



MINNESOTA HEALTH CARE DISPARITIES

BY RACE, HISPANIC ETHNICITY, LANGUAGE AND COUNTRY OF ORIGIN

2019 REPORT

RELEASED MAY 2020

2019 Minnesota Health Care Disparities

By Race, Hispanic Ethnicity, Language and Country of Origin

WHO IS MN COMMUNITY MEASUREMENT?

As an independent nonprofit dedicated to empowering health care decision makers with meaningful data, MN Community Measurement (MNCCM) is a statewide resource for timely, comparable information on health care costs and quality. Quality measurement in health care delivers value to patients, providers, payers and purchasers and the community.

PURPOSE OF THIS REPORT

While Minnesota consistently ranks as one of the healthiest states in the nation, there continues to be wide variation in health care outcomes across and within certain communities. This report summarizes these variations and identifies opportunities for improvement across race, Hispanic ethnicity, preferred language and country of origin (RELC).

KEY FINDINGS & NOTES

• RACE/ETHNICITY

- **American Indian/Alaskan Native, Black/African American and Hispanic patients** have **significantly lower** rates of optimal care compared to the statewide average in all reported measures.
- **White females** have **significantly higher** rates of optimal care compared to White males in most of the reported measures.
- **American Indian/Alaskan Native and Black/African American patients with diabetes** have the **lowest** rates of HbA1c control.
- **Black/African American and Hispanic patients who have diabetes** have **significantly lower** rates of blood pressure control compared to the statewide average for the Optimal Vascular Care measure.

• PREFERRED LANGUAGE

- **Non-English-speaking Black/African American patients** have **significantly higher** rates of optimal diabetes care, optimal vascular care and optimal asthma control among children compared to English-speaking Black/African American patients.

• COUNTRY OF ORIGIN

- **Black/African American patients born outside of the United States** have **significantly higher** rates of optimal care compared to Black/African American patients born in the United States on a majority of the reported measures.

ACKNOWLEDGEMENTS

This report is possible because of the engagement of several stakeholders who are committed to continuous improvement and recognize the important role measurement plays in helping our community establish priorities and improve together.

MNCCM extends our thanks to all medical groups and payers for contributing the data necessary for measurement, to the State of Minnesota for its support through the Statewide Quality Reporting and Measurement System, and to the many members of MNCCM committees and workgroups providing ongoing guidance to shape this important work.

REPORT PREPARATION DIRECTION

Jessica Donovan, MPH, RN, PHN
Measure Development Specialist

Gunnar Nelson
Health Economist

DIRECT QUESTIONS OR COMMENTS TO
support@mncm.org

Statewide Summary by Race and Hispanic Ethnicity

| QUALITY MEASURES | RACE | | | | | | | | | | | | ETHNICITY | | | |
|--|---------------------------------|--------|-------|--------|-------------------------|--------|------------|--------|---|--------|-------|--------|-----------|--------|--------------|--------|
| | American Indian/ Alaskan Native | | Asian | | Black/ African American | | Multi-Race | | Native Hawaiian/ Other Pacific Islander | | White | | Hispanic | | Not Hispanic | |
| | Rate | Rating | Rate | Rating | Rate | Rating | Rate | Rating | Rate | Rating | Rate | Rating | Rate | Rating | Rate | Rating |
| Colorectal Cancer Screening | 54.0% | ▼ | 62.9% | ▼ | 58.3% | ▼ | 61.2% | ▼ | 59.1% | ▼ | 72.9% | ▲ | 52.5% | ▼ | 71.9% | ▲ |
| Optimal Diabetes Care | 25.7% | ▼ | 47.6% | ▲ | 33.8% | ▼ | 32.0% | ▼ | 43.1% | ● | 46.6% | ▲ | 35.0% | ▼ | 45.5% | ● |
| Optimal Vascular Care | 47.3% | ▼ | 67.2% | ▲ | 46.7% | ▼ | 55.7% | ▼ | 59.1% | ● | 61.8% | ▲ | 55.3% | ▼ | 61.3% | ● |
| Optimal Asthma Control – Adults | 34.1% | ▼ | 53.5% | ● | 40.0% | ▼ | 47.6% | ▼ | 52.0% | ● | 55.6% | ▲ | 42.3% | ▼ | 53.8% | ● |
| Optimal Asthma Control – Children | 41.6% | ▼ | 65.9% | ▲ | 55.7% | ▼ | 60.2% | ● | 58.3% | ● | 61.2% | ▲ | 50.6% | ▼ | 60.4% | ● |
| Adolescent Mental Health and/or Depression Screening | 69.0% | ▼ | 88.7% | ▲ | 84.8% | ▼ | 88.1% | ▲ | 85.0% | ● | 85.9% | ● | 79.1% | ▼ | 86.1% | ● |
| Adult Depression: Follow-up at Six Months | 32.1% | ▼ | 33.6% | ● | 27.1% | ▼ | 26.9% | ▼ | 29.7% | ● | 36.7% | ▲ | 30.6% | ▼ | 35.8% | ● |
| Adult Depression: Response at Six Months | 10.6% | ▼ | 10.3% | ▼ | 7.5% | ▼ | 8.0% | ▼ | 12.9% | ● | 15.5% | ▲ | 11.0% | ▼ | 14.8% | ● |
| Adult Depression: Remission at Six Months | 5.4% | ▼ | 5.6% | ▼ | 3.8% | ▼ | 4.0% | ▼ | 7.9% | ● | 9.3% | ▲ | 6.8% | ▼ | 8.8% | ● |
| Adult Depression: Follow-up at 12 Months | 25.2% | ▼ | 29.4% | ● | 23.2% | ▼ | 21.6% | ▼ | 27.7% | ● | 32.1% | ▲ | 21.4% | ▼ | 31.3% | ● |
| Adult Depression: Response at 12 Months | 7.5% | ▼ | 8.7% | ▼ | 6.9% | ▼ | 7.2% | ▼ | 13.9% | ● | 13.9% | ▲ | 8.7% | ▼ | 13.2% | ● |
| Adult Depression: Remission at 12 Months | 4.1% | ▼ | 4.4% | ▼ | 3.5% | ▼ | 3.5% | ▼ | 5.9% | ● | 8.6% | ▲ | 4.7% | ▼ | 8.0% | ● |

▼ Below statewide average ● Average ▲ Above statewide average

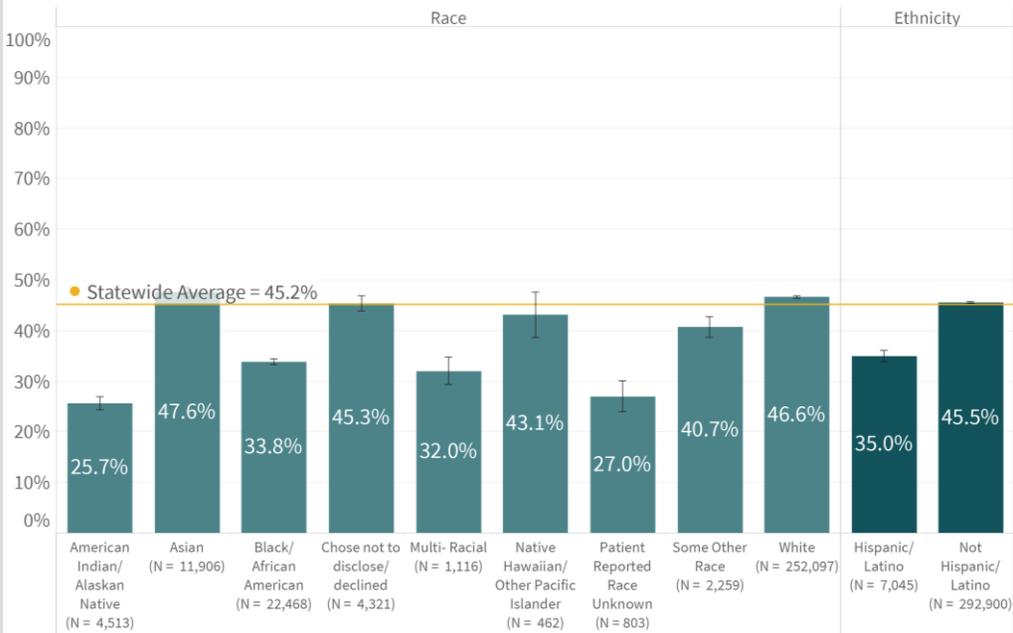
OPTIMAL DIABETES CARE

Race/Ethnicity Summary

2019 Report Year (2018 dates of service)

Optimal Diabetes Care

By Race/Ethnicity

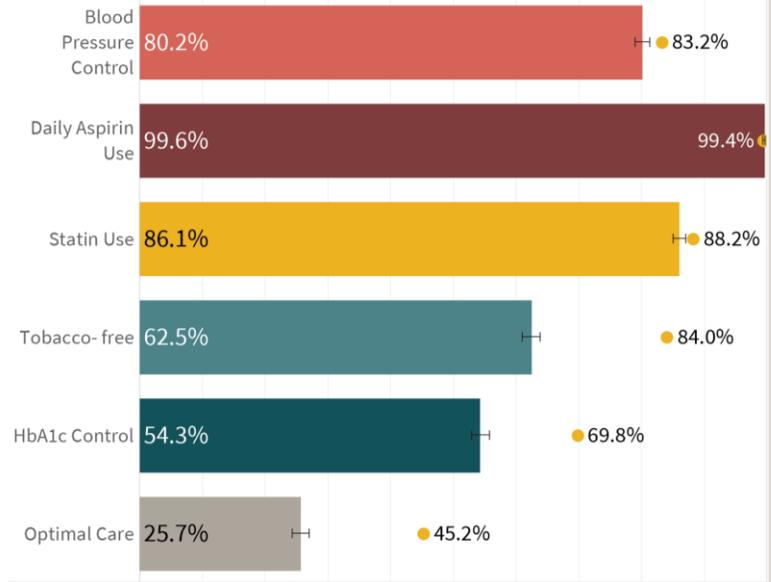


American Indian/Alaskan Native, Black/African American, Multi-Race and Hispanic/Latino patients have significantly lower rates of optimal diabetes care compared to the race/ethnicity average.

Black/African American female and White female patients have significantly higher rates of optimal diabetes care compared to Black/African American males and White males, respectively.

American Indian/Alaskan Native

By Optimal Diabetes Component



62.5%

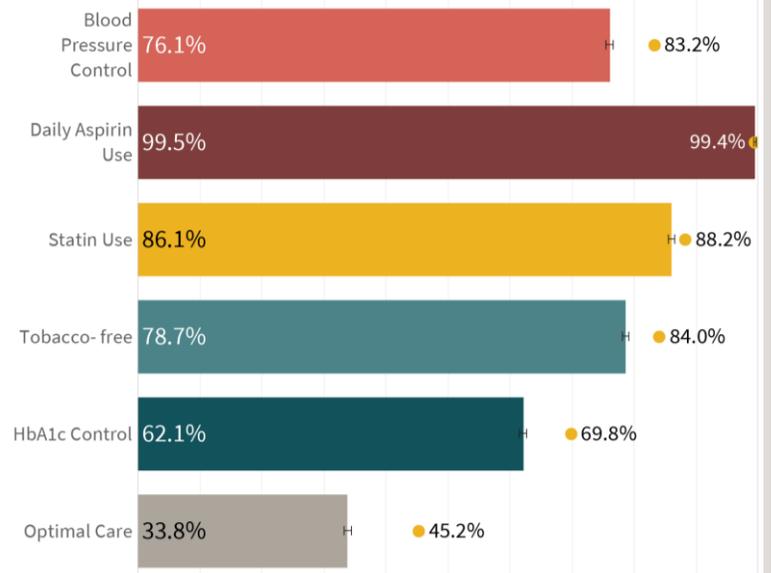
of American Indian patients are tobacco-free, the lowest of any race group.

54.3%

of American Indian patients have a controlled HbA1c (< 8.0), the lowest of any race group.

Black/African American

By Optimal Diabetes Component



62.1%

of Black/African American patients have a controlled HbA1c (< 8.0), the second lowest of any race group

● Statewide average for patients with race/ethnicity information available

OPTIMAL DIABETES CARE

Preferred Language Summary

2019 Report Year (2018 dates of service)

English-speaking vs. Non-English-speaking

By Optimal Diabetes Component

| | | |
|------------------------|-------------|-------|
| Blood Pressure Control | English | 83.3% |
| | Non-English | 81.4% |
| Daily Aspirin Use | English | 99.4% |
| | Non-English | 99.4% |
| Statin Use | English | 88.2% |
| | Non-English | 87.3% |
| Tobacco-free | English | 83.6% |
| | Non-English | 91.2% |
| HbA1c Control | English | 70.2% |
| | Non-English | 62.4% |
| Optimal Care | English | 45.4% |
| | Non-English | 41.7% |

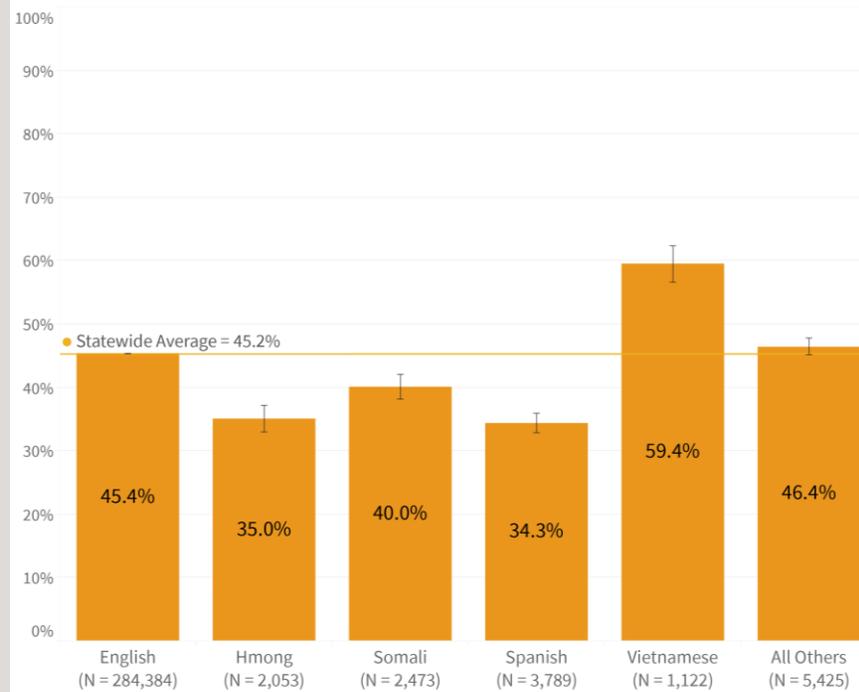
Non-English-speaking patients have **significantly lower rates of HbA1c control** compared to English-speaking patients.

English-speaking patients have **significantly lower rates of being tobacco-free** compared to Non-English-speaking patients.

● Statewide average for patients with preferred language information available

Optimal Diabetes Care

By Preferred Language



Patients who speak **English, Hmong, Somali, Spanish or Vietnamese** make up the largest portion of the eligible population.

Patients who speak **Hmong, Somali or Spanish** have **significantly lower** rates of optimal diabetes care compared to the statewide average.

49.2%
English-speaking
Asian patients

45.8%
Non-English-speaking
Asian patients

English-speaking Asian patients have **significantly higher** rates of optimal diabetes care compared to non-English-speaking Asian patients.

32.5%
English-speaking
Black/African
American patients

41.2%
Non-English-speaking
Black/African
American patients

Non-English-speaking Black/African American patients have **significantly higher** rates of optimal diabetes care compared to English-speaking Black/African American patients.

OPTIMAL DIABETES CARE

Country of Origin Summary

2019 Report Year (2018 dates of service)

Born in the U.S. vs. Born Outside the U.S. By Optimal Diabetes Component

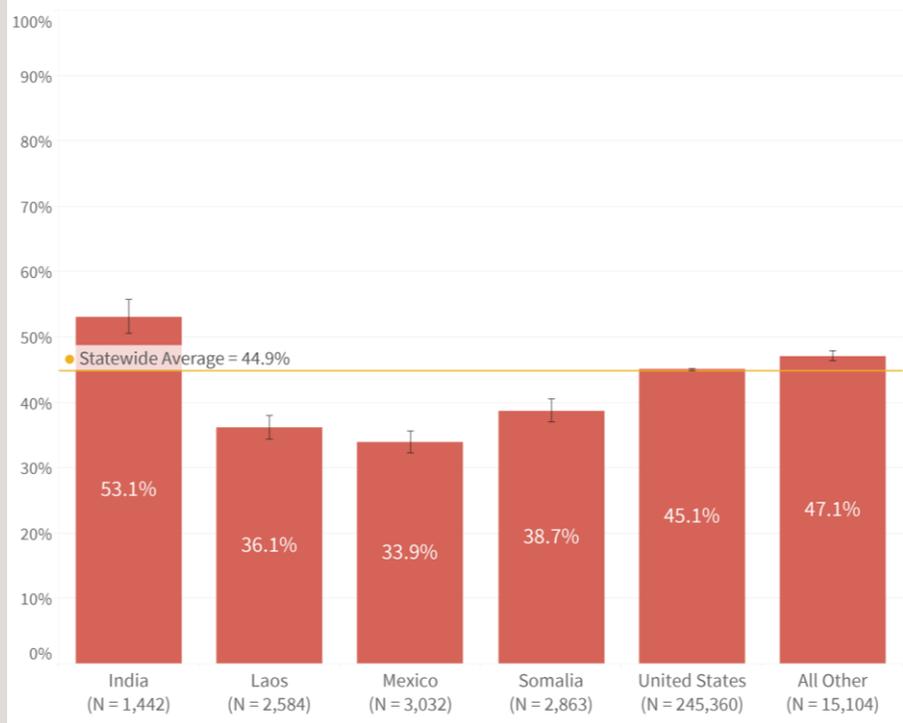
| | | |
|------------------------|---------------|-------|
| Blood Pressure Control | Foreign- born | 82.5% |
| | U.S.- born | 83.3% |
| Daily Aspirin Use | Foreign- born | 99.4% |
| | U.S.- born | 99.4% |
| Statin Use | Foreign- born | 86.5% |
| | U.S.- born | 88.2% |
| Tobacco-free | Foreign- born | 91.0% |
| | U.S.- born | 82.8% |
| HbA1c Control | Foreign- born | 65.2% |
| | U.S.- born | 70.3% |
| Optimal Care | Foreign- born | 43.8% |
| | U.S.- born | 45.1% |

Patients born outside the United States have significantly lower rates of HbA1c control compared to patients born in the United States.

Patients born in the United States have significantly lower rates of being tobacco-free compared to patients born outside the United States.

