CENTER FOR HEALTH INFORMATION AND ANALYSIS

Equity in Quality of Care

Select Clinical Quality and Patient Experience Measures Stratified by Race and Ethnicity, 2024

November 2026

CHIA

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Overview

CHIA examines clinical quality and patient experience measures to assess how health care processes and policies affect patient outcomes. This report analyzes those measures through a health equity lens to identify disparities, highlight opportunities for improvement, and support a more equitable health care system.

The report includes select measures of primary care quality and patient experience, stratified by patient race and ethnicity, from two sources: the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), a widely used measure of clinical quality, and the Massachusetts Health Quality Partners (MHQP) Patient Experience Survey (PES). It also reports hospital performance on the Leapfrog Group's Health Equity standard, which assesses hospitals' collection and use of patient demographic information to identify and reduce disparities. ■

Key Findings



Clinical quality performance varied significantly by race and ethnicity in 2024, with disparities in cancer screening rates. Black and Hispanic patients had significantly lower rates of cancer screenings compared with White and non-Hispanic patients, respectively.



Patient-reported primary care experiences varied by race and ethnicity. In surveys following a primary care provider visit, **Asian, Black, and Hispanic patients rated certain aspects of their experiences**, like support managing health conditions on their own and provider trust, **lower than White and non-Hispanic patients**.



More than half of reporting hospitals achieved the Leapfrog Group's Health Equity Standard in 2024. Leapfrog's Health Equity Standard focuses on building a sufficient infrastructure to identify and reduce disparities; in 2024, **30 of the 53 reporting hospitals achieved the standard**.

Introduction

Measuring health care quality facilitates system accountability and identifies areas for improvement, which are essential to ensure that patients receive high-quality care. CHIA regularly examines health care quality and patient-reported experiences with primary care among private commercial members in the Commonwealth; statewide data on select clinical quality performance measures are drawn from the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) and Massachusetts Health Quality Partners (MHQP) Patient Experience Survey (PES) results.

Results in this report indicate that for several metrics, disparities emerge when statewide performance is stratified by race and ethnicity, including worse care or experiences for some groups. Multiple charts include the overall statewide rate as a dashed gray line to highlight these instances.

Disparities in health outcomes, such as decreased life expectancy and increased chronic disease prevalence, place an undue burden on historically marginalized racial and ethnic communities, and recent research reveals that there is a meaningful financial cost associated with these disparities.[1,2,3] A 2023 report from the Blue Cross Blue Shield of Massachusetts Foundation estimated that the economic burden of health inequities experienced by Black, Hispanic, and Asian populations in Massachusetts totals $5.9 billion each year, and while the Commonwealth of Massachusetts has consistently been a national leader in health outcomes and quality, disparities persist.[4,5] It is critical to prioritize the collection and analysis of reliable and meaningful health care quality information on

subpopulations to achieve a more equitable health care system.

While there are many races and ethnicities represented in Massachusetts, this report presents stratified results for 3 racial groups (White, Black, and Asian) and two ethnic groups (Hispanic and non-Hispanic) to ensure sufficient sample sizes for all analyses. When comparing results among groups in this report, the reference groups for the results are the White population for race and non-Hispanic population for ethnicity because they represent the racial and ethnic majorities in Massachusetts.

This report highlights only statistically significant findings because non-statistically significant differences could be due to chance.

Future reports may analyze multi-year trends over a longer period to evaluate changes in stratified health care quality measure performance, recognizing that while improvements in health equity often emerge slowly, accelerating progress remains a critical priority. Detailed lists of racial and ethnic classifications and descriptions of each measure are available in the technical appendix. ■



SECTION 1:

Select Clinical Quality Metrics by Race and Ethnicity

CHIA reports HEDIS clinical quality measures stratified by race and ethnicity to identify strengths and disparities in primary care delivery across Massachusetts. HEDIS is a tool developed by NCQA and is widely used by payers and providers to assess quality and drive improvement, including measures related to significant public health issues and prevalent conditions such as cancer, heart disease, behavioral health diagnoses, and diabetes.

The HEDIS measures in this report were included in the 2024 Massachusetts Aligned Measure Set[6] in 5 domains: Screening/Preventive Care, Maternity Care, Pediatric/Adolescent Care, Chronic Condition Care, and Behavioral Health Care. HEDIS scores reflect the percentage of eligible patients who received the care being measured. Scores reflect members enrolled in commercial health maintenance organization (HMO) and point-of-service (POS) products in participating health plans and exclude plans sold on the Massachusetts Health Connector (see technical appendix).

For some measures, such as treatment for an acute ailment or behavioral health diagnosis, patients often seek care at urgent care centers or from specialists, not from their primary care provider or clinician (PCP). Therefore, some scores may be low because care was appropriately sought elsewhere rather than being reflective of poor performance. ■

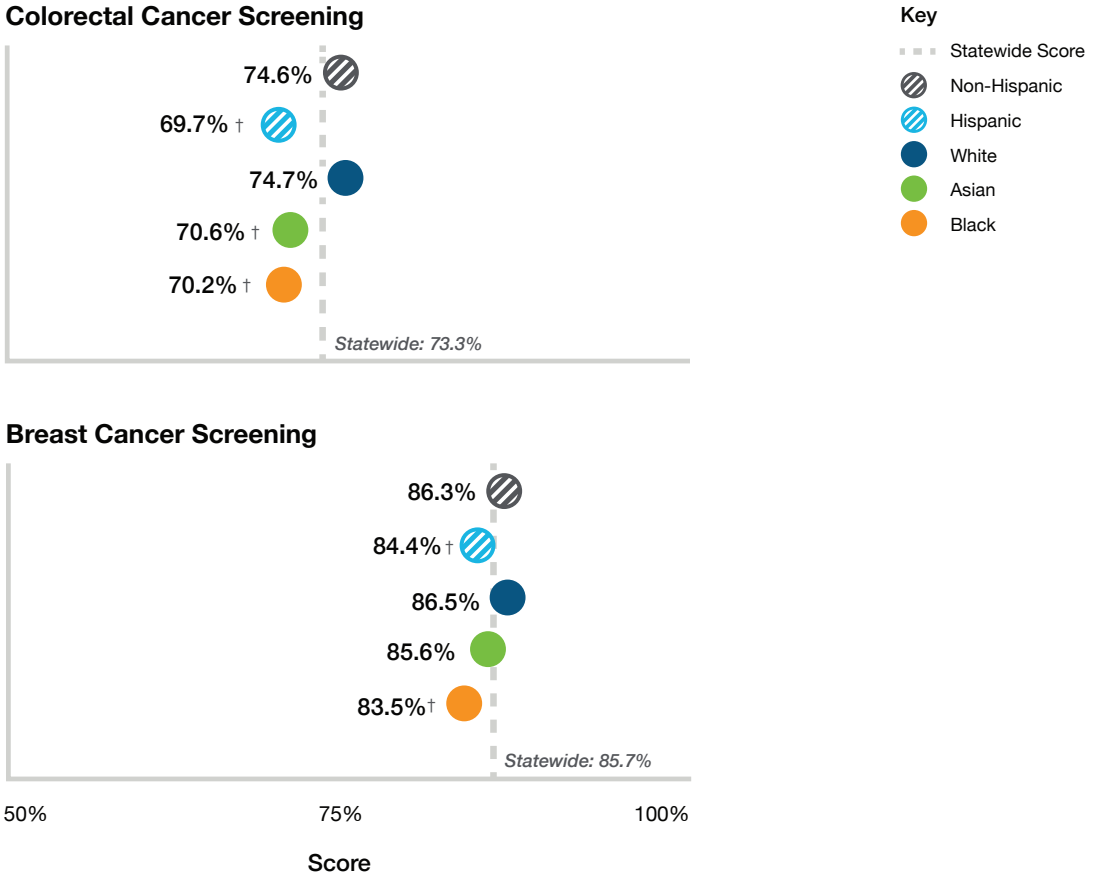
Select Clinical Quality Metrics by Race and Ethnicity

