2025 Population Assessment

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CareVio Overview

CareVio, a subsidiary of ChristianaCare, is a nationally recognized, primarily virtual care management organization serving as the central care coordination solution for the ChristianaCare Health System and its Clinically Integrated Network. CareVio partners with physicians and care teams across acute, post-acute, primary care, and community settings to deliver coordinated patient-centered support that improves outcomes and enhances the care experience. Its interdisciplinary team, including physicians, registered nurse care coordinators, social workers, pharmacists, behavioral health specialists, and care connectors, works collaboratively to ensure patients receive timely, appropriate, and compassionate care.

CareVio offers a comprehensive portfolio of services addressing transitional care, chronic disease management, complex case management, and targeted population health initiatives. In 2025, the organization expanded its focus on ambulatory care sensitive conditions through the creation of a dedicated team aimed at preventing avoidable hospitalizations. A standardized Admit Protocol was implemented across three hospital campuses, supported by embedded care coordinators to strengthen early engagement and improve transitions from hospital to home or skilled nursing facilities. Social workers were placed in two Emergency Departments to address social drivers of health and reduce preventable revisits, complemented by the launch of an ED Revisit Program for high-utilizing members. A Hospital Readmission Review Committee was also established to analyze trends and drive quality improvement.

Post-discharge support was further enhanced through expanded text outreach to all discharged inpatients and support for a post-discharge hotline, reinforcing continuity during vulnerable transition periods. Additional 2025 initiatives included piloting a tailored protocol for new members of a specific health plan, implementing a payer-aligned RN Task Force model to deepen plan-specific expertise, developing a chronic kidney disease assessment, launching a Cough & Cold hotline to support appropriate utilization, and relaunching the Healthy U program for individuals graduating from comprehensive case management who continue to benefit from lower-intensity engagement. A House Call pilot combined a virtual physician visit with in-home support from a care connector to improve access and coordination for high-risk patients.

CareVio engages patients through multiple modalities, including telephonic outreach, secure messaging, video visits, remote monitoring, and targeted in-person support. Planning is underway for “One CareVio,” an integrated model that merges transitional and longitudinal care management to create a seamless experience across the continuum. In preparation for continued growth and enhanced interoperability, CareVio began development work in October 2025 to transition to

the EPIC electronic case management platform, with implementation anticipated in October 2026.

CareVio remains NCQA-accredited in Case Management and Population Health and maintains HITRUST certification, demonstrating a strong commitment to quality, compliance, and information security. Through national RN licensure and expanding payer partnerships, CareVio continues to extend its reach beyond the Delaware Valley. Guided by its mission to deliver caring, compassionate, quality care, CareVio strives to improve quality of life, optimize coordination, advance health equity, and provide an exceptional experience for every patient and partner it serves.

Population Assessment Overview

The CareVio Population Assessment is conducted annually to evaluate the demographic profile, clinical conditions, cultural and linguistic characteristics, Social Determinants of Health (SDOH), and health equity opportunities across the populations served This comprehensive assessment is designed to identify key population needs, utilization patterns, risk trends, and gaps in care in order to inform the strategic direction of CareVio programming, services, and resource deployment.

CareVio leverages a combination of both primary and secondary data sources to support its analysis. Primary data includes payer claims and clinical information from electronic health records and health information exchanges. Secondary data is derived from publicly available federal, state, and sources including demographic and disability data from the U.S. Census Bureau. Measure specifications and analytic methodologies are standardized and reviewed by CareVio clinical and operational leadership to ensure validity, consistency, and alignment with organizational priorities.

This assessment examines the needs of the overall population, as well as defined subpopulations including those enrolled in selected CareVio programs. Attention is given to the influence and impact of SDOH factors on outcomes and access to care. This structured analysis supports identification of disparities and informs strategies to advance health equity across payer groups and communities.

Findings from the Population Assessment directly guide program development, quality improvement initiatives, staffing models, and benefit aligned interventions such as post-discharge outreach. The primary objective of Population Assessment is to ensure that CareVio's programming, services, and innovations remain responsive to the evolving medical, behavioral, and social needs of the communities we serve—advancing equitable, high-quality, and person-centered care across the continuum.

Data Sources

CareVio Data Sources

CareVio's 2025 Population Assessment was derived from a comprehensive set of primary and secondary data sources used to conduct descriptive analysis and inform population insights. The most current and complete data sets available at the time of analysis were used. As with all claims-based reporting, variations in reporting periods may exist due to claims run-out, and additional 2025 claims data may have been received following completion of the assessment.

Primary Data Sources: The following primary data sources were used in the development of this assessment.

1) **CareVio Claims and Encounter Data**: CareVio extracted medical and administrative claims and encounter data for the full member population from its internal databases. The dataset reflects services rendered between January 1st and December 31, 2025, based on claims received and processed at the time of analysis.

   a) **Methodology:** Descriptive analytic techniques were applied to evaluate demographic characteristics, health conditions, disability indicators, SDOH related factors, utilization patterns, and other population-level trends. Standardized measure definitions were applied to ensure consistency and comparability across analyses.

2) **Electronic Health Record (PowerChart):** Clinical data from PowerChart, an electronic health record (EHR) was used to supplement claims information and provide additional clinical depth, including documentation not fully reflected in administrative claims. While technically categorized as a secondary source, EHR data played a central role in contextualizing clinical aspects within the assessment.

3) **Program-Specific Data:** CareVio's Electronic Care Management platform was leveraged to analyze sub-population-specific metrics, including enrollment patterns, engagement activities, and program outcomes.

4) **Health Information Exchange (HIE) Data**: Data obtained from regional Health Information Exchanges supplemented internal datasets by capturing patient activity across geographic areas beyond ChristianaCare facilities. HIE data enhanced visibility into cross-continuum utilization, care transitions, and geographic care patterns, contributing to a more complete understanding of member experience across the broader healthcare landscape.

Delaware Population 2024

In 2025, aligning with previous years' reporting, the CareVio population continues to mostly reside in Delaware.

1) Delaware's median age of 41 in 2025 reflected no change from the year prior. Additionally, the ratio of female (51.7%) vs. male (48.3%) reflected nearly no changes from the previous year report (2024: 51.6% vs. 48.4%).[40]
2) In 2025, those with the racial composition of white were ranked first at 66.9%, a decrease from the year prior. Black or African American population remained second, followed by Asian.[40]
3) The total population of Delaware identified as non-Hispanic ethnicity, while consistent reporting of 11% identified with an ethnicity of Hispanic.[40]

U.S. Census Bureau

The United States Census Bureau estimates that the approximate population of Delaware (July 2025) was 1,059,952 (an increase from 2024 of 8,035 people). The census data showed that New Castle County remains the most heavily populated area, followed by Sussex County then Kent County for the fourth year in a row.

Modern Language Association (MLA) Language Map

1) The MLA Language map has not had an updated data set since the previous CareVio 2022 Population Health Assessment Report. Data from the Delaware Census State Data Center, US Bureau of Census and American Community Survey is displayed on 'World Population Review," which was used for comparison purposes in the body of this report (2024 World Population Review, 2025).
2) English is spoken by 86% of Delaware residents; Spanish is the second most frequently spoken language within the Delaware population. Other non-English languages spoken of Delaware residents are Chinese (Mandarin/Cantonese), French Creole and Gujarati.

Geocoding

Eligibility files and claims data were analyzed using a geocoding map to identify the primary residence of the CareVio population by zip code. As noted in the CareVio Population Health Assessment Report 2025, zip code residences may influence the health of members.

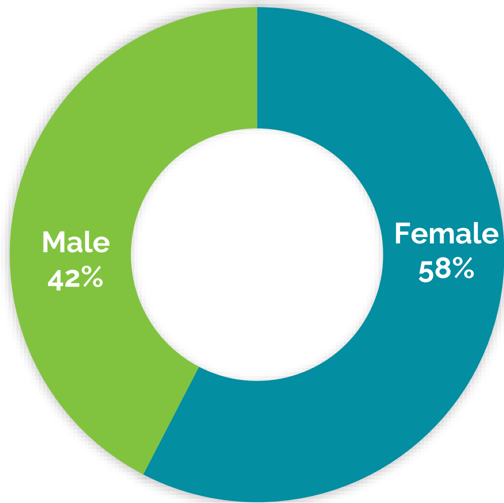
Lines of Business

In this population assessment, data points are often categorized by payer type: Commercial, Medicaid, Medicare, and Medicare Advantage, For the purposes of this report, Medicare refers to the population covered by Medicare Fee-For-Service (FFS).

Key Findings by CareVio Population By

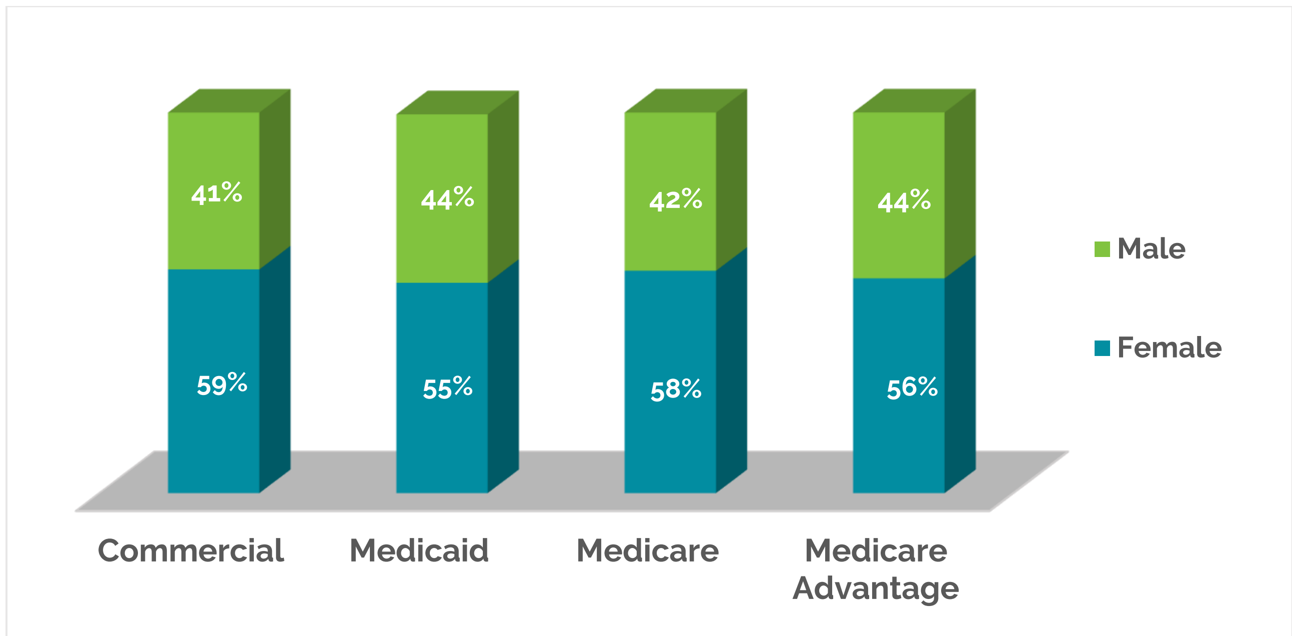
Gender

Total Population



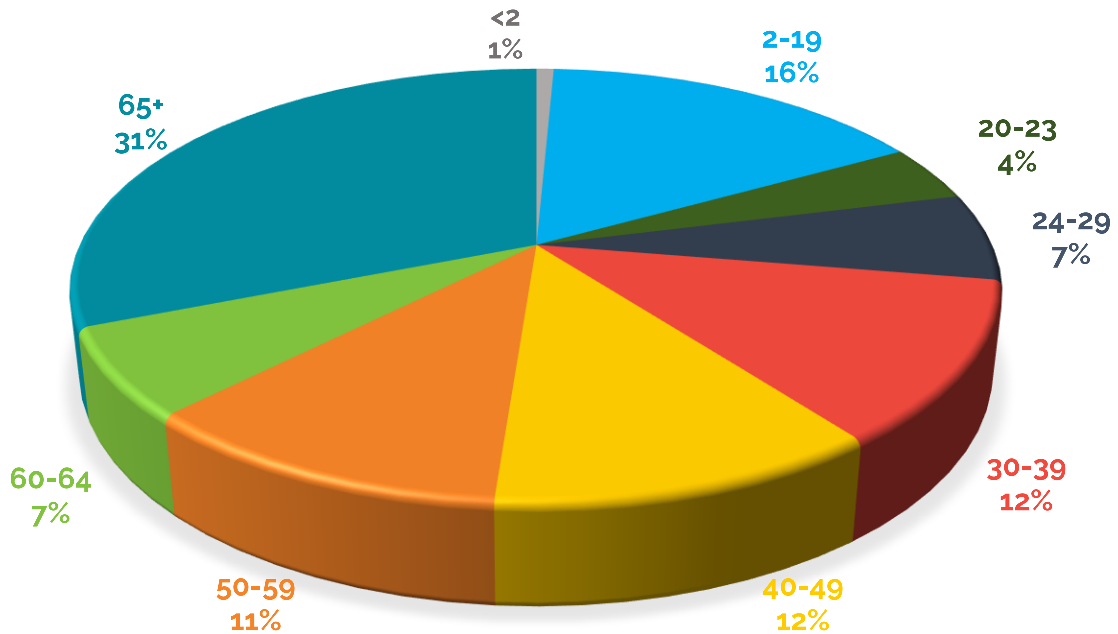
Gender	Member Count	Member %
Female	116,971	58%
Male	86,054	42%
Unknown	436	0%
Total	**203,461**	**100%**

By Line of Business



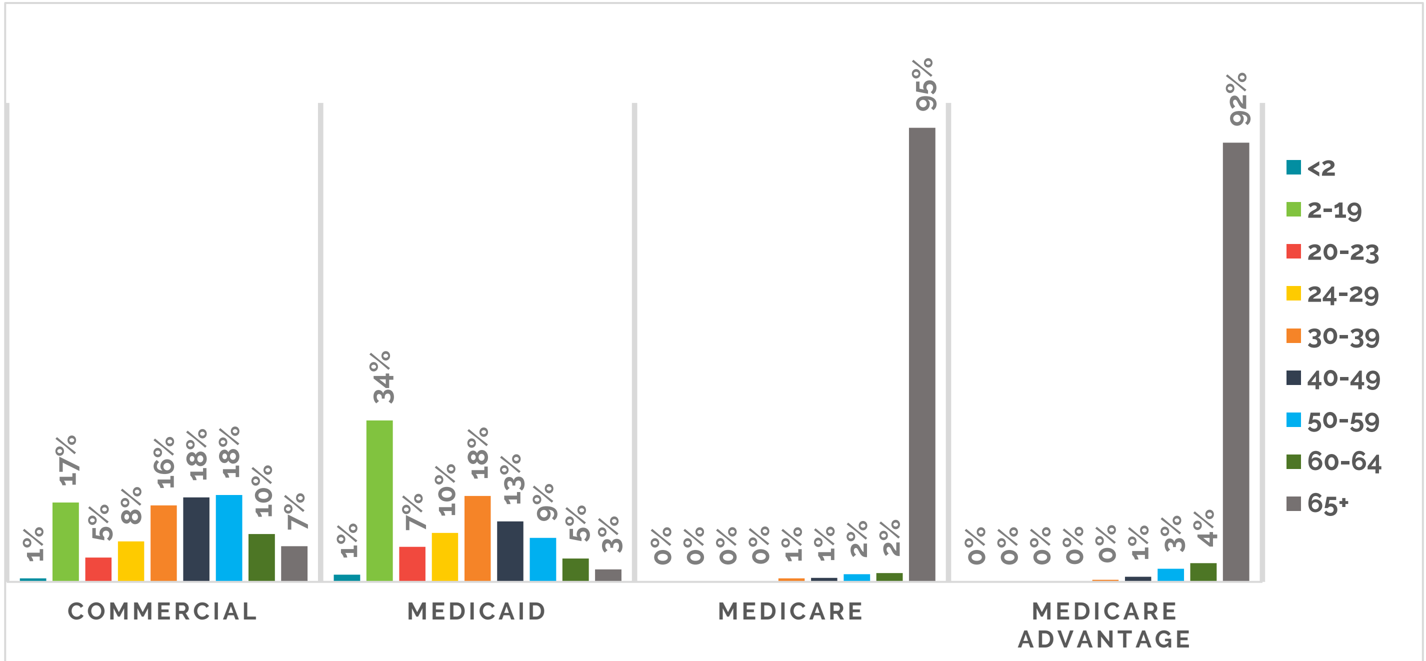
Age

Total Population



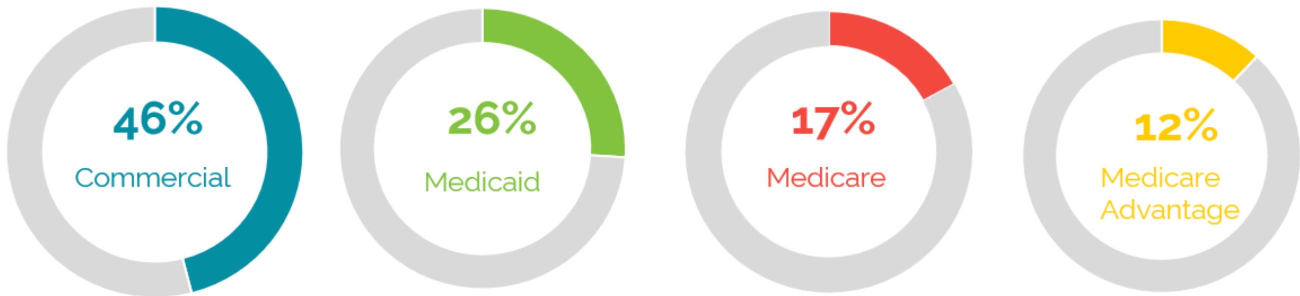
Age Group	Member Count	Member %
<2	1,468	1%
2-19	32,926	16%
20-23	8,514	4%
24-29	13,251	7%
30-39	24,533	12%
40-49	23,493	12%
50-59	22,827	11%
60-64	13,372	7%
65+	63,077	31%
Total	**203,461**	**100%**

Claim Information by Age



Age Group	Commercial	Medicaid	Medicare	Medicare Advantage
<2	1%	1%	0%	0%
2-19	17%	34%	0%	0%
20-23	5%	7%	0%	0%
24-29	8%	10%	0%	0%
30-39	16%	18%	1%	0%
40-49	18%	13%	1%	1%
50-59	18%	9%	2%	3%
60-64	10%	5%	2%	4%
65+	7%	3%	95%	92%
Total	**100%**	**100%**	**100%**	**100%**

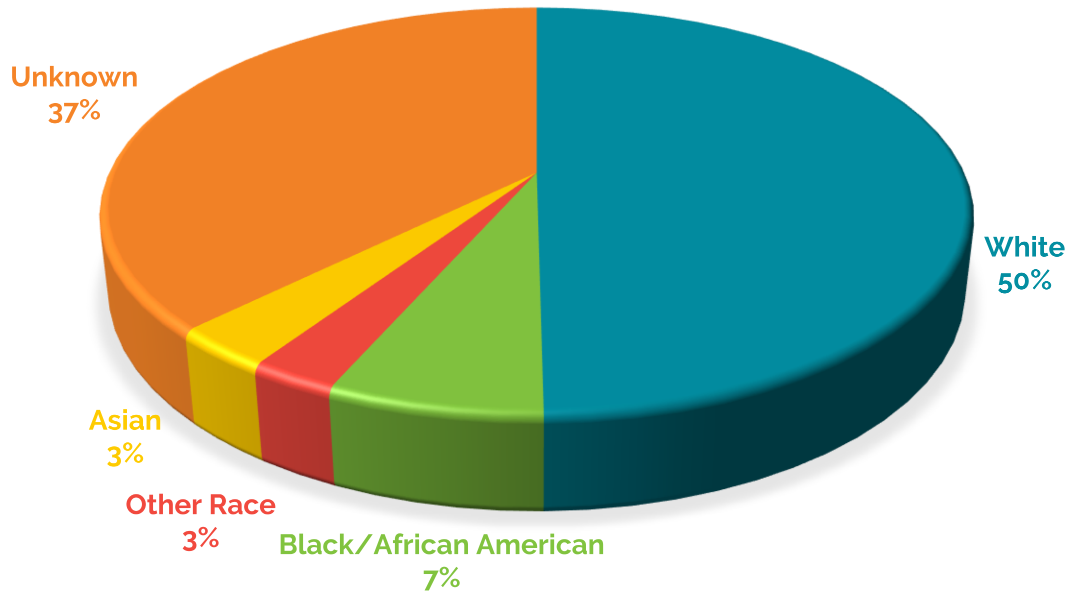
Line of Business (LOB)



Line of Business	Member Count	Member %
Commercial	92,746	46%
Medicaid	52,120	26%
Medicare	34,787	17%
Medicare Advantage	23,808	12%
Total	**203,461**	**100.00%**

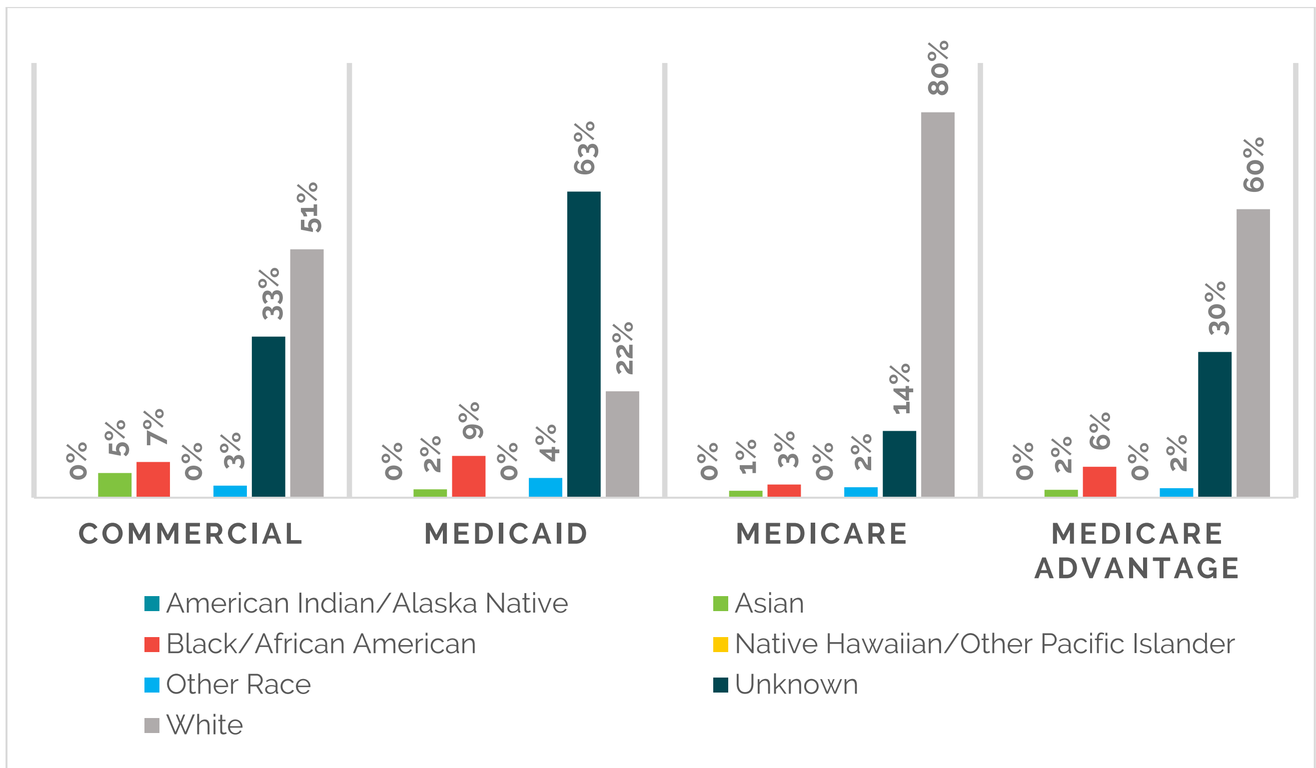
Race

Total Population



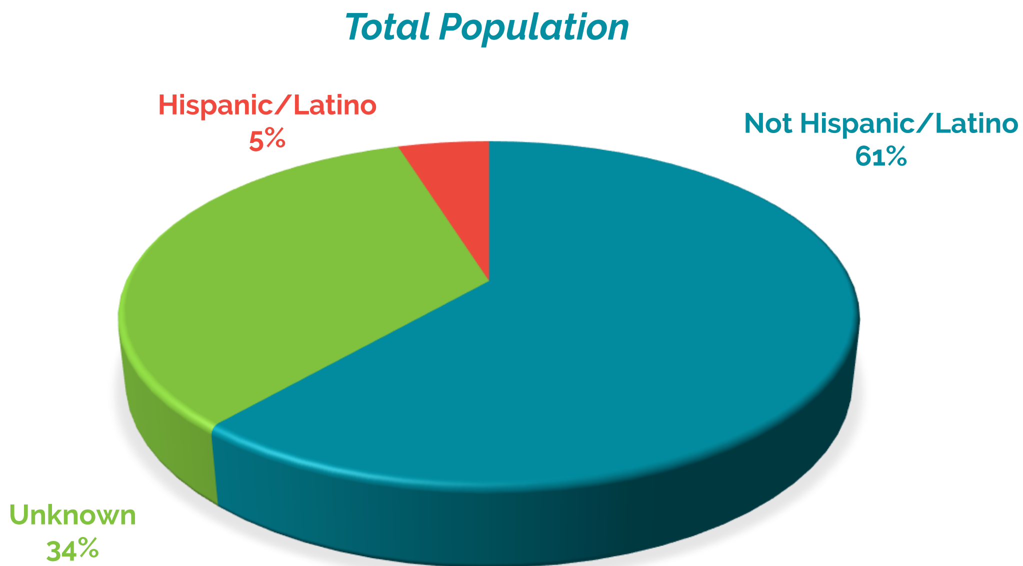
Race	Member Count	Member %
White	101,155	50%
Black/African American	13,847	7%
Other Race	5,671	3%
Asian	6,555	3%
Unknown	75,953	37%
American Indian/Alaska Native	214	0%
Native Hawaiian/Other Pacific Islander	66	0%
Total	**203,461**	**100%**

