REPORT SUMMARY TO COMMITTEE

TO: CalViva QI/UM Committee

FROM: Marianne Armstrong, Population Health and Clinical Operations

COMMITTEE DATE: March 21, 2024

SUBJECT: PHM Assessment 2023

Summary:

The Population Analysis reflects the following key findings:

- Top social determinants/drivers of health (SDoH) factors impacting CalViva Health: Smoking, Teen Birth, Air Pollution.
- Top needs of child and adolescent members: Pulmonary conditions
- Top needs of members with disabilities: Cardiovascular and Pulmonary conditions
- Top needs of members with serious and persistent mental illness (SPMI): Anxiety and Mood disorders
- Top Race/Ethnicity: Hispanic, White, Black, Asian
- Top language groups with Limited English Proficiency: Hispanic, Asian (SE Asian/Laotian Other)
- Top Health Conditions: Pulmonary, Cardiac, and Pregnancy

Purpose of Activity:

The purpose of the Annual Population Analysis is to:

1. Assess the needs and characteristics of the enrolled population, including review of the impact of SDoH;
2. Identify key sub-populations and determine their needs;
3. Assess the needs of child and adolescent members;
4. Assess the needs of members with disabilities;
5. Assess the needs of members with SPMI;
   Evaluate the extent to which current organization-wide population health management activities and resources address the needs identified in this analysis and determine if modifications are needed to better meet the needs of the enrolled population;
6. Evaluate the integration of community resources into population health management activities to address member needs not covered by the benefit plan and make recommendations if changes are needed.

Methodology:

- Data Sources and Tools:

  Data is combined from multiple sources to use in population and program eligibility process. Data elements from multiple sources are stored in data warehouses. Data from the warehouse is extracted into a predictive modeling tool, Impact Pro, a licensed proprietary model. This predictive

modeling tool was developed to identify those individual members with high-risk for several parameters, for example: readmission, opioid use, and behavioral health. The Tool can be sorted by those risks and includes an engagement score: those members most likely to respond to active intervention. It is used to generate a prioritized list of members for a range of activities, for example, care management, disease management, lists for participating physician groups (PPG)/providers for various Care Management (CM) interventions. Care Managers also use Impact Pro to find information on specific members, such as diagnoses, care gaps, medications, and utilization. In addition to Impact Pro, web-based customizable report generating systems, MicroStrategy/Centelligence/Snowflake, are used to produce adjunctive analytical reports that support tracking the goals of clinical programs.

- The following data is pulled from the main data warehouse into the risk stratification tool housed in Impact Pro:
    - medical and behavioral claims/encounters,
    - pharmacy claims,
    - laboratory results,
    - health appraisal results,
    - electronic health records,
    - data from health plan UM and/or CM programs,
    - advanced data sources such as all-payer claims databases or regional health information.

- Time Period of Data: January 2023 through December 2023

- Line of Business: Medicaid

- Age Ranges:
  Age cohorts are the following: Birth to age 19, age 20 to 64, and ages 65 and over.
  Children and adolescents are defined as: Age 2 through age 19.
  Adults: Unless otherwise specified, adults are age 20 and older.

- Methods used to identify persons with disabilities: Annually, a cohort of members with disabilities is identified and assessed for needs to determine the appropriateness and adequacy of the available clinical programs. A member with a disability is defined as needing assistance with Activities of Daily Living (ADL). Identification criteria used in this analysis are members with one or more of the following: 1) Power Wheelchair 2) Home Hospital Bed 3) Hoyer Lift. Analysis of this cohort was evaluated by diagnostic categories for acute inpatient admits.

Methods used to identify members with Serious and Persistent Mental Illness: A cohort of members with SPMI was identified and assessed for needs to determine the appropriateness and adequacy of the available clinical programs. Severe and persistent mental illnesses are defined as diagnoses such as schizophrenia, psychosis and bipolar disorder. Identification criteria used in this analysis are members prescribed one or more of the medications on the HEDIS SSD NDC list (See Appendix A). Analysis of this cohort consisted of diagnostic categories and percent of members with inpatient admissions, readmissions, emergency department utilization, and those receiving at least 3 outpatient medication management visits in 12 months.

Data/Results:

Age/Gender and Race, Ethnicity, Cultural and Linguistic Needs Analysis

2023

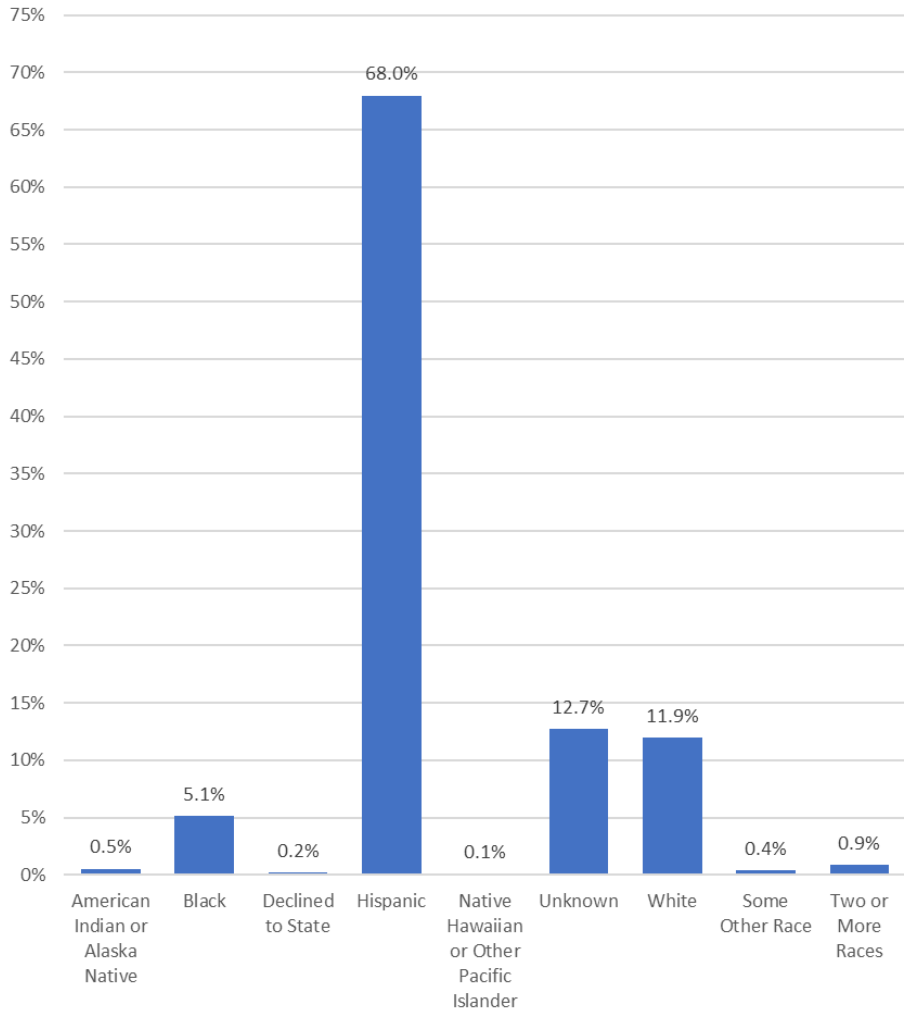
Total Members	% Male	% Female	% Age 0-19	% Age 2-19	% Age 20-64	% Age 65 or >
425,527	46.1%	53.9%	42.8%	39.4%	50.9%	6.4%

Gender and Age Distribution

Female membership is larger than male membership by 8%. The highest volume age-group are adults aged 20-64 followed by children aged 0-19. Seniors represent the lowest age segment for CalViva Health.

Plan Race/Ethnicity

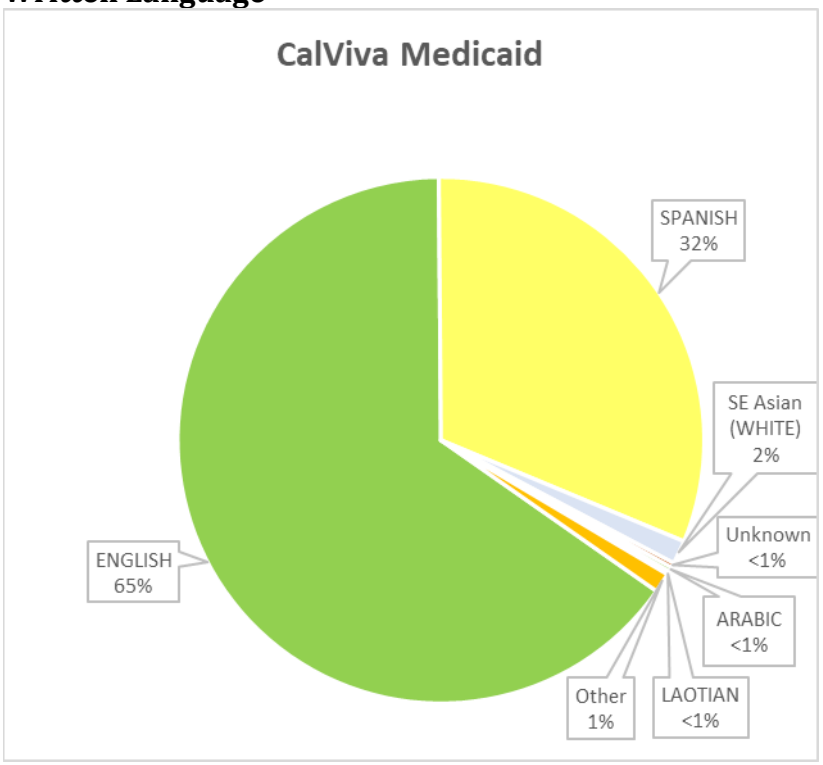
DATA SOURCE: Data collected directly from either the Enrollment File or member-reported information via customer service calls, or member reported race/ethnicity via the California Immunization Registration System (CAIR).



Details of Race & Ethnicity – Preferred Language

DATA SOURCE: Preferred written and spoken language are sourced from either the Enrollment File or member-reported information via customer service calls.

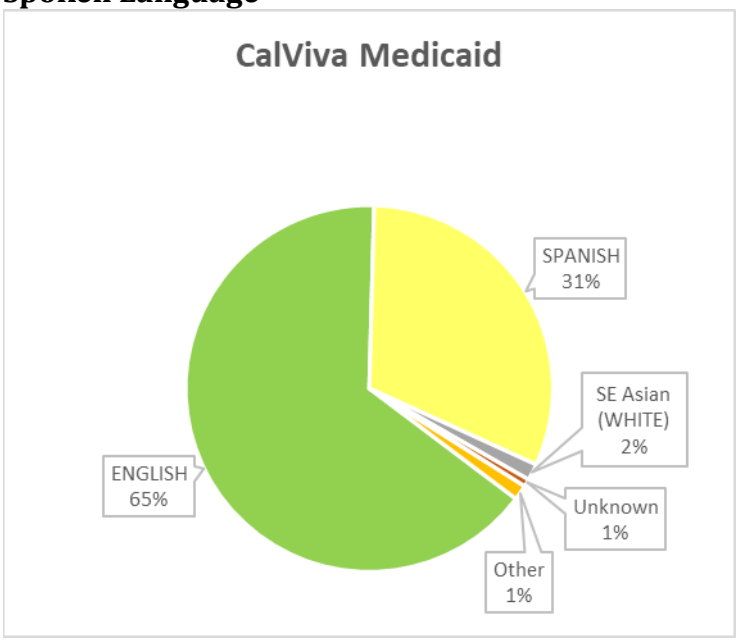
Written Language



Language	Count
English	*280,546*
Spanish	*135,211*
SE Asian (White)	*6,269*
Unknown	*1,284*
Arabic	*1,191*

The written languages are predominately English (65%) and Spanish (32%).

Spoken Language

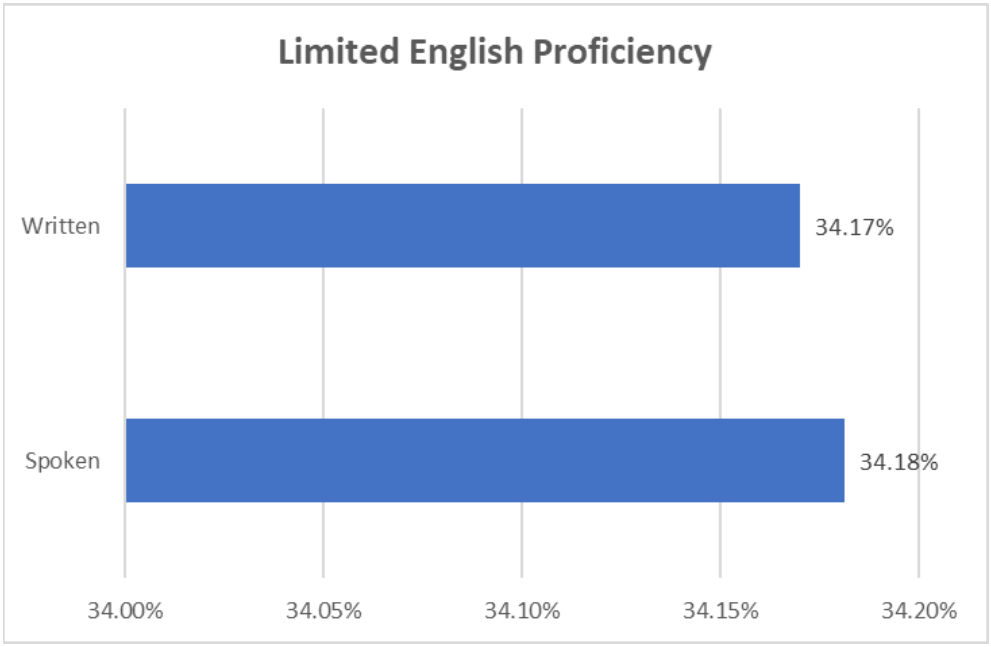


Language	Count
English	280,511
Spanish	135,201
SE Asian (White)	6,300
Unknown	2,892
Other	5,678

The spoken languages are predominantly English (65%) and Spanish (31%).

Details Race and Ethnicity and Limited English Proficiency

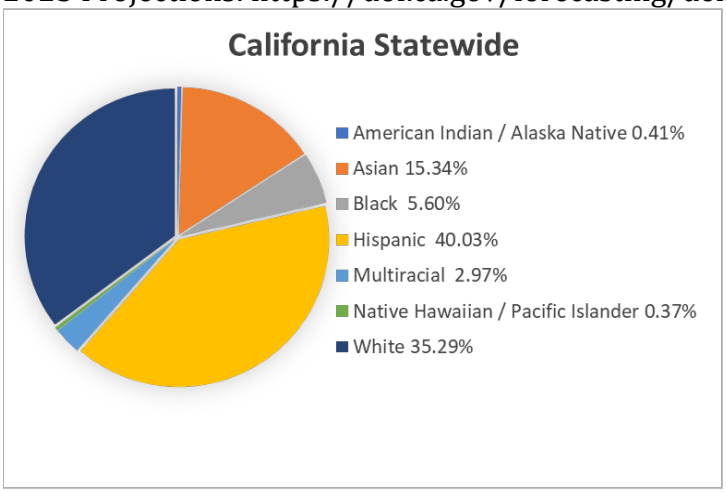
DATA SOURCE: Limited English Proficiency is determined based on preferred written and spoken language sourced from either the Enrollment File or member-reported information via customer service calls.

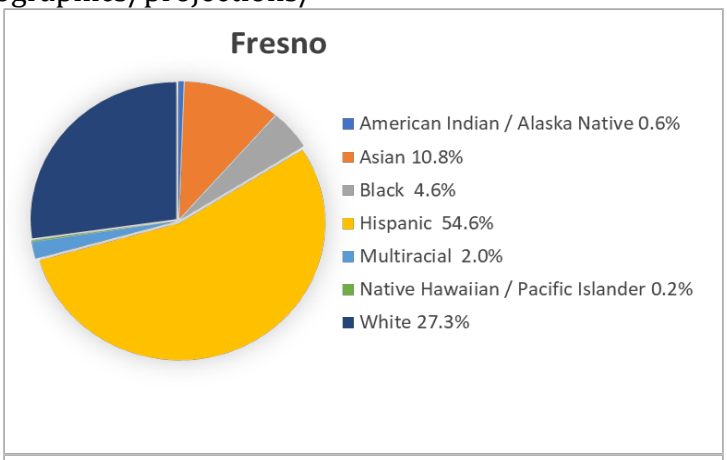


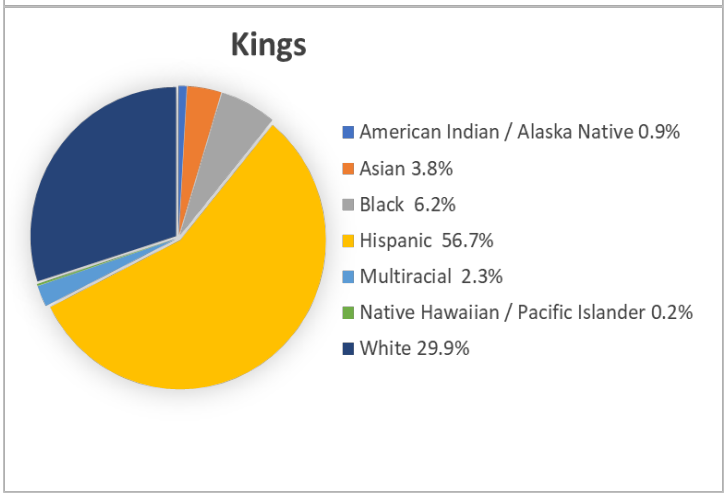
Approximately 34% of members reflect limited English proficiency.

All California Race/Ethnicity

DATA SOURCE: State of California Department of Finance, Projections, Total Population by Race/Ethnicity, 2023 Projections: https://dof.ca.gov/forecasting/demographics/projections/







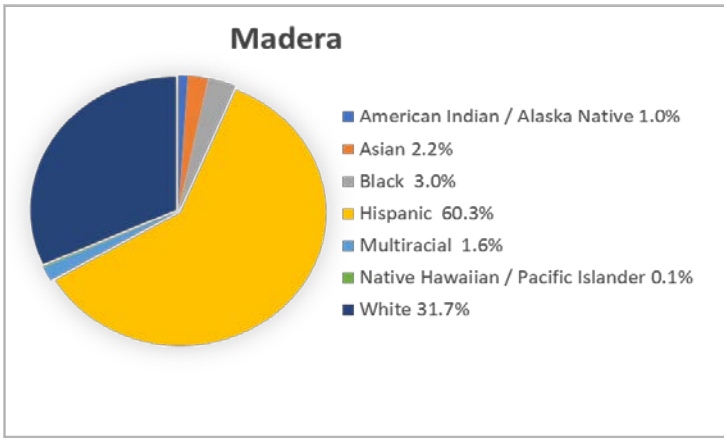
Based on public sources, race and ethnicity vary by region in California, with Hispanic/Latino comprising only 40% of the population in the entire state. However, in the counties CalViva serves, the Hispanic population ranges between 55-60%.

In Fresno, nearly 11% of the population is Asian and the White population is the lowest of the counties CalViva represents at 27%.

In Kings county the percentage of Black/African American people is highest at over 6%.

Madera county reflects both the highest Hispanic (60.3%) and White (31.7%) populations and lowest

in all other races for the counties that CalViva represents.



Race and Ethnicity Analysis

CalViva Health Medicaid membership is primarily Hispanic (68%), with White as the second most populous at just under 12%. There are 5.1% Black/African American, 0.5% American Indian or Alaska Native, 0.1% Native Hawaiian or Other Pacific Islander. The percentage unlisted (unknown) is 12.7% and there were 0.4% of combined other races. The preferred language data indicates a 2-3% Asian (SE Asian/Laotian/Other) population.

