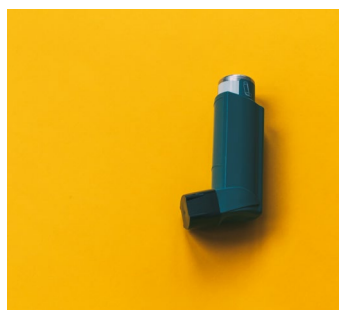




MINNESOTA HEALTH CARE DISPARITIES

By Race, Ethnicity, Preferred Language, and Country of Origin

RESULTS FOR CARE DELIVERED IN 2022 | REPORT RELEASED OCTOBER 2023

MINNESOTA HEALTH CARE DISPARITIES

By Race, Ethnicity, Preferred Language, and Country of Origin

Results for care delivered in 2022

ABOUT MN COMMUNITY MEASUREMENT

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 quality, costs, and equity. While Minnesota has some of the best health indicators in the country, there continues to be wide variation in health care quality and wide disparities in outcomes for different population groups. Measuring and reporting on health care quality helps consumers understand how care varies across providers, allows providers to identify improvement opportunities and how their quality results compare to others, and helps health plans and other purchasers better understand and improve value for the money that is spent on health care.

ABOUT THIS REPORT

This report presents information on disparities by race, ethnicity, language, and country of origin (RELC) for quality measures for the 2022 measurement year (data collected in 2023 for care delivered in 2022).

For the measures included in this report, MNCM collects patient-level data on RELC to enable these comparisons. The RELC data used in this report only includes data that has been verified by MNCM to have been collected using best practices. More information on best practice methods can be found here: <https://tinyurl.com/43byhcbk>. Additionally, a minimum of 30 patients is needed for reporting of the categories presented in the report. Difference from statewide rates are calculated using 95 percent confidence intervals.

This report includes:

- Summary of performance rates by each RELC category for each measure.
- Three-year trend analysis by RELC category from 2020 to 2022 for each measure.
- Snapshot summary of performance rates for each measure by Black, Indigenous, and People of Color (BIPOC) populations.

Medical group and clinic performance rates by RELC are available through MNCM's Appendix Tables, available here: <https://mncm.org/appendix-tables/>

To view more reports by MNCM, click here: <https://mncm.org/reports/#community-reports>

ACKNOWLEDGEMENTS

This report is made possible by the engagement of numerous stakeholders, including medical groups, payers and MNCM's Data Validation and Data Analysis teams. Each 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, workgroups and staff providing ongoing guidance to shape this important work.

REPORT AUTHORS & CONTRIBUTORS

Jess Donovan, MPH, BSN
Clinical Measurement Analyst

Liz Cinqueonce, MBA
Chief Operating Officer

Julie Sonier, MPA
President

Ma Xiong, MPH
Director, Data Strategy & Analytics

DIRECT QUESTIONS OR COMMENTS
TO support@mncm.org

MINNESOTA HEALTH CARE DISPARITIES

By Race, Ethnicity, Preferred Language, and Country of Origin

Results for care delivered in 2022

KEY FINDINGS

- In 2022, performance rates varied by race, ethnicity, preferred language, and country of origin (RELC) across all quality measures. The demographic groups that tended to have significantly lower health care quality rates compared to the statewide average included:
 - **Race:** Black, Indigenous, or Multi Racial
 - **Ethnicity:** Hispanic/Latinx
 - **Language:** Patients who prefer to Hmong, Somali, or Spanish
 - **Country of Origin:** Patients from Laos, Mexico, or Somalia
- The Colorectal Cancer Screening measure continued to have the largest disparities in performance rates across subgroups in 2022:
 - In 2022, the eligible age range was expanded to include patients 45 to 49. This update is based on the latest U.S. Preventive Services Task Force (USPSTF) recommendation and in alignment with the National Committee for Quality Assurance's (NQCA) Colorectal Cancer Screening measure.
 - Some of the decline in Colorectal Cancer Screening rates in 2022 was due to the expanded age range for the measures. An additional analysis was completed in which the 2022 rates for each subpopulation were recalculated so that the age range used matched the age range used in 2021 rates (50-75 years of age). Patients who are Black, Indigenous/Native, White, Not Hispanic/Latinx, English speakers, and/or U.S.-born had recalculated 2022 rates that remained significantly below their 2021 rates.
 - However, the recalculated 2022 rates for patients who are Multi Racial and/or non-English speakers were significantly higher than their 2021 rates, suggesting that while the change in age range did have an impact on rates, other factors contributed to the screening decreases.
- The 2022 rates for most subpopulations were either significantly higher or not statistically different than their respective 2021 rates. However, for the Optimal Vascular Care and Optimal Asthma Control – Children measures, several subpopulations had significantly lower rates in 2022 compared to 2021: White, Not Hispanic/Latinx, English speakers, or U.S.-born.
- The 2022 rates for most subpopulations were either significantly lower or not statistically different than their respective 2019 rates. However, the Adolescent Mental Health and/or Depression Screening measure that had 11 out of the 12 subpopulations had a 2022 rate that was higher than their 2019 rate.
- Wide variation in health care quality rates exists across medical groups and across subpopulations. For example, some medical groups achieved above average outcomes across patient subpopulations, while others have more substantial variation in outcomes. Results by medical group can be accessed here: <https://mnmc.org/appendix-tables/>

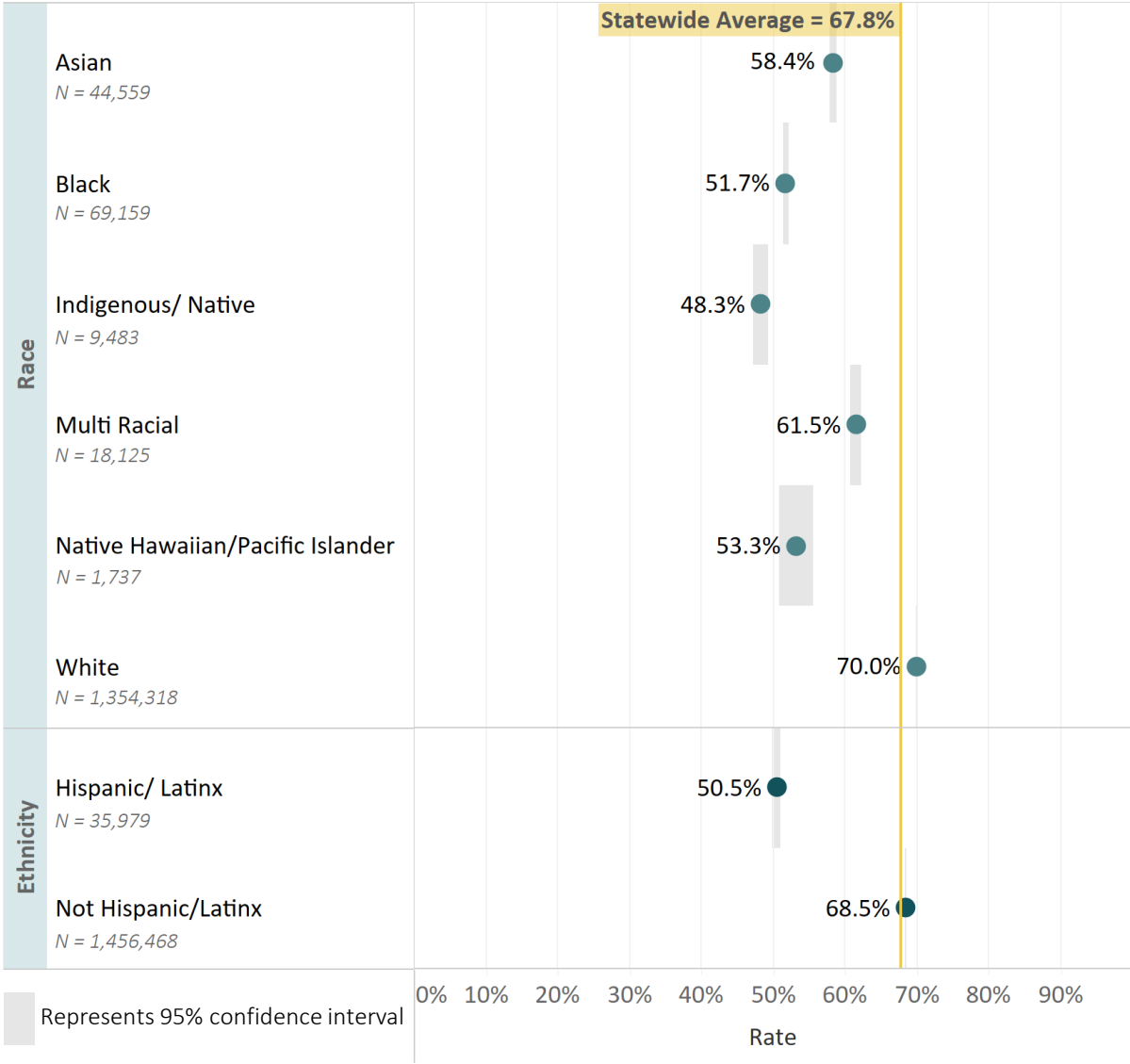
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COLORECTAL CANCER SCREENING

Race/Ethnicity Summary

2022 measurement year



Compared to the statewide average for Colorectal Cancer Screening, patients who are:

RACE

↓ Asian, Black, Indigenous/ Native, Multi Racial, or Native Hawaiian/ Pacific Islander have significantly lower rates of screening.

↑ White patients have significantly higher rates of screening.

ETHNICITY

↓ Hispanic/Latinx have significantly lower rates of screening.

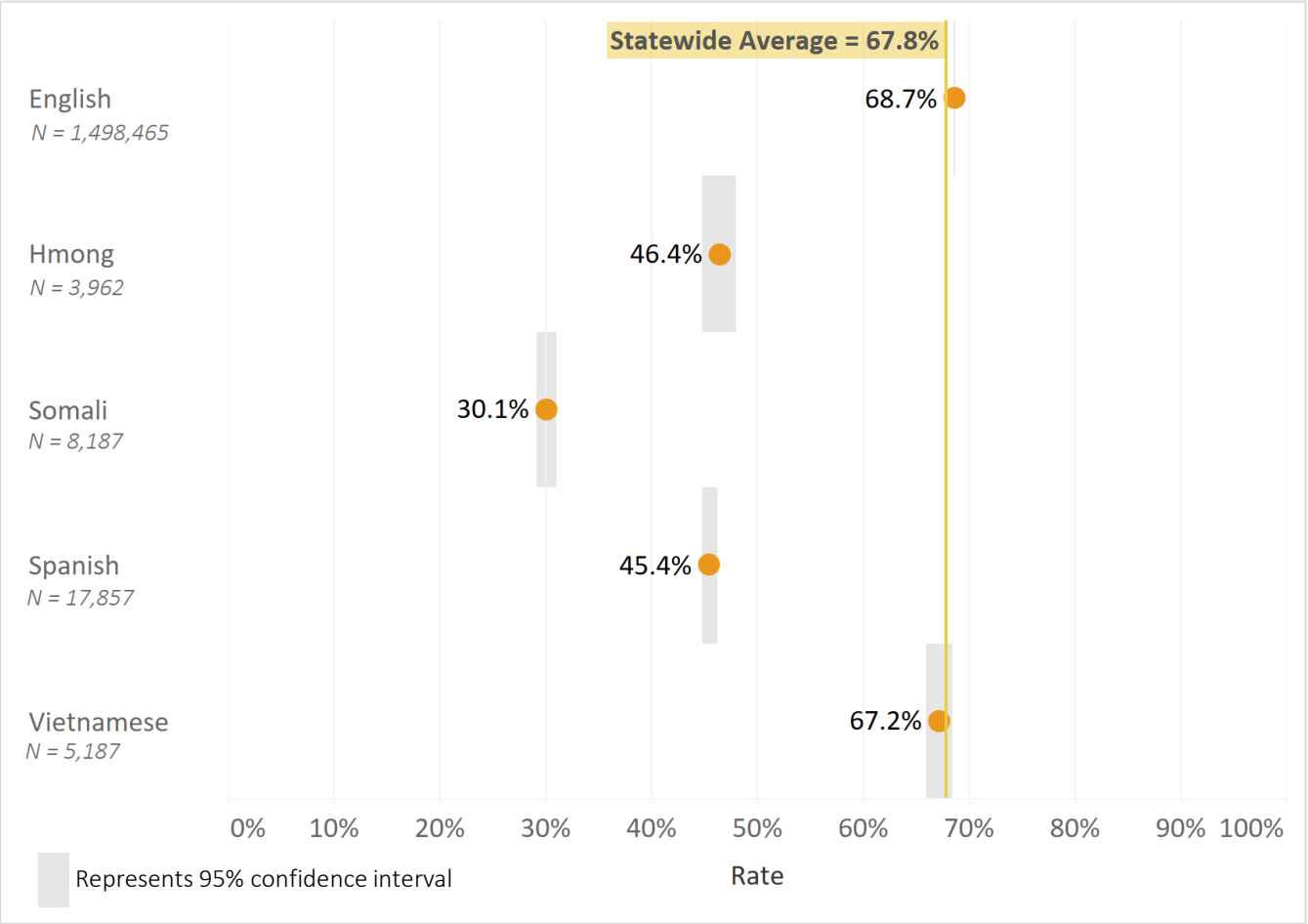
↑ Not Hispanic/Latinx have significantly higher rates of screening.

See [page 53](#) for measure definitions.

COLORECTAL CANCER SCREENING

Preferred Language Summary

2022 measurement year



Patients who prefer to speak English, Hmong, Somali, Spanish, or Vietnamese make up 99% of the eligible population for the Colorectal Cancer Screening measure.

Compared to the statewide average for Colorectal Cancer Screening, patients who prefer to speak:

↓ Hmong, Somali, or Spanish have significantly lower rates of screening.

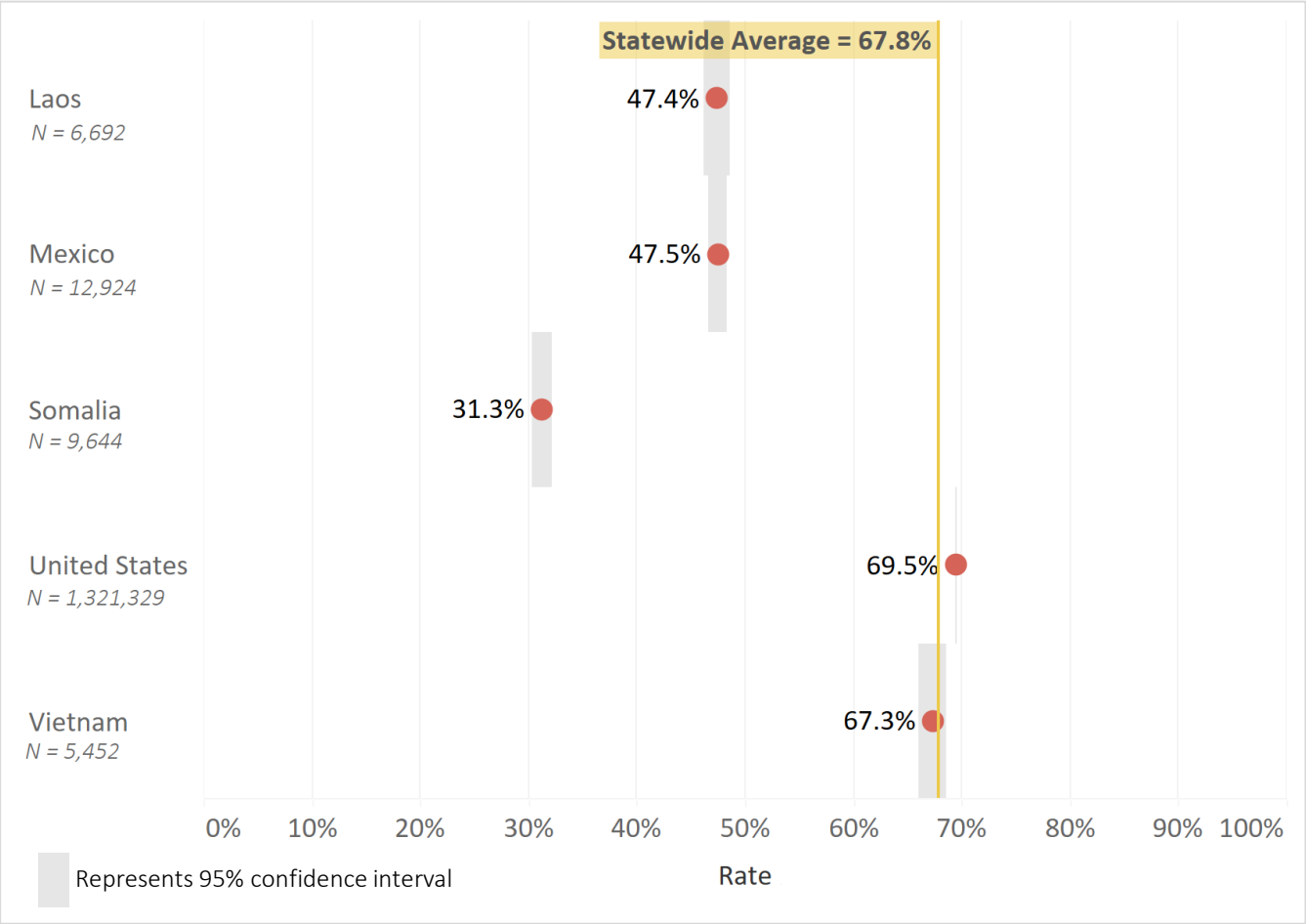
↑ English have significantly higher rates.

See [page 53](#) for measure definitions.

COLORECTAL CANCER SCREENING

Country of Origin Summary

2022 measurement year



Patients from Laos, Mexico, Somalia, the United States, or Vietnam make up 94% of the eligible population for the Colorectal Cancer Screening measure.

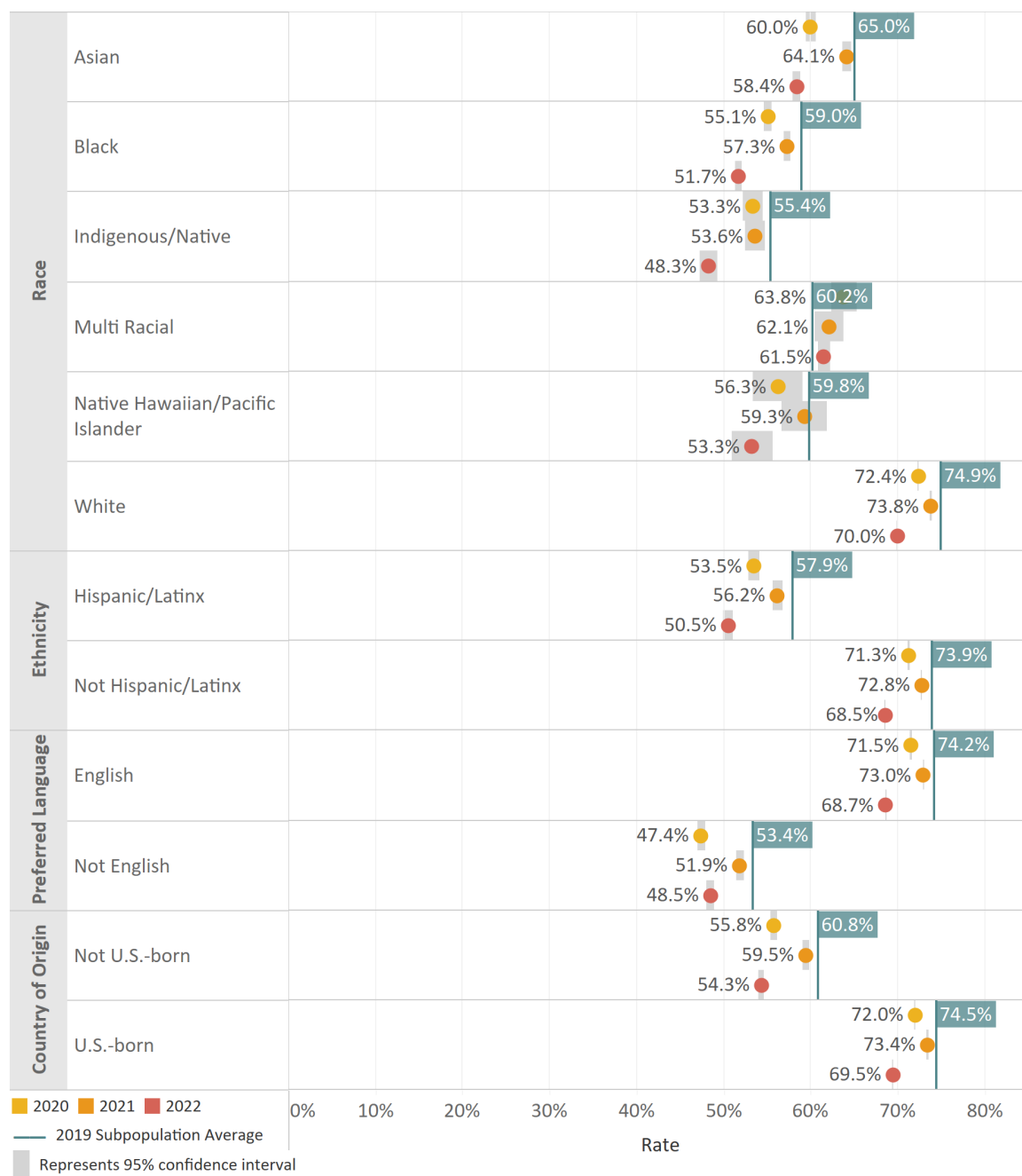
Compared to the statewide average for Colorectal Cancer Screening, patients from:

- ↓ Laos, Mexico, or Somalia have significantly lower rates of screening.
- ↑ The United States have significantly higher rates.

See [page 53](#) for measure definitions.

COLORECTAL CANCER SCREENING

Trend by RELC Subpopulations



Beginning in 2022, the eligible age range for the Colorectal Cancer Screening measure was expanded from 50-75 to 45-75 in 2022MY to reflect updated USPSTF recommendations and to align with NCQA's measure. As a result, comparisons to previous years should take this into consideration.

Comparison to 2021

The screening rates in 2022 significantly decreased compared to the respective 2021 rates in all subpopulations, except for the Multi Racial population. The 2022 rate for this population was not statistically different than its 2021 rate.

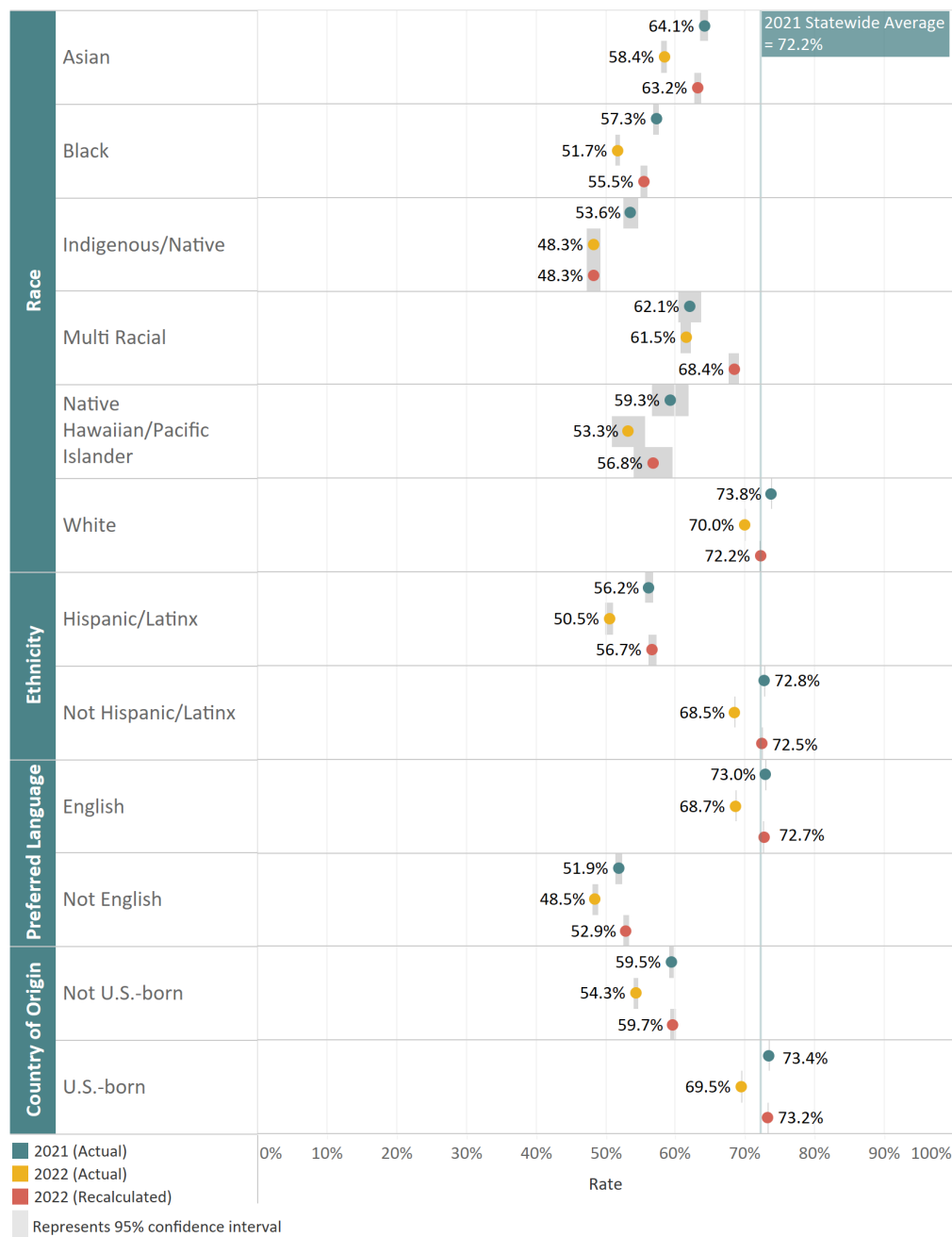
Comparison to Pre-Pandemic (2019)

The screening rates in 2022 remained significantly lower than the respective 2019 rates in all subpopulations, except for the Multi Racial population. The 2022 rate for this population was not statistically different than its 2019 rate.

See [page 53](#) for measure definitions.

COLORECTAL CANCER SCREENING

Age Analysis



Some of the decline in Colorectal Cancer Screening rates in 2022 was due to the expanded age range for the measures. MNCM completed an additional analysis to determine the impact the change had on rates.

The recalculated rate (red) in this chart removes the added patients from the 45-49 age range and recalculates each subpopulation's 2022 rate to match the age range used in 2021 (50-75).

