KERN HEALTH SYSTEMS

Population Needs Assessment Report

2021

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I. Population Needs Assessment Overview

In May 1996, Kern Health Systems (KHS) began to serve Medi-Cal Managed Care beneficiaries by offering Kern Family Health Care (KFHC) as the local initiative health plan. As of June 8, 2021, KHS provides services to over 301,187 Medi-Cal Managed Care beneficiaries in Kern County.

The goal of the 2021 KHS Population Needs Assessment (PNA) is to improve health outcomes for KHS members and ensure that KHS is meeting the needs of its members through:

1. Identification of member health needs and health disparities;
2. Evaluation of current health education (HE), cultural and linguistic (C&L), and quality improvement (QI) activities and available resources to address identified concerns; and
3. Implementation of targeted strategies for HE, C&L, and QI programs and services to address member needs.

KHS' 2021 PNA builds upon previous needs assessments and uses various data collection methods and sources. Total membership and demographics have changed slightly compared to KHS' last needs assessment in 2020. KHS' membership grew by 0.75% which may be due to the pandemic's impact on the economy. The adult share of KHS' membership grew slightly to 54.9%. The majority of members are still slightly more likely to be female. Hispanic/Latinos continue to be the majority of members, and English continues to be the most common primary language. Most members live in Bakersfield. The highest concentration of members continues to be in the 93307 zip code. Enrollment of Seniors and Persons with Disabilities (SPD) increased by 2.0%, the Health Homes Program (HHP) population now amounts to over 32,409 eligible members and KHS identified 14 homeless members through its Case Management (CM) department in 2020.

In 2020, COVID-19 related illnesses became one of the top diagnoses in all health care settings for adult members. The most common inpatient hospitalization diagnoses included sepsis, appendicitis, COVID-19 acute respiratory disease, hypertension, and heart disease. The most frequent Emergency Department (ED) visit diagnoses were respiratory infections, urinary tract infections, COVID-19 acute respiratory disease, and various types of pain, such as abdominal, pelvic, chest, or throat. The most frequent diagnoses for Urgent Care (UC) visits among members were respiratory infections and contact with communicable diseases (likely related to COVID-19). It is worth noting that COVID-19 diagnoses are likely to be underrepresented in the top 2020 diagnoses among KHS members since the new COVID-19 ICD-10 codes did not become effective until January 1, 2021.

Dyslipidemia, hypertension, asthma, depression, and diabetes were found to be the top 5 chronic conditions according to population analysis reports. Diagnosis totals increased in 2020 compared to 2019 for most of the top chronic conditions. However, diagnosis totals decreased slightly for persistent asthma and dramatically for diabetes and COPD. Review of KHS' pharmaceutical utilization identified Ibuprofen as the top medication prescribed followed by Albuterol HFA, Lisinopril, Atorvastatin, and Metformin HCL, which further supports KHS' chronic condition population health analysis conclusions.

Mental health diagnoses for depression, bipolar disorder and schizophrenia were found to have higher rates among female, English-speaking, and adult members, in comparison to male, non-English-speaking, and youth members. White members were disproportionately diagnosed with depression and bipolar disorders whereas Black or African American members had the highest share of members with a diagnosis of schizophrenia when compared to other racial/ethnic groups by a small margin.

The physical and behavioral chronic conditions associated with tobacco use identified anxiety, depression, and high blood pressure as the top 3 comorbidities.

Findings from KHS' member diagnosis data should be interpreted cautiously since the pandemic limited access to care. Health care providers temporarily closed offices and restricted the availability of in-person appointments to help reduce the spread of COVID-19. This likely resulted in under-utilization of health care services among KHS members which impacted the diagnosis totals for the top chronic conditions among KHS members.

Referrals for HE services decreased by 36.1% from 2019 to 2020. The majority of referrals were for weight management, asthma, nutrition counseling with a registered dietitian (RD), and tobacco cessation. The largest changes in referrals by topic were for nutrition counseling with a RD (+93.4%), smoking cessation (-84.1%), and asthma (-49.4%). The rate of members who accepted health education services decreased by 28.5%, yet the rate of members who received services increased by 22.2% in comparison to the prior year. The pandemic is likely a big factor for the decrease in the number of referrals. The launch of KHS' virtual nutrition education classes and new member incentive program soon after the start of the pandemic is significantly contributed to the increase in services received. Average attendance at the nutrition classes in 2020 increased dramatically compared to the previous year.

Requests for qualified interpreters decreased significantly in 2020 due to the COVID-19 restrictions and likely the community fear of contracting the disease. Use of a telephonic interpreter decreased by 14.7%, in-person interpreter requests decreased by 26.4%, and interpreter requests for American Sign Language (ASL) decreased by 23.5%. Interpreting requests decreased for all languages, except for telephonic requests for Punjabi.

KHS' access to care surveys identified a small percentage of providers who were found to be non-compliant with urgent and emergency care standards. Further review and analysis of KHS' access to care data revealed that KHS did not meet its 2020 CAHPS benchmark goals in the areas of:

- Rating of Health Plan
- Getting Needed Care
    - Getting care, tests or treatments
    - Obtained appointment with specialist as soon as needed
- Getting Care Quickly
    - Getting urgent care
    - Getting routine care
- How Well Doctors Communicate
    - Personal doctors explained things

    - Personal doctors listened carefully
    - Personal doctors spent enough time
- Coordination of Care
- Rating of Personal Doctor
- Rating of Specialist
- Advising Smokers and Tobacco Users to Quit Discussing Cessation Strategies

This data supports the decrease in member adherence to preventive care or treatment where several indicators on DHCS' RY 2020 Disparities Rate Sheet for KHS demonstrated a decrease in pediatric preventive care, women's health care and chronic condition care.

The lack of in-person classes continues to be a significant gap since this service format has historically been one of the most preferred environments for health education by members. KHS will continue to expand virtual health education services as demand increases for this service format. However, technology literacy and access barriers among members, especially non-English speaking members, will have to be addressed. Non-English speakers are generally less likely to participate in virtual health education classes or use virtual meeting apps.

The following key findings and recommendations were made based on the 2021 PNA.

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

II. Data Sources

KHS used various methods of internal and external data collection, review and analysis in the development of the 2021 Population Needs Assessment.

National, State, and County Data
National, state, and county data were compared to available membership indicators. Sources utilized for this report include the U.S. Census Bureau, California Health Interview Survey, William's Institute, Kern County Public Health Services Department Community Health Assessment and Improvement Plan, Kern County Health Status Profile, and the California Smokers Helpline.

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

2020 CAHPS Medicaid Adult 5.0 Final Report: Kern Health Systems
KHS administered its annual member satisfaction survey by mail and telephonically to all adult KHS members in 2020. A total of 721 surveys were collected which yielded a 18.0% response rate. Female members accounted for 69.9% of all respondents, 38.7% were between the ages of 18-34 years and 63.1% were Hispanic/Latino.

California Department of Health Care Services (DHCS) Data Health Disparities Data
The 2019-2020 health disparities data 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
Reporting Year 2020 MCAS rates were used to assess indicators of our members' health care.

2020 KHS Population Needs Assessment
This report was reviewed and compared with current findings to identify changes in utilization of health services, health education, and cultural and linguistic member needs.

Membership Eligibility Data
KHS membership eligibility data was reviewed and analyzed for 2020 to identify demographic changes by race, language, age, gender, and geographic region since KHS' last needs assessment.

Claims Data
Using ICD-10 codes, claims data from calendar year 2020 were analyzed by race, language, age, gender, and geographic region. Through this analysis, top diagnoses were identified. Emergency department, urgent care, outpatient and inpatient utilization for calendar year 2020 was also reviewed by these variables to identify the top diagnoses and changes in utilization. Additionally, KHS' tobacco registry report was used to identify current smokers and members exposed to tobacco smoke.

Pharmacy Data
Pharmacy claims data from calendar year 2020 was analyzed by top medications dispensed.

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

Kern Health Systems Nurse Line Year In Review
Utilization reports from KHS' 24 hours advice nurse line for the period November 1, 2019 – October 31, 2020 were reviewed to identify call frequency and the top reasons for the calls.

KHS Departmental Reports
The 2020 KHS Health Education (HE) Activities Report was reviewed to identify trends in need for health education services and allows projections for program development. KHS' CM and HHP reports were reviewed for data on KHS' homeless population and critically ill members. KHS' grievance, transportation and provider network management reports were reviewed to identify access to care concerns within the membership.

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

III. Key Data Assessment Findings

Membership/Group Profile

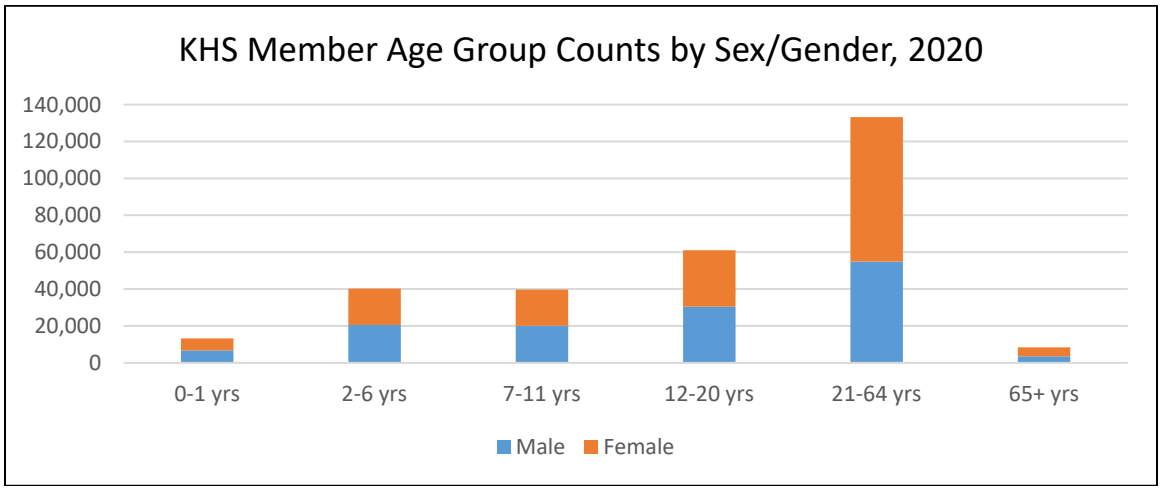
According to KHS' membership statistics, 297,806 Medi-Cal managed care members enrolled in the plan in 2020.[1] This was a 0.75% increase in total annual membership since 2019. KHS member enrollment in 2020 was nearly one third of the population of Kern County.[2] Although sex/gender makeup at the state and county levels is about evenly split, females account for a slightly larger share of the KHS member population than males. The table below provides a comparison of KHS' population with the county and state.

	California (CA)	Kern County (KC)	KHS
Population	39,512,223	900,202	297,806
Male (%)	49.7%	51.2%	45.9%
Female (%)	50.3%	48.8%	54.1%

Source: 2020 KHS Member Demographics Data Report; U.S. Census Bureau

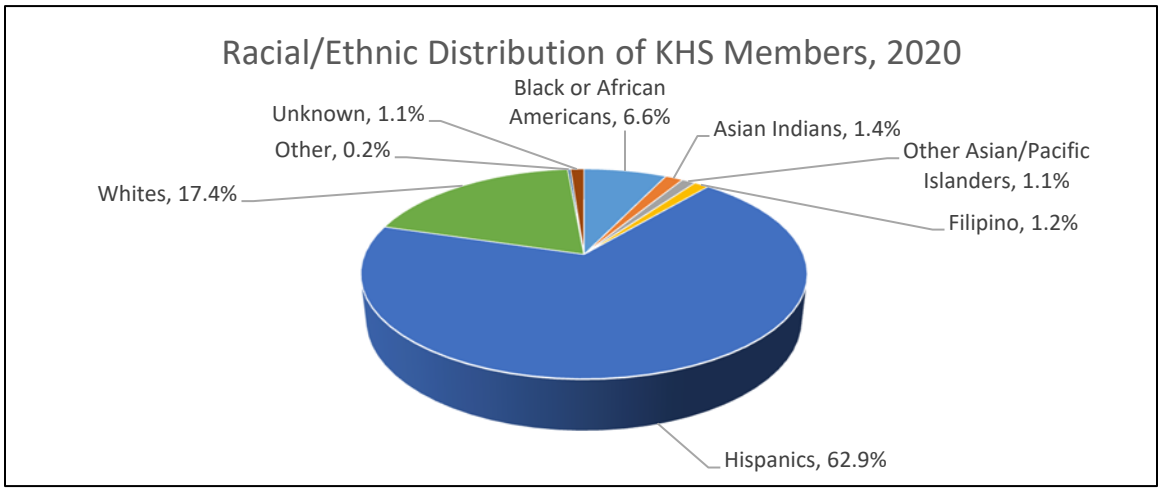
As KHS membership grows, the shares of adults and elderly members continue to increase. The rate of members under 18 years old decreased from 47.9% in 2019 to 45.1% in 2020. The proportion of adult members-increased from 49.3% to 54.9% for members 18-64 years old and from 2.8% to 3.2% for members 65 and older.[1] In comparison, at the county and state level, about 28.8% and 22.5% are under the age of 18, respectively.[2]

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

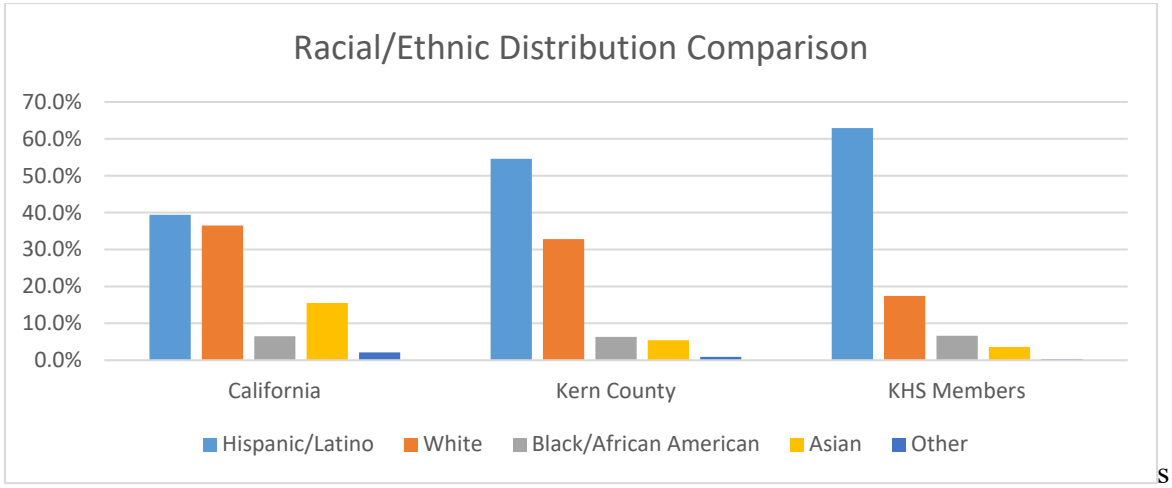


Source: 2020 KHS Member Demographics Data Report

KHS continues to have an ethnically diverse membership. Hispanic/Latinos continue to comprise the majority of our membership, followed by Whites, Black or African Americans, Asians, and other ethnicities. In comparison to data reported in the U.S. Census Bureau, 54.6% of Kern County and 39.4% of California residents are Hispanic/Latino, followed by White (KC-32.8%, CA-36.5%), Black or African American (KC-6.3%, CA-6.5%), Asian (KC-5.4%, CA-15.5%), and Other (KC-3%, CA-2%).[1]



Source: 2020 KHS Member Demographics Data Report



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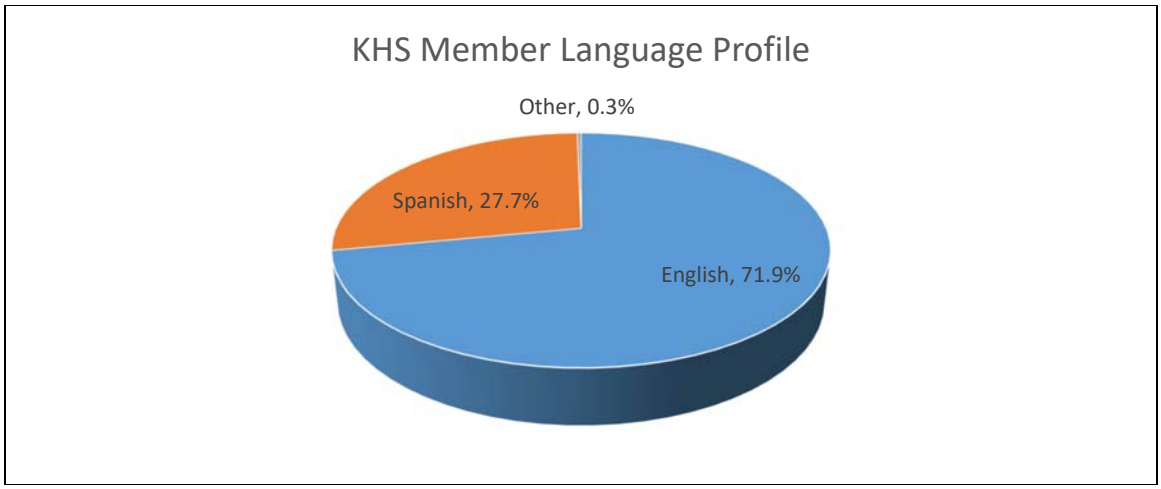
Source: 2020 KHS Member Demographics Report; US Census Bureau