Screening and Preventive Care Measures, 2024

In 2024, when stratified by race, CHIA found that colorectal cancer screening rates in Massachusetts were significantly lower for both Black and Asian patients compared with White patients (70.2% and 70.6% vs. 74.7%, respectively). When stratified by ethnicity, colorectal cancer screening rates were significantly lower for Hispanic patients compared with non-Hispanic patients (69.7% vs. 74.6%, respectively).

Additionally, when stratified by race, 2024 breast cancer screening rates were significantly lower for Black patients than White patients (83.5% and 86.5%, respectively) and significantly lower for Hispanic patients than non-Hispanic patients (84.4% and 86.3%, respectively).

Screenings and preventive care have an important role in health management because patients often have better outcomes when certain conditions are diagnosed early. Studies show that colorectal cancer incidence and mortality rates vary among racial and ethnic populations and disproportionately affect Black Americans, underscoring the importance of early detection and preventive care, which could mitigate these differences.[7] Similarly, early detection of breast cancer—currently the second-leading cause of cancer-related deaths in women—can significantly reduce morbidity and mortality.[8]



† Indicates statistically significant difference from the reference group (e.g., White or Non-Hispanic).

Source: Scores calculated by Massachusetts Health Quality Partners (MHQP). Measures drawn from Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA).[9]

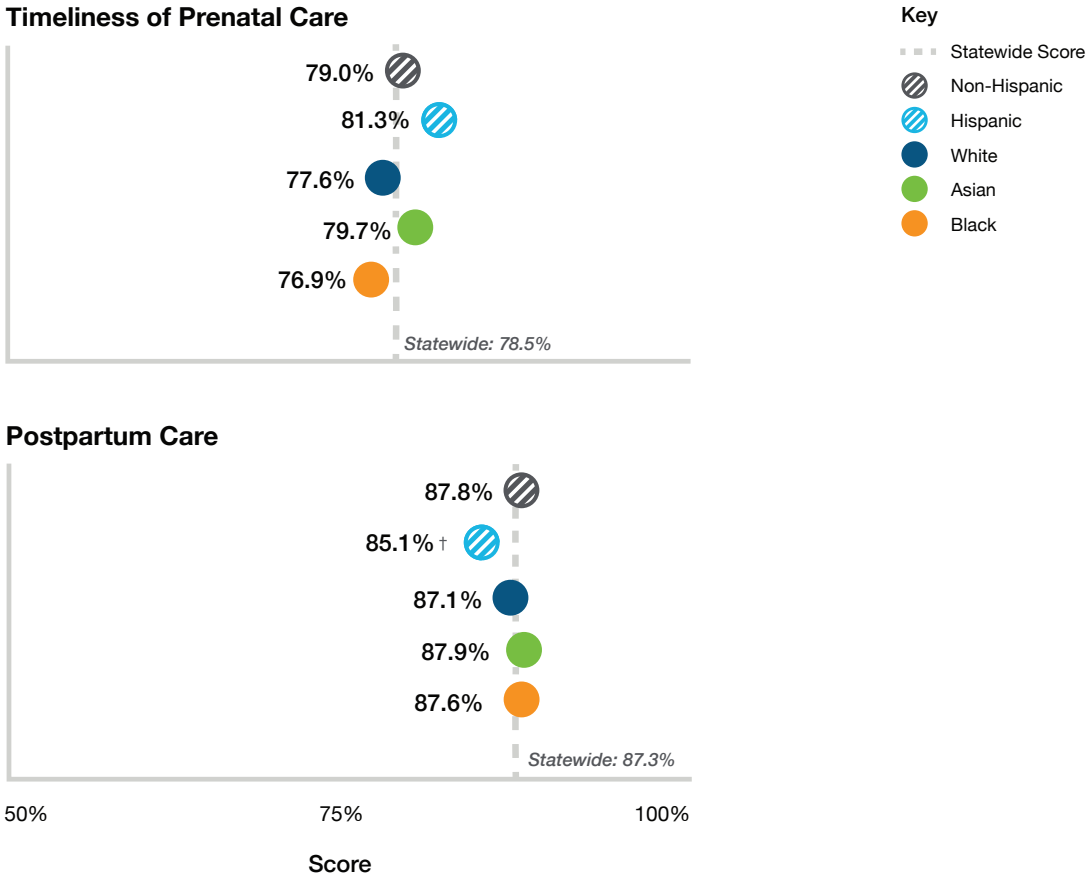
Notes: Higher score is better for all measures on this page. Data for populations with n<30 suppressed. Statistically significant ("significant") differences relative to reference group (White for race, non-Hispanic for ethnicity) at 5% level. See databook for specific measure reporting periods and technical appendix for descriptions of included measures.

Select Clinical Quality Metrics by Race and Ethnicity

Maternity Care Measures, 2024

The Timeliness of Prenatal Care measure assesses the percentage of people who received a prenatal care visit in the first trimester of pregnancy. While CHIA did not find any significant differences in rates of prenatal care by race or ethnicity in 2024, more than one-fifth (21.5%) of patients statewide did not receive timely prenatal care. These results highlight the need to increase access to and use of prenatal care services where the health of the pregnant patient can be monitored. Access to prenatal and postpartum care is critical for both short-term and long-term positive health outcomes for the birthing person and newborn. However, nationally, fewer people are beginning prenatal care in the first trimester, and at least 40% of people who give birth do not attend a postpartum care visit.[10,11] Meeting with a clinician early is important to identify potential medical concerns and inform patients about steps they can take to support a healthy pregnancy and reduce the risk of complications and negative outcomes.[12]

The Postpartum Care measure captures the percentage of people who had a postpartum care visit 7 to 84 days after delivery. In 2024, Hispanic patients had a statistically significant lower rate of postpartum care compared with non-Hispanic patients (85.1% vs. 87.8%, respectively). There were no statistically significant differences across racial groups.



