

2018 MINNESOTA HEALTH CARE DISPARITIES

by Insurance Type

RELEASED APRIL 2019



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HUMAN SERVICES

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Who is MN Community Measurement?

MN Community Measurement (MNCM) is a non-profit organization that empowers the community with data and information to drive improvement in health care cost and quality. MNCM was formed as a community resource where all health care stakeholders – whether they buy, manage, provide, deliver, oversee, or consume health care – come together and mutually invest in improvement for a better tomorrow.

MNCM specializes in developing, collecting, analyzing, and publicly reporting information on health care quality and cost. Founded in 2005, our multi-stakeholder collaborative includes physicians, hospitals and health systems, health plans, employers, consumers, and state government.

MNCM strives to deliver data and information that is timely, actionable, and relevant for each stakeholder in the community to fulfill their role in advancing improvement and affordability.

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INTRODUCTION

A worthy goal for our national health care system is quality care for all patients. Despite that, significant evidence shows widespread disparities exist in health care across the country. Quality measurement in health care delivers value to patients, providers, payers, and purchasers. Health care quality makes a difference in patients' ability to achieve good outcomes and lead healthy, productive lives. Health care quality, cost and patient outcomes vary by factors such as neighborhoods where patients live, where they receive health care, socioeconomic status, race, ethnicity and health insurance type.

The inaugural report, produced by MN Community Measurement (MNCM) in collaboration with the Minnesota Department of Human Services (DHS) in 2007, was the first in the nation to provide measurement results by insurance type at statewide, medical group and clinic levels. As a transparent mechanism for ongoing measurement, the annual report on disparities by insurance type is an important tool in understanding, monitoring, and working with providers to focus improvement initiatives. The 2018 report continues to summarize health care quality for patients enrolled in Minnesota Health Care Programs (MHCP), makes comparisons by insurance type, and features statewide MHCP results by race and Hispanic ethnicity. It also highlights high performing medical groups (per measure) for the MHCP patient population. For more information about MHCP, visit <https://mn.gov/dhs/partners-and-providers/program-overviews/>. This report focuses on the managed care components of Minnesota's Medical Assistance and MinnesotaCare programs. Throughout the report MHCP results are compared to Other Purchasers, which include commercial (employer-based and individual health insurance coverage) and Medicare managed care data. The data presented in this report was collected by MNCM in 2018 for 2017 dates of service.

Background

In 2005, the Minnesota Legislature directed DHS to establish a performance reporting system for medical groups and clinics providing health care services to patients enrolled in MHCP. Compared to the overall Minnesota population, patients enrolled in MHCP are of lower socioeconomic status and include a disproportionate number of persons of color, American Indian or Alaska Natives, persons with disabilities, and elderly adults. MHCP enrollees often experience significant challenges that create barriers to receiving appropriate health care. As a result, they may not receive care that meets best practices as often as patients insured with other types of insurance.

What's New

This year's report includes 10 quality measures. Compared to last year, the report includes: one new measure, removal of two measures, and expansion of the race and Hispanic ethnicity analysis to include more measures.

- » Measures are now categorized by Preventive Health, Chronic Conditions and Depression. The report includes more user-friendly visual displays of information to catalyze improvement.
- » The Adolescent Mental Health and/or Depression Screening measure is included for the first time.

- » Two measures reported previously were removed from the report: Appropriate Treatment for Children with Upper Respiratory Infection (URI) and Chlamydia Screening in Women. MNMCM retired the URI measure because rates were high with little room for improvement. Medical groups consistently scored higher for MHCP patients on the Chlamydia Screening in Women measure. As a result, DHS removed the URI measure from this report as well as the Chlamydia Screening measure to focus improvement efforts on other clinical priorities.
- » The report features statewide MHCP performance rates by race and Hispanic ethnicity for all 10 measures. Previous reports included race and Hispanic ethnicity for HEDIS measures only.



OVERVIEW OF QUALITY MEASURES

This report includes 10 health care quality measures chosen by DHS to address gaps in quality for patients enrolled in MHCP and to focus community efforts on improvement. The measures include:

Preventive Health

- » Breast Cancer Screening*
- » Colorectal Cancer Screening
- » Childhood Immunization Status (Combo 10)*

Chronic Conditions

- » Optimal Diabetes Care
- » Optimal Vascular Care
- » Optimal Asthma Control – Adults
- » Optimal Asthma Control – Children
- » Controlling High Blood Pressure*

Depression

- » Adult Depression Remission at Six Months
- » Adolescent Mental Health and/or Depression Screening

Key findings include:

- » Statewide MHCP results improved significantly since the 2017 report year for four measures: 1) Childhood Immunization Status (Combo 10); 2) Optimal Asthma Control – Adults; 3) Optimal Asthma Control – Children; and 4) Adult Depression Remission at Six Months. Childhood Immunization Status (Combo 10) had the largest improvement.
- » The Colorectal Cancer Screening measure had a statistically significant decrease in 2018 rates compared to 2017. Changes to the measure denominator in 2018 resulted in a significant drop in the population for this measure. This change likely contributed to the decreased rate. The good news is that the Colorectal Cancer Screening rate for MHCP patients has increased by over eight percentage points since 2011.
- » Statewide MHCP rates are consistently and significantly lower than the Other Purchasers' statewide rates for all 10 measures; however, the gap has significantly narrowed over time for four of these measures: Colorectal Cancer Screening; Optimal Asthma Control – Adults; Optimal Asthma Control – Children, and; Controlling High Blood Pressure. In contrast, the gap for two measures has significantly widened over time: Breast Cancer Screening and Optimal Vascular Care.

Data Source Enables Reporting Capability

The measures in this report are collected from two separate data sources: clinics and health plans. Direct Data Submission (DDS) measures use data from clinics. This data enables reporting of results by clinic location as well as by medical group. In contrast, the Healthcare Effectiveness Data and Information Set (HEDIS) measures use data from health plans. This data enables reporting of results by medical group only. HEDIS measures are indicated by an asterisk (*). For medical group and clinic-level results, see the *Detailed Medical Group and Clinic Level Tables* appendix.

- » MHCP results vary by race and Hispanic ethnicity:
 - » American Indian/Alaskan Native and Black/African American patients are significantly below the MHCP statewide rate on a majority of the measures.
 - » Asian, White and Non-Hispanic patients are significantly above the MHCP statewide rate on a majority of the measures.
 - » Hispanic patients are significantly above the MHCP statewide rate on two measures but have rates that are similar to the MHCP statewide rate on the remaining eight measures.
- » There is significant variation in medical group performance for all measures, but several medical groups are achieving noteworthy results for many of the measures. For example, nine primary care/multi-specialty care medical groups had rates significantly above the statewide rate on at least 50 percent of the measures for which they were eligible (see page 31).

NOTE: Adolescent Mental Health and/or Depression Screening is new to the report for 2018 so comparisons to previous years cannot be made.

TABLE 1: MHCP Statewide Performance Rates for 2018 Compared to Previous Years

Table 1 displays MHCP statewide results for 10 quality measures and compares them to the previous year.

QUALITY MEASURE	2018 MHCP Statewide Rate	MHCP Statewide Percentage Point Change (2018 Report Year–2017 Report Year)	MHCP Statewide Percentage Point Change Over Time (2018 Report Year–First Report Year)
PREVENTIVE HEALTH MEASURES			
Breast Cancer Screening	60.4%	-0.4%	-2.3%** (5 years)
Colorectal Cancer Screening* [^]	55.8%	-0.4%**	8.4%** (8 years)
Childhood Immunization Status (Combo 10)*	43.7%	6.1%**	6.1%** (2 years)
CHRONIC CONDITION MEASURES			
Optimal Diabetes Care* [^]	32.8%	0.3%	-0.8%** (3 years)
Optimal Vascular Care* [^]	45.7%	0.6%	-6.6%** (3 years)
Optimal Asthma Control – Adults* [^]	41.2%	0.7%**	-0.5% (4 years)
Optimal Asthma Control – Children* [^]	52.0%	1.0%**	-1.0%** (4 years)
Controlling High Blood Pressure*	72.7%	0.5%	3.1%** (4 years)
DEPRESSION MEASURES			
Adolescent Mental Health and/or Depression Screening	75.7%	N/A	N/A
Adult Depression Remission at Six Months	5.4%	0.9%**	0.6%** (3 years)

*These statewide rates are weighted samples (see Methodology)

**Statistically significant difference (p < 0.05)

[^] The criteria for including patients in the measure denominator changed in 2017. This change may have contributed to differences compared to earlier years.

TABLE 2: Summary of Statewide Differences by Insurance Type

Table 2 displays differences in the quality measures by insurance type.

QUALITY MEASURE	2018 MHCP Statewide Rate	2018 Other Purchasers Statewide Rate	2018 Rate Difference (Other Purchasers – MHCP)	Rate Difference Over Time 2018 Report Year vs. First Report Year (Other Purchasers – MHCP)
PREVENTIVE HEALTH MEASURES				
Breast Cancer Screening	60.4%	77.8%	17.5%**	Gap Widened** (2014–2018)
Colorectal Cancer Screening*	55.8%	73.3%	17.5%**	Gap Narrowed** (2011–2018)
Childhood Immunization Status (Combo 10)*	43.7%	67.5%	23.9%**	Gap Widened (2017–2018)
CHRONIC CONDITION MEASURES				
Optimal Diabetes Care*	32.8%	47.7%	15.0%**	Gap Narrowed (2016–2018)
Optimal Vascular Care*	45.7%	63.5%	17.8%**	Gap Widened** (2016–2018)
Optimal Asthma Control – Adults*	41.2%	54.7%	13.6%**	Gap Narrowed** (2015–2018)
Optimal Asthma Control – Children*	52.0%	61.8%	9.8%**	Gap Narrowed** (2015–2018)
Controlling High Blood Pressure*	72.7%	76.9%	4.2%**	Gap Narrowed** (2015–2018)
DEPRESSION MEASURES				
Adolescent Mental Health and/or Depression Screening	75.7%	80.5%	4.9%**	N/A
Adult Depression Remission at Six Months	5.4%	9.5%	4.1%**	Gap Narrowed (2016–2018)

*These statewide rates are weighted samples (see Methodology)

**Statistically significant difference ($p < 0.05$)

TABLE 3: Summary of Findings by Race/Ethnicity – HEDIS Measures

Table 3 compares the 2018 MHCP rate of each racial/ethnicity group to the 2018 MHCP statewide rate for the three HEDIS measures (see page 4 for definition).

HEDIS MEASURE	2018 MHCP Statewide Rate	RACE						ETHNICITY		
		American Indian/Alaskan Native	Black/African American	Asian	White	Multi-Racial	Unknown Race	Hispanic	Not Hispanic	Unknown Ethnicity
Breast Cancer Screening	60.4%	▼	▼	●	▲	▼	●	▲	●	▼
Childhood Immunization Status (Combo 10)	43.7%	▼	▼	▲	●	●	●	●	●	●
Controlling High Blood Pressure	72.7%	●	▼	●	▲	●	●	●	▼	▲

▲ Significantly above MHCP statewide rate ● Average ▼ Significantly below MHCP statewide rate

TABLE 4: Summary of Findings by Race/Ethnicity – DDS Measures

Table 4 compares the 2018 MHCP rate of each racial/ethnicity group to the 2018 MHCP statewide rate for the seven DDS measures (see page 4 for definition).

DDS MEASURE	2018 MHCP Statewide Rate	RACE									ETHNICITY		
		American Indian/Alaskan Native	Native Hawaiian/Other Pacific Islander	Black/African American	Asian	White	Multi-Racial	Some Other Race	Unknown Race	Chose Not to Disclose/Declined	Hispanic	Not Hispanic	Unknown Ethnicity
Colorectal Cancer Screening	55.8%	▼	●	▼	▲	▲	●	▼	▼	▼	●	▲	▼
Optimal Diabetes Care	32.8%	▼	●	▼	▲	●	▼	▲	●	▲	▲	●	▼
Optimal Vascular Care	45.7%	▼	●	▼	▲	▲	●	▲	●	●	●	▲	▼
Optimal Asthma Control – Adults	41.2%	▼	●	▼	▲	▲	●	●	▼	●	●	▲	▼
Optimal Asthma Control – Children	52.0%	▼	●	●	●	▲	●	●	▼	●	●	▲	▼
Adolescent Mental Health and/or Depression Screening	75.7%	▼	●	▲	●	▲	●	●	▼	●	●	▲	▼
Adult Depression Remission at Six Months	5.4%	●	▲	▼	▼	▲	●	●	▼	●	●	▲	▼

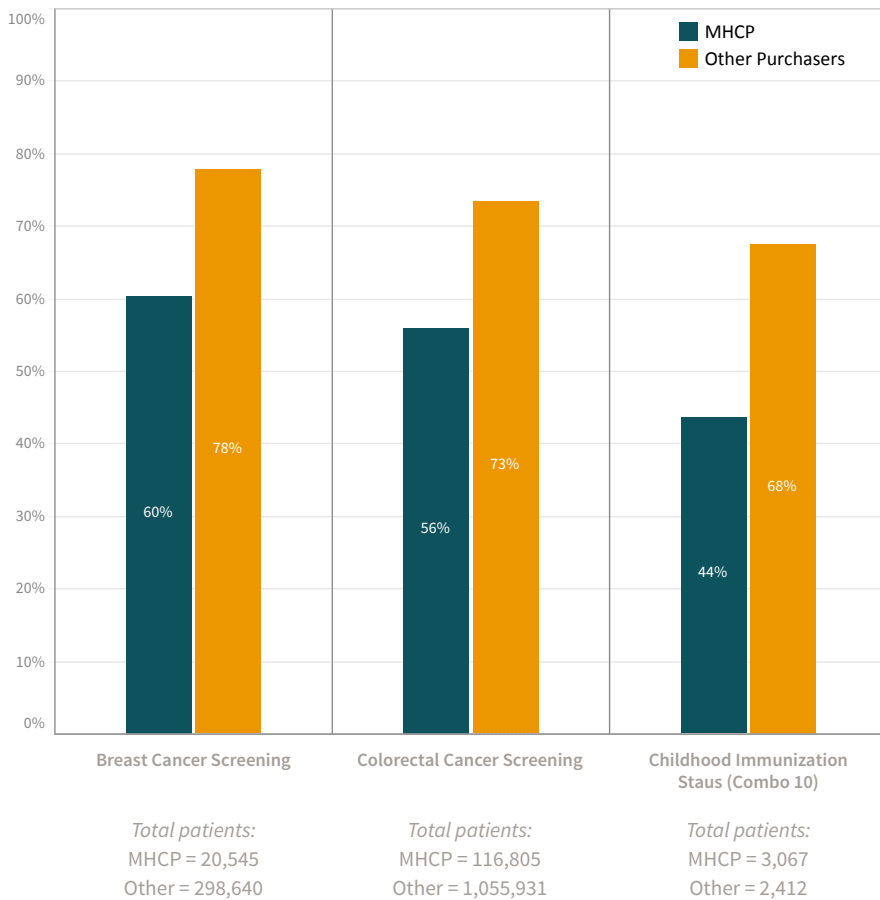
▲ Significantly above MHCP statewide rate ● Average ▼ Significantly below MHCP statewide rate

PREVENTIVE HEALTH MEASURES

This section of the report focuses on preventive health measures segmented by insurance type. Preventive health services are an important focus for quality measurement to aid in preventing disease, helping people live healthier lives, and keeping health care costs down. Even though these services are covered by public and private insurance plans, millions of individuals do not get recommended preventive services.¹

FIGURE 1: Statewide Results by Insurance Type for Preventive Health Measures

(2018 report year)



Results for all preventive health measures indicate room for improvement, regardless of insurance type; however, there are significant differences in performance rates by insurance type. The immunization measure has the widest gap.

