Proposed New Measure for HEDIS®[1] MY 2027: Person-Centered Outcome (PCO) Measures

NCQA seeks comments on the *Person-Centered Outcome* (PCO) measures, newly proposed measures for inclusion in HEDIS Measurement Year (MY) 2027 for Special Needs Plans (SNPs). This is a set of three measures that enable individuals and/or caregivers and their clinicians to identify and track meaningful, measurable goals for care planning, quality improvement and clinician accountability. The measures are as follows:

- *Person-Centered Outcome – Goal Identification (GID-E).* The percentage of persons 18 years of age and older with a complex care need who set a person-centered outcome goal.
- *Person-Centered Outcome – Goal Follow-Up (GIF-E)*. The percentage of persons 18 years of age and older with a complex care need who set a person-centered outcome goal and followed up on the goal.
- *Person-Centered Outcome – Goal Achievement (GIA-E)*. The percentage of persons 18 years of age and older with a complex care need who set a person-centered outcome goal and achieved the goal.

The measures are intended for reporting by SNPs only, excluding Institutional SNPs (I-SNPs).

There is growing consensus that health care should be guided by individuals' goals and preferences, especially for adults with complex care needs.[2] Over the past 10 years, with support from The John A. Hartford Foundation, The SCAN Foundation and The Gordon and Betty Moore Foundation, NCQA developed the Person-Centered Outcome (PCO) measures. These measures enable individuals and/or caregivers and their clinicians to identify and track meaningful, measurable goals for care planning, quality improvement and clinician accountability. The PCO measures have been successfully tested in multiple care delivery settings in over 30 organizations, across 17 states, with more than 700 clinicians (e.g., physicians, nurses, social workers, peer navigators and care managers) and over 30,000 individuals and are being used in a state Medicaid home and community-based care program for value-based payment. The PCO measures tailor measurement to the priorities that matter most to individuals and have the potential to fill a critical gap in accountability for whole-person care. SNPs are the ideal environment for the PCO measures due to the CMS Model of Care which requires documentation of person-centered goals.

Testing and Panel Feedback

NCQA conducted field testing in two Special Needs Plans (SNPs) to evaluate the feasibility and performance of the new measure concepts and to inform implementation at the health plan level. Field testing demonstrated strong feasibility and usability of the PCO measures across participating health plans. Plans successfully used electronic care management platforms to implement the PCO approach, validating the feasibility of digital reporting for these measures.

Overall, the average performance rate for GID-E was 95.67%, confirming that documenting person-centered goals is feasible and well-integrated into care management workflows. Participating plans were able to report the GIF-E (goal follow-up) and GIA-E (goal achievement) measures as well, demonstrating that plans can track progress toward goals over time. Overall, the average performance rate for GIF-E was 41.99% and 32.05% for GIA-E. Analysis of the results by demographics indicated that the measures can be implemented across diverse populations, and the diversity of goal domain selection highlights that plans were able to capture a wide range of priorities. This flexibility demonstrates that the PCO approach supports individualized care planning that is aligned with what matters most to members.

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[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[2] American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity. (2012). *Guiding principles for the care of older adults with multimorbidity: An approach for clinicians.* Journal of the American Geriatrics Society, 60(10), E1–E25.

Overall, testing confirms that the PCO measures (GID-E, GIF-E and GIA-E) are feasible, adaptable and capable of driving person-centered care.

Advisory panels expressed strong support for the measures and recognized their potential to advance the growing emphasis on person-centered care.

Public Comment Request

NCQA seeks general feedback on including the three PCO measures for SNPs only (excluding I-SNPs), and specific feedback on the **following:**

1. Do you support the inclusion of the new PCO measures in HEDIS MY 2027?
2. Should NCQA postpone public reporting of GIA-E until HEDIS MY 2029 to allow for additional time to monitor health plan performance?
3. Are there other populations for which the PCO measures would be applicable?

Supporting documents include three draft measure specifications and an evidence workup.

NCQA acknowledges the contributions of the Behavioral Health, Geriatric, Person-Centered Outcomes and Technical Measurement Advisory Panels.

Measure title	Person-Centered Outcome - Goal Identification	**Measure ID**	GID-E
Description	The percentage of persons 18 years of age and older with a complex care need who set a person-centered outcome goal.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	**Adapted with financial support from The John A. Hartford Foundation and The SCAN Foundation.* Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	There is broad agreement that a person's goals and priorities should guide care and quality measures used to evaluate care.[1-3] For older adults with multiple chronic conditions and functional limitations, clinical guidelines have pointed to the importance of providing goal-based care.[4,5] For this complex population, goal setting has been shown to reduce patient-reported treatment burden and receipt of unwanted care and correlates with greater physical and social well-being and care satisfaction.[6,7] The Centers for Medicare & Medicaid Services (CMS) support aligning care with persons' goals as demonstrated by the "Meaningful Measures" initiative, which calls for quality measures where "care is personalized and aligned with patient's goals".[8]		
Citations	[1] McGlynn, E. A., Schneider, E. C., & Kerr, E. A. (2014). Reimagining Quality Measurement. *New England Journal of Medicine*, *371*(23), 2150–2153. https://doi.org/10.1056/NEJMp1407883. [2] Reuben, D. B., & Tinetti, M. E. (2012). Goal-oriented patient care—An alternative health outcomes paradigm. The New England Journal of Medicine, 366(9), 777–779. https://doi.org/10.1056/NEJMp1113631. [3] Tinetti, M. E., Naik, A. D., & Dodson, J. A. (2016). Moving From Disease-Centered to Patient Goals–Directed Care for Patients With Multiple Chronic Conditions: Patient Value-Based Care. JAMA Cardiology, 1(1), 9. https://doi.org/10.1001/jamacardio.2015.0248. [4] American Geriatrics Society Expert Panel on the Care of Older Adults With Multimorbidity. (2012). Patient-centered care for older adults with multiple chronic conditions: A stepwise approach from the American Geriatrics Society: American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity. *Journal of the American Geriatrics Society*, 60(10), 1957–1968. https://doi.org/10.1111/j.1532- 5415.2012.04187. [5] The American Geriatrics Society Expert Panel on Person-Centered Care. (2016). Person-centered care: A definition and essential elements. *Journal of the American Geriatrics Society*, *64*(1), 15–18. https://doi.org/10.1111/jgs.13866. [6] Kuipers, S. J., Cramm, J. M., & Nieboer, A. P. (2019). The importance of patient-centered care and co-creation of care for satisfaction with care and physical and social well-being of patients with multi-morbidity in the primary care setting. *BMC Health Services Research*, *19*(1), 13. https://doi.org/10.1186/s12913-018-3818-y.		

	[7] Tinetti, M. E., Naik, A. D., Dindo, L., Costello, D. M., Esterson, J., Geda, M., Rosen, J., Hernandez-Bigos, K., Smith, C. D., Ouellet, G. M., Kang, G., Lee, Y., & Blaum, C. (2019). Association of Patient Priorities–Aligned Decision-Making With Patient Outcomes and Ambulatory Health Care Burden Among Older Adults With Multiple Chronic Conditions: A Nonrandomized Clinical Trial. *JAMA Internal Medicine*, 179(12), 1688–1697. https://doi.org/10.1001/jamainternmed.2019.4235 [8] Meaningful Measures Hub | CMS. (2019, September 10). https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page
Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	Medicare (only D-SNP and C-SNP benefit packages).
Stratifications	Age as of the start of the measurement period • 18–64 years. • 65 years and older.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. Refer to the *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Documenting multiple goals:** The measure only requires the documentation of one person-centered outcome goal per measurement period. If a person and/or care partner documents multiple goals, only one goal that meets measure requirements (i.e., documentation of a person-centered outcome goal that includes a goal domain, baseline measurement and care plan) will be reported for the measure numerator. • *For example:* – If an individual sets three goals in a measurement period and only one meets the measure requirements, they have met the GID-E numerator. – An individual sets a goal on August 1 but does not meet GID-E because a baseline measurement was not documented. The individual comes back October 2, notifies their clinician that the goal is no longer relevant, sets a new goal and meets all measure requirements. The second goal would meet the GID-E numerator.
Definitions	
Baseline measurement	Completion of goal attainment scaling (GAS) or a patient-reported outcome measure (PROM) for the person-centered outcome goal that was set.

Care plan

The documented steps required to achieve the person-centered outcome goal. Each time a new goal is documented, the care plan should be developed and/or reviewed.

Complex care need

A complex care need represents physical, behavioral health and/or social challenges. Individuals may have multiple complex care needs. Enrollment in a Special Needs Plan (SNP) is indicative of having a complex care need.

GAS

Goal attainment scaling is a well-tested approach to measuring individualized goals of care. Individuals and clinicians jointly identify a goal that is most important to the individual and define a set of possible outcomes along a 5-point scale (Table 1) from “much less than expected” to “much better than expected.”

Table 1. Goal Attainment Scaling Scoring

Much less than expected	Less than expected (at baseline, current state)	Expected outcome (person-centered outcome goal)	Better than expected	Much better than expected
-2	-1	0	+1	+2

Goal domain

A high-level description of the goal focus that must be chosen when the person-centered outcome goal is set. Recommended goal domain options are:

- Access to Services & Supports
- Housing
- Managing Conditions & Symptoms
- Caregiver Needs & Concerns
- Improving Health & Wellness
- Medication Management
- Emotional & Mental Health
- Independence
- Physical Function
- End of Life
- Legal
- Social & Role Functioning

PROM

A patient-reported outcome measure (PROM) is a standardized instrument used to report patient-reported outcomes. An example of a PROM includes the Patient-Reported Outcomes Measurement Information System (PROMIS®). The PROMIS instruments are used to assess and monitor mental, physical and social health in both children and adults. PROMIS instruments are used within the general population as well as with individuals living with chronic conditions. The following table provides the PROMs allowed for use for this measure.

Table 2. List of Approved PROMs

Instrument	Total Score LOINC Code
General Anxiety Disorder (GAD)–7	70274-6
PHQ-9	44261-6
Instrument	**T-Score LOINC Code**
PROMIS® Ability to Participate in Social Roles and Activities–Short Form v2.0–8a	77854-8
PROMIS® Alcohol Use–Short Form v1.0–7a	77848-0
PROMIS® Anger–Short Form v1.1–5a	89921-1
PROMIS® Anxiety–Short Form–7a	77862-1
PROMIS® Cognitive Function–Short Form v2.0–8a	81531-6
PROMIS® Depression	71965-8
PROMIS® Dyspnea Severity–Short Form v1.0–10a	92149-4
PROMIS® Fatigue–Short Form v1.0–7a	77864-7
PROMIS® Informational Support–Short Form v2.0–8a	77851-4

PROMIS® Instrumental Support–Short Form v2.0–8a	77850-6
PROMIS® Mobility Item Bank–v2.1	91614-8
PROMIS® Pain behavior–v1.0–7a	77856-3
PROMIS® Pain Interference–Short Form v1.0–6a	77865-4
PROMIS® Physical Function–Short Form v2.0–10a	91721-1
PROMIS® Satisfaction with Participation in Social Roles–Short Form v1.0–8a	77855-5
PROMIS® Self-Efficacy for Managing Daily Activities–Short Form v1.0–8a	92391-2
PROMIS® Self-Efficacy for Managing Emotions–Short Form v1.0–8a	92329-2
PROMIS® Self-Efficacy for Managing Medications and Treatments–Short Form v1.0–8a	92418-3
PROMIS® Self-Efficacy for Managing Symptoms–Short Form v1.0–8a	92448-0
PROMIS® Sleep-Related Impairment–Short Form v1.0–8a	77859-7
PROMIS® Smoking: Negative Health Expectancies for All Smokers–Short Form v1.0–6a	92266-6
PROMIS® Smoking: Nicotine Dependence for All Smokers–Short Form v1.0–8a	92305-2
PROMIS® Social Isolation–Short Form v2.0–8a	77849-8
PROMIS® Smoking: Coping Expectancies for All Smokers–Short Form v1.0–4a	92213-8

Person-centered outcome goal	A goal identified by an individual and/or care partner as important. The goal should be specific, measurable, achievable, relevant and time-bound. Person-centered outcome goals may include something the person wishes to accomplish (e.g., taking a special trip, living to see a relative's life milestone), health and well-being outcomes, behavioral health outcomes or outcomes related to receiving services. Person-centered outcome goals must be documented using GAS or PROM to monitor and determine goal achievement. If the person and/or care partner deem that the initial goal is no longer relevant (e.g., person was hospitalized and they can no longer work towards the original goal), the person and/or care partner can set a new goal.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* August 1 of the year prior to the measurement period through the last day of the measurement period. • *Allowable gap:* - *Measurement period:* No more than one gap of ≤ 45 days. - *August 1 of the year prior to the measurement period through December 31 of the year prior to the measurement period:* None. *Ages:* 18 years of age and older as of August 1 of the year prior to the measurement period. *Event:* None.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time on or between August 1 of the year prior to the measurement period and the last day of the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.