● Statewide average for patients with country of origin information available

Optimal Diabetes Care By Country of Origin



Patients from **India, Laos, Mexico, Somalia and United States** make up the largest portion of the eligible population.

Among these patients, those from **Laos, Mexico and Somalia** with diabetes have the **lowest rates of optimal care.**

25.3%
American Indian/
Alaskan Native
patients born in
U.S.

37.6%
American Indian/
Alaskan Native
patients born
outside U.S.

29.0%
Black/ African
American
patients born in
U.S.

41.0%
Black/ African
American
patients born
outside U.S.

American Indian/Alaskan Native patients born in the United States have significantly lower rates of optimal diabetes care compared to American Indian/Alaskan Native patients born outside the United States.

Black/African American patients born in the United States have significantly lower rates of optimal diabetes care compared to Black/African American patients born outside of the United States.

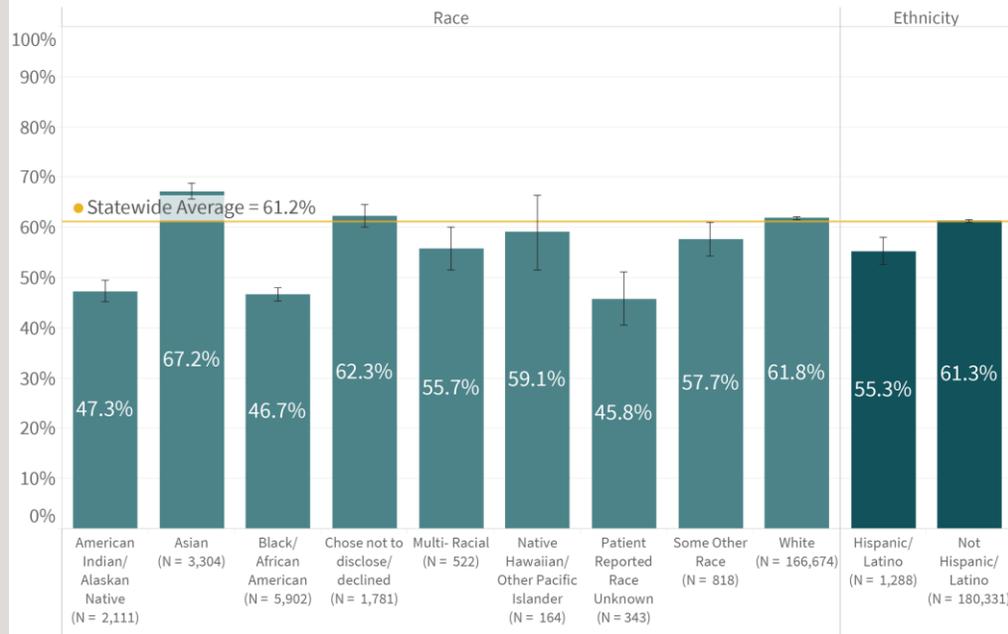
OPTIMAL VASCULAR CARE

Race/Ethnicity Summary

2019 Report Year (2018 dates of service)

Optimal Vascular Care

By Race/Ethnicity



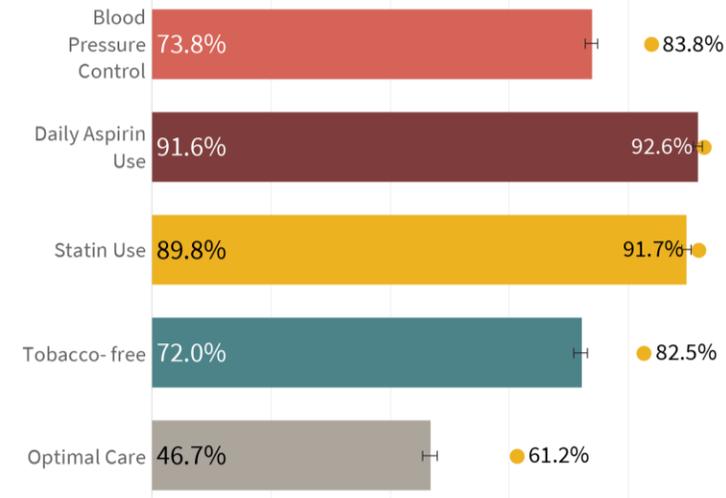
American Indian/Alaskan Native, Black/African American, Multi-Race and Hispanic/Latino patients have significantly lower rates of optimal vascular care compared to the race/ethnicity average.



American Indian/Alaskan Native males, Asian males and White males have significantly higher rates of optimal vascular care compared to American Indian females, Asian females and White females, respectively.

Black/African American

By Optimal Vascular Component

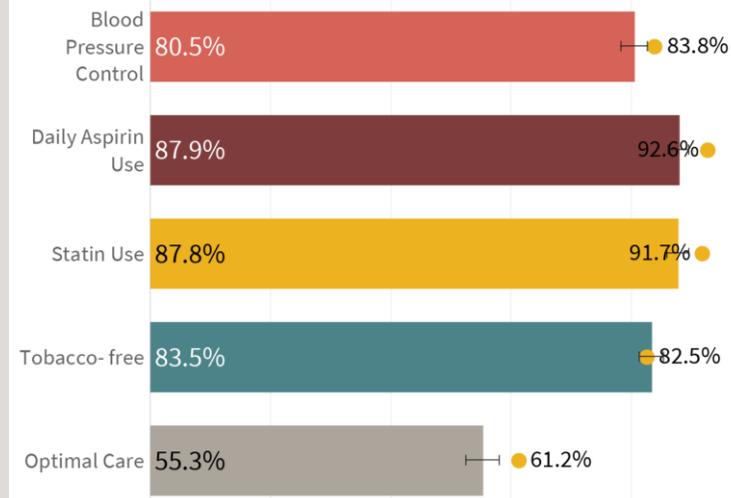


72.0% of Black/ African American patients are tobacco-free, which is **significantly below average.**

73.8% of Black/ African American patients have optimal blood pressure control which is **significantly below average.**

Hispanic Ethnicity

By Optimal Vascular Component



87.8% of Hispanic patients are on a statin medication, which is **significantly below average.**

80.5% of Hispanic patients have optimal blood pressure control, which is **significantly below average.**

● Statewide average for patients with race/ethnicity information available

OPTIMAL VASCULAR CARE Preferred Language Summary

2019 Report Year (2018 dates of service)

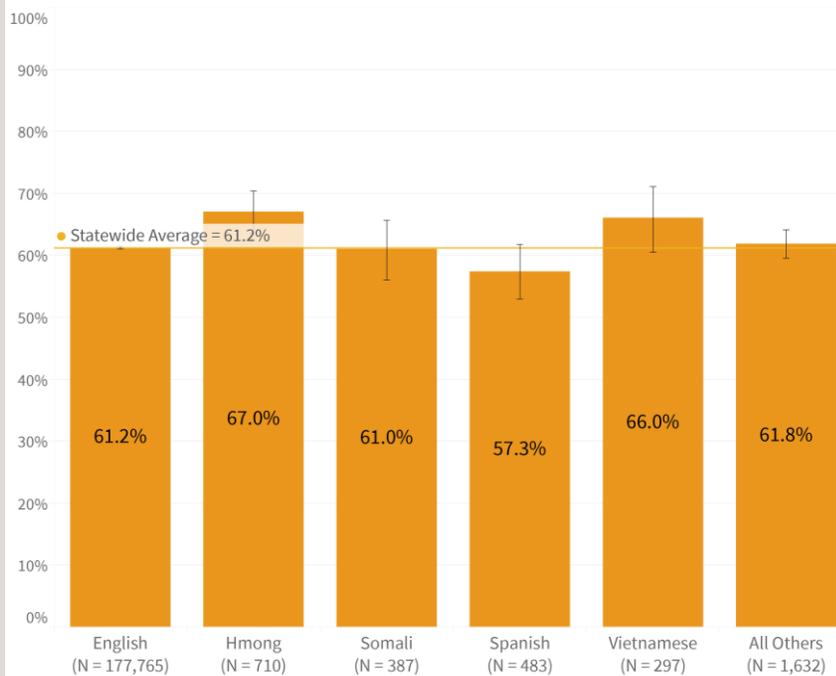
English-speaking vs. Non-English-speaking By Optimal Vascular Component

| | | |
|------------------------|-------------|-------|
| Blood Pressure Control | English | 83.8% |
| | Non-English | 79.3% |
| Daily Aspirin Use | English | 92.6% |
| | Non-English | 90.6% |
| Statin Use | English | 91.7% |
| | Non-English | 92.6% |
| Tobacco-free | English | 82.3% |
| | Non-English | 91.0% |
| Optimal Care | English | 61.2% |
| | Non-English | 62.5% |

Non-English-speaking patients have **significantly lower rates of blood pressure control** compared to English-speaking patients.

English-speaking patients have **significantly lower rates of being tobacco-free** compared to Non-English-speaking patients.

Optimal Vascular Care By Preferred Language



Patients who speak **English, Hmong, Somali, Spanish or Vietnamese** make up the largest portion of the eligible population.

Patients who speak **Hmong** have **significantly higher** rates of optimal vascular care compared to the statewide average.

45.3%

English-speaking Black/African American patients

61.7%

Non-English-speaking Black/African American patients

Non-English-speaking Black/African American patients have **significantly higher** rates of optimal vascular care compared to English-speaking Black/African American patients.

● Statewide average for patients with preferred language information available

OPTIMAL VASCULAR CARE

Country of Origin Summary

2019 Report Year (2018 dates of service)

Born in the U.S. vs. Born Outside the U.S.

By Optimal Vascular Component

| | | |
|------------------------|---------------|-------|
| Blood Pressure Control | U.S.- born | 83.9% |
| | Foreign- born | 81.2% |
| Daily Aspirin Use | U.S.- born | 92.7% |
| | Foreign- born | 91.3% |
| Statin Use | Foreign- born | 92.3% |
| | U.S.- born | 91.7% |
| Tobacco-free | Foreign- born | 89.8% |
| | U.S.- born | 81.9% |
| Optimal Care | Foreign- born | 63.8% |
| | U.S.- born | 61.0% |

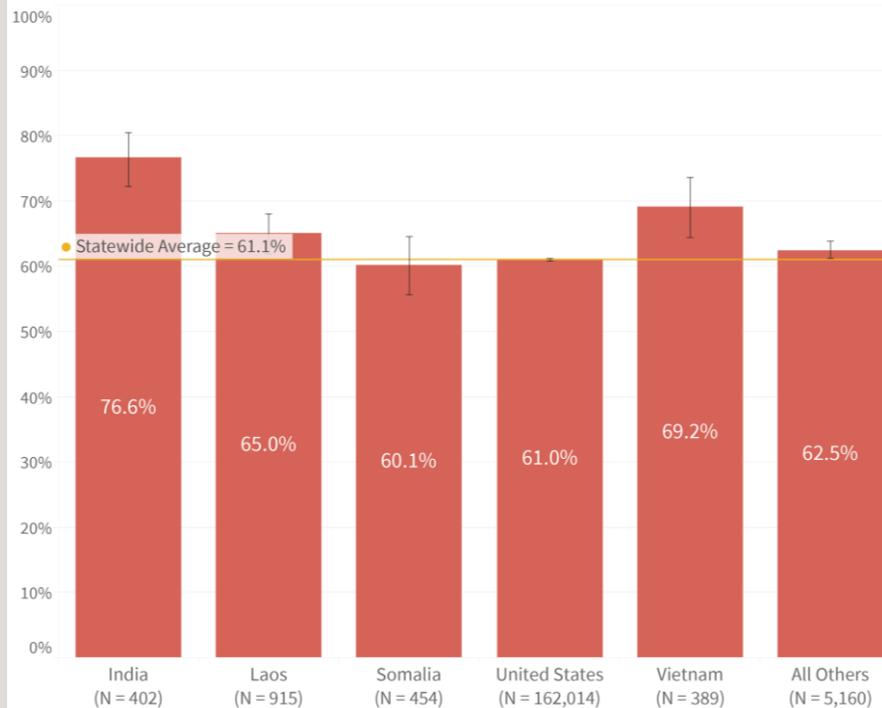
Patients born outside the United States have **significantly lower rates of optimal blood pressure control** compared to patients born in the United States.

Patients born in the United States have **significantly lower rates of being tobacco- free** compared to patients born outside the United States.

● Statewide average for patients with country of origin information available

Optimal Vascular Care

By Country of Origin



Patients from **India, Laos, Somalia, United States and Vietnam** make up the largest portion of the eligible population.

Among these patients, those from **India, Laos and Vietnam** have **significantly higher** rates of optimal vascular care.

47.3%

American Indian/
Alaskan Native
patients born in
U.S.

68.8%

American Indian/
Alaskan Native
patients born
outside U.S.

42.7%

Black/ African
American
patients born in
U.S.

62.2%

Black/ African
American
patients born
outside U.S.

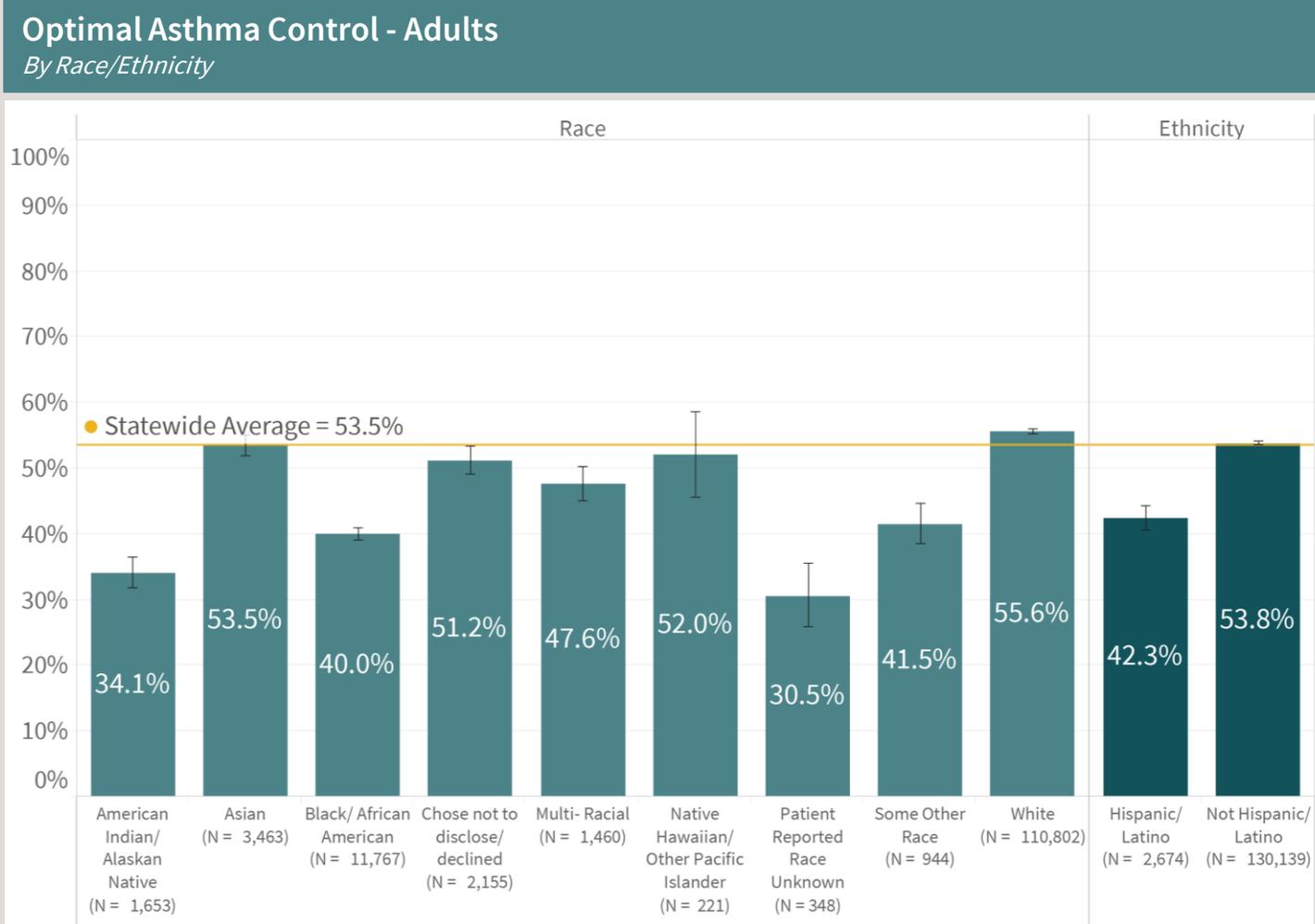
American Indian/Alaskan Native patients born in the United States have **significantly lower** rates of optimal vascular care compared to American Indian/ Alaskan Native patients born outside the United States.

Black/African American patients born in the United States have **significantly lower** rates of optimal vascular care compared to Black/African American patients born outside the United States.

OPTIMAL ASTHMA CONTROL - ADULTS

Race/Ethnicity Summary

2019 Report Year (2018 dates of service)




American Indian/Alaskan Native, Black/African American, Multi-Race and Hispanic/Latino adult patients have significantly lower rates of optimal asthma control compared to the race/ethnicity average.



White adult females have significantly higher rates of optimal asthma control compared to white adult males.

