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HE Plus 1: Program to Improve Social Risks and Address Social Needs

The organization annually defines the structure, processes and goals of its program to identify and address social risks and social needs, building on its culturally and linguistically appropriate services (CLAS) program in Health Equity Accreditation.

Intent

The organization engages the community where it operates and the individuals it serves to identify the most effective ways to reduce the negative effects of social risks in the community and offer services that address individuals' social needs.

Element A: Program Description

The organization has a written program description for addressing social risks in the community and individuals' social needs that specifies:

1. **The program structure.**
2. **A process to identify the community's social risks.***
3. **A process to identify the social needs of individuals it serves.***
4. **A process to identify subpopulations within the community and individuals most likely to benefit from specific social needs resources or interventions.**
5. **A process to involve a diverse group of community members and individuals in identifying and prioritizing social risks and needs.**
6. **A process to prioritize identified social risks and needs.**
7. **A list of measurable goals for reducing negative health effects related to social risks identified in the community.***
8. **A list of measurable goals for addressing the social needs of individuals it serves.***
9. **Annual approval by a governing body.**
10. **The program's commitment to addressing social risks and needs in a way that supports diversity, equity, inclusion and cultural humility.**

Critical factors: These factors must be scored "yes" to score at least "Partially Met."

Scoring

Met	Partially Met	Not Met
The organization meets 8-10 factors	The organization meets 5-8 factors	The organization meets 0-4 factors

Data source   Documented process

Scope of review   *For All Surveys:* NCQA reviews the organization's written program description in place throughout the look-back period.

Look-back period   For All Surveys: 6 months.

Explanation   Factors 2, 3, 7 and 8 are critical factors; all must be scored "yes" for the organization to score at least Partially Met on this element.

A **program description** is a formal decision-making arrangement where an organization's goals and structures are put into an operational framework and tasks to meet goals and objectives are identified, grouped and coordinated. It defines how the organization uses its resources to achieve its goals. The

program description is organized and written so that all staff members can understand the program's goals and structure.

Social risk factors are specific, adverse social conditions (e.g., social isolation, housing instability, poverty) that are associated with poor health outcomes. A community's social risks may be exacerbated by structural factors, such as policies on economics, housing, education and transportation, when or if the foundations of those structures are affected by racism, classism, sexism, ableism and other biases that perpetuate inequities.

Social needs are the nonclinical needs that individuals identify as essential to their well-being. An individual's social needs are related to the social risks they experience and their intersectional identities or characteristics such as race/ethnicity, preferred language, gender identity, sexual orientation and aspect of disability. Two individuals who experience the same social risks may have different social needs. Interventions address social needs at the individual level.

Individuals served by the organization include individuals, members or patients who directly access the organization's health care services or for whom the organization assumes financial risks associated with providing comprehensive medical services. The location-based **community where the organization operates** (the service area) includes the larger demographic population that has access to the organization's services, whether or not they choose to access the services, and that is located in the same geographical area.

Because the community's social risks are "upstream" factors that contribute to "downstream" social needs, the organization's program description addresses processes and goals for social risks in the community and social needs of the individuals it serves. **Upstream** interventions and strategies focus on improving fundamental social and economic structures to decrease barriers and improve supports that allow people to achieve their full health potential. **Downstream** interventions and strategies focus on addressing social needs by providing equitable access to care and services to mitigate the negative impacts of social risks on health.[1]

Factor 1: **Program structure**

The program description includes the following information about the program structure:

- How the program is organized to meet program goals.
- Functional areas or departments involved in the program and their responsibilities.
  - Involvement of the organization's diversity, equity and inclusion (DEI) officer, or a leadership position with equivalent responsibilities, in planning the program's structure and in the processes described in factors 2–9.
- The reporting relationship of program staff roles, leadership roles, governing bodies and external partners that refer and provide social needs resources for the program.
- Data sources and systems used and accessed by program staff to meet program goals.
- How the organization's CLAS program is related with regard to operations and oversight.
- Collaborative activities with the organization's CLAS program, if any.

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[1]https://nccdh.ca/glossary/entry/upstream-downstream

The structure of the program for identifying social risks and addressing social needs may be independent of or may be integrated into the organization's CLAS program from HE 5, Element A: Program Description in Health Equity Accreditation.

Factor 2: Process to identify social risks

The organization describes its process for identifying the social risks of the community where it operates (service area) in order to better understand the social needs of the individuals it serves. The description includes:

- The location of the community where it operates.
- The organization's methodology for integrating data about social risks at the community level.
- Data types and sources used (e.g., community health assessments, claims, population health registries, census, socioeconomic data, demographics).

Factor 3: Process to identify social needs

The organization describes its process for identifying the social needs of the individuals it serves, including how they determined which individuals should receive additional screening. The description identifies:

- The individuals from whom it collects data on social needs.
  - The organization is not required to collect data for the entire member population.
- The methodology for collecting data about individuals' social needs, including the data sources used to collect the data (e.g., screeners or assessments, claims, EHRs, health information exchanges [HIE], enrollment forms).
  - The organization may collect data directly at multiple points of interaction with individuals and through multiple mechanisms, using as many channels as are available.

Factor 4: Process to identify subpopulations

The organization describes its annual process for identifying subpopulations that are most likely to benefit from specific social needs resources or interventions by using population segmentation or risk stratification of data collected through the following processes, at minimum:

- Identifying the social risks of the community where it operates (HE Plus 1, Element A, factor 2).
- Identifying the social needs of the individuals it serves (HE Plus 1, Element A, factor 3).
- Identifying demographic characteristics or identities from Health Equity Accreditation, as detailed in HE 2, Elements B–E (race, ethnicity, language, sexual orientation, gender identity).

The organization may use additional characteristics not listed above (e.g., age, aspect of disability).

Population segmentation divides the population into meaningful subsets using information collected through the community and individual-level assessments.

Risk stratification uses the potential risk or risk status of individuals to assign them to tiers or subsets. Members in specific subsets may be eligible for programs or receive specific services or resources.

Segmentation and risk stratification result in categorization of individuals with care needs at all levels and intensities. Segmentation and risk stratification are means of targeting services and resources to individuals who can most benefit from them.

NCQA does not prescribe the subpopulations (e.g., racial, ethnic, language, sexual orientation, gender identity, aspect of disability) for stratification. The organization may focus on subpopulations most relevant to the demographics of the population served. Some subpopulations may have a sufficient number of individuals to be analyzed individually (e.g., White, Black/African American); some smaller subpopulations may need to be grouped together for analysis.

In some organizations, it may be possible to stratify distinct subgroups, for example:

- Specific ethnic subgroups such as Chinese, Japanese, Korean or Vietnamese, rather than "Asian," or Mexican/Mexican American/Chicano, Puerto Rican or Cuban rather than "Hispanic or Latino."
- Aspects of disability arising from specific functional limitations (e.g., hearing, vision, cognition, ambulation, self-care, or independent living) and that manifest consistently over time or recur in episodes of varying length, rather than an undifferentiated category such as "persons with disabilities."

Factor 5: **Process to involve community members and individuals served**

The organization's program for addressing social risks and needs has substantive input and participation from the community where it operates and the individuals it serves to ensure that it meets their needs in ways that are culturally and linguistically appropriate.

The organization describes its process for involving a diverse group of community members and individuals served by the organization in its process to identify and prioritize the social risks and needs of its program. The organization establishes a meaningful advisory function (e.g., community board, patient and family advisory council) that includes individuals who reflect the diversity of the population served and who are affected by the social risks in the community. Meaningful representation for each advisory function includes:

- For the community advisory function, individuals in the community who are either impacted by or represent organizations that focus on addressing the community's social risks, as identified in the process described in factor 2.
- For the consumer advisory function, individuals who reflect the diversity of the member or patient population the organization serves.
  - At a minimum, the consumer advisory board includes individuals representing groups that constitute at least 5 percent of the characteristics or identities the organization identified in Health Equity Accreditation as relevant to the population it serves (race/ethnicity, preferred language, gender identity, sexual orientation).

The organization may use the advisory committee established in Health Equity Accreditation (HE 5, Element A, factor 1) if the committee also includes individuals who experience the same social risks of the community.