† Indicates statistically significant difference from the reference group (e.g., White or Non-Hispanic).

Source: Scores calculated by Massachusetts Health Quality Partners (MHQP). Measures drawn from Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA).

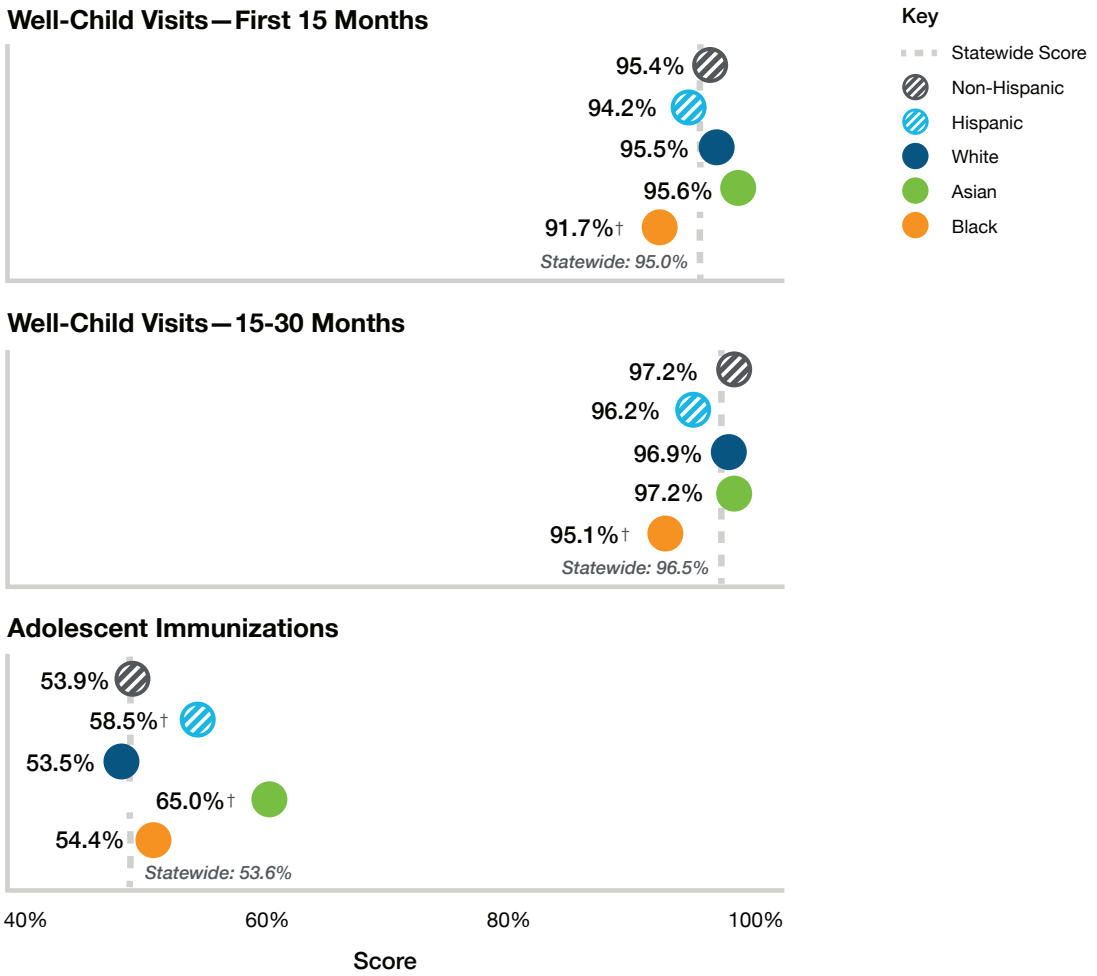
Notes: Higher score is better for all measures on this page. Data for populations with n<30 suppressed. Statistically significant ("significant") differences relative to reference group (White for race, non-Hispanic for ethnicity) at 5% level. See databook for specific measure reporting periods and technical appendix for descriptions of included measures. Changes made to Prenatal and Postpartum Care diagnosis criteria in 2024, so scores for this measure may reflect adaptation to new specifications.

Select Clinical Quality Metrics by Race and Ethnicity

Pediatric and Adolescent Care Measures, 2024

The well-child visit metrics included in this report reflect the percentage of pediatric patients receiving the recommended number of visits during 0-15 months of age and 15-30 months of age. For both age ranges, the scores for Black patients were significantly lower than for White patients, with a 3.9 percentage point difference in the first 15 months and a 1.8 percentage point difference for 15-30 months. There were no significant differences in scores by ethnicity. Well-child visits in the first 30 months of life are critical as an infant undergoes substantial changes in physical development as well as social and emotional growth to become a toddler. Visits during this period are foundational to preventive health care (such as recommended screenings and immunizations) because they promote better social, developmental, and health outcomes.[13]

In 2024, the overall statewide rate for the adolescent immunizations measure was low at 53.6%. Hispanic and Asian patients had significantly higher rates compared with reference groups (non-Hispanic and White patients, respectively). In addition to childhood immunizations associated with well-care visits, clinical guidelines recommend completing a series of immunizations for adolescents by age 13 (including meningococcal, Tdap, and HPV vaccines; see the technical appendix for details).[14] Receiving recommended vaccinations is the best defense against vaccine-preventable diseases that can otherwise cause serious negative health outcomes or death.[15]



† Indicates statistically significant difference from the reference group (e.g., White or Non-Hispanic).

Source: Scores calculated by Massachusetts Health Quality Partners (MHQP). Measures drawn from Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA).

Notes: Higher score is better for all measures on this page. Data for populations with n<30 suppressed. Statistically significant ("significant") differences relative to reference group (White for race, non-Hispanic for ethnicity) at 5% level. See databook for specific measure reporting periods and technical appendix for descriptions of included measures.

