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2026 Health Plan Accreditation

QI 1: Program Structure and Operations

The organization clearly defines its quality improvement (QI) program structure and processes, assigns responsibility to appropriate individuals and operationalizes its QI program.

Intent

The organization has the QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members and to oversee the QI program.

Element E: ~~Promoting Organizational Diversity, Equity and Inclusion~~ Developing and Maintaining a Responsive Workforce

The organization develops and maintains a workforce responsive to the needs of its members by:

1. **~~Promotes diversity in recruiting and hiring.~~ Having a process to recruit and hire a workforce with direct experience, knowledge or expertise relevant to the needs of its population.**
2. **~~Offers training to employees on cultural competency, bias or inclusion.~~ Offering training or education to all employees on culturally and linguistically appropriate practices, trauma-informed practices or reducing bias.**

Scoring

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

Data source Documented process, Reports, Materials

Scope of review

Product lines

For Interim Surveys, First Surveys and Renewal Surveys: This element applies to all product lines.

Documentation

For Interim Surveys: NCQA reviews the organization's policies and procedures that describe its recruiting and hiring process ~~for promoting diversity in recruiting and hiring and for offering training to employees~~.

For First Surveys and Renewal Surveys:

- *For factor 1:* NCQA reviews the organization's policies and procedures or materials that describe its recruiting and hiring process in place throughout the look-back period ~~for promoting diversity in recruiting and hiring~~.
- *For factor 2:* NCQA reviews ~~the organization's policies and procedures in place throughout the look-back period for offering training to employees, and reviews~~ reports or materials as evidence demonstrating that at least one training or educational course was offered during the look-back

period. ~~the organization offered the training at least once during the prior 24 months.~~

Look-back period

For Interim Surveys: Prior to the survey date.

For First and Renewal Surveys: 6 months for factor 1; At least once during the prior year for factor 2.

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

Explanation

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

This element is scored "Met" if the organization seeking Health Plan Accreditation also has an NCQA Health Equity Accreditation status.

Factor 1: ~~**Promotes diversity in recruiting and hiring**~~ **Recruiting and hiring a relevant workforce**

The organization demonstrates, through policies and procedures 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.

~~The organization describes how its recruiting and hiring processes promote a diverse workforce.~~

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

Factor 2: **Offer training**

The organization demonstrates, through reports or materials, that it offers at least one training or educational course to all employees on ~~cultural competence, bias or inclusion.~~ one of the following topics:

- Culturally and linguistically appropriate practices.
- Trauma-informed practices.
- Improving the impartiality of care or service delivery.

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 or services.

Trauma-informed practices for health care or services seek to recognize, understand and respond to the signs, symptoms, impacts and risks of patients' traumatic life experiences to their health and well-being.

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).

The organization determines training type, format and frequency. Training is not mandatory for employees, and the organization is not scored on the rate of employees who complete training.

Exceptions

None.

Related information

Use of vendors for training ~~on cultural competency, bias or inclusion~~. If the organization contracts with a vendor to provide training ~~on cultural competency, bias or inclusion~~ for factor 2, it provides access to the vendor's documentation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under QI 4. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors* in *Appendix 2: Delegation and Automatic Credit Guidelines*.

Examples

***Factor 1*: ~~Promoting diversity in recruiting and hiring~~ Recruiting and hiring a relevant workforce**

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 provision of culturally appropriate care practices.
- Certification in trauma-informed care practices.
- 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.

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

~~The organization includes the following in its policies and procedures for promoting diversity in recruiting and hiring:~~

- ~~Require that candidates interviewed for a position in the organization include at least one person from an underrepresented demographic and one person from an underrepresented gender.~~
- Create an inclusive job description:
  - Use gender neutral language.
  - Reduce requirements to "must-haves."
  - Indicate a salary range.
  - ~~Emphasize the organization's commitment to diversity and inclusion.~~
- Blind-review of resumes.
- Hold hiring decision makers responsible for ~~representational growth (i.e., diversity)~~staffing goals in teams and in the organization.
- ~~Dedicate resources to recruiting underrepresented groups (e.g., individuals with disabilities).~~
- Deploy technology that screens for bias in job descriptions and postings.
- Require interview panels to include interviewers ~~from underrepresented groups or genders.~~ with relevant experience, knowledge or expertise for the position being hired.

- Broaden recruitment sources; for example:
  - Schools with diverse student bodies or alumni networks.
  - 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.
- Base salaries on factors that support salary equity for historically marginalized, disenfranchised or disempowered groups; for example:
  - Offer salaries that align with similar positions at other organizations.
  - Offer salaries that align with same/similar positions in the organization.

PHM 1: PHM Strategy

The organization outlines its population health management (PHM) strategy for meeting the care needs of its member population.

Intent

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

Element A: Strategy Description

The strategy describes:

1. **Goals and populations targeted for each of the four areas of focus.***
2. **Programs or services offered to members.**
3. **Three activities that support practitioners, providers or community-based organizations.**
4. **How member programs are coordinated.**
5. **How members and practitioners are informed about available PHM programs.**
6. **How the organization ~~promotes health equity~~ addresses health disparities and their root causes.**

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

Scoring

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

Data source Documented process

Scope of review

Product lines

For Interim Surveys, First Surveys and Renewal Surveys: This element applies to all product lines.

