



Foundational Standards to Support Effective, Sustainable Advancement of Equity

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Better health care. Better choices. Better health.



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

NCQA's Health Equity Accreditation Programs



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).

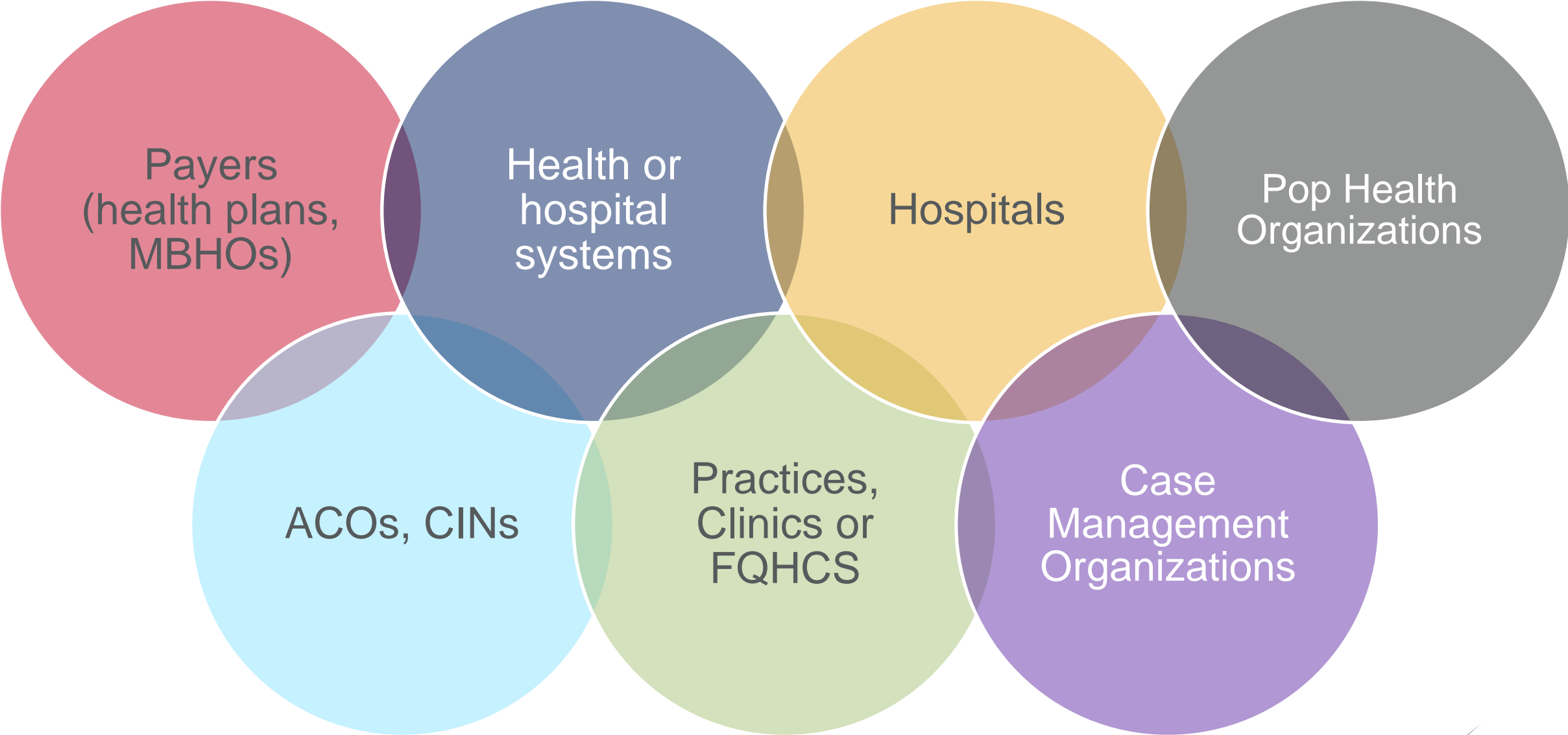


Designed for **organizations progressing to the next step** of their health equity journey.



