Population Needs Assessment Report

October 2024

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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 as the local initiative health plan. As of April 22, 2024, KHS provides services to 407,320 Medi-Cal Managed Care beneficiaries in Kern County.

The goal of the 2024 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.

The KHS 2024 PNA builds upon previous needs assessments and uses various data collection methods and sources. Total KHS membership and demographics in 2023 changed slightly compared to 2022 data. KHS membership grew by 11.7%. The adult share of KHS membership grew slightly from 58.0% in 2022 to 61.1% in 2023. The female shares of members decreased slightly from 53.9% to 53.8%. Hispanic/Latinos represent most members (63.0%), and English is the most common primary language (69.2%). Most members live in Bakersfield (54.5%) where the highest concentration of members is in the 93307-zip code (11.9%). The share of Seniors and Persons with Disabilities (SPD) increased from 6.5% in 2022 to 7.5% in 2023. The population of members who were identified as homeless increased to 15,595 in 2023, up 12.6% compared to the previous year.

The most commonly diagnosed health problems among KHS members excluding SPDs in 2023 included acute infections, acute illness or symptoms, routine child health exam, abdominal pain, chest pain, headache, poisoning, morbid obesity, heart disease, hypertension, type 2 diabetes, constipation, chemotherapy, and immunotherapy. The top diagnoses among SPDs included abdominal pain, chest pain, acute infections, COPD, end stage renal disease, type 2 diabetes, chemotherapy, preprocedural exams, schizophrenia, autism spectrum disorder, and hypertension.

Lipid metabolism disorder, hypertension, persistent asthma, diabetes, and low back pain were found to be the top five chronic conditions according to claims data. Review of KHS' pharmaceutical utilization identified ibuprofen as the most prescribed medication followed by atorvastatin, amoxicillin, albuterol HFA, and vitamin D2.
Mental health diagnoses for depression, bipolar disorder and schizophrenia were found to be more prevalent among females, English-speakers, and adult members. When comparing racial and ethnic groups, depression and bipolar disorders were most prevalent among White members whereas Native American members had the highest share of members with schizophrenia.

The top advice nurse line call reasons in 2023 included symptom check, followed by health plan and other general health question. The most frequent symptoms for inbound symptom check calls were pregnancy-related problems, followed by abdominal pain, fever, respiratory problems, and nausea and vomiting.

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 2023, anxiety and high blood pressure were identified as the top behavioral and physical health conditions, respectively.

Requests for qualified interpreters increased by 46.4% from 2022 to 2023. When looking at interpreting requests by modality excluding American Sign Language (ASL) requests, in-person requests increased by 24.2%, phone interpreting requests increased by 49.0%, video remote interpreting (VRI) requests increased by 1,060.0%. ASL interpreting requests increased by 18.5%. Among spoken languages, Spanish continued to be the most requested language, followed by Punjabi, Cantonese, Arabic, and Korean.

In 2023, provider survey results found that 98.9% of provider offices were compliant with the Emergency Access Standards and 97.9% were compliant with the Urgent Care Access Standards. In addition, 92.5% of providers surveyed were compliant with language interpreting access standards. Findings also revealed that 84.7% of primary care providers were accepting new members.

The results of MY 2022 KHS Adult CAHPS Simulation Survey Member Satisfaction Survey found that rates improved compared to the MY 2021 survey for all measures included in this PNA except getting routine care. 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”.

KHS resumed offering in-person health education programs in April 2023 after pausing them during the pandemic. KHS continues to offer health education programs in both in-person and virtual environments. Referrals for health education services decreased by 16.2% from 2022 to 2023. In 2023, weight management education was the top referral topic, followed by smoking/tobacco cessation education, asthma education, other nutrition education, and diabetes 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 increased from 42.3% in 2022 to 44.1% in 2023. The rate of members who declined health education services decreased from 36.8% in 2022 to 28.9% in 2023. 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 increased from 40.4% in 2022 to 50.4% in 2023. The portion of referrals that were closed with a “No Show” outcome (did not attend any program sessions) increased from 23.8% in 2022 to 29.5% in 2023. KHS nutrition education programs continued to be the most popular request for health education services in 2023. This was followed by asthma, tobacco cessation and diabetes prevention.

In 2024, 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 2024 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, Kern County Public Health Services Department Community Health Assessment and Improvement Plan, Kern County Health Status Profile, and Kick It California.

Consumer Assessment of Healthcare Providers Survey (CAHPS) Data
KHS' Adult and Child Medicaid CAHPS Survey results for Measurement Years (MY) 2022 and MY 2023 were reviewed to assess areas of improvement among plan and provider services.

MY 2022 KHS CAHPS Simulation Survey (Member Satisfaction Survey)
KHS administered its annual member satisfaction survey by mail and telephonically to all adult KHS members in late 2023 and early 2024. A total of 450 surveys were collected which yielded a 10.8% response rate. Female members accounted for 71.6% of all respondents. The largest age group included the ages of 55 and older, which accounted for 36.3% of respondents. Hispanics/Latinos were the largest racial/ethnic group at 46.1% of respondents.

California Department of Health Care Services (DHCS) Data Health Disparities Data
KHS' Health Disparities Rates for MY 2022 provided by DHCS were reviewed to assess health status and disease prevalence among KHS' membership and within race/ethnic groups.

Managed Care Accountability Set (MCAS) Data
KHS' MCAS rates for MYs 2022 and 2023 were used to assess indicators of member's health care.

2022 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 member key demographic and health statistics and identify changes from 2022 to 2023. 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 year 2023 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 2022 and 2023 were reviewed to identify call frequency and the top reasons for the calls.

KHS Departmental Reports
The 2023 KHS Health Education Activities Report was reviewed to identify trends in need for health education services and allows projections for program development. 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 data for 2022 and 2023. KHS' grievance, transportation and provider network management reports were reviewed to identify access to care concerns among members.

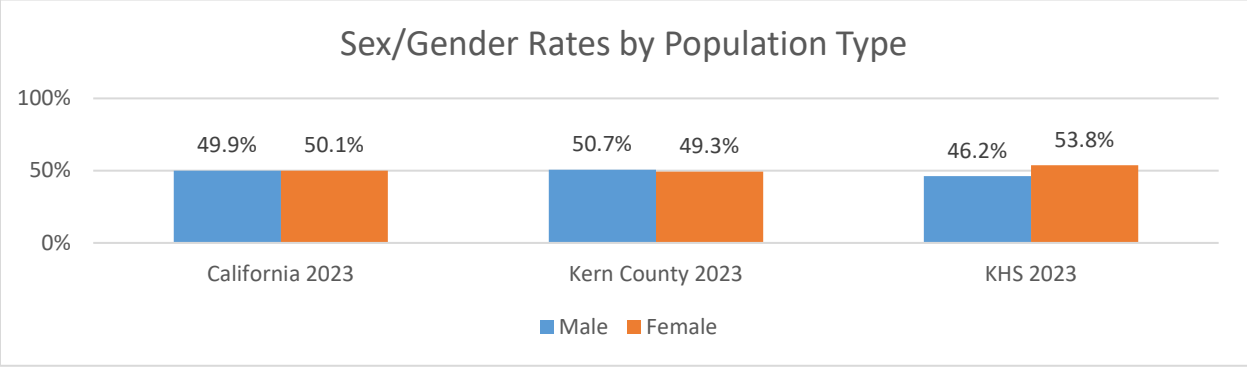
III. Key Data Assessment Findings

Membership/Group Profile

According to KHS' membership statistics, 392,166 Medi-Cal managed care members enrolled in the plan in 2023.[1] This was an 11.7% increase in total annual membership compared to 350,984 members in 2022. KHS member enrollment in 2023 was over one third of the population of Kern County.[2] 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
Population	39,029,342	916,108	392,166
Male (%)	49.9%	50.7%	46.2%
Female (%)	50.1%	49.3%	53.8%

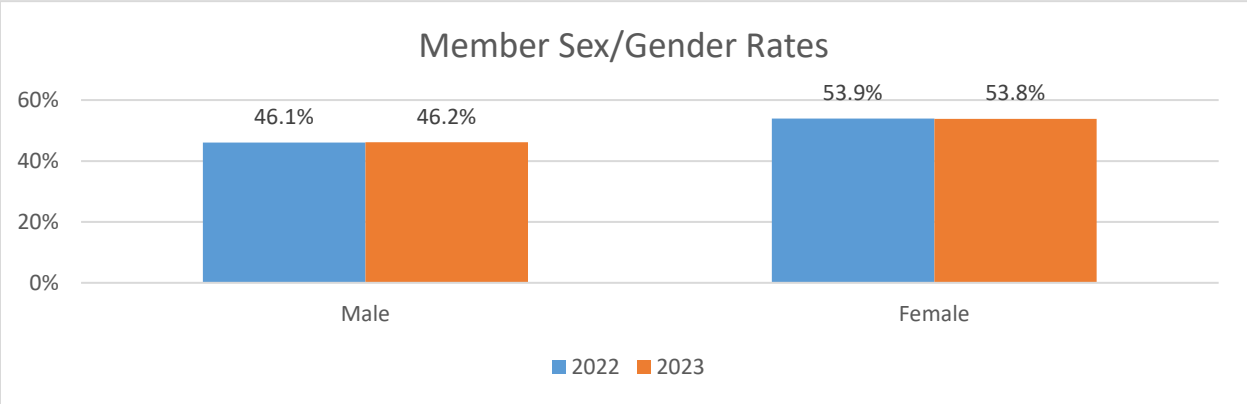
Source: KHS Member Demographics Data Report; U.S. Census Bureau



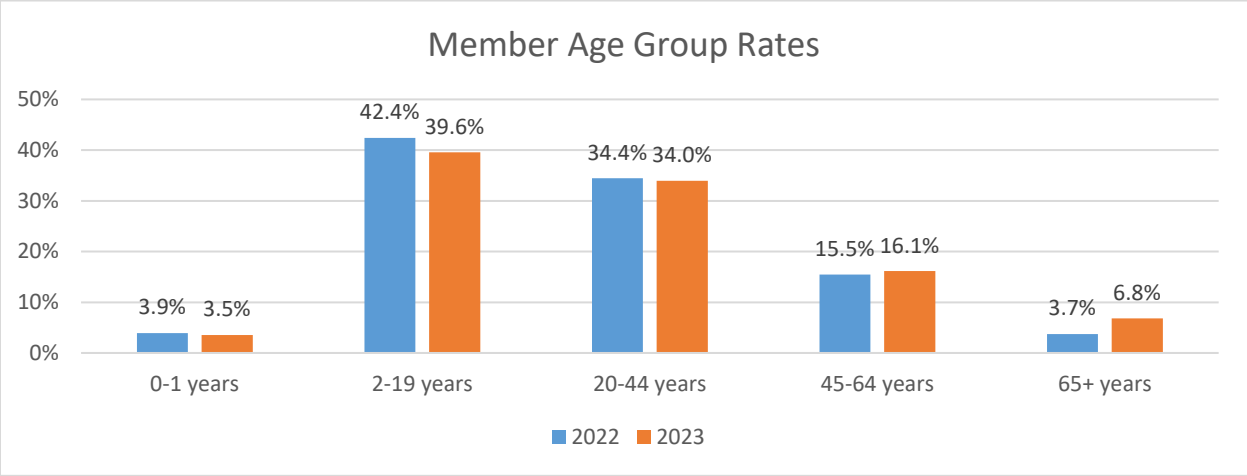
Source: KHS Member Demographics Report; U.S. Census Bureau

When looking at changes in member populations by age group, children, adolescents, and seniors changed the most. The percentage of members 0-19 years old decreased from 46.3% in 2022 to 43.1% in 2023.[1] The proportion of members 20-64 years old increased marginally from 49.9% to 50.1%. For members 65 years and older, that figure increased from 3.7% to 6.8%.[1] When looking at change in member population total, the number of members 0-19 years old increased by 3.9% from 2022 to 2023, compared to a 12.2% increase for members 20-64 years old 65 years and a 102.8% for members 65 years and older. For comparison, 28.4% of the Kern County population is under 18 years old and 11.8% are 65 years and older.[2] At the state level, 21.8% of the population is under 18 years old and 15.8% are 65 years and older.

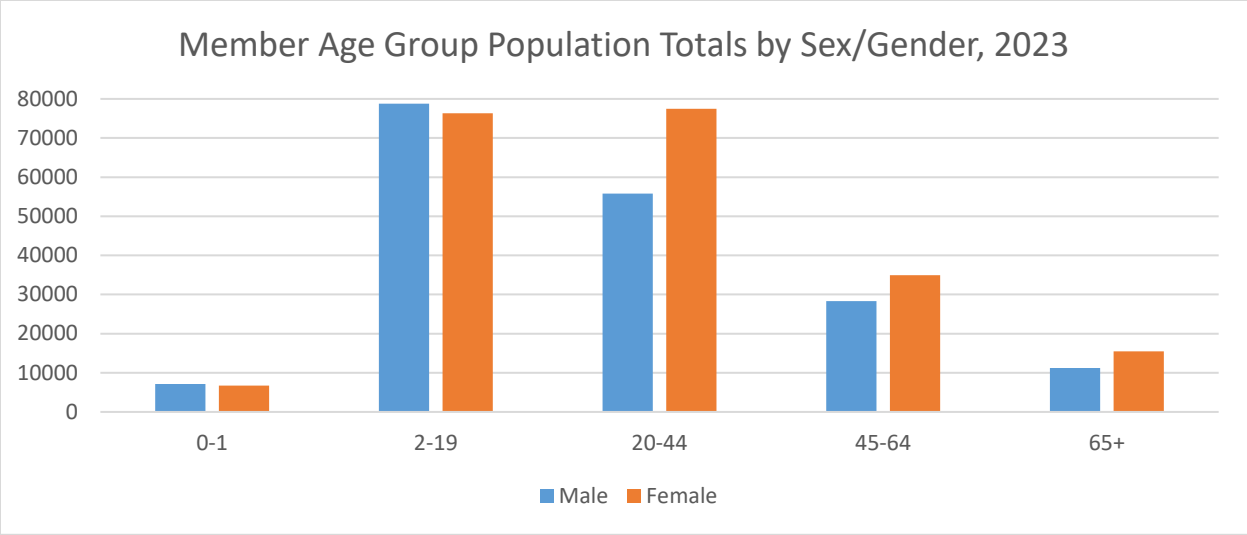
According to The Williams Institute, 5.5% of the U.S. adult population and 5.1% of California's adult population identify as Lesbian, Gay, Bisexual, Transgender (LGBT).[3] KHS does not currently collect or report on LGBTQ+ data of members.



Source: KHS Member Demographics Report

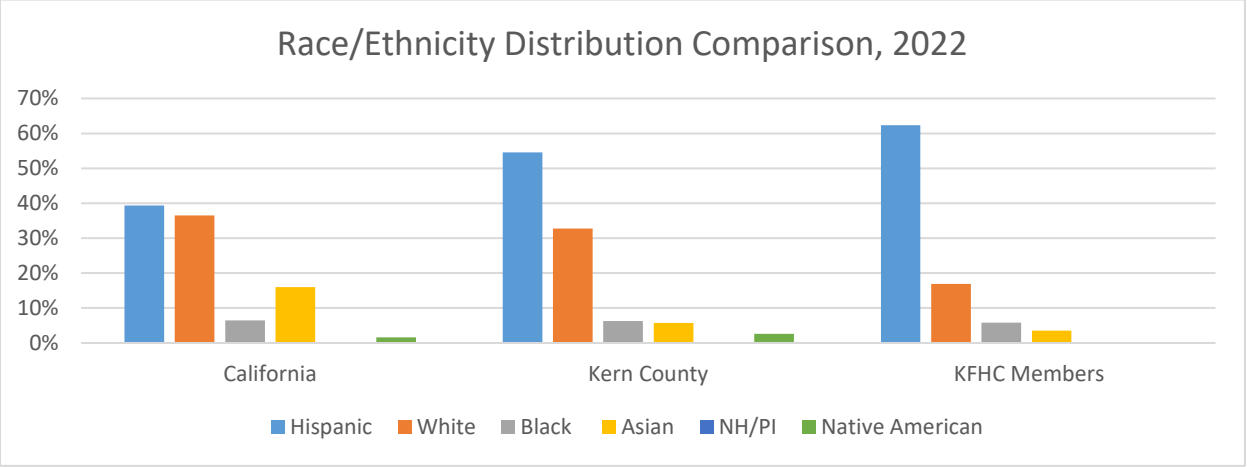


Source: KHS Member Demographics Report

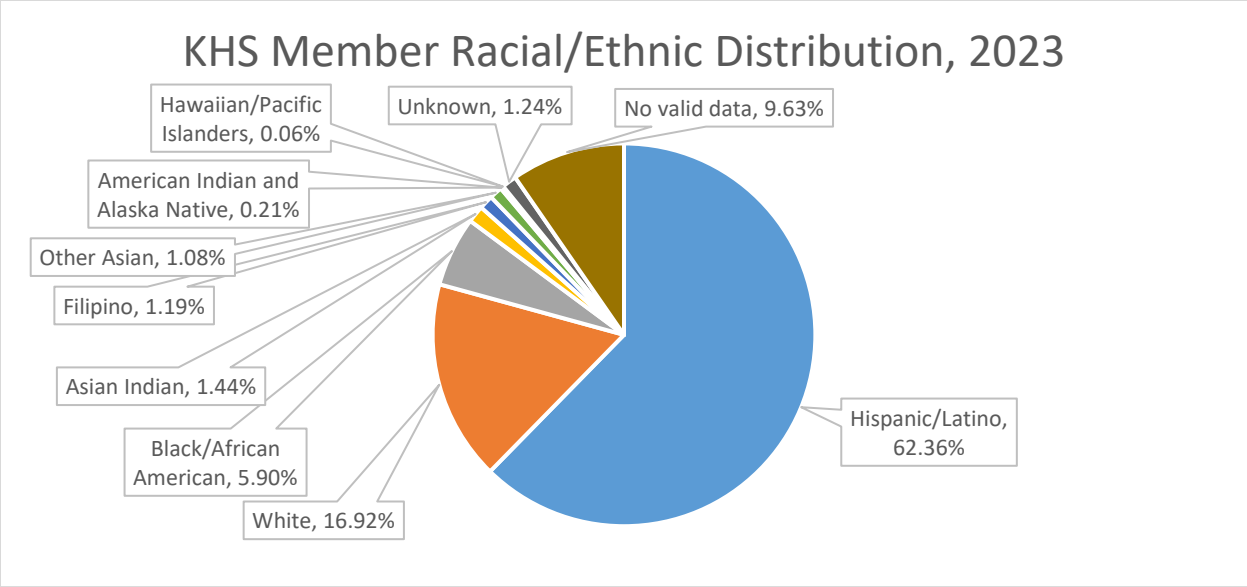


Source: KHS Member Demographics Report

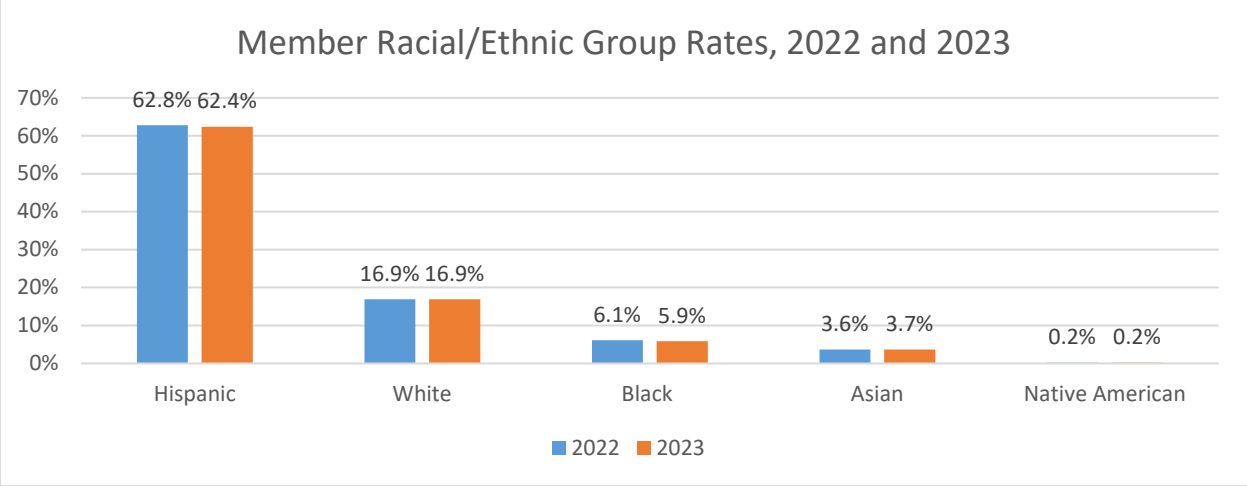
Hispanic/Latinos continue to be the largest racial/ethnic group among KHS members, accounting for most of the membership (62.4%). They are followed by Whites (16.9%), Black/African Americans (5.9%), Asians/Pacific Islanders (3.8%), and other races/ethnicities. The racial/ethnic makeup of KHS members in 2023 was very similar to 2022. For comparison, data reported in the U.S. Census Bureau in 2022 shows that 56.8% of Kern County and 40.3% of California residents are Hispanic/Latino, followed by White (KC-30.4%, CA-38.9%), Black/African American (KC-5.1%, CA-5.4%), Asian/Pacific Islander (KC-5.1%, CA-15.9%), and Native American (KC-.6%, CA-1.6%).[2]



Source: KHS Member Demographics Report; US Census Bureau

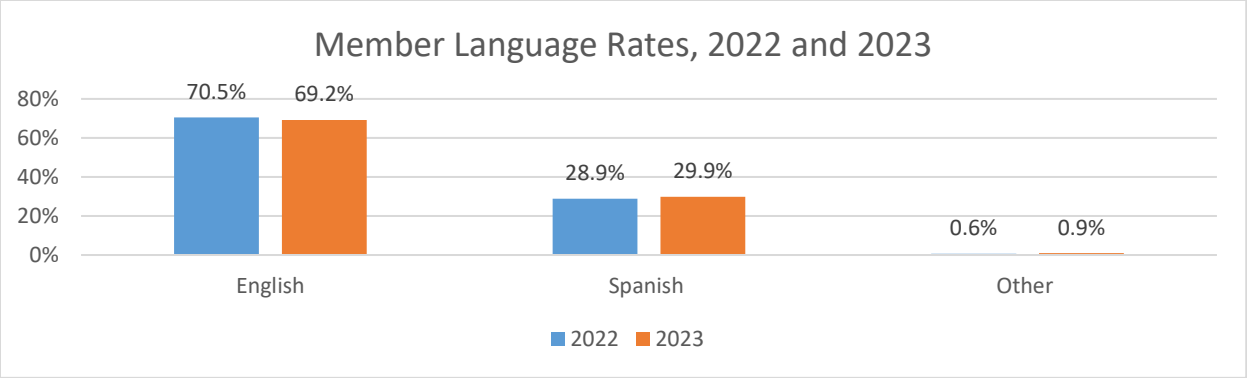


Source: KHS Member Demographics Data Report



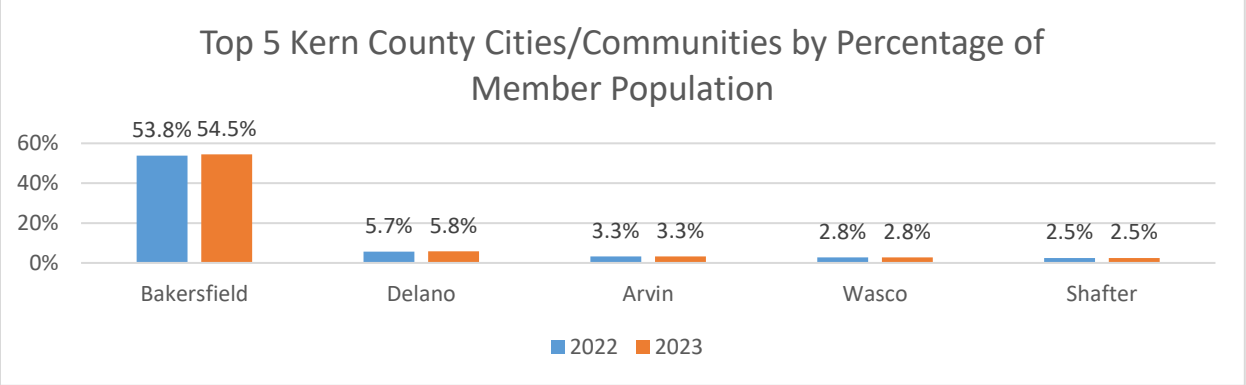
Source: KHS Member Demographics Data Report

In 2023, 69.2% of KHS members were English-speaking, while 29.9% were Spanish-speaking and 0.9% spoke a language other than English or Spanish.[1] This language profile changed slightly compared to 2022, where 70.5% of members spoke English, 28.9% spoke Spanish, and 0.6% 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.[2] This is followed by Spanish (KC-39.9%, CA-28.3%), and other languages (KC-6.1%, CA-16.1%).