Breast Cancer Screening

Breast cancer in the United States is the most common cancer in women, regardless of race or ethnicity. Breast cancer is the most common cause of death from cancer among Hispanic women. It is the second most common cause of death from cancer among white, black, Asian, and American Indian/Alaskan Native women.² Mammograms are the best way to find breast cancer early.

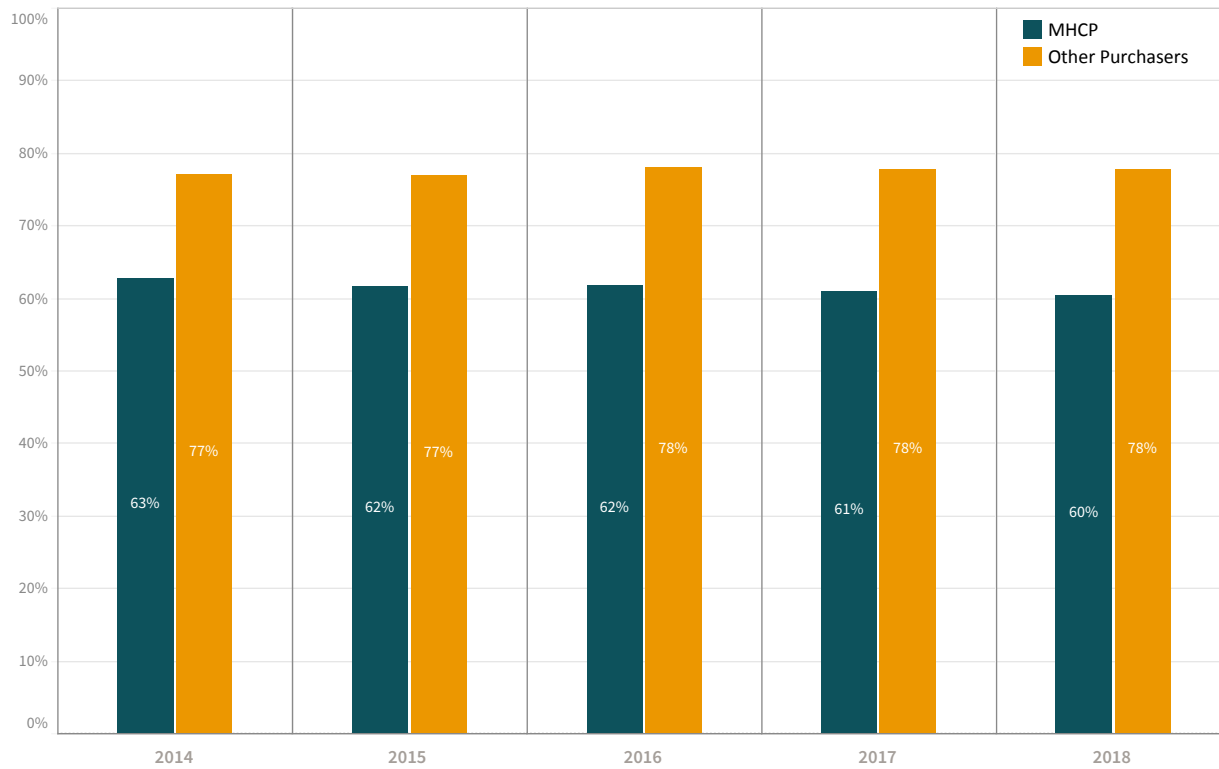
Measure Description

The percentage of women ages 50–74 who received a mammogram during the prior two years (the measurement year or prior year).

Data collected for this measure are from health plan claims (see *Methodology* appendix).

FIGURE 2: Trend in Breast Cancer Screening

(2014–2018 report years)



Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources, and other factors.

The Breast Cancer Screening rate for MHCP patients decreased slightly from 60.8% in 2017 to 60.4% in 2018; however, this decrease is not statistically significant. MHCP patients continue to have a significantly lower screening rate than patients insured by Other Purchasers and the gap in screening rates remains wide.

FIGURE 3: Breast Cancer Screening MHCP Rates by Race and Hispanic Ethnicity

(2018 report year)

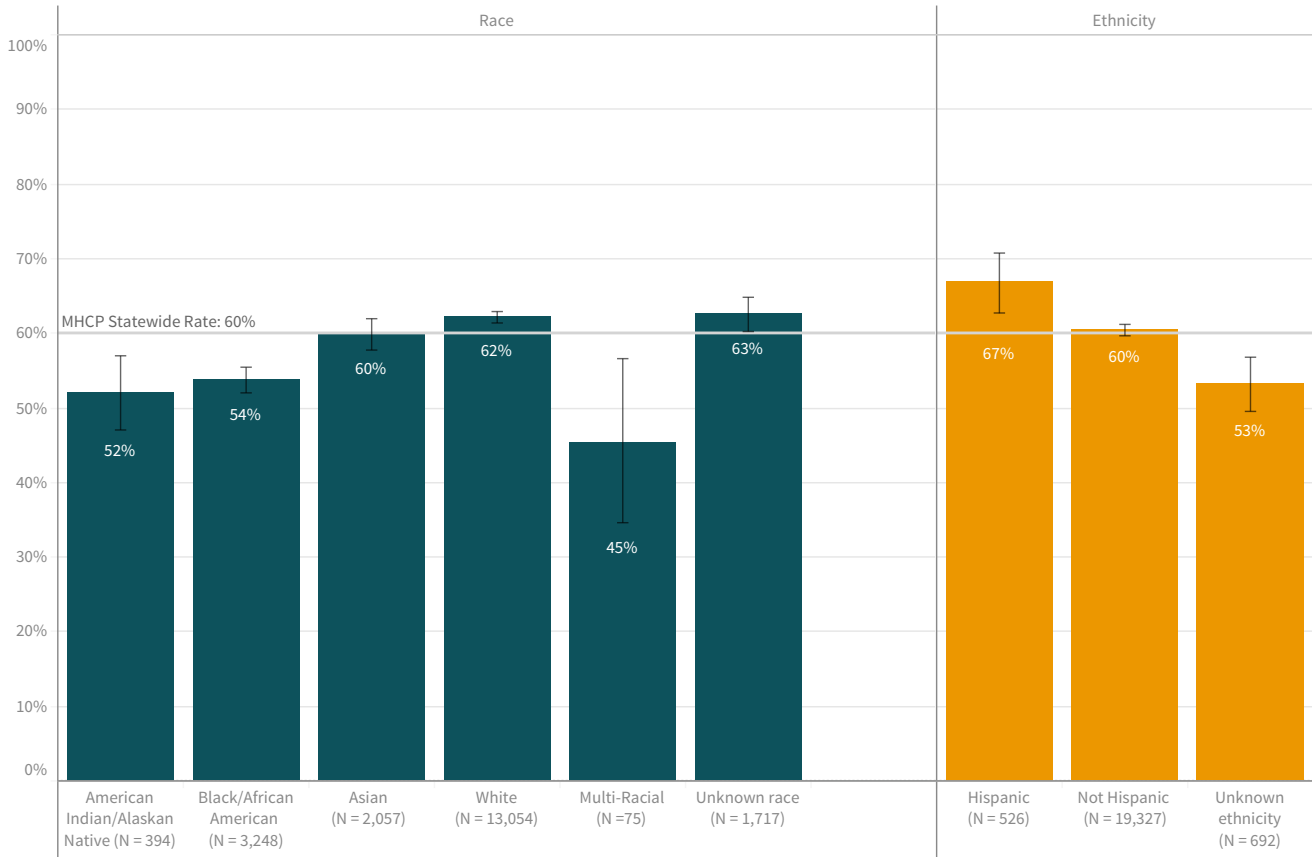
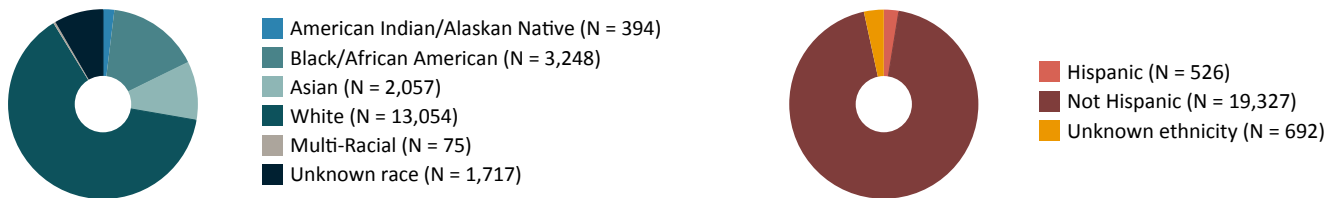


FIGURE 4: Proportion of Eligible MHCP Patients by Race and Hispanic Ethnicity

(2018 report year)



The Breast Cancer Screening rate for the White group is significantly higher than the MHCP statewide rate. The American Indian/Alaskan Native, the Black/African American and the Multi-Racial groups all have screening rates that are significantly lower than the MHCP statewide rate.

Additionally, the Hispanic ethnicity group has a screening rate that is significantly higher than the MHCP statewide rate.



Colorectal Cancer Screening

Colorectal cancer is the third most common cancer diagnosed in both men and women in the United States. The death rate from colorectal cancer has been dropping for decades. One likely reason is that colorectal polyps are being found more often by screening and removal before they can develop into cancer; or that cancers are being found earlier when the disease is easier to treat. In addition, colorectal cancer has improved over the last few decades.³

Medical groups and clinics report data directly to MNMCM for this measure based on electronic health records or paper-based medical charts (see *Methodology* appendix).

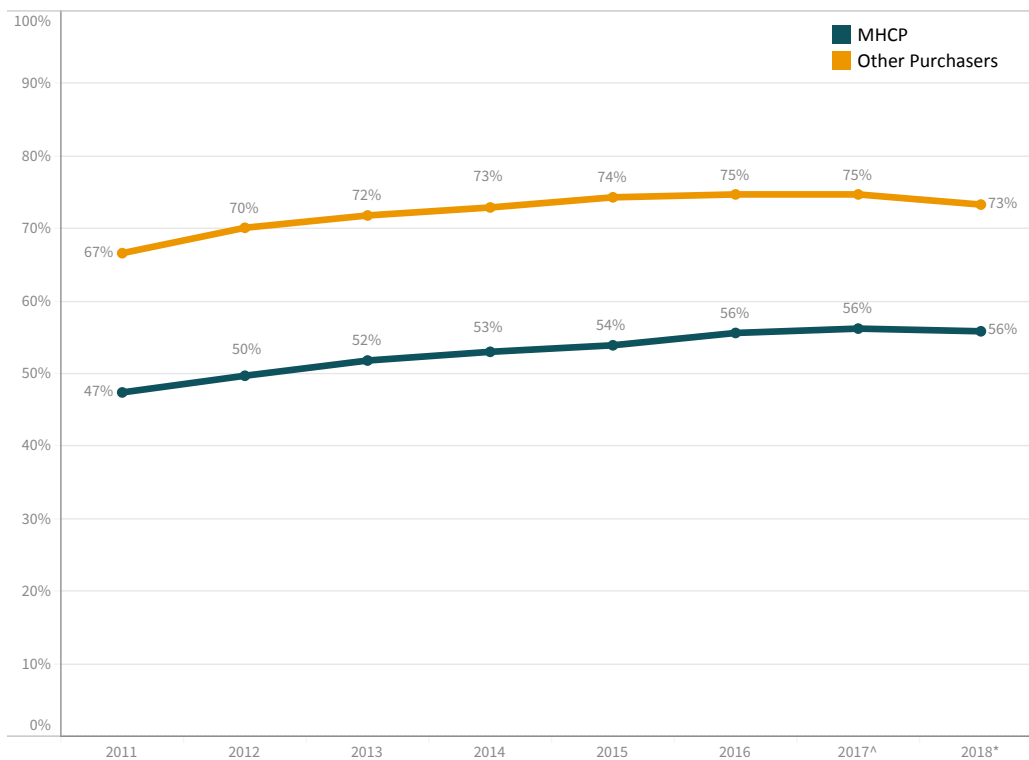
Measure Description

The percentage of adults ages 51–75 who are up-to-date with the appropriate screening for colorectal cancer. Appropriate screenings include one of the following:

- » Colonoscopy during the measurement year 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

FIGURE 5: Trend in Colorectal Cancer Screening

(2011–2018 report years)



Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources, and other factors.

[^] The criteria for including patients in the measure denominator changed in 2017. This change may have contributed to a change in statewide rates for this measure.

^{*} Changes to the measure denominator definition resulted in a significant drop in population for this measure and likely contributed to slight decrease in rate.

The Colorectal Cancer Screening rate for MHCP patients decreased from 56.2% in 2017 to 55.8% in 2018. This decrease is statistically significant. Changes to the measure denominator definition resulted in a significant drop in the population. This change likely contributed to the decrease in 2018. MHCP patients continue to have a significantly lower rate of Colorectal Cancer Screening than patients insured by Other Purchasers, but the gap between insurance types has narrowed.

FIGURE 6: Colorectal Cancer Screening MHCP Rates by Race and Hispanic Ethnicity

(2018 report year)