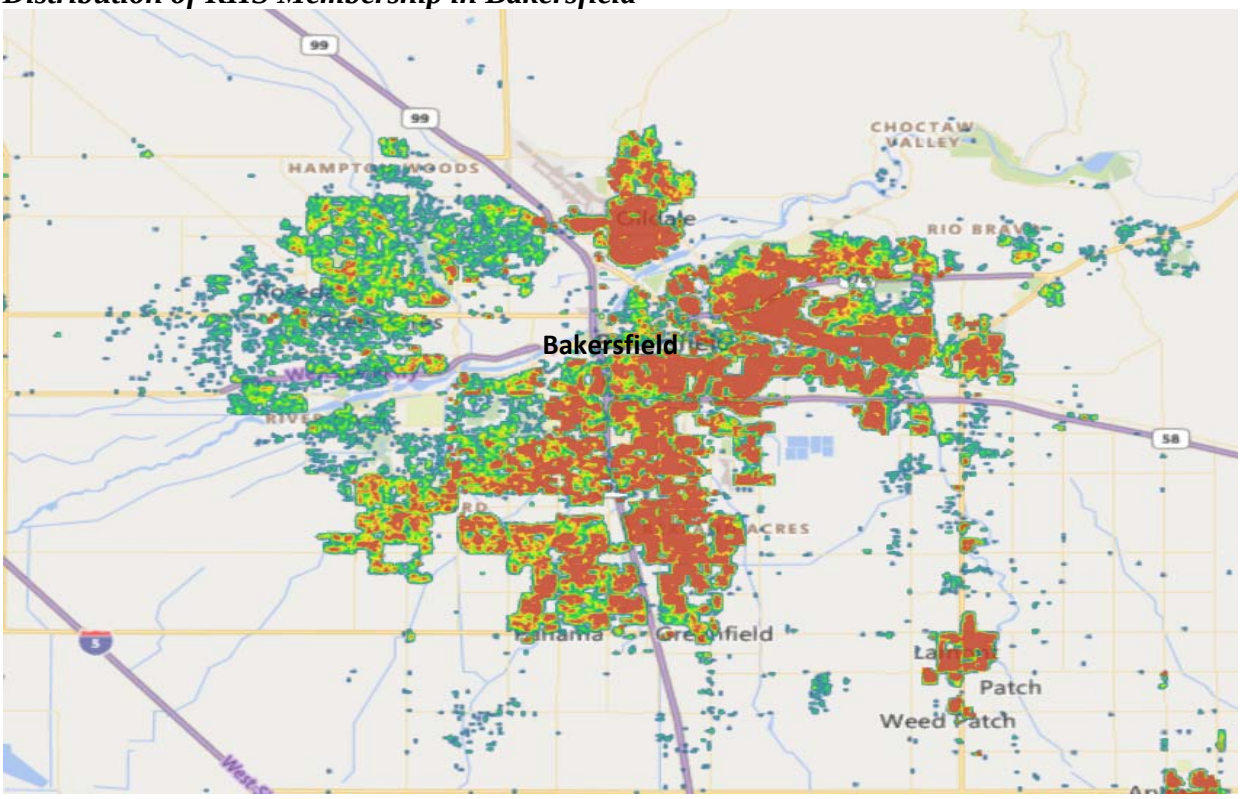
Almost 72% of KHS' membership is English speaking, nearly 28% of the membership is Spanish speaking and less than 1% of members speak a language other than English or Spanish.[1] In comparison to data reported in the U.S. Census Bureau, nearly 56% of Kern County and California residents speak English.[2] This is followed by Spanish (KC-38%, CA-29%), and other languages (KC-5%, CA-15%).



Source: 2020 KHS Member Demographics Data Report

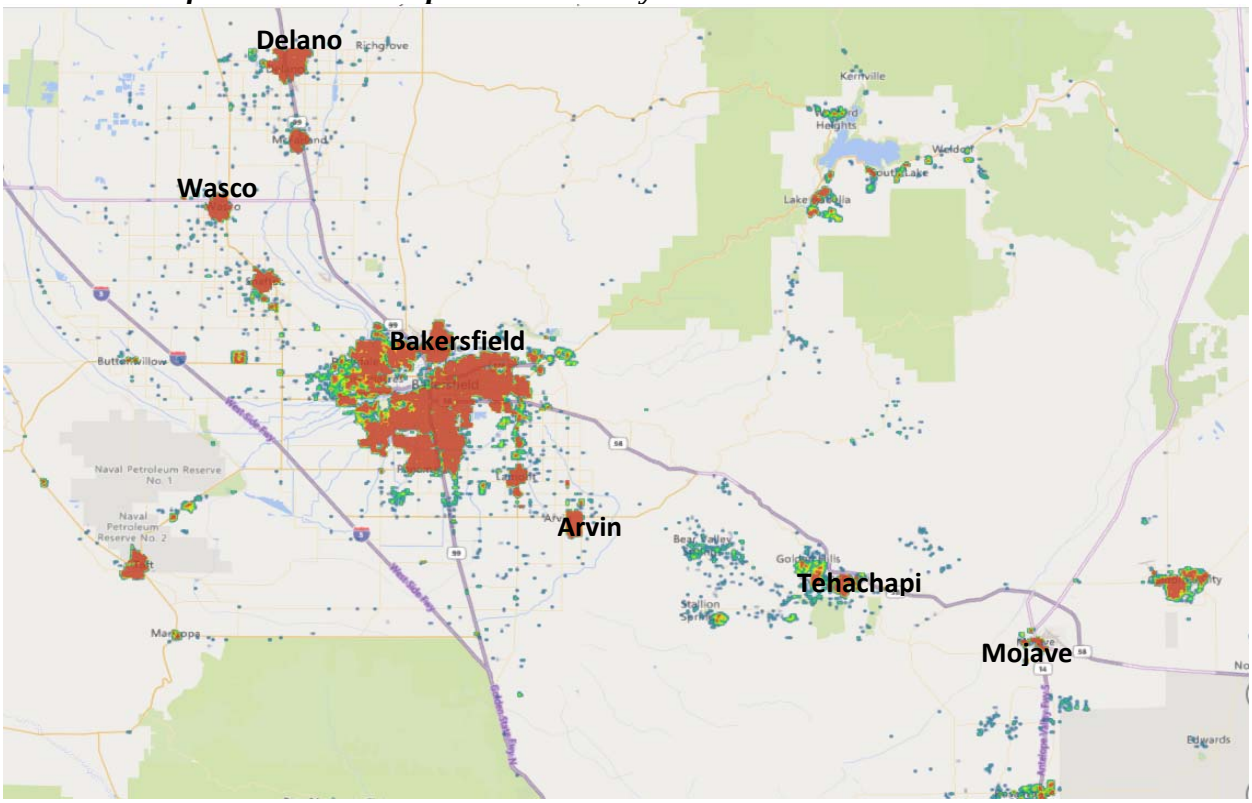
In 2020, the majority of KHS' members lived in Bakersfield (66.0%), Delano (7.1%), Arvin (3.8%), and Wasco (3.4%).[1] There was a 15.4% increase in members residing in Bakersfield, and a 12.0% increase in members living in Delano compared to the 2020 needs assessment. In Bakersfield, the highest concentration of KHS members is in the 93307 zip code (17.3%), followed by 93306 (8.7%), 93304 (7.7%), 93305 (6.3%), and 93309 (6.2%).

Distribution of KHS Membership in Bakersfield



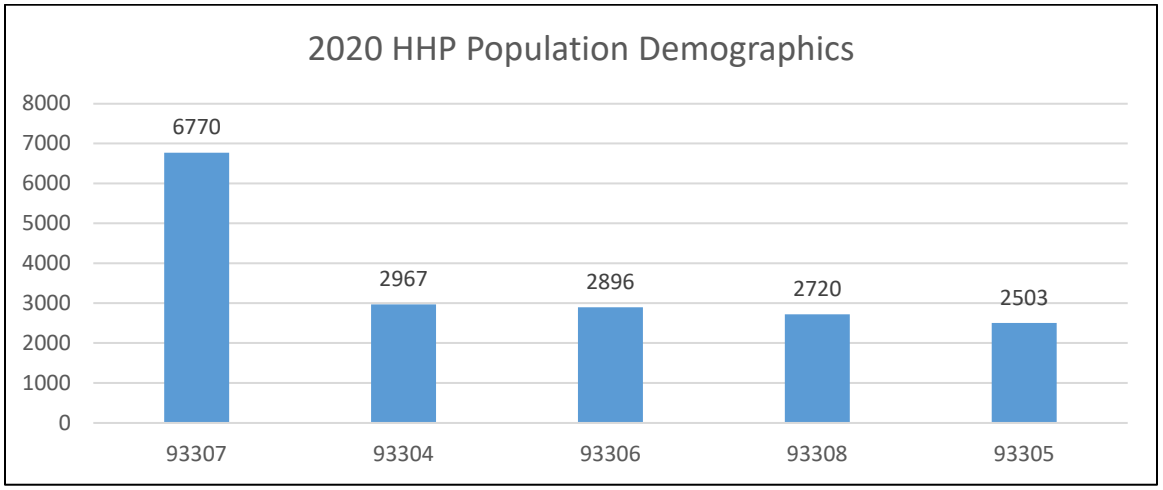
Source: 2020 KHS Member Demographics Data Report

Distribution of KHS Membership in Kern County



Source: 2020 KHS Member Demographics Data Report

KHS' SPD members account for 1.8% of the population in Kern County.[1,5] In 2020, KHS had 16,400 SPD members enrolled, which was 5.5% of our total membership that year.[1] In 2020, a total of 32,409 members had an eligible or open referral status for the HHP. The majority of these members resided in the 93307 zip code, followed by 93304 and 93306.[5]



Source: 2020 KHS HHP Member Demographics Data Report

KHS collects self-reported data of members who disclose they are homeless through the CM Department. In 2020, the CM Department identified 14 homeless members.[6] The majority (11) of homeless members reported living in Bakersfield, while one member reported living in Lamont, and the other two reported living in Los Angeles County.

Health Status and Disease Prevalence

Kern County Public Health Profile

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

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

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

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

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

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

Source: California Department of Public Health, California's County Health Status Profiles for 2019; Kern County Public Health Services Department, Community Health Assessment and Improvement Plan, 2018-2019

KHS Membership Health Conditions & Diagnoses

KHS medical service claims data revealed that the most commonly diagnosed health problems among KHS members in 2020 included common types of infections, chronic diseases, pain, and COVID-19 related illness.[9] The top diagnoses linked to infections included upper respiratory and viral infections, fever, bronchiolitis, bronchitis, pharyngitis, appendicitis, urinary tract infection, sepsis, pneumonia, COVID-19 acute respiratory disease, and contact with communicable diseases. The most commonly diagnosed chronic conditions included asthma, heart disease, kidney failure, diabetes, hypertension, and developmental disorders. The most commonly diagnosed forms of pain were headache, abdominal and pelvic pain, chest pain, low back pain, and throat and chest pain. The chart below is a breakdown of the top diagnoses by age group. Medical service claims from urgent care consistently included the diagnosis of contact with communicable diseases, likely caused by unconfirmed cases of COVID-19. COVID-19 diagnoses are likely to be underrepresented in the top 2020 diagnoses among KHS members since the new COVID-19 ICD-10 claim codes became effective on January 1, 2021.

Top Diagnoses among KHS Members				
Age Group	**ED**	**INPATIENT**	**OUTPATIENT**	**UC**
0-11 Years	• Upper respiratory and viral infections • Fever • Urinary tract infection	• Bronchiolitis • Neonatal jaundice • Appendicitis	• Routine child health exam • Upper respiratory and viral infections • Fever	• Respiratory infection • Contact with communicable diseases • Pharyngitis • Fever
12-20 Years	• Urinary tract infection • Upper respiratory and viral infections • Abdominal and pelvic pain • Headache	• Appendicitis • Sepsis • Poisoning by, adverse effect of and underdosing of narcotics, psychodysleptics, opioids, nonopioid analgesics, antipyretics, and antirheumatics	• Routine child health exam • Abdominal and pelvic pain • Urinary tract infections • Upper respiratory infections	• Contact with communicable diseases • Respiratory infection • Pharyngitis • Urinary tract infections
21-64 Years	• COVID-19 acute respiratory disease • Urinary tract infection	• Sepsis • COVID-19 acute respiratory disease • Overweight and obesity	• Type 2 diabetes • Hypertension • COVID-19 acute	• Contact with communicable diseases • Respiratory infection

	• Chest and throat pain • Abdominal and pelvic pain	• Hypertensive heart disease • Heart attack	respiratory disease • Urinary tract infection • Abdominal and pelvic pain	• Urinary tract infection Pharyngitis
65+ Years	• Urinary tract infection • Headache • COVID-19 acute respiratory disease • Low back pain • Hypertension	• Sepsis • COVID-19 acute respiratory disease • Pneumonia • Kidney failure • Hypertensive and chronic kidney disease	• Chemotherapy • Type 2 diabetes • Hypertension • Heart disease • COVID-19 acute respiratory disease	• Contact with communicable diseases • Acute bronchitis • Urinary tract infection • Hypertension • Upper respiratory infection
SPDs	• COVID-19 acute respiratory disease • Throat and chest pain • Urinary tract infection • Abdominal and pelvic pain	• Sepsis • COVID-19 acute respiratory disease • Cellulitis and acute lymphangitis • Hypertensive heart disease • Pneumonia	• Chronic kidney disease • Type 2 diabetes • Chemotherapy • Hypertension	• Developmental disorders • Hypertension • Type 2 diabetes • Contact with communicable diseases • Low back pain

Source: 2020 KHS Top Diagnosis Report

In late 2020, KHS conducted an analysis of its advice nurse line service for the period covering November 2019 – October 2020. [10] During that period, its advice nurse line received 4,935 inbound calls from members. Over 43% of these calls were for symptom checks by members. The top call reason during business hours (Monday – Friday, 8 AM – 5 PM) was about the health plan (47%). The top call reason after business hours (Monday – Friday, 5 PM – 8 AM, Saturday – Sunday) was symptom check (51%). Pregnancy-related problems were the top symptom check call reason among adult members. Fever or chills was the top symptom check call reason among members under age 18, English speaking members, and non-English language members.

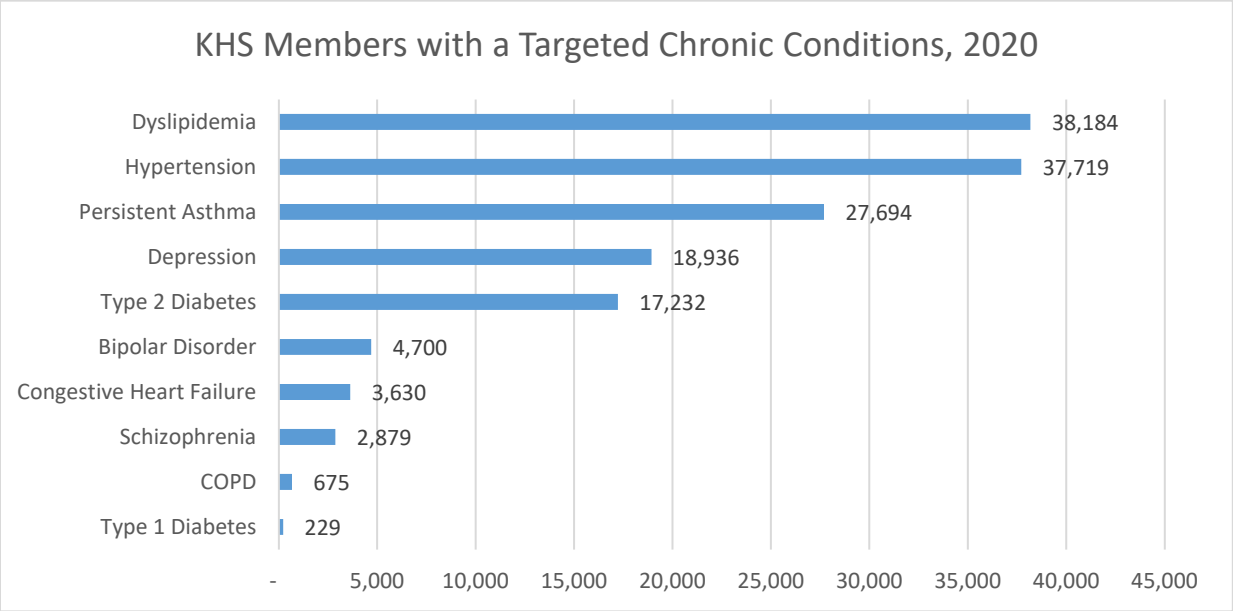
KHS Advice Nurse Line Member Inbound Symptom Call Reasons by Age and Language Preference

Age 18 & Over (66% of calls)	Age Under 18 (34% of calls)	English Language (89% of calls)	Non-English Language (11% of calls)

1. Pregnancy-related problems 2. Respiratory problems 3. Abdominal pain 4. Chest problems 5. Headaches	1. Fever or chills 2. Rash 3. Respiratory problems 4. Nausea and vomiting 5. Coughs	1. Fever or chills 2. Pregnancy-related problems 3. Respiratory problems 4. Abdominal pain 5. Rash	1. Fever or chills 2. Respiratory problems 3. Abdominal pain 4. Coronavirus COVID-19 symptom checker 5. Headaches

Source: 2020 KHS Advice Nurse Line Report

KHS uses the Johns Hopkins ACG Modeler to perform data analysis on member medical service claims for various chronic conditions in a given year. The following chart includes the total number of members identified for targeted chronic conditions in 2020.[11] Diagnosis totals increased in 2020 compared to 2019 for most of the chronic conditions shown in the chart, below. The exceptions were persistent asthma, diabetes, and COPD. Diagnosis totals decreased slightly for persistent asthma and dramatically for diabetes and COPD. This data should be interpreted cautiously since the pandemic limited access to care as health care providers temporarily closed offices or restricted the availability of in-person appointments to help reduce the spread of COVID-19. As a result, this likely resulted in under-utilization of health care services among KHS members which impacted the diagnosis totals for top chronic conditions among KHS members.



