For Public Comment
June 16–July 23, 2021
Comments due 11:59 p.m. ET
July 23

Evolution of Multicultural Health Care Distinction to Health Equity Accreditation

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Health Equity: Overview

NCQA's Mission: Improve the Quality of Health Care

NCQA is dedicated to improving health care quality. We believe quality care is equitable care.

NCQA has been driving improvement throughout the health care system for more than three decades, helping to advance health care quality to the top of the national agenda. NCQA's programs and services reflect a straightforward formula for improvement: measurement, transparency, accountability.

Given the dramatic improvements in clinical quality demonstrated by NCQA-Accredited health plans, this approach works. Today, approximately 176 million Americans are enrolled in an NCQA-Accredited health plan.

The COVID-19 pandemic and the Black Lives Matter movement have highlighted our country's health care disparities. In response, NCQA has reexamined its long-standing commitment to health equity. As we stated in NCQA's Recommendations to the Biden-Harris Administration, we believe in the importance of refining and developing quality measurement to help stakeholders drive toward health equity and address social determinants of health. Our multi-year strategy to execute this vision includes policy, research, measures and standards initiatives.

This public comment period examines NCQA's recommendation to transform the existing Multicultural Health Care (MHC) Distinction program and into one that better capture progress toward achieving health equity: Health Equity Accreditation.

NCQA's Commitment to Health Equity

Health is affected by both positive and negative factors—social determinants of health—beyond the receipt of health care. Most health disparities stem from systemic and systemic racism, bias and unmet social needs. Social risks have long been the "elephant in the room"; their negative impact on health outcomes has been known for decades. Racism is pervasive throughout the health care industry, in both the structures that allow or prevent access to health care and in the institutions themselves, where bias can lead to poor care. Health disparities affect populations that have "systematically experienced greater obstacles to good health based on their religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[1]

The Institute of Medicine's report, *Crossing the Quality Chasm*,[2] recommends achieving equitable outcomes of care as a key aim for improvement. Equitable care means providing care that does not vary in quality because of personal characteristics like gender, race, socioeconomic status and geographic location.[3] A sequence of factors feeds health inequity. Systemic and institutional drivers, such as racism, sexism and classism, affect the distribution of power and resources.

[1] https://www.aha.org/system/files/2018-11/value-initiative-issue-brief-3-equity.pdf
[2] Institute of Medicine (US) Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century.* National Academies Press (US); 2001. Accessed July 13, 2020. http://www.ncbi.nlm.nih.gov/books/NBK222274/
[3] Slonim, A.D., and M.M. Pollack. 2005. "Integrating the Institute of Medicine's Six Quality Aims into Pediatric Critical Care: Relevance and Applications." *Pediatric Critical Care Medicine* 6(3):264–9. doi:10.1097/01.PCC.0000160592.87113.C6

Unequal distribution of power and resources, and the resulting social, economic and environmental disparities, are made manifest in uneven health risk, access to high-quality care and health outcomes.[4]

With measurement and goal setting, organizations can identify disparities, address social risk factors and work toward dismantling systemic and structural barriers that generate bias or discrimination. NCQA can help organizations by creating measures, standards and guidelines for developing and tracking progress toward goals.

This document describes proposed updates to MHC standards and guidelines and potential future actions aimed at addressing social determinants of health. Updates are designed to usher organizations along the journey to health equity by accommodating current capabilities and providing guidance for additional efforts. Also included for public comment are concepts for an ***optional evaluation option*** for organizations seeking guidance on assessing and addressing social determinants of health.

Note: *The standard-level details of the evaluation option are not included in this public comment period. A public comment period specific to this topic will be held in fall 2021.*

[4] Committee on Community-Based Solutions to Promote Health Equity in the United States, Board on Population Health and Public Health Practice, Health and Medicine Division, National Academies of Sciences, Engineering, and Medicine. 2017. *Communities in Action: Pathways to Health Equity,* edited by J.N. Weinstein, A. Geller, Y. Negussie and A. Baciu. National Academies Press. doi:10.17226/24624

Health Equity Accreditation: Updates to MHC Standards

Background

NCQA's Distinction in Multicultural Health Care program was introduced in 2010 and is based on the Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) Standards. MHC Distinction focuses on race, ethnicity and language as avenues for improving culturally and linguistically appropriate care and reducing health care disparities. Health plans, MBHOs, health systems, hospitals and population health programs are eligible for MHC Distinction. Refer to Appendix 1 for an overview of the standards.

