HEPLUS 1: Collection~~, Acquisition~~ and Analysis of Community and ~~Individual~~ Member- or Patient-Level Data

The organization ~~acquires community data and collects individual data to segment or stratify its population and~~ collects, stratifies and analyzes data to understand the similarities and differences between the social risks of the community and the social needs of ~~the individuals it serves~~ its members or patients.

Intent

The organization collects data to make data-driven decisions about social risks and social needs it prioritizes and partnerships it selects. ~~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: Defining the Community

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 Reports

Scope of review *For All Surveys:* NCQA reviews ~~the organization's reports from up to four randomly selected communities, or from all communities if the organization's service area has fewer than four, that define~~ a summary report(s) defining the geographical boundaries or the nongeographical composition of each community in its service area, as applicable.

The organization may provide a single report describing ~~the~~ all communities in its service area or multiple reports specific to each community.

NCQA reviews evidence from up to four randomly selected communities, or from all communities if the organization's service area has fewer than four. The score for the element is the average of the scores for all communities.

Look-back period *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 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 organization's members or patients ~~individuals served by the organization (members, patients)~~ live, work and receive services.

The organization identifies its service area, or the geographic area where members or patients~~ 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 (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 organization's services (nonmembers).

If the organization operates virtually or provides virtual services only (telemedicine), it must identify the geographic location ~~of individuals served~~ and the nongeographical composition of members or patients ~~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

- The health system defines its communities using geographical boundaries that include individuals who live within a certain number of miles from health system facilities or within a certain distance from public transportation routes to facilities. The health system uses a geographic information system mapping tool to demonstrate how individuals in the community use public transit or transportation corridors in the region.
- 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).

Nongeographical composition

- The organization uses geographical boundaries (e.g., state-defined regions) to define its communities, then uses nongeographic characteristics (e.g., language) 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).
- A health system that specializes in providing gender-affirming care to individuals across a wide service area defines its communities by race/ethnicity and gender identity.

Element B: Acquiring Communities' Social Risk Data

Every 3 years, the organization acquires social risk data on each community ~~the communities identified in Element A for stratification~~ from:

1. **A community health assessment or community health needs assessment performed by a local public health agency or its equivalent.**
2. **A second data source endorsed by at least one of the organization's partners.**
3. **A third data source. ~~endorsed by at least one of the organization's partners.~~**

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 All Surveys:* NCQA reviews evidence for the same communities randomly selected in Element A, including:

- The organization's documented process in place throughout the look-back period for acquiring data on the social risks for each community. ~~all communities identified in Element A.~~
- Reports or materials (e.g., screenshots) demonstrating the organization acquired data from each source in factors 1–3 for each community~~. identified in Element A.~~
- Evidence that one data source for each community supports stratification by one demographic characteristic. ~~NCQA reviews evidence from up to four randomly selected communities.~~
    - ~~The organization may submit either multiple documents or one document.~~

For factor ~~3~~2: NCQA also reviews materials as evidence that one ~~the~~ data source for each community is endorsed by at least one partner.

The organization may submit one document or multiple documents.

~~NCQA reviews evidence for the same communities randomly selected in Element A~~. The score for the element is the average of sources across all selected communities.

~~Evidence that at least one data source allows stratification by at least one demographic characteristic/identity~~.

Look-back period *For All Surveys:* At least once during the prior 36 months, for factors 1 and 3; prior to the survey date, for factor 3.

Explanation **Social risk factors** are specific, adverse social or environmental conditions ~~(e.g., social isolation, housing instability, poverty)~~ associated with poor health outcomes. A community's social risks may be created or exacerbated by structural factors, (e.g., policies on economics or housing; lack of infrastructure for healthy food, education or transportation, if these factors create unfair, unjust or inequitable differences in opportunities available for community members to attain their highest level of health.

For example, a community's zoning policies or procedures for housing applications may exacerbate a lack of affordable housing or rate of individuals experiencing housing instability. Social risk factors or their root causes may broadly impact the community or a subset of community members with different characteristics (e.g., race, ethnicity, disability status, language, age, veteran status, dual eligibility status). ~~if the factors are fundamentally affected by racism, classism, sexism, ableism and other biases that perpetuate inequities.~~

~~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.~~

The organization has a documented process for acquiring social risk data across all communities~~, including the communities~~ identified in Element A from three different sources at least every 3 years. Organizations must use ~~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. At least one data source for each community must have sufficient variables or data elements to support stratification by at least one demographic characteristic (e.g., race, ethnicity, national origin, religion, preferred language, sex, gender identity, sexual orientation, disability status, age). The organization may also use socioeconomic factors such as ~~age, disability status,~~ income, education or employment status to supplement stratification. The organization provides a rationale for using each selected demographic characteristic or socioeconomic factor.

The organization may submit either multiple documents or one document that collectively demonstrates acquisition from all sources for each factor and for all communities identified in Element A.

Factor 1: **Community health assessment**

A **community health assessment or community health needs assessment (CHNA)** identifies key health needs and issues through systematic, comprehensive data collection and analysis.[1] Organizations that own or operate institutions that are federally required to produce a CHNA (e.g., hospitals, Certified Community Behavioral Health Clinics) may use it as evidence to meet this requirement. All other organizations must use a community health assessment or CHNA conducted by a local public health agency or institution, or the equivalent.

Factor 2~~3~~: **Partner-endorsed data source**

At least one data source for each community must be endorsed by a partner: an external entity (e.g., state agency, clinical provider, community-based organization or initiative, clinical organization) that collaborates with the organization to share or provide expertise, guidance, resources or services for the benefit of one or more communities where the organization operates. The organization provides materials or reports (e.g., meeting minutes) as evidence that it consulted with the partner on the data source.

Partners can provide insight into data sources that are relevant and represent the communities served. A data source endorsed by a partner—ideally, a community-based partner—also helps develop a common understanding of social risks that have a negative effect on communities ~~(e.g., lack of employment opportunities, limited economic mobility, fear of discrimination or ableism, associated effects of poverty and joblessness).~~

Factor 3: **Third data source**

No additional explanation necessary.

Exceptions

None.

Examples

Social risk factors

- Social isolation.
- Affordable housing.

- Housing insecurity.
- Lack of employment opportunities.
- Unemployment.
- Poverty.
- Financial insecurity.
- Access to fresh food or grocery stores.
- Food insecurity.
- Green spaces.
- Air or water pollution.
- Lead exposure.
- Life expectancy.

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/programs-surveys/acs/data.html
[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'~~ Process for Collecting Social Needs Data

~~The organization has a framework for direct collection of data and collects data on individuals' unmet social needs~~ <u>The organization has a process for collecting direct data on the unmet social needs of members or patients</u>, 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	The organization meets 3 factors	The organization meets 0-2 factors

Data source Documented process~~, Reports, Materials~~

Scope of review *For All Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period for collecting data on <u>member or patient</u> ~~individual~~ social needs~~, and reviews reports or materials for evidence of data collection~~.

Look-back period *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 <u>status.</u> Two individuals who experience the same social risks may have different social needs. Interventions address social needs at the individual level.

~~**Individuals served by the organization** include members or patients~~ <u>Members or patients include individuals</u> who directly access the organization's health care services or for whom the organization assumes financial risks associated with providing comprehensive medical services.

~~***Factors 1–6***~~

Although it is voluntary for members or patients ~~individuals~~ to report social needs, the organization must attempt to collect this information <u>from members or patients across all communities.</u> The organization may collect data directly at multiple points of interaction <u>with members or patients</u> ~~individuals~~ and through multiple mechanisms, using as many channels as are available.

Factors 1–6

The organization has a documented process for ~~collecting~~ direct collection of data on member or patient social needs. ~~and demonstrates data collection through materials or reports. For each social need, the organization defines its method for assessing or collecting data directly and determining if an internally developed or external screening tool, vendor or platform was used.~~

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

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.

An individual's response of "Other" or "Decline to Answer" is considered direct data because it is collected from the individual.

A direct data collection framework includes~~, at a minimum~~:

- A description of the population or subset of ~~individuals~~ members or patients from whom data will be collected.
- A defined process for soliciting information from ~~individuals~~ members or patients in the instance that a response was requested but not provided.
- When data will be collected.
- Where data will be collected (setting).
- How (e.g., method for 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.

Organizations may use a screening tool required by NCQA's HEDIS measure *Social Need Screening and Intervention (SNS-E),* but are not required to.

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

***Factor 6:* An additional domain**

The organization collects data on an additional social needs domain and describes the data's relevance to the population or membership 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

HEDIS measure Social Need Screening and Intervention (SNS-E) requires use of the following standardized screening instruments:

- American Academy of Family Physicians (AAFP) Social needs Screening Tool[15]
- American Academy of Family Physicians (AAFP) Social needs Screening Tool—short form Accountable Health Communities (AHC) Health-Related Social needs (HRSN) Screening Tool[14] created by CMS to support the CMS Accountable Health Communities Model.
- Children's Health Watch Housing Stability Vital Signs™.
- Comprehensive Universal Behavior Screen (CUBS).
- Health Leads Screening Panel® [18].
- Hunger Vital Sign™[1] (HVS).
- Inpatient Rehabilitation Facility—Patient Assessment Instrument (IRF-PAI)—version 4.0 (CMS).
- Norwalk Community Health Center Screening Tool (NCHC).
- Outcome and assessment information set (OASIS) form—version E—Start of Care (CMS).
- Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)® [12] from the National Association for Community Health Centers.
- Safe Environment for Every Kid (SEEK)®.
- U.S. Household Food Security Survey [U.S. FSS].
- We Care Survey.
- WellRx Questionnaire.
- PROMIS®.

~~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.kpwashingtonresearch.org/
[17] https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison
[18] https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

Element D: Evidence of Collecting Social Needs Data *(NEW)*

The organization demonstrates direct data collection of the unmet social needs of members or patients, 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	The organization meets 3 factors	The organization meets 0-2 factors

Data source Reports, Materials

Scope of review

For All Surveys: NCQA reviews reports or materials demonstrating direct data collection during the look-back period.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

Factors 1–6

The organization demonstrates, through reports or materials, that it collects direct data on the unmet social needs of members or patients, according to its documented process in Element C.

Exceptions

None.

Examples

None.

Element E: Reporting Social Needs Screening and Intervention *(NEW)*

The organization annually reports the HEDIS *Social Needs Screening and Intervention (SNS-E)* measure, including:

1. The screening indicator.

2. The social needs intervention indicator.

Scoring

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

Data source

Reports

Scope of review

Product lines

NCQA reviews and scores this element for each product line brought forward for Accreditation, if applicable.

Documentation

For all surveys: NCQA reviews audited IDSS reports from the most recent HEDIS reporting year.

Look-back period

For Initial and Renewal Surveys: Prior to the survey date.

Explanation

Factors 1, 2

The organization submits an audited IDSS report from the most recent HEDIS reporting year showing that it reported the HEDIS *Social Needs Screening and Intervention (SNS-E)* measure, which captures two indicators:

- The percentage of members who were screened using prespecified instruments or assessed by a practitioner at least once during the measurement period for unmet food, housing and transportation needs; and
- The percentage of members with a positive screen or identified need for food, housing and/or transportation who received a corresponding intervention on or up to 30 days after the date the need was screened or identified as positive (31 days total).

Exceptions

This element is NA for:

- All surveys scheduled between July 1, 2026, and June 30, 2027
- Organizations that are not health plans.
- The exchange product line.

~~Element E: Identifying Social Needs~~

~~At least annually, the organization uses data in Elements B–D to:~~

1. **~~Identify the social needs of the population of individuals it serves for each community in Element A.~~**
2. **~~Assess similarities and differences between the community's social risks and social needs of the population of individuals it serves.~~**

~~Scoring~~

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

~~Data source~~ ~~Reports~~

~~Scope of review~~

~~*For Initial Surveys:* NCQA reviews the organization's most recent reports from up to four randomly selected communities, or from all communities if the organization's service area has fewer than four, that demonstrates identification of social needs and assessment of similarities and differences. The organization may provide a single report or distinct reports for factors 1 and 2.~~

~~*For Renewal Surveys:* NCQA reviews the organization's most recent and previous year's annual reports from up to four randomly selected communities, or from all communities if the organization's service area has fewer than four, that demonstrates identification of social needs and assessment of similarities and differences. The organization may provide a single report or distinct reports for factors 1 and 2.~~

~~The score for the element is the average of the scores for all communities.~~

~~Look-back period~~	~~*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 it used the data gathered in Element C to identify the social needs of the population of individuals it serves (i.e., current members, patients who receive treatment, individuals who participate in the organization's programs) within the communities it identified in Element A. The organization may submit a single report or multiple reports identifying the social needs for each community identified in Element A.~~

~~Understanding the social needs experienced by each community in its service area better positions the organization to determine which social needs should be prioritized. A report describing the social needs across all communities identified in Element A (as an aggregate of the entire service area) does not meet the intent. Although there may be overlap, because needs differ between communities, the organization must provide evidence that it identified the needs for 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 each community's social risks (Element D) or social needs (Element E, factor 1).~~

~~Assessing the similarities and differences between risks and needs, 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 among:~~

- ~~The community's social risks identified in Element D.~~
- ~~The social needs of the population identified in Element E, factor 1.~~
- ~~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 identified in Element A. It may provide a single report describing assessment results for each community or may provide distinct reports for each community.~~

~~The assessment seeks to identify differences and their causes (e.g., the membership/individual population does 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~~

~~Factor 1:~~ **~~Identifying social needs~~**

- ~~The health system defines its communities using geographical boundaries that include individuals who live within a certain number of miles from health system facilities or within a certain distance from public transportation routes to facilities. The organization was built near an industrial zone and identified:~~
    - ~~Managing asthma as a social need for the community that lives within 5 miles.~~
    - ~~Food insecurity as a social need for individuals who live within 15 miles.~~
- ~~An organization with a large service area (operating across an entire state) uses state-defined geographical regions and rural vs urban neighborhoods to define communities, in addition to commonalities in infrastructure. The organization identified:~~
    - ~~Access to transportation as a social need for rural neighborhoods that lack access to health care services and employment opportunities.~~
    - ~~Housing stability as a social need for urban neighborhoods that lack access to education and social services and have high concentrations of violence.~~
- ~~The organization identified lack of employment opportunities as a social need for a community in its service area where individuals of Hispanic ethnicity and Asian race reside.~~

~~Factor 2:~~ **~~Assessing similarities and differences~~**

- ~~The health system identified air pollution as a community social risk and managing asthma as a social need for the population of individuals served. The organization determined that the individuals facing higher levels of air pollution and occurrences of asthma are of Hispanic/Latino ethnicity and Black or African American race and speak a language other than English. The organization found that White individuals did not experience the same social risk or need because they were less likely to live in or near industrial zones and were exposed to less air pollution, resulting in fewer cases of asthma.~~

Element ~~D~~F: ~~Identifying Social Risks~~ Assessing Community Social Risks and Social Needs

~~Every 3 years, the organization uses the data acquired in Element B to identify the social risks of each community identified in Element A.~~ For each community, the organization:

1. **Identifies community-level social risks every 3 years.**
2. **Annually identifies social needs experienced by members or patients.**
3. **Annually assesses similarities and differences between each community's profile of social risks and social needs.**

Scoring

Met	Partially Met	Not Met
~~The organization meets the requirement~~ The organization meets 2-3 factors	~~No scoring option~~ The organization meets 1 factor	~~The organization does not meet the requirement~~ The organization meets 0 factors

Data source Reports

Scope of review *For All Surveys:* NCQA reviews the organization's reports from up to four randomly selected communities, or from all communities if the organization's service area has fewer than four, that demonstrates identification of social risks.

The organization may submit a single report, or multiple reports, demonstrating the activities described in factors 1–3 were performed for each community described in Element A. A report describing the social risks across all communities identified in Element A (as an aggregate of the entire service area) does not meet the intent.

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

Look-back period *For All Surveys:* At least once during the prior 36 months; for factor 1; at least once during the prior year for factors 2–3.

Explanation Health care organizations are best positioned to determine the focus and priorities of their efforts when they have a holistic understanding of the social needs experienced by their members or patients, and the social risks that impact the broader population within each community.

Members of groups that have historically experienced discrimination in the health care setting, or that have been systemically denied access to health care services, may not be represented in either type of data. Analyzing similarities and differences between the social risk and social needs profiles of each community is an opportunity to explore why certain groups are missing from or underrepresented in data sources, and how the organization can change data sources or collection methods to include a broader range of individuals.