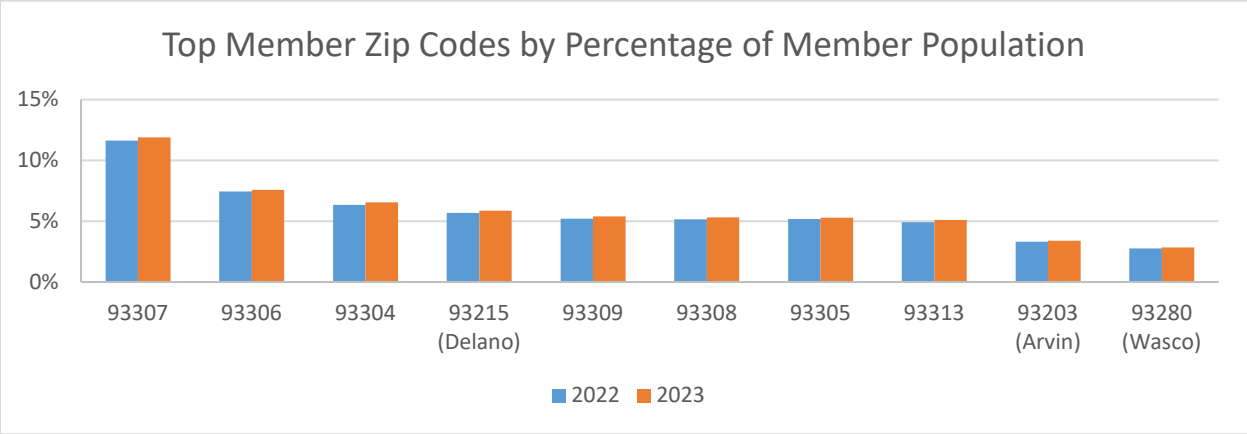
Source: KHS Member Demographics Data Report

In 2023, the majority of KHS' members lived in Bakersfield (55.5%), Delano (5.9%), Arvin (3.4%), Wasco (2.8%), and Shafter (2.5%).[1] The population total in each of the top 5 Kern County cities or communities increased from 2022 to 2023. The biggest change in share of the Kern County population occurred in Bakersfield, which had a 0.7%-point increase.



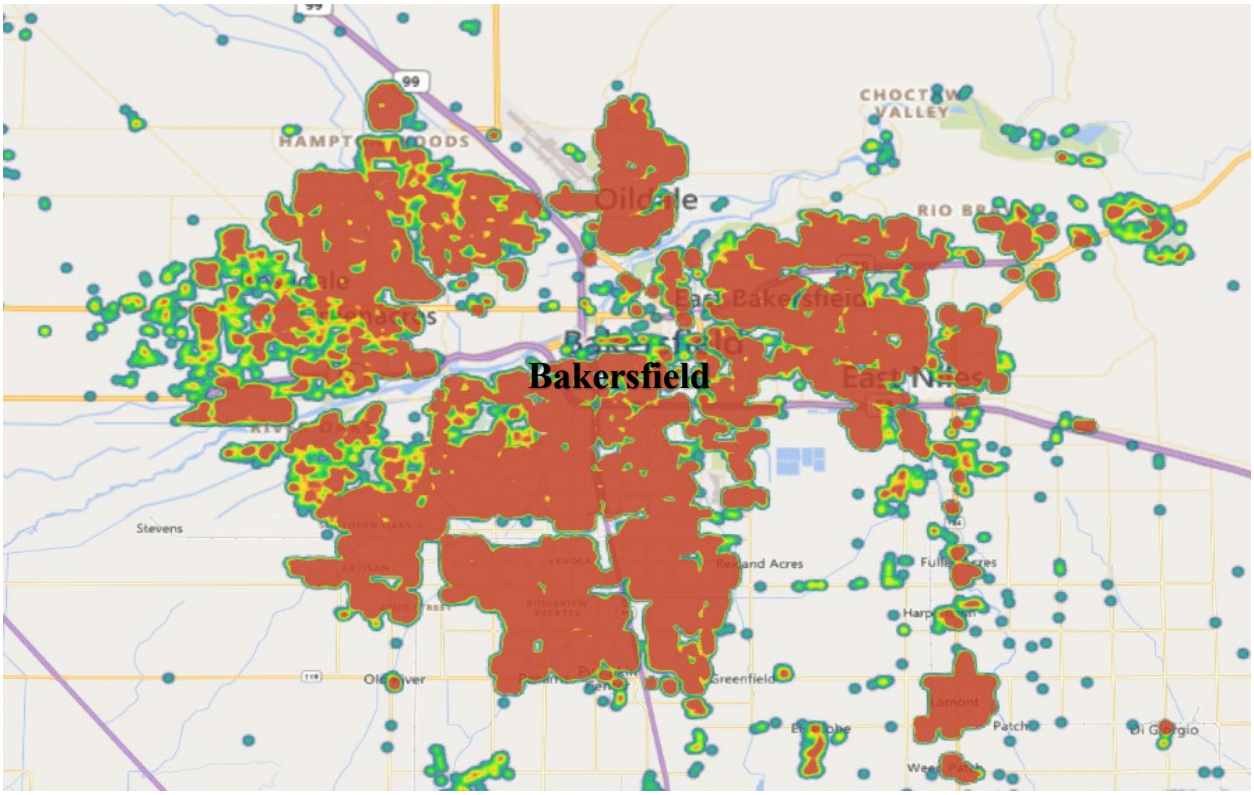
Source: KHS Member Demographics Data Report

In Bakersfield, the highest concentration of KHS members was in the 93307-zip code (11.9%), followed by 93306 (7.6%), 93304 (6.5%), 93309 (5.4%), and 93308 (5.3%). The 2022 data were very similar, with 11.6% of members in 93307, 7.5% in 93306, 6.4% in 93304, 5.2% in 93309, and 5.2% in 93308.



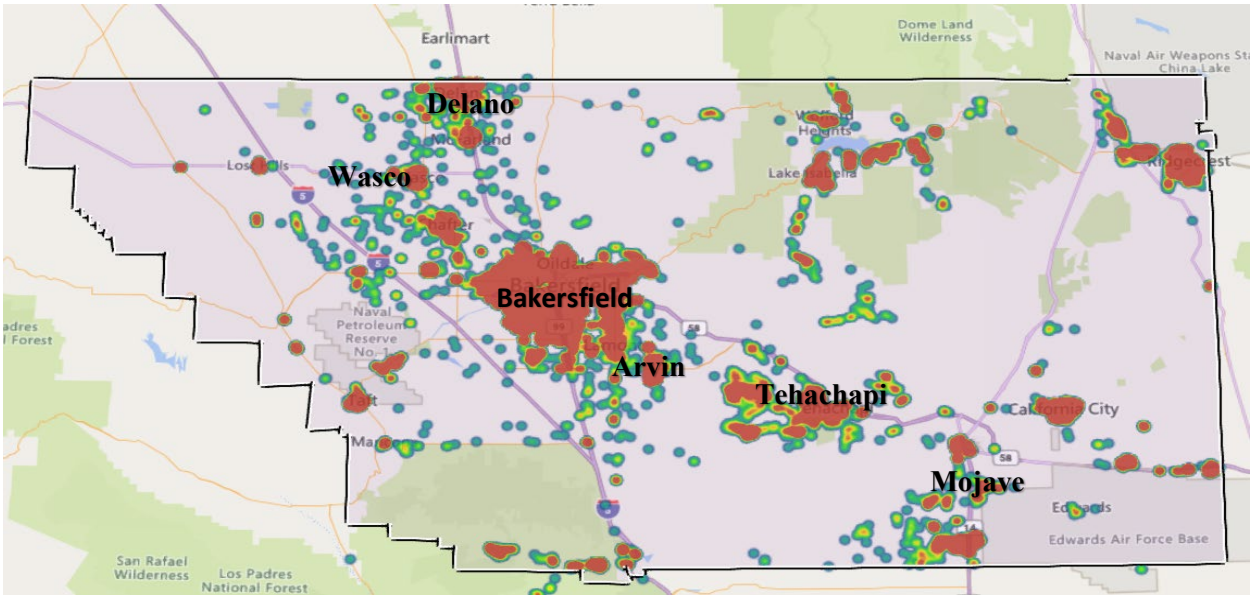
Source: KHS Member Demographics Data Report

Distribution of KHS Membership in Bakersfield, 2023



Source: KHS Member Demographics Data Report

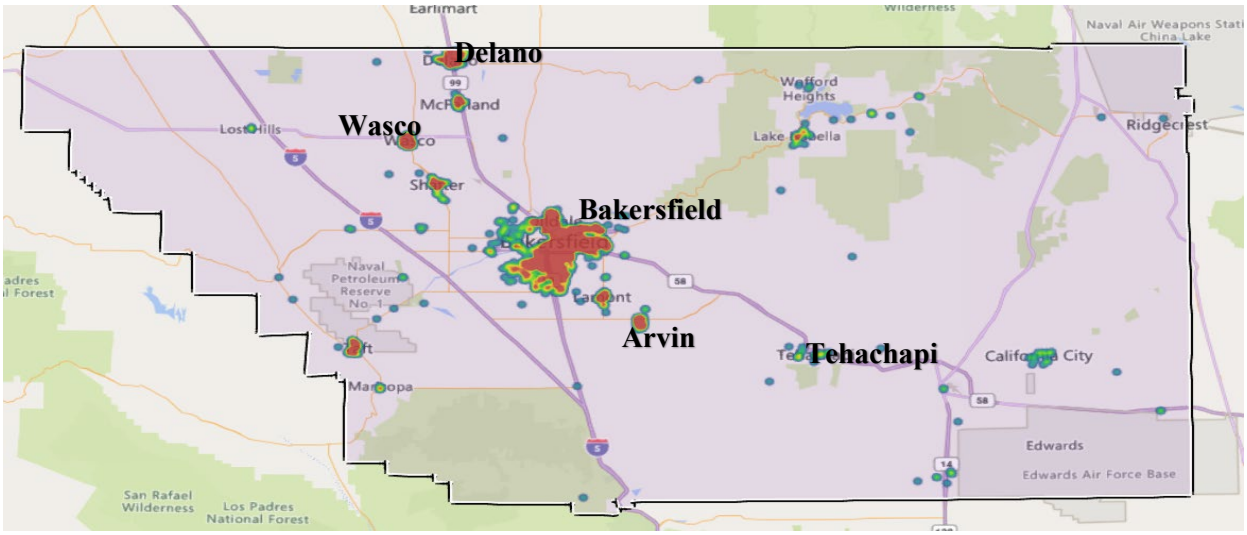
Distribution of KHS Membership in Kern County, 2023



Source: KHS Member Demographics Data Report

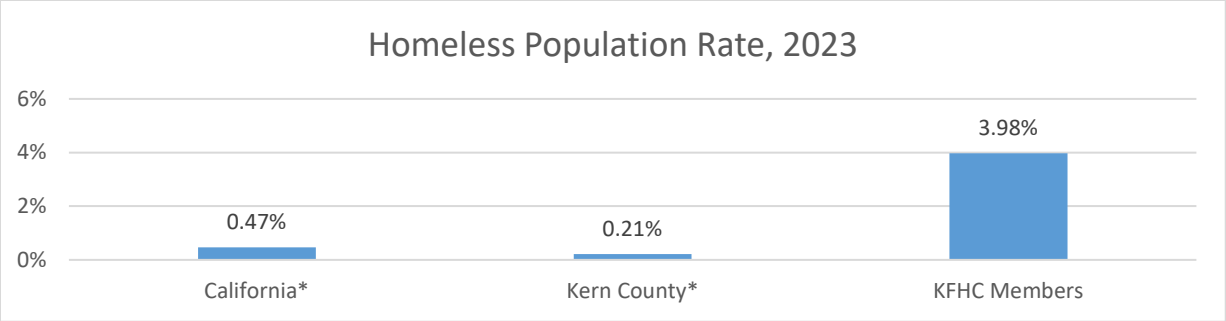
The population of seniors and persons with disabilities (SPDs) among members was estimated to be 29,526 members in 2023, a 29.9% increase compared to 22,731 members in 2022. SPDs accounted for 7.5% of members in 2023, up from 6.5% in 2022.

Distribution of KHS SPD Membership in Kern County, 2023



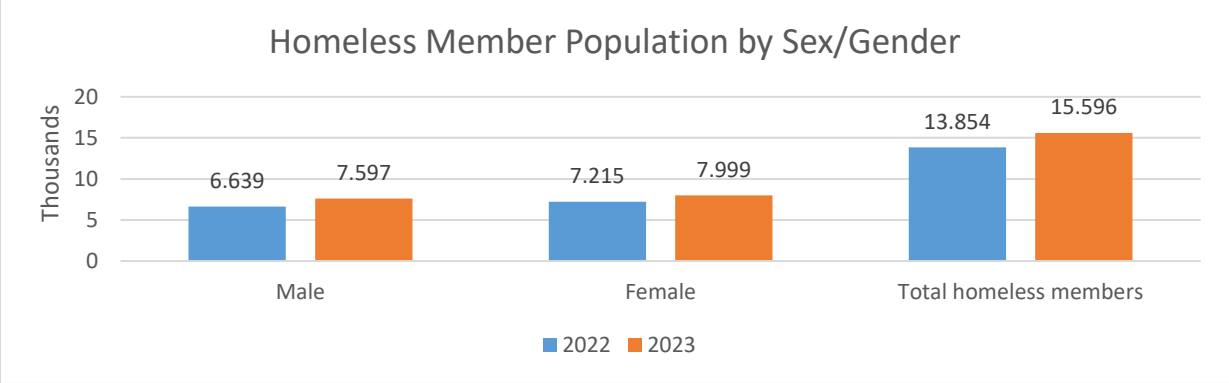
Source: KHS Member Demographics Data Report

KHS identifies homeless members primarily through claims data. In 2023, 15,596 homeless members were identified, a 12.6% increase compared to 2022.[1] Females constituted 51.3% of the homeless member population, while males made up 48.7%. English speakers accounted for 83.7% of homeless members whereas Spanish speakers accounted for 15.6%. The majority of homeless members (56.5%) reported living in Bakersfield, followed by Delano (3.1%), Arvin (1.7%), and Wasco (1.4%). The 2023 KHS homeless member rate was much higher than the homelessness rates for California[4] and Kern County[5], 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.

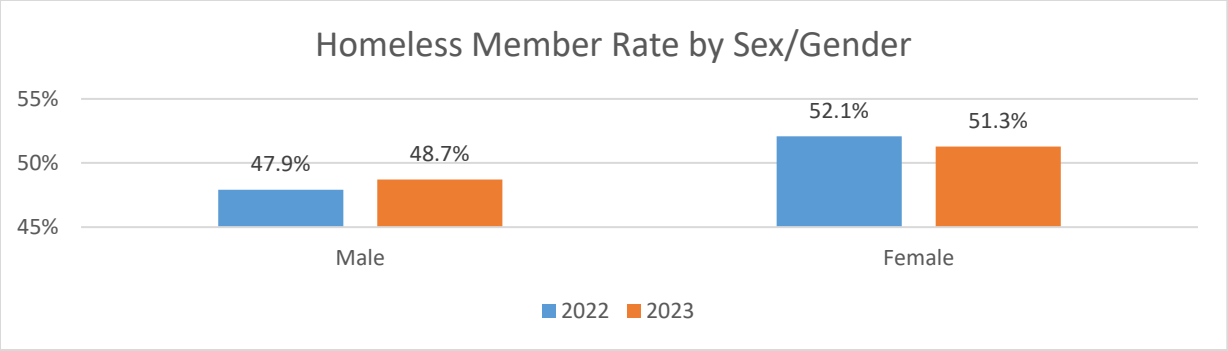


*Homeless data for California and Kern County is from the annual PIT. KHS member homeless member data is derived from claims.
Sources: KHS Member Demographics Data Report, The 2023 Annual Homelessness Assessment Report (AHAR) to Congress, and Kern County Point in Time Count 2023 Report

Source: KHS Member Demographics Data Report



Source: KHS Member Demographics Data Report



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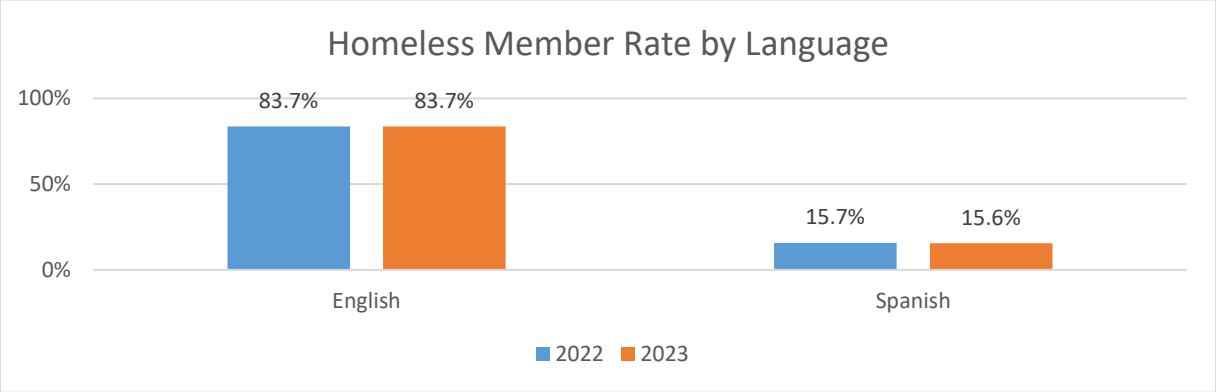
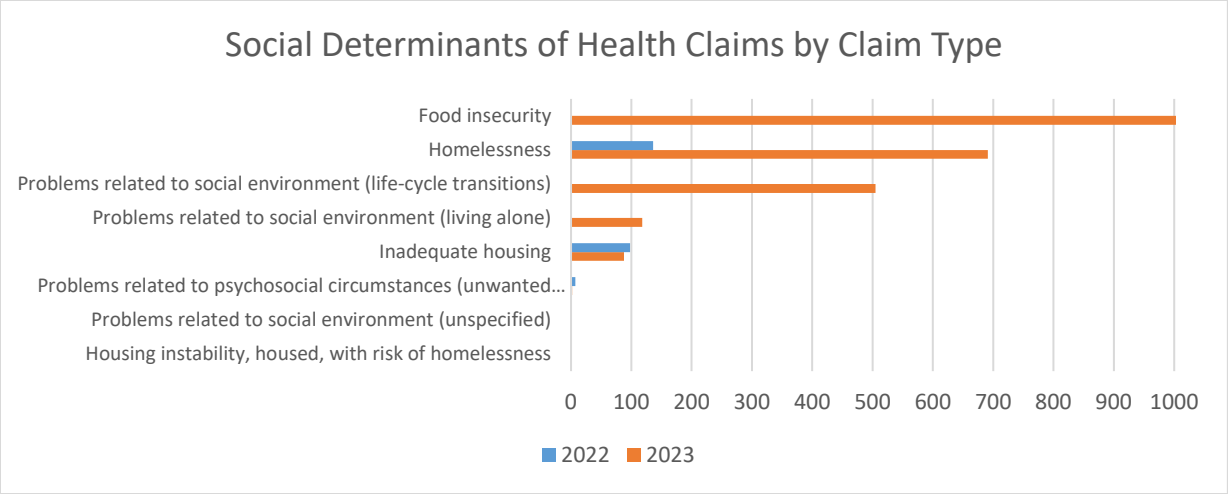


Source: KHS Member Demographics Data Report

Social Determinants of Health

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 956.8% from 241 in 2022 to 2,547 in 2023.[6] Feedback from KHS staff indicate that provider training or education may have been a factor of this large increase. Food insecurity was the top SDoH claim type in 2023, followed by homelessness, problems related to social environment (such as life-cycle transitions and living alone), and inadequate housing.



