KERN HEALTH SYSTEMS

Population Needs Assessment Report

2020

Responsible Health Education and/or Cultural and Linguistics Staff
Name: Isabel Silva, MPH, CHES
Title: Director of Health Education, Cultural and Linguistic Services
Email: isabelc@khs-net.com

Name: Carlos Bello, MPH, CHES
Title: Senior Member Health Educator
Email: carlos.bello@khs-net.com

Table of Contents

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. Today, KHS provides services to over 263,000 Medi-Cal Managed Care beneficiaries in Kern County.

The goal of the 2020 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 health education (HE), cultural and linguistic (C&L), and quality improvement (QI) activities and available resources to address identified concerns; and
3. Implementation of targeted strategies for HE, C&L, and QI programs and services to address member needs.

KHS' 2020 PNA builds upon previous needs assessments and uses various data collection methods and sources. Total membership and demographics have remained similar to KHS' last needs assessment in 2016. Although KHS' membership grew by 15%, half of KHS' membership continues to be children under 18 and the majority of members are still female. Hispanics continue to be the majority of members, and English continues to be the most common primary language. Most members live in Bakersfield and the highest concentration of members continue to reside in the 93307 zip code. Enrollment of Seniors and Persons with Disabilities (SPD) increased by 14% and the Health Home Program (HHP) population amounts to over 25,000 eligible members. KHS has also started collecting the home residence status of members through its Case Management (CM) department which has identified more than 1,500 self-reported homeless members since 2016.

The most frequent diagnoses for Urgent Care (UC) and Emergency Department (ED) visits continue to be upper respiratory infections, fever, urinary tract infections, pharyngitis and headache for KHS members. Obesity, asthma, and diabetes are among the most common chronic conditions affecting Kern County residents which supports KHS' findings of hypertension, dyslipidemia, low back pain, persistent asthma and diabetes as being the top 5 chronic conditions identified through population analysis reports. Review of KHS' pharmaceutical utilization identified Ibuprofen as the top medication prescribed followed by Lisinopril, Amoxicillin, Albuterol Sulfate and Metformin, which further supports KHS' chronic condition population health analysis conclusions. Mental health diagnoses for depression, bipolar disorder and schizophrenia were found to have higher rates among female and English-speaking members, in comparison to male and non-English-speaking members. Depression and bipolar disorder were also found to have the highest rates among Caucasian members whereas African American members had higher rates of schizophrenia. The physical and behavioral chronic conditions associated with tobacco use identified hypertension, anxiety and depression as the top 3 comorbidities.

Referrals requesting HE services have increased by 50.6% since 2018 and the majority of referrals were for weight management, asthma and tobacco cessation. Referrals for asthma education increased by 31 percentage points and tobacco cessation referrals increased by 14 percentage points due to targeted outreach performed by the HE department. Consequently, the

rate of members who accepted to receive health education services decreased by 18 percentage points and the rate of members who received services decreased by 7 percentage points in comparison to the prior year. Requests for qualified interpreters has grown significantly for KHS within the last year. Use of a telephonic interpreter has increased by 59%, in-person interpreter requests for American Sign Language (ASL) have increased by 30% and by 39% for non-English languages. Additionally, KHS has seen the most growth for Spanish- and Punjabi-speaking interpreters.

KHS' access to care surveys identified a small percentage of providers who were found to be non-compliant with urgent and emergent care standards. Further review and analysis of KHS' access to care data revealed KHS members needed better access to:

- Getting needed care;
- Getting care quickly;
- Communicating with their doctor;
- Medical assistance with smoking and tobacco use cessation; and
- Playing a role in shared decision making as it relates to health promotion and education around preventive care.

This data supports the decrease in member adherence to preventive care or treatment where several indicators on DHCS' 2019 Disparities Rate Sheet for KHS demonstrated a decrease in pediatric preventive care, women's health care and chronic condition care.

The following key findings and recommendations were made based on the 2020 PNA.

- Continued member education on the importance of accessing preventive care services with a high emphasis on members with one or more chronic conditions.
- Continued member and provider education on the availability of KHS' health education and interpreting services, the benefits of these services, and how to access these services.
- Explore more non-traditional modes of providing health education services with special emphasis on virtual forms of education and digital communications
- Bridge the communication gap between members and providers to allow for shared decision making around preventive care, effective communication and improvement in health literacy.
- Enhance member communication platforms to allow for more direct communications with members on understanding their gaps in care and how to close these gaps.
- Allow for more member opportunities to provide feedback on incentive programs, services and benefits to better align programs with member needs.
- Offer education and resources to help members and health care providers adapt to the risks of COVID-19.

II. Data Sources

KHS used various methods of internal and external data collection, review and analysis in the development of the 2020 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, William's Institute, Kern County Public Health Services Department Community Health Assessment and Improvement Plan, Kern County Health Status Profile, and the California Smokers Helpline.

Consumer Assessment of Healthcare Providers Survey (CAHPS) Data
The 2019 Kern Family Health Care Adult and Child Medicaid CAHPS 5.0 Survey results were reviewed to assess areas of improvement among plan and provider services.

California Department of Health Care Services (DHCS) Data Health Disparities Data
The 2018 and 2019 health disparities data provided by DHCS were reviewed to assess health status and disease prevalence among KHS' membership and within race/ethnic groups.

Healthcare Effectiveness Data and Information Set (HEDIS) Data
Reporting Year 2019 HEDIS rates were used to assess indicators of our members' health care.

2016 Medi-Cal Health Education and Cultural and Linguistic Group Needs Assessment
This report was reviewed and compared with current findings to identify changes in utilization of health services, health education, and cultural and linguistic member needs.

Membership Eligibility Data
KHS membership eligibility data was reviewed and analyzed for 2019 to identify demographic changes by race, language, age, gender, and geographic region since KHS' last needs assessment.

Claims Data
Using ICD-10 codes, claims data from calendar year 2019 were analyzed by race, language, age, gender, and geographic region. Through this analysis, top diagnoses were identified. Emergency department, urgent care, outpatient and inpatient utilization for calendar year 2019 was also reviewed by these variables to identify the top diagnoses and changes in utilization. Additionally, KHS' tobacco registry report was used to identify current smokers and members exposed to tobacco smoke.

Pharmacy Data
Pharmacy claims data from calendar year 2019 was analyzed by top medications dispensed.

2019 Member Satisfaction Survey
KHS administered its annual member satisfaction survey by mail and telephonically to all adult KHS members in 2019. A total of 898 surveys were collected which yielded a 23.1% response rate. Female members accounted for 70.9% of all respondents, 34% were between the ages of 18-34 years and 68.2% were Hispanic.

KHS Chronic Condition Population Analysis Reports
KHS developed population analysis reports to identify chronic condition trends within its membership to aid in program development and targeted intervention. These reports were reviewed to identify chronic condition prevalence rates and health disparities among race/ethnic groups.

2019 KHS Advice Nurse Line Report
Utilization reports from KHS' 24 hours advice nurse line were reviewed to identify call frequency and the top reasons for the calls.

KHS Departmental Reports
The 2019 KHS HE Activities Report was reviewed to identify trends in need for health education services and allows projections for program development. KHS' CM and HHP reports were reviewed for data on KHS' homeless population and critically ill members. KHS' grievance, transportation and provider network management reports were reviewed to identify access to care concerns within the membership.

Public Policy/Community Advisory Committee Survey
The survey investigated the major health concerns of KHS members, barriers to services, access issues, and activities needed to improve KHS' HE and C&L services.

III. Key Data Assessment Findings

Membership/Group Profile

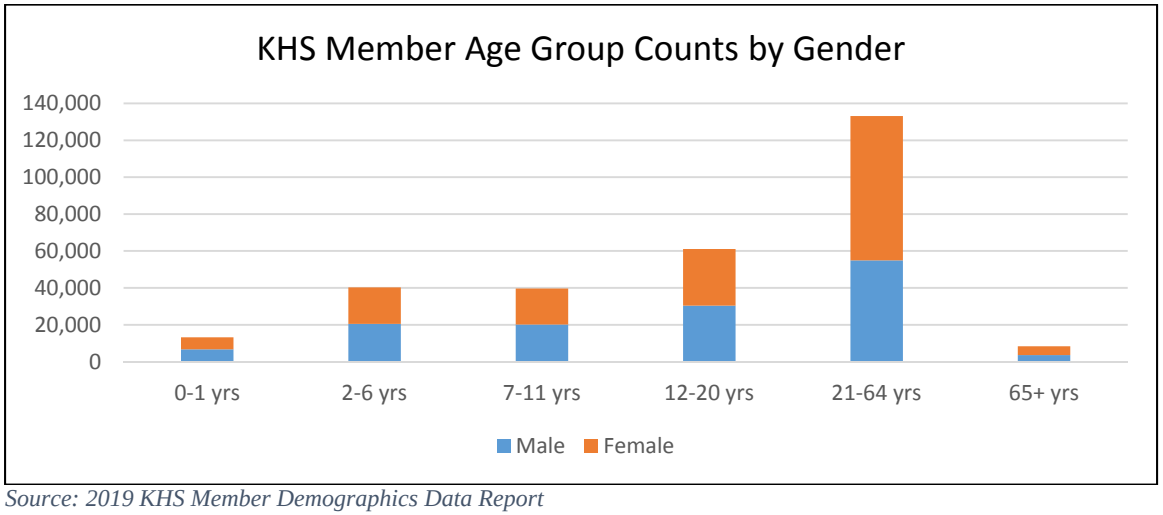
According to KHS' 2019 membership statistics, there were 295,602 Medi-Cal managed care members who had enrolled in the plan that year.[1] This is nearly one third of the population of Kern County[2] and a 15% increase in total annual membership since our last submitted needs assessment in 2016. Although gender makeup at the state and county levels is about evenly split, KHS members are slightly more likely to be female. The table below provides a comparison of KHS' population with the county and state.

	California (CA)	Kern County (KC)	KHS
Population	39,512,223	900,202	295,602
Male (%)	50%	51%	46%
Female (%)	50%	49%	54%

Source: 2019 KHS Member Demographics Data Report; U.S. Census Bureau

KHS' membership is comprised of a mixture of children under 18 (50%), and adults 18 and over (18 to 64 years-48%; 65 and older-2%).[1] In comparison, at the county and state level, nearly one-third of the population is under the age of 18.[1]

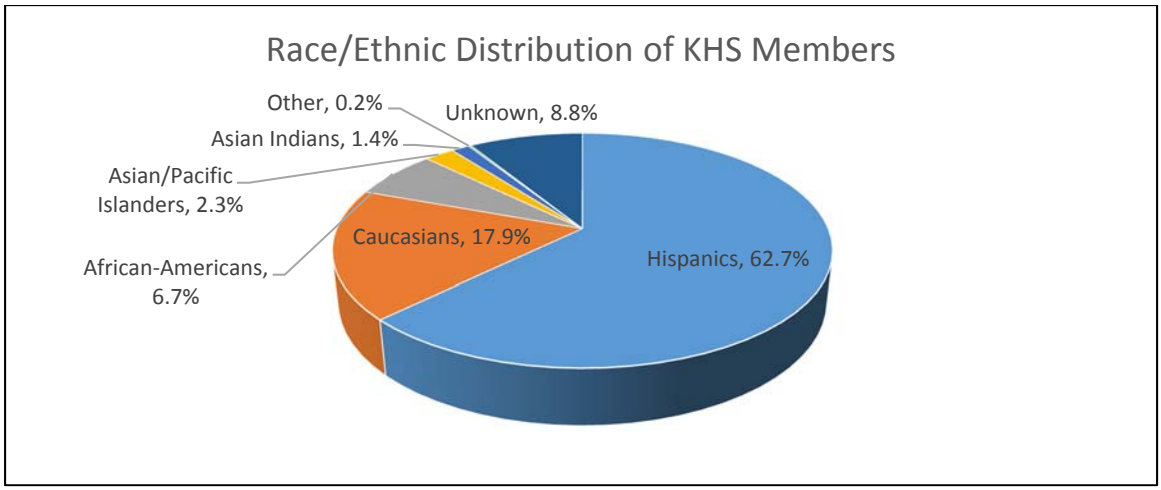
According to The Williams Institute, 5.3% of California's adult population identifies as a Lesbian, Gay, Bisexual, Transgender (LGBT) adult, 24% of this population have children and 23% have an annual income of less than $24,000.[3] The Williams Institute's 2015 publication on the LGBT Divide in California estimated 10% of LGBT adults in California resided in the Southern/Central Farm regions.[4] Although KHS does not currently collect and report on LGBT data of members, we estimate to have a similar percentage of LGBT adults in our county. It is possible that a quarter to a third of this population may be enrolled in our plan.



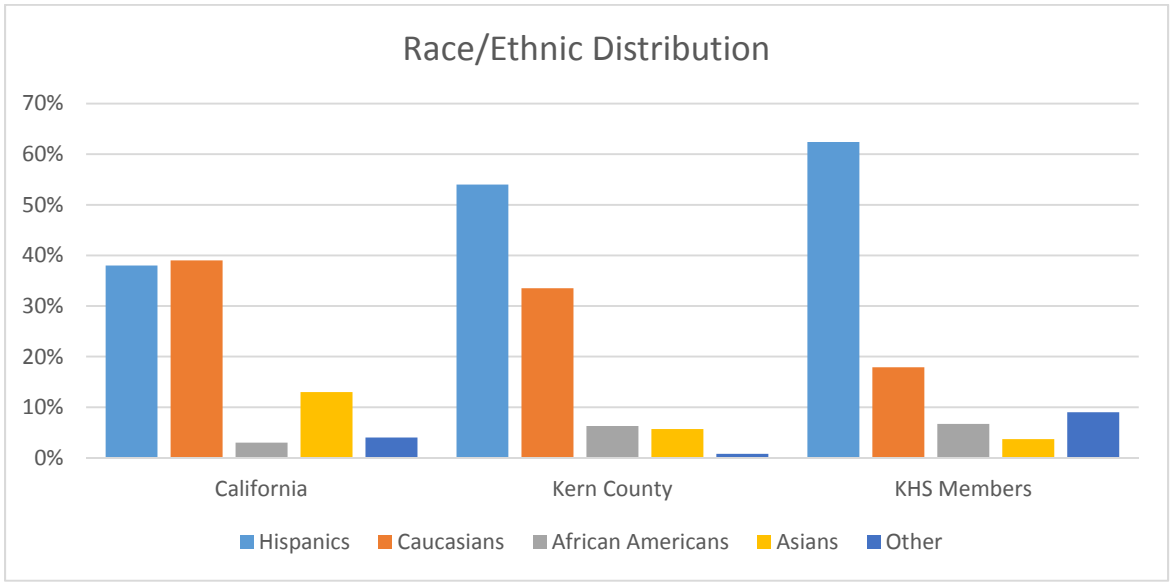
Source: 2019 KHS Member Demographics Data Report

KHS continues to have an ethnically diverse membership. Hispanics continue to comprise the majority of our membership, followed by Caucasians, African Americans, Asians, and other ethnicities. In comparison to data reported in the U.S. Census Bureau, 54% of Kern County and

38% of California residents are Hispanic, followed by Caucasian (KC-33.5%, CA-39%), African American (KC-6.3%, CA-3%), Asian (KC-5.7%, CA-13%), and Other (KC-0.8%, CA-4%).[2]

