

2021 MINNESOTA HEALTH CARE DISPARITIES By Insurance Type

Results for care delivered in 2020



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WHO IS MN COMMUNITY MEASUREMENT?

MN Community Measurement (MNCM) is an independent nonprofit organization that empowers health care decision makers with meaningful data to drive improvement. MNCM works with health plans, health care providers, employers, consumers, and state government to drive improvement in health care quality and cost.

In addition to its roles in collecting, aggregating, validating, and publicly reporting data, a crucial component of MNCM's work involves convening stakeholders to agree on common priorities for measurement. MNCM is also nationally known as a developer of quality measures, particularly for outcomes of care and for patient-reported outcome performance measures (PRO-PMs). Many MNCM-developed measures are endorsed by the National Quality Forum and/or used in Medicare quality reporting and incentive programs.

Beyond its role in performance measurement and reporting, MNCM is an active partner with others to drive improvement. These efforts include modernizing data collection and reporting to reduce burden on health care providers and health plans, meeting evolving stakeholder needs related to timely, consistent information to support value-based care, and actively partnering with state agencies and other nonprofits on key initiatives such as improving mental health and affordability of care.

WHO IS THE MN DEPARTMENT OF HUMAN SERVICES?

The MN Department of Human Services (MN DHS) is the state Medicaid agency responsible for purchasing health care services for over 1 million Minnesotans, covering approximately 20% of the state's population. Most Minnesotans enrolled in Medicaid receive services through the state's contracted managed care organizations. Minnesota Medicaid plays a critical role in ensuring access to high quality care for vulnerable populations including children, persons with disabilities, and seniors. DHS's mission is, working with others, to help people meet their basic needs so they can live in dignity and achieve their highest potential.

INTRODUCTION

Across Minnesota and across the nation, many health care systems have been pushed to provide optimal care in the face of overwhelming challenges since the start of the COVID-19 pandemic. As the pandemic continues, it has continued to expose the well-documented, widespread disparities in health care. These disparities exist in health care quality, cost, and patient outcomes, and can vary by where patients live, the type of care received, their type of health insurance coverage, their socioeconomic status, race, ethnicity, language of origin, and other factors.

A key step to formulate a strategy to address these issues is data collection and analysis. Achieving a better understanding of the variation in outcomes and assessing the impact of steps taken to close gaps in outcomes is critical.

For the past 15 years, MN Community Measurement (MNCM) has collaborated with the Minnesota Department of Human Services (DHS) to measure health care quality by type of health insurance. This report continues to summarize the analysis and data from MNCM that compare results on key measures for Minnesotans who get their health insurance coverage through state programs. DHS uses these in a variety of ways, including to inform the state's health care purchasing strategies. This work helps to fulfill a legislative requirement for DHS to establish a performance reporting and quality improvement system for medical groups and clinics providing health care services to patients enrolled in the managed care component of Minnesota Health Care Programs (MHCP).

When 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. These enrollees often experience barriers or significant challenges to receiving optimal health care. Because of this, these individuals might not receive care that meets best practices as often as patients insured with other types of insurance.

Specifically, this report summarizes health care quality for patients enrolled in Minnesota Health Care Programs Managed Care (MHCP MCO), makes comparisons by insurance type, and features statewide MHCP MCO results by race and Hispanic ethnicity. 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. Other Purchasers include commercial (employer-based and individual health insurance coverage) and Medicare managed care data. In addition, the report highlights high performing medical groups by measure for the MHCP MCO patient population.

The data collected in this report were collected by MNCM in 2021 for 2020 dates of service.

WHAT'S NEW

New to the report this year is the addition of two Healthcare Effectiveness Data Information Set (HEDIS) measures: Childhood Immunization Status (Combo 10) and Controlling High Blood Pressure. These measures have been included in past versions of this report but were not available for reporting in 2019 due to COVID-19 related disruptions.

OVERVIEW OF QUALITY MEASURES

This report includes 21 health care quality measures chosen by DHS and MNMCM to address gaps in quality for patients enrolled in MHCP Managed Care and to focus community efforts on improvement. The measures include:

PREVENTIVE HEALTH

1. Breast Cancer Screening*
2. Childhood Immunization Status (Combo 10)*
3. Colorectal Cancer Screening

CHRONIC CONDITIONS

4. Controlling High Blood Pressure*
5. Optimal Diabetes Care
 - Blood pressure control
 - Daily aspirin
 - HbA1c control
 - Statin use
 - Tobacco-free
6. Optimal Vascular Care
 - Blood pressure control
 - Daily aspirin
 - Statin use
 - Tobacco-free
7. Optimal Asthma Control – Adults
8. Optimal Asthma Control – Children

MENTAL HEALTH

9. Adolescent Mental Health and/or Depression Screening

ADOLESCENT DEPRESSION SUITE

10. Follow-up PHQ-9/PHQ-9M at Six Months
11. Response at Six Months
12. Remission at Six Months
13. Follow-up PHQ-9/PHQ-9M at 12 Months
14. Response at 12 Months
15. Remission at 12 Months

ADULT DEPRESSION SUITE

16. Follow-up PHQ-9/PHQ-9M at Six Months
17. Response at Six Months
18. Remission at Six Months
19. Follow-up PHQ-9/PHQ-9M at 12 Months
20. Response at 12 Months
21. Remission at 12 Months

Measure definitions are provided in the definitions section at the back of the report.

[Click here to view these descriptions.](#)

*HEDIS measure

IMPACT OF COVID-19

This report includes statewide data by insurance type from 2020 with comparisons to prior years and should be used as context for understanding the disruptions experienced in 2020 due to the COVID-19 pandemic. In 2020, MNMCM sought input from the community on measurement considerations and adjusted the measures to best reflect changes in care delivery. We urge caution in using these data or changes in rates to draw general conclusions about quality of care. In many respects, however, 2020 should be considered a new baseline from which recovery should be measured.

KEY FINDINGS

- Statewide MHCP MCO average rates decreased statistically significantly in 2020 compared to 2019 for six measures: Breast Cancer Screening; Colorectal Cancer Screening; Optimal Asthma Control – Adults; Optimal Diabetes Care; and Optimal Vascular Care. The Breast Cancer Screening measure had the largest percentage point change (decrease of 6.4 percentage points).
- While the Adolescent Mental Health and/or Depression Screening measure statistically significantly increased in 2020 compared to 2019, the number of adolescents who were eligible for the denominator (i.e., had an eligible visit) decreased by over 3,000 patients.
- In 2020, statewide MHCP MCO average rates were consistently and significantly lower than the other purchasers' statewide rates for all measures, except for Controlling High Blood Pressure.
- Statewide MHCP MCO average rates vary by race/ethnicity, country of origin and preferred language:
 - The rates for MHCP MCO patients who are Black are significantly below the MHCP MCO statewide averages on 13 out of the 21 measures found in this report.
 - The rates for MHCP MCO patients who are Indigenous/Native are significantly below the MHCP MCO statewide averages on seven out of the 21 measures found in this report.
 - The rates for MHCP MCO patients from the United States are significantly below the MHCP MCO statewide averages for the Optimal Diabetes Care measure and the Optimal Vascular Care measure.
 - The rates for MHCP MCO patients who speak Somali or Spanish are significantly above the MHCP MCO statewide averages for the Optimal Diabetes Care and Optimal Vascular Care measures. However, the Colorectal Cancer Screening rate for MHCP MCO patients who speak Somali or Spanish is significantly below the MHCP MCO statewide average.

SUMMARY TABLES

TABLE 1: 2020 MHCP MCO STATEWIDE RATES COMPARED TO PREVIOUS YEARS

Table 1 displays MHCP MCO statewide results for the quality measures in comparison to the previous year.

QUALITY MEASURE	2020 MHCP MCO Statewide Rate	2019 MHCP MCO Statewide Rate	MHCP MCO Statewide Percentage Point Change (2020 - 2019)	MHCP MCO Statewide Percentage Point Change Over Time
PREVENTIVE HEALTH MEASURES				
Breast Cancer Screening	56.9% N = 40,339	63.3% N = 27,760	-6.4*	-5.9* (8 years)
Childhood Immunization Status (Combo 10)**	46.6% N = 3,430	NA	NA	+9.1* (4 years)
Colorectal Cancer Screening	56.8% N = 87,451	59.4% N = 86,000	-2.6*	+0.6* (5 years)
CHRONIC CONDITIONS MEASURES				
Controlling High Blood Pressure**	62.3% N = 11,116	NA	NA	NA
Optimal Asthma Control – Adults	41.2% N = 27,271	44.9% N = 23,976	-3.7*	+0.7 (5 years)
Optimal Asthma Control - Children	52.5% N = 16,400	53.7% N = 17,731	-1.3	+0.5* (5 years)
Optimal Diabetes Care	31.4% N = 35,137	35.6% N = 32,301	-4.2*	-1.2* (5 years)
Optimal Vascular Care	42.9% N = 13,724	47.3% N = 12,230	-4.4*	-2.2* (5 years)
MENTAL HEALTH MEASURES				
Adolescent Mental Health and/or Depression Screening	89.5% N = 28,074	87.9% N = 31,294	+1.6**^	+13.9* (4 years)
Adolescent Depression: Remission at Six Months	7.2% N = 3,191	6.5% N = 2,503	0.7	0.7 (2 years)
Adult Depression: Remission at Six Months	8.0% N = 22,184	8.3% N = 20,993	-0.3	-0.3 (2 years)

*Statistically significant difference (p < 0.05) NA = Not applicable

**Note: Due to COVID-19 related interruptions, rates were not available for these measures in 2019

^While there was a statistically significant increase in rate for this measure, there was a decrease in the number of patients included in the denominator.

SUMMARY TABLES

TABLE 2: SUMMARY OF STATEWIDE DIFFERENCES BY INSURANCE TYPE

Table 2 displays trends in the quality measures between MHCP MCO and Other Purchasers.

QUALITY MEASURE	2020 MHCP MCO Statewide Rate	2020 Other Purchasers Statewide Rate	2020 Rate Difference (MHCP - Other Purchasers)	Rate Difference Over Time (MHCP - Other Purchasers)
PREVENTIVE HEALTH MEASURES				
Breast Cancer Screening	56.9% (N = 40,339)	74.5% (N = 271,254)	-17.6%*	Gap widened* (2013-2020)
Childhood Immunization Status (Combo 10)	46.6% (N = 3,430)	65.7% (N = 2,109)	-19.1%*	Gap narrowed* (2016-2020)
Colorectal Cancer Screening	56.8% (N = 87,451)	72.4% (N = 1,017,250)	-15.6%*	Gap narrowed* (2016-2020)
CHRONIC CONDITIONS MEASURES				
Controlling High Blood Pressure	62.3% (N = 11,116)	64.0% (N = 9,559)	-1.7%	NA
Optimal Asthma Control - Adults	41.2% (N = 27,271)	49.6% (N = 98,362)	-8.3%*	Gap narrowed* (2016-2020)
Optimal Asthma Control - Children	52.5% (N = 16,400)	60.1% (N = 35,588)	-7.6%*	Gap narrowed* (2016-2020)
Optimal Diabetes Care	31.4% (N = 35,137)	42.1% (N = 241,326)	-10.7%*	Gap narrowed* (2016-2020)
Optimal Vascular Care	42.9% (N = 13,724)	55.0% (N = 140,204)	-12.1%*	Gap narrowed* (2016-2020)
MENTAL HEALTH MEASURES				
Adolescent Mental Health and/or Depression Screening	89.5% (N = 28,074)	91.3% (N = 89,554)	-4.1%*	Gap narrowed* (2017-2020)
Adult Depression: Remission at Six Months	8.0% (N = 22,184)	11.7% (N = 88,486)	-3.7%*	Gap stable (2019-2020)
Adolescent Depression: Remission at Six Months	7.2% (N = 3,191)	9.2% (N = 8,986)	-2.0%*	Gap stable (2019-2020)

*Statistically significant difference (p < 0.05) NA = Not applicable

SUMMARY TABLES

TABLE 3: SUMMARY OF FINDINGS BY RACE/ETHNICITY

Table 3 compares the 2020 MHCP MCO rate of each racial/ethnicity group to the 2020 MHCP MCO statewide averages.

MEASURE	2020 MHCP MCO Statewide Average	RACE							ETHNICITY	
		Asian	Black	Hispanic/Latinx Only	Indigenous/Native	Multi-Race	Native Hawaiian/Pacific Islander	White	Hispanic/Latinx	Not Hispanic/Latinx
PREVENTIVE HEALTH										
Breast Cancer Screening	56.9%	●	▼	-	▼	●	●	▲	▲	●
Childhood Immunization Status (Combo 10)	46.6%	NR	▼	-	●	●	NR	●	▲	●
Colorectal Cancer Screening	56.8%	●	▼	●	▼	●	▼	▲	▼	●
CHRONIC CONDITIONS										
Controlling High Blood Pressure	62.3%	▼	▼	-	●	●	NR	▲	●	●
Optimal Asthma Control - Adults	41.2%	▲	▼	▲	▼	●	●	●	●	●
Optimal Asthma Control - Children	52.5%	●	●	▲	▼	●	▼	●	●	●
Optimal Diabetes Care	31.4%	▲	▼	▲	▼	▼	●	●	●	●
Optimal Vascular Care	42.9%	▲	▼	▲	●	●	●	●	▲	●
MENTAL HEALTH										
Adolescent Mental Health and/or Depression Screening	89.5%	●	●	▼	●	●	●	●	●	●
Adolescent Depression										
Follow-up PHQ-9/PHQ-9M at Six Months	42.6%	●	●	●	▼	●	NR	●	●	●
Response at Six Months	11.2%	●	●	▲	●	●	NR	▲	●	●
Remission at Six Months	7.2%	●	●	●	●	●	NR	●	●	●
Follow-up PHQ-9/PHQ-9M at 12 Months	32.7%	▼	●	●	●	●	NR	●	●	●
Response at 12 Months	11.2%	●	●	●	●	●	NR	●	●	●
Remission at 12 Months	6.0%	●	●	●	●	●	NR	●	●	●
Adult Depression										
Follow-up PHQ-9/PHQ-9M at Six Months	47.4%	●	▼	●	▼	▼	●	▲	▼	●
Response at Six Months	15.3%	●	▼	●	●	●	●	▲	●	●
Remission at Six Months	8.0%	●	▼	●	●	●	●	●	▼	●
Follow-up PHQ-9/PHQ-9M at 12 Months	36.9%	●	▼	▼	●	●	●	▲	▼	●
Response at 12 Months	13.2%	●	▼	●	●	●	●	▲	●	●
Remission at 12 Months	7.1%	●	▼	●	●	●	●	●	●	●

- ▲ Significant above statewide MHCP MCO statewide average
- Average
- ▼ Significantly below statewide MHCP MCO statewide average

NR = Not reportable. Did not meet minimum reporting threshold of at least 30 patients (60 patients for HEDIS measures) - Race category not reported for HEDIS
 "Hispanic/Latinx Only" race category represents patients who only indicated that they are Hispanic/Latinx and did not provide any other race information
 "Hispanic/Latinx" ethnicity category represents patients who indicated that they are Hispanic/Latinx along with a race category

BREAST CANCER SCREENING

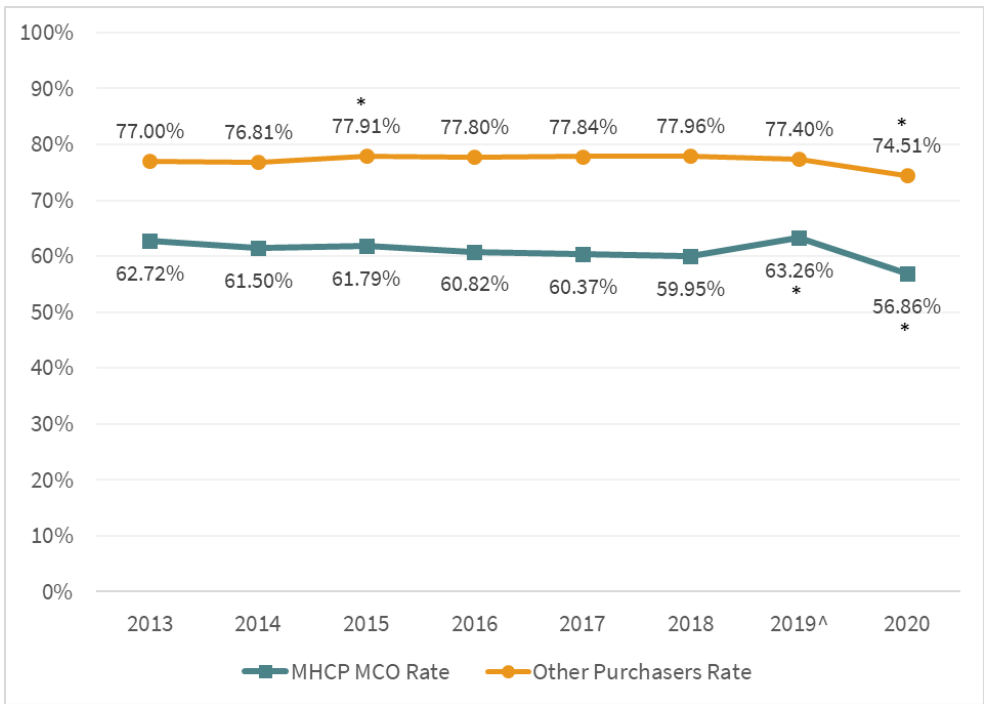
For women in the United States, breast cancer is the most common type of cancer (except for skin cancers) and the second leading cause of death.¹ Significant disparities in breast cancer severity are seen between race groups, with Black women having a relatively high rate of death from breast cancer and Asian/Pacific Islander women having a relatively low rate.¹

While screening cannot prevent breast cancer, it can help detect it early, making it easier to treat. The United States Preventive Services Task Force (USPSTF) currently recommends that women of average risk between the ages of 50-74 receive a mammogram every two years.²

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

[Click here for complete measure description.](#)

TREND IN BREAST CANCER SCREENING 2013 – 2020



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.

[^]In 2019, the Other Purchasers population only included commercial patients.

*Rate statistically significantly changed from previous year

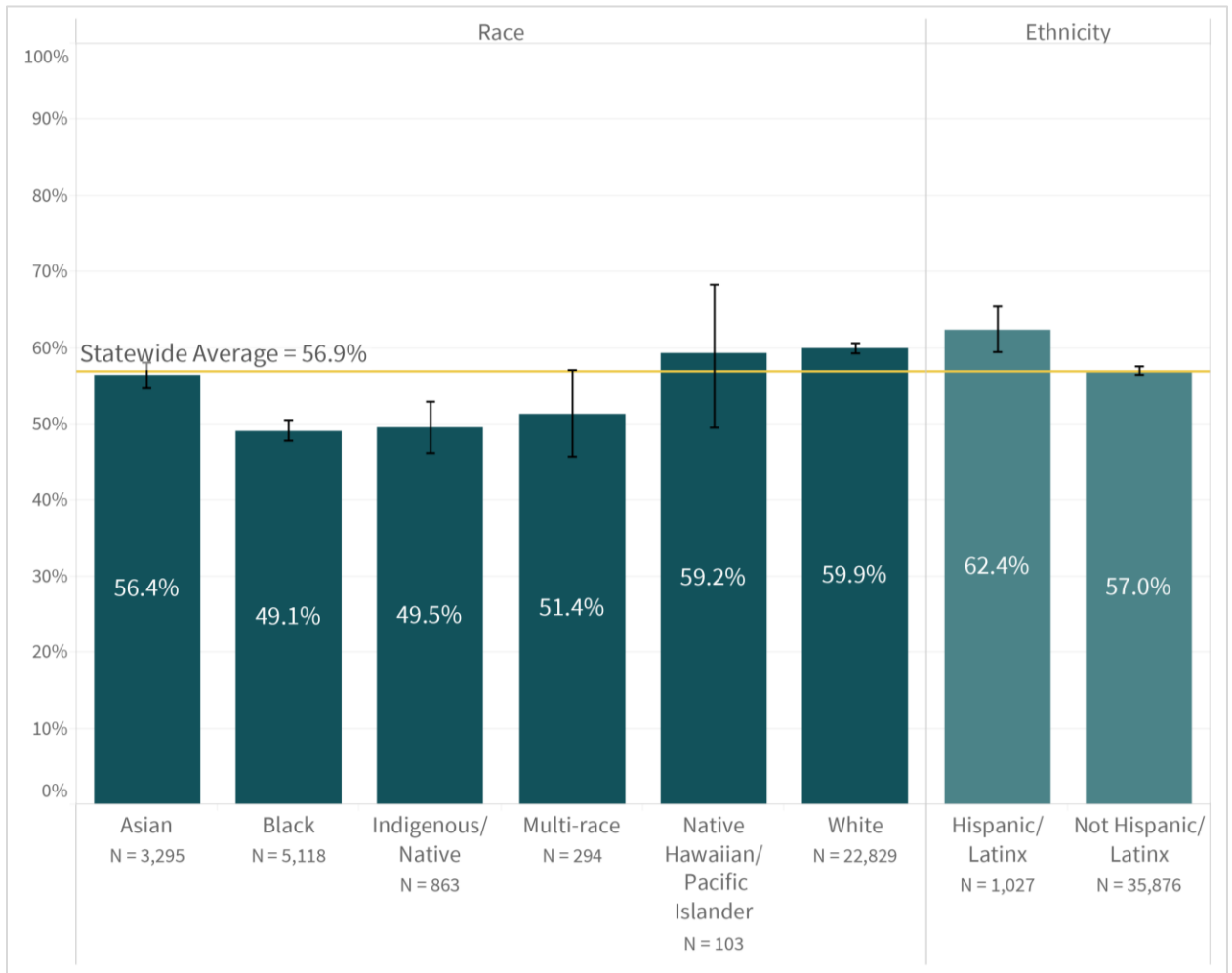
KEY TAKEAWAYS

- From 2019 to 2020, the MHCP MCO statewide average for the Breast Cancer Screening measure statistically significantly decreased by 6.4 percentage points.
- The gap in performance rates between the MHCP MCO population and the other purchasers population has statistically significantly widened since 2013.

NOTE: The 2020 rate for the other purchasers population was compared to 2018 for statistical significance since 2019 did not have a comparable population.

BREAST CANCER SCREENING

MHCP MCO RATES BY RACE/ETHNICITY
2020 measurement year



⌈ Represents 95% confidence interval

KEY TAKEAWAYS

- The screening rates for MHCP MCO patients who are **White** or **Hispanic/Latinx** are statistically significantly higher than the MHCP MCO statewide average.
- The screening rates of MHCP MCO patients who are **Black** or **Indigenous/Native** are statistically significantly lower than the MHCP MCO statewide average.

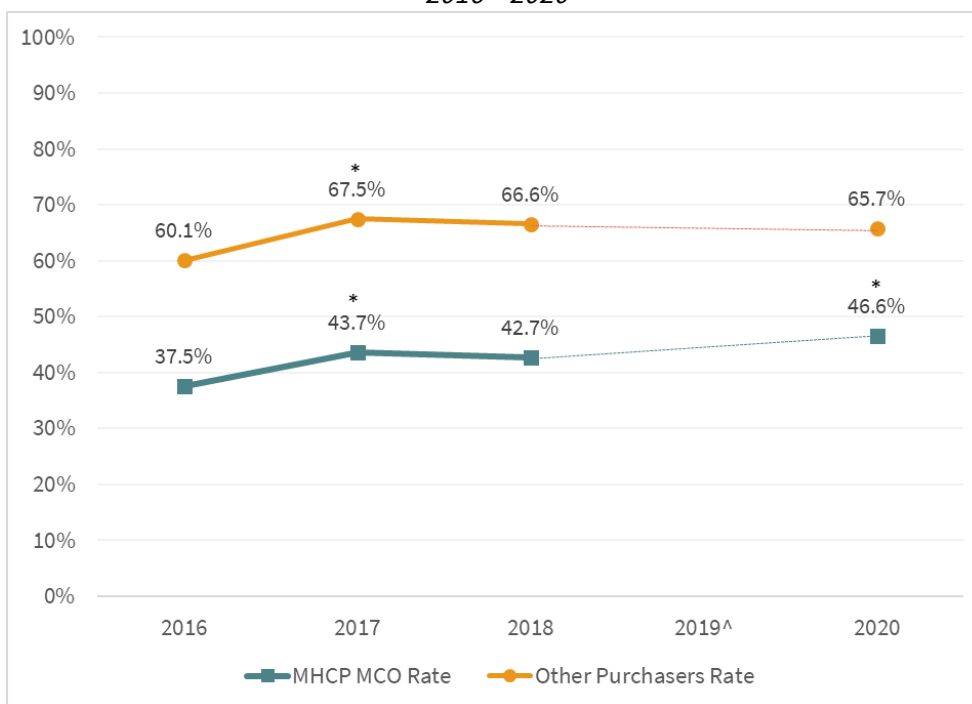
CHILDHOOD IMMUNIZATION STATUS (COMBO 10)

Immunizations are some of the safest and most effective public health tools in preventing disease and death. Since infants do not have fully developed immune systems when born, organizations like the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC) strongly encourage on-time immunizations to prevent disease and death from vaccine-preventable diseases.^{3,4} However, nationally, disparities in immunization rates persist, with lower rates of immunization among those without private health insurance and among Black and Hispanic/Latinx patients.⁵

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

[Click here for complete measure description](#)

TREND IN CHILDHOOD IMMUNIZATION STATUS
2016 – 2020



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.

[^]Due to COVID-19 related interruptions, 2019 performance rates are not available for this measure.

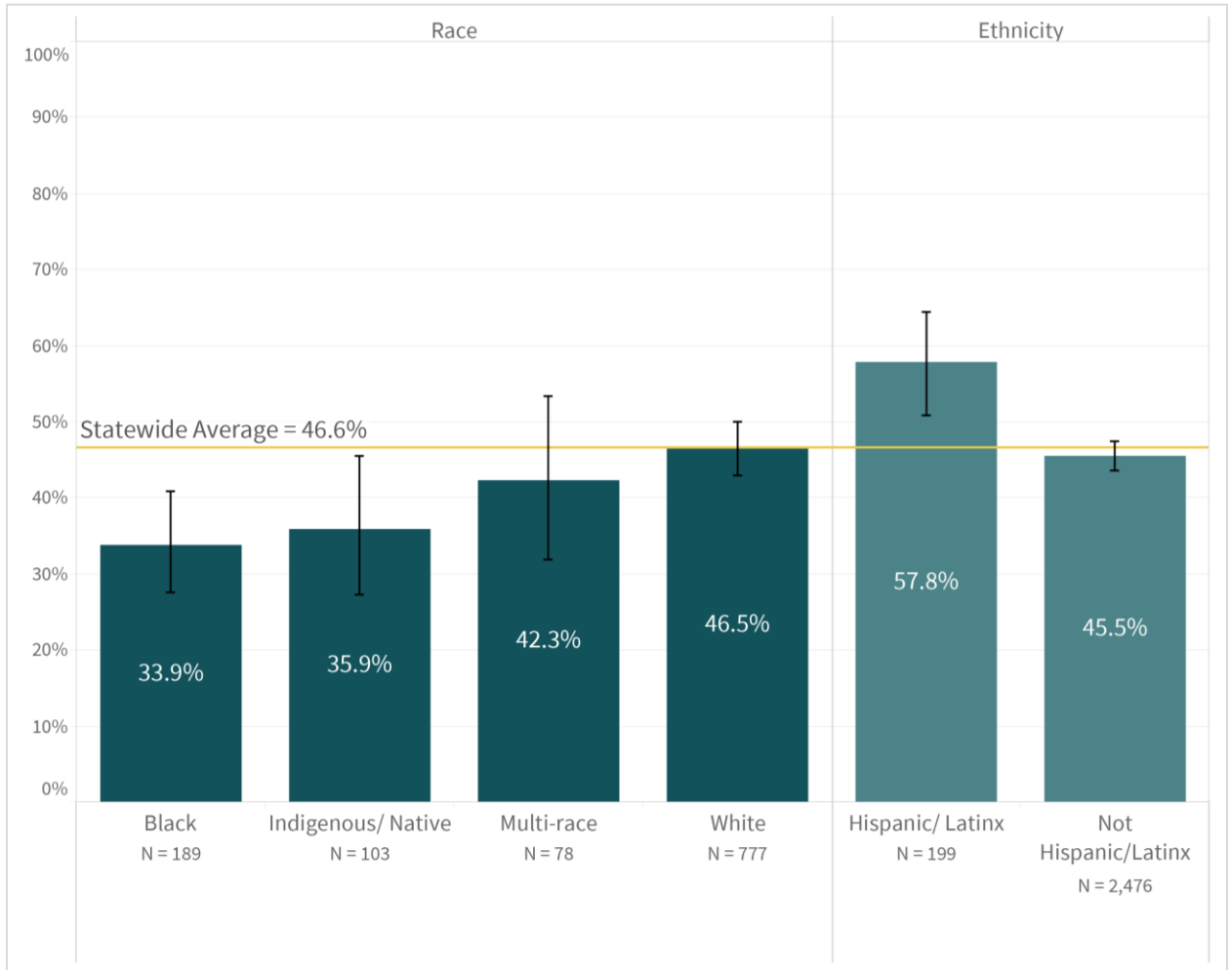
*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

- From 2018 to 2020, the MHCP MCO statewide average for the Childhood Immunization Status (Combo 10) measure statistically significantly increased by 3.9 percentage points.
- While the gap in performance between the MHCP MCO population and the other purchasers population remains statistically significant, it has narrowed over time.

