



Health Equity Partner Certification

Proposed Standards

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HEC 1: Organizational Readiness

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

Intent

The organization supports its health equity goals by taking action to improve diversity, equity, inclusion or cultural humility for its workforce.

Element A: Building a Diverse Workforce

The organization:

1. Has recruiting and hiring processes that support diversity in its workforce.
2. Identifies at least one opportunity to improve diversity, equity, inclusion or cultural humility for its workforce.
3. Acts on at least one opportunity identified in factor 2.

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

Data source Documented process, Reports, Materials

Scope of review *For Interim Surveys:* For factor 1, NCQA reviews a documented process describing the organization’s recruiting and hiring process in place throughout the look-back period.

For Initial Surveys: NCQA reviews:

- *For factor 1:* A documented process describing the organization’s recruiting and hiring process in place throughout the look-back period.
- *For factors 2 and 3:* 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 its workforce during the look-back period.
 - For factor 3, the organization may submit a plan to act on an opportunity identified in factor 2.

For Renewal Surveys: NCQA reviews:

- *For factor 1:* A documented process describing the organization’s recruiting and hiring process in place throughout the look-back period.
- *For factors 2 and 3:* 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 its workforce during the look-back period.

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

For Initial Surveys and Renewal Surveys: 6 months for factor 1; once during the prior year for factors 2 and 3.

Explanation THIS IS A MUST-PASS ELEMENT.

This element pertains to the organization seeking Certification, not its client organizations.

The organization’s workforce encompasses internal, external, temporary and permanent positions, and includes:

- Staff.
- Leadership (individuals with managerial authority and executive roles such as managers, directors, vice presidents or chief officers).
- Committees (individuals internal or external to the organization, appointed for a specific function).
- Governance bodies, including, but not limited to, the organization’s board of directors.

Diversity 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, or in the existing workforce that reflects the population served.

Equity is developing, strengthening and supporting procedural and outcome fairness in systems, procedures and resource distribution mechanisms to create fair 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 processes that support diversity

The organization’s recruiting and hiring practices explicitly address how the organization promotes diversity in its:

- Staff.
- Leadership.
- Committees.
- Governance bodies.

At a minimum, the organization’s recruiting and hiring practices consider:

- The diversity of the organization’s workforce compared with the diversity of the population served (e.g., members, patients, learners, users).
- Subpopulations of the population served that are inadequately represented in the organization’s workforce.

- Whether particular groups are marginalized, disenfranchised or disempowered by the organization’s recruiting and hiring practices.

Recruiting and hiring practices are specific to the organization and include, but are not limited to, internal and external positions, promotions and reclassifications and temporary and permanent positions.

Note: *This factor is specific to the organization’s recruiting and hiring processes, and does not apply to the organization’s pool or network of practitioners outside of staff, leadership, committees or governance bodies.*

Factor 2: Identifies at least one opportunity

The organization assesses its hiring and recruiting practices, and identifies at least one opportunity to improve diversity, equity, inclusion or cultural humility for each of the following:

- Staff.
- Leadership.
- Committees.
- Governing bodies.

The opportunities for each group may be different or may overlap, if appropriate.

Factor 3: Acts on at least one opportunity

The organization acts on at least one opportunity identified in factor 2 to improve diversity, equity, inclusion and cultural humility for at least one group in its workforce (staff, leadership, committees, governance bodies).

Exceptions

Factors 2 and 3 are NA for Interim Surveys.

Related information

Use of vendors to identify opportunities. If the organization contracts with a vendor or external consultant to meet factor 2, it provides the vendor or external consultant’s documentation for evaluation. NCQA does not consider the relationship to be delegation. NCQA evaluates the vendor’s documentation against the requirements. Refer to “Vendors” in *Appendix 2: Automatic Credit*.

Examples

Factor 1: Recruiting and hiring practices that support diversity

Documentation methods

- Policies and procedures.
- Employee handbook.

Recruiting and hiring practices

- 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.
- Use blind-review resumes when hiring new staff.
- Hold hiring decision makers and leadership responsible for representation growth within teams and the organization.

- Dedicate resources to recruiting underrepresented groups such as individuals with disabilities, on governing bodies.
- Deploy technology that screens for biased language in job descriptions and postings.
- Require interview panels to include interviewers from underrepresented populations, genders or diverse position levels.
- Broaden recruitment sources, for example:
 - Schools with diverse student bodies or alumni networks.
 - National associations or groups that advocate for marginalized, disenfranchised or disempowered groups.
 - Recruitment firms that specialize in job placement for diverse groups of executives.
- Require external committees to reflect the diversity of the organization.
- 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.

Factor 2: Identification of opportunities

- Compare the diversity of the organization’s workforce with groups or subgroups of the community or population the organization serves (e.g., racial/ethnic, preferred language, gender identity, sexual orientation) and with the diversity of the pool of available candidates in the labor market where the organization operates.
- 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.
- Survey staff to identify the primary barriers to maintaining employment, to reduce turnover rates for traditionally marginalized, disenfranchised or disempowered groups.

Factor 3: Acts on opportunities

- Build diversity, equity, inclusion and cultural humility performance metrics into all management and leadership job descriptions and goals.^[1,2]
- Suggest staff share pronouns in introductions and/or email signatures.
- Design workspaces 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, disenfranchised or disempowered groups.
- Create temporary or permanent positions, departments, councils or committees focused on highlighting underrepresented groups.

^[1]<https://givingusa.org/be-a-smartie-an-equity-forward-approach-to-goal-setting/J>

^[2]<https://healthcareanchor.network/anchor-mission-resources/>

HEC 2: Data Protections and Management

The organization clearly defines and communicates how it accesses, uses and shares individuals' demographic and social needs data.

Intent

The organization cultivates trust with individuals it serves, and has the infrastructure necessary to oversee appropriate access, use and sharing of individuals' demographic and social needs data.

Element A: Privacy and Security Protections for Data

The organization has policies and procedures for managing access to, using and sharing data on individuals' race, ethnicity, language, gender identity, sexual orientation and social needs, 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, using and sharing each type of required individual-level data.

Look-back period *For Interim Surveys:* Prior to the survey date.
For Initial Surveys and Renewal Surveys: 6 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

The organization has policies and procedures for managing access to, using and sharing data on individuals':

- Race and ethnicity.
- Language.
- Gender identity.
- Sexual orientation.
- Nonclinical social needs (e.g., financial or food insecurity, housing instability, lack of access to transportation, interpersonal safety).

The policies and procedures address each required data type the organization collects, accesses or uses at the individual-level data.

The policies and procedures may be independent of or integrated with the organization's HIPAA privacy policies and/or privacy protections. If the organization's privacy policies are intended to include race, ethnicity, language, gender identity and sexual orientation information, this must be explicitly stated in the policies and procedures.

Factor 1: Controls for access to data

The organization has policies and procedures for governing and tracking receipt, removal and access to devices and media that contain individual-level data on race, ethnicity, language, gender identity, sexual orientation and social needs, or that may be used to access these data.

Policies and procedures address data storage and movement; disposal and reuse of devices, hardware and media; and types of media used, as applicable, including:

- Diskettes, CDs, tapes and mobile applications.
- Portable drives.
- Laptops.
- Secure portals.

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

Factors 2, 3: Permissible and impermissible use

The organization outlines permissible and impermissible use of each type of data, outlining differences by client, as applicable. Use may align with rules defined by the Department of Health and Human Services (HHS) under HIPAA, or as defined by other applicable laws or regulations.

- Permissible or impermissible use of data may include care coordination and care management, as outlined on the HHS website¹ or other use defined by HIPAA rules and other applicable laws.
- Impermissible use explicitly includes underwriting and denial of services, coverage and benefits, if applicable to the organization's operations.

Exceptions

This element is NA for organizations that do not collect, access or use individual-level data on race, ethnicity, language, gender identity, sexual orientation or social needs.

Examples**Factor 1: Data access control**

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

- Disable or remove passwords of employees who leave the organization, and alert appropriate staff who oversee computer security.

Factor 2: Permissible use of data

- Identify and refer individuals to appropriate social needs resources or interventions.
- Inform health care practitioners and providers about individuals’ social needs.
- Assess health care disparities.
- Update work plan activities.
- Design intervention programs.
- Design and direct outreach materials.
- Inform the program’s prioritized activities and goals.
- Inform health care practitioners and providers about individuals’ language needs and pronouns.
- Provide clinical care.

Factor 3: Impermissible use of data

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

Element B: Notification of Protections for Demographic and Social Needs Data

When the organization collects data on individuals’ race, ethnicity, language, gender identity, sexual orientation and social needs, it discloses its policies and procedures for managing access to, using and sharing each type of 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.
4. How individuals can communicate data sharing preferences.

	Met	Partially Met	Not Met
Scoring	The organization meets 3-4 factors	No scoring option	The organization meets 0-2 factors

Data source Documented process, Materials

Scope of review *For Interim Surveys:* NCQA reviews:

- The organization’s policies and procedures for notifying individuals it serves about its policies for managing access to, using and sharing race, ethnicity, language, gender identity, sexual orientation and social needs data.
- Draft language of the notifications.

For Initial Surveys and Renewal Surveys: NCQA reviews materials (e.g., member handbook, letter, screenshot) as evidence that the organization notified individuals it serves about its policies and procedures for managing access to, using and

sharing race, ethnicity, language, gender identity, sexual orientation and social needs data.

Look-back period *For Interim Surveys:* Prior to the survey date.
For Initial Surveys: 6 months
For Renewal Surveys: 12 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

Disclosure to individuals

Notifying individuals about how the organization protects, uses and shares data (Element A) helps individuals understand what to expect from the organization and its clients, and may encourage them to disclose data when requested.

The notification must address all data types that the organization collects, accesses, or uses at the individual-level.

At a minimum, notifications about demographic data must be made or distributed at the time of direct data collection. Notifications about social needs data must be made or distributed at the time of direct data collection or during the social needs referral process.

For Interim Surveys, the organization's documented process for notifying individuals:

- Describes how (i.e., method), when (e.g., timing, circumstances) and by whom (e.g., case worker, member services staff) the organization's policies and procedures are disclosed to individuals served.
- May (but are not required to) outline how the organization determines the most appropriate method of notification for the individual's needs. For example:
 - Verbal communication for individuals with visual disabilities or low literacy, or who lack permanent housing.
 - Written translations or use of interpreters in the language an individual best understands.
 - Written notification or use of interpreters for individuals with impaired hearing.

Factors 1–3

The organization notifies individuals it serves about how data on their demographic (race, ethnicity, language, gender identity, sexual orientation) and nonclinical social needs are protected by the organization's policies, including:

- Controls for physical and electronic access to the data.
- Permissible and impermissible uses of each type of data.
- Impermissible use includes underwriting and denial of services, coverage and benefits, if applicable to the organization's operations.
- Whether such information will be shared, and with whom (e.g., practitioners, providers, payers, community-based partners, the individual's employer).

Factor 4: How to give data sharing preferences

The organization notifies individuals it serves about how they can give data-sharing preferences for each type of demographic and social needs data.

Exceptions

This element is NA for organizations that:

- Do not collect, access, use or share individual-level data on race, ethnicity, language, gender identity, sexual orientation and nonclinical social needs.
- Are contractually prohibited by their clients from directly contacting or engaging with the individuals they mutually serve.

Related information

Use of vendors/mail service organizations for notification of privacy protections. If the organization contracts with a mail service organization to provide distribution services, it provides access to the mail service organization's documentation for evaluation. NCQA does not consider the relationship to be delegation or subdelegation. Refer to *Vendors in Appendix 2: Delegation and Automatic Credit Guidelines*.

Examples

Factors 1–4

Materials as evidence of notification

- Welcome packets.
- Marketing materials.
- Call scripts.
- Disclosure statements.
- Electronic messaging (e.g., patient portal, EMR).

Methods of notification

- Distributing written information.
- Using a scripted telephone call.
- In-person contact.
- Online contact:
 - Secure email or portal.
 - Video conference.
 - Live chat.

HEC 3: Internal Quality Improvement Process

The organization has a process for internal continuous quality improvement to meet the needs of individuals it serves.

Intent

The organization has the infrastructure needed to continuously monitor and improve the quality of the services it provides.

Element A: QI Policies and Procedures

The organization has a written QI plan or comprehensive policies and procedures that include:

1. A defined scope of activities.
2. Defined goals and objectives.
3. A defined process for performance assessment.

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:* For factors 1–3, NCQA reviews the organization’s QI plan or policies and procedures in place throughout the look-back period.

Look-back period *For Interim Surveys:* Prior to the survey date.
For Initial Surveys and Renewal Surveys: 6 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

Factor 1: Scope of activities

The organization’s written QI plan or policies and procedures define:

- Functional areas, departments or staff involved in developing the QI plan.
- Quality indicators (measures) based on the type of services it provides to its population and to its clients.
- The QI activities performed by the organization to achieve performance expectations.
 - Staff roles responsible for each activity.
- Time frame for each activity’s completion.