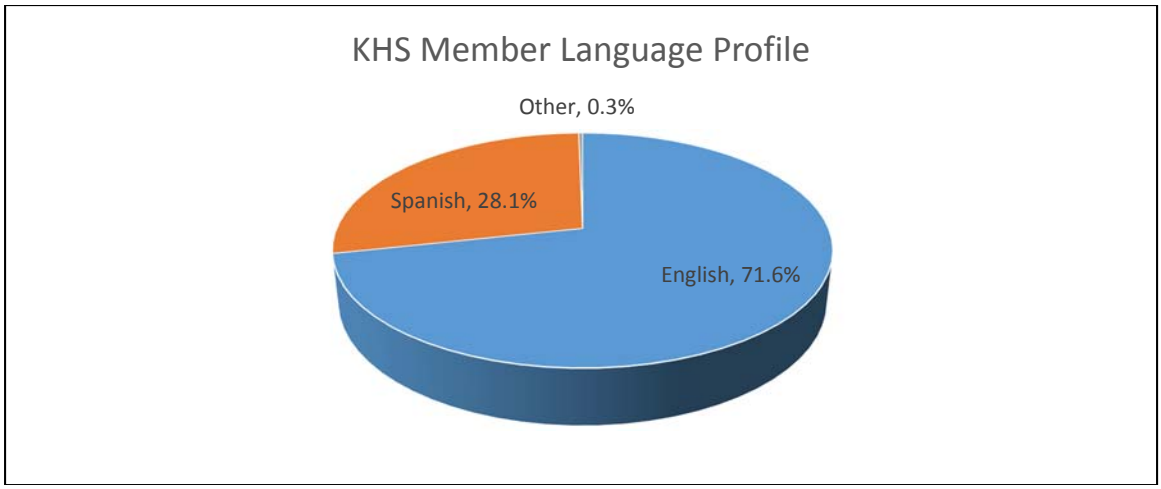


Source: 2019 KHS Member Demographics Data Report



Source: 2019 KHS Member Demographics Data Report

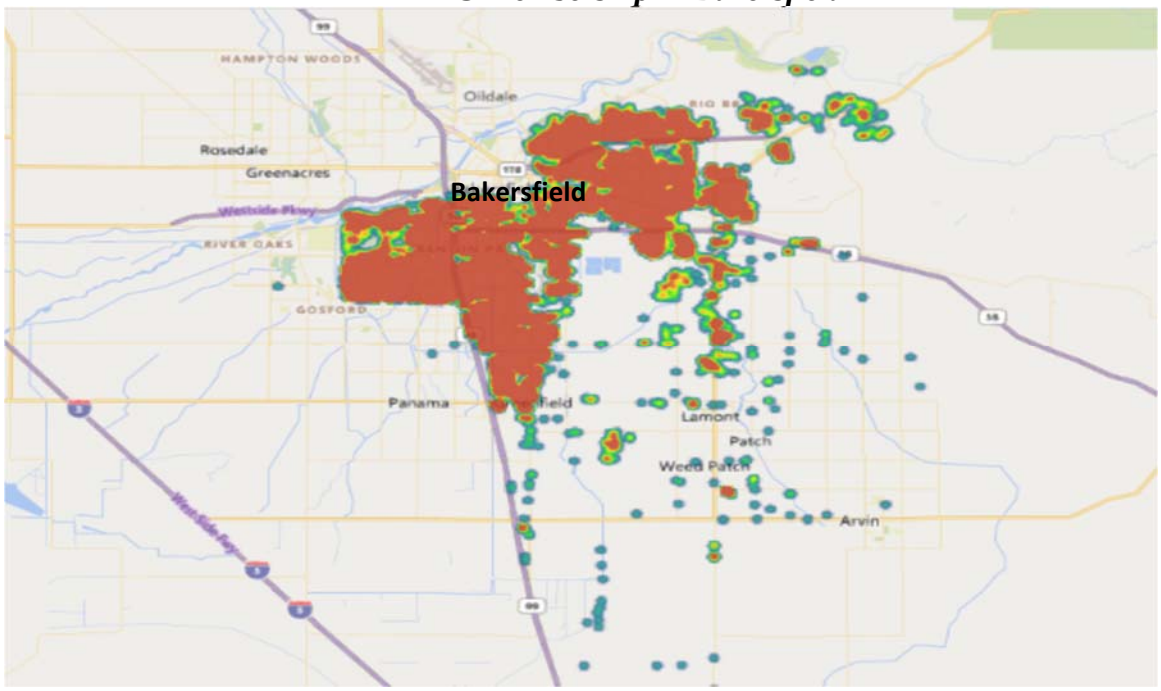
More than two-thirds of KHS' membership is English speaking, close to a third of the membership is Spanish speaking and less than 1% of members speak a language other than English or Spanish.[1] In comparison to data reported in the U.S. Census Bureau, 57% of Kern County and 56% of California residents speak English.[2] This is followed by Spanish (KC-38%, CA-29%), and other languages (KC-5%, CA-15%).



Source: 2019 KHS Member Demographics Data Report

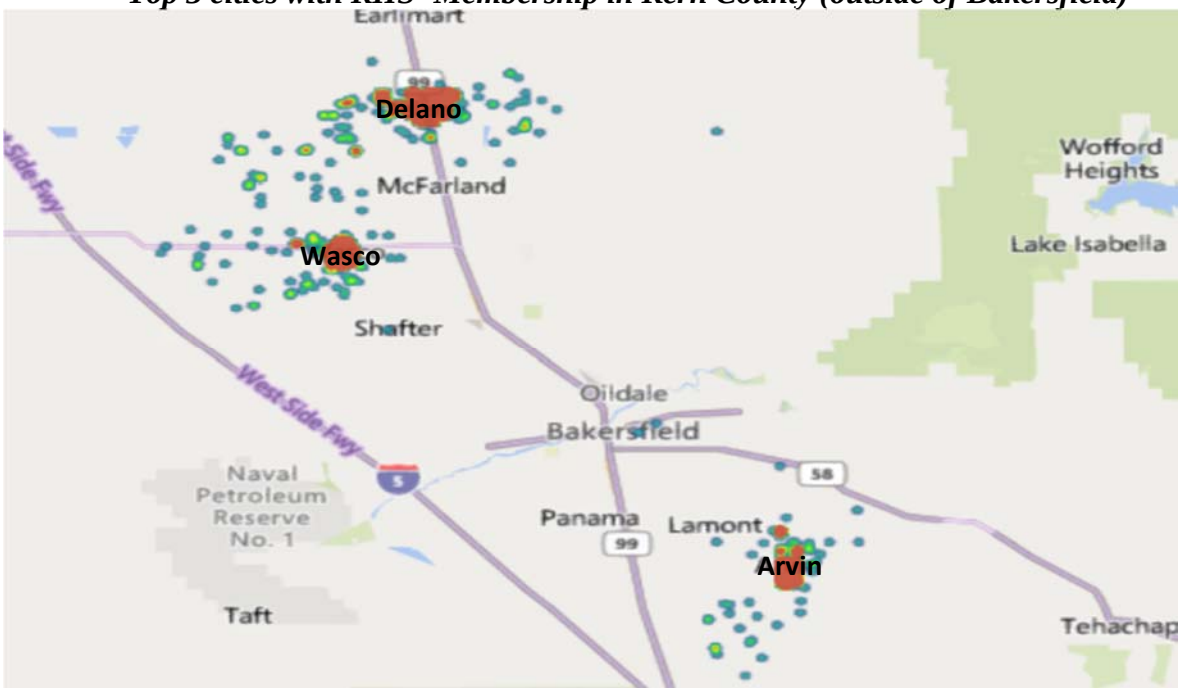
In 2019, the majority of KHS' members lived in Bakersfield (64%), Delano (7.2%), Arvin (3.8%), and Wasco (3.4%).[1] There was a 1% increase in members residing in Bakersfield, and a 1% decrease in members living in Delano compared to the 2016 needs assessment. In Bakersfield, the highest concentration of KHS members is in the 93307 zip code (17.5%), followed by 93306 (8.6%), 93304 (7.9%), 93305 (6.5%), and 93309 (6.2%).

KHS Membership in Bakersfield



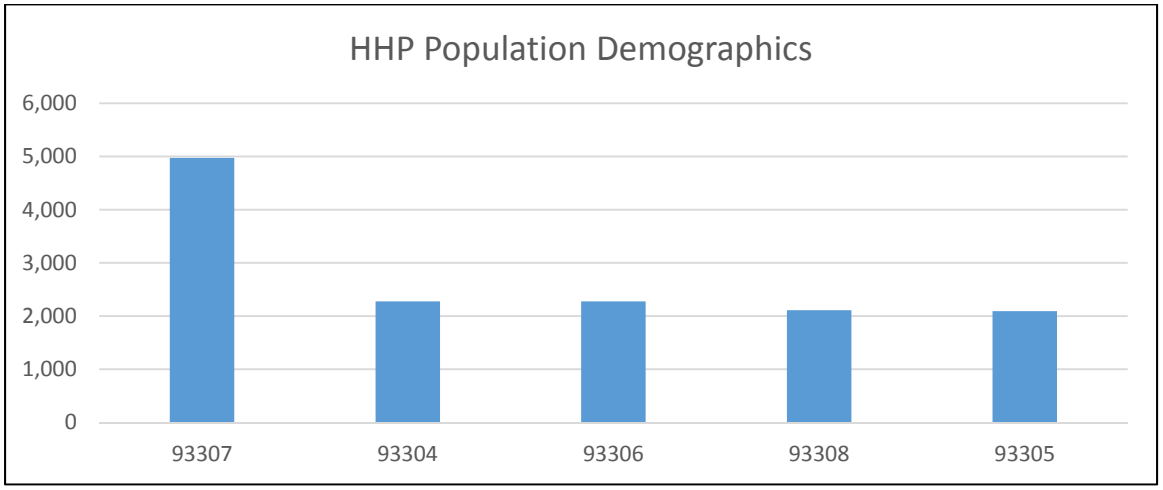
Source: 2019 KHS Member Demographics Data Report

Top 3 cities with KHS' Membership in Kern County (outside of Bakersfield)



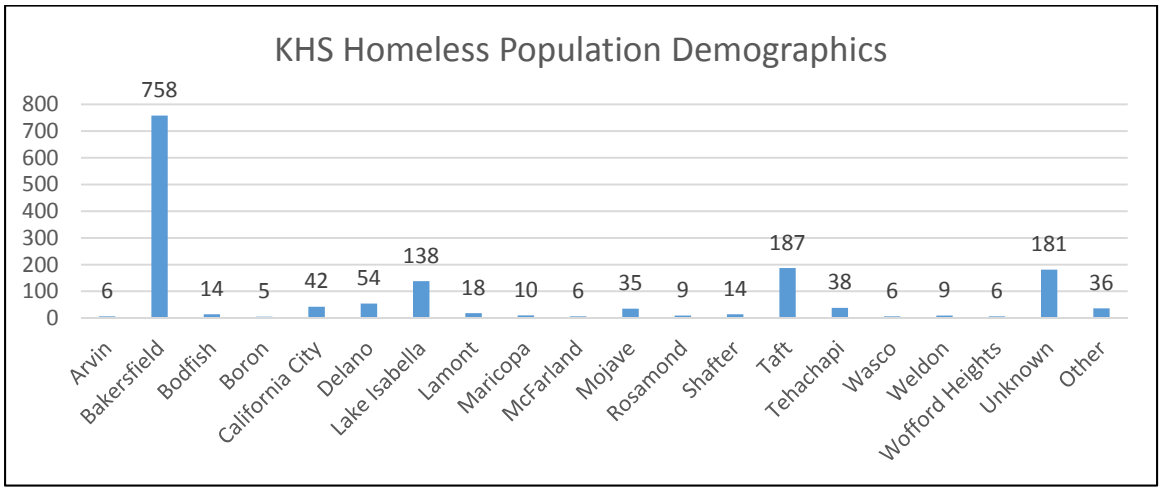
Source: 2019 KHS Member Demographics Data Report

KHS' SPDs account for slightly more than a tenth of the population in Kern County (11%).[1,2] In 2019, KHS had 16,078 SPD members enrolled, which is 5% of our total membership.[1] KHS' HHP population consists of 25,206 members and the majority of these members reside in the 93307 zip code, followed by 93306 and 93304.[5]



Source: 2019 KHS HHP Member Demographics Data Report

KHS collects self-reported data of members who disclose they are homeless through the KHS CM Department. Since 2016, KHS has identified 1,572 homeless members and the majority of these members have reported living in Bakersfield, followed by Taft and Lake Isabella.[6]



Source: 2016-2020 KHS Case Management Homeless Member List

Health Status and Disease Prevalence

Kern County Public Health Profile

Kern County ranks lower for a variety of public health indicators compared to the rest of California. Kern County is in the bottom 5 California counties for age-adjusted death rates due to diabetes, Alzheimer's disease, and coronary heart disease and ranks among the bottom 5 California counties for the incidence of chlamydia, incidence of gonorrhea among males 15-44 years old, and persons under 18 in poverty.[7]

In Kern County's most recent Community Health Assessment, asthma and other respiratory diseases were identified as the top 3 community health problems. Additionally, 13.3% of children and teens have ever been diagnosed with asthma and the age-adjusted emergency room rates due to pediatric asthma was 89.7 per 100,000 compared to the state average of 70.9 per 100,000.

Kern County's teen birth rate (31.7 per 1,000 live births) is considerably higher than the state average (15.7 per 1,000 live births) and the percentage of pregnancies accessing early prenatal care fell below the state average (KC-77.2%; CA-83.5%).[8]

Obesity continues to be on the rise in Kern County. While the state of California met the Healthy People 2020 objective for percentage of obese adults, Kern County ranked 8.5 percentage points higher than the national objective and 13 percentage points higher than the state's rate.

In regards to mental health, Kern County's age-adjusted mortality rate due to suicide is 14.1 per 100,000 which is higher than the state and national averages (CA-10.4 per 100,000; US-13.6 per 100,000).[8]

Health Indicator	Kern County	California
Age-Adjusted Emergency Room Rates for Pediatric Asthma	89.7 per 100,000	70.9 per 100,000
Teen Birth Rate	31.7 per 1,000 live births	15.7 per 1,000 live births
Access Early Prenatal Care	77.2%	83.5%
Percentage of Obese Adults	39%	26%
Age-Adjusted Suicide Mortality Rate	14.1 per 100,000	10.4 per 100,000

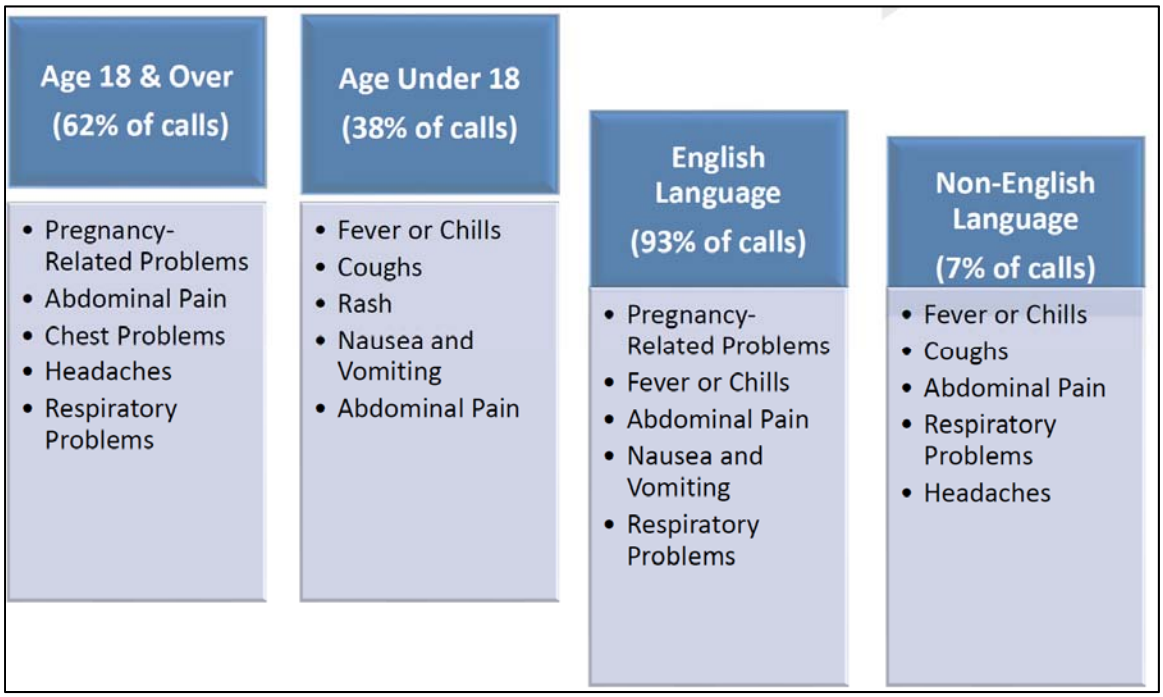
KHS Membership Health Conditions & Diagnoses

KHS medical service claims data revealed that the most commonly diagnosed health problems among KHS members in 2019 included common types of infections, chronic diseases, and pain.[9] The top diagnoses linked to infections included upper respiratory and viral infections, fever, cough, bronchiolitis, bronchitis, pharyngitis, appendicitis, urinary tract infection, sepsis, and pneumonia. The most commonly diagnosed chronic conditions included asthma, heart disease, kidney failure, diabetes, hypertension, chronic obstructive pulmonary disease (COPD), and developmental disorders. The most commonly diagnosed forms of pain were headache, abdominal and pelvic pain, chest pain, chronic pain, low back pain, and throat and chest pain. The table below has a breakdown of the top diagnoses by age group.