The recalculated 2022 rates for the following subpopulations still had significantly lower rates of screening compared to their respective 2021 rates:

- Black
- Indigenous/Native
- White
- Not Hispanic/Latinx
- English speakers
- U.S.-born

The recalculated 2022 rates for the following subpopulations were either not statistically different or significantly above their respective 2021 rates:

Not statistically different:

- Asian
- Native Hawaiian/Pacific Islander
- Hispanic/Latinx
- Not U.S.-born

Significantly above:

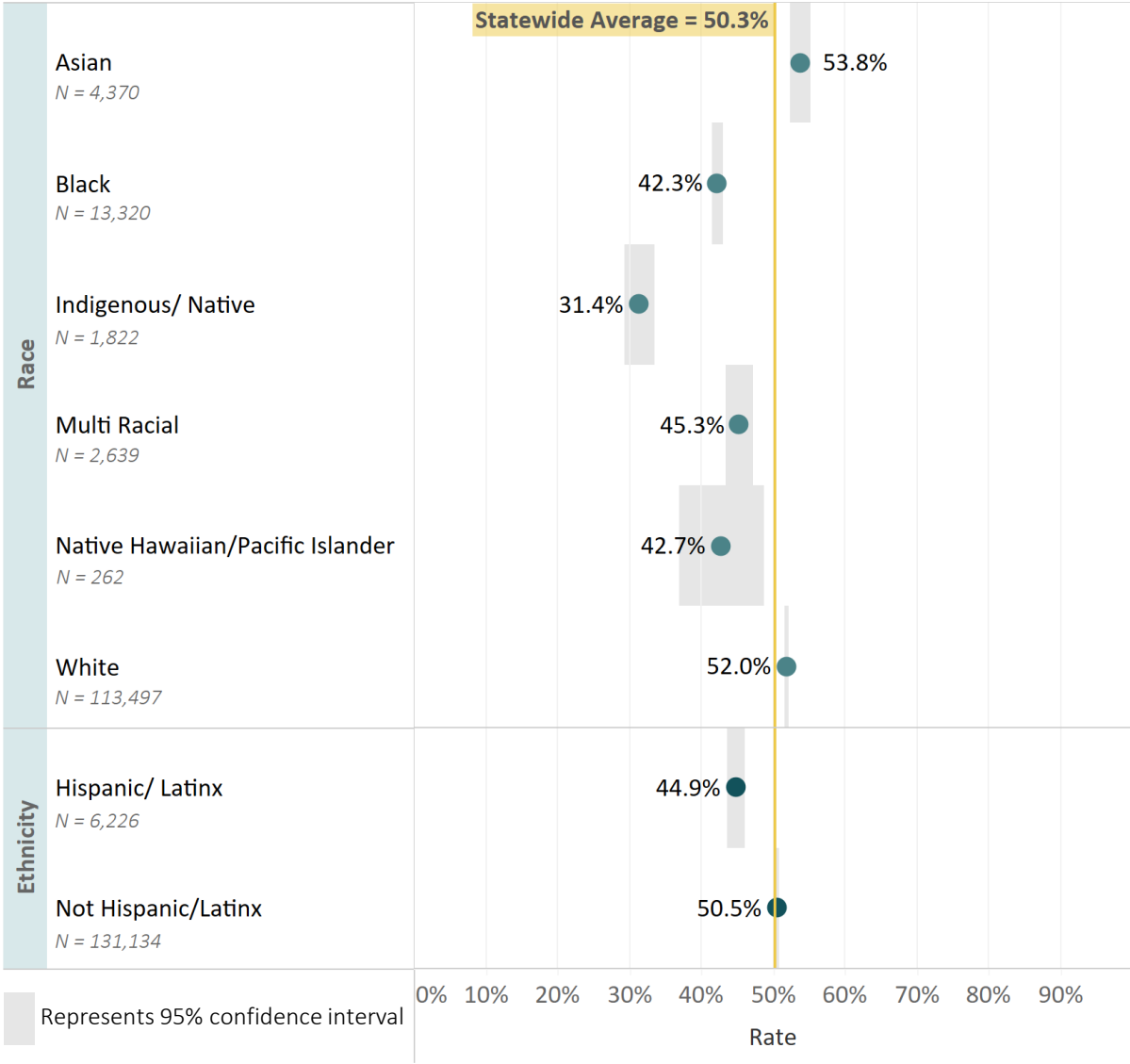
- Multi Racial
- Non-English speakers

See [page 53](#) for measure definitions.

OPTIMAL ASTHMA CONTROL – ADULTS

Race/Ethnicity Summary

2022 measurement year



Compared to the statewide average for Optimal Asthma Control, adults who are:

RACE

↓ Black, Indigenous/ Native, Multi Racial, or Native Hawaiian/ Pacific Islander have significantly lower rates of optimal control.

↑ Asian or White have significantly higher rates of optimal control.

ETHNICITY

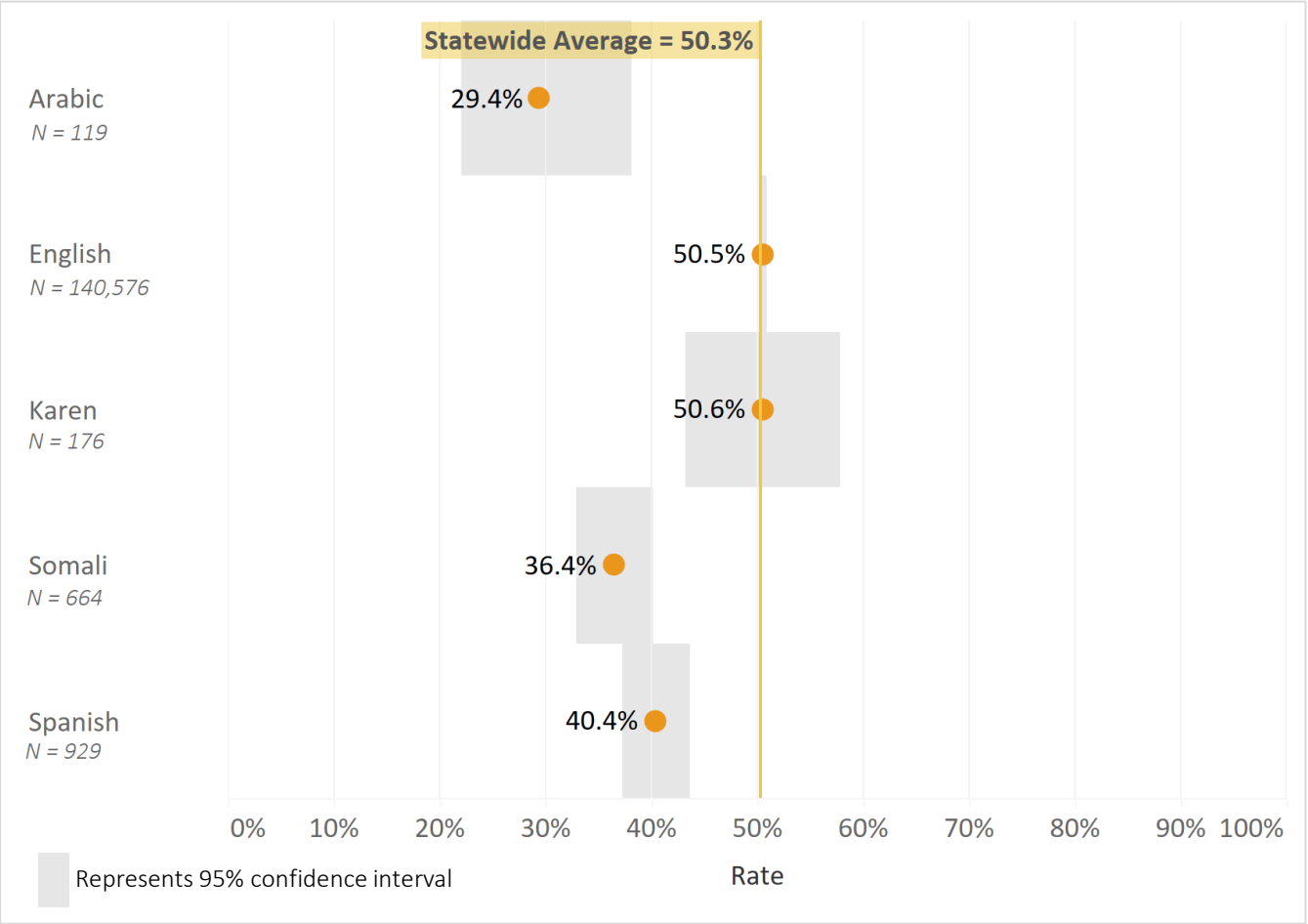
↓ Hispanic/Latinx have significantly lower rates of optimal control.

See [page 53](#) for measure definitions.

OPTIMAL ASTHMA CONTROL – ADULTS

Preferred Language Summary

2022 measurement year



Patients who prefer to speak Arabic, English, Karen, Somali, or Spanish make up 99% of the eligible adult population for the Optimal Asthma Control measure.

Compared to the statewide average for Optimal Asthma Control, adults who prefer to speak:

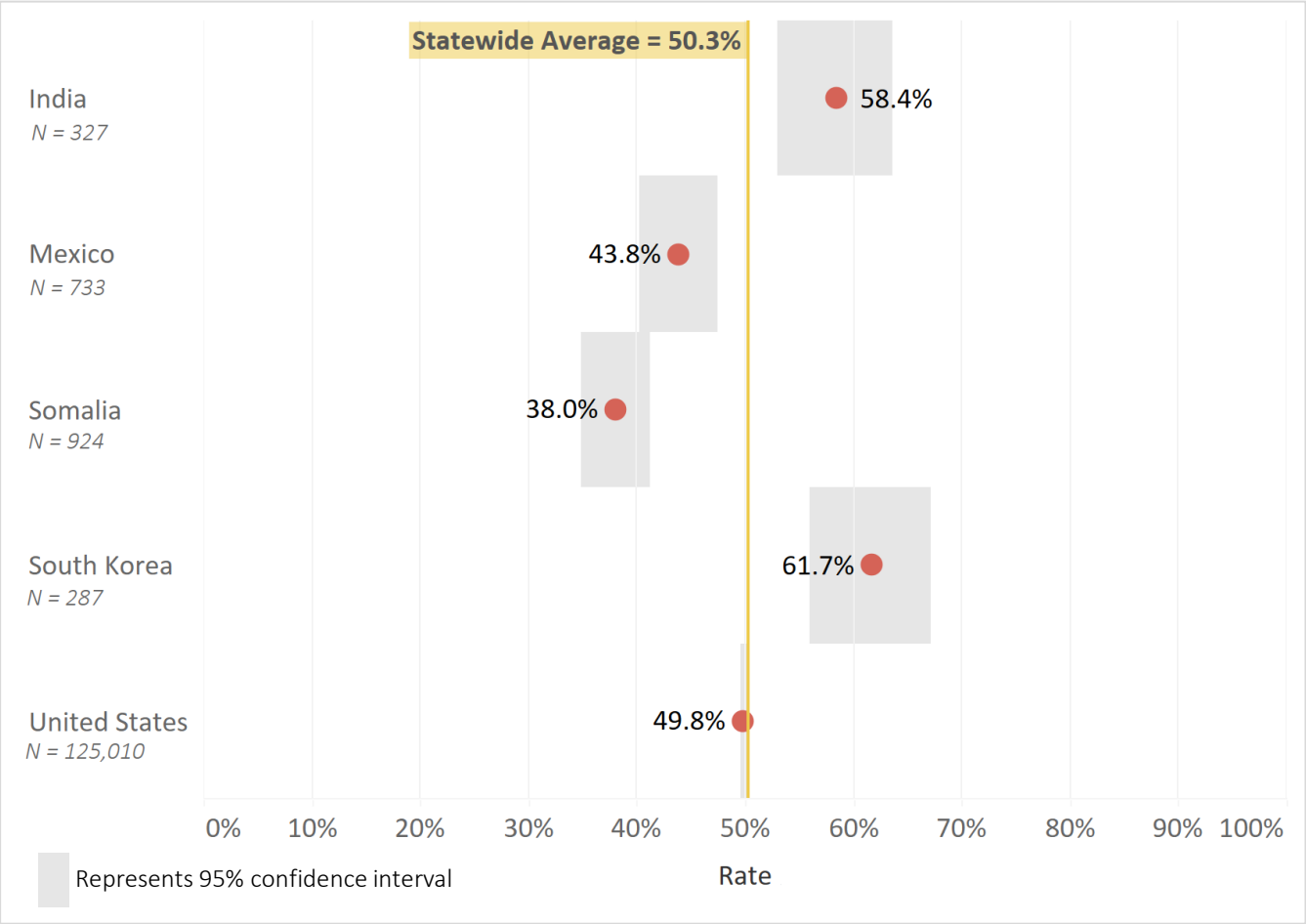
↓ Arabic, Somali, or Spanish have significantly lower rates of optimal control.

See [page 53](#) for measure definitions.

OPTIMAL ASTHMA CONTROL – ADULTS

Country of Origin Summary

2022 measurement year



Patients from India, Mexico, Somalia, South Korea, or the United States make up 96% of the eligible adult population for the Optimal Asthma Control measure.

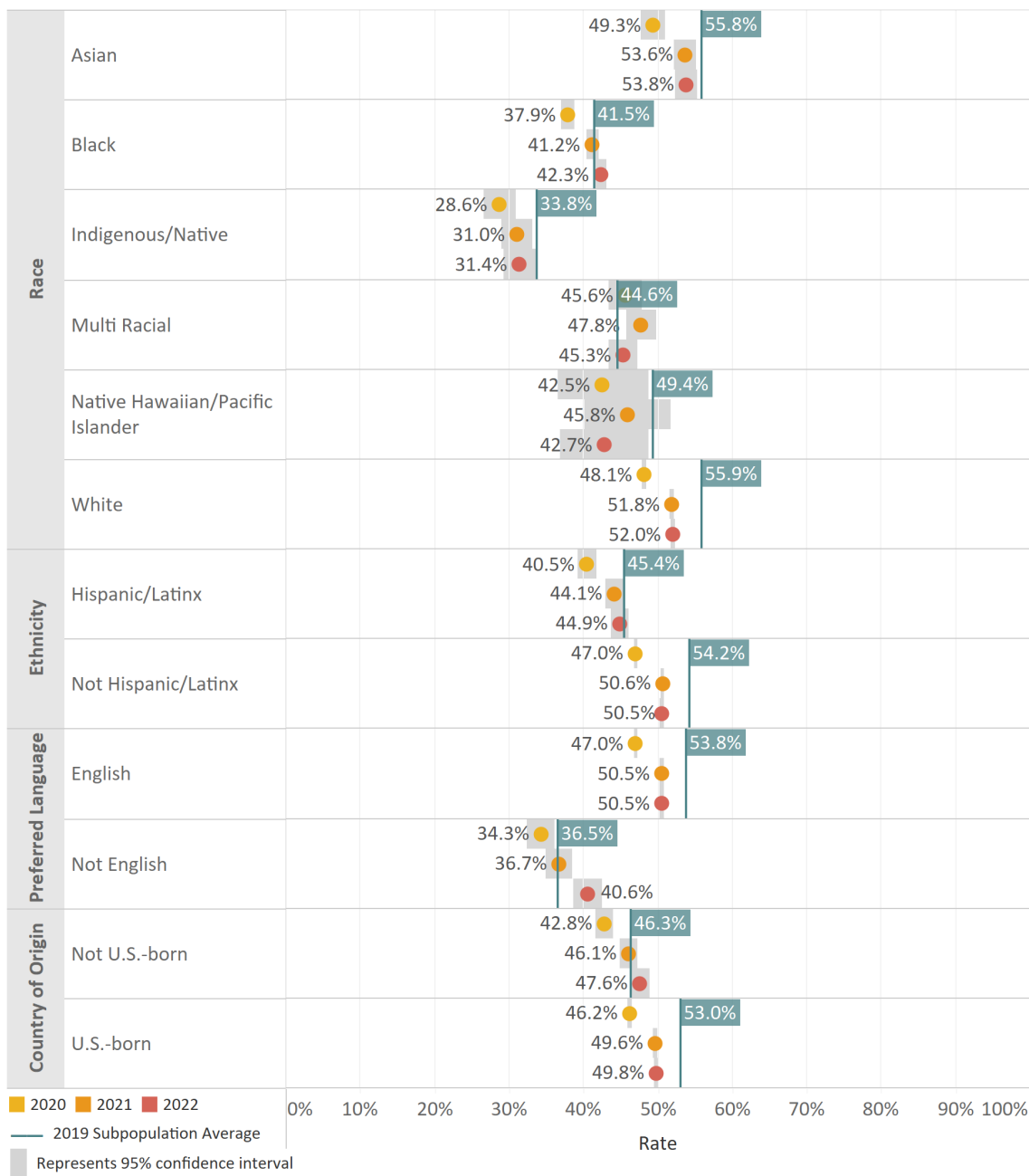
Compared to the statewide average for Optimal Asthma Control, adults from:

- ↓ Mexico or Somalia have significantly lower rates of optimal control.
- ↑ India or South Korea have significantly higher rates of optimal control.

See [page 53](#) for measure definitions.

OPTIMAL ASTHMA CONTROL – ADULTS

Trend by RELC Subpopulations



Comparison to 2021

The optimal rates in 2022 were not statistically different than the respective 2021 rates in all subpopulations, except for the Non-English speaker population. The 2022 rate for this population was significantly higher than its 2021 rate.

Comparison to Pre-Pandemic (2019)

The optimal rates in 2022 were not statistically different than the respective 2019 rates in all subpopulations, except for the following populations:

- White
- Not Hispanic/Latinx
- English-speakers
- U.S.-born

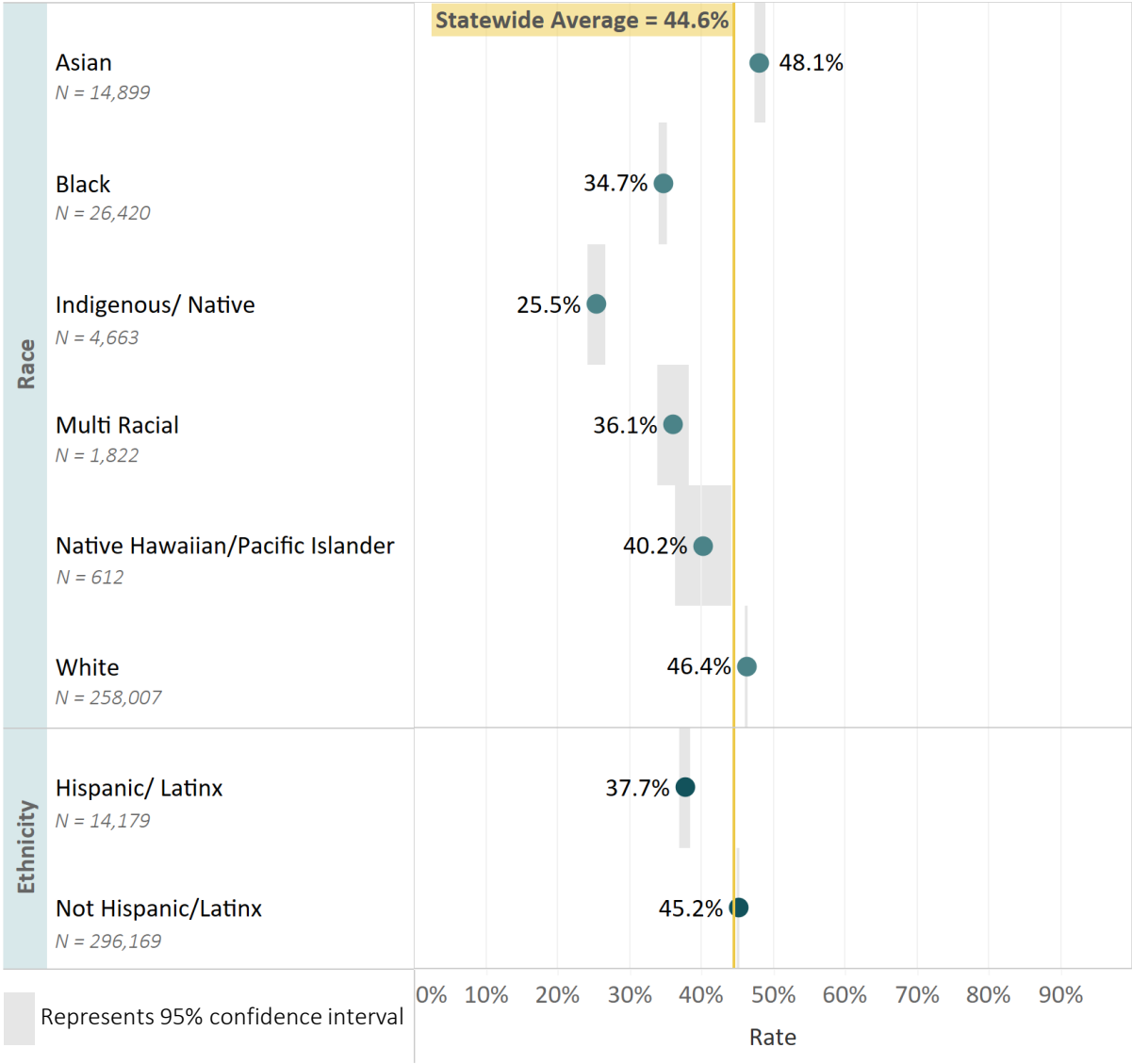
The 2022 rates for these populations were significantly lower than their 2019 rates.

See [page 53](#) for measure definitions.

OPTIMAL DIABETES CARE

Race/Ethnicity Summary

2022 measurement year



Compared to the statewide average for Optimal Diabetes Care, patients who are:

RACE

- ↓ Black, Indigenous/ Native, Multi Racial, or Native Hawaiian/ Pacific Islander have significantly lower rates of optimal care.
- ↑ Asian or White have significantly higher rates of optimal care.

ETHNICITY

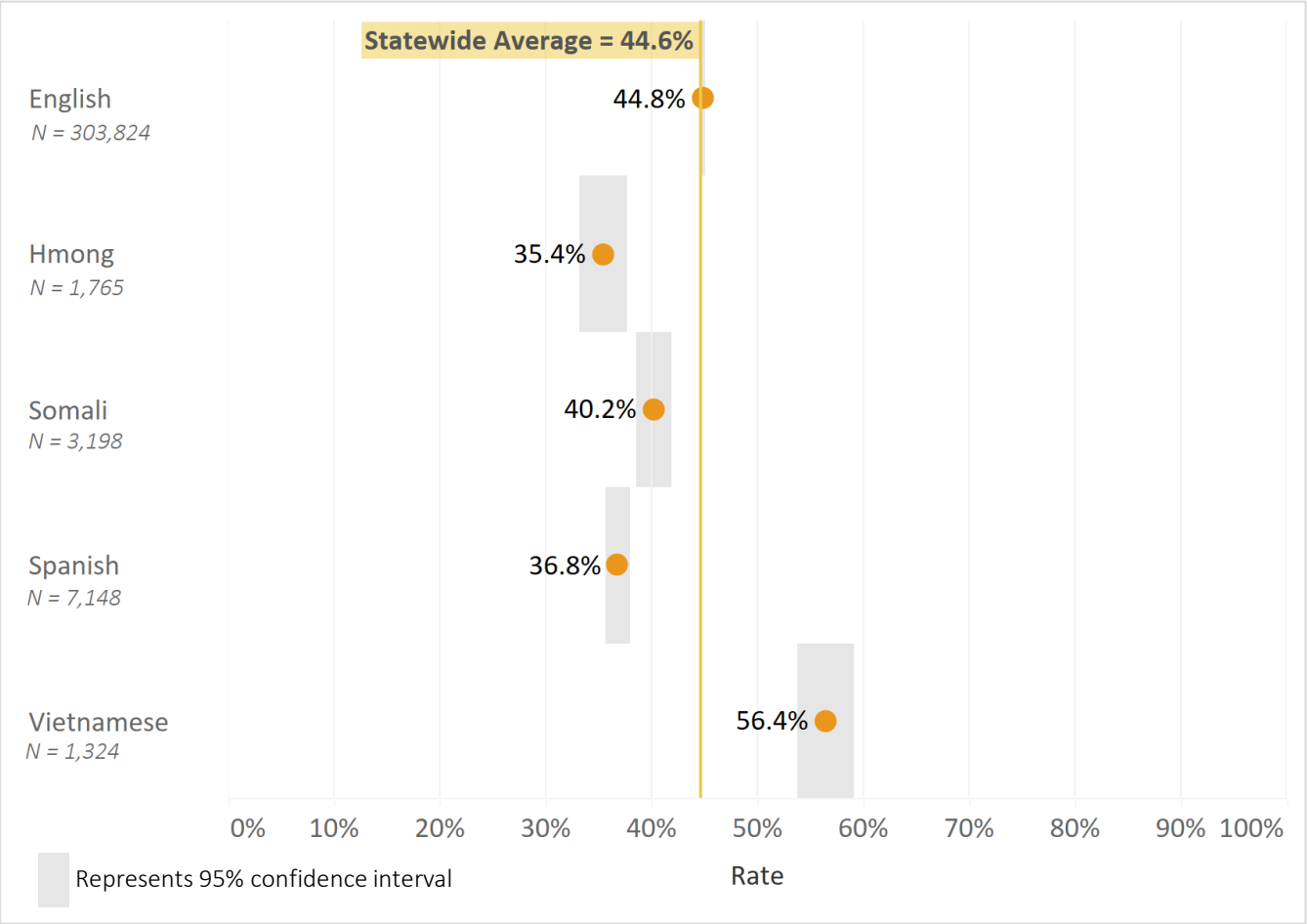
- ↓ Hispanic/Latinx have significantly lower rates of optimal care.
- ↑ Not Hispanic/Latinx have significantly higher rates of optimal care.

See [page 53](#) for measure definitions.

OPTIMAL DIABETES CARE

Preferred Language Summary

2022 measurement year



Patients who prefer to speak English, Hmong, Somali, Spanish, or Vietnamese make up 98% of the eligible population for the Optimal Diabetes Care measure.

Compared to the statewide average for Optimal Diabetes Care, patients who prefer to speak:

↓ Hmong, Somali, or Spanish have significantly lower rates of optimal care.