Factor 2: Goals and objectives

The organization’s written QI plan or policies and procedures includes defined, measurable performance goal or objective for quality improvement. The organization defines at least one measurable performance goal or objective related to each Certification the organization selects for evaluation (HEC 4—HEC 9), based on the services it provides to its population or its clients. Defined goals and objectives address actions or interventions performed by the organization, and may

- Address the areas of improving outcomes, quality of service, timeliness and experience (including complaints).
- Pertain to the population served by the organization (e.g., patients, members, users, learners) or to the population of a specific client.
- Be defined by the organization or in cooperation with clients.

Factor 3: Performance assessment

The organization’s written QI plan defines its process for:

- Monitoring performance on program activities defined in factor 1.
- Measuring performance on goals and objectives defined in factor 2.
- Identifying and taking action on opportunities for improvement.
- Collecting, assessing and resolving quality issues and concerns.
- Identifying barriers to meeting goals and completing planned activities.

Exceptions

None.

Examples

Factor 2: Goals and objectives

- By the end of the calendar year, reduce low African American infant birth weight by 15%.
- By the end of Q2, reduce the time between requesting and receiving language services by 10%.
- By the end of Q4, reduce by 5% the rate of Spanish-speaking patients who were referred for but did not receive transportation services.

Element B: Annual Analysis of QI Activities

The organization annually collects and analyzes data on its QI goals and objectives, including:

1. Evaluation of aggregate data and trends.
2. Assessment of opportunities for improvement.
3. Assessment of barriers to improvement.
4. Assessment of its performance.

Scoring	Met	Partially Met	Not Met
	The organization meets 4 factors	No scoring option	The organization meets 0-3 factors

Data source Reports

Scope of review *For Initial Surveys:* NCQA reviews the organization’s most recent evaluation report. The organization may submit a plan for meeting factors 1–4 in lieu of an evaluation report.

For Renewal Surveys: NCQA reviews the organization’s most recent and previous annual evaluation reports.

Look-back period	<p><i>For Initial Surveys:</i> At least once during the prior year.</p> <p>For Renewal Surveys: 24 months.</p>
Explanation	<p>THIS IS A MUST-PASS ELEMENT.</p> <p>The organization annually collects and analyzes data from each QI goal and objective, which may include client data, to identify opportunities for improvement. Analysis must go beyond displaying data.</p> <p>Factor 1: Evaluation of aggregate data</p> <p>The organization conducts quantitative analysis of data that incorporates aggregate results and trends over time and compares results against a standard or goal. Tests of statistical significance are not required, but may be useful when analyzing trends.</p> <p>Refer to <i>Appendix 3: Glossary</i> for the full definition of and requirements for “quantitative analysis.”</p> <p>Factor 2: Opportunities for improvement</p> <p>The organization assesses and chooses opportunities for improvement, and describes its reasons for taking action on each opportunity.</p> <p>Factor 3: Barriers to improvement</p> <p>The organization conducts a root cause analysis or barrier analysis to identify the reasons for the results. The analysis includes organization staff who bring understanding about the processes that may present barriers to improvement.</p> <p>Factor 4: Performance</p> <p>The organization assess its performance against the goals and objectives defined in its QI plan (Element A).</p> <p>Exception</p> <p>This element is NA for Interim Surveys.</p>
Examples	None.

Element C: Action and Follow-Up on Opportunities

For opportunities identified for improvement, the organization implements interventions and conducts a follow-up evaluation on actions taken.

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

Data source Reports

Scope of review *For Renewal Surveys:* NCQA reviews the organization’s most recent and previous implementation of interventions and follow-up of its actions on identified opportunities.

Look-back period	<i>For Renewal Surveys:</i> 24 months.
Explanation	<p>THIS IS A MUST-PASS ELEMENT.</p> <p>The organization follows up on opportunities identified in Element B, factor 2. Interventions are linked to identified barriers, and are of sufficient strength and specificity that there is the likelihood they contribute to measurable improvement. The organization also assesses the effectiveness of interventions to determine whether the interventions improved performance.</p> <p>Exceptions</p> <p>This element is NA:</p> <ul style="list-style-type: none"> • For Interim Surveys and Initial Surveys. • If the organization does not have any opportunities for improvement. <ul style="list-style-type: none"> – NCQA evaluates whether this conclusion is reasonable, given evaluation results.
Examples	None.

Element D: Cooperating With Client QI Efforts

The organization cooperates with the client’s efforts to implement quality improvement and other activities.

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	<p><i>For Initial Surveys and Renewal Surveys:</i> NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected clients, or from all clients if the organization has fewer than four, and reviews other evidence that the organization cooperates with the client’s efforts to implement QI activities.</p> <p>If no clients ask for cooperation with QI activities during the look-back period, the organization may present the delegation agreement specifying that it cooperates with clients’ QI activities.</p> <p>NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of the scores for all clients.</p>
Look-back period	<p><i>For Initial Surveys:</i> 6 months.</p> <p><i>For Renewal Surveys:</i> 24 months.</p>
Explanation	<p>THIS IS A MUST-PASS ELEMENT.</p> <p>The organization participates in affiliated clients’ QI activities and other appropriate activities related to Certifications the organization selected for evaluation (HEC 4—HEC 9).</p> <p>Exceptions</p>

This element is NA:

- For Interim Surveys and Initial Surveys.
- If the organization does not perform any NCQA required functions or activities for any clients.
- If the organization does not participate in any QI related activities on behalf of client organizations.

Examples

Evidence of cooperation with client initiatives

- Committee meeting minutes.
- Records of communication with clients.

HEC 4: 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 Race/Ethnicity and Language Data

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

1. Race/ethnicity.
2. Language.

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

Data source Documented process, Reports, Materials

Scope of review *For Interim Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period, and reviews reports or materials (e.g. screenshots) for evidence of the electronic data system's configuration.

For Initial Surveys and Renewal Surveys:

- NCQA reviews:
 - The organization's documented process in place throughout the look-back period, and reviews reports or materials (e.g. screenshots) for evidence of the electronic data system's configuration.
 - Reports or materials (e.g., screenshots) from each selected client for evidence that the organization follows its documented process.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation **Factors 1–2: Receiving, storing and retrieving data**

The organization has an electronic database that receives, stores and retrieves the individual-level data described in factors 1–2 and collected through direct data collection, as specified in Elements C–D.

Direct data collection describes methods that ask individuals to self-disclose information about themselves (e.g., enrollment or registration forms, surveys,

member or customer service call scripts, case management intake forms, health assessments). It includes information collected or assessed by the organization's clients and by other external sources which have asked individuals to self-disclose race/ethnicity, such as the Centers for Medicare & Medicaid Services (CMS), state or local agencies, community-based organizations, Federally Qualified Health Centers, health systems, hospitals, integrated delivery systems, provider networks, electronic health records, health information exchanges and case management systems.

The organization's documented process contains the following information, outlining differences by client, as applicable:

- The electronic database's data source(s).
- How the database receives, stores and retrieves responses for factors 1–2, including when an individual responds that they choose not to disclose the data.
- If the organization receives data from multiple sources, its process for reconciling differences or conflicts between data (i.e., how the organization decides which data source to select or prioritize if data sources contain conflicting information).

Exceptions

None.

Related information

Outsourcing health equity data storage to a cloud-based entity. It is not considered delegation if the organization only outsources data storage to a cloud-based entity that does not provide services that create, modify or use the data.

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 their 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 them as Black/African American. The individual's practitioner lists them 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 population health management program stating 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 there is conflicting information.

Element B: Systems for Individual-Level Sexual Orientation/Gender Identify Data

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

1. Gender identity.
2. Sexual orientation.

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

Data source Documented process, Reports, Materials

Scope of review *For Interim Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period, and reviews reports or materials (e.g. screenshots) for evidence of the electronic data system's configuration.

For Initial Surveys and Renewal Surveys:

- NCQA reviews:
 - The organization's documented process in place throughout the look-back period, and reviews reports or materials (e.g. screenshots) for evidence of the electronic data system's configuration.
 - Reports or materials (e.g., screenshots) from each selected client for evidence that the organization follows its documented process.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation **Factors 1–2: Receiving, storing and retrieving data**

The organization has an electronic database that receives, stores and retrieves the individual-level data described in factors 1–2 and collected through direct data collection, as specified in Elements E–F.

For factor 1, gender identity data includes:

- Sex assigned at birth.
- Gender identity.
- Pronouns.

Direct data collection describes methods that ask individuals to self-disclose information about themselves (e.g., enrollment or registration forms, surveys, member or customer service call scripts, case management intake forms, health assessments). It includes information collected or assessed by the organization's clients and by other external sources which have asked individuals to self-disclose race/ethnicity, such as the Centers for Medicare & Medicaid Services (CMS), state or local agencies, community-based organizations, Federally Qualified Health Centers, health systems, hospitals, integrated delivery systems, provider networks,

electronic health records, health information exchanges and case management systems.

The organization's documented process contains the following information, outlining differences by client, as applicable:

- The electronic database's data source(s).
- How the database receives, stores and retrieves responses for factors 1–2, including when an individual responds that they choose not to disclose the data.
- If the organization receives data from multiple sources, its process for reconciling differences or conflicts between data (i.e., how the organization decides which data source to select or prioritize if data sources contain conflicting information).

Exceptions

None.

Related information

Outsourcing health equity data storage to a cloud-based entity. It is not considered delegation if the organization only outsources data storage to a cloud-based entity that does not provide services that create, modify or use the data.

Examples

Reconciling, selecting or prioritizing data

- *Granular vs. high-level collection categories.* On the organization's enrollment form, an individual self-identifies as pansexual. Data received from the individual's health plan (the organization's client) lists the individual's sexual orientation as "something else, please describe," a classification some individuals choose when their sexual orientation is not listed in the response options. The organization outlines its processes for prioritizing data from sources that use different levels of granularity than its own categories.
- *Synonymous response categories.* An individual provides information to the organization's care manager that they are nonbinary. Data received from lists the individual as "Genderqueer, neither exclusively male nor female." The organization outlines its processes for mapping and reconciling responses from sources that use different response options than its own data collection framework .
- *Conflicting responses.* On the organization's user portal, an individual selected "she/her" as preferred pronouns. During a recent social needs referral, the individual self-identified "they/them" as preferred pronouns. The organization outlines its processes for directly verifying the accuracy of data when there is conflicting information.

Element C: Collection of Data on Race/Ethnicity

The organization's methods for assessing race/ethnicity of individuals it serves include:

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.

Scoring	Met	Partially Met	Not Met
	The organization meets 4 factors	No scoring option	The organization meets 0-3 factors

Data source Documented process, Reports, Materials

Scope of review *For Interim Surveys:* For factors 1–4, NCQA reviews the organization’s documented process in place throughout the look-back period for assessing the race and ethnicity of individuals served by the organization.

For Initial Surveys and Renewal Surveys:

- NCQA reviews:
 - *For factor 1:* Reports or materials demonstrating data collection for each selected client.
 - *For factors 1–4:*
 - The organization’s documented process in place throughout the look-back period for assessing the race and ethnicity of individuals served by the organization, outlining differences by client, as applicable.
 - Reports or materials demonstrating the organization followed its documented process for each selected client.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation **Factor 1: Direct data collection method and OMB categories**

The organization collects direct data on the race/ethnicity of all individuals it serves.

Direct data collection describes methods that ask individuals to self-disclose information about themselves (e.g., through enrollment or registration forms, surveys, member or customer service call scripts, case management intake forms, health assessments).

Though it is voluntary for individuals served by the organization (e.g., patients, members, users, learners) to disclose their race/ethnicity, the organization must attempt to collect this information. The organization may collect data directly at various points of interaction, and should use as many channels or mechanisms as available to collect race/ethnicity from individuals. If underwriting is involved, the organization may determine the appropriate timing of collection to avoid concerns about discrimination.

The organization may receive, exchange or use data stored, collected or assessed by external sources that have asked individuals to self-disclose race/ethnicity information that can be rolled up to the OMB categories, such as the Centers for Medicare & Medicaid Services (CMS), state or local agencies, community-based organizations, Federally Qualified Health Centers, health systems, hospitals,

integrated delivery systems, provider networks, electronic health records, health information exchanges and case management systems.

If an individual is unable to provide a response to a direct request (e.g., due to age or functional inability to communicate), data collected from the individual's caregiver is considered direct data collection.

Data collection framework. The organization's data collection framework includes, at a minimum, a description of:

- The population or subset of individuals from whom data will be collected.
- A defined process for soliciting information from individuals if a response was requested but not provided.
- When data will be collected.
- Where data will be collected (e.g., setting, data sources).
- How (i.e., method of collection) and by whom (e.g., case worker, Member Services staff) data will be collected.
- Questions in the documented process that will be used to collect data, including a script to guide staff who collect or assess data verbally, when applicable.

An individual declining to provide their race/ethnicity information (a category value of "Asked but no Answer") is considered direct data. An individual with a race category of "Other" may be considered as direct or indirect data, depending on whether the response was gathered from the individual.

OMB categories. 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, including the response option of "Other." The organization's data collection framework should be designed to fit the population served by the organization, and may include response options that are more detailed than the OMB race/ethnicity categories, as long as the organization's documented process outlines how it systematically aggregates responses into OMB categories.

