



CY 2025 Population Health Report

Barry

Southwest Michigan Behavioral Health

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1. Introduction

Southwest Michigan Behavioral Health (SWMBH) developed this Population Health Analysis to examine the health characteristics and healthcare utilization of Medicaid enrollees in Barry County. The report primarily evaluates calendar year 2025 data while incorporating trend and historical analyses from 2022 through 2025 where appropriate. Areas of focus include demographic characteristics, behavioral and chronic health conditions, multimorbidity, healthcare utilization, prescribing patterns, and healthcare quality measures.

Medicaid populations may experience complex physical, behavioral, and social health needs that influence healthcare utilization and outcomes. By examining diagnoses, utilization, and quality measures together, this report provides a broader view of population health and helps identify patterns and populations that may warrant additional attention, planning, or quality improvement efforts.

Data sources include Medicaid enrollment and encounter records for medical, behavioral health, and pharmacy services for residents of Barry County, made available to SWMBH by the State of Michigan. The Behavioral Health Treatment Episode Data Set (BH-TEDS) was also used to supplement living arrangement information for individuals receiving PIHP- or CMH-funded services.

Behavioral health and chronic physical health conditions were organized into broader diagnosis groups to examine disease prevalence, multimorbidity, and associations with healthcare utilization. Utilization analyses include inpatient hospitalizations and emergency department visits, while quality and prescribing analyses examine preventive care measures and medication use. Results are stratified by demographic characteristics, including age, sex, race and ethnicity, and Medicare-Medicaid dual eligibility, to identify populations with elevated health needs and potential disparities.

Relias's Population Performance platform was used to support analyses of healthcare quality measures and prescription patterns.

2. Key Findings

The following highlights summarize key findings from the 2025 Barry County Population Health Analysis. They are intended to provide a high-level overview of the most important local population health patterns, differences from the broader SWMBH region, and areas that may warrant continued monitoring or further review.

- **The Barry County Medicaid population became smaller in 2025 while indicators of healthcare need increased.** Medicaid enrollment declined from 15,626 in 2024 to 13,333 in 2025, while the percentage receiving at least one Medicaid service increased from 78.6% to 83.0%. Behavioral health and chronic condition prevalence also increased in 2025. These patterns may reflect a smaller Medicaid population with greater and more complex healthcare needs.
- **Barry County had higher documented behavioral health needs than the remainder of the SWMBH region.** Overall, 37.0% of Barry County Medicaid enrollees had a behavioral health diagnosis compared with 32.5% in the rest of the region. Anxiety, depressive disorders, ADHD, and dementia were significantly higher in Barry, while SUD, schizophrenia/psychosis, and IDD were significantly lower. Mild/Moderate MI accounted for much of the increase in behavioral health prevalence observed in 2025.
- **Barry County also had a higher overall chronic condition burden, with tobacco use standing out as a local difference.** The presence of any chronic condition was documented for 42.7% of Barry County enrollees compared with 37.8% in the rest of the region. Tobacco use showed the largest county difference at 11.8% versus 6.9%, while chronic pain/migraine, GI functional disorders, asthma, and documented Social Determinants of Health concerns were also significantly higher.
- **Behavioral and physical health needs frequently overlap.** Adults and children with behavioral health diagnoses had substantially higher chronic condition prevalence than those without a behavioral health diagnosis. Dual-eligible adults also showed greater chronic disease burden and were more concentrated among those with multiple co-occurring chronic conditions. These findings highlight populations with combined behavioral and medical complexity rather than isolated health needs.
- **A relatively small portion of the population experienced disproportionately high acute-care utilization.** The Complex Behavioral Health and High Chronic Complexity multimorbidity groups together represented 11% of the ever-diagnosed population but had the highest emergency department and inpatient utilization rates. Complex Behavioral Health had the highest ED utilization, while both groups had particularly high inpatient utilization.
- **SMI/SED and SUD were consistently associated with elevated acute-care utilization.** Individuals with SUD had the highest average medical ED utilization in 2025, while SMI/SED had the highest average medical inpatient utilization and the most consistently elevated behavioral health inpatient use. These differences remained evident within many age groups, suggesting that age alone does not explain the higher utilization observed among these populations.

- **Social needs were strongly associated with hospitalization risk.** After accounting for the other chronic conditions included in the model, documented Social Determinants of Health concerns were associated with more than three times the odds of inpatient hospitalization. This finding suggests that documented social and economic needs may be an important marker of individuals at elevated risk for acute-care use.
- **Pharmacy quality indicators identified small populations with substantially greater hospitalization risk.** Adults triggering at least one pharmacy quality indicator had nearly four times the overall hospitalization risk of adults triggering none, while children and adolescents had nearly six times the risk. Although these indicators do not establish that medication-related concerns caused hospitalization, they may help identify individuals with greater clinical complexity, medication-management challenges, or care-coordination needs.

3. Who is in the Study

The total Barry County Medicaid population in 2025 included 13,333 unique enrollees with full Medicaid or Health Michigan Plan benefits at some point during the one-year report period. Individuals enrolled with unmet spenddown or with coverage limited to maternal services or emergency services only were excluded. Individuals were included regardless of the number of months they were enrolled during the year.

Each enrollee was assigned to their most recent Medicaid County during 2025. As a result, county-level counts reflect an individual's latest county of enrollment rather than all counties in which they may have been enrolled during the year.

Of those enrolled, 83% had at least one Medicaid service during 2025, and 10.2% received at least one PIHP- or CMH-funded service. Enrollees were covered for an average of 9.1 months during the report period.

As shown in Table 1, total Medicaid enrollment declined from 15,626 in 2024 to 13,333 in 2025. At the same time, the percentage of enrollees receiving at least one Medicaid service increased from 78.6% to 83%. The percentage receiving PIHP/CMH-funded services also continued to increase, rising from 8% in 2022 to 10.2% in 2025. These patterns provide important context for interpreting changes in diagnosis prevalence and healthcare utilization later in the report.

Table 1: Enrollment and Service Utilization, 2022-2025 – Barry County			
Year	Total Enrollees	1+ Medicaid Service	1+ CMH/PIHP Service
2022	15,710	82.5%	8.0%
2023	16,896	81.8%	8.0%
2024	15,626	78.6%	9.4%
2025	13,333	83.0%	10.2%

Medicaid coverage varied across counties. Calhoun had the highest estimated Medicaid coverage rate at 35.8%, while Barry had the lowest at 20.8%. Berrien, Branch, Saint Joseph, and Van Buren each had coverage rates of approximately 30%. These differences provide additional context for interpreting county-level population health patterns throughout the report.

Unless otherwise specified, subsequent analyses in this report describe the Barry County Medicaid population defined above.

Table 2: County Population and Medicaid Coverage - CY 2025			
County	Medicaid Enrollees	Est. County Population	Medicaid Coverage Rate
Barry	13,333	63,991	20.8%
Berrien	46,972	152,444	30.8%
Branch	14,081	45,993	30.6%
Calhoun	47,743	133,408	35.8%
Cass	13,983	51,677	27.1%
Kalamazoo	68,218	263,795	25.9%
Saint Joseph	18,740	60,968	30.7%
Van Buren	23,356	76,071	30.7%

Estimated county population (total residents, not limited to Medicaid-eligible individuals) from U.S. Census Bureau County population estimates, CY 2025.

3.1. Distribution of Barry County Enrollees by Zip Code

The map below presents a heat map of the geographic distribution of the Barry County Medicaid cohort based on zip code of residence.

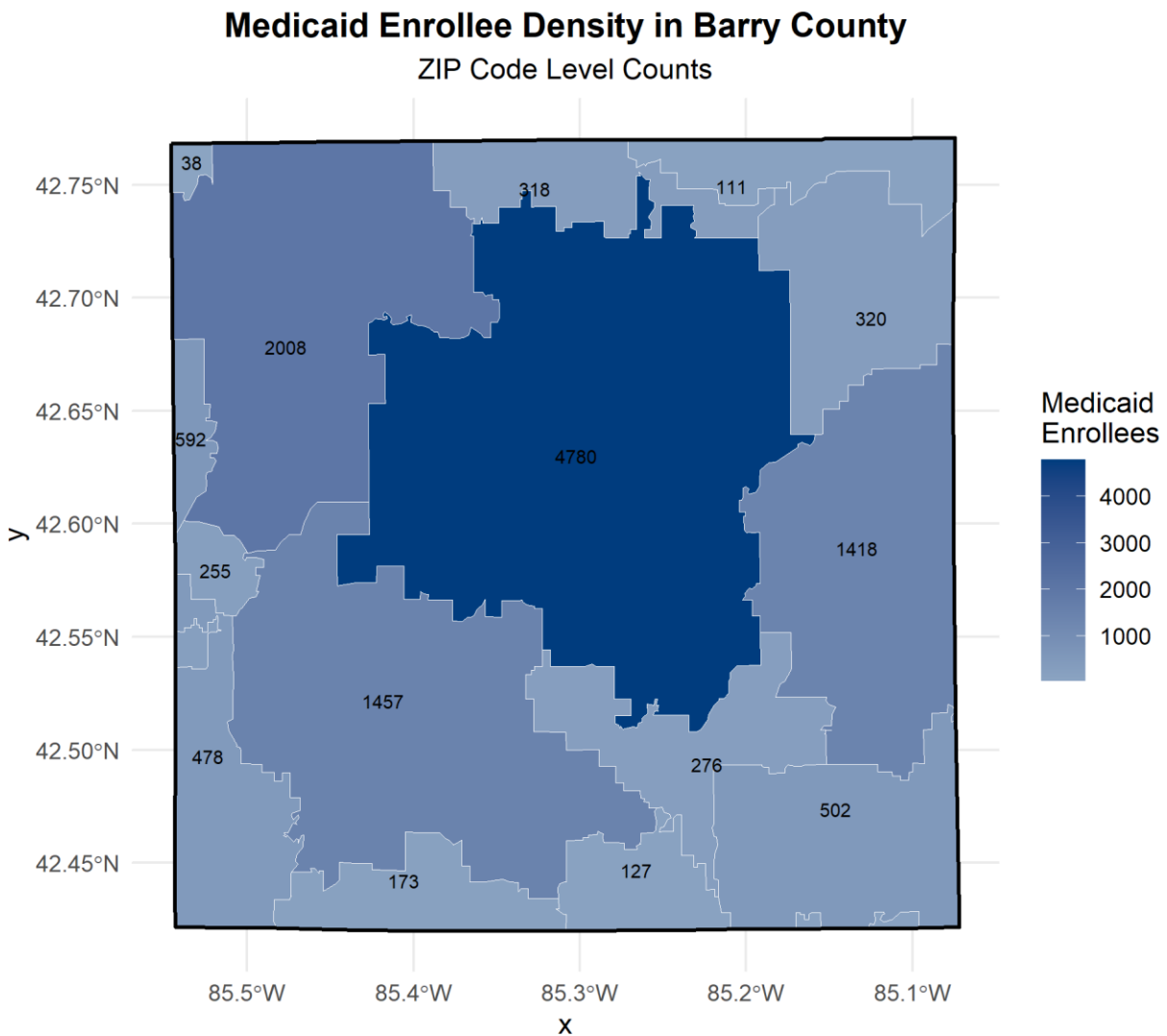


Figure 1: Count of CY 2025 Medicaid enrollees by zip code of address.

4. Population Characteristics

Understanding the demographic characteristics of the Medicaid population provides important context for interpreting the health conditions, healthcare utilization, and outcomes presented throughout the remainder of this report. This section summarizes the population by age, sex, race and ethnicity, living arrangement, and Medicare-Medicaid dual eligibility to provide a baseline description of the individuals included in the analysis.

4.1. Age and Sex

Age is strongly associated with patterns of disease burden and healthcare utilization, while both age and sex provide important context for understanding differences across the Medicaid population (Atella et al., 2019). Figure 2 shows the age distribution of Medicaid enrollees by sex, with percentages calculated within each sex to allow comparison of enrollment patterns across the lifespan. In Barry County, the average age at the end of 2025 was 28.6 years. Overall, 40.1% of enrollees were younger than 18 years, 53.2% were between 18 and 64 years, and 6.7% were 65 years or older. The population was 45.3% male and 54.7% female.

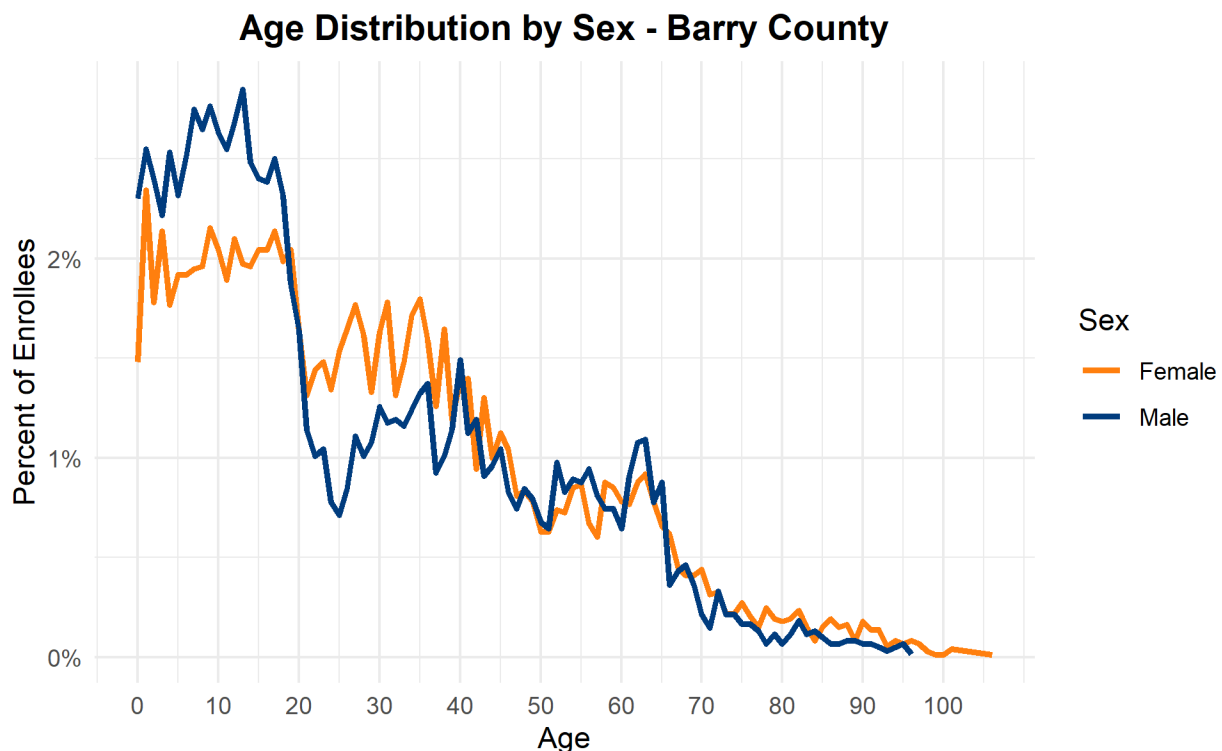


Figure 2: Percent of enrollees at each single year of age, by sex.

Male enrollees make up a larger share of the population at younger ages, while female enrollment becomes more prominent beginning in early adulthood, particularly through the 20s and 30s. After early adulthood, the age distributions for male and female enrollees become more similar. The higher representation of women during early adulthood may partly reflect Medicaid eligibility pathways related to pregnancy and parenting.

4.2. Race/Ethnicity

Race and ethnicity provide important context for identifying potential differences in health conditions, healthcare utilization, and quality of care across population groups. Throughout this report, race and ethnicity are used to examine whether meaningful disparities are present within the Barry County Medicaid population.

To align with MDHHS methodology for Core Set measures, race and ethnicity were assigned using the most recent Medicaid enrollment record available at the time of data extraction. Individuals identified as Hispanic ethnicity were classified in the Hispanic or Latino group regardless of reported race. For all other individuals, classification was based on the primary race field reported in Medicaid enrollment records.

Figure 3 summarizes the racial and ethnic composition of Medicaid enrollees in Barry County. Overall, 86% identified as White, 6.2% identified as Other Race, 4% identified as Hispanic or Latino, 2.4% identified as Black or African American, 1.1% identified as American Indian or Alaska Native, 0.2% identified as Asian, 0.1% identified as Native Hawaiian or Other Pacific Islander.

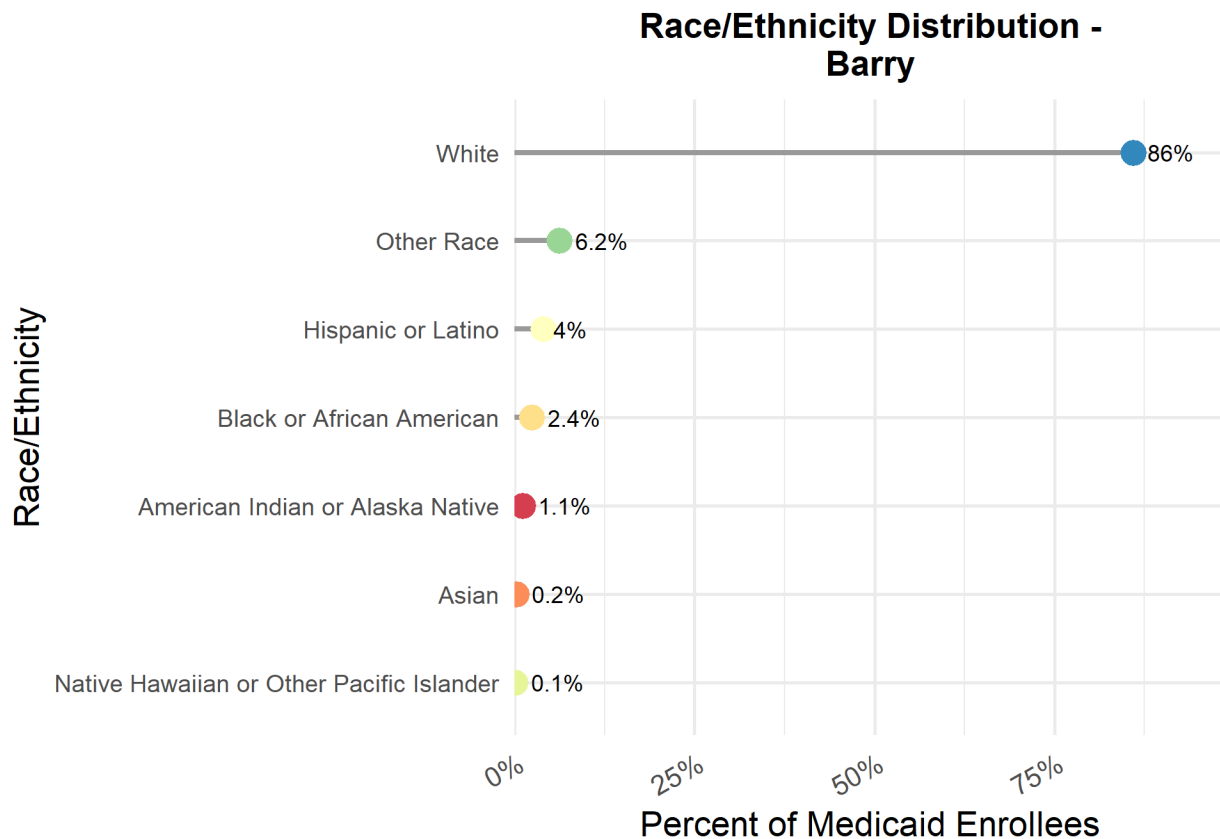


Figure 3: Percentage of Medicaid enrollees by race and ethnicity.

4.3. Living Arrangements for CMH/PIHP-Served Population

Living arrangement provides important context for understanding social support and housing stability among individuals receiving behavioral health services. Because living arrangement information is collected through the Behavioral Health Treatment Episode Data Set (BH-TEDS), this analysis is limited to Medicaid enrollees who received PIHP- or CMH-funded services and had a recorded living arrangement.

Living arrangements were grouped into four categories: dependent, independent, unhoused, and unknown. Individuals classified as “Other” were excluded from this analysis.

The following table compares the distribution of living arrangements in Barry County with the remainder of the SWMBH region. Living arrangements in Barry County differed from the rest of the SWMBH region. Among PIHP/CMH-served Medicaid enrollees with recorded living arrangement information, 91.6% were living independently compared with 81.7% in the rest of the region. Barry also had significantly lower percentages of individuals identified as dependent (5.6% vs. 11.5%) or unhoused (2.5% vs. 6.6%). These findings suggest that the PIHP/CMH-served population in Barry County was more likely to be living independently than comparable enrollees elsewhere in the region.

**Table 3. Living Arrangement –
Barry vs. Rest of Region**

Percent in each living arrangement category (2025)

Condition	Barry (N=1,744)	Rest of Region (N=31,903)
Dependent	5.6% ↓	11.5%
Independent	91.6% ↑	81.7%
Unhoused	2.5% ↓	6.6%
Unknown	0.3%	0.1%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

4.3.1. Living Arrangement Trends (2022-2025)

Monitoring living arrangements over time helps identify changes in housing stability among individuals receiving behavioral health services. The figure below displays annual trends in living arrangement categories from 2022 through 2025, allowing changes in the distribution of living arrangements to be compared across years. Exact annual percentages are presented in the table below the figure.