Factor 6: **Process to prioritize identified social risks and needs**

The organization describes its process for using the identified social risks of the community (HE Plus 1, Element A, factor 2) and the social needs of individuals it serves (HE Plus 1, Element A, factor 3) to prioritize the social risks and needs that the program focuses on addressing. The description outlines the organization's methodology, which includes, at minimum, consideration of:

- Social risks and needs that, if addressed, will have the greatest positive impact on the community and for individuals the organization serves.
- Social risks and needs already addressed by community resources.
- Gaps in available existing community resources.
- Social risks and needs that are outside the organization's scope, capacity (available resources) and/or capabilities (knowledge) to address.
  - For social risks and needs that lie outside the organization's scope and represent gaps in available existing community resources, the organization outlines its process for identifying opportunities to partner with other organizations to fill gaps.
- The expected impact, including unintended consequences, of the program on the community.

Factor 7: **Goals to reduce social risks in the community**

The organization describes at least one measurable goal for reducing negative health effects that result from the community's social risks (HE Plus 1, Element A, factor 2), in order to allow the organization to address those that have the most impact on community health. The description must include a rationale for each goal.

Goals must:

- Be specific.
- Be measurable.
- Be achievable and reasonable.
- Have a defined period for completion.
- Be relevant to the findings from the process for identifying the community's social risks (HE Plus 1, Element A, factor 2).

Factor 8: **Goals to address social needs of individuals**

The organization describes at least one measurable goal for addressing the social needs of individuals served by the organization. The description must include a rationale for each goal.

Goals must:

- Be specific.
- Be measurable.
- Be achievable and reasonable.
- Have a defined period for completion.
- Be relevant to the findings of the processes for identifying the community's social risks (HE Plus 1, Element A, factor 2) and social needs of individuals it serves (HE Plus 1, Element A, factor 3).
- Consider the role of individuals' intersectional identities (race, ethnicity, language, sexual orientation, gender identity). The organization may use the data collected in Health Equity Accreditation in HE 2, Elements B–E, and the analysis performed in HE 6, Element B.

Factor 9: **Annual approval by a governing body**

The organization's or the program's governing body (e.g., board of directors; diversity, equity and inclusion governance council) is responsible for organizational governance and annually reviews and approves the program description.

The governing body may designate a subcommittee or management staff role to oversee activities related to identifying social risks and addressing social needs. The program description must document the subcommittee's or management staff role's accountability to the governing body.

Factor 10: **Commitment to support diversity, equity, inclusion and cultural humility**

The organization's program description includes a statement or summary outlining the program's overall commitment to addressing the community's social risks and the social needs of the individuals it serves in a way that supports diversity, equity, inclusion and cultural humility, to ensure that individuals in the community and in the organization's population served receive appropriate resources and interventions.

Diversity describes the presence of differences in characteristics or identities such as race, ethnicity, preferred language, gender identity, sexual orientation, age, religion, aspect of disability and socioeconomic status. Supporting diversity means recognizing differences between individuals, acknowledging that these differences are a valued asset to the program, and representing diversity within the programs and services offered to individuals and the community.[2]

Equity is developing, strengthening and supporting procedural and outcome fairness in systems, procedures and resource distribution mechanisms to create equitable opportunities for all individuals. Equity and "equitable" are distinct from **equality** or "equal," which refers to everyone having the same treatment but does not account for different needs or circumstances. Equity focuses on eliminating barriers that have prevented the full participation of historically and currently oppressed groups. Addressing equity issues requires an understanding of the root causes of outcome disparities within our society.[3]

Inclusion is intentionally designed, active and ongoing engagement with individuals that ensures opportunities and pathways for participation in all aspects of a group, organization or community, including decision-making processes. Inclusion refers to showing that individuals are valued as respected members of the group, team, organization or community, and is often created through progressive, consistent actions to expand, include and share.

Cultural humility is the ability of organizations, systems and health care professionals to value, respect and respond to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services.

Examples

Factor 5: **Process to involve community members and individuals served**
- Patient or community surveys.
- Stakeholder interviews.
- Advisory committees (e.g., community boards, patient advisory councils, accountable communities for health).

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[2] https://www.ama-assn.org/about/ama-center-health-equity/advancing-health-equity-guide-language-narrative-and-concepts-0
[3] https://dei.extension.org/

Factor 6: Process to prioritize identified social risks and needs

Examples of considering the impact of the program may include, but are not limited to:

- Whether the organization's direct provision of services will compete with or undermine the work of existing community-based organizations serving the same population.
- Whether collaboration with community-based organizations will strengthen and empower the community.
- Asking community members and individuals if they think a planned intervention will be helpful and effective or harmful and ineffective.

Factor 9: Annual approval by a governing body

Bodies responsible for governance of the program for addressing social risks in the community and individuals' social needs may include, but is not limited to:

- The organization's Board of Directors.
- The organization's or program's governance council, board, committee or other body with similar responsibilities.
- The organization's or program's diversity, equity and/or inclusion-specific governance council, board, committee or other body with similar responsibilities.

Element B: Annual Work Plan

The organization documents and executes an annual work plan for its program to address the community's social risks and individuals' social needs that reflects ongoing activities throughout the year and addresses:

1. **The program scope.**
2. **Planned activities to meet goals identified in HE Plus 1, Element A, factors 7 and 8.**
3. **Interventions or resources offered by the organization or its partners.**
4. **A time frame for each activity's completion.**
5. **Staff responsible for each activity.**
6. **Monitoring of the work plan.**
7. **Annual approval by a governing body.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-7 factors	The organization meets 3 factors	The organization meets 1-2 factors

Data source   Documented process, Materials, Reports

Scope of review   *For All Surveys:* NCQA reviews updates made to the organization's annual work plan which may include the current version of the work plan, with cited revisions and approval dates, *or* the current and original versions of the work plan, if they are separate documents.

Look-back period   *For All Surveys:* At least once during the prior year.

Explanation The work plan is a dynamic document that can be as simple as a calendar of events scheduled for the year, a Gantt chart that shows planned activities or a brief text that includes the planned time frame for each activity.

Factor 1: **Program scope**

The work plan covers planned activities related to the organization's program description in HE Plus 1, Element A, for addressing social risks in the community and individuals' social needs, and includes:

- The prioritized social risks and needs identified in HE Plus 1, Element A, factor 6.
- The defined community where the organization operates (e.g., region, ZIP code, service area) as identified in HE Plus 1, Element A, factor 2.

Factor 2: **Planned activities to meet goals**

The organization identities at least one activity for meeting each goal identified in HE Plus 1, Element A, factors 7 and 8, including current or planned partnerships with other organizations.

Factor 3: **Interventions or resources**

The work plan describes the interventions or resources that will be offered directly to members of the community and/or individuals served by the organization as a result of the process described in HE Plus 1, Element A, factor 6.

Work plan activities may include community-level interventions to address or mitigate social risks and individual-level interventions to meet the social needs of the individuals the organization serves. The organization may be most effective by partnering with, and following the lead of, community-based organizations that specialize in addressing the upstream causes and downstream negative health effects and social needs resulting from specific social risks, and also considers how:

- Partnering with other organizations will address or mitigate social risk factors for members of the community and/or individuals served by the organization.
- Referrals will be subsequently made to partner organizations to deliver interventions and resources directly to individuals.

Factor 4: **Time frame for each activity's completion**

Each activity on the work plan has a time frame for completion. Time frames list specific dates (e.g., date, month, quarter), as opposed to frequency of activities (e.g., annually, semiannually).

Factor 5: **Staff responsible for each activity**

The work plan lists staff responsible for activities. Staff are not required to be listed by name; they may be listed by title or role. The list may be limited to activity leads.

Factor 6: **Monitoring of the work plan**

The organization routinely, but at a minimum, annually, updates the work plan to reflect progress on activities and includes identification of barriers to meeting goals and completing activities.

Factor 7: **Annual approval by a governing body**

The organization's or the program's governing body (e.g., board of directors; diversity, equity and inclusion governance council) is responsible for organizational governance and reviews and approves updates to the work plan at least annually.

The governing body may designate a subcommittee or management staff role to oversee the review and approval of updates to the work plan that occur more frequently than annually (i.e., routinely). The program description must document the subcommittee's accountability to the governing body.

Examples   None.

Element C: Program Evaluation

The organization performs a written annual evaluation of the program to address social risks and needs that includes:

1. **A description of completed and ongoing activities.**
2. **Trending of measures every 3 years to assess the performance of activities to reduce negative health effects resulting from the community's social risks.**
3. **Trending of measures to annually assess the performance of activities addressing individuals' social needs.**
4. **Annual collection of feedback from program stakeholders.**
5. **Analysis of results, including analysis of barriers to improvement, every 3 years.**
6. **Review and interpretation of results by representatives of the community and of the individuals the organization serves.**

	Met	Partially Met	Not Met
Scoring	The organization meets 4-6 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source   Documented process, Reports

Scope of review   *For All Surveys:* NCQA reviews the organization's program evaluation reports.