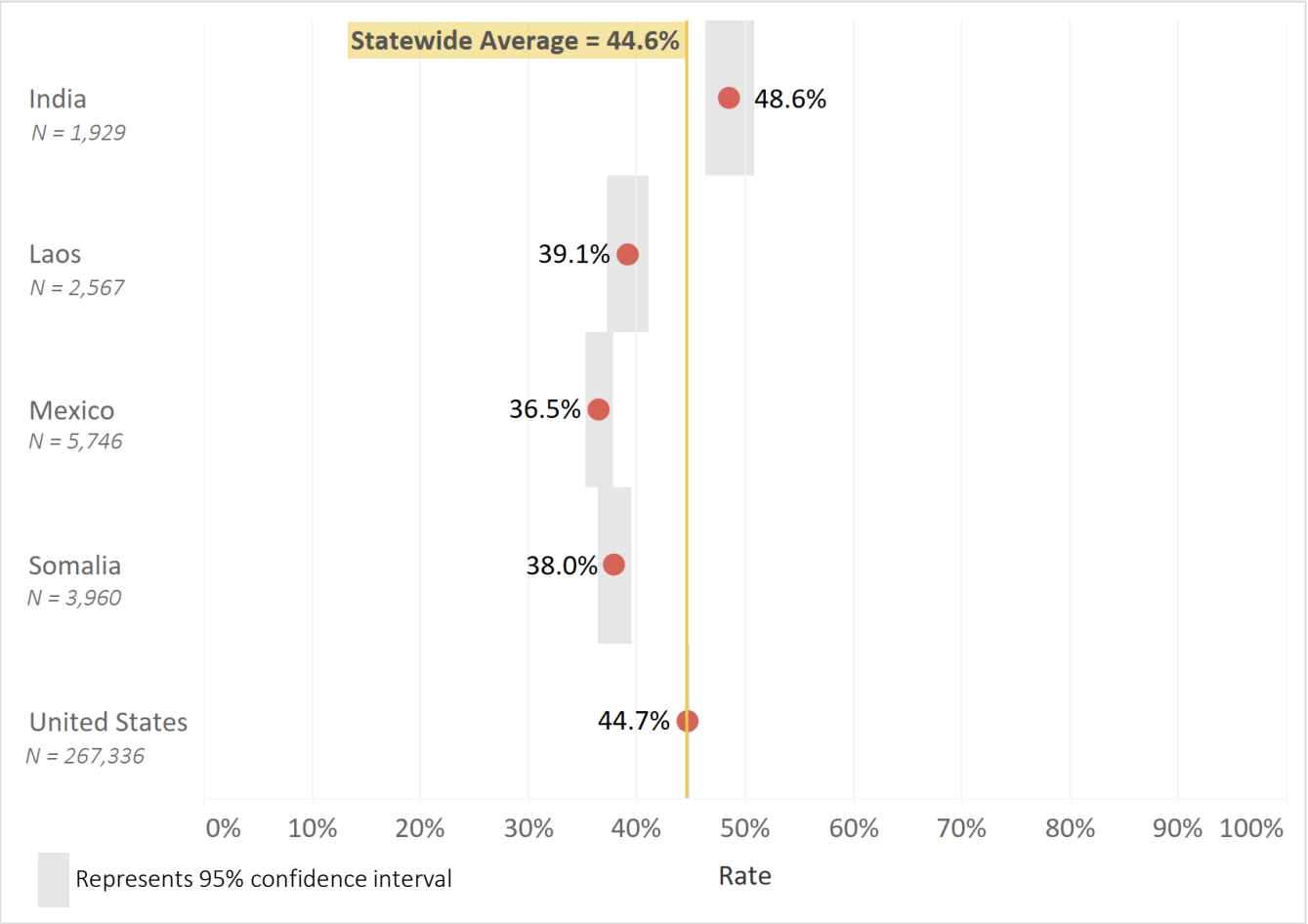
↑ Vietnamese have a significantly higher rate of optimal care.

See [page 53](#) for measure definitions.

OPTIMAL DIABETES CARE

Country of Origin Summary

2022 measurement year



Patients from India, Laos, Mexico, Somalia, or the United States make up 92% of the eligible population for the Optimal Diabetes Care measure.

Compared to the statewide average for Optimal Diabetes Care, patients from:

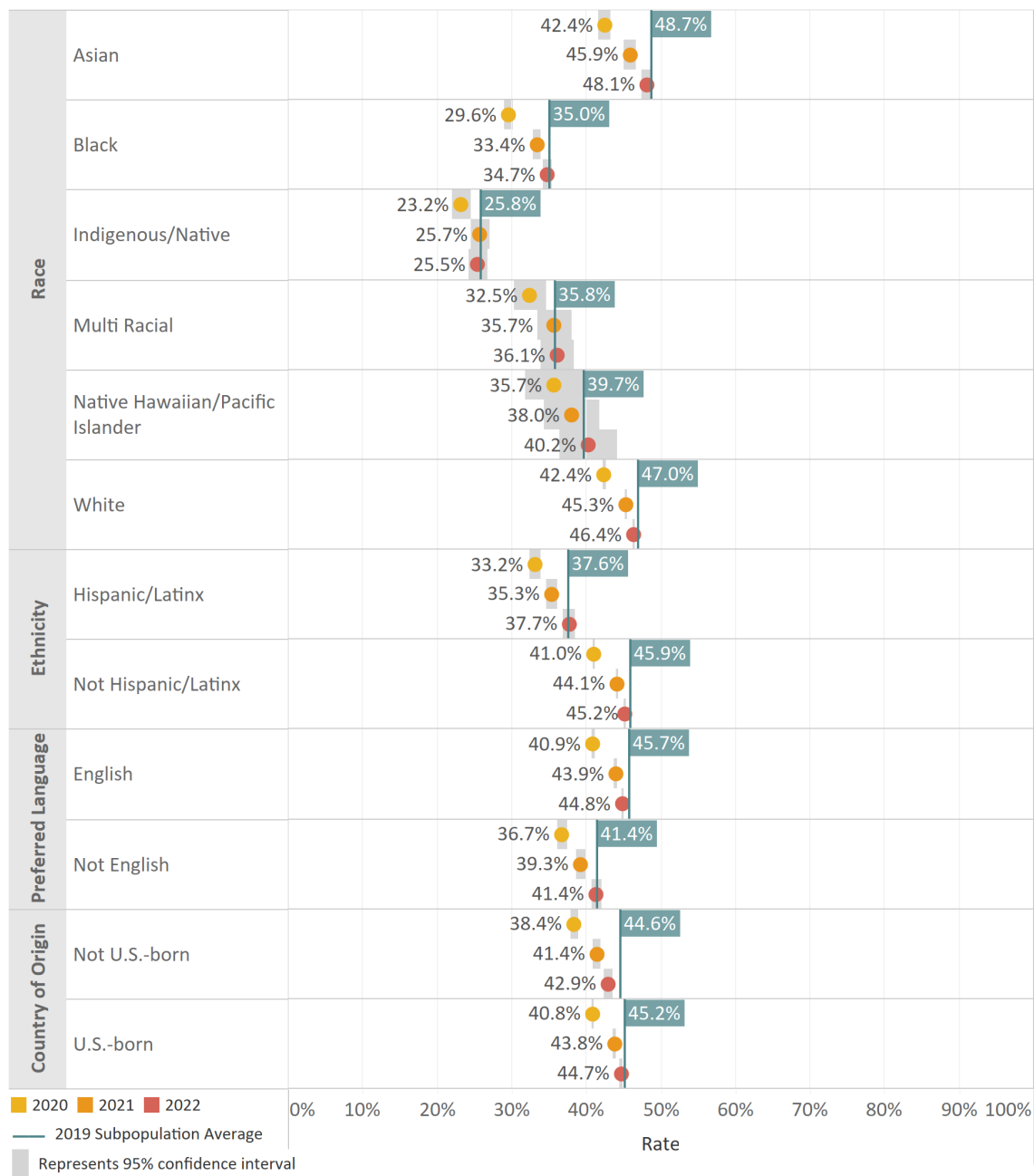
↓ Laos, Mexico, or Somalia have significantly lower rates of optimal care.

↑ India have a significantly higher rate of optimal care.

See [page 53](#) for measure definitions.

OPTIMAL DIABETES CARE

Trend by RELC Subpopulations



Comparison to 2021

The optimal care rates in 2022 significantly increased compared to the respective 2021 rates in all subpopulations, except for the following populations:

- Indigenous/Native
- Multi Racial
- Native Hawaiian/Pacific Islander

The rates for these populations were not statistically different than their rates 2021.

Comparison to Pre-Pandemic (2019)

The optimal care rates in 2022 were not statistically different than the respective 2021 rates in all subpopulations, except for the following populations:

- White
- Not Hispanic/Latinx
- English speakers
- Not U.S.-born
- U.S.-born

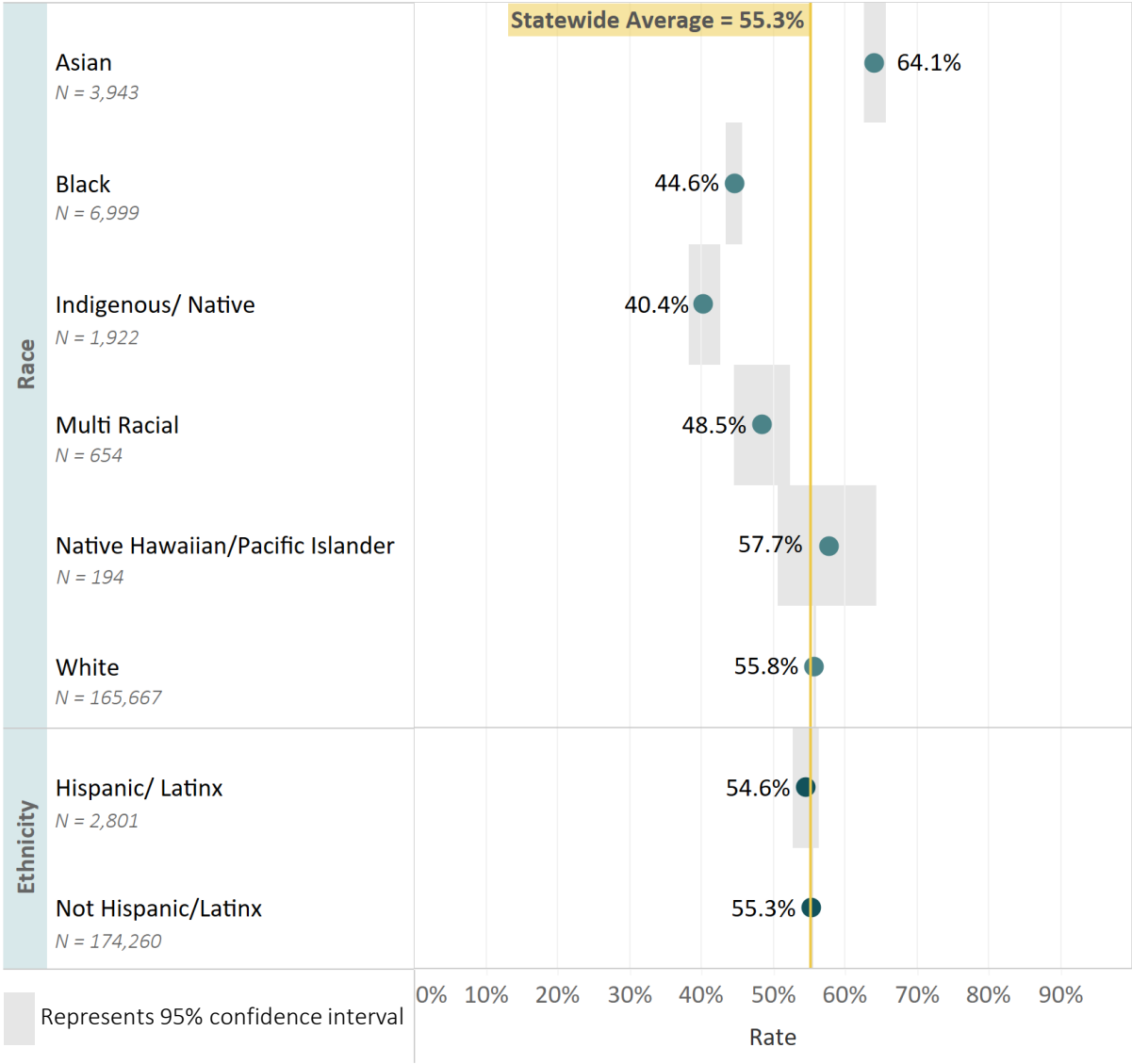
The 2022 rates for these populations were significantly lower than their 2019 rates.

See [page 53](#) for measure definitions.

OPTIMAL VASCULAR CARE

Race/Ethnicity Summary

2022 measurement year



Compared to the statewide average for Optimal Vascular Care, patients who are:

RACE

↓ Black, Indigenous/ Native, or Multi Racial have significantly lower rates of optimal care.

↑ Asian or White have significantly higher rates of optimal care.

ETHNICITY

↓ Hispanic/Latinx have significantly lower rates of optimal care.

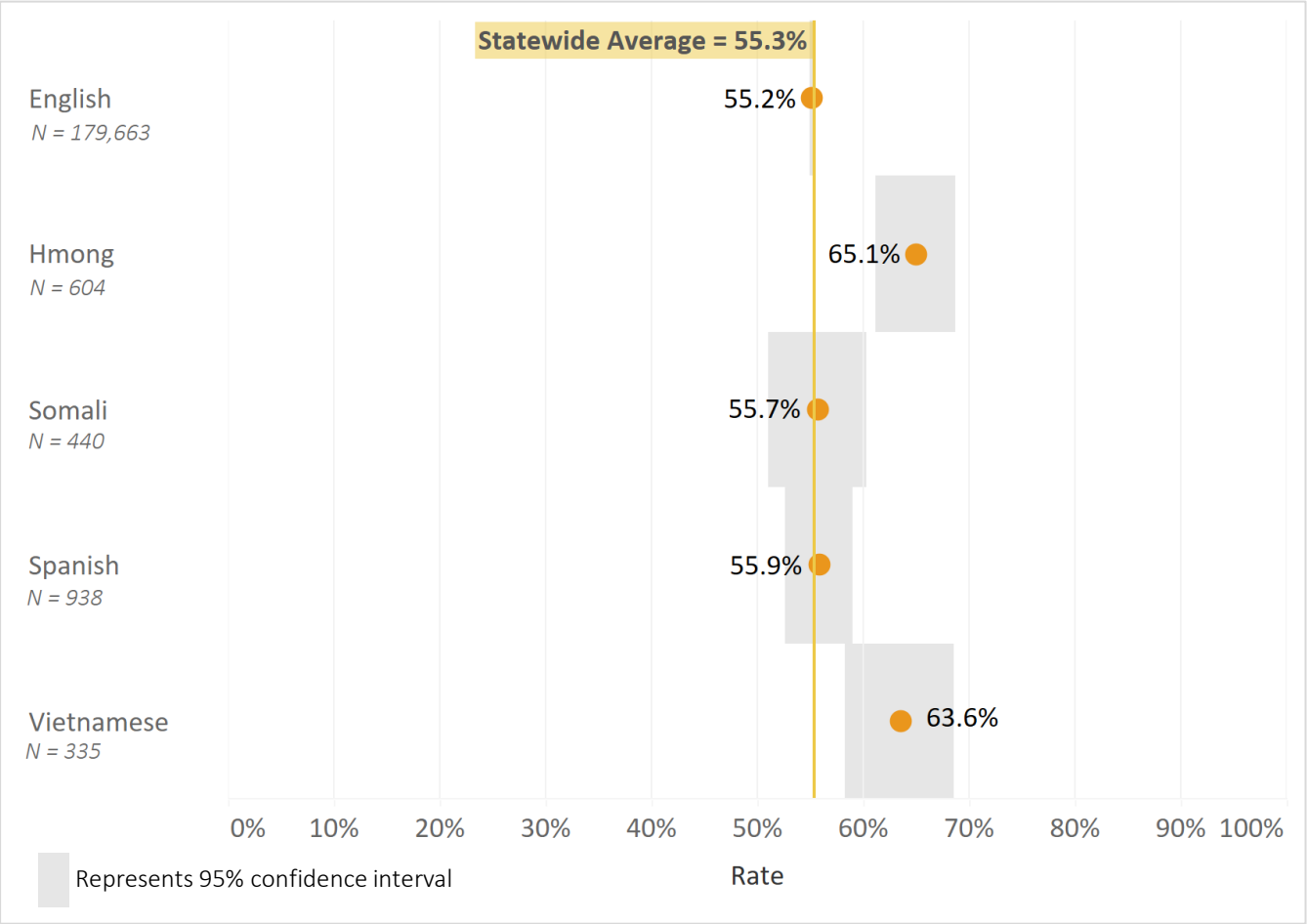
↑ Not Hispanic/Latinx have significantly higher rates of optimal care.

See [page 53](#) for measure definitions.

OPTIMAL VASCULAR CARE

Preferred Language Summary

2022 measurement year



Patients who prefer to speak English, Hmong, Somali, Spanish, or Vietnamese make up 99% of the eligible population for the Optimal Vascular Care measure.

Compared to the statewide average for Optimal Vascular Care, patients who prefer to speak:

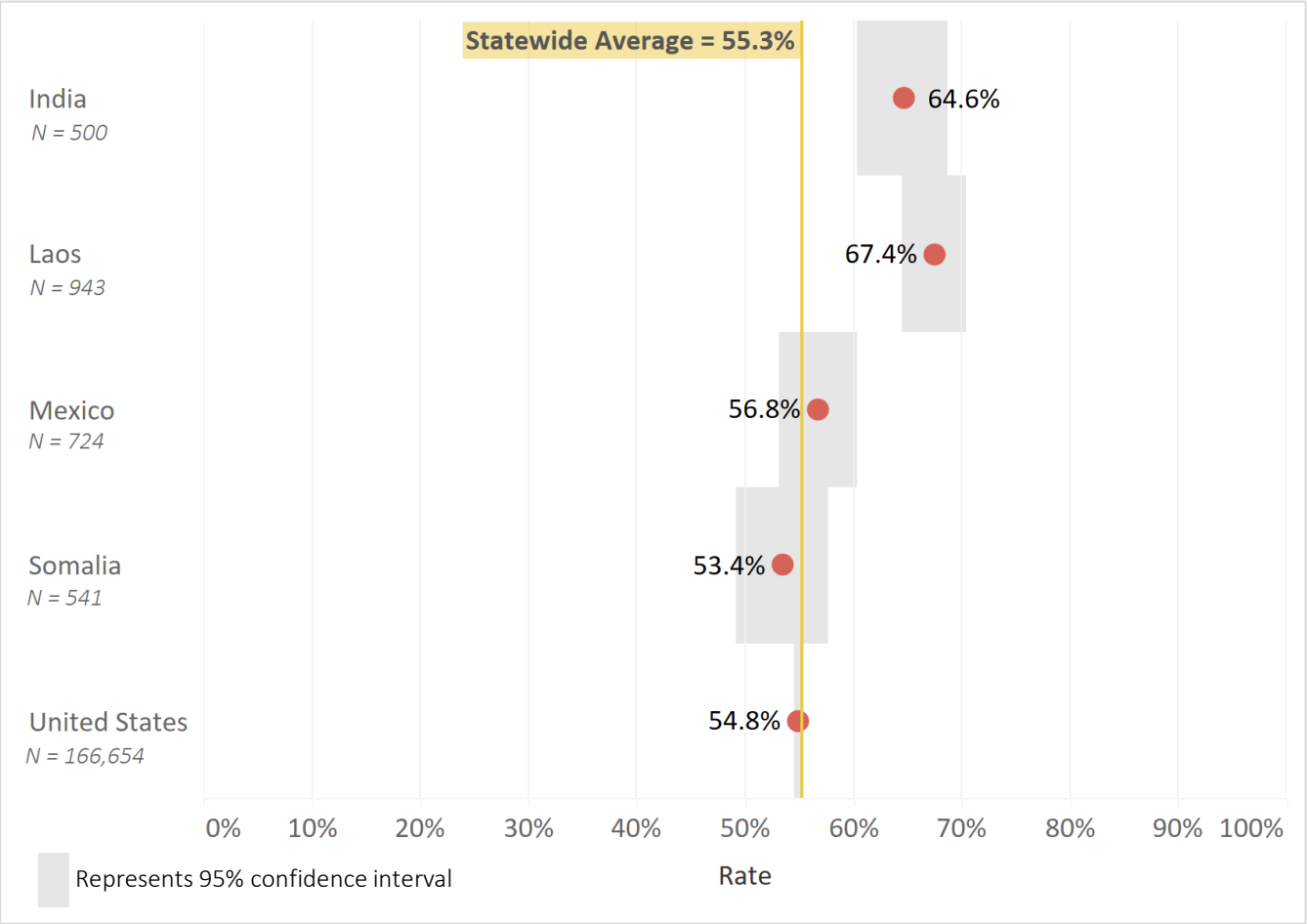
↑ Hmong or Vietnamese have significantly higher rates of optimal care.

See [page 53](#) for measure definitions.

OPTIMAL VASCULAR CARE

Country of Origin Summary

2022 measurement year



Patients from India, Laos, Mexico, Somalia, or the United States make up 96% of the eligible population for the Optimal Vascular Care measure.

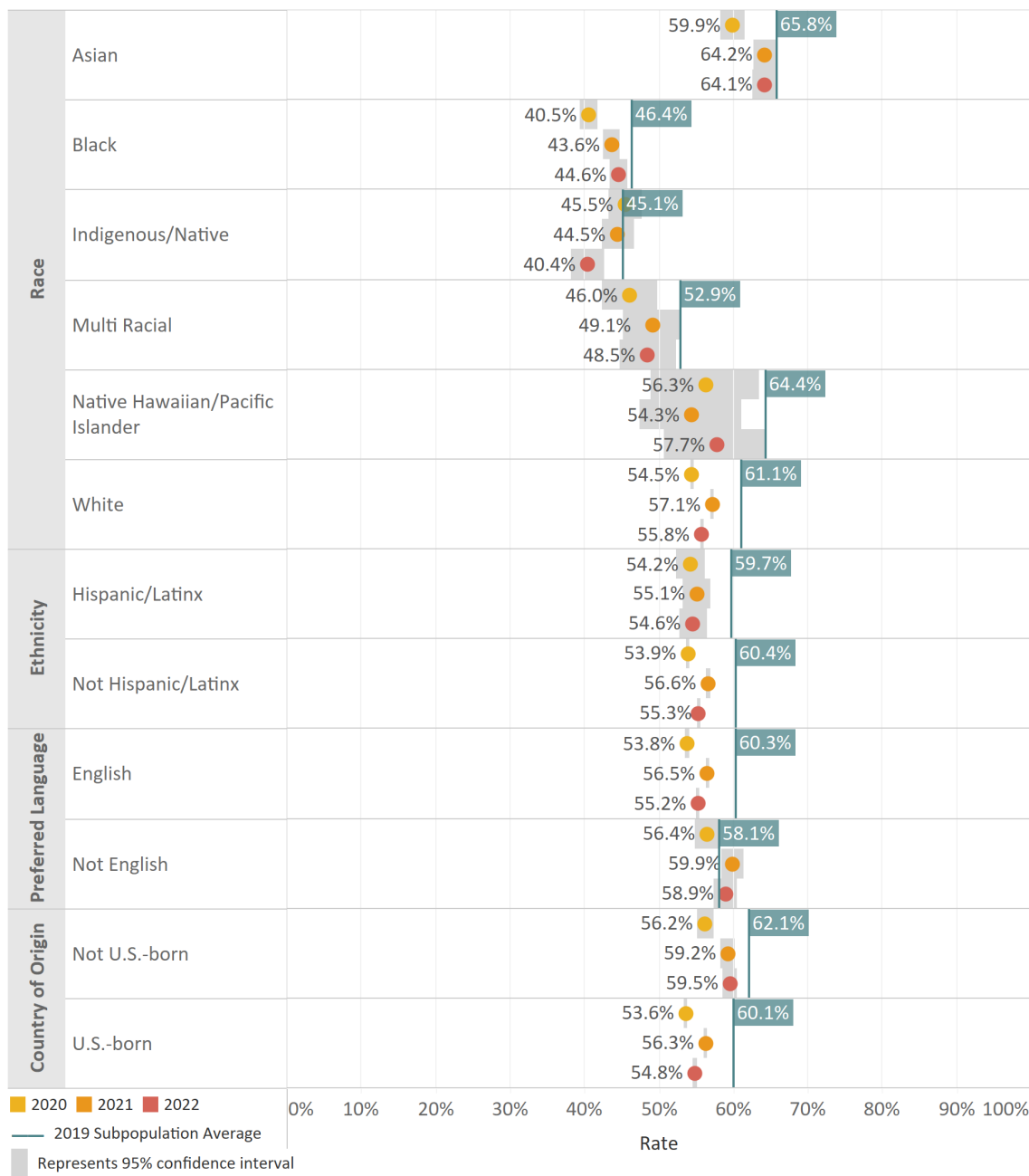
Compared to the statewide average for Optimal Vascular Care, patients from:

↑ India or Laos have significantly higher rates of optimal care.

See [page 53](#) for measure definitions.

OPTIMAL VASCULAR CARE

Trend by RELC Subpopulations



Comparison to 2021

The optimal rates in 2022 were not statistically different than the respective 2021 rates in all subpopulations, except for the following populations:

- White
- Not Hispanic/Latinx
- English speakers
- U.S.-born

The rates for these populations were significantly lower than their rates in 2021.

Comparison to Pre-Pandemic (2019)

The optimal rates in 2022 were significantly lower than the respective 2019 rates for all subpopulations, except for the following populations:

- Asian
- Black
- Multi Racial
- Native Hawaiian/Pacific Islander
- Non-English speakers

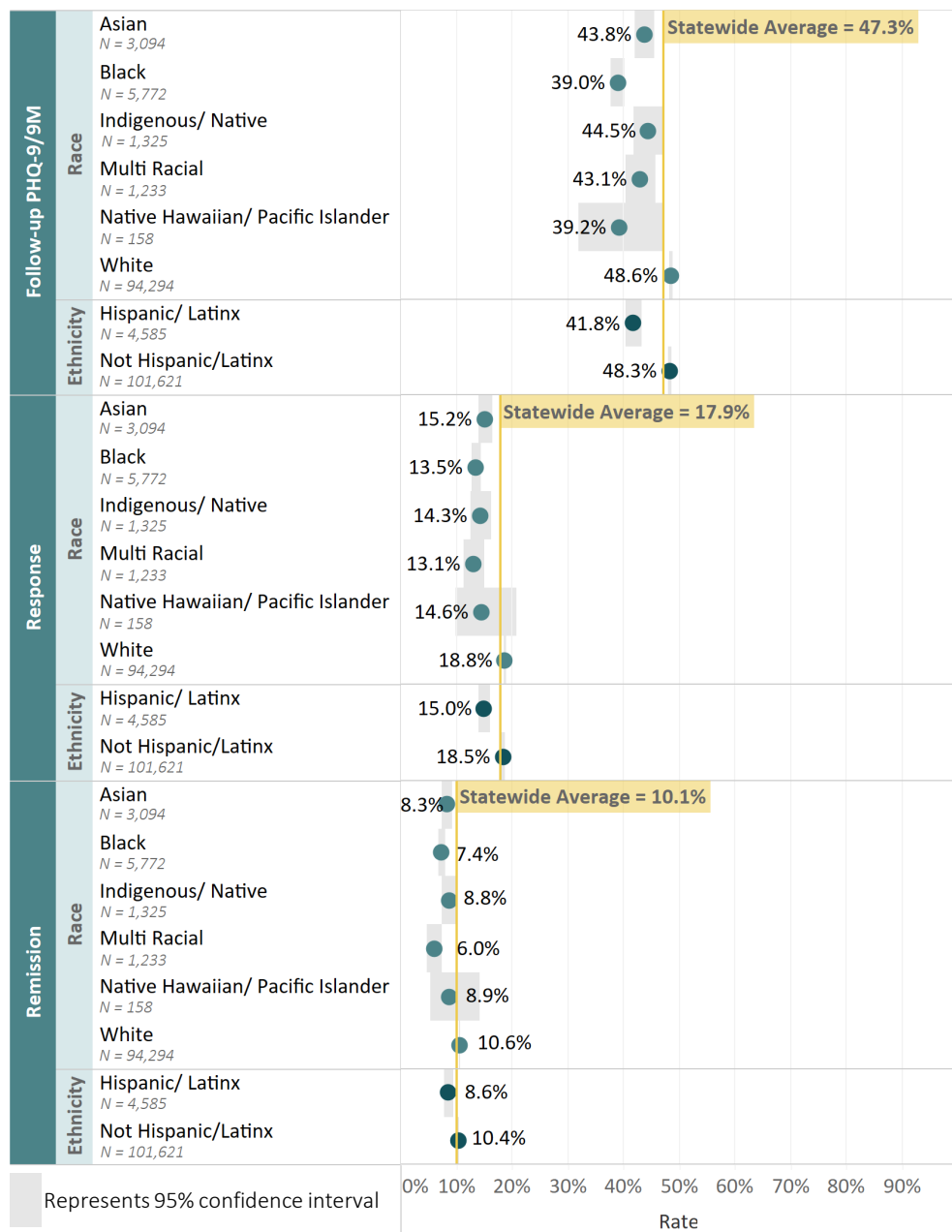
The 2022 rates for these populations were not statistically different than their 2019 rates.