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

Documentation

NCQA reviews a description of the organization's comprehensive PHM strategy that is in place throughout the look-back period. The strategy may be fully described in one document, or the organization may provide a summary document with references or links to supporting documents provided in other PHM elements. The organization may use a single document to describe a strategy that applies across all product lines, if the document also describes differences in strategy to support different populations, by product line.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months for factors 1, 2 and 4; prior to the survey date for factors 3 ~~and~~ 5 and 6.

For Renewal Surveys: 24 months for factors 1, 2 and 4; prior to the survey date for factors 3, ~~and~~ 5 and 6.

Explanation

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

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

***Factors 1, 2:* Four areas of focus**

The organization has a comprehensive strategy for population health management that must address member needs in the following four areas of focus:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.

The description includes the following for each of the four areas of focus:

- A goal (factor 1).
- A target population (factor 1).
- A program or service (factor 2).

Goals are measurable, time-targeted and specific to a target population. A **program** is a collection of services or activities to manage member health. A **service** is an activity or intervention in which individuals can participate to help reach a specified health goal.

***Factor 2*: Programs and services**

Programs and services offered to the organization's members align with its comprehensive strategy and the areas of focus in factor 1.

NCQA does not prescribe a specific number of programs or services that must be offered to members, nor does it require all programs and services to be included or limited to each focus area in factor 1. The organization must include a description of the programs and services that align with the goals in its comprehensive PHM strategy, including those programs and services involving any level of member interactive contact.

***Factor 3*: Activities that support practitioners, providers or community-based organizations.**

The organization's strategy includes and describes at least three activities aimed at supporting practitioners, providers or community-based organizations, including those that deliver clinical, behavioral or non-clinical care and services.

Factor 4: Coordination of member programs

The organization coordinates programs or services it directs and those facilitated by providers, external management programs and other entities. The PHM strategy describes how the organization coordinates programs across settings, providers and levels of care to minimize confusion for members who are contacted by multiple sources. Coordination activities are not required to be exclusive to one area of focus and may apply across the continuum of care and to initiatives in other organizations.

Factor 5: **Informing members and practitioners**

The PHM strategy describes the organization's process for informing members and practitioners about all available PHM programs and services, regardless of level of contact. The organization may make the information available on its website; by mail, email, text or other mobile application; by telephone; or in person.

The organization communicates the information to members by mail, telephone or in person and may use practitioners in its network to inform members. NCQA does not consider the use of a practitioner network to inform members about PHM programs and services to be delegation.

Factor 6: ~~**Promote health equity**~~ **Address health disparities and their root causes**

~~The World Health Organization defines health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."~~

The organization has a comprehensive PHM strategy that describes its commitment to ~~improving health equity~~ addressing health disparities (unfair, avoidable differences) and their root causes.

~~and~~ The organization also describes ~~a~~ its plan for at least one action ~~that promotes equity in management of member care~~ to address health disparities and their root causes. The plan includes a detailed description of actions the organization will take and a timeline for implementation.

Exceptions

None.

Examples ***Factors 1, 2:*** **Goals, target populations, opportunities, programs or services**

Keeping members healthy

Seasonal Influenza Vaccinations: This program focuses on providing children and adult members with their annual influenza vaccinations.

- *Program goal:* 55% of members in the target population report receiving annual influenza vaccinations within 12 months of enrollment.
- *Target population:* Children 5–17; adults 18 or older with no risk factors.
- *Programs or services:*
  - Distribute free influenza vaccinations at:
    - Community flu clinics (e.g., churches, recreation centers).
    - Mobile and drive-thru clinics.
    - Local pharmacies.
  - Send email and mail reminders.
  - Create radio and TV advertisement reminders to get vaccinated.

Managing members with emerging risk

Future Moms: Maternity program focused on providing care and treatment for high-risk maternity cases. The program helps expectant mothers focus on early prenatal interventions, risk assessments and education.

- *Program goal:* 90% of members 18–45 years identified as potential high-risk for pregnancy complications will enroll in the program within the next 12 months *from the date of identification.*
- *Target population:* Members 18–45 with an OB/GYN claim and other medical or pharmacy data that stratify them into high risk for pregnancy complications.
- *Programs or services:*
  - Prenatal and newborn education classes.
  - Lactation consultations.
  - Breastfeeding support groups.
  - Workshops on preventing preeclampsia.
  - Literature and follow-up appointments for recovery after emergency cesarean.

Patient safety

Combating Hospital-Acquired Infections: This program focuses on educating members to reduce the rate of hospital-acquired infections.

- *Program goal:* Improve clinical safety by reducing hospital-acquired infections by 5% over 3 years.
- *Target population:* Members receiving in-patient surgical procedures.
- *Programs or services:*
    - Distribute educational materials about proper hand hygiene, signs and symptoms of infection and when to seek care.
    - Post-discharge follow-up to confirm members receipt of post-surgical care instructions.

Outcomes across settings

Preventing Hospital Readmissions: This program provides focused care management services to members identified as high risk for readmission.

- *Program goal:* 75th percentile of clinical HEDIS® goal of Quality Compass® for Ambulatory Follow-Up After Emergency Department Visit for Mental Illness within 6 months.
- *Target population:* Members 18 or older admitted within the past 90 days who were diagnosed with a behavioral health disorder or mental illness.
- *Programs or services:*
    - Weekly outreach from a nurse care manager who:
        - Completes post-discharge assessment and creates member goals and interventions.
        - Performs medication reconciliation and encourages medication adherence.
        - Confirms follow-up appointments.

