HE 1: Organizational Readiness

The organization builds, trains and maintains a workforce with direct experience, knowledge or expertise relevant to the needs of its members. ~~is committed to advancing health equity by building a diverse and inclusive staff.~~

Intent

The organization has a workforce capable of supporting its goals to provide opportunities for members or patients to achieve their best possible health. ~~supports health equity goals and takes action to reduce bias and improve diversity, equity and inclusion.~~

~~Element A: Building a Diverse Staff~~

~~The organization:~~

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

~~Scoring~~

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

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

~~Scope of review~~ ~~*For All Surveys:*~~

- ~~*For factor 1:* NCQA reviews the organization's documented process or materials that describe the recruiting and hiring process in place throughout the look-back period.~~
- ~~*For factors 2 and 3:* NCQA reviews materials or reports as evidence that the organization identified and acted on at least one opportunity to improve diversity, equity, inclusion or cultural humility during the prior 24 months. The organization may submit a plan to meet factor 3.~~

~~Look-back period~~ ~~*For Initial Surveys:* 6 months for factor 1; 24 months for factors 2 and 3.~~

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

~~Explanation~~ ~~This element may not be delegated.~~

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

~~**Equity** is developing, strengthening and supporting procedural and outcome fairness in systems, procedures and resource distribution mechanisms to create fair opportunities for all individuals. Equity and "equitable" are distinct from **equality** or "equal," which refers to everyone having the same treatment, but does not account~~

~~for different needs or circumstances. Equity focuses on eliminating barriers that have prevented the full participation of historically and currently oppressed groups.~~

~~**Inclusion** is intentionally designed, active and ongoing engagement with individuals that ensures opportunities and pathways for participation in all aspects of a group, organization or community, including decision-making processes. Inclusion refers to how groups show that individuals are valued as respected members of the group, team, organization or community, and is often created through progressive, consistent actions to expand, include and share.~~

~~**Cultural humility** is the ability of organizations, systems and health care professionals to value, respect and respond to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services.~~

~~***Factor 1:*** **Recruiting and hiring processes that support diversity**~~

~~The organization's hiring and recruitment practices promote diversity, including for internal and external positions, promotions and reclassifications and temporary and permanent positions.~~

~~At a minimum, the organization's hiring and recruitment practices consider:~~

- ~~How the organization's workforce reflects the diversity of the population served.~~
- ~~Groups that are inadequately represented in the workforce.~~
- ~~Whether particular groups are marginalized, disenfranchised or disempowered by the organization's recruitment and hiring practices.~~

~~The organization's hiring and recruitment process explicitly addresses how the organization promotes diversity for:~~

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

~~If the organization has a board of directors, this constitutes the organization's governance body. If the organization does not have a board of directors as part of its organizational structure, then the organization defines its governing body, or bodies. The governance body should be the person or entity with authority to approve the Accredited entity's objectives, goals and funding for activities, and may be a single person (e.g., commissioner, agency director, department secretary) or a group of people with approval authority (e.g., legislature, cabinet, panel, board).~~

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

~~*Factor 2:* **Identifies at least one opportunity**~~

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

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

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

~~*Factor 3:* **Acts on at least one opportunity**~~

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

~~Providing staff training does not meet the intent of this factor.~~

~~**Exceptions**~~

~~This element is NA for all surveys through June 30, 2026~~

~~**Related information**~~

~~*Use of vendors to identify opportunities.* If the organization contracts with a vendor or external consultant to meet factor 2, it provides access to the vendor or external consultant's documentation for evaluation. NCQA does not consider the relationship to be delegation, and delegation oversight under *HE 7: Delegation* is not required. NCQA evaluates the vendor's documentation against the requirements. Refer to "Vendors" in *Appendix 2: Automatic Credit.*~~

~~**Examples**~~

~~*Factor 1:* **Recruiting and hiring practices that support diversity**~~

~~Documentation methods~~

- ~~Policies and procedures.~~
- ~~Employee handbook.~~

~~*Recruiting and hiring practices that support diversity*~~

- ~~Create inclusive job descriptions that:~~
    - ~~Use gender neutral language.~~
    - ~~Reduce requirements to "must-haves."~~
    - ~~Indicate a salary range.~~
    - ~~Emphasize the organization's commitment to diversity and inclusion.~~
- ~~Use blind-review resumes when hiring new staff.~~
- ~~Hold hiring decision makers and leadership responsible for representation growth within teams and the organization.~~

- ~~Dedicate resources to recruiting underrepresented groups such as individuals with disabilities, on governing bodies.~~
- ~~Deploy technology that screens for biased language in job descriptions and postings.~~
- ~~Require interview panels to include interviewers from underrepresented populations, genders or diverse position levels.~~
- ~~Broaden recruitment sources, for example:~~
    - ~~Schools with diverse student bodies or alumni networks.~~
    - ~~National associations or groups that advocate for marginalized, disenfranchised or disempowered groups.~~
    - ~~Recruitment firms that specialize in job placement for diverse groups of executives.~~
- ~~Require external committees to reflect the diversity of the organization.~~
- ~~Base the salaries offered to internal and external candidates on factors that support salary equity for traditionally marginalized, disenfranchised or disempowered groups, such as:~~
    - ~~Salaries for similar positions at other organizations.~~
    - ~~Salaries for the same position level and experience within the organization.~~

~~***Factor 2:*** **Identification of opportunities**~~

- ~~Regularly gather (through surveys or other engagement activities) and report on staff feedback on and satisfaction with the organization's promotion of diversity, equity, inclusion and cultural humility.~~
- ~~Survey staff to identify the primary barriers to maintaining employment, to reduce turnover rates for traditionally marginalized, disenfranchised or disempowered groups.~~
- ~~Compare the diversity of the organization's workforce with groups or subgroups of the community or population that the organization serves (e.g., racial/ethnic, preferred language, gender identity, sexual orientation) and with the available pool of candidates in the labor market where the organization operates.~~

~~***Factor 3:*** **Acts on opportunities**~~

- ~~Build diversity, equity, inclusion and cultural humility performance metrics into all management and leadership job descriptions and goals.~~[1,2]
- ~~Suggest staff share pronouns in introductions and/or email signatures.~~
- ~~Design work spaces to better accommodate staff of differing mobility.~~
- ~~Host, offer or promote events (e.g., webinars, speaker series, brown bag sessions) that foster diversity, equity, inclusion and cultural humility and highlight traditionally marginalized, disenfranchised or disempowered groups.~~
- ~~Create temporary or permanent positions, departments, councils or committees focused on highlighting underrepresented groups.~~

[1] ~~https://givingusa.org/be-a-smartie-an-equity-forward-approach-to-goal-setting/~~
[2] ~~https://healthcareanchor.network/anchor-mission-resources/~~

Element A: Building and Maintaining a Responsive Workforce

The organization builds and maintains a workforce responsive to the needs of its members or patient population by:

1. **Annually identifying direct experience, knowledge or expertise relevant to understanding and addressing the needs of its population.**
2. **Having a process to recruit and hire a workforce with direct experience, knowledge or expertise relevant to the needs of its population.**
3. **Identifying at least one opportunity to improve the representation of relevant direct experience, knowledge or expertise in its workforce.**
4. **Acting on at least one opportunity identified in factor 3 or 4.**

Scoring

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

Data source Documented process, Reports, Materials

Scope of review *For All Surveys:*

- *For factor 1:* NCQA reviews materials or reports as evidence that the organization evaluates direct experience, knowledge or expertise relevant to the needs of its member or patient population.
- For factor 2: NCQA reviews a documented process or materials that describe the organization's recruiting and hiring process in place throughout the look-back period.
- *For factors 3-5:* NCQA reviews materials or reports as evidence that the organization identified at least one opportunity to improve retention and representation for its workforce, each, and acted on at least one opportunity.

Look-back period *For Initial Surveys: 6 months for factor 2; Prior to the Survey date for factors 1, 3-5.*

For Renewal Surveys: 6 months for factor 2; Prior to the Survey date for factors 1, 3-5.

Explanation This element may not be delegated.

The organization develops and maintains a workforce responsive to the needs of its member or patient population (e.g., cultural, linguistic, disability-related, socioeconomic, condition prevalence). A responsive workforce includes individuals with necessary skills that may come from direct experience, knowledge or expertise relevant to understanding the needs of members or patients, and has the organization's support to meet these needs.

The organization's workforce encompasses all individuals whose conduct is under the direct control of the organization, including paid, volunteer, temporary and permanent positions.

The organization's recruiting and hiring practices must directly address:

- Staff.

- Leadership (individuals with managerial authority and executive roles such as managers, directors, vice presidents, chief officers).
- Promotions and reclassifications.
- Committees (individuals internal or external to the organization, appointed for a specific function).

The organization's practices may address governance bodies such as its board of directors (the people or entities with authority to approve objectives, goals and funding for activities), but is not required to.

Factor 1: **Relevant direct experience, knowledge or expertise**

In order to determine what direct experience, knowledge or expertise is relevant for serving its population of members or patients, the organization demonstrates through reports or materials that it annually assesses member or patient needs (e.g., cultural, linguistic, accessibility, social).

Factor 2: **Recruiting and hiring a relevant workforce**

The organization demonstrates, through documented processes or materials, that its recruitment and hiring practices seek to develop a workforce with direct experience, knowledge or expertise identified as relevant to the needs of its member or patient population (e.g., cultural, linguistic, accessibility, social).

Factor 3: **Identifying opportunities to improve representation**

The organization demonstrates, through reports or materials, that it evaluates and identifies at least one opportunity for each of the following to improve representation of relevant direct experience, knowledge or expertise compared to the needs of its member or patient population:

- Staff.
- Leadership.
- Committees.

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

Factor 4: **Acting on at least one opportunity**

The organization demonstrates, through reports or materials, that it acts on at least one opportunity identified in factor 3 or 4 to improve the representation of workforce with relevant direct experience, knowledge or expertise for at least one workforce group (staff, leadership, or committee).

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

Exceptions

None.

Related information

This element is specific to the organization’s recruiting and hiring processes, and does not apply to practitioner network management for health plans and managed behavioral healthcare organizations.

Care delivery organizations may also include employed practitioners in their workforce (e.g., full time faculty, residents, fellows, volunteers).

The organization’s recruiting and hiring practices may address governance bodies such as the organization’s board of directors (the person or entity with authority to approve objectives, goals and funding for activities), but is not required to.

Examples

Factor 1: **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 2: **Recruiting and hiring a relevant workforce**

Documentation methods

- Policies and procedures (e.g., staff recruitment, external committee nominations, internal committee selection).
- Employee handbook.
- Staffing plan.
- Applications.
- Job listings.

Recruiting and hiring practices

- Create inclusive job descriptions that:
  - Use gender neutral language.
  - Reduce requirements to “must-haves.”
  - Indicate a salary range.
- Use blind-review resumes when hiring new staff.
- Hold hiring decision makers and leadership responsible for staffing goals within teams and the organization.
- Deploy technology that screens for biased language in job descriptions and postings.
- Require interview panels to include interviewers with relevant experience, knowledge or expertise for the position being hired.

- Broaden recruitment sources, for example:
  - Schools in the organization’s service area or community served.
  - Relationships with community-based organizations.
  - Recruitment firms that specialize in job placement for groups with relevant direct experience, knowledge or expertise.

Factor 3: **Identifying opportunities to improve representation**

- Compare the qualifications of the workforce (e.g., direct experience, knowledge, expertise) with the identified needs of the member or patient population (e.g., cultural, linguistic, disability-related, socioeconomic, condition prevalence).
- Regularly gather (through surveys or other engagement activities) and report on member/patient satisfaction with the direct experience, knowledge and expertise of the organization’s workforce.
- Compare the current vs. needed volume of direct experience, knowledge and expertise with the available pool of candidates in the labor market where the organization operates.
- Interview internal or external stakeholders with needed direct experience, knowledge and expertise.

~~Element B: Promoting Diversity, Equity and Inclusion Among Staff~~

~~At least annually, the organization:~~

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

~~Scoring~~

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

~~Data source~~ ~~Reports, Materials~~

~~Scope of review~~ ~~*For All Surveys:*~~

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

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

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

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

~~**Culturally and linguistically appropriate practices** seek to advance health equity, improve the quality of health care and reduce health care disparities by assessing,~~

~~respecting and responding to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services.~~

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

~~**Employees** include any individual of the organization's internal workforce, regardless of position level or compensation, and may be temporary or permanent.~~

~~***Factor 1:*** **Provides trainings**~~

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

~~***Factor 2:*** **Reports on completion of training**~~

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

~~**Exceptions**~~

~~This element is NA for all surveys through June 30, 2026.~~

~~[1] http://kirwaninstitute.osu.edu/wp-content/uploads/2018/04/Combating-Implicit-Bias-in-the-workplace.pdf~~
~~[2] https://www.rbc.com/diversity-inclusion/_assets-custom/includes/pdf/Outsmarting_our_brains_Overcoming_hidden_biases.pdf~~

~~**Related information**~~

~~*Use of vendors for training on cultural competency, bias or inclusion.* If the organization contracts with a vendor to meet factor 1, it provides access to the vendor's documentation. NCQA does not consider the relationship to be delegation, and delegation oversight under *HE 7: Delegation of Health Equity Activities* is not required. NCQA evaluates the vendor's documentation against the requirements. Refer to "Vendors" in *Appendix 2: Automatic Credit.*~~

~~**Examples**~~ ~~***Factor 1:*** **Offers at least one training to all employees**~~

- ~~An email from the Human Resources department to all employees describing available trainings on culturally and linguistically appropriate practices, reducing bias or improving inclusion.~~
- ~~Screenshots of a training module in the organization's learning management or training system.~~
- ~~Providing trauma-informed care training to member-facing staff; provide training on reducing bias to all other staff members.~~

~~***Factor 2:*** **Reports on completion of training**~~

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

Element B: Trainings to Improve Care or Service Delivery *(NEW)*

At least annually, the organization offers training or education to all employees on:

1. **Culturally and linguistically appropriate practices.**
2. **Improving the impartiality of care or service delivery.**
3. **Reducing ableism in care or service delivery.**
4. **Respectful or non-stigmatizing data collection practices.**
5. **Trauma-informed care or service delivery.**

Scoring

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

Data source Reports, Materials

Scope of review *For All Surveys:* NCQA reviews reports or materials (e.g., slides, emails, screenshots, distributed training resources) as evidence that at least one training or education was offered to its entire staff at least annually.

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

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

At least annually, the organization offers training or education to all employees on at least one topic on improving the quality of health care services or the experience of members or patients.

Trainings may be general to all employees, or tailored for different types of roles (e.g., practitioners, customer service, digital design, financial, policy), as long as all employees are offered the opportunity to participate in training on the topic at least annually. The organization determines training type, format and timing. The organization may meet this requirement by providing one training that meets all the criteria outlined in factors 1–5, or may provide multiple trainings at its discretion.

NCQA reviews reports or materials as evidence that at least one training or education was offered to all employees at least annually. Training is not mandatory for employees, and the organization is not scored on the rate of employees who complete training.

***Factor 1:* Culturally and linguistically appropriate practices**

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

***Factor* 2: Improving the impartiality of care or services**

Organizations and practitioners may improve the impartiality of care when they intentionally seek to understand, acknowledge and overcome positive or negative associations, attitudes, preferences or stereotypes that influence their behavior and decisions. Associations, attitudes, preferences or stereotypes may be implicit (unconscious) or explicit (conscious).

***Factor 3:* Reducing ableism in care or services**

Ableism is a set of negatively biased beliefs and practices that assign a higher value or quality of life to a socially constructed idea of "normal" bodies or minds, and perpetuate the perception that the bodies or minds of people with disabilities should be "fixed" to align with "normal." [1] [2] [3]

***Factor 4:* Inclusive, non-stigmatizing or respectful data collection**

The organization provides at least one staff training or education focused on collecting member- or patient-level demographic data using methods designed to respect the responding individual and reduce the potential for stigmatization. The training focuses on at least one of the data types required in HE 2, Elements A–F.

***Factor 5:* Trauma-informed care practices**

The organization provides at least one staff training or education on trauma-informed practices for health care or service delivery, or organizational culture. **Trauma-informed care practices** seek to recognize, understand and respond to the signs, symptoms, impacts and risks of patients' traumatic life experiences on their health and well-being.

The organization determines the most relevant focus of training on trauma-informed care for its member or patient population (e.g., adverse childhood experiences, community violence, poverty, discrimination).

Exceptions

None.

Related information

Use of vendors for training or education. If the organization contracts with a vendor to meet factors 1–5, it provides access to the vendor's documentation. NCQA does not consider the relationship to be delegation, and delegation oversight under *HE 7: Delegation of Health Equity Activities* is not required. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors* in *Appendix 2: Automatic Credit.*

[1] https://www.ama-assn.org/system/files/health-equity-ableism-primer.pdf
[2] https://oadn.org/news/why-ableism-in-nursing-education-and-practice-matters/
[3] https://journals.healio.com/doi/10.3928/00220124-20240411-01

Examples

Factors 1–5

Focus areas of training/education

- Culturally and linguistically appropriate practices for recruiting practitioners, community health workers or advisory functions.
    - The US Department of Health and Human Services offers free continuing education programs to help health care professionals provide culturally competent care.
- Reducing ableism in user design (e.g., apps, websites, telehealth platforms, care encounter workflows).
- Trauma-informed practices for member- or patient-facing staff (e.g., data collection, care encounters, care navigation).
- Recognizing ableism in clinical decision-making policies, provision of care, decisions of resource allocation and investment, design of policies or workflows.

Materials demonstrating training/education offered

- An email from the Human Resources department to all staff, describing available trainings and how to access them.
- Screenshots of training module content in the organization's learning management or training system.
- PDFs of training content.

Reports demonstrating completion of training

- A report showing the number or percentage of staff who completed each offered training.

Element C: Incentivizing Medical Education for Practitioners *(NEW)*

The organization incentivizes or sponsors practitioners to complete medical education on the unique health or health care needs of:

1. **At least one racial, ethnic or cultural subgroup relevant to its member or patient population.**
2. **At least one gender or sexual orientation subgroup relevant to its member or patient population.**
3. **Patients with disabilities.**
4. **Patients in rural geographies.**

Scoring

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

Data source Reports, Materials

Scope of review *For All Surveys:* NCQA reviews materials or reports for evidence that the organization incentivizes or sponsors practitioners to complete medical education on the required topics, and reviews reports showing the percentage of practitioners in relevant specialties who completed training in the prior year.

Look-back period

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

Explanation

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

This element may not be delegated.

For factors 1–4, NCQA reviews materials or reports (e.g., slides, emails, screenshots) demonstrating that the organization either incentivizes or sponsors practitioners to complete medical education on the unique health or health care needs of:

- At least one racial, ethnic or cultural subgroup relevant to the organization’s member or patient population.
- At least one gender or sexual orientation subgroup relevant to its member or patient population.
- Patients with disabilities.
- Patients in rural geographies.

The organization determines the focus (e.g., subpopulation, type of health needs), types of relevant practitioner specialties (e.g., OB/GYN, endocrinology, primary care), and the timing of medical education (when it is offered, when it must be completed).

Medical education may also address a specific intersectional subgroup (e.g., LGBTQIA+ adults, pediatric patients with disabilities, mental health needs of rural men aged 65+).

NCQA also reviews reports showing the number of practitioners who completed medical education on each required topic during the prior year, represented as a total overall number or percentage of relevant practitioners. The organization is not scored on the rate of practitioners who complete training.

***Factor 1:* Relevant racial, ethnic or cultural subgroup**

The organization determines the focus (e.g., cultural subgroup, type of health care needs) of education offered to practitioners. The organization may use data collected in *HE 2: Collection of Member- or Patient-Level Data,* Element A to inform its educational offerings, but is not required to.

Health beliefs, behaviors and needs (e.g., social, cultural, linguistic) are influenced by cultural factors (e.g., race, ethnicity, religious affiliation, country of origin). Practitioners’ lack of knowledge about these beliefs, behaviors and needs—and strategies to understand and navigate related challenges—has implications for patients’ ability to achieve their best health. For example, a religious subgroup’s attitudes about modesty may impact no-show rates for surgical procedures or diagnostic exams.

***Factor 2:* Relevant gender or sexual orientation subgroup**

The organization determines the focus (i.e., subgroup, type of health care needs) of education offered to practitioners. The organization may use data collected in HE 2, Element C to inform its educational offerings, but is not required to.

***Factor 3:* Patients with disabilities**

The organization determines the focus (i.e., subgroup, type of health care needs) of education offered to practitioners. This may include education on health or the general health care needs of patients with disabilities, or may focus on one or more subgroups relevant to the organization's member or patient population.

The organization may use data collected in HE 2, Elements D or E to inform its educational offerings, but is not required to.

Health care organizations and practitioners have legal obligations to accommodate people with disabilities, but studies demonstrate that practitioners often have limited knowledge about the regulations with which they are obligated to comply. One study found that less than half of physicians feel "very confident" in their ability to provide the same quality of care to people with disabilities as to people without disabilities.

This lack of knowledge has implications for whether people with disabilities can easily access appropriate, timely and high-quality care. For example:

- A practitioner who has not received medical education on examining or treating people with disabilities, or who has not met federal obligations to make disability accommodations available, may:
    - Fail to appropriately diagnose patients, because health conditions may manifest differently for a person with a disability.
    - Seek to discharge an individual as a patient, exposing them to unlawful discrimination and excluding them from access to care.
- A practitioner who believes that a disability is a deficit from "normal" function or anatomy may dehumanize a patient with recommendations to "fix" their disability.
- A practitioner with misconceptions about the sexual or reproductive needs of people with disabilities may not offer appropriate or timely screenings (e.g., cervical cancer, HIV) and treatment or services (e.g., gynecological care, prenatal care, prescription contraception or prophylactics), or may overlook a relevant diagnosis (e.g., sexually transmitted infection).

***Factor 4:* Patients in rural geographies**

The organization determines the focus (i.e., subgroup, type of health care needs) of education offered to practitioners.

Exception

This element is scored NA for all surveys between July 1, 2026 and June 30, 2027.

Examples

***Factor 1:* Relevant racial, ethnic or cultural subgroups**

Examples of subgroup types

- Race.
- Ethnicity.
- National origin.
- Religion.

Examples of educational focus

- Attitudes about institutional trust, modesty, gender norms or family roles.

- Taboos or preferences for specific treatments, therapies or interventions (e.g., blood, medications, vaccines).
- Beliefs about health or healing.
- Behaviors related to faith, diet, adornment or dress.
- Trauma-informed care.