While the OMB recommends a two-question format that asks for ethnicity before race, the organization may also use a combined format. In both cases, the National Academy of Medicine (NAM) recommends that respondents be instructed to select one or more categories that may apply.^[1]

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).

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 use indirect methods to estimate the race/ethnicity of individuals for use in population-level 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 individual’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/indirect methods or data sources.

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 aggregating or rolling up its race/ethnicity data to OMB categories. The NAM recommends collecting detailed ethnicity data appropriate to the demographics of the local service area.

Exceptions

Factors 2 and 3 are NA if the organization has direct data on the race/ethnicity of 80% or more of the individuals it serves.

Individuals enrolled through Administrative Services Only (ASO) accounts, where the purchaser prohibits direct contact from the organization, are not included in this requirement.

^[1] Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. <https://nap.nationalacademies.org/catalog/12696/>

Related information

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 National Academy of Medicine (NAM; formerly the Institute of Medicine), 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.

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.
- Population health 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 rolled up to OMB categories.

HRET Toolkit.^[2] 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 NAM 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.^[3] 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.

^[2] hretdisparities.org

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

Element D: Collection of Data on Language

The organization’s methods for assessing the language needs of individuals it serves include:

1. Direct collection of language needs from all individuals.
2. Assessment of the population’s language profile.
3. Determination of threshold languages.
4. Determination of languages spoken by at least 1% of the population or 200 individuals, whichever is less.

Scoring	Met	Partially Met	Not Met
	The organization meets 4 factors	No scoring option	The organization meets 0-3 factors

Data source Documented process, Reports, Materials

Scope of review *For Interim Surveys:* For factors 1–4, NCQA reviews the organization’s documented process in place throughout the look-back period for assessing the language needs of individuals it serves.

For Initial Surveys and Renewal Surveys:

- For factors 1–4, NCQA reviews:
 - The organization’s documented process in place throughout the look-back period for assessing the language needs of individuals it serves, outlining differences by client, as applicable.
 - Reports or materials demonstrating data collection for each client and assessment of the general population’s languages, including threshold languages and languages spoken by 1% of the population or 200 individuals.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

Look-back period *For Interim Surveys:* Prior to the survey date.
For Initial Surveys: 6 months.
For Renewal Surveys: 36 months.

Explanation **Factor 1: Direct data collection method**

The organization collects direct data on the language needs of all individuals it serves.

Direct data collection describes methods that ask individuals to self-disclose information about themselves (e.g., through enrollment or registration forms, surveys, member or customer service call scripts, case management intake forms, health assessments).

Though it is voluntary for individuals served by the organization (e.g., patients, members, users, learners) to disclose their language needs, the organization must attempt to collect this information. The organization may collect data directly at various points of interaction, and should use as many channels or mechanisms as available to collect language needs information from individuals. If underwriting is involved, the organization may determine the appropriate timing of collection to avoid concerns about discrimination.

The organization may receive, exchange or use data stored, collected or assessed by external sources that have asked individuals to self-disclose information, such as the Centers for Medicare & Medicaid Services (CMS), state or local agencies, community-based organizations, Federally Qualified Health Centers, health systems, hospitals, integrated delivery systems, provider networks, electronic health records, health information exchanges and case management systems.

If an individual is unable to provide a response to a direct request (e.g., due to age or functional inability to communicate), data collected from the individual's caregiver is considered direct data collection.

Data collection framework. The organization's data collection framework includes, at a minimum, a description of:

- The population or subset of individuals from whom data will be collected.
- A defined process for soliciting information from individuals if a response was requested but not provided.
- When data will be collected.
- Where data will be collected (e.g., setting, data sources).
- How (i.e., method of collection) and by whom (e.g., case worker, member services staff) data will be collected.
- Questions in the documented process that will be used to collect data, including a script to guide staff who collect or assess data verbally, when applicable.

The organization may use the National Academy of Medicine (NAM; formerly the Institute of Medicine) recommendation to evaluate language needs, or may use another method of asking about language preference if it describes the process. The NAM 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 NAM 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, including information individuals self-disclosed to the client organization, to enable communication in the requested language (e.g., written information in a language other than English). The organization or its clients may also share language needs information with practitioners and providers, enabling them to provide language services more effectively to the individuals they mutually serve.

Factor 2: Assessing the population’s language profile

The organization assesses the languages spoken by the general population in its service area, using state-level census or community-level data. The organization assesses and reports on the language profile of the community, in order to anticipate and plan for changes in the language services it provides to the individuals it serves. National organizations that do not operate in defined service areas may use national census data to determine their population language profile.

The organization may use language needs information about the community’s population to plan for and improve its language services capabilities. Changing demographics may be more apparent at the community level than among the individuals served by the organization; 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

The organization uses census or community-level data to determine and report threshold languages used by the general population in its service area or its client’s service area for translation purposes. **Threshold languages** are all languages other than English spoken by 5% of the population or by 1,000 individuals, 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 used by the general population in its service area or its client’s service area spoken by 1% of the population or by 200 individuals, whichever is less, up to a maximum of 15 languages. The organization maintains a list of all languages spoken and updates the list at least every 3 years.

Exceptions

None.

Examples

Direct data collection mechanisms

- Enrollment form.
- The organization’s website.
- Surveys.
- Calls to Member Services.
- Population health 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 (<https://data.census.gov/cedsci/table?q=B16001>).
- Community surveys.
- School data on languages spoken by students.
- The Modern Language Association Language Map (http://www.mla.org/map_main).

Element E: Collection of Data on Gender Identity

The organization’s framework for collecting gender identity information of individuals it serves 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 organization staff that interact directly with individuals served.

***Critical factors: Score is Not Met if one critical factor is scored “no.”**

Scoring	Met	Partially Met	Not Met
	The organization meets 3-5 factors	No scoring option	The organization meets 0-2 factors

Data source Documented process, Reports, Materials

Scope of review *For Interim Surveys:* For factors 1–5, NCQA reviews the organization’s documented process in place throughout the look-back period.

For Initial Surveys and Renewal Surveys:

- NCQA reviews:
 - For factors 1–5: The organization’s documented process in place throughout the look-back period, outlining differences by client, as applicable.

- For factors 1–4: Reports or materials demonstrating data collection for each client and that the organization’s data collection methods follow its documented process.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

Look-back period

For Interim Surveys: Prior to the survey date.

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Factor 1 is a critical factor; if it is scored “No,” the organization’s score is “Not Met” for the element.

Direct data collection describes methods that ask individuals to self-disclose information about themselves (e.g., through enrollment or registration forms, surveys, member or customer service call scripts, case management intake forms, health assessments).

Though it is voluntary for individuals served by the organization (e.g., patients, members, users, learners) to report data on sex assigned at birth, gender identity and pronouns, the organization must attempt to collect this information. The organization may collect data directly at various points of interaction, and should use as many channels or mechanisms 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.

The organization may receive, exchange or use data stored, collected or assessed by external sources that have asked individuals to self-disclose information that can be aggregated to the minimum response option categories, such as the Centers for Medicare & Medicaid Services (CMS), state or local agencies, community-based organizations, Federally Qualified Health Centers, health systems, hospitals, integrated delivery systems, provider networks, electronic health records, health information exchanges and case management systems.

If an individual is unable to provide a response to a direct request (e.g., due to functional inability to communicate), data collected from the individual’s caregiver is considered direct data collection.

Data collection framework. At a minimum, the organization describes its process for direct collection of gender identity data from adults 18 and older. If the organization collects gender identity data described in factors 1–4 from individuals younger than 18, it describes differences between the data collection framework for these individuals and the data collection framework for adults.

The organization’s data collection framework includes, at a minimum, a description of:

- The population or subset of individuals from whom data will be collected.
- A defined process for soliciting information from individuals if a response was requested but not provided.
- When data will be collected.
- Where data will be collected (e.g., setting, data sources).
- How (i.e., method of collection) and by whom (e.g., case worker, member services staff) data will be collected.

- Questions in the documented process that will be used to collect data, including a script to guide staff who collect or assess data verbally, when applicable.

The organization's data collection framework should be designed to fit the population the organization serves, and may include response options that are more detailed than the minimum response options listed in factors 2–4, as long as the organization's documented process outlines how it systematically aggregates responses into the minimum response option categories.

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

The organization has a data collection method that seeks to respect the responding individual and reduce the potential for stigmatization (e.g., designs respectful screening questions, trains staff on how to respectfully collect data).

At a minimum, the data collection method includes:

- Nonbinary gender identity response options.
- An explanation for staff about offering nonbinary response options.

Factor 2: Direct collection of sex assigned at birth

The organization collects direct data on sex assigned at birth for the individuals it serves.

At a minimum, the organization's data collection methodology includes:^[1]

- 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 the response option "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 when a response was requested but not provided.

Factor 3: Direct collection of gender identity

The organization collects direct data on gender identity of the individuals it serves.

At a minimum, the organization's data collection methodology includes:^[2]

- The following response options:
 - 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 not provided (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 when a response was requested but not provided.

Factor 4: Direct collection of pronouns

The organization collects direct data on pronouns of the individuals it serves.

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 when a response was requested but not provided.

Factor 5: Sharing pronoun information

The organization has a documented process for making pronoun information available to organization staff who interact directly with individuals it serves in a way that makes respecting, sharing and educating about personal pronouns commonplace.

Exceptions

None.

Related information

Designing direct data collection. The Office of the National Coordinator for Health Information Technology (ONC)^[3] 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^[4] guidance on collecting sexual orientation and gender identity and the National Institute of Health: Sexual And Gender Minority Research Office^[5] offer research on surveying and collecting data, and highlight multiple studies on survey questions about collecting information on sexual orientation and gender identity.

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

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

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

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

Examples

Factor 4: Direct collection of pronouns

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

Element F: Collection of Data on Sexual Orientation

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

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

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

Data source Documented process, Reports, Materials

Scope of review *For Interim Surveys:* NCQA reviews the organization’s documented process in place throughout the look-back period.

For Initial Surveys and Renewal Surveys:

- NCQA reviews:
 - The organization’s documented process in place throughout the look-back period, outlining differences by client, as applicable.
 - Reports or materials demonstrating data collection for each client and that the organization’s data collection methods follow its documented process.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

For Initial Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation **Direct data collection** describes methods that ask individuals to self-disclose information about themselves (e.g., enrollment or registration forms, surveys, member or customer service call scripts, case management intake forms, health assessments).

Though it is voluntary for individuals served by the organization (e.g., patients, members, users, learners) to disclose their sexual orientation, the organization must attempt to collect this information. The organization may collect data directly at various points of interaction, and should use as many channels or mechanisms 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.

The organization may receive, exchange or use data stored, collected or assessed by external sources that have asked individuals to self-disclose information that can be aggregated to the minimum response option categories, such as the Centers for Medicare & Medicaid Services (CMS), state or local agencies, community-based organizations, Federally Qualified Health Centers, health systems, hospitals, integrated delivery systems, provider networks, electronic health records, health information exchanges and case management systems.

If an individual is unable to provide a response to a direct request (e.g., due to functional inability to communicate), data collected from the individual's caregiver is considered direct data collection.

Data collection framework. At a minimum, the organization describes its process for direct collection of sexual orientation data from adults 18 and older. If the organization collects sexual orientation data described in factors 1 and 2 from individuals younger than 18, it describes differences between its data collection framework for these individuals and its data collection framework for adults.

The organization's direct data collection framework includes, at a minimum, a description of:

- The population or subset of individuals from whom data will be collected.
- A defined process for soliciting information from individuals if a response was requested but not provided.
- When data will be collected.
- Where data will be collected (e.g., setting, data sources).
- How (i.e., method of collection) and by whom (e.g., case worker, member services staff) data will be collected.
- Questions that will be used to collect data, including a script to guide staff who collect or assess data verbally, when applicable.

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

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

The organization has a data collection method that seeks to respect the responding individual and reduce the potential for stigmatization (e.g., through electronic screeners, provide information on use of data, train staff).

Factor 2: Direct data collection

The organization collects direct data on gender identity of the individuals it serves.

At a minimum, the organization's data collection methodology includes:

- The following response options:^[1]
 - 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 when a response was requested but not provided.

Exceptions

None.

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^[3] and the National Institute of Health^[4] offer guidance and studies on surveying and collecting information on sexual orientation and gender identity.

^[1] <https://www.healthit.gov/isa/taxonomy/term/2741/uscdi-v2>

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

^[3] <https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html>

^[4] <https://dpcpsi.nih.gov/sgmro/measurement/questions>

Examples

None.

HEC 5: Access and Availability of Language Services

The organization provides materials and services that meets the language needs of individuals it serves.

Intent

The organization communicates effectively with individuals.

Element A: Access to Written Documents

The organization uses translation services to provide vital information in threshold languages by:

1. Using competent translators.
2. Having a mechanism for providing translations in a timely manner.
3. Specifying when translations will be written and when sight translation or oral interpretation of written information will be provided.
4. Having 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 Interim Surveys:* For factors 1–4, NCQA reviews the organization’s documented process in place during the look-back period for providing vital information in threshold languages.