See [page 53](#) for measure definitions.

ADULT DEPRESSION: SIX MONTH MEASURES

Race/Ethnicity Summary

2022 measurement year



Follow-up at Six Months

Compared to the statewide average for Follow-up PHQ-9/9M at Six Months, adults who are:

RACE

- ↓ Asian, Black, or Multi Racial have significantly lower rates of follow-up.
- ↑ White have a significantly higher rate of follow-up.

ETHNICITY

- ↓ Hispanic/Latinx have significantly lower rates of follow-up.

Response at Six Months

Compared to the statewide average for Response at Six Months, adults who are:

RACE

- ↓ Asian, Black, Indigenous/Native, or Multi Racial have significantly lower rates of response.
- ↑ White have a significantly higher rate of response.

ETHNICITY

- ↑ Not Hispanic/Latinx have significantly higher rates of response.

Remission at Six Months

Compared to the statewide average for Remission at Six Months, adults who are:

RACE

- ↓ Asian, Black, or Multi Racial have significantly lower rates of remission
- ↑ White have a significantly higher rate of remission.

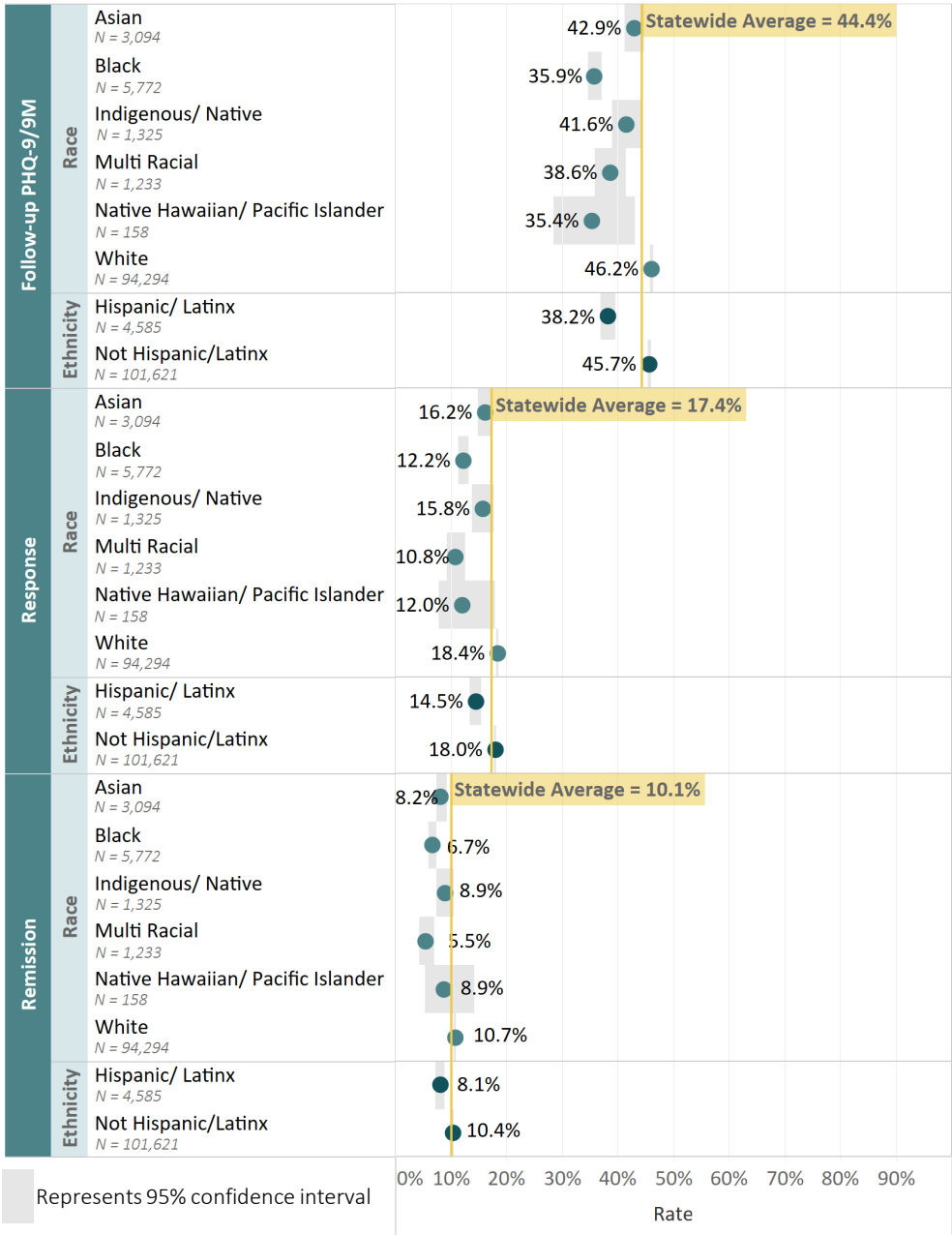
ETHNICITY

- ↓ Hispanic/Latinx have significantly lower rates of remission.

ADULT DEPRESSION: 12 MONTH MEASURES

Race/Ethnicity Summary

2022 measurement year



Follow-up at 12 Months

Compared to the statewide average for Follow-up PHQ-9/9M at 12 Months, adults who are:

RACE

- ↓ Black, Multi Racial, or Native Hawaiian/Pacific Islander have significantly lower rates of follow-up.
- ↑ White have a significantly higher rate of follow-up.

ETHNICITY

- ↓ Hispanic/Latinx have a significantly lower rate of follow-up.
- ↑ Not Hispanic/Latinx have a significantly lower rate of follow-up.

Response at 12 Months

Compared to the statewide average for Response at 12 Months, adults who are:

RACE

- ↓ Black or Multi Racial have significantly lower rates of response.
- ↑ White have a significantly higher rate of response.

ETHNICITY

- ↓ Hispanic/Latinx have a significantly lower rate of response
- ↑ Not Hispanic/Latinx have a significantly higher rate of response.

Remission at 12 Months

Compared to the statewide average for Remission at 12 Months, adults who are:

RACE

- ↓ Asian, Black, or Multi Racial have significantly lower rates of remission.
- ↑ White have a significantly higher rate of remission.

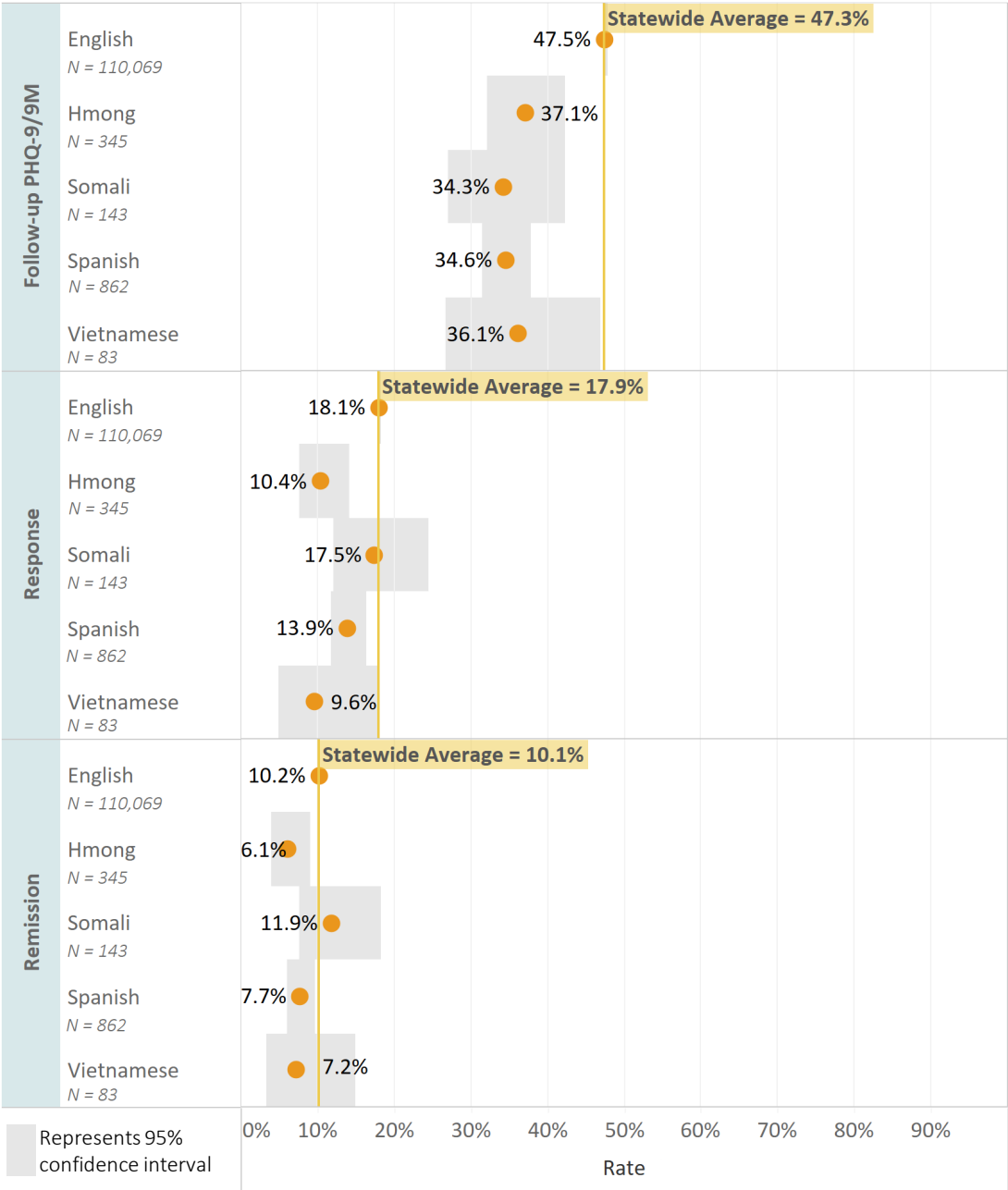
ETHNICITY

- ↓ Hispanic/Latinx have a significantly lower rate of remission.

ADULT DEPRESSION: SIX MONTH MEASURES

Preferred Language Summary

2022 measurement year



Patients who prefer to speak English, Hmong, Somali, Spanish, or Vietnamese make up 99% of the eligible population for the suite of Adult Depression measures.

Follow-up at Six Months

Compared to the statewide average for Follow-up PHQ-9/9M at Six Months, adults who prefer to speak:

↓ Hmong, Somali, Spanish, or Vietnamese have significantly lower rates of follow-up.

Response at Six Months

Compared to the statewide average for Response at Six Months, adults who prefer to speak:

↓ Hmong or Spanish have significantly lower rates of response.

Remission at Six Months

Compared to the statewide average for Remission at Six Months, adults who prefer to speak:

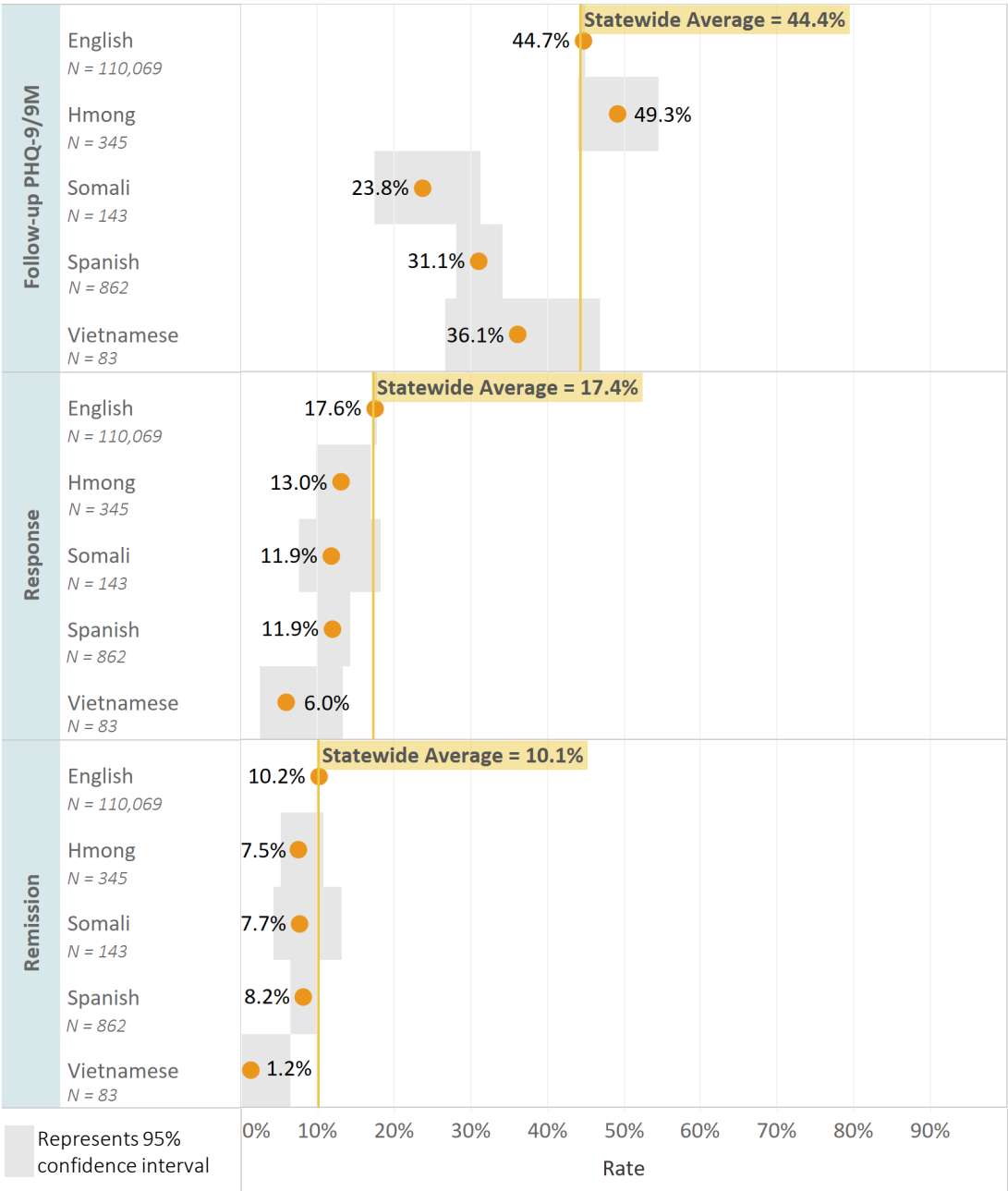
↓ Hmong or Spanish have significantly lower rates of remission.

See [page 53](#) for measure definitions.

ADULT DEPRESSION: 12 MONTH MEASURES

Preferred Language Summary

2022 measurement year



Patients who prefer to speak English, Hmong, Somali, Spanish, or Vietnamese make up 99% of the eligible population for the suite of Adult Depression measures.

Follow-up at 12 Months

Compared to the statewide average for Follow-up PHQ-9/9M at 12 Months, adults who prefer to speak:

↓ Somali or Spanish have significantly lower rates of follow-up.

Response at 12 Months

Compared to the statewide average for Response at 12 Months, adults who prefer to speak:

↓ Hmong, Spanish, or Vietnamese have significantly lower rates of response.

Remission at 12 Months

Compared to the statewide average for Remission at 12 Months, adults who prefer to speak:

↓ Vietnamese have a significantly lower rate of remission.

See [page 53](#) for measure definitions.

ADULT DEPRESSION: SIX MONTH MEASURES

Country of Origin Summary

2022 measurement year



Patients from China, Laos, Mexico, Somalia, or the United States make up 96% of the eligible population for the suite of Adult Depression measures.

Follow-up at Six Months

Compared to the statewide average for Follow-up PHQ-9/9M at Six Months, adults from:

↓ Laos, Mexico, or Somalia have significantly lower rates of follow-up.

Response at Six Months

Compared to the statewide average for Response at Six Months, adults from:

↓ Laos or Mexico have significantly lower rates of response.

Remission at Six Months

Compared to the statewide average for Remission at Six Months, adults from:

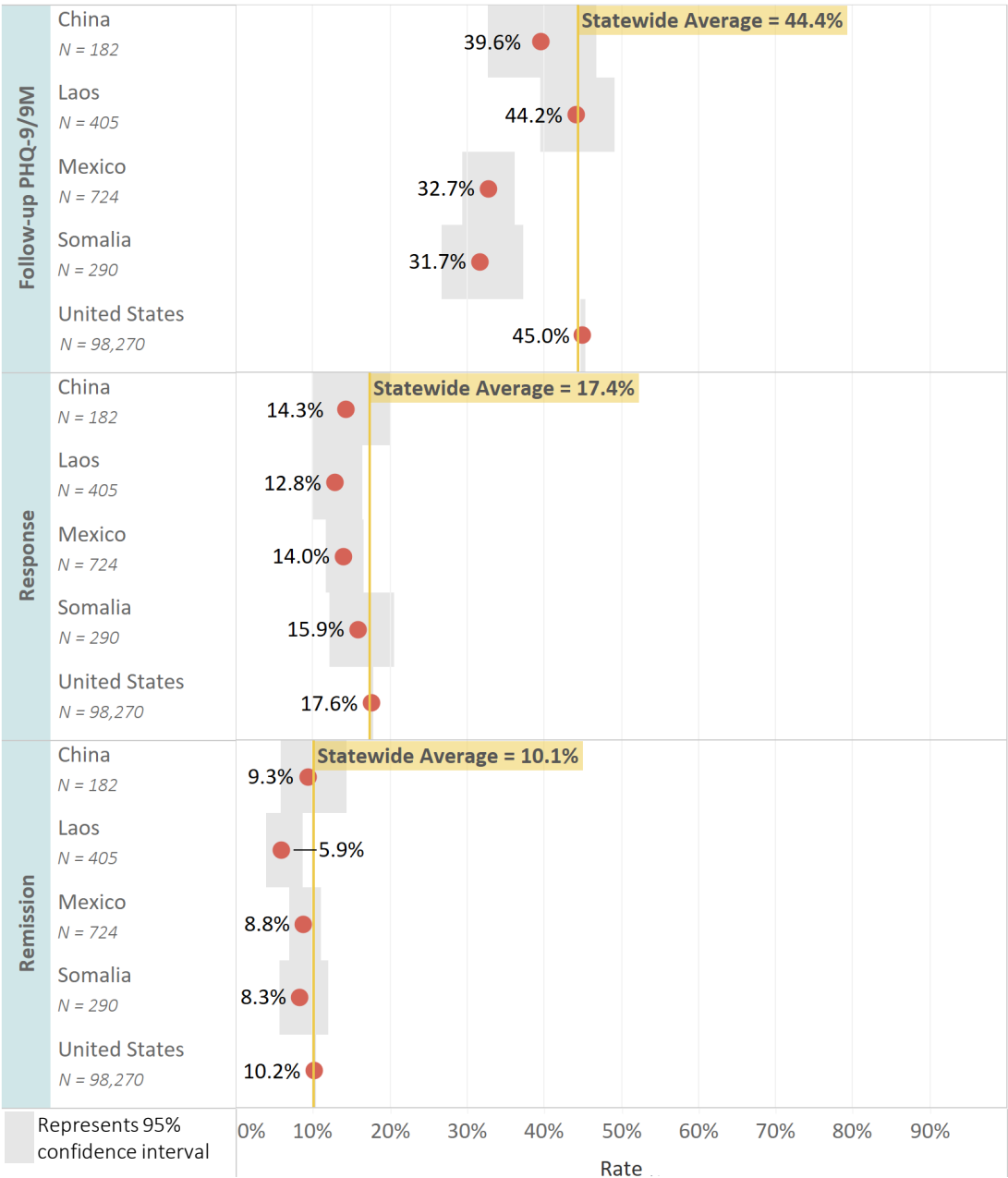
↓ Laos have a significantly lower rate of remission.

See [page 53](#) for measure definitions.

ADULT DEPRESSION: 12 MONTH MEASURES

Country of Origin Summary

2022 measurement year



Patients from China, Laos, Mexico, Somalia, or the United States make up 96% of the eligible population for the suite of Adult Depression measures.

Follow-up at 12 Months

Compared to the statewide average for Follow-up PHQ-9/9M at 12 Months, adults from:

↓ Mexico or Somalia have significantly lower rates of follow-up.

Response at 12 Months

Compared to the statewide average for Response at 12 Months, adults from:

↓ Laos or Mexico have significantly lower rates of response.

Remission at 12 Months

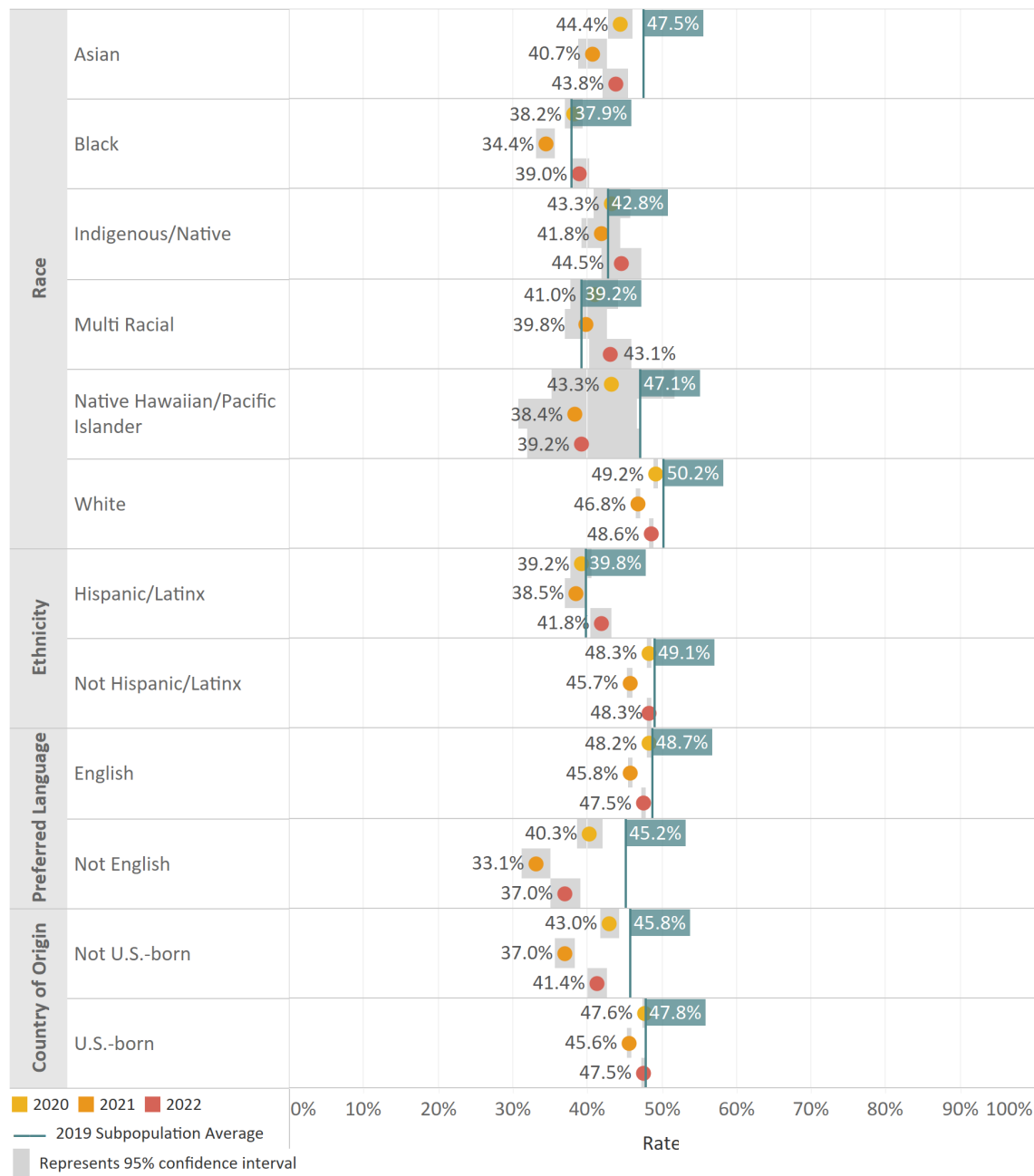
Compared to the statewide average for Remission at 12 Months, adults who prefer to speak:

↓ Laos have a significantly lower rate of remission.

See [page 53](#) for measure definitions.

ADULT DEPRESSION: FOLLOW-UP PHQ-9/9M AT SIX MONTHS

Trend by RELC Subpopulations



Comparison to 2021

The follow-up rates in 2022 significantly increased compared to the respective 2021 rates in all subpopulations, except for the following populations:

- Asian
- Indigenous/Native
- Multi Racial
- Native Hawaiian/Pacific Islander
- Non-English speakers

The rates for these populations were not statistically different than their rates in 2021.

Comparison to Pre-Pandemic (2019)

The follow-up rates in 2022 were significantly lower than the respective 2019 rates in all subpopulations, except for the following populations:

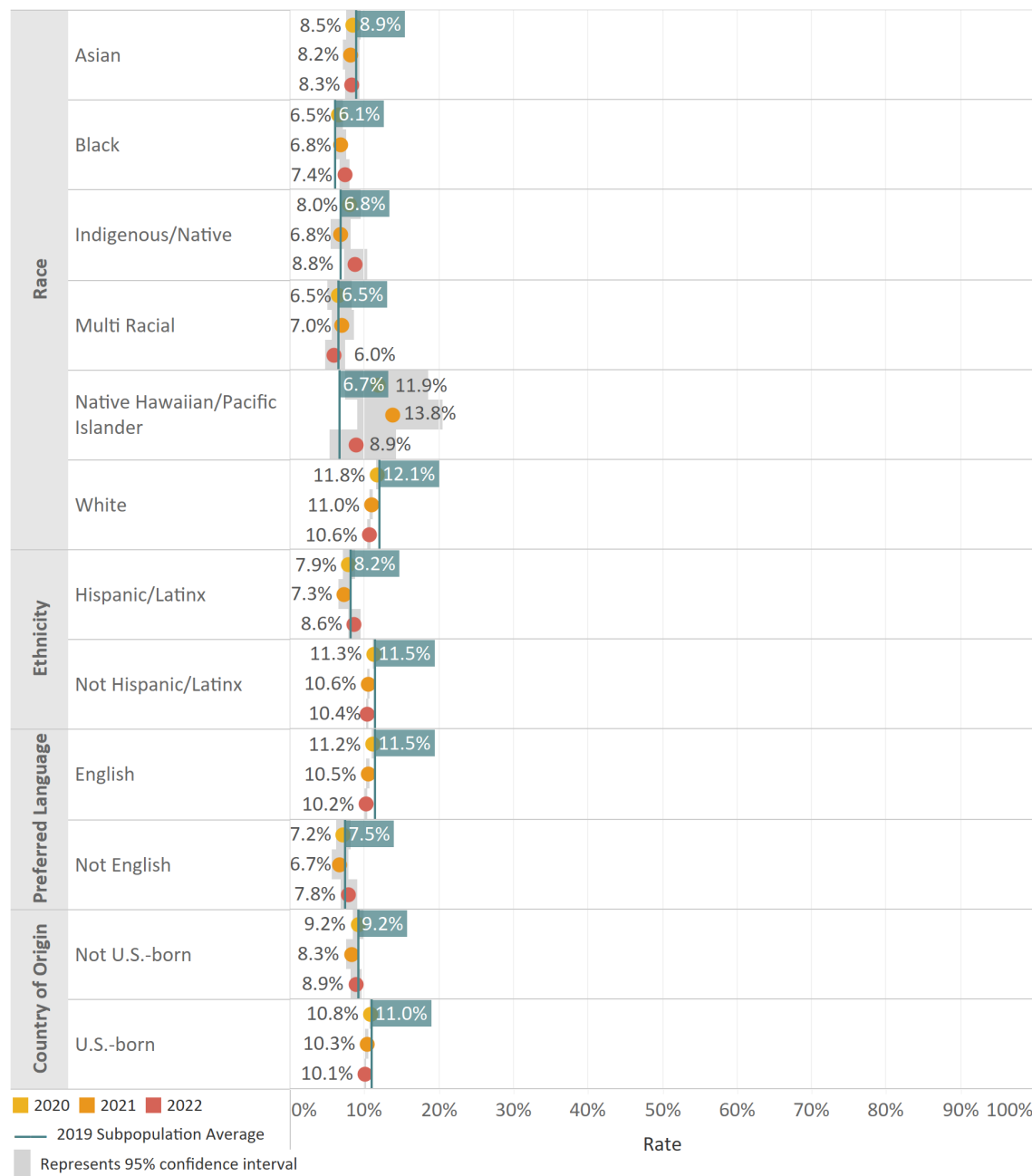
- Black
- Indigenous/Native
- Multi Racial
- Native Hawaiian/Pacific Islander
- Hispanic/Latinx
- U.S.-born

The rates for these populations were not statistically different than their rates in 2019.

