Foundational Standards to Support Effective, Sustainable Advancement of Equity

Elizabeth Ryder | Assistant Director, Product Management, NCQA

- 203 Million People covered in health plans that report HEDIS
- 73% of Americans with health insurance are covered in an NCQA-Accredited plan
- 60,000+ Clinicians work in an NCQA-Recognized medical practice
- 13,000+ entities and programs Accredited, Certified or Recognized by NCQA

**How NCQA Helps**

**ALIGN**
Meet regulatory standards and payer expectations.

**IMPROVE**
Improve quality and perform against quality measures and incentives.

**VALIDATE**
Evolve measurement, make data more usable and have confidence in the results.

**DIFFERENTIATE**
Substantiate value propositions and differentiate from peers.
NCQA invests in health equity in more ways than one

**RESEARCH**
- Evidence for Health System Equity Efforts through Community Health Workers’ programs in partnership w/ the National Urban League
- Accuracy and completeness of race and ethnicity data collected by health sector stakeholders
- Birth Equity Accountability through Measurement project in partnership w/ RH Impact (Formerly the National Birth Equity Collaborative)
- Advancing approaches for health equity accountability through measurement models and scoring
- And many more, in collaboration with community partners....

**MEASUREMENT & DATA**
- Begin stratifying HEDIS measures by race/ethnicity
- New social needs measure of screening and intervention
- Making HEDIS more inclusive of gender identity
- Digitalization of HEDIS® measures allows for greater and more flexible measure configurations that can support insights into sub-populations.
- Align with data standards, including USCDI, CARIN for Blue Button®, the Gravity Project and the Gender Harmony project.

**PROGRAMS**
- Health Equity Accreditation
- Health Equity Accreditation Plus
- Embedding health equity in other programs (e.g., LTSS Accreditation, Health Plan Accreditation, PCMH Recognition)

**BRIDGING INSIGHTS**

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Designed as a foundation for work to continuously improve and prioritize health equity.

Focused on collecting demographic data (e.g., race, ethnicity) to understand members’ or patients’ needs, then identify and act on opportunities to reduce disparities and improve the cultural and linguistic appropriateness of care.

Builds on NCQA’s Health Equity Accreditation (its prerequisite).

Designed for organizations progressing to the next step of their health equity journey.

Focused on collecting data and partnering with community-based organizations and cross-sector partners to address social needs of individuals served and mitigate social risks of the community.

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NCQA’s Health Equity Accreditation Programs Have Broad Eligibility

- Payers (health plans, MBHOs)
- Health or hospital systems
- Hospitals
- Pop Health Organizations
- ACOs, CINs
- Practices, Clinics or FQHCS
- Case Management Organizations
# Why NCQA’s Health Equity Accreditation?

<table>
<thead>
<tr>
<th><strong>Improve Quality &amp; Equity for Members</strong></th>
<th><strong>Create Structure &amp; Accountability for Long-Term Success</strong></th>
<th><strong>Earn a Reputation for Leadership</strong></th>
<th><strong>Align Staff and Leadership, Enterprise-Wide</strong></th>
<th><strong>Align with State &amp; Federal Priorities</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Empower your organization to <strong>identify and act</strong> on health disparities with a central focus on <strong>measurement and quality improvement</strong>.</td>
<td>NCQA Accreditation is an important tool for ensuring health equity work has the <strong>structure and accountability necessary to reach and sustain quality improvement goals</strong>.</td>
<td>Demonstrate to regulators, members, and your community that improving health equity is more than just a hot topic—it’s what you strive for every day.</td>
<td>Demonstrate that your entire enterprise is improving care and services. Help every part of your organization see how it contributes to improving patient or member health.</td>
<td>State and Federal policymakers have made health equity a priority. <strong>Position your organization to meet and anticipate state and federal regulators’ requirements</strong> across multiple care models, contracts, and payment programs.</td>
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### CMS Framework for Health Equity