By Line of Business



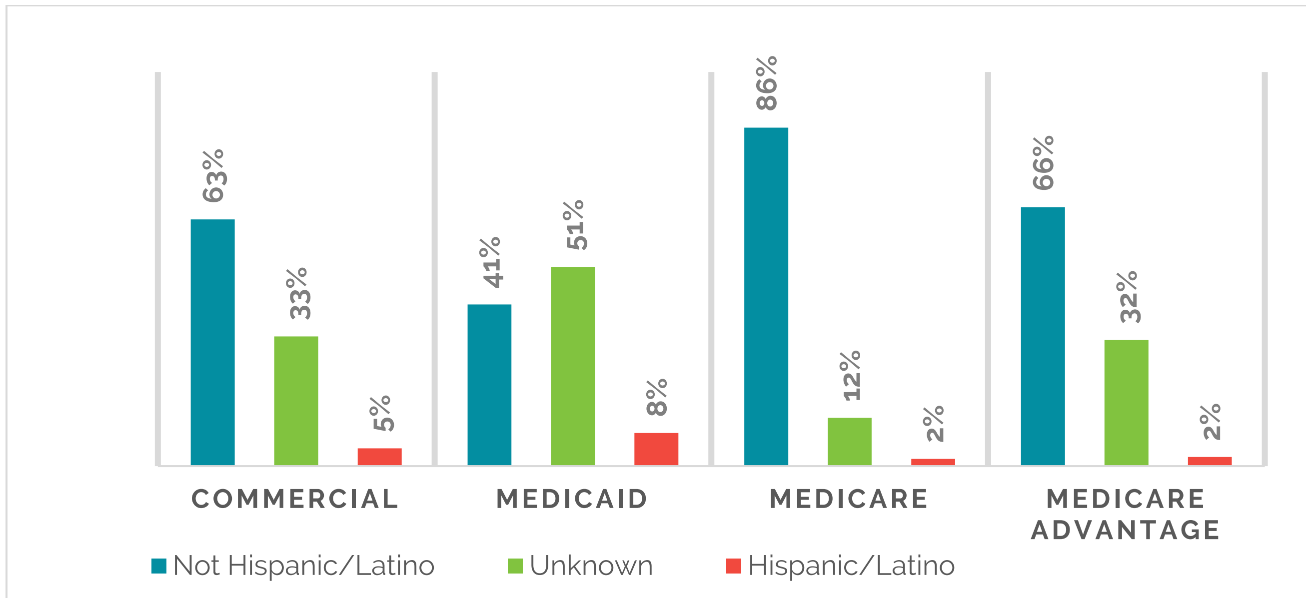
Race	Commercial	Medicaid	Medicare	Medicare Advantage
American Indian/Alaska Native	0%	0%	0%	0%
Asian	5%	2%	1%	2%
Black/African American	7%	9%	3%	6%
Native Hawaiian/Other Pacific Islander	0%	0%	0%	0%
Other Race	3%	4%	2%	2%
Unknown	33%	63%	14%	30%
White	51%	22%	80%	60%
Total	**100%**	**100%**	**100%**	**100%**

Ethnicity



Ethnicity	Member Count	Member %
Not Hispanic/Latino	124,949	61%
Unknown	68,759	34%
Hispanic/Latino	9,753	5%
Total	**203,461**	**100%**

By Line of Business



Ethnicity	Commercial	Medicaid	Medicare	Medicare Advantage
Not Hispanic/Latino	63%	41%	86%	66%
Unknown	33%	51%	12%	32%
Hispanic/Latino	5%	8%	2%	2%
Total	**100%**	**100%**	**100%**	**100%**

Primary Language

Population by Primary Language

Primary Language	Member Count	Member %
English	103,426	50.83%
Unknown/Unavailable	49,669	24.41%
Other	48,402	23.79%
Spanish	1,288	0.63%
Mandarin Chinese	160	0.08%
Arabic	157	0.08%
American Sign Language	57	0.03%
Korean	47	0.02%
Haitian Creole	44	0.02%

Vietnamese	41	0.02%
Slovenian	38	0.02%
Hindi	24	0.01%
Urdu	23	0.01%
Turkish	21	0.01%
French	17	0.01%
Gujarati	14	0.01%
Portuguese	9	0.01%
Italian	7	0.00%
Tagalog	5	0.00%
Thai	4	0.00%
Greek	2	0.00%
Albanian	2	0.00%
Afar	1	0.00%
Indonesian	1	0.00%
Japanese	1	0.00%
Armenian	1	0.00%
Total	**203,461**	**100%**

Primary Language by Line of Business

Primary Language	Commercial	Medicaid	Medicare	Medicare Advantage
English	50.52%	37.61%	73.60%	47.73%
Unknown/Unavailable	23.77%	38.79%	5.98%	22.36%
Other	25.25%	21.50%	19.66%	29.15%
Spanish	0.31%	1.44%	0.39%	0.46%
Mandarin Chinese	0.05%	0.11%	0.11%	0.06%
Arabic	0.01%	0.28%	0.01%	0.00%
American Sign Language	0.01%	0.01%	0.08%	0.04%
Korean	0.01%	0.02%	0.05%	0.06%
Haitian Creole	0.01%	0.06%	0.01%	0.02%
Vietnamese	0.00%	0.05%	0.01%	0.02%
Slovenian	0.03%	0.01%	0.01%	0.01%

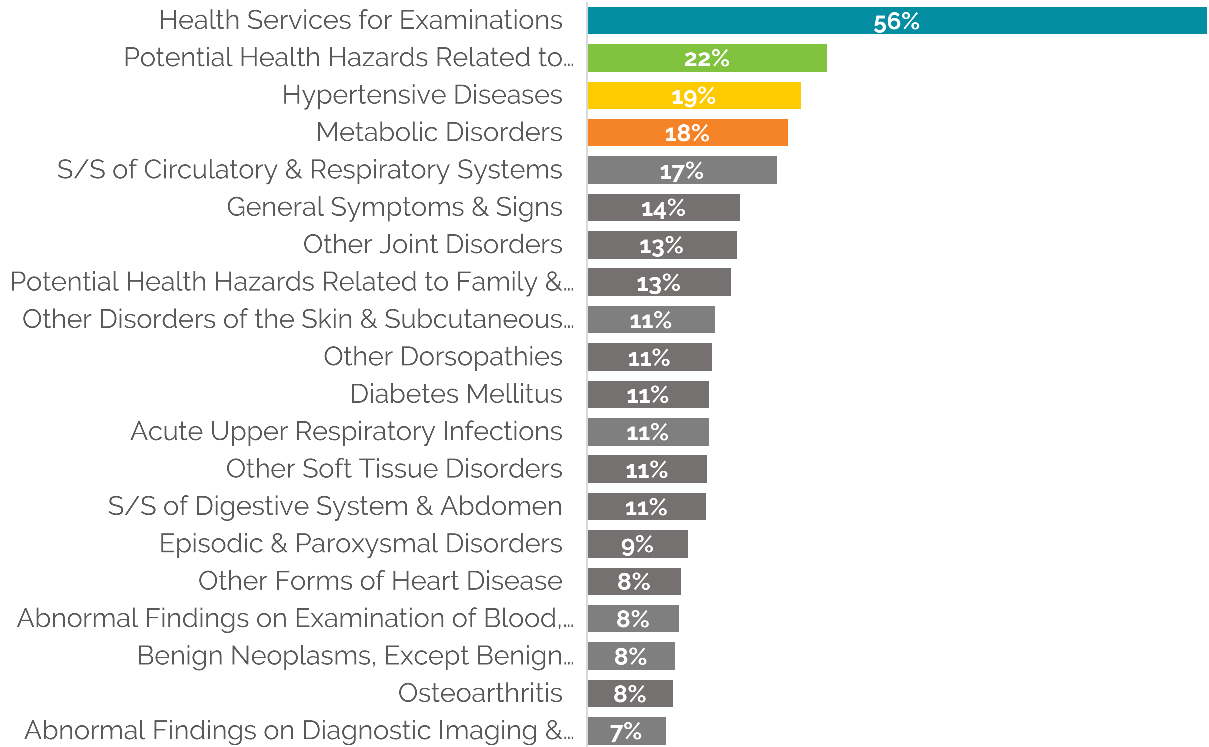
Hindi	0.01%	0.02%	0.01%	0.01%
Urdu	0.01%	0.02%	0.02%	0.00%
Turkish	0.00%	0.02%	0.01%	0.01%
French	0.00%	0.02%	0.01%	0.00%
Portuguese	0.00%	0.01%	0.00%	0.00%
Greek	0.00%	0.00%	0.01%	0.00%
Italian	0.00%	0.00%	0.01%	0.02%
Afar	0.00%	0.00%	0.00%	0.00%
Tagalog	0.00%	0.00%	0.01%	0.01%
Thai	0.00%	0.01%	0.00%	0.01%
Gujarati	0.00%	0.00%	0.00%	0.03%
Albanian	0.00%	0.00%	0.00%	0.00%
Indonesian	0.00%	0.00%	0.00%	0.00%
Japanese	0.00%	0.00%	0.00%	0.00%
Armenian	0.00%	0.00%	0.00%	0.00%
Total	**100%**	**100%**	**100%**	**100%**

Top 20 Physical Health Conditions

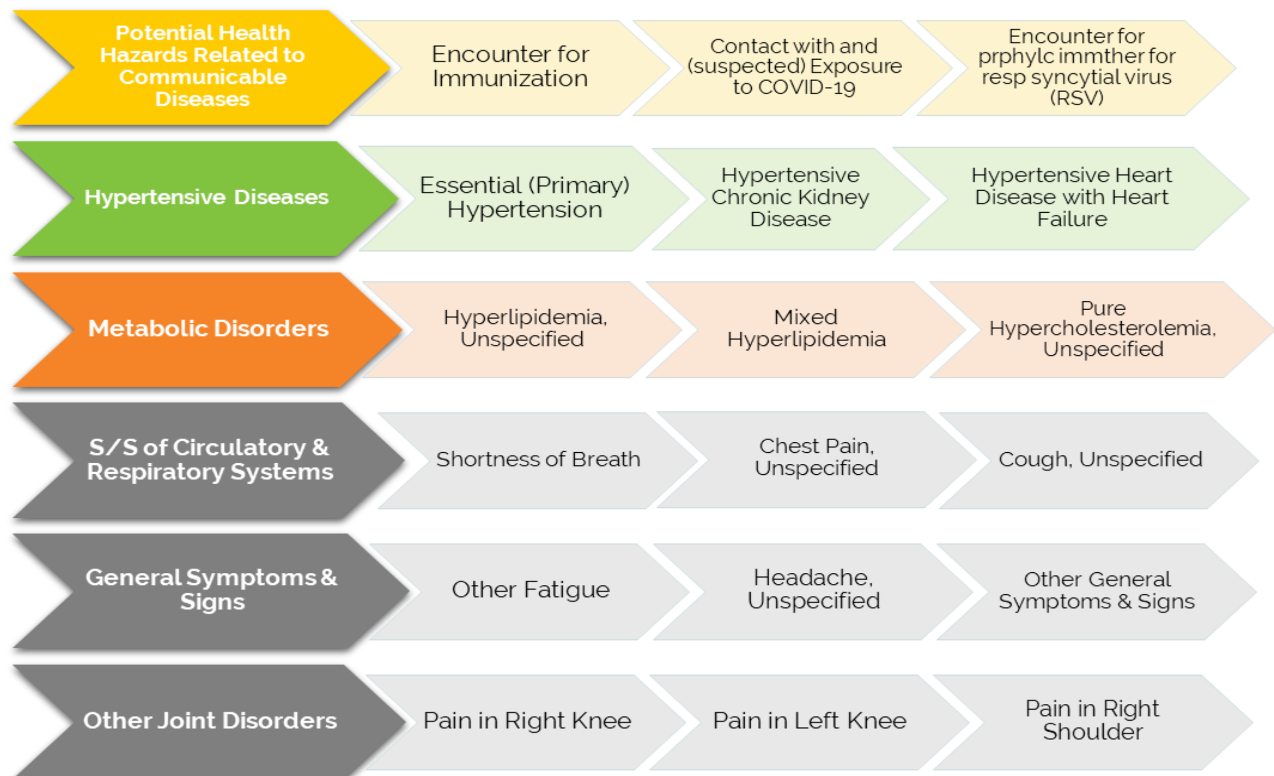
Data Source: CareVio Claims Data

Population – Top 20 Physical Health Conditions

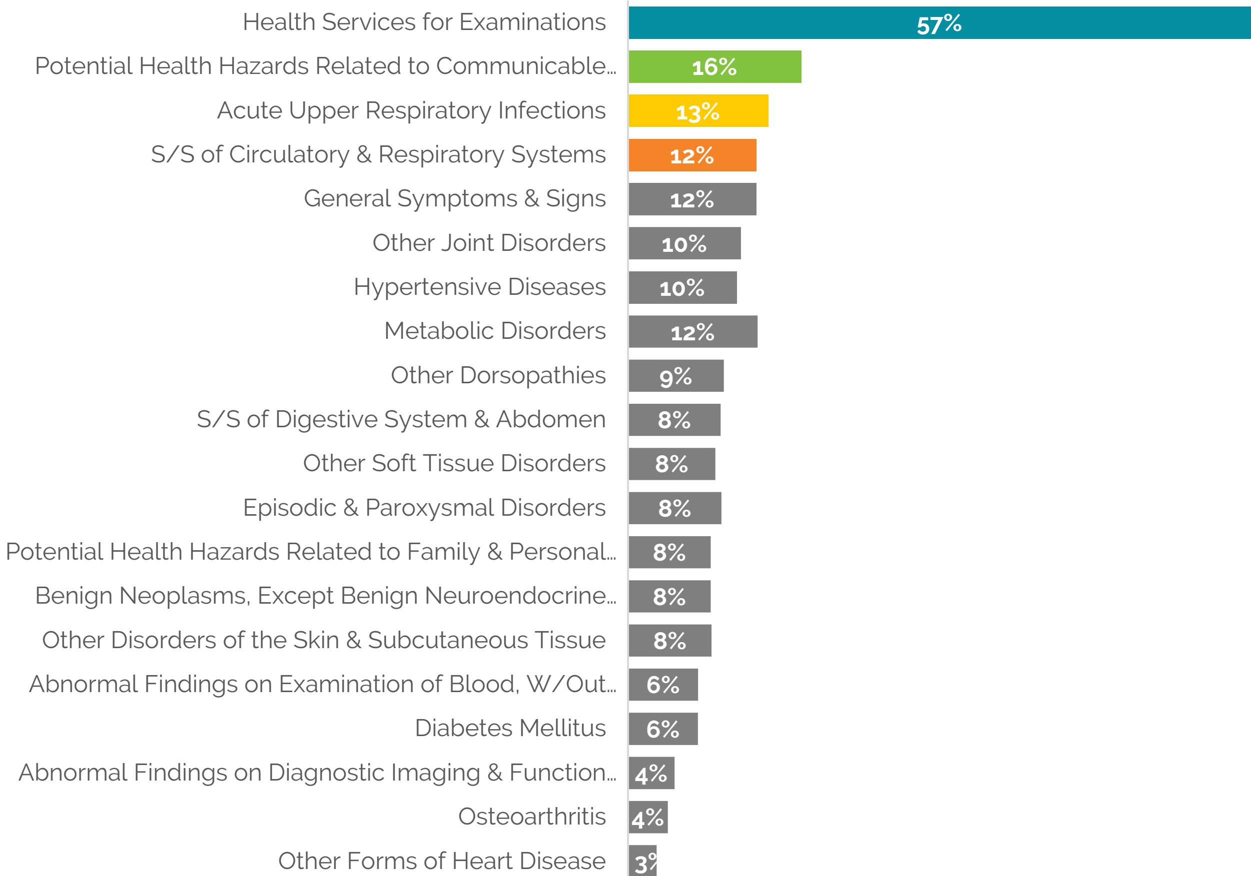
Condition	Member Count	Member % (Total Population) n=203,461
Health Services for Examinations	113,053	56%
Potential Health Hazards Related to Communicable Diseases	43,818	22%
Hypertensive Diseases	39,011	19%
Metabolic Disorders	36,708	18%
S/S of Circulatory & Respiratory Systems	34,654	17%
General Symptoms & Signs	27,979	14%
Other Joint Disorders	27,262	13%
Potential Health Hazards Related to Family & Personal History & Certain Conditions Influencing Health	26,220	13%
Other Disorders of the Skin & Subcutaneous Tissue	23,357	12%
Other Dorsopathies	22,749	11%
Diabetes Mellitus	22,277	11%
Acute Upper Respiratory Infections	22,203	11%
Other Soft Tissue Disorders	21,936	11%
S/S of Digestive System & Abdomen	21,701	11%
Episodic & Paroxysmal Disorders	18,450	9%
Other Forms of Heart Disease	17,186	8%
Abnormal Findings on Examination of Blood, W/Out Diagnosis	16,813	8%
Benign Neoplasms, Except Benign Neuroendocrine Tumors	16,024	8%
Osteoarthritis	15,693	8%
Abnormal Findings on Diagnostic Imaging & Function Studies, W/Out Diagnosis	14,315	7%



Condition Category – Top 3 ICD-10 Codes



Top Condition Categories by Line of Business



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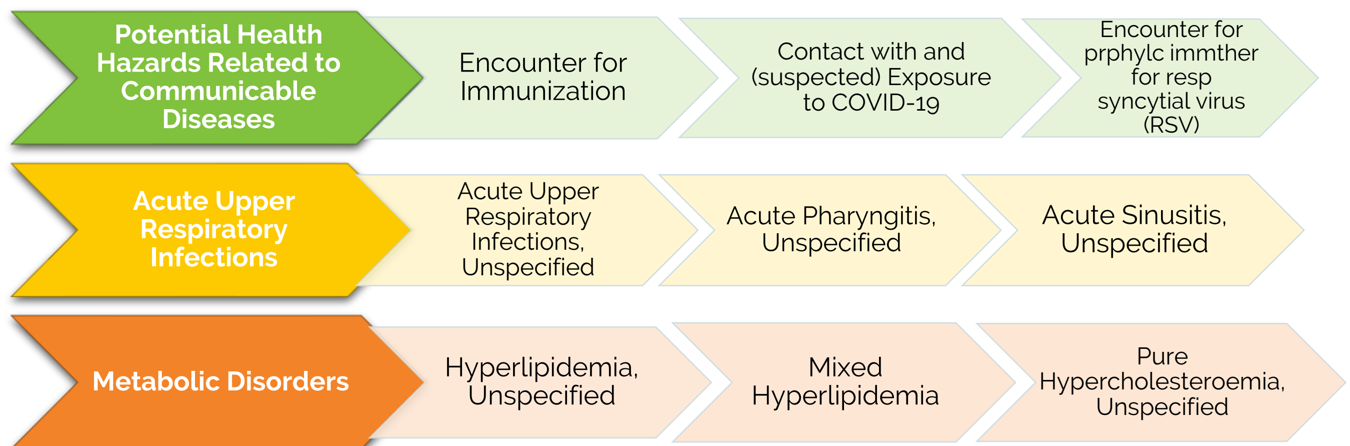

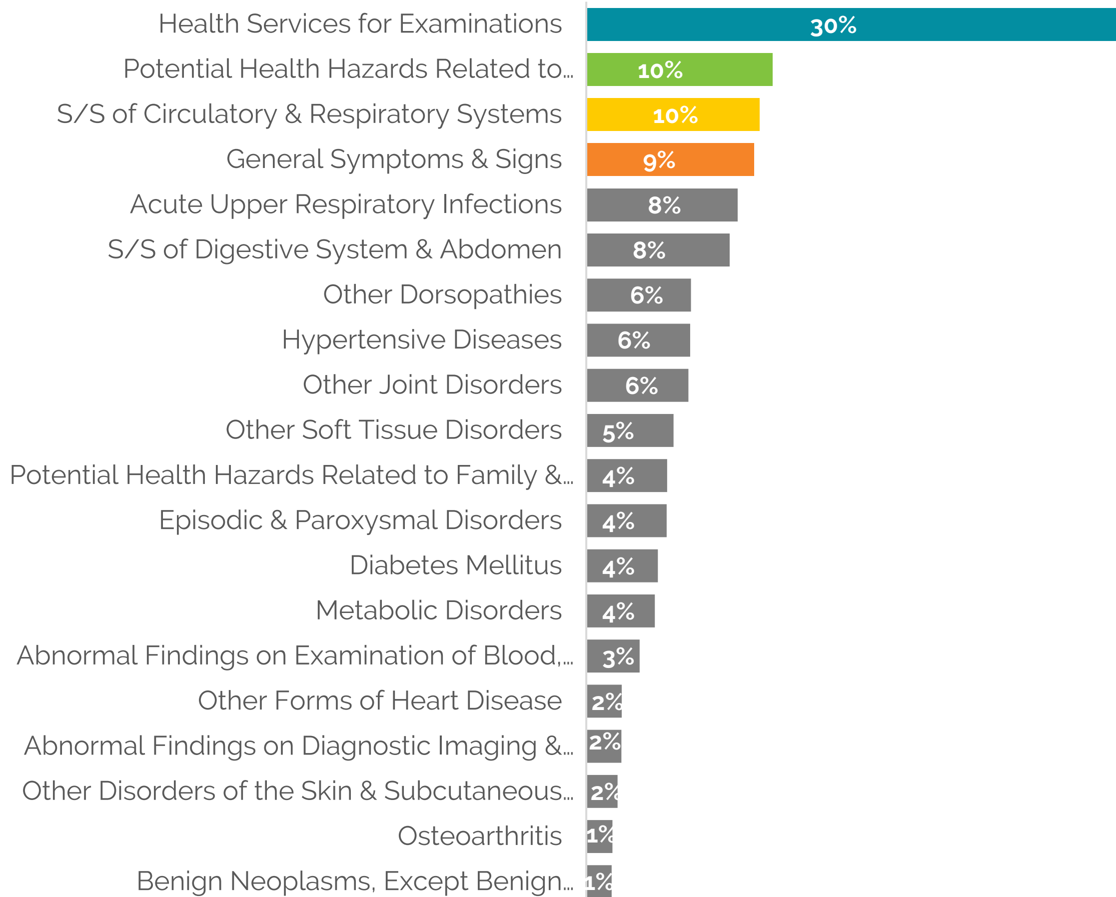

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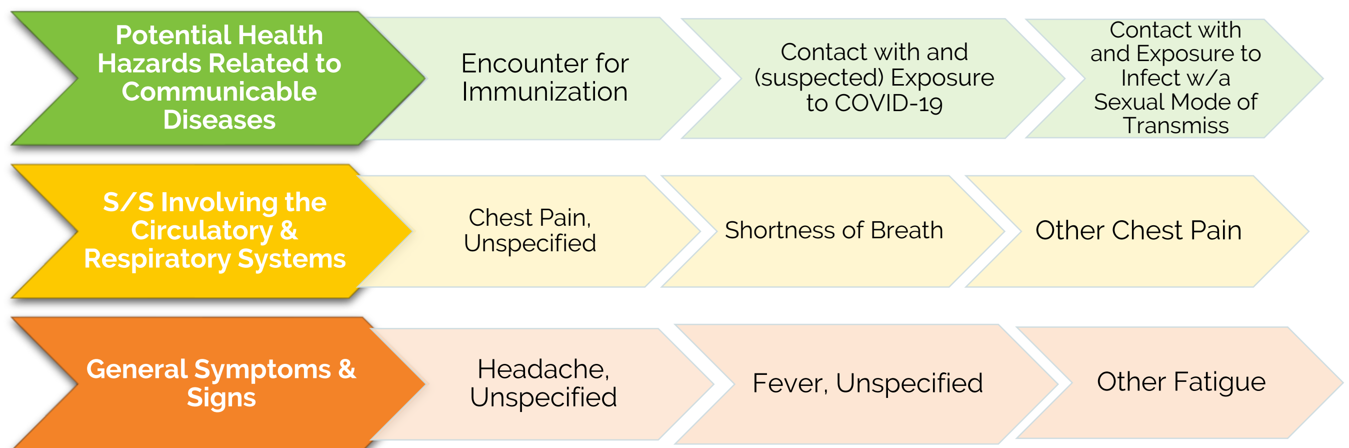
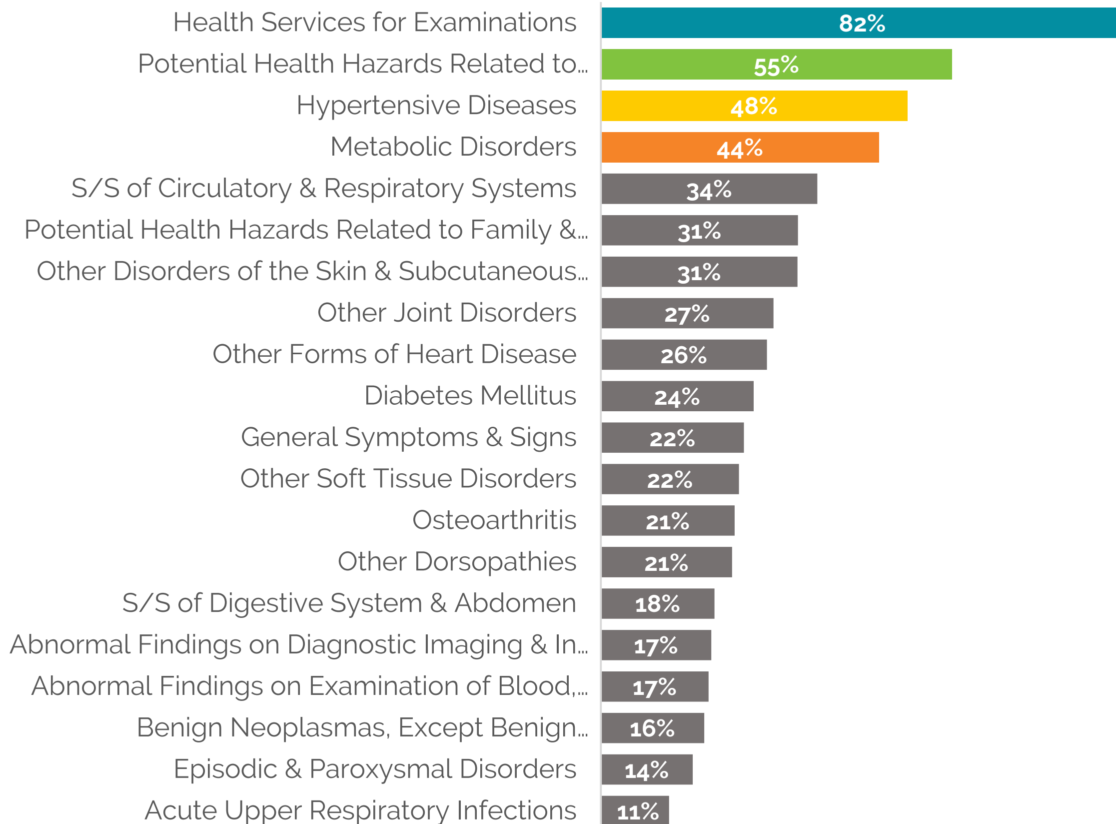
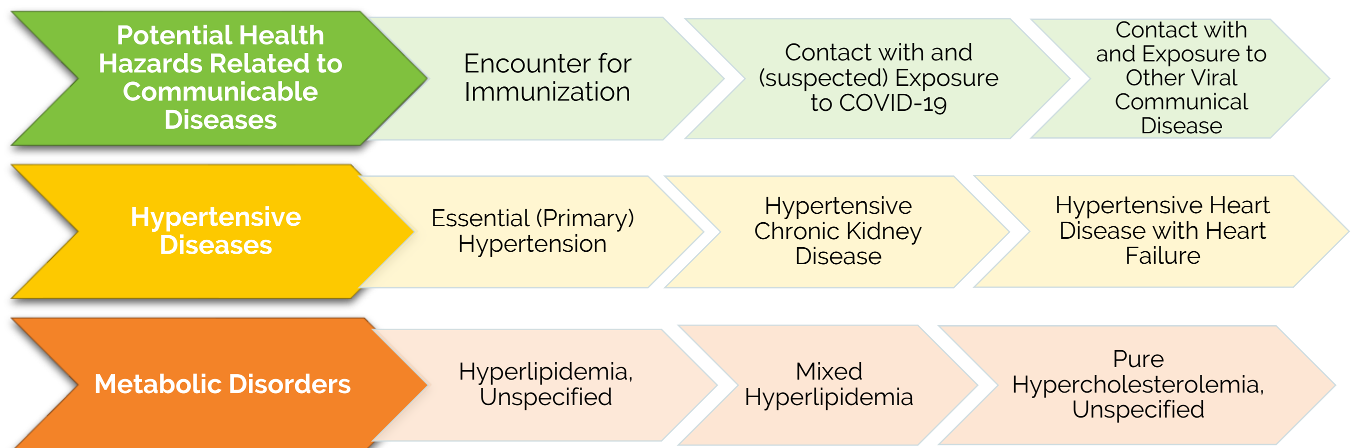
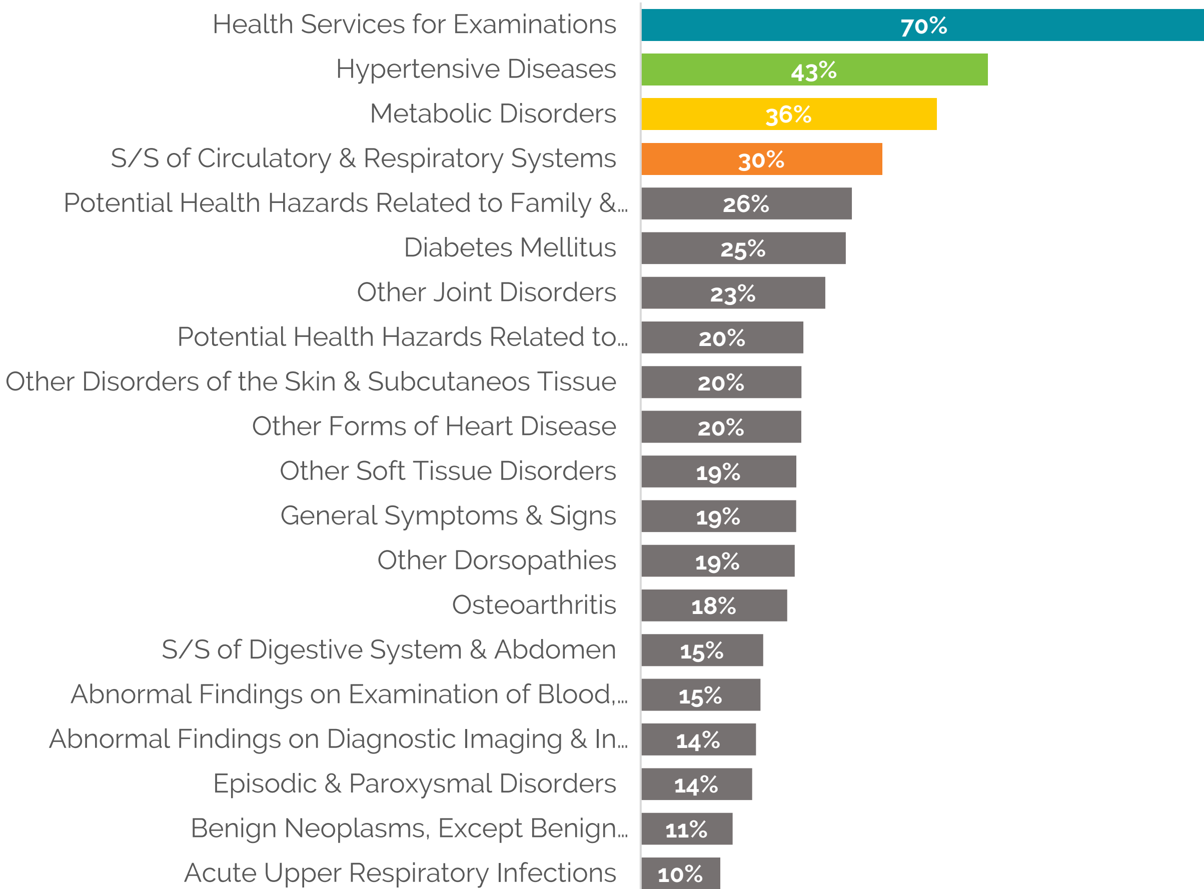