Source: KHS 2020 Chronic Condition Population Analysis Report

Pharmaceutical Utilization

KHS' review of the most frequently dispensed medications identified Ibuprofen, Albuterol HFA, Lisinopril, Atorvastatin, and Metformin HCL as the top 5 medications prescribed to KHS members in 2020.[12] These medications are used to treat health conditions that were identified as

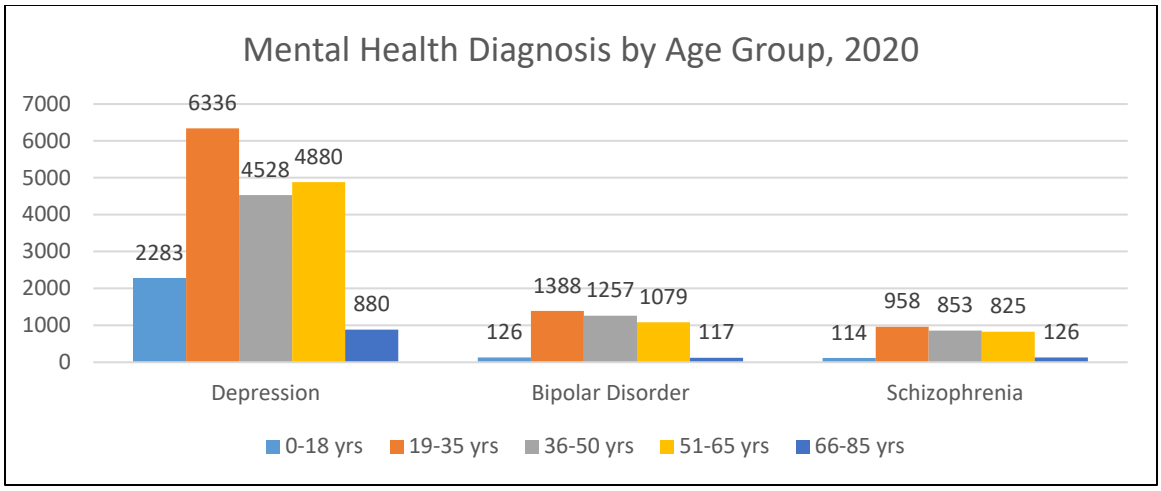
top diagnoses among KHS members in 2020, such as abdominal and pelvic pain, common infections, and chronic conditions, such as type 2 diabetes, asthma, hypertension, and heart disease. Other top medications included those prescribed to treat allergies, hyperlipidemia, fever, inflammation, and vitamin D deficiency. Insulin Glargine (Basaglar Kwikpen) was identified to be the most costly medication dispensed, which accounted for $6,550,441.60 and supports the treatment of diabetes.[12] Although Tradjenta was identified as the most costly medication in the 2020 PNA, a generic form of this class came to market and KHS made this the preferred agent. Tradjenta also appears to be falling out of favor among providers who may have historically prescribed this medication.

Top 10 Most Filled Medications	Relevant Health Conditions
1. Ibuprofen	Fever and pain
2. Albuterol HFA	Breathing problems, such as asthma and COPD
3. Lisinopril	High blood pressure and heart failure
4. Atorvastatin	High cholesterol and triglyceride levels; heart and blood vessel problems
5. Metformin HCL	Type 2 diabetes
6. Loratadine	Allergy symptoms and hives
7. Amoxicillin	Infections and stomach ulcers
8. Aspirin	Pain, fever, headache, inflammation, and heart problems
9. Hydrocodone/APAP	Pain and fever
10. Ergocalciferol	Vitamin D deficiency, hypoparathyroidism, refractory rickets, familial hypophosphatemia

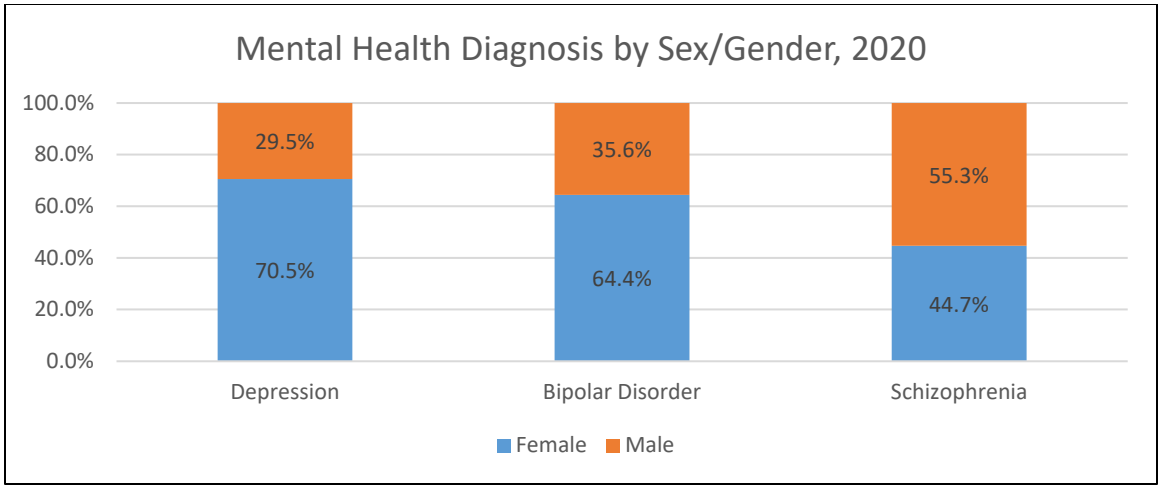
Source: 2020 KHS Top Medications Filled Report

Mental Health Conditions

According to KHS' chronic condition population analysis reports, 6.4% of KHS members were diagnosed with depression, 1.4% were diagnosed with a bipolar disorder, and 0.97% were diagnosed with schizophrenia in 2020.[13,14,15] All three of these rates increased slightly compared to 2019. Members with a diagnosis of depression, bipolar disorder or schizophrenia were more likely to be English speaking, female, or between the ages of 19-35 years. White members were more disproportionately diagnosed with depression and bipolar disorder disorders when looking at the share of White members with each diagnosis. Black or African American members had the highest share of members with a schizophrenia diagnosis than other racial/ethnic groups by a small margin.



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



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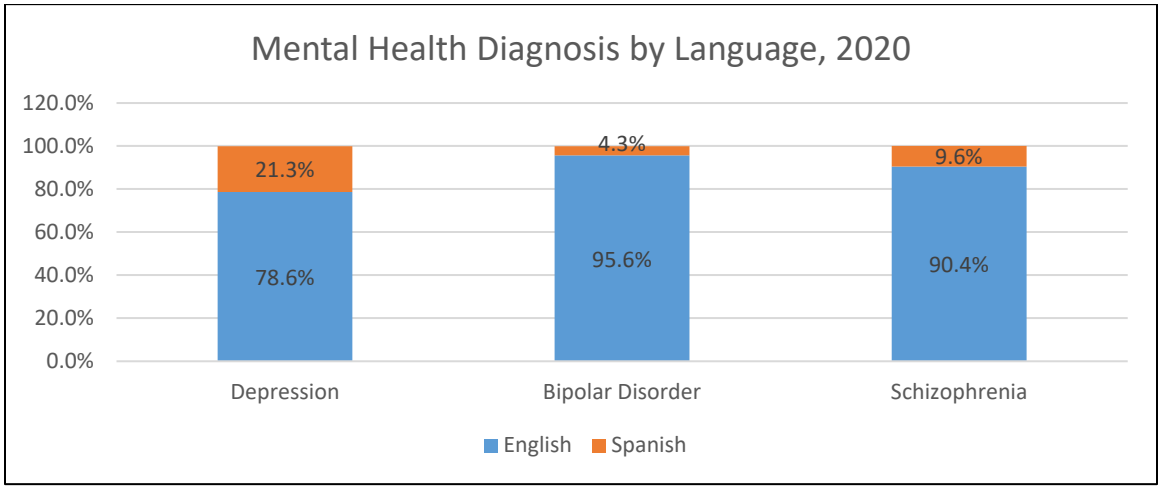

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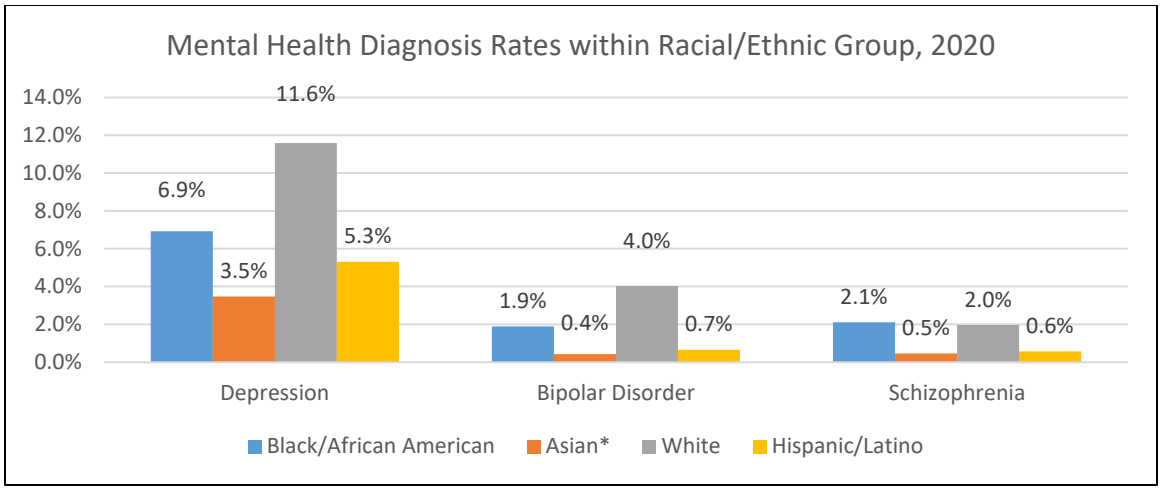
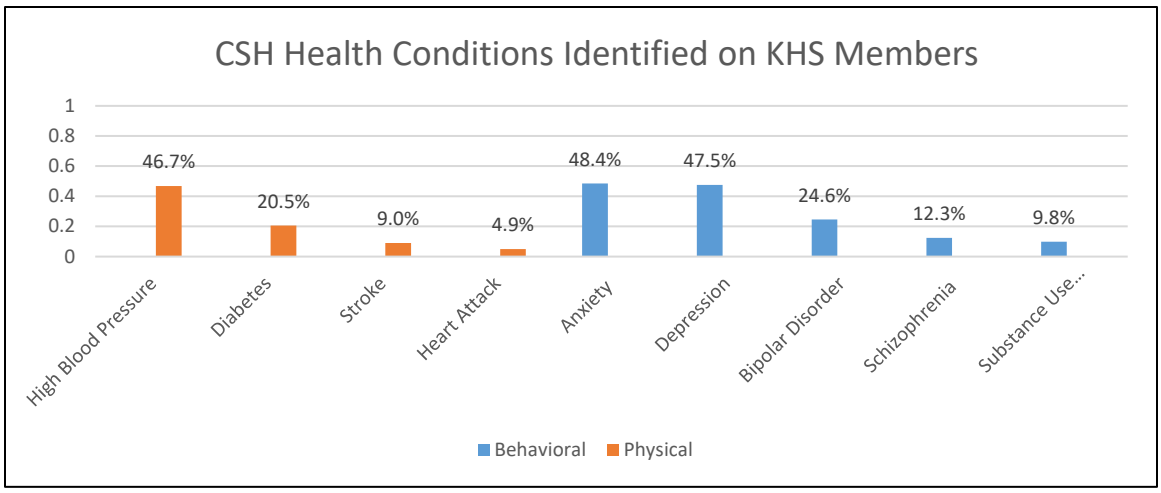


Source: KHS Depression, Bipolar Disorder and Schizophrenia Chronic Condition Population Analysis Reports, 2020
*This statistic may be an underestimate since the numerator includes only Asian Pacific, Asian Indian, and Filipino members. The denominator includes all Asian members.

Smoking, Tobacco Use and Associated Health Conditions

The 2019 CAHPS Adult Medicaid Survey performed by the DHCS Health Services Advisory Group (HSAG) identified 19.2% of KHS adult members are current smokers.[21] According to KHS' tobacco registry report, 12.9% of members are current smokers or have been exposed to tobacco.[16] The California Smokers Helpline (CSH) collects demographic and health data during phone counseling sessions and shares this data with Medi-Cal Managed Care health plans. CSH data revealed that KHS member callers were most likely to be English speaking (97.5%), female (61.5%), White (53.3%), between the ages of 45-64 years (50.0%), and have at least a high school education (71.3%).[17] Review of the behavioral and physical health conditions of KHS member callers identified anxiety and high blood pressure as the top diagnoses, respectively.



Source: 2020 California Smokers Helpline Demographic and Health Data for Medi-Cal Health Plans

Access to Care

KHS conducts an annual satisfaction survey with adult members using questions developed by CAHPS to capture accurate and complete information about member-reported experiences with health care. The survey specifically measures how well KHS is meeting member's expectations and goals; which areas of service have the greatest effect on overall satisfaction; and, identifies areas of opportunity for improvement. Additionally, HSAG conducts an adult and child CAHPS survey every 2 years with KHS members. In the table below, the 2020 KHS adult rates did not meet any of the benchmarks. However, the 2020 KHS adult rates for getting routine care, personal doctors listened carefully, and personal doctors showed respect improved compared to the 2019 rates. The other 2020 KHS adult rates shown in red, below, did not improve compared to 2019 rates.[18,19] KHS HSAG CAHPS child and adult rates for 2019 are also shown below for comparison.[20,21]

Measure	Question	KHS HSAG CAHPS Child Rate	KHS HSAG CAHPS Adult Rate	KHS Adult Rate		KHS Adult Benchmark
		2019	2019	2019	2020	2020
Getting Needed Care	Getting care, tests, or treatment	82.7%	82.6%	81.0%	77.8%	86.3%
	Getting specialist appointment	N/A	77.8%	75.7%	69.5%	80.7%
Getting Care Quickly	Getting urgent care	N/A	82.1%	81.6%	79.5%	85.0%
	Getting routine care	81.4%	70%	71.1%	75.7%	80.4%
How Well Doctors Communicate	Personal doctors explained things	91.3%	90.6%	88.5%	88.0%	93.5%
	Personal doctors listened carefully	95.1%	88.5%	89.5%	90.2%	93.5%
	Personal doctors showed respect	95.7%	90.1%	92.5%	92.6%	94.6%
	Personal doctors spent enough time	82.5%	87.8%	84.0%	83.7%	91.5%

Source: 2020 KHS CAHPS Adult 5.0 Final Report, 2019 HSAG CAHPS 5.0H Child Medicaid Survey Results Report, 2019 HSAG CAHPS 5.0H Adult Medicaid Survey Results Report

Data on the effectiveness of care measures for flu shots and tobacco use among adult members was also collected. Findings revealed that KHS did not improve upon advising current tobacco users to quit and discussing cessation strategies in 2020 compared to 2019.[20,21] However, KHS improved on discussing cessation medications and flu vaccinations compared to the previous year. The flu vaccination rate among adults was still low in 2020 since only 45.5% of its adult members received an annual flu shot in 2020.