Factor 2: **Relevant gender or sexual orientation subgroup**

Examples of subgroup types

- Sexual orientation.
- Gender.
- Sex assigned at birth.
- Organ diversity or anatomical status.

Examples of educational focus

- Use of an anatomical inventory to guide effective and appropriate preventive health screenings (e.g., cervical cancer, depression) and clinical decision making.
- Culturally responsive care practices and terminology for reproductive health.
- Creating a welcoming care environment for LGBTQIA+ patients.
- Male preventive care.
- Attitudes about institutional trust among LGBTQIA+ patients.

Factor 3: **Populations with disabilities**

Examples of educational focus

- Diagnostic overshadowing.
- The history of ableism in the traditional medical model of treatment.
- Screening, examination, treatment or counseling for sexual or reproductive health needs for individuals with disabilities.
- Examination, counseling or treatment for patients with intellectual or cognitive disabilities.
- Use of physical accommodations during examination and treatment (e.g., height-adjustable exam table, transfer board, low stimulation environment).
- Examination, counseling or treatment for patients who use auxiliary aids/services to be understood (e.g., text-to-speech app, white board, picture board, voice amplifier).
- The role of designated support persons during examination, counseling and treatment.
- Attitudes about institutional trust among persons with disabilities.

Factor 4: **Patients in rural geographies**

- Assessing barriers to accessing care.

HE 2: Collection of Member- or Patient-Level ~~Race/Ethnicity, Language, Gender Identity and Sexual Orientation Data~~

~~The organization gathers individuals' race/ethnicity, language, gender identity and sexual orientation data using standardized methods.~~ The organization gathers member- or patient-level demographic data using standardized methods.

Intent

The organization collects information that helps it identify population-level disparities and provide patient-centered, culturally and linguistically appropriate ~~services (CLAS)~~ and accessible care or services.

Element ~~B~~A: Collection of Data on Race and ~~/~~Ethnicity

~~The organization's methods for assessing race/ethnicity of individuals includes~~: The organization's methods for evaluating member or patient race and ethnicity include:

1. **~~Direct collection of data from all individuals.~~ A process for collecting direct data from all members or patients.**
2. **Evidence of direct data collection.**
3. **~~Estimation of race/ethnicity using indirect methods, if the organization has direct data on less than 80% of individuals.~~ A process for estimating race and ethnicity using imputed methods, if the organization has collected direct data for less than 80% of members or patients.**

~~3~~4. ~~Validation of estimation methodology, if indirect methods are used.~~ A process for validating imputation or estimation methodology, if indirect data collection methods are used.

~~4~~5. A process ~~for rolling up~~ to map or aggregate race and ~~/~~ethnicity data to 2024 Office of Management and Budget (OMB) categories.

~~5~~6. Reporting the HEDIS *Race/Ethnicity ~~Diversity~~ Description of Membership* measure, if applicable.

Scoring

Met	Partially Met	Not Met
The organization meets ~~4-5~~ 5-6 factors	The organization meets ~~3~~4 factors	The organization meets 0-~~2~~3 factors

Data source Documented process, Reports, Materials

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:

For factors 1, 3, 4, 5: NCQA reviews the organization's documented process that was in place throughout the look-back period ~~for assessing the race/ethnicity of individuals, and reviews reports or materials demonstrating the data collection.~~

For factor ~~1~~2: NCQA reviews reports or materials demonstrating direct data collection.

For Initial Surveys: For factor ~~5~~6, NCQA reviews IDSS reports from the most recent HEDIS reporting year.

For Renewal Surveys: For factor ~~5~~6, NCQA reviews IDSS reports from the most recent and the prior HEDIS reporting year.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

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

***Factor 1:* Process for direct data collection ~~method and OMB categories~~**

The organization has a documented process (e.g., data collection scripts, workflow) for collecting direct data ~~from all members and patients~~ and demonstrates data collection through materials or reports.

Direct data collection ~~is asking individuals for information~~ describes methods that ask members or patients to self-disclose 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 "Declines to Answer" is considered direct data because the information 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 if a response was requested but not provided.
- When data will be collected.
- Where data will be collected (setting).
- How (i.e., method of collection) and by whom (e.g., case worker, patient portal, Member Services staff) data will be collected.
- Questions in the documented process that will be used to collect data, including a script to guide staff who collect or assess data verbally, when applicable.

~~An individual's response of "Declined" (i.e., "Asked but no Answer") or "Other" is considered direct data because it is collected from the individual.~~

The organization may receive, exchange or use data stored, collected or assessed by sources that have made a direct request for race/ethnicity information from members or patients ~~individuals who can be rolled up to the OMB categories~~, such as the Centers for Medicare & Medicaid Services (CMS), state or local agencies, community-based organizations, payers, Federally Qualified Health Centers, health systems, hospitals, integrated delivery systems, provider networks, electronic health records (EHR), health information exchanges (HIE) and case management systems. ~~If an individual is unable to provide a response to a direct request (e.g., due to age or functional inability to communicate), data collected from the individual's caregiver is considered direct data collection.~~

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

OMB categories. In 2024, the OMB released updates to the terminology, question format, reporting categories and response options for collecting data on race/ethnicity.[1] The OMB recommends that data be collected in a single-question format with a consolidated list of detailed response options for race and ethnicity, instructing patients or members to select one or more, as applicable to them. However, collection in a two-question format aligns with current electronic data standards.

The organization may offer a write-in field for each "Another group" response option, but is not required to.

2024 OMB single-question format (Select all that apply)

- American Indian or Alaska Native
    - Navajo Nation.
    - Blackfeet Tribe of the Black Indian Reservation of Montana.
    - Native Village of Barrow Inupiat Traditional Government.
    - Nome Eskimo Community.
    - Aztec.
    - Maya.
    - Another group (for example, Choctaw, Quechua, Aleut, etc.): __________.
- Asian
    - Chinese
    - Asian Indian
    - Filipino
    - Vietnamese
    - Korean
    - Japanese

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[1] https://spd15revision.gov/content/spd15revision/en/2024-spd15/question-format.html

  - Another group (for example, Pakistani, Hmong, Afghan, etc.): __________.
- Black or African American
  - African American
  - Jamaican
  - Haitian
  - Nigerian
  - Ethiopian
  - Somali
  - Another group (for example, Trinidadian and Tobagonian, Ghanian, Congolese, etc.): __________.
- Hispanic or Latino
  - Mexican
  - Puerto Rican
  - Salvadoran
  - Cuban
  - Dominican
  - Guatemalan
  - Another group (for example, Colombian, Honduran, Spaniard, etc.): __________.
- Middle Eastern or North African
  - Lebanese
  - Iranian
  - Egyptian
  - Syrian
  - Iraqi
  - Israeli
  - Another group (for example, Moroccan, Yemeni, Kurdish, etc.): __________.
- Native Hawaiian or Pacific Islander
  - Native Hawaiian
  - Samoan
  - Chamorro
  - Tongan
  - Fijian
  - Marshallese
  - Another group (for example, Chuukese, Palauan, Tahitian, etc.): __________.

- White
    - English
    - German
    - Irish
    - Italian
    - Polish
    - Scottish
    - Another group (for example, French, Swedish, Norwegian, etc.): __________.
- *(Other, please specify: ______)*
- *(Decline to answer)*

The organization’s framework must also include the ability to record when a response was requested but the individual has not yet provided a response distinct from “Decline to Answer” (i.e., the individual declines to share the information).

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

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

~~The organization must be able to report race/ethnicity using the OMB categories, including the response option of “Other.” While the OMB recommends a two-question format, asking for ethnicity before race, the organization may also use a combined format. In both cases, the NAM recommends that respondents be instructed to select one or more categories that may apply.[1] If the organization uses more detailed subcategories of race/ethnicity, it must have a consistent process to aggregate responses into the OMB categories.~~

~~*OMB two-question format*~~

- ~~Ethnicity~~
    - ~~Hispanic or Latino.~~
    - ~~Not Hispanic or Latino.~~
    - ~~(Declined).~~
- ~~Race (select one or more):~~
    - ~~Black or African American.~~
    - ~~Native Hawaiian or Other Pacific Islander.~~

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

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

***Factor 2:* Evidence of direct data collection**

The organization provides materials (e.g., surveys, questionnaires, data collection scripts) or reports as evidence that its data collection methods for race and ethnicity follow the documented process.

***Factor ~~2~~3:* ~~Estimation of race/ethnicity~~ Process for imputation of race and ethnicity**

The organization has a documented process ~~for~~ describing how it ~~estimates~~ imputes race and ~~/~~ethnicity using indirect estimation methods.

While direct collection of race and ethnicity is preferred to imputation, when directly collected member or patient data are not available, a common alternative is to estimate demographic information using a mixture of other patient-level details (e.g., surname) and community proxy, such as aggregated geographic-level data from national surveys or data sources like the U.S. Census Bureau. In this approach, community-level (e.g., census block, ZIP code) data may be used to attribute a characteristic to a patient who resides in a particular location. The National Quality Forum (NQF), for instance, supports organizations using proxy data from geocoding (using an individual's home address and alternate, nationally representative data sources such as the American Community survey to infer other information, including race/ethnicity), surname analysis (using an individual's last name to infer other information, including race/ethnicity) and Bayesian estimation when conducting community-level interventions.

Although imputed methods of race and ethnicity assignment have value in population-level estimates of disparities, they are inappropriate for individual-level interventions. Community-level data are subject to the ecological fallacy that an individual in a particular neighborhood may not match the overall attributes of that neighborhood. Allowing imputed data for reporting HEDIS stratifications recognizes these limitations. NCQA hopes that use of imputed methods will help health plans estimate disparities in care across their member or patient populations (when directly collected data are unavailable), but reiterates that these methods cannot be used to assume the characteristics of an individual patient, and are therefore inappropriate to inform individual member or patient care.

NCQA does not prescribe a specific estimation method.

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

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

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

Factor 4~~3~~: **Process for validation of ~~estimation~~ imputation method**

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

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

The organization also evaluates the reliability and validity of the indirect data sources and ~~estimation~~ imputation methods. ~~should be evaluated for reliability and validity, and~~ Selection of a source and method should be prioritized based on demonstrated validity and reliability for the population to which it will be applied (e.g., age group, geography, product line).

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

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

Geocoding and surname analysis methods are more accurate when used together, although accuracy varies by geographic region, area demographics and race/ethnic group.

NCQA does not prescribe a specific method.

***Factor 4 5:* ~~Roll up race/ethnicity~~ Process to map/aggregate data to 2024 OMB categories**

The organization has a documented process for ~~rolling up~~ mapping or aggregating its race and ~~/~~ ethnicity data categories to the OMB's 2024 categories. ~~The NAM recommends collecting detailed ethnicity data appropriate to the demographics of the local service area.~~

***Factor ~~5~~6:* Reporting the HEDIS ~~Diversity~~ Description of Membership measure**

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

Exceptions

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

Factors ~~2~~ 3 and ~~3~~ 4 are NA if the organization has non-missing direct data on the race and ethnicity for at least 80% of its population. NCQA defines missing data as "unknown" or blank responses. Responses of "Decline to answer" or "Choose not to provide" are included in the 80% count. The 80% may be cumulative of both race and ethnicity data.

~~a non-missing value of race and ethnicity for 80% or more of their population, cumulatively. Missing includes "unknown" and blank responses, but does not include "Decline" or "Choose not to provide" responses. has direct data on the race/ethnicity of 80% or more of individuals. 80% may be cumulative of each race and ethnicity. The organization is not required to have 80% of each to be eligible for the exception. For example, an organization is eligible for an exception if it has race data on 90% of its population, but only has ethnicity data on 70% of its population.~~

The organization may meet the 80% threshold at any point during the look-back period to qualify for this exception.

Factor 5 is NA for organizations that use the 2024 OMB race and ethnicity categories for factor 1.

Factor ~~5~~ 6 is NA for:

- Organizations that are not health plans.
- The Exchange product line.
- Health plans that are not NCQA Accredited or have not reported an initial HEDIS submission or have chosen not to report HEDIS because their membership is less than 15,000.

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

Related Information

OMB categories. The federal government uses the OMB's Race and Ethnic Standards for Federal Statistics and Administrative Reporting for record keeping, collection and presentation of data on race and Hispanic origin, and they form the basis for race/ethnicity data collection for many health care organizations.

In 2009, the National Academy of Medicine (NAM; formerly the Institute of Medicine) formed the Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement to identify models for collecting and coding race, ethnicity and language data and to make recommendations for improvement. The subcommittee recommended the use of OMB race/ethnicity categories for health care reporting.

Examples

Factor 1: Process for direct data collection

Data collection mechanisms ~~and OMB categories~~

- Enrollment forms~~,~~ (when not prohibited by state law).
- Patient intake or registration forms.
- The organization's website or patient portal.
- Surveys.
- Calls to Member Services.
- Population health management intake or programs involving enrollment or registration.
- Health assessments.
- Data feeds from a state Medicaid agency, immunization registries, or health information exchanges that directly collect~~s~~ race and ~~/~~ethnicity data, and that can be rolled up to OMB categories.

Data collection frameworks

HRET Toolkit.[2] The Health Research and Educational Trust (HRET) Toolkit, endorsed by the National Quality Forum (NQF), provides detailed instructions for direct data collection of race/ethnicity data and may serve as a guide for asking about race/ethnicity. The toolkit uses the OMB categories with additional options, including "Declined" and "Multiracial." ~~Although NCQA does not currently require organizations to follow NAM data collection recommendations, organizations are advised to add a response option for "Other (specify)" and to replace the "multiracial" response option with "Select all that apply."~~

USCDI.[3] The United States Core Data for Interoperability version 2 (USCDI v2), released by the U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology (ONC), is a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange. NCQA does not currently require organizations to follow the USCDI data collection categories, which are more granular than OMB categories.

Third-party sources of direct data

- Employers.
- State Medicaid agencies.

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

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

Element ~~C~~B: Collection of Data on Language

The organization's methods for ~~assessing~~ evaluating the language needs of ~~individuals~~ members or patients include~~s~~:

1. ~~Direct collection of language needs from all individuals.~~ A process for collecting direct data from all members or patients.
2. Evidence of direct data collection.
3. ~~Assessment of~~ Assessing the population's language profile at least every 3 years.
~~3~~4. ~~Determination of~~ Determining threshold languages at least every 3 years.
~~4~~5. ~~Determination of~~ Determining languages spoken by at least 1% of the population or 200 ~~individuals~~ members or patients, whichever is less, at least every 3 years.
~~5~~6. Reporting the HEDIS *Language ~~Diversity~~ Description of Membership* measure, if applicable.

Scoring

Met	Partially Met	Not Met
The organization meets ~~4-5~~ 5-6 factors	The organization meets ~~3~~4 factors	The organization meets 0~~-2~~ 3 factors

Data source Documented process, Reports, Materials

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:

- *For factor 1,* NCQA reviews the organization's documented process ~~for assessing the language needs of individuals that was~~ in place throughout the look-back period.
- *For factors ~~1~~2–4:* NCQA also reviews reports or materials demonstrating that the organization collected direct data on language, assessed ~~data collection and assessment of~~ the population's language~~s~~ profile, ~~including~~ and determined threshold languages and languages spoken by 1% (or 200) of ~~individuals~~ members or patients.

For Initial Surveys: For factor ~~5~~6, NCQA reviews audited HEDIS report from the most recent HEDIS reporting year.

For Renewal Surveys: For factor ~~5~~6, NCQA reviews audited HEDIS report from the most recent and the prior HEDIS reporting year.

Look-back period

For Initial Surveys: 6 months for factors 1, 2 and ~~5~~6; at least once during the prior 36 months for factors 3-5 ~~2, 3 and 4~~.

For Renewal Surveys: 24 months for factors 1, 2 and ~~5~~6; at least once during the prior 36 months for factors 3-5 ~~2, 3 and 4~~.

Explanation

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

***Factor 1:* ~~Direct data collection method~~ Process for direct data collection**

The organization has a documented process for collecting direct data (e.g., data collection scripts, workflow) from all members and patients. ~~and demonstrates data collection through materials or reports.~~

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

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

The organization may receive, exchange or use data stored, collected or assessed by sources that have made a direct request for language needs information from individuals, 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. 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.

The organization may use the NAM recommendations, NCQA's specifications for the HEDIS measure *Language Description of Membership* or another method to evaluate or document language needs ~~or may use another method of asking about language preference if it describes the process~~. The NAM recommends the use of two questions to determine language needs:

- *Spoken English Language Proficiency (Very well, Well, Not well, Not at all)*, with limited English proficiency (LEP) defined as "Less than very well."
- *Spoken Language Preferred for Health Care*, using locally relevant choices from a national standard list, plus a response option for "Other, please

specify," and including American Sign Language (ASL) in the spoken language need list.

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

Language Description of Membership requires collection of data on both written and spoken language preferences as separate values. In this data collection framework, Braille or large font/print are considered "written" language needs, and use of a sign language interpreter is considered "spoken" language.

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

Factor 2: **Evidence of direct data collection**

The organization provides materials (e.g., surveys, questionnaires, data collection scripts) or reports as evidence that the organization's data collection methods for member or patient language needs follow its documented process.

Factor ~~2~~3: **Assessing the population's language profile**

At least every 3 years, the organization uses state-level census or community-level data to determine the languages spoken in its service area, and assesses and reports on the language profile of the community, in order to anticipate and plan for changes in the language services it provides to its population. National organizations that do not operate in defined service areas may use national census data to determine their population language profile.

The organization may use language needs information about the community to plan for and improve its language services capabilities. Changing demographics may be more apparent at the community level than among the~~ individuals served by the organization or ~~organization's member or patient population; thus, language data on the service area could provide early notice to an organization that it will need to produce translations in new languages or make interpreters available for emerging language areas.

Factor ~~3~~4: **Threshold languages**

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

Factor ~~4~~5: **Determining languages spoken**

The organization uses census or community-level data to determine and report the languages spoken by 1% of the population in the service area, or by 200~~ individuals~~ members or patients, whichever is less, up to a maximum of 15 languages.

Notification about the availability of language services must be provided in threshold languages and in languages that serve at least 1% of the population or 200 individuals. Refer to *HE 3: Access and Availability of Language Services,* Element D.

The organization maintains a list of all languages spoken and updates the list at least every 3 years.

~~***Factor 6:* Reporting *Diversity of Membership***~~

***Factor 6:* Reporting HEDIS measure**

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

Exceptions

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

Factor ~~5~~6 is NA for:

- Organizations that are not health plans.
- The Exchange product line.
- Health plans that are not NCQA Accredited, or have not completed an initial submission of HEDIS.

Examples

Direct data collection mechanisms

- Enrollment form.
- Patient intake or registration forms.
- The organization’s website or patient portal.
- Surveys.
- Calls to Member Services.
- Population health management intake.
- Other programs involving enrollment or registration.
- Data collection scripts.

Third-party sources of direct data

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

Framework for asking about language

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

Language Description of Membership measure specifications in NCQA's HEDIS *Volume 2: Technical Specifications for Health Plans* (https://store.ncqa.org/hedis.html)

Sources of population-level language information

- U.S. Census data (https://data.census.gov/cedsci/table?q=B16001).
- Community surveys.
- School data on languages spoken by students.
- The Modern Language Association Language Map (http://www.mla.org/map_main).

~~Element D: Collection of Data on Gender Identity~~

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

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

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

~~Scoring~~

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

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

~~Scope of review~~

~~Product lines~~

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

~~Documentation~~

- ~~*For All Surveys:* NCQA reviews the organization's documented process in place throughout the look-back period.~~
- ~~*For factors 2–4:*~~ NCQA reviews reports or materials for evidence that the organization's data collection methods follow its documented process.

~~For Initial Surveys scheduled on or between July 1, 2024, and June 30, 2025, the organization may submit a detailed implementation plan including a timeline in place of reports or materials.~~

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

~~*For Renewal Surveys:* 12 months.~~

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

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

~~At a minimum, the organization describes its process for direct collection of gender identity data from adults 18 and older. If the organization collects gender identity data described in factors 1–4 from individuals younger than 18, it describes differences between the data collection framework for these individuals and the data collection framework for adults. For factors 2–4, the direct data collection framework includes, at a minimum:~~

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

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

~~The organization may receive, exchange or use data stored or collected by sources that have made a direct request for information regarding sex assigned at birth, gender identity and pronouns, such as CMS, state or local agencies, community-based organizations, Federally Qualified Health Centers, health systems, hospitals, integrated delivery systems, provider networks, EHRs, HIEs and case management systems.~~

~~For initial surveys scheduled on or between July 1, 2024, and June 30, 2025, if the organization completes an implementation plan in place of reports or materials, the plan must include:~~

- ~~A detailed description of the actions the organization will take to directly collect gender identity data, as outlined in factors 1–4, or receive gender identity data from other sources.~~
  - ~~If the organization plans to use data from other sources, it lists the entities from which data will be received and a description of the data exchange method.~~

- ~~A timeline for implementation of data collection activities.~~

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

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

~~At a minimum, the data collection method includes:~~

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

~~***Factor 2:*** **Direct collection of sex assigned at birth**~~

~~The organization demonstrates data collection through materials or reports. The data collection methodology includes:~~[1]

- ~~The following response options:~~
  - ~~Male.~~
  - ~~Female.~~
  - ~~Unknown.~~
  - ~~Choose not to disclose.~~
- ~~The ability to record when a response was requested but the individual has not yet provided a response (i.e., the information is unavailable), distinct from receiving one of the response options "Unknown" (i.e., the individual does not know) or "Choose not to disclose" (i.e., the individual declines to share the information).~~
- ~~A defined process for soliciting information from individuals when a response was requested but not provided.~~

~~***Factor 3:*** **Direct collection of gender identity**~~

~~The organization demonstrates data collection through materials or reports. The data collection methodology includes:~~[2]

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

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

~~The organization demonstrates data collection through materials or reports.~~

~~The organization's data collection methodology includes:~~

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

~~***Factor 5:* Sharing pronoun information**~~

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

~~**Exceptions**~~

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

~~This element is NA for all surveys through June 30, 2026.~~

~~**Related information**~~

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

~~The CDC[4] guidance on collecting sexual orientation and gender identity and the National Institute of Health: Sexual And Gender Minority Research Office[5] offer research on surveying and collecting, and highlight multiple studies on survey questions about collecting information on sexual orientation and gender identity.~~

[1] ~~https://www.healthit.gov/isa/uscdi-data-class/patient-demographicsinformation#uscdi-v3~~

[2] ~~https://www.healthit.gov/isa/uscdi-data-class/patient-demographicsinformation#uscdi-v3~~

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

[4] ~~https://dpcpsi.nih.gov/sgmro/measurement-and-data/surveys-and-measures~~

[5] ~~2022 NASEM Report | DPCPSI (nih.gov)~~

~~**Examples**~~

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

- ~~What are your pronouns?~~

  - ~~He/him; she/her; they/them; other (please specify).~~

Element ~~E~~C: Collection of Data on Sexual Orientation

The organization's methods for evaluating member or patient sexual orientation ~~framework for collecting sexual orientation information of individuals~~ includes:

1. **A method for collecting data in a way intended to avoid stigmatizing ~~that does not stigmatize~~ individuals.***
2. **A process for collecting direct data on sexual orientation. ~~Direct collection of data.~~**
3. **Evidence of direct data collection.**

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

Scoring

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

Data source

Documented process, Reports, Materials

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:

- For factors 1 and 2, NCQA reviews the organization's documented process in place throughout the look-back period.
- ~~And~~ For factor 3, NCQA reviews reports or materials for evidence that the organization's data collection methods follow its documented process.