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.**

NCQA's Health Equity Accreditation Programs Have Broad Eligibility



Why NCQA's Health Equity Accreditation?



Improve Quality & Equity for Members

Empower your organization to **identify and act** on health disparities with a central focus on **measurement and quality improvement**.



Create Structure & Accountability for Long-Term Success

NCQA Accreditation is an important tool for ensuring health equity work has the **structure and accountability necessary to reach and sustain quality improvement goals**.



Earn a Reputation for Leadership

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**.



Align Staff and Leadership, Enterprise-Wide

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.



Align with State & Federal Priorities

State and Federal policymakers have made health equity a priority. **Position your organization to meet and anticipate state and federal regulators' requirements** across multiple care models, contracts, and payment programs.

CMS Framework for Health Equity

PRIORITY 1



Expand the Collection, Reporting, and Analysis of Standardized Data

PRIORITY 2



Assess Causes of Disparities Within CMS Programs and Address Inequities in Policies and Operations to Close Gaps

PRIORITY 3



Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

PRIORITY 4



Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

PRIORITY 5



Increase All Forms of Accessibility to Health Care Services and Coverage

Alignment with the AHA's Health Equity Roadmap

| The AHA's Six Levers for Transformation | HEALTH EQUITY ACCREDITATION | | | | | | HEALTH EQUITY ACCREDITATION PLUS | | | | |
|---|-----------------------------|---|--|--|--|----------------------------------|---|--|------------------------------------|---|------------------------------|
| | 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 | Collection, Acquisition and Analysis of Community & Individual Data | Cross-Sector Partnerships and Engagement | Data Management & Interoperability | Program to Improve Social Risks & Address Social Need | Referrals, Outcomes & Impact |
| Culturally Appropriate Patient Care | ✓ | | | | ✓ | | | | | ✓ | |
| Equitable & Inclusive Organizational Policies | ✓ | | | | | | ✓ | ✓ | | ✓ | |
| Collection & Use Of Data To Drive Action | | ✓ | | | ✓ | ✓ | ✓ | | | ✓ | |
| Diverse Representation In Leadership & Governance | ✓ | | | | | | | | | | |
| Community Collaboration For Solutions | | | | | | | ✓ | ✓ | | ✓ | |
| Systematic & Shared Accountability | ✓ | | | | | | | | | ✓ | |



