# HHS Decision Rules

## for

## Categorizing Measures of Health, Health Care Quality, and Health Care Affordability



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## Contents

# I. PURPOSE OF MEASURE CATEGORIZATION

The multiple divisions of the Department of Health and Human Services (HHS) currently use thousands of measures to evaluate and improve US health and health care. Efficiently using these measures— and additional measures under development—requires that HHS well understand what these measures represent. Analyzing HHS' set of measures according to the National Quality Strategy priorities, and setting and level of care is a key step in helping to achieve this understanding. An improved and shared understanding of these measures will facilitate better identification of measure gaps, priorities for new measure development, as well as any instances of a surplus of measures. It will also help improve coordination of new measure development and harmonization of existing measures, and provide insight on how best to move towards achieving a set of highly effective measures that minimizes measurement burden, while providing all stakeholders with useful information on health and healthcare.

# II. STANDARDS FOR THE DECISION RULES

## *A. Logic and transparency.*

Decision rules are written, explicit, logic statements that make clear the criteria that must be met in order to assign a measure into a particular measure category. Decision rules shall be available to all stakeholders.

## *B. Use of standardized definitions.*

To the extent possible, rules for categorizing measures shall be consistent with and use standardized definitions of concepts and criteria. Establishing formal links between measure concepts and standardized definitions helps to better link measures and measurement with health services research and databases, and work conducted in the broader national and international arena. To the extent that a standardized definition does not exist, identifying this can provide valuable feedback for health services research and policy makers.

## *C. Continuous improvement.*

Decision rules shall be subject to continuous quality improvement. As decision rules are applied, the need for revision or addition to the rules may become apparent. Measure creators, stewards, or others categorizing measures should document all instances when existing decision rules are insufficient to easily categorize a measure. These instances should be brought to the attention of the HHS Measures Coordination Group, who will analyze the problem and make recommendations for additions or revisions to the decision rules or measure categories, as needed. When such instances are identified internally within HHS, they should be forwarded to the MCG lead who will bring them to the full MCG. When such instances are identified by HHS contractors, the contractor should bring

them to the attention of the Contract Officer's Representative (COR) or Government Task Lead (GTL), who will bring it to the attention of the MCG.

### *D. Decision rules shall be endorsed by the HHS Measures Policy Council.*

The HHS Measures Coordination Group is the operational arm of the HHS Measures Policy Council. Decision rules and subsequent revisions shall take effect upon the date of endorsement by the HHS Measures Policy Council. The HHS Measures Policy Council will take the lead on coordinating HHS decision rules with rules used in the private sector.

## III. GENERAL RULES FOR CATEGORIZING MEASURES

### *A. Timing of categorization.*

Newly created measures shall be categorized by their creator when each measure's specifications are developed. Measures already in use shall be reviewed for categorization or re-categorization by the HHS division that is responsible for each measure as part of its annual update and any scheduled comprehensive review. Following the decision rules, measure creators shall document in writing the logic by which the measure is assigned to a specific category. When the logic used to categorize a measure is made explicit, reviewers will have the opportunity to comment on the proposed categorization as part of the measure's creation, endorsement and maintenance processes. This will aid in understanding the validity of the measure, and can help translate measurement results to all stakeholders. A given measure can be re-categorized if there is consensus from the HHS division responsible for the measure or the HHS Measures Policy Council that the measure belongs in a category different than the one initially identified.

### *B. Person-centered[1] approach.*

There are multiple different perspectives through which measures can be understood and categorized. Some measures may relate to more than one aspect of health care. Health care providers, purchasers of health care, measure developers, and others also may all have different views of what a specific measure represents. All of these ways of thinking

[1] Many different words can be used to refer to individuals whose health or healthcare is being measured, including "patient," "client," "consumer," "recipient," "beneficiary," and others. The use of the word, "person," is intended to include these perspectives, while also recognizing the broader life roles of individuals in the communities in which they live. Use of the word "person-centered" also is intended to include families of adults who, with the consent of the individual person, can play an essential role in health and health care. With respect to children and adolescents, we always intend "person-centered" to include families.

about a measure may be valid, but the healthcare system needs consistent categorization by the multiple parties who categorize measures.

