Population Needs Assessment Report

September 2025

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I. Population Needs Assessment Overview

In May 1996, Kern Health Systems (KHS) began to serve Medi-Cal Managed Care beneficiaries by offering Kern Family Health Care (KFHC) as the local initiative health plan. As of May 12, 2025, KHS provides services to 404,842 Medi-Cal Managed Care beneficiaries in Kern County.

The goal of the 2025 KHS Population Needs Assessment (PNA) is to improve health outcomes for KHS members and ensure that KHS is meeting the needs of its members through:

1. Identification of member health needs and health disparities.
2. Evaluation of current KHS activities and available resources to address identified concerns; and
3. Implementation of targeted strategies to address member needs and health disparities.

The KHS 2025 PNA builds upon previous needs assessments and uses various data collection methods and sources. Total KHS membership and demographics in 2024 changed slightly compared to 2023 data. KHS membership grew by 19.7%. The adult share of KHS membership grew slightly from 61.1% in 2023 to 62.4% in 2024. The female share of members decreased slightly from 53.8% to 53.3%. In 2024, Hispanic/Latinos represented most members (63.3%), and English was the most common primary language (66.6%). Most members lived in Bakersfield (54.7%) where the highest concentration of members was in the 93307 zip code (11.8%). The share of Seniors and Persons with Disabilities (SPD) increased slightly from 4.5% in 2023 to 4.6% in 2024. The population of members who were identified as homeless increased to 19,769 in 2024, up 25.6% compared to the previous year.

The most commonly diagnosed health problems among KHS members excluding SPDs in 2024 included acute respiratory infection, preprocedural exam, routine child health exam, type 2 diabetes, hypertension, acute cough or cough (unspecified), acute pharyngitis, and chest pain. The top diagnoses among SPDs included administrative exam, hypertension, type 2 diabetes, counseling, autism spectrum disorder, end stage renal disease, elevated urine levels (of drugs, medications, or biological substances), chest pain, illness (unspecified), and urinary tract infection.

Lipid metabolism disorder, hypertension, persistent asthma, diabetes, and low back pain were found to be the five most common chronic conditions according to claims data. Review of KHS' pharmaceutical utilization identified ibuprofen as the most prescribed medication followed by atorvastatin calcium, vitamin D2, amoxicillin, and albuterol sulfate HFA.

Mental health diagnoses for depression and bipolar disorder were found to be more prevalent among females, English-speakers, White members, and adult members 45-64 years old. Schizophrenia was most common among males, speakers of languages other than English, Native Americans, and adult members 45-64 years old.

The advice nurse line call volume increased by 18.4% from 2023 to 2024. The most frequent symptoms for inbound symptom check calls were abdominal pain, followed by respiratory problems, pregnancy-related problems, nausea and vomiting, and fever.

The MY 2023 CAHPS Adult Medicaid Survey found that 13.3% of KHS adult members were current smokers. Among members who received smoking cessation services from Kick It California in 2024, anxiety and high blood pressure were identified as the top behavioral and physical health conditions, respectively.

Requests for qualified interpreters increased by 32.0% from 2023 to 2024. When looking at interpreting requests by modality excluding American Sign Language (ASL) requests, in-person requests increased by 74.5%, phone interpreting requests increased by 26.4%, and video remote and telehealth interpreting (VRI) requests increased by 24.4%. ASL interpreting requests increased by 24.4%. Among spoken languages, Spanish continued to be the most requested language, followed by Punjabi, Arabic, Tagalog, and Vietnamese.

The results of MY 2023 KHS Adult CAHPS Simulation Survey Member Satisfaction Survey found that rates improved compared to the MY 2022 survey for all measures included in this PNA except for "getting needed care" and "getting a specialist appointment. However, the MY 2023 CAHPS Child Medicaid Survey results indicated that rates increased compared to the MY 2022 findings for only the measures "personal doctors listened carefully" and "personal doctors showed respect".

In 2024, provider access survey results found that 99.5% of provider offices were compliant with the Emergency Access Standards and 98.8% were compliant with the Urgent Care Access Standards. The average wait time for each type of KHS provider was in compliance with standard wait times. In addition, 92.5% of providers surveyed were compliant with language interpreting access standards. Findings also revealed that 86.8% of primary care providers were accepting new members.

KHS continues to offer health education programs in both in-person and virtual environments. Referrals for health education services increased by 36.3% from 2023 to 2024. In 2024, weight management education was the top referral topic, followed by diabetes education, other nutrition education, smoking/tobacco cessation education, and asthma education. Referrals for diabetes education and weight management education increased from 2022 to 2023. Referrals for asthma education, other nutrition education, and weight management education decreased.

The rate of members who accepted to receive health education services decreased from 44.1% in 2023 to 37.7% in 2024. The rate of members who declined health education services increased from 34.5% in 2023 to 37.6% in 2024. Among referrals with members who signed up for a health education program, the portion of referrals where a member attended at least one program session decreased from 49.9% in 2023 to 45.3% in 2024. The portion of referrals that were closed with a "No Show" outcome (did not attend any program sessions) increased from 29.1% in 2023 to 37.0% in 2024. KHS nutrition education programs continued to be the most popular request for health education services in 2024. This was followed by diabetes education, smoking/tobacco cessation, asthma education, and diabetes prevention.

KHS will continue to explore opportunities to better address the health needs of its members. Leveraging KHS' predictive analytics and stratification methodology will be crucial for engaging members in chronic condition management and wellness programs, helping to maintain

their health stability. KHS is committed to supporting its members and providers, having invested millions to enhance access to services, support clinical education pathways, partner with schools and community partners for onsite health services, and foster innovative programs that engage residents in Kern County. KHS's dedication to improving the health of both members and the broader community remains strong. By tailoring efforts to meet specific needs and increasing our visibility, KHS aims to make a positive impact on the lives of members.

II. Data Sources

KHS used various methods of internal and external data collection, review, and analysis in the development of the 2025 Population Needs Assessment.

National, State, and County Data
National, state, and county data were compared to available membership indicators. Sources utilized for this report include the U.S. Census Bureau, California Health Interview Survey, Williams Institute (UCLA School of Law), Kern County Public Health Services Department Community Health Assessment and Improvement Plan, California Department of Public Health Kern County Health Status Profile, Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System, and Kick It California.

NCQA HEDIS MY 2023 and MY 2024 Consumer Assessment of Healthcare Providers Survey (CAHPS) 5.1H Adult and Child Medicaid Survey Results Reports – NCQA Calculations
The California Department of Health Care Services (DHCS) contracted with a survey vendor to administer and report the results of the CAHPS Health Plan Survey. KHS' Adult and Child Medicaid CAHPS Survey Report results for Measurement Years (MY) 2023 and MY 2024 were reviewed to assess areas of improvement among plan and provider services.

MY 2023 KHS CAHPS Simulation Survey (Member Satisfaction Survey) Results
KHS contracted with a survey vendor to administer its annual member satisfaction survey by mail and internet to all adult KHS members in October and November 2024. A total of 524 survey responses were collected, which yielded a 10.5% response rate. Female members accounted for 72.2% of all respondents. The largest age group included the ages of 55 and older, which accounted for 38.3% of respondents. Hispanics/Latinos were the largest racial/ethnic group at 46.4% of respondents.

MY 2024 KHS Disparities Rate Sheet Data
KHS used internal MY 2024 Disparities Rate Sheet data to assess health status and disease prevalence among KHS' membership and within racial/ethnic groups. MY 2024 Disparities Rate Sheet data from DHCS were not available.

Managed Care Accountability Set (MCAS) Data
KHS' MCAS rates for MYs 2023 and 2024 were used to assess indicators of member's health care.

2023 KHS Population Needs Assessment
KHS' report was reviewed and compared with current findings to identify changes in utilization of health services, health education, and cultural and linguistic member needs.

Internal Reports
Data from internal reports were reviewed to summarize key member demographic and health statistics and identify changes from 2023 to 2024. The source of the data includes member eligibility and claims data. Top diagnoses and chronic health conditions were identified and summarized.

Pharmacy Data
Pharmacy claims data from calendar years 2023 and 2024 were analyzed by most frequently dispensed medication.

KHS Advice Nurse Line Program Summary Report
Utilization reports from the KHS 24 hours advice nurse line for 2023-2024 were reviewed to identify call frequency and the top reasons for the calls.

KHS Departmental Reports
The KHS Wellness and Prevention (W&P) Department Activities Report was reviewed to identify trends in need for health education services and projections for program development. KHS Community Health Worker (CHW) Services and Asthma Preventive Services (APS) claims data were reviewed to summarize service utilization in 2023 and 2024. KHS Enhanced Care Management Department and Community Support Services Department referral reports were used to summarize Enhanced Care Management and Community Support Services member referral and utilization data for 2023 and 2024. KHS' grievance, transportation and provider network management reports were reviewed to identify access to care concerns among members.

III. Key Data Assessment Findings

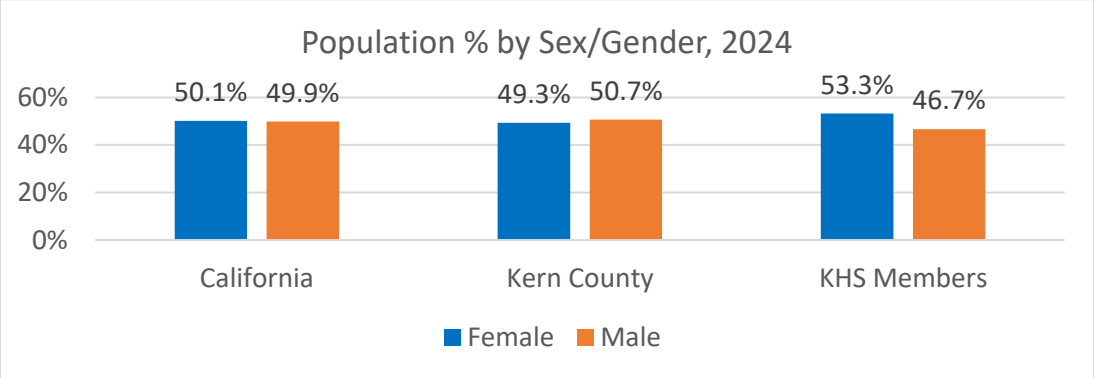
Membership/Group Profile

According to KHS' membership statistics, 469,317 Medi-Cal managed care members enrolled in the plan in 2024.[1] This was a 19.7% increase in total annual membership compared to 392,166 members in 2023. Most of this increase was due to members who transitioned from Health Net, the local commercial managed care Medi-Cal health plan that ended its Kern County contract with DHCS in 2024. In the first quarter of 2024, 66,890 Health Net members transitioned to KHS.[2] KHS members account for approximately 81% of Medi-Cal beneficiaries in Kern County.[3] KHS member enrollment in 2024 was slightly more than half of the population of Kern County.[4] Although males account for a slightly larger share of the population than females at the state and county levels, females account for a larger share of the KHS member population than

males. The table and chart below provide a comparison of the KHS member population with the county and state.

	California (CA)	Kern County (KC)	KHS
2024 Population	39,431,263	922,529	469,317
Male (%)	49.9%	50.7%	46.7%
Female (%)	50.1%	49.3%	53.3%

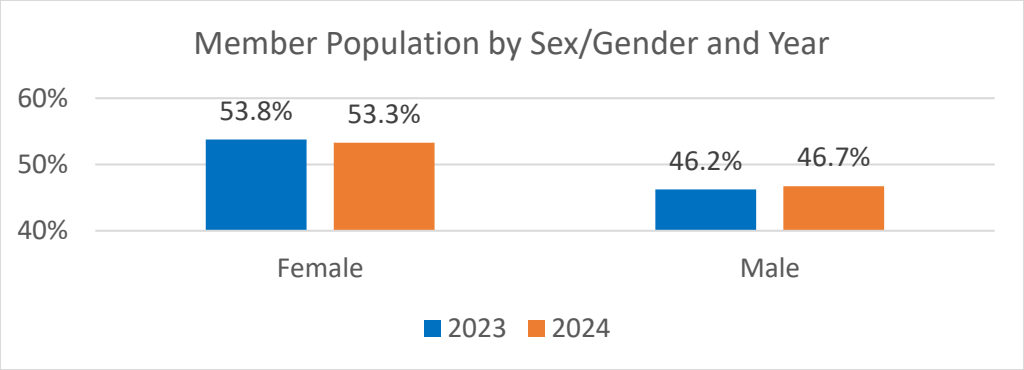
Source: KHS Member Demographics Data Report; U.S. Census Bureau



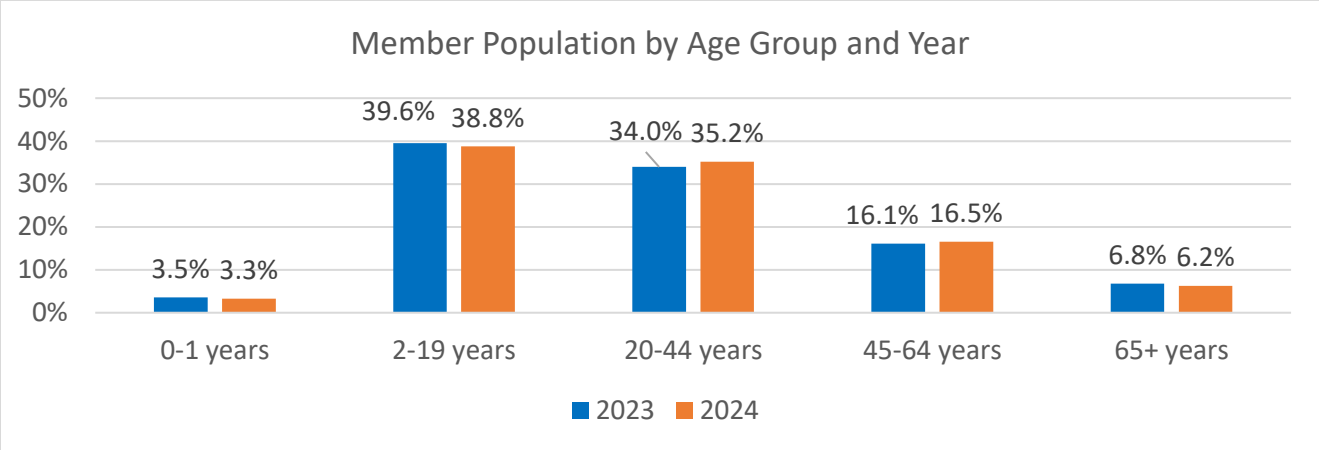
Source: KHS Member Demographics Report; U.S. Census Bureau

When looking at changes in member population by age group, adults ages 20-64 changed the most. The percentage of members 0-19 years old decreased from 43.1% in 2023 to 42.1% in 2024.[1] The proportion of members 20-64 years old increased from 50.1% to 51.7%. For members 65 years and older, that figure decreased from 6.8% to 6.2%.[1] When looking at the change in member population total from one year to the next, the number of members 0-19 years old increased by 16.8% from 2023 to 2024, compared to a 23.5% increase for members 20-64 years old and a 9.8% increase for members 65 years and older. For comparison, approximately 27.9% of the Kern County population is under 18 years old and 12.4% are 65 years and older.[4] At the state level, approximately 21.3% of the population is under 18 years old and 16.5% are 65 years and older.

According to The Williams Institute, 5.5% of the U.S. adult population and 5.1% of California's adult population identify as Lesbian, Gay, Bisexual, Transgender (LGBT).[5] KHS has integrated Sexual Orientation and Gender Identity (SOGI) questions into its customized Health Risk Assessment (HRA) and SOGI Assessment to enhance its understanding of member needs. KHS began collecting SOGI data in December 2024. SOGI data are expected to be included in the 2026 KHS PNA.



Source: KHS Member Demographics Report



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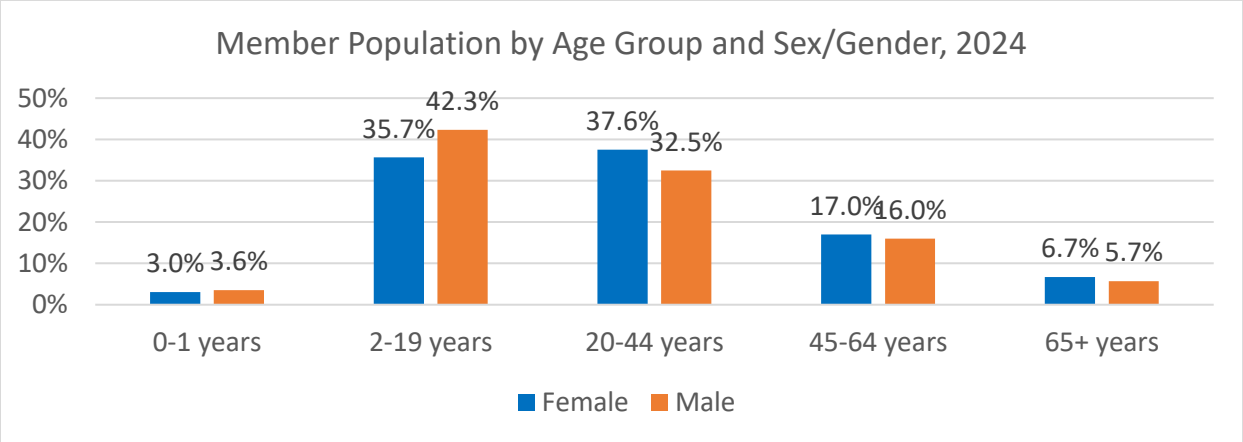
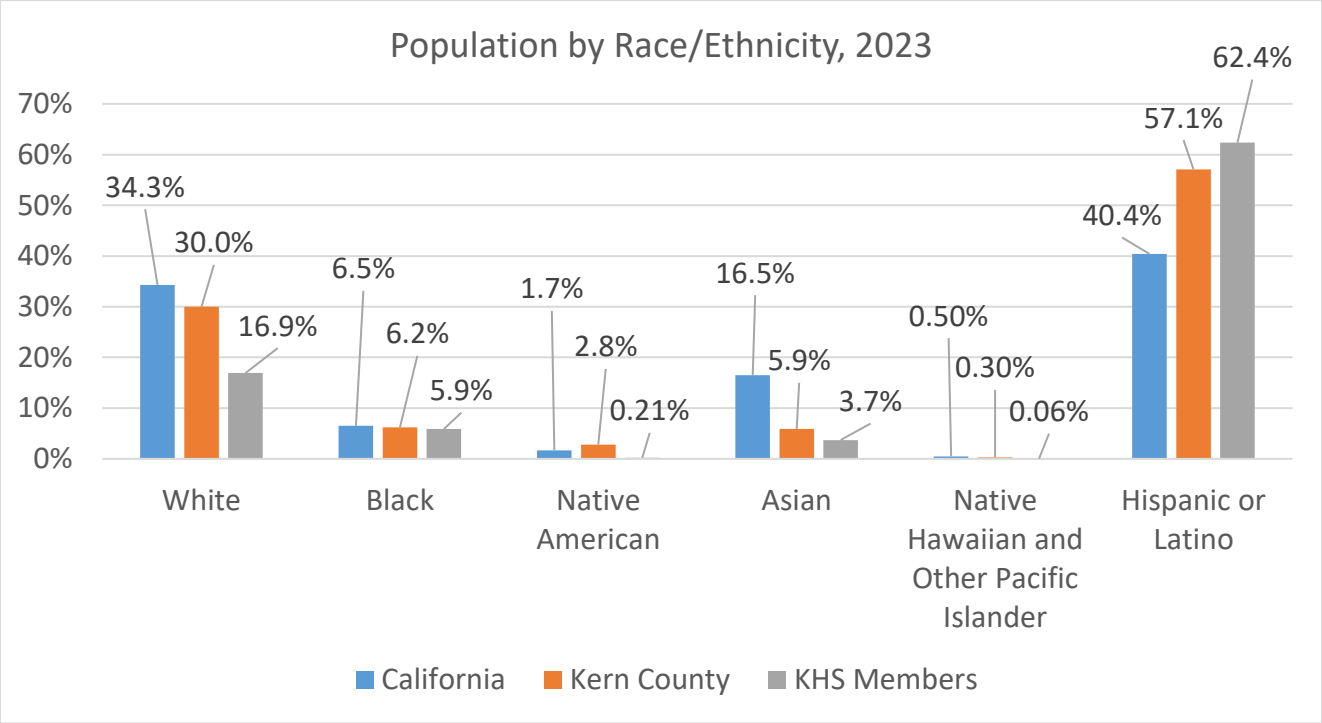


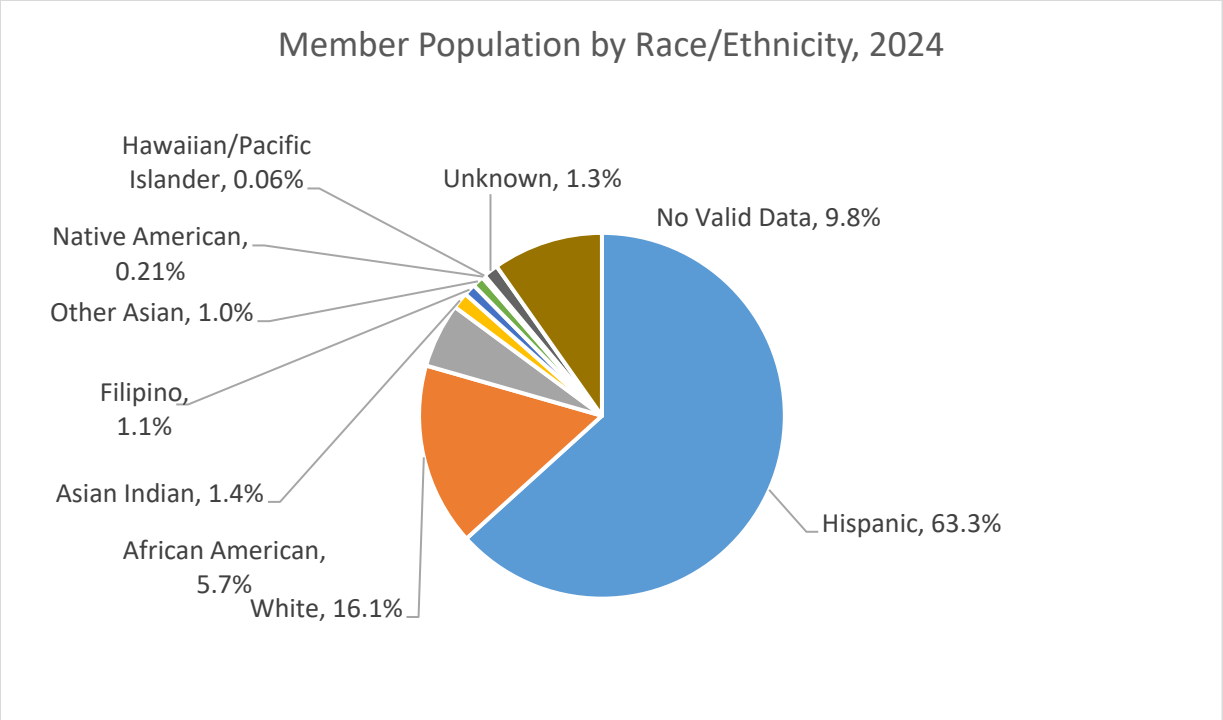
Source: KHS Member Demographics Report

Hispanic/Latinos continue to be the largest racial/ethnic group among KHS members, accounting for most of the membership (63.3%). They are followed by Whites (16.2%), Black/African Americans (5.7%), Asians/Pacific Islanders (3.6%), and Native Americans (0.2%). The racial/ethnic makeup of KHS members in 2023 was very similar to 2024. For comparison, 2023

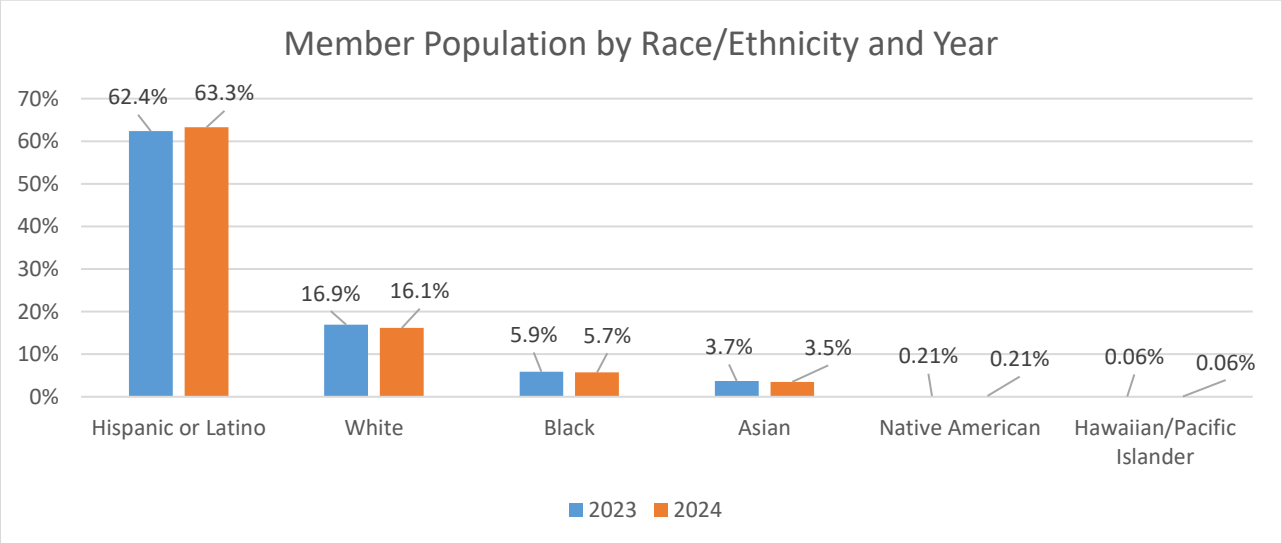
data reported by the U.S. Census Bureau shows that 57.1% of Kern County and 40.3% of California residents are Hispanic/Latino, followed by White (KC-30.0%, CA-34.3%), Black/African American (KC-6.2%, CA-6.5%), Asian/Pacific Islander (KC-6.2%, CA-17.0%), and Native American (KC-2.8%, CA-1.7%).[2]



Source: KHS Member Demographics Report; US Census Bureau

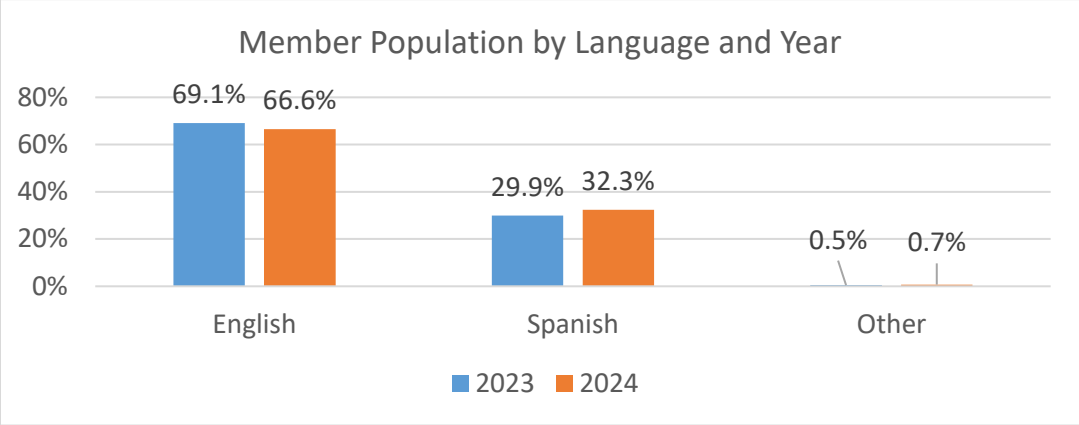


Source: KHS Member Demographics Data Report



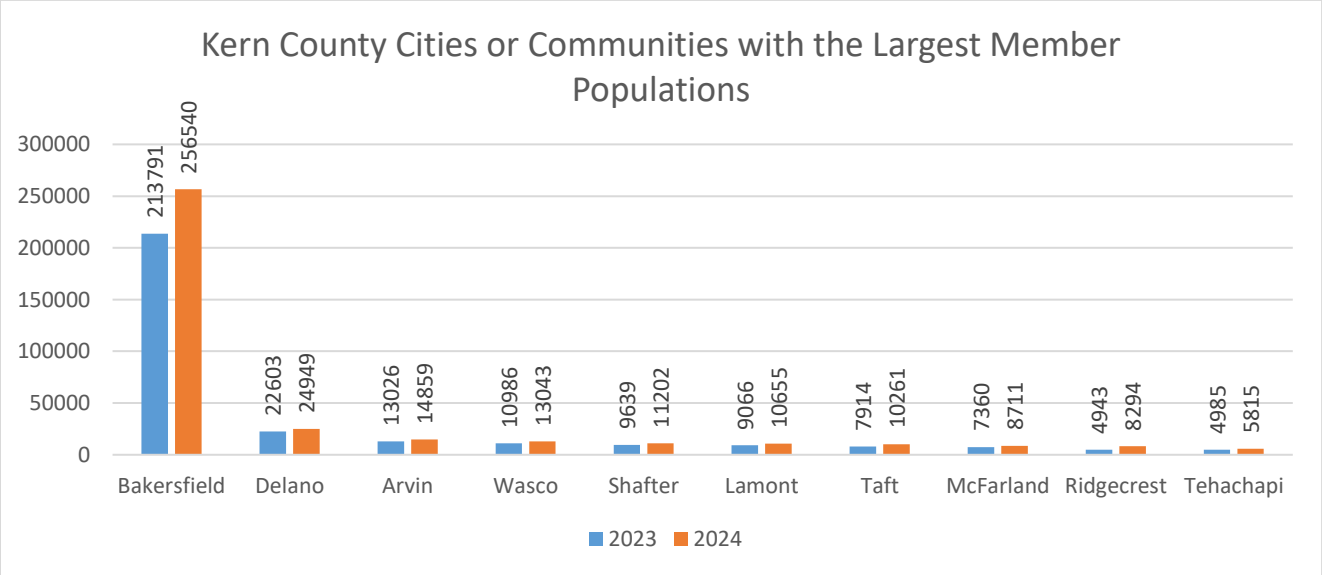
Source: KHS Member Demographics Data Report

In 2024, 66.6% of KHS members were English-speaking, while 32.4% were Spanish-speaking and 0.7% spoke a language other than English or Spanish.[1] This language profile changed slightly compared to 2023, where 69.1% of members spoke English, 29.9% spoke Spanish, and 0.5% spoke other languages. In comparison, data reported in the U.S. Census Bureau show that 54.0% of Kern County residents and 55.6% of California residents speak English.[4] This is followed by Spanish (KC-39.9%, CA-28.3%), and other languages (KC-6.1%, CA-16.1%).



Source: KHS Member Demographics Data Report

In 2024, the majority of KHS' members lived in Bakersfield (54.7%), Delano (5.3%), Arvin (3.2%), Wasco (2.8%), and Shafter (2.4%).[1] The member population in each of the Kern County cities or communities with the largest member populations increased considerably from 2023 to 2024. The biggest increase in those cities or communities occurred in Bakersfield, which had a 20.0% increase.



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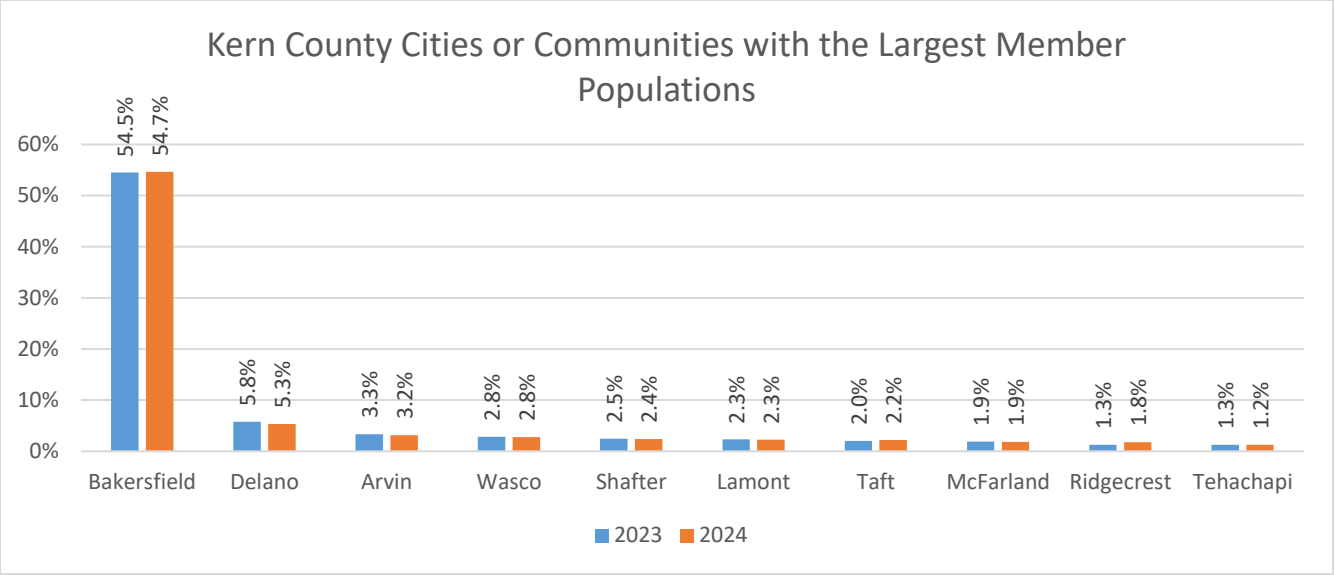
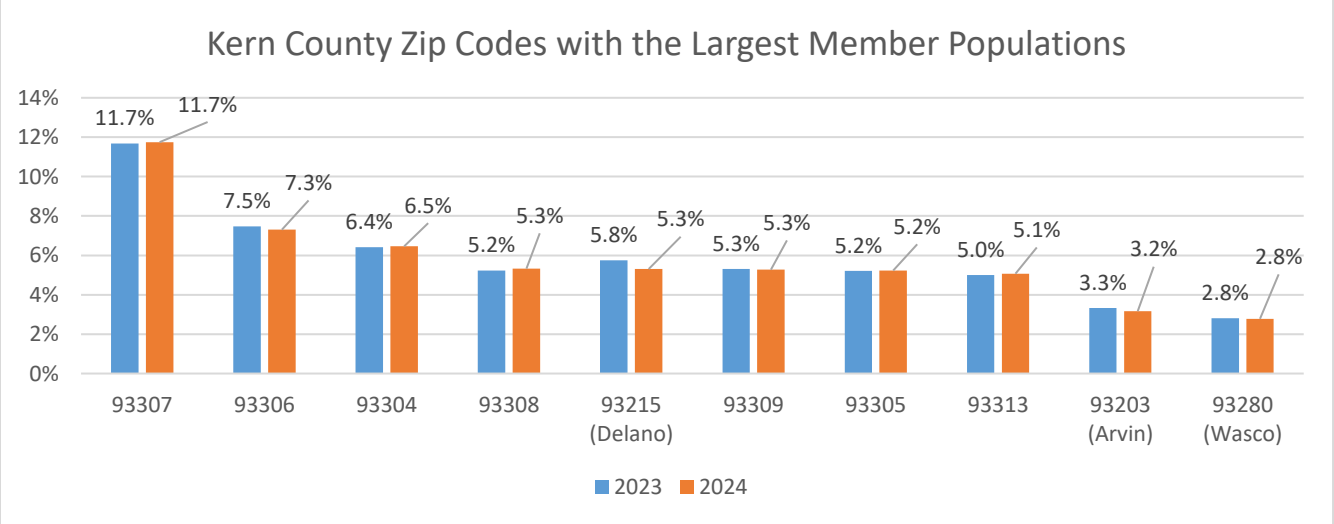


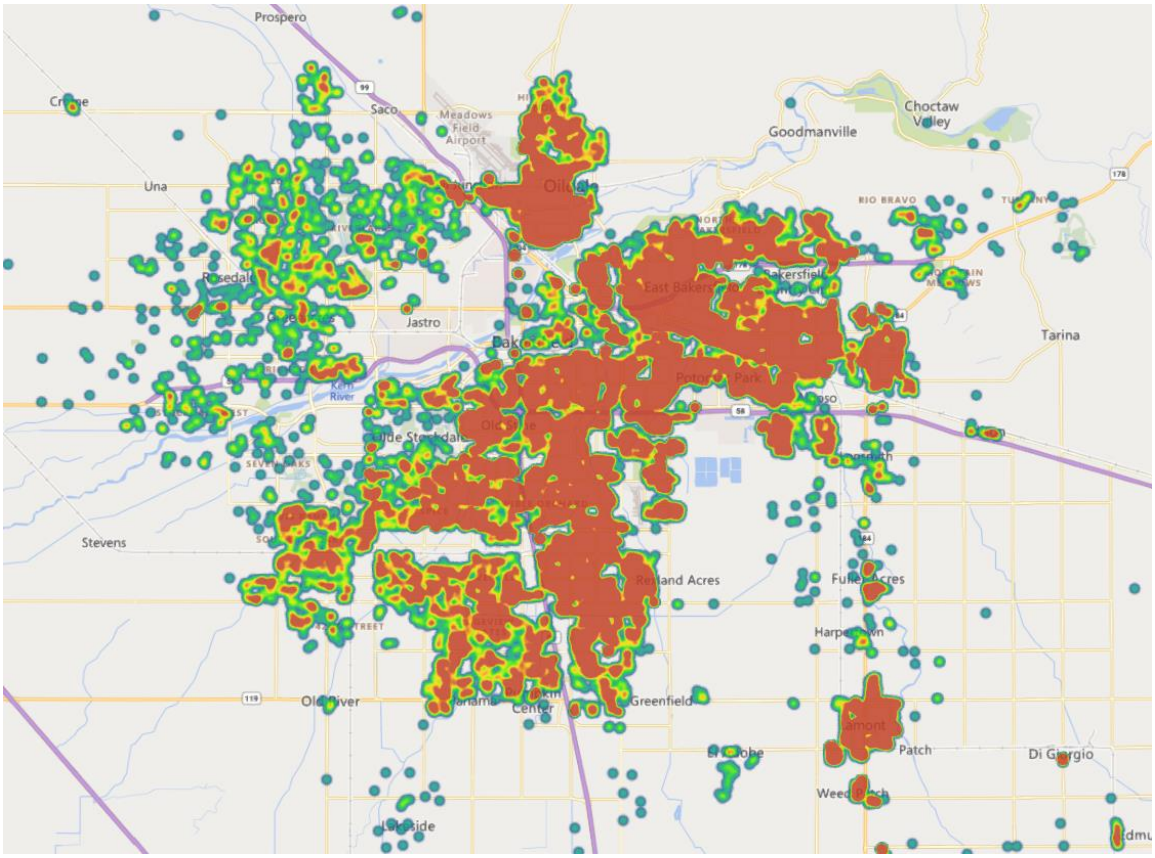
Source: KHS Member Demographics Data Report

The highest concentration of KHS members in 2024 was in the 93307-zip code (11.8%), followed by 93306 (7.3%), 93304 (6.5%), 93308 (5.3%), and 93215 (5.3%). The 2023 data were very similar, with the following zip codes in descending order: 93307 (11.7%), 93306 (7.5%), 93304 (6.4%), 93215 (5.8%), and 93309 (5.3%). Most of the Kern County zip codes with the 10 largest member populations in 2024 were in Bakersfield.