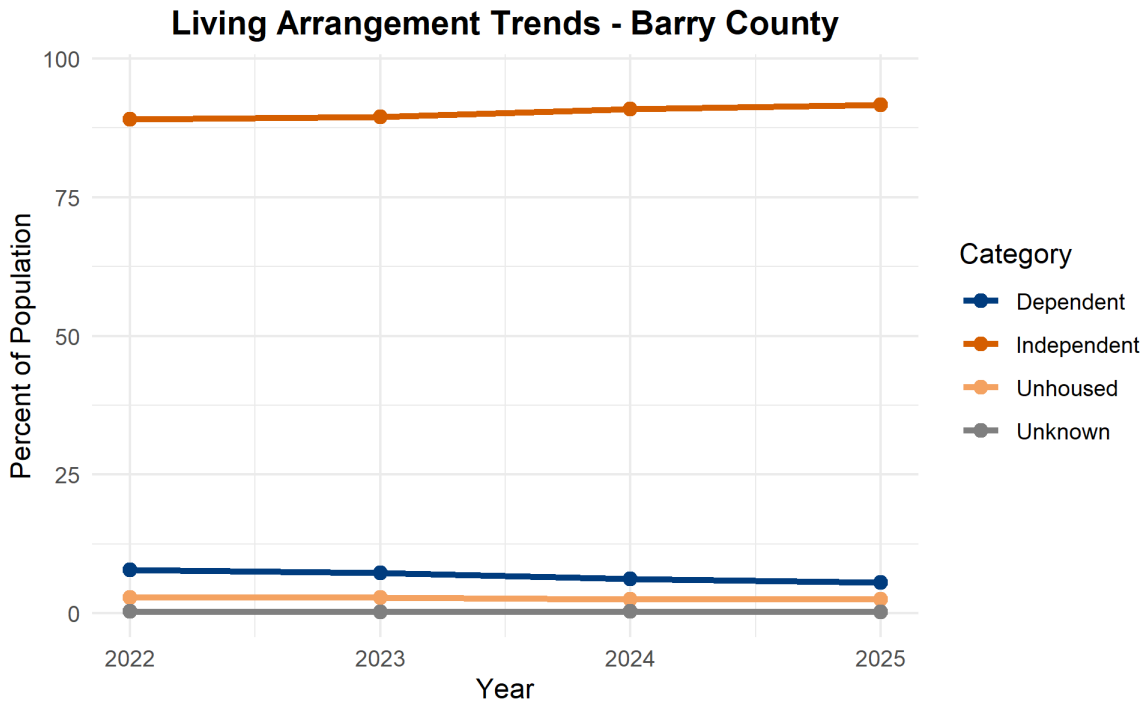


Figure 4: Percent of population in each living arrangement category, 2022-2025.

Table 4. Living Arrangement Trends

Percent of the population in each living arrangement category, 2022–2025.

Living Arrangement	2022	2023	2024	2025
Independent	89.0%	89.5%	90.9%	91.6%
Dependent	7.8%	7.3%	6.2%	5.6%
Unhoused	2.8%	2.9%	2.5%	2.5%
Unknown	0.4%	0.3%	0.4%	0.3%

Living arrangements in Barry County remained relatively stable from 2022 through 2025, with a gradual increase in the percentage of individuals living independently. Independent living increased from 89.0% in 2022 to 91.6% in 2025, while dependent living declined from 7.8% to 5.6%. The percentage identified as unhoused remained low and relatively stable, ranging from 2.5% to 2.9% over the four-year period. Overall, the trend suggests increasing independent living among the PIHP/CMH-served population in Barry County.

4.4. Medicaid-Medicare Dual Eligibility

Medicare-Medicaid dual eligibility identifies individuals enrolled in both Medicare and Medicaid. Dual-eligible populations often have greater medical complexity and healthcare needs, making dual eligibility an important consideration when interpreting differences in disease burden and healthcare utilization later in this report.

In 2025, 10.9% of the Barry County Medicaid population was also enrolled in Medicare in 2025. This report compares adults with Medicaid-only coverage to those who are dually enrolled in both Medicaid and Medicare. Dual enrollment increases sharply with age: 8.5% of adults aged 18 to 64 and 95.1% of those aged 65 and older were enrolled in both programs. No individuals younger than 18 in the study population were identified as Medicare-enrolled.

Table 5: Medicare Coverage by Age Group - Barry County			
Age Group	Total Enrollees	Enrolled in Medicare	Percent Medicare
<18	5,344	0	0.0%
18-64	7,095	606	8.5%
65+	894	850	95.1%
All Ages	13,333	1,456	10.9%

5. Behavioral Health

Behavioral health conditions are an important contributor to healthcare utilization, quality of care, and overall population health. Understanding the prevalence and distribution of behavioral health conditions helps identify populations with greater service needs, monitor changes over time, and support planning for behavioral health programs and resources.

This section summarizes the prevalence of behavioral health diagnoses among Medicaid enrollees, trends from 2022 through 2025, differences across demographic groups, and geographic variation within Barry County.

5.1. Primary Behavioral Health Group Definitions

To summarize the behavioral health population, individuals with a behavioral health diagnosis were assigned to a single primary behavioral health diagnosis group. Assignment was based on the behavioral health diagnosis category that appeared most frequently across an individual's Medicaid encounter history from 2022 through 2025. These groups provide a consistent way to compare healthcare utilization, chronic physical health conditions, and other outcomes throughout the remainder of this report.

Each enrollee was assigned to only one primary behavioral health diagnosis group, so the groups do not overlap. The primary behavioral health diagnosis groups used in this report are:

- **Intellectual/Developmental Disabilities (IDD):** Intellectual disabilities and pervasive developmental disorders such as autistic disorders are included.
- **Mild/Moderate Mental Illness:** This group is primarily comprised of anxiety disorders, ADHD, and mild to moderate forms of depressive and bipolar disorders.
- **Serious Mental Illness (SMI) / Serious Emotional Disturbance (SED):** This group is primarily comprised of schizophrenia and severe forms of depressive and bipolar disorders. SMI is the adult-focused term and SED is the child/adolescent-focused term for the same underlying diagnostic severity category.
- **Substance Use Disorders (SUD):** Includes addictive and substance use-related disorders including gambling disorders.
- **Other:** This group includes behavioral health conditions not included in the other groups, such as conditions with known physiological causes (e.g., dementia), specific learning disorders, communication disorders, and unspecified mental health conditions.

5.2. Prevalence of Behavioral Health (BH) Conditions

Figure 5 summarizes the proportion of Medicaid enrollees with and without a behavioral health diagnosis in 2025. Behavioral health diagnoses include mental health conditions, substance use disorders, and intellectual/developmental disabilities identified through Medicaid encounter data. Overall, 37% of the Barry County Medicaid population had a recorded behavioral health diagnosis in 2025. Among those with a behavioral health diagnosis, 63.6% had primarily Mild/Moderate MI diagnoses, 17.8% had primarily SMI/SED diagnoses, 10.2% had primarily Other diagnoses, 4.5% had primarily IDD diagnoses, 3.8% had primarily SUD diagnoses.

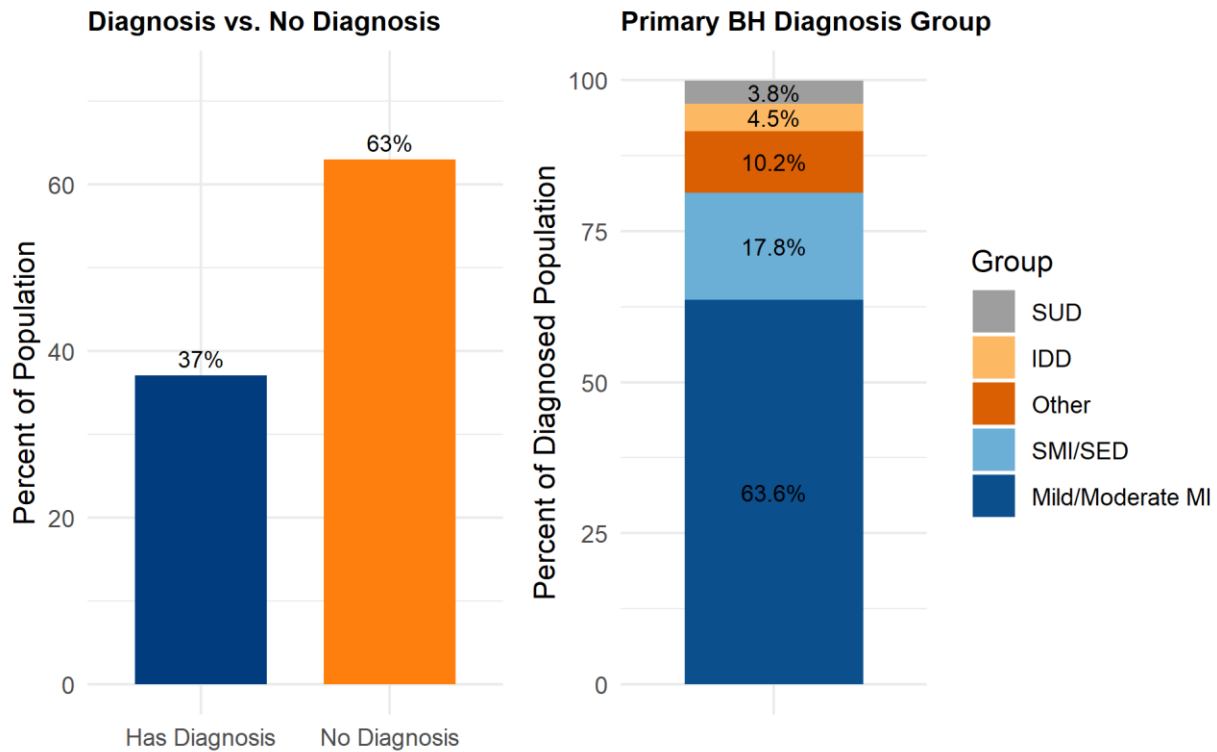


Figure 5: Left: percentage with and without a recorded BH diagnosis. Right: breakdown of primary BH diagnosis group among those with a diagnosis.

5.2.1. BH Condition Comorbidity by Primary Diagnosis Group

Behavioral health diagnoses often co-occur with one another. The following table summarizes the prevalence of individual behavioral health conditions within each primary behavioral health diagnosis group, illustrating how commonly additional diagnoses occur alongside the predominant diagnosis category.

Because each individual is assigned to only one primary behavioral health diagnosis group, the primary group reflects the diagnosis category most frequently represented in the individual's encounter history rather than the only behavioral health condition present. Several of the conditions shown are also used to define the primary diagnosis groups; therefore, this table is descriptive and was not statistically tested. Shading is used to highlight differences in diagnostic patterns across groups.

Table 6. BH Condition Comorbidity by Primary Diagnosis Group - SWMBH region

Percent with each condition, by primary BH diagnosis group among members with a BH diagnosis (2025)

Condition	IDD (N=4,364)	Mild/Moderate MI (N=47,995)	Other (N=8,248)	SMI/SED (N=14,378)	SUD (N=5,710)
Anxiety	18.7%	61.7%	10.0%	42.7%	27.3%
Depressive	8.3%	45.6%	9.3%	43.9%	23.8%
SUD	0.9%	6.7%	0.7%	19.7%	100.0%
Bipolar	4.2%	6.7%	1.1%	31.3%	10.9%
Schizophrenia/Psychosis	4.5%	2.8%	1.8%	28.5%	6.1%
Personality Disorder	1.7%	2.6%	0.3%	11.8%	2.8%
OCD	3.7%	1.8%	0.4%	2.9%	0.4%
Adjustment Disorder	5.5%	23.1%	4.6%	10.9%	7.3%
Dementia	1.1%	0.8%	19.6%	1.7%	0.3%
Impulse Control/Conduct	9.5%	3.9%	3.0%	11.3%	0.9%
Autism Spectrum	71.3%	2.4%	8.2%	3.2%	0.2%
IDD	43.5%	1.5%	1.8%	5.1%	0.2%
Trauma-Related (PTSD)	5.3%	11.9%	2.3%	36.2%	10.8%
ADHD	19.8%	26.3%	7.7%	15.2%	5.5%

Shading reflects diagnosis rate magnitude (lighter = lower, darker = higher). No statistical testing was performed for this table.

Distinct patterns of behavioral health comorbidity were evident across the primary diagnosis groups. Within the IDD group, autism spectrum disorder was particularly common (71.3%), while 43.5% had an IDD diagnosis and 19.8% had ADHD. The Mild/Moderate MI group showed considerable overlap with ADHD (26.3%), adjustment disorder (23.1%), and trauma-related disorders (11.9%). Among individuals in the SMI/SED group, trauma-related disorders were common (36.2%), along with ADHD (15.2%) and impulse control/conduct disorders (11.3%). The Other group was distinguished by a higher prevalence of dementia (19.6%), while the SUD group also showed overlap with trauma-related disorders (10.8%).

These patterns demonstrate that the primary behavioral health groups represent broader profiles rather than mutually exclusive diagnoses. Individuals assigned to one primary group may have multiple co-occurring behavioral health conditions that contribute to their overall needs.

5.2.2. Behavioral Health Diagnosis Trend (2022-2025)

Monitoring diagnosis rates over time helps identify changes in the behavioral health needs of the Medicaid population. Figure 6 displays annual trends in the percentage of Medicaid enrollees with at least one behavioral health diagnosis from 2022 through 2025.

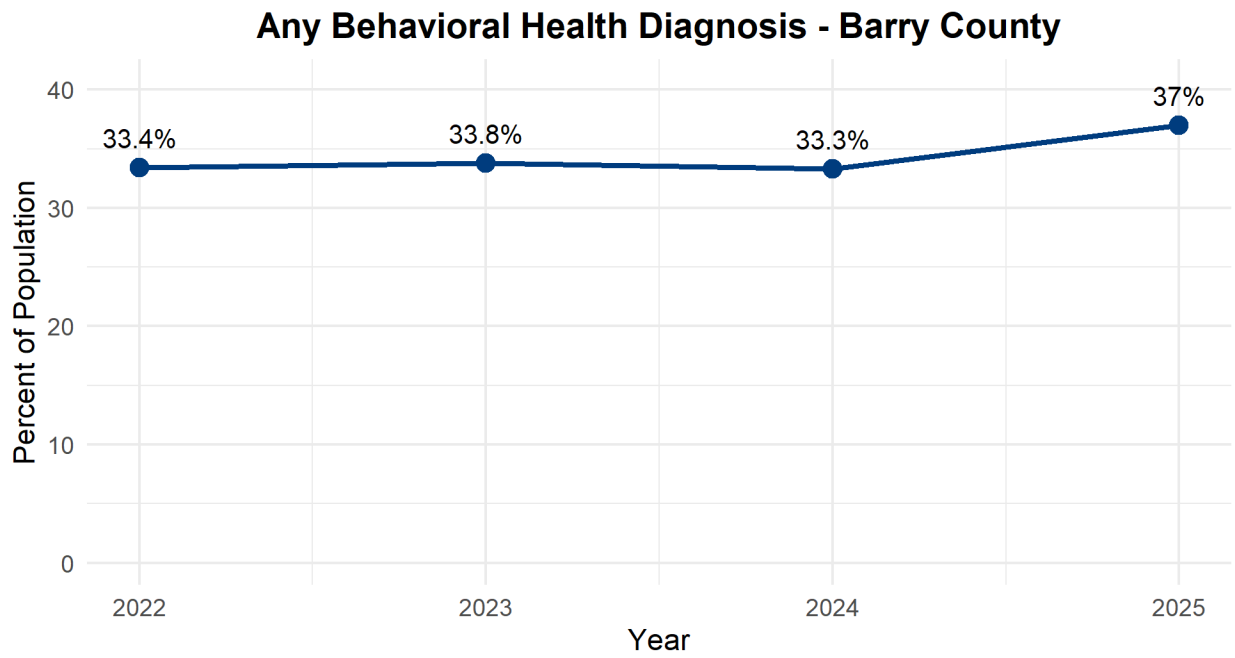


Figure 6: *Percent of population with any behavioral health diagnosis, 2022-2025.*

Behavioral health diagnosis prevalence remained relatively stable from 2022 through 2024 before increasing from 33.3% in 2024 to 37% in 2025. The percentage of enrollees receiving at least one Medicaid service also increased in 2025 after declining during the prior two years, suggesting that greater contact with the healthcare system may have contributed to increased identification of behavioral health conditions. However, the available data cannot determine whether the increase reflects greater underlying behavioral health need, increased identification or treatment, or a combination of factors.

5.2.3. Behavioral Health Diagnosis Trend by Primary Group (2022-2025)

Examining trends within each primary behavioral health diagnosis group helps identify whether changes in overall behavioral health prevalence are driven by specific diagnosis categories. The figure below displays annual trends in the percentage of Medicaid enrollees by primary behavioral health diagnosis group from 2022 through 2025. Exact annual percentages for each diagnosis group are presented in the table below the figure.

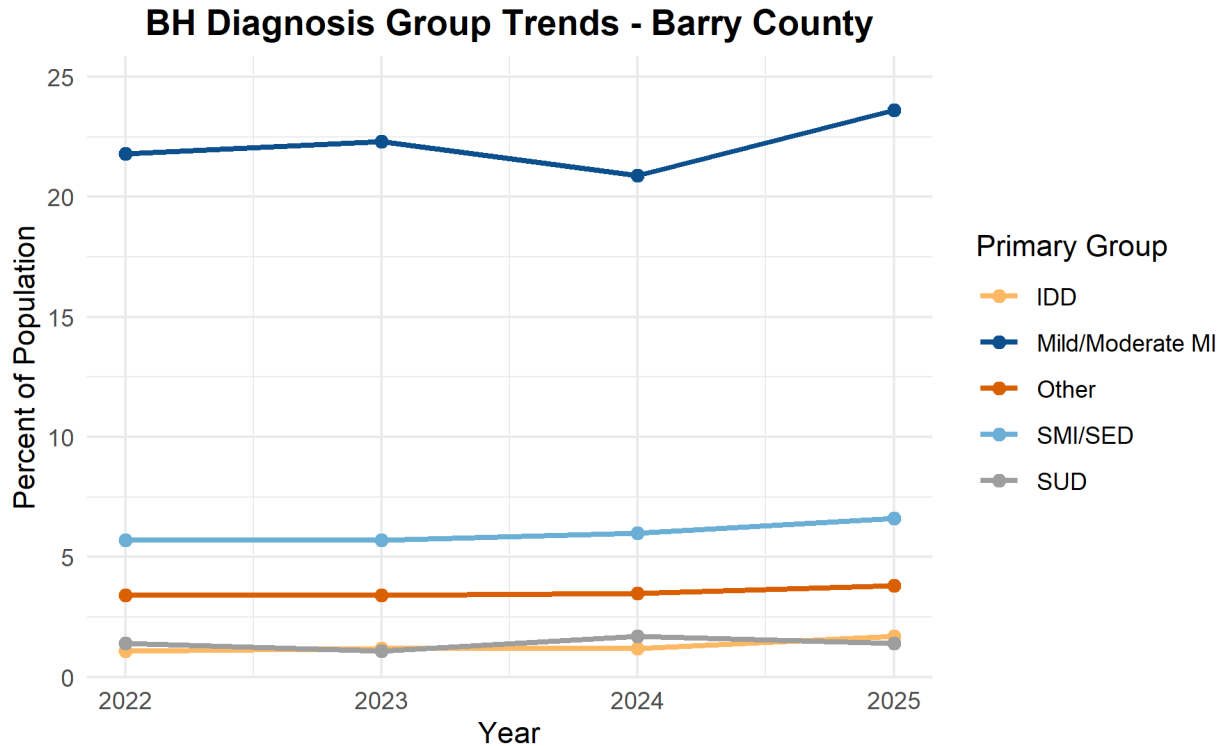


Figure 7: Percent of population with each primary BH diagnosis group, 2022-2025.

Table 7. BH Diagnosis Group Trends

Percent of the population in each primary behavioral health diagnosis group, 2022–2025.

Primary BH Diagnosis Group	2022	2023	2024	2025
IDD	1.1%	1.2%	1.2%	1.7%
Mild/Moderate MI	21.8%	22.3%	20.9%	23.6%
Other	3.4%	3.4%	3.5%	3.8%
SMI/SED	5.7%	5.7%	6.0%	6.6%
SUD	1.4%	1.1%	1.7%	1.4%

Trends varied across primary behavioral health groups. Mild/Moderate MI remained the largest group and accounted for much of the increase observed in 2025, rising from 20.9% of the Medicaid population in 2024 to 23.6% in 2025. In contrast, SMI/SED and IDD showed smaller but more consistent increases across the four-year period, reaching 6.6% and 1.7%, respectively, in 2025. SUD and Other diagnoses remained comparatively stable.

5.2.4. Year-Over-Year Change (2024 vs. 2025)

Changes in behavioral health diagnosis prevalence between 2024 and 2025 were evaluated among Medicaid enrollees who were active in both years (N = 10,813). Using the same individuals in both years reduces the influence of changes in Medicaid enrollment on the year-over-year comparison. As individuals age and remain engaged in care, additional conditions may be identified and documented over time; however, the matched comparison also provides insight into changes in the clinical complexity of the continuously enrolled population. Statistical significance was evaluated using McNemar's test with Bonferroni correction for multiple comparisons.

Table 8: Year-Over-Year Change – Barry County (N matched = 10,813)			
Condition	2024 %	2025 %	Change
Any BH Diagnosis	37.3%	38.7%	+1.4 ↑
Anxiety	20.4%	21.4%	+1 ↑
Depressive	16.0%	16.3%	+0.3 ↑
ADHD	8.4%	8.7%	+0.3 ↑
Adjustment Disorder	5.4%	5.6%	+0.2 ↑
Trauma-Related (PTSD)	4.9%	5.1%	+0.2 ↑
Bipolar	3.8%	3.9%	+0.1 ↑
SUD	4.2%	3.4%	-0.8 ↓
Autism Spectrum	2.3%	2.8%	+0.5 ↑
Impulse Control/Conduct	2.2%	2.0%	-0.2 ↓
Schizophrenia/Psychosis	1.6%	1.8%	+0.2 ↑
Dementia	1.3%	1.4%	+0.1 ↑
Personality Disorder	1.1%	1.2%	+0.1 ↑
IDD	1.2%	1.2%	0
OCD	0.7%	0.7%	0

Bold, colored Change values are statistically significant (McNemar's test, Bonferroni-corrected): red = significant increase, green = significant decrease.