In situations of competing views, concerns, and needs, experts remind us that "True north" lies in "the experience of patients, their loved ones, and the communities in which they live."[2] For this reason, in situations of multiple, competing views, categorization of measures shall be informed by considering how they would most likely to be perceived by the persons whose health or health care is being measured, when that person is informed about what is being measured and the evidence about its significance. Considering this perspective will help to maintain a person-centered approach to health care overall; by focusing not just on how health care is delivered, but how we measure, think about, and communicate to the public about these issues. Using a person-centered approach could also help in efforts to educate the public about the relevance of individual performance measures to themselves.

# IV. RULES FOR CATEGORIZING MEASURES ACCORDING TO NATIONAL QUALITY STRATEGY PRIORITIES

## *A. The National Quality Strategy priorities:*

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

***Adherence to General Rules.***

Categorization of measures according to the National Quality Strategy priorities shall follow the General Rules for Categorizing Measures in Section III, above.

***Measures of Disparities in Health and Health Care (Inequity in health resources and care).***

[2] D.M. Berwick. A User's Manual for the IOM's 'Quality Chasm' Report. Health Affairs, 21, no.3 (2002):80-90.

The categories below do not include a separate category for measures of heath care equity or disparities in health or health care. Although concern with eliminating disparities in care and taking into consideration the different health and health care needs of individuals are explicit principles of the National Quality Strategy, the absence of a separate category for such measures is due to the belief that all measures of health and health care can serve as such measures. Although we recognize that not all measures are specified for stratification according to such concepts as race, ethnicity, or socio-economic status, when measures are implemented across different groups and the results stratified, they can provide reliable information on differences in the health or healthcare across these groups, and thus provide information on disparities or inequities in health and health care.

***Number of categorizations.***

Some measures may relate to more than one NQS priority. For example, a measure of the delivery of inappropriate care may be categorized as a measure of healthcare waste because it is delivering care that is not needed. If such care also exposes the patient to risk, it can be conceived of as a measure of patient safety. In the future, composite measures might assess the combination of effective care and care coordination along with patient engagement or some other combination of dimensions of care. When a measure meets the decision rules for categorization into more than one NQS priority, the measures shall be mapped to all these NQS priorities. However, when a measure is assigned to more than one NQS priority category, one priority shall be designated as the measure's primary category and all other assignable categories shall be assigned as a secondary categorization. Determination of the measure's primary category shall be made by determining which NQS priority's decision rules the measure most strongly meets.

## *B. Criteria for categorizing measures.*

Each measure shall be categorized under the NQS priority or priorities to which it applies using the decision rules set forth below. When a measure does not meet the decision rules for any of the NQS priorities it shall be designated as "Not Assignable to a National Quality Strategy Priority."

### 1. Making care safer by reducing harm caused in the delivery of care.

This priority has two components:

a. "making care safer." This means that the measure must address either an explicit structure or process intended to make care safer, or the outcome of the presence or absence of such a structure or process; and

b. harm "caused in the delivery of care." This means that the structure, process or outcome described in "a" must occur as a part of or as a result of the delivery of care.

***Applicable definition:***

"Making care safer" shall be defined according to the National Library of Medicine (NLM) MeSH definition of safety; i.e., increasing "Freedom from exposure to danger and protection from the occurrence or risk of injury or loss including personal safety as well as the safety of property." This includes "patient safety" which includes "efforts to reduce risk, to address and reduce incidents and accidents that may negatively impact healthcare consumers" and "safety management," defined as "The development of systems to prevent accidents, injuries, and other adverse occurrences. . ."

***Criteria for inclusion:***

Include in this category measures that meet criteria "a" or "b" below:

a. The measure addresses a structure or process designed to reduce risk *in the delivery of health care* to healthcare consumers and employees in all settings in which health care is delivered, including institutional facilities, outpatient and ambulatory care settings, the home, and other locations in which care may be provided such as a place of employment or site of an accident or emergency;

OR

b. The measure addresses the occurrence of a health or health care outcome that results from the presence or absence of structures or processes identified in item a.