Health Equity Accreditation

NCQA's Health Equity Accreditation



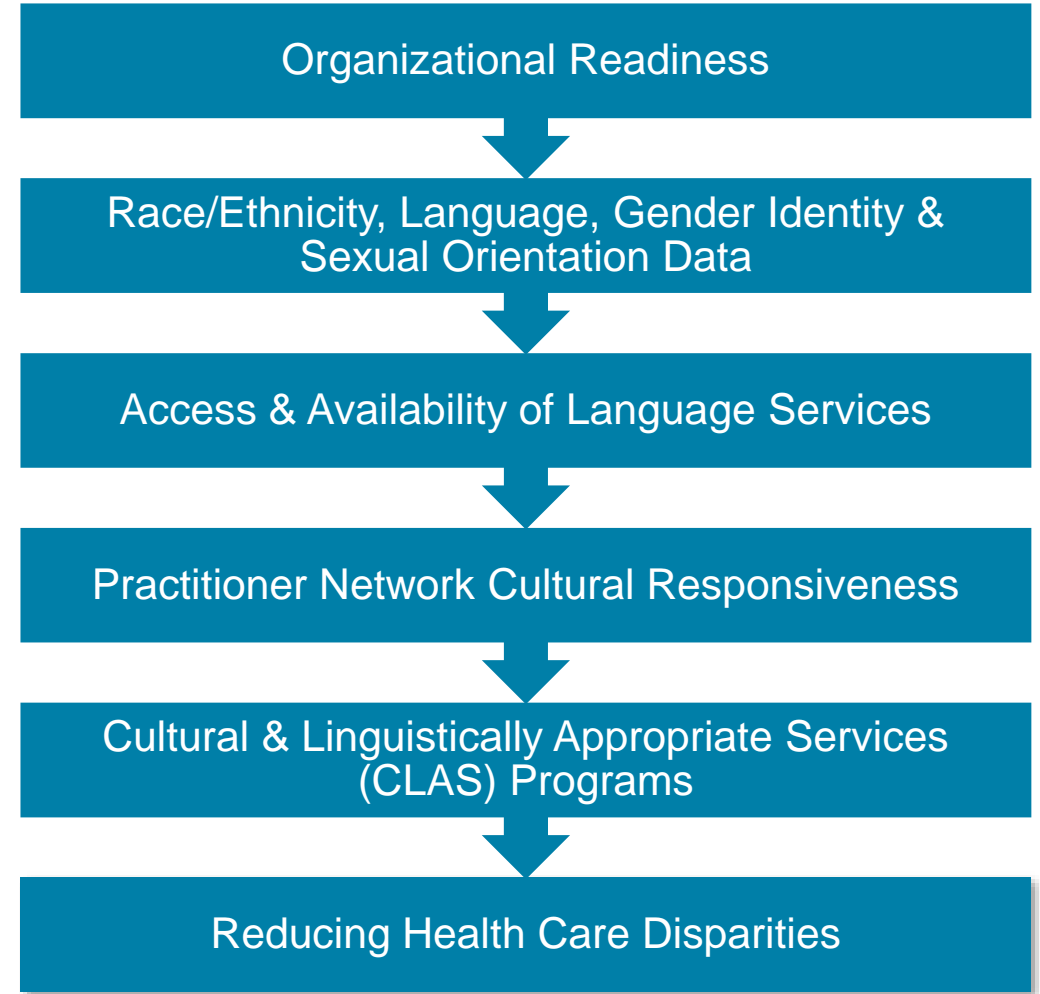
3-Year Standards-based program



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

Opportunities and actions to improve diversity, equity, inclusion or cultural humility for workforce

Employee training on culturally and linguistically appropriate practices, reducing bias or promoting inclusion



