KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Risk Stratification and Risk Assessment Process for Calfiornia Children's Services	**Policy #**	19.19-P
Policy Owner	Population Health Management	**Original Effective Date**	1/1/2026
Revision Effective Date		**Approval Date**	1/26/2026
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

This policy outlines the tools, procedures, and processes used in the Pediatric Risk Stratification Process (PRSP) and Risk Assessment Process for Members under the California Children's Services (CCS) program. These tools, including predictive modeling systems, screening instruments, informatics reports, and data integration resources, support the accurate stratification of pediatric Members based on their clinical, behavioral, social, and utilization risk factors. The policy ensures that CCS Members are appropriately categorized by risk level, and that effective, data-driven care management strategies are implemented to meet their needs, address care gaps, and connect them to appropriate programs and services.

II. POLICY

The Kern Health System (KHS) Population Health Management (PHM) Service will support whole-person care by integrating and aggregating historical administrative, medical, behavioral, dental, social service, and program information from multiple sources. This integrated information supports risk stratification, segmentation, tiering, assessment, screening, analytics, and reporting.

PHM will translate data into actionable information to identify opportunities for continuous quality improvement while reducing bias and error in decision-making. KHS will connect its Members to the right services and support at the right time and place based on their needs and preferences.

III. DEFINITIONS

TERMS	DEFINITIONS
Pediatric Risk Stratification Process (PRSP)	A systematic process for evaluating and categorizing pediatric Members based on clinical risk and healthcare needs. It helps prioritize Members for care management and ensures appropriate allocation of resources.
Risk Assessment Process	The assessment of clinical, behavioral, and social factors contributing to a pediatric Member's health risks. This includes evaluation of chronic illnesses, medical

	complexity, social determinants of health, and family support, which guide care management and coordination decisions.
California Children's Services (CCS):	A statewide program that provides specialty medical care and services to children with chronic illnesses, physical disabilities, or complex health needs.
Complex Case Management (CCM)	A program for children with complex or chronic conditions who require intensive, ongoing care coordination due to high medical complexity.
Episodic Case Management (EpiCM)	A program for children with acute, less complex, or non-chronic conditions requiring intermittent or short-term care coordination.
Resource Utilization Band (RUB)	It is a classification used in risk stratification and population health management to group Members based on their expected healthcare resource use.

IV. PROCEDURES

Methods for Pediatric Risk Stratification and Assessment

A. Data Sources for PRSP

1. KHS will use information collected during medical and quality management activities and stored in the KHS data warehouse. These data sources, integrated with information from assessments and screenings, support risk stratification and segmentation. Sources include:

    a. Screening results
    b. Claims and encounter data
    c. Available social needs data
    d. Electronic health records
    e. Referral data
    f. Behavioral health data
    g. Hospitalization or discharge data
    h. Pharmacy data
    i. Data collected through Utilization Management, Disease Management, Health Education, or Member Services
    j. Disengaged Member reports (e.g., assigned Members who have not used services)
    k. Laboratory results
    l. Admission, Discharge, and Transfer (ADT) data
    m. Race and ethnicity data
    n. Sexual orientation and gender identity data
    o. Predictive modeling risk scores
    p. Members with complex medical and social needs
    q. Referrals from health plan partners and regulatory agencies (e.g., Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC))

2. KHS analyzes service utilization patterns, disease burden, and care gaps across Member risk levels, geographic areas, and age groups.

a. Findings help determine whether KHS programs and benefits are adequate to meet Members' needs.

B. Understanding Risk

1. Understanding Member risk is critical to identifying opportunities for more efficient and effective interventions and ideally occurs well before a Member requires more intensive treatment and care.

2. KHS will use the Adjusted Clinical Groups (ACG) Modeler that meets National Committee for Quality Assurance (NCQA) standards.

    a. Data sources for the ACG Modeler include Member eligibility, medical claims, pharmacy claims, laboratory results, and supplemental medical data.

    b. The ACG Modeler outputs are referenced in PHM program stratification and performance measures.

3. KHS will implement a process for risk stratification, segmentation, and tiering to ensure the following:

    a. Proactively identify all Members who may benefit from services or interventions, e.g., wellness and prevention programs or basic PHM services.

    b. Those Members who may most benefit from additional or specialized care management services or other interventions are identified and stratified and offered those services.

    c. Use of data in a standardized way that reduces bias and promotes equity in Risk Stratification Segmentation (RSS) and risk tiering processes.