The organization may submit a plan detailing its strategy and implementation for meeting factors 2–6.

Look-back period   *For All Surveys:* At least once during the prior year.

Explanation   *Factor 1:* **Completed and ongoing efforts**

The annual evaluation summarizes completed and ongoing activities described in the program description from HE Plus 1, Element A and the work plan from HE Plus 1, Element B.

Factors 2, 3: **Trending of community-level and individual-level measures**

The organization uses data reported at the community level (e.g., community health assessments performed by a local public health agency or its equivalent) and individual level (e.g., individuals' social needs, characteristics or identities from Health Equity Accreditation) to demonstrate results of activities to meet goals determined in HE Plus 1, Element A, factors 7 and 8, in measurable terms.

The organization provides reports showing trended performance data at the community level and individual level over time, compared to each goal. To facilitate comparative analysis, trended data use charts, graphs or tables to display the organization's performance.

Population-based outcomes evolve more slowly than individual-level outcomes. For goals related to individuals' social needs, the organization provides results at least annually; for goals related to negative health effects resulting from the community's social risks, the organization may provide results every 3 years, to align with the 3-year cycle of community health assessments performed by most public health agencies and nonprofit hospitals.

Factor 4: Annual collection of feedback

The organization annually collects feedback from program stakeholders to identify opportunities for improvement, including for individuals receiving interventions. Stakeholders include, at a minimum:

- Individuals who have received interventions or resources through the program or who were offered services but did not receive them.
  - Feedback should include, but is not limited to, individuals' experience with referrals, appropriateness of interventions or resources and interactions with the organization's staff and systems.
- Community members.
  - Feedback should include, but is not limited to, issues with the delivery of services provided and concerns that the community's social risks are not addressed or are inadequately addressed by the program.[4]
- Program staff.
  - Feedback should include perceived level of preparedness to implement program activities and goals, in order to help determine future needs for training, resources and organizational support.
- Community partner organizations.
  - Feedback should include perceived burden of and experience with the program and working with organization staff and systems.

Factor 5: Analysis of results, including barriers to improvement

The organization analyzes results from HE Plus 1, Element C, factors 2 and 3 to determine if the performance of its program is improving, declining or remaining stable, and how its performance relates to each goal or performance threshold identified in the program description (HE Plus 1, Element A, factors 7 and 8).

For goals related to individuals' social needs, the organization performs the analysis annually; for goals related to negative health effects resulting from the community's social risks, the organization may perform the analysis every 3 years.

For each program goal defined in HE Plus 1, Element A, factors 7 and 8, the organization provides a report describing:

- Whether health outcome measures related to the goal show that program performance is improving, declining or remaining stable.
- How demonstrated performance compares to performance thresholds for each goal.

If analysis reveals that program goals fall below performance thresholds, the organization conducts a root cause analysis or barrier analysis to identify why.

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[4]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6510456/

Analysis involves organization staff who have direct experience with processes that present barriers to improvement.

Factor 6: Review and interpretation of results by representatives

The organization includes representatives of the community where it operates and the individuals it serves in the analysis of factor 5 results. At a minimum, the organization:

- Presents its analysis to community representatives for review and feedback.
- Consults community representatives for their perspective on the results of the root cause analysis and potential solutions.

The organization may also embed representatives on the evaluation team.

With regard to analyses related to individuals' social needs, the organization reviews results with representatives annually. Review of analyses related to negative health effects resulting from the community's social risks may occur every 3 years.

Examples   None.

HE Plus 2: Collection, Integration and Analysis of Community and Individual Data

The organization collects and integrates community and individual-level data to understand the social risks of the community where it operates and the needs of the individuals it serves.

Intent

The organization uses community and individual-level data to inform the design of its social risks and needs program and identifies needed resources and partnerships to address community social risks and individual social needs.

Element A: Community-Level Social Risk Data Integration

Every 3 years, the organization integrates community-level social risk data from:
1. **A community health assessment performed by a local public health agency or its equivalent.**
2. **A second source endorsed by at least one of the organization's partners.**
3. **A third source.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	No scoring option	The organization meets 0-2 factors

Data source   Reports, Materials

Scope of review   *For All Surveys:* NCQA reviews reports or materials (e.g., screenshots) for evidence that the organization integrated the data types and sources identified in its documented process (HE Plus 1, Element A, factor 2). NCQA also reviews evidence that at least one integrated data source allows stratification by demographic characteristics or identities.

The organization may submit multiple examples that collectively demonstrate integration from all data types and sources or may submit one example that demonstrates integration of all data types and sources.

Look-back period   *For All Surveys:* 6 months.

Explanation   *Factors 1, 2, 3*

Data integration is combining data from multiple sources or databases.

The organization follows its documented process for integrating community-level social risk data from three different sources (HE Plus 1, Element A, factor 2) at least every 3 years, in alignment with the 3-year cycle of community health assessments performed by most nonprofit hospitals and the 5-year cycle of community health assessments performed by most local public health agencies. The organization uses the most current version of each data source.

The use of three sources allows the organization to include a variety of data in its community-level analysis, reducing the risk that the analysis will draw biased or misleading conclusions. Data from various geographic regions (e.g., community, local, state, national) may be used to reduce the risk of bias and support a thorough understanding of social risks and their impact on health outcomes.

Data sources endorsed by partner organizations—ideally, community-based partners—help develop a common understanding of the social risks and their impact on the community, which the partners will collaborate to address (e.g., lack of employment opportunities, limited economic mobility, fear of discrimination, associated effects of poverty and joblessness).

Data sources may include quantitative or qualitative data and may also include, but are not limited to:

- Community, academic, local, state or national data that use scientifically rigorous, unbiased methodology.
  - Scientifically rigorous sources minimize bias in subject selection and data analysis, determine an appropriate sample size and conduct research that can likely be replicated.
  - Unbiased data sources do not exclude or oversample members of the population and do not promote private or political interests.
- Commercially available social risk indexes that include a transparent list of data sources and methods used to create the index.
- Interviews with community members who are representative of the population served by the organization.

At least one data source must provide or allow stratification of community risks by one or more characteristics or identities the organization identified in Health Equity Accreditation as relevant to the population it serves (e.g., race, ethnicity, language, sexual orientation, gender identity).

Examples

Factors 1, 2, 3

Local and national community-level data sources may include, but are not limited to:

- **The American Community (ACS) Survey,** sponsored by the U.S. Census Bureau, makes geographically detailed data available, including ZIP code, census tract and census block group. The data comprises economic characteristics (income, percentage of families in poverty), demographics (languages spoken at home, race, insurance coverage), housing (occupants per room, gross rent as a percentage of income) and educational attainment (for populations 25 years of age and older).[5]
- **The Area Deprivation Index (ADI)** and **Neighborhood Atlas,** sponsored by the University of Wisconsin, lets users rank neighborhoods by socio-economic disadvantage at the state and national levels. They include data on income, education, employment and housing quality.[6] They are based on a measure created by the Health Resources and Services Administration and use the ACS Survey in their construction.
- **The City Health Dashboard,** developed by NYU Langone Health and the Robert Wood Johnson Foundation, presents data on more than 35 measures of health and drivers of health for over 750 U.S. cities with populations above 50,000. The City Health Dashboard includes local data from multiple national sources to guide action on health equity.[7]
- **County Health Rankings & Roadmaps,** a program of the University of Wisconsin Population Health Institute, works to improve health outcomes and resolve health disparities between populations. Data sources include

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[5]https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/2015
[6]http://www.nejm.org/doi/10.1056/NEJMp1802313
[7]https://www.cityhealthdashboard.com/about

measures of health outcomes, health factors (behaviors, clinical care, social and economic factors, physical environment) and demographics.[8]

- **The Food Access Research Atlas,** sponsored by the USDA Economic Research Service, offers downloadable census tract-level data on food access.[9]

- The Michigan Department of Health and Human Services (MDHHS) produces the *Health Equity Report,* an annual report on disparities and MDHHS efforts to address racial and ethnic health disparities, as required by state legislation. The report presents data on morbidity, mortality and SDOH indicators, stratified by race and ethnicity. Data sources include the Michigan Behavioral Risk Factor Surveillance System, the MDHHS Division for Vital Records and Health Statistics, the U.S. Census and the Michigan Disease Surveillance System.[10]

- **The Opportunity Index,** sponsored by Opportunity Nation and Child Trends, produces an annual report that combines indicators of the economy, education, health and community at the national, state and county levels to give a "big picture" view of and perspective on conditions influencing neighborhoods.[11]