For Initial Surveys and Renewal Surveys:

- For factors 1–4, NCQA reviews:
 - The organization’s documented process in place during the look-back period for providing vital information in threshold languages, outlining differences by client, as applicable.
 - Reports or materials demonstrating that the organization follows its documented process for each client.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

Look-back period *For Interim Surveys:* Prior to the survey date.
For Initial Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation **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 and access organization/client services.
- Templates of notices pertaining to changes in service.

For organizations supporting health plans and managed behavioral healthcare client organizations, vital information also includes:

- Information about benefits and coverage provided through the organization or its clients.
- Templates of notices about denial, reduction, modification or termination of services and benefits provided through the organization or its clients.
- Templates of notices about the right to file a grievance or appeal with the organization or its clients (e.g., the portion of the notice that does not contain individual-specific information).
- Templates of notices about termination of practitioners in the client network.

In-language documents, unlike translated documents, are created in a language other than English; they may be used to satisfy or supplement this element's requirements for written documents in threshold languages.

Threshold languages are all languages other than English spoken by 5% of the population or by 1,000 individuals, whichever is less. The organization maintains a list of all threshold languages and updates the list at least every 3 years.

Use of contracted translation services is not considered subdelegation.

Factor 1: Translator competence

Competent translation services means that the translator understands and has enough proficiency in both the source and target languages to convey intended meaning.

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, sight translation; oral interpretation), its process for assessing translators includes proficiency in the source and target languages.
- *If the organization uses external translation services* (written, sight translation; oral interpretation), *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 vital information available in a timely manner to individuals who need the information translated in a language other than English, or orally translated or interpreted in a format other than writing. The process specifies request turnaround times, which may differ between types of information 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 for providing:

- Written translations of vital information in threshold languages.
- Sight translation or oral interpretation of written vital information into a spoken/signed language.

Factor 4: Evaluating the quality of the translation

Whether the organization translates documents internally, or contracts with a vendor to translate documents, it must have a documented process in place for evaluating the quality of the translations it provides to the individuals it serves. A high-quality translation ensures that the translated document conveys the intended meaning of the original document 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 through use of an external contracted vendor. The organization may demonstrate the evaluation through materials or reports.

Exceptions

None.

Examples

Factor 1: Using competent translators

- Job descriptions demonstrate that the organization employs translators certified by the American Translators Association.
- RFPs or contracts specify 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 4: 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 the translation service includes quality assurance provisions.
- The organization follows a translation process that includes one or more review/editing steps performed by a qualified translator not involved in the original translation.

Element B: Access to 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.

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

Data source Documented process, Reports, Materials

Scope of review	<p><i>For Interim Surveys:</i> NCQA reviews the organization’s documented process for assessing staff language fluency in place throughout the look-back period.</p> <p><i>For Initial Surveys and Renewal Surveys:</i></p> <ul style="list-style-type: none">• NCQA reviews:<ul style="list-style-type: none">– The organization’s documented process for assessing staff language fluency in place throughout the look-back period.– Reports or materials for evidence that the organization uses competent interpreter or bilingual services for each client to communicate with individuals who need language assistance. <p>NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.</p>
Look-back period	<p><i>For Interim Surveys:</i> Prior to the survey date.</p> <p><i>For Initial Surveys:</i> 6 months.</p> <p><i>For Renewal Surveys:</i> 24 months.</p>
Explanation	<p>Competent interpreter services means that the interpreter understands and speaks with enough fluency in both the source and target languages to convey intended meaning.</p> <p>The organization may provide interpreter services to the individuals it serves directly through its own professional interpreters or bilingual staff, or through contracts with external language service providers, including synchronous/asynchronous electronic media (e.g., telephone language lines, video links, text messages, mobile applications) and other remote systems.</p> <p>Bilingual staff speak both English and the individual’s language and can perform their responsibilities either in English or in another language.</p> <p>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.</p> <p>If the organization uses external interpreter services, its process for procuring interpreters includes provisions for assessing interpreter competence.</p> <p>Interpreter or bilingual services are provided for any interaction an individual is likely to have with the organization’s staff in person, over the telephone or via remote or virtual methods, including, but not limited to:</p> <ul style="list-style-type: none">• Customer service.• Claims.• Utilization management.• Population health management.• Case management.• Complaints, grievances and appeals. <p>Use of contracted interpretation services is not considered subdelegation.</p> <p>Exceptions</p> <p>None.</p>

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/ethics-and-standards-of-practice>).
- 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: Access to Support for Language Services

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

1. Provides practitioners with language assistance resources.
2. Offers training to practitioners on the provision of language services.

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

Data source Reports, Materials

Scope of review *For Interim Surveys:* NCQA reviews materials as evidence of the language assistance resources and trainings the organization makes available to its clients' practitioners.

For Initial Surveys and Renewal Surveys: NCQA reviews reports or materials for each client as evidence of language assistance resources the organization distributed and trainings it offered to its clients' practitioners during the look-back period.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation A **practitioner** is a licensed or certified professional who provides medical care or behavioral healthcare services.

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 health care organizations, their business partners and the practitioners with whom they contract. The organization provides language assistance resources and training to support and assist practitioners in this effort, within the scope of their respective responsibilities.

For Initial Surveys and Renewal Surveys, the organization uses materials such as language assistance resources it distributes, training curricula and reports documenting the provision of these materials, to demonstrate how it meets the requirements of factors 1–2. For collaborative activities, the organization uses reports such as meeting minutes to demonstrate its substantive participation in the activity.

Factor 1: Provides practitioners with language assistance resources

The organization distributes a minimum of one language assistance resource in all threshold languages to practitioners. The organization may collaborate with its clients or other organizations in the service area to provide common resources to practitioners.

Factor 2: Offers training to practitioners on provision of language services

The organization offers training to practitioners on identifying and serving patients with limited English proficiency. The organization may collaborate with other organizations in the service area to provide common training to practitioners.

Exception

None.

Examples

Factor 1: 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 2: 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 percent 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 Documented process, Reports, Materials

Scope of review *For Interim Surveys:* NCQA reviews:

- The organization’s documented process for distributing information on the availability of language services.
- Draft language of the notification.

For Initial Surveys: NCQA reviews the most recent distribution of information on the availability of language services for each client.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

For Renewal Surveys: NCQA reviews most recent and, if applicable, the prior year’s distribution of information on the availability of language services for each client.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

Explanation If the organization provides language services, it must provide them to all individuals it serves who need them, regardless of the frequency of the language in the broader community or among the individuals served by the organization. Notification of the availability of language services must be provided to the broadest possible number of individuals served, 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.

Annually mailing or electronically communicating the notice to all individuals served 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 annual written notification to all individuals that the information is available online and that a printed copy of the information is available upon request.

For Interim Surveys, the organization's documented process for distributing information includes, at a minimum, a description of how (i.e., method), when (e.g., timing, circumstances) and to whom (e.g., clients' enrolled members, pool of potential patients in the community, paneled patients) the notification is distributed.

Exception

None.

Related information

Use of vendors/mail service organizations for notification of language services. If the organization contracts with a mail service organization to provide distribution services, it provides access to the mail service organization's documentation for evaluation. NCQA does not consider the relationship to be delegation or subdelegation. Refer to *Vendors* in *Appendix 2: Delegation and Automatic Credit Guidelines*.

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.
- Electronic messaging (e.g., patient portals, EMR).

HEC 6: Practitioner Network Cultural and Linguistic Responsiveness

The organization collects and analyzes data on practitioners' race/ethnicity, fluent languages and available language services.

Intent

The organization helps its clients maintain a network or pool of practitioners that is responsive to the diverse cultural and linguistic needs of individuals it serves.

Element A: Collection of Data on Practitioners

The organization collects data on the practitioners in its clients' network/pool of practitioners, including:

1. Languages in which a practitioner is fluent when communicating about medical care.
2. Language services available through practitioner practices.
3. Practitioner race/ethnicity data.

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

Data source Documented process, Reports, Materials

Scope of review *For Interim Surveys:* For factors 1–3, NCQA reviews a documented process reflecting the organization's methodology in place throughout the look-back period for collecting data on practitioner languages, available language services and race/ethnicity.

For Initial Surveys and Renewal Surveys:

- NCQA reviews:
 - *For factors 1–3:* a documented process reflecting the organization's methodology in place throughout the look-back period for collecting data on practitioner languages, available language services and race/ethnicity, outlining differences by client, if applicable.
 - Reports or materials for each selected client demonstrating that the organization followed its documented process during the look-back period.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation The organization collects data on practitioners in its health care clients' network or pool of practitioners to support its client's ability to provide culturally and linguistically appropriate care and services.

A **network or pool of practitioners** comprises practitioners employed or contracted by a health care organization to provide services to a defined population of individuals served. NCQA considers both employed/paid and volunteer practitioners to be part of a health care organization's practitioner network/pool if they provide services to the population the health care organization serves.

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.^[1] Although it may not be possible for a health care organization to establish a practitioner pool/network that matches the demographic profile of all individuals it serves, the organization can facilitate high-quality care by providing (to the extent possible) a choice of practitioners that includes all major racial/ethnic and linguistic groups represented in the population of individuals served.

Direct data collection describes methods that ask individuals to self-disclose information about themselves. The organization's data collection framework includes, at a minimum, a description of:

- A defined process for soliciting information from individuals if a response was requested but not provided.
- When data will be collected.
- Where data will be collected (setting, data sources).
- How (i.e., method of collection) and by whom (e.g., case worker, Member Services staff) data will be collected.
- Questions in the documented process that will be used to collect data, including a script to guide staff who collect or assess data verbally, when applicable.

Though it is voluntary for practitioners to disclose their race, ethnicity or language, the organization must attempt to collect it. The organization communicates to practitioners that providing race, ethnicity or language information is voluntary.

The organization may determine the appropriate timing of data collection to avoid concerns about discrimination in contracting or credentialing, and does not use information about practitioners in its contracting or credentialing decisions or for a discriminatory purpose. The organization may receive, exchange or use practitioner information collected or assessed by external sources (e.g., credentials verification organizations) that ask the practitioner to self-disclose the information.

Factor 1: Practitioner languages

The organization collects information from all practitioners in the client's practitioner network/pool about languages in which the practitioner is fluent when communicating about medical or behavioral health care.

The organization must use or have a consistent process for aggregating practitioners' language data using the same categories its clients use to collect language data on the individuals it serves. Refer to *HEC 4*, Element D, factor 1.

Factor 2: Language services available through practices

The organization collects information about dedicated language services offered by the practices where practitioners in the client's practitioner network/pool provide services.

Practices offer language services to 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.

Factor 3: Practitioner race/ethnicity

The organization collects race/ethnicity information from all practitioners in the client's practitioner network/pool.

The organization must use or have a consistent process for aggregating practitioners' race/ethnicity data using:

- OMB race/ethnicity categories, including the response option of "Other."
- The same categories it or its clients use to collect race/ethnicity data on individuals served by the pool or network of practitioners.

OMB categories. 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 National Academy of Medicine (NAM; formerly the Institute of Medicine) recommends that respondents be instructed to select one or more categories that may apply.^[1]

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).

Exceptions

None.

^[1]Cooper 2003; Garcia 2003; Saha 2000; Street 2008.

Examples

Reports or materials demonstrating data collection

- 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.

Factor 1: Practitioner languages

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

Factor 2: Available language services

Practices may 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.
- ASL translators.

Element B: Enhancing Network Cultural and Linguistic Responsiveness

The organization helps clients identify and address gaps in their network or pool of practitioners by:

1. Analyzing the capacity of the client’s practitioner network/pool to meet the language needs of individuals it serves.
2. Analyzing the capacity of the client’s practitioner network/pool to meet the needs of individuals it serves for culturally appropriate care.
3. Developing a plan to address gaps identified as a result of analysis, if applicable.

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

Data source Documented process, Reports, Materials

Scope of review *For Interim Surveys:* For factors 1–2, NCQA reviews a documented process reflecting the organization’s methodology in place throughout the look-back period for analyzing the capacity of clients’ network/pool of practitioners.

For Initial Surveys and Renewal Surveys:

- NCQA reviews:
 - *For factors 1–2:* Reports for each selected client demonstrating that the organization assessed unmet individual needs in the client’s network/pool of practitioners during the look-back period.
 - *For factor 3:* The organization’s documented process in place throughout the look-back period for developing a plan for addressing gaps in clients’ practitioner network/pool.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

Look-back period

For Interim Surveys: Prior to the survey date.

For Interim and Renewal Surveys: At least once during the prior 36 months.

Explanation

The organization analyzes data on practitioners in its health care clients’ network or pool of practitioners to provide recommendations that help its clients to plan for improvement of its cultural and linguistic appropriateness of care and services.

A **network or pool of practitioners** comprises practitioners employed or contracted by a health care organization to provide services to a defined population of individuals served. NCQA considers both employed/paid and volunteer practitioners to be part of a health care organization’s practitioner network/pool if they provide services to the population the health care organization serves.

Factor 1: Analyzing practitioner network language capacity

The organization assesses and reports on practitioner and bilingual staff language capabilities in its clients’ network/pool, and determines whether the offered language services are sufficient to meet the needs of individuals served by the client. Assessment includes:

- Languages spoken by practitioners.
- Presence of bilingual staff in practitioners’ offices.
- Whether practitioners have worked with an interpreter (onsite, remote video, by telephone).