~~*For Initial Surveys scheduled on or between July 1, 2024, and June 30, 2026*, the organization may submit a detailed implementation plan including a timeline in place of reports or materials.~~

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 ~~12~~ months.

Explanation

Factor 1 is a critical factor; if this critical factor is scored "No" the organization's element score cannot exceed "Not Met." ~~for the element.~~

Sexual orientation is defined as an inherent or immutable and enduring emotional, romantic or sexual attraction or non-attraction to individuals of the same and/or other genders.

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

At a minimum, the organization describes its process for the direct collection of sexual orientation data from adults 18 and older. If the organization collects sexual orientation data described in factors 1-3 ~~and 2~~ from ~~individuals~~ members or patients younger than 18 (children), it describes differences between its data collection framework for these ~~individuals~~ members or patients and its data collection framework for adults.

For factor 2, the 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 if a response was requested but not provided.
- When data will be collected.
- Where data will be collected (setting).
- How (~~i.e.,~~ method of collection) and by whom (e.g., case worker, member services staff) data will be collected.
- Questions that will be used to collect data, including a script to guide staff who collect or assess data verbally, when applicable.

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

The organization may receive, exchange or use data stored or collected by sources that have made a direct request for information regarding sexual orientation, 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.

~~For Initial Surveys scheduled on or between July 1, 2024, and June 30, 2025, if the organization completes an implementation plan in place of reports or materials, the plan includes:~~

- ~~A detailed description of the actions the organization will take to directly collect sexual orientation data, as outlined in factors 1 and 2, or receive sexual orientation data from other sources.~~
  - ~~If the organization plans to use data from other sources, it lists the entities from which data will be received and a description of the data exchange method.~~
- ~~A timeline for implementation of data collection activities.~~

***Factor 1:* Non-stigmatizing data collection ~~Collecting data through methods that do not stigmatize individuals~~**

~~The organization has a documented process that describes how the data collection method respects the responding individual and reduces the potential for~~

~~stigmatization (e.g., through electronic screeners, providing information on use of data, training staff).~~

Factor 2: Process for direct data collection

The organization has a documented process (e.g., data collection scripts, workflow) for collecting direct data on sexual orientation from all members or patients 18 years of age and older, including: ~~The organization demonstrates data collection through materials or reports. The data collection methodology includes:~~

- The following response options, at a minimum:[1]
  - Lesbian or gay or homosexual.
  - Straight or heterosexual.
  - Bisexual.
  - Something else, please describe.
  - Don't know.
  - Choose not to disclose.
- Additional options, as the organization deems appropriate.
- The ability to record when a response was requested but the member or patient ~~individual~~ has not yet provided a response (i.e., the information is unavailable), distinct from receiving one of the response options "Don't know" (i.e., the individual does not know) or "Choose not to disclose" (i.e., the individual declines to share the information).
- A defined process for soliciting information from individuals when a response was requested but not provided.

Factor 3: Evidence of direct data collection

The organization provides materials (e.g., surveys, questionnaires, data collection scripts) or reports as evidence that its data collection methods for sexual orientation follow the documented process.

Exceptions

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

Related information

The Office of the National Coordinator for Health Information Technology (ONC)[2] has guidance on vocabulary and terminology used across data standards and specifications. This guidance may assist organizations in making decisions about which response options to offer, either in lieu of or in addition to ~~the minimum~~ those ~~response options~~ required in factors 2 and 3.

The National LGBTQIA+ Health Education Center offers guidance on collection and documentation of sexual orientation data in EHRs.[3]

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

[1] https://www.healthit.gov/isa/taxonomy/term/2741/uscdi-v2
[2] https://www.healthit.gov/isa/section-i-vocabularycode-setterminology-standards-and-implementation-specifications
[3] https://www.lgbtqiahealtheducation.org/publication/ready-set-go-a-guide-for-collecting-data-on-sexual-orientation-and-gender-identity-2022-update/

Examples *Factor 1:* **Non-stigmatizing data collection**

- Use of electronic vs. staff-administered screeners.
- Trainings that give direction and information on respectful data collection methods and questions.
- Workflows or scripts that provide in-text context or direction on respectful data collection methods and questions.
- Co-design of the organization's data collection framework and workflows with individuals or organizations with relevant direct experience, knowledge or expertise.

Element D: Collection of Data on Disability Status *(NEW)*

The organization's methods for evaluating member or patient disability status include:

1. **Methods for collecting data in a way that is accessible to members or patients with intellectual, visual, and auditory disabilities.***
2. **A process for collecting direct data on disability function from all members or patients.**
3. **Evidence of direct data collection on disability function.**
4. **A process for collecting direct data on disability identity from all members or patients.**
5. **Evidence of direct data collection on disability identity.**
6. **A process for estimating disability status using imputed methods, if the organization has collected direct data for less than 80% of members or patients.**
7. **A process for validating imputation method, if indirect data collection methods are used.**
8. **Reporting the HEDIS measure *Description of Membership*, if applicable.**

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

Scoring

Met	Partially Met	Not Met
The organization meets 4-8 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source Documented process, Reports, Materials

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:

- *For factor 1:* A documented process or materials for evidence that the organization's data collection methods are designed to be accessible to people with intellectual, visual, and auditory disabilities.
- *For factors 2, 4, 6, 7:* The documented process in place throughout the look-back period.
- *For factors 3, 5*: Reports or materials demonstrating direct data collection.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, the organization may submit a detailed implementation plan, including a timeline, in place of all evidence for factors 1-7.

For Initial Surveys: For factor 8, NCQA reviews IDSS reports from the most recent HEDIS reporting year.

For Renewal Surveys: For factor 8, NCQA reviews IDSS reports from the most recent and the prior HEDIS reporting year.

Look-back period

For All Surveys: Prior to the survey date.

Explanation

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

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

Background on disability status

NCQA defines **disability status** as a social construct that describes the interaction between an individual's contextual factors (e.g., physical environment, sense of identity or self and perception by others) and functioning (e.g., body functions and structures, participation in major life activities or activities for daily living).

Disability status, and the contextual factors and functioning it is determined by, may be short-term, long-term or intermittent, driven by the individual's perception of self or by factors external to the individual, including the perception or attitudes of others (which may be positive or negative, and may change over time) and the presence of policies or availability of supports that may either enable or limit the individual's participation in their social or physical environment. Limitations or restrictions to participating in major life activities or activities for daily living (e.g., caring for oneself, seeing, walking, eating, concentrating, communicating) are a result of this interaction between contextual factors and the individual's functioning, not an intrinsic characteristic of the individual with a disability status.

NCQA's definition of disability status is intended to include, to the extent possible, all individuals who may face barriers to accessing appropriate, timely health care services, and who may experience disparities in health outcomes. This definition differs from those commonly used in federal regulations, and does not:

- Focus on impairment or inability to engage in work.
- Require that status be demonstrably consistent and lasting for a minimum length of time.
- Presume status results in or results from a medical condition.
- Require that individuals demonstrate, or be diagnosed by a practitioner as having, disability status.

- Describe a health condition or diagnosis, though people with disabilities may have one or more health conditions that limit or restrict participation.
- Describe a permanent state of disability.

Federal regulations have traditionally described disabilities in terms of a demonstrated impairment or inability to engage in work that is consistent, long-lasting and related to a medical condition or diagnosis. These criteria help determine an individual's eligibility for public benefits or services, including length of eligibility time, and whether an individual has experienced unlawful discrimination. They do not help identify health disparities that may impact an individual, regardless of their ability to work; supports to overcome functional limitations; age; health status; or disability identity (having/not having a disability).

Direct data collection framework

For factors 2 and 4, the direct data collection framework includes:

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

The organization's data collection framework should be designed to fit the population it serves, and may include response options that are more detailed than those required in factors 2 and 4 if the organization's documented process outlines how it maps or aggregates to those options.

The organization may receive, exchange or use data stored or collected by sources that have made a direct request for information regarding disability status such as 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.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, if the organization completes an implementation plan in place of a documented process, reports or materials, the plan must include:

- A detailed description of actions the organization will take to directly collect and indirectly estimate data on disability status, as outlined in factors 1–7, or to receive data on disability status from other sources.
  - If the organization plans to use data from other sources, it lists the entities from which data will be received and a description of the data exchange method.
- A timeline for implementation of required activities.

Factor 1: **Accessible methods of data collection**

The organization demonstrates, through a documented processes or materials, that its methods for collecting data on disability status are designed to be accessible to people with intellectual, visual and auditory disabilities. When something is **accessible,** it is designed to be reasonably easy to approach, reach, enter, speak with, use or understand.

The organization demonstrates, through a documented process or materials, that it takes action to make its data collection methods accessible to people with intellectual, visual and auditory disabilities.

Factor 2: **Process for direct data collection on disability function**

Disability function is an aspect of disability status that describes the relationship between an individual's body functions or structures and the presence or absence of difficulty participating in major life activities or activities for daily living. Functioning is independent of an individual's identity as a person with a disability; an individual that experiences difficulty with one or more areas of functioning may not identify as a person with a disability.

The organization has a documented process for direct collection of data on disability function for all patients or members that includes:

- The following response options:
  - Hearing.
  - Seeing (including when wearing glasses).
  - Concentrating, remembering or making decisions.
  - Walking or climbing stairs.
  - Dressing or bathing.
  - Completing errands alone.
  - Communicating.
  - Other difficulties when doing activities throughout your day, please describe: __________.
  - Don't know.
  - Choose not to disclose at this time.
- Additional options, as the organization deems appropriate.
- The ability to record when a response was requested but the individual answered "no" to all response options, or selected none of the listed response options (i.e., "no disability," the individual does not experience difficulty with any listed functions), distinct from receiving one response option "Don't know" or "Choose not to disclose at this time" (i.e., the individual declines to share the information).
- The ability to record when a response was requested but the individual has not yet provided a response (i.e., Asked But No Answer, the information is unavailable), distinct from receiving the response option "Don't know" or "Choose not to disclose" (i.e., "Choose not to disclose at this time," the individual declines to share the information).

- A defined process for soliciting information from patients when a response was requested but the individual has not yet provided a response (i.e., Asked But No Answer, the information is unavailable).

Factor 3: **Evidence of direct data collection on disability function**

The organization provides materials (e.g., surveys, questionnaires, data collection scripts) or reports as evidence that its data collection methods for disability function follow the documented process.

Factor 4: **Direct collection of data on disability identity**

Disability identity is an aspect of disability that describes an individual's sense of identity or self. Identity as a person with a disability is independent of functioning; an individual may identify as having a type of disability, but not currently have difficulty functioning if they have adequate supports.

The organization has a documented process for collecting data from all patients or members on their sense of identity or self as an individual with a disability. The data collection methodology includes the following two-question format and minimum response options:

- Do you identify as having a disability?
  - Yes.
  - No.
  - Choose not to disclose at this time.
- How would you describe your disability? (Mark all that apply)
  - AD/ADHD.
  - Autism/ASD.
  - Blind or low vision.
  - Cognitive disability.
  - Chemical dependency.
  - Deaf, deafblind or hard of hearing.
  - Intellectual disability.
  - Learning disability.
  - Mental health condition.
  - Mobility-related disability.
  - Physical disability.
  - Speech-related disability.
  - Traumatic brain injury.
  - Choose not to disclose at this time.
- The ability to record when a response was requested but the individual selected "no" to identifying as having a disability (i.e., the individual does not experience difficulty with any listed functions), distinct from "Choose not to disclose at this time" (i.e., the individual declines to share the information).
- The ability to record when a response was requested but the individual has not yet provided a response (i.e., the information is unavailable), distinct from "Choose not to disclose at this time" (i.e., the individual declines to share the information).

- A defined process for soliciting information from members or patients when a response was requested but not provided (i.e., Asked But No Answer, the information is unavailable).

Factor 5: **Evidence of direct data collection on disability identity**

The organization provides materials (e.g., surveys, questionnaires, data collection scripts) or reports as evidence that its data collection methods for disability identity follow the documented process.

Factor 6: **Process for imputation method**

The organization has a documented process for validating its imputation methods for member or patient disability status using indirect methods.

While direct collection of race and ethnicity is preferred to imputation, when directly collected member or patient data are not available, a common alternative is to identify demographic information using a proxy, such as:

- Data on enrollment status for state or federal programs (e.g., SSI, dual eligibility in Medicare and Medicaid, state HCBS waiver programs).
- Indirect data from claims or EHRs, such as diagnoses (e.g., ICD-10 codes) or services rendered (e.g., durable medical equipment like walkers or wheelchairs).
- Direct data on disability accommodations.

But although imputed methods of disability status have value in population-level estimates of disparities or in resource planning, they are inappropriate for individual-level interactions or interventions. NCQA hopes that use of imputed methods will help health plans estimate disparities in care across their patient populations (when directly collected data are unavailable), but reiterates that these methods cannot be used to assume the characteristics of an individual member or patient, and are therefore inappropriate to inform individual member or patient care.

NCQA does not prescribe a specific estimation method.

Factor 7: **Process for validation of imputation method**

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

The organization assesses the accuracy of the selected imputation method (e.g., calculates the sensitivity, specificity and positive predictive value of estimated disability status results, compared with self-reported data for a sample of individuals). The organization may refer to studies that report on the accuracy of imputed data for certain populations (e.g., age).

The organization also evaluates the reliability and validity of the indirect data sources and imputation methods. Selection of a source and method should be prioritized based on demonstrated validity and reliability for the population to which it will be applied (e.g., age group, product line).

Factor 8: **Reporting HEDIS measure**

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

Exceptions

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

Factors 6 and 7 are NA if the organization has direct data on the disability status of 80% or more members or patients. 80% may be cumulative of disability function and identity. The organization is not required to have 80% of disability function and identity to be eligible for the exception; for example, an organization may have disability identity data on 81% of its population and disability function data on 60% of its population. The organization may meet the 80% threshold at any point during the look-book to qualify for this exception.

Factor 8 is NA for:

- All surveys before June 30, 2027.
- Organizations that are not health plans.
- The Exchange product line.

Examples

Factor 1: **Collecting data through accessible methods**

Accessible data collection methods

- Using simple, easy to understand language.
- Digital written methods that are screen-reader friendly.
- Paper-based written methods that offer large font options.
- A digital collection interface that allows users to adjust font size or color contrast.
- Use of multiple formats or methods (e.g., verbal and written collection opportunities).
- A process or policy for using sign language interpreters to collect data.

Documentation of accessible data collection methods

- Screenshots showing accessible user functionality for digital collection methods.
- Slides from curricula or trainings received by staff who collect data.
- Workflows showing how staff who collect data are directed to use different formats or methods, or seek involvement of an interpreter, based on the patient's request.

Factor 2: **Direct collection of data on disability function**

The following question and response format, based on the American Community Survey and the Washington Group Short Set:

- Are you deaf or do you have serious difficulty hearing?
  - ○ Yes.
  - ○ No.
- Are you blind or do you have serious difficulty seeing, even when wearing glasses?

    - Yes.
    - No.
  - Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
    - Yes.
    - No.
  - Do you have serious difficulty walking or climbing stairs?
    - Yes.
    - No.
  - Do you have difficulty dressing or bathing?
    - Yes.
    - No.
  - Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
    - Yes.
    - No.
  - Using your usual language, do you have difficulty communicating, for example, understanding or being understood?
    - Yes.
    - No.

The following question and response format, based on the Demographic Data Element Modernization (DEMo) Initiative:

Do you currently have difficulty with any of the following? Check all that apply.

- Hearing.
- Seeing, even when wearing glasses.
- Concentrating, remembering or making decisions.
- Walking or climbing stairs.
- Dressing or bathing.
- Cooking for oneself.
- Feeding oneself.
- Using the toilet.
- Doing errands alone, such as shopping or visiting a doctor's office.
- Communicating or being understood using your usual language.
- Understanding when someone speaks in your usual language.
- Other difficulties when doing activities throughout your day (please describe).
- Don't know.
- Choose not to respond at this time.

Element E: Collection of Data on Disability-Related Accommodations *(NEW)*

The organization's methods for assessing disability-related accommodation needs include:

1. **Methods for collecting data in a way that is accessible to patients with intellectual, visual, and auditory disabilities.***
2. **A process for collecting direct data on needed physical accommodations from all patients.**
3. **Evidence of direct data collection on physical accommodations.**
4. **A process for collecting direct data on needed auxiliary aids or services from all patients.**
5. **Evidence of direct data collection on needed auxiliary aids or services.**

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

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

Product lines

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

Documentation

For All Surveys: NCQA reviews:

- *For factor 1:* Documented processes or materials for evidence that the organization's data collection methods are designed to be accessible to people with intellectual, visual, and auditory disabilities.
- *For factors 2, 4:* The organization's documented process in place throughout the look-back period.
- *For factors 3, 5:* Reports or materials demonstrating direct data collection.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, the organization may submit a detailed implementation plan, including a timeline, in place of evidence for factors 1-5.

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

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

Physical disability accommodations in health care settings are modifications or adjustments to physical workflows, practices, procedures, equipment, staffing, functionality or environment that enable patients with disabilities to access and participate in the same experiences and services as patients who do not have disabilities, with the same level of quality and ease. Physical accommodations may include provision of supports (e.g., adjustable equipment, communication devices), involvement of additional participants (e.g., interpreters, support persons), flexible workflows or policies (e.g., examination process, appointment times or timing) or adjustments to functionality or use (e.g., magnification, font size, closed captioning).[2]

Auxiliary aids or services refer to supports that enable patients with disabilities to communicate, understand or be understood as effectively as patients without disabilities.

Though it is voluntary for patients to report whether they need disability-related accommodations or auxiliary aids/services for health care encounters, the organization must attempt to collect it. The organization may collect data directly at various points of interaction with patients and through multiple mechanisms. The organization should use as many channels as available to collect this information from individuals.

For factors 2 and 4, the direct data collection framework includes:

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

The organization's data collection framework should be designed to fit the population it serves, and may include response options that are more detailed than those required in factors 2 and 4 if the organization's documented process outlines how it maps or aggregates to those options.

The organization may receive, exchange or use data stored or collected by sources that have made a direct request for information regarding disability status 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.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, if the organization completes an implementation plan in place of a documented process, reports or materials, the plan must include:

- A detailed description of actions the organization will take to directly collect data on physical accommodations and auxiliary aids/services needed for health care encounters, as outlined in factors 1, 2 and 4, or receive data from other sources.
  - If the organization plans to use data from other sources, it lists the entities from which data will be received and a description of the data exchange method.
- A timeline for implementation of required activities.

***Factor 1:* Accessible data collection methods**

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[2] https://adata.org/factsheet/health-care-and-ada

The organization demonstrates, through documented processes or reports, that its methods for collecting data on disability status are designed to be accessible to people with intellectual, visual and auditory disabilities.

Factor 2: **Process for direct data collection of physical accommodations**

The organization has a documented process for direct collection of data on physical disability accommodations needed for health care encounters. The data collection methodology includes:

- A list of physical disability accommodations the organization is able to routinely provide to patients for health care encounters, upon request.
  - The organization lists only accommodations that it can readily or routinely provide when requested in advance of planned health care encounters.
  - Patients should be instructed to select all response options that apply.
- The following response options:
  - Height-adjustable exam tables or exam chairs.
  - Accessible weight scales or weight measurement equipment.
  - Accessible diagnostic equipment.
  - Use of a designated support person.
  - Use of a service animal.
  - Choose not to disclose at this time.
- Additional options, as the organization deems appropriate.
- The ability to record when a response was requested but the individual marked none of the listed response options (i.e., the individual does not need a disability accommodation for care), distinct from "Choose not to disclose" at this time" (i.e., the individual declines to share the information).
- The ability to record when a response was requested but the individual has not yet provided a response (i.e., Asked But No Answer, the information is unavailable), distinct from the response option "Choose not to disclose" at this time" (i.e., the individual declines to share the information at this time).
- A defined process for soliciting information from patients when a response was requested but the individual has not yet provided a response (i.e., Asked But No Answer, the information is unavailable).

Factor 3: **Evidence of direct data collection on physical accommodations**

The organization provides materials (e.g., surveys, questionnaires, data collection scripts) or reports as evidence that its data collection methods for physical disability accommodations follow the documented process.

Factor 4: **Direct data collection on communication auxiliary aids or services**

The organization has a documented process for direct collection of data on patients' needed auxiliary aids or services.

The ADA requires that title II entities (state and local governments) and title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with individuals who have communication-related disabilities, with the goal of ensuring that communication with people with these disabilities is equally effective as communication with people who do not have disabilities.[3]

Data on needed auxiliary aids or services may be collected simultaneous to, or independent of, data on language needs (*HE 2: Collection of Member- or Patient-Level Data, Element B).* If these data are collected in a single, combined question, the organization instructs patients to select all response options that apply.

The data collection methodology includes:

- A list of auxiliary aids or services the organization is able to provide to patients, upon request.
  - The organization should not list auxiliary aids or services that it can readily or routinely provide when requested in advance of planned patient interactions.
  - Patients should be instructed to select all response options that apply.
- The following response options, at minimum:
  - Sign language interpreter: ___________ (e.g., American Sign Language).
  - Qualified reader or oral interpreter.
  - Cued-speech interpreter.
  - Qualified notetaker.
  - Braille.
  - Large print or font.
  - Magnifier or magnification.
  - Qualified speech-to-speech transliterator.
  - Communication board (e.g., word board, picture board, letter board, dry erase board).
  - Choose not to disclose at this time.
- Additional options, as the organization deems appropriate.
- The ability to record when a response was requested but the individual selected none of the listed response options (i.e., the individual does not need a disability accommodation for communication), distinct from “Choose not to disclose at this time” (i.e., the individual declines to share the information).
- The ability to record when a response was requested but the individual has not yet provided a response (i.e., Asked But No Answer, the information is unavailable), distinct from the response option “Choose not to disclose at this time” (i.e., the individual declines to share the information at this time).
- A defined process for soliciting information from patients when a response was requested but the individual has not yet provided a response (i.e., Asked But No Answer, the information is unavailable).

