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HE 1: Organizational Readiness

The organization is committed to health equity by building a diverse and inclusive staff.

Intent

The organization supports health equity goals and takes actions toward reducing bias and improving diversity, equity and inclusion.

Element A: Building a Diverse Staff

The organization:

1. Has recruiting, ~~and hiring and retention~~ processes that support diversity in the workforce, including staff, leadership, committees and governance bodies.
2. Identifies at least one opportunity to improve diversity, equity, inclusion or cultural humility for staff, leadership, committees and governance bodies.
3. Acts on at least one of the opportunities identified in factor 2 for staff, leadership, committees or governance bodies.

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

Data source Documented process, Reports, Materials

Scope of review *For All Surveys:*

- *For factor 1:* NCQA reviews the organization's ~~policies and procedures~~ documented process for recruiting, ~~and hiring and retention.~~
- *For factors 2 and 3:* NCQA reviews materials or reports as evidence that the organization identified and acted on at least one opportunity to improve diversity, equity, inclusion or cultural humility.
- *For factor 3:* The organization may submit a plan for identifying and acting on an opportunity to improve diversity, equity, inclusion or cultural humility. ~~to meet factor 3.~~

Look-back period *For All Surveys:* Prior to the survey date.

Explanation This element may not be delegated, with the exception of factor 2.

Diversity in recruiting and hiring describes the presence of differences (e.g., race/ethnicity, preferred language, gender identity, sexual orientation, age, mobility) in the pool of candidates for employment opportunities.

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.

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 how groups show 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.

Factor 1: Recruiting, ~~and~~ hiring and retention processes that support diversity

The organization has ~~hiring and~~ recruitment, hiring and retention practices for internal and external positions—including promotions and reclassifications, temporary and permanent positions—that promote diversity by considering which groups might be in the minority or are inadequately represented in the organization’s workforce at all position levels, including staff, leadership, committees and governance bodies.

The organization describes how its ~~hiring and~~ recruitment, hiring and retention practices consider whether particular groups are marginalized, disenfranchised or disempowered by the organization’s recruitment, ~~and~~ hiring and retention practices for each position level.

Note: This factor is specific to the organization’s recruiting, ~~and~~ hiring and retention processes and does not apply to practitioner network management.

Factor 2: Identifies at least one opportunity

The organization identifies at least one opportunity to improve diversity, equity, inclusion or cultural humility for each of the following:

- Staff.
- Leadership (individuals with managerial authority and executive roles such as managers, directors, vice presidents or chief officers).
- Governance bodies, including the organization’s board of directors.
- Committees.

One opportunity may be used for more than one ~~of the above groups~~ group listed, if appropriate.

Factor 3: Acts on at least one opportunity

The organization acts on at least one of the opportunities that were identified in factor 2 to improve diversity, equity, inclusion and cultural humility for staff, leadership, committees or governance bodies.

Providing employee training does not meet the intent of this factor.

Exceptions

None.

Examples

Factor 1: Recruiting, ~~and~~ hiring and retention practices that support diversity

Recruiting:

- Create inclusive job descriptions that:
 - Use gender neutral language.

- Reduce requirements to “must-haves.”
- Indicate a salary range.
- Emphasize the organization’s commitment to diversity and inclusion.
- Dedicate resources to recruiting underrepresented groups such as individuals with disabilities.
- ~~Deploy~~ Employ technology that screens for biased languages in job descriptions and postings.
- Broaden recruitment sources; for example:
 - Schools with diverse student bodies or alumni networks.
 - National or local associations or groups that advocate for specific marginalized, disenfranchised or disempowered groups the organization seeks to recruit.
 - Recruitment firms that specialize in job placement for diverse groups of executives.

Hiring:

- Use blind-review resumes.
- Hold hiring decision makers responsible for representation growth on teams and in the organization.
- Require interview panels to include interviewers from underrepresented populations, gender identities or diverse position levels.
- Have documented interview-scoring practices and questions to remove subjectivity or bias in hiring decisions.
- Base the salaries offered to internal and external candidates on factors that support salary equity for traditionally marginalized, disenfranchised or disempowered groups, such as:
 - Salaries for similar positions at other organizations.
 - Salaries for the same position level and experience within the organization.

Retention:

- Evaluate the diversity of staff who are:
 - Given opportunities to travel, learn or network.
 - Promoted or receive performance-based incentives/rewards.
 - Made visible externally for performing important work.

Factor 2: Identification of opportunities

- Regularly gather (through surveys or other engagement activities) and report on staff feedback on and satisfaction with the organization’s promotion of diversity, equity, inclusion and cultural humility.
- Compare the diversity of the organization’s workforce with groups or subgroups of the community or population that the organization serves (e.g., racial/ethnic, preferred language, gender identity, sexual orientation) and to the available pool of candidates in the labor market where the organization operates.

Factor 3: Act on opportunities

- Build diversity, equity, inclusion and cultural humility performance metrics into all management and leadership job descriptions and goals.
- Suggest staff share pronouns in introductions or email signatures.
- Design work spaces to better accommodate staff of differing mobility.

- Host, offer or promote events (e.g., webinars, speaker series, brown bag sessions) that foster diversity, equity, inclusion and cultural humility and highlight traditionally marginalized groups.
- Create temporary or permanent positions, departments, councils or committees focused on highlighting underrepresented groups.

Element B: Promoting Diversity, Equity and Inclusion Among Staff

At least annually, the organization:

1. Provides at least one training to all employees on culturally and linguistically appropriate practices, reducing bias or promoting inclusion.
2. Reports on the number or percentage of employees who have completed training.

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

Data source Reports, Materials

Scope of review *For All Surveys:* For factor 1, NCQA reviews materials or reports for evidence that the organization offers trainings to its employees at least annually. For factor 2, NCQA reviews reports demonstrating annual completion of training.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation This element is a structural requirement. The organization must present its own documentation.

Culturally and linguistically appropriate practices seek to advance health equity, improve the quality of health care and reduce health care disparities inequities by assessing, respecting and responding to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services.

Bias describes the positive or negative associations, attitudes, preferences or stereotypes that influence behavior and decisions. Bias may be implicit (unconscious) or explicit (conscious) and requires awareness, acknowledgement, and conscious effort to overcome. ^{[1][2]}

Factor 1: Provides trainings

At least annually, the organization provides one or more trainings to all employees, regardless of position level, on culturally and linguistically appropriate practices, reducing bias or promoting inclusion. The organization determines training type and timing.

Factor 2: Reports on completion of training

The organization generates a report on the number of employees who completed training in a calendar year as a total overall number or percentage of total employees. The organization is not scored on rate of completion.

Exceptions

None.

[¹] <http://kirwaninstitute.osu.edu/wp-content/uploads/2018/04/Combating-Implicit-Bias-in-the-workplace.pdf>

[²] https://www.rbc.com/diversity-inclusion/_assets-custom/includes/pdf/Outsmarting_our_brains_Overcoming_hidden_biases.pdf

Examples

Factor 1: Offers at least one training to all employees

- An email from Human Resources to all employees describing available trainings on culturally and linguistically appropriate practices, reducing bias or improving inclusion.
- Screenshots of a training module in the organization’s learning management or training system.

Factor 2: Reports on completion of training

- A roster of all employees and their completion status for all offered trainings.

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

The organization gathers individuals' race/ethnicity, language, gender identity and sexual orientation data using standardized methods.

Intent

The organization collects information that helps it provide culturally and linguistically appropriate services (CLAS).

Element A: Systems for Individual-Level Data

The organization's electronic data system is able to receive, store and retrieve individual-level data on:

1. Race/ethnicity.
2. Language.
3. Gender identity.
4. Sexual orientation.

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, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period and reviews materials (e.g., screenshots) or reports for evidence that the organization follows its documented process.

NCQA also reviews materials (e.g. screenshots) or reports for evidence of the electronic data system's configuration.

For all Initial Surveys scheduled on or between July 1, 2022, and June 30, 2024 June 30, 2023, the organization may submit a detailed implementation plan that includes a timeline as evidence for factors 3 and 4, instead of submitting reports or materials.

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

Explanation This element may not be delegated.

Factors 1–4: Receiving, storing and retrieving data

The organization has a documented process for outlining its data source(s) and maintaining electronic database(s) that receive, store and retrieve the data in factors 1–4. For each factor, the organization collects data at the individual level through direct or indirect data collection as specified in HE 2, Elements B–E. The organization's documented process outlines how its database receives, stores and retrieves responses for factors 1–4 when an individual responds that they choose not to disclose the data.

If the organization receives data from multiple sources, it has a process for reconciling differences or conflicts between data (i.e., how the organization decides which data source to select or prioritize when two or more data sources contain conflicting information).

The organization provides evidence that it follows its documented process for each data type in factors 1–4.

Gender identity is defined as an individual’s innermost concept of self and experience of gender (how individuals perceive themselves and what they call themselves). An individual’s gender identity may be the same or different from the sex assigned at birth.

Sexual orientation, which is separate from gender identity, is defined as an inherent or immutable and enduring emotional, romantic or sexual attraction or nonattraction to individuals of the same and/or other genders.

For all Initial Surveys scheduled on or between July 1, 2022, and ~~June 30, 2023~~ June 30, 2024, if the organization completes an implementation plan in place of reports or materials for evidence of factors 3 and 4, the plan must include:

- A detailed description of the actions the organization will take to update its electronic data systems to receive, store and retrieve gender identity and sexual orientation data, including an outline of each electronic data system that is required to be updated.
 - If the organization plans to use data from other sources, it lists the entities that will provide data and a description of the data exchange method.
- A timeline for implementation of electronic data system functionality to receive, store and retrieve gender identity and sexual orientation data.

Exceptions

None.

Related Information

Use of vendors/electronic data systems. If the organization contracts with an external entity to house the data in factors 1–4, it provides access to the external entity’s documentation for evaluation. NCQA does not consider the relationship to be delegation, and delegation oversight under HE 7: *Delegation* is not required. Refer to “Vendors” in *Appendix 2: Automatic Credit*.

Examples

Reconciling, selecting or prioritizing data

- *Granular vs. high-level collection categories.* A practitioner collects data directly from an individual that identifies their ethnicity as Mexican/Mexican American/Chicano. Data received from the individual’s health plan indicates the member’s ethnicity as Hispanic or Latino, a less-detailed classification of race/ethnicity. The organization outlines its processes for prioritizing data from sources that use different levels of granularity.
- *Number of responses collected.* An individual’s health plan enrollment form lists the individual as Black/African American. The individual’s practitioner lists the individual as both Asian American and Black/African American. The organization has a process for selecting the most accurate data to classify race of the population it serves.
- *Conflicting responses.* An individual provides information to a care manager from their health plan’s disease management program that they are Black/African American. The individual’s race on file with the health plan is Hispanic. The organization outlines how it directly verifies the accuracy of its data when conflicting information is discovered.

Element B: Collection of Data on Race/Ethnicity

The organization's methods for assessing race/ethnicity of individuals includes:

1. Direct collection of data from all individuals.
2. Estimation of race/ethnicity using indirect methods, if the organization has direct data on less than 80% of individuals.
3. Validation of estimation methodology, if indirect methods are used.
4. A process for rolling up race/ethnicity data to Office of Management and Budget (OMB) categories.
5. Reporting HEDIS *Race/Ethnicity Diversity of Membership* measure, if applicable.

