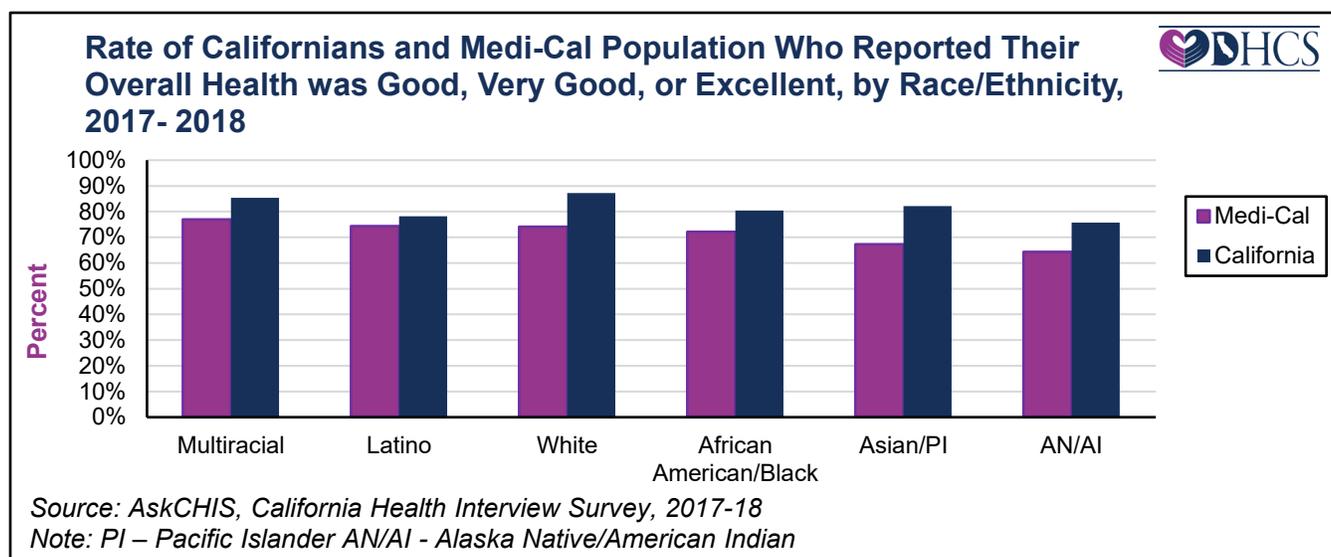## Acknowledgements/Contributors

Overall Health Status

Self-rated overall health status has been shown to be a strong predictor of morbidity and mortality.[1-2] Research indicates a strong relationship between poor self-rated health status and the onset of chronic conditions such as stroke, arthritis, heart disease, diabetes, and lung disease.[2] Poor self-rated health status has also been associated with risk factors for chronic disease (e.g. smoking and mental distress).[3] Self-rated health is valid across different races and ethnicities thereby allowing for comparisons of overall health between these groups.[4] Understanding disparities in self-rated overall health status can be useful in guiding intervention and prevention strategies in order to improve health status and avert more serious consequences.[5]

In California, Whites were more likely to report that their overall health status was good, very good, or excellent (87.2%), while in the Medi-Cal population the Multiracial group had the highest rate (76.9%). Regardless of race/ethnicity, the Medi-Cal population reported lower rates than the California population.

Figure

Rate of Californians and Medi-Cal Population Who Reported Their Overall Health was Good, Very Good, or Excellent, by Race/Ethnicity, 2017- 2018

Source: AskCHIS, California Health Interview Survey, 2017-18
Note: PI – Pacific Islander AN/AI - Alaska Native/American Indian