- **PHATE,** sponsored by the American Board of Family Medicine and built by the University of Missouri, uses EHR data from the PRIME registry,[12] a qualified clinical data registry available to all primary care practitioners, to create a view of neighborhood characteristics and local community-based organizations, and uses a neighborhood social deprivation index to highlight disease and poor-quality hot spots.[13]

Element B: Collection of Individual-Level Social Needs Data

The organization demonstrates that its framework for collecting data on individuals' unmet social needs includes a method for directly assessing:

1. **Financial insecurity.**
2. **Food insecurity.**
3. **Housing stability.**
4. **Access to transportation.**
5. **Interpersonal safety.**
6. **Barriers to accessing health care, including experiences with discrimination, bias or racism, or access to technology-based services.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-6 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source   Materials, Reports

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[8] https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/2021-measures
[9] https://www. ers.usda.gov/data-products/food-access-research-atlas
[10] https://www.michigan.gov/documents/mdhhs/2020_PA653-Health_Equity_Report_Full_731810_7.pdf
[11] https://opportunityindex.org
[12] https://registry.theabfm.org/Dashboard/login.aspx
[13] Lichkus J, Liaw WR, Phillips RL. Utilizing PHATE: A Population Health–Mapping Tool to Identify Areas of Food Insecurity. The Annals of Family Medicine. 2019;17(4):372-372. doi:10.1370/afm.2387

Scope of review	*For All Surveys:* NCQA reviews reports or materials for evidence that the organization's data collection methods follow its documented process (HE Plus 1, Element A, factor 3).
Look-back period	*For All Surveys:* 6 months.
Explanation	Although it is voluntary for individuals to report social needs, the organization attempts to collect these data from the individuals it identified in HE Plus 1, Element A, factor 3 (process to identify social needs).

For each social need in factors 1–6, the organization defines its method for screening or collecting data directly.

Direct data collection means asking individuals for information (e.g., through enrollment or registration forms, surveys, member or customer service calls, case management intake forms, health assessments). A direct data collection framework includes, at a minimum:

- When data will be collected.
- Where data will be collected (setting).
- How and by whom data will be collected.
- Questions that will be used to collect data.
- A process for asking individuals for data, including a script to guide staff who collect data verbally, when applicable.

The organization may receive, exchange or use data stored or collected by sources such as CMS, state or local agencies, community-based organizations, Federally Qualified Health Centers, health systems, hospitals, integrated delivery systems, provider networks, EHRs, HIEs and case management systems that have made a direct request for social needs information from individuals.

Examples	*Factors 1–6*

Widely accepted social needs assessment tools include, but are not limited to:

- The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool from the National Association for Community Health Centers (http://www.nachc.org/research-and-data/prapare).
- The Health Leads Model (https://healthleadsusa.org).
- The Accountable Health Communities-Health-Related Social Needs Screening Tool created by the Centers for Medicare & Medicaid Services (CMS) to support the CMS Accountable Health Communities Model (https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf).
- The EveryONE Project of the American Academy of Family Physicians (https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf

Catalogs of social needs screening and assessment tools include:

- *Systematic Review of Social Risk Screening Tools* by the Kaiser Permanente Washington Health Research Institute, in collaboration with the Social Interventions Research & Evaluation Network (SIREN) (https://sdh-tools-review.kpwashingtonresearch.org/).

- The *Social Needs Screening Tool Comparison Table,* compiled by SIREN, summarizes characteristics for several of the most widely used social health screening tools, including by intended population or setting, social health domains covered and number of questions about each domain (https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison).
- *The Health Leads Screening Toolkit* (https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/).

Element C: Identification of Individual Social Needs Resources

The organization has a process for using the data collected in HE Plus 2, Element B to identify applicable resources or interventions.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement.

Data source   Documented process

Scope of review   *For All Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period that outlines how it identifies resources based on individual social needs.

Look-back period   *For All Surveys:* 6 months.

Explanation   The organization provides its documented process for using the individual social needs data collected in HE Plus 2, Element B to identify appropriate resources. The process includes, at minimum:

- A description of departments and staff roles involved in the determination process.
- A list of social needs resources available to individuals it serves either directly or through a partner organization.
- A list of social needs that are outside the organization's scope, capacity (available resources) and/or capabilities (knowledge) to address.
  – For social needs outside the organization's scope that represent gaps in available existing community resources, a description of the organization's process for identifying opportunities to partner with other organizations to fill gaps.
- A description of the organization's process for documenting when individuals receive or access social needs resources identified by the organization.
  – The organization outlines its process for following up with individuals to determine if resources were accessed.

Examples   None.

Element D: Population Segmentation or Risk Stratification

The organization annually segments or stratifies the data collected in HE 2 Plus, Elements A and B, to:

1. **Identify subpopulations of the community with intersectional social risks and demographic characteristics/identities.**

2. **Identify subpopulations of individuals served by the organization with intersectional social needs and demographic characteristics/identities such as race, ethnicity, language, sexual orientation or gender identity.**

Scoring	Met	Partially Met	Not Met
	The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source   Reports

Scope of review   *For All Surveys:* NCQA reviews reports in place throughout the look-back period demonstrating that the organization segments or stratifies data.

Look-back period   *For All Surveys:* At least once during the prior year.

Explanation   ***Factors 1, 2***

Individuals with intersectional characteristics and identities such as race, ethnicity, language, sexual orientation and gender identity may experience similar social risks (e.g., someone who identifies as a Black transgender male may experience fear of discrimination that inhibits their ability to seek employment). Segmenting or stratifying the community and population by multiple characteristics ensures that the organization identifies subpopulations that share intersectionality and experience specific social risks or have specific social needs. It also allows the organization to target interventions that account for the multifaceted lived experience of the individuals they serve.

At a minimum, the organization uses its process identified in HE Plus 1, Element A, factor 4, data collected for community-level social risks (HE Plus 2, Element A) and individual-level social needs (HE Plus 2, Element B) and demographic characteristics/identities from Health Equity Accreditation, HE 2, Elements B–E (race, ethnicity, language, sexual orientation, gender identity) to identify subpopulations in the community and in the population served with intersectional social risks, needs and identities. The organization may use additional characteristics (e.g., age, aspect of disability).

NCQA does not prescribe subpopulations (e.g., racial, ethnic, language, sexual orientation, gender identity, aspect of disability) for stratification. The organization may focus on subpopulations most relevant to the demographics of the population served and that are feasible with consideration of subpopulations size. Some subpopulations may be large enough to analyze individually (e.g., White, Black/ African American; male, female, transgender; lesbian, gay), while smaller subpopulations may need to be grouped for analysis. Some organizations may be able to stratify distinct subgroups.

- Specific ethnic subgroups such as Chinese, Japanese, Korean or Vietnamese, rather than "Asian," or Mexican/Mexican American/Chicano, Puerto Rican or Cuban rather than "Hispanic or Latino."

- Aspects of disability arising from specific functional limitations (e.g., hearing, vision, cognition, ambulation, self-care, or independent living) and that manifest consistently over time or recur in episodes of varying length, rather than in an undifferentiated category such as "persons with disabilities."

Organizations should use the identified characteristics/identities of the community and the individuals it serves, as well as social risks and needs, when determining the appropriate level of stratification. In communities with a high volume of individuals in broader subpopulations, choosing not to stratify into specific subgroups jeopardizes the organization's ability to see and act on disparities between subgroups.

Examples   None.

Element E: Analysis of Community-Level and Individual-Level Data

The organization annually analyzes the data collected in HE 2 Plus, Elements A and B and the subpopulations identified in Element D to:

1. **Understand similarities and differences between the social risks and needs of the community and the individuals it serves.**
2. **Inform prioritization of work plan activities in HE Plus 1, Element A.**
3. **Inform measurable goals in HE Plus 1, Element A.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source   Reports, Materials

Scope of review

For All Surveys:

- For factor 1, NCQA reviews the organization's analysis of social risks and needs in place throughout the look-back period.
- For factors 2 and 3, NCQA reviews materials or reports in place throughout the look-back period demonstrating that the organization prioritizes work plan activities and updates the work plan and measurable goals based on analysis from factor 1.

Look-back period

For All Surveys: At least once during the prior year.

Explanation

Factor 1: **Understanding social risk and needs**

The organization annually uses the following data to analyze similarities and differences between data at the community and individual levels:

- Community-level data about social risks (HE Plus 2, Element A).
- Individual-level data about social needs (HE Plus 2, Element B).
- Individual-level data about characteristics/identities such as race, ethnicity, language, sexual orientation or gender identity from Health Equity Accreditation (HE 2, Elements B–E).
- Subpopulations of individuals with intersectional social needs and characteristics/identities such as race, ethnicity, language, sexual orientation or gender identity (HE Plus 2, Element D).