This section describes two recommendations for comment:

1. Add new requirements to tackle systemic and structural bias and help uncover disparities across underrepresented populations.
2. Update the scoring design to align with the Health Plan Accreditation scoring methodology.

NCQA has updated the name of MHC Distinction to Health Equity Accreditation to better reflect these proposed changes. See below sections for more details.

Stakeholders Participating in Public Comment

NCQA shares proposed changes in public comment to generate thoughtful commentary and constructive suggestions from interested parties. Many comments lead to changes in our standards and policies, and the review process makes our standards stronger for all stakeholders.

NCQA asks respondents to consider whether proposed requirements are feasible as written and are clearly articulated, and to highlight areas that might need clarification.

From Distinction to Accreditation

To align with the intent of proposed updates, *Distinction in Multicultural Health Care* will become *Health Equity Accreditation*. The change reflects the continuous quality improvement necessary to advance health equity and symbolizes the importance for all organizations to work toward a more equitable health care system.

The change from Distinction to Accreditation reflects the importance of the program and its "standalone" status: Organizations do not need to earn NCQA Health Plan Accreditation to pursue Health Equity Accreditation. The change also reflects eligibility: Health plans, health systems, hospitals, MBHOs, population health organizations, wellness organizations and more are eligible for Health Equity Accreditation.

Updates to Standards

Refer to *Appendix 1: Proposed Standard Changes to Health Equity Accreditation (formerly MHC Distinction)* to review the changes outlined below:

- One new standard, *HE 1: Organizational Readiness*, which includes three elements.
- Two new elements in *HE 2: Race/Ethnicity, Language, Sexual Orientation and Gender Identity Data.*

- One new element in *HE 6: Reducing Health Care Disparities.*
- Factor-level changes in HE 2 and HE 6.
- Scoring methodology update to all elements.

Standard Title Changes

Table text reflect the program changes.

MHC Distinction Standards	Health Equity Accreditation Standards
NA	HE 1: Organizational Readiness
MHC 1:Race/Ethnicity and Language Data	HE 2: Race/Ethnicity, Language, Sexual Orientation and Gender Identity Data
MHC 2:Access and Availability of Language Services	HE 3: Access and Availability of Language Services
MHC 3:Practitioner Network Cultural Responsiveness	HE 4: Practitioner Network Cultural Responsiveness
MHC 4:Cultural and Linguistically Appropriate Services Programs	HE 5: Cultural and Linguistically Appropriate Service Programs
MHC 5:Reducing Health Care Disparities	HE 6: Reducing Health Care Disparities

HE 1: Organizational Readiness

Add a new standard, *HE 1: Organization Readiness,* with three elements.

- Element A: Building a Diverse Staff.
- Element B: Promoting Diversity, Equity and Inclusion Among Staff.
- Element C: Systems for Individual-Level Data.

The new standard will help organizations prepare to tackle health equity. Stakeholders have said that fixing the institutions and structures that lead to disparities must start “at home”—within the industry itself. Organizations should examine and improve diversity and inclusion in their workforce to address bias and prejudice in the health care industry.

Element A requires organizations to promote diversity in recruiting and hiring and promote diversity, equity, inclusion or cultural competency among staff. Organizations choose how they conduct these activities; the intent is to encourage a more equitable workplace by focusing on staffing and hiring practices.

Element B requires organizations to offer annual training to their staff on cultural competency, bias or inclusion and on competition of trainings. Organizations choose training topics and delivery methods and are not scored on the number of staff who complete training. The intent is to encourage regular training to help improve cultural competency, reduce bias and/or teach staff about equity.

Element C streamlines factor 5 and factor 2 (“a system for storage and retrieval of data”) from the former MHC 1, Element A and Element B, respectively, and moves the factor language to HE 1, Element C, which requires organizations to have a system (or systems) for storing and retrieving data collected in HE 2, including race/ethnicity, language, gender identity and sexual orientation data.