***Factor 1:* Identifies social risks**

Every 3 years, the organization uses community-level data sources to identify the profile of social risks in each community. ~~**Identifying social risks**~~

~~The organization provides a summary report demonstrating that it used the data acquired in Element B to identify the social risks of each community in its service area identified in Element A. The organization may submit a single report or multiple reports demonstrating that it identified social risks.~~

~~Understanding the social risks experienced by each community in its service area better positions the organization to determine which social risks its program should prioritize mitigating. Identified social risks may be experienced by individuals served by the organization (e.g., current members, patients who receive treatment, individuals who participate in its programs), as well as by the broader population that resides in the service area and may not access the organization's services (nonmembers).~~

Factor 2: **Identifies social needs**

The organization uses direct data to identify the social needs experienced by each community's member or patient population.

The organization must provide evidence that it assessed the prevalent social needs in each community. A report describing the social needs of member or patients across all communities identified in Element A (as an aggregate of the entire service area) does not meet the requirement.

~~A report describing the social risks across all communities identified in Element A (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.~~

Factor 3: **Analyze similarities and differences**

At least annually, the organization uses the information from factors 1 and 2 to assess similarities and differences between community social risks and the member or patient population's social needs. The organization must seek to identify differences and their causes (e.g., the member or patient population does 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

***Factor 1*: Identifying social risks**

- ~~The~~ A health system operating in a single county defines its communities using ~~geographical boundaries that include individuals who live within a~~

~~certain number of miles~~ from proximity to the health system's facilities ~~or within a certain distance from public transportation routes to facilities~~ and commercial, industrial and residential zones. The organization~~'s site is near an industrial zone and~~ identifies~~d~~:
  - Air pollution as a social risk for the community that lives within 5 miles of a nearby industrial zone.
  - Poor water quality as a social risk for individuals who live within 15 miles of the industrial zone.

- An organization ~~with a large service area~~ (operating across an entire state uses state-defined geographical regions and rural vs urban neighborhoods to define communities, in addition to commonalities in infrastructure. The organization identifies~~d~~:
  - ~~Substance abuse~~ Lack of public transportation infrastructure as a~~the~~ social risk for its rural ~~neighborhoods~~ communities. ~~that lack access to health care services and employment opportunities.~~
  - Poverty as ~~the~~ a social risk for an urban neighborhood~~s~~ that lacks access to ~~education~~ employment opportunities and social services ~~with high concentrations of violence.~~

~~The organization uses state-defined regions to define its communities, then uses nongeographic characteristics to ascertain smaller communities in the broader service area. The organization identified lack of immigration status as the social risk for a community in its service area where individuals of Hispanic ethnicity and Asian race reside.~~

An organization uses social risk factors to define communities that span county lines. It identifies two communities, spanning three counties:
  - One community defined by both lack of public transportation and lack of access to nutritious food.
  - One community defined by lack of employment opportunities, community violence, and lack of broadband infrastructure.

***Factor 3:* Analyze similarities and differences**

- A health system identifies lack of affordable housing as the most prevalent social risk in one of its communities, and housing insecurity as the most prevalent social need self-reported by patients.
- An organization identifies air pollution and lack of access to nutritious food as the most prevalent social risk in its community, and utility, insecurity, and access to transportation as the most prevalent social needs self-reported by members. Its stratified social risk data source shows that community residents who speak languages other than English are more likely to experience lack of access to nutritious food. The organization determines that there are differences in the data on social risks and social needs because its process to screen members for unmet social needs is conducted in English only.

Element G~~F~~: ~~Population Segmentation or Risk Stratification~~ Identifying Subpopulations

~~At least annually, the organization segments or stratifies its population based on social risks and needs discovered in Elements D and E to identify~~ The organization analyzes data on social risks and social needs to:

1. **Every 3 years, identify s~~S~~ubpopulations of ~~the~~ its communities that share intersectional social risks and demographic characteristics.~~/identities~~.**
2. **Annually identify s~~S~~ubpopulations of ~~individuals served by the organization~~ members or patients that share intersectional social needs and demographic characteristics~~/identities~~.**
3. **Annually identify~~ies~~ subpopulations that~~ may~~ benefit from resources or interventions.**

Scoring

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

Data source Documented process, Reports

Scope of revie *For All Surveys:*

- *For factor 1:* NCQA reviews a documented process describing the organization's methods for identifying subpopulations across all communities that share intersectional social risks and demographic characteristics and the organization's most recent report showing it followed its documented process every 3 years.
- *For factor 2:* NCQA reviews a documented process describing the organization's methods for annually identifying subpopulations of members or patients across all communities that share intersectional social needs and demographic characteristics, and the organization's most recent report showing it followed its documented process. ~~a description of the methods used to segment or stratify subpopulations across all communities.~~
- *For factor 3:* NCQA reviews the organization's most recent report demonstrating identification of subpopulations that need resources or interventions across all communities.

~~*For Initial Surveys: NCQA also reviews the organization's most recent segmentation or risk stratification report.*~~

For Renewal Surveys: For factors 1- 3, NCQA also reviews the organization's ~~most recent and~~ previous year's segmentation or risk stratification report.

Look-back period *For ~~Initial~~ All Surveys:* At least once during the prior 36 months for factor 1; ~~year.~~at least once during the prior year for factors 2-3.

~~*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~~ both identify subpopulations that ~~individuals who~~ share ~~intersectional~~ intersecting demographic characteristics or identities, and may be negatively affected by the same community-level social risks, or experience the same individual-level social needs. These insights empower organizations to identify and act on opportunities to mitigate social risks for subpopulations most likely to benefit from benefits or resources, and to develop specific interventions that account for individuals' multifaceted life experiences.

~~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 identified in Element A. The organization is not required to perform segmentation/stratification for each community in its service area but may choose to identify subpopulations for each community.~~

Methodology. The organization describes its method for segmentation/ stratification. 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. The percentage may total more than 100% if individuals fall into more than one subpopulation. The organization may present evidence that represents a summary of all communities as a whole. 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~~ Identify community subpopulations**

~~The organization uses demographic characteristics/identities and the identified social risks in Element D to identify subpopulations based on intersecting identities and shared social risks. It determines the appropriate number and types of subpopulations most likely to benefit from specific social risk resources or interventions. Stratification may use additional demographic or socioeconomic characteristics (e.g., age, aspect of disability), and may also use the similarities and differences identified in Element E, factor 2.~~

Every 3 years, the organization segments or stratifies community-level data, or uses at least one stratified data source, to identify subpopulations of communities across its service area that share intersecting demographic characteristics/identities and social risks. Either segmentation or stratification meet the intent, and the organization may use more than one method.

NCQA reviews a documented process describing the organization’s segmentation or stratification methodology, and reviews a summary report demonstrating that in the prior 3 years (36 months), the organization identified subpopulations of the broader communities across its service area. 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. The percentage may total more than 100% because community residents may fall into more than one subpopulation (e.g., racial or ethnic, social risk).

Factor 2: ~~**Identification**~~ **Identify member or patient subpopulations**

~~The organization uses demographic characteristics/identities and the social needs identified in Element E, factor 1 to determine subpopulations based on intersecting identities and shared social needs. It determines the appropriate number and types of subpopulations most likely to benefit from specific resources or interventions. Stratification may use additional demographic or socioeconomic characteristics (e.g., age, aspect of disability), and may also use the similarities and differences identified in Element E, factor 2.~~

The organization annually segments or stratifies individual-level data to identify subpopulations of its member or patient population, across its service area, that share intersecting demographic characteristics/ identities and social needs. Either segmentation or stratification meet this element, and the organization may use more than one method.

NCQA also reviews a summary report demonstrating that the organization annually identified subpopulations of its member or patient population across all communities. 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. The percentage may total more than 100% because members or patients may fall into more than one subpopulation (e.g., disability status, social need).

Factor 3: **Subpopulations that may benefit from resources/interventions**

The organization annually uses the subpopulations identified in factors 1 and 2 to evaluate demographic subpopulations that may benefit from resources or interventions for specific social needs and social risks.

NCQA reviews a summary report demonstrating that the organization used the results of factors 1 and 2 to annually identify specific subpopulations, social needs and social risks.

Exceptions

None.

Related information

NCQA does not prescribe subpopulations (e.g., racial, ethnic, language, sexual orientation, gender identity, ~~aspect of~~ disability status) for stratification. The organization may use one or more demographic characteristics/identities, and ~~The organization~~ may focus on subpopulations that are feasible, with consideration of subpopulation size and that are most relevant to the demographics of the population served. Some subpopulations may be large enough to analyze individually (e.g., White, Black/African American; male, female, languages spoken) while smaller subpopulations 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.”
- Subgroups of patients with specific functional disabilities ~~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.”

Subpopulations of intersectional characteristics/~~identities~~

Generate a table for each community, showing the rate of positive screens for each social needs domain and each subgroup of a characteristic.

Characteristic	Financial Insecurity	Food Insecurity	Housing Stability	Access to Transportation	Interpersonal Safety
GEOGRAPHIC CLASSIFICATION					
Metro.					
Micro.					
Small town					
Rural					
RACE AND ETHNICITY					
American Indian/Alaska Native					
Asian					

Black/African American					
Hispanic or Latino					
Middle Eastern or North African					
Native Hawaiian or Pacific Islander					
White					
Some Other Race					
AGE					
<18 years					
18-44 years					
45-64 years					
65+ years					

Generate a table for each community and for each social need or social risk factor showing the rate of positive screens for each subgroup of two intersecting characteristics.

Race and ethnicity	**Medicare/Medicaid Dual Enrolled**	**Not Dual Enrolled**
American Indian/Alaska Native		
Asian		
Black/African American		
Hispanic or Latino		
Middle Eastern or North African		
Native Hawaiian or Pacific Islander		
White		
Some Other Race		

- ~~Someone who identifies as a Black 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 H~~G~~: Prioritizing Social Risks and Social Needs

The organization annually ~~uses Elements D–F to~~ prioritizes:

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

Scoring

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

Data source Reports

Scope of review *For Initial Surveys:* NCQA reviews the most recent ~~annual~~ report demonstrating that the organization annually prioritized ~~prioritization~~ of social risks and needs.

For Renewal Surveys: NCQA reviews the most recent and previous year's annual reports demonstrating prioritization of social risks and needs.

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

For Renewal Surveys: 24 months.

Explanation ***Factors 1, 2***

The organization annually prioritizes the community-level social risks it will seek to mitigate, and the member or patient population-level social needs it will seek to address, draws a conclusion or rationale for its selection and identifies a corresponding community or communities.

The organization uses its understanding of the community and the members or patients it serves to determine areas of high need that would be most affected by interventions. The organization may use information from Elements E–F in its analysis, but it is not required to do so, nor is it required to mitigate every social risk and address every social need, or prioritize a risk or need in every community in its service area.

~~The organization's report describes how it uses the information collected in Elements D–F to prioritize the social risks it will mitigate and the social needs it will address. 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 that would be most affected by interventions. After prioritization, the organization is equipped to begin engaging community-based partners to mitigate social risks and address social needs.~~

~~The organization is also not required to prioritize social risks and needs in each community in its service area in Element A. The organization provides a conclusion or rationale for each social risk and need chosen, including assessment of:~~

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

Exceptions

None.

Examples None.

HEPLUS 2: Cross-Sector Partnerships and Engagement

The organization collaborates with community-based partners and initiatives to mitigate and address prioritized social risks and social needs.

Intent

The organization establishes and maintains community-based partnerships that are mutually beneficial, supportive and appropriate for the communities and members or patients they serve. ~~mitigating the social risks and addressing the social needs of the community and individuals they mutually serve.~~

Element A: Social ~~Risk~~ Resource Gap Assessment

The organization annually assesses available resources or initiatives to address its prioritized social risks and social needs, including: ~~To mitigate the prioritized social risks identified in HE Plus 1, Element G, factor 1, the organization annually assesses:~~

1. Existing community resources or initiatives to mitigate prioritized social risks.
2. Existing community resources to address prioritized social needs.
~~2~~3. Organizational capacity and capability to mitigate prioritized social risks.
4. Organizational capacity and capability to address prioritized social needs.
~~3~~5. Gaps in existing resources or initiatives to mitigate prioritized social risks.
6. Gaps in existing resources to address prioritized social needs.

Scoring

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

Data source Reports

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

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

NCQA reviews one or multiple reports demonstrating the results of its assessment for all prioritized social risks and social needs, across all impacted communities. The organization is not required to demonstrate an assessment was performed for each community.

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

For Renewal Surveys: 24 months.

Explanation The organization performs an annual assessment to identify gaps between prioritized social risks and needs identified in HE Plus 1, Element G, existing community resources or initiatives and the organization's capacity and capability to mitigate or address them.

Assessment insights empower health care organizations to make decisions about whether internal investment or external collaboration best supports their priorities and goals for addressing or mitigating social risks and needs. For example, an organization may partner with a community-based initiative or organization to scale the success of their efforts and build on their successes. Or, if a prioritized social risk is not currently being addressed by community-led or cross-sector efforts, the organization may choose to build internal capabilities or convene cross-sector stakeholders to collaboratively address it.

Factors 1, 2: **Existing community initiatives or resources**

The organization assesses whether there are existing community-based resources (community-based organizations, community-based initiatives, cross-sector initiatives) to mitigate its prioritized social risks and social needs in impacted communities. The organization is not required to provide a full list of resources available in every community for every prioritized social risk and social need, but should seek to determine if priorities are being addressed by existing resources in impacted communities.

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

Cross-sector initiatives are cooperative relationships between organizations from different sectors that focus on mitigating a shared community social risk (e.g., local government entities, non-health care social services providers and community-based organizations).

For each prioritized social risk and social need, NCQA reviews the assessment report for evidence that the organization determined:

- Whether the risk or need is being addressed by existing community-based resources or initiatives.
- How collaborating with community-based organizations, community-based initiatives or cross-sector initiatives will strengthen the organization’s efforts.

Factors 3, 4: **Organizational capacity and capability**

The organization assesses the prioritized social risks and social needs for which it has the capacity (available resources) and capability (knowledge) to address internally, and which are outside of its scope and would be best addressed by partnering with or following the lead of existing community-based organizations, community-based initiatives or cross-sector initiatives.

For each prioritized social risk and social need, NCQA reviews the assessment report for evidence that the organization determined:

- Which it has the internal capacity or capability to address.

- If directly providing services or deploying solutions will compete with or undermine the work of existing community-based organizations, community-based initiatives or cross-sector initiatives serving the same community or communities.

Factor 5, 6: **Gaps in initiatives or resources**

The organization assesses whether there are gaps between existing community resources (factors 1–2) and its own capacity and capability (factors 3–4) to address prioritized social risks and social needs, and determines how best to support community-based organizations or cross-sector initiatives to create local solutions that address each gap.

NCQA reviews the assessment report for evidence that the organization determined whether there were gaps and that, for each identified gap, drew conclusions about potential solutions.

Related information

Resources may be local, regional or national, depending on the defined social risk or need and the relevant community. For example, an organization may have a national partner that focuses on connecting LGBTQIA+ individuals to safe housing as well as a local partner that addresses affordable housing for the general public.

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 members or patients 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.

The 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.

Exceptions

None.

~~At least annually, the organization assesses for gaps in available community resources and its capacity or capability to mitigate the social risks prioritized in *HE Plus 1: Collection, Acquisition and Analysis of Community and Individual Data*~~,

~~Element G, factor 1. If the organization prioritized a social risk that is being mitigated by an existing community initiative or by another organization, it may choose to partner with the initiative or organization to strengthen its efforts. If a social risk is not currently addressed by 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.~~

~~Assessments in Elements A and B may be combined or presented as one report or as multiple reports. The organization's assessment is based on the prioritized social risks, which may be in one or more communities identified in HE Plus 1, Element A. The organization may present evidence that represents an assessment summary of all prioritized social risks.~~

~~*Factor 1:* **Existing community resources**~~

~~The organization uses the prioritized social risks to assess for the presence of existing community resources to mitigate them. 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 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 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 in the community to mitigate social risks (factor 1) and its own capacity and capability (factor 2) to address them. Once gaps are identified, the organization determines how best to support partners, community-based organizations and community members to create local solutions for mitigating social risks.~~

Examples

None.