The increase in documented behavioral health diagnoses remained evident within the matched population, with any behavioral health diagnosis increasing by 1.4 percentage points. Anxiety increased by 1.0 percentage point, while Autism Spectrum diagnoses showed a statistically significant increase of 0.5 percentage points. In contrast, documented SUD prevalence decreased by 0.8 percentage points.

5.3. Behavioral Health Diagnosis Rates by County

Behavioral health diagnosis prevalence in Barry County was compared with the remainder of the SWMBH region. Because individuals may have more than one behavioral health diagnosis, condition-specific percentages are not mutually exclusive and should not be summed.

The table below compares Barry County's 2025 diagnosis rates with the rest of the SWMBH region. Statistically significant differences between Barry County and the remainder of the region are identified using bold text, colored shading, and arrows. Conditions are ordered from highest to lowest regional prevalence.

**Table 9. Behavioral Health Diagnosis Rates –
Barry vs. Rest of Region**

Percent with diagnosis (2025)

Condition	Barry (N=13,333)	Rest of Region (N=233,093)
Any BH Diagnosis	37.0% ↑	32.5%
Anxiety	20.5% ↑	15.5%
Depressive	15.7% ↑	12.3%
ADHD	8.2% ↑	6.7%
Adjustment Disorder	5.4%	5.6%
SUD	3.5% ↓	4.9%
Trauma-Related (PTSD)	5.1%	4.8%
Bipolar	3.9%	3.5%
Schizophrenia/Psychosis	1.8% ↓	2.5%
Autism Spectrum	2.5%	2.2%
Impulse Control/Conduct	2.0%	1.7%
IDD	1.1% ↓	1.4%
Personality Disorder	1.2%	1.3%
Dementia	1.4% ↑	0.9%
OCD	0.6%	0.6%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

Barry County had a significantly higher overall behavioral health diagnosis rate than the remainder of the region (37.0% vs. 32.5%). Anxiety, depressive disorders, ADHD, and dementia were also significantly more prevalent in Barry County. In contrast, SUD, schizophrenia/psychosis, and IDD were significantly less prevalent than in the remainder of the region.

5.4. Behavioral Health Conditions Demographic Comparisons

Examining behavioral health diagnoses across demographic groups helps identify populations with different patterns of behavioral health need and potential disparities in diagnosis or access to care. The following analyses compare diagnosis prevalence by age, sex, race and ethnicity, and Medicare-Medicaid dual eligibility.

5.4.1. Behavioral Health Conditions by Age Group

Behavioral health diagnosis patterns varied substantially across age groups. Overall, 29.3% of enrollees younger than 18 had at least one behavioral health diagnosis, compared with 42.2% of adults ages 18–64, and 42.4% of adults ages 65 or older.

Table 10. Behavioral Health Conditions by Age Group - Barry County

Percent with diagnosis (2025)

Condition	<18 (N=5,344)	18-64 (N=7,095)	65+ (N=894)
Any BH Diagnosis	29.3%	42.2%	42.4%
Anxiety	10.4%	28.2%	19.2%
Depressive	5.5%	22.4%	23.2%
SUD	0.3%	6.2%	1.2%
Bipolar	0.2%	6.8%	3.1%
Schizophrenia/Psychosis	0.2%	2.7%	3.9%
Personality Disorder	0.1%	2.2%	0.2%
OCD	0.4%	0.8%	0.8%
Adjustment Disorder	6.9%	4.7%	3.1%
Dementia	0.0%	0.3%	18.5%
Impulse Control/Conduct	3.9%	0.7%	0.3%
Autism Spectrum	4.3%	1.4%	0.0%
IDD	0.5%	1.5%	1.5%
Trauma-Related (PTSD)	2.3%	7.6%	1.3%
ADHD	10.7%	7.2%	0.3%

Shading reflects diagnosis rate magnitude (lighter = lower, darker = higher). No statistical testing was performed for this table.

Among children and adolescents, ADHD was the most commonly documented condition (10.7%), followed closely by anxiety (10.4%) and adjustment disorder (6.9%). Adults ages 18–64 had the highest rates of anxiety (28.2%), Bipolar (6.8%), SUD (6.2%), and trauma-related diagnoses (7.6%). Among adults ages 65 and older, depression (23.2%) and anxiety (19.2%) remained common, while dementia increased sharply to 18.5%. Schizophrenia/psychosis was also more prevalent among adults age 65 and older than among the younger age groups.

5.4.2. Behavioral Health Conditions by Sex

Behavioral health diagnosis patterns differed by both age and sex. Overall, 39.7% of females and 33.8% of males had at least one behavioral health diagnosis in 2025. Among adults, females had substantially higher rates of anxiety (32.9% vs. 19.1%), depression (26.8% vs. 16.3%), and trauma-related disorders (8.9% vs. 4.2%), while adult males had higher rates of SUD (7.7% vs. 4.1%) and schizophrenia/psychosis (3.9% vs. 2.2%). Among children, males had a higher overall behavioral health diagnosis rate than females (31.5% vs. 26.9%), with higher rates of ADHD (13.2% vs. 8.1%), autism spectrum disorder (5.8% vs. 2.7%), and impulse control/conduct disorders (5.4% vs. 2.3%).

Table 11. Behavioral Health Conditions by Age Group and Sex - Barry County

Percent with diagnosis (2025)

Condition	Adult Female (N=4,696)	Adult Male (N=3,293)	Child Female (N=2,597)	Child Male (N=2,747)
Any BH Diagnosis	46.7%	35.8%	26.9%	31.5%
Anxiety	32.9%	19.1%	12.3%	8.6%
Depressive	26.8%	16.3%	7.3%	3.8%
SUD	4.1%	7.7%	0.3%	0.3%
Bipolar	7.1%	5.3%	0.4%	0.1%
Schizophrenia/Psychosis	2.2%	3.9%	0.2%	0.2%
Personality Disorder	2.4%	1.5%	0.1%	0.0%
OCD	0.8%	0.9%	0.5%	0.2%
Adjustment Disorder	4.9%	3.9%	6.8%	6.9%
Dementia	2.5%	2.1%	0.0%	0.0%
Impulse Control/Conduct	0.4%	1.2%	2.3%	5.4%
Autism Spectrum	0.6%	2.2%	2.7%	5.8%
IDD	1.0%	2.1%	0.4%	0.7%
Trauma-Related (PTSD)	8.9%	4.2%	2.6%	2.0%
ADHD	6.9%	5.8%	8.1%	13.2%

Shading reflects diagnosis rate magnitude (lighter = lower, darker = higher). No statistical testing was performed for this table.

5.4.3. Behavioral Health Conditions by Medicare-Medicaid Dual Eligibility

Comparing behavioral health diagnoses by Medicare-Medicaid dual eligibility provides insight into differences between individuals with more complex healthcare needs and those covered by Medicaid alone. In 2025, 47% of dual-eligible Medicaid enrollees had at least one behavioral health diagnosis, compared to 35.8% of non-dual enrollees.

Table 12. Behavioral Health Conditions by Medicare Dual Status - Barry County

Percent with diagnosis (2025)

Condition	Dual (N=1,456)	No (N=11,877)
Any BH Diagnosis	47.0%	35.8%
Anxiety	23.5%	20.1%
Depressive	25.0%	14.5%
SUD	3.7%	3.5%
Bipolar	6.9%	3.5%
Schizophrenia/Psychosis	5.4%	1.3%
Personality Disorder	1.8%	1.2%
OCD	1.0%	0.6%
Adjustment Disorder	3.2%	5.7%
Dementia	12.2%	0.1%
Impulse Control/Conduct	1.2%	2.1%
Autism Spectrum	1.4%	2.6%
IDD	4.6%	0.6%
Trauma-Related (PTSD)	5.0%	5.1%
ADHD	2.5%	8.9%

Shading reflects diagnosis rate magnitude (lighter = lower, darker = higher). No statistical testing was performed for this table.

Dual-eligible enrollees had a higher overall behavioral health diagnosis rate than non-dual enrollees (47.0% vs. 35.8%), with higher documented rates across several conditions. Differences were particularly notable for dementia (12.2% vs. 0.1%), depressive disorders (25.0% vs. 14.5%), schizophrenia/psychosis (5.4% vs. 1.3%), IDD (4.6% vs. 0.6%), and bipolar disorder (6.9% vs. 3.5%). In contrast, ADHD was more common among non-dual enrollees (8.9% vs. 2.5%).

5.4.4. BH Diagnosis by Race/Ethnicity

Race and ethnicity are important factors for identifying potential disparities in behavioral health diagnoses. The following table, and the race/ethnicity tables later in this report, use abbreviated column labels for the following categories: American Indian or Alaska Native (AI/AN) and Native Hawaiian or Other Pacific Islander (NH/PI). The remaining categories - White, Black or African American, Hispanic or Latino, Asian, and Other Race - are shown by their full names.

The following table summarizes behavioral health diagnosis prevalence by race and ethnicity in 2025. Because individuals may have more than one behavioral health diagnosis, condition-specific percentages within each racial/ethnic group are not mutually exclusive and should not be summed. Statistical significance was assessed using chi-square tests with Bonferroni correction.

Table 13. Behavioral Health Diagnoses by Race/Ethnicity - Barry

Percent with diagnosis, by race/ethnicity (2025)

Condition	AI/AN (N=153)	Asian (N=22)	Black (N=321)	Hispanic (N=536)	NH/PI (N=9)	Other (N=825)	White (N=11,467)
Any BH Diagnosis	45.8%	13.6%	38.9%	29.9%	33.3%	28.4% ↓	37.9% ↑
Anxiety	28.1%	9.1%	14.0%	15.3%	22.2%	11.9% ↓	21.4% ↑
Depressive	20.9%	4.5%	11.2%	12.1%	22.2%	9.6% ↓	16.3% ↑
SUD	1.3%	0.0%	2.2%	2.8%	0.0%	1.2% ↓	3.8% ↑
Bipolar	5.2%	4.5%	2.5%	2.6%	0.0%	1.8%	4.1%
Schizophrenia/Psychosis	3.3%	4.5%	1.2%	1.1%	0.0%	0.8%	1.9%
Personality Disorder	3.3%	0.0%	1.2%	1.1%	0.0%	0.4%	1.3%
OCD	1.3%	0.0%	0.3%	0.2%	0.0%	0.5%	0.7%
Adjustment Disorder	6.5%	0.0%	9.3%	5.2%	11.1%	4.4%	5.4%
Dementia	0.0%	0.0%	0.6%	0.4%	0.0%	1.5%	1.5%
Impulse Control/Conduct	3.3%	0.0%	5.0% ↑	0.9%	0.0%	2.1%	1.9%
Autism Spectrum	2.0%	0.0%	5.6%	1.1%	0.0%	2.9%	2.4%
IDD	1.3%	0.0%	1.9%	0.2%	0.0%	1.9%	1.0%
Trauma-Related (PTSD)	6.5%	4.5%	7.8%	4.5%	22.2%	3.9%	5.1%
ADHD	8.5%	0.0%	10.3%	6.9%	0.0%	9.0%	8.1%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

Behavioral health diagnosis prevalence varied across racial and ethnic groups in Barry County. American Indian or Alaska Native enrollees had the highest overall documented behavioral health diagnosis rate at 45.8%, followed by Black enrollees at 38.9% and White enrollees at 37.9%. White enrollees had a significantly higher overall diagnosis rate than the remainder of the population, while enrollees in the Other Race category had a significantly lower rate at 28.4%.

White enrollees also had significantly higher rates of anxiety, depressive disorders, and SUD, while the Other Race group had significantly lower rates for these same conditions. Black enrollees had a significantly higher rate of impulse control/conduct disorders. Several other racial and ethnic groups showed notable differences in individual conditions, but small population sizes limit interpretation for some groups.

These differences should not be interpreted as direct measures of underlying behavioral health need. Diagnosis prevalence may also reflect differences in access to care, healthcare utilization, screening, diagnostic practices, cultural factors, and documentation. The patterns may therefore help identify areas where additional review of access and potential disparities is warranted.

Together, these findings show that behavioral health diagnosis patterns vary across demographic groups, geographic areas, and diagnosis categories within the Barry County Medicaid population. These differences provide important context for the chronic physical health, multimorbidity, and healthcare utilization analyses that follow.

6. Chronic Health Conditions

6.1. Overview and Methods

Chronic physical health conditions are an important contributor to healthcare utilization, quality of life, and overall healthcare costs (Centers for Disease Control and Prevention, 2026). Understanding the prevalence and distribution of chronic conditions helps identify populations with greater medical complexity, supports prevention and care management efforts, and provides context for the healthcare utilization and multimorbidity analyses presented later in this report.

This section summarizes documented chronic physical health conditions among Medicaid enrollees, trends from 2022 through 2025, and differences across demographic groups.

For this analysis, ICD-10 diagnosis codes from Medicaid service encounters between 2022 and 2025 were used to identify documented chronic conditions among the Barry County Medicaid population. Services funded by Medicaid Health Plans or Medicaid Fee-for-Service were included, along with PIHP/CMH-funded services containing one of the diagnoses of interest. A condition was considered present if a qualifying diagnosis appeared on an encounter during the study period, regardless of funding source, service type, diagnostic position on the claim, or number of times the diagnosis was reported.

To simplify interpretation, individual diagnosis codes were organized into broader analytic condition groups based on clinically related diseases. These groupings allow related conditions to be examined together when they share common risk factors, treatment approaches, or affected organ systems. The composite groups used in this section are:

- **Cardiac Disease:** Coronary artery disease (CAD), congestive heart failure, valvular heart disease, and other chronic ischemic heart disease.
- **Vascular Disease:** Atherosclerosis, peripheral vascular disease, stroke, and transient ischemic attack (TIA).
- **Metabolic Risk Factors:** Hypertension, diabetes, hyperlipidemia, obesity/morbid obesity, and sleep apnea.
- **GI Functional Disorder:** GERD/esophageal disorders and gastrointestinal motility disorders.
- **Chronic Pain/Migraine:** Chronic pain syndrome, migraine, fibromyalgia, and myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS).
- **Social Determinants of Health (SDoH):** Housing/economic instability, social/family circumstance concerns, education/employment problems, and other psychosocial circumstances.

SDoH are included as a health-related condition grouping rather than a chronic physical health condition because social and economic circumstances can substantially influence physical and behavioral health outcomes, access to care, and treatment stability (McQueen et al., 2021).

6.2. Prevalence of Chronic Conditions

The tables in this section examine the prevalence of documented chronic health conditions among Medicaid enrollees in Barry County. These results represent documented diagnosis history among the 2025 Medicaid population rather than conditions newly diagnosed during the year.

Conditions are not mutually exclusive; an individual may be represented in more than one category when multiple chronic conditions are present. Percentages across conditions therefore should not be summed to estimate overall chronic disease prevalence.

The table compares Barry County with the remainder of the SWMBH region. Overall, 42.7% of enrollees had at least one of the chronic conditions included in this analysis. The most commonly identified conditions were Metabolic Risk Factors (24.1%), Tobacco Use (11.8%), Chronic Pain/Migraine (11.2%). Statistical significance was assessed using chi-square tests with Bonferroni correction.

Table 14. Chronic Health Condition Rates - Barry vs. Rest of Region

Percent with condition (2025)

Condition	Barry (N=13,333)	Rest of Region (N=233,093)
Any Chronic Condition	42.7% ↑	37.8%
Metabolic Risk Factors	24.1%	23.9%
Chronic Pain/Migraine	11.2% ↑	9.5%
GI Functional Disorder	9.9% ↑	8.1%
Tobacco Use	11.8% ↑	6.9%
Asthma	7.8% ↑	6.1%
Social Determinants of Health	4.7% ↑	4.1%
Cardiac Disease	4.1%	3.9%
COPD	3.5%	3.5%
Hypothyroidism	2.7%	2.8%
Urinary Tract Infection	2.6%	2.7%
Vascular Disease	2.6%	2.3%
Liver Disease	2.5%	2.1%
Chronic Kidney Disease	1.9%	2.1%
Cancer	1.8%	1.8%

Table 14. Chronic Health Condition Rates - Barry vs. Rest of Region*Percent with condition (2025)*

Condition	Barry (N=13,333)	Rest of Region (N=233,093)
Epilepsy	1.9%	1.7%
Prediabetes	1.3%	1.6%
Traumatic Brain Injury	1.2%	1.0%
Feeding Difficulty	0.8% ↑	0.6%
Inflammatory Bowel Disease	0.5%	0.4%
Rheumatoid Arthritis	0.3%	0.3%
Lupus/SLE	0.1%	0.2%
Multiple Sclerosis	0.2%	0.2%
Sickle Cell Disease	0.0% ↓	0.2%
Long COVID	0.0%	0.0%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

Chronic condition prevalence was higher in Barry County than in the remainder of the SWMBH region. Several individual conditions were significantly more prevalent in Barry County. The largest difference was observed for tobacco use (11.8% vs. 6.9%). Chronic pain/migraine (11.2% vs. 9.5%), GI functional disorders (9.9% vs. 8.1%), asthma (7.8% vs. 6.1%), and documented Social Determinants of Health concerns (4.7% vs. 4.1%) were also significantly higher. Metabolic risk factors, despite being the most common chronic condition group, were similar in Barry County and the remainder of the region (24.1% vs. 23.9%).

These differences may reflect variation in underlying population health, risk factors, healthcare access, diagnostic practices, or documentation. The higher overall chronic condition prevalence and several specific areas of elevated prevalence may help identify conditions that warrant continued monitoring or more focused local review.

6.2.1. Chronic Condition Prevalence Trend (2022-2025)

Monitoring chronic condition prevalence over time helps identify changes in disease burden and may reflect shifts in population health, healthcare access, or diagnosis practices. The figure below displays annual trends in the percentage of Medicaid enrollees with at least one chronic physical health condition from 2022 through 2025.

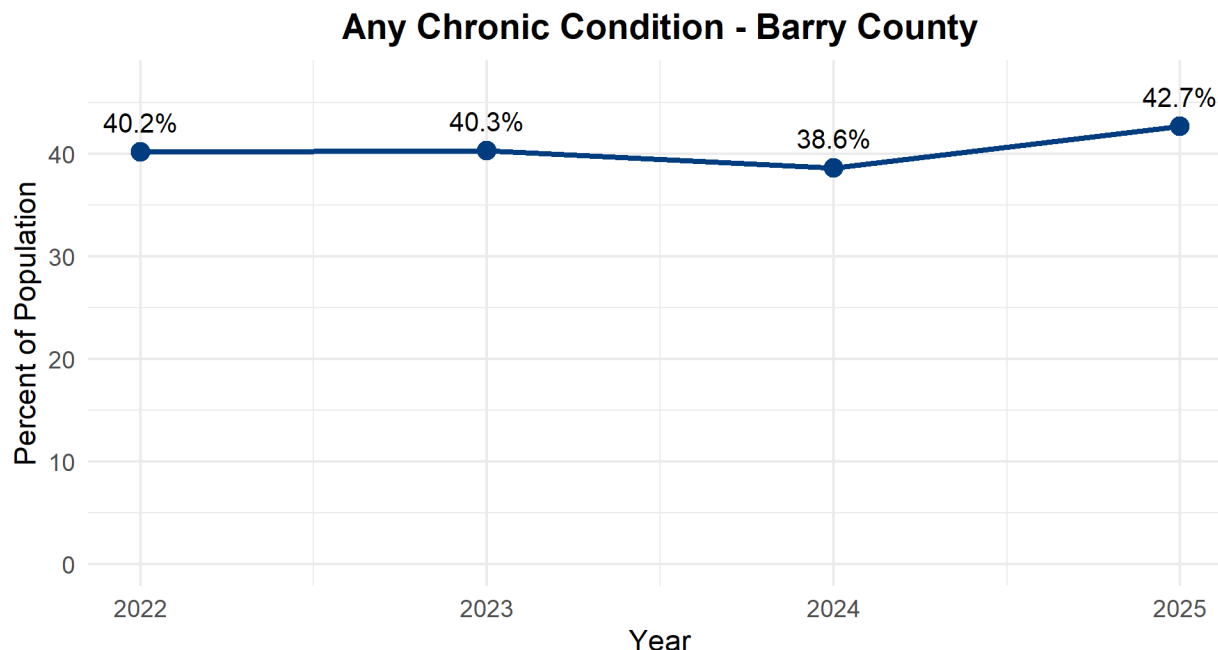


Figure 8: *Percent of population with any chronic condition studied, 2022-2025.*

Chronic condition prevalence was relatively stable from 2022 through 2024 before increasing from 38.6% in 2024 to 42.7% in 2025. This pattern is similar to the increase observed in behavioral health diagnoses during the same period. Because the percentage of enrollees receiving at least one Medicaid service also increased in 2025, greater healthcare contact may have contributed to increased identification of both chronic and behavioral health conditions.

Changes between 2024 and 2025 were also evaluated among Medicaid enrollees active in both years using McNemar’s test with Bonferroni correction. This matched-cohort approach reduces the influence of changes in Medicaid enrollment on the year-over-year comparison. Because individuals were one year older in 2025 and had additional opportunities for conditions to be identified and documented over time, some increase is expected within a continuously enrolled population. The matched comparison nevertheless provides insight into changes in the medical complexity of this population. Because the matched population differs from the full population used in the annual trend figure, the percentages below will not exactly match the 2024 and 2025 values shown above.