Top Diagnoses among KHS Members				
Age Group	**ED**	**INPATIENT**	**OUTPATIENT**	**UC**
0-11 Years	• Upper respiratory and viral infections • Fever • Cough	• Bronchiolitis • Appendicitis • Neonatal jaundice • Asthma	• Upper respiratory and viral infections • Routine child health exam • Fever	• Upper respiratory infections • Pharyngitis • Fever
12-20 Years	• Upper respiratory infections • Urinary tract infection • Headache	• Appendicitis • Sepsis	• Abdominal and pelvic pain • Upper respiratory infection • Headache	• Upper respiratory infections • Pharyngitis • Urinary tract infection
21-64 Years	• Urinary tract infection • Headache • Chest pain	• Sepsis • Hypertensive heart disease • Kidney failure	• Diabetes T2 • Hypertension • Urinary tract infection	• Upper respiratory infection • Pharyngitis • Urinary tract infection
65+ Years	• Urinary tract infection • Chronic pain • Low back pain	• Sepsis • COPD • Hypertension	• Heart disease • Low back pain • Hypertension	• Hypertension • Upper respiratory infection • Bronchitis
SPDs	• Urinary tract infection • Throat and chest pain • Abdominal and pelvic pain	• Sepsis • Pneumonia • Kidney failure	• Chronic kidney disease • Diabetes T2 • Hypertension	• Hypertension • Developmental disorders • Low back pain

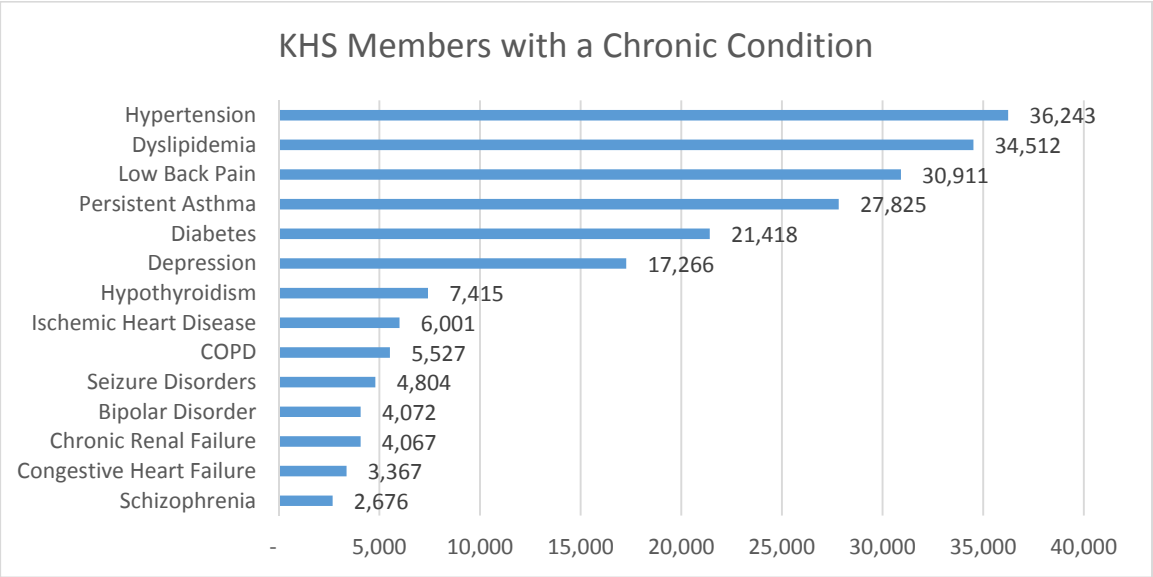
Source: 2019 KHS Top Diagnosis Report

In 2019, KHS's advice nurse line received 7,926 inbound calls from members and more than a third of these calls were for symptom checks by members. More than half of all calls were received between the hours of 9AM-6PM and 25.1% of these calls fell on a Wednesday. [10] Pregnancy-related problems were the top reason for calls received from English-speaking members and members aged 18 years and older. For non-English speaking members and members under 18 years of age, the primary reasons for symptom check calls was for fever or chills and coughs.[11]



Source: 2019 KHS Advice Nurse Line Report

KHS uses the Johns Hopkins ACG Modeler to perform data analysis on member medical service claims for various chronic conditions in a given year. The following data represents the total number of members identified for each targeted chronic condition in 2019.[12]



Source: KHS 2019 Chronic Condition Population Analysis Report

Pharmaceutical Utilization

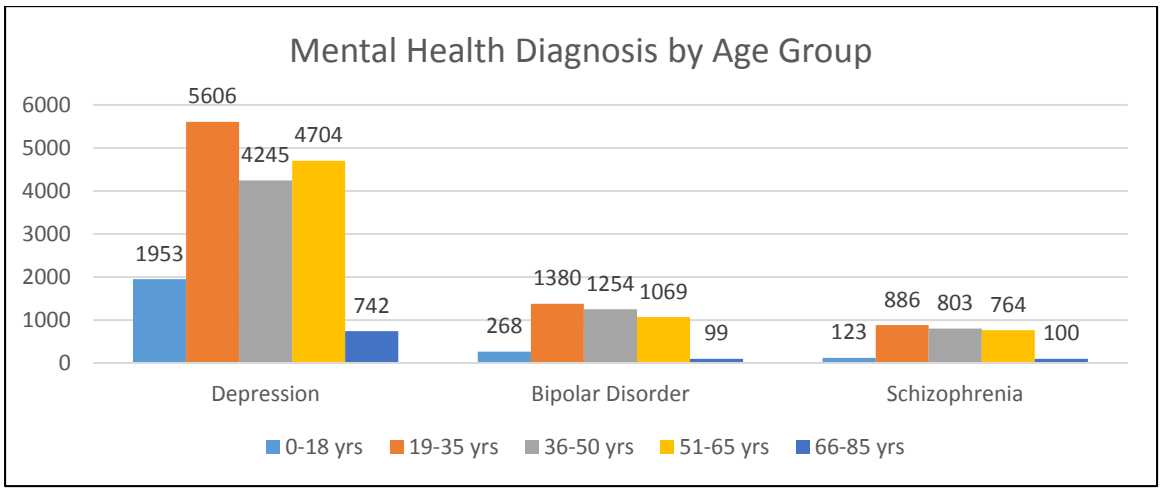
KHS' review of the most frequently dispensed medications in 2019 identified Ibuprofen, Lisinopril, Amoxicillin, Albuterol Sulfate, and Metformin as the top 5 medications prescribed to KHS members.[13] These medications are used to treat health conditions that were identified as top diagnoses among KHS members in 2019, such as abdominal, pelvic, and low back pain, common infections, and chronic conditions, such as type 2 diabetes, asthma, and COPD. Other top medications included those prescribed to treat allergies, hyperlipidemia, fever, inflammation, heart disease, and vitamin D deficiency. Tradjenta was identified to be the most costly medication dispensed, which accounted for $6,564,661 and supports the treatment of type 2 diabetes.[13]

Top 10 Most Prescribed Medications	Relevant Health Conditions
1. Ibuprofen	Fever and pain
2. Lisinopril	High blood pressure and heart failure
3. Amoxicillin	Infections and stomach ulcers
4. Albuterol Sulfate	Breathing problems, such as asthma and COPD
5. Metformin	Type 2 diabetes
6. Loratidine	Allergy symptoms and hives
7. Aspirin	Pain, fever, headache, inflammation, and heart problems
8. Atorvastatin	High cholesterol and triglyceride levels; heart and blood vessel problems
9. Acetaminophen	Pain and fever
10. Ergocalciferol	Vitamin D deficiency

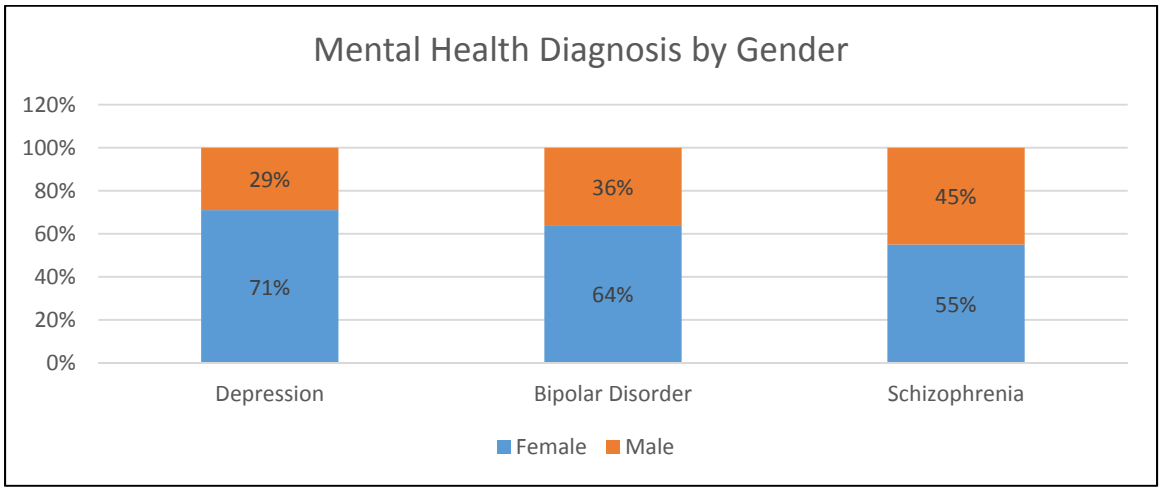
Source: 2019 KHS Top Medications Filled Report

Mental Health Conditions

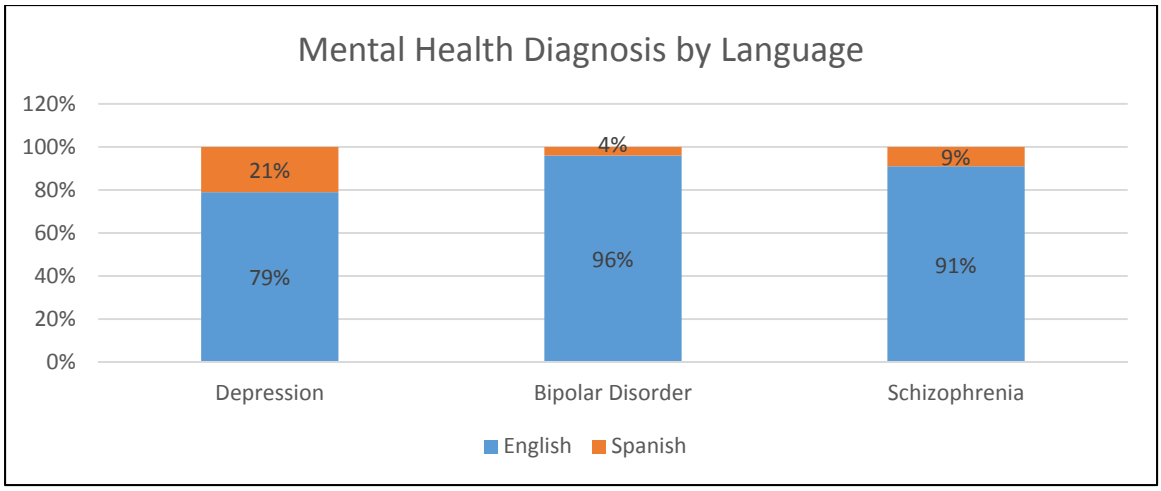
According to KHS' chronic condition population analysis reports, there are 5.9% of KHS members with a diagnosis of depression, 1.39% diagnosed with a bipolar disorder, and 0.91% diagnosed with schizophrenia.[12] Members with a diagnosis of depression, bipolar disorder or schizophrenia were more likely to be English speaking, female, and between the ages of 19-35 years.[14,15,16] Additionally, Caucasian members were more disproportionately affected by depression and bipolar disorder[12, 14] whereas African Americans were more likely to be diagnosed with schizophrenia[16].