Select Clinical Quality Metrics by Race and Ethnicity

Chronic Condition Care Measures, 2024

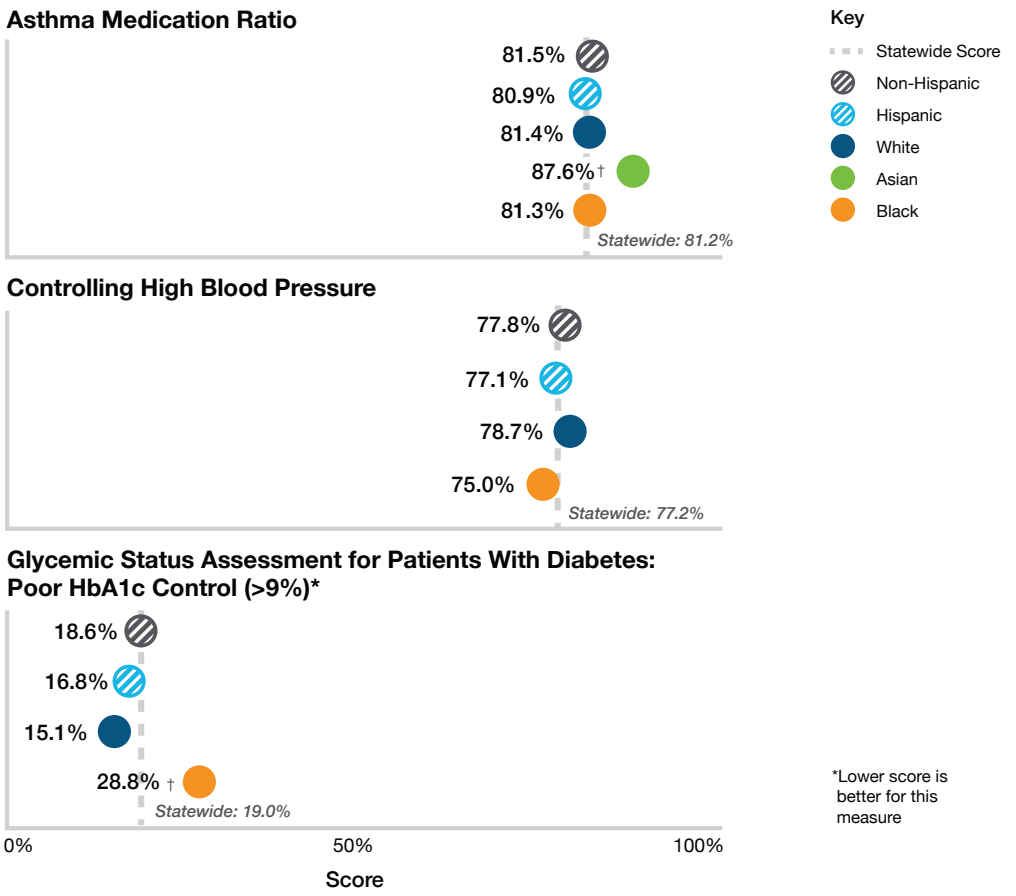
In 2024, the Asthma Medication Ratio score for Asian patients (87.6%) was significantly higher than for White patients (81.4%), indicating more usage of preventive medication over rescue medication to control asthma.[16]

Black patients had a significantly higher score of 28.8%, compared with 15.1% for White patients in 2024 for the Poor HbA1c Control measure, indicating worse control of HbA1c levels among Black patients.[17]

There was no statistically significant difference in scores by race or ethnicity for the Controlling High Blood Pressure measure.[18]

More than half of American adults have at least one chronic condition, which include some of the leading causes of death and disability in the United States (e.g., heart disease, diabetes, and cancer).[19] In addition, care for chronic conditions is a leading driver of health care costs, particularly due to vastly higher rates of health care utilization.[20] As the prevalence of chronic conditions continues to increase, so does the emphasis on primary care strategies to enhance monitoring, patient engagement, and management of conditions, to prevent negative outcomes.[21]

High HbA1c levels can lead to complications over time, such as damage to the heart blood vessels, nerves, kidneys, and more, underscoring the importance of early intervention.[22] No score was reported for Asian patients in 2024 for either the Controlling High Blood Pressure or Poor HbA1c Control measures due to a small sample size.



† Indicates statistically significant difference from the reference group (e.g., White or Non-Hispanic).

Source: Scores calculated by Massachusetts Health Quality Partners (MHQP). Measures drawn from Healthcare Effectiveness Data and Information Set (HEDIS®) developed by the National Committee for Quality Assurance (NCQA).

Notes: Higher score is better for Asthma Medication Ratio and Controlling High Blood Pressure while lower score is better for Poor HbA1c Control (>9%). Data for populations with n<30 suppressed. Statistically significant ("significant") differences relative to reference group (White for race, non-Hispanic for ethnicity) at 5% level. "Poor control" defined as HbA1c greater than 9% at most recent test during measurement year. Controlling High Blood Pressure and Poor HbA1c Control scores may be higher than previous years due to changes in denominator.

Select Clinical Quality Metrics by Race and Ethnicity

Behavioral Health Care Measures, 2024

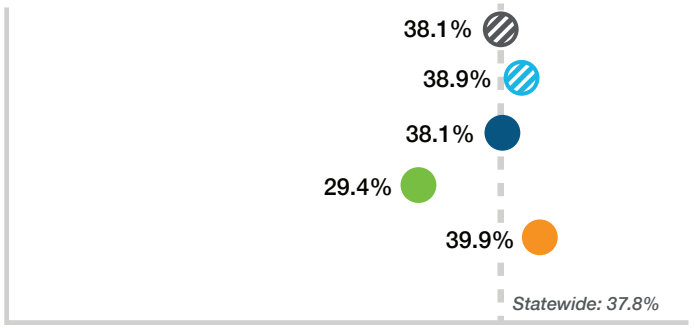
In 2024, the statewide score for adults for engagement of SUD treatment (12.7%) was notably lower than the initiation phase (37.8%). Performance on the engagement phase measure was also significantly lower among Asian patients compared with White patients (4.9% and 13.1%, respectively).

