Using Health Care Data and Provider Performance Measurement to Reduce Health Disparities in Minnesota's Health Care System

House File No. 1208 – Representative Nick Zerwas

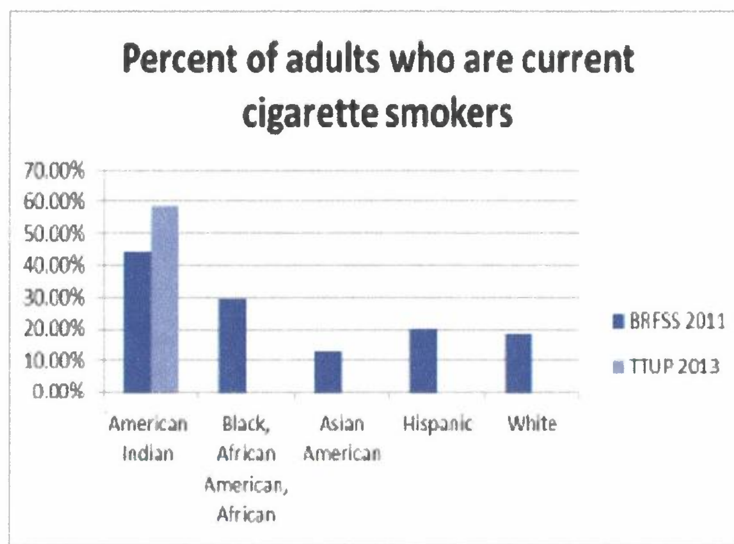
1. **Visibility. Make health disparities more visible so that actions can be taken to address them.**
    - Health care data on access, cost and quality of services does not fully reveal the health disparities experienced by people of color, American Indians/Native Americans, and other groups with socio-economic barriers because the data is not broken out by race, ethnicity, language, country of origin or other socio-economic risk factors that are correlated with health disparities.
    - Until disparities are made more visible, it will be difficult to plan programs and resources to overcome the added barriers experienced by these patients, compared to white, mainstream patients, or to measure progress or success.
    - This legislative proposal would: modify the state's existing Statewide Quality Reporting and Measurement System (SQRMS) to improve the ways in which quality and cost data provided by Minnesota hospitals and clinics are broken down or "stratified" by race, ethnicity, language, country of origin and other socio-economic characteristics of patients served.

2. **Equity. Change provider quality measures and payment rates to avoid penalizing providers who serve patients and communities impacted by disparities.**
    - The current health care system uses primarily a clinical model for setting quality standards for clinics, hospitals and other health care providers. The current system does not adequately recognize race, ethnicity, language and other social determinants of health that cause health disparities for some patients. These patients start out with poorer health and need more services and support to achieve the same health and treatment outcomes compared to mainstream, white patients. As a result, providers who serve these patients may be penalized financially by receiving inadequate payment rates and being ranked as lower quality or inefficient providers because of the patients they serve rather than their own quality or efficiency.
    - This legislative proposal would:
        1. Require SQRMS provider quality and cost measures to take into consideration the race, ethnicity, language, country of origin or other socio-demographic characteristics of patients that have an impact on provider performance.
        2. Authorize the Department of Human Services to develop a methodology for changing provider reimbursement rates under Minnesota Health Care Programs to take into consideration the higher cost, complexity and resources needed to serve patients and populations impacted by health disparities.

Example of How Health Care Provider Quality of Care Scores Are Affected by Race, Ethnicity and Socio-Economic Status

- Clinic quality scores for diabetes care are based in part on whether the patient uses tobacco. If the patient uses tobacco, the clinic fails the entire diabetes quality measure.

- Smoking rates vary dramatically by race and ethnicity:



- **Differences in patients' smoking rates directly affect a clinic's quality score**. A clinic with high clinical quality of care that serves more American Indian and African American patients will receive lower quality scores, may receive lower payment rates, and may not be included in some health insurance plans' provider networks unless changes are made to the quality measurement system.

- **Without changes, the current system will reduce access to needed care and services for patients** because it most directly harms those clinics that are located in communities with diverse populations or that specialize in providing culturally appropriate care and additional services to overcome socio-economic barriers. Clinics may be forced to make cuts, reduce services or close. It also creates incentives for clinics to avoid serving patients with racial, ethnic or socioeconomic complexities and needs.