Measure	Question	2019 KHS HSAG CAHPS Child Rate	2019 KHS HSAG CAHPS Adult Rate	KHS Adult Rate		KHS Adult Benchmark
		2019	2019	2019	2020	2020
Medical Assistance with Smoking and Tobacco Use Cessation	Advising Smokers and Tobacco Users to Quit	N/A	N/A	73.8%	67.8%	77.8%
	Discussing Cessation Medications	N/A	N/A	44.0%	48.3%	56.1%
	Discussing Cessation Strategies	N/A	N/A	37.4%	35.2%	50.2%
Flu Vaccinations for Adults Ages 18-64	Flu Vaccinations (% Yes)	N/A	60.2%	44.3%	45.5%	44.1%

Source: 2020 KHS CAHPS Adult 5.0 Final Report, 2019 HSAG CAHPS 5.0H Child Medicaid Survey Results Report, 2019 HSAG CAHPS 5.0H Adult Medicaid Survey Results Report

The following table includes a summary of CAHPS measure rates by domain. The 2020 KHS adult rate exceeded the 2020 adult benchmark on Rating of Health Plan (% 8, 9, or 10), Rating of Personal Doctor (% 8, 9 or 10), and Flu Vaccinations. The rates for those measures are shown in green. For all other rates included below, the 2020 adult benchmark was not met. The rates for those measures are shown in red. Nationwide CAHPS child and adult rates for 2020 are also shown, below, for comparison.[22]

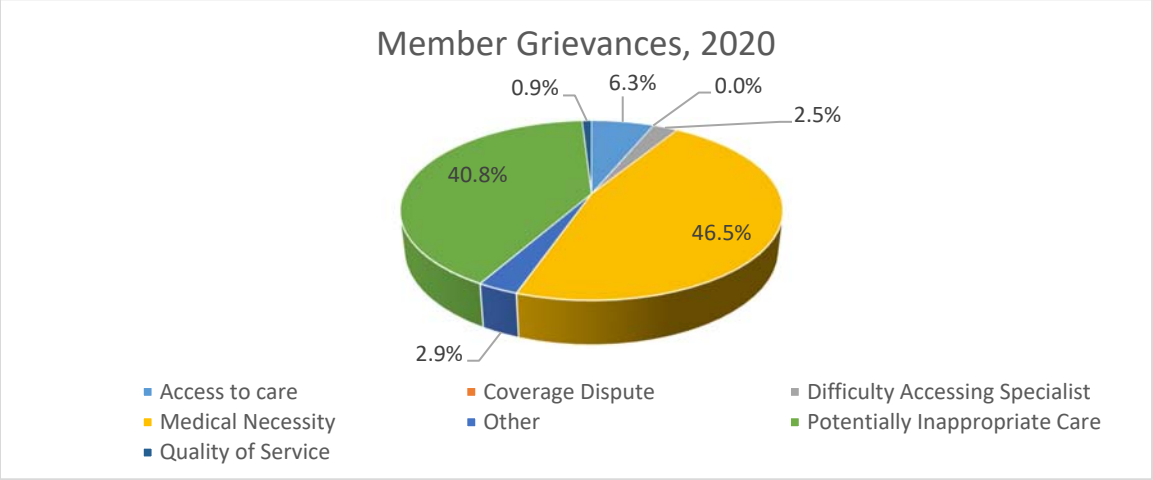
Domain	Measure	CAHPS Child Rate	CAHPS Adult Rate	KHS CAHPS Adult Rate		KHS Adult Benchmark
		2020	2020	2019	2020	2020
Health Plan	Rating of Health Plan (% 9 or 10)	71%	61%	65.7%	63.4%	64.6%
	Rating of Health Plan (% 8, 9 or 10)	N/A	N/A	81.3%	81.7%	80.3%
	Getting Needed Care (% Always or Usually)	85%	83%	78.4%	73.6%*	83.5%
	Customer Service (% Always or Usually)	88%	89%	91.7%	86.3%	89.4%
	Ease of Filling Out Forms (% Always or Usually)	N/A	N/A	94.1%	94.1%	95.6%
Health Care	Rating of Health Care (% 9 or 10)	70%	56%	51.5%	55.6%	58.8%
	Rating of Health Care (% 8, 9 or 10)	N/A	N/A	75.5%	77.0%	76.9%
	Getting Care Quickly (% Always or Usually)	90%	82%	76.4%	77.6%*	82.7%
	How Well Doctors Communicate (% Always or Usually)	95%	93%	88.6%	88.6%	93.2%
	Coordination of Care (% Always or Usually)	N/A	N/A	76.1%	75.3%*	85.9%
	Rating of Personal Doctor (% 9 or 10)	78%	69%	62.6%	69.4%*	70.7%
	Rating of Personal Doctor (% 8, 9 or 10)	N/A	N/A	82.1%	84.8%	84.2%
	Rating of Specialist (% 9 or 10)	74%	69%	64.4%	65.1%*	70.9%
	Rating of Specialist (% 8, 9 or 10)	N/A	N/A	81.1%	79.8%*	84.7%
Effectiveness of Care	Flu Vaccinations (% Yes)	N/A	44%	44.3%	45.5%	44.1%
	Advising Smokers and Tobacco Users to Quit (% Always, Usually or Sometimes)	N/A	57%	73.8%	67.8%*	77.8%
	Discussing Cessation Medications (% Always, Usually or Sometimes)	N/A	57%	44.0%	48.3%	56.1%

	Discussing Cessation Strategies (% Always, Usually or Sometimes)	N/A	51%	37.4%	35.2%*	50.2%

Sources: 2020 KHS CAHPS Adult 5.0 Final Report, 2020 CAHPS Health Plan Survey Database 2020 Chartbook
* – Current year score is significantly higher than the 2019 score or benchmark score.
* – Current year score is significantly lower than the 2019 score or benchmark score.

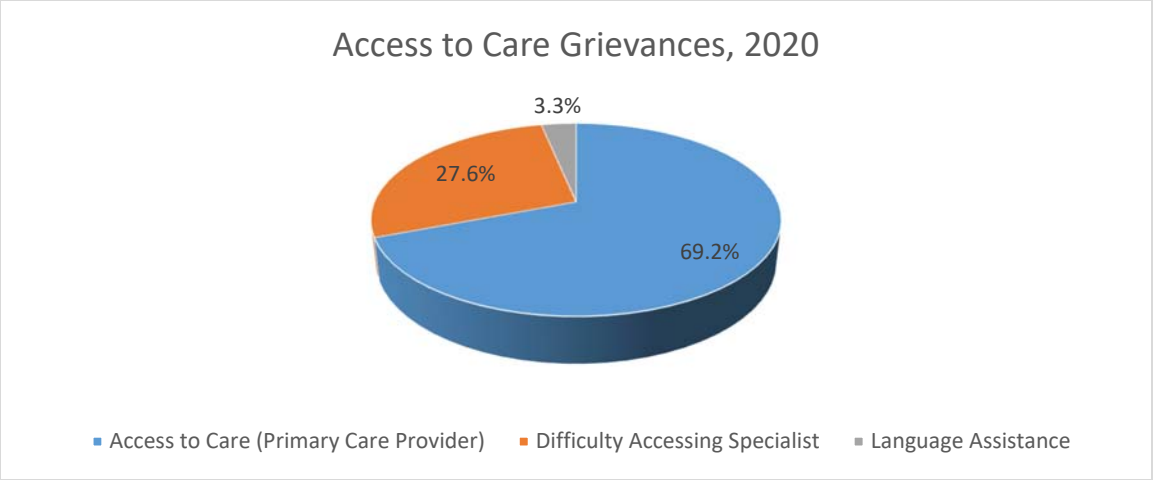
Member Grievances

KHS regularly monitors and reports on its member grievances related to access to care, coverage, medical necessity, quality of care and services, cultural and linguistic sensitivity and other issues. During 2020, there were 2,357 formal member grievances received and the majority of grievances were due to Medical Necessity, followed by Quality of Care and Access to Care. Twenty-six-point four percent (26.4%) of grievances were closed in favor of the member.[23]



Source: 2020 KHS Grievance Operational Board Reports

When looking at Access to Care grievances, Access to Care (Primary Care Provider) accounted for the majority of cases (69.2%) in this grievance category, followed by Difficulty Accessing a Specialist (27.6%) and Language Assistance (3.3%).[23]



Source: 2020 KHS Grievance Operational Board Reports

Access to Transportation

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

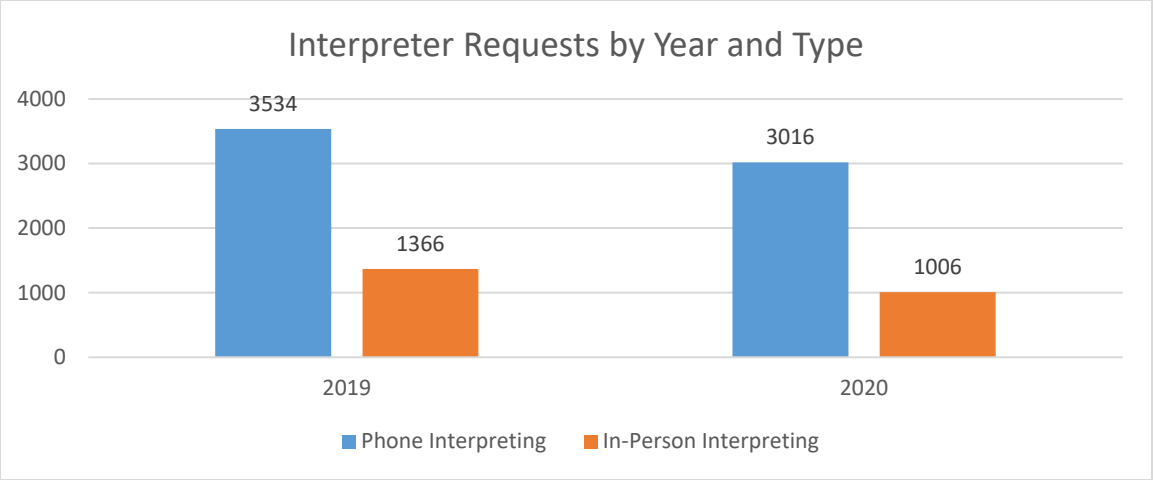
2020 NEMT and NMT Ridership

Mode	Number of Trips Provided	Approx. Number of Members Utilizing Transport Mode
NEMT Wheelchair	54,487	1,130
NEMT Gurney Van	2,855	412
NMT Public Transit	231,076	9,887
NMT Mileage Reimbursement	7,064	274

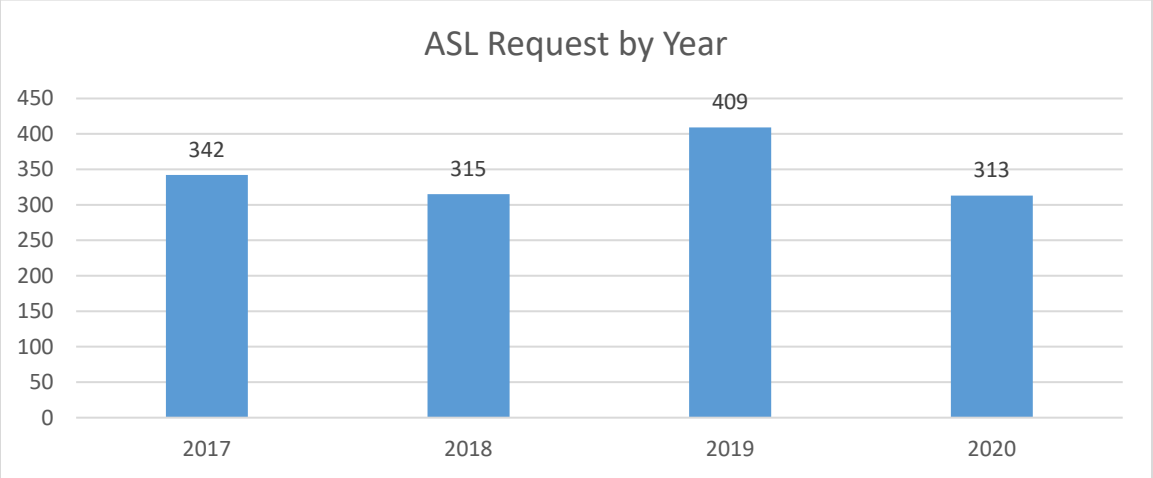
Source: KHS 2020 Transportation Benefit Summary

Access to Interpreter Services

KHS' HE department provides 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 2020, there was a 17.9% overall decrease in interpreting requests compared to 2019.[24] In the same period, phone interpreting requests decreased by 14.7%, in-person interpreting requests decreased by 26.4%, and in-person ASL interpreting requests decreased by 23.5%.

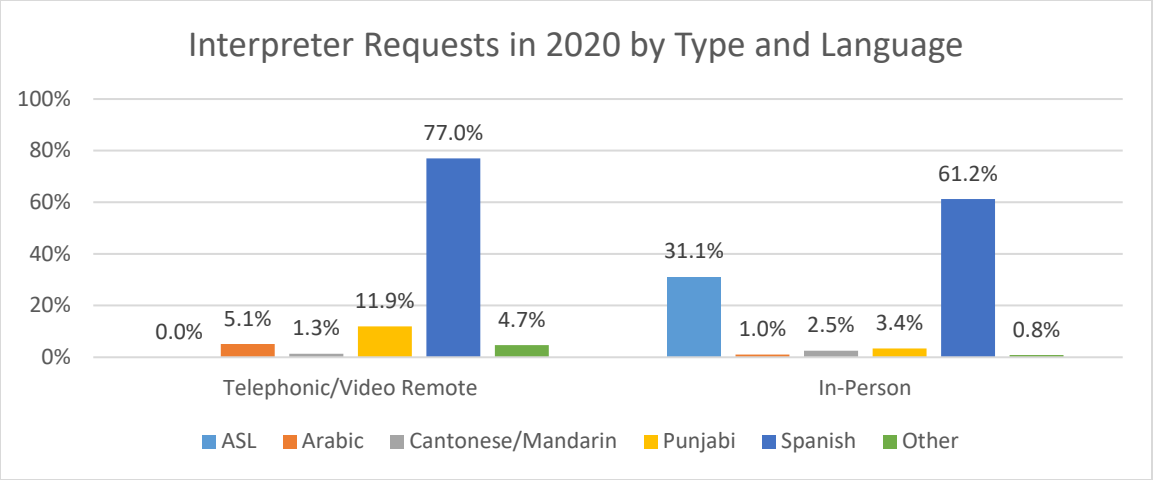


Source: 2020 KHS Health Education Department Annual Activities Report



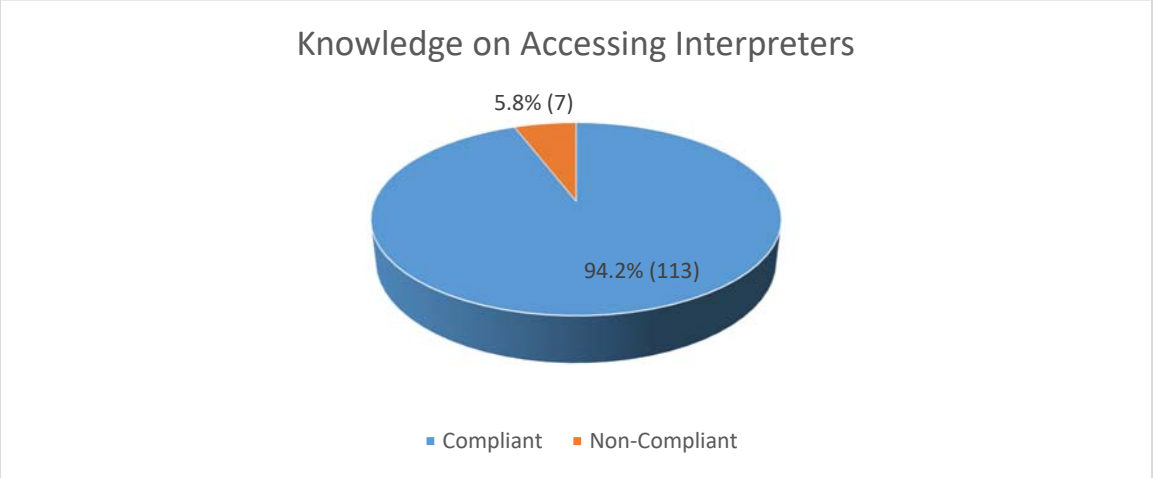
Source: 2020 KHS Health Education Department Annual Activities Report

When looking at interpreting requests by phone or video remote call, Spanish was the most common language, followed by Punjabi, Arabic, Vietnamese, and Tagalog. Among in-person interpreting requests, Spanish was the most common language, followed by ASL, Punjabi, Cantonese/Mandarin, and Arabic.[25, 26]



Source: 2020 KHS Health Education Department Annual Activities Report; 2020 CommGap KHS Annual Report; 2020 KHS ASL Annual Report

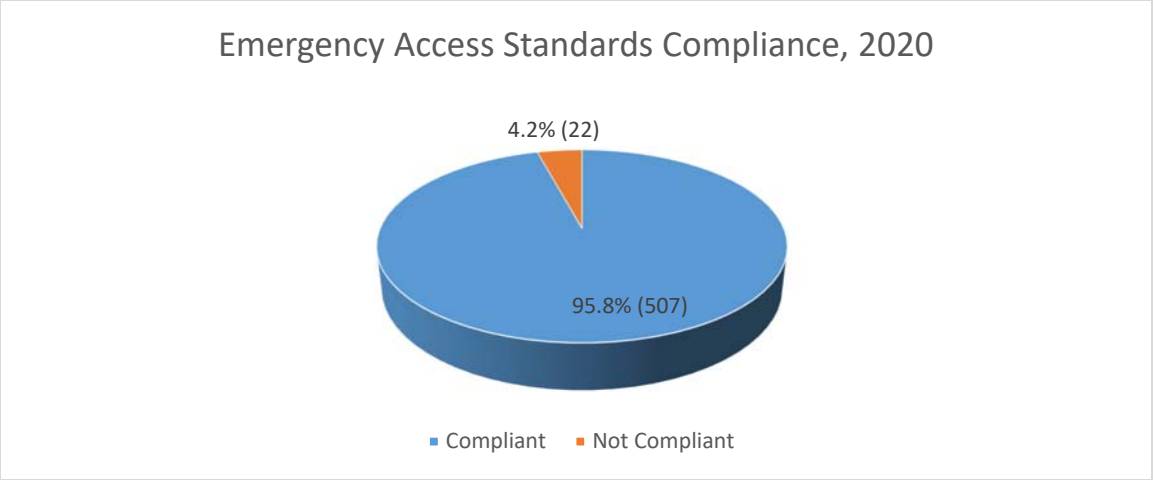
KHS conducts a quarterly interpreting access survey among its provider network. In 2020, a total of 60 primary care provider offices and 60 specialist offices were contacted to assess their knowledge on accessing interpreting services for limited English proficient (LEP) members. Findings revealed that 7 of these providers (5.8%) needed additional training on accessing interpreting services for LEP members.[27]