Factor 5: **Evidence of direct data collection**

The organization provides materials (e.g., surveys, questionnaires, data collection scripts) or reports as evidence that its data collection methods for auxiliary aids or services follow the documented process.

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[3] https://www.ada.gov/resources/effective-communication/

Exceptions

This element is NA for organizations that are contractually prohibited from directly communicating with members or patients.

Factors 2 and 3 are NA for organizations that do not provide in-person health care services or case management.

Factors 4 and 5 are NA for organizations that do not provide synchronous health care services or case management.

Examples

***Factor 1:* Collecting data through accessible methods**

Accessible data collection methods

- Using simple, easy to understand language.
- Digital written methods that are screen-reader friendly.
- Digital or paper-based written methods that offer large font options.
- Use of multiple formats or methods (e.g., verbal and written collection opportunities).
- Policy for using sign language interpreters to collect data from individuals who have deafness or are hard of hearing.

Documentation for accessible data collection methods

- Screenshots showing accessible user functionality for digital collection methods.
- Slides from curricula or trainings received by staff who collect data.
- Workflows showing how staff who collect data are directed to use different formats or methods, or seek involvement of an interpreter, based on the patient's abilities.

***Factor 2:* Direct collection of data on physical accommodations**

- Appointment times.
  - Late in the day, when there are fewer people in the waiting area (e.g., for patients who are immunocompromised or have sensory, cognitive, behavioral or emotional disabilities).
  - Longer appointment times, to accommodate use of disability accommodations (e.g., interpreter, listening assistive devices, accessible equipment, transfer table, staff support changing clothes) and in-facility travel time.
  - Flexible arrival times, to accommodate patients who use public transportation.
- Waiting or exam room with a low stimulation environment (e.g., low noise, light and odor).
- Sensory items (e.g., noise-cancelling headphones, sensory fidgets, sunglasses).
- Transfer board.
- Lift (Hoyer or ceiling track).
- Wheelchair.
- Bariatric wheelchair or bed.

- Support staff (e.g., for help with written forms, using kiosks, pushing wheelchair, positioning on exam tables or other surfaces, room orientation).

Factor 4: **Direct collection of auxiliary aids and services for communication**

- Closed captioning for telemedicine platforms or apps.
- Written material formats, electronic or print (e.g., use of picture format, plain language, audio recordings, large print or font, Braille).
- Magnifiers or magnification digital functionality.
- Picture schedules and social stories.
- Use of a qualified reader, in-person or through video remote interpreting.
- Communication Access Realtime Translation (CART).
- Assistive listening devices (e.g., sound amplification devices, voice amplifiers, portable hearing loops, text-to-speech apps, speech-to-text apps, open and closed captioning, closed caption decoders).
- Clear masks.
- Signature guides.

Element F: Classification of Geographic Data *(NEW)*

The organization's methods for evaluating the geographic classification of members or patients include:

1. **A process for collecting direct ZIP code data from all members or patients.**
2. **Evidence of direct ZIP code data collection.**
3. **A process to determine geographic classification for all members or patients.**
4. **Evidence of determining geographic classifications.**

Scoring

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

Data source Documented process, Reports, Materials

Scope of review *Product Lines*

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

For All Surveys:

- *For factors 1, 3:* NCQA reviews the organization's documented process in place throughout the look-back period.
- *For factors 2, 4:* NCQA reviews materials or reports as evidence that the organization follows its documented process.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, the organization may submit a detailed implementation plan that includes a timeline in place of evidence for factor 3.

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

Explanation ***Factor 1:* Process for direct data collection**

The organization has a documented process (e.g., data collection scripts) for collecting direct data on the most recent 5-digit residential ZIP code of all members/patients that describes:

- How the organization directly collects data on the residential ZIP code of all members/patients.
- How the organization determines the most recent residential ZIP code (e.g., use of effective dates for addresses, data hierarchy rules).
- How the organization documents ZIP code type (e.g., residential, mailing).
- How the organization estimates the most recent residential ZIP code using other geographic information (e.g., mailing address, city, county), when applicable.

The direct data collection framework also includes:

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

The organization may receive, exchange or use data stored, collected or assessed by sources that have made a direct request for ZIP code data from individuals, 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. If an individual is unable to provide a response to a direct request, data collected from the individual's caregiver is considered direct data collection.

***Factor 2:* Evidence of direct data collection**

The organization provides materials or reports (e.g., surveys, questionnaires, data collection scripts, enrollment files) as evidence that its data collection methods for ZIP code information follow the documented process.

***Factor 3:* Process for geographic classification**

The organization has a documented process for determining the geographic classification (e.g., rural, metropolitan, small town, urban) for each member or patient based on their 5-digit ZIP code. The organization's framework must include at least three geographic classifications, determined by the organization.

Its design must be relevant to the organization’s member or patient population, and must facilitate meaningful comparison.

RUCA Codes. The organization may use the USDA Economic Research Service’s Rural-Urban Commuting Area (RUCA) codes[4] to select or map 5-digit ZIP codes to relevant geographic classifications. The USDA’s RUCA codes classify US census tracts using measures of population density, urbanization and daily commuting. This framework offers a standardized and widely accepted method for geographic classification that provides more detailed insights on geographic relationships and patterns than at the county level. The USDA recommends that 5-digit ZIP codes be mapped to a primary RUCA code. The organization may use the USDA’s granular list of 10 primary RUCA codes, or collapse or aggregate them to correspond with the organization’s sample size or population.

If the organization uses a method other than RUCA codes, it describes its methodology for determining geographic classification based on member or patient ZIP code.

***Factor 4:* Evidence of geographic classification**

The organization provides materials or reports as evidence that its geographic classification methods follow the documented process.

Exceptions

None.

Examples ***Factors 3, 4***

RUCA Code		Patient %	Geographic Classification	Patient %
1	Metropolitan, core	60.5	Metropolitan, core	60.5
2	Metropolitan, high commuting	20.1	Metropolitan, high commuting	20.1
3	Metropolitan, low commuting	10.7	Metropolitan, low commuting	10.7
4	Micropolitan, core	3.4	Other	8.7
5	Micropolitan, high commuting	1.2		
6	Micropolitan, low commuting	3.0		
7	Small town, core	0.5		
8	Small town, high commuting	0.4		
9	Small town, low commuting	0.2		

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[4] https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/documentation

10	Rural areas	0.0		

RUCA Code		**Patient %**	**Geographic Classification**	**Patient %**
1	Metropolitan, core	12.0	Metropolitan	29.4
2	Metropolitan, high commuting	8.4		
3	Metropolitan, low commuting	9.0		
4	Micropolitan, core	14.6	Micropolitan	21.8
5	Micropolitan, high commuting	5.2		
6	Micropolitan, low commuting	2.3		
7	Small town, core	11.5	Small town	29.1
8	Small town, high commuting	7.4		
9	Small town, low commuting	10.2		
10	Rural areas	19.4	Rural	19.4

RUCA Code		**Patient %**	**Geographic Classification**	**Patient %**
1	Metropolitan, core	32.0	Urban	38.0
2	Metropolitan, high commuting	2.4		
3	Metropolitan, low commuting	3.6		
4	Micropolitan, core	4.0	Suburban	11.1
5	Micropolitan, high commuting	5.2		
6	Micropolitan, low commuting	1.9		
7	Small town, core	1.0	Rural	50.9
8	Small town, high commuting	7.2		
9	Small town, low commuting	3.3		

10	Rural areas	39.4		

Element ~~A~~G: Systems for ~~Individual~~ Member- or Patient-Level Data

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

1. Race/ethnicity.
2. Language.
~~3. Gender identity.~~
~~4~~3. Sexual orientation.
4. Disability function.
5. Disability identity.
6. Needed physical accommodations.
7. Needed auxiliary aids or services.
8. Geographic classification.

Scoring

Met	Partially Met	Not Met
The organization meets ~~3-4~~ 4-8 factors	The organization meets 2-3 factors	The organization meets 0-1factors

Data source Documented process, Reports, Materials

Scope of review

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

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

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, the organization may submit a detailed implementation plan that includes a timeline in place of evidence for factors 4–8.

Look-back period

For ~~Initial~~ All Surveys: 6 months for factors 1–3; prior to the survey date for factors 4–8.

~~*For Renewal Surveys:* 12 months.~~

Explanation

This element may not be delegated.

Receiving, storing and retrieving data

For factors 1–8, the organization has a documented process describing how its electronic database receives, stores and retrieves member- or patient-level data. The process outlines data source for each data type and, if the organization receives data from multiple sources, describes its process for reconciling differences or conflicts between data (how the organization decides which data source to select or prioritize when two or more data sources contain conflicting information).

The organization demonstrates, through materials or reports, that it follows its documented process for each data type described in factors 1–9. NCQA also reviews materials (e.g., screenshots) or reports for evidence of the electronic data system's configuration.

Factors 1–4 8: ~~**Receiving, storing and retrieving data**~~

The organization's electronic database receives, stores and retrieves member- or patient-level data as specified in HE 2, Elements A–G, including responses when a member or patient responds that they choose not to disclose data.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, if the organization submits an implementation plan in place of required evidence for factors 4–8, the plan must include:

- A detailed description of actions the organization will take to update its electronic data systems to receive, store and retrieve data specified in factors 4–8, including an outline of each electronic data system that must be updated.
    - If the organization plans to use data from other sources, it lists the entities that will provide data, and describes the data exchange method.
- A timeline for implementation of electronic data system functionality to receive, store and retrieve required data.

~~The organization has a documented process for outlining its data source(s) and maintaining electronic database(s) that receive, store and retrieve the data in factors 1–49. For each factor, the organization collects data at the individual level through direct or indirect data collection as specified in Elements B–E. The organization's documented process outlines how its database receives, stores and retrieves responses for factors 1–4 9when an individual responds that they choose not to disclose the data.~~

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

~~The organization provides evidence that it follows its documented process for each data type in factors 1–49.~~

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

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

~~For Initial Surveys scheduled on or between July 1, 2024, and June 30, 2025, if the organization completes an implementation plan in place of reports or materials for evidence of factors 3 and 4, the plan must include:~~

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

- ~~A timeline for implementation of electronic data system functionality to receive, store and retrieve gender identity and sexual orientation data.~~

Exceptions

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

Related information

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

Examples **Reconciling, selecting or prioritizing data**

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

Element ~~F~~H: Privacy Protections for Demographic Data

The organization has policies and procedures for managing physical and electronic access to and permissible/impermissible use of the following data ~~race/ethnicity, language, gender identity and sexual orientation data, including:~~

1. ~~**Controls for physical and electronic access to the data.**~~
2. ~~**Permissible use of the data.**~~
3. ~~**Impermissible use of the data, including underwriting and denial of coverage and benefits.**~~
1. **Race and ethnicity data.**
2. **Language data.**
3. **Sexual orientation data.**
4. **Disability status data, including function and identity.**
5. **Needed physical accommodations and auxiliary aids.**

Scoring

Met	Partially Met	Not Met
The organization meets ~~3~~ 4-5 factors	~~No scoring option~~ The organization meets 2-3 factors	The organization meets 0-~~2~~1 factors

Data source Documented process

Scope of review

For All Surveys: NCQA reviews the organization's policies and procedures in place throughout the look-back period for managing access to and use of ~~race/ethnicity, language, gender identity and sexual orientation~~ data.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, in lieu of materials, the organization may submit a detailed implementation plan that includes a timeline for updating its policies and procedures for factors 4-5.

Look-back period

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

Explanation

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

The organization's policies and procedures for managing access to and use of ~~race/ethnicity, language, gender identity and sexual orientation~~ the demographic data described in factors 1–5 may be integrated with its HIPAA privacy policies or may be separate. If the organization's privacy policies are intended to include ~~race/ethnicity, language, gender identity and sexual orientation information~~ these data in addition to HIPAA-defined PHI, this must be explicitly stated.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, if the organization completes an implementation plan in place of materials for notification of policies and procedures for factors 4–5, the plan must include:

- A detailed description of the actions the organization will take to update its notification~~s~~ for managing access to and use of these data.
- Draft language of the notification.
- A timeline for notifying individuals served by the organization.

Factors 1-5

Access to data

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

The organization's policies and procedures address:

- Types of media used, as applicable, including:
  1. Diskettes, CDs, tapes and mobile applications.
  2. Portable drives.
  3. Laptops.
  4. Secure portals.
- Devices and hardware movement.
- Data storage, including physical and cloud servers.

- Disposal and reuse of media and devices.

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

~~Factors 2, 3:~~ Permissible and impermissible uses

The organization outlines permissible and impermissible uses of the data. Impermissible use explicitly includes underwriting and denial of services, coverage and benefits, if applicable to the organization's operations.

The organization is not required to address underwriting for the Medicaid product line.

~~For Factor 3, Impermissible use of data, “including underwriting and denial of coverage and benefits” refers to when use of data for this purpose is contrary or not allowable according to state or federal law.~~

Exceptions

~~This element will be scored without evidence of gender identity for all surveys through June 30, 2026.~~ None.

Examples

Factors 1-5

Data access control

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

~~Factor 2:~~ Permissible uses of data

- Assess health care disparities using aggregate, population-level information.
- Design intervention programs using aggregate, population-level information.
- Design and direct outreach materials to align with the overall membership’s cultural, linguistic or accessibility-related needs.
- Inform health care practitioners and providers about individual patients’ language needs, or needed auxiliary aids/services ~~and pronouns~~.
- Provide appropriate and responsive clinical care.

~~Factor 3:~~ Impermissible uses of data

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

Element ~~G~~I: Notification of Demographic Data Privacy Protections

When the organization collects data from ~~individuals~~ members or patients, it ~~discloses its policies and procedures for managing access to and use of race/ethnicity, language, gender identity and sexual orientation data, including~~ communicates how it manages physical and electronic access to and permissible/impermissible use of data, including:

~~1. Controls for physical and electronic access to the data.~~
~~2. Permissible use of the data.~~
~~3. Impermissible use of the data, including underwriting and denial of coverage and benefits.~~
1. Race and ethnicity data.
2. Language data.
3. Sexual orientation data.
4. Disability status data, including function and identity.
5. Needed physical accommodations and auxiliary aids.

Scoring

Met	Partially Met	Not Met
The organization meets 4-5 factors ~~The organization meets 3 factors~~	The organization meets 2-3 factors ~~No scoring option~~	The organization meets 0-1 factors ~~The organization meets 0-2 factors~~

Data source Documented process, Materials

Scope of review

For All Surveys: NCQA reviews materials as evidence that the organization disclosed the organization's demographic data policies and procedures to members or patients ~~for managing access to and use of race/ethnicity, language, gender identity and sexual orientation data~~ during the look-back period.

For ~~Initial Surveys~~ all surveys scheduled on or between July 1, ~~2024~~ 2026, and June 30, ~~2026~~ 2027, in lieu of submitting reports or materials, the organization may submit a detailed implementation plan that includes a timeline for notifying individuals of its policies and procedures for ~~managing access to and use of gender identity and sexual orientation data~~ factors 4-5.

Look-back period

For ~~Initial~~ All Surveys: ~~6 months~~ Prior to the survey date.
~~*For Renewal Surveys:* 2412 months.~~

Explanation

Factors 1–5

Disclosure to individuals

~~The organization communicates to individuals its policies for use and protection of individuals' race/ethnicity, language, gender identity and sexual orientation information, including whether such information will be shared with practitioners and providers. The communication does not have to include the organization's full policies and procedures. The organization may summarize in communication how it operationalizes factors 1–3.~~

~~At a minimum, communication must be made when data are collected directly, and the information may be provided in additional communications the organization deems appropriate.~~

~~For Initial Surveys scheduled on or between July 1, 2024, and June 30, 2025, if the organization completes an implementation plan in place of materials for notification of policies and procedures for managing access to and use of gender identity and sexual orientation data, the plan must include:~~

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

The organization communicates to members or patients its policies for managing access to and use of the demographic data described in factors 1–5, including whether such information will be shared with practitioners, providers and state or public health agencies. The communication is not required to include the organization's full policies and procedures. The organization may summarize in concise, member/patient-friendly language how it operationalizes data access and use for factors 1–5.

At a minimum, communication must be made when members or patients are asked to self-disclose data, and the information may be provided in additional communications the organization deems appropriate.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, if the organization completes an implementation plan in place of materials for notification of policies and procedures for factors 4–5, the plan must include:

- A detailed description of the actions the organization will take to update its notifications for managing access to and use of these data.
- Draft language of the notification.
- A timeline for notifying individuals served by the organization.

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

~~The organization communicates to individuals its permissible and impermissible use of the data. Impermissible use includes underwriting and denial of services, coverage and benefits, if applicable to the organization's operations.~~

~~The organization is not required to address underwriting for the Medicaid product line. For factor 3, Impermissible use of data, "including underwriting and denial of coverage and benefits" refers to when use of data for this purpose is contrary or not allowable according to state or federal law.~~

Exceptions

~~This element will be scored without evidence of gender identity for all surveys through June 30, 2026.~~ None.

Related information

Use of vendors/mail service organizations for notification of privacy protections. If the organization contracts with a mail service organization to provide distribution services, it provides access to the mail service organization's documentation for evaluation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under *HE 7:Delegation.* Refer to *Vendors* in *Appendix 2: Delegation and Automatic Credit Guidelines.*

Examples

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

HE 3: Access and Availability of Language Services

The organization provides ~~materials~~ information and services in the languages its members or patients understand.~~ of individuals.~~

Intent

The organization communicates effectively with ~~individuals~~ members or patients, regardless of their language preferences or needs.

Element A: Written Documents

The organization ~~provides~~ has a process for providing written vital information ~~in threshold languages~~ that includes~~:~~

1. Use of competent translators.
2. Translation of information into threshold languages.
3. Translation of information into Braille and large print.
4. Specification of when sight translation (oral interpretation) or written information will be provided.
~~2.~~5. A mechanism for providing translations in a timely manner.
~~3. Specifying when translations will be written and when sight translation (oral interpretation) of written information will be provided.~~
~~4.~~6. ~~A mechanism for evaluating the quality of the translation~~. Evaluation of translation quality.

Scoring

Met	Partially Met	Not Met
The organization meets ~~2-4~~3-6 factors	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: For factors 1—6, NCQA reviews the organization's documented process in place during the look-back period for providing vital information in threshold languages~~,~~ and in accessible formats, and by oral translation, in a timely manner.

For factors 1,2, 5, 6, NCQA also reviews reports or materials demonstrating that the organization follows its documented process.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months for factors 1, 4, 5 and 6; 6 months for factors 2 and 3.

Explanation

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

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

- Information about eligibility for services and participation criteria.
- Information about how to use and access the organization's services. ~~and how to access services.~~

- Templates of notices pertaining to changes in service.

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

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

For organizations that deliver clinical or behavioral healthcare, in-person or virtually, vital information also includes, but is not limited to:

- Consent forms.
- Information about patient rights.
- Health history forms.
- Patient-facing instructions (e.g., medication, preparation for procedures, pre-appointment, discharge, financial assistance).
- Information about estimated or actual costs.

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

Use of contracted translation services is not considered delegation.

Factor 1: **Translator competence**

A high-quality translation is performed by a competent translator who ~~has proficiency~~ is proficient in the source and target languages. Whether the organization uses internal translators or contracts with a vendor to translate documents, it must have a mechanism to assess the competency of the translator, or procure competent translation services.

- *If the organization uses internal translation services (written or sight translation),* NCQA reviews the organization's documented process for assessing translator competency, including an evaluation of proficiency in the source and target languages, and reviews evidence that the organization followed its documented process.
- *If the organization uses external translation services,* NCQA reviews materials or reports as evidence of the external translator's competency (e.g., contract describing the vendor's competency assessment process, professional certificates).

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

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

***Factor 2:* Threshold languages**

The organization has a documented process for translating written vital information into threshold languages, and provides materials or reports demonstrating it followed the process.

***Factor 3:* Braille and large print**

The organization has a documented process for translating written vital information into Braille and large print, and provides materials or reports demonstrating it followed the process.

~~***Factor 2:* Timeliness of translations**~~

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

***Factor ~~3~~4:* Oral and written interpretation**

The organization's documented process must specify when translations will be written and when sight translation (oral interpretation) of written information will be provided. This process must address the circumstances in which oral interpretation (sight translation) is provided in place of written translation.

***Factor 5:* Timeliness of translations**

The organization has a documented process for making translated vital information available in a timely manner, in languages or formats other than English, including Braille and large print. The process specifies request turnaround times, and ~~it~~ may differentiate turnaround times for different information and for translations into more commonly requested languages and less commonly requested languages.

***Factor ~~4~~6:* ~~Evaluating the quality of the translation~~ Translation quality**

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

The ~~At a minimum, the evaluation~~ ~~assessment~~ process must include review by a competent translator not involved in the original translation, or review by back-translation (or reverse translation). The assessment ~~Evaluation~~ may be internal to the organization or may be included in the organization's contract with a translation vendor.

- *If the organization performs the translation quality assessment,* NCQA reviews the organization's documented process, and reports or materials evidence that the organization followed its documented process.
- *If an external translation vendor performs the quality assessment ~~on~~ of its services,* NCQA reviews materials or reports as evidence of the external vendor's translation quality assessment (e.g., contract).

~~The organization may demonstrate the evaluation through the documented process or materials and reports.~~

Exceptions

None.

Examples

Vital information

- Patient safety instructions.
- Visitor guides or guidelines.
- Condition-specific, wellness or health management brochures (e.g., HIV, asthma, healthy eating, exercise).
- Information about spiritual or religious counseling.

***Factor 1:* Using competent translators**

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

***Factor 4:* Oral interpretation**

- A process for providing sight translation of information immediately if a written translation is not readily available.

~~***Factor 1:* Using competent translators**~~

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

***Factor ~~2~~5:* ~~Provision of timely translation~~ Timeliness of translations**

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

***Factor 46:* Evaluation of translation quality**

- The organization uses an evidence-based quality assurance method, such as the Hablamos Juntos TQA process

(https://www.yumpu.com/en/document/view/49829570/translation-quality-assessment-tool-pdf-hablamos-juntos).
- The contract with translation service includes quality assurance provisions.
- The organization follows a translation process that includes one or more review/editing steps performed by a qualified translator not involved in the original translation.

