MINNESOTA HEALTH CARE DISPARITIES

BY RACE, HISPANIC ETHNICITY, LANGUAGE AND COUNTRY OF ORIGIN

2020 REPORT

RELEASED MAY 2021

MN Community MEASUREMENT

Minnesota Health Care Disparities

By Race, Hispanic Ethnicity, Language and Country of Origin

Results for care delivered in 2019

INTRODUCTION

As an independent nonprofit dedicated to empowering health care decision makers with meaningful data, MN Community Measurement (MNCM) is a statewide resource for timely, comparable information on health care costs and quality. 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 presents information on disparities by race, ethnicity, language, and country of origin (RELC) for quality measures collected by MNCM in 2020, reflecting care provided in 2019. For the measures included in this report, MNCM collects patient-level data on RELC to enable these comparisons. This comprehensive, high-quality data on RELC is fairly unique in the nation and creates the potential for targeting interventions to address identified disparities as well as research to demonstrate what works. While data is a first step in understanding and addressing disparities, data alone is not sufficient – as a society we must take action to address inequities, and MNCM actively seeks to partner with others who leverage the data in these ways.

REPORT OUTLINE

This report presents analysis of the following measures for which MNCM collects clinical data directly from medical groups (full descriptions of each measure are provided beginning on page 49):

- Colorectal cancer screening
- Optimal diabetes care
- Optimal vascular care
- Optimal asthma control (separately for adults and children)
- Adolescent mental health and/or depression screening
- Depression (rates of follow-up, response, and remission, analyzed separately for adolescents and adults)

The analysis for each measure includes race/ethnicity, preferred language, and country of origin, as well as some combinations of these factors (for example, preferred language and race). This report uses only data from medical groups that have been verified by MNCM as using best practices to collect RELC data from patients (see page 52 for more details on best practice), and a minimum of 30 patients is needed for reporting either at the statewide or medical group level. Throughout the report, differences from statewide averages are calculated using 95 percent confidence intervals.

ACKNOWLEDGEMENTS

This report is possible by 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.

MNCM 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 MNCM committees and workgroups providing ongoing guidance to shape this important work.

REPORT AUTHORS

Jess Donovan, MPH, RN, PHN
Clinical Measurement Analyst

Gunnar Nelson
Health Economist

DIRECT QUESTIONS OR COMMENTS TO support@mncm.org

Minnesota Health Care Disparities

By Race, Hispanic Ethnicity, Language and Country of Origin

Results for care delivered in 2019

KEY FINDINGS

- In general, **Indigenous/Native, Black and Hispanic/Latinx patients** have **significantly lower** rates of optimal care compared to the statewide average in most of the reported measures.

- There is also variation in outcomes by preferred language and country of origin: for most measures, groups with a preferred language other than English have lower rates of optimal care than the statewide average. Similarly, it is often the case that patients born outside of the U.S. have lower rates of optimal care.

- Within race categories, there is variation by language and country of origin. For example:
    - **Black patients whose preferred language is English** have **significantly lower rates** of optimal diabetes care, optimal vascular care, and depression remission at six months compared to Black patients whose primary language is not English.

    - **Asian patients whose preferred language is English** have **significantly higher rates** of colorectal cancer screening, optimal diabetes care, optimal asthma control for adults, and adolescent mental health screening compared to their counterparts whose preferred language is not English.

- Similarly, there are differences within race categories by county of origin. For example, **Black patients who were born in the United States** have **significantly lower rates** of optimal care on most measures compared to Black patients born outside the U.S.

ONLINE APPENDICES

Online appendices to the report presents results by medical group:

- Race/Ethnicity
- Preferred Language
- Country of Origin

TABLE OF CONTENTS

4 Colorectal Cancer Screening

7 Optimal Diabetes Care

13 Optimal Vascular Care

19 Optimal Asthma Control – Adults

22 Optimal Asthma Control – Children

25 Adolescent Mental Health and/or Depression Screening

28 Adolescent Depression: Six Month Measures

31 Adolescent Depression: 12 Month Measures

34 Adult Depression: Six Month Measures

37 Adult Depression: 12 Month Measures

40 Snapshot Summary by BIPOC

46 Statewide Summary by Race and Hispanic Ethnicity

48 Definitions & Methodology

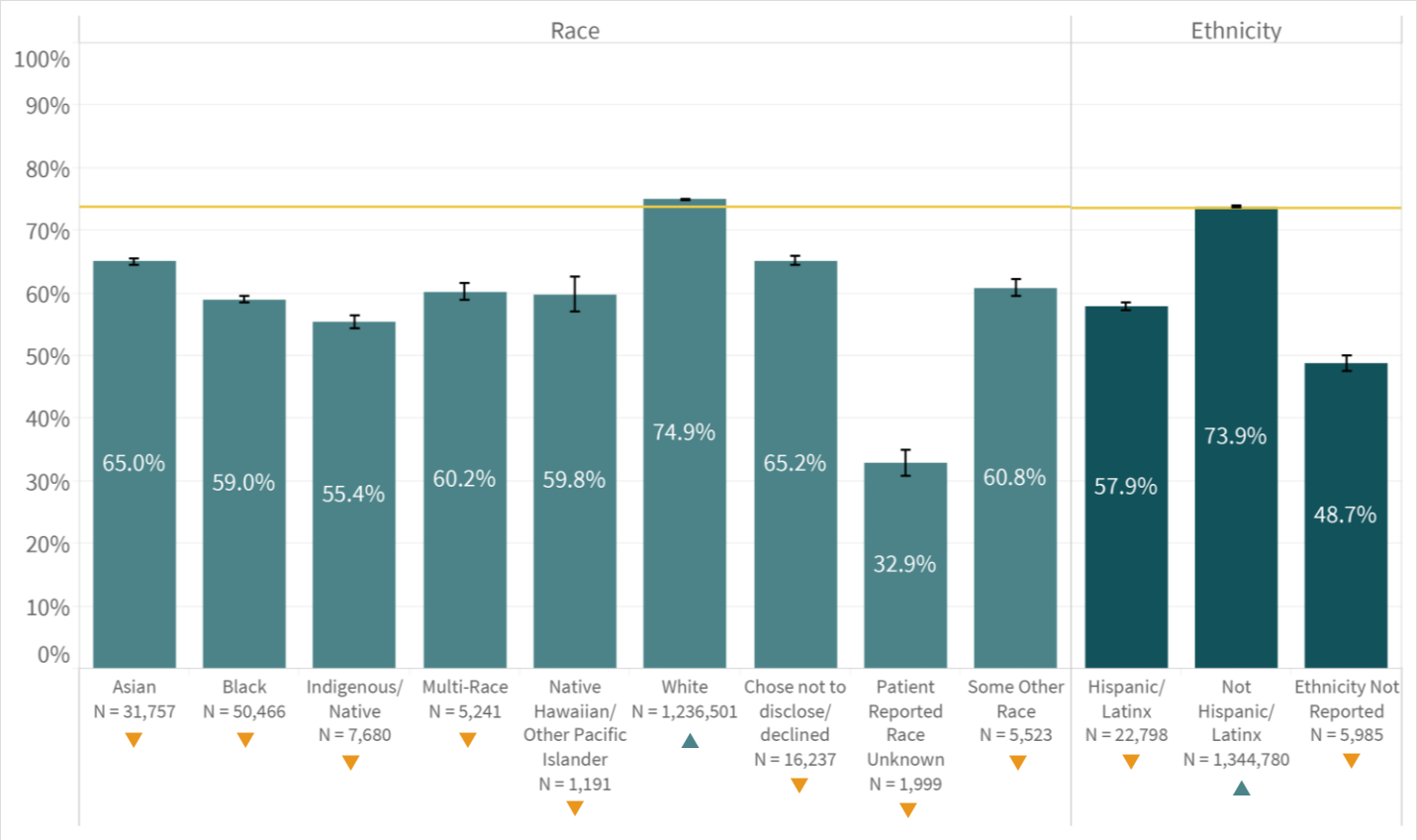
COLORECTAL CANCER SCREENING

Race/Ethnicity Summary

2020 Report Year (2019 dates of service)

Colorectal Cancer Screening

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 73.7% **Ethnicity average = 73.5%**

▼ Significantly lower than average
▲ Significantly higher than average

Patients who are Asian, Black, Indigenous/Native, Multi-Race, Native Hawaiian/Other Pacific Islander or Hispanic/Latinx are among those who have **significantly lower** rates of colorectal cancer screening compared to the race/ethnicity average.

Asian, White and Hispanic/Latinx females have **significantly higher** rates of colorectal cancer screening compared to males within the respective races/ethnicities.

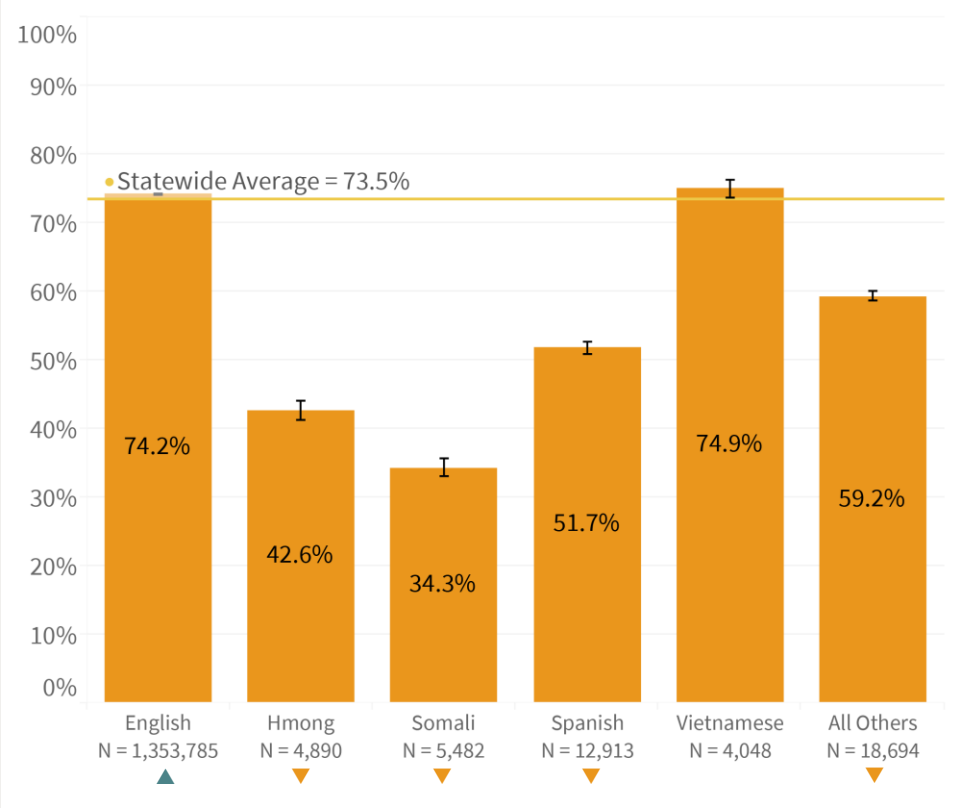
COLORECTAL CANCER SCREENING

Preferred Language Summary

2020 Report Year (2019 dates of service)

Colorectal Cancer Screening

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 colorectal cancer screening compared to the statewide average.

● Statewide average for patients with Preferred Language information available
▼ Significantly lower than average ▲ Significantly higher than average
All Others: Combines all other languages not listed in the graph that were submitted for patients

69.0% English-speaking Asian patients

61.1% Non-English-speaking Asian patients

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

62.9% English-speaking Black patients

38.8% Non-English-speaking Black patients

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

64.3% English-speaking Hispanic/Latinx patients

51.8% Non-English-speaking Hispanic/Latinx patients

English-speaking Hispanic/Latinx patients have **significantly higher** rates of colorectal cancer screening compared to non-English-speaking Hispanic/Latinx patients.

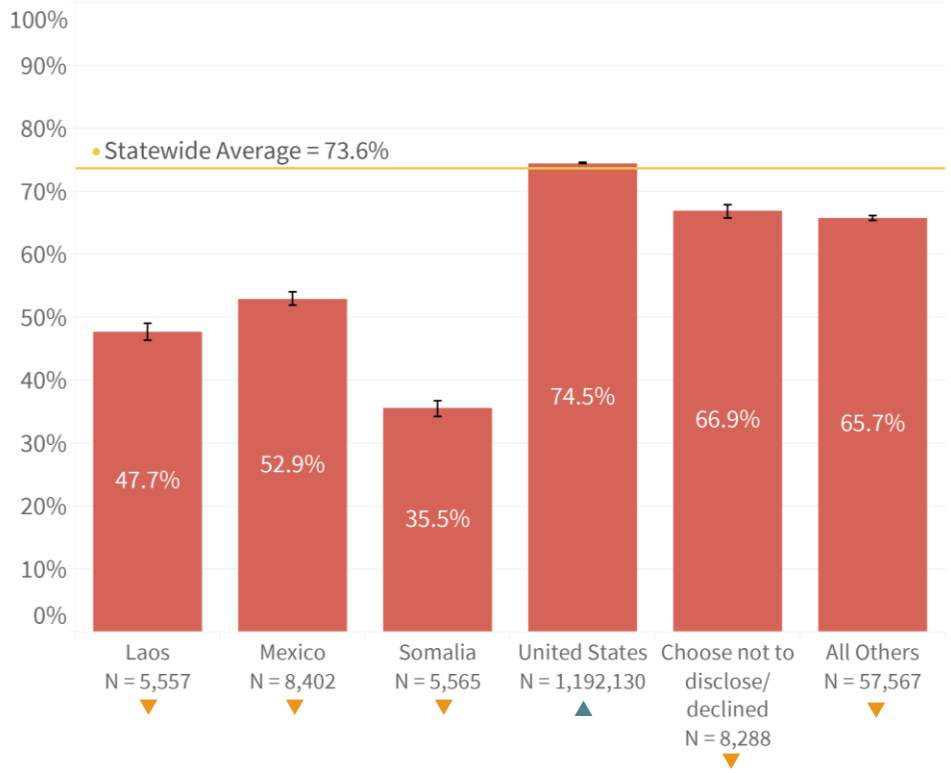
COLORECTAL CANCER SCREENING

Country of Origin Summary

2020 Report Year (2019 dates of service)

Colorectal Cancer Screening

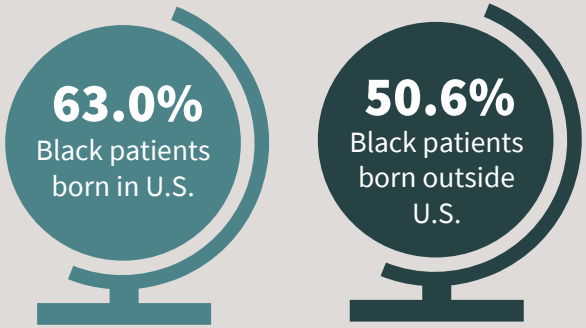
By Country of Origin



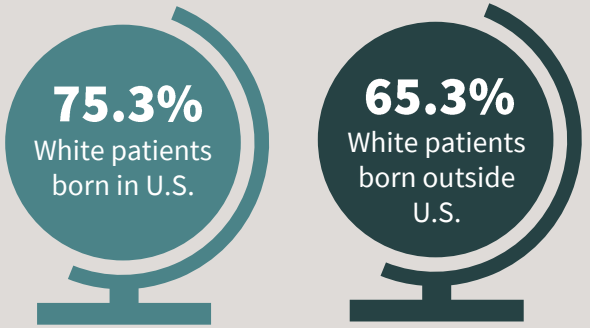
Patients from **Laos, Mexico, Somalia or the United States** or patients whose **country of origin was not disclosed** make up the largest portion of the eligible population.

Patients from **Laos, Mexico and Somalia** or **whose country of origin was not disclosed** have **significantly lower** rates of colorectal cancer screening compared to the statewide average.

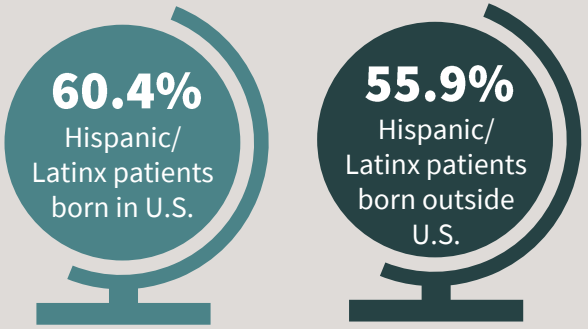
● Statewide average for patients with Country of Origin information available
▼ Significantly lower than average ▲ Significantly higher than average
All Others: Combines all other countries not listed in the graph that were submitted for eligible patients



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



Hispanic/Latinx patients born in the United States have **significantly higher** rates of colorectal cancer screening compared to Hispanic/Latinx patients born outside the United States.

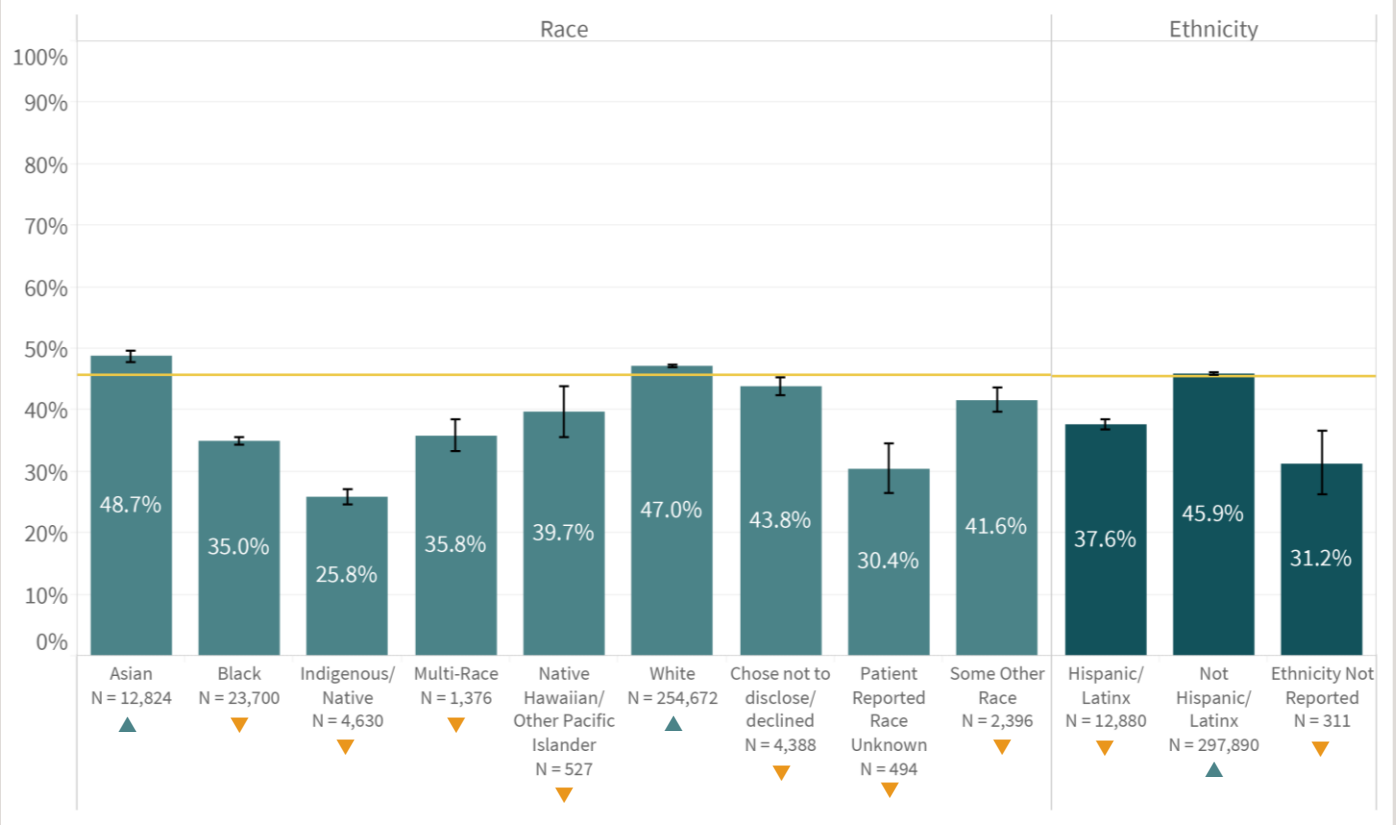
OPTIMAL DIABETES CARE

Race/Ethnicity Summary

2020 Report Year (2019 dates of service)

Optimal Diabetes Care

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 45.7% **Ethnicity average = 45.5%**

▼ Significantly lower than average
▲ Significantly higher than average

Patients who are Black, Indigenous/Native, Native Hawaiian, Multi-Race or Hispanic/Latinx are among those with **significantly lower** rates of optimal diabetes care compared to the race/ethnicity averages.

Black, White, Hispanic/Latinx and not Hispanic/Latinx females have **significantly higher** rates of optimal diabetes care compared to males within the respective races/ethnicities.