California Latino / Hispanic Health Needs Based on Risks

From Latino Health Statistics: (cretscmhd.psych.ucla.edu/healthfair/pdf)

- Heart disease, cancer, stroke, and diabetes account for nearly 60 percent of all deaths
- Risk Factors:
    - Diet
        - Only 38% of adults consume the recommended amounts of fruits and vegetables
        - 70% report that fruits and vegetables are hard to buy in fast food restaurants
        - 64% say that fruits and vegetable are hard to get at work
        - 41% say that fruits and vegetables are too expensive
        - 20% say they take too much time to prepare
        - 13% report they are not in the habit of eating them
    - Food Security
        - ~40% of low-income adults could not afford food or had to forego other basic needs for food
    - Physical Activity
        - Only 43% engage in 30 minutes five days a week
        - 30% did not engage in physical activity outside their regular job
        - 45% of 5th graders and 57% of 9th graders did not pass the aerobic capacity test
    - Obesity
        - 40% are overweight
        - 29% are obese
        - About 30% of adolescents are overweight (or at risk)
    - Chronic Disease
        - Cardiovascular disease accounted for 23% of deaths
        - ~19% have high blood pressure
        - Cancer is the second leading cause of death (21%)
            - Less cancer screening than Caucasian and Black
                - 64% of men aged 50 or greater never had colorectal cancer exam
                - Half of women reported never having a mammogram

- Diabetes
  - 1.5 times higher than non-Latino White
    - Increased from 5.7 to 7.2 % from 1995-2004.
  - 5% of all deaths
  - 8% of those 20 years or older
  - 25% of those age 45-75

Black/African American Health Needs Based on Risks

From US Department of Health and Human Services, Office of Minority Health (minorityhealth.hhs.gov):

- Death rate for African Americans was generally higher than Whites for heart disease, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide.
- Sickle Cell disease is found in this population, although generally low for Health Net with a lower population of Black/African American.

Asian American Health Needs Based on Risks

From the US Department of Health and Human Services, Office of Minority Health (minorityhealth.hhs.gov):

- Asian American are most at risk for the following health conditions: cancer, heart disease, stroke, unintentional injuries, and diabetes.
- High prevalence of COPD, Hepatitis B, HIV/ AIDS, smoking, liver disease, and tuberculosis (in 2019, 33 times more common among Asians).

Health Outcomes from Public Data Sources

Health Outcomes vary by Race/Ethnicity, according to data present in www.countyhealthrankings.org, and since Race/Ethnicity varies by county and region, this, in addition to other SDOH, help drives the differences seen in health outcomes for CalViva Health members.

According to www.countyhealthrankings.org:

Differences in Health Outcome Measures among Counties and for Racial/Ethnic Groups in California

	Healthiest CA County	Least Healthy CA County	AI/AN	Asian/PI	Black	Hispanic	White
Premature Death (years lost/100,000)	3,100	11,600	9,300	3,100	9,700	4,700	5,700
Poor or Fair Health (%)	11%	18%	16%	10%	16%	31%	10%
Poor Physical Health Days (avg)	3.0	4.2	4.3	2.1	4.7	3.8	3.4
Poor Mental Health Days (avg)	3.3	4.4	2.0	2.4	4.4	3.2	3.9
Low Birthweight (%)	6%	7%	7%	8%	12%	6%	6%

American Indian/Alaskan Native (AI/AN), Asian/Pacific Islander (Asian/PI)

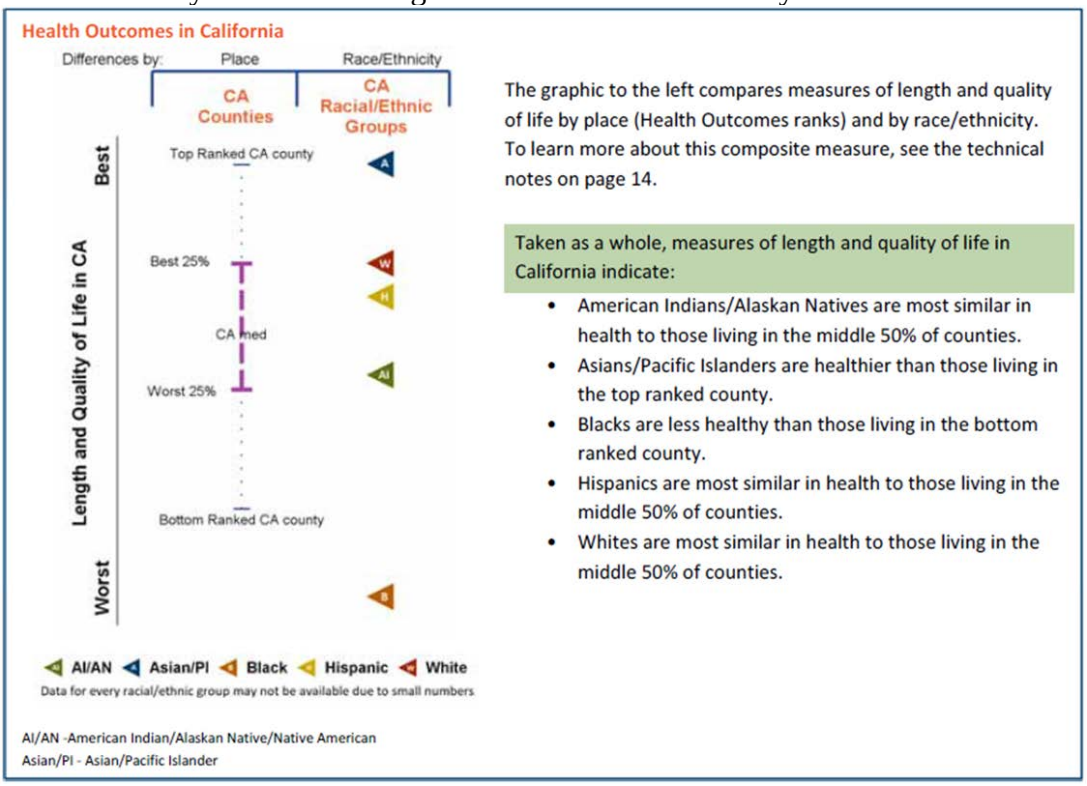
N/A = Not available. Data for all racial/ethnic groups may not be available due to small numbers

The rate of premature death (most years lost per 100 thousand), is lowest among Asians and Pacific Islanders (PI) (3.1 K/100 K). American Indians and Alaskan Natives (AI/AN) and Blacks have about 3 times that rate (9.3K & 9.7/100/K0. Whites and Hispanics statewide are somewhat higher than the healthiest county at 4.7 K and 5.7 K/100 K. The percent of low birth weights is high (greater than the least health county) in Asian/Pacific Islanders (8%) and in Blacks (12%).

The self-reporting of poor or fair health are not aligned with premature death. For example, American Indians/Alaskan Natives and Blacks only self-report poor or fair health half as often as Hispanics, despite having double the rate of premature death. Poor physical health days in the past 30 days are in alignment with premature death, with AI/AN and Blacks reporting 4.3 and 4.7 days, Asians 2.1 and Hispanics and

Whites 3.8 and 3.4. The lowest number of self-reported poor mental health days is among AI/AN and highest among Blacks.

- American Indians/Alaskan Natives as well as Hispanics and Whites are most similar in health to those living in the middle 50% of counties (as ranked by length and quality of life)
- Asians/Pacific Islanders are healthier than those living in the top ranked county
- Blacks are less healthy than those living in the bottom ranked county



Source: [www.countyhealthrankings.org.](http://www.countyhealthrankings.org)

Addressing Member Needs

The Plan tailors care management support based on members' cultural and linguistic needs, including addressing barriers. This is supported by a robust Health Equity department that evaluates health disparities and implements solutions. As linguistic needs change throughout the life span, Plan members may require translation of materials into alternative formats, such as large print or accessible electronic formats. In addition to translation services, the Plan also imposes maximum reading grade level requirements for member materials in order to ensure that members' health literacy levels do not impede understanding of their health care, regardless of cultural or linguistic background.

Social Determinants/Drivers of Health (SDoH) and Health Outcomes

According to the County Health Rankings and Roadmaps (www.countyhealthrankings.org) CalViva counties experience higher rates compared to California of the following social economic contributing factors. Refer to the full comparision in Appendix B:

- premature death,
- percentages of adult smoking
- adult obesity
- physical inactivity
- excessive drinking
- teen births

- children in poverty
- injury deaths
- air pollution
- ratio of population to primary care physicians and mental health providers (limted access)
- Fresno and Kings counties experience higher sexually transmitted infections

CalViva counties compared to California overall have lower rates of

- access to exercise opportunities
- Kings and Madera counties experience lower percentage of flu vaccintation completion
- education (High school and college completion)
- social associations

The process to identify the social needs of targeted members CalViva Health serves includes:

- Social needs assessment (SNA) conducted through FindHelp.
- Care Management assessment to identify social needs.
- Community-level searches for social need categories through FindHelp.
- Member Connections mini-screener tool, which identifies SDoH, including social needs like food, transportation, housing, utilities, and safety.

CalViva Health uses community and individual social needs and risk data to identify needed partnerships with community partners and engages with cross-sector partners to address social risks and social needs of the community and individuals that the organizations mutually serve. Engaging with partner organizations with a shared goal of reducing negative effects of social risks to improve outcomes provides an effective way to address social needs. Cross-collaboration is mutually beneficial and enables partners to support each other in providing resources and interventions.

CalViva Health offers numerous Community Supports non-benefit services to its members to address the nuanced SDoH needs of members including:

- Asthma remediation
- Community transition services/nursing facility transition to a home
- Day habilitation
- Environmental accessibility adaptations (home modifications)
- Housing deposits
- Housing tenancy and sustaining services
- Housing transition navigation services
- Meals/medically tailored meals
- Nursing facility transition/diversion to assisted living facilities
- Personal care and homemaker services
- Recuperative care (medical respite)
- Respite services
- Short-term post-hospitalization housing
- Sobering centers

Overview of Population Health Risk Status

Definition of each health category appears in Appendix C

CalViva Health 2023 Subpopulations by Health Risk	All Ages		Age 0-19		Age 2-19		Age 20-64		Age 65+	
	Count	%	Count	%	Count	%	Count	%	Count	%
Member Count	425,527		181,938	42.8%	167,683	39.4%	216,562	50.9%	27,027	6.4%
POP Health Category										
_01: Healthy	155,172	36.47%	92,905	51.06%	85,103	50.75%	59,246	27.36%	3,021	11.18%
_02: Acute Episodic	42,008	9.87%	25,606	14.07%	21,694	12.94%	16,118	7.44%	284	1.05%
_03: Healthy: At Risk	50,851	11.95%	11,813	6.49%	11,649	6.95%	34,732	16.04%	4,306	15.93%
_04a: Chronic - Big 5: Stable	45,601	10.72%	23,540	12.94%	23,362	13.93%	20,590	9.51%	1,471	5.44%
_04b: Chronic - Other Condition: Stable	10,198	2.40%	8,001	4.40%	6,734	4.02%	1,937	0.89%	260	0.96%
_04c: BH Primary: Stable	8,588	2.02%	3,536	1.94%	3,305	1.97%	4,974	2.30%	78	0.29%
_05a: Health Coaching	48,929	11.50%	9,220	5.07%	9,113	5.43%	34,417	15.89%	5,292	19.58%
_05b: Physical Health CM	51,048	12.00%	6,812	3.74%	6,227	3.71%	36,965	17.07%	7,271	26.90%
_05c: Behavioral Health CM	3,826	0.90%	296	0.16%	296	0.18%	3,419	1.58%	111	0.41%
_06: Rare High Cost Condition	1,077	0.25%	97	0.05%	93	0.06%	821	0.38%	159	0.59%
_07a: Catastrophic: Dialysis	1,073	0.25%	9	0.00%	9	0.01%	786	0.36%	278	1.03%
_07b: Catastrophic: Active Cancer	1,199	0.28%	56	0.03%	56	0.03%	803	0.37%	340	1.26%
_07c: Catastrophic: Transplant	33	0.01%	6	0.00%	5	0.00%	26	0.01%	1	0.00%
_08a: Dementia	897	0.21%	2	0.00%	2	0.00%	202	0.09%	693	2.56%
_08b: Institutional (custodial care)	133	0.03%	1	0.00%	1	0.00%	92	0.04%	40	0.15%
_09a: LTSS MMP and DSNP - Service Coordination	2,191	0.51%	0	0.00%	0	0.00%	372	0.17%	1,819	6.73%
_09b: LTSS MMP and DSNP - High Needs Care Management	382	0.09%	0	0.00%	0	0.00%	153	0.07%	229	0.85%
10: EOL(Non-LTSS)	2,321	0.55%	38	0.02%	34	0.02%	909	0.42%	1,374	5.08%

Subpopulations by Health Risk Segment Analysis

- Healthy (01) is the largest segment at 36.47% for members of all ages and is highest all age groups except members aged 65+ whose largest segment is Physical Health CM (5b) at 26.9%.
- Physical Health CM (05b) is the second largest segment for all members at 12% and specifically for adult members aged 20-64 at 17.07%.
- Healthy: at Risk (03) is also significant at 11.95% for all members followed by Health Coaching (05a) at 11.5%, Chronic – Big 5: Stable (04a) at 10.72% and Acute Episodic (2) at 9.87%.

Summary of Health Risk Subpopulations by Age Group

Children and Adolescents

- 01: Healthy: children and adolescents have an understandably higher healthy population than other age groups
- Members aged 0-19 second highest segment is Acute episodic (02) at 14.07%
- Members aged 2-19 second highest segment is Chronic – Big 5: Stable (04a) at 13.93%.

Adults Aged 20-64

- 01: Healthy Although this population is the highest health category for this age group, it has a lower overall average (27.36%) than other age groups (36.47%).
- Behavioral Health categories are slightly higher for this age group than other age brackets; 04c: Behavioral Health Primary, Stable: 2.3%, 05c Behavioral Health CM: 1.58%.
- 05a: Health Coaching is also higher for this age group (15.89%) than all members (11.5%)

Age 65 and older

- Members aged 65+ second highest segment is Healthy Coaching (05a) at 19.58% followed by Healthy: at Risk (03)at 15.93%

- 08a: Dementia is understandably much higher percentage in this age group at 2.56% versus 0.21% all ages.
- LTSS and End of Life segments are similarly much higher for members aged 64 and older compared to all members.

Health Care Needs of All Members

Top Inpatient Diagnoses

Top Inpatient Diagnoses Aggregated into Categories	All Ages	
	%	#
Pregnancy and Birth	25.7%	6,695
Cardiovascular	6.49%	1,691
Septicemia (except in labor)	6.18%	1,610
Pulmonary related	5.08%	1,323

Summary of Member Needs Based on Top Inpatient Diagnoses for All Members

- **Pregnancy and Birth** related admissions rank highest at 25.7%
- **Cardiovascular disease** including Hypertension with complications and secondary hypertension, Acute myocardial infarction, and Cardiac dysrhythmias is the next most common for the entire population, with the highest prevalence of hypertension related admissions at 6.49%.
- **Sepsis** is highest singular diagnostic category at 6.18% overall. However, sepsis is the end stage of multiple diseases, and is not useful for population analysis and target intervention.
- **Pulmonary-related admissions** including Pneumonia, Respiratory failure, Chronic Obstructive Pulmonary Disease and Bronchiectasis, and Viral infection (COVID-19) were the next most common at 5.08%

Top Inpatient Diagnoses Age 0-19 (excluding birth)	Age 0-19	
	%*	#
Asthma	11.16%	141
Respiratory failure; insufficiency; arrest	11.16%	141
Acute bronchitis	10.77%	136
Appendicitis and other appendiceal conditions	6.97%	88

Summary of Member Needs Based on Top Inpatient Diagnoses for Members Aged 0-19

(excluding birth)

- **Pulmonary-related admissions** are the top three inpatient diagnoses with **Asthma** and **Respiratory Failure** tying for first at 11.16%.
- **Appendicitis** also ranks high for members aged 0-19.

Top Inpatient Diagnoses	Age 2-19	
	%*	#
Asthma	13.78%	140
Respiratory failure; insufficiency; arrest (adult)	9.65%	98
Appendicitis and other appendiceal conditions	8.66%	88
Acute bronchitis	7.48%	76

Summary of Member Needs Based on Top Inpatient Diagnoses for Members Aged 2-19

- **Pulmonary-related Admissions** are the three of the top four inpatient diagnoses with **Asthma** ranking highest at 13.78%.
- **Appendicitis** ranks third for members aged 0-19at 8.66%.

Top Inpatient Diagnoses (excluding pregnancy and birth-related diagnoses)	Age 20-64	
	%*	#
Septicemia (except in labor)	5.43%	1,087
Hypertension with complications and secondary hypertension	4.28%	858
Diabetes mellitus with complications	3.45%	692
Other nutritional; endocrine; and metabolic disorders	3.41%	683

Summary of Member Needs Based on Top Inpatient Diagnoses for Adult Members Aged 20-64

- **Sepsis** is highest singular diagnostic category at 5.43% overall. However, sepsis is the end stage of multiple diseases, and is not useful for population analysis and target intervention.
- **Hypertension** ranks second for adult members aged 20-64.
- **Diabetes** admissions rank third.

Top Inpatient Diagnoses	Age 65+	
	%*	#
Septicemia (except in labor)	10.69%	510
Hypertension with complications and secondary hypertension	7.77%	371
Acute and unspecified renal failure	3.96%	189
Acute cerebrovascular disease	3.86%	184
Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	3.67%	175

Summary of Member Needs Based on Top Inpatient Diagnoses for Senior Members Aged 65+

- **Sepsis** is highest singular diagnostic category at 10.69% overall. However, sepsis is the end stage of multiple diseases, and is not useful for population analysis and target intervention.
- **Hypertension** ranks second for senior members at 7.77%.
- **Renal failure** related admissions rank third at 3.96%.

Top Prescription Aggregated Category	All Ages	
	%	Count
ANTIDIABETICS	7.51%	280,859
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	6.15%	229,821
ANALGESICS/ANTI-INFLAMMATORY	5.39%	201,390
ANTIHISTAMINES	4.48%	167,608
ANTIHYPERTENSIVES	4.44%	165,866

Summary of Member Needs Based on Top Prescriptions for All Members

- **Diabetic drugs and supplies** are the most commonly prescribed drugs for the entire population (7.51%).
- **Anti-asthmatic and bronchodilator agents** are the second most commonly prescribed drugs for the entire population, comprising 6.15%.
- **Anti-inflammatory/Analgesics** rank third overall (5.39%).

Top Prescription Aggregated Category	Age 0-19	
	%	Count
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	13.64%	91,897
ANTIHISTAMINES	9.96%	67,114
ANALGESICS/ANTI-INFLAMMATORY	8.50%	57,251
DERMATOLOGICALS	7.64%	51,465
PENICILLINS	6.53%	44,008

Summary of Health Care Needs based on Top 30 Prescriptions for Infants, Children and Adolescents (Aged 0-19)

- **Antiasthmatic and bronchodilator agents** are the most commonly prescribed drugs for children and adolescents at 13.64% of all medications.
- **Antihistamines** are the second most commonly prescribed drugs for children and adolescents 9.96%.
- **Anti-inflammatory/Analgesics** rank third at 8.5%.

Top Prescription Aggregated Category	Age 2-19	
	%	Count
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	13.90%	89,789
ANTIHISTAMINES	10.33%	66,732
ANALGESICS/ANTI-INFLAMMATORY	8.59%	55,444
DERMATOLOGICALS	7.43%	47,956
PENICILLINS	6.53%	42,192

Summary of Health Care Needs Based on Top 30 Prescriptions for Children and Adolescents (Aged 2-19).

There is negligible variation in the top prescription categories from the Infants, Children and Adolescents aged 0-19 compared to the Children and Adolescents aged 2-19.

- **Antiasthmatic and bronchodilator agents** are the most commonly prescribed drugs for children and adolescents at ~14% of all medications.
- **Antihistamines** are the second most commonly prescribed drugs for children and adolescents 10.3%.
- **Anti-inflammatory/Analgesics** rank third at 8.59%.