~~*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 B: Social Need Resource Assessment~~

~~To address the prioritized social needs identified in HE Plus 1, Element G, factor 2, the organization annually assesses:~~

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

~~Scoring~~

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

~~Data source~~ ~~Reports~~

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

~~*For Renewal Surveys:* NCQA reviews the organization’s most recent and the previous year’s annual assessment reports.~~

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

~~**Explanation**~~

~~At least annually, the organization assesses for gaps in available community resources and its capacity/capability to address the social needs prioritized in *HE Plus 1: Collection, Acquisition and Analysis of Community and Individual Data*, Element G, factor 2. If the organization prioritized a social need that is being addressed by an existing community initiative or by another organization, it may choose to partner with the initiative or organization to strengthen its efforts. If a social need is not currently addressed by 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.~~

~~Assessments in Elements A and B may be combined or presented as one report or as multiple reports. The organization's assessment is based on the prioritized social needs, which may be in one or more communities identified in HE Plus 1, Element A. The organization may present evidence that represents an assessment summary of all prioritized social needs.~~

~~***Factor 1:*** **Existing community resources**~~

~~The organization uses the prioritized social needs to assess for the presence of existing community resources to address them. 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 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 in the community to address social needs (factor 1) and its own capacity/capability (factor 2) to address them. Once gaps are identified, the organization determines how best to support partners, community-based organizations and community members to create local solutions for addressing social needs.~~

~~**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.~~

Element ~~F~~B: Selecting Community-Based or Cross-Sector Initiatives

The organization~~’s process for selecting community-based or cross-sector initiatives to mitigate social risks includes assessment of~~ has a process for selecting community-based or cross-sector initiatives to mitigate social risks based on:

1. **Its annual prioritized social risks. ~~Results of the prioritization from HE Plus 1, Element G, factor 1.~~**
2. **Its understanding of gaps between existing community initiatives and its own internal capacity and capabilities. ~~Results of the gap analysis from Element A, factor 3.~~**

Scoring

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

Data source Documented process

Scope of review *For All Surveys:* NCQA reviews the organization’s documented process for selecting community-based initiatives or cross sector partners in place throughout the look-back period.

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

For Renewal Surveys: 24 months.

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

~~**Cross-sector initiatives** are cooperative relationships between organizations from different sectors that focus on mitigating a shared community social risk (e.g., local~~

~~government entities, non-health care social services providers and community-based organizations).~~

~~The organization outlines its process for selecting community-based or cross-sector initiatives. NCQA does not prescribe the number of initiatives or partnerships. The organization determines the appropriate number and types of initiatives necessary to mitigate the social risks of the community.~~

***Factors 1, 2:* Prioritization and gap analysis**

The organization has a documented process for selecting community-based or cross-sector initiatives using:

- The organization's annual list of prioritized social risks identified in communities across its service area.
- The organization's understanding of gaps between existing community-based or cross-sector initiatives and its own internal capacity and capabilities.

~~***Factors 1, 2:* Prioritization and gap analysis**~~

~~The organization outlines how it uses the social risks prioritized in *HE Plus 1: Collection, Acquisition and Analysis of Community and Individual Data, Element G*, factor 1, and the results from its gap analysis in Element A, factor 3, to select community-based initiatives or cross-sector partners to mitigate social risks. Gap analysis helps the organization understand the lack of existing community resources and its capacity/capability to mitigate social risks, and to determine community-based initiatives or cross-partnerships for mitigating prioritized social risks.~~

Exceptions

None.

Examples The organization determines it will be most effective by partnering with or following the lead of community-based organizations that specialize in mitigating upstream social, economic and policy barriers that prevent individuals from achieving equitable health outcomes. For example:

- An organization prioritizes housing instability as a prevalent social risk in the communities in its service area. It partners with a community-based organization conducting research on public policies and systemic barriers preventing its African American LGBTQ+ population from accessing affordable housing. The organization and its partner jointly draft a white paper advocating for policy reform.
- An organization prioritizes food and nutrition security as a prevalent social risk in seven ZIP codes in its service area. It partners with a local coalition of health care organizations, community-based organizations and businesses to build affordable grocery stores and invest in local farmers markets to develop long-term neighborhood access to nutritious food.

Element C: Selecting Appropriate Partners to Deliver Resources/Interventions

The organization~~'s~~ has a process for ~~determining~~ selecting appropriate partners to deliver social needs resources or interventions based on ~~includes~~:

1. **~~The subpopulations of individuals identified in HE Plus 1, Element F, factor 2.~~Its understanding of member or patient subpopulations with shared demographic characteristics and social needs.**
2. **~~The results of the prioritization from HE Plus 1, Element G, factor 2.~~Its annual prioritized social needs.**
3. **~~The results of the gap analysis in Element B, factor 3~~. Gaps between existing community resources and its own internal capacity and capabilities.**

.

Scoring

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

Data source

Documented process

Scope of review

For All Surveys: NCQA reviews the organization's documented process for ~~determining~~ selecting appropriate partners ~~organizations~~ that was in place throughout the look-back period.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization has a documented process for selecting appropriate partners to deliver resources or interventions for the social needs of members or patients, using:

- Insights about subpopulations of the organization's member or patient population with shared demographic characteristics and social needs.
- The organization's annual list of prioritized social needs identified in communities across its service area.
- Insights about gaps between existing community resources and the organization's own internal capacity and capabilities.

~~**Partners** are entitles that the organization works with to deliver social needs resources or interventions to individuals served by the organization. Appropriate partners may be local government entities, non-health care social service providers, community-based organizations and other organizations.~~

Partners are external entities (e.g., community-based organizations, local government entities, social care providers with a local or national footprint) the organization collaborates with to deliver resources or interventions that address the social needs of members or patients. Partners are experienced in meeting the organization's prioritized social needs. They have established relationships in the community to deliver resources or interventions, but may require the organization's support to build or scale capacity.

Appropriate partners have the capacity (resources) and capability (knowledge) to provide resources or interventions in a ~~nondiscriminatory and culturally and linguistically appropriate~~ manner that meets or accommodates the cultural, linguistic or disability needs of the subpopulations of members or patients who most acutely experience the social needs addressed by the partner's resources or interventions.

Partners may differ in their capacity and capability. The organization may determine that certain partners are more appropriate for meeting the needs of specific subpopulations.

~~Some partners may have the capacity to provide social needs resources or interventions, but require the organization's support to obtain additional capacity. Some organizations may be better suited to a support role, collaborating with partners experienced in meeting social needs and/or that have established relationships in the community.~~

The organization outlines its process for selecting partners to deliver social needs resources or interventions. NCQA does not prescribe the number or types of partners~~;~~. The organization determines the number and types of partnerships~~those~~ necessary to meet the social needs ~~of the individuals it serves~~ its members or patients, while respecting the role of community-based organizations that provide resources and interventions.

Social care networks or referral platforms and vendors that facilitate social needs resources or interventions, but do not directly provide them, do not meet the intent of partners for this element unless they are partially owned or staffed by an entity that directly provides resources or interventions (e.g., community care hub, regional health hub, backbone organization).

***Factor 1: S*ubpopulations**

~~The organization's process outlines how it uses the subpopulations identified in *HE Plus 1: Collection, Acquisition and Analysis of Community and Individual Data*, Element F, factor 2 to select partners. Some individuals feel more comfortable receiving services from partners that provide specialized services or whose staff characteristics or identities align with their race, ethnicity, language, sexual orientation or gender identity. The absence of partners that can accommodate or offer services aligned with individuals' needs may be a barrier to accessing needed resources or interventions.~~

~~It may not always be possible for the organization to establish partnerships with entities that align with the demographic profile of the individuals served; however, the organization should seek to identify partners that represent the demographic characteristics/identities and specialize in providing needed resources/interventions of the subpopulations served.~~

The organization has a documented process for using annually identified subpopulations to select partners to deliver social needs resources or interventions.

The organization is not required to establish partnerships with entities that specialize in or have an affinity with every demographic characteristic represented by the organization's population of members or patients, nor may this always be possible, but absence of appropriate partners for a subpopulation can be a barrier to accessing resources. At a minimum, the organization's selection process should seek to identify partners that have the capability to accommodate (e.g., respectfully, culturally, linguistically or accessibly) the needs of member or patient subpopulations who most acutely experience its prioritized social needs.

Factors 2, 3: **Prioritization and gap analysis**

The organization has a documented process for using annual priorities and its understanding of gaps between existing community resources and its own internal capacity or capabilities to select appropriate partners. ~~outlines how it uses the social needs prioritized in HE Plus 1, Element G, factor 2, and the results from its gap analysis in Element B, factor 3, to determine partners. Gap analysis helps the organization understand the lack of existing community resources and its capacity/capability to address social needs and to determine organizations which with to partner to meet prioritized social needs.~~

Exceptions

None.

Examples

Factor 1: **~~Individual~~ s~~S~~ubpopulations**

An organization ~~determines~~ identifies that subpopulation with (via community scan, resource referral vendor list or participation in a community hub)

whether resources exist to meet the needs of subpopulations in their communities that most acutely experience ~~experiencing~~ unmet social needs related to poor health outcomes ~~in their communities~~. If those resources exist, the organization determines whether they provide accessible and culturally and linguistically appropriate services before referring individuals to the programs, partnering with them on interventions, or supporting them for service provision.

Factors 2, 3: **Prioritization and gap analysis**

If the organization determines that a resource does not exist in the community, or that an existing resource does not provide accessible and equitable programs, the organization uses its analysis to understand why subpopulations do not have access to programming that addresses their social needs. For example, if the only housing organization in the community does not provide resources that are safe and inclusive for transgender members or patients ~~individuals~~, then it does not address social needs for the whole community.

The organization partners with or follows the lead of community-based organizations that specialize in addressing downstream interventions or strategies (i.e., provide equitable access to care and services for immediate social needs); for example:

- An organization ~~that~~ prioritizes housing instability as a prevalent social need among its members or patients. ~~the population of individuals it serves.~~ It decides to partner with a nonprofit housing organization to coordinate grants and affordable loans for individuals to become homeowners, and collaborates with an establishment that provides lodging for individuals who need temporary housing following surgical procedures.

- An organization that prioritizes food and nutrition security as a prevalent social need in certain neighborhoods in its service area selects a partner with food assistance programs, and provides transportation and vouchers for individuals to purchase groceries.

Element D: Agreements With Partners to Deliver Resources/Interventions

The organization has a written contract~~s~~ or agreement~~s~~ with at least one partner that describes ~~with which it collaborates to deliver social needs resources or interventions that describe~~:

1. Each organization's roles and responsibilities~~, including investments and supports~~.*
2. Methods and timing of communication.
3. Methods, mechanisms and timing of funding and support.
~~2~~4. ~~How data are shared~~ A process for sharing data bidirectionally.
~~3~~5. An annual process for collaboratively evaluating the partnership.

Critical factor: Score cannot exceed Not Met if critical factor is scored "no."

Scoring

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

Data source Documented process, Materials

Scope of review

For Initial Surveys: NCQA reviews contracts or agreements in effect during the look-back period ~~from up to four randomly selected partners, or reviews all contracts and agreements if the organization has fewer than four.~~

For factors 1–~~3~~5: In lieu of submitting contracts/agreements as evidence, the organization may submit a detailed implementation plan for updating existing or establishing new contracts/agreements.

For Renewal Surveys: NCQA reviews contracts or agreements in effect during the look-back period. ~~from up to four randomly selected partners, or reviews all partnership agreements if the organization has fewer than four partners.~~

~~The score for the element is the average of the scores for all partners.~~

Look-back period

For Initial Surveys: Prior to the survey date.

For Renewal Surveys: 24 months.

Explanation

The organization has a direct, written partnership agreement with at least one community-based entity or agency that delivers resources or interventions for social needs to its members or patients.

~~The organization seeks to be a partner to organizations in the communities it serves by establishing (through contracts or agreements) at least one direct partnership with a community-based entity or agency that delivers social needs resources or interventions to individuals. Agreements with social care networks or referral platforms and vendors do not meet this element.~~

The organization is not required to provide evidence that it has an agreement with every partner, because some partnerships may not require it, but it must provide evidence from at least one partner ~~that it has established at least one partnership~~.

Written partnership agreements are mutually agreed-on documents describing all activities performed by each entity in the partnership. Mutual agreements must contain effective dates, and may be represented in one or more documents, including a letter, email, meeting minutes, signed legal document (e.g., sponsorship agreement, grant agreement) or other form of communication between the organization and its partner (e.g., memorandum of understanding).

A generic policy statement about the content of a contract/agreement does not meet this element.

For Initial Surveys, if the organization submits an implementation plan, it may also submit existing contracts or agreements that support ~~the plan for updating~~ its plan to update contracts or agreements to include information required in factors 1–5. The implementation plan must include:

- A detailed description of the actions the organization will take to update existing ~~or establish new~~ contracts or agreements or establish new ones.
- A timeline for implementation.

Factor 1: **Roles and responsibilities~~, including investments and supports~~**

The contract or agreement specifies:

- Shared expectations for providing unbiased, accessible, culturally appropriate services, resources or interventions to meet ~~individuals~~the social needs of members or patients.
- Roles and responsibilities of each organization.
- ~~Terms of financial or other investments and support for providing services, resources or interventions, if applicable.~~

Factor 2: **Communication**

The contract or agreement specifies the methods (e.g., virtual check-ins, in-person meetings, email) and timing (e.g., weekly, quarterly) of communication between the organization and its partner. Methods and timing should align with the partnership's shared expectations and each organization's roles and responsibilities.

***Factor 3:* Funding and support**

The contract or agreement describes the terms of financial funding or payment, and other investments and supports, to facilitate provision of services, resources or interventions. At a minimum, the contract or agreement specifies:

- Methods of funding or payment.
- Mechanisms for facilitating funding or payment.
- Timing of funding or payment (e.g., monthly, quarterly).
- Investments and supports other than direct financial funding or payment.

Methods, mechanisms and timing of funding or payment should align with the agreement's scope of work and the metrics that will be used to mutually evaluate the partnership's effectiveness.

***Factor ~~2~~4:* Data sharing**

The contract or agreement describes the process for sharing relevant data between partners.

Relevant data are directly related to the partner's ability to plan or provide social needs resources/interventions (e.g., languages that staff should prepare to speak or understand) and to meet the needs of referred members or patients (e.g., language or communication, disability-related accommodations, patient age). Relevant data may be at the community, member or patient levels.

~~The organization shares data with partner organizations. The contract or agreement describes how data are shared bidirectionally with all partners, including:~~ At a minimum, the contract or agreement specifies:

- Which data the organization and its partner share bidirectionally.
- Permissible and impermissible data use.
- How data are accessed, ~~which data are shared and with whom.~~
    - ~~The contract or agreement specifies~~ Staff roles that have access to ~~shared~~ the data, and specific circumstances for access.
- Common language or terminology used, where applicable.
- How the status of referrals is tracked.

***Factor ~~3~~5:* Collaborative partnership evaluation**

The annual partnership evaluation process is bidirectional, and supports joint quality improvement objectives, allowing ~~all partner organizations~~ both entities to assess and improve the partnership's effectiveness for staff and for the individuals they mutually serve. Collaborative improvement requires involvement of ~~all~~ both partner organizations and their staff.

The contract or ~~/~~agreement describes the process for collaborating on annual evaluation of the partnership ~~how the organizations will collaborate to evaluate the effectiveness of the partnership~~, including:

- The metrics or measures used to evaluate the partnership's performance. Metrics or measures address:
    - At least one aspect of staff experience with the partnership's operations (e.g., perceived burden of and experience with referrals, data sharing, organization staff and systems).
    - At least one aspect of member or patient experience with accessing or receiving resources/interventions through the partnership.
- How the evaluation process ~~how evaluation~~ informs improvements to the partnership (e.g., amending the contract, agreement, terms of funding, resource allocation or working relationship), if applicable.

Exception

Factor 2 is NA if a partnership does not include data sharing.

Related information

Agreements with social care networks or referral platforms that facilitate resources or interventions, but do not directly provide them, do not meet the intent of element unless they are partially owned or staffed by an entity that directly provides resources or interventions (e.g., community care hub, regional health hub, backbone organization).

Examples

Factor ~~1~~3: **~~Roles and responsibilities, including investments~~ Funding and supports**

Investments and supports in shared or joint programs or activities may differ because of each partner's capacity (available resources) and capability (knowledge).

Direct financial funding or payment

- Per member, per month payments.
- Payment per encounter.
- Grant funding.
- Value-based incentive payments.
- Funding to establish technological infrastructure.
- Funding to make physical spaces more accessible to persons with disabilities.

~~For example, a health system provides funding for its community-based partner to establish technological infrastructure,~~ *Investments and supports other than direct financial funding or payment*

- ~~and its community-based partner provides staffing~~ Providing staff to execute on established roles and responsibilities.
- Free access to interpreters or translators.

- Sponsorship for partner's staff to receive education or training.