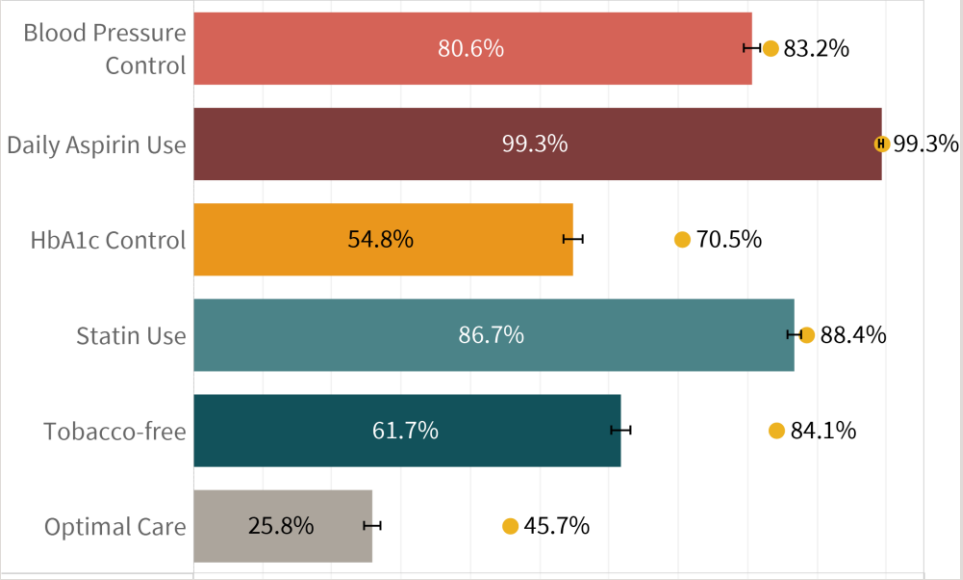
OPTIMAL DIABETES CARE

Focus on components

2020 Report Year (2019 dates of service)

Optimal Diabetes Care Components

Among Indigenous/Native patients

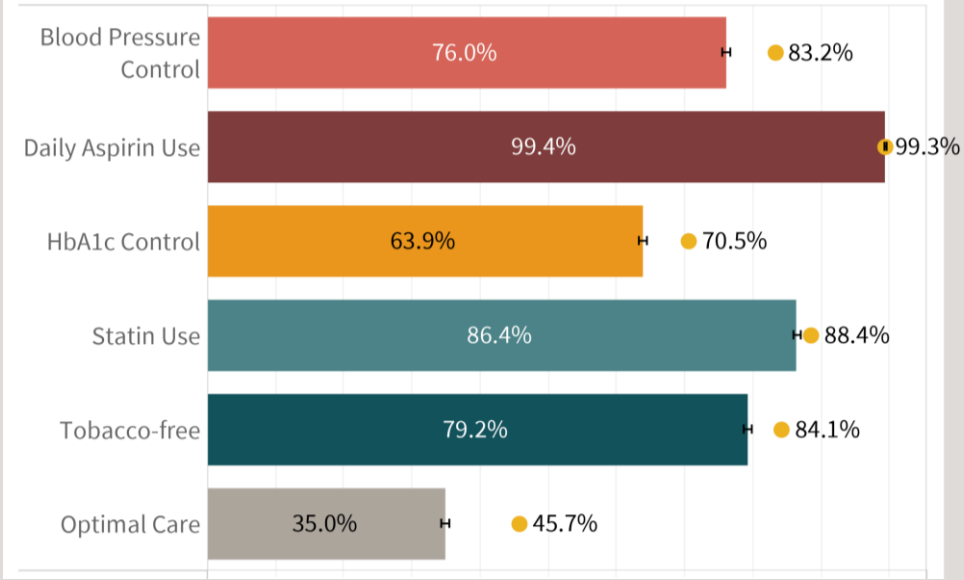


Patients who are Indigenous/Native and who have diabetes have **significantly lower** rates on **four out of the five** optimal diabetes care components. These components include blood pressure control, HbA1c control, statin use and being tobacco-free.

Additionally, Indigenous/Native patients have the **lowest rate** of **HbA1c control** (54.8%) and the **lowest rate** of being **tobacco-free** (61.7%) among all race groups.

Optimal Diabetes Care Components

Among Black patients



Patients who are Black and who have diabetes have **significantly lower** rates on **four out of the five** optimal diabetes care components. These components include blood pressure control, HbA1c control, statin use and being tobacco-free.

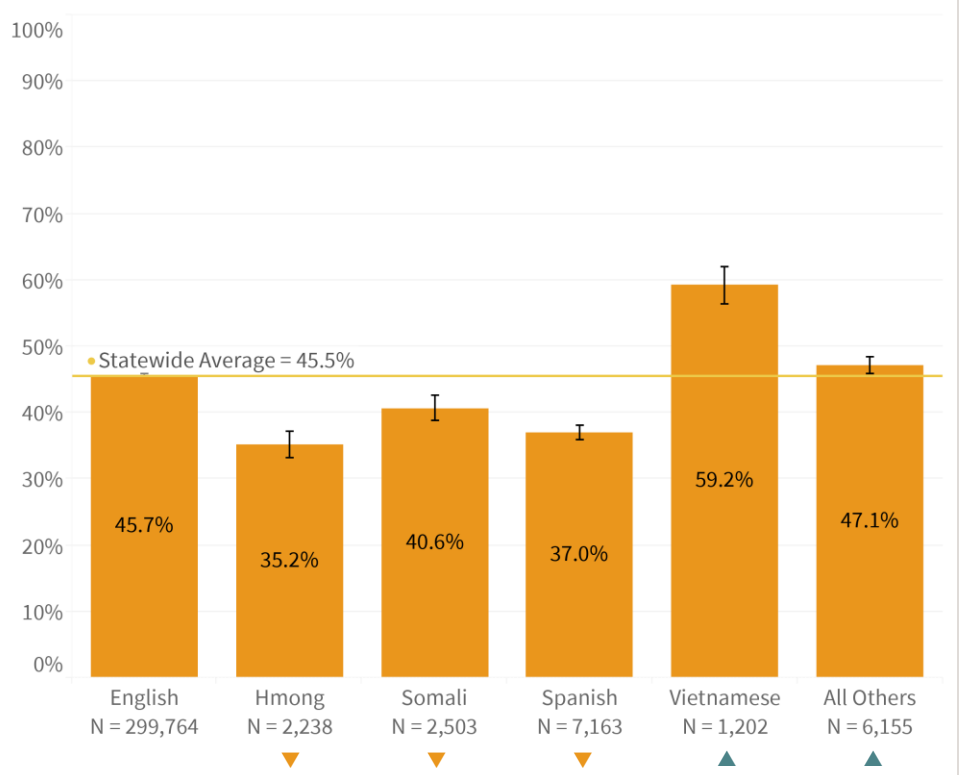
OPTIMAL DIABETES CARE

Preferred Language Summary

2020 Report Year (2019 dates of service)

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

● Statewide average for patients with Preferred Language information available
▼ Significantly lower than average ▲ Significantly higher than average
All Others: Combines all other languages not listed in the graph that were submitted for patients

50.1% English-speaking Asian patients

46.9% Non-English-speaking Asian patients

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

33.8% English-speaking Black patients

41.6% Non-English-speaking Black patients

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

47.2% English-speaking White patients

38.4% Non-English-speaking White patients

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

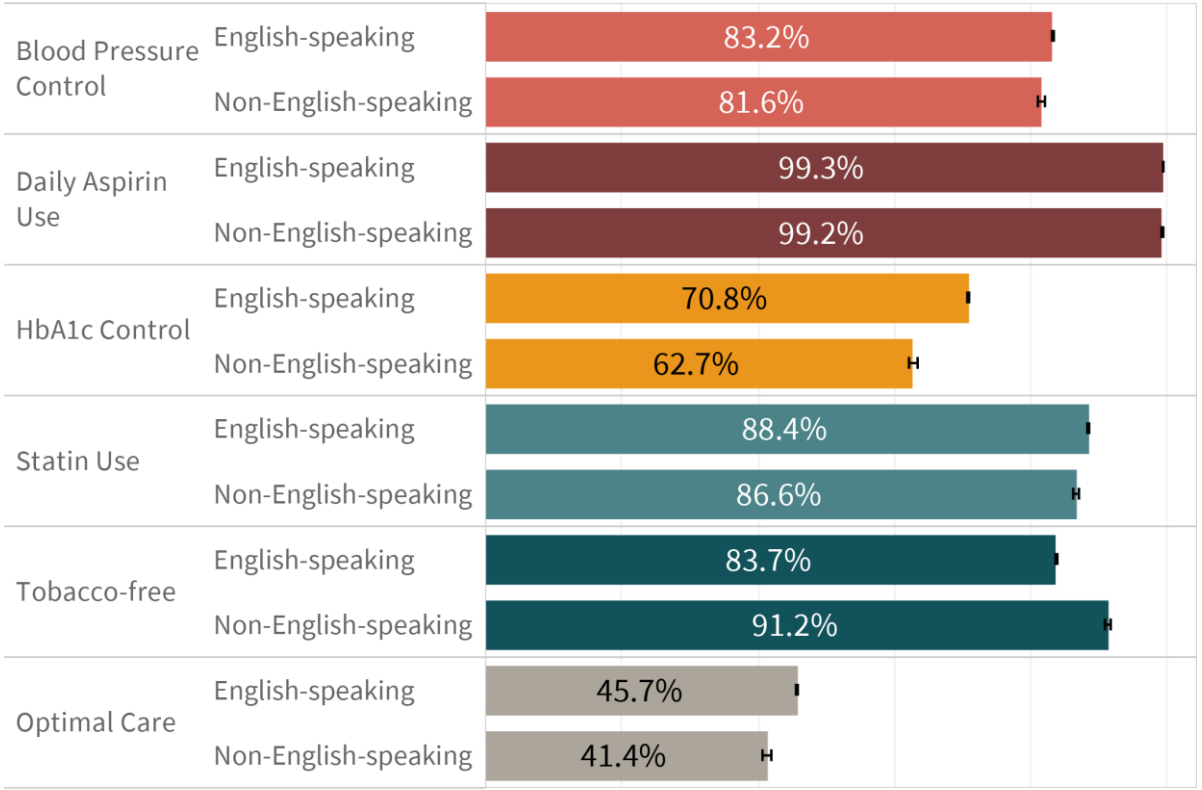
OPTIMAL DIABETES CARE

Preferred Language Summary

2020 Report Year (2019 dates of service)

Optimal Diabetes Care Components

Among English-speaking patients vs. non-English-speaking patients



English-speaking patients have **significantly higher** rates of **HbA1c control, statin use and optimal care** compared to **non-English-speaking patients.**

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

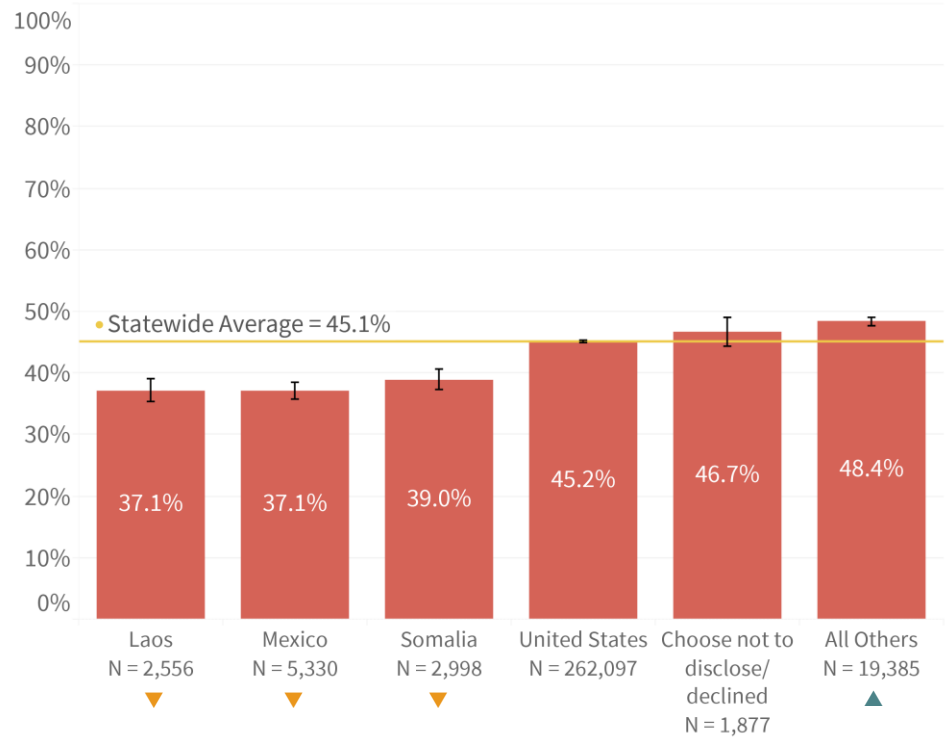
OPTIMAL DIABETES CARE

Country of Origin Summary

2020 Report Year (2019 dates of service)

Optimal Diabetes Care

By Country of Origin



Patients from **Laos, Mexico, Somalia or the United States** or patients whose **country of origin was not disclosed** make up the largest portion of the eligible population.

Patients from **Laos, Mexico or Somalia** have **significantly lower** rates of optimal diabetes care compared to the statewide average.

● Statewide average for patients with Country of Origin information available
▼ Significantly lower than average ▲ Significantly higher than average
All Others: Combines all other countries not listed in the graph that were submitted for eligible patients

41.7% Asian patients born in U.S.

49.3% Asian patients born outside U.S.

Asian patients born in the United States have **significantly lower** rates of optimal diabetes care compared to Asian patients born outside the United States.

30.3% Black patients born in U.S.

42.0% Black patients born outside U.S.

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

34.7% Hispanic/Latinx patients born in U.S.

39.1% Hispanic/Latinx patients born outside U.S.

Hispanic/Latinx patients born in the United States have **significantly lower** rates of optimal diabetes care compared to Hispanic/Latinx patients born outside the United States.

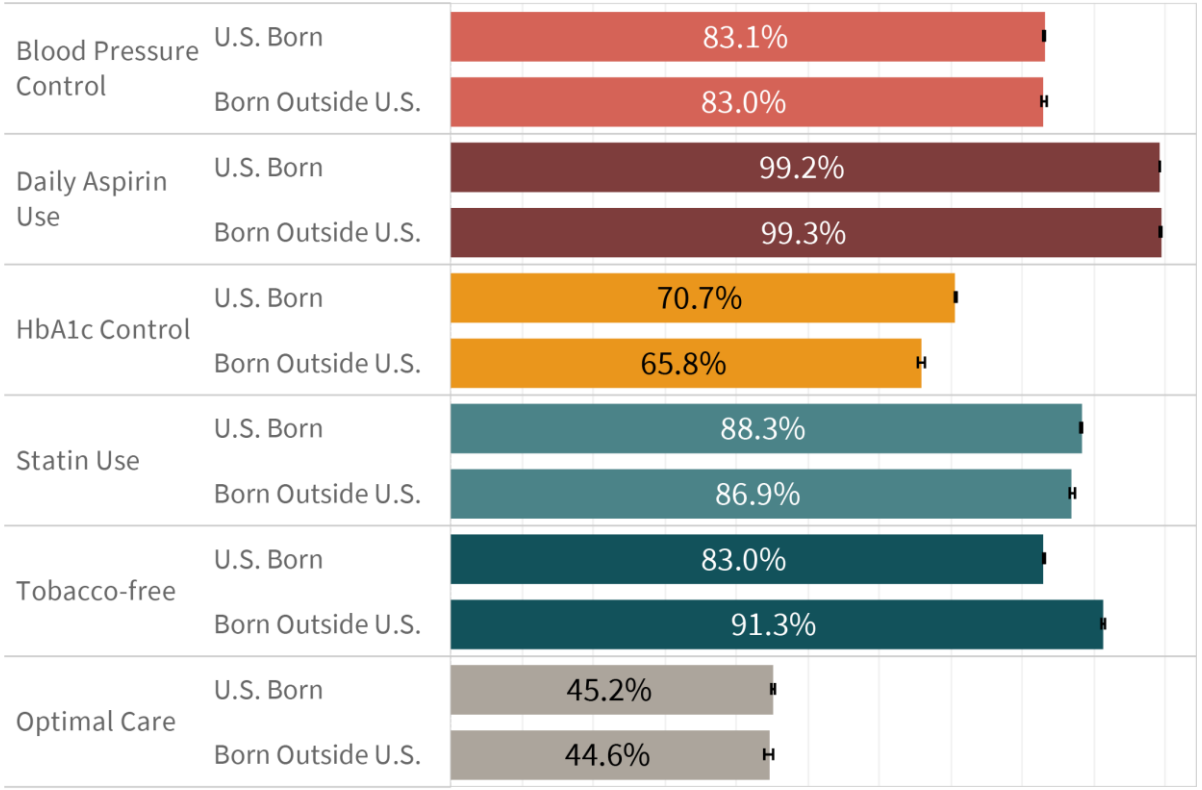
OPTIMAL DIABETES CARE

Country of Origin Summary

2020 Report Year (2019 dates of service)

Optimal Diabetes Care Components

Among U.S. born patients vs. patients born outside U.S.



U.S. born patients have **significantly higher** rates of **HbA1c control and daily aspirin use** compared to **patients born outside of the United States**.

However, **U.S. born patients** have **significantly lower** rates of being **tobacco-free** compared to **patients born outside of the United States.**

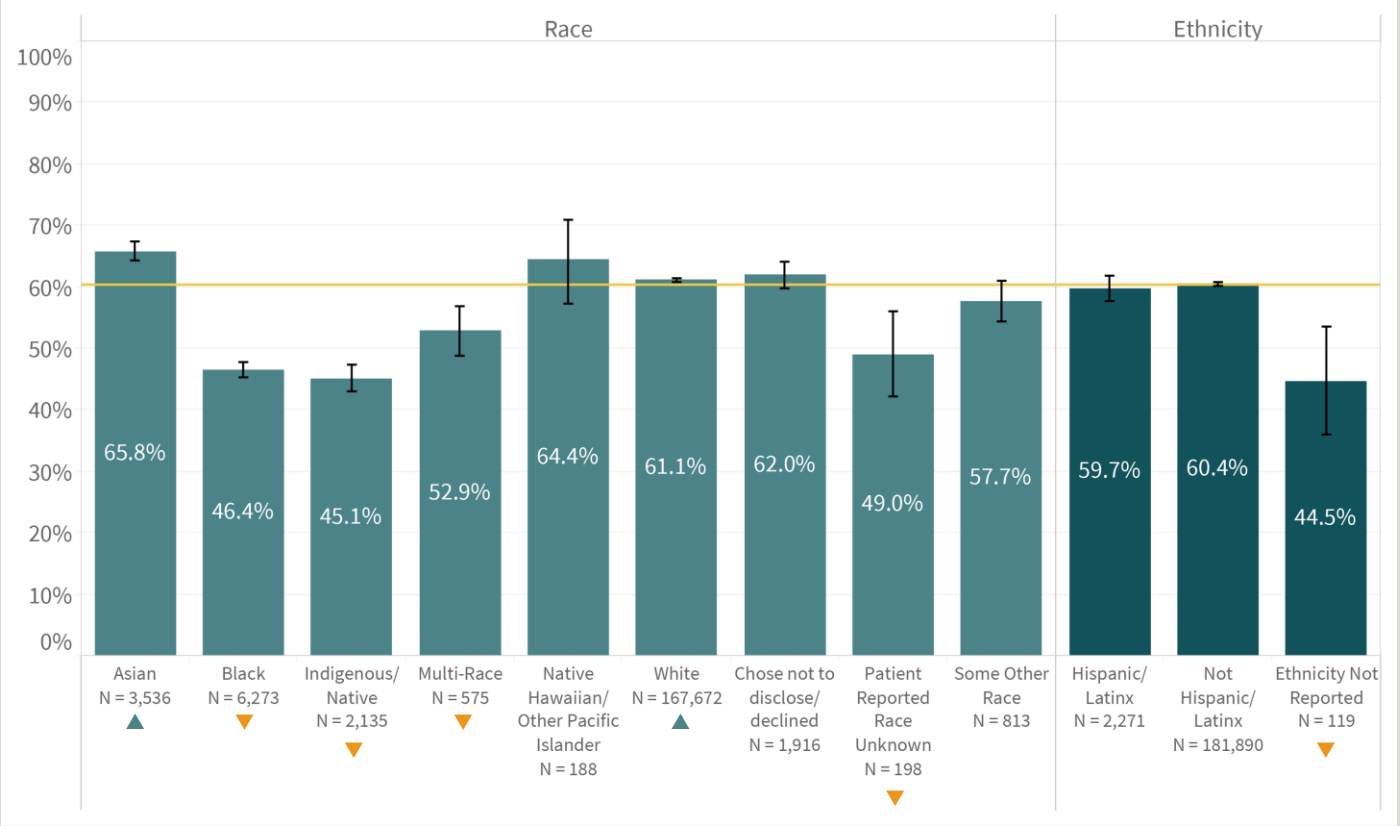
OPTIMAL VASCULAR CARE

Race/Ethnicity Summary

2020 Report Year (2019 dates of service)

Optimal Vascular Care

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 60.4% **Ethnicity average = 60.4%**

▼ Significantly lower than average
▲ Significantly higher than average

Patients who are Black, Indigenous/Native or Multi-Race are among those who have **significantly lower** rates of optimal vascular care compared to the race/ethnicity average.

Indigenous/Native, Asian and White females have **significantly lower** rates of optimal vascular care compared to males within the respective races/ethnicities.