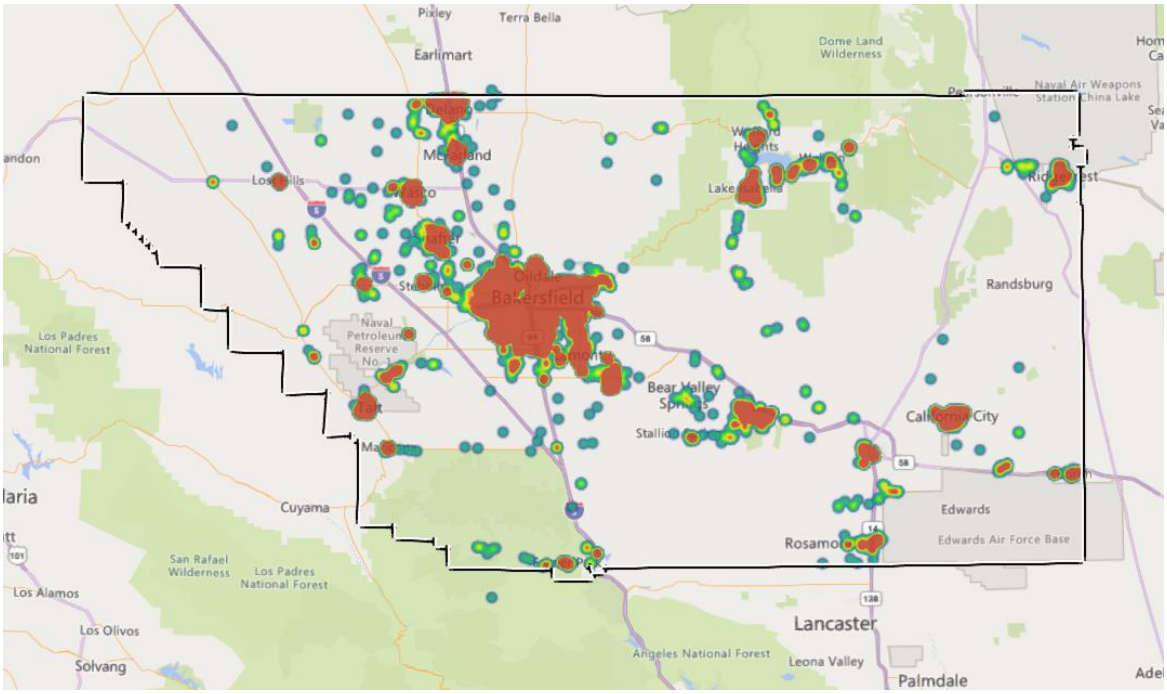
Source: KHS Member Demographics Data Report

Distribution of KHS Members in Bakersfield, 2024



Source: KHS Member Demographics Data Report

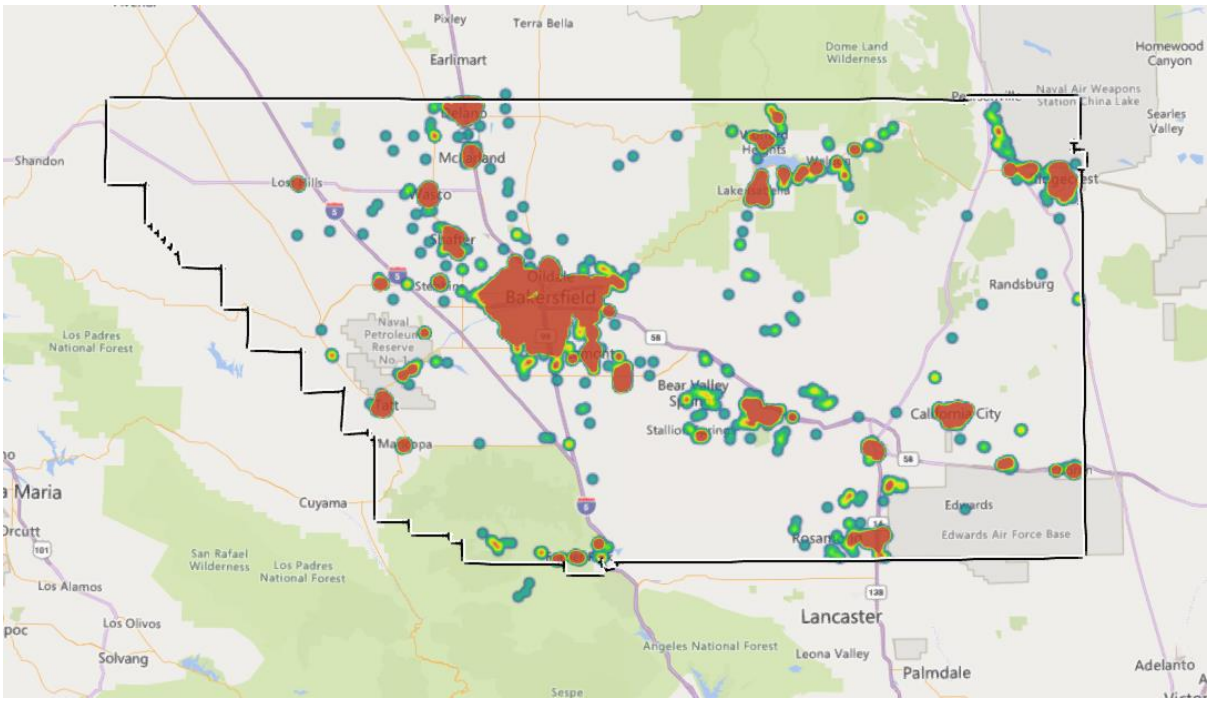
Distribution of KHS Members in Kern County, 2024



Source: KHS Member Demographics Data Report

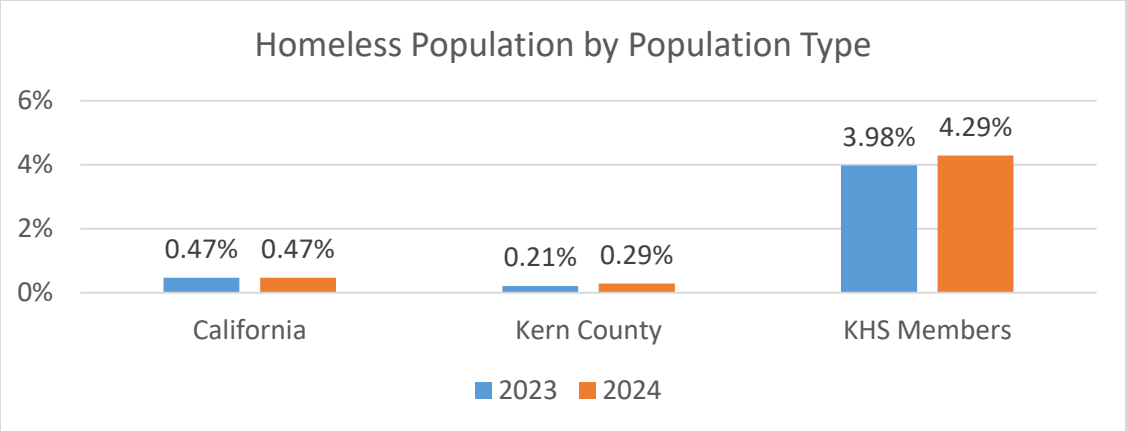
The population of seniors and persons with disabilities (SPDs) among members was 21,478 members in 2024, a 21.8% increase compared to 17,628 members in 2023. SPDs accounted for 4.6% of members in 2024, up from 4.5% in 2023.

Distribution of KHS SPD Members in Kern County, 2024

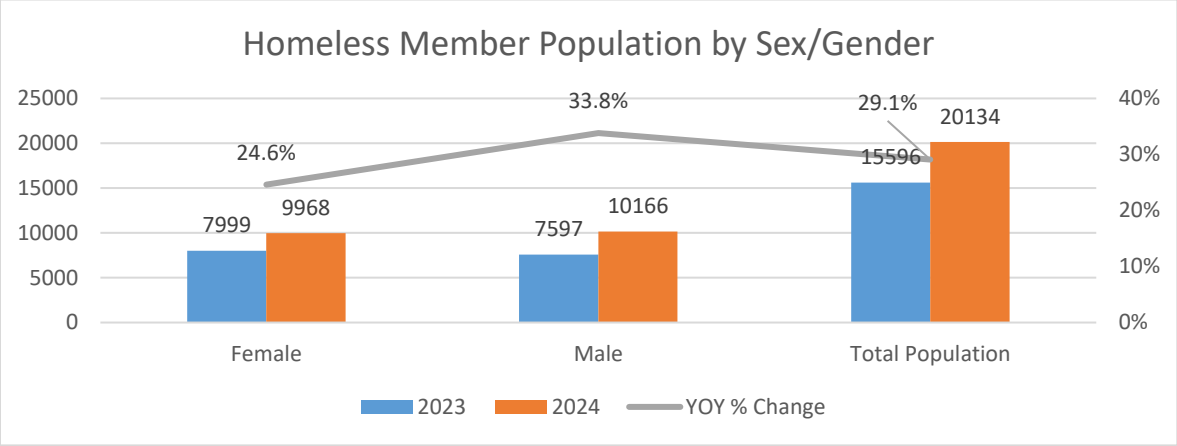


Source: KHS Member Demographics Data Report

KHS identifies homeless members primarily through claims data. In 2024, 20,134 homeless members were identified, a 29.1% increase compared to 2023.[1] Females constituted 49.5% of the homeless member population, while males made up 50.5%. English speakers accounted for 83.8% of homeless members whereas Spanish speakers accounted for 15.4%. The majority of homeless members (53.6%) reported living in Bakersfield, followed by Delano (2.8%), Shafter (1.6%), and Wasco (1.6%), and Arvin (1.5%). The 2024 KHS homeless member rate was much higher than the homelessness rates for California[6,7] and Kern County[8], which are based on the annual homelessness point-in-time (PIT) count. Due to differences in methodology, caution should be used when comparing homelessness rates between state, county, and KHS member populations. Claims data was used to identify KHS homeless members. PIT counts are snapshots of experiences of homelessness. They are usually one-night estimates of sheltered and unsheltered populations experiencing homelessness. In the case of Kern County, the count includes a single night sheltered count and a three-day unsheltered count.



*Homeless data for California and Kern County is from the annual PIT. KHS homeless member data is derived from claims.
Sources: KHS Member Demographics Data Report, The 2023 Annual Homelessness Assessment Report (AHAR) to Congress, and Kern County Point in Time Count 2024 Report



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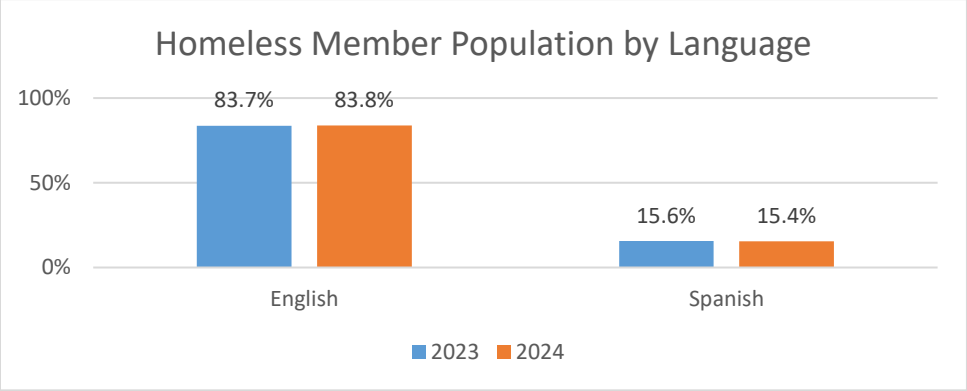

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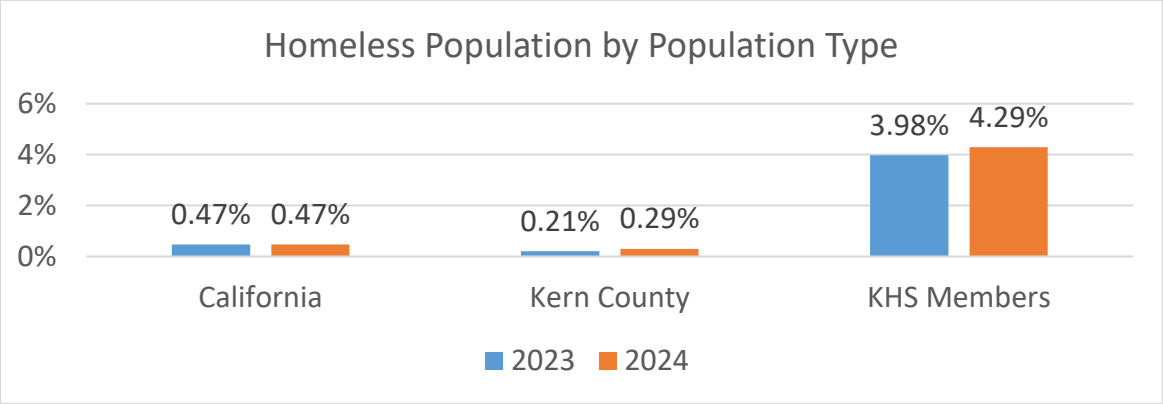


Source: KHS Member Demographics Data Report

Social Determinants of Health

KHS members live in communities that face higher levels of socioeconomic hardship than the overall California and United States populations. The Kern County 2023 Community Health Assessment (CHA) describes the Social Vulnerability Index (SVI) model as a way to rank overall population well-being and mobility relative to county, state, and national figures.[9] The SVI model was developed by the U.S. Centers for Disease Control and Prevention to use data to identify vulnerable populations. The Kern County 2023 CHA includes SVI measure data that highlight factors that impact the needs of the most vulnerable residents in Kern County. Selected SVI measures are included below.

SVI Measure	Kern County	California	United States
Population Below Poverty Level	19.2%	12.0%	12.5%
Unemployment Rate	8.4%	5.5%	4.3%
Median Household Income	$68,893	$95,521	$77,719
No High School Diploma	14.6%	9.8%	11.4%
Living With a Disability	13.4%	11.7	13.6%
Foreign-Born Persons	19.7%	26.7%	13.9%

Source: U.S. Census Bureau, 2023 American Community Survey 1-Year Estimates; U.S. Census Bureau, QuickFacts, 2019-2023 5-Year Estimates

- The poverty level in Kern County is much higher than in both California and the U.S.[10]
- The unemployment rate in Kern County is higher than in California and the U.S.
- The median household income of residents in Kern County is much lower than California's median household income.

- Kern County has a larger proportion of residents without a high school diploma than both California and the U.S.
- Kern County has a higher rate of persons living with a disability than California but slightly lower than the U.S.[11]
- Kern County has a smaller proportion of foreign-born persons than California but higher than the U.S.

The Kern County 2023 CHA summarized data about transportation and built environment indicators:

- Workers in Kern County are less likely to commute to work via public transit compared to California and the U.S.[9]
- Kern County has a higher percentage of workers who drive to work alone than the state and nation.
- The National Walkability index includes measures of the built environment that affect the likelihood of walking for transportation. A higher score represents more walkable areas. Kern County is less walkable and less accessible for pedestrians than California, but more walkable and accessible for pedestrians than the U.S.

Transportation Indicators for Kern County, California, and the United States

	Kern County	California	United States
Mean Travel Time to Work (in minutes)	23.7	29.5	26.8
Workers Commuting by Public Transit	0.6%	4.1%	4.2%
Workers who Drive Alone to Work	79.7%	70.1%	73.2%
Percent of Income Spent on Housing and Transportation - Median Income Families	56.5%	50.0%	54.3%
Walkability Index	10.3	12.2	9.6

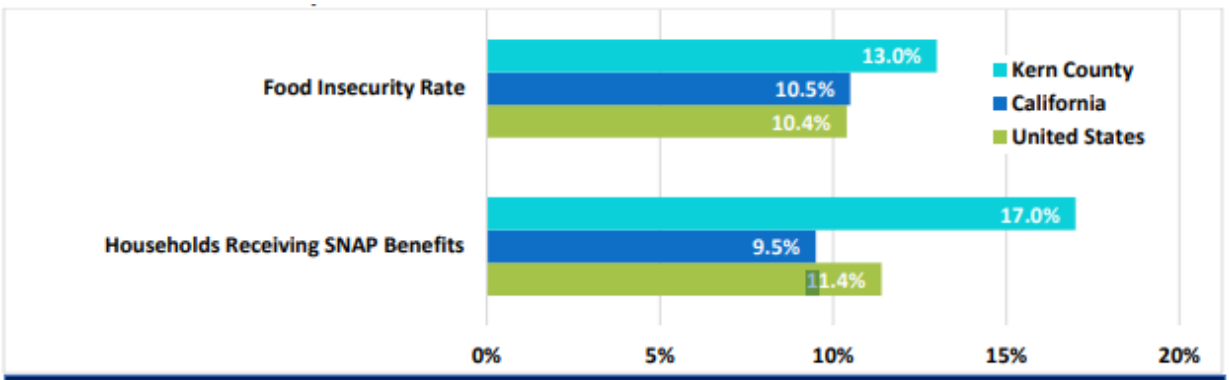
Source: HUD DOT Location Affordability Index 2016 | U.S. Census Bureau. American Community Survey Five-Year Estimates, 2017-2021 | U.S. Environmental Protection Agency Smart Location Walkability Index 2019

Source: Kern County 2023 Community Health Assessment

According to the Kern County 2023 CHA, food insecurity levels are higher or worse compared to California and U.S. based on the following indicators:

- The percentage of students eligible to receive either free or reduced-price lunch is considerably higher for Kern County than for California and the U.S.
- Kern County has a higher percentage of households receiving SNAP benefits.
- Kern County has a higher food insecurity rate.

Food Insecurity Indicators for Kern County, California, and the United States

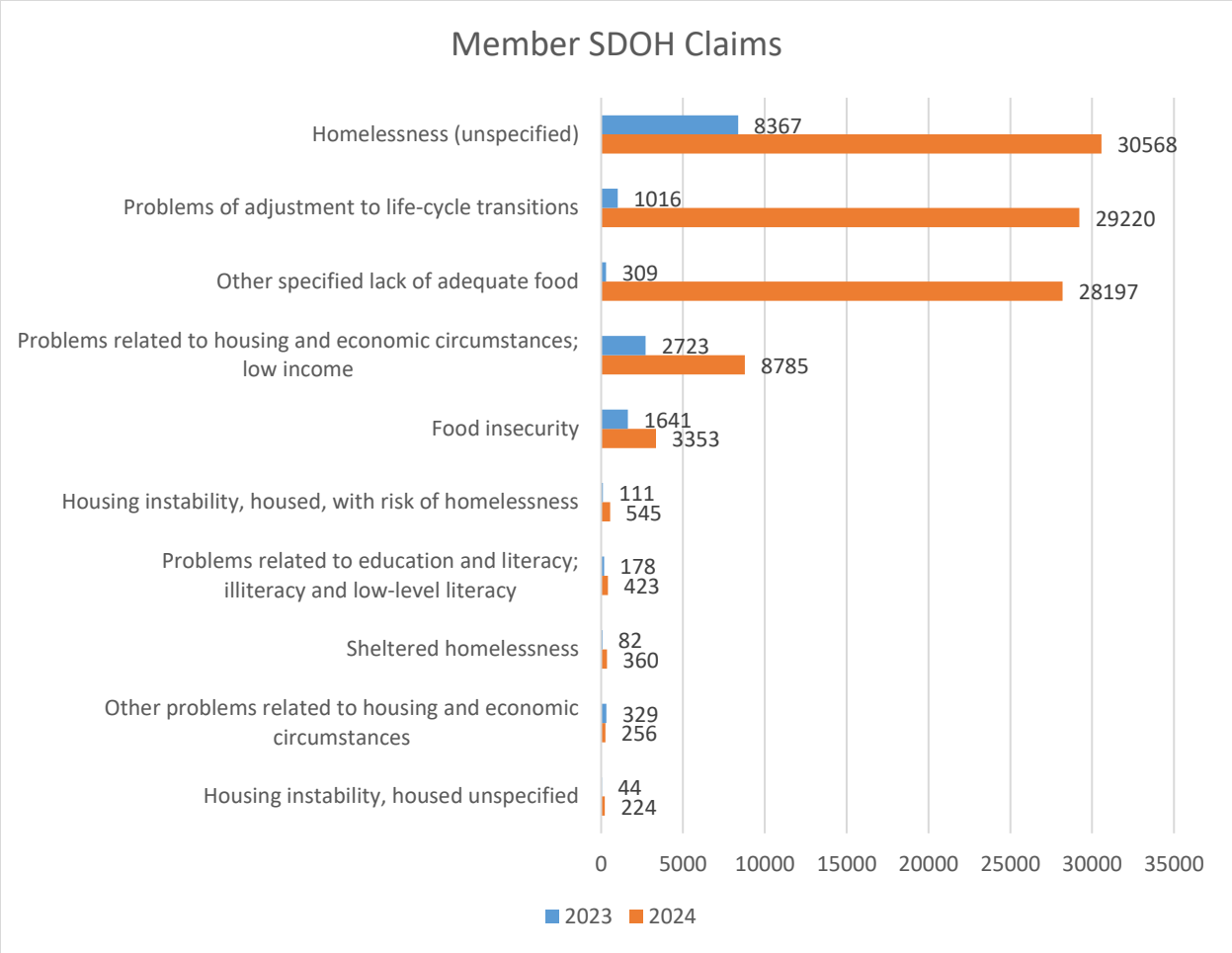


	Kern County	California	United States
Households Receiving SNAP Benefits (2021)	17.0%	9.5%	11.4%
Food Insecurity Rate (2021)	13.0%	10.5%	10.4%

Sources: Feeding America Map the Meal Gap 2021 | U.S. Census Bureau. American Community Survey Five-Year Estimates, 2017-2021

Source: Kern County 2023 Community Health Assessment

KHS collects social determinants of health (SDOH) data with SDOH codes that KHS providers use when submitting claims. Collection of SDOH data is part of the Population Health Management (PHM) initiative of CalAIM that identifies and manages member risk and need through whole person care approaches. SDOH claims increased by 535.9% from 16,304 in 2023 to 103,671 in 2024.[12] Feedback from KHS staff indicates that provider training or education may have been a factor of this large increase. The first most frequent SDOH claims in 2024 included the following in descending order: homelessness (unspecified), problems of adjustment to life-cycle transitions, other specified lack of adequate food, problems related to housing and economic circumstances (low income), and food insecurity.



Source: 2023 and 2024 KHS SDOH Claims Reports

Transportation Tips

KHS' Transportation Department provides non-emergency transportation for members to travel to their medical and other Medi-Cal covered services. Member transportation benefits include Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT). NEMT is provided when medically necessary and requires a completed and signed Physician Certified Statement from the member's medical provider. NMT is provided to all members who qualify. Total provided trips for all modes of transportation combined increased by 9.9% from 2023 to 2024.[13] However, change in total provided trips varied by mode of transportation. ECM also provides additional transportation to locations that are non-medical but are aligned with ECM needs as long as members have an authorization and are currently enrolled in their ECM site.

NEMT and NMT Ridership

Mode	Provided Trips, 2023	Provided Trips, 2024	Year Over Year % Change
NEMT Wheelchair	234,262	97,388	-58.4%

NEMT Gurney Van	6,398	10,449	63.3%
NMT Public Transit	22,462	12,220	-45.6%
NEMT Rideshare	321,308	515,044	60.3%
NMT Mileage Reimbursement	14,853	23,740	59.8%
All Modes Combined	599,283	658,841	9.9%

Source: 2023 and 2024 KHS Transportation Reports

Summary of Member Needs Related to SDOH

1. The member population grew by 19.7% from 2023 to 2024. Access to health care and other services covered by KHS will need to scale up to keep up with the rapid growth in membership.
2. The fastest population growth by age group occurred among members 20-44 years old. This age group grew by 23.9% from 2023 to 2024.
3. Most members live in Bakersfield. The member population percent in Bakersfield increased slightly from 54.5% in 2023 to 54.7% in 2024. The member population in Bakersfield grew by 20.0% from 2023 to 2024. This was a faster growth rate than the next five largest cities or communities in Kern County.
4. The KHS member population outside of Bakersfield grew by 21.1% from 2023 to 2024. This indicates an increasing member need for KHS benefits and services to be accessible to outlying areas of Kern County.
5. Collection of gender identity data is needed to understand the needs of members who identify as 2SLGBTQIA+ and other diverse identities. KHS has integrated sexual orientation and gender identity (SOGI) questions into its Health Risk Assessment (HRA), which launched in December 2024, to better understand the diverse identities of members. In May 2025, KHS launched the SOGI assessment, which is a short questionnaire about member gender identity.
6. The KHS homeless member population rate is much higher than the homeless population rates for Kern County and California. These findings support the need for affordable housing among members. Other resources are needed to prevent and respond to homelessness. Resources such as housing navigation services, housing deposits, housing tenancy and sustaining services are needed to directly address the issue. Services such as mental or behavioral health services, case management, chronic disease management programs, and degree or job training programs would help address other contributing factors to homelessness. Some of these resources are covered by KHS benefits, such as Community Support Services (CSS), Behavioral Health Therapy (BHT), and Enhanced Care Management (ECM).
7. Addressing SDOH is needed to improve member health. SDOH claims data indicate that homelessness, support problems of adjustment to life-cycle transitions, food insecurity, and support for problems or hardships related to having a low income are among top member needs. The increasing cost of housing and other living expenses are sources of stress. Member data on SDOH are consistent with Kern County statistics where SDOH indicators are worse than California or U.S. rates. For example, the rates of poverty,

unemployment, persons without a high school diploma, and food insecurity are all higher for Kern County compared to the California and U.S. populations.

8. The health gap is closely tied to the uneven distribution of wealth, with relative poverty playing a significant role in poorer health outcomes and widening health disparities. In Kern County, this issue is particularly evident. While the median sold price of existing single-family homes in Kern County was notably lower at $409,000 in June 2025 compared to $899,560 for California overall during the same time period[14], the median household income of $68,893[15] still presents a challenge for Kern County residents. This disparity creates financial strain, making it difficult for the average resident to remain resilient in the face of unexpected challenges, such as illness or job loss. The economic pressures exacerbate health disparities, as those with limited financial resources often struggle to access healthcare or maintain stability during crises.
9. Completed member transportation trips grew by 9.9% from 2023 to 2024. NEMT gurney, NEMT rideshare, and NMT mileage reimbursement trips increased by 63.3%, 60.3%, and 59.8% year over year, respectively. These findings indicate that member need for transportation access has increased substantially.
10. Transportation challenges for members vary based on location and time of day or day of the week. Members have more transportation assistance options in urban areas and during weekdays. Options are more limited during weekends and in less populated or outlying areas of Kern County. However, public transit service in Bakersfield has gradually increased while public transit staff levels and ridership have steadily increased since the start of the COVID-19 pandemic.
11. Members who reenter society from a correctional facility will need resources to assist them with accessing their Medi-Cal benefits. For example, California's Justice-Involved Reentry Initiative will help people coming out of incarceration stay healthy and get the support they need to land on their feet.
12. Members access to consistent phone services including active phone numbers and affordable phone service has been identified as a member need based on feedback from KHS staff. KHS provides resources to members for low cost and lifeline phone services during care coordination, community health worker engagement, and community outreach. Through its outreach programs—including care managers, care coordinators, and community health workers—KHS works to support and empower members to utilize these essential resources and improve access to communication to facilitate their health and mental health need management.

Conclusion:

Based on the member demographic and needs summary, the following key unmet needs were identified:

1. Increase Access to Healthcare Services

- **Need**: As membership grows, access to healthcare and community resources must scale up to accommodate the increasing population.
- **Action**: Expand healthcare services, focusing on preventive care and areas with the fastest member population growth.

2. **Support for SPD Members**

- **Need**: A significant increase in members aged in the SPD population requires targeted health services.
- **Action**: Develop tailored programs and incorporate care management and coordination for these members. Increase access to existing programs, such as BHT, CSS, ECM, Population Health Management Complex Case Management (PHM CCM) and specialized programs, member Wellness and Prevention program, CHW Services, and Asthma Preventive Services (APS).

3. **Resources for the Homeless Members**

- **Need**: A disproportionately high homeless member population necessitates urgent resources for housing, mental health, substance abuse, and chronic disease management.
- **Action**: Strengthen case management programs and services that address homelessness, including behavioral health, mental health, substance abuse treatment services.

4. **Resources to Address SDOH**

- **Need**: Homelessness, housing, food insecurity, problems of adjustment to life cycle transitions, and problems related to having a low income (economic hardship) are top SDOH concerns.
- **Action**: Enhance CSS to address the need for affordable housing and financial assistance. PHM CCM and internal and external Community Health Workers (CHWs) can connect members with local homelessness resources, financial assistance including the utilization of HFI services, and food assistance (Cal-Fresh and supplementary medically tailored meals) resources. Asthma Preventive Services (APS) can control or eliminate environmental asthma triggers in the home. BH CHWs can connect members with BHT and mental health services that may address problems of adjustment to life cycle transitions.

5. **Transportation Access**

- **Need**: A significant increase in requests for transportation assistance reflects a rapidly growing member need. Transportation service will need to be increased to overcome barriers to accessing healthcare services, especially in rural areas or during evening hours.
- **Action**: Expand transportation options and optimize services to meet needs in underserved areas and during off-peak hours.

Summary of Relevant Services and Actions to Address Member Needs Related to SDOH:

- **APS**: Increase outreach efforts among members and providers to promote awareness of APS and increase access. Develop and streamline the APS referral process.

- **BHT, Mental Health Services, and Substance Abuse Treatment Services**: Increase access to BHT, mental health services, and substance abuse services and resources tailored to the needs of members with various demographics.
- **CHW Services**: Increase outreach efforts among members, KHS providers, and community partners to raise awareness and facilitate access to CHW Services.
- **CSS**: Expand offerings related to housing and financial assistance.
- **PHM**: Implement targeted interventions for older adults and Seniors and Persons with Disabilities (SPDs), including Complex Case Management (CCM) and specialized programs designed to meet members' specific needs.
- **ECM**: Focus on holistic support for vulnerable populations, including the homeless, members with serious mental health or substance use disorder needs, members involved in child welfare, individuals transitioning from incarceration, and the birth equity population.
- **Member Transportation Benefits**: Optimize transportation resources to ensure timely access to care.

To better understand the diverse identities of our members, KHS has integrated SOGI data collection into its HRA, which launched in December 2024. To support this implementation, targeted staff trainings were conducted in early 2025 for key departments including Behavioral Health, Wellness & Prevention, and Population Health Management. In May 2025, the SOGI assessment, a short questionnaire about gender identity available in both English and Spanish, went live in KHS' clinical and referral tracking software and in the Member Portal. It can be administered by KHS staff with members or completed by members in the Member Portal. These efforts aim to ensure that members are seen, respected, and better served based on their individual identities and health needs.

Collected HRA responses are entered into KHS' clinical software, which systematically adjusts risk calculations for members. This approach ensures that incremental risk is appropriately identified within defined cohorts experiencing poorer health outcomes. By incorporating SOGI data, KHS works to mitigate biases inherent in traditional risk management software, which may not always account for health inequities stemming from historical discrimination against specific subgroups within its population. This initiative represents one of the many ways KHS is proactively addressing disparities and refining risk assessments to promote equitable health outcomes.

Starting in October 2024, California correctional facilities were allowed to offer pre-release services to people in jail or prison who are within 90 days of getting out, thanks to a new federal waiver (1115 Demonstration Waiver). The California Department of Corrections and Rehabilitation (CDCR) launched these services statewide in all state prisons as of February 1, 2025. The whole state is required to have this up and running by September 2026 (county entities and youth facilities). The goal of California's Justice-Involved (JI) Reentry Initiative is to help people coming out of incarceration stay healthy and get the support they need to land on their feet. It allows eligible individuals to sign up for Medi-Cal before they're released so they can start receiving things like doctor visits, medication, and care coordination while still inside. After they're out, they can continue getting help for up to a year through community-based programs

and care managers who assist with things like mental health, housing, and recovery. The JI Reentry Initiative is intended to help people avoid falling through the cracks and have a fresh start. KHS's ECM Department oversees the JI Reentry Initiative for members.

Overall Strategy:

To effectively address these unmet needs, KHS will prioritize scaling existing services, develop new programs specifically for growing populations, and enhance partnerships with community organizations to tackle the underlying social determinants of health.

Health Status and Disease Prevalence

Kern County Public Health Profile

Kern County ranks low or among the worst compared to other California counties for a variety of public health indicators. Kern County ranks in the bottom 10 California counties for age-adjusted death rates due to all causes, diabetes (ranked last), Alzheimer's disease, coronary heart disease, chronic lower respiratory disease, homicide (ranked last), firearm related deaths, and drug overdose deaths.[16] It is also among the bottom 10 California counties for the incidence of chlamydia, gonorrhea among females 15-44 years old, infant mortality, births to mothers 15-19 years old, and breastfeeding initiation during early postpartum. In addition, Kern County is in the bottom 10 counties for the rate of persons under 18 in poverty. The Kern County rate is more than twice as high as the state rate for deaths due to diabetes, deaths due to chronic lower respiratory disease, homicide, firearm related deaths, congenital syphilis, primary and secondary syphilis among females 15-44 years old, and teen births.

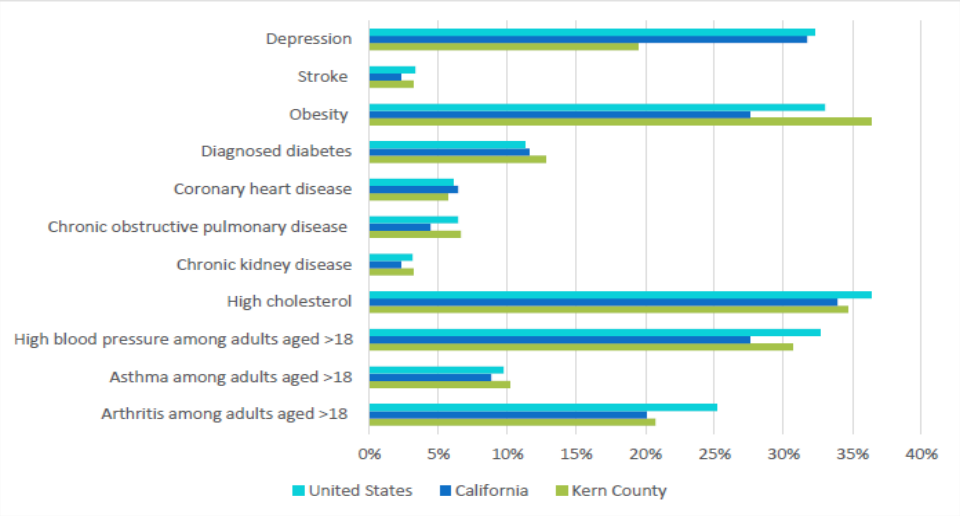
Health Indicators Where Kern County Ranks in the Bottom 10 California Counties	Kern County Rate*	California Rate*
Deaths Due to All Causes	951.1	670.0
Deaths Due to Diabetes	48.8 (ranked last)	23.6
Deaths Due to Alzheimer's Disease	51.9	35.5
Deaths Due to Coronary Heart Disease	118.6	77.2
Deaths Due to Chronic Lower Respiratory Disease	52.6	24.5
Homicide	13.8 (ranked last)	6.1
Firearm Related Deaths	17.4	8.7
Drug Overdose Deaths	50.0	25.3
Incidence of Chlamydia (crude case rate)	618.3	468.9

Gonorrhea Among Females 15-44 Years Old (crude case rate)	453.3	332.4
Infant Death Rate	5.3 per 1,000 births	3.7 per 1,000 births
Births to Mothers 15-19 Years Old	19.5 per 1,000 live births	9.5 per 1,000 live births
Breastfeeding Initiation During Early Postpartum (Percent)	93.6%	88.5%
Persons Under 18 Years Old in Poverty	25.3%	15.8%

*Age-adjusted rate per 100,000 population unless otherwise noted.
Source: California Department of Public Health, California's County Health Status Profiles 2024

In the Kern County 2023 Community Health Assessment, obesity, high cholesterol, high blood pressure, arthritis, depression, diabetes, asthma, chronic obstructive pulmonary disease (COPD), coronary heart disease, and cancer were identified as the most commonly diagnosed chronic diseases among Kern County adults.[9] Obesity and stroke prevalence in Kern County are about 1.3 times higher than the state average. The rates of high cholesterol, high blood pressure, arthritis, diabetes, asthma, and chronic kidney disease are slightly higher among adults in Kern County adults than adults in California. COPD is 1.5 times more prevalent in Kern County than the state overall. On the other hand, the rates of coronary heart disease and cancer are slightly lower than the state. There is a much smaller proportion of adults reporting depression in Kern County compared to the state prevalence. KHS has partnered with Kern County Public Health to support planning and implementation efforts of the Kern County Community Health Assessment, which is completed every 3 years.

Chronic Disease Prevalence Among Adults Aged 18 Years and Older



	Kern County	California	United States
Arthritis	20.7%	20.1%	25.8%
Asthma	10.2%	8.8%	9.8%
High Blood Pressure	30.2%	27.9%	32.7%
Coronary Heart disease	5.7%	3.2%	3.8%
Ever had a stroke	3.2%	2.7%	3.0%
COPD	6.6%	4.6%	6.1%
Diabetes	12.8%	11.6%	10.9%
Cancer	5.3%	5.4%	7.0%

Source: CDC Behavioral Risk Factor Surveillance System (BRFSS), 2021

Source: Kern County 2023 Community Health Assessment

According to 2019-2021 data from the Behavioral Risk Factor Surveillance System, 10.1% of Kern County adults had current asthma prevalence compared to 8.8% for California adults.[17,18] When looking at children, the current asthma prevalence was 7.2% in Kern County and 5.0% in California. According to the California Department of Public Health, the emergency department (ED) visit rate due to asthma was 46.1 per 100,000 Kern County residents compared to the state average of 42.6 per 10,000 residents in 2019.[19] Black/African American people in Kern County experience asthma disparities as demonstrated by their asthma ED visit rate of 181.5 per 100,000 people. This rate is more than four times the rate of the next highest racial/ethnic group and more than three times the overall rate in Kern County. Bad air quality is a risk factor for asthma. Kern County is known to have unhealthy levels of air quality. Kern County received an "F" or "Fail" grade for ozone and particle pollution in the 2025 State of the Air Report published by the American Lung Association.[20]

Kern County is also known for having the highest incidence of Valley fever out of all California counties. According to Kern County Public Health, Valley fever incidence in Kern County rose from 346.3 cases per 100,000 people in 2023 to 436.3 cases per 100,00 people in 2024.[21] According to the California Department of Public Health, Kern County had the highest Valley fever incidence in the state in 2023 with a rate of 330.9 per 100,000.[22] California had an overall rate of 23.2 that same year. Most cases of Valley fever in California are reported in people who live in the Central Valley and Central Coast regions.[23]

KHS Member Health Conditions & Diagnoses

KHS medical service claims data revealed that the most common diagnoses among KHS members in 2024 varied by age group and service type.[24] The top 10 diagnoses among members (excluding SPDs) included the following in descending order: acute upper respiratory infection, preprocedural exam, routine child health exam without abnormal findings, type 2 diabetes, hypertension, acute cough, acute pharyngitis, chest pain, routine child health exam with abnormal findings, and cough. Diagnoses involving chronic conditions are more prevalent among older age groups. The chart below includes a breakdown of the top 5 diagnoses by age group and service type (excluding SPDs).