● Statewide average for patients with race/ethnicity information available

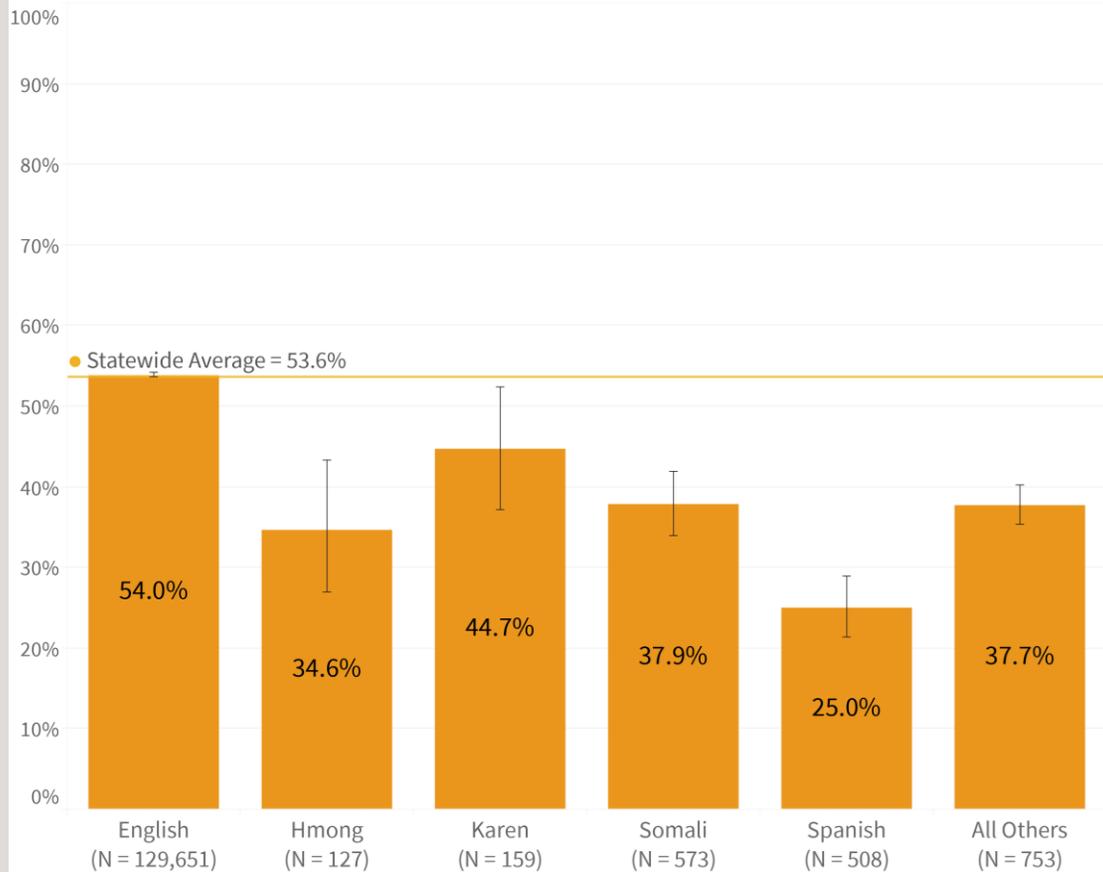
OPTIMAL ASTHMA CONTROL - ADULTS

Preferred Language Summary

2019 Report Year (2018 dates of service)

Optimal Asthma Control - Adults

By Preferred Language



Patients who speak **English, Hmong, Karen, Somali or Spanish** make up the largest portion of the eligible adult population.

Adult patients who speak **Hmong, Karen, Somali or Spanish** have **significantly lower** rates of optimal asthma control compared to the statewide average.

55.1%

English-speaking adult Asian patients

44.0%

Non-English-speaking adult Asian patients

English-speaking adult Asian patients have **significantly higher** rates of optimal asthma control compared to non-English-speaking Asian adult patients.

55.9%

English-speaking adult White patients

32.2%

Non-English-speaking adult White patients

English-speaking adult White patients have **significantly higher** rates of optimal asthma control compared to non-English-speaking White adult patients.

● Statewide average for patients with preferred language information available

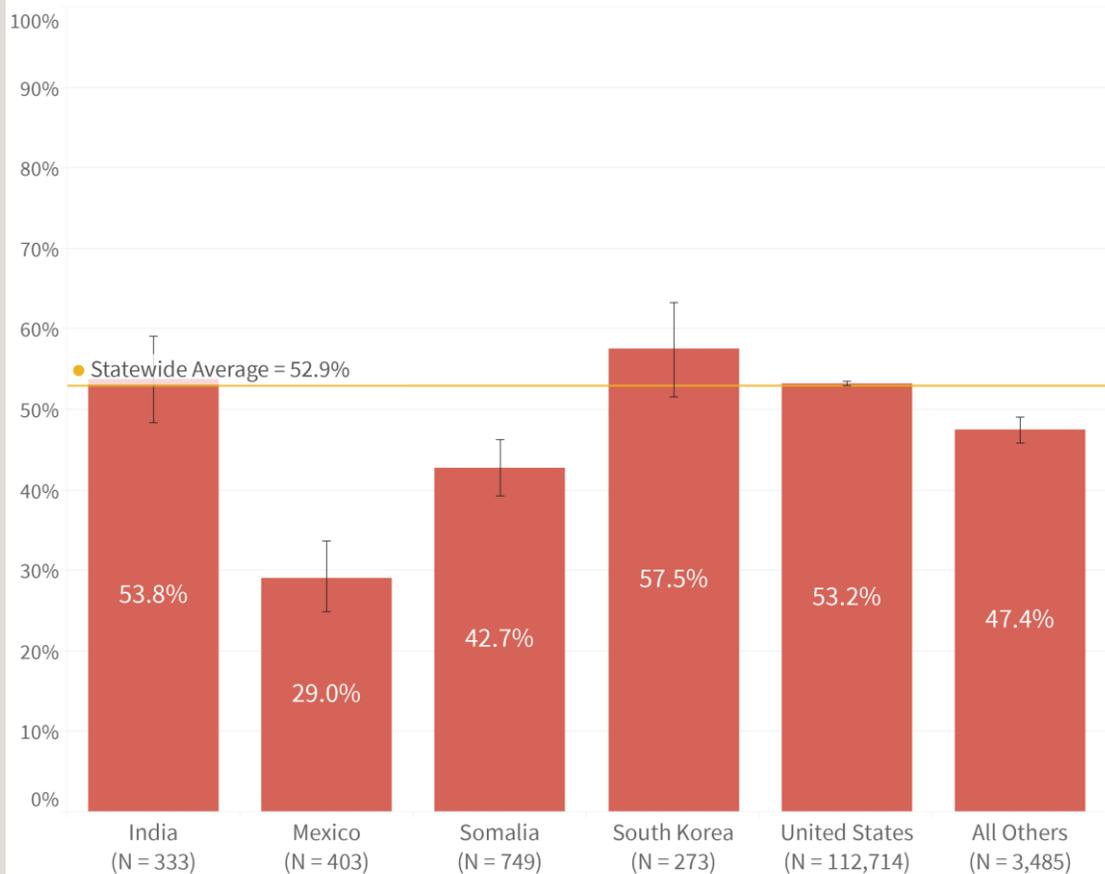
OPTIMAL ASTHMA CONTROL - ADULTS

Country of Origin Summary

2019 Report Year (2018 dates of service)

Optimal Asthma Control - Adults

By Country of Origin



Patients from **India, Mexico, Somalia, South Korea or the United States** make up the largest portion of the eligible adult population.

Adult patients from **Mexico and Somalia** have **significantly lower** rates of optimal asthma control compared to the statewide average.

37.8%

Black/ African American adults born in U.S.

45.9%

Black/African American adults born outside U.S.

Black/African American adults born in the United States have **significantly lower** rates of optimal asthma control compared to Black/African American adults born outside the United States.

55.1%

White adults born in U.S.

44.7%

White adults born outside U.S.

White adults born in the United States have **significantly higher** rates of optimal asthma control compared to White adults born outside of the United States.

● Statewide average for patients with country of origin information available

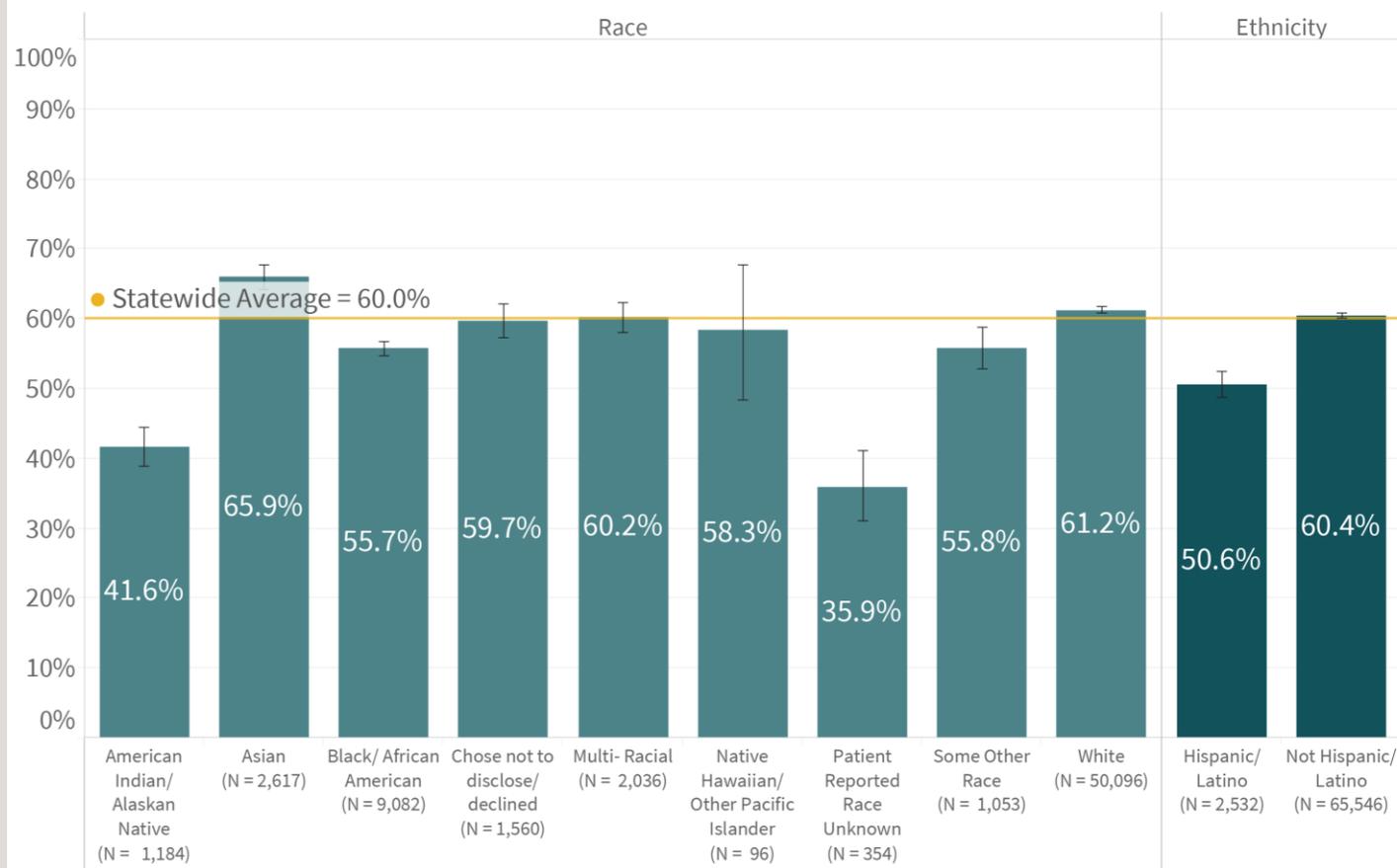
OPTIMAL ASTHMA CONTROL - CHILDREN

Race/Ethnicity Summary

2019 Report Year (2018 dates of service)

Optimal Asthma Control - Children

By Race/Ethnicity



American Indian/Alaskan Native, Black/African American, and Hispanic/Latino children have significantly lower rates of optimal asthma control compared to the race/ethnicity average.



White male children have significantly higher rates of optimal asthma control compared to white female children.

● Statewide average for patients with race/ethnicity information available

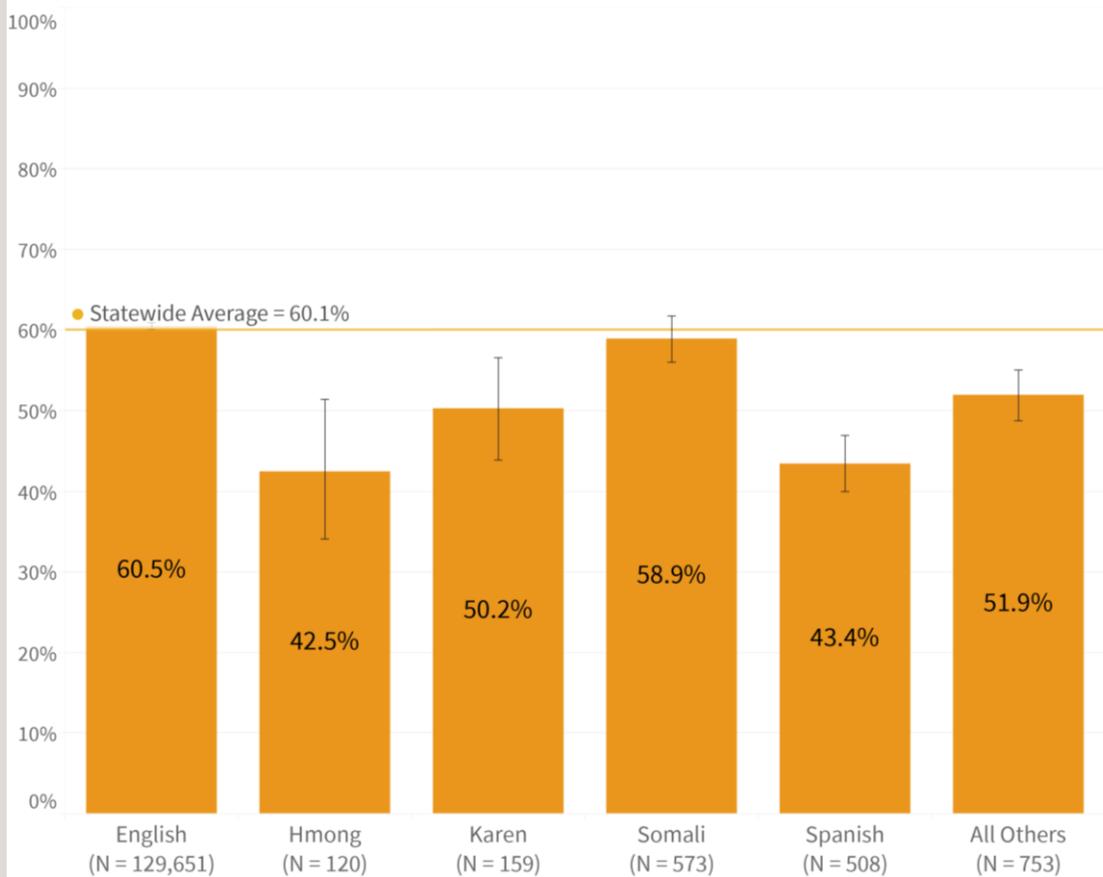
OPTIMAL ASTHMA CONTROL - CHILDREN

Preferred Language Summary

2019 Report Year (2018 dates of service)

Optimal Asthma Control - Children

By Preferred Language



Patients who speak **English, Hmong, Karen, Somali or Spanish** make up the largest portion of the eligible child population.

Children who speak **Hmong, Karen or Spanish** have **significantly lower** rates of optimal asthma control compared to the statewide average.

● Statewide average for patients with preferred language information available

68.8%

English-speaking Asian children

56.8%

Non-English-speaking Asian children

English-speaking Asian children have **significantly higher** rates of optimal asthma control compared to non-English-speaking Asian children.

52.2%

English-speaking Black/African American children

59.2%

Non-English-speaking Black/African American children

English-speaking Black/African American children have **significantly lower** rates of optimal asthma control compared to non-English-speaking Black/African American children.

61.7%

English-speaking White children

41.6%

Non-English-speaking White children

English-speaking White children have **significantly higher** rates of optimal asthma control compared to non-English-speaking White children.

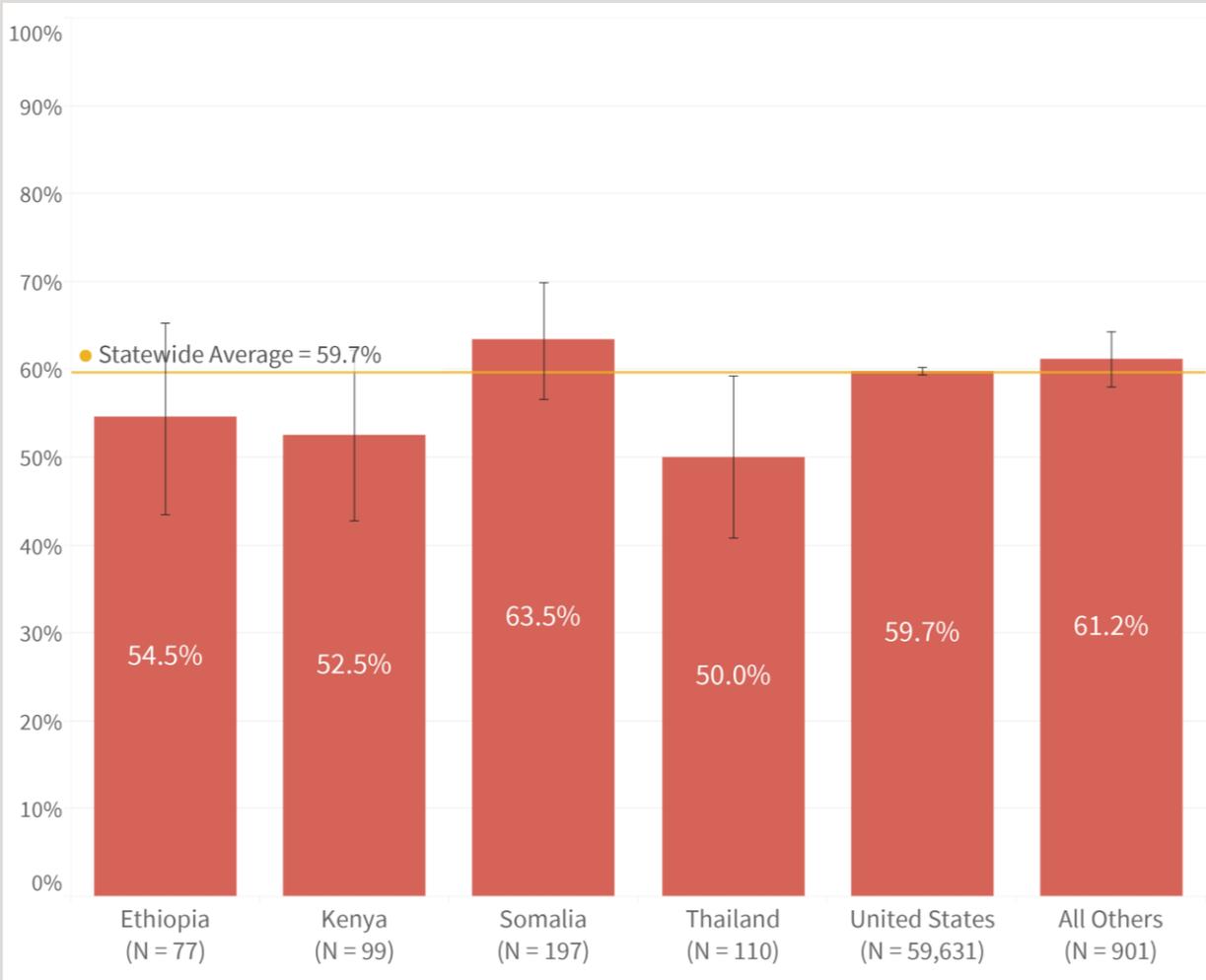
OPTIMAL ASTHMA CONTROL - CHILDREN

Country of Origin Summary

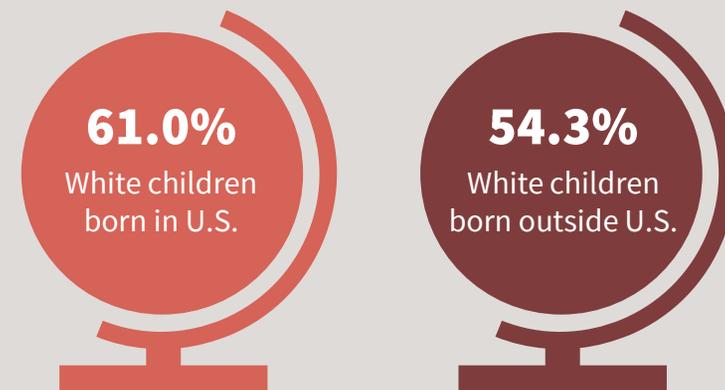
2019 Report Year (2018 dates of service)

Optimal Asthma Control - Children

By Country of Origin



● Statewide average for patients with country of origin information available



White children born in the United States have **significantly higher** rates of optimal asthma control compared to White children outside the United States.