Scoring	Met	Partially Met	Not Met
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source Documented process, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period for assessing the race/ethnicity of individuals, and reviews reports or materials demonstrating the data collection.

For Initial Surveys: For factor 5, NCQA also reviews audited HEDIS reports from the most recent HEDIS reporting year.

For Renewal Surveys: For factor 5, NCQA also reviews audited HEDIS reports from the most recent and the prior HEDIS reporting year.

Look-back period *For Initial Surveys:* 6 months.
For Renewal Surveys: 24 months.

Explanation Though it is voluntary for individuals to report race/ethnicity, the organization must attempt to collect it. The organization may collect data directly at various points of interaction with individuals and through multiple mechanisms. The organization should use as many channels as available to collect race/ethnicity information from individuals. If underwriting is involved, it may determine the appropriate timing of collection, to avoid concerns about discrimination.

Factor 1: Direct data collection method and OMB categories

The organization has a documented process (e.g., data collection scripts) for collecting data and demonstrates data collection through materials or reports.

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 or health assessments). A direct data collection framework must include, at a minimum:

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

The organization may use data collected from third-party sources, such as the Centers for Medicare & Medicaid Services (CMS), state or local agencies, community-based organizations, electronic health records (EHR), health information exchanges (HIE) and case management systems, that have made a direct request for race/ethnicity information from individuals that can be rolled up to the OMB categories. If the individual is unable to provide a response to a direct request (due to age or functional inability to communicate), data collected from the individual's caregiver is considered direct data collection.

The organization's direct data collection framework for race/ethnicity must also include use of, or the ability to roll up to, OMB race/ethnicity categories. The organization's data collection framework may include the use of race/ethnicity categories that are more detailed and/or granular than the OMB race/ethnicity categories, as long as the organization has the ability to roll up to OMB race/ethnicity categories.

OMB categories. In 1977, the OMB issued the Race and Ethnic Standards for Federal Statistics and Administrative Reporting that are set forth in Statistical Policy Directive No. 15. The federal government uses these standards for recordkeeping, collection and presentation of data on race and Hispanic origin, and they form the basis for race/ethnicity data collection for many health care organizations. They have been used in two decennial censuses and in surveys of the population; in data collections to meet statutory requirements for civil rights monitoring and enforcement; and in other administrative program reporting.

In 2009, under a contract with the Agency for Health Care Quality and Research (AHRQ), the Institute of Medicine (IOM) formed the Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement to identify models for collecting and coding race, ethnicity and language data and to make recommendations for improvement. The subcommittee recommended the use of OMB race/ethnicity categories for health care reporting.

The organization must be able to report race/ethnicity using the OMB categories, including the response option of "Other." While the OMB recommends a two-question format, asking for ethnicity before race, the organization may also use a combined format. In both cases, the IOM recommends that respondents be instructed to select one or more categories that may apply (Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement <http://www.nap.edu/catalog/12696.html>.) If the organization uses more detailed subcategories of race/ethnicity, it must have a consistent process to aggregate responses into the OMB categories.

OMB two-question format

- Ethnicity
 - Hispanic or Latino
 - Not Hispanic or Latino
 - (Declined)
- Race (select one or more)
 - Black or African American
 - Native Hawaiian or Other Pacific Islander
 - White
 - Asian
 - American Indian or Alaska Native
 - Some other race
 - (Declined)

- OMB combined format (check all that apply)
 - American Indian or Alaska Native
 - Asian
 - Black or African American
 - Hispanic or Latino
 - Native Hawaiian or Other Pacific Islander
 - White
 - Other, please specify: _____
 - (Declined)

Organizations may use another method to ask these questions if responses can be systematically aggregated to OMB categories.

Factor 2: Estimation of race/ethnicity

The organization has a documented process for how it estimates race/ethnicity using indirect methods.

Asking all individuals to self-identify race/ethnicity may yield initial results from only a small percentage of individuals, and even when a large percentage responds, there is no way to know if the results represent the population served. Thus, it may be necessary to estimate the race/ethnicity of the population of individuals for use in planning and evaluation. Some commonly used estimation methods are **geocoding** (using an individual's home address and alternate, nationally representative data sources such as the American Community survey to infer other information, including race/ethnicity) and **surname analysis** (using an individual's last name to infer other information, including race/ethnicity).

When applying indirect methods that involve assignment of race or ethnicity based on geographic data and member's location of residence, the smallest geographic unit possible is preferred. For example, geographic assignment at the census block level is likely to be more accurate than assignment using census tract or ZIP code-level data.

Geocoding and surname analysis methods are more accurate when used together, although accuracy varies by geographic region, area demographics and race/ethnic group. NCQA does not prescribe a specific method.

Factor 3: Validation of estimation method

The organization has a documented process for validating its estimation method.

Indirect data sources and estimation methods should be evaluated for reliability and validity, and selection of a source and method should be prioritized based on demonstrated validity and reliability for the population to which it will be applied (e.g., age group, geography, product line).

The organization assesses the accuracy of the selected estimation method (e.g., calculates the sensitivity, specificity and positive predictive value of estimated race/ethnicity results, compared with self-reported data for a sample of individuals). The organization may refer to studies that report on the accuracy of estimates for the population in the relevant service area.

Factor 4: Roll up race/ethnicity data to OMB categories

The organization has a documented process for rolling up race/ethnicity data to OMB categories. The IOM recommends collecting detailed ethnicity data appropriate to the demographics of the local service area.

Factor 5: Reporting the HEDIS Diversity of Membership measure

Factor 5 may not be delegated.

The organization submits audited HEDIS data and reports to demonstrate reporting the HEDIS *Race/Ethnicity Diversity of Membership* measure. HEDIS and CAHPS results must be collected and reported separately for populations covered by commercial, Medicaid and Medicare product lines.

Exceptions

Factors 2 and 3 are NA if the organization has direct data on the race/ethnicity of 80% or more of its individuals. Individuals enrolled through Administrative Services Only (ASO) accounts, where the purchaser prohibits direct contact from the organization, are not included in this requirement.

Factor 5 is NA for:

- Organizations that are not health plans.
- The Exchange product line.

Examples**Factor 1: Direct data collection mechanisms and OMB categories**

- Enrollment forms, when not prohibited by state law.
- The organization's website.
- Surveys.
- Calls to Member Services.
- Disease management intake or programs involving enrollment or registration.
- Health assessments.
- Data feeds from a state Medicaid agency that directly collects race/ethnicity data that can be incorporated into OMB categories.

HRET Toolkit.^[3] The Health Research and Educational Trust (HRET) Toolkit, endorsed by the National Quality Forum (NQF), provides detailed instructions for direct data collection of race/ethnicity data and may serve as a guide for asking about race/ethnicity. The toolkit uses the OMB categories with additional options, including "Declined" and "Multiracial." Although NCQA does not currently require organizations to follow IOM data collection recommendations, organizations are advised to add a response option for "Other (specify)" and to replace the "multiracial" response option with "Select all that apply."

USCDI.^[4] The United States Core Data for Interoperability version 2 (USCDI v2), released by the U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology (ONC), is a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange. NCQA does not currently require organizations to follow the USCDI data collection categories, which are more granular than OMB categories.

Third-party sources of direct data

- Employers.
- State Medicaid agencies.
- State or federal agencies (e.g., CMS).
- Health care providers.
- Health care practitioners.

^[3] hretdisparities.org^[4] <https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v2>

Element C: Collection of Data on Language

The organization's methods for assessing the language needs of individuals include:

1. Direct collection of language needs from all individuals.
2. Assessment of the population's language profile at least every 3 years.
3. Determination of threshold languages.
4. Determination of languages spoken by at least 1% of the population or 200 individuals, whichever is less.
5. Reporting the HEDIS *Language Diversity of Membership* measure, if applicable.

Scoring	Met	Partially Met	Not Met
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source Documented process, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews the organization's documented process for assessing the language needs of individuals that was in place throughout the look-back period.

NCQA also reviews reports or materials demonstrating data collection and assessment of the population's languages, including threshold languages and languages spoken by 1% (or 200) of individuals.

For Initial Surveys: For factor 5, NCQA also reviews audited HEDIS report from the most recent HEDIS reporting year.

For Renewal Surveys: For factor 5, NCQA also reviews audited HEDIS report from the most recent and the prior HEDIS reporting year.

Look-back period *For Initial Surveys:* 6 months.
For Renewal Surveys: 24 months.

Explanation Though it is voluntary for individuals to report language needs, the organization must attempt to collect it. The organization may collect data directly at various points of interaction with individuals and through multiple mechanisms. The organization should use as many channels as available to collect language need information from individuals. If underwriting is involved, it may determine the timing of collection, to avoid concerns about discrimination.

Factor 1: Direct data collection method

The organization has a documented process for collecting data and demonstrates data collection through materials or reports.

The organization's data collection framework must include, at a minimum:

- When data will be collected.
- Where data will be collected (setting).

- How and by whom data will be collected.
- What questions will be used to collect data.
- A planned process for asking individuals for information, including a script for staff who collect data verbally, when applicable.

The organization may use data collected from third-party sources, such as CMS, state or local agencies, community-based organizations, EHRs, HIEs and case management systems that have made a direct request for language needs information from individuals. If the individual is unable to provide a response to a direct request (due to age or functional inability to communicate), data collected from the individual's caregiver is considered direct data collection.

The organization may use the IOM recommendation to evaluate language needs or may use another method of asking about language preference if it describes the process. The IOM recommends the use of two questions to determine language needs:

- *Spoken English Language Proficiency (Very well, Well, Not well, Not at all)*, with limited English proficiency (LEP) defined as “Less than very well.”
- *Spoken Language Preferred for Health Care*, using locally relevant choices from a national standard list, plus a response option for “Other, please specify,” and including American Sign Language (ASL) in the spoken language need list.

The IOM also recommends collecting preferred language for written materials, where possible, and including Braille when written language is elicited.

The organization may use language needs information obtained directly from individuals to enable communication in the requested language (e.g., written information in a language other than English). The organization may also share language needs information with practitioners and providers, enabling them to provide language services more effectively. The organization must also disclose to individuals the possibly of the information being shared.

Factor 2: Assessing the population's language profile

At least every 3 years, the organization uses state-level census or community-level data to determine the languages spoken in its service area, and assesses and reports on the language profile of the community, in order to anticipate and plan for changes in the language services it provides. National organizations that do not operate in defined service areas may use national census data to determine the population language profile. The organization may use language need information about the community to plan for and improve its language services capabilities. Changing demographics may be more apparent at the community level than among the organization's membership, and thus, language data on the service area could provide early notice to an organization that it will need to produce translations in new languages or make interpreters available for emerging language areas.

Factor 3: Threshold languages

At least every 3 years, the organization uses census or community-level data to determine and report threshold languages for translation purposes. **Threshold languages** are all languages other than English spoken by 5% of the population or by 1,000 individuals (assuming the same distribution of languages among individuals as found in the service area), whichever is less. The organization maintains a list of all threshold languages and updates the list at least every 3 years.

Factor 4: Determining languages spoken

The organization uses census or community-level data to determine and report the languages spoken by 1% of the population or 200 individuals (assuming the same distribution of languages among individuals as found in the service area), whichever is less, up to a maximum of 15 languages.