Policymakers have identified behavioral health integration with primary care as a crucial strategy for improving behavioral health care access and outcomes.[23] The Initiation and Engagement of Substance Use Disorder Treatment (IET) measure assesses support in the primary care setting in two phases: 1) initiation of substance use disorder (SUD) treatment, which is the percentage of new SUD episodes that result in an inpatient admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days of the diagnosis; and 2) engagement of SUD treatment, which is the percentage of new SUD episodes that have evidence of treatment beginning within 34 days of initiation.[24]

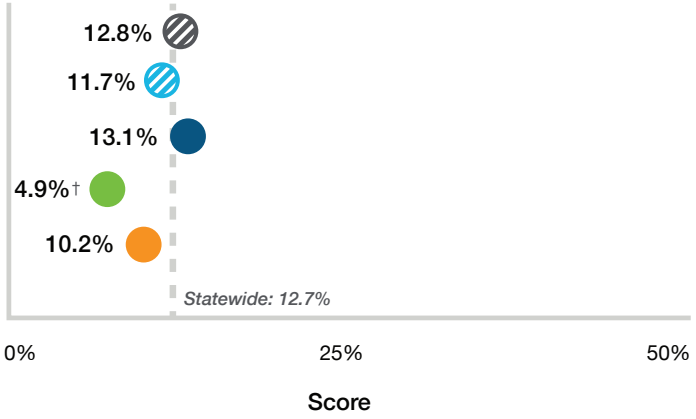
Individuals who engage in early SUD treatment (within 34 days) show decreased odds of negative outcomes, including mortality.[25,26]

The difference between initiation and engagement rates may reflect access or coverage challenges that make it harder for patients to continue receiving SUD treatment, but it may also reflect an inability to count instances where patients sought ongoing care in specialized settings and their PCP was not informed.

IET: SUD Treatment—Initiation Phase



IET: SUD Treatment—Engagement Phase



† Indicates statistically significant difference from the reference group (e.g., White or Non-Hispanic).

Source: Scores calculated by Massachusetts Health Quality Partners (MHQP). Measures drawn from Healthcare Effectiveness Data and Information Set (HEDIS®) developed by the National Committee for Quality Assurance (NCQA).

Notes: Higher score is better for all measures on this page. Data for populations with n<30 suppressed. Statistically significant ("significant") differences relative to reference group (White for race, non-Hispanic for ethnicity) at 5% level. See databook for specific measure reporting periods and technical appendix for descriptions of included measures.



SECTION 2:

Commercial Patient Experience Survey Results by Race and Ethnicity

CHIA reports results from MHQP's Patient Experience Survey (PES) for adult and pediatric patients by race and ethnicity to identify disparities in primary care experiences and target quality improvement efforts. The survey captures patients' experiences on whether patients feel heard, respected, and supported in managing their health, including sufficient access to their primary care provider and whether the provider was aware of and discussed specialty care, medications, or recent tests. Substantial evidence supports the relationship between positive patient experience and improved health processes and outcomes, including patients' decreased use of unnecessary health care services, greater likelihood of following medical recommendations, and better performance on clinical quality process measures.[27,28]

The 2024 PES underscores that Asian, Black, and Hispanic patients report worse primary care experiences than their White and non-Hispanic counterparts, which aligns with national trends.[29,30] Scores are stratified by race and by ethnicity as part of MHQP's Measured Equity program, which seeks to capture data on a range of demographic and social determinants of health from payers and providers.

Descriptions of each of the PES composites in this report, survey questions, and information about how responses are converted to numeric scores can be found in the technical appendix. ■

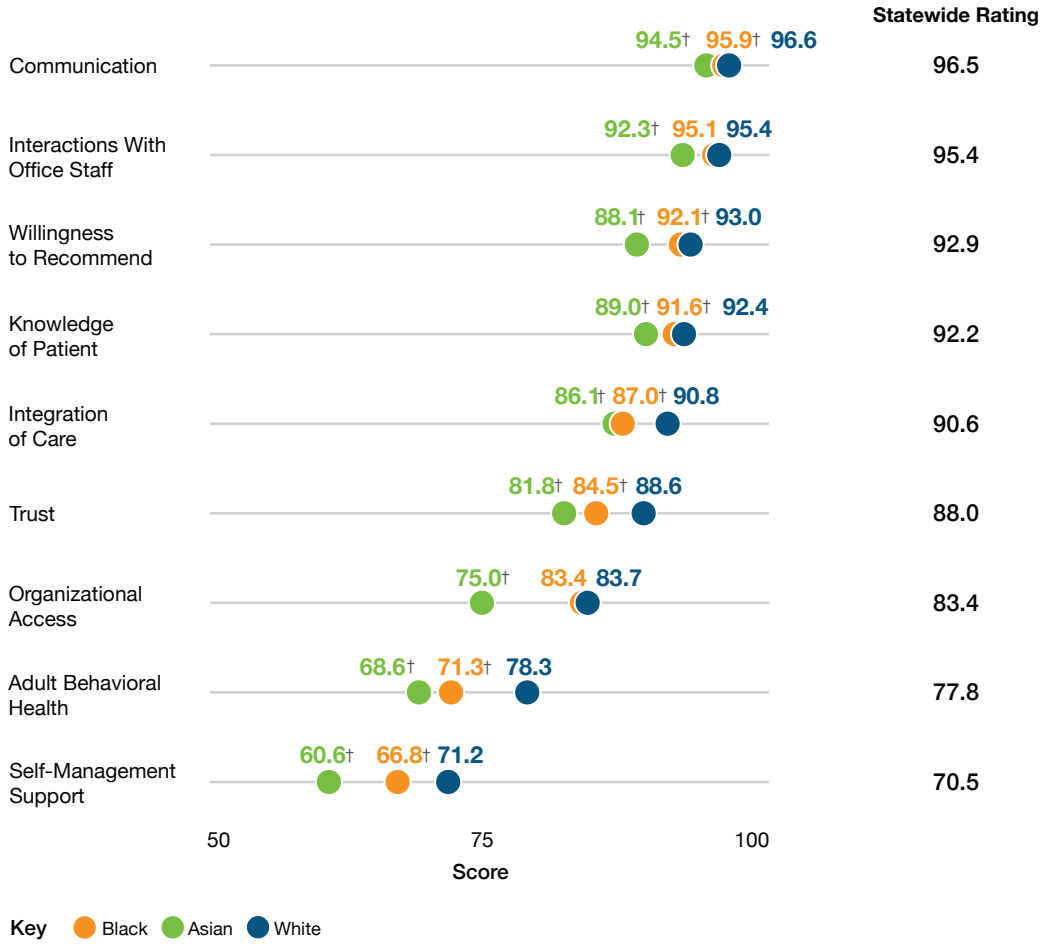
Commercial Patient Experience Survey Results by Race and Ethnicity

Adult Primary Care Patient Experience Survey Results by Race, 2024

In 2024, Black and Asian adults reported lower satisfaction with their primary care providers than White adults in key care domains, including Communication and Trust. Asian patients rated their experiences significantly lower than White patients in all 9 survey domains, similar to 2023 results. Black patients rated their experiences significantly lower than White patients in 7 of the 9 domains, 2 more domains than in 2023, highlighting opportunities to improve patient experience and reduce disparities.