Targeted Questions for HE 1

- Do you support adding new element HE 1A: Building A Diverse Staff?
- Do you support adding new element HE 1B: Promoting Diversity, Equity and Inclusion Among Staff?
- Should HE 1B be an annual requirement?
- What other activities does your organization implement (besides training) to promote diversity, equity and inclusion?
- Do you support moving factors from former MHC 1, Elements A and B, and adding additional data sources to HE 1C: Systems for Individual-Level Data?

HE 2: Race/Ethnicity, Language, Sexual Orientation and Gender Identity Data

Move factors from MHC 1, Element A: Collection of Data on Race/Ethnicity and MHC 2, Element B: Collection of Data on Language to the new HE 1, Element C: Systems for Individual-Level Data.

NCQA recommends moving factor 5 and factor 2 ("a system for storage and retrieval of individual-level data") from MHC 1, Elements A and B, respectively, to the new HE 1, Element C. The intent of the update is to streamline reporting and require appropriate systems for all collected data types.

Add two new elements to HE 2:

- Element C: Collection of Data on Gender Identity.
- Element D: Collection of Sexual Orientation Data.

Lack of data on gender identity and sexual orientation is a major barrier in determining sexual or gender minority disparities and addressing health care needs or preventive services.[5] CDC guidance on collecting sexual orientation and gender identity and the National Institute of Health's Sexual & Gender Minority Research Office[6] highlight multiple research studies on survey questions that collect sexual orientation and gender identity information. Both can assist organizations in designing direct data collection.

NCQA recommends requiring organizations to collect gender identity data (HE 2, Element C) and sexual orientation (HE 2, Element D) directly, as appropriate. For both elements:

- Direct data collection is voluntary disclosure by individuals.
- Organizations will not be scored on data completeness.
- Organizations will describe their data collection method, including how it will not stigmatize individuals and honor their dignity.

Element C requires organizations to have at least one option beyond "male/female/decline to answer" for collecting gender identify, and to ask individuals which pronoun they prefer to use ("she/her, he/him, they/them, other"). Organizations establish a process to share members' preferred pronouns with member-facing staff, as appropriate for care. Using preferred pronouns affirms members' choices and maintains their dignity when they interact with the organization.

[5]https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html
[6]https://dpcpsi.nih.gov/sgmro/measurement/questions

Organizations may choose to collect information about sex assigned at birth to better assess health disparities within the concordance of members' current gender identity, but are not required to do this.

Element D requires organizations to collect individuals' sexual orientation through direct methods. The data collection framework must include at least two sexual orientation options; organizations determine which options are appropriate for their population.

Update HE 2, Element E: Privacy Protections and Element F: Notification of Privacy Protections (formerly MHC 1, Elements C and D) to include language about gender identity and sexual orientation in the element stem and update the scoring.

The intent of this proposed update is to extend privacy protections to all collected data and require protections to earn a score of "Met." Privacy protections are vital to instill trust in the data collection process.

Targeted Questions for HE 2: Race/Ethnicity, Language, Sexual Orientation and Gender Identity Data

- Do you support adding a new element, HE 2C: Collection of Data on Gender Identity?
- Do you support adding a new element, HE 2D: Collection of Sexual Orientation Data?
- Does your organization use direct methods to collect data on sexual orientation and/or gender identity? If yes, describe.
- If your organization does not use direct methods to collect data on sexual orientation and/or gender identity, what methods does it use?
- Does your organization collect and use data about members' preferred pronouns?
- Do you support updating HE 2E: Privacy Protections to include protections for collection of data on gender identity and sexual orientation?
- Do you support updating HE 2E: Privacy Protections to require organizations to meet three factors to earn a "Met" score?
- Do you support updating HE 2F: Notification of Privacy Protections to include protections for collection of data on gender identity and sexual orientation?
- Do you support updating HE 2F: Notification of Privacy Protections to require organizations to meet three factors to earn a "Met" score?

HE 6: Reducing Health Care Disparities

Add a new element to HE 6:

- Element A: Reporting Stratified Measures.

NCQA is adding stratifications on race and ethnicity to five existing HEDIS measures for HEDIS Measurement Year 2022. NCQA encourages all eligible organizations to submit stratified rates as part of annual reporting.