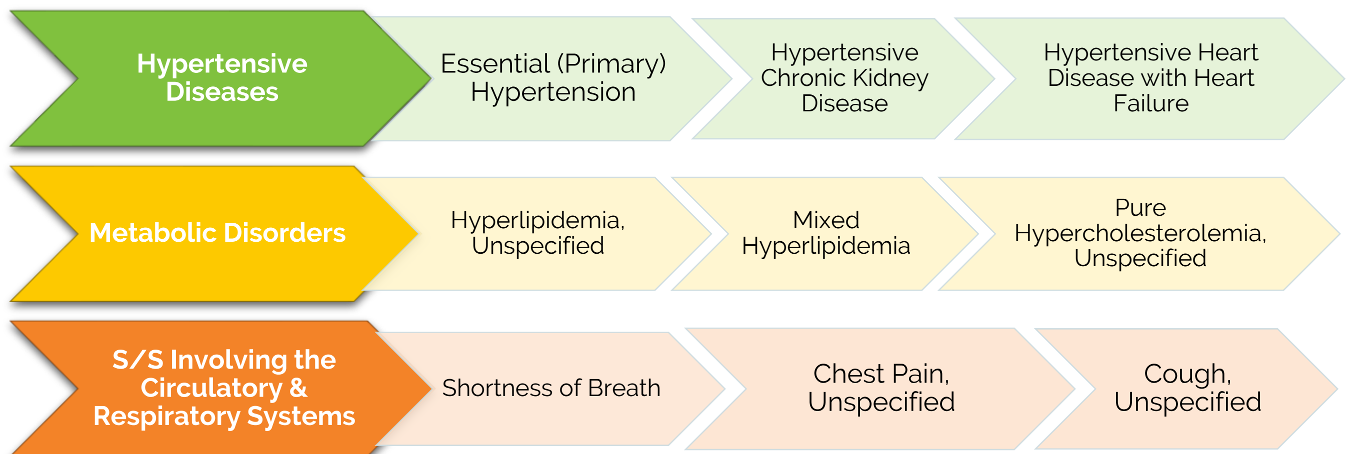


Condition Category – Top 3 ICD-10 Codes



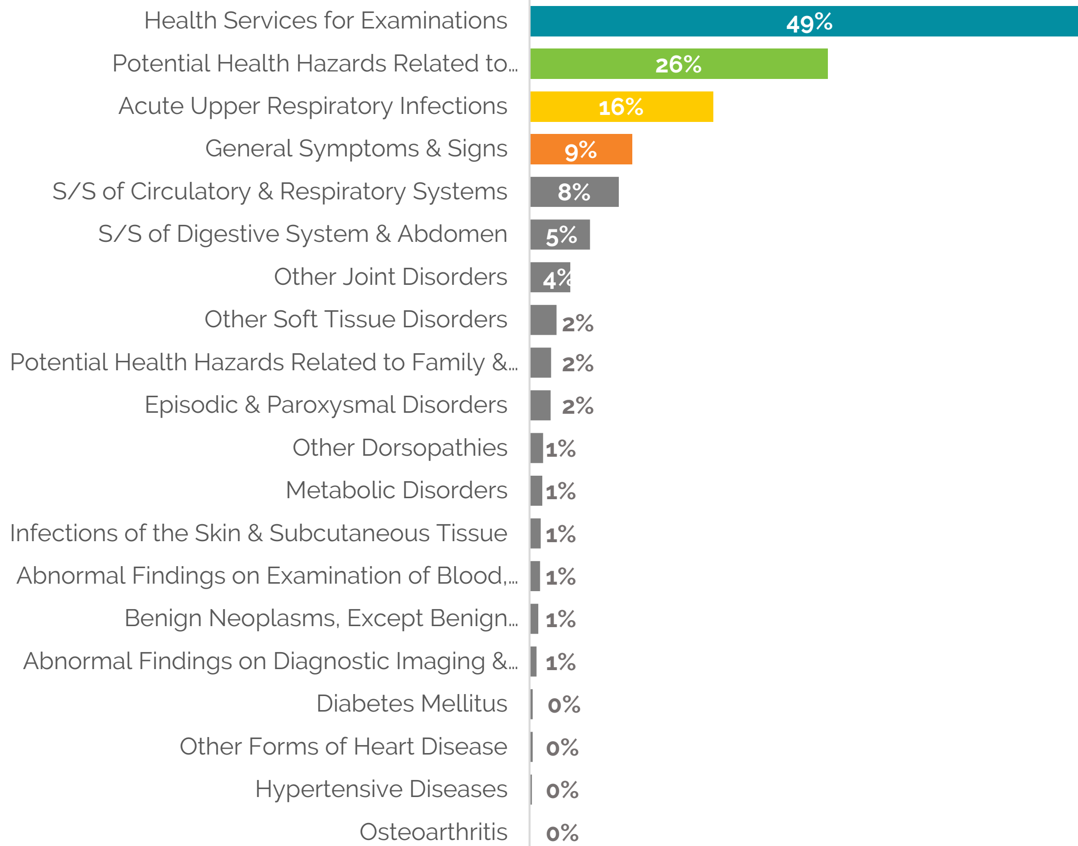


Condition Category – Top 3 ICD-10 Codes

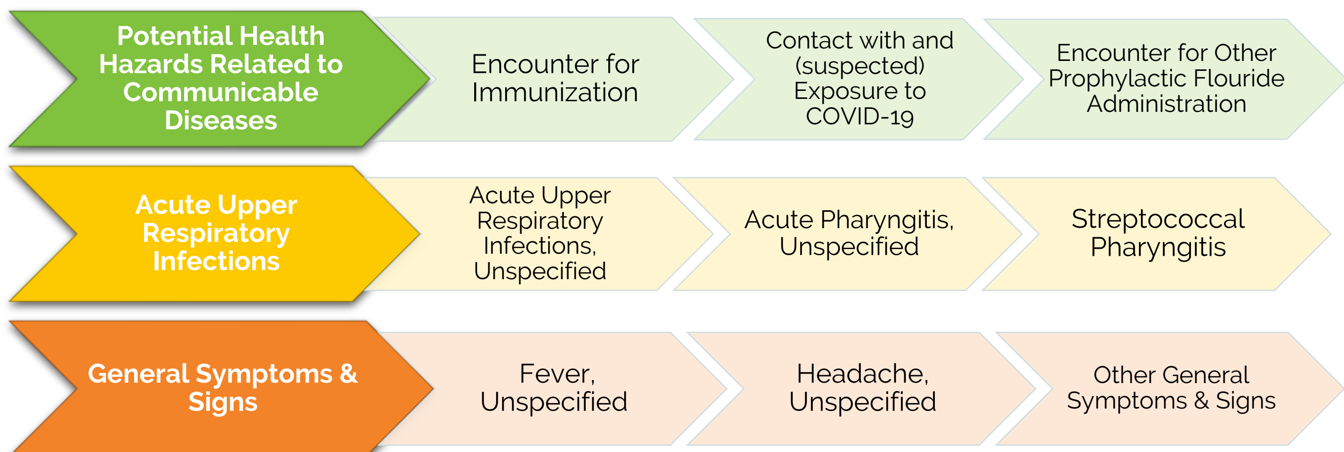


Children and Adolescents (ages 2-19)

Children and Adolescent Population – Top 20 Physical Health Conditions



Condition Category – Top 3 ICD-10 Codes

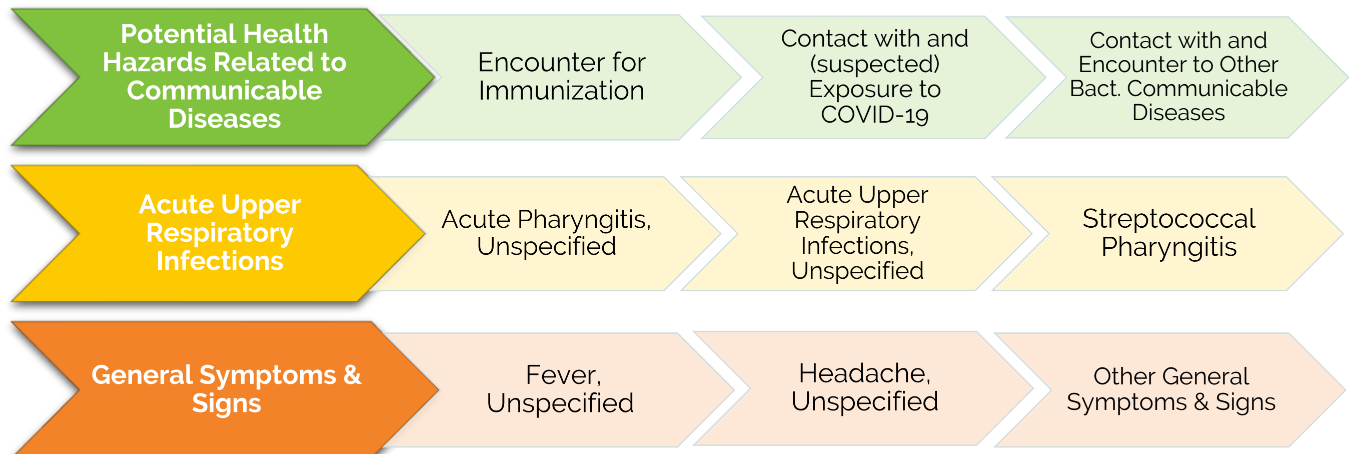


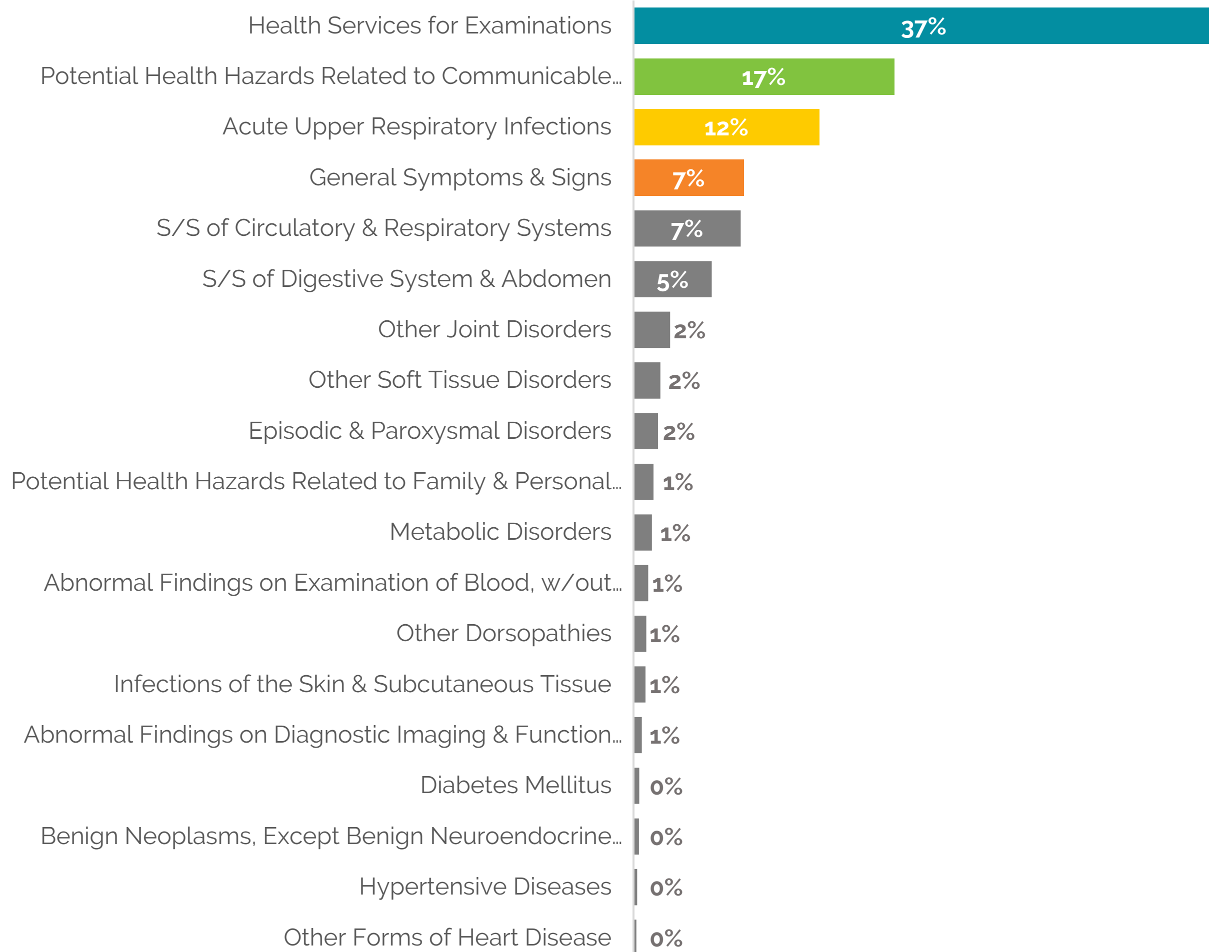
Children and Adolescents Clinical Category by Line of Business

2-19 Years Old Population By Clinical Category
Commercial

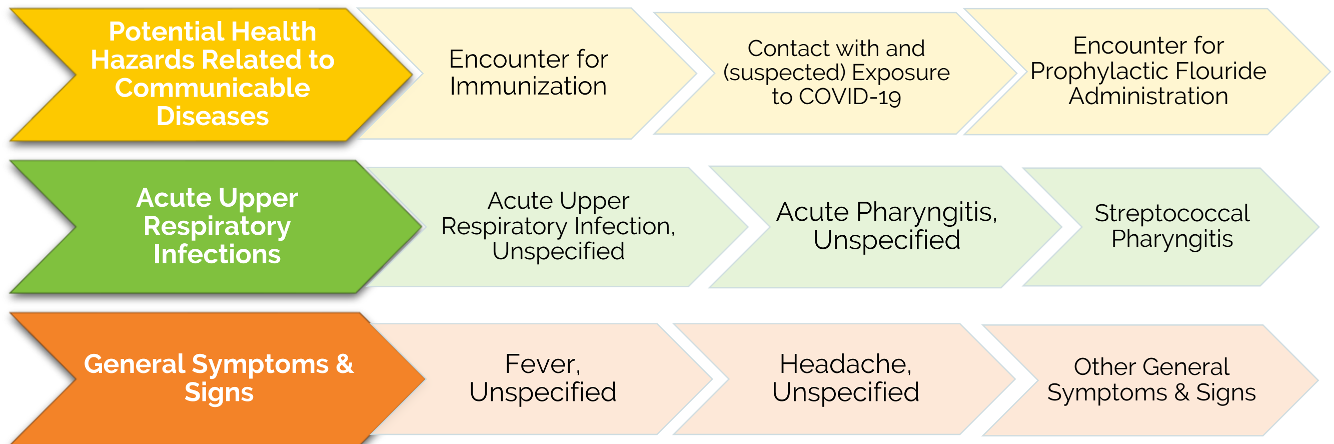
Clinical Category	%
Health Services for Examinations	62%
Potential Health Hazards Related to Communicable...	37%
Acute Upper Respiratory Infections	21%
General Symptoms & Signs	11%
S/S of Circulatory & Respiratory Systems	9%
S/S of Digestive System & Abdomen	6%
Other Joint Disorders	5%
Other Soft Tissue Disorders	3%
Potential Health Hazards Related to Family & Personal...	3%
Episodic & Paroxysmal Disorders	2%
Other Dorsopathies	2%
Benign Neoplasms, Except Benign Neuroendocrine...	1%
Infections of the Skin & Subcutaneous Tissue	1%
Metabolic Disorders	1%
Abnormal Findings on Examination of Blood, w/out...	1%
Abnormal Findings on Diagnostic Imaging & Function...	1%
Other Forms of Heart Disease	0%
Diabetes Mellitus	0%
Hypertensive Diseases	0%
Osteoarthritis	0%

Condition Category – Top 3 ICD-10 Codes



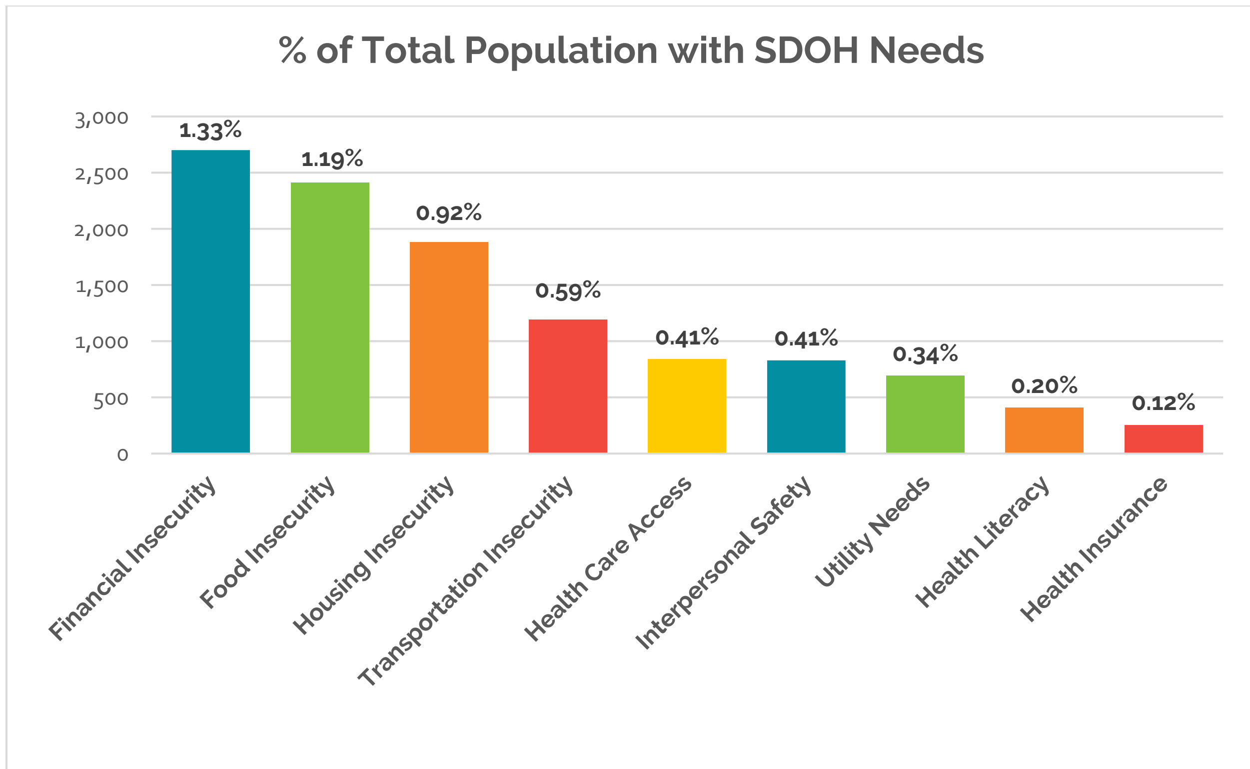


Condition Category – Top 3 ICD-10 Codes



Social Determinants of Health

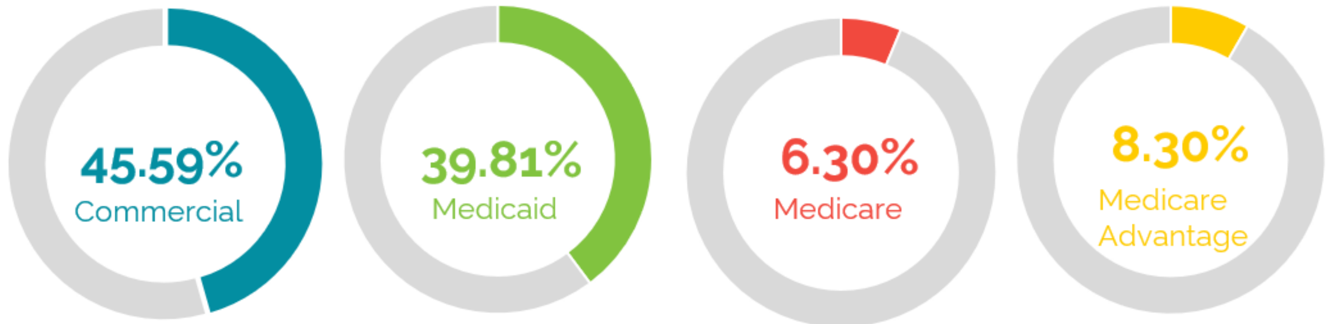
Total Population



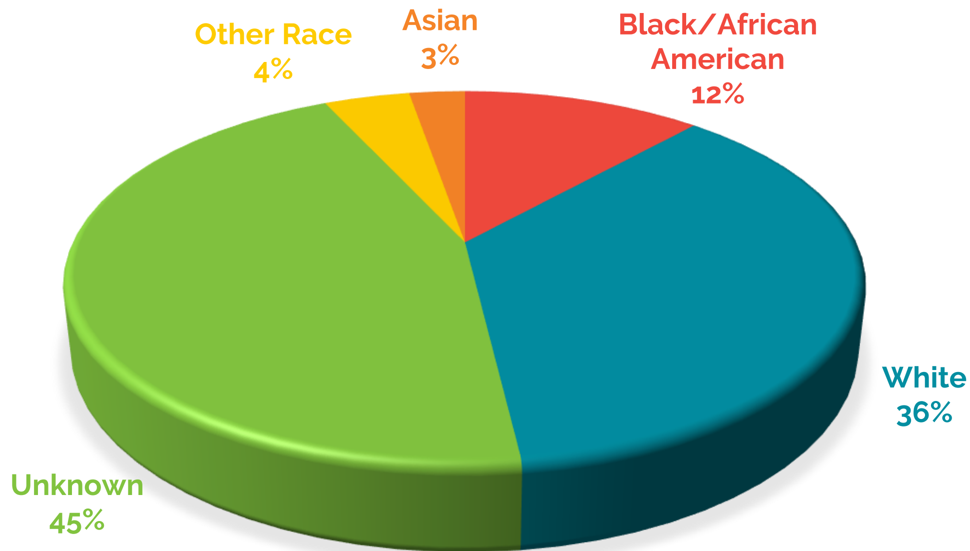
SDOH Category	Commercial	Medicaid	Medicare	Medicare Advantage	Grand Total (% of Total Population)
Financial Insecurity	1224	1116	140	221	2,701 (1.33%)
Food Insecurity	788	1248	146	230	2,412 (1.19%)
Housing Insecurity	691	943	90	157	1,881 (.92%)
Transportation Insecurity	270	663	111	148	1,192 (.59%)
Health Literacy	197	147	42	23	409 (.20%)
Health Care Access	412	319	27	82	840 (.41%)
Utility Needs	250	356	35	54	695 (.34%)
Interpersonal Safety	443	288	58	49	838 (.41%)
Health Insurance	33	189	11	20	253 (.12%)
Total SDOH Count (% of Total Payer Population)	**2759 (2.97%)**	**2409 (4.65%)**	**381 (1.10%)**	**502 (2.11%)**	**6051 (2.97%)**
Total SDOH % (by identified total SDOH)	**45.60%**	**39.81%**	**6.30%**	**8.30%**	

