



Person-Centered Outcome Measures

Promoting better, more efficient and more effective health care for people with chronic and complex needs

What Matters to People

Everyone deserves fair and just access to high-quality health care that addresses their unique needs, reflects their diverse background and culture, and is designed to deliver the outcomes they want. This is particularly true for people with complex health care needs, many of whom are older adults who often receive care that may be misaligned with their needs and goals. Nearly 30% of Medicare beneficiaries have complex health care needs, and more than 14 million people in the U.S. need long-term services and supports. These numbers are growing every year.¹



Measuring What Matters

To address this challenge, the National Committee for Quality Assurance (NCQA), with support from The John A. Hartford Foundation and The SCAN Foundation, developed, implemented and tested a set of **person-centered outcome (PCO) measures**.

These measures (shown in blue in the illustration) work in tandem with clinical care (shown in red) to help people living with complex health needs make progress toward a health outcome goal that matters to them. Clinicians throughout the care continuum—from primary care, to specialty care, to home- and community-based services—can use this approach to elicit what is important to a person (e.g., feeling well enough to visit grandchildren). After capturing what matters, the clinician documents these health outcome goals and collaborates with the person on clinical action steps to achieve them. The PCO measures standardize documentation and tracking, and measure progress using patient-reported outcome measures or goal attainment scaling.

¹ "Long-Term Services and Supports," AARP Public Policy Institute

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NCQA's PCO measures drive care that matters and encourage organizations throughout the care continuum to work together to help people achieve their health outcome goals. The measures are the result of seven years of collaboration between NCQA, people and their families, clinicians, researchers and health care organizations. They were tested in a variety of settings, including Medicaid case management, home-based primary care and general case management, so NCQA could better understand training and workflow changes needed to provide care that is person-centered and aligns with a person's health outcome goals.

Benefits of PCO Measures	
For People	<ul style="list-style-type: none">• Feel heard and respected in the design and delivery of care and have more equitable access to quality care• Experience care that matters to them, become more engaged in their care and have an improved care experience
For Clinicians	<ul style="list-style-type: none">• Improve relationships with patients, leading to better understanding of how to design care to meet patient needs• Deliver care that matters—rather than care that “checks boxes” or lacks evidence for use in individuals with complex care needs
For States and Health Plans	<ul style="list-style-type: none">• Increase transparency in oversight for delivery of person-centered care that can be integrated across the care continuum, improve care coordination and individual and community well-being• Receive support for quality improvement, performance benchmarks and value-based payment to ensure effective and efficient delivery of health care

NCQA is introducing PCO measures across our practice, health system and plan-level quality evaluation programs. We are working with states and health delivery systems to increase accountability for delivery of care for people with complex health needs to achieve person-centered, age-friendly care.

By organizing the health care system around what matters to people, their families and their communities, we have the opportunity to deliver care that produces better health outcomes, in a more efficient and cost-effective way.

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The John A. Hartford Foundation