Table 15: Year-Over-Year Change (Chronic Conditions) – Barry County (N matched = 10,813)

Condition	2024 %	2025 %	Change
Any Chronic Condition	43.1%	44.1%	+1 ↑
Metabolic Risk Factors	24.9%	25.4%	+0.5 ↑
Tobacco Use	11.7%	12.4%	+0.7 ↑
Chronic Pain/Migraine	11.4%	11.9%	+0.5 ↑
GI Functional Disorder	10.6%	10.2%	-0.4 ↓
Asthma	8.7%	8.3%	-0.4 ↓
Social Determinants of Health	4.9%	4.5%	-0.4 ↓
Cardiac Disease	4.1%	4.2%	+0.1 ↑
COPD	3.9%	3.8%	-0.1 ↓
Vascular Disease	2.6%	2.7%	+0.1 ↑
Hypothyroidism	2.9%	2.7%	-0.2 ↓
Urinary Tract Infection	2.7%	2.7%	0
Liver Disease	2.3%	2.6%	+0.3 ↑
Epilepsy	1.7%	2.0%	+0.3 ↑
Chronic Kidney Disease	1.7%	1.9%	+0.2 ↑
Cancer	1.7%	1.8%	+0.1 ↑
Prediabetes	1.1%	1.3%	+0.2 ↑
Traumatic Brain Injury	1.2%	1.2%	0
Feeding Difficulty	0.9%	0.7%	-0.2 ↓
Inflammatory Bowel Disease	0.4%	0.5%	+0.1 ↑
Rheumatoid Arthritis	0.3%	0.3%	0
Multiple Sclerosis	0.2%	0.2%	0
Lupus/SLE	0.1%	0.1%	0
Long COVID	0.1%	0.0%	-0.1 ↓
Sickle Cell Disease	0.0%	0.0%	0

Bold, colored Change values are statistically significant (McNemar's test, Bonferroni-corrected): red = significant increase, green = significant decrease.

The matched Barry County population showed a modest increase in documented chronic condition prevalence, from 43.1% in 2024 to 44.1% in 2025, although the overall change was not statistically significant. Tobacco use had the largest observed increase (+0.7 percentage points), followed by metabolic risk factors and chronic pain/migraine (+0.5 each), while several conditions showed small decreases. Overall, chronic condition prevalence remained relatively stable, with shifts across individual conditions that may reflect evolving medical complexity within the continuously enrolled population.

6.3. Chronic Conditions by Age Group

Chronic disease burden varies considerably across the lifespan, making age an important consideration when comparing condition prevalence across populations (Watson et al., 2025). In Barry County, 71.9% of adults age 65 and older had at least one chronic condition, compared with 53% of adults ages 18–64 years, and 24% of children younger than 18.

Table 16. Chronic Conditions by Age Group - Barry County

Percent with condition (2025)

Condition	<18 (N=5,344)	18-64 (N=7,095)	65+ (N=894)
Any Chronic Condition	24.0%	53.0%	71.9%
Cardiac Disease	0.2%	4.7%	22.7%
Vascular Disease	0.1%	2.6%	16.6%
Metabolic Risk Factors	4.7%	34.1%	61.1%
GI Functional Disorder	4.5%	12.4%	22.6%
Chronic Pain/Migraine	2.6%	16.8%	17.9%
Social Determinants of Health	4.9%	4.9%	2.0%
Asthma	8.9%	7.4%	4.5%
COPD	0.0%	4.3%	18.9%
Cancer	0.1%	2.3%	8.2%
Epilepsy	0.9%	2.4%	3.8%
Hypothyroidism	0.3%	3.4%	10.9%
Long COVID	0.0%	0.0%	0.2%
Tobacco Use	0.2%	19.3%	21.5%
Prediabetes	0.1%	1.8%	3.8%

Table 16. Chronic Conditions by Age Group - Barry County

Percent with condition (2025)

Condition	<18 (N=5,344)	18-64 (N=7,095)	65+ (N=894)
Sickle Cell Disease	0.0%	0.0%	0.0%
Traumatic Brain Injury	1.1%	1.2%	1.6%
Urinary Tract Infection	1.0%	3.0%	9.8%
Feeding Difficulty	1.9%	0.1%	0.3%
Inflammatory Bowel Disease	0.0%	0.9%	0.3%
Liver Disease	0.2%	4.0%	3.7%
Rheumatoid Arthritis	0.0%	0.5%	0.9%
Lupus/SLE	0.0%	0.2%	0.2%
Multiple Sclerosis	0.0%	0.3%	0.2%
Chronic Kidney Disease	0.1%	1.7%	14.0%

Shading reflects diagnosis rate magnitude (lighter = lower, darker = higher). No statistical testing was performed for this table.

Metabolic Risk Factors showed one of the strongest age-related patterns, increasing from 4.7% among children to 34.1% among adults ages 18–64 and 61.1% among adults age 65 and older. Several other conditions also increased markedly with age. Cardiac disease, vascular disease, GI functional disorder, COPD, chronic kidney disease, cancer, hypothyroidism, and urinary tract infection were all substantially more common among adults age 65 and older. In contrast, conditions such as asthma and Social Determinants of Health showed less pronounced age-related differences, while children had the lowest overall chronic condition burden across most categories.

These patterns underscore the importance of age when interpreting chronic disease prevalence and suggest that older adults may require more intensive management of multiple co-occurring physical health conditions.

6.4. Chronic Conditions by Age Group and Dual Eligibility

Medicare dual eligibility provides another way to examine differences in chronic disease burden within the Medicaid population. Individuals enrolled in both Medicare and Medicaid represent a diverse population that differs in age, disability status, healthcare needs, and patterns of service use (Fox & Reichard, 2013).

The table below presents chronic condition prevalence by age group and Medicare dual eligibility status. Examining dual and non-dual populations within age groups helps distinguish differences associated with dual eligibility from patterns that may primarily reflect the older age distribution of the dual-eligible population. Statistical comparisons are made between dual-eligible and non-dual enrollees within the same adult age group.

Table 17. Chronic Conditions by Age Group and Dual Eligibility – Barry County

Percent with condition (2025)

Condition	Dual 18-64 (N=606)	Dual 65+ (N=850)	No <18 (N=5,344)	No 18-64 (N=6,489)	No 65+ (N=44)
Any Chronic Condition	61.6% ↑	72.8% ↑	24.0% ↓	52.2% ↑	54.5%
Cardiac Disease	11.7% ↑	23.1% ↑	0.2% ↓	4.1%	15.9% ↑
Vascular Disease	5.1% ↑	16.9% ↑	0.1% ↓	2.4%	9.1%
Metabolic Risk Factors	48.8% ↑	62.0% ↑	4.7% ↓	32.7% ↑	43.2%
GI Functional Disorder	20.1% ↑	22.9% ↑	4.5% ↓	11.7% ↑	15.9%
Chronic Pain/Migraine	25.1% ↑	18.6% ↑	2.6% ↓	16.0% ↑	4.5%
Social Determinants of Health	7.1%	1.9% ↓	4.9%	4.7%	4.5%
Asthma	8.6%	4.6%	8.9% ↑	7.3%	2.3%
COPD	9.7% ↑	18.9% ↑	0.0% ↓	3.7%	18.2% ↑
Cancer	4.3% ↑	8.5% ↑	0.1% ↓	2.1%	2.3%
Epilepsy	6.9% ↑	4.0% ↑	0.9% ↓	2.0%	0.0%
Hypothyroidism	8.4% ↑	11.1% ↑	0.3% ↓	2.9%	6.8%
Long COVID	0.0%	0.2%	0.0%	0.0%	0.0%
Tobacco Use	20.0% ↑	21.5% ↑	0.2% ↓	19.2% ↑	20.5%
Prediabetes	3.1% ↑	3.8% ↑	0.1% ↓	1.7% ↑	4.5%
Sickle Cell Disease	0.0%	0.0%	0.0%	0.0%	0.0%
Traumatic Brain Injury	1.2%	1.5%	1.1%	1.2%	2.3%

Table 17. Chronic Conditions by Age Group and Dual Eligibility – Barry County

Percent with condition (2025)

Condition	Dual 18-64 (N=606)	Dual 65+ (N=850)	No <18 (N=5,344)	No 18-64 (N=6,489)	No 65+ (N=44)
Urinary Tract Infection	5.0%	10.1% ↑	1.0% ↓	2.8%	4.5%
Feeding Difficulty	0.2%	0.4%	1.9% ↑	0.1% ↓	0.0%
Inflammatory Bowel Disease	1.5%	0.4%	0.0% ↓	0.8% ↑	0.0%
Liver Disease	5.0% ↑	3.8%	0.2% ↓	4.0% ↑	2.3%
Rheumatoid Arthritis	1.2%	0.9%	0.0% ↓	0.4%	0.0%
Lupus/SLE	0.2%	0.2%	0.0%	0.2%	0.0%
Multiple Sclerosis	1.0% ↑	0.2%	0.0%	0.2%	0.0%
Chronic Kidney Disease	5.1% ↑	14.4% ↑	0.1% ↓	1.4% ↓	6.8%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

Among adults ages 18–64, dual-eligible enrollees had substantially greater chronic disease burden than non-dual adults in the same age group. Any chronic condition was documented for 61.6% of dual-eligible adults ages 18–64 compared with 52.2% of non-dual adults. Metabolic risk factors were also more common among dual-eligible adults (48.8% vs. 32.7%). Significantly higher rates were observed across several other conditions, including cardiac and vascular disease, chronic pain/migraine, COPD, cancer, epilepsy, hypothyroidism, chronic kidney disease, and liver disease.

Differences were also present among adults age 65 and older. Any chronic condition was documented for 72.8% of dual-eligible older adults compared with 54.5% of non-dual older adults, while metabolic risk factors were present in 62.0% and 43.2%, respectively. Dual-eligible older adults also had higher rates of cardiac disease, vascular disease, COPD, cancer, urinary tract infection, hypothyroidism, and chronic kidney disease.

Overall, dual-eligible adults in Barry County demonstrated greater chronic health complexity than non-dual adults within the same age groups, particularly across cardiovascular, metabolic, respiratory, and kidney-related conditions.

6.5. Multiple Chronic Conditions by Dual Eligibility (Adults)

The number of chronic conditions present provides another measure of overall medical complexity. Individuals with multiple chronic conditions often require more intensive care management and may experience higher healthcare utilization.

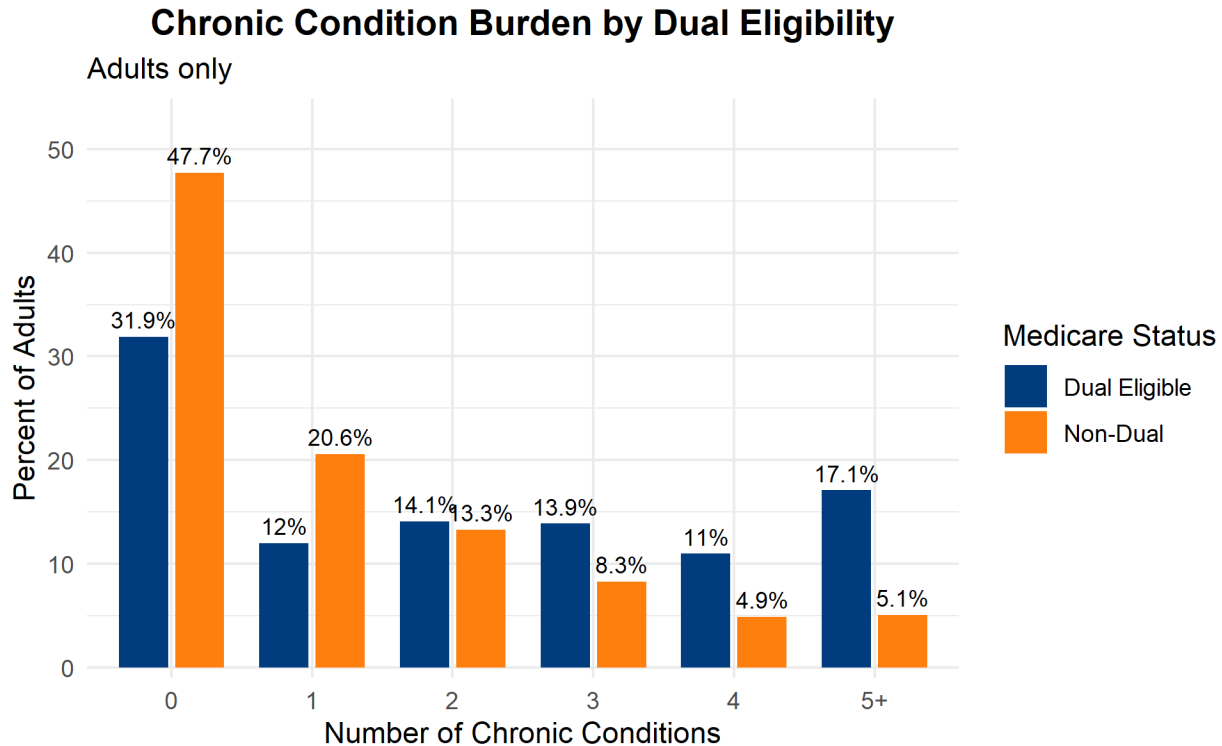


Figure 9: *Percent of adult enrollees by number of chronic conditions, by Medicare dual eligibility status.*

Dual-eligible adults had a greater chronic condition burden than non-dual adults. Nearly half of non-dual adults had none of the chronic conditions included in this analysis (47.7%), compared with 31.9% of dual-eligible adults. Differences became more pronounced as the number of chronic conditions increased. Dual-eligible adults were more likely to have three, four, or five or more chronic conditions, with 17.1% having five or more compared with 5.1% of non-dual adults.

Overall, the distribution shows a greater concentration of multiple co-occurring chronic conditions among dual-eligible adults in Barry County. This pattern may indicate a greater need for care coordination and management of complex medical needs within this population.

6.6. Chronic Conditions by Behavioral Health Diagnosis Group

Physical and behavioral health conditions frequently occur together, and examining chronic disease prevalence across behavioral health populations can help identify groups with greater combined medical and behavioral health needs.

The following tables compare chronic condition prevalence across the primary behavioral health diagnosis groups defined earlier in this report. Individuals without an identified behavioral health diagnosis are included as a comparison group. Because chronic condition prevalence differs substantially by age, results are presented separately for children and adolescents and for adults. This stratification allows behavioral health groups to be compared within more similar age ranges and reduces the influence of age-related differences in chronic disease burden.

Table 18. Chronic Conditions by BH Diagnosis Group - Adults*Percent with condition among enrollees age 18 and older (2025)*

Condition	No BH Diagnosis (N=4,616)	IDD (N=101)	Mild/Moderate MI (N=2,222)	Other (N=168)	SMI/SED (N=692)	SUD (N=190)
Any Chronic Condition	36.6% ↓	77.2% ↑	81.2% ↑	91.7% ↑	79.5% ↑	67.9%
Cardiac Disease	4.6% ↓	4.0%	9.4% ↑	26.8% ↑	8.1%	6.8%
Vascular Disease	2.4% ↓	4.0%	6.0% ↑	31.0% ↑	4.5%	3.7%
Metabolic Risk Factors	22.4% ↓	52.5%	57.1% ↑	79.2% ↑	58.4% ↑	40.5%
GI Functional Disorder	5.4% ↓	18.8%	25.0% ↑	45.8% ↑	22.3% ↑	14.7%
Chronic Pain/Migraine	9.2% ↓	5.9%	30.6% ↑	14.3%	27.2% ↑	14.7%
Social Determinants of Health	1.1% ↓	10.9%	7.8% ↑	2.4%	15.9% ↑	9.5%
Asthma	3.5% ↓	6.9%	12.9% ↑	5.4%	13.4% ↑	4.2%
COPD	3.5% ↓	1.0%	9.1% ↑	13.7% ↑	9.1% ↑	9.5%
Cancer	2.2% ↓	1.0%	4.5% ↑	4.2%	2.6%	3.2%
Epilepsy	1.0% ↓	28.7% ↑	3.1%	12.5% ↑	5.1% ↑	1.6%
Hypothyroidism	2.2% ↓	16.8% ↑	6.1% ↑	20.2% ↑	5.9%	4.7%
Long COVID	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Tobacco Use	12.0% ↓	4.0% ↓	30.3% ↑	17.9%	34.0% ↑	35.3% ↑
Prediabetes	1.0% ↓	2.0%	3.3% ↑	5.4%	3.6%	2.6%
Sickle Cell Disease	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓
Traumatic Brain Injury	0.4% ↓	1.0%	2.2% ↑	5.4% ↑	2.3%	3.2%
Urinary Tract Infection	1.9% ↓	2.0%	5.6% ↑	20.8% ↑	5.9%	3.7%
Feeding Difficulty	0.0%	0.0%	0.3%	0.6%	0.0%	0.5%
Inflammatory Bowel Disease	0.4% ↓	1.0%	1.8% ↑	0.0%	0.4%	1.6%
Liver Disease	2.1% ↓	3.0%	7.3% ↑	1.2%	5.2%	10.5% ↑
Rheumatoid Arthritis	0.3% ↓	0.0%	1.1% ↑	0.6%	0.7%	0.0%
Lupus/SLE	0.1%	0.0%	0.3%	0.0%	0.4%	0.0%
Multiple Sclerosis	0.2%	0.0%	0.4%	0.6%	0.1%	0.5%
Chronic Kidney Disease	1.6% ↓	1.0%	4.5% ↑	19.6% ↑	5.1%	3.2%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

Among adults, chronic condition prevalence was substantially higher across all behavioral health diagnosis groups than among adults without a behavioral health diagnosis. Any chronic condition was documented for 36.6% of adults with no behavioral health diagnosis, compared with 67.9% to 91.7% across the behavioral health groups.

Adults in the Other diagnosis group had the highest overall chronic condition prevalence at 91.7%, with particularly high rates of metabolic risk factors (79.2%), GI functional disorders (45.8%), vascular disease (31.0%), cardiac disease (26.8%), chronic kidney disease (19.6%), and urinary tract infection (20.8%). Adults with Mild/Moderate MI and SMI/SED also showed broad elevations across many chronic conditions compared with adults without a behavioral health diagnosis.

The pattern differed somewhat by behavioral health group. IDD was especially associated with epilepsy and hypothyroidism, while SUD and SMI/SED had particularly high tobacco-use rates. Overall, the table demonstrates substantial overlap between behavioral and physical health conditions among adults in Barry County.

Table 19. Chronic Conditions by BH Diagnosis Group - Children and Adolescents*Percent with condition among enrollees under age 18 (2025)*

Condition	No BH Diagnosis (N=3,780)	IDD (N=122)	Mild/Moderate MI (N=919)	Other (N=336)	SMI/SED (N=187)
Any Chronic Condition	17.1% ↓	41.8% ↑	40.5% ↑	37.5% ↑	46.0% ↑
Cardiac Disease	0.0% ↓	0.0%	0.4%	0.6%	1.1%
Vascular Disease	0.1%	0.0%	0.4%	0.0%	0.0%
Metabolic Risk Factors	3.1% ↓	9.8%	7.5% ↑	9.8% ↑	8.6%
GI Functional Disorder	3.3% ↓	10.7%	5.7%	10.4% ↑	9.6%
Chronic Pain/Migraine	1.4% ↓	0.0%	7.5% ↑	2.1%	4.8%
Social Determinants of Health	2.5% ↓	9.0%	11.3% ↑	7.1%	16.0% ↑
Asthma	6.4% ↓	14.8%	15.9% ↑	11.6%	17.1% ↑
COPD	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓
Cancer	0.1%	0.0%	0.4%	0.0%	0.0%
Epilepsy	0.5% ↓	4.9% ↑	1.2%	3.3% ↑	0.5%
Hypothyroidism	0.2%	2.5% ↑	0.3%	0.3%	0.0%
Long COVID	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓
Tobacco Use	0.0% ↓	0.0%	0.7%	0.0%	3.2% ↑
Prediabetes	0.1%	0.0%	0.3%	0.3%	0.5%
Sickle Cell Disease	0.0%	0.0%	0.1%	0.0%	0.0%
Traumatic Brain Injury	0.6% ↓	0.8%	2.6% ↑	1.8%	2.1%
Urinary Tract Infection	0.8%	0.0%	1.3%	2.1%	2.7%
Feeding Difficulty	1.1% ↓	11.5% ↑	1.3%	8.0% ↑	2.1%
Inflammatory Bowel Disease	0.1%	0.0%	0.0%	0.0%	0.0%
Liver Disease	0.2%	0.8%	0.1%	0.3%	1.6%
Rheumatoid Arthritis	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓
Lupus/SLE	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓
Multiple Sclerosis	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓	0.0% ↓
Chronic Kidney Disease	0.0%	0.0%	0.1%	0.6%	0.0%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

A similar pattern was observed among children and adolescents. Those without a behavioral health diagnosis had the lowest overall chronic condition prevalence at 17.1%, while prevalence ranged from 37.5% to 46.0% across the behavioral health groups. Children in the SMI/SED group had the highest overall chronic condition prevalence and notably higher rates of Social Determinants of Health concerns and asthma. Children with IDD also had elevated chronic condition prevalence, including higher rates of epilepsy, hypothyroidism, and feeding difficulty.

Other group-specific patterns were also evident. Children with Mild/Moderate MI had higher rates of chronic pain/migraine, asthma, Social Determinants of Health concerns, and traumatic brain injury, while the Other diagnosis group showed elevated GI functional disorders and feeding difficulty. Overall, these findings indicate substantial overlap between behavioral and physical health needs among children and adolescents in Barry County.