C. Data Integration

1. KHS will perform ongoing population assessment of our membership by using data from various sources (as mentioned above) to identify the needs of our Members.

2. KHS's Business Intelligence department will extract data from diverse sources to assemble an integrated data source that provides detailed information on individual Members' needs and behavior.

3. KHS will integrate the following data sources (but not limited) to use for population health management functions:

    a. Medical and behavioral claims or encounters

        i. Claims paid by KHS are processed in the QNXT core system and referenced in PHM program stratifications to identify Members via diagnosis or service codes. Additionally, these core system claims are incorporated into performance measures for PHM programs to track utilization and costs.

        ii. Vision claims paid by KHS' vision services provider are received monthly and are

referenced for PHM program stratification and performance measures.

iii. Claims paid by KHS' delegated plan partners are received weekly and are available for PHM program stratification and performance measures.

iv. Fee for medical service and behavioral claims paid directly by Department of Health Care Services (DHCS) which are not KHS financial responsibility are provided to KHS monthly in the form of encounter data and are referenced as supplemental data sources for PHM program stratification.

b. Pharmacy claims

i. Pharmacy claims paid by KHS' Pharmacy Benefit Manager (PBM) are received weekly and are referenced for PHM program stratification and performance measures.

ii. Pharmacy claims paid by the DHCS Medi-Cal Rx program are received daily and are referenced for PHM program stratification and performance measures.

iii. Pharmacy claims paid by KHS' delegated plan partners are received weekly and are available for PHM program stratification and performance measures.

iv. Fee for service pharmacy claims paid directly by DHCS which are not KHS financial responsibility are provided to KHS monthly in the form of encounter data and are referenced as supplemental data sources for PHM program stratification.

c. Laboratory results

i. Laboratory results are received on a regular basis from the major lab providers in KHS' network and are available to utilize for PHM program stratification and performance measures.

d. Electronic health records

i. Member diagnosis history for Members enrolled in Enhanced Care Management is exported from provide Electronic Health Record (EHR) / Electronic Medical Record (EMR) systems on a regular basis and referenced as a supplemental data source for PHM program stratification.

ii. Comprehensive EHR data is available from our largest Federally Qualified Health

Center (FQHC) providers and is available to utilize for PHM program stratification and performance measures.

e. Health services programs within the organization

i. Existing health services program enrollments are used as part of stratification criteria to ensure proper Member placement and avoid duplicative care.

f. Advanced data sources

i. The Johns Hopkins ACG Modeler is utilized to identify chronic conditions and risk scores. The entire KHS population is stratified monthly using this tool. Data sources for the ACG Modeler include Member eligibility, medical claims, pharmacy claims, laboratory results, and supplemental medical data. The ACG Modeler outputs are referenced in PHM program stratification and performance measures.

ii. KHS has implemented its own version of the Potentially Preventable Admission (PPA) tool which evaluates all inpatient admissions and flags whether each was potentially preventable based on diagnosis and service codes. The PPA tool is referenced to stratify Members for PHM programs as well as for performance measure tracking.

iii. KHS has implemented the LACE Index which applies a readmission risk score for every inpatient admit entered in Jiva core system by the inpatient Utilization Management (UM) team. This risk score is referenced to stratify Members for PHM programs.

D. Timeframes of RSS and Risk Tiering to Risk Stratify and Segment All Members

1. No less than annually, KHS segments or stratifies its entire population into subsets for targeted intervention and during each of the following time frames:

a. Upon each Member's enrollment.

b. Annually after each Member's enrollment.

c. Upon a significant change in the health status or level of care of the Members (e.g., inpatient medical admission or emergency room visit, pregnancy, or diagnosis of depression).

d. Upon the receipt of new information, KHS will determine as potentially changing a Member's level of risk and need, including but not limited to information contained in

assessments or referrals for Complex Care Management (CCM), Enhanced Care Management (ECM), Transitional of Care Services (TCS), and Community Services Supports (CSS).

E. RSS and Risk Tiering Approach / Connecting Members to Programs and Services

1. KHS will offer a broad range of programs and services to meet the needs of all Members.

    a. Segmenting the population according to health care needs allows KHS to better target resources more efficiently and at a lower cost.

    b. Segmentation produces segments with specific diagnoses or social problems that need attention.

    c. Stratification produces different levels of risk.