**Members can be counted twice within percentages*

By Line of Business for Total SDOH Identified



Race by SDOH Identified



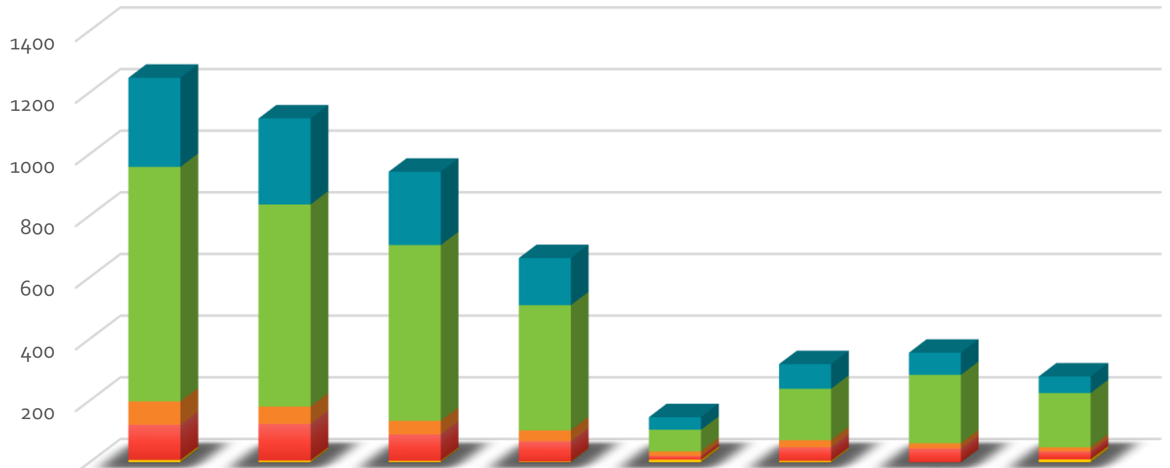
Language Literacy Among Members with SDOH Needs

Language	Member Count	Member %
English	3,408	56.3%
Other	1,746	28.9%
Unknown/Unavailable	803	13.3%
Spanish	65	1.1%
Mandarin Chinese	8	0.1%
American Sign Language	5	0.1%
Arabic	5	0.1%

Slovenian	4	0.1%
Haitian Creole	2	0.0%
French	2	0.0%
Korean	1	0.0%
Urdu	1	0.0%
Vietnamese	1	0.0%
Total	**6,051**	**100%**

Medicaid SDOH by Category & Race

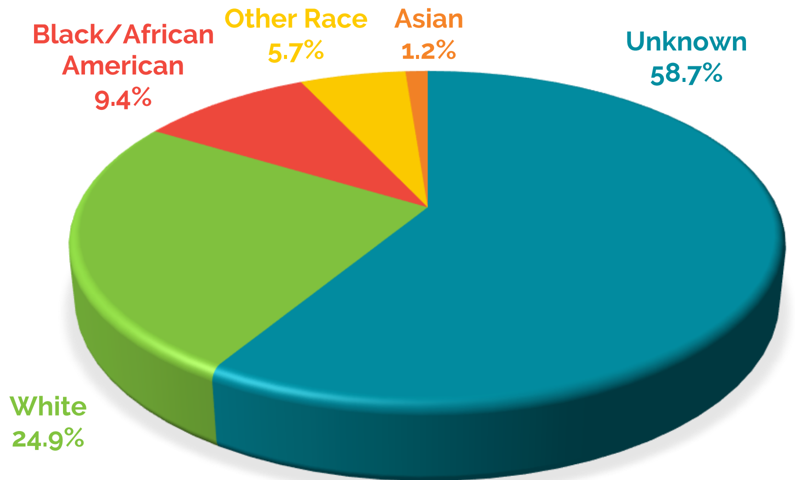
Medicaid Member Count of SDOH Needs by Category & Race



	Food Insecurity	Financial Insecurity	Housing Insecurity	Transp. Insecurity	Health Literacy	Health Care Access	Utility Needs	Interpersonal Safety
White	289	279	238	153	41	80	72	54
Unknown	761	656	570	406	70	167	222	176
Other Race	76	56	44	35	15	23	17	13
Black/African American	114	119	86	66	12	44	44	26
Asian	7	6	4	2	9	5	1	10
American Indian/Alaska Native	1	0	1	1	0	0	0	0

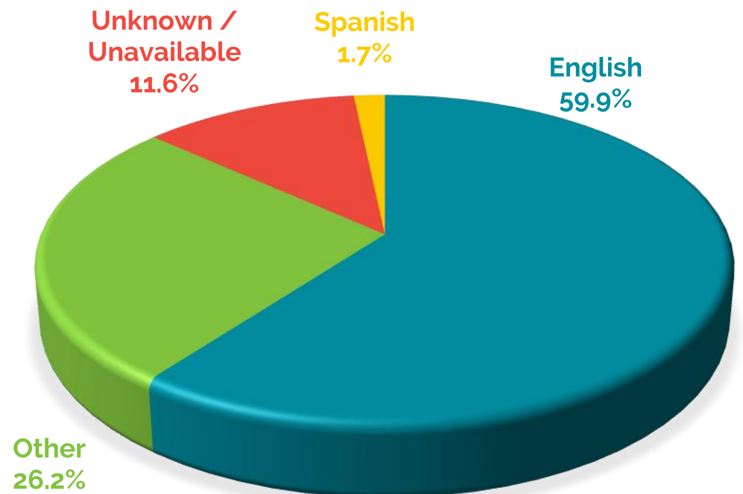
Medicaid SDOH Member Demographics

Race	Member Count	Member %
Unknown	1414	58.7%
White	601	24.9%
Black/African American	226	9.4%
Other Race	138	5.7%
Asian	29	1.2%
American Indian/Alaska Native	1	0.0%
Total	**2409**	**100%**



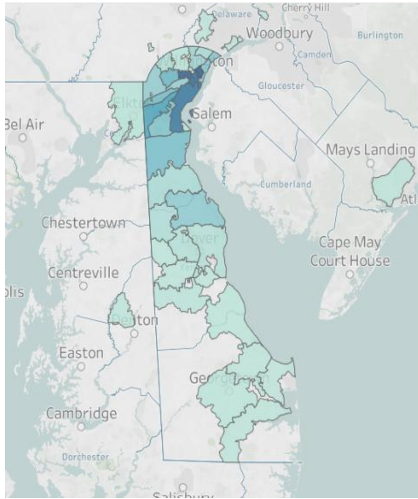
Language of Medicaid Members with SDOH Needs

Language	Member Count	Member %
English	1444	59.9%
Other	630	26.2%
Unknown / Unavailable	280	11.6%
Spanish	40	1.7%
American Sign Language	2	0.1%
Arabic	5	0.2%
Mandarin Chinese	4	0.2%
French	1	0.0%
Haitian Creole	1	0.0%
Korean	1	0.0%
Vietnamese	1	0.0%
Total	**2409**	**100%**

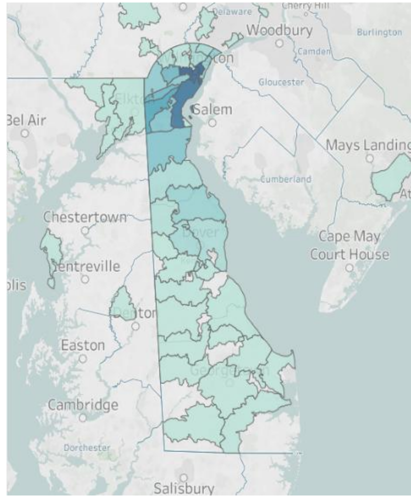


Medicaid SDOH Needs by Category and Zip Code Geocoding

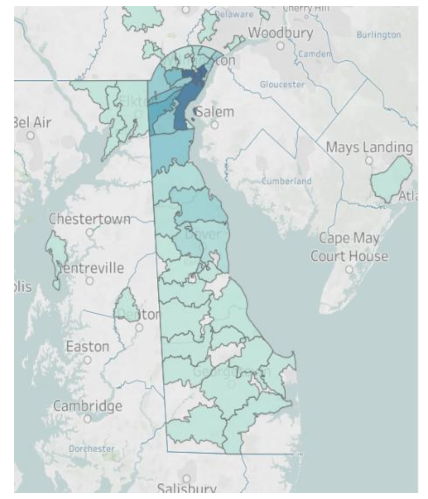
Financial Insecurity



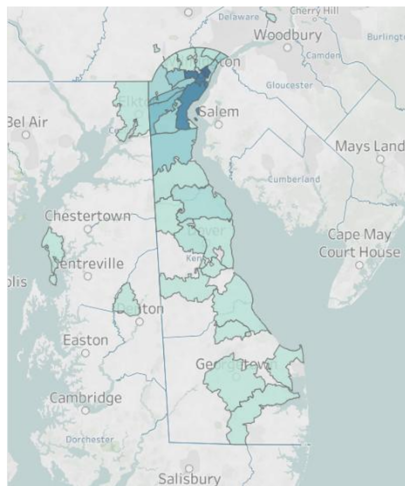
Food Insecurity



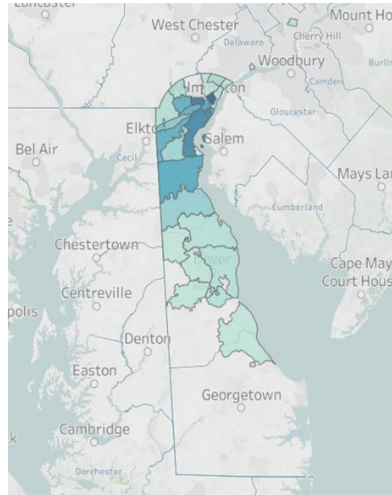
Housing Insecurity



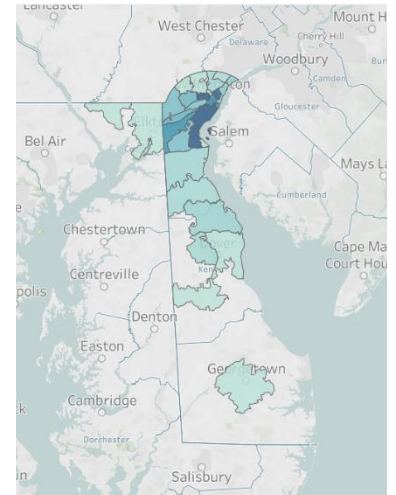
Transportation Insecurity



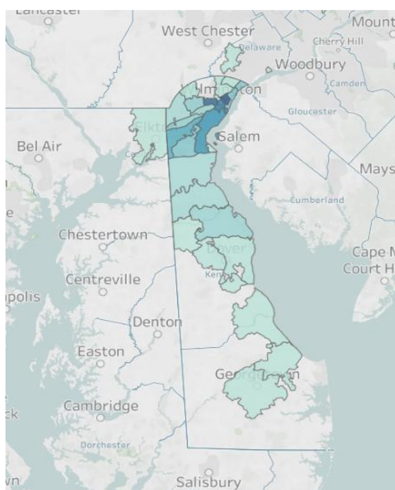
Health Literacy



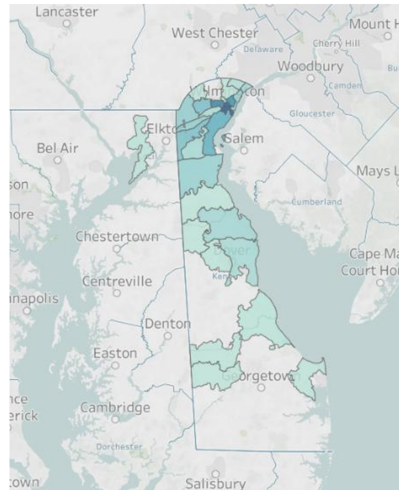
Health Care Access



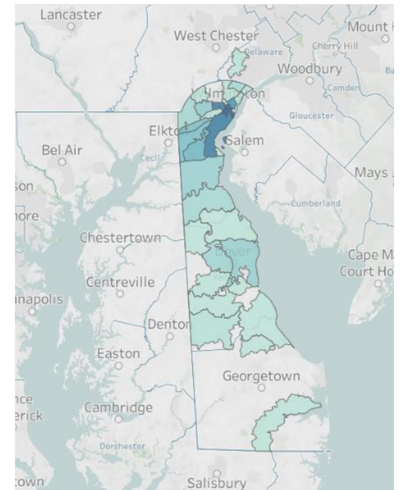
Utility Needs



Interpersonal Safety



Health Insurance



Members with Disabilities

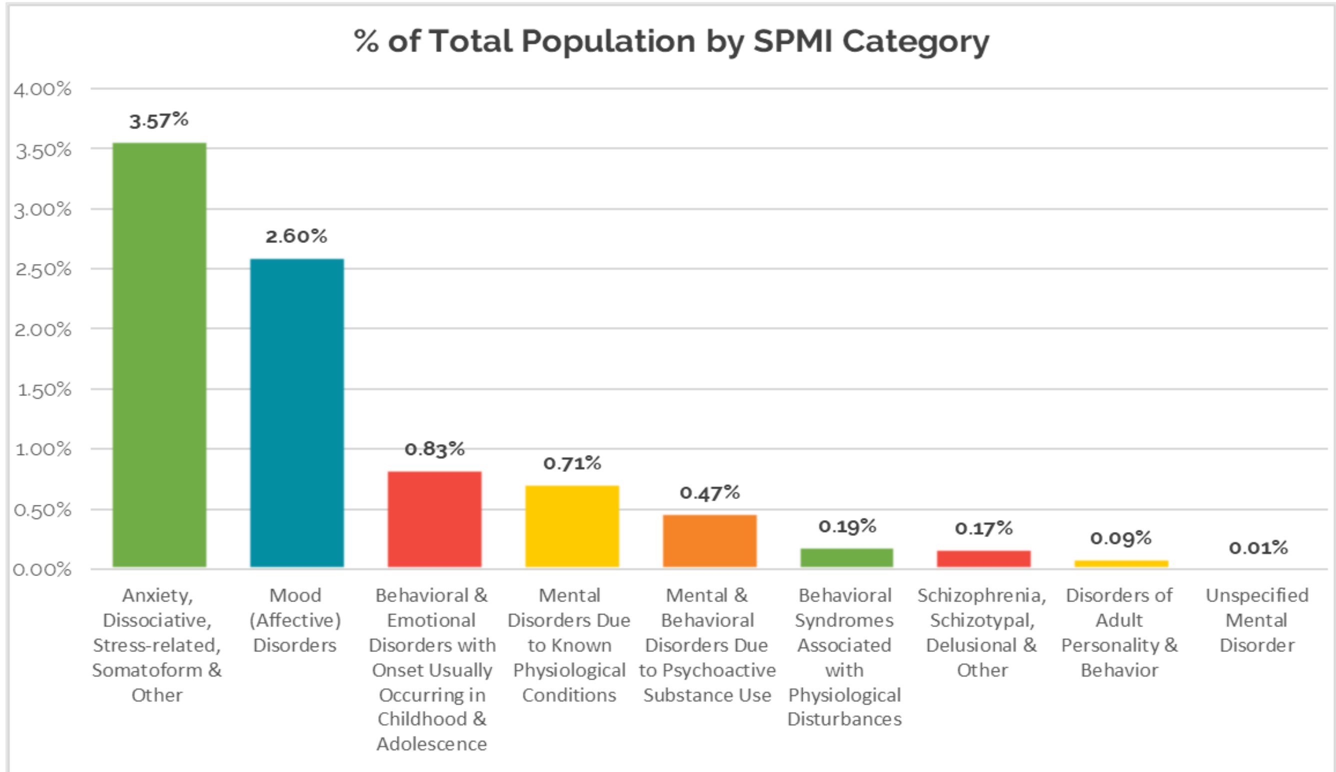
Disability	*Commercial*	*Medicaid*	*Medicare*	*Medicare Advantage*	Total # in Disability Category
Hearing Loss	1,235	284	2,908	1,216	5,643
Mobility Impairment	457	627	2,511	1,156	4,751
Visual Loss	569	283	638	292	1,782
Speech Impairment	140	72	278	131	621
Pervasive and Specific Developmental Disorders	146	175	82	0	403
Intellectual Disabilities	5	12	73	1	91
Total	**2,448**	**1,394**	**5,834**	**2,603**	**12,279 (6.04%)**
Total % of Payer Population	**2.64%**	**2.67%**	**16.77%**	**10.93%**	

**Member may have more than one disability, and may be attributed to more than one insurance payer*

Members with Serious and Persistent Mental Illness (SPMI)

Total Population

SPMI Category	Distinct Member Count	SPMI Claims/Total SPMI Identified (%)	% of Total Population (203,461)
Anxiety, Dissociative, Stress-related, Somatoform & Other	7,259	51.95%	3.57%
Mood (Affective) Disorders	5,298	37.91%	2.60%
Behavioral & Emotional Disorders with Onset Usually Occurring in Childhood & Adolescence	1,688	12.08%	0.83%
Mental Disorders Due to Known Physiological Conditions	1,442	10.32%	0.71%
Mental & Behavioral Disorders Due to Psychoactive Substance Use	948	6.78%	0.47%
Behavioral Syndromes Associated with Physiological Disturbances	395	2.83%	0.19%
Schizophrenia, Schizotypal, Delusional & Other	352	2.52%	0.17%
Disorders of Adult Personality & Behavior	175	1.25%	0.09%
Unspecified Mental Disorder	25	0.18%	0.01%
Total	**13,974**	**100.0%**	**6.87%**

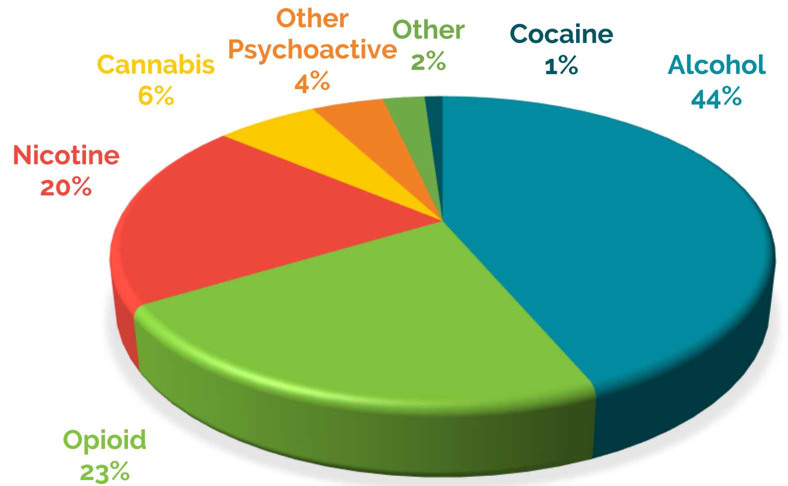


SPMI Category	Commercial	Medicaid	Medicare	Medicare Advantage
Anxiety, Dissociative, Stress-related, Somatoform & Other	23.27%	7.26%	21.26%	0.16%
Mood (affective) Disorders	12.21%	6.13%	19.41%	0.16%
Behavioral & Emotional Disorders with Onset Usually Occurring in Childhood & Adolescence	8.70%	2.39%	0.97%	0.01%
Mental Disorders Due to Known Physiological Conditions	0.62%	0.74%	7.22%	1.74%
Mental & Behavioral Disorders Due to Psychoactive Substance Use	1.86%	1.86%	2.61%	0.45%
Behavioral Syndromes Associated with Physiological Disturbances	1.26%	0.29%	1.23%	0.04%
Schizophrenia, Schizotypal, Delusional & Other	0.21%	0.72%	1.57%	0.03%
Disorders of Adult Personality & Behavior	0.66%	0.31%	0.27%	0.01%
Unspecified Mental Disorder	0.02%	0.10%	0.06%	0.00%

Mental and Behavioral Disorders Due to Psychoactive Substance Use (Substance Use Disorder)

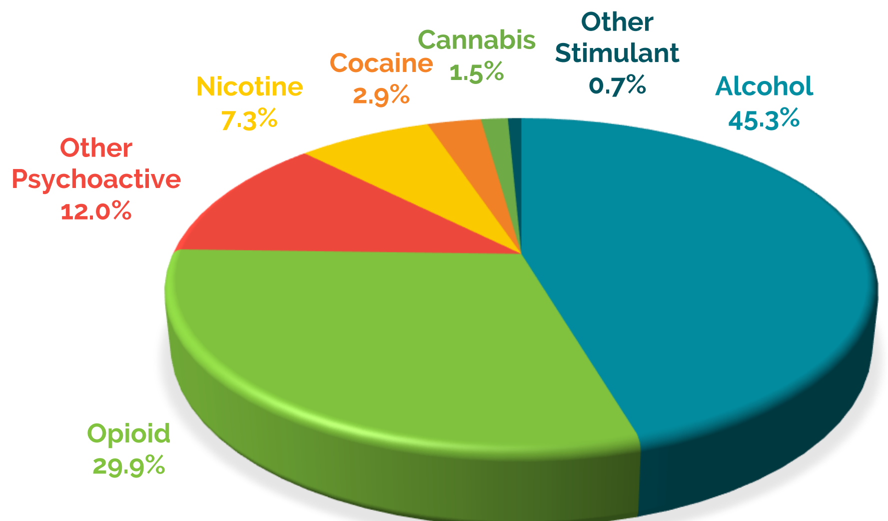
Commercial Population

Substance	Member Count	Member %
Alcohol	123	43.6%
Opioid	64	22.7%
Nicotine	56	19.9%
Cannabis	17	6.0%
Other Psychoactive	12	4.3%
Other	7	2.5%
Cocaine	3	1.1%
Total	**282**	**100%**



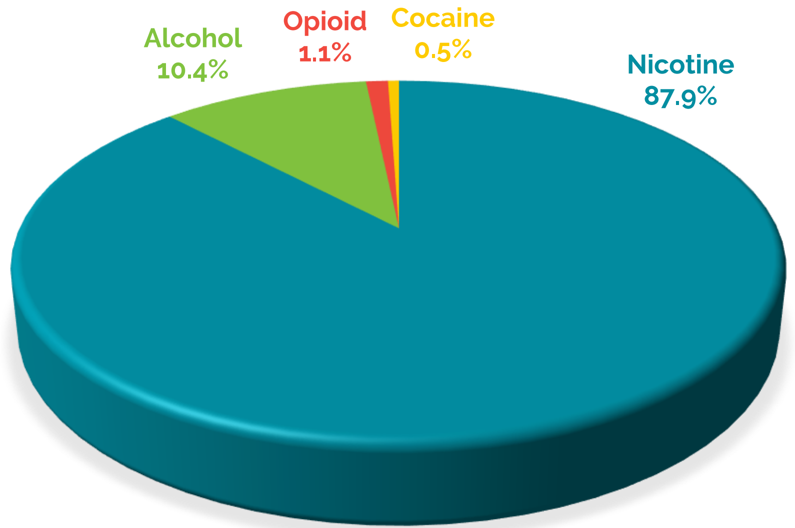
Medicaid Population

Substance	Member Count	Member %
Alcohol	124	45.3%
Opioid	82	29.9%
Other Psychoactive	33	12.0%
Nicotine	20	7.3%
Cocaine	8	2.9%
Cannabis	4	1.5%
Other Stimulant	2	0.7%
Other	1	0.4%
Total	**274**	**100%**



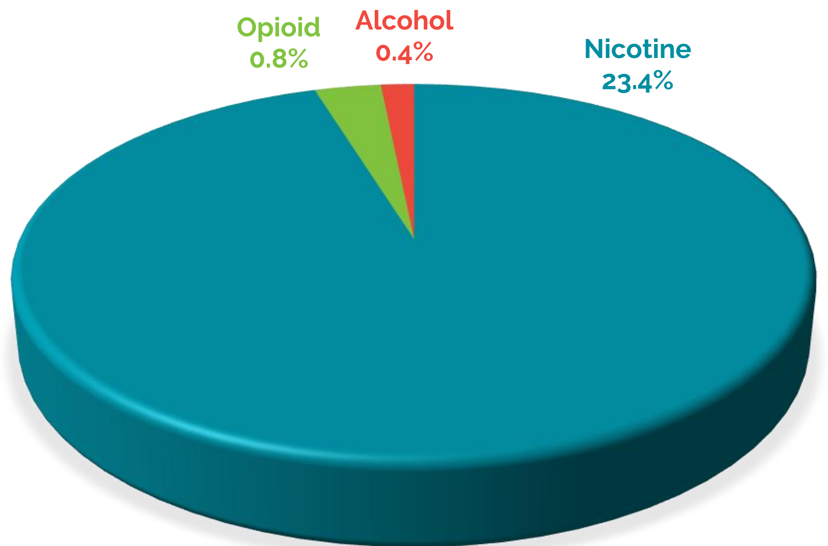
Medicare Population

Substance	Member Count	Member %
Nicotine	321	87.5%
Alcohol	38	10.4%
Opioid	4	1.1%
Cocaine	2	0.5%
Cannabis	1	0.3%
Other Psychoactive	1	0.3%
Total	**367**	**100%**



Medicare Advantage Population

Substance	Member Count	Member %
Nicotine	60	23.4%
Opioid	2	0.8%
Alcohol	1	0.4%
Cocaine	0	0.0%
Other	0	0.0%
Cannabis	0	0.0%
Total	**63**	**100%**



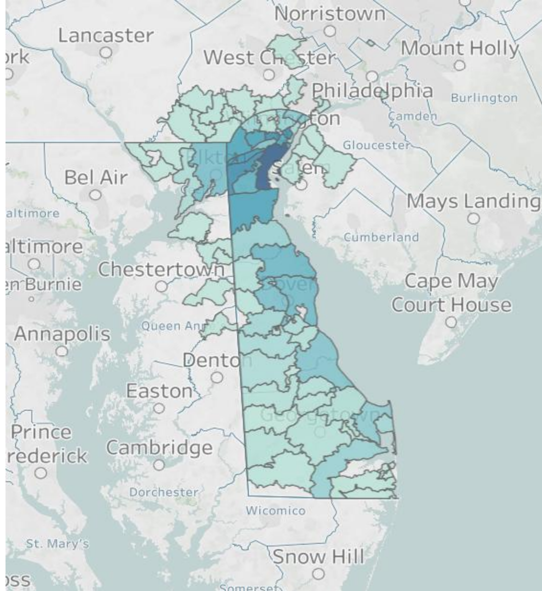
Other Subpopulations

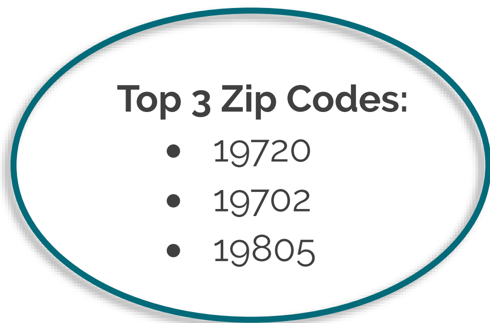
Data Source: CareVio Program Data (enrolled in a program >60 Days)