Source: 2022 and 2023 KHS SDoH Claims Reports

Transportation Requests

KHS' Transportation Program provides non-emergency transportation for members to get to their medical and other Medi-Cal covered services. Coverage includes 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 trips for all modes of transportation combined increased by 50.0% in 2023 compared to 2022.[7] However, change in total trips varied by mode of transportation.

NEMT and NMT Ridership

Mode	Trips Provided, 2022	Trips Provided, 2023	% Change
NEMT Wheelchair	144,769	234,262	61.8%
NEMT Gurney Van	2,502	6,398	155.7%
NMT Public Transit	23,843	22,462	-5.8%
NEMT Rideshare	218,140	321,308	47.3%
NMT Mileage Reimbursement	10,267	14,853	44.7%
All Modes Combined	399,521	599,283	50.0%

Source: 2022 and 2023 KHS Transportation Reports

Member Demographic and Needs Summary:

1. The member population grew by 11.7% from 2022 to 2023. 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 population of members 65 years and older grew by 102.8% from 2022 to 2023. This increase was much larger than for the younger age groups.
3. Most members live in Bakersfield. The portion of members who live in Bakersfield increased from 53.8% in 2022 to 54.5% in 2023. The member population in Bakersfield grew by 13.2% from 2022 to 2023.
4. The KHS member population outside of Bakersfield grew by 17.7% from 2022 to 2023. Members need KHS benefits and services to be accessible to outlying areas of Kern County.
5. KHS does not collect LGBTQ+ data on members. Collecting this data would allow for an assessment of LGBTQ+ member needs.
6. Housing and cost of living are becoming more expensive. These issues are sources of stress and associated with SDoH that impact member health. Affordable housing, financial assistance, and energy bill assistance are urgent member needs.
7. The KHS homeless member population rate is much higher than the homeless population rates for Kern County and California. These data indicates that affordable housing is a need 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).
8. Addressing SDoH is needed to improve member health. SDoH claims data indicate that food security, homelessness resources, affordable housing, and resources that address problems related to the social environment (such as adjustment to life-cycle transitions and living alone) are among member needs.
9. Member requests for transportation assistance grew by 50.0%. All types of transportation trips grew except NMT public transit. These findings indicate that transportation access is an increasing member need.
10. Transportation challenges for members continue to vary based on location and time of day. Members have more transportation assistance options in urban areas and during the day. In the evening or in outlying areas, options are more limited. Public transit service has had limited evening service in Bakersfield due to staffing shortages.
11. Feedback from KHS staff have identified the need for support in navigating the complexities of reentry to society from incarceration, including securing healthcare coverage through Medi-Cal.

12. Assistance with the cost of phones and phone services has been identified as a member need based on feedback from KHS staff.

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, particularly in high-demand areas.

2. Affordable Housing and Financial Assistance

- **Need**: Rising housing costs and financial stress are critical issues affecting member health.
- **Action**: Enhance CSS to further address affordable housing and the need for financial assistance.

3. Support for Older Adults and Special Populations

- **Need**: A significant increase in members aged 65 and older and in the SPD population requires targeted health services.
- **Action**: Develop tailored programs and incorporate care management and coordination for these groups.

4. Resources for the Homeless Population

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

5. Addressing Social Determinants of Health

- **Need**: Food insecurity, homelessness, issues related to social environments, and inadequate housing are top SDoH concerns.
- **Action**: Implement programs that target these SDoH, such as food assistance, support for life-cycle transitions, and housing resources.

6. Transportation Access

- **Need**: A significant increase in requests for transportation assistance suggests that many members face 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:

- **CSS**: Expand offerings related to housing and financial assistance.
- **PHM Complex Case Management (PHM CCM)**: Develop targeted interventions for older adults and SPDs.
- **ECM**: Focus on holistic support for vulnerable populations, including the homeless.
- **Behavioral Health (BH)**: Increase mental health resources tailored to the needs of various member demographics.

Current Activities:

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. The following programs and services are made available to all identified members:

- Activity & Eating Program
- Eat Healthy Be Active Program
- Live Better Program
- Health Library and Self-Management Tools

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

- Breast Cancer Screening
- Cervical Cancer Screening
- Diabetes Prevention Program (Centers for Disease Control and Prevention Recognition)

Overall Strategy:

To effectively address these unmet needs, KHS will prioritize scaling existing services, developing new programs specifically for growing populations, and enhancing 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 diabetes, Alzheimer's disease, coronary heart disease, chronic lower respiratory disease, homicide, firearm related deaths, and drug overdose deaths.[8] It is also among the bottom 10 California counties for the incidence of chlamydia, gonorrhea among females 15-44 years old, congenital syphilis, primary and secondary syphilis among females 15-44 years old, infant mortality, and births to mothers 15-19 years old. 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.

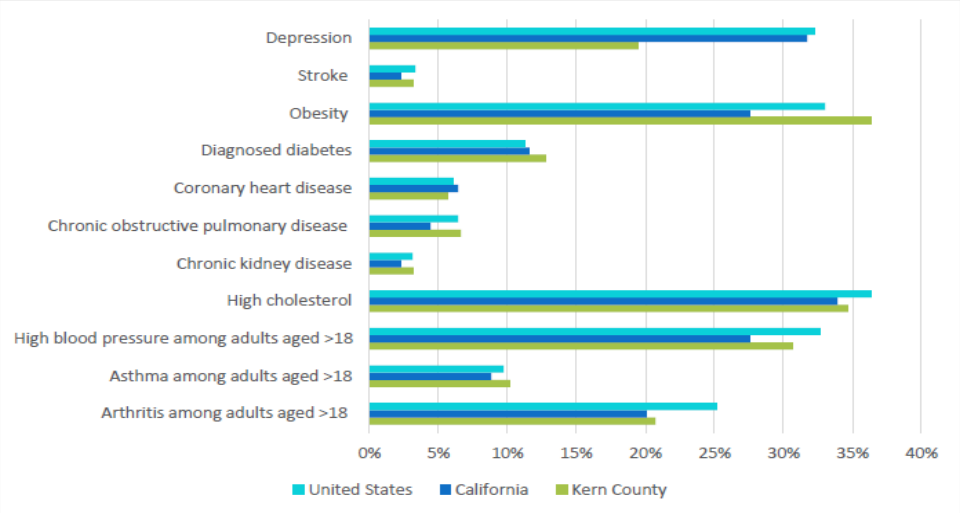
Health Indicators Where Kern County Ranks in the Bottom 10 California Counties	Kern County*	California*
Deaths Due to Diabetes	46.9	23.1
Deaths Due to Alzheimer's Disease	54.0	36.6
Deaths Due to Coronary Heart Disease	118.1	79.0
Deaths Due to Chronic Lower Respiratory Disease	55.1	26.3
Homicide	13.1	5.7
Firearm Related Deaths	16.8	8.3
Drug Overdose Deaths	41.8	21.4
Chlamydia	663.7	507.3
Gonorrhea Among Females 15-44 Years Old	496.5	345.2
Congenital Syphilis	287.1	112.9
Primary and Secondary Syphilis Among Females 15-44 Years Old	41.3	18.3
Infant Mortality	6.7 per 1,000 births	4.0 per 1,000 births
Teen Birth Rate (15-19 Years Old)	21.0 per 1,000 live births	10.2 per 1,000 live births
Persons Under 18 Years Old in Poverty	24.6%	14.6%

*Per 100,000 population unless otherwise noted.
Source: California Department of Public Health, California's County Health Status Profiles 2023

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.

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 the California Department of Public Health, 17.7% of the Kern County population has ever been diagnosed with asthma compared to 15.1% for the California population.[10] The Kern County asthma prevalence for people 18 years and older (22.0%) is slightly higher than the state rate (16.2%). In 2019, the emergency department (ED) visit rate due to asthma was 46.1 per 100,000 compared to the state average of 42.6 per 100,000. 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.

KHS Membership Health Conditions & Diagnoses

KHS medical service claims data revealed that the most common diagnoses among KHS members in 2023 varied by age group and service type.[11] The top diagnoses among members (excluding SPDs) included acute infections, acute illness or symptoms, routine child health exam, abdominal pain, chest pain, headache, poisoning, morbid obesity, heart disease, hypertension, type 2 diabetes, constipation, preprocedural exams, chemotherapy, and immunotherapy. COVID-19 acute respiratory disease was no longer a top diagnosis as it was identified in the 2022 PNA. The chart below includes a breakdown of the top diagnoses by age group and service type.

2023 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. Constipation 5. Urinary tract infection	1. Acute bronchiolitis due to respiratory syncytial virus 2. Acute bronchiolitis 3. Neonatal jaundice 4. Acute appendicitis (without abscess) 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. Fever 3. Acute pharyngitis 4. Cough 5. Acute cough
12-20 Years	1. Acute URI 2. Abdominal pain 3. Viral infection 4. URI 5. Headache	1. Acute appendicitis 2. Poisoning by underdosing of nonopioid analgesics, antipyretics and antirheumatics 3. Sepsis 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. Acute URI	1. Acute URI 2. Acute pharyngitis 3. Acute cough 4. Cough 5. Other respiratory disorder
21-64 Years	1. Chest pain 2. Urinary tract infection 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. Preprocedural exams 4. Chest pain 5. Abdominal pain	1. Acute URI 2. Acute pharyngitis 3. URI 4. Acute cough 5. Acute bronchitis

65+ Years	1. URI 2. Hypertension 3. Abdominal pain 4. Constipation 5. Dizziness and giddiness	1. Sepsis 2. Hypertensive heart disease with heart failure 3. Pneumonia 4. Acute kidney failure 5. URI	1. Antineoplastic chemotherapy 2. Hypertension 3. Antineoplastic immunotherapy 4. Chronic ischemic heart disease 5. URI	1. URI 2. Acute pharyngitis 3. Acute bronchitis 4. Acute URI 5. Dysuria (painful urination)

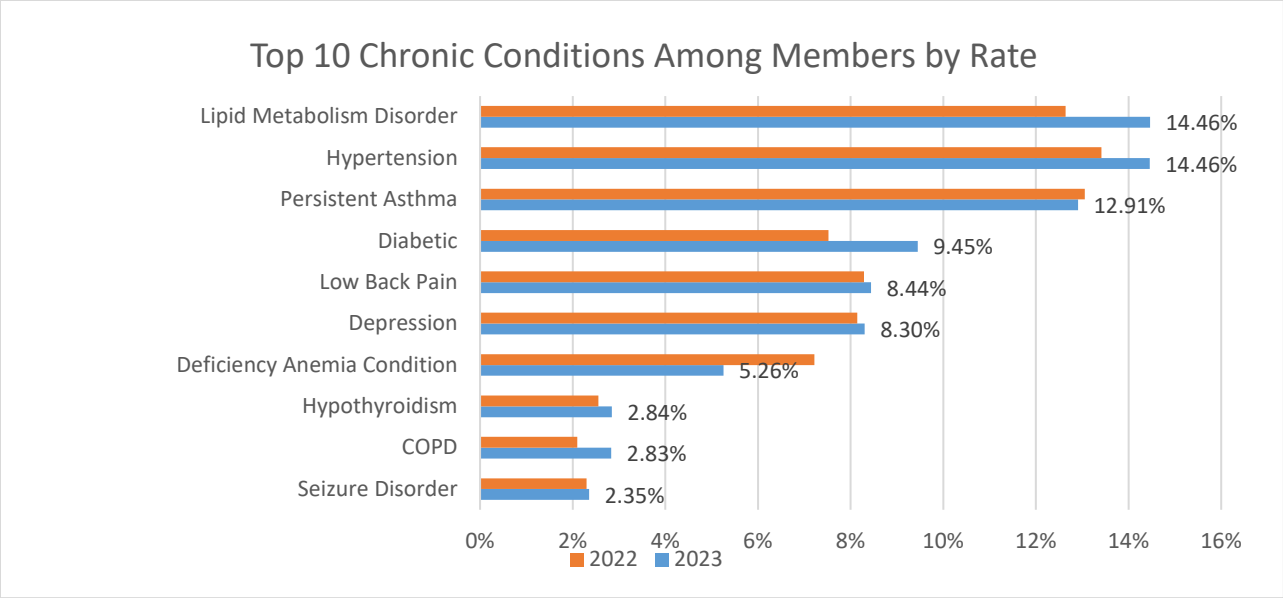
Source: 2023 KHS Top Diagnosis Report

The chart below includes the top five diagnoses among SPD members by service type. The top diagnoses among SPD members included different types of pain, acute infections, acute illness or symptoms, chronic conditions (such as COPD, end stage renal disease, type 2 diabetes, and hypertension), chemotherapy, different types of exams, schizophrenia, and autism spectrum disorder.

2023 TOP 5 Diagnoses Excluding SPD's			
ER	**INPATIENT**	**OUTPATIENT**	**URGENT CARE**
1. Abdominal pain 2. URI 3. Acute URI 4. Chest pain **5.** Other chest pain	1. Sepsis 2. COPD 3. Acute respiratory failure with hypoxia 4. COPD with exacerbation 5. Pneumonia	1. End stage renal disease 2. Type 2 diabetes 3. Antineoplastic chemotherapy 4. Preprocedural exams 5. Other preprocedural exam	1. Schizophrenia 2. Autistic disorder 3. Hypertension 4. Administrative exam 5. Type 2 diabetes

Source: 2023 KHS Top Diagnosis Report

KHS uses predictive analytics to perform data analysis on member medical service claims for various chronic conditions each year. The following chart includes the top ten chronic conditions by member diagnosis rate for both 2022 and 2023.[1] The list includes the same chronic health conditions for both years. Rates increased in 2023 compared to 2022 for all the chronic conditions shown in the chart below except for deficiency anemia condition and persistent asthma.



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 2023. Data findings indicate that diabetes, hypertension, and disorders of lipid metabolism may disproportionately impact Asian/Pacific Islander members whereas Black/African American members are more likely to be disproportionately affected by asthma.[11] 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, 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.

Chronic Obstructive Pulmonary Disease (COPD): KHS has partnered with a provider to ensure comprehensive care for high-risk members with COPD. Using the Gold Guidelines[12], 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.

Rates of the Top 5 Chronic Conditions by Race/Ethnicity, 2023

Chronic Condition	Black/ African American	Asian & Pacific Islander	White	Hispanic	Native American
Asthma	16.5%	12.4%	14.4%	11.9%	14.8%

Diabetes	8.7%	15.1%	9.0%	9.9%	13.3%
Hypertension	17.9%	25.7%	18.2%	13.2%	21.6%
Low Back Pain	11.3%	9.9%	11.4%	7.9%	11.3%
Lipid Metabolism Disorder	11.2%	27.8%	14.2%	14.9%	16.4%

Source: KHS Member Demographics Report

Pharmaceutical Utilization

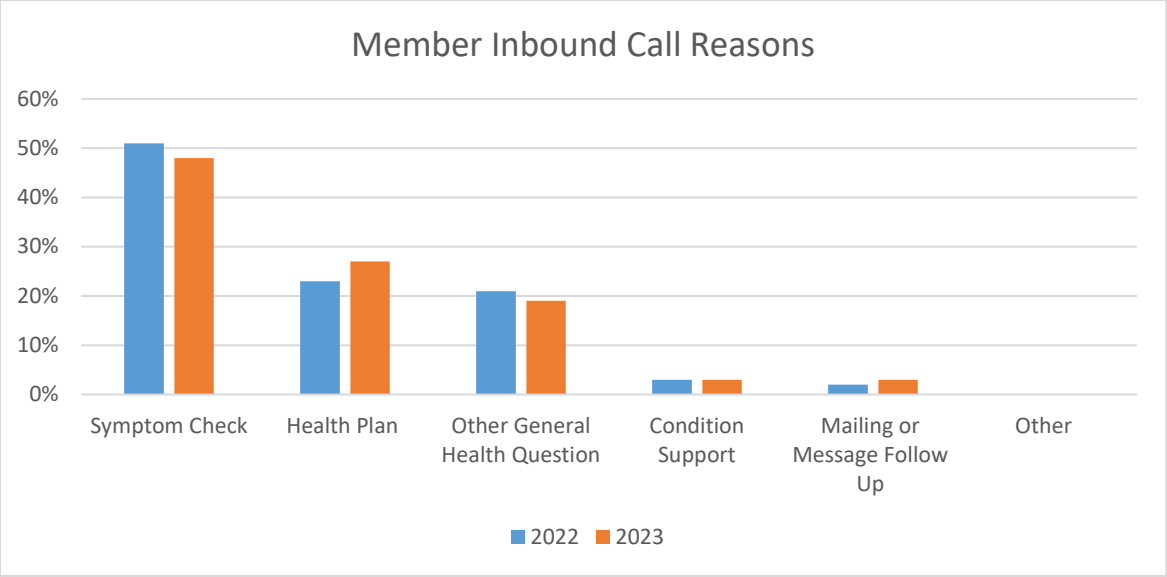
KHS' review of the most frequently dispensed medications identified ibuprofen, atorvastatin, amoxicillin, albuterol HFA, and vitamin D2 as the top five medications prescribed to KHS members in 2023.[13] Most of the top 10 medications prescribed for members in 2023 are prescribed to treat health conditions that were among the most frequent diagnoses among KHS members in 2023. Out of the top ten medications, four are used to treat chronic conditions that were identified in the top 10 chronic conditions among members in 2023. Ozempic had the highest total cost among all medications dispensed, resulting in a total of $31,585,116.94. 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 2023	Targeted/Relevant Health Conditions
1. Ibuprofen	Fever and pain
2. Atorvastatin	High cholesterol and triglyceride levels; heart and blood vessel problems
3. Amoxicillin	Infections and stomach ulcers
4. Albuterol HFA	Breathing problems, such as asthma and COPD
5. Vitamin D2 (Ergocalciferol)	Vitamin D deficiency, hypoparathyroidism, refractory rickets, familial hypophosphatemia
6. Lisinopril	High blood pressure and heart failure
7. Metformin HCL	Type 2 diabetes
8. Promethazine DM	Symptoms of allergies and the common cold
9. Gabapentin	Seizures and pain caused by shingles
10. Loratadine	Allergy symptoms and hives

Source: 2023 KHS Pharmacy Data Report

Advice Nurse Line

In 2023, the KHS advice nurse line received 5,412 inbound calls from members.[14] This was a 9.9% decrease in total inbound calls compared to 2022. The top call reasons in 2023 included symptom check (48%), followed by health plan (27%) and other general health question (19%).



Source: 2023 KHS Advice Nurse Line Report

The most frequent symptoms for inbound symptom check calls in 2023 were pregnancy-related problems, followed by abdominal pain, fever, respiratory problems, and nausea and vomiting. This compares to the top five for 2022, which were abdominal pain, followed by fever, pregnancy related problems, cough, and COVID-19 symptom tracker.

2022		2023	
Five Most Frequent Symptoms, Inbound Symptom Check Calls	Symptom Prevalence	Five Most Frequent Symptoms, Inbound Symptom Check Calls	Symptom Prevalence
Abdominal Pain	7.2%	Pregnancy-Related Problems	6.1%
Fever or Chills	6.0%	Abdominal Pain	6.0%
Pregnancy-Related Problems	4.9%	Fever	5.2%
Cough	4.3%	Respiratory Problems	4.8%
COVID-19 Symptom Tracker	4.1%	Nausea & Vomiting	4.1%

Source: 2022 and 2023 Kern Family Health Nurse Advice Line Year in Review

Programs to Address Maternal Health Outcomes

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.

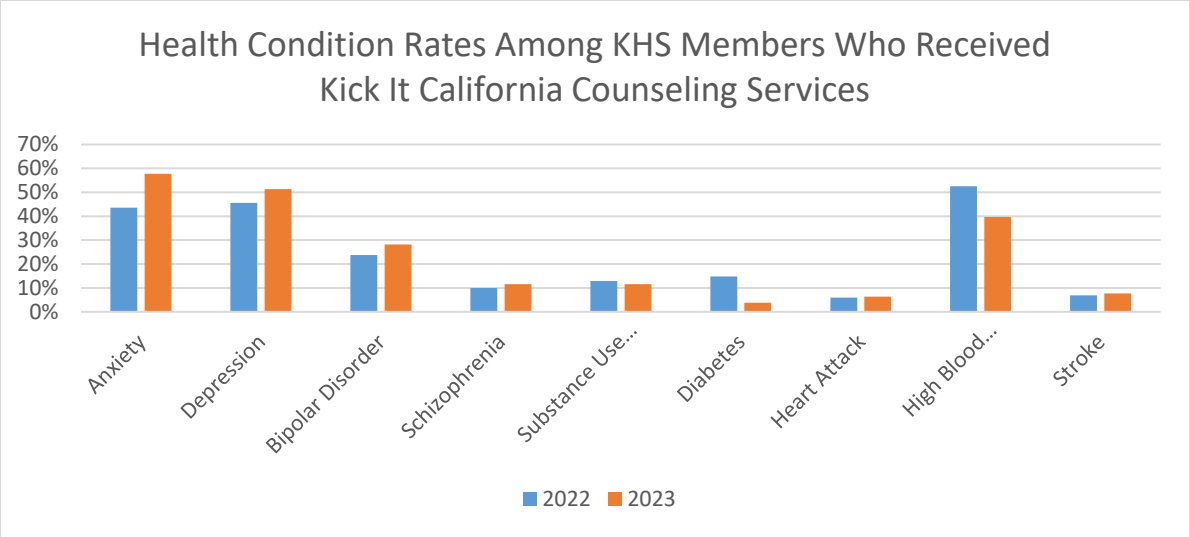
Baby Steps Plus Program

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.

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 13.3% of KHS adult members were current smokers.[15] According to KHS' Tobacco Registry Report, 2.3% of members in 2023 were identified as current smokers compared to 1.5% of members in 2022.[16] 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 2023 were most likely to be English-speaking (98.7%), female (66.7%), White (59.0%), and between the ages of 25 and 44 years (59.0%).[17] In that same year, 73.1% of KHS member callers had a high school diploma or higher and 47.4% 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: Kick It California Reports: Kern Health Systems Member Data

Member Health Status and Disease 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. Members will need chronic disease management programs to manage these conditions.
2. 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 needs summary, the key unmet member needs include:

1. Chronic Disease Management Programs

- **Need**: Members are struggling with high cholesterol, high blood pressure, asthma, low back pain, and depression, indicating a demand for chronic disease management.
- **Action**: Develop and expand programs focused on effective management strategies for these prevalent conditions.

2. Culturally Sensitive Care

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

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.