See [page 53](#) for measure definitions.

ADULT DEPRESSION: REMISSION AT SIX MONTHS

Trend by RELC Subpopulations



Comparison to 2021

The remission rates in 2022 were not statistically different than the respective 2021 rates in all subpopulations.

Comparison to Pre-Pandemic (2019)

The remission rates in 2022 were not statistically different than the respective 2019 rates in all subpopulations, except for the following populations:

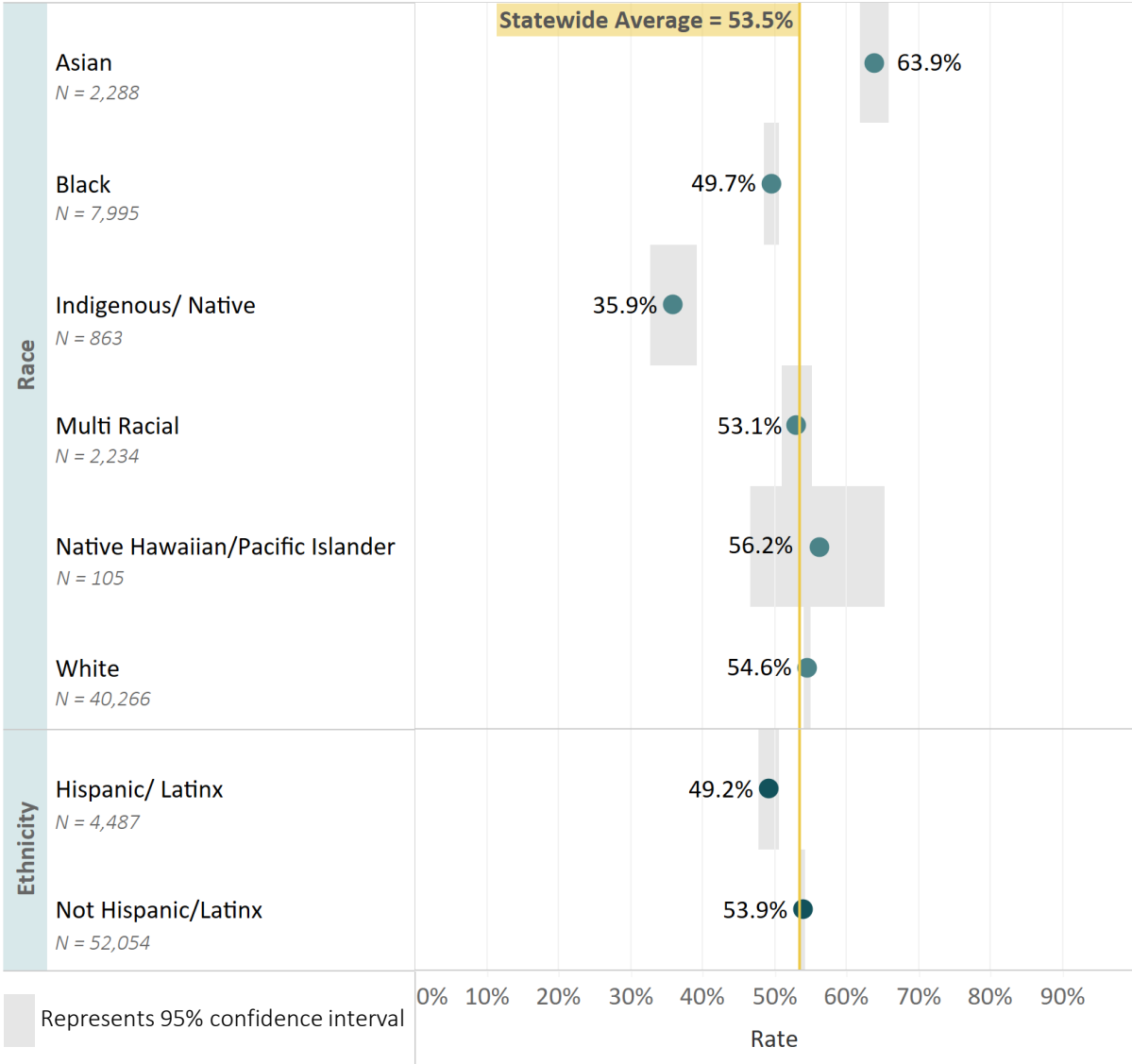
- Black
Significantly higher than 2019 rate
- White
Significantly lower than 2019 rate
- Not Hispanic/Latinx
Significantly lower than 2019 rate
- English speakers
Significantly lower than 2019 rate
- U.S.-born
Significantly lower than 2019 rate

See [page 53](#) for measure definitions.

OPTIMAL ASTHMA CONTROL – CHILDREN

Race/Ethnicity Summary

2022 measurement year



Compared to the statewide average for Optimal Asthma Control, children who are:

RACE

↓ Black or Indigenous/Native have significantly lower rates of optimal control.

↑ Asian or White have significantly higher rates of optimal control.

ETHNICITY

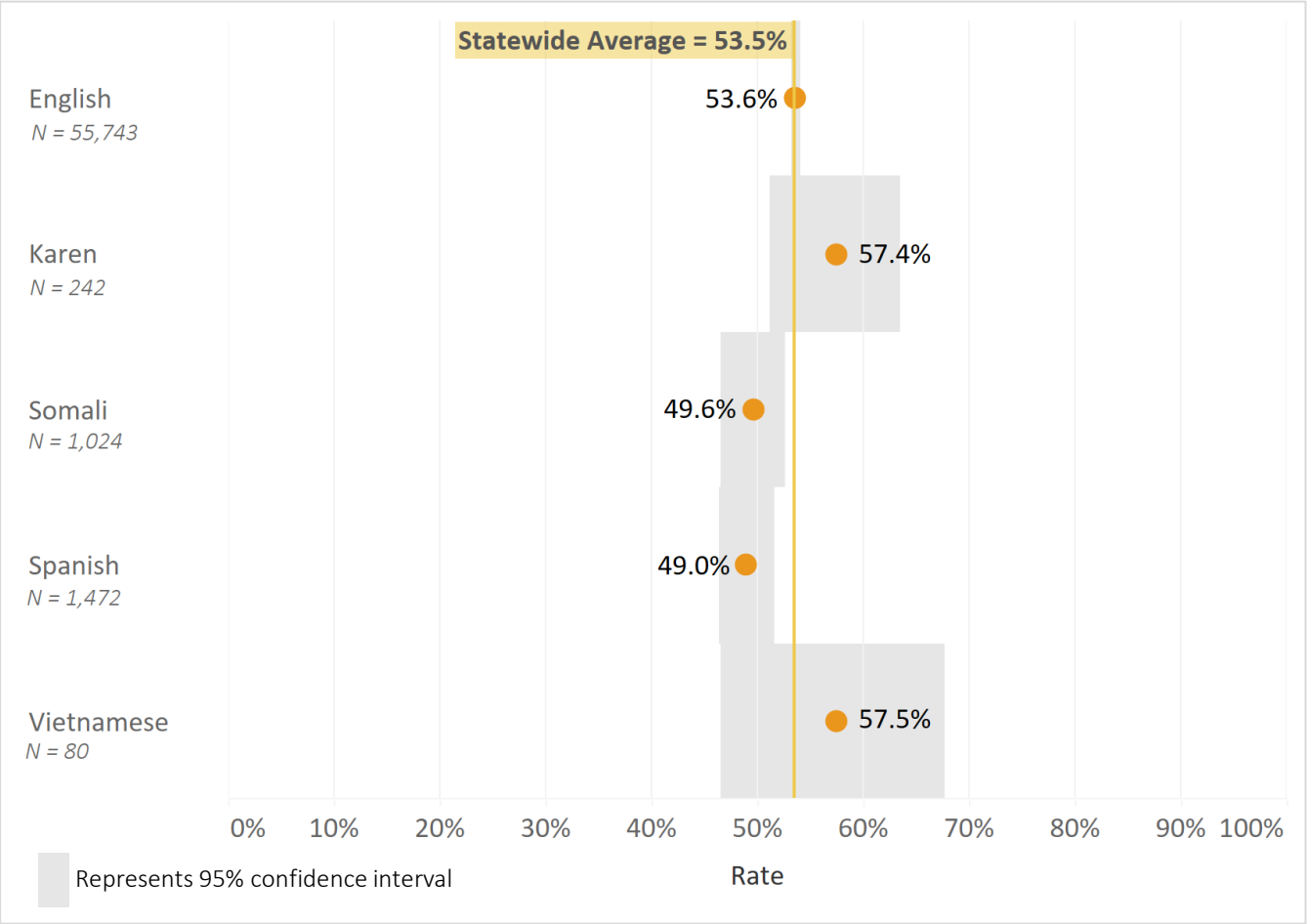
↓ Hispanic/Latinx have significantly lower rates of optimal control.

See [page 53](#) for measure definitions.

OPTIMAL ASTHMA CONTROL – CHILDREN

Preferred Language Summary

2022 measurement year



Patients who prefer to speak English, Karen, Somali, Spanish, or Vietnamese make up 99% of the eligible child population for the Optimal Asthma Control measure.

Compared to the statewide average for Optimal Asthma Control, children who prefer to speak:

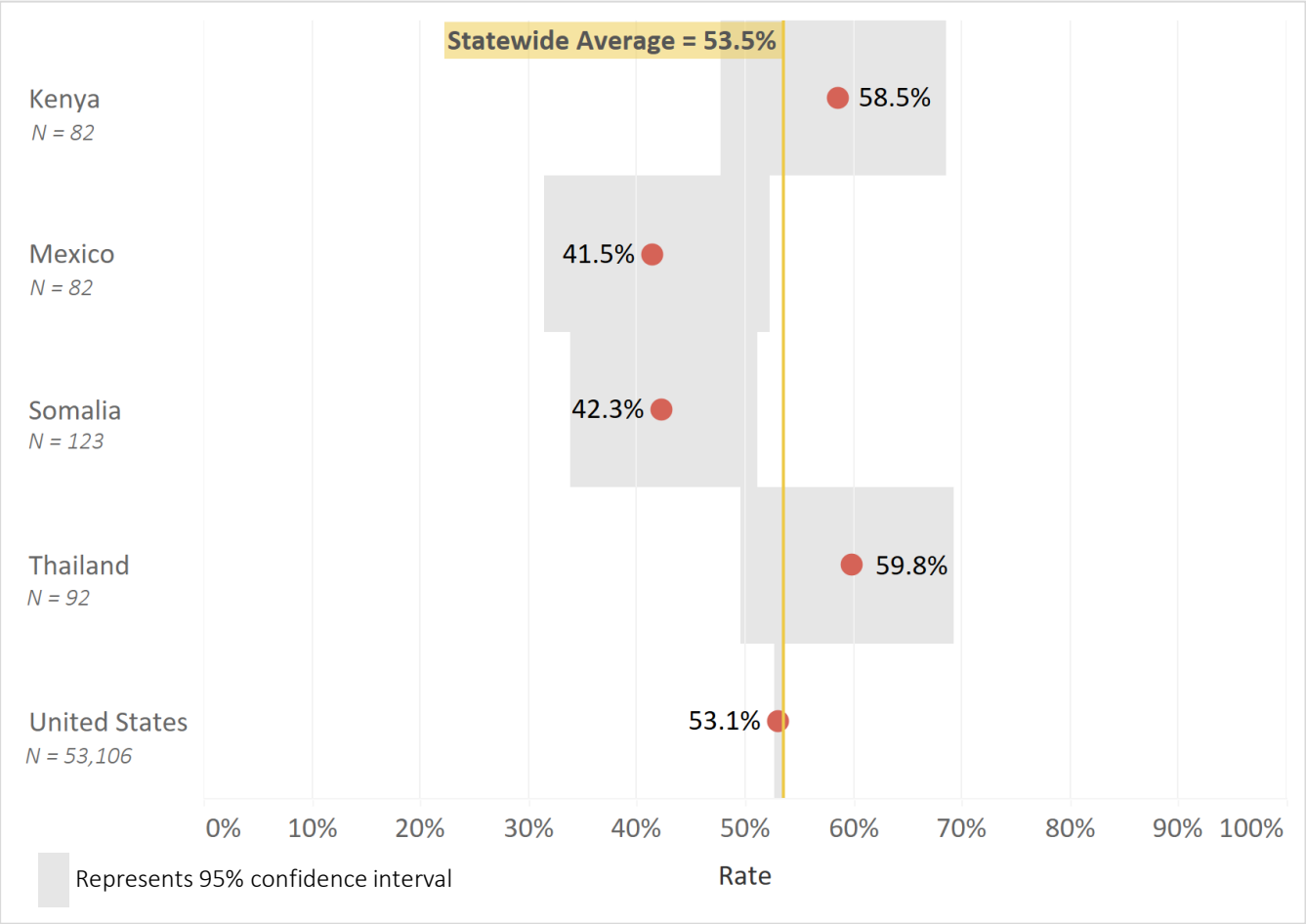
↓ Somali or Spanish have significantly lower rates of optimal control.

See [page 53](#) for measure definitions.

OPTIMAL ASTHMA CONTROL – CHILDREN

Country of Origin Summary

2022 measurement year



Patients from Kenya, Mexico, Somalia, Thailand, or the United States make up 98% percent of the eligible child population for the Optimal Asthma Control measure.

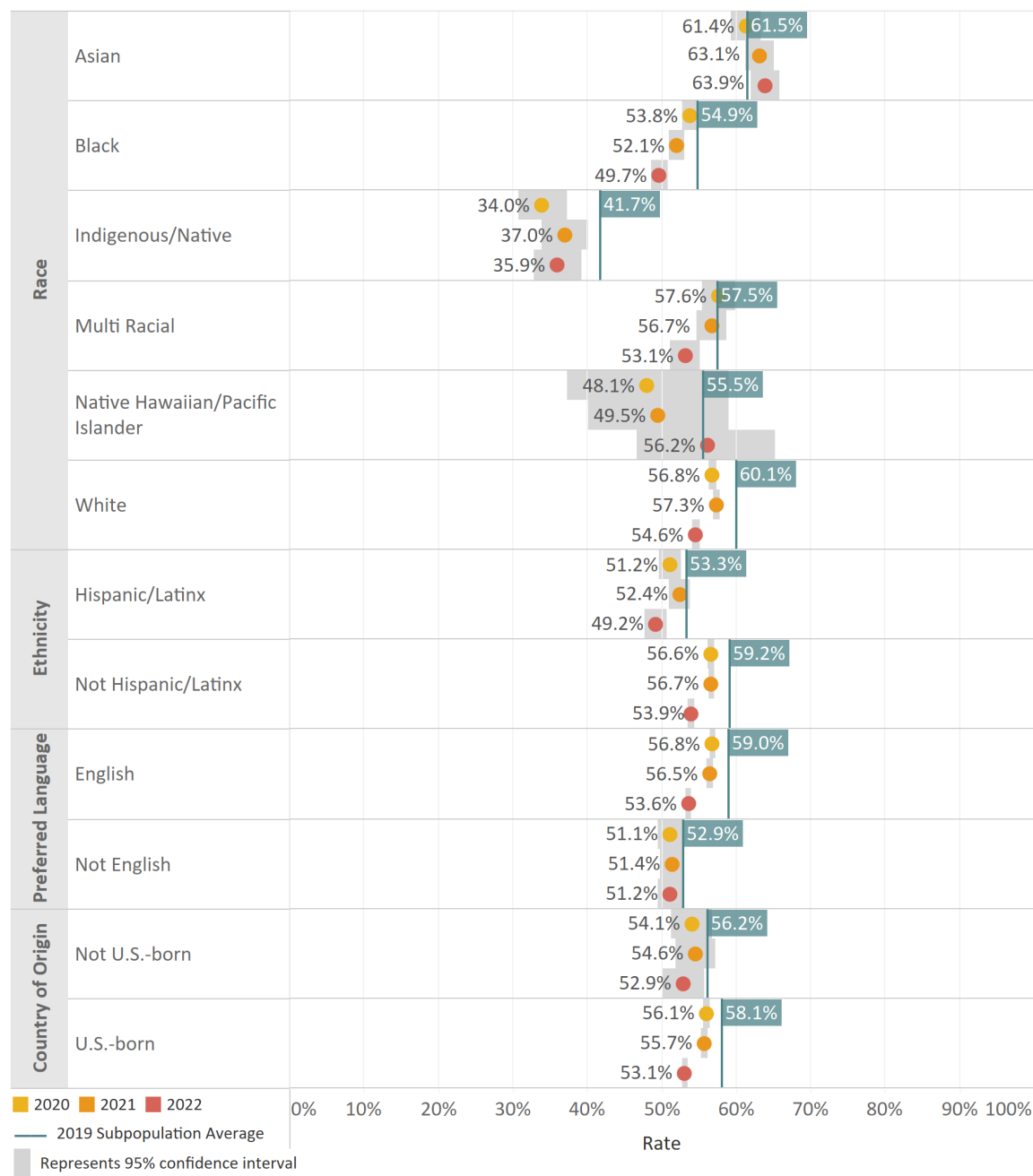
Compared to the statewide average for Optimal Asthma Control, children from:

↓ Mexico or Somalia have significantly lower rates of optimal control.

See [page 53](#) for measure definitions.

OPTIMAL ASTHMA CONTROL – CHILDREN

Trend by RELC Subpopulations



Comparison to 2021

The optimal rates in 2022 significantly decreased compared to the respective 2021 rates in all subpopulations, except for the following populations:

- Asian
- Indigenous/Native
- Multi Racial
- Native Hawaiian/Pacific Islander
- Non-English speakers
- Not U.S.-born

The rates for these populations were not statistically different than their rates in 2021.

Comparison to Pre-Pandemic (2019)

The optimal rates in 2022 were significantly lower than the respective 2019 rates in all subpopulations, except for the following populations:

- Asian
- Indigenous/Native
- Native Hawaiian/Pacific Islander
- Non-English speakers
- Not U.S.-born

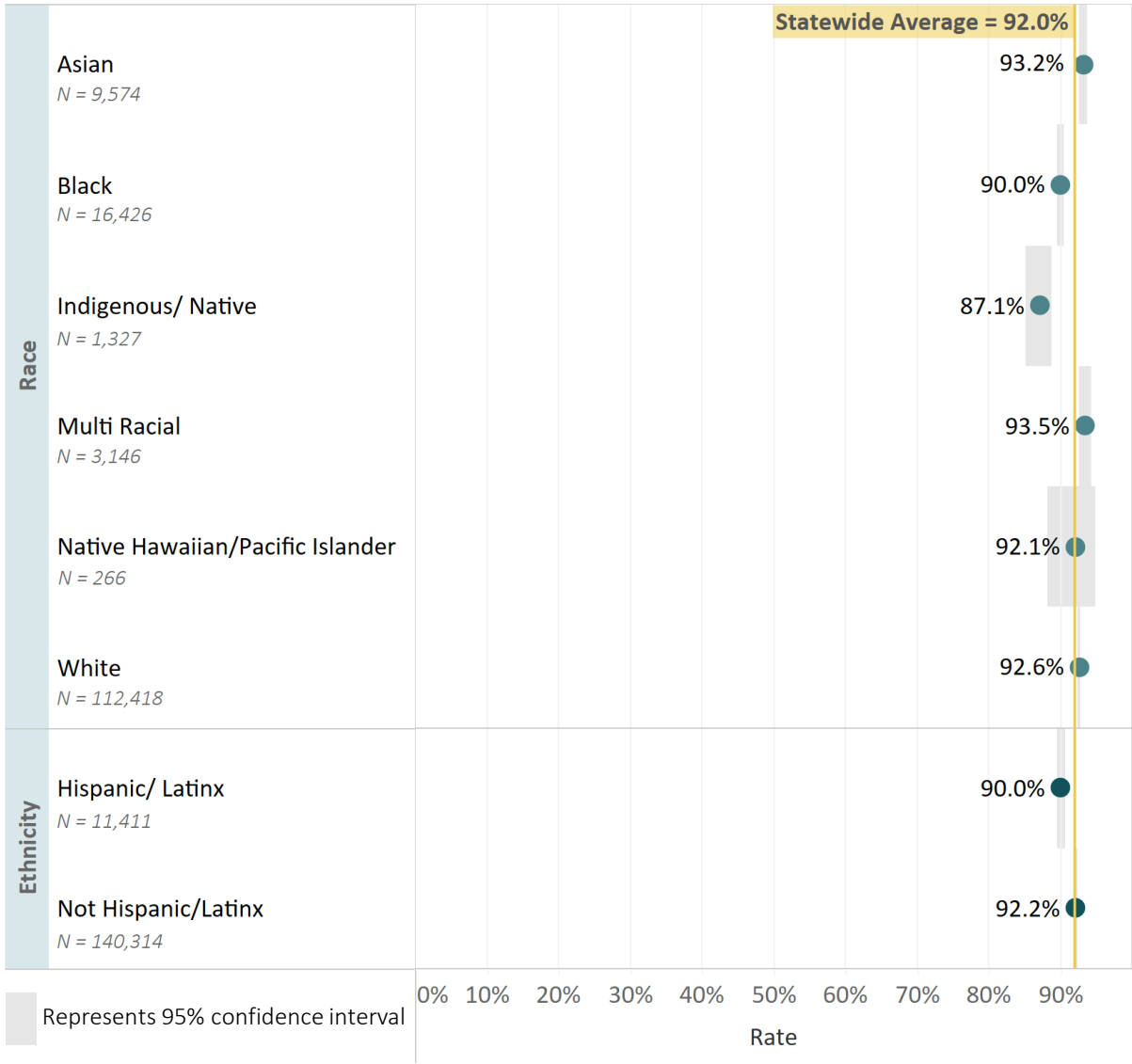
The rates for these populations were not statistically different than their rates in 2019.

See [page 53](#) for measure definitions.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

Race/Ethnicity Summary

2022 measurement year



Compared to the statewide average for Adolescent Mental Health Screening, patients who are:

RACE

↓ Black or Indigenous/Native have significantly lower rates of screening.

↑ Asian, Multi Racial, or White have significantly higher rates of screening.

ETHNICITY

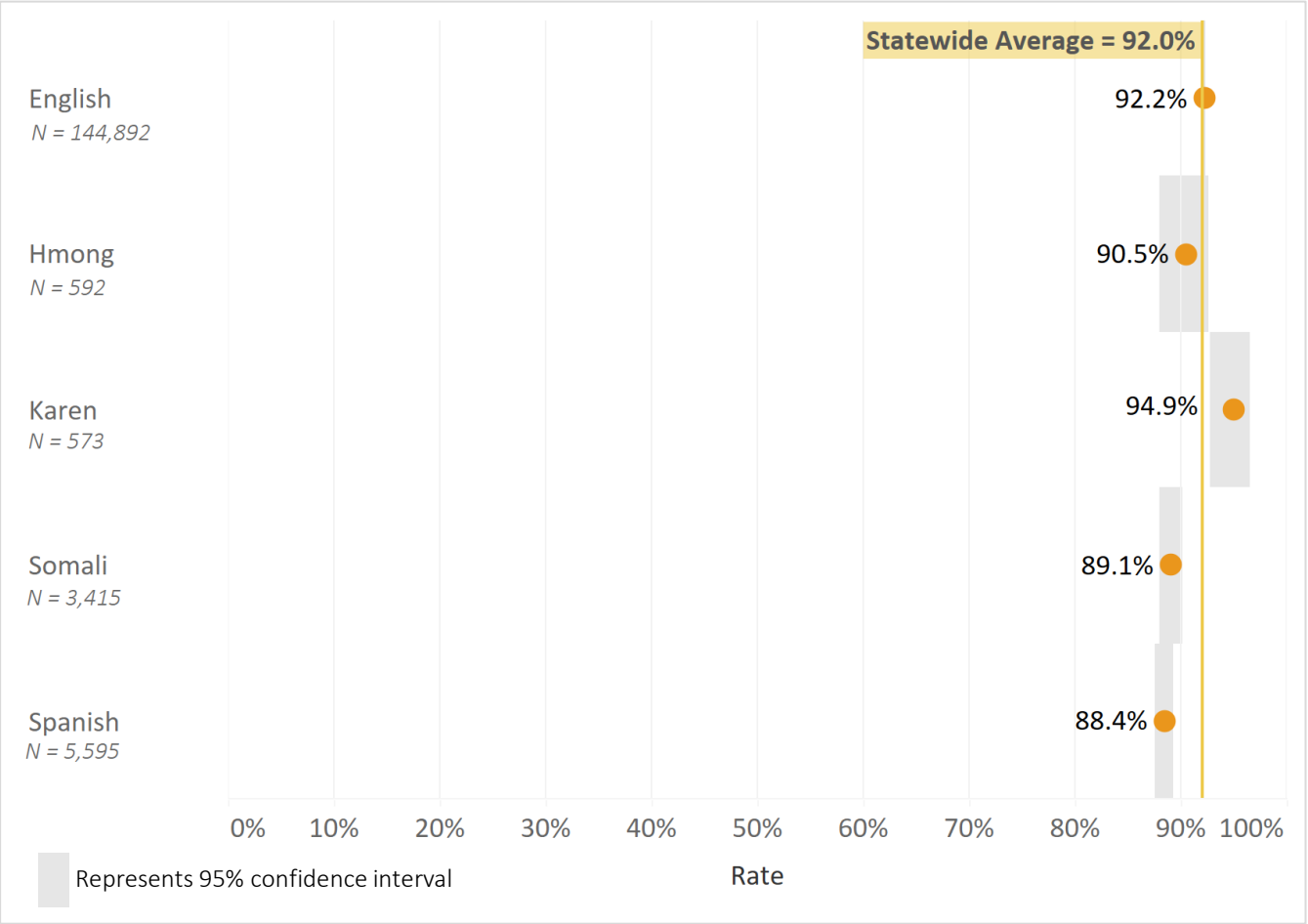
↓ Hispanic/Latinx have significantly lower rates of screening.