<table>
<thead>
<tr>
<th>PRIORITY 1</th>
<th>PRIORITY 2</th>
<th>PRIORITY 3</th>
<th>PRIORITY 4</th>
<th>PRIORITY 5</th>
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<tbody>
<tr>
<td>Expand the Collection, Reporting, and Analysis of Standardized Data</td>
<td>Assess Causes of Disparities Within CMS Programs and Address Inequities in Policies and Operations to Close Gaps</td>
<td>Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities</td>
<td>Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services</td>
<td>Increase All Forms of Accessibility to Health Care Services and Coverage</td>
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Source: CMS Framework for Health Equity 2022–2032
Health Equity Accreditation is becoming the foundation for states to build on

36M+ covered lives in NCQA’s Accreditations in Health Equity or Health Equity Plus

Required to Achieve NCQA’s Health Equity Accreditation (16 States + D.C)

Required to Achieve NCQA’s Health Equity Accreditation Plus (3 States)

States with voluntary adoption by organizations serving one or more populations (Medicaid, Exchange, Medicare or Commercial).
### Alignment with the AHA’s Health Equity Roadmap

<table>
<thead>
<tr>
<th>The AHA’s Six Levers for Transformation</th>
<th>HEA LTH E Q U I T Y  A C C R E D I T A T I O N</th>
<th>HEA LTH E Q U I T Y  A C C R E D I T A T I O N  P L U S</th>
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<tbody>
<tr>
<td>Organizational Readiness</td>
<td>Race/Ethnicity, Language, Gender Identity &amp; Sexual Orientation Data</td>
<td>Access &amp; Availability of Language Services</td>
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<tr>
<td>✓</td>
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<tr>
<td>Culturally Appropriate Patient Care</td>
<td>Equitable &amp; Inclusive Organizational Policies</td>
<td>Collection &amp; Use Of Data To Drive Action</td>
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<tr>
<td>Diverse Representation In Leadership &amp; Governance</td>
<td>✓</td>
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<tr>
<td>Community Collaboration For Solutions</td>
<td>Systematic &amp; Shared Accountability</td>
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</tbody>
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Health Equity Accreditation
Reducing Health Care Disparities

Cultural & Linguistically Appropriate Services (CLAS) Programs

- Organizational Readiness
- Race/Ethnicity, Language, Gender Identity & Sexual Orientation Data
- Access & Availability of Language Services
- Practitioner Network Cultural Responsiveness
- Cultural & Linguistically Appropriate Services (CLAS) Programs
- Reducing Health Care Disparities

3-Year Standards-based program

Designed as a foundation for work to continuously improve and prioritize health equity.

Focused on collecting data to understand members’ or patients’ needs, then identify and act on opportunities to reduce disparities and improve the cultural and linguistic appropriateness of care.
HE 1: Organizational Readiness

**Activities in this standard category:**

- **Recruitment and hiring** practices that support **diversity** in its workforce
- **Employee training** on culturally and linguistically appropriate practices, reducing bias or promoting inclusion
- **Opportunities and actions to improve** diversity, equity, inclusion or cultural humility for workforce

**Prepares organizations to:**

- Build an internal culture to support and sustain external health equity work
- Value, respect, and respond to the beliefs, behaviors, and needs of patients/members
HE 2: Race/Ethnicity, Language, Gender Identity & Sexual Orientation Data

Activities in this standard category:

- Collection of individual-level patient/member data:
  - Race and ethnicity
  - Language
  - Gender Identity
  - Sexual Orientation

- Policies and procedures for protection, access to and use of individual-level data on race, ethnicity, language, gender identity and sexual orientation

Notifying individuals served about how individual-level data on race, ethnicity, language, gender identity and sexual orientation will be protected and used

Prepares organizations to:

- Understand and meet patients’ cultural and linguistic needs
- Identify and measure disparities by characteristic
- Establish and track performance on measurable goals for reducing disparities
- Maintain a pool of practitioners to meet cultural and linguistic needs

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Direct Data Collection means asking individuals for information (directly)