Factor 2: Analyzing practitioner network cultural responsiveness

The organization uses information about the demographic profile of the individuals the client serves and the client’s network/pool to identify potential unmet needs.

The organization assesses and reports on practitioner demographics and the network/pool’s ability to deliver culturally appropriate care.

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.

Factor 3: Plan to address gaps

The organization has a documented process for determining if gaps exist between the network's capacity and the identified needs of individuals served (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 a plan to meet needs.

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

Exceptions

Factor 3 is NA:

- For Interim Surveys.
- If the organization's analysis does not identify gaps in the capacity of the pool/network to meet the needs of individuals served.

Examples**Analysis of network capacity**

- Compare the number of practitioners who speak a specific language with the number of individuals 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 individuals in the area.
- Survey practitioners to assess practitioner attitudes, awareness and knowledge of cultural humility concepts.
- Analyze the percentage of practitioners who have participated in CME training on cultural humility.

Planned 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 service 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 patients 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.

HEC 7: Reducing Health Care Disparities

The organization uses race/ethnicity, language, gender identity and/or sexual orientation data to assess the existence of disparities and to focus quality improvement efforts toward reducing health care disparities and improving the provision of culturally and linguistically appropriate services.

Intent

The organization uses data about its population to improve care and services, and reduce disparities in clinical performance and individual experience.

Element A: Use of HEDIS Measures to Assess Disparities

The organization annually uses the following HEDIS measures, stratified by race/ethnicity, to determine if health care disparities exist:

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	No scoring option	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review *For Initial Surveys and Renewal Surveys:*

- For factors 1–5, NCQA reviews:
 - Reports for each selected client describing the organization’s analysis of disparities by race/ethnicity during the look-back period.
 - The organization’s documented process in place throughout the look-back period for validating the reliability and accuracy of indirect data sources and estimation methods, if applicable.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

Explanation **Factors 1–5**

For each measure, the organization analyzes the performance of race/ethnicity subgroups within the population it or its health plan clients serve, as defined in *HEDIS Volume 2: Technical Specifications for Health Plans*, by comparing them against a reference group. When determining whether disparities exist at a single point in time, the organization may compare all subgroups in the client’s population 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 its population or the client’s population and that are more detailed than described in HEDIS Volume 2; however, the subgroups must be able to aggregate into categories defined in the technical specifications.

If the organization uses indirect data sources and estimation methods, it also 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).

Exceptions

This element is NA for Interim Surveys.

The organization is ineligible for this element if it cannot demonstrate two or more subgroups with greater than 30 individuals in the denominator for factors 1, 2, 3, 4 or 5.

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

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

1. Analyzes 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	No scoring option	The organization meets 0-2 factors

Data source Documented process, Reports

Scope of review *For Interim Surveys:* NCQA reviews the organization’s documented process or materials (e.g., screenshots) reflecting its stratification methodology in place throughout the look-back period.

For Initial Surveys:

- NCQA reviews:
 - The organization’s documented process or materials (e.g., screenshots) reflecting its stratification methodology in place throughout the look-back period, outlining differences by client, as applicable.
 - The organization’s most recent measurement reports for each selected client.
- NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

For Renewal Surveys:

- NCQA reviews:
 - The organization’s documented process or materials (e.g., screenshots) reflecting its stratification methodology in place throughout the look-back period, outlining differences by client, as applicable.
 - The organization’s most recent and, if applicable, the prior year’s measurement reports for each selected client.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

Look-back period

For Interim Surveys: Prior to the survey date.

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

For Renewal Surveys: 24 months.

Explanation**Methodology**

The organization describes its methodology for stratifying data by race/ethnicity, language, gender identity and/or sexual orientation to assess health care disparities. It may use direct data collection for language, gender identity and sexual orientation data, and may use direct or indirect data collection, or a combination, for race/ethnicity data. Clinical performance measures and individual experience measures must be measured annually.

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 each data type 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 National Quality Forum (NQF); in particular, measures of care processes or outcomes relevant to the organization's population.

Valid clinical performance measures

If the organization uses measures other than HEDIS, the measures must:

- 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.
- Include the uninsured population, if applicable to the organization's population of individuals served.

Valid individual experience measures

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 produces valid and reliable results.

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.

Quantitative analysis

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 the organization or its client has multiple locations in a state or a statewide service area, it may analyze statewide data, but aggregate data might not provide sufficient information to suggest actions the organization should take at each location.

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.

Factor 1: Analyzing clinical performance measures by race/ethnicity

The organization analyzes two or more valid measures of clinical performance by race/ethnicity (e.g., HEDIS). The organization analyzes the performance of subgroups by comparing them against a reference group. When determining whether 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 group with the best performance). This 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

The organization analyzes the performance of gender identity and/or sexual orientation subgroups by comparing them against a reference group. When determining whether 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 group with the best performance). This is the reference group.

If the organization's data collection only identified individuals with binary gender identity options (man/male, 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 and focuses on population subgroups most relevant to the demographics of the population served.

Exceptions

This element is NA for Interim Surveys.

Organizations are ineligible for this element if they cannot demonstrate two or more subgroups with greater than 30 individuals in the denominator for factors 1, 2, 3 or 4.

Related information

NQF disparity-sensitive measures. The NQF published a national set of disparity-sensitive performance measures^[1] 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.

[1] *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 men/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 Vietnamese.
- Experience with choice of practitioner (not a CAHPS item) by White Latino/Hispanic, White Not Latino/Hispanic, African American Latino/Hispanic, African American Not Latino/Hispanic.

Element C: Use of Data to Monitor and Assess Language 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	No scoring option	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review *For Interim Surveys:* NCQA reviews the organization’s documented process in place throughout the look-back period for soliciting feedback and assessing experience with language services for organization functions.

For Initial Surveys: NCQA reviews the organization’s most recent annual assessment.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

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

For Renewal Surveys: 24 months.

Explanation Language services include:

- Bilingual services.
- Oral interpretation or sight translation.
- Written translation.

The organization may use a variety of mechanisms, including quantitative or qualitative data, to evaluate the experience of its staff and the individuals served with the language services offered through the organization. To the extent that the organization uses CAHPS items or supplemental questions, the organization uses

sampling methods appropriate for capturing individuals served by the organization 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, in person, over the telephone or via remote or virtual methods, including, but not limited to:

- Member Services.
- Claims.
- Utilization management.
- Population health management.
- Case management.
- Referrals (e.g., social needs resources, clinical care).
- Complaints, grievances and appeals.

Exceptions

None.

Examples

Utilization indicators

- The percentage of individuals who requested and received language services.
- The percentage of individuals who used one or more language services.
- The percentage of individuals whose primary language is not English and who used one or more language services.

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.
- Mail a questionnaire to or interview individuals who used language services, to obtain feedback on their experience with services administered in the clinical setting.
- Focus groups with individuals or community advocates.

Methods to evaluate staff experience

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

Indicators of individual or staff experience

- Individual 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 Improve Cultural and Linguistic Appropriateness of Services

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

1. Identifies and prioritizes opportunities to improve CLAS.
2. Implements at least one intervention to improve CLAS.
3. Evaluates the effectiveness of an intervention to improve CLAS.

Scoring	Met	Partially Met	Not Met
	The organization meets 2-3 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review *For Interim Surveys:* NCQA reviews a documented process describing the organization's methodology in place throughout the look-back period for identifying and prioritizing opportunities and implementing interventions and evaluating the effectiveness of interventions.

For Initial Surveys:

- *For factors 1–3,* NCQA reviews the organization's most recent annual assessment for each selected client.
- *For factor 3,* the organization may submit a plan for evaluation of interventions.
- NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

For Renewal Surveys:

- *For factors 1–3,* NCQA reviews the organization's most recent and the prior year's annual assessment, if applicable, for each selected client.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

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

For Renewal Surveys: 24 months.

Explanation **Factor 1: Identifying and prioritizing opportunities**

The organization annually uses results from its measurement of disparities in clinical performance and individual experience, or its assessment of language services, to identify and prioritize opportunities to improve CLAS for the individuals it or its clients serve. The organization may use findings from Elements A–C to identify opportunities to improve CLAS, but is not required to.

The organization identifies as many opportunities as possible, prioritizes them based on its analysis and their significance for concerns to the individuals it or its client serve and indicates 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 action 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.

The organization may choose opportunities and interventions related to subpopulations of individuals served, defined by race, ethnicity, language, gender identity or sexual orientation, as well as to structural and systemic causes of differences in health outcomes, such as lack of access to affordable housing, education or food insecurity.

Opportunities may directly address individuals served by the organization or may address its clients' practitioners or practitioner network, or within the organization. NCQA does not prescribe the types of opportunities the organization may identify or select.

Factor 2: Implementing interventions

The organization annually implements at least one intervention to address each prioritized opportunity for improving CLAS. 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 its clients' network/pool of practitioners; for example, sharing data on race/ethnicity and language (with individuals' permission) with network practitioners to facilitate targeted outreach or more proactive arrangements for language services.

Factor 3: Evaluating the effectiveness of an intervention

The organization annually evaluates the effectiveness of the interventions it implemented in factor 2, addressing the measures or assessments from factor 1.

Direct or indirect data, or a combination, may be used for the evaluations. If insufficient time has elapsed to evaluate the effectiveness of the interventions, the organization's evaluation may address measures, assessments and interventions undertaken in the prior year.

Exceptions

Factors 2 and 3 are NA if no opportunities for improving CLAS 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.

Examples**Factor 2: Implementing an intervention 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 distribute culturally tailored information about health issues significant to certain subpopulations of individuals the organization serves.
- Hire staff or engage community volunteers (“patient navigators”) to advocate for and help individuals from diverse backgrounds navigate the organization’s services or the health care system.

Element E: Use of Data to Address Health Care Inequities

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

1. Identifies and prioritizes opportunities to address health care inequities.
2. Implements at least one intervention to address an inequity.
3. Evaluates the effectiveness of an intervention to address an inequity.

Scoring	Met	Partially Met	Not Met
	The organization meets 2-3 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review *For Interim Surveys:* NCQA reviews a documented process in place throughout the look-back period describing the organization’s methodology for identifying and prioritizing opportunities and implementing interventions and evaluating the effectiveness of interventions.

For Initial Surveys and Renewal Surveys:

- *For factors 1–3*, NCQA reviews the organization’s most recent annual assessment for each selected client.
- *For factor 3*, the organization may submit a plan for evaluation of interventions.
- NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

For Renewal Surveys:

- *For factors 1–3*, NCQA reviews the organization’s most recent and the prior year’s annual assessment, if applicable, for each selected client.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

Explanation **Health care inequities** are systemic health differences arising from social conditions that are avoidable, unnecessary, unfair and unjust. **Health care disparities** are the result of inequities and can be reduced by addressing inequities.

The organization should identify opportunities and implement interventions aimed at reducing the inequities that may be resulting in disparities in access to care, experience, or health outcomes.

Factor 1: Identifying and prioritizing opportunities

The organization annually uses results from its measurement of disparities in clinical performance and individual experience or its assessment of language services to identify and prioritize opportunities to address health care inequities for the individuals it or its clients serve. The organization may use findings from Elements A–C to identify opportunities to address inequities, but is not required to. The organization identifies as many opportunities as possible, prioritizes them based on its analysis and their significance for concerns to the individuals it or its clients serve and indicates 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 action 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.

The organization may choose opportunities and interventions related to race, ethnicity, language, gender identity or sexual orientation, as well as to structural and systemic causes of differences in health outcomes, such as lack of access to affordable housing, education or food insecurity.

Opportunities may directly address individuals served by the organization or may address its clients' practitioners or practitioner network, or within the organization. NCQA does not prescribe the types of opportunities the organization may identify or select.

Factor 2: Implementing interventions

The organization annually implements at least one intervention to address each prioritized opportunity for addressing 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 its clients' network/pool of practitioners. Research^{[1][2]} indicates that the most successful approaches to reducing health care inequities are multifaceted. NCQA recognizes that implementing interventions can be a complex process that occurs over time.

Factor 3: Evaluating the effectiveness of an intervention

The organization annually evaluates the effectiveness of the interventions it implemented in factor 2, addressing the measures or assessments the organization used in factor 1.

Direct or indirect data, or a combination, may be used for the evaluations. If insufficient time has elapsed to evaluate the effectiveness of the interventions, the evaluation may address measures, assessments and interventions undertaken in the prior year.

Exceptions

Factors 2 and 3 are NA if no opportunities for addressing inequities 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.

^[1] Beal, A.C. 2004. “Policies To Reduce Racial And Ethnic Disparities In Child Health And Health Care.” *Health Affairs*. 23(5): 171-9.

^[2] Cooper, L.A., M.N. Hill, N.R. Power. 2002. “Designing and Evaluating Interventions to Eliminate Racial and Ethnic Disparities in Health Care.” *JGIM*. 2002, Vol 17(6): 477-86.)