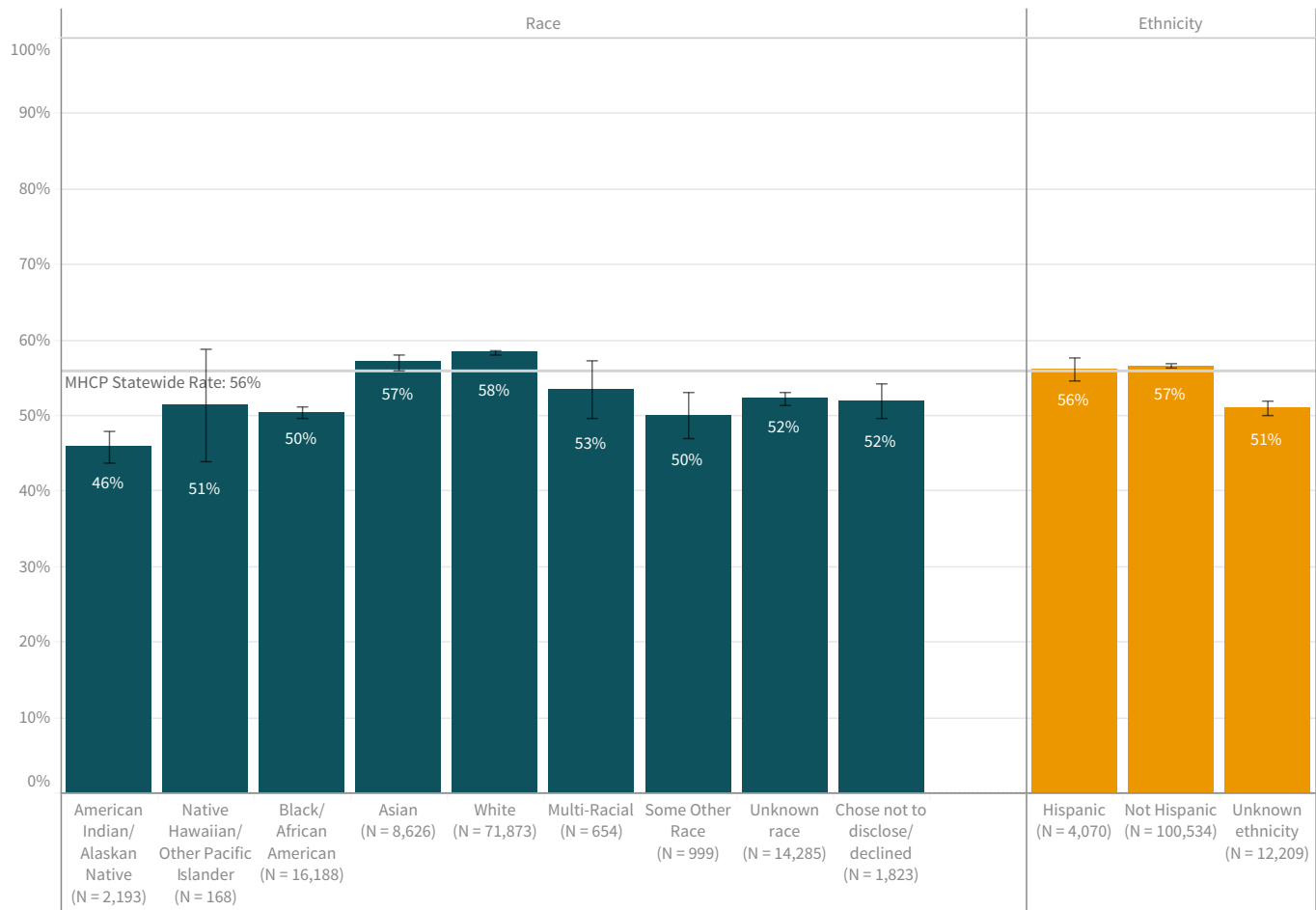
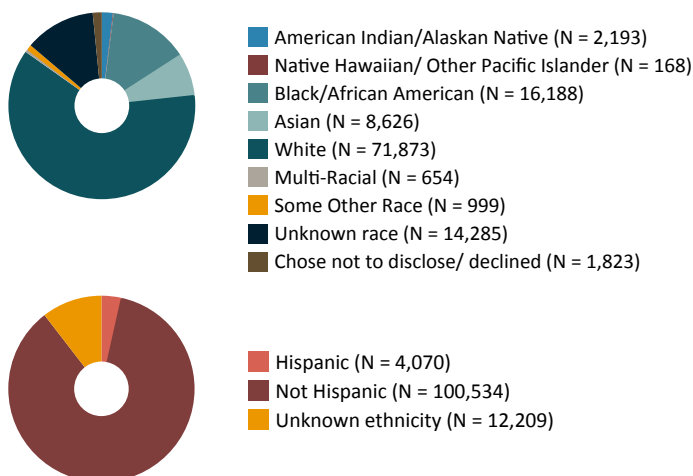


FIGURE 7: Proportion of Eligible MHCP Patients by Race and Hispanic Ethnicity

(2018 report year)



The White and the Asian groups have Colorectal Cancer Screening rates that are significantly higher than the MHCP statewide rate. The American Indian, the Black/African American, the Some Other Race and the Chose not to disclose groups all have screening rates that are significantly lower than the MHCP statewide average.

Additionally, the Non-Hispanic ethnicity group has a screening rate that is significantly higher than the MHCP statewide rate.

Childhood Immunization Status (Combo 10)

Vaccination is one of the best ways to protect children and teens from potentially harmful diseases that may require hospitalization and can even be deadly.⁴

Diseases that used to be common, including polio, measles, diphtheria, pertussis, rubella, mumps, tetanus, rotavirus, chickenpox, influenza and human papillomavirus can now be prevented by vaccination.⁵ While patient compliance with some of the recommended vaccines for children two years and younger is high and stable, children are less likely to be up-to-date on Hepatitis A, the combined seven-vaccine series* and rotavirus.⁶ Immunization of infants and toddlers is recommended by the American Academy of Pediatrics (AAP).

Data collected for this measure are from health plan claims, the Minnesota Immunization Information Connection (MIIC) registry and medical record review (see *Methodology* appendix).

*DTaP, poliovirus vaccine, MMR, H influenzae type b conjugate vaccine, HepB vaccine, varicella vaccine, and pneumococcal conjugate vaccine.

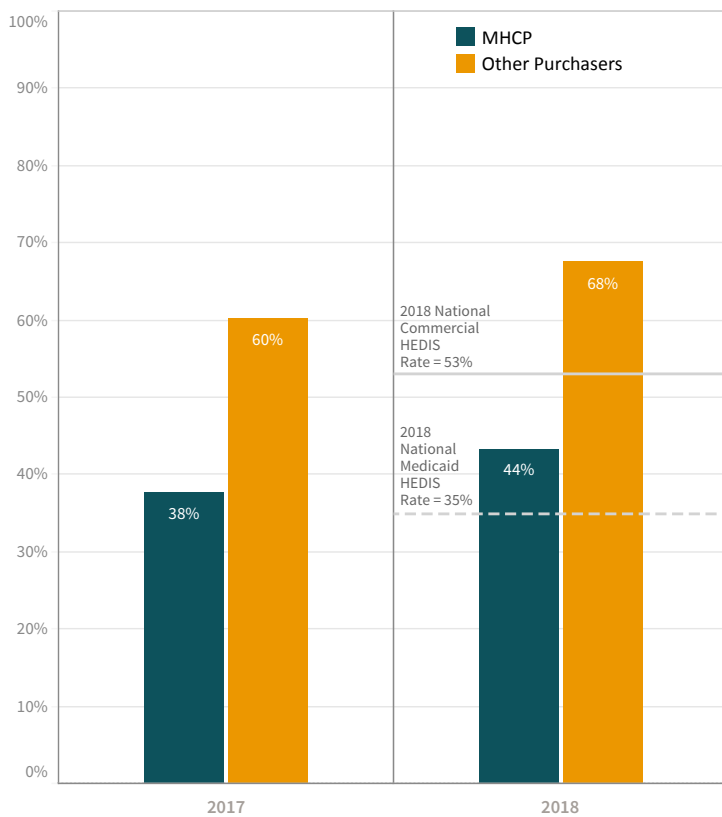
Measure Description

The percentage of two-year old children who received all of the following vaccines by their second birthday:

- » Fourth diphtheria, tetanus and acellular pertussis (DTaP)
- » Three inactivated polio (IPV)
- » One measles, mumps and rubella (MMR)
- » Three H influenza type B
- » Three hepatitis B
- » One chicken pox (VZV)
- » Four pneumococcal conjugate
- » One hepatitis A
- » Two or three rotavirus
- » Two influenza

FIGURE 8: Trend in Childhood Immunization Status (Combo 10)

(2017 and 2018 report years)



The Childhood Immunization Status (Combo 10) rate for MHCP patients increased from 37.5% in 2017 to 43.7% in 2018. This increase is statistically significant. MHCP patients continue to have a significantly lower rate of childhood immunization than patients insured by Other Purchasers, with a 24-percentage point gap in rates between insurance types. This gap is the largest of any measure in the 2018 report year. The statewide rates for both MHCP and Other Purchasers are above the national Medicaid rate (35%) and the national commercial rate (53%).

Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources, and other factors.

National rates source: National Committee for Quality Assurance (NCQA)⁷

FIGURE 9: Childhood Immunization Status (Combo 10) MHCP Rates by Race and Hispanic Ethnicity

(2018 report year)

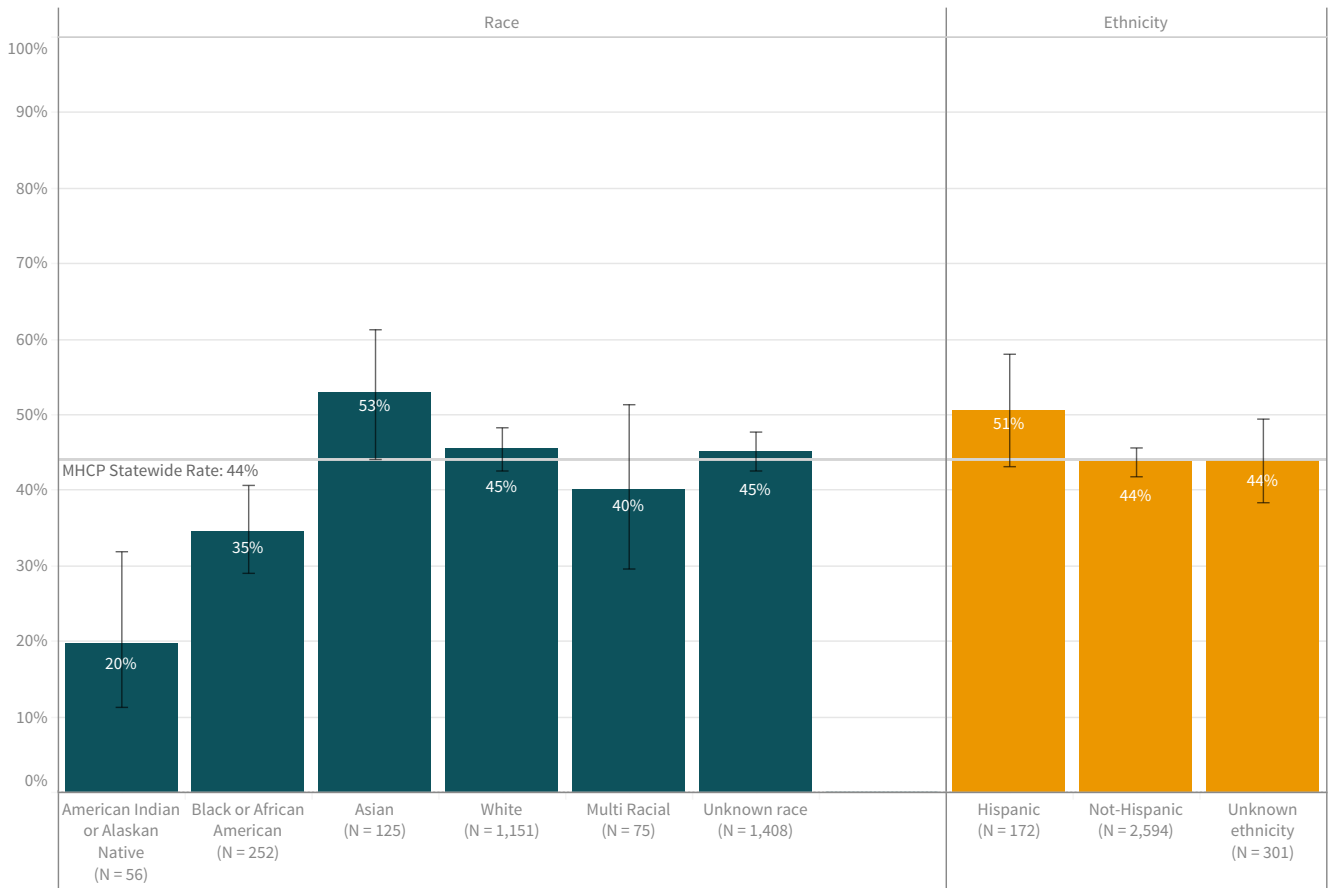
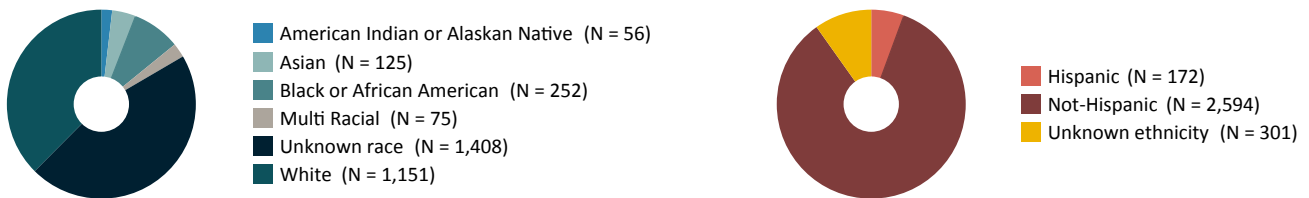


FIGURE 10: Proportion of Eligible MHCP Patients by Race and Hispanic Ethnicity

(2018 report year)



The Asian group has a Childhood Immunization Status (Combo 10) rate that is significantly higher than the MHCP statewide rate. The American Indian group has an immunization rate that is significantly lower than the MHCP statewide rate.

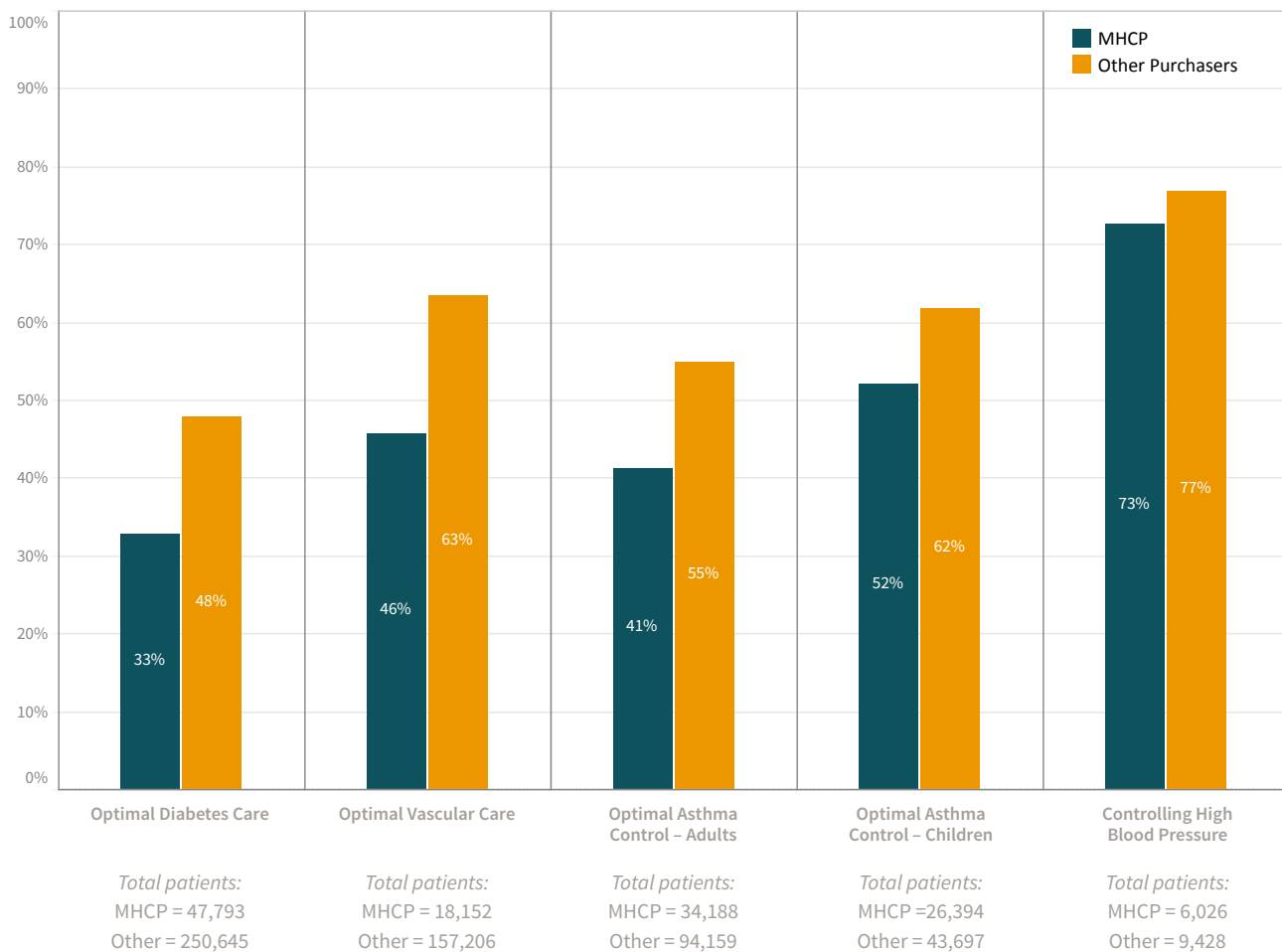
The rates are similar for each of the Hispanic ethnicity categories and are not statistically different than the MHCP statewide rate.