2. KHS will monitor and improve the penetration rate of PHM programs and services, including, but not limited to, the percentage of Members who require additional assessments who complete them as well as the connection of Members to the programs and services they are eligible for.

    a. The number of Members, by Risk Tier, who needed further assessment and received it.

    b. The number of Members, by Risk Tier who were enrolled in programs they were eligible for.

3. KHS PHM will connect all Members, including those with rising risks, to an appropriate level of service, including but not limited to:

    a. Basic Population Health Management (BPHM).

    b. Care Management Services.

    c. Transitional Care Services.

    d. Wellness and Prevention Services.

4. Risk groupings include highly complex, high-risk, rising-risk, and low-risk individuals. See Attachment A: RSS PHM Stratification Subset of Population.

    a. Unique care models and intervention strategies are then used for each group.

    b. The Members move seamlessly from one risk level to another as their health situation improves or gets worse.

        i. Highly complex (ECM). This is a small group of patients with the greatest care

needs. This group has multiple complex illnesses, often including psychosocial concerns, and Social Drivers of Health (SDOH) barriers. Care models for this population require intensive, pro-active care management. Members must belong to a pre-defined population of focus as set forth by the Department of Health Care Services (DHCS).

ii. High-risk (Special Programs). This next tier includes patients with multiple risk factors that, if left unmanaged, would result in the Members transitioning into the highly complex group. This cohort of patients is appropriately engaged in a structured care management program that provides one-on-one support in managing medical, social, and care coordination needs.

iii. Rising risk (Care Management and Care Coordination). This tier includes patients who often have one or several chronic conditions or risk factors and move in and out of stability with their conditions. With rising-risk patients, successful models of care focus on managing risk factors more than disease states. Common risk factors include obesity, smoking, blood pressure, and cholesterol levels. Identifying these risks enables staff to target the root causes of multiple conditions.

iv. Low risk (BPHM and Wellness & Prevention). This group includes patients who are stable or healthy and have minor conditions that can be easily managed. The care model for this group aims to keep them healthy and engaged in the health care system, without the use of unnecessary services. This group can effectively be managed by their Primary Care Physician (PCP) with support from KHS Wellness and Prevention program.

F. Providing Services and Supports

1. KHS will interface with data to support information gathering and understanding risks of poor health and well-being outcomes, including development of standardized risk tiers in compliance with DHCS requirements requiring its use to assess Member needs and determine the appropriate level and type of services for individual Members.

2. KHS will connect all Members to primary care, appropriate wellness, prevention, and disease management activities and to identify and connect those Members who are at risk for developing complex health issues to more specialized services.

    a. These programs (e.g., Complex Care Management, Episodic Case Management, Wellness and Prevention Programs, etc.) and services (e.g., transportation, preventative services, etc.)

3. As part of Basic Population Health Management (BPHM) Risk Stratification, KHS identifies cost drivers, at-risk individuals in patient population, prioritizes at-risk patients for clinicians, identifying and offering tailored interventions for the different segments.

    a. This helps the PCP prioritize at-risk patients, intervene to decrease both acute and long-term risks and offer appropriate patient support based on risk, provides more efficient encounters for patients/clinicians, and help the provider to implement proactive interventions to maximize outcomes and Pay-4-Performance (P4P) payments.

G. Incorporation of PHM Service's RSST Methodologies

1. Upon the release of PHM Service's RSST methodologies, KHS will:

    a. Align internal risk stratification processes with RSST guidelines and methodologies.

    b. Integrate RSST findings into existing population health management programs.

    c. Ensure risk segmentation and tiering are based on comprehensive data sources, including medical, behavioral, pharmacy, social determinants of health (SDOH), and utilization data.

    d. Conduct periodic evaluations to assess the accuracy and effectiveness of RSST methodologies in stratifying Member risk levels.

    e. Ensure compliance with National Committee for Quality Assurance (NCQA) Population Health Management (PHM) standards and Department of Health Care Services (DHCS) requirements.

2. The health plan will incorporate RSST methodologies into the following processes:

    a. Member Enrollment: Risk stratification will occur at the time of enrollment to assign an initial risk tier.

    b. Annual Population Health Review: All Members will be reassessed annually to update risk stratification based on new health and utilization data.

    c. Significant Health Changes: Members experiencing major health status changes (e.g., hospital admission, new diagnosis, or pregnancy) will be re-stratified in real time.