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

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

Factor 2: Implementing an intervention to address an inequity

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 even when screening rates were comparable, these patients’ blood pressure was more often above normal. Follow-up interviews with providers suggested two contributing factors:

- African American patients found it 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 considerations. Interviews generally validated what practitioners reported, 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, and that their doctors had not told them to take the medicine every day regardless of how they felt. The interviews also revealed that a percentage of patients with hypertension experienced food insecurity.

Based on this assessment, the organization determined that a patient-focused intervention was required. The organization worked with its Diabetes Management Program to develop outreach materials that were culturally responsive and addressed 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 its Hypertension Management Program. The organization also partnered with a local farmers market to provide subsidized groceries and nutrition meal plans to these patients. Following implementation of the intervention, the organization decided to continue to study the reasons for poor medication adherence and food insecurity.

Factors 3: Evaluating effectiveness

While the organization hoped that its intervention would result in improved blood pressure control, it recognized that this would take time. In the interim, the organization evaluated intermediate outcomes: measured the rate of enrollment by African American individuals in the Hypertension Management Program before and after the intervention, and conducted chart reviews for a sample of patients and practitioners to determine if blood pressure was recorded more frequently in patients' charts.

HEC 8: Data on Social Risks and Social Needs

The organization acquires community-level data and collects individual-level data to segment or stratify its population and understand the similarities and differences between the social risks of the community and the social needs of the individuals it serves.

Intent

The organization uses the data it collects to inform prioritization of social risks and social needs that may have the most impact on communities and individuals through interventions.

Element A: Use of Data to Define Communities

The organization defines its service area and the communities in its service area.

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

Scope of review *For Interim Surveys:* NCQA reviews a documented process describing the organization’s methodology in place throughout the look-back period for identifying communities.

For Initial Surveys and Renewal Surveys: NCQA reviews a summary report defining the geographical boundaries or nongeographical composition of each community in its service area or a client’s service area.

The organization may provide a single report describing all communities in its service area across clients, or reports specific to the service area of each selected client.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation A **community** can be described as a social unit (group) that shares commonalities such as geographic locations, norms, religion, values, customs, characteristics or identities. An individual can be “in” a community that shares a physical or geographical location (e.g., institution, region, area, neighborhood), a virtual space, one or more characteristics or identities (e.g., race/ethnicity, language, gender identity, sexual orientation) or multiple, intersectional commonalities (a combination of characteristics). Communities are the context in which the individuals served by the organization or its clients live, work and receive services.

The organization identifies its service area, or the geographic area where individuals may obtain or access services, and describes the communities that comprise the service area, including each community’s:

- Geographical boundaries (e.g., region, county or neighborhood) of the communities in its service area; **or**
- Nongeographical composition (e.g., race/ethnicity, language, religion, values, customs, identity) of the communities in its service area.

A community includes individuals served by the organization and its clients (e.g., current members, patients who receive treatment, individuals who participate in its programs), as well as the broader population that resides in the service area and may not access the services of the organization or its clients.

If the organization operates virtually or provides virtual services only (telemedicine), it must identify define communities by both the geographic location and the nongeographical composition of the individuals served. A robust understanding of the broader environment within the organization’s service area is the first step to making informed choices about community data sources, program priorities and partnerships.

Exceptions

None.

Examples

Geographical boundaries

- An organization with a large service area (operating across an entire state) uses state-defined geographical regions to define communities, in addition to other geographical boundaries (e.g., urban vs. rural areas, neighborhoods, counties, cities) to ascertain smaller communities in each region that share commonalities in infrastructure (access to health care services, education, employment opportunities, environmental, transportation, safety, social services). The organization then layers each client’s membership or patients onto these defined communities.

Nongeographical composition

- The organization uses geographical boundaries (e.g., state-defined regions) to define communities in its service area, then uses nongeographic characteristics (e.g., language, ethnicity, chronic condition) to ascertain smaller communities in the broader service area.
- The organization uses nongeographical characteristics (e.g., race/ethnicity) to define communities across its entire service area, then layers geographical boundaries to identify where individuals who share characteristics also share commonalities in infrastructure (access to health care services, education, employment opportunities, environmental, transportation, safety, social services).
- An organization that specializes in providing gender-affirming care to individuals across a wide service area (e.g., multiple states) first layers other characteristics such as race/ethnicity and gender identity, then layers geographical boundaries to define a community that shares multiple identities as well as commonalities in experience with infrastructure (access to health care services, education, employment opportunities, environmental, transportation, safety, social services).

Element B: Acquiring Communities' Social Risk Data

The organization acquires social risk data on the communities in its service area or its client's service area from:

1. A community health assessment performed by a local public health agency or its equivalent.
2. A second source.
3. A third source.

Scoring	Met	Partially Met	Not Met
	The organization meets 2-3 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review *For Interim Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period for acquiring data on social risks for all communities in its service area or its client's service area.

For Initial Surveys and Renewal Surveys:

- NCQA reviews:
 - The organization's documented process in place throughout the look-back period for acquiring data on social risks for all communities in its service area or its client's service area, outlining differences by client, as applicable.
 - Reports or materials (e.g., screenshots) demonstrating the data sources.
 - Evidence that at least one data source allows stratification by at least one demographic characteristic/identity.

The organization may submit evidence that collectively demonstrates acquisition of data in each community of in its service area, across all selected clients, or evidence specific to communities in the service area of each selected client.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

For Initial Surveys and Renewal Surveys: At least once during the prior 36 months.

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

The organization has a documented process for acquiring social risk data across all communities identified in its service area or its client's service area from three different sources at least every 3 years, using the most current version of each data source in factors 1–3. Using three data sources allows inclusion of more robust data in the organization's community-level analysis, reducing the risk that the analysis will draw biased or misleading conclusions. Data from different geographic regions (e.g., community, local, state) increase the likelihood that the

organization has a comprehensive understanding of social risks and their effect on health outcomes.

At least one data source must provide for or allow stratification by demographic characteristics such as race, ethnicity, preferred language, gender identity or sexual orientation. The organization may also use socioeconomic factors such as age, disability status, income, education or employment status to supplement stratification. The documented process describes the organization's rationale for using each selected characteristic.

Factor 1: Community health assessment

A **community health assessment** identifies key health needs and issues through systematic, comprehensive data collection and analysis.^[1]

Exceptions

None.

Examples

Factors 1–3

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

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

Examples of local and national community-level data sources include, but are not limited to:

- **The American Community (ACS) Survey**,^[2] sponsored by the U.S. Census Bureau, makes geographically detailed data available, including ZIP code, Census tract and Census block group. The data comprises economic characteristics (income, percentage of families in poverty), demographics (languages spoken at home, race, insurance coverage), housing (occupants per room, gross rent as a percentage of income) and educational attainment (for populations 25 years of age and older).
- **The Area Deprivation Index (ADI)**^[3] and **Neighborhood Atlas**,^[4] sponsored by the University of Wisconsin, let users rank neighborhoods by socio-economic disadvantage at the state and national levels, and include data on income, education, employment and housing quality. They are based on a measure created by the Health Resources and Services Administration and use the ACS Survey in their construction.
- **The City Health Dashboard**,^[5] developed by NYU Langone Health and the Robert Wood Johnson Foundation, presents data on more than 35 measures of health and drivers of health for over 750 U.S. cities with populations above 50,000. The City Health Dashboard includes local data from multiple national sources to guide action on health equity.

- **County Health Rankings & Roadmaps**,^[6] a program of the University of Wisconsin Population Health Institute, works to improve health outcomes and resolve health disparities between populations. Data sources include measures of health outcomes, health factors (behaviors, clinical care, social and economic factors, physical environment) and demographics.
- **The Food Access Research Atlas**,^[7] sponsored by the USDA Economic Research Service, offers downloadable census tract-level data on food access.
- State-sponsored equity reports such as the **Health Equity Report**,^[8] sponsored by the Michigan Department of Health and Human Services (MDHHS), is an annual report on disparities and MDHHS efforts to address racial and ethnic health disparities, as required by state legislation. The report presents data on morbidity, mortality and SDOH indicators, stratified by race and ethnicity. Data sources include the Michigan Behavioral Risk Factor Surveillance System, the MDHHS Division for Vital Records and Health Statistics, the U.S. Census and the Michigan Disease Surveillance System.
- **The Opportunity Index**,^[9] sponsored by Opportunity Nation and Child Trends, produces an annual report that combines indicators of the economy, education, health and community at the national, state and county levels to give a “big picture” view of and perspective on conditions influencing neighborhoods.
- **PHATE**,^[10] sponsored by the American Board of Family Medicine and built by the University of Missouri, uses EHR data from the PRIME registry,^[11] a qualified clinical data registry available to all primary care practitioners, to create a view of neighborhood characteristics and local community-based organizations, uses a neighborhood social deprivation index to highlight disease and poor-quality hot spots.

^[1]<https://www.cdc.gov/publichealthgateway/cha/index.html>

^[2]<https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/2015>

^[3]https://www.cdc.gov/pcd/issues/2016/16_0221.htm

^[4] <http://www.nejm.org/doi/10.1056/NEJMp1802313>

^[5]<https://www.cityhealthdashboard.com/about>

^[6]<https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/2021-measures>

^[7]<https://www.ers.usda.gov/data-products/food-access-research-atlas>

^[8]https://www.michigan.gov/documents/mdhhs/2020_PA653-Health_Equity_Report_Full_731810_7.pdf

^[9]<https://opportunityindex.org>

^[10]Lichkus J, Liaw WR, Phillips RL. Utilizing PHATE: A Population Health–Mapping Tool to Identify Areas of Food Insecurity. *The Annals of Family Medicine*. 2019;17(4):372-372. doi:10.1370/afm.2387

^[11]<https://registry.theabfm.org/Dashboard/login.aspx>

Element C: Collecting Individuals' Social Needs Data

The organization collects data on individuals' unmet social needs, including:

1. Financial insecurity.
2. Food insecurity.
3. Housing stability.
4. Access to transportation.
5. Interpersonal safety.
6. An additional domain.

Scoring	Met	Partially Met	Not Met
	The organization meets 4-6 factors	No scoring option	The organization meets 0-3 factors

Data source Documented process, Reports, Materials

Scope of review *For Interim Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period for collecting data on individual social needs.

For Initial Surveys and Renewal Surveys:

- NCQA reviews:
 - The organization's documented process in place throughout the look-back period for collecting data on individual social needs, outlining differences by client, as applicable
 - Reports or materials for each selected client for evidence of data collection.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

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

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

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

Direct data collection describes methods that ask individuals to self-disclose information about themselves (e.g., through enrollment or registration forms, surveys, member or customer service call scripts, case management intake forms, health assessments).

Though it is voluntary for individuals served by the organization (e.g., patients, members, users, learners) to disclose the social needs they are experiencing, the organization must attempt to collect this information. The organization may collect data directly at various points of interaction, and should use as many channels or mechanisms as available to collect the information from individuals.

The organization may receive, exchange or use data stored, collected or assessed by external sources that have asked individuals to self-disclose social needs (e.g., CMS, state or local agencies, community-based organizations, Federally Qualified Health Centers, health systems, hospitals, integrated delivery systems, provider networks, electronic health records, health information exchanges, case management systems).

If an individual is unable to provide a response to a direct request (e.g., due to age or functional inability to communicate), data collected from the individual's caregiver is considered direct data collection.

Data collection framework. The organization's data collection framework includes, at a minimum, a description of:

- The population or subset of individuals from whom data will be collected.
- A defined process for soliciting information from individuals if a response was requested but not provided.
- When data will be collected.
- Where data will be collected (e.g., setting, data sources).
- How (e.g., method of collection) and by whom (e.g., case worker or member services staff) data will be collected.
- Questions that will be used to collect data, including a script to guide staff who collect or assess data verbally, when applicable.

Factors 1–6

The organization collects direct data on the social needs data of the individuals it serves. For each social need, the organization defines its direct data collection framework and method for determining if an internally developed or external screening tool, vendor or platform was used.

Factor 6: An additional domain

The organization collects data on an additional social needs domain and describes that data's relevance to the population of individuals served. Additional social needs domains may include, but are not limited to, barriers to achieving health, including experiences with discrimination, bias or racism, or access to technology-based services.

Exceptions

None.

Examples

Factors 1–6

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

- The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)^[12] tool from the National Association for Community Health Centers.
- The Health Leads Model.^[13]
- The Accountable Health Communities-Health-Related Social Needs Screening Tool^[14] created by the Centers for Medicare & Medicaid Services (CMS) to support the CMS Accountable Health Communities Model.
- The EveryONE Project^[15] of the American Academy of Family Physicians.

Catalogs of social needs screening and assessment tools include:

- *Systematic Review of Social Risk Screening Tools* by the Kaiser Permanente Washington Health Research Institute, in collaboration with the Social Interventions Research & Evaluation Network (SIREN).^[16]
- The *Social Needs Screening Tool Comparison Table*, compiled by SIREN, summarizes characteristics for several of the most widely used social health screening tools, including by intended population or setting, social health domains covered and number of questions about each domain.^[17]
- The *Health Leads Screening Toolkit*.^[18]

^[12]<https://www.nachc.org/research-and-data/prapare>

^[13]<https://healthleadsusa.org>

^[14]<https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

^[15]https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf

^[16]<https://sdh-tools-review.kpashingtonresearch.org/>

^[17]<https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison>

^[18]<https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/>

Element D: Identifying Communities’ Social Risks

The organization identifies the social risks of each community in its service area or its client’s service area.