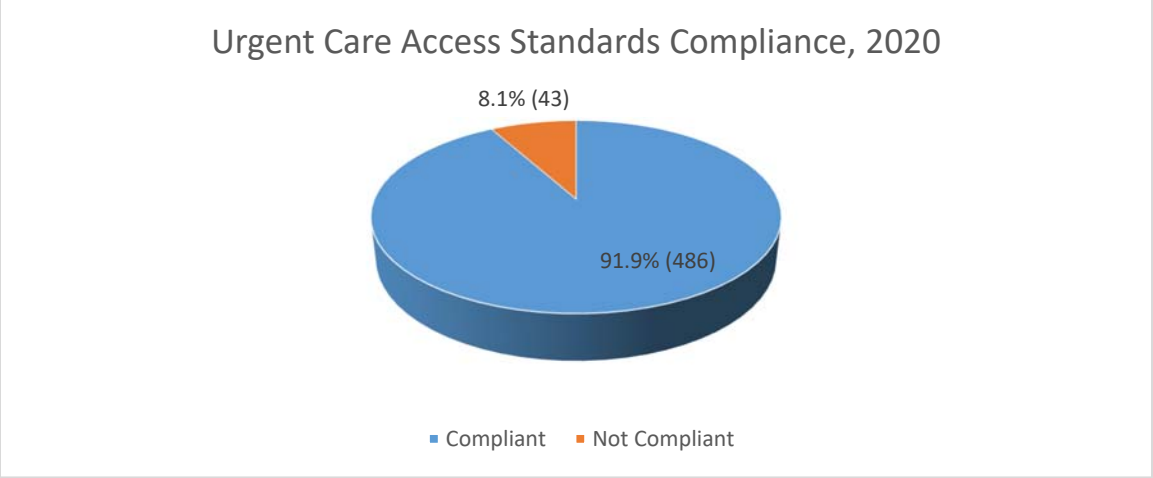
Source: 2020 KHS Interpreter Access Survey Results

Emergency & Urgent Care Access Standards

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 2020, 95.8% of provider offices were compliant with the Emergency Access Standards and 91.9% of provider offices were compliant with the Urgent Care Access Standards.[28]



Source: 2020 KHS Provider Network Management Network Review Reports



Source: 2020 KHS Provider Network Management Network Review Reports

Appointment Availability

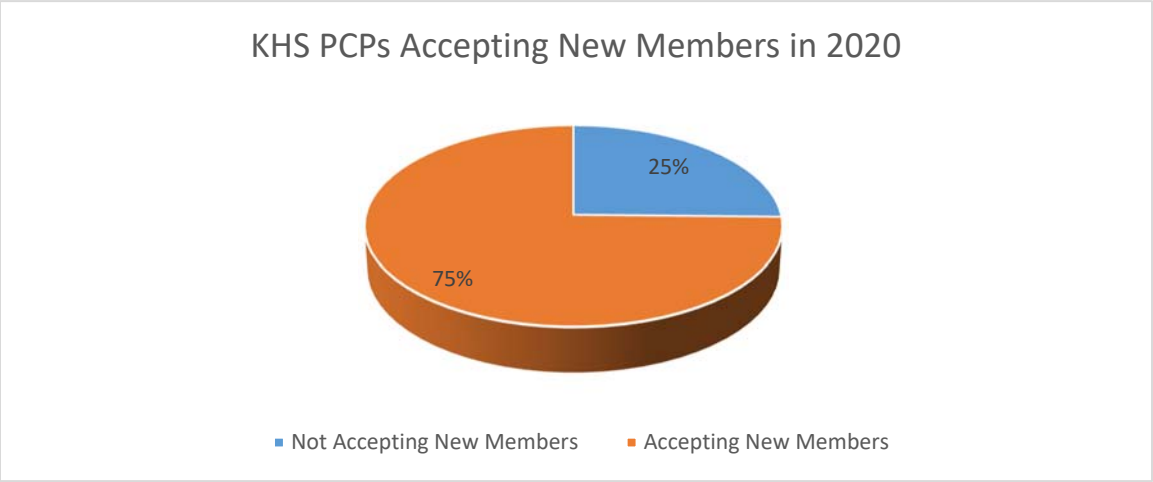
As required by the DHCS and Title 28 CCR Section 1300.67.2.2, KHS uses an appointment availability survey to assess compliance with access standards for KHS Members. A random sample of 55 primary care provider (PCP) offices, 55 specialist offices, and 10 Obstetrics & Gynecology (OBGYN) offices were contacted during 2020 and found to be in-compliance with the standard wait times.[28]

	Providers Contacted	Average Wait Time in Business Days/Provider	Standard Wait Time in Business Days
PCP Offices	55	7.3	10
Specialist Offices	55	5.9	15
OB/GYN Offices	10	7.9	10

Source: 2019 KHS Provider Network Management Network Review Reports

New Member PCP Access

KHS monitors the adequacy of its primary care network by reviewing the count/percentage of PCPs who are accepting new members. During 2020, the plan had an average network of 403 PCPs, of which 75% were accepting new members at a minimum of one location.[28]



Source: 2020 KHS Provider Network Management Network Review Reports

Health Disparities

2020 DHCS Disparities and Preventive Services indicator rates show that among the ethnic groups identified, Black or African American members generally have the worst outcomes for preventive health measures, followed by Whites, and Hispanic/Latinos.[29,30] The exceptions are found in the asthma medication ratio, screening for depression, dental fluoride varnish, substance use, and women's preventive health indicators. White members had the lowest asthma medication ratio and dental fluoride varnish rate. Female Asian members generally have the worst outcomes for women's preventive health indicators. Screening for depression and substance use indicators were low for all racial and ethnic groups.

English speakers generally have worse indicator rates than Spanish speakers, except for antidepression medication management, contraceptive care, and development screening in the first 3 years of life.

Racial/ethnic disparities for the top chronic health conditions among KHS members vary by chronic health condition.

A comparison of the 2019 and 2020 DHCS Disparities Rate Sheets revealed improvement in the asthma medication ratio, breast cancer screening, and plan all-cause readmission rates.29 These were the only indicators to appear in the DHCS Disparities Rate Sheets for both years. A summary is provided in the table below.

Rate Difference (Percentage Points)	Description of Measurement
+27.3 PP	Increase in Asthma Medication Ratio—Total (AMR–Tot)
+0.7 PP	Increase in Breast Cancer Screening (BCS)
-2.7 PP	Decrease in Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR–Tot)

Source: 2019 and 2020 DHCS Disparities Rate Sheets

DHCS reviewed the following health indicators from the 2020 DHCS Disparities and Preventive Services Rate Sheets for all Medi-Cal Managed Care Health Plans:

- Alcohol Use Screening (AUS)
- Antidepressant Medication Management—Effective Acute Phase Treatment (AMM–Acute)
- Antidepressant Medication Management—Effective Continuation Phase Treatment (AMM–Cont)
- Asthma Medication Ratio—Total (AMR–Tot)
- Breast Cancer Screening (BCS)
- Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years (CCP–MMEC60–2144)
- Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years (CCW–MMEC–1520)
- Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years (CCW–MMEC–2144)
- Screening for Depression and Follow-Up Plan—Ages 12–17 Years (CDF–1217)
- Screening for Depression and Follow-Up Plan—Ages 18–64 Years (CDF–1864)
- Screening for Depression and Follow-Up Plan—Ages 65+ Years (CDF–65)
- Chlamydia Screening in Women—Total (CHL–Tot)
- Developmental Screening in the First Three Years of Life—Total (DEV–Tot)
- Dental Fluoride Varnish (DFV)
- Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR–Tot)
- Tobacco Use Screening (TUS)
- Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6)
- Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 to 30 Months—Two or More Well-Child Visits (W30-2)
- Child and Adolescent Well-Care Visits (WCV)

Review of racial/ethnic health disparities revealed Black or African American members have the lowest pediatric preventive care indicators compared to other racial/ethnic groups. When looking at language preferences, Spanish speakers have significantly higher rates than English speakers, with the except being DEV-Tot where English speakers have a slight edge.2020 Pediatric Preventive Care Indicators

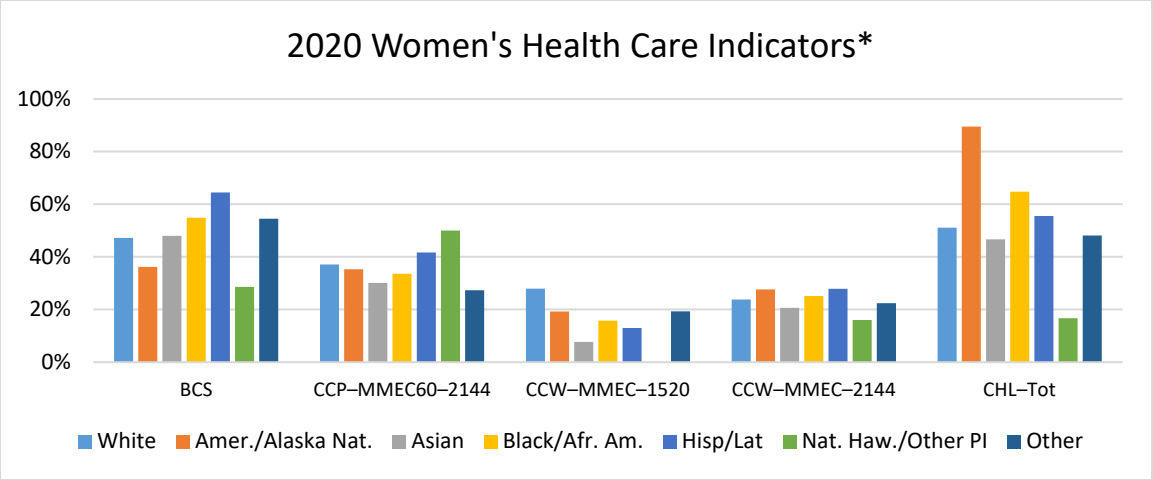
Measure	White	American Indian/ Alaska Native	Asian	Black or African American	Hispanic/ Latino	Native Hawaiian/Other Pacific Islander	Other
DEV-Tot	5.4%	0.0%*	5.0%	2.7%	6.0%	0.0%*	7.9%
DFV	14.25%	14.71%	21.14%	15.37%	16.88%	33.33%*	24.51%
W30-6	12.9%	25.0%*	18.2%*	3.8%	19.9%	N/A	10.0%*
W30-2	51.5%	50.0%*	81.9%	37.1%	62.0%	0.0%*	58.2%
WCV	37.1%	37.4%	48.2%	34.8%	46.8%	27.0%*	49.9%

Source: 2020 DHCS Health Disparities Rate Sheet
*Small sample size (<100)

DHCS reviewed the following women's health indicators from the 2020 DHCS Disparities Rate Sheet for all Medi-Cal Managed Care Health Plans:

- Breast Cancer Screening (BCS)
- Contraceptive Care – Postpartum Women – Most or Moderately Effective Contraception – 60 Days – Ages 21-44 Years (CCP-MMEC60-2144)
- Contraceptive Care – All Women – Most or Moderately Effective Contraception – Ages 15-20 Years (CCW-MEC-1520)
- Contraceptive Care – All Women – Most or Moderately Effective Contraception – Ages 21-44 Years (CCW-MEC-2144)
- Chlamydia Screening in Women – Total (CHL-Tot)

Asian members have the lowest rates for these women's health indicators compared to other racial/ethnic groups. The exception was the BCS rate for White members, which have the lowest rate. When looking at language preferences, there isn't a clear pattern. Rate differences between English and Spanish speakers vary by the indicator.



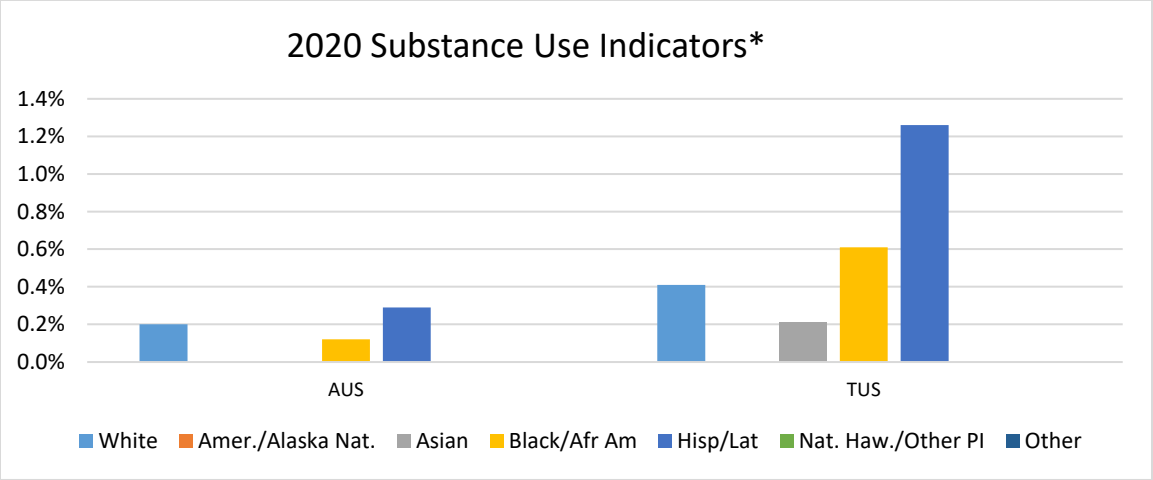
Source: 2020 DHCS Health Disparities Rate Sheet

**The American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Other groups have a small sample size (<100). The exceptions are the BCS and CCW-MMEC-2144 rates for the Other group.*

DHCS reviewed the following substance use indicators from the 2020 DHCS Disparities Rate Sheet for all Medi-Cal Managed Care Health Plans:

- Alcohol Use Screening (AUS)
- Tobacco Use Screening (TUS)

Alcohol and substance use screening was low among all racial/ethnic groups. When looking at language, the rate of alcohol use screening among Spanish speakers was twice the rate of English speakers. Tobacco use screening was nearly four times higher among Spanish speakers compared to English speakers.



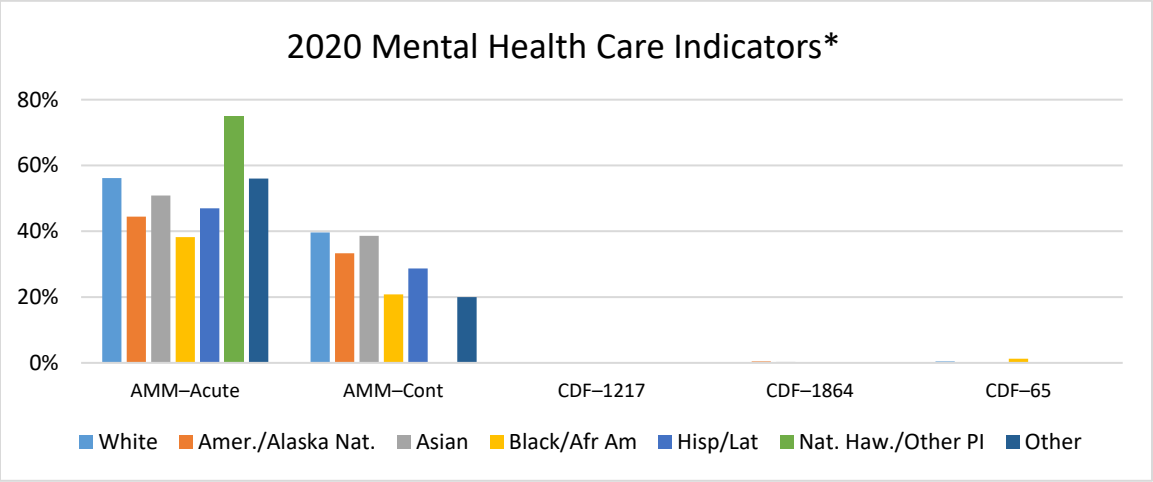
Source: 2020 DHCS Preventive Services KHS Rate Sheet

**The American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and Other groups have a small sample size (<100). The exception is the TUS rate for the Other group.*

DHCS reviewed the following mental health indicators from the 2020 DHCS Disparities Rate Sheet for all Medi-Cal Managed Care Health Plans in the:

- Antidepressant Medication Management – Effective Acute Phase Treatment (AMM-Acute)
- Antidepressant Medication Management – Effective Continuation Phase Treatment (AMM-Cont)
- Screening for Depression and Follow-Up Plan – Ages 12-17 Years (CDF-1217)
- Screening for Depression and Follow-Up Plan – Ages 18-64 Years (CDF-1864)
- Screening for Depression and Follow-Up Plan – Ages 65+ Years (CDF-65)

Black or African American members have the lowest AMM indicator rates compared to other racial/ethnic groups. For the CDF indicators, rates were low for all racial/ethnic groups. When looking at language preferences, English speakers had higher AMM indicator rates than Spanish speakers. For the CDF rates were low for all languages.