***Additional instructions for assigning measures into this category:***

a. **Measure must be linked to the delivery of care.** Measures of health care safety address efforts to reduce the presence of a specific risk to the person receiving health care or health care worker *that is caused by the delivery of health care*. All measures in this category of health care safety must address a structure or process that is part of care delivery or an adverse outcome (i.e., errors, harm, complications, or death) that is the result of care delivery. For example, failure to receive a mammogram may increase the risk for late detection of breast cancer; however, this is not a safety measure as it did not involve risk caused by the delivery of health care. This measure would be a measure of effective treatment practices in category 4, below. However, measures of the incidence of pressure ulcers in a nursing home or measures of processes to prevent these pressure ulcers are examples of a health care safety measure because it addresses processes or outcomes that are concerned with the reduction of risk that takes place during care delivery.

b. **Determining measures of safety versus affordability.** When there is a question about whether a measure, for example a measure of the provision of inappropriate

care, should be assigned to the category of "Making care safer . . ." because it could result in harm, or the category of "Making quality care more affordable . . . ." because the provision of inappropriate care also is a measure of waste, examine the measure from the perspective of the person whose care is being measured. If the provision of inappropriate care; e.g., such as an unnecessary invasive procedure would or should be perceived by a knowledgeable patient as placing the patient at significant risk, categorize the measure as a measure of patient safety. If the measure measures the delivery of inappropriate care that does not place the person's health at risk, e.g., measures of certain unnecessary radiologic or laboratory studies, categorize the measure as a measure of waste under "Making quality care more affordable."

c. **Measures of Safety Culture.** Include in this category measures of organizations' safety cultures and characteristics that define "high reliability organizations" (HROs).[3] Features of cultures of safety include:

- acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations;
- a blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment;
- encouragement of collaboration across ranks and disciplines to seek solutions to health care safety problems; and
- organizational commitment of resources to address safety concerns.

Characteristics of HROs similarly include:

- *Sensitivity to Operations* that make every employee and team mindful of the complexities of systems to eliminate errors,
- *Reluctance to Simplify* explanations of difficulties and problems they face,
- *Proactive Preoccupation with Failure* and Near misses,
- *Deference to Expertise* so that staff at every level comfortably share information to report and solve problems, and a
- *Commitment to Resilience* in quickly containing errors and developing the capacity for continuous improvement and learning.

[3] HROs can be defined as organizations that consistently minimize adverse events despite carrying out intrinsically complex and hazardous work. (See: http://psnet.ahrq.gov/primer.aspx?primerID=5 )

d. **Handling of measures of mortality and complications of health care delivery.** As above, sometimes a measure (particularly measures of mortality or complication of care delivery) may meet the decision rules for both "Making Care Safer" and "Promoting the most effective prevention and treatment practices." While many measures of patient mortality and complications are expected to be assigned to "Promoting the most effective prevention and treatment practices" because of their relationship to a disease process, measures of mortality or complications of care related to or resulting from the delivery of care would be categorized under "Making care safer…" (e.g., Rate of Complications of Anesthesia; Accidental Puncture or Laceration Rate).

## 2. Ensuring that each person and family is engaged as partners in their care.

This priority has two components:

1) the experience of each person and their family; and
2) the extent to which they are "engaged as partners in their care."

***Applicable definitions:***

The concept of person/family "engagement" is defined as "a set of behaviors by patients, family members, and health professionals and a set of organizational policies and procedures that foster both the inclusion of patients and family members as active members of the health care team and collaborative partnerships with providers and provider organizations."[4]

***Criteria for inclusion:***

Include in this category only measures of either:

a. Organizational structures or processes that foster both the inclusion of persons and family members as active members of the health care team and collaborative partnerships with providers and provider organizations;

OR

[4] Guide to Patient and Family Engagement: Environmental Scan Report. May 2012. Agency for Healthcare Research and Quality. Rockville, MD. http://www.ahrq.gov/research/findings/final-reports/ptfamilyscan/index.html. Accessed 7/15/13.

b. Person or family-reported experiences (outcomes) of being engaged as active members of the health care team and in collaborative partnerships with providers and provider organizations.

