Health Equity Accreditation Plus: Helping Improve Care for Your Community

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NCQA
Measuring quality.
Improving health care.

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

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

Activities in this standard category:

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

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

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

Prepares organizations to:

- Make informed decisions about the focus of its programs and initiatives
- Select relevant, appropriate partners
- Select relevant goals for addressing social needs and mitigating social risks

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HE Plus 1, Element A: Defining the Community

The organization defines its service area and the communities in its service area.

⚠ Minimum Requirements ⚠

The report must identify each community's:

- **Geographical boundaries** of the communities in its service area; *or*
- **Nongeographical composition** of the communities in its service area.

Examples: Approaches

- Defining geographical boundaries for communities based on shared nongeographical factors: characteristics, social needs, social risks, and/or and infrastructure (e.g., transportation, education).
- Aligning with externally-defined, reportable geographical boundaries (e.g., counties, state-defined contract regions).

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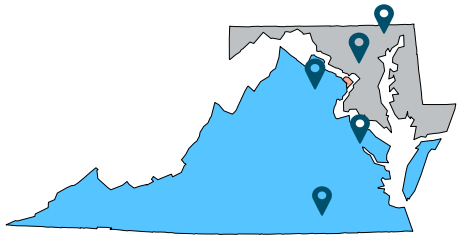
Defining Communities

Examples

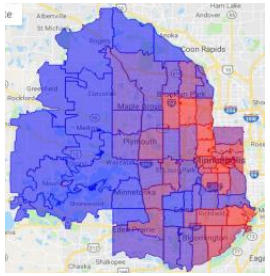


Health System A

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

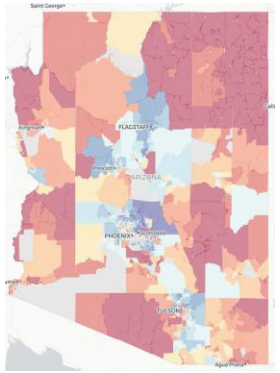
Health Plan C

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



Health System B

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



Health Plan D

- Serves multiple counties in Arizona.
- Defines its communities using product line, community-level social risk score by zip code, race/ethnicity and spoken language

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HE Plus 1, Element B: Acquiring Communities' Social Risk Data

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

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

Additional Considerations

- Data sources may be **quantitative or qualitative.**
- **Hospitals and health systems** may use their own CHA.
- Partners may endorse a data source they produced.

Examples: Evidence

- State-sponsored **reports**.
- **Screenshots** demonstrating data sources, graphs, charts and stratification.
- **Commercially available indexes or surveys.**
- **Communications, meeting minutes** or **contracts** demonstrating the organization consulted a partner **for factor 3**.

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HE Plus 1, Element C: Collecting Individuals' Social Needs Data

The organization has a framework for direct collection of data and collects data on individuals' unmet **social needs**, including:

1. Financial insecurity.
2. **Food insecurity.**
3. **Housing stability.**
4. **Access to transportation.**
5. Interpersonal safety.
6. An additional domain.

Other Information

- **Factors 2 – 4 align** with NCQA's HEDIS measure for **Social Need Screening and Intervention (SNS-E)**
- The percentage of members who, during the measurement period, were:
  - ✓ Screened at least once for unmet food, housing and transportation needs using a pre-specified screening instrument
  - ✓ If screened positive, received a corresponding intervention.
- **Reporting SNS-E is not required** for Health Equity Accreditation Plus

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HE Plus 1, Element D: Identifying Social Risks

Every 3 years, the organization uses the data acquired in Element B (*Acquiring Communities' Social Risk Data*) to identify the social risks of each community identified in Element A (*Defining the Community*).

Examples: Evidence

- **A single summary report** that describes and maps the prevalence of social risks for each community in its service area.
  - May describe or map how social risks compare across neighborhoods or rural vs. urban areas within its service area.
- **Multiple system output reports** that each show the social risks identified for a specific community.