<table>
<tr>
<td></td>
<td>Persons 18 years of age or older by the last day of the measurement period, with Medicare benefits, enrolled in an institutional SNP (I-SNP) or living long-term in an institution (LTI).

Enrolled in an I-SNP any time on or between August 1 of the year prior to the measurement period and the last day of the measurement period.
Living long-term in an institution any time on or between August 1 of the year prior to the measurement period and the last day of the measurement period, as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag any time on or between August 1 of the year prior to the measurement period and the last day of the measurement period.
</td>
</tr>
<tr>
<td>Denominator</td>
<td>The initial population minus denominator exclusions.</td>
</tr>
<tr>
<td>Numerator</td>
<td>Goal Identification
<p>Persons with documentation of a person-centered outcome goal that includes a goal domain, baseline measurement and care plan.</p>
<p>Either of the following baseline measurements on or between August 1 of the year prior to the measurement period and July 31 of the measurement period:</p>

Documentation of GAS (LOINC code 112296-9) and a goal domain (goal domain field is not null) on the same date of service. A care plan (Care Plan Value Set) documented within 7 days of GAS and goal domain documentation.
A documented score from a standardized PROM (Patient Reported Health Assessment Scores Value Set) and a goal domain (goal domain field is not null) on the same date of service. A care plan (Care Plan Value Set) documented within 7 days of standardized PROM score and goal domain documentation.

<p>Do not include baseline measurements taken in an inpatient setting or during an ED visit.</p></td>
</tr>
<tr>
<td>Summary of changes</td>
<td>This is a first-year measure.</td>
</tr>
<tr>
<td>Data element tables</td>
<td><p>Organizations that submit data to NCQA must provide the following data elements in a specified file.</p>
<p><i>Table GID-E-3: Data Elements for Person-Centered Outcome–Goal Identification</i></p>
<table>
<tr><th>Metric</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td>Goal Identification</td><td>18-64</td><td>InitialPopulation</td><td>For each Stratification</td></tr>
<tr><td></td><td>65+</td><td>Exclusions</td><td>For each Stratification</td></tr>
<tr><td></td><td>Total</td><td>Denominator</td><td>For each Stratification</td></tr>
<tr><td></td><td></td><td>Numerator</td><td>For each Stratification</td></tr>
<tr><td></td><td></td><td>Rate</td><td>(Percent)</td></tr>
</table></td>
</tr>
</table>

Measure title	Person-Centered Outcome—Goal Follow-Up	**Measure ID**	GIF-E
Description	The percentage of persons 18 years of age and older with a complex care need who set a person-centered outcome goal and followed up on the goal.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	**Adapted with financial support from The John A. Hartford Foundation and The SCAN Foundation.* Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	There is broad agreement that a person's goals and priorities should guide care and quality measures used to evaluate care.[1-3] For older adults with multiple chronic conditions and functional limitations, clinical guidelines have pointed to the importance of providing goal-based care.[4,5] For this complex population, goal setting has been shown to reduce patient-reported treatment burden and receipt of unwanted care and correlates with greater physical and social well-being and care satisfaction.[6,7] The Centers for Medicare & Medicaid Services (CMS) support aligning care with persons' goals as demonstrated by the "Meaningful Measures" initiative, which calls for quality measures where "care is personalized and aligned with patient's goals".[8]		
Citations	[1] McGlynn, E. A., Schneider, E. C., & Kerr, E. A. (2014). Reimagining Quality Measurement. *New England Journal of Medicine*, *371*(23), 2150–2153. https://doi.org/10.1056/NEJMp1407883. [2] Reuben, D. B., & Tinetti, M. E. (2012). Goal-oriented patient care—An alternative health outcomes paradigm. The New England Journal of Medicine, 366(9), 777–779. https://doi.org/10.1056/NEJMp1113631. [3] Tinetti, M. E., Naik, A. D., & Dodson, J. A. (2016). Moving From Disease-Centered to Patient Goals–Directed Care for Patients With Multiple Chronic Conditions: Patient Value-Based Care. JAMA Cardiology, 1(1), 9. https://doi.org/10.1001/jamacardio.2015.0248. [4] American Geriatrics Society Expert Panel on the Care of Older Adults With Multimorbidity. (2012). Patient-centered care for older adults with multiple chronic conditions: A stepwise approach from the American Geriatrics Society: American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity. *Journal of the American Geriatrics Society*, 60(10), 1957–1968. https://doi.org/10.1111/j.1532- 5415.2012.04187.x [5] The American Geriatrics Society Expert Panel on Person-Centered Care. (2016). Person-centered care: A definition and essential elements. *Journal of*		

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Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	Medicare (only D-SNP and C-SNP benefit packages).
Stratifications	Age as of the start of the measurement period. • 18–65 years. • 65 years and older.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. Refer to the *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Documenting goal follow-up:** Multiple follow-ups on a goal can be completed during the measurement period. If the clinician completes multiple follow-ups on the goal with the person and/or care partner, only one follow-up that meets measure requirements (see numerator criteria below) will be reported for the measure numerator. • *For example:* – A goal was developed on August 1. An initial follow-up was completed on September 10, but the goal was not met. Although the goal was not met, all GIF-E measure requirements were met meeting the GIF-E numerator.

<table>
<tr><th colspan="2">Definitions</th></tr>
<tr><td>Baseline measurement</td><td>Completion of goal attainment scaling (GAS) or a patient-reported outcome measure (PROM) for the person-centered outcome goal that was set.</td></tr>
<tr><td>Care plan</td><td>The documented steps required to achieve the person-centered outcome goal. Each time a new goal is documented, the care plan should be developed and/or reviewed.</td></tr>
<tr><td>Complex care need</td><td>A complex care need represents physical, behavioral health and/or social challenges. Individuals may have multiple complex care needs. Enrollment in a Special Needs Plan (SNP) is indicative of having a complex care need.</td></tr>
<tr><td>Follow-up period</td><td>The 14–180 days after the baseline measurement (167 total days).</td></tr>
<tr><td>GAS</td><td>Goal attainment scaling is a well-tested approach to measuring individualized goals of care. Individuals and clinicians jointly identify a goal that is most important to the individual and define a set of possible outcomes along a 5-point scale (Table 1) from “much less than expected” to “much better than expected.”
<i>Table 1. Goal Attainment Scaling Scoring</i>
<table>
<tr><th>Much less than expected</th><th>Less than expected
(at baseline, current state)</th><th>Expected outcome
(person-centered outcome goal)</th><th>Better than expected</th><th>Much better than expected</th></tr>
<tr><td>-2</td><td>-1</td><td>0</td><td>+1</td><td>+2</td></tr>
<tr><td>LOINC code LA34484-8</td><td>LOINC code LA34483-0</td><td>LOINC code LA34481-4</td><td>LOINC code LA34480-6</td><td>LOINC code LA34479-8</td></tr>
</table>
</td></tr>
<tr><td>Goal domain</td><td>A high-level description of the goal focus that must be chosen when the person-centered outcome goal is set. Recommended goal domain options are:

Access to Services & Supports
Housing
Managing Conditions & Symptoms
Caregiver Needs & Concerns
Improving Health & Wellness
Medication Management
Emotional & Mental Health
Independence
Physical Function
End of Life
Legal
Social & Role Functioning

</td></tr>
<tr><td>Goal intake period</td><td>August 1 of the year prior to the measurement period through July 31 of the measurement period.</td></tr>
<tr><td>PROM</td><td>A patient-reported outcome measure (PROM) is a standardized instrument used to report patient-reported outcomes. An example of a PROM includes the Patient-Reported Outcomes Measurement Information System (PROMIS®). The PROMIS instruments are used to assess and monitor mental, physical and social health in both children and adults. PROMIS instruments are used within the general population as well as with individuals living with chronic conditions. The following table provides the PROMs allowed for use for this measure and the meaningful change to count for goal achievement.</td></tr>
</table>

Table 2. List of Approved PROMs

Instrument	Total Score LOINC Code
General Anxiety Disorder (GAD)—7	70274-6
PHQ-9	44261-6
PROMIS® Ability to Participate in Social Roles and Activities—Short Form v2.0–8a	77854-8
PROMIS® Alcohol Use—Short Form v1.0–7a	77848-0
PROMIS® Anger—Short Form v1.1–5a	89921-1
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PROMIS® Cognitive Function—Short Form v2.0–8a	81531-6
PROMIS® Depression	71965-8
PROMIS® Dyspnea Severity—Short Form v1.0–10a	92149-4
PROMIS® Fatigue—Short Form v1.0–7a	77864-7
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PROMIS® Instrumental Support—Short Form v2.0–8a	77850-6
PROMIS® Mobility Item Bank—v2.1	91614-8
PROMIS® Pain behavior—v1.0–7a	77856-3
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PROMIS® Physical Function—Short Form v2.0–10a	91721-1
PROMIS® Satisfaction with Participation in Social Roles–Short Form v1.0–8a	77855-5
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PROMIS® Self-Efficacy for Managing Emotions—Short Form v1.0–8a	92329-2
PROMIS® Self-Efficacy for Managing Medications and Treatments—Short Form v1.0–8a	92418-3
PROMIS® Self-Efficacy for Managing Symptoms—Short Form v1.0–8a	92448-0
PROMIS® Sleep-Related Impairment—Short Form v1.0–8a	77859-7
PROMIS® Smoking: Negative Health Expectancies for All Smokers—Short Form v1.0–6a	92266-6
PROMIS® Smoking: Nicotine Dependence for All Smokers—Short Form v1.0–8a	92305-2
PROMIS® Social Isolation—Short Form v2.0–8a	77849-8
PROMIS® Smoking: Coping Expectancies for All Smokers—Short Form v1.0–4a	92213-8

Person-centered outcome goal

A goal identified by an individual and/or care partner as important. The goal should be specific, measurable, achievable, relevant and time-bound. Person-centered outcome goals may include something the person wishes to accomplish (e.g., taking a special trip, living to see a relative's life milestone), health and well-being outcomes, behavioral health outcomes or outcomes related to receiving services. Person-centered outcome goals must be documented using GAS or PROM to monitor and determine goal achievement. If the person and/or care partner deem that the initial goal is no longer relevant (e.g., person was hospitalized and they can no longer work towards the original goal), the person and/or care partner can set a new goal.

Initial population

Measure item count: Person.

Attribution basis: Enrollment.

- *Benefits:* Medical.
- *Continuous enrollment:* August 1 of the year prior to the measurement period through the last day of the measurement period.

	- *Allowable gap:* – *Measurement period:* No more than one gap of ≤ 45 days. – *August 1 of the year prior to the measurement period through December 31 of the year prior to the measurement period:* None. *Ages:* 18 years of age and older as of August 1 of the year prior to the measurement period. *Event:* None.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time on or between August 1 of the year prior to the measurement period and the last day of the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons 18 years of age or older by the last day of the measurement period, with Medicare benefits, enrolled in an institutional SNP (I-SNP) or living long-term in an institution (LTI).** - Enrolled in an I-SNP any time on or between August 1 of the year prior to the measurement period and the last day of the measurement period. - Living long-term in an institution any time on or between August 1 of the year prior to the measurement period and the last day of the measurement period, as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag any time on or between August 1 of the year prior to the measurement period and the last day of the measurement period.
Denominator	The initial population minus denominator exclusions.
Numerator	**Goal Follow-up** Persons with documentation of a person-centered outcome goal that includes a goal domain, baseline measurement, care plan and who had a follow-up measurement on or between 14 and 180 days after baseline measurement. **Step 1**. Identify documentation of a person-centered outcome goal using either of the following baseline measurements on or between August 1 of the year prior to the measurement period and July 31 of the measurement period: - Documentation of GAS (LOINC code 112296-9) and a goal domain (goal domain field is not null) on the same date of service. A care plan (Care Plan Value Set) documented within 7 days of GAS and goal domain documentation. - A documented score from a standardized PROM (refer to direct reference codes in Table 2) and a goal domain (goal domain field is not null) on the same date of service. A care plan (Care Plan Value Set) documented

- within 7 days of standardized PROM score and goal domain documentation.