Examples of the Need for Better Data on Health Disparities by Racial and Ethnic Group

Colorectal Cancer Screening: Minneapolis

- **Overall Rate for "Black" Patients: 54%**
  - **Rate for Somali Speaking Black Patients: 18%**

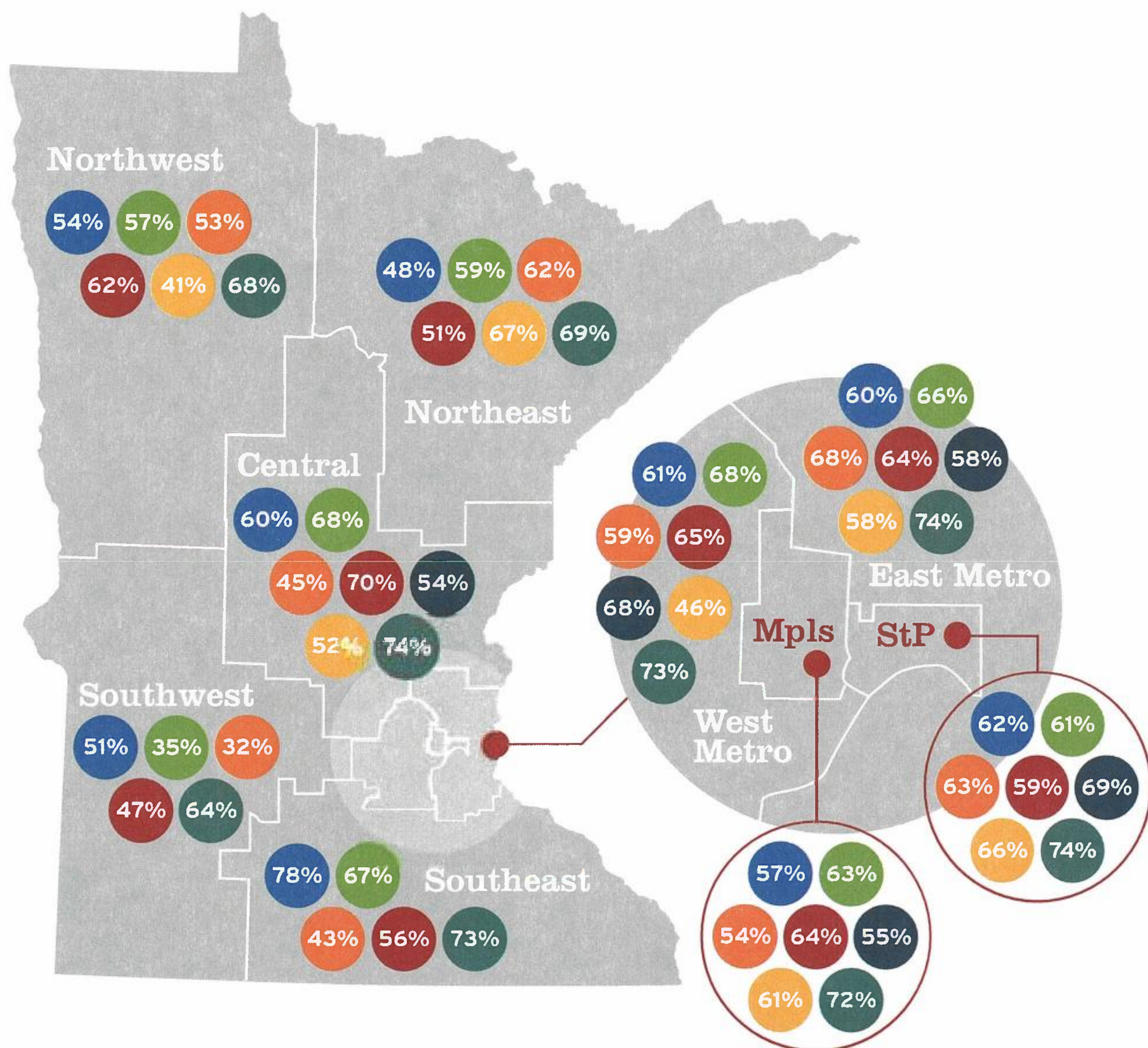
Optimal Diabetes Care: Minneapolis

- **Overall Rate for "Asian" Patients: 44%**
  - **Rate for Hmong Speaking Asian Patients: 26%**
  - **Rate for Vietnamese Speaking Patients: 51%**
  - **Rate for Cantonese Speaking Patients: 73%**

The attached charts from a Minnesota Community Measurement report based on data from a voluntary pilot project show the importance of breaking out data into more categories of race and ethnicity.