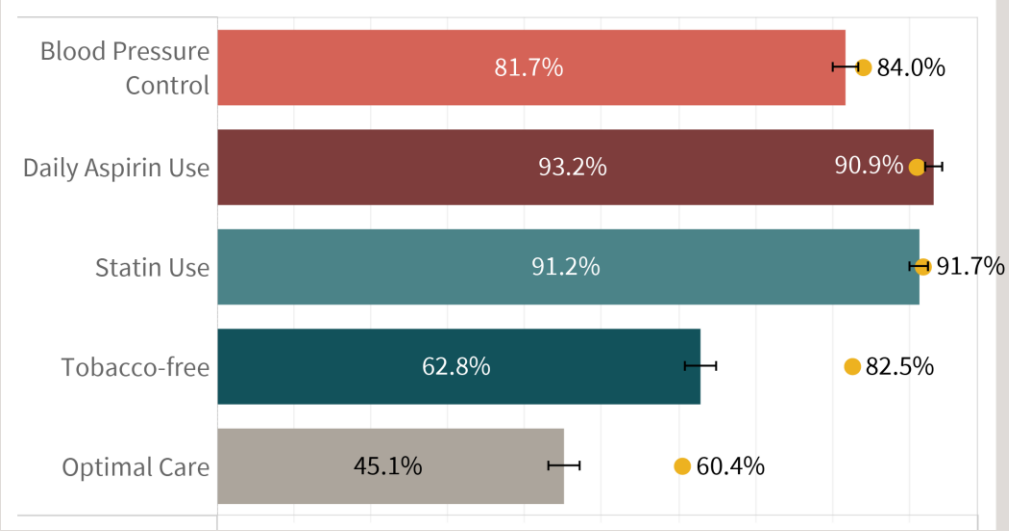
OPTIMAL VASCULAR CARE

Race/Ethnicity Summary

2020 Report Year (2019 dates of service)

Optimal Vascular Care Components

Among Indigenous/Native patients

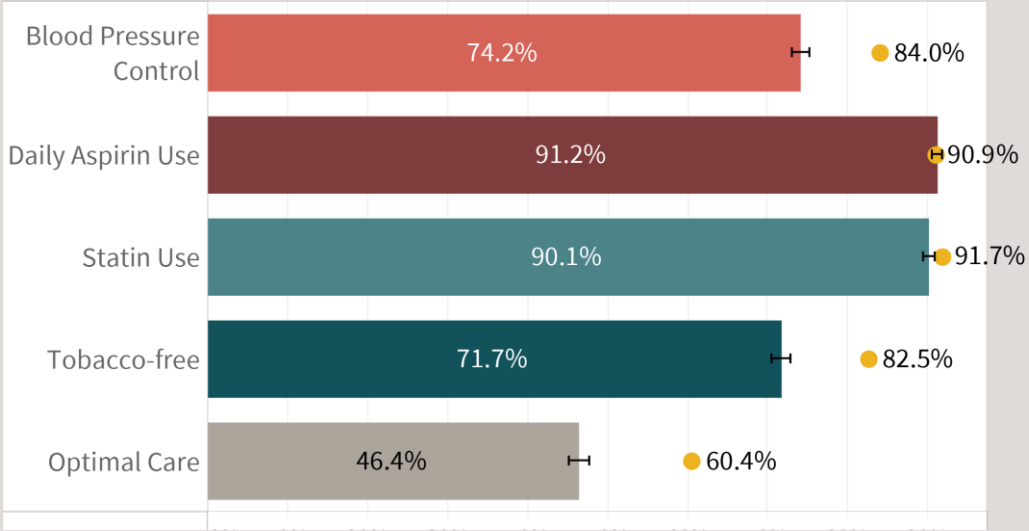


Patients who are Indigenous/Native and who have ischemic vascular disease have **significantly lower** rates on **two out of the four** optimal vascular care components. These components include blood pressure control and being tobacco-free.

Additionally, Indigenous/Native patients have the **lowest rate** of being **tobacco-free** (62.8%) among all race groups.

Optimal Vascular Care Components

Among Black patients



Patients who are Black and who have ischemic vascular disease have **significantly lower** rates on **three out of the four** optimal vascular care components. These components include blood pressure control, statin use and being tobacco-free.

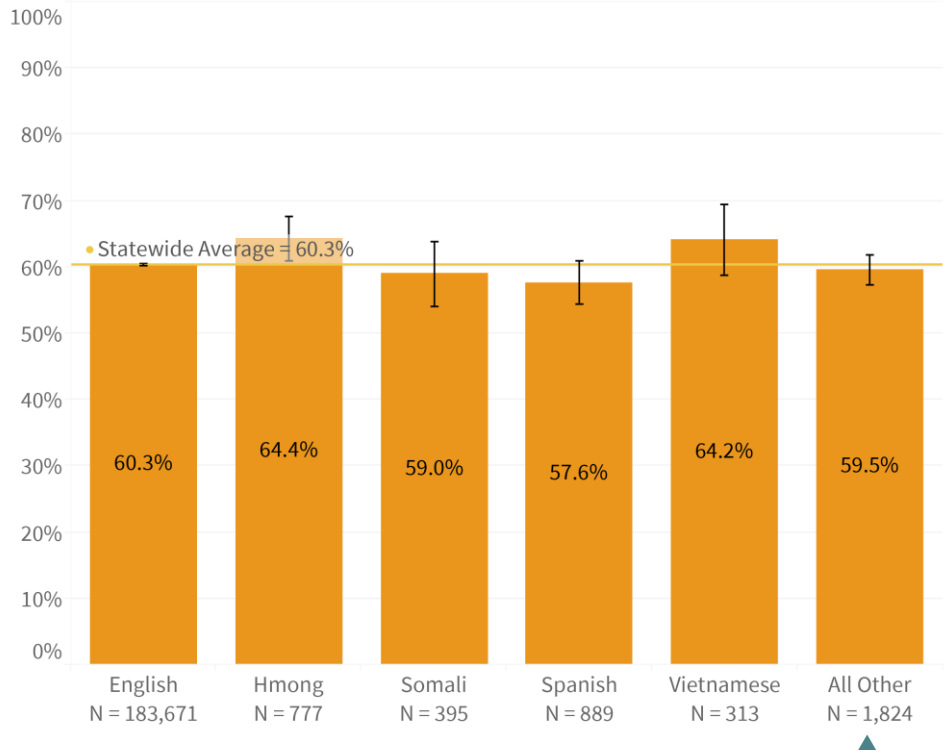
OPTIMAL VASCULAR CARE

Preferred Language Summary

2020 Report Year (2019 dates of service)

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 English, Hmong, Somali, Spanish or Vietnamese** have average rates of optimal vascular care compared to the statewide average.

● Statewide average for patients with Preferred Language information available
▼ Significantly lower than average ▲ Significantly higher than average
All Others: Combines all other languages not listed in the graph that were submitted for patients

45.1% English-speaking Black patients

61.0% Non-English-speaking Black patients

English-speaking Black patients have **significantly lower** rates of optimal vascular care compared to non-English-speaking Black patients.

61.2% English-speaking White patients

56.6% Non-English-speaking White patients

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

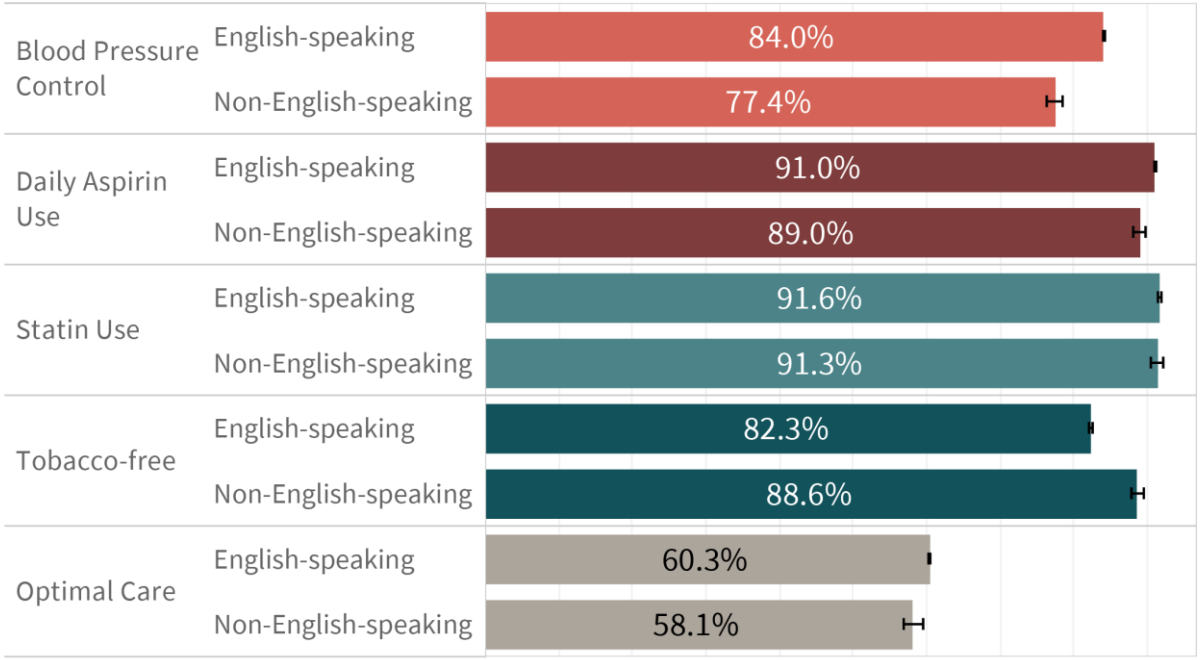
OPTIMAL VASCULAR CARE

Preferred Language Summary

2020 Report Year (2019 dates of service)

Optimal Vascular Care Components

Among English-speaking patients vs. non-English-speaking patients



English-speaking patients have **significantly higher** rates of **blood pressure control, daily aspirin use and optimal care** compared to **non-English-speaking patients.**

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

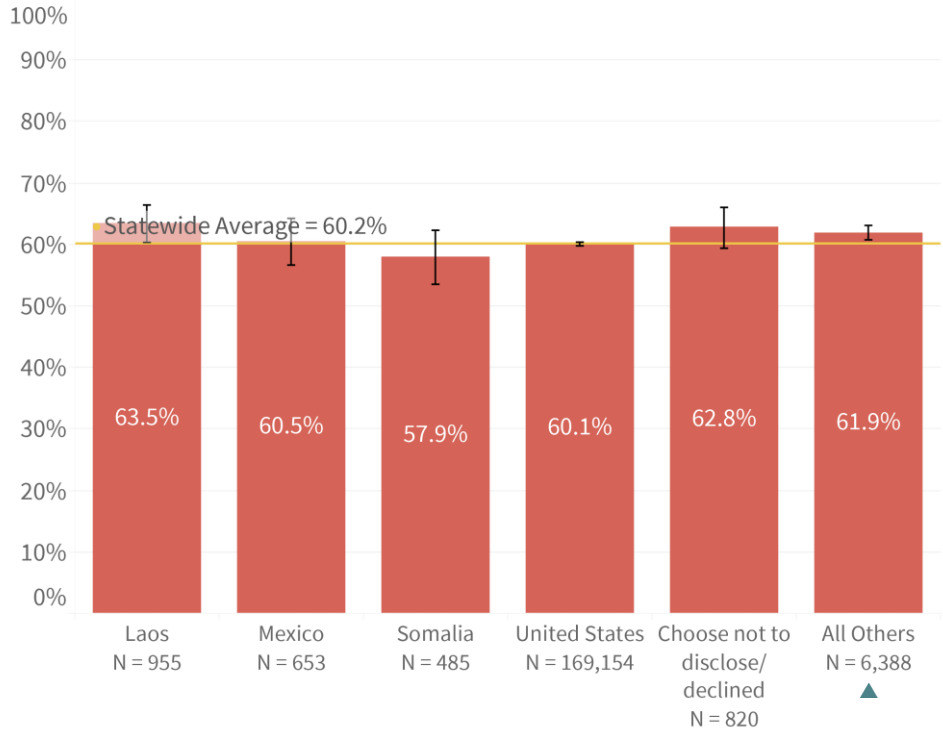
OPTIMAL VASCULAR CARE

Country of Origin Summary

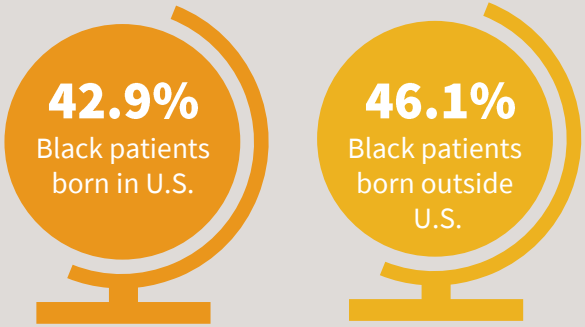
2020 Report Year (2019 dates of service)

Optimal Vascular Care

By Country of Origin



Patients from **Laos, Mexico, Somalia or the United States** or patients whose **country of origin was not disclosed** make up the largest portion of the eligible population.



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

● Statewide average for patients with Country of Origin information available
▼ Significantly lower than average ▲ Significantly higher than average
All Others: Combines all other countries not listed in the graph that were submitted for eligible patients

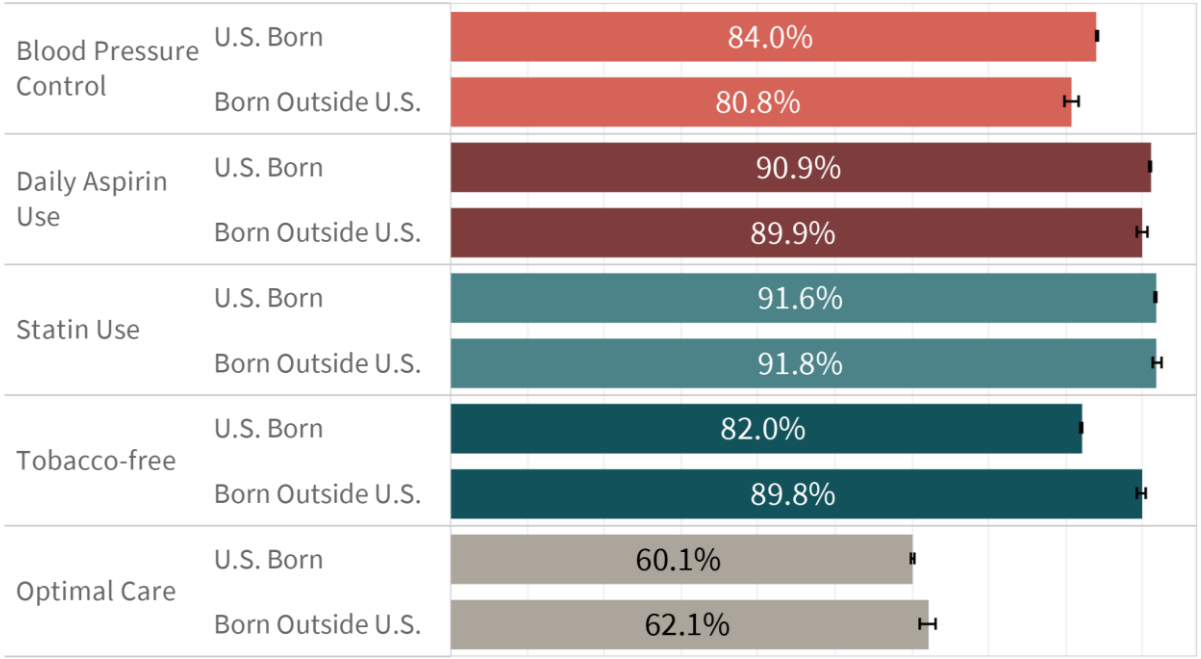
OPTIMAL VASCULAR CARE

Country of Origin Summary

2020 Report Year (2019 dates of service)

Optimal Vascular Care Components

Among U.S. born patients vs. patients born outside U.S.



U.S. born patients have **significantly higher** rates of **blood pressure control and daily aspirin use** compared to **patients born outside of the United States**.

However, **U.S. born patients** have **significantly lower** rates of being **tobacco-free and optimal care overall** compared to **patients born outside of the United States.**

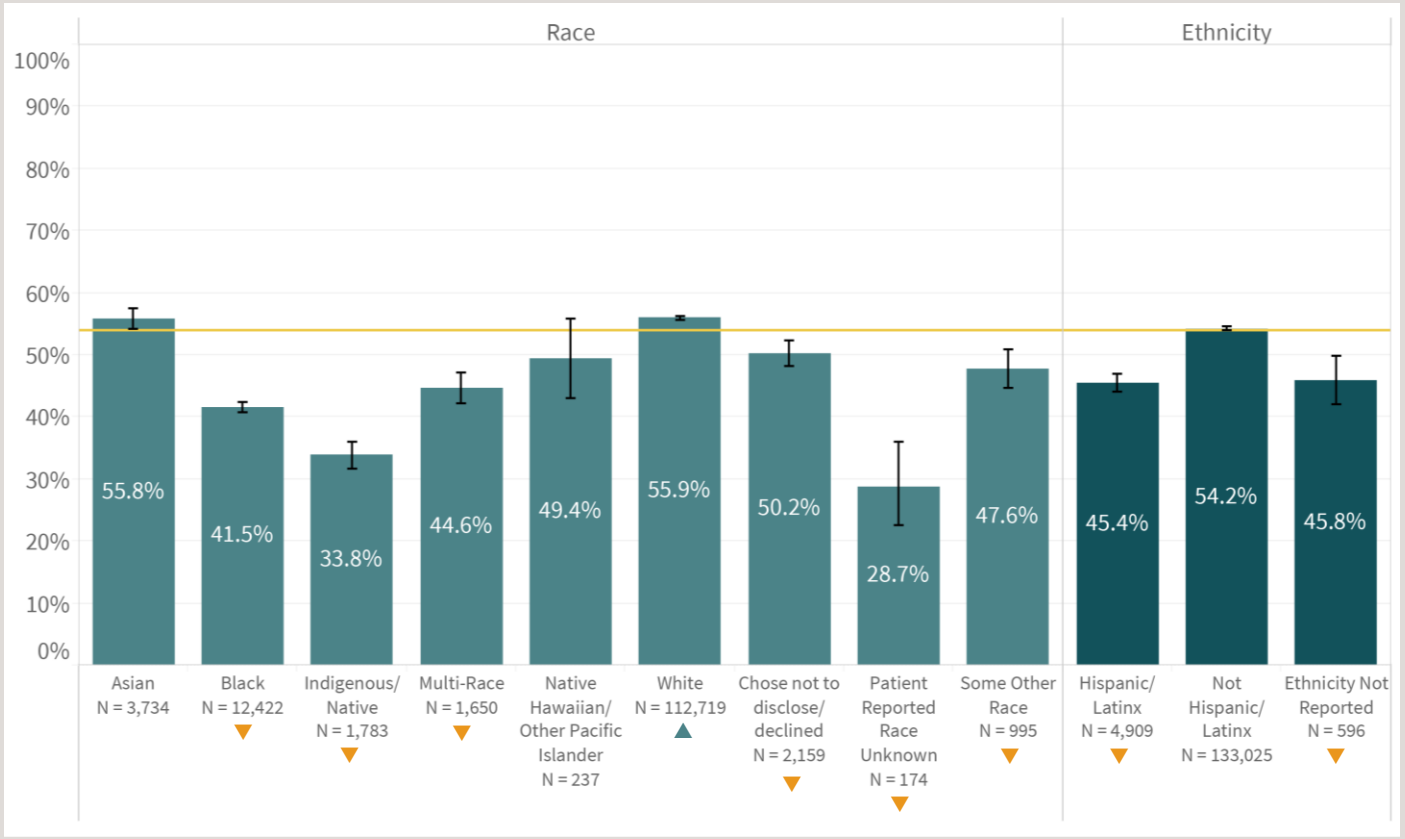
OPTIMAL ASTHMA CONTROL - ADULTS

Race/Ethnicity Summary

2020 Report Year (2019 dates of service)

Optimal Asthma Control - Adults

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 54.0% **Ethnicity average = 53.9%**

▼ Significantly lower than average
▲ Significantly higher than average

Adults who are Black, Indigenous/Native, Multi-Race or Hispanic/Latinx are among those who have **significantly lower** rates of optimal asthma control compared to the race/ethnicity average.

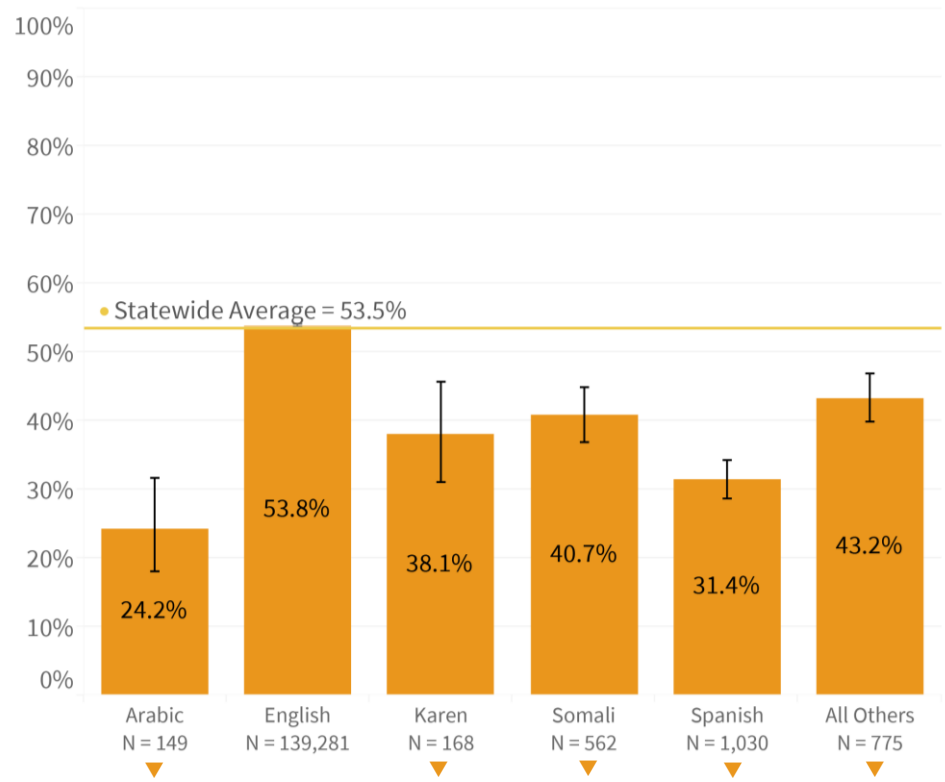
OPTIMAL ASTHMA CONTROL - ADULTS

Preferred Language Summary

2020 Report Year (2019 dates of service)

Optimal Asthma Control - Adults

By Preferred Language



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

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

48.7% English-speaking Hispanic/Latinx adults

31.6% Non-English-speaking Hispanic/Latinx adults

English-speaking Hispanic/Latinx adults have **significantly higher** rates of optimal asthma control compared to non-English-speaking Hispanic/Latinx adults.