2024 TOP 5 Diagnoses Excluding SPDs				
Age Group	**ER**	**INPATIENT**	**OUTPATIENT**	**URGENT CARE**
0-11 Years	1. Acute upper respiratory infection (URI) 2. Viral infection 3. Fever 4. Nausea and vomiting 5. Head injury	1. Acute bronchiolitis due to respiratory syncytial virus 2. Acute respiratory failure with hypoxia 3. Neonatal jaundice 4. Acute bronchiolitis 5. Acute appendicitis (with abscess)	1. Routine child health exam without abnormal findings 2. Acute URI 3. Routine child exam with abnormal findings 4. Viral infection 5. Fever	1. Acute URI 2. Acute cough 3. Fever 4. Cough 5. Acute pharyngitis
12-20 Years	1. Abdominal pain 2. Headache 3. Acute URI 4. Viral infection 5. URI	1. Sepsis 2. Acute appendicitis 3. Self-harm poisoning by 4-Aminophenol derivatives 4. Acute appendicitis (without abscess) 5. Acute appendicitis (with abscess)	1. Routine child health exam without abnormal findings 2. Routine child exam with abnormal findings 3. Abdominal pain 4. Headache 5. Chest pain	1. Acute URI 2. Acute pharyngitis 3. Acute cough 4. Cough 5. Abdominal pain
21-64 Years	1. Chest pain 2. Urinary tract infection (UTI) 3. Headache 4. Abdominal pain 5. Other chest pain	1. Sepsis 2. Morbid (severe) obesity due to excess calories 3. Hypertensive heart disease with heart failure 4. Type 2 diabetes with ketoacidosis without coma 5. Acute kidney failure	1. Type 2 diabetes 2. Hypertension 3. Chest pain 4. Preprocedural exams 5. Abdominal pain	1. Acute URI 2. Acute URI 3. Acute pharyngitis 4. Cough 5. Dysuria

65+ Years	1. UTI 2. Hypertension 3. Low back pain 4. Abdominal pain 5. Constipation	1. Sepsis 2. Pneumonia 3. Hypertensive heart disease with heart failure 4. Sepsis due to E. Coli 5. non-ST-segment elevation myocardial infarction	1. Antineoplastic chemotherapy 2. Hypertension 3. UTI 4. Malignant neoplasm 5. Antineoplastic immunotherapy	1. UTI 2. Acute URI 3. Acute cough 4. Acute bronchitis 5. Cough

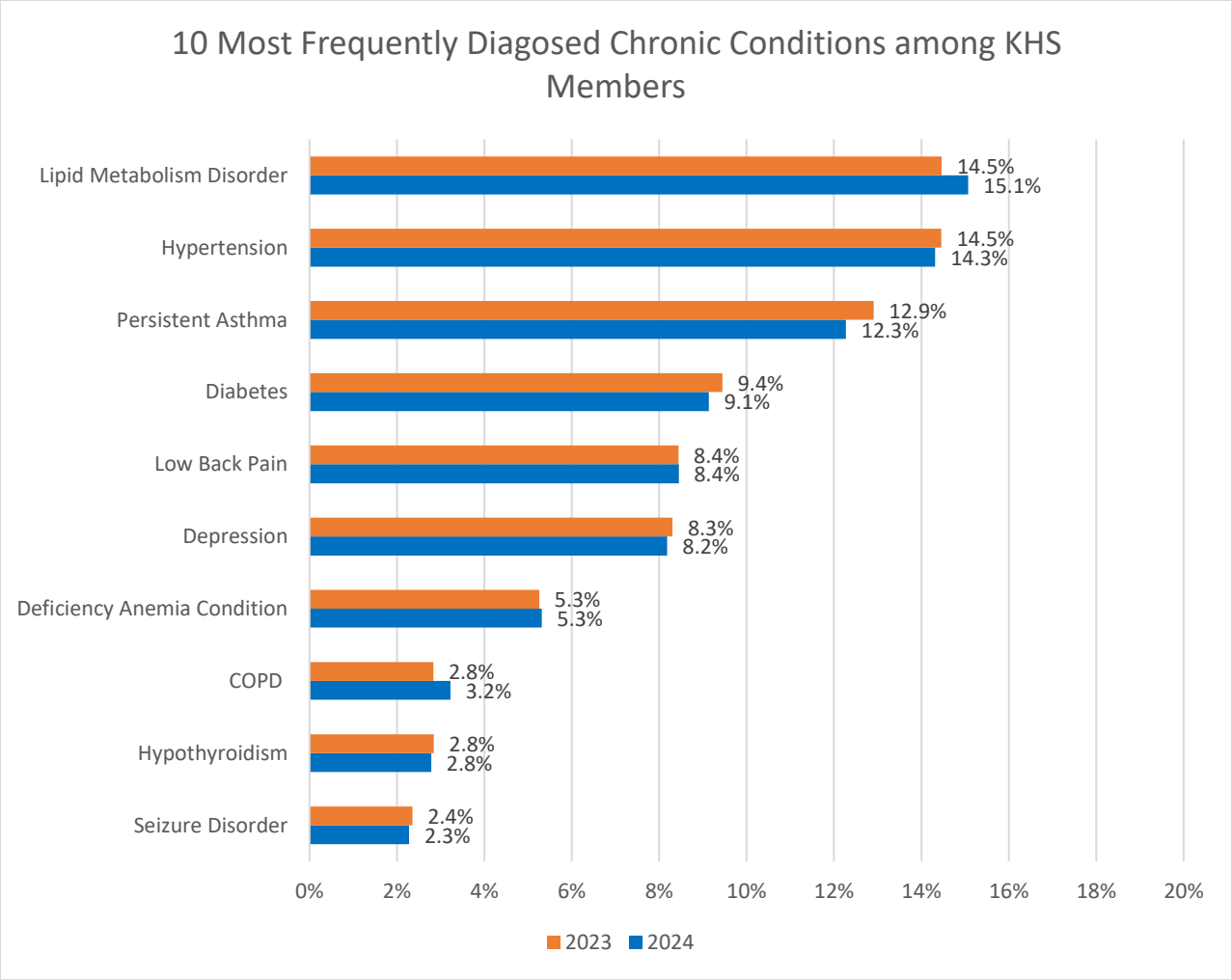
Source: 2024 KHS Top 5 Diagnoses for ER, UC, Outpatient, and Inpatient Paid Claims Report

The top 10 diagnoses among SPD members included the following in descending order hypertension, type 2 diabetes, administrative exam, counseling, autistic disorder, end stage renal disease, urinary tract infection, influenza, antineoplastic chemotherapy, and abdominal pain. The chart below includes the top five diagnoses among SPD members by service type.

2024 TOP 5 Diagnoses Among SPD's			
ER	**INPATIENT**	**OUTPATIENT**	**URGENT CARE**
1. UTI 2. Abdominal pain 3. Influenza 4. Chest pain **5.** Viral infection	1. Sepsis 2. COPD 3. Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side 4. Hypertensive heart disease with heart failure 5. COPD with exacerbation	1. End stage renal disease 2. Type 2 diabetes 3. Hypertension 4. Antineoplastic chemotherapy 5. Other preprocedural exam	1. Autistic disorder 2. Hypertension 3. Administrative exam 4. Type 2 diabetes 5. Counseling

Source: 2024 KHS Top 5 Diagnosis for ER, UC, Outpatient, and Inpatient Paid Claims Report

The following chart includes the top ten chronic conditions by member diagnosis rate for both 2023 and 2024.[1] The list includes the same chronic health conditions for both years. Diagnosis rates increased slightly in 2024 compared to 2023 for lipid metabolism disorder, low back pain, deficiency anemia condition, and COPD. Rates decreased slightly for the other chronic conditions that were among the 10 most prevalent in 2024.



Source: KHS Member Demographics Report

When looking at the top five chronic health conditions among KHS members, racial/ethnic disparities varied by health condition in 2024. Data findings indicate that diabetes, hypertension, and disorders of lipid metabolism may disproportionately impact Asian/Pacific Islander members.[11] Black/African American members are more likely to be disproportionately affected by asthma. White members had the highest rate of low back pain. The racial/ethnic group with the highest rates for each of the top chronic conditions among KHS members is shown in red, respectively, in the table, below.

These results should be interpreted cautiously since claims data may not capture all cases of chronic condition rates, leading to underestimates. Racism, negative past health care experiences among Black/African American members and other members of color, culture, linguistics, and other factors may influence their willingness to seek medical care. As a result, this may have resulted in under-utilization of health care among KHS members.

Rates of the Top 5 Chronic Conditions by Race/Ethnicity, 2024

Chronic Condition	Black/ African American	Asian & Pacific Islander	White	Hispanic	Native American
Asthma	16.0%	12.8%	13.8%	11.3%	14.6%
Diabetes	8.5%	15.1%	8.7%	9.6%	12.3%
Hypertension	17.9%	25.6%	18.6%	13.0%	20.4%
Low Back Pain	11.2%	10.7%	11.4%	7.9%	11.1%
Lipid Metabolism Disorder	11.5%	28.5%	14.7%	15.7%	17.2%

Source: KHS Member Demographics Report

Pharmaceutical Utilization

KHS' review of the most frequently dispensed medications identified ibuprofen, atorvastatin calcium, vitamin D2, amoxicillin, and albuterol HFA as the top five medications prescribed to KHS members in 2024.[25] The 10 most prescribed medications are used for treatment of chronic conditions, allergies, infections, stomach ulcers, vitamin D deficiency, fever, and pain. Cost data for medications prescribed in 2024 was not available since the pharmacy benefit had become a carve out. In 2023 when cost data was last available, Ozempic had the highest total cost among all medications dispensed, resulting in a total of $31,585,116.94.[26] It is prescribed to lower blood sugar in adults with type 2 diabetes. In adults with type 2 diabetes and known heart disease, Ozempic is prescribed to reduce the risk of major cardiovascular events such as stroke, heart attack, or death.

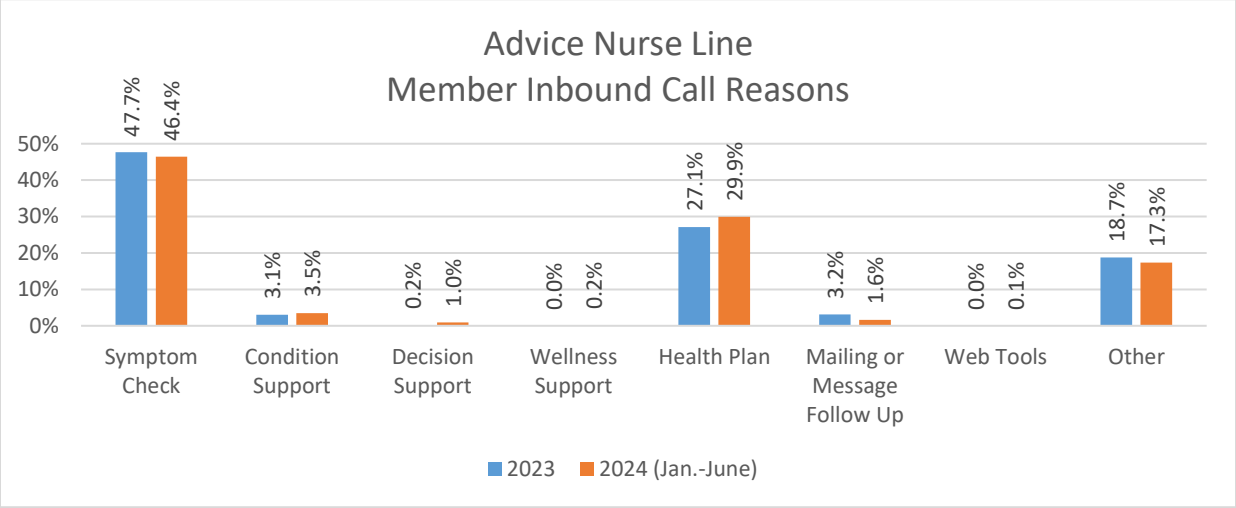
Top 10 Most Filled Medications in 2024	Targeted/Relevant Health Conditions
1. Ibuprofen	Fever and pain
2. Atorvastatin calcium	High cholesterol and triglyceride levels; heart and blood vessel problems
3. Vitamin D2	Vitamin D deficiency, hypoparathyroidism, refractory rickets, familial hypophosphatemia
4. Amoxicillin	Infections
5. Albuterol sulfate HFA	Breathing problems, such as asthma and COPD
6. Metformin HCL	Type 2 diabetes
7. Lisinopril	High blood pressure and heart failure
8. Promethazine DM	Symptoms of allergies and the common cold
9. Loratadine	Allergy symptoms and hives
10. Ozempic	Type 2 diabetes and weight management

Source: KHS Medication Prescriptions Report

Advice Nurse Line

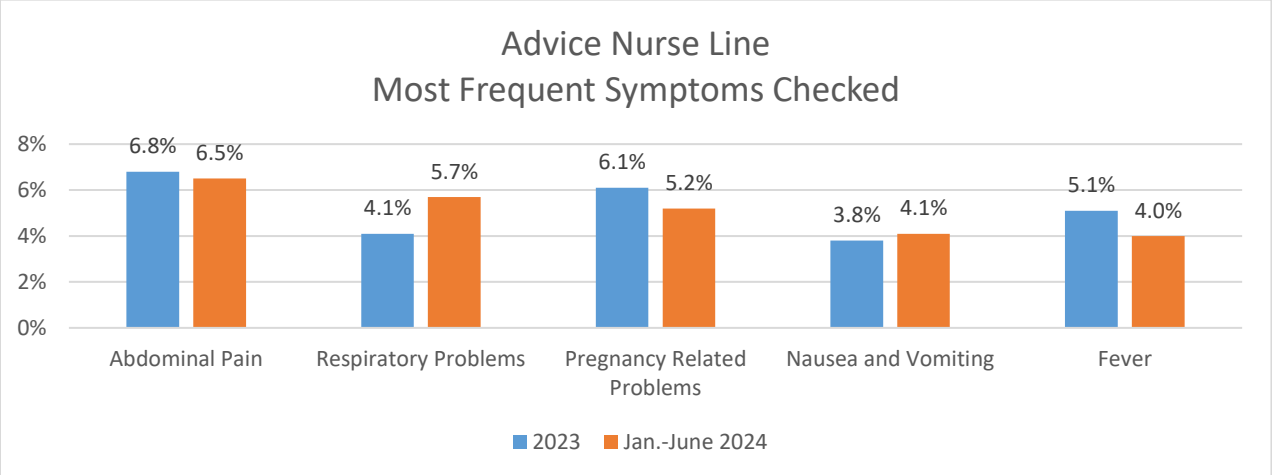
In 2024, the KHS advice nurse line total call volume was 6,104.[27,28] This was a 18.4% increase compared to the total call volume in 2023. From January 2024 through June 2024, the top three

inbound call reasons included symptom check (46.4%), followed by health plan (29.9%), and other (17.3%).[29] Starting in June 2024, inbound call reasons were no longer tracked with the same categories after the nurse advice line service contract was acquired by a company that tracks call reasons differently. The top three inbound call reasons were the same in 2023.

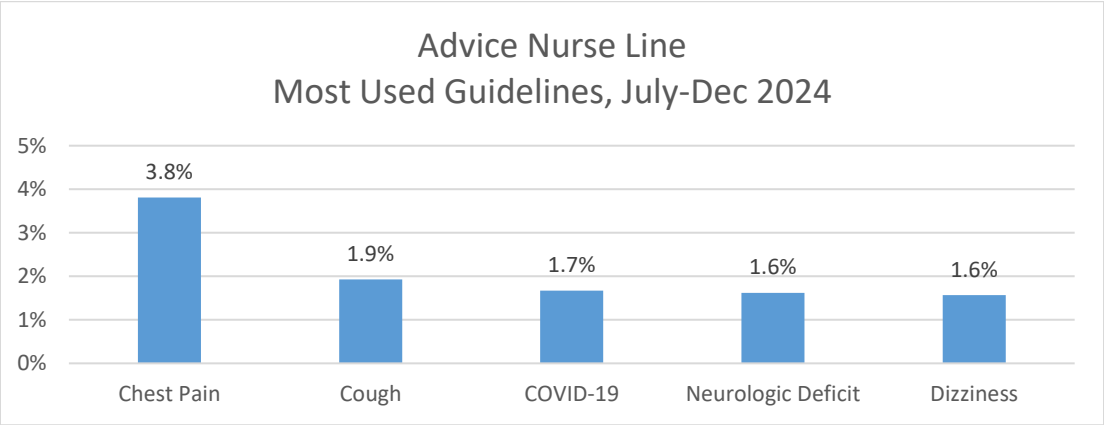


Source: 2023 and 2024 Kern Family Health Nurse Advice Line Program Summary Reports

The most frequent symptoms for inbound symptom check calls during January 2024 through June 2024 were abdominal pain, followed by respiratory problems, pregnancy related problems, nausea and vomiting, and fever. Starting in July 2024, symptom check calls were tracked with a different symptom tracking system where symptoms or call reasons are referred to as guidelines after the nurse advice line service contract was acquired by another company. From July 2024 through December 2024, the 5 most frequent symptoms or guidelines for symptom related calls included chest pain, cough, COVID-19, neurologic deficit, and dizziness. This compares to the top five symptoms checked for 2023, which were abdominal pain, pregnancy related problems, fever, respiratory problems, and nausea and vomiting.



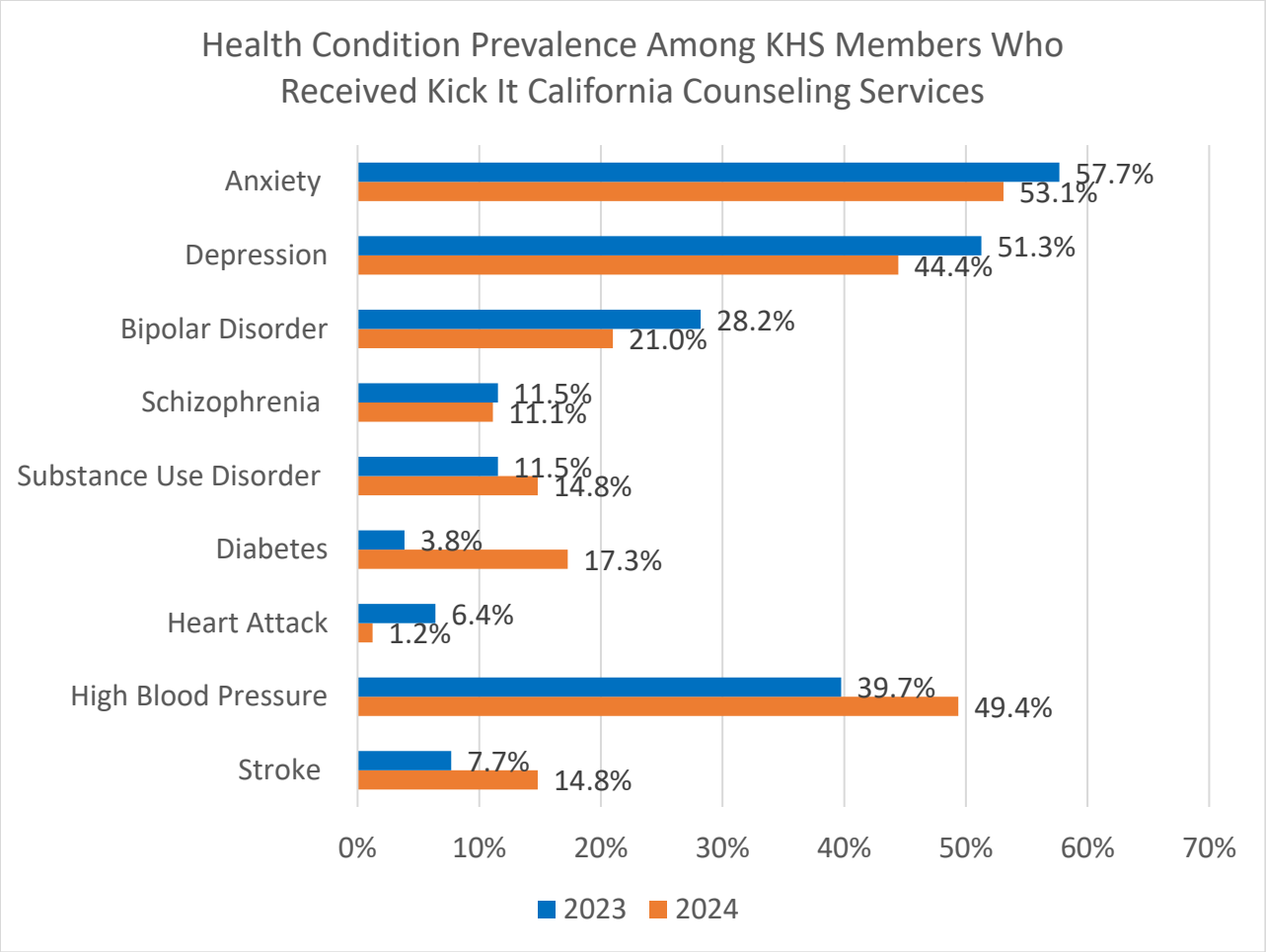
Sources: 2023 Kern Family Health Nurse Advice Line Program Summary Report; 2024 Kern Family Health Care Nurse Advice Line Program Summary Report



Source: 2024 Kern Family Health Care Nurse Advice Line Year End Review

Smoking, Tobacco Use and Associated Health Conditions

The NCQA HEDIS® MY 2023 CAHPS Adult Medicaid Survey performed by the DHCS Health Services Advisory Group (HSAG) found that 11.26% of KHS adult members were current smokers.[30] According to KHS' Tobacco Registry Report, 3.1% of members in 2024 were identified as tobacco users compared to 1.7% of members in 2023.[31] Kick It California (KIC) collects demographic and health data during phone counseling sessions and shares this data with Medi-Cal Managed Care health plans. KIC data revealed that KHS member callers in 2024 were most likely to be English-speaking (98.8%), female (65.1%), White (47.0%), and between the ages of 45-64 years (49.4%).[32] In that same year, 56.6% of KHS member callers had a high school diploma or higher and 41.0% had some college education or higher. Anxiety and high blood pressure were identified as the top behavioral and physical health conditions, respectively, among KHS members.



Source: 2023 and 2024 Kern Health Systems Callers to the California Smokers' Helpline Reports

Member Health Status and Disease Prevention and Management Needs Summary

1. High cholesterol, high blood pressure, asthma, low back pain, and depression continue to be the most frequently diagnosed chronic conditions among members. Diagnoses involving chronic conditions are more prevalent among older age groups. Chronic disease management programs are needed to help members manage these conditions.
2. In 2024, the KHS advice nurse line total call volume increased by 18.4% compared to 2023. This reflects an increase in member need for this service, which can help members identify an appropriate type of health care to address symptoms.
3. Racial and ethnic disparities vary by chronic disease. Chronic disease management programs should be culturally sensitive and orientated towards the needs of different racial and ethnic groups.

Conclusion:

Based on the member health status and disease prevention and management needs summary, the key unmet member needs include:

1. Chronic Disease Management Programs

- **Need**: High cholesterol, high blood pressure, asthma, low back pain, diabetes and depression are the most prevalent chronic conditions among members, indicating need for chronic disease management and mental health programs and resources.
- **Action**: Due to resource constraints, use systematic screenings or risk assessments to identify and prioritize members with high-risk or uncontrolled chronic health conditions. Use demographic variables to identify and address health disparities with member outreach strategies. Develop and expand programs focused on effective management strategies for these prevalent conditions, especially those where limited program options or resources are available. For example, KHS does not directly offer a heart health education and disease management program. KHS is considering the development of its own community heart health education program. Explore opportunities to partner with health education service providers or health care providers.

2. Culturally Sensitive Care

- **Need**: There are disparities in chronic disease prevalence among different racial and ethnic groups, necessitating culturally tailored management services and programs.
- **Action**: Create and implement chronic disease management programs that are culturally sensitive and address the unique needs of diverse populations.

3. Access to Appropriate Health Care and Supportive Resources

- **Need**: Advice nurse line call volume increased by 18.4% in 2024 compared to 2023. Members call the advice nurse line with a variety of common symptoms. Members who call the advice nurse line may need help navigating the health care system and finding appropriate health care and resources to address health conditions and SDOH. Members who receive costly hospital or medical care (based on claims data) or have been identified to have high-risk health conditions may also need assistance finding appropriate medical care and supportive resources.
- **Action**: PHM CHWs can follow up with members who call the advice nurse line to ensure members receive appropriate medical care and address SDOH by linking members with any needed supportive resources and mental health services. Use internal data and systematic screenings or risk assessments to identify members with high-risk health conditions and connect them with appropriate KHS programs.

Summary of Relevant Actions:

- **Chronic Disease Management Programs**: Focus on education, lifestyle interventions, and regular monitoring for conditions like high cholesterol, high blood pressure, asthma, low back pain, and depression.
- **Cultural Competency Training**: Ensure that healthcare providers are trained in cultural competency to effectively serve diverse racial and ethnic groups.
- **Connect Members with Appropriate Health Care and Supportive Resources:** Follow up with members who call the advice nurse line and connect them with appropriate health care services and supportive resources. Also prioritize outreach efforts with members who have high-risk health conditions.

Current Activities That Address Member Disease Prevention and Management Health Needs:

KHS is actively engaged in initiatives that address the full continuum of care for our members. These programs and interventions have been designed to meet the diverse needs of our members across various PHM programs. These initiatives include:

Keeping Members Healthy – KHS has several programs focused on keeping members healthy, including:

- Activity & Eating Program
- Eat Healthy Be Active Program
- Live Better Program
- Health library and self-management tools

Early Detection/Emerging Risk – KHS offers programs and services aimed at early identification and prevention of risk factors among members. The following programs and services are available to eligible members:

- Breast cancer screening
- Cervical cancer Screening
- Child and adolescent well-care visits
- Childhood immunization record
- Chlamydia screening in women
- Diabetes Prevention Program (Centers for Disease Control and Prevention Recognition)
- Developmental screening in the first three years of life
- Engagement with dental services
- Hypertension screening and assessment
- Immunizations for adolescents
- Lead screening in children
- Monitoring use of ER services (determining root causes)
- Prenatal and postnatal care
- Well child visits in the first 30 months of life.

Chronic Condition Management – KHS has several programs focused on helping members manage their chronic conditions. The following programs and services are made available to all identified members:

- Asthma Preventive Services
- Behavioral Health Services
- Breathe Better Asthma Program
- Chronic Obstructive Pulmonary Disease Program
- Community Health Worker Services
- Community Support Services
- Complex Care Management

- Diabetes Empowerment Education Program™
- Enhancement Care Management
- End Stage Renal Disease Program
- ER Navigation Program
- Fresh Start and Fresh Start Plus Smoking Cessation Programs
- Kids and Youth Transitional Program
- Long Term Care and Support Services
- Member Centric Care Coordination
- Mental Health Services
- Major Organ Transplant Program
- Palliative Care Services
- Transition of Care Services
- Substance Abuse Treatment Services

Maternal and Child Health – The following KHS programs and community resources promote maternal and child health among eligible members:

- Black Infant Maternal Health Initiative
- Baby Steps Program
- Baby Steps Plus Program
- Member baby showers

Children's Health – KHS offers programs that focus on access to and utilization of primary and preventive health care, developmental screenings, and services oriented towards children with special needs and health conditions:

- Basic Population Health Management (BPHM)
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Kids and Youth Transition Program for Children with Special Health Care Needs

SDOH – KHS offers programs and benefits that address SDOH, including:

- Asthma Preventive Services
- Behavioral Health Treatment
- Community Health Worker Services
- Community Support Services
- Complex Case Management
- Enhanced Care Management
- Mental Health Services
- Substance Abuse Treatment Services

Chronic Obstructive Pulmonary Disease (COPD): KHS has partnered with a health care provider to ensure comprehensive care for high-risk members with COPD. Using the Gold Guidelines[33], comprehensive care is provided with the goal of mitigating risk for COPD exacerbations that are known to negatively impact health status and disease progression while increasing rates of hospitalizations and readmissions.

Programs That Address Maternal Health Outcomes

Analysis of member health status and disease needs highlights significant disparities in maternal health outcomes, particularly among high-risk and underserved populations. Key unmet needs include limited early access to prenatal care, gaps in postpartum follow-up, underdiagnosis and treatment of perinatal depression, and low uptake of recommended vaccinations during pregnancy.

In response, KHS has implemented targeted initiatives such as the Baby Steps and Baby Steps Plus programs. These programs provide health education, care coordination, and social support to encourage early and consistent prenatal care, postpartum follow-up, and behavioral health screenings. The Baby Steps Plus program further addresses social determinants of health through field-based outreach and connection to community services.

Baby Steps Program

The Baby Steps Program was developed to encourage KHS members to seek and obtain early and consistent pregnancy care. The program provides health and pregnancy education through various channels including the KHS website and member portal, social media channels, and printed health guides. Outreach is also conducted to members to provide education and resources. Members are eligible to receive a member reward for completing specific pregnancy care visits.

Baby Steps Plus Program

The Baby Steps Plus Program provides care coordination and management to high-risk pregnant women. Staff conducts field visits to provide health education on the importance of prenatal and postpartum care, identify social determinants of health and gaps in services, connect pregnant women with a provider and community services, and assist in transportation to medical appointments. The goals of the program are:

- Improve the percentage of women who obtain early entry to prenatal care in the first trimester;
- Improve the percentage of women who obtain postpartum visit on or between 7 and 84 days after delivery;
- Improve the percentage of women who screen for clinical depression during prenatal care and receive follow up care within 30 days of a positive depression screening;
- Improve the percentage of women who screen for clinical depression during postpartum care and receive follow up care within 30 days of a positive depression screening; and
- Improve the percentage of women to obtain influenza and Tdap vaccinations during pregnancy.

Current Maternal Health Activities:

KHS will continue to strengthen culturally sensitive maternal health programs, enhance member engagement, and collaborate with providers and stakeholders to reduce barriers to care. This strategy supports improved maternal and infant health outcomes across the member population.

PHM has partnered with Mommy's House, a program operated by Bakersfield Recovery Services that supports pregnant and postpartum women recovering from substance use. The Director and Manager of Bakersfield Recovery Services have expressed a need for more comprehensive prenatal and postpartum education for their participants. Although the women receive care from OB-GYN providers, there remains a clear gap in supplemental education and support.

In response, an 8-week educational curriculum was developed to address these needs and will culminate in a celebration recognizing participants' completion of the course. Additionally, the mothers have the opportunity to enroll in the Baby Steps Plus Program, which offers individualized support from a dedicated nurse. This initiative will launch as a 3-month pilot project beginning in July 2025.

Overall Strategy:

To address these unmet needs, KHS will prioritize the development of comprehensive, accessible chronic disease management and maternal health programs while ensuring cultural sensitivity in program or care delivery. Engaging with members, health care providers, and other stakeholders to understand specific barriers and preferences can enhance program effectiveness and health outcomes.

Assessment of Members with Behavioral Health Conditions

This section of the PNA outlines the mental health, substance use disorder (SUD), and behavioral health treatment (BHT) needs of Kern Health Systems (KHS) members, based on demographic trends, service utilization, and key challenges. The goal is to identify gaps in services, trends in health conditions, and propose actionable solutions to improve access and care delivery for behavioral health services.

Mental Health Overview Services

Mental health plays a vital role in a person's emotional, psychological, and social well-being, influencing how individuals handle stress, relate to others, and make decisions. It is estimated that 1 in 2 individuals will experience a mental health condition at some point in their lifetime. These conditions may range in severity—from mild disturbances to serious mental illnesses that significantly impair functioning.

Behavioral Health Services requires no prior authorization and under no wrong door members can access behavioral health services to initiate care through any system of care.

Non-Specialty Mental Health Services (NSMHS)

KHS coordinates NSMHS for members with mild to moderate impairment resulting from a mental health condition. These services are delivered through a network of licensed mental health professionals and include:

- Mental health evaluation
- Individual, group and family psychotherapy
- Dyadic behavioral health services
- Psychological and neuropsychological testing (when clinically indicated)
- Outpatient psychiatric consultation and medication management

Access and Screening

- Members scoring 5 or below on the DHCS Mental Health Screening Tool (Adult 21+ or Youth 20 and under) are referred to NSMHS.
- Under the CalAIM "No Wrong Door" initiative, KHS ensures seamless access to behavioral health care regardless of entry point.

Specialty Mental Health Services (SMHS)

KHS collaborates with Kern Behavioral Health and Recovery Services (KBHRS) to support the delivery of Specialty Mental Health Services (SMHS), which are carved out under the county-administered Behavioral Health Plan (BHP).

KHS Roles in SMHS Collaboration

KHS contributes to SMHS delivery through:

- Member referrals
- Screening and triage
- Transition of Care and Coordination
- Member support services
- Grievance resolution

SMHS are designed for members with moderate to severe mental health impairments and include the following services:

- Targeted Case Management
- Psychosocial Rehabilitation
- Intensive Care Coordination (ICC)
- Intensive Home-Based Services (IHBS)
- Therapeutic Behavioral Services (TBS)
- Crisis Intervention
- Peer support and recovery services
- Substance Use Disorder (SUD) treatment
- Inpatient and outpatient psychiatric care

Access and Screening

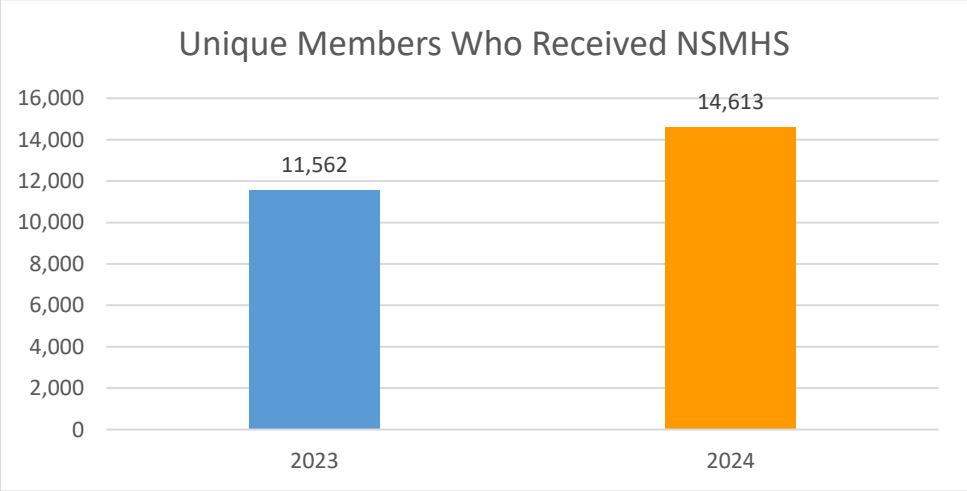
- Members scoring 6 or above on the DHCS Mental Health Screening Tool are referred to KBHRS for SMHS.
- Under CalAIM's "No Wrong Door" policy, KHS ensures access to behavioral health care regardless of the point of entry, supporting integrated and seamless member experiences.

Member Population Data (2024)

- 89,832 KHS Members were identified with a diagnosed mental health condition in 2024. These diagnoses range from mild to moderate concerns to conditions qualifying as Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).
    - SMI (adults, 18+): Diagnoses such as schizophrenia, bipolar disorder, major depressive disorder; substantially impaired functioning.
    - SED (children and youth <18): Mental health disorders causing functional impairments at home, school, and in the community.

Utilization Trends

- 14,613 members received Non-Specialty Mental Health Services (NSMHS) in 2024.[34]
- NSMHS utilization increased by 26% from 2023 to 2024, indicating rising demand and potential early identification of members who may require SMHS.

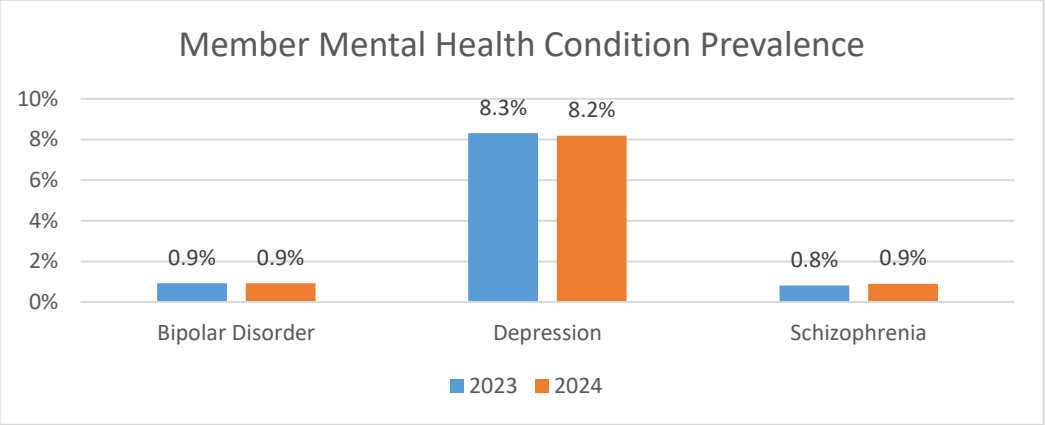


Source: KHS BH NSMHS Services Report

Member Mental Health Condition Diagnosis Prevalence in 2024:

- 8.2% of members had a diagnosis of depression[1]
    - A decrease of 0.1 percentage points from 2023
- 0.9% had a bipolar disorder diagnosis
    - Unchanged from the prior year
- 0.9% had a schizophrenia diagnosis

- An increase of 0.1 percentage points from 2023

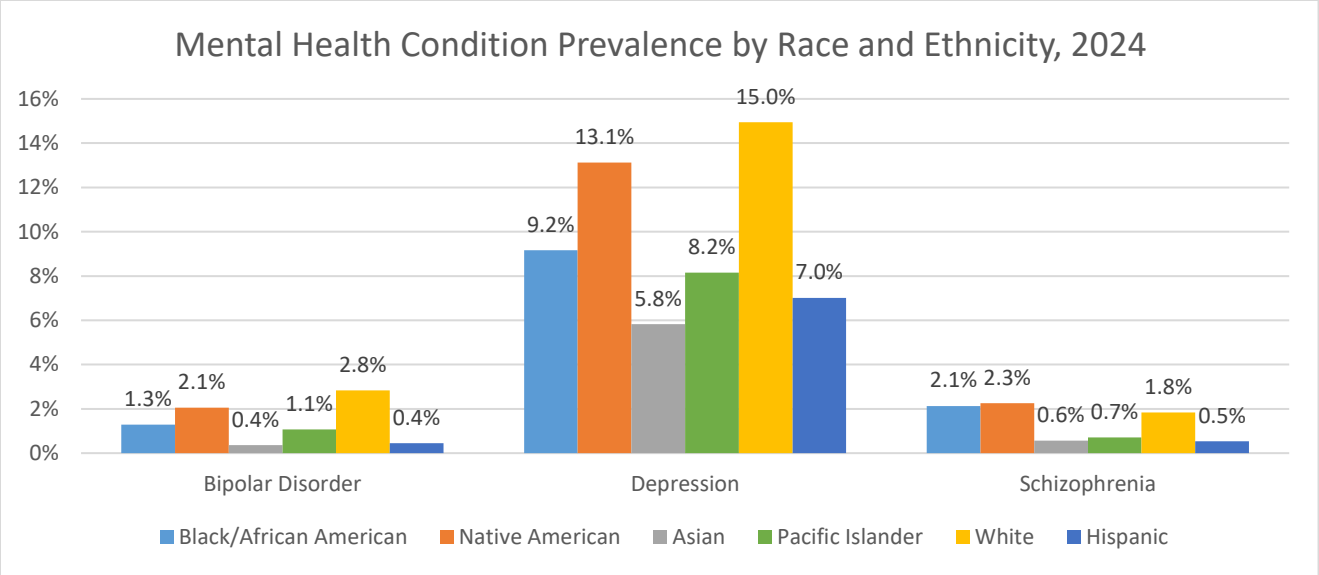


Source: KHS Member Demographics Report

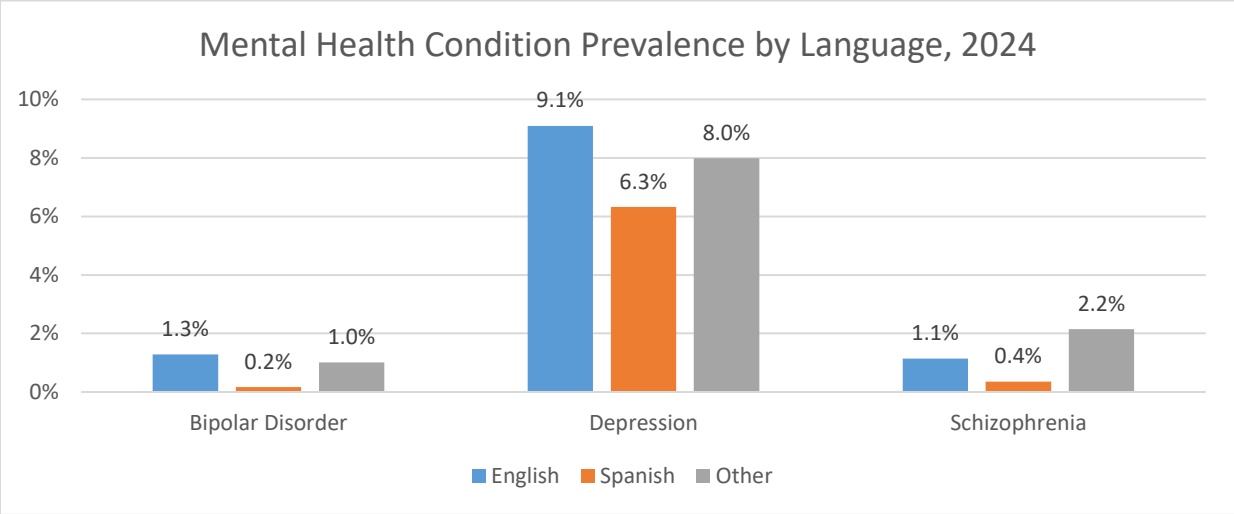
Based on 2024 data from the KHS Member Demographics Report diagnostic patterns indicate notable disparities across gender, language, age, and race/ethnicity among members with behavioral health conditions:

- Gender: Depression and bipolar disorder were more commonly diagnosed among female members, while schizophrenia was more frequently diagnosed among male members.
- Primary Language: Behavioral health diagnoses were most prevalent among English-speaking members, which may reflect differences in service access, cultural stigma, or diagnostic practices among non-English speakers.
- Age Groups:
  - Depression and bipolar disorder were most common among members aged 18–64 years.
  - Schizophrenia was most frequently diagnosed in members aged 65 and older.
- Race/Ethnicity:
  - Depression and bipolar disorder had the highest prevalence among White members.
  - Schizophrenia was most commonly diagnosed among Native American members.