Managing multiple chronic illnesses

Population Health Management: This program is designed to help maximize health status, improve health outcomes and reduce health care costs for members diagnosed with asthma (adult), diabetes (types 1 and 2, adult), coronary artery disease, heart failure and chronic obstructive pulmonary disease.

- *Program goal:* 95% of members with a chronic illness report improved self-management of their illness on patient-reported outcome surveys within 24 months of enrollment.
- *Target population:* Members 18–65 who have more than one chronic illness, identified through claims, lab and pharmacy data.
- *Programs or services:*
    - 24-hour Inbound Calling Program: Informs members of identified gaps in care and actions to improve overall health.
    - Health Information Profile tool: Dynamic resource that captures and houses members' medical history, medication, self-monitoring and control/prevention information.

- Mobile app with community support networks, condition-specific management education, trigger-tracking and on-demand coaching.

Factor 3: **Activities that support practitioners, providers or community-based organizations**

- Share actionable data with practitioners to support the four areas of focus in the strategy.
- Promote and enable accurate and efficient patient attribution under alternative payment model arrangements.
- Collaborate with practitioners or providers to establish an agreed-on benchmarking methodology and approach under alternative payment model arrangements.
- Provide quality measures, methodologies and performance targets at the beginning of the performance period and regularly thereafter.
- Provide transformation support to primary care practices (e.g., PCMHs).
- Collaborate with community-based organizations (e.g., LTSS providers) to improve transitions of care from the post-acute setting to the home, or integrate community health workers in the program or in care delivery.
- Collaborate with hospitals to improve care transitions and reduce readmissions.

Approaches could consider:

- Claims-based attribution.
- Voluntary patient selection
- Automatic new-member attribution.

Factor 4: **Coordination of member programs**

- Coordinate care for hospitalized members between inpatient case management and transition of care programs.
- Share data with providers to coordinate closure of care gaps.
- Determine member eligibility in multiple programs and coordinate between programs to avoid duplication of services or member contacts.

Factor 6: **Address health disparities and their root causes**

Types of health care opportunities and outcomes

- Receipt of care or services.
- Being offered screenings, language services, disability-related accommodations or social needs interventions.
- Access to care or services (e.g., availability, usability, approval).
- Receipt of culturally or linguistically appropriate interventions, care or services.
- Experience interacting with organizational functions.
- Preventive screening rates.

PHM 3: Delivery System Supports

The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements.

Intent

The organization works with practitioners or providers to achieve population health management goals.

Element B: Practitioner or Provider Collaboration and Support

The organization supports practitioners or providers in its network to achieve population health management goals by:

1. **Providing practice transformation support to primary care practitioners.**
2. **Providing comparative quality information on selected specialties.**
3. **Defining roles and responsibilities to achieve collaborative care management with provider partners.**
4. ~~**Providing training on equity, cultural competency, bias, diversity or inclusion.**~~

Scoring

Met	Partially Met	Not Met
The organization meets <u>2-3</u>~~3-4~~ factors	The organization meets 1-~~2~~ factors.	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review

Product lines

For Interim Surveys, First Surveys and Renewal Surveys: This element applies to all product lines.

Documentation

For All Surveys: NCQA reviews the organization's documented process for supporting practitioners or providers.

For factors 1–3: NCQA reviews reports or materials demonstrating that the organization provides support to primary care practitioners, and reviews comparative quality information on selected specialties.

For factor 3: NCQA reviews the organization's defined roles and responsibilities with at least one provider partner in collaborative care management.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months; prior to the survey date for factor 3.

For Renewal Surveys: 24 months; prior to the survey date for factor 3.

Explanation

The organization identifies and implements activities that support and improve collaboration with practitioners and providers in meeting population health goals and moving to alternative payment model arrangements. Practitioners and providers may include accountable care entities, primary or specialty practitioners, PCMHs or other providers included in the organization's network. Organizations may determine the practitioners or providers they support.

***Factor 1*: Practice transformation Support**

Transformation support includes helping practices to become integrated or advanced (e.g., ACO, PCMH) and capable of entering alternative payment arrangements.

The organization describes at least one activity that supports practice transformation. Organizations may offer financial incentives, learning collaboratives, Maintenance of Certification credits and other methods.

***Factor 2*: Comparative quality and cost information on selected specialties**

The organization provides comparative quality and, if available, cost information about selected specialties to practitioners or providers to help them make referral decisions. The organization provides comparative quality information about selected specialties to practitioners or providers and reports cost information if it is available. Comparative cost information may be cost or efficiency information and may be represented as relative rates or as a relative range. Information must be accompanied by quality information; the organization may not provide only cost information.

Cost refers to a financial amount determined by using actual unit prices per service or unit prices in a standardized fee schedule.

Note: *For this factor, "specialties" and "specialty" refer to nonprimary care (specialties other than pediatrics, internal medicine and general or family medicine).*

***Factor 3*: Defining roles and responsibilities**

The organization has a documented process for defining roles and responsibilities, and includes information on the defined roles and responsibilities in communications with partners.

Communications may include, but are not limited to, contract, memorandum of understanding, agreement.

The intent of this requirement is to prevent care fragmentation and patient frustration due to lack of collaborative care management.

~~***Factor 4*: Training on equity, culturally competency, bias, diversity or inclusion~~

~~The organization provides at least one training to network practitioners on health equity, including cultural competence, bias, diversity or inclusion. The organization chooses training frequency, and provides training documents, or provides access to documents, through a link, module, download or other method.~~

Exceptions

Factor 3 is NA for Interim Surveys.