Element B: Spoken Language Services

The organization ~~uses competent interpreter or bilingual services to communicate~~ has a process for communicating with ~~individuals~~ members or patients ~~who need to communicate in a language other than English.~~ that includes:

1. **Use of interpreter services or bilingual staff for organizational functions.**
2. **Assessment of interpreter or bilingual staff competency.**

Scoring

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

Data source Documented process, Reports, Materials

Scope of review

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

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

- *For factor 1,* NCQA reviews the organization's documented process for using interpreter services or bilingual staff for organizational functions, and reviews reports or materials showing that the organization uses interpreter services or bilingual staff to communicate with members or patients who need language assistance.
- *For factor 2,* NCQA reviews the organization's documented process for assessing the competency of its interpreter and bilingual services, reviews interpretation training for staff who provide interpreter services and reviews reports or materials showing that the organization follows its documented process.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

***Factor 1:* Use of interpreter services**

The organization has a documented process for providing interpreter services, including sign language interpreters, for any interaction an individual is likely to have with the organization in person, over the telephone or via remote or virtual methods. including, but not limited to, organization functions such as:

- Billing.
- Care coordination or navigation.
- Case management.
- Claims.
- Check-in or triage.
- Complaints, grievances and appeals.
- Customer service or patient services.
- Discharge.
- Health care encounters (e.g., clinical, behavioral or social care examination, diagnostic testing, treatment or counseling)
- Informed consent.
- Population health management.
- Utilization management.

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

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

Bilingual staff, which may include practitioners, speak both English and the individual's language and can perform their responsibilities either in English or in another language.

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

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

- ~~Customer service.~~
- ~~Claims.~~
- ~~Utilization management.~~
- ~~Population health management.~~
- ~~Case management.~~
- ~~Complaints, grievances and appeals.~~

Factor 2: **Interpreter competence**

Competent interpreter services means that the interpreter understands and speaks with enough fluency in both the source and target languages to convey intended meaning. Whether the organization uses internal interpreter services (e.g., staff interpreters, bilingual staff) or contracts with a vendor, it must have a mechanism to assess the competency of the interpreter, or procure competent interpreter services.

- *If the organization uses staff interpreters or bilingual staff*, NCQA reviews the organization's documented process for assessing interpreters, including an evaluation of proficiency in the source and target languages and interpretation training for staff who provide interpreter services, and reviews evidence that the organization followed its documented process.
- *If the organization uses external interpreter services*, NCQA reviews materials or reports as evidence of the external interpreter's competency (e.g., contract describing the vendor's competency assessment process, professional certificates).

~~Use of contracted interpretation services is not considered delegation.~~

Exceptions

None.

Related information

Use of contracted interpretation services is not considered delegation.

Examples

Assessment of language fluency for bilingual staff and staff interpreters

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

Competence of interpreter services

- Policies for staff serving as interpreters or contracts with interpreter services require interpreters to follow National Standards of Practice for Interpreters in Health Care issued by the National Council on Interpreting in Health Care (https://www.ncihc.org/ethics-and-standards-of-practice).
- RFP about the service's methods for ensuring interpreter competence.
- The contract with the interpreter service includes quality provisions.
- The RFP or contract requires interpreters to be certified.

Element C: Support for Language Services

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

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

Scoring

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

Data source Reports, Materials

Scope of review *For All Surveys:* NCQA reviews evidence of language services the organization distributes during the look-back period.

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

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

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

Under Title VI of the Civil Rights Act, health care practitioners who receive federal funds are responsible for providing language and communication services to their patients as required to meet clinical needs. Understanding and meeting the linguistic needs of members and patients ~~individuals~~ is a shared concern among organizations and the practitioners with whom they contract. The organization supports and assists practitioners in this effort, within the scope of their respective responsibilities.

The organization uses materials (e.g., reports it sends to practitioners, language resources or user guides distributed to practitioners, training curricula or plan, certificates of completion) or reports (e.g., meeting minutes, attendance logs, records documenting distributing or provision) to demonstrate how it meets the requirements of factors 1–4. For collaborative activities, the organization uses reports such as meeting minutes to demonstrate its substantive participation in the activity.

***Factor 1:* Shares data on ~~individual~~ patient-level language needs with practitioners**

The organization shares data with practitioners about the language needs of their patients ~~individuals~~. The organization provides ~~individual~~ patient-level ~~language~~ information, either as part of patient-specific communications with the practitioner (e.g., registry downloads, service reminders, notice of selection as a primary care provider, evidence of coverage) or in a report or dashboard listing the~~ language~~ needs of all patients in the practitioner's panel or practice.

***Factor 2:* Shares data on population language needs with practitioners**

In addition to providing language data on ~~an individual~~ patient level, the organization provides practitioners with information about the language patterns of the organization's population or service area.

***Factor 3:* Provides practitioners with language assistance resources**

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

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

No additional explanation required.

Factor 5: **Offers training to practitioners on provision of language services**

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

~~The organization uses materials such as sample reports it sends to practitioners, language assistance resources it distributes, training curricula and reports documenting the provision of these materials, to demonstrate how it meets the requirements of factors 1–4. For collaborative activities, the organization uses reports such as meeting minutes to demonstrate its substantive participation in the activity.~~

Exception

This element is NA if the organization does not employ or hold contracts with practitioners.

Examples

Factor 1: **Data on individual language needs**

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

Factor 2: **Data on service area language needs**

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

Factor 3: **Language assistance resources**

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

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

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

- Make equipment available for video interpretation.

Factor 5: **Practitioner training on the provision of language services**

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

Element D: Notification of Language Services

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

Scoring

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

Data source Reports, Materials

Scope of review

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

For Renewal Surveys: NCQA reviews most recent and the prior year's distribution of information on the availability of language services.

Look-back period

For Initial Surveys: At least once during the prior year.
For Renewal Surveys: 24 months.

Explanation

The organization must provide interpreter services to all members or patients ~~individuals~~ who need them, regardless of the frequency of the language spoken in the community or among the members or patients ~~individuals~~ served by the organization. Notification of the availability of language services must be provided to the broadest possible number of ~~individuals~~ current members or patients who received services in the past 12 months, in a language they can understand. This lower language threshold ~~of~~ (1% of the population in the service area or 200 members or patients up to 15 languages), ~~up to a maximum of 15 languages,~~ provides a finite boundary for the number of languages in which notices must be provided.

Annually ~~M~~mailing the notice to all ~~individuals~~ current members or patients ~~annually~~ meets the intent of the element. The organization may provide notification of language services as an independent ~~discrete~~ communication or include the notification in a routine distribution of information to all individuals.

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

Exception

This element is NA if the organization does not ~~have a defined membership or~~ serve a defined group of individuals (e.g., members, patients, enrollees).

Related information

Use of vendors/mail service organizations for notification of language services. If the organization contracts with a mail service organization to provide distribution services, it provides access to the mail service organization’s documentation for evaluation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under *HE 7: Delegation.* Refer to *Vendors* in *Appendix 2: Delegation and Automatic Credit Guidelines.*

Examples

Notice of the availability of language services

- Statement/tagline in multiple languages in newsletters or other documents distributed to all individuals.
- Brochure.
- Website.
- Reports of distribution of notices.
- Electronic messaging (e.g., patient portals, EMR).

HE X: Access and Availability of Disability Accommodations *(NEW)*

The organization provides accommodations, functionality and formats that enable members or patients with disabilities to engage with health care services and information.

Intent

The organization acts to improve access to health care services and information for members or patients with disabilities.

Element A: Availability of Disability Accommodations *(NEW)*

The organization has a process for making needed disability accommodations available in advance of planned in-person or virtual interactions with members or patients, including:

1. **Physical disability accommodations.**
2. **Auxiliary aids and services.**

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 making needed accommodations available in advance of planned patient interactions.

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

Explanation

Factors 1, 2

The organization has a documented process for providing physical accommodations and auxiliary aids/services in advance of planned in-person or virtual interactions with members or patients, including, but not limited to, the following functions, as applicable to the organization's offerings:

- Case management.
- Check-in or front desk interactions.
- Diagnostic testing.
- Health care encounters (e.g., clinical, behavioral or social care visits, sessions, procedures).
- Pre-appointment assessments or questionnaires.

The organization's documented process addresses the same response options it used to collect data on patients' needed physical accommodations and auxiliary aids/services (*HE 2: Collection of Member- or Patient-Level Data,* Element F).

Exceptions

This element is NA for organizations that do not provide any planned in-person or virtual services.

Factor 1 is NA for organizations that do not provide in-person care or services.

Examples None.

Element B: Accessible Digital Content *(NEW)*

The organization makes digital content accessible to members or patients with disabilities, including:

1. **Vital information available in plain, easy-to-understand language.**
2. **Vital information available in screen reader-accessible formats.**
3. **Speech-to-text functionality available for vital information in audio or video formats.**
4. **Large-scale text functionality.**
5. **Easy-to-find accessibility functions or formats.**
6. **A process to test the usability of accessibility functionality or formats for the intended audience.**

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 in place throughout the look-back period for making digital content accessible and assessing intended usability.

For factors 1–5: NCQA also reviews reports or materials demonstrating that the organization follows its documented process.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, organizations may submit a detailed implementation plan in place of a documented process and reports or materials for factors 1–6.

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

Explanation

Digital content

Digital content includes information available and communicated to patients or members through digital mediums, including:

- Websites.
- Mobile apps or platforms.
- Patient portals.
- Downloadable files (e.g., PDFs).
- Kiosk, tablets or other in-person, patient-facing interfaces.

Vital information

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

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

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

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

For organizations that deliver clinical or behavioral health care, in-person or virtually, vital information also includes, but is not limited to:

- Consent forms.
- Information about patient rights.
- Health history forms.
- Patient-facing instructions (e.g., medication, preparation for procedures, pre-appointment, discharge, financial assistance).
- Information about estimated or actual costs.

***Factor 1:* Plain, easy-to-understand language**

Plain language is a way of speaking and writing that makes health care information easier for everyone to understand. It uses language that the average person would understand and does not include abbreviations, acronyms or health care procedure codes that an average person would not understand.

Use of plain language improves accessibility for people with cognitive or intellectual disabilities, supports screen reader accessibility and removes communication barriers for people whose primary language is not English.

The organization provides materials (e.g., screenshots, PDFs) demonstrating that vital information made available and communicated to members or patients through digital mediums is provided in plain, easy to understand language.

***Factor 2:* Screen reader accessibility**

Screen readers use software that turns digital content into spoken words or Braille, allowing individuals with blindness or low vision to access and interact with digital content.

The organization provides materials (e.g., screenshots, PDFs, user guides) demonstrating that written vital information made available and communicated to members or patients through digital mediums is screen-reader accessible.

***Factor 3:* Speech-to-text formats for audio or video formats**

Speech-to-text formats turn synchronous or asynchronous digital content provided in audio or video formats into equivalent text descriptions or translations, allowing individuals who are deaf or hard of hearing to access and interact with sound content.

The organization provides materials (e.g., screenshots, PDFs, user guides) demonstrating that written vital information made available and communicated to members or patients through digital mediums is screen-reader accessible.

***Factor 4:* Large-scale text functionality**

The organization provides materials (e.g., screenshots, PDFs, user guides) demonstrating that digital mediums offer options to make text larger.

***Factor 5:* Easy-to-find accessibility functionality or formats**

The organization provides materials (e.g., screenshots, user guides) demonstrating that all accessibility functionality or formats requiring user selection or activation are prominently placed and can be easily discovered by the intended audience.

Some accessibility functionality or formats may be designed to be passively available to users (e.g., screen-reader friendliness), while others require that users actively select or activate them. These "active" functionalities (e.g., large-scale text) cannot be used by the intended audience when they are difficult or time-consuming to find, or not discoverable using the abilities of the intended audience. For example, individuals with low vision may have difficulty finding large-scale text functionality to access vital information if the digital medium requires several clicks or swipes to select the functionality, or if the mechanism to select or activate the functionality is too small to be discoverable without using the functionality itself.

***Factor 6:* Testing usability**

The organization provides a documented process demonstrating that it tests the functionality or formats required in factors 1–6 for usability by the intended audience.

Exceptions

None.

Related information

Use of vendors to test usability of functionality or formats. If the organization contracts with a vendor or external consultant to meet factor 6, it provides the vendor or external consultant's documentation for evaluation. NCQA does not consider the relationship to be delegation. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors* in *Appendix 3: Automatic Credit.*

Examples

***Factor 6:* Testing usability**

Testing conducted by individuals representative of intended audiences.

- Ease of navigation to important information.
- Ease of navigation to accessibility formats or functions.

- Intuitiveness of content organization.
- Understandability of content.

Element C: Support for Disability Accommodations *(NEW)*

The organization supports the effective provision of disability accommodations and auxiliary aids/services by:

1. **Sharing patient-level data on needed physical accommodations with practitioners.**
2. **Sharing patient-level data on needed auxiliary aids or services with practitioners.**
3. **Offering training to patient-facing staff on the use of physical accommodations during health care encounters.**
4. **Offering training to practitioners on the use of physical accommodations during health care encounters.**
5. **Offering training to patient-facing staff on the use of auxiliary aids or services during health care encounters.**
6. **Offering training to practitioners on the use of auxiliary aids or services during health care encounters.**

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:

- *For factors 1, 2:* NCQA reviews reports or materials demonstrating data shared with practitioners during the look-back period.
- *For factors 3–6:* NCQA reviews reports or materials demonstrating that trainings were offered to patient-facing staff and practitioners during the look-back period.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, organizations may submit a detailed implementation plan in place of reports or materials for factors 1–6.

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

Explanation

***Factors 1, 2*: Sharing patient-level data**

The organization shares patient-level data with practitioners about needed physical disability accommodations and communication-related auxiliary aids or services to facilitate planned patient interactions (e.g., office visits, telehealth encounters, scheduled procedures). Data may be shared with the practitioner as part of patient-specific communications (e.g., registry downloads, service reminders, notice of selection as a primary care provider, evidence of coverage), or in a report or dashboard showing all patients in the practitioner's panel or practice.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, if the organization completes an implementation plan in place of reports or materials, the plan must include:

- A detailed description of actions the organization will take to share member or patient-level data on needed accommodations.
- A timeline for implementation.

***Factors 3—6:* Offering training**

The organization offers training to patient-facing staff and practitioners on the use of physical disability accommodations and auxiliary aids/services during health care encounters, including on use of patients' personal support equipment or devices.

Training may focus on physical accommodations and auxiliary aids/services the organization readily provides to members or patients, or may be more comprehensive. The organization may also collaborate with other organizations in the service area to provide common training.

The organization determines training frequency. For example, care delivery organizations may consider offering training after acquisition of new equipment and requiring training for all new hires employed, requiring annual training for all staff or for specific roles.

The organization uses materials (e.g., resources or user guides distributed to practitioners, training curricula or plan, certificates of completion) or reports (e.g., attendance logs, records of distributing materials) to demonstrate how it meets the requirement. For collaborative activities, the organization may use reports such as meeting minutes to demonstrate its substantive participation in the activity.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, if the organization completes an implementation plan in place of reports or materials, the plan must include:

- A detailed description of the organization's process for offering training to practitioners and patient-facing staff on use of accommodations during health care encounters.
- A timeline for implementation.

Exceptions

This element is NA if the organization does not employ or hold contracts with practitioners.

Factors 3 and 5 are NA for organizations that do not directly provide in-person health care services or case management.

Examples

***Factors 3–6:* Offers training to patient facing staff and practitioners**

Training focus

- Questions scheduling staff should ask regarding accommodations, aids or services when scheduling appointments or procedures.
- How staff should document patient requests for physical accommodations, or requests for auxiliary aids/services for practitioners in advance of planned patient interactions.
- How to anticipate physical accommodations for specific examinations or procedures.
- Workflows for scheduling and placing patients in rooms with medical equipment that aligns with their requested physical accommodations.
- Use of physical accommodations during examination and treatment (e.g., height-adjustable exam table, transfer board, low stimulation environment).
- Use of auxiliary aids or services for patients during examination, counseling or treatment (e.g., sign language interpreter, picture board, Communication Access Realtime Translation [CART] or speech-to-text app, portable hearing loop).
- Examination, counseling or treatment for patients who use auxiliary aids/services to be understood (e.g., text-to-speech app, white board, picture board, voice amplifier).
- How to involve patients' designated support persons during examination, counseling and treatment.
- Respectful, patient-focused communication when auxiliary aids/services or designated support persons are involved.

Documentation for offering training~~*s*~~

- Slides or other materials from offered curricula or trainings.
- Reports, attendance logs or dashboards documenting participation.
- Meeting minutes.
- Training plan.

HE 4: Practitioner Network and Care Site Cultural Responsiveness

The organization collects data on practitioners and care sites to assess its ability to meet the needs and preferences of its members or patients. ~~maintains a practitioner network that is capable of serving the diversity of individuals served and is responsive to their needs and preferences.~~

Intent

The organization builds and maintains practitioner networks or care systems that are capable of supporting the organization's ability to meet the cultural, linguistic and accessibility needs of its members or patients. ~~maintains a practitioner network that can meet the cultural and linguistic needs of individuals.~~

Element A: ~~Assessment and Availability Information~~ Practitioner and Site-Level Information

~~To enable individuals to choose practitioners best able to meet their cultural and linguistic needs, the organization:~~ The organization collects information about practitioners and care sites, including:

1. **~~Collects information about l~~Languages in which a practitioner is fluent when communicating about medical care.**
2. **Practitioner race and ethnicity data.**
3. **Practitioner population-specific focus areas, training, credentials or services.**

~~2~~4.~~Collects information about l~~Language services available through ~~the practice~~ care sites.

5. **Auxiliary aids or services available through care sites.**

~~**3. Collects practitioner race/ethnicity data.**~~

~~**4. Publishes practitioner languages in the physician directory.**~~

~~**5. Publishes language services available through practices in the physician directory.**~~

~~**6. Provides practitioner race/ethnicity on request.**~~

Scoring

Met	Partially Met	Not Met
The organization meets ~~4-6~~ 3-5 factors	The organization meets 2~~-3~~ factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews a documented process, reports or materials as evidence of the organization's data collection methodology~~, and reviews the organization's physician directories and evidence that the organization made directories available to individuals during~~ throughout the look-back period.

For all surveys scheduled on or between July 1, 2026, and June 30, 2027, the organization may submit a detailed implementation plan, including a timeline, in place of evidence for factors 3 and 5.

~~*For factor 6*: NCQA also reviews the organization's documented process for providing information on request and reviews evidence that the organization followed its documented process.~~

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

Explanation

Practitioners

Contracted network practitioners are practitioners the organization~~ employs or~~ contracts with to provide services to a defined population. Refer to the Policies and Procedures, *Section 1: How NCQA Defines an Eligible Entity*. NCQA considers both employed/paid and volunteer practitioners to be part of a network if they provide services to the organization's population.

Effective practitioner-patient relationships require trust, communication and common understanding. Health care organizations can facilitate high-quality care by providing a choice of practitioners who share a background and have direct experience or training relevant to the member or patient population's needs (e.g., cultural, linguistic, disability) and beliefs.

Collecting information on practitioners' race, ethnicity, language, relevant experience or expertise, and on care sites' available language services and auxiliary aids, also supports the organization's ability to identify opportunities to improve the choices available to members or patients.

In-person care sites

Effective communication and mutual understanding is a shared concern among health care organizations, the practitioners they employ or contract and the members or patients to whom they provide health care or services.

For surveys scheduled on or between July 1, 2026, and June 30, 2027, the organization may submit an implementation plan in place of a documented process, reports or materials for factors 3 and 5. The plan must include:

- A detailed description of how the organization will implement required activities.
  - If the organization will use data from other sources, the description lists the entities from which data will be received and a description of the data exchange method.
- A timeline for implementation of required activities.

~~Some patients feel more comfortable with practitioners who share their language and racial/ethnic background. Patient/practitioner communications are enhanced when there is a common language and culture[1]. Although it may not be possible for the organization to establish a practitioner network that matches the demographic profile of all individuals it serves, the organization facilitates high-quality care by providing (to the extent possible) a choice of practitioners that includes all major racial/ethnic and linguistic groups represented.~~

Factor 1: Practitioner languages

~~The organization requests practitioner language~~ collects ~~information from all contracted network practitioners on the. It requests practitioners to provide this information and identifies languages in which a practitioner is fluent when communicating about medical care, using the same categories used to collect individuals' language information (*HE 2*, Element C, factor 1). The organization communicates to practitioners that providing language information is voluntary.~~

The organization requests practitioner language collects information from all contracted network practitioners on the languages in which they are fluent when communicating about medical care, using the same response options it used to collect data on member language needs (*HE 2: Collection of Member- or Patient-*

Level Data, Element B, factor 1). The organization may obtain data on practitioner language directly or from third-party sources, such as credentials verification organizations (CVO).

The organization communicates to practitioners that providing language information is voluntary and, if disclosed, will not be used for discriminatory purposes during the organization's employment, contracting or credentialing processes. The organization may determine the appropriate timing of data collection to avoid concerns about discrimination ~~in contracting, and does not use information about practitioner language in its contracting or credentialing decisions or for a discriminatory purpose. The organization may obtain data on practitioner language directly or from third-party sources, such as credentials verification organizations (CVO).~~

~~*Factor 2:* Language services available through practices~~

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

Factor 2~~3~~: Practitioner race and ~~/~~ethnicity

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

The organization collects information from all contracted network practitioners on their race and ethnicity, using the same response options it used to collect data on members' or patients' race and ethnicity (*HE 2,* Element A, factor 1). The organization may obtain data on practitioner race/ethnicity directly or from third-party sources such as CVOs.

The organization communicates to practitioners that providing race and ethnicity information is voluntary and, if disclosed, will not be used for discriminatory purposes in the organization's employment, contracting or credentialing processes. ~~The organization demonstrates data collection through data collection forms, surveys or reports such as counts or identification of complete/incomplete data.~~

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

Factor 3: Practitioner focus areas, training, credentials or services

The organization collects information from all contracted network practitioners on focus areas, training, credentials or expertise in providing services relevant to specific subgroups of the organization's member population.

The organization communicates to practitioners that providing this information is voluntary and, if disclosed, will not be used for discriminatory purposes during the organization's employment, contracting or credentialing process. The organization determines the focus areas, training, credentials or services relevant and meaningful to its member population, and how this information is labeled in the organization's member-facing physician directory.

Factor 4: **Available language services**

The organization collects information about dedicated language services offered at care sites it owns or operates, or that is served by its contracted network practitioners.