Top 30 Prescription Aggregated Category	Age 20-64	
	%	Count
ANTIDIABETICS	9.12%	251,091
ANTIDEPRESSANTS	5.23%	144,046
ANTIHYPERLIPIDEMICS	5.12%	140,836
ANTIHYPERTENSIVES	5.07%	139,659
ANALGESICS - ANTI-INFLAMMATORY	4.99%	137,471

Summary of Health Care Needs Based on Top 30 Prescriptions for Adults (Aged 20-64)

- **Antidiabetics** are the most commonly prescribed drugs for adults aged 20-64 at 9.12%.
- **Antidepressants** are the second most commonly prescribed drugs for adults at 5.23%.
- **Antihyperlipidemics** rank third at 5.12%.

Top 30 Prescription Aggregated Category	Age 65+	
	%	Count
ANTIDIABETICS	8.43%	26,233
ANALGESICS – Non Narcotic	8.24%	25,659
VITAMINS	6.93%	21,575
ANTIHYPERLIPIDEMICS	6.07%	18,906
ANTIHYPERTENSIVES	6.02%	18,746

Summary of Health Care Needs Based on Top 30 Prescriptions for Seniors (Aged 65+)

- **Antidiabetics** similar to the adult population, are the most commonly prescribed drugs for seniors over age 65 at 8.43%.
- **Non-narcotic Analgesics** are the second most commonly prescribed drugs for seniors at 8.24%.
- **Vitamins** rank third at 6.93%.

Health Care Needs of Persons with Disabilities

Top Inpatient Diagnoses of Persons with Disabilities Aggregated into Categories	All Ages	
	%*	#
Cardiovascular	13.16%	724
Septicemia (except in labor)	10.49%	577
Pulmonary related	9.31%	512
Diabetes mellitus with complications	4.38%	241
Complication of device; implant or graft	3.65%	201
Musculoskeletal and Arthritis	2.78%	153
Cerebrovascular	2.27%	125

Summary of Health Care Needs of Persons with Disabilities by Inpatient Condition Prevalence

- **Cardiovascular Disease**, including Hypertension, Acute Myocardial Infarction, and Cardiac Dysrhythmias is highest overall grouping at 13.16%.
- **Sepsis** is the second most common of the top specific inpatient diagnosis for persons with disabilities, (13.16%), sepsis is the more prevalent of the total inpatient admits for persons with disabilities. However, this is a condition that is a complication of many other diseases and is not useful for population analysis.
- **Pulmonary–related** admissions including COPD, Pneumonia, Respiratory Failure, and Viral Infection (COVID-19) are third overall at 9.31% of all admissions.

Top Inpatient Diagnosis of Persons with Disabilities	Age 0-19	
	%*	#
Epilepsy; convulsions	12.50%	7
Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	8.93%	5
Intestinal infection	8.93%	5
Asthma	7.14%	4

Other gastrointestinal disorders	7.14%	4

Summary of Health Care Needs of Persons with Disabilities Infants, Children and Adolescents aged 0-19 by Inpatient Condition Prevalence

- **Epilepsy** is highest overall grouping at 12.5%.
- **Pulmonary-related** conditions including **Pneumonia** (8.93%) and **Asthma** (7.14%) are both in the top 5
- **Intestinal-related** conditions including **Intestinal infection** (8.93%) and **Other gastrointestinal disorders** (7.14%) are also in the top 5 for persons with disabilities aged 0-19.

Top Inpatient Diagnoses of Persons with Disabilities	Age 2-19	
	%*	#
Epilepsy; convulsions	12.73%	7
Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	9.09%	5
Intestinal infection	9.09%	5
Asthma	7.27%	4
Other gastrointestinal disorders	7.27%	4

Summary of Health Care Needs of Persons with Disabilities Children and Adolescents aged 2-19 by Inpatient Condition Prevalence

The top 5 conditions are the same as the aged 0-19 population.

- **Epilepsy** is highest overall grouping at 12.73%.
- **Pulmonary-related** conditions including **Pneumonia** (9.09%) and **Asthma** (7.27%) are both in the top 5
- **Intestinal-related** conditions including **Intestinal infection** (9.09%) and **Other gastrointestinal disorders** (7.27%) are also in the top 5 for persons with disabilities aged 2-19.

Top Inpatient Diagnoses of Persons with Disabilities	Age 20-64	
	%*	#
Hypertension with complications and secondary hypertension	10.62%	408
Septicemia (except in labor)	9.81%	377
Diabetes mellitus with complications	4.84%	186
Complication of device; implant or graft	3.96%	152
Complications of surgical procedures or medical care	2.86%	110

Summary of Health Care Needs of Persons with Disabilities Adults aged 20-64 by Inpatient Condition Prevalence

- **Hypertension** is highest overall diagnosis at 10.62%.
- **Sepsis** is the second most common of the top specific inpatient diagnoses for adult persons with disabilities, (9.81%). However, this is a condition that is a complication of many other diseases and is not useful for population analysis.
- **Diabetes** ranks third for adult persons with disabilities representing 4.84% of inpatient admissions.

Top Inpatient Diagnosis of Persons with Disabilities	Age 65+	
	%*	#
Septicemia (except in labor)	12.48%	200
Hypertension with complications and secondary hypertension	9.17%	147
Acute and unspecified renal failure	4.30%	69
Chronic obstructive pulmonary disease and bronchiectasis	4.05%	65

Diabetes mellitus with complications	3.43%	55

Summary of Health Care Needs of Persons with Disabilities Seniors Aged 65+ by Inpatient Condition Prevalence

- **Sepsis** is the most common of the top specific inpatient diagnosis for adult persons with disabilities, (12.48%). However, this is a condition that is a complication of many other diseases and is not useful for population analysis.
- **Hypertension** is second highest diagnosis at 9.17%.
- **Renal failure** ranks third at 4.3% for senior persons with disabilities.

Needs of Persons with Serious and Persistent Mental Illness (SPMI)

See SPMI Guidelines in Appendix A. Medicaid SPMI is carved out to California Counties. Since the Plan only managed the mild to moderate mental health and substance use disorders the data is not representative of the total population experience.

2023 SERIOUS and PERSISTENT MENTAL ILLNESS (SPMI) SUMMARY of INPATIENT DATA

# of SPMI Mbrs	Admits	Age 0-19		Age 2-19		Age 20-64		Age 65+		All Ages	
		Count	%	Count	%	Count	%	Count	%	Count	%
18,929	1 Admit	24	0.10%	24	0.10%	421	2.20%	90	0.50%	535	2.80%
	>1 Admit	10	0.10%	10	0.10%	208	1.10%	45	0.20%	263	1.40%
	Total	**34**	**0.20%**	**34**	**0.20%**	**629**	**3.30%**	**135**	**0.70%**	**798**	**4.20%**

Inpatient SPMI data reflects the highest ratio of admissions in members aged 20-64.

2023 SERIOUS and PERSISTENT MENTAL ILLNESS (SPMI) SUMMARY of OUTPATIENT DATA

# of SPMI Mbrs	Service Type	Unit	Age 0-19		Age 2-19		Age 20-64		Age 65+		All Ages	
			Count	%	Count	%	Count	%	Count	%	Count	%
18,929	ER	<=3	417	2.20%	417	2.20%	1,575	8.30%	98	0.50%	2,090	11.00%
		>3	6	0.00%	6	0.00%	245	1.30%	9	0.00%	260	1.40%
	OP	<=3	901	4.80%	901	4.80%	2,308	12.20%	311	1.60%	3,520	18.60%
		>3	141	0.70%	141	0.70%	651	3.40%	271	1.40%	1,063	5.60%
	Other	<=3	1,269	6.70%	1,269	6.70%	5,512	29.10%	584	3.10%	7,365	38.90%
		>3	3,291	17.40%	3,291	17.40%	6,727	35.50%	300	1.60%	10,318	54.50%
	Total		**4,664**	**24.60%**	**4,664**	**24.60%**	**13,007**	**68.70%**	**1,174**	**6.20%**	**18,845**	**99.60%**

- ER visits are highest for ages 20-64 at 8.3%. ER visits shown above represent only ER visits from which a member did not get admitted to inpatient. If a member is admitted, the ER visit is not billed separately but instead as a part of the overall stay.
- The greatest percentage of visits overall for all ages falls in the “Other” category. This category captures psychiatric visits, PCP visits, specialist visits and office-administered drug visits. This can be viewed in a positive light as members can be receiving medication management from their PCPs and regular attendance at medication management visits is an indication of a better-managed mental health condition.
- Outpatient visits overall make up 18.6 percent of visits and fall in between the percentage of ER visits and visits for the “Other” category.

2023 SERIOUS and PERSISTENT MENTAL ILLNESS (SPMI) TOP DIAGNOSIS	Count	%
Anxiety disorders	608	49.30%
Mood disorders	337	27.30%
Schizophrenia and other psychotic disorders	212	17.20%
Disorders usually diagnosed in infancy, childhood, or adolescence	46	3.70%
Total Top 4 Admits	1,203	97.60%
Total ALL Admits for SPMI/SED Pop.	**1,233**	

SPMI top diagnoses are Anxiety disorders followed by Mood disorders. The lowest volume diagnoses are Disorder diagnosed in infancy, childhood or adolescence.

Needs identified based on High Volume Conditions (excluding sepsis)

All Members	Infant, Children and Adolescents	Children and Adolescents	Adults	Seniors
1. Pregnancy and Birth	1. Asthma **(Pulmonary)**	1. Asthma **(Pulmonary)**	**1. Pregnancy and Birth**	1. Hypertension **(Cardiovascular)**
2. Cardiovascular	2. Respiratory Failure **(Pulmonary)**	2. Respiratory Failure **(Pulmonary)**	2. Hypertension **(Cardiovascular)**	2. Renal Failure
3. Pulmonary	3. Bronchitis **(Pulmonary)**	3. Appendicitis	3. Diabetes	3. Cerebrovascular disease

Cardiovascular disease was a top volume condition for the overall population, particularly prominent in the Adult and Senior populations.

The prevalence of heart disease is evidenced by high cardiovascular admissions, anti-hypertensives, lipid lowering agents, and diabetic drugs being in the top four prescription drugs.

- Race and Ethnicity influences the prevalence of heart disease and its comorbid conditions, being generally higher for Black/African American and Hispanic/Latino.
    - Hispanic/Latino membership is more than half of the Plan's population. Cultural and linguistic challenges affect the health of this population. 23% of Latino deaths are from cardiovascular disease, 19% have hypertension, 29% are obese (with 30% of adolescents overweight), and 25% of the adults aged 45-75 have diabetes mellitus.
    - Black/African Americans comprise ~5% of the population.

We examined HEDIS results for Controlling High Blood Pressure since this is a key measures with clear impact on morbidity and mortality. We compared our Reporting Year (RY) 2023 (measurement year 2022) HEDIS rates to our goal of the 50th percentile 2022 Quality Compass values as well whether the measure was required California Department of Health Care Services to meet the 50th percentile Minimum Performance Level (MPL) (MPL requirements: https://www.dhcs.ca.gov/Documents/MCQMD/MY2022-RY2023-MCAS.pdf). Results are below.

Controlling High Blood Pressure (CBP)

County	Rate	50th percentile	Goal Met?	MPL required
Fresno	61.73	59.85	Yes	Yes
Kings	71.81		Yes	
Madera	67.49		Yes	

All counties exceeded the 50th percentile goal for this measure. The Plan's Cardiac + Diabetes program consists of multi-modal outreach to high-risk members with diabetes, coronary artery disease, and hypertension. This includes outreach to members to encourage statin refills along with outreach to members with high blood pressure care gaps. The Chronic Condition Disease Management program targets members with asthma, COPD, diabetes, cardiovascular conditions (CAD), and congestive heart failure (CHF).

- Gap: Opportunities exist to improve control of high blood pressure
  - Action 2024: Increase focus on Chronic Condition Domain HEDIS Care Gap Campaigns for CBP (Controlling Blood Pressure)

Pulmonary related admits were a top-volume condition for the overall population, particularly prominent in the Infant, Children and Adolescents age groups for Asthma. We examined HEDIS results for Asthma Medication Ration (AMR), Childhood Immunization Status (CIS) and Immunizations for Adolescents (IMA) since these are key measures related to respiratory conditions and directly impact health outcomes. We compared our Reporting Year (RY) 2023 (measurement year 2022) HEDIS rates to our goal of the 50th percentile 2022 Quality Compass values as well whether the measure was required California Department of Health Care Services to meet the 50th percentile Minimum Performance Level (MPL) (MPL requirements: https://www.dhcs.ca.gov/Documents/MCQMD/MY2022-RY2023-MCAS.pdf). Results are below.

Asthma Medication Ration (AMR)

County	Rate	50th percentile	Goal Met?	MPL required
Fresno	62.15	64.26	No	No
Kings	64.37		Yes	
Madera	72.93		Yes	

Childhood Immunization Status (CIS) - DTaP

County	Rate	50th percentile	Goal Met?	MPL required
Fresno	67.15	69.71	No	No
Kings	64.23		No	
Madera	82.24		Yes	

Childhood Immunization Status (CIS) - Rotavirus

County	Rate	50th percentile	Goal Met?	MPL required
Fresno	67.4	69.59	No	No
Kings	72.02		Yes	
Madera	81.02		Yes	

Childhood Immunization Status (CIS) - Influenza

County	Rate	50th percentile	Goal Met?	MPL required
Fresno	38.44	47.2	No	No
Kings	28.47		No	
Madera	63.02		Yes	

Immunizations for Adolescents (IMA) - Tdap

County	Rate	50th percentile	Goal Met?	MPL required
Fresno	91	85.18	Yes	No
Kings	92.21		Yes	
Madera	91.83		Yes	

Fresno County met the 50th percentile goal for the Immunizations for Adolescents (IMA) - Tdap measure but did not meet the goal for the other measures. Kings County met the Asthma Medication Ration (AMR), Childhood Immunization Status (CIS) – Rotavirus, and Immunizations for Adolescents (IMA) - Tdap Goals but did not meet Childhood Immunization Status (CIS) – DTaP or Influenza. Madera County met the goals for all measures listed. The Plans' COPD/Asthma program initiated in 2019 consists of targeted outreach to members and their families to educate them on their disease, improve members' self-management and self-sufficiency skills, and optimize COPD and/or Asthma medication including maintenance medications.

Smoking is a key driver for respiratory diseases and complications. Within some ethnic groups, smoking may be part of the culture. For example, Asians have 10% higher incidents of smoking than other ethnic groups. The SDoH analysis reflects higher rates of adult smokers in CalViva counties could contribute to worse health outcomes for both adults and children in the homes of adult smokers.

Asthma is exacerbated by Social Determinants/Drivers of Health, especially environmental factors, particularly air quality, and a large number of members live in areas of poor air quality the Central Valley.

Central California has healthier air than only 7.8% of the other counties in California (i.e., 92.2% of the other counties in the State have a healthier environment). Clean air measurements are poor due to Diesel Particulate Matter (16.3%), Ozone (35.8%), and Particulate Matter which is particularly bad at (15.4%), due to a dusty, dry agricultural environment.

- Gap: Opportunities exist for increased respiratory related vaccine access and adoption
  - Action 2024: Evaluate existing vaccination programs to establish additional opportunities to improve vaccination rates.
- Gap: Opportunities exist for increased asthma medication adherence
  - Action 2024: Initiate Chronic Condition Domain HEDIS Care Gap Campaigns that include AMR Care Gap and refer identified members for potential Asthma Remediation

Pregnancy and Births including High-Risk Pregnancy were top volume conditions for adults ages 20-64. Complications of pregnancy are influenced by SDoH including teen births as identified with higher prevalence in the counties CalViva Health serves. We examined HEDIS results for Prenatal and Postpartum care since timely and adequate prenatal and postpartum care can prevent complications. We compared our Reporting Year (RY) 2023 (measurement year 2022) HEDIS rates to our goal of the 50th percentile 2022 Quality Compass values as well whether the measure was required California Department of Health Care Services to meet the 50th percentile Minimum Performance Level (MPL) (MPL requirements: https://www.dhcs.ca.gov/Documents/MCQMD/MY2022-RY2023-MCAS.pdf). Results are below.

Prenatal and Postpartum Care - Timeliness of Prenatal Care (PPC)

County	Rate	50th percentile	Goal Met?	MPL required
Fresno	89.62	85.4	Yes	Yes
Kings	87.76		Yes	
Madera	90.37		Yes	

Prenatal and Postpartum Care - Postpartum Care (PPC)

County	Rate	50th percentile	Goal Met?	MPL required
Fresno	84.23	77.37	Yes	Yes
Kings	84.18		Yes	
Madera	87.04		Yes	

CalViva Health Medicaid exceeded the 50th percentile goal for these measures. Member beliefs and behavior have a significant impact on these rates. Members may not understand why a prenatal and/or postpartum visit is

important or feel that they do not need frequent visits, especially if they are not encountering any issues. CalViva's Pregnancy Program has a multi-faceted approach to prenatal and postpartum care that includes extensive member outreach, wellness materials, and intensive case management, which reinforces the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease. HEDIS tip sheets are also made available to Providers to educate on the importance of timely prenatal and postpartum care.

- Gap: Opportunities exist to continue focus on prenatal and postpartum care
  - Action 2024: Continue Pregnancy Program

Social Determinants/Drivers of Health

All CalViva Health counties have both poor SDoH and Health Outcomes. Activities in these counties would impact health needs for any sub-population.

During the third and fourth quarters of 2023, CalViva Health representatives began collaboration with Fresno, Madera, and Kings counties' Local Health Jurisdictions/Local Health Departments to begin "meaning participation" in their current or future CHA/CHIP cycles. CalViva Health representatives are also engaging with these LHJs to co-develop joint SMART goals. This collaborative work includes CalViva Health/Health Net partnering and aligning with the other Managed Care Plans (Anthem and Kaiser) providing Medi-Cal services in these three counties.

- Gap: Opportunities exist to continue Plan participation and representation with LHJs/LHDs
  - Action 2024: Co-develop SMART goals in collaboration with LHJs

Cultural and Linguistic, Race Ethnicity Needs Assessment, Review and Update of PHM Activities and Resources

Based on the CalViva and County comparison of race, the highest needs are among Spanish speaking, Black, and Asian members.

The Health Equity department is dedicated to addressing the needs of members with cultural and linguistic issues that impact health care. The Department also looks at SDoH. The goal is to identify health care disparities, identify gaps, then develop and implement strategies to address those gaps.

Race, ethnicity, written and spoken language preferences are collected from members and providers to enable matching of members and providers with the same language and/or ethnic background. The Language Assistance Program (LAP) meets standards set by the Office of Minority Health for culturally and linguistically appropriate services for members. Annual Notices in the top 15 languages and Member Newsletters advise how to access language support services. Provider Updates and online provider portal news articles also inform providers of LAP to provide interpreter services. Certified bilingual staff are also available, including Spanish speaking Care Managers.

Translation services for materials that are culturally and linguistically appropriate are available, and an updated annual threshold language grid is maintained to identify any changes to the threshold languages. Notable language trends are reported to the Health Equity and Quality Improvement Committees. Plain language and readability training is also available to all departments to ensure appropriate grade level of reading materials and letters.

The Plan engages in multiple collaborations in the community to improve cultural and linguistic appropriateness of programs and services and to impact positive health outcomes related to Health Equity. The Plan Community Advisory Committees meet quarterly. The Plan partners with local

Community Based Organizations (CBOs) such as West Fresno Resource Center, Fresno Metro Ministry, and The Fresno Center to engage members and the surrounding communities in disparity reduction efforts. The Plan also partners with state and national collaborations for best-practice sharing and to leverage resources: Disparities Leadership Program, California Healthcare Interpreters Association, Industry Collaboration Efforts and Medicaid Health Education and Health Equity Workgroup.