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



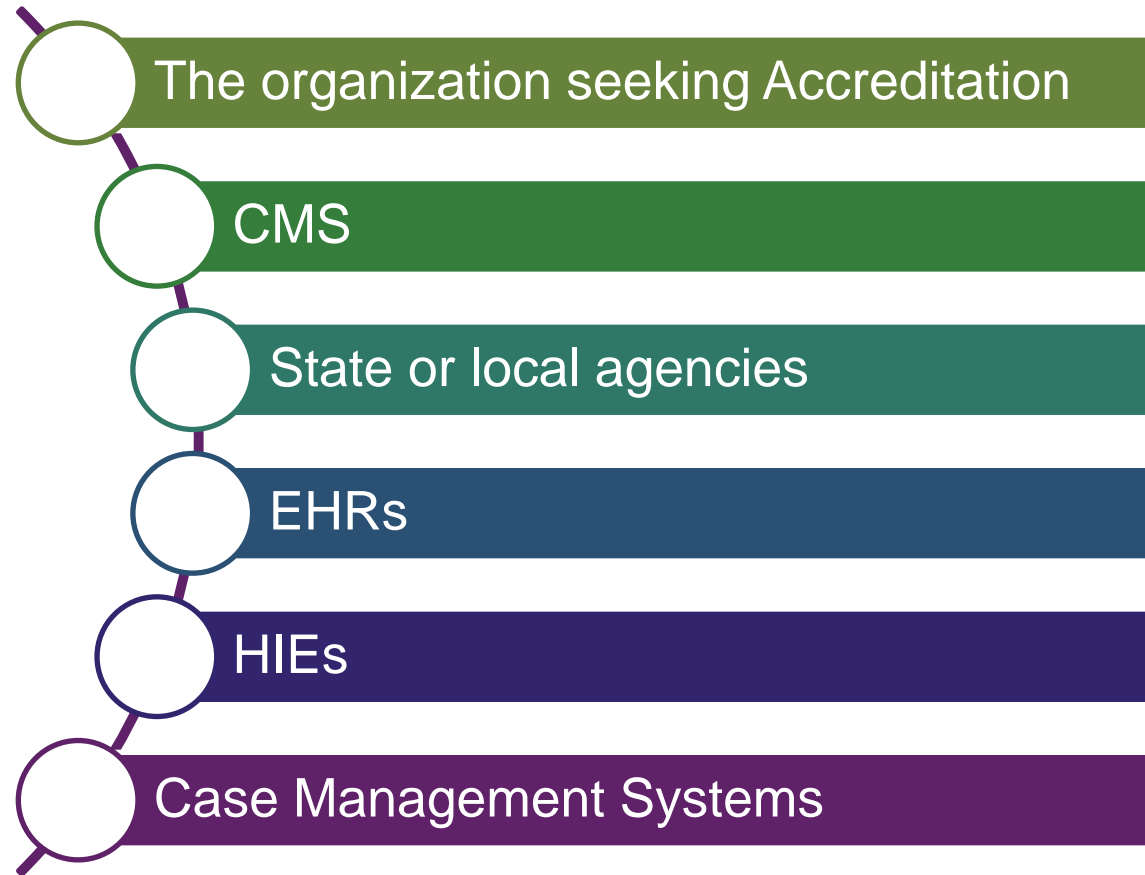
Establish and track performance on measurable goals for reducing disparities



Maintain a pool of practitioners to meet cultural and linguistic needs

Data Collection is an Opportunity for Collaboration

Direct Data Collection
means asking individuals
for information (directly)



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

Support practitioners in providing **competent language services**

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)

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

HE 4: Practitioner Network Cultural Responsiveness

The scope of a “network” may look different across payers and care delivery organizations, but the goal is the same



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).

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 **assess individual utilization** of language services and individual and staff **experience** with language services.

Annually **identify, prioritize and act on opportunities** to reduce health care inequities and improve CLAS.



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**.