Notification about the availability of language services must be provided in threshold languages and in languages that serve at least 1% of the population or 200 individuals. Refer to Element D of HE 3: Access and Availability of Language Services. The organization maintains a list of all languages spoken and updates the list at least every 3 years.

Factor 5: Reporting the HEDIS Diversity of Membership measure

Factor 5 may not be delegated.

The organization submits audited HEDIS data and reports to demonstrate reporting the HEDIS *Language Diversity of Membership* measure. HEDIS and CAHPS results must be collected and reported separately for populations covered by commercial insurance, Medicaid and Medicare.

Exceptions

Factor 5 is NA for:

- Organizations that are not health plans.
- The Exchange product line.

Examples**Direct data collection mechanisms**

- Enrollment form.
- The organization's website.
- Surveys.
- Calls to Member Services.
- Disease management intake.
- Other programs involving enrollment or registration.
- Data collection scripts.

Third-party sources of direct data

- Employers.
- State Medicaid agencies.
- Health care providers.
- Health care practitioners.

Framework for asking about language

- The HRET Toolkit provides detailed instructions for direct collection of language data.

Sources of population language information

- U.S. Census data.
- Community surveys.
- School data on languages spoken by students.
- The Modern Language Association Language Map (http://www.mla.org/map_main).

Element D: Collection of Data on Gender Identity

The organization's framework for collecting gender identity of all individuals includes:

1. A method for collecting data that does not stigmatize individuals who do not identify as male or female. *
2. Direct collection of sex assigned at birth.
3. Direct collection of gender identity.
4. Direct collection of pronouns.
5. Sharing pronoun information with patient or member-facing staff.

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

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

Data source Documented process, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period that outlines its methodology that does not stigmatize individuals and its process for collecting data on individuals' sex assigned at birth, gender identity and pronouns.

NCQA reviews reports or materials for evidence that the organization's data collection methods follow its documented process.

For all Initial Surveys scheduled on or between July 1, 2022, and June 30, 2024 ~~June 30, 2023~~, the organization may submit a detailed implementation plan including a timeline and risk mitigation strategy in place of reports or materials.

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

Explanation Factor 1 is a critical factor and must be scored "yes" for the organization to score at least "Partially Met" on this element.

Though it is voluntary for individuals to report gender identity, the organization must attempt to collect it. The organization may collect data directly at various points of interaction with individuals and through multiple mechanisms. The organization should use as many channels as available to collect this information from individuals. If underwriting is involved, it may determine the appropriate timing of collection, to avoid concerns about discrimination.

For factors 2–4, the organization describes its framework for, at a minimum, collecting direct data from adults 18 and older. If the organization collects data described in factors 2–4 from individuals younger than 18, it describes any differences between its data collection framework for these individuals and its framework for adults. The direct data collection framework must include, at a minimum:

- When data will be collected.
- Where data will be collected (setting).
- How and by whom data will be collected.

- What questions will be used to collect data.
- A planned process for asking individuals for information, including a script to guide staff who collect data verbally, when applicable.

The data collection framework should be designed to fit the population served by the organization, and may include response options that are more detailed or granular than and/or synonymous to the minimum response options listed in factors 2–4 if the organization’s documented process outlines how it rolls up to the minimum response option categories.

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 information regarding sex assigned at birth, gender identity and pronouns.

For all Initial Surveys scheduled on or between July 1, 2022, and ~~June 30, 2023~~ June 30, 2024, if the organization completes an implementation plan in place of reports or materials, the plan must include:

- A detailed description of the actions the organization will take to directly collect gender identity data, as outlined in factors 1–4, or receive gender identity data from other sources.
 - If the organization plans to use data from other sources, it lists the entities from which data will be received and a description of the data exchange method.
- A timeline for implementation of data collection activities.
- A documented strategy for mitigating risk that may result from using internal data that does not yet fully reflect the individual’s gender identity (e.g., the organization refers the individual to a community resource whose goals may be misaligned with the needs and identity of the individual).

Factor 1: Collecting data through methods that do not stigmatize individuals

The organization has a documented process that describes how the data collection method respects the responding individual and reduces the potential for stigmatization (e.g., designing respectful screening questions, training staff on how to respectfully collect data).

At a minimum, the data collection method must include:

- Nonbinary gender identity options.
- An explanation to staff about offering members nonbinary options.

Factor 2: Direct collection of sex assigned at birth

The organization demonstrates data collection through materials or reports. The data collection methodology includes^[5]:

- The following response options:
 - Male.
 - Female.
 - Unknown.
 - Choose not to disclose.
- The ability to record when a response was requested but the individual has not yet provided a response (i.e., the information is unavailable), distinct from receiving one of the response options “Unknown” (i.e., the individual does

not know) or “Choose not to disclose” (i.e., the individual declines to share the information).

- A defined process for soliciting information from individuals in the instance that a response was requested but not provided.

Factor 3: Direct collection of gender identity

The organization demonstrates data collection through materials or reports. The data collection methodology includes:^[6]

- The following response options, at a minimum:
 - Male.
 - Female.
 - Transgender male/trans man/female-to-male (FTM).
 - Transgender female/trans woman/male-to-female (MTF).
 - Genderqueer, neither exclusively male nor female.
 - Additional gender category or other, please specify.
 - Choose not to disclose.
 - Additional options, as the organization deems appropriate.
- The ability to record when a response was requested but the individual has not yet provided a response (i.e., the information is unavailable), distinct from receiving the response option “Choose not to disclose” (i.e., the individual declines to share the information).
- A defined process for soliciting information from individuals in the instance that a response was requested but not provided.

~~The CDC^[7] has guidance on collecting sexual orientation and gender identity and the National Institute of Health: Sexual And Gender Minority Research Office^[8] offer guidance and research studies about surveying and collecting highlights multiple research studies on survey questions on the collection of sexual orientation and gender identity information. This guidance can assist organizations in designing their direct data collection.~~

Factor 4: Direct collection of pronouns

The organization demonstrates data collection through materials or reports.

The organization’s data collection methodology includes:

- An option to choose not to disclose.
- The ability to record when a response was requested but the individual has not yet provided a response (i.e., the information is unavailable), distinct from receiving the response option “Choose not to disclose.”
- A defined process for soliciting information from individuals in the instance that a response was requested but not provided.

Factor 5: Sharing pronoun information

The organization has a defined process for making pronoun information available to member-facing staff in a way that makes respecting, sharing and educating about personal pronouns commonplace.^[9]

Exceptions

None.

Related information

Designing direct data collection. The Office of the National Coordinator for Health Information Technology (ONC)¹ has guidance on vocabulary and terminology used across data standards and specifications. This guidance may assist organizations in making decisions about which response options to offer, either in lieu of or in addition to the minimum response options required in factor 3.

The CDC^[7] guidance on collecting sexual orientation and gender identity and the National Institute of Health: Sexual And Gender Minority Research Office^[8] offer research on surveying and collecting, and highlight multiple studies on survey questions about collecting information on sexual orientation and gender identity.

^[5]<https://www.healthit.gov/isa/taxonomy/term/731/uscdi-v2>

^[6]<https://www.healthit.gov/isa/taxonomy/term/2736/uscdi-v2>

^[7]<https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html>

^[8]<https://dpcpsi.nih.gov/sgmro/measurement/questions>

^[9]<https://www.hrc.org/>

Examples **Factor 4: Direct collection of pronouns**

- What are your pronouns?
 - He/him; she/her; they/them; other (please specify).

Element E: Collection of Data on Sexual Orientation

The organization’s framework for collecting sexual orientation information of individuals includes:

1. A method for collecting data that does not stigmatize individuals.*
2. Direct collection of data.

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

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

Data source Documented process, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews the organization’s documented process in place throughout the look-back period that outlines its methodology for collecting data on individuals’ sexual orientation and reviews reports or materials for evidence that the organization follows its documented process.

For all Initial Surveys scheduled on or between July 1, 2022, and June 30, 2024 June 30, 2023, the organization may submit a detailed implementation plan including a timeline and risk mitigation strategy in place of reports or materials.

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

¹ <https://www.healthit.gov/isa/section-i-vocabularycode-setterminology-standards-and-implementation-specifications>

Explanation Factor 1 is a critical factor and must be scored “yes” for the organization to score at least “Partially Met” on this element.

Though it is voluntary for individuals to report sexual orientation, the organization must attempt to collect it. The organization may collect data directly at various points of interaction with individuals and through multiple mechanisms. The organization should use as many channels as available to collect this information from individuals. If underwriting is involved, it may determine the appropriate timing of collection, to avoid concerns about discrimination.

For factor 2, the organization describes its framework for, at a minimum, collecting direct data from adults 18 and older. If the organization collects the data described in factor 2 from individuals younger than 18, it describes differences between the data collection framework for these individuals and the framework for adults.

The direct data collection framework must include, at a minimum,

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

The data collection framework should be designed to fit the population served by the organization, and may include response options that are more detailed or granular than and/or synonymous to the minimum response options listed in factors 2–4 if the organization’s documented process outlines how it rolls up to the minimum response option categories.

The organization should seek to design a data collection framework that best fits the population it serves, which may include the use of response options more detailed or granular than and/or synonymous to the minimum response options listed in factor 2 as long as the organization’s documented process outlines how it rolls up to the minimum response option categories.

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 information regarding sexual orientation.

For ~~all~~ Initial Surveys scheduled on or between July 1, 2022, and June 30, 2024 ~~June 30, 2023~~, if the organization completes an implementation plan in place of reports or materials, the plan must include:

- A detailed description of the actions the organization will take to directly collect sexual orientation data, as outlined in factors 1 and 2, or receive sexual orientation data from other sources.
 - If the organization plans to use data from other sources, it lists the entities from which data will be received and a description of the data exchange method.
- A timeline for implementation of data collection activities.
- A documented strategy for mitigating risk that may result from using internal data that does not yet fully reflect the individual’s sexual orientation (e.g., the organization refers the individual to a community resource whose goals may be misaligned with the needs and identity of the individual).

Factor 1: Collecting data through methods that do not stigmatize individuals

The organization has a documented process that describes how the data collection method respects the responding individual and reduces the potential for stigmatization (e.g., through electronic screeners, providing information on use of data, training staff).

Factor 2: Direct data collection

The organization demonstrates data collection through materials or reports. The data collection methodology includes:

- The following response options, at a minimum^[10]:
 - Lesbian or gay or homosexual.
 - Straight or heterosexual.
 - Bisexual.
 - Something else, please describe.
 - Don't know.
 - Choose not to disclose.
- Additional options, as the organization deems appropriate.
- The ability to record when a response was requested but the individual has not yet provided a response (i.e., the information is unavailable), distinct from receiving one of the response options "Don't know" (i.e., the individual does not know) or "Choose not to disclose" (i.e., the individual declines to share the information).
- A defined process for soliciting information from individuals in the instance that a response was requested but not provided.

~~The CDC^[11] and the National Institute of Health^[12] offer guidance and research studies about surveying and collecting sexual orientation and gender identity information.~~

Exceptions

None.