6.7. Chronic Conditions by Race/Ethnicity

The table below examines chronic condition prevalence across race and ethnicity groups to identify differences in diagnosed chronic disease burden within the Medicaid population. Differences observed across groups may reflect a combination of underlying health risk, social and environmental conditions, access to healthcare, healthcare utilization, and differences in opportunities for conditions to be diagnosed. Statistical significance was assessed using chi-square tests with Bonferroni correction.

Table 20. Chronic Conditions by Race/Ethnicity - Barry County*Percent with condition (2025)*

Condition	AI/AN (N=153)	Asian (N=22)	Black (N=321)	Hispanic (N=536)	NH/PI (N=9)	Other (N=825)	White (N=11,467)
Any Chronic Condition	49.7%	40.9%	35.8%	34.5% ↓	44.4%	30.7% ↓	44.0% ↑
Cardiac Disease	5.2%	4.5%	1.6%	2.1%	11.1%	3.9%	4.3%
Vascular Disease	0.7%	4.5%	1.2%	1.5%	0.0%	2.7%	2.7%
Metabolic Risk Factors	26.8%	27.3%	16.8%	17.2% ↓	44.4%	15.2% ↓	25.2% ↑
GI Functional Disorder	15.0%	18.2%	6.5%	6.3%	11.1%	9.0%	10.2%
Chronic Pain/Migraine	13.7%	18.2%	3.7% ↓	6.2% ↓	11.1%	5.9% ↓	11.9% ↑
Social Determinants of Health	5.2%	0.0%	7.2%	5.8%	0.0%	3.8%	4.7%
Asthma	12.4%	0.0%	10.6%	6.0%	11.1%	5.5%	7.9%
COPD	5.9%	0.0%	0.3%	0.2% ↓	11.1%	2.1%	3.9% ↑
Cancer	3.3%	0.0%	1.2%	0.4%	0.0%	1.5%	1.9%
Epilepsy	2.0%	0.0%	2.5%	1.3%	0.0%	1.1%	2.0%
Hypothyroidism	5.2%	9.1%	0.6%	1.9%	0.0%	1.7%	2.8%
Long COVID	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Tobacco Use	14.4%	4.5%	3.7% ↓	5.8% ↓	11.1%	5.7% ↓	12.7% ↑
Prediabetes	2.0%	4.5%	0.9%	1.1%	0.0%	1.0%	1.3%
Sickle Cell Disease	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%
Traumatic Brain Injury	0.7%	0.0%	1.9%	0.9%	0.0%	0.6%	1.2%
Urinary Tract Infection	1.3%	4.5%	2.2%	1.7%	0.0%	2.1%	2.8%
Feeding Difficulty	0.7%	4.5%	2.2%	0.7%	0.0%	2.1% ↑	0.7% ↓
Inflammatory Bowel Disease	0.0%	0.0%	0.3%	0.2%	0.0%	0.2%	0.6%
Liver Disease	0.7%	9.1%	1.2%	1.5%	0.0%	1.2%	2.7%
Rheumatoid Arthritis	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.4%
Lupus/SLE	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Multiple Sclerosis	0.0%	0.0%	0.3%	0.0%	0.0%	0.1%	0.2%
Chronic Kidney Disease	2.0%	4.5%	0.9%	0.7%	0.0%	1.0%	2.0%

Bold font with red or green shading and an arrow indicates a rate is significantly higher (red ↑) or lower (green ↓) than the remaining population.

Darker shading indicates a greater proportional difference in rates.

Chronic condition prevalence varied across racial and ethnic groups in Barry County. American Indian or Alaska Native enrollees had the highest overall documented prevalence of any chronic condition at 49.7%, followed by White enrollees at 44.0%. White enrollees had a significantly higher overall prevalence than the remainder of the population, while Hispanic enrollees (34.5%) and those in the Other Race category (30.7%) had significantly lower prevalence.

Several condition-specific differences were also evident. White enrollees had significantly higher rates of metabolic risk factors, chronic pain/migraine, COPD, and tobacco use. In contrast, Black, Hispanic, and Other Race enrollees had significantly lower rates of chronic pain/migraine and tobacco use, and Hispanic and Other Race enrollees also had lower rates of metabolic risk factors. Feeding difficulty was significantly higher among the Other Race group and lower among White enrollees.

These patterns may reflect differences in underlying health risk, environmental and social conditions, healthcare access and utilization, and opportunities for conditions to be identified and documented. Lower documented prevalence should therefore not be interpreted as lower health need without additional context. Results for racial and ethnic groups with small population sizes should also be interpreted cautiously.

6.8. Chronic Conditions and Inpatient (IP) Hospitalization Risk

Chronic conditions are associated not only with disease burden but also with healthcare utilization. The following analyses examine the relationship between chronic conditions and inpatient hospitalization during 2025.

Inpatient utilization generally increased as the number of chronic conditions increased. Individuals with no identified chronic conditions averaged approximately 0.2 inpatient days during 2025, with average inpatient days increasing as chronic condition burden increased. The relationship became particularly pronounced among individuals with six or more chronic conditions, with average inpatient utilization exceeding six days among several of the higher-burden groups. Rates were more variable at the highest condition counts, likely reflecting the smaller number of individuals with these levels of multimorbidity. Overall, the pattern indicates a strong relationship between greater chronic condition burden and inpatient utilization in Barry County.

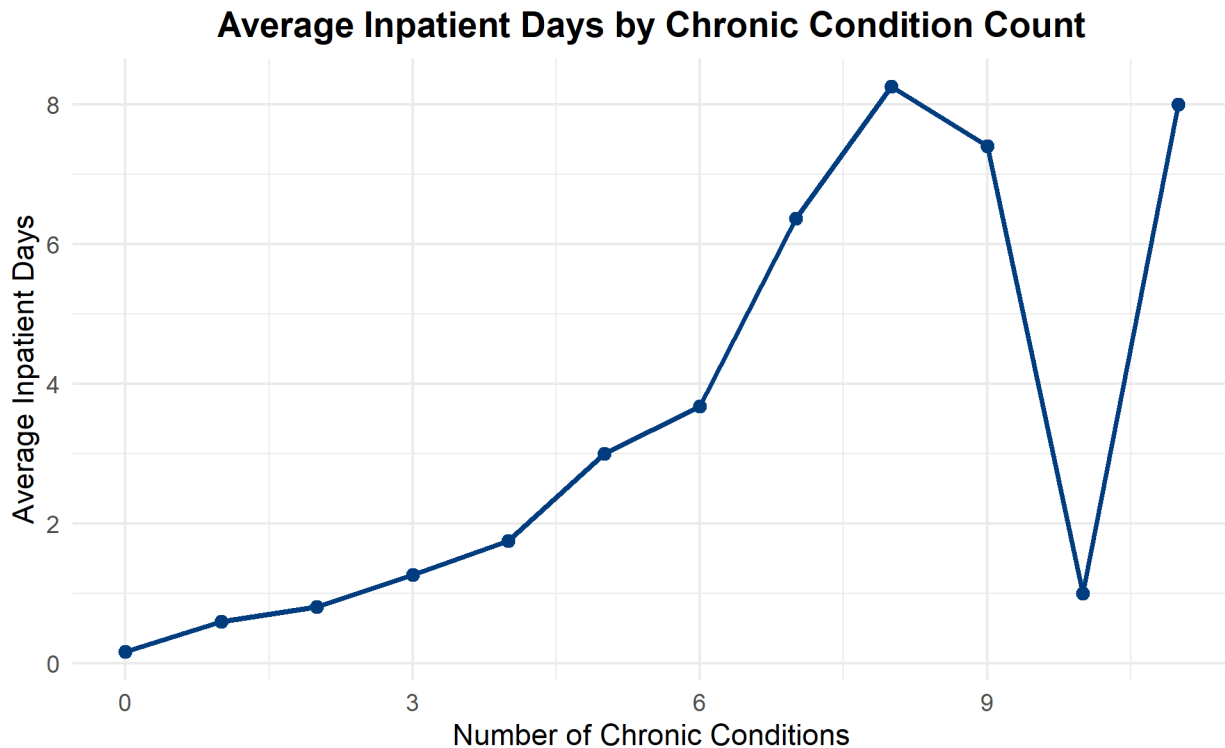


Figure 10: Average number of inpatient days among Medicaid enrollees, by total number of chronic conditions.

To identify which chronic conditions were most strongly and independently associated with inpatient hospitalization, a multivariable logistic regression model was used, predicting any inpatient hospitalization in 2025 from all conditions studied simultaneously. This approach estimates the association between each condition and hospitalization while accounting for the other conditions included in the model (LaValley, 2008).

Results are reported as adjusted odds ratios (ORs). An odds ratio greater than 1 indicates higher odds of hospitalization among individuals with the condition, while an odds ratio below 1 indicates lower odds, after accounting for the other conditions in the model.

Because very large samples can produce statistically significant results even when differences are small, statistical significance should be considered alongside the magnitude of the observed association (Peeters, 2016). For this reason, the table emphasizes conditions with **meaningfully large** associations (odds ratios greater than 1.5 or less than 0.67) rather than relying solely on statistical significance. These thresholds help distinguish conditions that may have greater practical importance for understanding hospitalization risk.

Table 21: Chronic Conditions Associated with Inpatient Hospitalization - Barry County			
Condition	Odds Ratio	95% CI	p-value
Feeding Difficulty	3.31	(2.00 - 5.31)	<0.001
Social Determinants of Health	3.14	(2.53 - 3.89)	<0.001
Epilepsy	2.53	(1.83 - 3.45)	<0.001
Multiple Sclerosis	2.42	(0.79 - 6.84)	0.106
Rheumatoid Arthritis	2.32	(1.06 - 4.78)	0.028
Cardiac Disease	2.10	(1.65 - 2.66)	<0.001
Traumatic Brain Injury	1.93	(1.20 - 3.00)	0.005
GI Functional Disorder	1.92	(1.60 - 2.29)	<0.001
Tobacco Use	1.84	(1.55 - 2.19)	<0.001
Cancer	1.84	(1.31 - 2.56)	<0.001
Urinary Tract Infection	1.82	(1.36 - 2.41)	<0.001
Liver Disease	1.77	(1.32 - 2.36)	<0.001
Vascular Disease	1.66	(1.25 - 2.19)	<0.001
Chronic Kidney Disease	1.65	(1.19 - 2.26)	0.002

Table 21: Chronic Conditions Associated with Inpatient Hospitalization - Barry County

Condition	Odds Ratio	95% CI	p-value
COPD	1.60	(1.24 - 2.06)	<0.001
Metabolic Risk Factors	1.52	(1.28 - 1.79)	<0.001
Inflammatory Bowel Disease	1.37	(0.66 - 2.64)	0.368
Hypothyroidism	1.17	(0.86 - 1.58)	0.298
Asthma	0.99	(0.79 - 1.24)	0.965
Chronic Pain/Migraine	0.86	(0.71 - 1.04)	0.122
Prediabetes	0.79	(0.49 - 1.24)	0.317
Lupus/SLE	0.43	(0.06 - 1.88)	0.318
Sickle Cell Disease	Not estimable	-	-
Long COVID	Not estimable	-	-

Multivariable logistic regression predicting any inpatient hospitalization in 2025, adjusting for all conditions listed simultaneously. OR > 1 indicates increased odds of hospitalization. Bold/colored rows have a meaningfully large odds ratio (>1.5 or <0.67), not just a significant p-value.

Odds ratios and confidence intervals could not be reliably estimated for some very rare conditions because of sparse hospitalization events.

Several chronic conditions remained strongly associated with inpatient hospitalization after accounting for the other conditions included in the model. Feeding difficulty had the largest adjusted association, with more than three times the odds of hospitalization (OR 3.31), followed by documented Social Determinants of Health concerns (OR 3.14) and epilepsy (OR 2.53). Cardiac disease was also associated with more than twice the odds of hospitalization (OR 2.10).

Other conditions with meaningfully elevated hospitalization odds included traumatic brain injury, GI functional disorders, tobacco use, cancer, urinary tract infection, liver disease, vascular disease, chronic kidney disease, COPD, and metabolic risk factors. Together, these findings suggest that inpatient hospitalization risk in Barry County is associated with a broad combination of medical, behavioral, and social complexity rather than a single condition.

The association with Social Determinants of Health is particularly notable. Although SDoH diagnoses do not represent a chronic physical disease, their strong association with hospitalization suggests that documented social and economic needs may help identify individuals at elevated risk for acute healthcare utilization.

While individual conditions provide useful information about hospitalization risk, the preceding analyses also demonstrate the importance of overall disease burden. Many Medicaid enrollees experience multiple chronic and behavioral health conditions simultaneously. Examining these conditions together provides a more complete picture of health complexity and its relationship with healthcare utilization than considering individual diagnoses in isolation.

7. Inpatient and Emergency Department Utilization

Emergency department visits and inpatient hospitalizations represent some of the most intensive forms of healthcare utilization. Examining these patterns helps identify populations with greater healthcare needs and may highlight opportunities for prevention, care coordination, and earlier intervention. This section summarizes inpatient and emergency department utilization during 2025 and examines how utilization varies by age and behavioral health diagnosis group.

7.1. Overview and Methods

Medicaid inpatient and emergency department (ED) encounters during 2025 were analyzed to assess patterns of acute healthcare utilization in Barry County. The analysis included PIHP- and CMH-funded behavioral health inpatient services, including behavioral health state inpatient services, as well as acute medical inpatient and ED services funded by Medicaid Health Plans and Medicaid Fee-for-Service.

ED visits and medical inpatient days with a primary substance use service diagnosis were not available for this report because of 42 CFR Part 2 privacy protections. As a result, ED and medical inpatient utilization among individuals with substance use disorders is underrepresented in the analyses that follow.

For this analysis, an ED visit or inpatient day was classified as behavioral when the principal service diagnosis associated with the claim was behavioral and as medical when it was not. If multiple ED claims were billed on the same day and included both behavioral and medical principal service diagnoses, the visit was counted in both categories.

7.2. Overall Utilization

The following summary provides an overview of medical and behavioral health ED and inpatient utilization during 2025. Percentages represent the proportion of enrollees with at least one visit or inpatient day, while averages reflect utilization across the full Medicaid population, including individuals with no utilization during the year.

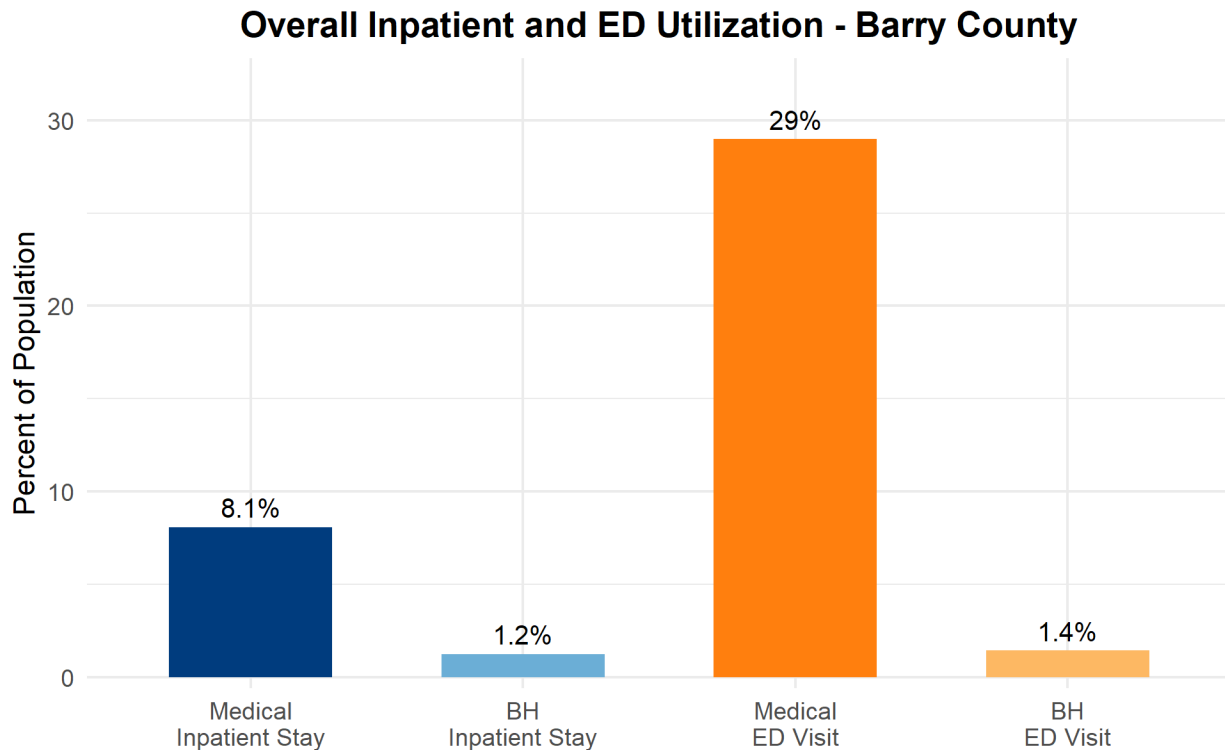


Figure 11: *Percent of Medicaid enrollees with at least one inpatient stay or emergency department visit, by service type, 2025.*

Medical emergency department use was the most common form of acute-care utilization in Barry County, with 29.0% of enrollees having at least one medical ED visit during 2025. In comparison, 8.1% had at least one medical inpatient stay, 1.4% had a behavioral health ED visit, and 1.2% had a behavioral health inpatient stay. Across the full Medicaid population, enrollees averaged 1.95 medical ED visits and 0.07 behavioral health ED visits, along with 7.6 medical inpatient days and 2.15 behavioral health inpatient days.

7.3. Utilization by Age

Patterns of healthcare utilization vary across the lifespan as healthcare needs change with age. The following figures compare average medical and behavioral health ED visits and inpatient days across age groups during 2025.

7.3.1. Emergency Department Visits

The figure below compares average medical and behavioral health ED visits per enrollee across age groups.

Average BH and Medical ED Visits per Person by Age Group

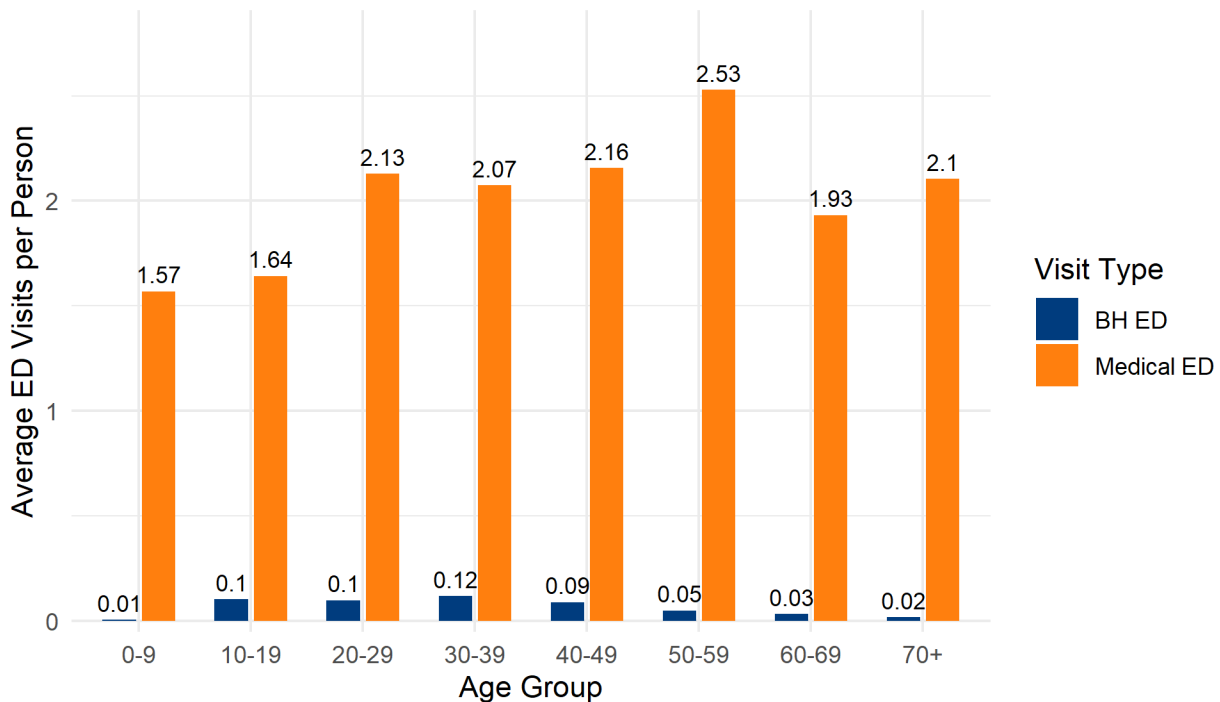


Figure 12: Average number of ED visits per Medicaid enrollee stratified by age group and visit type.

Medical ED utilization increased from childhood through middle adulthood, peaking among adults ages 50–59 at 2.53 visits per person before declining somewhat at older ages. Behavioral health ED utilization was much lower overall and showed a different age pattern, with the highest average rates among adolescents and younger adults. Behavioral health ED visits peaked among ages 30–39 at 0.12 visits per person and then declined steadily with age.

7.3.2. Inpatient Utilization

The figure below compares average medical and behavioral health inpatient days per enrollee across age groups.