The Plan utilizes an innovative and multipronged approach to advance health equity. Through meaningful engagement at the member, provider, and community levels, the Plan and our partners develop programs that improve access to quality care and help to reduce disparities. Current disparity projects include:

- Diabetes Control Project for Black and Hispanic Members in Fresno County
- Improving Infant Well Child Visits Among Black Members in Fresno County
- Breast Cancer Screening Project for the SE Asian Population in Fresno County
- Comprehensive Diabetes Care Project for Hispanic Members in Fresno County

Community Resources for Integration into Program Offerings

The Plan connects members with community resources and also promotes community programs. The Plan actively responds to members' needs with respect to those discovered on this population assessment, especially around SDoH, which vary widely by region and county. Individual needs are evaluated with health risk assessments and during general care management assessments, identifying which needs can be met by Plan benefits and which will require connections to community resources.

All Care Management staff have access to and utilize a central directory for local community resources (FindHelp) for this purpose, in addition to actively educating members, for example, on agencies on aging, transportation, and Meals on Wheels. In addition, Licensed Clinical Social Workers (LCSW) are an integral part of the Integrated Care Team (ICT) for Care Management. Care Managers (CM) may refer cases directly to the LCSW with requests to outreach to members to connect them to local community resources such as financial assistance (e.g., utility and pharmacy discounts), housing (e.g., shelters, low income housing resources,), food (e.g., Cal Fresh/Food Stamps, Food Banks), support groups (e.g., AA, specific diagnosis support, bereavement groups), transportation, local groups for home accessibility improvements, and other community programs. When member safety is of concern, LCSWs and Care Managers work with local Child and Adult Protective Services. Care Management staff also have access to web portals to determine if members have been evaluated or authorized for State-sponsored In Home Supportive Services (IHSS), and refer to IHSS directly where appropriate.

The Plan website has links to community resources by county or zip code for access by both care managers and members. CalViva Health also promotes and actively participates in community programs. For example the Whole Person Care initiative that aligns local community services, health providers, and health care plans for improved coordination, with a focus on housing needs.

Social Determinants/Drivers of Health: Review and Update PHM Activities and Resources

SDOH as they affect the specific needs of the subpopulations are discussed within each subpopulation above and gaps are identified. Community resources are actively engaged to close gaps between needs and benefit coverage. FindHelp, an online service with detailed information on community resources, is available to Care Management staff and members. Members engaged in Care Management are actively given resources and follow up is done to encourage engagement with those resources. Integrated Team Rounds for Care Management include LCSWs with local knowledge.

SDOH affect health outcomes for all of the conditions described above. Programs focused on areas with poor SDOH should improve health. Several counties have large plan populations and both poor SDOH and Health Outcomes. Activities in these counties would impact health needs for any sub-population with high membership in those counties.

Actions Taken:

Gap Addressed	Actions	Date Started
A large portion of the adult as well as children and adolescent sub-populations are healthy or healthy at-risk. Several wellness and prevention programs and activities are in place to help keep members healthy. One of these programs is a digital behavioral health platform which offers educational resources on mental and behavioral health. While utilization has increased significantly due to Plan efforts, continued strategy is required to promote this valuable offering.	Provide trainings for providers and internal staff on availability of the digital behavioral health platform and its effectiveness.	Aug 2021
A large portion of the adult as well as children and adolescent sub-populations are healthy or healthy at-risk. Several wellness and prevention programs and activities are in place to help keep members healthy. One of these programs is a digital behavioral health platform, which offers educational resources on mental and behavioral health. While utilization has increased significantly due to Plan efforts, continued strategy is required to promote this valuable offering.	Continue email campaign to promote the digital behavioral health platform, educating members on topics such as depression, anxiety, mindfulness, and chronic pain.	Aug 2021
A large portion of the adult as well as children and adolescent sub-populations are healthy or healthy at-risk. Several wellness and prevention programs and activities are in place to help keep members healthy. One of these programs is a digital behavioral health platform, which offers educational resources on mental and behavioral health. While utilization has increased significantly due to Plan efforts, continued strategy is required to promote this valuable offering.	Calls to adult members diagnosed with major depression and are demonstrating refill gaps, to improve medication adherence	Jan 2023
Heart Disease is a top inpatient diagnosis in the adult sub-population as well as in the members with disabilities sub-population. Additional provider education and collaboration opportunities exist.	Exploration of alternate remote monitoring tools for high-risk members with diabetes, coronary artery disease and hypertension to trigger alerts to the care team for early intervention.	Jan 2021
Heart Disease is a top inpatient diagnosis in the adult sub-population as well as in the members with disabilities sub-population. Additional provider education and collaboration opportunities exist.	Increasing awareness of provider-driven remote patient monitoring tools to members through multi-modal communications.	Jan 2023
Heart Disease is a top inpatient diagnosis in the adult sub-population as well as in the members with disabilities sub-population. Additional provider education and collaboration opportunities exist.	Multimodal (mailer, telephonic, IVR, SMS) educational campaigns exist to provide member and provider education.	Jan 2021
Heart Disease is a top inpatient diagnosis in the adult sub-population as well as in the members with disabilities sub-population. Additional member educational and engagement opportunities exist.	Heart Health: Cardiac + Diabetes- social media post to create awareness to members and community for heart health, diabetes & medication adherence	March 2023
Heart Disease is a top inpatient diagnosis in the adult sub-population as well as in the members with disabilities sub-population. Race and Ethnicity influences the prevalence of heart disease. A significant portion of our membership is Hispanic /Latinos with a relatively high incidence of cardiovascular disease, hypertension, obesity and diabetes mellitus. Opportunity exists to increase utilization of Video Remote Interpreting (VRI) Services to support member language needs.	Enhance language vendor network offering VRI services and educate internal Call Center staff on these services to support provider interpreter requests.	Aug 2021
Heart Disease is a top inpatient diagnosis in the adult sub-	Multimodal (mailer, telephonic, IVR, SMS) outreach	Jan 2021

Gap Addressed	Actions	Date Started
population as well as in the members with disabilities sub-population. Race and Ethnicity influences the prevalence of heart disease. A significant portion of our membership is Hispanic /Latinos with a relatively high incidence of cardiovascular disease, hypertension, obesity and diabetes mellitus. Additional member educational and engagement opportunities exist.	and education exists for high-risk populations such as Hispanic/Latino communities with a continued goal of health equity and improvement of outcomes.	
Pregnancy and birth admissions are the highest admission category in the age 20-64 adult population. Opportunity exists to address substance use in pregnancy.	Explore timely treatment options for pregnant mothers with substance use disorder.	2022
Pregnancy and birth admissions are the highest admission category in the age 20-64 adult population. Opportunity exists to address substance use in pregnancy.	Assess members for risk of opioid overuse and perform early engagement through multimodal outreach to members and their providers to optimize therapy and reduce risk of overdose.	Jan 2023
Pregnancy and birth admissions are the highest admission category in the age 20-64 adult population. Opportunity exists to outreach pregnant member about C-section overuse and promote new doula benefit.	Outreach to pregnant Medicaid members about C-section overuse and to promote new Doula benefit.	May 2023
Pregnancy and birth admissions are the highest admission category in the age 20-64 adult population. Opportunity exists to address post-partum needs including follow up care and depression.	Outreach to newly delivered moms to address post-partum needs including encouraging follow up visit with OB, screening for post-partum depression, and referral to Behavioral Health Care Management.	July 2023
Pregnancy and birth admissions are the highest admission category in the age 20-64 adult population. Opportunity exists to address post-partum needs including follow up care as well as child immunizations and well child visits.	Enroll babies in First Year of Life to promote healthier outcomes for infants including immunizations, well child visits, and educational support for parents and more.	March 2023
Pregnancy and birth admissions are the highest admission category in the age 20-64 adult population. Opportunity exists to address post-partum needs including follow up care.	Social Media Post to encourage members to have prenatal visits within time frame.	May 2023
Pulmonary-related admits, including COVID-19, are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist to educate at risk members to reduce readmission.	Multimodal (mailer, telephonic, IVR, SMS) outreach exists to members at risk for hospitalization as well as members who were hospitalized for respiratory-related reasons to prevent readmission.	Jan 2021
Pulmonary-related admits, including COVID-19, are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased COVID-19, pneumococcal and other age-appropriate vaccine access and adoption.	Multi-modal outreach provided to at risk home bound members to connect them to home vaccination (including COVID-19) options.	Sep 2021
Pulmonary-related admits, including COVID-19, are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased COVID-19, pneumococcal and other age-appropriate vaccine access and adoption.	Continued educational campaigns on importance of COVID-19, pneumococcal, and flu vaccination.	Sep 2021
Pulmonary-related admits, including COVID-19, are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased COVID-19, pneumococcal and other age-appropriate vaccine access and adoption.	Provide continued education to providers on COVID-19 treatment options.	Sep 2021

Gap Addressed	Actions	Date Started
Pulmonary-related admits, including COVID-19, are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased COVID-19, pneumococcal and other age-appropriate vaccine access and adoption.	Media campaigns such as social media, TV, newspaper, radio and/or mailings continue to be used to directly and indirectly to disseminate information to Members about vaccines, resources, and availability.	Sep 2021
Pulmonary-related admits, including COVID-19, are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased COVID-19, pneumococcal and other age-appropriate vaccine access and adoption.	Continue delivery of video-based content on how to have effective, empathy-forward conversations around vaccine hesitancy. These videos will be used internally and will be shared externally.	Sep 2021
Pulmonary-related admits, including COVID-19, are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased COVID-19, pneumococcal and other age-appropriate vaccine access and adoption.	Continued vaccine outreach, primarily to Medicaid members in areas with the lowest COVID-19 vaccine rates.	Sep 2021
Pulmonary-related admits, including COVID-19, are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased COVID-19, pneumococcal and other age-appropriate vaccine access and adoption.	Partnership with trusted institutions that serve populations/regions with the lowest vaccine levels as well as local public health agencies to provide helpful public-facing materials, set up pop-up vaccine clinics on-site, conduct in-person presentations that provide information and address misperceptions directly and deliver training on how to have effective vaccine conversations.	Sep 2021
Pulmonary-related admits, including COVID-19, are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased COVID-19, pneumococcal and other age-appropriate vaccine access and adoption.	Partner with school districts to hold vaccination clinics for school-age youth, focusing on regions with the lowest Medicaid vaccination rates among children and young adults ages 12-25.	Sep 2021
Pulmonary-related admits, including COVID-19, are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased COVID-19, pneumococcal and other age-appropriate vaccine access and adoption.	Share messaging and other vaccine resources with the Boys and Girls Club.	Sep 2021
Pulmonary-related admits, including COVID-19, are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased COVID-19, pneumococcal and other age-appropriate vaccine access and adoption.	Distribute analytics reports to schools, MCP partners and care delivery partners in order to optimize messaging.	Sep 2021
Pulmonary-related admits, including COVID-19, are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased COVID-19, pneumococcal and other age-appropriate vaccine access and adoption.	Continue to partner with local community colleges in efforts to vaccinate their student, faculty, and staff populations such as offering speakers to address vaccine hesitancy and current COVID-19 and other vaccination trends.	Sep 2021
Pulmonary-related admits are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased flu vaccine access and adoption.	Multimodal (mailer, telephonic, IVR, SMS) outreach exists to members at risk for hospitalization as well as members who were hospitalized for respiratory-related reasons to prevent readmission. Continued educational campaigns on importance of COVID-19, pneumococcal, and flu vaccination. Continue pop-up vaccine clinics.	Sep 2021

Gap Addressed	Actions	Date Started
Pulmonary-related admits are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased flu vaccine access and adoption.	Distribute custom Fluvention communications to share with members and providers.	Oct 2021
Pulmonary-related admits are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional opportunities exist for increased flu vaccine access and adoption.	Continue to promote and distribute flu promotion resources or toolkits to providers and their office staff.	Nov 2021
Pulmonary-related admits are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional member education and engagement opportunities exist.	Continue English and Spanish text message or email campaigns for asthma, flu, and COVID.	Dec 2021
Pulmonary-related admits are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional member education and engagement opportunities exist.	Enrollment of members who are active smokers to Smoking/Vaping Cessation app via Clinical Pharmacist outreach and education. Smoking Cessation app assists members in tracking progress towards cessation of smoking/vaping and offers additional tools and resources.	Jan 2023
Pulmonary-related admits are a top volume condition in adults, children and adolescents, as well as members with disabilities. Additional member education and engagement opportunities exist.	Promotion of KickIt California and distribution of kits to quit smoking	Feb 2023
Alcohol and substance use disorder are a top volume condition for with SPMI. Additional educational and collaboration opportunities exist for providers and internal staff.	Provide annual provider updates to inform on best practices for supporting members who had an ED visit for alcohol and other drug abuse as substance abuse treatment during or after an ED visit can reduce substance use, future ED use, hospital admissions and bed days.	May 2021
Alcohol and substance use disorder are a top volume condition in members with SPMI. Additional opportunities exist to expand access to care.	Transitions of Care (TOC) Clinical Pharmacist identifies hospitalized members needing SUD treatment initiation and performs telephonic outreach to hospitalist to provide clinical recommendations and continuation of treatment outpatient.	Jan 2023
Anxiety and Mood disorders are top volume conditions for members with SPMI. Additional provider educational and collaboration opportunities exist.	Continued provider updates issued to inform on best practices for supporting members who had an ED visit for Behavioral Health as follow-up care is linked to fewer repeat ED visits, improves mental function and increases compliance with follow-up instructions.	May 2021
Anxiety and Mood disorders are top volume conditions for members with SPMI. Additional provider educational and collaboration opportunities exist.	Continued provider updates issued for Minority Mental Health Month to inform on the disproportionately high burden of mental health disorders in BIPOC and LGBTQ patients and stigmas faced when accessing health services. A toolkit was supplied along with information on the digital behavioral health platform.	July 2021
Anxiety and Mood disorders are top volume conditions for members with SPMI. Additional member educational and engagement opportunities exist.	Continued use of a digital application designed to reduce loneliness and engage members.	Jan 2022
Anxiety and Mood disorders are top volume conditions for members with SPMI. Additional member educational and engagement opportunities exist.	Implementation of Enhanced Wellness Platform to improve stress management and quality of life.	Jan 2023

Appendix A

Serious and Persistent Mental Illness (SPMI) Guidelines

DMHC has provided specific DSM codes (Diagnostic and Statistical Manual of Mental Disorders) in the categories below for Health Plans to use to identify members with SPMI. Both claims and encounter data (including MHN) are used for members that have utilization during the reporting period(s).

Conditions Included:

- Adjustment disorders
- Anxiety disorders
- Attention-deficit, conduct, and disruptive behavior disorders
- Disorders usually diagnosed in infancy, childhood, or adolescence
- Impulse control disorders, NEC
- Mood disorders
- Personality disorders
- Schizophrenia and other psychotic disorders
- Other female genital disorders (if related to BH)
- Other inflammatory conditions of skin (if related to BH)
- Miscellaneous categories such as dissociative disorders, eating disorders, personality/behavioral, etc.

See criteria below on how to identify members with persistency (this reporting year as well as previous).

- Admit in both years for specific DSM 5 Codes
- More than one admit in reporting year for specific DSM 5 Codes
- ER Visit in both years for specific DSM 5 Codes
- More than one ER Visit in reporting year for specific DSM 5 Codes
- More than one OP visit (other than ER) in both years for specific DSM 5 Codes
- More than two OP visits (other than ER) in reporting year for specific DSM 5 Codes
- More than two other services, including Office Visits in reporting year for specific DSM 5 Codes
- More than three other services, including Office Visits in both years for specific DSM 5 Codes

Appendix B1

County Health Rankings & Roadmaps

Compare Counties

Select from all counties or choose based on demographic, social and economic indicators.

Select year: 2023

To add any additional locations, an existing selection will need to be removed.

Ranked

		Fresno, CA	Kings, CA	Madera, CA	California
Health Outcomes					
Length of Life		Fresno, CA	Kings, CA	Madera, CA	California
Premature Death		**7,500**	**6,900**	**7,200**	**5,700**

Definition: Years of potential life lost before age 75 per 100,000 population (age-adjusted).

Error margin for Fresno, CA: 7,300-7,700

Error margin for Kings, CA: 6,400-7,300

Error margin for Madera, CA: 6,700-7,700

Error margin for California: 5,700-5,700

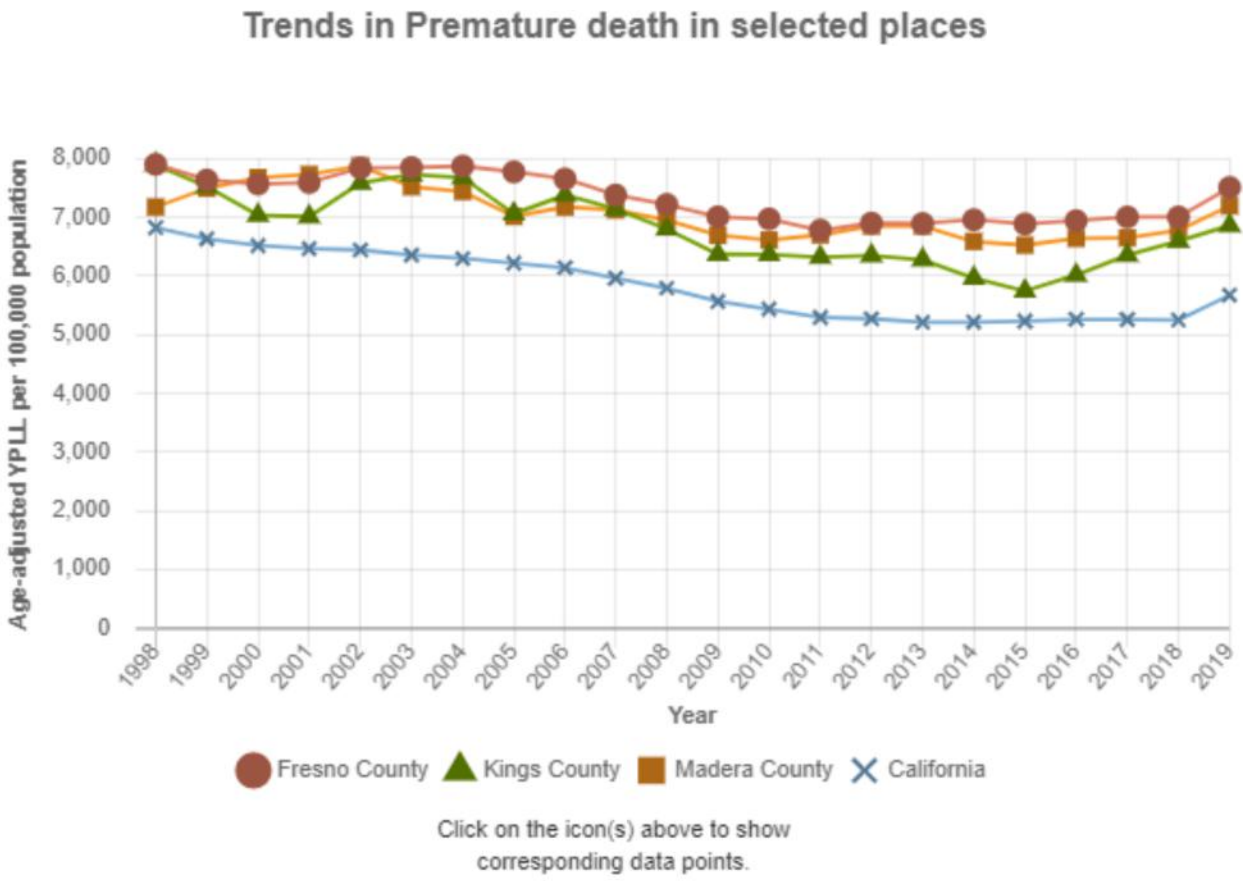
Years of data used: 2018-2020

The 2023 Rankings do not include updated data for this measure. *Please visit our FAQs to learn about methods changes in the 2020 census.*

- Learn more about this measure's methods and limitations.