H. Assessment of High-Risk Members Identified Through PHM Service

1. Identification Process

a. High-risk Members will be identified using RSST methodologies, predictive analytics, and clinical judgment.
b. Data sources used for identification include:

    i. Claims and encounter data
    ii. Emergency department and inpatient utilization data
    iii. Pharmacy records
    iv. Behavioral health screenings
    v. SDOH screenings
    vi. Care coordination referrals from providers, case managers, and community organizations
    vii. Predictive modeling risk scores (e.g., ACG Modeler)

2. Members will be screened using the Child and Adolescent Health Measurement Initiative (CAHMI) Children with Special Health Care Needs (CSHCN) Screener. The CAHMI CSHCN Screener identifies children with ongoing health conditions that have lasted or are expected to last at least twelve (12) months.

    a. Need or use of prescription medications
    b. Use of services above what is routine for age
    c. Need or use of specialized therapies or services
    d. Need or use of mental health counseling
    e. Functional limitations

        i. This screening tool is also used to determine whether a Member needs CCM or EpiCCM.

3. Pediatric Assessment and Care Planning

    a. All high-risk Members identified through PHM Service will be:

        i. Assigned to a care management team for comprehensive assessment within thirty (30) days of identification.
        ii. Referred to appropriate programs such as Complex Case Management (CCM), Enhanced Care Management (ECM), or Transitional Care Services (TCS).
        iii. Evaluated for care coordination needs, including behavioral health, Long Term Supportive Services (LTSS), and SDOH interventions.

    b. Assessments will include:

        i. Comprehensive health risk evaluation
        ii. Review of chronic conditions, medication adherence, and care gaps
        iii. Social needs assessment to identify barriers such as housing instability, food insecurity, and transportation issues

iv. Development of an individualized care plan (ICP) in collaboration with the Member, provider, and care team
v. Connection to available resources such as community-based organizations, transportation assistance, and wellness programs

4. Monitoring and Reassessment

a. High-risk Members will receive continuous monitoring and support through:

i. Regular check-ins by care managers
ii. Coordination with primary care and specialists
iii. Alerts for hospital admissions, emergency visits, and gaps in care

b. Members will be re-stratified weekly or upon significant health status changes.

I. Other Informatics & Reporting Tools

1. Medical Informatics: The Medical Informatics Report includes standardized, comprehensive data elements critical for pediatric risk stratification:

a. Demographics:

i. Language, gender, ethnicity, geographic distribution, chronic condition distribution, aid group.

b. Member Participation Metrics:

i. Average years of KHSS enrollment
ii. Average Member months
iii. Share of Cost (SOC) compliance rate
iv. Percentage of Members disenrolled
v. Percentage of Members deceased

c. Population Risk Management Indicators:

i. Average six (6)-month inpatient admission probability
ii. High-cost risk indicators
iii. Average number of chronic conditions
iv. Average Resource Utilization Band (RUB)
v. Percentage of potentially preventable admissions (PPA)

d. The Medical Informatics Report supports risk stratification by:

i. Standardizing Data for Accurate Risk Identification: Ensures consistent categories (e.g., demographics, chronic condition burden, utilization) for accurate assignment into risk tiers.

ii. Enhancing Early Detection of High-Risk Pediatric Members: Metrics such as PPA, inpatient probability, and high-cost risk help identify Members needing early, intensive intervention.

iii. Supporting Tailored Care Planning: Detailed condition and utilization data allow care managers to create individualized care plans based on clinical and social needs.

iv. Improving Monitoring of Clinical Outcomes: Tracks SOC compliance, disenrollment, mortality, and condition progression to support ongoing risk adjustment and prioritization.

2. Stratification of Entire Population Report**:** This report stratifies the entire Membership, including the subsets to which Members are assigned. See Attachment A: RSS PHM Stratification Subset of Population.

    a. The report specifies the number of Members in each category and the programs or services for which they are eligible. It serves as a "point-in-time" snapshot during the look-back period as per NCQA requirements.

    b. The report reflects the number of Members eligible for each PHM program. Data are displayed in both raw numbers and as percentages of the total enrolled member population. Percentages may exceed 100% because Members can qualify for more than one (1) category.

    c. PHM programs or services included in the report may include, but are not limited to, Complex Case Management.

    d. This report is generated monthly.