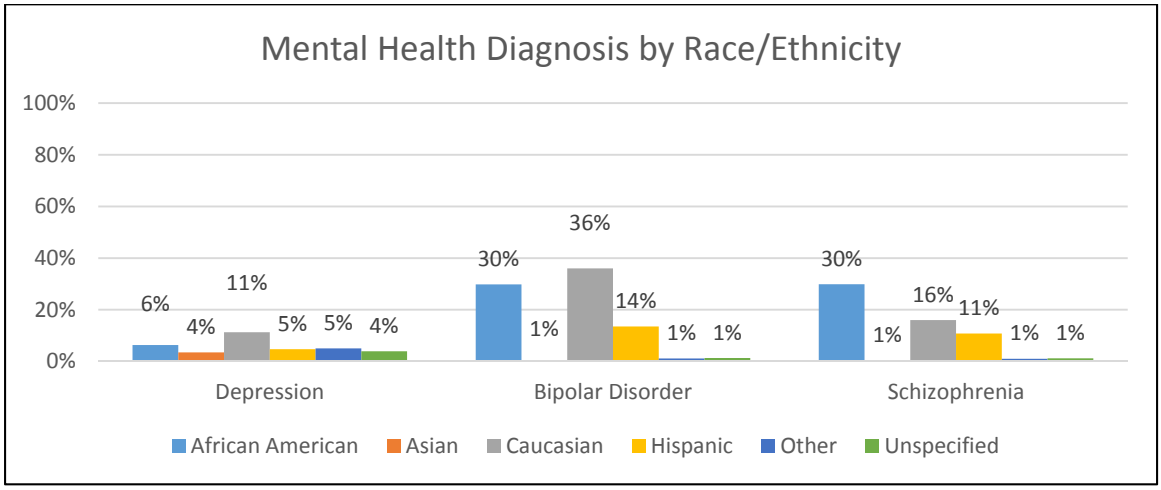
Source: KHS Depression, Bipolar Disorder and Schizophrenia Chronic Condition Population Analysis Reports, 2020



Source: KHS Depression, Bipolar Disorder and Schizophrenia Chronic Condition Population Analysis Reports, 2020



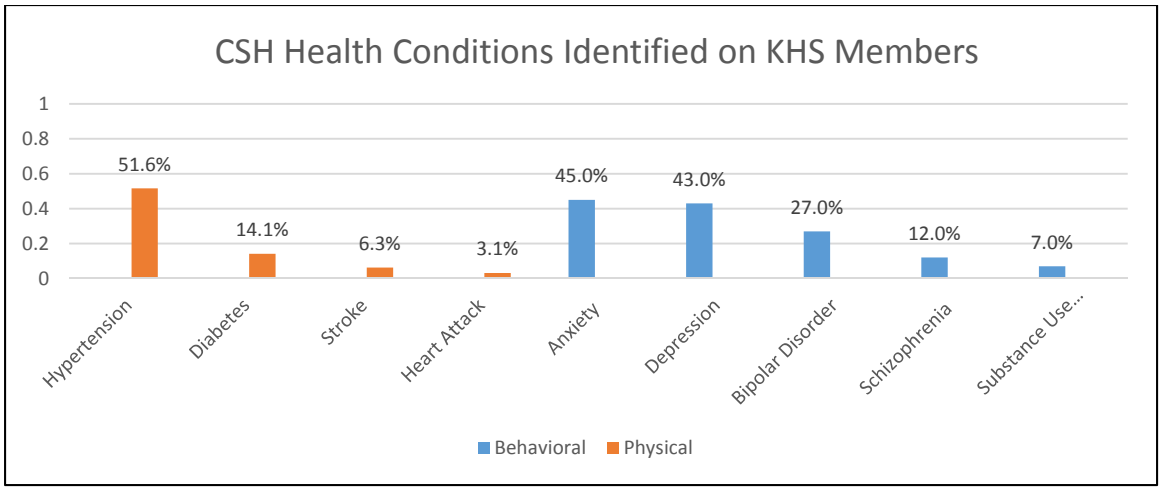
Source: KHS Depression, Bipolar Disorder and Schizophrenia Chronic Condition Population Analysis Reports, 2020



Source: KHS Depression, Bipolar Disorder and Schizophrenia Chronic Condition Population Analysis Reports, 2020

Association of Health Conditions with Smoking and Tobacco Use

The 2019 CAHPS Adult Medicaid Survey performed by the DHCS Health Services Advisory Group (HSAG) identified 19.2% of KHS adult members are current smokers.[20] KHS' tobacco registry report identified about 12% of members are current smokers or have been exposed to tobacco.[17] The California Smokers Helpline (CSH) collects demographic and health data during phone counseling sessions and shares this data with Medi-Cal Managed Care health plans. CSH data revealed most KHS member callers to be English speaking (95.3%), female (69.5%), Caucasian (52.3%), between the ages of 25-44 years (34.4%), and have a high school educational level (34.4%).[18] Review of the behavioral and physical health conditions of KHS member callers identified hypertension and anxiety as the top diagnoses.



Source: 2019 California Smokers Helpline Demographic and health data for Medi-Cal Health Plan

Access to Care

KHS conducts an annual satisfaction survey with adult members using questions developed by CAHPS to capture accurate and complete information about member-reported experiences with health care. The survey specifically measures how well KHS is meeting member's expectations and goals; which areas of service have the greatest effect on overall satisfaction; and, identifies areas of opportunity for improvement. Additionally, HSAG conducts an adult and child CAHPS survey every 2 years with KHS members. Although KHS met or exceeded its 2019 benchmarks on customer service, providing needed information, and ease of filling out forms, the rates shown in red, below, did not meet KHS' 2019 benchmarks.[19,20,21]

Measure	Question	2019 KHS HSAG CAHPS Child Rate	2019 KHS HSAG CAHPS Adult Rate	2019 KHS Adult Rate	2019 KHS Adult Benchmark
Getting Needed Care	Getting care, tests, or treatments necessary	82.7%	82.6%	81.0%	85.2%
	Obtained appointment with specialist as soon as needed	N/A	77.8%	75.7%	80.5%
Getting Care Quickly	Obtaining needed care right away	N/A	82.1%	81.6%	84.6%
	Obtained appointment for care as soon as needed	81.4%	70%	71.1%	79.7%

How Well Doctors Communicate	Doctors explained things in an understandable way	91.3%	90.6%	88.5%	92.0%
	Doctors listened carefully to you	95.1%	88.5%	89.5%	92.2%
	Doctors showed respect for what you had to say	95.7%	90.1%	92.5%	93.7%
	Doctors spent enough time with you	82.5%	87.8%	84.0%	89.5%
Shared Decision Making	Doctor/health care provider talked about reasons you might want to take a medicine	N/A	N/A	90.2%	91.6%
	Doctor/health care provider talked about reasons you might not want to take a medicine	N/A	N/A	65.6%	68.0%
	Doctor/health care provider asked you what you thought was best when talking about starting or stopping a prescription	N/A	N/A	82.1%	79.1%
	Health Promotion and Education	65.0%	69.2%	67.3%	71.3%

Source: 2019 KHS Annual Member Satisfaction Survey, 2019 CAHPS Adult Survey, 2019 CAHPS Child Survey

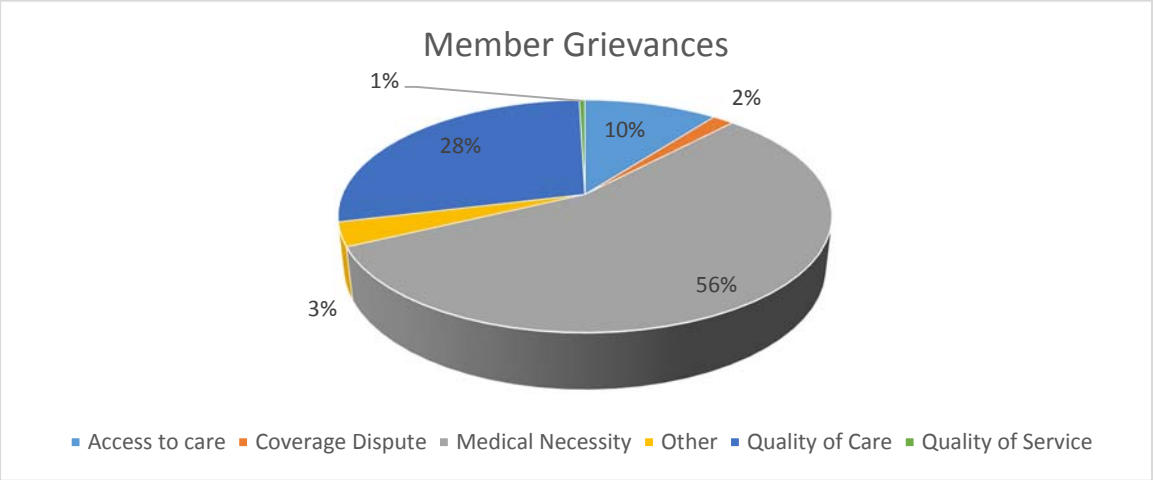
Data on the effectiveness of care measures for flu shots and tobacco use among adults was also collected. Findings revealed the KHS did not meet its 2019 benchmarks on advising current tobacco users to quit and discussing cessation medications and strategies[19] and 39.8% of its adult members did not receive an annual flu shot.[20]

Measure	Question	2019 KHS HSAG CAHPS Child Rate	2019 KHS HSAG CAHPS Adult Rate	2019 KHS Adult Rate	2019 KHS Adult Benchmark
Medical Assistance with Smoking and Tobacco Use Cessation	Advising Smokers and Tobacco Users to Quit	N/A	N/A	73.8%	76.5%
	Discussing Cessation Medications	N/A	N/A	44.0%	52.0%
	Discussing Cessation Strategies	N/A	N/A	37.4%	45.9%
Flu Vaccinations for Adults Ages 18-64	Had a flu shot since July 1 of previous year	N/A	60.2%	N/A	N/A

Source: 2019 KHS Annual Member Satisfaction Survey, 2019 CAHPS Adult Survey

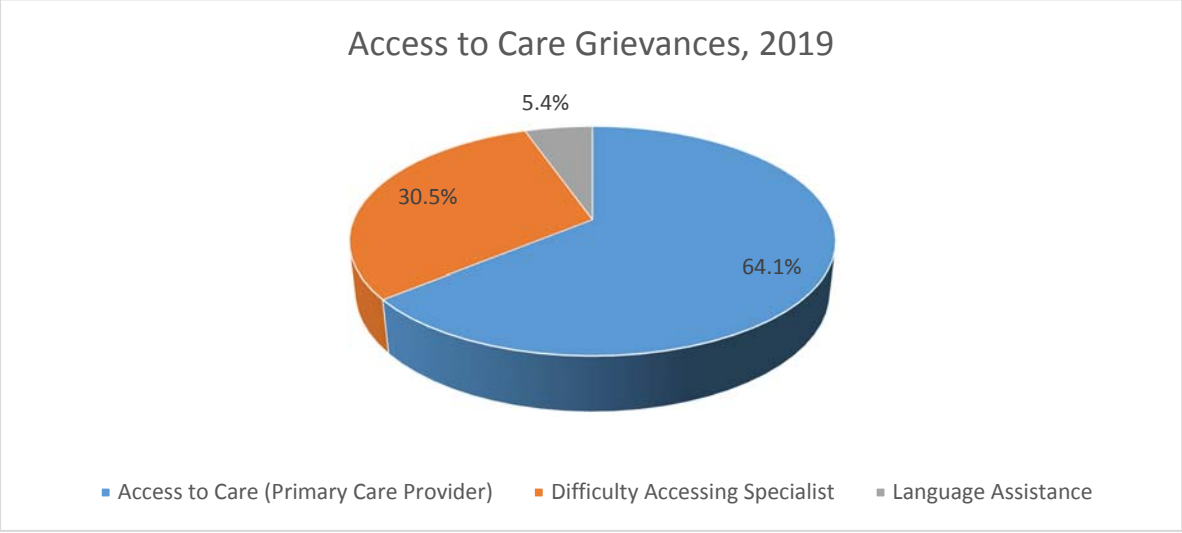
Member Grievances

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. During 2019, there were 1,564 formal member grievances received and the majority of grievances were due to Medical Necessity followed by Quality of Care and Access to Care and 38.7% of these grievances were closed in favor of the member.[22]



Source: 2019 KHS Grievance Operational Board Report

When looking at access to care grievances, Access to Care (Primary Care Provider) accounted for the majority of cases (64.1%) in this grievance category, followed by Difficulty Accessing a Specialist (30.5%) and Language Assistance (5.4%).[23]



Source: 2019 KHS Grievance Operational Board Report

Access to Transportation

KHS' Transportation Program provides transportation for members to get to their medical and other Medi-Cal covered services. Covered modes include Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT). NEMT is provided when medically necessary and requires a Provider Certified Statement from the member's medical provider. NMT is provided to all members who qualify.

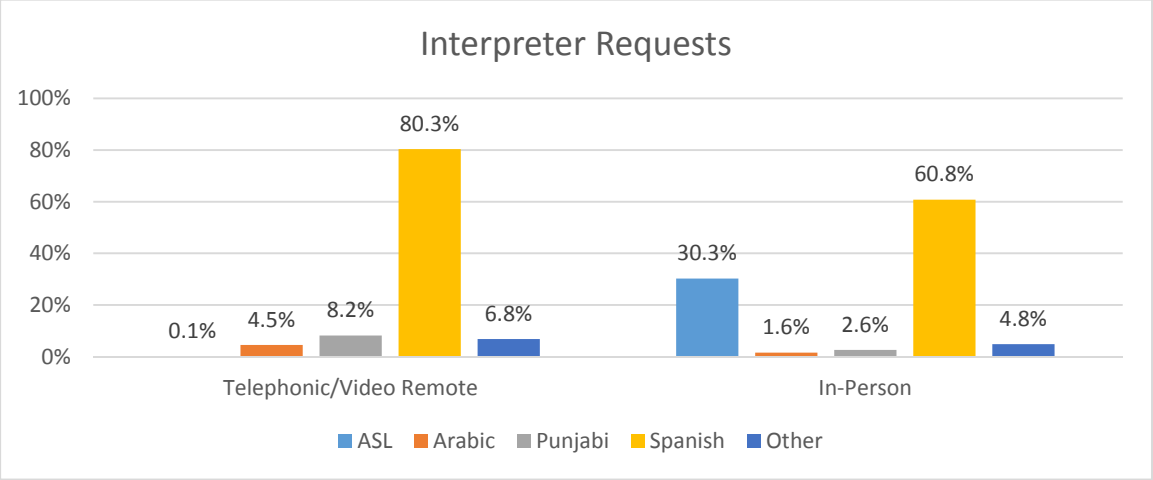
2019 NEMT and NMT Ridership

Mode	Number of Trips Provided	Approx. Number of Members Utilizing Transport Mode
NEMT Wheelchair	65,139	1,200
NEMT Gurney Van	2,130	260
NMT Public Transit	390,427	5,000
NMT Mileage Reimbursement	9,680	4,300

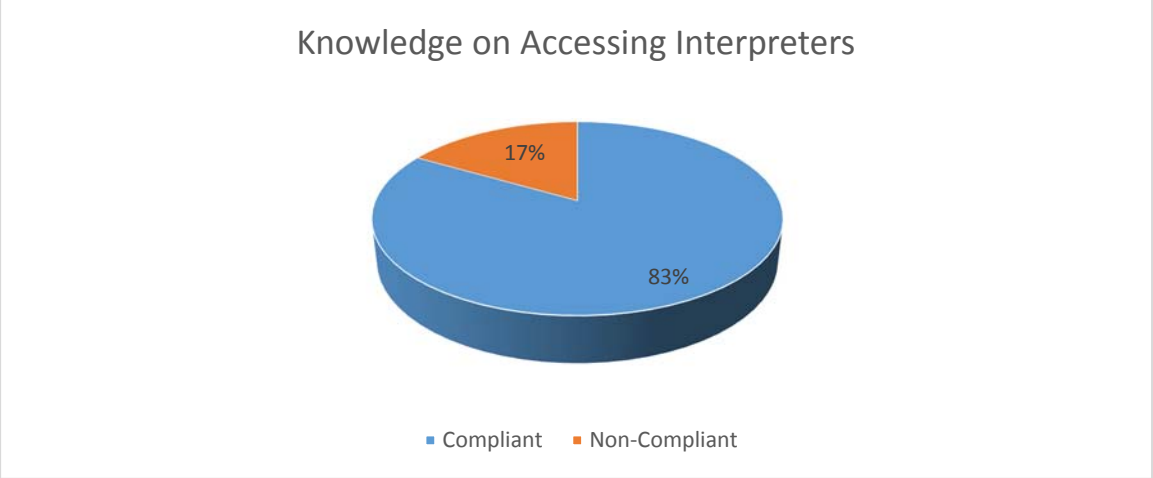
Source: KHS 2019 Transportation Benefit Summary

Access to Interpreter Services

KHS' HE department provides services to a culturally and linguistically diverse member population. KHS' language threshold is English and Spanish and all services and materials are available in these languages. In 2019, there was a 30% increase is requests for ASL interpreters, a 59% increase in telephonic interpreters, and a 39% increase for in-person interpreters when compared to 2018.[24]