Colorectal Cancer Screening Rates by Race

- American Indian or Alaskan Native
- Asian
- Black or African American
- Multi Racial
- Native Hawaiian or Other Pacific Islander
- Some Other Race
- White



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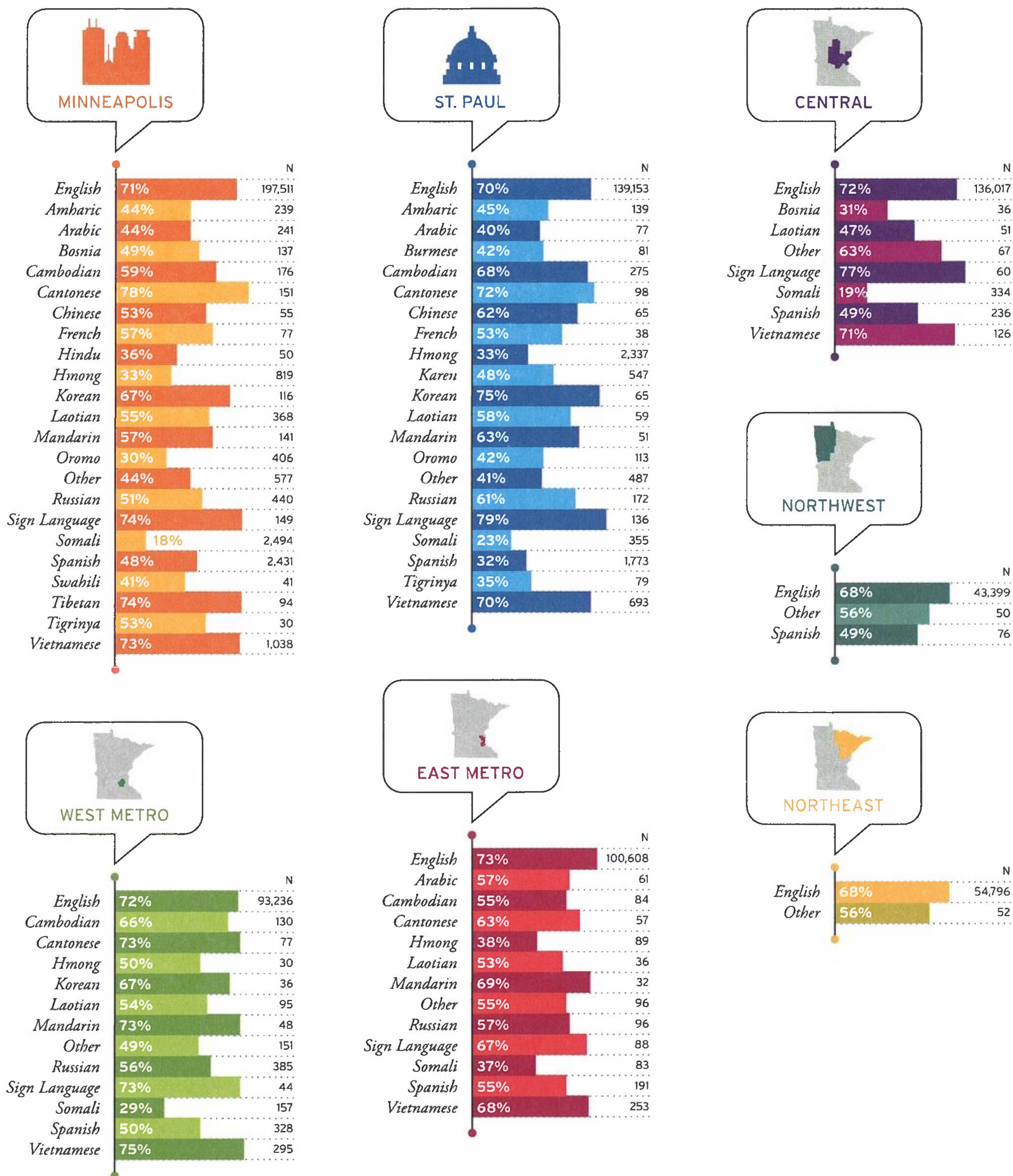
Colorectal Cancer Screening Rates by Preferred Language



N = The total number of patients within that REL or geographic category (denominator), out of which the percentage were screened.