Scoring

- Organization receives the average score across all selected communities (same as Element A).

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HE Plus 1, Element E: Identifying Social Needs

At least annually, the organization uses data in Elements B–D (*acquiring and collecting data on social risks and social needs; identifying social risks*) to:

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

Evidence

NCQA Reviews

- **Reports** that demonstrate the organization **annually**:
  - **Identified** social needs for the population served (members, patients) **within each community**.
  - **Assessed** similarities and differences between social risks (community) and social needs (individuals served)
- **A sample from up to 4 randomly-selected communities**.

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HE Plus 1, Element G: Prioritizing Social Risks and Social Needs

The organization annually uses Elements D–F (*identifying and stratifying social risks, social needs*) to prioritize:

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

Examples: Approaches

- 1 social risk that is prevalent in the highest number of communities.
- 2 geographical communities that have the greatest concentration of social risks and social needs among the broader population.
- 3 subgroups of individuals that share one or more demographic characteristics—and several social needs related to a common social risk.
- 1 social need that impacts a high % of members but that neither the organization nor local CBOs have existing capabilities to address.

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HE PLUS 2: Cross-Sector Partnerships and Engagement

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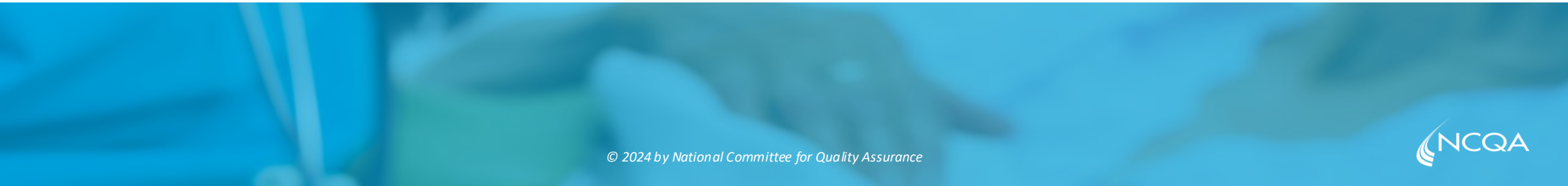

HE Plus 2: Cross-Sector Partnerships & Engagement

Activities in this standard category:

Assess gaps in **existing community resources** and **the organization's capabilities** to address social needs and risks.

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

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

Establish at least one bidirectional and mutually-supportive partnership to deliver social needs resources

Prepares organizations to:

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

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HE Plus 2: Cross-Sector Partnerships and Engagement

Partners

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

Community-Based Initiatives

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

Cross-Sector Initiatives

Cooperative relationships between organizations from different sectors that **focus on addressing a shared community-level *social risk***

Social Risk & Need Resource Assessment

HE Plus 2, Element A:

***Social Risk** Resource Assessment*

To mitigate the prioritized **social risks** identified in HE Plus 1, Element G, **factor 1**, the organization annually assesses:

HE Plus 2, Element B:

***Social Need** Resource Assessment*

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

Factor 1: **Existing community resources**	**Assess whether there are existing community resources** to mitigate or address the **prioritized social risks and social needs**.
Factor 2: **Organizational capacity and capability**	**Determine whether the organization has the capacity** *(available resources)* and **capability** *(knowledge)* to mitigate or address them.
Factor 3: **Gaps in resources**	**Assess gaps between existing community resources and its own capacity and capability** to mitigate or address prioritized social risks and social needs.

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HE Plus 2, Element D: Agreements With Partners to Deliver Resources/Interventions

The organization has written contracts or agreements with **at least one partner** with which it collaborates to deliver social needs resources or interventions that describe:

1. Each organization's roles and responsibilities, including investments and supports.
2. How data are shared bidirectionally.
3. An annual process for collaboratively evaluating the partnership.