● Statewide average for patients with Preferred Language information available
▼ Significantly lower than average ▲ Significantly higher than average
All Others: Combines all other languages not listed in the graph that were submitted for patients

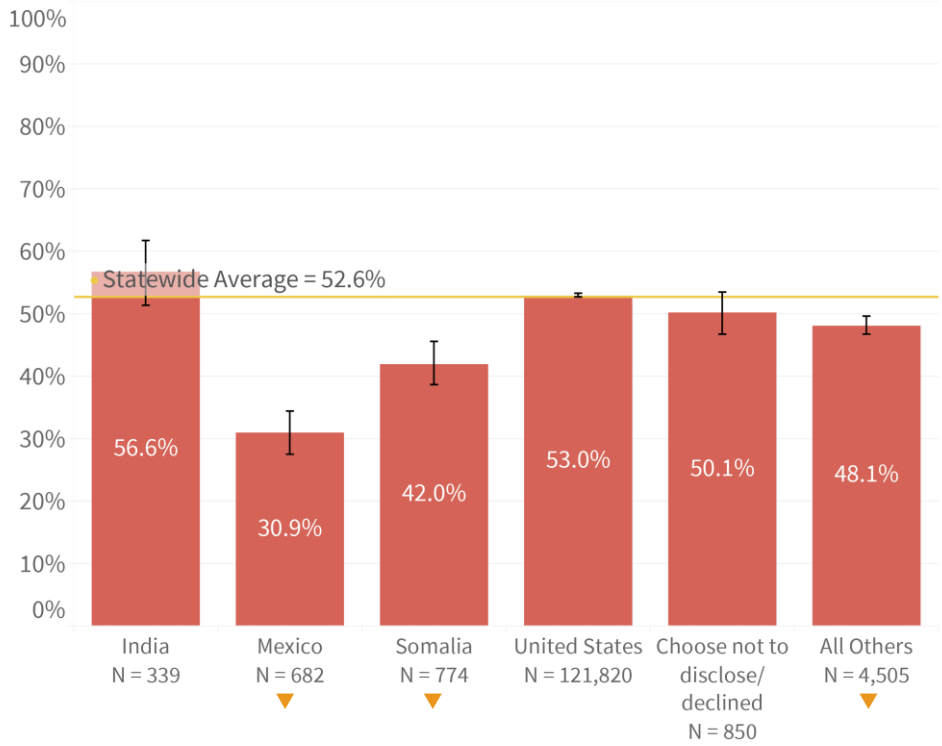
OPTIMAL ASTHMA CONTROL - ADULTS

Country of Origin Summary

2020 Report Year (2019 dates of service)

Optimal Asthma Control - Adults

By Country of Origin



Patients from **India, Mexico, Somalia or the United States** or adults who **country of origin was not disclosed** make up the largest portion of the eligible population.

Adults from **Mexico or Somalia** have **significantly lower** rates of optimal asthma control compared to the statewide average.

● Statewide average for patients with Country of Origin information available
▼ Significantly lower than average ▲ Significantly higher than average
All Others: Combines all other countries not listed in the graph that were submitted for eligible patients

55.3% White adults born in U.S.

44.2% 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 the United States.

39.7% Black adults born in U.S.

46.4% Black adults born outside U.S.

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

46.8% Hispanic/ Latinx adults born in U.S.

38.2% Hispanic/ Latinx adults born outside U.S.

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

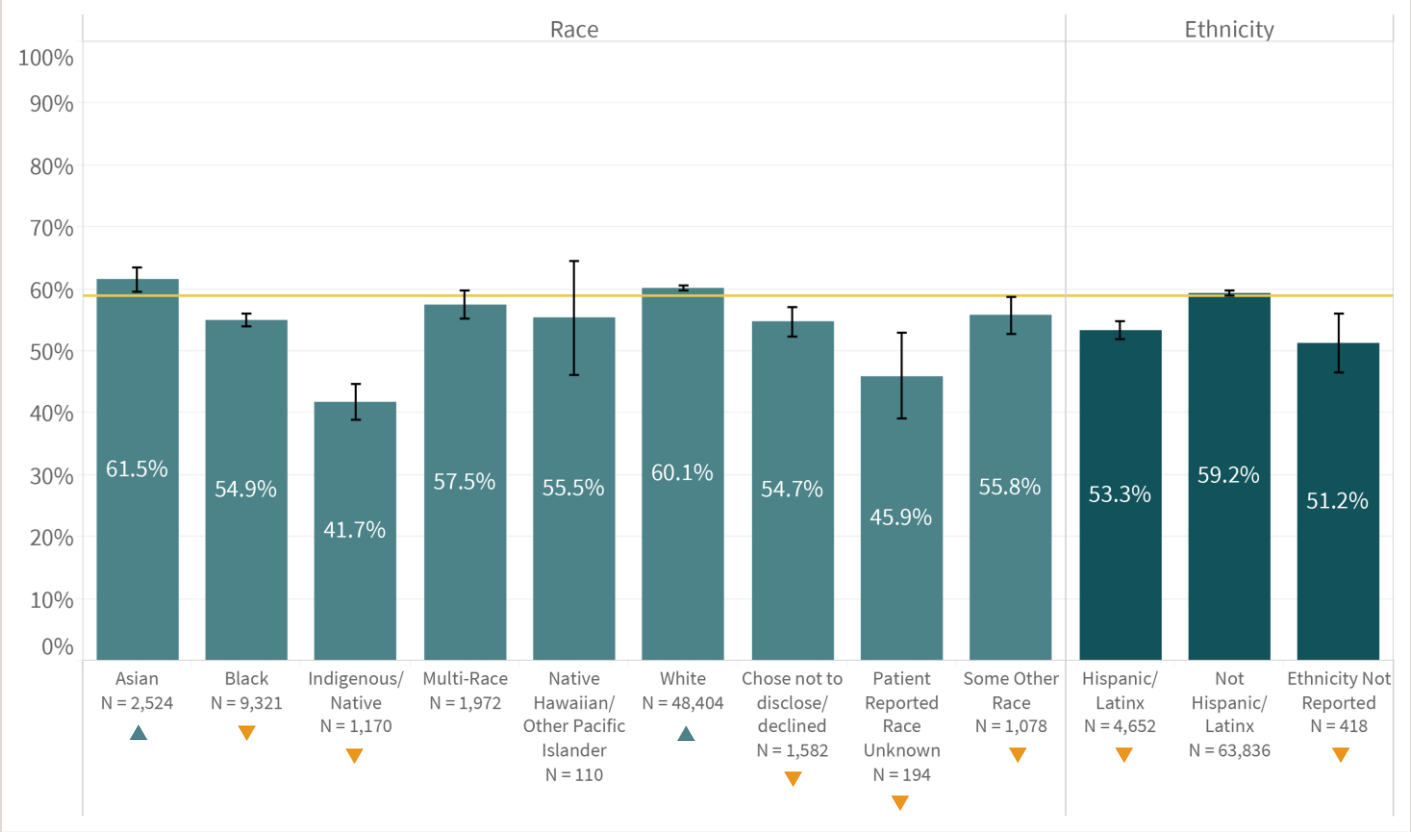
OPTIMAL ASTHMA CONTROL - CHILDREN

Race/Ethnicity Summary

2020 Report Year (2019 dates of service)

Optimal Asthma Control - Children

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 58.8% **Ethnicity average = 58.8%**

▼ Significantly lower than average
▲ Significantly higher than average

Children who are Asian, Black, Indigenous or Hispanic/Latinx are among those who have **significantly lower** rates of optimal asthma control compared to the race/ethnicity average.

White, Hispanic/Latinx or not Hispanic/Latinx female children have **significantly lower** rates of optimal asthma control compared to males within the respective races/ethnicities.

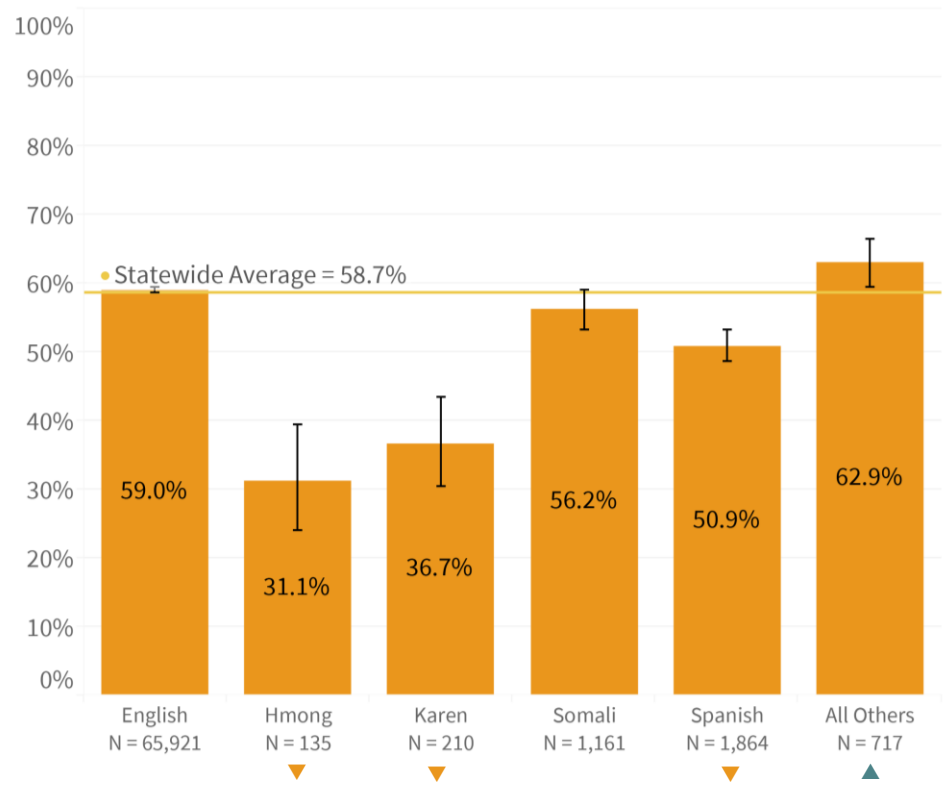
OPTIMAL ASTHMA CONTROL - CHILDREN

Preferred Language Summary

2020 Report Year (2019 dates of service)

Optimal Asthma Control - Children

By Preferred Language



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

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

66.0% English-speaking Asian children

49.4% Non-English-speaking Asian children

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

61.0% English-speaking White children

38.3% Non-English-speaking White children

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

● Statewide average for patients with Preferred Language information available
▼ Significantly lower than average ▲ Significantly higher than average
All Others: Combines all other languages not listed in the graph that were submitted for patients

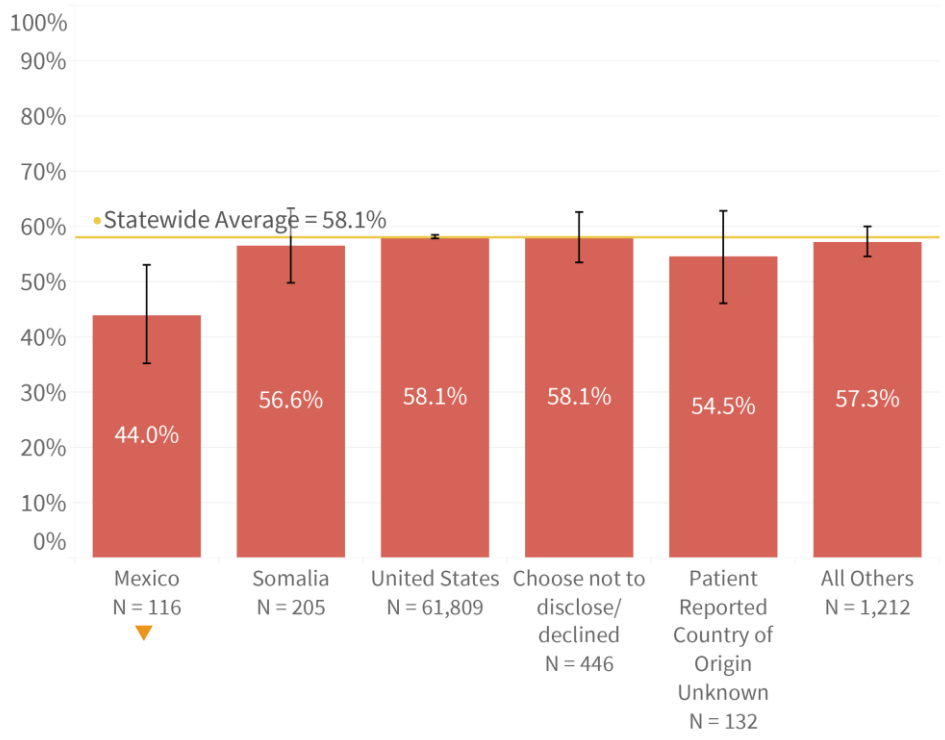
OPTIMAL ASTHMA CONTROL - CHILDREN

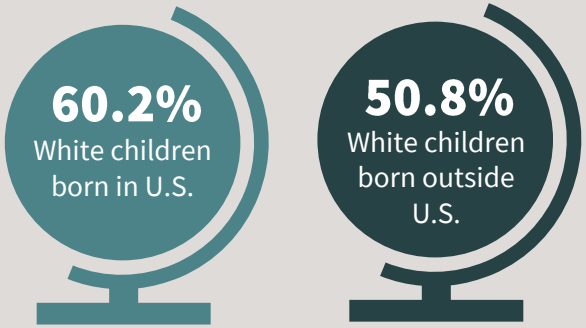
Country of Origin Summary

2020 Report Year (2019 dates of service)

Optimal Asthma Control - Children

By Country of Origin





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

Children whose **country of origin was not disclosed or who reported their country of origin is unknown** or children from **Mexico, Somalia or the United States** make up the largest portion of the eligible child population.

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

● Statewide average for patients with Country of Origin information available
▼ Significantly lower than average ▲ Significantly higher than average

All Others: Combines all other countries not listed in the graph that were submitted for eligible patients

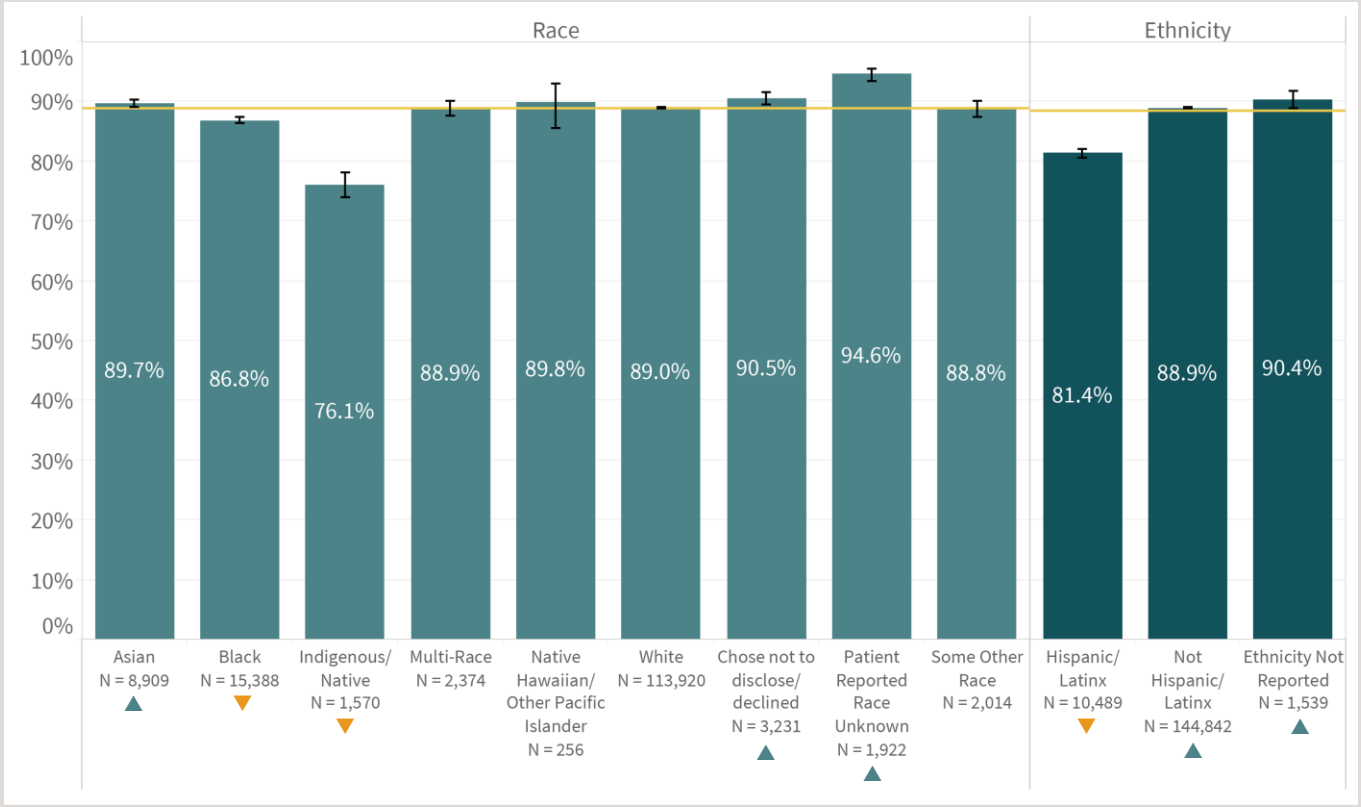
ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

Race/Ethnicity Summary

2020 Report Year (2019 dates of service)

Adolescent Mental Health and/or Depression Screening

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 88.8% **Ethnicity average = 88.4%**

▼ Significantly lower than average
▲ Significantly higher than average

Adolescents who are Black, Indigenous/Native or Hispanic/Latinx have **significantly lower** rates of adolescent mental health and/or depression screening compared to the race/ethnicity average.

White or Hispanic/Latinx female adolescents have **significantly higher** rates of mental health screening compared to males within the respective races/ethnicities.

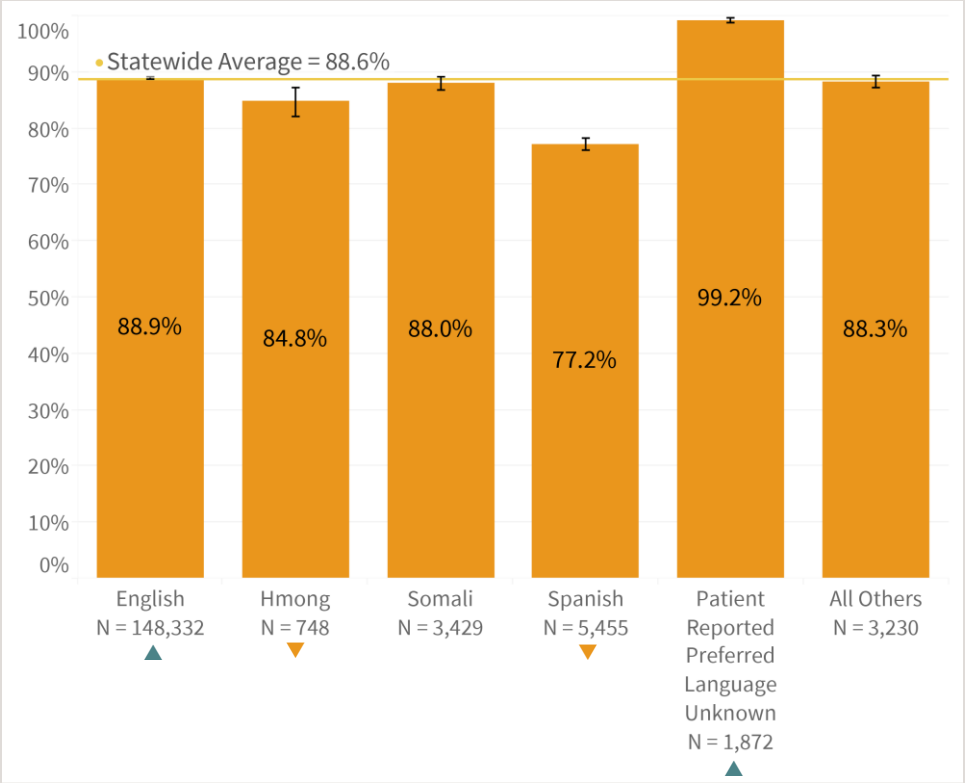
ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

Preferred Language Summary

2020 Report Year (2019 dates of service)

Adolescent Mental Health and/or Depression Screening

By Preferred Language



Adolescents who **speak English, Hmong, Somali, Spanish** or who **reported that their preferred language is unknown** make up the largest portion of the eligible adolescent population.

Adolescents who **speak Hmong or Spanish** have **significantly lower** rates of mental health screening compared to the statewide average.

● Statewide average for patients with Preferred Language information available
▼ Significantly lower than average ▲ Significantly higher than average
All Others: Combines all other languages not listed in the graph that were submitted for patients

90.4% English-speaking Asian adolescents

87.4% Non-English-speaking Asian adolescents

English-speaking Asian children have **significantly higher** rates of mental health screening compared to non-English-speaking Asian adolescents.

88.9% English-speaking White adolescents

84.8% Non-English-speaking White adolescents

English-speaking White patients have **significantly higher** rates of mental health screening compared to non-English-speaking White adolescents.

85.7% English-speaking Hispanic/Latinx adolescents

76.4% Non-English-speaking Hispanic/Latinx adolescents

English-speaking Hispanic/Latinx adolescents have **significantly higher** rates of mental health screening compared to non-English-speaking Hispanic/Latinx adolescents.