The greatest overall disparity was for the Self-Management Support domain, with a significant difference of 10.6 points between Asian and White patients. This domain evaluates whether the provider discussed specific health goals and any challenges patients have in managing their health. Patients with chronic illnesses such as asthma, cardiovascular disease, and diabetes must actively manage their health, and research indicates that patient perception of physical and mental exhaustion due to self-management is negatively associated with patient well-being and adherence.[31,32] Effective support could play a valuable role in helping patients manage their health outside the primary care provider's office.

While primary care provider satisfaction was high across the 3 racial groups, the statewide rating most closely aligned with the reference group (White patients); stratifying results helps identify groups whose experiences may not be reflected in the statewide score.



† Indicates statistically significant difference from the reference group (e.g., White or Non-Hispanic).

Source: Scores calculated by Massachusetts Health Quality Partners (MHQP) from the Patient Experience Survey (PES).

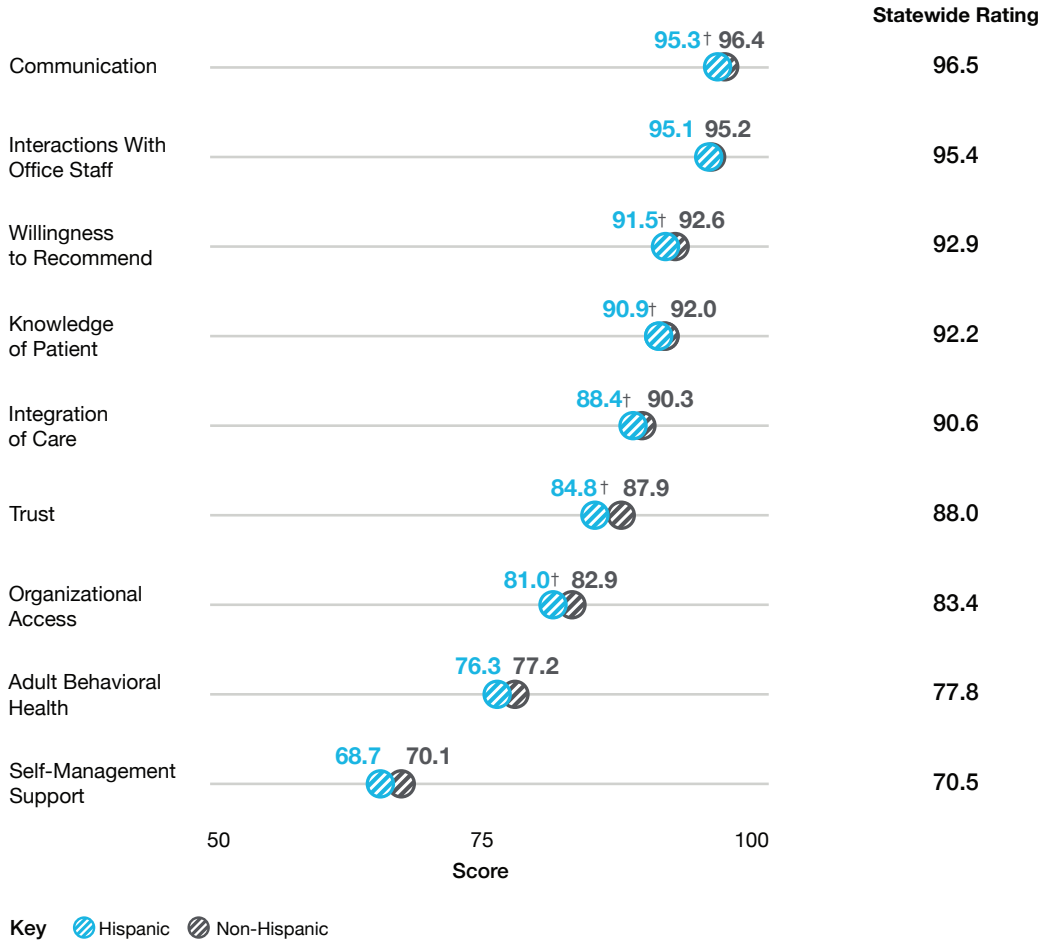
Notes: Scores out of 100. Data includes adult patients aged 18 years and up. Survey conducted on sample of private commercial health plan members.

Commercial Patient Experience Survey Results by Race and Ethnicity

Adult Primary Care Patient Experience Survey Results by Ethnicity, 2024

In 2024, self-reported experience scores were significantly lower for Hispanic patients than non-Hispanic patients for 6 of the 9 domains: Communication, Willingness to Recommend, Knowledge of Patient, Integration of Care, Trust, and Organizational Access. For the second year in a row, Hispanic patients rated their experiences with Trust and Organizational Access significantly lower than non-Hispanic patients. Research has shown that Hispanic patients often must advocate for themselves to receive proper care and that their pain is not taken seriously.[33]

The greatest overall disparity was for the Trust domain, with a significant difference of 3.1 points between Hispanic and non-Hispanic patients in 2024. The statewide rating closely reflected non-Hispanic patient scores for almost all domains, highlighting the importance of disaggregating scores by ethnicity to identify population groups whose experiences are not captured in the statewide score.



† Indicates statistically significant difference from the reference group (e.g., White or Non-Hispanic).

Source: Scores calculated by Massachusetts Health Quality Partners (MHQP) from the Patient Experience Survey (PES).

Notes: Scores out of 100. Data includes adult patients aged 18 years and up. Survey conducted on sample of private commercial health plan members.