Comprehensive Case Management (CCM)

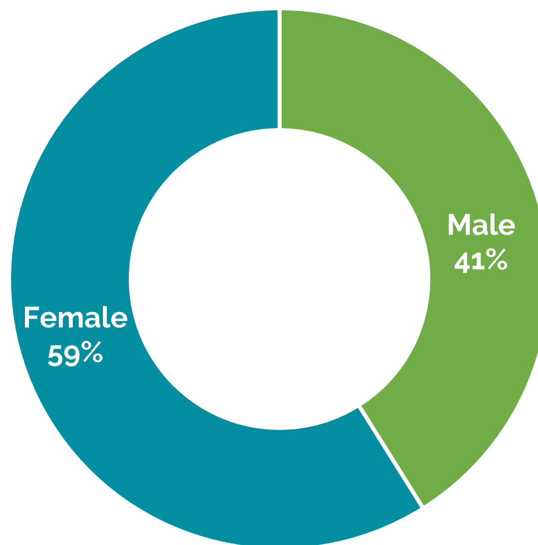
Denominator: 1251 Unique Patients

CCM Member Demographic Location:



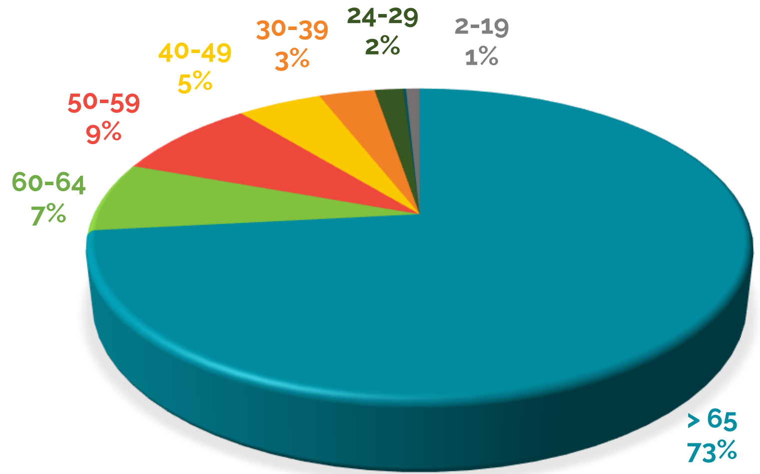


CCM Participant Gender:

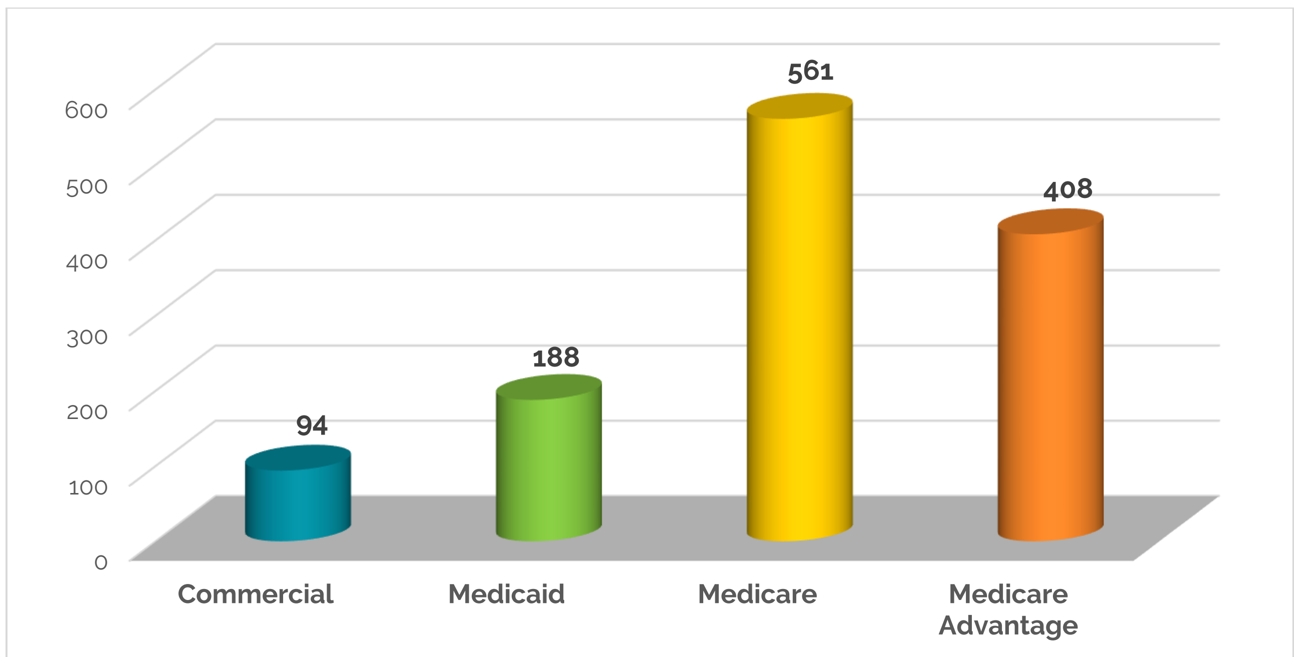


CCM Age Distribution:

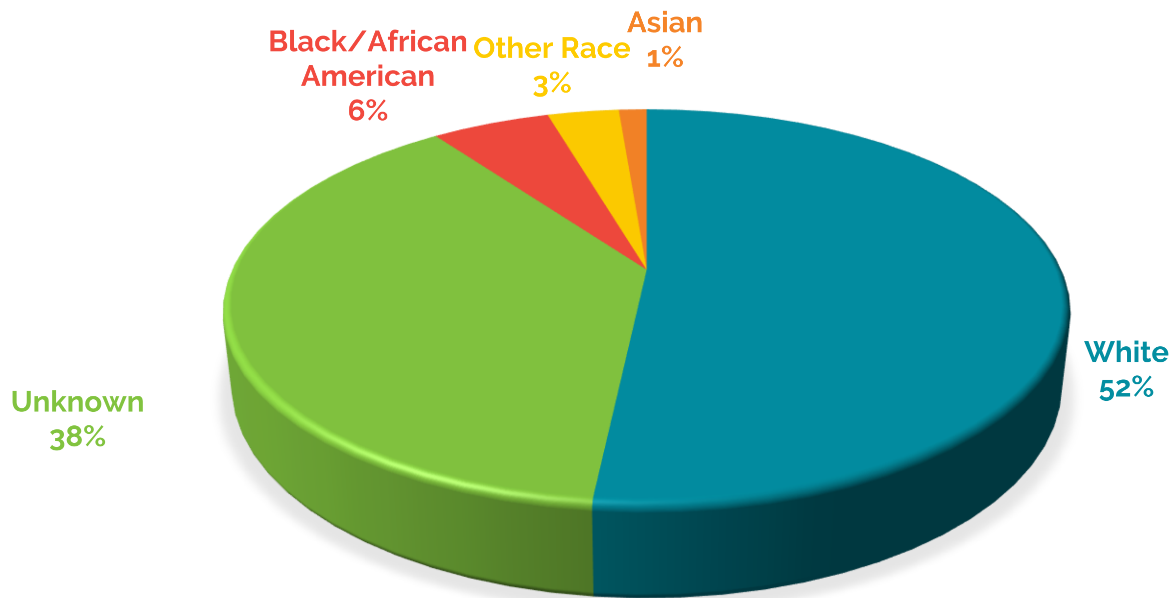
Age	Member Count	Member %
≥ 65	917	73%
60-64	91	7%
50-59	107	9%
40-49	62	5%
30-39	41	3%
24-29	21	2%
20-23	2	0%
2-19	10	1%
< 2	0	0%
Total	**1251**	**100%**



CCM Participant Member Count Line of Business:



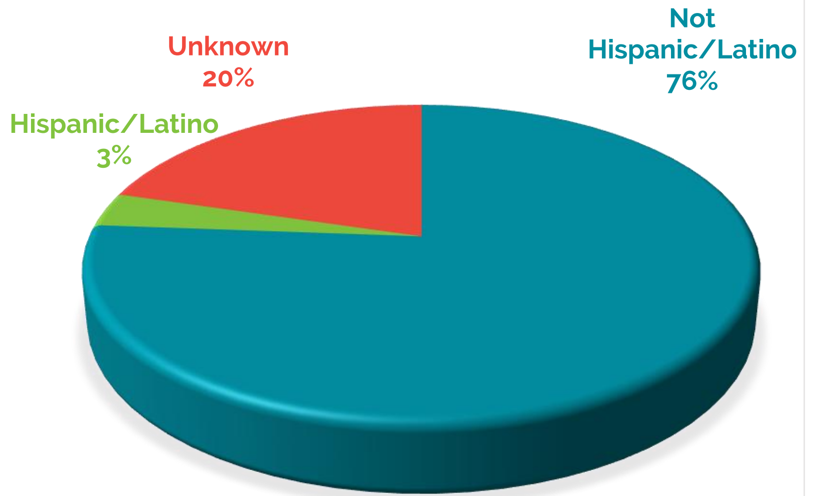
CCM Race Distribution



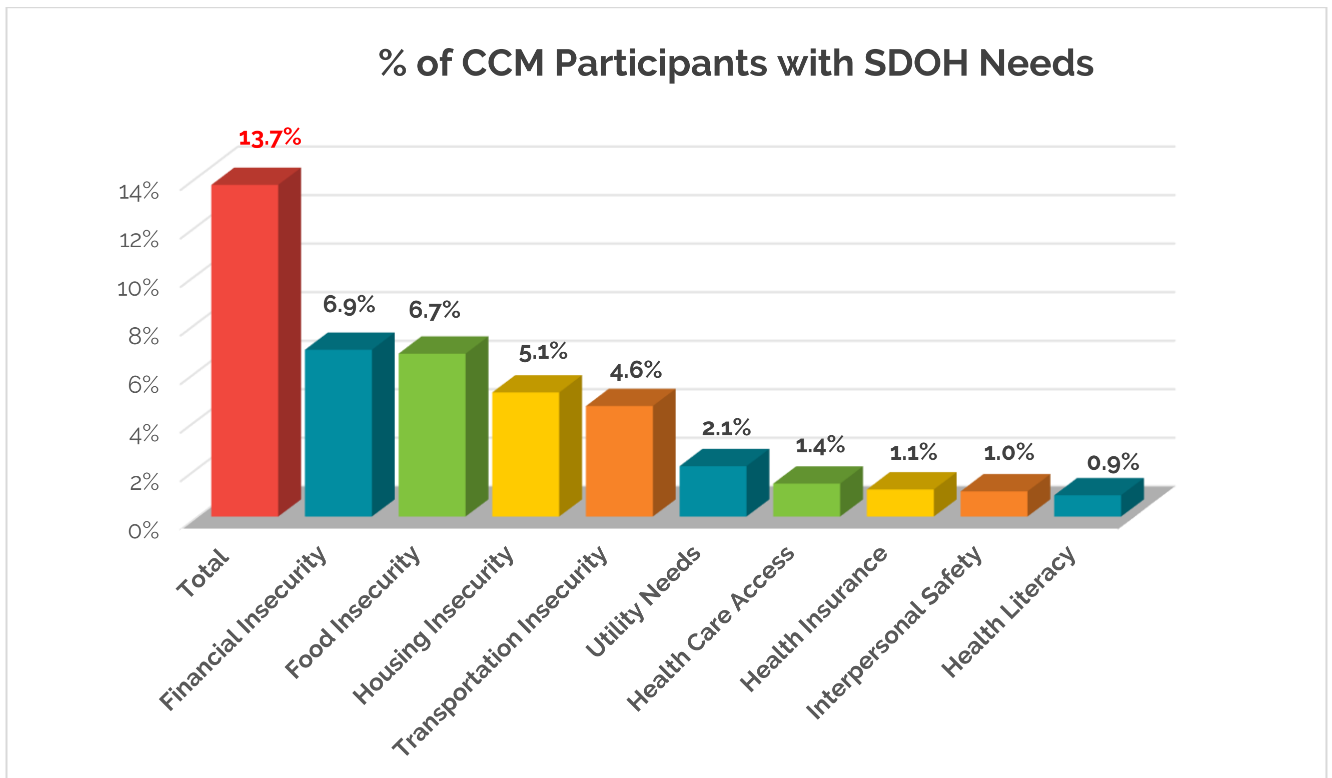
Race	Member Count	Member %
White	647	52%
Unknown	479	38%
Black/African American	68	6%
Other Race	41	3%
Asian	16	1%
American Indian/Alaska Native	0	0%
Native Hawaiian/Other Pacific Islander	0	0%

CCM Ethnicity Distribution:

Ethnicity	Member Count	Member %
Not Hispanic/Latino	953	76%
Hispanic/Latino	43	3%
Unknown	255	20%

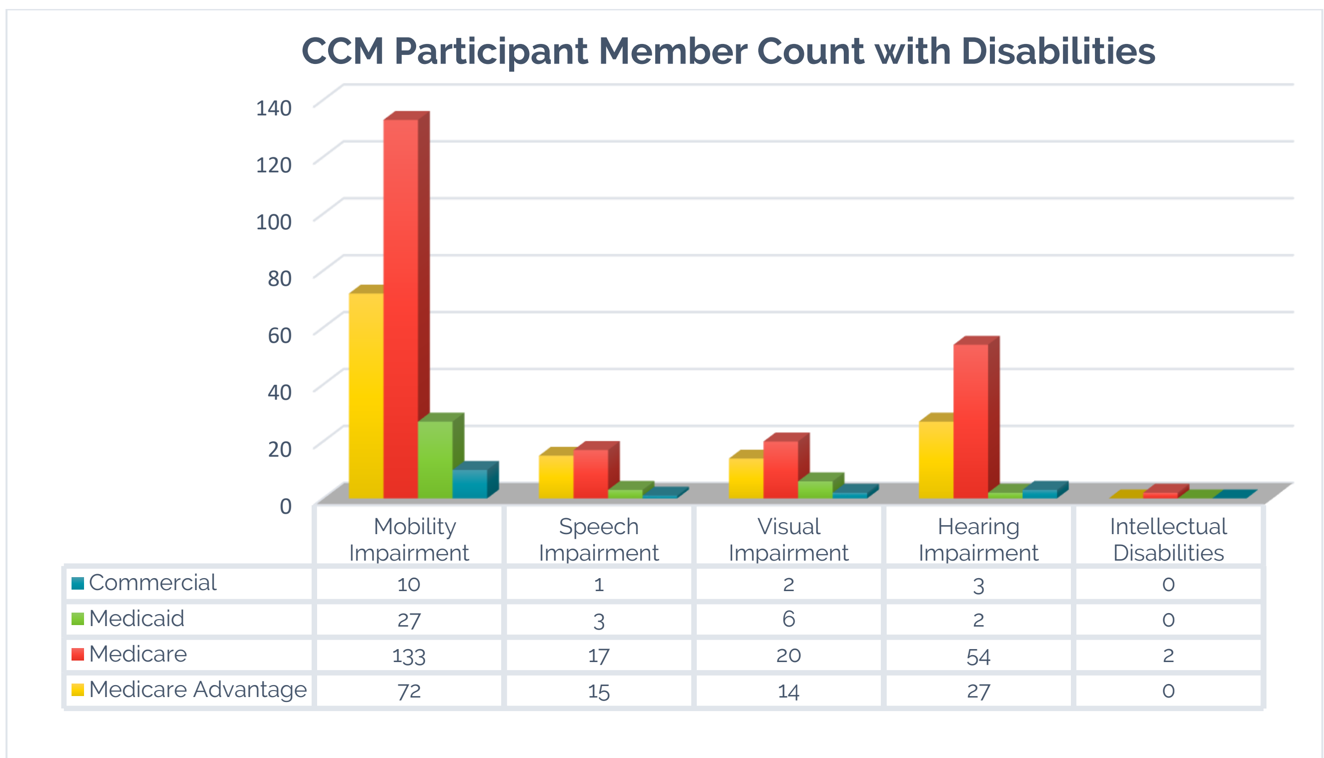


CCM SDOH:



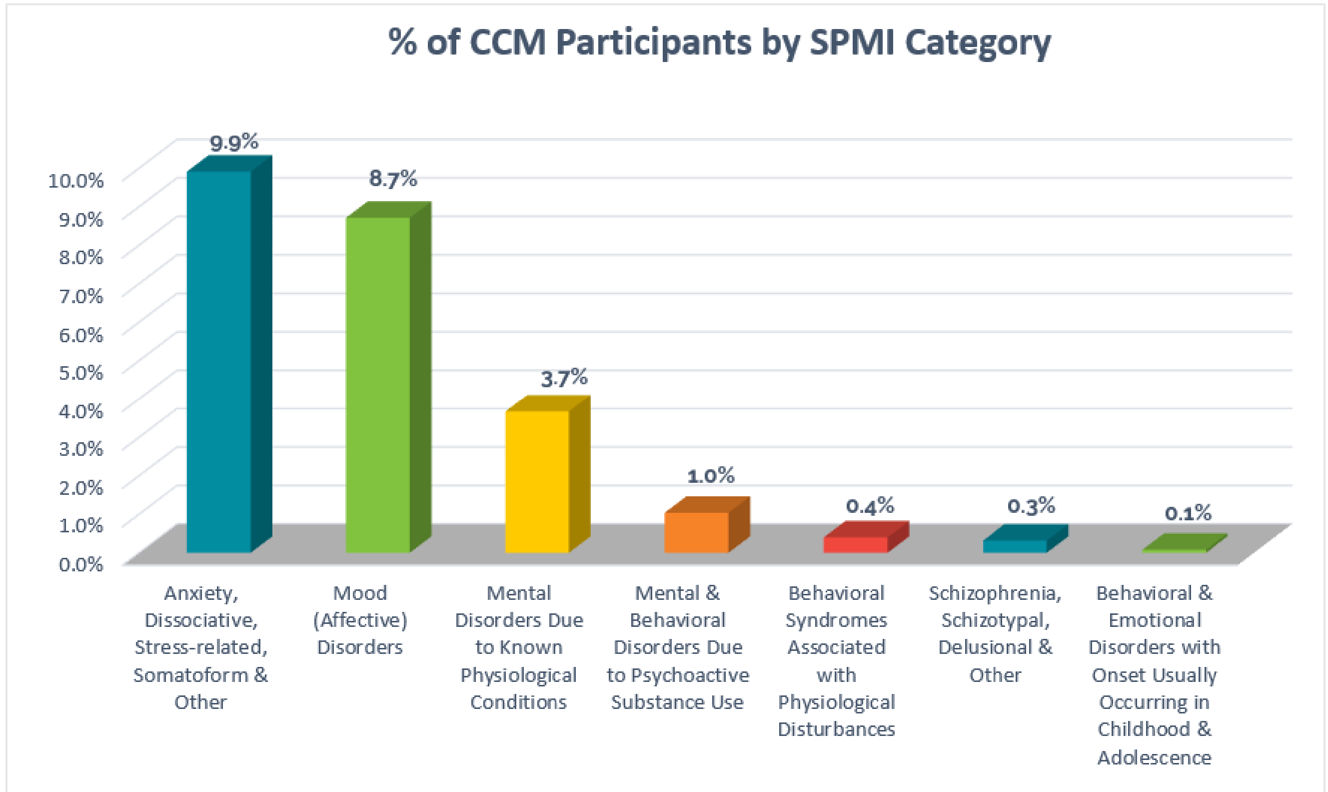
SDOH Need	Member Count	Member %
Health Literacy	11	0.9%
Interpersonal Safety	13	1.0%
Health Insurance	14	1.1%
Health Care Access	17	1.4%
Utility Needs	26	2.1%
Transportation Insecurity	57	4.6%
Housing Insecurity	64	5.1%
Food Insecurity	84	6.7%
Financial Insecurity	86	6.9%
Total	**171**	**13.7%**

CCM Disabilities:



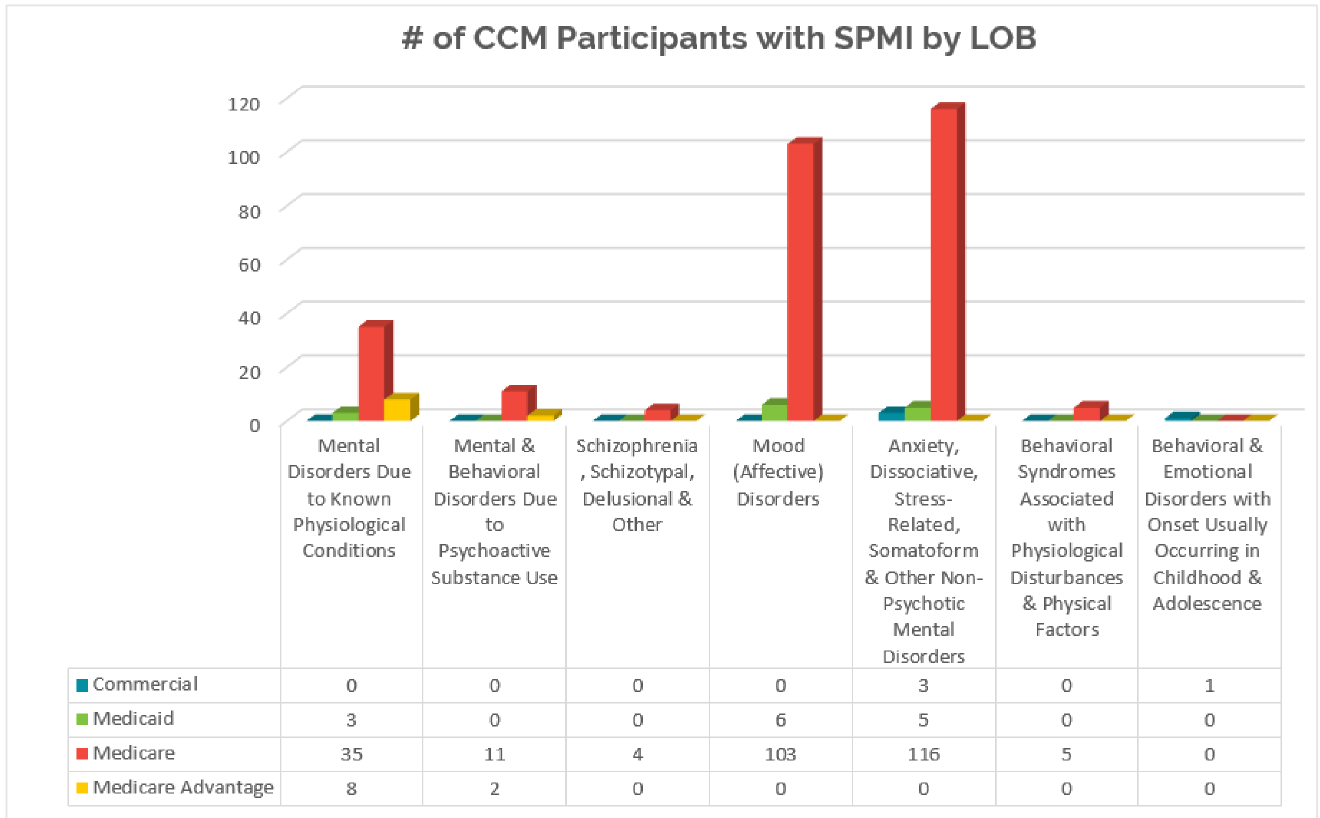
	Mobility Impairment	Speech Impairment	Visual Impairment	Hearing Impairment	Intellectual Disabilities
Commercial	10	1	2	3	0
Medicaid	27	3	6	2	0
Medicare	133	17	20	54	2
Medicare Advantage	72	15	14	27	0

CCM SPMI Distribution by Category:



SPMI Category	Member Count	% of CCM Participants
Anxiety, Dissociative, Stress-related, Somatoform & Other	124	9.9%
Mood (Affective) Disorders	109	8.7%
Mental Disorders Due to Known Physiological Conditions	46	3.7%
Mental & Behavioral Disorders Due to Psychoactive Substance Use	13	1.0%
Behavioral Syndromes Associated with Physiological Disturbances	5	0.4%
Schizophrenia, Schizotypal, Delusional & Other	4	0.3%
Behavioral & Emotional Disorders with Onset Usually Occurring in Childhood & Adolescence	1	0.1%
Total	**235**	**18.8%**

CCM SPMI by LOB:

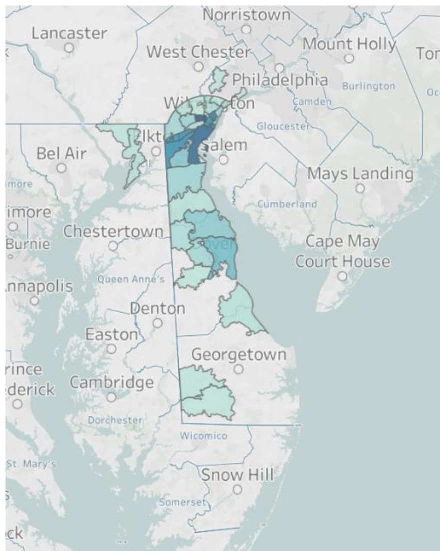


	Mental Disorders Due to Known Physiological Conditions	Mental & Behavioral Disorders Due to Psychoactive Substance Use	Schizophrenia, Schizotypal, Delusional & Other	Mood (Affective) Disorders	Anxiety, Dissociative, Stress-Related, Somatoform & Other Non-Psychotic Mental Disorders	Behavioral Syndromes Associated with Physiological Disturbances & Physical Factors	Behavioral & Emotional Disorders with Onset Usually Occurring in Childhood & Adolescence
Commercial	0	0	0	0	3	0	1
Medicaid	3	0	0	6	5	0	0
Medicare	35	11	4	103	116	5	0
Medicare Advantage	8	2	0	0	0	0	0

High-Risk Pregnancy

Denominator: 122 Unique Patients

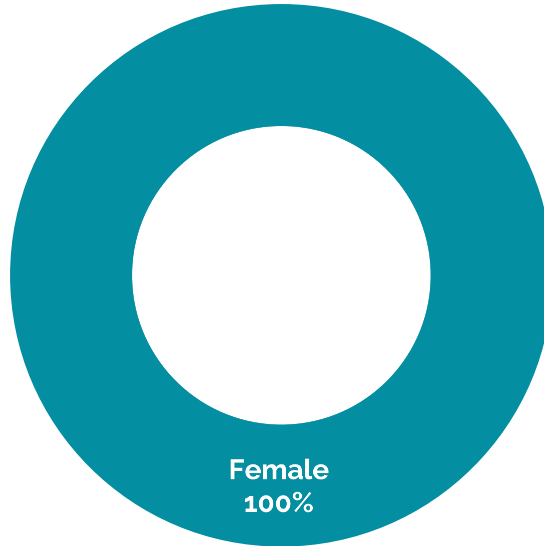
High-Risk Pregnancy Member Demographic Location:



Top 3 Zip Codes:

