programs, 60 percent were free-standing, 21 percent hospital-based, 13 were home health based, and 6 percent were other. [12] Of the days of care provided, 73 percent were provided at home, 19 percent in skilled nursing homes, and 8 percent in residential care, congregate living facilities or other sites. [12]

Ownership. Of the total hospice programs, 52 percent are for-profit and 48 percent are not profit organizations. [12]

Accreditation. Accreditation is an evaluation process that requires a health care organization to meet standards of care determined by an independent accrediting organization. Hospice programs can choose to be accredited either by the Joint Commission of Healthcare Organizations (JCAHO) or the Community Health Accreditation Program (CHAP). Accreditation standards are independent from government regulations required for Medicare or Medi-Cal certification, although in some cases an accredited hospice does not have to go through the certification process as the accreditation inspection may serve in lieu of the certification survey. After a program is accredited, it is monitored by the accrediting organization to make sure it continues to meet the standards. Twenty-eight percent of hospice programs in California have JCAHO accreditation and 5 percent are accredited by CHAP.[15,16]

Clients

California hospice programs served about 48,000 individuals in 2003.[12] Of the total clients, over half (55 percent) were women and three-fourths (72 percent) were

Caucasian. [12] 56 percent had cancer or a blood disorder, 17 percent had heart or lung disease, and the remainder had other diseases. [12]

Age of Clients. Hospice programs serve individuals across all age groups, but they primarily serve older individuals who have chronic illness, injuries, and disabilities. About 3 percent of the clients were under age 50, 24 percent were 51-70, 28 percent were age 71-80, and 45 percent were age 81 or older. [12]

Payments for Care. Of the total hospice programs, 90 percent are certified to take Medicare payments, 80 percent take Medi-Cal payments, and 9 percent take only private pay or private insurance payments in 2003. [12]

Of the total client days in hospice care, 80 percent was paid by Medicare, 9 percent was paid by Medi-Cal, and 11 percent was paid by other sources, such as private insurance or health maintenance organizations in 2001. [12]

Medicare pays hospice programs a per day rate regardless of the number of visits made, with a cap on the total expenditures per client which varies by the type of hospice care provided (regular care, continuous 24 hour care, inpatient hospital care, or inpatient respite care). The average California Medicare hospice payment was $6,824 per individual served in 2002.[56]

Because the nature of hospice care is to care for the terminally ill, and because less high-cost technology is used and the patient is most often cared for at home instead of in an expensive hospital, it is a principle of hospice to offer services based upon need, rather than the ability to pay. While each hospice has its own policies concerning payment for care and hospice care is a covered benefit under many insurance plans, some hospices rely upon community support for donations to provide care to those who cannot otherwise afford it.

Specialized Services Offered. Seventeen percent of the hospice programs offered services in inpatient units and 9 percent offered pediatric programs. Twelve percent offered palliative care (comfort) programs and 93 percent offer bereavement services to hospice patient survivors. Medicare covered hospice programs are required to provide bereavement services. [12]

Number of Visits. California hospice programs made about 1.4 million visits for an average of about 30 visits per individual client served in 2001. [12] Of the visits reported, an average of 13 visits were by registered nurses, 11 visits by home health aides or homemakers, 3 visits by social workers, and the remaining visits were made by other types of staff. [12]

Most individuals (64 percent) received services for 30 days or less, 15 percent received services for 31-60 days, and the remainder received services for 61 days or more in 2001 in California. [12]

Compliance with Regulations

Examining deficiencies and complaints is the best way to determine whether a hospice program is meeting the quality of care standards. Complaints are formal problems that were reported to and investigated and substantiated by the California Licensing and Certification Program. Deficiencies are issued for violations of federal and state regulations.

Deficiencies. Deficiencies for violating federal standards fall under two categories: condition-level or standard-level. For hospice programs, there are 24 conditions of participation. Each of these represents a performance area that could have a serious impact on the quality of care given to clients. Standards are the specific regulations that must be met within the conditions of participation. If a surveyor believes there is a significant problem that "adversely affects or has the potential to adversely affect clients," the surveyor will assign a condition-level deficiency, which is the most serious kind of deficiency.

Of the hospice programs in the state, 20 percent (35 programs) were out of compliance with at least one federal condition on the most recent survey, showing that they had very serious problems and were not meeting the federal standards. In addition, 91 hospice programs had less serious deficiencies on their most recent survey.[14]

In 2003, the average hospice program received 8 deficiencies for failure to meet quality standards and conditions. [14] The average number of deficiencies has declined steadily from 15 deficiencies in 2000 to 8 in 2003. [14] It is not known whether quality of agencies is improving or whether the state survey agency is giving fewer deficiencies in general.

The number of deficiencies received by an agency varied widely for the period of January 2000 through February 2003. The total ranged from 3 to 91 with an average of 17. Programs with the highest number of deficiencies, especially those with 22 or more deficiencies (in the top 33 percent of programs) are considered to offer poorer quality of care than other programs.[14] Programs with 4 or fewer deficiencies (in the lowest 33 percent of programs) are considered to have the best quality of care.

The average agency had less than one complaint per year, but the number ranged from 0 to 6 complaints.[14] Agencies with more complaints may have more quality problems.

State Inspection Surveys. The state does not inspect hospices on a frequent basis. Of the total hospice programs, 58 percent (91 programs) were not inspected in the 2000 to 2004 period.[14] Only 14 programs were inspected in 2003, 29 programs in 2002, 11 in 2001, and 12 in 2000. [14] There has been a reduction in the number of visits to programs over the period because of state budget constraints on the California Licensing and Certification program that regulates the agencies.

Measures of the Quality of Care Provided. The federal government Center for Medicare and Medicaid Services has not developed clinical measures of quality for hospice programs.

Summary. The number and types of visits and the quality of care vary across hospice programs. Consumers should use available information to first select those programs that take the type of payment an individual plans to use (Medicare, Medi-Cal or other), the types of services needed, and the age group of the client. Then consumers should make sure that the agency provides an adequate number of visits with the appropriate types of staff. Agencies with the worst ratings on deficiencies should be questioned before they are selected as a provider.

CONCLUSION

While attempting to educate and empower individual consumers, *California Nursing Home Search* might expect to achieve its greatest impact on providers simply by making this degree of quality information publicly available. It is commonly understood that closely observed processes tend to improve more than which are not studied. Without independent, routine reporting of performance and changes in performance, it is very difficult for program administrators to obtain the full benefit of quality improvement efforts. Also, through public exposure in the press and the community, providers with poor performance are given strong motivation to address their problems. Consumer advocates and other watchdog organizations will also play an important role by monitoring changes in quality over time.

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