Factor ~~2~~4: **Data sharing**

~~The organization receives data from its community-based partner regarding community mental health needs. In turn, it shares aggregated, de-identified data on ED visits involving self-harm. The bidirectional flow of data gives insight on community mental health needs, and helps the organization and its community-based partner determine which resources/interventions might address needs.~~ *Community-level and aggregated data*

- The organization receives data from its community-based partner regarding community behavioral health needs, and in turn, shares aggregated, de-identified data on ED visits involving self-harm.
  - The bidirectional flow of data gives insight on community behavioral health needs, and helps the organization and its partner determine which resources/interventions might address needs.
- The organization shares aggregated data on disparities in the rate at which referred members with disabilities access the partner's resources. The organization and partner collaborate to examine root causes and identify the need for accessibility upgrades to the site where members access resources.

Individual-level data

- The partner identifies a previously undisclosed health need limiting a patient's ability to use a referred service. The partner notifies the referring case manager of the identified health need to give the partner enough information to help the member access its resources.

Element ~~G~~E: Engaging with Community Based or Cross-Sector Initiatives

~~The organization implements a process for engaging with community-based initiatives or cross-sector partnerships that includes~~ The organization engages with community-based or cross-sector initiatives by:

1. Collaborating ~~on initiatives~~ to mitigate community social risks.
2. Supporting their capacity.

Scoring

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

Data source Documented process, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period ~~for supporting community-based initiatives or cross-sector partnerships,~~ and reviews materials or reports as evidence that the organization collaborates with and supports ~~its~~ community-based initiatives or cross-sector ~~partnerships~~ initiatives.

For factors 1–2, NCQA reviews a documented process for collaborating with and supporting community-based or cross-sector initiatives to mitigate a community-level social risk, and reviews materials or reports demonstrating the organization followed its process for at least one initiative.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

~~Engaging in community-based initiatives ensures that individuals and communities benefit from shared efforts, responsibilities, capacity (resources), capabilities (knowledge) and experience in mitigating social risks. To facilitate equitable engagement, the organization describes its process for supporting and collaborating on community-based initiatives identified in Element F to mitigate community social risks.~~

Community-based or cross-sector initiatives leverage shared efforts, responsibilities, capacity (resources), capabilities (knowledge) and experience to mitigate community-level social risks in ways that no organization or sector could accomplish alone. When health care organizations meaningfully, equitably engage in these initiatives, they are active collaborators and provide substantive support that helps initiatives scale and sustain efforts. Active collaboration requires the organization to act over time to facilitate, sustain or grow the initiative's efforts.

~~For factors 1–2, NCQA reviews a documented process for collaborating with and supporting community-based or cross-sector initiatives to mitigate a community-level social risk, and reviews materials or reports demonstrating the organization followed its process for at least one initiative.~~

The organization may demonstrate evidence of collaboration and support for two different initiatives in factors 1–2, or for a single initiative. The organization determines which initiatives may benefit most from its collaboration and support. The organization is not required to provide evidence of how it collaborates with and supports all community-based or cross-sector initiatives.

***Factor 1:* Collaborating**

~~The organization has a process for actively collaborating with community-based initiatives or cross-sector partners.~~The organization collaborates in at least one community-based or cross-sector initiative.

***Factor 2:* Supporting**

~~The organization describes its process for supporting community-based initiatives or cross-sector partners. The organization is not required to provide evidence of how it supports all community-based initiatives or cross-sector partners identified in Element F. The organization determines which initiatives or partners may benefit most from its support.~~ The organization supports the capacity (resources) of at least one community-based or cross-sector initiative to sustain or grow its efforts. Support may include providing financial resources, but is not required.

Exceptions

None.

Examples

Factor 1: **Collaborating with community-led initiatives**

- Joint application or sponsorship for grants.
- Policy and legislative advocacy to reduce a community social risk.
- Authoring or supporting development of a white paper.

Factor 2: **Supporting community-led initiatives**

- Providing or hosting a location for the initiative.
- Sharing information through resource directories, data repositories or health information exchanges.
- Sharing workflows, processes, information or de-identified aggregate population level data.
- Funding to establish technological infrastructure.
- Funding to operationalize initiative's direct actions.
- Funding to make physical spaces more accessible to persons with disabilities.

Element ~~E~~F: Engaging With Partners to Deliver Resources/Interventions

The organization ~~implements a process for engaging~~ engages with its partners to deliver social needs resources or interventions by: ~~that includes:~~

1. **Collaborating on direct provision of resources or interventions ~~to meet individuals' prioritized social needs~~.**
2. **Supporting ~~partners'~~ their capacity ~~to provide resources to meet the social needs of individuals~~.**

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, Materials

Scope of review

For All Surveys: NCQA reviews the organization's documented process in place throughout the look-back period ~~for collaborating with and supporting its partners~~, and reviews materials or reports as evidence ~~of how~~ that the organization collaborates with and supports its partners.

For factors 1–2, NCQA reviews a documented process for collaborating with and supporting partners in the direct provision of resources or interventions to address social needs, and reviews materials or reports demonstrating the organization followed its process for at least one partner.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

~~For factors 1–2, NCQA reviews a documented process for collaborating with and supporting partners in the direct provision of resources or interventions to address social needs, and reviews materials or reports demonstrating the organization followed its process for at least one partner.~~

Partner organizations are often better positioned to provide specific resources or interventions (e.g., food delivery or aid, transportation, temporary or permanent supportive housing) because they have specific experience and expertise and/or have established relationships and trust in the community. In this case, the organization may be more suited to a support role where it equips partners with resources they need to sustain or scale their efforts.

When health care organizations meaningfully, equitably engage with non-clinical partners, they are active collaborators and provide substantive support that helps in the direct provision of resources for social needs. Active collaboration requires the organization to act over time to facilitate, sustain or grow the initiative’s efforts.

The organization may demonstrate evidence of collaboration and support for two different partners in factors 1–2, or for a single partner. The organization determines which partners may benefit most from its collaboration and support. The organization is not required to provide evidence of how it collaborates with and supports all partners.

***Factor 1:* Collaborating with partners**

~~Collaborating in partnerships ensures that individuals and communities benefit from shared efforts, responsibilities, capacity (resources), capability (knowledge) and experience in meeting social needs. The organization describes its process for collaborating with partners to provide resources or interventions that meet social needs. The organization plays an active role in collaboration, which may include sharing workflows, processes, information or de-identified aggregate-level data (if applicable).~~

The organization collaborates with at least one partner that delivers resources or interventions for social needs to patients or members.

***Factor 2:* Supporting partners**

The organization supports the capacity (resources) of at least one partner to sustain or grow its efforts. Support may include providing financial resources, but is not required.

~~Partner organizations are often better positioned to provide specific resources or interventions (e.g., food delivery or aid, transportation, temporary or permanent supportive housing) because they have specific experience and expertise and/or~~

~~have established relationships and trust in the community. In this case, the organization may be more suited to a support role where it equips partners with resources they need. The organization describes its process for supporting partner organizations in providing resources or interventions.~~

~~The organization is not required to provide evidence of how it supports all partners identified in Element D; the organization determines which partners may benefit most from support. The organization may provide supplemental evidence of how it supports partners with which it has no formal agreement.~~

Exceptions

None.

Examples

Factor 1: **Collaborating with partners**

- Identifying or securing sustainable funding streams or opportunities for joint initiatives.
- Cooperating on ~~position~~ development of roles in the organization or in the partner's organization.
- Jointly producing white papers or advocating on legislative issues.
- Learning from partners about mutually served populations through informational sessions or field visits.

Factor 2: **Supporting partners**

- Connecting partners with other organizations as needed.
- Payment for services rendered, or other types of financial support, including grants.
- Providing or paying staff to help the organization deliver resources or interventions.
- Providing funding or grants to make physical spaces or communication with staff accessible to people with disabilities.
- Providing free access to the organization's language services.
- Providing onsite interpreters for threshold languages.
- Providing or hosting a location for a partner to deliver resources or interventions.
- Offering relevant education or training to a partner.

Direct financial funding or payment

- Per member, per month payments.
- Payment per encounter.
- Funding grants.
- Value-based incentive payments.
- Funding to establish technological infrastructure.
- Funding to make physical spaces more accessible to persons with disabilities.

Investments and supports other than direct financial funding or payment

- Providing staff to execute on established roles and responsibilities.
- Free access to interpreters or translators.

~~Element F: Selecting Community-Based or Cross-Sector Initiatives~~

~~The organization's process for selecting community-based or cross-sector initiatives to mitigate social risks includes assessment of:~~

~~1. Results of the prioritization from HE Plus 1, Element G, factor 1.~~
~~2. Results of the gap analysis from Element A, factor 3.~~

~~Scoring~~

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

~~Data source~~ ~~Documented process~~

~~Scope of review~~ ~~*For All Surveys:* NCQA reviews the organization's documented process for selecting community-based initiatives or cross sector partners in place throughout the look-back period.~~

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

~~*For Renewal Surveys:* 24 months.~~

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

~~**Cross-sector initiatives** are cooperative relationships between organizations from different sectors that focus on mitigating a shared community social risk (e.g., local government entities, non-health care social services providers and community-based organizations).~~

~~The organization outlines its process for selecting community-based or cross-sector initiatives. NCQA does not prescribe the number of initiatives or partnerships. The organization determines the appropriate number and types of initiatives necessary to mitigate the social risks of the community.~~

~~***Factors 1, 2:* Prioritization and gap analysis**~~

~~The organization outlines how it uses the social risks prioritized in *HE Plus 1: Collection, Acquisition and Analysis of Community and Individual Data, Element G*, factor 1, and the results from its gap analysis in Element A, factor 3, to select community-based initiatives or cross-sector partners to mitigate social risks. Gap analysis helps the organization understand the lack of existing community resources~~

~~and its capacity/capability to mitigate social risks, and to determine community-based initiatives or cross-partnerships for mitigating prioritized social risks.~~

~~**Exceptions**~~

~~None.~~

~~**Examples**~~ ~~The organization determines it will be most effective by partnering with or following the lead of community-based organizations that specialize in mitigating upstream social risk interventions or strategies (i.e., improve the fundamental social, economic and policy barriers that prevent people from achieving equitable health outcomes); for example:~~

- ~~An organization that prioritizes housing instability as a prevalent social risk in its communities in its service area partners with a community-based organization conducting research on public policies and systemic barriers that prevent its African American LGBTQ+ population from accessing affordable housing. The organization engages with its partner to jointly draft a white paper advocating for policy reform.~~
- ~~An organization that prioritizes food and nutrition security as a prevalent social risk in seven urban, low-income ZIP codes in its service area partners with other organizations to build affordable grocery stores and invest in local farmers markets to develop long-term access to nutritious food and improve neighborhood conditions.~~

~~Element G: Engaging with Community Based or Cross-Sector Initiatives~~

~~**The organization implements a process for engaging with community-based initiatives or cross-sector partnerships that includes:**~~

1. ~~**Collaborating on initiatives to mitigate community social risks.**~~
2. ~~**Supporting initiatives or cross sector partner's capacity to provide resources to mitigate the community's social risks.**~~

~~**Scoring**~~

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

~~**Data source**~~ ~~Documented process, Materials~~

~~**Scope of review**~~ ~~*For All Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period for supporting community-based initiatives or cross-sector partnerships, and reviews evidence that the organization supports its community-based initiatives or cross-sector partnerships.~~

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

~~*For Renewal Surveys:* 24 months.~~

~~Explanation~~

~~Engaging in community-based initiatives ensures that individuals and communities benefit from shared efforts, responsibilities, capacity (resources), capabilities (knowledge) and experience in mitigating social risks. To facilitate equitable engagement, the organization describes its process for supporting and collaborating on community-based initiatives identified in Element F to mitigate community social risks.~~

~~***Factor 1:* Collaborating**~~

~~The organization has a process for actively collaborating with community-based initiatives or cross-sector partners.~~

~~***Factor 2:* Supporting**~~

~~The organization describes its process for supporting community-based initiatives or cross-sector partners. The organization is not required to provide evidence of how it supports all community-based initiatives or cross-sector partners identified in Element F. The organization determines which initiatives or partners may benefit most from its support.~~

~~**Exceptions**~~

~~None.~~

~~Examples~~

~~***Factor 1:* Collaborating with community-led initiatives**~~

- ~~Joint application or sponsorship for grants.~~
- ~~Policy and legislative advocacy to reduce a community social risk.~~
- ~~Authoring or supporting development of a white paper.~~

~~***Factor 2:* Supporting community-led initiatives**~~

- ~~Providing financial support to the initiative.~~
- ~~Providing or hosting a location for the initiative.~~
- ~~Sharing information through resource directories, data repositories or health information exchanges.~~
- ~~Sharing workflows, processes, information or de-identified aggregate population level data.~~

HE PLUS X: Integration of Community Health Workers *(NEW)*

The organization has policies for recruitment, use, support and supervision of employed community health workers.

Intent

The organization integrates employed community health workers as part of its workforce to address social needs, improve health outcomes or reduce health care disparities.

Element A: Community Health Worker Program *(NEW)*

The organization has written policies and procedures for employed community health workers that describe:

1. **The scope of work for employed community health workers.**
2. **The use of evidence-based methods or materials for community health worker tasks.**
3. **How community health workers are integrated in the organization's workforce structures or processes.**
4. **How community health workers' caseloads are determined.**
5. **Tools and technology to minimize community health workers' administrative burden.**
6. **Emergency and safety protocols for clients and community health workers.***

****Critical factors: Score cannot exceed Partially Met if one critical factor is scored "no."***

Scoring

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

Data source Documented process, Materials

Scope of review *For All Surveys:* NCQA reviews the organization's policies and procedures for factors 1–6, and reviews materials demonstrating that the organization follows its policies and procedures for factors 5 and 6.

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

Explanation Factor 6 is a critical factor; if a critical factor is scored "No," the organization's element score cannot exceed Partially Met.

Studies show that integrating community health workers into care teams is a cost-effective way to advance health equity and promote improved patient outcomes. Evidence shows that community health workers are effective in:

- Reducing emergency department utilization and inpatient hospital length of stay.[1]

---

[1] https://www.vizientinc.com/insights/all/2024/community-health-worker-model-improves-quality-care-reduces-ed-utilization-and-length-of-stay

- Reducing health care costs.[2,3]
- Improving chronic disease management and outcomes.[4,5]
- Advancing health equity.[6,7]
- Improving access to the health care system.[8]

***Factor 1:* Community health worker scope of work**

The organization has policies and procedures that describe the scope of work for directly employed community health workers, including:

- Community health workers' core roles.
- A description of how each role translates to community health workers' day-to-day tasks.
- A description of how each role responds to, or is adapted to meet, the unique needs of the community.

Directly employed community health workers are hired and supervised by the organization. This does not include community health workers who are contracted through a community-based partner.

***Factor 2:* Evidence-based methods or materials**

The organization's policies and procedures describe:

- The evidence-based methods or materials used by employed community health workers in client encounters.
- The organization's rationale for using the methods or materials, and the evidence supporting their use.

***Factor 3:* Integration of community health workers**

The organization's policies and procedures outline:

- How employed community health workers are embedded in the organization's workforce structures, including staff, leadership and committees.
- The role of community health workers in workforce convenings, including in staff meetings, on internal and external committees and on clinical or behavioral health care teams.
- Community health workers' decision-making role in the organization and its processes, including, but not limited to:
    - Improving their core role.

---

[2] https://communityhealthalignment.org/wp-content/uploads/2024/03/CHW-ROI-Report-South-Carolina.pdf
[3] https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00981
[4] https://www.ncdhhs.gov/fqhc-evaluation-reports/download?attachment
[5] https://hdsbpc.cdc.gov/s/article/Evidence-of-Impact-for-Community-Health-Workers
[6] https://www.annualreviews.org/content/journals/10.1146/annurev-publhealth-071521-031648
[7] https://link.springer.com/article/10.1007/s10900-021-01052-6
[8] https://pmc.ncbi.nlm.nih.gov/articles/PMC11624670/

  - Improving their role in the workforce.
  - Improving their working conditions (e.g., compensation, training, caseloads, work practices, equipment, supplies).

Factor 4: **Caseloads**

The organization's policies and procedures address the assignment of employed community health worker caseloads, including:

- How the organization determines caseload size.
- How the organization assigns or matches community health workers with clients.
- How the organization determines the complexity of client needs.

Factor 5: **Tools and technology**

The organization's policies and procedures outline the tools and technology that support employed community health workers' scope of work, including:

- Tools/technology to minimize administrative burden and support data collection.
- Personal protective equipment, as needed.