Link to Overall Health Status 2013 Fact Sheet

1. Bamia C, Orfanos P, Juerges H, et al. Self-rated health and all-cause and cause-specific mortality of older adults: Individual data meta-analysis of prospective cohort studies in the CHANCES Consortium. *Maturitas*. 2017;103:37-44.
2. Latham K, Peek CW. Self-rated health and morbidity onset among late midlife U.S. adults. *J Gerontol B Psychol Sci Soc Sci.* 2013;68(1):107-116.
3. Rohrer, JE, Arif A, Denison A, Young R, Adamson S. Overall self-rated health as an outcome indicator in primary care. *J Eval Clin Pract*. 2007;13(6):882-888.
4. Allen CD, McNeely CA, Orme, JG. Self-rated health across race, ethnicity, and immigration status for US adolescents and young adults. *J Adolesc Health*. 2016; 58(1):47-56.
5. Centers for Disease Control and Prevention (CDC). *Health-Related Quality of Life (HRQOL)*. October 31, 2018. http://www.cdc.gov/hrqol/concept.htm. Accessed July 20, 2020.
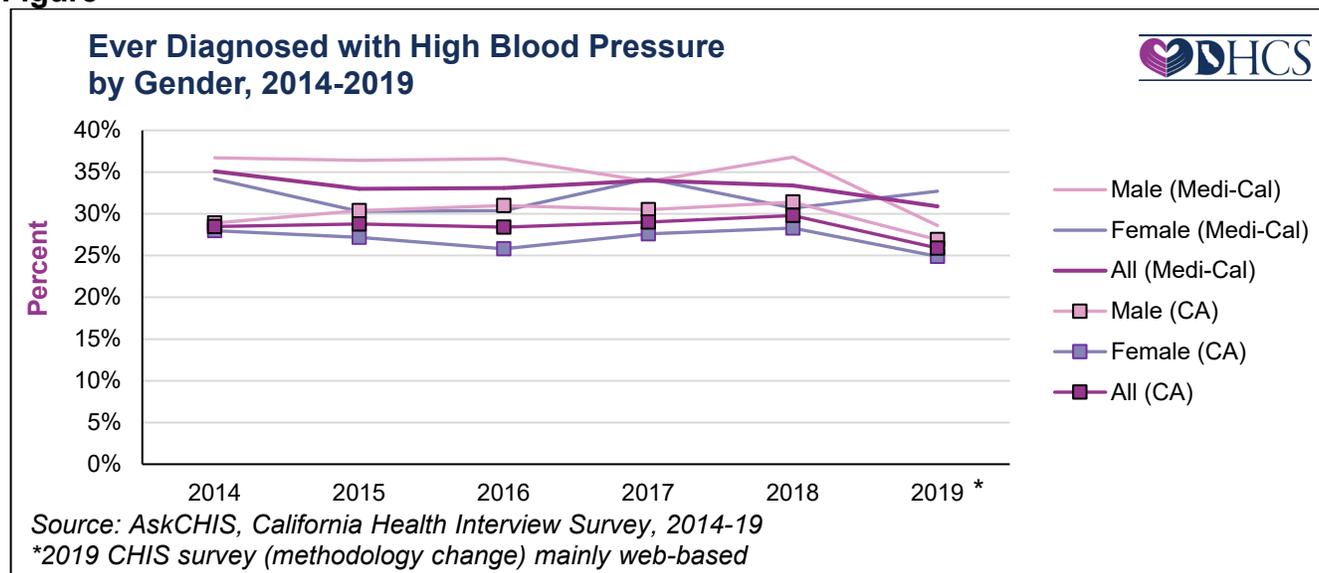
Link to Data Sources and Methods

Hypertension by Gender

Hypertension, or high blood pressure (HBP), increases the risk for two of the leading causes of death in the United States, heart disease and stroke.[1] HBP is often coined the "silent killer" as it does not have symptoms and can only be diagnosed by being measured.[2] Men tend to have a higher prevalence of HBP than women until menopause, after which women's rate of HBP increases and eventually surpasses that of men.[2-3] Women also experience specific types of HBP, such as pregnancy HBP and post-menopausal HBP, which are leading causes of morbidity and mortality for these groups.[3] Research has also found that men have less awareness of having HBP than women.[3] It is important to understand these disparities as it can help inform efforts to increase awareness and control of HBP.[4]

In 2019, the rate of ever being diagnosed with HBP was 25.9% for California and 30.9% for the Medi-Cal population. From 2014 to 2019, California females had the lowest rates of all the groups (see Figure). Medi-Cal males have consistently reported the highest rates of all the groups, except for a drop in 2017 and 2019 in which Medi-Cal females slightly surpassed Medi-Cal males. Regardless of the year, the Medi-Cal population had higher rates of ever being diagnosed with HBP than the California population.

Figure

Ever Diagnosed with High Blood Pressure by Gender, 2014-2019

Source: AskCHIS, California Health Interview Survey, 2014-19
*2019 CHIS survey (methodology change) mainly web-based