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

Factor 5: **Auxiliary aids or services**

The organization collects information about communication-related auxiliary aids or services offered at care sites it owns or operates, or that are served by its contracted network practitioners, using the same response options it used to collect data on patients' needed auxiliary aids/services.

For surveys scheduled on or between July 1, 2026, and June 30, 2027, if the organization completes an implementation plan in place of a documented process, reports or materials, the plan includes:

- A detailed description of actions the organization will take to directly collect data on auxiliary aids or services at the practice or site level.
    - If the organization plans to use data from other sources, the description lists the entities from which data will be received and a description of the data exchange method.
- A timeline for implementation of required activities.

~~***Factor 4:*** **Publishes practitioner languages in the physician directory**~~

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

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

~~***Factor 5:*** **Publishing language services available through the practice**~~

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

~~The physician directory indicates languages for which the practice can readily offer translation services, but it is not required to list every language for which the practice offers translation services.~~

~~***Factor 6:*** **Practitioner race/ethnicity**~~

~~The organization has a documented process for providing information about practitioner race/ethnicity upon request (e.g., Member Services staff or other methods, such as a directory or website.)~~

~~The organization meets evidence requirements if it distributes the information on its website and in the physician directory (written and electronic). If the information is not available in the physician directory, but can be found elsewhere (e.g., by contacting Member Services), the organization places prominent notice in the written and web-based directory indicating how individuals can obtain the information.~~

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

Exceptions

This element is NA if the organization does not:

- C~~c~~ontract with or employ clinical or behavioral health practitioners.
- Own, operate or contract with in-person clinical or behavioral health care sites.

Factors 1–3 are NA for organizations that are not health plans.

Factors 4–5 are NA for organizations that do not own, operate or contract with in-person clinical or behavioral health care sites.

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

Examples

Factors 1, 2: **Practitioner language, race and ethnicity**

Evidence of practitioner language, ~~and~~ race and ~~/~~ethnicity ~~information~~ collection

- Data collection forms or surveys.
- ~~Reports such as counts or identification of complete/incomplete data.~~
- ~~Practitioner survey, c~~Credentialing application forms or screenshots.
- Data collection script.
- Screenshots or reports from dashboards or electronic storage systems.
- Reports showing practitioner data collection fields and percentage or counts of complete vs. incomplete data.
- Screenshots of member- or patient-facing practitioner listing, directory or appointment scheduling platform.

Factor 3: **Practitioner focus areas, training, credentials or services**

- A focus or affinity on providing care to subpopulations with specific health needs such as:
  - Patients with intellectual or developmental disabilities (IDD).
  - Veterans.
  - LGBTQIA+ friendly or supportive.
- Completion of training, certification or continuing medical education relevant to the unique care needs of specific subpopulations such as:
  - Culturally appropriate care

  - Cultural humility.
  - Culturally responsive care.
  - Care for patients with IDD.
  - Inclusive care.
  - Trauma-informed care.
- Providing services specific or relevant to specific subpopulations such as:
  - LGBTQIA+ mental health.
  - Immigrant or refugee health.

***Factor ~~2~~4:* ~~Available l~~ Language services**
Practices offer language services to patients through a variety of mechanisms, including:

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

Element B: Availability of Information on Practitioners and Care Sites

To enable members or patients to choose practitioners best able to meet their unique care needs, the organization:

1. **Publishes practitioner languages in the physician directory.**
2. **Provides information on practitioner race/ethnicity, upon request.**
3. **Publishes practitioners focus areas, training, credentials or services in the physician directory.**
4. **Publishes language services available through practices or sites in the physician directory.**
5. **Provides information on auxiliary aids or services available at practices or sites, upon request.**
6. **Has a web-based search function for at least one data point described in factors 1–5.**

Scoring

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

Data source Documented process, Materials

Scope of review

For All Surveys:

- *For factors 1, 3 and 4:* NCQA reviews materials as evidence that the organization’s directory or listing made information about practitioner- and practice-level information available to members or patients during the look-back period.
- *For factors 2, 5:* NCQA reviews the organization’s documented process for providing information on request. In lieu of a documented process, the organization may provide materials demonstrating that it makes information available in its directory or listing.

- *For factor 6:* NCQA reviews materials as evidence of the organization's web-based directory functionality.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months for factors 1, 2 and 4; 6 months for factors 3, 5 and 6.

Explanation

Factor 1: **Publishes practitioner languages in the physician directory**

The organization publishes practitioner language information in its online or printed practitioner directories and through any other mechanisms intended to facilitate selection of practitioners. The organization makes information about practitioner languages available through other means (e.g., mailing) for members or patients who do not have internet access.

Factor 2: **Practitioner race and ethnicity**

The organization has a documented process for providing information about practitioner race and ethnicity upon member or patient request (e.g., Member Services staff or other methods, such as a directory or website), or publishes practitioner race and ethnicity information in its online or printed practitioner directories. The organization meets evidence requirements if it distributes the information in its practitioner directory (written and electronic).

If the information is not available in the practitioner directory, but can be requested elsewhere (e.g., by contacting Member Services or scheduling), the organization must provide materials (e.g., screenshots) demonstrating that it places prominent notice in the written or web-based directory indicating how members or patients can obtain the information.

Practitioners that decline to provide race/ethnicity information to the organization may be listed as having a blank or "Unknown" race/ethnicity in practitioner directories.

Factor 3: **Practitioner focus, training, credentials or services**

The organization publishes information on practitioners' population-specific focus areas, training, credentials or expertise in its online or printed practitioner directories and through any other mechanisms intended to facilitate selection of practitioners. The organization makes information about practitioners' focus areas, training, credentials or expertise available through other means (e.g., mailing) for members or patients who do not have internet access.

Factor 4: **Publishing language services available through the practice**

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

The practitioner directory indicates languages for which the practice can readily offer translation or interpretation services, but it is not required to list every language for which the practice offers translation or interpretation services.

***Factor 5:* Auxiliary aids or services available through the practice**

The organization has a documented process for providing information about auxiliary aids or services offered by the practices in its network, or at the sites served by its pool of practitioners, upon member or patient request (e.g., Member Services staff or other methods, such as a directory or website), or publishes the information in its online or printed practitioner directories. The organization meets evidence requirements if it distributes the information on its practitioner directory (written and electronic).

If the information is not available in the practitioner directory, but can be requested elsewhere (e.g., by contacting Member Services or scheduling), the organization must provide materials (e.g., screenshots) demonstrating that it places prominent notice in the written or web-based directory indicating how members or patients can obtain the information.

***Factor 6:* Web-based search function**

The organization's online (web-based) directory allows customized filters or searches based on at least one of the practitioner-level information types described in factors 1–3. NCQA does not prescribe how the organization labels this information in the practitioner directory. The organization determines which focus areas, training, credentials or services are relevant and meaningful to its members or patients.

Exceptions

This element is NA if the organization does not:

- Employ or contract with clinical or behavioral health practitioners.
- Own, operate or contract with in-person clinical or behavioral healthcare sites.

Factors 1–3 are NA for organizations that are not health plans.
Factor 4 is NA for organizations that do not own or operate in-person clinical or behavioral care sites.

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

Examples

Physician directories

- In-network directory.
- Find-a-doctor tool.
- "Our providers" list.

***Factor 2:* Available language services**

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

- Bilingual staff or onsite interpreters.
- Remote video or telephone interpreters.
- Dedicated language services for a specific linguistic minority.
- American Sign Language (ASL) translators.

Factor 3: **Practitioner focus, training, credentials or services**

- A focus or affinity on providing care to subpopulations with specific health needs such as:
  - Patients with intellectual or developmental disabilities (IDD).
  - Veterans.
  - LGBTQIA+ friendly or supportive.
- Completion of training, certification or continuing medical education relevant to the unique care needs of specific subpopulations, such as:
  - Culturally appropriate care
  - Cultural humility.
  - Culturally responsive care.
  - Care for patients with IDD.
  - Inclusive care.
  - Trauma-informed care.
- Providing services specific or relevant to specific subpopulations such as:
  - LGBTQIA+ mental health.
  - Immigrant or refugee health.

Element C~~B~~: Enhancing Network Responsiveness

At least every 3 years, the organization:

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

****Critical factors: Score cannot exceed Partially Met if one critical factor is scored "no," and cannot exceed Not Met if two or more critical factors are scored "no."***

Scoring

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

Data source Documented process, Reports, Materials

Scope of review

For All Surveys:

- *For factors 1–2:* NCQA reviews a report demonstrating that the organization analyzed ~~the~~ capacity ~~of its practitioner network or pool~~ to meet member or patient needs.
- *For factor 3:* NCQA reviews a documented process or materials as evidence that the organization developed a plan to address identified gaps.
- *For factor 4:* NCQA reviews a documented process, reports or materials as evidence that the organization took action to address identified gaps, based on its plan.

- ~~*For factors 1–2:* NCQA reviews a report demonstrating that the organization assesses unmet individual needs.~~
- ~~*For factor 3:* NCQA reviews the organization's documented process for addressing gaps.~~
- ~~*For factor 4:* NCQA reviews the organization's documented process, reports or materials as evidence of a plan or adjustments to the network to meet identified individuals' needs~~

Look-back period

All Surveys: At least once during the prior 36 months.

Explanation

Factor 4 may not be delegated.

Factors 1 and 2 are critical factors; if one critical factor is scored "no," the organization's element score cannot exceed Partially Met ~~for the element~~. If both critical factors are scored "no," the organization's element score cannot exceed ~~"~~Not Met~~"~~ ~~for the element~~.

Contracted network practitioners are practitioners the organization employs or contracts with to provide services to a defined population. Refer to the Policies and Procedures, *Section 1: How NCQA Defines an Eligible Entity*. NCQA considers both employed/paid and volunteer practitioners to be part of a network if they provide services to the organization's population.

Factor 1: **Analyzing ~~practitioner network~~ language capacity at the point of care**

At least every 3 years, the organization analyzes its capacity to meet the identified language needs of its member or patient population at the point of care.

NCQA reviews reports demonstrating that at least once in the past 3 years, the organization performed an analysis of capacity in comparison to the language needs of its member or patient population, and drew conclusions about the presence of gaps. ~~The organization assesses and reports on practitioner and bilingual staff language capabilities and determines whether its language services are sufficient to meet the needs of individuals. Assessment includes:~~

The analysis includes an assessment of:

- Languages spoken by practitioners (employed, contracted, volunteer).
- Presence of bilingual staff or trained interpreters at care sites.
- Whether practitioners have worked with an interpreter.

The analysis may also assess:

- The language profile of the population in comparison to languages spoken by practitioners and bilingual staff.
- Communication-related auxiliary aids or services available at practices or sites.
- Whether practitioners have completed training on interpretation services and auxiliary aids or services.

Factor 2: **Analyzing practitioner network cultural responsiveness**

At least every 3 years, the organization analyzes the capacity of its practitioner network or pool to deliver culturally appropriate care to the organization's member population. NCQA reviews reports demonstrating that at least once in the past 3 years, the organization performed an analysis of capacity in comparison to the race and ethnicity of its member population, and drew conclusions about the presence of gaps.

The analysis must include an assessment of:

- Practitioners' race/ethnicity.
- Practitioners' population-specific focus areas, training, credentials or expertise.

The analysis may also assess:

~~The organization uses information about the demographic profile of the individuals it serves and the practitioner network to identify potential unmet needs, and assesses the network's ability to deliver culturally appropriate care. The organization may assess practitioners':~~

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

~~The organization's report describes practitioner demographics and assessments of identified needs.~~

***Factor 3:* Plan to address gaps**

The organization demonstrates that at least once in the past 3 years, it developed a detailed plan to address the gaps identified by the organization's analysis in factors 1 and 2, as applicable. The plan includes:

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

- A detailed description of actions the organization plans to take to address identified gaps.
- A timeline of activities the organization plans to complete for each gap.

***Factor 4:* Taking action**

The organization demonstrates that at least once in the prior 3 years, it took action to address identified gaps based on its plan. NCQA reviews documented processes, materials or reports that demonstrate actions taken. ~~The organization implements its plan to address identified gaps.~~

~~NCQA recognizes that it may not be practical to address gaps by recruiting practitioners with specific racial/ethnic or linguistic backgrounds, in an environment~~

~~where there is a shortage of primary care practitioners. Organizations might need to consider other approaches, such as community partnerships, faith-based organizations, public health agencies or other community-based organizations, practitioner training or social networking.~~

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

Exceptions

This element is NA if the organization does not employ or contract with clinical or behavioral health practitioners.

Factor 2 is NA for organizations that are not health plans.

Factors 3 and 4 are NA if the organization’s analysis does not identify gaps in the practitioner network’s capacity to meet member or patient needs. NCQA assesses whether this conclusion is reasonable, based on the organization’s analysis in factors 1 and 2. ~~Factors 3 and 4 are NA if the organization’s analysis does not identify gaps in the network’s capacity to meet individuals' needs.~~

Examples

Factors 1, 2: **Analysis of ~~network~~ capacity**

- A comparison of the number of practitioners who speak a specific language with the number of members or patients residing in the service area who speak that language. Analysis may focus on:
  - Common language categories in the membership; for example, languages spoken by at least 5% of members or patients in the area.
  - Particular specialties, such as primary care practitioners. ~~Compare the number of practitioners who speak a specific language with the number of individuals residing in the service area who speak that language.~~
  - ~~Analysis may focus on common language categories in the membership; for example, languages spoken by at least 5% of individuals in the area.~~
- A comparison of available interpreter languages available at care sites compared to threshold languages of the organization’s patient population.
- Percentage of practitioners that have completed continuing medical education (CME) or training on:
  - Cultural humility
  - Use of video interpretation services during a health care encounter.
  - Providing interpretation services during a front desk interaction.
  - Health beliefs and health-related behaviors specific to race, ethnicity or other cultural needs relevant to the organization’s member or patient population (e.g., religious, country of origin, immigration or refugee status).
  - Assessing patient understanding.
  - Identifying barriers to patient understanding (e.g., linguistic, cognitive, cultural).
  - Using auxiliary aids during a health care encounter.
- Survey practitioners to assess their ~~practitioner~~ attitudes, awareness and knowledge of cultural humility concepts.
- Survey practitioners to assess their comfort with or knowledge of using language services.

- ~~Analyze the percentage of practitioners who have participated in CME training on cultural humility.~~

~~***Actions to address gaps***~~ ***Factor 3:* Plan to address gaps**

Recruiting new practitioners with specific racial/ethnic or linguistic backgrounds may not always be possible or practical. Approaches to address gaps and their root causes may include:

- Offer higher reimbursement rates to practitioners that speak additional languages, or for health care encounters that use language services (e.g., interpretation).
- Offer auxiliary aids/services for practitioner use during health care encounters (e.g., letter board, assistive listening device, text-to-speech app).
- Hire bilingual staff (including community health workers, advocates or patient navigators) to act as interpreters for practitioners.
- Expand the pool or network of practitioners to virtual practitioners.
- Offer or provide access to educational materials, trainings or CME that address culturally and linguistically appropriate care practices for relevant member or patient populations.
- Incentivize practitioners to complete trainings or CME that address culturally and linguistically appropriate care practices for relevant member or patient populations.
- Contract with vendors to produce health education or communications that are culturally or linguistically tailored to relevant member or patient populations.
- Collaborate with health care, community health worker, community-based or public health partners that mutually serve the organization's members or patients to conduct outreach, health education and other important health communication.
- Sponsor (e.g., offer grants, scholarships) the enrollment of practitioners and practice staff in Certified Healthcare Interpreter courses.

***Factor 4:* Taking action**

Evidence of actions

- Revised policies (e.g., recruitment and hiring) and workflows (e.g., for use of new language services).
- New or revised contracts (e.g., vendors, community-based partners).
- Communications sent to members, patients or practitioners.
- Job listings for new practitioners or staff.
  - Reports showing practitioner or staff recruitment, before and after planned actions.
  - ~~Provide onsite, telephone or video-enhanced interpretation services for a specific language group or geographic area.~~
  - ~~Encourage practitioners to complete additional or specific cultural humility training based on the racial/ethnic composition of the service population.~~
  - ~~Engage community organizations and partners to extend the capabilities of the practitioner network to conduct outreach, health education and other important health communication.~~
  - ~~Hire or direct practitioners to community health workers, advocates or patient navigators to help patients interact with practitioners.~~

- ~~Give practitioners access to culturally and linguistically appropriate health education materials.~~
- ~~Give practitioners lists of pharmacies or ancillary providers who offer services in languages other than English.~~

Element D: Information on Accessible Equipment *(NEW)*

The organization annually collects information about the volume of:

1. Height-adjustable exam tables or exam chairs available at each site.
2. Accessible weight scales or weight measurement equipment available at each care site.
3. Accessible medical diagnostic equipment available at each care site.

Scoring

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

Data source Reports

Scope of review *For All Surveys:* NCQA reviews reports demonstrating annual data collection during the look-back period.

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

Explanation Collecting information on the volume of accessible exam tables or chairs, weight scales or measurement equipment and diagnostic medical equipment supports the organization's ability to assess the extent to which the practices or sites it owns and operates can adequately examine and treat members with physical disabilities.

Factors 1–3

The organization annually collects information on the volume of exam tables or chairs, weight scales or measurement equipment and diagnostic medical equipment available at each site it owns or operates. Volume may be represented as a count or percentage of overall similar non-accessible equipment.

Exceptions

This element is NA for:

- Health plans.
- Organizations that do not own or operate in-person clinical or behavioral care sites.

Examples None.

Element E: Enhancing Care Site Accessibility *(NEW)*

To assess gaps in the accessibility of its care sites, the organization annually:

1. **Analyzes the capacity of each site to provide height-adjustable exam tables or exam chairs.**
2. **Analyzes the capacity of each site to provide accessible weight scales or weight measurement equipment.**
3. **Analyzes the capacity of each site to provide accessible diagnostic equipment.**
4. **Develops a plan to address gaps identified as a result of analysis, if applicable.**
5. **Acts to address gaps based on its plan, if applicable.**

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 1–3:* NCQA reviews reports demonstrating that the organization analyzed the capacity of each care site to provide each type of equipment.
- *For factor 4:* NCQA reviews a documented process or materials as evidence that the organization developed a plan to address identified gaps.
- *For factor 5:* NCQA reviews documented processes, reports or materials as evidence that the organization took actions to address identified gaps based on its plan.

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

Explanation Factor 5 may not be delegated.

Factors 1–3

The organization annually analyzes the capacity of each care site it owns or operates to provide accessible exam tables or chairs, weight scales or measurement equipment and diagnostic medical equipment. The organization determines the type of exam tables or chairs and diagnostic medical equipment relevant to the site's scope of services.

NCQA reviews reports demonstrating that at least once during the prior year, the organization performed an analysis of each site's capacity, and drew conclusions about the presence of gaps.

The analysis must include:

- Assessment of the volume of accessible exam tables or chairs, weight scales and measurement equipment and diagnostic medical equipment as an overall percentage of similar equipment.
- A comparison of each site's percentage of accessible equipment to a benchmark or goal.

***Factor 4:* Plan to address gaps**

The organization demonstrates that at least once during the prior year, it developed a detailed plan to address the gaps identified by its analysis in factors 1–3. The plan must include:

- A detailed description of actions the organization planned or plans to take to address identified gaps.
- A timeline of activities the organization planned or plans to complete for each gap.

***Factor 5:* Taking action**

The organization demonstrates that at least once during the prior year, it took action to address identified gaps based on its plan. NCQA reviews documented processes, materials or reports to demonstrate actions taken.

Exceptions

This element is NA for organizations that do not own or operate in-person clinical or behavior health care sites.

Factors 4 and 5 are NA if the organization's analysis does not identify gaps in the network's capacity for factors 1–3.

NCQA assesses whether "NA" is a reasonable conclusion, based on the organization's analysis in factors 1–3.

Factor 5 is NA for all surveys on or between July 1, 2026, and June 30, 2027.

Examples

Factors 1–3

The analysis may also assess:

- Accessibility of other types of medical equipment.
- Accessibility of the site's overall physical environment.
- Availability of accommodations for physical disabilities.
- Data on disability-related function, identity or needed accommodations collected from the organization's patient population.

***Factor 5*: Taking action**

Evidence of actions

- Revised policies or workflows demonstrating that the organization prioritizes the purchase of accessible equipment when existing equipment needs to be replaced or new equipment needs to be added.
- Reports showing the percentage of accessible equipment at sites where gaps were identified, before and after planned actions.
- Invoices showing the purchase of specific accessible equipment at sites where gaps were identified.

HE 5: ~~Culturally and Linguistically Appropriate Services~~ Program to Improve Service Appropriateness and Accessibility

~~The organization continually improves its services to meet the needs of multicultural populations.~~ The organization has clearly defined processes, goals and responsibilities for continuously improving the appropriateness and accessibility of its services.

Intent

~~The organization improves care and services for all individuals served by the organization.~~

The organization has the infrastructure to monitor and improve its ability to meet member or patient needs.

Element A: Program Description

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

1. ~~A written statement describing the organization's overall objective for serving a culturally and linguistically diverse population.~~ A description of the organization's overall objectives for meeting its population's cultural, linguistic, accessibility and other relevant needs or preferences.
2. A description of the program's structure.
~~2~~ 3. A process to involve community representatives with relevant direct experience, knowledge and expertise ~~members of the culturally diverse community~~ in identifying and prioritizing opportunities for improvement.
~~3~~ 4. A list of measurable goals for reducing health disparities and improving the appropriateness and accessibility of services. ~~the improvement of CLAS and reduction of health care inequities.~~
~~4~~ 5. An annual work plan.
~~5~~ 6. A plan for monitoring against ~~the~~ goals.
~~6~~ 7. Annual approval by the governing body.

Scoring

Met	Partially Met	Not Met
The organization meets 4-~~6~~7 factors	The organization meets 3 factors	The organization meets 0-2 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.

Look-back period *For Initial Surveys:* 6 months. For factors 4, 6 and 7, the organization is required to complete the activity at least once during the prior year.
For Renewal Surveys: 24 months; For factors 4, 6 and 7, the organization is required to complete the activity at least once during the prior year.

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

The organization has a structured program focused on reducing health disparities and improving the appropriateness (e.g., cultural, linguistic) and accessibility (e.g., disability-related, linguistic) of its services for members or patients. The program's structure may be independent of or integrated with the organization's program from *HE Plus 4: Program to Mitigate Social Risks and Address Social Needs*, Element A, or similar programs focused on quality improvement (QI), culturally and linguistically appropriate services (CLAS) or population health.