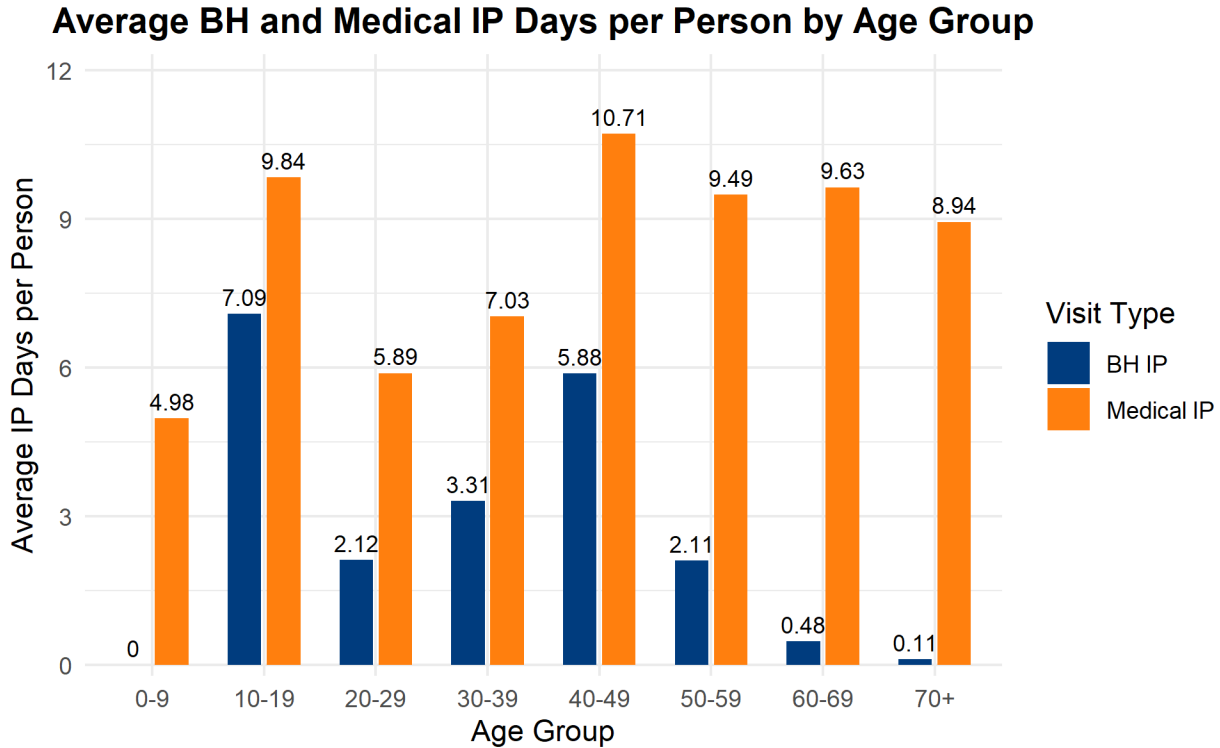


Figure 13: Average number of IP days per Medicaid enrollee stratified by age group and stay type.

Medical inpatient utilization varied across age groups, with the highest average number of medical inpatient days observed among adults ages 40–49 at 10.71 days per person. Medical inpatient days remained relatively high among adults ages 50 and older compared with younger age groups. Behavioral health inpatient utilization followed a different pattern, with the highest average among adolescents ages 10–19 at 7.09 days per person. Behavioral health inpatient days were also elevated among adults ages 30–49 before declining substantially in older age groups.

7.4. Utilization Among Individuals with Behavioral Health Diagnoses

The following analyses examine medical and behavioral health utilization across the primary behavioral health diagnosis groups defined earlier in this report. Trends from 2022 through 2025 show average utilization per enrollee over time, while 2025 age-stratified comparisons help account for differences in age distribution across behavioral health populations.

For the age-stratified comparisons, each behavioral health diagnosis group is compared with enrollees in the same age bracket who had no behavioral health diagnosis. Ratios above 1 indicate higher average utilization than the same-age no-BH-diagnosis comparison group, while ratios below 1 indicate lower utilization.

7.4.1. Medical Emergency Department Visits

The figure and table below show average medical ED visits per enrollee by primary behavioral health diagnosis group from 2022 through 2025. The figure highlights changes over time, while the accompanying table provides the annual values and uses shading to make differences across groups easier to identify.

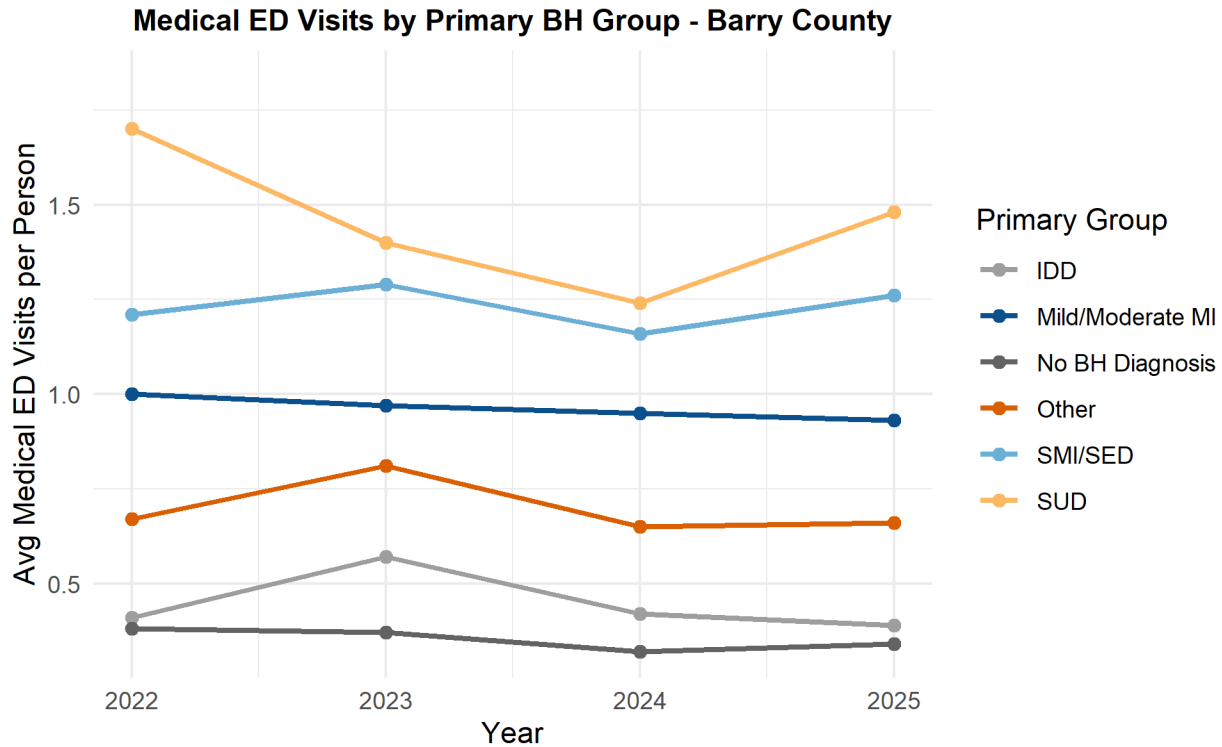


Figure 14: Average medical ED visits per person by primary BH group, 2022-2025.

Table 22. Average Medical ED Visits by Primary BH Group and Year - Barry County

Average visits per person, 2022-2025

Primary BH Group	2022	2023	2024	2025
IDD	0.41	0.57	0.42	0.39
Mild/Moderate MI	1.00	0.97	0.95	0.93
No BH Diagnosis	0.38	0.37	0.32	0.34
Other	0.67	0.81	0.65	0.66
SMI/SED	1.21	1.29	1.16	1.26
SUD	1.70	1.40	1.24	1.48

Medical ED utilization was consistently higher among enrollees with behavioral health diagnoses than among those with no behavioral health diagnosis. In 2025, individuals with SUD had the highest average medical ED utilization at 1.48 visits per person, followed by SMI/SED at 1.26 and Mild/Moderate MI at 0.93. Enrollees with no behavioral health diagnosis averaged 0.34 medical ED visits per person. Utilization patterns were relatively stable from 2022 through 2025, although SMI/SED and SUD remained persistently elevated.

The following table presents age-stratified risk ratios for having at least one medical ED visit in 2025, comparing each behavioral health diagnosis group with enrollees in the same age bracket who had no behavioral health diagnosis.

Table 23. Risk Ratios for Medical ED Visits - Barry County

Risk of 1+ medical ED visits compared with individuals with no BH diagnosis, by age bracket (2025)

Age Bracket	IDD	Mild/Moderate MI	Other	SMI/SED	SUD
0-9	1.29	1.35	1.48	1.90	N/A
10-19	1.39	2.06	1.91	2.82	2.14
20-29	1.23	1.76	0.85	2.25	2.54
30-39	1.00	1.94	1.45	2.23	2.50
40-49	0.85	2.02	4.69	2.45	2.75
50-59	0.81	2.12	3.23	1.99	2.19
60-69	1.73	2.19	2.06	1.46	2.55
70+	0.00	2.49	1.78	2.67	N/A

Risk ratio compares the proportion with at least one utilization event with the same-age No BH Diagnosis group. "N/A" indicates the reference group's risk was 0, so a risk ratio could not be calculated.

The elevated medical ED utilization observed among behavioral health populations generally remained evident when comparing the likelihood of any ED use within the same age groups. SMI/SED and SUD showed elevated risk across most age brackets, although the highest relative risks varied by age. Among adolescents ages 10–19, individuals with SMI/SED were 2.82 times as likely to have at least one medical ED visit as same-age enrollees without a behavioral health diagnosis, while those with SUD were 2.14 times as likely.

Among adults, SUD was consistently associated with elevated medical ED risk, ranging from 2.19 to 2.75 across most age groups. The Other diagnosis group also stood out among adults ages 40–49 and 50–59, with risk ratios of 4.69 and 3.23, respectively. IDD showed a less consistent pattern, with relative risk near or below 1.0 in several adult age groups.

Medical ED utilization among individuals with SUD should be interpreted cautiously because ED services with a primary substance use diagnosis are not fully represented in the available data due to 42 CFR Part 2 restrictions.

7.4.2. Behavioral Health Emergency Department Visits

The figure and table below show average behavioral health ED visits per enrollee by primary behavioral health diagnosis group from 2022 through 2025. The figure highlights changes over time, while the accompanying table provides the annual values and uses shading to make differences across groups easier to identify.

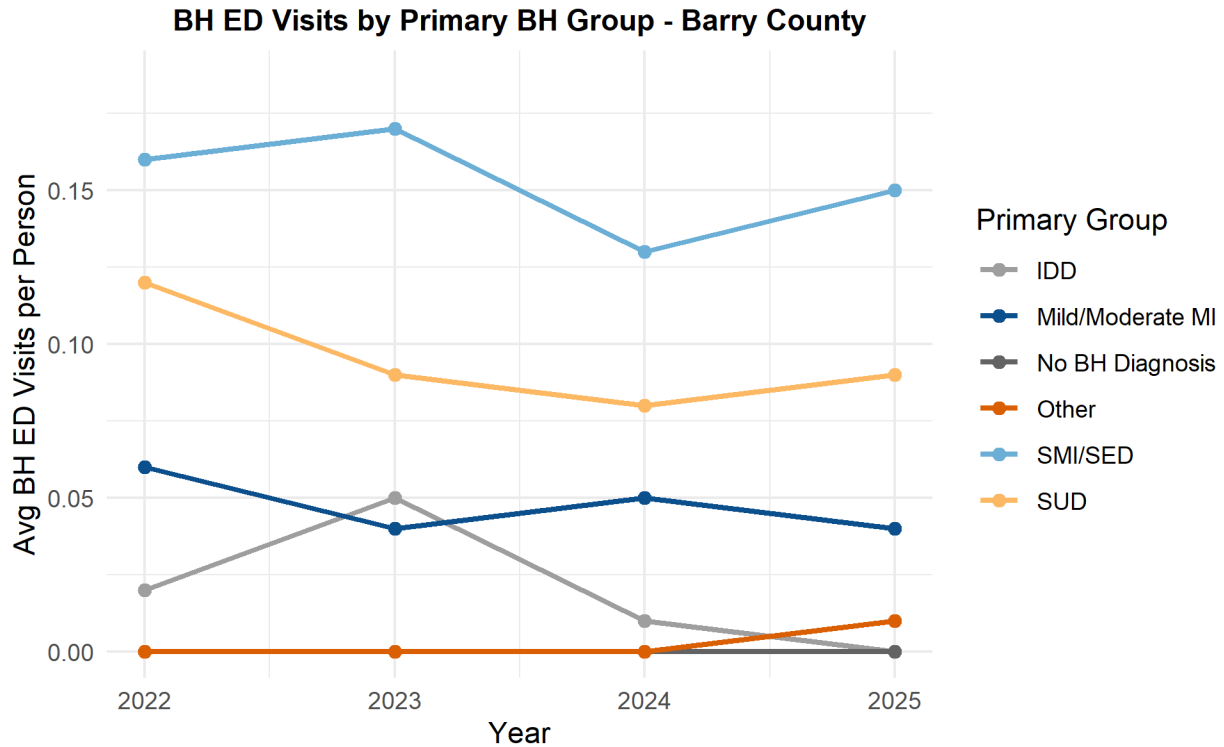


Figure 15: Average BH ED visits per person by primary BH group, 2022-2025.

Table 24. Average BH ED Visits by Primary BH Group and Year - Barry County

Average visits per person, 2022-2025

Primary BH Group	2022	2023	2024	2025
IDD	0.02	0.05	0.01	0.00
Mild/Moderate MI	0.06	0.04	0.05	0.04
No BH Diagnosis	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.01
SMI/SED	0.16	0.17	0.13	0.15
SUD	0.12	0.09	0.08	0.09

Behavioral health ED utilization was concentrated primarily among individuals with SMI/SED and SUD. In 2025, the SMI/SED group had the highest average behavioral health ED utilization at 0.15 visits per enrollee, followed by SUD at 0.09. Utilization was substantially lower among the remaining behavioral health groups and was near zero among individuals without a behavioral health diagnosis. Although behavioral health ED utilization declined slightly among SMI/SED and SUD from 2022 through 2025, both groups remained consistently elevated relative to the other diagnosis groups.

The following table further breaks down 2025 average utilization by age bracket to examine whether differences across primary behavioral health groups are consistent across age groups.

Table 25. Average BH ED Visits by Age Bracket and Primary BH Group - Barry County

Average visits per person, by age bracket (2025)

Age Bracket	IDD	Mild/Moderate MI	No BH Diagnosis	Other	SMI/SED	SUD
0-9	0.00	0.00	0.00	0.00	0.04	
10-19	0.00	0.04	0.00	0.05	0.22	0.00
20-29	0.00	0.05	0.00	0.00	0.19	0.08
30-39	0.00	0.06	0.00	0.00	0.21	0.07
40-49	0.00	0.04	0.00	0.00	0.12	0.15
50-59	0.00	0.03	0.00	0.00	0.09	0.04
60-69	0.00	0.03	0.00	0.00	0.01	0.06
70+	0.00	0.02	0.00	0.00	0.04	

Age-specific patterns show that behavioral health ED utilization was concentrated primarily among individuals with SMI/SED and SUD. SMI/SED had the highest average utilization among adolescents and younger adults, peaking at 0.22 visits per person among ages 10–19 and remaining elevated through ages 30–39. SUD became relatively more prominent in some later age groups, including ages 40–49 and 60–69. In contrast, behavioral health ED utilization was minimal among individuals with no behavioral health diagnosis and generally low among the other diagnosis groups.

Overall, these findings suggest that crisis-oriented behavioral health utilization in Barry County is concentrated among populations with more severe or complex behavioral health needs, although the predominant diagnosis group varies somewhat by age.

7.4.3. Medical Inpatient Utilization

The figure and table below show average medical inpatient days per enrollee by primary behavioral health diagnosis group from 2022 through 2025. The figure highlights changes over time, while the accompanying table provides the annual values and uses shading to make differences across groups easier to identify.

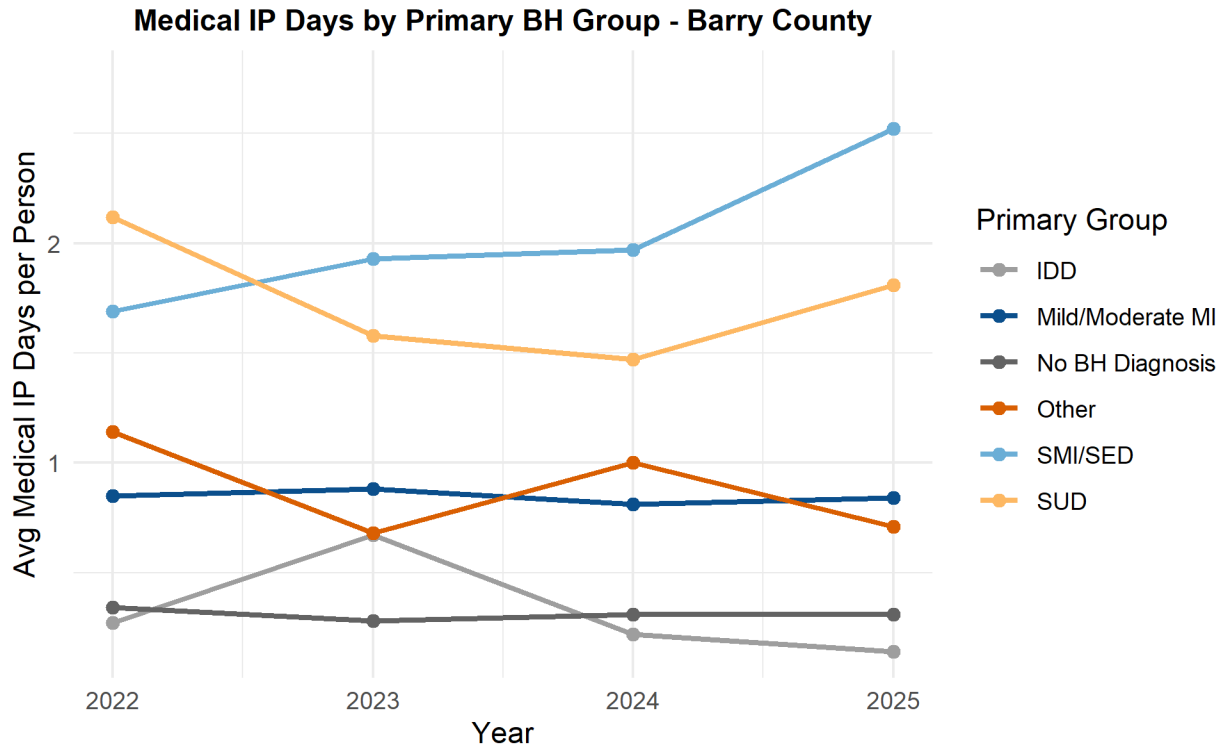


Figure 16: Average medical inpatient days per person by primary BH group, 2022-2025.

Table 26. Average Medical IP Days by Primary BH Group and Year - Barry County

Average days per person, 2022-2025

Primary BH Group	2022	2023	2024	2025
IDD	0.27	0.67	0.22	0.14
Mild/Moderate MI	0.85	0.88	0.81	0.84
No BH Diagnosis	0.34	0.28	0.31	0.31
Other	1.14	0.68	1.00	0.71
SMI/SED	1.69	1.93	1.97	2.52
SUD	2.12	1.58	1.47	1.81

Medical inpatient utilization was consistently higher among enrollees with behavioral health diagnoses than among those without a behavioral health diagnosis. In 2025, individuals with SMI/SED had the highest average medical inpatient utilization at 2.52 days per enrollee, followed by SUD at 1.81 days. Individuals without a behavioral health diagnosis averaged only 0.31 medical inpatient days. Medical inpatient utilization among the SMI/SED group also increased steadily from 1.69 days in 2022 to 2.52 days in 2025.

The following table presents age-stratified risk ratios for having any medical inpatient utilization in 2025, comparing each behavioral health diagnosis group with enrollees in the same age bracket who had no behavioral health diagnosis.

Table 27. Risk Ratios for Medical Inpatient Utilization – Barry County

Compared to individuals with no BH diagnosis, by age bracket (2025)

Age Bracket	IDD	Mild/Moderate MI	Other	SMI/SED	SUD
0-9	0.26	0.17	0.22	1.31	N/A
10-19	3.56	4.63	2.84	15.76	0.00
20-29	0.47	1.99	0.00	4.49	1.74
30-39	0.75	3.15	0.00	4.59	3.48
40-49	0.00	2.85	41.72	4.98	10.23
50-59	0.00	3.38	3.33	2.92	2.77
60-69	5.15	2.21	3.68	2.79	5.31
70+	0.00	4.32	1.92	3.22	N/A

Risk ratio compares the proportion with at least one utilization event with the same age No BH Diagnosis group. "N/A" indicates the reference group's risk was 0, so a risk ratio could not be calculated.

Medical inpatient risk was generally higher among several behavioral health groups when compared with same-age enrollees without a behavioral health diagnosis, although the pattern varied by age and diagnosis group. SMI/SED showed elevated risk from adolescence through older adulthood, while Mild/Moderate MI was also associated with higher inpatient risk across most adult age groups.

SUD showed elevated risk across much of adulthood, with particularly high relative risk among ages 40–49. IDD and the Other diagnosis group showed more variable patterns, with elevated risk concentrated in selected age groups. Overall, the findings indicate that differences in medical inpatient utilization persist within age groups but are not uniform across behavioral health populations.

Very large risk ratios in groups with low baseline hospitalization rates should be interpreted alongside the underlying utilization rates, as relatively small absolute differences can produce large relative differences.

7.4.4. Behavioral Health Inpatient Utilization

The figure and table below show average behavioral health inpatient days per enrollee by primary behavioral health diagnosis group from 2022 through 2025. The figure highlights changes over time, while the accompanying table provides the annual values and uses shading to make differences across groups easier to identify.