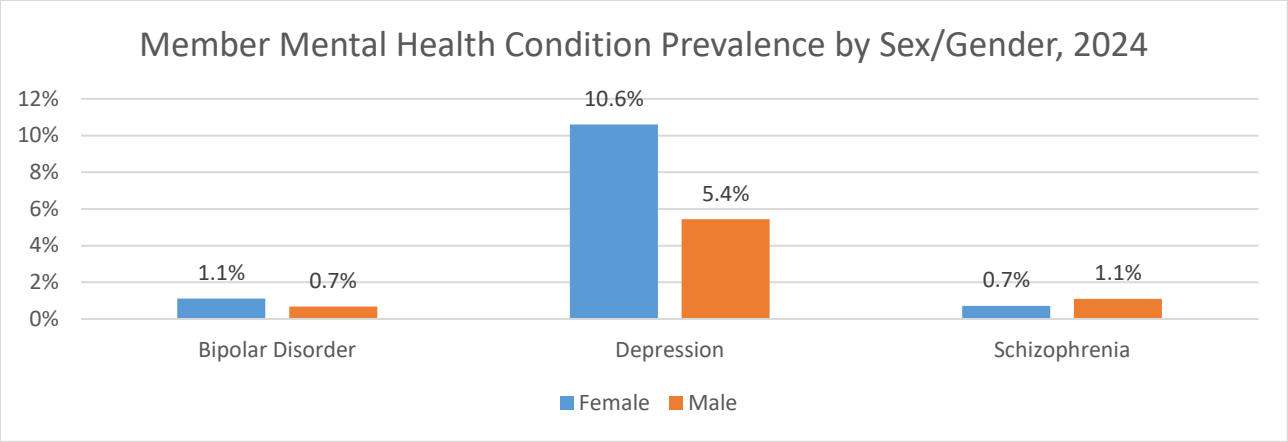
These demographic insights underscore the need for targeted outreach, culturally competent care, and ongoing efforts to address health disparities in behavioral health services.



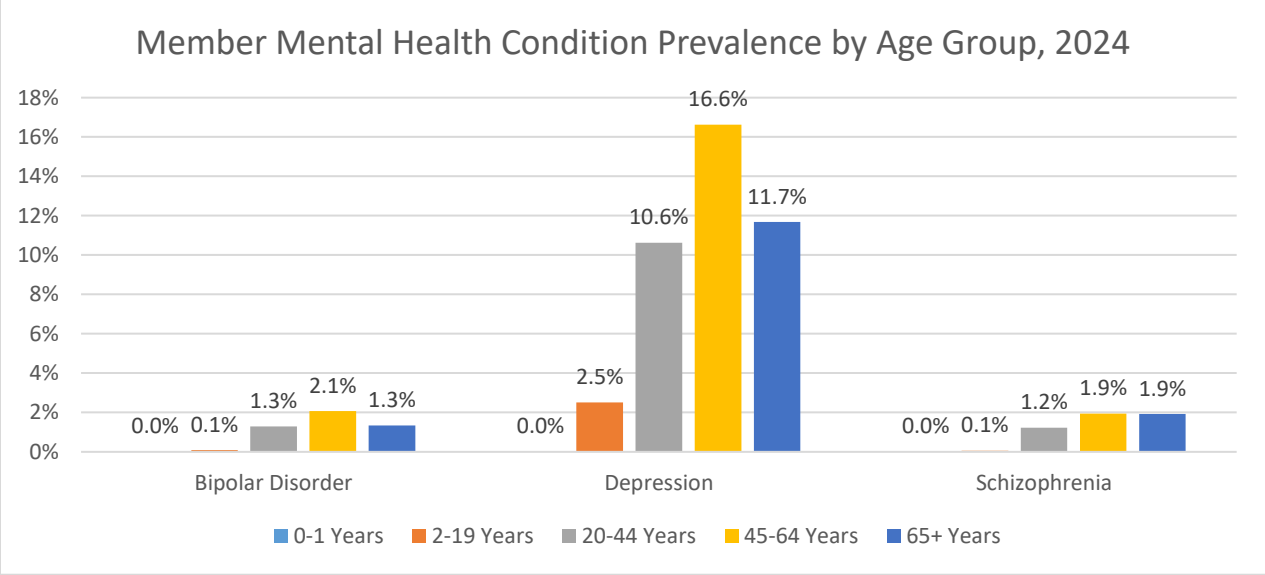
Source: KHS Member Demographics Report



Source: KHS Member Demographics Report



Source: KHS Member Demographics Report



Source: KHS Member Demographics Report

Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA)

Kern Health Systems (KHS) holds primary responsibility for ensuring that members with medically necessary BHT needs, including children diagnosed with Autism Spectrum Disorder (ASD), have timely and appropriate access to services. BHT services, such as Applied Behavioral Analysis (ABA), must be provided when a licensed physician, surgeon, or clinical psychologist determines they are medically necessary. Coverage is not limited to ASD but applies whenever BHT is needed to maintain the member's health, prevent deterioration of functioning, or reduce the likelihood of developing additional health conditions.

KHS ensures that BHT services align with state and federal requirements and are delivered in a manner that is accessible, evidence-based, and person-centered. This includes care coordination with primary care providers, behavioral health specialists, and educational systems when appropriate.

Utilization Trends

- In **2023**, a total of **2,394 authorizations** for ABA services were approved.
- In **2024**, this increased to **2,788 authorizations**, representing a **16% year-over-year growth**.

This upward trend demonstrates both increasing demand and improved access to ABA services within the KHS service area. The increase may reflect greater awareness of ASD, earlier screening and diagnosis, and expansion of provider networks. Ongoing monitoring of utilization patterns, workforce capacity, and member outcomes will be essential to meeting the growing needs of children and families requiring BHT.

Eligibility Criteria

Medi-Cal beneficiaries must meet the following coverage criteria to be eligible for BHT/ABA services:

1. Be under 21 years of age.
2. Have a recommendation from a licensed physician and surgeon or a licensed clinical psychologist that evidence based BHT/Behavioral Intervention Services (BIS) are medically necessary.
3. Be medically stable.
4. Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

Care Coordination and Support

KHS covers BHT for Autism Spectrum Disorder (ASD), including ABA and other evidence-based interventions. The KHS Behavioral Health (BH) Department—which includes a Board-Certified Behavior Analyst (BCBA) and Behavioral Health Care Coordinators—plays a central role in:

- Facilitating care coordination across providers and systems.
- Assisting families with navigation of BHT and related resources.
- Linking and referring members to appropriate services.
- Supporting ongoing communication with schools, primary care providers, and specialty providers to promote continuity of care.

Substance Use Disorder Treatment

Substance Use Disorder (SUD) is a medical condition where individuals are unable to control the use of substances like drugs or alcohol despite experiencing harmful consequences. SUD treatment is managed through the Drug Medi-Cal Organized Delivery System (DMC-ODS) by Kern Behavioral Health and Recovery Services (KBHRS). However, KHS continues to play a significant role in the coordination of care and outreach for SUD services.

A comparison of 2023 and 2024 data shows a 459.4% increase in SUD referrals sent to DMC-ODS for linkage to services.

SUD Referrals and Episodes		
Year	**2023**	**2024**
Total SUD Referrals	101	565
Status of Episodes		
Referral	16	34
Open	1	47
Closed	84	484

Summary of Needs of Members with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED)

When comparing 2023 and 2024 data, key trends and insights have emerged regarding the mental health needs of Kern Health Systems (KHS) members:

- **Prevalence Trends:**
  - Rates for bipolar disorder and schizophrenia increased slightly in 2024 compared to 2023. The rate of depression decreased slightly.
  - Depression continues to be the most prevalent mental health condition among KHS members.
  - English speakers, females, White members, and adults aged 18–64 have the highest rates of depression and bipolar disorder.
  - Schizophrenia remains most prevalent among Native American members.
- **Emerging Needs:**
  - Access to depression treatment services remain a key concern due to the high prevalence.
  - Data on anxiety, autism spectrum disorder (ASD), and ADHD is currently limited due to tracking constraints.
  - There is a noted need for community health worker (CHW) referrals and outreach for members with behavioral health conditions.
- **Service Utilization & Follow-Up:**
  - In 2024, KHS assisted 16.1% of members with follow-up after ED visits for mental illness (FUM), and 20.8% for substance use (FUA), reflecting ongoing care coordination efforts.

Identified Needs and Gaps

- Access Disparities: Lower penetration rates in rural or outlying areas (e.g., East Kern, Delano, Wasco, Lost Hills, Buttonwillow, Arvin, Lebec).
  - Action Plan: Expand outreach and engagement efforts in underserved regions.
- Performance Data: KHS tracks and monitors Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) metrics.

Summary of Needs of Members with Substance Use Disorder (SUD)

1. Comprehensive SUD Services
    a. Need: Limited access to outpatient care and Medication-Assisted Treatment (MAT) in certain areas.
    b. Action: Expand urgent care and same-day appointments for SUD treatment. Collaborate with KBHRS to establish walk-in clinics and mobile units in underserved areas to prevent unnecessary ED visits.
2. Improve Follow-Up Care for SUD Post-ED Visit
    a. Need: Timely follow-up care for members discharged from the ED with SUD concerns.
    b. Action: Collaborate with KBHRS and SUD treatment providers to implement enhanced care coordination, proactively schedule follow-up appointments, and set up automated reminders to ensure continuity of care within 7 days of discharge.
3. Integration of MAT and Behavioral Health Services with ED Care
    a. Need: Need for better integration of MAT and behavioral health services in the ED.
    b. Action: Work with KBHRS and ED staff to create collaborative care models where MAT and behavioral health professionals provide immediate treatment post-ED visit, ensuring warm handoffs to ensure no gap in care.
4. Enhance Member Education and Engagement
    a. Need: Educating members at high risk for SUD to reduce unnecessary ED visits.
    b. Action: Partner with KBHRS, Community Advisory Committees (CACs), and Regional Advisory Committees (RACs) to conduct outreach and educational campaigns, encouraging members to seek care before crises arise. Use peer support groups and outreach initiatives to engage members in continuous care.
5. Improve Data Tracking and Monitoring
    a. Need: Better tracking of SUD-related ED visits and follow-up care adherence.
    b. Action: Collaborate with KBHRS to use data analytics to monitor ED visits and follow-up care adherence (FUA MCAS measure). Engage care coordinators in targeted outreach for members who frequently visit the ED, ensuring appropriate SUD treatment is provided.
6. Increase Access to Peer Support and Recovery Services
    a. Need: Expanding peer support services for individuals with SUD.
    b. Action: Work with KBHRS to establish or expand peer support programs to connect individuals to ongoing treatment and provide emotional support. Integrate peer specialists into post-ED visit care teams to ensure better engagement and care continuity.

Summary of Needs of Members with Autism Spectrum Disorder (ASD)

- Provider Access: There is a significant need for additional BHT providers with greater availability, particularly in outlying areas of Kern County, including East and West Kern. Members in these regions often face barriers to accessing timely services.
- Service Availability: Expanded time slots for services and more in-person services are necessary to meet the growing demand.

- Wait Times and Navigation: Feedback from KHS staff indicates that members require assistance navigating the system, finding appropriate providers, and reducing wait times for appointments. There is also a need to better connect members with primary care providers to initiate referrals for service and provide education to help members understand available services.
- Provider Recruitment: There is a clear need to recruit more BHT providers to expand the provider network, particularly in underserved areas of East and West Kern. Increasing provider availability will ensure better access to services for members in these areas.
- Outreach and Engagement: Marketing and member outreach are critical to increasing awareness and utilization of BHT services. Ongoing outreach efforts can help connect members to the services they need.
- Member Retention and Engagement: Keeping members engaged with their BHT provider or team is essential. Peer support groups can play an important role in reducing stigma surrounding BHT services and improving retention.
- Provider Education:
    - Pediatric Primary Care Providers need ongoing education to support the early identification and timely treatment of members with potential developmental or functional deficits, which could indicate autism or other conditions. This education will improve the accuracy of early screenings.
    - ABA provider education is essential for supporting providers in managing services for members with aggression, co-occurring disorders, or complex presentations. Proper education and collaboration with other service providers can prevent disconnection and delays in service provision.

Activities to Address Member Needs

Mental health needs are met through a network of currently available services, including:

- Behavioral Health Treatment (BHT) for ASD
- Non-specialty mental health services (NSMHS)
- Screening, Assessment, Brief Intervention and Treatment (SABIRT) services
- Medication Assisted Treatment (MAT)
- CHW referrals and outreach
- Specialty Mental Health Services (SMHS) through the County Behavioral Health Plan (BHP)
- Substance Use Disorder (SUD) treatment through County Drug Medi-Cal Organized Delivery System (DMC-ODS)
- Crisis Response and 988 Hotline through Behavioral Health Plan (BHP)
- Transportation assistance for in-person appointments

Supportive Activities for Member Needs:

- Care Coordination: Use of DHCS screening tools, timely scheduling of non-urgent (10 days) and urgent (2 days) appointments, and transitions of care within 30 days.
- Community Health Workers (CHWs): Outreach to members referred through various sources (PCPs, schools, internal referrals).
- Care Management: Targeted support for high-risk members via Behavioral Health Care Managers.

- Telehealth Barriers: Limited access to the internet and technology among members hinders telehealth usage.
- Geographic Challenges: Members in outlying areas (e.g., Ridgecrest, Lake Isabella, Shafter, Wasco) face appointment access and transportation barriers.

Unmet Member Needs:

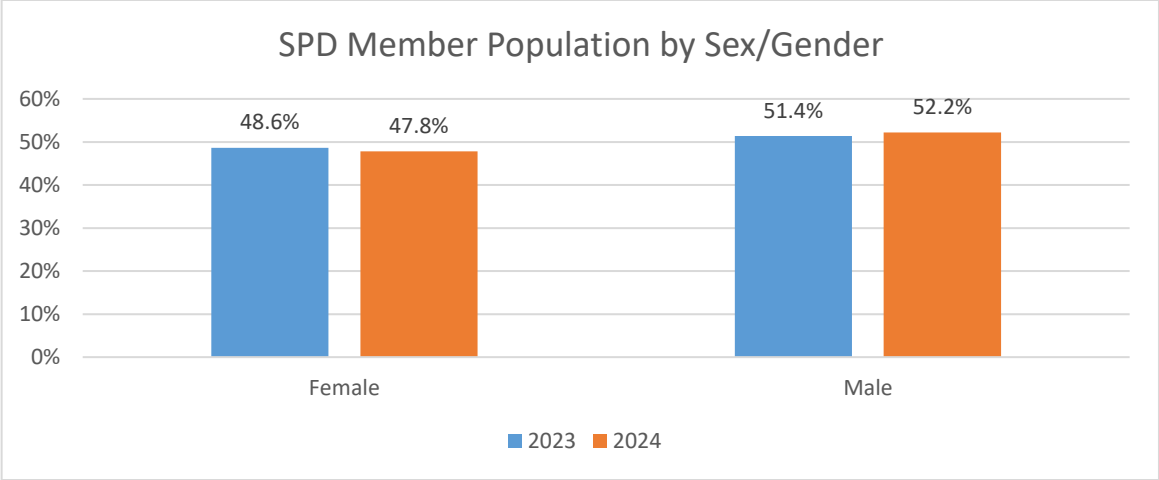
1. Insufficient provider network for BHT and mental health services.
2. Inadequate staffing and resources to support member needs.
3. Limited member engagement and outreach around available services.
4. Need for peer support groups to reduce stigma and improve engagement.
5. Provider training gaps in coordinating NSMHS and SMHS services.

Key Initiatives to Address Identified Needs:

- Expand Provider Network: Recruit additional BHT and mental health professionals.
- Improve Access: Address staffing, scheduling, and telehealth barriers.
- Boost Outreach & Engagement: Leverage CHWs and targeted campaigns to raise awareness and reduce stigma.
- Establish Peer Support Groups: Support member wellness and build community.
- Enhance Provider Collaboration: Strengthen training and simplify transitions between care levels.
- Strengthen Partnerships: Collaborate with county and community-based organizations to expand crisis and SUD services.
- Outreach and education are conducted via the Regional Advisory Committees (RACs) and Community Advisory Committee (CAC) to raise awareness and reduce stigma.

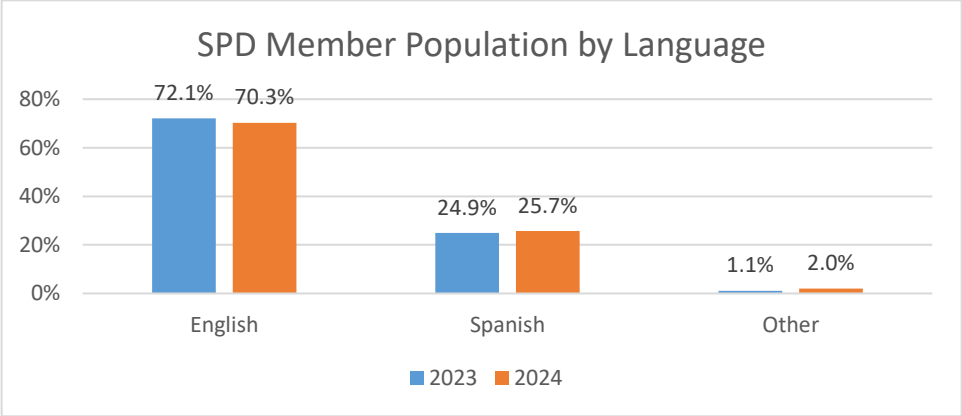
Assessment of SPD Members

The population of SPD members was estimated to be 21,478 members in 2024, a 21.8% increase compared to 17,628 members in 2023.[1] SPDs accounted for 4.6% of members in 2024, up from 4.5% in 2023. Females were 47.8% of SPD members compared to 48.6% in 2023. Males accounted for 52.2% of SPD members in 2024, an increase from 51.4% for the previous year.



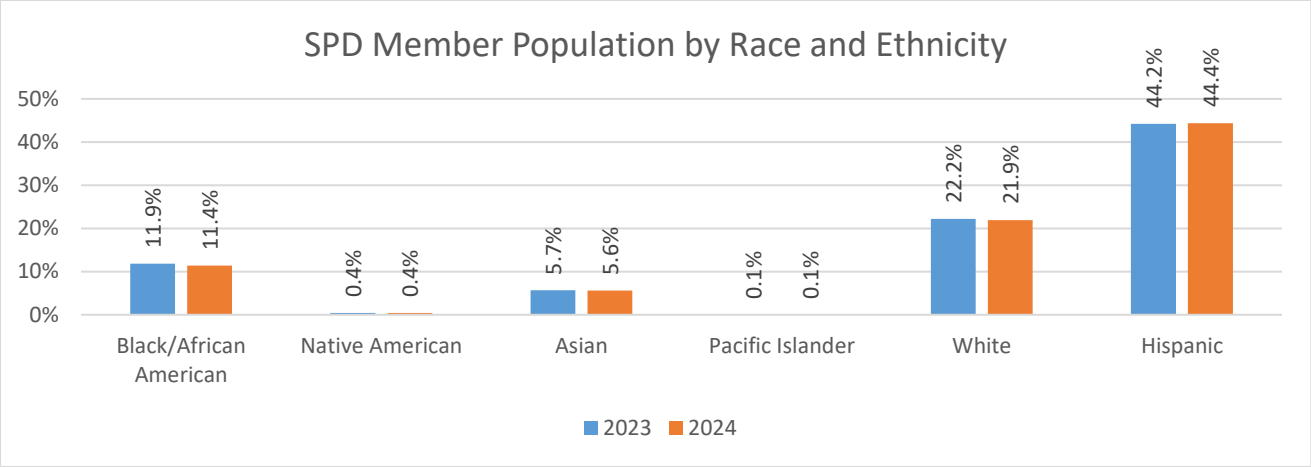
Source: KHS Member Demographics Report

English speakers accounted for 70.3% of SPD members in 2024, down from 72.1% in 2023. Spanish speakers and other languages combined were 25.7% and 2.0%, respectively, of SPD members in 2024. Both percentages increased compared to the previous year.



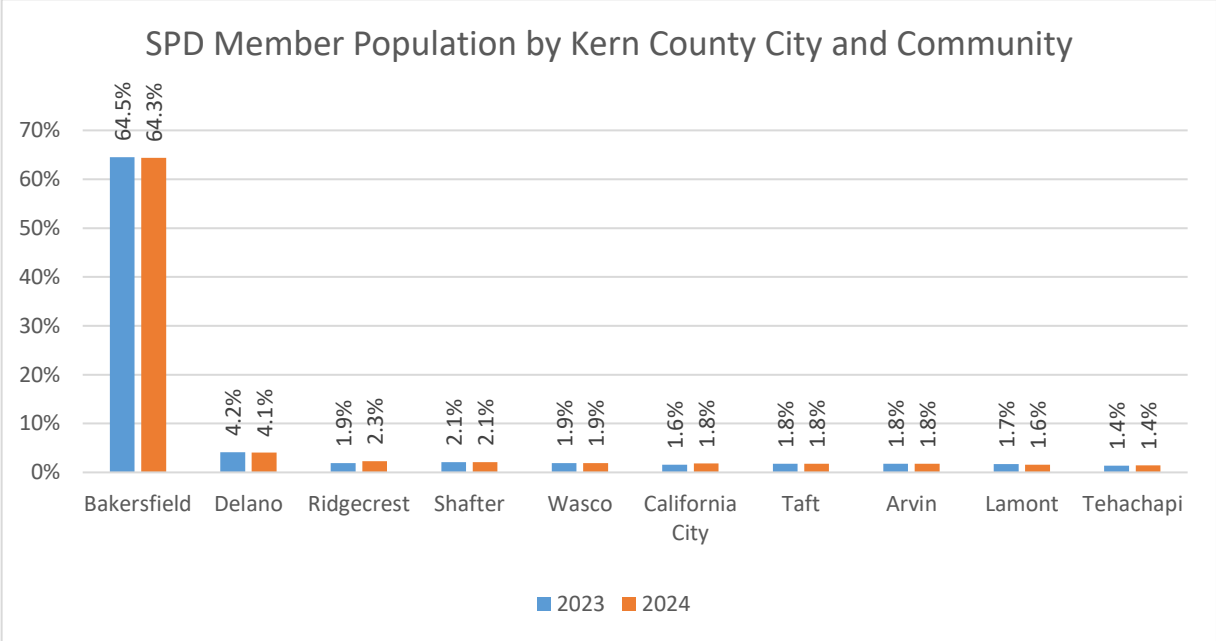
Source: KHS Member Demographics Report

When looking at race and ethnicity, Hispanics were the largest group in 2024, followed by Whites, Black/African Americans, Asian and Pacific Islanders, and Native Americans. The member racial/ethnic group distribution was similar in 2023.



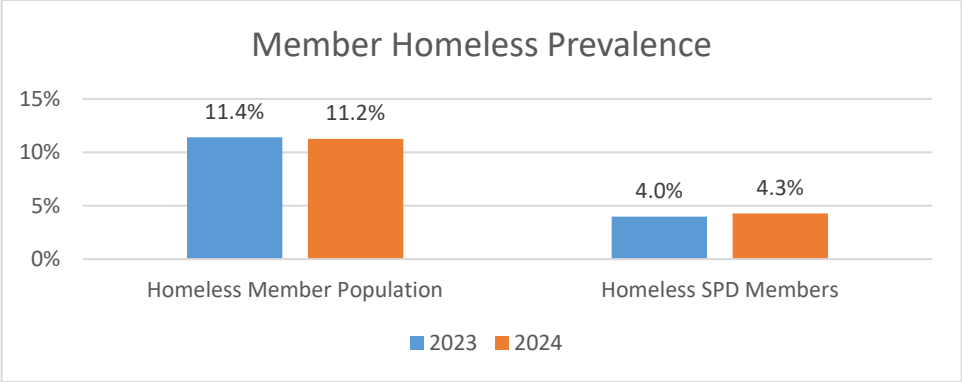
Source: KHS Member Demographics Report

SPD members were concentrated in Bakersfield in 2024, followed by much smaller populations in Delano, Ridgecrest, Shafter, and Wasco as shown by the chart below. The Kern County city and community population distribution was similar in 2023.



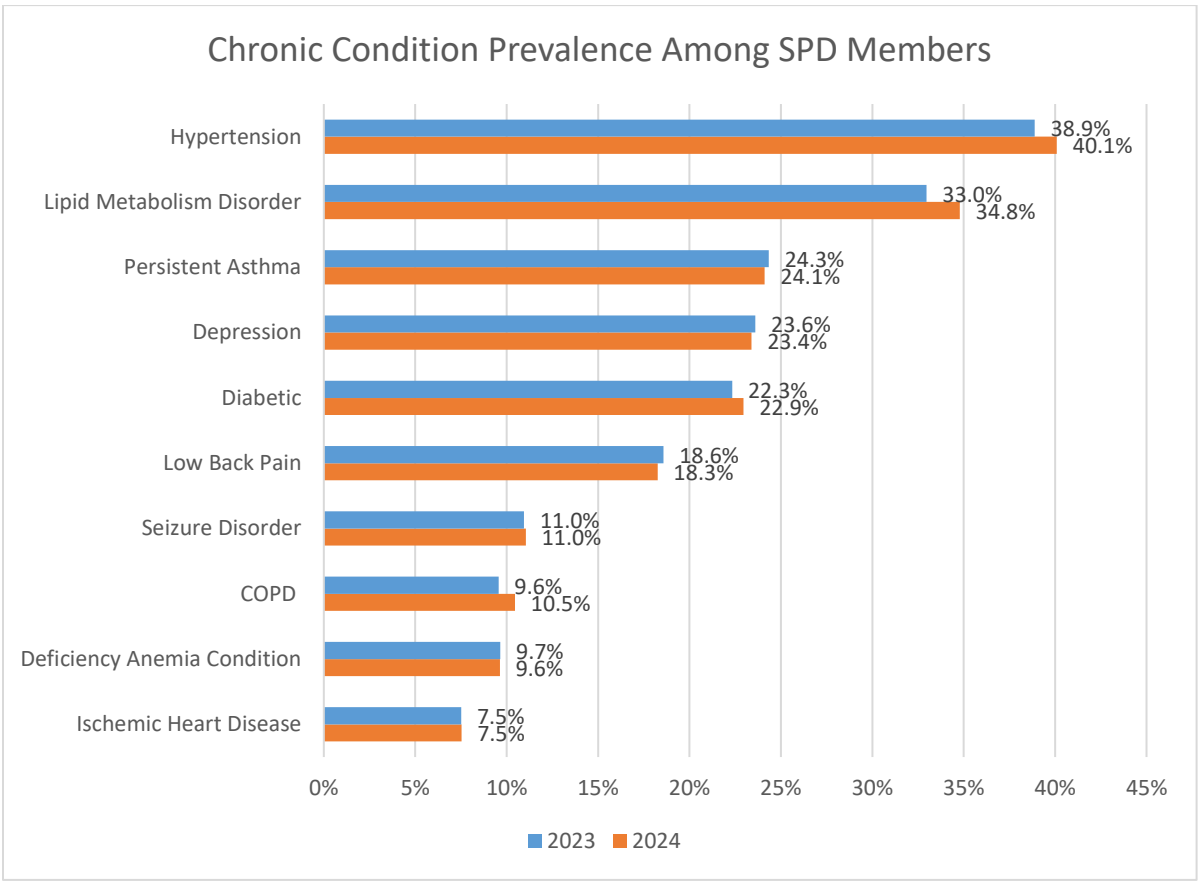
Source: KHS Member Demographics Report

The homelessness prevalence among SPD members was 11.2% in 2024 compared to 4.3% among the entire KHS member population that year.



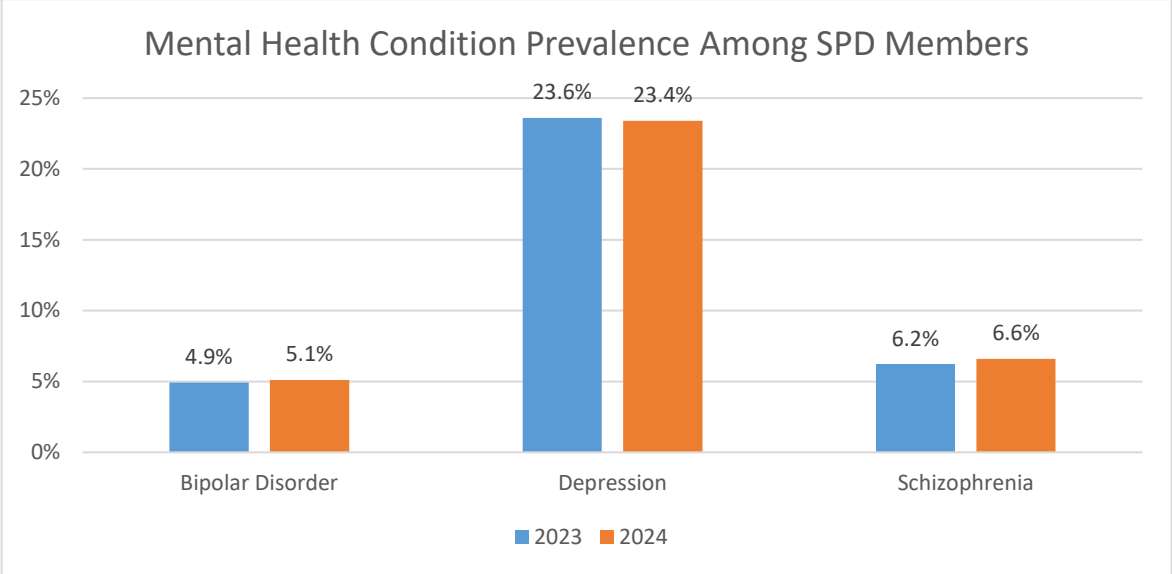
Source: KHS Member Demographics Report

The chronic condition prevalence rates among SPD members are much higher compared to the overall KHS member population in 2024. When looking at the 10 most frequently diagnosed chronic conditions among SPD members, the change in rate from 2023 to 2024 varied by chronic condition.



Source: KHS Member Demographics Report

Mental health condition prevalence is much higher among SPD members compared to the entire KHS member population. Mental health condition rates among SPD members were similar when comparing 2023 to 2024.



Source: KHS Member Demographics Report

Summary of Member Needs

The following SPD member needs are met:

1. Since chronic and mental health conditions rates are higher among SPD members than the entire KHS member population, they have a greater need for and utilization of medical and mental health services and disease management programs. KHS offers a variety of chronic disease management and prevention programs that address this SPD member need. For example, KHS offers the Breathe Better Asthma Program, Asthma Preventive Services, Asthma Remediation Services, a COPD program, the Diabetes Prevention Program, the Diabetes Empowerment and Education Program, PHM Complex Case Management, ECM, and a diabetic clinic partnership with Kern Medical.
2. SPD members have higher rates of mental health conditions than the entire KHS member population. KHS offers BHT and outpatient mental health services and can refer members to SMHS to help address the need.
3. SPD members may depend on non-emergency medical transportation to access plan-covered services due to their chronic health conditions and mobility level. KHS offers different transportation options to members who have mobility issues or need wheelchair access.
4. By distributing Health Risk Assessments (HRAs) to all members, KHS identifies higher-risk Seniors and People with Disabilities (SPDs) based on specific criteria. These members are offered care management services, aligning with NCQA standards, which require these high-risk members to opt out if they choose not to participate.

Based on the SPD member assessment, the key unmet member needs include:

1. **Lack of BHT and Mental Health Service Providers**
    - **Need**: There are not enough BHT, outpatient mental health, and substance use providers to meet member demand for these services.
    - **Action**: Develop strategies to recruit more BHT, mental health, and substance abuse service providers.

2. **Lack of Staffing and Resources**
    - **Need**: Adequate staffing and resources to support BH services and determine an appropriate level of care.
    - **Action**: Improve access to and utilization of BH services among SPD members.

3. **Collaboration with Community Partners on Education and Referrals**
    - **Need**: Communication and collaboration between internal departments and external community partners on education about disease management and behavioral health programs and community resources that benefit SPD members and member referrals to internal and external programs.
    - **Action**: Identify key community partners, resources, and communication and education methods regarding services and supports offered to SPD members. Create MOUs with community partners to identify member needs and share information about resources that benefit SPD members.

4. **Homelessness and Housing Assistance Resources**
    - **Need**: The SPD member homeless rate is 8.9% compared to 4.0% for the KHS member population. This indicates that the need for homelessness resources is greater among SPDs.
    - **Action**: Explore expanding access to temporary and permanent housing solutions, including emergency shelters, transitional housing, and supportive housing options tailored for individuals with disabilities.

Access to Care

DHCS contracts with a vendor to conduct an annual satisfaction survey with Medi-Cal health plan members to capture information about member-reported experiences with health care. The survey is called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Medi-Cal Survey. The survey specifically measures how well a health plan is meeting members' expectations and goals and the areas of service that have the greatest effect on overall satisfaction. It also identifies areas of opportunity for improvement. The survey results shown below are divided between child and adult rates for MY 2023 and MY 2024.[35,36,37,38] For the child measures included in this analysis, rates improved from MY 2023 to MY 2024 for all measures shown below where data was available excepted for "getting urgent care". For the adult measures included in this report, rates improved from MY 2023 to MY 2023 where data was available.

KHS conducts a separate CAHPS survey with its adult members. This survey is called the KHS CAHPS Medicaid Adult Simulation Survey. In the table below (most recent data available), all MY 2023 KHS CAHPS Adult Simulation Survey rates increased compared to MY 2022 rates except for "getting needed care" and "getting a specialist appointment".[39,40]

Measure (Always or Usually)	DHCS KHS CAHPS Child Rate		DHCS KHS CAHPS Adult Rate		KHS CAHPS Adult Simulation Survey Rate	
	MY 2023	MY 2024	MY2023	MY 2024	MY 2022	MY 2023
Getting Care Quickly	80.21%	80.99%	N/A	80.84%	80.7%	84.1%
Getting urgent care	84.43%	83.14%	N/A	82.00%	83.7%	89.5%
Getting routine care	76.00%	78.84%	70.97%	79.67%	77.6%	78.8%
Getting Needed Care	76.63%	79.27%	76.65%	84.28%	84.5%	84.3%
Getting care, tests, or treatment	82.61%	85.75%	75.41%	87.36%	85.4%	86.1%
Getting a specialist appointment	N/A	72.78%	N/A	81.20%	83.7%	82.5%
How well doctors communicate	89.28%	92.34%	88.30%	91.56%	92.5%	92.6%
Personal doctors explained things	89.87%	92.06%	88.33%	91.62%	91.9%	93.8%
Personal doctors listened carefully	93.62%	94.66%	90.83%	92.13%	92.7%	93.3%
Personal doctors showed respect	96.20%	97.34%	90.00%	93.79%	96.9%	97.0%
Personal doctors spent enough time	77.45%	85.29%	84.03%	88.70%	88.5%	86.2%

Sources: MY 2023 CAHPS 5.1H Data Submission, Child Medicaid Survey Results Report; MY 2023 CAHPS 5.1H Data Submission, Adult Medicaid Survey Results Report; MY 2024 CAHPS 5.1H Data Submission, Child Medicaid Survey Results Report; MY 2024 CAHPS 5.1H Data Submission, Adult Medicaid Survey Results Report; MY 2022

CAHPS Medicaid Adult Simulation Survey: Kern Health Systems; MY 2023 CAHPS Medicaid Adult Simulation Survey: Kern Health Systems

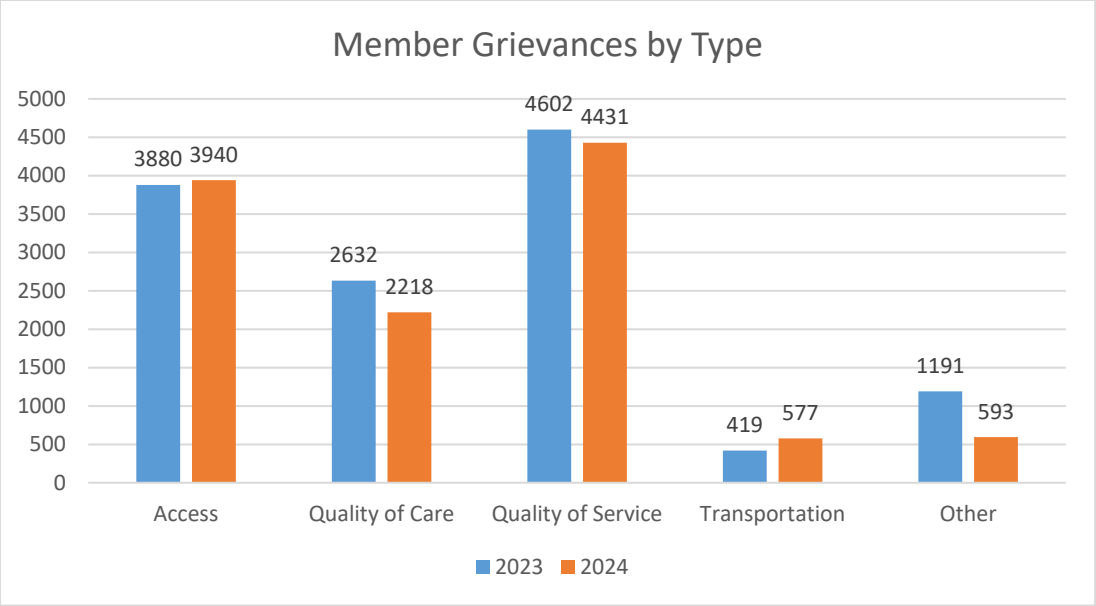
Data on the effectiveness of care, flu vaccination, and tobacco cessation measures among adult and child members were not available for the DHCS CAHPS. Data on the effectiveness of care and flu vaccination measures were not available for the KHS Adult Medicaid Simulation Survey. However, rates improved for the "advising smokers and tobacco users to quit" and "discussing cessation medications" measures for MY 2023 KHS CAHPS Medicaid Adult Simulation Survey compared to MY 2022.
3940

Measure (% Sometimes, Usually, or Always)	KHS CAHPS Child Rate		KHS CAHPS Adult Rate		KHS CAHPS Adult Simulation Survey Rate	
	MY 2023	MY 2024	MY 2023	MY 2024	MY 2022	MY 2023
Effectiveness of Care Measure	N/A	N/A	N/A	N/A	N/A	N/A
Flu Vaccinations for Adults Ages 18-64	N/A	N/A	N/A	N/A	N/A	N/A
Advising Smokers and Tobacco Users to Quit	N/A	N/A	N/A	N/A	74.4%	75.4%
Discussing Cessation Medications	N/A	N/A	N/A	N/A	47.4%	49.2%
Discussing Cessation Strategies	N/A	N/A	N/A	N/A	40.7%	38.6%

Sources: MY 2023 CAHPS 5.1H Data Submission, Child Medicaid Survey Results Report; MY 2023 CAHPS 5.1H Data Submission, Adult Medicaid Survey Results Report; MY 2024 CAHPS 5.1H Data Submission, Child Medicaid Survey Results Report; MY 2024 CAHPS 5.1H Data Submission, Adult Medicaid Survey Results Report; MY 2022 CAHPS Medicaid Adult Simulation Survey: Kern Health Systems; MY 2023 CAHPS Medicaid Adult Simulation Survey: Kern Health Systems

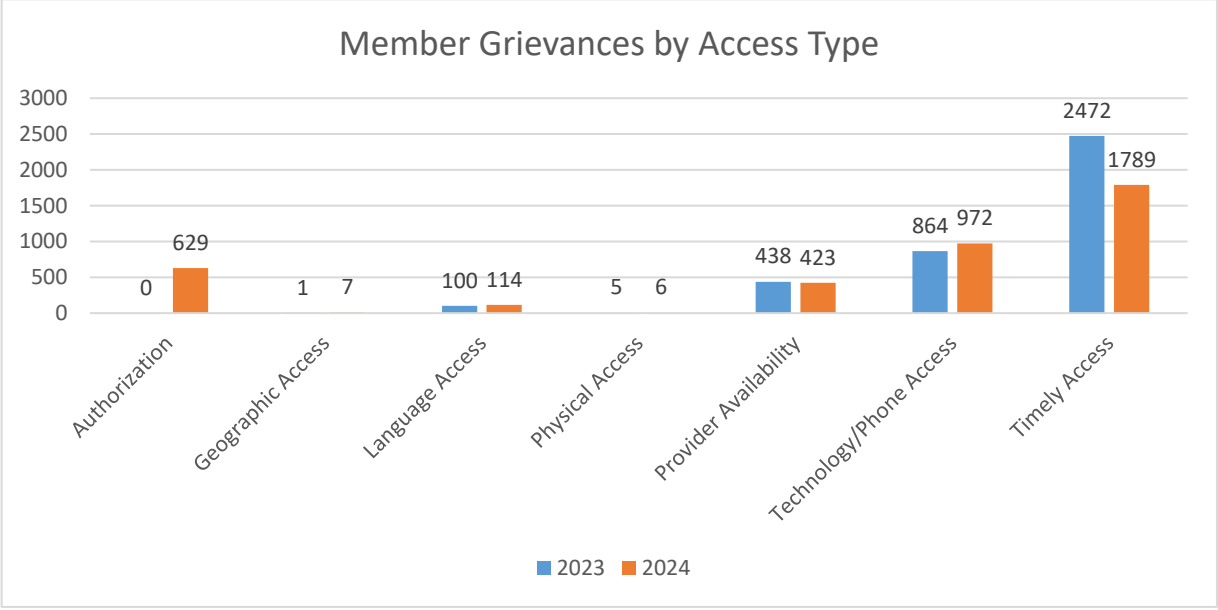
Member Grievances

KHS regularly monitors and reports on its member grievances related to access to care, coverage, medical necessity, quality of care and services, cultural and linguistic sensitivity, and other issues. There were 11,759 grievances in 2024, which was a decrease of 7.6% compared to the previous year. In 2024, 4,739 grievances were exempt (resolved in one day) and 7,020 were formal.[41] Quality of service was the top grievance type by volume, followed by access, quality of care, other, and transportation. Over half (55.2%) of grievances were closed in favor of the member.