Data Collection is an Opportunity for Collaboration

The organization seeking Accreditation

CMS

State or local agencies

EHRs

HIEs

Case Management Systems
HE 3: Access and Availability of Language Services

**Activities in this standard category:**

- Communicate and translate important information in languages used by community and individuals served
- Inform individuals served about how to access the organization’s free language services for care/services

**Prepares organizations to:**

Communicate with individuals about their care and health in the language they understand (and help practitioners to do the same)

Support practitioners in providing competent language services

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HE 4: Practitioner Network Cultural Responsiveness

Activities in this standard category:

- Collect practitioner data on fluent languages for medical care, race/ethnicity, and available language services
- Make information on practitioner fluent languages, race/ethnicity and language services available to patients
- Analyze network capacity to meet individuals’ linguistic needs and provide culturally appropriate care, and act on opportunities to improve

Prepares organizations to:

- Build and maintain a pool or network of practitioners capable of meeting, understanding, and responding to patients’ needs
- Empower patients to choose practitioners that share and/or understand their cultural and linguistic background

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Practitioner

A licensed or certified professional who provides medical care or behavioral healthcare services.

Contracted network practitioners

The pool of practitioners the organization employs or contracts with to provide services to a defined population (patients, members).

The scope of a “network” may look different across payers and care delivery organizations, but the goal is the same.
HE 5: Culturally and Linguistically Appropriate Services Programs

Activities in this standard category:

- Document the **scope, objectives and community involvement** of program to improve the cultural and linguistic appropriateness of care and services (CLAS).
- Set and monitor improvement on measurable goals for improving CLAS.
- **Annually evaluate performance** on measurable goals and the **overall effectiveness** of the CLAS program.

Prepares organizations to:

- Create infrastructure to continuously measure and improve care and services for all patients.
- Set measurable goals for reducing disparities and improving the cultural and linguistic appropriateness of care and services.
HE 6: Reducing Health Care Disparities

Activities in this standard category:

- Annually stratify measures, by race/ethnicity, language, gender identity and/or sexual orientation data to determine if health care disparities exist.
- Annually identify, prioritize and act on opportunities to reduce health care inequities and improve CLAS.
- Annually assess individual utilization of language services and individual and staff experience with language services.

Prepares organizations to:

- Use data on patients, practitioners, and language services to identify and act on opportunities to improve care and services, and to reduce health care inequities.
Health Equity Accreditation Plus
NCQA’s Health Equity Accreditation Plus

3-Year Standards-based program

Builds on NCQA’s Health Equity Accreditation (its prerequisite).

Designed for organizations progressing to the next step of their health equity journey.

Focused on partnering with community-based organizations and cross-sector partners to address social needs of individuals served and mitigate social risks of the community.

Collection, Acquisition and Analysis of Community and Individual Data

Cross-Sector Partnerships and Engagement

Data Management and Interoperability

Program to Improve Social Risks and Address Social Need

Referrals, Outcomes and Impact

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Community in Context

**Service Area**
Geographic area where individuals may obtain or access services.

**Population of Individuals Served**
The organization’s current members, patients who receive treatment, or individuals who participate in its programs.

**Community**
A social unit (group) that shares commonalities such as geographic locations, norms, religion, values, customs, characteristics or identities. Includes the population of individuals served by the organization, as well as the broader population that resides in the service area but may not access the organization’s services (nonmembers/nonpatients).
Defining Communities

**Examples**

**Health System A**
- Has sites across Washington D.C., Maryland and Virginia
- Defines its communities as 3 distinct markets aligned with state boundaries

**Health System B**
- Has care sites across a single county in Wisconsin
- Defines communities using zip code and density of patients

**Health Plan C**
- Serves counties in 4 out of 7 state-defined regions in Illinois
- Defines communities by county

**Health Plan D**
- Serves multiple counties in Arizona.
- Defines its communities using product line, community-level social risk score by zip code, race/ethnicity and spoken language
Activities in this standard category:

- Collect and compare data on patients’ social needs and the broader communities’ social risks.
- Annually prioritize social needs and social risks to mitigate and address.
- Stratify social needs and social risks by demographic characteristics to identify the most impacted subpopulations.