Step 2. Identify follow-up measurement using either of the following on or between 14 and 180 days after the baseline measurement (167 total days):

- For persons who used GAS (LOINC code 112296-9) as their baseline measurement, a follow-up GAS score. Persons who have both of the following on the same date of service meet criteria:
  - Documentation of a follow-up GAS score by the practitioner (LOINC code 107333-7) with Goal Attainment Scaling Scores Value Set).
  - Documentation of a follow-up GAS score by the patient (LOINC code 107334-5) with Goal Attainment Scaling Scores Value Set) or caregiver (LOINC code 107331-1) with Goal Attainment Scaling Scores Value Set).
- For persons who used PROM as their baseline measurement, a documented total score or t-score from the same PROM instrument that was used at baseline. To identify the same instrument, refer to direct reference codes in Table 2.

For persons with multiple goals, if any goal is compliant the person is compliant.

Do not include baseline or follow-up measurements taken in an inpatient setting or during an ED visit.

Summary of changes

- This is a first-year measure.

Data element tables

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table GIF-E-3: Data Elements for Person-Centered Outcome–Goal Follow up

Metric	Age	Data Element	Reporting Instructions
Goal Follow-up	18-64	InitialPopulation	For each Stratification
	65+	Exclusions	For each Stratification
	Total	Denominator	For each Stratification
		Numerator	For each Stratification
		Rate	(Percent)

Measure title	Person-Centered Outcome – Goal Achievement	**Measure ID**	GIA-E
Description	The percentage of persons 18 years of age and older with a complex care need who set a person-centered outcome goal and achieved the goal.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	**Adapted with financial support from The John A. Hartford Foundation and The SCAN Foundation.* Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	There is broad agreement that a person's goals and priorities should guide care and quality measures used to evaluate care.[1-3] For older adults with multiple chronic conditions and functional limitations, clinical guidelines have pointed to the importance of providing goal-based care.[4,5] For this complex population, goal setting has been shown to reduce patient-reported treatment burden and receipt of unwanted care and correlates with greater physical and social well-being and care satisfaction.[6,7] The Centers for Medicare & Medicaid Services (CMS) support aligning care with persons' goals as demonstrated by the "Meaningful Measures" initiative, which calls for quality measures where "care is personalized and aligned with patient's goals".[8]		
Citations	[1] McGlynn, E. A., Schneider, E. C., & Kerr, E. A. (2014). Reimagining Quality Measurement. *New England Journal of Medicine*, *371*(23), 2150–2153. https://doi.org/10.1056/NEJMp1407883. [2] Reuben, D. B., & Tinetti, M. E. (2012). Goal-oriented patient care—An alternative health outcomes paradigm. The New England Journal of Medicine, 366(9), 777–779. https://doi.org/10.1056/NEJMp1113631. [3] Tinetti, M. E., Naik, A. D., & Dodson, J. A. (2016). Moving From Disease-Centered to Patient Goals–Directed Care for Patients With Multiple Chronic Conditions: Patient Value-Based Care. JAMA Cardiology, 1(1), 9. https://doi.org/10.1001/jamacardio.2015.0248. [4] American Geriatrics Society Expert Panel on the Care of Older Adults With Multimorbidity. (2012). Patient-centered care for older adults with multiple chronic conditions: A stepwise approach from the American Geriatrics Society: American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity. *Journal of the American Geriatrics Society*, 60(10), 1957–1968. https://doi.org/10.1111/j.1532- 5415.2012.04187.x [5] The American Geriatrics Society Expert Panel on Person-Centered Care. (2016). Person-centered care: A definition and essential elements. *Journal of the American Geriatrics Society*, *64*(1), 15–18. https://doi.org/10.1111/jgs.13866. [6] Kuipers, S. J., Cramm, J. M., & Nieboer, A. P. (2019). The importance of patient-centered care and co-creation of care for satisfaction with care and physical and social well-being of patients with multi-morbidity in the primary care setting. *BMC Health Services Research*, *19*(1), 13. https://doi.org/10.1186/s12913-018-3818-y.		

	[7] Tinetti, M. E., Naik, A. D., Dindo, L., Costello, D. M., Esterson, J., Geda, M., Rosen, J., Hernandez-Bigos, K., Smith, C. D., Ouellet, G. M., Kang, G., Lee, Y., & Blaum, C. (2019). Association of Patient Priorities–Aligned Decision-Making With Patient Outcomes and Ambulatory Health Care Burden Among Older Adults With Multiple Chronic Conditions: A Nonrandomized Clinical Trial. *JAMA Internal Medicine*, 179(12), 1688–1697. https://doi.org/10.1001/jamainternmed.2019.4235 [8] Meaningful Measures Hub | CMS. (2019, September 10). https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page
Characteristics	
Scoring	Proportion.
Type	Outcome.
Product lines	Medicare (only D-SNP and C-SNP benefit packages).
Stratifications	Age as of the start of the measurement period. • 18–65 years. • 65 years and older.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. Refer to the *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Documenting goal achievement:** Documenting goal progress/achievement should be done during each follow-up visit. Goal achievement can be used to meet the GIA-E numerator if it happens by the initial follow-up or a subsequent follow-up, and if it meets all other GIA-E measure requirements.
Definitions	
Baseline measurement	Completion of goal attainment scaling (GAS) or a patient-reported outcome measure (PROM) for the person-centered outcome goal that was set.
Care plan	The documented steps required to achieve the person-centered outcome goal. Each time a new goal is documented, the care plan should be developed and/or reviewed.
Complex care need	A complex care need represents physical, behavioral health and/or social challenges. Individuals may have multiple complex care needs. Enrollment in a Special Needs Plan (SNP) is indicative of having a complex care need.
Follow-up period	The 14–180 days after the baseline measurement (167 total days).
Goal Achievement	Achievement of a person-centered outcome goal on or between 14 and 180 days after the baseline measurement (167 total days). Achievement is defined as a GAS score of 0, +1 or +2 documented by both the individual or caregiver **and** the clinician, or a PROM score with

meaningful change (see Table 1 below for meaningful change requirements for each PROM).

GAS

Goal attainment scaling is a well-tested approach to measuring individualized goals of care. Individuals and clinicians jointly identify a goal that is most important to the individual and define a set of possible outcomes along a 5-point scale (Table 1) from "much less than expected" to "much better than expected."

Table 1. Goal Attainment Scaling Scoring

Much less than expected	Less than expected (at baseline, current state)	Expected outcome (person-centered outcome goal)	Better than expected	Much better than expected
-2	-1	0	+1	+2
LOINC code LA34484-8	LOINC code LA34483-0	LOINC code LA34481-4	LOINC code LA34480-6	LOINC code LA34479-8

Goal domain

A high-level description of the goal focus that must be chosen when the person-centered outcome goal is set. Recommended goal domain options are:

- Access to Services & Supports
- Housing
- Managing Conditions & Symptoms
- Caregiver Needs & Concerns
- Improving Health & Wellness
- Medication Management
- Emotional & Mental Health
- Independence
- Physical Function
- End of Life
- Legal
- Social & Role Functioning

Goal intake period

August 1 of the year prior to the measurement period through July 31 of the measurement period.

PROM

A patient-reported outcome measure (PROM) is a standardized instrument used to report patient-reported outcomes. An example of a PROM includes the Patient-Reported Outcomes Measurement Information System (PROMIS®). The PROMIS instruments are used to assess and monitor mental, physical and social health in both children and adults. PROMIS instruments are used within the general population as well as with individuals living with chronic conditions. The following table provides the PROMs allowed for use for this measure and the meaningful change to count for goal achievement.

Table 2. List of Approved PROMs

Instrument	Total Score LOINC Code	Meaningful Change
General Anxiety Disorder (GAD)–7	70274-6	4-point decrease from initial total raw score
PHQ-9	44261-6	5-point decrease from initial total raw score
Instrument	**Total T-Score LOINC Code**	**Meaningful Change**
PROMIS® Ability to Participate in Social Roles and Activities–Short Form v2.0–8a	77854-8	3-point increase from initial T-score
PROMIS® Alcohol Use–Short Form v1.0–7a	77848-0	3-point decrease from initial T-score

PROMIS® Anger–Short Form v1.1–(5a)	89921-1	3-point decrease from initial T-score
PROMIS® Anxiety Short Form 7a	77862-1	3-point decrease from initial T-score
PROMIS® Cognitive Function–Short Form v2.0–8a	81531-6	3-point increase from initial T-score
PROMIS® Depression	71965-8	3-point decrease from initial T-score
PROMIS® Dyspnea Severity–Short Form v1.0–10a	92149-4	3-point decrease from initial T-score
PROMIS® Fatigue–Short Form v1.0–7a	77864-7	3-point decrease from initial T-score
PROMIS® Informational Support–Short Form v2.0–8a	77851-4	3-point increase from initial T-score
PROMIS® Instrumental Support–Short Form v2.0–8a	77850-6	3-point increase from initial T-score
PROMIS® Mobility Item Bank v2.1	91614-8	3-point increase from initial T-score
PROMIS® Pain behavior–v1.0–7a	77856-3	3-point decrease from initial T-score
PROMIS® Pain Interference–Short Form v1.0–6a	77865-4	3-point decrease from initial T-score
PROMIS® Physical Function–Short Form v2.0–10a	91721-1	3-point increase from initial T-score
PROMIS® Satisfaction with Participation in Social Roles–Short Form v1.0–8a	77855-5	3-point increase from initial T-score
PROMIS® Self-Efficacy for Managing Daily Activities–Short Form v1.0–8a	92391-2	3-point increase from initial T-score
PROMIS® Self-Efficacy for Managing Emotions–Short Form v1.0–8a	92329-2	3-point increase from initial T-score
PROMIS® Self-Efficacy for Managing Medications and Treatments–Short Form v1.0–8a	92418-3	3-point increase from initial T-score
PROMIS® Self-Efficacy for Managing Symptoms–Short Form v1.0–8a	92448-0	3-point increase from initial T-score
PROMIS® Sleep-Related Impairment–Short Form v1.0–8a	77859-7	3-point decrease from initial T-score
PROMIS® Smoking: Negative Health Expectancies for All Smokers–Short Form v1.0–6a	92266-6	3-point decrease from initial T-score
PROMIS® Smoking: Nicotine Dependence for All Smokers–Short Form v1.0–8a	92305-2	3-point decrease from initial T-score
PROMIS® Social Isolation–Short Form v2.0–8a	77849-8	3-point decrease from initial T-score
PROMIS® Smoking: Coping Expectancies for All Smokers–Short Form v1.0–4a	92213-8	3-point decrease from initial T-score

Person-centered outcome goal	A goal identified by an individual and/or care partner as important. The goal should be specific, measurable, achievable, relevant and time-bound. Person-centered outcome goals may include something the person wishes to accomplish (e.g., taking a special trip, living to see a relative's life milestone), health and well-being outcomes, behavioral health outcomes or outcomes related to receiving services. Person-centered outcome goals must be documented using GAS or PROM to monitor and determine goal achievement. If the person and/or care partner deem that the initial goal is no longer relevant (e.g., person was

	hospitalized and they can no longer work towards the original goal), the person and/or care partner can set a new goal.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* August 1 of the year prior to the measurement period through the last day of the measurement period. • *Allowable gap:* – *Measurement period:* No more than one gap of ≤ 45 days. – *August 1 of the year prior to the measurement period through December 31 of the year prior to the measurement period:* None. *Ages:* 18 years of age and older as of August 1 of the year prior to the measurement period. *Event:* None.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time on or between August 1 of the year prior to the measurement period and the last day of the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons 18 years of age or older by the last day of the measurement period, with Medicare benefits, enrolled in an institutional SNP (I-SNP) or living long-term in an institution (LTI).** • Enrolled in an I-SNP any time on or between August 1 of the year prior to the measurement period and the last day of the measurement period. • Living long-term in an institution any time on or between August 1 of the year prior to the measurement period and the last day of the measurement period, as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag any time on or between August 1 of the year prior to the measurement period and the last day of the measurement period.
Denominator	The initial population minus denominator exclusions.
Numerator	**Goal Achievement** Persons with documentation of a person-centered outcome goal that includes a goal domain, a baseline measurement, a care plan and who achieved their goal on or between 14 and 180 days after baseline measurement. **Step 1**. Identify documentation of a person-centered outcome goal using either of the following baseline measurements on or between August 1 of the year prior to the measurement period and July 31 of the measurement period:

- Documentation of GAS (LOINC code 112296-9) and a goal domain (goal domain field is not null) on the same date of service. A care plan (Care Plan Value Set) documented within 7 days of GAS and goal domain documentation.
- A documented score from a standardized PROM (refer to direct reference codes in Table 2) and a goal domain (goal domain field is not null) on the same date of service. A care plan (Care Plan Value Set) documented within 7 days of standardized PROM score and goal domain documentation.