If there are differences between the community and individual levels, the organization identifies the reason (e.g., the population does not reflect the broader community; bias or gaps in the method of collecting data from individuals).

The organization provides a report describing the results of its analysis and, if applicable, a summary of its root cause or barrier analysis.

Factor 2: Informing the work plan

The organization uses its analysis from factor 1 to identify necessary updates to its work plan (HE Plus 1, Element B). The organization may either provide:

- The current version of the work plan, with cited revisions and approval dates.
- The current and original versions of the work plan, if they are separate documents.

Factor 3: Informing measurable goals

The organization uses the analysis from factor 1 to inform its measurable goals for reducing negative health effects related to social risks identified in the community (HE Plus 1, Element A, factor 7) and social needs of the individuals it serves (HE Plus 1, Element A, factor 8).

Examples   None.

HE Plus 3: Cross-Sector Partnerships and Engagement

The organization selects and collaborates with cross-sector partners to support and inform the prioritized activities of its social risks and social needs program.

Intent

The organization establishes mutually-beneficial cross-sector partnerships that equitably engage and support both partners in providing resources or interventions to address the social risks and social needs of the community and individuals that they mutually serve.

Element A: Selection of Appropriate Cross-Sector Partners

The organization's process for selecting appropriate partner organizations is based on:
1. **The social risks of the community in which it operates, as identified in HE Plus 2, Element A.**
2. **The social needs of individuals it serves, as identified in HE Plus 2, Element B.**
3. **The annual work plan, as identified in HE Plus 1, Element B.**
4. **The list of measurable goals for reducing negative health effects related to social risks and social needs, as identified in HE Plus 1, Element A.**
5. **The individual-level characteristics/identities of the population it serves, as identified in Health Equity Accreditation 2, Elements B–E.**
6. **The results of a gap analysis of the organization's capacity and capabilities to address the social risks of the community and social needs of individuals it serves.**

Scoring	**Met**	**Partially Met**	**Not Met**
	The organization meets 4-6 factors	The organization meets 1-3 factors	The organization meets 0 factors

Data source Documented process, Reports

Scope of review *For All Surveys:* NCQA reviews the organization's documented process for selecting appropriate partner organizations that was in place throughout the look-back period. NCQA reviews reports or materials demonstrating that the organization followed its documented process.

Look-back period *For All Surveys:* 6 months.

Explanation *Factors 1–5*

The organization has a process for using the following information, at minimum, to select appropriate partner organizations with which to collaborate on reducing social risks and providing resources to address social needs:

- The social risks of the community in which it operates, as identified in HE Plus 2, Element A.
- The social needs of the individuals it serves, as identified in HE Plus 2, Element B.
- Prioritized activities from the organization's annual work plan (HE Plus 1, Element B, factor 2).
- The list of measurable goals from the organization's program description (HE Plus 1, Element A, factors 7–8).

- The individual-level characteristics/identities of the population served, as identified in Health Equity Accreditation, HE 2, Elements B–E (race, ethnicity, language, sexual orientation or gender identity).

Appropriate partner organizations have the capacity (resources) and capabilities (knowledge) to provide the resources and interventions needed by the community and individuals served in a way that is nondiscriminatory and culturally and linguistically appropriate. Examples of appropriate cross-sector partners may be, but are not limited to, local government entities, non-health care social services providers and community-based organizations.

The organization determines the appropriate number and types of partners necessary to meet the social needs of the individuals they serve, while respecting the role of organizations that provide community resources and interventions. Some organizations may be better suited to a support role, collaborating with partners that have experience addressing social risks and needs and/or that have established relationships in the community.

The organization provides a documented process and reports demonstrating how it uses the information from factors 1–4 to identify partner organizations that are appropriate for the community in which it operates and the individuals it serves.

- If there are no appropriate organizations in the community (service area) that can provide resources or interventions for the social risk or needs identified in factors 1–4, the organization describes its process for:
  - Identifying appropriate organizations geographically closest to the community.
  - Attempting to collaborate with appropriate organizations geographically closest to the community, to create local access to needed resources.

Factor 6: Capacity and capabilities

The organization uses the gaps in available existing community resources that it identified in HE Plus 1, Element A, factor 6 to identify appropriate partner organizations to improve and provide the resources beyond the organization's scope, capacity and capabilities to address social needs.

Examples   None.

Element B: Equitable Partnership Agreements

The organization's written contracts or agreements with partners with which it collaborates to address individuals' social needs clearly and transparently describe:

1. Each organization's roles and responsibilities.

2. How data is shared bidirectionally for the mutual benefit of all collaborating organizations.

3. How the organization obtains individuals' consent to collect and use their data.

4. An annual process for evaluating the partnership.

Scoring

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source   Materials

Scope of review	*For All Surveys:* NCQA reviews contracts or agreements, including addenda to the contract or agreement, in effect during the look-back period from up to four randomly selected partnerships.
Look-back period	*For All Surveys*: 6 months for factors 1-3; at least once during the prior year for factor 4.
Explanation	Written contracts or partnership agreements, whether for direct provision of services by one organization or the joint actions of partners, are mutually agreed-upon documents that outline a shared understanding of how the partners work collaboratively to address individual social needs. They describe all activities to address social needs that will be performed by each organization in the partnership. A generic policy statement about the content of a contract or agreement does not meet this element.

An equitable partnership agreement is not required to be a formal legal contract and may be represented in one or more documents reflecting partners' roles and shared responsibilities to address each factor. Documents must contain partnership effective dates.

NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other forms of communication between the organization and partner that references the parties' agreement on the effective date of the agreement.

Factor 1: **Roles and responsibilities**

The contract or agreement specifies shared expectations for providing unbiased, culturally appropriate services, resources or interventions to address individuals' social needs; outlines the roles and responsibilities of each organization; and specifies terms of financial support for services provided. Partnerships may include asymmetrical investments in shared or joint programs or activities (e.g., a health system or organization may provide funding for a program while a community-based organization provides staffing or other in-kind support.

If a partner organization delegates an activity, the contract or agreement must specify which organization is responsible for delegate oversight.

Factor 2: **Data sharing**

If the organization shares data with partner organizations, the contract or agreement describes how data are shared bidirectionally for the mutual benefit of all partners, including:

- How data are accessed, which data are shared and with whom.
  - The contract or agreement specifies staff roles that have access to shared data, and specific circumstances for access.
- Common language or terminology used, where applicable.
- How the status of referrals will be tracked.

Factor 3: **How individual consent will be obtained**

The contract or agreement:

- Addresses the responsibilities of all partner organizations for obtaining individuals' authorization or consent to share their data, including communicating to individuals which data will be shared, with whom and why.
- Specifies that all partner organizations obtain documentation and confirmation of the individual's consent or authorization to share data, as required, before data are shared.

Obsolete After December 17, 2021

- Outlines each organization's responsibility for monitoring changes to or revocations of an individual's consent or authorization to share data.

Factor 4: **Partnership evaluation**

Evaluation of the partnership should be bidirectional and support joint quality improvement objectives, allowing all partner organizations to assess and improve the partnership's effectiveness for staff and for the individuals they serve.

The contract or agreement describes how partner organizations annually use findings from the bidirectional partnership assessment (HE Plus 5, Element D) to identify necessary improvements to the contract or agreement and to their shared working relationship. Improvements may focus on the experience of individuals served, administrative processes or another area of improvement identified in the assessment.

Collaborative improvement requires meaningful involvement of staff from all partner organizations. Collaborative improvement activities may require updates to the agreement to reflect revised processes.

Examples   None.

Element C: Collaboration With Cross-Sector Partners

The organization has a process for collaborating with the organizations identified in HE Plus 3, Element A in order to:
1. **Support direct provision of resources or interventions to address individuals' social needs.**
2. **Create and annually maintain a shared community resource directory.**
3. **Document community-based initiatives that serve the community.**
4. **Refer individuals to resources available through community-based initiatives.**
5. **Support community-based initiatives.**

	Met	Partially Met	Not Met
Scoring	The organization meets 2-5 factors	No scoring option	The organization meets 0-1 factors

Data source   Documented process, Materials

Scope of Review   *For All Surveys:*
- For factor 1, NCQA reviews materials in place throughout the look-back period for evidence that the organization supports partner organizations.
- For factors 2–5, NCQA reviews the organization's documented process in place throughout the look-back period.