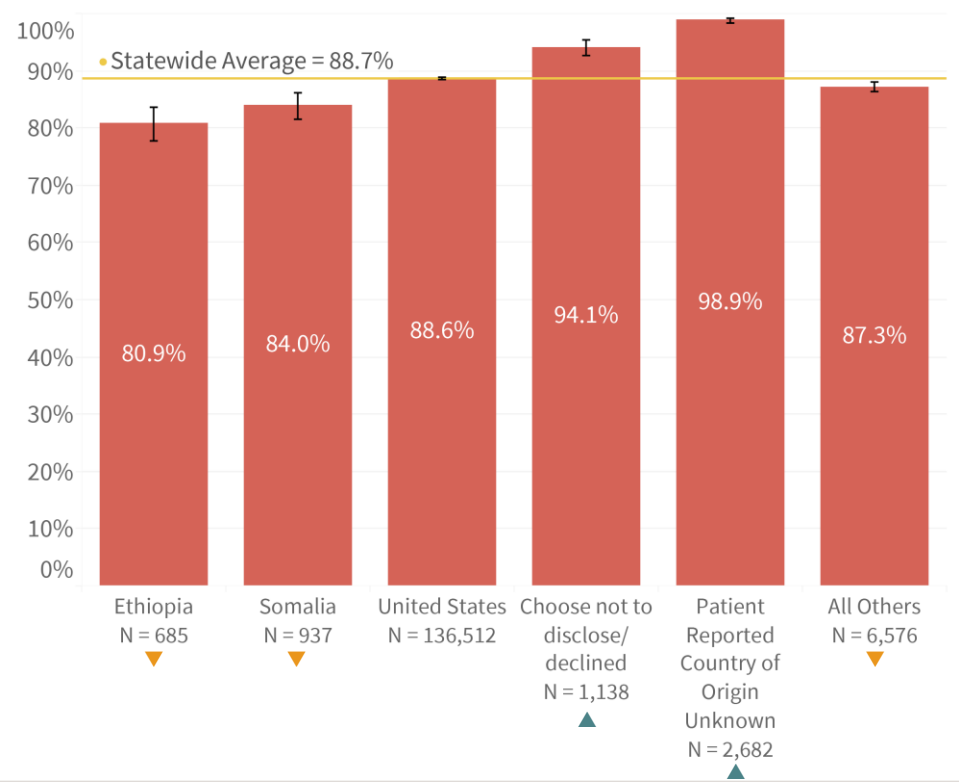
ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

Country of Origin Summary

2020 Report Year (2019 dates of service)

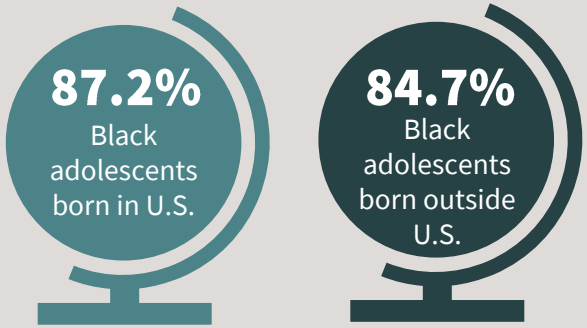
Adolescent Mental Health and/or Depression Screening

By Country of Origin

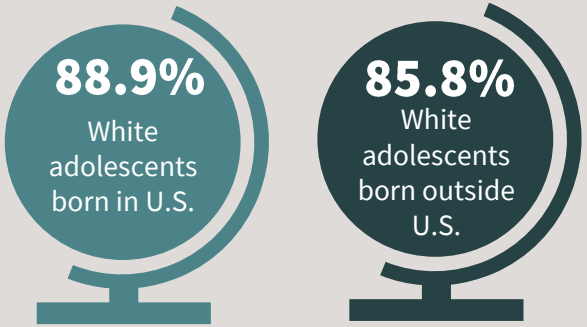


Adolescents from **Ethiopia, Somalia or the United States, whose country of origin was not disclosed** or **who reported their country of origin is unknown** make up the largest portion of the eligible adolescent population.

Adolescents from **Ethiopia or Somalia** have **significantly lower** rates of mental health screening compared to the statewide average.



Black adolescents born in the United States have **significantly higher** rates of mental health screening compared to Black adolescents born outside the United States.



White adolescents born in the United States have **significantly higher** rates of mental health screening compared to White adolescents born outside the United States.

● Statewide average for patients with Country of Origin information available
▼ Significantly lower than average ▲ Significantly higher than average
All Others: Combines all other countries not listed in the graph that were submitted for eligible patients

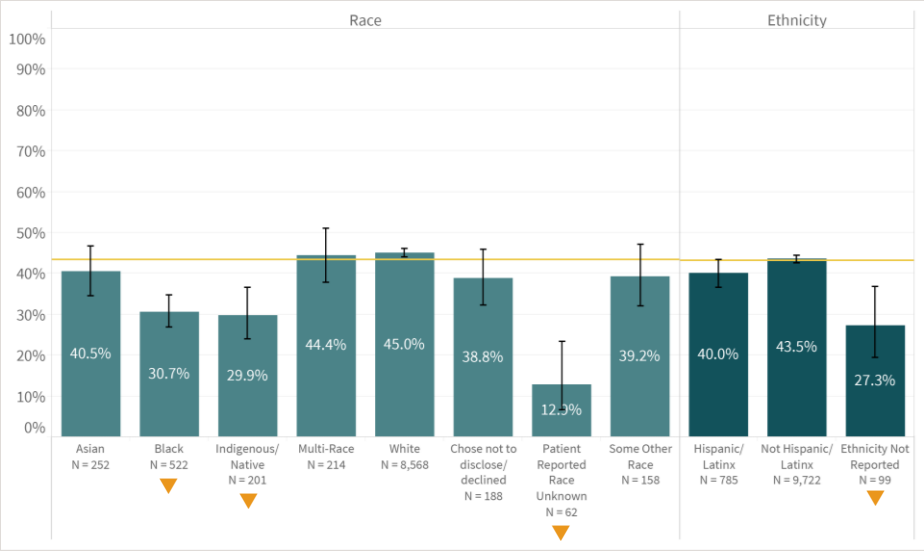
ADOLESCENT DEPRESSION: SIX MONTH MEASURES

Race/Ethnicity Summary

2020 Report Year (2017 - 2019 dates of service)

Adolescent Depression: Follow-up at Six Months

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 43.4% **Ethnicity average = 43.1%**

Patients who are Black have significantly lower rates of follow-up, response and remission at six months compared to the race/ethnicity averages. **Patients who are Indigenous/Native** have significantly lower rates of follow-up at six months compared to the race average.

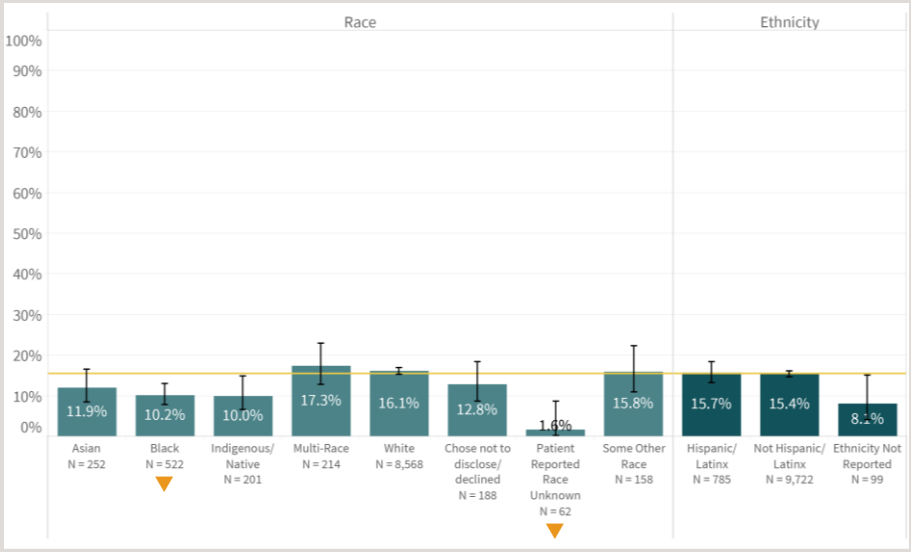
White female adolescents have significantly higher rates of depression follow-up at six and compared to White male adolescents. However, White female adolescents have significantly lower rates of remission at six months compared to White male adolescents.

▼ Significantly lower than average
▲ Significantly higher than average

NOTE: Native Hawaiian/Other Pacific Islander population had less than 30 patients, making the rates unreliable. While removed from the bar charts, this population remained in the calculation for the overall race average.

Adolescent Depression: Response at Six Months

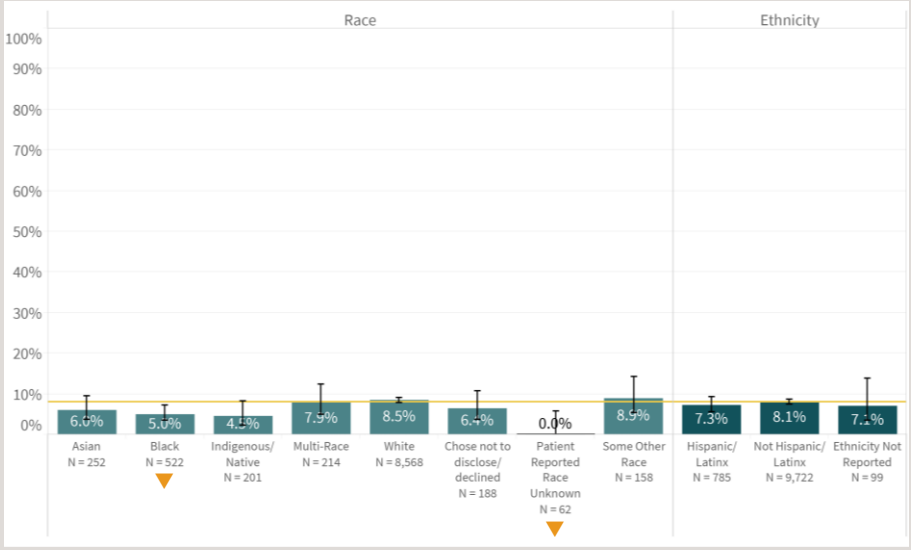
By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 15.5% **Ethnicity average = 15.4%**

Adolescent Depression: Remission at Six Months

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 8.1% **Ethnicity average = 8.0%**

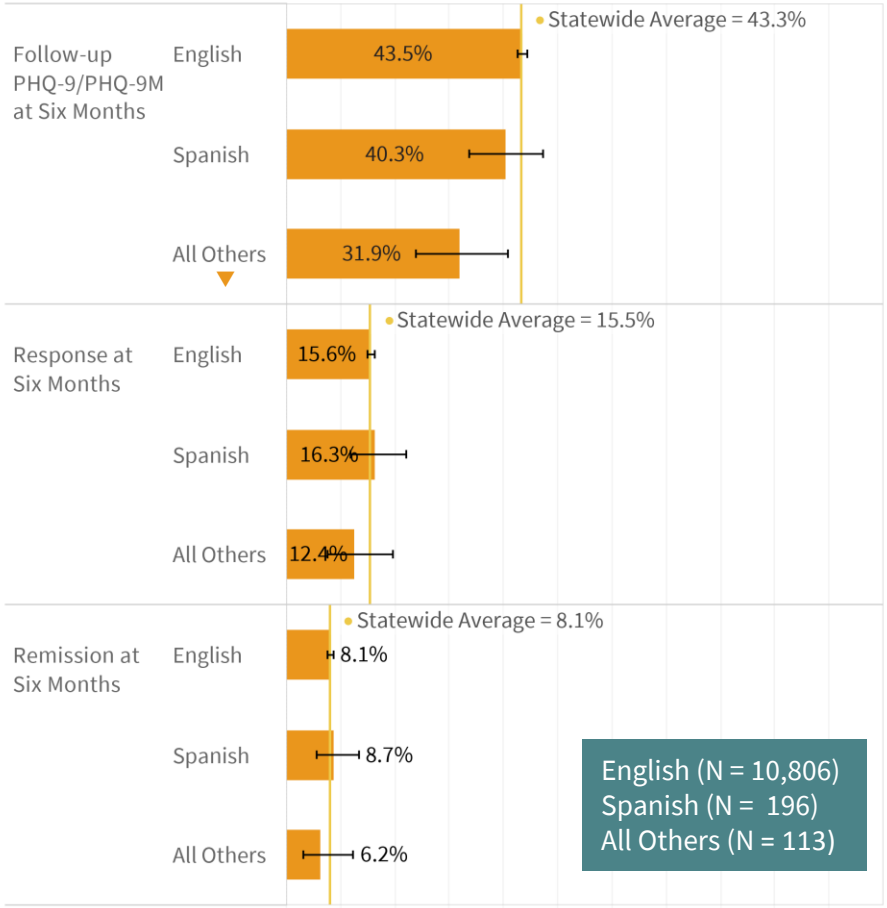
ADOLESCENT DEPRESSION: SIX MONTH MEASURES

Preferred Language Summary

2020 Report Year (2017 - 2019 dates of service)

Adolescent Depression: Six Month Measures

By Preferred Language



Adolescents who speak **English** or **Spanish** make up the largest portion of the eligible population.

Adolescents who speak **English** or **Spanish** have average rates of follow-up at six months, response at six months and remission at six months compared to the statewide average.

● Statewide average for patients with Preferred Language information available
▼ Significantly lower than average
▲ Significantly higher than average
All Others: Combines all other languages not listed in the graph that were submitted for patients

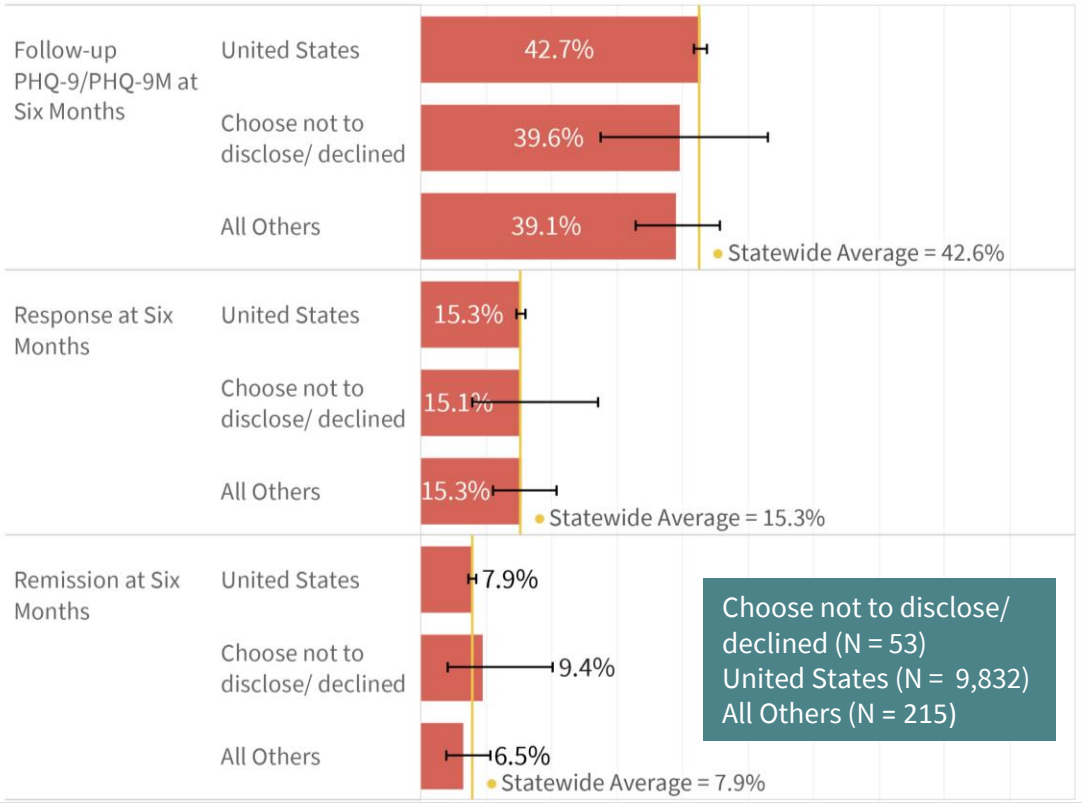
ADOLESCENT DEPRESSION: SIX MONTH MEASURES

Country of Origin Summary

2020 Report Year (2017 - 2019 dates of service)

Adolescent Depression: Six Month Measures

By Country of Origin



Adolescents from the **United States** or whose **country of origin was not disclosed** make up the largest portion of the eligible population.

Adolescents from the **United States** or whose **country of origin was not disclosed** have average rates of follow-up, response and remission at six months.

● Statewide average for patients with Country of Origin information available
▼ Significantly lower than average ▲ Significantly higher than average
All Others: Combines all other countries not listed in the graph that were submitted for eligible patients

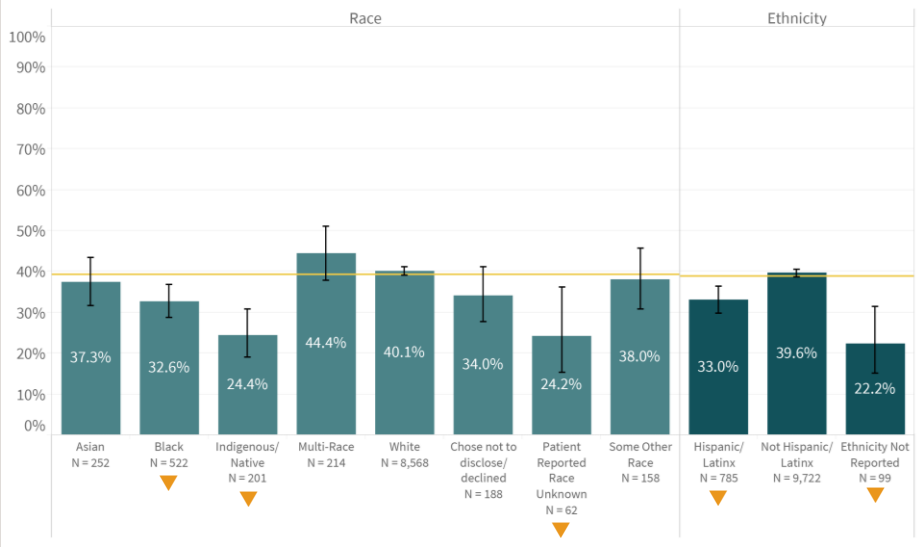
ADOLESCENT DEPRESSION: 12 MONTH MEASURES

Race/Ethnicity Summary

2020 Report Year (2017 - 2019 dates of service)

Adolescent Depression: Follow-up at 12 Months

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 39.2% **Ethnicity average = 38.9%**

Adolescents who are Indigenous/Native have **significantly lower** rates of follow-up and response six months compared to the race/ethnicity averages. Additionally, **adolescents who are Black or Hispanic/Latinx** are among those who have **significantly lower** rates of follow-up at six months compared to the race average.

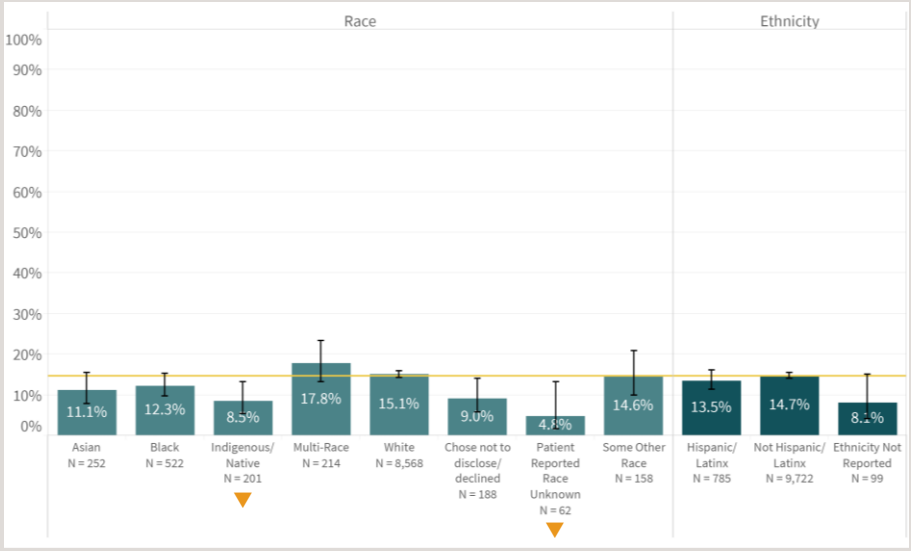
White female adolescents have **significantly higher** rates of depression follow-up at 12 months compared to White male adolescents.

▼ Significantly lower than average
▲ Significantly higher than average

NOTE: Native Hawaiian/Other Pacific Islander population had less than 30 patients, making the rates unreliable. While removed from the bar charts, this population remained in the calculation for the overall race average.