Step 2. Identify achievement using either of the following on or between 14 and 180 days after the baseline measurement (167 total days):

- For persons who used GAS (LOINC code 112296-9) as their baseline measurement both of the following on the same date of service:
  - Documentation of a follow-up GAS score by the practitioner (LOINC code 107333-7) with a GAS score of 0, +1 or +2 (GAS Achieved Outcome Scores Value Set).
  - Documentation of a follow-up GAS score by the patient (LOINC code 107334-5) or caregiver (LOINC code 107331-1) with a GAS score of 0, +1 or +2 (GAS Achieved Outcome Scores Value Set).
- For persons who used the same PROM for baseline and follow-up measurement, a meaningful change between their baseline and follow-up measurement scores. To identify meaningful change, refer to Table 2.

For persons with multiple goals, if any goal is compliant the person is compliant.

Do not include baseline or follow-up measurements taken in an inpatient setting or during an ED visit.

Summary of changes

- This is a first-year measure.

Data element tables

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table GIA-E-3. Data Elements for Person-Centered Outcome–Goal Achievement

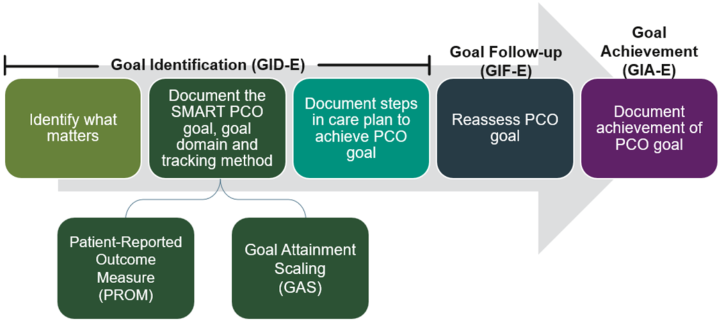
Metric	Age	Data Element	Reporting Instructions
Goal Achievement	18-64	InitialPopulation	For each Stratification
	65+	Exclusions	For each Stratification
	Total	Denominator	For each Stratification
		Numerator	For each Stratification
		Rate	(Percent)

Person-Centered Outcomes (PCO)
Measure Workup

Topic Overview

Background

Figure 1. Person-Centered Outcomes Approach



There is growing consensus that health care should be guided by individuals' goals and preferences, especially for adults with complex care needs (American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity, 2012). Over the past 10 years, with support from The John A. Hartford Foundation, The SCAN Foundation, and The Gordon and Betty Moore Foundation, NCQA developed the Person-Centered Outcome (PCO) measures, an approach captured by three measures (see Figure 1) that enable individuals or caregivers to identify and track meaningful, measurable goals for care planning, quality improvement and clinician accountability. The PCO measures have been successfully tested in multiple care delivery settings in over 30 practices across 17 states, with more than 700 clinicians (e.g., physicians, nurses, social workers, peer navigators and care managers) and over 30,000 individuals and are being used in a state Medicaid home and community-based care program for value-based payment.

This workup describes the evidence and rationale to support the three measures that evaluate the implementation of the person-centered outcomes approach:

1. ***Person-Centered Outcomes – Goal Identification (GID-E).*** Percentage of persons 18 years of age and older with a complex care need who set a person-centered outcome goal.
2. ***Person-Centered Outcomes – Goal Follow-up (GIF-E).*** Percentage of persons 18 years of age and older with a complex care need who set a person-centered outcome goal and followed up on the goal.
3. ***Person-Centered Outcomes – Goal Achievement (GIA-E).*** Percentage of persons 18 years of age and older with a complex care need who set a person-centered outcome goal and achieved the goal.

Importance of Goal-Based Care

Prevalence of Adults with Complex Care Needs

Individuals with multiple chronic conditions, functional limitations and/or behavioral health or social challenges are classified as having complex care needs, a group that comprises a substantial portion of the U.S. population. The 2011 Medicare Expenditure Panel Survey (MEPS) found that about 12 million U.S. adults, age 18 and older, living in the community had three or more chronic conditions and a functional limitation in their ability to care for themselves (defined as experiencing difficulties with activities of daily living) or perform routine daily activities (defined as experiencing difficulties with instrumental activities of daily living) (Hayes et al., 2016). In 2018, just over a quarter (27.2%) of US adults had multiple chronic conditions, with multiple chronic conditions higher among older adults, adults aged 18–64 on Medicaid, and dual-eligible adults (Medicare and Medicaid) (Boersma et al., 2020). These individuals often face trade-offs when determining the appropriate course of treatment and frequently require services and supports beyond traditional medical care (American Geriatrics Society Expert Panel on Person-Centered Care, 2016; American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity, 2012; The SCAN Foundation, 2016).

Current State of Measurement

Many quality measures focus on a single condition or disease. Such measures are frequently based on evidence from clinical trials which underrepresent individuals with complex care needs. The causes and nature of complex care needs are varied and diverse, resulting in health-related concerns, experiences and preferences for care that may not align with single-disease guideline-based care (Bayliss et al., 2014; Fried et al., 2011; Montori et al., 2013).

Disease-specific measures may also have an unintended consequence of encouraging care that is misaligned with an individual's preferences or goals. In recent years, NCQA has taken steps to exclude patients with complex health status and near end-of-life conditions from quality measures to avoid this unintended consequence. However, there is still a need to measure quality of care for this vulnerable population. Given the heterogeneity and complexity in this population, traditional measures that use a "one-size fits all" approach may not be appropriate. Goal-based care based on an individual's priorities and goals has the ability to complement traditional disease-specific care.

Person-centered outcomes support whole person care by aligning care delivery with individual goals and preferences**.** Several experts in the field of geriatrics have suggested the use of patient-centered goals for assessing health outcomes rather than disease-specific outcomes, such as blood pressure or hemoglobin A1c targets, particularly for populations with complex care needs (Reuben & Tinetti, 2012; Tinetti et al., 2016). The Centers for Medicare and Medicaid Services (2019) have also identified a desire for quality measures that support "care [that] is personalized and aligned with patient's goals."

Utilization Impact

The Centers for Disease Control and Prevention (CDC) reports that chronic diseases and mental health conditions account for about 90% of the $4.5 trillion the U.S. spends on healthcare each year (Feke, 2025). While the implementation of the person-centered outcomes approach can increase operational costs – particularly due to staff training, workflow redesign and system updates – long-term financial benefits can outweigh these upfront costs. By incorporating goal-based care into the clinical workflow, Tinetti et al. found a statistically significant improvement in reducing treatment burden; individuals in the intervention group were more likely to have medications stopped (52.0% vs. 33.8%) and had fewer diagnostic tests ordered (80.8% vs. 86.4%) (Tinetti et al., 2019).

Individuals who perceive their visit as person-centered receive fewer diagnostic tests and referrals and lower hospital utilization (Bertakis & Azari, 2011). During PCO measures' testing, NCQA found a significant decrease in hospitalization six months post-goal conversation and a non-significant decrease in ED use (Blaum et al., 2024).

Supporting Evidence for Goal-Based Care

Goal-based care enables a clinician to learn more about the outcomes that the individual values and about their preferences regarding their conditions, possible treatments and their tradeoffs (Lenzen et al., 2017; Vermunt et al., 2017). Goal setting has become a key component of rehabilitation programs for adults with disabilities (Levack et al., 2015) and for care management of adults with complex conditions (National Committee for Quality Assurance, 2015).

There is growing evidence that supports the use of personalized goal setting in specific patient populations. Goal setting has been linked to more positive outcomes and improvements in health and functioning in a variety of populations, such as those with dementia (Clare et al., 2015), coronary heart disease (Janssen et al., 2013), stroke (Warner et al., 2015), mental health conditions (Bouwens et al., 2008; McCue et al., 2021), end-stage renal disease (Kauric-Klein, 2012), diabetes (Naik et al., 2011), and those with rehabilitation needs (Müller et al., 2011).

An established model for developing and setting personalized goals is the SMART framework. SMART goals are Specific, Measurable, Attainable, Realistic, and Time-specific. Using structured goal setting frameworks has been demonstrated as feasible in the clinical setting (Naik et al., 2018) and shown to improve self-management and clinical outcomes in adults with diabetes (Naik et al., 2011; Teal et al., 2012).

Guidelines on Goal-Based Care

The American Geriatric Society's Guiding Principles for the Care of Older Adults with Multimorbidity and Person-Centered Care: A Definition and Essential Elements recommends that an individual's preferences and goals should guide their care (American Geriatrics Society Expert Panel on Person-Centered Care, 2016; American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity, 2012).

In addition to those recommendations, The John A. Hartford Foundation and the Institute for Healthcare Improvement's Age Friendly Health System initiative (Institute for Healthcare Improvement, 2020) and the Health Resources and Services Administration (HRSA) both promote care focused on "What Matters" to older adults (Health Resources & Service Administration, 2016).

Other guidelines and organizations that recommend patient-centered goals and preferences include:

- Clinical Practice Guidelines for Quality Palliative Care, National Coalition for Hospice and Palliative Care (National Coalition for Hospice and Palliative Care, 2018)
- The Medicaid Final Rule for Home and Community Based Services, Centers for Medicare and Medicaid Services (Centers for Medicare & Medicaid Services, 2014)
- Person-Centered Planning and Practice, National Quality Forum (2020)
- 2025 Standards of Medical Care in Diabetes, American Diabetes Association Professional Practice Committee (2024)
- Department of Health and Human Services Centers for Medicare & Medicaid Services (42 CFR Part 422.101) (2025)

Rationale for Person-Centered Outcomes

A central challenge to measuring individual goal attainment is the lack of adequate processes to elicit, document and monitor progress towards patient goals. Goals, when discussed and documented, are frequently documented in multiple places in the electronic record (e.g., progress notes, scanned documents or problem lists) and may conflict with one another (Bernacki et al., 2014; Berntsen et al., 2015). When clinicians document goals of care, the identified goals often focus on end-of-life care or the clinician's goals for disease management, resulting in disease-specific biomarker goals (e.g., blood pressure) or referral for specific medical care (e.g., get preventive screenings) (Berntsen et al., 2015; Sockolow et al., 2017) rather than on quality-of-life outcomes, such as participating in social activities (Bernacki et al., 2014). Furthermore, clinicians and individuals may disagree about documented goals of care (Bogardus et al., 2001; Heisler et al., 2003). Even when documented, these goals are rarely communicated across care teams or tracked systematically (Dykes et al., 2014). Movement towards patient-centered, goal-based care requires a more structured approach to eliciting, documenting and monitoring goals from the patient's perspective. Recent studies have explored more structured approaches to eliciting patient-centered goals (Blaum et al., 2018; Jennings et al., 2018; Naik et al., 2018; Tinetti et al., 2019, Clair et al., 2022).

Using evidence from these studies, NCQA developed and tested an approach to identifying, documenting and measuring structured patient goals called person-centered outcomes. A person-centered outcome is a goal identified by an individual or caregiver that can be used for care planning and quality measurement. The person centered-outcome is measured using either goal attainment scaling or a patient-reported outcome measure (PROM). This approach promotes the development of SMART goals (specific, measurable, achievable, relevant and time-bound) while also standardizing goal measurement and tracking, simplifying chart review and eventually facilitating digitalization of goal tracking and measurement.

The Person-Centered Outcomes Approach

NCQA has developed an approach to goal-based care called the person-centered outcomes approach. Person-centered outcomes are goals identified by an individual or caregiver that can be used for care planning and quality measurement.

The PCO Approach

The PCO approach is an iterative, incremental process for goal-based care. The steps outlined below represent the general framework of the approach.

Step 1: Identify what matters to the individual. The clinician and individual or caregiver discuss personal goals, ensuring the selected goal is meaningful and relevant to the individual's needs.