J. Method(s) for Discovering and Reducing Biases

1. KHS will meet the following requirements prior to the PHM Service's RSS functionalities becoming available:

    a. Utilize an RSS approach that complies with NCQA PHM standards, including using utilization data integrated with other data sources such as findings from the Population Needs Assessment, clinical and behavioral data, or population and social needs data;

    b. Incorporates a minimum list of data sources listed above to the greatest extent possible;

    c. Avoids and reduces biases to prevent exacerbation of health disparities.

2. According to the U.S. Department of Health and Human Services (HHS) (2015), there are documented examples of health inequities affecting people of color, including children. These inequities may stem from social, economic, and environmental factors and can result in differences in health outcomes, access to care, and quality of services received. Examples affecting children include:

a. Children of color, especially Black and Hispanic children, are more likely to live in neighborhoods with higher levels of particulate matter, contributing to asthma disparities (Woo et al., 2021).

b. Centers for Disease Control (CDC) surveillance continues to show significantly higher asthma prevalence among Black and Puerto Rican children compared with White children (CDC, 2023).

c. Agency for Healthcare Research and Quality (AHRQ) (2024) reports that preventive care disparities widened during COVID-19, with Black and Hispanic children attending fewer well-child visits than White children.

d. Hispanic and Black children face significantly greater barriers to accessing mental health treatment, with state-level inequities exacerbating these gaps (Lin et al., 2024).

e. Non-Hispanic Black infants experience infant mortality rates more than twice as high as White infants, according to 2023 U.S. mortality data (National Center for Health Statistics [NCHS], 2023).

f. The Office of Minority Health (2023) reports Black infants are ~2.5 times more likely to die from low-birth-weight–related causes than White infants.

3. Any current RSS methodologies rely on utilization or cost data only, which may result in racial, condition, or age bias.

4. To address these biases and improve outcomes for all Members, KHS will use all relevant data, keep the information updated (e.g., through care managers), continuously evaluate key performance indicators and RSS outputs, monitoring health disparities over time, use appropriate metrics to measure the accuracy and effectiveness of RSS model prediction of people who do or do not need help monitor whether RSS improves care for all populations

K. Process for segmenting population to ensure there is no racial bias in the process.

1. Evaluate eligible and enrolled program Members and compare utilization and costs by ethnicity in the Program Dashboard drilldown data.

2. Use information collected through assessments and/or screenings on Members who share specific

needs, characteristics, identities, conditions, or behaviors.

3. Evaluate data from zip codes where Members reside that are historically underrepresented or underutilized. Members residing in rural areas have limited access to health care and services. These Members are prioritized.

L. Risk Stratification Tools

1. The table below summarizes the tools utilized by KHS to meet DHCS and NCQA Population Health Management (PHM) requirements for pediatric risk stratification. These tools collectively support consistent data analysis, risk prediction, early identification of high-risk Members, and ongoing evaluation of health and social needs, ensuring appropriate stratification and connection to PHM programs.

Type of Tool	Name of Tool	How It Is Used
Predictive Modeling & Risk Scoring Tools	Johns Hopkins ACG Modeler	Generates risk scores, identifies chronic conditions, and predicts future utilization; used monthly to stratify the entire population.
	LACE Index	Calculates readmission risk for inpatient admissions; supports transitional care planning and higher-risk tier identification. "L": the length of stay of the admission "A": the acuity of the admission (emergency or elective) "C": co-morbidities (the Charlson Co-Morbidity Index) "E": the number of Emergency Department visits within the last 6 months
	Predictive Modeling Risk Scores (includes PPA indicators)	Uses predictive algorithms and PPA (Potentially Preventable Admission) indicators to identify high-risk and rising-risk Members needing early or intensive intervention.
Clinical Screening Tools	Child and Adolescent Health Measurement Initiative (CAHMI) CSHCN Screener	Identifies children with special health care needs based on ongoing conditions and service use; determines need for CCM or Episodic CCM.
	Behavioral Health (BH) Screenings	Identifies behavioral health risks and Members requiring specialized BH coordination or interventions.
Social Needs Screening Tools	Social Determinants of Health (SDOH) Screenings	Identifies social risk factors such as food insecurity, housing instability, transportation barriers, and other social conditions influencing health risk and resource needs.
Data Analytics Tools	Service Utilization Analysis	Examines Emergency Department (ED), inpatient, outpatient, and other utilization patterns to identify high-risk or unstable Members.
	Care Gaps Analysis	Detects missing preventive or chronic care interventions, signaling rising risk and the need for preventive outreach or care management.
Data Integration & Informatics Tools	Integrated Business Intelligence (BI) Population Dataset	Consolidates claims, pharmacy, lab, EHR, ADT, SDOH, BH, and referral data to support comprehensive and accurate stratification.