1. Centers for Disease Control and Prevention. High Blood Pressure. https://www.cdc.gov/bloodpressure/about.htm. Published May 19, 2020. Accessed August 20, 2020.
2. Ramirez LA, Sullivan JC. Sex differences in hypertension: Where we have been and where we are going. *Am J Hypertens*. 2018;31(12):1247-1254. doi:10.1093/ajh/hpy148.
3. Reckelhoff, Jane F. Gender differences in hypertension. *Curr Opin Nephrol Hypertens*. 2018:27(3):176-181. doi: 10.1097/MNH.0000000000000404.
4. Balfour PC Jr, Rodriguez CJ, Ferdinand KC. The role of hypertension in race-ethnic disparities in cardiovascular disease. *Curr Cardiovasc Risk Rep*. 2015;9(4):18. doi:10.1007/s12170-015-0446-5.
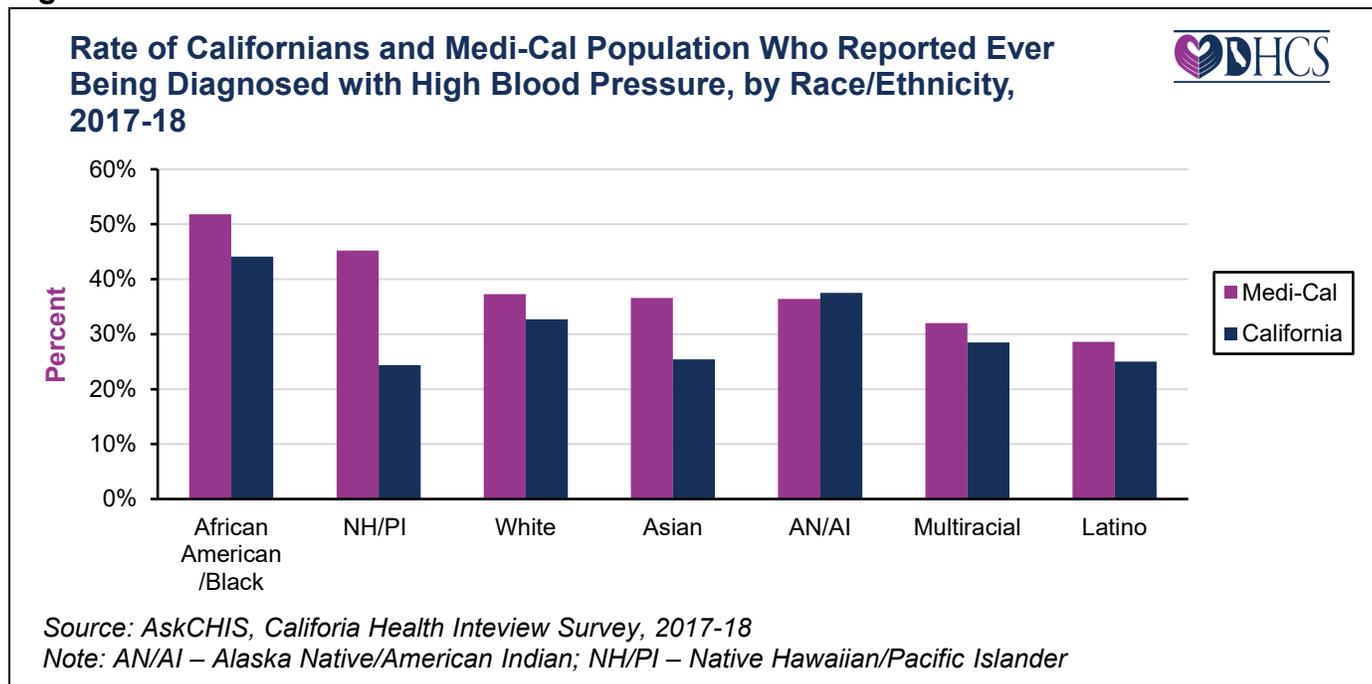
Link to Data Sources and Methods

Hypertension by Race/Ethnicity

Hypertension, or high blood pressure (HBP), increases the risk for other health conditions, such as cardiovascular disease and chronic kidney disease.[1] HBP often has no symptoms, and it can only be caught by being measured.[1] Research has found that in the United States, HBP prevalence is highest among African Americans/Blacks, and related morbidity and mortality risks are higher for African Americans/Blacks than for Whites.[2-4] Hispanics and Asians have varying prevalence of HBP that is often similar to or less than that of Whites, but controlled HBP is highest among Whites.[2-3] Understanding these disparities can allow for concentrated efforts to increase awareness and control of HBP in these groups.[5]

In both the California and Medi-Cal population, African Americans/Blacks were more likely to report ever being diagnosed with HBP (44.1%; 51.8%, respectively), (see Figure). The Medi-Cal population reported higher rates of being diagnosed with HBP than the general California population for every race/ethnicity except AN/AI.

Figure

Rate of Californians and Medi-Cal Population Who Reported Ever Being Diagnosed with High Blood Pressure, by Race/Ethnicity, 2017-18

Source: AskCHIS, Califoria Health Inteview Survey, 2017-18
Note: AN/AI – Alaska Native/American Indian; NH/PI – Native Hawaiian/Pacific Islander

1. Centers for Disease Control and Prevention. High Blood Pressure. https://www.cdc.gov/bloodpressure/about.htm. Published May 19, 2020. Accessed August 20, 2020.
2. Ostchega Y, et al.. Hypertension prevalence among adults aged 18 and over: United States, 2017-2018. NCHS data brief, no 364. Hyattsville, MD: National Center for Health Statistics. 2020.
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4. Lackland DT. Racial differences in hypertension: implications for high blood pressure management. *Am J Med Sci*. 2014;348(2):135-138. doi:10.1097/MAJ.0000000000000308.
5. Balfour PC Jr, Rodriguez CJ, Ferdinand KC. The Role of Hypertension in Race-Ethnic Disparities in Cardiovascular Disease. *Curr Cardiovasc Risk Rep*. 2015;9(4):18. doi:10.1007/s12170-015-0446-5.

Link to Data Sources and Methods

Health Maintenance Organizations

In the past few decades, managed care has become the main payment model for health care in many parts of the United States.[1] More than 70 million Americans have been enrolled in Health Maintenance Organizations (HMOs), a type of managed care plan.[1] HMOs have a network of providers that treat patients for a pre-paid cost, with goals of improved care coordination, lower costs, and increased emphasis on preventative care.[2] The evidence also supports that managed care plans are successful in reducing health disparities. For instance, research has found HMOs to be effective in minimizing racial and ethnic disparities in rates of mammography.[4]

In California, African Americans/Blacks were more likely to report being in an HMO, while in the Medi-Cal population, Asians/Pacific Islanders were most likely (see Figure). Data from 2011-2012 also showed that African Americans/Blacks reported being in an HMO at the highest rates and Whites reported at the lowest rates in California (see Health Maintenance Organization 2013). Regardless of race/ethnicity, the Medi-Cal population reported higher rates of being in an HMO than the general California population.