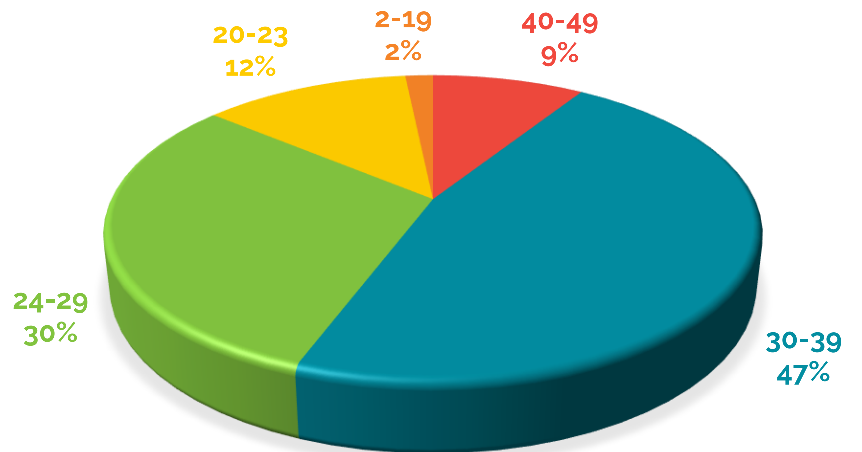
- 19805
- 19720
- 19802

High-Risk Pregnancy Participant Gender:

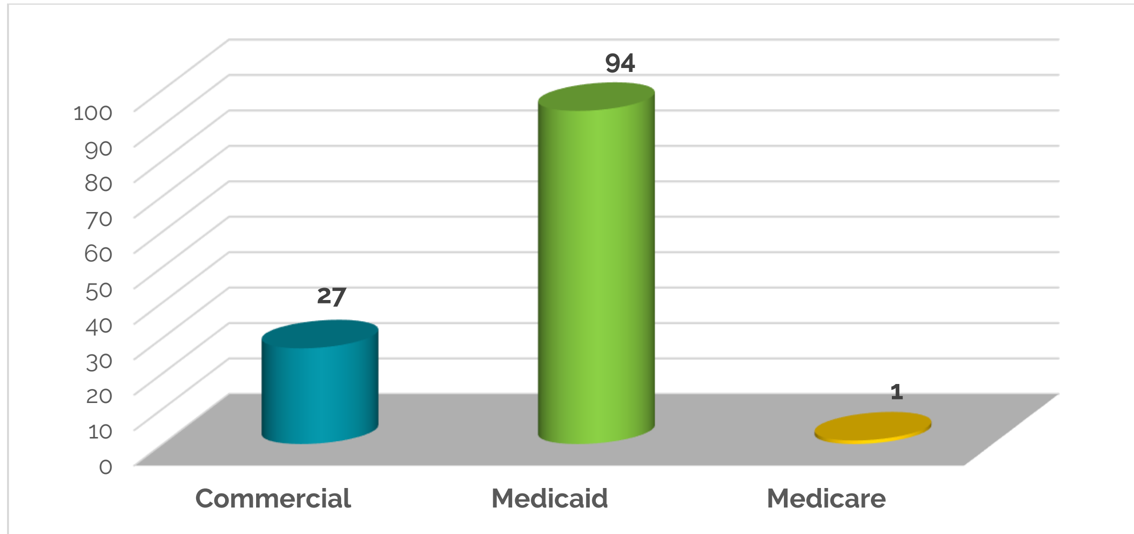


High-Risk Pregnancy Age Distribution:

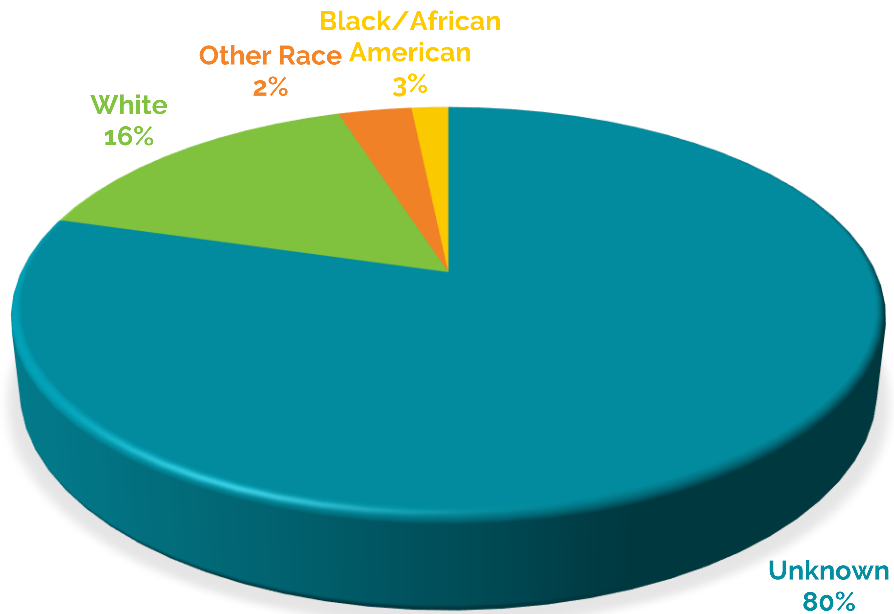
Age	Member Count	Member %
≥ 65	0	0%
60-64	0	0%
50-59	0	0%
40-49	11	9%
30-39	57	47%
24-29	37	30%
20-23	15	12%
2-19	2	2%
< 2	0	0%
Total	**122**	**100%**



High-Risk Pregnancy Participant Member Count Line of Business:



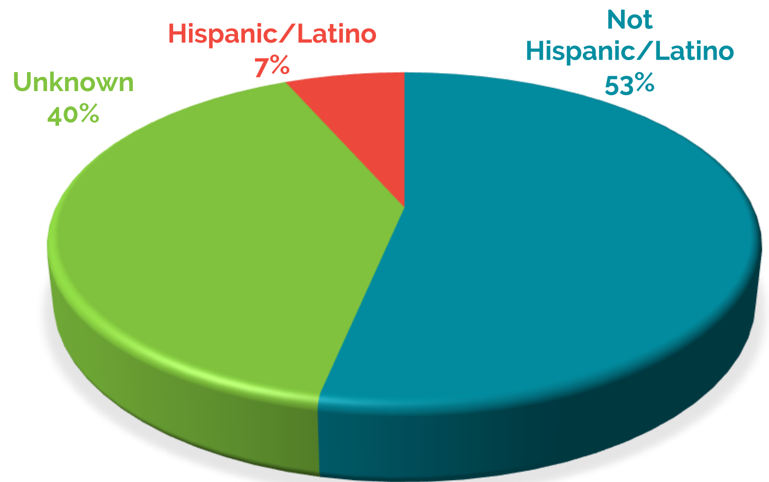
High-Risk Pregnancy Race Distribution:



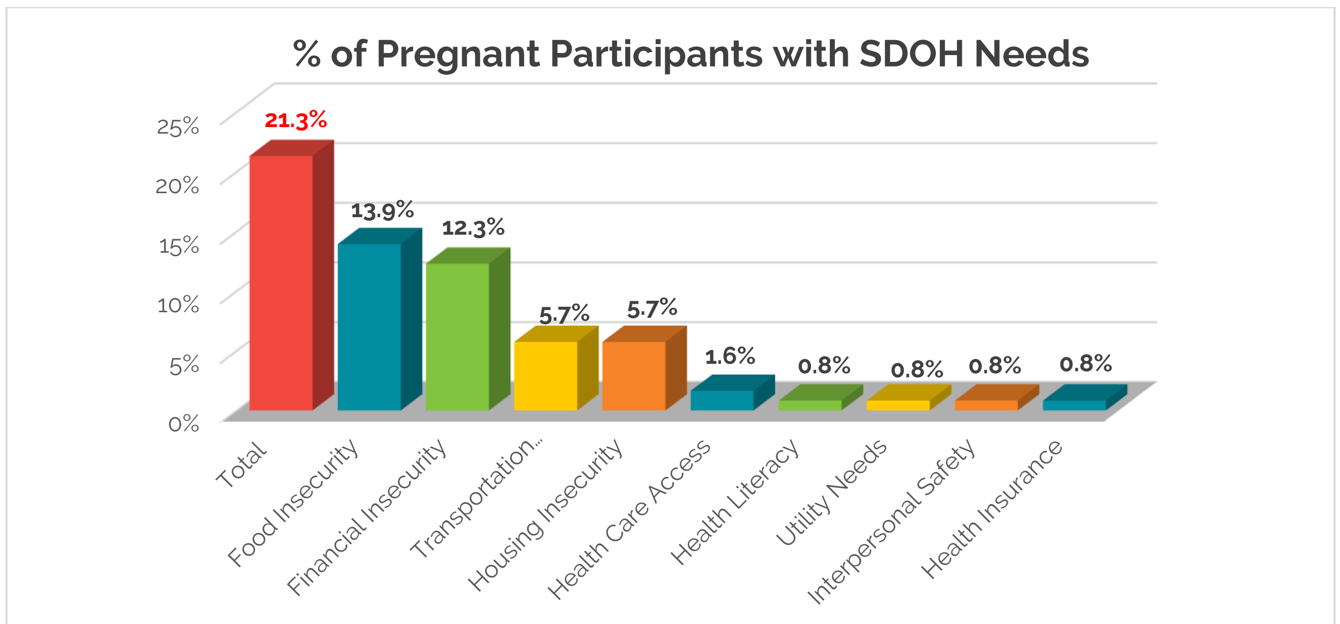
Race	Member Count	Member %
Unknown	97	80%
White	19	16%
Black/African American	4	3%
Other Race	2	2%
Total	**122**	**100%**

High-Risk Pregnancy Ethnicity Distribution:

Ethnicity	Member Count	Member %
Not Hispanic/Latino	65	53%
Unknown	49	40%
Hispanic/Latino	8	7%
Total	**122**	**100%**

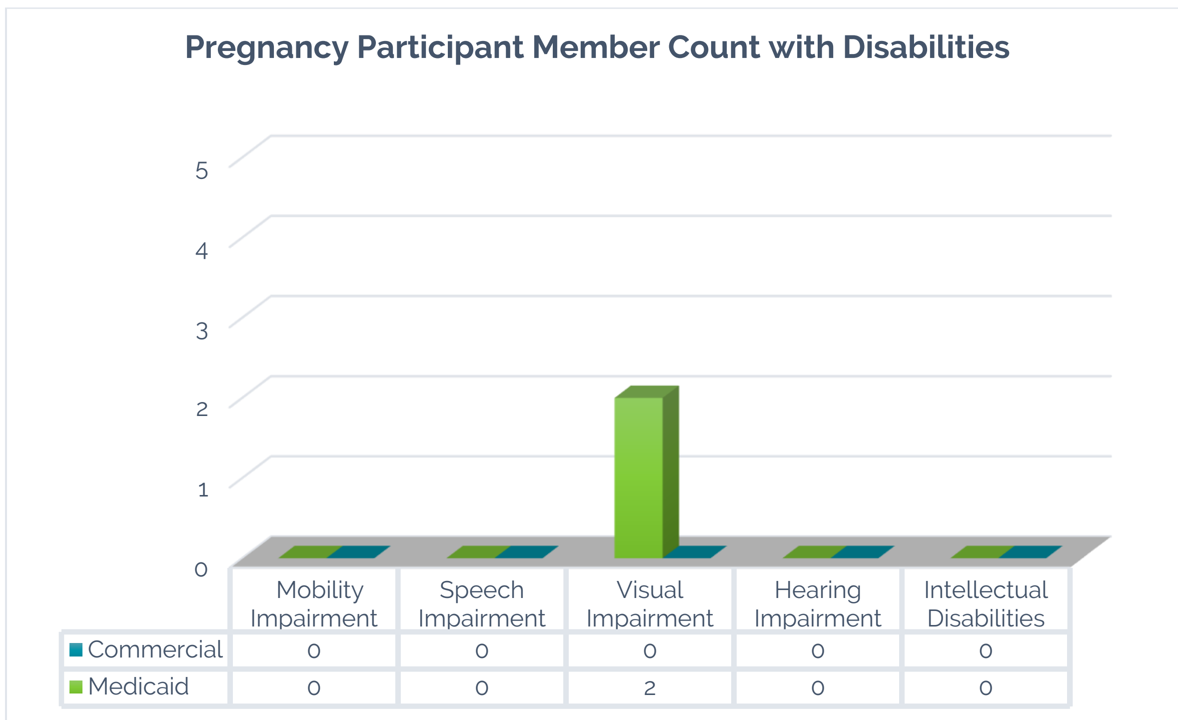


High-Risk Pregnancy SDOH:

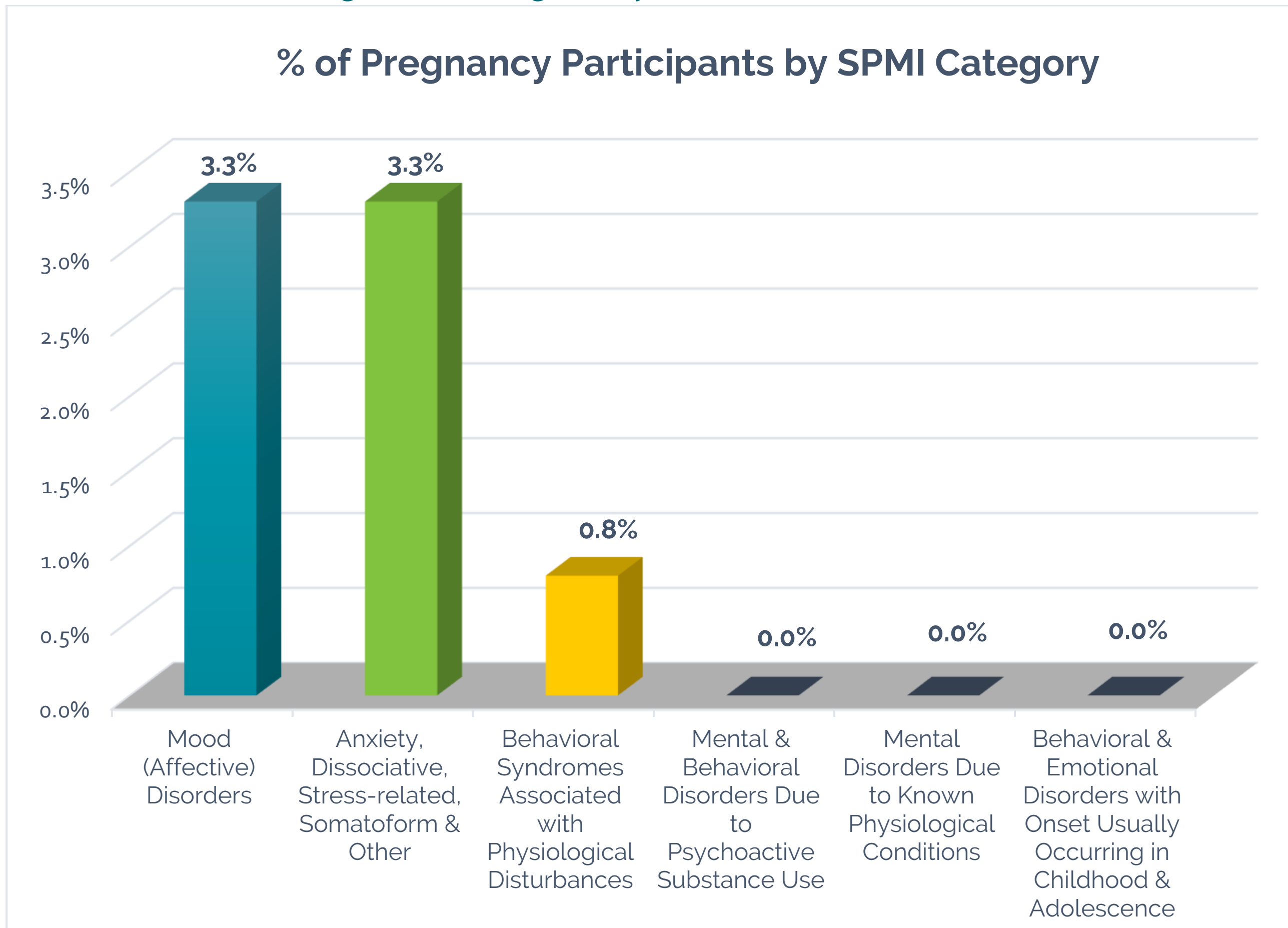


SDOH Need	Member Count	Member %
Health Insurance	1	0.8%
Interpersonal Safety	1	0.8%
Utility Needs	1	0.8%
Health Literacy	1	0.8%
Health Care Access	2	1.6%
Housing Insecurity	7	5.7%
Transportation Insecurity	7	5.7%
Financial Insecurity	15	12.3%
Food Insecurity	17	13.9%
Total	**26**	**21.3%**

High-Risk Pregnancy Disabilities:

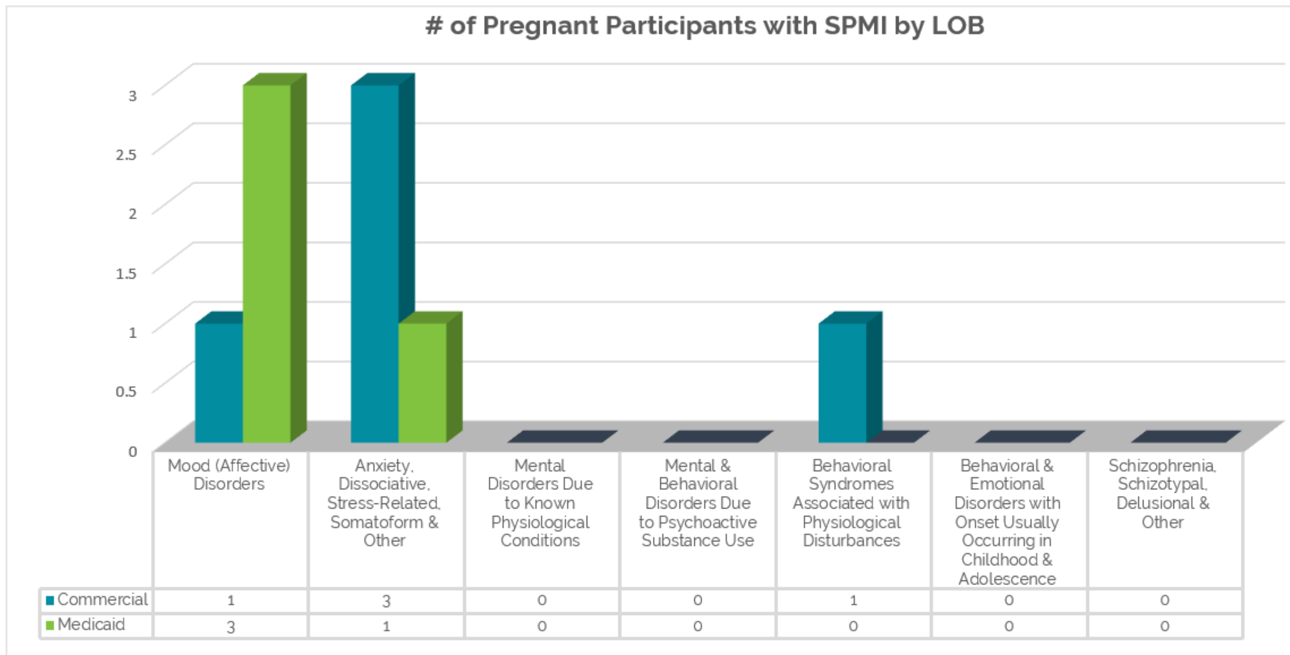


High-Risk Pregnancy SPMI Distribution:



SPMI Category	Member Count	% of Pregnancy Participants
Mood (Affective) Disorders	4	3.3%
Anxiety, Dissociative, Stress-related, Somatoform & Other	4	3.3%
Behavioral Syndromes Associated with Physiological Disturbances	1	0.8%
Mental & Behavioral Disorders Due to Psychoactive Substance Use	0	0.0%
Mental Disorders Due to Known Physiological Conditions	0	0.0%
Behavioral & Emotional Disorders with Onset Usually Occurring in Childhood & Adolescence	0	0.0%
Schizophrenia, Schizotypal, Delusional & Other	0	0.0%
Total	**8**	**6.6%**

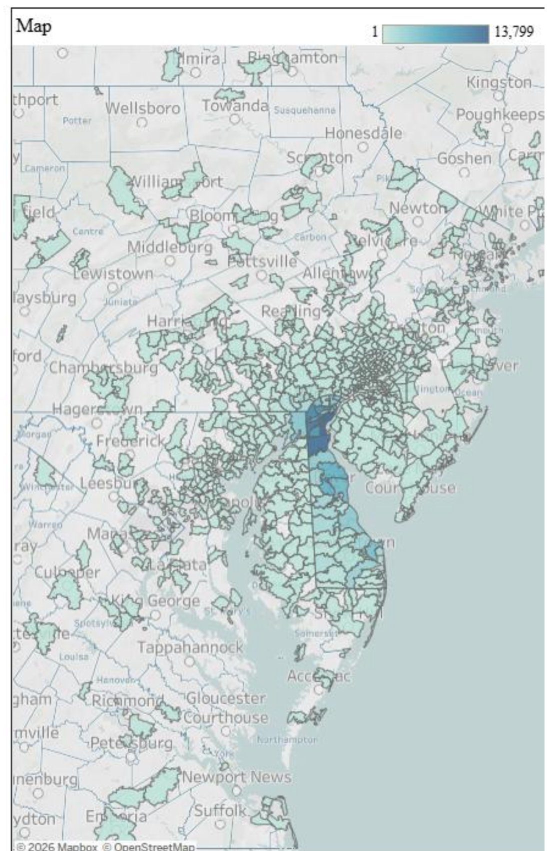
High-Risk Pregnancy SPMI by LOB:



Population Assessment Heat Map

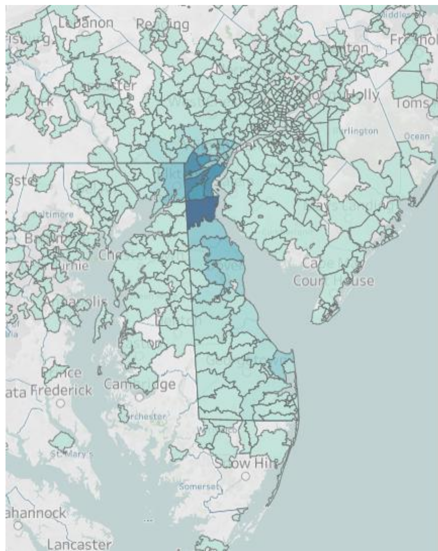
Total Population

Top 20 Cities	
City	**Count**
Wilmington	48,263
Newark	29,907
New Castle	13,805
Middletown	13,075
Dover	11,509
Bear	8,965
Smyrna	6,093
Lewes	4,600
Hockessin	4,497
Elkton	3,786
Milford	3,520
Townsend	3,372
Claymont	3,249
Millsboro	2,616
Camden Wyoming	2,137
Clayton	2,127
Milton	2,113
Felton	2,002
Magnolia	1,937
Harrington	1,776

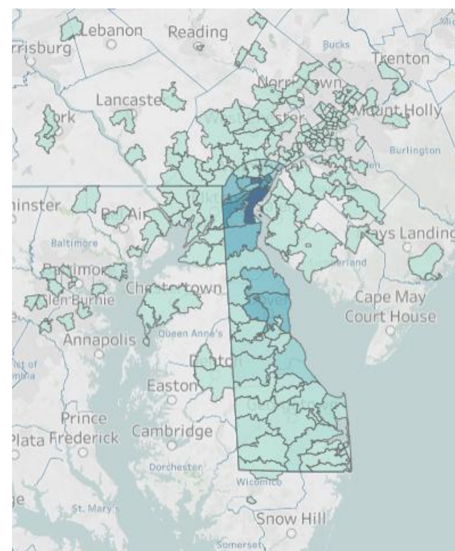


By Payer

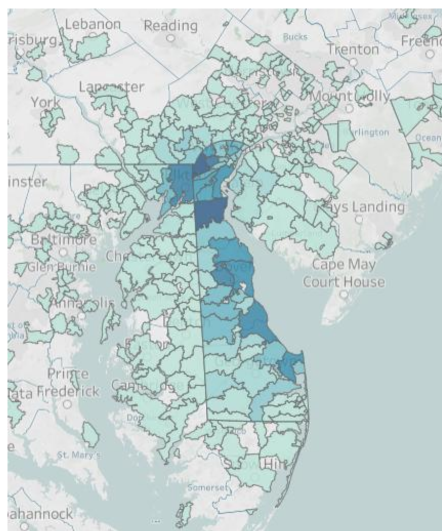
Commercial



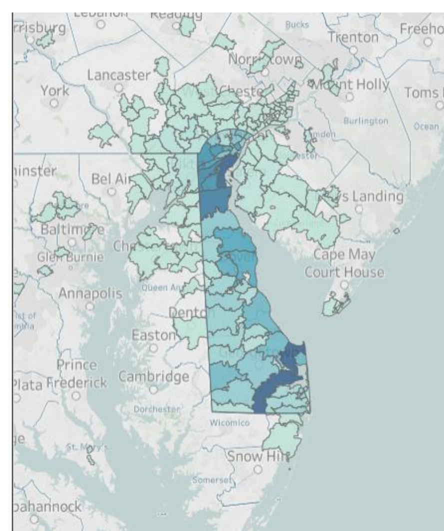
Medicaid



Medicare



Medicare Advantage



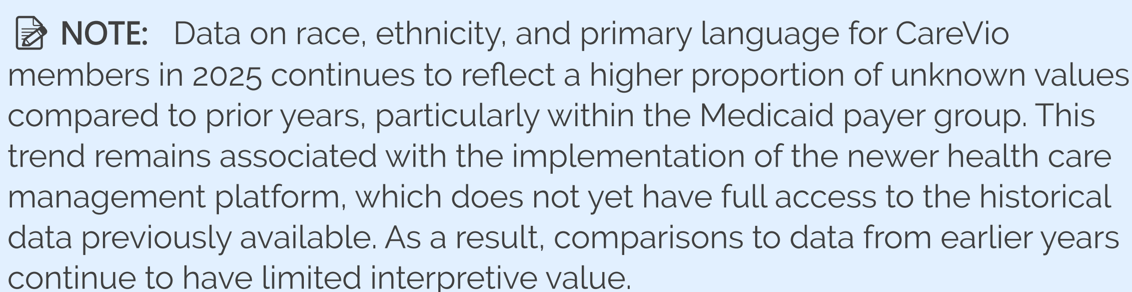
Executive Summary

Key Findings of Total Population

The 2025 CareVio Population Assessment provides a comprehensive review of member and regional data, incorporating year-over-year comparisons to 2024 where applicable. The analysis emphasizes priority populations, key subpopulations, and Social Drivers of Health (SDOH). For benchmarking and consistency, Delaware-specific data was utilized, reflecting that the majority of the CareVio population resides within the state.