^[10] [healthit.gov/isa/taxonomy/term/2741/uscdi-v2](https://www.healthit.gov/isa/taxonomy/term/2741/uscdi-v2)

^[11] [cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html](https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html)

^[12] <https://dpcpsi.nih.gov/sgmro/measurement/questions>

Related information

The Office of the National Coordinator for Health Information Technology (ONC)² has guidance on vocabulary and terminology used across data standards and specifications. This guidance may assist organizations in making decisions about which response options to offer, either in lieu of or in addition to the minimum response options required in factor 2.

The CDC^[11] and the National Institute of Health^[12] offer guidance and studies on surveying and collecting information on sexual orientation and gender identity.

^[10] <https://www.healthit.gov/isa/taxonomy/term/2741/uscdi-v2>

^[11] <https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html>

^[12] <https://dpcpsi.nih.gov/sgmro/measurement/questions>

Examples

None.

² <https://www.healthit.gov/isa/section-i-vocabularycode-setterminology-standards-and-implementation-specifications>

Element F: Privacy Protections for Data

The organization has policies and procedures for managing access to and use of race/ethnicity, language, gender identity and sexual orientation data, including:

1. Controls for physical and electronic access to the data.
2. Permissible use of the data.
3. Impermissible use of the data, including underwriting and denial of coverage and benefits.

Scoring	Met	Partially Met	Not Met
	The organization meets 3 factors	No scoring option	The organization meets 0-2 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 managing access to and use of race/ethnicity, language, gender identity and sexual orientation data.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation This element is a **structural requirement**. The organization must present its own documentation.

Factor 1: Access to data

The organization has policies and procedures to govern and track the receipt, removal of and access to devices and media that contain individual-level race/ethnicity, language, gender identity and sexual orientation data or that may be used to access these data. Policies and procedures cover media, devices and hardware movement, data storage, disposal and reuse of media and devices.

Media include, but are not limited to:

- Diskettes, CDs, tapes, and mobile applications.
- Portable drives.
- 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.

Factors 2, 3: Permissible and impermissible uses

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

The organization's policies and procedures for managing access to and use of race/ethnicity, language, gender identity and sexual orientation data may be integrated with its HIPAA privacy policies or they may be separate. If the organization's privacy policies are intended to include race/ethnicity, language,

gender identity and sexual orientation information in addition to HIPAA-defined PHI, this must be explicitly stated.

Exceptions

None.

Examples

Factor 1: Data access control

- Maintain paper documents in locked file cabinets.
- Require that protected electronic data remain on physically secure media.
- Maintain electronic data in password-protected files.

Factor 2: Permissible uses of data

- Assess health care ~~disparities~~ inequities.
- Design intervention programs.
- Design and direct outreach materials.
- Inform health care practitioners and providers about individuals’ language needs and pronouns.
- Provide clinical care.

Factor 3: Impermissible uses of data

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

Element G: Notification of Privacy Protections

When the organization collects data from individuals, it discloses its policies and procedures for managing access to and use of race/ethnicity, language, gender identity and sexual orientation data, including:

1. **Controls for physical and electronic access to the data.**
2. **Permissible use of the data.**
3. **Impermissible use of the data, including underwriting and denial of coverage and benefits.**

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

Data source Documented process, Materials

Scope of review *For All Surveys:* NCQA reviews materials sent during the look-back period to individuals that discloses the organization’s policies and procedures for managing access to and use of race/ethnicity, language, gender identity and sexual orientation data.

For all Initial Surveys scheduled on or between July 1, 2022, and June 30, 2024 ~~June 30, 2023~~, the organization may submit a detailed implementation plan that includes a timeline for notifying members of its policies and procedures for managing access to and use of gender identity and sexual orientation data, instead of submitting reports or materials.

Look-back period For All Surveys: Prior to the survey date.

Explanation Disclosure to individuals

The organization communicates to individuals, its policies for use and protection of race/ethnicity, language, gender identity and sexual orientation information, including whether such information will be shared with practitioners and providers. At a minimum, communication must be made at the time of direct data collection, and it may be provided in additional communications if the organization deems appropriate. The organization uses materials distributed to individuals to demonstrate how it meets this requirement.

For all Initial Surveys scheduled on or between July 1, 2022, and June 30, 2024 ~~June 30, 2023~~, if the organization completes an implementation plan in place of materials for member notification of policies and procedures for managing access to and use of gender identity and sexual orientation data, the plan must include:

- A detailed description of the actions the organization will take to update its notifications for managing access to and use of gender identity and sexual orientation data.
- Draft language of the notification.
- A timeline for notifying members.

Exceptions

None.

Examples

- Welcome packets.
- Marketing materials.
- Call scripts.
- Disclosure statements.

HE 3: Access and Availability of Language Services

The organization provides materials and services in the languages of individuals.

Intent

The organization communicates effectively with individuals.

Element A: Written Documents

The organization provides vital information in threshold languages that includes:

1. Use of competent translators.
2. A mechanism for providing translations in a timely manner.
3. Specifying when translations will be written and when sight translation (oral interpretation) of written information will be provided.
4. A mechanism for evaluating the quality of the translation.

Scoring	Met	Partially Met	Not Met
	The organization meets 2-4 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews the organization's documented processes in place during the look-back period for providing vital information in threshold languages.
NCQA also reviews reports or materials demonstrating that the organization provides vital information that meets requirements.

Look-back period *For Initial Surveys:* 6 months.
For Renewal Surveys: 24 months.

Explanation This element is a **structural requirement**. The organization must present its own documentation.

Vital information may be entire documents or portions of documents and includes:

- Information about eligibility for services and participation criteria.
- Information about how to use the organization's services and how to access services.
- Templates of notices pertaining to changes in service.

For health plans and MBHOs, vital information also includes:

- Information about benefits and coverage.
- Templates of notices pertaining to denial, reduction, modification or termination of services and benefits and the right to file a grievance or appeal (e.g., the portion of the notice that does not contain individual-specific information).
- Notification of practitioner termination.

In-language documents are created in a language other than English; they may be used to satisfy this element.

Factor 1: Translator competence

The organization describes its process for procuring or assessing translators, or demonstrates that it assesses translators (e.g., request for information [RFP], contract).

- *If the organization uses internal translation services (written or sight translation), its process for assessing translators includes proficiency in the source and target languages.*
- *If the organization uses external translation services, its process for procuring translators includes assessing translator competence and quality of translations.*

Factor 2: Timeliness of translations

The organization has a documented process for making translated vital information available in a timely manner to individuals who need the information in a language other than English. The process specifies request turnaround times, and it may differentiate turnaround times for different information and for translations into more commonly requested languages and less commonly requested languages.

Factor 3: Oral interpretation

The organization's documented process specifies the circumstances in which oral interpretation (sight translation) is provided in place of written translation.

Factor 4: Evaluating the quality of the translation

A high-quality translation ensures that the translated document conveys the intended meaning of the original document. Whether the organization translates documents or contracts with a vendor to translate documents, it must have a documented process in place for evaluating the quality of the translation, to ensure that the meaning intended in the source document is conveyed and that the translation is culturally appropriate.

At a minimum, the evaluation process includes review by a competent translator not involved in the original translation, or review by back-translation (or reverse translation). Evaluation may be internal to the organization or may be included in the organization's contract with a translation vendor. The organization may demonstrate the evaluation through the documented process or materials and reports.

Exceptions

None.

Examples**Factor 1: Using competent translators**

- Job descriptions demonstrate how the organization or translation service employs translators certified by the American Translators Association.
- The RFP or contract specifies how the translation service ensures translator competence.

Factor 2: Provision of timely translation

- Maintain an inventory of specific documents in common languages.
- Provide sight translation of information that must be provided immediately and for which written translation is not readily available.
- The translation service contract specifies turnaround times.

Factor 3: Evaluation of translation quality

- The organization uses an evidence-based quality assurance method, such as the Hablamos Juntos TQA process
<http://www.hablamosjuntos.org/mtw/index.asp>.
- The contract with translation service includes quality assurance provisions.
- The organization follows a translation process, which includes one or more review/editing steps performed by a qualified translator not involved in the original translation.

Element B: Spoken Language Services

The organization uses competent interpreter or bilingual services to communicate with individuals who need to communicate in a language other than English.

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, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews the organization’s documented process for assessing staff fluency in place throughout the look-back period.

NCQA also reviews reports or materials for evidence that the organization uses competent interpreter or bilingual services to communicate with individuals who need language assistance.

Look-back period *For Initial Surveys:* 6 months.
For Renewal Surveys: 24 months.

Explanation **Competent interpreter services** means that the interpreter understands and speaks with enough fluency in both the source and target languages to convey intended meaning.

The organization may provide interpreter services directly through professional interpreters or bilingual staff, or through contracts with language service providers, including electronic media (e.g., telephone language lines, video links, mobile applications) and other remote systems.

Bilingual staff speak both English and the individual’s language and can perform their responsibilities either in English or in another language.

- *If the organization uses staff interpreters or bilingual staff, its process for assessing translators includes proficiency in the source and target languages and interpretation training for staff who provide interpreter services.*

- If the organization uses external interpreter services, its process for procuring interpreters includes provisions for assessing interpreter competence.

Interpreter or bilingual services are provided for any interaction an individual is likely to have with the organization, either in person or over the telephone, including, but not limited to:

- Customer service.
- Claims.
- Utilization management.
- Disease management.
- Case management.
- Complaints, grievances and appeals.

Exceptions

None.

Examples

Assessment of language fluency for bilingual staff and staff interpreters

- Job descriptions and policies for assessing staff fluency.
- Tests administered by the organization or consideration of test results, credentials or certificates offered by language testing services.
- Grades or certification in interpretation issued by an accredited college or university, or by another entity.

Competence of interpreter services

- Policies for staff serving as interpreters or contracts with interpreter services require interpreters to follow National Standards of Practice for Interpreters in Health Care, issued by the National Council on Interpreting in Health Care (<https://www.ncihc.org/assets/documents/publications/NCIHC%20National%20Standards%20of%20Practice.pdf>).
- RFP about the service’s methods for ensuring interpreter competence.
- The contract with the interpreter service includes quality provisions.
- The RFP or contract requires interpreters to be certified.

Element C: Support for Language Services

The organization supports practitioners in providing competent language services, including:

1. Shares individual data on language needs with practitioners.
2. Shares organization or service area population data on language needs.
3. Provides practitioners with language assistance resources.
4. Makes in-person, video or telephone interpretation services available to practitioners.
5. Offers training to practitioners on the provision of language services.