Figure

Rate of People in California and Medi-Cal in Health Maintanence Organizations by Race/Ethnicity, 2017-2018

Source: AskCHIS, California Health Interview Survey, 2017-18.
Note: PI – Pacific Islanders; AN/AI - Alaska Native/American Indian
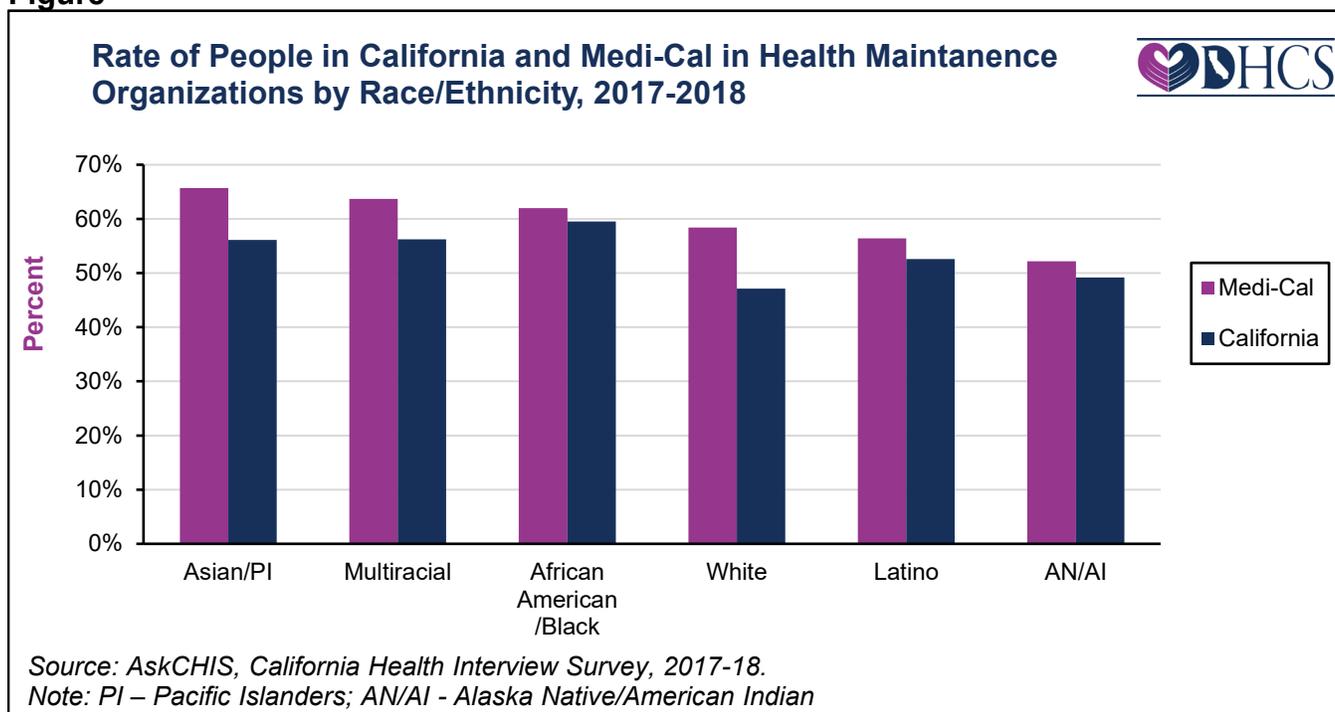
Link to Health Maintenance Organizations 2013 Fact Sheet

1. Cauchi R. Managed Care, Market Reports and the States. https://www.ncsl.org/research/health/managed-care-and-the-states.aspx. Published July 7, 2017. Accessed August 30, 2020.
2. Falkson SR, Srinivasan VN. Health Maintenance Organization (HMO). In: StatPearls. Treasure Island (FL): StatPearls Publishing; May 2, 2020.
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Link to Data Sources and Methods

Smoking Prevalence By Insurance

While smoking prevalence has declined over the years, it remains a costly national and state public health issue. 1 in 5 deaths each year in the United States (U.S.) is attributed to smoking, and California has the largest number of smokers in U.S.[1] The U.S. economic cost of smoking is estimated at more than $300 billion in direct health care costs and lost productivity.[2] In California, smoking-attributable illnesses are 11% of Medi-Cal medical expenditures.[3] Research has shown higher rates of smoking among those in Medicaid and those uninsured, and in some cases, these smoking rates are more than twice that of adults with private health insurance.[4]

Smoking is a risk factor for various chronic diseases and cancers; however, quitting can mitigate and in some cases eliminate these health risks.[1] Research has found that while many smokers want to quit, it takes multiple quit attempts before being successful.[1] However, those who are able to quit smoking before age 40 decrease their risk of dying from smoking-related diseases by 90%.[5]

In 2019, the smoking rate for Californian adults was 7%, compared to 10% for the Medi-Cal population. From 2011 to 2019, the adult smoking rates were highest among those without insurance, except in 2016 and 2018 when the Medi-Cal group had the highest rate.