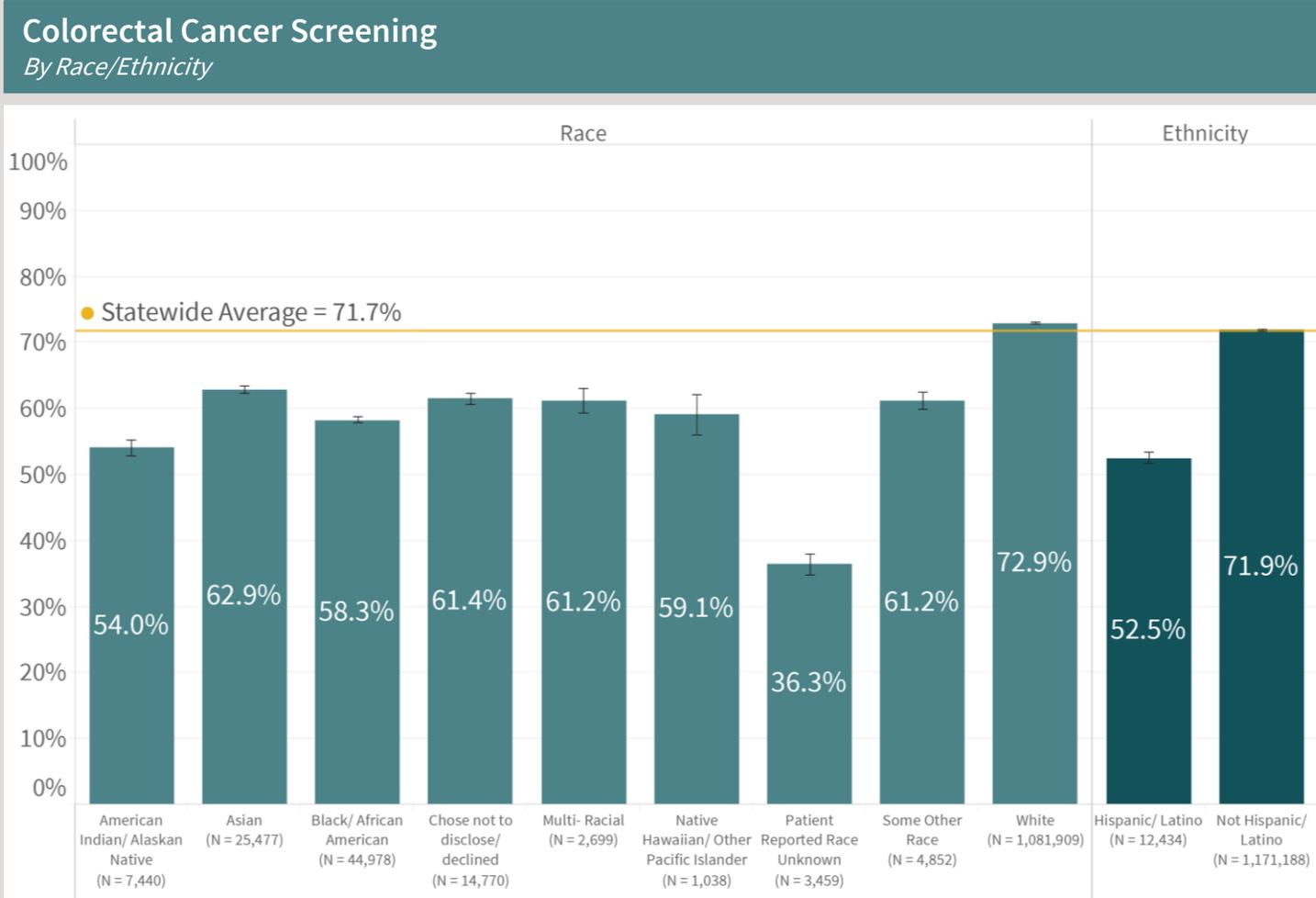
Patients from **Ethiopia, Kenya, Somalia, Thailand or the United States** make up the largest portion of the eligible child population.

Children from **Thailand** have **significantly lower** rates of optimal asthma control compared to the statewide average.

COLORECTAL CANCER SCREENING

Race/Ethnicity Summary

2019 Report Year (2018 dates of service)



American Indian/Alaskan Native, Asian, Black/African American, Multi-Race, Native Hawaiian/Other Pacific Islander and Hispanic/Latino patients have significantly lower rates of colorectal cancer screening compared to the race/ethnicity average.



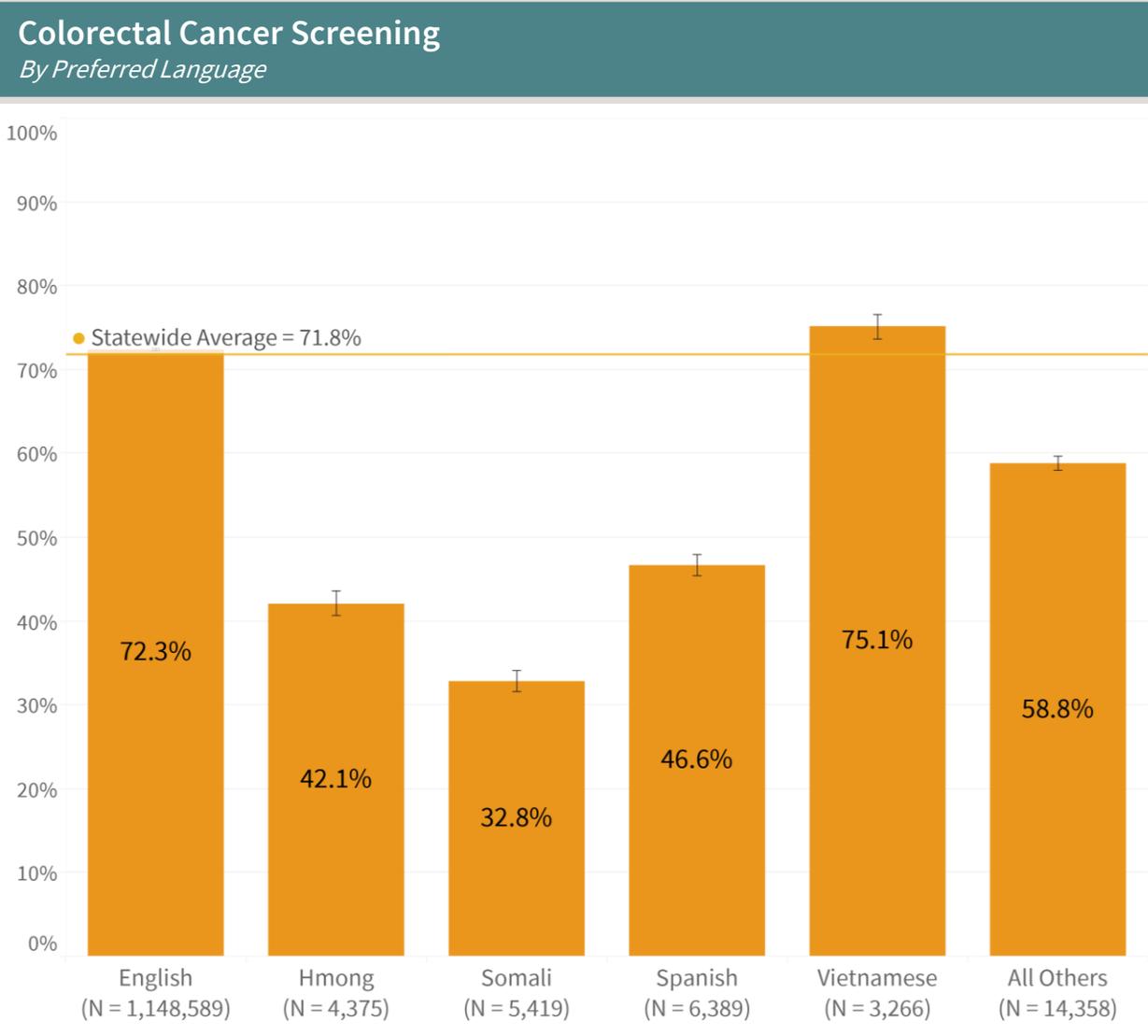
White female patients have significantly higher rates of colorectal cancer screening compared to White male patients.

● Statewide average for patients with race/ethnicity information available

COLORECTAL CANCER SCREENING

Preferred Language Summary

2019 Report Year (2018 dates of service)



72.3%

English-speaking patients

51.7%

Non-English-speaking patients

Statewide, **English-speaking patients** have **significantly higher** rates of colorectal cancer screening compared to non-English-speaking patients

Patients who speak **English, Hmong, Somali, Spanish or Vietnamese** make up the largest portion of the eligible population.

Patients who speak **Hmong, Somali or Spanish** have **significantly lower** rates of colorectal cancer screening compared to the statewide average.

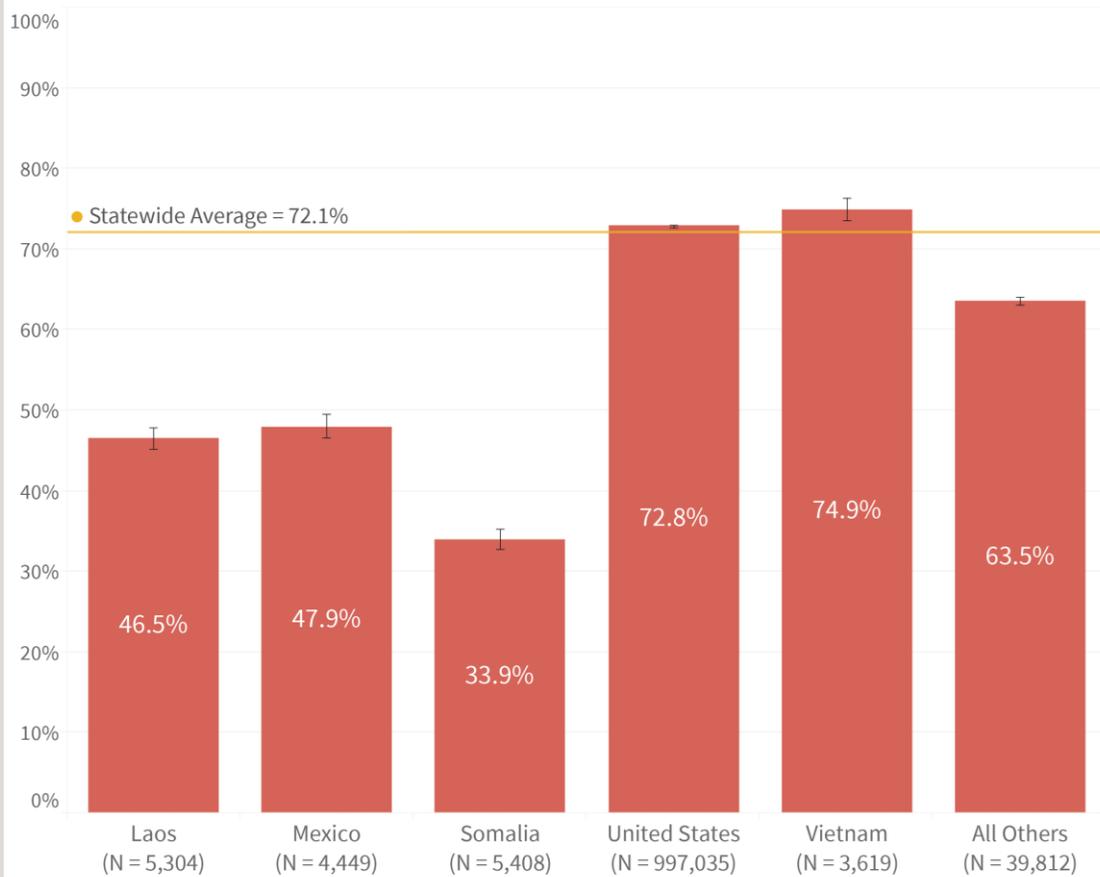
● Statewide average for patients with preferred language information available

COLORECTAL CANCER SCREENING

Country of Origin Summary

2019 Report Year (2018 dates of service)

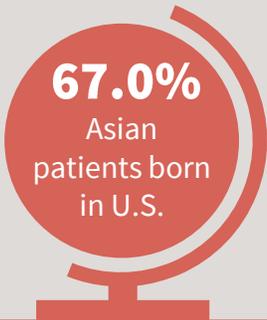
Colorectal Cancer Screening By Country of Origin



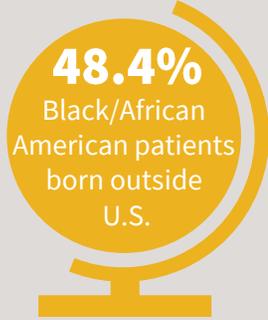
Patients from **Laos, Mexico, Somalia, United States and Vietnam** make up the largest portion of the eligible population.

Patients from **Laos, Mexico and Somalia** have **significantly lower** rates of colorectal cancer screening compared to the statewide average.

● Statewide average for patients with country of origin information available



Asian patients born in the United States have significantly higher rates of colorectal cancer screening compared to Asian patients born outside the United States.



Black/African American patients born in the United States have significantly higher rates of colorectal cancer screening compared to Black/African American patients born outside the United States.



White patients born in the United States have significantly higher rates of colorectal cancer screening compared to White patients born outside the United States.

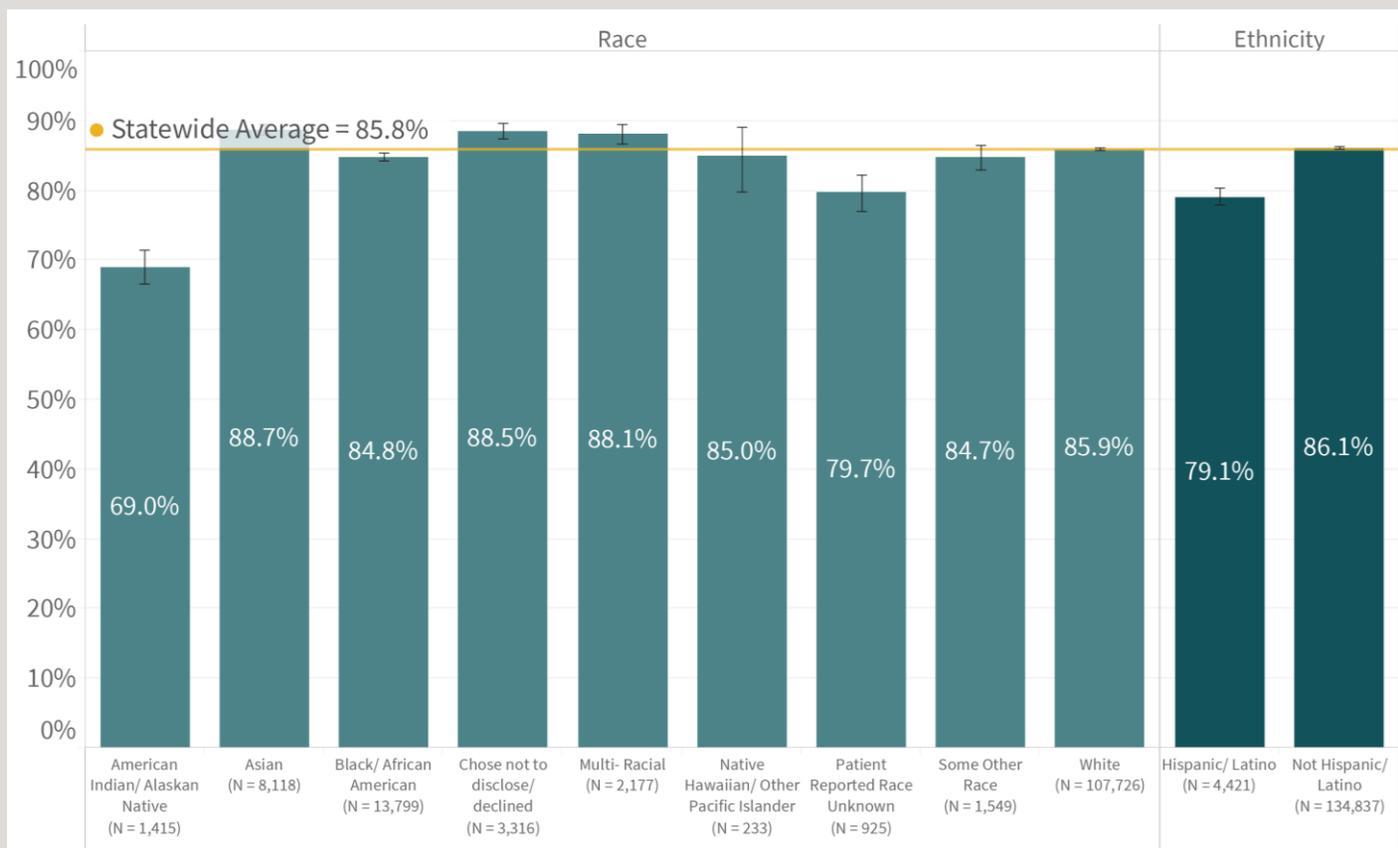
Adolescent Mental Health and/or Depression Screening

Race/Ethnicity Summary

2019 Report Year (2018 dates of service)

Adolescent Mental Health and/or Depression Screening

By Race/Ethnicity



American Indian/Alaskan Native, Black/African American and Hispanic/Latino patients have **significantly lower** rates of adolescent mental health and/or depression screening compared to the race/ethnicity average.