Related information

Partners in Quality. The organization receives automatic credit for factor 3 if it is an NCQA-designated Partner in Quality. The organization must provide documentation of its status.

~~*Use of vendors for training on cultural competency, bias or inclusion.* If the organization contracts with a vendor to provide training on cultural competency, bias or inclusion for factor 4, it provides access to the vendor's documentation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under *PHM 7: Delegation of PHM*. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors* in *Appendix 2: Delegation and Automatic Credit Guidelines*.~~

Examples

***Factor 1:* Practice transformation support**

- Practice transformation readiness assessment and financial incentives to enable transformation.
- Dashboards displaying quality, cost and utilization data to enable data-driven insights, such as monthly trends toward achieving agreed-upon quality metrics or comparison to other in network providers (i.e., peer comparison).
- Patient attribution reconciliation for entities entering alternative payment models.
- Pay application fees for 50% of the organization's primary care practices to earn PCMH Recognition.
- Supply staff, consultants or resources to help the practice with the transformation process.
- Facilitate recurring performance/QI discussions with providers, sharing current data and offering suggestions and resources as necessary, applicable and/or available.
- Notify practices that earning PCMH Recognition will make them eligible for quality-based incentives.
- Support or finance efforts to establish a relationship with an Accountable Care Organization (ACO).
- Incentive payments for PCMH arrangement.
- Technology support.

- Best practices.
- Supportive educational information, including webinars or other education sessions.
- Help with application fees for NCQA PCMH Recognition (beyond the NCQA program's sponsor discount).
- Help practices transform into a medical home.
- Provide incentives for NCQA PCMH Recognition (e.g., pay-for-performance).
- Use NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network.

Factor 2: **Quality and cost information**

- Selected specialties:
  - Specialties to which a primary care practitioner refers members most frequently.
- Quality information:
  - Organization-developed performance measures based on evidence-based guidelines.
    - AHRQ patient safety indicators associated with a provider.
    - In-patient quality indicators.
    - Risk-adjusted measures of mortality, complications and readmission.
    - Quality Payment Program (QPP) measures.
    - Non-QPP Qualified Clinical Data Registry (QCDR) measures.
    - CAHPS Clinician and Group Survey.
  - Cost information:
    - Relative cost of episode of care.
    - Relative cost of practitioner services.
    - In-office procedures.
    - Relative dollars per member per month (PMPM), overall or by type of service or dollars per procedure.
  - Care pattern reports that include quality and cost information.
  - External cost-comparison databases with information about the potential cost of members seeking care out-of-network.

~~***Factor 4:*** **Training on equity, culturally competency, bias, diversity or inclusion**~~

- ~~Delivery types:~~
  - ~~Practitioner portal.~~
  - ~~Newsletter or other practitioner communications during initial credentialing or recredentialing cycles.~~
- ~~Practitioner training:~~
  - ~~U.S. Department of Health and Human Services, Office of Minority Health has free, continuing education e-learning (Culturally and Linguistically Appropriate Services in Maternal Health Care, Behavioral Health, Oral Health) programs to help health care professionals provide culturally competent care.~~
- ~~Training provided by Johns Hopkins University of Medicine Office of Diversity, Inclusion and Health Equity:~~
  - ~~Unconscious Bias Collection (via LinkedIn Learning).~~

2026 Behavioral Health Accreditation
(formerly MBHO Accreditation)

QI 1: Program Structure and Operations

The organization clearly defines its quality improvement (QI) structures and processes, assigns responsibility to appropriate individuals and operationalizes its QI program.

Intent

The organization has the QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members and to oversee the QI program.

Element F: Promoting Organizational Diversity, Equity and Inclusion

The organization develops and maintains a workforce responsive to the needs of its members by:

1. **~~Promotes diversity in recruiting and hiring.~~ Having a process to recruit and hire a workforce with direct experience, knowledge or expertise relevant to the needs of its population.**
2. **~~Offers training to employees on cultural competency, bias or inclusion.~~ Offering training or education to all employees on culturally and linguistically appropriate practices, trauma-informed practices or reducing bias.**

Scoring

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

Data source Documented process, Reports, Materials

Scope of review

For Initial Surveys: NCQA reviews the organization's policies and procedures that describe its recruiting and hiring process ~~for promoting diversity in recruiting and hiring and for offering training to employees~~.

For Renewal Surveys:

- *For factor 1:* NCQA reviews the organization's policies and procedures or materials that describe its recruiting and hiring process in place throughout the look-back period ~~for promoting diversity in recruiting and hiring~~.
- *For factor 2:* NCQA reviews ~~the organization's policies and procedures in place throughout the look-back period for offering training to employees, and reviews~~ reports or materials as evidence ~~demonstrating~~ that at least one training or educational course, was offered during the look-back period. ~~the organization offered the training at least once during the prior 24 months.~~

Look-back period

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

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

Explanation

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

Factor 1: ~~**Promotes diversity in recruiting and hiring**~~ **Recruiting and hiring a relevant workforce**

The organization demonstrates, through policies and procedures 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.

~~The organization describes how its recruiting and hiring processes promote a diverse workforce.~~

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

Factor 2: **Offer training**

The organization demonstrates, through reports or materials, that it offers at least one training or educational course to all employees on ~~cultural competence, bias or inclusion.~~ one of the following topics:

- Culturally and linguistically appropriate practices.
- Trauma-informed practices.
- Improving the impartiality of care or service delivery.

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 or services.