***Additional instructions for assigning measures into this category:***

a. Include in this category measures that address:

   1) engaging both the person and his/her family in their care;
   2) engaging only the person in their care, or
   3) only the engagement of families.

   This is because some methods (e.g., CAHPS survey questions) may address these separately but address all dimensions when individual measures are combined.

b. Include in this category measures that address the "personalization" of health care and personalized risk assessments.

c. Include in this category measures of cultural sensitivity, patient decision-making support, or care that reflects patient preferences.

d. Include in this category measures of patient adherence to activities prescribed by a health care provider, such as patient adherence to medication therapy or follow-up appointments.

### 3. Promoting effective communication and coordination of care.

This priority has two components:
1) the promotion of effective communication and coordination of care (emphasis added); and
2) "communication and coordination of care."

For purpose of categorization, assume that all actions to promote effective coordination of care involve efforts to promote effective communication.

***Applicable definitions:***

This category uses the following definition of care coordination:

"Care coordination is a conscious effort to ensure that all key information needed to make clinical decisions is available to patients and providers. It is defined as the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate appropriate delivery of health care services."[5]

***Criteria for inclusion:***

Include in this category measures of:

a. Structures or processes of the *deliberate organization of health care activities* between two or more participants involved in a person's care to facilitate the appropriate delivery of health care services, including the marshalling of personnel and other resources needed to facilitate appropriate delivery of health care services. (Include only measures of actions whose purpose is to improve coordination of care *between health care providers*. Actions designed to improve communication between persons receiving care / families and their provider(s) shall be categorized under, "Ensuring that each person and family is engaged as partners in their care.");

OR

b. Person-reported experiences of the extent to which their care was deliberately organized between two or more participants involved in a person's care to facilitate the appropriate delivery of health care services (outcomes). This can include reports by a person receiving care of the extent to which personnel and other resources were marshaled to carry out all required health care activities or information was exchanged among participants responsible for different aspects of the person's health care.

OR

c. Outcomes that primarily reflect successful care coordination; e.g., 30-day readmission, avoidable admissions from post-acute care facilities, emergency department visits, and service duplication.

***Additional instructions for assigning measures into this category:***

[5] US DHHS. "National Healthcare Quality Report 2012." AHRQ Publication N: 13-0002. May 2013. Available at: www.ahrq.gov/research/findings/nhqrdr/nhqr12/nhqr12_prov.pdf.

Include in this category measures of the use of electronic health records, and other information technology that facilitates communication between health care providers.

### 4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.

This priority includes measures of practices to promote effective prevention and treatment of health conditions.

***Applicable definitions:***

This category uses the definition of "effective" put forth by the Institute of Medicine:

Care that is consistent with systematically acquired evidence to determine whether an intervention, such as a preventive service, diagnostic test, or therapy, produces better outcomes than alternatives – including the alternative of doing nothing.[6]

***Criteria for inclusion:***

Include in the category measures whose specifications:

a. include measurement of a specific practice or practices related to treatment, management and prevention of complications/disability among individuals *with an existing health condition or conditions*;

OR

b. Patient-centered outcomes of a disease state or states.

***Additional instructions for assigning measures into this category:***

a. Although the priority addresses, "the most effective" prevention and treatment practices, it is beyond the scope of these decision rules to distinguish "most effective" practices from "lesser effective" practices. Therefore, this portion of the priority is not operationalized in these decision rules.

b. When categorizing measures of prevention or behavior changes, categorize measures whose specifications address a specific diagnosed condition or conditions

[6] Institute of Medicine, 2001. Crossing the Quality Chasm: A New Health System for the 21st Century. National Academy Press. Washington DC.

under this category. Measures of prevention should be included in this category when the preventive practice is recommended specifically because of its relationship to an existing condition(s). An example would be screening for retinopathy in patients with diabetes. Similarly a measure of exercise as part of cardiac rehabilitation would be categorized under "Promoting the most effective prevention and treatment practices for the leading causes of mortality. Measures of screening, prevention activities, and health behaviors that do not specify a particular diagnosed condition or conditions, (such as a measure of exercise as it relates to good health generally) are to be classified under, "Working with communities to promote wide use of best practices to enable healthy living."