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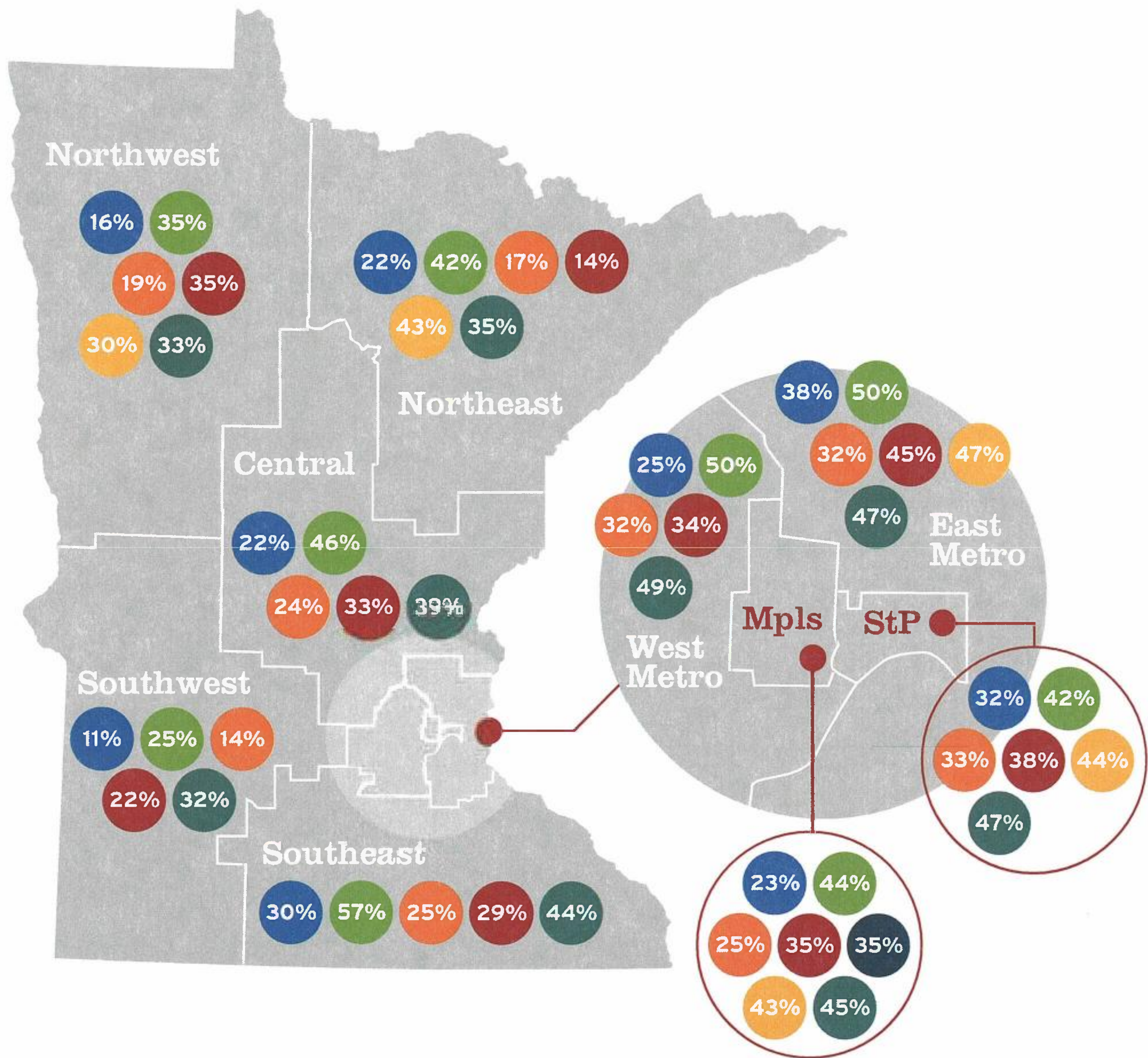
Optimal Diabetes Care Rates by Race