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

Scope of review

For Interim Surveys: NCQA reviews a documented process describing the organization’s methodology in place throughout the look-back period for identifying communities’ social risks, including the organization’s sources of social risk data.

For Initial Surveys and Renewal Surveys: NCQA reviews a summary report that demonstrates identification of social risks for each community in the organization’s service area, across clients, or each community in selected clients’ service areas.

The organization may provide a single report describing all communities in its service area across all selected clients, or reports specific to the service area of each selected client.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

Look-back period

For Interim Surveys: Prior to the survey date.

For Initial Surveys and Renewal Surveys: At least once during the prior 36 months.

Explanation Identifying social risks

The organization provides a summary report or reports demonstrating that it identified the social risks of each community in its or its client’s service area.

Understanding the social risks experienced by each community in its service area or its client’s service area better positions the organization to determine which social risks the organization or its clients should prioritize mitigating for individuals served. Identified social risks may be experienced by individuals served by the organization, as well as by the broader population that resides in the service area and may not access the organization’s services (nonmembers).

A report describing the social risks across all communities (as an aggregate of the entire service area) does not meet the intent. Although there may be overlap, because risks differ between communities, the organization must provide evidence that it identified the risks for each community in its service area or its client’s service area.

Exceptions

None.

Examples Identifying social risks

- Air pollution and poor water quality in a community within 5 miles of an industrial zone.
- Poverty in an urban neighborhood that lacks access to social services, and has a high concentration of violence.

Element E: Identifying Social Needs

At least annually, the organization:

1. Identifies the social needs of the individuals served for each community in its service area.
2. Assess similarities and differences between the community’s social risks and the social needs of the individuals it serves.

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

Data source Documented process, Reports

Scope of review *For Interim Surveys:* NCQA reviews a documented process describing the organization’s methodology in place throughout the look-back period for:

- Identifying the social needs of individuals it serves.
- Assessing similarities and differences between the social risks identified for a community and the social needs of the individuals it serves that reside in the same community.

For Initial Surveys:

- NCQA reviews the organization’s most recent summary report or reports that demonstrate:

- Identification of social needs experienced by individuals the organization serves in each community in the organization’s service area or the client’s service area.
- Assessment of similarities and differences between the social risks of each community and the social needs of the individuals the organization serves in the same community.
 - The organization may provide a single report describing all communities in its service area across clients, or reports specific to the service area of each selected client.
- NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

For Renewal Surveys:

- NCQA reviews the organization’s most recent and previous year’s annual reports that demonstrate:
 - Identification of social needs experienced by individuals served that reside in each community in the organization’s service area or the client’s service area.
 - Assessment of similarities and differences between the social risks of each community and the social needs of the individuals the organization serves in the same community.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

Look-back period

For Interim Surveys: Prior to the survey date.
For Initial Surveys: At least once during the prior year.
For Renewal Surveys: 24 months.

Explanation

Factor 1: Identifying social needs

The organization provides a summary report demonstrating that, at least annually, it identified the social needs experienced by the individuals it or its client serve in each community in its service area or its client’s service area.

Understanding the social needs experienced by each community better positions the organization to determine which social needs should be prioritized by the organization or its client.

A report describing the social needs across all communities (as an aggregate of the entire service area) does not meet the intent. Although there may be overlap, because the social needs experienced by individuals differ between communities, the organization must provide evidence that it identified the needs of each community in its service area.

Factor 2: Assessment of similarities and differences

Members of groups that have historically experienced discrimination in the health care setting, or who have systemically been denied access to health care services, may not be represented in the data sets used to inform identification of social needs (factor 1).

Assessing the similarities and differences between social risks experienced by a community and the social needs of individuals who reside in the same community,

including how demographic characteristics/identities evolve annually, provides an opportunity to explore why certain groups are missing from data sources or are underrepresented in screenings and how the organization can change data sources or collection methods to include a broader range of individuals.

The organization provides a summary report demonstrating that, at least annually, it assessed similarities and differences between:

- Each community’s social risks.
- The social needs of individuals served in each community.
- The demographic characteristics/identities (race, ethnicity, language, sexual orientation, gender identity) of the community and individuals served.

The organization must identify the similarities and differences for all communities in its service area or its client’s service area. The assessment seeks to identify differences and their causes (e.g., the individuals served by the organization do not reflect the broader community, a social needs assessment is not offered in a language prevalent in the broader community, social needs are only screened in clinical settings).

Exceptions

None.

Examples *Factors 1 and 2*

- Food insecurity as a social need for individuals who live in a food desert.
- Housing instability as a social need for an urban neighborhood with a low volume of affordable housing..

Element F: Population Segmentation or Risk Stratification

At least annually, the organization segments or stratifies its population to identify:

1. Subpopulations of the communities that share intersectional social risks and demographic characteristics/identities.
2. Subpopulations of individuals served by the organization that share intersectional social needs and demographic characteristics/identities.

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

Data source Documented process, Reports

Scope of review *For Interim Surveys:* NCQA reviews a documented process describing the organization’s methods for segmenting or stratifying subpopulations across communities.

- For Initial Surveys:*
- NCQA reviews:
 - A documented process describing the organization’s methods in place throughout the look-back period for segmenting or stratifying

subpopulations across all communities, outlining differences by client, as applicable.

- The organization’s most recent segmentation or risk stratification report or reports.
 - The organization may submit a single report describing an aggregate of all communities in its service area across clients, or reports specific to communities in the service area of each selected client.
- NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

For Renewal Surveys:

- NCQA reviews:
 - A documented process describing the organization’s methods in place throughout the look-back period for segmenting or stratifying subpopulations across all communities, outlining differences by client, as applicable.
 - The organization’s most recent and previous year’s segmentation or risk stratification report or reports.
 - The organization may submit a single report describing an aggregate of all communities in its service area, or reports specific to communities in the service area of each selected client.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

Look-back period

For Interim Surveys: Prior to the survey date.

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

For Renewal Surveys: 24 months.

Explanation

Population segmentation is the process of dividing a population into meaningful subsets—members who share specific needs, characteristics, identities, conditions or behaviors—using information collected through population assessments and other data sources.

Risk stratification refers to a subset of population segmentation methods and is the process of dividing a population into groups or categories based on potential risk (e.g., poor health outcomes, barriers to access, high utilization or expense) and then assigning individuals to specific risk tiers or subsets.

Segmentation and risk stratification categorize individuals who share intersectional social risks, social needs and demographic characteristics/ identities, and who may be negatively affected by experiences with the same social risks.

Segmenting/stratifying communities and populations by multiple characteristics helps the organization identify subpopulations that share intersecting identities and experience shared social risks or have similar social needs. Organizations can identify and act on opportunities to improve inequities that intersect between subpopulations and can target interventions that account for the multifaceted, lived experiences of the individuals they serve.

The organization performs segmentation/stratification at least annually to determine how populations and characteristics shift. The organization presents one or more reports representing an aggregate or summary of all communities in its service area or its client’s service area. The organization is not required to perform

segmentation/stratification for each community in its service area or the client's service area but may choose to identify subpopulations for each community.

Methodology. The organization describes its method for segmentation or stratification, outlining differences by client, as applicable. Either segmentation/stratification may meet this element, and the organization may use more than one method.

Reports. The organization's reports are a "point-in-time" view during the look-back period and may display data in raw numbers or as a percentage of the total population or community served, across clients or specific to clients. The percentage may total more than 100% if individuals fall into more than one subpopulation. The organization may submit evidence that represents a summary of all communities as a whole (an aggregate). If the organization concludes that the denominator is too small (less than 30 individuals) to draw meaningful conclusions, it includes this information in the report.

Factor 1: Identification of community subpopulations

The organization uses data on demographic characteristics/identities (e.g., race, ethnicity, preferred language, gender identity, sexual orientation) and social risks to identify subpopulations of communities in its service area or the client's service area based on intersecting identities and shared social risks. Stratification may use additional demographic or socioeconomic characteristics meaningful to the organization or its clients (e.g., age, aspect of disability).

The organization also determines the appropriate number and types of subpopulations most likely to benefit from specific social risk resources or interventions.

Factor 2: Identification of individual subpopulations

The organization uses data on demographic characteristics/identities (e.g., race, ethnicity, preferred language, gender identity, sexual orientation) and social needs identified among individuals served to identify subpopulations in the communities in its service area or the client's service area based on intersecting identities and shared social needs. Stratification may use additional demographic or socioeconomic characteristics meaningful to the organization or its clients (e.g., age, aspect of disability).

The organization also determines the appropriate number and types of subpopulations most likely to benefit from specific social needs resources/interventions.

Exceptions

None.

Related information

NCQA does not prescribe subpopulations (e.g., racial, ethnic, language, sexual orientation, gender identity, aspect of disability) for stratification. The organization may focus on subpopulations that are feasible, with consideration of subpopulation size, and that are most relevant or meaningful to the demographics of the population it or its client serve.

Some subpopulations may be large enough to analyze individually (e.g., White, Black/African American; male, female, languages spoken), while subpopulations represented by a smaller denominator in the organization's data may need to be

grouped for analysis (transgender, lesbian, gay). Some organizations may be able to stratify distinct subgroups.

Examples

Factors 1, 2

Granular subpopulations

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

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

Intersectional characteristics/identities

- Someone who identifies as Black and transgender male may experience fear of discrimination that inhibits their ability to seek employment, imposes financial difficulties, results in a lack of health insurance and ultimately affects their ability to access health care services.
- A person with mobility limitations may not be able to find accessible housing near their place of work or near their medical provider, which may impact their ability to commute, remain employed, obtain health insurance, or access needed medical care or supportive resources.

Element G: Prioritizing Social Risks and Social Needs

The organization annually prioritizes:

1. The social risks it will mitigate.
2. The social needs it will address.

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

Data source Documented process, Reports

Scope of review *For Interim Surveys:* NCQA reviews a documented process describing the organization’s methods in place throughout the look-back period for assessing and prioritizing social risks and social needs.

- For Initial Surveys:*
- NCQA reviews the organization’s most recent annual report or reports demonstrating prioritization of social risks and needs across all communities in its service area or the client’s service area.
 - The organization may submit a single report describing an aggregate of all communities in its service area across clients, or reports specific to communities in the service area of each selected client.

- NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

For Renewal Surveys:

- NCQA reviews the most recent and previous year’s annual reports demonstrating prioritization of social risks and needs across all communities in its service area or the client’s service area.
 - The organization may submit a single report describing an aggregate of all communities in its service area across clients, or reports specific to communities in the service area of each selected client.

NCQA reviews evidence from up to four randomly selected clients, or from all clients if the organization has fewer than four. The score for the element is the average of scores across all selected clients.

Look-back period

For Interim Surveys: Prior to the survey date.

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

For Renewal Surveys: 24 months.

Explanation

The organization’s report describes how it uses the following information to prioritize the social risks it will mitigate and the social needs it will address:

- Social risks identified in each community in its service area.
- Social needs identified for individuals served in each community in its service area.
- Subpopulations across all communities in its service area that share intersectional social risks and demographic characteristics/identities.
- Subpopulations of individuals served across all communities in its service area that share intersectional social needs and demographic characteristics/identities.

NCQA does not prescribe the criteria the organization uses to prioritize a social risk or social need over another. The organization is not required to mitigate every social risk and address every social need; it uses its understanding of the community and individuals served to determine areas of high need.

The organization is also not required to prioritize social risks and needs in each community in its service area.

The organization provides a conclusion or rationale for each social risk and need chosen as a priority, including assessment of:

- Whether the organization directly providing services will compete with or undermine the work of existing community-based organizations serving the same population.
- Whether the organization collaborating with community-based organizations will strengthen and empower the community.

Exceptions

None.

Examples

Factors 1, 2: Prioritizes social risks and social needs

- The organization prioritizes a lack of affordable housing in a community where it will seek to strengthen the existing efforts of its clients, or a community initiative or organization working to mitigate this social risk.

- The organization prioritizes interpersonal safety, an identified social need that is not being addressed by its clients or existing community efforts.

Element H: Social Risk Resource Assessment

Using prioritized social risks, the organization annually assesses:

1. Existing client and community resources.
2. Organizational capacity and capability.
3. Gaps in existing resources.

Scoring	Met	Partially Met	Not Met
	The organization meets 2-3 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review *For Interim Surveys:* NCQA reviews a documented process describing the organization’s methodology in place throughout the look-back period for assessing social risks resources.

For Initial Surveys:

- NCQA reviews the organization’s most recent annual assessment report or reports.
 - The organization may submit a single report describing an aggregate of all communities in its service area across clients, or reports specific to communities in the service area of each selected client.
- The score for the element is the average of scores across all selected clients.

For Renewal Surveys:

- NCQA reviews the organization’s most recent annual assessment report or reports.
 - The organization may submit a single report describing an aggregate of all communities in its service area across clients, or reports specific to communities in the service area of each selected client.