### 5. Working with communities to promote wide use of best practices to enable healthy living.

This priority has two components:

1) working with communities; and
2) promotion of practices to enable healthy living.

***Applicable definitions:***

a. A community is defined as follows:
"Community is a group of people who have common characteristics; communities can be defined by geographic proximity, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other similar common bonds."[7]

b. A practice to enable healthy living is defined as any intervention to improve the health behaviors or health of a group of individuals.

***Criteria for inclusion:***

Include in this category only measures whose specifications explicitly include:

a. Outcomes and indicators of the health of a community; examples include prevalence of obesity, incidence of dental decay or cavities in children, days of school missed, etc.

OR

[7] Derived from: Turnock, BJ. Public Health: What It Is and How It Works. Jones and Bartlett, 2009.

b. Measurement of process(es) – regardless of the environment or setting of the process(es) – focused on primary prevention of disease or general screening for early detection of disease unrelated to a current or prior condition. Examples include immunization of healthy individuals, counseling on smoking cessation, best practices for housing programs, age-based colon cancer screening, etc. Screening done in individuals at increased risk due to a preexisting condition should go under Priority #4).

OR

c. Structural components deemed necessary to support promotion of health and well-being; examples include establishment and maintenance of electronic public health information systems, capacity for providing preventive and health maintenance services, etc.

***Additional instructions for assigning measures to this category:***

Include in this category measures of structures or processes designed to prevent accidents and injuries in the community that are not directly related to health care:

### 6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

This priority addresses measurement of the affordability of health care.

***Applicable definitions:***

Affordability is defined as including health care costs, health care expenditures, resource use, and efficiency. This includes measures of unnecessary health services, inefficiencies in health care delivery, high prices, and fraud.

***Criteria for inclusion:***

Include in this category measures whose specifications explicitly include a measure of affordability of healthcare for individuals, families, employers, or governments.

Include measures of access to care in this category.

### 7. Measures not able to be categorized.

Measures that do not meet the decision rules for assignment to any National Quality Strategy priority shall be assigned to the category of: "Not assignable to a National Quality Strategy priority."

# V. RULES FOR CATEGORIZING MEASURES ACCORDING TO SETTING OF CARE AND UNIT OF ANALYSIS.

## *A. Categorizing measures according to "Settings of Care."*

People receive health care in many different places – in the office of a clinician or group practice, in a hospital or nursing home, in an urgent care center, or at the site of a traffic accident, for example. This means that efforts to improve health care quality must address care delivered in all these places. Similarly, measures of health care quality will need to address care delivered in all these settings. Categorizing measures according to the setting(s) of care to which they apply will enable HHS to assess the comprehensiveness of its measure set and more easily identify measure gaps.

A "setting of care" is defined as the type of place in which a person receiving healthcare would perceive that they are in, when healthcare is delivered. The "setting of care" measures categories listed below were derived from a review of how "settings of care" is treated in the following categorization and classification approaches used in or related to health care:

1. The Federal Department of Health and Human Service's Measures Inventory;
2. National Quality Forum's measures database (NQF's "Quality Positioning System");
3. National Quality Measures Clearinghouse, which uses standard terminology (Controlled Vocabulary Concepts) to classify various measure attributes;
4. AHRQ's Common Formats - definitions and formats providers are required to use to submit information on patient safety events;
5. Census Bureau classification system for all settings that are inpatient and/or residential (i.e., called group quarters);
6. North American Industry Classification System (NAICS) - the standard used by Federal statistical agencies in classifying business establishments for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy;
7. 2010 Standard Occupational Classification (SOC) system used by Federal statistical agencies to classify workers into occupational categories for the purpose of collecting, calculating, or disseminating data;
8. "Places of care" categories used in the Medical Expenditure Panel Survey;
9. "Places of care" categories used in the NHANES Survey;
10. "Place of service" codes used in the UB 04 claim form; and
11. "Place of service" codes used in the CMS 1500 claim form.