CHILDHOOD IMMUNIZATION STATUS (COMBO 10)

MHCP MCO RATES BY RACE/ETHNICITY
2020 measurement year



⌈ Represents 95% confidence interval

KEY TAKEAWAYS

- The immunization rate for MHCP MCO children who are **Hispanic/Latinx** is statistically significantly higher than the MHCP MCO statewide average.
- The immunization rate for MHCP MCO children who are **Black** is statistically significantly lower than the MHCP MCO statewide average.

The Asian category and the Native Hawaiian/ Pacific Islander category had less than 30 patients reported, which does not meet the reporting threshold for reliability.

COLORECTAL CANCER SCREENING

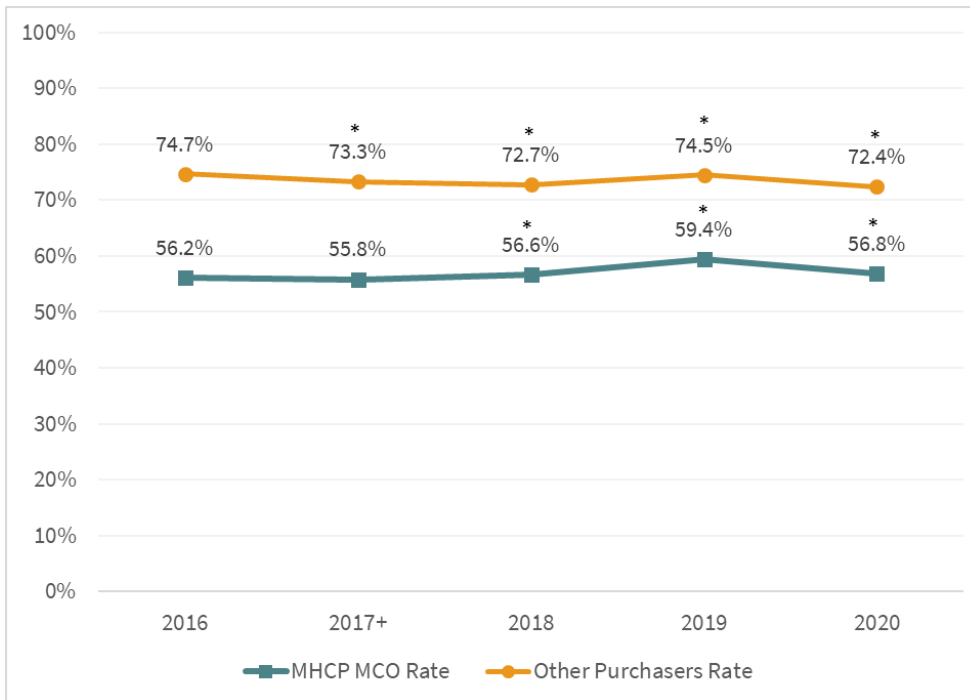
For both men and women in the United States, colorectal cancer is the third most common type of cancer (except for skin cancers) and the third leading cause of cancer-related deaths.^{6,7} Screening for colorectal cancer can help to detect colorectal polyps early before developing into cancer and has contributed to the decline in number of deaths related to colorectal cancer since the 1980s.^{6,7} Currently, the United States Preventive Services Task Force (USPSTF) recommends that all adults between the ages of 50 and 75 be screened for colorectal cancer.⁸

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).

[Click here for complete measure description](#)

TREND IN COLORECTAL CANCER SCREENING

2016 – 2020



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.

+Changes to the measure denominator definition resulted in significant drop in population for this measure and likely contributed to slight decrease in rate.

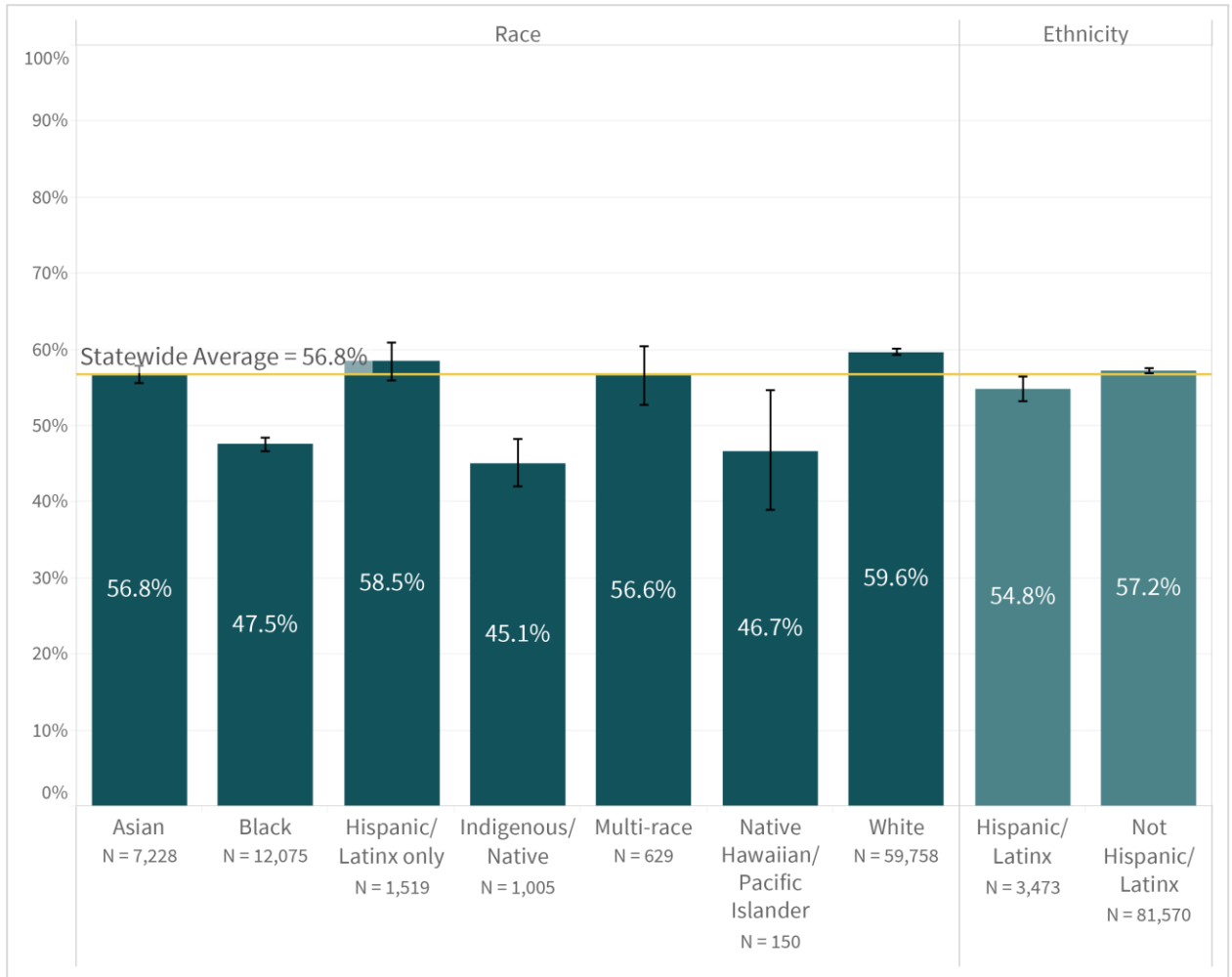
*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

- From 2019 to 2020, the MHCP MCO statewide average for the Colorectal Cancer Screening measure statistically significantly decreased by 2.6 percentage points.
- The gap in performance between the MHCP MCO population and the other purchasers population is statistically significant for 2020.

COLORECTAL CANCER SCREENING

MHCP MCO RATES BY RACE/ETHNICITY 2020 measurement year



┆ Represents 95% confidence interval

KEY TAKEAWAYS

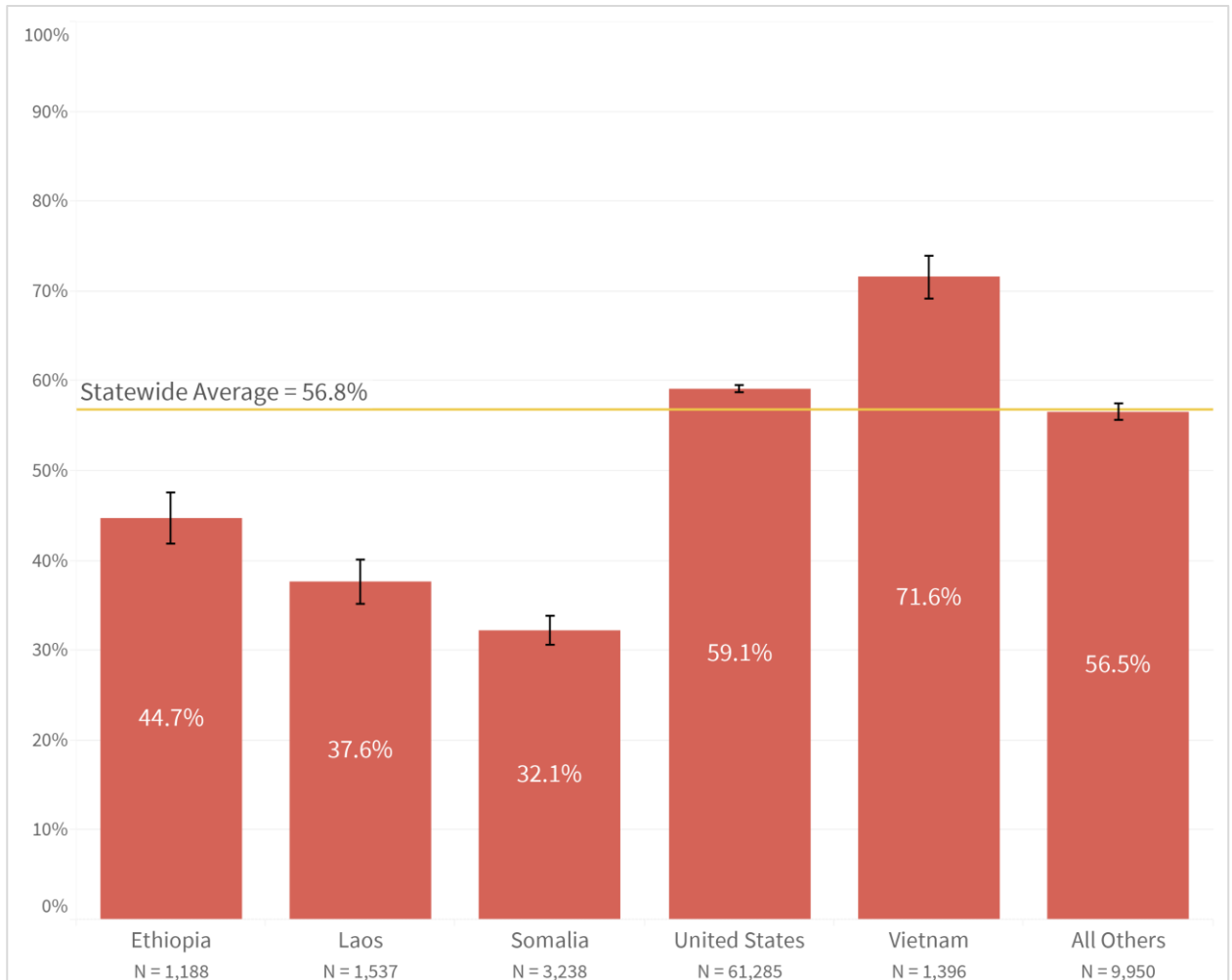
- The screening rate for MHCP MCO patients who are **White** is statistically significantly higher than the MHCP MCO statewide average.
- The screening rates for MHCP MCO patients who are **Black, Indigenous/Native, Native Hawaiian/Pacific Islander** or **Hispanic/Latinx** are statistically significantly lower than the MHCP MCO statewide average.

Note: “Hispanic/Latinx Only” patients represent those who only indicated that they are Hispanic/Latinx and did not provide any race information. “Hispanic/Latinx” ethnicity represents patients who indicated that they are Hispanic/Latinx along with a race category.

COLORECTAL CANCER SCREENING

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 measurement year



┆ Represents 95% confidence interval

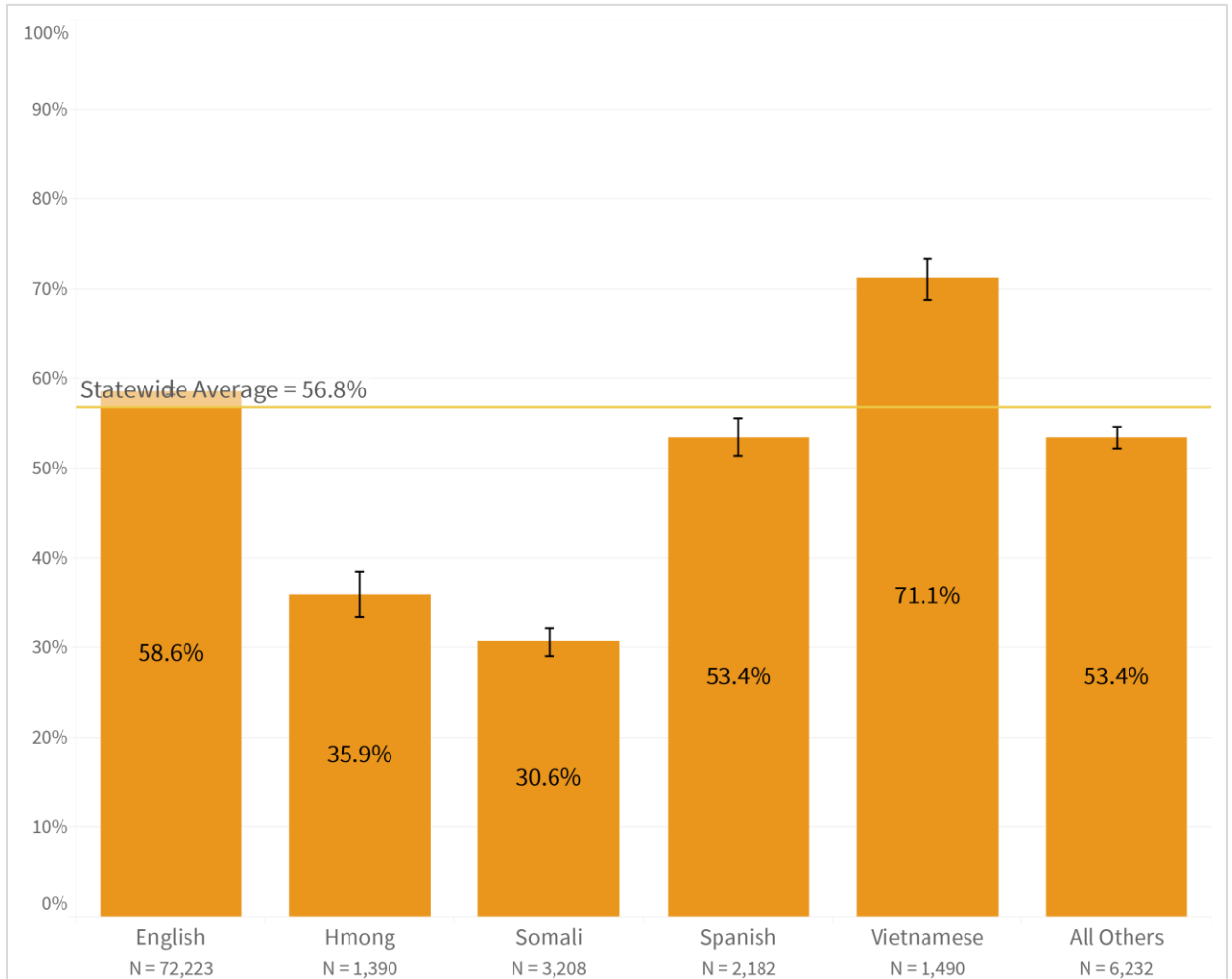
KEY TAKEAWAYS

- Patients from **Ethiopia, Laos, Somalia, the United States** and **Vietnam** make up the largest proportion of the MHCP MCO population for the Colorectal Cancer Screening measure.
- The screening rates for MHCP MCO patients from the **United States** and **Vietnam** are statistically significantly higher compared to the MHCP MCO statewide average.
- The screening rates for MHCP MCO patients from **Laos, Ethiopia** and **Somalia** are statistically significantly lower compared to the MHCP MCO statewide average.

COLORECTAL CANCER SCREENING

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 measurement year



┆ Represents 95% confidence interval

KEY TAKEAWAYS

- Patients who speak **English, Hmong, Somali, Spanish** or **Vietnamese** make up the largest proportion of the MHCP MCO population for the Colorectal Cancer Screening measure
- The screening rates for MHCP MCO patients who speak **English** or **Vietnamese** are statistically significantly higher compared to the MHCP MCO statewide average.
- The screening rates for MHCP MCO patients who speak **Hmong, Somali** or **Spanish** are statistically significantly lower compared to the MHCP MCO statewide average.

CONTROLLING HIGH BLOOD PRESSURE

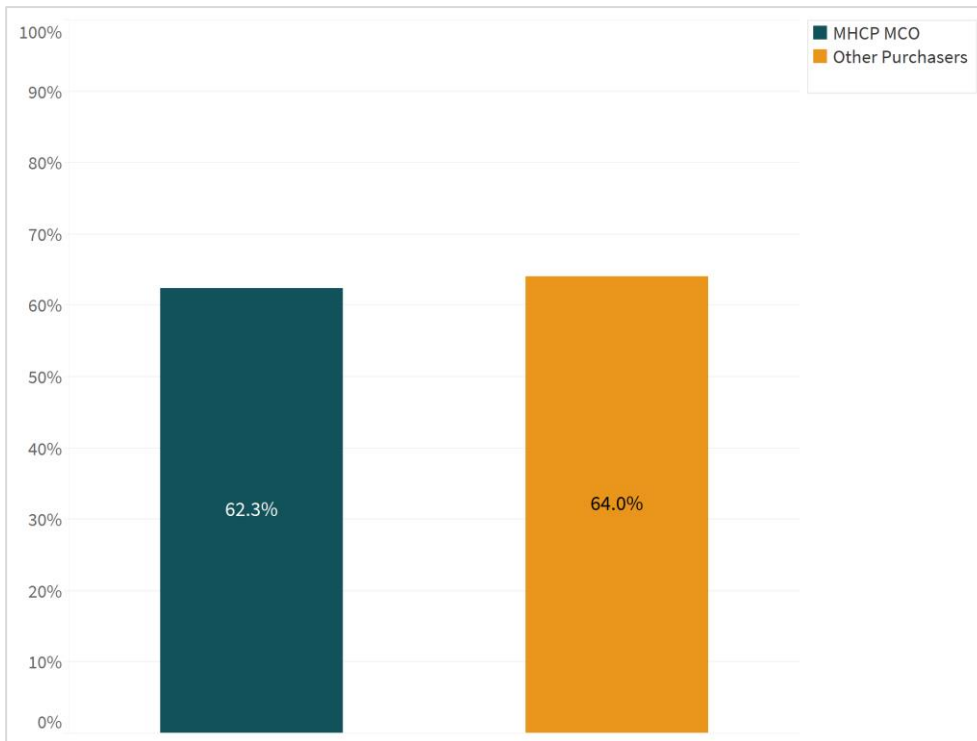
The American Heart Association (AHA) and the Centers of Disease Control and Prevention (CDC) estimate that nearly half of Americans have high blood pressure (47%).^{9,10} High blood pressure can increase risk of heart disease and stroke, which are the leading causes of death in the United States.¹⁰ Additionally, non-Hispanic Black patients have a higher prevalence of high blood pressure compared to non-Hispanic White patients, non-Hispanic Asian patients and Hispanic patients.¹⁰

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

[Click here for complete measure description.](#)

CONTROLLING HIGH BLOOD PRESSURE

2020 measurement year



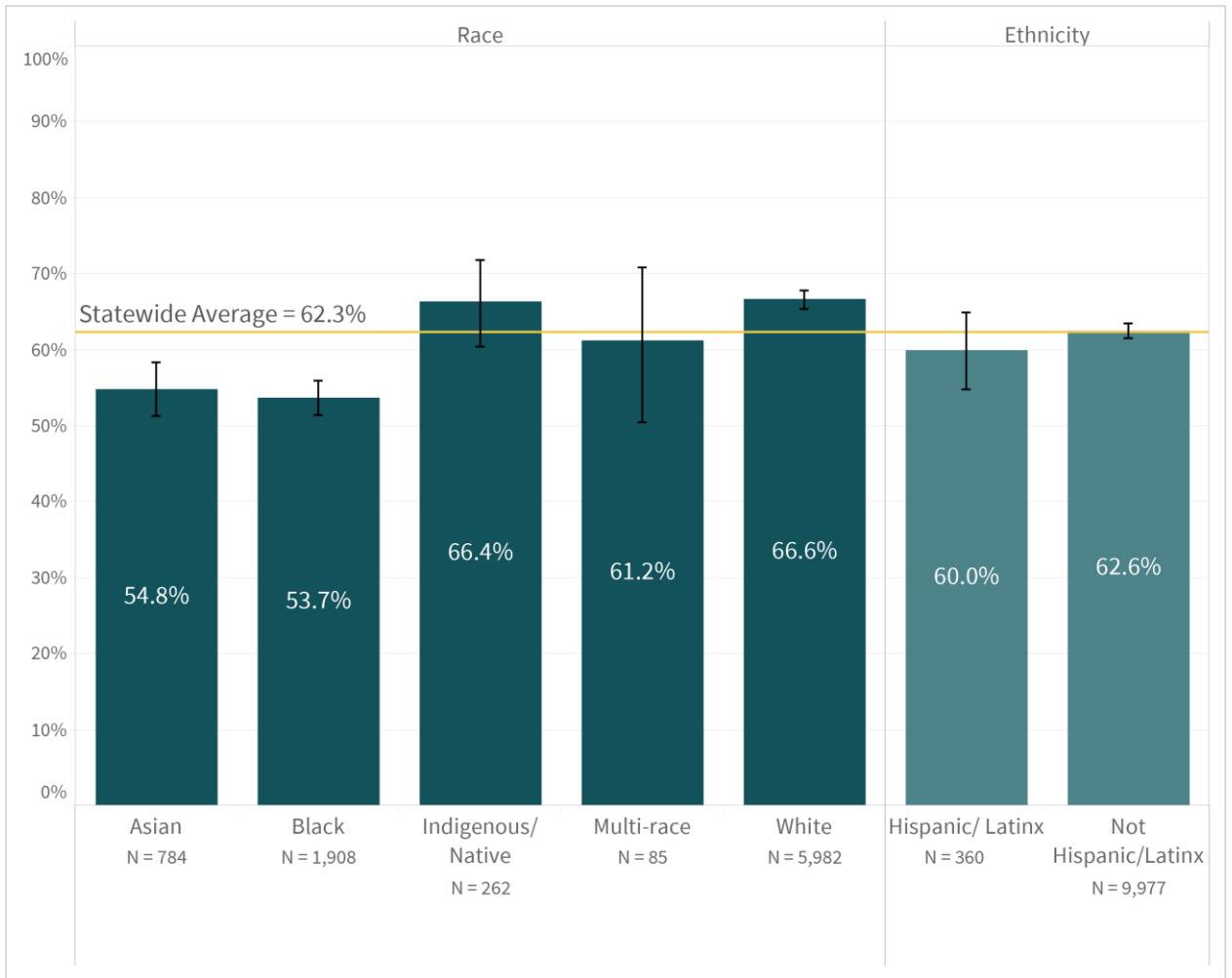
NOTE: Due to measure related changes and COVID-19 related interruptions, the 2020 measurement year is the only year available for trending for this measure.

KEY TAKEAWAY

The Controlling High Blood Pressure rates are not statistically different between the MHCP MCO population and the other purchasers population.

CONTROLLING HIGH BLOOD PRESSURE

MHCP MCO RATES BY RACE/ETHNICITY 2020 measurement year



┆ Represents 95% confidence interval

KEY TAKEAWAYS

- The Controlling High Blood Pressure rate for MHCP MCO patients who are **White** is statistically significantly higher than the MHCP MCO statewide average
- The Controlling High Blood Pressure rates for MHCP MCO patients who are **Asian** or **Black** are statistically significantly lower than the MHCP MCO statewide average

OPTIMAL DIABETES CARE

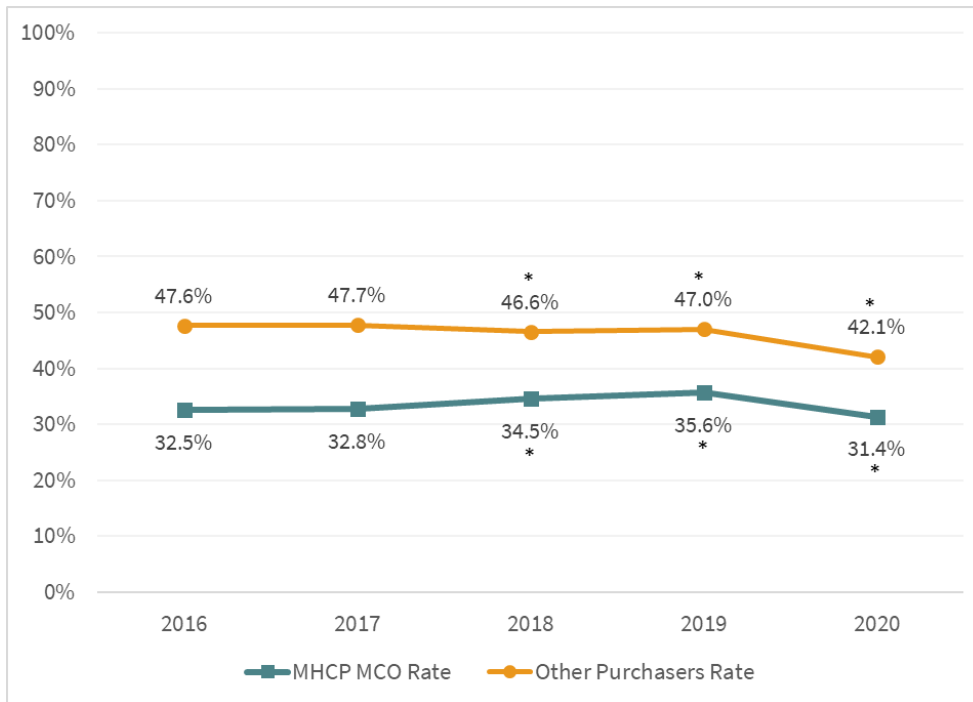
The CDC estimates that approximately 37.3 million people are living with diabetes in the United States and approximately 1.4 million are diagnosed with diabetes each year.^{11,12} While diabetes affects people of all racial and ethnic backgrounds, the American Diabetes Association (ADA) estimates approximately 14.5% of Indigenous/Native patients and 12.1% of non-Hispanic Black patients have diagnosed diabetes compared to 7.4% of non-Hispanic White patients.¹²

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).

[Click here for complete measure description.](#)

TREND IN OPTIMAL DIABETES CARE

2016 – 2020



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.