KHS' Current Activities

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 Education Program
- Diabetes Empowerment Education Program™
- Fresh Start and Fresh Start Plus Smoking Cessation Programs
- Complex Care Management
- Chronic Obstructive Pulmonary Program
- End Stage Renal Disease Program
- ER Navigation Program
- Kids and Youth Transitional Program
- Long Term Care and Support Services
- Member Centric Care Coordination
- Major Organ Transplant Program
- Palliative Care Services
- Transition of Care Services
- CSS
- ECM Program

Maternal Health

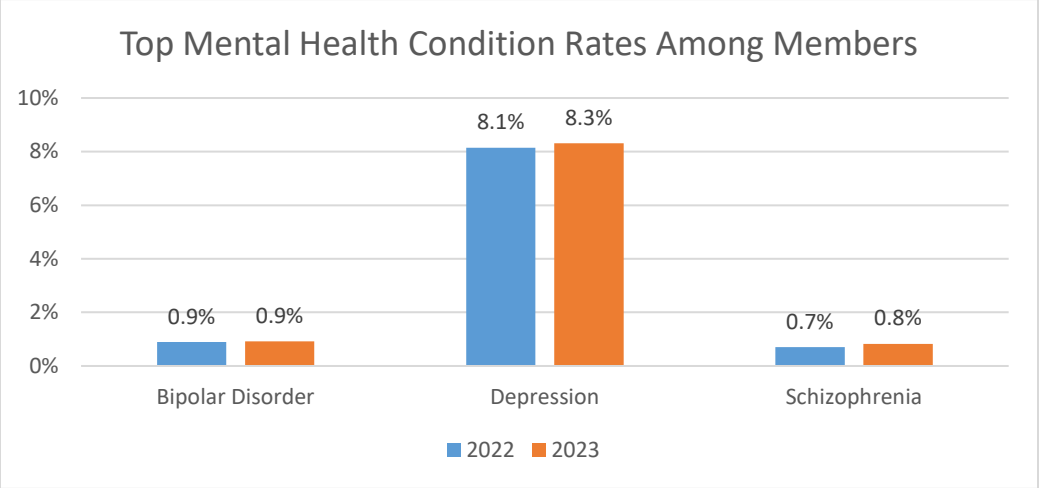
- Black Infant Maternal Health Initiative
- Baby Steps Program
- Baby Steps Plus Program

Overall Strategy:

To address these unmet needs, KHS will prioritize the development of comprehensive, accessible chronic disease management 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.

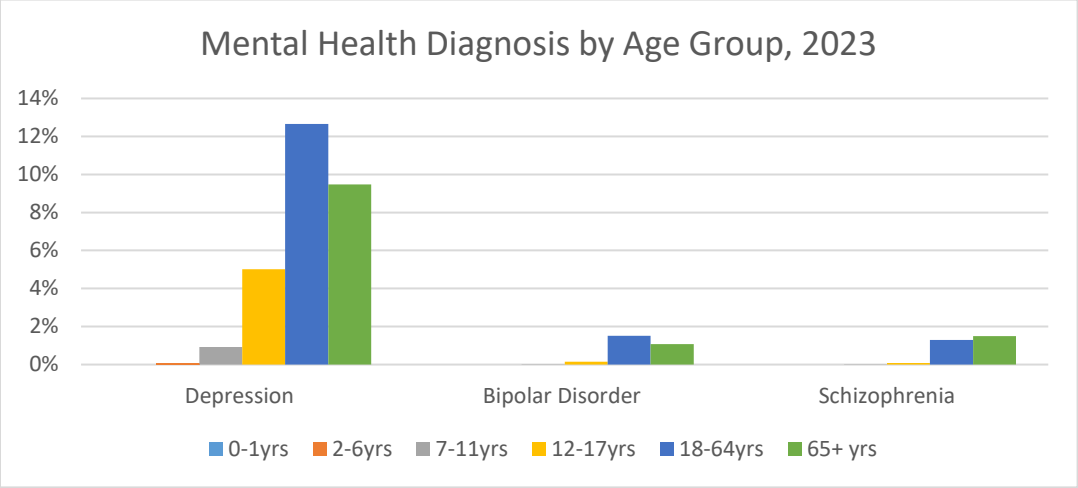
Assessment of Members with Mental Health Illness or Serious Emotional Disturbance

In 2023, 8.3% of KHS members were identified to have had a depression diagnosis, 0.9% had a bipolar disorder diagnosis, and 0.8% had a schizophrenia diagnosis.[1] The 2023 rates for these mental health conditions increased slightly compared to the 2022 rates.

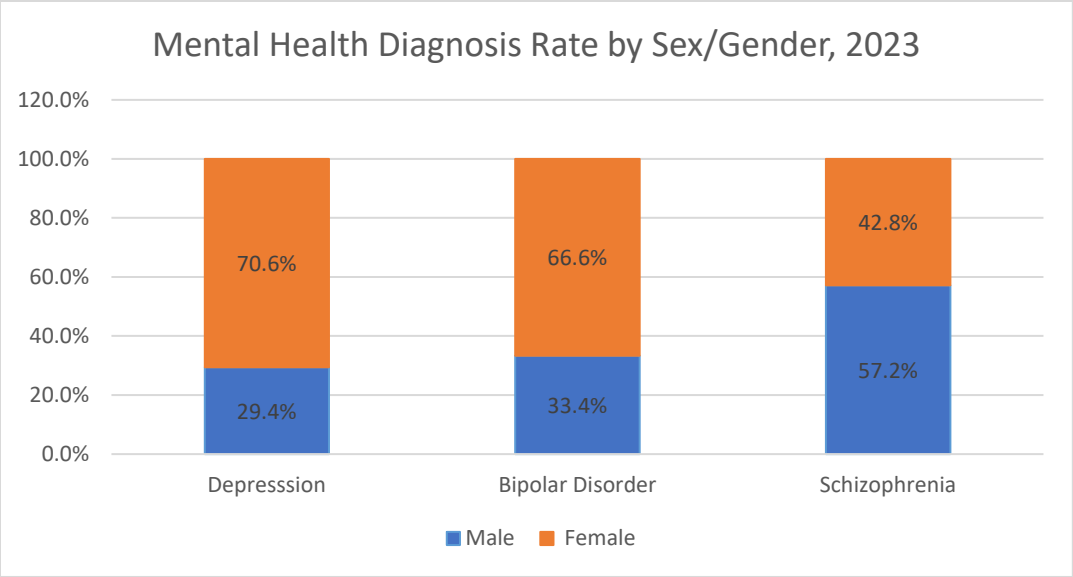


Source: KHS Member Demographics Report

In 2023, depression and bipolar disorder were more common among female members than male members. Schizophrenia was more common among male members. When looking at language, these conditions were most common among English-speaking members. When looking at age groups, depression and bipolar disorder were most common among members aged 18-64 years old. Schizophrenia was most common among members 65 years and older. When comparing racial/ethnic groups, depression and bipolar disorder were most common among White members. Schizophrenia was most common Native American members.



Source: KHS Member Demographics Report



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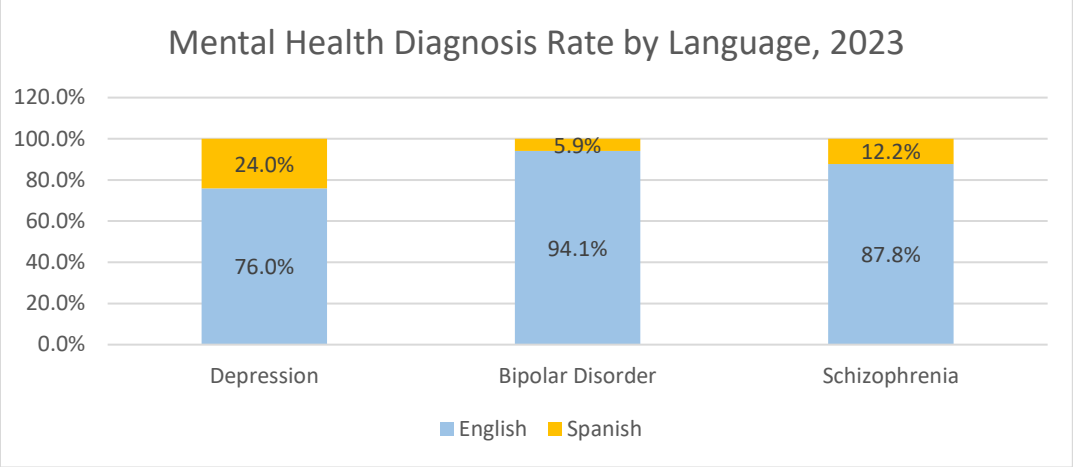

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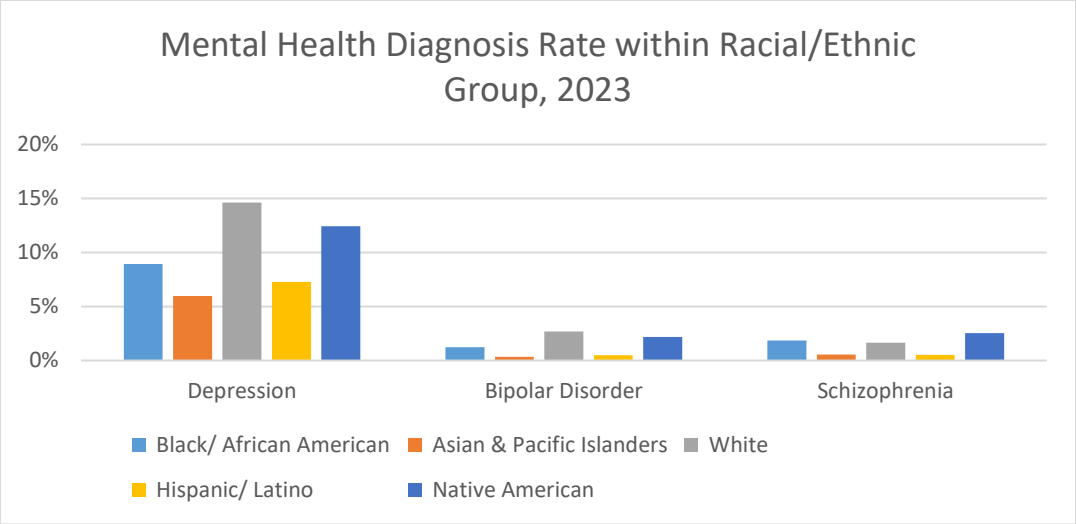


Source: KHS Member Demographics Report

Summary of Needs of Members with Serious Mental Illness or Emotional Disturbance

1. The 2023 member rates for bipolar disorder, depression, and schizophrenia increased slightly compared to the 2022 rates.
2. Depression is the most common mental health condition among members by far. Access to depression treatment services is a key mental health need among members.
3. Depression and bipolar disorder rates are highest among English speakers, females, White members, and adult members 18-64 years old.
4. Schizophrenia is most prevalent among Native Americans when comparing racial and ethnic groups.
5. KHS covers behavioral health treatment (BHT) for autism spectrum disorder (ASD), non-specialty outpatient mental health services, and alcohol misuse screening services. BHT includes applied behavior analysis (ABA) and other evidence-based services. Crisis response services and resources and substance use disorder treatment are offered by the county mental health agency and other community organizations.
6. KHS Behavioral Health (BH) Department community health worker (CHW) referral and member outreach data indicate CHW services are needed among members with BH or mental health conditions.
7. Feedback from KHS staff has indicated that a strategic approach, staff, and resources are needed to improve member access to and utilization of BHT and mental health services.
8. BHT provider recruitment is needed to increase the BHT provider network and access among members. Marketing and member outreach would likely result in an increase of member awareness and utilization of needed BHT services.
9. Member outreach is also needed to help keep members engaged with their BHT provider or team. Peer support groups would help reduce destigmatization associated with mental illness and BHT services.

The following member mental health needs are met with a combination of KHS benefits and community resources:

1. BHT for ASD
2. Non-specialty outpatient mental health services
3. Alcohol misuse screening services
4. BH CHW referrals and member outreach
5. Substance use disorder treatment services
6. Severe mental health and crisis services and resources, such as 988 Crisis Hotline, crisis response, and mobile evaluation team
7. Transportation assistance

Based on the member mental health needs summary, the key unmet member needs include:

1. Lack of BHT and mental health service providers

- **Need:** There are not enough BHT and mental health service providers that KHS has contracted with to address the member need for BHT and mental health services.
- **Action:** Develop strategies to recruit more BHT and mental health providers.

2. Lack of staffing and resources

- **Need:** Adequate staffing and resources to support BHT services.
- **Action:** A strategic approach to improve access to and utilization of behavioral health treatment (BHT) and mental health services.

3. Marketing and member outreach

- **Need:** Marketing and member outreach by CHWs are needed to raise awareness of BHT services and mental health services. Raising awareness will reduce stigma, increase needed utilization, and keep members engaged with BHT.
- **Action:** Develop a member engagement strategy to raise awareness of BHT and mental health services. Increase staff resources, including CHWs.

4. Peer support groups

- **Need:** Peer support groups that reduce destigmatization associated with mental health illness and BHT services.
- **Action:** Start member peer support groups oriented towards mental health and BHT.

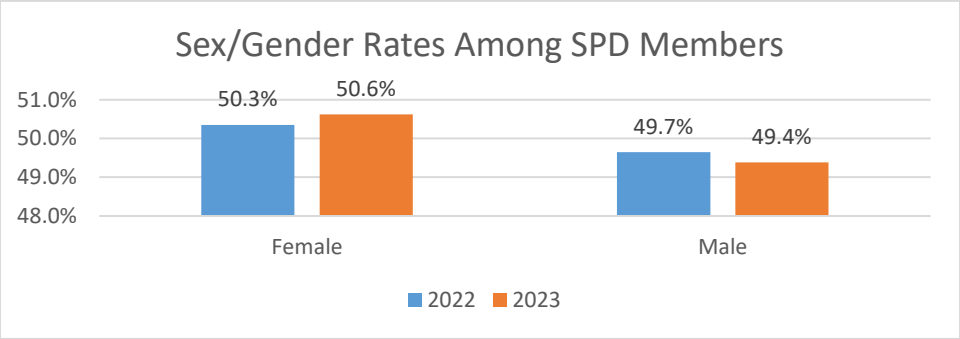
Overall Strategy

1. **Expand Provider Network:** Prioritize recruitment of BHT and mental health providers to meet rising demand.
2. **Enhance Marketing Efforts:** Implement targeted marketing and outreach initiatives to inform members of available services, utilizing CHWs effectively.
3. **Foster Community Engagement:** Develop peer support groups to create a supportive environment and reduce stigma around mental health issues.
4. **Leverage Community Resources:** Collaborate with community organizations to enhance service delivery, especially in crisis intervention and substance use treatment.
5. **Monitor and Evaluate:** Continuously assess the effectiveness of strategies implemented and adapt based on member feedback and changing needs.

This comprehensive approach aims to improve access to mental health services, enhance member engagement, and ultimately better support individuals with serious mental illness or emotional disturbances.

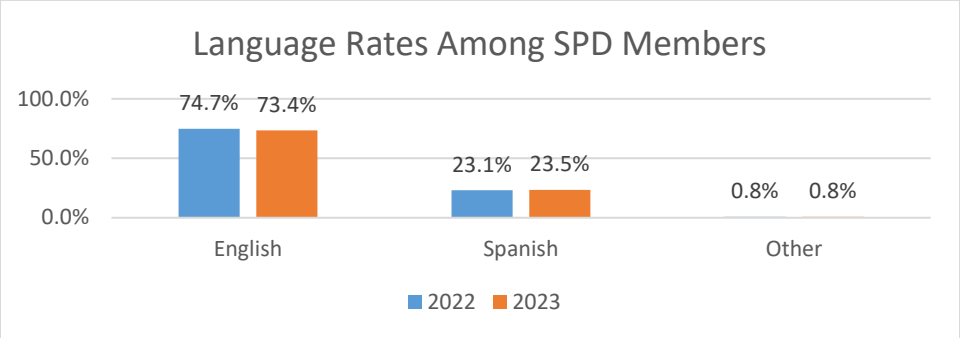
Assessment of SPD Members

The population of SPD members was estimated to be 29,526 members in 2023, a 29.9% increase compared to 22,731 members in 2022.[1] SPDs accounted for 7.5% of members in 2023, up from 6.5% in 2022. Females were 50.6% of SPD members compared to 49.4% for males in 2023. The gender/sex rates were similar when comparing to 2022 data.



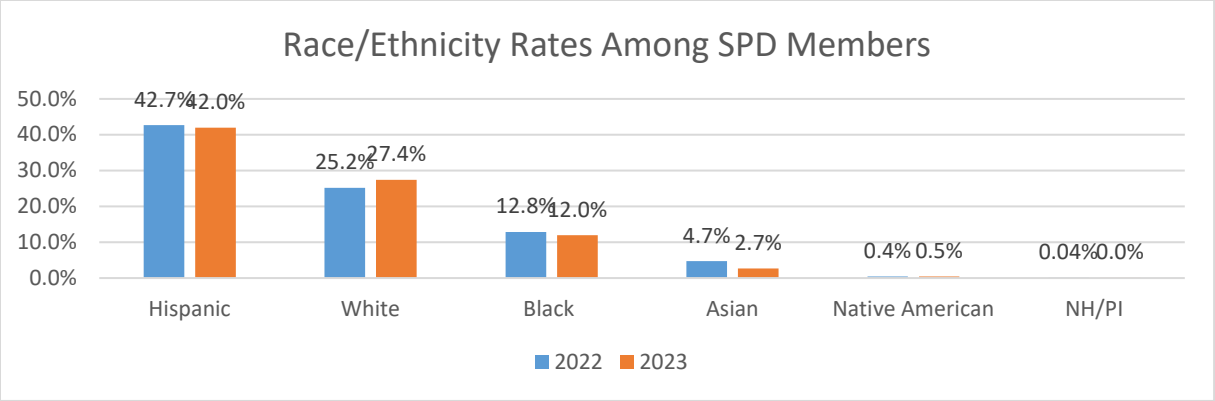
Source: KHS Member Demographics Report

English speakers accounted for 73.4% of SPD members in 2023, followed by Spanish speakers at 16.3%, and other languages combined at 0.2%. These rates were similar to those for 2022.



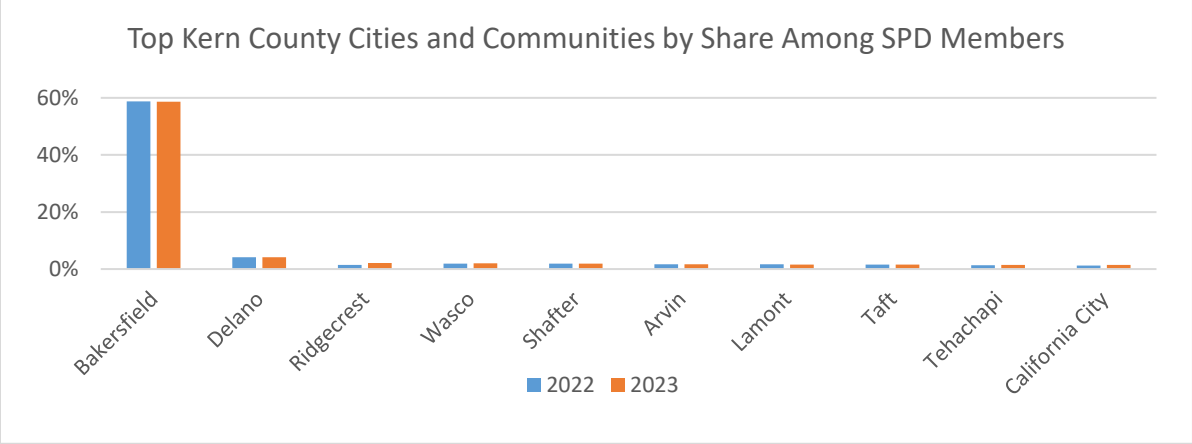
Source: KHS Member Demographics Report

When looking at race and ethnicity, Hispanics were the largest group in 2023, followed by Whites, Blacks, Asians, Native Americans, and Native Hawaiians and Pacific Islanders. The member racial/ethnic group distribution was similar in 2022.



Source: KHS Member Demographics Report

Members with disabilities were concentrated in Bakersfield in 2023, followed by much smaller populations in Delano, Ridgecrest, Wasco, and Shafter as shown by the chart and heat map below. The Kern County city and community population distribution was similar in 2022.



Source: KHS Member Demographics Report

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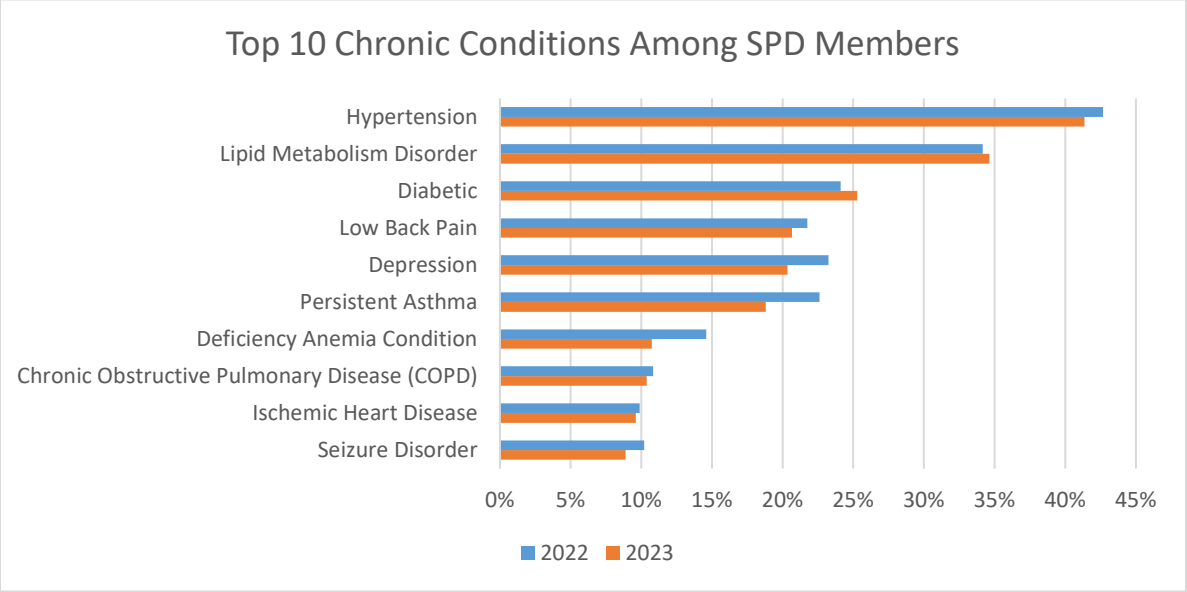

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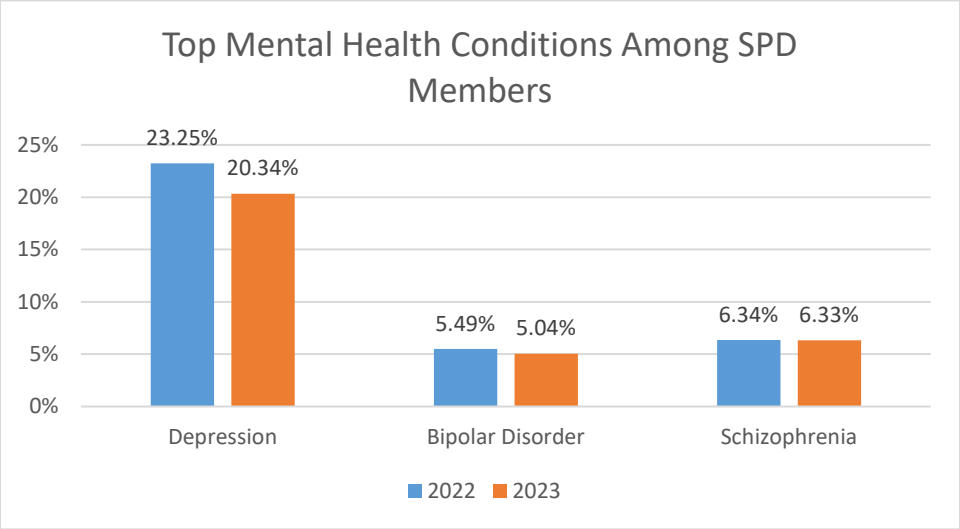


Source: KHS Member Demographics Report

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 Diabetes Prevention Program, Diabetes

Empowerment and Education Program, 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 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.