Step 2: Document and measure a person-centered outcome goal. The goal is measured using either Goal Attainment Scaling (GAS) or a Patient-Reported Outcome Measure (PROM), both of which provide structured, specific, and measurable ways to track progress.

Step 3: Care planning. The clinician and individual create a care plan outlining steps and responsibilities to support goal achievement, addressing barriers and involving care team members as needed.

Step 4: Goal follow-up. Progress is reassessed within 14 and 180 days of when the goal was developed to determine if the goal is on track, needs adjustment, or has been met, while also addressing any challenges.

Step 5: Assess goal achievement. The clinician and individual evaluate whether the goal has been achieved based on the selected measurement method.

Goal Domains

A goal domain is a high-level description of the focus of a goal, used to categorize and organize individual goals. Our list of 12 goal domains was originally based off Jennings et al. (2017) goal taxonomy for adults with dementia and later refined for older adults with functional limitations (Clair et al., 2020). Based on extensive reviews of goals developed by individuals and care partners through our testing, we expanded the list to the 12 domains provided in **Table 1**. For quality measurement, the goal domains provide a high-level understanding of the goal focus, which is typically provided in free text and not documented in a standard, reportable format. Tracking goal domains is also beneficial in helping an organization understand the overall needs of their population and better tailor their resources to meet those needs.

Table 1. Goal Domains and Definitions

Goal Domain	Definition
Housing	Goals related to individuals' place of residence.
Access to Services & Supports	Goals focused on the ability to access, afford, and utilize appropriate health and community resources including access to transportation, stable food resources, and assistance with financial concerns.

Caregiver Needs & Concerns	Goals expressed by and for caregivers that focus on caregiving responsibilities and skills, finding respite care, and receiving social support.
End of Life	Goals related to end-of-life care and desires.
Independence	Goals that center on living one's life independently without help or assistance from others.
Legal	Goals related to legal issues or legal involvement.
Managing Conditions & Symptoms	Goals related to health care received or desired and to experiences with providers and the health care system.
Medication Management	Goals focused on the ability to manage medications.
Improving Health & Wellness	Goals related to developing, improving and maintaining positive health and wellness habits.
Physical Function	Goals related to managing physical functioning, physical symptoms or conditions and improving or maintaining the ability to participate in physical activities.
Social & Role Functioning	Goals focused on engaging in meaningful activities like work, hobbies, or social interaction with family and friends.
Emotional & Mental Health	Goals related to managing mental health symptoms or participating in activities that impact emotional aspects of quality of life.

Goal Attainment Scaling

Goal attainment scaling is a well-tested approach to measuring individualized goals of care. Originally developed for use in mental health, goal attainment scaling is a reliable, valid, and sensitive measurement approach often used for evaluating complex interventions (Kiresuk & Sherman, 1968; Lewis et al., 2013; Rockwood et al., 2003). See **Figure 1** for an example of goal measurement using goal attainment scaling.

Goal attainment scaling has been used among older adult populations in various settings, including psychiatric (Bouwens et al., 2008), hospital (Rockwood et al., 1993; Stolee et al., 1992, 2012), primary care (Toto et al., 2015; Verdoorn et al., 2018), and physical rehabilitation (Rushton & Miller, 2002). Research has found goal attainment scaling to be a feasible strategy in facilitating patient-centered care among diverse populations of older adults with complex needs, including older adults with multiple chronic conditions (Toto et al., 2015; Giovannetti et. al, 2021; Clair et. Al., 2022) and individuals with dementia (Jennings et al., 2018).

Achievement of goals using goal attainment scaling is associated with increased patient engagement, satisfaction with their treatment (Scobbie et al., 2013; Turner-Stokes, 2011) and improved health outcomes (Anderson et al., 2010).

Figure 1. Goal Attainment Scaling

Individuals and clinicians jointly set a goal and define a set of possible outcomes along a 5-point scale from "worse than expected" to "much better than expected." A numerical weight from -2 to +2 is assigned to each possible outcome. At follow-up, the individual and clinician discuss the individual's progress and decide independently which outcome most closely matches what the individual achieved.

Example Goal: Walk her dog outside once a week for the next 2 months.

Worse than expected (-2)	Current state (-1)	Expected level (0)	Better than expected (+1)	Much better than expected (+2)
Unable to let the dog outside.	Does not go outside to walk her dog	Walk her dog outside once a week for the next 2 months.	Walk her dog outside twice a week for the next 2 months.	Walk her dog outside three times a week for the next 2 months.

Patient-Reported Outcome Measures

Patient-reported outcome measures (PROMs) are tools that offer an alternative approach to setting goals and assessing outcomes. PROMs add value by bringing attention to feelings, functioning and experiences that matter to the individual (Nelson et al., 2015; Snyder et al., 2012). These tools can assist individuals, caregivers and clinicians with tracking the impact of lifestyle changes and treatments on symptoms and inform clinicians when additional treatment may be necessary to manage a condition or functional limitation (Forsberg et al., 2015; Lavallee et al., 2016).

As the use of PROMs increases, there is interest in using PROM results in quality measurement as part of value-based purchasing (Centers for Medicare & Medicaid Services, 2016; Safran & Higgins, 2019). However, the goals expressed by older adults and their caregivers are heterogeneous (Bogardus et al., 2001; Howard & Louvar, 2017; Morrow et al., 2008; Schulman-Green et al., 2006), and a single PROM tool, such as a standardized quality of life questionnaire, may not address the goals and priorities relevant to a specific individual. Some individuals may prioritize their physical functioning, while others may prioritize their mental health. To address this limitation, some experts recommend clinicians use multiple PROMs to measure the condition or symptom most relevant to a patient's priorities (Working Group on Health Outcomes for Older Persons with Multiple Chronic Conditions, 2012). See **Figure 2** for a list of PROMs used in NCQA's person-centered outcome measures testing.

Figure 2. Patient-Reported Outcome Measures (PROMs)

<table>
<tr><td colspan="2">Individuals and clinicians jointly set a goal and select a PROM from the table below that best matches that goal (i.e., a patient's goal is to reduce pain would correspond to a pain PROM). At follow-up, the individual completes the same PROM to assess change over time in their outcome.</td></tr>
<tr><td>General Anxiety (GAD-7)</td><td>PROMIS© Pain Behavior – v1.0 – 7a</td></tr>
<tr><td>Anxiety (PHQ-9)</td><td>PROMIS© Pain Interference – Short Form v1.0 – 6a</td></tr>
<tr><td>PROMIS© Ability to Participate in Social Roles and Activities – Short Form v2.0 – 8a</td><td>PROMIS© Physical Function – Short Form v2.0 – 10a</td></tr>
<tr><td>PROMIS© Alcohol Use – Short Form v1.0 – 7a</td><td>PROMIS© Satisfaction with Participation in Social Roles – Short Form v1.0 – 8a</td></tr>
<tr><td>PROMIS© Anger – Short Form v1.1 – 5a</td><td>PROMIS© Self-Efficacy for Managing Daily Activities – Short Form v1.0 – 8a</td></tr>
<tr><td>PROMIS© Anxiety – Short Form – 7a</td><td>PROMIS© Self-Efficacy for Managing Emotions – Short Form v1.0 – 8a</td></tr>
<tr><td>PROMIS© Cognitive Function – Short Form v2.0 – 8a</td><td>PROMIS© Self-Efficacy for Managing Medications and Treatments – Short Form v1.0 – 8a</td></tr>
<tr><td>PROMIS© Depression</td><td>PROMIS© Self-Efficacy for Managing Symptoms – Short Form v1.0 – 8a</td></tr>
<tr><td>PROMIS© Dyspnea Severity – Short Form v1.0 – 10a</td><td>PROMIS© Sleep-Related Impairment – Short Form v1.0 – 8a</td></tr>
<tr><td>PROMIS© Fatigue – Short Form v1.0 – 7a</td><td>PROMIS© Smoking: Negative Health Expectancies for All Smokers – Short Form v1.0 – 8a</td></tr>
<tr><td>PROMIS© Informational Support – Short Form v2.0 – 8a</td><td>PROMIS© Smoking: Nicotine Dependence for All Smokers – Short Form v1.0 – 8a</td></tr>
<tr><td>PROMIS© Instrumental Support – Short Form v2.0 – 8a</td><td>PROMIS© Social Isolation – Short Form v2.0 – 8a</td></tr>
</table>

PROMIS© Mobility Item Bank – v2.1	PROMIS© Smoking: Coping Expectancies for All Smokers – Short Form v1.0 – 4a

Development and Testing of the Person-Centered Outcome (PCO) Measures

Since 2013, The John A. Hartford Foundation, The SCAN Foundation, and The Gordon and Betty Moore Foundation have funded NCQA's development, testing and expansion of PCO measures. To date, the PCO measures have been successfully tested in multiple care delivery settings in over 30 practices and across 17 states, with more than 700 clinicians (e.g., physicians, nurses, social workers, peer navigators and care managers) and over 30,000 individuals. NCQA is leading this work in collaboration with Patient Partners and a diverse, multi-stakeholder PCO Measures Advisory Panel. Target audience groups represented on the panel include consumers, policymakers, providers and payers. To accelerate adoption, NCQA developed a resource page, implementation resources and outreach materials tailored for providers, state leaders and industry stakeholders. For additional information on dissemination activities since 2024, please see Appendix A-1.

Person-Centered Outcomes Pilot in Complex Care Sites

In 2016-2017 NCQA conducted a prospective cohort study of feasibility in seven sites (33 clinicians) using goal attainment scaling and PROMs with 229 individuals. We found both approaches were feasible to implement, and a goal-based outcome could be calculated for 189 (82%) of participants (Giovanetti et al, 2021). Most individuals met their goal-based outcome (73%) with no statistical difference between the goal attainment scaling approach (74%) and the PROMs approach (70%). Goals were heterogeneous, ranging from participating in activities, health management, independence and physical health. Clinicians chose to use goal attainment scaling (N=184, 80%) more often than prioritized PROMs (N=49, 20%) and rated the goal attainment scaling approach as useful for providing patient care (Clair et al., 2022). Qualitative findings on the use of goal attainment scaling indicated that most individuals and clinicians had positive experiences using the approach (Giovannetti et al., 2021).

Person-Centered Outcomes Demonstration in Complex Care Sites

Between 2017-2020, NCQA tested both approaches (goal attainment scaling and PROMs) in a sample of 384 individuals enrolled in 4 geographically diverse organizations (mix of health plans, integrated care network, geriatric primary care) with 33 clinicians (mix of MD, RN, SW and care coordinators). Data sources for the intervention group included clinical encounters, telephone surveys, service utilization and qualitative interview data.

Of the 384 individuals who set a goal, 238 had a follow-up completed, with 157 individuals achieving their goal. Clinicians had a choice to use either goal attainment scaling or a PROM. Qualitative analysis found that individuals and caregivers had a positive experience with the person-centered outcomes approach. Individuals and caregivers appreciated being asked what matters most; for some, it was the first time a health care professional had asked what was important to them. Patients mentioned that the approach offered accountability for their progress; for some, this accountability was motivating, but for a few, it was demotivating. Clinicians and administrators had more mixed reactions to the approach. Many clinicians felt the approach improved the quality of the care discussions with their patients and offered accountability for an individual's progress; however, clinicians and administrators pointed to the need for documentation of goals to be seamless and integrated into the current workflow and their organization's existing goal setting requirements. Claims-based analysis of hospitalization and emergency department use showed a significant decrease (multi-level model, interaction effect = 0.45, $p<0.001$) in hospital admissions for the intervention arm pre/post (38% vs. 23%) compared to the comparison group (33% vs. 34%), with a non-significant decrease in emergency department visits pre/post (Intervention: 43% vs. 39%; Comparison: 56% vs. 58%) (Blaum et al, 2024).