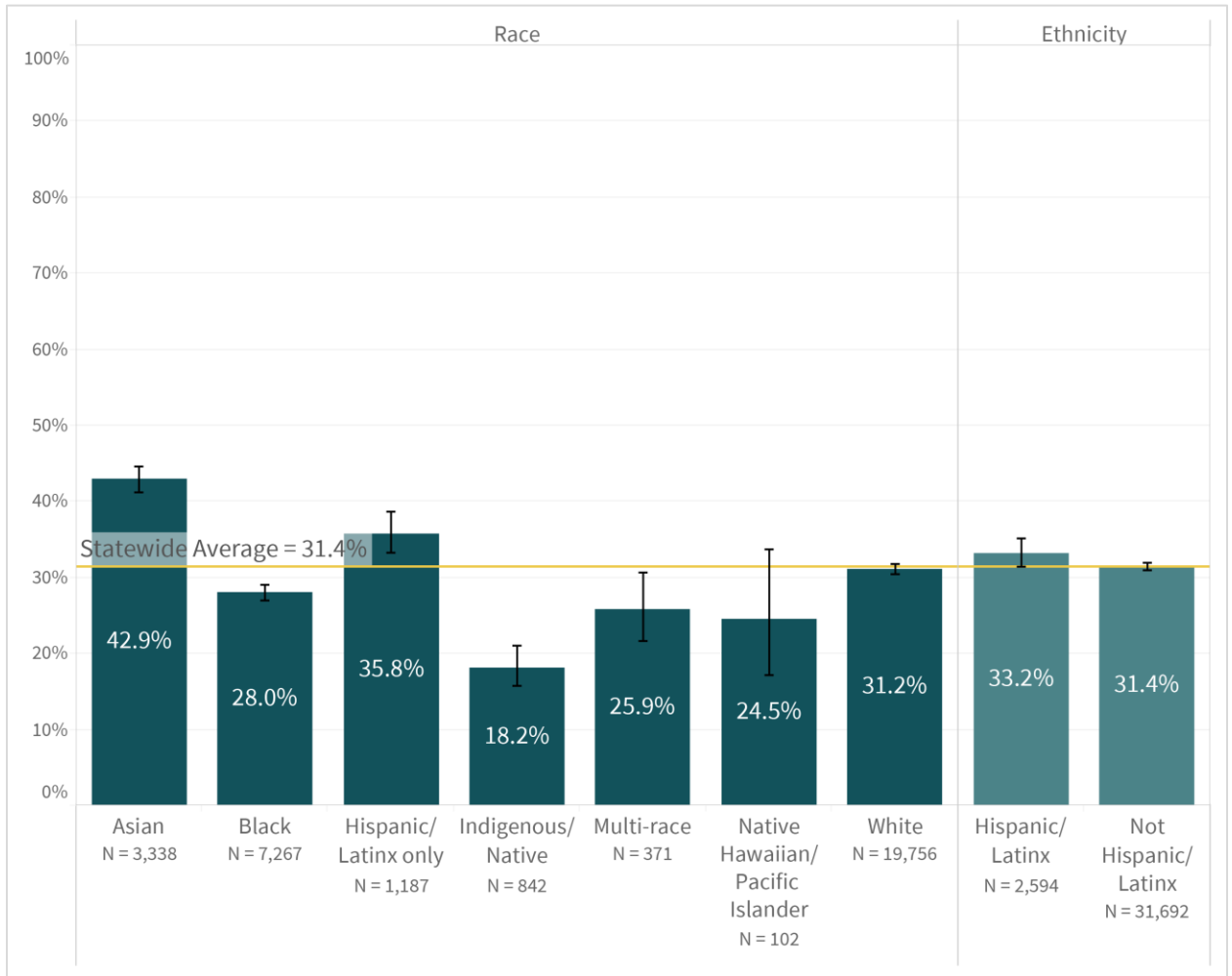
*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

- From 2019 to 2020, the MHCP MCO statewide average for the Optimal Diabetes Care measure statistically significantly decreased by 4.2 percentage points.
- The gap in performance between the MHCP MCO population and the other purchasers population is statistically significant for 2020.

OPTIMAL DIABETES CARE

MHCP MCO RATES BY RACE/ETHNICITY 2020 measurement year



┆ Represents 95% confidence interval

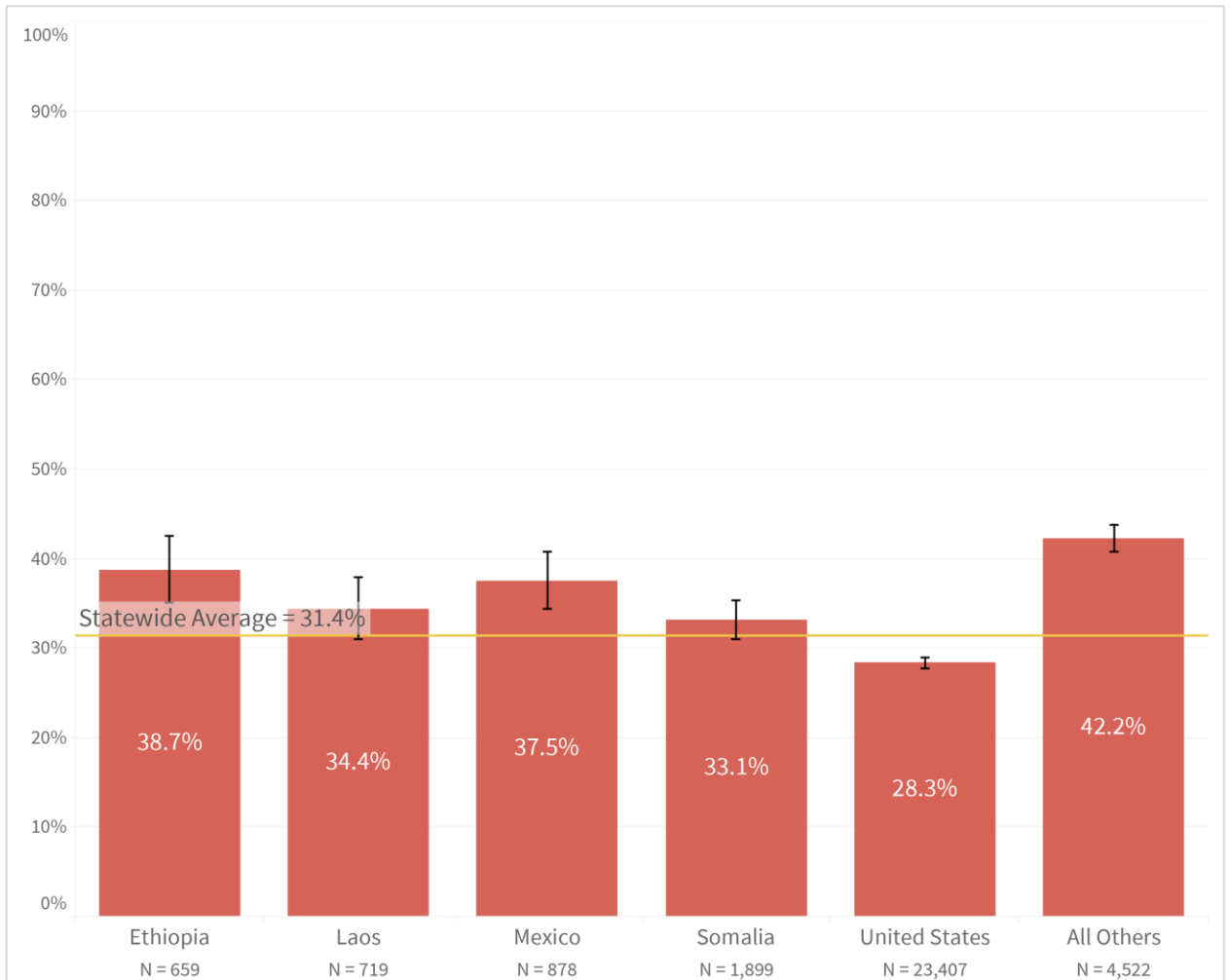
KEY TAKEAWAYS

- The optimal care rate for MHCP MCO patients who are **Asian** is statistically significantly higher than the MHCP MCO statewide average.
- The optimal care rates for MHCP MCO patients who are **Black, Indigenous/Native** or **Multi-Race** are statistically significantly lower than the MHCP MCO statewide average.

Note: “Hispanic/Latinx Only” patients represent those who only indicated that they are Hispanic/Latinx and did not provide any race information. “Hispanic/Latinx” ethnicity represents patients who indicated that they are Hispanic/Latinx along with a race category.

OPTIMAL DIABETES CARE

MHCP MCO RATES BY COUNTRY OF ORIGIN 2020 measurement year



┌ Represents 95% confidence interval

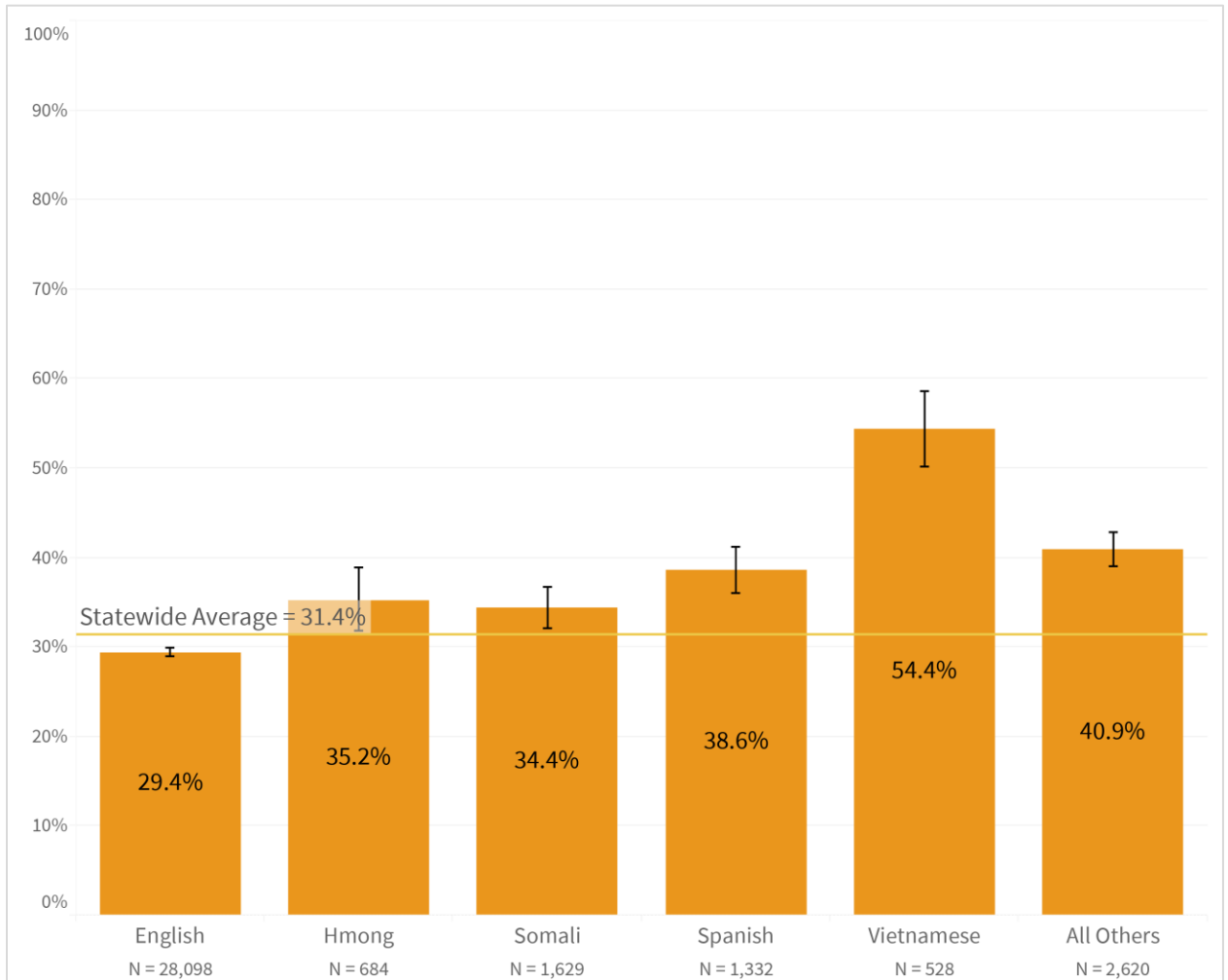
KEY TAKEAWAYS

- Patients from **Ethiopia, Laos, Mexico, Somalia** and the **United States** make up the largest proportion of the MHCP MCO population for the Optimal Diabetes Care measure.
- The optimal care rates for MHCP MCO patients from **Ethiopia** and **Mexico** are statistically significantly higher compared to the MHCP MCO statewide average.
- The optimal care rates for MHCP MCO patients from the **United States** are statistically significantly lower compared to the MHCP MCO statewide average.

OPTIMAL DIABETES CARE

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 measurement year



┆ Represents 95% confidence interval

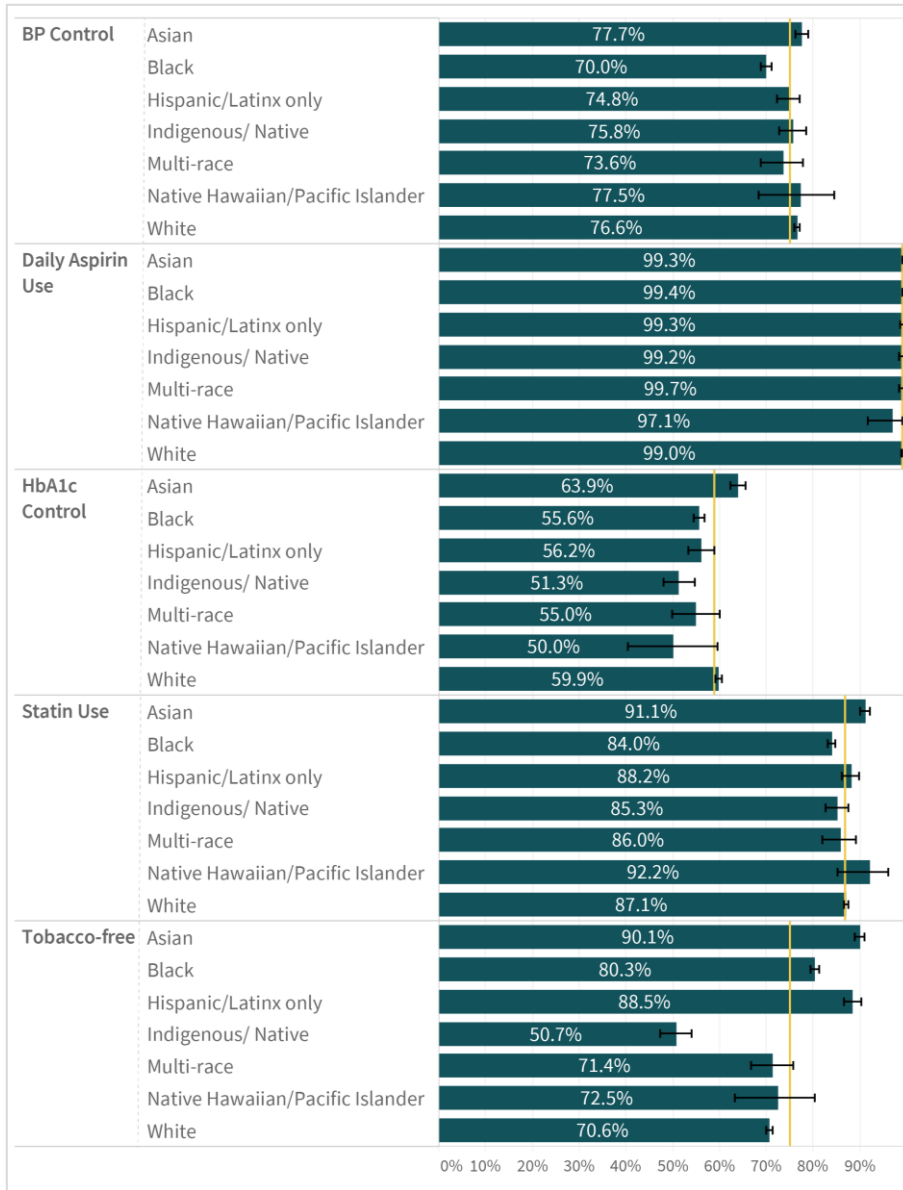
KEY TAKEAWAYS

- Patients who speak **English, Hmong, Somali, Spanish** or **Vietnamese** make up the largest proportion of the MHCP MCO population for the Optimal Diabetes Care measure.
- The optimal care rates for MHCP MCO patients who speak **Somali, Spanish** or **Vietnamese** are statistically significantly higher compared to the MHCP MCO statewide average.
- The optimal care rate for MHCP MCO patients who speak **English** is statistically significantly lower compared to the MHCP MCO statewide average.

OPTIMAL DIABETES CARE: COMPONENTS

MHCP MCO RATES BY RACE

2020 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component (represented by yellow line)

- **BP Control:** 75.1%
- **Daily Aspirin:** 99.1%
- **HbA1c Control:** 58.8%
- **Statin Use:** 86.7%
- **Tobacco-free:** 75.1%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- **Asian:** 3,338
- **Black:** 7,267
- **Hispanic/Latinx Only:** 1,187
- **Indigenous/ Native:** 842
- **Multi-Race:** 371
- **Native Hawaiian/ Pacific Islander:** 102
- **White:** 19,756

— Represents 95% confidence interval

KEY TAKEAWAYS

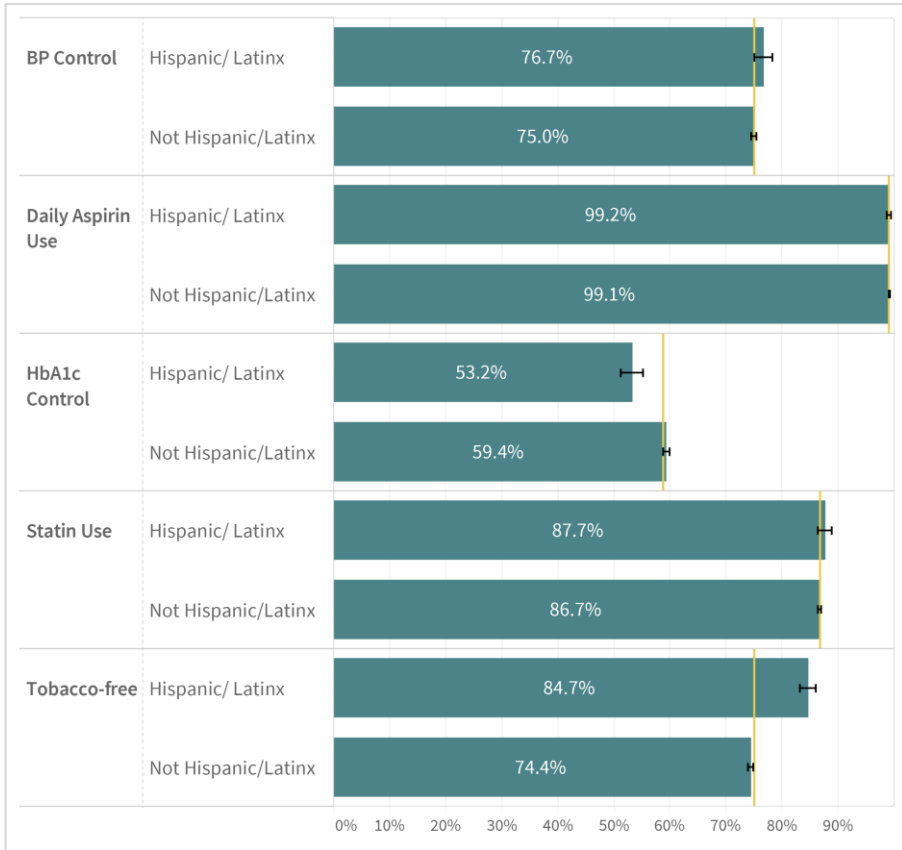
Compared to the MHCP MCO statewide averages for the above components:

- MHCP MCO patients who are **Asian** have statistically significantly higher rates of **HbA1c control, statin use and being tobacco-free**.
- MHCP MCO patients who are **Black** have statistically significantly lower rates of **blood pressure control, HbA1c control and statin use**, but statistically significantly higher rates of **being tobacco-free**.
- MHCP patients who are **Indigenous/Native** have statistically significantly lower rates of **HbA1c control and being tobacco-free**.

OPTIMAL DIABETES CARE: COMPONENTS

MHCP MCO RATES BY ETHNICITY

2020 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component
(represented by yellow line)

- **BP Control:** 75.1%
- **Daily Aspirin:** 99.1%
- **HbA1c Control:** 58.8%
- **Statin Use:** 86.7%
- **Tobacco-free:** 75.1%

DENOMINATORS BY ETHNICITY

(Denominators are the same for each measure)

- **Hispanic/Latinx:** 2,594
- **Not Hispanic/Latinx:** 31,692

— Represents 95% confidence interval

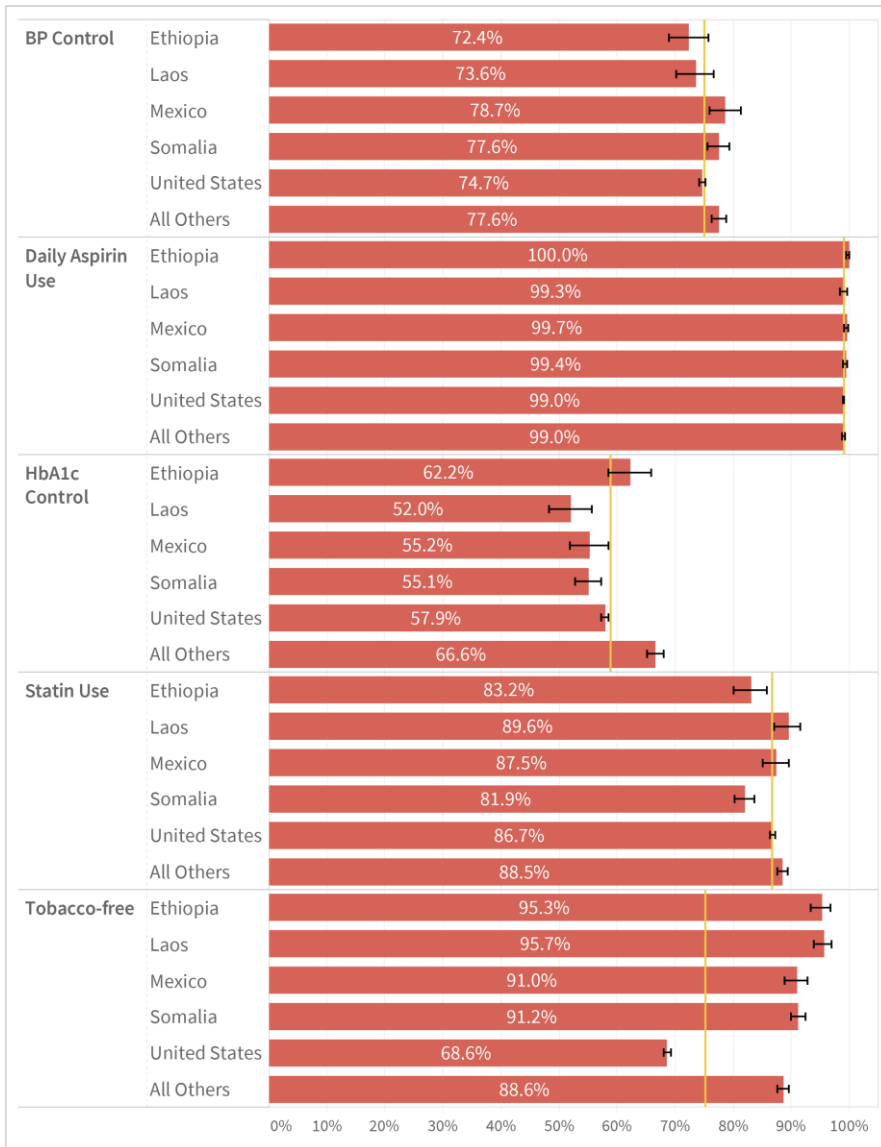
KEY TAKEAWAYS

- The rate of being **tobacco-free** for MHCP MCO patients who are **Hispanic/Latinx** is statistically significantly higher than the MHCP MCO statewide average for this component.
- The rate of **HbA1c control** for MHCP MCO patients who are **Hispanic/Latinx** is statistically significantly lower than the MHCP MCO statewide average for this component.

OPTIMAL DIABETES CARE: COMPONENTS

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component

(represented by yellow line)

- **BP Control:** 75.1%
- **Daily Aspirin:** 99.1%
- **HbA1c Control:** 58.8%
- **Statin Use:** 86.7%
- **Tobacco-free:** 75.1%

DENOMINATORS BY COUNTRY

(Denominators are the same for each measure)

- **Ethiopia:** 659
- **Laos:** 719
- **Mexico:** 878
- **Somalia:** 1,899
- **United States:** 23,407
- **All Others:** 4,522

— Represents 95% confidence interval

KEY TAKEAWAYS

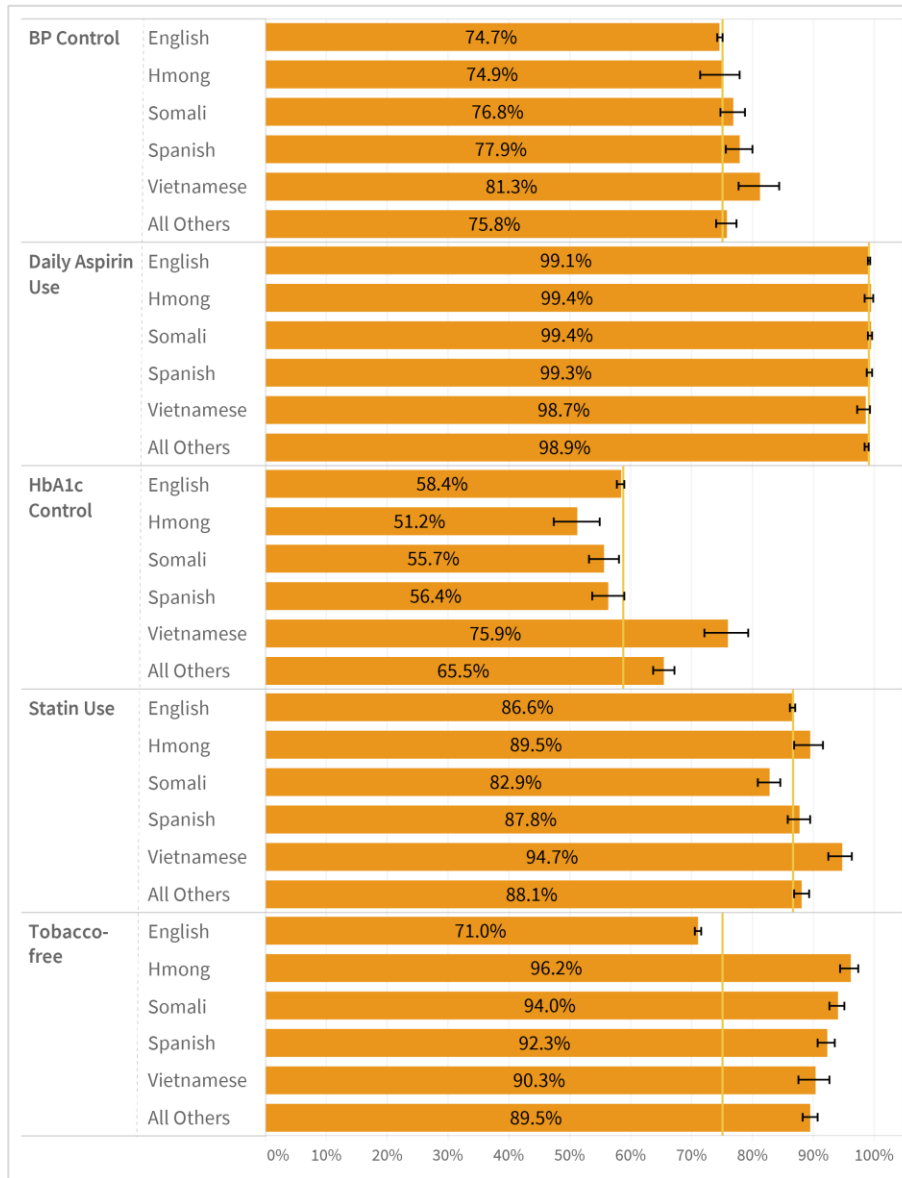
Compared to the MHCP MCO statewide averages for the above components:

- MHCP MCO patients from **Somalia** have statistically significantly lower rates of **HbA1c control** and **statin use**, but statistically significantly higher rates of **blood pressure control** and **being tobacco-free**.
- MHCP MCO patients from **Ethiopia** have a statistically significantly lower rate **statin use**, but statistically significantly higher rates of **daily aspirin use** and **being tobacco-free**.