Trends

Download



Notes:
Each year represents a 3-year average around the middle year (e.g. 2015 is the middle year of 2014-2016).

Data and documentation for trend graphs can be found here.
Click here to learn more about measuring progress and using trends.

Quality of Life	Fresno, CA	Kings, CA	Madera, CA	California

Poor or Fair Health		**20%**	**20%**	**21%**	**14%**

Definition: Percentage of adults reporting fair or poor health (age-adjusted).

Error margin for Fresno, CA: 18-22%

Error margin for Kings, CA: 18-22%

Error margin for Madera, CA: 19-24%

Error margin for California: 13-16%

Years of data used: 2020

Data should not be compared with prior years

Compare across states with caution

Learn more about this measure's methods and limitations.

Poor Physical Health Days		**3.9**	**3.9**	**4.1**	**3.0**

Definition: Average number of physically unhealthy days reported in past 30 days (age-adjusted). **Error margin for Fresno, CA:** 3.6-4.2

Error margin for Kings, CA: 3.6-4.2

Error margin for Madera, CA: 3.8-4.5

Error margin for California: 2.7-3.3

Years of data used: 2020

Data should not be compared with prior years

Compare across states with caution

Learn more about this measure's methods and limitations.

Poor Mental Health Days		**4.8**	**4.8**	**5.5**	**4.0**

Definition: Average number of mentally unhealthy days reported in past 30 days (age-adjusted).

Error margin for Fresno, CA: 4.6-5.1

Error margin for Kings, CA: 4.6-5.0

Error margin for Madera, CA: 5.2-5.8

Error margin for California: 3.7-4.3

Years of data used: 2020

Data should not be compared with prior years

Compare across states with caution

Learn more about this measure's methods and limitations.

Low Birthweight		**8%**	**6%**	**6%**	**7%**

Definition: Percentage of live births with low birthweight (< 2,500 grams).

Error margin for Fresno, CA: 7-8%

Error margin for Kings, CA: 6-7%

Error margin for Madera, CA: 6-7%

Error margin for California: 7-7%

Years of data used: 2014-2020

The 2023 Rankings do not include updated data for this measure. Please visit our FAQs to learn about methods changes in the 2020 census.

Learn more about this measure's methods and limitations.

Health Factors

Health Behaviors		Fresno, CA	Kings, CA	Madera, CA	California
Adult Smoking		**14%**	**15%**	**15%**	**9%**

Definition: Percentage of adults who are current smokers (age-adjusted).

Error margin for Fresno, CA: 13-16%

Error margin for Kings, CA: 13-17%

Error margin for Madera, CA: 14-18%

Error margin for California: 8-10%

Years of data used: 2020

Data should not be compared with prior years

Compare across states with caution

Learn more about this measure's methods and limitations.

Find strategies to address Adult Smoking.

Adult Obesity		**35%**	**35%**	**36%**	**30%**

Definition: Percentage of the adult population (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2 (age-adjusted).

Error margin for Fresno, CA: 33-36%

Error margin for Kings, CA: 34-36%

Error margin for Madera, CA: 34-37%

Error margin for California: 28-32%

Years of data used: 2020

Data should not be compared with prior years

Compare across states with caution

Learn more about this measure's methods and limitations.

Find strategies to address Adult Obesity.

Food Environment Index		**7.3**	**7.6**	**7.7**	**8.8**

Definition: Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2019 & 2020

Compare across states with caution

Learn more about this measure's methods and limitations.

Find strategies to address Food Environment Index.

Physical Inactivity		**28%**	**28%**	**27%**	**21%**

Definition: Percentage of adults aged 18 and over reporting no leisure-time physical activity (age-adjusted). **Error margin for Fresno, CA:** 25-30%

Error margin for Kings, CA: 25-30%

Error margin for Madera, CA: 25-30%

Error margin for California: 20-23%

Years of data used: 2020

Data should not be compared with prior years

Compare across states with caution

Learn more about this measure's methods and limitations.

Find strategies to address Physical Inactivity.

Access to Exercise Opportunities		**84%**	**68%**	**74%**	**95%**

Definition: Percentage of population with adequate access to locations for physical activity.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2022 & 2020

Data should not be compared with prior years

Learn more about this measure's methods and limitations.

Find strategies to address Access to Exercise Opportunities.

Excessive Drinking		**19%**	**20%**	**19%**	**18%**

Definition: Percentage of adults reporting binge or heavy drinking (age-adjusted).

Error margin for Fresno, CA: 18-19%

Error margin for Kings, CA: 19-20%

Error margin for Madera, CA: 18-20%

Error margin for California: 17-20%

Years of data used: 2020

Data should not be compared with prior years

Compare across states with caution

Learn more about this measure's methods and limitations.

Find strategies to address Excessive Drinking.

Alcohol-Impaired Driving Deaths		**26%**	**35%**	**33%**	**28%**

-
-

Definition: Percentage of driving deaths with alcohol involvement.

Error margin for Fresno, CA: 24-28%

Error margin for Kings, CA: 30-40%

Error margin for Madera, CA: 29-37%

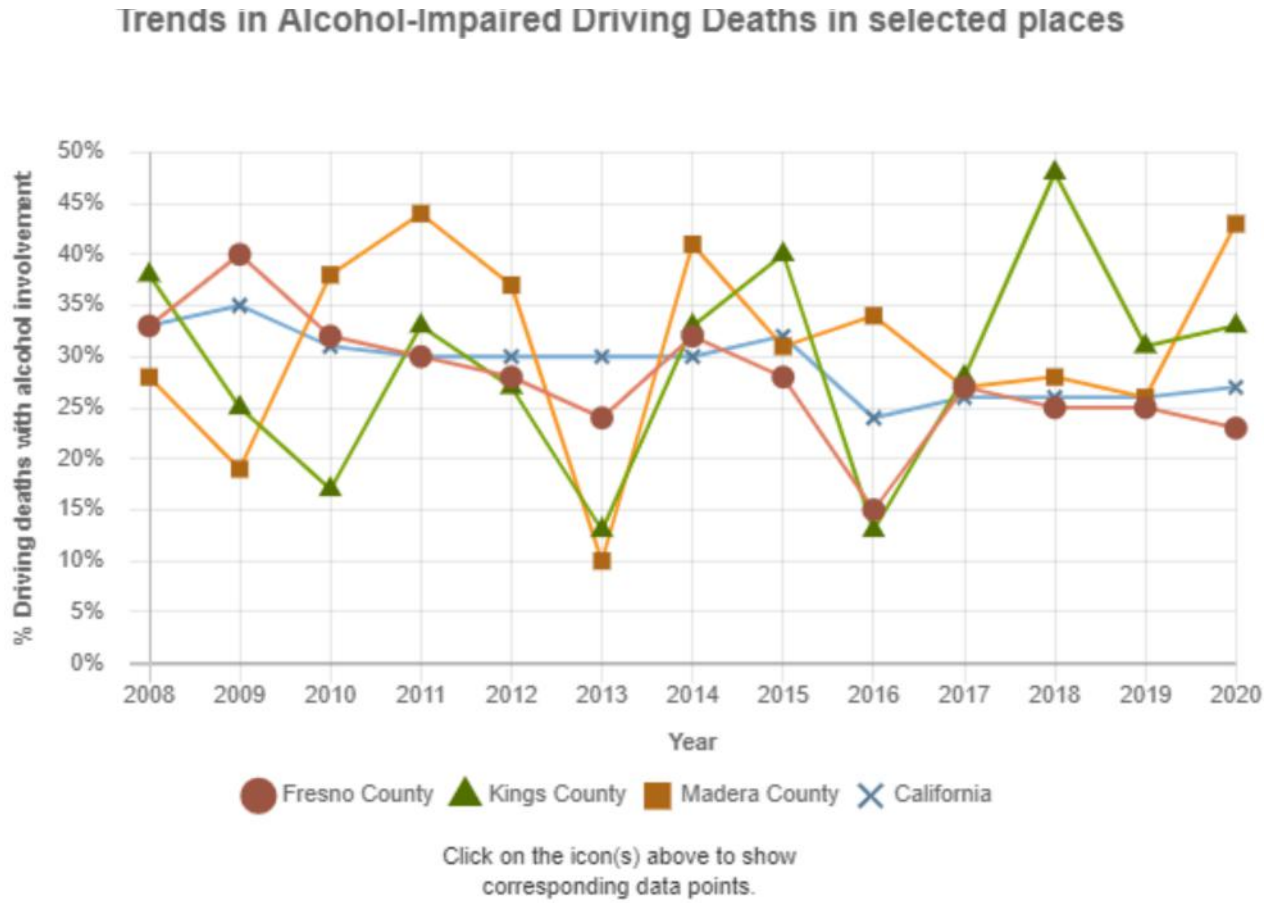
Error margin for California: 27-28%

Years of data used: 2016-2020

- Learn more about this measure's methods and limitations.
- Find strategies to address Alcohol-Impaired Driving Deaths.

Trends

Download



Notes:
This trend graph uses single-year estimates.

Data and documentation for trend graphs can be found here.
Click here to learn more about measuring progress and using trends.

Sexually Transmitted Infections		**560.9**	**672.2**	**424.6**	**452.2**

Definition: Number of newly diagnosed chlamydia cases per 100,000 population.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2020

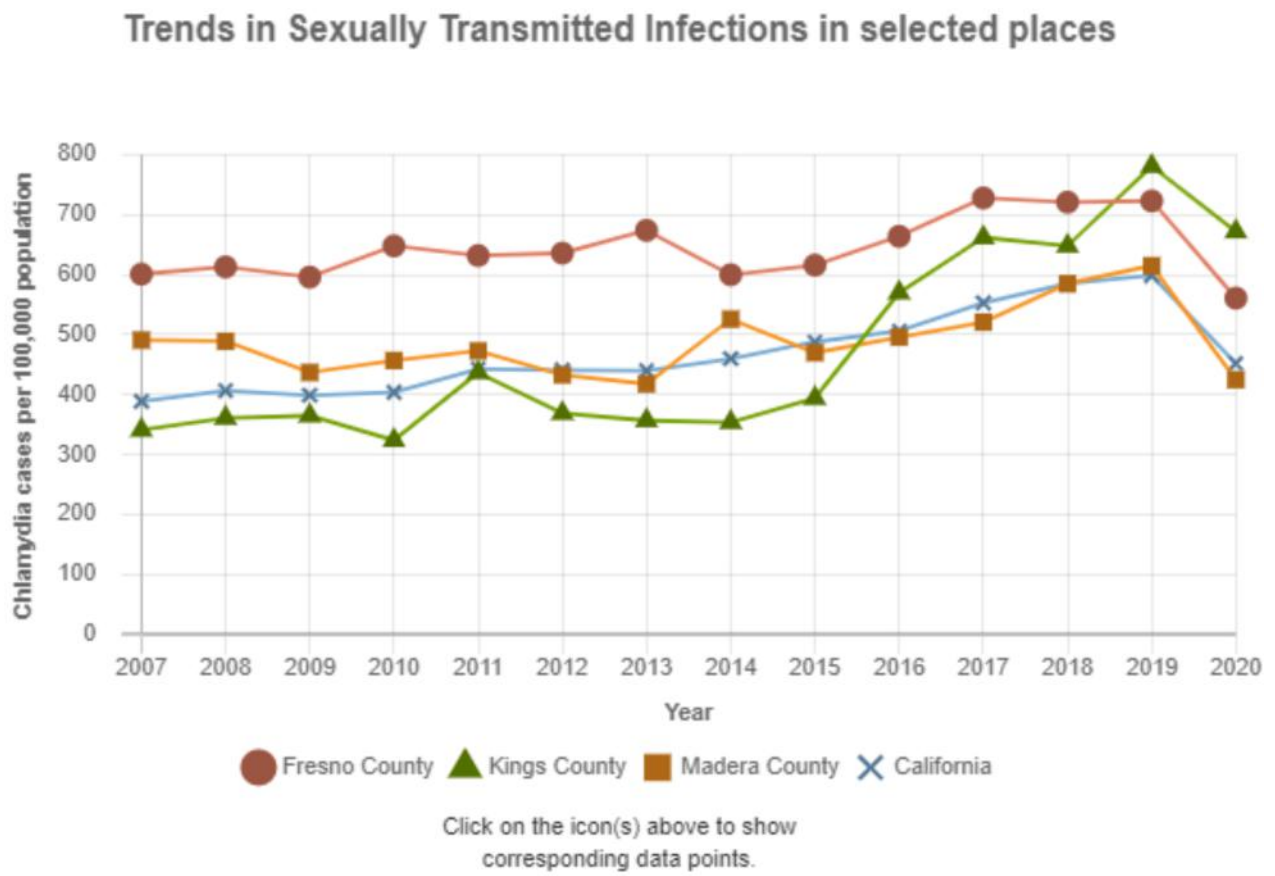
Compare across states with caution

- Learn more about this measure's methods and limitations. Find strategies to address Sexually Transmitted Infections.

Compare Counties | County Health Rankings & Roadmaps

Trends

Download



Notes:
Sexually transmitted infections should only be compared across states with caution.

Data and documentation for trend graphs can be found here.
Click here to learn more about measuring progress and using trends.

Teen Births		**27**	**31**	**30**	**16**

Definition: Number of births per 1,000 female population ages 15-19.

Error margin for Fresno, CA: 27-28

Error margin for Kings, CA: 29-33

Error margin for Madera, CA: 28-31

Error margin for California: 16-16

Years of data used: 2014-2020

The 2023 Rankings do not include updated data for this measure. *Please visit our FAQs to learn about methods changes in the 2020 census.*

Learn more about this measure's methods and limitations.

Find strategies to address Teen Births.

Clinical Care		Fresno, CA	Kings, CA	Madera, CA	California
Uninsured		9%	9%	10%	8%
PrimaryCare Physicians		**1,450:1**	**2,630:1**	**2,290:1**	**1,230:1**

Definition: Ratio of population to primary care physicians.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

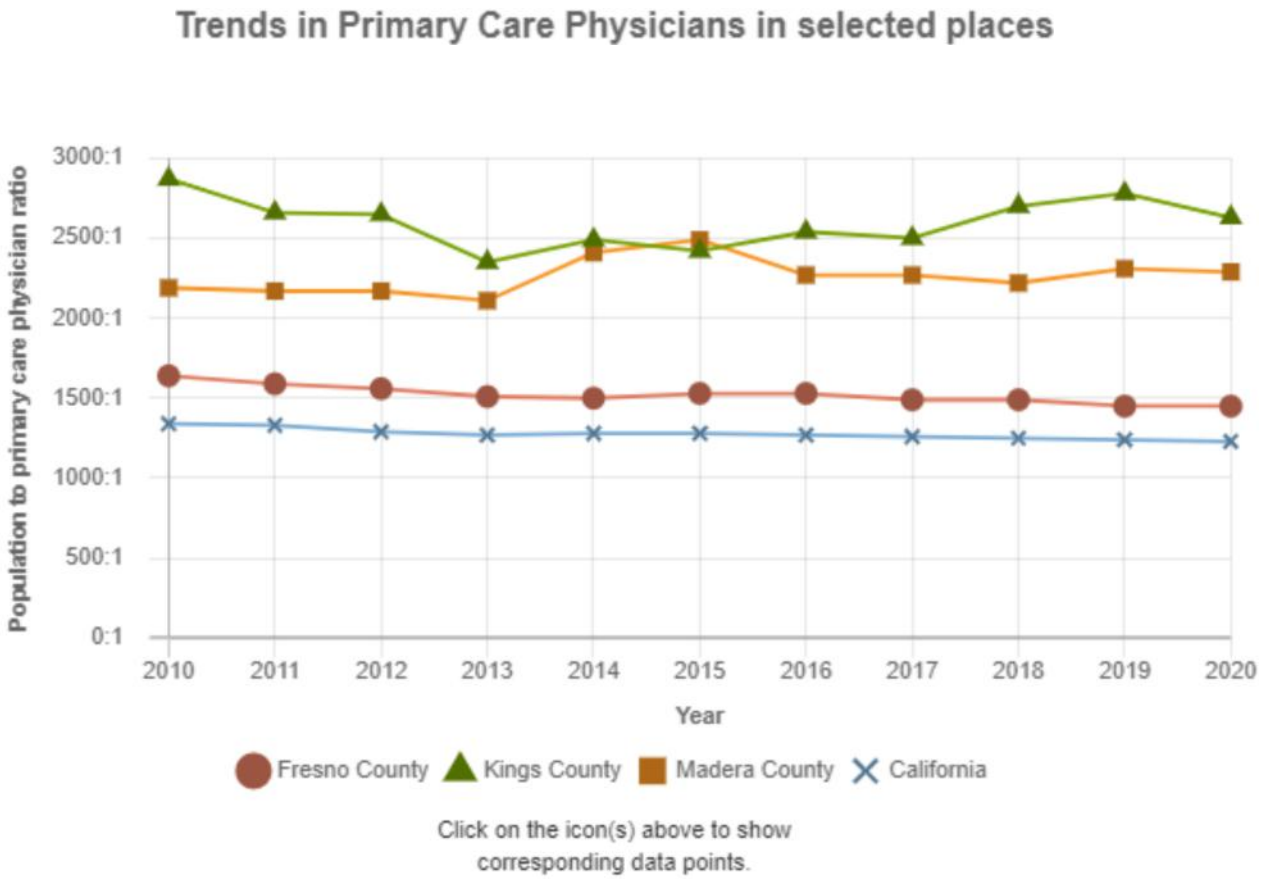
Years of data used: 2020

Learn more about this measure's methods and limitations.

Find strategies to address Primary Care Physicians.

Trends

Download



Notes:
The data in this table reflect the average population served by a single primary care physician.

Data and documentation for trend graphs can be found here.
Click here to learn more about measuring progress and using trends.

Dentists		**1,580:1**	**1,670:1**	**2,180:1**	**1,100:1**

Definition: Ratio of population to dentists.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

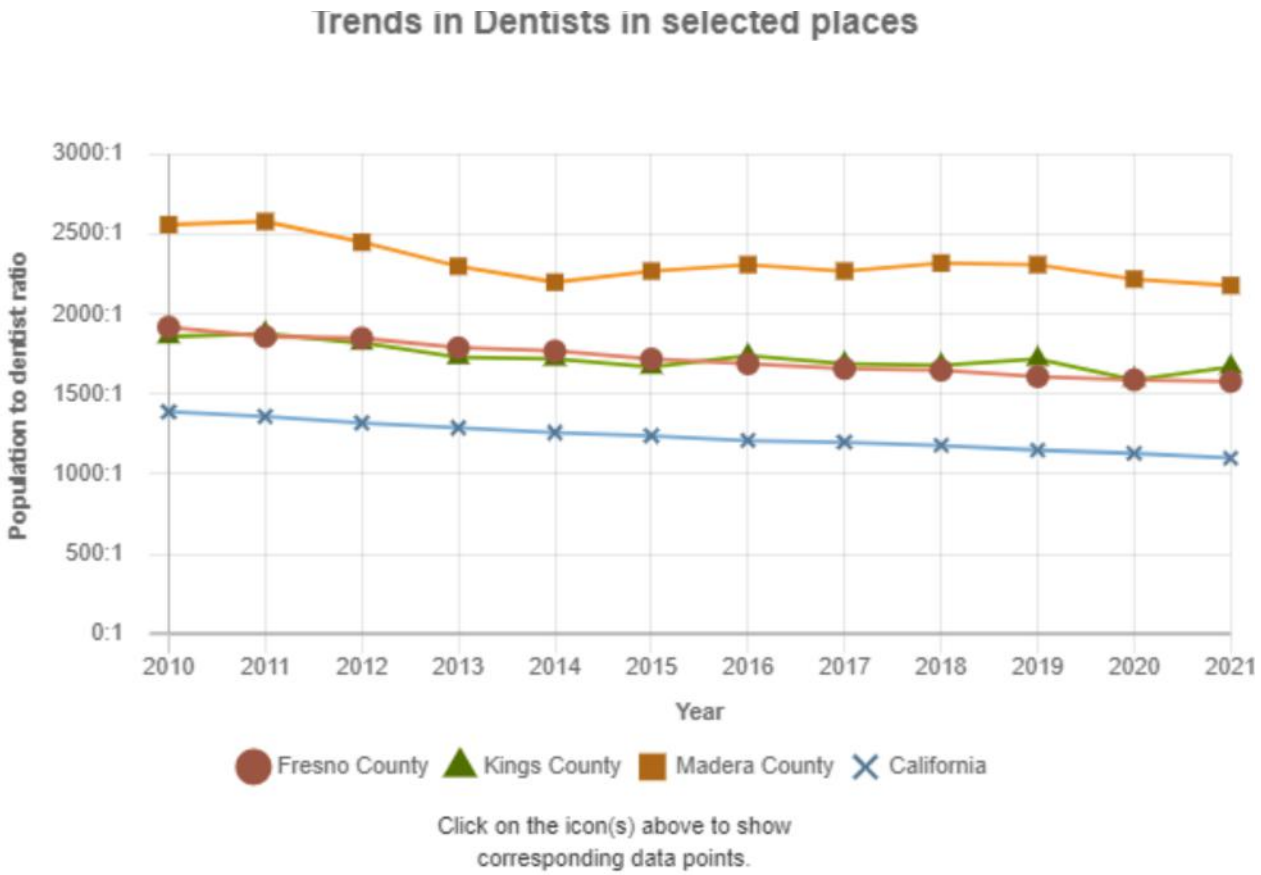
Error margin for California: N/A

Years of data used: 2021

- Learn more about this measure's methods and limitations.
- Find strategies to address Dentists.