Adolescent Depression: Response at 12 Months

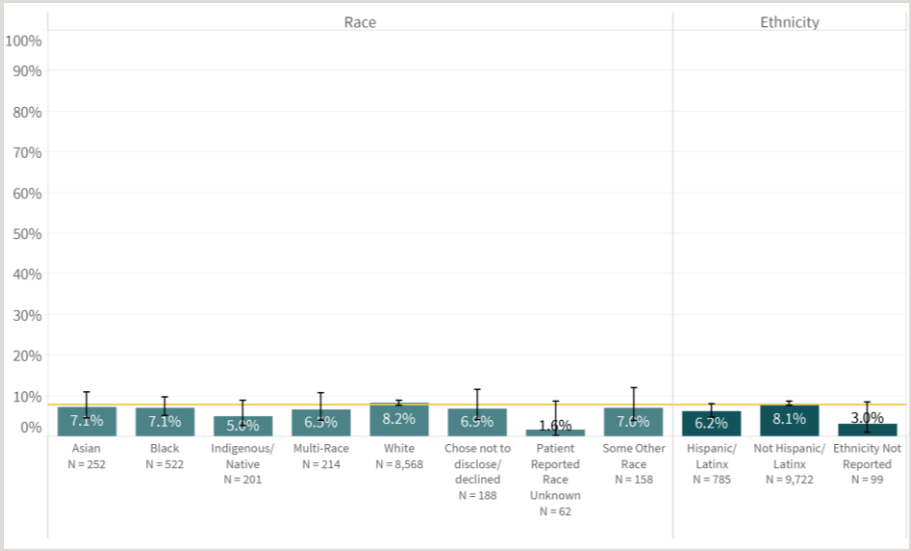
By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 14.6% **Ethnicity average = 14.6%**

Adolescent Depression: Remission at 12 Months

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 7.9% **Ethnicity average = 7.9%**

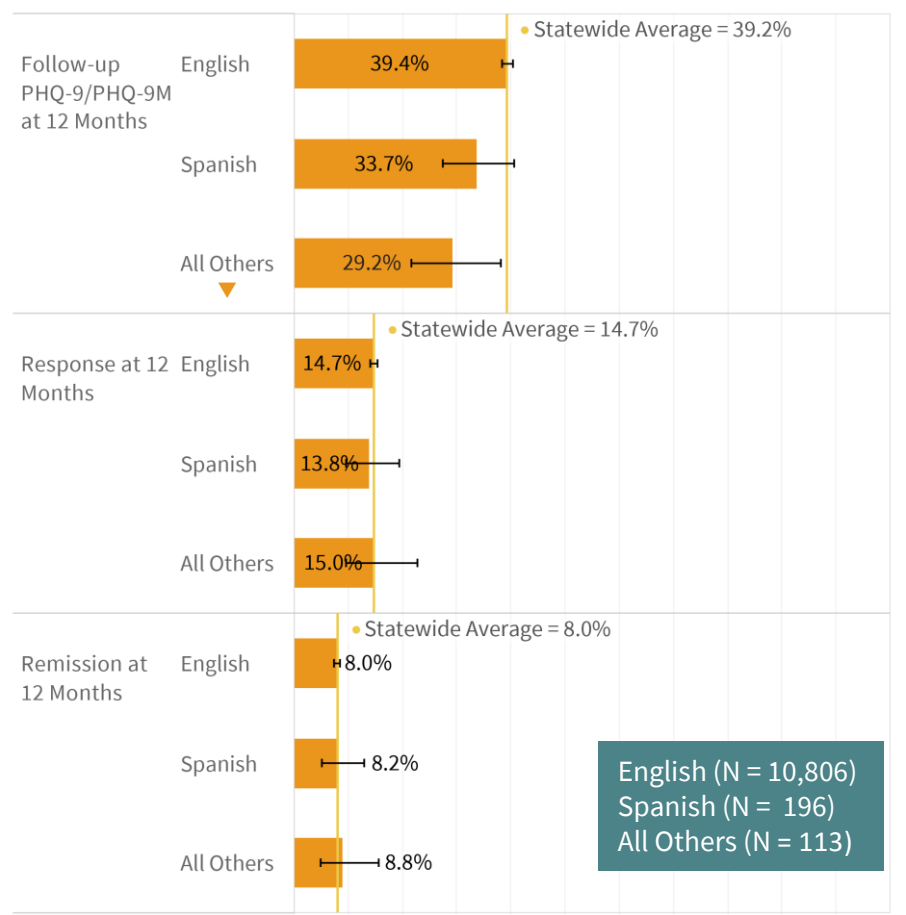
ADOLESCENT DEPRESSION: 12 MONTH MEASURES

Preferred Language Summary

2020 Report Year (2017 - 2019 dates of service)

Adolescent Depression: 12 Month Measures

By Preferred Language



Adolescents who speak **English** or **Spanish** make up the largest portion of the eligible population.

Adolescents who speak **English** or **Spanish** have average rates of follow-up at 12 months, response at 12 months and remission at 12 months compared to the statewide average.

● Statewide average for patients with Preferred Language information available
▼ Significantly lower than average
▲ Significantly higher than average
All Others: Combines all other languages not listed in the graph that were submitted for patients

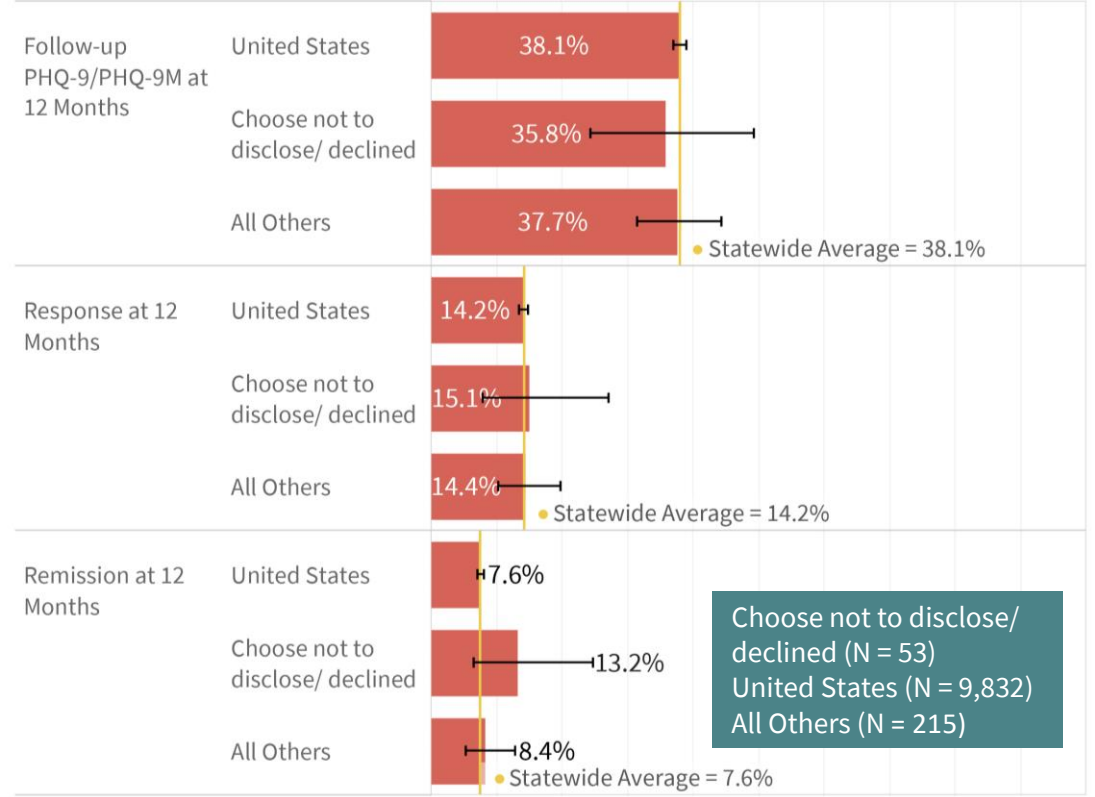
ADOLESCENT DEPRESSION: 12 MONTH MEASURES

Country of Origin Summary

2020 Report Year (2017 - 2019 dates of service)

Adolescent Depression: 12 Month Measures

By Country of Origin



Adolescents from the **United States** or whose **country of origin was not disclosed** make up the largest portion of the eligible population.

Adolescents from the **United States** or whose **country of origin was not disclosed** have average rates of follow-up, response and remission at 12 months.

● Statewide average for patients with Country of Origin information available
▼ Significantly lower than average ▲ Significantly higher than average
All Others: Combines all other countries not listed in the graph that were submitted for eligible patients

ADULT DEPRESSION: SIX MONTH MEASURES

Race/Ethnicity Summary

2020 Report Year (2017 - 2019 dates of service)

Adult Depression: Follow-up at Six Months

By Race/Ethnicity

Statewide average for patients with race/ethnicity information available
Race average = 48.9% **Ethnicity average = 48.6%**

Adults who are Black, Indigenous/Native, Multi-Race or Hispanic/Latinx are among those who have significantly lower rates of depression follow-up, response and remission at six months compared to the race/ethnicity averages. Additionally, **adults who are Asian** have significantly lower rates of depression response and remission at six months.

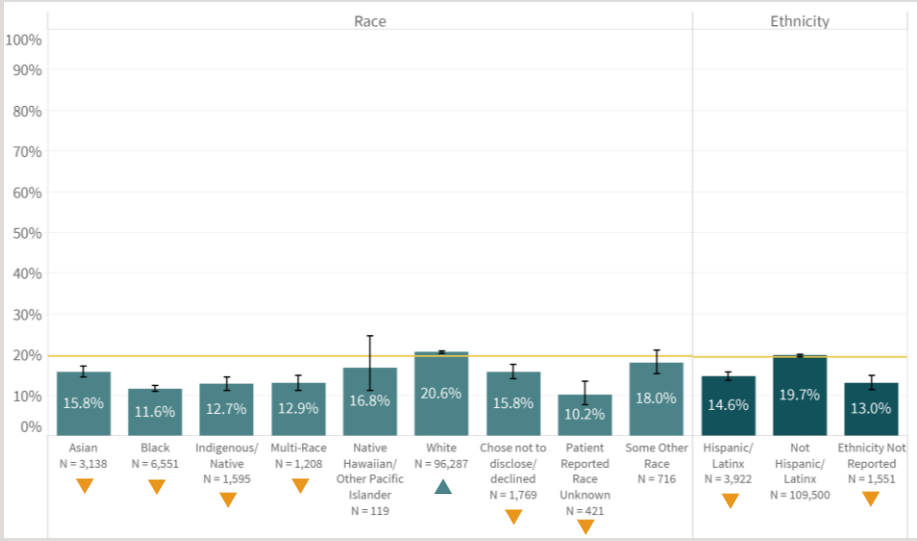
Black female adults have significantly higher rates of depression follow-up and response at six months compared to Black male adults.

Indigenous/Native and Hispanic/Latinx female adults have significantly higher rates of depression follow-up at six months compared to Indigenous/Native and Hispanic/Latinx male adults, respectively.

▼ Significantly lower than average
▲ Significantly higher than average

Adult Depression: Response at Six Months

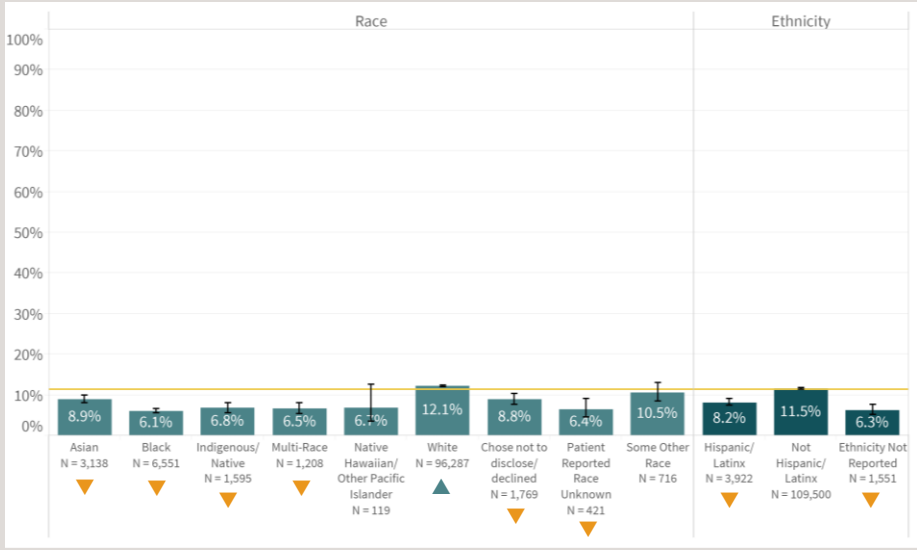
By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 19.6% **Ethnicity average = 19.5%**

Adult Depression: Remission at Six Months

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 11.4% **Ethnicity average = 11.3%**

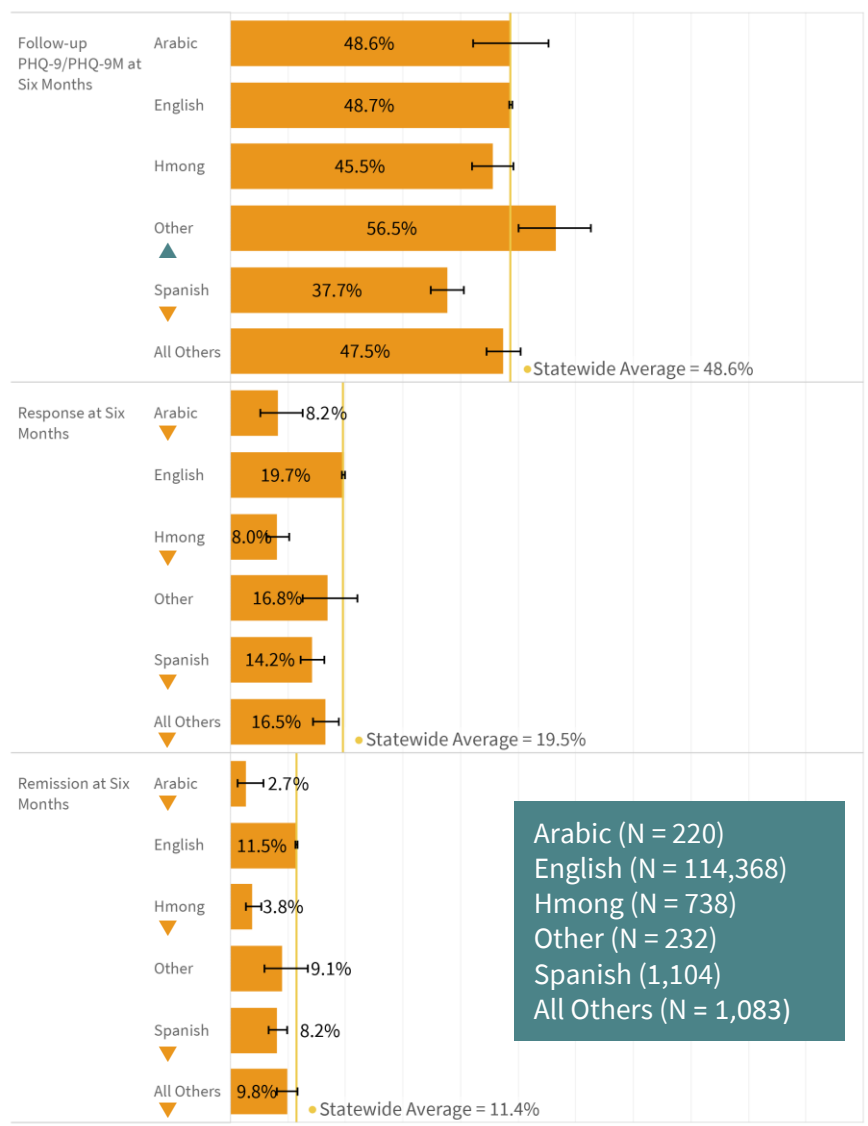
ADULT DEPRESSION: SIX MONTH MEASURES

Preferred Language Summary

2020 Report Year (2017 - 2019 dates of service)

Adult Depression: Six Month Measures

By Preferred Language



Adults who speak **Arabic, English, Hmong, Spanish or other language*** make up the largest portion of the eligible population.

Adults who speak **Spanish** have **significantly lower** rates of follow-up, response and remission at six months compared to the statewide average.

Adults who speak **Hmong or Arabic** **significantly lower** rates of response and remission at six months compared to the statewide average.

● Statewide average for patients with Preferred Language information available
▼ Significantly lower than average
▲ Significantly higher than average
*Other: Patient indicated their preferred language was not listed
All Others: Combines all other languages not listed in the graph that were submitted for patients

45.3% English-speaking Asian adults

50.9% Non-English-speaking Asian adults

English-speaking Asian adults have **significantly lower** rates of follow-up at six months compared to non-English-speaking Asian adults.

20.8% English-speaking White adults

12.5% Non-English-speaking White adults

English-speaking White adults have **significantly higher** rates of response at six months compared to non-English-speaking White adults.

5.9% English-speaking Black adults

10.3% Non-English-speaking Black adults

English-speaking Black adults have **significantly lower** rates of remission at six months compared to non-English-speaking Black adults.

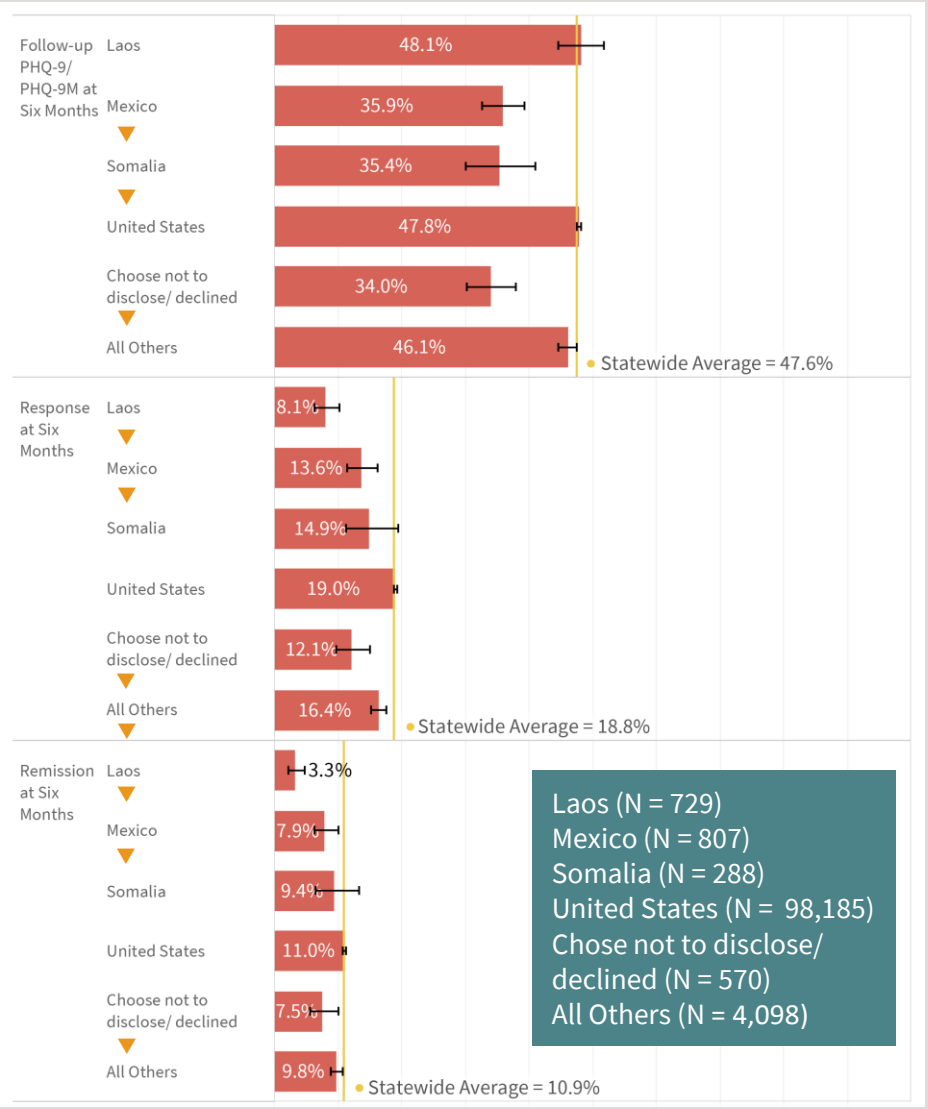
ADULT DEPRESSION: SIX MONTH MEASURES

Country of Origin Summary

2020 Report Year (2017 - 2019 dates of service)

Adult Depression: Six Month Measures

By Country of Origin



Adults from **Laos, Mexico, Somalia, the United States** or whose **country of origin was not disclosed** make up the largest portion of the eligible population.

Adults from Mexico have rates that are **significantly lower** than the statewide average for follow-up, response and remission at six months.

While the rate of follow-up at six months for adults from **Laos** is average, these patients have rates that are **significantly lower** than the statewide average for both response and remission at six months.

Adults from **Somalia** have average rates of response and remission at six months, but **significantly lower** rates of follow-up at six months compared to the statewide average.

- Statewide average for patients with Country of Origin information available
- ▼ Significantly lower than average
- ▲ Significantly higher than average

All Others: Combines all other countries not listed in the graph that were submitted for eligible patients

38.8% Asian adults born in U.S.

49.3% Asian adults born outside U.S.

Asian adults born in the United States have **significantly lower** rates of follow-up at six months compared to Asian adults born outside the United States.

Response **10.4%** Remission **5.1%** — Black adults born in the U.S.

Response **13.8%** Remission **8.7%** — Black adults born in outside U.S.

Black adults born in the United States have **significantly lower** rates of response and remission at six months compared to Black adults born outside the United States.

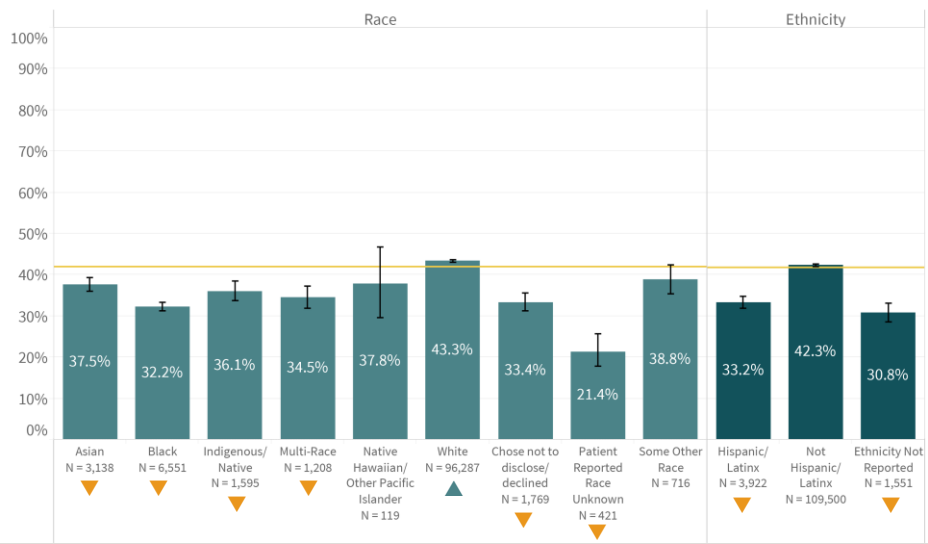
ADULT DEPRESSION: 12 MONTH MEASURES

Race/Ethnicity Summary

2020 Report Year (2017- 2019 dates of service)

Adult Depression: Follow-up at 12 Months

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 42.0% **Ethnicity average = 41.8%**

Patients who are Asian, Black, Indigenous/Native, Multi-Race or Hispanic/Latinx are among those who have **significantly lower** rates of depression follow-up, response and remission at 12 months compared to the race/ethnicity averages.