Figure

California Smoking Rates Among Adults, by Insurance Type for 2011-2019

Source: AskCHIS, California Health Interveiew Survey, 2014-19
*2019 CHIS survery (methodology change) mainly web-based

1. California Department of Public Health, California Tobacco Control Program, *California Tobacco Facts and Figures, 2018*, Sacramento, CA: California Department of Public Health, 2018.
2. Jamal A, et al. Current cigarette smoking among adults — United States, 2005–2014. MMWR Morb Mortal Wkly Rep 2015;64:1233-1240.
3. Department of Health Care Services. *Quitting Smoking Just Got Easier for Medi-Cal Members.* 2013. https://www.dhcs.ca.gov/individuals/Documents/MIQS%20Patient%20Flyers/MIQS_News_Release_9-30-13.pdf. Published Sept 13, 2020. Accessed Aug. 26, 2020.
4. Centers of Disease Prevention and Control. *Smoking Rates for Uninsured and Adults on Medicaid more than Twice those for Adults with Private Health Insurance.* https://www.cdc.gov/media/releases/2015/p1112-smoking-rates.html. Accessed Aug. 8, 2020.
5. Jha P, Ramasundarahettige C, Landsman V, et al. 21st Century hazards of smoking and benefits of cessation in the United States. New England JN of Med, 2013;368(4):341-50.

Link to Data Sources and Methods
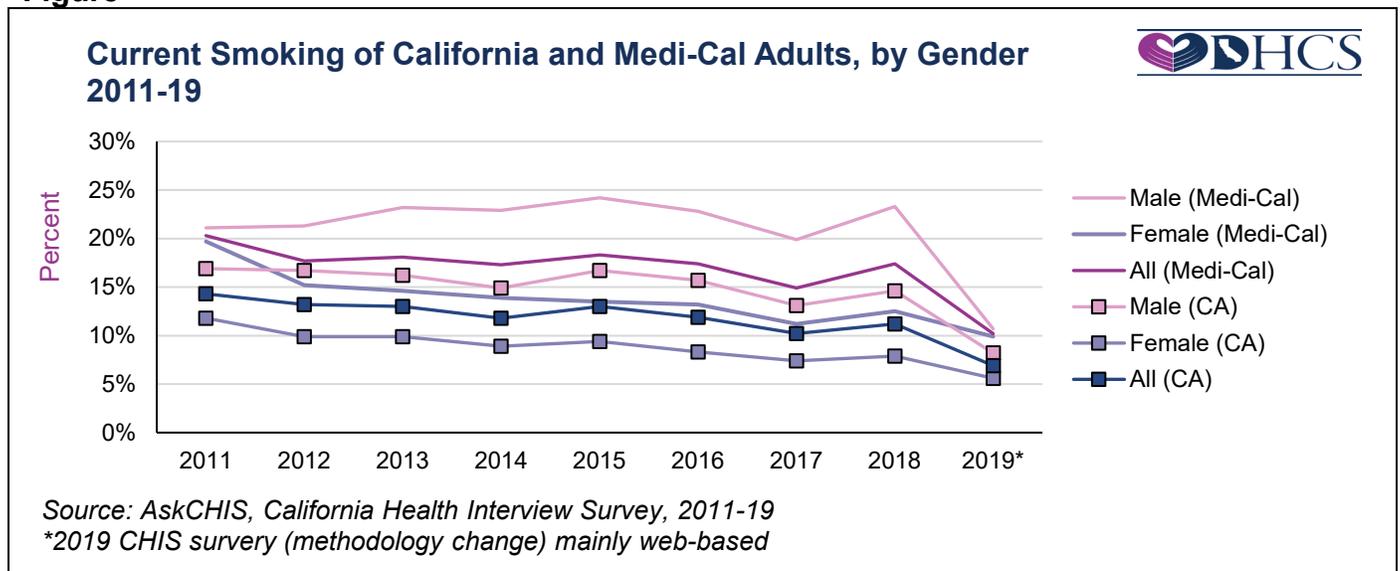
Smoking Prevalence by Gender

Smoking remains a national and state public health issue, with 1 in 5 deaths each year in the United States (U.S.) attributed to smoking,[1] and the number of Californian smokers at close to 4 million, exceeding the entire populations of 21 U.S. states.[2] In California, tobacco is one of the leading causes of mortality and morbidity.[4] Smoking in the U.S. causes 87% of lung cancer deaths, 32% of coronary heart deaths, and 79% of all cases of chronic obstructive pulmonary diseases (COPD).[1] However, quitting before the age of 40 can reduce the risk of dying from a smoking-related disease by about 90%.[5]

There continues to be a gender difference in smoking rates, with men reporting higher rates than women (5-10% difference).[3] Over the past 50 years, women's risk of smoking related diseases has increased, and now more women are dying from COPD than men.

In 2019, the smoking rate for California was 7%, while it was 10% for the Medi-Cal population. Males consistently had higher smoking rates than their female counterparts in both the Medi-Cal and the general California population regardless of the year.