CHRONIC CONDITION MEASURES

This section of the report focuses on chronic condition measures segmented by insurance type. Chronic disease is defined as a condition that lasts one year or more and requires ongoing medical attention or limits activities of daily living or both.⁸ Chronic diseases are an important focus for measurement because of the large numbers of adults and children living with these conditions and known gaps in care related to optimal treatment. The number of people with chronic conditions is estimated to increase rapidly – by 2025, nearly half of the U.S. population will have a chronic disease.⁹

FIGURE 11: Statewide Results by Insurance Type for Chronic Condition Measures

(2018 report year)



Results for all chronic conditions measures indicate room for improvement, regardless of insurance type; however, there are significant differences in performance rates by insurance type. The diabetes, vascular and asthma – adults measures have the widest gaps.

Optimal Diabetes Care

Diabetes is the seventh leading cause of death in the United States.^{10,11} Over 30 million people in the U.S. have diabetes (about 1 in 10), and approximately 90 percent of them have type 2 diabetes.¹² Type 2 diabetes most often develops in people over 45 and can develop at any age, but is becoming more common in children, teens and young adults.¹⁰ Age, family history and a previous history of gestational diabetes are indicators of increased risk for diabetes, along with being African American, Hispanic/Latino or American Indian.

Medical groups and clinics submitted data directly to MNMCM for this measure, based on electronic health records or paper-based medical charts (see [Methodology](#) appendix).

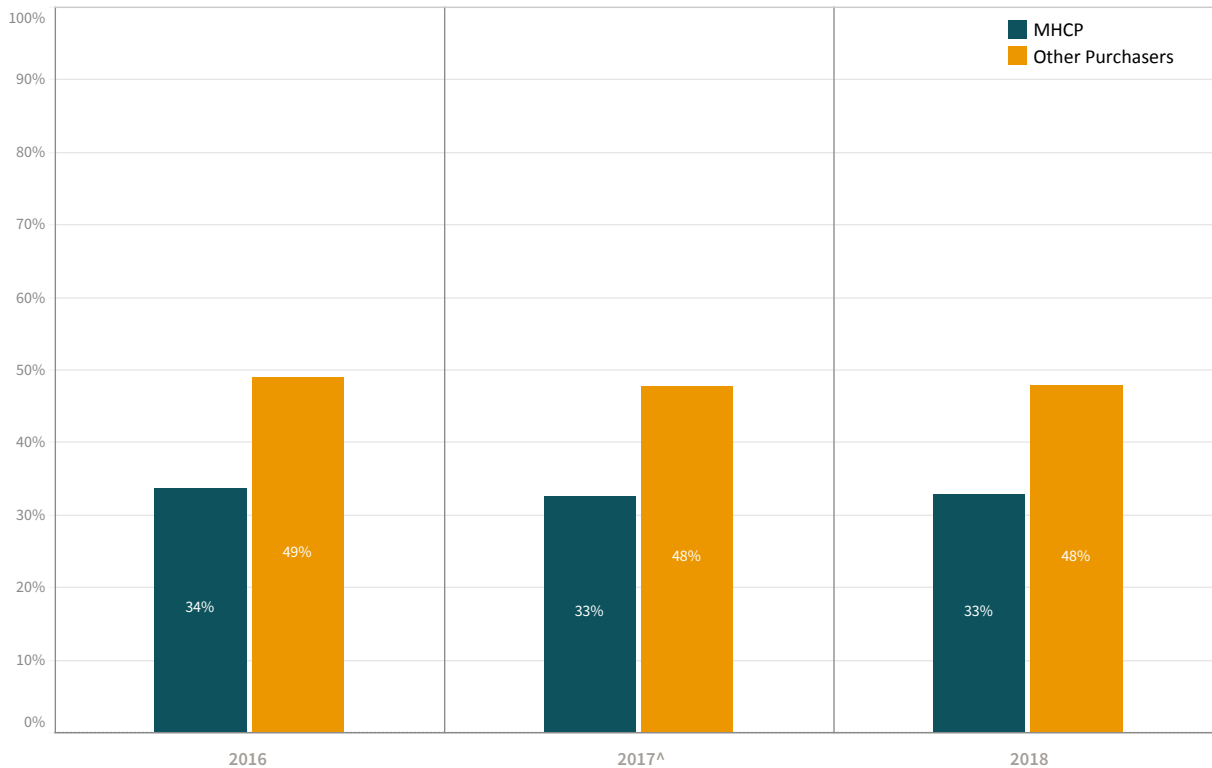
FIGURE 12: Trend in Optimal Diabetes Care

(2016–2018 report years)

Measure Description

The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) and whose diabetes was optimally managed as defined by achieving ALL five of the following:

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



Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources, and other factors.

[^] The criteria for including patients in the measure denominator changed in 2017. This change may have contributed to changes in the statewide rate.

The Optimal Diabetes Care rate for MHCP patients increased slightly from 32.5% in 2017 to 32.8% in 2018; however, this increase is not statistically significant. MHCP patients continue to have a significantly lower rate than patients insured by Other Purchasers and the gap in rates between the insurance types remains.

FIGURE 13: Optimal Diabetes Care MHCP Rates by Race and Hispanic Ethnicity

(2018 report year)

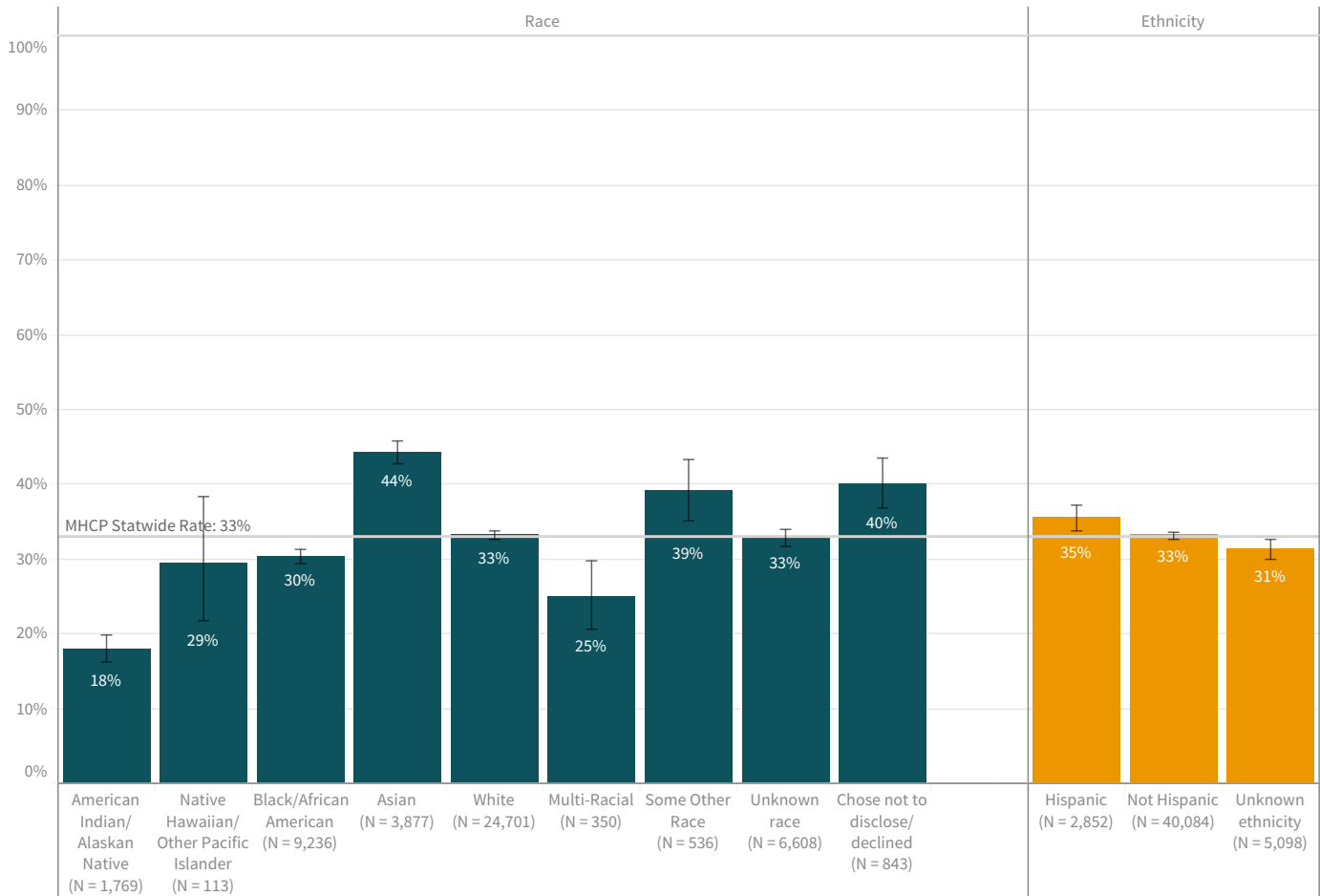
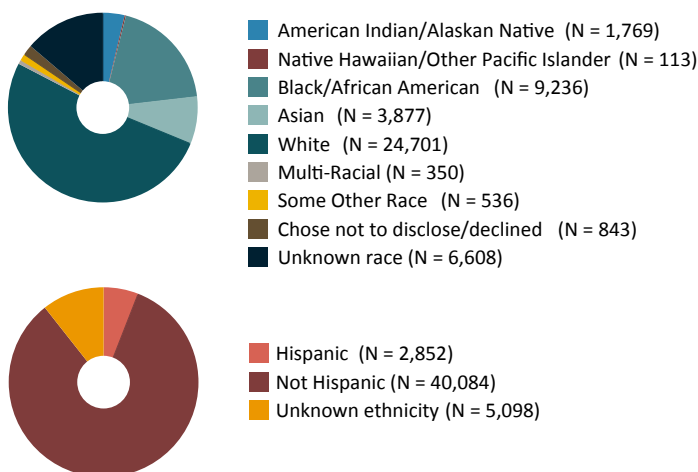


FIGURE 14: Proportion of Eligible MHCP Patients by Race and Hispanic Ethnicity

(2018 report year)



The Asian, the Some Other Race and the Chose not to disclose groups have Optimal Diabetes Care rates that are significantly higher than the MHCP statewide rate. The rates for the American Indian, the Black/ African American and the Multi-Racial groups are significantly lower than the MHCP statewide rate.

Additionally, the Hispanic ethnicity group has a rate that is significantly higher than the MHCP statewide rate.

Optimal Vascular Care

Cardiovascular disease is the leading cause of death for both men and women in the United States. Heart disease is the leading cause of death for people of most racial/ethnic groups in the United States, including African Americans, Hispanics, and whites. For Asian Americans or Pacific Islanders and American Indians or Alaskan Natives, heart disease is second only to cancer.¹³

Medical groups and clinics submitted data directly to MNMCM for this measure, based on electronic health records or paper-based medical charts (see [Methodology](#) appendix).

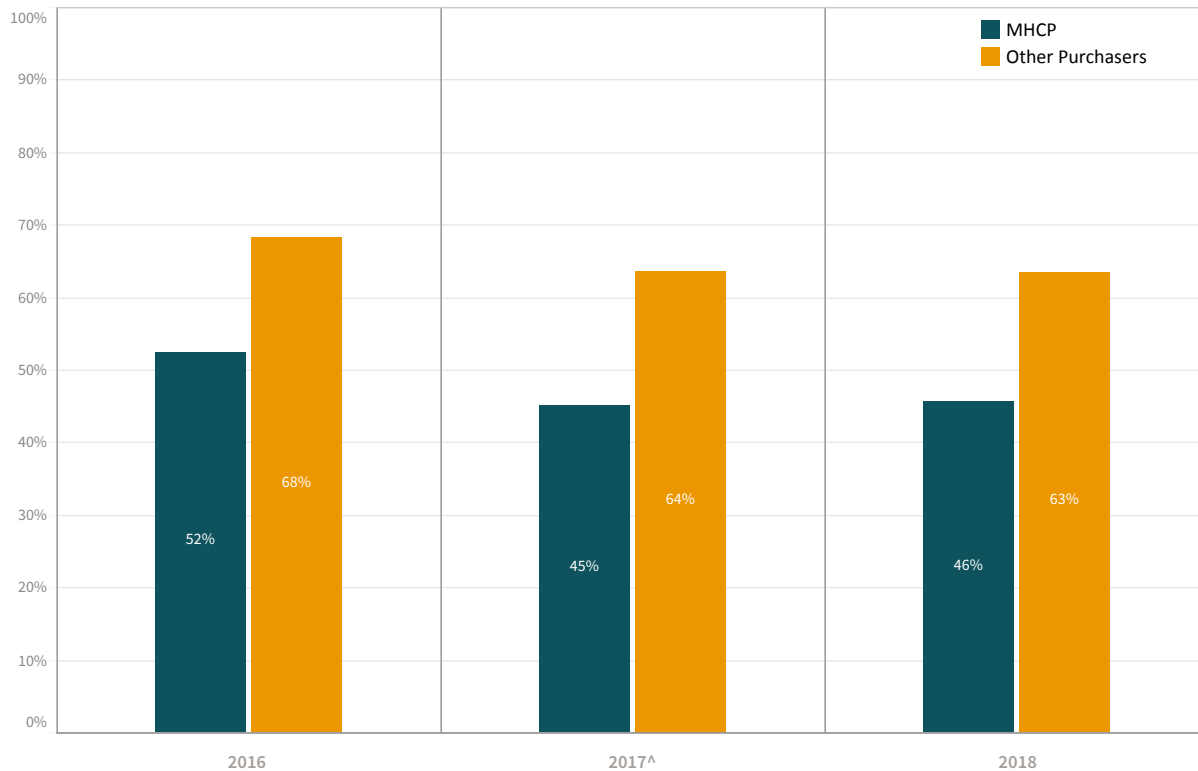
Measure Description

The percentage of patients 18–75 years of age who had a diagnosis of ischemic vascular disease (IVD) and whose IVD was optimally managed as defined by achieving ALL four of the following:

- » Blood Pressure less than 140/90 mmHg
- » On a statin medication, unless allowed contraindications or exceptions are present
- » Non-tobacco use
- » On daily aspirin or anti-platelet, unless allowed contraindications or exceptions are present

FIGURE 15: Trend in Optimal Vascular Care

(2016–2018 report years)



Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources, and other factors.

[^] The criteria for including patients in the measure denominator changed in 2017. This change may have contributed to changes in the statewide rate.

The Optimal Vascular Care rate for MHCP patients increased slightly from 45.1% in 2017 to 45.7% in 2018 but is not statistically significant. MHCP patients continue to have a significantly lower rate of Optimal Vascular Care than patients insured by Other Purchasers and the gap between the insurance types remains wide.