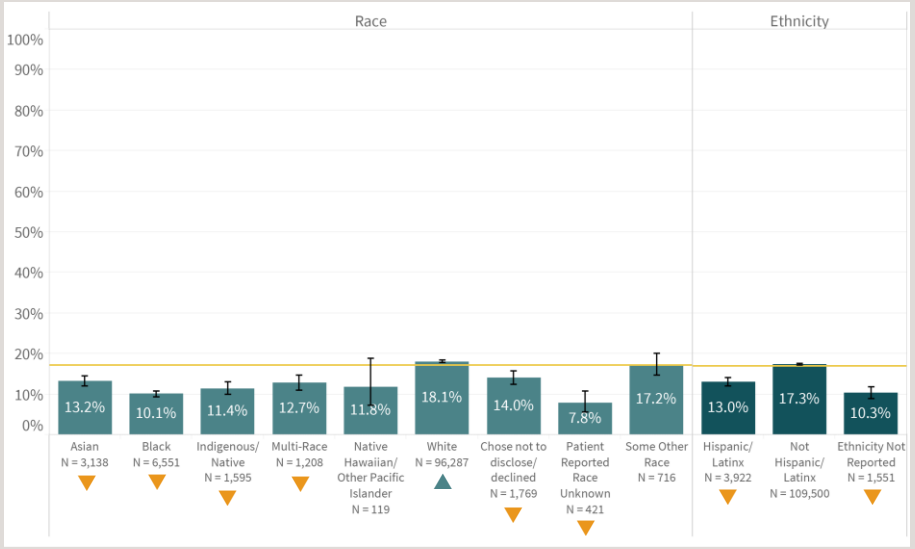
Indigenous/Native, Black and White female adults have **significantly higher** rates of depression follow-up, response and remission at 12 months compared to Indigenous/Native, Black and White male adults, respectively.

Hispanic/Latinx female patients have **significantly higher** rates of follow-up at 12 months compared to Hispanic/Latinx male adults.

▼ Significantly lower than average
▲ Significantly higher than average

Adult Depression: Response at 12 Months

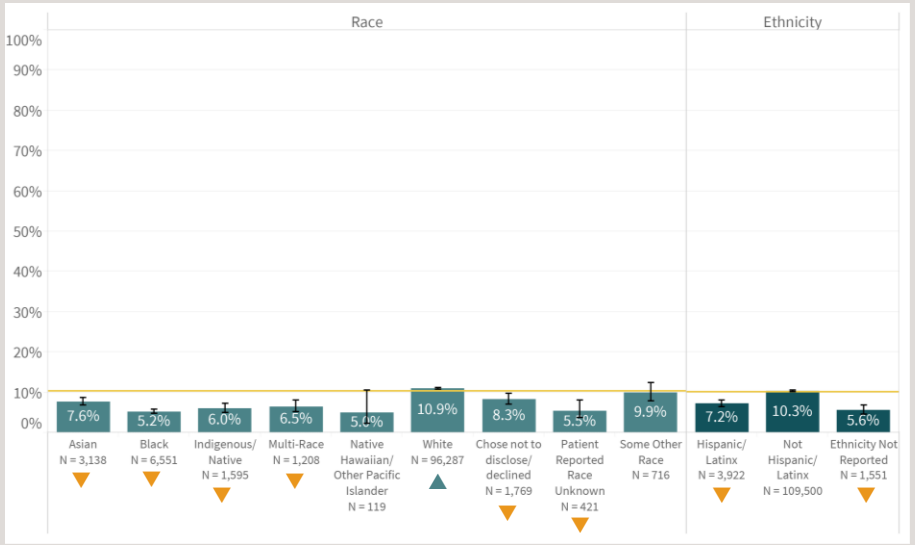
By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 17.2% **Ethnicity average = 17.0%**

Adult Depression: Remission at 12 Months

By Race/Ethnicity



Statewide average for patients with race/ethnicity information available
Race average = 10.3% **Ethnicity average = 10.2%**

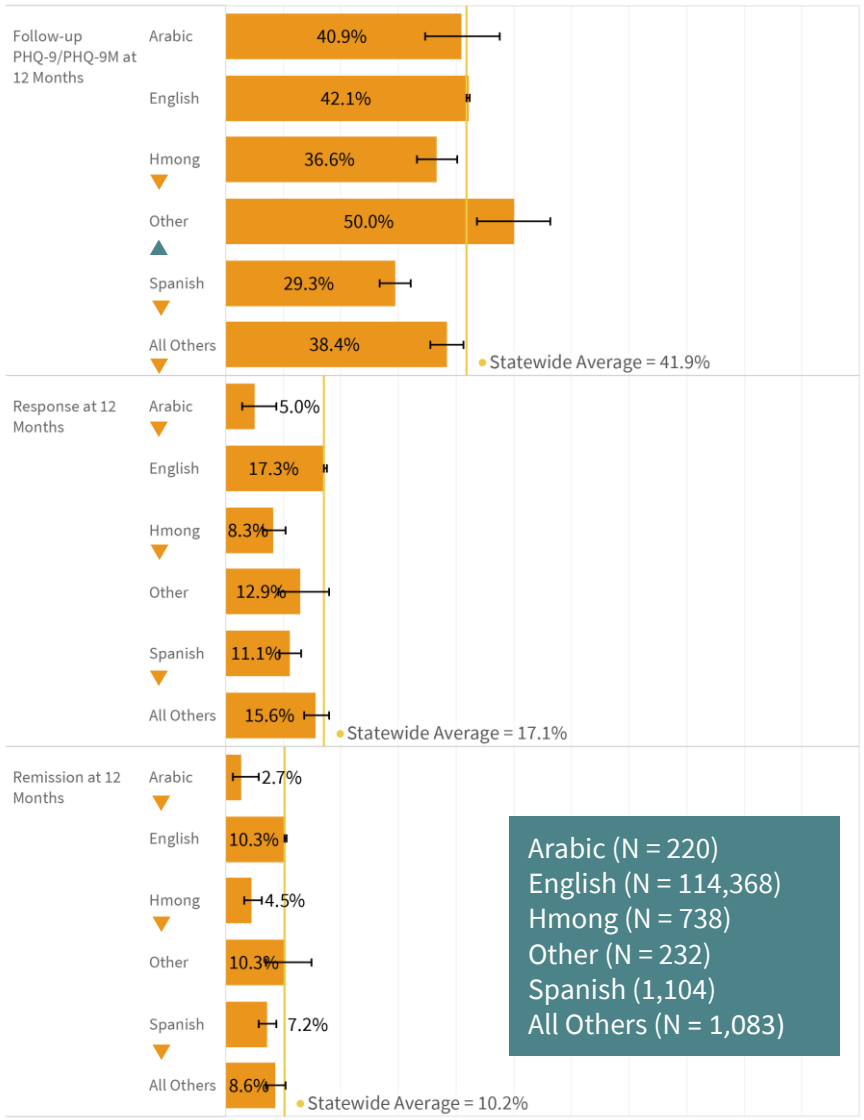
ADULT DEPRESSION: 12 MONTH MEASURES

Preferred Language Summary

2020 Report Year (2017 - 2019 dates of service)

Adult Depression: 12 Month Measures

By Preferred Language



Arabic (N = 220)
English (N = 114,368)
Hmong (N = 738)
Other (N = 232)
Spanish (1,104)
All Others (N = 1,083)

Adults who speak **Arabic, English, Hmong, Spanish** or **other language*** make up the largest portion of the eligible population.

Adults who speak **Spanish or Hmong** have rates that are **significantly lower** than the statewide average for follow-up, response and remission at 12 months.

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

● Statewide average for patients with Preferred Language information available
▼ Significantly lower than average
▲ Significantly higher than average
*Other: Patient indicated their preferred language was not listed
All Others: Combines all other languages not listed in the graph that were submitted for patients

34.7%
English-speaking Hispanic/ Latinx adults

29.5%
Non-English-speaking Hispanic/ Latinx adults

English-speaking Hispanic/Latinx adults have **significantly higher** rates of follow-up at 12 months compared to non-English-speaking Hispanic/Latinx adults.

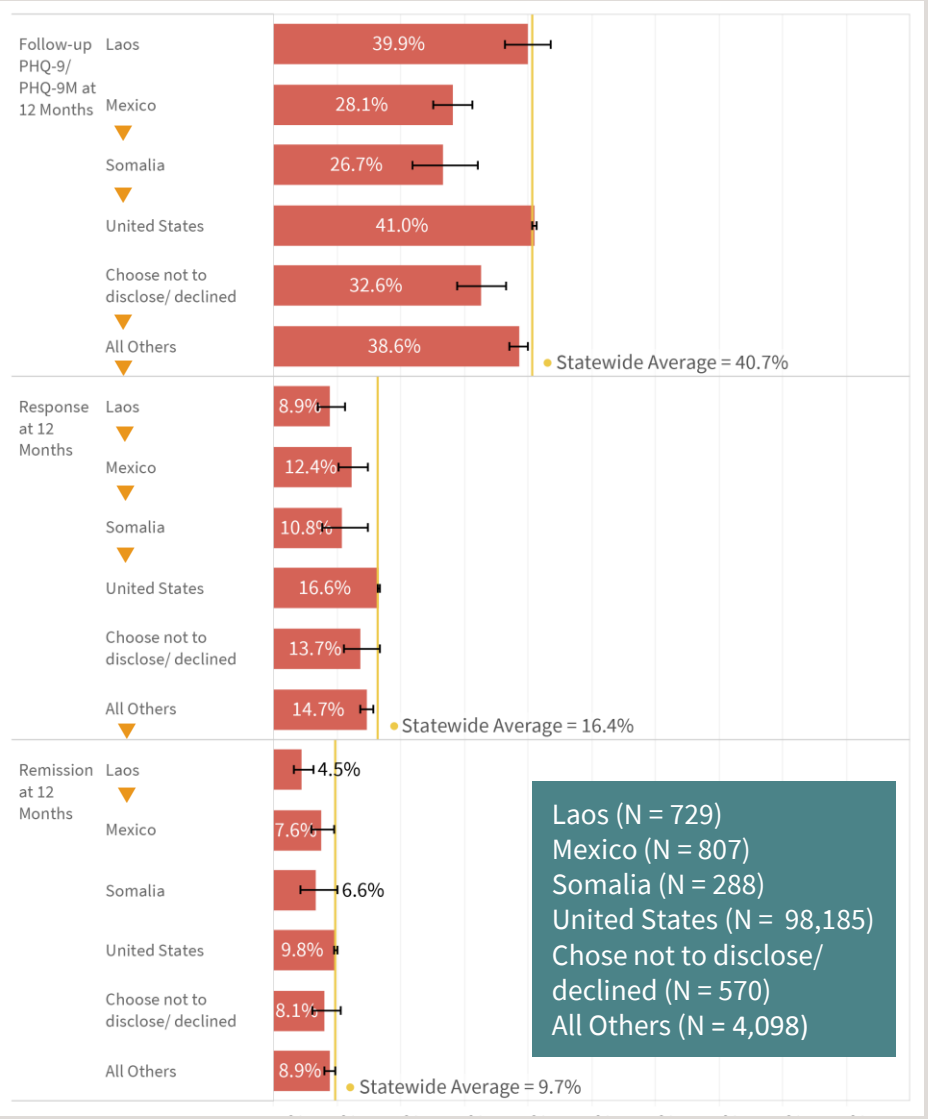
ADULT DEPRESSION: 12 MONTH MEASURES

Country of Origin Summary

2020 Report Year (2017 - 2019 dates of service)

Adult Depression: 12 Month Measures

By Country of Origin



Adults from **Laos, Mexico, Somalia, the United States** or whose **country of origin was not disclosed** make up the largest portion of the eligible population.

While the rate of follow-up at 12 months for adults from **Laos** is average, these patients have **significantly lower** rates of response and remission at 12 months compared to the statewide average.

Adults from **Mexico** or **Somalia** have **significantly lower** rates of follow-up and response at 12 months compared to the statewide average.

- ● Statewide average for patients with Country of Origin information available
- ▼ Significantly lower than average
- ▲ Significantly higher than average

All Others: Combines all other countries not listed in the graph that were submitted for eligible patients

28.7% Asian adults born in U.S.

38.7% Asian adults born outside U.S.

Asian adults born in the United States have **significantly lower** rates of follow-up at 12 months compared to Asian adults born outside the United States.

Response **9.0%** Remission **4.5%** — Black adults born in the U.S.

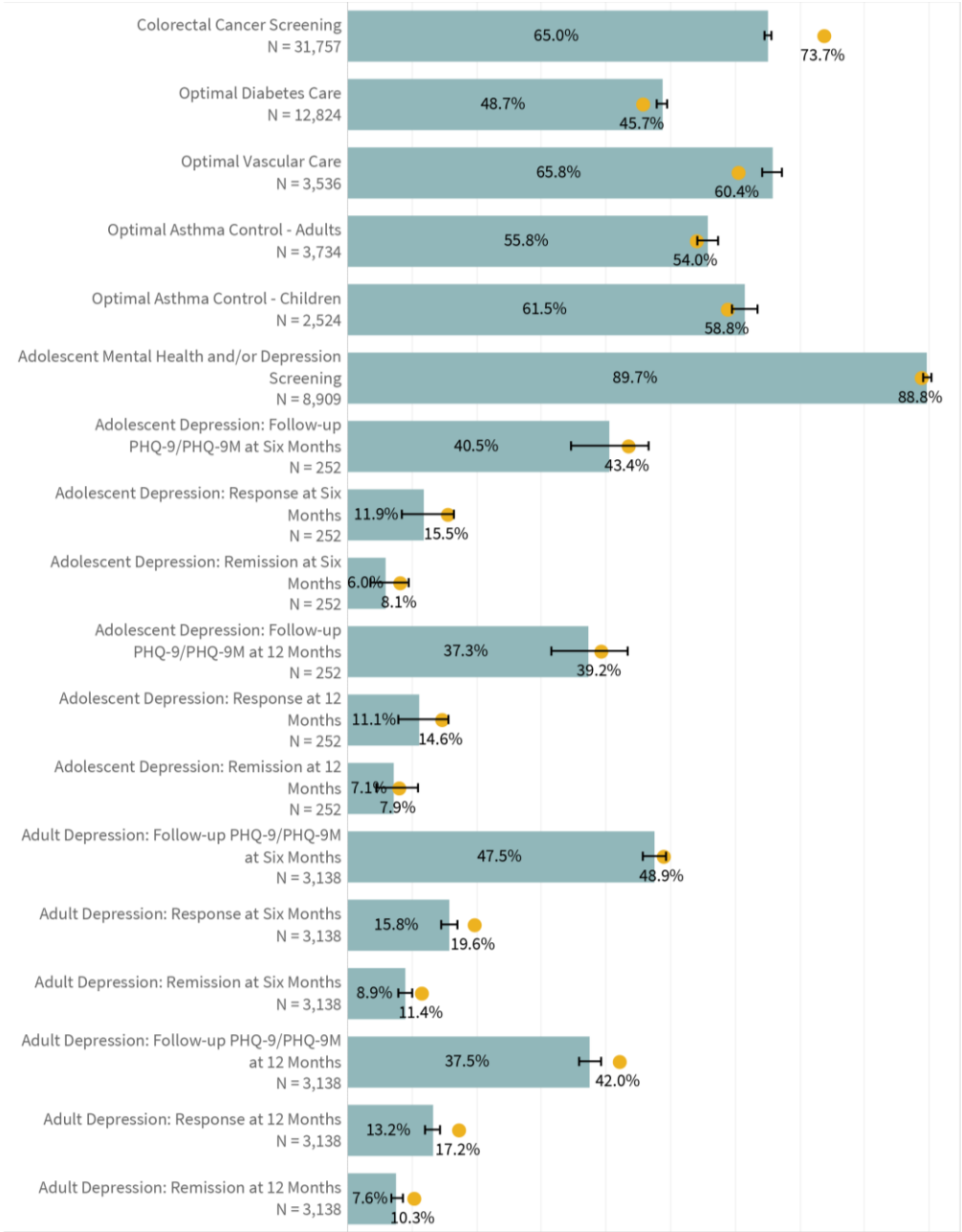
Response **12.9%** Remission **7.2%** — Black adults born in outside U.S.

Black adults born in the United States have **significantly lower** rates of response and remission at 12 months compared to Black adults born outside the United States.

Asian Patients

Snapshot Summary

2020 Report Year (2019 dates of service)



Eliminating Disparities

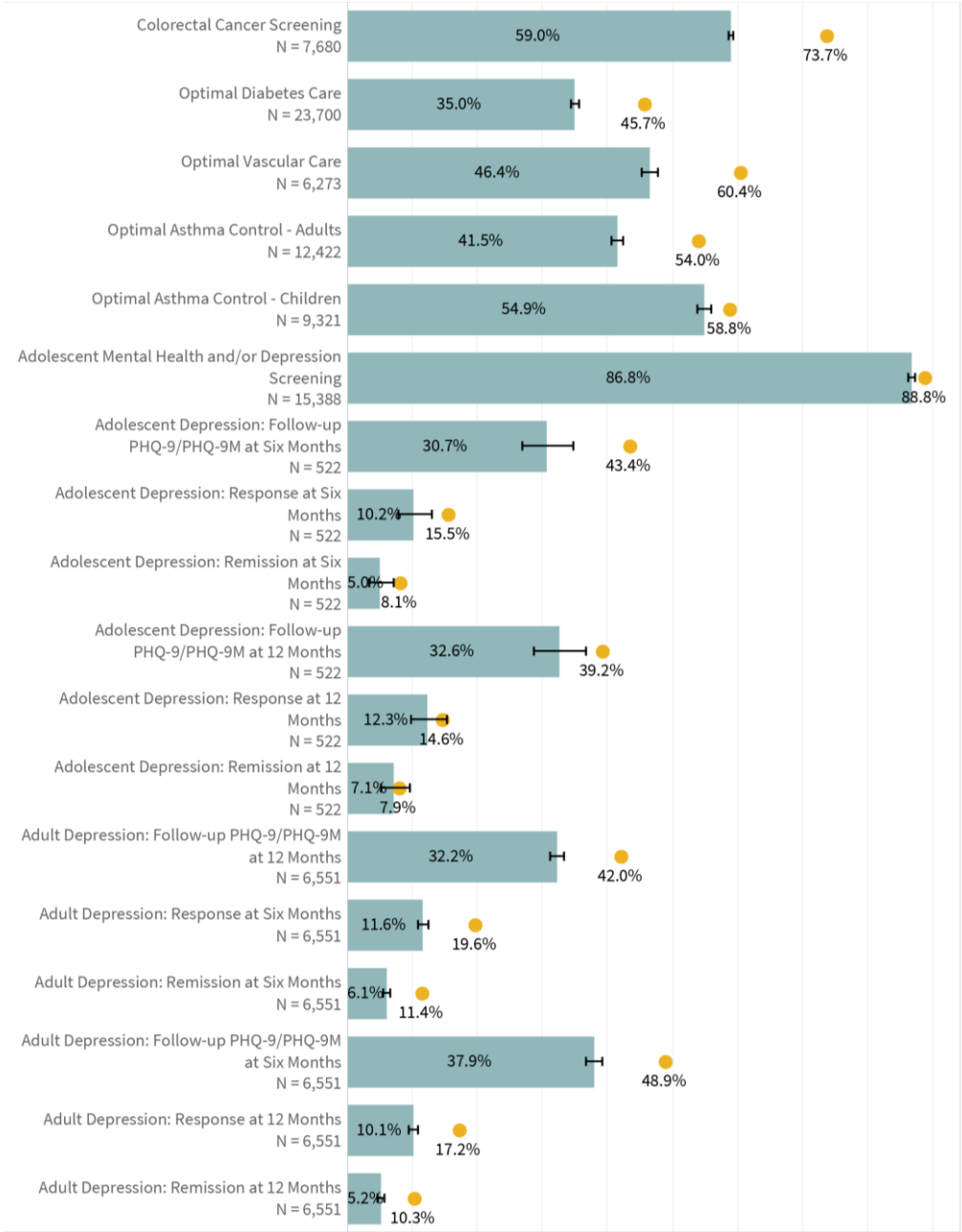
+2,814

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

Black Patients

Snapshot Summary

2020 Report Year (2019 dates of service)



Eliminating Disparities

+ 7,706 Increase in number of eligible Black patients with an updated **colorectal cancer screening** needed to eliminate the disparity in screening.

Increase in number of eligible Black patients receiving **optimal diabetes care** needed to eliminate the disparity in outcomes. **+ 2,752**

+ 908 Increase in number of eligible Black patients receiving **optimal vascular care** needed to eliminate the disparity in outcomes.