The total CareVio membership for 2025 reached 203,461, representing an increase 13% of continued growth compared to 2024. This increase (more than 20,000 members) reflects ongoing business and contractual changes across CareVio, with notable expansion and contraction across payer segments. Compared to the prior year, the payer mix shifted toward a greater proportion of Commercial (46% in 2025 vs 38% in 2024) while the relative share of Medicaid declined (26% in 2025 vs. 32% in 2024). The proportion of the Medicare and Medicare Advantage populations remain consistent over the prior year. Overall, these changes represent a measurable redistribution of membership across lines of business.

The overall population continues to be predominantly female, consistent with prior years. Age distribution also remained consistent with 2024, although the proportion of members < 2 years of age decreased by over 50% (1% in 2025 vs. 1.5% in 2024). This decrease likely represents the decreased representation in the Medicaid population.



NOTE: Data on race, ethnicity, and primary language for CareVio members in 2025 continues to reflect a higher proportion of unknown values compared to prior years, particularly within the Medicaid payer group. This trend remains associated with the implementation of the newer health care management platform, which does not yet have full access to the historical data previously available. As a result, comparisons to data from earlier years continue to have limited interpretive value.

Ongoing efforts to enhance data capture, integration, and system functionality are expected to improve data completeness over time. In addition, the planned transition of the broader health system to Epic in October 2026 is anticipated to further support data standardization and accessibility, which may help reduce the proportion of unknown values and strengthen the reliability of demographic data in future assessments.

A majority of CareVio members identified their race as White (50%), followed by Black/African American at 7%. However, like last year, a significant proportion of race data remains unknown, with 37% of race values underreported. In previous years (prior to 2024) CareVio's Black/African American population was approximately 15%.

Regarding ethnicity, 61% of CareVio members identified as "Not Hispanic / Latino" and 5% identified as "Hispanic Latino." Again, there was a high proportion of values that were unknown (34%). Similar to last year, the Medicaid population had a higher proportion of Hispanic / Latino members compared to other payer groups.

For the Medicaid population, the most frequently reported race was "Unknown" (41%). In the Commercial, Medicare and Medicare Advantage populations, the most frequently reported race was "White" (51%, 80% and 60% respectively). Comparing all payer groups, Medicaid had the highest percentage of "Black/African American" members (9%), and members identified as "Other Race" (4%).

In terms of primary language, most CareVio members spoke English as their primary language (50.8%), with Spanish being the second most frequently identified single language (0.63%). However, these language data are likely skewed due to a high proportion of "Unknown / Unavailable" (24.4%) and "Other" (23.8%) responses.

Geocoding

The geocoding heat map continues to illustrate population density by zip code, while the member count chart reflects the concentration of members within cities across Delaware and surrounding service areas. Like prior years, the highest concentration of members remains in northern Delaware, particularly within New Castle County, with dense clusters extending into neighboring areas of Maryland, New Jersey, and southeastern Pennsylvania.

In 2025, Wilmington remains the most highly populated city in the CareVio population with 48,263 members, continuing to represent a substantial portion of the total population. Newark remains the second most populated city with 29,907 members, followed by New Castle (13,805) and Middletown (13,075). Compared to 2024, the overall distribution of the population across the top cities appears largely stable, with the greatest concentration continuing to be located in the northern region of the state. Middletown continues to show strong population presence, reflecting ongoing residential growth trends in southern New Castle County.

The most populated zip code appears to remain consistent with prior years, with zip code 19720 in New Castle County continuing to represent one of the highest-density areas within the CareVio population. As noted in previous reports, this zip code accounts for a significant proportion of members and includes a substantial share of Medicaid beneficiaries. Additionally, the percentage of individuals living below the

poverty line in this area is 10.9%, highlighting an important socioeconomic factor when evaluating care management needs and prioritizing interventions.[12]

The commercial population continues to predominantly reside in the northern part of DE. These areas continue to reflect suburban and higher-growth communities, particularly in the Newark and Middletown regions.

The Medicaid population remains concentrated in urban and higher-poverty areas of the state. The highest populated Medicaid regions continue to align with historically underserved urban zip codes in Wilmington and surrounding areas. This pattern is consistent with 2024 findings and reinforces the ongoing need for care management resources focused on social drivers of health, access to care, and behavioral support in these communities

The Medicare Advantage population continues to reside primarily in New Castle county, though there remains notable representation in Kent and Sussex Counties, particularly in the eastern portions of those counties. Similar to 2024, increased density is observed in coastal and central Delaware areas, likely reflecting population aging, and migration trends.

The traditional Medicare population continues to represent members residing across all three Delaware counties, as well as neighboring Cecil County, Maryland, with distribution patterns remaining relatively unchanged from prior years.

Overall, the 2025 geocoding analysis demonstrates that the CareVio population has remained relatively stable year over year, with continued concentration in northern Delaware and persistent population patterns across payer lines. This consistency supports continuity in regional case management strategy while highlighting the continued importance of targeted interventions in high-density, high-poverty, and high-growth communities.

Top 20 Physical Health Conditions in 2025

Understanding the distribution of physical health conditions across the CareVio population provides important context for healthcare utilization patterns and care needs across the continuum.

In 2025, the top physical health condition categories reported across the CareVio population remained largely consistent with 2024, with variation primarily observed in the frequency of encounters rather than the composition of conditions. Preventative care, classified as "Health Services for Examinations," continued to be the most common reason for a healthcare encounter, increasing to 56% of members (from 48% in 2024). This increase aligns with national trends reflecting expanded access to preventive services and continued normalization of outpatient care utilization. As noted in the literature, preventive visits are becoming a larger share of

primary care encounters" as coverage expansion and reduced cost barriers drive utilization.[19]

The second most reported condition category remained "Potential Health Hazards Related to Communicable Diseases," representing 22% of the population in 2025, compared to 20% in 2024, and continuing to reflect routine vaccination, screening, and exposure-related encounters. This pattern is consistent with ongoing public health guidance emphasizing vaccination and infection prevention, as respiratory viruses and communicable diseases remain a persistent component of ambulatory care demand.[43]

As in 2024, claim activity continued to reflect a high volume of encounters related to cardiovascular and metabolic conditions. Hypertensive Diseases increased from 17% to 19%, and Metabolic Disorders increased from 15% to 18%, while Signs and Symptoms of the Circulatory and Respiratory Systems increased from 15% to 17%. These findings are consistent with the sustained burden of chronic disease nationally; nearly half of U.S. adults have hypertension and require ongoing monitoring and management. Other commonly reported categories remained relatively stable, including General Symptoms and Signs (14% vs. 13%), Other Joint Disorders (13% vs. 12%), and Potential Health Hazards Related to Family and Personal History (13% vs. 11%).[7]

Respiratory-related conditions remained prominent, with Acute Upper Respiratory Infections increasing slightly (11% vs. 10%). National surveillance data indicate that respiratory illnesses continue to follow expected seasonal patterns, with ongoing outpatient utilization rather than sustained surge conditions.[43] Symptom-based categories, including Signs and Symptoms of the Digestive System and Abdomen (11% vs. 9%), also remained a notable portion of encounters, reflecting continued evaluation of non-specific or early clinical presentations.

Musculoskeletal and dermatologic conditions demonstrated modest increases, including Other Dorsopathies (11% vs. 10%), Other Soft Tissue Disorders (11% vs. 10%), and Other Disorders of the Skin and Subcutaneous Tissue (12% vs. 9%). Chronic disease categories such as Diabetes Mellitus (11% vs. 10%) and Other Forms of Heart Disease (8% in 2024 and 2025) remained stable or with slight increases. Additional changes in 2025 included growth in diagnostic-related categories, with Abnormal Findings on Examination of Blood increasing from 6% to 8%, the addition of Abnormal Findings on Diagnostic Imaging and Function Studies (7%) to the top 20. These shifts are consistent with broader trends in diagnostic utilization, as "the volume, complexity, and influence of lab testing continue to grow" within patient care.[6]

Patterns by line of business remained consistent with the distribution in 2024, with variation reflecting differences in population age, clinical complexity, and access to care. Preventative care remained the most frequent category across all payer groups in both 2024 and 2025 and increased in all four payer groups; however, the increase

observed in 2025 was more pronounced in the Medicare Advantage population, where preventive and wellness-focused visits continue to expand. This aligns with broader evidence that insured populations demonstrate higher uptake of preventive services over time, particularly as financial barriers are reduced. In contrast, the Medicaid population continued to demonstrate comparatively lower proportional use of preventative services year over year,

Within the Commercial population, the overall condition mix remained stable compared to 2024, with preventative care, communicable disease-related encounters, and respiratory conditions continuing to account for the largest share of utilization, and only modest increases in chronic condition categories. In the Medicaid population, the relative distribution also remained consistent; similar to 2024, there was continued concentration in symptom-based and acute categories in 2025,

Medicare and Medicare Advantage populations continued to demonstrate a high concentration of chronic condition categories, including hypertensive diseases, metabolic disorders, diabetes, and heart disease, with slight increases in 2025 reflecting ongoing disease burden. Despite this, preventative care remained the single most frequent category across these populations, reinforcing the role of routine monitoring, screenings, and longitudinal management in older and higher-risk populations. These patterns are consistent with national utilization trends showing that chronic disease management and preventive care increasingly occur in parallel, rather than as separate phases of care.[24]

Among children and adolescents (ages 2–19), condition patterns remained consistent with 2024, with utilization heavily weighted toward preventative and acute conditions. Preventative care remained the most frequent category, accounting for approximately 49% of the population in 2025, with a similar distribution observed in 2024. Potential Health Hazards Related to Communicable Diseases increased in 2025 over the prior year (26% vs 18%). Acute Upper Respiratory Infections (16%) and General Symptoms and Signs (9%) remained stable year over year, reflecting continued reliance on routine pediatric care, vaccinations, and management of acute illnesses common to this age group. These patterns are consistent with national pediatric care guidelines emphasizing preventive services, immunizations, and early intervention as foundational components of care delivery.[20]

Variation by line of business within the 2–19 population also remained consistent with 2024, with preventative care and acute conditions representing a larger proportion in the Commercial population compared to Medicaid. Differences in claim patterns between commercially insured and Medicaid populations among children aged 2–19 are well documented in the literature and are primarily driven by variation in access, continuity of coverage, and care-seeking patterns. Studies have consistently shown that privately insured children have higher rates of outpatient

and routine care utilization, including preventive visits, while Medicaid-insured children demonstrate lower outpatient engagement but higher rates of emergency and inpatient care utilization.[5] Chronic disease categories remained minimal across both payer groups, consistent with expected age-related disease prevalence.

Overall, the 2025 findings demonstrate stability in the composition of physical health conditions, with the primary change being increased utilization, particularly in preventive care, rather than shifts in the overall distribution of conditions. Preventive service use rose across all lines of business, most notably in the Medicare Advantage population, aligning with national evidence that expanded coverage and reduced cost barriers increase the uptake of preventive care. At the same time, modest increases in chronic conditions such as hypertension and metabolic disorders, along with greater diagnostic testing, reflect the ongoing burden and earlier identification of chronic disease.[38] Persistent variation by payer, particularly lower preventive care utilization in the Medicaid populations, continues to highlight the impact of access barriers and social drivers of health. Collectively, these patterns suggest a shift toward more proactive, prevention-oriented care, with implications for targeted care management and resource planning.

Social Determinants of Health

Obtaining Social Determinants of Health (SDOH) data continues to present challenges due to the complexity of data sources and variability in documentation practices. While electronic health records (EHRs) may be supplemented with external data sources such as census data, community-based assessments, and screening tools, integration remains inconsistent. Additionally, SDOH information is not always systematically captured in clinical workflows, and reliance on self-reported or assessment-based data can result in under-identification or variability in reporting across populations.

In 2025, a total of 2.97% of the population was identified with at least one SDOH need, representing a notable increase from 1.56% in 2024. This increase likely reflects the inclusion of data from the ChristianaCare Health System's electronic health record, a combination of enhanced screening efforts, improved documentation, and growing recognition of social needs within clinical and care management settings, rather than a sudden shift in underlying social risk alone. Unlike 2024, where Medicaid accounted for the majority of identified SDOH needs (59.5%), the 2025 distribution is more balanced between Commercial and Medicaid, with Commercial representing 45.6%, Medicaid 39.8%, Medicare Advantage 8.3%, and Medicare 6.3%. This shift reflects the notable expansion and contraction across payer segments previously mentioned. Compared to the prior year, the payer mix shifted toward a greater proportion of Commercial while the relative share of Medicaid declined. The shift

may also suggest expanded identification efforts beyond traditionally high-risk populations, particularly within the Commercial population.[39]

The most frequently identified SDOH categories in 2025 were Financial Insecurity (1.33%), Food Insecurity (1.19%), Housing Insecurity (0.92%), and Transportation Insecurity (0.59%), all of which increased substantially from 2024 levels. These findings continue to underscore persistent challenges related to economic stability and access to basic needs, while also reflecting broader categorization and improved capture of housing-related risks compared to the prior year's "Housing Quality" category. Notably, Interpersonal Safety (0.41%) and Health Care Access (0.41%) emerged as prominent categories in 2025, suggesting a widening scope of SDOH identification to include safety and access-related concerns. The addition of Health Insurance (0.12%) as a reported category further reflects increased attention to identification of coverage-related barriers.[47]

As previously reported, data on primary language and race reflect a higher proportion of "Unknown" and "Other" values compared to prior years, particularly in the Medicaid payer group. Thus, analysis of SDOH by these parameters shows a significant shift compared to 2024. While 89.2% of members with identified SDOH needs were English-speaking in 2024, this decreased to 56.3% in 2025, with substantial increases in both "Other" languages (28.9%) and Unknown/Unavailable (13.3%) categories. In addition to data capture issues, this change may reflect a broader reach into more linguistically diverse populations. These findings highlight ongoing and potentially increasing language accessibility barriers, reinforcing the importance of culturally and linguistically appropriate services.[5]

Racial distribution patterns also shifted notably in 2025 due to the high percentage of Unknown responses. In contrast to 2024, where Black/African American members represented 48% of those with identified SDOH needs, in 2025, only 12% identified as Black/African American. This pattern was also observed within the Medicaid population which showed a substantial proportion categorized as Unknown (58.7%), followed by White (24.9%) and Black/African American (9.4%). This substantial increase in unknown race data limits direct year-over-year comparisons but likely represents data quality or completeness issues, rather than a true demographic shift. Despite this limitation, the persistence of disparities among known populations continues to align with broader evidence demonstrating disproportionate SDOH burden among historically underserved communities.[46]

Within the Medicaid population, patterns of SDOH need remained generally consistent in terms of category distribution, with financial, food, and housing-related needs continuing to represent the largest areas of concern. Similar to the total population, the demographic profile shifted due to increased unknown race and language data. Language distribution within Medicaid reflects greater diversity, with English speakers comprising 59.9% in 2025 compared to 93% in 2024, and notable

increases in other and unknown language categories. These findings may indicate expanded screening reach but also highlight the need for improved data capture and standardized documentation practices.

Overall, the 2025 data suggest that SDOH needs have increased across all payers, particularly within the commercial population, indicating progress toward more comprehensive, population-wide screening approaches, expanded data capture, and improved detection. Persistent economic insecurity, rising housing-related needs, and emerging safety and access concerns reinforce the continued importance of integrating SDOH into care management strategies and resources.[34]

Disabilities

As reported in previous years, some commercial payers continue to restrict the provision of disability and behavioral health claims data to CareVio. As a result, the data described below remain an incomplete representation of disability-related and behavioral health/SPMI claims for the commercial population.

In 2025, a total of 12,279 disability-related claims were recorded across the CareVio population, representing 6.04% of the total membership. This reflects a decrease from 12,790 claims (7.1%) in 2024. As in prior years, a single member may have more than one disability category and may be represented across multiple payer groups; therefore, the total number of claims does not represent unique individuals with disabilities.

Consistent with 2024, the highest proportion of disability-related claims in 2025 was observed in the Medicare population at 16.77%, followed by Medicare Advantage at 10.93%. Both reflect declines compared to 2024 (19.2% and 13.9%, respectively). The Commercial and Medicaid populations remained comparatively lower and relatively stable, at 2.64% and 2.67% in 2025, compared to 3.0% and 2.6% in 2024. These patterns are consistent with established literature demonstrating higher documented disability prevalence among older adults and Medicare beneficiaries, driven by increased rates of chronic conditions, functional limitations, and age-associated health decline. National data indicate that approximately two in five adults aged 65 and older report at least one disability, compared to substantially lower rates in younger populations. Functional disability prevalence is also shown to increase at the point of Medicare eligibility and with advancing age, reinforcing higher observed rates within Medicare populations relative to commercially insured cohorts.[9]

Across disability categories, several shifts were observed between 2024 and 2025. Hearing Loss increased from 4,597 claims in 2024 to 5,643 in 2025, and continues to be the most frequently reported category. This increase aligns with national epidemiological data demonstrating that hearing loss prevalence rises significantly

with age, affecting approximately 65% of adults over age 70 and nearly all adults over age 90.[41] Mobility Impairment decreased from 5,882 to 4,751, though it continued to represent a substantial portion of claims; notably, mobility limitations remain one of the most common functional disabilities among older adults, with up to 30% of individuals aged 75 and older reporting difficulty walking or climbing stairs.[48] Vision Impairment increased from 1,475 to 1,782, consistent with evidence that more than one quarter of U.S. adults aged 71 and older experience vision impairment, with prevalence increasing with age.[26] Speech Impairment increased from 506 to 621. Pervasive and Specific Developmental Disorders increased from 257 to 403 overall, while Medicare Advantage reported no cases in 2025 compared to 8 in 2024. Intellectual Disabilities increased modestly from 73 to 91 claims and remained the least frequently reported category.

Overall, the 2025 data reflect a decline in both the rate and total number of disability-related claims relative to 2024, even in the context of significant population growth. This pattern may indicate changes in documentation practices, shifts in population composition, or variation in data capture across payer sources. As noted in prior research, administrative claims data may underestimate the true level of disability-related need, particularly when standardized functional assessment tools are not uniformly applied. Claims based identification of disability has been shown to have limited sensitivity, as functional limitations are not consistently captured in billing data, and individuals with disabilities may not be identifiable without supplemental clinical or survey-based measures.[37] Broader disability measurement research similarly highlights that commonly used data sources may fail to capture the full spectrum of disability due to definitional and methodological constraints.[28]

Severe and Persistent Mental Illness

In 2025, 6.87% of the CareVio population was identified as having at least one Serious and Persistent Mental Illness (SPMI), compared to 5.7% in 2024. This represents an overall increase in the prevalence of documented SPMI conditions within the CareVio population. The rise may reflect higher identification of behavioral health diagnoses across multiple SPMI categories rather than a shift attributable to population growth alone. This trend is consistent with national epidemiologic data demonstrating increasing prevalence of serious mental illness and related conditions in the United States. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), rates of both any mental illness and serious mental illness among adults have increased in recent years, alongside sustained growth in anxiety and depressive disorders.[44]

Anxiety-related disorders and mood (affective) disorders continued to be the most prevalent SPMI categories in 2025. Anxiety-related conditions increased from 2.3% of the total population in 2024 to 3.57% in 2025, representing one of the largest

year-over-year increases among all SPMI categories. Mood disorders also increased, from 2.3% to 2.6% of the population. Together, these conditions accounted for the majority of all SPMI diagnoses in 2025 and were the primary contributors to the overall increase in SPMI diagnoses. These findings align with established psychiatric epidemiology showing that anxiety and depressive disorders are the most prevalent classes of mental illness in the United States and contribute substantially to overall disease burden. Data from the National Institute of Mental Health (NIMH) indicates that anxiety disorders affect over 30% of adults at some point in their lives, while major depressive disorder remains one of the leading causes of disability nationwide.[33]

Other SPMI categories showed mixed trends when compared to 2024. Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence increased from 0.4% to 0.83%, continuing an upward trend observed in recent years. This increase is consistent with national pediatric mental health trends; the Centers for Disease Control and Prevention (CDC) has reported rising rates of anxiety, depression, and behavioral disorders among children and adolescents, particularly following the COVID-19 pandemic.[12]

Mental and Behavioral Disorders Due to Psychoactive Substance Use declined from 0.8% in 2024 to 0.47% in 2025, representing a decrease in overall population prevalence. However, national data suggest that substance use disorders remain a significant and evolving concern, with overlapping comorbidity among individuals with serious mental illness. Mental Disorders Due to Known Physiological Conditions remained stable, affecting 0.71% of the population in 2025, compared to 0.7% the prior year.

Lower-prevalence SPMI categories remained uncommon in 2025. Schizophrenia, schizotypal, delusional, and related disorders declined slightly from 0.2% in 2024 to 0.17% in 2025. Behavioral Syndromes Associated with Physiological Disturbances showed minimal change, decreasing slightly from 0.2% to 0.19%. Disorders of Adult Personality and Behavior, which were not identified at the total population level in 2024, accounted for 0.09% of members in 2025, while Unspecified Mental Disorders remained rare at 0.01%.

SPMI prevalence and diagnostic distribution varied across payer groups in 2025. Among Commercial members, anxiety-related disorders and mood disorders represented the largest proportion of SPMI diagnoses, and this group demonstrated the highest proportional representation of behavioral and emotional disorders with onset usually occurring in childhood and adolescence compared to other payer types. This pattern is consistent with recent claims-based epidemiologic research demonstrating variation in diagnosed mental health conditions across insurance types, with differences in prevalence and identification of anxiety and depressive

disorders between commercially insured and publicly insured populations, reflecting differences in access to care, utilization, and diagnostic practices.[29]

Medicaid members also primarily demonstrated anxiety-related and mood disorders among those with SPMI. Childhood-onset behavioral and emotional disorders were present within the Medicaid population but occurred at lower proportions than in Commercial members. Mental and Behavioral Disorders Due to Psychoactive Substance Use occurred at the same proportional rate in both Commercial and Medicaid populations, indicating no difference between these payer groups for this SPMI category. These findings are supported by recent peer-reviewed analyses of Medicaid populations, which demonstrate a high prevalence of serious mental illness and behavioral health conditions among Medicaid enrollees, particularly among low-income and socially complex populations. A 2025 study published in the *Journal of Adolescent Health* found substantial prevalence of serious mental illness among Medicaid-enrolled young adults and highlighted the influence of social and community-level risk factors on mental health burden.[42] Additional research indicates that Medicaid populations experience significant variability in mental health service utilization and access across regions, further reinforcing the high burden and heterogeneity of behavioral health conditions within this payer group. Moreover, recent analyses continue to show that Medicaid plays a central role in covering individuals with serious mental illness and facilitating access to care, particularly among medically underserved populations receiving care through safety-net settings such as Federally Qualified Health Centers.[27]

Among Medicare beneficiaries, anxiety-related disorders and mood disorders accounted for a substantial share of identified SPMI diagnoses. Mental disorders due to known physiological conditions and mental and behavioral disorders related to psychoactive substance use were proportionally higher in the Medicare population than in Commercial or Medicaid populations, consistent with increased medical complexity in older adults. This pattern is well supported in the literature, which demonstrates that older adults frequently experience co-occurring chronic medical conditions, cognitive impairment, and neuropsychiatric symptoms that contribute to higher rates of medically related mental disorders and substance use complications. Studies of Medicare populations with mental illness also highlight high levels of multimorbidity and healthcare utilization, particularly among dually eligible beneficiaries.[18]

Medicare Advantage members accounted for a smaller proportion of SPMI diagnoses overall. Within this payer group, “Mental disorders due to known physiological conditions” represented a comparatively larger share of SPMI diagnoses relative to anxiety and mood disorders, which were identified less frequently. This distribution may reflect differences in data availability, risk adjustment, and coding practices within Medicare Advantage, as well as more structured care coordination for medically complex members.[16]

Overall, the 2025 Case Management Population Assessment reflects a continued increase in the prevalence of documented SPMI, driven primarily by rising rates of anxiety-related and mood disorders and continued growth in childhood-onset behavioral and emotional conditions. Persistent variation in SPMI prevalence and diagnostic patterns across payer groups highlights the need for payer-specific case management approaches that account for differing clinical profiles and complexity. These findings are consistent with a growing body of literature emphasizing the importance of integrated behavioral health care models, particularly for populations with serious mental illness and co-occurring medical and social risk factors. Recent studies examining Medicaid expansion and mental health outcomes further underscore the role of insurance coverage and care access in shaping population-level mental health trends.[1]

Mental and Behavioral Disorders Due to Psychoactive Substance Use

Across all populations in 2025, patterns of “Mental and Behavioral Disorders Due to Psychoactive Substance Use” demonstrate notable shifts in substance distribution compared to 2024, with decreases in opioid predominance in several populations and a relative increase in alcohol and nicotine-related diagnoses in selected cohorts. These changes may reflect evolving prescribing practices, improved screening and coding specificity, shifts in treatment engagement, and potential changes in data capture as behavioral health integration matures across payer types.

In the Commercial population, total identified cases decreased from 319 in 2024 to 282 in 2025. A significant shift in substance distribution is observed, with alcohol becoming the leading identified substance at 43.6% in 2025 compared to 20.1% in 2024. Opioid-related disorders declined substantially from 67.7% to 22.7%, while nicotine-related disorders increased from 7.8% to 19.9% and cannabis increased from 1.6% to 6.0%. The increase in cannabis-related disorders may reflect broader changes in cannabis accessibility and social acceptance following legalization efforts in Delaware, as research has demonstrated that recreational cannabis legalization is associated with increased use[49]. This shift away from opioid predominance may reflect improved prescribing stewardship, expanded use of non-opioid pain management strategies, and increased uptake of monitoring programs designed to reduce long-term opioid exposure. However, national surveillance continues to identify synthetic opioids, particularly fentanyl, as a leading driver of overdose mortality, even as prescribing patterns evolve, as noted by CDC.[32]

In the Medicaid population, total cases decreased slightly from 291 in 2024 to 274 in 2025. Alcohol remains the leading substance category at 45.3% in 2025 compared to 48.1% in 2024, followed by opioids at 29.9% in 2025 compared to 32.0% in 2024. “Other Psychoactive” substances were not reported in 2024 but appeared as 12.0% of the distribution in 2025, while nicotine increased from 5.5% to 7.3%. Cocaine and cannabis

showed significant decreases. The continued prominence of alcohol and opioid-related conditions is consistent with well-documented trends within Medicaid populations, where substance use disorders (SUDs) are highly prevalent and frequently co-occur with behavioral health and chronic medical conditions. Medicaid disproportionately covers individuals with opioid use disorder and other SUDs, many of whom present with significant clinical complexity, including high rates of co-occurring mental health disorders and polysubstance use.[36] These patterns are closely tied to underlying socioeconomic factors, including poverty, housing instability, and limited access to outpatient care, which are more common among Medicaid beneficiaries and contribute to both increased SUD risk and challenges in treatment engagement.[31]

In the Medicare population, total cases decreased from 504 in 2024 to 367 in 2025. Nicotine remains the dominant substance category but declined from 93.5% to 87.5%. Alcohol increased from 6.2% to 10.4%, while opioid-related diagnoses, cocaine, and cannabis remained very low but increased slightly. The continued predominance of nicotine is consistent with long-standing tobacco exposure patterns in older adult populations, where "older smokers account for the greatest tobacco-related morbidity and mortality" and tobacco use remains a major contributor to chronic conditions such as cardiovascular disease, cancer, and cerebrovascular disease. The gradual decline in nicotine proportion alongside an increase in alcohol-related diagnoses may reflect evolving screening and recognition patterns, particularly as substance use in older adults has become more recognized in clinical practice.[23] Recent literature notes that substance use disorders in this population are "becoming increasingly prevalent among the older adult population" yet remain difficult to identify due to comorbidities and polypharmacy.[22]

In the Medicare Advantage population, total identified cases decreased substantially from 256 in 2024 to 63 in 2025. Nicotine decreased from 65.2% to 23.4%, while opioid-related diagnoses declined from 20.7% to 0.8% and alcohol from 12.1% to 0.4%. No cases of cocaine, cannabis, or other substances were reported in 2025. While these reductions may reflect improved prevention efforts, cessation support, or enhanced care management engagement, the magnitude of change combined with the sharp reduction in total cases suggests potential influences from changes in claims capture or a restriction in data sharing. As such, these findings should be interpreted cautiously and monitored for sustained trends over time

CareVio Subpopulations Key Findings

Comprehensive Case Management

In 2025, there was a 26% increase in the number of members enrolled in the Comprehensive Management (CCM) program for >60 days, rising from 991 members

in 2024 to 1,251 members in 2025. This increase reflects both the ongoing expansion of CareVio's managed population and the sustained impact of CareVio's new care management platform enabling expanded data driven strategies that identified high-risk, complex patients who would benefit from case management services.