Person-Centered Outcomes Demonstration in Serious Illness Sites

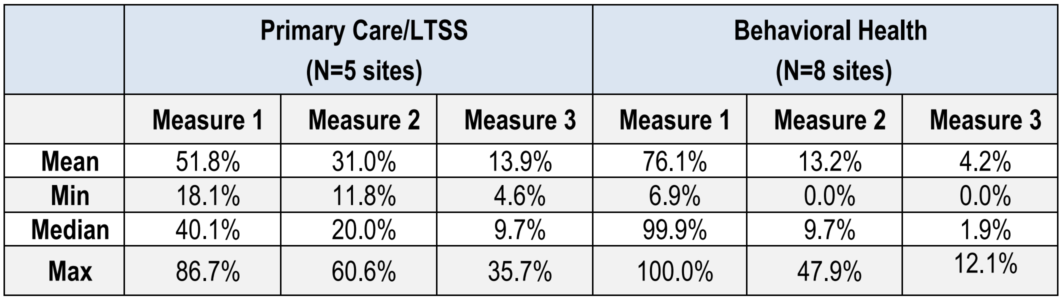
Serious illness care programs are often characterized by patient-clinician discussion and documentation regarding advance care planning and end-of-life preferences and wishes (Bernacki et al., 2015). In 2019-2020, NCQA tested the PCO measures in this population using goal attainment scaling for 679 individuals across 4 geographically diverse serious illness care programs with 37 clinicians (mix of MD, NP, RN, SW and DO). Data sources for the intervention group included clinical encounter data, mixed methods survey data and qualitative interview data. The majority of individuals (77%) had a follow-up, with 62% of those with a follow-up achieving their goal. Findings from this work were presented at the 2025 American Geriatrics Society Annual Meeting, highlighting disparities in performance metrics between dementia and non-dementia patients and the positive impact of caregiver involvement on goal achievement (Zhou et al., 2025).

Implementing and Disseminating Person-Centered Outcome Measures

Incorporation into NCQA Products. NCQA incorporated the PCO approach into four NCQA products: PCMH Recognition, Patient-Centered Specialty Practice (PCSP) Recognition, Accreditation of Case-Management for LTSS (CM-LTSS), and LTSS Distinction for Health Plans.

Testing in Learning Collaboratives. Between 2021-2024, NCQA implemented and tested the PCO measures in Age-Friendly Health Systems, primary care, LTSS and behavioral health care settings in 17 sites across 6 states. Over 180 clinicians, including registered nurses, social workers and mental health therapists, completed training and technical assistance webinars on the PCO approach and set goals with over 8,000 individuals over the testing period. Measure performance varied based on care setting, as shown in **Figure 3**. The behavioral health sites performed significantly higher on goal identification (measure 1) compared to the primary care/LTSS sites; however, performance significantly decreased for goal follow-up (measure 2) and goal achievement (measure 3). Some reasons shared by behavioral health clinicians for the decline were loss to follow-up, staff turnover and difficulty with onboarding new clinicians to the process for documenting goals in reportable fields. Overall, clinicians in both settings noted the PCO approach was useful for helping monitor patient progress, eased broaching difficult conversations and provided a good way to engage their patients.

Figure 3. 2021-2024 PCO Learning Collaborative Measure Performance



	Primary Care/LTSS (N=5 sites)			Behavioral Health (N=8 sites)		
	Measure 1	**Measure 2**	**Measure 3**	**Measure 1**	**Measure 2**	**Measure 3**
Mean	51.8%	31.0%	13.9%	76.1%	13.2%	4.2%
Min	18.1%	11.8%	4.6%	6.9%	0.0%	0.0%
Median	40.1%	20.0%	9.7%	99.9%	9.7%	1.9%
Max	86.7%	60.6%	35.7%	100.0%	47.9%	12.1%

Inclusion of PCO Measures in CMS Measures Under Consideration List. In 2024, NCQA submitted the PCO measures to CMS' Measures Under Consideration (MUC) list and participated in the 2024 Pre-Rulemaking Measure Review (PRMR) cycle. At CMS' recommendation, NCQA submitted one measure with three indicators for MUC consideration for use in the Merit-based Incentive Payment System (MIPS) program. The PRMR final recommendation for the submitted measure was Recommend with conditions. The conditions outlined were for the measures to get consensus-based endorsement, stratify performance by program (NCQA recommendation) and further assess for reporting burden.

Implementation of the PCO Measures in a State

The Connecticut Home and Community-Based Services Person-Centered Outcome Measures contract (January 2023–September 2025) aimed to use the PCO measures for value-based payment for home and community-based services (HCBS) in the state of Connecticut. In collaboration with the Connecticut Department of Social Services and the University of Connecticut Health Center on Aging, NCQA trained staff from four Access Agencies to implement, monitor and report on the three PCO measures. The project's primary goal was to drive better team-based care, coordination and follow-up for individuals receiving HCBS, with the measures being integrated into case management records within the Connecticut Health Information Exchange for benchmarking and value-based payment purposes. (Campbell et al., 2025; Robison et al, 2025). In testing, nearly 300 clinicians worked with approximately 19,500 clients enrolled in Medicaid waiver programs to implement and report the PCO measures. Measure performance across the four Access Agencies is shown in **Figure 4**. Based on more detailed data (not shown) and a payment model developed by Connecticut, the PCO measures will be used as part of value-based payment for home and community-based care providers beginning in November 2025.

Figure 4. CT HCBS PCO Implementation Measure Performance

	Measure 1 Goal Identification	Measure 2 Goal Follow-Up	Measure 3 Goal Achievement
Mean	99.9%	51.5%	35.2%
Min	99.8%	27.8%	20.7%
Median	100%	44.1%	34.4%
Max	100%	89.2%	56.7%

Person-Centered Outcomes Current and Ongoing Work

NCQA is actively advancing the implementation and testing of the PCO measures across multiple initiatives.

Testing in Special Needs Plans (SNPs). NCQA is advancing the PCO measures for broader adoption beyond the delivery system and completed testing the measures in Special Needs Medicare Advantage health plans (April 2024 – March 2026), aiming to enhance quality improvement and support value-based payment. This work is supported through funding from The John A. Hartford Foundation and The SCAN Foundation. Testing within SNPs concluded in September 2025 and data from testing will be used to support potential inclusion of these measures in HEDIS MY 2027. NCQA will also be conducting additional qualitative interviews with SNPs in early 2026.

Individuals with Intellectual and Developmental Disabilities (IDD). NCQA is conducting an environmental scan (June 2024 – December 2025) to identify and review measures relevant to individuals with intellectual and developmental disabilities. PCO measures will be voted on by individuals with lived experience for inclusion in an IDD health outcomes framework.

Transition for Youth with Autism and/or Epilepsy (YAES). NCQA, under the Health Resources and Services Administration (HRSA) YAES initiative, is evaluating the applicability of PCO measures for youth with autism and/or epilepsy transitioning to adult systems (September 2024 – August 2029).

Testing in Certified Community Behavioral Health Clinics (CCBHC). Using funding from the National Institute of Mental Health (NIMH), NCQA is currently testing the PCO measures in five CCBHC sites to assess reliability and effectiveness for individuals with a serious mental illness (September 2024 – June 2028). The project builds off past work assessing the feasibility of the PCO measures within these five

CCBHCs to assess the usability, validity and alignment with recovery orientation through both measure performance and qualitative research.

Digital Considerations

As part of NCQA's strategic transition to a fully digital quality measurement portfolio, we conducted a feasibility assessment to inform eventual digital measure implementation. The assessment evaluates the measure's intent and associated clinical concepts within a digital framework.

The PCO measures display medium digital feasibility. Goal assessment tools (GAS, PROM), goal domains and care plans have high to medium feasibility related to data standards and terminology, with some standards work still in progress to enhance feasibility. Data availability and structure challenges likely exist related to goal assessments, domain and care plans being captured in structured fields and available to health plans. Elements display high to medium feasibility for clinical workflow and accuracy, with some current limitations likely existing for rolling goals up to goal domains. NCQA continues to partner with HL7® and standards bodies to improve data availability and exchange of these important data points. Refer to Appendix B for more detail.

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Appendix A: PCO Measures Dissemination Activities (2024 – Present)

Activity	Details
FHIR Connectathon and Work Group Meetings (January 2026)	***Meeting:*** HL7 FHIR Connectathon
	Audience: EHR Vendors, Providers, Health Plans, Interoperability Experts, Digital Programmers
	***Date**:* January 13 – 15 ***Title**:* PACIO PROMIS Session ***Speakers**:* **Daniela Lawton** ***Description**:* Provide feedback on how PACIO PROMs workflow aligns with the PCO IG and approach.
Presentation – Connecticut State Webinar (December 2025)	***Meeting:*** Connecticut State Webinar
	Audience: Area Agencies on Aging, State Medicaid, Clinicians
	Date: Monday, December 8 from 12:45 – 2pm ET ***Title:*** State Spotlight: Connecticut's Strategy for Leveraging Its HIE and NCQA's Person-Centered Outcomes Measures in Value-Based Care ***Speakers:*** **Daniela Lawton**, Julie Robinson, Erin Kane ***Description:*** This session will focus on the implementation of Person-Centered Outcome (PCO) measures within Connecticut's Access Agencies (AAs) for value-based payment purposes, including adapting the measures for use in Connecticut's HIE to support sharing of an individual's goals, provider services and support care coordination.
Presentation –Civitas Webinar (November 2025)	***Meeting:*** Civitas Network Webinar
	Audience: Leaders in health care data and community health ecosystems
	Date**:* Wednesday, November 12 from 3 – 4pm ET ***Title**:* A Pragmatic Glidepath for Digitizing Goal-Directed Care and Person-Centered Outcomes ***Speakers**:* **Daniela Lawton**, Evelyn Gallego, Dave Carlson ***Description: This session offers a focused look at how FHIR®-based technologies are already transforming care planning and coordination. Using real-world implementation examples, the webinar will explore how HL7® FHIR® Implementation Guides—including the MCC eCare Plan IG, eLTSS IG, and Person-Centered Outcomes (PCO) IG—can help digitize person-centered care and align with regulatory, quality, and strategic goals.
Presentation –SNP Alliance Fall Forum (October 2025)	***Meeting**:* SNP Alliance Fall Forum
	***Audience**:* State Medicaid, Clinicians, Health Plans, Consumer Advocates
	***Date**:* Monday, October 27 from 3:00 - 4:50pm ET ***Title**:* Measuring Quality and Managing Care within SNPs: Part 1 – Quality Measurement and Part 2 – Care Management ***Speakers**:* Anne Boffa, **Alan Hoffman,** Sherri Simko, Lisa Benrud, Deborah Paone ***Description**:* This session provides attendees with a high-level understanding of SNP performance measurement and shared options for addressing challenges and seeking opportunities in this measurement environment for special needs plans.
Presentation –Health Innovation Summit (October 2025)	***Meeting**:* Health Innovation Summit
	***Audience**:* State Medicaid, Clinicians, Health Plans, Consumer Advocates
	***Date**:* Wednesday, October 15 from 10:30 – 11:15am PT ***Title**:* What Matters Most to You? Incorporating Patient Goals into Quality Measurement ***Speakers**:* **Caroline Blaum,** Meghan Crane, Esther Elefant, Steven Phillips ***Description**:* This session will focus on the implementation of Person-Centered Outcome (PCO) measures within Medicare Advantage Special Needs Plans (SNPs) via a learning collaborative as part of their transition into HEDIS. Attendees will gain insight into feasibility testing, structured data reporting and best practices essential for integrating PCO measures into SNP workflows.
Presentation – Health and Aging Policy Fellows (September 2025)	***Meeting**:* Health and Aging Policy Fellows Meeting
	***Audience**:* Professionals in health and aging, clinicians, health care administrators, lawyers
	***Date**:* Wednesday, September 17 from 2:40-3:40pm ET ***Title**:* Health Care Quality for Older People ***Speakers**:* **Daniela Lawton**