Trauma-informed practices for health care or services seek to recognize, understand and respond to the signs, symptoms, impacts and risks of patients' traumatic life experiences to their health and well-being.

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).

The organization determines training type, format and frequency. Training is not mandatory for employees, and the organization is not scored on the rate of employees who complete training.

Exceptions

None.

Related information

Use of vendors for training ~~on cultural competency, bias or inclusion~~. If the organization contracts with a vendor to provide training ~~on cultural competency, bias or inclusion~~ for factor 2, it provides access to the vendor's documentation. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under QI 4. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendors* in *Appendix 2: Delegation and Automatic Credit Guidelines*.

2026 LTSS Distinction

LTSS 1: Core Features

The organization has processes in place that organizations can use as a foundation for coordinating long-term services and supports (LTSS).

Intent

The organization uses current best practices to coordinate LTSS to eligible members.

Element A: Program Description

The description of the organization's case management program ~~includes~~ describes:

1. **Criteria for identifying members who are eligible for the program.**
2. **Services offered to members.**
3. **Evidence and professional standards used for program operations.***
4. **Defined program goals.**
5. **How case management services are coordinated with the services of others involved in members' care.**
6. **How the organization ~~promotes health equity~~ addresses health disparities and their root causes.**

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

Scoring

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

Data source Documented process

Scope of review

Product lines

For First Surveys and Renewal Surveys: This element applies to all product lines.

Documentation

NCQA reviews the organization's program description.

NCQA scores this element for each program the organization brings forward for distinction. The score for the element is the average of the scores for all programs.

Look-back period

For First Surveys: 6 months; prior to the survey date for factor 6.

For Renewal Surveys: 24 months; prior to the survey date for factor 6.

Explanation

This element may not be delegated.

Factor 3 is a critical factor; if it is scored "No," the element score cannot exceed Partially Met for each program.

Case management is a collaborative process of assessment, planning, facilitation, coordination, evaluation and advocacy for supports and services to meet the needs of a member while promoting quality and cost-effective outcomes.

Long-term services and supports ~~is~~ are care for older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions, or other functional limitations that restrict their ability to care for themselves. NCQA does not prescribe populations to include, or how care is delivered to these populations. Some members with overlapping conditions may fall under multiple populations. The program description should identify all populations served, and may include individuals:

- 65 and older.
- With intellectual/developmental disorders.
- With disabilities.
- With traumatic brain injury.
- With acquired brain injury.
- With serious mental illness.
- With serious emotional disturbance.
- With mental health/substance use disorder.

The overall goal of case management LTSS programs is to help members function optimally in their preferred setting.

Factor 1: **Eligibility criteria**

A **purchaser** is an entity (e.g., state, health plan) that purchases services provided by the organization.

The program description states the eligibility criteria for the case management program. Eligibility criteria may be set by the purchaser. NCQA does not require the organization to use specific criteria.

Factor 2: **Services**

The program description specifies services available to eligible members across all programs the organization brings forward for Distinction. The organization may provide the services directly, or may arrange for the services to be provided by other entities.

Factor 3: **Evidence and professional standards**

Professional standards of care are stated ethical or legal requirements to exercise the level of care, diligence and skill prescribed in a profession's code of practice.

The program description specifies the evidence and professional standards the organization uses to determine which services it offers to members and how it provides services.

Evidence derives from:

- Scientific evidence from technical literature or government research sources.
- Literature reviews on best practices (e.g., motivational interviewing, methods to improve health literacy).

Evidence includes:

- Guidelines.
- Statements of recommendation.
- Algorithms or materials created through an unbiased and transparent process of systematic review, appraisal and best practices to aid in the delivery of optimum care.

The program description includes professional standards that may be derived from:

- MCOs or state waiver requirements.
- Standardized techniques.
- Specialized models (e.g., chronic care, patient-centered care nursing model).

***Factor 4*: Program goals**

The program description includes the organization's desired level of achievement expressed in explicit, measurable objectives and targets for the case management program. A mission or vision statement alone is not acceptable.

***Factor 5:* Case management coordination**

Coordination is essential to optimizing care delivery for members receiving services through multiple programs. The program description includes how care is coordinated with other programs and services received outside the case management organization.

***Factor 6:* ~~Promote health equity~~ Address health disparities and their root causes**

~~The World Health Organization defines health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."~~

The organization has a comprehensive strategy that describes its commitment to ~~improving health equity~~ addressing health disparities (unfair, avoidable differences) and their root causes.

The organization also describes ~~and~~ its plan for at least one action ~~that promotes health equity in~~ to improve fairness for opportunities and outcomes in its LTSS program. The plan includes a detailed description of actions the organization will take and a timeline for their implementation.

Exceptions

This element is NA for Interim Surveys.

Related information

Factors 2, 3: Services and evidence of professional standards. The organization may have a contractual relationship with a state or other purchaser that specifies services it must offer or tools it must use to operate the program (e.g., a specific needs assessment tool). In this case, the organization provides requirements of the state or purchaser and presents evidence for the models of care or tools it uses for program components that are not dictated by contractual or regulatory requirements.

Factor 6: Address health disparities and their root causes ~~Promote health equity~~. The organization may have an enterprisewide ~~health equity~~ strategy, that applies to its PHM strategy (*PHM 1: PHM Strategy,* Element A, factor 6*)*, all lines of business and populations served. In this case, the organization provides the strategy and demonstrates that it includes at least one action to ~~promote equity~~ improve fairness in the delivery of LTSS.