Scoring	Met	Partially Met	Not Met
	The organization meets 5 factors	The organization meets 2-4 factors	The organization meets 0-1 factors

Data source	Reports, Materials
Scope of review	<i>For All Surveys:</i> NCQA reviews evidence of language services the organization distributes during the look-back period.
Look-back period	<i>For Initial Surveys:</i> 6 months. <i>For Renewal Surveys:</i> 24 months.
Explanation	<p><u>This element is a structural requirement. The organization must present its own documentation.</u></p> <p>Under Title VI of the Civil Rights Act, health care practitioners who receive federal funds are responsible for providing language and communication services to their patients as required to meet clinical needs. Understanding and meeting the linguistic needs of individuals is a shared concern among organizations and the practitioners with whom they contract. The organization supports and assists practitioners in this effort, within the scope of their respective responsibilities.</p> <p>Factor 1: Shares data on individual language needs with practitioners</p> <p>The organization shares data with practitioners about the language needs of individuals. The organization provides individual language information, either as part of patient-specific communications with the practitioner (e.g., registry downloads, service reminders, notice of selection as a primary care provider, evidence of coverage) or in a report listing the language needs of all patients in the practitioner’s practice.</p> <p>Factor 2: Shares data on population language needs</p> <p>In addition to providing language data on an individual level, the organization provides practitioners with information about the language patterns of the organization’s population or service area.</p> <p>Factor 3: Provides practitioners with language assistance resources</p> <p>The organization distributes a minimum of one language assistance resource in all threshold languages to practitioners. The organization may collaborate with other organizations in the service area to provide common resources to practitioners.</p> <p>Factor 4: In-person, video or telephone interpretation services</p> <p>No additional explanation required.</p> <p>Factor 5: Offers training to practitioners on provision of language services</p> <p>The organization offers training to practitioners on identifying and serving LEP patients. The organization may collaborate with other organizations in the service area to provide common training to practitioners.</p> <p>The organization uses materials such as sample reports it sends to practitioners, language assistance resources it distributes, training curricula and reports documenting the provision of these materials, to demonstrate how it meets the requirements of factors 1–4. For collaborative activities, the organization uses reports such as meeting minutes to demonstrate its substantive participation in the activity.</p> <p>Exception</p> <p>This element is NA if the organization does not hold contracts with practitioners.</p>
Examples	Factor 1: Data on individual language needs

- Reports listing the language needs of individuals.
- Individual-level communication listing the language needs of individuals (e.g., registry reports, remittance advice, evidence of benefits information, reminder notices).
- Inclusion of language information on profile of individuals communicated as part of electronic or telephone eligibility verification.
- Printing individuals' language on ID cards.

Factor 2: Data on service area language needs

- Reports on language needs, based on census data for the neighborhoods served by the practice.
- Reports on the service area demographics.
- Meeting minutes.

Factor 3: Language assistance resources

- Language identification cards, such as "I speak [language]" cards.
- Downloadable multilingual signage.
- Translated or in-language patient education materials.
- Websites or resource directories identifying translation or health care interpretation and other services.

Factor 4: In-person, video or telephone interpretation services

- Provide practitioner access to the organization's contracted interpretation service.
- Provide practitioner access to the organization's staff interpreters via telephone or video link.
- Make equipment available for video interpretation.

Factor 5: Practitioner training on the provision of language services

- Workshops, online tutorials, manuals or other written or in-person instruction to practitioners on:
 - Responding to LEP patients and written LEP communications.
 - Interacting with LEP patients during in-person visits.
- Training on obtaining interpreter services and working with interpreters.

Element D: Notification of Language Services

The organization annually distributes a written notice in English and in up to 15 languages spoken by 1% of individuals served by the organization or by 200 individuals, whichever is less, that the organization provides free language assistance and how individuals can obtain it.

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

Data source Reports, Materials

Scope of review *For Initial Surveys:* NCQA reviews the most recent distribution of information on the availability of language services.
For Renewal Surveys: NCQA reviews most recent and the prior year’s distribution of information on the availability of language services.

Look-back period *For Initial Surveys:* 6 months.
For Renewal Surveys: 24 months.

Explanation The organization must provide interpreter services to all individuals who need them, regardless of the frequency of the language in the community or among the membership. Notification of the availability of language services must be provided to the broadest possible number of individuals in a language they can understand. This lower threshold of 1% or 200 individuals, up to a maximum of 15 languages, provides a finite boundary for the number of languages in which notices must be provided.

Mailing the notice to all individuals annually meets the intent of the element. The organization may provide notification of language services as a discrete communication or include the notification in a routine distribution of information to all individuals.

Distributing the notice on the organization’s website meets the intent of the element if the organization provides written notification to all individuals annually that the information is available online and that a printed copy of the information is available upon request.

Exception

This element is NA if the organization does not have a defined membership.

Examples **Notice of the availability of language services**

- Statement/tagline in multiple languages in newsletters or other documents distributed to all individuals.
- Brochure.
- Website.
- Reports of distribution of notices.

HE 4: Practitioner Network Cultural Responsiveness

The organization maintains a practitioner network that is capable of serving its diverse membership and is responsive to member needs and preferences.

Intent

The organization maintains a practitioner network that can meet the cultural and linguistic needs of its members.

Element A: Assessment and Availability of Information

To enable members to choose practitioners best able to meet their cultural and linguistic needs, the organization:

1. Collects information about languages in which a practitioner is fluent when communicating about medical care.
2. Collects information about language services available through the practice.
3. Collects practitioner race/ethnicity data.
4. Publishes practitioner languages in the physician directory.
5. Publishes language services available through practices in the physician directory.
6. Provides practitioner race/ethnicity on request.

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

Data source Documented process, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews the organization's data collection methodology (presented as a documented process or report), reviews the organization's physician directories and reviews evidence that the organization made directories available to members during the look-back period.

For factor 6: NCQA also reviews the organization's documented processes and evidence that the organization followed its documented process for providing information on practitioner race/ethnicity upon request.

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

For Renewal Surveys: 24 months.

Explanation Some patients feel more comfortable with practitioners who share their language and racial/ethnic background. Patient/practitioner communications are enhanced when there is a common language and culture [Cooper 2003; Garcia 2003; Saha 2000; Street 2008]. Although it may not be possible for the organization to establish a practitioner network that matches the demographic profile of its membership exactly, the organization facilitates high-quality care by providing (to the extent possible) a choice of practitioners that includes all major racial/ethnic and linguistic groups represented by its membership.

Factor 1: Practitioner languages

The organization requests practitioner language information from all contracted network practitioners. It requests practitioners provide this information and identifies languages in which a practitioner is fluent when communicating about medical care, using the same categories used to collect member language information. The organization must communicate to practitioners that providing language information is voluntary.

The organization may determine the appropriate timing of data collection to avoid concerns about discrimination in contracting. The organization must not use information about practitioner language in its contracting or credentialing decisions or for any other discriminatory purpose. The organization may obtain data on practitioner language directly or from third-party sources, such as credentials verification organizations (CVO).

Factor 2: Language services available through practices

Practices offer language services to their patients through a variety of mechanisms, including bilingual staff or onsite interpreters and remote video or telephone interpreters. Although Title VI of the Civil Rights Act requires practitioners to provide language services to any patient who needs them, many practitioners have dedicated language services available to serve the language needs of a specific linguistic minority in their local communities. The organization collects information about dedicated language services offered by the practices in its network.

Factor 3: Practitioner race/ethnicity

The organization has a documented process for requesting all contracted network practitioners to volunteer their race/ethnicity information, using the same categories as when it collects member race/ethnicity information.

The organization must communicate to practitioners that providing race/ethnicity information is voluntary. The organization demonstrates data collection through data collection forms, surveys or reports such as counts or identification of complete/incomplete data.

The organization may determine the appropriate timing of data collection to avoid concerns about discrimination in contracting. It must not use information about practitioner race/ethnicity in its contracting or credentialing decisions or for any other discriminatory purpose. The organization may obtain data on practitioner race/ethnicity directly or from third-party sources, such as CVOs.

Factor 4: Publishes practitioner languages in the physician directory

The organization publishes practitioner language information in its online or printed physician directories and through any other mechanism intended to facilitate member selection of practitioners.

The organization makes information about practitioner languages available through other means (e.g., mailing) for members who do not have internet access.

Factor 5: Publishing language services available through the practice

If practitioners are committed to providing dedicated language services and are responsive to patients from specific language groups, the organization identifies these languages in its physician directory, includes instructions for contacting practices directly for current information.

The physician directory is not required to list every language a practice might offer, but must indicate languages in which the practice is equipped to serve patients.

Factor 6: Practitioner race/ethnicity

Factor 6 may not be delegated.

At a minimum, the organization has a documented process for providing information about practitioner race/ethnicity through its Member or Patient Services staff.

Distributing the information on the organization's website and in the physician directory (written and electronic) meets the intent of the element. If the information is not available in the physician directory but can be found elsewhere (e.g., by contacting Member Services), the organization places prominent notice in the written or web-based directory indicating how members can obtain the information.

If a practitioner declines to provide race/ethnicity information, the organization may report race/ethnicity as "Unknown." The organization demonstrates that it provides this information through materials such as screenshots or reports.

Exception

This element is NA if the organization does not contract with practitioners.

Examples

Sources of practitioner language and race/ethnicity information

- Data collection forms or surveys.
- Reports such as counts or identification of complete/incomplete data.
- Practitioner survey, credentialing application, provider relations script, CVO, medical association or medical specialty directory.

Methods of sharing practitioner language information

- Web-based or printed practitioner directory.

Methods of sharing practitioner race/ethnicity information

- Web-based or printed practitioner directory or Member Services staff.

Factor 2: Available language services

Practices offer language services to patients through a variety of mechanisms, including:

- Bilingual staff or onsite interpreters.
- Remote video or telephone interpreters.
- Dedicated language services for a specific linguistic minority.

Element B: Enhancing Network Responsiveness

At least every 3 years, the organization:

1. Analyzes the capacity of its network to meet the language needs of members.*
2. Analyzes the capacity of its network to meet the needs of members for culturally appropriate care.*
3. Develops a plan to address gaps identified as a result of analysis, if applicable.
4. Acts to address gaps based on its plan, if applicable.

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

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, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews the organization's assessment of unmet member needs and documentation of any ~~plan or adjustment~~ or planned adjustments made in to the network to meet identified member needs throughout the look-back period.

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

For Renewal Surveys: Once during the prior 36 months.

Explanation Factors 1 and 2 are critical factors; both factors must be scored "yes" for the organization to score at least Partially Met on this element.

Factor 1: Analyzing practitioner network language capacity

The organization assesses and reports on practitioner and bilingual staff language capabilities and determines whether its language services are sufficient to meet the needs of members. Assessment includes:

- Languages spoken by practitioners.
- Presence of bilingual staff in practitioners' offices.
- Whether practitioners have worked with an interpreter.

Factor 2: Analyzing practitioner network cultural responsiveness

The organization uses information about the demographic profile of its membership and practitioner network to identify potential unmet need, and assesses the network's ability to deliver culturally appropriate care to members. The organization may assess practitioners':

- Attitude about working with people from different cultures.
- Awareness of health beliefs and health-related behaviors among people from prevalent cultures in the service area.
- Ability to determine language or cultural barriers interfering with communication.
- Skills in assessing patient understanding.
- Participation in CME cultural humility training.

The organization's report describes practitioner demographics and assessments of identified member need.

Factor 3: Plan to address gaps

The organization has a documented process for determining if gaps exist between the network's capacity and member needs (e.g., limited numbers of primary care practitioners who can provide culturally competent care or who speak a prevalent language). Where gaps exist, the organization develops and implements a plan to meet member needs.

NCQA recognizes that it may not be practical to address gaps by recruiting practitioners with specific racial/ethnic or linguistic backgrounds, in an environment where there is a shortage of primary care practitioners. Organizations might need to consider other approaches to meeting member needs such as community partnerships, faith-based organizations, public health agencies or other community-based organizations, practitioner training or social networking.

Factor 4: Taking action

Factor 4 may not be delegated.