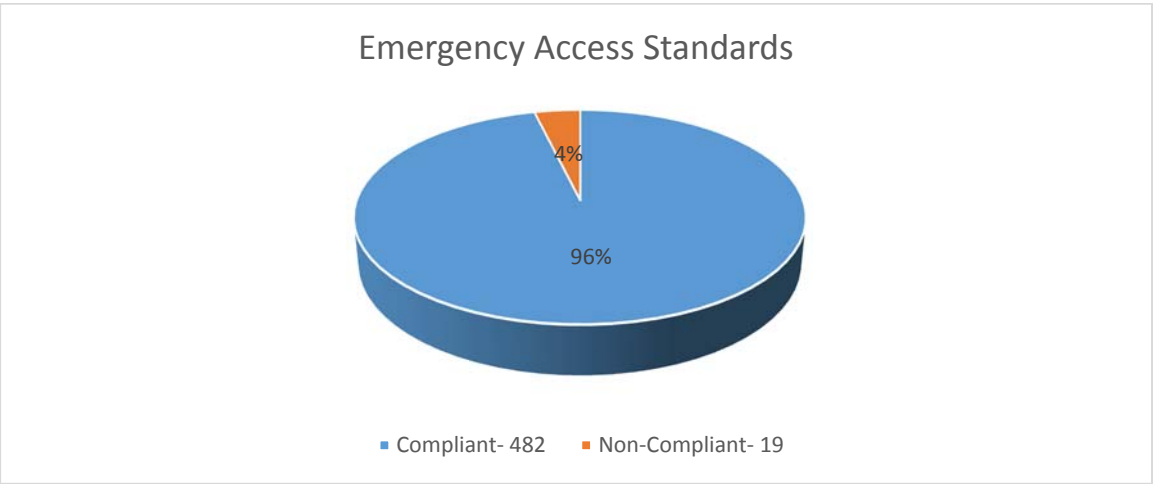
KHS conducts a quarterly interpreting access survey among its provider network. In 2019, a random sample of 60 primary care provider offices and 60 specialist offices were contacted to assess their knowledge on accessing interpreting services for limited English proficient (LEP) members. Findings revealed, 17% of these providers needed additional training on accessing interpreting services for LEP members.[25]



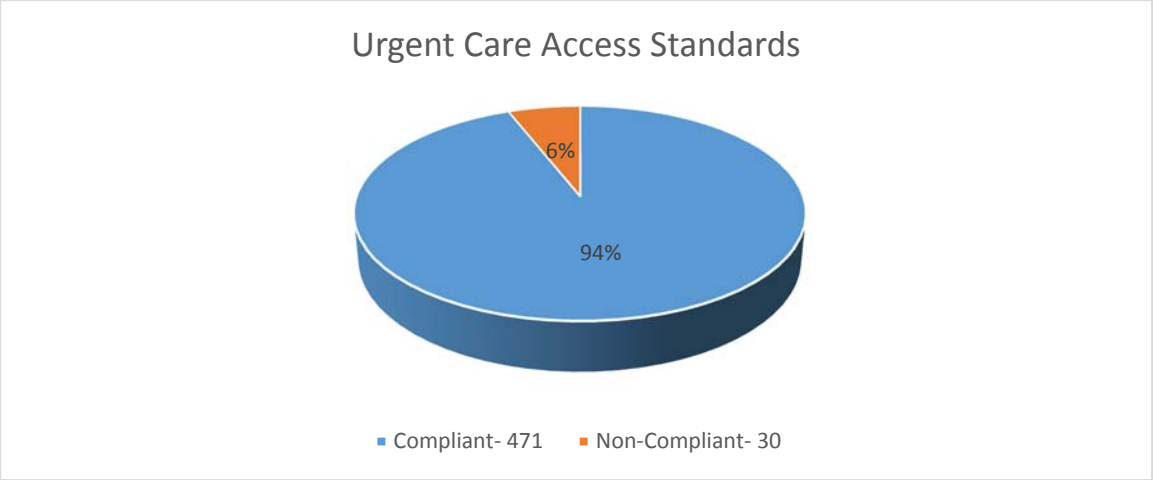
Source: 2019 KHS Interpreter Access Survey Results Report

Emergency & Urgent Care Access Standards

As required by the Department of Managed Health Care (DMHC) Health & Safety Code 1348.8, KHS uses an afterhours caller program to assess compliance with access standards for KHS Members. In 2019, 96% of provider offices were compliant with the Emergency Access Standards and 94% if provider offices were compliant with the Urgent Care Access Standards.[26]



Source: 2019 KHS Provider Network Management Network Review Reports



Source: 2019 KHS Provider Network Management Network Review Reports

Appointment Availability

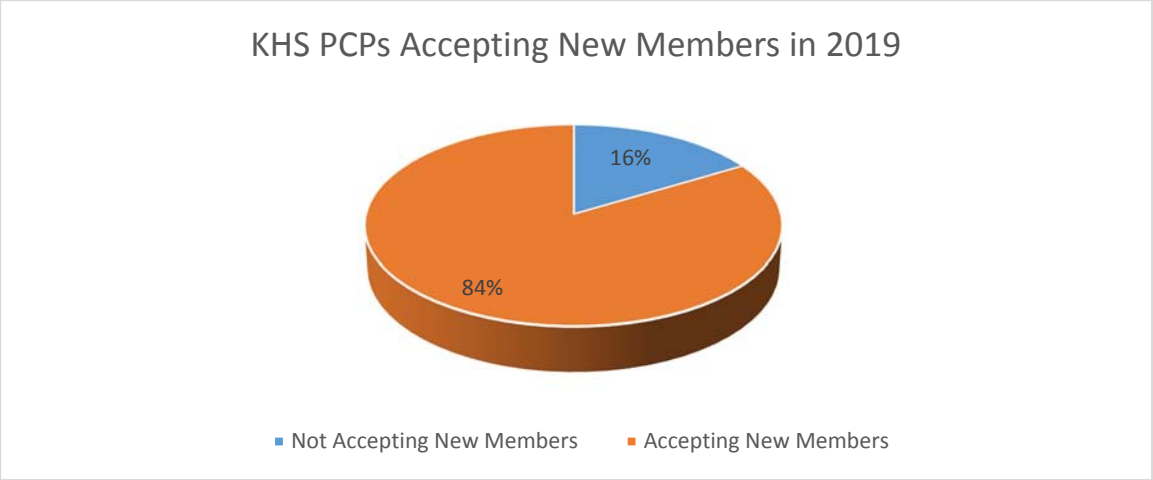
As required by the DHCS and Title 28 CCR Section 1300.67.2.2, KHS uses an appointment availability survey to assess compliance with access standards for KHS Members. A random sample of 60 primary care provider (PCP) offices, 60 specialist offices, and 5 Obstetrics & Gynecology (OBGYN) offices were contacted during 2019 and found to be in-compliance with the standard wait times.[26]

	Providers Contacted	Average Wait Time in Business Days/Provider	Standard Wait Time in Business Days
PCP Offices	60	3.6	10
Specialist Offices	60	7.6	15
OBGYN Offices	5	5.4	10

Source: 2019 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 2019, the plan had a combined quarterly average network of 385 PCPs and 84% were accepting new members at a minimum of one location.[26]



Source: 2019 KHS Provider Network Management Network Review Reports

Health Disparities

Health disparities among KHS members vary by race/ethnicity, language, and health outcome. 2019 DHCS Disparities Rate Sheet indicator rates show that African American members are mostly likely to have the worst outcomes for preventive health measures. English speakers generally have worse 2019 DHCS Disparities Rate Sheet indicator rates than Spanish speakers. Racial/ethnic disparities for the top chronic health conditions among KHS members vary by chronic health condition.

A comparison of the 2018 and 2019 DHCS Disparities Rate Sheets revealed improvements in avoidance of antibiotics, cervical cancer screenings, poorly controlled diabetes, immunizations for adolescents, and pediatric counseling for nutrition and physical activity. Consequently, there were also several indicators that decreased, demonstrating a decrease in member adherence to preventive care or treatment.[27] A summary is provided in the table below.

Rate Difference (Percentage Points)	Description of Measurement
-28.3 pp	Decrease in asthma medication management
-4.8 pp	Decrease in outpatient visits based on total population.
-4.3 pp	Decrease in emergency department visits based on total populations.
-4.1 pp	Decrease in hypertensive members with controlled blood pressure readings.
-3.4 pp	Decrease in members who received all childhood immunizations by the age of 2.
-2.7 pp	Decrease in members aged 3-6 years who completed a well child visit.
-1.2 pp	Decrease in members accessing early prenatal care.
-1.2 pp	Decrease in children ages 25 months-6 years accessing primary care services
-1.0 pp	Decrease in children ages 7-11 years accessing primary care services
-0.5 pp	Decrease in children ages 12-19 years accessing primary care services
-0.1 pp	Decrease in children ages 12-24 months accessing primary care services

Source: 2019 DHCS Disparities Rate Sheets

DHCS reviewed the following pediatric preventive care indicators for all Medi-Cal Managed Care Health Plans in the 2019 DHCS Disparities Rate Sheet:

- Children's Access to Primary Care for 12-24 month olds (CAP-1224)
- Children's Access to Primary Care for 25 months to 6 year olds (CAP-256)
- Children's Access to Primary Care for 7-11 year olds (CAP-711)
- Children's Access to Primary Care for 12-19 year olds (CA-1219)
- Childhood immunizations by age 2 (CIS-3)
- Well child visits for 3-6 years (W34)
- Weight Assessment and Counseling for Nutrition (WCC-N)
- Weight Assessment and Counseling for Physical Activity (WCC-PA)

In review of the 2019 DHCS Disparities Rate Sheet indicators by race/ethnicity for pediatric preventive care, there is a trend of unfavorable outcomes for African American KHS members and other members of color. KHS' African Americans most frequently had the worst 2019 DHCS indicators rates in children's access to primary care services and childhood immunizations, whereas KHS' Caucasian members had the worst rates well child visits for 3-6 years olds and weight assessment and counseling for nutrition and physical activity. Conclusions about the preventive health outcomes for Asian, American Indian/Alaskan Native, and Native Hawaiian/Other Pacific Island members cannot not always be drawn because there was not enough data for most of the DHCS Disparities Rate Sheet indicators. In review of language preferences, Spanish-speaking members were more likely to be compliant with all pediatric preventive care indicators compared to English-speaking members.

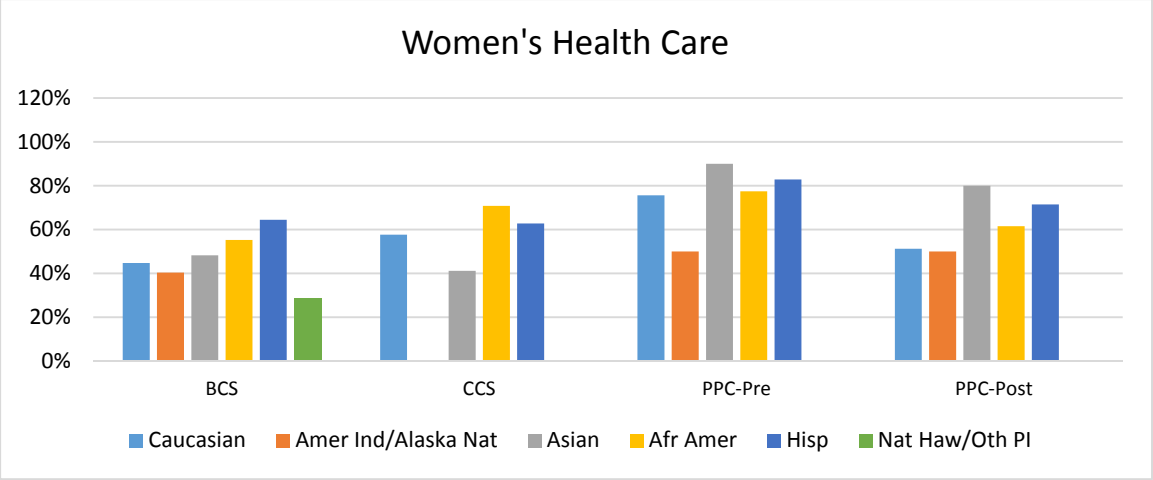
PEDIATRIC PREVENTIVE CARE						
MEASURE	**Caucasian**	**American Indian/ Alaska Native**	**Asian**	**African American**	**Hispanic**	**Native Hawaiian/Other Pacific Islander**
CAP1224	82.9%	100.0%	94.2%	80.9%	91.7%	N/A
CAP256	73.3%	76.0%	84.2%	66.1%	82.7%	100.0%
CAP711	74.3%	63.2%	85.1%	64.8%	82.1%	100.0%
CAP1219	73.3%	66.7%	77.1%	69.9%	80.0%	73.3%
CIS-3	50.00%	N/A	83.33%	40.91%	71.54%	N/A
IMA-2	36.96%	N/A	44.44%	31.25%	41.87%	N/A
W34	60.0%	N/A	57.1%	63.0%	66.0%	N/A
WCC-N	57.1%	0.0%	50.0%	83.3%	71.9%	N/A
WCC-PA	53.1%	0.0%	50.0%	66.7%	68.1%	N/A

Source: 2019 DHCS Health Disparities Rate Sheet

DHCS reviewed the following women's health care indicators for all Medi-Cal Managed Care Health Plans in the 2019 DHCS Disparities Rate Sheet:

- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Early Prenatal Care (PPC-PRE)
- Postpartum Care (PPC-Post)

In review of the 2019 DHCS Disparities Rate Sheet indicators by race/ethnicity for women's health care, KHS' Caucasian members were less likely to obtain breast and cervical cancer screenings, access early prenatal care and complete their postpartum care. KHS' Asian members were also less likely to obtain cervical cancer screenings and KHS' American Indian/Alaskan Native members were less likely to obtain breast cancer screenings. In review of language preferences, Spanish-speaking members were more likely to be compliant with breast and cervical cancer screenings and postpartum care whereas English-speaking members were more likely to be compliant with early prenatal care.



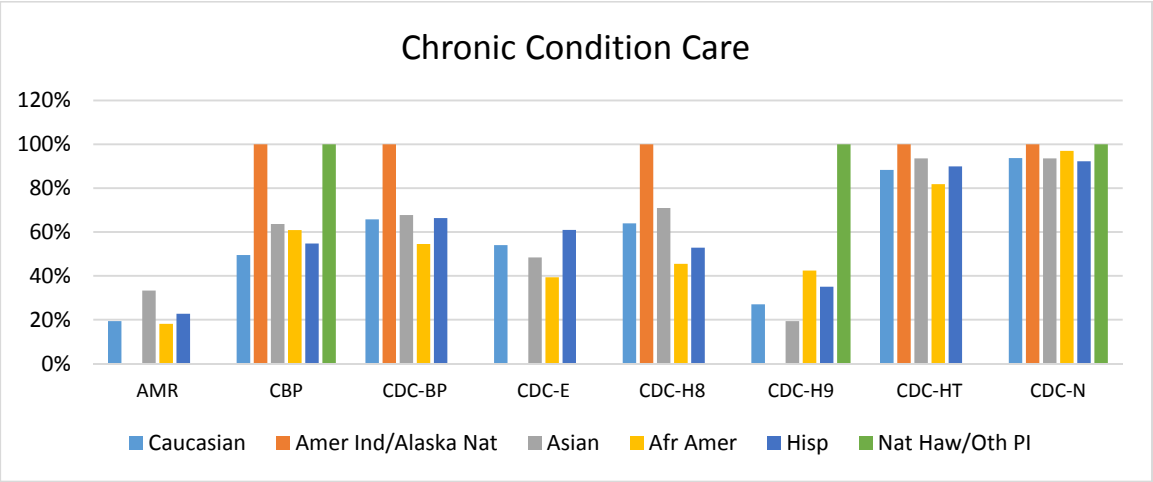
Source: 2019 DHCS Health Disparities Rate Sheet

DHCS reviewed the following chronic condition care indicators for all Medi-Cal Managed Care Health Plans in the 2019 DHCS Disparities Rate Sheet:

- Asthma Medication Management (AMR)
- Control of High Blood Pressure (CBP)
- Comprehensive Diabetes Care – Blood Pressure Control (CBP)
- Comprehensive Diabetes Care – Retinal Eye Exam (CDC-E)
- Comprehensive Diabetes Care – HbA1c Control <8% (CDC-H8)
- Comprehensive Diabetes Care – HbA1c Poor Control >9% (CDC-H9)
- Comprehensive Diabetes Care – HbA1c Testing (CDC-HT)
- Comprehensive Diabetes Care – Nephropathy Monitoring (CDC-N)

In review of the 2019 DHCS Disparities Rate Sheet indicators by race/ethnicity for chronic condition care, there is also a trend of unfavorable outcomes for African American KHS members. KHS' African Americans were more likely to be less compliant with asthma medication adherence, HbA1c testing and control, diabetic retinal exams, and diabetic blood pressure control. Although KHS' Asian, American Indian/Alaskan Native, and Native Hawaiian/Other Pacific Island members may appear to worse preventative care rates, there was not enough data for KHS to draw statistically valid assumptions for these groups in all indicators.