Source: 2020 DHCS Health Disparities Rate Sheet

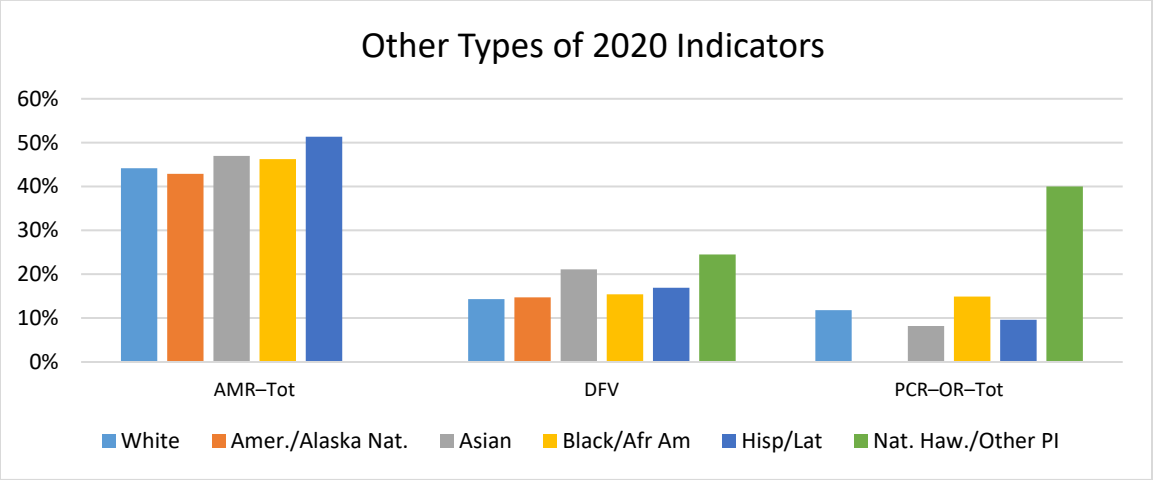
**The American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and Other groups have a small sample size (<100). The exceptions are the CDF-1217 and CDF 1864 rates for the Other group. In addition, Asian members have a small sample size (<100) for both AMM indicators. Black or African American members have a small sample size (<100) for CDF-65.*

DHCS reviewed the following 2020 DHCS Disparities and Preventive Services Rate Sheets indicators for all Medi-Cal Managed Care Health Plans:

- Asthma Medication Ratio – Total (AMR-Tot)
- Dental Fluoride Varnish (DFV)
- Plan All-Cause Readmissions – Observed Readmission Rate – Total (PCR-OR-Tot)

White members have the lowest AMR compliance rates compared to other racial/ethnic groups. For the PCR-OR indicator, Black or African American members have the highest readmission rate. When looking at language preferences, Spanish speaking members have a higher AMR

compliance rate than English speakers. English speaking members have a higher hospital readmission rate than Spanish speakers.



Source: 2020 DHCS Health Disparities and Preventive Services Rate Sheets
**The American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and Other groups have a small sample size (<100). The AMR-Tot rate for the Asian group also has a denominator that is less than 100. The exception is DFV rate for the Other group.*

When looking at the top 5 chronic health conditions among KHS members, racial/ethnic disparities vary by health condition. Claims data indicate that dyslipidemia, hypertension, and diabetes may disproportionately impact Asian members compared to other ethnic/racial groups. The share of Black or African American members with a persistent asthma diagnosis is higher compared to other racial/ethnic groups.[11] White members have the highest rate of depression. The racial/ethnic group with the highest rate for each of the top chronic conditions among KHS members is shown in red, below.

These results should be interpreted cautiously since claims data may not represent the true chronic condition rates by racial/ethnic group among KHS members. Racism, lack of access to care, and concerns about COVID-19 among Black or African American members and other members of color may be factors in their willingness to seek medical care. In addition, the pandemic limited access to care as health care providers closed offices or restricted the availability of in-person appointments to help reduce the spread of COVID-19. As a result, this likely resulted in under-utilization of health care among KHS members.

Top 5 Chronic Conditions Shown as a Share of Racial/Ethnic Groups, 2020

Chronic Condition	Black or African American	Asian*	White	Hispanic/ Latino
Dyslipidemia	10.3%	24.7%	13.8%	12.4%
Hypertension	17.0%	21.8%	16.6%	11.1%
Persistent Asthma	15.3%	6.8%	12.1%	8.0%
Depression	6.9%	3.5%	11.6%	5.3%
Diabetes	5.8%	10.0%	5.5%	5.9%

Source: KHS All Populations Analysis Report, 2020
**These statistics may be underestimates since the numerator includes only Asian Pacific, Asian Indian, and Filipino members. The denominator includes all Asian members.*

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

Gaps in Access to Care

As mentioned previously, KHS did not meet its 2020 CAHPS benchmark goals in the areas of:

- Health Plan
  - Rating of Health Plan
  - Getting Needed Care
    - Getting care, tests or treatments
    - Obtained appointment with specialist as soon as needed
- Health Care
  - Getting Care Quickly
    - Getting urgent care
    - Getting routine care
  - How Well Doctors Communicate
    - Personal doctors explained things
    - Personal doctors listened carefully
    - Personal doctors spent enough time
  - Coordination of Care
  - Rating of Personal Doctor
  - Rating of Specialist
- Effectiveness of Care
  - Advising Smokers and Tobacco Users to Quit
  - Discussing Cessation Strategies

KHS' access to care grievance data revealed potential challenges involving documentation of medical necessity for treatment authorization requests and quality of care. These two types of

grievances accounted for 46.1% and 40.7% of all grievances in 2020.[23] Over 34% of medical necessity grievances were closed in favor of the enrollee, indicating that members may be facing a legitimate challenge with treatment authorization requests.

Although 94.2% of KHS' provider network understand how to access interpreting services for KHS members, the remaining 5.8% is in need of reminders of this member benefit.[27] KHS C&L Team will continue to partner with its Provider Network Management and QI Departments to help coordinate refresher trainings for providers who are identified as non-compliant through the quarterly interpreter access survey; have had a cultural and linguistic grievance filed against the office site; or, have been identified as an office site that would benefit from additional training.

Transportation challenges for members vary based on location and time of day. Members have more transportation assistance options in urban areas and during the day. In the evening, options are more limited. For example, public transit NMT and fixed route bus service have had more limited evening service in Bakersfield during the pandemic due to losses in ridership that have resulted in cuts in service. Rural areas have limited public transportation availability and geographic coverage. However, public transit vehicles are wheelchair accessible. Commercial rideshare providers such as Uber and Lyft may not always offer these types of vehicles.

Commercial rideshare providers typically serve the more urban areas without issue and usually have no availability limits. Since rideshare drivers are independent contractors who rely on short route trips to be lucrative and Kern County has an expansive geographic footprint, rural areas are not preferable given that the expense of traveling without a passenger outweighs the benefit of servicing the minimal population in those areas.[31] Single passenger trips for rural areas may be provided by the public transit's on demand where available.

Responses from this year's KHS' Public Policy/Community Advisory Committee (PP/CAC)[32] PNA survey identified the following gaps or challenges in accessing health care services among members:

- Long wait times for medical appointments
- Lack of awareness or understanding of KFHC language interpreting services among health care providers
- Distance to the nearest health care provider
- Transportation access
- Availability of specialists
- Technology
- Lack of compassion among health care providers

Challenges in accessing health education services included:

- Transportation access
- Literacy level of health education services or materials
- Health education class availability
- Lack of promotion of health education services
- Lack of materials that are translated into a member's preferred language

- Competing priorities or lack of free time
- Lack of technology literacy
- Technology access barriers, such as lack of a computer, internet, or a printer
- Lack of availability of mailed health education materials

Gaps in Language Needs and Cultural and Linguistic Competency

KHS' threshold languages as determined by DHCS continues to be English and Spanish; however, the top 5 languages for telephonic interpreting for KHS members in 2020 were Spanish, Punjabi, Arabic, Vietnamese, and Tagalog. The top languages for in-person interpreting for KHS members in 2020 were Spanish, ASL, Punjabi, Cantonese, Arabic, and Mandarin. Although the top non-Spanish languages for interpreters do not meet DHCS' criteria to constitute as a new threshold language for KHS, KHS recognizes that its 4th largest racial/ethnic group are Asian Indian members and requests for Punjabi interpreters continue to grow each year. Responses from this year's PP/CAC survey did not specifically address the language interpreting or translation needs of the Asian Indian community. However, last year's PP/CAC survey found recommendations for KHS to start building a staffing model and inventory of both health education and member informing material, educational curriculums and media campaigns that are culturally and linguistically representative of this population. Other considerations to better understand the cultural and linguistic needs of Asian Indian or Punjabi speaking members might include, but not be limited to:

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

Member requests for ASL interpreters decreased by 23.5% from 2019 to 2020. This dip was due to the pandemic since there was an upward trend in ASL requests before 2020. KHS recognizes that access to in-person ASL interpreters is highly limited in Kern County. With only 5 ASL interpreters residing in Kern County, KHS' interpreting vendor must recruit Los Angeles County interpreters to commute to Kern County to assist ASL members. These interpreters not only face an extensive geographic commute, but also face challenges with severe weather conditions and road closures on the Interstate Highway 5 grapevine route during the Winter and Summer seasons. KHS may need to encourage more use of video remote interpreting services with its provider network and ASL membership to avoid interpreter access delays.

Findings from this year's PP/CAC PNA survey included the following challenges that KFHC members face when trying to access language interpretation services:

- Lack of patience or willingness among health care provider staff to secure language interpreting services
- Lack of awareness or understanding of KFHC interpreting services or how to access them among health care provider staff
- Lack of cultural competency among health care provider staff

- Health care provider staff bias against members who request language interpreting services
- Fear of requesting language interpreting services due to embarrassment and perceived risk of being reported to immigration authorities
- Lack of awareness of KFHC language interpreting services among members
- Length of time required to secure a language interpreter

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

- Continue to research and identify additional vendors to perform in-person interpreting services for members.
- Train KHS providers on telehealth interpreting best practices
- Train KHS providers on how to access video remote interpreting services.
- Continue to promote the KHS provider training guide on how to access an interpreter using VRI.
- Identify and recruit additional vendors to provide bilingual certification for KHS staff.
- Increase opportunities for the KHS provider network to participate in trainings on cultural competency, effective interpreting and accessing KHS interpreter Services.
- Increase training opportunities for KHS and its network providers to learn more about the needs the LGBT population.
- Increase promotion of interpreter services among KHS members along with the concerns with using family or friends as interpreters.
- Continue outreach and education efforts with KHS providers on how to access KHS' interpreting services.
- Offer trainings on the principles and ethics for effective interpreting for provider staff used as interpreters during appointments.
- Research and identify additional member and provider tools to communicate interpreter needs for medical appointments.
- Research and connect with growing ethnic groups among KHS members to better understand the cultural aspects around accessing health care and use of alternative medicine.

Gaps in Health Education Services

KHS offers health education services and incentives through a variety of modalities, such as in-person group sessions, telephonic counseling, printed mailings, and social media communications. Yet member's awareness of and participation in KHS' health education services continue to remain low. KHS' ability to offer regular health education services throughout the county, outside of regular business hours, and in-person has not an option during the pandemic due to health and safety concerns related to COVID-19 and the low vaccination rate among KHS members.

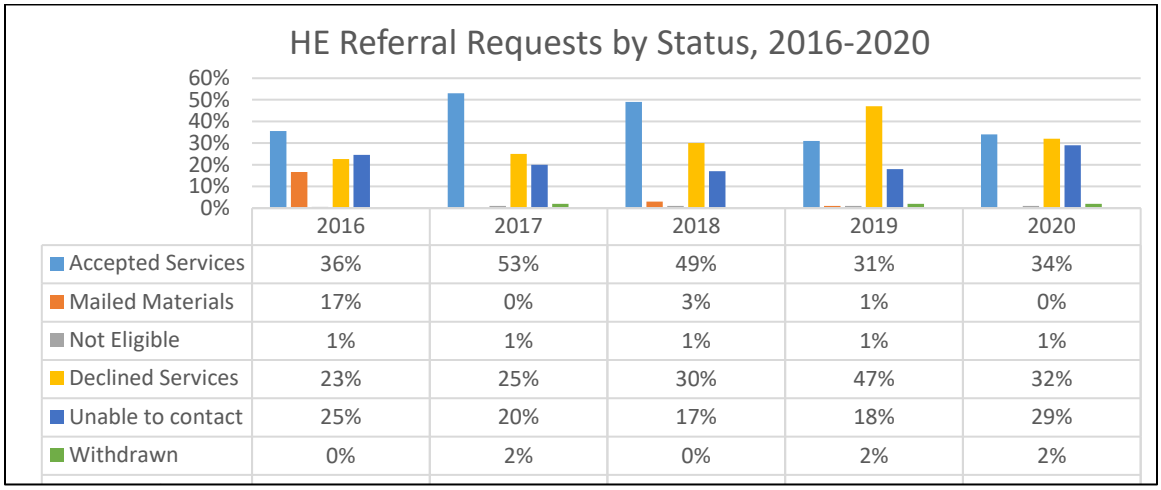
However, KHS has adapted to the pandemic by offering virtual health education classes and individual phone counseling appointments. Attendance at virtual nutrition education classes has

been promising during the pandemic. Attendance at nutrition education classes increased significantly after KHS began offering health education classes in a virtual learning environment in April 2020. KHS' average class attendance was 2.6 members per nutrition class and 2.1 members per asthma class during the first quarter of 2020 when classes were offered in-person through mid-March. During the rest of 2020, average class attendance was 20.5 members per nutrition class and 1.8 members per asthma class. Low attendance at asthma classes may be due to less asthma education referrals from KHS providers, staff and members during the pandemic. Other top reasons include a high rate of members who are not interested in asthma education services or cannot be contacted.

Demand for individual phone counseling appointments has been high during the pandemic. Appointments are usually fully booked every month. However, there are limitations in providing health education by phone since this type of education format may lack the visual element. While phone counseling appointments can be offered with a virtual learning app such as Zoom, Spanish speakers are less likely to be familiar with how to use these apps or have access to internet services that are necessary for a virtual learning environment.

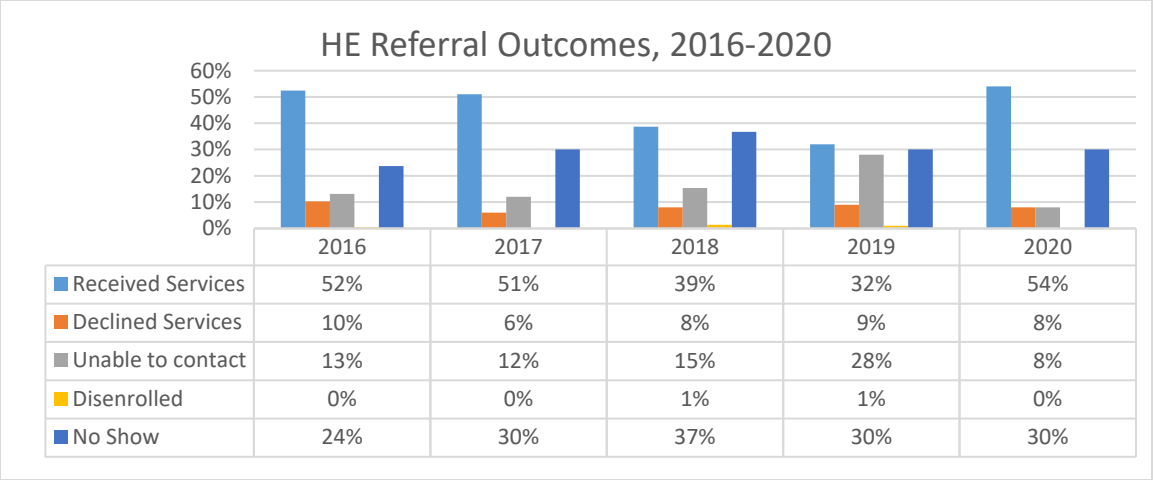
Health Education Service Utilization

The KHS HE Department processed 2,852 referral requests for health education services in 2020, a significant decrease compared to the previous year. Weight management, asthma management, nutrition counseling with a registered dietitian (RD), and smoking cessation were the top types of referral requests received.[24] Nutrition counseling with a RD and smoking cessation referrals increased in 2020 compared to 2019, whereas referrals for other topics decreased. The rate of members who accepted to receive health education services increased from 31% in 2019 to 34% in 2020. The rate of members who declined health education services decreased from 47% in 2019 to 32% in 2020.[24] Referral outcome data revealed a 22% percentage point increase in the Received Services rate and a 20 percentage point decrease in the Unable to Contact rate.[24]



	2016	2017	2018	2019	2020
Accepted Services	36%	53%	49%	31%	34%
Mailed Materials	17%	0%	3%	1%	0%
Not Eligible	1%	1%	1%	1%	1%
Declined Services	23%	25%	30%	47%	32%
Unable to contact	25%	20%	17%	18%	29%
Withdrawn	0%	2%	0%	2%	2%

Source: 2020 KHS Health Education Activities Report



	2016	2017	2018	2019	2020
Received Services	52%	51%	39%	32%	54%
Declined Services	10%	6%	8%	9%	8%
Unable to contact	13%	12%	15%	28%	8%
Disenrolled	0%	0%	1%	1%	0%
No Show	24%	30%	37%	30%	30%

Source: 2020 KHS Health Education Activities Report

KHS member health disparities data from DHCS' 2019 and 2020 Rate Sheets revealed a trend of unfavorable indicator rates among Black or African American KHS members compared to other racial/ethnic groups. Black or African American members were disproportionately overrepresented in claims data for the most prevalent chronic conditions among KHS members. These racial/ethnic disparities may require more in-depth investigations of contributing factors, such as physical characteristics and access to health promoting resources or services in neighborhoods with different social and economic profiles. A better understanding of these contributing factors will lead to evidence-based health promotion and disease prevention program that address top health disparities among KHS members.