Community in Context

Service Area

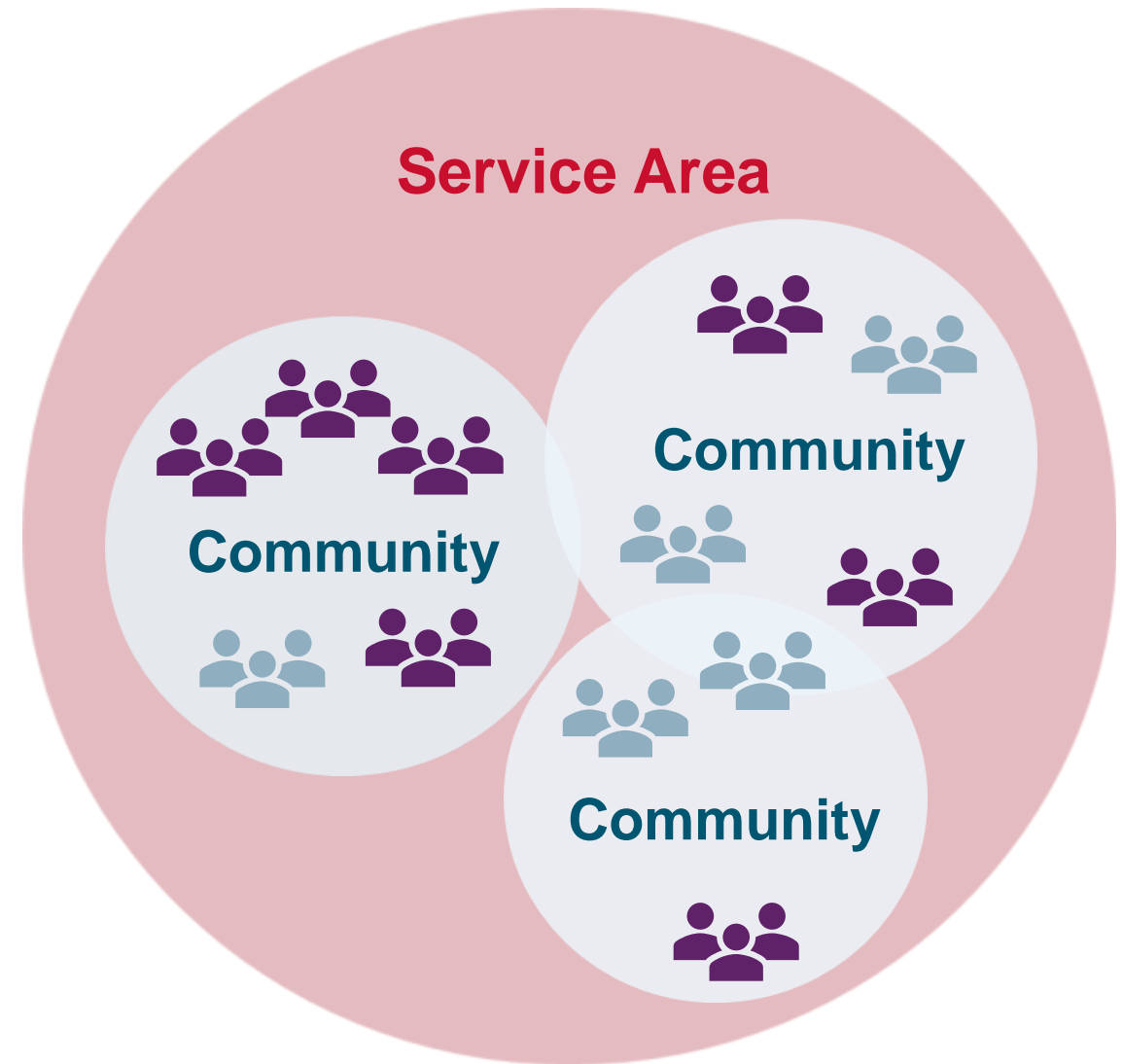
Geographic area where individuals may obtain or access services.

Population of Individuals Served

The organization's current members, patients who receive treatment, or individuals who participate in its programs.

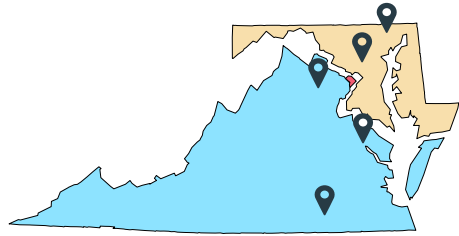
Community

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 Plan C

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



Health System B

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



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

HE Plus 1: Collection, Acquisition & Analysis of Community & Individual Data

Activities in this standard category:

Collect and compare data on patients' social needs and the broader communities' social risks.

Stratify social needs and social risks by demographic characteristics to **identify the most impacted subpopulations.**

Annually **prioritize social needs and social risks** to mitigate and address.



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.

Select relevant, appropriate partners to deliver social needs resources and address social risks

(Actively) collaborate and support partners on providing social needs resources and mitigating 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

HE Plus 3: Data Management & Interoperability

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

HE Plus 4: Program to Mitigate Social Risks & Address Social Needs

Activities in this standard category:



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

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.

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

HE Plus 5: Referrals, Outcomes & Impact

Activities in this standard category:

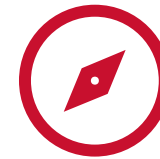
Identify and refer individuals to appropriate social needs resources

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

NCQA's Health Equity Accreditation *Plus*



Collecting social needs data



Collecting community social risk data



Support CBO capacity to provide resources



Support cross-sector initiatives for social risks



Meaningful stakeholder engagement



Tracking and stratifying social needs referrals



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.