Look-back period   *For All Surveys:* 6 months.

Explanation   Engaging in collaborative, cross-sector partnerships ensures that individuals and communities benefit from shared efforts, responsibilities, capacity (resources), capabilities (knowledge) and experience in addressing social risks and needs.

The organization's policies and procedures describe its process for developing partnerships with organizations identified in HE Plus 3, Element A (e.g., local government entities, non-health care social services organizations, community-

based organizations) and it how it collaborates with partners, whether or not it has established a contract or agreement as described in HE Plus 3, Element B, to address the social risks of the community in which it operates and the social needs of the individuals it serves.

Factor 1: **Support direct provision of resources or interventions**

The organization provides evidence demonstrating how it supports its partner organizations in providing social needs resources or interventions for the individuals they serve.

Some organizations (e.g., health systems) may be better suited to a support role and choose to collaborate with partner organizations that are better positioned, have more experience or expertise in directly providing specific resources or interventions (e.g., food delivery or aid, transportation, temporary or permanent supportive housing), or have established relationships and trust in the community.

Factor 2: **Create and annually maintain a shared community resource directory**

The organization has a process for collaborating with partner organizations to create and annually maintain a directory of community resources and interventions available in the community that includes at least the following information:

- The community resource or intervention's stated mission.
- The characteristics of the populations served by the resource or intervention, if applicable.
- The location (e.g., neighborhood, community, ZIP code) served by the resource or intervention.

The organization may use information from an existing directory of community resources that was created by a third party but must describe its process for annually updating available community resources.

Factors 3, 4, 5

Community-based initiatives are led by community members, community health workers and community-based organizations. They often address equity and the broader social risks faced by the community and may provide direct services. Community-based initiatives can be wide ranging and may focus on improving the upstream structural or institutional social risk factors that impact the community in which the organization operates.

The organization's process describes how it:

- Documents the community-based initiatives that serve the community, including at least the following information:
  – The initiative's stated mission.
  – The characteristics of the populations served by the initiative, if applicable.
  – The location (e.g., neighborhood, community, ZIP code) served by the initiative.
- Identifies and refers individuals to appropriate initiatives.
- Collaborates with partner organizations identified in HE Plus 3, Element A to identify and refer individuals to initiatives.
- Collaborates with partner organizations to support initiatives.

Examples   *Factors 1, 5:* **Organizational support for provision of direct services**

- Payment for services rendered or other type of financial support.
- Providing or paying staff to help the organization deliver the resource or intervention.
- Joint application or sponsorship for grants.
- Providing or hosting a location for a partner to deliver a resource or intervention.
- Sharing access to technology, platforms or systems to support delivery of a resource or intervention.

Factors 2, 3, 4: **Community-based initiatives**

- The organization may engage in partnerships to leverage existing community resource directories, document community-based initiatives and refer individuals to appropriate resources. Community-based organizations, state or local health departments, social service agencies, health systems, independent providers and other community partners may also have access to the data repository that integrates resource directories across the state to share data, send and receive secure electronic referrals, seamlessly communicate in real-time, securely share client information and track outcomes through a shared technology platform.[14]

Element D: Equitable Community Engagement

The organization establishes at least one advisory function that equitably engages members of the community to gather input about how well the program meets the community's needs, including:

1. **The social risks and needs that are the focus of the program.**
2. **The program's partner organizations or community-based initiatives.**
3. **The resources and interventions made available by the program.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source   Materials, Reports

Scope of review   *For All Surveys:* NCQA reviews materials in place throughout the look-back period as evidence of the organization's established advisory function, and reviews reports demonstrating:

- How the organization engaged members of the community in which it operates.
- Updates made to prioritization of work plan activities and measurable goals based on the input received in factors 1–3, if applicable.

Look-back period   *For All Surveys:* 6 months.

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[14]https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/nccare360

Explanation   **Equitable community engagement is** a bidirectional learning process. The community is treated as a shared leader and cooperative partner in identifying, developing and implementing social needs and risks programs and initiatives that benefit the well-being of individuals in the community. Equitable engagement seeks input from stakeholders that have been historically excluded, underrepresented and underresourced and incorporates their voices in the decision-making process.

Meaningful community involvement includes working with and taking direction from community members most affected by the social needs and risk programs of the organization or its partners. By leveraging their expertise and experiences, the organization and its partners may understand the social risks affecting the community, the role of the organization and its partners and the effectiveness of community-based initiatives and resources in addressing social risks. The organization engages with a diverse group of individuals from the community where it operates and may include representation from the advisory committee established in HE 5, Element A, factor 1 if committee members reflect the community's social risks identified in HE Plus 2, Element A and if the committee gathers input for HE Plus 3, Element D, factors 1–3.

The organization provides evidence that it:

- Established an advisory function (e.g., community board, patient and family advisory council) that includes individuals who:
  - Are impacted by the community's social risks, *or*
  - Represent organizations that focus on addressing the community's social risks (e.g., CBOs, community health workers, community health centers, community advocacy groups).
- Gathered input from the community advisory function about whether the program meets the community's needs, for HE Plus 3, Element D, factors 1–3.

The organization uses input from HE Plus 3, Element D, factors 1–3 to inform updates to its program's focus and activities, partnerships and participation in community-based initiatives, as applicable.

If there are differences between input received from the community and consumer advisory functions in HE Plus 3, Elements D and E, the organization performs a root cause analysis and determines if there is bias or gaps in its data collection method.

The organization provides a report describing the results of its analysis and, if applicable, a summary of its root cause analysis.

Examples   Equitable engagement may include, but is not limited to:

- Ensuring that engagement is culturally and linguistically appropriate.
- Ensuring that engagement meets individuals' access or accommodation needs, for example:
  - Accessible offices and equipment.
  - Materials in multiple formats.
  - Sign language interpreters.
- A feedback loop to communicate how participation affects policies, procedures or programming.
- Designing roles that are substantive rather than symbolic (i.e., a demonstrated incorporation of ideas into policy design, implementation and assessment).

- Providing resources to address potential trauma arising from discussions about members' experiences with bias, racism and discrimination.
- Providing resources that support individuals' participation; for example:
  - Childcare assistance or transportation to advisory meetings.
  - Reimbursement or gift cards for time or mechanisms to travel.

Methods of equitable and meaningful community engagement may include, but are not limited to:

- Establishing an advisory body (e.g., community board, patient and family advisory council or committee).
- Interviewing individuals or focus groups.
- Convening a cross-sector collaborative to address the social risks and needs that are the focus of the program and that includes individuals from the community and/or the organization's partners.

Element E: Equitable Consumer Engagement

The organization establishes at least one advisory function that equitably engages individuals from the population it serves to gather input about:

1. **The social risks and needs that are the focus of the program.**
2. **The program's partner organizations or community-based initiatives.**
3. **The quality of the resources and interventions made available by the program.**
4. **Structural, technical and/or institutional barriers to accessing program resources and interventions.**

Scoring	Met	Partially Met	Not Met
	The organization meets 3-4 factors	The organization meets 1-2 factor	The organization meets 0 factors

Data source   Materials, Report

Scope of review   *For All Surveys:* NCQA reviews materials in place throughout the look-back period as evidence that the organization established advisory functions and reports demonstrating:

- How the organization engaged individuals from the populations it serves.
- Updates made to the program's focus, prioritization of work plan activities and measurable goals based on the input received in factors 1–4, if applicable.

Look-back period   *For All Surveys:* 6 months.

Explanation   The organization has a process for equitably and meaningfully involving a diverse group of individuals from the populations it serves (e.g., consumers) in gathering input about its program for addressing social risks and needs. **Meaningful consumer involvement** includes working with and listening to the individuals served, who best understand how consumers experience the program, including the quality of the resources and interventions made available by the program and barriers to accessing or receiving resources and interventions.

The group may be the same as the advisory committee established in HE 5, Element A, factor 1 if it includes individuals who reflect the diversity of the populations served and gathers input for HE Plus 3, Element E, factors 1–4.

The organization provides evidence that it:
- Established an advisory function (e.g., community board, patient and family advisory council) that includes individuals who reflect the diversity of the member or patient population.
    – At a minimum, it includes individuals representing groups that constitute at least 5 percent of the characteristics or identities the organization identified in Health Equity Accreditation as relevant to the population it serves (race/ethnicity, preferred language, gender identity, sexual orientation).
- Gathered input from the advisory function about HE Plus 3, Element E, factors 1–4.

The organization uses the input for HE Plus 3, Element E, factors 1–4 to inform updates to its program focus and activities, partnerships and participation in community-based initiatives, as applicable.