White female patients and American Indian/Alaskan Native female patients have **significantly higher** rates of adolescent mental health and/or depression screening compared to White male patients and American Indian/Alaskan Native male patients, respectively.

● Statewide average for patients with race/ethnicity information available

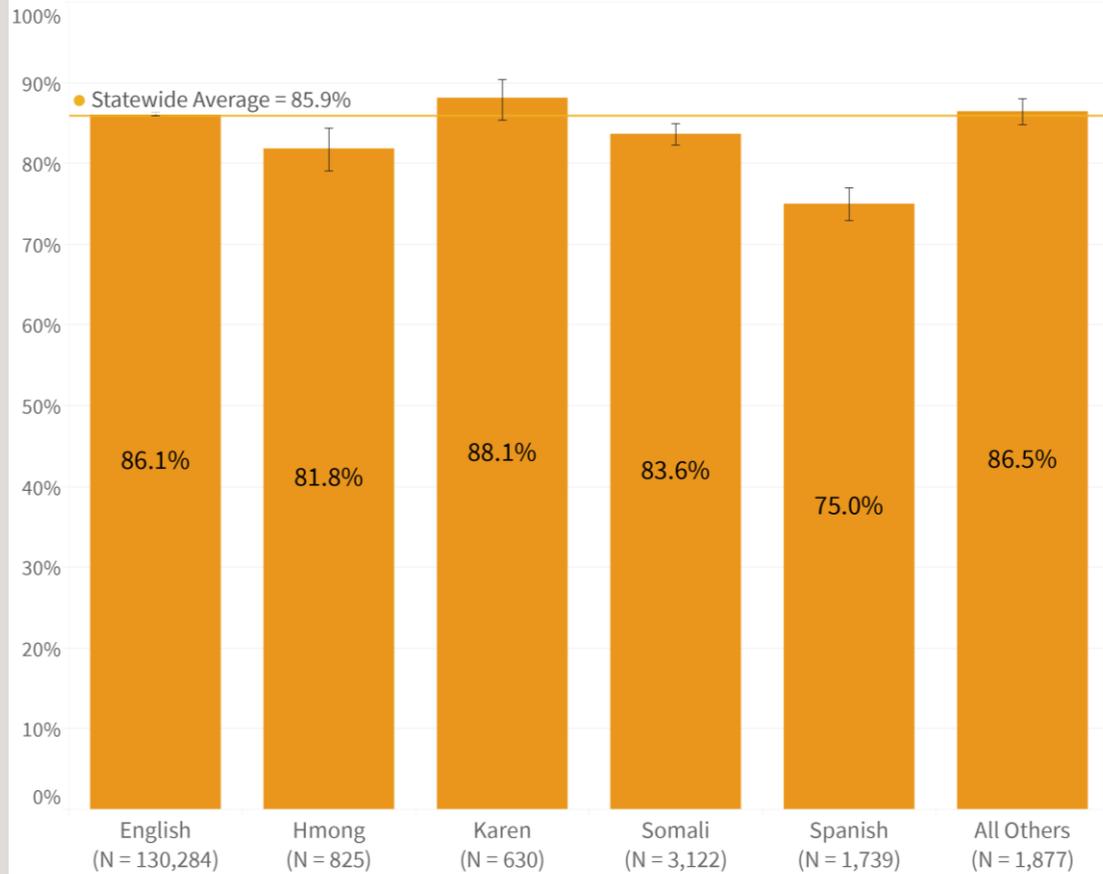
Adolescent Mental Health and/or Depression Screening

Preferred Language Summary

2019 Report Year (2018 dates of service)

Adolescent Mental Health and/or Depression Screening

By Preferred Language



Patients who speak **English, Hmong, Karen, Somali or Spanish** make up the largest portion of the eligible population.

Patients who speak **Hmong, Somali or Spanish** have **significantly lower** rates of adolescent mental health and/or depression screening compared to the statewide average.

86.1%

English-speaking White patients

77.0%

Non-English-speaking White patients

English-speaking White patients have **significantly higher** rates of adolescent mental health and/or depression screening compared to non-English-speaking White patients.

89.8%

English-speaking Asian patients

85.9%

Non-English-speaking Asian patients

English-speaking Asian patients have **significantly higher** rates of adolescent mental health and/or depression screening compared to non-English-speaking Asian patients.

● Statewide average for patients with preferred language information available

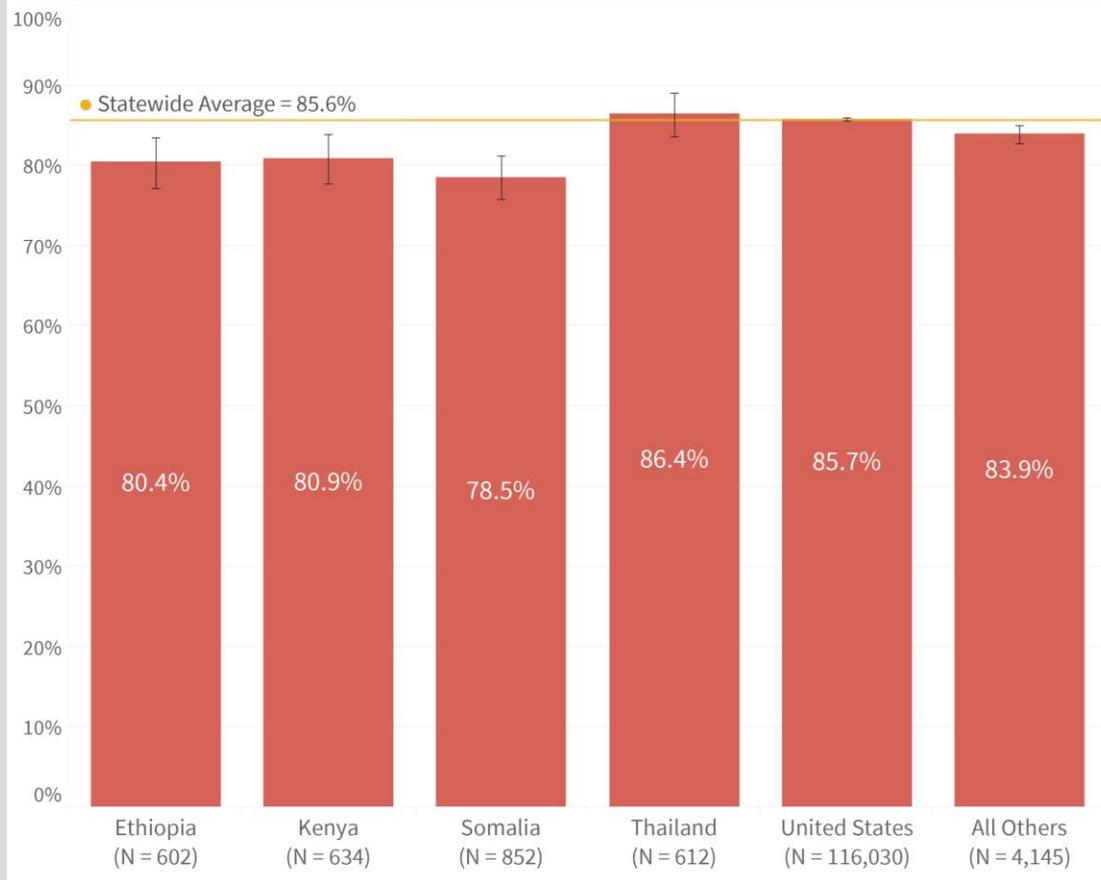
ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

Country of Origin Summary

2019 Report Year (2018 dates of service)

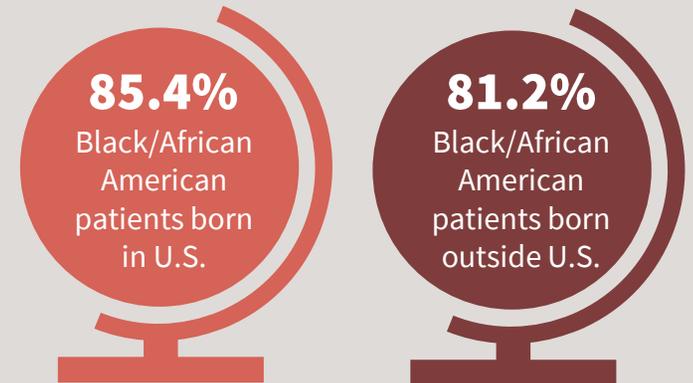
Adolescent Mental Health and/or Depression Screening

By Country of Origin

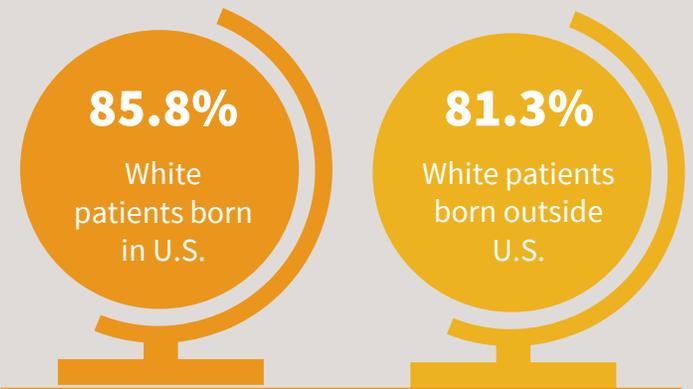


Patients from **Ethiopia, Kenya, Somalia, Thailand and the United States** make up the largest portion of the eligible population.

Patients from **Ethiopia, Kenya and Somalia** have **significantly lower** rates of adolescent mental health and/or depression screening compared to the statewide average.



Black/African American patients born in the United States have **significantly higher** rates adolescent mental health and/or depression screening compared to Black/African American patients born outside the United States.



White patients born in the United States have **significantly higher** rates adolescent mental health and/or depression screening compared to White patients born outside of the United States.

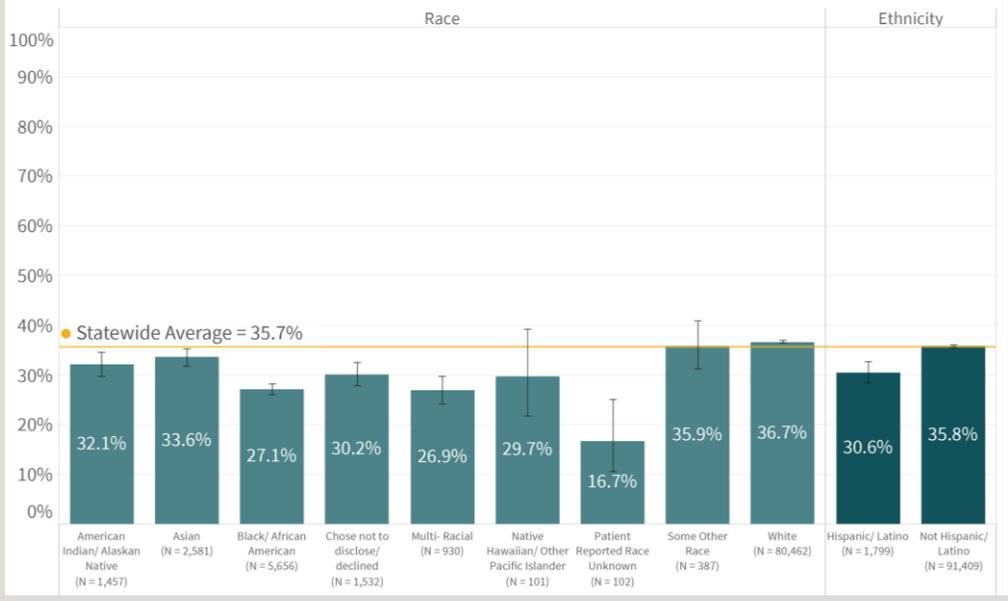
● Statewide average for patients with country of origin information available

ADULT DEPRESSION: SIX MONTH MEASURES

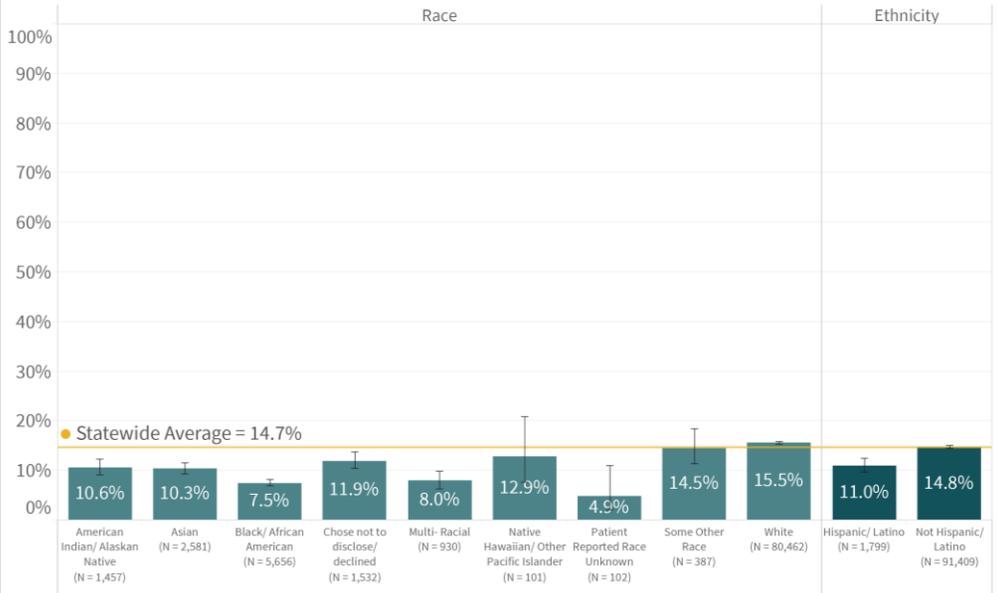
Race/Ethnicity Summary

2019 Report Year (2016 - 2018 dates of service)

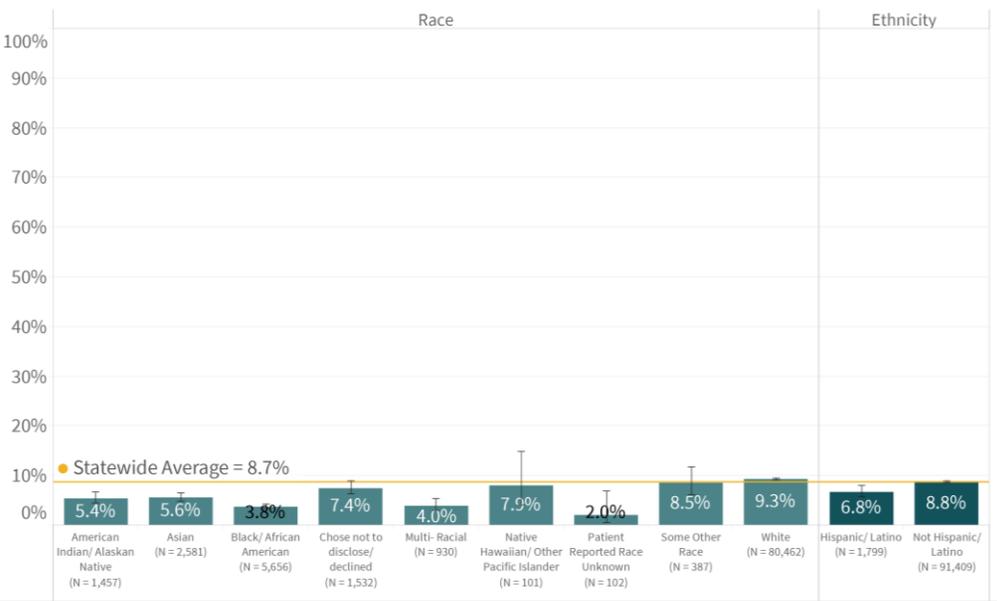
Adult Depression: Follow-up at Six Months By Race/Ethnicity



Adult Depression: Response at Six Months By Race/Ethnicity



Adult Depression: Remission at Six Months By Race/Ethnicity



● Statewide average for patients with race/ethnicity information available

 **American Indian/Alaskan Native, Asian, Black/African American and Hispanic/Latino patients have significantly lower rates of depression follow-up, response and remission at six months compared to the race/ethnicity averages.**

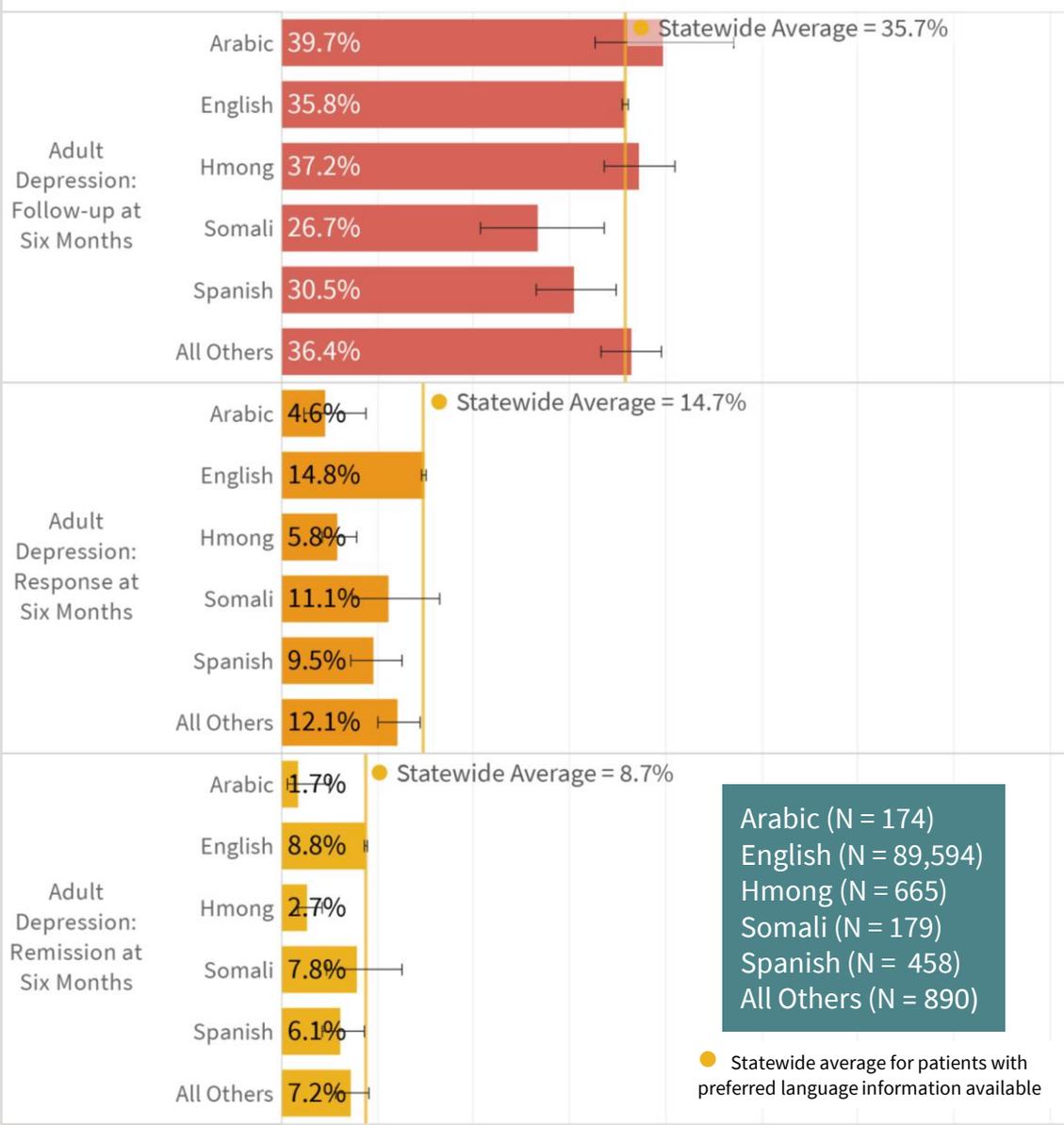
 **White female patients have significantly higher rates of depression follow-up, response and remission at six months compared to White male patients.**

ADULT DEPRESSION: SIX MONTH MEASURES

Preferred Language Summary

2019 Report Year (2016 - 2018 dates of service)

Adult Depression: Six Month Measures By Preferred Language



14.8%
English-speaking patients

9.2%
Non-English-speaking patients

Statewide, **English-speaking patients** have **significantly higher** rates of **response to depression treatment at six months** compared to non-English-speaking patients.