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

- Hybrid in-person and virtual educational home visiting programs for chronic condition management programs when it is safe to do so.
- Structured programs facilitated by promotores or community health workers that represent or are familiar with priority racial/ethnic groups.
- Expansion of virtual health education classes and individual counseling.
- Expanded member access to digital health education material.
- Group exercise classes, walking groups and gym memberships.
- New incentive programs to encourage participation and adherence with program.
- Educational text message and robocall campaigns.
- Childcare and senior care for participants attending in-person classes.
- Social media videos and other digital media content.
- KHS community resource or satellite centers throughout the county.
- Continued enhancement of KHS' corporate website with health education content with consideration of adding non-threshold languages.

- Enhance KHS' Member Portal LiNK to allow members to register for health education services, receive health education communications, and access health education material content.
- Increase promotion and details of KHS health education services and incentive programs and collaborate with community organizations that work directly with KHS members to share information.
- Increase access to health education services through virtual class options, community partnerships, service contracts, and new venue locations throughout Kern County.
- Explore ways to connect members with internal and external resources to address complex health problems by working with KHS' Health Homes Program and Case Management Departments, KHS' provider network, and local community-based organizations.
- Work with local policymakers and government officials on ways to plan safer, healthier and more walkable communities.
- Work with health plan trade associations to advocate for health promotion and prevention-oriented policies at the state and federal levels.

Quality Improvement Program Gap Analysis

In 2020, 100% of the Initial and Periodic Facility Site Reviews (FSRs) that were conducted, passed. Of all the Medical Record Reviews (MRRs) that were conducted during 2020, 6 providers needed a follow-up scheduled.

Due to the Public Health Emergency (PHE) and for the health and safety of the staff, our providers, and our members, KHS staff did not physically go to provider offices to conduct Site Reviews. FSRs were conducted by using a provisional model. The provisionary model allowed the KHS Certified Site Reviewers (CSRs) address as many topics as possible within the required review as possible in a remote location from a virtual standpoint. These provisionary reviews are not intended to be a substitute for a full on-stie review. MRRs were conducted virtually as well. However, we were able to complete the entire MRR for each site as we utilized the tools available on-line to complete the record review for each member in a secured virtual setting.

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

- Documentation of checking of emergency medications.
- Firefighting equipment – fire extinguisher not inspected at least annually.
- Spore testing results of autoclave/steam sterilizer with documented results.

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

- Efforts/follow up contacts documentation for missed primary care appointments.
- No evidence of follow-up case of specialty referral made and results/reports of diagnostic test, when appropriate.
- Incomplete adult and pediatric immunizations.

MCAS/HEDIS 2020

Healthcare Effectiveness Data and Information Set (HEDIS) 2020 is a tool used by more than 90 percent of America's health plans, to measure performance on important dimensions of health care and services. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA), a private, not-for-profit organization dedicated to improving health care quality, since 1990.

All Medi-Cal managed care health plans must submit annual measurement scores for the required External Accountability Set (EAS) performance measures. DHCS currently requires all contracted health plans to report selected Managed Care Accountability Set (MCAS) measures to comply with the EAS reporting requirement MCAS measures are a combination of measures selected by the Department of Health Care Services (DHCS) from the library of HEDIS and Core Measures sets from the Centers for Medicare and Medicaid Services (CMS). The previous calendar year is the standard measurement year for MCAS data. Therefore, the MCAS 2020 results shown in this report are based on 2019 data. All Plan Letter 19-017 Quality and Performance Improvement Adjustments due to COVID-19, including supplement to APL 19-017, states for RY 2020/MY 2019, MCPs will not be held to the MPLs, or be subject to sanctions or corrective action plans for any MCAS measures designated for reporting by the hybrid methodology. This decision in-part was made because of the COVID-19 pandemic.

Hybrid Measures Held to MPL								
Measure		Current RY2020 Rate	RY2020 MPL	RY2020 HPL	RY2019 KHS Rate	Current Vs. RY2020 MPL	Current Vs. RY2020 HPL	Current Vs. RY2019 KHS
AWC	Adolescent Well-Care Visits	36.01	54.26	68.14	N/A	-18.25	-32.13	N/A
ABA	Adult Body Mass Index Assessment	78.10	90.27	95.88	N/A	-12.17	-17.78	N/A
CCS	Cervical Cancer Screening	56.20	60.65	72.02	60.34	-4.45	-15.82	-4.14
CIS-10	Childhood Immunization Status	29.93	34.79	49.27	N/A	-4.86	-19.34	N/A
CDC-HT	Comprehensive Diabetes Care HbA1c Testing	85.16	88.55	92.94	89.13	-3.39	-7.78	-3.97
CDC-H9*	HbA1c Poor Control (>9.0%)	57.91	38.52	27.98	33.15	-19.39	-29.93	-24.76
CBP	Controlling High Blood Pressure <140/90 mm Hg	38.93	61.04	72.26	54.26	-22.11	-33.33	-15.33
IMA-2	Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)	41.36	34.43	47.2	40.63	6.93	-5.84	0.73
PPC-Pre	Prenatal & Postpartum Care – Timeliness of Prenatal Care	84.18	83.76	90.98	81.27	0.42	-6.80	2.91
PPC-Post	Prenatal & Postpartum Care – Postpartum Care	81.02	65.69	74.36	67.64	15.33	6.66	13.38
WCC-BMI	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents	66.42	79.09	90.4	N/A	-12.67	-23.98	N/A
W15	Well-Child Visits in the First 15 months of Life – Six or More Well Child Visits	32.60	65.83	73.24	N/A	-33.23	-40.64	N/A
W34	Well-Child Visits in the 3rd 4th 5th & 6th Years of Life	65.21	72.87	83.85	63.99	-7.66	-18.64	1.22

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

Administrative Measures Held to MPL								
Measure		Current RY2020 Rate	RY2020 MPL	RY2020 HPL	RY2019 KHS Rate	Current Vs. RY2020 MPL	Current Vs. RY2020 HPL	Current Vs. RY2019 KHS
AMM -Acute	Antidepressant Medication Management – Acute Phase Treatment	50.24	52.33	65.95	N/A	-2.09	-15.71	N/A
AMM - Cont.	Antidepressant Medication Management – Continuation Phase Treatment	32.64	36.51	48.68	N/A	-3.87	-16.04	N/A
AMR	AsthmaMedication Ratio	48.78	63.58	71.62	21.49	-14.80	-22.84	27.29
BCS	Breast Cancer screening	57.29	58.67	69.23	56.57	-1.38	-11.94	0.72
CHL	Chlamydia Screening in Women Ages 16 – 24	55.29	58.34	71.58	N/A	-3.05	-16.29	N/A

Indicates we met or exceeded MPL/RY2019 rate/Health Net RY2019 rate

Indicates we met the HPL.

'N/A' is for measures that were not reported for RY2019

Since KHS did not meet the MPL for multiple measures DHCS presented KHS an opportunity to develop a SWOT analysis and action plan to improve scores for the given measures. KHS accepted this partnership with DHCS for support in moving forward with a more expansive evaluation and development of interventions to improve MCAS measure compliance. It will be a two-year project aimed at developing a sustainable infrastructure for compliance with MCAS.

A collaborative meeting with DHCS was conducted every month to discuss the status of the SWOT project. After completing a SWOT analysis, this information was used to develop an action plan focused on increasing current MCAS compliance and infrastructure for continuous improvement. A core component to the plan was establishing a new MCAS Committee aimed at providing oversight and direction for our compliance with these measures. The QI Department monitored SWOT project activities weekly and monthly to resolve any identified issues or impediments. Below is the progress report for the SWOT Analysis Project for 2020:

SWOT Analysis Project 2020-2022 -Progress Timeline			
Items	Year 2020		
	Oct	Nov	Dec
Stragegy 1: Increase number of members attending preventive care appointments for W30, WCV, BCS, CIS, IMA, PPC Pre, PPC Post measures. Use MCAS trending reports and the minimum performance levels as benchmarks to evaluate effectiveness of actions.			
Action Item 1.A: The Quality Improvement Department will form a strategic group to meet regularly for review of MCAS trending data and timely initiation of interventions to increase measure compliance.			
Action Item 1.B: KHS will start a media 'Back to Care' campaign aimed at encouraging members to return to their providers for preventive and/or chronic care. Baseline will be monthly trending data starting October 01, 2019.			
Action Item 1.C: 'KHS is partnering with West Side Family Health Care and Alinea Mobile Imaging for a clinical outreach project for women, 50 years old and above, in Taft, CA, who have not had a mammogram in the last 2 years' 'was completed successfully.			
Action Item 1.D: Engagement with Kern Medical (KM), our local county medical system, to identify interventions aimed to increase compliance of MCAS measures for MY2021.			
Strategy 2: KHS will increase compliance of MCAS Well Child Visits (W30 and WCV) and Prenatal and Post-Partum Visits (PPC) by 5 percentage points compared to HEDIS MY 2019 and for each year after until the minimum performance level is met.			
Action Item 2.A: Quality Improvement and Health Education Departments will perform outreach using robocalls to KHS non-compliant members to complete the PPC Prenatal, PPC Post, WCV, W30 visits.			
Action Item 2.B: SWOT Team will collaborate with Health Net, Kern County, for one year on a project aimed at increasing the MCAS Well Care Visits for members 3 to 21 years of age (WCV) measure by 5 percentage points.			
Action Item 2.C: Stakeholders will form the Member Engagement and Rewards Program, an on-going program that will increase members' knowledge of necessary preventive health care and support and increase compliance 5 percentage points from MCAS MY2019.			
Strategy 3: KHS will increase preventive care compliance for MCAS measures by implementing new processes within the health plan aimed at decreasing members' gaps in care.			
Action Item 3.A: KHS health services division will institute a new process to incorporate Gaps in Care lists into telephonic contact with members.			
Action Item 3.B Member Services Department will increase number of members who opted in to receive robocalls from Kern Health Systems. Goal will be to double the number of members opted in by the end of the first quarter in 2021.			
Action Item 3.C KHS will support use of telehealth visits to provide preventive health and chronic condition management services to members who are not accessing care due to the pandemic or who are challenged under normal conditions in accessing care.			
Action Item 3.D A $10 Gift Card will be sent to any member who enrolls in the Member Portal. The portal will provide the member with their Gaps in Care and a list of services needed for closing the gap.			
Strategy 4: KHS will increase compliance with MCAS AMR measure by 5 percentage points compared to MY 2019 and for each year after that until the minimum performance level is met.			
Action Item 4.A: SWOT Team will collaborate with Health Net, Kern County for one year to develop and implement a plan to increase the MCAS Asthma Medication Ratio measure by 5 percentage points			
Action Item 4.B KHS SWOT Team will conduct a meeting with Provider Network Management to review results of the P4P outcome-based program for 2020 as compared to a fee for service-based program that occurred in 2019 for the Asthma Medication Ratio. Results of this review may lead to changes to the 2021 P4P program.			
Action Item 4.C: Quality Improvement Department will meet with Public Health Department, Health Education and Provider Network Management quarterly in support of finding opportunities for improving AMR outcomes.			

Note:
- Completed
- Work In-Progress
- Need Progress
- No Progress

QI Performance Improvement Projects (PIPs)

KHS is mandated by DHCS to participate in two (2) PIPs. The PIPs span over an approximate 18-month time frame and are broken into four (4) modules. 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 2020, the following two (2) PIPs were approved by DHCS for KHS:

- **Health Care Disparity in Well-Child Visits (WCV) ages 3-21**
  This PIP targets health care disparities to Improve the health and wellness of low-income children and adolescents, ages 3 to 21, through well-care visits. This PIP is focused on

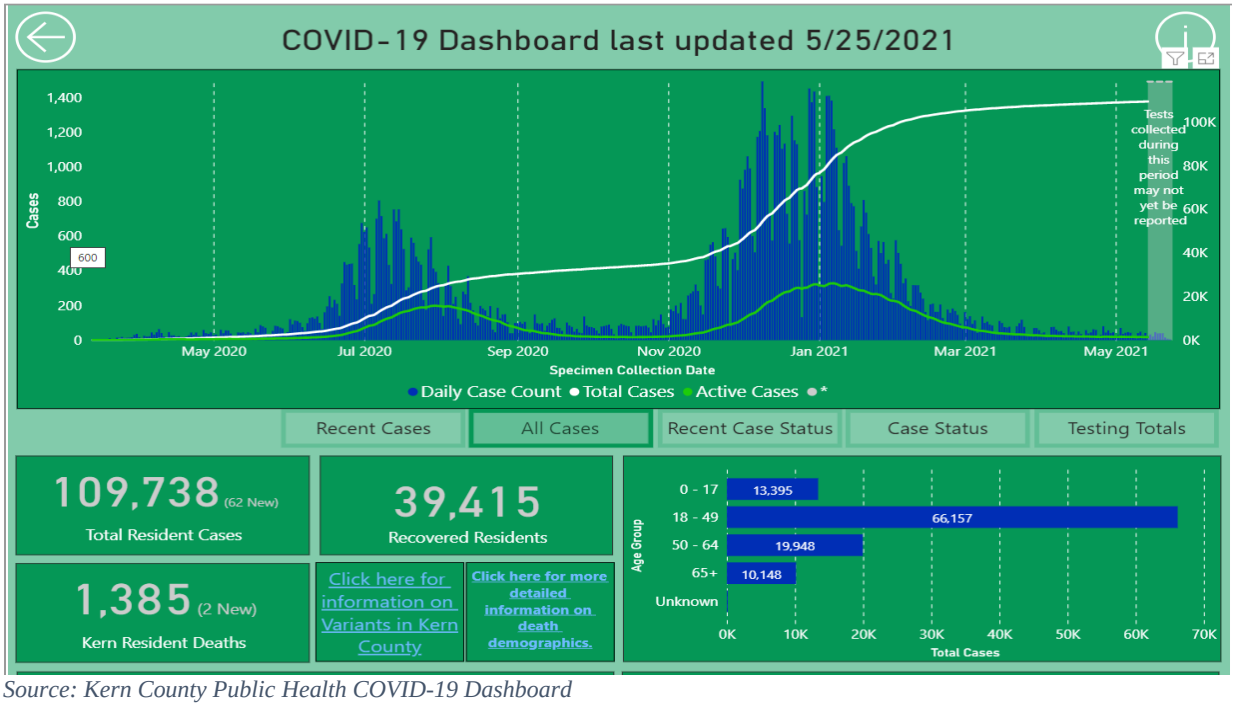
improving the health and well-being of children, ages 8 to 10 years old, by aligning the WCV with industry standards of care and evidence-based practices.

- **Child/Adolescent Health Asthma Medication Ratio (AMR)**
  This PIP is focused on improving the health of members aged 5 to 21 years old with persistent asthma who have a ratio of controller medication to total asthma medications of 0.5 or greater. A two-pronged approach was established to capture the highest volume of non-compliant members. The PIP will focus on a community project called the Asthma Mitigation Project (AMP) and KHS' Asthma Disease Management (DM) Program. A key aim will be to collaborate with providers to encourage the members to enroll and participate in the two programs.

Other: COVID-19

A total of 109,738 positive COVID-19 resident cases and 1,385 resident deaths due to COVID-19 have been confirmed in Kern County as of May 25, 2021.[33] The image below, from the Kern County Public Health Services Department (KCPHSD) website summarizes COVID-19 cases since testing began in Kern County. After two waves of rising rates of COVID-19 daily cases, the total number of cases is now rising slowly as more residents are vaccinated.