Type of Tool	Name of Tool	How It Is Used
Operational & Reporting Tools	Medical Informatics Report	Provides standardized demographic, chronic condition, utilization, and risk metrics (e.g., RUB, high-cost flags, PPA percentages) used for risk tier assignment and ongoing monitoring.
	Stratification of Entire Population Report	NCQA-compliant population stratification snapshot showing risk tier distribution and PHM program eligibility across the entire Member population.

V. ATTACHMENTS

Attachment A:	PHM Stratification Subset of Population

VI. REFERENCES

Reference Type	Specific Reference
Regulatory	CalAIM: Population Health Management (PHM) Policy Guide July 2025. https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf
Other KHS Policies	Policy 19.30-P Risk Stratification and Segmentation (RSS) and Risk Tiering
Other	Agency for Healthcare Research and Quality. (2024, June 4). Racial and ethnic disparities widened in well-child visits during COVID-19. AHRQ News Now. https://www.ahrq.gov/news/newsletters/e-newsletter/915.html
Other	CAHMI / Foundation for Accountability. The Children With Special Health Care Needs (CSHCN) Screener. (User guide / tool). https://cahmi.org/docs/default-source/default-document-library/cshcnscreener-print-version.pdf?sfvrsn=9e98a4b3_0
Other	Centers for Disease Control and Prevention. (2023). Asthma data by race/ethnicity. https://www.cdc.gov/asthma/asthmadata/Child_Prevalence_Race.html
Other	Lin, X., et al. (2024). State-level disparities in children's access to mental health treatment. Academic Pediatrics. https://pubmed.ncbi.nlm.nih.gov/40808377/
Other	National Center for Health Statistics. (2023). Infant mortality statistics from the 2021–2022 period. National Vital Statistics Reports. https://www.ncbi.nlm.nih.gov/books/NBK618116/
Other	Office of Minority Health. (2023). Infant mortality & Black/African American populations. https://minorityhealth.hhs.gov/infant-health-and-mortality-and-blackafrican-americans
Other	Woo, B., et al. (2021). Neighborhood air pollution and racial disparities in childhood asthma. Environmental Health Perspectives. https://pmc.ncbi.nlm.nih.gov/articles/PMC6728803/

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	1/1/2026	Policy developed in response to DHCS Audit Category 2: Population Health Management and Coordination of Care, Section 2.14, Request 46.	M.C. PHM

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Business Intelligence

Attachment A: RSS PHM Stratification Subset of Population.

Run Date: 9/1/2025 8:45:32 AM

Kern Health Systems Subset of Population	Risk Groupings
Enhance Care Management	Highly Complex
Major Organ Transplant	High Risk
Chronic Obstructive Pulmonary Disease	High Risk
ER Navigation	High Risk
Transitional Care	High Risk
Long Term Care	High Risk
BH - Substance Use Disorder Program	High Risk
Complex Care Management	Rising Risk
California Children's Services	Rising Risk
BH - Mental Health Program	Risking Risk
No risk factors	Low Risk
No associated data	Low Risk
Total number of KHS Members	

Targeted Intervention for Eligible Members	Number of Members	Percentage of Membership
ECM-Care Management	37,332	9.13%
Care Management	597	0.15%
Care Management	1,030	0.25%
Care Management	27,459	6.72%
TOC-Care Management	10,694	2.62%
Care Management	1,385	0.34%
KCBHR--Care Management	575	0.14%
CCM-Care Management	16,248	3.97%
CCM-Care Management		
BH-Care Management / Care Coordination	11,258	2.75%
Health Risk Assessment; KHS Newsletter	266,338	65.15%
Health Risk Assessment; KHS Newsletter	89,768	21.96%
	408,821	113.18%