Examples: Evidence

- **Agreements** that demonstrate factors 1-3.
- An **implementation plan** that outlines the **timeline** by which the organization will take **specific actions** to update its existing contracts and agreements to meet factors 1-3.
- An **implementation plan** that outlines the **timeline** by which all partnership contracts will be updated to **include language** that meets factors 1-3, as **demonstrated in 3 existing contracts**.

Scoring

- **Organization submits** a list of all partnerships, and NCQA selects a random sample of up to four.
- Organization receives the average score across all selected partnerships.

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HE Plus 2, Element D: Agreements With Partners to Deliver Resources/Interventions

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Additional Information

- Agreements with social care networks or referral platforms **do not meet the intent**.
- **A generic policy statement** about the content of a contract/agreement does not meet this element.

⚠ Minimum Requirements ⚠

- **Factor 1 must specify:**
  - Shared expectations;
  - Roles and responsibilities for each partner;
  - Terms of financial or other investments or support.

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HE Plus 2, Element E: Engaging With Partners to Deliver Resources/Interventions

The organization implements a process for engaging with its partners that includes:

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

Evidence

NCQA Reviews

- **Documented process** describing **how the organization collaborates with and supports its partner organizations** that deliver social needs resources or interventions.
- **Materials** demonstrating the organization provided support.

⚠ Minimum Requirements ⚠

- **For factor 1, demonstrate "active" collaboration** (sharing workflows, processes, information or de-identified aggregate-level data).

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Examples: Collaboration and Support

F2: Collaborating

- Shared workflows or processes (e.g., data sharing/exchange)
- Joint efforts (to secure external funding, advocate on policy or legislation)
- Staff participation in delivery of resources or interventions
- Co-developing positions/roles to operationalize the partnership

F3: Supporting

- Payment for services rendered or other financial support (grants).
- Providing or paying staff to help the organization deliver resources or interventions.
- Providing or hosting a location for a partner to deliver resources or interventions.
- Offering relevant education or training to a partner.
- Connecting partners with other organizations, as needed.

HE PLUS 3: Data Management and Interoperability

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HE Plus 3: Data Management & Interoperability

Activities in this standard category:

Policies and procedures for protection, access to, use and sharing of individual-level data on social needs

Process for bidirectional data sharing with external organizations and partners.

Prepares organizations to:

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

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HE PLUS 4: Program to Improve Social Risks and Address Social Needs

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

Activities in this standard category:

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

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

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

Prepares organizations to:

- Create infrastructure to continuously measure and improve the program (e.g., priorities, partners, goals)
- Set measurable goals for addressing patients' social needs and mitigating communities' social risks
- Meaningfully involve stakeholders that best understand the needs, risks and challenges of the community

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HE Plus 4, Element C: Process for Meaningful Stakeholder Involvement

The organization has a **process to meaningfully involve members of its communities and population of individuals served** in improving the program that includes:

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

⚠ Minimum Requirements ⚠

Community Served

Representatives of the communities the organization identified in *HE Plus 1, Element A: Defining the Community.*

- **Members of the broader community** *(individuals that might not access the organization's services),* ***or***
- **Representatives of community-based organizations** *(e.g., partners)*

Population of Individuals Served

Individuals served directly by the organization *(e.g., current members, patients who receive treatment, individuals who participate in its programs)*

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HE Plus 4, Element D: Meaningful Stakeholder Engagement

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

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

⚠ Minimum Requirements ⚠

- **Same stakeholders as Element C.**
- **For factors 1 and 2, input** on the **goals** selected in the annual work plan *(Element B).*
- **Factors 3 and 4** require **input** on:
  - **Partners** identified in HE Plus 2, Elements C and D (*selection and agreements with partners*) to deliver social needs resources or interventions; ***and***
  - **The resources** themselves.
- **For factor 5,** input on **at least one barrier**
- **At least annually:** Demonstrate activity is completed **at least every 12 months**, if not less (semiannually, quarterly), **at least once within prior year.**

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HE PLUS 5: Referrals Outcomes and Impact