OPTIMAL DIABETES CARE: COMPONENTS

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component
(represented by yellow line)

- **BP Control:** 75.1%
- **Daily Aspirin:** 99.1%
- **HbA1c Control:** 58.8%
- **Statin Use:** 86.7%
- **Tobacco-free:** 75.1%

DENOMINATORS BY LANGUAGE

(Denominators are the same for each measure)

- **English:** 28,098
- **Hmong:** 684
- **Somali:** 1,629
- **Spanish:** 1,332
- **Vietnamese:** 528

↔ Represents 95% confidence interval

KEY TAKEAWAYS

Compared to the MHCP MCO statewide averages for the above components:

- MHCP MCO patients who speak **Somali** have statistically significantly lower rates of **HbA1c control** and **statin use**, but a statistically significantly higher rate of **being tobacco-free**.
- MHCP MCO patients who speak **Spanish** have statistically significantly higher rates **blood pressure control** and **being tobacco-free**.
- MHCP MCO patients who speak **Vietnamese** have statistically significantly higher rates for all components, except for daily aspirin use, which is average.

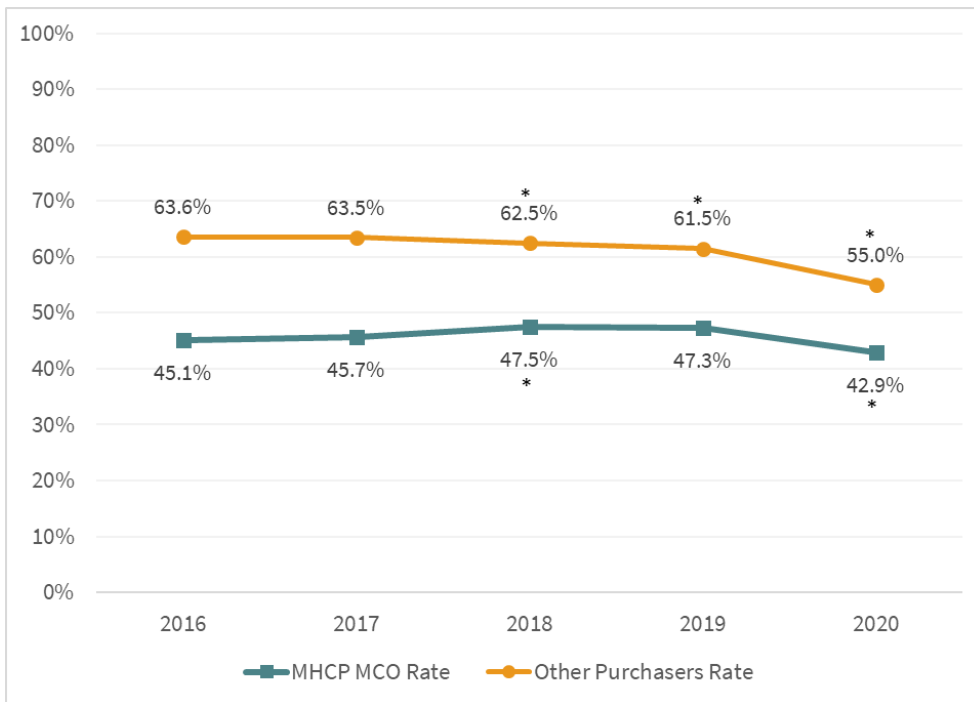
OPTIMAL VASCULAR CARE

Cardiovascular disease continues to be the leading cause of death in the United States.¹³ The Centers for Disease Control and Prevention (CDC) estimates that one person dies from cardiovascular disease every 36 seconds in the United States.¹³ Several factors increase the risk of cardiovascular disease, including but not limited to high blood pressure, high cholesterol and smoking.¹⁴ While some risk factors cannot be changed, management of these risk factors can help to reduce the risk of cardiovascular disease.¹⁵

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).

[Click here for complete measure description.](#)

TREND IN OPTIMAL VASCULAR CARE 2016 - 2020



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.

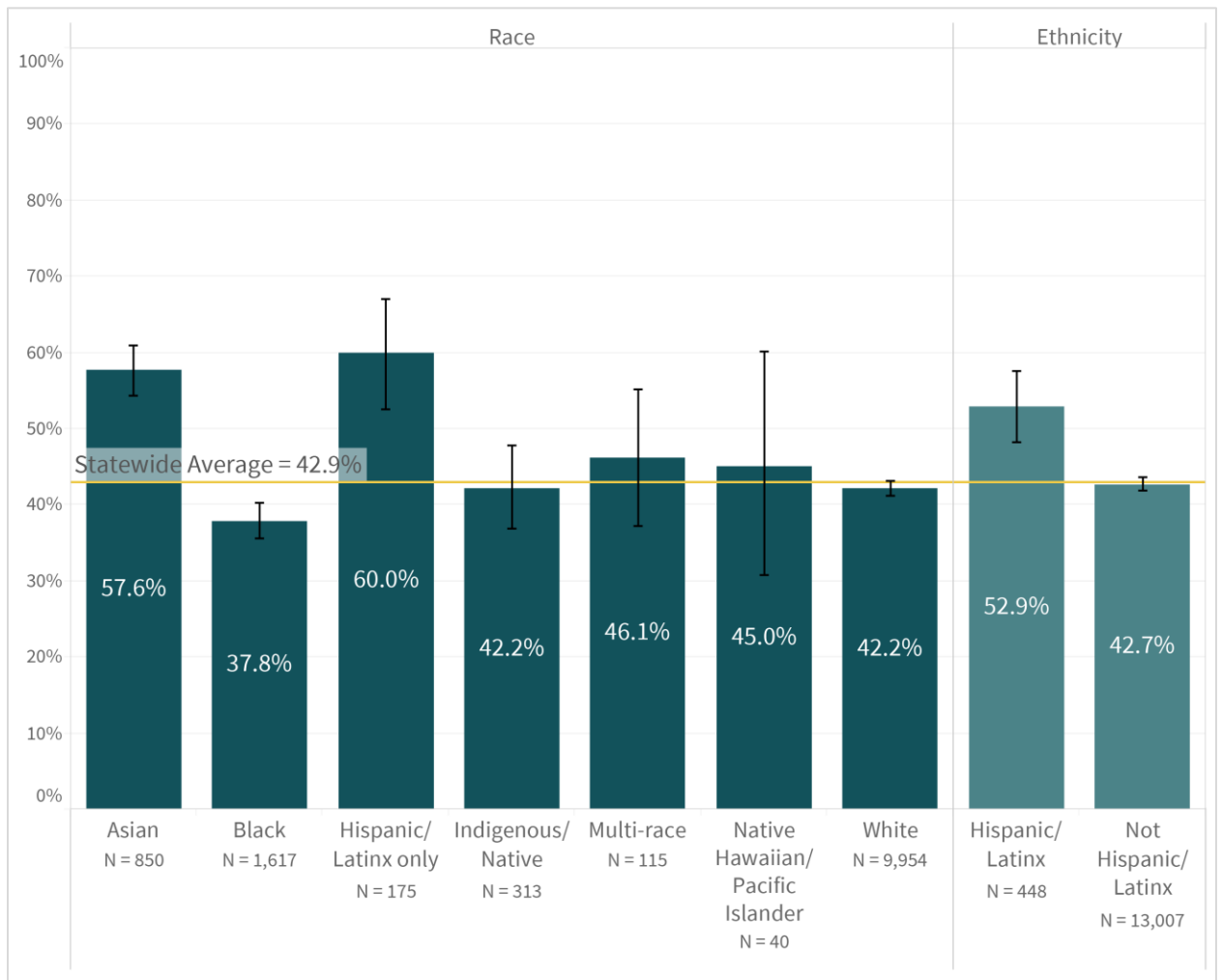
*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

- From 2019 to 2020, the MHCP MCO statewide average for the Optimal Vascular Care measure statistically significantly decreased by 4.4 percentage points.
- The gap in performance between the MHCP MCO population and the other purchasers population is statistically significant for 2020.

OPTIMAL VASCULAR CARE

MHCP MCO RATES BY RACE/ETHNICITY 2020 measurement year



┌ Represents 95% confidence interval

KEY TAKEAWAYS

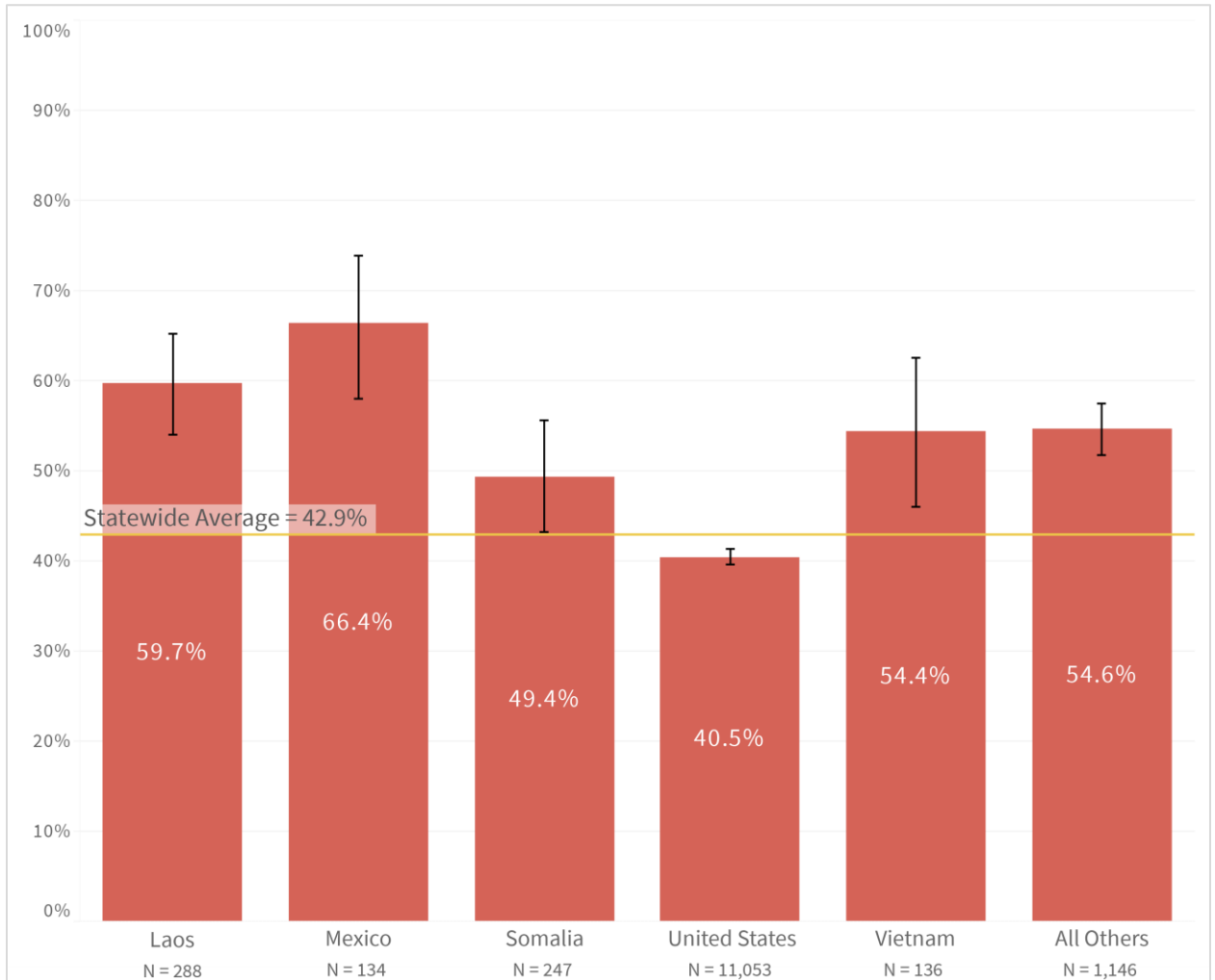
- The optimal care rates for MHCP MCO patients who listed **Hispanic/Latinx as their race** and patients who listed their **ethnicity as Hispanic/Latinx** are statistically significantly higher than the MHCP MCO statewide average.
- The optimal care rate for MHCP MCO patients who are **Black** is statistically significantly lower than the MHCP MCO statewide average.

Note: “Hispanic/Latinx Only” patients represent those who only indicated that they are Hispanic/Latinx and did not provide any race information. “Hispanic/Latinx” ethnicity represents patients who indicated that they are Hispanic/Latinx along with a race category.

OPTIMAL VASCULAR CARE

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 measurement year



┆ Represents 95% confidence interval

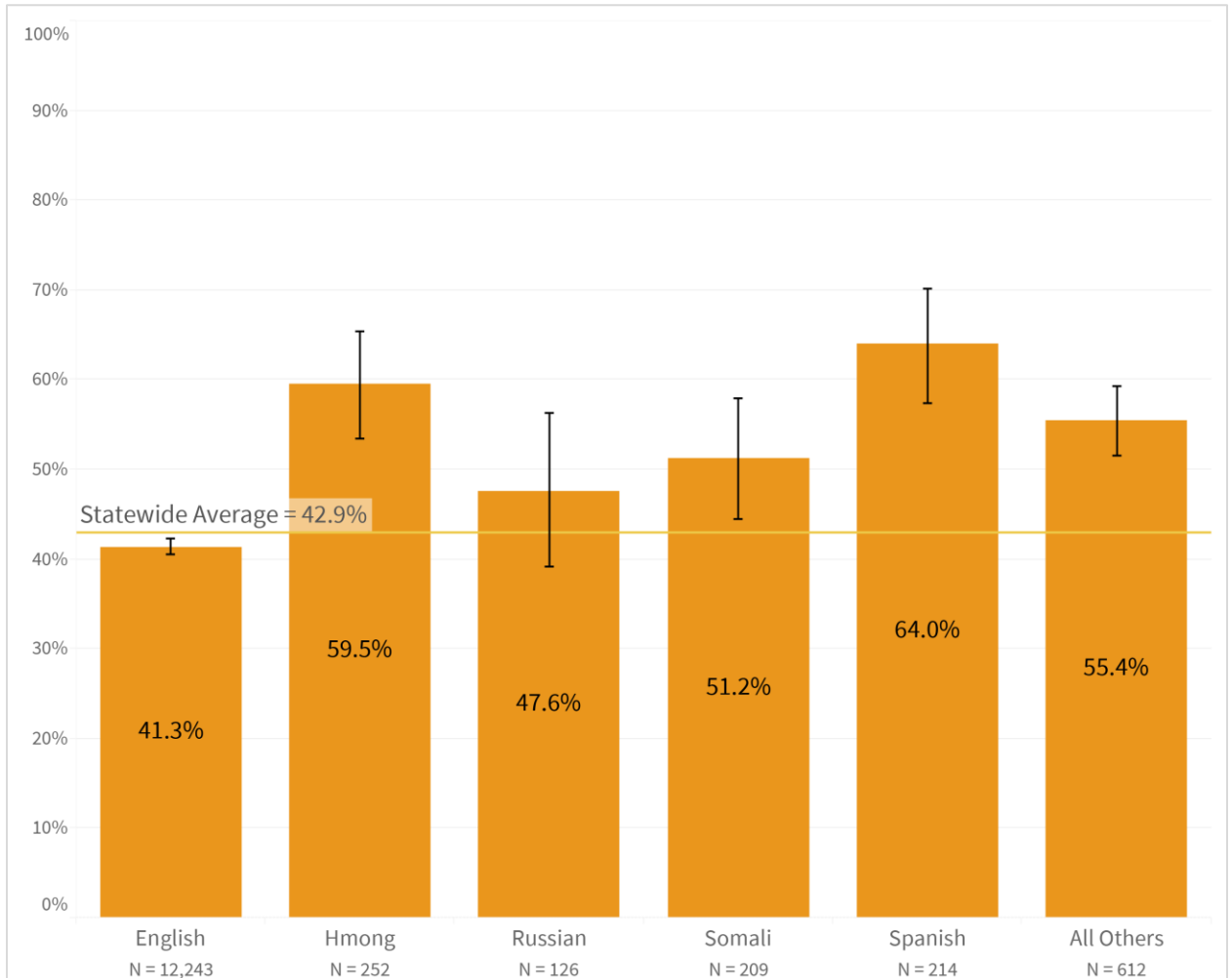
KEY TAKEAWAYS

- Patients from **Laos, Mexico, Somalia, the United States** and **Vietnam** make up the largest proportion of the MHCP MCO population for the Optimal Vascular Care measure.
- The optimal care rates for MHCP MCO patients from **Laos, Mexico** and **Vietnam** are statistically significantly higher compared to the MHCP MCO statewide average.
- The optimal care rates for MHCP MCO patients from the **United States** are statistically significantly lower compared to the MHCP MCO statewide average.

OPTIMAL VASCULAR CARE

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 measurement year



┌ Represents 95% confidence interval

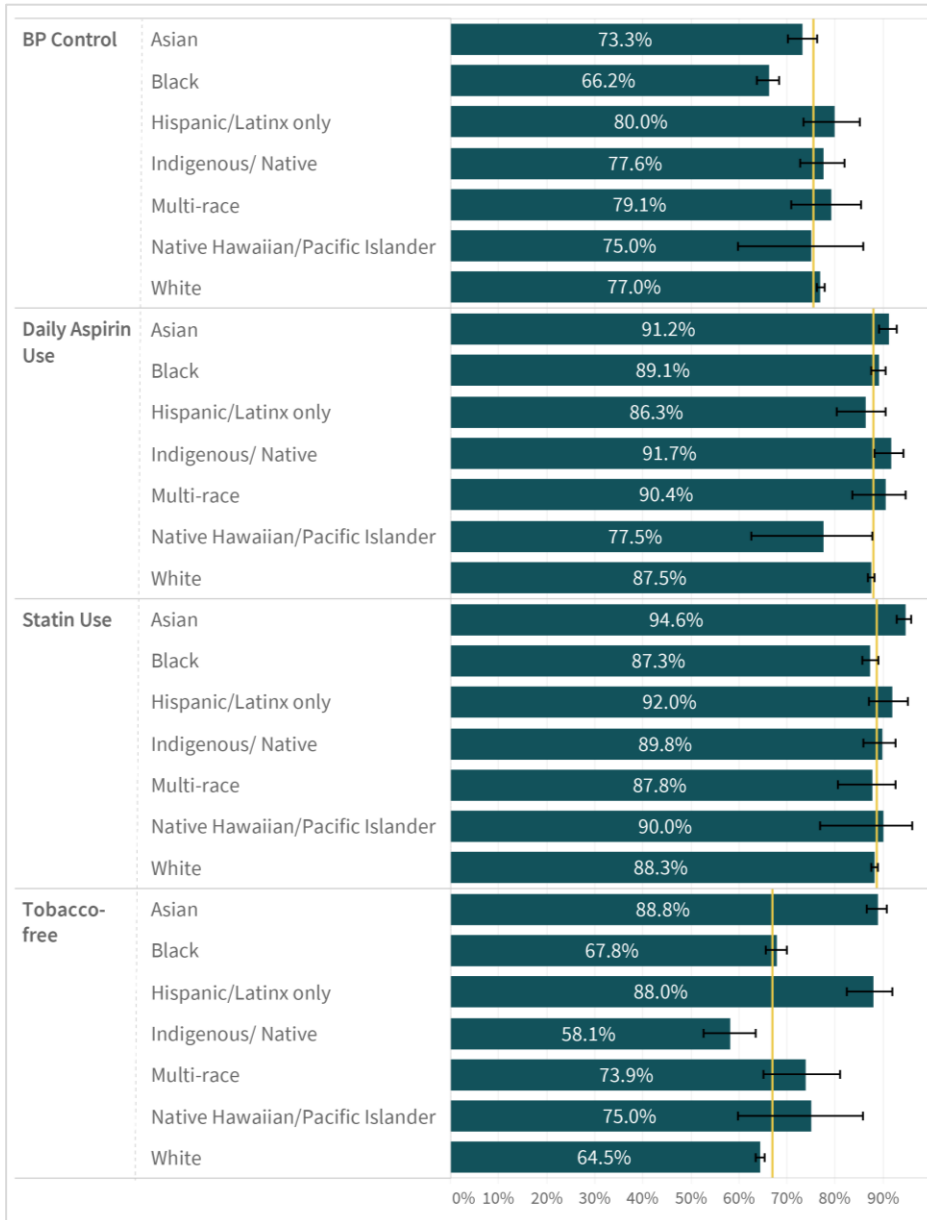
KEY TAKEAWAYS

- Patients who speak **English, Hmong, Russian, Somali** or **Spanish** make up the largest proportion of the MHCP MCO population for the Optimal Vascular Care measure.
- The optimal care rates for MHCP MCO patients who speak **Hmong, Somali** or **Spanish** are statistically significantly higher compared to the MHCP MCO statewide average.

OPTIMAL VASCULAR CARE: COMPONENTS

MHCP MCO RATES BY RACE

2020 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component (represented by yellow line)

- **BP Control:** 75.5%
- **Daily Aspirin:** 88.0%
- **Statin Use:** 88.7%
- **Tobacco-free:** 66.9%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- **Asian:** 850
- **Black:** 1,617
- **Hispanic/Latinx Only:** 175
- **Indigenous/Native:** 313
- **Multi-Race:** 115
- **Native Hawaiian/Pacific Islander:** 40
- **White:** 9,954

— Represents 95% confidence interval

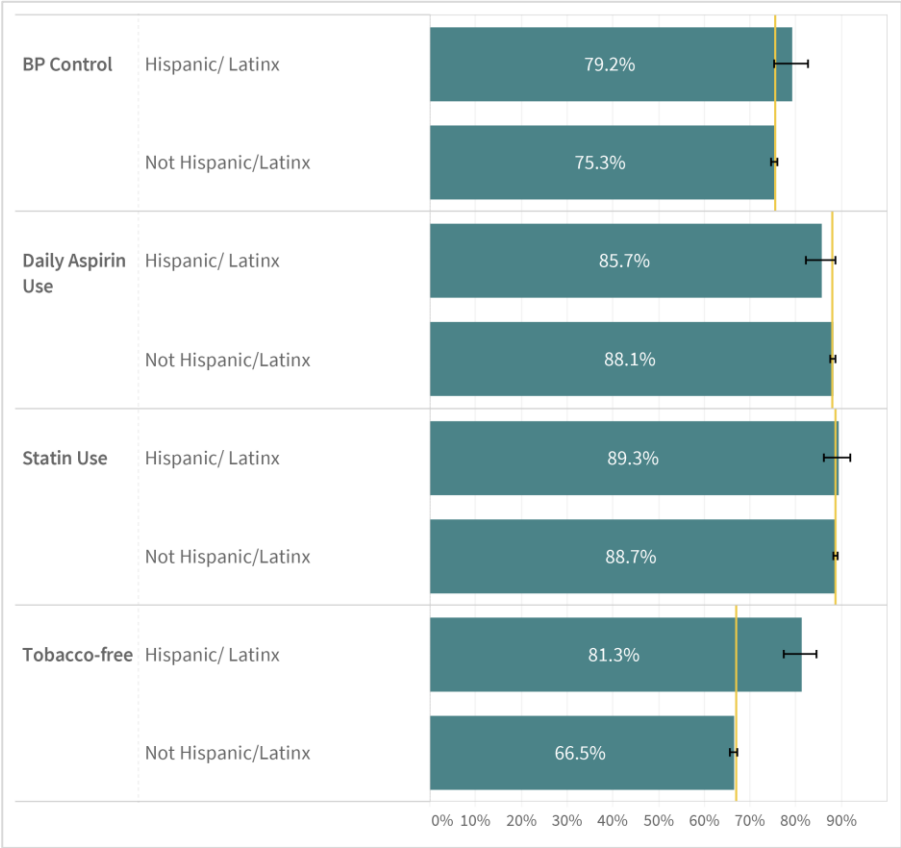
KEY TAKEAWAYS

Compared to the MHCP MCO statewide averages for the above components:

- MHCP MCO patients who are **Asian** have statistically significantly higher rates of **daily aspirin use, statin use and being tobacco-free**.
- MHCP MCO patients who are **Indigenous/Native** or **White** have statistically significantly lower rates of **being tobacco-free**.

OPTIMAL VASCULAR CARE: COMPONENTS

MHCP MCO RATES BY ETHNICITY 2020 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component (represented by yellow line)

- **BP Control:** 75.5%
- **Daily Aspirin:** 88.0%
- **Statin Use:** 88.7%
- **Tobacco-free:** 66.9%

DENOMINATORS BY ETHNICITY

(Denominators are the same for each measure)

- **Hispanic/Latinx:** 448
- **Not Hispanic/Latinx:** 13,007

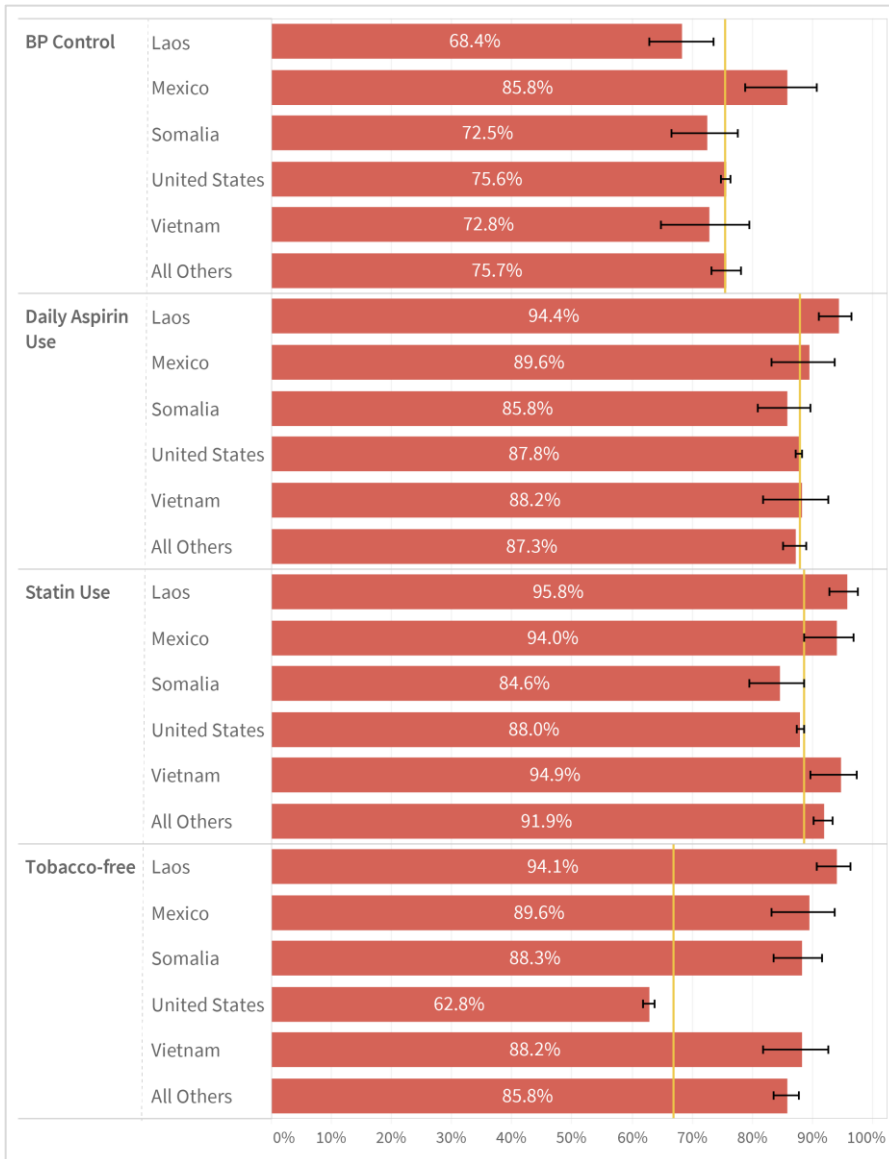
— Represents 95% confidence interval

KEY TAKEAWAY

- The rate of being **tobacco-free** for MHCP MCO patients who are **Hispanic/Latinx** is statistically significantly higher than the MHCP MCO statewide average for this component.