Figure

Current Smoking of California and Medi-Cal Adults, by Gender 2011-19

Source: AskCHIS, California Health Interview Survey, 2011-19
*2019 CHIS survery (methodology change) mainly web-based

1. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Accessed Jan 2017.
2. California Department of Public Health, California Tobacco Control Program, *California Tobacco Facts and Figures, 2015*, Sacramento, CA: California Department of Public Health, 2015.
3. California Department of Public Health, California Tobacco Control Program, *California Tobacco Facts and Figures, 2016*, Sacramento, CA: California Department of Public Health, 2016.
4. Department of Health Care Services. *Quitting Smoking Just Got Easier for Medi-Cal Members.* 2013. https://www.dhcs.ca.gov/individuals/Documents/MIQS%20Patient%20Flyers/MIQS_News_Release_9-30-13.pdf. Accessed Aug. 26, 2020.
5. Centers for Disease Control and Prevention. Tobacco-related mortality. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality/index.htm. Published May 15, 2017. Accessed April 20 2018.

Link to Data Sources and Methods
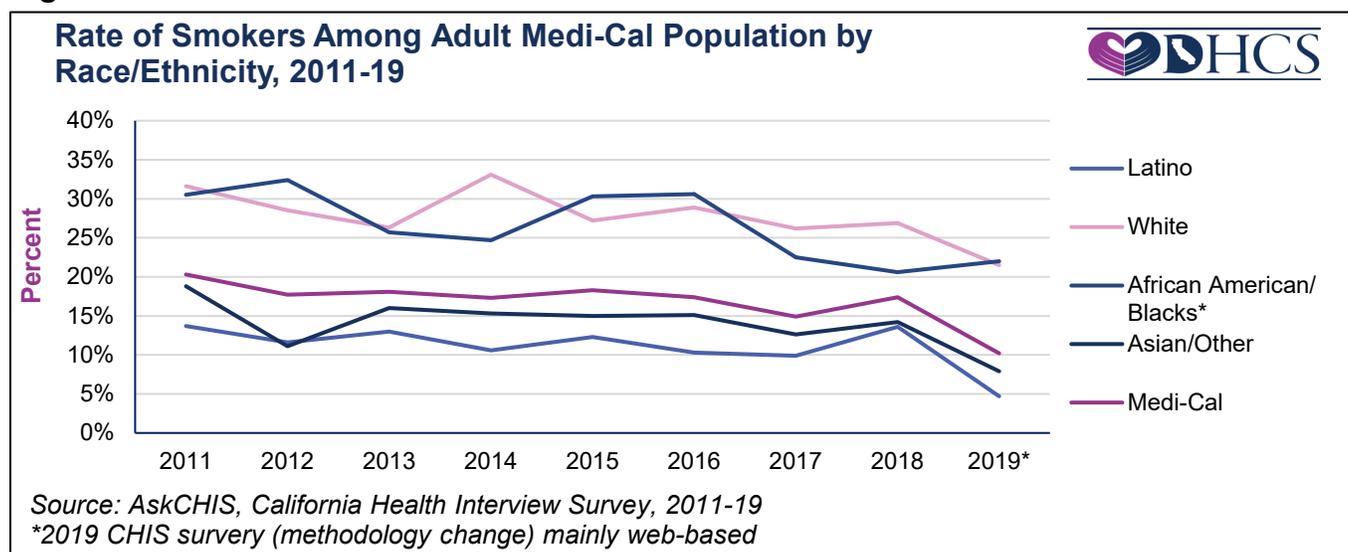
Smoking Prevalence by Race/Ethnicity

Smoking prevalence continues to be a national public health issue, with 1 in 5 deaths each year in the United States (U.S.) attributed to smoking.[1] 10 times as many people in the U.S. have died from smoking as have in all U.S. wars.[1] Smoking increases the risk of coronary heart disease (2-4 times), stroke (2-4 times), and lung cancer (25-25.7 times).[2]

Smoking in California continues to be a public health issue, with the number of Californian smokers at close to 4 million, a figure which exceeds the entire population of 21 U.S. states.[3] From 1998 to 2014, the smoking prevalence in California declined by 51%.[4] However, tobacco remains the leading cause of mortality and morbidity in California.[2] When looking at racial/ethnic differences, the data shows that African Americans/Blacks and Native Americans have higher smoking rates compared to other race/ethnicities.[3]

In 2018, the smoking rate for California was 11.2%, while it was 17.4% for the Medi-Cal population. From 2011 to 2018, in the Medi-Cal population, there were racial/ethnic smoking differences, with Whites and African Americans/Blacks having higher rates and Latinos having the lowest rate regardless of the year (see Figure).

Figure

Rate of Smokers Among Adult Medi-Cal Population by Race/Ethnicity, 2011-19

Source: AskCHIS, California Health Interview Survey, 2011-19
*2019 CHIS survery (methodology change) mainly web-based

1. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Accessed January 4, 2017.
2. Centers for Disease Control and Prevention. Smoking and Tobacco. Health Effects of Cigarettes. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm. Published May 15, 2017. Accessed January 5, 2017.
3. California Department of Public Health, California Tobacco Control Program, *California Tobacco Facts and Figures, 2015*, Sacramento, CA: California Department of Public Health, 2015.
4. California Department of Public Health, California Tobacco Control Program, *California Tobacco Facts and Figures, 2016*, Sacramento, CA: California Department of Public Health, 2016.