Activity	Details
	Description: This session will provide an overview of NCQA's work towards advancing health care quality for older people, highlighting the PCO measures and testing efforts.
Panel Presentation – Advancing States (August 2025)	***Meeting:*** 2025 HCBS Conference
	***Audience**:* State Medicaid, Clinicians, Health Policy, Consumer Advocates
	Date**:* Wednesday, August 26 from 3:30 – 4:15pm ET ***Title**:* Jerry is My Client Too: Improving HCBS Provider Teaming and Quality of Life Through Value-Based Payments and Health Information Exchange ***Speakers**:* Julie Robison, Martha Porter, **Daniela Lawton**, Erin Kane, Heidi Wilson, Michael Peccerilli ***Description: This session will describe Connecticut's three value-based payment (VBP) performance measures and implementation using CT's health information exchange (CONNIE). Care management agencies use NCQA's person-centered outcome (PCO) measures to develop, track, and measure achievement of a participant's person-centered goals over time. Presenters from NCQA, CT Community Care, CONNIE, UConn and CT DSS will provide their perspectives on the development and implementation of the HCBS provider VBP program. Participants will learn about a novel, comprehensive approach to support VBP achievement among diverse HCBS providers.
Panel Presentation – USAging (July 2025)	***Meeting**:* USAging Answers on Aging Annual Conference and Tradeshow
	***Audience**:* Area Agencies on Aging, State Medicaid, Implementers
	***Date**:* Sunday, July 20 from 2:30 – 3:30pm CT ***Title**:* What is Important to You? Integrating Goal Conversations into Value-Based Care ***Speakers**:* **Lauren Campbell**, Bonnie Sutherland, Andy Mincey ***Description**:* Since 2023, NCQA, Connecticut Department of Social Services, and the UConn Center of Aging have been collaborating to implement the person-centered outcomes (PCO) measures in Connecticut's Access Agencies (AAs) for value-based payment purposes. We will discuss our experiences implementing the PCO approach including clinician training, technical assistance and adapting the measures for use in Connecticut's HIE to support sharing of an individual's goals, provider services and support care coordination. Session attendees will learn how to successfully implement the PCO approach, measures, strategies and learnings on building person-centered care into clinical workflows for value-based care from a participating AA.
Poster Presentation – AcademyHealth (June 2025)	***Meeting**:* AcademyHealth 2025 Annual Research Meeting
	***Audience**:* Clinicians, Health Systems, Health Plans, Health Policy, Consumer Advocates
	***Date**:* Monday, June 9 from 5 – 6:15pm ET ***Title**:* Distinct Pathways: Comparative Analysis of PCO Implementation Outcomes in Certified Community Behavioral Health Clinics and Long-Term Services and Supports/Primary Care Settings ***Speakers**:* **Daniela Lawton** ***Description**:* This presentation will share study results focused on differences in goal identification, follow-up, and goal achievement to uncover contextual factors driving variations, while evaluating and comparing the implementation of Person-Centered Outcomes (PCOs) in Certified Community Behavioral Health Clinics (CCBHCs) and Long-Term Services and Supports/Primary Care (LTSS/PC) settings.
Presidential Poster Session – AGS (May 2025)	***Meeting:*** 2025 Annual Scientific Meeting of the American Geriatrics Society
	Audience: Clinicians
	Date: Thursday, May 8 from 5 – 6pm CT ***Title:*** Driving Care That Matters for Individuals with Dementia ***Speaker:*** Xiaofei Zhou ***Description:*** Care that matters focused on personal health-outcome goals is essential for individuals with dementia and their care partners. NCQA has developed Person-Centered Outcome (PCO) measures to assess and promote the delivery of goal-directed care. This presentation will share results from a study that compares performance on PCO measures—specifically goal follow-up and achievement—between individuals with dementia and those without.
HL7 Workgroup Meeting (May 2025)	***Meeting**:* HL7 Workgroup Meetings – Madrid
	Audience: Health Policy, Vendors, Clinicians
	***Date**:* Monday, May 12 – Thursday, May 15 ***Title**:* Person-Centered Outcomes Implementation Guide ***Speaker**:* **Daniela Lawton** ***Description**:* Presentation on PCO FHIR IG and PCO measures

Activity	Details
Presentation – Suburban Hospital Alliance New York State (May 2025)	***Meeting****:* Suburban Hospital Alliance of New York State Presentation
	Audience*:* Hospital Executives, Policymakers and Advocates, Health Care Administrators, Regulatory and Compliance Experts
	Date*:* Wednesday, May 28 from 9 – 10am ET ***Title****:* Person-Centered Outcome (PCO) Measures ***Speakers****:* **Daniela Lawton** ***Description****:* This presentation offered an overview of the history of the PCO measures, including development and testing. The presentation also highlighted how these measures align with and support the goals of Age-Friendly Health Systems and current testing efforts. Implementation resources were shared with meeting attendees.
Presentation – AGS (May 2024)	***Meeting****:* Annual Scientific Meeting of the American Geriatrics Society
	Audience*:* Clinicians, policymakers, research professionals, advocacy groups
	Date*:* Saturday, May 11, 2024 from 10 – 11am ET ***Title****:* Impact of Goal-Directed Care in Patients with Functional Disabilities: A Quality Improvement Outcome Study ***Speakers****:* Kah Poh Loh (Moderator), **Caroline Blaum**, Anil Prasad & Carolyn Chen, Jennifer Gabbard, Christina Minami ***Description****:* Presentation on the latest peer-reviewed geriatrics research with questions and answers. Learning Objectives: (1) discuss new and original geriatrics research; (2) describe an emerging concept or new scientific focus in aging research; and (3) summarize the key findings of projects with relevance to care of older adults.
Panel Presentation – International Center of Mental Health Policy and Economics (March 2025)	***Meeting*****:** Seventeenth Workshop on Costs and Assessment in Psychiatry (March 28-30, 2025)
	Audience**:** Global leaders in behavioral health care
	Date**:** March 29, 2025 ***Speaker*****: Caroline Blaum** ***Title*****:** Patient Centered Outcome Measures: Driving care that matters to people ***Description****:* Goal directed care (GDC) is crucial for recovery-oriented mental health services, but there are no existing quality measures that directly assess GDC outcomes. Patient-Centered Outcome (PCO) measures, a suite of 3 standardized measures under development by the National Committee for Quality Assurance (NCQA) that feature two process measures, goal identification and goal follow up, and one outcome measure, goal achievement, fill this gap by combining individualized treatment goals with formal quantitative process and outcome assessments.
NCQA Blog (March 2025)	***Title:*** NCQA's Person-Centered Outcome Measures Recommended for MIPS
	Audience: All NCQA connections on Listserv
	Date: March 25, 2025 ***Author:*** Becky Kolinsky. ***Description:*** This blog discusses how the PCO measures recently went through CMS measures under consideration process and have been recommended for inclusion in MIPs for Medicare.
Panel Presentation – Association for Behavioral Health and Wellness (March 2025)	***Meeting*****:** Association for Behavioral Health and Wellness (ABHW)
	Audience**:** Health plans, Healthcare organizations, and Hill staffers.
	Date**:** March 24, 2025 ***Speaker*****:** Tom Valentine ***Title*****:** Leveraging Measurement-Informed Strategies to Improve Behavioral Health ***Description****:* NCQA participated as a panelist on a webinar on measurement-informed care (MIC) in behavioral health. The discussion focused primarily on what can be done to promote acceptance of MIC, challenges to implementing MIC, and overcoming implementation barriers. NCQA shared recent developments in PCO including SNP testing and future inclusion in HEDIS and recommendation for PCO to be added into MIPs.
Short Session – HIMSS 2025	***Meeting****:* HIMSS Global Health Conference & Exhibition (March 3-6, 2025)
	Audience**:** Health care leaders, IT professionals

Activity	Details
(March 2025)	***Date*****:** March 4, 2025 ***Speakers*****: Daniela Lawton** and Anne Marie Smith ***Title*****:** Industry Readiness for Incorporating Patient-Reported Data into Quality Measurement ***Description***: Speakers shared an overview of the PCO FHIR IG, which standardizes the exchange of person-centered care data among patients, caregivers, healthcare practitioners and digital health platforms.
Presentation – Fountain House: Measures that Matter Advisory Committee Meeting (January 2025)	***Meeting:*** Fountain House Measures that Matter Advisory Committee Meeting
	Audience: National policy and clinical stakeholders, individuals with lived experience (SMI)
	Date: January 15, 2025 ***Speaker:* Sarah Sweeney** ***Description:*** The Measures that Matter Project, led by Fountain House, aims to reshape approaches to measuring recovery for people with SMI and lay the groundwork for adopting measures that reflect their recovery needs. The goal is to identify the most important behavioral health measures, as identified by people with SMI and other key stakeholders, determine how they can be integrated into payment and reimbursement programs, and develop a roadmap for moving forward.
FHIR Connectathon and Work Group Meetings (January 2025)	***Meeting:*** HL7 FHIR Connectathon 38 (January 13-15, 2025)
	Audience: EHR Vendors, Providers, Health Plans, Interoperability Experts, Digital Programmers
	Date*:* January 13 – 16, January 29 (all day) ***Title****:* Goal-Directed Care Planning Track ***Speakers****:* **Daniela Lawton (Co-Lead),** Dave Carlson (Lead), ***Description****:* Advancing the use of goal-directed, person-centered care planning and outcome assessment for patients with multiple chronic conditions (MCC). Presented on the PCO measures and approach and discussed the PCO FHIR IG at multiple Work Group Meetings.
Presentation – Gerontological Society of America (November 2024)	***Meeting****:* GSA 2024 Annual Scientific Meeting (November 13-16, 2024)
	Audience*:* Researchers, clinicians, educators, and other professionals in the aging field
	Date*:* November 14, 2024 from 8:00-9:30am ET (Room 3A) ***Title****:* Health Priorities Identification for Individuals Living with Dementia and Their Caregivers ***Speaker****:* **Caroline Blaum** ***Description****:* "What matters" is the foundation for the Age-Friendly Health System Initiative and yet many clinicians have a difficult time addressing it with their patients. Patient Priorities Care (PPC) is an evidence-based approach that identifies health priorities by first eliciting health values of older adults with multiple chronic conditions, integrating values into health outcome goals, and describing the one-thing to focus on. This symposium will present results from three studies that use PPC across diverse cultural and clinical contexts and discuss the role of PPC to achieve better dementia care.
Panel Presentation – BH Tech 2024 (November 2024)	***Meeting:*** Behavioral Health Tech
	Audience: Diverse audience of health plan executives, providers/health systems, investors, employers/benefits consultants, and digital health enthusiasts.

Activity	Details
	Date: November 6, 2024 ***Title*****:** Looking for your insight goldmine? Check the Qual. ***Speakers*****: Sarah Sweeney**, Chris Hemphill, Kay Nikiforova, Katrina Roundfield ***Description*****:** With the increasing focus on outcomes in behavioral health tech, there has been a strong turn towards quantitative assessments and measurement-based care. The addition of established measures to behavioral health treatment in the healthtech space is important to gauge efficacy of treatments and products. However, the use of these measures and other quantitative data can obscure meaningful underlying trends in treatment that cannot be captured by questionnaires. What do patients and providers really think and feel? While qualitative data often goes unanalyzed, it can often be the source of deep understanding of behavioral health patient and provider motivations, states and concerns. In this workshop, the presenters will share an overview of qualitative data and its various forms in behavioral health treatment. From open text entry fields to interviews, the presenters will share on the methods of collection of qualitative data and its analysis. They will use real-life examples of qualitative insights that have produced rich insights above and beyond quantitative data within the same dataset. They will also explore how qualitative insights can be used to power care and business decisions. The presenters will lastly review how qualitative data may provide insights on patient communities that may otherwise be missed because measurements that are currently popularized may not have the same level of validity for culturally diverse patients.
NCQA Blog (November 2024)	***Title:*** Moving Forward With Person-Centered Outcome Measures
	Audience: All NCQA connections on Listserv
	Date: November 6, 2025 ***Author:*** Becky Kolinski ***Description:*** This blog reviews the evolution of the PCO measures and where they are currently being implemented. Also highlighted the new SNP learning collaborative and focus on incorporating into HEDIS and other payment mechanisms.
Presentation – University of Texas-Houston Huffington Lecture Series (November 2024)	***Meeting****:* Geriatric and Palliative Care Grand Rounds
	Audience*:* Geriatric, Oncology and Palliative Care Providers
	Date*:* November 9, 2024 from 9 – 10am ET ***Title****:* Geriatric and Palliative Grand Rounds ***Speakers****:* **Caroline Blaum, Daniela Lawton** ***Description****:* Provide a high-level overview of the person-centered outcome measures and specifically the structured processes (PROMs and goal attainment scaling) to track and monitor goals over time.
Presentation – Health Innovation Summit (November 2024)	***Meeting****:* Health Innovation Summit (October 31-November 2, 2024)
	Audience*:* Health plans, health systems, government, technology vendors and consultancies
	Date*:* November 2, 2024 from 10 – 10:45AM ET ***Title****:* Persons and Payers: How Incorporating What Matters Most Can Support Value-Based Care ***Speakers****:* **Caroline Blaum (Moderator)**, Desiree Bradley, Michael Mason, Sarah Scholle ***Description****:* During this session, presenters will share how health plans are implementing person-centered care, the benefits of incorporating the PCO approach into clinical care for both the patient and clinician, and opportunities to promote person-centered care through quality measurement and payment mechanisms.
Presentation – Society for Medical Decision Making (October 2024)	***Meeting****:* Society for Medical Decision Making 46th Annual Meeting (October 27-30, 2024)
	Audience: Experts from numerous fields, including economics, psychology, sociology, education, communication, mathematics, organizational theory, clinical epidemiology, public health, and clinical medicine
	Date*:* October 28, 2024 from 4:10 – 5:35PM ET ***Title****:* Implementation of the Person-Centered Outcome Measures in Certified Community Behavioral Health Clinics ***Speaker****:* **Sarah Sweeney** ***Description****:* SMDM24 will offer attendees opportunities to explore diverse topics in medical decision making. The meeting will provide interactive forums for the presentation of novel research and plenty of time to network with colleagues from around the world.
Presentation – AHRQ Meeting	***Meeting:*** AHRQ Person-Centered Care Planning for Persons with Multiple Chronic Conditions Partner Roundtable Meeting