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 and mental health service providers.

2. **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 2022 and MY 2023.[18,19,20,21] Child rates decreased from MY 2022 to MY 2023 for all rates shown below where data was available. The exceptions were "personal doctor listened carefully" and "personal doctor showed respect" where there were increases. For the adult rates, data was only available for "getting needed care" and "how well doctors communicate" for both MY 2022 and MY 2023. Both rates decreased from one year to the next.

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), the MY 2022 KHS CAHPS Adult Simulation Survey rates for "getting needed care", "getting care quickly", and "how well doctors communicate" increased compared to MY 2021 rates except for "getting routine care".[22,23]

Measure (Always or Usually)	KHS CAHPS Child Rate		KHS CAHPS Adult Rate		KHS CAHPS Adult Simulation Survey Rate	
	MY 2022	MY 2023	MY2022	MY 2023	MY 2021	MY 2022
Getting Care Quickly	84.5%	80.2%	78.6%	N/A	79.4%	80.7%
Getting urgent care	90.3%	84.4%	N/A	N/A	78.5%	83.7%
Getting routine care	78.8%	76.0%	N/A	71.0%	80.2%	77.6%
Getting Needed Care	79.9%	76.6%	82.6%	76.7%	81.9%	84.5%
Getting care, tests, or treatment	84.7%	82.6%	N/A	75.4%	84.6%	85.4%
Getting a specialist appointment	75.0%	N/A	N/A	N/A	79.2%	83.7%
How well doctors communicate	90.3%	89.3%	91.3%	88.3%	89.3%	92.5%
Personal doctors	91.5%	89.9%	N/A	88.3%	90.0%	91.9%

explained things						
Personal doctors listened carefully	92.4%	93.6%	N/A	90.8%	89.3%	92.7%
Personal doctors showed respect	94.9%	96.2%	N/A	90.0%	94.7%	96.9%
Personal doctors spent enough time	82.4%	77.5%	N/A	84.0%	83.3%	88.5%

Sources: MY 2022 CAHPS 5.1H Data Submission, Child Medicaid Survey Results Report; MY 2022 CAHPS 5.1H Data Submission, Adult Medicaid Survey Results Report; 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 2021 CAHPS Medicaid Adult Simulation Survey: Kern Health Systems; MY 2022 CAHPS Medicaid Adult Simulation Survey: Kern Health Systems

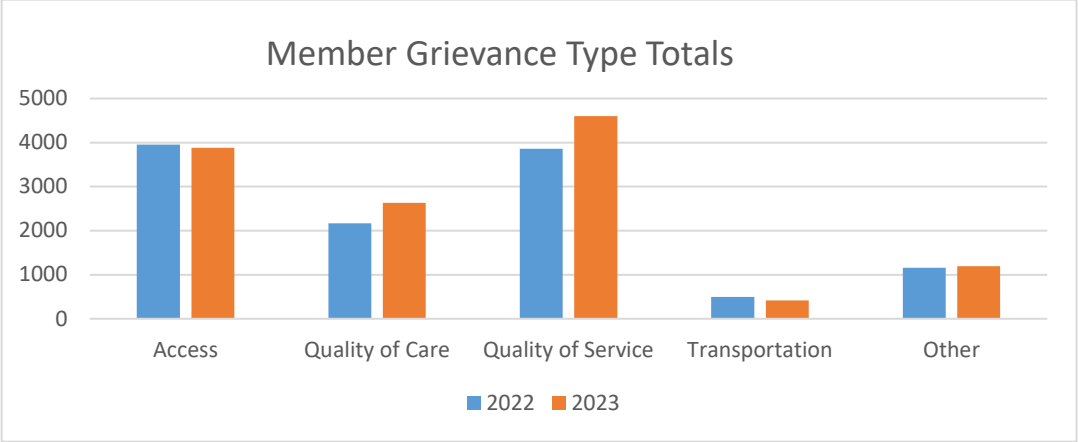
Data on the effectiveness of care measures for flu shots and tobacco use among adult members was also collected. The KHS Adult Medicaid Simulation Survey rate improved for all effectiveness of care measures in 2023 compared to 2022.[22,23]

Measure (% Sometimes, Usually, or Always)	**KHS CAHPS Child Rate**		**KHS CAHPS Adult Rate**		**KHS CAHPS Adult Simulation Survey Rate**	
	MY 2022	**MY 2023**	**MY 2022**	**MY 2023**	**MY 2021**	**MY 2022**
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	40.7%	N/A	48.4%	52.2%
Advising Smokers and Tobacco Users to Quit	N/A	N/A	65.2%	N/A	71.9%	74.4%
Discussing Cessation Medications	N/A	N/A	46.6%	N/A	43.8%	47.4%
Discussing Cessation Strategies	N/A	N/A	42.1%	N/A	33.3%	40.7%

Sources: MY 2022 CAHPS 5.1H Data Submission, Child Medicaid Survey Results Report; MY 2022 CAHPS 5.1H Data Submission, Adult Medicaid Survey Results Report; 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 2021 CAHPS Medicaid Adult Simulation Survey: Kern Health Systems; MY 2022 CAHPS Medicaid Adult Simulation Survey: Kern Health Systems

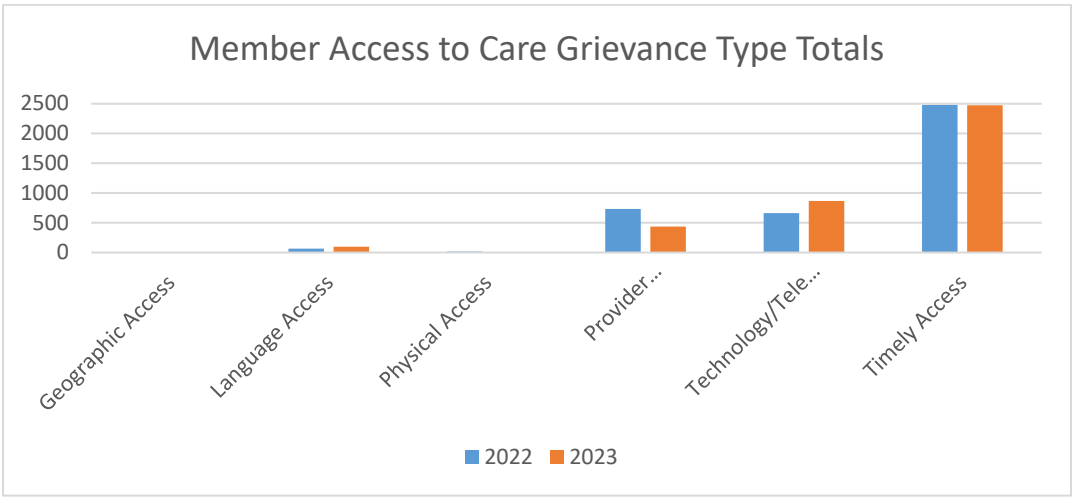
Member Grievances

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. In 2023, there were 12,724 grievances, of which 7,502 were exempt (resolved in one day) and 5222 were formal.[24] Quality of Service was the top grievance type, followed by Access to Care, and Quality of Care. Nearly three in four (71.4%) grievances were closed in favor of the member. The total number of grievances in 2023 increased by 9.4% compared to 2022.



Source: 2022 and 2023 Grievance and Appeal Summaries

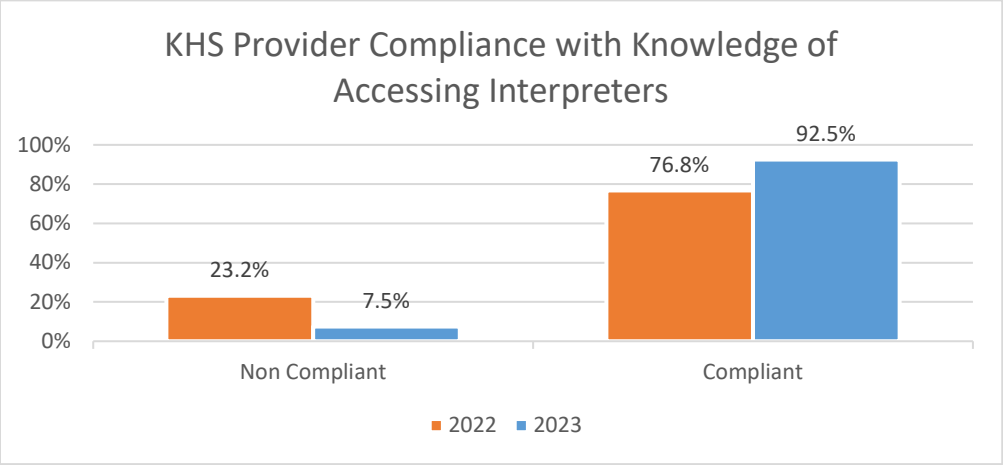
Access to Care grievances totaled 3880 in 2023, a 2.0% decrease compared to 2022. Timely Access accounted for most Access to Care grievances (63.7%), followed by Technology/Telephone Access (22.3%), and Provider Availability (11.3%).



Source: 2022 and 2023 Grievance and Appeal Summaries

KHS conducts a quarterly interpreting access survey among its health care provider network.[25] In 2023, a total of 147 providers were contacted of which 66 were PCPs and 81 were specialists. Of the 147 calls, 11 providers (4 PCPs and 7 specialists) were considered noncompliant and

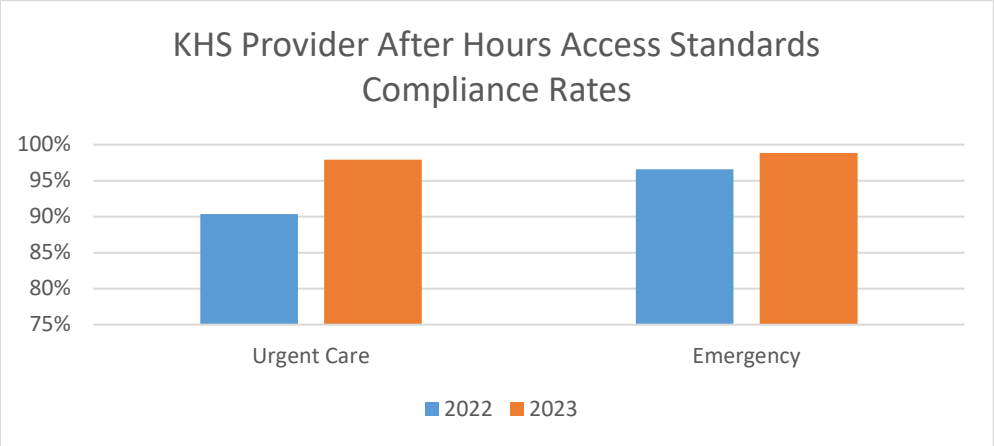
needed additional C&L Services training on resources available to members. The rate of providers who were considered compliant increased from 76.8% in 2022 to 92.5% in 2023.



Source: 2022 and 2023 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 2023, 98.9% of provider offices were compliant with the Emergency Access Standards and 97.9% were compliant with the Urgent Care Access Standards.[26] Both 2023 rates increased compared to their respective 2022 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 60 primary care providers (PCP) offices, 60 specialist offices, 20 mental health provider offices, 20 ancillary provider offices, and 20 obstetrics & gynecology (OB/GYN)

offices were contacted during 2023. Average wait times for each provider type were in-compliance with the standard wait times.[26]

Provider Type	2022 Average Wait Time in Business Days	2023 Average Wait Time in Business Days	Standard Wait Time in Business Days
Primary (60 Providers)	3.87	3.22	10
Specialist (60 Providers)	7.67	8.58	10
Mental Health (20 Providers)	2.95	4	10
Ancillary (20 Providers)	0.95	3.45	15
OB/GYN (20 Providers)	3.95	4.65	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 2023, the plan had a quarterly average network of 428.5 PCPs, of which 81.7% were accepting new members.[26]

New Member PCP Access	2022	2023
PCPs	1744	1814
PCPs Accepting	1430	1537
PCPs Accepting Rate	82.0%	84.7%

Source: KHS Provider Network Management Network Review Reports

Summary of Gaps in Access to Care and Member Needs

1. CAHPS survey results were mixed. KHS performance improved overall on CAHPS measures when comparing MY 2021 and MY 2022 KHS CAHPS Simulation Survey results.
2. On the other hand, KHS performance decreased for most measures with MY 2022 and MY 2023 results from the DHCS CAHPS Survey. 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.
3. Quality of Service was the top grievance type, followed by Access to Care, and Quality of Care. Most grievances (71.4%) were closed in favor of the enrollee, indicating that members may be facing legitimate challenges with quality of services, access to care, and quality of care.
4. Overall language interpreting requests increased by 47.7% from 2022 to 2023. Demand for interpreting services grew drastically.
5. Although the KHS Interpreter Access Survey results showed that provider knowledge of interpreting access improved from 76.8% in 2022 to 92.5% in 2023, conducting provider trainings regarding this member benefit will be needed for existing and new KHS providers.

6. Average wait time in business days decreased for PCPs but increased for other types of providers (specialists, mental health, ancillary, and OB/GYN). Member access to provider types other than PCPs may be a growing need.

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**: Mixed results from CAHPS surveys indicate potential issues with member access to care, particularly for specialists and other non-PCP providers.
- **Action**: Conduct a detailed analysis of barriers affecting access and implement strategies to enhance availability of these services.

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 improving service delivery and quality assurance measures.

3. Language Interpretation Services

- **Need**: The demand for language interpreting services has risen sharply, indicating that many members require support in navigating healthcare communication.
- **Action**: Enhance the availability of interpreting services and ensure providers are trained to effectively utilize these resources.

4. Provider Training on Accessing Services

- **Need**: While provider knowledge of interpreting services improved, ongoing training is necessary to ensure all providers are equipped to assist members effectively.
- **Action**: Implement regular training sessions focused on accessing interpreting services and understanding member needs.

5. Specialist Access Issues

- **Need**: Increased wait times for specialists and other non-PCP providers indicate a growing gap in access to specialized care.
- **Action**: Evaluate and adjust provider networks to increase the availability of specialists and reduce wait times.

Summary of Relevant Actions:

- **Provider Network Management (PNM)**: Strengthen network to improve access to diverse provider types.
- **Mobile Clinic Project**: Leverage mobile services to reach underserved areas and provide healthcare access directly.
- **Member Transportation Benefits**: Optimize transportation resources to ensure timely access to care.
- **Interpreter Access Survey**: Use survey findings to tailor training and improve interpreting service usage.

Overall Strategy:

To address these unmet needs, KHS will focus on enhancing access to care through better provider networks, improving transportation solutions, and ensuring that all members can communicate effectively with their healthcare providers. Regular evaluation and adjustment based on member feedback will be crucial for continuous improvement.

Health Disparities and Preventive Services Indicators

DHCS provided to KHS member data on the following indicators from the Measurement Year (MY) 2022 DHCS Disparities Rate Sheet for Medi-Cal Managed Care Health Plans.[27]

Indicator Abbreviation	Indicator Name
AAP	Adults' Access to Preventive/Ambulatory Health Services—Total
ADD–C&M	Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase
ADD–Init	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication—Initiation Phase
AMB–ED	Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Years—Total
AMM–Acute	Antidepressant Medication Management—Effective Acute Phase Treatment
AMM–Cont	Antidepressant Medication Management—Effective Continuation Phase Treatment
AMR	Asthma Medication Ratio
APM–B	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total
APM–BC	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total
APM–C	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total
BCS	Breast Cancer Screening—Total
CBP	Controlling High Blood Pressure—Total
CCP–MMEC60–1520	Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years
CCP–MMEC60–2144	Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years
CCS	Cervical Cancer Screening
CCW–MMEC–1520	Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years
CCW–MMEC–2144	Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years
CHL	Chlamydia Screening in Women—Total
CIS–10	Childhood Immunization Status—Combination 10
COL	Colorectal Cancer Screening—Total
DEV	Developmental Screening in the First Three Years of Life—Total
DRR–E–PHQ	Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total

DRR–E–RM	Depression Remission or Response for Adolescents and Adults—Depression Remission—Total
DRR–E–RS	Depression Remission or Response for Adolescents and Adults—Depression Response—Total
DSF–E–DS	Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—Total
DSF–E–FU	Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—Total
FUA–7	Follow-Up After Emergency Department Visit for Substance Abuse—7-Day Follow-Up
FUA–30	Follow-Up After Emergency Department Visit for Substance Abuse—30-Day Follow-Up
FUM–7	Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up
FUM–30	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up
HBD–H9	Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)
IMA–2	Immunizations for Adolescents—Combination 2
LSC	Lead Screening in Children
PCR–OR	Plan All-Cause Readmissions—Observed Readmission Rate—Total
PDS–E–DS	Postpartum Depression Screening and Follow-up—Depression Screening
PDS–E–FU	Postpartum Depression Screening and Follow-up—Follow-Up on Positive Screen
PND–E–DS	Prenatal Depression Screening and Follow-up—Depression Screening
PND–E–FU	Prenatal Depression Screening and Follow-up—Follow-Up on Positive Screen
POD	Pharmacotherapy for Opioid Use Disorder
PPC–Pre	Prenatal and Postpartum Care—Timeliness of Prenatal Care
PPC–Pst	Prenatal and Postpartum Care—Postpartum Care
PRS–E	Prenatal Immunization Status—Combination (Influenza and Tdap)
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
TFL–DO	Topical Fluoride for Children—Dental or Oral Health Services—Total
TFL–DS	Topical Fluoride for Children—Dental Services—Total
TFL–OH	Topical Fluoride for Children—Oral Health Services—Total
W30–2+	Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits
W30–6+	Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits
WCV	Child and Adolescent Well-Care Visits—Total

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, English speakers had the lowest rates for most indicators.

MY 2022 DHCS Health Disparities KHS Rate Sheet Indicators: Child Development and Health

Indicator	American/ Alaska Native	Asian	Black/ African American	Hispanic/ Latino	Native Hawaiian / Other Pacific Islander	White	Other
ADD-C&M	N/A	100.0%*	40.0%*	45.5%	N/A	39.6%	N/A
ADD-Init	100.0%*	75.0%*	30.6%	46.5%	N/A	41.1%	0.0%*
APM-B	0.0%*	87.5%*	51.7%	64.4%	N/A	57.4%	100.0%*
APM-BC	0.0%*	50.0%*	34.5%	41.8%	N/A	44.2%	50.0%*
APM-C	0.0%*	50.0%*	34.5%	42.9%	N/A	45.7%	50.0%*
CIS-10	N/A	100.0%*	7.1%*	32.4%	0.0%*	21.4%	25.0%*
DEV	0.0%*	22.1%	10.8%	12.8%	0.0%*	11.4%	18.4%
IMA-2	N/A	33.3%*	10.5%*	34.2%	N/A	7.8%	50.0%*
LSC	N/A	50.0%*	14.3%*	53.2%	100.0%*	39.3%	25.0%*
TFL-DO	6.6%	12.1%	7.5%	12.7%	12.5%	7.1%	14.3%
TFL-DS	6.6%	11.4%	6.8%	11.9%	10.0%	6.5%	11.8%
TFL-OH	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
W30-2+	0.0%*	74.7%	31.3%	57.3%	0.0%*	43.4%	47.5%
W30-6+	40.0%*	43.8%	14.6%	38.6%	N/A	36.6%	29.8%
WCV	32.5%	42.4%	32.1%	41.5%	29.0%	31.9%	43.9%

Source: MY 2022 DHCS Health Disparities KHS Rate Sheet
*Insufficient data. The denominator is less than 20.

For the women's and perinatal health indicators with sufficient data, White members had the lowest rates for contraceptive care among postpartum women indicators (CCP-MMEC60-1520 and CCP-MMEC60-2144) compared to other racial/ethnic groups. For all other women's or perinatal health indicators, racial/ethnic disparities in rates varied by indicator. English speakers had the lowest rates for prenatal and postpartum care indicators (PPC-Pre and PPC-Pst) compared to other languages. For all other women's or perinatal health indicators, language disparities in rates varied by indicator.