In review of language preferences, Spanish speaking members were more likely to be compliant with all chronic condition care indicators with the exception of the following indicators where English speaking members were more compliant: CBP, CDC-H9, and CDC-N.



Source: 2019 DHCS Health Disparities Rate Sheet

When looking at the most prevalent chronic health conditions among KHS members, racial/ethnic disparities vary by health condition. White members have the highest rate of depression compared to other racial/ethnic groups.[12] Asian members have the highest rates of diabetes, dyslipidemia, and hypertension. African Americans have the highest rates of low back pain and persistent asthma. The racial/ethnic group with the highest rate for each of the top chronic conditions among KHS members is shown in red, below.

	African American	Asian	Caucasian	Hispanic	Other/ Unspecified
Depression	6.3%	3.5%	11.2%	4.7%	3.9%
Diabetes	7.2%	14.5%	7.0%	7.1%	6.1%
Dyslipidemia	9.3%	25.8%	12.6%	11.2%	10.0%
Hypertension	16.4%	23.5%	16.0%	10.5%	10.3%
Low Back Pain	14.0%	13.8%	15.2%	9.0%	7.3%
Persistent Asthma	15.2%	7.2%	12.0%	8.2%	9.1%

Source: KHS All Populations Analysis Report, 2020

IV. Health Education, Cultural & Linguistics, and Quality Improvement Program Gap Analysis

Gaps in Access to Care

As mentioned previously, KHS did not meet its 2019 CAHPS benchmark goals in the areas of:

- Getting Needed Care
  - Getting care, tests or treatments necessary
  - Obtained appointment with specialist as soon as needed
- Getting Care Quickly
  - Obtaining needed care right away
  - Obtained appointment for care as soon as needed
- Health Promotion and Education
- Access to Tobacco Cessation Medication and Strategies to Quit

KHS' access to care grievance data revealed potential challenges that members may face when accessing a specialist where nearly half of the "Difficulty Accessing a Specialist" grievance outcomes were in favor of the enrollee.[23]

Although 83% of KHS' provider network understand how to access interpreting services for KHS members, the remaining 17% is in need of reminders of this member benefit.[25] KHS HE, C&L Department should continue to partner with its Provider Network Management and QI Departments to help coordinate in-services and refresher trainings for providers who are identified as non-compliant through the quarterly interpreter access survey; have had a cultural and linguistic grievance filed against the office site; or, have been identified as an office site that would benefit from additional training.

Transportation challenges for NMT are similar to the challenges for NEMT. Rural areas have limited public transportation availability. Rideshare providers (Uber) typically service the more urban areas without issue and usually have no availability limits. Since rideshare drivers are independent contractors who rely on short route trips to be lucrative and Kern County has an expansive geographic footprint, rural areas are not preferable given that the expense of traveling without a passenger outweighs the benefit of servicing the minimal population in those areas.[28] Single passenger trips for rural areas may be provided by the public transit's curbside bus where available.

Survey responses from KHS' Public Policy/Community Advisory Committee (PP/CAC) identified the following opportunities that KHS should consider to aid members in accessing health care services[29]:

- Improve member awareness and understanding of their medical benefits and how to access these services.
- Reassess length of time to for members to obtain approval for medications and authorizations.

- Improve member health literacy on understanding health plan and medical terminology by creating easy to understand materials and incorporating a glossary of terms.
- Encourage providers to spend more time listening, affirming and being attentive to member needs during visits.
- Expand transportation services, particularly in rural areas.

Gaps in Language Needs and Cultural and Linguistic Competency

KHS' threshold languages as determined by DHCS continues to be English and Spanish; however, the top 4 languages for telephonic interpreting for KHS members in 2019 were Spanish, Punjabi, Arabic and Tagalog. The top 4 languages for in-person interpreting for KHS members in 2019 were Spanish, Punjabi, Cantonese and Mandarin. Although the top 4 non-Spanish languages for interpreters do not meet DHCS' criteria to constitute as a new threshold language for KHS, KHS recognizes that its 4th largest ethnic group are Asian Indian members and requests for Punjabi interpreters continues to grow each year. Survey responses from KHS' PP/CAC members also found recommendations for KHS to start building a staffing model and inventory of both health education and member informing material, educational curriculums and media campaigns that are culturally and linguistically representative of this population. Other considerations to better understand the cultural and linguistic needs of Asian Indian or Punjabi speaking members might include, but not be limited to:

- Effective ways to promote our services to these members
- Engagement of community liaisons, gatekeepers, or organizations that can help KHS connect and communicate
- Identify geographic concentration areas of residence for these members

Requests for ASL interpreters also continues to grow within KHS' membership. KHS has seen a 30% increase in ASL requests since 2018 and a 45% increase since 2016. KHS recognizes that access to in-person ASL interpreters is highly limited in Kern County. With only 12 ASL interpreters residing in Kern County, KHS' interpreting vendor must recruit Los Angeles County interpreters to commute to Kern County to assist ASL members. These interpreters not only face an extensive geographic commute, but also face challenges with severe weather conditions and road closures on the Interstate Highway 5 grapevine route during the Winter and Summer seasons. KHS may need to encourage more use of video remote interpreting services with its provider network and ASL membership to avoid interpreter access delays.

Through the review and analysis of KHS' C&L data, the following areas should also be explored for consideration and inclusion in future program planning in order to expand and enhance KHS' C&L services for its members.

- Continue to research and identify additional vendors to perform in-person interpreting services for members.
- Explore and develop a procedure on how to access and use interpreters during virtual health care visits.
- Identify and recruit additional vendors to provide bilingual certification for KHS staff.

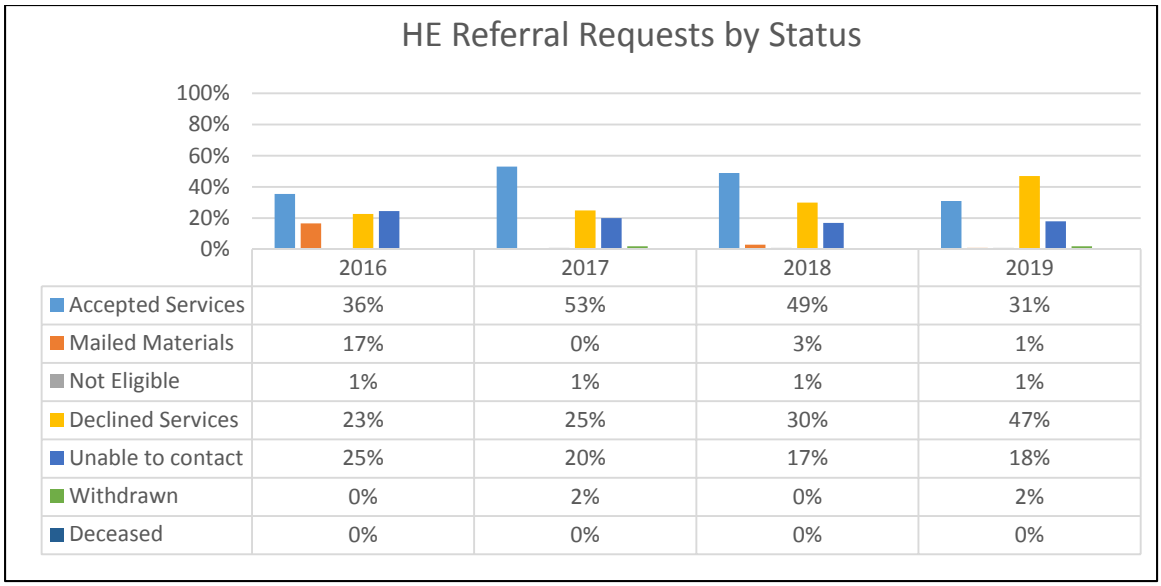
- Increase opportunities for KHS' provider network to participate in trainings on Cultural Competency, Effective Interpreting and Accessing KHS Interpreter Services.
- Increase training opportunities for KHS and its network providers to learn more about the needs the LGBT population.
- Increase promotion of interpreter services among KHS members along with the concerns with using family or friends as interpreters.
- Continue outreach and education efforts with KHS providers on how to access KHS' interpreting services.
- Offer trainings on the principles and ethics for effective interpreting for provider staff used as interpreters during appointments.
- Research and identify additional member and provider tools to communicate interpreter needs for medical appointments.
- Research and connect with growing ethnic groups within KHS' membership to better understand the cultural aspects around accessing health care and use of alternative medicine.

Gaps in Health Education Services

KHS has historically offered health education services and incentives through a variety of modalities, such as in-person group sessions, telephonic counseling, printed mailings, and social media communications. Yet member's awareness and participation in KHS' health education services continues to remain low. KHS' ability to offer regular health education services throughout the county and outside of regular business hours has also been a challenge due to limited venue locations and member's interest and comfort level with travelling to health education service site. KHS' average class attendance was 6.5 members per class for nutrition classes and 3.3 members per class at asthma classes in 2019. Additionally, KHS offered very few individual counseling sessions for nutrition and asthma with a health educator and services were limited due lack of resources and the availability of the KHS health educators.

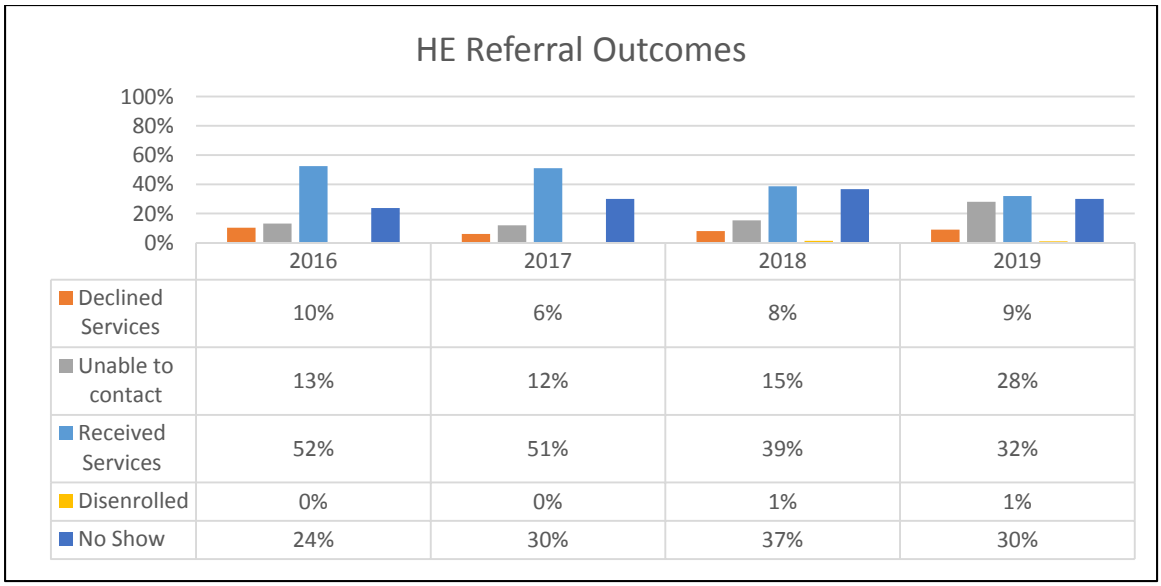
Health Education Utilization

The KHS HE Department processed 4,357 referral requests for health education services in 2019 and weight management, asthma management, and smoking cessation were the top types of referral requests received.[24] Asthma management and smoking cessation referrals increased significantly in 2019 compared to previous years due to targeted outreach performed by KHS HE Department. The rate of members who accepted to receive health education services decreased from 49% in 2018 to 31% in 2019 and the rate of members who declined to receive services increased from 30% in 2018 to 47% in 2019.[24] Referral outcome data revealed a 7 percentage point decrease in the Received Services rate and a 13 percentage point increase in the Unable to Contact rate.[24]



	2016	2017	2018	2019
Accepted Services	36%	53%	49%	31%
Mailed Materials	17%	0%	3%	1%
Not Eligible	1%	1%	1%	1%
Declined Services	23%	25%	30%	47%
Unable to contact	25%	20%	17%	18%
Withdrawn	0%	2%	0%	2%
Deceased	0%	0%	0%	0%

Source: 2019 KHS Health Education Activities Report



	2016	2017	2018	2019
Declined Services	10%	6%	8%	9%
Unable to contact	13%	12%	15%	28%
Received Services	52%	51%	39%	32%
Disenrolled	0%	0%	1%	1%
No Show	24%	30%	37%	30%

Source: 2019 KHS Health Education Activities Report

KHS member health disparities data from DHCS' 2019 Rate Sheet revealed a trend of unfavorable indicator rates among African American KHS members compared to other racial/ethnic groups. African Americans, Asians, and Caucasians were disproportionately overrepresented in claims data for the most prevalent chronic conditions among KHS members. These racial/ethnic disparities may require more in-depth investigations of contributing factors, such as physical characteristics and access to health promoting resources or services in neighborhoods with different social and economic profiles. A better understanding of these contributing factors will lead to evidence-based health promotion and disease prevention program that address top health disparities among KHS members.

Through KHS' health education data collection from class evaluations, member assessments and focus groups, KHS has identified the list of service gaps below. The list below should be explored for consideration and inclusion in future program planning in order to expand and enhance KHS' health education services for its members.

- In-person and virtual educational home visiting programs for chronic condition management.
- Structured programs facilitated by promotores or community health workers that represent targeted racial/ethnic groups.
- Virtual health education classes and individual counseling in lieu of in-person services.
- Expanded member access to digital health education material.
- Group exercise classes, walking groups and gym memberships.
- New incentive programs to encourage participation and adherence with program.
- Educational text message and robocall campaigns.
- Provide childcare and senior care for participants attending in-person classes.
- Social media videos and other digital media content.
- KHS community resource or satellite centers throughout the county.
- Continued enhancement of KHS' corporate website with health education content
- Enhance KHS' Member Portal LiNK to allow members to register for health education services, receive health education communications, and access health education material content.
- Increase promotion and details of KHS health education services and incentive programs and collaborate with community organizations that work directly with KHS members to share information.
- Increase access to health education services through virtual class settings, community partnerships, service contracts, and new venue locations throughout Kern County.
- Explore ways to connect members with internal and external resources to address these complex health problems by working with KHS' Health Homes Program and Case Management Departments, KHS' provider network, and local community-based organizations.
- Work with local policymakers and government officials on ways to plan safer, healthier and more walkable communities.

Quality Improvement Program Gap Analysis

Initial medical record reviews of KHS providers conducted in 2019 by the KHS QI Department found a high fail rate. Twenty-five percent (25%) of the Medical Records Reviews performed passed on the first visit and 75% required additional follow-up.[30] Typically, there are more follow-ups required for Medical Record Reviews.

The QI Department explores opportunities to improve areas on a broader basis for areas with consistent non-compliance.