OPTIMAL VASCULAR CARE: COMPONENTS

MHCP MCO RATES BY COUNTRY OF ORIGIN 2020 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component
(represented by yellow line)

- **BP Control:** 75.5%
- **Daily Aspirin:** 88.0%
- **Statin Use:** 88.7%
- **Tobacco-free:** 66.9%

DENOMINATORS BY COUNTRY

(Denominators are the same for each measure)

- **Laos:** 288
- **Mexico:** 134
- **Somalia:** 247
- **United States:** 11,053
- **Vietnam:** 136
- **All Others:** 1,146

— Represents 95% confidence interval

KEY TAKEAWAYS

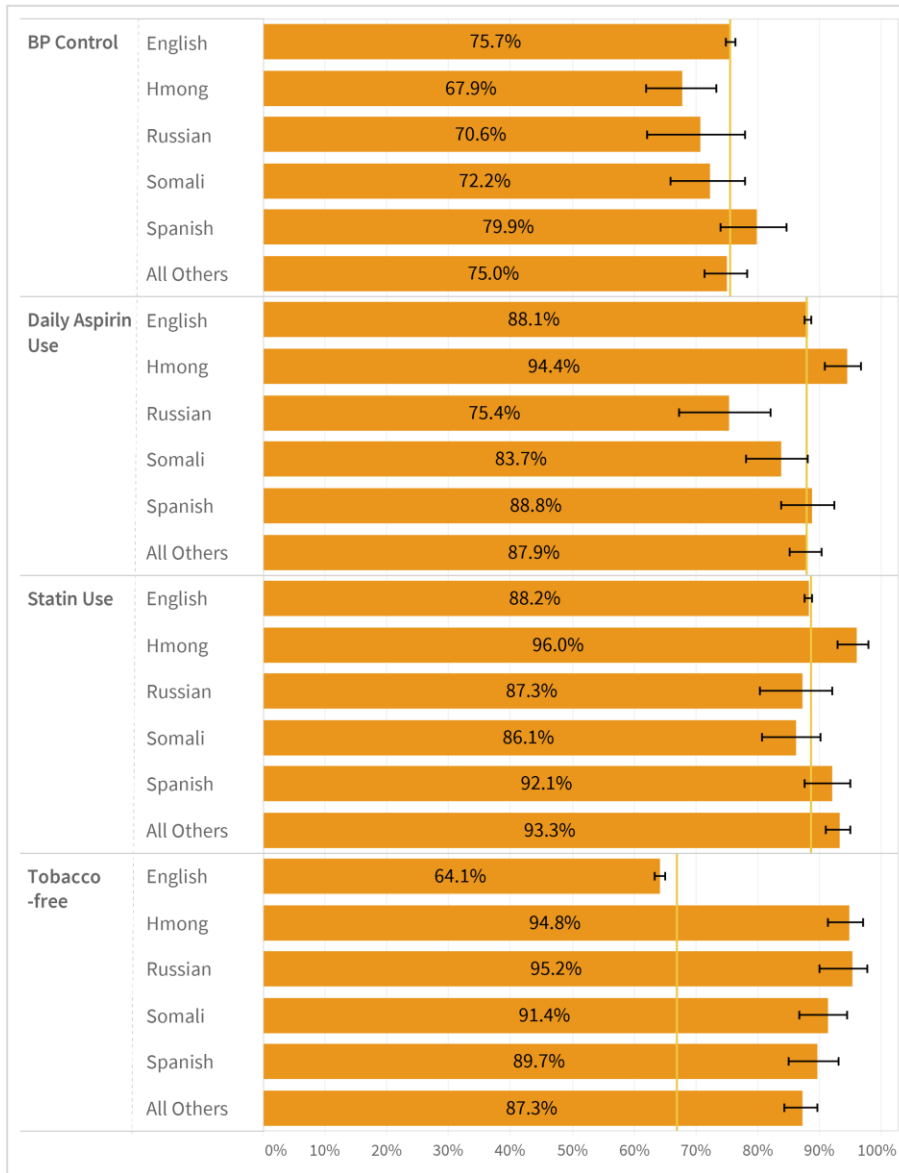
Compared to the MHCP MCO statewide averages for the above components:

- MHCP MCO patients from **Laos** have statistically significantly **higher** rates of **daily aspirin use, statin use and being tobacco-free**, but statistically significantly **lower** rates of **blood pressure control**.

OPTIMAL VASCULAR CARE: COMPONENTS

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component
(represented by yellow line)

- **BP Control:** 75.5%
- **Daily Aspirin:** 88.0%
- **Statin Use:** 88.7%
- **Tobacco-free:** 66.9%

DENOMINATORS BY LANGUAGE

(Denominators are the same for each measure)

- **English:** 12,243
- **Hmong:** 252
- **Russian:** 126
- **Somali:** 209
- **Spanish:** 214
- **All Others:** 612

— Represents 95% confidence interval

KEY TAKEAWAYS

Compared to the MHCP MCO statewide averages for the above components:

- MHCP MCO patients who speak **Hmong** have statistically significantly higher rates of **daily aspirin use, statin use and being tobacco-free**.
- MHCP MCO patients who speak **Spanish, Somali or Russian** have statistically significantly higher rates **being tobacco-free**
- MHCP MCO patients who speak **English** have a statistically significantly lower rate of **being tobacco-free**.

OPTIMAL ASTHMA CONTROL - ADULTS

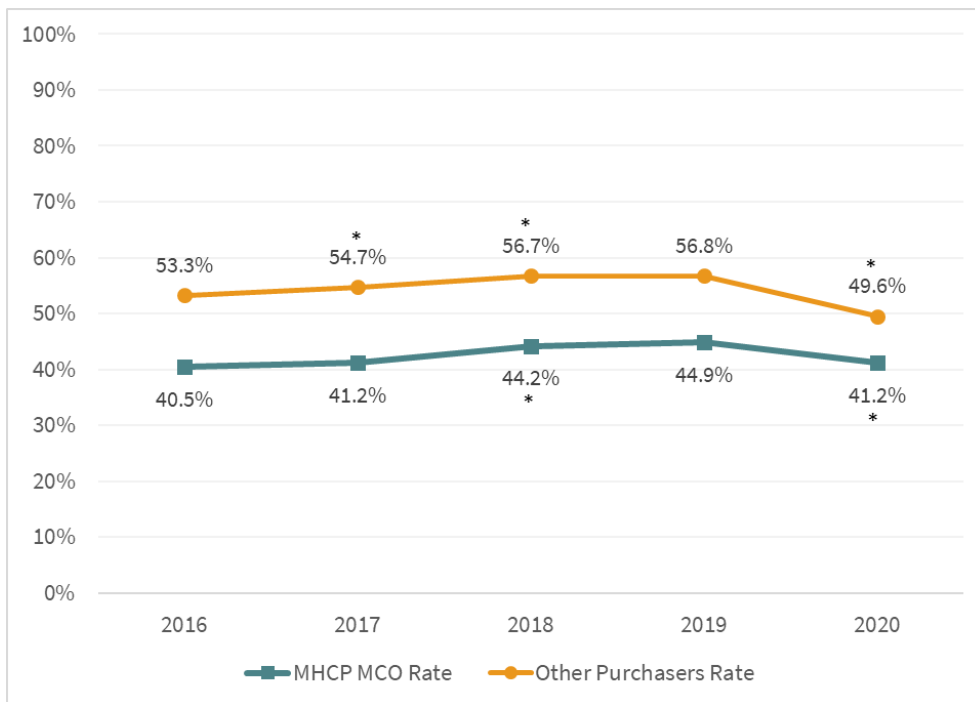
In 2019, the Centers for Disease Control and Prevention (CDC) estimated that over 20 million adults in the United States were living with asthma.¹⁶ The CDC also estimated that, in 2016, approximately 60% of adults in the United States had uncontrolled asthma, leading to emergency department visits and hospitalizations, which are costly to both the patient and the health care system.¹⁷

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).

[Click here for complete measure description.](#)

TREND IN OPTIMAL ASTHMA CONTROL - ADULTS

2016 – 2020



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.

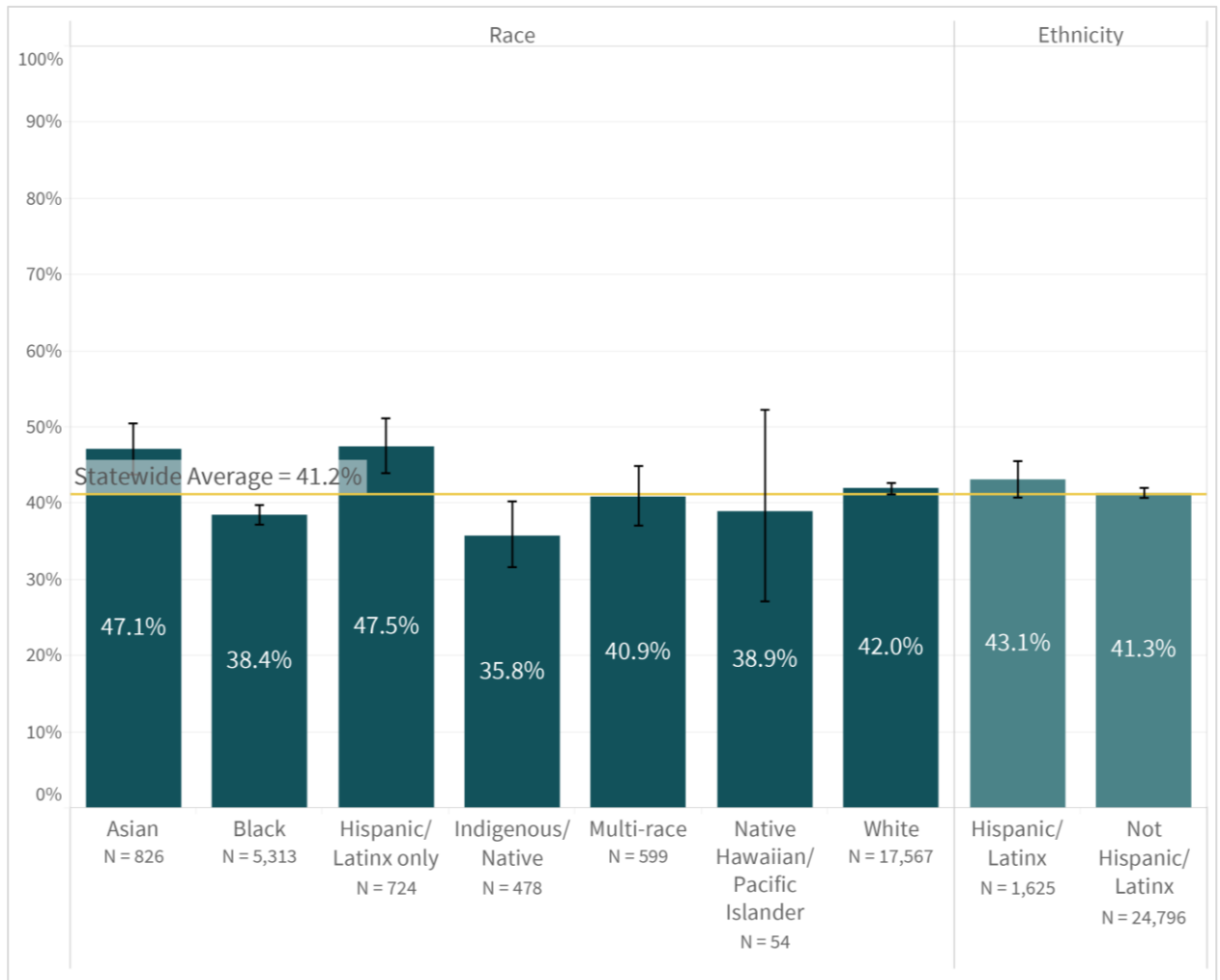
*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

- From 2019 to 2020, the MHCP MCO statewide average for the Optimal Asthma Control – Adults measure statistically significantly decreased by 3.7 percentage points.
- The gap in performance between the MHCP MCO population and the other purchasers population is statistically significant for 2020.

OPTIMAL ASTHMA CONTROL – ADULTS

MHCP MCO RATES BY RACE/ETHNICITY 2020 measurement year



┌ Represents 95% confidence interval

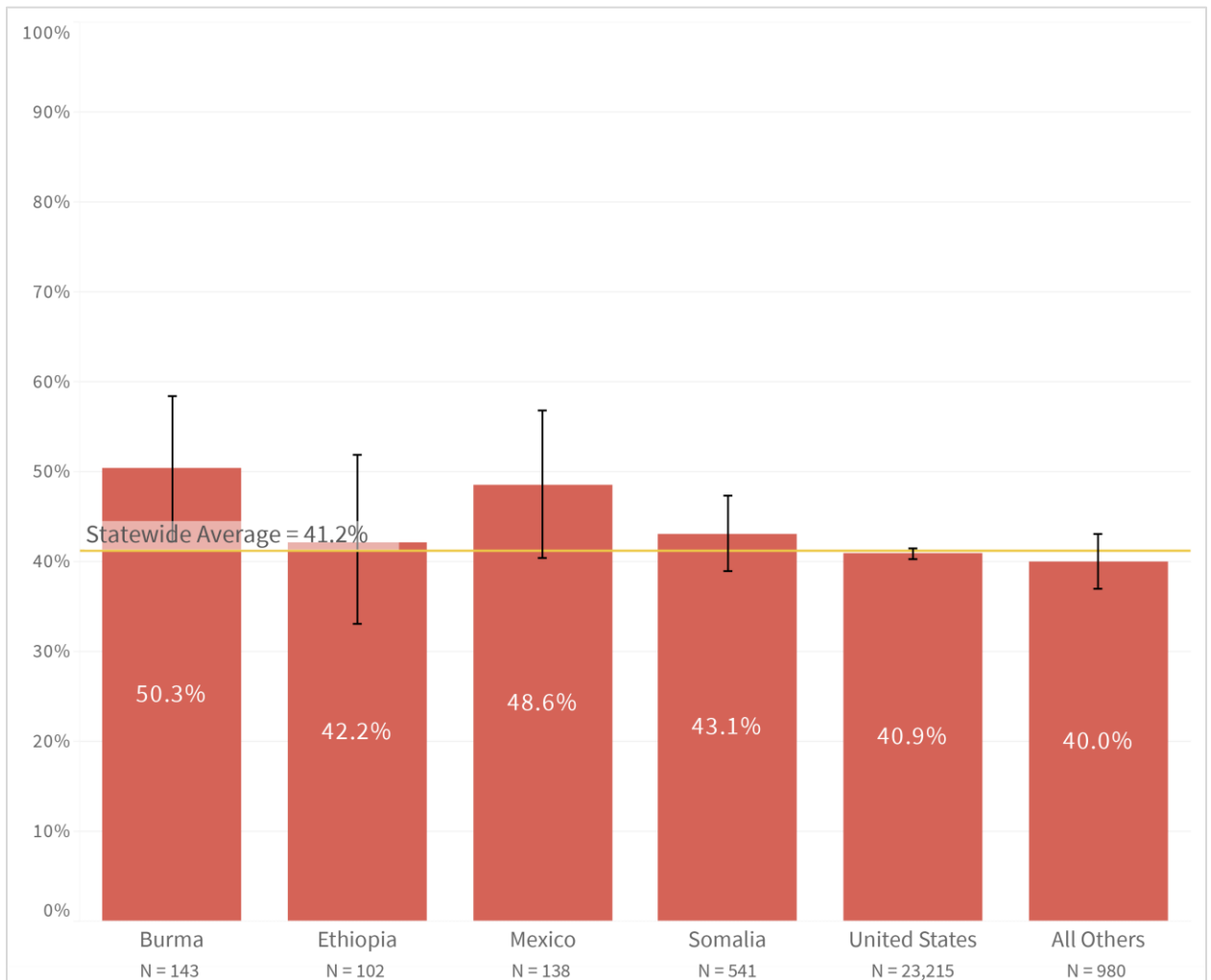
KEY TAKEAWAYS

- The optimal care rates for MHCP MCO adults who are **Asian** or who listed **Hispanic/Latinx as their race** are statistically significantly higher than the MHCP MCO statewide average
- The optimal care rates for MHCP MCO adults who are **Black** or **Indigenous/Native** are statistically significantly lower than the MHCP MCO statewide average

Note: “Hispanic/Latinx Only” patients represent those who only indicated that they are Hispanic/Latinx and did not provide any race information. “Hispanic/Latinx” ethnicity represents patients who indicated that they are Hispanic/Latinx along with a race category.

OPTIMAL ASTHMA CONTROL – ADULTS

MHCP MCO RATES BY COUNTRY OF ORIGIN 2020 measurement year



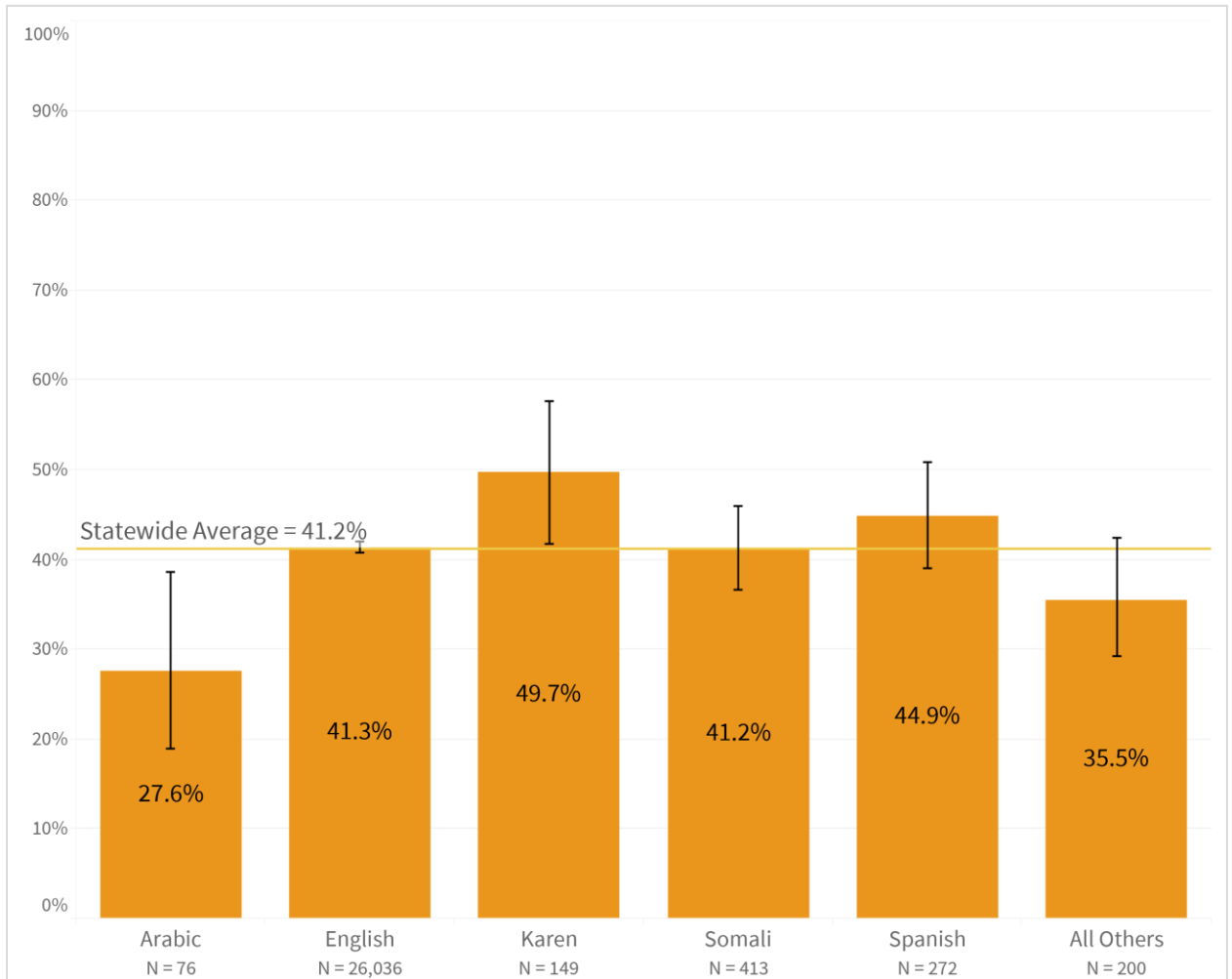
┌ ┐ Represents 95% confidence interval

KEY TAKEAWAYS

- Adults from **Burma, Ethiopia, Mexico, Somalia** and the **United States** make up the largest proportion of the MHCP MCO adult population for the Optimal Asthma Control measure.
- The optimal control rate for MHCP MCO adults from **Burma** is statistically significantly higher compared to the MHCP MCO statewide average.

OPTIMAL ASTHMA CONTROL – ADULTS

MHCP MCO RATES BY PREFERRED LANGUAGE 2020 measurement year



⌈ Represents 95% confidence interval

KEY TAKEAWAYS

- Adults who speak **Arabic, English, Karen, Somali** or **Spanish** make up the largest proportion of the MHCP MCO adult population for the Optimal Asthma Control measure.
- The optimal control rate for MHCP MCO adults who speak **Arabic** is statistically significantly lower compared to the MHCP MCO statewide average.

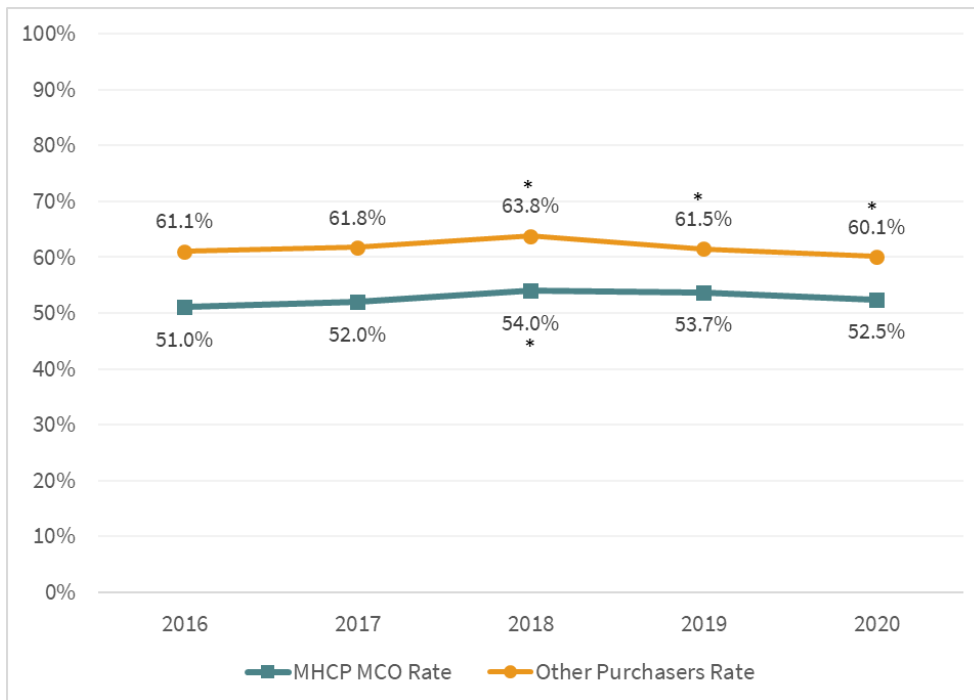
OPTIMAL ASTHMA CONTROL - CHILDREN

The Centers for Disease Control and Prevention (CDC) estimated that over 5 million children (< 18 years of age) had asthma in 2019.¹⁶ In 2018, it was estimated that there were over 700,000 emergency department visits and over 70,000 inpatient hospital stays for children with asthma. Ensuring that asthma is optimally controlled can help to prevent visits to the emergency room and hospitalizations¹⁸

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).

[Click here for complete measure description.](#)

TREND IN OPTIMAL ASTHMA CONTROL - CHILDREN 2016 - 2020



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.

*Rate statistically significantly changed from previous year

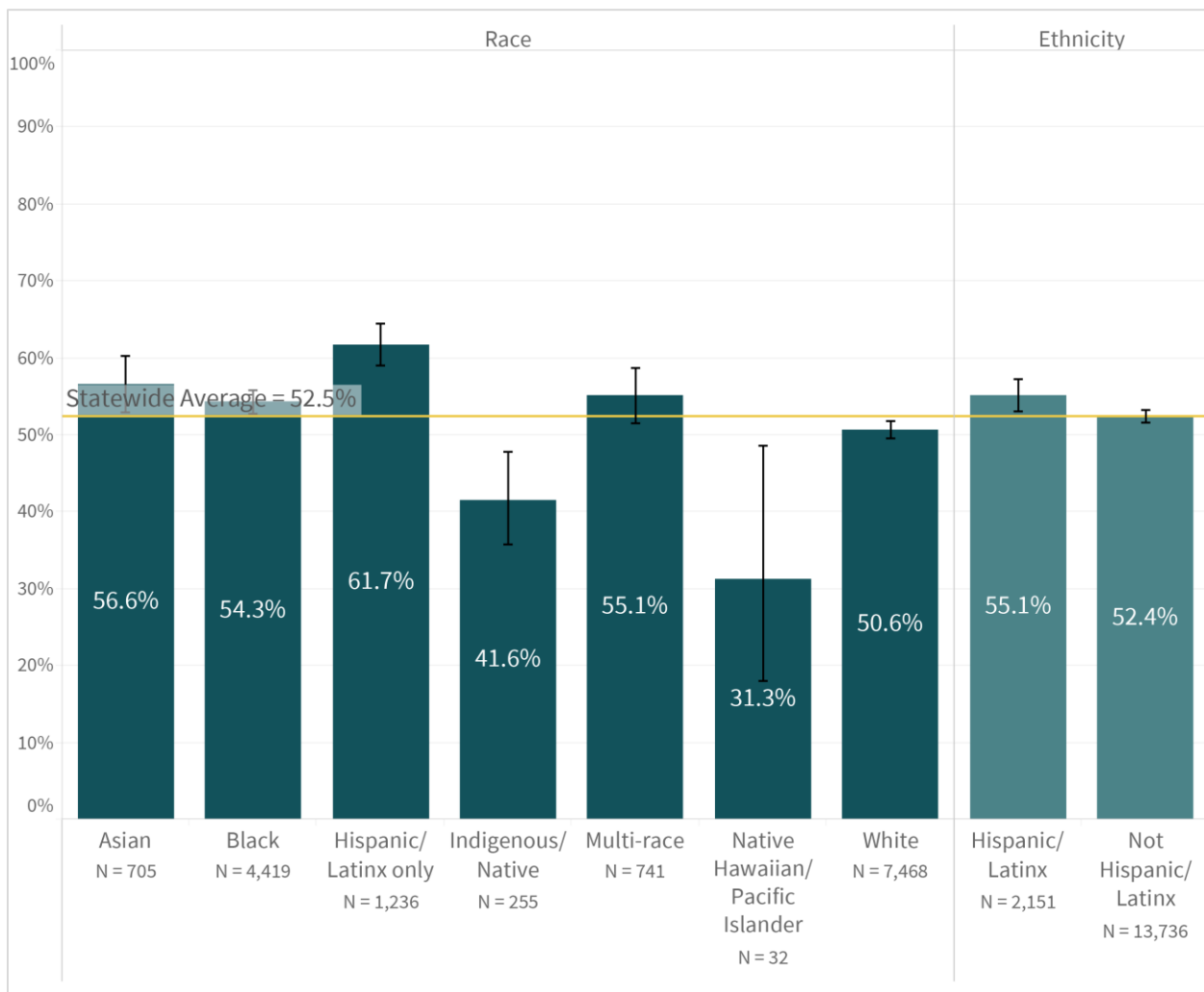
KEY TAKEAWAYS

- From 2019 to 2020, the MHCP MCO statewide average for the Optimal Asthma Control – Children measure did not statistically significantly change.
- The gap in performance between the MHCP MCO population and the other purchasers population is statistically significant for 2020.