Examples

***Factor 2:* Services**

- Care coordination, including arranging appointments and referrals to community resources.
- Case management plan development, with person-centered goals.
- Assistance with navigating the appeal process and/or information about resources, agencies or advocacy groups that individuals can use or connect with to aid their appeal.
- Self-management plan development and monitoring.
- Self-directed services.
- Personal care assistance.
- Housekeeping and chore services.
- Money management.
- Transportation.
- Housing-related services.

***Factor 3:* Evidence and professional standards**

The organization uses a combination of evidence and professional standards to support staff interactions with members, which may be derived from its research or from research organizations such as:

- Administration for Community Living.
- Administration on Aging.
- Advancing States (formerly National Association of States United for Aging and Disabilities).
- American Case Management Association.
- American Nurse Association Guidelines.
- American Society on Aging.
- Association for Behavioral Analysis International.
- Case Management Society of America.
- Leadership Council of Aging Organizations.
- National Association of Social Workers.

- National Association of State Directors of Developmental Disabilities Services.
- National Coalition of Care Coordination.
- National Core Indicators—Aging and Disabilities.
- National Council on Independent Living.
- The John A. Hartford Foundation.
- The SCAN Foundation.

Factor 4: **Program goals**

- 30% of participants served for 6 months or longer report that their quality of life improved since the initial assessment.
- Improve member experience with the program by 20% during the calendar year.
- 85% of members served in the community for at least 6 months have no long-term nursing home stays.
- Reduce 30-day hospital readmissions by 10%.
- Increase rates of supported employment by 25%.

Factor 5: **How case management services are coordinated**

Coordination of case management program and services may involve:

- Medical providers, including palliative care providers.
- Behavioral healthcare providers.
- Social services providers (e.g., housing, employment support, nutritional assistance).
- Case managers from other organizations with whom the member is affiliated (e.g., discharge care managers, health plan care managers).
- Caregivers.

Factor 6: **Address health disparities and their root causes ~~Promote health equity~~**

Types of health care opportunities and outcomes

- Receipt of care or services.
- Being offered screenings, treatments, language services, disability-related accommodations or social needs interventions.
- Access to care or services (e.g., availability, usability, approval).
- Receipt of culturally or linguistically appropriate interventions, care or services.
- Experience interacting with organizational functions.

Actions to improve fairness

- Launch a 24-hour “language line” service for individuals who need assistance with understanding and/or speaking a language other than English.
- Employ LTSS providers who provide gender-affirming care.

- Provide quarterly educational seminars about the importance of health, nutrition and wellness for members and their caregivers with an identified need.
- Expand the diversity of direct experience, knowledge or expertise of network providers relevant to individuals served.
- Partner with rideshare companies to provide transportation assistance for members with an identified need.

2026 Accreditation for Case Management LTSS

LTSS 1: Program Description

The organization's case management program description includes the evidence and professional standards on which the program was built, and the organization reviews and adopts relevant findings as they become available.

Intent

The organization uses up-to-date evidence and professional standards to develop its case management program, and regularly updates the program with emerging findings and information.

Element A: Program Description

The description of the organization's case management program includes:

1. **Criteria for identifying individuals who are eligible for the program.**
2. **Services offered to individuals.**
3. **Evidence and professional standards used for program operations.***
4. **Defined program goals.**
5. **How clinical and/or nonclinical case management services are coordinated with the services of others involved in individuals' care.**
6. **How the organization ~~promotes health equity~~ addresses health disparities and their root causes.**

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

Scoring

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

Data source Documented process

Scope of review NCQA reviews the organization's program description for factors 1–6.

NCQA scores this element for each program the organization brings forward for Accreditation. The score for the element is the average of the scores for all programs.

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

For Initial Surveys: 6 months; prior to the survey date for factor 6.

For Renewal Surveys: 24 months; prior to the survey date for factor 6.

Explanation This element may not be delegated.

Factor 3 is a critical factor; if this critical factor is scored "no," the organization's score cannot exceed Partially Met for each program.

Case management is a collaborative process of assessment, planning, facilitation, coordination, evaluation and advocacy for supports and services to meet the needs of an individual while promoting quality and cost-effective outcomes.

Long-term services and supports (LTSS) is care for older adults and people with disabilities who need support because of age; physical, cognitive, developmental or chronic health conditions; or other functional limitations that restrict their ability to care for themselves. NCQA does not prescribe the populations that should be included, or how care is delivered. Some members with overlapping conditions may fall into multiple populations. The program description should identify all populations served, and may include individuals:

- 65 and older.
- With intellectual/developmental disorders.
- With disabilities.
- With traumatic brain injury.
- With acquired brain injury.
- With serious mental illness.
- With serious emotional disturbance.
- With mental health/substance use disorder.

The overall goal of case management LTSS programs is to help individuals function optimally in their preferred setting.

Factor 1: **Eligibility criteria**

A **purchaser** is an entity (e.g., state, health plan) that purchases services provided by the organization.

The program description states the eligibility criteria for the case management program. Eligibility criteria may be set by the purchaser. NCQA does not require the organization to use specific criteria.

Factor 2: **Services**

The program description specifies services available to eligible individuals across all programs the organization brings forward for Accreditation. The organization may provide the services directly, or may arrange for the services to be provided by other entities.

Factor 3: **Evidence and professional standards**

Professional standards of care are stated ethical or legal requirements to exercise the level of care, diligence and skill prescribed in a profession's code of practice.

The program description specifies the evidence and professional standards the organization uses to determine which services it offers to individuals and how it provides services.