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

How Does Scoring Translate Into Points?

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

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

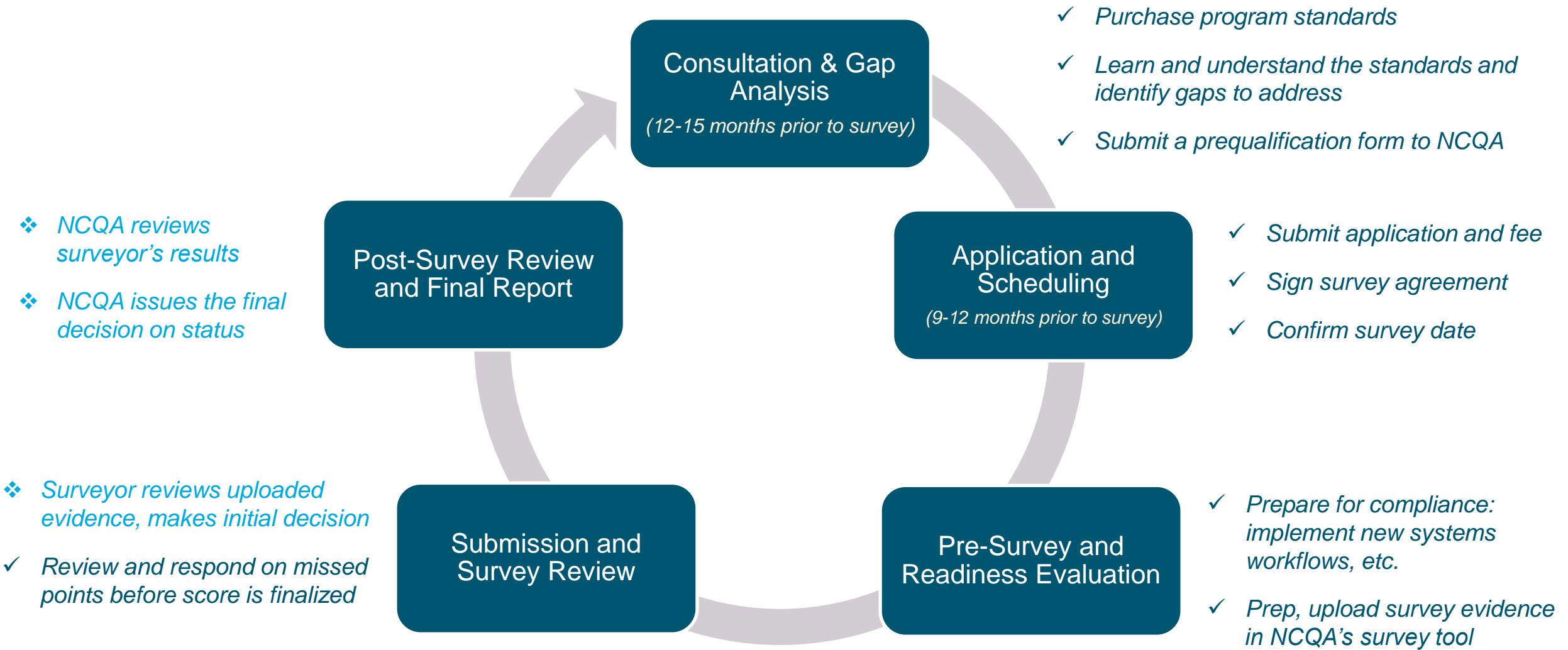
- ✓ Website screenshots
- ✓ Patient-facing call script
- ✓ Practitioner newsletter
- ✓ Delegate contract/agreement