8.8%
English-speaking patients

5.3%
Non-English-speaking patients

Statewide, **English-speaking patients** have **significantly higher** rates of **remission at six months** compared to non-English-speaking patients.

Patients who speak **Arabic, English, Hmong, Somali or Spanish** make up the largest portion of the eligible population.

Patients who speak **Somali** are **significantly below** the statewide average for follow-up at six months; however, the response and remission rates at six months are average.

Patients who speak **Spanish** are **significantly below** the statewide average for both follow-up at six months and response to treatment at six months

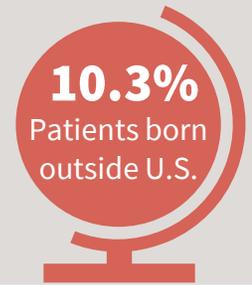
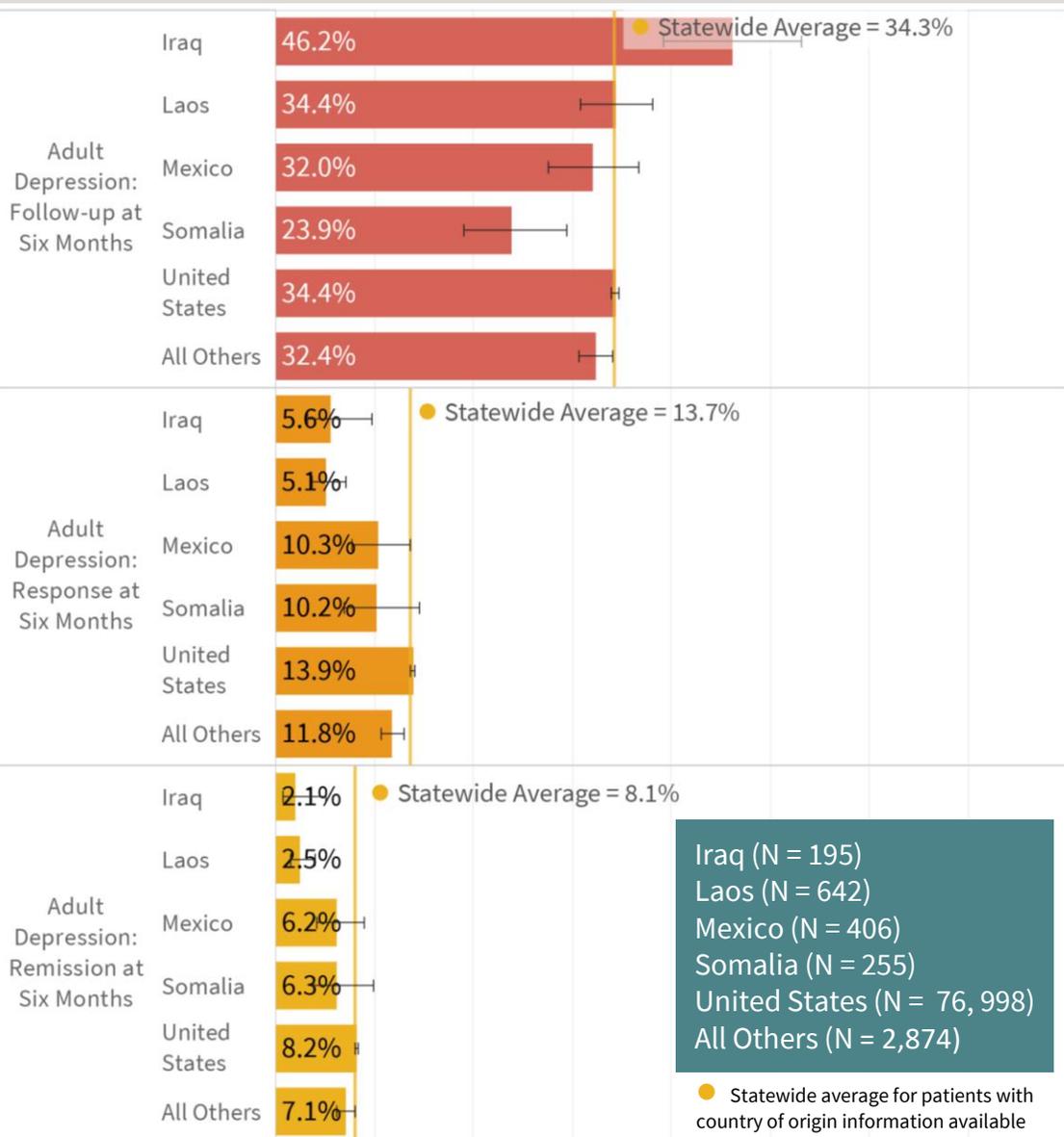
ADULT DEPRESSION: SIX MONTH MEASURES

Country of Origin Summary

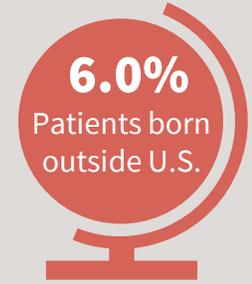
2019 Report Year (2016 - 2018 dates of service)

Adult Depression: Six Month Measures

By Country of Origin



Patients born in the United States have **significantly higher** rates of **response to treatment at six months** compared to patients born outside the United States.



Patients born in the United States have **significantly higher** rates of **remission at six months** compared to patients born outside the United States.

Patients from **Iraq, Laos, Mexico, Somalia or the United States** make up the largest portion of the eligible population.

Patients from **Somalia** are **significantly below** the statewide average for follow-up at six months; however, the response and remission rates at six months are average.

Patients from **Laos** are **significantly below** the statewide average for both response to treatment and remission at six months.

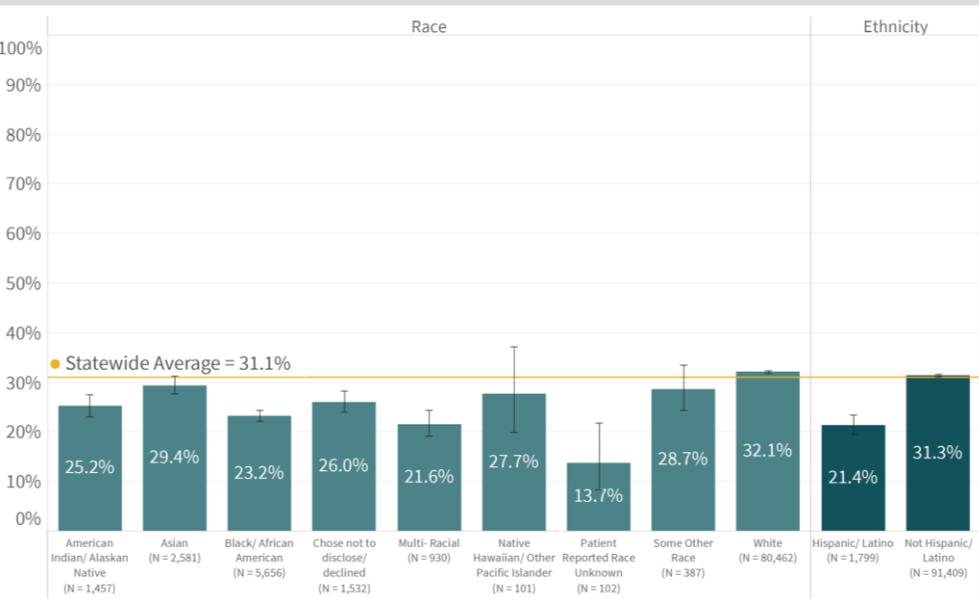
ADULT DEPRESSION: 12 MONTH MEASURES

Race/Ethnicity Summary

2019 Report Year (2016- 2018 dates of service)

Adult Depression: Follow-up at 12 Months

By Race/Ethnicity



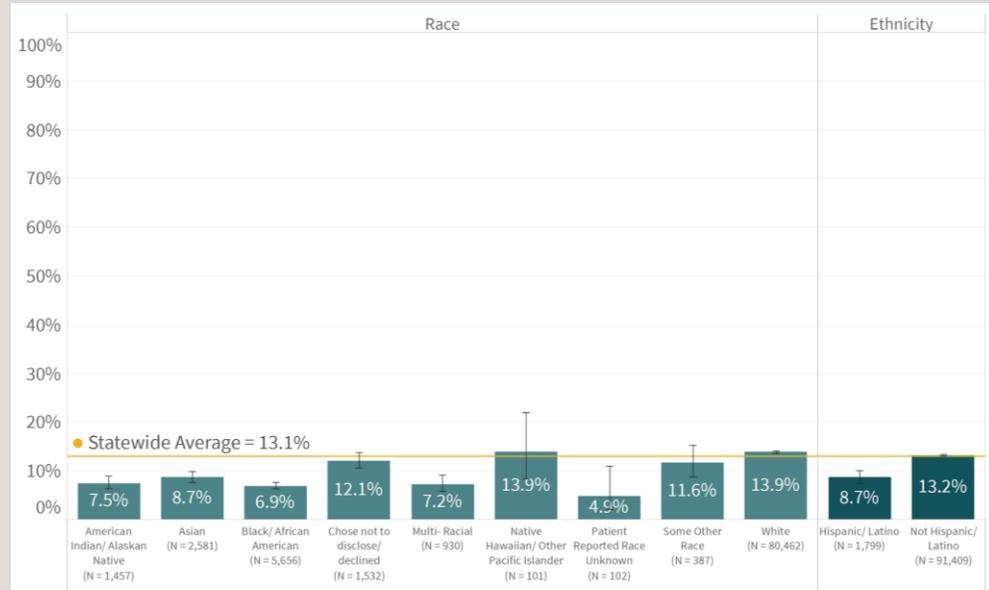
American Indian/Alaskan Native, Black/African American, Multi-Race and Hispanic/Latino patients have significantly lower rates of depression follow-up, response and remission at 12 months compared to the race/ethnicity averages.

White female patients have significantly higher rates of depression follow-up, response and remission at 12 months compared to White male patients.

Black/African American female patients have significantly higher rates of follow-up at 12 months compared to Black/African American male patients.

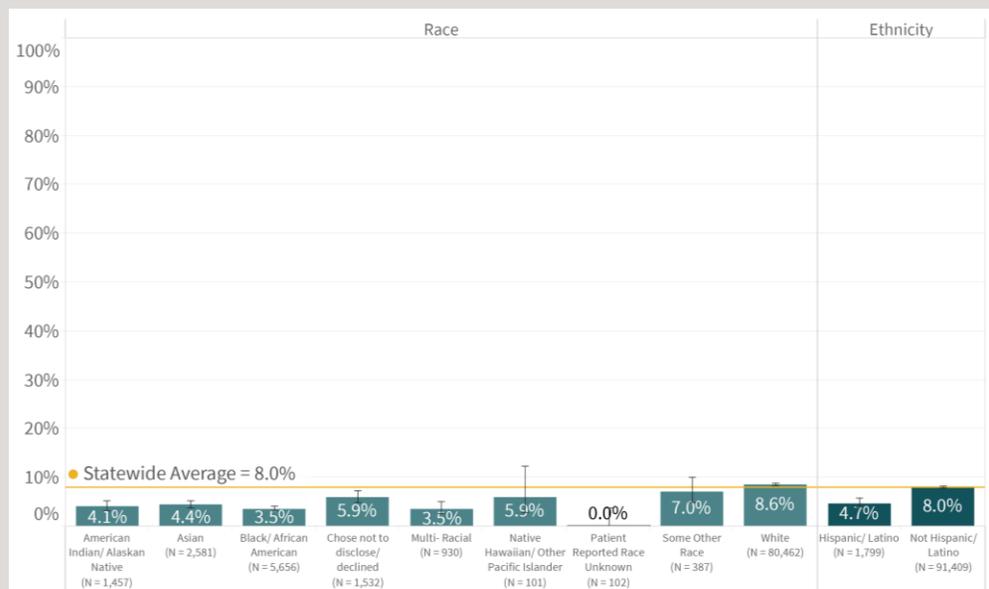
Adult Depression: Response at 12 Months

By Race/Ethnicity



Adult Depression: Remission at 12 Months

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available

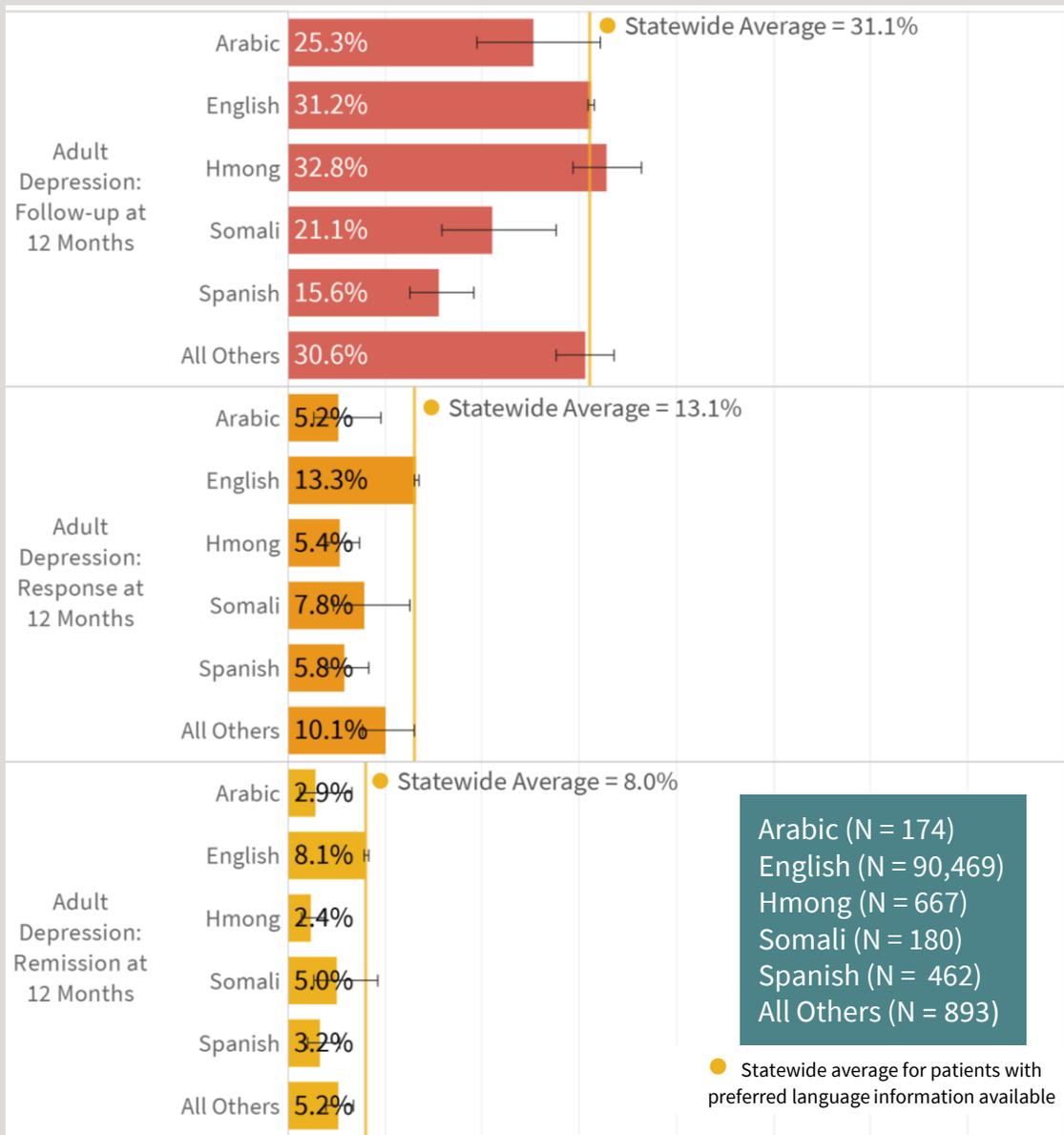
ADULT DEPRESSION: 12 MONTH MEASURES

Preferred Language Summary

2019 Report Year (2016 - 2018 dates of service)

Adult Depression: 12 Month Measures

By Preferred Language



31.2%
English-speaking patients

Statewide, **English-speaking patients** have **significantly higher** rates of **follow-up at 12 months** compared to non-English-speaking patients.

27.2%
Non-English-speaking patients

13.3%
English-speaking patients

Statewide, **English-speaking patients** have **significantly higher** rates of **response to treatment at 12 months** compared to non-English speaking patients.

7.4%
Non-English-speaking patients

8.1%
English-speaking patients

Statewide, **English-speaking patients** have **significantly higher** rates of **remission at 12 months** compared to non-English-speaking patients.

3.8%
Non-English-speaking patients

Patients who speak **Arabic, English, Hmong, Somali or Spanish** make up the largest portion of the eligible population.