Activity	Details
(October 2024)	***Meeting Focus:*** The purpose of the Partner Roundtable is to discuss innovative models of PCCP that may hold promise for further development, testing, dissemination, and implementation, and identify key organizational, policy, payment, technology, cost, and resource requirements for implementing equitable PCCP across diverse health systems and populations, practices, and settings.
	Date: October 17, 2024 ***Title:*** Implementing and Disseminating the Person-Centered Outcome Measures ***Speaker:*** **Caroline Blaum** ***Description:*** Provided a high-level overview of the PCO measures and existing testing efforts.
Article – Health Affairs (September 2024)	***Title:*** A Core Measure Set For Age-Friendly Health Care Delivery
	Audience: Government and health industry leaders; health care advocates; scholars of health, health care and health policy; and others concerned with health and health care issues in the United States and worldwide.
	Date: *Friday, September 13, 2024* ***Authors:*** **Caroline Blaum**, Helaine Resnick, Daniela Lawton, Angelia Bowman ***Description:*** This article discusses a set of measures based on the 4M's AFHS framework that NCQA believes can drive quality of care for older adults with complex health needs.
FHIR Connectathon (September 2024)	***Meeting****:* HL7 FHIR Connectathon 37 (September 21-27, 2024)
	Audience: EHR Vendors, Providers, Health Plans, Interoperability Experts, Digital Programmers
	Date*:* September 21 – 22, 2024 (all day) ***Title****:* Goal-Directed Care Planning Track ***Speakers****:* **Daniela Lawton (Co-Lead),** Dave Carlson (Lead), Anne Marie Smith, Karen Bertodatti ***Description****:* Advancing the use of goal-directed, person-centered care planning and outcome assessment for patients with multiple chronic conditions (MCC). Goal-directed care in healthcare centers on setting and achieving specific, personalized goals that prioritize an individual's well-being and "What Matters Most" to each person.
Presentation – PTAC (June 2024)	***Meeting****:* Physician-Focused Payment Model Technical Advisory Committee (June 10-11, 2024)
	PTAC Description: Independent federal advisory committee that makes recommendations to the Secretary of HHS on stakeholder-submitted physician-focused payment models and related topics.
	Date*:* Monday, June 10, 2024 from 2:40 – 4:10pm ET ***Title****:* Listening Session 1 - Best Practices for Measuring Quality and Outcomes Related to Caring for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models ***Speakers****:* Brynn Bowman, Paul Mulhausen, **Caroline Blaum**, David Kendrick ***Description****:* Best practices for measuring quality and outcomes related to caring for patients with complex chronic conditions or serious illnesses in population-based total cost of care (PB-TCOC) models with a focus on their area of expertise
Presentation – ISPOR 2024 (May 2024)	***Meeting****:* ISPOR 2024 (May 5-8, 2024)
	Audience*:* Global health leaders, clinicians, policymakers, research professionals
	Date*:* Monday, May 6, 2024 from 8:30-9:45AM ET ***Title****:* Advancing Whole Health: How do We Know When We're Succeeding? ***Speakers****:* Charlene Wong (Moderator), Seth Berkowitz, **Eric Schneider,** Denise Webb ***Description*** Whole person health requires a holistic approach that considers multiple factors that promote health or disease. In this session, panelists made the case for why HEOR needs to help drive innovation in whole person health by evaluating the effectiveness and value of interventions designed to support whole health
NCQA Blog (April 2024)	***Blog Title****:* The YOU FIRST Approach to Quality Measurement
	Audience*:* All NCQA connections on Listserv
	Date: Thursday, April 18, 2024 ***Author***: Andy Reynolds ***Description****:* Authored by Andy Reynolds*.* This blog covered an overview of the PCO measures. It explains the value of the PCO measures as well as how the measures can be used in health plans.

Appendix B: Digital Feasibility

As part of NCQA's strategic transition to a fully digital quality measurement portfolio, we conduct a feasibility assessment to evaluate the measure's intent and associated clinical concepts within a digital framework. The primary objectives were to determine whether the clinical concepts could be represented using standardized data models and nationally recognized terminologies, and to assess the availability of discrete, structured data necessary to support accurate and reliable digital measurement.

Data and Terminology Standards

NCQA's digital quality measures are built on the Fast Healthcare Interoperability Resources (FHIR®) standard, developed by HL7®, to support interoperable exchange of electronic health data. In the U.S., FHIR US Core profiles provide detailed implementation guidance aligned with the United States Core Data for Interoperability (USCDI), a federal standard maintained by the Assistant Secretary for Technology Policy (ASTP) (formerly the Office of the National Coordinator for Health Information Technology [ONC]). USCDI defines essential data classes and elements, while FHIR US Core specifies how to represent and exchange them. Additionally, NCQA uses nationally recognized clinical terminologies (e.g., ICD-10, CPT, LOINC) to define value sets, ensuring standardized interpretation and representation of clinical data in quality measures.

Digital Feasibility Assessment

The digital feasibility assessment is conducted at two stages during the measure development process, pre-testing phase and post-testing phase, summarized below. This assessment examines each measure concept across three high-level categories:

- **Data Standards & Terminology**. Evaluates the alignment with national standards (FHIR, USCDI) and recognized terminology standards (i.e., LOINC, ICD).
- **Clinical Workflow & Data Accuracy**. Evaluates whether the concept aligns with standard clinical practice and the likelihood that the data will be accurate, complete and reliable.
- **Data Availability & Structure**. Assesses if the data is likely to be present, in structured fields, and accessible to health plans.

The digital feasibility assessment (shown in Figure A) rates each concept from high to low. High = Feasible with no concerns, Medium = Feasible with some concerns (with a potential mitigation strategy); Low = Low feasibility with concerns (with little to no mitigation strategy for the current development cycle).

Post-Testing Feasibility Findings.

> **Summary:** The PCO measures display medium digital feasibility. Goal assessment tools (GAS, PROM), goal domains and care plans have high to medium feasibility related to data standards and terminology, with some standards work still in progress to enhance feasibility. Data availability and structure challenges likely exist related to goal assessments, domain and care plans being captured in structured fields and available to health plans. Elements display high to medium feasibility for clinical workflow and accuracy, with some current limitations likely existing for rolling goals up to goal domains. NCQA continues to partner with HL7® and standards bodies to improve data availability and exchange of these important data points.

Data Standards & Terminology. Pre-testing data standard feasibility rating remain consistent, with all concepts able to be modeled in the FHIR data standard and some gaps in interoperability requirements for goal domains. Regarding terminology standards, care plan (LOINC, SNOMED), GAS (LOINC), and PROM (LOINC) are represented by standard terminology, however there is likely still limited use of the terminology codes across elements. The goal domains used by the measures do not currently have terminology standards available, however NCQA has submitted for standard codes (LOINC) and continues to expects the codes to be available prior to the measures being included in HEDIS.

Data Availability & Structure. Testing confirmed medium feasibility for elements across data availability and accessibility, with the goal domain element remaining low feasibility due to the gaps in coding at current state. Challenges exist as GAS and PROM results and goal documentation are not always documented in structured fields. Additionally, there may be challenges with the care plans being available in a structured way, however care plans are included in Models of Care requirements for SNPs.

Clinical Workflow & Data Accuracy. High feasibility was confirmed for goal assessments, results, domain, and care plans related to workflows and accuracy. There may be some workflow challenges related to tracking goal progress over time in a timely manner, and rolling up goals to goal domains given current data standard and terminology limitations.

As noted in the pre-testing assessment, NCQA continues to recommend additions to USCDI and future iterations of US Core to further specify care plans, which will support better availability and exchange of these data. Additionally, given the priority of person-centered data and care, NCQA partnered with HL7 and Veterans Affairs to develop a PCO Implementation Guide that provides further specificity and guidance on how to collect and exchange person-centered outcomes data. This implementation guide supports the PCO measures as well as goal-directed care in general.

Figure A-1: Post-Testing Digital Concept Feasibility Assessment

Score key: H = high, M = medium, L = low						
	Data Standards & Terminology		**Clinical Workflow & Data Accuracy**		**Data Availability & Structure**	
Clinical Concept	**Data Standards**	**Terminology Standards**	**Workflow**	**Data Accuracy**	**Data Availability**	**Data Accessibility**
Assessments: GAS, PROM	H	M	H	H	M	M
Assessment results: GAS, PROM scores	H	M	H	H	M	M
Person-centered goal: goal domain	M	M	M	M	L	L
Care plan	H	M	H	H	M	M

Pre-Testing Feasibility Findings.

Summary: Goal assessment tools (GAS, PROM), goal domains and care plans have high to medium feasibility related to data standards and terminology, with some standards work still in progress to improve feasibility. Data availability and structure challenges likely exist related to goal assessments, domain and care plans being captured in structured fields and available to health plans. Clinical workflow and accuracy challenges also may exist related to utilizing goal domains and tracking goal progress over time. NCQA continues to partner with HL7® and standards bodies to improve data availability and exchange of these important data points.

Data Standards & Terminology. All the concepts (GAS and PROM assessments, goal domains and care plans) used in the measures can be modeled in the FHIR data standard. While USCDI includes a “patient goals” element, it does not require specific tools such as GAS or PROM be used to assess goals and does not require goals be categorized into goal domains. Goal domain is also not required to be included in the related FHIR profile, though it can be modeled. Regarding terminology standards, care plan (LOINC, SNOMED), GAS (LOINC), and PROM (LOINC) are represented by standard terminology, however there may be limited use of the available terminology codes especially for care plans. The goal domains used by the measures do not all currently have terminology standards available, however NCQA is in the process of submitting for standard codes (LOINC) and expects the codes to be available prior to the measures being included in HEDIS.

Data Availability & Structure. Data availability challenges may exist as GAS and PROM tools may not be utilized consistently with results documented in structured fields; Unstructured goal documentation and goals not rolled up to structured goal domains are still common. Additionally, there may be challenges with the care plans being available in a structured way, however care plans are included in Models of Care requirements for SNPs. Because all critical goal elements for these measures are captured in clinical systems, there may also be challenges related to health plan accessibility of the data.

Clinical Workflow & Data Accuracy. Workflow challenges may exist as not all clinical workflows utilize GAS and PROM tools and it is not always standard workflow to roll goals up to goal domains. Additionally, there may be some workflow and accuracy challenges related to tracking goal progress over time, specifically related to accessing both a clinician and patient GAS score.

While some challenges currently exist, NCQA continues to recommend additions to USCDI and future iterations of US Core to further specify care plans, which will support better availability and exchange of these data. Additionally, given the priority of person-centered data and care, NCQA partnered with HL7 and Veterans Affairs to develop a PCO Implementation Guide that provides further specificity and guidance on how to collect and exchange person-centered outcomes data. This implementation guide supports the PCO measures as well as goal-directed care in general.

Figure A-2: Pre-Testing Digital Concept Feasibility Assessment

Score key: H = high, M = medium, L = low						
	Data Standards & Terminology		**Clinical Workflow & Data Accuracy**		**Data Availability & Structure**	
Clinical Concept	**Data Standards**	**Terminology Standards**	**Workflow**	**Data Accuracy**	**Data Availability**	**Data Accessibility**
Assessments: GAS, PROM	H	H	M	H	M	M
Assessment results: GAS, PROM scores	H	H	M	M	M	M
Person-centered goal: goal domain	M	M	L	L	L	L
Care plan	H	H	H	H	M	M