The score for the element is the average of scores across all selected clients.

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

Explanation At least annually, the organization assesses gaps in available resources, capacity and capability to mitigate social risks. The organization’s assessment is based on its prioritized social risks (Element G, factor 1), which may be in one or more communities in its service area or in its client’s service area. The organization may submit evidence that represents an assessment summary of all prioritized social risks.

If the organization prioritized a social risk that is being mitigated by the efforts of a client, an existing community initiative or another organization, it may choose to partner with the client, initiative or organization to strengthen its efforts. If a social

risk is not currently addressed by client or community efforts, the organization may choose to build internal capabilities or convene community-based stakeholders to collaboratively mitigate the risk.

By conducting a scan of community resources and understanding its own internal capacity/capability, the organization is better positioned to determine gaps in resources that perpetuate health inequities, select appropriate partners to mitigate social risks and assign resources where they will be most effective.

Factor 1: Existing client and community resources

The organization assesses whether there are existing client and community resources to mitigate its prioritized social risks. The organization is not required to provide a full list of resources for every prioritized social risk, but should determine if identified risks are being addressed by existing resources.

Factor 2: Organizational capacity and capability

The organization uses its understanding of the social risks that are not met by existing client and community resources (factor 1) to determine whether it has the capacity (available resources) and capability (knowledge) to mitigate them. The organization's assessment summarizes how it determines its capacity and capability. The organization is not required to mitigate every social risk, but should determine which risks it can mitigate internally and which are outside its scope and require a partnership to mitigate. The organization may be most effective by partnering with or following the lead of community-based organizations or initiatives that specialize in mitigating social risks by improving the fundamental upstream social, economic and policy barriers that prevent people from achieving equitable health outcomes.

Factor 3: Gaps in resources

The organization assesses for gaps between existing resources offered by its clients and the community to mitigate social risks (factor 1), and its own capacity and capability (factor 2) to address them.

Examples

Factor 1: Existing community resources

Resources may be local, regional, or national, depending on the defined community. For example, an organization with a large LGBTQ+ population and a population experiencing homelessness identified a national organization that provides legal support to LGBTQ+ individuals to obtain housing without discrimination, but has not identified a local resource that addresses homelessness in general. Some individuals experiencing homelessness would prefer to use local resources to obtain safe housing.

The organization may participate in an Accountable Communities for Health Model^[1] that allows stakeholders to collaborate to implement strategies for improving population health and health equity for all individuals in the service area. States that participate in this model determine existing resources and promote cross-sector collaboration for mitigating community social risks through:

- Screenings, to identify unmet needs.
- Referrals, to increase awareness of community resources and interventions.
- Provision of navigation services, to help high-risk communities access community resources and interventions.

- Alignment between clinical and community-based resources and interventions, to ensure that services are available and responsive to the needs of community members.

An area deprivation index (ADI)^[2] assesses resources and gaps by exploring theoretical domains of income, education, employment and housing quality in Census Block Groups. Organizations can use the ADI to inform health delivery and policy, especially for the most disadvantaged neighborhood groups.

^[1] <https://innovation.cms.gov/innovation-models/ahcm>

<https://www.preventioninstitute.org/publications/accountable-communities-health-factsheet>

^[2] https://www.cdc.gov/pcd/issues/2016/16_0221.htm

Element I: Social Need Resource Assessment

Using prioritized social needs, the organization annually assesses:

1. Existing client and community resources.
2. Organizational capacity and capability.
3. Gaps in existing resources.

Scoring	Met	Partially Met	Not Met
	The organization meets 2-3 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review *For Interim Surveys:* NCQA reviews a documented process describing the organization's methodology for assessing social needs resources or interventions.

For Initial Surveys:

- NCQA reviews the organization's most recent annual assessment report or reports.
 - The organization may submit a single report describing an aggregate of all communities in its service area across clients, or reports specific to communities in the service area of each selected client.
- The score for the element is the average of scores across all selected clients.

For Renewal Surveys:

- NCQA reviews the organization's most recent annual assessment report or reports.
 - The organization may submit a single report describing an aggregate of all communities in its service area across clients, or reports specific to communities in the service area of each selected client.

The score for the element is the average of scores across all selected clients

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

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

For Renewal Surveys: 24 months.

Explanation At least annually, the organization assesses gaps in available resources, capacity and capability to mitigate social risks. The organization's assessment is based on

its prioritized social needs (Element G, factor 2), which may be in one or more communities in its service area or in its client's service area. The organization may submit evidence that represents an assessment summary of all prioritized social needs.

If the organization prioritized a social need that is being addressed by the efforts of a client, an existing community initiative or by another organization, it may choose to partner with the client, initiative or organization to strengthen its efforts. If a social need is not currently addressed by client or community efforts, the organization may choose to build internal capabilities or convene community-based stakeholders to collaboratively address the need.

By conducting a scan of community resources and understanding its own internal capacity/capability, the organization is better positioned to determine gaps in resources that perpetuate health inequities, select appropriate partners to address social needs and assign resources where they will be most effective.

Factor 1: Existing community resources

The organization assesses whether there are existing community resources/interventions to address its prioritized social needs. The organization is not required to provide a full list of resources for every social need, but should determine if identified needs are being addressed by existing resources.

Factor 2: Organizational capacity and capabilities

The organization uses its understanding of the social needs that are not addressed by existing client and community resources (factor 1) to determine whether it has the capacity (available resources) and capability (knowledge) to address them.

The organization's assessment summarizes how it determines its capacity and capability. The organization is not required to address every social need, but should determine which needs it can address internally and which are outside its scope and require a partnership to address. The organization may be most effective by partnering with or following the lead of community-based organizations that specialize in addressing social needs through interventions and equitable access to care and services for immediate needs.

Factor 3: Gaps in resources

The organization assesses for gaps between existing resources offered by its clients and the community to address social needs (factor 1) and its own capacity/capability (factor 2) to address them.

Exceptions

None.

Examples

Factor 1: Existing community resources

The ADI assesses resources and gaps by exploring theoretical domains of income, education, employment and housing quality in Census Block Groups. An organization can use the ADI to inform health delivery and policy, especially for the most disadvantaged neighborhood groups.

HEC 9: Social Needs Referrals

The organization refers individuals to social needs resources or interventions and identifies disparities in referral status.

Intent

The organization and its partners help individuals with social needs obtain access to resources and interventions.

Element A: Identifying Resources to Address Social Needs

The organization has a process for identifying appropriate social needs resources or interventions for the individuals it serves.

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

Data source Documented process

Scope of review *For All Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period for identifying appropriate resources/interventions for individuals based on assessed social needs, outlining differences by client, as applicable.
For Initial Surveys and Renewal Surveys: The score for the element is the average of scores across all selected clients.

Look-back period *For Interim Surveys:* Prior to the survey date.
For Initial Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation The organization provides its documented process for determining appropriate resources/interventions for individuals with identified social needs, including consideration of the individual's demographic characteristics. At a minimum, the process specifies the departments and staff involved in identifying social needs resources/interventions, including resources/interventions available through a partner organization, social care network or third-party vendor or platform, and how they determine which resources/interventions are appropriate.

Appropriate social needs resources/interventions align with the individual's identified social need, and are provided by partners organizations that have the capacity (resources) and capability (knowledge) to meet their cultural, linguistic and accommodation needs.

Resources/interventions may not be appropriate if the organization does not have the capacity to serve new individuals, is unsafe for the individual based on one or more demographic characteristics/identities (e.g., gender identity, sexual orientation), is unable to communicate in the individual's preferred language or is unable to meet their accommodation needs (e.g., accessible offices and equipment, materials in multiple formats, sign language interpreter).

Exceptions

None.

Examples The process for identifying resources may include, but is not limited to, use of a community hub, vendor platform, community health workers, case management or other outreach team.

Element B: Facilitating Social Needs Referrals

The organization implements a process for referring individuals to social needs resources and interventions, or for accepting referrals from partner organizations that provide resources and interventions, which includes:

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

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

Data source Documented process, Materials

Scope of review

For Interim Surveys: NCQA reviews:

- *For factors 1–4:* the organization’s documented process in place during the look-back period.
- *For factors 3 and 4:* a draft of materials that will be used to communicate information to individuals.

For Initial Surveys and Renewal Surveys:

- NCQA reviews:
 - *For factors 1–4:* the organization’s documented process in place during the look-back period, outlining differences by client, as applicable.
 - *For factors 3 and 4:* materials for each client demonstrating that the organization communicated information to individuals served during the look-back period.

The score for the element is the average of scores across all selected clients.

Look-back period

For Interim Surveys: Prior to the survey date.

For Initial Surveys: Prior to the survey date.

For Renewal Surveys: 24 months.

Explanation The organization has a documented process for referring individuals to social needs resources/interventions provided directly by the organization and its community-based or clinical partners, in a manner that respects individuals’ priorities and goals, autonomy and privacy. The documented process also

describes how the organization accepts referrals from its client and community-based or clinical partners, if applicable.

Respecting autonomy includes empowering individuals to have a central role in decision making during the referral process and acknowledging decisions that differ from the organization's recommendations, including the decision to not receive a referred resource or intervention.

Factors 1, 2

At minimum, the organization's process contains the following information:

- If the organization uses a third-party platform or vendor to facilitate the referral process.
- That the organization confirms with individuals that identified needs reflect their priorities.
- That the organization confirms individual consent to referrals to a resource or intervention.
- That, if an individual does not agree an identified need reflects their priorities, or does not consent to a referral, the organization collaborates with the individual to:
 - Identify the individual's priorities.
 - Identify the individual's reasons for not consenting to the resource or intervention.

The organization documents its findings from collaboration with the individual, as applicable. If an individual agrees that a social need is a priority, but declines to consent to a referral, the organization describes its process for determining whether the resources available in the community are meeting the needs of individuals it serves.

Factors 3, 4

Communicating expectations helps individuals served by the organization understand what to expect from the organization and its community-based or clinical partners, and their role in giving the organization enough information to ensure that the referral is effective.

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

For factor 3, the organization's process includes communicating the following minimum expectations of the organization and its partners:

- How the individual's information is kept secure during the referral process.
- How the individual can communicate at any time that the resource or intervention addressed by the referral is not wanted, effective or appropriate.
- How the individual's progress and completion of the referral is tracked.
- How ongoing collection of information is used.

For factor 4, minimum expectations include:

- Providing the organization and its partners with information necessary to carry out the referral.

- Notifying the organization and its partners, as applicable, if the individual no longer uses, wants or needs the resource or intervention provided by the referral.

Exceptions

None.

Examples**Factors 1–4**

A script for staff (e.g., care managers, nurse practitioners, community health workers, care navigators) to read at the time of referrals.

Factors 3, 4

A written notification shared with all individuals at the time of enrollment in a care management program that provides referrals for social needs resources or interventions.

Element C: Tracking Social Needs Referral Status

The organization tracks the status of individuals' referrals.

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

Scope of review *For Interim Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period for tracking individuals' referral status.
For Initial Surveys and Renewal Surveys: NCQA reviews reports for each selected client demonstrating that the organization tracked individuals' referral statuses during the look-back period. The score for the element is the average of scores across all selected clients.

Look-back period *For Interim Surveys:* Prior to the survey date.
For Initial Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation The organization collaborates with its community-based or clinical partners to track the status of individuals' referrals to social resources/interventions and from partners back to the organization. At a minimum, collaboration to track referral status includes confirming that the referral request was received and the individual received/accessed the service (if this information is available).

The organization demonstrates tracking using one of the following methods:

- Reports from the partner organization involved in the referral.
- Internal reports for individuals referred from partner organizations.
- Reports from shared referral platforms or systems.

Exceptions

None.

Examples

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

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

Element D: Assessing Social Needs Referrals for Disparities

The organization annually analyzes social needs referral statuses to identify if disparities exist by:

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

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

Data source Documented process, Reports

Scope of review *For Interim Surveys:* NCQA reviews a documented process reflecting the organization's stratification methodology in place throughout the look-back period.

For Initial Surveys: NCQA reviews the organization's most recent annual assessment report for each selected client.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual assessment reports for each selected client.

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

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

For Renewal Surveys: 24 months.

Explanation Having information on disparities by characteristics and identities such as race, ethnicity, language, gender identity or sexual orientation is an important step to identifying opportunities for improving the referral process, delivery of resources/interventions and methods of communicating. Organizations may need to adjust their approach to the referral process, or tailor communications to better meet the needs of and build trust with subpopulations of the individuals they serve.

Factors 1–4

The organization annually stratifies data on social needs referral status by race, ethnicity, language, gender identity and/or sexual orientation to assess if there are disparities in accessing or receiving referred resources and interventions. At a minimum, stratified referral statuses must include confirming that the referral request was received and the individual received/accessed the service (if this information is available).

If the organization concludes that the denominator is too small (less than 30 individuals) to draw meaningful conclusions, it includes this information in the report.

For factor 3, if the organization’s data collection only includes binary gender identity options (man/male, woman/female), it may use the available data to support its gender identity analysis.

Exceptions

None.

Examples

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

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