FIGURE 16: Optimal Vascular Care MHCP Rates by Race and Hispanic Ethnicity

(2018 report year)

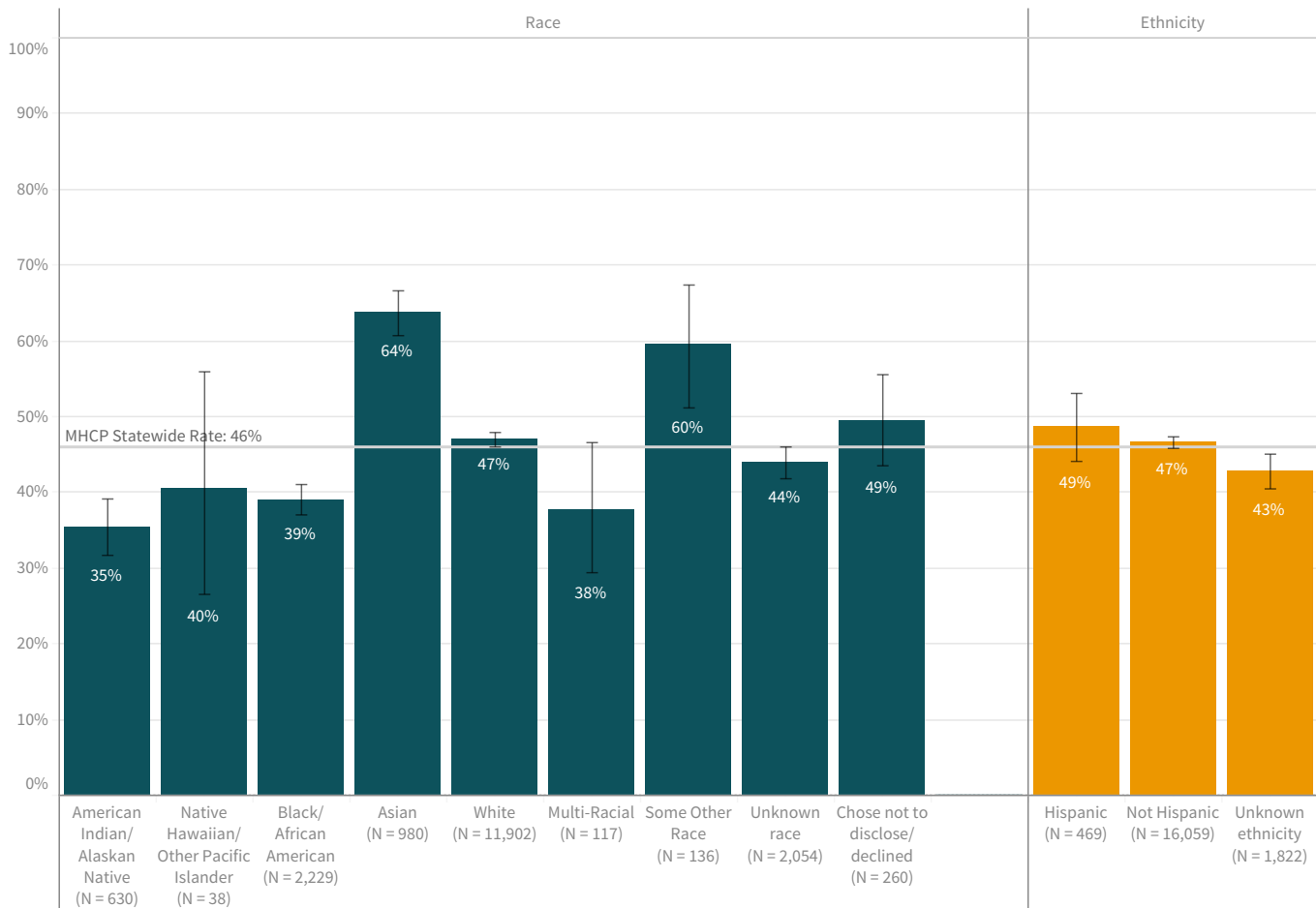
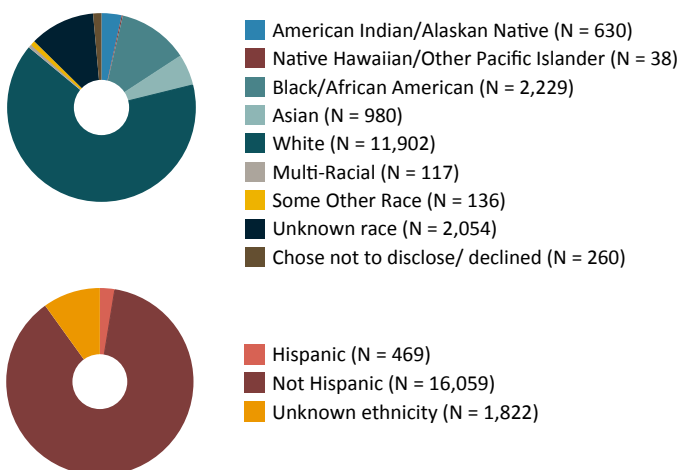


FIGURE 17: Proportion of Eligible MHCP Patients by Race and Hispanic Ethnicity

(2018 report year)



The Asian, White and the Some Other Race groups have Optimal Vascular Care rates that are significantly higher than the MHCP statewide rate. The rates for the American Indian and the Black/African American groups are significantly lower than the MHCP statewide rate.

Additionally, the Not Hispanic ethnicity group has a rate that is significantly higher than the MHCP statewide rate.

Optimal Asthma Control – Adults

Asthma is a common respiratory disease that affects over 26 million people in the United States.¹⁴ In the last decade, the proportion of people with asthma in the United States grew by nearly 15 percent. Nationally, nearly 2 million people visited an emergency department (ED) for asthma-related care and over 470,000 people were hospitalized because of asthma. Regarding race and ethnicity, multi-race and black adults are more likely to have asthma than white adults.¹⁵

Medical groups and clinics report data directly to MNMCM for this measure, based on electronic health records or paper-based medical charts (see [Methodology](#) appendix).

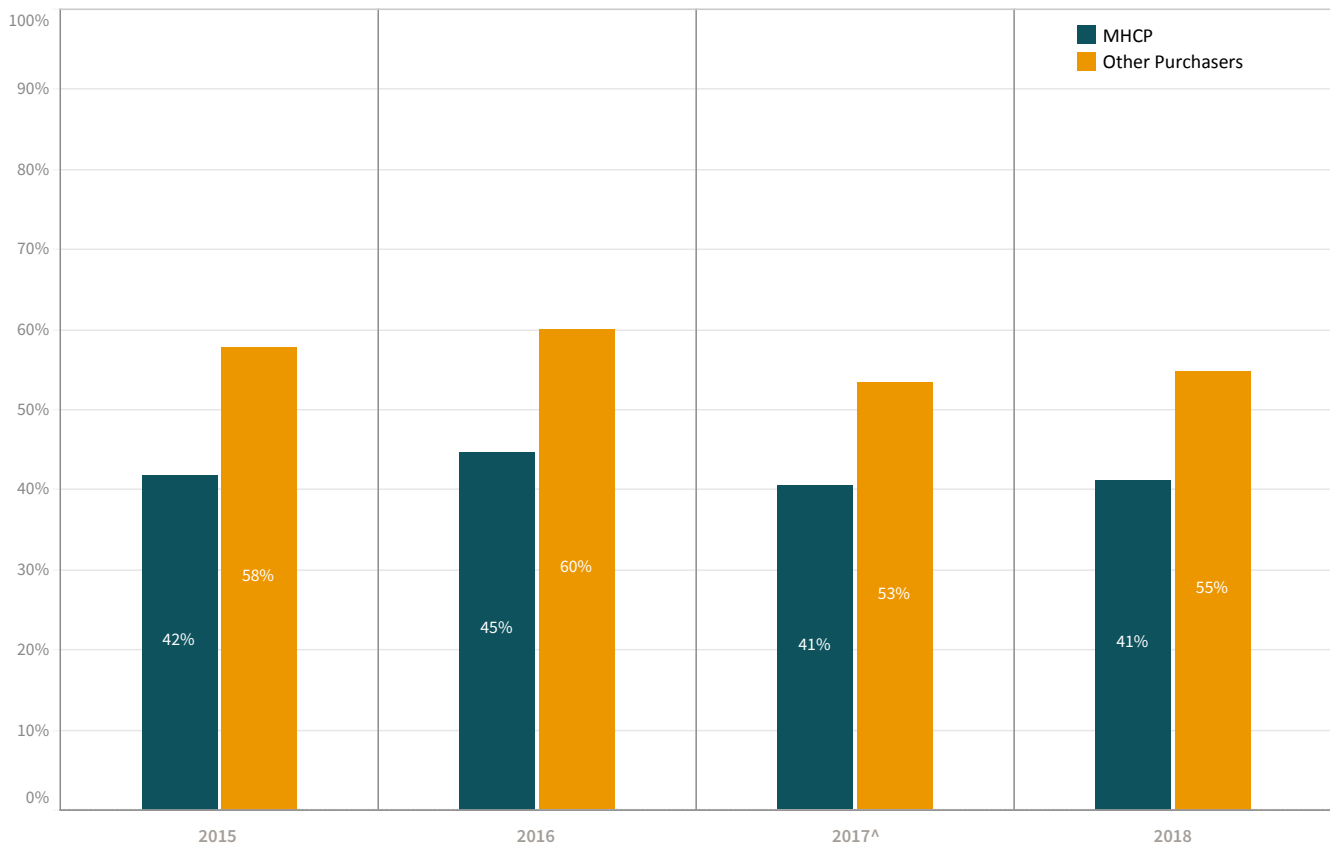
Measure Description

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

- » Asthma well-controlled as defined by the most recent asthma control tool result
- » Patient not at risk of exacerbation (i.e., fewer than two emergency department visit and/or hospitalizations due to asthma in the last 12 months)

FIGURE 18: Trend in Optimal Asthma Control – Adults

(2015–2018 report years)



Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources, and other factors.

[^] The criteria for including patients in the measure denominator changed in 2017. This change may have contributed to changes in the statewide rate.

The Optimal Asthma Control – Adults rate for MHCP patients increased slightly from 40.5% in 2017 to 41.2% in 2018, which is statistically significant. MHCP patients continue to have a significantly lower rate than patients insured by Other Purchasers and the gap between the insurance types remains wide.

FIGURE 19: Optimal Asthma Control – Adults MHCP Rates by Race and Hispanic Ethnicity

(2018 report year)

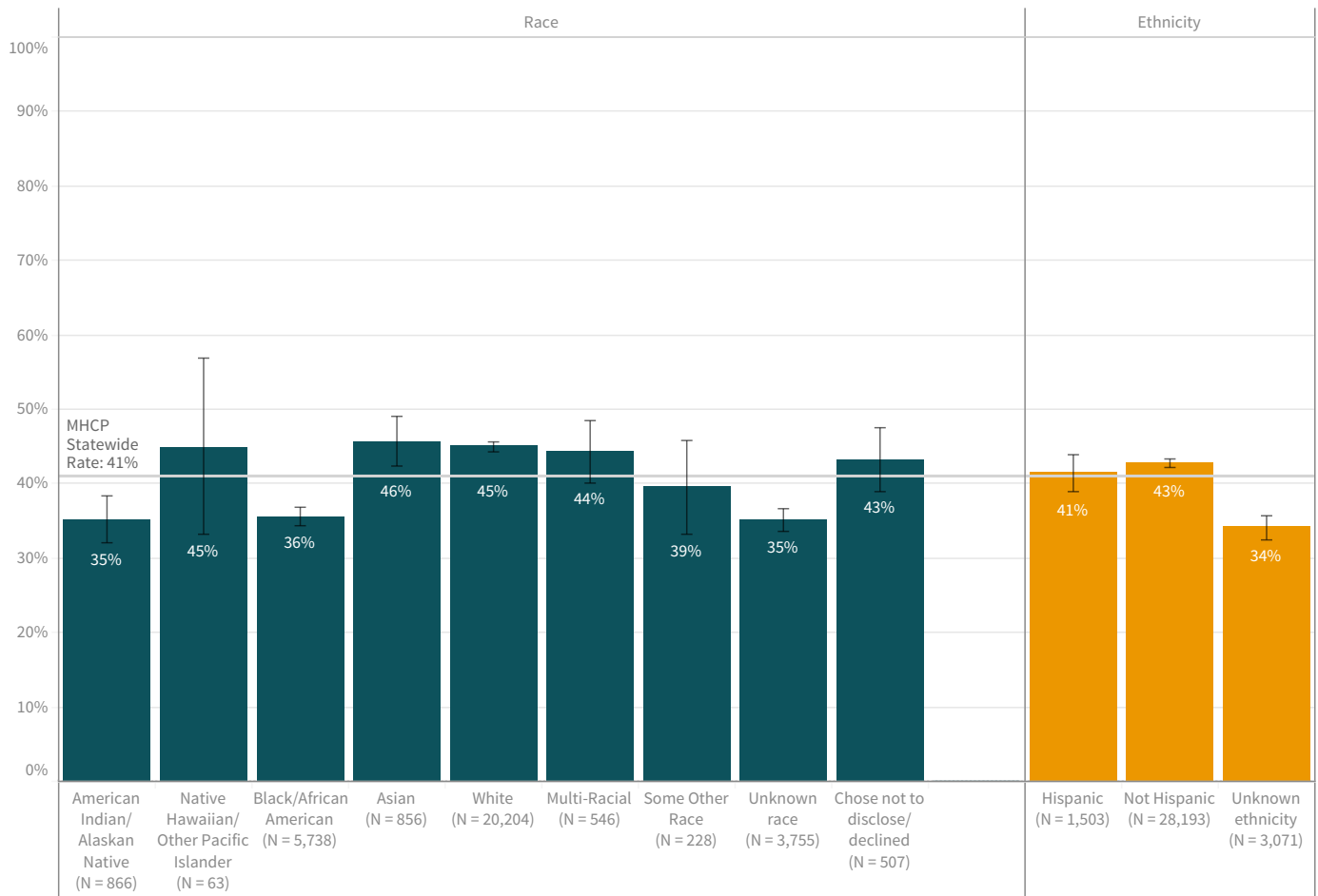
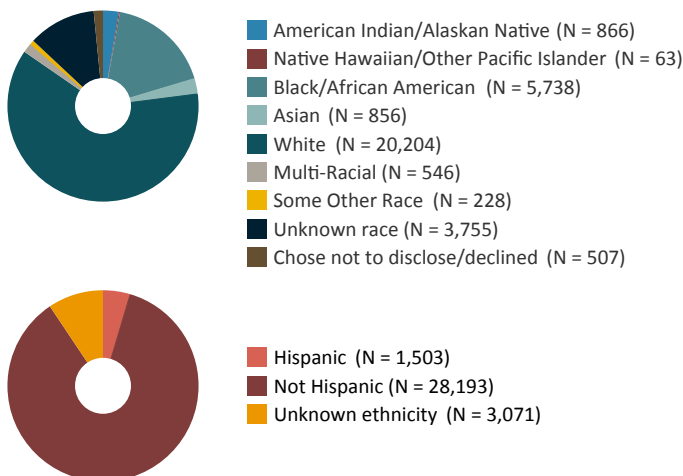


FIGURE 20: Proportion of Eligible MHCP Patients by Race and Hispanic Ethnicity

(2018 report year)



The Asian and the White groups have Optimal Asthma Control – Adult rates that are significantly higher than the MHCP statewide rate. The rates for the American Indian, the Black/African American and the Unknown race groups are significantly lower than the MHCP statewide rate.

Additionally, the Not Hispanic ethnicity group has a rate that is significantly higher than the MHCP statewide rate.

Optimal Asthma Control – Children

Asthma is a common respiratory disease affecting over 6 million children in the United States.¹⁴ In the last decade, the proportion of people with asthma in the United States grew by nearly 15 percent. Nationally, nearly 2 million people visited an emergency department (ED) for asthma-related care and over 470,000 people were hospitalized because of asthma. Black children are two times more likely to have asthma than White children.¹⁵

Medical groups and clinics report data directly to MNMCM for this measure, based on electronic health records or paper-based medical charts (see [Methodology](#) appendix).