Members enrolled in CCM in 2025 remained predominantly female (59%), consistent with 2024, and were primarily ≥65 years of age, representing the majority of the population. The payer mix continued to be concentrated within Medicare and Medicare Advantage populations, with Medicare showing the largest increase in volume (561 members in 2025 vs. 470 in 2024), followed by notable growth in Medicare Advantage enrollment (408 in 2025 vs. 239 in 2024). Medicaid participation increased slightly, while Commercial enrollment decreased slightly. Geographically, members continued to concentrate in New Castle County, with zip code 19720 remaining the most represented, consistent with prior year patterns

Demographic distributions shifted due to an increase in the number of "Unknown" related to race and ethnicity shifted. The racial composition continued to be primarily White (~52%), followed by "Unknown" (38%), and Black/African American (~6%), Similarly, most members were identified as non-Hispanic (76%) followed by "Unknown" (20%), and Hispanic/Latino (3%).

A total of 13.7% of program participants had SDOH needs identified representing a decrease from 28.9% in 2024. The most frequently reported SDOH categories were "Financial Insecurity" (6.9%) and "Food Insecurity" (6.7%), similar to the entire CareVio population. Despite the observed decrease in identification rates, the continued presence of these needs remains clinically significant, as noted by Jia, Fung, Meigs, et al (2021) "food insecurity was associated with higher rates of hospitalization and mental health service use," and more broadly, "social determinants have a major impact on health, well-being, and quality of life."[25]

Consistent with prior years, "Ambulatory Issues/Mobility Impairment" remained the most frequently reported disability category across all payers. Given that the CCM population continues to be largely composed of older adults, this finding remains expected and aligned with the clinical profile of an aging population. It is also consistent with the literature where Freiberger, Sieber & Kob (2020) acknowledged that "mobility limitations are increasingly prevalent in older adults . . . and are associated with increased risk of hospitalization, disability, and mortality."[17]

The most frequently reported SPMI conditions in 2025 continued to be "Anxiety" Disorders" and "Mood Disorders," mirroring trends observed in 2024. While the relative distribution shifted slightly, both categories remained the most prevalent behavioral health conditions within the CCM population. Substance use–related disorders continued to represent a smaller proportion of identified SPMI conditions and remained stable or slightly decreased compared to the prior year. These findings align with global and national data indicating that "the most common mental

health conditions for older adults are depression and anxiety," and that these conditions continue to contribute substantially to disability burden in aging populations.[48]

In summary, the continued growth of the CCM program in 2025 reflects both sustained demand and the effectiveness of enhanced identification strategies care model implemented. The population remains clinically complex, with a high proportion of older adults and persistent behavioral health needs. While overall SDOH identification rates declined compared to 2024, the continued presence of financial and other social barriers reinforces the importance of ongoing screening and intervention. Collectively, these findings support the continued value of a comprehensive, patient-centered, integrated case management approach that addresses medical, functional, behavioral, and social determinants to optimize outcomes for high-risk populations,

High Risk Pregnancy

In 2025, enrollment in the High-Risk Pregnancy program for >60 days decreased from 209 members to 122 members in 2025, representing a notable decline following the substantial growth observed in the prior year. While the 2024 increase was driven in part by expanded identification following acute care utilization, the 2025 decrease may be due to the decrease in the total Medicaid population from 32% in 2024 to 26% in 2025. Despite the decline in overall volume, the program continues to prioritize members with complex clinical and psychosocial needs, consistent with evidence that "High-risk pregnancies involve acute and chronic medical conditions, and establishment of a comprehensive prenatal care model is essential to improve outcomes."[45]

Members enrolled in the high-risk pregnancy program in 2025 remained primarily within the age category of 30–39 (47%), consistent with 2024, followed by those aged 24–29 (30%). Younger members aged 20–23 accounted for 12%, while adolescents (2–19) represented approximately 2% of the population, reflecting a two-fold decrease compared to 2024. Older members aged 40-49 increased from 6.7% in 2024 to 9% in 2025. These findings align with national trends indicating that pregnancy in older individuals is associated with increased risks of adverse pregnancy outcomes for both the pregnant patient and the fetus.[4]

The racial and ethnic distribution shifted notably in 2025 compared to 2024. In 2025, the majority of members were categorized as Unknown race (80%), a marked increase from 13.9% in 2024. Correspondingly, the proportion of Black/African American members decreased from 48.8% in 2024 to 3% in 2025 and White members decreased from 26.3% to 16%. Ethnicity data shows a similar shift. In 2025, 53% of members were identified as Not Hispanic/Latino, down from 71.29% in 2024, while the proportion categorized as Unknown increased from 15.31% to 40%. The percentage of Hispanic /Latino members decreased from 13.40% in 2024 to 7% in

2025. These changes likely reflect differences in data capture rather than meaningful demographic shifts, as disparities in maternal health outcomes by race remain well established.[11]

Consistent with 2024, the majority of participants in 2025 were enrolled in Medicaid (94 members), followed by Commercial (27 members), with minimal Medicare representation. This distribution continues to reflect the disproportionate burden of high-risk pregnancy among Medicaid populations, as Medicaid finances 41% of births nationally and is the largest single payer of pregnancy-related services in the United States.[27]

In 2025, 21.3% of program participants had a documented SDOH need, representing a decrease from 29.2% in 2024, but remaining substantially higher than pre-2024 levels. Similar to the prior year, the most frequently reported SDOH categories were “Food Insecurity” (13.9%), and “Financial Insecurity” (12.3%) followed by transportation insecurity (5.7%) and housing instability (5.7%). Compared to 2024, rates food insecurity increased. “Food insecurity in pregnancy was associated with a higher risk of gestational diabetes, preeclampsia, preterm birth, and neonatal intensive care admission,” as noted by Chehab, Croen, Laraia, et al (2025).[14]

Disability prevalence in the high-risk pregnancy population remained low in 2025. The only reported condition was “Visual Impairment,” limited to two Medicaid members. This represents a shift from 2024, when a broader distribution of disabilities was observed, though overall prevalence remained low across both years.

In 2025, a total of nine SPMI conditions were identified, consistent with the low number of five observed in 2024. Similar to 2024, “Mood Disorder” and “Anxiety” were the most frequently reported conditions. Despite relatively small numbers, behavioral health conditions in pregnancy remain clinically important. The American College of Obstetricians and Gynecologist further note, as “perinatal mood and anxiety disorders are among the most common complications of pregnancy that occur in pregnancy or in the first 12 months after delivery. Despite the negative effects on maternal, obstetric, birth, offspring, partner, and family outcomes, perinatal mental health disorders often remain underdiagnosed, and untreated or under-treated.”[3]

In summary, while enrollment in the High-Risk Pregnancy program decreased in 2025 following significant growth in 2024, the population continues to reflect a clinically complex, predominantly Medicaid-supported patient cohort with persistent social and behavioral health needs. Although SDOH identification rates declined, financial and food insecurity remain key barriers to optimal maternal health outcomes. Demographic data limitations in 2025 highlight an opportunity for improved data capture and documentation. Overall, these findings reinforce the importance of targeted, multidisciplinary care management approaches that

address both clinical and social risk factors to improve outcomes in these high-risk populations.

CareVio Subpopulation Programs Summary

In 2025, CareVio's subpopulation programs demonstrated divergent enrollment trends but continued to reflect the delivery of targeted, high-impact care to clinically complex populations. The Comprehensive Case Management (CCM) program experienced continued growth, increasing from 991 members in 2024 to 1,251 in 2025, driven by enhanced data-driven identification strategies and a mature care management platform. In contrast, the High-Risk Pregnancy program declined from 209 to 122 members, likely reflecting a reduction in the overall Medicaid population and stabilization following significant expansion in the prior year. Despite these differing trajectories, both programs maintained a focus on identifying and managing high-risk individuals with complex clinical and social needs, consistent with evidence that risk stratification enables health systems to identify patients requiring intensive care coordination and focus resources on those with the greatest need and impact on outcomes.[15]

Across both populations, member characteristics aligned with expected risk profiles. CCM participants were primarily older adults (≥65 years) with a concentration in Medicare and Medicare Advantage, while the High-Risk Pregnancy population remained largely Medicaid-based and concentrated among members aged 30–39. Social determinants of health (SDOH) needs were prevalent in both programs, though identification rates declined year over year (CCM: 13.7% vs. 28.9%; High-Risk Pregnancy: 21.3% vs. 29.2%). Financial and food insecurity remained the most commonly reported barriers across both cohorts.

Both programs also demonstrated consistent patterns in clinical complexity. In CCM, mobility impairment remained the most frequently reported disability, reflecting the aging population, while anxiety and mood disorders continued to represent the most prevalent behavioral health conditions. Similarly, although less frequent in volume, behavioral health conditions in the High-Risk Pregnancy population persisted across both years. This is consistent with national clinical guidance indicating that "perinatal mood and anxiety disorders are among the most common complications that occur in pregnancy or in the first 12 months after delivery,"[3] underscoring the importance of routine screening and early intervention within maternal care programs.

Key opportunities identified in 2025 include improved documentation of demographic data in the High-Risk Pregnancy program, particularly related to race and ethnicity, as well as continued refinement of SDOH screening and documentation processes across both populations.

In summary, while program volumes varied, both CCM and High-Risk Pregnancy programs continue to demonstrate the value of a comprehensive, integrated care management approach. These findings highlight the importance of leveraging data-driven identification strategies and multidisciplinary interventions to address the medical, behavioral, and social needs of high-risk populations, ultimately supporting improved health outcomes and more effective resource utilization.

Opportunities for Improvement/Action Plan

Summary of Findings for 2024 Population Health Assessment and Corresponding Action Plans Undertaken in 2025

As part of the improvement plan proposed in the CareVio 2024 Population Health Assessment, several interventions were implemented.

Decrease Utilization for Severe Episodic Upper Respiratory Infections

Findings from the 2024 Population Health Assessment, highlighted Respiratory illnesses as a significant driver of healthcare utilization across multiple populations. Within the Commercial population, acute upper respiratory infections represented the most frequently reported claim type, (excluding preventive services) while respiratory conditions ranked among the leading causes of utilization in the Medicaid population.

In response, CareVio advanced several key strategies in 2025 to better manage respiratory conditions and reduce unnecessary acute care utilization. In partnership with ChristianaCare, the Cough and Cold Line was further integrated into operations and transitioned from a seasonal initiative to a permanent resource. This service provides timely, evidence-based guidance for adults experiencing symptoms related to common respiratory illnesses, including cold, flu, and COVID-19. By promoting self-management when appropriate and directing patients to the most suitable level of care, the program has strengthened access to real-time clinical support while helping to reduce avoidable in-person visits

Additionally, CareVio launched and operationalized a broader initiative in early 2025 focused on reducing emergency department utilization for ambulatory care sensitive conditions, including respiratory illness. This effort emphasizes proactive outreach, early engagement, and enhanced care coordination to connect patients with appropriate alternatives before escalation to the emergency department occurs.

pathways to care. CareVio continues to play a central role in this approach by facilitating education, supporting timely intervention, and guiding patients toward lower-acuity care settings when clinically appropriate.

Collectively, these initiatives demonstrate CareVio's continued commitment to addressing respiratory health needs through proactive population management, improved access to care, and more effective utilization of healthcare resources. Ongoing evaluation of these efforts will inform continued refinement and support sustained improvements in care delivery and utilization outcomes.

Reduce Language Disparities Among Members with SDOH

The 2024 population assessment identified meaningful shifts in the language distribution among individuals identified with social determinants of health (SDOH) needs. Notably, the number of members who spoke English as their primary language decreased from 97% in 2023 to 89% in 2024, reflecting a growing segment of individuals who speak other languages or have an unknown language preference. This shift highlighted increasing language diversity within the CareVio population and reinforced the need for enhanced language accessibility.

In response, CareVio implemented targeted strategies in 2025 to strengthen language access and reduce communication barriers. Efforts included expanding the availability of translated educational and resource materials, with a primary focus on Spanish as the most commonly spoken non-English language in the service area. These enhancements improved the clarity of health information, supported more effective communication between care teams and members, and facilitated improved navigation of healthcare and community-based services for individuals with limited English proficiency.

These actions reflect CareVio's ongoing commitment to delivering culturally and linguistically appropriate services and to reducing disparities associated with SDOH. Continued focus in this area remains a key component of promoting equitable access and optimizing health outcomes across the populations served

Preventing Falls due to Mobility Impairment

In 2025, CareVio continued and expanded upon the mobility-related interventions identified in the 2024 population assessment, reinforcing its focus on fall prevention and functional stability across the population. Mobility impairment remained one of the most prevalent disability categories, with 4,751 members identified with mobility-related limitations in 2025, compared to 5,882 claims reported in 2024, although a decrease, it remains a sustained and high-impact area of need. As in the prior year, the burden continued to be most prominent within the Medicare (2,511) and Medicare Advantage (1,156) populations, reflecting the increased vulnerability associated with aging and chronic conditions. In response, CareVio maintained its

enhanced referral pathways to the Safe Steps program and continued staff education efforts initiated in 2024, ensuring that mobility limitations remain a central component of care planning and interdisciplinary collaboration.

Building on these foundational efforts, CareVio further strengthened its standardized approach to fall risk identification in 2025 through the implementation of the CDC's Stopping Elderly Accidents, Deaths, and Injuries (STEADI) initiative. The STEADI assessment is now routinely administered to members with a history of falls or expressed fear of falling, enabling earlier identification of modifiable risk factors and more targeted intervention planning. This aligns with evidence demonstrating that structured fall risk screening combined with multifactorial interventions can significantly reduce fall incidence among older adults in both community and clinical settings.[10]

Additionally, mobility considerations continued to be prioritized within CareVio's health care management platform, allowing for more consistent documentation, risk stratification, and referral tracking. Compared to 2024, the 2025 data reflect a more structured capture of mobility-related needs, reflecting a more proactive, prevention-focused model of care, rather than reactive management following fall-related events.

Overall, CareVio's 2025 approach demonstrates a deliberate progression from targeted interventions to a more standardized and scalable model for mobility and fall risk management. Continued emphasis on early identification, evidence-based assessment tools, and streamlined referral processes positions the program to further reduce fall risk, improve functional outcomes, and support aging in place for high-risk populations.

Continued Focus on Behavioral Health and Substance Use Disorders

Behavioral health conditions continued to represent a significant portion of the population in 2025, with anxiety-related disorders (3.57%) and mood (affective) disorders (2.60%) remaining the most prevalent SPMI categories. The proportion of members identified with SPMI increased to 6.87% in 2025, compared to 5.7% in 2024, reflecting both growing complexity and improved identification of behavioral health needs. These findings are consistent with broader national trends, which show that mental health and substance use disorders remain highly prevalent and frequently co-occurring, while access to treatment continues to be limited for many individuals.[2]

Substance use disorders continue to be a significant contributor to overall behavioral health burden. In 2025, opioid use accounted for 23% of substance use cases within the Commercial population and 30% of cases in the Medicaid population. These trends align with national data demonstrating that substance use disorders, particular opioid disorders, remain a major and evolving public health challenge.[30]

In response to these needs, CareVio continued to advance its integrated behavioral health model in 2025. Referrals to behavioral health services remain embedded within care management workflows and are supported by a licensed clinical social worker and Certified Advanced Alcohol and Drug Counselor. This model aligns with evidence demonstrating that integration of behavioral health into care delivery improves access, enhances care coordination, and leads to better patient outcomes and patient experience. Recent studies further demonstrate that integrated care models can reduce healthcare utilization and improve clinical outcomes,[2]

Building on planned improvements identified in 2024, CareVio also expanded staff development efforts through targeted behavioral health education. In 2025, the Behavioral Health Specialist led structured in-service trainings for care management staff covering topics including *Stigma of Addictions and Mental Illness*, codependency, hoarding, cognitive distortions, defense mechanisms, and burnout and self-care. These initiatives are supported by a growing body of evidence indicating that stigma remains a major barrier to engagement in behavioral health treatment and that targeted training can improve knowledge, attitudes, and provider readiness to address mental illness and substance use disorders. Reducing stigma is particularly critical, as it is consistently identified as a key factor limiting access to timely diagnosis, treatment, and recovery support.[50]

CareVio continues to collaborate closely with payer partners to ensure members are connected to appropriate behavioral health programs. Routine case review discussions support accurate program alignment and enhance coordination across care settings. This collaborative approach reflects best practices in integrated care, where multidisciplinary coordination improves both access and outcomes while supporting more efficient use of healthcare resources.

Collectively, these enhancements demonstrate meaningful progress on previously identified opportunities. Through strengthened integration, targeted staff education, and continued collaboration with payer partners, CareVio continues to advance its ability to address the complex and evolving behavioral health and substance use needs of the population while reinforcing a holistic, person-centered approach to care.

Summary of Findings for 2025 Population Health Assessment and Corresponding Action Plans

The 2025 CareVio Population Assessment identified a continued high burden of chronic physical health conditions across the population, most notably hypertensive disease, and metabolic disorders, as well as symptoms related to circulatory and respiratory systems. Acute upper respiratory infections also remain among the most frequently identified conditions. In addition, the assessment highlights the presence of SDOH needs, particularly financial insecurity, food insecurity, and housing

instability, along with a measurable prevalence of disabilities, most commonly mobility impairment and Serious & Persistent Mental Illness (SPMI), including anxiety and mood disorders. Limitations in the completeness of demographic data, including race, ethnicity and primary language, were also identified, constraining the ability to fully assess disparities across the population.

In response to the high prevalence of hypertensive disease and metabolic disorders, CareVio will strengthen longitudinal care management through continued advancement of the One CareVio model, integrating transitional and chronic care management to support continuity across settings. This approach will be reinforced by early identification and engagement through the Admit Team and embedded case managers within primary care practices. The Admit Team is a dedicated care coordination function that engages members at the bedside during an inpatient admission to support early assessment, initiate discharge planning, and facilitate connection to appropriate post-acute and longitudinal care management services. Embedded case managers in primary care settings further support continuity by coordinating care, reinforcing care plans, and maintaining engagement in the ambulatory setting. Collectively, these interventions are designed to improve chronic disease management and reduce fragmentation across the care continuum

To address the continued prevalence of respiratory conditions, including acute upper respiratory infections, CareVio will expand the use of targeted strategies, including Cough & Cold hotline, to support appropriate site-of-care decision making and provide accessible clinical guidance. This intervention is intended to promote timely management of low-acuity conditions while reducing unnecessary emergency department utilization.

In response to identified SDOH needs, CareVio will enhance multidisciplinary interventions through the integration of social workers within the Emergency Department, inpatient settings, and the Admit Team. These resources will support early identification of social barriers during acute episodes of care, facilitate connection to community-based services, and ensure that social needs are addressed concurrently with clinical care.

To address the prevalence of SPMI, including anxiety and mood disorders, CareVio will strengthen behavioral health integration by leveraging care management social workers to support comprehensive assessment, care planning, and ongoing engagement of members with behavioral health needs. This approach will enhance coordination between medical and behavioral health services and support improved member stability and outcomes.

Given the prevalence of mobility impairment and other disabilities within the population, CareVio will continue to implement targeted interventions focused on functional assessment and fall prevention within care management workflows. These efforts will be supported through interdisciplinary coordination and referral to

appropriate clinical and community-based resources to promote safety and independence.

Finally, in response to ongoing limitations in demographic data completeness, CareVio will continue to support efforts to improve data capture and integration processes to enhance the accuracy of race, ethnicity, and language data. However, these limitations are largely driven by system-level constraints and data availability across platforms and therefore require broader organizational and technological solutions. While CareVio will reinforce consistent documentation practices within care management workflows, meaningful improvement is expected to be dependent on the planned transition to the case management platform within EPIC which is anticipated to enhance data standardization, interoperability, and accessibility across care settings. As a result, significant improvements in data completeness and reliability will likely not be fully realized until after EPIC implementation and stabilization, with expected impact beginning in 2027

Collectively, these action plans reflect a targeted, population-informed approach that aligns identified health needs with specific, programmatic interventions. Through continued integration of care management services, enhanced multidisciplinary collaboration, and improved data capture, CareVio aims to strengthen care delivery, address key population health needs, and improve outcomes in 2026.

Conclusion

The 2025 CareVio Population Assessment underscores the continued complexity of the population served, characterized by a high prevalence of chronic physical health conditions, persistent behavioral health needs, and the ongoing impact of SDOH barriers. Hypertensive disease, metabolic disorders, and respiratory conditions remain among the most common drivers of healthcare need, while the presence of mobility impairment and serious and persistent mental illness (SPMI) further reflects the multidimensional challenges faced by members. Concurrently, limitations in demographic data completeness continue to constrain CareVio's ability to fully assess and target interventions with precision.

In response, CareVio's 2026 strategy is intentionally aligned to these identified needs, emphasizing an integrated and proactive approach to the delivery of care. Through the advancement of the One CareVio model, alongside early engagement strategies such as the Admit Team and embedded case managers within primary care settings, CareVio is strengthening continuity across the care continuum and reinforcing connections between acute and ambulatory care. Targeted interventions, including

the Cough and Cold line for respiratory conditions and expanded social work integration across emergency, inpatient, and care coordination teams, will support more appropriate utilization and improved management of both clinical and social needs.

These efforts reflect a broader recognition that improving outcomes requires not only condition-specific interventions, but also cohesive, interdisciplinary care models that address the full spectrum of medical, behavioral, and social factors influencing health. As noted in a 2023 review of integrated care models, "service delivery, person-centeredness, and integration across health systems are core elements required to improve quality of care and outcomes in population health initiatives."[35]

This approach is particularly important in the context of chronic disease management, where evidence demonstrates that "interventions with multiple components, including case management, self-management, and multidisciplinary teams, are more likely to improve health outcomes and health care utilization. "Overall, the 2025 Population Assessment highlights both the complexity of the population served and the deliberate targeted strategies being implemented to address identified needs. Through sustained focus on coordination, accessibility, and data informed decisions, CareVio will continue to strengthen its ability to meet the evolving needs of the population it serves.

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Appendix A

Disabilities: ICD-10 codes utilized for obtaining disabilities via claims data

Disability Category	Code
Intellectual Disabilities	F70: Mild intellectual disabilities F71: Moderate intellectual disabilities F72: Severe intellectual disabilities F73: Profound intellectual disabilities F78: Other intellectual disabilities F79: Unspecified intellectual disabilities
Pervasive and Specific Developmental Disorders	F80: Specific developmental disorders of speech and language F82: Specific developmental disorders of scholastic skills F84: Pervasive developmental disorders F88: Other disorders of psychological development F89: Unspecified disorder of psychological development
Hearing Impairment	H90: Conductive and Sensorineural hearing loss H91: Other and unspecified hearing loss
Visual Impairment	H53: Visual disturbances H54: Blindness and low vision
Mobility Impairment	R26-R26.9: Abnormalities of gait and mobility Z74.09: Other reduced mobility
Speech Impairment	R47: Speech disturbances, not elsewhere classified

Severe and Persistent Mental Illness (SPMI): ICD-10 codes utilized for SPMI via claims data

SPMI Category	Code
Mental disorders due to known physiological conditions	F01: Vascular dementia F02: Dementia in other disease classified elsewhere F03: Unspecified dementia F04: Amnestic disorder due to known physiological condition F05: Delirium due to known physiological condition F06: Other mental disorders due to known physiological condition F07: Personality and behavioral disorders due to known physiological condition F09: Unspecified mental disorder due to known physiological condition

Mental and behavioral disorders due to psychoactive substance use	F10: Alcohol related disorders F11: Opioid related disorders F12: Cannabis related disorders F13: Sedative, hypnotic, or anxiolytic related disorders F14: Cocaine related disorders F15: Other stimulant related disorders F16: Hallucinogen related disorders F17: Nicotine dependance F18: Inhalant related disorders F19: Other psychoactive substance related disorders
Schizophrenia, Schizotypal, delusional, and other non-mood psychotic disorders	F20: Schizophrenia F21: Schizotypal disorder F22: Delusional disorder F23: Brief psychotic disorder F24: Shared psychotic disorder F25: Schizoaffective disorder F28: Other psychotic disorder not due to a substance or known physiological condition F29: Unspecified psychosis not due to a substance or known physiological condition
Mood (affective) disorders	F30: Manic episode F31: Bipolar disorder F32: Depressive episode F33: Major depressive disorder, recurrent F34: Persistent mood [affective] disorder F35: Unspecific mood [affective] disorder
Anxiety, dissociative, stress-related, somatoform and other non-psychotic disorders	F40: Phobic anxiety disorders F41: Other anxiety disorders F42: Obsessive-compulsive disorder F43: Reaction to severe stress, and adjustment disorder F44: Dissociative and conversion disorders F45: Somatoform disorders F48: Other non-psychotic mental disorders
Behavioral syndromes associated with physiological disturbances and physical factors	F50: Eating disorders F51: Sleep disorders not due to a substance or known physiological condition F52: Sexual dysfunction not due to a substance or known physiological condition F53: Mental behavioral disorders associated with disorders or disease classified elsewhere F55: Abuse of non-psychoactive substances

	F59: Unspecified behavioral syndromes associated with physiological disturbances and physical factors
Disorders of adult personality and behavior	F60: Specific personality disorders F63: Impulse disorders F64: Gender identity disorders F65: Paraphilias F66: Other sexual disorders F68: Other disorders of adult personality and behavior F69: Unspecified disorder of adult personality and behavior
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	F90: Attention-deficit hyperactivity disorders F91: Conduct disorders F93: Emotional disorders with onset specific to childhood F94: Disorders of social functioning with onset specific to childhood and adolescence F95: Tic disorder F98: Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence
Unspecified mental disorder	F99: Mental disorder, not otherwise specified

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