Source: 2023 and 2024 Grievance and Appeal Reports

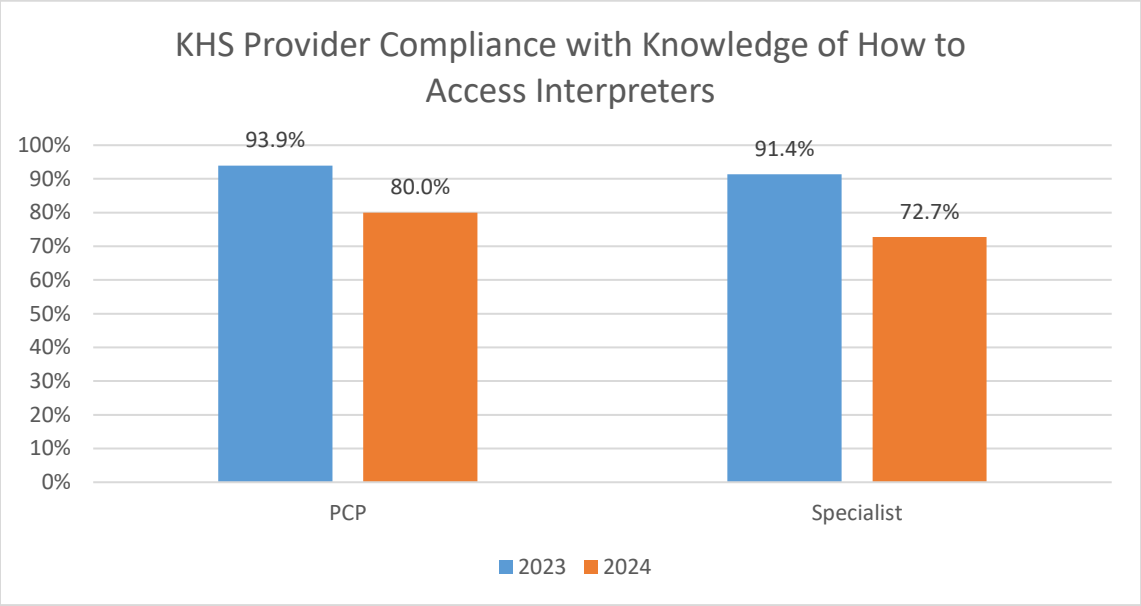
Access to Care grievances totaled 3,940 in 2024, a 1.5% increase compared to 2023. The top three access grievance types by percent included timely access (45.4%), followed by technology/phone access (24.7%) and timeliness of an authorization (16.0%).



Source: 2023 and 2024 Grievance and Appeal Reports

KHS conducts a quarterly interpreting access survey among its health care provider network.[42] In 2024, a total of 178 providers were surveyed, of which 90 were PCPs and 88 were specialists. Of the providers surveyed, 42 providers (18 PCPs and 24 specialists) were considered noncompliant and needed additional training on interpreting and translation services and resources available to

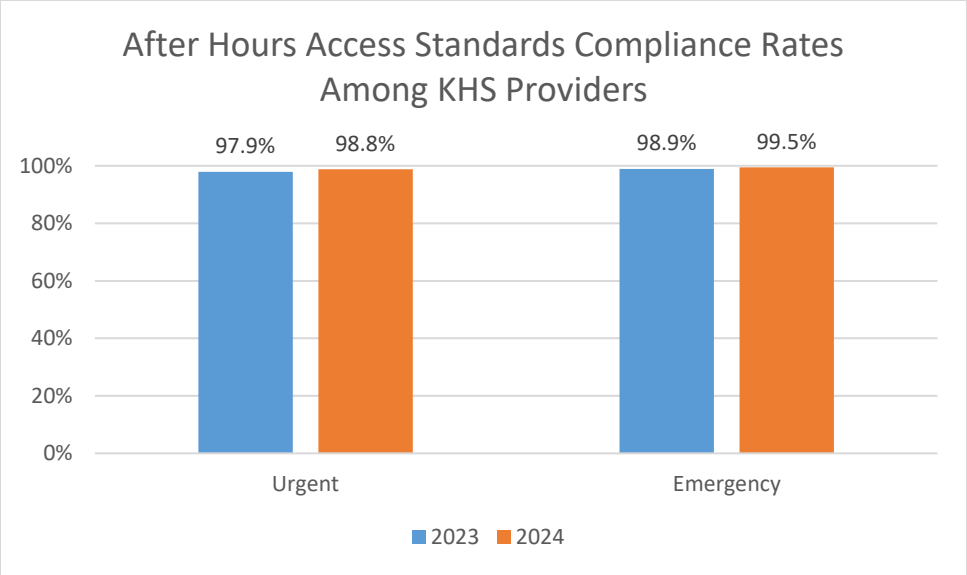
members. The rate of providers who were considered compliant decreased from 92.5% in 2023 to 76.4% in 2024.



Source: 2023 and 2024 KHS Interpreter Access Survey Results

Emergency & Urgent Care Access

As required by the Department of Managed Health Care (DMHC) Health & Safety Code 1348.8, KHS uses an after-hours caller program to assess compliance with access standards for KHS Members. In 2024, 99.5% of provider offices were compliant with the Emergency Access Standards and 98.8% were compliant with the Urgent Care Access Standards.[43] Both 2024 rates increased compared to their respective 2023 rates.



Source: KHS Provider Network Management Network Review Reports

Appointment Availability

As required by the DHCS and Title 28 CCR Section 1300.67.2.2, KHS uses an appointment availability survey to assess compliance with access standards for KHS Members. A random sample of 90 primary care providers (PCP) offices, 88 specialist offices, 20 mental health provider offices, 20 ancillary provider offices, and 20 obstetrics & gynecology (OB/GYN) offices were contacted during 2024. Average wait times for each provider type were in-compliance with the standard wait times.[43] Average wait time improved for all provider types in 2024 compared to 2023 except for ancillary providers.

Provider Type	2023 Average Wait Time in Business Days	2024 Average Wait Time in Business Days	Standard Wait Time in Business Days
Primary (60 Providers in 2023, 90 in 2024)	3.2	2.4	10
Specialist (60 Providers in 2023, 88 in 2024)	8.6	4.9	10
Mental Health (20 Providers)	4	3.6	10
Ancillary (20 Providers)	3.5	3.7	15
OB/GYN (20 Providers)	4.7	4.3	10

Source: KHS Provider Network Management Network Review Reports

New Member PCP Access

KHS monitors the adequacy of its primary care network by reviewing the count/percentage of PCPs who are accepting new members. During 2024, the plan had a quarterly average network

of 484.25 PCPs, of which 86.8% were accepting new members.[43] Both figures were improvements compared to the previous year.

New Member PCP Access	2023	2024
PCPs (quarterly average)	453.5	484.3
PCPs Accepting (quarterly average)	384.3	420.5
PCPs Accepting Rate	84.7%	86.8%

Source: KHS Provider Network Management Network Review Reports

Summary of Gaps in Access to Care and Member Needs

1. KHS performance improved overall for almost all child and adult measures included in the analysis (where data was available) when comparing MY 2023 and MY 2024 rates from the DHCS CAHPS Survey. The lowest performing measures for both the child and adult results were "getting routine care" and "getting a specialist appointment". Data for the "Effectiveness of Care", "Flu Vaccinations for Adults Ages 18-64", "Advising Smokers and Tobacco Users to Quit", "Discussing Cessation Medications", and "Discussing Cessation Strategies" were not available for either MY 2023 or MY 2024. A closer look at member access to care may be needed to understand member health plan needs and factors that are impacting member ratings of health plan experience.
2. KHS performance improved overall when comparing MY 2022 and MY 2023 CAHPS Adult Simulation Survey results that were included in the analysis.
3. Quality of service was the top type of grievance, followed by access, quality of care, other, and transportation. Most grievances (55.2%) were closed in favor of the enrollee, indicating that members may be facing legitimate challenges with quality of services or care and access.
4. The KHS Interpreter Access Survey results showed a decrease in provider knowledge of interpreting access from 92.5% in 2023 to 76.5% in 2024. This indicates that training regarding access to member interpreting services will be needed to improve provider compliance.
5. Average wait time in business days decreased for PCPs, specialists, mental health providers, and OB/GYN providers but increased for ancillary providers. Overall, these data indicate improvement in member access to different types of health care providers.

Conclusion:

Based on the summary of gaps in access to care and member needs, the following key unmet needs were identified:

1. Improved Access to Care

- **Need**: While CAHPS results improved overall for both child and adult measures when comparing MY 2023 and My 2024 data, measures for access to routine care and specialists were the lowest performing. These outcomes indicate potential issues with member access to care.
- **Action**: Conduct a detailed analysis of barriers affecting access to routine care and specialists.

2. Quality of Service Concerns

- **Need**: Quality of service was the top grievance, highlighting challenges with both access and care quality.
- **Action**: Address grievances by investigating them, identifying access and quality of care barriers, and developing strategies to address or overcome barriers.

3. Provider Training on Accessing Interpreting Services

- **Need**: Since provider knowledge of interpreting services may have decreased based on provider survey results, ongoing training is necessary to ensure all providers are equipped to assist members effectively.
- **Action**: Implement regular training sessions focused on member interpreting needs and how to access to interpreting services.

4. Specialist Access Issues

- **Need**: The average wait time for specialists decreased considerably and more than the average wait time of other types of health care providers. Despite this improvement, the average wait time for specialists continues to be longer than for other types of health care providers.
- **Action**: Evaluate challenges and strategies to increase the availability of specialists and reduce the average wait time.

5. Follow Up on Members who Contacted the Advice Nurse Line

- **Need**: Advice nurse line call volume increased by 18.4% in 2024 compared to 2023. Members who call the advice nurse line may need help navigating the health care system, finding appropriate health care and managing an illness or health condition.
- **Action:** PHM CHWs can follow up with members who call the advice nurse line to ensure members receive appropriate medical care, connect them with necessary medical services and resources. CHWs can help address SDOH by linking members with CSS and other supportive resources. They can also conduct psychological screenings with members and then connect them with services to address their mental and emotional health needs.

A key component of member care is the Nurse Advice Line, a 24/7 service that provides medical guidance to members facing non-emergency health concerns. This service is designed to help members make informed decisions about when and where to seek care, offering immediate support and reassurance. The Population Health Management (PHM) Department plays a vital role in following up with members who utilize the Nurse Advice Line, ensuring they continue to receive the support and resources needed to maintain their health and well-being.

Through these follow-up efforts, PHM helps ensure that members receive appropriate medical attention and are able to follow the guidance given by the nurse. The department also facilitates care coordination by connecting members with necessary medical resources, including primary care providers and specialists. In addition, PHM addresses social determinants of health by linking members to supportive services and conducting psychosocial screenings to attend to their mental and emotional health needs. These efforts collectively promote preventive care and wellness, ultimately aiming to improve overall health outcomes for the member population.

Summary of Relevant Actions:

- **Provider Network Management (PNM)**: Strengthen network to improve access to primary care providers and specialists.
- **Mobile Clinic Project**: Leverage mobile services to reach underserved areas and provide healthcare access directly.
- **Interpreter Access Survey**: Use survey findings to identify providers that may benefit from interpreting access and cultural competency training and offer training to them.
- **Population Health Management**: Continue to follows up with members to ensure they receive appropriate support, connect to needed services, and address both medical and social determinants of health to improve overall outcomes.
- **Follow Up with Members Who Call the Advice Nurse Line:** Follow up with members to connect them with appropriate health care services and address SDOH by linking them with any needed supportive resources and mental health services.

Overall Strategy:

To address these unmet needs, KHS will focus on enhancing access to care through expanding the provider network, improving transportation solutions, and ensuring that all members can communicate effectively with their healthcare providers and receive culturally competent and sensitive health care and customer service. Regular evaluation and adjustment based on member feedback will be crucial for continuous improvement.

Health Disparities and Preventive Services Indicators

KHS evaluates performance measures called Disparities Rate Sheet Indicators to identify member health disparities. They are a set of quality metrics used by the DHCS to measure and evaluate healthcare disparities within the Medi-Cal population. These indicators track performance on specific health outcomes and services, and the results are stratified by demographic characteristics to identify and address inequities. These indicators are based on the Managed Care Accountability Set (MCAS) measures and are used in DHCS's annual Health Disparities Reports. The following measures were provided by DCHS to KHS for Measurement Year (MY) 2024.

Indicator Abbreviation	Indicator Name
AAP	Adults' Access to Preventive/Ambulatory Health Services
ADD-E-C&M	Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase
ADD-E-Init	Follow-Up Care for Children Prescribed (ADHD) Medication: Initiation Phase
AMM–Acute	Antidepressant Medication Management: Acute Phase Treatment

AMM–Cont	Antidepressant Medication Management: Continuation Phase Treatment
AMR	Asthma Medication Ratio
APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics
BCS-E	Breast Cancer Screening
CBP	Controlling High Blood Pressure
CCP–MMEC	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception
CCS	Cervical Cancer Screening
CCW–MMEC	Contraceptive Care—All Women: Most or Moderately Effective Contraception
CHL	Chlamydia Screening in Women
CIS–10	Childhood Immunization Status—Combination 10
COL-E	Colorectal Cancer Screening
DEV	Developmental Screening in the First Three Years of Life
DRR–E	Depression Remission or Response for Adolescents and Adults
DSF–E	Depression Screening and Follow-Up for Adolescents and Adults
FUA	Follow-Up After ED Visit for Substance Abuse – 7 days
FUA	Follow-Up After ED Visit for Substance Abuse – 30 days
FUM	Follow-Up After ED Visit for Mental Illness – 7 days
FUM	Follow-Up After ED Visit for Mental Illness – 30days
GSD	Glycemic Status Assessment for Patients With Diabetes (>9%)
HFS	Number of Out-patient ED Visits per 1,000 Long Stay Resident Days
IMA–2	Immunizations for Adolescents—Combination 2
LRCD	Low-Risk Cesarean Delivery
LSC	Lead Screening in Children
PCR	Plan All-Cause Readmissions
PDS–E	Postpartum Depression Screening and Follow-up
PND–E	Prenatal Depression Screening and Follow-up
POD	Pharmacotherapy for Opioid Use Disorder
PPC–Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care
PPC–Pst	Prenatal and Postpartum Care: Postpartum Care
PPR	Potentially Preventable 30-day Post-Discharge Readmission
PRS–E	Prenatal Immunization Status
SNF HAI	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
TFL–CH	Topical Fluoride for Children

W30–2+	Well-Child Visits in the First 30 Months of Life -15 to 30 Months—Two or More Well-Child Visits
W30–6+	Well-Child Visits in the First 30 Months of Life— 0 to 15 Months—Six or More Well-Child Visits
WCV	Child and Adolescent Well-Care Visits

The most recent DHCS Health Disparities KHS Rate Sheet Indicators data were not yet available. The 2024 PNA included MY 2022 data.[44] KHS has provided the following MY 2024 rates from internal data.[45] This data has been stratified by race and ethnicity. The Disparities Indicators are divided by category into data tables below. The lowest or worst rate for each indicator is shown in red font.

When reviewing child development and health indicators with sufficient data, Black/African American members had the lowest rate for most indicators compared to other racial/ethnic groups. When comparing rates by language, French, Hindi, and Punjabi speakers had the lowest rates for most indicators in 2024.

MY 2024 Health Disparities KHS Rate Sheet Indicators: Child Development and Health

Indicator	American Indian/ Alaska Native	Asian	Black/ African American	Hispanic/ Latino	Native Hawaiian/ Other Pacific Islander	White	Unknown
ADD- -E-C&M	N/A	100.0%*	35.29%	52.34%	N/A	45.45%	51.20%
ADD-E-Init	N/A	75.0%*	45.83%	52.48%	N/A	48.00%	51.95%
APM-E	50.00%	44.44%	50.94%	42.37%	N/A	47.51%	59.27%
CIS-10	0.00%	42.86%	10.53%	32.49%	100.00%	8.33%	26.39%
DEV	23.53%	24.58%	24.11%	30.54%	20.00%	31.58%	31.79%
IMA-2	N/A	50.00%	25.00%	41.67%	N/A	25.00%	39.17%
LSC	N/A	71.43%	47.37%	72.59%	100.00%	50.00%	68.61%
TFL-CH	16.29%	26.80%	16.17%	26.38%	27.08%	16.48%	26.74%
W30-2+	55.56%	85.92%	47.62%	71.37%	75.00%	60.70%	70.71%
W30-6+	25.00%	54.55%	38.10%	54.53%	N/A	41.52%	53.18%
WCV	36.75%	53.75%	39.57%	52.69%	33.33%	38.51%	53.54%

Source: MY 2024 Internal KHS Disparities Rate Sheet Indicators Data

For the women's and perinatal health indicators, racial and ethnic disparities varied by indicator. Native American members had the lowest rate for slightly more indicators than the other racial or ethnic groups. English and Spanish speakers had the lowest rates for prenatal and postpartum

care indicators (PPC-Pre and PPC-Pst) compared to other languages in 2024. For all other women's or perinatal health indicators, language disparities in rates varied by indicator.

MY 2024 Health Disparities KHS Rate Sheet Indicators: Perinatal and Women's Health

Indicator	American Indian/ Alaska Native	Asian	Black/ African American	Hispanic/ Latino	Native Hawaiian/ Other Pacific Islander	White	Unknown
BCS-E	50.00%	47.74%	55.27%	65.87%	37.50%	42.98%	64.88%
CCS	N/A	50.00%	51.72%	64.73%	N/A	45.33%	63.30%
CHL	50.00%	53. 89%	64.70%	57.88%	57.14%	49.94%	57.83%
PDS–E	0.0%	0.00%	1.28%	2.15%	0.0%	0.85%	2.20%
PND–E	0.0%	0.71%	9.33%	5.24%	25.00%	6.04%	5.31%
PPC–Pre	N/A	87.50%	87.10%	88.37%	N/A	80.77%	88.75%
PPC–Pst	N/A	100.00%	70.97%	83.72%	N/A	80.77%	84.38%
PRS–E	0.00%	19.15%	15.30%	28.53%	0.00%	13.16%	28.28%
LRCD	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*
CCW-MMEC	15.15%	14.17%	16.61%	18.91%	20.00%	17.70%	18.75%
CCP-MMEC	16.67%	28.46%	39.39%	49.98%	66.67%	40.25%	49.48%

Source: MY 2024 Internal KHS Disparities Rate Sheet Indicators Data
*No data available for LRCD as CMS was to collect data independently to determine rates.

When looking at the mental health and substance abuse indicators by race or ethnicity, Native Hawaiian and Other Pacific Islander (NHPI) members had the lowest rate for more indicators than other racial or ethnic groups, followed by Black/African American members, and Asian members. When comparing indicator rates by language, Spanish speakers had the lowest antidepressant medication management rates in 2024. For all other mental health and substance abuse indicators, rates varied by language.

MY 2024 Health Disparities KHS Rate Sheet Indicators: Mental Health and Substance Abuse

Indicator	American Indian/ Alaska Native	Asian	Black/ African American	Hispanic/ Latino	Native Hawaiian/ Other Pacific Islander	White	Unknown
AMM–Acute	100.00%	85.71%	81.08%	82.63%	N/A	86.76%	83.44%

AMM–Cont	100.00%	81.63%	67.03%	70.25%	N/A	77.83%	71.02%
DRR–E	N/A	33.33%	16.67%	9.26%	N/A	15.38%	8.33%
DSF–E	3.38%	2.92%	3.93%	4.36%	1.69%	2.84%	4.35%
FUA (7 days)	12.50%	28.57%	21.56%	20.57%	0.00%	24.91%	20.61%
FUA (30 days)	25.00%	28.57%	37.13%	31.15%	0.00%	37.03%	31.52%
FUM (7 days)	N/A	10.00%	20.18%	16.30%	N/A	18.92%	16.06%
FUM (30 days)	N/A	20.00%	34.21%	31.19%	N/A	33.11%	31.09%
POD	0.00%	25.00%	15.38%	31.17%	N/A	31.67%	29.57%

Source: MY 2024 Internal KHS Disparities Rate Sheet Indicators Data

When reviewing chronic condition indicators, racial and ethnic disparities varied indicator. It should be noted that a lower rate for poor glycemic control for patients with diabetes (GSD) means better performance for that indicator. English speakers show lower rates for chronic disease indicators compared to other language groups.

MY 2024 Health Disparities KHS Rate Sheet Indicators: Chronic Conditions

Indicator	American Indian/ Alaska Native	Asian	Black/ African American	Hispanic / Latino	Native Hawaiian/ Other Pacific Islander	White	Unknown
AMR	75.00%	83.82%	71.83%	74.96%	N/A	70.57%	74.65%
CBP	50.00%	83.33%	53.57%	65.48%	N/A	62.86%	65.51%
COL-E	20.18%	27.02%	24.76%	33.94%	10.34%	22.46%	33.42%
GSD*	100.00%	26.09%	30.77%	32.41%	N/A	35.00%	31.95%
SSD	80.00%	69.70%	79.25%	79.18%	N/A	78.29%	78.66%

Source: MY 2024 Internal KHS Disparities Rate Sheet Indicators Data
*A lower rate means better performance for this indicator.

With the remaining disparities indicators, racial and ethnic disparities varied by indicator. When comparing rates by language, Chinese and Samoan speakers had the worst performing rates 2024.

MY 2024 Health Disparities KHS Rate Sheet Indicators: Other Indicators

Indicator	American Indian/ Alaska Native	Asian	Black/ African American	Hispanic/ Latino	Native Hawaiian/ Other	White	Unknown

					Pacific Islander		
AAP	71.02%	75.65%	70.89%	74.62%	69.44%	68.96%	75.45%
PCR Expected*	9.50%	8.68%	8.89%	8.24%	9.47%	9.05%	8.30%
PCR Observed*	16.67%	9.32%	9.60%	8.45%	16.67%	9.69%	8.76%
PCR Outlier*	71.4	23.1	86.3	43.31	0.0	50.7	43.5
SNF HAI*	0.00%	0.00%	0.00%	N/A	N/A	0.00%	0.66%
PPR*	0.00%	20.00%	0.00%	N/A	N/A	9.09%	7.04%

Source: MY 2024 Internal KHS Disparities Rate Sheet Indicators Data
*A lower rate is considered a better outcome.

Summary of Member Needs Based on Health Disparities Indicators

1. Black/African American members had the lowest Health Disparities Rate Sheet Indicator rate for most child development and health indicators.
2. For the women's and perinatal health indicators, racial and ethnic disparities varied by indicator.
3. NHPI members had the lowest rate for more mental health and substance abuse indicators than other racial or ethnic groups, followed by Black/African American and Asian members.
4. These indicator disparities indicate the need for disease prevention and chronic condition management strategies that are oriented towards Black/African American, Native Hawaiian, and Pacific Islander members.
5. Racial and ethnic disparities among the chronic condition indicators varied by indicator. Addressing chronic condition screening and management disparities will require chronic disease programs or strategies that are culturally competent and oriented towards the needs of different racial/ethnic member populations.
6. French, Hindi, and Punjabi speakers had the lowest rates for child development and health indicators in 2024.
7. English speakers had the lowest rates for the most chronic disease indicators when compared to other language groups in 2024.

Conclusion:

Based on the summary of member needs from the KHS Health Disparities Rate Sheet Indicators, the key unmet needs include:

1. Addressing Health Disparities Among Black/African American Child Members

- **Need**: Black/African American members had lower rates for child development and health indicators, indicating significant health disparities.

- **Action**: Develop targeted child development and health promotion programs tailored to the needs of Black/African American children and collaborate with community stakeholders focused on this demographic. The objectives are to:
    - Increase well-baby visit compliance among Black/African American families by addressing specific barriers, providing culturally sensitive education, and improving care coordination.
    - Reduce the number of missed or late well-baby appointments for this population.
    - Improve parent and caregiver satisfaction with member outreach efforts. Assess satisfaction with the outreach efforts and whether they felt the services were accessible, convenient, and culturally appropriate.

2. Mental Health and Substance Abuse Programs

- **Need**: NHPI members had the lowest rates for mental health and substance abuse indicators, followed by Black/African American and Asian members. These findings suggest barriers to accessing these services.
- **Action**: Implement mental health and substance abuse programs specifically designed for NHPI, Black African American, and Asian members. Address cultural and community-specific factors.

3. Culturally Competent Chronic Disease Management Program and Services

- **Need**: Racial and ethnic disparities among the chronic condition indicators varied by indicator, indicating the need for targeted interventions.
- **Action**: Develop culturally competent chronic disease management and prevention programs that are tailored to the diverse needs of various racial and ethnic groups, ensuring equitable access to screening and management.

4. Language Services to Address Disparities

- **Need**: English, Arabic, Punjabi, and Russian speakers show the lowest rates for most indicators. French, Hindi, and Punjabi speakers had the lowest rates for child development and health indicators. English speakers show lower rates for chronic disease indicators compared to other language groups. This suggests a potential gap in service access or quality.
- **Action**: Enhance language access services and develop health programs that cater to non-English-speaking populations to ensure they receive adequate support in child development. Evaluate service access and quality for chronic disease management.

Summary of Relevant Actions:

- **Partnerships**: Establish collaborations with community organizations that serve racial or ethnic groups that face health disparities, such as Black/African American, Asian, Native American, and NHPI populations to strengthen health initiatives.

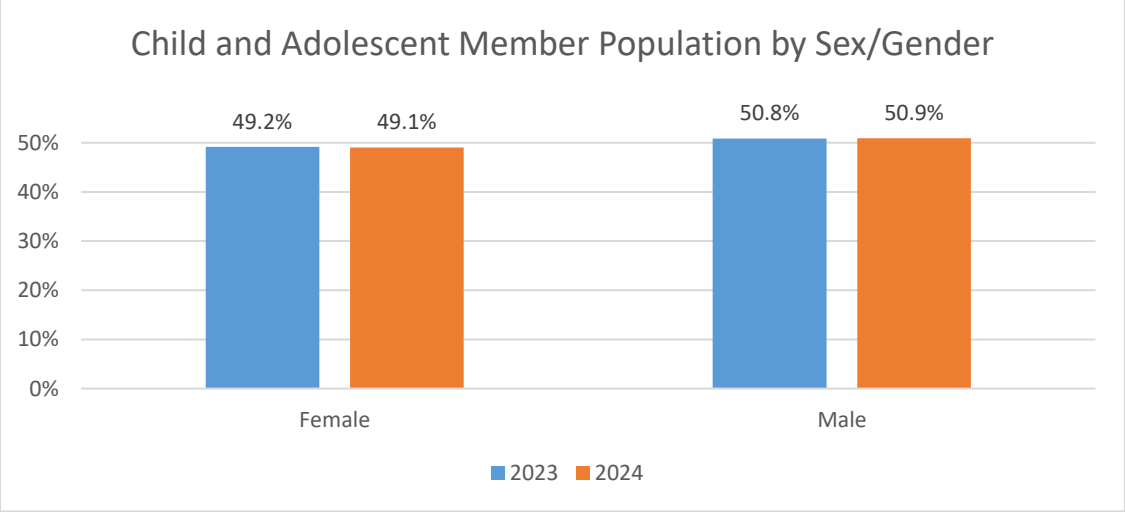
- **Targeted Programs**: Develop child development, child health, mental health, and substance abuse programs that reflect the cultural contexts of racial and ethnic groups impacted by health disparities, such as NHPI, Black/African American, and Asian members.
- **Cultural Competence Training**: Provide training for KHS providers on cultural competence in child health, mental health, substance abuse, and chronic disease management to better serve diverse populations.
- **Language Services**: Expand language services and develop materials in multiple languages to improve health outcomes for non-English speakers.

Overall Strategy:

To effectively address these unmet needs, KHS will focus on enhancing health equity through targeted programs, community partnerships, and culturally sensitive care. Continuous assessment of health disparities will be essential in developing and refining interventions to support all member populations.

Assessment of Child and Adolescent Members

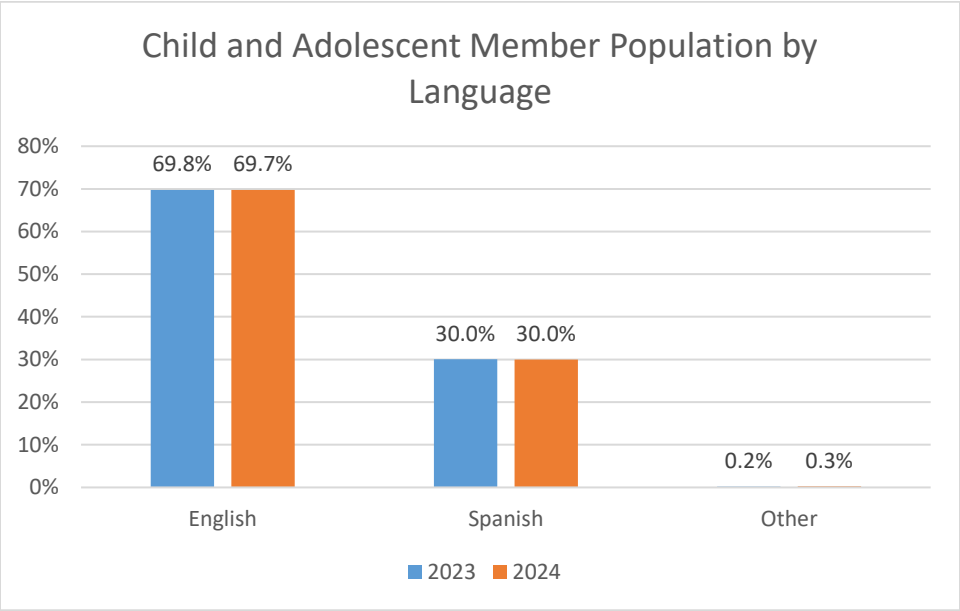
The population of child and adolescent members (ages 0-19 years old) increased by 16.8% from 2023 to 2024. Child and adolescents accounted for 42.1% of members in 2024, down from 43.1% in 2023. The proportion of child and adolescent members who were female in 2024 was 49.1% compared to 50.9% for males. The gender/sex rates changed slightly when comparing 2023 to 2024 data.



Source: KHS Member Demographics Report

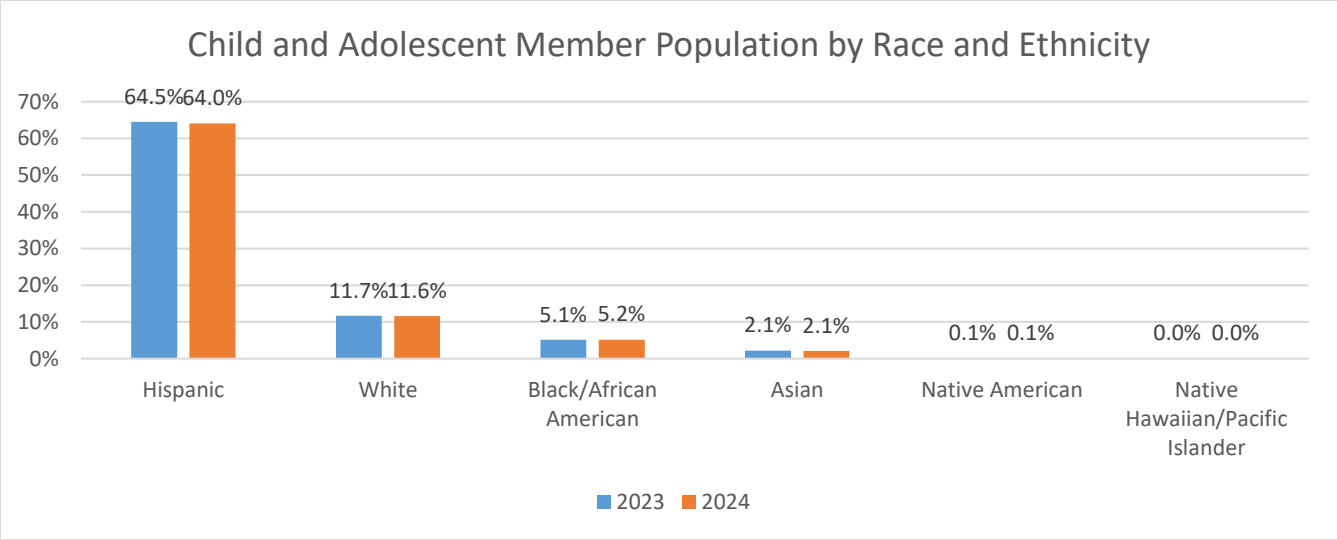
English-speaking members accounted for 68.7% of child and adolescent members in 2024, followed by Spanish-speakers at 30.0%, and other languages combined at 0.2%. These

proportions were similar to those for 2023 with a slight decrease for English-speakers and a slight increase for other languages combined.



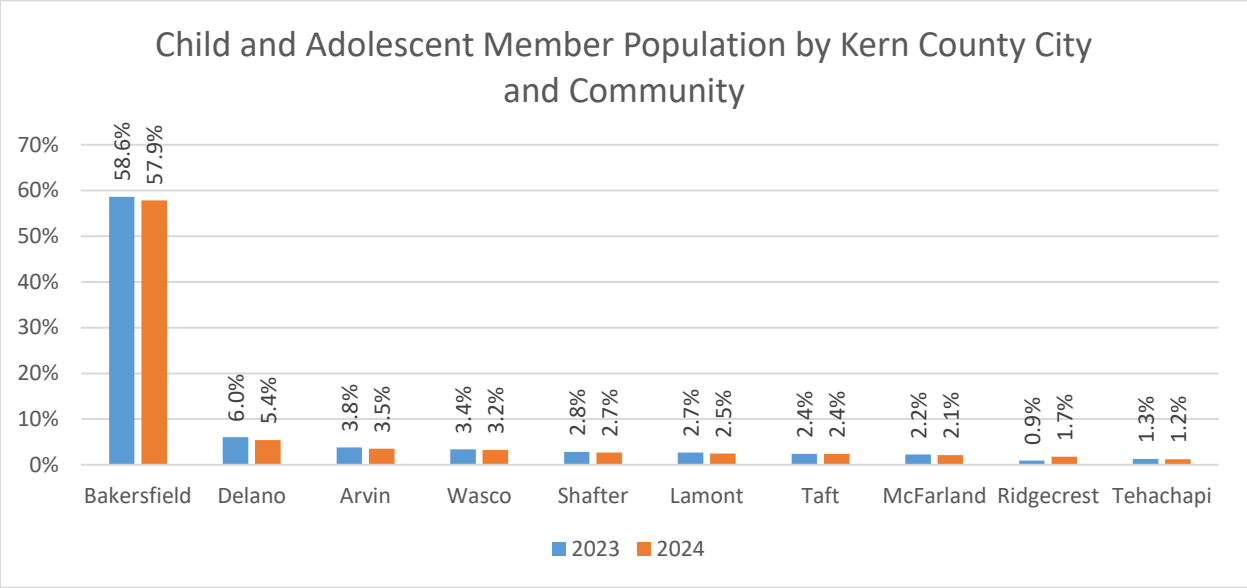
Source: KHS Member Demographics Report

When looking at child and adolescent members by race and ethnicity, Hispanics were the largest group, followed by White, Blacks/African American, Asian, Native American, and NHPI members in descending order.



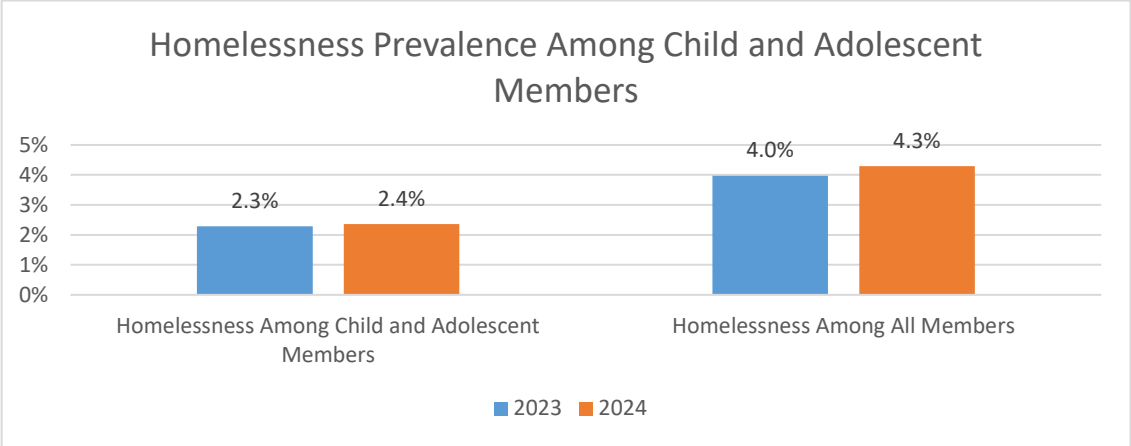
Source: KHS Member Demographics Report

Child and adolescent members are concentrated in Bakersfield, followed by much smaller populations in Delano, Arvin Wasco, and Shafter.