See [page 53](#) for measure definitions.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

Preferred Language Summary

2022 measurement year



Patients who prefer to speak English, Hmong, Karen, Somali, or Spanish make up 98% of the eligible population for the Adolescent Mental Health Screening measure.

Compared to the statewide average for Adolescent Mental Health Screening, patients who prefer to speak:

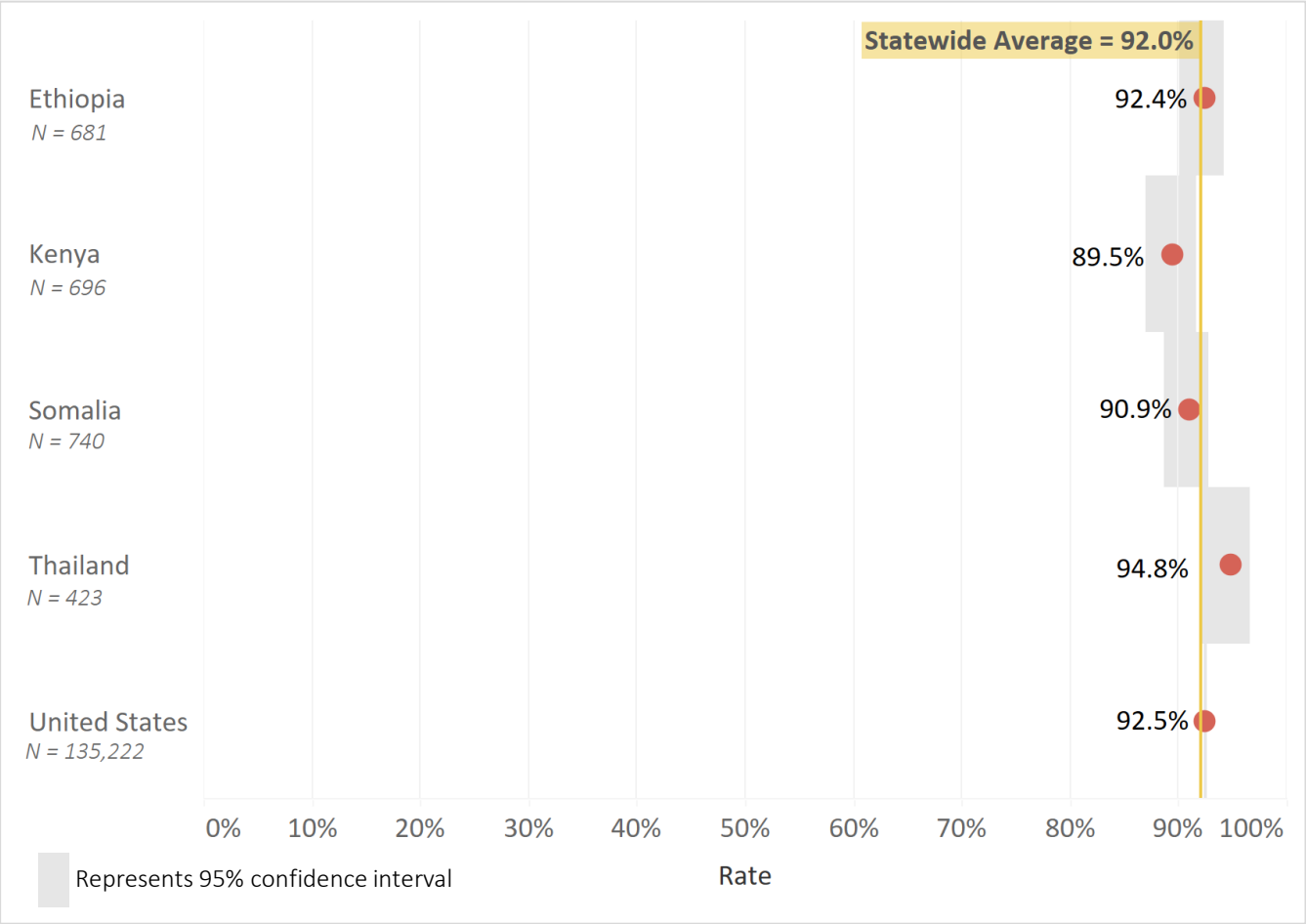
- ↓ Somali or Spanish have significantly lower rates of screening.
- ↑ Karen have a significantly higher rate of screening.

See [page 53](#) for measure definitions.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

Country of Origin Summary

2022 measurement year



Patients from Ethiopia, Kenya, Somalia, Thailand, and the United States make up 95% of the eligible population for the Adolescent Mental Health Screening measure.

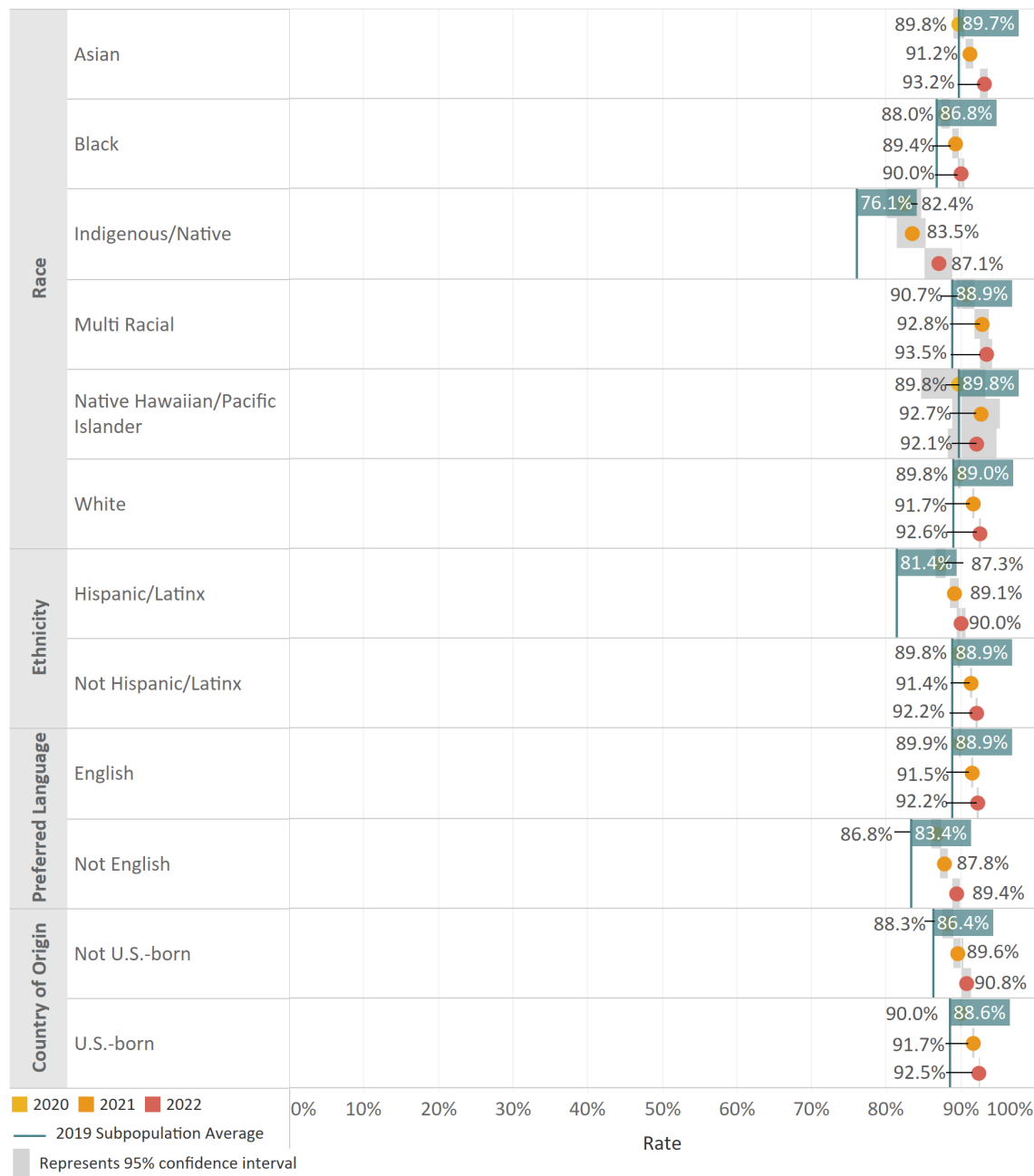
Compared to the statewide average for Adolescent Mental Health Screening, patients from:

- ↓ Kenya have a significantly lower rate of screening.
- ↑ Thailand or the United States have significantly higher rates of screening.

See [page 53](#) for measure definitions.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

Trend by RELC Subpopulations



Comparison to 2021

The screening rates in 2022 significantly increased compared to the respective 2021 rates in all subpopulations, except for the following populations:

- Black
- Indigenous/Native
- Multi Racial
- Native Hawaiian/Pacific Islander
- Hispanic/Latinx
- Not U.S.-born

The rates for these populations were not statistically different than their rates in 2021.

Comparison to Pre-Pandemic (2019)

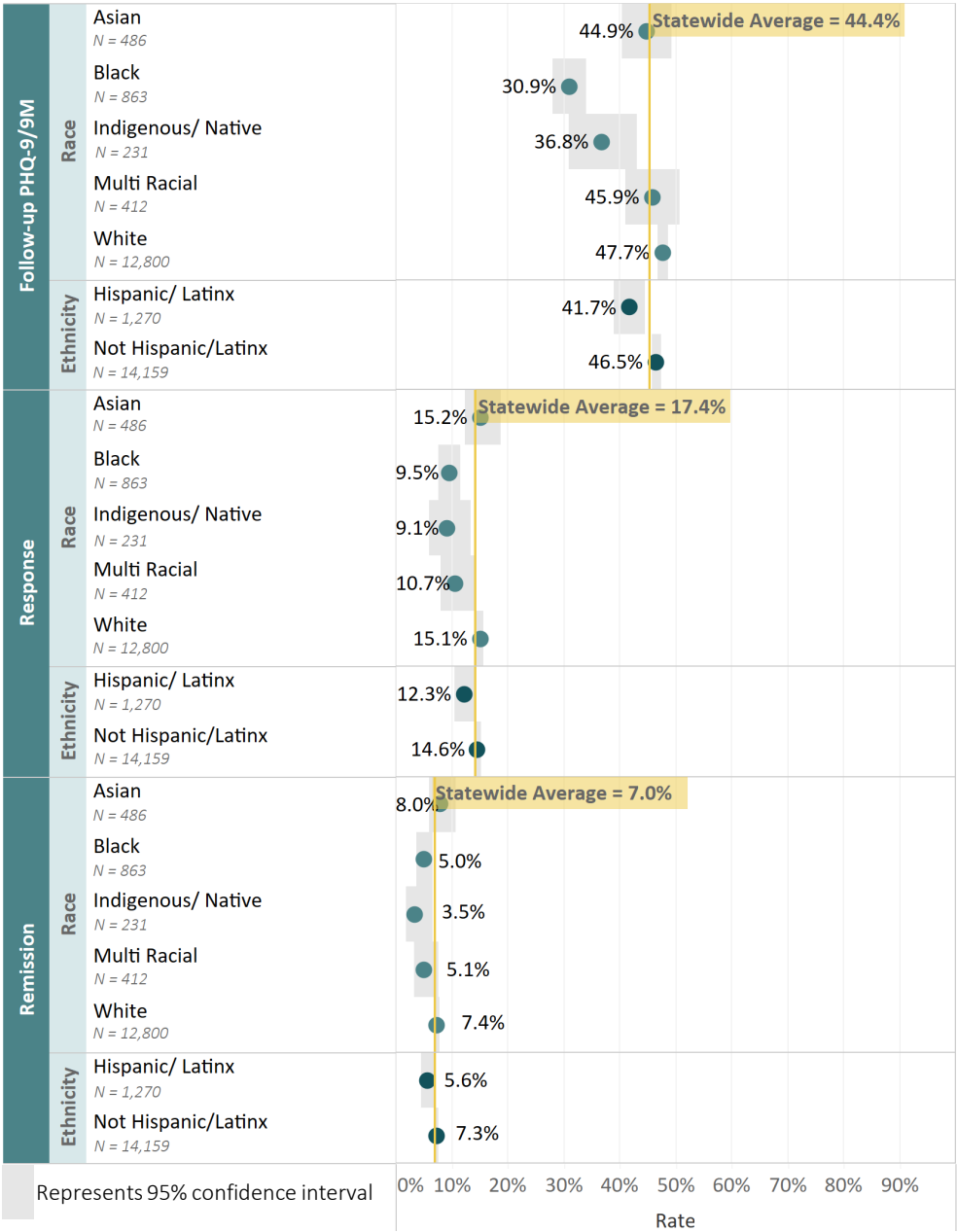
The screening rates in 2022 were significantly higher than the respective 2019 rates in all subpopulations, except for the Native Hawaiian/Pacific Islander population. The 2022 rate for this population was not statistically different than its 2019 rate.

See [page 53](#) for measure definitions.

ADOLESCENT DEPRESSION: SIX MONTH MEASURES

Race/Ethnicity Summary

2022 measurement year



Follow-up at Six Months

Compared to the statewide average for Follow-up PHQ-9/9M at Six Months, adolescents who are:

RACE

↓ Black or Indigenous/Native have significantly lower rates of follow-up.

↑ White have a significantly higher rate of follow-up.

ETHNICITY

↓ Hispanic/Latinx have significantly lower rates of follow-up.

Response at Six Months

Compared to the statewide average for Response at Six Months, adolescents who are:

RACE

↓ Black or Indigenous/Native have significantly lower rates of response.

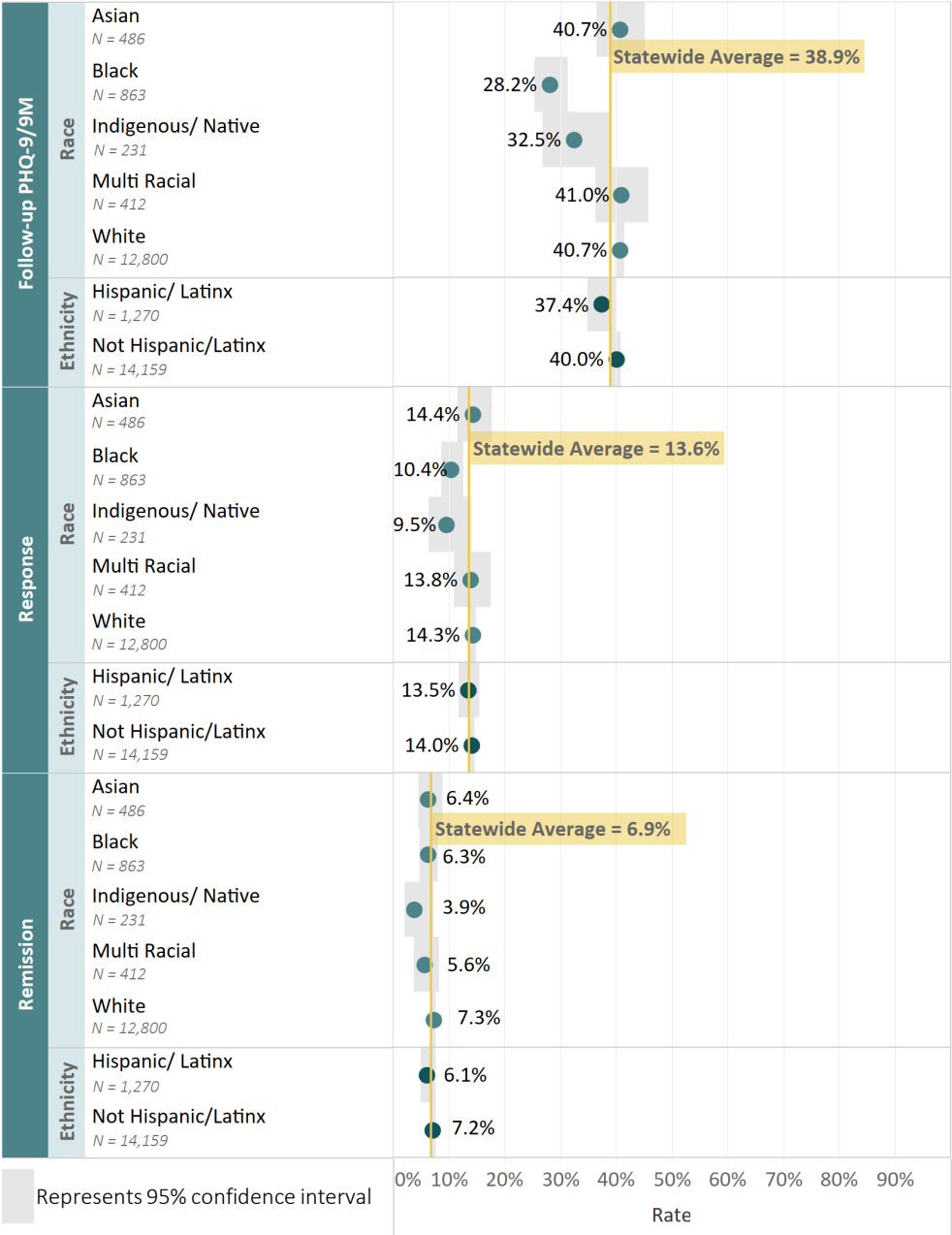
Note: The Native Hawaiian/Pacific Islander category was removed because the number of patients did not meet the reporting threshold of at least 30 patients.

See [page 53](#) for measure definitions.

ADOLESCENT DEPRESSION: 12 MONTH MEASURES

Race/Ethnicity Summary

2022 measurement year



Follow-up at 12 Months

Compared to the statewide average for Follow-up PHQ-9/9M at 12 Months, adolescents who are:

RACE

↓ Black have a significantly lower rate of follow-up.

↑ White have a significantly higher rate of follow-up.

Response at 12 Months

Compared to the statewide average for Response at 12 Months, adolescents who are:

RACE

↓ Black have a significantly lower rate of response.

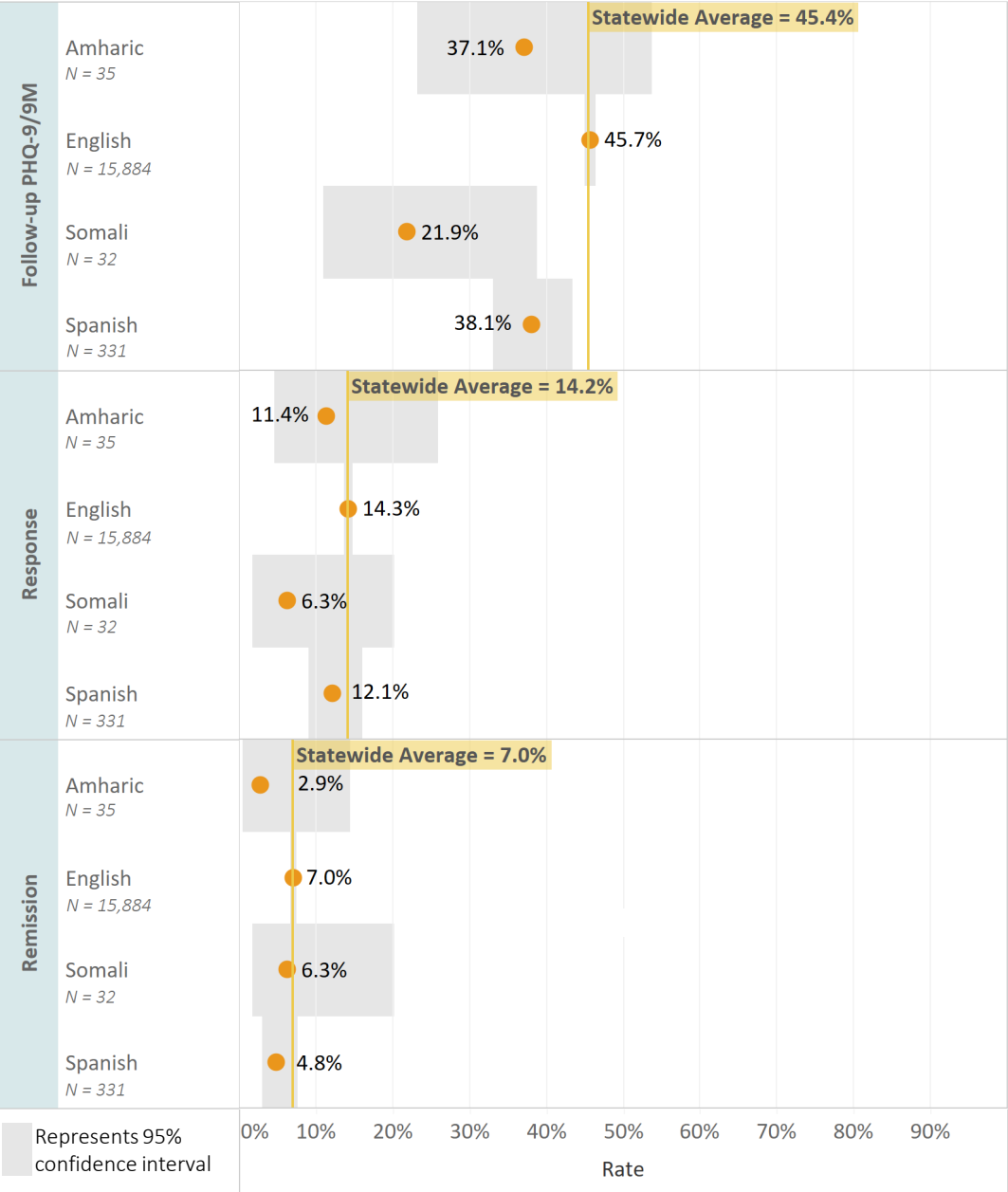
Note: The Native Hawaiian/Pacific Islander category was removed because the number of patients did not meet the reporting threshold of at least 30 patients.

See [page 53](#) for measure definitions.

ADOLESCENT DEPRESSION: SIX MONTH MEASURES

Preferred Language Summary

2022 measurement year



Patients who prefer to speak Amharic, English, Somali, or Spanish make up 99% of the eligible population for the suite of Adolescent Depression measures.

Compared to the statewide average for Follow-up PHQ-9/9M at Six Months, adolescents who prefer to speak:

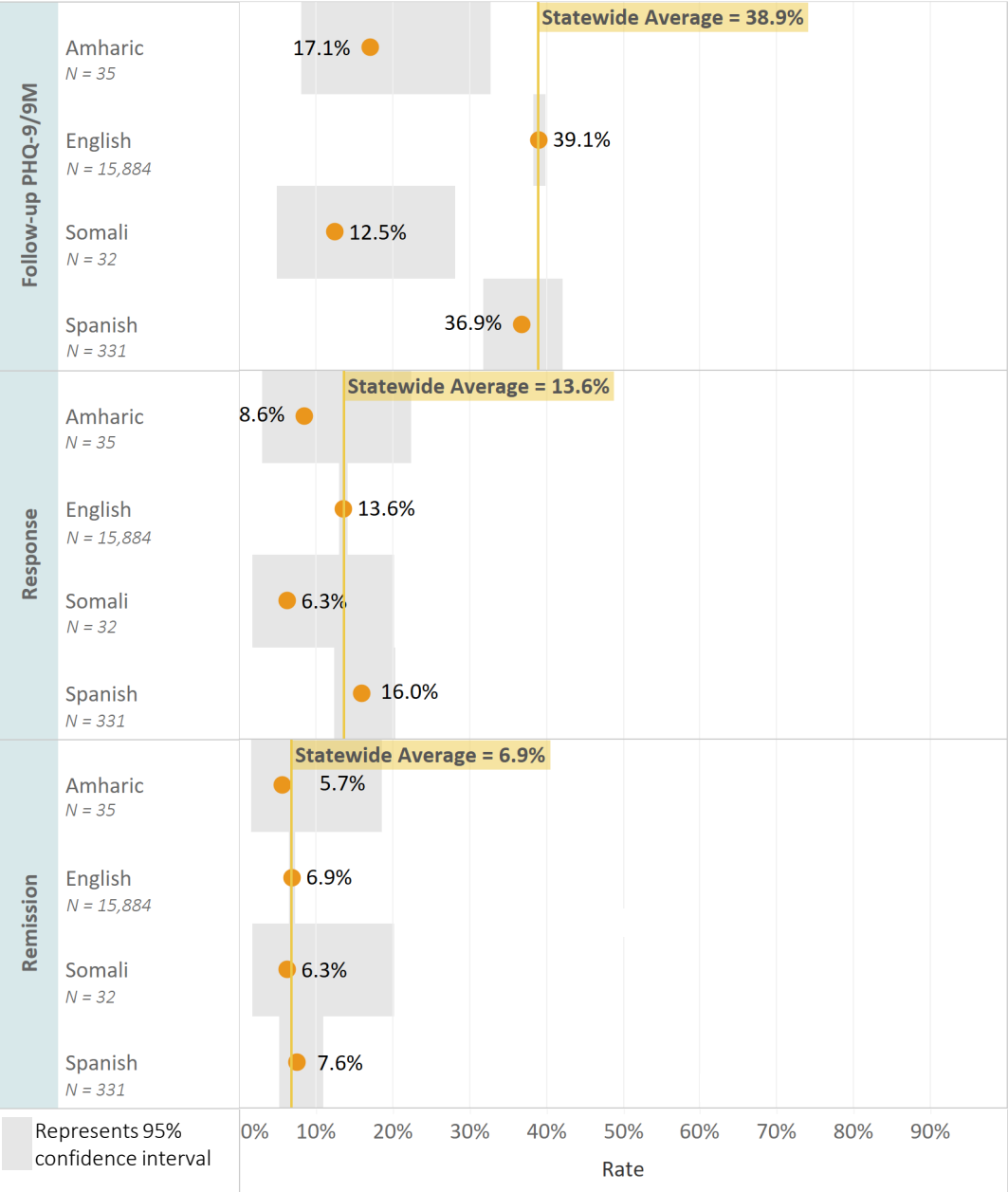
↓ Somali or Spanish have significantly lower rates of follow-up.

See [page 53](#) for measure definitions.

ADOLESCENT DEPRESSION: 12 MONTH MEASURES

Preferred Language Summary

2022 measurement year



Patients who prefer to speak Amharic, English, Somali, or Spanish make up 99% of the eligible population for the suite of Adolescent Depression measures.