If there are differences between input received from the community and consumer advisory functions in HE Plus 3, Elements D and E, the organization performs a root cause analysis and determines if there is bias or gaps in its data collection method.

The organization provides a report describing the results of its analysis and, if applicable, a summary of its root cause analysis.

Examples
Equitable engagement may include, but is not limited to:
- Ensuring that engagement is culturally and linguistically appropriate.
- Ensuring that engagement meets individuals' access or accommodation needs, for example:
    - Accessible offices and equipment.
    - Materials in multiple formats.
    - Sign language interpreters.
- A feedback loop to communicate how participation affects policies, procedures or programming.
- Designing roles that are substantive rather than symbolic (i.e., a demonstrated incorporation of ideas into policy design, implementation and assessment).
- Providing resources to address potential trauma arising from discussions about individuals' experiences with bias, racism and discrimination.
- Providing resources that support individuals' participation, for example:
    – Childcare assistance or transportation to advisory meetings.
    – Reimbursement or gift cards for time or mechanisms to travel.

HE Plus 4: Data Management and Interoperability

The organization has data privacy and security processes in place for managing access to, using and sharing individuals' social needs data.

Intent

The organization protects individuals' social needs data and supports interoperability when sharing data with partner organizations and communicates protections to individuals.

Element A: Privacy and Security Protections for Data

The organization has policies and procedures for managing access to, using and sharing social needs data, including:

1. **Controls for physical and electronic access to data.**
2. **Privacy and security protocols for sharing individual-level data.**
3. **Permissible use of data.**
4. **Impermissible use of data.**
5. **Recording individuals' data sharing preferences.**

Scoring	Met	Partially Met	Not Met
	The organization meets 5 factors	No scoring option	The organization meets 0-4 factors

Data source   Documented process

Scope of review   *For All Surveys:* NCQA reviews the organization's policies and procedures in place throughout the look-back period for factors 1-5.

Look-back period   *For All Surveys:* 6 months.

Explanation   The organization's policies and procedures for managing access to, use of and sharing of social needs data may be independent of or integrated with the organization's HIPAA privacy policies and/or privacy protections for race/ethnicity, language, gender identity and sexual orientation data, as described in Health Equity Accreditation (HE 2, Element F). If the organization's privacy policies are intended to include social needs data in addition to HIPAA-defined PHI, this is explicitly stated.

Factor 1: **Controls for access to data**

The organization has policies and procedures that govern and track the receipt, removal of and access to media, devices and systems, including the employee titles or roles that have access to data on individual-level social risks and needs.

Policies and procedures cover movement of media, devices and hardware; data storage; and disposal and reuse of media and devices. Media include, but are not limited to:

- Mobile applications.
- Portable drives, disks, CDs or other physical storage devices.
- Laptops.
- Secure portals.

To minimize the risk of impermissible access to sensitive information, the organization has a process for limiting employee access and for terminating access of employees who are no longer authorized to have access.

Factor 2: Privacy and security protocols for sharing data

The organization describes its policies and procedures for protecting the privacy and security of individuals' personally identifiable data, including physical and electronic access to and use of data by the organization and its partners. Having privacy and security protocols in place protects data from loss, manipulation, corruption or unauthorized disclosure.

Factors 3, 4: Permissible and impermissible use

The organization outlines permissible and impermissible use of the data. Impermissible use explicitly includes underwriting and denial of services, coverage and benefits, as applicable.

Factor 5: Recording individuals' data sharing preferences

The organization describes its policies and procedures for:

- How individuals expressly give and revoke consent to data sharing.
- Recording individuals' data sharing preferences.

Examples

Factors 1, 2

- Define limitations on the use of data.
- Amend or revoke authorization to share, use or disclose data.
- Manage permitted use and disclosure of data.
- Limit physical access to the operating environment that houses individuals' data.
  - Physical access may include, but is not limited to, the organization's computer servers, hardware and physical records and files. It does not refer to the organization's building or office location.
- Prevent unauthorized access to and release of individuals' data.
- Password-protect electronic systems, including user requirements to:
  - Use strong passwords.
  - Discourage staff from writing down passwords.
  - Use IDs and passwords unique to each user.
  - Change passwords when requested by staff or if passwords are compromised.
  - Disable or remove passwords of employees who leave the organization and alert appropriate staff who oversee computer security.

Factor 3: Permissible use of data

- Care coordination and care management as outlined in the Department of Health and Human Services website (https://www.hhs.gov/hipaa/for-professionals/faq/3014/uses-and-disclosures-for-care-coordination-and-continuity-of-care/index.html).
- Identify and refer individuals to appropriate resources or interventions.
- Assess health care disparities.
- Update work plan activities.
- Inform the program's prioritized activities and goals.
- Design and direct outreach materials.

- Inform health care practitioners and providers about individuals' social risks and needs.

Factor 4: **Impermissible use of data**

- Perform underwriting, rate setting or benefit determinations.
- Disclose individuals' data to unauthorized users.

Element B: Data Sharing

The organization has a data sharing strategy that includes:

1. **A process for sharing individuals' demographic characteristics/identities and social needs data with established partners.**
2. **A process for sharing individuals' demographic characteristics/identities and social needs data with organizations with which the organization has no formal partnership agreement.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process

Scope of review *For All Surveys:* NCQA reviews the organization's policies and procedures in place throughout the look-back period for data sharing with established partners and with organizations with which it has no formal partnership agreement.

Look-back period *For All Surveys:* 6 months.

Explanation **Data sharing** is transmission of individual data from the organization to the end user, such as a provider, practitioner or community-based organization that assists in delivering services, programs or care.

Interoperability is the ability of two or more systems to exchange health information and use the information once it is received.[15]

Sharing information about health and social needs across organizations facilitates interoperability and multi-sector collaboration in mitigating social risks and addressing social needs. The organization's process for providing resources/ interventions should create a seamless experience for individuals it serves, and must protect data security, whether or not the organization has a contract or agreement with the organization that provides resources/interventions.

Factor 1: **Process for sharing data with established partners**

The organization describes its policies and procedures for sharing data with organizations it established contracts or agreements with in HE Plus 3, Element C. Policies and procedures specify the methods, systems or processes for sharing data.

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[15]https://www.healthit.gov/sites/default/files/factsheets/onc_interoperabilityfactsheet.pdf

Factor 2: **Process for sharing data with other organizations**

The organization describes its policies and procedures for sharing data upon request from organizations with which it does not have an established contract or agreement.

Policies and procedures describe:

- How the organization determines which data to share.
- How the organization verifies that the request falls within its security protocols.
- The methods, systems or processes the organization uses to share data.

Examples

Methods, systems or processes for sharing data may include, but are not limited to:

- Via secure electronic mail or other secure approach.
- Using a single EHR.
- Transmitting data through Health Level Seven (HL7) interfaces.
- Providing access to shared systems via a portal.
- Providing access to health or community information exchanges that let providers of health and social services view and collaborate on individuals' experience across systems, agencies, organizations and clinical or nonclinical sites.

Element C: Notification of Privacy, Security and Data Sharing Protections

At least annually, the organization communicates its policies and procedures for managing access to, use of and sharing of social needs data to the individuals it serves, including:

1. Controls for physical and electronic access to data.

2. Privacy and security protocols for sharing individual-level data.

3. Permissible use of data.

4. Impermissible use of data.

5. How individuals can expressly consent to data sharing.

Scoring

Met	Partially Met	Not Met
The organization meets 5 factors	No scoring option	The organization meets 0-3 factors

Data source   Materials, Reports

Scope of review   *For All Surveys:* NCQA reviews evidence of communications distributed to individuals during the look-back period for managing access to, use of and sharing of social needs data.

Look-back period   *For All Surveys:* At least once during the prior year.

Explanation   **Communications to individuals**

The organization communicates the information in factors 1–5 to the individuals it serves annually and at the time individuals' social needs data are collected or integrated from an external source. Communication may also be provided at additional times the organization deems appropriate. The communication states whether social needs data will be shared, and with whom (community-based organizations, organizational partners, practitioners, providers, other care delivery organizations).

Communicating this information helps individuals understand enough about what they can expect from the organization and its partners to be able to give express consent or authorization for data sharing. **Express consent** or authorization occurs when an individual makes a voluntary and informed decision to expressly allow their data to be shared and used.

Communicating the information to individuals may include, but is not limited to:

- Distributing written information.
- Telephone call.
- In-person contact.
- Online contact:
  - Secure email or portal.
  - Video conference.
  - Live chat.