Commercial Patient Experience Survey Results by Race and Ethnicity

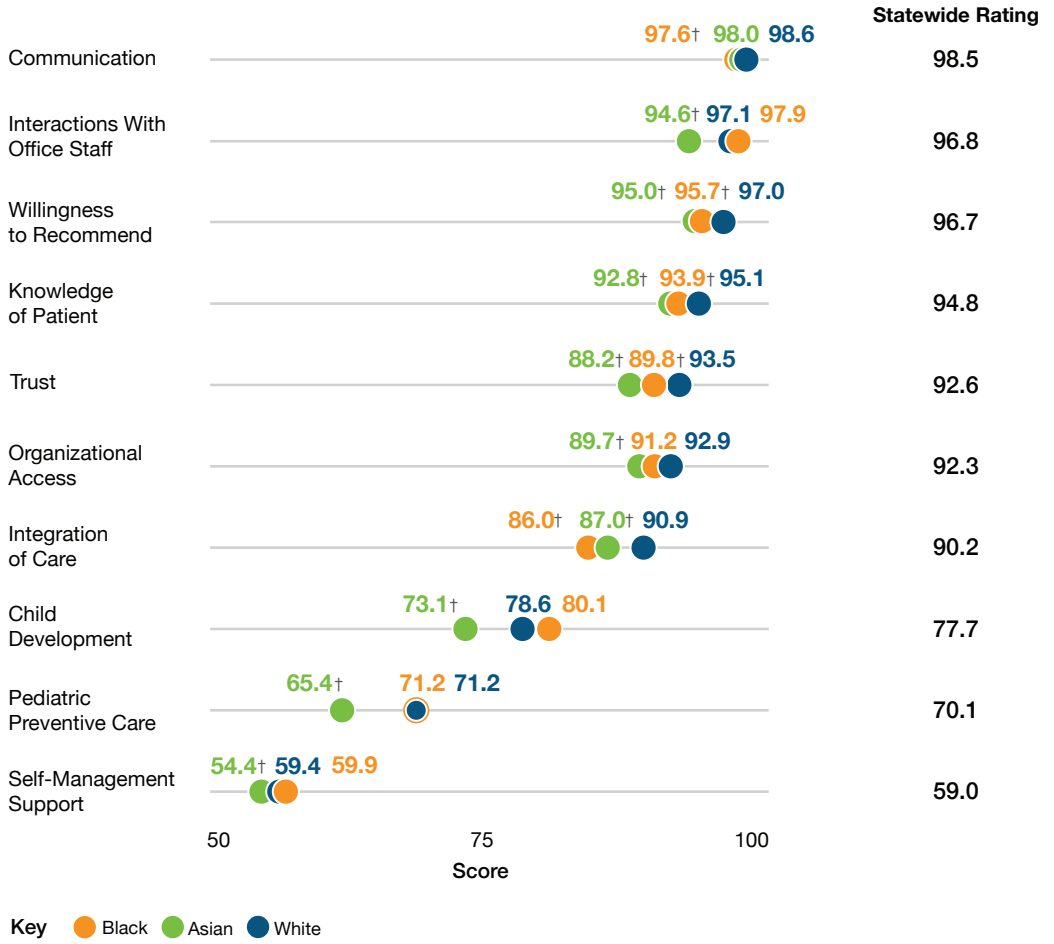
Pediatric Primary Care Patient Experience Survey Results by Race, 2024

The Pediatric Patient Experience Survey is completed by caregivers who took a child to see a primary care clinician and includes 2 pediatric-specific domains: 1) Child Development; and 2) Pediatric Preventive Care.[34]

In 2024, Asian patients rated pediatric primary care experiences significantly lower than White patients for 9 of the 10 survey domains, including a 5.8-point difference for Pediatric Preventive Care. Compared with 2023, this represents 3 additional domains where Asian patients rated pediatric primary care experiences significantly lower than White patients, indicating further areas where primary care providers could target efforts to improve patient experience.

In 2024, Black patients rated their pediatric primary care experiences significantly lower than White patients for 5 of the 10 survey domains, including a 4.9-point difference for Integration of Care. Compared with 2023, this represents 1 additional domain where Black patients rated pediatric primary care experiences significantly lower than White patients.

Patient and clinician focus groups have highlighted the importance of understanding patient experiences with health care and how improvements in one area of care can strengthen care in other domains.[35] Moreover, pediatric primary care visits are often a child's first interaction with health care, underscoring the need to continue engaging children and their caregivers to support positive experiences with health care clinicians.



† Indicates statistically significant difference from the reference group (e.g., White or Non-Hispanic).

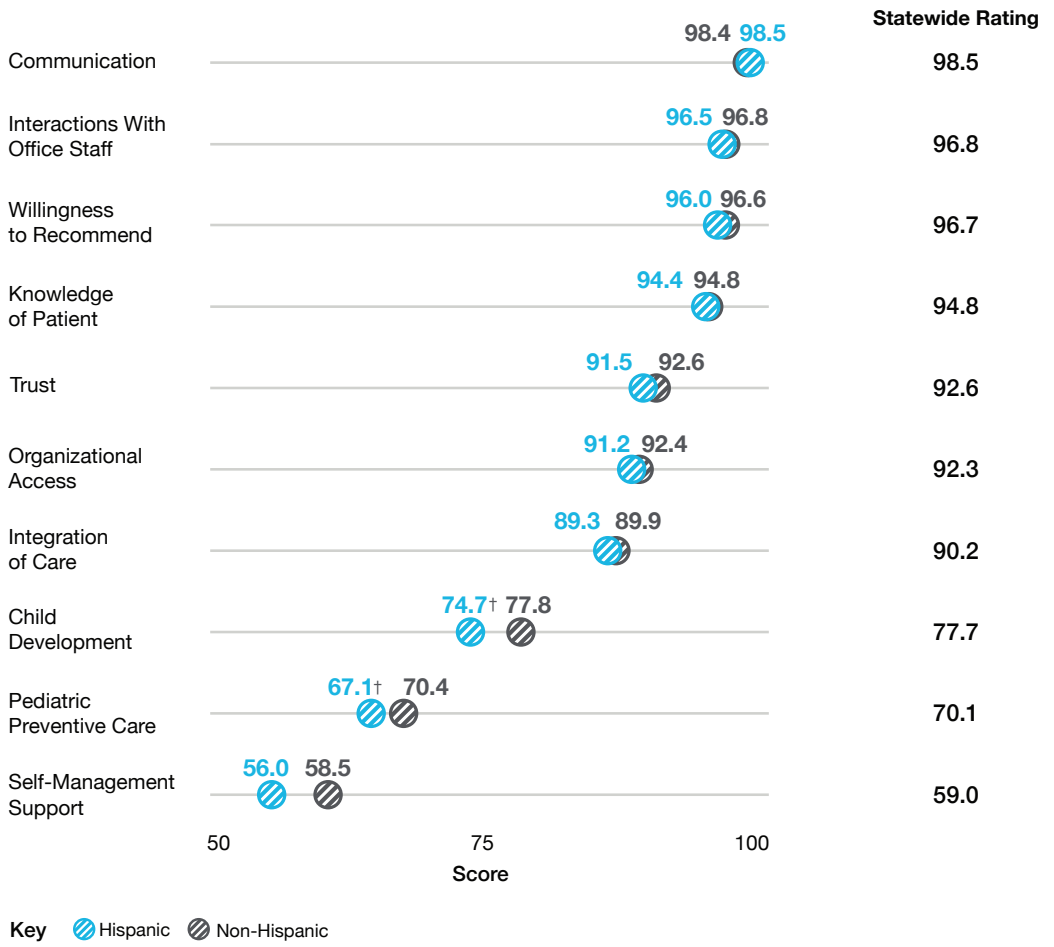
Source: Scores calculated by Massachusetts Health Quality Partners (MHQP) from the Patient Experience Survey (PES).

Notes: Scores out of 100. Data includes pediatric patients ages 0-17 years; parent or caregiver surveyed on patient's behalf. Survey conducted on sample of private commercial health plan members.