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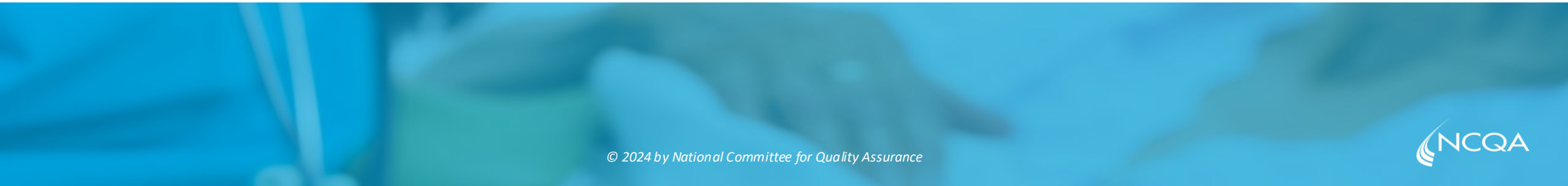

HE Plus 5: Referrals, Outcomes & Impact

Activities in this standard category:

Identify and refer individuals to appropriate social needs resources

Track and identify disparities in social needs referral statuses

Annually collaborate with partners to **evaluate and improve** the partnership's effectiveness

Prepares organizations to:

- Empower patients to have an active and informed role in the social resource referral process
- Evaluate and identify necessary improvements or changes to partnership or the program

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HE Plus 5, Element E: Evaluating Bidirectional Partnership

The organization and its partners **collaborate to annually evaluate** the effectiveness of the partnership based on:

3. **The status of referrals, as tracked in Element C.**
4. **Disparities in referral status, as analyzed in Element D.**
5. **Bidirectional feedback on the partnership process.**

⚠ Minimum Requirements ⚠

- ***For Factor 3***, documentation **must show agreement** between the organization and partner **about what is used** to evaluate effectiveness.
- ***For Factor 5***, documentation must include feedback used for the evaluation.

Examples: Bidirectional Feedback

- **Reports** showing rates of resources accessed or timeframes for receiving interventions.
- **Meeting minutes** documenting discussion of each partner's experience with the agreed upon referral process or data sharing workflow.
- **Survey results** for staff perception of burden.

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Advancing Analytics Capabilities

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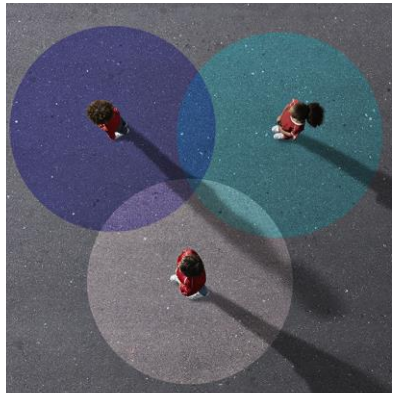
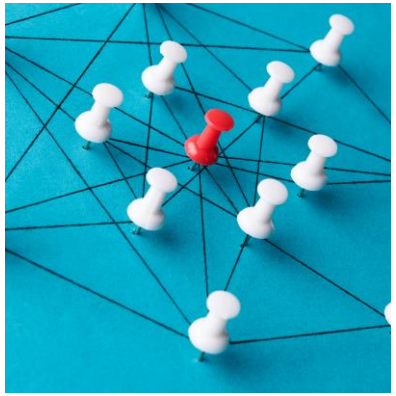
Identify and Select Indicators of Health Outcomes



Collect and stratify data on multiple environmental indicators

- **Social needs** (e.g., financial, food, housing, transportation, interpersonal safety)
- **Demographic characteristics** (e.g., income, education, race, ethnicity, language, sexual orientation, disability status)
- **Geography** (e.g., residence in a high needs zip code or rural area, census tract)

Proxy indicators for socioeconomic and environmental ("social") drivers of health outcomes.