Compared to the statewide average for Follow-up PHQ-9/9M at 12 Months, adolescents who prefer to speak:

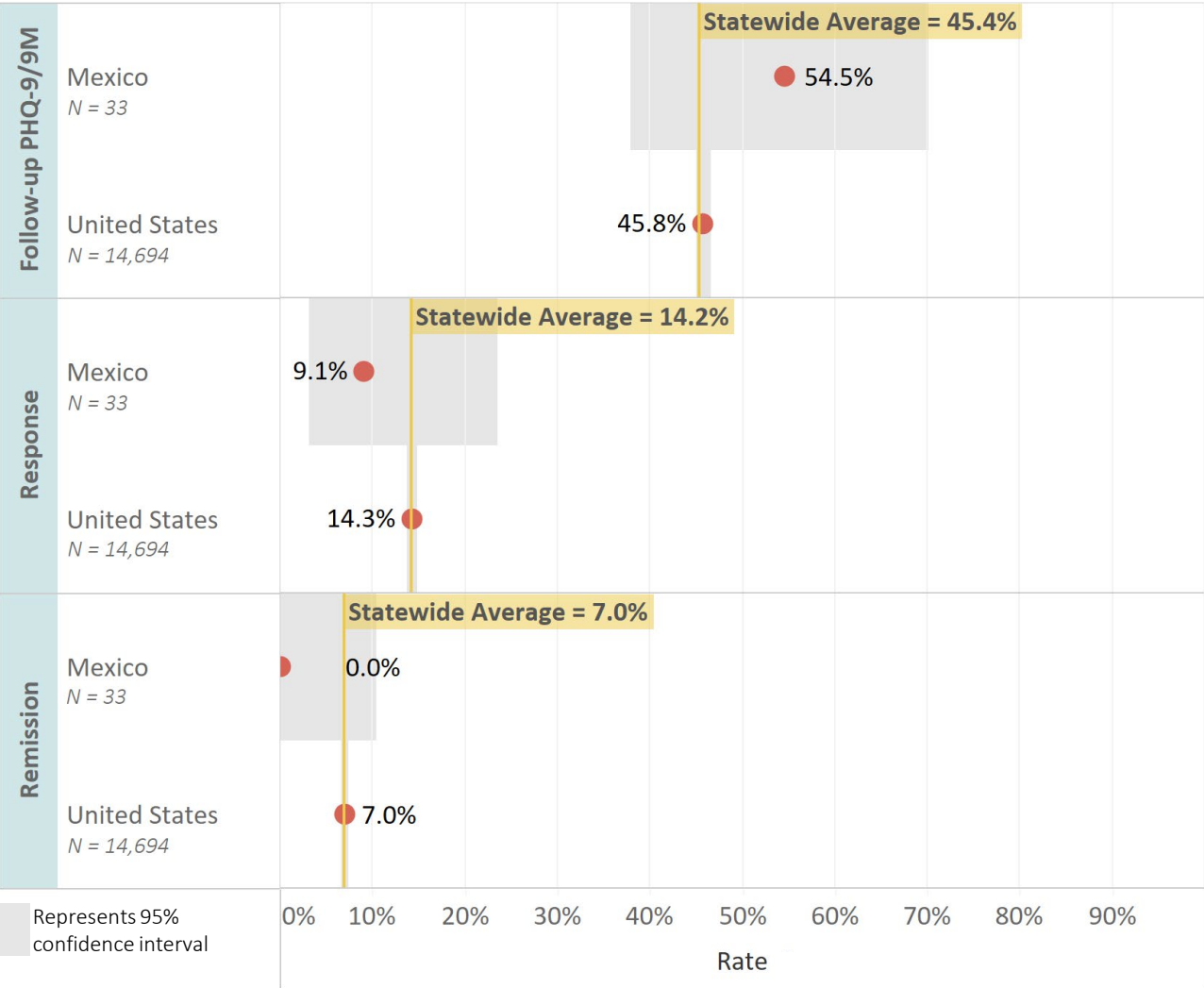
↓ Amharic and Somali have a significantly lower rate of follow-up.

See [page 53](#) for measure definitions.

ADOLESCENT DEPRESSION: SIX MONTH MEASURES

Country of Origin Summary

2022 measurement year



Patients from Mexico or the United States make up 97% of the eligible population for the suite of Adolescent Depression measures.

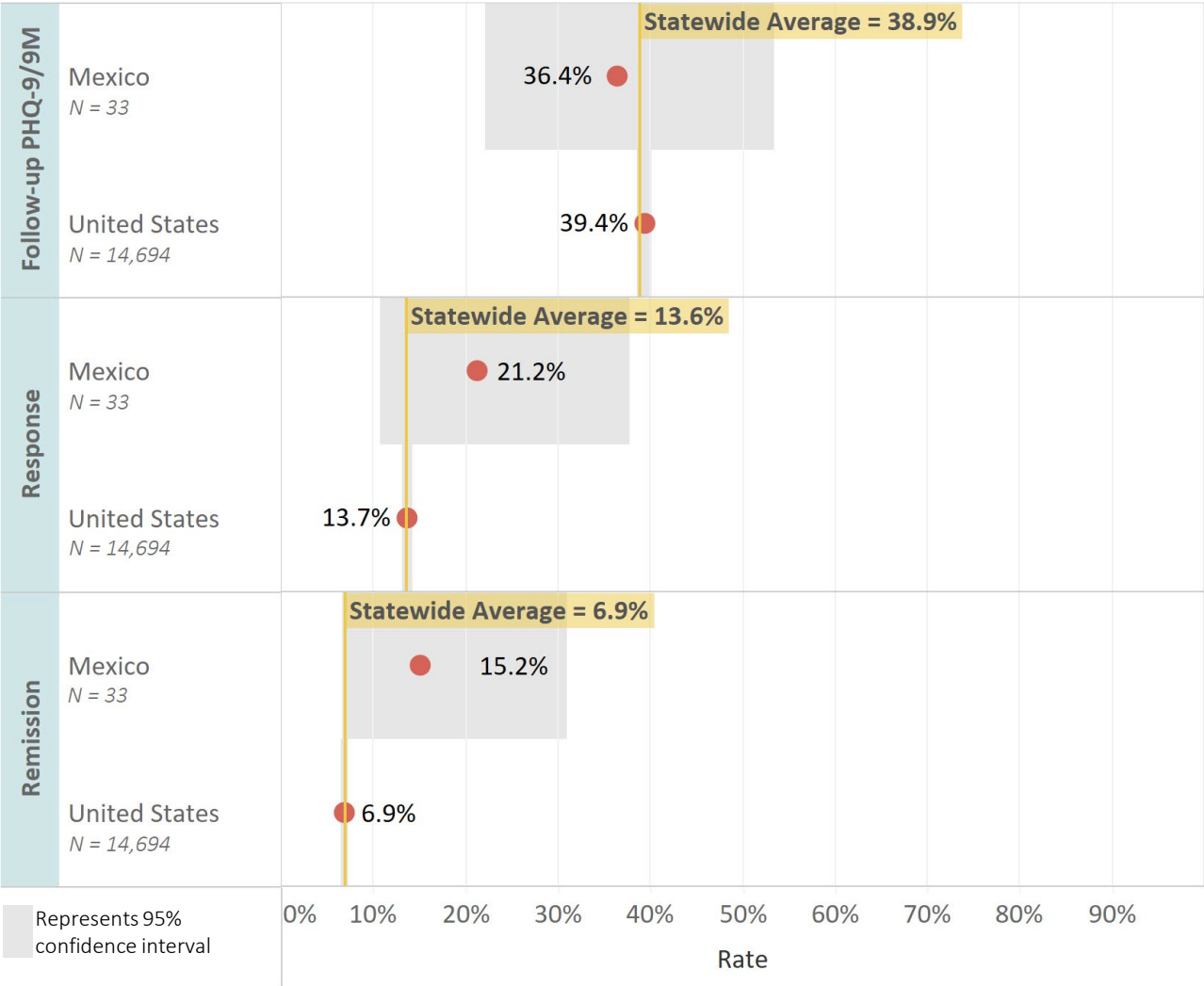
Patients from either country had average rates compared to the respective statewide averages for each measure.

See [page 53](#) for measure definitions.

ADOLESCENT DEPRESSION: 12 MONTH MEASURES

Country of Origin Summary

2022 measurement year



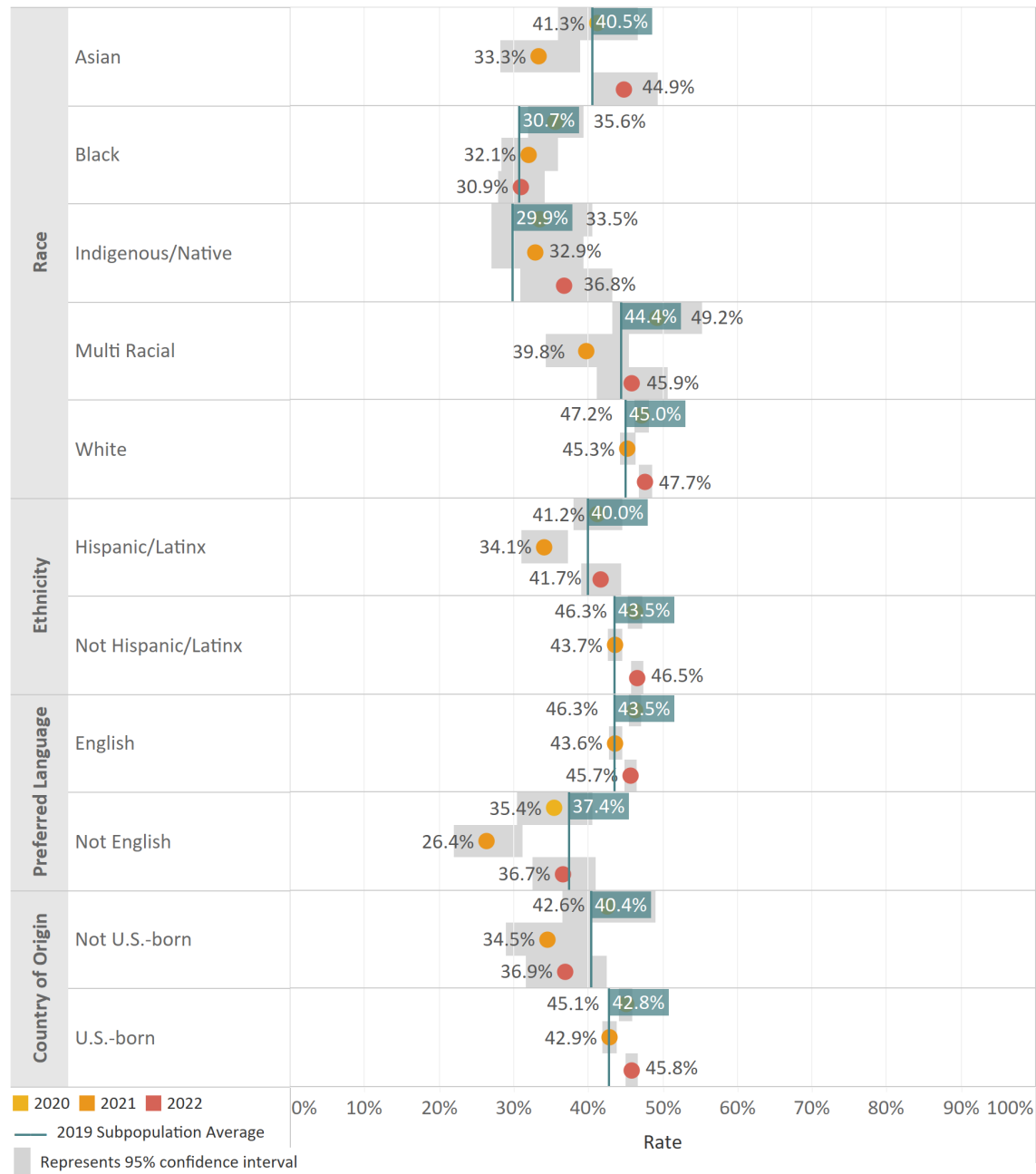
Patients from Mexico or the United States make up 97% of the eligible population for the suite of Adolescent Depression measures.

Patients from either country had average rates compared to the respective statewide averages for each measure.

See [page 53](#) for measure definitions.

ADOLESCENT DEPRESSION: FOLLOW-UP PHQ-9/9M AT SIX MONTHS

Trend by RELC Subpopulations



Comparison to 2021

The follow-up rates in 2022 significantly increased compared to the respective 2021 rates in all subpopulations, except for the following populations:

- Black
- Indigenous/Native
- Multi Racial
- Not U.S.-born

The rates for these populations were not statistically different than their rates in 2021.

Comparison to Pre-Pandemic (2019)

The follow-up rates in 2022 were not statistically different than the respective 2019 rates in all subpopulations, except for the following populations:

- White
- Not Hispanic/Latinx
- English speakers
- Not U.S.-born

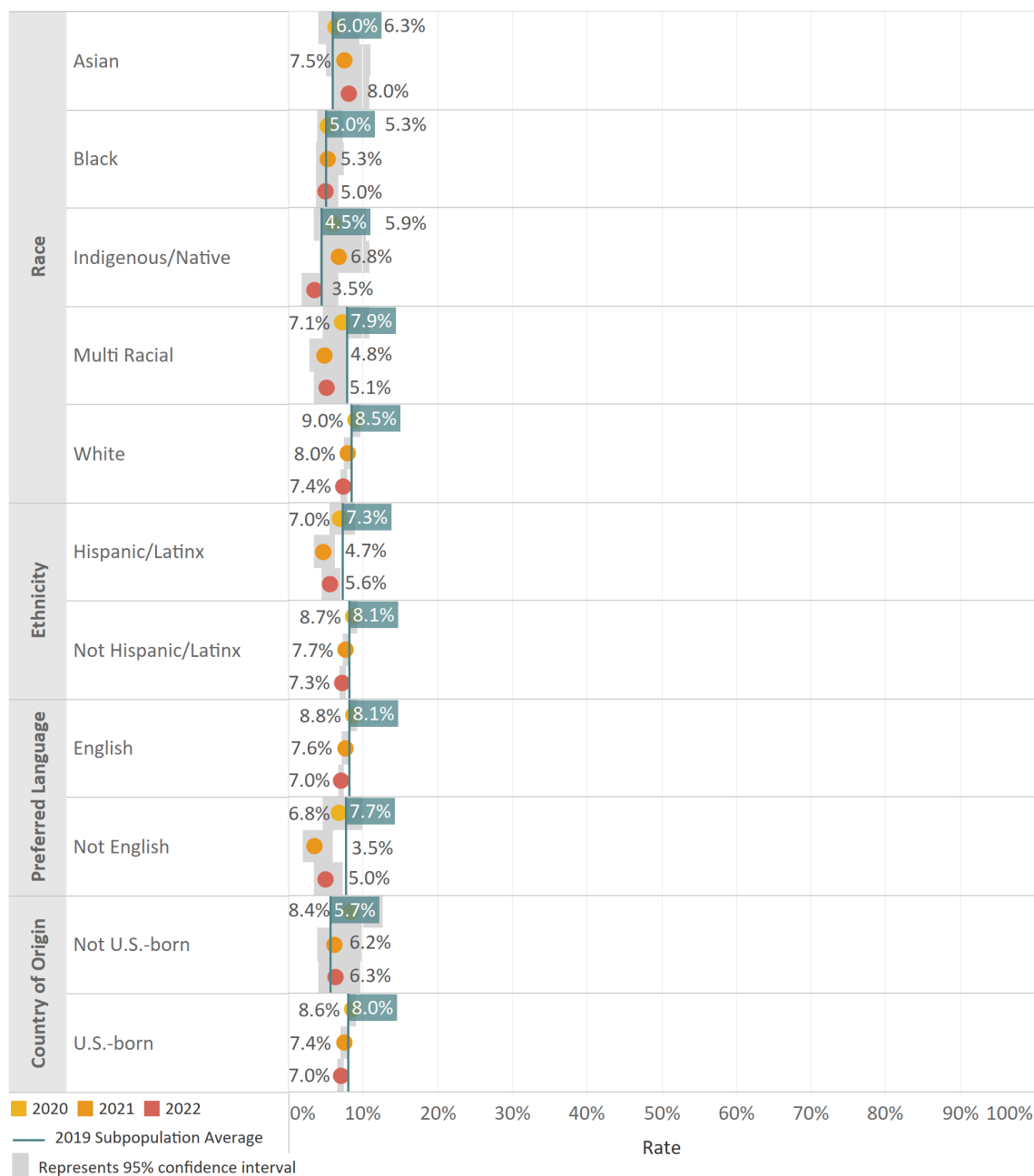
The 2022 rates for these populations were significantly higher than their rates in 2019.

Note: The Native Hawaiian/Pacific Islander category was removed because the number of patients did not meet the reporting threshold of at least 30 patients.

See [page 53](#) for measure definitions.

ADOLESCENT DEPRESSION: REMISSION AT SIX MONTHS

Trend by RELC Subpopulations



Comparison to 2021

The follow-up rates in 2022 were not statistically different compared to the respective 2021 rates in all subpopulations.

Comparison to Pre-Pandemic (2019)

The follow-up rates in 2022 were not statistically different than the respective 2019 rates in all subpopulations, except for the following populations:

- White
- English speakers
- U.S.-born

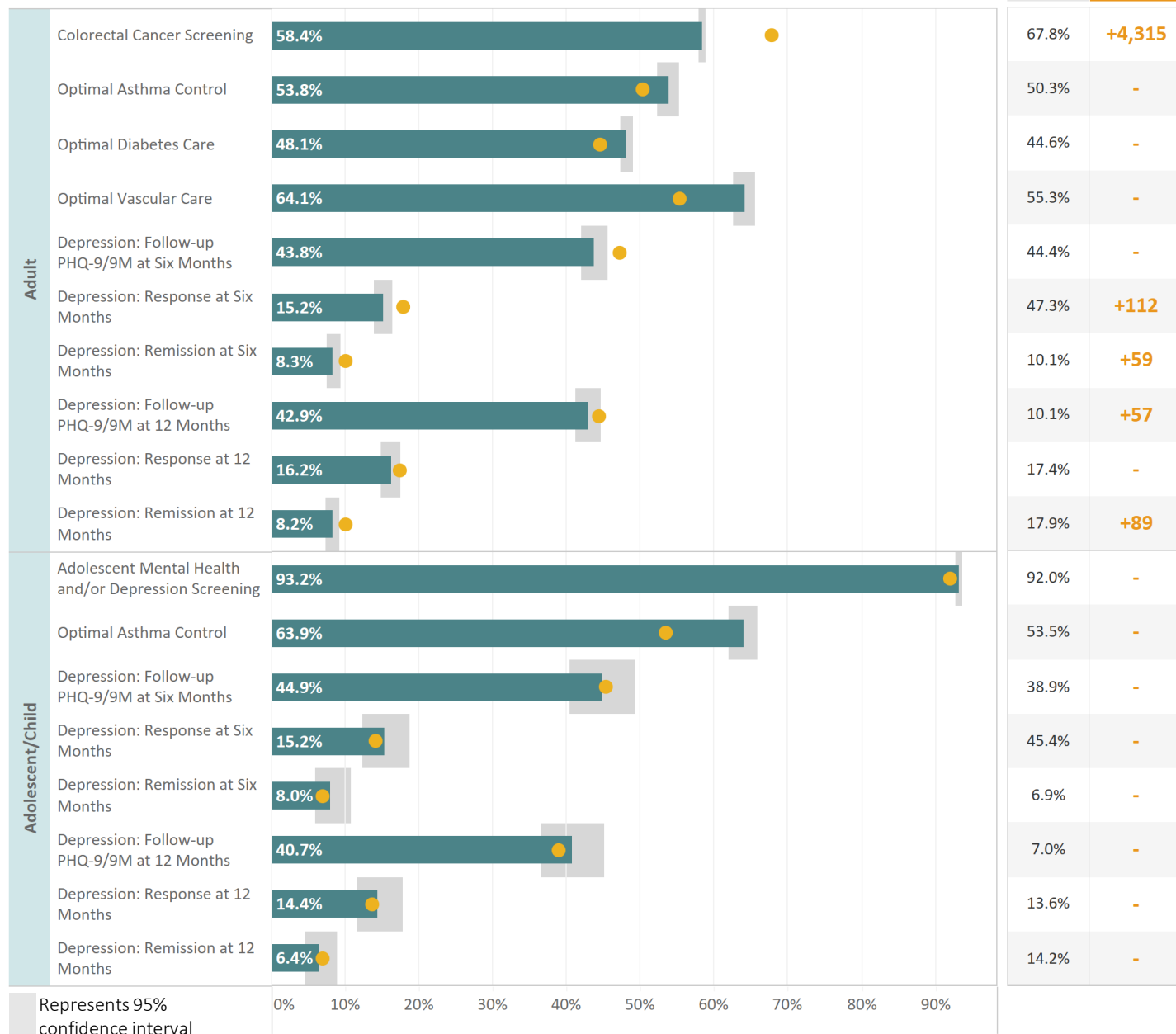
The rates for these populations were significantly lower than their rates in 2019.

Note: The Native Hawaiian/Pacific Islander category was removed because the number of patients did not meet the reporting threshold of at least 30 patients.

See [page 53](#) for measure definitions.

ASIAN PATIENTS

2022 Measure Results Snapshot



ELIMINATING DISPARITIES

The “# of Patients Needed to Close Gap” in the chart provided represents the number of additional Asian patients receiving optimal care needed to eliminate the disparity in outcomes.

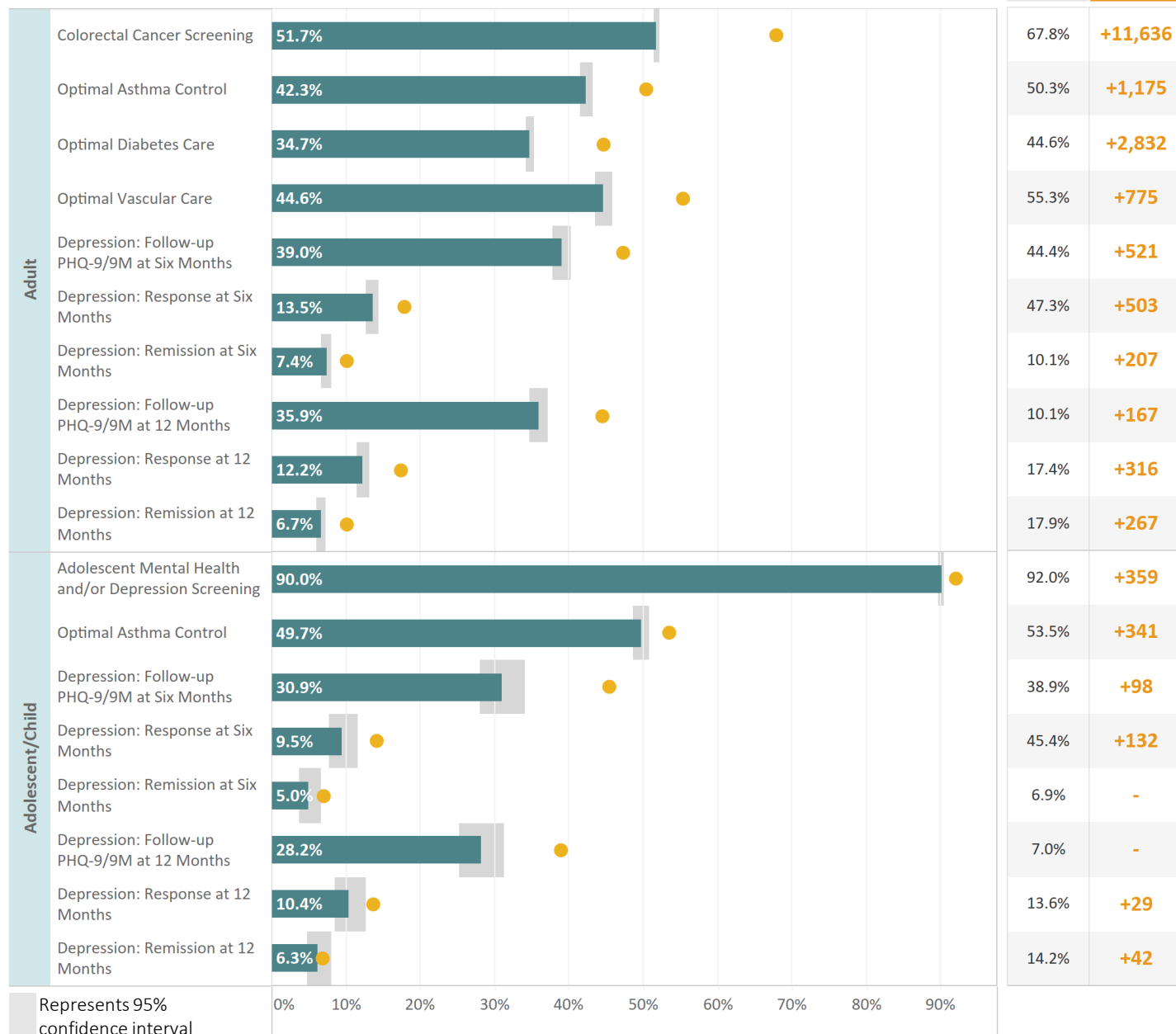
For example, 4,315 additional Asian patients from the Colorectal Cancer Screening measure denominator would need to have an up-to-date screening to close the gap between the screening rate for Asian patients and the statewide average.

Asian patients have significant disparities in performance rates on five out of the 18 measures included in this report compared to the statewide average.

See [page 53](#) for measure definitions.

BLACK PATIENTS

2022 Measure Results Snapshot



ELIMINATING DISPARITIES

The “# of Patients Needed to Close Gap” in the chart provided represents the number of additional Black patients receiving optimal care needed to eliminate the disparity in outcomes.

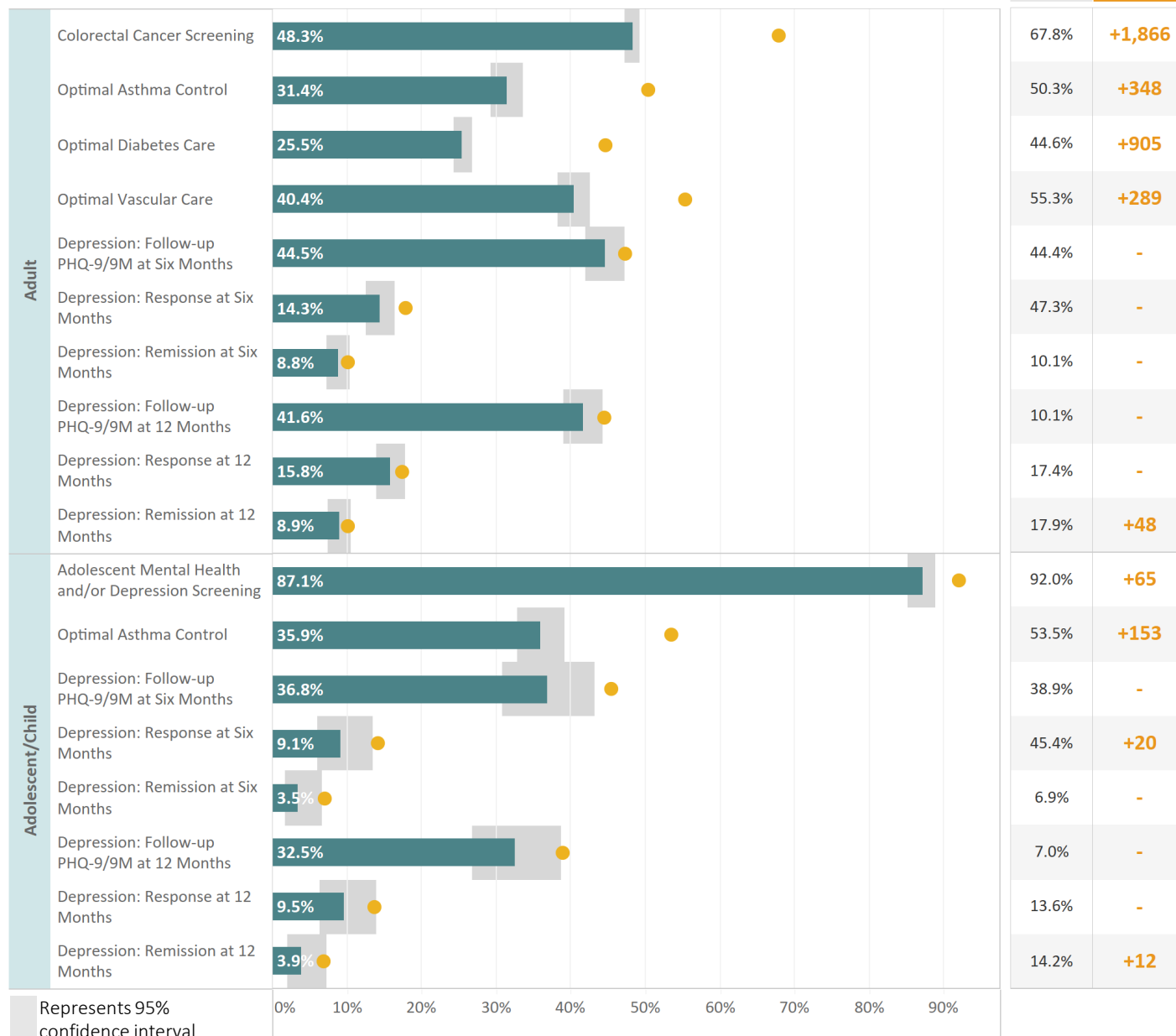
For example, 11,363 additional Black patients from the Colorectal Cancer Screening measure denominator would need to have an up-to-date screening to close the gap between the screening rate for Black patients and the statewide average.