~~The~~ A **program description** may be a single, comprehensive document, or a set of interconnected documents, that describes, in plain language, the CLAS program's governance, scope, goals, measurable objectives, structure and responsibilities. The description is organized and written so staff can understand the program's structure, purpose and commitment. T~~he CLAS program structure may be independent or it may be integrated into the organization's quality improvement (QI) program.~~ It also defines how the organization uses its resources to achieve its goals. ~~and includes the following information:~~

- ~~How the CLAS program is organized to meet program objectives.~~
- ~~Functional areas and their responsibilities.~~
- ~~Reporting relationship of staff who provide CLAS~~.

NCQA reviews the organization's program description for evidence of factors 1–7.

Factor 1: ~~**Written document**~~ **Description of program objectives**

T~~he CLAS program description is organized and written so staff can understand the program's goals, objectives and structure. It may be an independent document or it may be integrated into the QI program description.~~

The program description outlines the program's overall objectives or goals for serving all members or patients in the organization's population in a way that is responsive to their diverse cultural, linguistic, accessibility and other relevant needs (e.g., age-related, social).

***Factor 2:* Program structure**

The program description includes the following information:

- How the program is organized to meet program objectives.
- Functional areas involved in the program and their responsibilities.
  - Involvement of a leadership position with responsibilities in program planning.
  - A staff member or role primarily responsible for oversight of organizational efforts to improve the accessibility of services and the provision of disability-related accommodations for members or patients.
- Reporting relationship of staff who provide culturally and linguistically appropriate services (CLAS) and accessibility-related services.
- How the organization's program from HE Plus 4, Element A is related to its operations and oversight, if applicable.
  - Collaborative activities with this program, if any.

Factor ~~2~~ 3: **Process to involve community representatives ~~members of the culturally diverse community~~**

The ~~CLAS~~ program description ~~has~~ outlines the organization's process for gathering substantive input and participation from the community it serves in order to ensure that it meets the needs of its members or patient population.

The organization establishes an advisory function that seeks advice from people who have direct experience, knowledge or expertise relevant to the diverse cultural, linguistic and other relevant needs ~~reflect the diversity~~ of the ~~community~~ member or patient population it serves. The advisory function includes a mix of consumers such as members, patients and program participants or their advocates, as well as practitioners and community representatives.

The organization may engage an advisory committee, or the advisory function may be fulfilled in other ways, such as:

- E~~e~~ngaging community groups relevant to the needs of the organization's population.
- C~~c~~onducting focus groups with consumers, practitioners ~~eligible individuals~~ or community residents. ~~At a minimum, the advisory function includes individuals representing the racial/ethnic and linguistic groups that constitute at least 5% of the population.~~
- Jointly convening an advisory function with other health care organizations that serve the same community, or with community-based partners.

Factor ~~3~~ 4: Measurable goal

~~**Inequities** are defined as health differences that are avoidable, unnecessary, unfair and unjust. They may include those related to race/ethnicity, language, gender identity or sexual orientation, as well as to structural and systemic causes of differences in health outcomes, such as lack of access to affordable housing, education or food security.~~

The program description contains at least one measurable goal for the improvement of accessible care or services, provision of culturally and linguistically appropriate services (CLAS) or reduction of health care inequities disparities. The goal ~~reflects~~ must be relevant to characteristics meaningful to the demographics of the member or patient population ~~community~~, their known or expected needs ~~of individuals~~ and previously identified opportunities for improvement. The goal may be related to improving or addressing the root cause(s) of an opportunity (e.g., structural, systemic, barriers to access) to improve care/service accessibility, provide CLAS or reduce health disparities.

The goal must be specific, measurable, achievable and reasonable, and have a defined period for completion.

***Factor ~~4~~5:* Work plan**

The work plan is a dynamic document of events scheduled and executed to achieve yearly program goals. ~~The CLAS work plan~~ It may be a separate document or it may be included in the ~~CLAS~~ program description. It may also be included in the QI, CLAS or population health program description or ~~the QI~~ work plan~~, and.~~

The work plan must address:

- Practitioner's ~~Network~~ cultural responsiveness.
- Language services.
- Disability-related accommodations and accessibility.
- Program scope.
- Yearly objectives.
- Yearly planned activities, relative to specific goals or issues.

- Time frame for each activity.
- The staff member responsible for each activity.
- Monitoring of previously identified issues.
- Evaluation of the ~~CLAS~~ program.

The work plan can be as simple as a calendar of events scheduled for the year, a Gantt chart that shows planned activities or a brief text that includes the planned time frame for each activity. The organization updates the work plan frequently throughout the year to reflect progress on ~~CLAS~~ activities.

***Factor ~~5~~ 6:* A plan for monitoring against goals**

The program description outlines the organization's process for ~~organization indicates how it~~ monitoring~~s~~ progress against goals, including measures that will be collected, frequency of monitoring and staff responsible for review and sign-off of monitoring reports.

***Factor ~~6~~7:* Approval by the governing body**

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

Where its participation in ~~QI or CLAS~~ the program's activities is indirect, ~~it~~ the governing body may designate a subcommittee or organization management staff (external to the QI Committee) to oversee ~~CLAS~~ program activities. If applicable, t~~T~~he ~~CLAS~~ program description must document the subcommittee's accountability to the governing body.

Exceptions

~~Factor 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.

Examples

Community representatives ~~Members of the culturally diverse community~~

- ~~Individuals/patients from cultural or linguistic minority groups.~~ Members or patients.
- Community advocates with direct experience, knowledge or expertise relevant to the member or patient population.
- 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.
- A professional certification in provision of culturally appropriate care practices.
- Knowledge or training in trauma-informed care practices.
- Research expertise related to condition-specific health disparities for BIPOC.
- Professional experience working in a homeless shelter.
- 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.

- Employers with ~~diverse populations and with~~ which the organization contracts to provide health care benefits or services.
- Labor union representatives.
- Representatives of agencies that serve the member or patient population, or the communities where they reside ~~of interest~~.
- Researchers involved in community-based research in ~~diverse~~ relevant subsets of the member or patient population~~s~~.

Opportunities to involve the community

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

Goals to reduce ~~inequities~~ health disparities

- Reduce low birth weight among African American mothers by 15% at the end of the calendar year.
- Increase the utilization of pre and post-natal care services by 25% in the Hispanic population in 12 months.
- Increase cervical cancer screenings by 10% among Dual-eligible patients who identified “yes” to any disability function or identity question by end of Q4.
- Reduce procedure no-show rates by 5% for Metropolitan, Haitian Creole-speaking patients by the end of Q3.

Governing body

- The organization’s board of directors, council, committee or other body with similar responsibilities.
- The practice’s owner(s).
- The organization’s health equity or community engagement governance council, board or committee with similar responsibilities.

Evidence of governing body approval

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

Element B: Annual Evaluation

~~There is an~~ The organization performs a written annual ~~written~~ evaluation of the ~~CLAS~~ program that includes the following:

1. **A description of completed and ongoing activities for improving the appropriateness and accessibility of services ~~culturally and linguistically appropriate services~~.**
2. **Trending of measures to assess performance.**
3. **Analysis of results of initiatives, including barrier analysis.**
4. **Review and evaluation of the analysis results by community representatives.**

5. Evaluation of the overall effectiveness of the program.

Scoring

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

Data source Documented process, Reports

Scope of review

For Initial Surveys: NCQA reviews the organization's most recent annual written evaluation report. The organization may submit a plan for meeting factors 2–5.

For Renewal Surveys: NCQA reviews the most recent and the prior year's annual written evaluation reports.

Look-back period

For Initial Surveys: At least once during the prior year.
For Renewal Surveys: 24 months.

Explanation

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

The annual evaluation may be independent or it may be integrated into the QI annual evaluation for the program.

Factor 1: **Completed and ongoing activities**

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

Factor 2: **Trending of measures**

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

Factor 3: **Analysis of results, including barrier analysis**

The organization analyzes results to determine whether its performance is improving, declining or remaining stable, and how it relates to the goals or performance thresholds identified in the plan. If performance falls short of goals, the organization conducts a root cause analysis or barrier analysis to identify the reason. Analysis involves organization staff with direct experience with processes that present barriers to improvement.

Factor 4: **Review and evaluation of results by community representatives**

The organization includes community representatives in its analysis of results in factor 3 by presenting the results for their review and evaluation. ~~At a minimum, the organization presents the analysis to community representatives for review and feedback. The organization may include community representatives on the evaluation team.~~ The organization ~~should~~ must consult community representatives for their perspective on the root causes of barriers and possible solutions.

Community representatives must represent (e.g., shared direct experience, knowledge or expertise) a population relevant to each goal, initiative or barrier presented in the analysis.

The organization may include community representatives on the annual evaluation team, seek review and input from the same advisory functions convened in Element A, factor 3, or convene a separate advisory function.

Factor 5: **Evaluation of overall effectiveness**

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

Exceptions

None.

Examples

Annual written evaluation contents

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

Factor 4: **Review and evaluation by c~~C~~ommunity representatives**

- ~~Individuals/patients from culturally diverse groups.~~
- ~~Community advocates.~~
- ~~Employers with which the organization contracts, with diverse populations.~~
- ~~Labor unions.~~
- ~~Representatives of agencies that serve the population of interest.~~
- ~~Researchers involved in community-based research in diverse populations.~~ Members or patients with direct experience, knowledge or expertise relevant to the goal or identified barrier, root cause or challenge.
- Community advocates with direct experience, knowledge or expertise relevant to the member or patient population.
- Employers with which the organization contracts.
- Labor union representatives.
- Representatives of agencies that serve the member or patient population, or the communities where they reside.
- Researchers involved in community-based research in relevant subsets of the member or patient population.

HE 6: Reducing Health Care Disparities

The organization uses data to focus its quality improvement efforts on reducing health disparities and improving the accessibility and appropriateness of its services. ~~data to assess the existence of disparities and to focus quality improvement efforts toward improving the provision of culturally and linguistically appropriate services and decreasing health care disparities.~~

Intent

The organization uses data to prioritize opportunities for improvement and measure the effectiveness of interventions ~~about its population to improve services and reduce disparities~~.

Element A: Reporting Stratified Measures

The organization annually reports HEDIS measures and determines if health care disparities exist for each HEDIS measure, stratified by ~~race/ethnicity~~ race and ethnicity:

1. Colorectal Cancer Screening (COL, COL-E).
2. Adult Immunization Status (AIS-E).
3. Immunizations for Adolescents (IMA-E).
4. Breast Cancer Screening (BCS-E).
5. Asthma Medication Ratio (AMR).
6.~~2.~~ Controlling High Blood Pressure (CBP).
7.~~3.~~ ~~Hemoglobin A1c Control for Patients With Diabetes (HBD) or Glycemic~~ Status Assessment for Patients with Diabetes (GSD).
8. Follow-Up After Emergency Department Visits for Substance Use (FUA).
9. Pharmacotherapy for Opioid Use Disorder (POD).
10.~~4.~~ Prenatal and Postpartum Care (PPC).
11. Initiation and Engagement of Substance Use Disorder Treatment (IET).
12.~~5~~ Child and Adolescent Well Care Visits (WCV).
13. Well-Child Visits in the First 30 Months of Life (W30).

Scoring

Met	Partially Met	Not Met
The organization meets ~~2~~ 4-13 ~~5~~ factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, 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, and reviews reports describing the organization's analysis of disparities by race~~/~~ and ethnicity.

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

Factors 1–13 ~~5~~

The organization reports HEDIS measures to NCQA by race/ethnicity following the HEDIS specifications as defined in HEDIS *Volume 2 Technical Specifications for Health Plans*.

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

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

Exceptions

This element is NA for:

- Organizations that can demonstrate fewer than 30 members ~~individuals~~ in the denominator for every racial/ethnic group and subgroup.
- Organizations that are not health plans.
- The Exchange product line.
- Health plans that are not NCQA Accredited, or have not completed initial submission of HEDIS.

Factor 1 is NA for the Medicaid product line.

Factors 10~~4~~ and 12~~5~~ are NA for the Medicare product line.

Examples

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

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

Element B: ~~Use of Data~~ Stratifying Measures to Assess Disparities

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

1. **Analyzes two or more valid measures of clinical performance by race and ~~/~~ethnicity.**
2. **Analyzes one or more valid measures of clinical performance, ~~such as HEDIS~~ by preferred language.**
3. **Analyzes one or more valid measures of clinical performance ~~such as HEDIS~~ by ~~gender identity and/or~~ sexual orientation.**
4. **Analyzes one or more valid measures of clinical performance by disability status.**
5. **Analyzes one or more valid measures of clinical performance by geographic classification.**
6. **Analyzes one or more valid measures of clinical performance by an additional characteristic.**

~~5~~ 7. Analyzes ~~one~~ two or more valid measures of individual experience ~~, such as CAHPS~~, by a characteristic of the organization's choice. ~~race/ethnicity or preferred language~~.

Scoring

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

Data source Documented process, Reports

Scope of review

Product lines

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

Documentation

For Initial Surveys: NCQA reviews the organization's most recent measurement reports. NCQA also reviews a documented process or report reflecting the organization's stratification methodology. If the organization uses measures other than HEDIS or CAHPS, NCQA also reviews the measure's data collection methodology.

For Renewal Surveys: NCQA reviews the organization's most recent and the prior year's measurement reports. For factor 3, NCQA reviews the organization's most recent year's measurement reports. NCQA also reviews a documented process or report reflecting the organization's stratification methodology. If the organization uses measures other than HEDIS or CAHPS, NCQA also reviews the data collection methodology for validity and reliability.

Look-back period

For Initial Surveys: At least once during the prior year.
For Renewal Surveys: 24 months for factors 1-3; at least once during the prior year for factor 4-7.

Explanation

Methodology

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

The organization describes its method for annually stratifying measures by demographic characteristics to analyze whether there are health care disparities. It may use direct data collection for factors 2, 3 and 5, and may use direct or imputed data collection, or a combination, for factors 1 and 4.

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

Stratification

The organization annually stratifies HEDIS and CAHPS measures, or other clinical performance and individual experience measures, using member- or patient-level data. Stratification focuses on subgroups most relevant to the demographics of the population served, and for which stratification is feasible, given the size of the subgroup.

Some subgroups may have sufficient numbers of individuals to be analyzed individually (e.g., White, Black/African American); some subgroups represented in the organization's population by a small number of individuals may need to be grouped together for ~~the purpose of~~ analysis. In some organizations, it may be possible to stratify distinct subgroups—Chinese, Japanese, Korean or Vietnamese, rather than “Asian,” or Mexican/Mexican American/Chicano, Puerto Rican or Cuban rather than “Hispanic or Latino.”

NCQA does not prescribe ~~racial or ethnic~~ subgroups for stratification, nor does it prescribe performance measures, but suggests that the organization focus on disparity-sensitive measures ~~specified by the NQF~~; in particular, measures of care processes or outcomes relevant to the organization’s population.

Valid clinical performance measures

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

- Address a relevant process or outcome.
- Produce a quantifiable result.
- Be population based.
- Use data and a method that are valid for the process or outcome being measured.
- Include the uninsured population, if applicable to the organization’s patient population.

~~For care delivery organizations, results must include the uninsured population.~~

Valid individual experience measures

If the organization uses individual experience measures other than CAHPS, NCQA reviews the organization’s description of its data collection methodology to determine if the methodology produces valid and reliable results.

The sample size drawn for the survey must be sufficient to reach conclusions about the population of individuals served. Survey reports completed by the organization must show annual measurement of the population, sample size, sampling technique, method of administration (e.g., telephone or mail; administered by an outside vendor or by the organization) and response rates.

Quantitative analysis

Annual analysis of findings includes a first-level, quantitative data analysis that incorporates aggregate results and compares results for each subsample against the best-performing subsample or a predefined benchmark or reference group.

For each factor, the organization uses either individual-level, self-identified data (e.g., for measures that use the Hybrid Method) or information systems to identify individuals captured in the measure's numerator and denominator.

For factors 1–7, the organization analyzes the performance of subgroups by comparing them against a reference group. When determining if disparities exist at a single point in time, the organization may compare all subgroups against each other. When evaluating trended data over time, the organization may compare all subgroups against the most advantaged group (the group with the best performance). This is the reference group.

For HEDIS and CAHPS data, the comparison could be against overall or regional benchmarks and thresholds published by NCQA. If an organization has multiple locations in a state, it may analyze statewide data, but aggregate data might not provide sufficient information to suggest actions the organization should take at each location.

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

Stratification

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

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

Factor 1: Analyzing clinical performance measures by race/ethnicity

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

Factor 2: Analyzing clinical performance measures by preferred language

~~The organization stratifies one or more HEDIS or other clinical performance, measures by~~

The organization analyzes one or more valid measures of clinical performance (e.g., HEDIS) stratified by preferred language.

~~The organization must stratify the measure by individuals' self-identified preferred language.~~ ~~***Factor 3:* Analyzing clinical performance measures by gender identity and/or sexual orientation**~~

~~NCQA reviews the organization's most recent measurement report.~~

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

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

Factor 3: Analyzing clinical performance measures by sexual orientation

The organization analyzes one or more valid measures of clinical performance stratified by sexual orientation.

Factor 4: Analyzing clinical performance measures by disability status

The organization analyzes one or more valid measures of clinical performance stratified by disability status. The organization may analyze disability function and identity separately, or may combine them.

If the organization can demonstrate that its data collection did not identify subgroups of disability status with more than 30 individuals in the denominator, it may compare the population with any disability status to the population identified as having no disability function and no disability identity.

Factor 5: Analyzing clinical performance measures by geographic classification

The organization analyzes one or more valid measures of clinical performance stratified by geographic classification (e.g., metropolitan, micropolitan, urban, suburban, rural).

Factor 6: Analyzing clinical performance measures by a characteristic of the organization's choice

The organization chooses an additional characteristic and describes its relevance to the member or patient population. Additional characteristics may include, but are not limited to, age, veteran status, gender, socioeconomic status, dual eligibility status or positive social needs screen. The organization should choose a characteristic for which it has a large enough denominator (i.e., 30 individuals or more) to perform a meaningful comparison.

Factor 7: Analyzing measures of individual experience by a characteristic of the organization's choice

The organization analyzes two or more valid measures of experience of care (e.g., CAHPS) stratified by one or more characteristics. The organization may use the same characteristics for both measures of experience, or a different characteristic for each measure.

The organization determines which characteristics are relevant to the organization's member or patient population, and for which it has a large enough denominator (i.e., 30 individuals or more) to perform a meaningful comparison. It may use one or more of the following characteristics:

- Race and ethnicity.
- Preferred language.
- Sexual orientation.
- Disability status.
- Geographic classification.
- An additional characteristic (e.g., age, veteran status, gender, socioeconomic status, dual eligibility status).

Exceptions

~~This element is~~ Factors 1–5 are NA if the organization can demonstrate that it has only one ~~racial/ethnic and preferred language~~ subgroup with more than 30 individuals in the denominator, or has no subgroups with more than 30 individuals in the denominator to perform a meaningful comparison for each factor. ~~, for race/ethnicity, preferred language, gender identity, sexual orientation.~~

Factor 1 is NA for:

- Organizations that ~~report at least two measures scored~~ Met in Element A.
- Organizations that can demonstrate they have only one racial and ~~/~~ethnic subgroup with more than 30 individuals in the denominator.

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

Factor 3 is NA for:

- Organizations that can demonstrate they have only one sexual orientation subgroup with more than 30 individuals in the denominator.
- Organizations with at least 85% of the organization's patient population or membership is under the age of 18 (e.g., pediatric practices, Children's Health Insurance Programs).

Factor 4 is NA if the organization can demonstrate that it has no subgroups of disability status with more than 30 individuals in the denominator, other than the subgroup identified as having no disability ~~functional~~ status (function or identity).

Factor 5 is NA if the organization can demonstrate that it has only one geographic classification subgroup with more than 30 individuals in the denominator.

~~Factor 6 is NA if at least 85% of the organization's patient population or membership is under the age of 18 (e.g., pediatric practices, Children's Health Insurance Programs).~~

Related information

NQF disparity-sensitive measures. The NQF published a national set of disparity-sensitive performance measures[1] in eight priority areas (asthma; diabetes; heart disease; hypertension; medication management; mental health and substance use; prenatal care; and prevention, immunization and screening) and one additional measure in patient experience with care.

[1] *National Voluntary Consensus Standards for Ambulatory Care—Measuring Healthcare Disparities: A Consensus Report.* NQF. 2008.

Examples

Stratifying performance data

When organizations stratify clinical performance or individual experience measures by ~~race/ethnicity, language, gender identity or sexual orientation~~ demographic characteristics, ~~they must~~ the organization should focus on subgroups most relevant to the demographics of the population it serves and the selected measure. Examples of stratifying clinical performance or individual experience measures may include, but are not limited to, analyzing:

- HbA1c screening rates ~~for~~ by racial subgroups (African American~~s~~, White,~~s~~ ~~and~~ Other).
- ~~Cervical cancer screening rates for cisgender women and transgender men/ trans men/female-to-males (FTM).~~
- Clinical depression screening rates for bisexual, lesbian/gay/homosexual and straight/heterosexual individuals.
- How well doctors communicate in English/Spanish/Other.
- Ratings for personal doctor by individuals whose preferred language is English, Spanish, Cantonese and Vietnamese.
- Hypertension control rates for individuals classified as metropolitan, micropolitan and rural.
- Breast cancer screening rates for individuals who identified as having one or more disabilities compared to individuals who identified as having none. ~~for individuals with a disability vs. the general population~~
- Experience with choice of practitioner (not a CAHPS item) by White Latino/Hispanic, White Not Latino/Hispanic, African American Latino/Hispanic, African American Not Latino/Hispanic.

Element C *(NEW)*: Using Multi-Factor Analysis to Assess Disparities

The organization annually performs a multi-factor analysis to assess health disparities by:

1. **Identifying intersectional subgroups of at least two relevant demographic characteristics.**
2. **Selecting at least two meaningful and relevant measures.**
3. **Stratifying the measures identified in factor 2 by the intersectional subgroups identified in factor 1.**
4. **Analyzing each stratified measure in factor 3 to determine if there are disparities.**
5. **Evaluating key similarities and differences between identified intersectional subgroups across the two stratified measures.**

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

Scope of review *For Renewal Surveys:* NCQA reviews the organization's documented process describing its method for multi-factor analysis. The organization may include reports in place of a documented process for factors 1–3.

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

Explanation Analyzing measures, simultaneously, by multiple sociodemographic characteristics provides detailed insights about the relationship between factors that impact individuals' outcomes. Such an approach supports person-centered care by understanding the interaction of different parts of a person's experience, identify or environment. These insights can be useful for designing programs and interventions tailored to subgroups of members or patients who most acutely experience health disparities, and for evaluating the effectiveness of interventions over time.