Organizations should consider methods of communication that are appropriate for the individual. For example, distributing written information does not meet the intent for individuals who have visual disabilities or low literacy, or who do not have permanent housing.

Factors 1–4

The organization communicates its policies and procedures (HE Plus 4, Element A) to individuals.

Factor 5: How to expressly consent to sharing data

The information communicated to individuals outlines how individuals can give or revoke consent to sharing social needs data.

Examples   None.

HE Plus 5: Referrals, Outcomes and Impact

The organization refers individuals to social needs resources, closes the loop to track progress and evaluates the effectiveness of the referral process.

Intent

To ensure that its referral process meets individuals' needs, the organization tracks referral statuses, identifies disparities between subpopulations and collaborates with partners to evaluate the effectiveness of partnerships that provide social needs resources and interventions.

Element A: Facilitating Referrals

The organization has a process for referring individuals to social needs resources and interventions that includes:

1. **Confirming that the individual agrees the identified social need is a priority.**
2. **Obtaining the individual's consent to the referral.**
3. **Communicating the minimum expectations of the organization and its partners during the referral process.**
4. **Communicating the minimum expectations of the individual during the referral process.**

Scoring	Met	Partially Met	Not Met
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source   Documented process, Materials

Scope of review   *For All Surveys:*

- For factors 1–4, NCQA reviews the organization's documented process in place throughout the look-back period for referring individuals to community partners and distributing information to individuals.

- For factors 3 and 4, NCQA also reviews materials demonstrating that the organization distributed information to individuals within the look-back period.

Look-back period   *For All Surveys:* 6 months.

Explanation   The organization has a documented process for connecting individuals to social needs resources and interventions provided directly by the organization and its partners, in a manner that respects individuals' priorities and goals, autonomy and privacy. Respecting autonomy includes empowering individuals to have a central role in decision making during the referral process and acknowledging decisions that differ from the organization's recommendations, including the decision to not receive a referred resource or intervention.

Factors 1, 2

The organization's process describes:

- How the organization acts on social needs resources or interventions identified in HE Plus 2, Element C.

- That the organization confirms with the individual that identified needs reflect the individual's priorities.
- That the organization confirms that the individual consents to the referral to the resource or intervention.
- That if an individual does not agree that identified needs reflect their priorities, or does not consent to a referral, the organization collaborates with the individual to:
  - Identify priorities.
  - Identify the individual's reasons for not consenting to the resource or intervention.

  The organization documents its findings from collaboration with the individual, as applicable.

Factors 3, 4

Communicating expectations helps individuals understand what to expect from the organization and its partners, and their role in giving the organization enough information to ensure that the referral is effective.

The process for communicating expectations may include, but should not be limited to, distributing written information. Organizations should consider methods of communication that are appropriate for the individual. For example, distributing written information does not meet the intent for individuals who have visual disabilities or low literacy, or who do not have permanent housing.

For factor 3, minimum expectations include:
- Communicating how the individual's information is kept secure during the referral process.
- Communicating how the individual can communicate at any time that the resource or intervention addressed by the referral is not wanted, effective or appropriate.
- Tracking the individual's progress and completion of the referral.
- Ongoing collection of information.

For factor 4, minimum expectations include:
- Providing the organization and its partners with information necessary to carry out the referral.
- Notifying the organization and its partners, as applicable, if the individual no longer uses, wants or needs the resource or intervention provided by the referral.

Examples   None.

Element B: Tracking Referral Status

The organization collaborates with partner organizations to track the status of referrals.

	Met	Partially Met	Not Met
Scoring	The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source   Report

Scope of review   *For All Surveys:* NCQA reviews the organization's reports demonstrating tracking individuals' referral statuses within the look-back period.

Look-back period   *For All Surveys:* 6 months.

Explanation   The organization collaborates with its partners to track the status of individuals' referrals to social resources and interventions. At a minimum, tracking includes:

- Confirming the referral request was received.
- Confirming that the individual received/accessed the service.

The organization demonstrates tracking using the following methods:

- Reports from the partner organization, if it was involved in the referral.
- Reports from shared referral platforms or systems.

Examples   Examples of referral statuses may include, but are not limited to:

- Individual not yet contacted.
- Individual contacted.
- Resource/intervention/service scheduled.
- Resource/intervention/service attended, received or accessed.
- Referral issued but resource/intervention/service has not been scheduled, attended, received or accessed.
- Referral issued but no resource/intervention/service available.

Element C: Assessing Referral Status for Disparities

The organization annually analyzes referral statuses tracked in HE Plus 5, Element B to identify if disparities exist by:
1. **Race/ethnicity.**
2. **Preferred language.**
3. **Gender identity and/or sexual orientation.**

	Met	Partially Met	Not Met
Scoring	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source   Reports

Scope of review   *For All Surveys:* NCQA reviews the organization's most recent measurement reports.

Look-back period   *For All Surveys:* At least once during the prior year.

Explanation   *Factors 1, 2, 3*

The organization stratifies the referral status data from HE Plus 5, Element B by race/ethnicity and language, as well as gender identity and/or sexual orientation, to assess if there are disparities in accessing or receiving referred resources and interventions.

Having information on disparities by characteristics and identities such as race/ethnicity, language, gender identity and sexual orientation is an important step to identifying opportunities for improving the referral process, delivery of resources and interventions and how the organization communicates with the individuals it serves. Organizations may need to adjust their approach to the referral process or communication to better meet the needs of and build trust with subpopulations of individuals in the population it serves.

Examples   None.

Element D: Bidirectional Partnership Evaluation

The organization and its partners collaborate annually to evaluate the effectiveness of the partnership based on:

1. **The overall experience of individuals in the population it serves when accessing/receiving resources and interventions.**
2. **The experience of individuals in the population it serves with discrimination or bias when accessing/receiving resources and interventions.**
3. **The status of referrals, as tracked in HE Plus 5, Element B.**
4. **Disparities in referral status, as analyzed in HE Plus 5, Element C.**
5. **Bidirectional feedback on the partnership process.**

Scoring

Met	Partially Met	Not Met
The organization meets 3-5 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source   Reports

Scope of review   *For All Surveys:* NCQA reviews up to four randomly selected annual partnership evaluation reports completed during the look-back period, or reviews all annual partnership evaluation reports if the organization has fewer than four.

Each report summarizes the results for each evaluation performed in factors 1–5.

Look-back period   *For All Surveys:* At least once during the prior year.

Explanation   The organization annually collaborates with its partners, including partners with which it does not have a contract or agreement, to evaluate the experience of individuals they mutually serve and the partnership process.

Evaluation of the partnership is bidirectional and supports joint quality improvement objectives, allowing partner organizations to identify opportunities to streamline processes and improve effectiveness in addressing the needs of individuals.

Evaluation should allow all partners to identify how effectively the partnership supports individuals who access or receive resources and interventions, and to make improvements as needed.

For partners with which the organization has a contract or agreement, as detailed in HE Plus 3, Element B, the evaluation aligns with the process outlined in the contract or agreement.

For partners with which the organization does not have a contract or agreement, as outlined in HE Plus 3, Element B, and that decline to participate in a bidirectional evaluation, the organization completes the evaluation for factors 1–4 without the partner's feedback.

Factors 1, 2

The organization and its partners survey the entire population of individuals referred through the partnership, or a statistically valid sample of individuals referred to resources or interventions by the organization or its partners, about their experiences accessing or receiving resources or interventions, overall and with respect to discrimination or bias with either the organization or its partners. The organization uses the survey to evaluate the effectiveness of the partnership.

If the organization surveys a sample, it describes the sample universe and the methodology. The sampling methodology should be designed to ensure a representative sample across race, ethnicity, language, gender identity and sexual orientation.

Factor 3: Status of referrals

The organization and its partners use the referral statuses tracked in HE 5 Plus, Element B to evaluate whether the partnership is effective in connecting individuals with referred resources or interventions. The organization and partners agree on the standard they use to measure the effectiveness of the referral process.

Factor 4: Disparities in referral status

The organization and its partners use the results of the organization's analysis in HE 5 Plus, Element C to evaluate the partnership's effectiveness.

Factor 5: Bidirectional feedback on the partnership process

The organization and its partners use bidirectional feedback (e.g., perceived burden of and experience with referrals, data sharing, organization staff and systems) during the look-back period to evaluate the partnership's effectiveness.

Examples

Factors 1, 2

Survey questions about individual experience may include:
- Did you have any issues accessing the service or intervention?
- Did you receive enough information about the service or intervention?
- Did you have to wait to access the service or intervention?
- Would you recommend the service or intervention?
- Did you experience discrimination or racism when you accessed the service or intervention?