OPTIMAL ASTHMA CONTROL – CHILDREN

MHCP MCO RATES BY RACE/ETHNICITY

2020 measurement year



┆ Represents 95% confidence interval

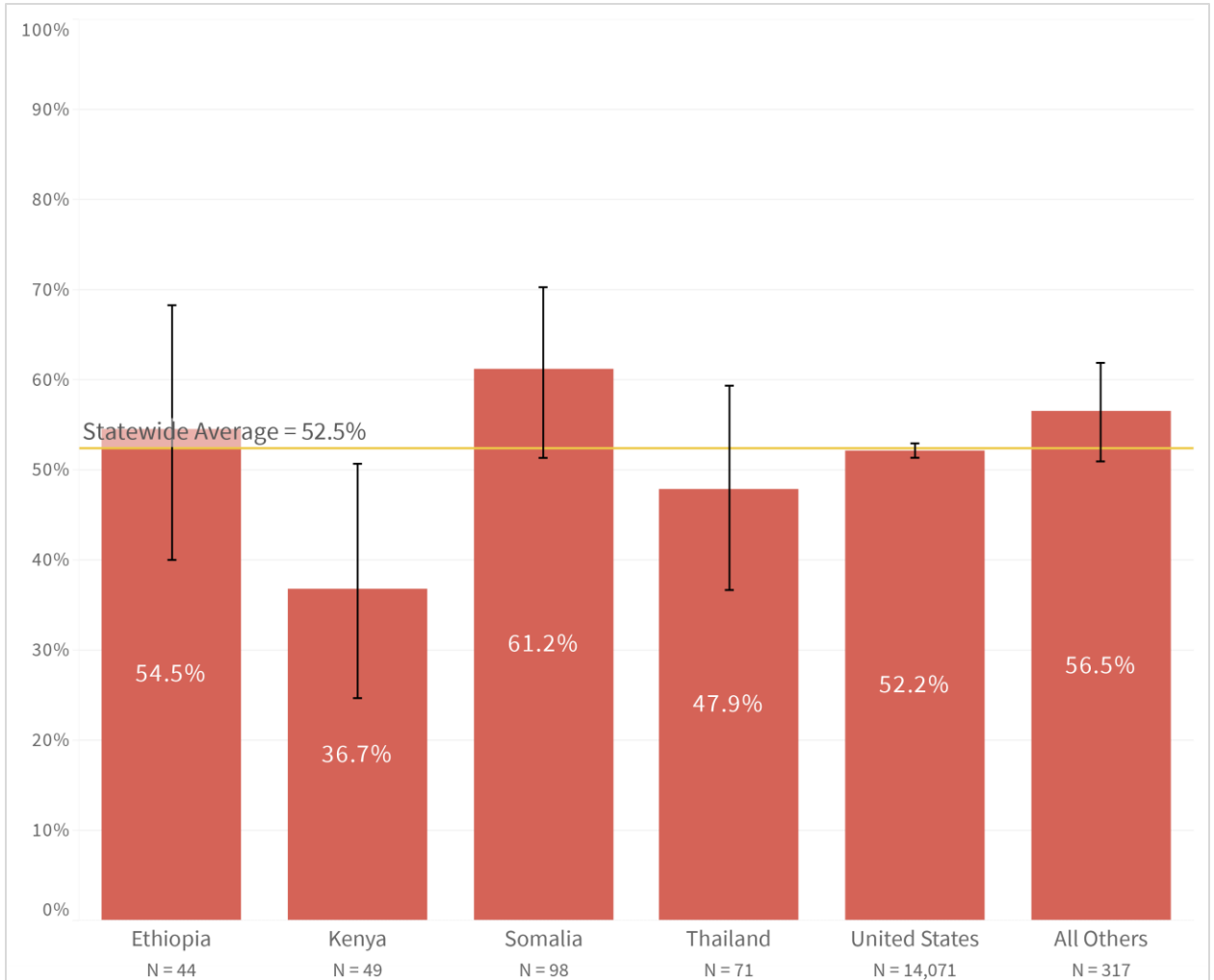
KEY TAKEAWAYS

- The optimal care rate for MHCP MCO children who listed **Hispanic/Latinx as their race** is statistically significantly higher than the MHCP MCO statewide average.
- The optimal care rates for MHCP MCO adults who are **Indigenous/Native** or **Native Hawaiian/Pacific Islander** are statistically significantly lower than the MHCP MCO statewide average.

Note: “Hispanic/Latinx Only” patients represent those who only indicated that they are Hispanic/Latinx and did not provide any race information. “Hispanic/Latinx” ethnicity represents patients who indicated that they are Hispanic/Latinx along with a race category.

OPTIMAL ASTHMA CONTROL – CHILDREN

MHCP MCO RATES BY COUNTRY OF ORIGIN 2020 measurement year



┌ ─┬─┐ Represents 95% confidence interval

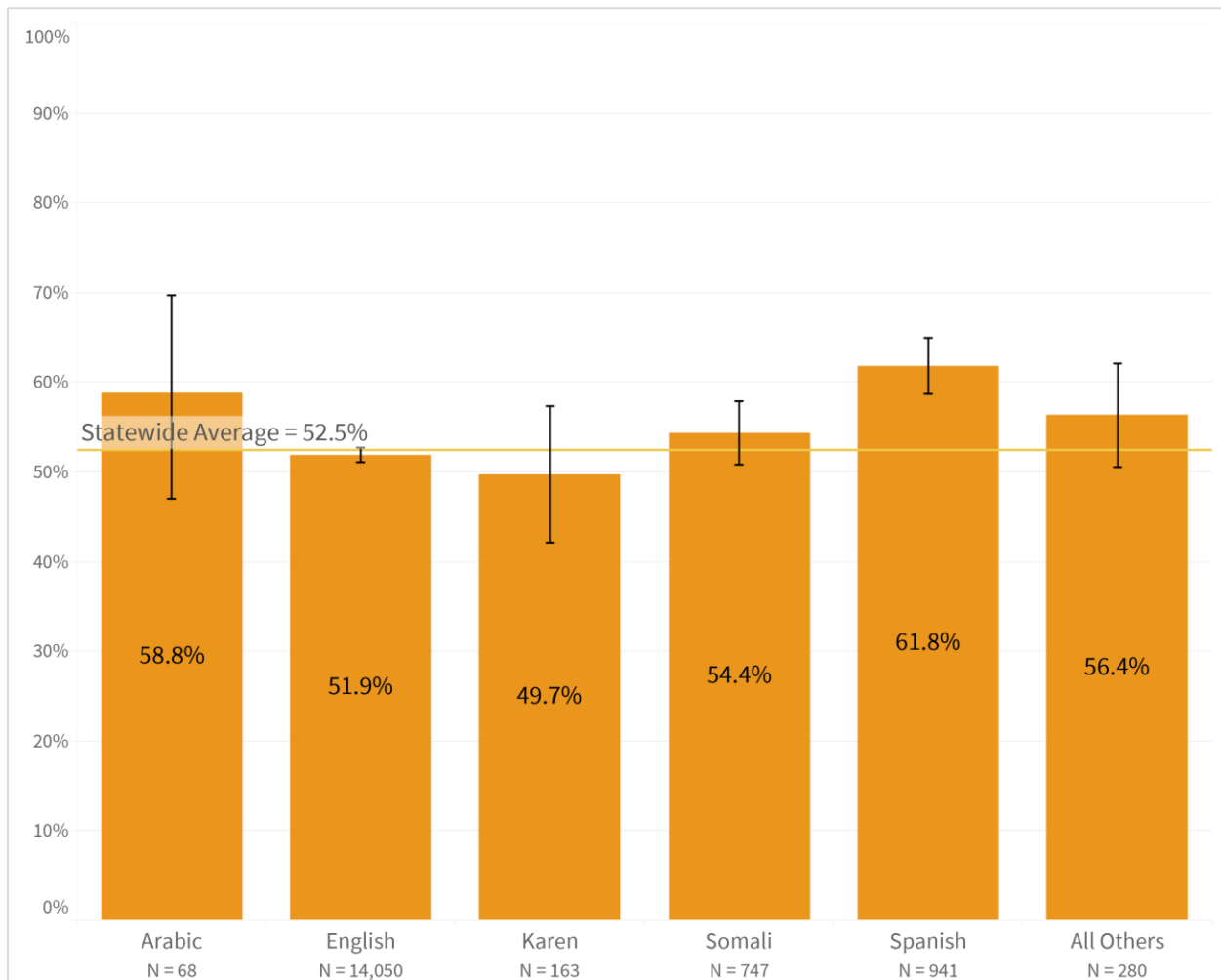
KEY TAKEAWAYS

- Children from **Ethiopia, Kenya, Somalia, Thailand** and the **United States** make up the largest proportion of the MHCP MCO child population for the Optimal Asthma Control measure.
- The optimal control rate for MHCP MCO children from **Kenya** is statistically significantly lower compared to the MHCP MCO statewide average.

OPTIMAL ASTHMA CONTROL – CHILDREN

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 measurement year



⌈ Represents 95% confidence interval

KEY TAKEAWAYS

- Adults who speak **Arabic, English, Karen, Somali** or **Spanish** make up the largest proportion of the MHCP MCO child population for the Optimal Asthma Control measure.
- The optimal control rate for MHCP MCO children who speak **Spanish** is statistically significantly higher compared to the MHCP MCO statewide average.

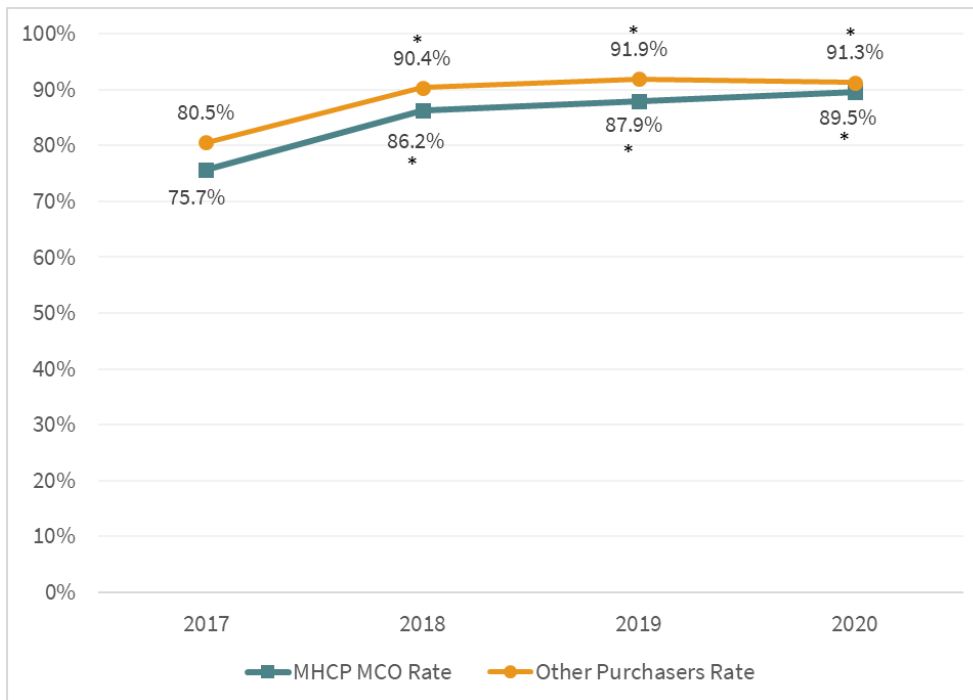
ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

In 2019, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that the lifetime prevalence of any mental health disorder among adolescents was 49.5%.¹⁹ In 2021, the National Alliance on Mental Illness (NAMI) called for the need of better access to mental health services, including screening, for adolescents, especially considering the impact of the COVID-19 pandemic on mental health.¹⁹

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).

[Click here for complete measure description.](#)

TREND IN ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING 2017 - 2020



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.

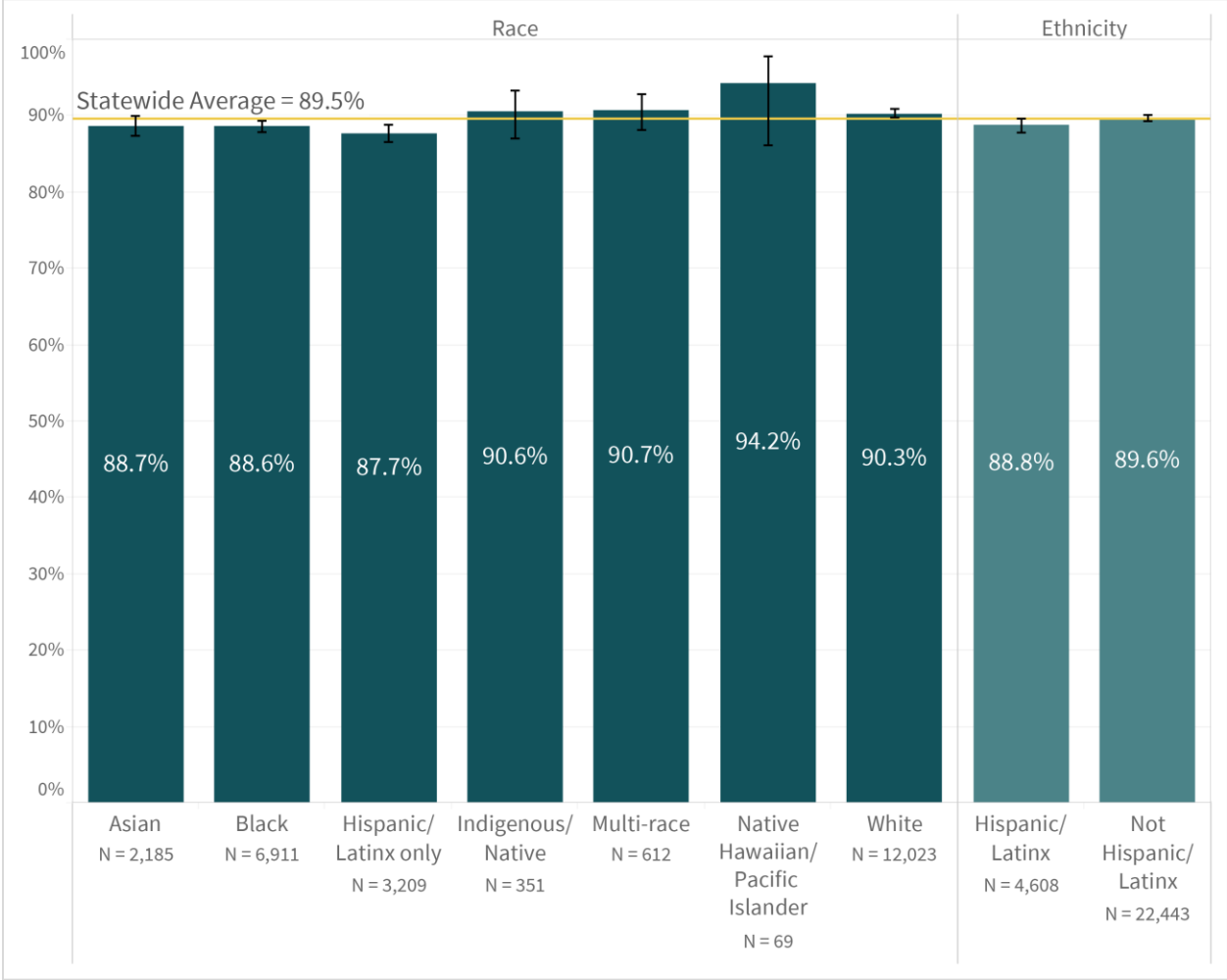
*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

- From 2019 to 2020, the MHCP MCO statewide average for the Adolescent Mental Health and/or Depression Screening measure statistically significantly increased by 1.6 percentage points.
- While the gap in performance between patients insured by MHCP MCO and patients insured by other purchasers remains (1.8 percentage points), it has statistically significantly narrowed since 2017.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

MHCP MCO RATES BY RACE/ETHNICITY
2020 measurement year



⌋ Represents 95% confidence interval

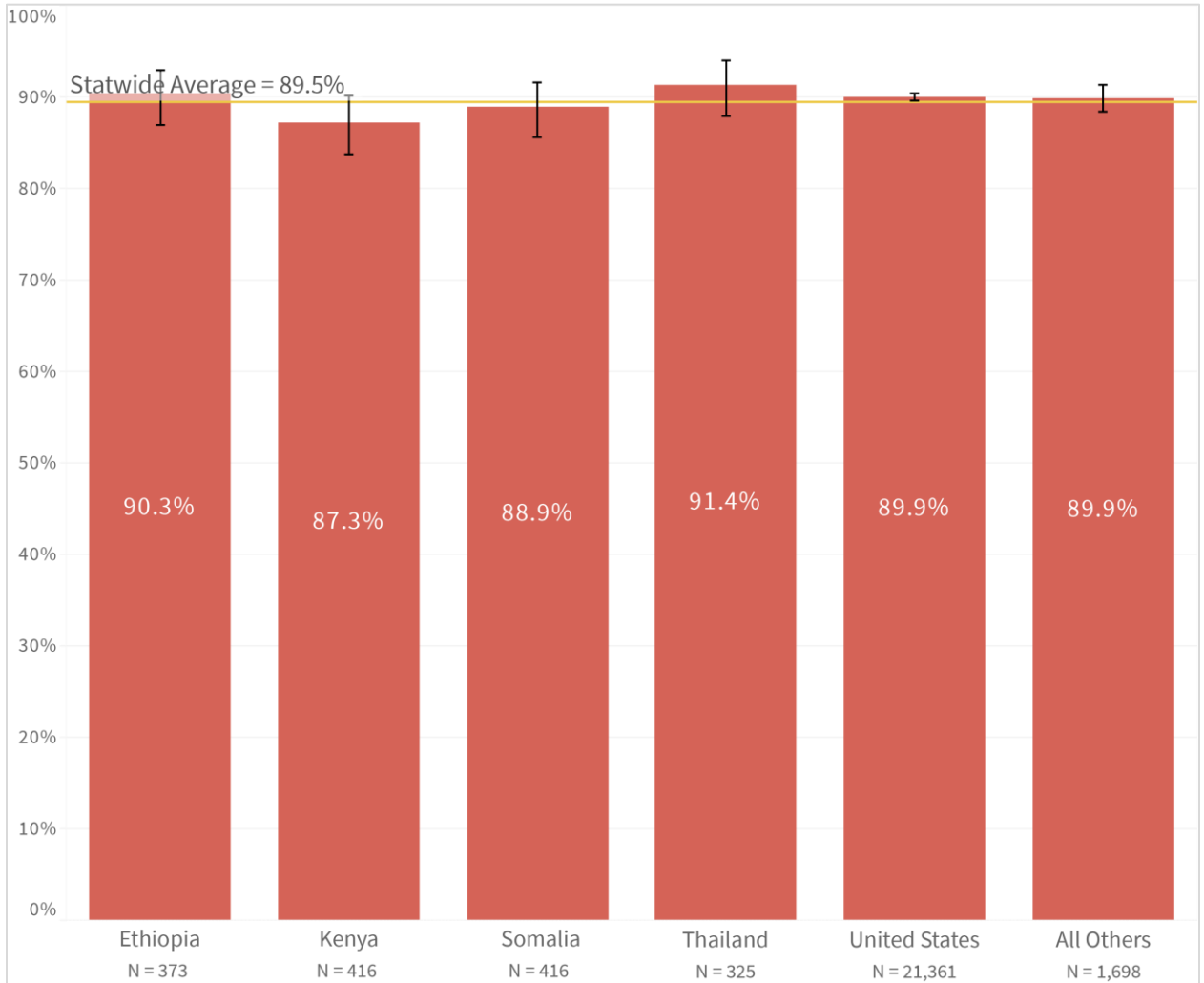
KEY TAKEAWAY

The screening rate for MHCP MCO adolescents who listed **Hispanic/Latinx as their race** is statistically significantly lower than the MHCP MCO statewide average.

Note: “Hispanic/Latinx Only” patients represent those who only indicated that they are Hispanic/Latinx and did not provide any race information. “Hispanic/Latinx” ethnicity represents patients who indicated that they are Hispanic/Latinx along with a race category.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

MHCP MCO RATES BY COUNTRY OF ORIGIN
2020 measurement year



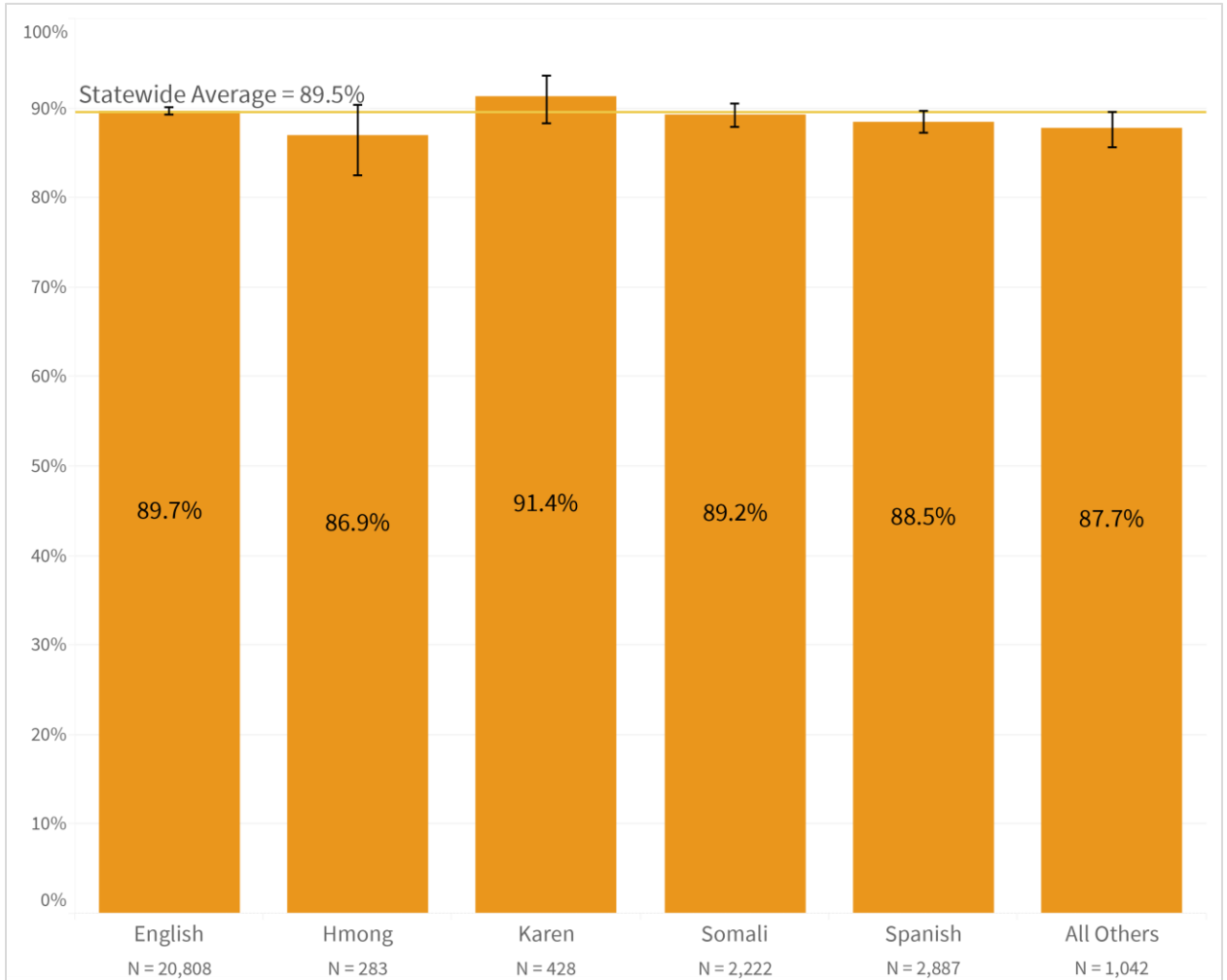
[] Represents 95% confidence interval

KEY TAKEAWAYS

- Adolescents from **Ethiopia, Kenya, Somalia, Thailand** and **the United States** make up the largest proportion of the MHCP MCO population for the Adolescent Mental Health Screening measure.
- Adolescents from any of the listed countries have average rates of screening compared to the MHCP MCO statewide average.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

MHCP MCO RATES BY PREFERRED LANGUAGE
2020 measurement year



┆ Represents 95% confidence interval

KEY TAKEAWAYS

- Adolescents who speak **English, Hmong, Karen, Somali** or **Spanish** make up the largest proportion of the MHCP MCO population for the Adolescent Mental Health Screening measure.
- Adolescents who speak any of the listed languages have average rates of screening compared to the MHCP MCO statewide average.

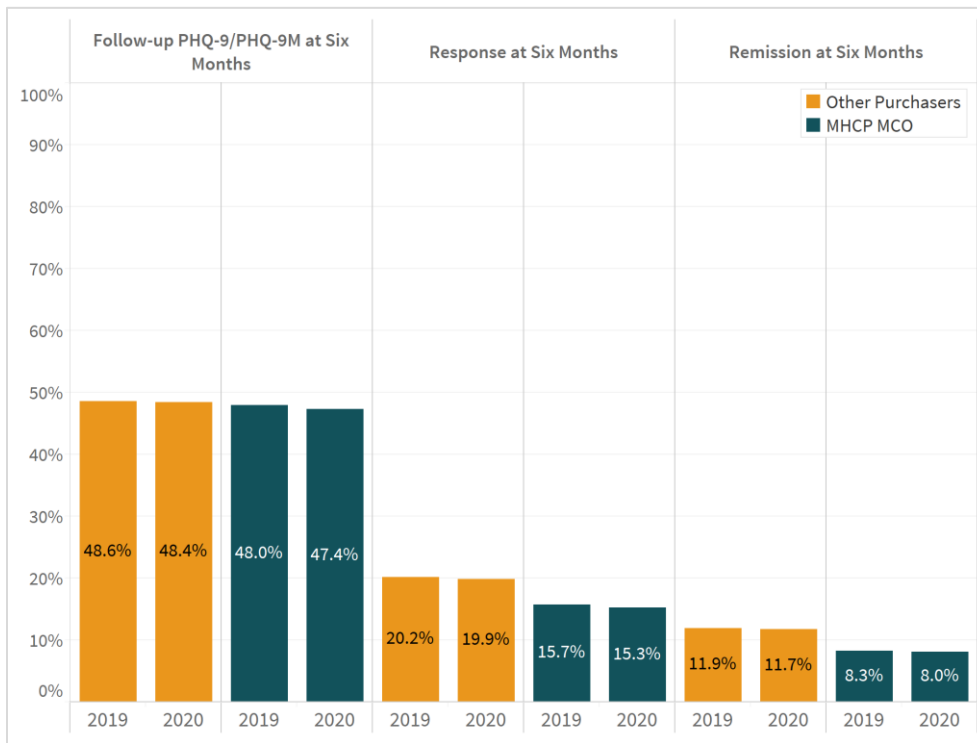
ADULT DEPRESSION SUITE

Approximately 8.4% (21 million) of adults in the United States experienced at least one depressive episode in 2020.²⁰ Of these adults, it is estimated that 66% received treatment for their depression.²¹ The 2020 National Survey on Drug Use and Health showed that the highest portion of adults with a depressive episode in 2020 occurred among young adults between the ages of 18 and 25 years.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).

[Click here for complete measure description.](#)

ADULT DEPRESSION SUITE SIX MONTH MEASURES TREND 2019-2020



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.

*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

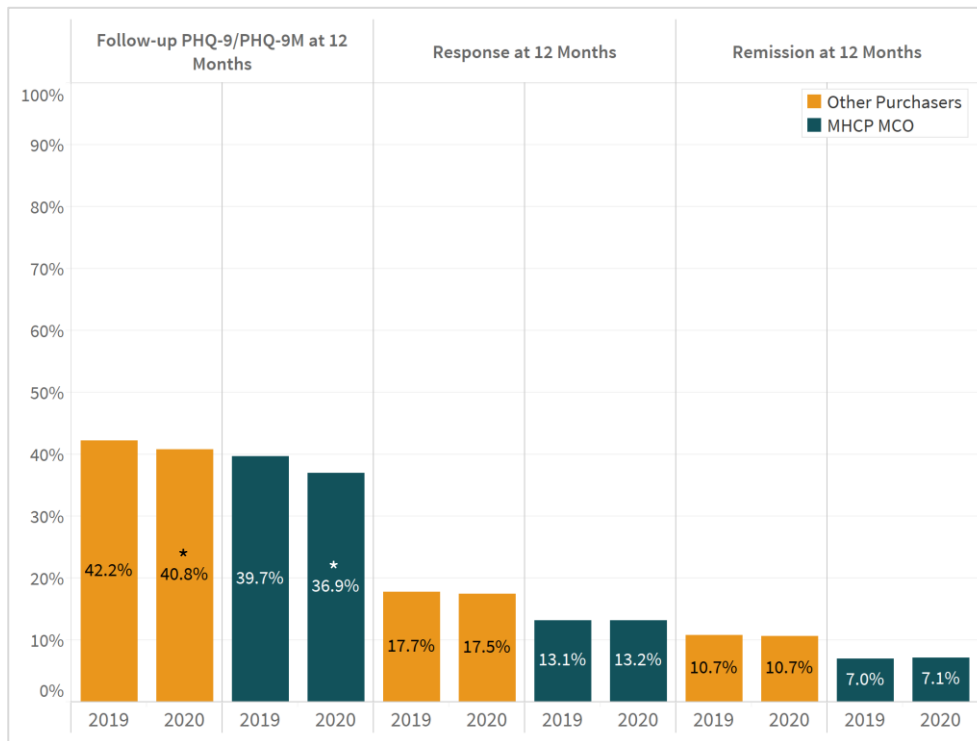
- There is significant room for improvement across all six-month depression measures, regardless of payer type.
- The statewide averages for both payer types did not significantly change from 2019 to 2020.
- There are statistically significant differences in performance rates by insurance type for each of the six-month measures.