Commercial Patient Experience Survey Results by Race and Ethnicity

Pediatric Primary Care Patient Experience Survey Results by Ethnicity, 2024

In 2024, caregivers of Hispanic pediatric patients reported significantly lower scores for 2 of the 10 survey domains, Child Development and Pediatric Preventive Care, when compared to non-Hispanic patients. Scores for these 2 domains, which are exclusive to the pediatric version of the PES, were both significantly lower for Hispanic patients than for non-Hispanic patients, identifying specific areas where clinicians can target efforts to improve the pediatric patient experience. In 2024, the greatest overall disparity was for Pediatric Preventive Care with a 3.3-point difference between Hispanic and non-Hispanic patients.



† Indicates statistically significant difference from the reference group (e.g., White or Non-Hispanic).

Source: Scores calculated by Massachusetts Health Quality Partners (MHQP) from the Patient Experience Survey (PES).

Notes: Scores out of 100. Data includes pediatric patients ages 0-17 years; parent or caregiver surveyed on patient's behalf. Survey conducted on sample of private commercial health plan members.



SECTION 3:

Adherence to Leapfrog Standards for Hospitals

The Leapfrog Group is a national nonprofit watchdog organization that sets standards and collects voluntary data from hospitals. Each year, it fields the Leapfrog Hospital Survey to measure safety, quality, and efficiency based on national performance measures. CHIA reports adherence to the Leapfrog Health Equity Standard to monitor hospitals' progress toward collecting and leveraging patient demographic data to identify and reduce disparities in patient care.[36] This section presents CY 2024 hospital-level performance against the Leapfrog standard for health equity compared with results from the prior year.

By collecting demographic data, hospitals can better identify which patient populations may benefit from quality improvements and tailor more effective interventions. The Leapfrog Health Equity Standard data reflects voluntary reporting from acute hospitals in Massachusetts regardless of health insurance payer and does not include data from all Massachusetts hospitals.

Hospitals met the Leapfrog standard for health equity by taking the following steps:

1. Collect patient demographic data (race, ethnicity, and preferred written or spoken language).
2. Train staff to collect demographic data directly from patients.
3. Stratify quality measure(s) by demographic data.
4. Create an action plan to address any disparities found.
5. Share and report on efforts to identify and reduce health care disparities.

For detailed information on the Leapfrog Group's survey questions and methodology, see the **technical appendix**. ■

Hospital Adherence to Leapfrog Health Equity Standard

Leapfrog Hospital Survey Health Equity Standard, 2024

In 2024, 30 of the 53 reporting hospitals achieved the Leapfrog standard for health equity. From 2023 to 2024, 8 hospitals improved from considerable achievement to achieved the standard. During the same period, 7 hospitals dropped from achieved the standard to considerable achievement and 2 dropped from achieved the standard to limited achievement. "Considerable Achievement" hospitals implemented most standards, with "Some Achievement" and "Limited Achievement" indicating greater deviation.

Collecting patient-reported demographic information in a sensitive and respectful way is an important step for providers to identify and address disparities in the populations they serve. With this information, they can implement targeted approaches to reduce gaps in patient health outcomes and negative experiences, but achieving this goal requires significant investment in appropriate demographic data collection and evaluation.

Achieved the Standard 2024 (30 Hospitals)	**2023** (Last Year)
Baystate Franklin Medical Center	Considerable
Baystate Medical Center	Considerable
Baystate Noble Hospital	Considerable
Baystate Wing Hospital	Considerable
Berkshire Medical Center	Achieved
Beth Israel Deaconess Hospital-Milton	Achieved
Boston Medical Center	Achieved
Boston Medical Center South	Achieved
Cape Cod Hospital	Achieved
CHA Everett Hospital	Considerable
Charlton Memorial Hospital	Achieved
Emerson Hospital	Achieved
Fairview Hospital	Achieved
Falmouth Hospital	Achieved
HealthAlliance-Clinton Hospital Clinton Campus	N/A
HealthAlliance-Clinton Hospital Leominster Campus	N/A
Holyoke Medical Center	Achieved
Lowell General Hospital - Main Campus	Achieved
Lowell General Hospital - Saints Campus	Achieved
Melrose-Wakefield Hospital	Achieved
Mercy Medical Center	Considerable
Morton Hospital	Considerable
Mount Auburn Hospital	Achieved
Saint Anne's Hospital	Achieved
South Shore Hospital	Achieved
St. Luke's Hospital	Achieved
Sturdy Memorial Hospital	Considerable
Tobey Hospital	Achieved
UMass Memorial Medical Center - Memorial Campus	N/A
UMass Memorial Medical Center - University Campus	N/A

Considerable Achievement 2024 (13 Hospitals)	**2023** (Last Year)
Addison Gilbert Hospital	Achieved
Anna Jaques Hospital	Some
Beth Israel Deaconess Hospital-Plymouth	Achieved
Beth Israel Deaconess Medical Center	Achieved
Beth Israel Hospital - Needham	Achieved
Beverly Hospital	Achieved
Boston Medical Center - Brighton	Considerable
CHA Cambridge Hospital	Considerable
Harrington Memorial Hospital	N/A
Lahey Hospital and Medical Center	Achieved
UMass Memorial Health Marlborough Hospital	N/A
UMass Memorial Health Milford Regional Medical Center	Limited
Winchester Hospital	Achieved

Limited Achievement 2024 (10 Hospitals)	**2023** (Last Year)
Brigham and Women's Faulkner Hospital	Limited
Brigham and Women's Hospital	Limited
Cooley Dickinson Hospital	Limited
Holy Family Hospital - Methuen	Achieved
Lawrence General Hospital	Achieved
Massachusetts Eye and Ear	Limited
Massachusetts General Hospital	Limited
Newton-Wellesley Hospital	Limited
Salem Hospital	Limited
Tufts Medical Center	Limited

Key

- Achieved Standard
- Considerable Achievement
- Some Achievement
- Limited Achievement

Source: Leapfrog Hospital Survey. Based on voluntary hospital reporting; does not include data from all Massachusetts hospitals.

Notes: Data includes voluntary self-reported survey responses from Massachusetts acute hospitals. See databook for hospital-specific results.

Notes

1. NCQA, *Health Equity and Social Determinants of Health in HEDIS*: Data for Measurement (Washington, D.C., June 2021), https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2021/06/20210622_NCQA_Health_Equity_Social_Determinants_of_Health_in_HEDIS.pdf.
2. Hilary Daniel, Sue S. Bornstein, and Gregory C. Kane, "Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper," *Annals of Internal Medicine 168*, no. 8 (2018): https://doi.org/10.7326/M17-2441.
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