Patients who speak **Spanish** are **significantly below** the statewide average for follow-up, response and remission at 12 months.

While the rate of follow-up at 12 months for patients who speak **Hmong** is average, these patients have rates that are **significantly below** average for both response and remission at 12 months.

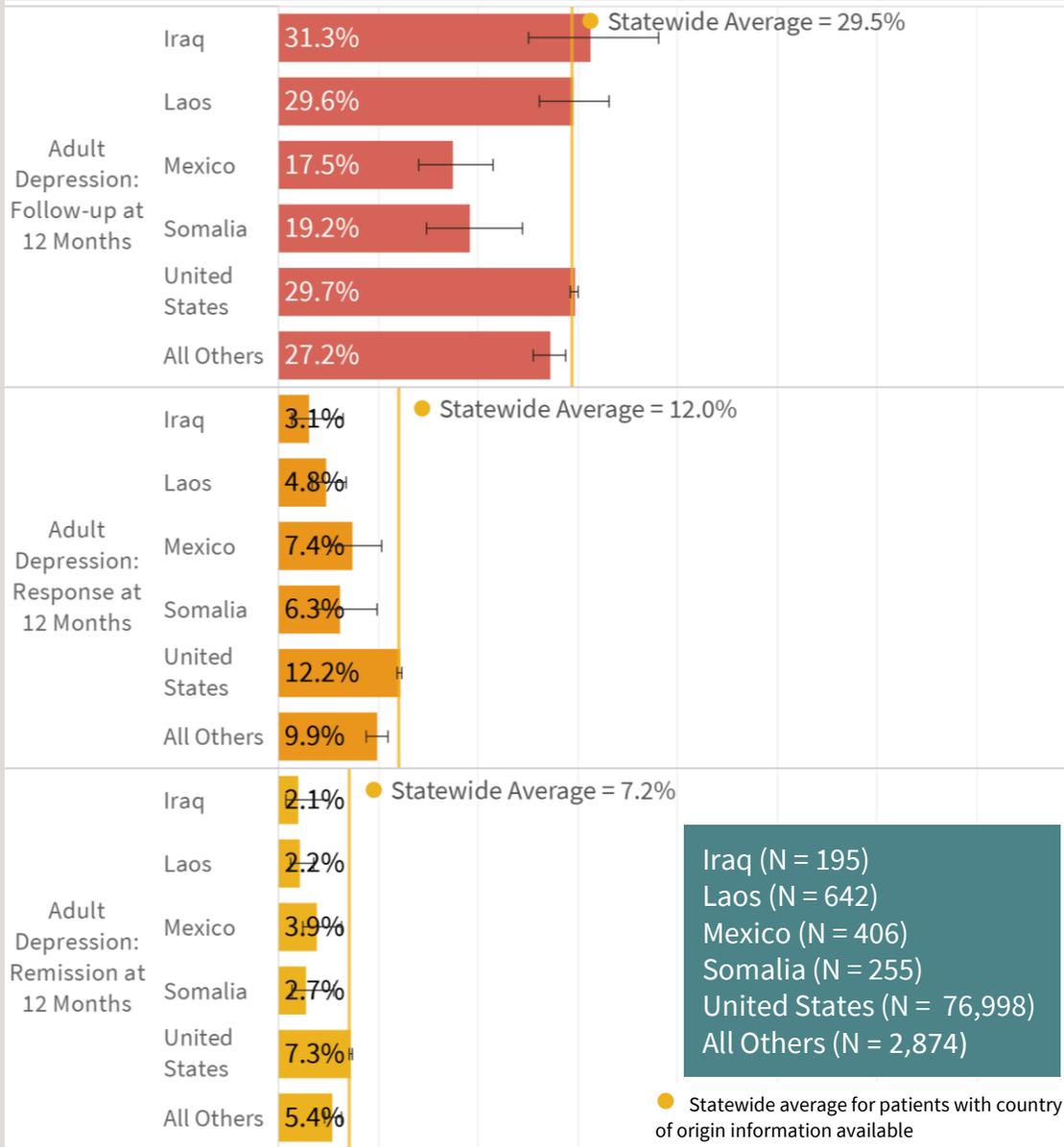
ADULT DEPRESSION: 12 MONTH MEASURES

Country of Origin Summary

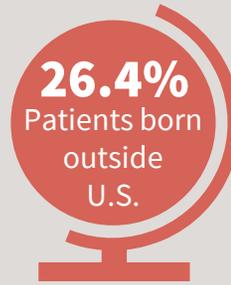
2019 Report Year (2016 - 2018 dates of service)

Adult Depression: 12 Month Measures

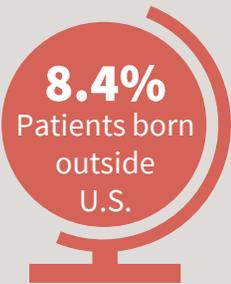
By Country of Origin



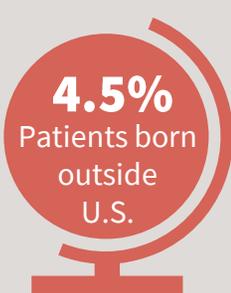
Patients born in the United States have **significantly higher** rates of **follow-up at six months** compared to patients born outside the United States.



Patients born in the United States have **significantly higher** rates of **response to treatment at 12 months** compared to patients born outside the United States.



Patients born in the United States have **significantly higher** rates of **remission at 12 months** compared to patients born outside the United States.



Patients from **Iraq, Laos, Mexico, Somalia or the United States** make up the largest portion of the eligible population.

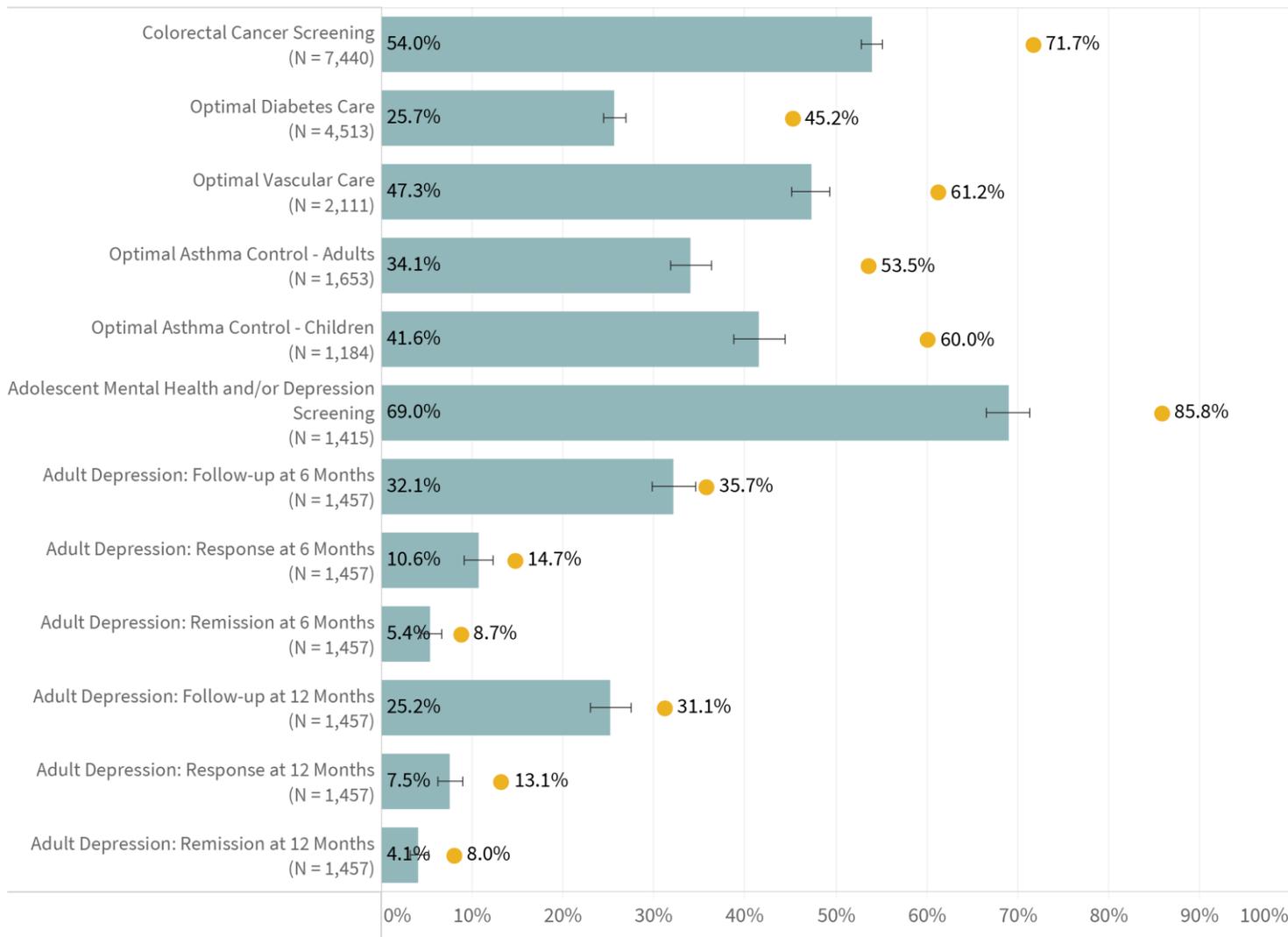
Patients from **Somalia or Mexico** are **significantly below** the statewide average follow-up, response and remission at 12 months.

Patients from **Laos** are **significantly below** the statewide average for both response to treatment and remission at 12 months.

American Indian/Alaskan Native

Snapshot Summary

2019 Report Year (2018 dates of service)



● Statewide average for patients with race/ethnicity information available

Eliminating Disparities



Increase in number of eligible American Indian/Alaskan Native **adult** patients with **optimal asthma control** needed to eliminate the disparity in outcomes.



Increase in number of eligible American Indian/Alaskan Native **children** with **optimal asthma control** needed to eliminate the disparity in outcomes.

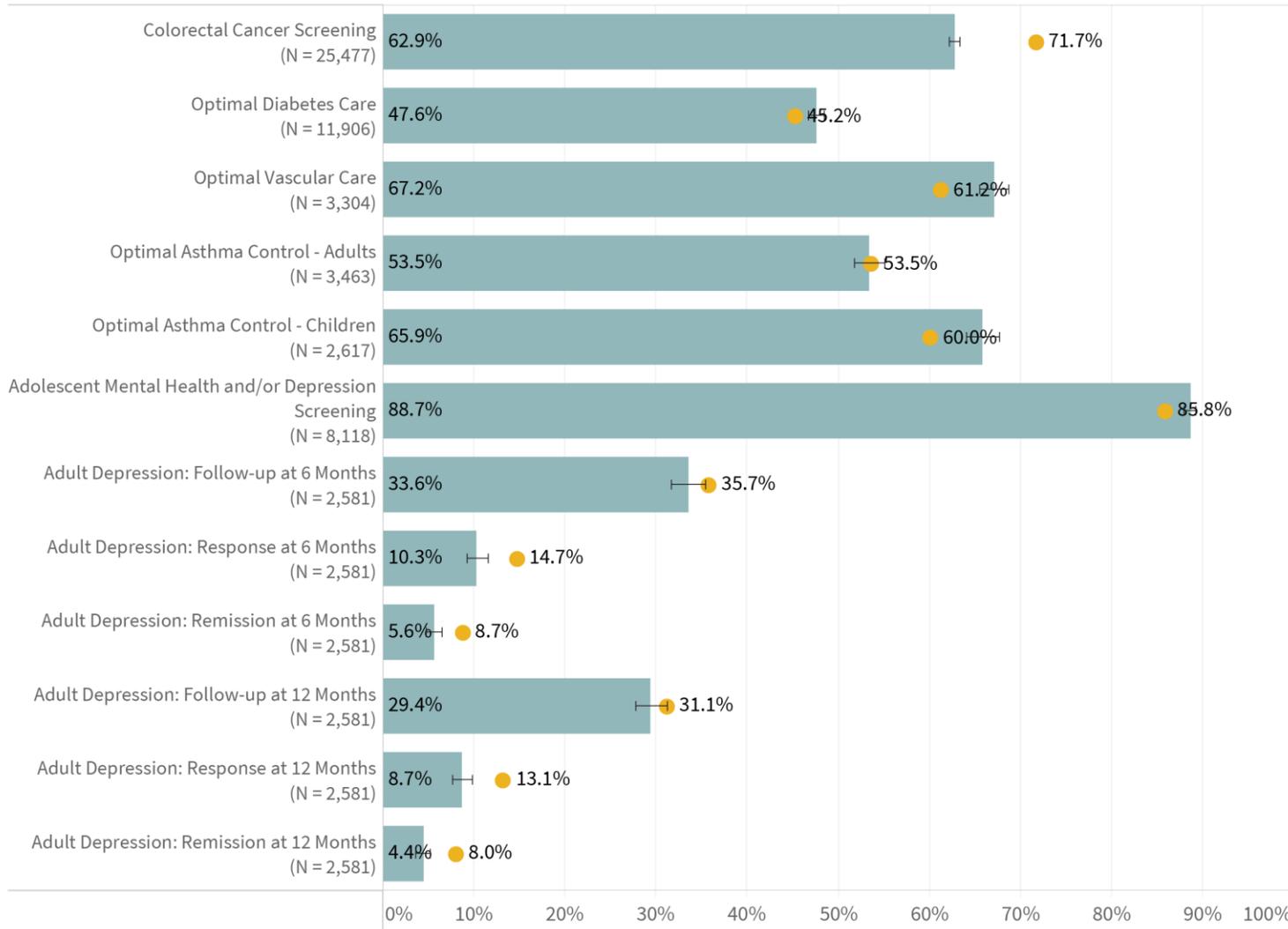


Increase in number of eligible American Indian/Alaskan Native patients with **optimal diabetes care** needed to eliminate the disparity in outcomes.

Asian

Snapshot Summary

2019 Report Year (2018 dates of service)



● Statewide average for patients with race/ethnicity information available

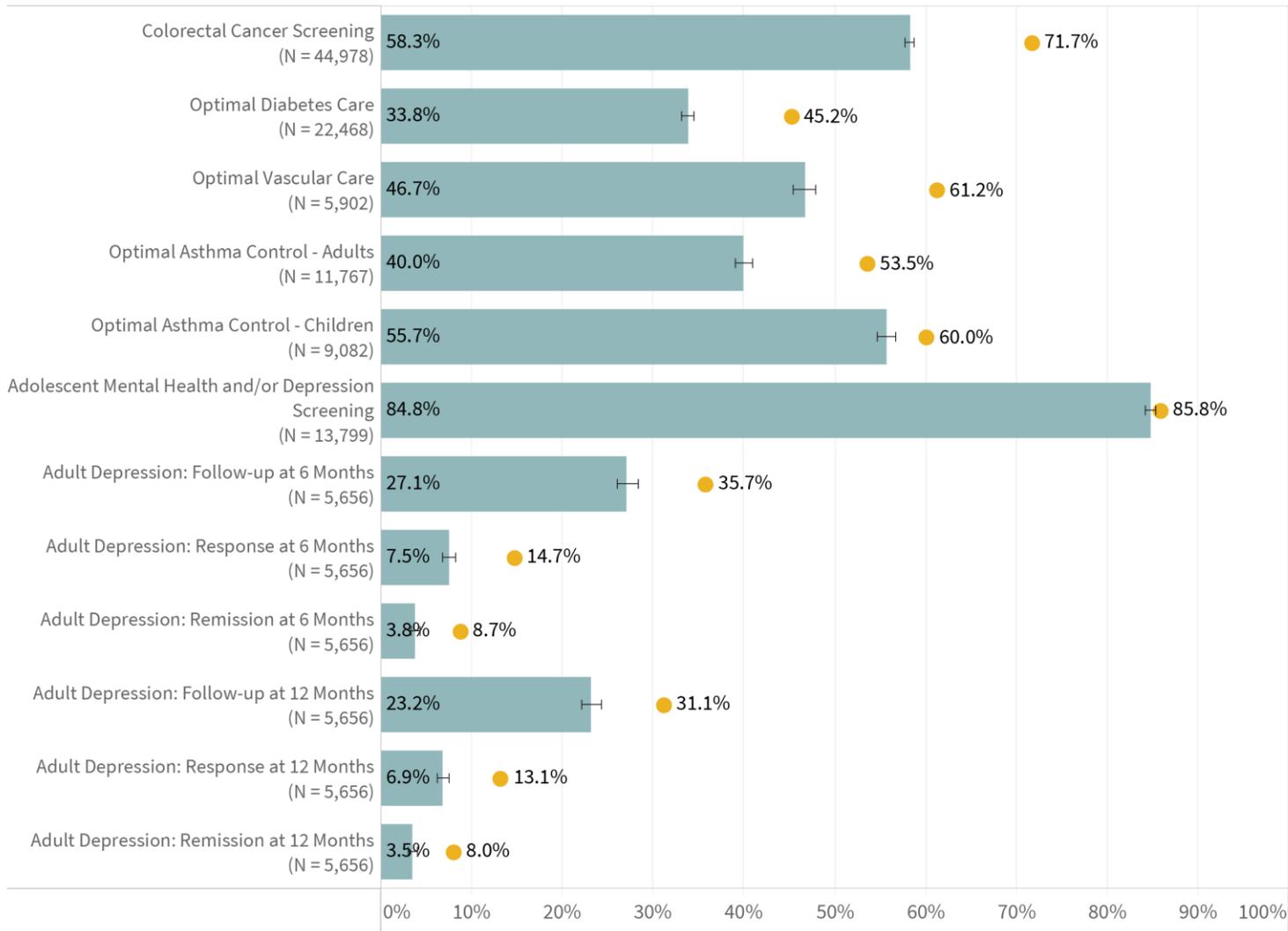
Eliminating Disparities



Increase in number of eligible Asian patients with an updated **colorectal cancer screening** needed to eliminate the disparity in screening.

Black/African American Snapshot Summary

2019 Report Year (2018 dates of service)



● Statewide average for patients with race/ethnicity information available

Eliminating Disparities



Increase in number of eligible Black/African American **adult** patients with **optimal asthma control** needed to eliminate the disparity in outcomes.



Increase in number of eligible Black/African American patients with an updated **colorectal cancer screening** needed to eliminate the disparity in screening.