The resulting categories specified below reflect the dual goals of

1) when appropriate, achieving as much consistency as possible with the above categorization approaches; and

2) ensuring that the resulting categories are logical and useful to the diverse public and private sector programs delivering health care and measuring healthcare quality.

When categorizing a measure according to the setting (or settings) of care to which it applies, assign it to the category(ies) below that are reflected in the measure's specifications. If a measure's specifications do not include any setting of care, categorize the measures as "measure does not specify a setting of care delivery."

Setting of care categories:

1. Adult day care facility
2. Ambulance or site of an emergency that is not a home
3. Ambulatory Surgery Site
4. Behavioral Health / Mental Health / Substance Abuse Treatment Setting
   a. Inpatient
   b. Outpatient (including intensive outpatient services)
   c. Partial Hospitalization
   d. Residential
5. Birthing Center
6. Community Sites of wellness services or non-medical health services; e.g., senior centers, community centers, places of worship, gyms, other non-medical places offering one or more health related services such as exercise or nutrition classes
7. Correctional Institution (includes prisons and jails)
8. Dialysis Facility
   a. Inpatient
   b. Outpatient
9. Employment site
10. Home (a person's personal residence that is not a residential facility or operated as a group home)
11. Hospice facility (inpatient)
12. Hospital/Acute Care Facility – Inpatient
    a. Critical Access Hospitals
13. Hospital/Acute Care Facility – Outpatient
14. Imaging Facility
15. Laboratory
16. Office or clinic
    a. Clinician Office
    b. Urgent Care Office
    c. School-based clinic
    d. Community Health Center (e.g. public health clinic, community-based organization (CBO), Federally Qualified Health Center (FQHC) or FQHC "look-alikes.")
    e. Retail-based clinics located in settings such as drugstores, food stores and other retail settings.
    f. Mobile Unit

   g. Other (specify: _____)
17. Pharmacy
18. Post-Acute or Long Term Care Facility
    a. Long Term Acute Care Hospital
    b. Skilled Nursing Facility
    c. Nursing Facility
    d. Inpatient Rehabilitation Facility
    e. Intermediate Care Facility/ MR
19. Residential Facilities
    a. Mental health or substance abuse residential care facility/group home
    b. Residential care facility for people with intellectual disabilities
    c. Assisted Living Facility
20. Other (Specify: _____)
21. Measure does not specify a setting of care delivery
22. Not Applicable; e.g., a health outcome that is measured for a geopolitical community that is not a reflection of care or service delivered in a particular setting.

## *B. Categorizing measures according to "Level of analysis."*

All measures target a level of the healthcare system that is held accountable for performance. This level—that also is the focus of measurement and targeted improvement—is called the level of analysis. Categorize each measure according to its level of analysis.

1. Individual Health Care Provider
   a. Physician
   b. Nurse
   c. Dentist
   d. Licensed clinician/therapist
   e. Other behavioral health practitioner (non-MD, non-RN, e.g., paraprofessional or peer counselor)
   f. Aide
   g. Team
   h. Other (Specify: _____)
2. Health care delivery organization (public or private); e.g. group practice, hospital, home health agency, public hospital or health program
3. Health Plan, such as a managed care plan or other health insurance plan
4. Health Care Delivery System
   a. Integrated Delivery System (i.e., a network of health care providers and organizations which provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the clinical outcomes and health status of the population served. An Integrated Delivery System may own or could be closely aligned with an insurance product.)
   b. Accountable Care Organization

   c. Medical Home
   d. Other
5. Geopolitical unit
   a. Community, County or City
   b. National
   c. Regional
   d. State
6. Other (Specify: _____)
   e.g., an internet community or other community that is not a geopolitical unit. ("Community" is defined as a group of people who have common characteristics; communities can be defined by geographic proximity, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other similar common bonds. (Turnock, BJ. Public Health: What It Is and How It Works. Jones and Bartlett, 2009.))