MY 2022 DHCS Health Disparities KHS Rate Sheet Indicators: Perinatal and Women's Health

Indicator	American / Alaska Native	Asian	Black/ African American	Hispanic / Latino	Native Hawaiian/ Other Pacific Islander	White	Other
BCS	44.4%	49.0%	51.8%	64.6%	33.3%*	42.1%	48.8%
CCP–MMEC60–1520	0.0%*	75.0%*	35.5%	33.1%	0.0%*	26.3%	100.0%*
CCP–MMEC60–2144	40.0%*	29.7%	30.1%	40.6%	25.0%*	29.5%	29.0%
CCS	33.3%*	50.0%	50.0%	59.9%	N/A	39.4%	25.0%*
CCW–MMEC–1520	8.7%	6.3%	12.8%	10.9%	14.3%*	20.9%	9.3%
CCW–MMEC–2144	18.6%	19.5%	19.7%	24.3%	13.2%	18.9%	21.5%
CHL	61.9%	41.2%	58.6%	55.4%	33.3%*	44.6%	50.0%
PDS–E–DS	0.0%*	2.9%	2.37%	2.40%	0.0%*	3.1%	4.6%
PDS–E–FU	N/A	N/A	0.0%*	40.0%*	0.0%*	N/A	N/A
PND–E–DS	0.0%*	0.0%	0.0%	0.1%	0.0%*	0.0%	0.0%
PND–E–FU	N/A	N/A	N/A	0.0%*	N/A	N/A	N/A
PPC–Pre	100.0%*	94.7%*	65.4%	90.8%	N/A	77.2%	83.3%*
PPC–Pst	100.0%*	89.5%*	76.9%	87.3%	N/A	66.7%	83.3%*
PRS–E	0.0%*	15.5%	7.6%	21.0%	0.0%*	10.0%	7.7%

Source: MY 2022 DHCS Health Disparities KHS Rate Sheet
*Insufficient data. The denominator is less than 20.

When looking at the mental health and substance abuse indicators by race or ethnicity, Black/African American members had the lowest rate for most indicators with sufficient data. When comparing indicator rates by language, Spanish speakers had the lowest antidepressant medication management rates. For all other mental health and substance abuse indicators, rates varied by language.

MY 2022 DHCS Health Disparities KHS Rate Sheet Indicators: Mental Health and Substance Abuse

Indicator	American / Alaska Native	Asian	Black/ African American	Hispanic/ Latino	Native Hawaiian/ Other Pacific Islander	White	Other
AMM–Acute	42.9%*	53.7%	47.3%	52.4%	50.0%*	63.8%	64.3%*
AMM–Cont	42.9%*	44.8%	36.7%	36.4%	50.0%*	49.1%	57.1%

DRR–E–PHQ	N/A	N/A	N/A	N/A	N/A	N/A	N/A
DRR–E–RM	N/A	N/A	N/A	N/A	N/A	N/A	N/A
DRR–E–RS	N/A	N/A	N/A	N/A	N/A	N/A	N/A
DSF–E–DS	1.0%	0.6%	1.0%	0.8%	1.0%	1.1%	0.7%
DSF–E–FU	0.0%*	63.6%*	29.6%	34.3%	N/A	44.8%	50.0%*
FUA–7	33.3%*	22.2%*	4.6%	9.2%	0.0%*	11.1%	33.3%*
FUA–30	33.3%*	22.2%*	9.1%	14.0%	0.0%*	19.7%	33.3%*
FUM–7	0.0%*	0.0%*	7.1%	9.1%	N/A	9.1%	16.7%*
FUM–30	50.0%*	10.0%*	9.4%	20.1%	N/A	20.7%	16.7%*
POD	100.0%*	50.0%*	12.5%*	34.3%	N/A	29.0%	0.0%*

Source: MY 2022 DHCS Health Disparities KHS Rate Sheet
* Insufficient data. The denominator is less than 20.

When reviewing chronic condition indicators by race or ethnicity, rate disparities varied by indicator. For each chronic condition indicator, a different racial/ethnic group had the lowest or worst rate. It should be noted that a lower rate for poor hemoglobin A1c control for patients with diabetes (HBD-H9) means better performance for that indicator. When comparing rates by language, English speakers had the lowest or worst rate for all chronic condition indicators. The exception was colorectal cancer screening (COL), where Arabic speakers had the lowest rate.

MY 2022 DHCS Health Disparities KHS Rate Sheet Indicators: Chronic Conditions

Indicator	American/ Alaska Native	Asian	Black/ African American	Hispanic/ Latino	Native Hawaiian/ Other Pacific Islander	White	Other
AMR	50.0%*	80.0%	66.5%	70.7%	N/A	63.1%	92.9%*
CBP	0.0%*	68.0%	43.3%	64.3%	N/A	61.0%	28.6%*
COL	17.1%	23.8%	24.5%	30.1%	10.0%	21.3%	22.7%
HBD-H9^	50.0%*	36.0%	38.5%	40.7%	100.0%*	34.6%	12.5%*
SSD	45.5%*	73.9%	77.8%	76.8%	N/A	78.9%	83.3%*

Source: MY 2022 DHCS Health Disparities KHS Rate Sheet
*Insufficient data. The denominator is less than 20.
^A lower rate means better performance for this indicator.

With the remaining DHCS Disparities Indicators, rate disparities varied by racial/ethnic group and language.

MY 2022 DHCS Health Disparities KHS Rate Sheet Indicators: Other Indicators

Indicator	American/ Alaska Native	Asian	Black/ African American	Hispanic/ Latino	Native Hawaiian/ Other Pacific Islander	White	Other

AAP	68.0%	75.8%	70.1%	74.8%	69.1%	68.1%	74.1%
AMB-ED	466.9	227.1	610.9	420.8	676.8	517.5	363.84
PCR-OR^	0.0%*	8.7%	10.2%	8.0%	40.0%*	9.5%	6.7%

Source: MY 2022 DHCS Health Disparities KHS Rate Sheet
*Insufficient data. The denominator is less than 20.
^A lower rate means better performance for this indicator.

Summary of Member Needs Based on DHCS Health Disparities KHS Rate Sheet Indicators

1. Black/African American members had the lowest Health Disparities Rate Sheet Indicator rate for most child development and health indicators.
2. Black/African American members had the lowest rate for most mental health and substance abuse indicators.
3. These disparities indicate the need for disease prevention and chronic condition management strategies that are oriented towards Black/African American members.
4. Chronic condition indicator disparities vary by race or ethnicity. 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.
5. English speakers have a disproportionately lower rates for child development and health indicator rates and chronic disease indicator rates compared to other language groups.

Conclusion:

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

1. Addressing Health Disparities in Black/African American Children

- **Need**: Black/African American members have 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 external organizations 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.
    - Track a reduction in 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 for Black/African American Members

- **Need**: This population also has the lowest rates for mental health and substance abuse indicators, suggesting barriers to accessing these services.
- **Action**: Implement prevention and management programs specifically designed for Black/African American members, addressing cultural and community-specific factors.

3. Culturally Competent Chronic Disease Management

- **Need**: Disparities in chronic condition indicators vary by race and ethnicity, 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. Addressing Language Disparities

- **Need**: English speakers show lower rates for child development, health, and chronic disease indicators compared to other language groups, suggesting 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 and chronic disease management.

Summary of Relevant Actions:

- **Partnerships**: Establish collaborations with community organizations that serve Black/African American populations to strengthen health initiatives.
- **Targeted Programs**: Create mental health and substance abuse programs that reflect the cultural contexts of Black/African American members.
- **Culturally Competent Training**: Provide training for providers on cultural competence in 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.

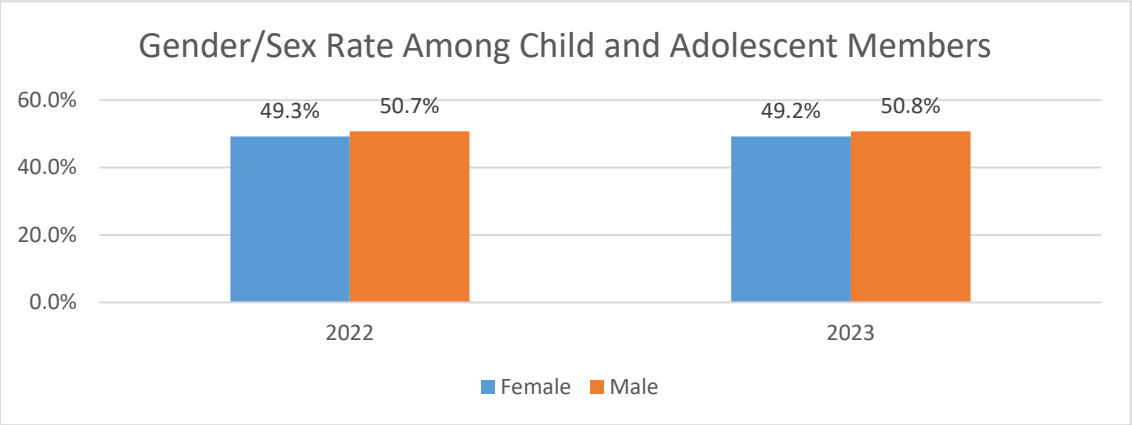
Overall Strategy:

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

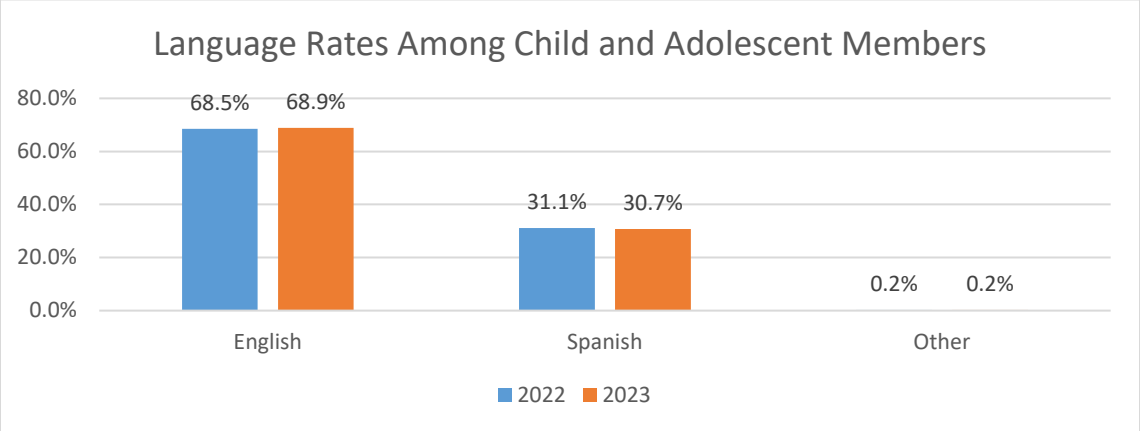
The population of child and adolescent members (ages 2-19 years old) increased by 11.7% from 2022 to 2023. Child and adolescents accounted for 39.6% of members in 2023, down from 42.4% in 2022.

The proportion of child and adolescent members who were males in 2023 was 50.8% compared to 49.2% for females. The gender/sex rates were very similar when comparing 2022 to 2023 data.



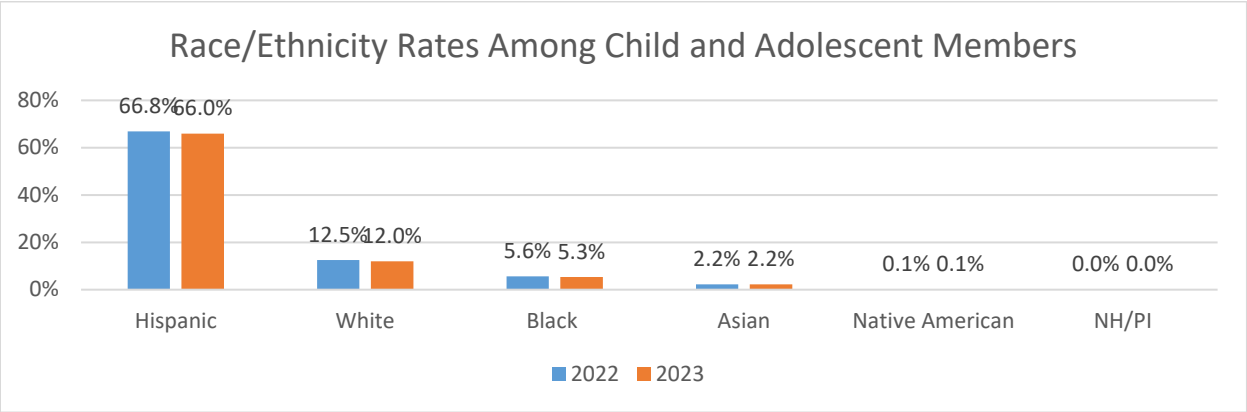
Source: KHS Member Demographics Report

English-speaking members accounted for 68.9% of child and adolescent members in 2023, followed by Spanish-speakers at 30.7%, and other languages combined at 0.2%. These rates were similar to those for 2022 with a slight increase for English-speakers and a slight decrease for Spanish-speakers.



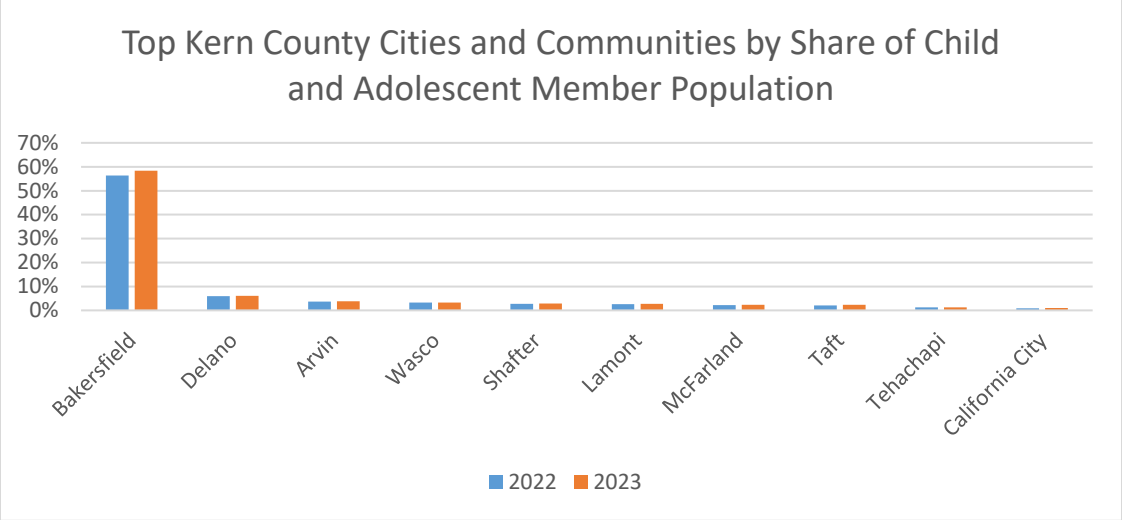
Source: KHS Member Demographics Report

When looking at child and adolescent members by race and ethnicity, Hispanics were the largest group, followed by Whites, Blacks/African Americans, Asians, Native Americans, and Native Hawaiians and Pacific Islanders in descending order.



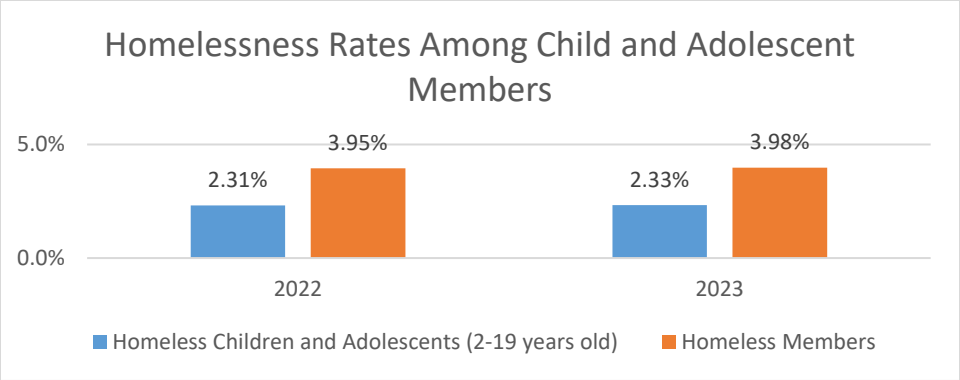
Source: KHS Member Demographics Report

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



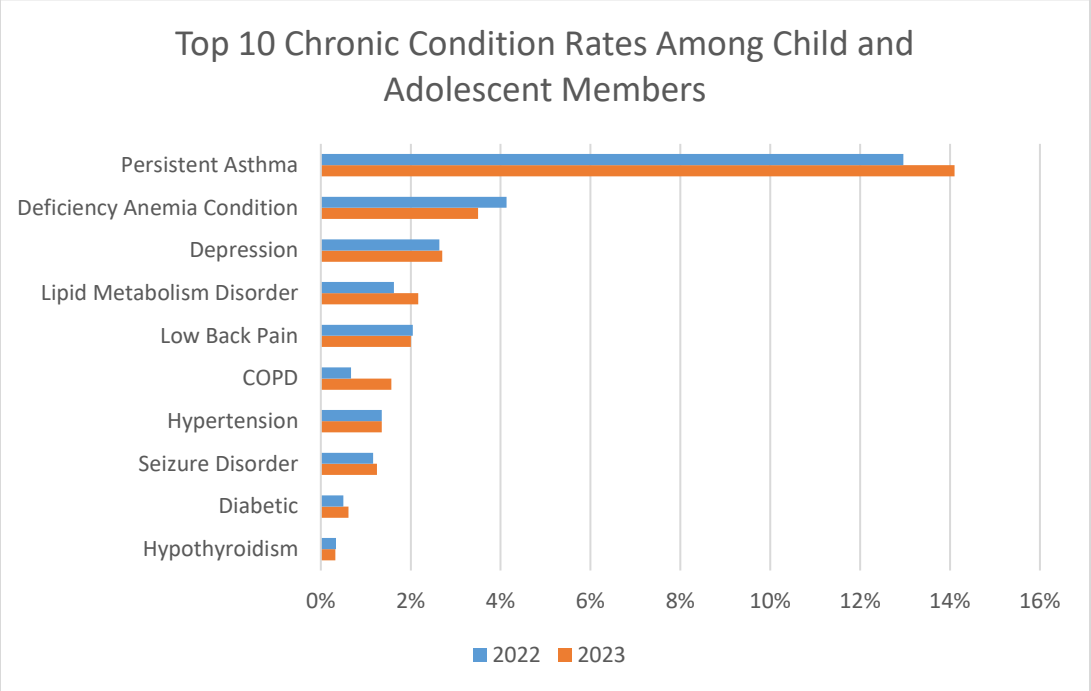
Source: KHS Member Demographics Report

Children and adolescents have a lower rate of homelessness compared to the overall KHS member population.

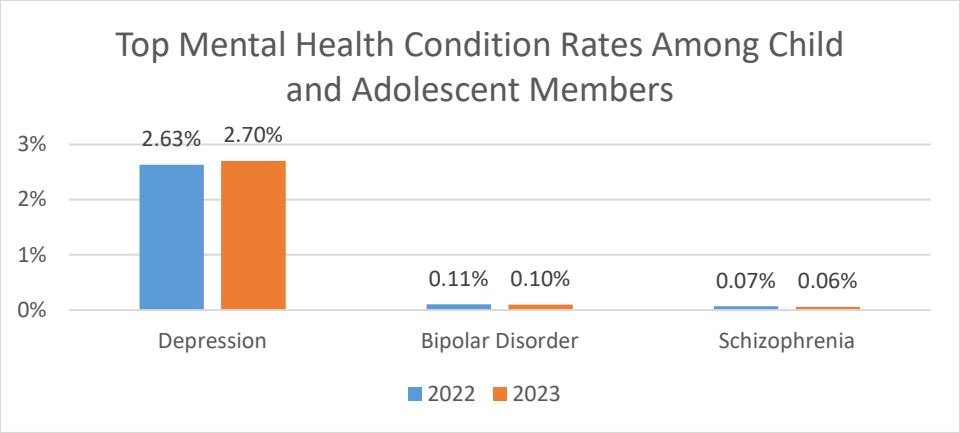


Source: KHS Member Demographics Report

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 14.1% in 2023, 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



Source: KHS Member Demographics Report

According to the MY 2023 MCAS Rate Tracking Report, preliminary KHS MY 2023 MCAS rates have not met 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. LSC: Lead Screening for Children
4. DEV: Developmental Screening in the First Three Years of Life
5. TFL: Topical Fluoride for Children
6. W30 (0-15M): Well-Child Visits in the First 15 Months, Six or More Well-Child Visits
7. W30 (15-30): Well-Child Visits for Age 15-30 Months, Two or More Well-Child Visits
8. WCV: Child and Adolescent Well-Care Visits

These findings indicate that strategies and activities are needed to improve immunization, lead screening, developmental screening, topical fluoride application, and well-care visits among children and adolescent members. See the Quality Improvement Program Gap Analysis section for rates and other details.

Child and Adolescent Member Needs Summary:

1. Child and adolescent members are concentrated in Bakersfield.
2. Persistent asthma is the top chronic condition among child and adolescent members. 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 and depression are the next most common chronic conditions among children and adolescent members. Nutrition counseling or 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, lead screening, developmental screening, topical fluoride application, and

well-care visit outcomes among child and adolescent members. Barriers must be identified to develop effective strategies.
5. Health education, fitness, 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, or lifestyle change.
6. KHS has found through its School Wellness Grant Program that student behavioral and health outcomes benefit from school wellness programs.

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
7. Primary and secondary school physical education and sports programs
8. After school programs, such as the Boys and Girls Clubs of Kern County
9. Community youth recreational programs

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

1. **Preventive health and developmental screening outcomes**
    - **Need:** Improvement is needed with immunization, lead screening, developmental screening, topical fluoride application, and well-care visit outcomes among child and adolescent members. Barriers must be identified to develop effective strategies.
    - **Actions:** Work with KHS staff to 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. Include information about child and adolescent preventive health and development screening in the Member Newsletter, which is mailed to members twice a year.
        - Promote child and adolescent preventive health and development screening as part of member text message campaigns.

KHS' Current Activities

- **Children's Health**
    - Basic PHM: Children

Primary care is the foundation of all health care and is critical to achieving quality and equity. Central to the BPHM concept is providing strong access to and utilization of primary care, as well as leveraging culturally and linguistically appropriate primary care to increase trust with members, reduce health care disparities, and provide 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 to periodic well-child and developmental screenings according to a prescribed schedule, 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).