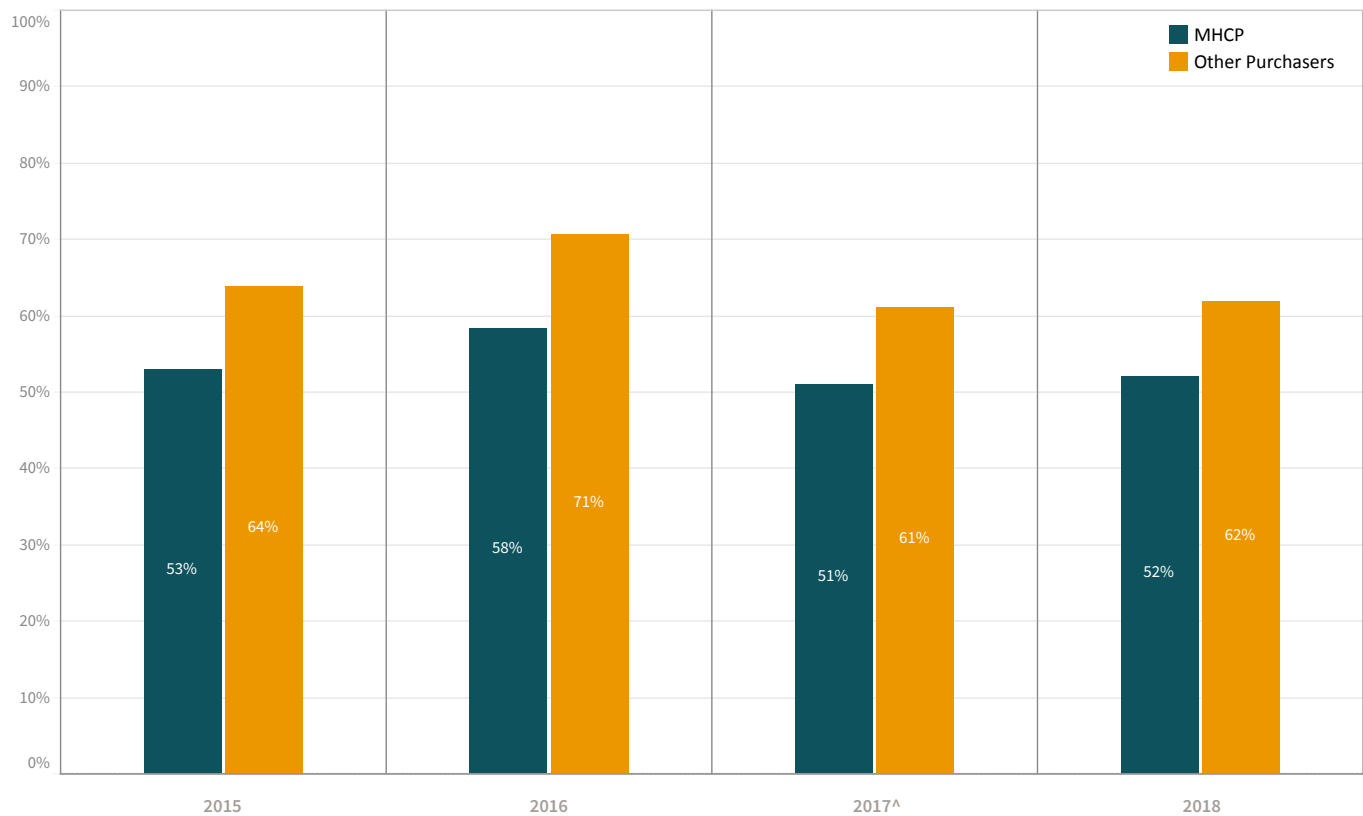
Measure Description

The percentage of children (5–17 years of age) who had a diagnosis of asthma and whose asthma was optimally controlled as defined by achieving the following:

- » Asthma well-controlled as defined by the most recent asthma control tool result
- » Patient not at risk of exacerbation (i.e., fewer than two emergency department visit and/or hospitalizations due to asthma in the last 12 months)

FIGURE 21: Trend in Optimal Asthma Control – Children

(2015–2018 report years)



Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources, and other factors.

[^] The criteria for including patients in the measure denominator changed in 2017. This change may have contributed to changes in the statewide rate.

The Optimal Asthma Control – Children rate for MHCP patients increased from 51.0% in 2017 to 52.0% in 2018, which is statistically significant. MHCP patients continue to have a significantly a lower rate than patients insured by Other Purchasers. While the gap in rates between the insurance types remains the same since last year, it has narrowed since 2015.

FIGURE 22: Optimal Asthma Control – Children MHCP Rates by Race and Hispanic Ethnicity

(2018 report year)

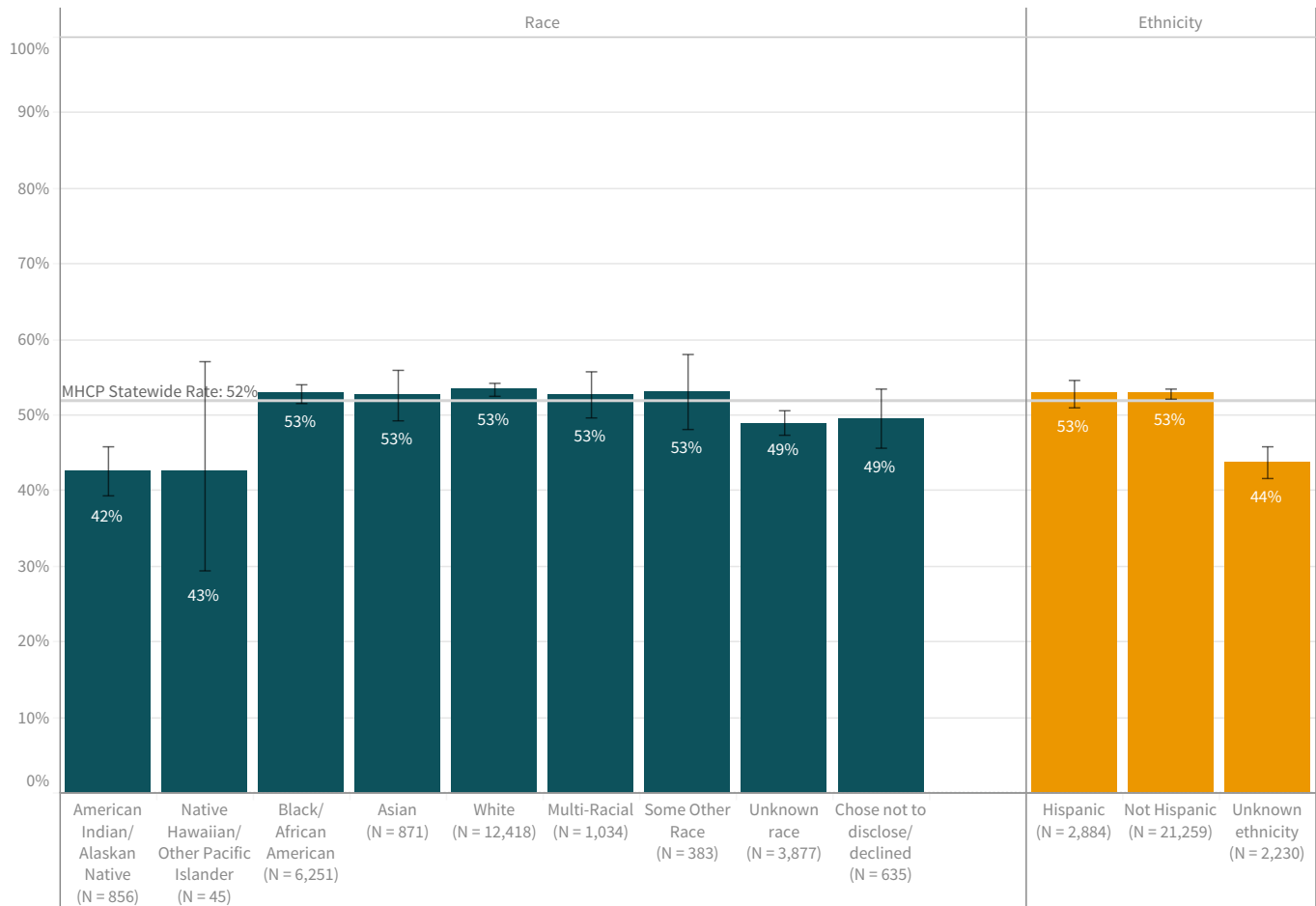
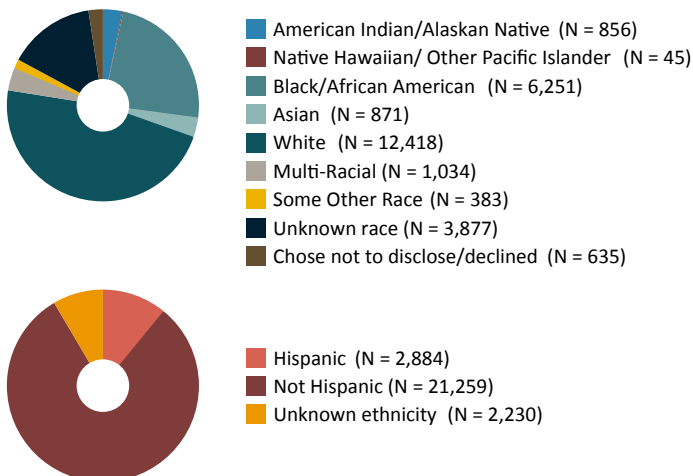


FIGURE 23: Proportion of Eligible MHCP Patients by Race and Hispanic Ethnicity

(2018 report year)



The White group has an Optimal Asthma Control – Children rate that is significantly higher than the MHCP statewide rate. The rates for the American Indian and the Unknown race groups are significantly lower than the MHCP statewide rate.

Additionally, the Not Hispanic ethnicity group has a rate that is significantly higher than the MHCP statewide rate.

Controlling High Blood Pressure

Hypertension, or high blood pressure, increases the risk for heart disease and stroke, two of the leading causes of death for Americans. One out of every three Americans has hypertension. Even with the availability of effective treatment options, only half of Americans with hypertension have their blood pressure under control.¹⁶ According to the American Heart Association, the death rate attributed to high blood pressure increased by over 10 percent between 2005 and 2015, and the number of deaths attributed to high blood pressure rose by over 37 percent.¹⁷

Data collected for this measure are from health plan claims and medical record review (see [Methodology](#) appendix).

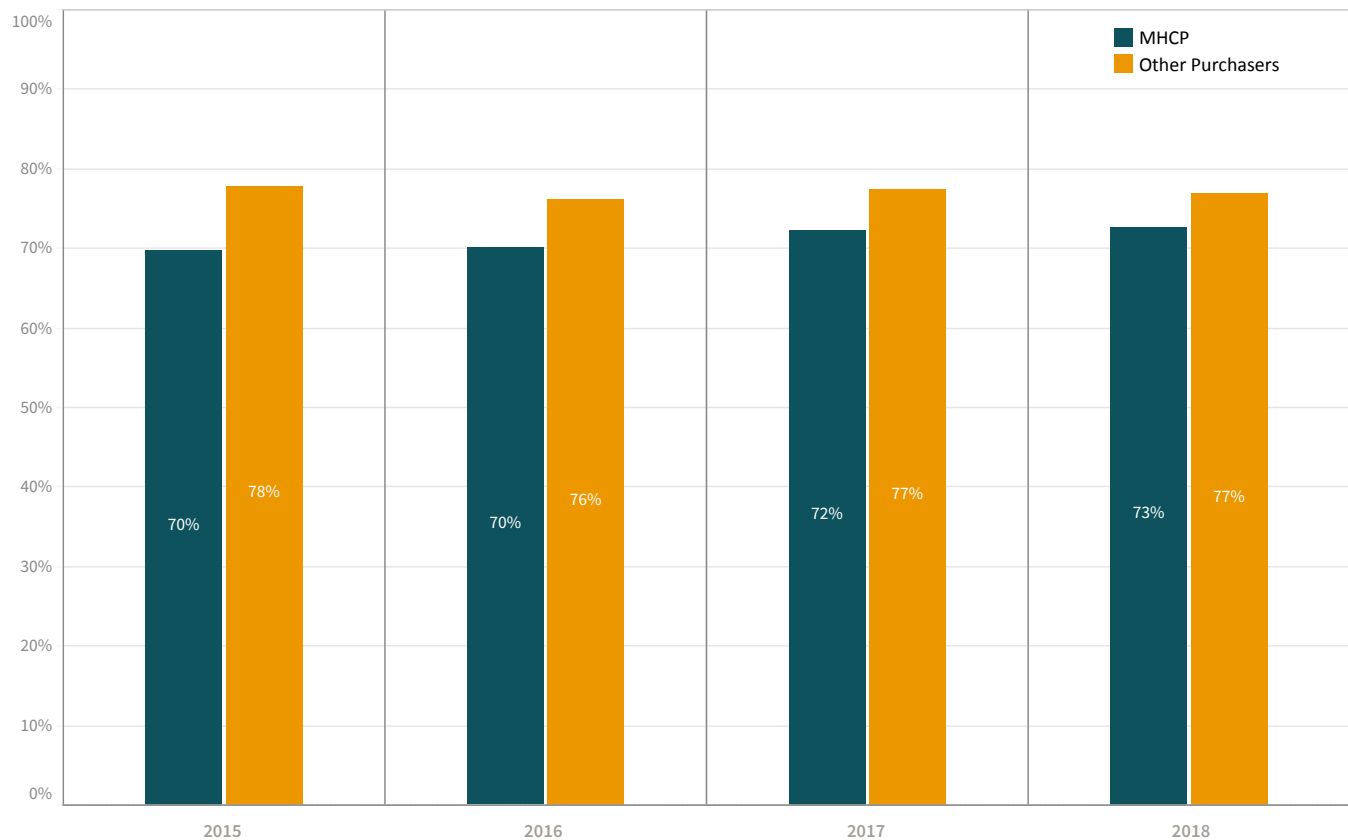
Measure Description

The percentage of adults 18–75 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled based on the following:

- » Adults 18–59 years of age whose BP was <140/90 mm Hg
- » Adults 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg
- » Adults 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg

FIGURE 24: Trend in Controlling High Blood Pressure

(2015–2018 report years)



Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources, and other factors.

The Controlling High Blood Pressure rate for MHCP patients increased slightly from 72.2% in 2017 to 72.7% in 2018; however, this increase is not statistically significant. MHCP patients continue to have a significantly lower rate of Controlling High Blood Pressure than patients insured by Other Purchasers, but the gap in rates between the insurance types has narrowed since 2015.