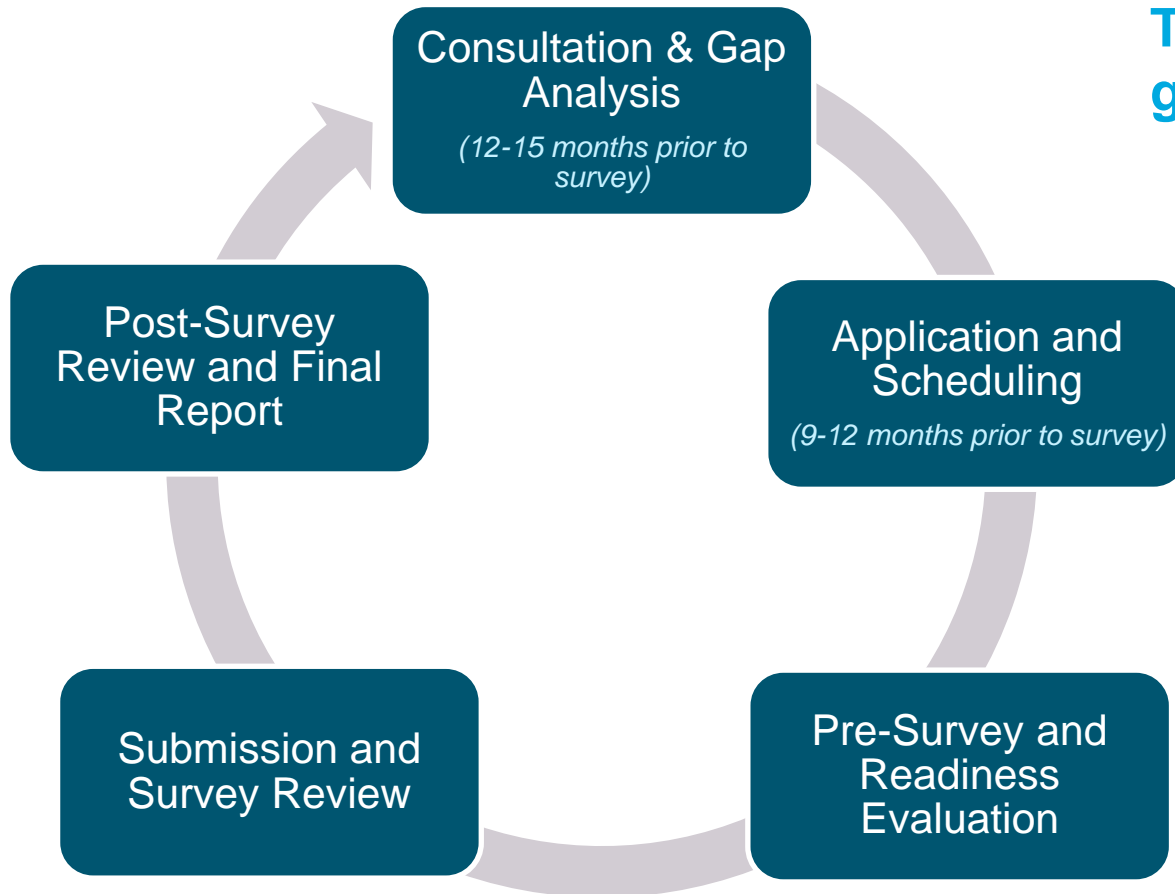
Implementation Plan

- ❑ 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



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

Recent Publications and News (as of April 2024)

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)



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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.



High-quality care
is equitable care.

Contact Us



Ask a Question

Submit a content question to NCQA's policy champions via [My.NCQA.org](https://www.ncqa.org/my-ncqa)



Contact a NCQA Representative

Speak to someone by contacting us at [ncqa.org/equityinfo](https://www.ncqa.org/equityinfo)



Download the Health Equity Standards

Start to review the program standards and guidelines



Learn more with online trainings

Find on-demand courses at [ncqa.org/equityedu](https://www.ncqa.org/equityedu)

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QUALITY**

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