Valid clinical performance measures

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

- Address a relevant process or outcome.
- Produce a quantifiable result.
- Be population based.
- Use data and a method that are valid for the process or outcome being measured.
- Include the uninsured population, if applicable to the organization's patient population.

~~For care delivery organizations, results must include the uninsured population.~~

Valid individual experience measures

If the organization uses individual experience measures other than CAHPS, NCQA reviews the organization's description of its data collection methodology to determine if the methodology produces valid and reliable results.

The sample size drawn for the survey must be sufficient to reach conclusions about the population of individuals served. Survey reports completed by the organization must show annual measurement of the population, sample size, sampling technique, method of administration (e.g., telephone or mail; administered by an outside vendor or by the organization) and response rates.

Quantitative analysis

Annual analysis of findings includes a first-level, quantitative data analysis that incorporates aggregate results and compares results for each subsample against the best-performing subsample or a predefined benchmark or reference group.

For each factor, the organization uses either individual-level, self-identified data (e.g., for measures that use the Hybrid Method) or information systems to identify individuals captured in the measure's numerator and denominator.

For factors 1–2, the organization analyzes the performance of subgroups by comparing them against a reference group. When determining if disparities exist at a single point in time, the organization may compare all subgroups against each other. When evaluating trended data over time, the organization may compare all subgroups against the most advantaged group (the group with the best performance). This is the reference group.

For HEDIS and CAHPS data, the comparison could be against overall or regional benchmarks and thresholds published by NCQA. If an organization has multiple locations in a state, it may analyze statewide data, but aggregate data might not provide sufficient information to suggest actions the organization should take at each location.

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

***Factor 1:* Identifying intersectional subgroups**

The organization annually identifies two or more demographic characteristics that are:

- Relevant to its member or patient population.
- Complementary to each other, while providing meaningfully distinct information (provide different types of insights).
- Represented in data from a substantial volume of its member or patient population to support meaningful comparison.

NCQA does not prescribe demographic characteristics for intersectional stratification but suggests that the organization focus on characteristics that are known to be sensitive to disparities; for instance, race and ethnicity, language, sexual orientation, disability status, geographic classification.

***Factor 2:* Selecting meaningful and relevant measures**

The organization annually selects two measures that are:

- Relevant to its member or patient population.
- Complementary, while providing meaningfully distinct information (provide different insights and do not substantially overlap).

The organization must use at least one clinical performance measure. It may use the same clinical performance or individual experience measures it selected for HE 6, Element B, but is not required to.

NCQA does not prescribe measures but suggests that the organization focus on disparity-sensitive measures; in particular, measures of care processes or outcomes relevant to the organization's population.

***Factor 3:* Stratifying measures**

The organization stratifies each measure it selected for factor 2 by the intersectional subgroups it identified in factor 1. The organization may stratify each measure separately or as a single composite score, and may must use the same or different intersectional subgroups across measures.

***Factor 4:* Analyzing stratified measures**

The organization annually analyzes each stratified measure (or a single composite score) from factor 3 to determine if there are disparities by intersectional subgroup and identify where they are most pronounced.

***Factor 5:* Evaluating key similarities and differences**

The organization compares differences and similarities between intersectional subgroups across both measures (or within a single composite score).

Related information

There are many valid approaches to using multiple factors to identify health disparities. A simple approach includes calculating measure rates for all subgroups, followed by comparing across subgroups. Results can be assessed in a tabular or graphic format, highlighting subgroups' experience and best and worst outcomes.

More computationally advanced methods that create a composite across multiple measure and subgroup performance outcomes into summary scores may also be leveraged, such as the Health Equity Metric, the Population Health Performance Index, the Health Equity Summary Score and others.

NCQA outlines considerations around use of these methods in a 2023 issue brief, *Measuring Health Equity: A Review of Scoring Approaches*.[5]

Exceptions

This element is NA for all Initial Surveys.

Examples

***Factor 1:* Identifying intersectional subgroups**

Race and ethnicity	Medicare/Medicaid Dual Enrolled	Not Dual Enrolled
American Indian/Alaska Native	Dual—American Indian/ Alaska Native	Non-Dual—American Indian/Alaska Native
Asian	Dual—Asian	Non-Dual—Asian
Black/African American	Dual—Black/African American	Non-Dual—Black/African American

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[5] https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2023/02/NCQA-MeasuringHealthEquity-Whitepaper-FINAL_WEB.pdf

Hispanic or Latino	Dual—Hispanic or Latino	Non-Dual –Hispanic or Latino
Middle Eastern or North African	Dual—Middle Eastern or North African	Non-Dual—Middle Eastern or North African
Native Hawaiian or Pacific Islander	Dual—Native Hawaiian or Pacific Islander	Non-Dual—Native Hawaiian or Pacific Islander
White	Dual—White	Non-Dual—White
Some Other Race	Dual—Some Other Race	Non-Dual—Some Other Race

Sex Assigned at Birth	**<18 Years**	**18–44 Years**	**45–64 Years**	**65+ Years**
Male	Male/<18	Male/18–44	Male/45–64	Male/65+
Female	Female/<18	Female/18–44	Female/45–64	Female/65+

Spoken Language	**Rural**	**Metro Non-Urban**	**Metro Urban**
Cantonese	Cantonese/Rural	Cantonese/Metro Non-Urban	Cantonese/Metro Urban
English	English/Rural	English/Metro Non-Urban	English/Metro Urban
Hindi	Hindi/Rural	Hindi/Metro Non-Urban	Hindi/Metro Urban
Mandarin	Mandarin/Rural	Mand/Metro Non-Urban	Mandarin/Metro Urban
Spanish	Spanish/Rural	Spanish/Metro Non-Urban	Spanish/Metro Urban
All Other Languages	All Other Languages/Rural	All Other Languages/Metro Non-Urban	All Other Languages/Metro Urban

Factors 2, 3

- Procedure no-show rate, stratified by ethnicity and geography.
- Participation rates for the organization’s smoking cessation programs, stratified by age and veteran status.
- The HEDIS Follow-Up After Emergency Department Visits for Substance Use, stratified by disability status and race/ethnicity.
- The HEDIS Asthma Medication Ratio measure, stratified by dual eligibility and language.

Element ~~C~~ D: ~~Use of Data to Monitor and Assess Services~~ Assessing Language Services, Auxiliary Aids/Services and Accommodations

The organization assesses the following at least annually:

1. **Utilization of language services for organization functions.**
2. **~~Individual~~ Member or patient experience with language services for organization functions.**
3. **Staff experience with language services for organization functions.**
4. **Utilization of physical disability accommodations or auxiliary aids/services during health care encounters.**
5. **Staff experience with physical disability accommodations or auxiliary aids/services during health care encounters.**
6. **~~Individual~~ Member or patient experience with language services during health care encounters.**
7. **Member or patient experience with physical disability accommodations or auxiliary aids/services during health care encounters.**

Scoring

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

Data source Reports

Scope of review

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

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

Look-back period

For Initial Surveys: At least once during the prior year.
For Renewal Surveys: 24 months for factors 1, 2, 3 and 6; at least once during the prior year for factors 4, 5 and 7.

Explanation

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

The organization may use a variety of mechanisms, including quantitative or qualitative data, to evaluate ~~individual~~ member/patient and staff experience ~~with language services~~. To the extent that the organization uses CAHPS items or supplemental questions, the organization uses sampling methods appropriate for capturing ~~individuals~~ members or patients who needed or used language services, physical accommodations or auxiliary aids/services. The organization may solicit point-of-contact feedback through survey or interview and may obtain feedback through interviews, focus groups or other qualitative analysis. Analysis of complaint and grievance data alone does not meet factors 2–~~4~~ 7~~.~~

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

Organization functions

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

- Billing.
- Care coordination or navigation.
- Case management.
- Claims.
- Check-in or triage.
- Complaints, grievances and appeals.
- Customer service or patient services.
- Discharge.
- Informed consent.
- Population health management.
- Utilization management.

- ~~Member Services.Claims.~~
- ~~Utilization management.~~
- ~~Population health management.~~
- ~~Case management.~~
- ~~Complaints, grievances and appeals.~~

Exceptions

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

- Health plans.
- Organizations that do not directly provide health care.

Factors 5–7 are NA if the organization does not employ or contract with practitioners.

Examples

Utilization indicators

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

Methods to evaluate individual experience

- Survey:
  - All members/patients ~~individuals~~ who indicated a language preference other than English, ***or***
  - All individuals who used language services to obtain feedback on their experience with language services in the clinical setting.

- Follow-up calls to members/patients ~~individuals~~ who requested or used language services to obtain feedback on their experience with language services in the clinical setting.
- Mail a questionnaire to or interview members/patients ~~individuals~~ who used language services, to obtain feedback on their experience with services administered in the clinical setting.
- Focus groups with members/patients ~~individuals~~ or community advocates.

Methods to evaluate staff experience

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

Indicators of individual or staff experience

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

Element ~~D~~ E: ~~Use of Data to Measure CLAS and Inequities~~ Evaluating Effectiveness of Interventions

Based on its assessment of health care disparities, language services, disability accommodations and auxiliary aids/services ~~the results of measurement of health care inequities and language services,~~ the organization annually:

1. **Identifies and prioritizes opportunities to reduce health care ~~inequities~~ disparities.**
2. **Identifies and prioritizes opportunities to improve ~~CLAS~~ the appropriateness or accessibility of care or services.**
3. **Implements at least one intervention to address ~~an inequity~~ a health care disparity and its root cause(s).**
4. **Implements at least one intervention to improve ~~CLAS~~ the appropriateness or accessibility of care or services.**
5. **Evaluates the effectiveness of an intervention to reduce ~~an inequity~~ a health care disparity and its root cause(s).**
6. **Evaluates the effectiveness of an intervention to improve the appropriateness or accessibility of care or services ~~CLAS~~.**

Scoring

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

Data source Documented process, Reports

Scope of review

For Initial Surveys: NCQA reviews the organization’s most recent annual assessment; for factors 5 and 6, NCQA reviews a plan for evaluation of interventions.

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

Look-back period

For All ~~Initial~~ Surveys: At least once during the prior year.
~~*For Renewal Surveys:* 24 months.~~

Explanation

The organization performs annual QI interventions to improve ~~CLAS and~~ appropriateness (e.g., cultural, linguistic, responsiveness to population needs) or the accessibility (e.g., environment, equipment, process) of its services and to reduce health care~~ inequities~~ disparities and their root cause(s).

~~**Inequities** are systemic health differences arising from social conditions that are avoidable, unnecessary, unfair and unjust. **Disparities** are the result of inequities and can be reduced by addressing inequities.~~

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

The organization should identify opportunities and implement interventions aimed at reducing ~~the inequities that may be resulting in~~ disparities in access to care or services, accessibility of care or services, patient or member experience, or health outcomes, as well as the root causes of these disparities.

The organization may use findings from Elements A~~–C~~D to identify opportunities to improve the appropriateness or accessibility of services, reduce ~~inequities~~ health disparities, but is not required to. The organization may choose opportunities and interventions related to: ~~race/ethnicity, language, gender identity or sexual orientation, as well as to structural and systemic causes of differences in health outcomes, such as lack of access to affordable housing, education or food security.~~

- Race, ethnicity, language, sexual orientation, disability status, geographic classification or other member/patient demographic characteristics.
- Two or more intersectional demographic characteristics.
- Structural, systemic, institutional or social root causes of health disparities, such as:
  - Differences in access to affordable housing, education or food security.
  - Organizational policies, procedures, systems or workflows that create or perpetuate differences in outcomes, experience or accessibility.

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

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

The organization identifies as many opportunities as possible, prioritizes them based on its analysis and their significance for concerns to ~~individuals~~ members or patients and indicates how it chose the opportunities. NCQA uses the analysis to evaluate whether chosen priorities reflect significant issues. For each opportunity or barrier, the organization must describe its reasons for taking action or not taking action.

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

Opportunities may be identified for ~~individuals~~ members or patients, practitioners, the contracted practitioner network or the organization (e.g., policies, workflows, investments, programs, staffing). NCQA does not prescribe the types of opportunities the organization may identify or select.

Factors 3, 4: **Implementing interventions**

Research[1][2] indicates that the most successful approaches to reducing health care ~~inequities~~ disparities and their root cause(s) are multifaceted. NCQA recognizes that implementing interventions can be a complex process that occurs over time. NCQA evaluates whether the organization has implemented at least one intervention each to address a prioritized opportunity for improving the accessibility or appropriateness of services, and one intervention for ~~CLAS~~ and reducing ~~inequities~~ health care disparities. The organization must indicate the rationale for choosing a particular intervention, and may include a description of the intervention's relationship to root cause(s) of disparities.

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

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

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

Exceptions

Factor 3–6 are NA if no opportunities ~~for inequity reduction~~ are identified by the organization based on its analysis of results.

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

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

NCQA assesses whether ~~"NA" is a~~ this conclusion is reasonable, ~~conclusion~~ based on the organization's analysis.

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

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

Examples

~~***Factors 1, 2*** **Identifying and prioritizing opportunities for improvement**~~ ***Factors 1, 3 and 5 in action*:**

Identification. The organization's analysis by race and ethnicity identifies significant disparities in mammography screening, HbA1c control and blood pressure control for African American members compared to White members (as the reference group).

Prioritization. The organization prioritizes addressing the disparities in HbA1c control and blood pressure control over the disparity in mammography screenings due to the immediate, serious consequences of both high blood pressure and uncontrolled diabetes. The organization then determines it will prioritize high blood pressure as the subject of its first intervention because its diabetes program was recently redesigned.

Root cause analysis. The organization identifies network practitioners that provide care to the largest volume of African American patients with hypertension and practitioners who provide care primarily to White patients with hypertension, then conducts chart reviews and interviews. Analysis determines that blood pressure screening was documented somewhat less frequently for African American patients, but that even when screening rates were comparable, these patients' blood pressure was more often above normal. Follow-up interviews with providers suggests two contributing factors:

- A perception held by African American patients that it is difficult to visit the doctor's office as frequently as required to check blood pressure and adjust medication.
- An attitude held by practitioners that African American patients do not adhere to medication regimens as well as other patients.

Follow-up interviews with a sample of African American patients with hypertension indicate that some patients take their prescribed hypertension medication only during stressful situations, when they feel their blood pressure will be higher. They report that their doctors had not told them to take their medicine every day regardless of how they feel. A percentage of patients also indicate they experience food insecurity.

Intervention. The organization works with a vendor that administers its hypertension program to develop culturally appropriate outreach materials that address risks and concerns specific to its African American members. It also recruits an African American nurse to conduct outreach calls and provide home blood pressure monitoring kits to members enrolled in the program. Last, it enters into a partnership with a local farmers market to provide subsidized groceries and nutrition meal plans to members enrolled in the program.

Evaluation of effectiveness. The organization has a multi-year plan to monitor the results of its intervention. In the short term, it evaluates its results by measuring the rate of African American members enrolled in its hypertension program before and after the intervention, and continues sampling their charts to determine if blood pressure screenings are increasingly recorded over time. ~~The organization's analysis by race indicates that significant health care inequities exist in mammography screening, HbA1c control and blood pressure control. In the case of all three measures, the African American population fares worse than the White population. Because of the prevalence of hypertension and diabetes among African Americans, and because of the serious consequences of both high blood pressure~~

~~and uncontrolled diabetes, the organization prioritizes addressing disparities in hypertension and diabetes over mammography screening. To focus on a manageable effort and because the diabetes management program was recently reorganized, the organization selected hypertension as the first area for which to develop an intervention.~~

***Factors 3, 4:* ~~Developing an~~ Implementing an intervention**

- Recruit staff with specific language skills where gaps exist.
- Sponsor (e.g., offer grants, scholarships) the enrollment of practitioners, staff, community health workers or patient navigators in language or Certified Healthcare Interpreter courses, to increase the pool of bilingual and interpreter staff available to patients or members.
- Offer higher reimbursement rates to practitioners who:
  - Speak two or more languages.
  - Serve a significant number of members or patients:
    - In rural counties.
    - In Medically Underserved Areas or Health Professional Shortage areas.
    - With intellectual or developmental disabilities.
    - Whose primary language is not English.
  - Have completed medical education or training on provision of care for specific subpopulations (e.g., sexual or gender-diverse individuals, individuals with disabilities, individuals who use language services, relevant cultural or linguistic subgroups of the organization’s population).
- Offer higher reimbursement rates for health care encounters that use language services (e.g., interpretation) or auxiliary aids/services for communication (e.g., letter board, assistive listening device, text-to-speech app).
- Change appointment policies to allow flexibility in arrival time for patients with disabilities, or to hold end-of-day appointment times for patients who are immunocompromised or have emotional or behavioral health issues.
- Expand the accessibility of digital content on the organization’s website, beyond pages with vital information.
- Provide or require staff training in cultural humility and cross-cultural communication skills.
- Incentivize practitioners to complete trainings or CME that address culturally and linguistically appropriate care practices for relevant member or patient populations.
- Partner with community organizations to develop patient education and communications about health conditions (e.g., depression, diabetes) to the cultural context and language spoken by groups with observed disparities in relevant measures
- Change processes for screening outreach (e.g., cervical cancer) to include individuals with gender identities or anatomical inventories aligned with the organ addressed by screening.
- Offer culturally and religiously responsive options for examination or procedures (e.g., a medical-grade hijab for surgery).
- Hire or engage community volunteers to advocate for and help members or patients from diverse backgrounds to navigate the health care system (“patient navigators”).
- ~~The organization recognized the need to understand the reasons for disparate results in order to develop an effective intervention. QI staff identified~~

~~practitioners who provide care to a large number of African American patients with hypertension, and identified practitioners who provide care to White patients with hypertension. Chart reviews and interviews were conducted during the first quarter, to understand the differences in care provided and outcomes achieved.~~

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

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

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

~~Based on this assessment, the organization determined that a patient-focused intervention was required. The organization worked with its diabetes management program to develop outreach materials that were culturally competent and addressed risks specific to African Americans. The organization recruited an African American nurse to conduct outreach calls and provided home blood pressure monitoring kits to patients enrolled in the hypertension management program. The organization also partnered with a local farmers market to provide subsidized groceries and nutrition meal plans to these patients. Following implementation of the intervention, the organization decided to continue to study the reasons for poor medication adherence and food insecurity.~~

~~*Interventions to improve CLAS*~~

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

~~***Factors 5, 6:***~~ **Evaluating effectiveness**

~~While the organization hoped that its intervention would result in an improvement of blood pressure control, it recognized that this would take time. In the interim, the organization evaluated intermediate outcomes. It measured the rate of enrollment by African American individuals in the hypertension management program before and~~

~~after implementation, and conducted chart reviews for a sample of patients and practitioners to determine whether blood pressure was being recorded more frequently in patients' charts.~~

HE 7: Delegation of ~~Health Equity~~ Program Activities

If the organization delegates NCQA-required ~~health equity~~ activities for its program to improve service appropriateness and accessibility, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated ~~health equity~~ activities for its program to improve service appropriateness and accessibility.

Element A: Delegation Agreement

The written delegation agreement:

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

Scoring

Met	Partially Met	Not Met
The organization meets 5 ~~4-~~6 factors	The organization meets 3-4 ~~2-3~~ factors	The organization meets 0-2 ~~1~~factors

Data source Materials

Scope of review NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

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

Look-back period *For Interim Surveys and First Surveys:* 6 months.

For Renewal Surveys: 24 months.

~~*For All Surveys:* Prior to the survey date.~~

Explanation This element may not be delegated.

This element applies to agreements that are in effect within the look-back period.

The delegation agreement describes all delegated health equity activities. A generic policy statement about the content of delegated arrangements does not meet the intent.

Factor 1: **Mutual agreement**

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

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (the date of last signature) as the mutually agreed upon effective date.

NCQA accepts other dated forms of the mutually agreed-upon, such as: a letter, meeting minutes or other documented communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities.

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

Factor 2: **Assigning responsibilities**

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

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

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

Factor 3: **Reporting**

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

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

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

Factor 4: **Performance monitoring**

The delegation agreement specifies how the organization evaluates the delegate's performance.

Factor 5: **Providing individual and clinical data**

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

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

***Factor 6:* Consequences for failure to perform**

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

Exceptions

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

The individual experience and clinical performance aspect of factor 5 is NA if these data are not relevant to delegated activities.

Examples None.

Element B: Predelegation Evaluation

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

Scoring

Met	Partially Met	Not Met
The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data source Reports

Scope of review

NCQA reviews the organization’s predelegation evaluation from up to four delegates, or reviews all delegates if the organization has fewer than four.

This element applies if delegation was implemented in the look-back period.

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

Look-back period

For Interim and First Surveys: 6 months.

For Renewal Surveys: 12 months.

~~*For All Surveys:* 6 months~~.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health equity organizations, unless the element is NA.

Note: *For organizations that have both NCQA-Accredited and non-Accredited delegates:*

- *NCQA-Accredited delegates are eligible for automatic credit.*
- *Non-Accredited delegates are reviewed and scored accordingly.*

Predelegation evaluation

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

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

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

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

Exceptions

This element is NA if:

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

Related information

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

- Predelegation evaluation.
- Annual evaluation.

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

Examples

Predelegation evaluation

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

Element C: Review of Performance

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

1. **Annually reviews its delegates health equity program.**
2. **Annually evaluates delegate performance against NCQA standards for delegated activities, as specified in Element A.**
3. **Semiannually evaluates regular reports, as specified in Element A.**

Scoring

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

Data source Reports

Scope of review

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

NCQA reviews the organization’s most recent semiannual and annual performance evaluation reports completed during the look-back period.

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

Look-back period

For Interim Surveys and First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

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

Explanation

***Factor 1:* Review of health equity program**

Appropriate organization staff or committee reviews the delegate’s health equity program. At a minimum, the organization reviews parts of the health equity program that apply to the delegated functions.

***Factor 2:* Evaluation of reports**

No additional explanation required.

***Factor 3:* Annual evaluation**

No additional explanation required.

Exceptions

This element is NA if:

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

Related information

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

- Predelegation evaluation.
- Annual evaluation.

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

Examples None.

Element D: Opportunities for Improvement

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

Scoring

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

Data source Documented process, Reports, Materials

Scope of review NCQA reviews reports for opportunities for improvement, if applicable, from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

NCQA also reviews the organization’s most recent annual review and follow-up on improvement opportunities.

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

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

For Renewal Surveys: 24 months.

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

Explanation This element may not be delegated.

Identify and follow up on opportunities

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

Exceptions

This element is NA if:

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

- The organization has no opportunities to improve performance.
    - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.