The organization implements its plan to address identified gaps.

The organization uses materials (e.g., member or provider communications), revised process flows or reports to demonstrate actions taken.

Exceptions

This element is NA if the organization does not contract with practitioners.

Factors 3 and 4 are NA if the organization's analysis does not identify gaps in the network's capacity to meet member needs.

Examples

Analysis of network capacity

- Compare the number of practitioners who speak a specific language with the number of members residing in the service area who speak that language.
 - Analysis may focus on common language categories in the membership; for example, languages spoken by at least 5% of members in the area.
- Survey practitioners to assess their attitudes, awareness and knowledge of cultural humility concepts.
- Analyze the percentage of practitioners who have participated in CME training on cultural humility.

Actions to address gaps

- Provide onsite, telephone or video-enhanced interpretation services for a specific language group or geographic area.
- Encourage practitioners to complete additional or specific cultural humility training based on the racial/ethnic composition of the member population.
- Engage community organizations and partners to extend the capabilities of the practitioner network to conduct outreach, health education and other important health communication.
- Hire or direct practitioners to community health workers, advocates or patient navigators to help members interact with practitioners.
- Give practitioners access to culturally and linguistically appropriate health education materials.

- Give practitioners lists of pharmacies or ancillary providers who offer services in languages other than English.

HE 5: Culturally and Linguistically Appropriate Services Programs

The organization has structures, processes and goals for continually improving its culturally and linguistically appropriate services (CLAS) programs and reducing health inequities in the population of individuals it serves. ~~services to meet the needs of multicultural populations.~~

Intent

The organization continually improves the care and services it provides to all individuals for all members.

Element A: Program Description

The organization has a written program description for improving ~~culturally and linguistically appropriate services (CLAS)~~ that includes the following:

1. A written statement describing the organization's overall objective for serving a culturally and linguistically diverse population.
2. A process to involve members of the culturally diverse community in identifying and prioritizing opportunities for improvement.
3. A list of measurable goals for the improvement of CLAS and reduction of health care disparities inequities.
4. An annual work plan.
5. A plan for monitoring against the goals.
6. Annual approval by the governing body.

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 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 Initial Surveys:* 6 months. For factors 4 and 6, the organization is required to complete the activity at least once during the prior year.
For Renewal Surveys: 24 months.

Explanation This element is a **structural requirement**. The organization must present its own documentation.

A **program description** is a formal decision-making arrangement where an organization's goals and objectives are put into an operational framework and tasks to meet goals, and objectives are identified, grouped and coordinated. The CLAS program structure may be independent or it may be integrated into the organization's quality improvement (QI) program. It defines how the organization uses its resources to achieve its goals and includes the following information:

- How the CLAS program is organized to meet program objectives.
- Functional areas and their responsibilities.

- Reporting relationship of staff who provide CLAS.

Factor 1: Written document

The CLAS program description is organized and written so that staff members can understand the program’s goals, objectives and structure. It may be an independent document or it may be integrated into the QI program description.

Factor 2: Process to involve members of the culturally diverse community

The CLAS program has substantive input and participation from the community it serves in order to ensure that it meets the needs of the population.

The organization establishes an advisory function that seeks advice from people who reflect the diversity of the membership. It may engage an advisory committee that includes a mix of consumers (including individual consumers or advocates), practitioners and community representatives, or the advisory function can be fulfilled in other ways, such as engaging community groups or conducting focus groups with individuals or community residents. At a minimum, the advisory function involves consumers and includes individuals representing the racial/ethnic and linguistic groups that constitute at least 5% of individuals.

Factor 3: Measurable goal

The program description must contain at least one measurable goal for provision of culturally and linguistically appropriate services or reduction of health care ~~disparities~~-inequities. The goal reflects the demographics of the community, known or expected needs of individuals and previously identified opportunities for improvement. It must be specific, measurable, achievable and reasonable, and must have a defined period for completion.

Factor 4: Work plan

The CLAS work plan may be a separate document or it may be included in the culturally and linguistically appropriate services program description, the QI program description or the QI work plan, and it must address:

- Network cultural responsiveness.
- Language services.
- Program scope.
- Yearly objectives.
- Yearly planned activities.
- Time frame for each activity.
- The staff member responsible for each activity.
- Monitoring previously identified issues.
- Evaluation of the CLAS program.

The work plan 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. The organization updates the work plan frequently throughout the year to reflect progress on CLAS activities.

Factor 5: A plan for monitoring against goals

The organization indicates how it monitors progress against goals, including measures that will be collected, frequency of monitoring and staff responsible for review and sign-off of monitoring reports.

Factor 6: Approval by the governing body

The **governing body** is the organization’s board of directors, which is responsible for organizational governance. The governing body reviews and approves the CLAS program description annually. Where its participation in QI or CLAS activities is indirect, it may designate a subcommittee or organization management staff (external to the QI Committee) to oversee CLAS activities. The CLAS program description must document the subcommittee’s accountability to the governing body.

Exceptions

None.

Examples

Members of the culturally diverse community

- Individuals/patients from cultural or linguistic minority groups.
- Community advocates.
- Employers with diverse populations and with which the organization contracts.
- Labor union representatives.
- Representatives of agencies that serve the population of interest.
- Researchers involved in community-based research in diverse populations.

Opportunities to involve the community

- Advisory panels.
- Community forums to review and solicit feedback on CLAS initiatives.
- Focus groups.

Evidence of governing body approval

- Minutes reflecting review of goals by governing body.
- Approved budget reflecting resource allocation to meet goals.
- Minutes or a signed plan reflecting sign-off on goals and resources by the governing body.

Element B: Annual Evaluation

There is an annual written evaluation of the CLAS program that includes the following:

1. A description of completed and ongoing activities for culturally and linguistically appropriate services.
2. Trending of measures to assess performance.
3. Analysis of results of initiatives, including barrier analysis.
4. Review and evaluation of the results by community representatives.
5. Evaluation of the overall effectiveness of the program.

Scoring	Met	Partially Met	Not Met
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source Documented process, Reports

Scope of review *For Initial Surveys:* NCQA reviews the organization’s most recent annual written evaluation report. The organization may submit a plan for meeting factors 2–5.
For Renewal Surveys: NCQA reviews the most recent and the prior year’s annual written evaluation reports.

Look-back period *For Initial Surveys:* At least once during the prior year.
For Renewal Surveys: 24 months.

Explanation This element is a **structural requirement**. The organization must present its own documentation.
 The annual evaluation may be independent or it may be integrated into the QI annual evaluation.

Factor 1: Completed and ongoing activities

The organization annually evaluates its performance on planned CLAS activities described in the program description and work plan, including all delegated functions. Evaluation includes a description of completed and ongoing CLAS activities for the previous year.

Factor 2: Trending of measures

The organization presents the results of CLAS initiatives in measurable terms. To facilitate comparative analysis, evaluation includes trended data using charts, graphs or tables for displaying this information. Trended data show performance over time.

Factor 3: Analysis of results, including barrier analysis

The organization analyzes results to determine whether its performance is improving, declining or remaining stable, and how it relates to the goals or performance thresholds identified in the plan. When performance falls short of goals, the organization conducts a root cause analysis or barrier analysis to identify why goals were not met. Analysis involves organization staff with direct experience with processes that present barriers to improvement.

Factor 4: Review and evaluation of results by community representatives

The organization includes community representatives in its evaluation of analysis of results in factor 3. At a minimum, the organization presents the analysis to community representatives for review and feedback. The organization may choose a more integrated approach that includes community representatives on the evaluation team. The organization should consult community representatives about the barrier analysis for their perspective on the root causes of barriers and possible solutions.

Factor 5: Evaluation of overall effectiveness

After considering its performance in all aspects of the program, the organization determines and describes the program’s overall effectiveness. It considers adequacy of resources, program structure, participation of practitioners and community representatives and leadership involvement in the program, and determines whether to restructure or change the program for the subsequent year based on its findings.

Exceptions

None.

Examples Annual written evaluation contents

- The title, description and major accomplishments of each CLAS initiative described in the work plan.
- Appropriate measures trended over time, including:
 - Individual experience data.
 - Practitioner experience data.
 - Staff feedback.
 - Service performance (e.g., telephone hold times; interpreter wait times).
- Issues and barriers that make objectives more difficult to achieve.
- Recommended interventions to overcome issues and barriers.
- Assessment of whether yearly planned activities were completed and yearly objectives were met.

Community representatives

- Individuals/patients from culturally diverse groups.
- Community advocates.
- Employers with which the organization contracts, with diverse populations.
- Labor unions.
- Representatives of agencies that serve the population of interest.
- Researchers involved in community-based research in diverse populations.

HE 6: Reducing Health Care Disparities Inequities

The organization uses race/ethnicity, language, gender identity and/or sexual orientation data to identify and reduce health assess the existence of disparities inequities and to focus quality improvement efforts toward on improving the provision of culturally and linguistically appropriateness of its services, and decreasing health care disparities.

Intent

The organization uses data about its population to improve services and reduce disparities health care inequities.

Element A: Reporting Stratified Measures

Annually, the organization reports HEDIS measures and determines if health care inequities disparities exist for each HEDIS measure, stratified by race/ethnicity:

1. Colorectal Cancer Screening (COL).
2. Controlling High Blood Pressure (CBP).
3. Hemoglobin A1c Control for Patients With Diabetes (HBD).
4. Prenatal and Postpartum Care (PPC).
5. Child and Adolescent Well Care Visits (WCV).

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

Data source Documented process, Reports

Scope of review *For All Surveys:* NCQA reviews the organization's documented process for validating the reliability and accuracy of indirect data sources and estimation methods, if applicable. NCQA also reviews audited HEDIS reports from the most recent HEDIS reporting year and reviews reports describing the organization's analysis of disparities inequities by race/ethnicity for factors 1–5.

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

Explanation ***Factors 1–5***

The organization reports HEDIS measures to NCQA by race/ethnicity following the HEDIS specifications as defined in HEDIS *Volume 2: Technical Specifications for Health Plans*. Measures and race/ethnicity stratifications are collected and reported separately by product line (commercial, Medicaid, Medicare).

If the organization uses indirect data sources and estimation methods, it provides its documented process for validating their reliability and accuracy for the population to which they are applied (e.g., age group, geography, product line).

For each measure, the organization analyzes the performance of race/ethnicity subgroups by comparing them against a reference group. When determining whether disparities inequities exist at a single point in time, the organization may compare all subgroups against each other. When evaluating trended data over time, the organization may prefer to compare all subgroups against the most advantaged group (i.e., the group with the best performance).

Organizations may choose to examine subgroups of race/ethnicity that are meaningful for their population and are more granular than described in HEDIS Volume 2; however, HEDIS reporting must be rolled up into categories defined in the technical specifications.

Exceptions

This element is NA for:

- Organizations that can demonstrate fewer than 30 individuals in the denominator for every racial/ethnic group and subgroup.
- Organizations that are not health plans.
- The Exchange product line.
- ~~Surveys before June 2023. Stratified reporting will be in place for HEDIS Measurement Year 2022.~~

Factor 1 is NA for the Medicaid product line.

Factors 4 and 5 are NA for the Medicare product line.