Element A requires organizations to report stratified HEDIS measures to determine disparities, as applicable. HEDIS specifications allow organizations the confidence of having a valid methodology for stratifying and determining disparities. Organizations that meet the requirement may be eligible for a "NA" in Element B, factor 1 ("analyzes one or more valid measures of clinical performance, such as HEDIS, by race/ethnicity"; formerly MHC 5, Element A).

Add a new factor to HE 6, Element B: Use of Data to Assess Disparities (formerly MHC 5, Element A):

- Factor 3: Analyze one or more valid measure of clinical performance, such as HEDIS, by gender."

Factor 3 requires organizations to examine disparities by gender that may negatively affect their populations.

Update scoring so organizations that meet 3–4 factors are scored "Met," to allow organizations to adjust to examining disparities by gender.

Targeted Questions for HE 6

- Do you support adding a new element HE 6A: Reporting Stratified Measures?
- Do you support having HE 6A: Reporting Stratified Measures be an annual requirement?
- Do you support adding a new factor 3 to HE 6B: Use of Data to Assess Disparities?
- Do you support the scoring update to 3-4 factors to be "met" in HE 6B?
- Should HE 6B be an annual requirement?
- In addition to stratifying by race, ethnicity and language, what other demographics or data sources has your organization used or considered to assess for potential disparities in care access, delivery, utilization and/or coordination?

Update Scoring Methodology

NCQA recommends updating Health Equity Accreditation scoring to align with the Health Plan Accreditation scoring design to:

- Maintain positive incentives for high performance against the standards.
- Provide clear and transparent scoring so organizations know what is required and stakeholders understand what Accreditation means.
- Require organizations to meet an overall scoring threshold of 80% on elements that apply to their survey type in order to earn Accreditation.
  - MHC Distinction requires 70 points to earn Distinction; and 69.99 points or below results in Denied.

Table 1 describes the scoring updates. Refer to *Appendix 1: Proposed Standard Changes to Health Equity Accreditation (formerly MHC Distinction)*.

Table 1. Update Scoring Methodology

Scoring Item	Current Methodology	Recommended Update
Element levels of performance	There are five levels of performance for evaluating compliance with elements: **100%, 80%, 50%, 20%, 0%.** Scoring levels are granular, producing narrow results (e.g., 20% of 0.570 points is 0.114 points). Points earned do not clearly communicate organization performance to stakeholders.	Replace element scoring levels with three levels: • **Met:** Equivalent to the 80%–100% scoring threshold. • **Partially Met:** Equivalent to the 50% scoring threshold. • **Not Met:** Equivalent to the 0%–20% scoring threshold. Refer to **Table 2** for a scoring conversion example.
Number of points assigned to each element: Convert to relative weights	Although point allocations initially reflected the relative importance of each element, over time, changes to the standards eroded the relative element weights.	Adopt a point system that assigns relative weights to each element *rather than* allocating points based on a fixed number of points. In this system: • All elements are assumed to be important functions for which that an organization must demonstrate competence. • All elements are worth 1 point, beyond those deemed of high value as described below. • Organizations that earn "Met" also earn the full point value for the element. • Organizations that earn "Partially Met" receive half the element's points (e.g. 0.5). • Organizations that earn "Not Met" receive zero (0) element points.
Number of points assigned elements of high importance: Convert to relative weights	Although point allocations initially reflected the relative importance of each element, over time, changes to the standards eroded the relative element weights. Additionally, rescoring due to updates is cumbersome: Points must be reallocated annually for each evaluation option (First, Renewal) across all elements. Rescaling to a higher number of fixed points (e.g., 200) will not resolve this issue.	Elements that are critical for ensuring patient safety and delivery of high-quality care will be weighted more heavily and will have the following point values/designations: • Elements that are of **high importance (2 points)** but are not must-pass. Organizations *are not* subject to corrective action if the element is not met. • **Must-pass elements (1 point).** Organizations are subject to corrective action if the element is not met. ***Note:*** *There are no must-pass elements in MHC Distinction and none are proposed for Health Equity Accreditation, but a methodology should be implemented for potential future updates.*