Trends

Download



Notes:
The data in this table reflect the average population served by a single dentist.

Data and documentation for trend graphs can be found here.
Click here to learn more about measuring progress and using trends.

Mental Health Providers		**230:1**	**450:1**	**570:1**	**240:1**	counties?compareCounties=06019%2C06031%2C0603

9%2C06000&year=... 11/24

Definition: Ratio of population to mental health providers.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2022

- Learn more about this measure's methods and limitations.
- Find strategies to address Mental Health Providers.

Preventable Hospital Stays		3,057	2,824	2,638	2,256

Definition: Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

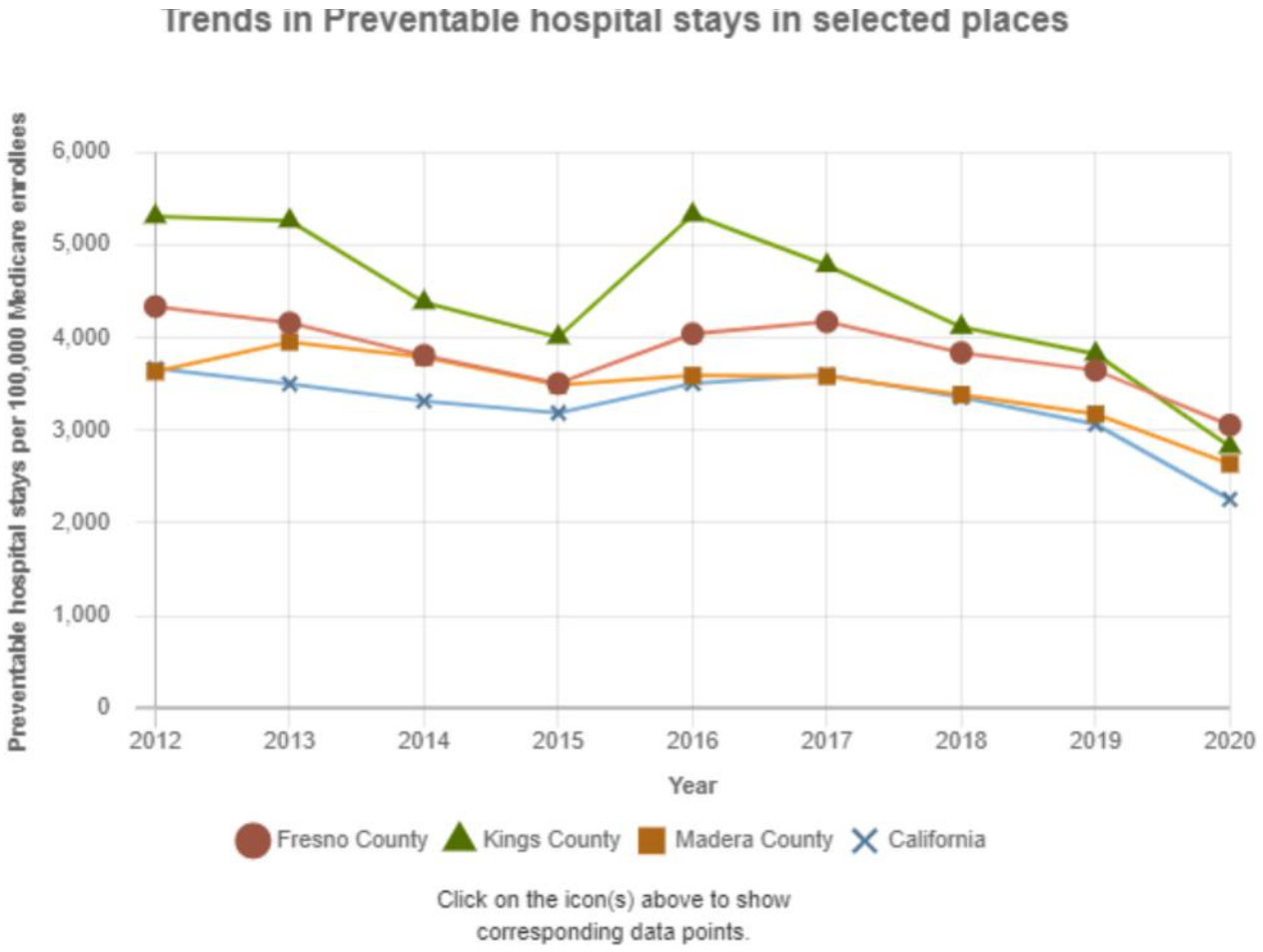
Error margin for California: N/A

Years of data used: 2020

- Learn more about this measure's methods and limitations.
- Find strategies to address Preventable Hospital Stays.

Trends

Download



Data and documentation for trend graphs can be found here.
Click here to learn more about measuring progress and using trends.

Mammography Screening		**34%**	**30%**	**32%**	**30%**

Definition: Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

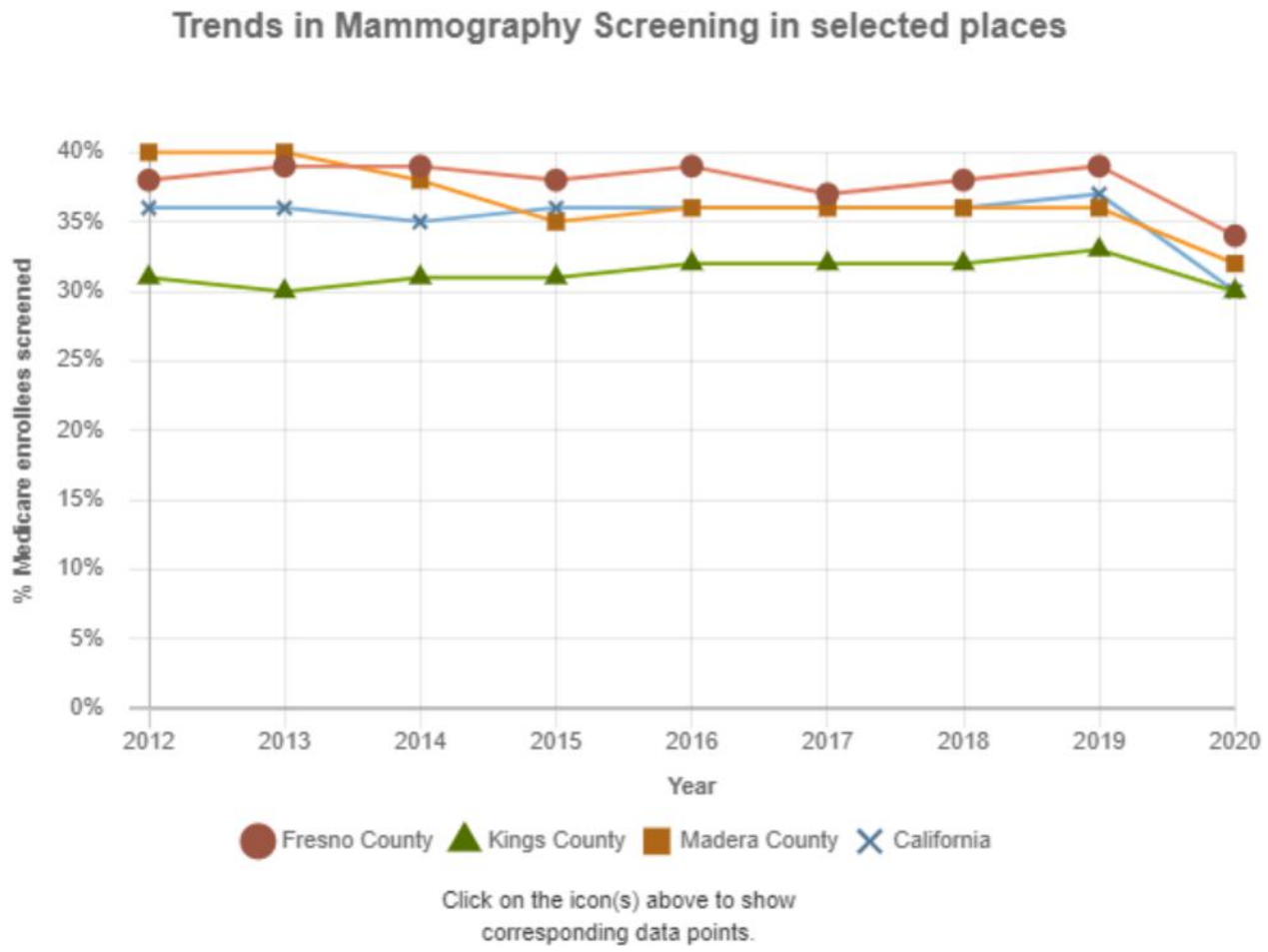
Error margin for California: N/A

Years of data used: 2020

- Learn more about this measure's methods and limitations.
- Find strategies to address Mammography Screening.

Trends

Download



Data and documentation for trend graphs can be found here.
Click here to learn more about measuring progress and using trends.

Flu Vaccinations		**46%**	**39%**	**39%**	**46%**

Definition: Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

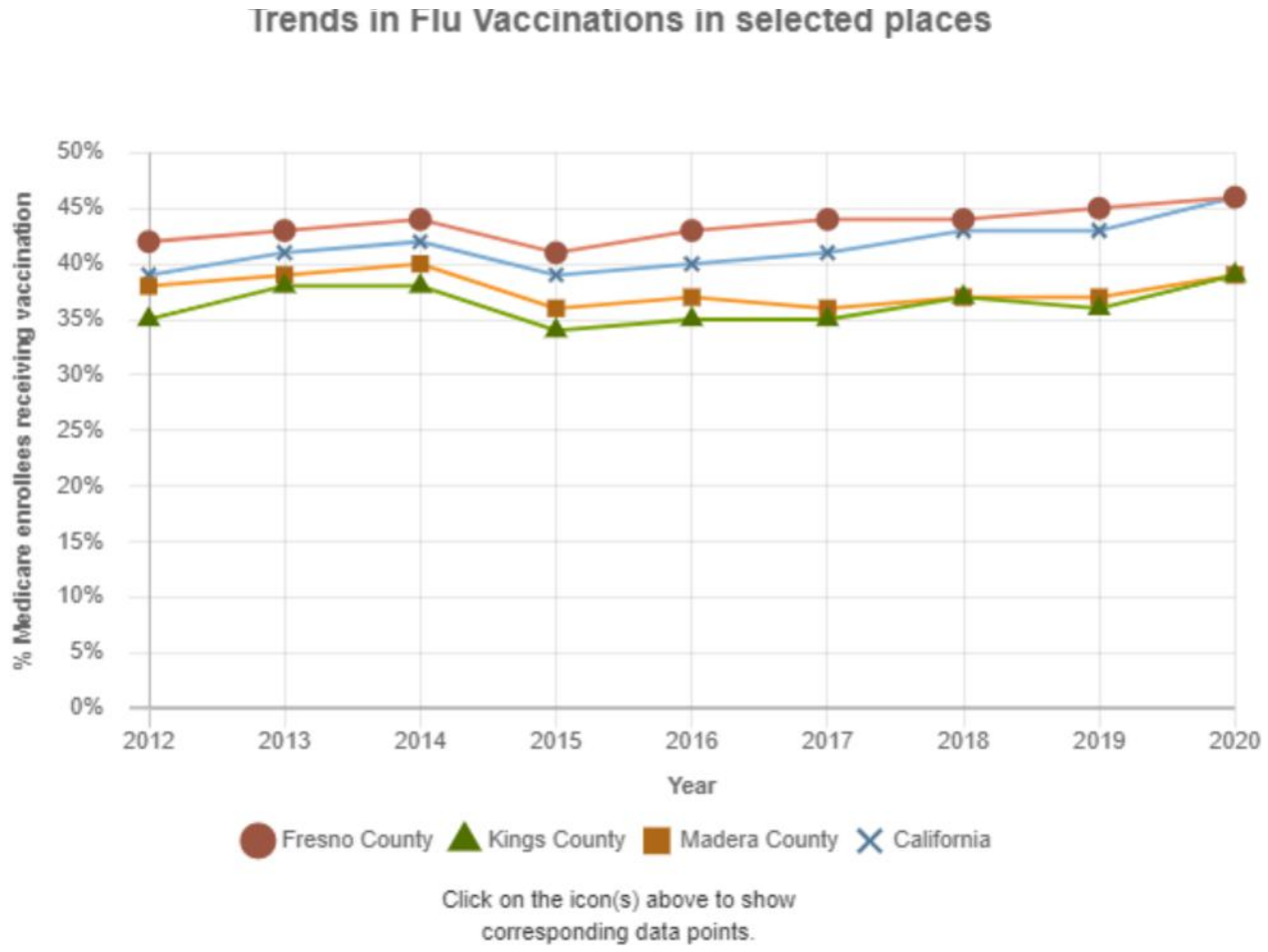
Error margin for California: N/A

Years of data used: 2020

- Learn more about this measure's methods and limitations.
- Find strategies to address Flu Vaccinations.

Trends

Download



Data and documentation for trend graphs can be found here.
Click here to learn more about measuring progress and using trends.

Social & Economic Factors		Fresno, CA	Kings, CA	Madera, CA	California
High School Completion		**78%**	**74%**	**72%**	**84%**

Definition: Percentage of adults ages 25 and over with a high school diploma or equivalent.

Error margin for Fresno, CA: 77-78%

Error margin for Kings, CA: 72-75%

Error margin for Madera, CA: 70-73%

Error margin for California: 84-84%

Years of data used: 2017-2021

Learn more about this measure's methods and limitations.

Find strategies to address High School Completion.

Some College		**57%**	**51%**	**49%**	**67%**

Definition: Percentage of adults ages 25-44 with some post-secondary education.

Error margin for Fresno, CA: 56-59%

Error margin for Kings, CA: 48-54%

Error margin for Madera, CA: 45-52%

Error margin for California: 67-67%

Years of data used: 2017-2021

Learn more about this measure's methods and limitations.

Find strategies to address Some College.

Unemployment		**9.2%**	**9.6%**	**8.8%**	**7.3%**

Definition: Percentage of population ages 16 and older unemployed but seeking work.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

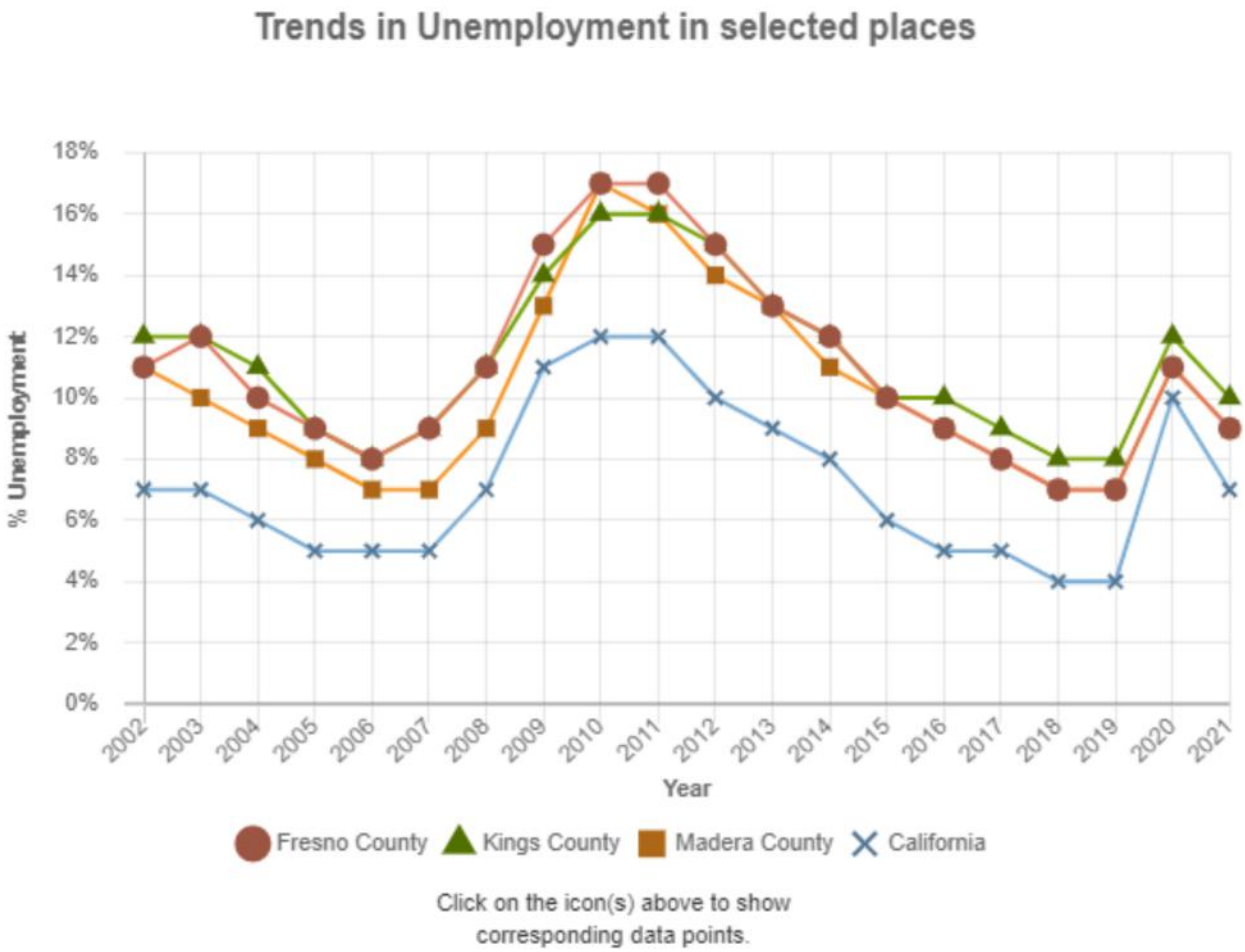
Years of data used: 2021

Compare across states with caution

- Learn more about this measure's methods and limitations.
- Find strategies to address Unemployment.

Trends

Download



Data and documentation for trend graphs can be found here.
Click here to learn more about measuring progress and using trends.

Children in Poverty		**27%**	**23%**	**28%**	**16%**

Definition: Percentage of people under age 18 in poverty.