Prepares organizations to:

- Make informed decisions about the focus of its programs and initiatives.
- Select relevant, appropriate partners.
- Select relevant goals for addressing social needs and mitigating social risks.
HE Plus 2: Cross-Sector Partnerships and Engagement

**Partners**
Organizations that deliver social needs resources or interventions (CBOs, local government entities, non-health care social service providers)

**Community-Based Initiatives**
Cooperative relationships led by community members, CHWs and CBOs; often address equity and broader social risks faced by community

**Cross-Sector Initiatives**
Cooperative relationships between organizations from different sectors that focus on addressing a shared community-level social risk
HE Plus 2: Cross-Sector Partnerships & Engagement

Activities in this standard category:

- Assess gaps in existing community resources and the organization’s capabilities to address social needs and risks.
- (Actively) collaborate and support partners on providing social needs resources and mitigating social risks.
- Select relevant, appropriate partners to deliver social needs resources and address social risks.
- Establish at least one bidirectional and mutually-supportive partnership to deliver social needs resources.

Prepares organizations to:

- Act on identified priorities.
- Reposition relationships with non-health care organizations as partnerships vs. transactional.
- Collaborate with the broader ecosystem to address upstream, community social risks.
- Provide resources to meet individuals’ immediate needs.
Activities in this standard category:

- Policies and procedures for protection, access to, use and sharing of individual-level data on social needs.
- Process for bidirectional data sharing with external organizations and partners.

Prepares organizations to:

- Establish structures that facilitate interoperability, collaboration and a seamless experience for patients.
- Standardize processes for sharing social needs data across sectors.
- Help patients understand how their social needs data is protected and may be used or shared for their benefit.

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**Activities in this standard category:**

- Set and monitor improvement on measurable goals for addressing social needs and mitigating social risks.

- Processes to recruit and meaningfully involve stakeholders like patients, community partners, and community members.

- Document the **scope, objectives and community involvement of program/initiatives** to address social needs and mitigate social risks.

**Prepares organizations to:**

- Create infrastructure to continuously measure and improve the program (e.g., priorities, partners, goals)

- Set measurable goals for addressing patients’ social needs and mitigating communities’ social risks

- Meaningfully involve stakeholders that best understand the needs, risks and challenges of the community
## Activities in this standard category:

| Identify and refer individuals to appropriate social needs resources |
| Track and identify disparities in social needs referral statuses |

| Annually collaborate with partners to evaluate and improve the partnership’s effectiveness |

## Prepares organizations to:

- Empower patients to have an active and informed role in the social resource referral process
- Evaluate and identify necessary improvements or changes to partnership or the program
<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
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<tbody>
<tr>
<td>Collection, Acquisition and Analysis of Community and Individual Data</td>
<td>Collecting social needs data, Collecting community social risk data</td>
</tr>
<tr>
<td>Cross-Sector Partnerships and Engagement</td>
<td>Support CBO capacity to provide resources, Support cross-sector initiatives for social risks</td>
</tr>
<tr>
<td>Data Management and Interoperability</td>
<td>Meaningful stakeholder engagement</td>
</tr>
<tr>
<td>Program to Improve Social Risks and Address Social Need</td>
<td>Tracking and stratifying social needs referrals</td>
</tr>
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NCQA’s Health Equity Accreditation Plus

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What to Expect: Standards, Evidence and Surveys
## NCQA Accreditation Standards

### Element
Worth 1 or 2 points depending on how many factors earned

### Factor
Individual requirement that must be demonstrated through evidence

### Score
Number of factors that must be demonstrated to earn full (Met), half (Partially Met) or none (Not Met) of element’s full point value

#### Element C: Collecting Individuals’ Social Needs Data

The organization has a framework for direct collection of data and 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.

#### Score Table

<table>
<thead>
<tr>
<th>Met</th>
<th>Partially Met</th>
<th>Not Met</th>
</tr>
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<td>The organization meets 4-6 factors</td>
<td>The organization meets 3 factors</td>
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</table>
How Does Scoring Translate Into Points?