Scoring Item	Current Methodology	Recommended Update
Number of points assigned to each element, must-pass element and critical factor: Convert to relative weights	Critical factors are defined as basic requirements the organization must meet to achieve the objectives of the element, or an essential component of the element that exists to protect organization members. Organizations cannot earn more than 20% on an element if a critical factor is not met.	NCQA recommends that the score cannot exceed "partially met" if critical factors are not met. The following element has a critical factor: • HE 4B: Enhancing Network Responsiveness (formerly MHC 3B).
Treatment of "Not Applicable" (NA) elements	If an element is NA, its points are redistributed among elements in the standard or across standards in the standard category. Elements can be NA because: • They do not apply to an entity. • The organization does not contract with practitioners.	Remove "NA" elements from scoring. **For element level NAs:** Remove the element from being counted for/against Accreditation. Points will be removed from the denominator for the total points applicable in the standard category. **Dependency:** This is feasible only if the scoring design does not rely on a fixed number of points that organizations must meet to earn Accreditation.

Table 2. Element Scoring Conversion Example

HE 6C: Use of Data to Monitor and Assess Services (formerly MHC 5B)

MHC 2021 Scoring

100%	80%	50%	20%	0%
The organization meets 3-4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0-1 factors

HE 2022 Scoring

Met (1 points)	Partially Met (0.5 points)	Not Met (0 points)
3-4 factors	2 factors	0-1 factors

Targeted Questions for Update Scoring Methodology

- Do you support the scoring methodology as described?
- Do you have any specific concerns with the updated scoring design?
- Do you support NCQA's recommendation that organizations must achieve at least 80% of the eligible points to earn Accreditation?
  Note: *Health Plan Accreditation requires 80% of points per category.*

Automatic Credit Opportunities

NCQA will evaluate programs to maximize automatic credit opportunities. Table 4 outlines automatic credit that Health Equity Accreditation may convey to Health Plan Accreditation and where that credit could apply. Automatic credit opportunities will be finale with the release of the final Health Equity Accreditation standards in fall 2021. All automatic credit and delegation rules apply.

Table 4. Health Equity Accreditation Autocredit to Health Plan Accreditation 2022

Proposed Health Equity Accreditation Element		Health Plan Accreditation 2022 Element
HE 2, Element A: Collecting Data on Race/Ethnicity		PHM 2, Element B: Population Assessment *Factor 5: Assesses the needs of members of racial or ethnic groups* *Factor 6: Assesses the needs of members with limited English proficiency*
HE 2, Element B: Collecting Data on Language		
HE 6, Element D: Use of Data to Measure CLAS and Disparities		PHM 2, Element C: Activities and Resources *Factor 3: Review and update activities or resources to address health care disparities for at least one identified population.*
HE 2, Element A: Collecting Data on Race/Ethnicity		NET 1, Element A: Cultural Needs and Preferences
HE 2, Element B: Collecting Data on Language		
HE 4, Element A: Assessment and Availability of Information	***Conveys Credit to…***	NET 5, Element A: Physician Directory Data *Factor 8: Languages spoken by the physician or clinical staff*
HE 3, Element D: Notification of Language Services		ME 2, Element A: Subscriber Information *Factor 5: How to obtain language assistance*
HE 3, Element B: Spoken Language Services		ME 2, Element B: Interpreter Services
HE 3, Element A: Written Documents		ME 7, Element A: Policies and Procedures for Complaints *Factor 5: Provision of language services for the complaint process*
HE 3, Element A: Written Documents		Policies and Procedures for Appeals *Factor 5: Provision of language services for the appeal process*

Health Equity Accreditation Plus: An SDOH Evaluation Option

Background

Social determinants of health (SDOH) are the conditions in which people live, work and play—they are the forces and institutions shaping the conditions of daily life, including political systems, public policies and social norms.[7] The *Healthy People Initiative* identified five key areas of SDOH:

1. Economic stability.
2. Education.
3. Social and community context.
4. Health and health care
5. Neighborhood and built environment.[8]

Social and environmental factors play a fundamental role in the health of every individual. SDOH may be positive (promote better health) or negative (undermine health). For example, income is a social determinant: A high income can mean access to more resources that support better health; a low income can limit access to essential resources and be an obstacle to achieving optimal health.