Examples

Validating the reliability and accuracy of indirect data sources and estimation methods

- Calculate the sensitivity, specificity and positive predictive value of estimated race/ethnicity results, compared with self-reported data, for a sample of individuals.
- Refer to studies that report on the accuracy of estimates for the population in the relevant service area.

Element B: Use of Data to Assess Disparities Health Care Inequities

The organization annually uses race/ethnicity, language, gender identity and/or sexual orientation data and the following methods to determine if health care disparities inequities exist:

1. Analyzes ~~one~~ two or more valid measures of clinical performance, by race/ethnicity.
2. Analyzes one or more valid measures of clinical performance, such as HEDIS, by preferred language.
3. Analyzes one or more valid measure of clinical performance, such as HEDIS, by gender identity and/or sexual orientation.
4. Analyzes one or more valid measures of individual experience, such as CAHPS, by race/ethnicity or preferred language

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, Reports

Scope of review	<p><i>For Initial Surveys:</i> NCQA reviews the organization's most recent measurement reports.</p> <p><i>For Renewal Surveys:</i> NCQA reviews the organization's most recent and the prior year's measurement reports. For factor 3, NCQA reviews the organization's most recent year's measurement reports.</p>
Look-back period	<p><i>For Initial Surveys:</i> At least once during the prior year.</p> <p><i>For Renewal Surveys:</i> 24 months for factors 1, 2 and 4; at least once in the last 24 months for factor 3.</p>
Explanation	<p><u>Methodology</u></p> <p>The organization <u>describes</u> stratifies its <u>method for stratifying</u> data by race/ethnicity and language, as well as gender identity and/or sexual orientation, to assess health care disparities <u>inequities</u>. It may use direct or indirect data, or a combination, to determine health-care inequities <u>disparities</u>. Clinical performance measures and individual experience measures must be measured annually and must specify the organization's selection rationale for selection.</p> <p>Valid clinical performance measures</p> <p>If the organization uses measures other than HEDIS, the measures must:</p> <ul style="list-style-type: none"> • Address a relevant process or outcome. • Produce a quantifiable result. • Be population based. • Use data and a method that are valid for the process or outcome being measured. <p>Results must be collected and reported separately for populations covered by commercial insurance, Medicaid and Medicare.</p> <p>Valid individual experience measures</p> <p>If the organization uses individual experience measures other than CAHPS, NCQA reviews the organization's description of its data collection methodology to determine if the methodology is sound enough to produce valid and reliable results.</p> <p>The sample size drawn for the survey must be sufficient to reach conclusions about individuals. Survey reports completed by the organization must show annual measurement of the population, sample size, sampling technique, method of administration (e.g., telephone or mail; administered by an outside vendor or by the organization) and response rates.</p> <p>Quantitative analysis</p> <p>Annual analysis of findings includes a first-level, quantitative data analysis that incorporates aggregate results and compares results for each subsample against the best-performing subsample or a predefined benchmark or reference group. For HEDIS and CAHPS data, the comparison could be against overall or regional benchmarks and thresholds published by NCQA. If an organization has multiple locations in a state, it may analyze statewide data, but aggregate data might not provide sufficient information to suggest actions the organization should take at each location.</p>

Because stratification of quantitative data can yield sample sizes too small to make valid statistical inferences, the organization may conduct qualitative analyses, such as through interviews or focus groups, or evaluation of complaints and grievances, to supplement its understanding of the data. Qualitative analysis alone does not satisfy this element.

Stratification

The organization stratifies one or more HEDIS or other clinical performance measures by using individual-level data; for example, for measures that use the Hybrid Method, or by using information systems to identify individuals captured in the measure's numerator and denominator. The organization must stratify the measure by race/ethnicity using direct or indirect data and focus on subgroups most relevant to the demographics of the population served and that are feasible, given the number of individuals in the groups.

Some subgroups may have sufficient numbers of individuals to be analyzed individually (e.g., White, Black/African American), while some subgroups represented in the organization's population by a small number of individuals may need to be grouped together for the purpose of analysis. In some organizations, it may be possible to stratify distinct subgroups—Chinese, Japanese, Korean or Vietnamese, rather than “Asian,” or Mexican/Mexican American/Chicano, Puerto Rican or Cuban rather than “Hispanic or Latino.” NCQA does not prescribe racial or ethnic subgroups for stratification, nor does it prescribe performance measures, but suggests that the organization focus on disparity-sensitive measures specified by the NQF; in particular, measures of care processes or outcomes relevant to the organization's population.

Factor 1: Analyzing clinical performance measures by race/ethnicity

If the organization does not report HEDIS measures, it analyzes one or more valid measures of clinical performance by race/ethnicity. The organization analyzes the performance of subgroups by comparing them against a reference group. When determining whether inequities ~~disparities~~ exist at a single point in time, the organization may compare all subgroups against each other. When evaluating trended data over time, the organization may prefer to compare all subgroups against the most advantaged group. The most advantaged group, or the group with the best performance, is the reference group.

Factor 2: Analyzing clinical performance measures by preferred language

The organization stratifies one or more HEDIS or other clinical performance measures by using individual-level data (e.g., for measures that use the Hybrid Method) or by using information systems to identify individuals captured in the measure's numerator and denominator. The organization must stratify the measure by individuals' self-identified preferred language.

Factor 3: Analyzing clinical performance measures by gender identity and/or sexual orientation

NCQA reviews the organization's most recent measurement report.

The organization analyzes the performance of gender identity and/or sexual orientation subgroups by comparing them against a reference group. When determining whether inequities ~~disparities~~ exist at a single point in time, the organization may compare all subgroups against each other. When evaluating trended data over time, the organization may compare all subgroups against the most advantaged group. The most advantaged group, or the group with the best performance, is the reference group.

If the organization's data collection only identified individuals with binary gender identity options (i.e., man/male and woman/female), the organization may display the analysis of its measures by those genders.

Factor 4: Analyzing individual experience measures by race/ethnicity or preferred language

The organization stratifies one or more CAHPS or other individual experience of care measures using individual-level data, including data collected by the CAHPS survey, and focuses on population subgroups most relevant to the demographics of the population served.

Exceptions

This element is NA if the organization can demonstrate that it has only one racial/ethnic and preferred language subgroup group with greater than 30 individuals in the denominator.

Factor 1 is NA for:

- Organizations that report at least one measure in HE 6, Element A.
- Organizations that can demonstrate they have only one racial/ethnic subgroup with ~~greater~~ more than 30 individuals in the denominator.

Factor 2 is NA if the organization can demonstrate that it has only one preferred language subgroup with ~~greater~~ more than 30 individuals in the denominator.

Related information

NQF disparity-sensitive measures. The NQF published a national set of disparity-sensitive performance measures in eight priority areas (asthma; diabetes; heart disease; hypertension; medication management; mental health and substance use; prenatal care; and prevention, immunization and screening) and one additional measure in patient experience with care (*National Voluntary Consensus Standards for Ambulatory Care—Measuring Healthcare Disparities: A Consensus Report*. NQF. 2008).

Examples

Stratifying performance data

When organizations stratify clinical performance or individual experience measures by race/ethnicity, language, gender identity or sexual orientation, they must focus on subgroups most relevant to the demographics of the population they serve. Examples of stratifying clinical performance or individual experience measures may include, but are not limited to, analyzing:

- HbA1c screening rates for African Americans, Whites and Other.
- Cervical cancer screening rates for cisgender women and transgender men/trans male/female-to-males (FTM).
- Clinical depression screening rates for bisexual, lesbian/gay/homosexual and straight/heterosexual individuals.
- How well doctors communicate in English/Spanish/Other.
- Ratings for personal doctor by individuals whose preferred language is English, Spanish, Cantonese ~~and~~ or Vietnamese.
- Experience with choice of practitioner (not a CAHPS item) by the White Latino/Hispanic, White Not Latino/Hispanic, African American Latino/Hispanic or African American Not Latino/Hispanic populations.

Element C: Use of Data to Monitor and Assess Services

The organization assesses the following at least annually:

1. Utilization of language services for organization functions.
2. Individual experience with language services for organization functions.
3. Staff experience with language services for organization functions.
4. Individual experience with language services during health care encounters.

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 Reports

Scope of review *For Initial Surveys:* NCQA reviews the organization's most recent annual assessment.

For Renewal Surveys: NCQA reviews the organization's most recent and the prior year's annual assessment.

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

For Renewal Surveys: 24 months.

Explanation **Language services** include bilingual services, oral interpretation and written translation.

The organization may use a variety of mechanisms, including quantitative or qualitative data, to evaluate individual and staff experience with language services. To the extent that the organization uses CAHPS items or supplemental questions, the organization uses sampling methods appropriate for capturing individuals who needed or used language services. The organization may solicit point-of-contact feedback through survey or interview and may obtain feedback through interviews, focus groups or other qualitative analysis. Analysis of complaint and grievance data alone does not meet factors 2–4.

Organization functions

Organization functions include any interaction an individual is likely to have with the organization, either in person or over the telephone, including, but not limited to:

- Member Services.
- Claims.
- Utilization management.
- Disease management.
- Case management.
- Complaints, grievances and appeals.

Exception

Factor 4 is NA if the organization does not contract with practitioners.

Examples**Utilization indicators**

- The percentage of individuals requesting language services who receive such services for organization functions.
- The total percentage of ~~total~~ individuals who used one or more language service.
- The percentage of individuals whose primary language is not English and who used one or more language service.

Methods to evaluate individual experience

- Survey:
 - All individuals, **or**
 - All individuals who indicated a language preference other than English, **or**
 - All individuals who used language services to obtain feedback on their experience with language services in the clinical setting.
- Follow-up calls to individuals who requested or used language services to obtain feedback on their experience with language services in the clinical setting.
- Mailed questionnaire or interview with individuals who used language services, on their experience with services administered in the clinical setting.
- Focus groups with individuals or community advocates.

Methods to evaluate staff experience

- Survey front-line staff about their experience using language services.
- Analyze rating forms completed by staff for each language service used.
- Focus groups/meetings with staff who use language services.

Indicators of individual or staff experience

- Individuals' ratings of access to language services.
- Staff ratings of the ~~length of time~~ it takes to obtain language services.
- ~~Indicators of individual experience~~
- Overall rating of interpretation services.
- Access to language services at a health care encounter.

Element D: Use of Data to Measure CLAS and ~~Disparities~~ Health Care Inequities

Based on the results of measurement of health care ~~disparities~~ inequities and language services, the organization annually:

1. Identifies and prioritizes opportunities to reduce health care ~~disparities~~ inequities.
2. Identifies and prioritizes opportunities to improve CLAS.
3. Implements at least one intervention to address a health care ~~disparity~~ inequity.
4. Implements at least one intervention to improve CLAS.
5. Evaluates the effectiveness of an intervention to reduce a health care ~~disparity~~ inequity.
6. Evaluates the effectiveness of an intervention to improve CLAS.

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 Documented process, Reports

Scope of review *For Initial Surveys:* NCQA reviews the organization's most recent annual assessment.
For Renewal Surveys: NCQA reviews the organization's most recent and the prior year's annual assessment.

Look-back period *For Initial Surveys:* At least once during the prior year.
For Renewal Surveys: 24 months.