Error margin for Fresno, CA: 24-29%

Error margin for Kings, CA: 18-28%

Error margin for Madera, CA: 22-33%

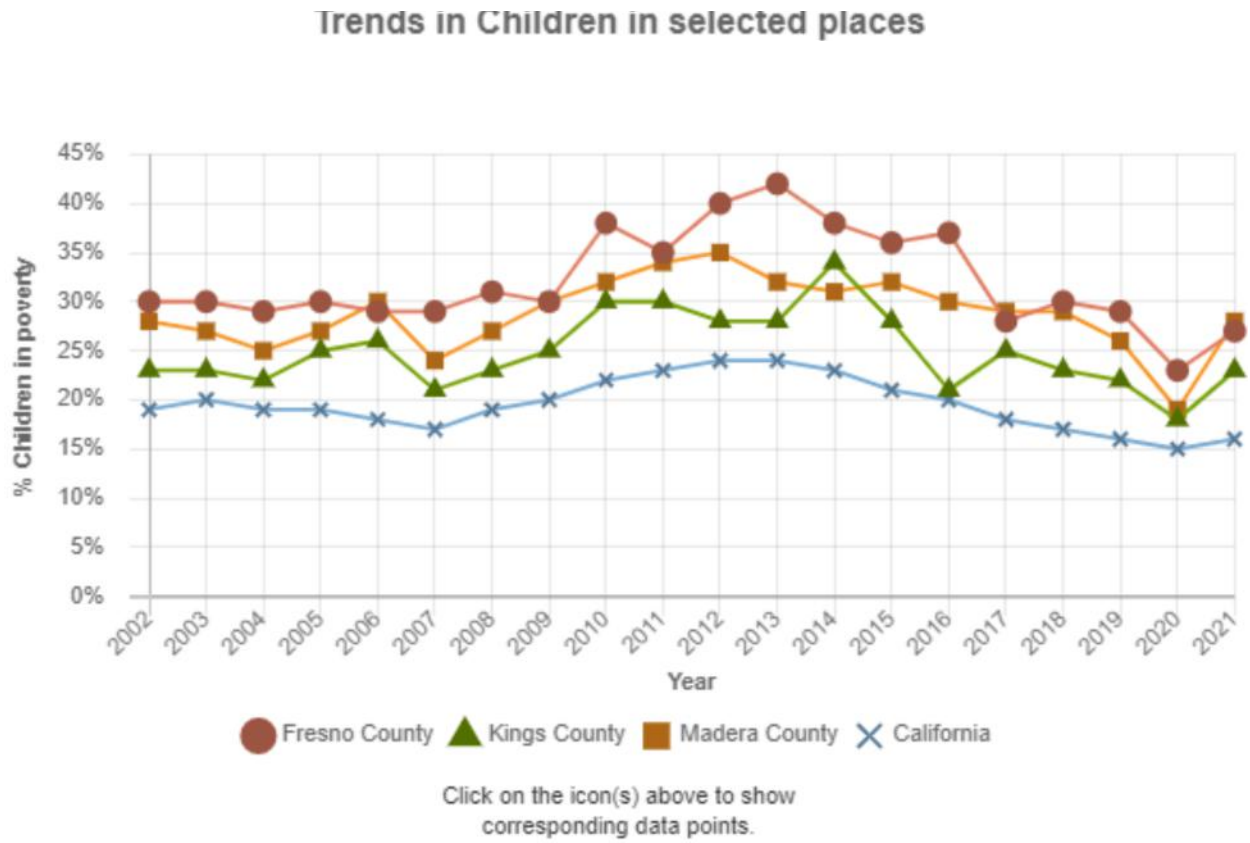
Error margin for California: 15-16%

Years of data used: 2021

- Learn more about this measure's methods and limitations.
- Find strategies to address Children in Poverty.

Trends

Download



Notes:
Prior to 2005, Children in poverty was based on the Current Population Survey; beginning in 2005, it was based on the American Community Survey.

Data and documentation for trend graphs can be found here.
Click here to learn more about measuring progress and using trends.

Income Inequality		**5.1**	**4.0**	**4.3**	**5.1**

Definition: Ratio of household income at the 80th percentile to income at the 20th percentile.

Error margin for Fresno, CA: 4.9-5.3

Error margin for Kings, CA: 3.6-4.3

Error margin for Madera, CA: 3.9-4.6

Error margin for California: 5.1-5.2

Years of data used: 2017-2021

Learn more about this measure's methods and limitations.

Find strategies to address Income Inequality.

Children in Single-Parent Households		**28%**	**25%**	**23%**	**22%**

Definition: Percentage of children that live in a household headed by a single parent.

Error margin for Fresno, CA: 27-30%

Error margin for Kings, CA: 21-28%

Error margin for Madera, CA: 19-26%

Error margin for California: 22-23%

Years of data used: 2017-2021

Learn more about this measure's methods and limitations.

Find strategies to address Children in Single-Parent Households.

Social Associations		**5.2**	**3.8**	**4.6**	**6.0**

Definition: Number of membership associations per 10,000 population.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2020

Learn more about this measure's methods and limitations.

Find strategies to address Social Associations.

Injury Deaths		**65**	**61**	**69**	**55**

Definition: Number of deaths due to injury per 100,000 population.

Error margin for Fresno, CA: 63-67

Error margin for Kings, CA: 56-67

Error margin for Madera, CA: 63-75

Error margin for California: 55-55

Years of data used: 2016-2020

The 2023 Rankings do not include updated data for this measure. *Please visit our FAQs to learn about methods changes in the 2020 census.*

- Learn more about this measure's methods and limitations.
- Find strategies to address Injury Deaths.

Physical Environment		Fresno, CA	Kings, CA	Madera, CA	California
Air Pollution- Particulate Matter		**11.7**	**12.3**	**10.0**	**7.1**

Definition: Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

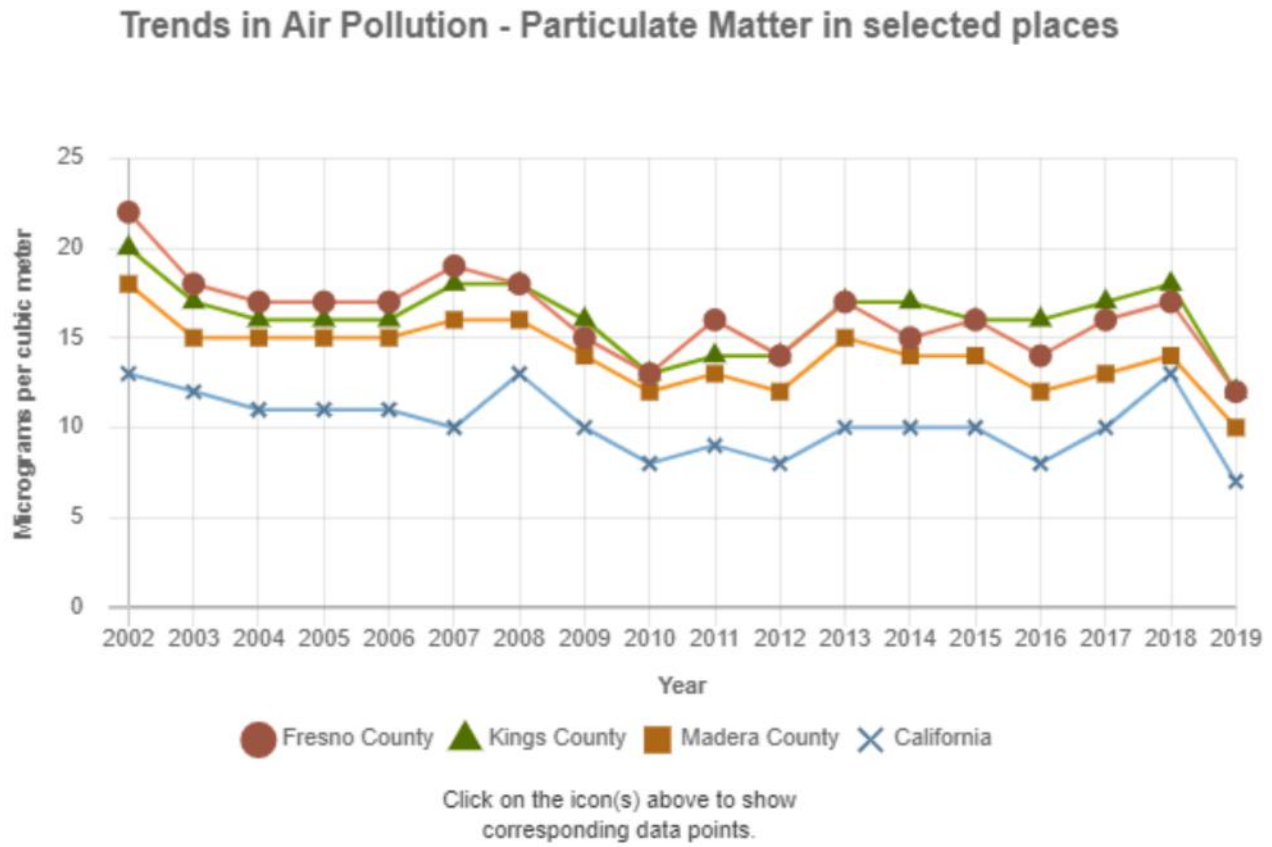
Error margin for California: N/A

Years of data used: 2019

- Learn more about this measure's methods and limitations.
- Find strategies to address Air Pollution- Particulate Matter.

Trends

Download



Notes:
Data in this trend graph are taken from the Environmental Public Health Tracking Network, and will not match data used in the 2014-2016 Rankings.

Data and documentation for trend graphs can be found here.
Click here to learn more about measuring progress and using trends.

Drinking Water Violations		**Yes**	**Yes**	**Yes**

Definition: Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2021

Learn more about this measure's methods and limitations.

Find strategies to address Drinking Water Violations.

Severe Housing Problems		**26%**	**21%**	**23%**	**26%**

Definition: Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.

Error margin for Fresno, CA: 26-27%

Error margin for Kings, CA: 19-23%

Error margin for Madera, CA: 21-25%

Error margin for California: 26-26%

Years of data used: 2015-2019

Learn more about this measure's methods and limitations.

Find strategies to address Severe Housing Problems.

Driving Alone to Work		**78%**	**78%**	**73%**	**70%**

Definition: Percentage of the workforce that drives alone to work.

Error margin for Fresno, CA: 77-78%

Error margin for Kings, CA: 76-79%

Error margin for Madera, CA: 71-75%

Error margin for California: 70-70%

Years of data used: 2017-2021

Learn more about this measure's methods and limitations.

Find strategies to address Driving Alone to Work.

Long Commute- Driving Alone		**26%**	**30%**	**41%**	**42%**

Definition: Among workers who commute in their car alone, the percentage that commute more than 30 minutes.

Error margin for Fresno, CA: 25-26%

Error margin for Kings, CA: 27-33%

Error margin for Madera, CA: 38-44%

Error margin for California: 42-42%

Years of data used: 2017-2021

Learn more about this measure's methods and limitations.

Find strategies to address Long Commute - Driving Alone.

Appendix B2

County Health Rankings & Roadmaps

Compare Counties

Select from all counties or choose based on demographic, social and economic indicators.

Select year: 2023

Additional

To add any additional locations, an existing selection will need to be removed.

		Fresno, CA	Kings, CA	Madera, CA	California
Health Outcomes					
Length of Life		Fresno, CA	Kings, CA	Madera, CA	California
Life Expectancy		**78.0**	**79.2**	**79.1**	**81.0**

Definition: Average number of years a person can expect to live.

Error margin for Fresno, CA: 77.8-78.2

Error margin for Kings, CA: 78.7-79.7

Error margin for Madera, CA: 78.6-79.6

Error margin for California: 81.0

Years of data used: 2018-2020

The 2023 Rankings do not include updated data for this measure. *Please visit our FAQs to learn about methods changes in the 2020 census.*

Learn more about this measure's methods and limitations.

Premature Age-Adjusted Mortality		**380**	**360**	**350**	**290**

Definition: Number of deaths among residents under age 75 per 100,000 population (age-adjusted).

Error margin for Fresno, CA: 370-390

Error margin for Kings, CA: 340-380

Error margin for Madera, CA: 340-370

Error margin for California: 290-290

Years of data used: 2018-2020

The 2023 Rankings do not include updated data for this measure. *Please visit our FAQs to learn about methods changes in the 2020 census.*

Learn more about this measure's methods and limitations.

Child Mortality		**50**	**40**	**40**	**40**

Definition: Number of deaths among residents under age 18 per 100,000 population.

Error margin for Fresno, CA: 40-50

Error margin for Kings, CA: 30-60

Error margin for Madera, CA: 30-60

Error margin for California: 30-40

Years of data used: 2017-2020

The 2023 Rankings do not include updated data for this measure. *Please visit our FAQs to learn about methods changes in the 2020 census.*

Learn more about this measure's methods and limitations.

Infant Mortality		**6**	**5**	**5**	**4**

Definition: Number of infant deaths (within 1 year) per 1,000 live births.

Error margin for Fresno, CA: 6-7

Error margin for Kings, CA: 4-6

Error margin for Madera, CA: 4-6

Error margin for California: 4-4

Years of data used: 2014-2020

The 2023 Rankings do not include updated data for this measure. *Please visit our FAQs to learn about methods changes in the 2020 census.*

Learn more about this measure's methods and limitations.

Quality of Life		Fresno, CA	Kings, CA	Madera, CA	California
Frequent Physical Distress		**12%**	**12%**	**13%**	**10%**

Definition: Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).

Error margin for Fresno, CA: 11-13%

Error margin for Kings, CA: 11-13%

Error margin for Madera, CA: 12-14%

Error margin for California: 8-11%

Years of data used: 2020

Data should not be compared with prior years

Compare across states with caution

Learn more about this measure's methods and limitations.

Frequent Mental Distress		**15%**	**16%**	**17%**	**13%**

Definition: Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted). **Error margin for Fresno, CA:** 14-16%

Error margin for Kings, CA: 15-16%

Error margin for Madera, CA: 16-18%

Error margin for California: 11-14%

Years of data used: 2020

Data should not be compared with prior years

Compare across states with caution

Learn more about this measure's methods and limitations.

Diabetes Prevalence		**12%**	**12%**	**12%**	**9%**

Definition: Percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted).

Error margin for Fresno, CA: 12-13%

Error margin for Kings, CA: 12-13%

Error margin for Madera, CA: 12-13%

Error margin for California: 8-10%

Years of data used: 2020

Data should not be compared with prior years

Compare across states with caution

Learn more about this measure's methods and limitations.

HIV Prevalence		**267**	**154**	**166**	**406**

Definition: Number of people aged 13 years and older living with a diagnosis of Human Immunodeficiency Virus (HIV) infection per 100,000 population.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2020

This measure should not be compared across states

Learn more about this measure's methods and limitations.

Health Factors

Health Behaviors		Fresno, CA	Kings, CA	Madera, CA	California
Food Insecurity		**14%**	**13%**	**13%**	**9%**

Definition: Percentage of population who lack adequate access to food.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2020

Compare across states with caution

Learn more about this measure's methods and limitations.

Find strategies to address Food Insecurity.

Limited Access to Healthy Foods		**5%**	**7%**	**5%**	**3%**

Definition: Percentage of population who are low-income and do not live close to a grocery store.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2019

Learn more about this measure's methods and limitations.

Find strategies to address Limited Access to Healthy Foods.

DrugOverdoseDeaths		**14**	**15**	**14**	**17**

Definition: Number of drug poisoning deaths per 100,000 population.

Error margin for Fresno, CA: 12-15

Error margin for Kings, CA: 11-19

Error margin for Madera, CA: 10-17

Error margin for California: 17-18

Years of data used: 2018-2020

The 2023 Rankings do not include updated data for this measure. Please visit our FAQs to learn about methods changes in the 2020 census.

Learn more about this measure's methods and limitations.

Find strategies to address Drug Overdose Deaths.

InsufficientSleep		**33%**	**35%**	**35%**	**31%**

Definition: Percentage of adults who report fewer than 7 hours of sleep on average (age-adjusted).

Error margin for Fresno, CA: 32-34%

Error margin for Kings, CA: 34-36%

Error margin for Madera, CA: 34-37%

Error margin for California: 29-33%

Years of data used: 2020

Data should not be compared with prior years

Compare across states with caution

Learn more about this measure's methods and limitations.

Clinical Care	Fresno, CA	Kings, CA	Madera, CA	California

Uninsured Adults		12%	12%	13%	10%
Uninsured Children		3%	4%	4%	3%
Other Primary Care Providers		**1,100:1**	**1,160:1**	**1,170:1**	**1,260:1**

Definition: Ratio of population to primary care providers other than physicians.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2022

Learn more about this measure's methods and limitations.

Find strategies to address Other Primary Care Providers.

Social & Economic Factors		Fresno, CA	Kings, CA	Madera, CA	California
High School Graduation		**86%**	**91%**	**88%**	**88%**

Definition: Percentage of ninth-grade cohort that graduates in four years.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2019-2020

Compare across states with caution

Learn more about this measure's methods and limitations.

Find strategies to address High School Graduation.

Disconnected Youth		**9%**	**11%**	**7%**	**7%**

Definition: Percentage of teens and young adults ages 16-19 who are neither working nor in school.

Error margin for Fresno, CA: 8-11%

Error margin for Kings, CA: 8-15%

Error margin for Madera, CA: 5-10%

Error margin for California: 6-7%

Years of data used: 2017-2021

Learn more about this measure's methods and limitations.

Find strategies to address Disconnected Youth.

Reading Scores		**2.9**	**2.7**	**2.6**	**2.9**

Definition: Average grade level performance for 3rd graders on English Language Arts standardized tests. **Error margin for Fresno, CA:** N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2018

Learn more about this measure's methods and limitations.

Find strategies to address Reading Scores.

Math Scores		**2.7**	**2.5**	**2.4**	**2.7**

Definition: Average grade level performance for 3rd graders on math standardized tests.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2018

Learn more about this measure's methods and limitations.

Find strategies to address Math Scores.

School Segregation		**0.16**	**0.12**	**0.24**	**0.25**

Definition: The extent to which students within different race and ethnicity groups are unevenly distributed across schools when compared with the racial and ethnic composition of the local population. The index ranges from 0 to 1 with lower values representing a school composition that approximates race and ethnicity distributions in the student populations within the county, and higher values representing more segregation.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2021-2022

- Learn more about this measure's methods and limitations.
- Find strategies to address School Segregation.