Evidence derives from:

- Scientific evidence from technical literature or government research sources.
- Literature reviews on best practices (e.g., motivational interviewing, methods to improve health literacy).

Evidence includes:

- Guidelines.
- Statements of recommendation.
- Algorithms or materials created through an unbiased and transparent process of systematic review, appraisal and best practices to aid in the delivery of optimum care.

The program description includes professional standards that may be derived from:

- MCOs or state waiver requirements.
- Standardized techniques.
- Specialized models (e.g., chronic care, patient-centered care nursing model).

Factor 4: **Program goals**

The program description includes the organization's desired level of achievement expressed in explicit, measurable objectives and targets for the case management program. Goals must be more than mission and vision statements.

Factor 5: **Case management coordination**

Coordination is essential to optimizing care delivery for individuals receiving services through multiple programs. The program description includes how care is coordinated with other programs and services the individual receives outside the case management organization.

Factor 6: ~~**Promote health equity**~~ **Address health disparities and their root causes**

~~The World Health Organization defines health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."~~

The organization's program description describes its commitment to ~~improving health equity~~ addressing health disparities (unfair, avoidable differences) and their root causes.

~~and~~ The organization also describes ~~a~~ its plan for at least one action ~~for promoting health equity~~ to address health disparities and their root causes in their LTSS program. The plan includes a detailed description of action(s) the organization will take and a timeline for their implementation.

Exceptions

~~Factor 6 is NA for all surveys through June 30, 2026~~None.

Related information

Factors 2, 3: Services and evidence of professional standards. The organization may have a contractual relationship with a state or other purchaser that specifies services it must offer or tools it must use to operate the program (e.g., a specific needs assessment tool). In this case, the organization provides requirements of the state or purchaser and presents evidence for the models of care or tools it uses for program components that are not dictated by contractual or regulatory requirements.

Examples

***Factor 2:* Services**

- Care coordination, including arranging appointments and referrals to community resources.
- Case management plan development, with person-centered goals.
- Assistance with navigating the appeal process and/or information about resources, agencies or advocacy groups that individuals can use or connect with to aid in their appeal.
- Self-management plan development and monitoring.
- Self-directed services.
- Personal care assistance.
- Housekeeping and chore service.
- Money management.
- Transportation.
- Housing-related services.

***Factor 3:* Evidence and professional standards**

The organization uses a combination of evidence and professional standards to support staff interactions with individuals, which may be derived from its research or from research organizations such as:

- Administration for Community Living.
- Administration on Aging.
- ADvancing States (formerly National Association of States United for Aging and Disabilities).
- American Case Management Association.
- American Nurse Association Guidelines.
- American Society on Aging.
- Association for Behavioral Analysis International.
- Case Management Society of America.
- Leadership Council of Aging Organizations.
- National Association of Social Workers.
- National Association of State Directors of Developmental Disabilities Services.
- National Coalition of Care Coordination.
- National Core Indicators—Aging and Disabilities.
- National Council on Independent Living.
- The John A. Hartford Foundation.

- The SCAN Foundation.

Factor 4: **Program goals**

Program goals may include:

- 30% of participants who are served for 6 months or longer report that their quality of life improved since the initial assessment.
- Improve individual experience with the program by 20% within the calendar year.
- 85% of individuals who are served in the community for at least 6 months have no long-term nursing home stays.
- Reduce 30-day hospital readmissions by 10%.
- Increase rates of supported employment by 25%.

Factor 5: **How clinical and/or nonclinical case management services are coordinated**

Coordination of clinical case management services may involve:

- Medical providers, including palliative care providers.
- Behavioral healthcare providers.
- Case managers from other organizations with whom the individual is affiliated (e.g., discharge care managers, health plan care managers).

Coordination of nonclinical case management services may involve:

- Social services providers (e.g., housing, employment supports, nutritional assistance).
- Case managers.
- Caregivers.

Factor 6: ~~**Actions to promote health equity**~~ **Address health disparities and their root causes**

Actions to address root causes of identified disparities

- Offering a new 24-hour language line service that helps individuals who need assistance with understanding and/or speaking a language other than English.
- Employing LTSS providers who provide gender affirming care on an on-going basis.
- Providing quarterly educational seminars about the importance of health, nutrition and wellness in communities with an identified need.
- Expanding the diversity of direct experience, knowledge or expertise represented on the panel of providers available to individuals on an on-going basis.

LTSS 6: Staffing, Training and Verification

The organization defines staffing needs, provides staff with ongoing training and oversight and verifies health care staff credentials.

Intent

The organization builds a workforce responsive to its population's needs ~~diverse and inclusive staff,~~ and provides training and oversight to staff so their interactions with individuals are evidence based and supported by professional standards.

Element A: Building a ~~Diverse Staff~~Responsive Workforce

The organization has processes to recruit and hire a workforce with direct experience, knowledge or expertise relevant to the needs of its population. ~~recruiting and hiring processes that support diversity, equity and inclusion in the organization's workforce.~~

Scoring

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

Data source Documented process, Materials

Scope of review NCQA reviews the organization's documented process for recruiting and hiring.

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

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, aspect of disability) in the pool of candidates for employment 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.~~

The organization demonstrates, through policies and procedures 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.