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Select Relevant, Impactful Health Care Quality Metrics

Select multiple metrics or measures

Example

Measure Type	*Focus Area*	*Measure*
Clinical Area	Cardiometabolic Focus	Kidney Function Measure
Internal KPIs		Diabetes Measure
Subpopulations		

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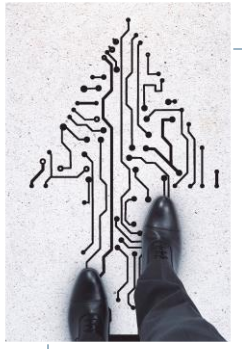
Select a Reference Group

Determine whether analysis will consider indicators as discrete or intersectional

- **Ex: Discrete**. Assesses a metric by preferred language and by housing insecurity, separately
- **Ex: Intersectional**. Assesses metric by white/low income, white/high income, Hispanic/low income, Hispanic/high income

Identify a reference group that makes sense for your data and population.



Determine whether analysis will use an “a priori” or data-driven approach:

- **Ex: a priori**. assumes English-speaking, high-income subgroup will have the best health outcomes
- **Ex: data-driven.** Uses data to determine “Middle Eastern or North African” subgroup as highest or poorest performing.

Use understanding of population’s composition and state/community environmental (“social”) factors to determine most appropriate method.

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Use Benchmarking

Monitor progress and performance, over time, relative to other similar health care organizations

Identify gaps in health outcomes, provider performance or quality of care

Different from selecting a reference group (internal focus)

Sources

- NCQA HEDIS® Measures
- State health or health equity reports
- CBO Publications

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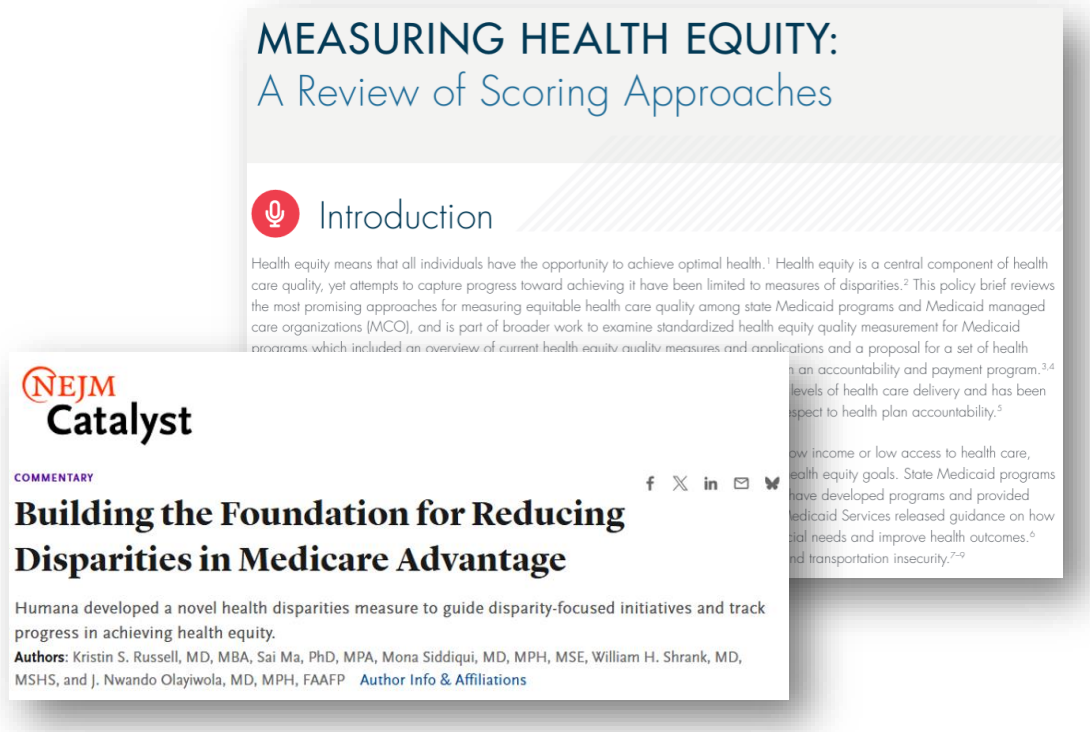
Leverage Composite Analytic Methods of Quality Performance