Factor 6: **Emergency and safety protocols**

The organization has policies and procedures to ensure the safety of employed community health workers while they perform their scope of work, including, but not limited to:

- Managing client emergencies during and after hours.
- Communicating and making decisions during emergencies (e.g., weather emergencies, pandemics), including how and when community health workers will be informed of changes and have access to emergency hotlines.
- Tracking when community health workers are conducting home visits, clinical encounters and community activities.
- Identifying and resolving concerns related to the safety of community health workers.
- Managing situations involving behavioral health, substance exposure, potential medical emergencies and interpersonal violence.

Exceptions

This element is NA:

- For surveys scheduled between July 1, 2026, and June 30, 2027.
- If the organization contracts with a community-based organization partner to provide a community health worker workforce.

Related information

The organization may use the C3 Council's recommendations for community health workers' core roles:[9]

- Cultural mediation among individuals, communities and health and social service systems.
- Care coordination, case management, and system navigation.
- Advocating for individuals and communities.
- Providing direct services.
- Conducting outreach.
- Providing culturally appropriate health education and information.
- Providing coaching and social support.
- Building individual and community capacity.
- Implementing individual and community assessments.
- Participating in evaluation and research.

Examples

***Factor 1:* Community health worker scope of work**

Core Role	**Daily Responsibilities**
Conducting outreach	Contact assigned patients by phone or text to provide updates about appointments, prescriptions and transportation schedule.
Care coordination	Schedule medical appointments. Call or message practitioners to coordinate treatment or medication. Arrange transportation to medical appointments.

***Factor 2:* Evidence-based methods or materials**

Documentation or formats

- Assessment guides.
- Templates (e.g., PRAPARE for screening social needs).
- Decision-making guides.
- Handouts.

---

[9] https://www.c3council.org/roles-competencies

Sources of supporting evidence for materials

- Peer reviewed literature.
- Handbooks.
- Clinical guidelines.
- Case studies.

Factor 3: **Integration of community health workers**

Documentation

- Organizational chart showing reporting relationships or staffing.
- Staffing plan.
- Committee charter.
- Program description.

Factor 4: **Caseloads**

Processes that consider community health worker skills, and the time needed to address the patient's health or social needs.[10,11]

Factor 5: **Tools and technology**

- Case management software.
- Electronic scheduling applications.
- Note-taking tools.
- Templates or software used for treatment or action planning.
- Personal protective equipment such as masks or gowns.
- Tablets, cell phones or other mobile devices.

Element B: Community Health Worker Recruitment and Hiring *(NEW)*

The organization has a process for recruiting and hiring community health workers that includes:

1. **Use of community-based channels for recruiting.**
2. **Recruiting communications and materials that reflect the community served.**
3. **Interactive interview techniques.**
4. **Use of standardized interview guides with predefined questions.**
5. **Educating community health worker candidates on the role, including a description of day-to-day activities.**
6. **Participation of community health workers or community members in the interview and candidate selection process.**

---

[10] https://www.cthealth.org/wp-content/uploads/2018/01/HHC-CHW-SDOH-Policy-Briefi-1.30.18.pdf

[11] https://www.chcs.org/integrating-community-health-workers-care-teams-lessons-field/

Scoring

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

Data source Documented process, Materials

Scope of review

For All Surveys:

- *For factor 1,* NCQA reviews the organization's documented process for using community-based channels to recruit community health workers.
- *For factor 2,* NCQA reviews the organization's documented process and recruiting materials or communications, including its description of the community health worker position.
- *For factor 3,* NCQA reviews the organization's documented process or interview materials for use of interactive techniques.
- *For factor 4,* NCQA reviews the organization's documented process for using standardized interview guides with predefined questions and scoring guidelines.
- *For factor 5,* NCQA reviews the organization's documented process for educating community health workers on their role.
- *For factor 6,* NCQA reviews the organization's documented process for including employed community health workers or community members in the interview process.

Look-back period

For First Surveys: Prior to the survey.

For Renewal Surveys: 6 months.

Explanation

***Factor 1:* Community-based channels**

The organization has a documented process for using community-based channels, including other community agencies and/or partners, to recruit community health worker candidates.

***Factor 2:* Recruiting communications**

Effective recruitment communications and materials, including the community health worker job description, reflect the communities served. The organization's documented process describes the preferred languages and literacy levels of the communities the community health worker role is intended to serve, and demonstrates that recruitment communications and materials are responsive to community needs.

The organization’s materials outlines the desired qualifications for the community health worker role, which may include:

- Shared direct experience with the intended community.
- Cultural humility.
- Respect earned in the community.
- On-the-job experience (vs. academic credentials).
- Previous work or volunteer experience helping others.
- Demonstrated trust-building skills.
- Demonstrated problem-solving skills.

Community health workers have shared direct experience when they come from the same community as their clients or when they share relevant life experiences or perspectives, personal identities or history. Individuals with direct experience have cultivated skills, knowledge and understanding from direct involvement with the community or subpopulation.

Direct experience differs from professional or educational expertise, which describes acquired knowledge, experience and understanding of a community or subpopulation.[12]

Cultural humility is the ability to value, respect and respond to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic). Cultural humility can be a key skill for community health workers, health care professionals and health care organizations to build honest and trustworthy relationships.

Factor 3: **Interactive interview techniques**

The organization’s materials or documented interview process uses interactive techniques, including, but not limited to, behavioral scenarios or role playing.

Factor 4: **Standardized interview guides**

The organization’s interview process includes the use of standardized interview guides with predefined questions.

The documented process describes how the interview guides are created and tested, including participation of community health workers, supervisors, and community members. The testing process may include the use of feedback from past interviewees.

Factor 5**: Education on the community health worker role**

---

[12] https://aspe.hhs.gov/sites/default/files/documents/5840f2f3645ae485c268a2784e1132c5/What-Is-Lived-Experience.pdf

The organization's interview process describes how and when the organization educates candidates about the community health worker role and the role's day-to-day activities.

Factor 6: **Participation of community health workers or community members**

The organization's interview process describes how community members, employed community health workers or partners that deliver social needs resources or interventions participate in the interview and selection process, including their specific roles and responsibilities, and how they are selected to participate.

Exceptions

This element is NA:

- For surveys scheduled between July 1, 2026, and June 30, 2027.
- If the organization contracts with a community-based organization partner to provide a community health worker workforce.

Examples

Factor 1: **Community-based channels**

Community-based channels, agencies or partners

- Partners that deliver social needs resources or interventions.
- Local health departments.
- Community recreation centers.
- Churches.
- Prison reentry programs.

Recruitment methods

- Delivering quarterly presentations at a prison reentry center to encourage individuals with direct experience to apply to be community health workers.
- A process to list all new community health worker job positions at physical locations of local community recreation centers, churches and partners that deliver social needs resources.

Factor 2: **Recruiting communications**

- Four versions of a job description in the threshold languages identified across the communities where the community health worker will serve patients.
- Job description written in Spanish for a community where the organization seeks to scale efforts for a prioritized social need among Spanish-speaking members.
- Job description written at a 10th grade reading level to reflect the average literacy level of the community.

Factor 3: **Interactive interview techniques**

Include a role-playing scenario within an interview process; for example:

- "A community member was just diagnosed with high blood pressure, and feels anxious. What would you say to them, and how will you connect them with resources?"

Factor 5: **Education on the community health worker role**

Education may be provided

- Verbally, at the beginning of an interview.
- Through a handout distributed before the interview.
- Through a group workshop for prospective candidates before individual interviews.

Factor 6: **Participation of community health workers or community members**

- Invite employed community health workers to participate in interviews.
- Invite community members to participate in interviews.

Element C: Community Health Worker Training and Supports *(NEW)*

The organization supports high performance and fair advancement of community health workers by providing:

1. **Initial training for all newly employed community health workers within 30 days of hire.***
2. **An assessment following the completion of initial training.**
3. **Relevant, ongoing training for all community health workers at least twice annually.**
4. **Relevant educational materials.**
5. **Supports for community health worker well-being.**
6. **Opportunities for peer-to-peer networking and connection.**
7. **A market analysis comparing data on the role of the community health worker with similar roles in and external to the organization, at least every 2 years.**
8. **Performance evaluations within defined time frames.**
9. **Professional development plans.**

****Critical factors: Score cannot exceed Partially Met if one critical factor is scored "no."***

Scoring

Met	Partially Met	Not Met
The organization meets 4-9 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source Documented process, Reports, Materials

Scope of review

For All Surveys:

For factors 1–3: NCQA reviews the organization's documented process for training and assessing community health workers.

For factor 4: NCQA reviews educational materials provided to employed community health workers.

For factor 5: NCQA reviews materials as evidence that the organization provides supports for community health workers' well-being.

For factor 6: NCQA reviews materials as evidence that the organization provides peer-to-peer networking opportunities for community health workers.

For factor 7: NCQA reviews the organization's documented process for conducting and sharing a market analysis.

For factors 8–9: NCQA reviews the organization's documented process for providing performance evaluations and developing professional development plans.

Look-back period

For First Surveys: Prior to the survey.
For Renewal Surveys: 6 months.

Explanation

***Factor 1:* Initial training**

The organization has a documented process for training newly employed community health workers, initiated within 30 days of their start date and completed before they interact with clients independently.

Training topics and materials:

- Include materials provided by national, regional or local organizations, or by community-based agencies.
- Align with community health workers' scope of work.

Training may be provided by the organization or facilitated externally; it may be tailored to individual experience and training needs or standardized across community health workers with a similar scope of work.

***Factor 2:* Initial training assessment**

The organization has a documented process for assessing employed community health workers' understanding of concepts core to their roles and responsibilities, following completion of initial training and before they interact with clients independently. The documented process describes:

- How the employed community health worker selects the assessment format (verbal or written) and language, based on their communication preferences, strengths and needs.
- The metrics and success criteria used to assess understanding of core concepts, roles and responsibilities.
- How the organization makes assessment metrics and success criteria available in advance.
- How the organization makes reassessment timing and expectations available in advance.

***Factor 3:* Ongoing training**

The organization has a documented process for offering ongoing, relevant training to all employed community health workers at least twice annually.

Training topics and materials:

- Include materials provided by national, regional or local organizations, or by community-based agencies.
- Align with community health workers' scope of work.

Training may be provided by the organization or facilitated externally; it may be tailored to individual experience and training needs or standardized across community health workers with a similar scope of work.

***Factor 4:* Relevant educational materials**

The organization provides relevant educational materials to all employed community health workers that may include materials that help them:

- Meet and get to know clients.
- Provide tailored care and support based on clients' health-related social needs.
- Build relationships with clients based on mutually agreed-on goals, and a timeline for achieving goals
- Document their work with clients.
- Handle potentially unsafe situations.
- Create and maintain professional boundaries.

NCQA does not prescribe the number of materials. Relevant educational topics include content that aligns with employed community health workers' scope of work and the communities or member/patient population served.

***Factor 5:* Supports for well-being**

The organization provides resources or supports to help manage employed community health worker stress and prevent burnout, including:

- Resources and mental health supports for employed community health workers experiencing stress or burnout.
- Resources or education for supervisors of community health workers, focused on recognizing stress and burnout.

***Factor 6:* Peer-to-peer opportunities**

The organization provides employed community health workers with compensated (during paid work time) opportunities to network, connect and learn with their peers.

Factor 7: **Market analysis**

The organization has a documented process for sharing a comparative analysis of compensation with employed community health workers and their supervisors at least every 2 years. The analysis compares the compensation of employed community health workers with compensation for similar roles, internal and external to the organization.

At a minimum, the documented process describes:

- The role or staff responsible for performing the analysis.
- Data sources used in the analysis.
- How (setting or mechanism) the analysis will be shared with community health workers and their supervisors.
- How frequently the analysis is shared with community health workers and their supervisors.
- How the organization's leadership uses the analysis to inform compensation.

Factor 8: **Performance evaluations**

The organization has a documented process for annually evaluating the performance of employed community health workers and sharing results within 14 calendar days of completing the evaluation. The documented process describes:

- How the employed community health worker selects the evaluation format (verbal or written) and language, based on their personal communication preferences, strengths and needs.
- The metrics and success criteria used to evaluate performance.
- How the organization makes performance metrics and success criteria available in advance.
- How the organization makes reevaluation timing and expectations available in advance.

Factor 9: **Professional development plans**

The organization has a documented process for supporting the professional development of employed community health workers that includes:

- Expectations for supervisors to initiate and document conversations about career objectives with employed community health workers they oversee.
- Creation of a professional development plan for each employed community health worker that outlines their personal and professional goals.
    - Professional goals include requirements for progression.

Exceptions

This element is NA:

- For surveys scheduled between July 1, 2026, and June 30, 2027.

- If the organization contracts with a community-based organization partner to provide a community health worker workforce.

Related information

The National Association of Community Health Workers (NACHW) provides a directory of community health worker training and certification programs, available by state. [13]

Examples

***Factor 4:* Relevant educational materials**

- Community Health Worker Handbook.
- Health literacy guides.
- Workflow for scheduling patient appointments or transportation.
- Educational infographics.
- Training slides for interpersonal and professional conduct during client encounters.

***Factor 5:* Supports for well-being**

- Slides from a virtual stress and resilience workshop.
- Handouts from an in-person “lunch and learn” on recognizing peers’ stress.
- Signup sheet for a mindfulness meditation session series.
- Tip sheet for recognizing and coping with burnout.

***Factor 6:* Peer-to-peer opportunities**

- Flyer for virtual or in-person networking events.
- Slides from “lunch and learn” sessions for community health workers to share best practices, strategies and success stories with peers.
- A Handbook section describing the organization’s peer-to-peer “buddy” programs for community health workers.

Element D: Community Health Worker Supervision *(NEW)*

The organization’s process for supervising community health workers includes:

1. **Supervisors with prior community health worker experience or who have completed relevant training.***
2. **Initial training for all immediate supervisors of community health workers.**
3. **Assigning no more than one supervisor or point of contact for each community health worker.**
4. **Contact with a supervisor at least twice a month.**
5. **A method for community health workers to voluntarily provide anonymous input about their supervisor’s performance.**

---

[13] https://nachw.org/generalresources/networks-and-training-programs/

6. Consideration of anonymous community health worker input in supervisors' annual performance evaluation.

****Critical factors: Score cannot exceed Partially Met if one critical factor is scored "no."***

Scoring

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

Data source Documented process, Reports, Materials

Scope of review

For All Surveys:

NCQA reviews the organization's documented process for factors 1–6.

For factor 2, the organization may submit materials or reports in place of a documented process to demonstrate that initial training covers the required topics and is completed in the defined time frames.

For factor 3, the organization may submit materials or reports in place of a documented process to demonstrate the assignment of supervisor to employed community health workers.

Look-back period

For First Surveys: Prior to the survey.
For Renewal Surveys: 6 months.

Explanation

Factor 1 is a critical factor; if a critical factor is scored "No," the organization's element score cannot exceed Partially Met.

***Factor 1:* Supervisor qualifications**

The organization's documented process describes the training and qualifications required for immediate supervisors of employed community health workers. At a minimum, the organization requires that supervisors either have prior professional experience as a community health worker or have:

- Completed all training required by the organization for the role, ***and***
- Shadowed employed community health workers to gain basic familiarity with the challenges of the role.

***Factor 2:* Supervisor initial training**

The organization's documented process for training all newly hired immediate supervisors of employed community health workers before they work independently includes, at a minimum, the following topics:

- The community health workers' unique role.
- How to provide effective and supportive supervision (e.g., how to use observation, community health worker input, performance data and community feedback to improve community health worker performance).

- Protocols for high-risk situations.

The training may be provided by the organization or facilitated externally.

***Factor 3:* Supervisor assignment**

The organization's documented process for assigning supervisors requires that each community health worker has no more than one assigned supervisor or point of contact.

***Factor 4:* Supervision schedule**

The organization has a documented process for a minimum of twice-monthly meetings between employed community health workers and their immediate supervisor.

***Factor 5:* Anonymous input**

The organization's documented process for submitting anonymous feedback describes how employed community health workers submit voluntary and anonymous feedback about their immediate supervisor's performance, and steps the organization takes to keep feedback anonymous.

***Factor 6:* Consideration of input**

The organization's documented process for submitting anonymous feedback describes how this information factors into performance evaluations for direct supervisors of community health workers. community health worker.

Exceptions

This element is NA:
- For surveys scheduled between July 1, 2026, and June 30, 2027.
- If the organization contracts with a community-based organization partner to provide a community health worker workforce.

Examples

***Factor 2:* Supervisor initial training**

- Policy or process on supervision.
- Training materials and report showing training start and completion dates.

***Factor 3:* Supervisor assignment**

- Supervision guidelines.
- A log of supervisor names and their assigned community health workers.
- An organizational chart showing reporting relationships of specific staff or roles.