School Funding Adequacy		**-$5,255**	**-$1,749**	**-$2,268**	**-$1,882**

Definition: The average gap in dollars between actual and required spending per pupil among public school districts. Required spending is an estimate of dollars needed to achieve U.S. average test scores in each district.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

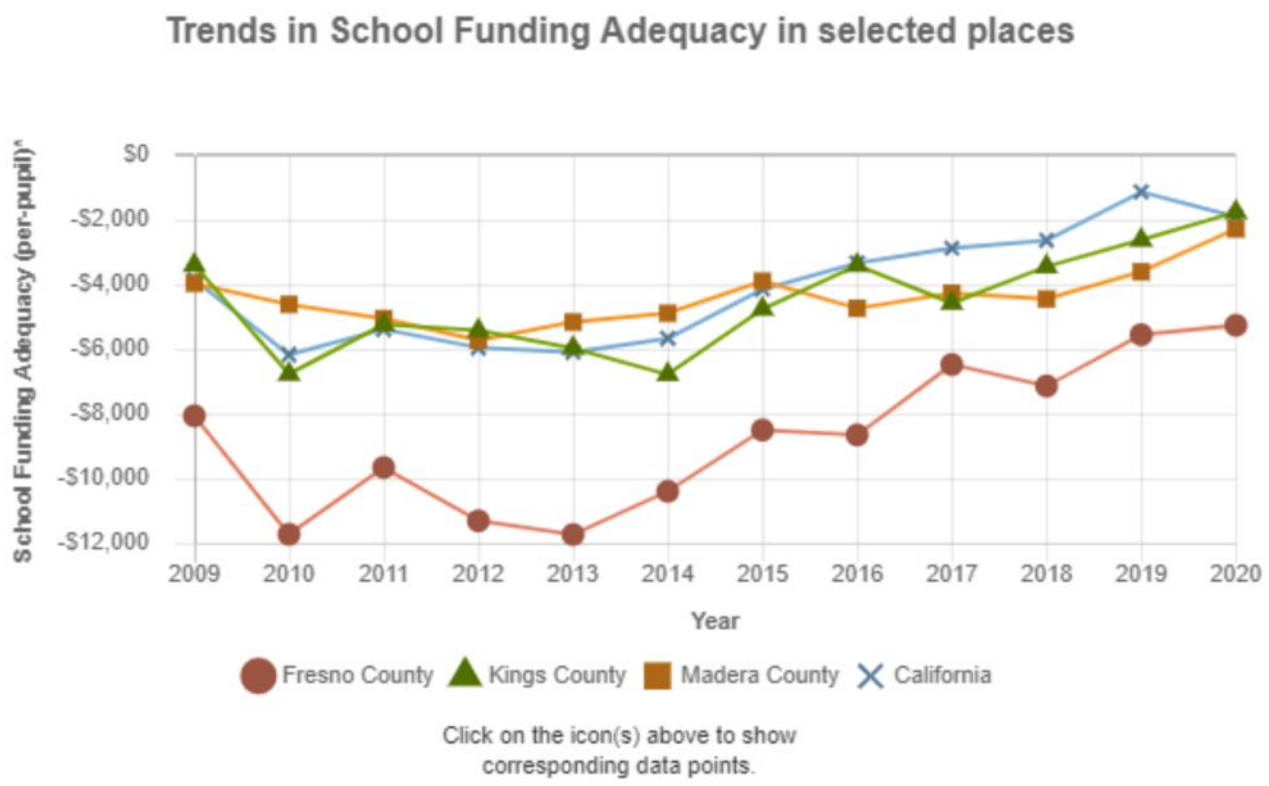
Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2020

- Learn more about this measure's methods and limitations.
- Find strategies to address School Funding Adequacy.

Trends Download



Notes:
*School Funding Adequacy is the actual per-pupil spending compared with an estimated amount that would need to be spent to achieve U.S. average test scores in each school district. The county value is the cross-district average of the spending surplus or deficit.

Data and documentation for trend graphs can be found here.
Click here to learn more about measuring progress and using trends.

Gender Pay Gap		**0.88**	**0.90**	**0.79**	**0.86**

Definition: Ratio of women's median earnings to men's median earnings for all full-time, year-round workers, presented as "cents on the dollar."

Error margin for Fresno, CA: 0.85-0.91

Error margin for Kings, CA: 0.81-0.99

Error margin for Madera, CA: 0.68-0.90

Error margin for California: 0.85-0.86

Years of data used: 2017-2021

Learn more about this measure's methods and limitations.

Find strategies to address Gender Pay Gap.

Median Household Income		**$63,100**	**$60,800**	**$60,200**	**$84,800**

Definition: The income where half of households in a county earn more and half of households earn less.

Error margin for Fresno, CA: $61,000 to $65,300

Error margin for Kings, CA: $56,300 to $65,300

Error margin for Madera, CA: $54,000 to $66,500

Error margin for California: $84,200 to $85,500

Years of data used: 2021

Learn more about this measure's methods and limitations.

Find strategies to address Median Household Income.

Living Wage		**$46.86**	**$46.02**	**$46.57**	**$56.48**

Definition: The hourly wage needed to cover basic household expenses plus all relevant taxes for a household of one adult and two children.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2022

Data should not be compared with prior years

This measure should not be compared across states

Learn more about this measure's methods and limitations.

Find strategies to address Living Wage.

ChildrenEligibleforFreeorReduced Price Lunch		**76%**	**71%**	**81%**	**59%**

Definition: Percentage of children enrolled in public schools that are eligible for free or reduced price lunch.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2020-2021

This measure should not be compared across states

Learn more about this measure's methods and limitations.

Find strategies to address Children Eligible for Free or Reduced Price Lunch.

Residential Segregation- Black/White		**49**	**36**	**64**	**57**

Definition: Index of dissimilarity where higher values indicate greater residential segregation between Black and white county residents.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2017-2021

Learn more about this measure's methods and limitations.

Find strategies to address Residential Segregation - Black/White.

ChildCareCostBurden		**32%**	**31%**	**32%**	**30%**

Definition: Child care costs for a household with two children as a percent of median household income.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2022 & 2021

Data should not be compared with prior years

This measure should not be compared across states

Learn more about this measure's methods and limitations.

Find strategies to address Child Care Cost Burden.

Child Care Centers		**5**	**4**	**5**	**8**

Definition: Number of child care centers per 1,000 population under 5 years old.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2010-2022

Data should not be compared with prior years

This measure should not be compared across states

Learn more about this measure's methods and limitations.

Find strategies to address Child Care Centers.

Homicides		**7**	**6**	**6**	**5**

Definition: Number of deaths due to homicide per 100,000 population.

Error margin for Fresno, CA: 7-8

Error margin for Kings, CA: 5-8

Error margin for Madera, CA: 5-8

Error margin for California: 5-5

Years of data used: 2014-2020

The 2023 Rankings do not include updated data for this measure. *Please visit our FAQs to learn about methods changes in the 2020 census.*

Learn more about this measure's methods and limitations.

Find strategies to address Homicides.

Suicides		**11**	**14**	**12**	**10**

Definition: Number of deaths due to suicide per 100,000 population (age-adjusted).

Error margin for Fresno, CA: 10-12

Error margin for Kings, CA: 11-16

Error margin for Madera, CA: 10-15

Error margin for California: 10-11

Years of data used: 2016-2020

The 2023 Rankings do not include updated data for this measure. *Please visit our FAQs to learn about methods changes in the 2020 census.*

Learn more about this measure's methods and limitations.

Find strategies to address Suicides.

Firearm Fatalities		**10**	**10**	**10**	**8**

Definition: Number of deaths due to firearms per 100,000 population.

Error margin for Fresno, CA: 10-11

Error margin for Kings, CA: 8-12

Error margin for Madera, CA: 8-13

Error margin for California: 8-8

Years of data used: 2016-2020

The 2023 Rankings do not include updated data for this measure. *Please visit our FAQs to learn about methods changes in the 2020 census.*

Learn more about this measure's methods and limitations.

Find strategies to address Firearm Fatalities.

MotorVehicleCrashDeaths		**16**	**14**	**19**	**10**

Definition: Number of motor vehicle crash deaths per 100,000 population.

Error margin for Fresno, CA: 15-16

Error margin for Kings, CA: 12-16

Error margin for Madera, CA: 16-21

Error margin for California: 10-10

Years of data used: 2014-2020

The 2023 Rankings do not include updated data for this measure. *Please visit our FAQs to learn about methods changes in the 2020 census.*

Learn more about this measure's methods and limitations.

Find strategies to address Motor Vehicle Crash Deaths.

Juvenile Arrests		**12**	**8**	**26**	

Definition: Rate of delinquency cases per 1,000 juveniles.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2019

This measure should not be compared across states

Learn more about this measure's methods and limitations.

Find strategies to address Juvenile Arrests.

VoterTurnout		**60.5%**	**47.1%**	**57.6%**	**67.9%**

Definition: Percentage of citizen population aged 18 or older who voted in the 2020 U.S. Presidential election.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2020 & 2016-2020

This measure should not be compared across states

Learn more about this measure's methods and limitations.

Find strategies to address Voter Turnout.

Census Participation		**66.2%**	**65.0%**	**60.9%**	

Definition: Percentage of all households that self-responded to the 2020 census (by internet, paper questionnaire or telephone).

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2020

This measure should not be compared across states

Learn more about this measure's methods and limitations.

Find strategies to address Census Participation.

Physical Environment		Fresno, CA	Kings, CA	Madera, CA	California
Trafc Volume		**567**	**159**	**267**	**1,319**

Definition: Average traffic volume per meter of major roadways in the county.

Error margin for Fresno, CA: N/A

Error margin for Kings, CA: N/A

Error margin for Madera, CA: N/A

Error margin for California: N/A

Years of data used: 2019

This measure should not be compared across states

Learn more about this measure's methods and limitations.

Find strategies to address Traffic Volume.

Homeownership		**54%**	**55%**	**66%**	**55%**

Definition: Percentage of owner-occupied housing units.

Error margin for Fresno, CA: 53-55%

Error margin for Kings, CA: 52-57%

Error margin for Madera, CA: 64-68%

Error margin for California: 55-56%

Years of data used: 2017-2021

Learn more about this measure's methods and limitations.

Find strategies to address Homeownership.

Severe Housing Cost Burden		**18%**	**14%**	**17%**	**20%**

Definition: Percentage of households that spend 50% or more of their household income on housing. **Error margin for Fresno, CA:** 18-19%

Error margin for Kings, CA: 12-15%

Error margin for Madera, CA: 15-19%

Error margin for California: 19-20%

Years of data used: 2017-2021

Learn more about this measure's methods and limitations.

Find strategies to address Severe Housing Cost Burden.

Broadband Access		**84%**	**85%**	**87%**	**90%**

Definition: Percentage of households with broadband internet connection.

Error margin for Fresno, CA: 83-84%

Error margin for Kings, CA: 84-87%

Error margin for Madera, CA: 85-89%

Error margin for California: 90-91%

Years of data used: 2017-2021

Learn more about this measure's methods and limitations.

Find strategies to address Broadband Access.

Demographics		Fresno, CA	Kings, CA	Madera, CA	California
Population		1,013,581	153,443	159,410	39,237,836
%Below18YearsofAge		28.2%	27.0%	27.4%	22.4%
% 65 and Older		12.6%	10.7%	14.3%	15.2%
% Non-Hispanic Black		4.6%	6.3%	3.1%	5.6%
% American Indian or Alaska Native		3.2%	3.2%	4.5%	1.7%
%Asian		11.6%	4.4%	2.8%	15.9%
% Native Hawaiian or Other Pacific Islander		0.3%	0.4%	0.3%	0.5%
% Hispanic		54.7%	56.6%	60.2%	40.2%
%Non-Hispanic White		27.2%	30.0%	31.7%	35.2%
% Not Proficient in English		10%	11%	13%	9%
%Female		49.8%	44.7%	51.4%	50.0%
%Rural		10.8%	10.9%	32.9%	5.0%

Note: Blank values reflect unreliable or missing data.

Appendix C

2023 Population Health Management Strategy Appendix C

Health Risk Definitions

This table contains guidance to determine specific medical conditions that are included within each population health category

Level 01: Healthy	Includes Members that meet *ALL* of the following criteria: No chronic conditions See Attachment No behavioral health conditions See Attachment Risk of future costs for the next 12 months: • When age <65 then risk of future costs < 2 o When age >= 65 then risk of future costs < 4 Risk of an admission in the next 12 months < 10% No inpatient stays regardless of reason in the last 12 months No emergency room visits regardless of the reason in the last 12 months No medication adherence gaps: See Attachment Medication Adherence Gaps.do No 'clinically important' care opportunities See Attachment Clinically Important Care Opportunities. No drug safety care opportunities See Attachment Drug Safety Care Opportunities.docx
Level 02: Acute Episodic	Includes Members that meet both of the following criteria: No chronic conditions See Attachment Chronic Conditions.docx No behavioral health conditions See Attachment Behavioral Health Conditions.docx

	AND *one* or more of the criteria below 1 or more emergency room visits regardless of the reason in the last 12 months 1 or more inpatient stays regardless of reason in the last 12 months
Level 03: Healthy, At Risk	Includes Members that meet both of the following criteria: No chronic conditions See Attachment  Chronic Conditions.docx No behavioral health conditions See Attachment  Behavioral Health Conditions.docx AND NOT in any of the following categories 01: Healthy 02: Acute Episodic
Level 04a: Chronic,Big 5: Stable	Includes Members that meet *all* of the following criteria: Diabetes or COPD or Asthma or CHF or CAD Risk of future costs for the next 12 months: o When age <65 then risk of future costs < 2 o When age >= 65 then risk of future costs < 4 Behavioral Health Risk Score < 20 Risk of an admission in the next 12 months < 10% No inpatient stays regardless of reason in the last 12 months No emergency room visits with a primary diagnosis of diabetes, CAD, CHF, asthma or COPD in the last 12 months No medication adherence gaps: See Attachment  Medication Adherence Gaps.do No 'clinically important' care opportunities See Attachment  Clinically Important Care Opportunities. No drug safety care opportunities See Attachment  Drug Safety Care Opportunities.docx AND NOT in any of the following categories: 04b: Chronic, other condition, stable 05a: Health Coaching 05b: Physical Health Care Management 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis

	07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services & Medicare-Medicaid Plan – Service Coordination 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 04b: Chronic, Other Condition: Stable	Includes Members that meet *all* the following criteria: 1 or more non big 5 chronic conditions See Attachment  Chronic Conditions.docx Risk of future costs for the next 12 months: o When age <65 then risk of future costs < 2 o When age >= 65 then risk of future costs < 4 Behavioral Health Risk Score < 20 Risk of an admission in the next 12 months < 10% No inpatient stays regardless of reason in the last 12 months No "True" emergency room visits in the last 12 months No medication adherence gaps: See Attachment  Medication Adherence Gaps.do No 'clinically important' care opportunities See Attachment  Clinically Important Care Opportunities. No drug safety care opportunities See Attachment  Drug Safety Care Opportunities.docx AND NOT in any of the following categories: 05a: Health Coaching 05b: Physical Health Care Management 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services & Medicare-Medicaid Plan & DSNP – Service Coordination 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High-Needs Care Management

	10: EOL
Level 04c: BH Primary: Stable	Includes Members that meet *all* of the following criteria: 1 or more behavioral health conditions that are not flagged as high needs See Attachment  Behavioral Health Conditions.docx Risk of future costs for the next 12 months: • When age <65 then risk of future costs < 2 • When age >= 65 then risk of future costs < 4 Behavioral Health Risk Score < 20 Risk of an admission in the next 12 months < 10% No inpatient stays regardless of reason in the last 12 months No emergency room visits regardless of reason in the last 12 months No medication adherence gaps: See Attachment  Medication Adherence Gaps.do No 'clinically important' care opportunities See Attachment  Clinically Important Care Opportunities. No drug safety care opportunities See Attachment  Drug Safety Care Opportunities.docx OR A behavioral health condition that is not flagged as high needs AND NOT in any of the following categories: 04a: Chronic Big 5, Stable 04b: Chronic, other condition, stable 05a: Health Coaching 05b: Physical Health Care Management 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services & Medicare-Medicaid Plan & DSNP – Service Coordination 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 05a: Health Coaching	Includes Members that meet both the following criteria:

	Diabetes or COPD or Asthma or CHF or CAD or HbA1c over 9 Behavioral Health Risk Score < 20 AND meet 1 or more of the following criteria: Risk of future costs for the next 12 months: o When age <65 then risk of future costs between 2 o When age >= 65 then risk of future costs between 4 Risk of an admission in the next 12 months between 10% 1 or more inpatient stays with a primary diagnosis of diabetes, CAD, CHF, asthma, or COPD in the last 12 months 1 or more "True" emergency room visits in the last 12 months 1 or more emergency room visits with a primary diagnosis of diabetes, CAD, CHD, asthma or COPD in the last 12 months 1 or more medication adherence gaps: See Attachment  Medication Adherence Gaps.do 1 or more 'clinically important' care opportunities See Attachment  Clinically Important Care Opportunities. 1 or more drug safety care opportunities See Attachment  Drug Safety Care Opportunities.docx A Big 5 condition with 1 or more diagnosis of: • Atherosclerosis • Hyperlipidemia • Obesity • Hypertension AND NOT in any of the following categories: 05b: Physical Health Care Management 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services & Medicare-Medicaid Plan & DSNP – Service Coordination 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 05b: Physical Health Care Management	Includes Members that meet both the following criteria: 1 or more non big 5 chronic conditions See Attachment

	Chronic Conditions.docx Behavioral Health Risk Score <20 AND meet 1 or more of the following criteria: Risk of future costs for the next 12 months: • When age <65 then risk of future costs greater than or equal to 2 • When age ≥ 65 then risk of future costs greater than or equal to4 Risk of an admission in the next 12 months greater than or equal to10% 1 or more inpatient stays regardless of reason in the last 12 months 1 or more "True" emergency room visits in the last 12 months 1 or more medication adherence gaps: See Attachment Medication Adherence Gaps.do 1 or more 'clinically important' care opportunities See Attachment Clinically Important Care Opportunities. 1 or more drug safety care opportunities See Attachment Drug Safety Care Opportunities.docx PRG risk greater than 10 AND NOT in any of the following categories: A Big 5 condition with 1 or more diagnosis of: • Atherosclerosis • Hyperlipidemia • Obesity • Hypertension 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services & Medicare-Medicaid Plan & DSNP – Service Coordination 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 05c Behavioral Health	Includes Members that meet the following criteria:

Care Management	Flagged as having a high behavioral health needs status based on either having: • High mental health risk • High substance-use disorder risk AND NOT in any of the following categories: 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services & Medicare-Medicaid Plan & DSNP – Service Coordination 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 06: Rare High Cost Condition	1 or more rare, high cost conditions See Attachment  Rare High Cost Conditions.docx AND NOT in any of the following categories: 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services & Medicare-Medicaid Plan & DSNP – Service Coordination 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 07a: Catastrophic: Dialysis	1 or more claims indicating dialysis services in the most recent 12 months AND NOT in any of the following categories: 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services & Medicare-Medicaid Plan & DSNP – Service Coordination 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 07b: Catastrophic: Active Cancer	1 or more episodes of care indicating active cancer treatment in the most recent 12 months AND NOT in any of the following categories:

	07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services & Medicare-Medicaid Plan & DSNP – Service Coordination 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 07c: Catastrophic Transplants	1 or more of the following transplants in the most recent 12 months: • Bone Marrow • Heart • Liver • Lung • Pancreas • Renal AND NOT in any of the following categories: 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services & Medicare-Medicaid Plan & DSNP – Service Coordination 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 08a: Dementia	2 or more claims indicating dementia in the most recent 12 months AND NOT in any of the following categories: 08b: Institutional (custodial care) 09a: Long-Term Supportive Services & Medicare-Medicaid Plan & DSNP – Service Coordination 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 08b: Institutional (custodial care)	1 or more claims with a place of service code=33 (Custodial Care Facility) AND NOT in any of the following categories: 09a: Long-Term Supportive Services & Medicare-Medicaid Plan & DSNP – Service Coordination 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 09a: Long-Term Supportive Services & Medicare-Medicaid Plan & DSNP – Service Coordination	Includes Members that meet *one* or more of the criteria below: Be enrolled in an LTC or MMP product, that do not have a high-needs condition AND NOT in: 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High-Needs Care Management

Level 09b: Long-Term Supportive Services & Medicare-Medicaid Plan & DSNP – High Needs Care Management	Includes Members that meet *one* or more of the criteria below: Be currently enrolled in at least one of the LTSS/MMP products 1 or more claims in the last 12 months with any of the following diagnoses in any position o Traumatic Brain Injury (TBI) o Cystic Fibrosis o Multiple Sclerosis o Hip or Pelvic Fracture o Ulcers o Spinal Cord Injury o Acute Myocardial Infarction (AMI) o Muscular Dystrophy o Learning Disabilities o Spina Bifida o Fibromyalgia o Intellectual Disabilities o Other Developmental Delays o Migraine Please refer to attachment for a list of diagnosis codes that correspond to the above clinical groups.  LTSS High Needs Codes.xlsx
Level 10: End of Life (Non-LTSS)	Includes Members that meet one or more of the criteria below: 1 or more claims in last 12 months indicating hospice care OR Metastatic Cancer AND NOT in any of the following categories: 09a: Long-Term Supportive Services & Medicare-Medicaid Plan – Service Coordination 09b: Long-Term Supportive Services & Medicare-Medicaid Plan – High

	Needs Care Management