- Allows for evaluation of intersectional disparities across indicators and measures
- Identify trends and relationships between measures
- Facilitating comparisons between business units
- Easily display, track and communicate action to management



[NCQA Whitepaper: Measuring Health Equity]

[NEJM Catalyst Article]

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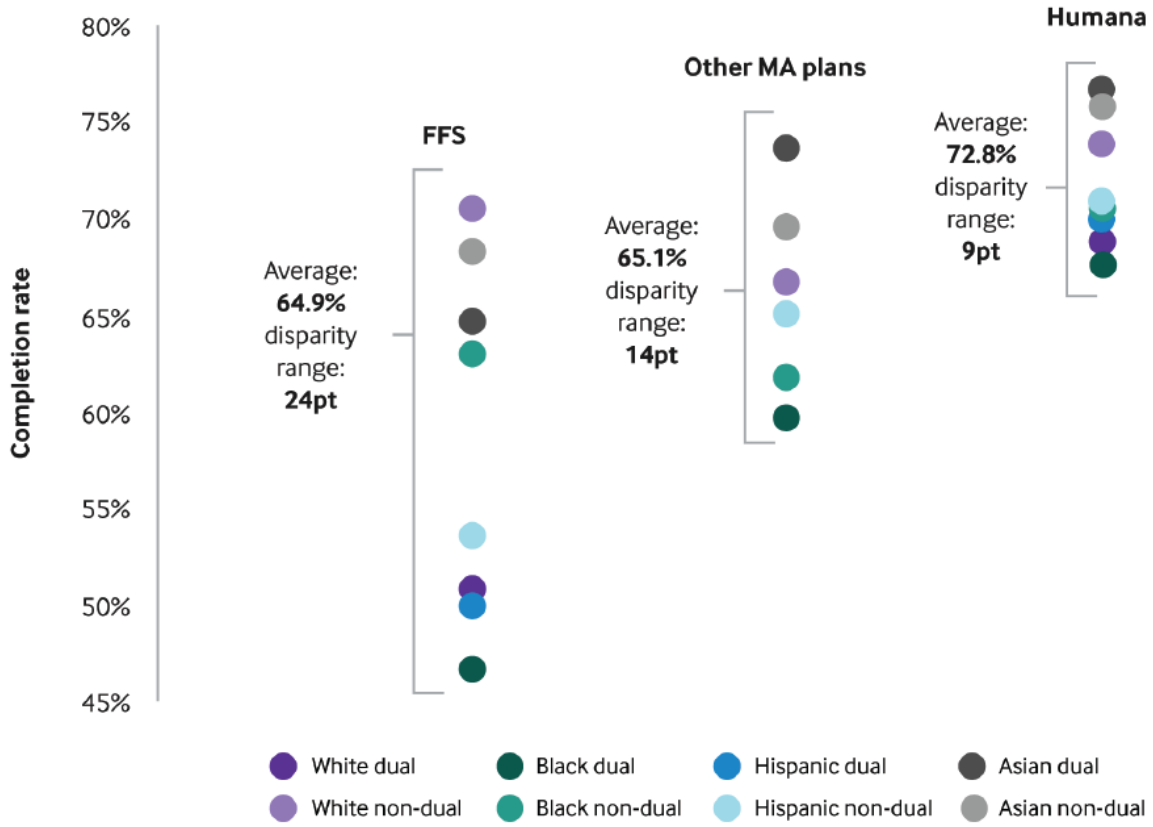
Example: Composite Analytic Methods



NEJM Catalyst Article

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Have Questions? Want to Learn More?

Ask a Question

Submit content-specific questions to NCQA's policy champions via ***My.NCQA.org***

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