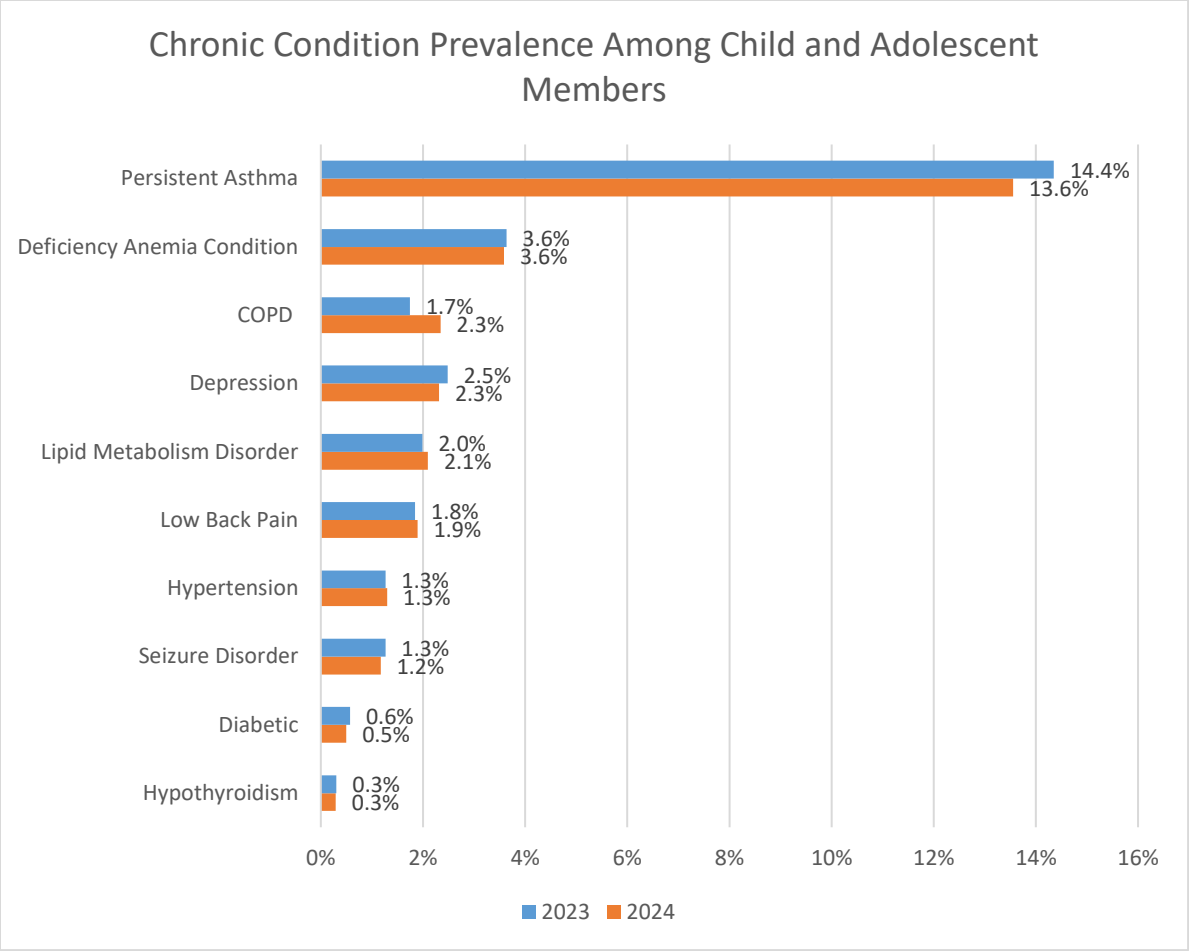
Source: KHS Member Demographics Report

Children and adolescent members have a lower prevalence of homelessness compared to the overall KHS member population. The percentage of child and adolescent members who were found to have experienced homelessness increased slightly from 2023 to 2024.



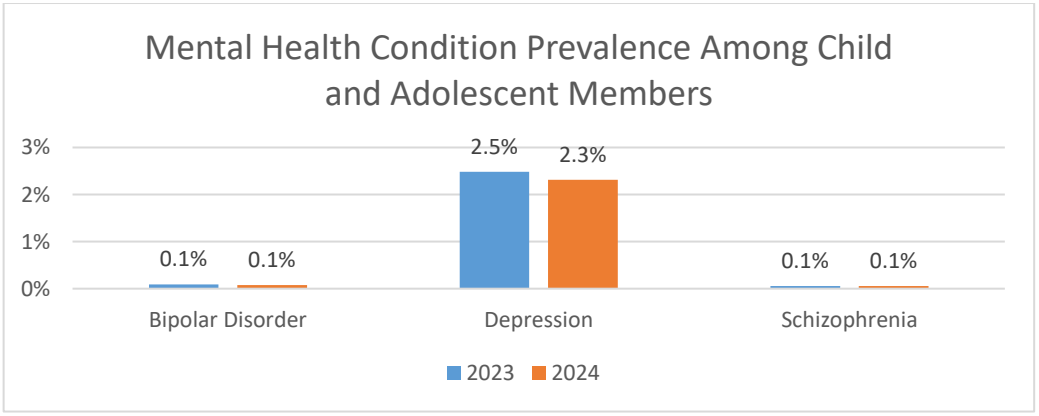
Source: KHS Member Demographics Report

The top 10 chronic condition rates among child and adolescent members look different compared to the overall KHS member population. Persistent asthma was the most common chronic condition among children and adolescents at 13.6% in 2024, followed by much lower rates of all other chronic conditions. In contrast, rates of the top 10 chronic conditions are much higher among adult members except for persistent asthma.



Source: KHS Member Demographics Report

Mental health condition prevalence is much lower among child and adolescent members compared to the entire KHS member population. Depression prevalence among child and adolescent members decreased slightly from 2023 to 2024. Bipolar disorder and schizophrenia prevalence did not change.



Source: KHS Member Demographics Report

According to the MY 2023 MCAS Rate Tracking Report, KHS MY 2023 MCAS rates did not meet the minimum performance level (MPL) for the following childhood and adolescent measures:

1. CIS-10: Childhood Immunization Status
2. IMA-2: Immunizations for Adolescents – Combo 2 (Meningococcal, Tdap, HPV)
3. DEV: Developmental Screening in the First Three Years of Life
4. W30 (0-15M): Well-Child Visits in the First 15 Months, Six or More Well-Child Visits
5. W30 (15-30): Well-Child Visits for Age 15-30 Months, Two or More Well-Child Visits
6. WCV: Child and Adolescent Well-Care Visits

These findings indicate that strategies and activities were needed to improve immunization, developmental screening, and well-care visits among children and adolescent members.

According to the MY 2024 MCAS Rate Tracking Report, KHS preliminary MY 2024 MCAS rates did not meet the minimum performance level (MPL) for the following childhood and adolescent measures:

1. CIS-10: Childhood Immunization Status
2. DEV: Developmental Screening in the First Three Years of Life
3. W30 (0-15M): Well-Child Visits in the First 15 Months, Six or More Well-Child Visits
4. WCV: Child and Adolescent Well-Care Visits

There was an improvement in performance for childhood and adolescent measures from MY2023 to MY2024. These findings indicate that strategies and activities implemented for immunizations and well-care visits among ages 3-21 years were successful. However, continued interventions are needed to improve immunizations, developmental screening, and well-care visits for children younger than 3 years of age. See the Quality Improvement Program Gap Analysis section for rates and other details.

The results of a parent/guardian survey on childhood immunization and vaccination survey sponsored by First 5 Kern and conducted in 2025 revealed that most parents with children under 18 years old who were surveyed expressed support for vaccination.[46] However, nearly half of respondents (46%) reported delaying or skipping a recommended vaccine. Vaccine compliance was highest in and around Bakersfield and Southeastern Kern County. Skipping or delaying vaccines was most common in parts of Northeastern and Northwestern Kern County. Trust in information sources and personal vaccine concerns mattered more than income or education. Delays were most common among parents with lower trust, especially when concerns involved mandates, beliefs, or institutional skepticism. Many hesitant parents were open to change if given better information and communication. These findings indicate that evidence-based and community-oriented public health messaging campaigns are needed to address concerns about vaccine delay among parents with children under 18 years old in Kern County.

Summary of Child and Adolescent Member Needs

1. Child and adolescent members are concentrated in Bakersfield.

2. Persistent asthma is the top chronic condition among child and adolescent members in 2023 and 2024. The rates of other chronic conditions are much lower. This indicates that asthma management and prevention programs may be a top need among this population.
3. Deficiency anemia condition, COPD, and depression are the next most common chronic conditions among children and adolescent members in 2023 and 2024. Nutrition counseling, pulmonary education and therapy, or Behavioral Health therapy and mental health services are needed for these conditions.
4. Strategies are needed to support members and health care providers in efforts to improve immunization, developmental screening, and well-care visit outcomes among child and adolescent members. Barriers must be identified to develop effective strategies.
5. Health education, fitness, school wellness, and after school programs that address nutrition, physical activity, and lifestyle change may also be needed among child and adolescent members. Some of the top chronic conditions for this population can be managed or prevented with nutrition education, nutrition therapy, physical activity programs, or lifestyle change.
6. KHS continues to support Kern County public schools through its School Wellness Grant Program, which offers funding for school wellness programs. KHS has found through its School Wellness Grant Program evaluations that participating schools implement wellness program activities or environmental changes and accomplish work plan objectives that can support student behavioral and health outcomes.
7. Community-oriented public health messaging campaigns are needed to address concerns about vaccine delay among parents of children under 18 years old in Kern County. Vaccine messaging campaigns for parents of child members may also be needed

The following needs of child and adolescent members are met:

1. KHS asthma, nutrition education, and weight management programs and benefits are open to children and adolescents.
2. Nutrition counseling or nutrition therapy
3. WIC Program offered by local agencies
4. Mental health and substance abuse services for children and their families
5. Health care and services for children with certain diseases or health conditions, such as California Children's Services
6. School wellness programs sponsored and supported by KHS
7. Child development and family services offered by agencies such as Community Connection for Child Care, Headstart CAPK, child development centers offered by local public school districts, and family resource centers
8. Primary and secondary school physical education and sports programs
9. After school and educational support programs offered by nonprofit organizations, such as but not limited to the Boys and Girls Clubs of Kern County, CAPK Friendship House, and Greenfield After School SUCCESS Program, the Bakersfield Police Activities League, Kern Literacy Council, Youth 2 Leaders Education Foundation, and Children First

10. Community youth recreational programs, such as the CAPK Friendship House, City of Bakersfield Recreation and Parks Department programs, North of the River Recreation and Park District, Shafter Youth Center, Children First, and the Wildlands Conservancy

The following needs of child and adolescent members are not met:

1. **Preventive health and developmental screening outcomes**
   - **Need:** Improvement is needed with child immunization, developmental screening, and well-care visit outcomes.
   - **Actions:** Collaboration between KHS departments is needed to identify barriers and implement strategies to improve child and adolescent preventive health outcomes.
     - Work with the KHS Strike Team to develop and implement strategies to close gaps in care and improve MCAS rates.
     - Implement member reward campaigns to improve member preventive health and development screening outcomes.
     - Promote child and adolescent preventive health and development screening with a variety of communication methods, such member text message campaigns, member newsletter articles, and member portal notifications.
     - Work with community partners, such as the Kern County Immunization Coalition, to promote public health messaging campaigns that address childhood vaccine delay concerns.

KHS' Current Activities: Children's Health

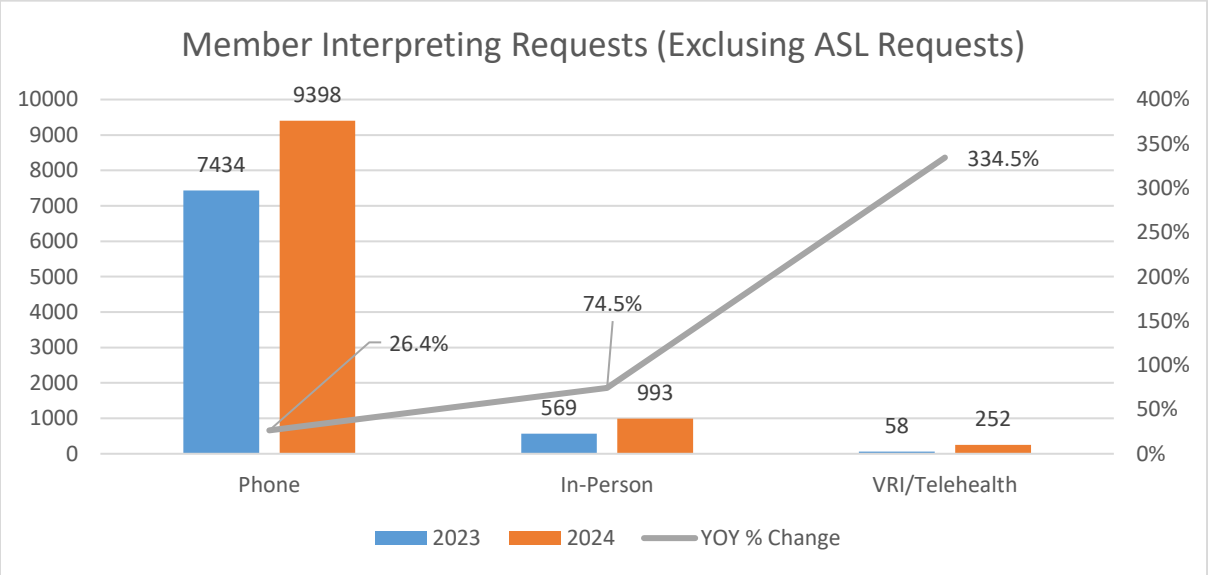
- Primary care is the foundation of all health care and is critical to achieving quality and equity. Central to the Basic Population Health Management (BPHM) concept is providing strong access to and promoting utilization of primary care, as well as leveraging culturally and linguistically appropriate primary care to increase trust with members, reducing health care disparities, and providing comprehensive and equitable care for addressing the physical and behavioral health conditions of all members. Additionally, KHS offers support to PCPs for children who need periodic well-child and developmental screenings according to a prescribed schedule and in line with the guidelines provided by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.
- All children under the age of 21 enrolled in Medi-Cal are entitled under federal law to the EPSDT benefit, which requires that children receive all screening, preventive, and medically necessary diagnostic and treatment services, regardless of whether the service is included in the Medi-Cal State Plan (DHCS Road Map Strategy 2022).
- EPSDT offers preventive health visits, including age-specific screenings, assessments, and services, at intervals consistent with the AAP Bright Futures periodicity schedule, and immunizations specified by the ACIP childhood immunization schedule.
- KHS offers a program for Children with Special Health Care Needs (CSCHN) known as the Kids and Youth Transition (KYAT) Program. Many children in this program also

qualify for the California Children's Services (CCS) Program. CCS is a state- and county-sponsored program supporting children under 21 with complex health conditions. The KAYT Team at KHS works closely with its CSCHN members and their families, collaborating with various doctors and local services, including the CCS county program, to ensure that children receive the care they need and experience an improved quality of life. The transition to adulthood for CSCHN/CCS children turning 21 is a critical milestone that requires specialized intervention. Ensuring they are equipped to navigate our often complex healthcare system is essential for meeting their ongoing healthcare needs.

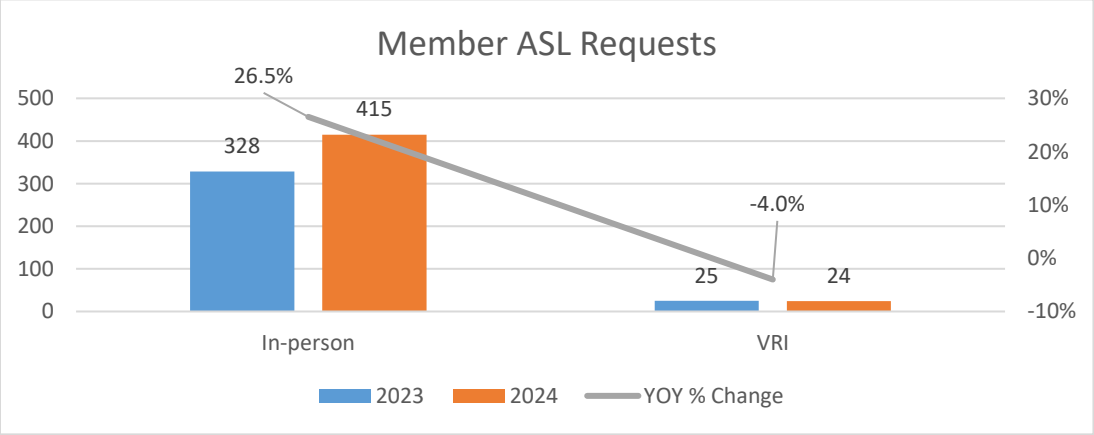
- Baby Steps Plus focuses on keeping members healthy and promoting maternal and infant health by supporting preventative and early interventions. Black Infant Health has been designated as a special priority through a collaborative effort with Kern County Public Health Services, ensuring enhanced support and resources for the community.
- KHS nutrition and asthma education programs are available to child and adolescent members. Considering that asthma is the most prevalent chronic condition among child and adolescent members based on claims data, KHS will continue to seek ways to promote and increase access to its asthma education and home visiting programs, include the Breathe Better Program, Asthma Preventive Services, and Asthma Remediation Services.
- The KHS School Wellness Grant Program is available to public schools who seek funding to start or expand school wellness programs that are designed to address top health issues or disparities among children and adolescents in Kern County.

Assessment of Members with Limited English Proficiency

KHS' WP department provides interpreting services to a culturally and linguistically diverse member population. KHS' threshold languages are English and Spanish, and all services and materials are available in these languages. In 2024, there was an overall 32.0% increase in interpreting requests compared to 2023.[47] When looking at interpreting requests by type excluding American Sign Language (ASL) requests, in-person requests increased by 74.5%, phone interpreting requests increased by 26.4%, and video remote interpreting (VRI) and telehealth requests increased by 334.5%. ASL interpreting requests increased by 24.4%.[48]



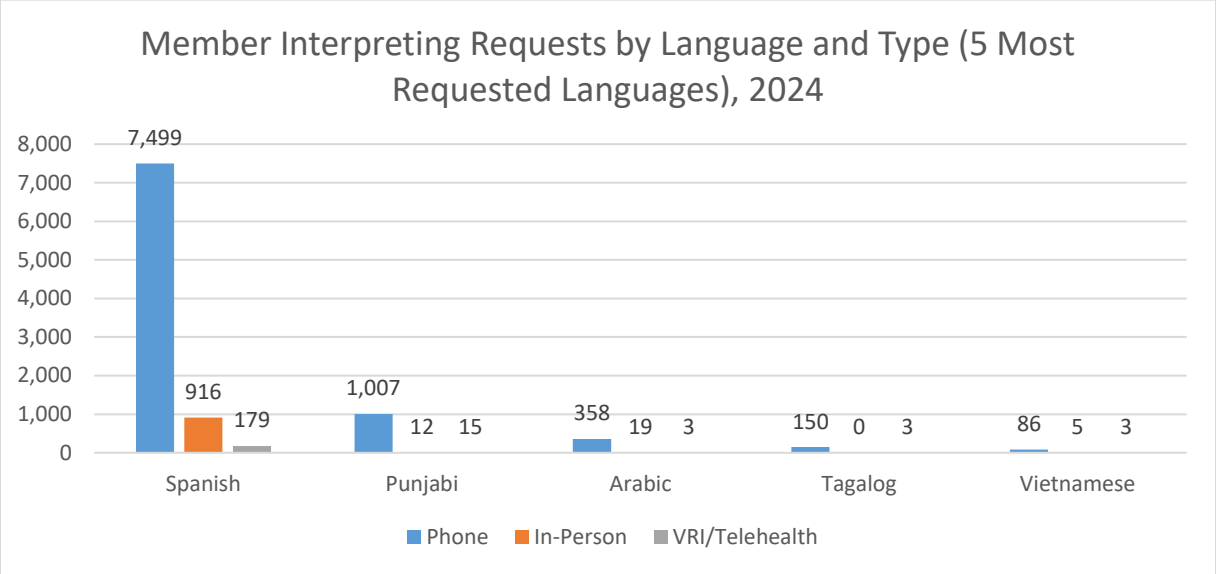
Source: 2023 and 2024 KHS Interpreting Request Activities Reports



Source: 2023 and 2024 KHS ASL Request Activities Reports

When looking at face-to-face interpreting requests, Spanish was the most requested language, followed by Arabic, Punjabi, Vietnamese, and Russian.**Error! Bookmark not defined.** Among phone requests, Spanish was the most common language, followed by Punjabi, Arabic, Tagalog,

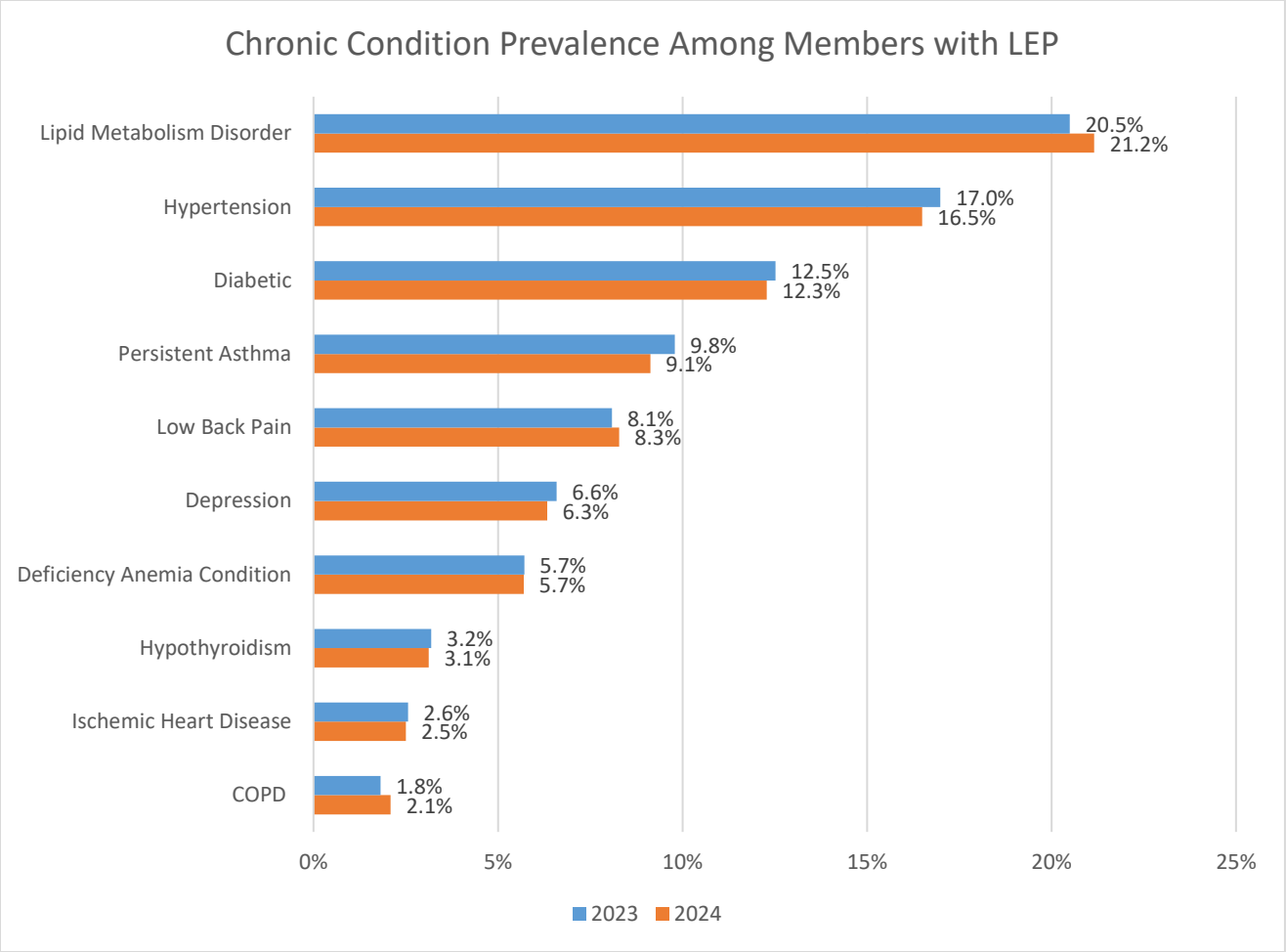
and Vietnamese. Among VRI and telehealth requests, Spanish was the most requested language, followed by Punjabi, Arabic, Tagalog, and Vietnamese.



Source: KHS Interpreting Request Annual Activities Reports

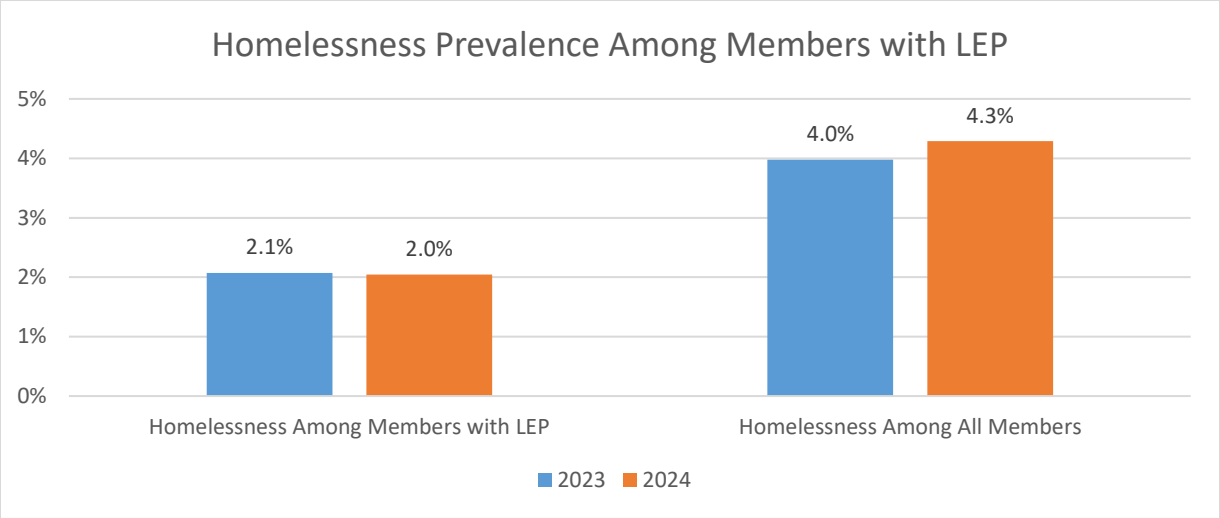
See the Access to Care section for a summary of the KHS quarterly interpreting access survey among its health care provider network.[49] The rate of providers who were considered compliant with knowledge of access to interpreters decreased from 92.5% in 2023 to 76.4% in 2024.

A comparison of the top 10 chronic conditions among members with limited English proficiency (LEP) with the overall membership reveals some disparities. Lipid metabolism, hypertension and diabetes were considerably more prevalent among members with LEP than the entire member population in 2024. The deficiency anemia condition, hypothyroidism, and ischemic heart disease were slightly more prevalent among members with LEP than all members combined. There were increases in the prevalence of lipid metabolism (from 20.5% to 21.5%), low back pain (from 8.1% to 8.3%), and COPD (from 1.8% to 2.1%) from 2023 to 2024. The rest of the 10 most prevalent conditions among members with LEP decreased slightly or remained the same.



Source: KHS Member Demographics Report

The prevalence of homelessness among members with LEP is lower than all members in 2024. Homelessness among members with LEP and all members may be more common than homelessness among the entire Kern County population when comparing data with the annual homelessness point in time count.



Source: KHS Member Demographics Report

Summary of Needs of Members with Limited English Proficiency

1. Member interpreting requests increased by 32.0% from 2023 to 2024. This reflects a growing member need for interpreting services.
2. Although the top non-Spanish languages for interpreters do not meet DHCS' criteria to constitute as a new threshold language for KHS, interpreting requests for the non-Spanish languages, such as Punjabi and indigenous languages, continue to grow each year.
3. Member ASL interpreting requests increased by 74.5% from 2023 to 2024. ASL interpreting is a growing member need. However, there continues to be a slight shortage of ASL interpreters based in Kern County. Occasionally, KHS' interpreting vendor must recruit interpreters from outside Kern County to commute into the area and assist ASL members.
4. More in-person interpreters are needed for KHS Wellness and Prevention programs (such as health education classes), the KHS Community Advisory Committee Meetings, the KHS Regional Advisory Committee Meetings, the Kern Health Equity Partnership Community Conversation events, and other member or community outreach events.
5. Conducting recurring trainings on KHS member interpreting services with the same provider sites will be needed due to provider staff turnover.
6. Increasing awareness about our interpreting services among members, providers, and community partners would improve member access to interpreting and translation services.
7. LEP members have a need for similar types of disease management programs compared to the entire member population. LEP members may have a greater need for lipid metabolism, hypertension, and diabetes management programs than the overall member population.

The following needs of LEP members are met:

1. Members need interpreting services in diverse languages and modalities. KHS offers interpreting services in any language requested and in different modalities, such as in-person, over the phone, and video remote.

2. Members need health care providers to offer culturally competent health care and have access to interpreting services. KHS conducts a periodic interpreter access survey to monitor providers and ensure they are meeting interpreting access standards. KHS also offers interpreting service trainings to providers as needed.

The following needs of LEP members are not met:

1. **Lack of in-person language interpreters based in Kern County**
   a. **Need:** There is a lack of in-person language interpreters who are based in Kern County to meet member demand for certain languages, such as Punjabi and indigenous languages of immigrants from Mexico or other Latin American countries.
   b. **Action:** Work with language interpreting service providers and local educational institutions to identify strategies to train, recruit, and hire more language interpreters who are based in Kern County.

2. **Lack of over-the-phone interpreters for indigenous languages**
   1. **Need:** There is a significant shortage of qualified over-the-phone interpreters for indigenous languages, limiting access to essential services for indigenous communities.
   2. **Action:** Work with language interpreting service providers to ensure language providers have indigenous interpreters.

3. **Lack of in-person ASL interpreters based in Kern County**
   - **Need:** There is a lack of in-person ASL interpreters based in Kern County to meet member demand.
   - **Action:** Work with language interpreting service providers and local educational institutions to identify strategies to train, recruit, and hire more ASL interpreters who are based in Kern County.

4. **Member interpreting service trainings for KHS providers**
   - **Need:** Member interpreting service trainings are needed for some KHS providers.
   - **Action:** Reach out to providers and offer interpreting service trainings, as needed. Increase KHS Culture and Linguistics (C&L) Team resources for provider outreach and trainings.

5. **Lack of community awareness of KHS member interpreting services**
   - **Need:** There is a lack of awareness of interpreting services among members, KHS staff, KHS providers, and community stakeholders.
   - **Action:** Reach out to member-facing KHS departments to offer periodic interpreting service trainings. Increase KHS C&L staff resources, if needed. Work with the KHS Marketing, Member Engagement, Community Engagement, and Provider Network Management Teams to develop member, community, and provider outreach strategies to promote KHS language interpreting services.

Identification and Assessment of Needs for Relevant Member Subpopulations

A **subpopulation** is a group of individuals within the membership who share characteristics.

KHS uses its assessment of the member population to identify and assess the characteristics and needs of relevant subpopulations.

KHS' risk stratification uses a mechanism to identify members who will benefit from preventative health interventions, enable better planning of health-related services, and decrease health-related costs. Risk stratification, or predictive modelling, is used to predict future adverse events, such as unplanned hospital admissions, which are costly, undesirable, and potentially preventable. If effective, risk stratification can have a range of benefits:

1. Identifying individuals who may be at risk allows KHS to offer interventions aimed at reducing the likelihood of serious health risks.
2. Identify and target appropriate proactive interventions. It can ensure that the highly complex and high-risk members receive appropriate care for their needs; rising risk members might be referred to a lighter touch intervention; and lower-risk members could be managed through usual care and self-care.
3. Utilize as a population health planning tool, enabling KHS PHM leadership to gain a detailed picture of the future risk profile of its population, allowing them to design care pathways and target funds and interventions appropriately.

KHS uses The Johns Hopkins ACG Modeler as an advanced data source and tool to identify member chronic conditions and risk scores across the entire KHS population. Data sources for the ACG Modeler include member eligibility, medical claims, pharmacy claims, laboratory results, and supplemental medical data. The ACG Modeler outputs are referenced in PHM program stratification and performance measure. KHS analyzes the data to understand how members use services, the types of health conditions they face, and where there may be gaps in care—taking into account their risk level, geographic location, and age group.

KHS uses these findings to evaluate the programs and services offered by KHS and determine if the benefits offered are adequate to meet our member needs.

The first identified subpopulation of focus are members with end-stage renal disease (ESRD).

End-stage renal disease, or ESRD, refers to a medical condition in which a person's kidneys cease functioning permanently leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. According to the CDC, over 6 million Americans live with chronic kidney disease (CKD) and nearly 786,000 Americans live with ESRD. As recently as 2018, CKD is the 10th leading cause of death in the United States.

CKD is a condition that can worsen over time, progressing through various stages of severity. Because of the slow progression, CKD often goes undiagnosed. It is estimated that 9 in 10 adults with CKD do not know they have it. In its most advanced stage, it can develop into ESRD. At this stage, the kidneys are no longer able to remove enough waste and excess fluid from the body. At this point, dialysis or a kidney transplant is needed.

Despite technological advances, there are excessive costs for ESRD management and the failure of current treatment programs to adequately rehabilitate the ESRD patient. Patients with end-stage kidney disease (ESKD) are exposed to multiple physical and psychological stressors due to their illness. Treatment of ESKD in the form of dialysis imposes considerable stress, including potential changes in family relations, social interactions, and occupational demands.

The chronic condition profile of the ESRD dialysis population reveals an extremely high burden of comorbidities. Out of 1,276 members analyzed, over 83% have six or more chronic conditions, underscoring the clinical complexity of this group.[50]

The largest segment of the population falls into the 6 to 10 chronic condition range (36.6%), followed closely by those with 11 to 15 conditions (29.2%). Additionally, nearly 1 in 5 members (17.8%) live with 16 or more chronic conditions, indicating a need for highly coordinated, multidisciplinary care to manage frequent complications and prevent deterioration.

In contrast, only 3.6% of members have 0 or 1 chronic condition, and fewer than 6% have between 2 and 3 conditions. This small fraction represents the least medically complex subgroup, though they remain vulnerable due to their ESRD status.

The overall distribution reflects a population with severe and overlapping chronic illnesses, requiring intensive case management, ongoing monitoring, and tailored interventions to avoid preventable hospitalizations and reduce overall healthcare costs.

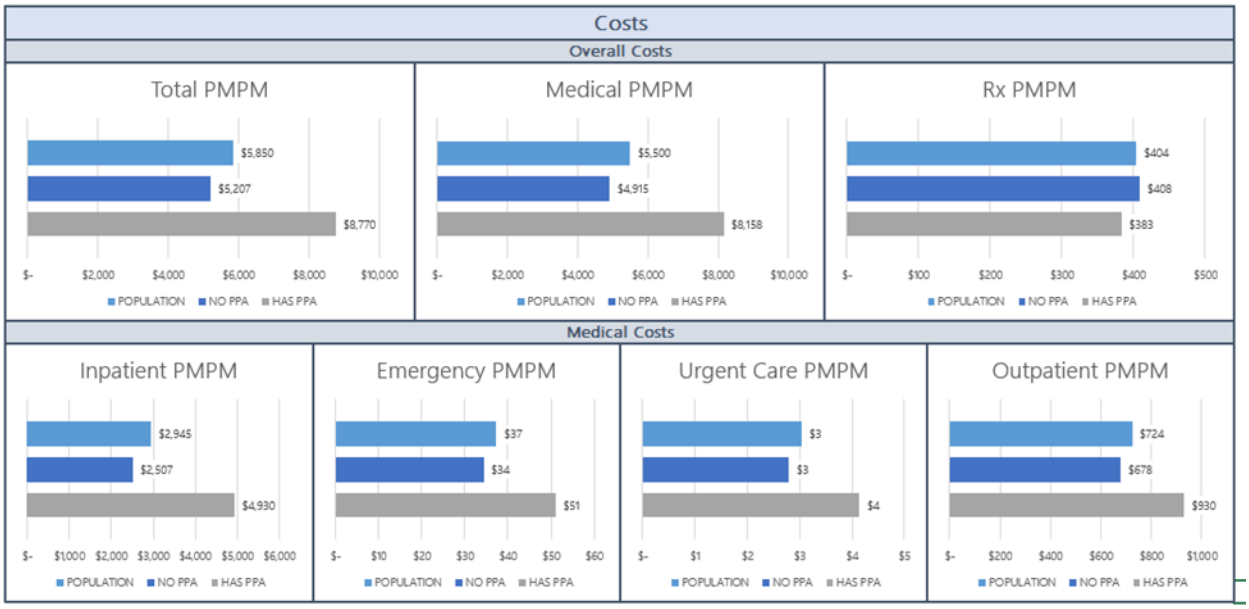
This multimorbidity is likely a major contributor to the high PMPM costs observed among members with preventable potential admissions (PPAs), reinforcing the importance of early intervention and proactive chronic disease management in this group.

The Resource Utilization Band (RUB) for ESRD members is scored at 4.71, which is in the very high category. This means that the ESRD members with multiple comorbidities require more intensive healthcare services. ECM and PHM CCM services will be needed to ensure care coordination and management continuum of care are provided to the members.

Hypertension (88.2%) is the most common comorbidity among ERSD patients while diabetes (72.5%), dyslipidemia (69.9), and various cardiovascular disorders are also common comorbidities. Improvement in outcomes for ESRD members would depend on them gaining a better understanding of management of comorbid conditions. A follow-up communication with members is critical to ensure members received timely services.

Furthermore, 22.2% of members with ESRD suffer from depression due to the psychological stressors of their illness. Managing kidney disease can be mentally challenging; therefore, it is critical that members are connected to behavioral health services to help members manage the difficulties they are facing.

Overall Costs for ESRD Members (N=1,276) (Date: 3/14/2025)



Source: KHS ESRD Utilization Cost Report

This analysis examines per member per month (PMPM) healthcare costs for members with End-Stage Renal Disease (ESRD) undergoing dialysis, segmented by their association with Preventable Potential Admissions (PPA). The population is divided into those with no PPA, those with a PPA, and the total ESRD population.

Overall, members with a PPA incur significantly higher total healthcare costs ($8,770 PMPM) compared to those without a PPA ($5,207 PMPM). This trend is primarily driven by higher medical costs, including inpatient ($4,930 vs. $2,507) and outpatient ($930 vs. $678) PMPM values. These figures reflect the substantial burden that potentially avoidable complications and hospitalizations place on the healthcare system for this high-risk population.

While Rx PMPM costs are slightly lower for PPA members ($383) compared to those without PPA ($408), this modest difference is overshadowed by the much larger disparities in hospital-based and emergency care.

The elevated costs across all service categories — especially inpatient and emergency services — among PPA members suggest that these patients are more likely to experience complications that could potentially be prevented through earlier intervention, better chronic condition management, or improved care coordination.

In contrast, members without a PPA demonstrate significantly lower utilization across inpatient, emergency, and outpatient settings, which may reflect better-managed care, fewer acute events, or earlier interventions that help avoid preventable admissions.

The overall goal of the ESRD Program is to work in partnership with nephrologist providers to:

1. Prevent or slow disease progression,
2. Promote physical and psychosocial well-being, and
3. Monitor disease and treatment complications.

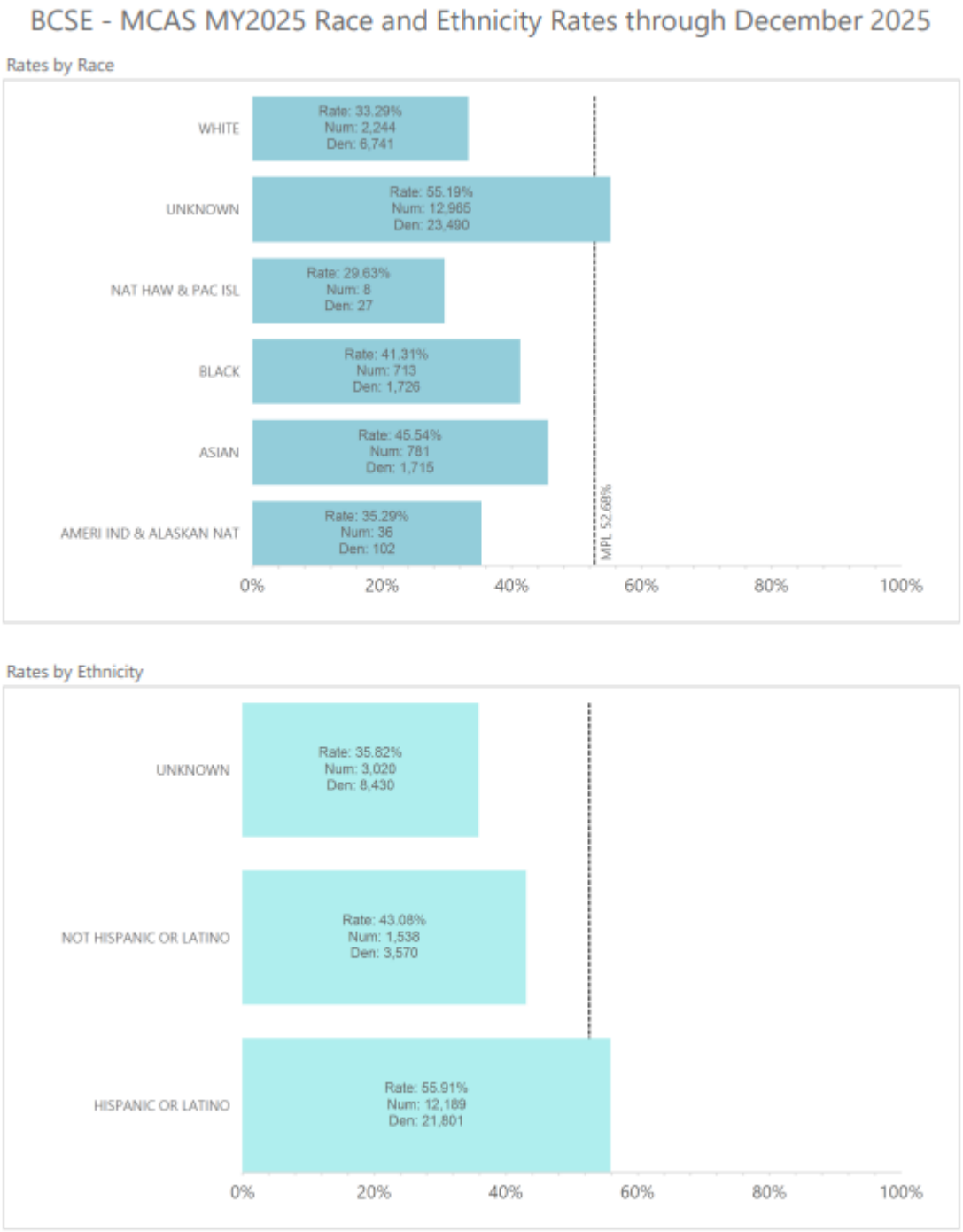
The KHS ESRD program services include:

- Provide care coordination and care management services to optimize disease management;
- Educate members on self-management;
- Screen and address patients' psychological issues and refer to appropriate behavioral health services;
- Ensure members receive timely, seamless comprehensive healthcare including preventative care;
- Reduce acute hospital admissions and readmissions, ER and UC utilization;
- Address social determinants of health and gaps in services through linkages of members to ancillary services; and
- Reduce non-dialysis cost by 20%.