FIGURE 25: Controlling High Blood Pressure MHCP Rates by Race and Hispanic Ethnicity

(2018 report year)

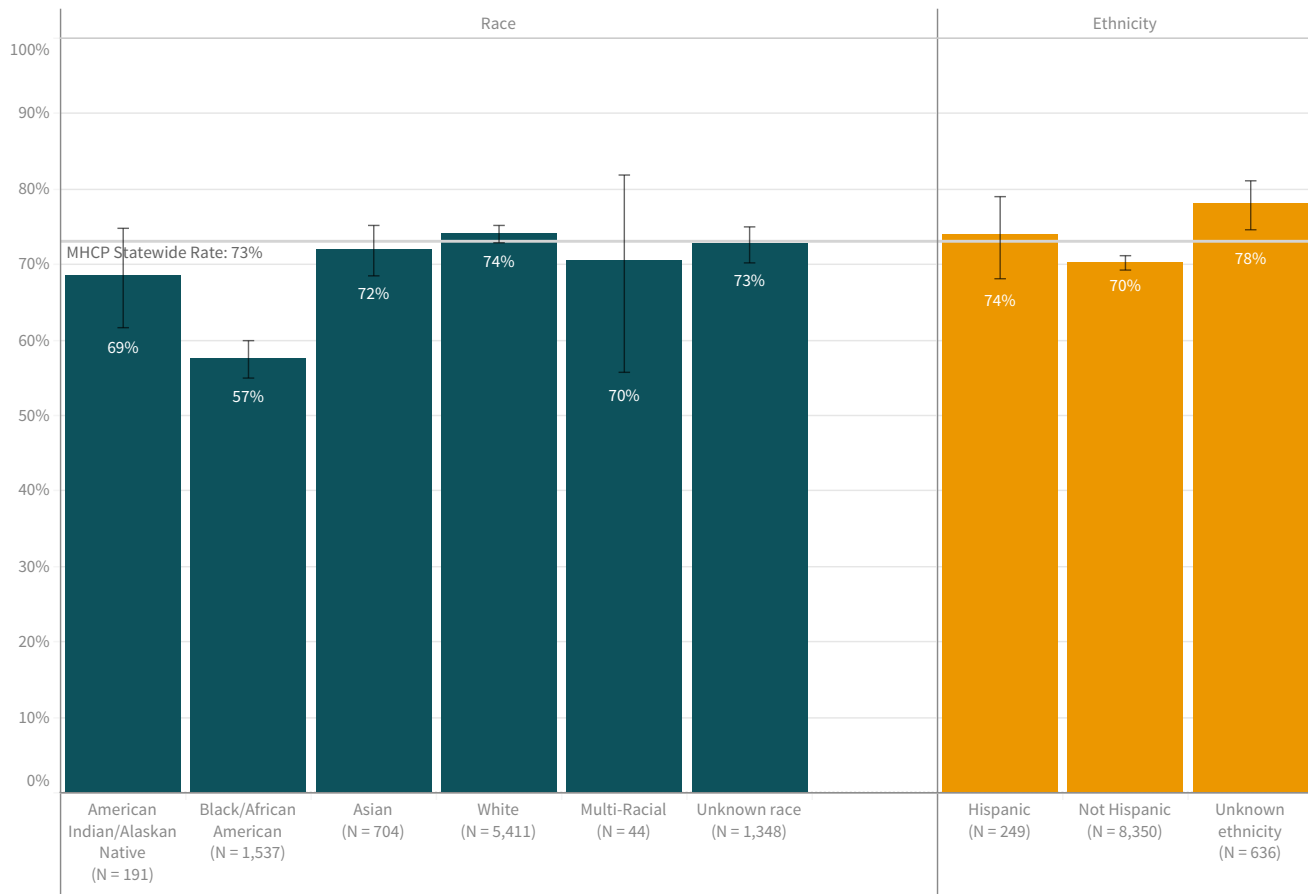
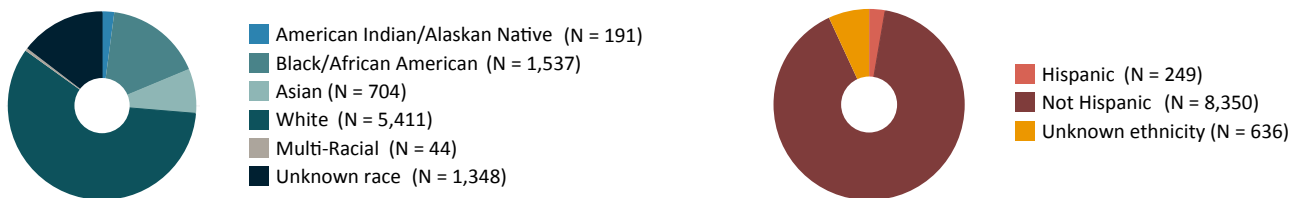


FIGURE 26: Proportion of Eligible MHCP Patients by Race and Hispanic Ethnicity

(2018 report year)



The White group has a Controlling High Blood Pressure rate that is significantly higher than the MHCP statewide rate. The rate for the Black or African American group is significantly lower than the MHCP statewide rate.

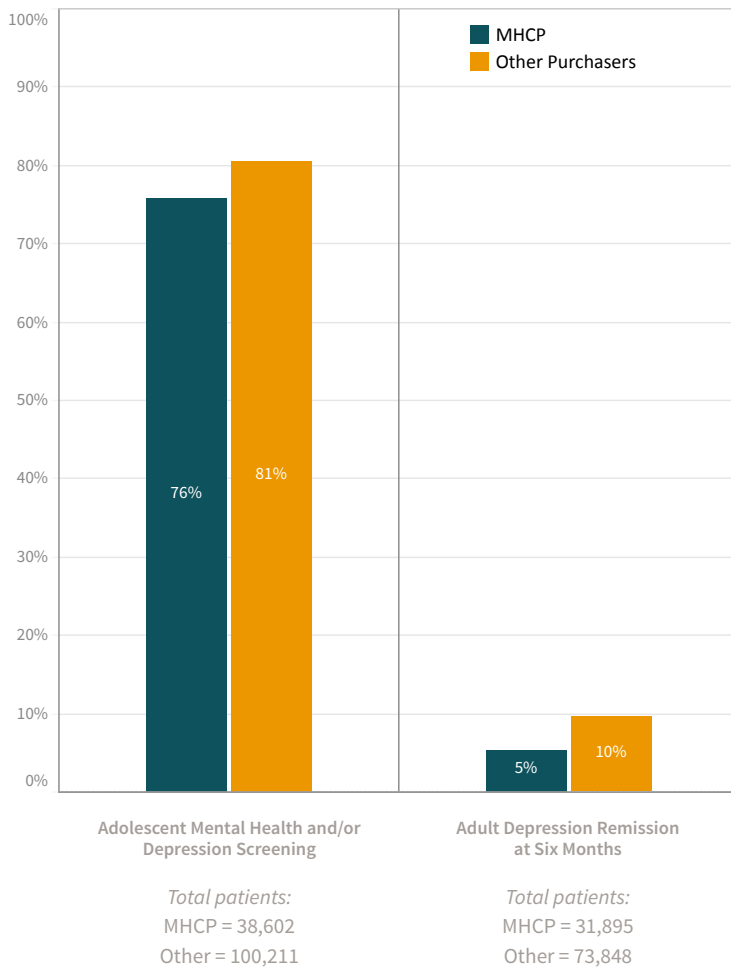
Additionally, the Not Hispanic ethnicity group has a rate that is significantly lower than the MHCP statewide rate.

DEPRESSION MEASURES

This section of the report focuses on depression measures segmented by insurance type. Depression is an important focus for measurement because of the large numbers of patients with this chronic episodic condition and known gaps in care related to follow-up and treatment. Patients with depression, an isolating condition, are less capable of reaching out, keeping appointments, and maintaining a connection with their provider compared to patients with other conditions. Maintaining proactive contact (in person, phone or other mode) is key to recovery and improved outcomes.

FIGURE 27: Statewide Results by Insurance Type for Depression Measures

(2018 report year)



Results for the adolescent and adult depression measures indicate room for improvement, regardless of insurance type; however, there are significant differences in performance rates by insurance type. Both measures have a similar gap between insurance types.

Adolescent Mental Health and/or Depression Screening

Major depression is a common mental health disorder affecting adolescents. In 2016, over 3 million adolescents aged 12 to 17 (13%) had at least one major depressive episode.¹⁸ Many mental health conditions (anxiety, bipolar, depression, eating disorders, and substance abuse) are evident by age 14.¹⁹ Adolescent-onset depression is associated with chronic depression in adulthood.²⁰

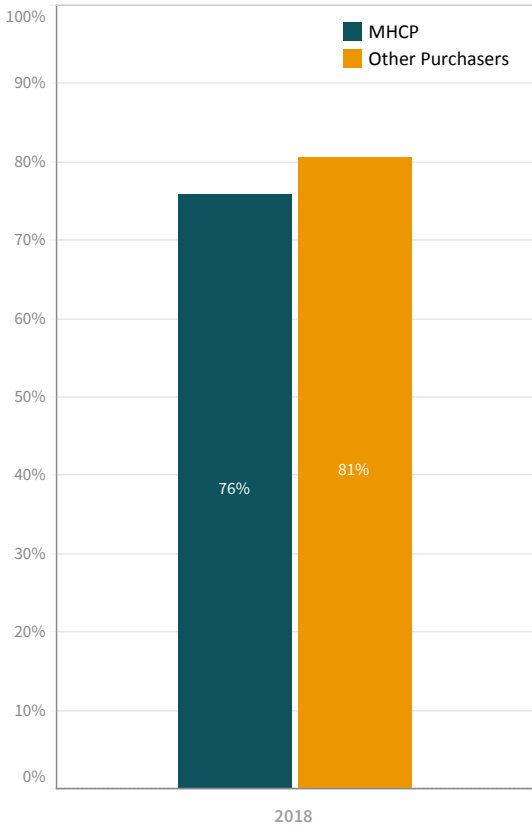
Measure Description

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.

Medical groups and clinics report data directly to MNMCM for this measure, based on electronic health records or paper-based medical charts (see *Methodology* appendix).

FIGURE 28: Adolescent Mental Health and/or Depression Screening

(2018 report year)



This is the first year that the Adolescent Mental Health and/or Depression Screening measure has been included in the report. The gap in rates between insurance types is statistically significant with a difference of five percentage points.



FIGURE 29: Adolescent Mental Health and/or Depression Screening MHCP Rates by Race and Hispanic Ethnicity

(2018 report year)

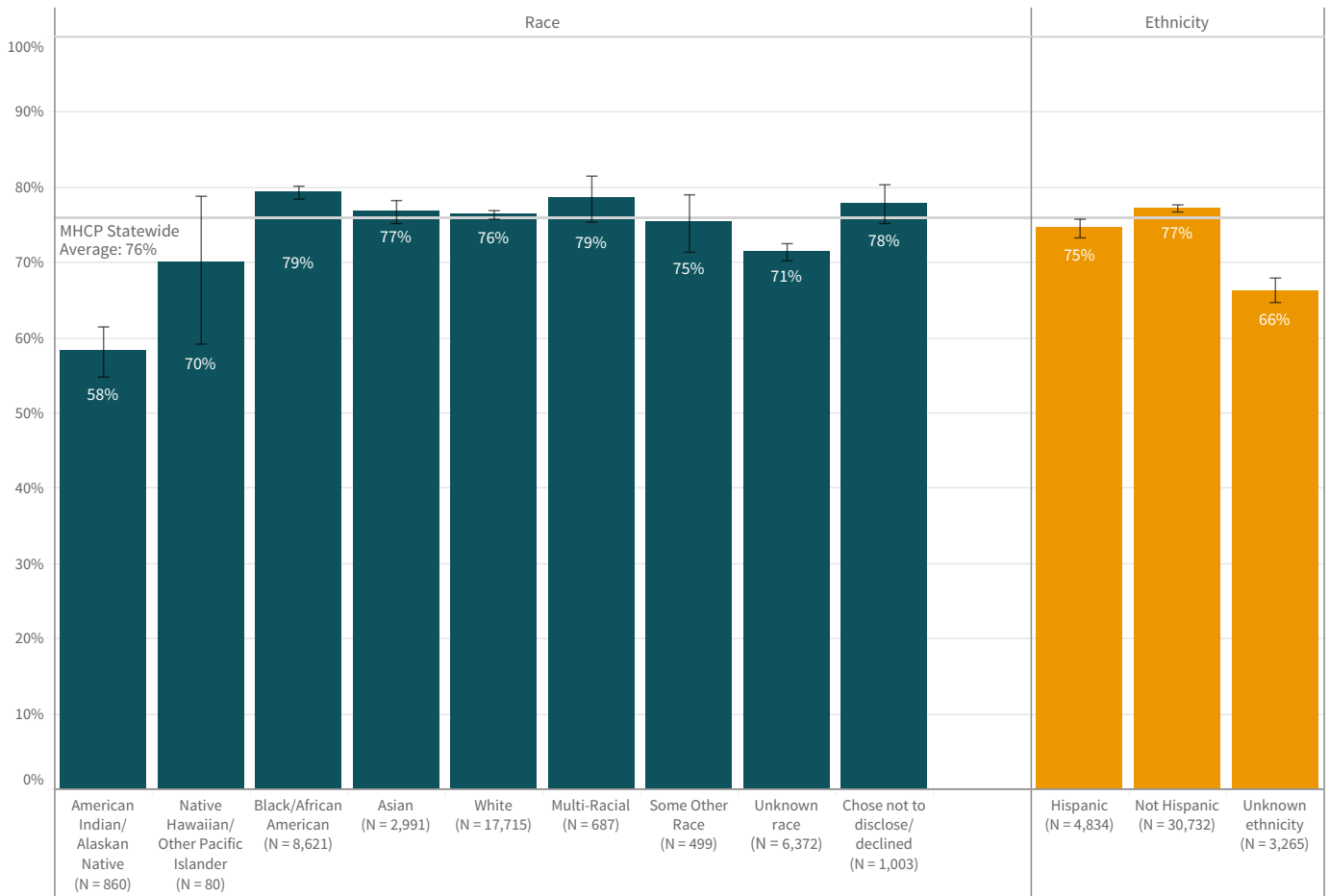
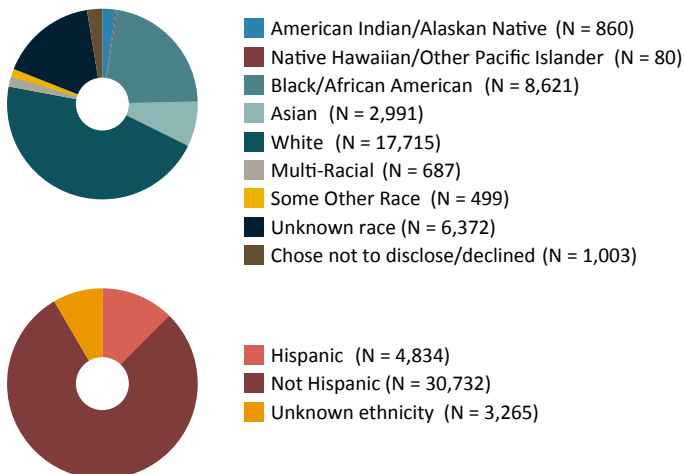


FIGURE 30: Proportion of Eligible MHCP Patients by Race and Hispanic Ethnicity

(2018 report year)



The Black/African American and the White groups have an Adolescent Mental Health and/or Depression Screening rate that is significantly higher than the MHCP statewide rate. The screening rates for the American Indian and the Unknown race groups are significantly lower than the MHCP statewide rate.

Additionally, the Not Hispanic ethnicity group has a screening rate that is significantly higher than the MHCP statewide rate.