Mitigating the negative effects of SDOH and affecting sustainable change may require coordinated societal interventions beyond the health care industry. Health care organizations should engage in these interventions while assessing their populations' social risks and addressing immediate social needs.

For more information on how SDOHs affect populations and how to implement strategies to address them, refer to *NCQA's Social Determinants of Health Resource Guide.*

Health Equity Accreditation Plus

As stated above, the standards in Health Equity Accreditation are the foundation and first step toward health equity goals. NCQA proposes an evaluation option for organizations seeking a framework for assessing and addressing SDOH. The option would be added to the existing Health Equity Accreditation standards and could only be pursued with or after earning Health Equity Accreditation (the Health Equity Accreditation standards are required). Organizations that complete the standards in Health Equity Accreditation and the SDOH evaluation option earn the status modifier of "Plus" (Health Equity Accreditation Plus). "Plus" indicates an organization's commitment to health equity.

The evaluation option standards will be released in March 2022 for surveys beginning on or after July 1, 2022.

Health Equity Accreditation Plus: Concepts

Standard concept areas are presented below for comment. The standard concept areas will be developed into full standards as guided by a multi-stakeholder Advisory Panel, literature reviews, and engagement sessions with community-based organizations and other stakeholders.

Full standard details and a public comment period are scheduled for fall 2021.

[7] World Health Organization (WHO). *Social Determinants of Health.* Accessed May 6, 2020. http://www.who.int/social_determinants/en/

[8] U.S. Department of Health and Human Services (HHS) Office of Disease Prevention and Health Promotion (ODPHP). Disparities. HealthyPeople.gov. n.d. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

Proposed Standard Concept Areas

Data Collection, Storage, Interoperability

Data describing a person's social needs—the immediate necessities that reflect a person's preferences and priorities—is necessary for whole-person care, which includes coordination of physical health, behavioral health and social services to promote better health outcomes and more effective use of resources.[9]

Data collection, storage and interoperability is a barrier to assessing and address social risk. Many systems do not communicate with each other or have the ability to store SDOH data, or data is not useful once collected; however, understanding an individual's social risks and needs is important in guiding health care decisions and providing appropriate support.

Equitable Evaluation of Technology

Scientific research found that commercial algorithms used to guide health care decisions display racial bias. Developing best practices for assessing bias is ongoing, but for now, NCQA signals the importance of mitigating the effects of inadvertent bias.

Social Determinants of Health Assessments

SDOH must be assessed and understood before they can be addressed. Organizations often create "homegrown" assessment tools or adapt existing assessment tools to fit their population. Organizations need to have confidence in the accuracy and reliability of their assessment data and the information shared by other organizations and integrated across systems. To be useful, SDOH data must be available when it is needed and it must be accurate. The standards encourage collection of SDOH data while being flexible to accommodate organizational capacity and needs.

Establishing Cross-Sector Partnerships With Community-Based Organizations and Practitioners or Providers

Community-based organizations (food banks, shelters, long-term services and supports, community centers) and practices communicating with and caring directly for individuals are often at the front lines of addressing social needs and social risks. Partnerships—including between health care organizations and CBOs, practices or government agencies—can meet the needs of the community better than when these organizations work independently. Working with multidisciplinary partners, health care organizations gain community buy-in, increase their capacity to address community needs and extend limited resources.[10]

Cross-sector collaborations should emphasize mutual autonomy and respect and should not burden less-resourced CBOs with excessive administrative requirements. CBOs should be valued as equal partners that have extensive grassroots experience and have established trust with the communities they serve.

[9] Thomas, H., G. Mitchell, J. Rich, M. Best. 2018. "Definition of Whole Person Care in General Practice in the English Language Literature: A Systematic Review." *British Medical Journal* (8):12. Accessed June 3, 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6303638/

[10] *Developing Cross-Sector Partnerships to Address Social Determinants of Health - RHIhub Toolkit. Rural Health Information Hub.* Accessed June 9, 2020. https://www.ruralhealthinfo.org/toolkits/sdoh/4/cross-sector-partnerships

It is important that the CBOs or practices are not overly burdened by establishing and maintain these relationships. The onus should be on health plans or other health care organizations to consult and coordinate with CBOs or practices in a mutually beneficial, appropriate way that serves the individual/patient at the center of care.