HEPLUS 3: Data Management and Interoperability

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

Intent

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

Element A: Privacy and Security Protections for Data

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

1. **Controls for physical and electronic access to data.**
2. **Permissible use of data.**
3. **Impermissible use of 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

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

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

For Renewal Surveys: 24 months.

Explanation The organization's policies and procedures for managing access to, use of and sharing of social needs data may be independent of or integrated with the organization's HIPAA privacy policies and/or privacy protections. The organization may provide its HIPAA privacy policies as evidence if they are intended to include social needs data.

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

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

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

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

- Laptops.
- Secure portals.
- Paper documentation or records.

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

Factors 2, 3: **Permissible and impermissible use**

The organization outlines permissible and impermissible use of the data, which may align with rules defined by the Department of Health and Human Services 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 in the Department of Health and Human Services website,[1] or other uses as defined by HIPAA rules and other applicable laws.
- Impermissible use explicitly includes underwriting and denial of services, coverage and benefits, as applicable.
- The organization is not required to address underwriting for the Medicaid product line.

Exceptions

None.

---

[1] https://www.hhs.gov/hipaa/for-professionals/faq/3014/uses-and-disclosures-for-care-coordination-and-continuity-of-care/index.html

Examples

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

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

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

Factor 2: **Permissible use of data**

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

Factor 3: **Impermissible use of data**

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

Element B: Bidirectional Data Sharing

The organization has a process for sharing data with organizations, including partners in HE Plus 2, Element D.

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 data sharing with organizations.

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

For Renewal Surveys: 24 months.

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

Interoperability is the ability of two or more systems to exchange and use health information.[2]

Sharing information about health and social needs across organizations facilitates interoperability and multi-sector collaboration in mitigating social risks and meeting social needs. The organization’s process for providing resources/ interventions creates a seamless experience for members or patients ~~individuals it serves~~ and protects data security.

The organization describes its process for sharing data with external organizations, including partners with which it has an established contract or agreement *(HE Plus 2: Cross-Sector Partnerships and Engagement,* Element D). NCQA does not prescribe the types of data that must be shared; the organization determines which partners are appropriate to receive certain types of data. The organization's process for decision making includes how it determines whether data are shared, and with whom.

The organization describes the methods or systems for data sharing, including how information is securely shared and received. If the organization uses a social care network, referral platform or vendor, it describes the process for sharing data on the platform and whether data are returned to the organization.

Exceptions

None.

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

Examples

Data sharing with partners

When referring ~~an individual~~ a member or patient to a partner, the organization outlines when it is appropriate to share data with partners. The organization receives consent from ~~an individual~~ a member or patient who needs language services to share language data with a partner.~~for an individual who needs language services.~~ The organization documents that it is not appropriate to share member or patient ~~an individual's~~ immigration status~~,~~ or sexual orientation ~~or gender identity~~ with a housing authority without their ~~individual's~~ consent as there may be concerns for discrimination, bias or safety.

The organization may receive information from a partner that helps guide member or patient ~~individual~~ interventions. For example, it may learn that a patient recently lost their housing and now struggles with medication adherence, or that a transportation resource became unavailable and the patient can no longer reliably access a health center.

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

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

Element C: Communicating Privacy, Security and Data Sharing Protections

When the organization collects data on member or patient ~~individuals'~~ social needs, or refers ~~individuals~~ them for social needs resources or interventions, it communicates its policies and procedures ~~to individuals~~ members or patients for managing access to, using and sharing social needs data, including:

1. **Controls for physical and electronic access to data.**
2. **Permissible use of data.**
3. **Impermissible use of data.**
4. **How individuals can communicate data sharing preferences.**

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, Materials

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

- The documented process for communicating to members or patients ~~individuals~~ its policies and procedures for managing access to, using and sharing social needs data.
- The most recent communication of the policies and procedures to members or patients ~~individuals~~ via reports and materials.

For Initial Surveys: In lieu of a documented process, materials or reports, the organization may submit a detailed implementation plan that includes the draft communication and a timeline for communicating factors 1–4 to members or patients ~~individuals~~.

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

Explanation **Communicating policies and procedures**

Communicating how the organization manages access to, uses and shares social needs data helps members or patients ~~individuals~~ understand what to expect from the organization and its partners, and may encourage them to share the information when requested.

The organization communicates to individuals how social needs data is protected by its privacy, security and data sharing policies and procedures, including whether such information will be shared and with whom (e.g., practitioners, providers, community-based partners). At a minimum, communication must be made or distributed at the time of direct data collection of social needs or during the social needs referral process, and it may be provided at additional times the organization deems appropriate.

The documented process outlines how the organization determines the most appropriate method of communication. For example, the intent of "communication" is not met if the organization:

- Distributes written information to members or patients ~~individuals~~ with visual disabilities or low literacy, or who do not have permanent housing.
- Verbally communicates or distributes written information in a language the member or patient ~~individual~~ does not read or speak.
- Verbally communicates to members or patients with auditory disabilities ~~individuals with impaired hearing~~.

Organizations undergoing an Initial Survey may submit an implementation plan for communicating to individuals in place of the documented process, reports or materials for communicating to members or patients ~~individuals~~ about its policies and procedures for access to, using and sharing social needs data. The plan must include:

- A detailed description of the actions the organization will take to communicate its policies and procedures for managing access to, using and sharing social needs data.
- Draft language of the communication.
- A timeline for communicating factors 1–4.

Factors 1–3

The organization communicates its policies and procedures (Element A) to individuals.

Factor 4: **How to give data sharing preferences**

The information communicated to individuals outlines how they can give data-sharing preferences for social needs data. This may include how to opt in or opt out of sharing social needs data, but is not required.

Exceptions

None.

Examples

Methods for communicating the information to individuals may include, but is not limited to:

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

HEPLUS 4: Program to Mitigate Social Risks and Address Social Needs

The organization has clearly defined ~~structures~~, processes, ~~and~~ goals and responsibilities for continuously improving its program to mitigate social risks and address~~ing~~ social needs.

Intent

The organization has the infrastructure to engage~~s~~ the communities and ~~individuals~~ members or patients it serves to improve the program's ability to mitigate social risks and address social needs.

Element A: Program Description

The organization~~'s~~ has a written program description for addressing social needs and mitigating social risks that includes:

1. **The program's scope.**
2. **The program's structure.**
3. **~~The program's commitment to mitigating social risks and meeting social needs in a way that supports diversity, equity, inclusion and cultural humility.~~ A description of the organization's commitment to providing resources and interventions in a way that is responsive to the needs and preferences of its population and communities.**
4. **Approval by a governing body.**

Scoring

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

Data source Documented process, Materials

Scope of review *For All Surveys:* NCQA reviews the organization's written program description in place throughout the look-back period, and reviews materials as evidence for factor 3, if applicable.

Look-back period *For Initial Surveys:* 6 months for factors 1, 2 and 4; prior to the survey date for factor 3.

For Renewal Surveys: 24 months for factors 1, 2 and 4; 6 months for factor 3.

Explanation The organization has a structured program for meeting the social needs of its members or patients and mitigating community-level social risks. The program's structure may be independent of or integrated with the organization's program from *HE 5: Program to Improve Service Appropriateness and Accessibility,* Element A, or with similar programs focused on quality improvement (QI), culturally and linguistically appropriate services (CLAS) or population health.

A **program description** may be a single comprehensive document or a set of interconnected documents that describe, in plain language, the program's governance, scope and commitment to identifying community social risks and meeting individual social needs. The description is organized and written so staff can understand the program's structure, purpose and commitment.

NCQA reviews the organization's program description for evidence of factors 1–4.

~~The organization's program for mitigating social risks and meeting social needs may be independent of or integrated in its quality improvement, population health management or the culturally and linguistically appropriate services (CLAS) program from *HE 5: Culturally and Linguistically Appropriate Services Programs,* Element A.~~

Factor 1: **Program scope**

The program scope is a roadmap for staff to understand the overall intent of the program and the organization's rationale for investing in the work. The program scope outlines ~~how the organization's~~:

- How the organization's m~~M~~ission and vision statement align to support the program.
- ~~Prioritized social risks and needs identified in *HE Plus 1: Collection, Acquisition and Analysis of Community and Individual Data,* Element G, inform the program.~~
- How the organization's p~~P~~artnerships with external organizations to mitigate social risks and address social needs support the program.

Factor 2: **Program structure**

The program description includes the following information:

- Functional areas or departments involved in the program and their responsibilities.
    - Involvement ~~of the organization's diversity, equity and inclusion officer, or~~ a leadership position with responsibilities in program planning ~~the program's structure.~~
- The reporting relationship of program staff roles, leadership roles, governing bodies and external partners that refer and provide social needs resources for the program.
- Data sources and systems used and accessed by program staff.
- How the organization's ~~CLAS~~ program from HE 5, Element A is related to its operations and oversight, if applicable.
    - Collaborative activities with ~~the organization's CLAS~~ this program, if any.
- Involvement of external stakeholders from the community and the population of individuals served with roles in evaluating the program.

Factor 3: **Commitment to ~~support diversity, equity, inclusion and cultural humility~~ providing resources/interventions**

The program description outlines the organization's overall commitment to providing resources and interventions for social needs and risks in a way that is responsive to the needs or preferences (e.g., cultural, linguistic, accessibility) of its member/patient population and the communities it serves.

~~The organization includes a description or summary outlining the program's overall commitment to mitigating the community's social risks and meeting the social needs of the individuals it serves in a way that supports diversity, equity, inclusion and cultural humility.~~ The description or summary may include an overview of objectives, goals, activities, investments, or budgetary commitments ~~as they relate to diversity, equity, inclusion and cultural humility~~ that occur enterprise-wide or across departments as evidence of its overall commitment.

The organization may submit materials as evidence demonstrating commitment.

Factor 4: **Approval by a governing body**

The program description outlines the organization's process for annual review and approval of the program description by its governing body ~~organization or the program's governing body is responsible for organizational governance and approval of the program description.~~ A **governing body** is the organization's board of directors, or other entity or person responsible for organizational governance, if the organization does not have a board of directors

The governing body may designate a subcommittee or management staff role to oversee activities related to identifying social risks and meeting member or patient social needs. If applicable, the program description must document accountability of the subcommittee or management staff to the governing body.

The organization may use its process for receiving approval for its ~~CLAS~~ program (HE 5, Element A, factor ~~6~~7) from the governing body.

Exceptions

~~Factor 2 will be scored without evidence of DEI officer involvement for all surveys through June 30, 2026.~~

~~Factor 3 is NA for all surveys through June 30, 2026.~~None.

Examples

Factor 4: **Approval by a governing body**

~~Bodies responsible for governance of the program for mitigating social risks in the community and meeting individuals' social needs may include, but are not limited to~~

Governing body

- The organization's board of directors, council, committee or other body with similar responsibilities.
- The clinic or practice's owner(s).

- The organization's health equity or community engagement ~~diversity, equity and inclusion-specific~~ governance council, board or committee with similar responsibilities.

Evidence of governing body approval

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

Element B: Annual Work Plan

The organization documents and executes an annual work plan that reflects ongoing activities to mitigate social risks and address social needs throughout the year and includes:

1. **Goals to mitigate social risks.**
2. **Goals to address social needs.**
3. **Planned activities to meet goals.**
4. **A time frame for each activity's completion.**
5. **Staff roles responsible for each activity.**
6. **Monitoring of the work plan.**
7. **Annual approval by a governing body.**

Scoring

Met	Partially Met	Not Met
The organization meets 6-7 factors	The organization meets 4-5 factors ~~No scoring option~~	The organization meets 0-~~5~~ 3 factors

Data source Documented process, Reports, Materials

Scope of review *For Initial Surveys:* NCQA reviews the organization's most recent annual work plan for mitigating social risks and meeting social needs. If the organization integrates these activities into its ~~CLAS~~ program work plan from *HE 5: Program to Improve Service Appropriateness and Accessibility* ~~*Culturally and Linguistically Appropriate Services Programs*,~~ Element A, NCQA reviews the most recent annual version of the ~~CLAS~~ combined work plan.

- For factor 7: NCQA reviews materials as evidence of governing body approval.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual work plans for mitigating social risks and meeting social needs. If the organization integrates these activities into its ~~CLAS~~ program work plan from ~~(~~HE 5, Element A~~)~~, NCQA reviews the most recent and the previous year's version of the CLAS work plan.

- For factor 7: NCQA reviews materials as evidence of governing body approval for each year of the look-back period.

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

The work plan is a dynamic document of events scheduled and executed to achieve yearly program goals. The organization determines work plan format, which may be presented as a documented process or reports.

***Factor 1:* Goals to mitigate social risks**

~~The organization uses the prioritized social risks identified in~~ ~~*HE Plus 1: Collection, Acquisition and Analysis of Community and Individual Data,*~~ ~~Element G, factor 1, to inform selection of at least one goal for mitigating social risks in the community. The work plan includes a rationale for each goal selected and the goal's intended impact on community health~~.

The work plan describes at least one measurable goal for mitigating social risks in the community, related to at least one social risk prioritized in *HE Plus 1: Collection, Acquisition and Analysis of Community and Individual Data*, Element F.

Goals must:

- Be specific.
- Be measurable.
- Be achievable and reasonable.
- Have a defined time for completion.

***Factor 2:* Goals to address social needs**

The organization uses prioritized social risks identified in HE Plus 1, Element G, factor 2 to inform selection of at least one measurable goal for addressing at least one social need~~s~~ prioritized in Element G. The work plan includes a rationale for each goal selected and the goal's intended impact on individuals.

Goals must:

- Be specific.
- Be measurable.
- Be achievable and reasonable.
- Have a defined period for completion.
- Consider the role of demographic characteristics (e.g., race, ethnicity, language, sexual orientation, disability status, veteran status, age, sex assigned at birth, gender ~~identity~~, geographic classification).

The work plan includes a rationale for each goal selected, and the goal's intended impact on members or patients.

For Renewal Surveys, a goal to increase the number of partnerships or volume of referrals for social needs resources do not meet the intent of this factor.

Factor 3: **Planned activities to meet goals**

The work plan lists activities for meeting each goal identified in factors 1 and 2.

Work plan activities may include community-level interventions to mitigate social risks and ~~individual~~ member- or patient-level interventions to address social needs that are not directly tied to goals.

The organization also considers how planned activities may require:

- Partnering with organizations to mitigate social risk factors for members of the community and/or ~~individuals served by the organization~~ members/patients.
- Referrals to partner organizations to deliver interventions or resources directly to ~~individuals~~ members/patients.

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

Each activity in the work plan has a time frame for completion that lists specific dates (e.g., date, month, quarter) (as opposed to frequency of activities [e.g., annually, semiannually]).

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

The work plan lists staff roles or titles responsible for activities. The list may be limited to activity leads.

Factor 6: **Monitoring of planned activities**

The work plan outlines annual monitoring of planned activities to reflect progress on activities, and goals and includes identification of barriers to meeting goals and completing planned activities.

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

The organization or the program's governing body is the body responsible for organizational governance. The governing body annually approves updates to the work plan.

Exceptions

None.

Examples The work plan may be presented as:

- A calendar of events scheduled for the year.
- A Gantt chart that shows planned activities.
- A brief text that includes the planned time frame for each activity.

Element C: Process for Meaningful Stakeholder Involvement

The organization has a process to meaningfully involve ~~members~~ representatives of its communities and member or patient population ~~of individuals served~~ in improving the program that includes:

1. **Stakeholder recruitment practices that are culturally and linguistically representative of the demographic characteristics or identities of the community.**
2. **Stakeholder recruitment practices that are culturally and linguistically representative of the demographic characteristics or identities of the member or patient population. ~~of individuals served.~~**
3. **Methods for accessibility. ~~meeting access or accommodation needs.~~**
4. **Communicating to stakeholders the actions that resulted from their input.**

Scoring

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

Data source Documented process

Scope of review *For All Surveys:* NCQA reviews the organization's documented process for meaningful involvement of stakeholders representative of relevant direct experience, knowledge or expertise ~~who reflect the diversity and representation of the community and the population of individuals served.~~

Look-back period *For Initial Surveys:* 6 months for factors 1, 2 and 4; prior to the survey date for factor 3.

For Renewal Surveys: 24 months for factors 1, 2, and 4; 6 months for factor 3.

Explanation The organization has a documented process to meaningfully involve stakeholders in the engagement opportunities under Element D.

Stakeholders are **meaningfully involved** in the organization's program when their roles are substantive rather than symbolic, meaning they provide input through engagement opportunities ~~under~~ (such as in Element D), with the expectation that ~~it~~ their engagement will lead to changes ~~to~~ or improvements to program design, priorities or processes. Meaningful involvement formalizes stakeholders' critical role in promoting the program's goals, partnerships and resources/interventions for the greatest positive impact on mitigating the community's social risks and addressing social needs.