Adult Depression Remission at Six Months

Depression is one of the most common and treatable mental disorders in the United States. It is associated with higher mortality rates in all age groups. People who are depressed are 30 times more likely to take their own lives than people who are not depressed and five times more likely to abuse drugs.²¹

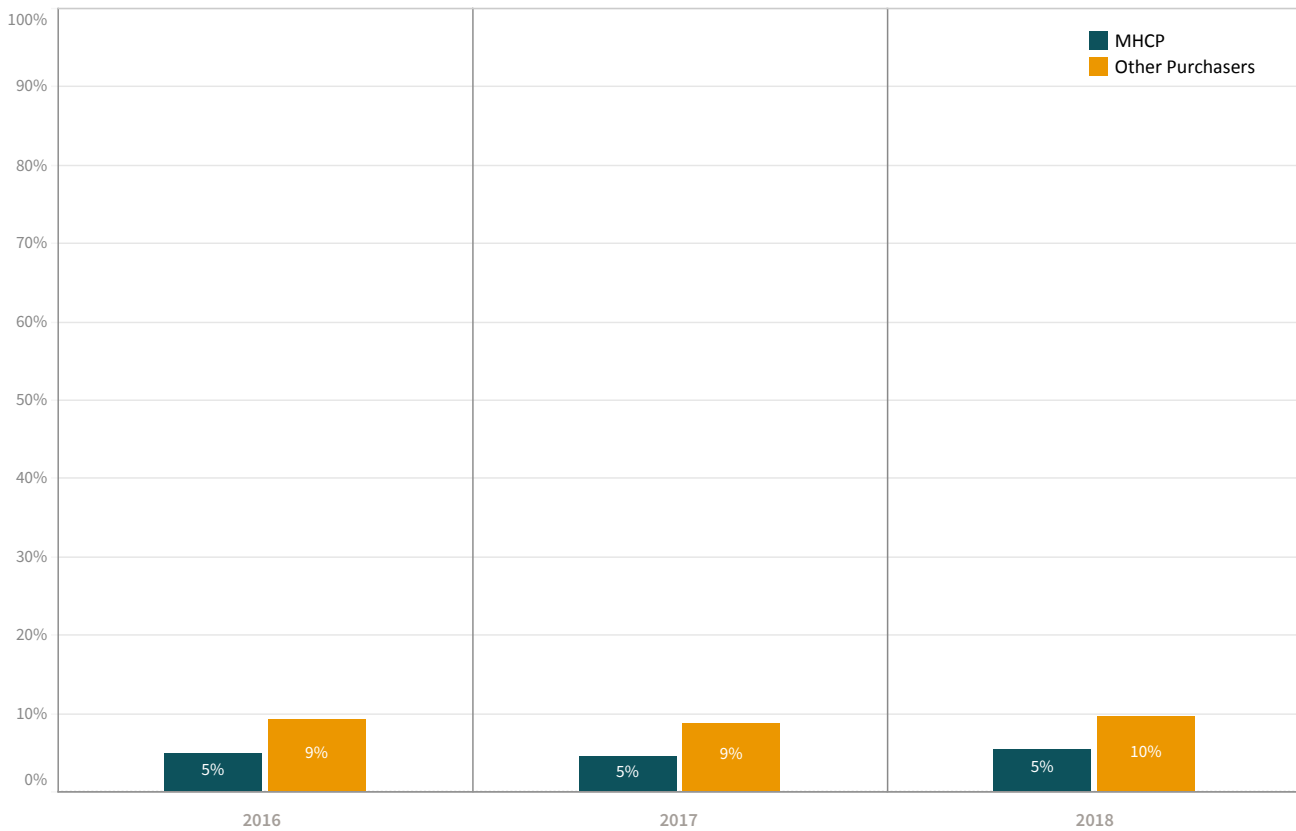
Medical groups and clinics report data directly to MNMCM for this measure, based on electronic health records or paper-based medical charts (see [Methodology](#) appendix).

Measure Description

The percentage of adult patients (18 years and older) with depression who reached remission (PHQ-9 score less than five) six months after the index event (+/- 30 days).

FIGURE 31: Trend in Adult Depression Remission at Six Months

(2016 – 2018 report years)



Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources, and other factors.

The Adult Depression Remission at Six Months rate for MHCP patients increased slightly from 4.5% in 2017 to 5.4% in 2018, which is statistically significant. MHCP patients continue to have a significantly lower rate of Adult Depression Remission at Six Months than patients insured by Other Purchasers; however, the gap in rates between insurance types significantly narrowed in 2018.

FIGURE 32: Adult Depression Remission at Six Months MHCP Rates by Race and Hispanic Ethnicity

(2018 report year)

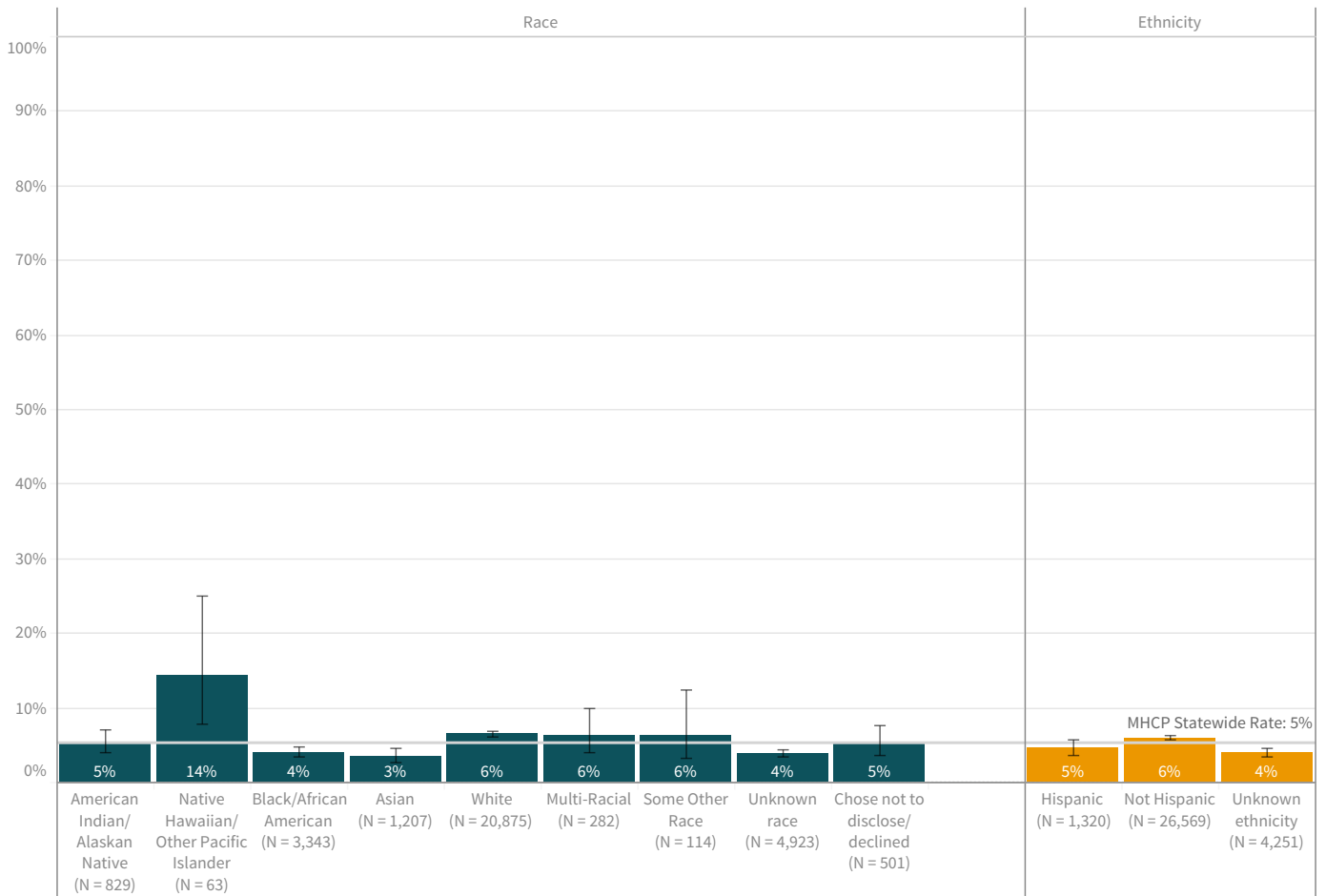
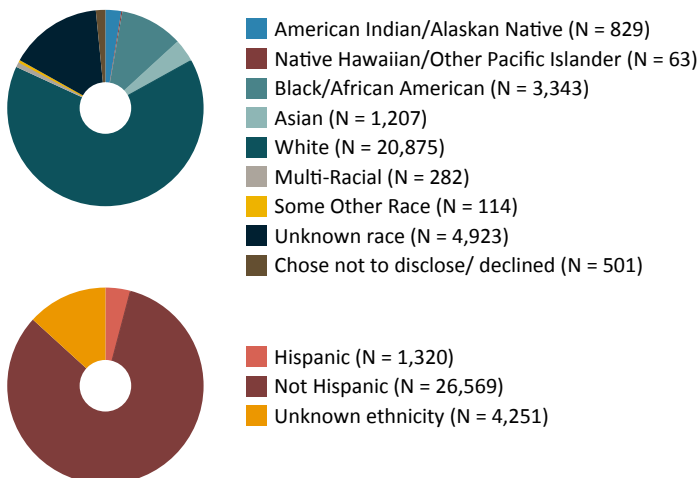


FIGURE 33: Proportion of Eligible MHCP Patients by Race and Hispanic Ethnicity

(2018 report year)



The Native Hawaiian/Other Pacific Islander and the White groups have Adult Depression Remission at Six Months rates that are significantly higher than the MHCP statewide rate. The rates for the Black/African American, the Asian and the Unknown race groups are significantly lower than the MHCP statewide rate.

Additionally, the Not Hispanic ethnicity group has a rate that is significantly higher than the MHCP statewide rate.

HIGH PERFORMING MEDICAL GROUPS FOR MHCP

In 2018, there were nine primary care/multi-specialty medical groups with MHCP rates significantly higher than the MHCP statewide rate on at least 50 percent of the measures for which they were eligible.* These medical groups are listed below in alphabetical order.

TABLE 5: High Performers by Medical Group – Primary Care/Multi-Specialty

QUALITY MEASURE	MEDICAL GROUP (Number of measures with rates above MHCP Statewide)								
	Allina Health (9 of 10)	Entira Family Clinics (6 of 10)	Essentia Health (7 of 10)	Fairview Health Services (7 of 10)	Health-Partners Clinics (6 of 10)	Lakewood Health System (6 of 10)	Mankato Clinic, Ltd. (5 of 10)	Park Nicollet Health Services (7 of 10)	Sanford Health - Sioux Falls Region (5 of 10)
PREVENTIVE HEALTH	Breast Cancer Screening			•		•			•
	Colorectal Cancer Screening	•		•	•	•	•	•	
	Childhood Immunization Status (Combo 10)	•							•
CHRONIC CONDITIONS	Optimal Diabetes Care	•	•		•	•	•	•	
	Optimal Vascular Care	•	•		•			•	
	Optimal Asthma Control – Adults	•	•	•	•	•	•	•	•
	Optimal Asthma Control – Children	•	•	•	•	•	•	•	•
	Controlling High Blood Pressure	•	•	•	•		•		•
	Adult Depression Remission at Six Months	•	•	•				•	•
	Adolescent Mental Health and/or Depression Screening	•		•	•	•	•	•	

*Included if eligible for at least five measures.

Blank = average or below average

For detailed medical group and clinic results, refer to the [Detailed Medical Group and Clinic Level Tables](#) appendix.

DEFINITIONS

General Definitions

Continuous enrollment criteria: The minimum amount of time for a member/patient to be enrolled in a health plan to be eligible for a HEDIS measure. It ensures the health plan has enough time to render services. If a member/patient does not meet minimum continuous enrollment criteria, they are not eligible to be included in the measure denominator.

Composite measures: A measure of two or more component measures, each of which individually reflects quality of care, combined into a single performance measure with a single score. The individual components are treated equally (not weighted). Every component must meet criteria to be counted in the numerator for the overall composite measure. The composite measures in this report include:

- » Childhood Immunization Status (Combo 10)
- » Optimal Diabetes Care
- » Optimal Vascular Care
- » Optimal Asthma Control – Adults
- » Optimal Asthma Control – Children

Direct Data Submission (DDS) measures: Measures collected using the DDS process, which include:

- » Optimal Diabetes Care
- » Optimal Vascular Care
- » Adult Depression Remission at Six Months
- » Optimal Asthma Control – Children
- » Optimal Asthma Control – Adults
- » Colorectal Cancer Screening
- » Adolescent Mental Health and/or Depression Screening.

These measures are calculated using data submitted by medical groups/clinics. These data come from electronic health records or paper-based medical charts. See the Methodology Appendix for more information.

Healthcare Effectiveness Data and Information Set (HEDIS) measures: A national set of performance measures used in the managed care industry and developed and maintained by the National Committee for Quality Assurance (NCQA). Clinical HEDIS measures use data from the administrative or hybrid data collection methodology.

Insurance type: Health care insurance type includes the following categories:

- » Commercial (employer-based and individual coverage)
- » State health care programs, which include Medical Assistance (Medicaid) and MinnesotaCare
- » Medicare (federal health care programs for people ages 65 years and older and people who are disabled)
- » Uninsured



Medical group: One or more clinic sites operated by a single organization.

Minnesota Health Care Programs (MHCP): These health care programs (i.e., Medical Assistance including dual eligible and MinnesotaCare) provide service under both fee-for-service and managed care delivery systems purchased by DHS. This report only includes performance rates for the managed care programs (i.e., Medical Assistance and MinnesotaCare).

National Benchmarks: The benchmarks (standards used for national comparisons) include the 2018 national commercial HEDIS rate and the 2018 national Medicaid HEDIS rate. The benchmark HEDIS rate is a national average by insurance type of more than 90 percent of managed health care plans and some PPO health plans that submit data to NCQA to measure performance against a detailed set of measure criteria. Benchmarks are only included for the Childhood Immunization Status (Combo 10) measure.

National Committee for Quality Assurance (NCQA): A national, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations, as well as produces HEDIS measures.

Other Purchasers: This includes commercial (employer-based insurance coverage) and/or Medicare managed care data.

Outcome measures: These measures reflect the actual results of care. They are generally the most relevant measures for patients and the measures that providers most want to change. The outcome measures in this report include:

- » Optimal Diabetes Care
- » Optimal Vascular Care
- » Optimal Asthma Control – Adults
- » Optimal Asthma Control – Children
- » Controlling High Blood Pressure
- » Adult Depression Remission at Six Months

Patient Reported Outcome (PRO): Information reported by the patient.

Patient Report Outcome Measure (PROM): A validated instrument or survey tool that collects data from a patient.

- » Optimal Asthma Control measures – Adults and Children: Asthma Control Test (ACT); Childhood Asthma Control Test (C-ACT); Asthma Control Questionnaire (ACQ); Asthma Therapy Assessment Questionnaire (ATAQ)
- » Adult Depression Remission at Six Months: Patient Health Questionnaire – 9 item version (PHQ-9)

Patient Report Outcome – Performance Measure (PRO-PM): Measures built from a PROM.

The PRO-PM outcome measures in this report include:

- » Optimal Asthma Control – Adults
- » Optimal Asthma Control – Children
- » Adult Depression Remission at Six Months



The PRO-PM process measures in this report include:

- » Adolescent Mental Health and/or Depression Screening

Process measures: A measure that shows whether steps proven to benefit patients are followed correctly. They measure whether an action was completed (e.g., having a medical exam or test, writing a prescription, or administering a drug). The process measures in this report include:

- » Breast Cancer Screening
- » Colorectal Cancer Screening
- » Adolescent Mental Health and/or Depression Screening

Statewide rates: This included patients meeting measurement criteria enrolled in managed care health plans including commercial, Medicaid managed care and Medicare managed care.

Online Appendices

[Methodology](#)

[Detailed Medical Group and Clinic Level Tables](#)

Endnotes

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