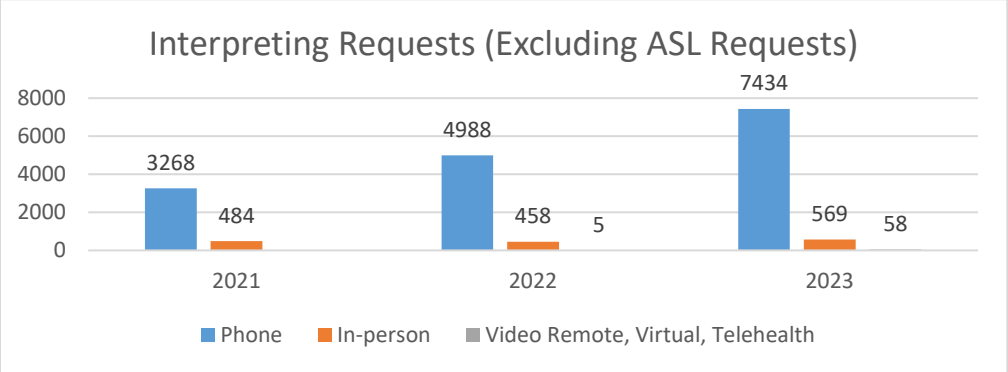
EPSDT offers preventive health visits, including age-specific screenings, assessments, and services, at intervals consistent with the AAP Bright Futures periodicity schedule, and immunizations specified by the ACIP childhood immunization schedule.

- Children with Special Health Care Needs (CSCHN) program helps children under 21 who have complex health problems. This program has a special team that works together to help CSCHN members and their families. They team up with different doctors and local services to make sure the children get the care they need and have a better life.

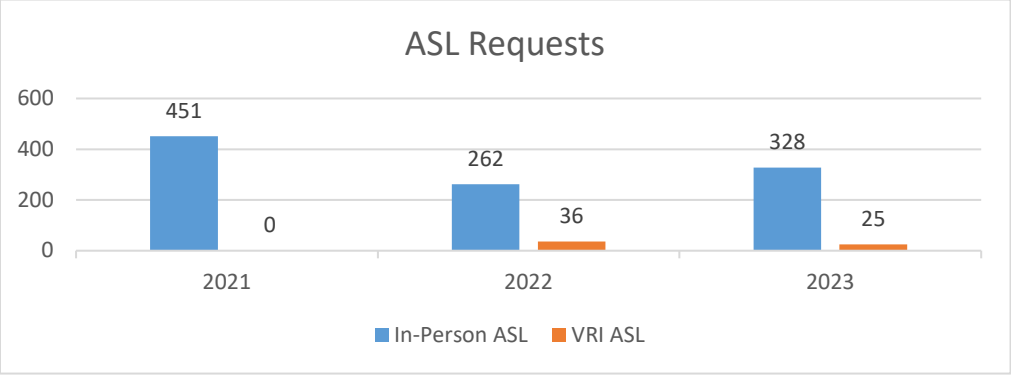
IV. KHS Program Gap Analysis

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 2023, there was an overall 46.4% increase in interpreting requests compared to 2022.[28] When looking at interpreting requests by type excluding American Sign Language (ASL) requests, in-person requests increased by 24.2%, phone interpreting requests increased by 49.0%, video remote interpreting (VRI) requests increased by 1,060.0%. ASL interpreting requests increased by 18.5%.[29]

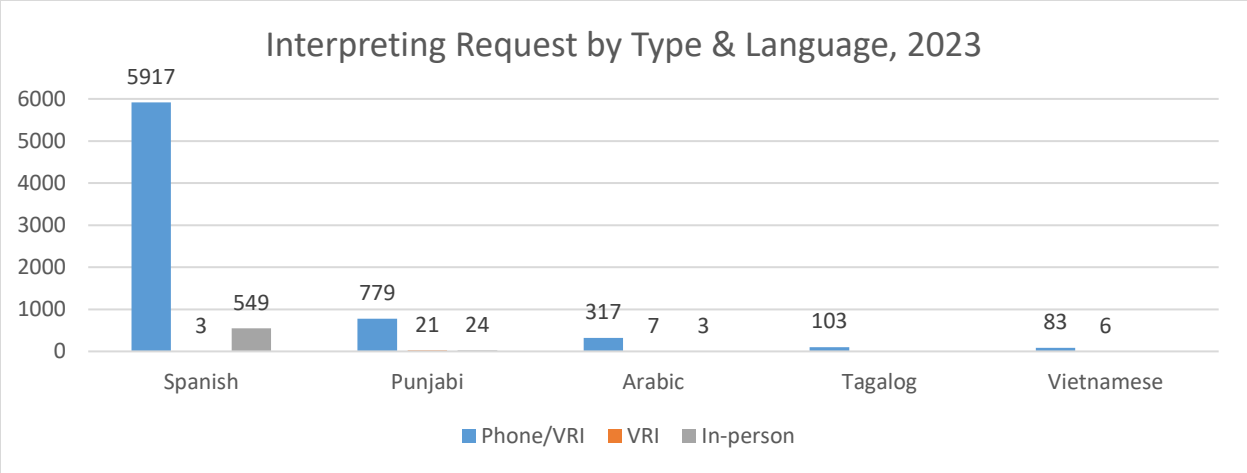


Source: KHS Interpreting Request Annual Activities Reports



Source: KHS ASL Request Annual Activities Reports

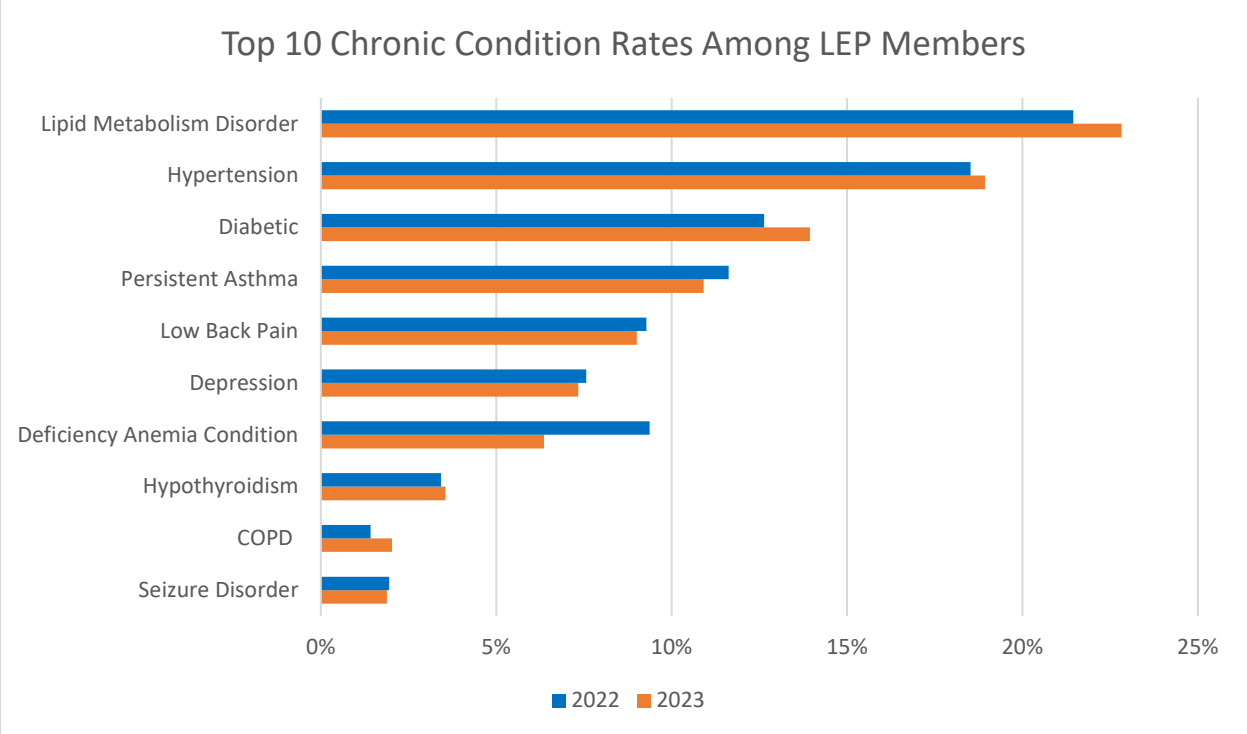
When looking at face-to-face interpreting requests, Spanish was the most common language, followed by Punjabi, Cantonese, Arabic, and Korean.[28] Among phone or VRI interpreting requests, Spanish was the most common language, followed by Punjabi, Arabic, Tagalog, and Vietnamese.



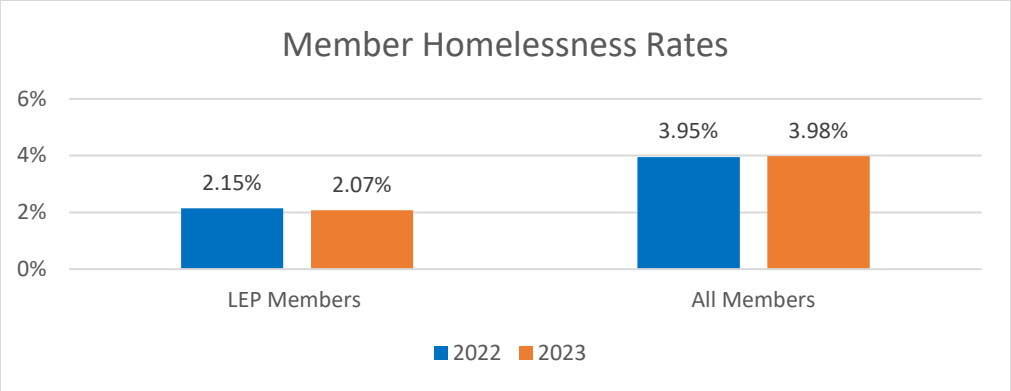
Source: KHS Interpreting Request Annual Activities Reports

See the Access to Care section for a summary of the KHS quarterly interpreting access survey among its health care provider network.[30] The rate of providers who were considered compliant with knowledge of access to interpreters increased from 76.8% in 2022 to 92.5% in 2023. The results show improvement in 2023 compared to 2022.

The profile of top chronic conditions among members with limited English proficiency (LEP) is similar to the overall membership. Lipid metabolism and hypertension are much more prevalent among LEP members than the entire member population.



Source: KHS Member Demographics Report



Source: KHS Member Demographics Report

Summary of Needs of Members with Limited English Proficiency

1. Member interpreting requests increased by 46.4% from 2022 to 2023. This reflects a growing member need for interpreting services. The COVID-19 pandemic may have been a factor for this significant increase. Members may have delayed needed medical care due to pandemic restrictions.
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 top non-Spanish languages continue to grow each year.
3. Member ASL interpreting requests increased by 24.2% from 2022 to 2023. ASL interpreting is a growing member need. However, there continues to be a shortage of ASL interpreters based in Kern County. 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 and fitness programs offered by KHS and community partners), the KHS Public Policy and Community Advisory Committee, and other member outreach events.
6. Conducting recurring trainings on KHS member interpreting services with the same provider sites will be needed due to provider staff turnover.
7. Increasing awareness about our interpreting services among members, providers, and community partners would improve member access to interpreting services.
8. 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 heart health disease management programs.

The following needs of LEP members are met:

1. Members need language interpreting services in a variety of languages and formats. KHS offers language interpreting service in any language requested and in different formats, 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 language interpreting services. KHS conducts a periodic interpreter access survey to monitor providers and ensure they are meeting interpreting access standards. KHS also offers language 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**
   - **Need:** There is a lack of in-person language interpreters who are based in Kern County to meet member demand.
   - **Action:** Work with language interpreting service providers and local educational institutions to identify strategies to recruit and hire more language interpreters who are based in Kern County.

2. **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 recruit and hire more ASL interpreters who are based in Kern County.

3. **Member interpreting service trainings for health care providers**
   - **Need:** Member interpreting service trainings are needed for some KHS health care providers.
   - **Action:** Reach out to providers and offer interpreting service trainings if needed. If needed, increase KHS Culture and Linguistics (C&L) staff resources for provider outreach and trainings.

4. **Lack of community awareness of KHS member interpreting services**
   - **Need:** There is a lack of awareness of interpreting services among members, KHS staff, health care 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, Community Engagement, and Provider Network Management Teams to develop community and provider outreach strategies to promote KHS language interpreting services.

Wellness and Prevention Programs

The KHS Wellness and Prevention (W&P) Department offers health education programs, services, and incentives to members and the community. The department offers a variety of modalities, such as in-person classes, virtual classes, community fitness classes, follow-up calls, printed mailings, and social media content. KHS stopped offering in-person classes in March

2020 and began to offer virtual classes in April 2020 in response to the COVID-19 pandemic. KHS resumed in-person classes in April 2023. Most KHS W&P programs are offered at the KHS office in Central Bakersfield or on Zoom. Some programs, such as the Diabetes Prevention Program and the Diabetes Empowerment and Education Program, are only offered in person at the KHS office. Other KHS W&P programs may be offered at offsite locations in Bakersfield and in outlying areas of Kern County on a limited basis.

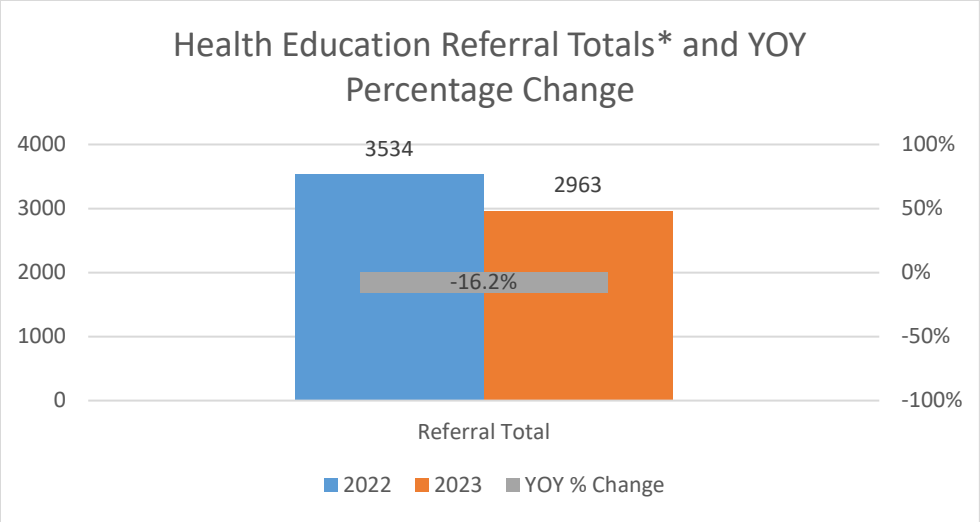
KHS began to offer a community benefit called the Live Better Program in 2022. It includes free nutrition and exercise classes at community sites in Kern County. This program is free and open to the public.

In addition to W&P programs offered directly by KHS staff, KHS began offering the Community Health Worker (CHW) and Asthma Preventive Services (APS) benefits in 2023. 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.

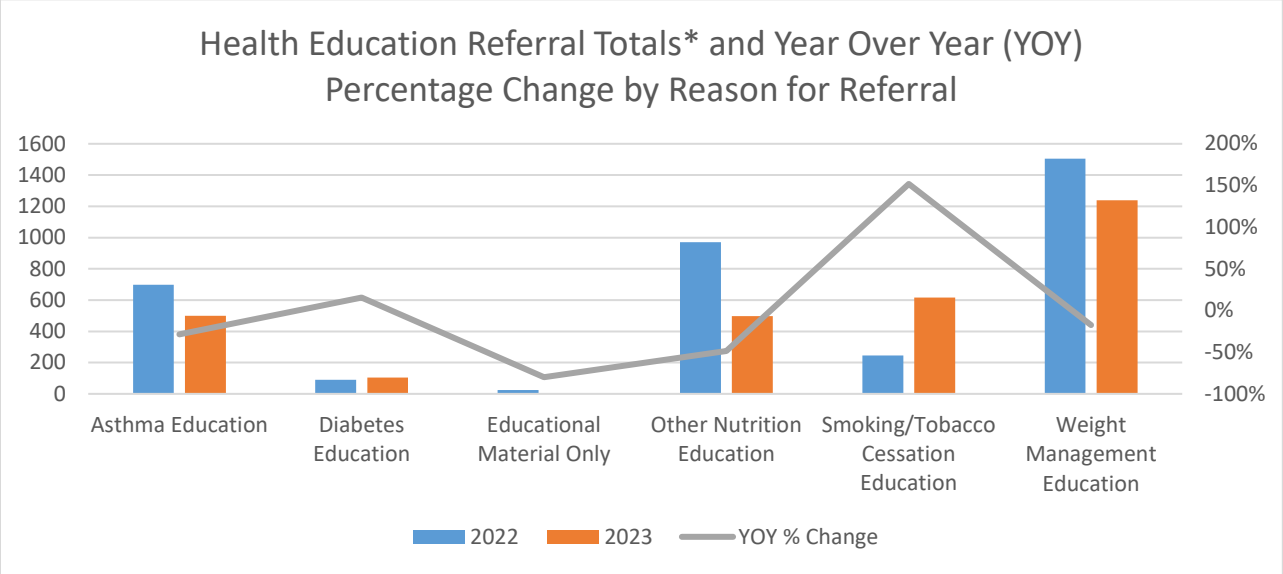
APS includes clinic-based asthma self-management education, home-based asthma self-management education, and in-home environmental trigger assessments for members with asthma. Both CHW services and APS require the recommendation of a health care provider.

Health Education Referrals

The KHS Wellness and Prevention (W&P) Department received 2,963 referral requests for health education services in 2023, a 16.2% decrease compared to the previous year.[31] Weight management education was the top referral topic, followed by smoking/tobacco cessation education, asthma education, other nutrition education, and diabetes education. Referrals for smoking/tobacco and diabetes education increased from 2022 to 2023. Referrals for weight management education, asthma education, and other nutrition education decreased.

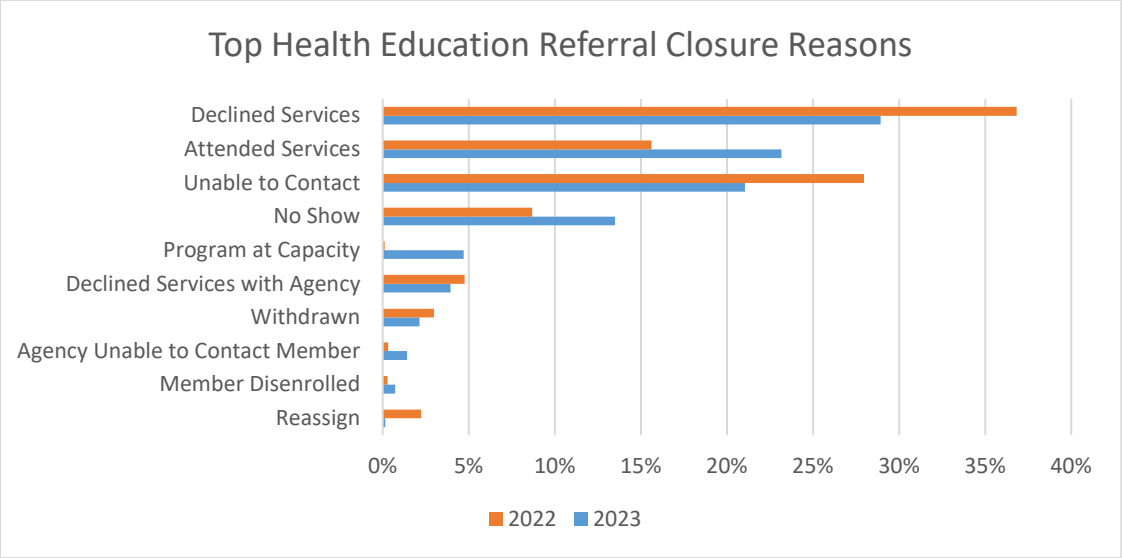


*Referral totals are based on referral start date.
Source: KHS HECL Report



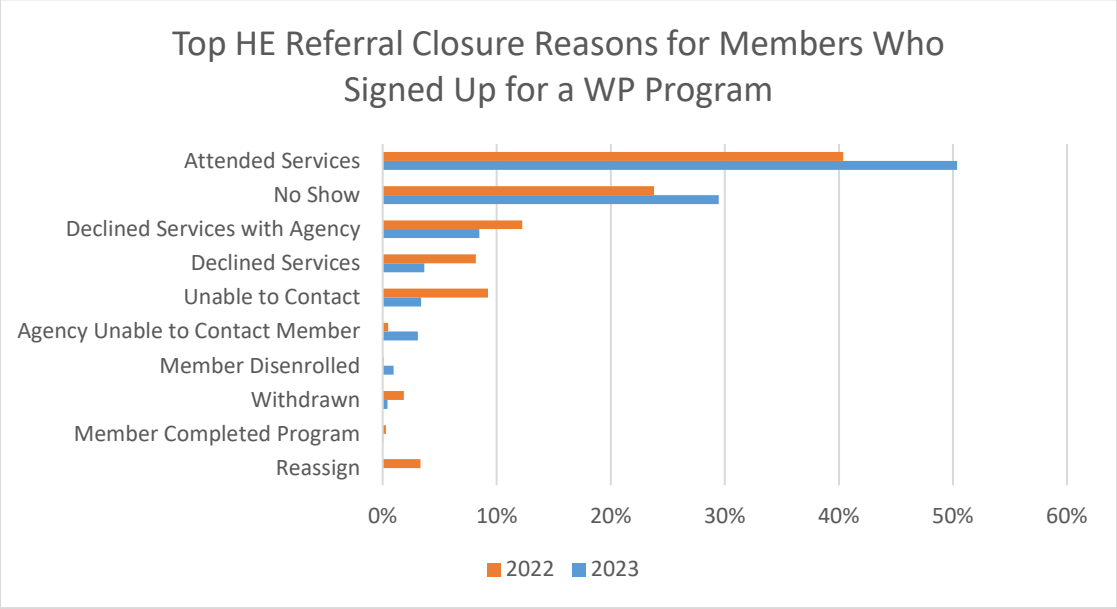
*Referral totals are based on referral start date.
Source: KHS HECL Report

The rate of members who accepted health education services increased from 42.3% in 2022 to 44.1% in 2023. The rate of members who declined health education services decreased from 36.8% in 2022 to 28.9% in 2023.