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</table>

**Important Requirements**
- Majority of Elements
  - 1 point
  - 0.5 points
  - 0 points

**Very Important Requirements**
- 2 points
- 1 point
- 0 points
NCQA’s Evidence Expectations for Survey

**Documented Process**
Describes the methodology or process that the organization follows/uses to complete a required task

*Examples*
- Policies and procedures
- Process workflow charts
- Protocols

**Reports**
Documents the organization’s actions taken or performance of a requirement

*Examples*
- Management report
- Key indicator report
- Summary review report
- Systems output report

**Materials**
Demonstrates information the organization provides or communicates to external audiences

*Examples*
- Website screenshots
- Patient-facing call script
- Practitioner newsletter
- Delegate contract/agreement

**Implementation Plan**
- Documents specific actions and timeline the organization will take to meet the requirement
- Demonstrates information the organization will provide or communicate with external audiences
The Accreditation Survey Process

- Consultation & Gap Analysis (12-15 months prior to survey)
  - Purchase program standards
  - Learn and understand the standards and identify gaps to address
  - Submit a prequalification form to NCQA

- Application and Scheduling (9-12 months prior to survey)
  - Submit application and fee
  - Sign survey agreement
  - Confirm survey date

- Pre-Survey and Readiness Evaluation
  - Prepare for compliance: implement new systems workflows, etc.
  - Prep, upload survey evidence in NCQA’s survey tool

- Submission and Survey Review
  - ✓ Purchase program standards
  - ✓ Learn and understand the standards and identify gaps to address
  - ✓ Submit a prequalification form to NCQA

- Post-Survey Review and Final Report
  - ✓ Purchase program standards
  - ✓ Learn and understand the standards and identify gaps to address
  - ✓ Submit a prequalification form to NCQA

- ✓ Surveyor reviews uploaded evidence, makes initial decision
- ✓ Review and respond on missed points before score is finalized

❖ NCQA reviews surveyor’s results
❖ NCQA issues the final decision on status

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Timing Considerations for Scheduling Your Survey

Timing depends on how many—and which—gaps the organization must address before survey.

- **Updating system configuration**, i.e., sexual orientation and gender identity data fields (1-2 years)
- **Updating, getting approval for internal policies** (6-9 months)
- **Updating, getting approval for, and deploying patient-facing communications** (6-18 mo.)
- **Identifying/establishing/updating partnerships**, signing agreements (6 mo. – 2 years)
- **Collecting data usable for analysis** (multi-year, staged)
Wrap Up
Cross-Sector Partnerships to Address Health-Related Social Needs
- Navigating Cross-Sector Partnerships: A Reference Guide for Community-Based Organizations Collaborating with Health Care Organizations
- Co-Developing Cross-Sector Partnerships to Address Health-Related Social Needs: A Toolkit for Health Care Organizations Collaborating with Community Based Organizations

Birth Equity Accountability Through Measurement
- Measurement Framework: A Quality Measurement Strategy to Promote Equitable Birthing Care
- Webinar: Measuring What Matters – Highlights from Phase One of the Birth Equity Accountability through Measurement Initiative

Creating a Digital Healthcare Equity Framework
- Evidence- and Consensus-Based Digital Healthcare Equity Framework
- A Practical Guide for Implementation

Assessing and Addressing the Diverse Spectrum of Social Care Needs (Blog)
Other NCQA Health Equity Resources

Health Equity Resource Center

ncqa.org/health-equity

Access tools, best practices and more to support equity action.

Watch recordings from the 2024 Health Equity Forum and other equity related events at NCQA.

Learn about NCQA health equity offerings and initiatives.
NCQA HEALTH INNOVATION SUMMIT

THIS IS QUALITY

OCTOBER 31 - NOVEMBER 2, 2024
GAYLORD OPRYLAND RESORT & CONVENTION CENTER
NASHVILLE, TN

www.ncqasummit.com