Stakeholders ~~reflect the diversity~~ are representative (have relevant direct experience, knowledge or expertise) of the organization's communities served (e.g., community-based organizations, partners, community residents who might not access the organization's services) ~~identified in *HE Plus 1: Collection, Acquisition and Analysis of Community and Individual Data,* Element A~~ and consumers (e.g., members, patients, program participants or their advocates)~~the population of individuals served, and.~~ They may also offer ~~lived~~ direct experience, knowledge or expertise in the social risks and needs that are the program's focus. ~~Stakeholders must include:~~

- ~~Representatives of the communities identified in HE Plus 1, Element A, which may include members of the broader community (individuals that might not access the organization's services) or representatives of community-based organizations, ***and***~~
- ~~The population of individuals served (current members, patients who receive treatment, individuals who participate in its programs).~~

The organization's process may meaningfully involve stakeholders representing both ~~the~~ its communities and ~~population of individuals served~~ consumers by engaging them in a single committee or in another function (e.g., focus group, work group), or by separately engaging community and consumer stakeholders ~~from the community and the population of individuals served~~ through multiple committees or functions. The organization's process may include the use of a committee or function facilitated or convened by an external partner.

Factors 1, 2: **Stakeholder recruitment practices**

Culturally and linguistically appropriate recruitment practices assess, respect and respond to the cultural beliefs, behaviors and needs of individuals the organization seeks to recruit ~~the characteristics or identities represented in the community and population of individuals served~~.

Recruitment practices that are culturally and linguistically appropriate ~~advance health equity by reducing~~ reduce the barriers that prevent or exclude individuals from participating in opportunities ~~to have~~ or having meaningful involvement in the program (e.g., planning, execution, investment, evaluation, decision making).

Culturally and linguistically appropriate recruitment practices also make stakeholders feel more welcome to express~~ing~~ feedback, and ~~makes~~ better positions the organization ~~better positioned~~ to receive meaningful and diverse stakeholder input in Element D.

For factor 1, the organization's process describes its ~~culturally and linguistically appropriate~~ practices for recruiting community ~~members~~ representatives to provide meaningful input on its program in ways that are culturally and linguistically appropriate for the communities. ~~who represent at least 5% of the demographic characteristics or identities (e.g., race/ethnicity, language, gender identity, sexual orientation, religion, aspect of disability) of the communities identified in HE Plus 1, Element A.~~

For factor 2, the organization's process describes its ~~culturally and linguistically appropriate~~ practices for recruiting ~~individuals~~ consumer representatives (e.g., members, patients, program participants or their advocates) to provide meaningful input on its programs in ways that are culturally and linguistically appropriate for its member or patient population. ~~who represent at least 5% of demographic characteristics or identities of the population of individuals served.~~

Factor 3: **Methods for meeting accessibility ~~or~~ and accommodations ~~needs~~**

~~The organization's process describes the methods by which its committees, or other functions that meaningfully involve stakeholders, meet the access or accommodation needs of stakeholders, and remove barriers that prevent or exclude stakeholders from participating in opportunities for meaningful engagement in Element D. The organization determines the access or accommodation needs that are most relevant to its stakeholders.~~ The organization's documented process describes the methods its advisory committees or functions use to make meaningful involvement (Element D) accessible to stakeholders and remove barriers that prevent or exclude their participation. Something **accessible** is easy to approach, reach, enter, speak with, use or understand.

Disability accommodations for engagement are modifications or adjustments to digital or physical workflows, practices, procedures, equipment, staffing, functionality or environment that enable individuals with disabilities to access and meaningfully participate with the same level of ease as individuals who do not have disabilities. Disability accommodations may include physical supports (e.g., ramps, communication devices), additional participants (e.g., interpreters, support persons), flexible workflows or policies (e.g., timing, activity methodology) or adjustments to functionality or use (e.g., magnification, font size, closed captioning).

Methods for accessibility or accommodations include:

- Making in-person meeting space accessible (individuals of all abilities can access the meeting space and participate in planned discussion or activities with little effort).

- Providing written information in relevant formats or languages (e.g., screen reader-friendly digital content; translated materials).

- Interpreters or assistive technology (e.g., auxiliary aids) that helps individuals understand, and be understood, during live presentations or discussions (e.g., in-person or remote interpreter, closed captioning).

The organization determines the accessibility or accommodation needs that are most relevant to its stakeholders.

Factor 4: **Communicating actions**

The organization's process describes how it communicates to stakeholders the actions that have been taken, or that will be taken, as a result of stakeholder input received in Element D. Stakeholder input is crucial to identifying opportunities to improve the program; cultivating trust encourages stakeholders to be more open to providing input. Communicating the outcomes of stakeholder input—including why no actions have been taken—can reinforce stakeholders' expectation of having a substantive role in the program.

Exceptions

~~Factors 1 and 2 will be scored without evidence that the organization's advisory function includes representation from racial/ethnic and linguistic groups that constitute at least 5% of the population for all surveys through June 30, 2026.~~None.

Related information

Resources for improving meaningful involvement may include:

- The Agency for Healthcare Research and Quality (AHRQ) website on patient engagement.[1] This site offers free tools to help prioritize concerns and maximize interactions between providers, patients and families.
- Equity and Inclusion Guiding Engagement Principles created by the Advisory Panel on Patient Engagement of the Patient-Centered Outcomes Research Institute® (PCORI®).[2]

[1] https://www.ahrq.gov/patient-safety/patients-families/index.html
[2] https://www.pcori.org/sites/default/files/Equity-and-Inclusion-Guiding-Engagement-Principles.pdf

Examples

Factors 1, 2: Stakeholder recruitment practices

Recruitment practices for the community and population served

- Creating recruitment materials or messaging that:
  - Use gender neutral language.
  - ~~Emphasize the organization's commitment to diversity and inclusion.~~
  - Use languages relevant to the community or population of members or patients ~~individuals~~ served.
  - Are available in multiple formats.
- Dedicate resources to accessible recruitment methods for ~~recruiting underrepresented groups such as~~ individuals with a disability.
- Hiring external consultants or resources that specialize in engaging stakeholders who reflect ~~the diversity~~ relevant needs or preferences of the community or the population of members or patients ~~individuals~~ served.
- Broaden recruitment sources, for example:
  - Networks or connections, through the organization's community-based partners or initiatives, that focus on mitigating social risks or addressing social needs for the entire community or for a subpopulation of the community.
  - ~~National associations or groups that advocate for marginalized, disenfranchised or disempowered groups.~~

Relevant direct experience, knowledge or expertise

- Direct experience with mental and substance use conditions.

- Professional expertise working with older adults.
- Direct experience as a member of or interpreter for a language group (e.g., Spanish) prevalent in the organization’s service area.
- Certification in providing culturally appropriate care practices.
- Knowledge or training in trauma-informed care practices.
- Research expertise related to condition-specific health disparities for a subgroup.
- Professional experience working in a homeless shelter.
- Direct experience as a person who has experienced homelessness.
- Professional experience as a community health worker within the organization’s service area or community served.
- Direct experience as a parent of a child with an intellectual disability.

Factor **3: Methods for ~~meeting~~ accessibility ~~or~~ and accommodations ~~needs~~**

- Make offices and equipment physically accessible.
- Make digital content s~~S~~creen-reader friendly ~~digital content~~.
- ~~Materials~~ Hold meetings in multiple formats. (e.g., hybrid in-person and virtual).
- Provide flexible scheduling options or opportunities to participate asynchronously.
- Offer ~~S~~sign language interpreters.
- Provide auxiliary aids.
- Offer language assistance.
- Technological support.
- ~~Resources that support stakeholders’ participation such as:~~
- Use ~~E~~engagement mechanisms that facilitate remote or virtual participation (e.g., text surveys, social media-based focus groups, virtual meetings).
- Offer ~~C~~childcare assistance during meetings.
- Provide or reimburse for t~~T~~ransportation to advisory meetings.
- Reimburse~~ment~~ or offer honoraria or gift cards for time spent, or for travel expenses.

Element D: Meaningful Stakeholder Engagement

At least annually, the organization engages stakeholders to gather input on:

1. Program goals for mitigating social risks.
2. Program goals for addressing social needs.
3. Experience with partners.
4. Experience with the resources or interventions made available through the program.
5. Barriers to accessing program resources and interventions.

Scoring

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

Data source Reports, Materials

Scope of review

For Initial Surveys: NCQA reviews materials or reports as evidence that the organization engaged stakeholders of the community and population of members or patients ~~individuals served~~ by gathering input on factors 1–5 (e.g., screenshots, meeting minutes, communications). If it has not had meetings with stakeholders but plans to do so, the organization may submit a proposed meeting agenda that includes the proposed meeting date and discussion topics (factors 1–5). The proposed meeting date must be within one year of the organization's scheduled survey date.

For Renewal Surveys: NCQA reviews the most recent and the previous year's materials or reports as evidence the organization engaged stakeholders of the community and population of members or patients individuals served by gathering input on factors 1–5 (e.g., screenshots, meeting minutes, communications).

Look-back period

For Initial Surveys: Prior to the survey date.

For Renewal Surveys: 24 months.

Explanation

At least annually, the organization meaningfully engages stakeholders of the community and population of members or patients ~~individuals served~~ by gathering input on the program.

Meaningful engagement promotes bidirectional communication and learning that strengthens the relationship between the organization and stakeholders.

***Factors 1, 2:* Program goals**

The organization receives input from stakeholders on its goals that mitigate social risks and address social needs ~~goals identified in Element B, factors 1–2~~.

***Factors 3, 4:* Partners and resources/interventions**

The organization receives input on stakeholder experience with the organization's partners that deliver social needs resources or interventions, and their experience accessing or receiving resources or interventions. ~~resources and/or services from the organization's partners identified in *HE Plus 2: Cross-Sector Partnerships and Engagement,* Elements C and D.~~

***Factor 5:* Barriers to accessing resources/interventions**

The organization receives input from stakeholders on at least one barrier to accessing or receiving resources and interventions.

Exceptions

None.

Related information

Resources for improving meaningful involvement and engagement may include:

- The Agency for Healthcare Research and Quality (AHRQ) website on patient engagement.[1] This site offers free tools to help prioritize concerns and maximize interactions between providers, patients and families.
- Equity and Inclusion Guiding Engagement Principles created by the Advisory Panel on Patient Engagement of the Patient-Centered Outcomes Research Institute® (PCORI®).[2]

[1] https://www.ahrq.gov/patient-safety/patients-families/index.html
[2] https://www.pcori.org/sites/default/files/Equity-and-Inclusion-Guiding-Engagement-Principles.pdf

Examples *Factor 5:* **Barriers to accessing resources/interventions**

Barriers may include, but are not limited to:

- Past and present experiences with discrimination, bias, racism or trauma.
- Systemic racism.
- Institutional policies that perpetuate discrimination, bias or racism.
- Limited access to technology-based services.
- Physical limitations to access (e.g., lack of transportation, lack of accommodations for ~~individuals~~ members or patients with disabilities).
- Lack of language supports.

Element E: Program Evaluation

The organization performs a written annual evaluation of the program that includes:

1. **A description of completed and ongoing activities to mitigate social risks and address social needs.**
2. **Trending of measures to assess performance on goals for social risks.**
3. **Trending of measures to assess performance on goals for social needs.**
4. **Feedback received from community and consumer stakeholders ~~in HE PLUS 4, Element D~~.**
5. **Analysis of results, including barrier analysis.**
6. **Review and interpretation of program effectiveness by community and consumer stakeholders.**

~~6~~7. Evaluation of overall program effectiveness.

~~7. Review and interpretation of program effectiveness to community and consumer stakeholders.~~

Scoring

Met	Partially Met	Not Met
The organization meets 4-7 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review *For Initial Surveys:* NCQA reviews the organization's implementation plan detailing its strategy for meeting factors 2–7, including a timeline.

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

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

Organizations undergoing an Initial Survey may submit an implementation plan detailing their strategy for completing the activities in factors 2–7. The plan must include a detailed description of the actions the organization will take and a timeline for implementing each activity.

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

The organization annually evaluates its performance on planned activities to mitigate social risks and address social needs described in the program description and the work plan. Evaluation includes a description of completed and ongoing activities for the previous year.

***Factors 2, 3:* Trending of measures**

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

***Factor 4:* Stakeholder input**

The organization uses ~~feedback received~~ input from community (e.g., community residents, community-based partners) and consumer (e.g., members, patients) stakeholders in ~~Element D~~ to ~~determine~~ evaluate program effectiveness. The organization may use input gathered from engagement in Element D, but is not required to.

***Factor 5:* Analysis of results, including barrier analysis**

The organization analyzes results to determine whether its performance on social risks and social needs goals is improving, declining or remaining stable. If performance falls short of goals, the organization conducts a root cause or barrier analysis to identify why stated goals were not met. Analysis involves organization staff who have direct experience with processes that present barriers to improvement.

~~***Factor 6:* Evaluation of program effectiveness**~~

~~After considering its performance on factors 1–5, the organization evaluates the program’s overall effectiveness to mitigate social risks and address social needs. It considers adequacy of resources, program structure, participation of partners and~~

~~involvement of leadership in the program, and decides whether to restructure or change the program for the subsequent year based on its findings.~~

Factor ~~7~~6: **Review and evaluation of results by stakeholders**

The organization presents the results of the evaluation in factor ~~6~~5 to community and consumer stakeholders for review and feedback. The organization must consult community representatives for their perspective on the root causes of barriers and possible solutions. Community representatives must represent (e.g., direct experience, knowledge or expertise) at least one individual from a population relevant to each goal, initiative or barrier presented in the analysis.

The organization may use the same group of community and consumer stakeholders convened in Element~~ C and~~ D, but is not required to. ~~to receive input on program effectiveness. If applicable, the organization presents the barrier analysis from factor 5 to stakeholders for their perspective on the root causes of barriers and possible solutions.~~

Factor 7: **Evaluation of overall program effectiveness**

After considering its performance on factors 1–6, the organization evaluates the program's overall effectiveness to mitigate social risks and address social needs. The organization considers adequacy of resources, program structure, partner participation and involvement of leadership in the program. The organization decides whether to make ~~restructure or~~ program changes ~~the program~~ for the subsequent year, based on its findings (e.g., resources, program structure, partners, processes).

Exception

Factor 1 is NA for Initial Surveys.

Examples None.

HEPLUS 5: Referrals, Outcomes and Impact

The organization refers ~~individuals~~ members or patients to social needs resources, ~~accepts~~ tracks the progress of referrals from community-based organizations ~~to track progress~~ and evaluates the effectiveness of the referral process.

Intent

The organization and its partners help ~~individuals~~ members or patients with social needs obtain access to resources and interventions, and evaluate the effectiveness of the referral process.

Element A: Identifying Resources to Address Social Needs

The organization has a process for identifying social needs resources or interventions appropriate for individual members or patients.

~~The organization has a process to identify appropriate social needs resources or interventions for individuals.~~

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 ~~based on individual~~ for ~~social needs~~ individual patients or members.

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

For Renewal Surveys: 6~~24~~ months.

Explanation The organization ~~provides its~~ has a documented process for identifying social needs resources or interventions appropriate for individual members or patients. ~~using the social needs identified in *HE Plus 1: Collection, Acquisition and Analysis of Community and Individual Data,* Element E, factor 1, to identify appropriate resources for the individuals it serves. At a minimum, t~~The process specifies:

- ~~d~~Departments and staff involved in identifying appropriate social needs resources, including resources available for referral through a partner~~organization~~, social care network or third-party vendor or platform.~~, and how~~
- How ~~they~~ staff determine ~~which~~ appropriate resources/interventions for individual members or patients ~~are appropriate~~.

Appropriate social needs resources or interventions both align with the member or patient's ~~individual's~~ identified social need, and are provided by partner organizations that have the capacity (resources) and capability (knowledge) to meet their cultural, linguistic and disability accommodation needs. These resources or interventions should seek, whenever possible, to address the root cause of the social need.