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

~~**LTSS providers** are paid and unpaid people and organizations that provide long-term services and supports.~~

~~The organization's process describes how it supports diversity, equity and inclusion in hiring and recruitment practices, including internal and external positions, promotions and reclassifications, and temporary and permanent positions.~~

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

- ~~Whether 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:~~

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

- Staff, including LTSS providers.
  - **LTSS providers** are paid and unpaid people and organizations that provide long-term services and supports.
- 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), if applicable.
- Promotions and reclassifications.
- ~~Governance bodies, including, but not limited to, the organization's board of directors, if applicable.~~

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.

Exceptions

~~This element is NA for all surveys through June 30, 2026~~None.

Examples **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 provision of culturally appropriate care practices.
- Certification in trauma-informed care practices.
- 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.

Recruiting and hiring processes

- Recruit candidates via community-based avenues and clear, inclusive job descriptions.
- Minimize traditional hiring barriers, such as checking applicants' immigration status, to expand the recruitment pool.
- Select candidates in the hiring process based on their ~~lived~~ direct experiences, relationship with the community and trust-building traits, rather than on formal education.
- Promote supervisors who have a deep understanding of the program and can support, coach and advocate for other staff.
- Encourage professional development through pay raises that are commensurate with experience and career development opportunities.
- Create a welcoming environment for staff to foster teamwork at all levels of the organization and across environments (clinical settings and social service organizations).
- Develop processes for providing supplies and materials that support staff in their work (e.g., personal protective equipment).
- Establish measures to protect staff from unsafe situations while on the job (e.g., documented protocols for emergencies).
- Identify measures that support career advancement (e.g., develop career ladder to progress to higher-responsibility positions).

Source: https://www.ncqa.org/wp-content/uploads/2021/11/Critical-Inputs-for-Successful-CHW-Programs-White-Paper-November2021.pdf

2026 Accreditation/Certifications for Wellness and Health Promotion

WHP 1: Client Organization Engagement

The organization assesses current client organization wellness and health promotion activities and provides education, recommendations and guidance for an effective wellness and health promotion program.

Intent

The organization provides information and direction to help client organizations implement wellness and health promotion programs that will enable eligible individuals to improve their health.

Element A: Assessment

The organization assesses the client organization against the following factors to provide feedback and recommendations for an effective wellness and health promotion program.

1. **Leadership engagement.**
2. **Communication strategies.**
3. **Corporate culture.**
4. **Work facilities and policies.**
5. **Existing wellness and health promotion program.**
6. **Benefit design.**
7. ~~**Workforce demographics.**~~
8. **Resources.**

Scoring

100%	80%	50%	20%	0%
The organization meets all ~~8~~7 factors	The organization meets ~~7~~ 6 factors	The organization meets 4~~-6~~ 5 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review NCQA reviews evidence of an assessment for at least one client during the look-back period. If the organization conducts in-person assessments, it presents policies and procedures and assessment materials.

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

For Renewal Surveys: 24 months.

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

This element may not be delegated.

Assessment content

Employer support for health promotion is a key factor in successful wellness and health promotion programs. This element evaluates whether the organization implements processes to assess the employer's foundation in supporting a wellness and health promotion program. Assessment results can help the organization make specific recommendations to increase program effectiveness.

Assessment process

The organization's assessment may be an in-person consultation, or a paper or online self-assessment tool.

Factors 1–~~7~~8: **Scope of assessment**

The organization assesses:

- Leadership's efforts to inspire and influence others to engage in a wellness and health promotion program.
- Communication strategies that educate and inform individuals.
- Corporate culture to understand how a wellness and health promotion program can be integrated into daily operations.
- Work facilities and policies to identify opportunities for change to current practices.
- Existing program to understand program availability.
- Benefit design to determine how wellness and health promotion can be offered as part of the benefits plan.
- ~~Workforce demographics to tailor services offered to participants.~~
- Resources to support wellness and health programs goals.

Exceptions

~~Factor 7 is NA for all surveys through June 30, 2026~~None.

Examples

Factors 1–~~8~~ 7

- HERO Employee Health Management Best Practice Scorecard.
- In-person consultation template of questions and areas to examine.
- Questionnaires to learn more about the employer and its interest in and support for a wellness and health promotion program.

Factor 1: **Assessment of leadership support**

- Senior leadership commitment to employee health, as demonstrated by involvement and behavior.
- Group-level manager and supervisor encouragement of employee participation in the program.
- Level of importance leadership places on wellness and health promotion within the workforce.

Factor 2: **Assessment of communication strategies**

- Communication of the wellness and health promotion program in advance of its start date.

- Reminders to encourage participation.

Factor 3: **Assessment of corporate culture**

- Employer attitudes and values regarding health.
- Employer goals for improving health.
- Employee buy-in and willingness to participate.
- Recent reorganization or business changes.
- Employee turnover rates.

Factor 4**: Assessment of work facilities and policies**

- Smoke-free workplace.
- Availability of healthy food options.
- Flex-time.
- Mechanisms to protect privacy and prevent discrimination against nonparticipants.

Factor 5: **Assessment of existing wellness and health promotion program**

- Health fairs, gym discounts, health and wellness courses or seminars, walking clubs.
- Educational resources.
- Health appraisals (HA).

Factor 6: **Assessment of benefit design**

- Out-of-pocket costs for preventive health services.
- Current wellness and health promotion program.

~~***Factor 7:*** **Assessment of workforce demographics~~

- ~~Age.~~
- ~~Racial or ethnic make-up.~~
- ~~Socioeconomic status.~~

Factor ~~8~~<u>7</u>: **Assessment of resources**

- Extent of program offerings.
- Employee availability for wellness and health promotion program planning and implementation.