The second identified subpopulation of focus are all women, ages 40-74 with a particular emphasis on Black/African America women.

Breast cancer is the most frequently diagnosed cancer in women and the second leading cause of cancer death in American women.[51] Regular screening mammography starting at age 40 years reduces breast cancer mortality in average-risk women. Screening, however, also exposes women to potential harms, such as callbacks, anxiety, false-positive results, overdiagnosis and overtreatment. Varying judgments about the appropriate balance of benefits and harms have led to differences among the major guidelines about what age to start, what age to stop and how frequently to recommend mammography screening in average-risk women.

In 2025, KHS reported 33,801 women ages 42-74 who needed a mammogram.[52] Of these women, KHS has been successful in providing screening for 16,747 women—indicating a success rate of 49.55% so far. In terms of rates by race, the rate for breast screening compliance among Black/African American women was 41.31% (see graph below).



Source: HEDIS Trending Measure Report

However, studies show that African American/Black women have more aggressive breast cancer subtypes, are diagnosed at younger ages, and have an increasing incidence rate.[53] These disparities have resulted in Black women are more likely to die from breast cancer than women of all other racial and ethnic groups.

- In 2023, Black/African American women had higher rates of screening mammography than women of other races.[54] Overall, the breast cancer incidence rate (rate of new cases) is lower among Black/African American women than among White women. However, the breast cancer mortality rate is higher among Black/African American women. For example, the breast cancer mortality rate from 2019 to 2023 (most recent data available) was about 37% higher for Black/African American women than White women.

To address the health disparities among Black/African American women, KHS PHM developed a strategy to promote breast cancer prevention and improve the health outcomes of racial/ethnic minorities. Evidence-based education for breast cancer screening will emphasize shared decision making between women and their doctors, supporting women to make an informed decision based on personal preferences when the balance between benefits and harms is uncertain. The decision about the age to begin mammography screening will be made through a shared decision-making process. KHS will also continue to work collaboratively with network providers to underscore the importance of screening mammography and its role in early detection and consequent reduction in mortality.

Achieving Equity in Breast Cancer

Many barriers may make it hard for some women to get breast cancer screening and follow-up on abnormal mammograms.[55] Increasing access, awareness and sensitivity may help remove some barriers (especially for women with low income who do not have health insurance). This includes:

1. Improving access to mammography and primary care
2. Removing financial barriers
3. Removing language barriers
4. Community education (such as health campaigns that address negative beliefs and feelings about mammography)
5. Making sure health care providers are sensitive to the needs of women from different communities and cultures. When a provider does not recommend a mammogram, some women do not feel they need one.

KHS has partnered with providers/practitioners to use evidence-based education on breast cancer screening with their patients. The goal is to empower Black/African American women to fully consider their breast cancer screening options and take an active and informed role in their health care through shared decision-making with their health care providers.

Selection of Patient Decision Aids (PDAs)

KHS selected two PDAs below (see table) that meets the requirements of the NCQA PHM Standards.

PDA	Organization	Audience	Description
Should I Get a Mammogram? (ages 40-49), also translated into Español - Spanish	Confluence Health 1201 S. Miller St. Wenatchee, WA 98801	All women, ages 40-49	This PDA is to help women, ages 40-49, decide if they want to start having mammograms before age 50 and how often to get them, if a woman decides to start having mammograms.
How Often Should I Get a Mammogram? (ages 50-74), also translated into Español - Spanish	Confluence Health 1201 S. Miller St. Wenatchee, WA 98801	All women, ages 50-74	This PDA is to help women, ages 50-74, decide how often to get screening mammograms.

IV. KHS Program Gap Analysis

Wellness and Prevention Programs

The KHS Wellness and Prevention (W&P) Department offers a variety of health education and community wellness programs to support and promote member and community health. The department offers educational programs with different modalities, such as in-person classes, virtual classes, community fitness classes, follow-up calls, printed mailings, and social media content. The KHS W&P Department stopped offering in-person classes in March 2020 and began to offer virtual classes in April 2020 in response to the COVID-19 pandemic. The KHS W&P Department resumed in-person classes in April 2023. KHS W&P programs are offered at the KHS office in Central Bakersfield, at a variety of community sites in Kern County, and remotely via video conferencing software.

KHS offers member reward programs to motivate members to receive W&P programs that include health education classes and follow-up calls. Member engagement campaigns include Member Newsletter content and text message campaigns to promote member W&P programs.

The KHS W&P Department began to offer a community benefit called the Live Better Program in 2022. It includes free nutrition and exercise classes at community sites in Kern County. KHS sponsors the exercise classes and may offer the nutrition classes directly or train program partners to offer them. This program is free and open to the public. KHS is also piloting a gym membership program with a local gym that is only for KHS members.

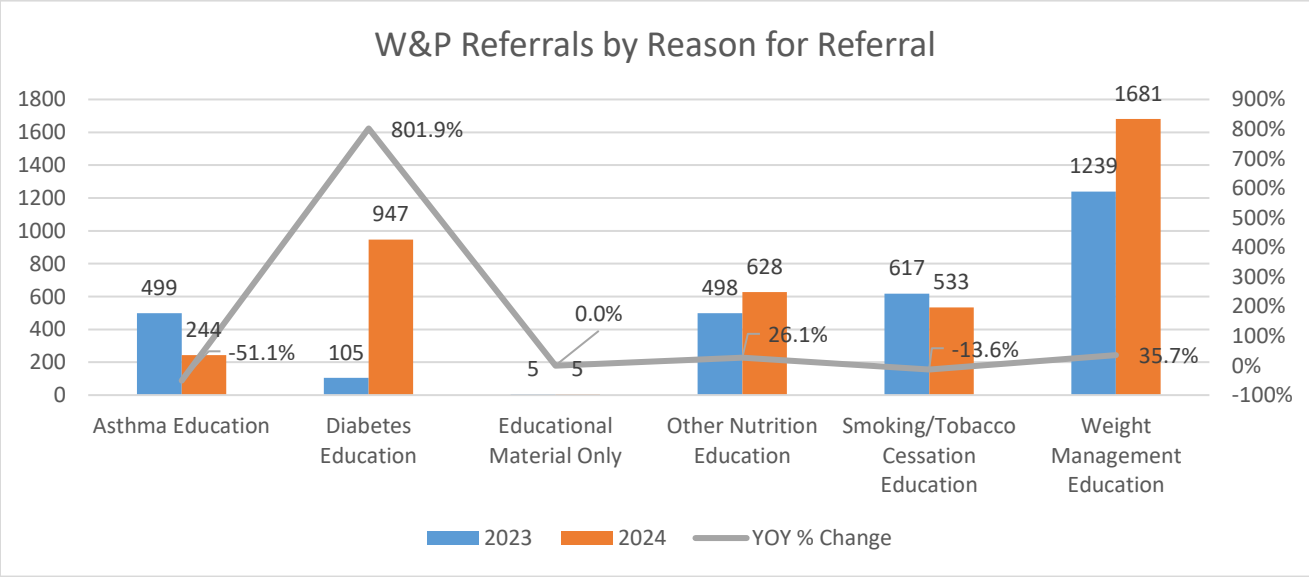
KHS offers a school wellness grant program that includes 2-year funding and program support for public schools that seek to start or expand a school wellness program. Eligible school wellness programs can cover a range of priority health topics. KHS staff meet with awarded schools on a regular basis throughout the grant period and organize events that allow schools to share ideas, network, and learn about KHS and community resources. The current cohort of the school wellness grant program includes 10 public schools in Kern County.

In addition to W&P programs offered directly by KHS staff, KHS began offering the Community Health Worker (CHW) Services and Asthma Preventive Services (APS) benefits in 2023. In 2024, KHS recruited and contracted with CHW and APS providers, increased service capacity, and developed a member referral process. Progress in these areas has continued in 2025. These benefits cover services that offer convenience to members since they can be provided by qualified CHWs at a variety of locations, such as, but not limited to, a clinic site or a member's home. They can also be offered via telehealth. CHW services are designed to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and well-being. CHW services may assist with a variety of concerns impacting members, including, but not limited to, the control and prevention of chronic conditions or infectious diseases, behavioral health conditions, and need for preventive services. Additionally, CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, domestic violence, and other violence prevention services.

APS includes clinic-based asthma self-management education, home-based asthma self-management education, and in-home environmental trigger assessments for members with asthma. APS require the recommendation of a licensed health care provider.

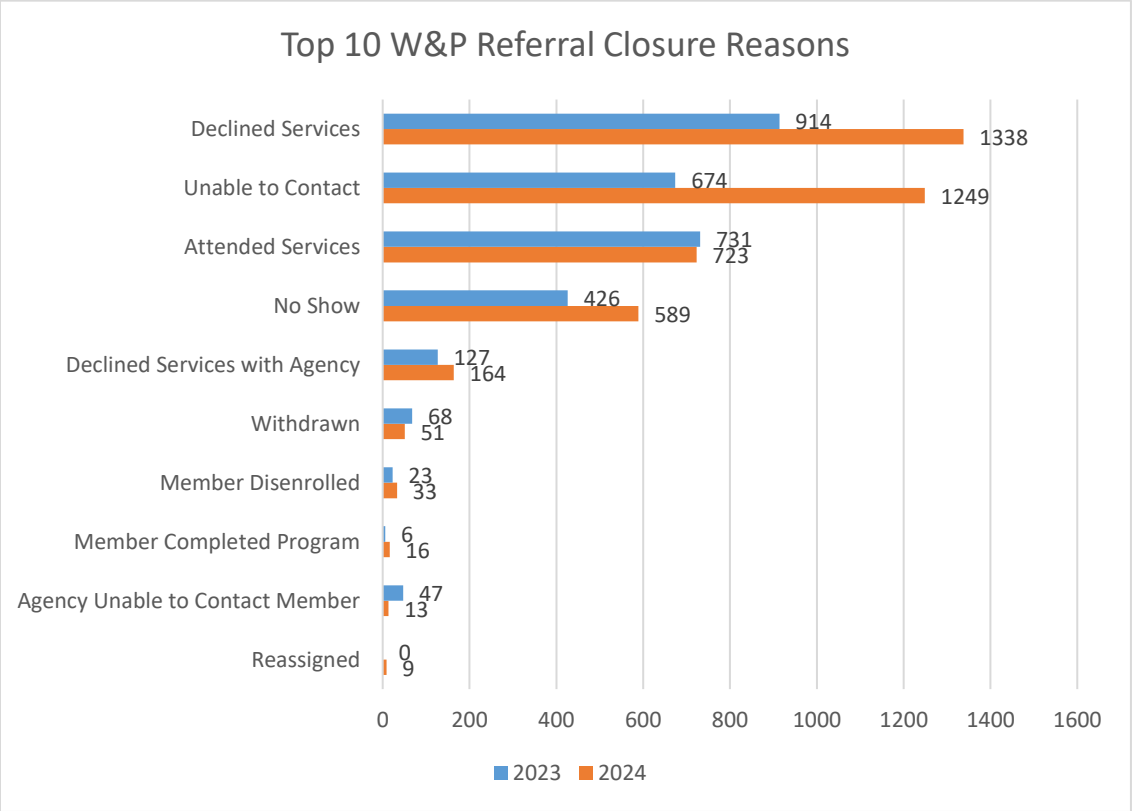
Health Education Referrals

The KHS Wellness and Prevention (W&P) Department received 4,038 referrals for health education services in 2024, a 36.3% increase compared to the previous year.[56] Weight management education was the top referral topic, followed by diabetes education, other nutrition education, smoking/tobacco cessation education, and asthma education. Referrals for diabetes education, other nutrition education, and weight management increased from 2023 to 2024. Referrals for asthma education and smoking/tobacco cessation decreased.



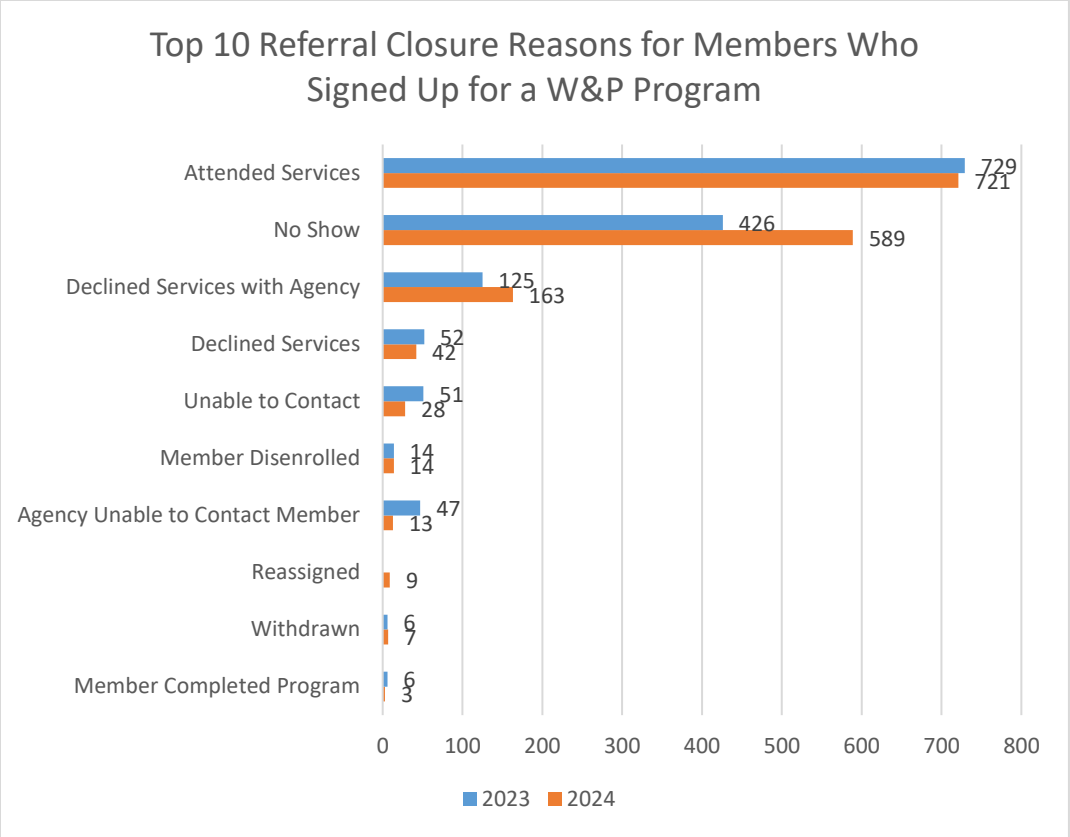
Source: KHS HECL Report

The rate of members who accepted health education services decreased from 44.1% in 2023 to 37.8% in 2024. The rate of members who declined health education services increased from 34.5% in 2023 to 37.6% in 2024.



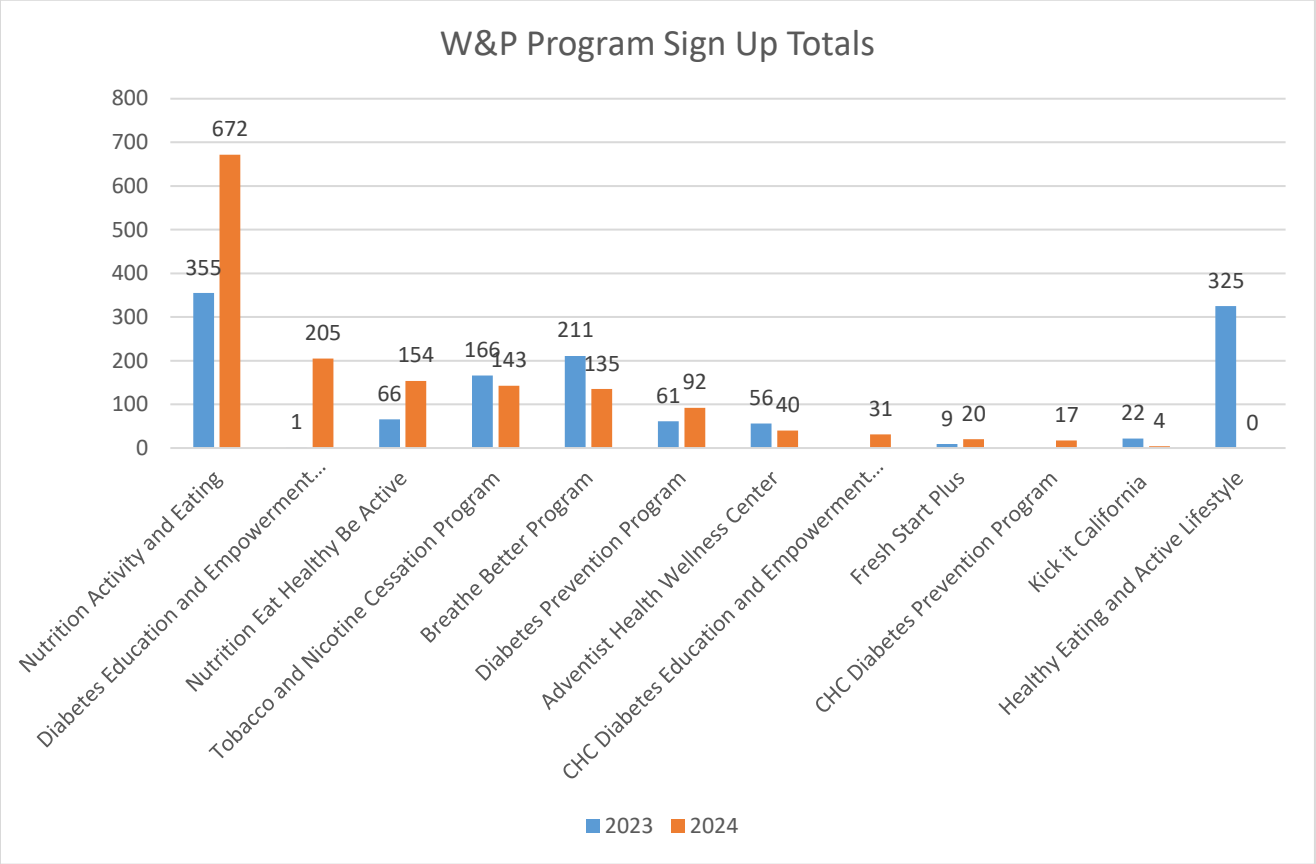
Source: KHS HECL Report

Among referrals with members who signed up for a W&P program, the proportion of referrals that were closed with an "Attended Services" or "Member Completed Program" outcome (attended at least one program session) decreased from 50.3% in 2023 to 45.5% in 2024. The proportion of referrals that were closed with a "No Show" outcome (did not attend any program sessions) increased from 29.1% in 2023 to 37.0% in 2024.[24]



Source: KHS HECL Report

KHS nutrition education classes were the most popular type of health education service in 2024 based on program registration, followed by the Diabetes and Education Empowerment Program, the Fresh Start and Fresh Start Plus Programs (smoking/tobacco cessation education), and the Breathe Better Asthma Program. KHS nutrition classes accounted for 54.3% of all accepted services referrals and 50.3% of closed referrals with an attended services closure reason (meaning the member attended at least one program session as part of the referral).



Source: KHS HECL Report

Summary of W&P Programs and Member Needs

1. The 36.3% increase in W&P referrals from 2023 to 2024 indicates there may be a growing demand for W&P programs among members and referring KHS providers.
2. The rate of members who accepted health education services after being referred decreased from 44.1% in 2023 to 37.7% in 2024. The percentage of referrals with a W&P program registration where a member attended at least one W&P program session decreased from 50.3% in 2023 to 45.5% in 2024. Investigation is needed to understand why these rates have declined despite a substantial increase in referral volume in 2024 compared to 2023.
3. W&P program registration totals in 2024 indicate that member needs include education on top chronic conditions and healthy lifestyle topics such as nutrition, weight management, diabetes management, diabetes prevention, smoking or tobacco cessation, and asthma education.
4. Diabetes is a top chronic condition among members. Diabetes education W&P referrals increased by 801.9% in 2024 compared to 2023. The Diabetes Empowerment and Education Program (DEEP) had the highest program registration total of all the W&P chronic disease education programs. These findings indicate that diabetes education is a growing member need.

5. KHS offers a limited amount of DEEP and Diabetes Prevention Program series because it is a resource intensive program. To scale up this program so that it is offered more frequently, KHS has contracted with California Health Collaborative to offer them via video conferencing software. To offer in-person DEEP and DPP more frequently and at locations through Kern County, KHS may need to train and contract with health education service providers.
6. Members have different preferences for how and where they would like to receive health education services. To address this need, KHS offers the CHW and APS benefits, which can be offered at a variety of locations by qualified and culturally competent CHWs. These services can also be offered virtually. KHS has contracted with a limited number of CHW and APS providers and continues to contract with more providers. More CHW and APS providers will be needed to scale up the service capacity and meet member demand. Promotion of the CHW and APS benefits among members and KHS providers will be needed to increase access to and utilization of these services.
7. The Live Better Program may need to be scaled up to meet member demand. It is offered at a limited number of locations in Kern County.

Conclusion:

Based on the summary of wellness and prevention (W&P) programs and member needs, the key unmet needs are as follows:

1. Increased Access to Wellness and Prevention Programs
- **Need**: Although participation rates in W&P programs have increased, there is a growing demand for more extensive and accessible offerings.
- **Action**: Expand the availability of W&P programs, especially in diverse locations across Kern County, to ensure all members can participate.

2. Education on Chronic Conditions and Healthy Lifestyles
- **Need**: Members have expressed a need for education on managing chronic conditions and healthy lifestyle choices, such as nutrition and tobacco cessation.
- **Action**: Develop and promote educational workshops and resources focused on the most common chronic conditions and lifestyle topics relevant to member needs.

3. Scaling Diabetes Education Programs
- **Need**: Growing referral and program registration volume for W&P diabetes education programs reflect growing demand and member need. However, these programs are limited in terms of frequency and locations due to their resource intensive nature.
- **Action**: Increase the number of DPP sessions offered and expand the locations where they are available to better meet member demand. Consider training and contracting with health education service providers.

4. Enhanced Diabetes Education and Management Resources
- **Need**: With diabetes being a prevalent chronic condition, there is significant demand for education and management resources.

- **Action**: Scale up the DEEP to meet the need for more education and support for members living with diabetes.

5. Diverse Delivery Preferences for Health Education Services

- **Need**: Members have varied preferences for how and where they receive health education services, necessitating a flexible approach.
- **Action**: Increase the number of CHWs and APS providers to offer services in more locations and through virtual options.

6. Scaling the Live Better Program

- **Need**: The Live Better Program, currently offered at limited locations, may not be meeting the full demand from members.
- **Action**: Expand the program's reach by identifying community partners and increasing the number of locations and sessions available to members.

Summary of Relevant Actions:

- **Program Expansion**: Offer more sessions and locations for W&P programs, particularly DEEP, DPP, nutrition and weight management education, smoking cessation, asthma education, and the Live Better Program.
- **Educational Workshops**: Create targeted educational initiatives focusing on chronic conditions and healthy lifestyle changes.
- **CHW and APS Capacity**: Hire and contract with additional CHWs and APS providers to enhance service capacity.

Overall Strategy:

To effectively address these unmet needs, KHS will prioritize scaling wellness and prevention programs, improving access to diabetes management resources, and ensuring that health education is culturally competent and flexible. Regular assessment of member feedback and participation rates will be vital for continuous improvement in program offerings.

CalAIM Programs

CalAIM is a series of Medi-Cal initiatives that offer access to new and improved services to get well-rounded care that goes beyond the doctor's office or hospital and addresses all the physical, mental health, and community-based service needs of members. These changes are part of a broad transformation of Medi-Cal to create a more coordinated, person-centered, and equitable health system that works for all Californians. The summary below covers four CalAIM Initiatives: Community Health Worker (CHW) Services, Asthma Preventive Services (APS), Community Support Services (CSS), and Enhanced Care Management (ECM).

CHW Services and APS require a recommendation from a licensed health care provider. But they do not require prior authorization. KHS does not have data that captures all CHW Services

or APS referrals. Claims data is used to track service utilization. In 2024, a total of 3,319 claims included a paid APS self-management asthma education home visit and 1,766 claims included a paid APS in-home environmental trigger assessment. In 2023, there were 2 claims with a paid APS self-management asthma education home visit and 2 with a paid APS in-home environmental trigger assessment. There were 175 claims with a paid CHW service in 2024 compared to 4 in 2023.

CSS referrals require prior authorization. A total of 10,536 CSS referrals were authorized and resulted in service enrollment in 2024, a 190.7% increase compared to 3,624 in 2023.[57] Enrollment increased most for Personal Care Services and Medically Tailored Meals. In 2024, the remaining CSS services became active and available to members. In 2025, DHCS released CSS policy refinements, resulting in adjustments in member benefits and referral processes. Some of those refinements impacted APS, such as requiring the in-home environmental trigger assessment to be offered as an APS benefit and no longer as a CSS Asthma Remediation Services benefit.

CSS Enrollment			
CSS Service	**2023**	**2024**	**% Change**
Asthma Remediation	1,496	1,424	-4.8%
Caregiver Respite	139	554	325.9%
Community or Home Transition Services	0	2	N/A
Day Habilitation	0	827	N/A
Environmental Accessibility Adaptation	0	20	N/A
Housing Deposits	164	380	131.7%
Housing Navigation	1,252	1,670	33.5%
Housing Sustainability	278	399	43.5%
Assisted Living Facility Transitions	5	8	60.0%
Personal Care Services	68	1,012	1470.6%
Recuperative Care	135	217	60.7%
Short Term Post Hospitalization Housing	93	175	88.2%
Sobering Centers	324	493	52.2%
Tailored Meals	272	5,334	1857.0%
Total	4226	12515	190.7%

Source: CSS Membership by Program and Site Report

A total of 31,042 ECM referrals were received in 2024.[58] This was a 37.4% increase compared to 22,599 in 2023. In 2024, 9,238 members enrolled in ECM, resulting in a 75.4% increase compared to a member enrollment total of 5,266 in 2023.

As described previously, KHS' ECM Department oversees the Justice-Involved (JI) Reentry Initiative for members. Enrollment in the program began in 2022 with a total of 128 members, followed by a 338.3% increase to 561 members in 2023. In 2024, the ECM JI population was 488 members.

For a summary of member substance abuse disorder referrals, see the section Assessment of Members with Behavioral and Mental Health Conditions.

Conclusion:

Based on the member needs summary, the key unmet needs are as follows:

1. **Promote and Increase Capacity for CHW Services and APS**
   - **Need**: Since CHW Services and APS are new benefits, outreach and promotion will be needed to increase awareness among members, KHS providers, and community partners. As CHW and APS referrals and utilization increase, more CHW and APS providers will need to be recruited to the KHS provider network.
   - **Action**: Develop and implement an outreach and communication plan to increase awareness of CHW Services and APS. Identify prospective CHW and APS providers and contract with them to meet the increasing demand for service
2. **Expand CSS**
   - Need: The 190.7% increase in CSS enrollment suggests a significant need for CSS to address SDOH among members.
   - Action: Scale up CSS offerings by increasing the number of providers, resources, and available programs to meet this surging demand.
3. **Increase Capacity for ECM**
   - **Need**: The 37.4% increase in ECM referrals indicates a significant demand for ECM services, which has outpaced the growth in member enrollment.
   - **Action**: Increase ECM sites and expand ECM resources to ensure that all members requiring these services can receive timely and effective support and ensure all eligible members are contacted and engaged through the implementation of the closed loop referral process. Continue in-person outreach for members who are referred for ECM to increase enrollment in ECM.
4. **Alignment of Resources with Rapid Growth**
   - **Need**: With member population growth of 19.7% and large increases in service utilization from 2023 to 2024, resources must be aligned with service demand.
   - **Action**: Conduct a comprehensive needs assessment to identify gaps in service delivery and allocate resources effectively to match the increasing demand.

Summary of Relevant Actions:

- **Resource Allocation**: Invest in hiring and training additional staff for ECM and CSS.

- **Program Development**: Create new programs or enhance existing ones to address the specific needs identified through the increase in referrals.
- **Continuous Monitoring**: Implement systems to regularly monitor referral trends and adjust services accordingly to ensure that member needs are consistently met.

Overall Strategy:

To effectively address these unmet needs, KHS will focus on scaling ECM and CSS to match the rapid increase in demand. Engaging with members to gather feedback and insights will be essential in shaping services that truly meet their needs.

Quality Performance Gap Analysis

In 2025 year-to-date, 95% of Initial and Periodic Facility Site Reviews (FSR) that were conducted passed with a score of 80% or higher. Year-to-date, there were 60 site reviews conducted that included 14 Facility Site Reviews (FSRs) and 26 Medical Record Reviews (MRR). Only one MRR resulted in a failing score. However, following the failed review, additional education was provided, and Corrective Action Plans (CAPs) were issued to correct deficiencies.

For Quarter 1 2025, the top three deficiencies identified for opportunities to improve for the FSR include:

-
- Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu-bag; Ambu – bag masks were not functioning properly.
- Stethoscope and sphygmomanometer with various size cuffs are missing one size. Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons; Sign on door was not in English and Spanish.

For Quarter 1 2025, the top three deficiencies identified for opportunities to improve the MRR include:

- Hepatitis B Virus Screenings are not being completed for both pediatrics and adults.
- HIV Screening are not being completed for both adults and pediatrics.
- Folic Acid supplementation is not being screened or supplemented.

Education was provided regarding these deficiencies and will continue to be monitored for any trends.

MCAS/HEDIS

All Medi-Cal managed care health plans must submit annual measurement scores for the required Managed Care Accountability Set (MCAS) performance measures to DHCS. MCAS

measures are a combination of measures selected by the Department of Health Care Services (DHCS) from the library of Healthcare Effectiveness Data and Information Set (HEDIS) and Core Measures sets from the Centers for Medicare and Medicaid Services (CMS). The results shown below cover the measures held to minimum performance level (MPL) measurement year (MY) 2024.

The MY 2024 rates for the following measures did not meet the MPL:

1. Child Development and Health
    a. CIS-10: Childhood Immunization Status
    b. DEV: Developmental Screening in First 3 Years of Life
    c. W30 (0-15 Months): Well-Child Visits in the First 15 Months. Children who turned 15 months during the measurement year: Six or more well-child visits.
    d. WCV: Child and Adolescent Well-Care Visits.
2. Mental Health and Substance Abuse
    a. FUA: Follow Up After ED Visit for Substance Abuse – 30 Day Follow Up
    b. FUM: Follow Up After ED Visit for Mental Illness – 30 Day Follow Up

MY2024 MCAS Rate Tracking Report
Note: These are the Preliminary Rates pending HSAG's approval

Hybrid Measures Held to MPL

	Measure	Current MY2024 Rate	MPL	HPL	MY2023 Rate	MY2024 Vs MPL	MY2024 Vs HPL	MY2024 Vs. MY2023	Hits Needed to meet MPL
CCS	Cervical Cancer Screening	58.88	57.18	67.46	57.18	▲ 1.70	-8.58	▲ 1.70	0
CIS-10	Childhood Immunization Status *	25.06	27.49	42.34	24.82	▼ -2.43	-17.28	▲ 0.24	10
GSD*	Glycemic Status Assessment for Patients with Diabetes (>9.0%)	32.36	33.33	27.01	32.85	▲ 0.97	-5.35	▲ 0.49	0
CBP	Hg	65.21	64.48	72.75	65.21	▲ 0.73	-7.54	▲ 0.00	0
IMA-2	Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)*	36.98	34.3	48.66	34.06	▲ 2.68	-11.68	▲ 2.92	0
PPC-Pre	Prenatal & Postpartum Care – Timeliness of	87.59	84.55	91.85	87.10	▲ 3.04	-4.26	▲ 0.49	0
PPC-Post	Prenatal & Postpartum Care – Postpartum Care	83.21	80.23	86.62	86.37	▲ 2.98	-3.41	▼ -3.16	0
LSC	Lead Screening for children	66.67	63.84	79.51	58.64	▲ 2.83	-12.84	▲ 8.03	0

GSD* is an inverse measure, low rate indicates better performance.
MRR-Medical Record Reviews

Administrative Measures Held to MPL

	Measure	Current MY2024 Rate	MPL	HPL	MY2023 Rate	MY2024 Vs MPL	MY2024 Vs HPL	MY2024 Vs. MY2023	Hits Needed to meet MPL
AMR	Asthma Medication Ratio	73.87	66.24	76.65	71.20	▲ 7.63	-2.78	▲ 2.67	0
BCS-E	Breast Cancer Screening	58.78	52.68	63.48	59.30	▲ 6.10	-4.70	▼ -0.52	0
CHL	Chlamydia Screening in Women Ages 16 – 24	57.17	55.95	69.07	56.87	▲ 1.22	-11.90	▲ 0.30	0
DEV	Developmental Screening in the First Three Years of Life	31.42	35.70	NA	25.94	▼ -4.28	NA	▲ 5.48	575
FUA	Follow-Up After ED Visit for Substance Abuse – 30 day Follow up*	33.81	36.18	49.40	18.85	▼ -2.37	-15.59	▲ 14.96	42
FUM	Follow-Up After ED Visit for Mental Illness – 30 days Follow up*	31.93	53.82	73.12	19.12	▼ -21.89	-41.19	▲ 12.81	219
TFL	Topical Fluoride for Children	25.08	19.00	NA	16.44	▲ 6.08	NA	▲ 8.64	0
W30 (0-15M)	Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.	52.18	60.38	69.67	39.21	▼ -8.20	-17.49	▲ 12.97	246
W30(15-30M)	Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child	69.43	69.43	79.94	63.74	▲ 0.00	-10.51	▲ 5.69	0
WCV	Child and Adolescent Well-Care Visits*	51.08	51.81	64.74	46.55	▼ -0.73	-13.66	▲ 4.53	1,017

Indicates KHS did not met MPL
Indicates KHS need 5% or less to met MPL
Indicates KHS met or exceeded MPL
Indicates KHS met or exceeded HPL.

MCAS Initiatives:

1. The Strike Team was reimplemented in 2025 to focus on initiatives that improve MCAS rates. The Strike Team consists of representatives from Marketing/Member Engagement, Business Intelligence, Provider Network Management, and Quality Performance.
2. The Strike Team is focused on developing key strategies to close gaps in care and monitoring and analyzing outcomes for continuous improvements.
3. KHS continued Member services Outreach Team focused calls and appointment scheduling.
4. KHS has partnered with Pilot Clinics for focused scheduling for the W30 African American population. KHS has also implemented Smartwatch Raffles for Well Visits for ages 12-18 years.
5. KHS continues to partner with a telehealth service provider to provide follow-up care after ED visits for mental health and substance abuse disorders. The KHS Behavioral Health (BH) Team has also started outreach to providers for members with established BH Care Teams.
6. The Quality Performance team has continued monthly and quarterly meetings with assigned providers. The purpose of these meetings is to review MCAS Year-over-Year Rates and discuss any barriers or initiatives to improve MCAS scores.
7. Dr. Duggal, an endocrinologist and KHS provider, began outreach for diabetic members with uncontrolled diabetes. The goal of the program is to improve members'A1C levels with appropriate interventions.
8. Mobile Units are now being utilized to address all Gaps-in-Care.
9. Member Engagement Reward Program (MERP) Campaigns:
    a. Include in the quarterly Member Newsletter content that raises awareness about preventative health screenings:
        i. Well Child Visits
        ii. Prenatal Care
        iii. Cervical Cancer Screening
        iv. Chlamydia Screening
    b. Text messages to members encouraging them to schedule appointments for gaps in care with a focus on preventative care, such as:
        i. Breast Cancer Screening
        ii. Blood Lead Screening
        iii. Initial Health Appointment
        iv. Chlamydia Screening
        v. Cervical Cancer Screening
        vi. Prenatal & Postpartum Care
        vii. Well-Care Visits
        viii. Well-Baby Visits in First 30 Months of Life
    c. KHS added FUA, FUM and Hbg A1c to the MERP list in 2024.

QI Performance Improvement Projects (PIPs)

KHS is mandated by DHCS to participate in 2 PIPs. The latest PIPs span over an approximate 4-year time frame and are broken into yearly submissions after initial baseline assessment. Each module is submitted to DHCS' External Quality Review Organization (EQRO), Health Services

Advisory Group (HSAG), for review, input, and approval throughout the project. For 2023-2026, the following 2 PIPs were approved by DHCS for KHS:

1. Clinical PIP- Well-Baby Visits within the Black/African American population (W15) ages 0-15 months

This PIP tracks and regulates targeted interventions to address health care disparities and improve the percentage of Well-Baby Visits that Black/African American infants 0-15 months old are able to attend. Increased attendance of Well-Baby Visits has the potential to provide opportunities for preventive care, review and discussion of infant's milestones/behaviors/development, and identification and prompt treatment of any delays or anomalies, resulting in a reduction of hospitalizations and emergency department use. Stronger relationships may be created between pediatricians, caregivers, and children, engaging families in care during a time of critical growth and providing a long-lasting foundation of preventive care and health benefits.

2. Non-Clinical PIP- Behavioral Health

The Behavioral Health Performance Improvement Project intends to improve the percentage of provider notification for members with SMH/SUD diagnoses within 7 days of an emergency department (ED) visit. This is a non-clinical measure mandated by DHCS. The period after the ED visit is important for engaging individuals in treatment and establishing continuity of care. Provider notification of ED visits has the potential for enhancing care coordination and ensuring timely follow-up care. This may reduce repeat ED visits, prevent hospital admissions, improve physical and mental function, and increase compliance.

V. Stakeholder Engagement

KHS Listening Sessions

KHS hired a consultant to conduct listening sessions in Kern County communities to gather community feedback on health care access, quality, and trust during the first quarter of 2024.

1. Participants shared positive feedback about experiences with specific health care providers and clinics.
2. Common concerns included issues with appointment availability, transportation, trust in the medical system, and quality of health care services.
3. These concerns indicate that members may need improvement with health care access, quality, and trust.

Potential solutions (or needs) were identified. These included:

1. Improve appointment availability. Increase the number of providers, optimize scheduling, and offer extended hours.
2. Enhance transportation services. Provide shuttle services, offer transportation vouchers, and partner with rideshare companies.

3. Strengthen patient education. Provide detailed information on health care services, referrals, and processes.
4. Improve trust and communication. Enhance provider-patient communication and address referral issues.

Regional Access Committees (RACs)

RACs were established in the second quarter of 2024 to hear from KHS members and community stakeholders about topics impacting their health. Five meetings were held each quarter representing each of the five regions of the county. 259 Kern County residents attended the RACs and 118 (46%) were Kern Family Health Care members. Spanish interpreters provided services at each meeting.