- American Indian or Alaskan Native
- Asian
- Black or African American
- Multi Racial
- Native Hawaiian or Other Pacific Islander
- Some Other Race
- White



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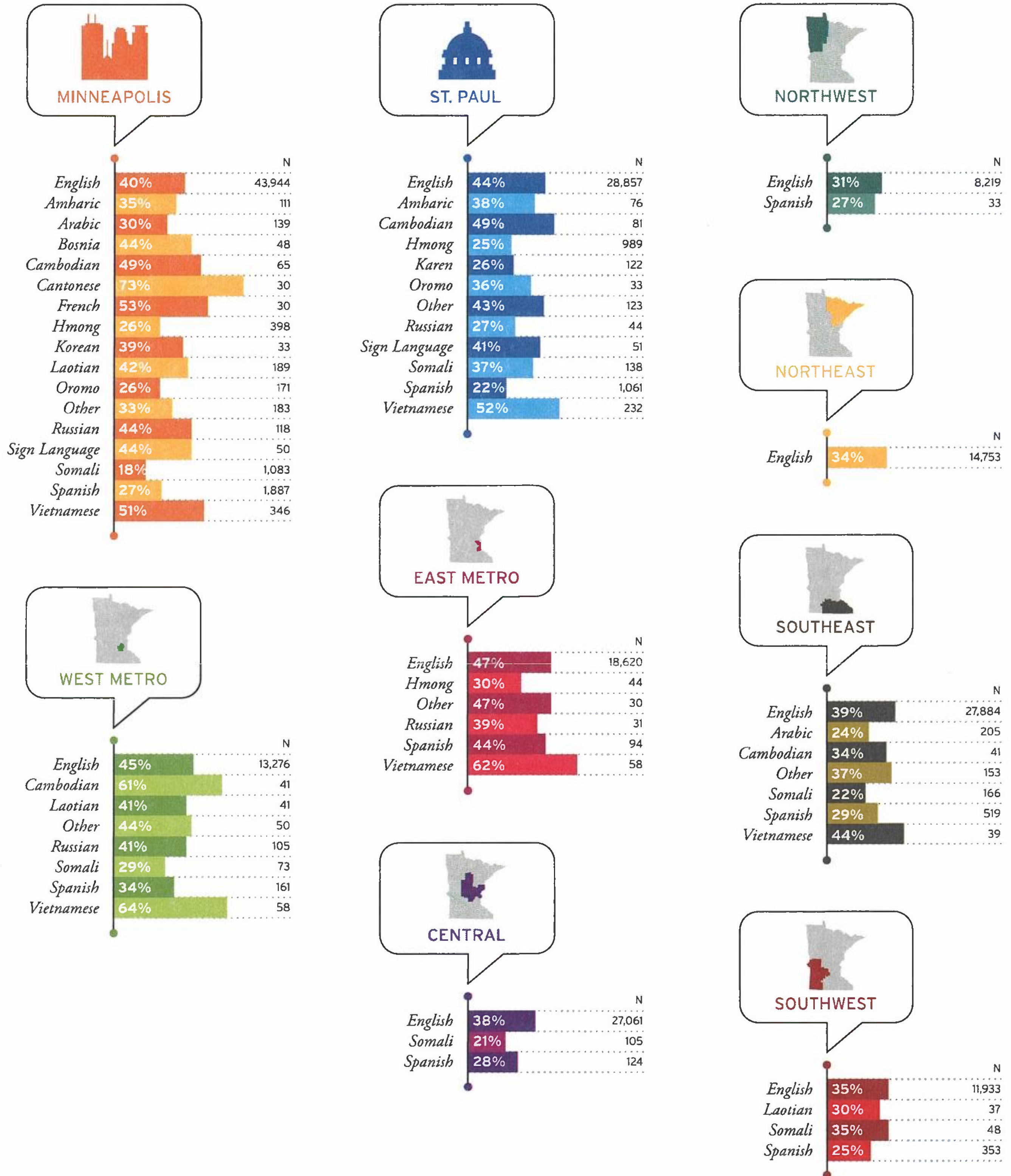
Optimal Diabetes Care Rates by Preferred Language



N = The total number of patients within that REL or geographic category (denominator), out of which the percentage received optimal care.

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