Facility Site Review deficiencies are listed below:

- No documentation of checking of medication expiration dates, yielding expired medications found in site
- Compliance with annual training required for providers and staff
- Compliance with spore testing for infection control purposes
- No evidence of physician and staff education (child/elder abuse, sensitive services)
- Tracking of referral process thru closures

Medical Record Review opportunities for improvement during quality audits for 2019 are listed below.

- Outreach efforts for missed appointments
- Timely immunizations for children
- Pediatric dental assessment
- Adolescent immunizations
- Vision and hearing screening
- Cervical cancer screening
- TB screening
- Adult immunizations
- Staying healthy assessments
- Pap smear
- STI and chlamydia screening

When looking at the Individual Health Education Behavioral Assessment (IHEBA) monitoring results, KHS providers scored lower in the 4th quarter when compared with previous quarters. Skewed results may have been caused by one KHS provider who had 0 Staying Healthy Assessments (SHA) done for all ten patients reviewed; in addition, there were five other providers who scored below Minimum Performance Level (MPL). Corrective Action Plans (CAPS) were issued and follow up reviews were done.

HEDIS 2019

HEDIS 2019 is a tool used by more than 90 percent of America's health plans, to measure performance on important dimensions of health care and services. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA), a private, not-for-profit organization dedicated to improving health care quality, since 1990.

All Medi-Cal managed care health plans must submit annual measurement scores for the required External Accountability Set (EAS) performance measures. DHCS currently requires all contracted health plans to report selected HEDIS measures to comply with the EAS reporting requirement. The previous calendar year is the standard measurement year for HEDIS data. Therefore, the HEDIS 2019 results shown in this report are based on 2018 data. All Plan Letter 17-014 states that for each measure below the established MPL or with an audit result of "Not Reportable" (NR), the health plan must submit a rapid-cycle improvement and implementation of Plan, Do, Study, Act (PDSA) cycles to increase the potential for improved outcomes within 60 days of being notified by DHCS of the measures for which Improvement Plans (IP) are required. KHS did not meet the MPL for two EAS measures. One was the Asthma Medication Ratio (AMR) and the other was for Well-Child Visits (W34 - ages 3-6 years old).

Hybrid Measures

Measure		Current 2019 Rate	2019 MPL	2019 HPL	2018 KHS Rate	Current Vs. 2019 MPL	Current Vs. 2019 HPL	Current Vs. 2018 KHS
CCS	Cervical Cancer Screening	60.34	54.26	70.68	58.39	6.08	-10.34	1.95
CIS-3	CIS – Combo 3	65.45	65.45	79.56	68.86	0.00	-14.11	-3.41
CDC-E	Eye Exam (Retinal) Performed	56.93	50.85	68.61	58.94	6.08	-11.68	-2.01
CDC-HT	HbA1c Testing	89.13	84.93	92.70	89.60	4.20	-3.57	-0.47
CDC-H9 *	HbA1c Poor Control (>9.0%)	33.15	47.20	29.68	30.66	14.05	-3.47	-2.49
CDC-H8	HbA1c Control (<8.0%)	55.43	44.44	59.49	58.21	10.99	-4.06	-2.78
CDC-N	Medical Attn. for Nephropathy	92.93	88.56	93.43	92.88	4.37	-0.50	0.05
CDC-BP	Blood Pressure Control <140/90	65.58	56.20	77.50	69.89	9.38	-11.92	-4.31
CBP	Controlling High Blood Pressure	54.26	49.15	71.04	58.39	5.11	-16.78	-4.13
IMA-2	Immunizations for Adolescents (Combo 2)	40.63	26.28	46.72	36.74	14.35	-6.09	3.89
PPC-Pre	Timeliness of Prenatal Care	81.27	76.89	90.75	82.48	4.38	-9.48	-1.21
PPC-Pst	Postpartum Care	67.64	59.61	73.97	66.67	8.03	-6.33	0.97
WCC-N	Counseling for Nutrition	70.56	59.85	83.45	63.02	10.71	-12.89	7.54
WCC-PA	Counseling for Phys Activity	65.21	52.31	78.35	57.91	12.90	-13.14	7.30
W-34	Well-Child Visits	63.99	67.15	83.70	66.67	-3.16	-19.71	-2.68

* A lower rate indicates better performance therefore the number of required numerators must decrease by the number shown.

Administrative Measures								
Measure		Current 2019 Rate	2019 MPL	2019 HPL	2018 KHS Rate	Current Vs. 2019 MPL	Current Vs. 2019 HPL	Current Vs. 2018 KHS
AAB**	Avoidance of Antibiotic Treatment	31.33	27.63	44.64	27.63	3.70	-13.31	3.70
AMR	Asthma Medication Ratio	21.49	56.85	71.93	49.80	-35.36	-50.44	N/A
BCS	Breast Cancer Screening	56.57	51.78	68.94	55.98	4.79	-12.37	N/A
CAP-1224	12-24 Months	89.62	93.64	97.71	89.69	-4.02	-8.09	-0.07
CAP-256	25 Months – 6 Years	80.28	84.39	92.88	81.44	-4.11	-12.60	-1.16
CAP-711	7-11 Years	79.9	87.73	96.18	80.88	-7.83	-16.28	-0.98
CAP-1219	12-19 Years	78.35	85.81	94.75	78.84	-7.46	-16.40	-0.49
DSF	Depression Screening and Follow-Up for Adolescents and Adults	0.00	N/A	N/A	0.00	N/A	N/A	N/A
LBP**	Use of Imaging for Low Back Pain	73.33	67.19	79.88	71.59	6.14	-6.55	1.74
MPM-ACE	ACE inhibitors or ARBs	89.71	85.97	92.87	90.19	3.74	-3.16	-0.48
MPM-Diu	Diuretics	90.50	86.06	92.90	89.79	4.44	-2.40	0.71

** Rate for these measures derived by an inverse calculation. The number of required numerators must decrease by the number shown.

Note: For measures shaded in gray, DHCS is not holding MCPs accountable to meet the MPLs for HEDIS Report Year 2019 (Measurement Year 2018).

QI Performance Improvement Projects

Based on the final 2019 rates of HEDIS, two new Performance Improvement Projects (PIPs) were initiated in 2019 and DHCS allowed KHS to incorporate the required rapid-cycle improvement PDSA cycles into those two projects. Those two measures are the Asthma Medication Ratio (AMR) and the W34 Well-Child visits (ages 3-6 years old). IPs are required for both of these measures and are being incorporated into the 2019-2021 PIPs. DHCS has approved this approach. For 2019-2021, KHS has chosen the following PIP topics:

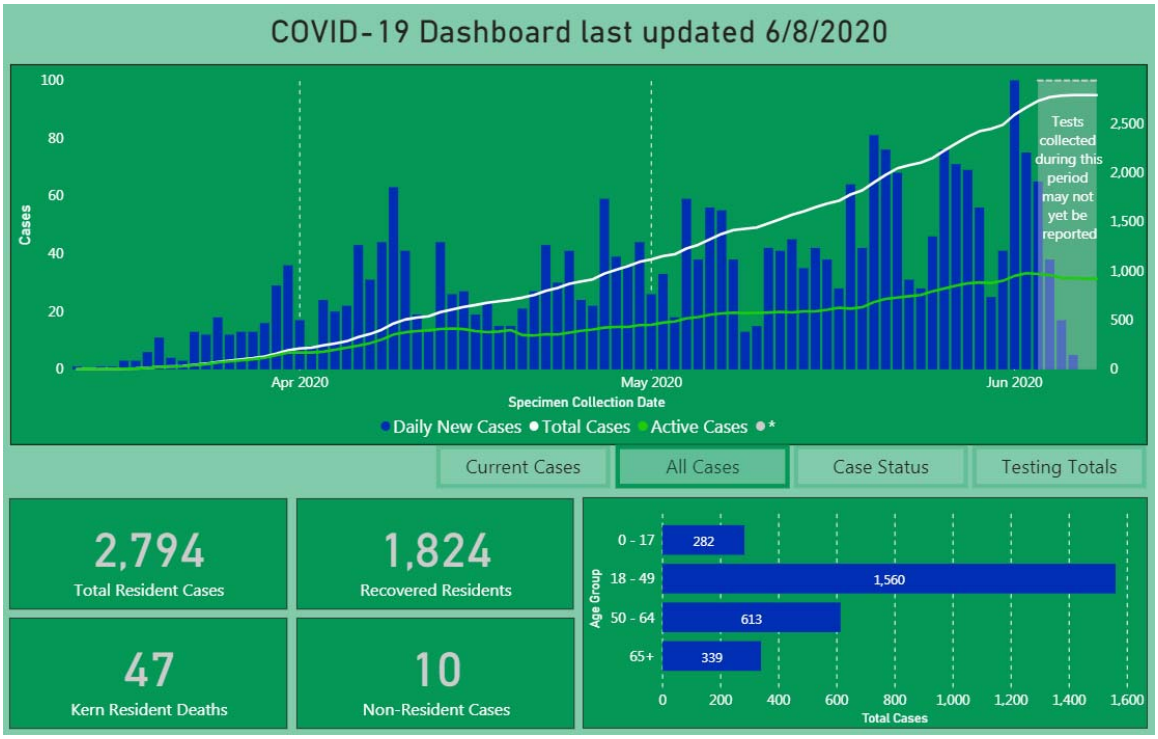
- Disparities in W34 (Well Child Visits on ages 3-6 years old): The proposal for the KHS' Disparities W34 (Well Child Visits on ages 3-6 years old) PIP got accepted by DHCS for 2019-2021 on August 15, 2019. Kern Pediatrics has accepted to partner with us on this PIP to improve member care. Our PIP team is working closely with providers to identify gaps in care and act appropriately to address them.

- Child/Adolescent Health AMR PIP: The proposal for the KHS Child/Adolescent AMR PIP was accepted by DHCS for 2019-2021 on August 30, 2019. Riverwalk Pediatrics and Bakersfield Pediatrics have accepted the invitation to partner with KHS on this PIP project. We will be working with these two Pediatric Providers to identify common areas for improvement in their processes in order to improve our overall HEDIS AMR number. Module 1 was submitted on November 22, 2019. We received feedback from HSAG for some corrections to be made and resubmission is due on January 24, 2020 for Module 1.

Other: COVID-19

A total of 2,794 positive COVID-19 cases and 47 deaths due to COVID-19 have been confirmed in Kern County as of June 8, 2020.[31] The image below, from the Kern County Public Health Services Department (KCPHSD) website summarizes COVID-19 cases since testing began in Kern County. The total number of cases continues to steadily increase.

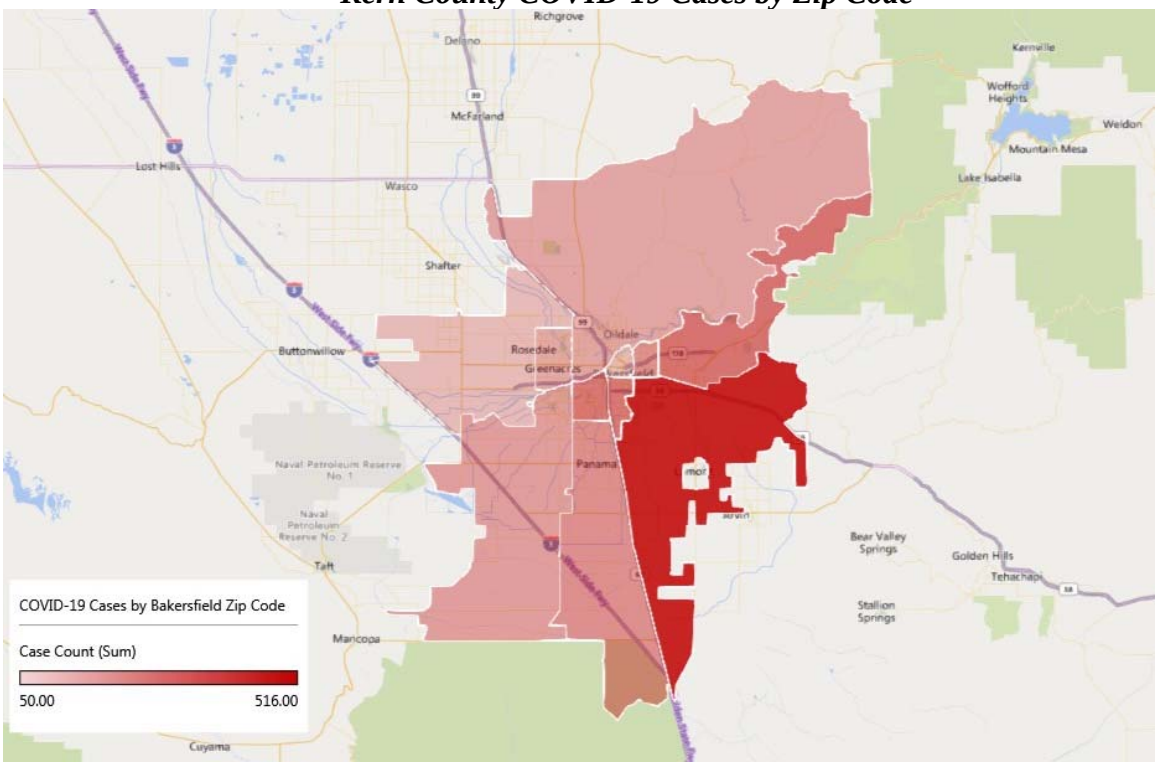
KCPHSD COVID-19 Dashboard



Source: Kern County Public Health COVID-19 Dashboard

In Kern County, 74.8% of COVID-19 cases are in Bakersfield and 65.5% of cases in Bakersfield are in zip codes that are east of California State Route 99. The map below shows that COVID-19 cases in Bakersfield are concentrated in zip codes in the eastern and southern areas of Bakersfield. Zip codes with a darker red color have more cases.