ADULT DEPRESSION SUITE

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).

[Click here for complete measure description.](#)

ADULT DEPRESSION SUITE 12 MONTH MEASURES TREND 2019-2020



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.

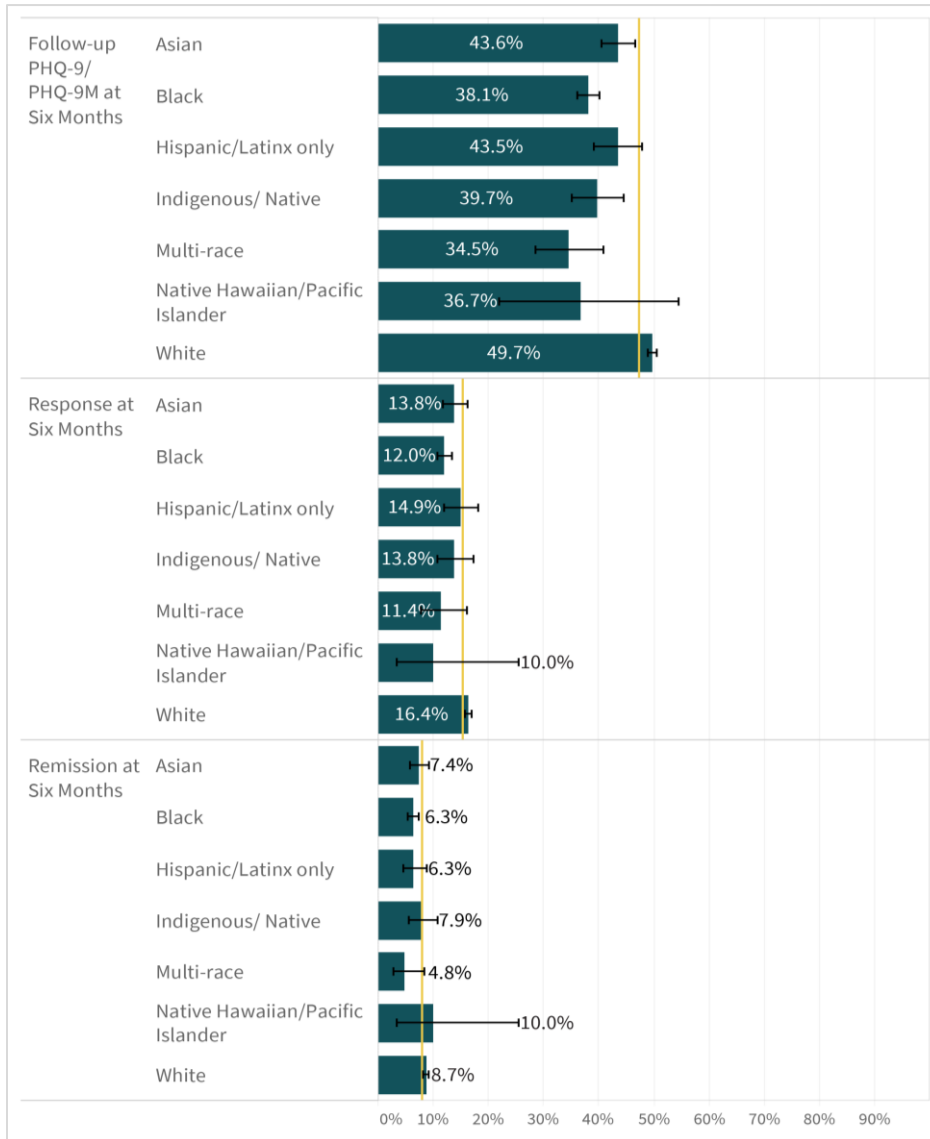
*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

- There is significant room for improvement across all 12-month depression measures, regardless of payer type.
- The statewide averages for both payer types statistically significantly decreased for the Follow-up PHQ-9/PHQ-9M at 12 Months measure in 2020 compared to 2019.
- The statewide averages for 12-month response and remission measures for both payer types did not significantly change from 2019 to 2020.
- There are statistically significant differences in performance rates by insurance type for each of the six-month measures.

ADULT DEPRESSION SUITE: Six Month Measures

MHCP MCO RATES BY RACE 2020 measurement year



— Represents 95% confidence interval

OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

- Follow-Up PHQ-9/ PHQ-9M at Six Months: 47.4%
- Response at Six Months: 15.3%
- Remission at Six Months: 8.0%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- Asian: 952
- Black: 2,302
- Hispanic/Latinx Only: 504
- Indigenous/Native: 420
- Multi-Race: 229
- Native Hawaiian/Pacific Islander: 30
- White: 15,601

KEY TAKEAWAYS

Compared to the MHCP MCO statewide averages for each six-month measure:

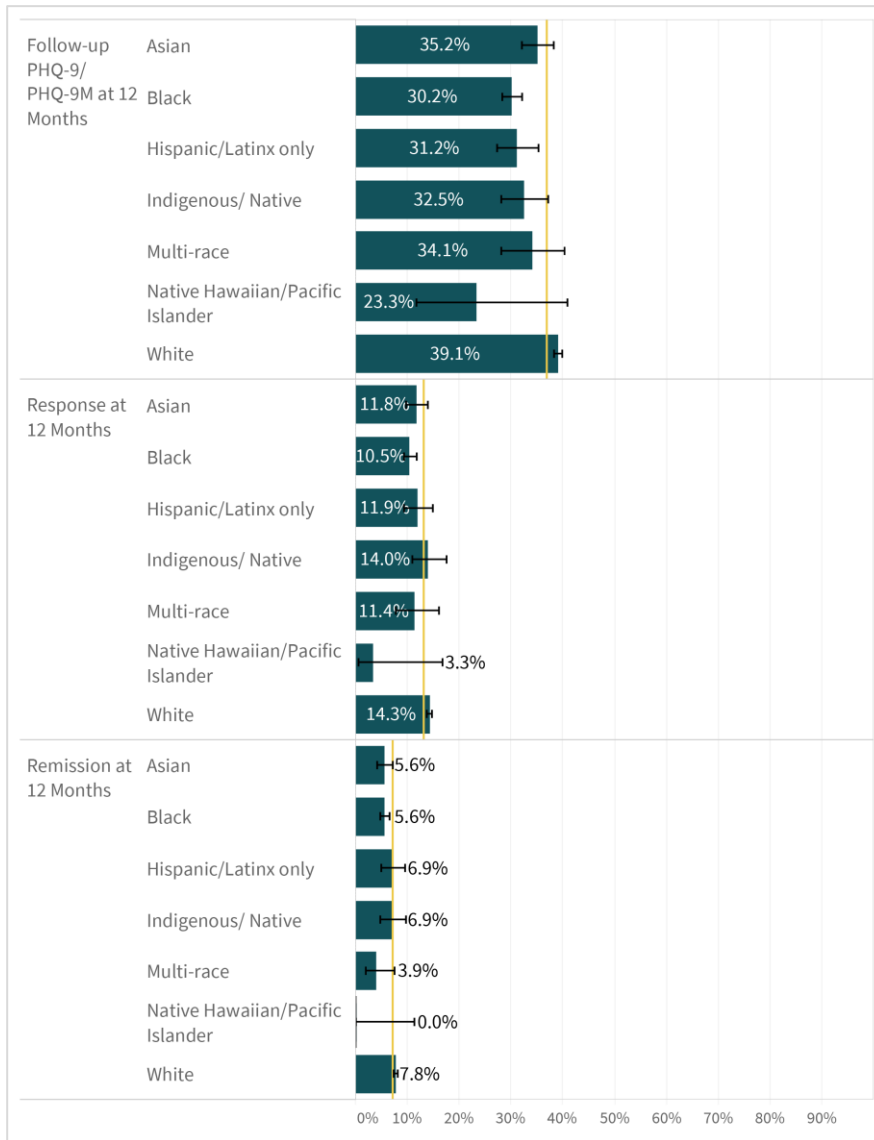
- MHCP MCO patients who are **White** have statistically significantly higher rates of **follow-up** and **response at six months**.
- MHCP MCO patients who are **Black** have statistically significantly lower rates for all three measures.

ADULT DEPRESSION SUITE:

12 Month Measures

MHCP MCO RATES BY RACE

2020 measurement year



— Represents 95% confidence interval

OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

- Follow-Up PHQ-9/PHQ-9M at 12 Months: 36.9%
- Response at 12 Months: 13.2%
- Remission at 12 Months: 7.1%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- Asian: 952
- Black: 2,302
- Hispanic/Latinx Only: 504
- Indigenous/Native: 420
- Multi-Race: 229
- Native Hawaiian/Pacific Islander: 30
- White: 15,601

KEY TAKEAWAYS

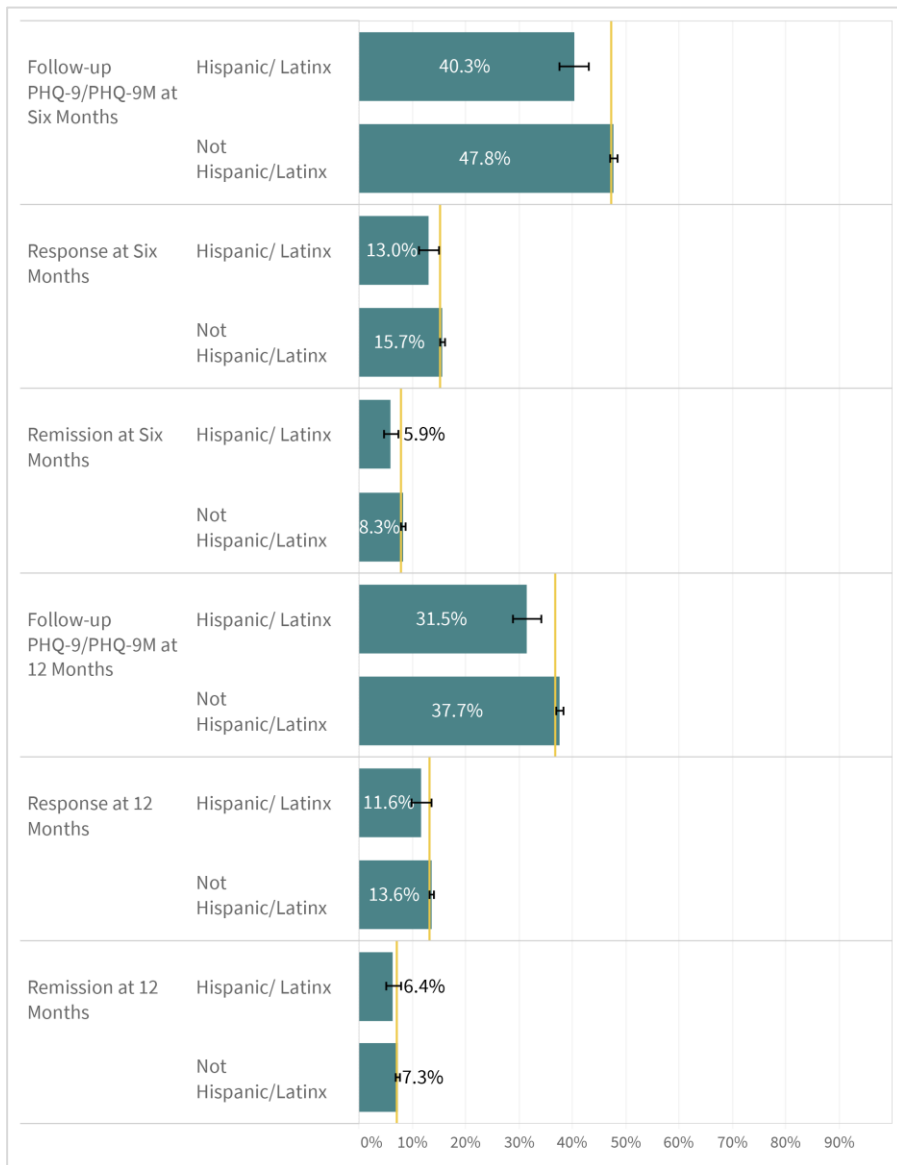
Compared to the MHCP MCO statewide averages for each 12-month measure:

- MHCP MCO patients who are **White** have statistically significantly higher rates of **follow-up** and **response at 12 months**.
- MHCP MCO patients who are **Black** have statistically significantly lower rates for all three measures.

ADULT DEPRESSION SUITE

MHCP MCO RATES BY ETHNICITY

2020 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

- Follow-Up PHQ-9/PHQ-9M at Six Months: 47.4%
- Response at Six Months: 15.3%
- Remission at Six Months: 8.0%
- Follow-Up PHQ-9/PHQ-9M at 12 Months: 36.9%
- Response at 12 Months: 13.2%
- Remission at 12 Months: 7.1%

DENOMINATORS BY ETHNICITY

(Denominators are the same for each measure)

- Hispanic/Latinx: 1,161
- Not Hispanic/Latinx: 19,470

— Represents 95% confidence interval

KEY TAKEAWAYS

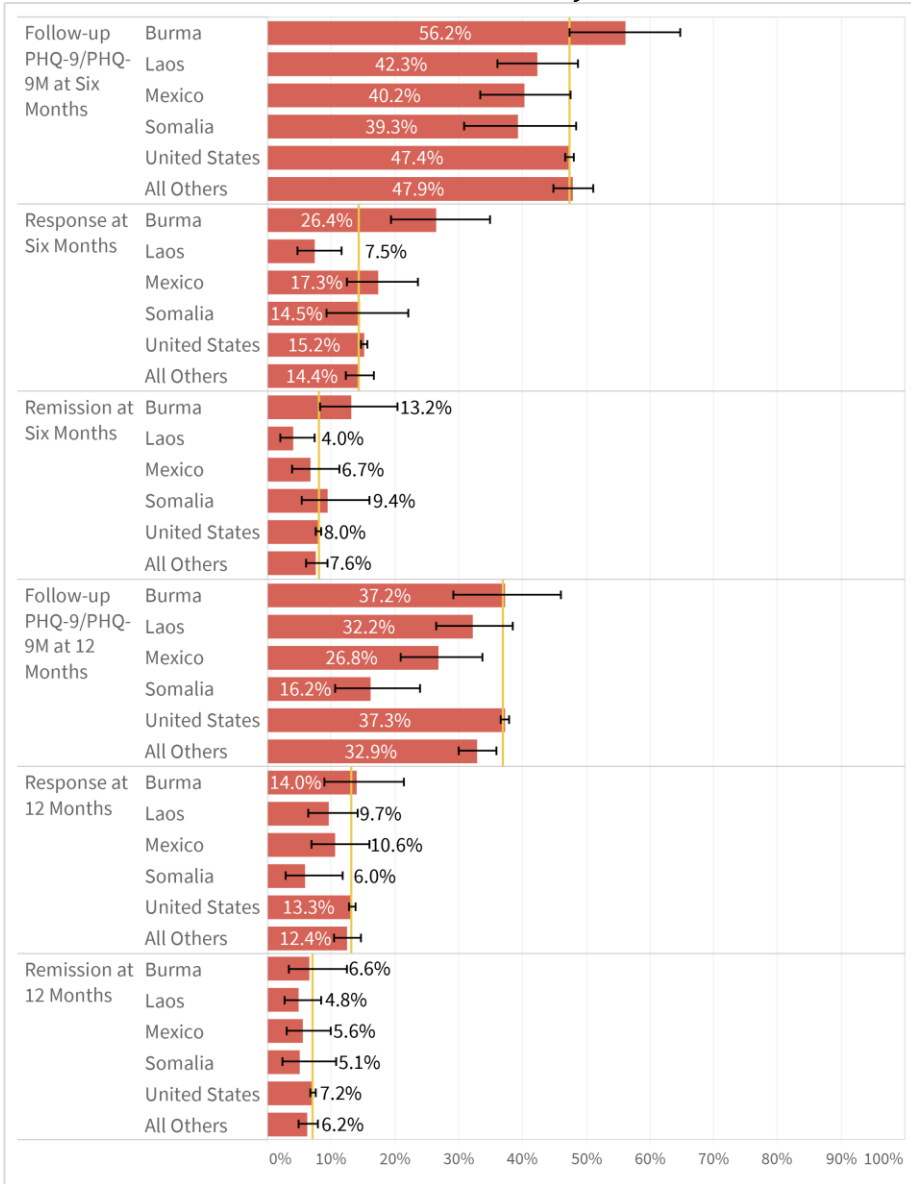
Compared to the MHCP MCO statewide averages for each measure:

- MHCP MCO patients who are **Hispanic/Latinx** have statistically significantly lower rates of **follow-up at six months, follow-up at 12 months and remission at six months.**

ADULT DEPRESSION SUITE

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

- Follow-Up PHQ-9/PHQ-9M at Six Months: 47.4%
- Response at Six Months: 15.3%
- Remission at Six Months: 8.0%
- Follow-Up PHQ-9/PHQ-9M at 12 Months: 36.9%
- Response at 12 Months: 13.2%
- Remission at 12 Months: 7.1%

DENOMINATORS BY COUNTRY

(Denominators are the same for each measure)

- Burma: 121
- Laos: 227
- Mexico: 179
- Somalia: 117
- United States: 18,211
- All Others: 972

— Represents 95% confidence interval

KEY TAKEAWAYS

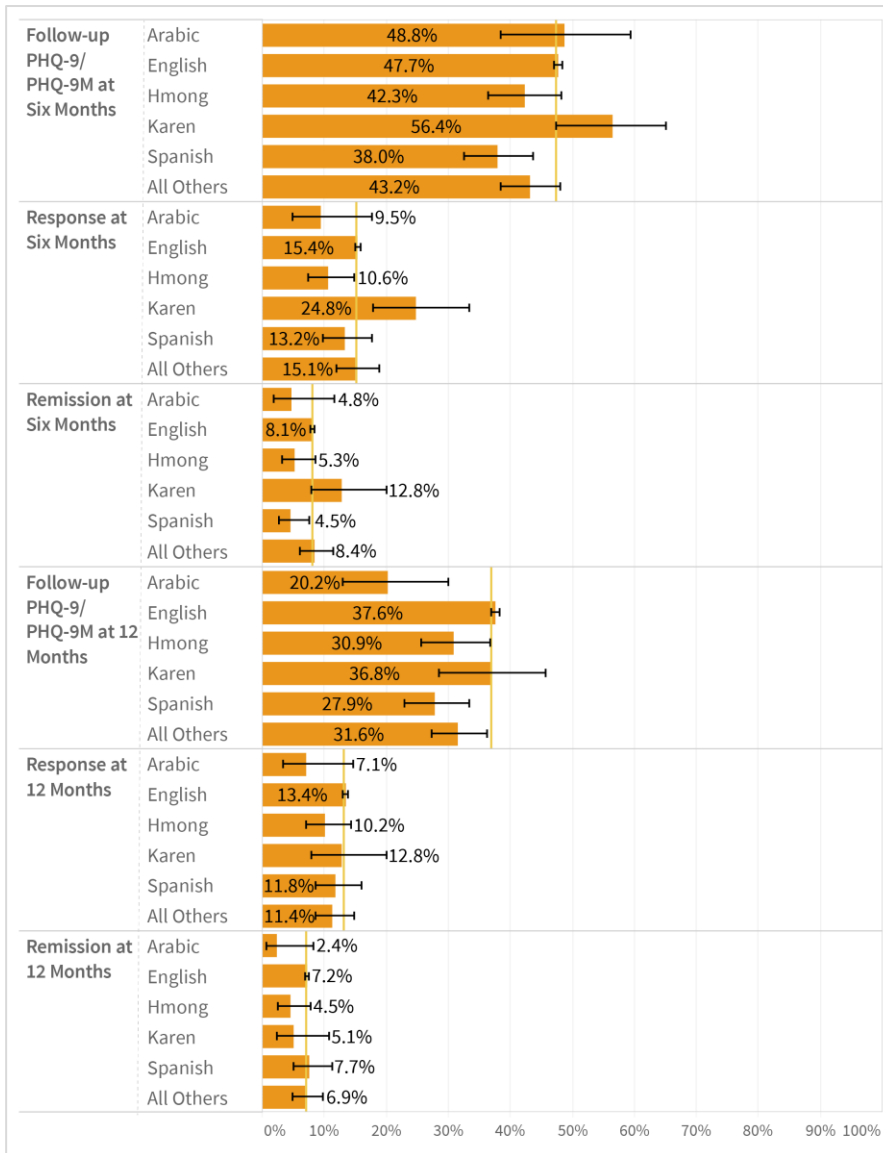
Compared to the MHCP MCO statewide averages for each measure:

- Adults from **Burma, Laos, Mexico, Somalia** and the **United States** make up the largest proportion of the MHCP MCO population for the adult depression measures.
- MHCP MCO patients from **Laos** have statistically significantly lower rates of **response** and **remission at six months**.
- MHCP MCO patients from **Somalia** have statistically significantly lower rates **follow-up** and **response at 12 months**.

ADULT DEPRESSION SUITE

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 measurement year



— Represents 95% confidence interval

OVERALL MHCP MCO STATEWIDE AVERAGES

by measure

(represented by yellow line)

- **Follow-Up PHQ-9/PHQ-9M at Six Months:** 47.4%
- **Response at Six Months:** 15.3%
- **Remission at Six Months:** 8.0%
- **Follow-Up PHQ-9/PHQ-9M at 12 Months:** 36.9%
- **Response at 12 Months:** 13.2%
- **Remission at 12 Months:** 7.1%

DENOMINATORS BY LANGUAGE

(Denominators are the same for each measure)

- **Arabic:** 84
- **English:** 20,533
- **Hmong:** 265
- **Karen:** 117
- **Spanish:** 287
- **All Others:** 405

KEY TAKEAWAYS

Compared to the MHCP MCO statewide averages for each measure:

- Adults who speak **Arabic, English, Hmong, Karen** and **Spanish** make up the largest proportion of the MHCP MCO population for the adult depression measures.
- MHCP MCO patients who speak **Spanish** have statistically significantly lower rates of **follow-up at six months, follow-up at 12 months** and **remission at six months**.

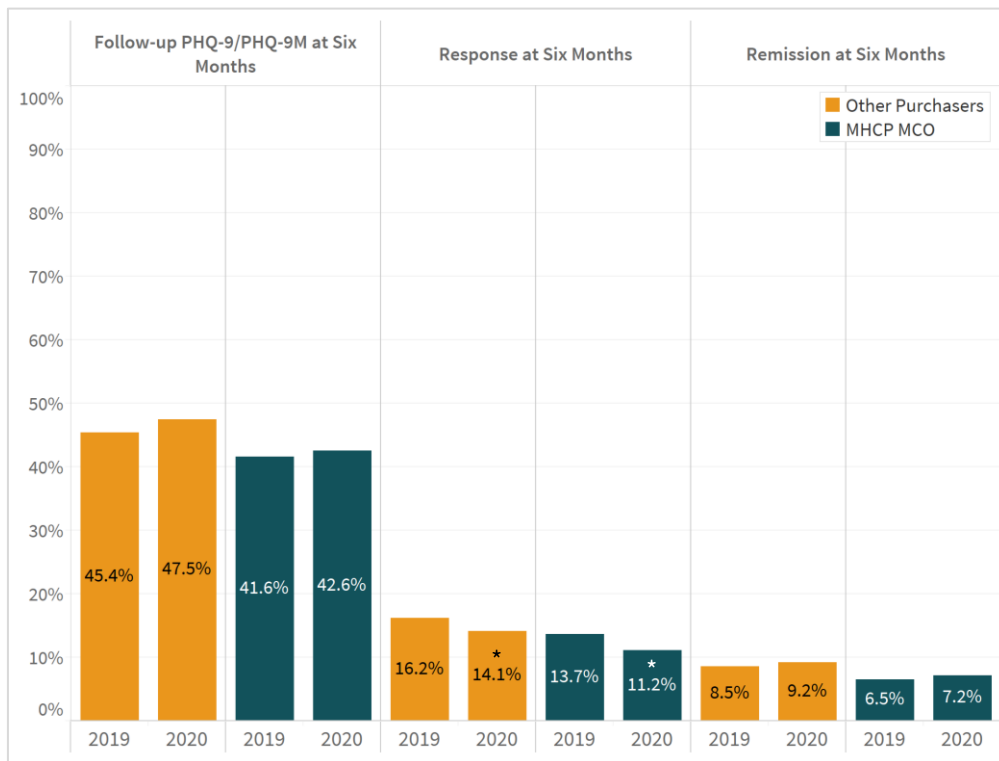
ADOLESCENT DEPRESSION SUITE

The National Survey on Drug Use and Health showed that approximately 17% (4.1 million) of adolescents in the United States experienced at least one depressive episode in 2020.²¹ Of these adolescents, it is estimated that only 41.6% received treatment for their depression.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).

[Click here for complete measure description.](#)

ADOLESCENT DEPRESSION SUITE 6 MONTH MEASURES TREND 2019-2020



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.

*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

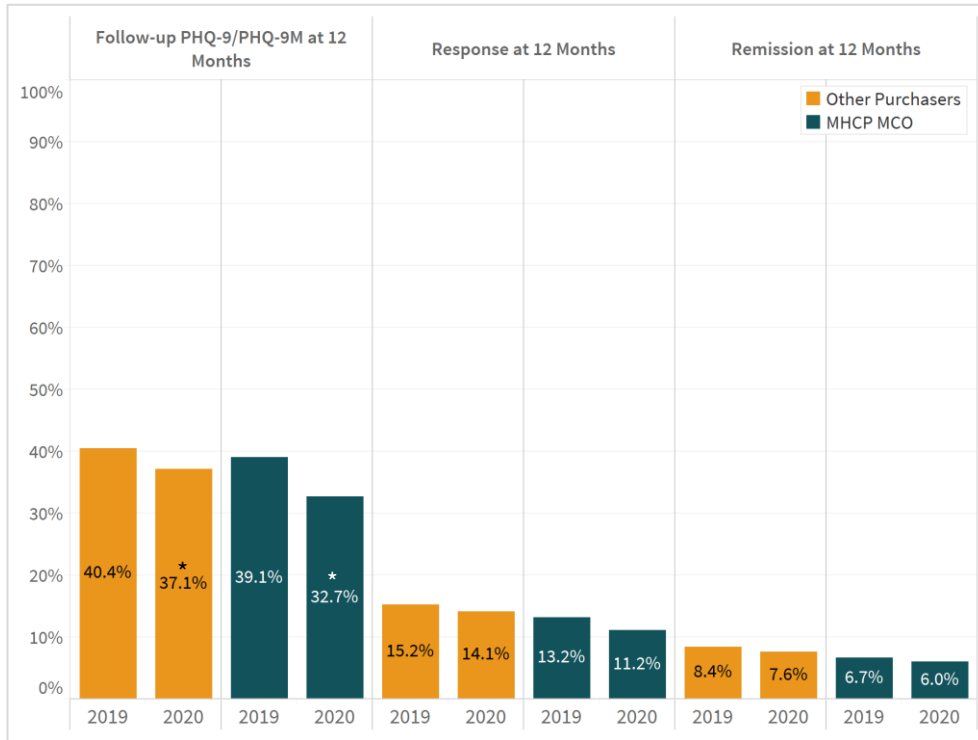
- As with the adult depression suite, there is significant room for improvement across all six-month depression measures, regardless of payer type.
- The statewide averages for the Response at Six Months measure statistically significantly decreased for both payer types in 2020 compared to 2019.
- There are statistically significant differences in performance rates by insurance type for each of the six-month measures.

ADOLESCENT DEPRESSION SUITE

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).

[Click here for complete measure description.](#)

ADOLESCENT DEPRESSION SUITE 12 MONTH MEASURES TREND 2019-2020



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.