The following topics were discussed each quarter:

- Quarter 2 – Access to Care
- Quarter 3 – Quality of Care
- Quarter 4 – Trust in the Health Care System

There were various themes that came up throughout the sessions. An emphasis on the access of education, providers, medical facilities, transportation, healthy food, and special needs services in the second quarter. During the discussions on quality (quarter 3), there was an emphasis on provider and transportation delivery, as well as obtaining education, referral and appointments service modifications. The fourth quarter discussed ways the health care systems could build and retain trust.

Reviewing the quarterly data, Kern Health Systems determined there were four key themes coming from the stakeholders: Behavioral Health services, Telehealth services, Transportation services, and Wrap-Around Services (such as CalAIM, Doulas, CHW, APS, etc). In 2025, each of these topics will be a quarterly RAC, to gain more insight into the needs around these topics and to provide education of the current services available to Kern Family Health Care members.

The PNA findings will be presented to KHS' Quality Improvement/Utilization Management Committee which is comprised of KHS primary care providers, specialists, pharmacies, home health and durable medical equipment providers. KHS' contracted provider network will be notified of the PNA findings through the KHS website, provider portal and provider bulletin. Providers will be encouraged to contact KHS for additional information, questions, and comments.

VII. Population Needs Assessment Findings and Impact on KHS Activities and Resources

In 2024, the Medi-Cal program implemented significant changes, primarily driven by CalAIM, which mandates comprehensive population health management across all state plans. Key

initiatives include implementing the major organ transplant program, integrating CHWs within KHS and its provider network, recruiting APS providers, enhancing care for justice-involved individuals, adding the remaining CSS services, recruiting of CSS providers, improving transitions of care, addressing health disparities, and improving quality metrics around the children's preventive health and women's health domains.

KHS is committed to these improvements, striving to uplift our members' lives in line with KHS' mission. KHS' annual Population Needs Assessment evaluates data trends among members, helping to identify areas for intervention and improvement in member health outcomes and satisfaction with services.

Furthermore, beginning January 1, 2023, all Managed Care Plans (MCPs) are required to comply with PHM standards and either secure full National Committee for Quality Assurance (NCQA) Health Plan Accreditation or demonstrate to DHCS that they meet the NCQA Health Plan Accreditation standards. Accreditation ensures that KHS adheres to quality standards, resulting in better healthcare outcomes for members. It holds KHS accountable for their performance, encourages ongoing improvement, and helps them meet regulatory requirements. The NCQA Health Equity Accreditation specifically addresses the need to reduce disparities in care, promoting fair treatment for all populations. Attaining both NCQA Health Plan Accreditation and NCQA Health Equity Accreditation by January 1, 2026, will further solidify KHS' commitment to delivering high-quality, equitable care.

In June 2025, KHS received accreditation from the National Committee for Quality Assurance (NCQA), a nationally recognized organization that sets rigorous standards for healthcare quality and performance. NCQA accreditation demonstrates KHS's commitment to delivering high-quality, member-centered care and maintaining strong systems for clinical management, population health, and continuous quality improvement. This recognition is particularly important as it confirms that KHS meets nationally established benchmarks for managing care, reducing health disparities, and promoting equitable health outcomes. In alignment with our mission to advance health equity, KHS is also actively pursuing NCQA Health Equity Accreditation. This additional accreditation underscores our dedication to identifying and addressing social drivers of health, engaging diverse communities, and implementing data-driven strategies to ensure all members receive equitable, high-quality care.

KHS' Current Activities

KHS is actively engaged in initiatives that address the full continuum of care for members. These programs and interventions have been designed to meet the diverse needs of members across various PHM programs.

KHS has several programs focused on keeping members healthy. The following programs and services are available to all eligible members:

1. Health and Wellness – KHS offers the following educational programs and resources oriented towards promoting member wellness and prevention:
    a. Activity & Eating Program
    b. Community Health Worker (CHW) Services
    c. Eat Healthy Be Active Program

d. Health library and self-management tools
e. Live Better Program

2. Early Detection/Emerging Risk – KHS offers member reward programs and outreach campaigns aimed at early identification and prevention of risk factors. The following programs and services are available to all eligible members:
    a. Blood lead screening
    b. Breast cancer screening
    c. Cervical cancer screening
    d. Chlamydia screening
    e. Diabetes Prevention Program (Centers for Disease Control and Prevention Recognition)
    f. Prenatal and postpartum care
    g. Well child visits

3. Chronic Condition Management – KHS has several programs focused on helping members manage their chronic conditions. The following programs and services are available to all eligible members:
    a. Asthma Preventive Services
    b. Behavioral Health Services
    c. Breathe Better Asthma Program
    d. CHW Services
    e. Community Support Services
    f. Chronic Obstructive Pulmonary Disease Program
    g. Complex Care Management (CCM)
    h. Diabetes Empowerment Education Program™
    i. Enhanced Care Management
    j. Fresh Start and Fresh Start Plus Smoking Cessation Programs
    k. End Stage Renal Disease Program
    l. ER Navigation Program
    m. Kids and Youth Transitional Program
    n. Long Term Care and Support Services
    o. Member Centric Care Coordination
    p. Major Organ Transplant Program
    q. Palliative Care Services
    r. Transition of Care Services
    s. Mental Health Services
    t. Substance Abuse Treatment Services

4. Maternal and Child Health – The following KHS programs and community resources promote maternal and child health among eligible members:
    a. Black Infant Maternal Health Initiative
    b. Baby Steps Program
    c. Baby Steps Plus Program
    d. Member baby showers

5. Children's Health – KHS offers programs that focus on access to and utilization of primary and preventive health care, developmental screenings, and services oriented towards children with special needs and health conditions:
    a. Basic Population Health Management (BPHM)
    b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
    c. Kids and Youth Transition Program for Children with Special Health Care Needs

6. SDOH – KHS offers programs and benefits that address SDOH, including:
    a. Asthma Preventive Services
    b. Behavioral Health Treatment
    c. Community Health Worker Services
    d. Community Support Services
    e. Complex Case Management
    f. Enhanced Care Management
    g. Mental Health Services
    h. Substance Abuse Treatment Services

KHS Resources

KHS has resources in place through dedicated staff, specialized roles, teams, and committees to efficiently manage and enhance current activities for KHS members.

a. Staffing consists of a multidisciplinary team designed to address the health needs of specific populations effectively.
b. Some key roles include nurses, physicians, social workers, pharmacists, health educators, data analysts, IT and data management professionals, project managers, community health workers, outreach specialists, program specialists, health education assistants, customer service staff (Member Services), provider relations staff, contracting staff, and other support staff.
c. A collaborative, multidisciplinary approach is essential for effectively managing population health and improving health outcomes.

The KHS W&P Department provides following member health education programs:

- Activity and Eating Class
- Breathe Better Asthma Program
- Diabetes Empowerment Education Program™
- Diabetes Prevention Program
- Eat Healthy Be Active Program
- Fresh Start and Fresh Start Plus Smoking Cessation Programs

These programs use evidence-based resources to develop and implement each program's unique goals and objectives, self-care and health maintenance tools, health education and promotion handouts, class curriculum, communication plan, and evaluation methodology. The KHS W&P Department directly offers classes in both virtual and in-person environments and incentives to encourage member participation. KHS W&P contracts with health education service providers to offer health education and wellness programs to members. KHS W&P works with community

partners to offer community health and wellness programs in outlying communities of Kern County. In addition, they contract with community health workers (CHWs) to offer CHW Services and APS. KHS W&P monitors program participation rates, referral sources, referral volume per program, race and ethnicity, and other available demographic data.

KHS W&P staff involved in implementing and evaluating member and community wellness programs include managers, member health educators, health education specialists, health and wellness lifestyle coaches, and health education assistants.

Under the PHM Department, the team of registered nurses (RN), social workers and certified medical assistants provide the following services:

a. Complex Care Management (1 RN: 70 members)
The Complex Case Management (CCM) Program for Kern Health Systems is available to members who meet CCM specified criteria. The KHS program identifies high risk members with complex health care needs due to multiple chronic conditions, underlying psychosocial and social determinants of health factors affecting frequent encounters with the health care delivery system, who show a risk of predicted admission to the hospital within the next six months of admission, through use of a predictive modeler.

b. Kids and Youth Transitional Program (1 RN: 70 members)
The Kids and Youth Transitional Program, also known as the Children with Special Health Care Needs (CSHCN) program, helps children and adolescents under 21 years of age who have complex health problems. This program has a special team consisting of an RN and Certified Medical Assistant who work together to help members who are in the CSHCN program and their families.

c. Major Organ Transplant Program (1 RN: 70 members)
Specialty-trained transplant case managers serve as a resource for members enrolled in the Major Organ Transplant (MOT) Case Management Program. They establish dialogue and support that lasts throughout the duration of the member's treatment plan. The transplant case manager remains in frequent contact with the member and throughout the enrollment. During the months or years prior to the transplant, the transplant case manager coordinates all needs that the member has. At the time of the actual transplant, the transplant case manager also coordinates with the member's caregivers reviewing travel and lodging benefits.

   The transplant case manager follows the member's admission and continued stay review during the initial transplant period and calls to speak with either the member or the caregiver frequently. The case manager typically follows members throughout the phases of transplant until one year after transplant.

d. Palliative Care Services (1 Social Worker: 90 members)
The Palliative Care Program is a dedicated community/home-based care program for members. Unlike hospice care, which provides a comfortable environment for those in the final stages of life, palliative care is appropriate for any stage of serious illness and any age. The Palliative Care Program consists of at least one consultation visit. This includes an assessment of eligibility for program enrollment when criteria are met as documented on the Certification of Advanced Disease (CAD).

e. Transition of Care Services (1 Certified Medical Assistant: does not carry a caseload)
KFHC Transition of Care Services (TCS) program provides a broad range of time-limited services available for all KFHC members. This includes members transferring from one setting or level of care to another in order to ensure continuity of health care and avoid poor health outcomes.

f. Long Term Care and Support Services (1 RN and 2 Outreach Specialists – Staff do not carry a caseload)

KHS offers a Long-Term Care Program that includes Complex Care Management (CCM) benefits to help members who are staying in or are trying to get placed in a long-term care (LTC) facility. These services provide members with assistance in obtaining the appropriate care they need to improve their health. The LTC Team works with members, their health care team including their doctors, and caregivers.

g. Chronic Obstructive Pulmonary Disease (COPD) Program
KHS has partnered with a team of medical providers to ensure comprehensive care for high-risk members with COPD. Using the Gold Guidelines, comprehensive care is provided with the goal of mitigating risk for COPD exacerbations that are known to negatively impact health status, increase rates of hospitalizations and readmissions, and further disease progression.

h. End Stage Renal Disease (ESRD) Program
Despite technological advances, there are high costs for end-stage renal disease (ESRD) management and current treatment programs do not adequately rehabilitate the ESRD patient. Patients with end-stage kidney disease (ESKD) are on dialysis and exposed to multiple physical and psychological stressors due to their illness. Treatment of ESKD in the form of dialysis imposes considerable stress, including potential changes in family relations, social interactions, and occupational demands.

Kern Health Systems (KHS) will partner with nephrologists to provide comprehensive and continuous care for all members with increased use of non-dialysis costs, and enhance patient care and efficiency, resulting in fewer hospital readmissions and unnecessary ER and urgent care visits. The overall expected outcome is to reduce non-dialysis, non-medication, and other unnecessary utilization costs by 20%. The anticipated launch date for the ESRD Program will be in early 2025.

i. Emergency Room (ER) Navigation Program
The goal of the ER Navigation Program is to help members maintain optimum health and/or improved functional capability, educate members regarding their health and reinforce the providers prescribed treatment plan. The ER Navigation Program assists in the evaluation of potentially preventable admissions and coordinates care and services with members upon discharge. The program helps with navigating the healthcare system to facilitate appropriate delivery of care and services in the appropriate clinical setting. KHS has partnered with providers to administer this program. The ER Navigation Team medical doctor works collaboratively with the ER physicians to determine if inpatient admission is appropriate for the patient based on Milliman admission criteria.

j. Transition of Care (TOC) Clinic

The TOC clinics are physician managed and are required to provide comprehensive transitional care services including, but not limited to:

- Providing medication review and reconciliation;
- Assigning a care coordinator to each member;
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners;
- Collaborating, communicating, and coordinating with all members of the patient's care team;
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management;
- Planning appropriate care and/or setting post-discharge, including temporary or stable housing and social services;
- Arranging transportation for transitional care, including medical appointments, as per Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) policy and procedures; and
- Developing and facilitating the member's transition plan.

k. Baby Steps Program

The Baby Steps Program was developed to encourage KHS members to seek and obtain early and consistent pregnancy and postpartum care. The program provides health and pregnancy education through various channels including the KHS website and member portal, social media channels and via printed health guides. Outreach is also conducted to members to provide education and resources. Members are eligible to receive a Member Reward for completing specific pregnancy care visits. The team consists of Certified Medical Assistants.

l. Baby Steps Plus Program

The Baby Steps Plus program provides care coordination and management to high-risk pregnant women. Staff conducts field visits to provide health education on the importance of prenatal and postpartum care; identify social determinants of health and gaps in services; connect pregnant women to a provider and community services; and assist in transportation to medical appointments. The team consists of an RN and Certified Medical Assistants.

m. BPHM for Children

All children under the age of 21 enrolled in Medi-Cal are entitled under federal law to the EPSDT benefit, which requires that children receive all screening, preventive, and medically necessary diagnostic and treatment services, regardless of whether the service is included in the Medi-Cal State Plan (DHCS Road Map Strategy 2022). KHS will implement different strategies to follow this requirement. The strategies will include ensuring all members under age 21 receive an Initial Health Appointment (IHA) within 120 calendar days of enrollment or within the American Academy of Pediatrics (AAP) Bright Futures periodicity timeline for children ages 18 months and younger, whichever is sooner.

KHS routinely reviews and analyzes data on the utilization of EPSDT services to identify gaps, barriers, or disparities and implement new programs to close gaps in services and address disparities and ensure equitable utilization of the EPSDT benefit for all KHS eligible populations.

The ECM Program is managed by the ECM Department. ECM is a statewide Medi-Cal benefit which became effective on January 1, 2022. ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. ECM is part of a broader population health strategy design within CalAIM, under which KHS systematically risk-stratifies enrolled populations and offers a menu of care management interventions at different levels of intensity. ECM is at the highest intensity level. Eligibility for ECM is defined by DHCS, and members are grouped into different populations of focus. Each population of focus implementation timeline is defined by DHCS and county specific. KHS has partnered with various providers to administer ECM services to members.

Community Supports Services (CSS) are managed by the CSS Department. In contrast to care management, which is focused on populations with significant or emerging needs, all members receive BPHM, regardless of their level of need. A variety of more universal CSS (also known as "In Lieu of Services"), are offered by KHS, such as housing supports and medically tailored meals, which play a fundamental role in meeting enrollees' needs for heath and health-related services that address social drivers of health under BPHM. CSS are medically appropriate and cost-effective alternatives to traditional medical services or settings that are designed to address SDOH.

KHS has implemented all 14 approved CSS (listed below). KHS teams have worked together and integrate both wellness programs and CSS selections into the broader endeavor of population health and the KHS annual PHM Strategy. These services are outsourced to different agencies and monitored by the CSS Department.

a. Housing Transition Navigation Services
b. Housing Deposits
c. Housing Tenancy and Sustaining Services
d. Short-Term Post-Hospitalization Housing
e. Recuperative Care (Medical Respite)
f. Day Habilitation Programs
g. Caregiver Respite Services
h. Assisted Living Facility Transition
i. Community or Home Transition Services
j. Personal Care and Homemaker Services
k. Environmental Accessibility Adaptations (Home Modifications)
l. Medically Supportive Food/Meals/Medically Tailored Meals
m. Sobering Centers
n. Asthma Remediation

<u>Black Infant Maternal Health Initiative (BIMHI):</u>

a. KHS serves as a primary stakeholder of BIMHI.

b. The team developed a comprehensive three-year strategic plan which includes addressing mental health as a factor of maternal and infant mortality in the Black/African American community in Kern County.
c. The team reviewed barriers to accessing mental health services among Black/African American members.

Ongoing Staff Development

KHS will continue to provide ongoing staff development that incorporates cultural competency. This emphasis on cultural awareness fosters a more inclusive and respectful workplace, enhancing team collaboration and boosting employee morale. It also enables KHS to better understand and serve its diverse member base.

External Resource

KHS may seek external resource needs and contacts, including consultants, training programs, or recruitment agencies, to support its staffing, address skill gaps, enhance cultural competency, and assist in recruitment efforts. This approach ensures the organization has access to the expertise and resources essential for effective talent management.

KHS Member Health Disparities

KHS' analysis and assessment of available data have highlighted ongoing gaps in available activities for KHS members, including:

- PHM follows NCQA standards to effectively identify and address health disparities, ensuring that our programs and services are equitable, data-driven, and aligned with nationally recognized best practices. These standards guide our efforts in measuring care quality across different populations, identifying gaps in access and outcomes, and implementing targeted interventions to promote health equity for all members.
- KHS needs to initiate data collection capabilities to capture accurate member race, ethnicity, primary language, gender identity, sexual orientation, and other factors that help advance health equity. By collecting this data, KHS can better identify and measure disparities and develop programs that address the inequities within KHS' subpopulations.
- Focused interventions on health disparities. KHS has long recognized disparities related to race, ethnicity, language, and geographical location. KHS needs to have a greater focus on incorporating these factors into the goals of its PHM strategy, population stratification algorithms, and monitoring and reporting metrics. High priority disparities include
    - Prenatal care, infant care, and hypertension among Black/African Americans
    - Well woman care among White members
    - Diabetes control among Hispanic/Latino members

A thorough assessment of KHS' population needs has revealed several resource gaps that persist from the previous assessment, indicating ongoing challenges in meeting the community's requirements. These gaps encompass areas such as access to preventive services, behavioral health, mental health support, CSS, reliable transportation, educational resources, and SOGI data. Addressing these issues is crucial to ensuring that all members receive the comprehensive care they need. The identified gaps include:

- The demand for additional staffing to address health disparity initiatives is increasingly critical, especially as regulatory requirements evolve and KHS' focus on bridging these gaps intensifies. These disparities can significantly impact health outcomes in underserved populations, making it essential to bolster our workforce to effectively manage and implement targeted strategies. Investing in a diverse staffing workforce representative of the members KHS serves and strengthening community partnerships will enable KHS to create a more inclusive health system. This approach not only addresses immediate disparities but also builds a sustainable framework for promoting equity and improving health outcomes for all members of the community.
- KHS is currently engaged in various initiatives to better engage members to be active participants in their health care and enhance their experience with accessing services. To address this, we plan to implement a member engagement project that integrates these initiatives into a cohesive framework. This will involve assessing our existing efforts to identify gaps and overlaps and ensuring we meet the unique needs of both members and providers. We plan to introduce targeted resources such as a customer relationship management (CRM) tool and a new member rewards platform involving reloadable gift cards. This project brings together cross-functional teams with diverse perspectives, fostering a holistic understanding of the member experience. Our goal is to create an integrated program that not only improves member satisfaction but also aligns with our mission of delivering excellent, innovative, and equitable healthcare.
- As KHS continues to gather SOGI data from members, it will strategically work to identify and bridge the health gap between 2SLGBTQIA+ populations and its general member population by ensuring the equitable distribution of preventative care. According to findings presented in the KHS Health Equity Accreditation initiative, 2SLGBTQIA+ populations face disproportionate health and social challenges compared to the general population. To assess inequities among members, KHS plans to analyze SOGI data from members. If the data confirms any disparities, KHS will strategically allocate additional health care and wellness resources to support impacted 2SLGBTQIA+ member populations.

Activities to Address Health Disparities

Well-Baby Visits for Black/African American Members (W15) Ages 0-15 Months

The W15 measure evaluates the percentage of infants who receive the recommended number of well-baby visits in their first 15 months. For Black/African American members, the goal is to increase the percentage of infants who receive timely, comprehensive, and culturally appropriate well-baby visits to promote early childhood health, prevent illnesses, and identify developmental concerns early.

Action Plan for Promoting Health Equity:

A. Action: Implement a culturally tailored outreach and education program.

B. Objective: To increase well-baby visit compliance among Black/African American families by addressing specific barriers, providing culturally sensitive education, and improving care coordination.

C. Approach:

1. Targeted Outreach Campaigns
   a. Launch a culturally competent public health campaign that emphasizes the importance of well-baby visits. Materials will be distributed via digital platforms, print media, and community events such as church services, daycare centers, and community centers.
      - Include in the Member Newsletter content that brings awareness to preventative health screenings such as well-child visits.
      - Send mailers to member households reminding them of monetary (Members Reward) incentives for the completion of preventative health screenings.
      - Develop outreach materials in partnership with Black/African American community leaders and organizations that reflect cultural preferences, beliefs, and languages.

2. Mobile Health Units
   a. Utilize mobile health units to bring pediatric care directly to underserved areas with high concentrations of Black/African American families. These units will offer convenient, onsite well-baby visits, immunizations, and developmental screenings.
   b. Mobile units will focus on neighborhoods with low health access and provide a comfortable, familiar setting for parents and caregivers.

3. Text Reminders and Phone Outreach
   a. Implement a tailored appointment reminder system, utilizing SMS/text, phone calls, and apps that accommodate the communication preferences of the target population. Messaging will be customized to emphasize the importance of early health visits for infant development and well-being.
      - Text messages to members encouraging the scheduling of their appointments for gaps in care with a focus on well-child visits.
      - Send robocalls to members that do not receive text messages.
      - Add FUA, FUM and HBD text messages to the campaign list.
   b. Explore multichannel approach to follow up with families who miss well-baby appointments to reschedule and provide additional education or transportation support as needed.

4. Enhance Provider Training on Cultural Competency
   a. Offer cultural competency training for all pediatric and primary care providers to ensure that interactions with Black/African American families are respectful, understanding, and aligned with cultural preferences.
   b. Training will focus on the importance of building trust, addressing implicit bias, and improving communication with families from different backgrounds.

D. Metrics of Success
    1. Increase in well-baby visit rates (W15): Achieve a measurable increase in the percentage of Black/African American infants who receive well-baby visits in the 0–15-month age range.
    2. Reduction in missed appointments: Track a reduction in the number of missed or late well-baby appointments for this population.
    3. Improved parent and caregiver satisfaction: Survey families to assess satisfaction with the outreach efforts and whether they felt the services were accessible, convenient, and culturally appropriate.

E. Opportunities
    1. Establish a formal advisory board consisting of community leaders, healthcare providers, and member representatives to oversee the continuation of culturally competent initiatives.
    2. Partnerships with Local Organizations
        a. Partner with local Black/African American community organizations, faith-based groups, and parent advocacy groups to build trust and foster community relationships that facilitate access to care.
        b. Leverage these partnerships to create community-based wellness events, where well-baby visits can be incorporated into larger health initiatives and gatherings.
    3. Regularly assess the impact of these interventions through data analysis and member feedback, using this information to adapt and improve outreach strategies.
    4. Innovate by expanding mobile health units and digital health interventions to ensure broader reach and access to care.

Through this targeted action plan, KHS is committed to improving health equity for Black/African American families by addressing barriers to well-baby visits and ensuring that all children, regardless of background, receive the best possible start in life. By promoting culturally competent care, building trust within the community, and improving access to preventive services, we aim to reduce health disparities and improve outcomes for children in this population.

Breast Cancer Screening Among African American Women

To address health disparities among African American women, KHS Population Health Management (PHM) has developed and continues to implement a strategy to promote breast cancer prevention and improve health outcomes for racial and ethnic minorities. This strategy includes providing evidence-based education on breast cancer screening, with an emphasis on shared decision-making between women and their healthcare providers. This approach supports women in making informed decisions based on personal preferences, particularly when the balance between benefits and harms is uncertain. The decision regarding the appropriate age to begin mammography screening is determined through this shared decision-making process.

KHS continues to collaborate with network providers to underscore the importance of screening mammography and its role in early detection and the reduction of mortality.

KHS PHM has selected two Patient Decision Aids (PDAs) that meet the requirements of the NCQA PHM Standards:

1. **Breast Cancer Screening PDA** – This tool emphasizes patient-provider shared decision-making to support African American women in making informed, individualized decisions about mammography.
    a. The Breast Cancer Screening PDA pamphlet is an evidence-based resource certified by the Washington State Health Care Authority pursuant to RCW 7.70.060.
2. **Distribution and Engagement Strategy**:
    a. KHS PHM partners with providers to distribute the evidence-based breast cancer screening PDAs to patients, particularly African American women aged 40–49 and 50–74.
    b. KHS PHM engages with contracted practitioners and providers to review the PDA content.

The PDA includes information on screening options and outcomes. It is designed to complement, not replace, provider counseling. The PDA facilitates meaningful discussions between patients and providers regarding treatment decisions.

Cultural and Linguistic Services

Kern Health Systems' Cultural and Linguistic (C&L) Services Program helps ensure that comprehensive, culturally, and linguistically competent services are provided to plan members with the intent of improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care. The activities below highlight the larger efforts currently being implemented by the C&L team to reflect the language and translation services experience for both KHS members and staff. This includes ongoing monitoring and evaluation of both KHS staff and KHS contracted vendors along with opportunities for improvement within each activity. The C&L Team includes a manager, specialists, and an assistant.

Member and Staff Survey Monitoring

- C&L Services Surveys:
    - Post Call Survey Results
    - Over-the-phone & Video Remote Interpretation (OPI/VRI) Member Satisfaction Survey
    - Onsite Interpreting Member Satisfaction Survey
        - Internal Call Audits & External Vendor Survey
    - Translation Services Member Satisfaction Survey
    - KHS Staff OPI Services Satisfaction Survey

Member Utilization of Language Services

- Over-the-Phone (OPI)
- Video Remote Interpreting (VRI)
- Onsite

Staff & Vendor Monitoring & Evaluation
    - KHS Staff Linguistic Performance
    - Vendor Linguistic Performance

Community Resources

KHS actively integrates a wide array of community resources into its programs to comprehensively address the diverse needs of its members. These resources include:

- Access to telehealth services. Members can utilize telemedicine services directly from their healthcare providers. This ensures that members have convenient access to medical consultations, especially for non-emergency situations, reducing barriers to care and enhancing overall health management.
- CHW Services. This member benefit allows members to receive CHW services in a medical setting, at home, or community locations. These services are designed to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and well-being. CHW services may assist with a variety of health concerns impacting members. Additionally, CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, domestic violence, and other violence prevention services.
- CSS. This department connects members with various social and community resources tailored to their specific needs. Through assessments, members are referred to services that may include housing assistance, recuperative care, asthma care, medically tailored meals, sobering centers, respite services, nursing facility transitions, homemaker services, environmental accessibility, and day habilitation, facilitating a holistic approach to their health and well-being.
- Mobile Clinic Initiatives. KHS has implemented a series of targeted initiatives to increase access to well care visits and immunizations among its membership, particularly among rural communities. These efforts encompass:
    - Outreach Events: Focused on areas with low well care visit and immunization rates, these events engage all community partners, including faith-based organizations, growers/farmworkers, and the Hispanic/Latino, Black/African American communities, creating trust and encouraging participation.
    - Grant Funding: Nearly $5 million has been allocated to support health care providers to enhance their outreach and services, reinforcing the healthcare infrastructure in these communities. In addition, KHS offers a community grant program that aims to support initiatives that promote community health, eliminate health disparities, provide resources, and enhance access to care for our vulnerable populations.
    - Community Sponsorships and Events: KHS supports events and partners with local organizations willing and able to host mobile units within their community to create a supportive environment for immunizations, well care visits and other health care services, alongside promoting these events through KHS communication and outreach channels to KHS members and the communities they reside.

- Support for Homeless Populations: KHS is actively involved in the county's efforts to address homelessness and serves on the leadership board of the Bakersfield Kern Regional Homeless Collaborative. KHS also collaborates with various community-based organizations to advise and provide essential social support services. This includes programs like Papo Hernandez Respite, Rest and Recovery Home (Recuperative Care), which offers a short-term care home to help KHS' homeless members heal and recover after hospitalization, ensuring that vulnerable populations receive the support they require to maintain their health and well-being. KHS staff and providers refer members to homelessness assistance resources, such as, but not limited to, Flood Ministries, Housing Authority of Kern County, Kern County Department of Human Services, Kern Behavioral Health and Recovery Services, Mercy House: Brundage Lane Navigation Center, the Mission at Kern County, and the Open Door Network.
- KHS has partnered with Kern County Public Health along with other managed care Medi-Cal health plans and community partners that serve Kern County to support the Kern County Community Health Assessment and Community Health Improvement Plan. Both are completed every 3 years. KHS contributes resources and participates in planning efforts. This collaboration helps to reduce duplication of efforts and results in a more comprehensive assessment of the needs of Kern County.

By integrating these resources, KHS aims to create a comprehensive support system that addresses the multifaceted needs of its members, promoting healthier communities and improving access to essential services.

Strategies to Address Gaps in Member Engagement and Access to Community Resources

KHS has confirmed that it has sufficient community resources to meet the needs of its members. However, significant gaps have been identified in how KHS engages its members and the accessibility of services within communities of Kern County, especially in ways that resonate with their comfort levels, communication preferences, and ability to access health care services.

- Addressing these gaps is crucial and will involve a thorough analysis of the feedback received from KHS Regional Advisory Committees (RACs), Community Advisory Committee (CAC), member utilization patterns and member grievance trends.
- This data will help KHS pinpoint those who require more targeted outreach strategies.
- For instance, KHS may find that certain populations may not have internet access, or the internet connectivity is not sufficient for accessing telehealth services, limiting members' ability to access remote health care services.

KHS recognizes that understanding member needs must come from direct communication. KHS must actively solicit feedback and truly listen to what members express as their priorities. By translating their needs into actionable strategies, KHS can improve member outreach and support services.

KHS will work with service providers and partner organizations to reduce duplication of efforts and lessen the burden on members. By utilizing existing resources, KHS aims to implement coordinated programs and activities that will enhance the well-being of members and their families. KHS is also committed to raising awareness among community partners about health disparities and inequities, as well as the underlying causes of barriers related to coverage, access,

quality health outcomes, and social determinants affecting members. Furthermore, KHS will continue to develop and implement new evidence-based programs and interventions to address health disparities, service gaps, and social determinants of health (SDOH).

For KHS, a goal for 2025 is to create a framework that effectively incorporates members' voices, ensuring that their insights guide KHS initiatives and resources. This member-driven approach will not only enhance engagement but also foster a sense of community ownership and trust in the services KHS provides.

Conclusion

KHS has rigorously reviewed its various programs and resources in alignment with the needs of our diverse member population. Through comprehensive activities across health and wellness, chronic condition management, maternal and children's health, and cultural competency, we are meeting the evolving healthcare needs of our members. Our commitment to continuous improvement, as demonstrated through our Population Health Management strategies, the integration of Community Supports, and the pursuit of NCQA accreditation standards, reflects our ongoing dedication to delivering high-quality, equitable care. We remain focused on addressing identified disparities, engaging our members, and enhancing the effectiveness of our programs to ensure that all individuals, regardless of background, have access to the care and services necessary to improve their health outcomes. KHS is steadfast in its mission to uplift the lives of our members and will continue to evaluate and refine our efforts to meet the needs of the community.

VII. References

[1] Kern Health Systems (KHS), Business Intelligence Department. (2025). KHS Member Demographics Report. KHS Data Analytics and Reporting (Internal Site).
[2] Kern Health Systems, Business Intelligence Department. (2025). *2024 Health Net Member Transition Data*.
[3] *Medi-Cal Enrollment and Renewals Dashboard*. (2025). California Department of Health Care Services. https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/Medi-Cal-Enrollment-and-Renewals-Dashboard-June2025.aspx
[4] *QuickFacts*. (2025). U.S. Census Bureau. https://www.census.gov/quickfacts/
[5] The Williams Institute. (2023). *Adult LGBT Population in the United States*. https://williamsinstitute.law.ucla.edu/publications/adult-lgbt-pop-us/
[6] U.S. Department of Housing and Urban Development. (2023). *The 2023 Annual Homelessness Assessment Report (AHAR) to Congress: Part 1: Point-In-Time Estimates of Homelessness, December 2023*. https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf.
[7] U.S. Department of Housing and Urban Development. (2024). *The 2024 Annual Homelessness Assessment Report (AHAR) to Congress: Part 1: Point-In-Time Estimates of Homelessness, December 2024*. https://www.huduser.gov/portal/sites/default/files/pdf/2024-AHAR-Part-1.pdf
[8] Bakersfield-Kern Regional Homeless Collaborative. (2024). *Kern County Point In Time Count 2024 Report*. https://bkrhc.org/wp-content/uploads/2023/07/2024-PIT-Count-Report-Kern-County.pdf
[9] Kern County Public Health. (2024). *Kern County 2023 Community Health Assessment*. https://www.kernpublichealth.com/healthy-community/assessments/how-we-serve-you

[10] *2023 American Community Survey 1-Year Estimates*. (2025). U.S. Census Bureau. https://data.census.gov/
[11] *QuickFacts, 2019-2023 5-Year Estimates*. (2025). U.S. Census Bureau. https://www.census.gov/quickfacts/
[12] Kern Health Systems (KHS), Business Intelligence Department. (2025). *KHS SDOH Claims Report*. KHS Data Analytics and Reporting (Internal Site).
[13] American Logistics. (2025). *2023 and 2024 Kern Health Systems Transportation Trip Counts*.
[14] *Current Sales & Price Statistics, June 2025.* (2025). California Association of Realtors. https://www.car.org/marketdata/data/countysalesactivity
[15] *2023 American Community Survey 1-Year Estimates*. (2025). U.S. Census Bureau. https://data.census.gov/
[16] California Department of Public Health, Research and Analytics Branch. (2025). *County Health Status Profiles 2024*. https://www.cdph.ca.gov/Programs/CHSI/pages/county-health-status-profiles.aspx
[17] Centers for Disease Control and Prevention. (2023). *State Maps for Asthma Prevalence by Six-Level Urban-Rural Classification, 2019-2021*. https://www.cdc.gov/asthma/national-surveillance-data/asthma-prevalence-state-classification.htm
[18] Centers for Disease Control and Prevention. (2023). *Behavioral Risk Factor Surveillance System Asthma Prevalence Data, 2021*. https://www.cdc.gov/asthma/brfss/default.htm
[19] *California Asthma Dashboard*. (2025). California Department of Public Health, Environmental Health Investigations Branch. https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/EHIB/CPE/Pages/CaliforniaBreathingCountyAsthmaProfiles.aspx
[20] American Lung Association. (2025). *2025 State of the Air Report*. https://www.lung.org/research/sota/city-rankings/states/california/kern
[21] *Valley Fever*. (2025). Kern County Public Health. https://www.kernpublichealth.com/healthy-community/illness-disease/valley-fever
[22] *Valley Fever in California Year-End Data Dashboard*. (2025). California Department of Public Health. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/ValleyFeverDashboard.aspx
[23] California Department of Public Health. (2025). *Epidemiologic Summary of Valley Fever (Coccidioidomycosis) in California, 2022*. https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/CocciEpiSummary2022.pdf
[24] Kern Health Systems (KHS), Business Intelligence Department. (2024). *Top 5 Diagnoses for ER, UC Outpatient, and Inpatient Paid Claims Report*. KHS Data Analytics and Reporting (Internal Site).
[25] Kern Health Systems, Business Intelligence Department. (2025). *2024 Pharmacy Data Report*.
[26] Kern Health Systems, Business Intelligence Department. (2024). *2023 Pharmacy Data Report*.
[27] Health Dialog. (2024). *2023 Kern Family Health Nurse Advice Program Summary Report*.
[28] Carenet Health. (2025). *Kern Family Health Care Year End Review* (PowerPoint Presentation).
[29] Carenet Health. (2025). *2023 and 2024 Kern Family Health Care Nurse Advice Line Program Summary Report*.
[30] California Department of Health Care Services. (2025). *NCQA HEDIS MY 2024 CAHPS 5.1H Data Submission, Adult Medicaid Survey Results Report – NCQA Calculations*.
[31] Kern Health Systems (KHS), Business Intelligence Department. (2025). *Tobacco Registry Report*. KHS Data Analytics and Reporting (Internal Site).
[32] Kick It California (KIC). (2025). *2023 and 2024 Kern Health Systems Callers to the California Smokers' Helpline Reports*.
[33] Global Initiative for Chronic Obstructive Lung Disease. (2024). *Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease, 2022 Report*. https://goldcopd.org/wp-content/uploads/2021/11/GOLD-REPORT-2022-v1.1-22Nov2021_WMV.pdf
[34] Kern Health Systems (KHS), Business Intelligence Department. (2025). *KHS BH NSMHS Services Report*. KHS Data Analytics and Reporting (Internal Site).
[35] California Department of Health Care Services. (2024). *NCQA HEDIS MY 2023 CAHPS 5.1H Data Submission, Child Medicaid Survey Results Report – NCQA Calculations*.
[36] California Department of Health Care Services. (2024). *NCQA HEDIS MY 2023 CAHPS 5.1H Data Submission, Adult Medicaid Survey Results Report – NCQA Calculations*.
[37] California Department of Health Care Services. (2025). *NCQA HEDIS MY 2024 CAHPS 5.1H Data Submission, Child Medicaid Survey Results Report – NCQA Calculations*.
[38] California Department of Health Care Services. (2025). *NCQA HEDIS MY 2024 CAHPS 5.1H Data Submission, Adult Medicaid Survey Results Report – NCQA Calculations*.

[39] Press Ganey. (2023). *MY 2022 CAHPS Medicaid Adult Simulation Survey: Kern Health Systems* (PowerPoint Presentation).
[40] Press Ganey. (2024). *MY 2023 CAHPS Medicaid Adult Simulation Survey: Kern Health Systems* (PowerPoint Presentation).
[41] Kern Health Systems, Member Services Department. (2025). *2023 and 2024 Grievance and Appeal Reports*.
[42] Kern Health Systems, Wellness and Prevention Department. (2025). *2023 and 2024 KHS Interpreter Access Survey Results*.
[43] Kern Health Systems, Provider Network Management Department. (2024). *2023 and 2024 Provider Network Management Network Review Reports*.
[44] California Department of Health Care Services (DHCS). (2024). *MY 2022 DHCS Disparities KHS Rate Sheet Indicators*.
[45] Kern Health Systems, Quality Performance Department. (2025). *MY 2024 Internal KHS Disparities Rate Sheet Indicators Data*.
[46] Wright, J. (2025). *Parent/Guardian Survey on Childhood Immunization and Vaccination, 2025* (PowerPoint Presentation). Kern County Immunization Coalition.
[47] Kern Health Systems, Wellness and Prevention Department. (2025). *2023 and 2024 KHS Interpreting Request Activities Reports*.
[48] Kern Health Systems, Wellness and Prevention Department. (2025). *2023 and 2024 KHS ASL Reports*.
[49] Kern Health Systems, Wellness and Prevention Department. (2025). *2023 and 2024 KHS Interpreter Access Survey Results*.
[50] Kern Health Systems, Business Intelligence Department. (2025). *ESRD Utilization Cost Report*.
[51] American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (2017). *Guidelines for perinatal care (8th ed.)*. https://www.hscsnhealthplan.org/sites/default/files/OB%20-%20ACOG%20Guidelines%20for%20Perinatal%20Care%20-%208th%20Edition.pdf.
[52] Kern Health Systems (KHS), Business Intelligence Department, 2025. *HEDIS Trending Measure Report*. KHS Data Analytics and Reporting (Internal Site).
[53] Oppong, B. A., Wang, L., & Yao, K. (2021). Disparities in breast cancer care and outcomes. *Journal of the National Comprehensive Cancer Network*, 19(8), 967–973. https://doi.org/10.6004/jnccn.2021.7021
[54] *Breast Cancer Statistics*. (2025). Susan G. Komen. https://www.komen.org/breast-cancer/facts-statistics/breast-cancer-statistics/
[55] *Breast Cancer Statistics*. (2025). Susan G. Komen. https://www.komen.org/breast-cancer/screening/screening-disparities/https://www.komen.org/breast-cancer/facts-statistics/
[56] Kern Health Systems (KHS), Business Intelligence Department. (2025). *HECL Report*. KHS Data Analytics and Reporting (Internal Site).
[57] Kern Health Systems (KHS), Community Support Services (CSS) Department. (2025). *CSS Membership by Program and Site Report*.
[58] Kern Health Systems, Enhanced Care Management (ECM) Department. (2025). *ECM Member Referral and Enrollment Report*.