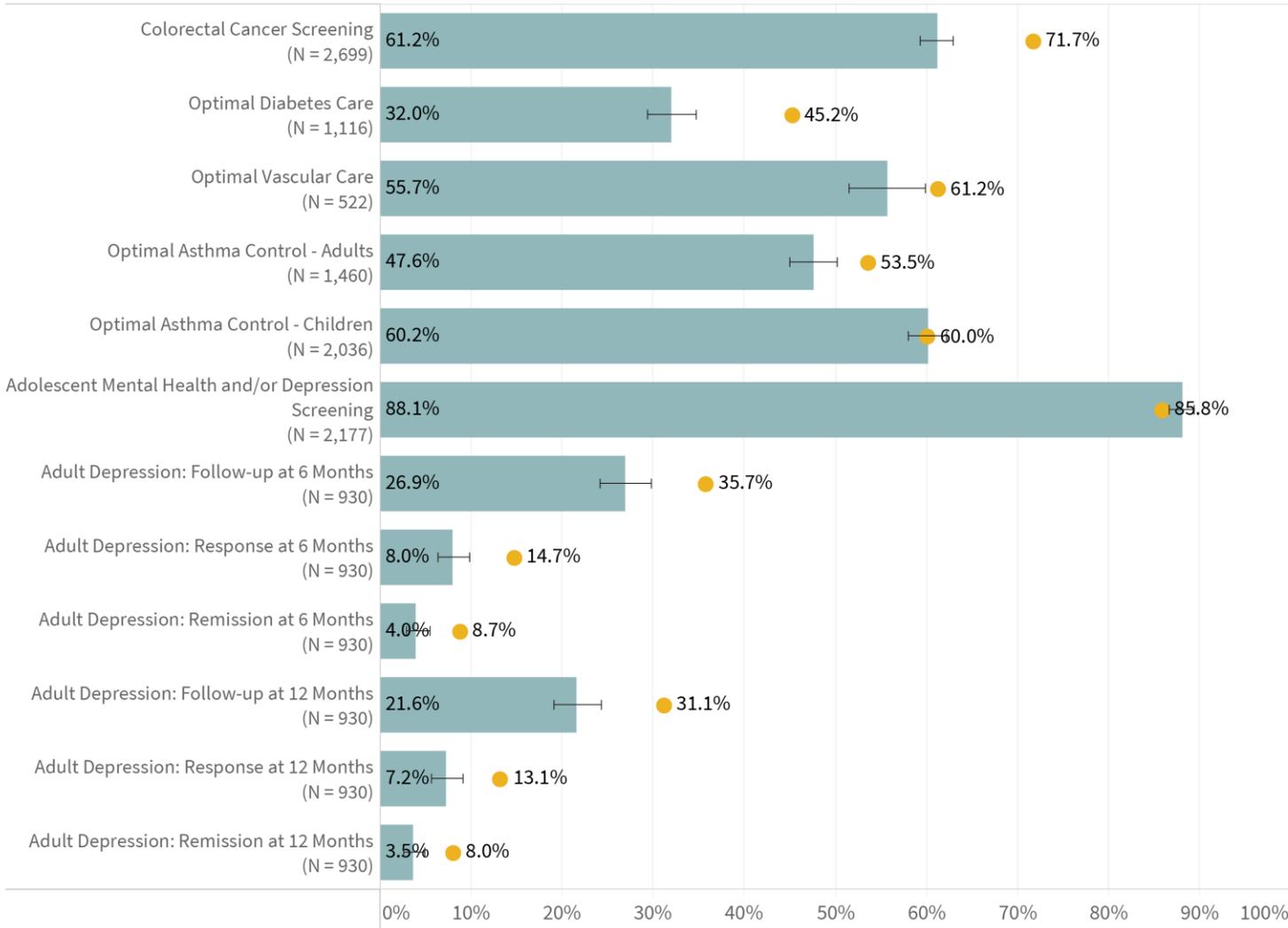


Increase in number of eligible Black/African American patients with **optimal vascular care** needed to eliminate the disparity in outcomes.

Multi-Race

Snapshot Summary

2019 Report Year (2018 dates of service)



● Statewide average for patients with race/ethnicity information available

Eliminating Disparities



Increase in number of eligible Multi-race patients with an updated **colorectal cancer screening** in order to eliminate the disparity in screening.

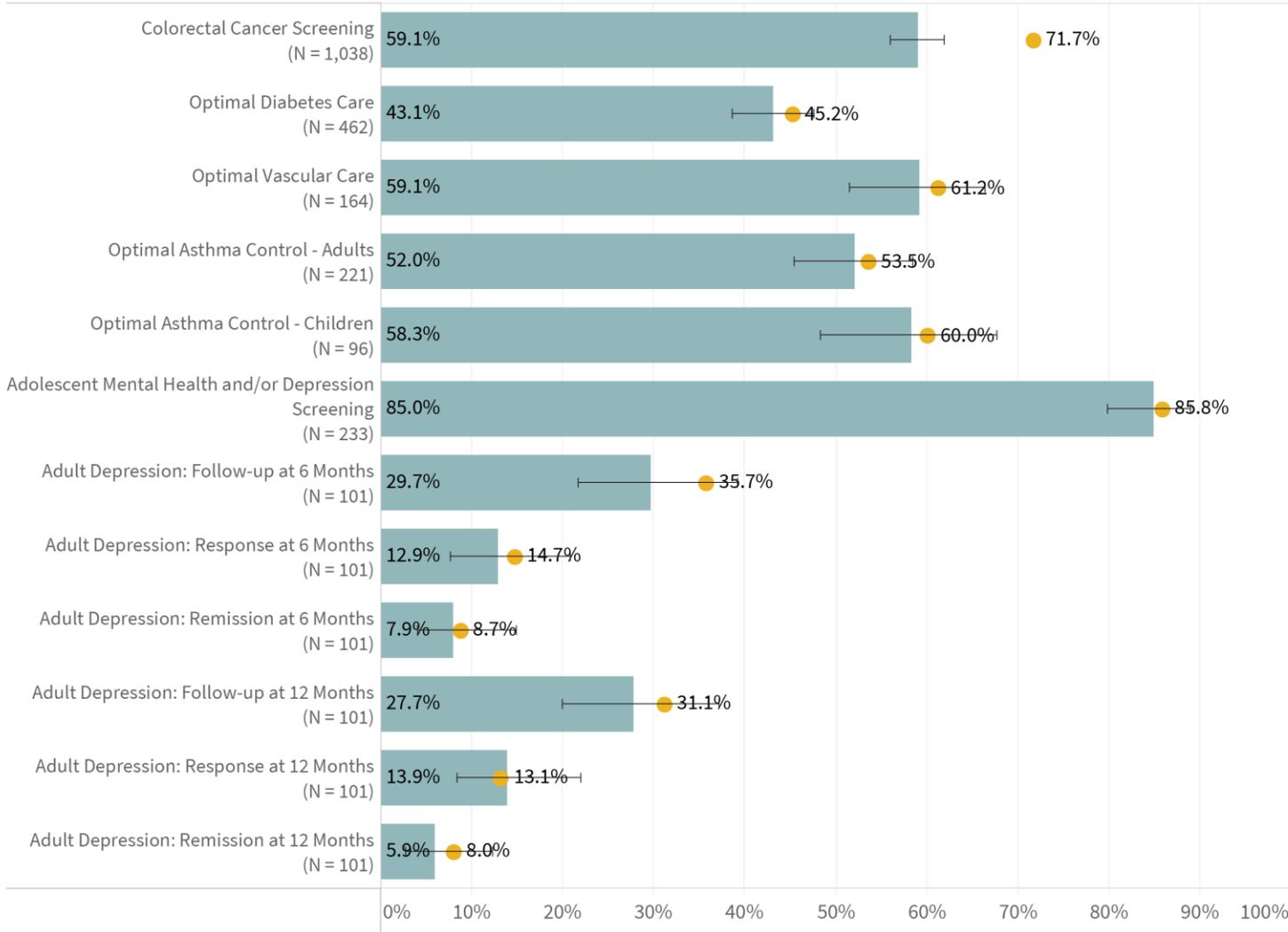


Increase in number of eligible Multi-race patients with **optimal diabetes care** needed to eliminate the disparity in outcomes.

Native Hawaiian/Pacific Islander

Snapshot Summary

2019 Report Year (2018 dates of service)



● Statewide average for patients with race/ethnicity information available

Eliminating Disparities

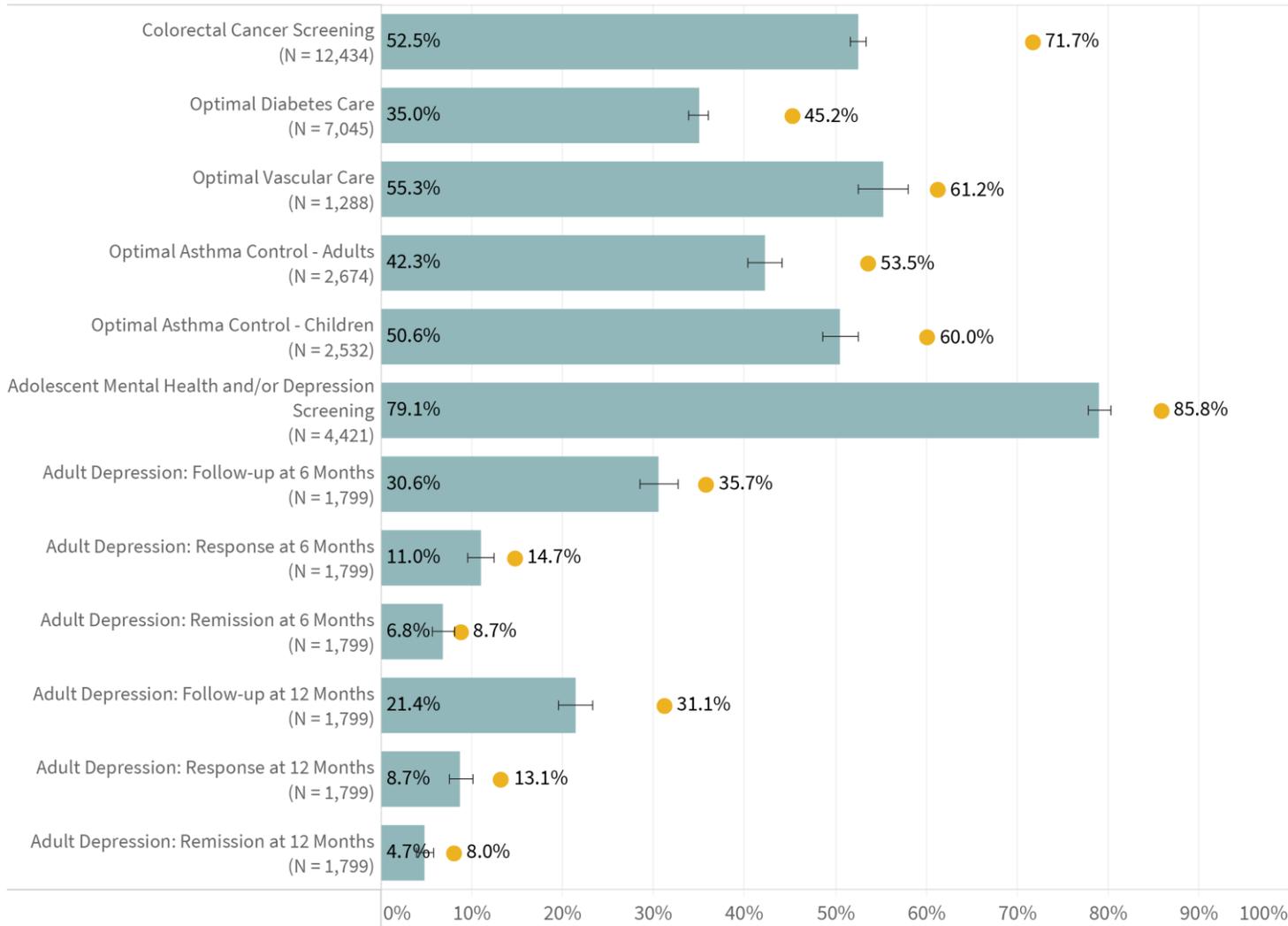


Increase in number of eligible Native Hawaiian/Pacific Islander patients with an updated **colorectal cancer screening** needed to eliminate the disparity in screening.

Hispanic Ethnicity

Snapshot Summary

2019 Report Year (2018 dates of service)



● Statewide average for patients with race/ethnicity information available

Eliminating Disparities



Increase in number of eligible Hispanic **adult** patients with **optimal asthma control** needed to eliminate the disparity in outcomes.



Increase in number of eligible Hispanic patients with an updated **colorectal cancer screening** in order needed to eliminate the disparity in screening.



Increase in number of eligible Hispanic patients with **optimal diabetes care** needed to eliminate the disparity in outcomes.

DEFINITIONS & METHODOLOGY

MEASURE DEFINITIONS

OPTIMAL DIABETES CARE

The percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes and whose diabetes was optimally managed during the measurement period as defined by achieving all of the following:

- HbA1c less than 8.0 mg/dL
- Blood pressure less than 140/90 mm Hg
- On a statin medication, unless allowed contraindications or exceptions are present
- Non-tobacco user
- Patient with ischemic vascular disease on daily aspirin or anti-platelets, unless allowed contraindications or exceptions are present

OPTIMAL VASCULAR CARE

The percentage of patients 18-75 years of age who had a diagnosis of ischemic vascular disease (IVD) and whose IVD was optimally managed during the measurement period as defined by achieving all of the following:

- Blood pressure less than 140/90 mm Hg
- On a statin medication, unless allowed contraindications or exceptions are present
- Non-tobacco user
- On daily aspirin or anti-platelets, unless allowed contraindications or exceptions are present

OPTIMAL ASTHMA CONTROL - ADULTS

The percentage of adults 18-50 years of age who had a diagnosis of asthma and whose asthma was optimally controlled during the measurement period as defined by achieving both of the following:

- Asthma well-controlled as defined by the most recent asthma control tool result available during the measurement period
- Patient not at elevated risk of exacerbation as defined by less than two emergency department visits and/or hospitalizations due to asthma in the last 12 months

OPTIMAL ASTHMA CONTROL - CHILDREN

The percentage of children 5-17 years of age who had a diagnosis of asthma and whose asthma was optimally controlled during the measurement period as defined by achieving both of the following:

- Asthma well-controlled as defined by the most recent asthma control tool result available during the measurement period
- Patient not at elevated risk of exacerbation as defined by less than two emergency department visits and/or hospitalizations due to asthma in the last 12 months

COLORECTAL CANCER SCREENING

The percentage of adults ages 50-75 who are up-to-date with the appropriate screening for colorectal cancer. Appropriate screenings include one of the following:

- Colonoscopy during the measurement period or the nine years prior; **OR**
- Flexible sigmoidoscopy during the measurement year or the four years prior; **OR**
- CT colonography during the measurement year or the four years prior; **OR**
- Fecal immunochemical test (FIT)-DNA during the measurement year or the two years prior; **OR**
- Guaiac-based fecal occult blood test (gFOBT) or FIT during the measurement year

MEASURE DEFINITIONS

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

The percentage of patients ages 12-17 who were screened for mental health and/or depression at a well-child visit using a specified tool. *Note: Adolescents diagnosed with depression are excluded from this measure.*

6 MONTH MEASURES

- **PHQ-9 Follow-up at 6 Months:** The percentage of patients with depression who have a completed PHQ-9 tool within six months after the index event (+/- 30 days)
- **6 Month Response:** The percentage of patients with depression who demonstrated a response to treatment (at least 50 percent improvement) six months after the index event (+/- 30 days)
- **6 Month Remission:** The percentage of patients with depression who reached remission (PHQ-9 score less than five) six months after the index event (+/- 30 days)

12 MONTH MEASURES

- **PHQ-9 Follow-up at 12 Months:** The percentage of patients with depression who have a completed PHQ-9 tool within 12 months after the index event (+/- 30 days)
- **12 Month Response:** The percentage of patients with depression who demonstrated a response to treatment (at least 50 percent improvement) 12 months after the index event (+/- 30 days)
- **12 Month Remission:** The percentage of patients with depression who reached remission (PHQ-9 score less than five) 12 months after the index event (+/- 30 days)

DIRECT DATA SUBMISSION (DDS)

Each of the measures included in this report is collected through a process known as Direct Data Submission (DDS). DDS measures use data submitted directly to MNMCM by medical groups and clinics.

Data Collection

Clinic abstractors collect data from medical records either by extracting the data from an electronic medical record (EMR) via data query or from abstraction of paper-based medical records. All appropriate Health Insurance Portability and Accountability (HIPAA) requirements are followed for data transfer to MNMCM.

MNMCM staff conduct an extensive validation process including pre-submission data certification, post submission data quality checks of all files, and audits of the data source for selected clinics. For medical record audits, MNMCM uses NCQA's "8 and 30" File Sampling Procedure, developed in 1996 in consultation with Johns Hopkins University. For a detailed description of this procedure, see www.ncqa.org. Audits are conducted by trained MNMCM auditors who are independent of medical groups and/or clinics. The validation process ensures the data are reliable, complete and consistent.

Eligible Population Specifications

The eligible population for each measure is identified by a medical group on behalf of their individual clinics. MNMCM's 2019 DDS Data Collection Guides provide technical specifications for the standard definitions of the eligible population, including elements such as age.

Numerator Specifications

For DDS measures, the numerator is the number of patients identified from the eligible population who meet the numerator criteria. The numerator is calculated using the clinical quality data submitted by the medical group; this data is verified through MNMCM's validation process.

Calculating Rates

Due to the dynamic nature of patient populations, rates and 95 percent confidence intervals are calculated for each measure for each medical group/clinic regardless of whether the full population or a sample is submitted. The statewide average rate is displayed when comparing a single medical group/clinic to the performance of all medical groups/clinics to provide context. The statewide average is calculated using all data submitted to MNMCM which may include some data from clinics located in neighboring states.

RACE, HISPANIC ETHNICITY, LANGUAGE, AND COUNTRY OF ORIGIN ANALYSES

For the nine DDS measures, the race, ethnicity, language, and country of origin data is submitted by medical groups through MNMCM's DDS process. Please refer to the MNMCM [*Handbook on the Collection of Race/Ethnicity/Language Data in Medical Groups*](#) for more information about this data.

Best Practices for Clinical Quality Measures

Race, Hispanic ethnicity, language, and country of origin data collection undergoes a unique validation process to ensure that medical groups collect these data elements from patients using best practices. Best practices are defined as:

1. Patients self-report their race and Hispanic ethnicity.
2. Patients have the option to select one or more categories for race (i.e., medical groups/clinics do not collect data using a multi-racial category).
3. Medical groups/clinics have the ability to capture and report more than one race as reported by the patient.

A medical group/clinic must meet all the criteria for each data element to achieve best practice status and to have their data included in the rate calculation. Only validated data, collected using best practices, are used to calculate rates by race, Hispanic ethnicity, language, and country of origin.