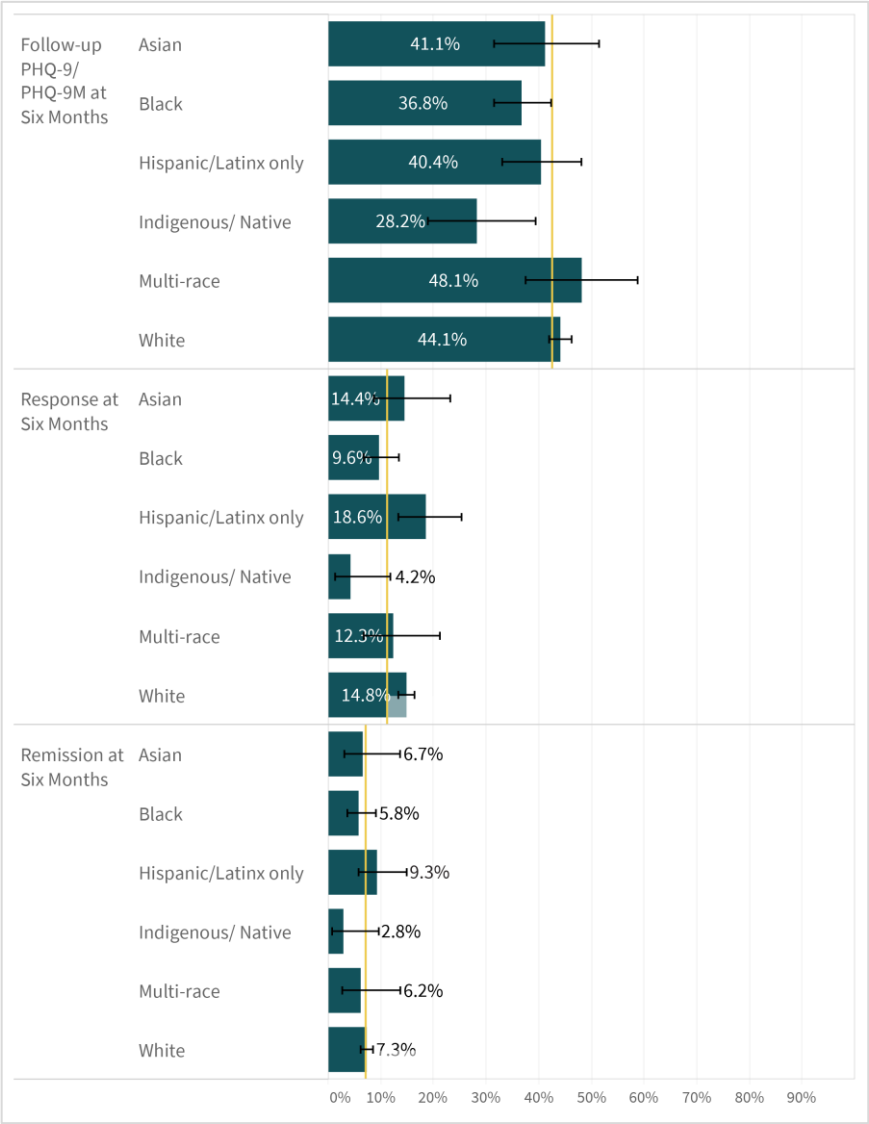
*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

- There is significant room for improvement across all 12-month depression measures, regardless of payer type.
- The statewide averages for both payer types statistically significantly decreased for the Follow-up PHQ-9/PHQ-9M at 12 Months measure in 2020 compared to 2019.
- The statewide averages for 12-month response and remission measures for both payer types did not significantly change from 2019 to 2020.
- There are statistically significant differences in performance rates by insurance type for each of the six-month measures.

ADOLESCENT DEPRESSION SUITE: Six Month Measures

MHCP MCO RATES BY RACE
2020 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

- Follow-Up PHQ-9/PHQ-9M at Six Months: 42.6%
- Response at Six Months: 11.2%
- Remission at Six Months: 7.2%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- Asian: 90
- Black: 291
- Hispanic/Latinx Only: 161
- Indigenous/Native: 71
- Multi-Race: 81
- White: 2,037

The Native Hawaiian/ Pacific Islander category had less than 30 patients reported, which does not meet the reporting threshold for reliability.

↔ Represents 95% confidence interval

KEY TAKEAWAYS

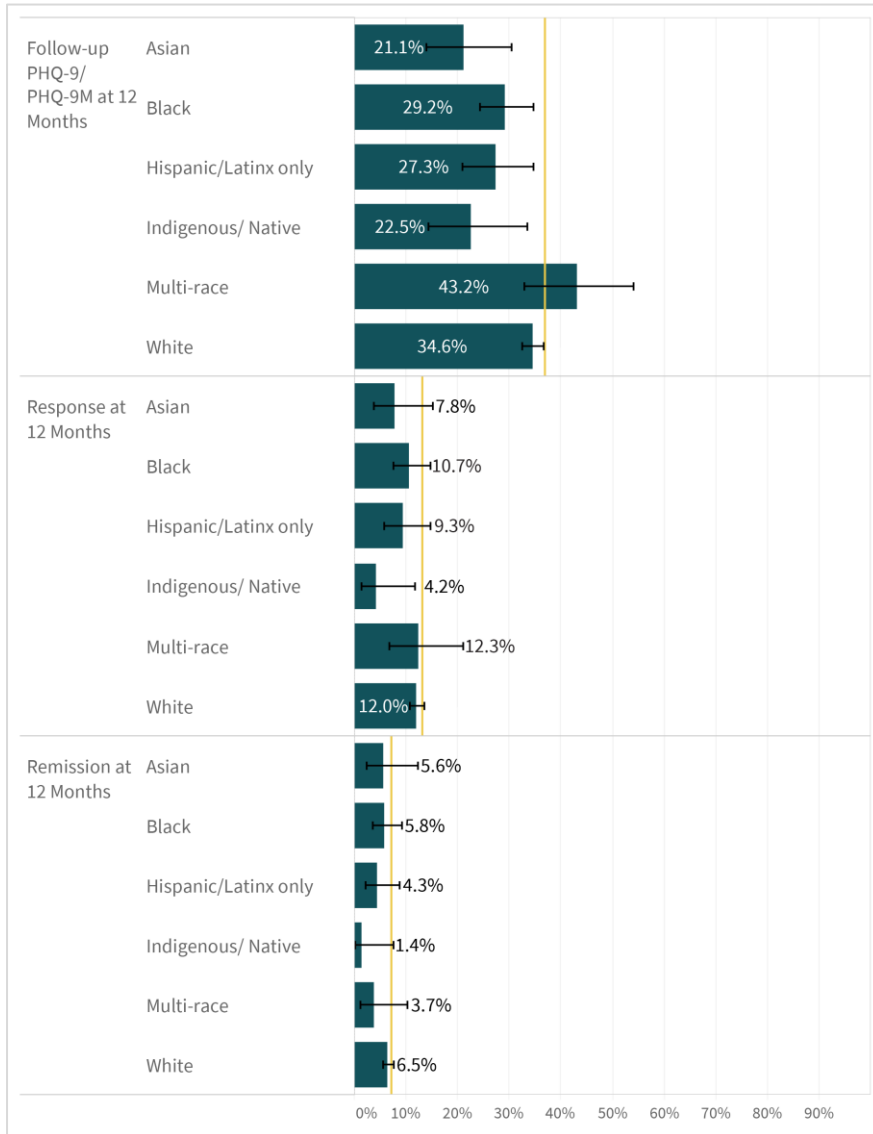
Compared to the MHCP MCO statewide averages for each six-month measure:

- MHCP MCO patients who are **Indigenous/Native** have statistically significantly lower rates of **follow-up at six months**.

ADOLESCENT DEPRESSION SUITE: 12 Month Measures

MHCP MCO RATES BY RACE

2020 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

- Follow-Up PHQ-9/
PHQ-9M at 12 Months: 32.7%
- Response at 12 Months: 11.2%
- Remission at 12 Months: 6.0%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- Asian: 90
- Black: 291
- Hispanic/Latinx Only: 161
- Indigenous/Native: 71
- Multi-Race: 81
- White: 2,037

The Native Hawaiian/ Pacific Islander category had less than 30 patients reported, which does not meet the reporting threshold for reliability.

— Represents 95% confidence interval

KEY TAKEAWAYS

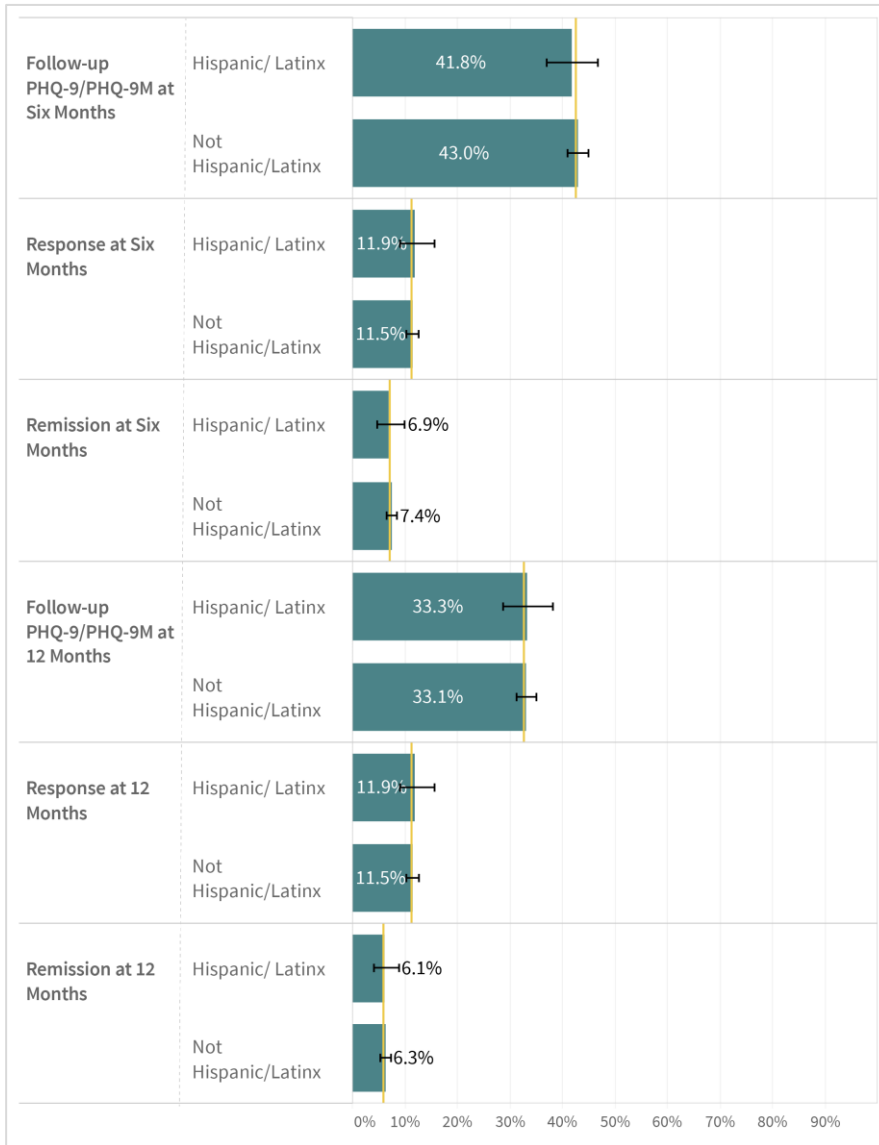
Compared to the MHCP MCO statewide averages for each 12-month measure:

- MHCP MCO patients who are **Asian** have statistically significantly lower rates of **follow-up at 12 months**.

ADOLESCENT DEPRESSION SUITE

MHCP MCO RATES BY ETHNICITY

2020 measurement year



— Represents 95% confidence interval

OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

- Follow-Up PHQ-9/PHQ-9M at Six Months: 42.6%
- Response at Six Months: 11.2%
- Remission at Six Months: 7.2%
- Follow-Up PHQ-9/PHQ-9M at 12 Months: 32.7%
- Response at 12 Months: 11.2%
- Remission at 12 Months: 6.0%

DENOMINATORS BY ETHNICITY

(Denominators are the same for each measure)

- Hispanic/Latinx: 378
- Not Hispanic/Latinx: 2,530

KEY TAKEAWAYS

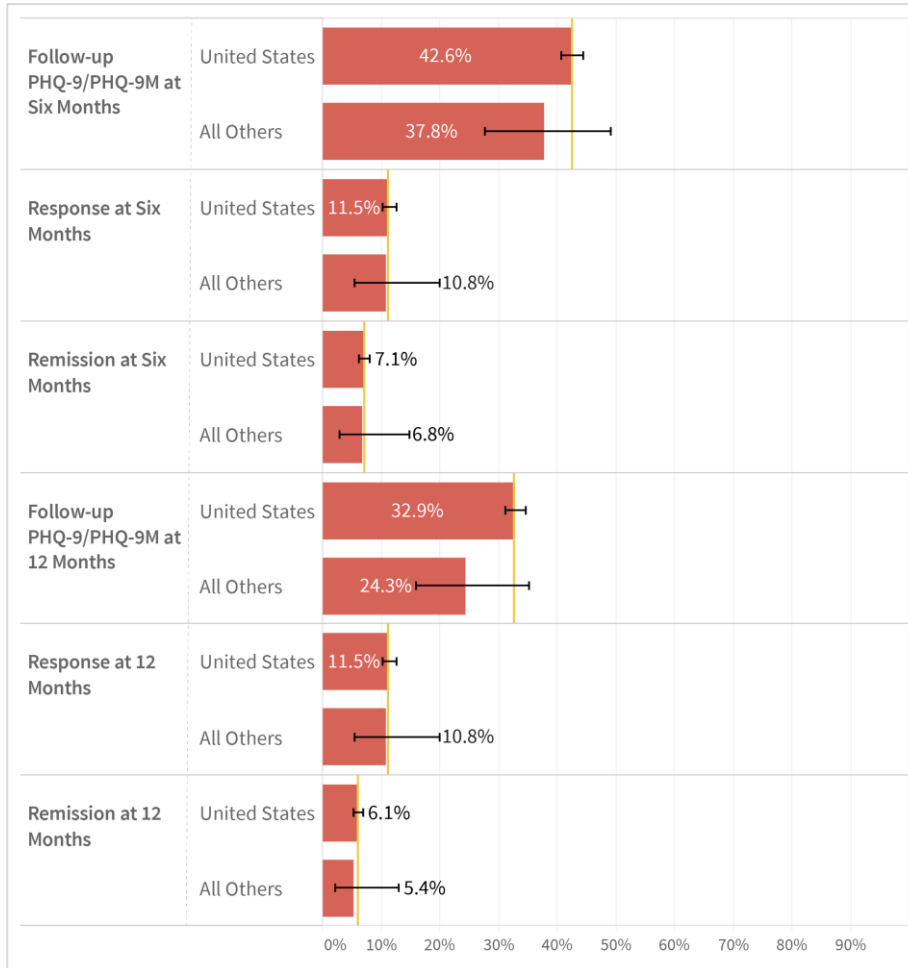
Compared to the MHCP MCO statewide averages for each measure:

- MHCP MCO patients who are of either ethnicity have average rates for all measures.

ADOLESCENT DEPRESSION SUITE

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 measurement year



— Represents 95% confidence interval

OVERALL MHCP MCO STATEWIDE AVERAGES

by measure (represented by yellow line)

- Follow-Up PHQ-9/PHQ-9M at Six Months: 42.6%
- Response at Six Months: 11.2%
- Remission at Six Months: 7.2%
- Follow-Up PHQ-9/PHQ-9M at 12 Months: 32.7%
- Response at 12 Months: 11.2%
- Remission at 12 Months: 6.0%

DENOMINATORS BY COUNTRY

(Denominators are the same for each measure)

- United States: 2,739
- All Others: 74

KEY TAKEAWAYS

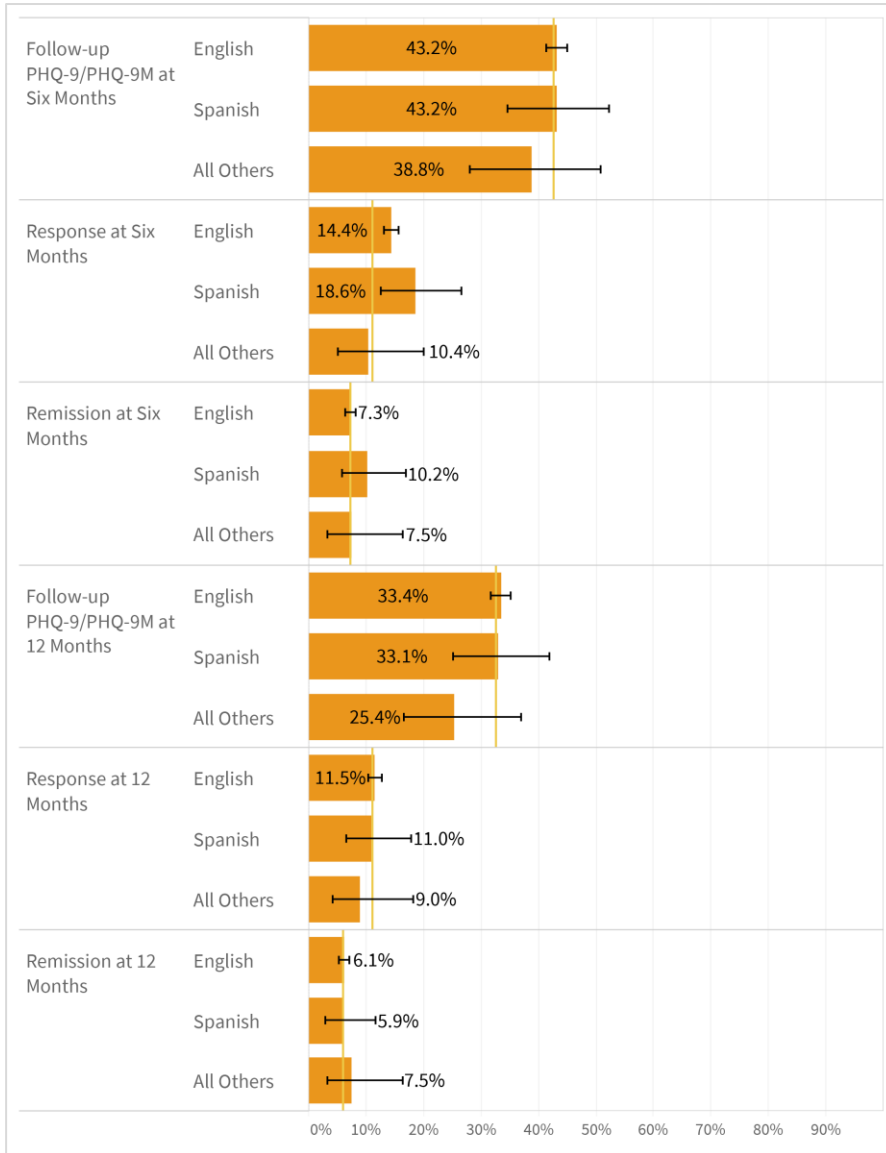
Compared to the MHCP MCO statewide averages for each measure:

- Adolescents from **the United States** make up the largest proportion of the MHCP MCO population for the adolescent depression measures. No other country had a large enough denominator (at least 30 patients) to allow comparisons.
- MHCP MCO adolescents from **the United States** have average rates compared to all measures.

ADOLESCENT DEPRESSION SUITE

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 measurement year



— Represents 95% confidence interval

OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

- Follow-Up PHQ-9/PHQ-9M at Six Months: 42.6%
- Response at Six Months: 11.2%
- Remission at Six Months: 7.2%
- Follow-Up PHQ-9/PHQ-9M at 12 Months: 32.7%
- Response at 12 Months: 11.2%
- Remission at 12 Months: 6.0%

DENOMINATORS BY LANGUAGE

(Denominators are the same for each measure)

- English: 2,888
- Spanish: 118
- All Others: 67

KEY TAKEAWAYS

Compared to the MHCP MCO statewide averages for each measure:

- Adolescents who speak **English** or **Spanish** make up the largest proportion of the MHCP MCO population for the adolescent depression measures. No other language had a large enough denominator (at least 30 patients) to allow comparisons.
- MHCP MCO adolescents who speak **English** or **Spanish** have statistically significantly higher rates of **response at six months**.

DEFINITIONS

GENERAL DEFINITIONS

95% confidence interval: The degree of certainty in which the performance rate falls between the specified range of values.

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:

- **Optimal Diabetes Care**
- **Optimal Vascular Care**
- **Optimal Asthma Control – Adults**
- **Optimal Asthma Control – Children**

Clinical Data Submission measures: Measures include:

- **Optimal Diabetes Care**
- **Optimal Vascular Care**
- **Adult Depression Suite**
- **Adolescent Depression Suite**
- **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 maintain by the National Committee for Quality Assurance (NCQA). Clinical HEDIS measures use data from the administrative or hybrid data collection methodology. These measures include:

- **Breast Cancer Screening**
- **Childhood Immunization Status (Combo 10)**
- **Controlling High Blood Pressure**

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.

DEFINITIONS

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 (MCO) programs (i.e., Medical Assistance and MinnesotaCare).

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:

- **Controlling High Blood Pressure**
- **Optimal Diabetes Care**
- **Optimal Vascular Care**
- **Optimal Asthma Control – Adults**
- **Optimal Asthma Control – Children**
- **Adult Depression: Remission and Response measures**
- **Adolescent Depression: Remission and Response measures**

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 and Adolescent Depression Suites:** Patient Health Questionnaire – 9 item version (PHQ-9/PHQ-9M)

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 Suite**
- **Adolescent Depression Suite**

The PRO-PM process measures in this report include:

- **Adolescent Mental Health and/or Depression Screening**

DEFINITIONS

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**
- **Childhood Immunization Status (Combo 10)**
- **Colorectal Cancer Screening**
- **Adolescent Mental Health and/or Depression Screening**

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

MEASURE DEFINITIONS

To see the most recent measure specifications, click on the measure names below.

- **[Breast Cancer Screening](#)**²²: The percentage of women ages 50-74 who received a mammogram during the prior two years (the measurement year or prior year)
- **[Childhood Immunization Status \(Combo 10\)](#)**²³: The percentage of children 2 years of age who had the following by their second birthday:
 - Four diphtheria
 - Tetanus and acellular pertussis (DTaP)
 - Three polio (IPV)
 - One measles, mumps and rubella (MMR)
 - Three *haemophilus influenzae* type B (HiB)
 - Three hepatitis B
 - One chicken pox (VZV)
 - Four pneumococcal conjugate (PCV)
 - One hepatitis A
 - Two or three rotavirus (RV)
 - Two influenza vaccines
- **[Colorectal Cancer Screening](#)**: The percentage of adults 51-75 years of age who are up-to-date with one of the following appropriate screenings:
 - 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 two years prior OR
 - Guaiac-based fecal occult blood test (gFOBT) or FIT during the measurement year
- **[Controlling High Blood Pressure](#)**²⁴: The percentage of adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year

MEASURE DEFINITIONS CONTINUED

- **Optimal Diabetes Care:** The percentage of patients 18-75 years of age with diabetes (type 1 or 2) whose diabetes was optimally managed as defined as achieving ALL five of the following components:
 1. HbA1c less than 8.0 mg/mL
 2. Blood pressure less than 140/90 mmHg
 3. On a statin medication, unless allowed contraindications or exceptions are present
 4. Non-tobacco use
 5. If patient has ischemic vascular disease, on a daily aspirin or antiplatelet, unless allowed contraindications or exceptions are present
- **Optimal Vascular Care:** The percentage of patients 18-75 years of age with ischemic vascular disease (IVD) whose IVD was optimally managed as defined as achieving ALL four of the following components:
 1. Blood pressure less than 140/90 mmHg
 2. On a statin medication, unless allowed contraindications or exceptions are present
 3. Non-tobacco use
 4. If patient has ischemic vascular disease, on a daily aspirin or antiplatelet, unless allowed contraindications or exceptions are present
- **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 as defined by achieving both of the following:
 1. Asthma well-controlled as defined by the most recent asthma control tool result:
 - Asthma Control Test (ACT)TM result greater than or equal to 20 (patients 12 years of age and older)
 - Childhood Asthma Control Test (C-ACT)[©] result greater than or equal to 20 (patients 11 years of age and younger)
 - Asthma Control Questionnaire (ACQ)[©] result less than or equal to 0.75 (patients 17 years of age and older)
 - Asthma Therapy Assessment Questionnaire (ATAQ)[©] result equal to 0 – Pediatric (5 to 17 years of age) or Adult (18 years of age and older).
 2. 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)
- **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 one of the specified tools below:
 - Patient Health Questionnaire – 9 item version (PHQ-9)
 - PHQ-9M Modified for Teens and Adolescents
 - Kutcher Depression Scale (KADS)
 - Beck Depression Inventory II (BDI-II)
 - Beck Depression Inventory Fast Screen (BDI-FS)
 - Child Depression Inventory (CDI)
 - Child Depression Inventory II (CDI-2)
 - Patient Health Questionnaire – 2 item version (PHQ-2)
 - Pediatric Symptom Checklist – 17 item version (PSC-17) - parent version
 - Pediatric Symptom Checklist – 35 item (PSC-35) - parent version
 - Pediatric Symptom Checklist – 35 item Youth Self-Report (PSC Y-SR)
 - Global Appraisal of Individual Needs screens for mental health and substance abuse (GAIN-SS)

MEASURE DEFINITIONS CONTINUED

DEPRESSION SUITES

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

DEPRESSION MEASURES

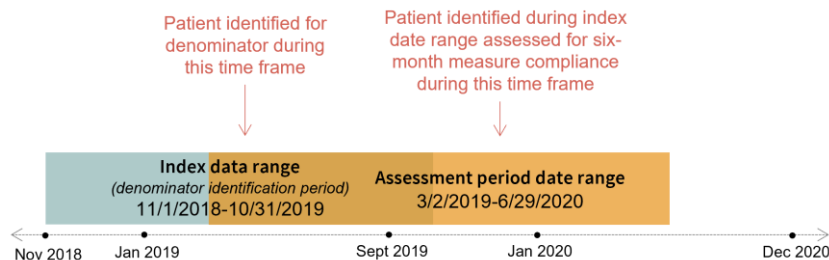
The depression measures are unique in that the time period for identifying eligible patients for the denominators do not follow the typical measurement period that the other quality measures do. The depression measures are longitudinal in design, meaning patients are followed through a period of time 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. Patients are identified as being eligible for the denominator by the following:

- **Depression diagnosis:** The patient had an encounter with an eligible provider in an eligible specialty, coded with one of the diagnosis indicating Major Depression or Dysthymia during the denominator identification period.
- **PHQ-9/PHQ-9M score greater than 9:** The patient completed a PHQ-9/PHQ-9M tool and the score was greater than 9 during the denominator identification period.
- **Age:** The patient was 12 years or older at the time of the encounter.

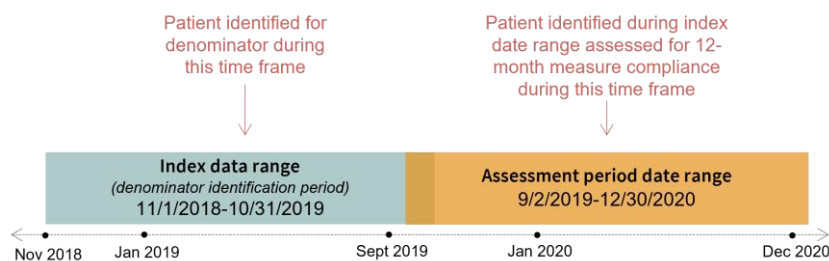
NOTE: The diagnosis of depression does not have to be new for the patient to be included in the denominator.

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 Measure Timeline



12-Month Measure Timeline



Example: A 23-year-old patient with depression was assessed at an encounter with an eligible provider on 12/2/2018 and had a PHQ-9 score of 20 (index event). Their six-month assessment period would be between 4/3/2019 and 8/1/2019. The patient would be considered numerator compliant for the six-month measures if the following was achieved during the assessment period:

- **Follow-up PHQ-9/PHQ-9M:** Patient was screened using PHQ-9/PHQ-9M tool
- **Response:** Most recent PHQ-9/PHQ-9M score was 10 or below (score reduced by 50% or more)
- **Remission:** Most recent PHQ-9/PHQ-9M score was less than 5

The patient is then assessed 12 months after the index event (10/3/2019 to 1/31/2020) using the same criteria as above.

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