Black patients have significant disparities in performance rates on 16 out of the 18 measures included in this report compared to the statewide average.

See [page 53](#) for measure definitions.

INDIGENOUS/NATIVE PATIENTS

2022 Measure Results Snapshot



ELIMINATING DISPARITIES

The “# of Patients Needed to Close Gap” in the chart provided represents the number of additional Indigenous/Native patients receiving optimal care needed to eliminate the disparity in outcomes.

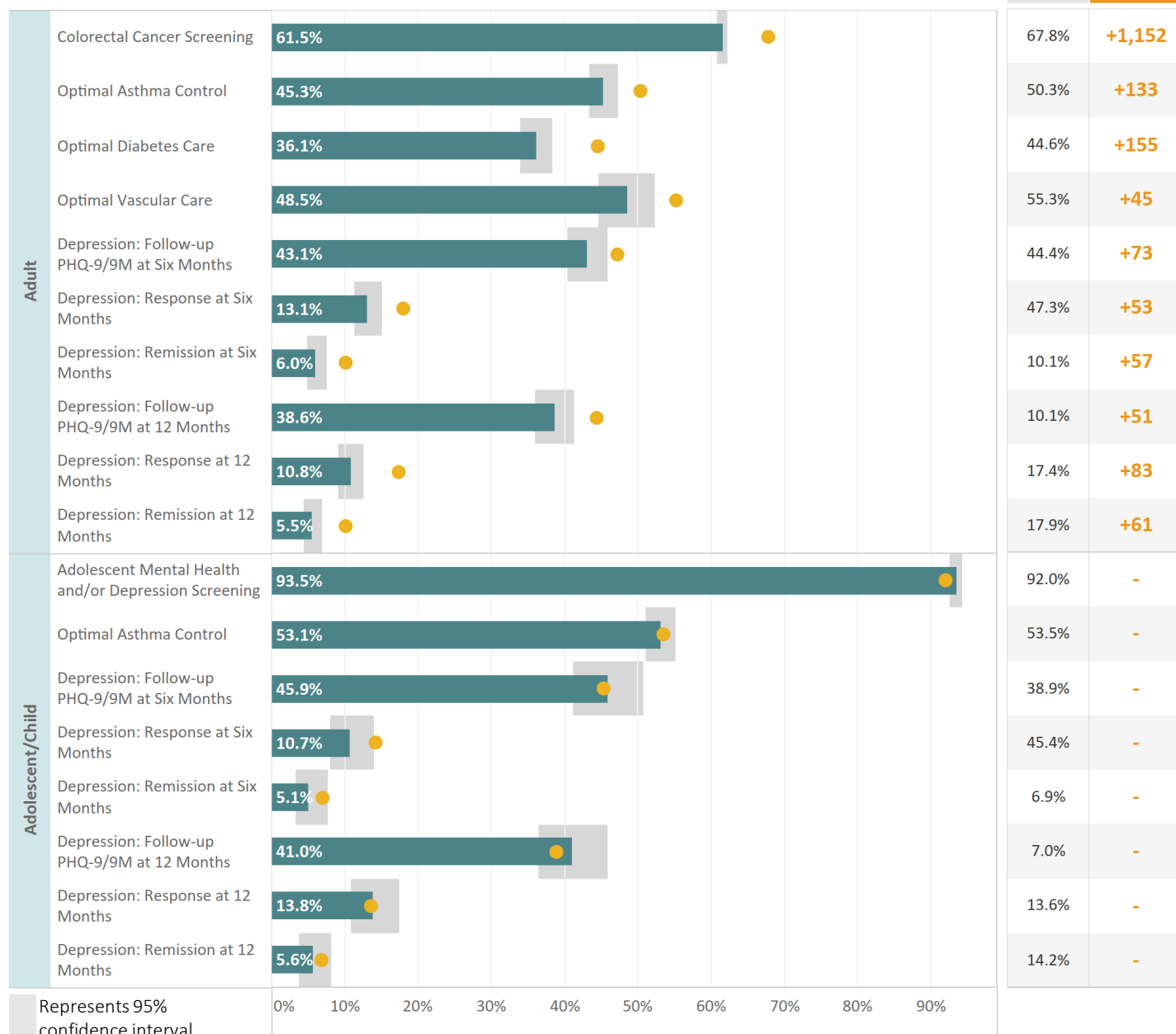
For example, 1,866 additional Indigenous/Native patients from the Colorectal Cancer Screening measure denominator would need to have an up-to-date screening to close the gap between the screening rate for Indigenous/Native patients and the statewide average.

Indigenous/Native patients have significant disparities in performance rates on nine out of the 18 measures included in this report compared to the statewide average.

See [page 53](#) for measure definitions.

MULTI RACIAL PATIENTS

2022 Measure Results Snapshot



ELIMINATING DISPARITIES

The “# of Patients Needed to Close Gap” in the chart provided represents the number of additional Indigenous/Native patients receiving optimal care needed to eliminate the disparity in outcomes.

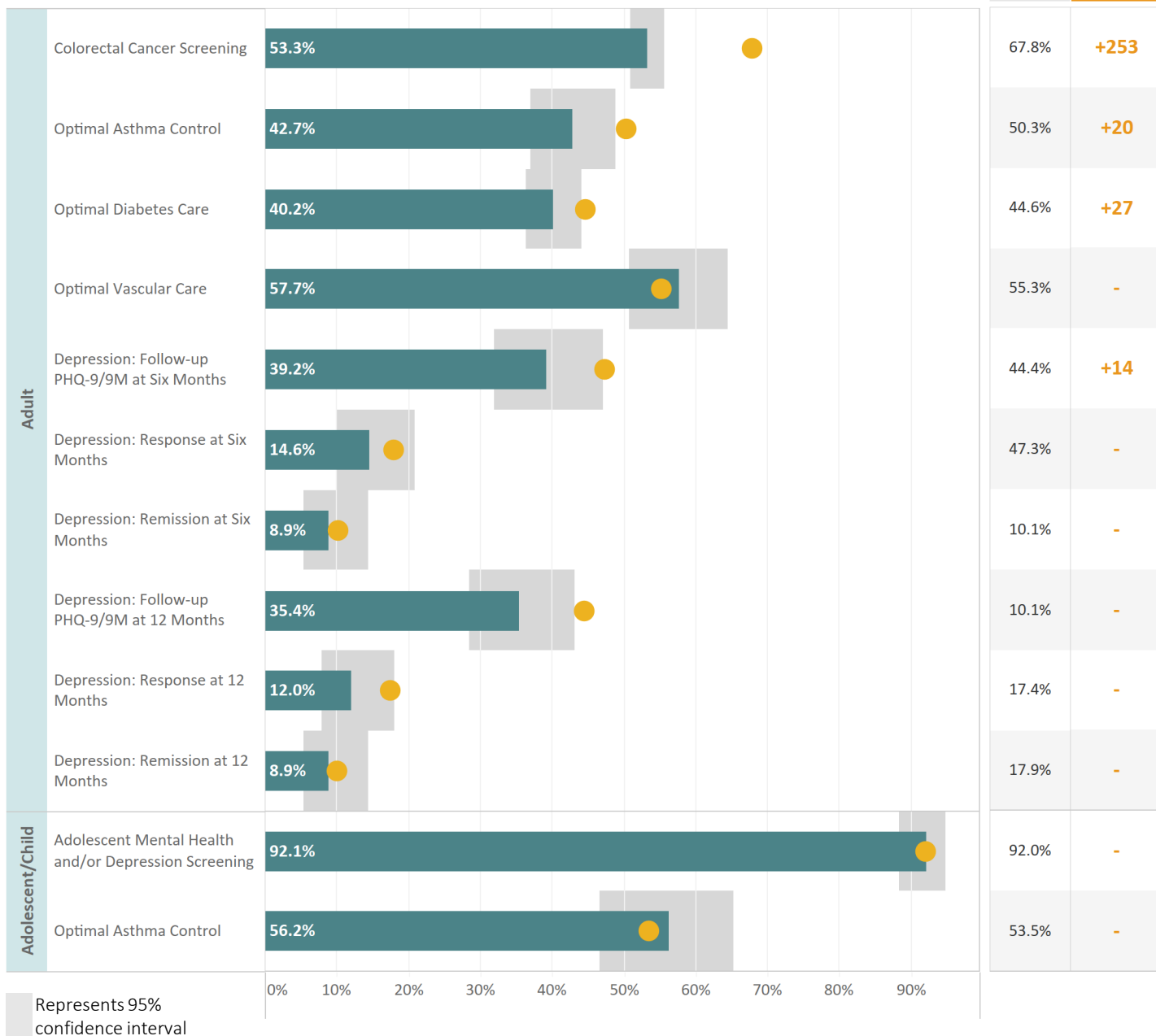
For example, 1,152 additional Multi Racial patients from the Colorectal Cancer Screening measure denominator would need to have an up-to-date screening to close the gap between the screening rate for Multi Racial patients and the statewide average.

Multi Racial patients have significant disparities in performance rates on ten out of the 18 measures included in this report compared to the statewide average.

See [page 53](#) for measure definitions.

NATIVE HAWAIIAN/PACIFIC ISLANDER PATIENTS

2022 Measure Results Snapshot



ELIMINATING DISPARITIES

The “# of Patients Needed to Close Gap” in the chart provided represents the number of additional Native Hawaiian/Pacific Islander patients receiving optimal care needed to eliminate the disparity in outcomes.

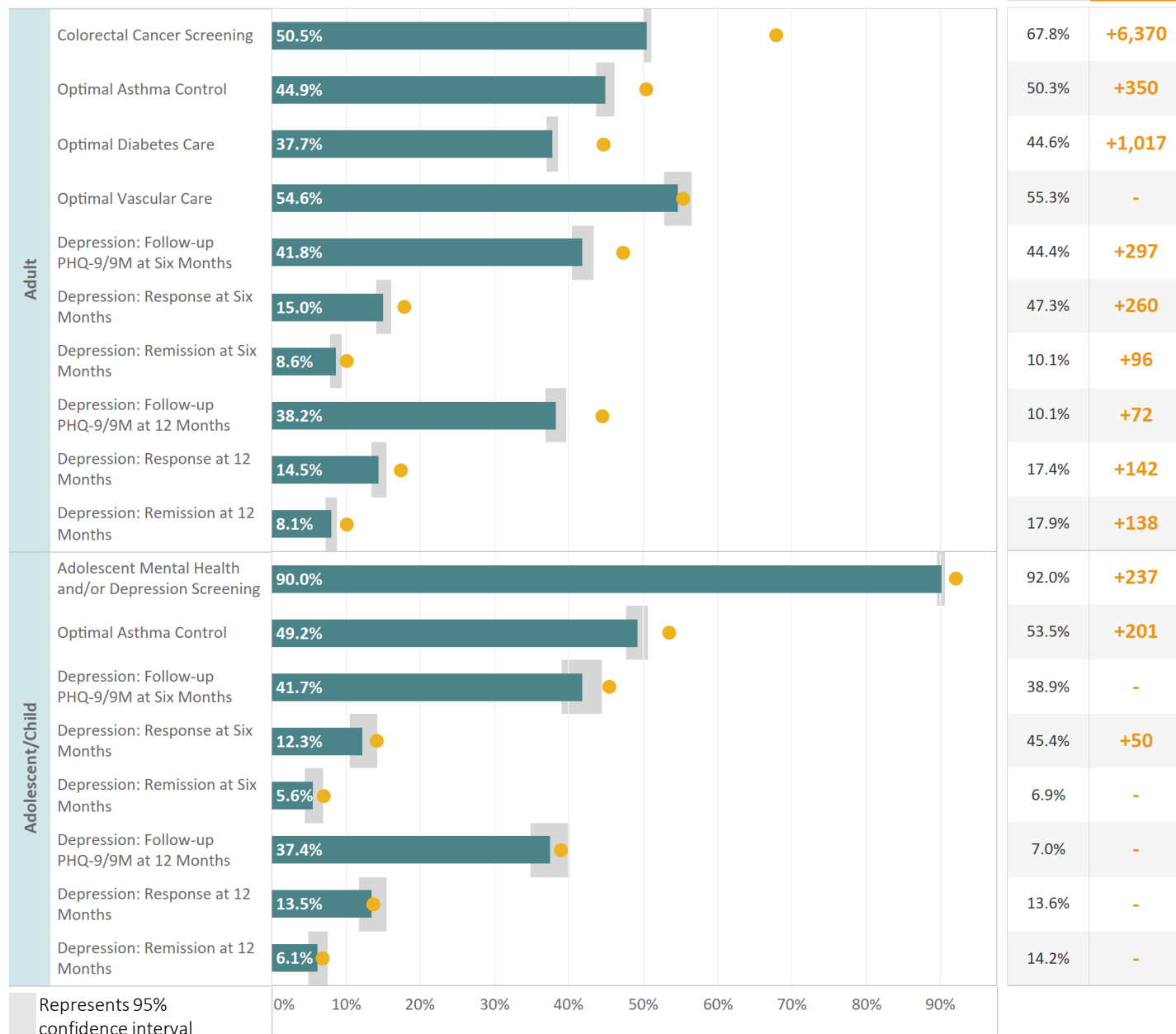
For example, 253 additional Native Hawaiian/Pacific Islander patients from the Colorectal Cancer Screening measure denominator would need to have an up-to-date screening to close the gap between the screening rate for Native Hawaiian/Pacific Islander patients and the statewide average.

Native Hawaiian/Pacific Islander patients have significant disparities in performance rates on four out of the 18 measures included in this report compared to the statewide average.

See [page 53](#) for measure definitions.

HISPANIC/LATINX PATIENTS

2022 Measure Results Snapshot



ELIMINATING DISPARITIES

The “# of Patients Needed to Close Gap” in the chart provided represents the number of additional Hispanic/Latinx patients receiving optimal care needed to eliminate the disparity in outcomes.

For example, 6,370 additional Hispanic/Latinx patients from the Colorectal Cancer Screening measure denominator would need to have an up-to-date screening to close the gap between the screening rate for Hispanic/Latinx patients and the statewide average.

Hispanic/Latinx patients have significant disparities in performance rates on 12 out of the 18 measures included in this report compared to the statewide average.

See [page 53](#) for measure definitions.

STATEWIDE SUMMARY BY RACE/ETHNICITY

Adult Population

2022 Measurement Year

MEASURE		STATEWIDE RATE	RACE					ETHNICITY		
			Asian	Black	Indigenous	Multi Racial	Native Hawaiian	White	Hispanic/ Latinx	Not Hispanic/ Latinx
Colorectal Cancer Screening		67.8%	58.4% ▼	51.7% ▼	48.3% ▼	61.5% ▼	53.3% ▼	70.0% ▲	50.5% ▼	68.5% ▲
Optimal Asthma Control		50.3%	53.8% ▲	42.3% ▼	31.4% ▼	45.3% ▼	42.7% ▼	52.0% ▲	44.9% ▼	50.5% ●
Optimal Diabetes Care		44.6%	48.1% ▲	34.7% ▼	25.5% ▼	36.1% ▼	40.2% ▼	46.4% ▲	37.7% ▼	45.2% ▲
Optimal Vascular Care		55.3%	64.1% ▲	44.6% ▼	40.4% ▼	48.5% ▼	57.7% ●	55.8% ▲	54.6% ●	55.3% ●
Depression Care	Follow-up at Six Months	47.3%	43.8% ▼	39.0% ▼	44.5% ●	43.1% ▼	39.2% ●	48.6% ▲	41.8% ▼	48.3% ▲
	Response at Six Months	17.9%	15.2% ▼	13.5% ▼	14.3% ▼	13.1% ▼	14.6% ●	18.8% ▲	15.0% ▼	18.5% ▲
	Remission at Six Months	10.1%	8.3% ▼	7.4% ▼	8.8% ●	6.0% ▼	8.9% ●	10.6% ▲	8.6% ▼	10.4% ●
	Follow-up at 12 Months	44.4%	42.9% ●	35.9% ▼	41.6% ●	38.6% ▼	35.4% ▼	46.2% ▲	38.2% ▼	45.7% ▲
	Response at 12 Months	17.4%	16.2% ●	12.2% ▼	15.8% ●	10.8% ▼	12.0% ●	18.4% ▲	14.5% ▼	18.0% ▲
	Remission at 12 Months	10.1%	8.2% ▼	6.7% ▼	8.9% ●	5.5% ▼	8.9% ●	10.7% ▲	8.1% ▼	10.4% ●

▼ Below statewide rate ● Not statistically different from statewide rate ▲ Above statewide rate

See [page 53](#) for measure definitions.

STATEWIDE SUMMARY BY RACE/ETHNICITY

Adolescent/Child Population

2022 Measurement Year

MEASURE		STATEWIDE RATE	RACE					ETHNICITY		
			Asian	Black	Indigenous	Multi Racial	Native Hawaiian	White	Hispanic/ Latinx	Not Hispanic/ Latinx
Optimal Asthma Control		53.5%	63.9% ▲	49.7% ▼	35.9% ▼	53.1% ●	56.2% ●	54.6% ▲	49.2% ▼	53.9% ●
Adolescent Mental Health and/or Depression Screening		92.0%	93.2% ▲	90.0% ▼	87.1% ▼	93.5% ▲	92.1% ●	92.6% ▲	90.0% ▼	92.2% ●
Depression Care	Follow-up at Six Months	45.4%	40.5% ●	27.9% ▼	30.8% ▼	41.1% ●	NR	46.8% ▲	39.0% ▼	45.7% ●
	Response at Six Months	14.2%	15.2% ●	9.5% ▼	9.1% ▼	10.7% ●	NR	15.1% ●	12.3% ●	14.6% ●
	Remission at Six Months	7.0%	8.0% ●	5.0% ●	3.5% ●	5.1% ●	NR	7.4% ●	5.6% ●	7.3% ●
	Follow-up at 12 Months	38.9%	40.7% ●	28.2% ▼	32.5% ●	41.0% ●	NR	40.7% ▲	37.4% ●	40.0% ●
	Response at 12 Months	13.6%	14.4% ●	10.4% ▼	9.5% ●	13.8% ●	NR	14.3% ●	13.5% ●	14.0% ●
	Remission at 12 Months	6.9%	6.4% ●	6.3% ●	3.9% ●	5.6% ●	NR	7.3% ●	6.1% ●	7.2% ●

▼ Below statewide rate ● Not statistically different from statewide rate ▲ Above statewide rate

See [page 53](#) for measure definitions.

DEFINITIONS

GENERAL DEFINITIONS

Established patient criteria: Several measures use an established patient criteria, which requires that the patient have at least one established patient office or telehealth visit during the measurement period in order to be included in the measure. Measures that utilize this criteria include Optimal Asthma Control; Optimal Diabetes Care; and Optimal Vascular Care.

Measurement year: The period being assessed and the year in which care was delivered.

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.*

Colorectal Cancer Screening: The percentage of adults ages 45-75 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

Depression Measures (Adults & Adolescents)

- **PHQ-9/9M Utilization:** The percentage of adults (18 years of age and older) and adolescents (12-17 years of age) with a diagnosis of Major Depression or Dysthymia who also have a completed PHQ-9/9M tool during the measurement period.
- **Follow-up PHQ-9/9M at 6/12 Months:** The percentage of adults (18 years of age and older) and adolescents (12-17 years of age) with depression who have a completed PHQ-9/9M tool within six or 12 months after the index event (+/- 60 days).
- **Response at 6/12 Months:** The percentage of adults (18 years of age and older) and adolescents (12-17 years of age) with depression who demonstrated a response to treatment (at least 50 percent improvement) six or 12 months after the index event (+/- 60 days).
- **Remission at 6/12 Months:** The percentage of adults (18 years of age and older) and adolescents (12-17 years of age) with depression who reached remission (PHQ-9/9M score less than five) six months after the index event (+/- 60 days).

[Page 56](#) provides more information about how the index event is defined.

DEFINITIONS CONTINUED

Optimal Asthma Control (Adults & Children): The percentage of adults (18-50 years of age) and 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:

1. Asthma well-controlled as defined by the most recent asthma control tool result available during the measurement period
2. 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 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:

1. HbA1c less than 8.0 mg/dL
2. Blood pressure less than 140/90 mm Hg
3. On a statin medication, unless allowed contraindications or exceptions are present
4. Non-tobacco user
5. 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:

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

METHODS

The measures in this report are collected from medical groups that submit data directly to MN Community Measurement. These clinical quality measures enable reporting of results by clinic location as well as by medical group.

DATA COLLECTION

MNCM is in the midst of transitioning its data collection for the clinical quality measures reported by medical groups to a modernized system known as PIPE that reduce quality measurement burden on health care providers and enables more timely feedback on performance. The previous data collection system, known as Direct Data Submission or DDS, required providers to separately identify the relevant population for each measure. The new PIPE system identifies the numerators, denominators, and performance rates for each measure centrally. About 53 percent of the data reported to MNCM for the clinical quality measures for 2022 measurement year was submitted via PIPE, and the transition to the new system is expected to be complete by the end of 2024.

CONFIDENCE INTERVALS

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 rate is displayed when comparing a single medical group/clinic to the performance of all medical groups/clinics to provide context. The statewide rate is calculated using all data submitted to MNCM which may include some data from clinics located in neighboring states.

MEDICAL GROUP RESULTS

Medical group results and ratings for the 2022 measurement year can be found via the appendix tables, which can be accessed [here](#).

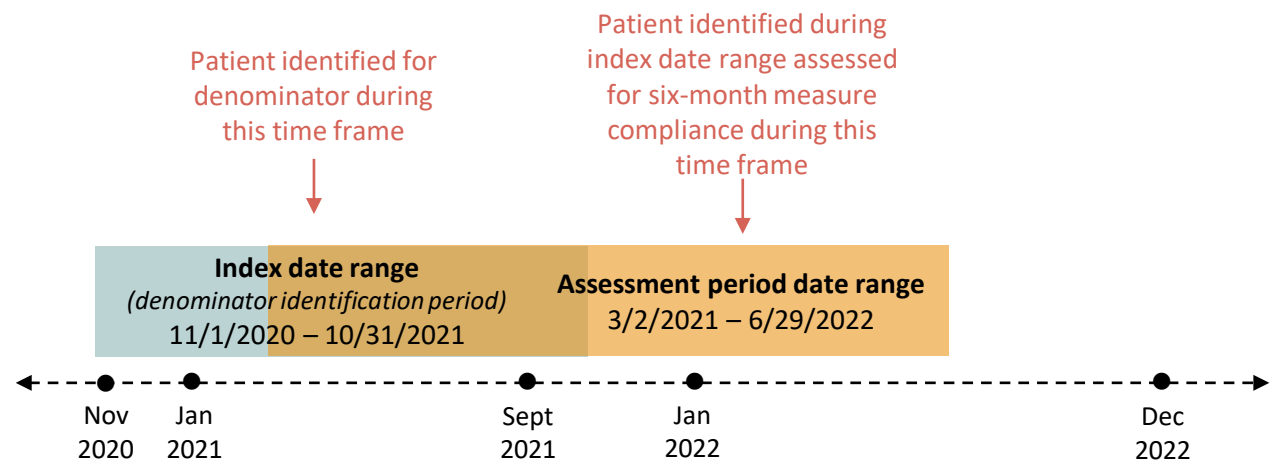
THRESHOLD FOR PUBLIC REPORTING

MNCM has established minimum thresholds for public reporting of clinical quality measures reported by medical groups to ensure statistically reliable rates. Only medical groups and clinics that meet the threshold of 30 patients in the denominator of a measure are publicly reported.

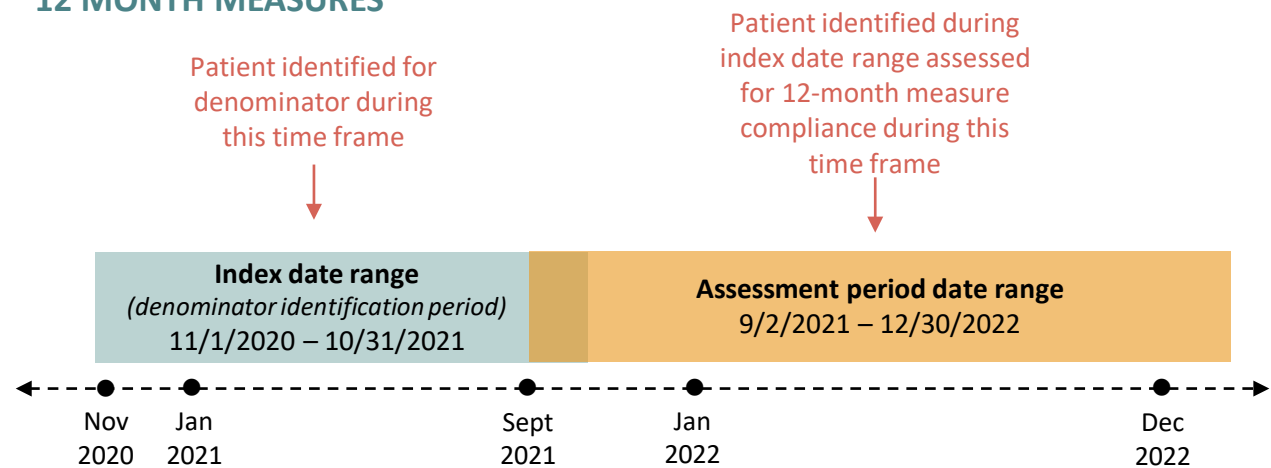
OVERVIEW OF DEPRESSION MEASURES

The depression measures are unique in that the time period for identifying eligible patients for the denominators does not follow the typical measurement period of a calendar year that the other quality measures do. The depression measures are longitudinal in design, meaning patients are followed through a period of time and assessed for the desired outcome. A patient is first identified for the denominator during the denominator identification period (shown below), which primarily occurs two years prior to when the data are submitted. The assessment period (shown below) is the time in which those patients identified in the denominator identification period are assessed for the desired outcome and primarily occurs in the year prior to data submission.

SIX MONTH MEASURES



12 MONTH MEASURES



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

For the quality measures, the RELC data is submitted by medical groups through MNCM’s clinical data submission process. Please refer to the *MNCM Handbook on Collection of RELC Data in Medical Groups* for more information about this data: <https://tinyurl.com/43byhcbk>.

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