Link to Data Sources and Methods

Smoking Cessation By Gender

Smoking cessation efforts have succeeded in lowering the prevalence of smoking in the United States (U.S.), [1] and in California, which decreased by 57% between 1988 to 2017 (24% to 10%).[2] However, smoking continues to be a national and state public health issues with 1 in 5 deaths annually in the U.S. attributed to smoking and the number of California smokers exceeding the population of 23 U.S. states.[2] Smoking prevalence continues to vary by gender with men reporting higher smoking rates than women.[2]

Smoking is associated with various health risks, including heart disease, lung cancer, and stroke,[1] although quitting can decrease people's disease risk.[3] Research has indicated that if no one smoked then one of every three cancer deaths in the U.S. would not happen.[3]

Among smokers, cessation efforts were mostly higher for Medi-Cal adults than California adults. Smoking cessation efforts among Medi-Cal adults varied by gender and decreased over time.

Figure

Thinking about Quitting Smoking Among Medi-Cal Adults by Gender, 2013-19

Quit Attempts in the Past Year Among Medi-Cal Adults by Gender, 2013-19

Source: AskCHIS, California Health Interview Survey, 2011-19
*In 2017 the rate for males was statistically unstable
**2019 CHIS survey (methodology change) mainly web-based

1. U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Accessed Jan 2017.
2. California Department of Public Health, California Tobacco Control Program, *California Tobacco Facts and Figures, 2019*, Sacramento, CA: California Department of Public Health, 2019.
3. Centers for Disease Control and Prevention. Health Effects of Cigarette Smoking. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/. Published Apr. 28, 2018. Accessed Aug. 24 2018.

Link to Data Sources and Methods
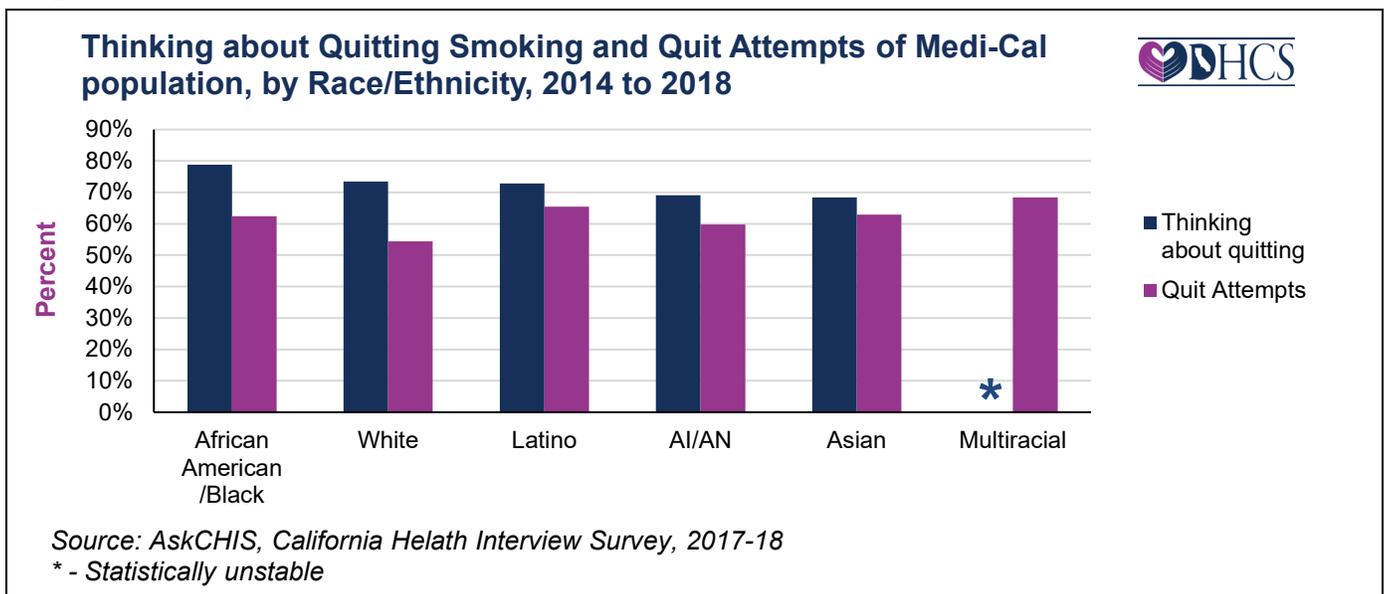
Smoking Cessation By Race/Ethnicity

National and state smoking cessation programs have been successful at decreasing smoking prevalence in the United States (U.S.) and California. However, smoking prevalence continues to be a national and state public health issue, with 1,300 deaths a day in the U.S. attributed to smoking[2] and California being the state with the highest amount of adult smokers.[1] The rate of smoking varies by race/ethnicity in California with higher rates among American Indians/Alaska Natives and African Americans/Blacks and lower rates among Hispanics and Asians/Pacific Islanders.[2]

Smoking is a risk factor for various chronic diseases, heart disease, and lung cancer; however, quitting can mediate and, in some cases, eliminate these health risks.[2] African Americans/Blacks have reported higher rates of wanting to quit than others groups.[3] Those who are able to quit smoking before age 40 decrease their risk of dying from smoking-related diseases by 90%.[4]

For Medi-Cal adults, rates were higher for thinking about quitting in the next six months than making a quit attempt. Also, African Americans/Blacks reported the highest rates of thinking about quitting both in Medi-Cal and California in general. There were not enough people in the Native Hawaiian/Pacific Islander group to report their rates (see figure).