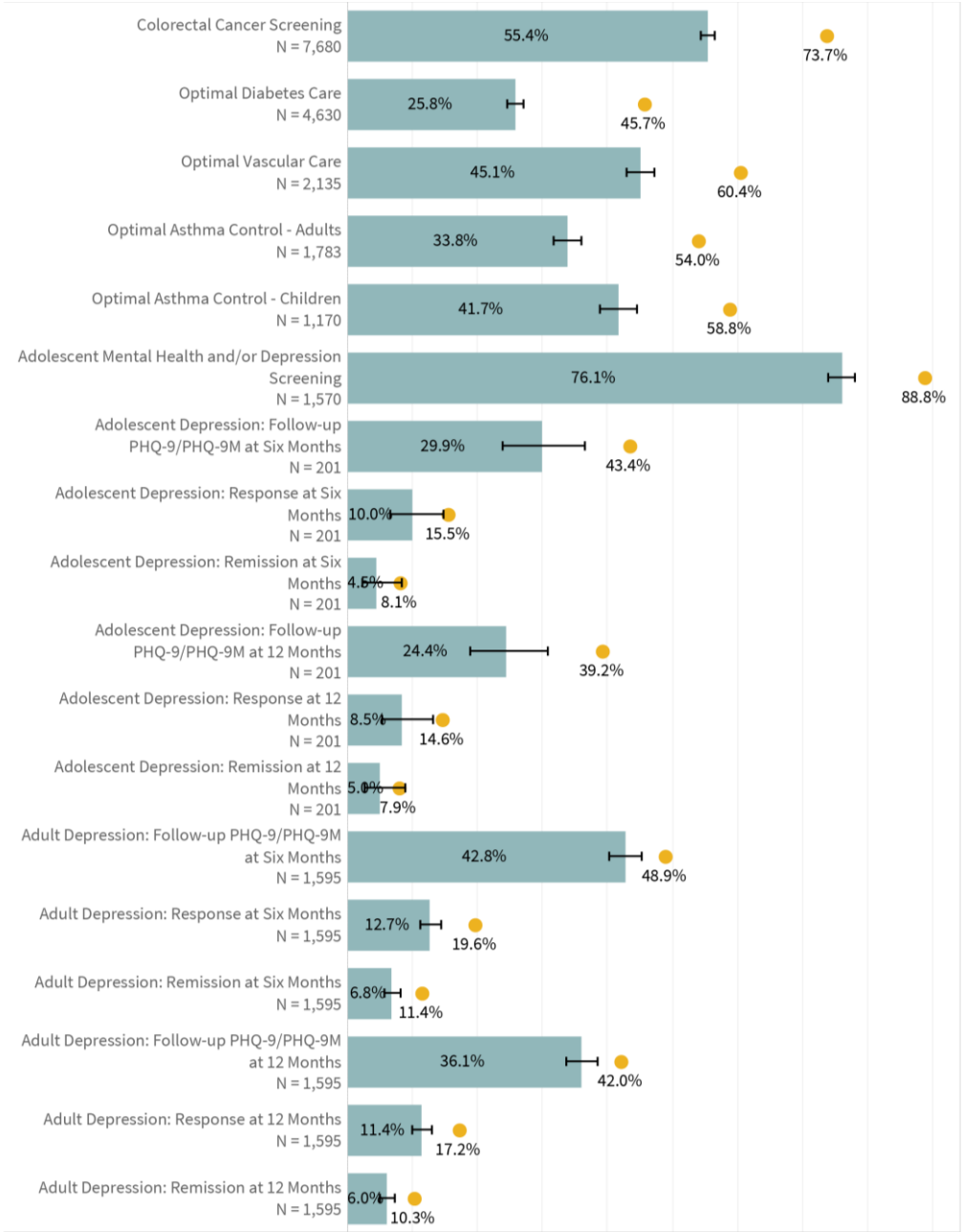
Increase in number of eligible Black adult patients receiving **optimal asthma control** needed to eliminate the disparity in outcomes. **+ 1,698**

+ 706 Increase in number of eligible Black patients who received a **follow-up PHQ-9/ PHQ-9M at six months** needed to eliminate the disparity in outcomes.

Indigenous/Native Patients

Snapshot Summary

2020 Report Year (2019 dates of service)



Eliminating Disparities

+ 1,414 Increase in number of eligible Indigenous/ Native patients with an updated colorectal cancer screening needed to eliminate the disparity in screening.

Increase in number of eligible Indigenous/ Native patients with optimal diabetes care needed to eliminate the disparity in outcomes. **+ 933**

+ 331 Increase in number of eligible Indigenous/ Native patients with optimal vascular care needed to eliminate the disparity in outcomes.

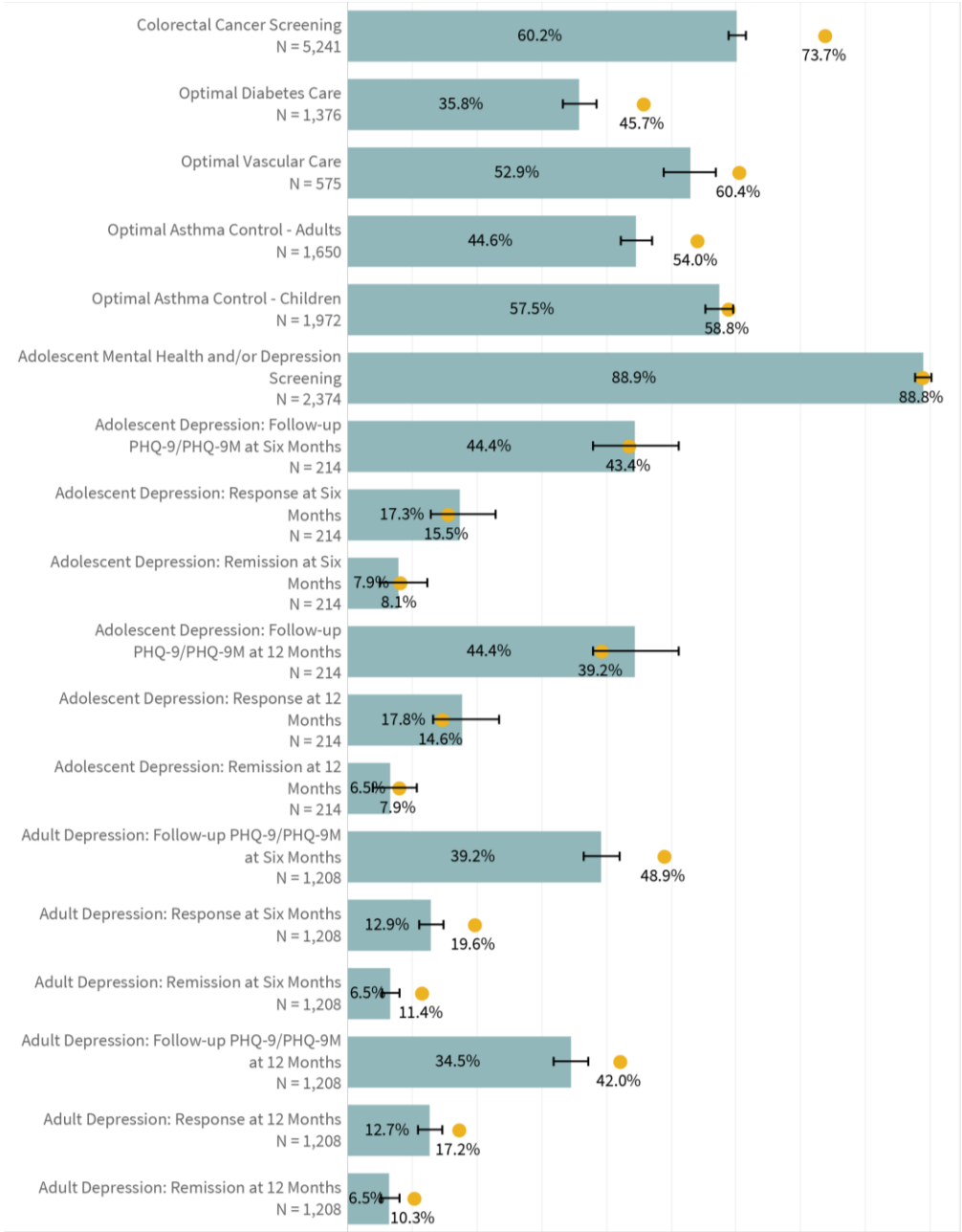
Increase in number of eligible Indigenous/ Native adult patients with optimal asthma control needed to eliminate the disparity in outcomes. **+ 364**

+ 203 Increase in number of eligible Indigenous/ Native children who with optimal asthma control needed to eliminate the disparity in outcomes.

Multi-Race Patients

Snapshot Summary

2020 Report Year (2019 dates of service)



Eliminating Disparities

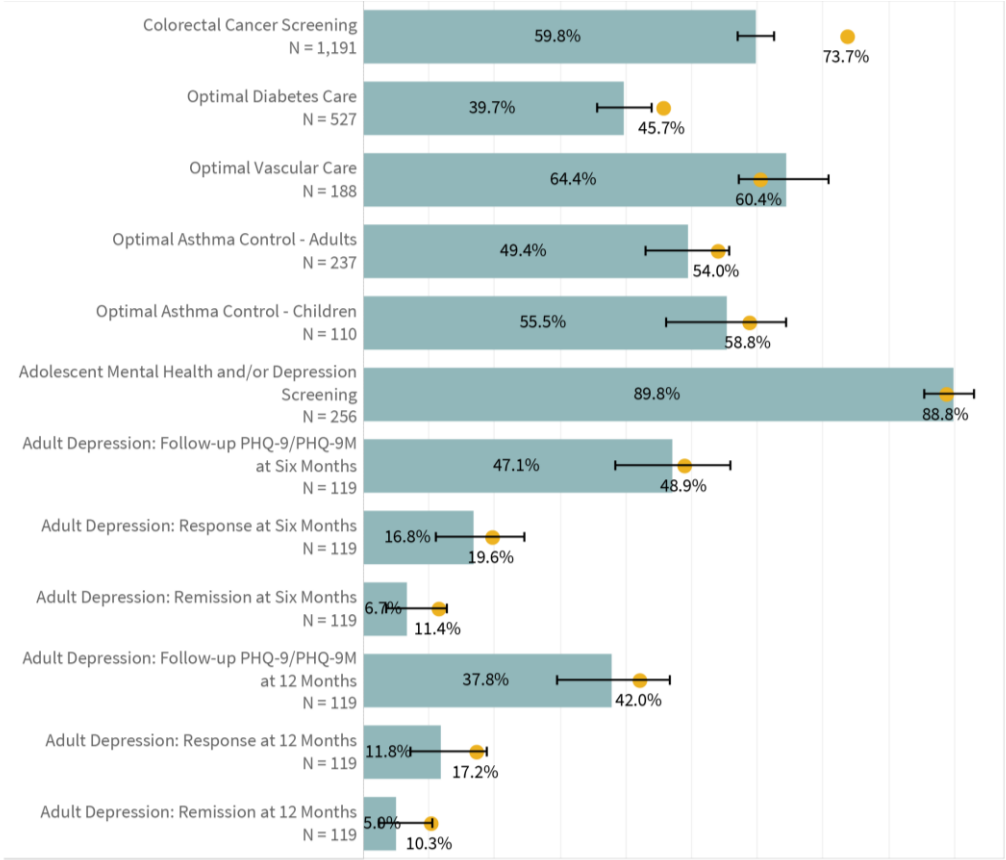
+ 710

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

Native Hawaiian/Pacific Islander Patients

Snapshot Summary

2020 Report Year (2019 dates of service)



Eliminating Disparities

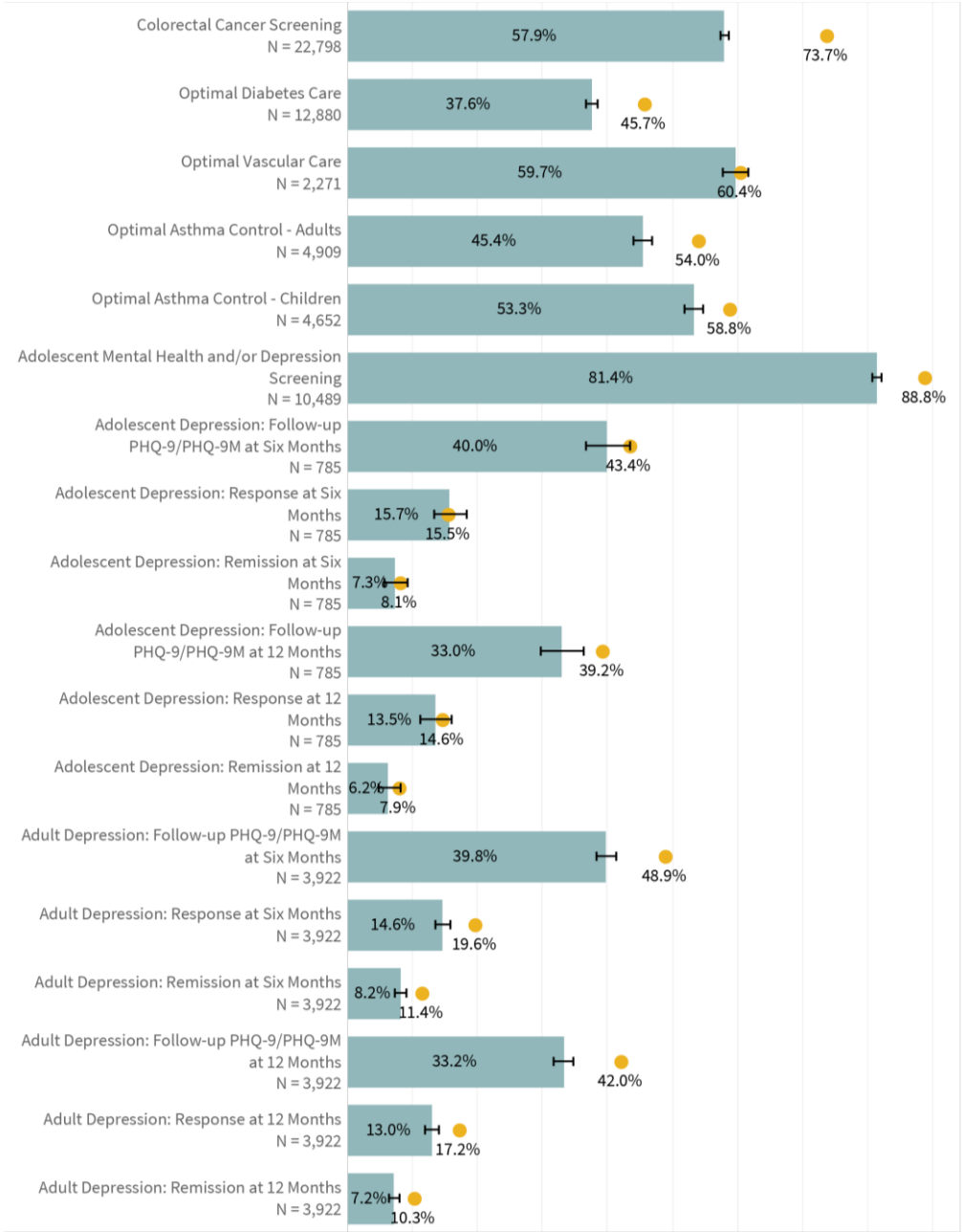
+166

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

Hispanic/Latinx Patients

Snapshot Summary

2020 Report Year (2019 dates of service)



Eliminating Disparities

+3,605

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

+792

Increase in number of eligible Hispanic patients with **adolescent mental health and/or depression screening** needed to eliminate the disparity in screening.

Statewide Summary by Race and Hispanic Ethnicity

Rate comparison of race/ethnicity averages to statewide average

QUALITY MEASURES	RACE												ETHNICITY			
	Asian		Black		Indigenous/ Native		Multi-Race		Native Hawaiian/ Other Pacific Islander		White		Hispanic/ Latinx		Not Hispanic/ Latinx	
	Comparison		Comparison		Comparison		Comparison		Comparison		Comparison		Comparison		Comparison	
Colorectal Cancer Screening	65.0%	▼	59.0%	▼	55.4%	▼	60.2%	▼	59.8%	▼	74.9%	▲	57.9%	▼	73.9%	▲
Optimal Diabetes Care	48.7%	▲	35.0%	▼	25.8%	▼	35.8%	▼	39.7%	▼	47.0%	▲	37.6%	▼	45.9%	▲
Optimal Vascular Care	65.8%	▲	46.4%	▼	45.1%	▼	52.9%	▼	64.4%	●	61.1%	▲	59.7%	●	60.4%	●
Optimal Asthma Control – Adults	55.8%	●	41.5%	▼	33.8%	▼	44.6%	▼	49.4%	●	55.9%	▲	45.4%	▼	54.2%	●
Optimal Asthma Control – Children	61.5%	▲	54.9%	▼	41.7%	▼	57.5%	●	55.5%	●	60.1%	▲	53.3%	▼	59.2%	●
Adolescent Mental Health and/or Depression Screening	89.7%	▲	86.8%	▼	76.1%	▼	88.9%	●	89.8%	●	89.0%	●	81.4%	▼	88.9%	▲
Adolescent Depression: Follow-up at Six Months	40.5%	●	30.7%	▼	29.9%	▼	44.4%	●	NR	-	45.0%	●	40.0%	●	43.5%	●
Adolescent Depression: Response at Six Months	11.9%	●	10.2%	▼	10.0%	●	17.3%	●	NR	-	16.1%	●	15.7%	●	15.4%	●
Adolescent Depression: Remission at Six Months	6.0%	●	5.0%	▼	4.5%	●	7.9%	●	NR	-	8.5%	●	7.3%	●	8.1%	●
Adolescent Depression: Follow-up at 12 Months	37.3%	●	32.6%	▼	24.4%	▼	44.4%	●	NR	-	40.1%	●	33.0%	▼	39.6%	●
Adolescent Depression: Response at 12 Months	11.1%	●	12.3%	●	8.5%	▼	17.8%	●	NR	-	15.1%	●	13.5%	●	14.7%	●
Adolescent Depression: Remission at 12 Months	7.1%	●	7.1%	●	5.0%	●	6.5%	●	NR	-	8.2%	●	6.2%	●	8.1%	●

▼ Below statewide average ● Average ▲ Above statewide average NR = Not reportable (< 30 patients)

Statewide Summary by Race and Hispanic Ethnicity Continued

Rate comparison of race/ethnicity averages to statewide average

QUALITY MEASURES	RACE												ETHNICITY			
	Asian		Black		Indigenous/ Native		Multi-Race		Native Hawaiian/ Other Pacific Islander		White		Hispanic/ Latinx		Not Hispanic/ Latinx	
	Comparison		Comparison		Comparison		Comparison		Comparison		Comparison		Comparison		Comparison	
Adult Depression: Follow-up at Six Months	47.5%	●	37.9%	▼	42.8%	▼	39.2%	▼	47.1%	●	50.2%	▲	39.8%	▼	49.1%	●
Adult Depression: Response at Six Months	15.8%	▼	11.6%	▼	12.7%	▼	12.9%	▼	16.8%	●	20.6%	▲	14.6%	▼	19.7%	●
Adult Depression: Remission at Six Months	8.9%	▼	6.1%	▼	6.8%	▼	6.5%	▼	6.7%	●	12.1%	▲	8.2%	▼	11.5%	●
Adult Depression: Follow-up at 12 Months	37.5%	▼	32.2%	▼	36.1%	▼	34.5%	▼	37.8%	●	43.3%	▲	33.2%	▼	42.3%	●
Adult Depression: Response at 12 Months	13.2%	▼	10.1%	▼	11.4%	▼	12.7%	▼	11.8%	●	18.1%	▲	13.0%	▼	17.3%	●
Adult Depression: Remission at 12 Months	7.6%	▼	5.2%	▼	6.0%	▼	6.5%	▼	5.0%	●	10.9%	▲	7.2%	▼	10.3%	●

▼ Below statewide average ● Average ▲ Above statewide average

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.*

SIX MONTH MEASURES

Adults & Adolescents

- **PHQ-9/PHQ-9M Follow-up at Six Months:** The percentage of adults (18 years and older) or adolescents (12-17 years) with depression who have a completed PHQ-9/PHQ-9M tool within six months after the index event (+/- 60 days)
- **Response at Six Months:** The percentage of adults (18 years and older) or adolescents (12-17 years) with depression who demonstrated a response to treatment (at least 50 percent improvement) six months after the index event (+/- 60 days)
- **Remission at Six Months:** The percentage of adults (18 years and adolescents (12-17 years) with depression who reached remission (PHQ-9/PHQ-9M score less than five) six months after the index event (+/- 60 days)

12 MONTH MEASURES

Adults & Adolescents

- **PHQ-9/PHQ-9M Follow-up at 12 Months:** The percentage of adults (18 years and older) or adolescents (12-17 years) with depression who have a completed PHQ-9/PHQ-9M tool within 12 months after the index event (+/- 60 days)
- **Response at 12 Months:** The percentage of adults (18 years and older) or adolescents (12-17 years) with depression who demonstrated a response to treatment (at least 50 percent improvement) 12 months after the index event (+/- 60 days)
- **Remission at 12 Months:** The percentage of adults (18 years and adolescents (12-17 years) with depression who reached remission (PHQ-9/PHQ-9M score less than five) 12 months after the index event (+/- 60 days)

DATA COLLECTION AND MEASURE CALCULCATION

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 MNCM 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 MNCM.

MNCM 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, MNCM 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 MNCM 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. MNCM's 2020 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 MNCM'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 MNCM which may include some data from clinics located in neighboring states.

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

For the 18 DDS measures, the race, ethnicity, language, and country of origin data is submitted by medical groups through MNCM's DDS process. Please refer to the MNCM *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, preferred 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, preferred language, and country of origin.

LABELING CHANGES

Certain race/ethnicity categories have undergone labeling changes for this report to be consistent with more updated and appropriate terminology. Below is a table describing how the category was submitted to MNCM and its corresponding label change:

Submitted Label	Updated Label
American Indian or Alaska Native	Indigenous/Native
Black or African American	Black
Hispanic or Latino	Hispanic/Latinx
Not Hispanic or Latino	Not Hispanic/Latinx