Resources or interventions may not be appropriate if the ~~organization~~ partner:

- Does not have the capacity to serve new members or patients. ~~individuals,~~
- Is unsafe for the member or patient ~~individual~~ based on one or more demographic characteristics/identities (e.g., gender identity, sexual orientation).
- Is unable to communicate in the ~~individual's~~ member or patient's preferred language or is unable to meet their ~~accommodation~~ needs (e.g., does not have physically accessible offices and equipment, cannot communicate with members or patients who use auxiliary aids or services, cannot provide patient educational materials in multiple formats, does not have access to a 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~~ members or patients to social needs resources and interventions, or for accepting referrals from partner organizations that provide resources and interventions, which includes:

1. **Confirming that the member or patient ~~individual~~ agrees the identified social need is a priority.**
2. **Obtaining the member or patient's ~~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	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *For All Surveys:* For factors 1–4, NCQA reviews the organization's documented process for referring members or patients ~~individuals~~ to community partners. For factors 3 and 4, NCQA reviews materials demonstrating that the organization communicated information to members or patients. ~~individuals.~~

For Initial Surveys: In lieu of materials, the organization may submit a detailed implementation plan for factors 3 and 4, including a timeline for communicating expectations with individuals.

Look-back period

For Initial Surveys: Prior to the survey date.

For Renewal Surveys: 24 months.

Explanation

The organization has a documented process for referring members or patients ~~individuals~~ to social needs resources and interventions provided directly by the organization and its partners, in a manner that respects members' or patients' ~~individuals'~~ priorities and goals, autonomy and privacy. The documented process also describes how the organization accepts referrals from partner organizations, if applicable.

Respecting autonomy includes empowering members or patients ~~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.

If the organization completes an implementation plan in place of materials, the plan must include:

- A detailed description of the actions the organization will take to communicate expectations to members or patients ~~individuals~~, as outlined in factors 3 and 4.
- Draft language of the communication.
- A timeline for communicating factors 3 and 4.

Factors 1, 2

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

- ~~If~~ Whether the organization uses a third-party platform or vendor to facilitate the referral process.
- That the organization confirms with members or patients ~~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 member or patient ~~individual~~ to:
    - Identify ~~the individual's~~ their priorities.
    - Identify ~~the individual's~~ their reasons for not consenting to the resource or intervention.

The organization documents its findings from collaboration with the ~~individual~~ member or patient, 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 served.~~

Factors 3, 4

Communicating expectations helps members or patients ~~individuals~~ understand what to expect from the organization and its partners during the referral process, and what information they must provide to ensure the referral is effective (e.g., communication, providing information to make the referral effective). ~~their role in giving the organization enough information to ensure that the referral is effective.~~

~~The process for communicating expectations may include, but should not be limited to, distributing written information. Organizations should consider methods of communication that are appropriate for the individual. For example, distributing written information does not meet the intent for individuals who have visual disabilities or low literacy, or who do not have permanent housing.~~ Organizations should consider methods of accessible and appropriate methods of communicating expectations to members or patients (e.g., written materials, with other options to accommodate the needs of individuals with visual disabilities or low literacy, who do not have permanent housing, who speak languages other than English).

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

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

For factor 4, minimum expectations include:

- Providing the organization and its partners with the information necessary to carry out the referral.
- Notifying the organization and its partners, as applicable, if the ~~individual~~ member or patient 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 members or patients ~~individuals~~ at the time of enrollment in a care management program that provides referrals for social needs resources or interventions.

Element C: Tracking Referral Status

The organization collaborates with partner organizations to track the status of ~~individuals'~~ member or patient referrals.

Scoring

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

Data source Reports

Scope of review *For All Surveys:* NCQA reviews the organization's reports demonstrating that the organization tracked~~ individuals' ~~member or patient referral statuses during the look-back period.

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

For Renewal Surveys: 24 months.

Explanation The organization collaborates with its partners to track the status of ~~individuals'~~ member or patient referrals to social resources and interventions and from community partners to the organization. ~~The organization is not required to track referral status with all partners.~~ The organization presents evidence for the partners with which it tracks referral status~~es~~ it is not required to track referral status with all partners. ~~At a minimum, c~~Collaborative~~on~~ tracking of referral status includes confirming that the referral request was received and that the member or patient ~~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 members or patients ~~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~~ Member or patient not yet contacted.
- ~~Individual~~ Member or patient 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 Referral Status for Disparities~~

~~The organization annually analyzes referral statuses tracked in Element C 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~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

~~Data source~~ ~~Documented process, Reports~~

~~Scope of review~~ ~~*For Initial Surveys:* NCQA reviews the organization's most recent annual assessment report. In lieu of reports, the organization may submit a detailed implementation plan for analyzing referral statuses to identify disparities for any or all factors.~~

~~*For Renewal Surveys:* NCQA reviews the organization's most recent and the previous year's annual assessment reports.~~

~~Look-back period~~ ~~*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 and 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.~~

~~Organizations undergoing an Initial Survey may submit an implementation plan describing how they analyze referrals tracked in Element C to identify disparities based on race or ethnicity, language, gender identity and sexual orientation.~~

~~Factors 1–4~~

~~The organization annually stratifies referral status data from Element C by race, ethnicity, language, gender identity and/or sexual orientation to assess if there are disparities in accessing or receiving referred resources and interventions. 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**~~

~~Factor 3 is NA for all surveys through June 30, 2026.~~

~~**Examples**~~ ~~None.~~

Element D: Assessing Disparities in Screening, Referrals and Interventions *(NEW)*

The organization annually analyzes the following to identify disparities:

1. **Receipt of a social needs screening, stratified by one characteristic.**
2. **Receipt of a social needs screening, stratified by two or more characteristics.**
3. **Screening positive for a social need, stratified by one characteristic.**
4. **Screening positive for a social need, stratified by two or more characteristics.**
5. **Social needs referral status, stratified by one characteristic.**
6. **Social needs referral status, stratified by two or more characteristics.**

Scoring

Met	Partially Met	Not Met
The organization meets 2-6 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports

Scope of review *For Initial Surveys:* NCQA reviews a documented process demonstrating the organization's stratification methodology and its most recent annual assessment report. In lieu of reports, the organization may submit a detailed implementation plan for any or all factors.

For Renewal Surveys: NCQA reviews a documented process demonstrating the organization's stratification methodology and its most recent and the previous year's annual assessment report. For surveys scheduled between July 1, 2026, and June 30, 2027, the organization may submit a detailed implementation plan for factors 1–4 and 6 in place of reports.

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

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

Explanation The organization demonstrates, through a documented process and reports or materials, that it annually analyzes qualitative or quantitative information about the following metrics, stratified by demographic characteristics of the organization's choice, to identify disparities:

- Receipt of a social needs screening.

- Screening positive for a social need.
- Social needs referral status.

Together, these metrics help the organization identify opportunities to improve the fairness of its screening process, identify communities or subgroups who most acutely need specific social needs resources and remove barriers to receiving timely and appropriate interventions.

The organization determines which demographic characteristics are most relevant to its member or patient population and communities (e.g., race, ethnicity, language, sexual orientation, sex, gender identity, disability status, geography, veteran status, age, insurance type). The organization should select demographic characteristics for which it has at least two subgroups with a sufficient denominator (30 or more individuals) to meaningfully facilitate comparison.

Organizations undergoing an Initial Survey may submit a detailed implementation plan in place of a documented process, materials or reports for factors 1, 3 and 5. Organizations undergoing a Renewal Survey may submit a detailed implementation plan in place of a documented process, materials or reports for factors 1–4 and 6. Implementation plans must include:

- A detailed description of actions the organization will take to implement the required analysis.
- A timeline for implementing activities.

Methodology

The organization describes its method for annually performing a qualitative or quantitative analysis and stratifying the required metrics to assess health care disparities.

Refer to *Appendix 3: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.

Stratification

The organization annually stratifies each required metric by using member- or patient-level data. Data may be direct or indirect. The organization should select demographic characteristics and subgroups most relevant to its member or patient population, and that are feasible to draw meaningful conclusions, given the number of members or patients in subgroups.

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.”

The organization may use the same subpopulations it assessed for *HE Plus 1: Collection, Acquisition and Analysis of Community and Individual Data,* Element G, but is not required to.

Factors 1, 3, 5

For each required metric, the organization annually uses qualitative or quantitative information to identify disparities, stratified by at least one demographic characteristic.

Factors 2, 4, 6

For each required metric, the organization annually uses qualitative or quantitative information to identify disparities, stratified by two or more intersectional demographic characteristics (e.g., Asian and aged 18–44; Russian speakers in rural geographies).

Exceptions

Factors 2, 4 and 6 are NA for all Initial Surveys.

Examples

Factors 2, 4, 6

Percentage of membership that received a food insecurity screening, stratified by language and geographic classification.

Spoken Language	Rural	Metro Non-Urban	Metro Urban
Cantonese	35%	55%	61%
English	42%	65%	58%
Hindi	35%	25%	27%
Mandarin	25%	20%	20%
Spanish	45%	51%	49%
All Other Languages	40%	45%	44%

Percentage of membership that received the organization’s standardized social needs screener (including financial insecurity, food insecurity, housing instability, transportation access, interpersonal safety) stratified by language and geographic classification.

Spoken Language	Rural	Metro Non-Urban	Metro Urban
Cantonese	35%	55%	61%
English	42%	65%	58%
Hindi	35%	25%	27%
Mandarin	25%	20%	20%
Spanish	45%	51%	49%
All Other Languages	40%	45%	44%

Element E: Evaluating Bidirectional Partnership

The organization annually collaborates with at least one partner ~~and its partners collaborate~~ to ~~annually~~ bidirectionally to evaluate the effectiveness of the partnership based on:

1. **The overall experience of ~~individuals in the population served~~ members or patients when accessing/receiving resources and interventions.**
2. **The overall experience of ~~individuals in the population served~~ members or patients with regard to ableism, discrimination or bias when accessing/receiving resources and interventions.**
3. **The tracked statuses of social need referrals~~., as tracked in Element C~~.**
4. **Disparities in ~~tracked social need~~ referral status~~., as analyzed in Element D~~.**
5. **Bidirectional feedback on the partnership process.**

Scoring

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

Data source Documented process, Reports, Materials

Scope of review

For All Surveys:

- *For factors 1—5,* NCQA reviews reports summarizing the results of the annual bidirectional partnership evaluation.
- *For factor 5,* NCQA also reviews reports or materials demonstrating the bidirectional feedback used in the partnership evaluation.

~~For partnerships in effect for 12 months or longer, NCQA reviews the four partners selected in HE Plus 2, Element D for the annual partnership evaluation reports completed during the look-back period, or reviews all annual partnership evaluation reports if the organization has fewer than four. Each report must summarize results of each evaluation performed in factors 1–5.~~*For Initial Surveys:* In lieu of reports, the organization may submit a detailed implementation plan for collaborating to annually evaluate the effectiveness of the partnership, as described in factors 1–5, or provide a proposed meeting agenda as evidence of planned or scheduled collaboration to evaluate the partnership for factors 1–5.

~~The score for the element is the average of the scores for all partners.~~

Look-back period

For Initial Surveys: Prior to the survey date.

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

Explanation

The organization annually collaborates with ~~its~~ at least one partner~~s~~ to evaluate the experience of ~~individuals~~ members or patients they mutually serve and the partnership process.

Evaluation of the partnership aligns with the process outlined in the contract or agreement (Refer to *HE Plus 2: Cross-Sector Partnerships and Engagement,* Element D). ~~It~~ Evaluation is bidirectional and supports joint quality improvement objectives, allowing ~~partner~~ the organization~~s~~ and the partner entity to identify opportunities to streamline the partnership's processes and improve their effectiveness in meeting the needs of members or patients ~~individuals.~~

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

Organizations undergoing an Initial Survey may submit either:

- An implementation plan describing how ~~it~~ they will collaborate with partners to evaluate the partnership's effectiveness (factors 1–5), which includes a timeline for conducting evaluation activities, ***or***
- A proposed meeting agenda, if a meeting to evaluate the partnership is planned or scheduled, but has not occurred. ~~there has not been a meeting to evaluate the partnership but one is planned or scheduled~~.
    - The meeting agenda must include the proposed meeting date and discussion topics (factors 1–5).

Factors 1, 2

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

If the organization surveys a sample, it describes the sample universe and the methodology. The sampling methodology should be designed to ensure a representative sample across relevant demographic characteristics (e.g., race, ethnicity, language, ~~gender identity and~~ sexual orientation, disability status, age, veteran status, dual eligibility status).

Factor 3: **Status of referrals**

The organization and its partner~~s~~ use ~~the~~ tracked ~~referral~~ statuses for social need referrals ~~tracked in Element C~~ to evaluate whether the partnership is effective in connecting members or patients ~~individuals~~ with referred resources or interventions. The organization and partner~~s~~ agree on the ~~standard~~ criteria for measuring the effectiveness of the referral process. The partnership may use the same statuses tracked in Element C in its evaluation, but is not required to.

Factor 4: **Disparities in referral status**

The organization and its partner~~s~~ use identified disparities in tracked statuses for social need referrals, or the lack thereof, ~~the results of the organization's analysis in~~

~~Element D~~ to evaluate the partnership's effectiveness. The partnership may use the results of the analysis in Element D in its evaluation, but is not required to.

Factor 5: **Bidirectional feedback on the partnership process**

The organization and its partner~~s~~ use bidirectional feedback (e.g., perceived burden of and experience with referrals, data sharing, organization staff and systems) during the look-back period to evaluate the partnership's effectiveness. Feedback may be demonstrated by materials or reports used in the annual evaluation of effectiveness (e.g. meeting minutes, reports, documented referral rates, surveys, focus groups and partnership metrics).

Exception~~s~~

This element is NA ~~for~~ if the organization has no partnership arrangements in effect for ~~less than~~ 12 months or more.

Examples

Factors 1, 2

Survey questions about individual experience may include:

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

Element F: Assessing Effectiveness of Social Needs Referrals and Interventions *(NEW)*

Based on the results of its disparities assessment and bidirectional partnership evaluations, the organization annually:

1. **Identifies and prioritizes opportunities to reduce health disparities related to social needs.**
2. **Identifies and prioritizes opportunities to improve its social needs referral process.**
3. **Implements at least one intervention to address health disparities related to social needs.**
4. **Implements at least one intervention to improve its social needs referral process.**
5. **Evaluates the effectiveness of an intervention to reduce health disparities related to social needs.**
6. **Evaluates the effectiveness of an intervention to improve its social needs referral process.**

Scoring

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

Data source Documented process, Reports

Scope of review *For All Surveys:*

- *For factors 1, 2,* NCQA reviews the organization's most recent annual assessment report.
- *For factors 3–6,* NCQA reviews a plan for implementation and evaluation of interventions.

Look-back period

For Initial Surveys: Prior to the survey date.

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

Explanation

The organization performs annual QI interventions to reduce disparities related to social needs, including, but not limited to, social needs screenings, positive screen rates and referral status. The organization may use findings from Elements D and E, but is not required to.

The organization should prioritize opportunities and implement interventions intended to mitigate community-level social risks or structural root causes related to the identified social needs disparity.

***Factors 1, 2:* Identifying and prioritizing opportunities**

The organization's annual assessment report identifies as many opportunities as possible, and prioritizes them based on the results of its analysis and their significance for concerns to its members or patients, partners and communities.

For each identified opportunity or barrier, the report describes the organization's reasons for taking action or not taking action, and how it selected each prioritized opportunity. NCQA uses the analysis to evaluate whether chosen priorities reflect significant issues.

The organization may engage members of the target community through community advisory boards, including community representatives or leaders on an internal project team; bringing data to a community meeting and soliciting input on priorities; or through other means that provide a meaningful avenue for members of the affected community or subpopulation to contribute to the selection and design of interventions.

Opportunities may be identified for a group or subgroup of members or patients with shared characteristics, practitioners, the organization, community members or in collaboration with partners. NCQA does not prescribe the volume or types of opportunities the organization may identify or select.

***Factors 3, 4:* Implementing interventions**

NCQA evaluates whether the organization implemented at least one intervention to address a prioritized opportunity for improving a social needs disparity and to improve its social needs referral process. For each intervention, the organization's report describes:

- Subpopulations of the organization's member or patient population the intervention is intended to benefit.

- The measure(s) that will be used to evaluate the intervention's effectiveness and impact.
- The intervention's relevance to the subpopulation(s) and measure(s) in question.

Interventions and QI activities may take place at the organization level or in collaboration with partners that deliver social needs resources and interventions.

Factors 5, 6: **Evaluating the effectiveness of an intervention**

The organization must evaluate the effectiveness of both an intervention to reduce a social needs disparity and to improve its social needs referral process. Direct or indirect data, or a combination, may be used in the evaluations. Evaluations address opportunities and interventions reflected in factors 1–4, or, if insufficient time has elapsed to evaluate their effectiveness, may address measures and interventions undertaken in the prior year.

Exceptions

Factors 1, 3 and 5 are NA if no opportunities for reducing health disparities related to social needs are identified by the organization, based on its analysis of results.

Factors 2, 4 and 6 are NA if no opportunities for improving the organization's social needs referral process 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 None.