Figure

Thinking about Quitting Smoking and Quit Attempts of Medi-Cal population, by Race/Ethnicity, 2014 to 2018

Source: AskCHIS, California Helath Interview Survey, 2017-18
* - Statistically unstable

1. California Department of Public Health, California Tobacco Control Program, *California Tobacco Facts and Figures, 2016*, Sacramento, CA: California Department of Public Health, 2016.
2. U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Accessed Jul 27 2018.
3. Centers for Disease Control and Prevention. Quitting smoking among adults- United States, 2001-2010. MMWR, 2011;60(44):1513-9. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6044a2.htm . Accessed Aug 3 2018.
4. Jha P, Ramasundarahettige C, landsman V, et al. 21st Century hazards of smoking and benefits of cessation in the United States. New England JN of Med, 2013;368(4):341-50.

Link to Data Sources and Methods

Chlamydia Screening by Race/Ethnicity

Chlamydia trachomatis is the most common sexually transmitted infection in the United States (US) with over 1.7 million cases reported to the Centers for Disease Control and Prevention in 2018.[1] In California, the chlamydia infection rate is highest among women aged 15 to 24.[2] Notably, the majority of cases are asymptomatic; thus, the true burden of chlamydia infection is underestimated.[3] In 2014, the US Preventive Services Task Force updated its previous recommendation on chlamydia screening for all sexually active females who are 24 years or younger and reserved screening for women 25 and older based on behavior risk criteria.[4] The Family Planning, Access, Care and Treatment (Family PACT) Program updated policy according to this recommendation and continually monitors chlamydia-screening rates within the Program.

In Fiscal Year (FY) 2018-19, 71% of sexually active women aged 24 years and younger had at least one chlamydia screening test in the Family PACT Program. In women aged 24 and under, African American/Black women had the highest chlamydia screening rate (75%) with Hispanics (70%) having the lowest (see Figure 1).

Figure 1. Chlamydia Screening in Female Family PACT Clients by Age and Ethnicity, FY 2018-19
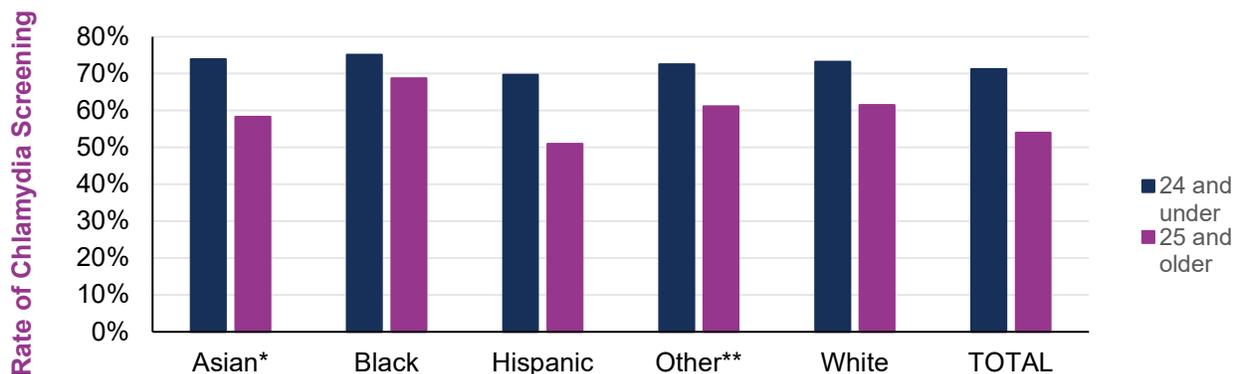
Data Source: Medi-Cal Management Information System/ Decision Support System | Date Represented: FY 2018-19 | Date Downloaded: 12 October 2020
*Asian include Pacific Islanders and Filipinos; ** Other include American Indian and Alaskan Native

1. CDC. Sexually Transmitted Disease Surveillance, 2018. Atlanta, GA: Department of Health and Human Services; October 2019. Accessed on October 7, 2020.
2. Torrone E, Papp J, Weinstock H. Prevalence of *Chlamydia trachomatis* genital infection among persons aged 14–39 years — United States, 2007–2012. *MMWR Morb Mortal Wkly Rep*. 2014;63(38):834–838.
3. Stamm WE. *Chlamydia trachomatis* infections in the adult. In: Holmes KK, Sparling PF, Stamm WE, et al., eds. *Sexually Transmitted Diseases.* 4th ed. New York, NY: McGraw-Hill; 2008:575–606
4. U.S. Preventive Services Task Force. (2019). Final recommendation statement: Chlamydia and gonorrhea: Screening. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening. This link is external to health.gov. (Accessed on October 7, 2020.

Link to Data Sources and Methods