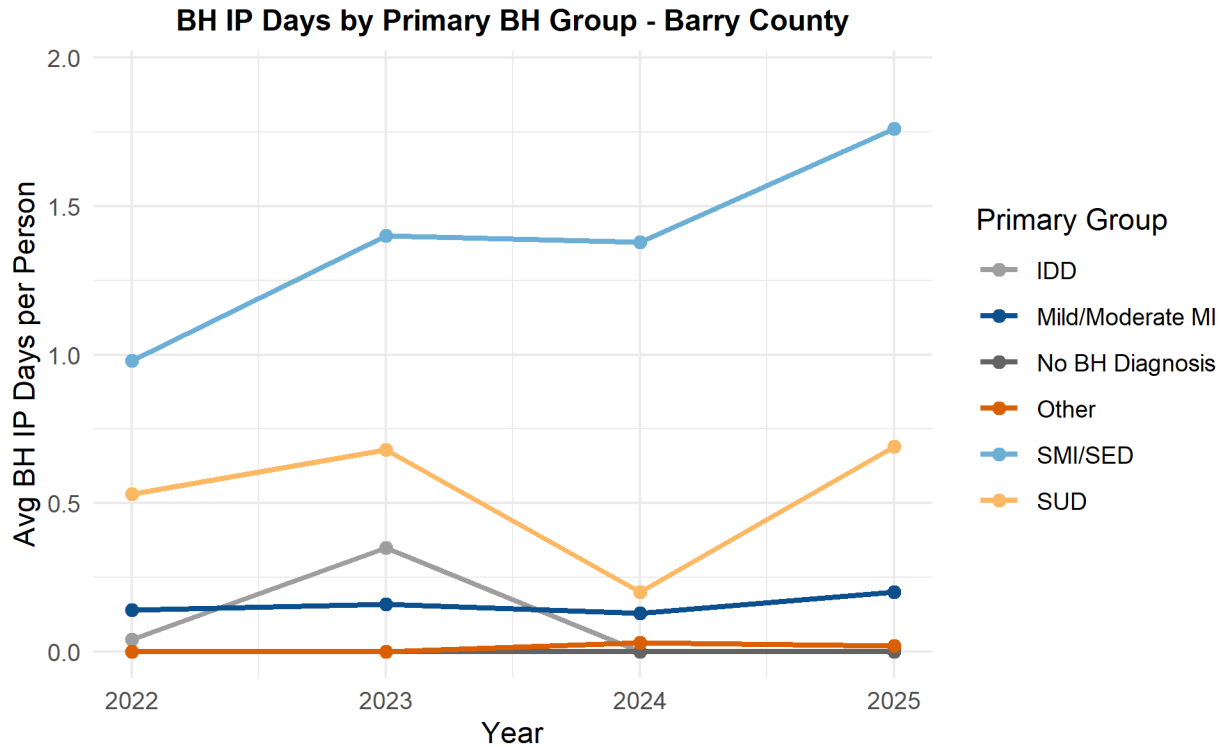


Figure 17: Average BH inpatient days per person by primary BH group, 2022-2025.

Table 28. Average BH IP Days by Primary BH Group and Year - Barry County

Average days per person, 2022-2025

Primary BH Group	2022	2023	2024	2025
IDD	0.04	0.35	0.00	0.00
Mild/Moderate MI	0.14	0.16	0.13	0.20
No BH Diagnosis	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.03	0.02
SMI/SED	0.98	1.40	1.38	1.76
SUD	0.53	0.68	0.20	0.69

Behavioral health inpatient utilization was most heavily concentrated among individuals with SMI/SED. Average behavioral health inpatient days in this group increased from 0.98 per enrollee in 2022 to 1.76 in 2025. SUD had the second-highest utilization in 2025 at 0.69 days per enrollee, while utilization remained substantially lower among the other diagnosis groups.

The following table breaks the 2025 average down further by age bracket, to show whether the relationship between primary BH group and BH inpatient utilization holds consistently across age groups.

Table 29. Average BH IP Days by Age Bracket and Primary BH Group - Barry County

Average days per person, by age bracket (2025)

Age Bracket	IDD	Mild/Moderate MI	No BH Diagnosis	Other	SMI/SED	SUD
0-9	0.00	0.00	0.00	0.00	0.00	
10-19	0.00	0.35	0.00	0.14	2.26	0.00
20-29	0.00	0.13	0.00	0.00	2.27	0.24
30-39	0.00	0.21	0.00	0.00	2.13	0.13
40-49	0.00	0.15	0.00	0.00	2.19	1.81
50-59	0.00	0.24	0.00	0.00	1.48	0.54
60-69	0.00	0.15	0.00	0.00	0.18	0.41
70+	0.00	0.12	0.00	0.00	0.00	

Behavioral health inpatient utilization was concentrated primarily among individuals with SMI/SED and, to a lesser extent, SUD. SMI/SED had the highest average inpatient utilization from adolescence through ages 50–59, with rates remaining around two days per person across much of young and middle adulthood. Utilization declined substantially among older adults.

SUD-related inpatient utilization was more concentrated among working-age adults and was highest among ages 40–49 at 1.81 days per person. In contrast, behavioral health inpatient utilization was minimal among individuals with no behavioral health diagnosis and generally low among the other diagnosis groups.

Overall, the pattern identifies SMI/SED as the group with the most consistently elevated behavioral health inpatient use across age groups in Barry County, while SUD shows a more age-specific pattern concentrated in midlife.

7.5. Medical Emergency Department and Hospital Utilization by Type of Behavioral Health Diagnosis

The analyses above compare utilization across the broader primary behavioral health diagnosis groups used throughout this report. The following figure provides a more detailed view by examining the most common specific behavioral health diagnosis categories.

Average medical ED visits and medical inpatient days are shown together to illustrate how patterns of acute medical utilization differ across behavioral health diagnoses. Diagnosis categories appearing farther to the right have higher average medical ED utilization, while those appearing higher on the figure have higher average medical inpatient utilization.

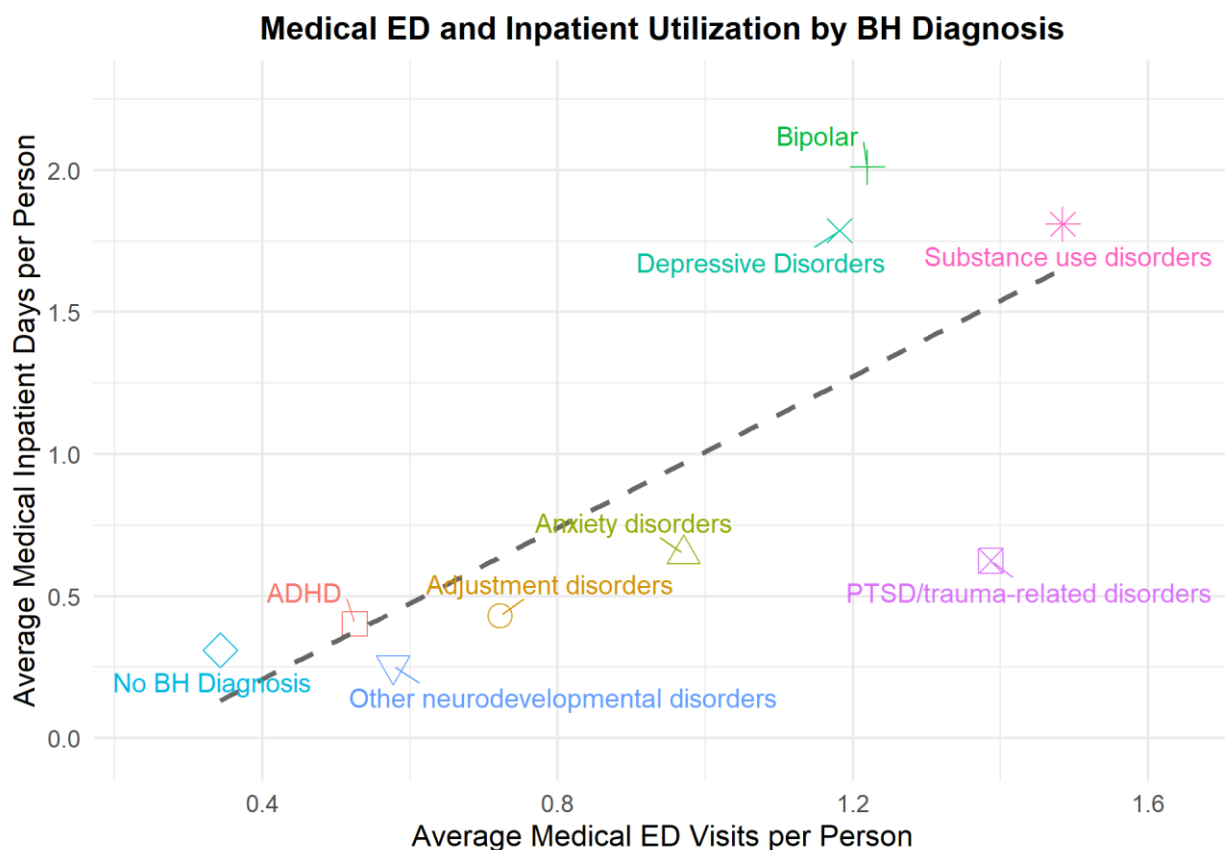


Figure 18: Average medical ED visits and inpatient days per Medicaid enrollee among the most common behavioral health diagnosis categories.

Acute medical utilization differed across behavioral health diagnosis categories in Barry County. Substance use disorders had the highest average medical ED utilization, while bipolar disorder had the highest average medical inpatient utilization. Depressive disorders were also elevated in both measures.

PTSD/trauma-related disorders showed relatively high medical ED utilization but lower inpatient utilization, while anxiety and adjustment disorders had more moderate levels of

acute medical use. Individuals with no behavioral health diagnosis and those with other neurodevelopmental disorders had comparatively low utilization on both measures.

Together, these analyses demonstrate that healthcare utilization varies substantially across behavioral health populations. Differences are evident in both emergency department and inpatient use and persist across multiple years and age groups. The consistently elevated utilization observed among populations with SMI/SED, SUD, and several specific serious behavioral health diagnoses reinforces the importance of integrated medical and behavioral health care, care coordination, and strategies aimed at reducing avoidable acute-care use.

8. Multimorbidity and Hospitalization Risk

8.1. Overview and Methodology

Individuals with multiple chronic and behavioral health conditions often have more complex healthcare needs, making care coordination, resource planning, and prevention efforts more challenging (Skou et al., 2022). Understanding which conditions commonly occur together can help identify groups of individuals with similar healthcare needs and support more targeted interventions.

To better understand these patterns, this report uses **latent class analysis (LCA)**. LCA is a statistical method used to identify unobserved groups within a population based on patterns across multiple observed characteristics (Sinha et al., 2021). Rather than examining one diagnosis at a time, LCA considers an individual's broader pattern of chronic and behavioral health conditions and groups people with similar profiles together. Unlike approaches that require disease combinations to be defined in advance, LCA identifies these patterns directly from the data. LCA has been used in healthcare research to identify patterns of multimorbidity and examine differences in healthcare utilization across the resulting groups (Whitson et al., 2016).

The analysis was conducted once at the regional level using all SWMBH Medicaid enrollees who were ever diagnosed with at least one condition of interest between 2022 and 2025. Based on the overall patterns of co-occurring conditions, six distinct multimorbidity classes were identified:

- **Low Diagnosis Complexity** - Few diagnosed chronic or behavioral health conditions, with no condition strongly elevated relative to the other classes.
- **Metabolic Health Complexity** - Predominantly characterized by metabolic syndrome, with modest elevations in related chronic conditions such as cardiac disease, chronic kidney disease, prediabetes, and tobacco use.
- **Anxiety and Depressive Disorders** - Primarily characterized by elevated anxiety and depressive disorders, with some additional behavioral health conditions but comparatively lower chronic physical health burden.
- **High Chronic Complexity** - Multiple co-occurring chronic physical health conditions, including metabolic, cardiovascular, gastrointestinal, respiratory, kidney, liver, vascular, and chronic pain-related conditions.
- **Neurodevelopmental Disorders & IDD** - Predominantly characterized by ADHD, other neurodevelopmental conditions, impulse control or conduct disorders, and intellectual/developmental disabilities.
- **Complex Behavioral Health** - Multiple co-occurring behavioral health conditions, including anxiety, depression, PTSD, bipolar disorder, substance use disorders, schizophrenia or psychosis, personality disorders, and related conditions.

Every enrollee in the ever-diagnosed 2022–2025 population was assigned to the single class that best matched their overall pattern of diagnoses. Because class assignment was

based on diagnoses accumulated over the full four-year period, the classes represent longer-term health profiles rather than an individual's health status during 2025 alone.

Once each enrollee was assigned to a multimorbidity class, the classes were examined to better understand how common each health profile was within the population and whether different profiles were associated with differences in healthcare utilization. Rather than focusing on individual diagnoses, the following analyses compare groups of individuals with similar overall patterns of chronic and behavioral health conditions.

8.2. Multimorbidity Class Diagnosis Profiles

The figure below illustrates the diagnosis patterns that distinguish the six multimorbidity classes. Each cell represents the estimated probability that an enrollee assigned to a class had a particular chronic or behavioral health condition. Darker shading and higher percentages indicate that the condition was more characteristic of that class. These probabilities describe the profile of each class and should not be interpreted as the percentage of the full Medicaid population with the condition.

The multimorbidity classes and diagnosis profiles shown here were developed using the full SWMBH regional population. The same regional class definitions were then applied in each county report, allowing class distributions and outcomes to be compared consistently across the region. The figure is therefore identical across the regional and county reports, while the class distribution and utilization results that follow are specific to Barry County.

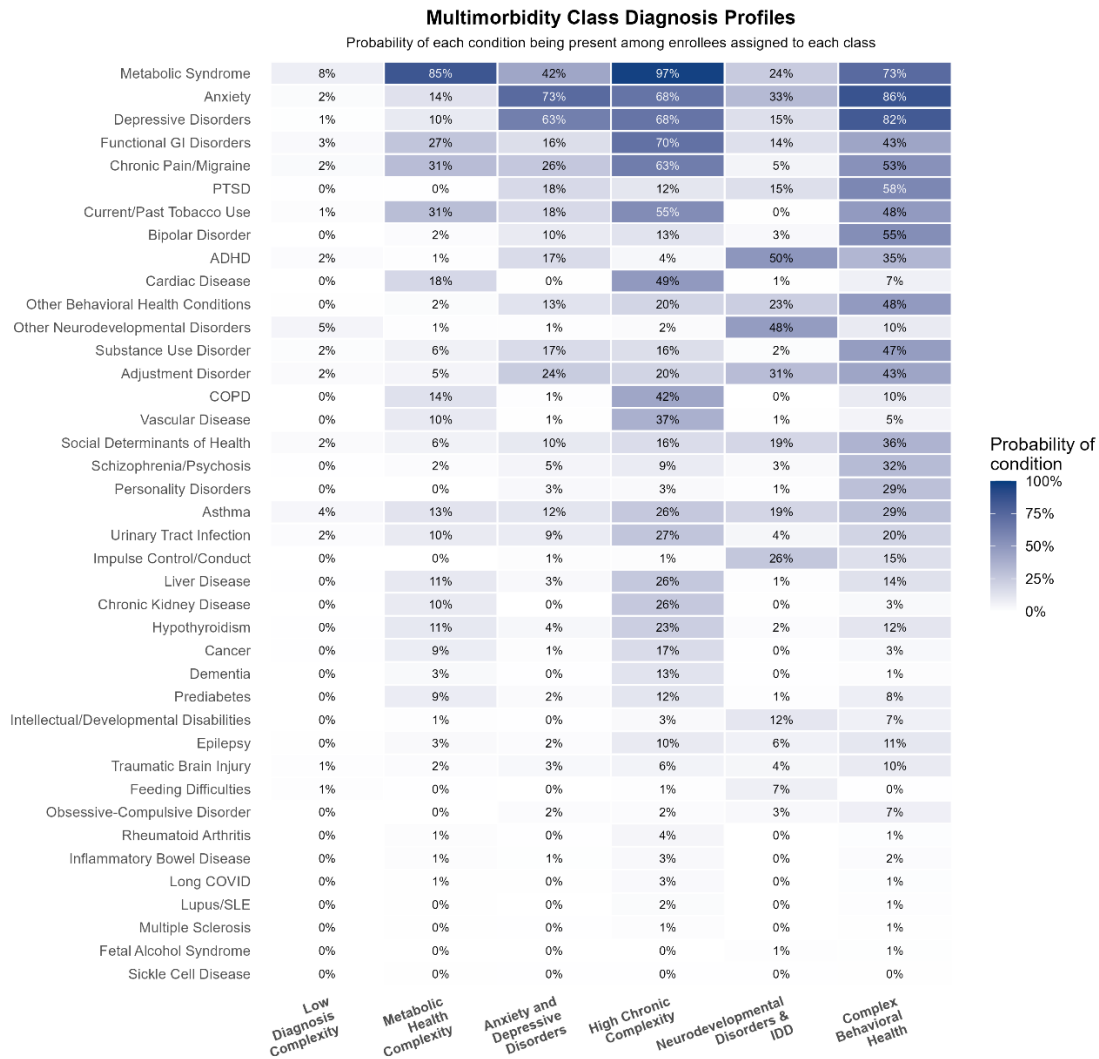


Figure 19: Estimated probability of each condition being present within each regionally defined multimorbidity class.

The six classes reflect distinct patterns of physical and behavioral health complexity. Low Diagnosis Complexity is characterized by relatively low probabilities across nearly all conditions, while Metabolic Health Complexity is dominated by metabolic syndrome and related chronic conditions. Anxiety and Depressive Disorders are distinguished primarily by anxiety and depression with comparatively lower physical health burden. High Chronic Complexity shows broad elevation across multiple physical health conditions, particularly metabolic, cardiac, gastrointestinal, respiratory, kidney, liver, and pain-related diagnoses. Neurodevelopmental Disorders & IDD is characterized by ADHD, other neurodevelopmental conditions, impulse control/conduct disorders, and IDD, while Complex Behavioral Health shows the broadest concentration of co-occurring behavioral health diagnoses, including anxiety, depression, PTSD, bipolar disorder, SUD, schizophrenia/psychosis, and personality disorder.

8.3. Class Distribution and Utilization

The following table summarizes the distribution of multimorbidity classes within the ever-diagnosed Medicaid population and compares department utilization and inpatient utilization across classes. Together, these measures illustrate how overall health complexity is associated with healthcare utilization.

Table 30: Multimorbidity Class Distribution and Utilization - Barry County				
Multimorbidity Class	N	% of Population	ED per 1,000	IP per 1,000
Low Diagnosis Complexity	12,258	54.8%	266.9	269.4
Metabolic Health Complexity	2,577	11.5%	660.7	921.2
Anxiety and Depressive Disorders	3,708	16.6%	655.2	490.3
High Chronic Complexity	1,539	6.9%	1,615.7	2,513.1
Neurodevelopmental Disorders & IDD	1,368	6.1%	627.0	686.8
Complex Behavioral Health	907	4.1%	2,118.9	2,661.1

Ever-diagnosed population, 2022-2025. Utilization rates are annualized averages across each person's active years.

Most individuals in the ever-diagnosed population were classified as Low Diagnosis Complexity (54.8%), while the more clinically complex classes represented substantially smaller portions of the population. Despite their smaller size, the Complex Behavioral Health and High Chronic Complexity classes had markedly higher acute-care utilization than the other multimorbidity groups. Together, these two classes represented 11% of the ever-diagnosed population but had the highest ED and inpatient utilization rates.

The following figure provides a visual summary of the distribution of multimorbidity classes within the Medicaid population.

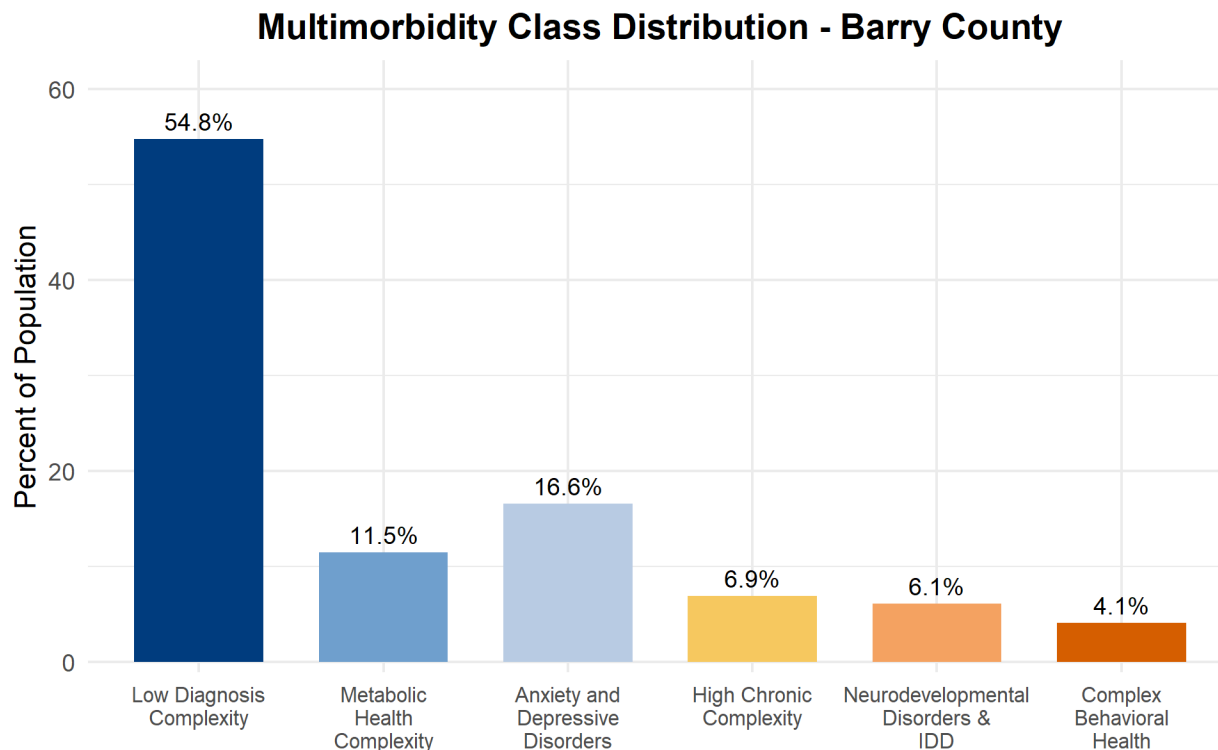


Figure 20: *Percent of the ever-diagnosed population in each multimorbidity class.*

The Complex Behavioral Health and High Chronic Complexity classes may represent particularly important populations for intensive care coordination, transitions-of-care interventions, and strategies addressing co-occurring behavioral and physical health needs.