Source: KHS HECL Report

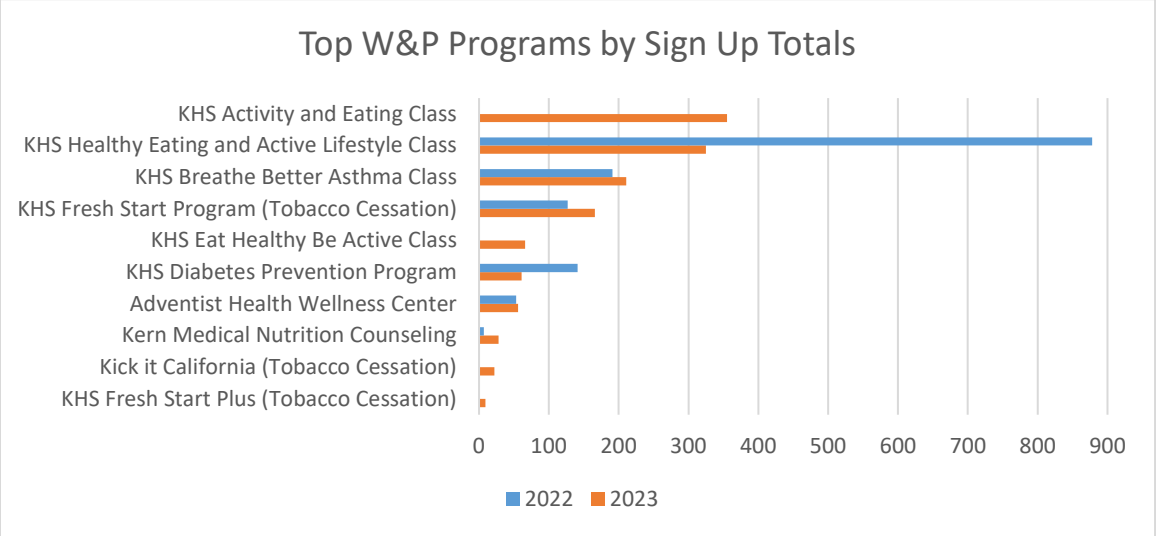
Among referrals with members who signed up for a W&P program, the proportion of referrals that were closed with an "Attended Services" outcome (attended at least one program session) increased from 40.4% in 2022 to 50.4% in 2023. The proportion of referrals that were closed with a "No Show" outcome (did not attend any program sessions) increased from 23.8% in 2022 to 29.5% in 2023.[24]



Source: KHS HECL Report

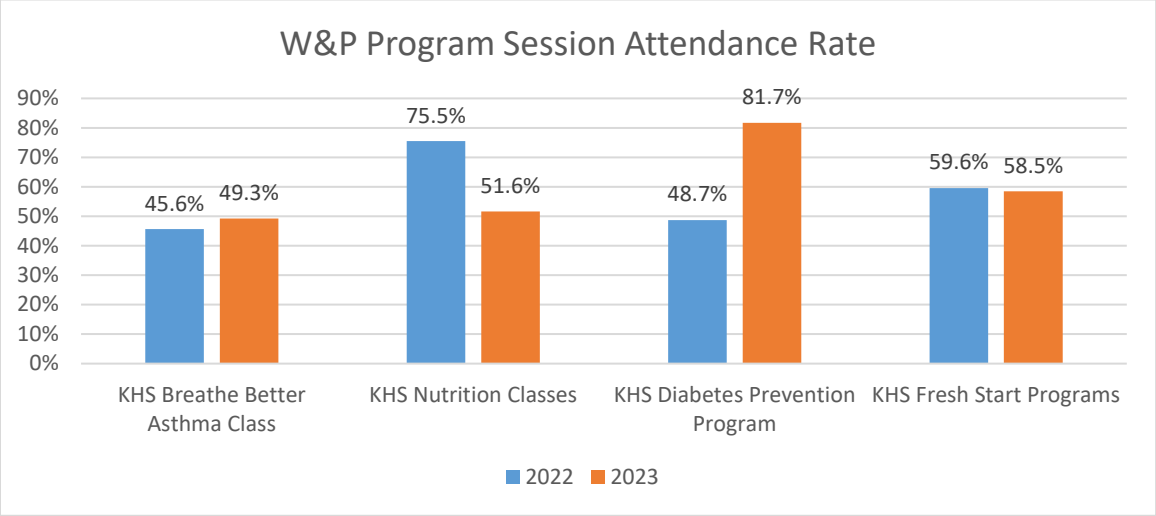
KHS nutrition education classes were the most popular type of health education services in 2023 based on program registration, followed by the Breathe Better Asthma Class, the Fresh Start Program (tobacco cessation), and the Diabetes Prevention Program (DPP). KHS nutrition classes

accounted for 57.1% of all accepted services referrals and 58.6% 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

The overall W&P program session attendance rate increased from 55.1% in 2022 to 61.1% in 2023. KHS DPP had the highest attendance rate, followed by KHS Fresh Start Programs, KHS nutrition classes, and the KHS Breathe Better Class.



Source: KHS HECL Report

Summary of W&P Programs and Member Needs

1. The rate of members who accepted health education services after being referred increased from 42.3% in 2022 to 44.1% in 2023. The percentage of referrals with a W&P

program registration where a member attended at least one W&P program session increased from 40.4% in 2022 to 50.4% in 2023. These increases reflect a growth in member interest or need for wellness and prevention programs.

2. W&P program registration totals in 2023 indicate that member needs include education on top chronic conditions and healthy lifestyle topics such as nutrition, weight management, asthma, tobacco cessation, diabetes prevention, and diabetes management.
3. DPP has the highest attendance rate compared to other KHS W&P programs. However, KHS offers 1 or 2 DPP series each year because it is a resource intensive program. It is only offered in person at the KHS office. There may be a need among members to scale up this program so that it is offered with more sessions and at more locations in Kern County.
4. Diabetes management is a top chronic condition among members. KHS began offering the Diabetes Empowerment and Education Program in February 2024. There may be a need to scale up this program to meet member demand for diabetes education and management.
5. 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. More CHW and APS providers will be needed to scale up the service capacity and meet member demand.
6. 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 the Diabetes Prevention Program (DPP)

- **Need**: The DPP has high attendance rates, indicating strong member interest. However, it is currently limited in terms of frequency and locations.
- **Action**: Increase the number of DPP sessions offered and expand the locations where they are available to better meet member demand.

4. Enhanced Diabetes Management Resources

- **Need**: With diabetes being a prevalent chronic condition, there is significant demand for education and management resources.
- **Action**: Scale up the Diabetes Empowerment and Education Program to provide more comprehensive 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 increasing the number of locations and sessions available to members.

Summary of Relevant Actions:

- **Program Expansion**: Develop more sessions and locations for W&P programs, particularly DPP 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 additional CHWs and APS providers to enhance service delivery options.

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 Program Referrals

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 and mental health 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 ECM and CSS, two CalAIM initiatives.

A total of 953 members were referred for ECM in 2023.[32] This was a 95.3% increase compared to 2022. The top 5 zip codes by number of members referred for ECM in 2023 included 93307, followed by 93308, 93304, 93305, and 93306.

CSS referrals require prior authorization. A total of 3,351 CSS referrals were authorized in 2023, a 524.0% increase compared to 537 in 2022.[33]

Conclusion:

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

1. Increased Capacity for ECM

- **Need**: The 95.3% increase in ECM referrals indicates a significant demand for ECM services, which has outpaced the growth in member enrollment.
- **Action**: Expand ECM resources and staffing to ensure that all members requiring these services can receive timely and effective support.

2. Expanded CSS

- **Need**: The remarkable 524.0% increase in CSS referrals suggests a critical need for CSS among members.
- **Action**: Scale up CSS offerings by increasing the number of providers, resources, and available programs to meet this surging demand.

3. Alignment of Resources with Rapid Growth

- **Need**: Overall member population growth of 11.7% indicates that resources must be aligned with both enrollment and 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.

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 to 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. Case finding can ensure that individuals at risk of an adverse event can be offered an intervention designed to reduce that risk.
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 utilized to identify member chronic conditions and risk scores across the entire KHS population.

   a. Data sources for the ACG Modeler include member eligibility, medical claims, pharmacy claims, laboratory results, and supplemental medical data.
   b. The ACG Modeler outputs are referenced in PHM program stratification and performance measures.

KHS uses that data to analyze service utilization patterns, disease burden, and gaps in care for our members considering their risk level, geographic location, and age groups.

KHS uses these findings to evaluate the programs and services offered by KHS and to 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 wastes and excess fluids 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.

Patients with ESRD usually have a certain number of comorbid factors. The KHS ESRD Population Analysis (N=721) report shows there are 41% (297) members with 6 to 10 chronic conditions, 21% (156) members with 11 to 15 chronic conditions and 8% (57) members with 16 or more chronic conditions. The average probability of inpatient hospitalization in 6 months is 29.60%, and the average probability of excessive cost is 85.47%.

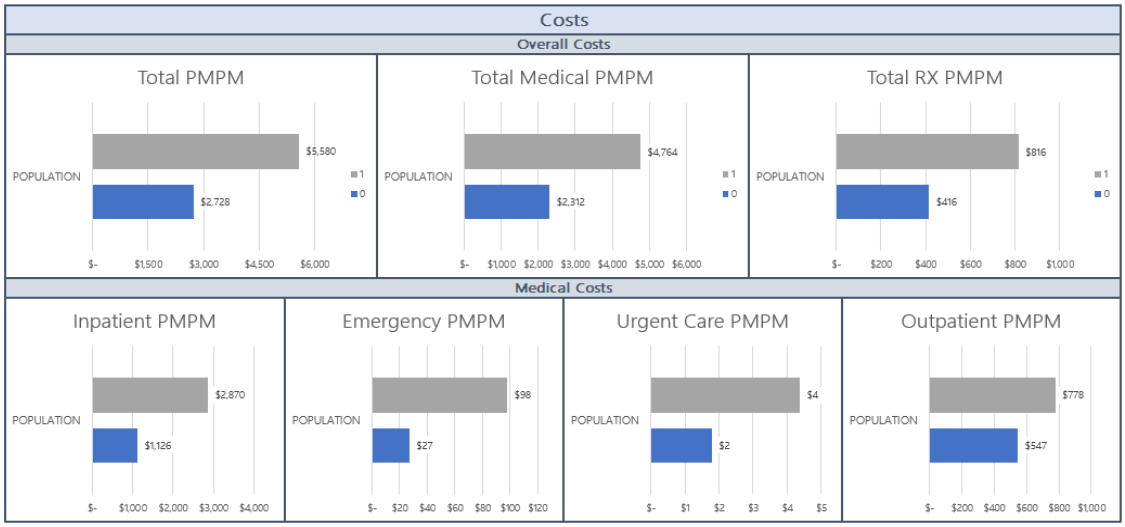
The Resource Utilization Band (RUB) for ESRD members is scored at 4.68, which is in the very high category. This means that the ESRD members with multiple comorbidities require more intensive healthcare services. ECM and PHM CCM services will be needed to ensure care coordination and management continuum of care are provided to the members.

Hypertension (94%) is the most common comorbidity among ERSD patients while diabetes (74%), dyslipidemia (70%), 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, 16% 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. KHS has also experienced higher than normal potentially preventable admission (PPA) rates on members with ESRD. Approximate PPA rates for different types of visits or services are included below:

- 66% of ER visits
- 75% of inpatient admissions
- 35% of outpatient visits
- 60% of PCP visits
- 45% of pharmacy services

Overall Costs for ESRD Members (N=721) (Date: 1/8/2023)



Note: *Blue bar: No PPA* *Gray bar: Members with PPA*

There are opportunities to cut costs for these services. The total overall cost per member per month for ESRD members with PPA is more than double compared with non-ESRD members. The cost for ESRD members with PPA is double or more compared with non-ESRD for total medical, inpatient, emergency, and urgent care services.

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:

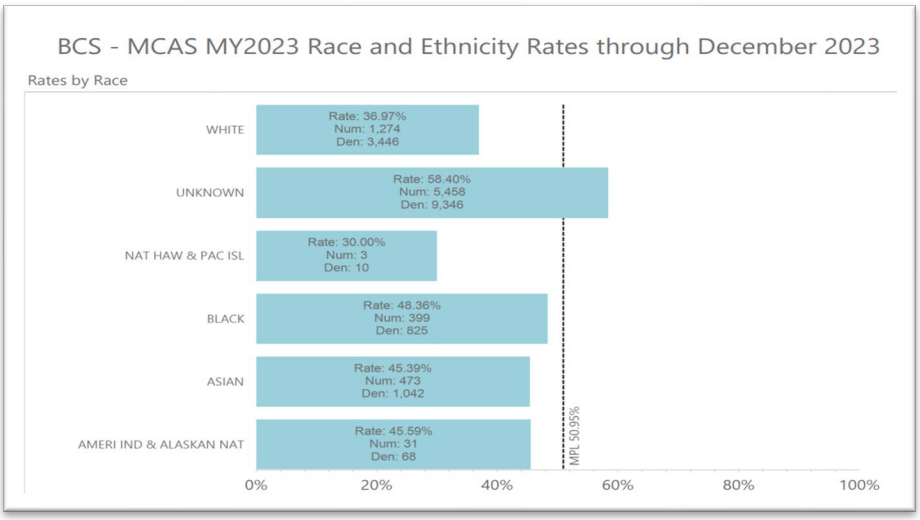
- Provide care coordination and care management services to optimize disease management;
- Educate members on self-management;
- Screen and address patients' psychological issues and refer to appropriate behavioral health services;
- Ensure members receive timely, seamless comprehensive healthcare including 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 (ACOG 2017). 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 (ACOG 2017). 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 (ACOG 2017).

In 2023, Kern Health Systems (KHS) reported 14,753 women ages 50-74 who needed a mammogram. Of these 14,753 women, KHS has been successful in providing screening for 7,576 women—indicating a success rate of 51.35%. In terms of rates by race, the rate for breast screening compliance among Black/African American women was 48.36% (see graph below).



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 (Oppong et al., 2021). These disparities have resulted in Black women are more likely to die from breast cancer than women of all other racial and ethnic groups (Oppong et al., 2021).

- In 2021, Black/African American women had higher rates of screening mammography than women of other races. 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 2016 to 2020 (most recent data available) was about 39% higher for Black/African American women than White women (Komen 2023).

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. An 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 (Komen 2023).

1. Increasing access, awareness and sensitivity may help remove some barriers (especially for women with low income who do not have health insurance). This includes:
2. Improving access to mammography and primary care
3. Removing financial barriers
4. Removing language barriers
5. Community education (such as health campaigns that address negative beliefs and feelings about mammography)
6. 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.

Quality Improvement Program Gap Analysis

In 2023, 96% of Initial and Periodic Facility Site Reviews (FSR) that were conducted passed with a score of 80% or higher. There were 60 site reviews conducted that included 27 FSRs and 33 Medical Record Reviews (MRR). Only one MRR resulted in a failing score.

In 2023, the volume of Site and Medical Record reviews increased compared to last year due to completion of the backlog that had evolved from the pandemic.

The Initial Health Assessment changed to an Initial Health Appointment effective January 1, 2023. The primary change removes the specific requirement for completion of the Staying Healthy Assessment to more general screening and assessment areas that must be included with follow-up of areas that need to be addressed.

The top three deficiencies identified for opportunities to improve for the FSR include:

- No evidence that site staff has received annual training on the following: Infection Control/Universal Precautions
- Site not registered with CAIR
- Patient confidentiality training missing for staff and physician

The top three deficiencies identified for opportunities to improve the MRR include:

- Hearing screen not documented.
- HIV screenings not performed.
- Adult immunizations not given according to ACIP guidelines.

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 measurement years 2022 and 2023.

MY2023 MCAS Rate Tracking Report Note: These are the Preliminary Rates pending HSAG's approval						
Hybrid Measures Held to MPL						
Measure		**Current MY2023 Rate**	**MPL**	**MY2022 Rate**	**MY2023 Vs MPL**	**MY2023 Vs. MY2022**
CCS	Cervical Cancer Screening	57.18	57.11	52.80	0.07	▲ 4.38
CIS-10	Childhood Immunization Status *	24.82	30.9	27.98	-6.08	▼ -3.16
HBD-H9**	HbA1c Poor Control (>9.0%)*	32.85	37.96	39.17	5.11	▲ 6.32
CBP	Controlling High Blood Pressure <140/90 mm Hg	65.21	61.31	60.58	3.90	▲ 4.63
IMA-2	Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)*	34.06	34.31	29.68	-0.25	▲ 4.38
PPC-Pre	Care	87.10	84.23	87.35	2.87	▼ -0.25
PPC-Post	Prenatal & Postpartum Care – Postpartum Care	86.37	78.1	83.94	8.27	▲ 2.43
LSC	Lead Screening for children	58.64	62.79	47.45	-4.15	▲ 11.19
HBD-H9** is an inverse measure, low rate indicates better performance. **MRR**-Medical Record Reviews						
Administrative Measures Held to MPL						
Measure		**Current MY2023 Rate**	**MPL**	**MY2022 Rate**	**MY2023 Vs MPL**	**MY2023 Vs. MY2022**
AMR	Asthma Medication Ratio	71.20	65.61	69.48	5.59	▲ 1.72
BCS-E	Breast Cancer Screening	59.30	52.60	56.68	6.70	▲ 2.62
CHL	Chlamydia Screening in Women Ages 16 – 24	56.87	56.04	53.67	0.83	▲ 3.20
DEV	Developmental Screening in the First Three Years of Life	25.94	34.70	13.47	-8.76	▲ 12.47
FUA	Follow-Up After ED Visit for Substance Abuse – 30 day Follow up*	18.85	36.34	15.74	-17.49	▲ 3.11
FUM	Follow-Up After ED Visit for Mental Illness – 30 days Follow up*	19.12	54.87	18.80	-35.75	▲ 0.32
TFL	Topical Fluoride for Children	16.44	19.30	12.27	-2.86	▲ 4.17
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.	39.21	58.38	37.12	-19.17	▲ 2.09
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 visits.	63.74	66.76	55.12	-3.02	▲ 8.62
WCV	Child and Adolescent Well-Care Visits*	46.55	48.07	40.64	-1.52	▲ 5.91
	Indicates KHS did not met MPL		Indicates KHS met or exceeded MPL			
	Indicates KHS need 5% or less to met MPL		Indicates KHS met or exceeded HPL.			

MCAS Initiatives:

1. The Strike Team was created in February 2023 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 created a member outreach team to contact members aging out of measures and schedule appointments for their preventative health services.
4. Measures of focus include Child and Adolescent Well – Care Visits (WCV), Childhood Immunization Status – Combination 10 (CIS-10), Immunizations for Adolescents – Combination 2 (IMA-2), Lead Screening in Children (LSC), and Well-Child Visits in the first 30 months of life (W30)
5. KHS partnered with a telehealth service provider to provide follow-up care after ED visits for mental health and substance abuse disorders.

6. The Quality Performance team has initiated 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 began a pilot for diabetic members with uncontrolled diabetes. The goal of the program is to improve members'A1C levels with appropriate interventions. This is an incentive-based reimbursement structure similar to other programs, such as COVID-19 vaccines and the BCS pilot with the Comprehensive Blood and Cancer Center.
8. Komoto Pharmacy completed their first mobile unit at the Black Family Wellness Expo. KHS is supporting this effort with a targeted call campaign for Black/African American families within three miles of the event.
9. Member Engagement Reward Program (MERP) Campaigns:
    a. Include in the 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. Mailers sent to member households reminding them of incentives for the completion of preventative health screenings.
    c. Text messages to members encouraging them to schedule appointments for gaps in care with a focus on:
        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
    d. Robocalls will be sent out to members that do not receive text messages.
    e. KHS will be adding FUA, FUM and HBD text messages to the campaign list.

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 pediatrician, caregiver, and child, 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.

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.

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 Results and Impact on KHS Activities and Resources

In 2023, the Medi-Cal program underwent significant changes, primarily driven by CalAIM, which mandates comprehensive population health management across all state plans. Key initiatives include implementation of the major organ transplant program, integration of Community Health Workers (CHW) within KHS and its network, enhancing care for justice-involved individuals, improving transitions of care, addressing health disparities, and improving on 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. By January 1, 2026, attaining both NCQA Health Plan Accreditation and NCQA Health Equity Accreditation will further solidify KHS' commitment to delivering high-quality, equitable 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 made available to all identified members:

1. Health and Wellness
    a. Activity & Eating Program
    b. Eat Healthy Be Active Program
    c. Live Better Program
    d. Health Library and Self-Management Tools

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

a. Breast Cancer Screening
b. Cervical Cancer Screening
c. Diabetes Prevention Program (Centers for Disease Control and Prevention Recognition)

3. 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:
    a. Asthma Education Program
    b. Diabetes Empowerment Education Program™
    c. Fresh Start and Fresh Start Plus Smoking Cessation Programs
    d. Complex Care Management
    e. Chronic Obstructive Pulmonary Program
    f. End Stage Renal Disease Program
    g. ER Navigation Program
    h. Kids and Youth Transitional Program
    i. Long Term Care and Support Services
    j. Member Centric Care Coordination
    k. Major Organ Transplant Program
    l. Palliative Care Services
    m. Transition of Care Services
    n. CSS
    o. ECM Program

4. Maternal Health
    a. Black Infant Maternal Health Initiative
    b. Baby Steps Program
    c. Baby Steps Plus Program

5. Children's Health
    a. Basic Population Health Management (BPHM)
    b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
    c. Children with Special Health Care Needs

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, community health workers, and outreach specialists.

c. A collaborative, multidisciplinary approach is essential for effectively managing population health and improving health outcomes.

Under the Department of Wellness and Prevention, a team provides education on the following: Asthma Education Program; Diabetes Empowerment Education Program, and Fresh Start and Fresh Start Plus Smoking Cessation Programs. The 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 Wellness and Prevention Department directly offers classes in both virtual and in-person environments and incentives to encourage member participation. They also monitor the participation rates, referral sources, and referral rates per program, race and ethnicity, and other available demographic data.

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 effecting 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) (also known as Children with Special Health Care Needs)
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 assistance in obtaining the appropriate care they need to improve their health. The LTC Team works with the member, 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 of 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 at 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's goal is to implement as many of the approved 14 CSS (listed below) as possible through a phased 6- or 12-month schedule as teams work 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. Nursing Facility Transition/Diversion to Assisted Living Facilities
i. Community Transition Services/Nursing Facility Transition to a Home
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.

<u>Ongoing Staff Development</u>

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:

- 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 in 2022, indicating ongoing challenges in meeting the community's requirements. These gaps encompass areas such as access to preventive services, mental health support, CSS, reliable transportation, and educational resources. 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 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, 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 reward platform. 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.

Activities to Address Health Care Disparities among Black/African American Members

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 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.

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.

Member and Staff Survey Monitoring

- C&L Services Surveys:
  - Post Call Survey Results
  - Over-the-phone & Video Remote (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.

- 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.
    - 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.

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, the ultimate 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.

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