Explanation The organization performs annual QI interventions to improve CLAS and reduce health care ~~disparities inequities~~. ~~Disparities~~ The organization may include, but is not limited to, these inequities found in Elements A–C. race/ethnicity, language, gender identity or sexual orientation.

Factors 1, 2: Identifying and prioritizing opportunities

The organization identifies as many opportunities as possible, prioritize them based on its analysis and their significance for concerns to individuals and indicate how it chose the opportunities. NCQA uses the analysis to evaluate whether chosen priorities reflect significant issues. For each opportunity or barrier, the organization must describe its reasons for taking (or not taking) action. The organization may engage members of the target community in this effort through community advisory boards, including community representatives or leaders on an internal project team; bringing data to a community meeting and soliciting input on priorities; or through other means that provide a meaningful avenue for members of the affected community or subpopulation to contribute to the selection and design of interventions.

Opportunities may be identified for individuals or patients, practitioners, the network or the organization. NCQA does not prescribe the types of opportunities the organization may identify or select.

Factors 3, 4: Implementing interventions

Research indicates that the most successful approaches to reducing health care ~~disparities inequities~~ are multifaceted (Beal, A.C. Policies To Reduce Racial And Ethnic Disparities In Child Health And Health Care. *Health Affairs*. 2004, 23(5): 171-9, Cooper, L.A., M.N. Hill, N.R. Power. Designing and Evaluating Interventions to Eliminate Racial and Ethnic Disparities in Health Care. *JGIM*. 2002, Vol 17(6): 477-86.). NCQA recognizes that implementing interventions can be a complex process that occurs over time, NCQA evaluates whether the organization has implemented at least one intervention each to address a prioritized opportunity for improving CLAS and reducing ~~disparities inequities~~. The organization must indicate the rationale for choosing a particular intervention.

Interventions and QI activities may take place at the organization level or, if the organization plays a significant supporting or sponsoring role, in the network; for example, including sharing data on race/ethnicity and language (with individuals' permission) with network practitioners to facilitate targeted outreach or more proactive arrangements for language services.

Factors 5, 6: Evaluating the effectiveness of an intervention

The organization must evaluate the effectiveness of both an intervention to improve culturally and linguistically appropriate services and an intervention to reduce disparities health care inequities. Direct or indirect data, or a combination, may be used for the evaluations. Evaluations address measures and interventions reflected in factors 1–4, or if insufficient time has elapsed to evaluate the effectiveness of the interventions, they may address measures and interventions undertaken in the prior year.

For organizations undergoing an Initial Survey, a plan for completion of the evaluation satisfies factors 5 and 6.

For organizations undergoing a Follow-Up Survey, an actual evaluation is required.

Exceptions

Factor 1 is NA if Element B, factors 1 and 2 are NA.

Factor 3 is NA if Element B, factors 1 and 2 are NA, or if no opportunities for reducing disparities health care inequities reduction are identified by the organization based on its analysis of results.

Factor 4 and 6 are NA if no opportunities for improvement in CLAS are identified by the organization based on its analysis of results.

Factor 5 is NA if no opportunities for disparity reduction are identified by the organization based on its analysis of results.

NCQA assesses whether “NA” is a reasonable conclusion based on the organization’s analysis.

For Initial Surveys, factors 5 and 6 can be met by completing a plan for evaluation of interventions.

Examples**Factors 1, 2: Identifying and prioritizing opportunities for improvement**

The organization’s analysis of disparities health care inequities by race indicates that significant health care inequities disparities exist in mammography screening, HbA1c control and blood pressure control. In the case of all three measures, the African Americans population fares worse than the White populations do. Because of the prevalence of hypertension and diabetes among African Americans individuals, and because of the serious consequences of both high blood pressure and uncontrolled diabetes, the organization prioritizes addressing health care inequities disparities in hypertension and diabetes over mammography screening. To focus on a manageable effort and because the diabetes disease management program was just recently reorganized, the organization selected hypertension as the first area for which to develop an intervention.

Factors 3, 4: Developing an intervention

The organization recognized the need to understand the reasons for disparate results in order to develop an effective intervention. QI staff identified practitioners who provide care to a large number of African American patients with hypertension and identified practitioners who provide care to White patients with hypertension. Chart reviews and interviews were conducted during the first quarter, to understand the differences in care provided and outcomes achieved.

Analysis revealed that blood pressure screening was documented somewhat less frequently for African American patients, but that even when screening rates were comparable, African American patients’ blood pressure was more often above normal. Follow-up interviews with providers suggested two contributing factors:

- African American patients found it more difficult to visit the doctor's office as frequently as required to check blood pressure and adjust medicines
- Practitioners felt that African American patients did not adhere to medication regimens as well as other patients.

As a final step in understanding the cause of the disparity, the organization conducted brief telephone interviews with a sample of African American patients with hypertension, to validate practitioner impressions and determine if there were other patient considerations. Interviews generally validated the practitioners' report and provided additional insight into the problem of medication regimen adherence. Some patients reported taking their hypertension medication only during stressful situations, when they felt their blood pressure would be higher. They reported that their doctors had not told them to take the medicine every day, regardless of how they felt.

Based on this assessment, the organization determined that a patient-focused intervention was required. It worked with its disease management program to develop outreach materials that were culturally competent and addressed the risks specific to African Americans. The organization recruited an African American nurse to conduct outreach calls and provided home blood pressure monitoring kits to patients enrolled in the disease management program. Following implementation of this intervention, the organization decided to continue to study the reasons for poor medication adherence.

Interventions to improve CLAS

- Recruit staff with specific language skills where gaps exist.
- Provide or require staff training in cultural humility and cross-cultural communication skills.
- Partner with community organizations to develop and provide culturally tailored information to individuals.
- Hire or engage community volunteers to advocate for and help individuals from diverse backgrounds to navigate the health care system ("patient navigators").

Factors 5, 6: Evaluating effectiveness

While the organization hoped that its intervention would result in an improvement of blood pressure control, it recognized that this would take time. In the interim, the organization evaluated intermediate outcomes. It measured the rate of enrollment by African American individuals with hypertension in the disease management program before and after implementation, and it conducted chart reviews for a sample of patients and practitioners to determine whether blood pressure was being recorded more frequently in patients' charts.

HE 7: Delegation of Health Equity Activities

If the organization delegates NCQA-required health equity activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated health equity activities.

Element A: Delegation Agreement

The written delegation agreement:

- 1. Is mutually agreed upon.**
- 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity.**
- 3. Requires at least semiannual reporting by the delegated entity to the organization.**
- 4. Describes the process by which the organization evaluates the delegated entity's performance.**
- 5. Describes the process for providing individual experience and clinical performance data to its delegates when requested.**
- 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Scoring	Met	Partially Met	Not Met
	<u>The organization meets 5-6 factors</u>	<u>The organization meets 3-4 factors</u>	<u>The organization meets 0-2 factors</u>

Data source Materials

Scope of review NCQA reviews delegation agreements in effect during the look-back period of up to four delegates, or reviews all delegates if the organization has fewer than four.
The score for the element is the average of the scores for all delegates.

Look-back period For All Surveys: 6 months.

Explanation This element may not be delegated.
This element applies to agreements that are in effect during the look-back period.
The delegation agreement describes all delegated health equity activities. A generic policy statement about the content of delegated arrangements does not meet this element.

Factor 1: Mutual agreement

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the

signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (the date of last signature) as the mutually agreed upon effective date.

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

NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.

Factor 2: Assigning responsibilities

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the health equity activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
- The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other health equity functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

Factor 3: Reporting

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about health equity delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited/Certified delegates.

Factor 4: Performance monitoring

The delegation agreement specifies how the organization evaluates the delegate's performance, including specific metrics or performance targets that are mutually agreed-upon.

Factor 5: Providing individual and clinical data

The organization's delegation agreement describes what the delegate must do to obtain the following data when it is needed or on an ongoing basis:

- **Individual experience data:** Complaints, CAHPS survey results or other data collected using valid measures of individuals' experience with the delegate's services.
- **Clinical performance data:** HEDIS measures, claims and other clinical data collected by the organization using valid measures of clinical performance. The organization may provide data feeds for relevant claims data or clinical performance measure results.

Factor 6: Consequences for failure to perform

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exception

This element is NA if the organization does not delegate health equity activities.

Examples

Factor 4: Performance monitoring

Metrics or performance targets that are mutually agreed upon may include but are not limited to:

- 80% of race/ethnicity data on membership.
- 90% individual satisfaction rate when providing translation services during healthcare encounters.
- Publish language data on 70% of practitioners in the network in the directories.

Element B: Predelegation Evaluation

For new delegation agreements initiated in the Look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Scoring	Met	Partially Met	Not Met
	<u>The organization evaluated delegate capacity before delegation began</u>	<u>The organization evaluated delegate capacity after delegation began</u>	<u>The organization did not evaluate delegate capacity</u>

Data source Reports

Scope of review This element applies if delegation was implemented in the look-back period.
NCQA reviews the organization’s predelegation evaluation of up to four delegates, or reviews all delegates if the organization has fewer than four.
The score for the element is the average of the scores for all delegates.

Look-back period For All Surveys: 6 months.

Explanation This element may not be delegated.

Predelegation evaluation

The organization evaluated the delegate’s capacity to meet NCQA requirements within 12 months prior to implementing delegation. The evaluation may include a review of the organization’s structure, processes, and staffing in order to determine its capability to perform the delegated function.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional health equity activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Examples**Exceptions**

This element is NA if:

- The organization does not delegate health equity activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaboratives. The organization may enter into a collaboration with other organizations to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.

The collaborative must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared processes to reduce burden, as permitted in the program standards.

Predelegation evaluation

- Site visit.
- Telephone or virtual consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of Performance

For arrangements in effect for 12 months or longer, the organization:

- 1. Semiannually evaluates regular reports, as specified in Element A.**
- 2. Annually evaluates delegate performance against NCQA standards for delegated activities, as specified in Element A.**

	Met	Partially Met	Not Met
Scoring	<u>The organization meets 2 factors</u>	<u>The organization meets 1 factor</u>	<u>The organization meets 0 factors</u>

Data source Reports

Scope of review NCQA reviews evidence of the organization's review from up to four delegates, or all delegates if the organization has fewer than four.

For All Surveys: NCQA reviews the organization's most recent semiannual and annual performance evaluation reports completed during the look-back period.

The score for the element is the average of the scores for all delegates.

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

Explanation This element may not be delegated.

Factor 1: Evaluation of reports
No additional explanation required.

Factor 2: Annual evaluation
No additional explanation required.

Exceptions
This element is NA if:

- The organization does not delegate health equity activities.
- Delegation arrangements have been in effect for less than 12 months.

Related information
Use of collaboratives. The organization may enter into a collaboration with other organizations to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.

The collaborative must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared processes to reduce burden, as permitted in the standards.

Examples None.

Element D: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Scoring	Met	Partially Met	Not Met
	<u>The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect</u>	<u>The organization took inappropriate or weak action, or acted only in the past year</u>	<u>The organization has not acted on identified problems</u>

Data source Documented process, Reports, Materials

Scope of review NCQA reviews reports for opportunities for improvement if applicable of up to four delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.
For All Surveys: NCQA reviews the organization’s most recent annual review and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

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

Explanation This element may not be delegated.

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports, or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate health equity activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
 - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.