Health Equity Programs

Organizations should develop interventions or programs based on their understanding of the population's needs through data collection. Interventions should include support from the community and have clear goals or targets and a plan for measuring the impact of interventions and programs.

Interventions may be centered on one SDOH (e.g., housing, food security, transportation) or cross multiple SDOHs, as supported by the data. NCQA encourages thoughtful program development without limiting innovation.

Referrals, Outcomes and Impact

Individuals are often referred to community-based services or programs. In a "closed-loop referral," an organization determines if the referral was followed—although the responsibility to follow through always lies with the individual being assisted. Organizations may want to use a community resource repository or referral platforms such as Aunt Bertha,[136] NowPow,[127] Unite Us,[128] Healthify[129] or Health Leads to track resource hours, analyze most-used partners and determine follow-through.[60] They can also choose to guide individuals through this process by using a community health worker or case manager. In both cases, organizations need a clear process for closed-loop referrals to interventions or community-based organizations.

Organizations must also assess the impact of their partnerships, programs and referrals on the population. SDOH interventions often take months—or years—to yield positive changes to clinical outcomes; thus, assessments should include evaluating changes in clinical outcomes, patient-reported outcomes and experience and satisfaction with care. Organizations can make adjustments as they learn more about the impacts of their programs.

Questions for Health Equity Accreditation Plus Standard Concept Areas

- In what areas does your organization need guidance to assess and address SDOH (i.e., what standards concept areas should be included)?
- Are there concept areas that your organization might have difficulty meeting?
- Would your organization be interested in participating in a pilot program for these standards?
- How does your organization store and share SDOH data between partners (e.g., across health plans, practices or community-based organizations)?
- Is your organization building partnerships with community-based organizations? If so, how?
- Would standards for creating and maintaining a community health worker program be beneficial to your organization?
- Does your organization employ community health workers? If so, how are those relationships maintained without overmedicalizing their roles?

Public Comment Instructions

Public Comment Questions

Public comment is integral to development of all NCQA standards and measures. NCQA considers all suggestions and encourages reviewers to provide insights on global issues related to proposed updates, including:

1. Will proposed updates help your organization meet its objectives? If so, how? If not, why not?
2. Are key expectations not addressed in the proposed requirements?

Documents

Find draft standards in *Appendix 1: Proposed Standard Changes to Health Equity Accreditation (formerly MHC Distinction).*

How to Submit Comments

Respond to topic and element-specific questions for each product on NCQA's public comment website. NCQA does not accept comments by mail, email or fax.

1. Go to http://my.ncqa.org and enter your email address and password.
2. Once logged in, scroll down and click **Public Comments**.
3. Click **Add Comment** to open the comment box.
4. Select one or more of the following from the drop-down box:
   a. **HE 1: Organizational Readiness**
   b. **HE 2: Race/Ethnicity, Language, Sexual Orientation and Gender Identity Data**
   c. **HE 6: Reducing Health Care Disparities**
   d. **Update Scoring Methodology**
   e. **Health Equity Accreditation Plus: Standard Concept Areas**
5. Click to select the **Topic** and **Element** (question) on which you would like to comment.
6. Click to select your support option (**Support, Do not support, Support with modifications**).
   a. If you choose **Do not support**, include your rationale in the text box.
   b. If you choose **Support with modifications**, enter the suggested modification in the text box.
7. Enter your comments in the **Comments** box.
   Note: *There is a 2,500-character limit for each comment. We suggest developing comments in Word to check your character limit; use the "cut and paste" function to copy into the Comments box.*
8. Use the **Submit** button to submit more than one comment. Use the **Close** button to finish leaving comments; you can view all submitted comments in the **Public Comments** module.

All comments must be entered by July 23, at 11:59 p.m. ET

Next Steps

The final Standards and Guidelines for Health Equity Accreditation will be released in fall 2021, following approval by the NCQA Standards Committee and the Board of Directors.

Requirements will take effect for surveys on or after July 1, 2022. Organizations coming forward for Accreditation after this date must meet the new requirements.