Comparing emergency department and inpatient utilization across multimorbidity classes helps identify which health profiles are associated with the greatest use of acute healthcare services. The following figure presents annualized utilization rates for each class.

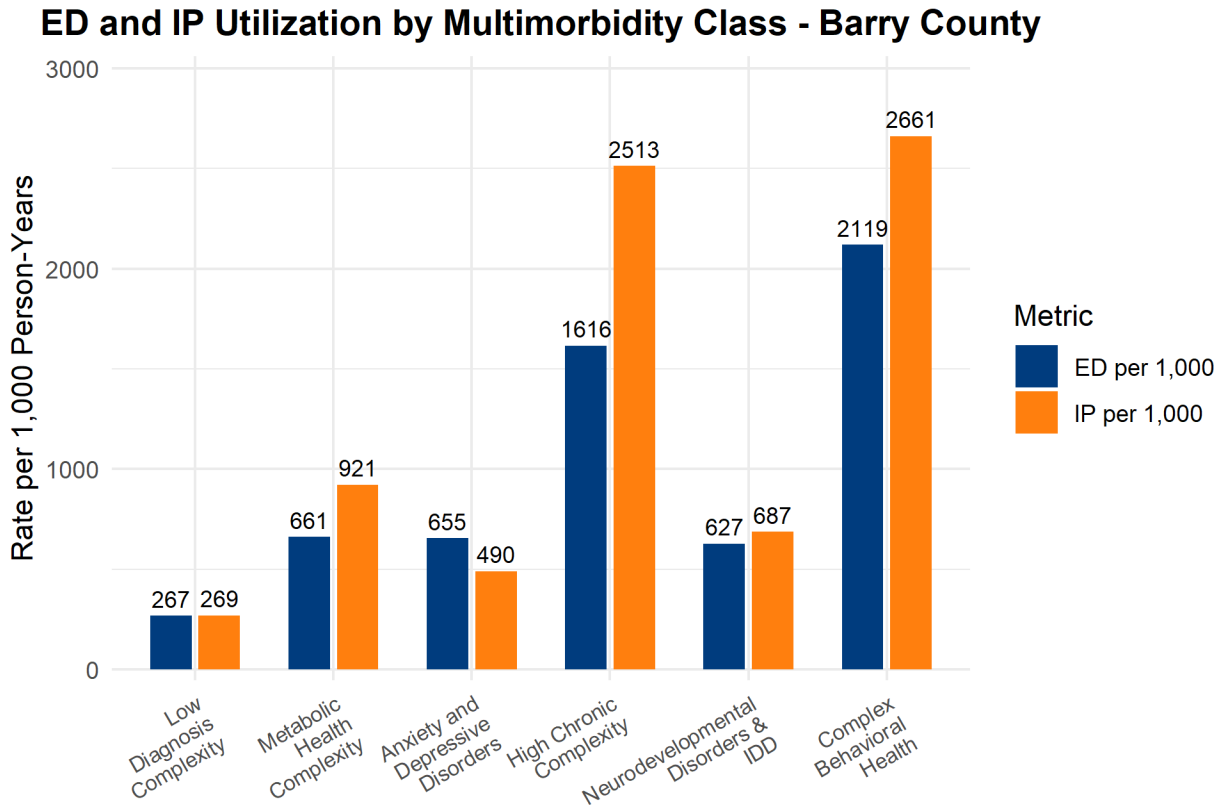


Figure 21: Average ED and IP utilization rates per 1,000 person-years, by multimorbidity class.

Acute-care utilization increased substantially with overall health complexity. Complex Behavioral Health had the highest ED utilization at 2,119 visits per 1,000 person-years and the highest inpatient utilization at 2,661 per 1,000 person-years. High Chronic Complexity had similarly elevated inpatient utilization at 2,513 per 1,000 person-years. In contrast, Anxiety and Depressive Disorders and Neurodevelopmental Disorders & IDD had considerably lower inpatient utilization despite representing clinically important populations.

Together, these findings demonstrate that examining patterns of co-occurring chronic and behavioral health conditions provides additional insight beyond individual diagnoses alone. The multimorbidity classes identify distinct populations with different combinations of acute-care utilization and healthcare needs and may support more targeted population health planning and care-management strategies.

9. Healthcare Quality and Medication Monitoring

9.1. Disease Management Metrics

Monitoring adherence to evidence-based clinical guidelines helps identify opportunities to improve healthcare quality and prevent avoidable complications. This section summarizes selected adult disease management measures reported through the Relias Population Performance platform. These measures evaluate whether eligible Medicaid enrollees received recommended monitoring or treatment for selected conditions.

Measure direction varies across the analyses in this section. For disease management measures, higher percentages generally indicate better adherence to recommended care. Medication utilization rates are descriptive and do not have an inherently favorable direction. For pharmacy quality indicators, lower triggering rates are generally preferable because higher rates indicate that a greater proportion of individuals met criteria for a situation warranting clinical review. Specific interpretation guidance is provided with each analysis. Individuals dually eligible for Medicare and Medicaid are excluded because complete Medicare claims were not available for this analysis.

Table 31. Adult Disease Management Metric Completion - Barry County

Percent completed, 2025

Metric ID	Quality Metric	SWMBH	Barry
343	Presence of at least 84 days of continuous treatment with an Antidepressant medication	62.7%	77.8%
515	Adherence to Mood Stabilizer medications for individuals with bipolar disorder	55.6%	53.6%

Barry County performed above the SWMBH regional rate for continuous antidepressant treatment, with 77.8% meeting the measure compared with 62.7% regionally. For adherence to mood stabilizer medications among individuals with bipolar disorder, Barry County's rate was slightly below the regional rate (53.6% vs. 55.6%). These results suggest stronger performance on antidepressant continuity, while mood stabilizer adherence may warrant continued monitoring.

9.2. Behavioral Pharmacy Analysis

Medication use and medication management are important components of behavioral healthcare quality. The following analyses summarize behavioral health medication utilization, pharmacy quality indicators, and associations between pharmacy quality indicators and hospitalization among adults and children.

9.2.1. Adults

9.2.1.1. Adult General Behavioral Pharmacy Use Data

The following table summarizes behavioral health medication utilization among adults in 2025 and compares Barry County with the overall SWMBH region. Medication utilization rates are descriptive and should not be interpreted as measures in which a higher or lower percentage necessarily represents better performance. Differences may reflect variation in diagnoses, clinical need, prescribing practices, or other population characteristics.

Table 32. Adult Behavioral Health Medication Utilization - Barry County

Percent utilizing, 2025

Medication Class	SWMBH	Barry
Opioids	4.2%	4.3%
Insomnia Agents	3.0%	3.9%
ADHD: Stimulants	2.8%	4.2%
Antipsychotics	5.5%	6.0%
Antidepressants	14.5%	18.9%
Antidepressants: SSRIs	8.7%	11.9%
Mood Stabilizers	2.7%	3.3%
Benzodiazepines	3.4%	3.4%
ADHD Medication	3.3%	4.7%
Antidepressants: TCAs	1.2%	1.4%

Antidepressants were the most commonly utilized behavioral health medication class among adults in Barry County, with 18.9% receiving an antidepressant and 11.9% receiving an SSRI. Antipsychotics were used by 6.0% of adults, while ADHD medications were used by 4.7% and stimulants by 4.2%. Insomnia agents, mood stabilizers, opioids, benzodiazepines, and TCAs each had utilization rates below 5%.

Compared with the SWMBH region overall, Barry County had higher utilization across several medication classes, including antidepressants, SSRIs, ADHD medications, stimulants, insomnia agents, antipsychotics, and mood stabilizers. Benzodiazepine use was the same as the regional rate, while opioid use was very similar.

9.2.1.2. Adult Quality Indicator Triggering Rates

Pharmacy quality indicators identify medication-related situations that may warrant additional clinical review. For these measures, lower triggering rates are generally preferable because a higher percentage indicates that more individuals met the criteria for a potential medication-management concern. Triggering an indicator does not, however, confirm inappropriate care for any individual.

Table 33. Adult Pharmacy Quality Indicator Triggering Rates - Barry County

Percent triggered, 2025

Metric ID	Quality Metric	SWMBH	Barry
214	Failure to Refill Antipsychotic Medication	11.2%	9.1%
217	Use of four or more psychotropic medications for 60 or more days	3.5%	4.8%
231	Use of Opioids and Benzodiazepines for 30 or More Days	35.3%	18.6%
283	Multiple prescribers of the same class of psychotropic medications for 45 or more days	3.9%	4.9%

Among adults in Barry County, the most common pharmacy quality indicator was concurrent use of opioids and benzodiazepines for 30 or more days, which triggered for 18.6% of the population evaluated for that measure. Failure to refill antipsychotic medication triggered for 9.1% of adults, while 4.8% triggered the indicator for use of four or more psychotropic medications for 60 or more days and 4.9% triggered the indicator for multiple prescribers of the same class of psychotropic medications for 45 or more days.

Compared with the SWMBH regional population, Barry County had a lower rate of concurrent opioid and benzodiazepine use and a lower rate of failure to refill antipsychotic medication, but somewhat higher rates for the indicators involving four or more psychotropic medications and multiple prescribers of the same medication class. These patterns may help identify areas for additional clinical review, although a higher triggering rate should not be interpreted on its own as evidence of inappropriate prescribing.

9.2.1.3. Adult Hospitalization Rates by Quality Indicator

The following table compares hospitalization rates among adults with and without each pharmacy quality indicator. Rates are expressed per 100 individuals, and relative risks compare each quality indicator group with adults who triggered no pharmacy quality indicators.

Table 34. Adult Hospitalization Rates by Pharmacy Quality Indicator - Barry County

Hospitalizations per 100, with risk ratio vs. no QIs triggered (2025)

Metric ID	Quality Indicator	N	% of Population	Total / 100	RR - Total	BH / 100	RR - BH	Non-BH / 100	RR - Non-BH
1	No QIs Triggered	5,528	95.2%	8.8	Ref.	1.0	Ref.	7.9	Ref.
2	1+ QIs Triggered	280	4.8%	35.0	3.96 ↑	9.3	9.52 ↑	25.7	3.27 ↑
515	Adherence to Mood Stabilizer medications for individuals with bipolar disorder	24	0.4%	50.0	5.65 ↑	29.2	29.89 ↑	20.8	2.64 ↑
231	Use of opioids and benzodiazepines for 30 or more days	19	0.3%	15.8	1.79 ↑	0.0	0.00 ↓	15.8	2.01 ↑
343	Presence of at least 84 days of continuous treatment with an Antidepressant medication	156	2.7%	9.0	1.02	1.9	1.95 ↑	7.1	0.90
214	Failure to refill antipsychotic medication within 30 days of the prescription ending	31	0.5%	45.2	5.11 ↑	25.8	26.41 ↑	19.4	2.47 ↑
217	Use of four or more psychotropic medications for 60 or more days	48	0.8%	29.2	3.30 ↑	16.7	17.10 ↑	12.5	1.59 ↑
283	Multiple prescribers of the same class of psychotropic medications for 45 or more days	70	1.2%	27.1	3.06 ↑	11.4	11.67 ↑	15.7	2.00 ↑

Shading with an arrow identifies meaningfully elevated (red ↑, RR > 1.20) or lower (green ↓, RR < 0.83) risk ratios. "Ref." indicates the no-QI reference group.

Adults who triggered at least one pharmacy quality indicator experienced substantially higher hospitalization rates than those who triggered none. Individuals with one or more indicators had 35.0 hospitalizations per 100 people, compared with 8.8 per 100 among adults with no indicators, corresponding to nearly four times the overall hospitalization risk. Elevated risk was observed for both behavioral health and non-behavioral health hospitalizations.

Several individual indicators were also associated with markedly elevated hospitalization risk. The mood stabilizer indicator had the strongest association with behavioral health hospitalization, with nearly 30 times the risk observed among adults with no quality indicators. This likely reflects the underlying severity and complexity of bipolar disorder

among individuals prescribed these medications, rather than an effect of adherence itself. Failure to refill antipsychotic medication, use of four or more psychotropic medications, and multiple prescribers of the same psychotropic medication class were also associated with substantially elevated behavioral health hospitalization risk. Concurrent opioid and benzodiazepine use showed a different pattern, with no behavioral health hospitalizations observed in this group but approximately twice the non-behavioral health hospitalization risk of the reference population.

These findings do not establish that the medication-related indicators caused hospitalization. Rather, the indicators may identify individuals with greater clinical complexity, medication-management challenges, or care-coordination needs who are also at elevated risk for acute-care utilization.

9.2.2. Children and Adolescents

The same pharmacy analyses were performed for children and adolescents. Because medication recommendations and quality indicators differ between pediatric and adult populations, separate results are presented below.

9.2.2.1. Child General Behavioral Pharmacy Use Data

The following table summarizes behavioral health medication utilization among children and adolescents. As with the adult analysis, medication utilization rates are descriptive and do not have an inherently favorable higher or lower direction.

Table 35. Pediatric Behavioral Health Medication Utilization - Barry County

Percent utilizing, 2025

Medication Class	SWMBH	Barry
Opioids	0.4%	0.4%
Insomnia Agents	0.5%	0.9%
ADHD: Stimulants	5.4%	6.8%
Antipsychotics	1.6%	1.8%
Antidepressants	3.1%	5.0%
Antidepressants: SSRIs	2.6%	4.0%
Mood Stabilizers	0.6%	0.8%
Benzodiazepines	0.3%	0.4%
ADHD Medication	6.1%	7.8%
Antidepressants: TCAs	0.2%	0.1%

ADHD medications were the most commonly utilized behavioral health medication class among children and adolescents in Barry County, with 7.8% receiving an ADHD medication and 6.8% receiving a stimulant. Antidepressants were used by 5.0% of the pediatric population, including 4.0% receiving an SSRI, while antipsychotics were used by 1.8%. Compared with the SWMBH region overall, Barry County had higher utilization across most behavioral health medication classes, particularly ADHD medications, stimulants, antidepressants, and SSRIs.

9.2.2.2. Child Quality Indicator Triggering Rates

Pediatric pharmacy quality indicators identify medication-related situations that may warrant additional clinical review. Lower triggering rates are generally preferable for each of the indicators presented below; however, triggering an indicator does not by itself indicate inappropriate prescribing or care.

Table 36. Pediatric Pharmacy Quality Indicator Triggering Rates - Barry County

Percent triggered, 2025

Metric ID	Quality Metric	SWMBH	Barry
214	Failure to Refill Antipsychotic Medication	10.0%	13.4%
283	Multiple prescribers of the same class of psychotropic medications for 45 or more days	1.6%	1.6%
301	Use of Antipsychotic Medication for Member Under the Age of 18 Diagnosed with ADHD	49.8%	46.5%

Pediatric quality indicator triggering rates varied substantially by measure. The most common indicator in Barry County was antipsychotic use among children diagnosed with ADHD, which triggered for 46.5% of the eligible population. Failure to refill antipsychotic medication triggered for 13.4%, while multiple prescribers of the same psychotropic medication class triggered for 1.6%. Compared with the SWMBH region, Barry County had a higher rate of failure to refill antipsychotic medication, the same rate of multiple prescribers, and a somewhat lower rate of antipsychotic use among children diagnosed with ADHD. As with the adult measures, these indicators identify situations that may warrant review and should not be interpreted as evidence of inappropriate care without additional clinical context.

9.2.2.3. Child Hospitalization Rates by Quality Indicator

The following table compares hospitalization rates across pediatric pharmacy quality indicator groups using the same methodology described for adults.

Table 37. Pediatric Hospitalization Rates by Pharmacy Quality Indicator - Barry County

Hospitalizations per 100, with risk ratio vs. no QIs triggered (2025)

Metric ID	Quality Indicator	N	% of Population	Total / 100	RR - Total	BH / 100	RR - BH	Non-BH / 100	RR - Non-BH
1	No QIs Triggered	4,122	98.6%	3.2	Ref.	0.5	Ref.	2.6	Ref.
2	1+ QIs Triggered	59	1.4%	18.6	5.90 ↑	10.2	20.02 ↑	8.5	3.21 ↑
283	Multiple prescribers of the same class of psychotropic medications for 45 or more days	7	0.2%	28.6	9.07 ↑	28.6	56.14 ↑	0.0	0.00 ↓
214	Failure to refill antipsychotic medication within 30 days of the prescription ending (any diagnosis)	10	0.2%	20.0	6.34 ↑	20.0	39.26 ↑	0.0	0.00 ↓
301	Use of Antipsychotic Medication for Member Under the Age of 18 Diagnosed with ADHD	38	0.9%	18.4	5.83 ↑	5.3	10.40 ↑	13.2	4.99 ↑

Shading with an arrow identifies meaningfully elevated (red ↑, RR > 1.20) or lower (green ↓, RR < 0.83) risk ratios. "Ref." indicates the no-QI reference group.

Children and adolescents who triggered at least one pharmacy quality indicator had substantially higher hospitalization rates than those who triggered none. The overall hospitalization rate was 18.6 per 100 among children with one or more indicators compared with 3.2 per 100 among those with none, corresponding to nearly six times the hospitalization risk. Elevated risk was observed for both behavioral health and non-behavioral health hospitalization.

Multiple prescribers of the same psychotropic medication class was associated with the highest overall hospitalization rate at 28.6 per 100, followed by failure to refill antipsychotic medication at 20.0 per 100. All three pediatric indicators were associated with markedly higher behavioral health hospitalization risk. These large risk ratios should be interpreted alongside the underlying hospitalization rates and small numbers of children triggering some indicators, as low baseline rates and small groups can produce large relative differences.

Across both adults and children, pharmacy quality indicators identified relatively small populations with substantially higher hospitalization rates. Among adults in Barry County, individuals triggering at least one indicator experienced nearly four times the overall hospitalization risk of those triggering none; among children and adolescents,

hospitalization risk was nearly six times as high. Although these associations do not establish that medication-related concerns caused hospitalization, the indicators may help identify individuals with greater clinical complexity, medication-management challenges, or care-coordination needs.

Together, these quality measures provide additional context regarding medication management, adherence to recommended care, and populations that may benefit from further clinical review. They complement the diagnosis, utilization, and multimorbidity findings presented earlier in the report.

10. Conclusion

This Population Health Analysis brings together information on demographics, behavioral and chronic health conditions, healthcare utilization, multimorbidity, and healthcare quality to provide a broad view of the health needs of Medicaid enrollees in Barry County. Examining these topics together provides a more complete understanding of local population health than considering individual diagnoses or services in isolation.

Findings demonstrate that Barry County has several population health patterns that differ from the broader SWMBH region. Behavioral health diagnoses and chronic health conditions were both more prevalent overall, with particularly notable differences in anxiety, depressive disorders, ADHD, tobacco use, chronic pain/migraine, GI functional disorders, and asthma. At the same time, Barry County's PIHP/CMH-served population had higher independent-living rates and lower documented unhoused and dependent-living rates than the remainder of the region.

Trends from 2022 through 2025 provide additional context for understanding changing needs. Although Medicaid enrollment declined from 15,626 in 2024 to 13,333 in 2025, the percentage of enrollees receiving at least one Medicaid service increased from 78.6% to 83.0%. Behavioral health and chronic condition prevalence also increased in 2025 after remaining comparatively stable in prior years. These patterns may indicate that the 2025 Medicaid population was more concentrated among individuals with ongoing healthcare needs, while increased healthcare contact may also have contributed to greater identification and documentation of health conditions.

The analysis also demonstrates substantial overlap between behavioral and physical health complexity. Individuals with behavioral health diagnoses, dual-eligible adults, and those with multiple co-occurring conditions generally experienced greater chronic disease burden and higher acute-care utilization. The Complex Behavioral Health and High Chronic Complexity multimorbidity groups were relatively small but had the highest emergency department and inpatient utilization, while SMI/SED and SUD populations also showed persistently elevated acute-care use across multiple analyses.

Healthcare quality analyses identified additional opportunities for monitoring and clinical review. Barry County performed above the regional rate for continuous antidepressant treatment, while pharmacy quality indicators identified small adult and pediatric populations with substantially elevated hospitalization risk. These indicators may be useful for identifying individuals with greater clinical complexity or care-coordination needs, although the observed associations do not establish causation.

This report is intended to support local population health planning, quality improvement, resource allocation, and further analysis. Findings should be interpreted alongside local knowledge of service availability, access to care, population characteristics, and documentation practices. Observed associations and statistically significant differences can identify areas that warrant attention but do not, by themselves, explain why those differences occurred.

Overall, the analysis provides a foundation for identifying priority populations in Barry County, developing strategies responsive to local patterns of need, and monitoring changes in health conditions, healthcare utilization, and quality over time.

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