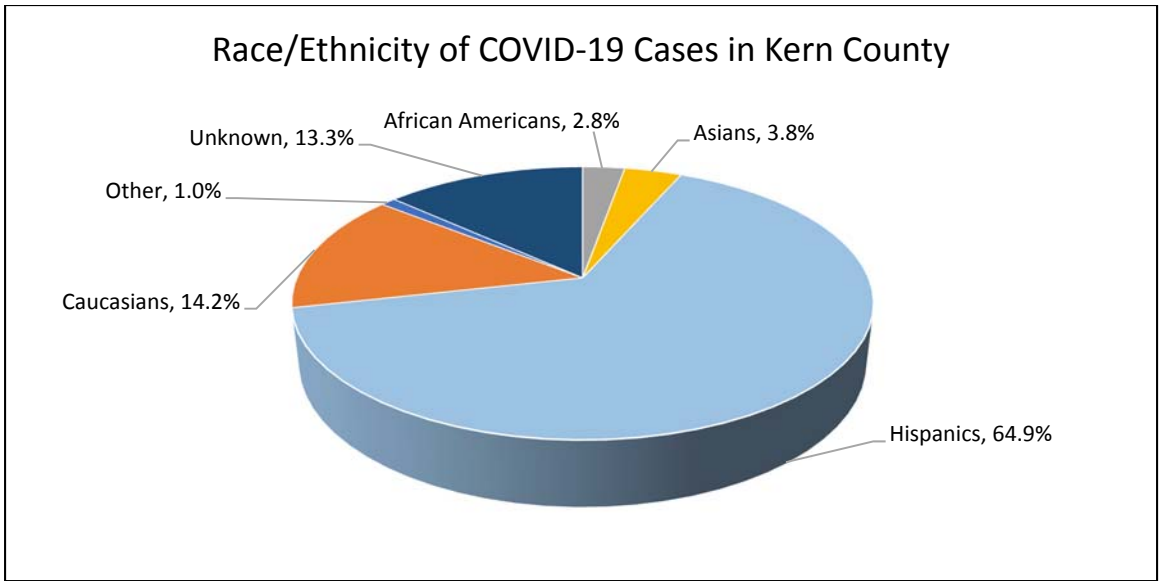
Kern County COVID-19 Cases by Zip Code



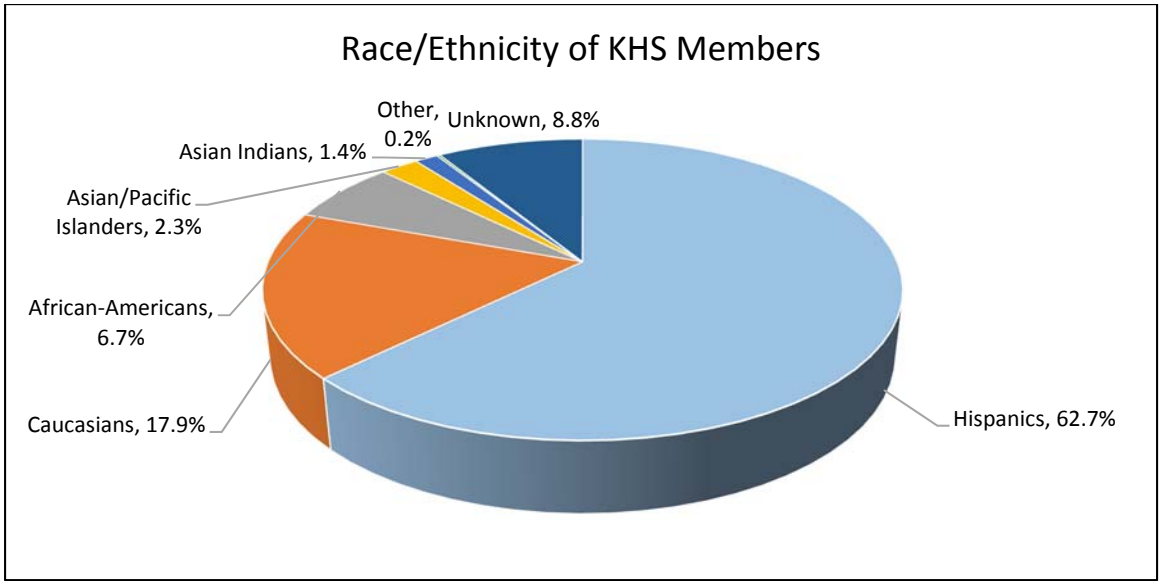
Source: Kern County Public Health COVID-19 Dashboard

The effects of COVID-19 on the health of racial and ethnic minority groups is still emerging. However, current data suggest there is a disproportionate burden of illness and death among racial and ethnic minority groups.[32] COVID-19 cases in Kern County are following this nationwide health disparity and appear to be disproportionately higher among Hispanics than Caucasians. Hispanics account for the largest proportion of cases (64.9%), followed by Caucasians (14.2%), and Unknown (13.3%), and Asians (3.8%), African Americans (2.8%), and Other (1.0%).[31] When looking at the overall Kern County racial/ethnic profile, Hispanics are 54.0% of the population, followed by Caucasians (33.5%), African Americans (6.3%), Asians (5.4%), and American Indians and Alaska Natives (2.6%).[33]

The racial/ethnic breakdown of COVID-19 cases in Kern County is similar to the racial/ethnic profile of KHS members. The exception appears to be African Americans, where their proportion of COVID-19 cases in Kern County is lower than their share of the KHS member population. This may change as more Kern County residents are tested.



Source: Kern County Public Health COVID-19 Dashboard

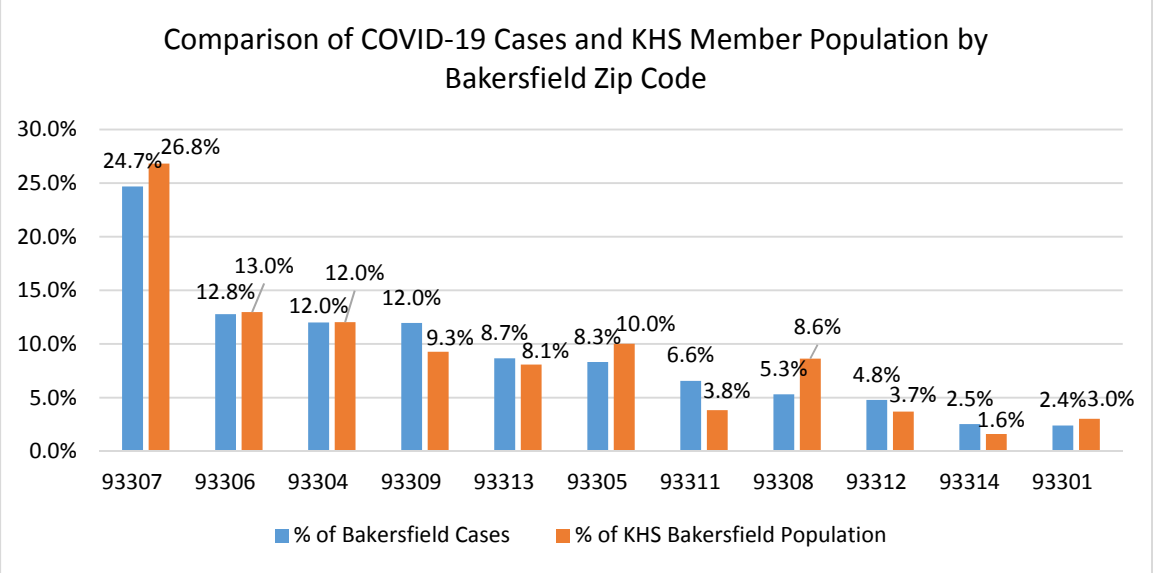


Source: 2019 KHS Member Demographics Data Report

A comparison of Kern County COVID-19 cases by zip code reveals a resemblance to the distribution of KHS members by zip code. The distribution of COVID-19 cases in the top three Bakersfield zip codes is very similar to the distribution of KHS members in the same zip codes.

Bakersfield Zip Code	Population	COVID-19 Case Count	% of Bakersfield Zip Code Cases	KHS Member Population	% of KHS Bakersfield Population
93307	84,948	516	24.7%	45,697	26.8%
93306	70,208	267	12.8%	22,105	13.0%
93304	50,787	251	12.0%	20,490	12.0%
93309	60,893	250	12.0%	15,809	9.3%
93313	51,245	181	8.7%	13,756	8.1%
93305	39,114	174	8.3%	17,069	10.0%
93311	44,862	137	6.6%	6,530	3.8%
93308	54,042	111	5.3%	14,709	8.6%
93312	59,359	100	4.8%	6,295	3.7%
93314	26,992	53	2.5%	2,726	1.6%
93301	12,345	50	2.4%	5,151	3.0%

Sources: Kern County Public Health COVID-19 Dashboard; 2019 KHS Member Demographics Data Report



Sources: Kern County Public Health COVID-19 Dashboard

COVID-19 is likely to disproportionately impact the KHS population compared to the overall county population. KHS members have lower incomes and are more likely to be racial or ethnic minority groups compared to the overall Kern County population. COVID-19 is likely to continue to be a burden for KHS members as they may be less likely to have the option to work from home and limit exposure to the coronavirus. They may be more likely to be or live with essential workers who interact with the general public.

The shelter-in-place mandate due to the COVID-19 pandemic has created significant gaps in KHS' ability to offer health education and cultural and linguistic services to KHS members and its provider network. Although KHS is currently not able to offer any in-person health education services, KHS has used this time as an opportunity to test out virtual health education sessions with members. KHS anticipates that members will be reluctant to attend in-person group classes due to COVID-19 concerns and fears. A survey among KHS' PP/CAC identified virtual health education classes as the primary service that would be most effective with KHS members and in-person classes as being the least effective. KHS will continue to expand its virtual health education services as member demand increases. For members who do not have access to a smart device, limited internet access, or are technologically challenged, KHS will need to continue to look for options that address this health education service gap.

V. Action Plan

Objective 1: *By May 2023, there will be a 5% increase in the percentage of newly enrolled members and members aged 0-15 months, 3-6 years and 12-21 years accessing preventive care services as measured by the W15, W34 and AWC MCAS measures and KHS' IHA Completion rate.* **Data Source:** *(RY 2019 HEDIS Data, KHS Claims Data, 2019 DHCS Health Disparities Rate)*
Strategies
1. Implement member rewards programs that encourage members to see their PCP for a wellness exam at age appropriate intervals.
2. Create a member and provider communication and outreach plan, timeline and calendar to promote the importance of wellness exams and member rewards programs through all KHS communication channels, health education classes, community partners and KHS' provider network.
3. Procure an Interactive Voice Response (IVR) solution to assist with performing member outreach through automated calls on preventive care and gaps in care.
4. Partner with schools, network providers and School Wellness Centers to bridge the gap in member's access to preventive care services.
5. Obtain member feedback on the member rewards program, reward interests and barriers to accessing preventive care services that is inclusive of cultural beliefs on accessing care.
6. Show gaps in care to members through the Member Portal
7. Provide visibility to gaps in care to all member facing staff and KHS' provider network.
8. Create monthly reports for each new rewards program to monitor and track member participation and effectiveness of the rewards program.
9. Develop a program evaluation plan, methodology and timeline for the member rewards program.
10. Develop and distribute a MCAS Provider Booklet that explains each MCAS measure for MY 2020 and offer tips for staying compliant.

Objective 2: *By June 2021, increase the percentage of African American members who receive all recommended childhood immunizations by the age of 2 years from 41% to 46%.* **Data Source:** *(RY 2019 HEDIS Data, 2019 DHCS Health Disparities Rate Sheet)*
Strategies
1. Partner with local community based organizations, such as the Black Infant Health program, to encourage and educate parents on the importance of completing childhood immunizations for members under 2 years of age.
2. Create an outreach script and leverage KHS' IVR solution to send automated childhood immunization reminder calls to African American member households with a member under 2 years of age.
3. Identify and develop outreach material that connects African American members to childhood immunizations.
4. Distribute preventive care guides and well-baby reward postcards and posters to family resource centers and community programs and at community events that focus on the African American population.

5.	Identify geographic areas within the county that have a high concentration of African American members and work with the providers in these areas to distribute outreach and educational material.
6.	Distribute a provider bulletin on the health disparity correlation between African Americans and childhood immunizations.
7.	Include an article in the Spring 2021 member newsletter that provides resources on where to obtain childhood immunizations.
8.	Coordinate social or mass media messaging on childhood immunizations during national observances, such as Black History Month and World Children's Day.

VI. Stakeholder Engagement

KHS' PP/CAC is comprised of members and representatives from the county's Department of Human Services, KCDPHS, Family Resource Centers, and the Center for Gender Identity and Sexual Diversity. The PP/CAC was engaged to provide input on KHS' PNA through an online and telephonic survey on the current issues impacting the community, major challenges KHS members face when accessing services, suggestions on how to encourage participation in preventive care screenings and health education services, and how to improve KHS' understanding of the diverse cultural and linguistic needs of KHS members. Due to the COVID-19 pandemic, KHS was limited in its ability to obtain in-person feedback from the PP/CAC and other community groups.

The PNA findings and action plan 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 and action plan through the KHS website, provider portal and provider bulletin. Providers will be encouraged to contact KHS' Director of Health Education, Cultural and Linguistic Services for additional information, questions and comments.

References

[1] Kern Health Systems, Business Intelligence Department, 2020. 2019 KHS Member Demographics Data Report.
[2] U.S. Census Bureau, 2020. Data derived from Population Estimates, Demographic and Housing Estimates, and Social Characteristics in the United States. Retrieved from www.census.gov on 4/3/2020.
[3] The Williams Institute, 2019. Data derived from LGBT Data and Demographics. Retrieved from https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#density on 5/1/2020.
[4] The Williams Institute, 2015. The LGBT Divide in California: A look at the socioeconomic well-being of LGBT people in California.
[5] Kern Health Systems, Business Intelligence Department, 2020. 2019 HHP Member Demographics Data Report.
[6] Kern Health Systems, Case Management Department, 2020. 2016-2020 Case Management Homeless Member List.
[7]California Department of Public Health, 2019. California's County Health Status Profiles for 2019. Retrieved from https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CountyProfiles_2019.pdf on 4/3/2020.
[8] Kern County Public Health Services Department, 2019. Community Health Assessment and Improvement Plan 2018-2019.
[9] Kern Health Systems, Business Intelligence Department, 2020. 2019 Top 5 Diagnoses for ER, UC, Outpatient, and Inpatient Claims.
[10] Kern Health Systems, Advice Nurse Line, 2019. Kern Health Systems Nurse Line Year in Review Report.
[11] Kern Health Systems, Advice Nurse Line, 2019. Kern Family Health Care Total Population Program Summary Report.
[12] Kern Health Systems, Business Intelligence Department, 2020. 2019 All Population Chronic Condition Population Analysis Report.
[13] Kern Health Systems, Pharmacy Department, 2020. 2019 KHS Member Medication Filled.
[14] Kern Health Systems, Business Intelligence Department, 2020. 2019 Depression Chronic Condition Population Analysis Report.
[15] Kern Health Systems, Business Intelligence Department, 2020. 2019 Bipolar Disorder Chronic Condition Population Analysis Report.
[16] Kern Health Systems, Business Intelligence Department, 2020. 2019 Schizophrenia Chronic Condition Population Analysis Report.
[17] Kern Health Systems, Business Intelligence Department, 2020. Tobacco Registry Report, March 2019.
[18] California Smokers' Helpline, 2020. Demographic and health data for Medi-Cal Health Plan clients who received CSH services in 2019. Data sent from CSH by email on April 7, 2020 to the Department of Health Care Services Health Education, Culture, and Linguistics Workgroup.
[19] Kern Health Systems, 2020. 2019 Member Satisfaction Survey Report.
[20] Health Services Advisory Group, Inc (2019). 2019 CAHPS 5.0H Adult Medicaid Survey.
[21] Health Services Advisory Group, Inc (2019). 2019 CAHPS 5.0H Child Medicaid Survey.
[22] Kern Health Systems, Grievance Department, 2020. 2019 Grievance Operational Board Report.
[23] Kern Health Systems, Grievance Department, 2020. 2019 KHS Grievance Summary Reports.
[24] Kern Health Systems, Health Education Department, 2020. 2019 Health Education Department Annual Activities Report
[25] Kern Health Systems, Cultural & Linguistics Department, 2020. 2019 Interpreter Access Survey Results Report.
[26] Kern Health Systems, Provider Relations Department, 2020. 2019 Provider Network Management Network Review Reports.
[27] California Department of Health Care Services, 2020. Reporting Years 2018 and 2019 California DHCS Disparities KFHC Rate Sheets. The data was compiled by the Health Services Advisory Group, Inc. The data was accessed from HSAG's FTP site.
[28] Kern Health Systems, Transportation Department, 2020. 2019 Transportation Benefit Summary.
[29] Kern Health Systems, Public Policy/Community Advisory Committee, 2020. 2020 Population Needs Assessment Survey Summary.
[30] Kern Health Systems, 2020. Regular Meeting of the QI/UM Committee Kern Health Systems (2019-2020). KHS Quality Improvement Department Summary Reports for Q1, Q2, Q3, and Q4 of 2019. Available online at: https://www.kernfamilyhealthcare.com/about-us/committees/.

[31] Kern County Public Health Services Department, 2020. Kern County Public Health COVID-19 Dashboard. Retrieved from kernpublichealth.com on 6/8/2020.
[32] Centers for Disease Control and Prevention, 2020. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html on 6/8/2020.
[33] U.S. Census Bureau, 2020. Data derived from Population Estimates, Demographic and Housing Estimates, and Social Characteristics in the United States. Retrieved from www.census.gov on 4/3/2020.