KCPHSD COVID-19 Dashboard

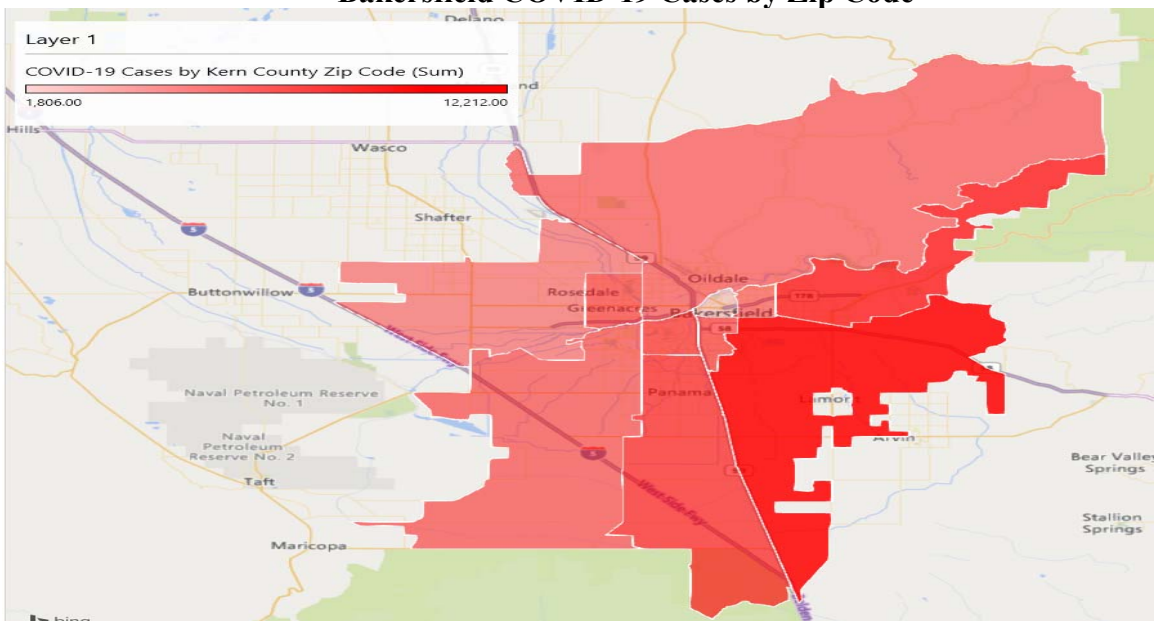


Source: Kern County Public Health COVID-19 Dashboard

In Kern County, the proportion of COVID-19 cases that are in Bakersfield has decreased from 74.8% in June 2020 to 63.6% in May 2021. The percentage of cases in Bakersfield in zip codes

that are east of California State Route 99 has decreased from 65.5% to 56.8% in that same period. The map below shows that COVID-19 cases in Bakersfield are slightly more concentrated in zip codes in the eastern and southern areas of Bakersfield. Zip codes with a darker red color have more cases.

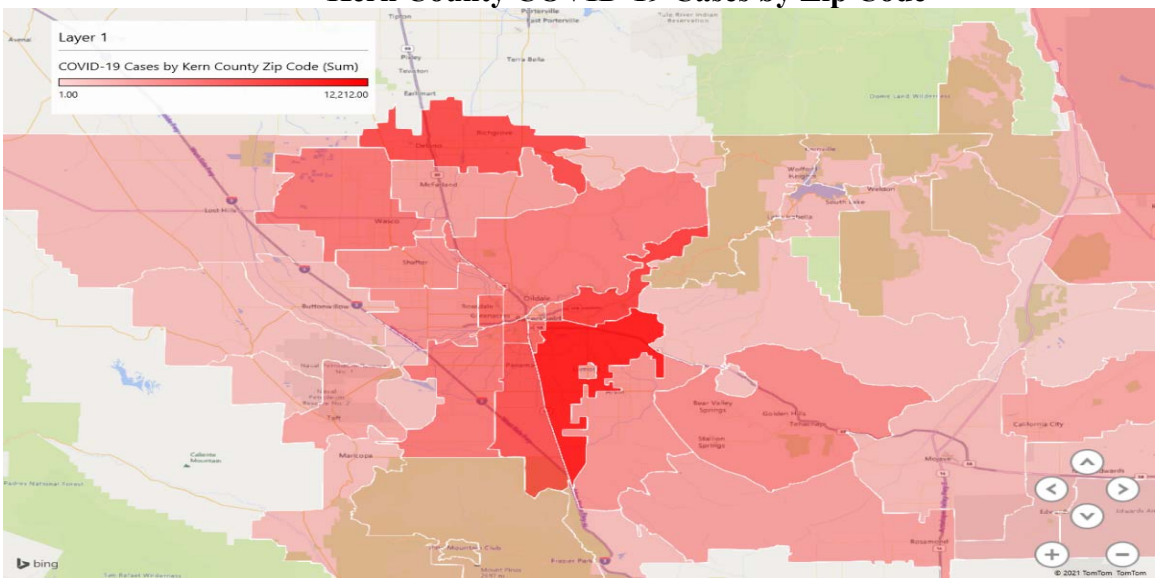
Bakersfield COVID-19 Cases by Zip Code



Source: Kern County Public Health COVID-19 Dashboard

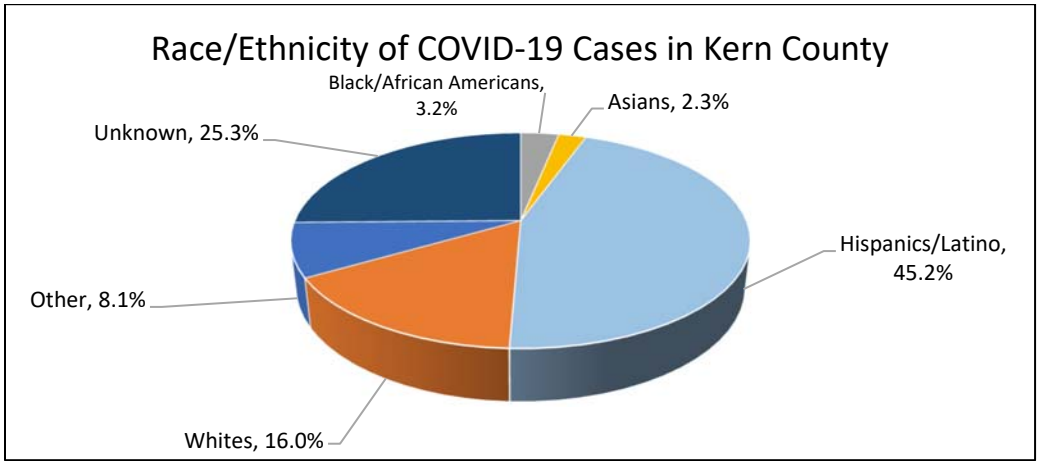
The map, below, shows that Kern County COVID-19 Cases are concentrated in Bakersfield and Delano zip codes.

Kern County COVID-19 Cases by Zip Code



Source: Kern County Public Health COVID-19 Dashboard

Current data indicates that there is a disproportionate burden of illness and death due to COVID-19 among racial and ethnic minority groups nationwide.[34] The COVID-19 hospitalization rates for Native Americans, Black or African Americans, and Hispanics/Latinos are about 3 times the rate for non-Hispanic Whites. Deaths due to COVID-19 are disproportionately higher among these racial/ethnic groups compared to their respective shares of the population. COVID-19 cases in Kern County may be following this nationwide health disparity. The racial/ethnic breakdown of COVID-19 cases in Kern County has some resemblance to the racial/ethnic profile of KHS members. However, it is unclear since 25.3% of COVID-19 cases have an unknown ethnicity. Hispanic/Latinos account for 45.2% of cases, followed by Whites (16.0%), Other (8.1%), and Asians (3.8%), Black or African Americans (3.2%), and Asians (2.3%).[33] When looking at the overall Kern County racial/ethnic profile, Hispanic/Latinos are 54.0% of the population, followed by Whites (33.5%), Black or African Americans (6.3%), Asians (5.4%), and American Indians and Alaska Natives (2.6%).[2]

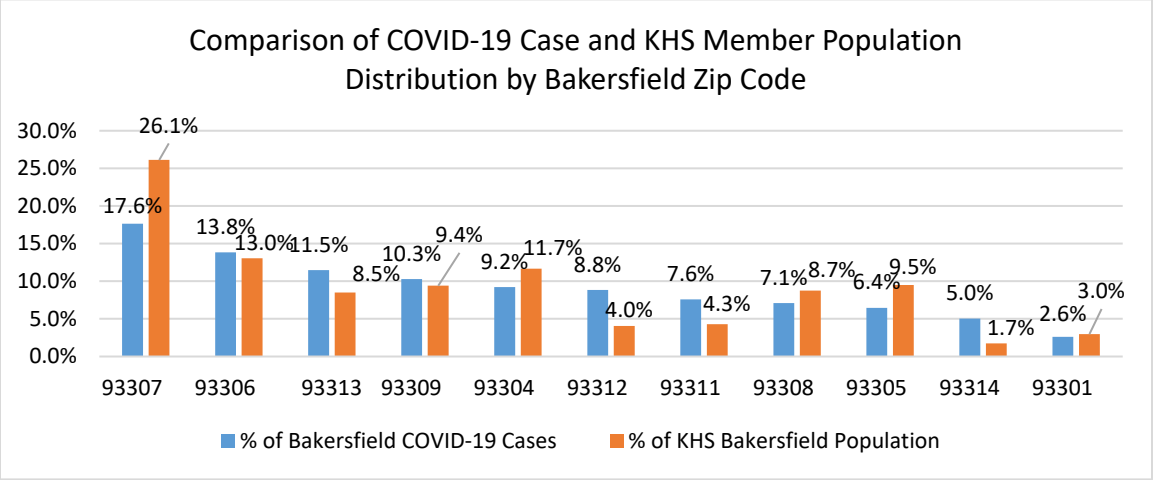


Source: Kern County Public Health COVID-19 Dashboard

A comparison of Kern County COVID-19 cases by zip code reveals a resemblance to the distribution of KHS members by zip code.

Bakersfield Zip Code	Population	COVID-19 Case Count	% of Bakersfield Cases	KHS Member Population	% of KHS Bakersfield Population
93307	84948	12212	17.6%	51,644	26.1%
93306	70208	9579	13.8%	25,775	13.0%
93313	51245	7943	11.5%	16,807	8.5%
93309	60893	7114	10.3%	18,593	9.4%
93304	50787	6389	9.2%	23,069	11.7%
93312	59359	6117	8.8%	7,999	4.0%
93311	44862	5245	7.6%	8,473	4.3%
93308	54042	4912	7.1%	17,297	8.7%
93305	39114	4466	6.4%	18,775	9.5%
93314	26992	3473	5.0%	3,438	1.7%
93301	12345	1806	2.6%	5,860	3.0%

Sources: Kern County Public Health COVID-19 Dashboard; 2020 KHS Member Demographics Data Report



Sources: Kern County Public Health COVID-19 Dashboard

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

The shelter-in-place mandate due to the COVID-19 pandemic has created significant gaps in KHS' ability to offer health education and cultural and linguistic services to KHS members and its provider network. Although KHS is currently not able to offer any in-person health education services, KHS has used this time as an opportunity to test out virtual health education sessions with members. Results are promising for the KHS virtual health education classes, since attendance has increased significantly, especially for nutrition classes. KHS anticipates that members may be reluctant to attend in-person group classes due to COVID-19 concerns and fears. However, this year's PP/CAC GNA survey produced findings that identified in-person classes as the most preferred type of health education service, followed by individual counseling, and then a combination of different health education services. Offering in-person classes will be difficult at this time since less than 5% of members have been fully vaccinated and less 8% have been partially vaccinated according to internal and external data sources.[35] However, this data may not include all fully vaccinated members since vaccination registration sites do not always capture health plan details.

However, KHS will look at ways to promote and encourage members to obtain COVID-19 vaccination along with implementing safety precautions to make in-person classes a possibility, sooner. KHS will continue to expand its virtual health education services as member demand increases and offer incentives for participation. For members who do not have access to a smart device, limited internet access, or are technologically challenged, KHS will need to continue to look for options that address this health education service gap.

V. Action Plan

2021-22 Action Plan

Objective 1. (Revised and Continuing) *By June 2023, the IHA completion rate will have increased from 11.29% to 21.29%.* **Objective 2. (Revised and Continuing due to removal of W15 MCAS measure)** *By June 2023, the W30-6 MCAS rate will have increased from 17.62% to 25.62%.* **Objective 3. (Revised and Continuing due to removal of W15 MCAS measure)** *By June 2023, the W30-2 MCAS rate will have increased from 60.22% to 68.22%.* **Objective 4. (Revised and Continuing due to removal of W34 and AWC MCAS measures)** *By June 2023, the WCV MCAS rate will have increased from 45.32% to 53.32%.* **Data source:** *(RY 2020 HEDIS Data, KHS Claims Data, 2020 DHCS Health Disparities Rate Sheet)*
Strategies
1. Revise member rewards programs to include new MCAS measures that encourage members to see their PCP for a wellness exam at age appropriate intervals.
2. Revise the member and provider communication and outreach plan, timeline and calendar to promote the importance of wellness exams and member rewards programs through all KHS communication channels, health education classes, community partners and KHS' provider network.
3. Leverage the Interactive Voice Response (IVR) solution to assist with performing member outreach through automated calls on preventive care and gaps in care.
4. Partner with schools, network providers and School Wellness Centers to bridge the gap in member's access to preventive care services.
5. Obtain member feedback on the member rewards program, reward interests and barriers to accessing preventive care services that is inclusive of cultural beliefs on accessing care.
6. Update gaps in care to members through the Member Portal to align with new MCAS pediatric preventive care measures.
7. Update gaps in care visibility to all member facing staff and KHS' provider network with new MCAS pediatric preventive care measures.
8. Update monthly reports to include revised rewards programs for monitoring and tracking of member participation and effectiveness of the rewards program

Objective 5. (New): *By June 2023, the average class participation rate in the asthma education class series will have increased from 1.8 to 3.6.* **Data Source:** *(KHS Population Analysis Reports, KHS Health Education Activities Report)*
Strategies
1. Research and develop questionnaires to obtain member and provider feedback.

2. Identify targeted members and providers to obtain feedback with special emphasis on Black or African American members who are disproportionately more at risk for poor asthma management and providers who serve this population at large.
3. Evaluate current incentive program and recommend revisions based on survey findings
4. Evaluate effectiveness of member communication and education channels.
5. Research and identify technology solutions to connect with members on their asthma management
6. Conduct an internal strategic planning session with stakeholders to identify program strengths, weaknesses, opportunities, and threats (SWOT).
7. Implement the asthma member engagement strategy based on member and provider feedback, evaluation data and strategic planning analysis.

Objective 6. (New-Health Disparity):
By June 2024, increase the percentage of Black or African American pediatric members who complete at least 6 well child visits by 15 months of age from 3.83% to 13.83%.

Objective 7. (New-Health Disparity):
By June 2024, increase the percentage of Black or African American pediatric members who complete at least 2 well child visits between 15 and 30 months of age from 37.05% to 47.05%.

Data Source: *(RY 2020 MCAS Data, KHS Claims Data, 2020 DHCS Health Disparities Rate)*

Strategies
1. Meet with key community stakeholders serving the Black or African American community to understand the perceptions around preventive care and wellness, the challenges experienced with accessing care and obtain recommendations on how KHS can close the health care gaps.
2. Expand partnerships with key community stakeholders serving the Black or African American community and participate in community events and public presentations that allow engagement with this population to promote KHS well child rewards, the importance of accessing care and how to access KHS benefits such as transportation services.
3. Facilitate a member survey or focus groups with KHS Black or African American members to better understand the challenges they encounter when trying to access well child visits.
4. Revise current outreach material and communication campaigns to better meet the cultural relevancy of KHS Black or African American members.
5. Evaluate and revise the well child visit member rewards program to include incentives that may influence higher completion rates with well child visits and allow for onsite receipt of the rewards.
6. Create a member and provider engagement strategy to increase awareness on the health inequities among KHS Black or African American members under 3 years old, address challenges and concerns with access care, educate on the importance of well child visits, and promote the member rewards program.
7. Pilot targeted clinic hours with at least 2 provider sites with a high concentration of KHS Black or African American members assigned.

8. Send automated reminder calls, text messages and/or mailers to non-compliant member households.

2020-21 Action Plan Review and Update

Objective 1.(Revised and Continuing due to removal of W15 , W34 and AWC MCAS Measures – See Revised Objectives 1-4) *By May 2023, there will be a 5% increase in the percentage of newly enrolled members and members aged 0-15 months, 3-6 years and 12-21 years accessing preventive care services as measured by the W15, W34 and AWC MCAS measures and KHS' IHA Completion rate.* **Data source:** *(RY 2019 HEDIS Data, KHS Claims Data, 2019 DHCS Health Disparities Rate Sheet)*	**Progress Measure:** • Baseline rate of 32.60% was established for the W15 rate in RY2020. • Increased the W34 rate from 63.99% in RY2019 to 65.21% in RY2020 • Baseline rate of 36.01% was established for the AWC in RY2020. • The IHA completion rate decreased from 21.69% to 11.29%. **Data source:** *(RY 2020 MCAS Data, KHS Claims Data, 2020 DHCS Health Disparities Rate Sheet)* **Progress Toward Objective:** Baseline rates for the W15 and AWC were established for RY2020 as these were not reportable measures in RY 2019. The COVID-19 pandemic caused significant delays and barriers towards members accessing preventive care services which resulted in a marginal increase in the W34 rate and a decreased IHA completion rate. Although KHS encouraged members to seek out care through the member rewards and transportation assistance, the pandemic likely imposed member concerns and hesitancy around the safety of provider offices and may not have perceived preventive care as an essential service. Provider staffing reductions and social distancing in provider offices also contributed towards delayed access to preventive care services. All six rewards programs were in place by October 2020 and KHS is in the process of updating the rewards program to align with the current W30 and WCV MCAS measures. With the retirement of the W15, W34 and AWC MCAS measures, KHS will start reporting on the progress of this objective using the W30 and WCV rates in the 2022 PNA Update to evaluate effectiveness of the rewards program and intervention strategies. This change is reflected in the new Objectives 1 through 4 listed in the 2021-2022 Action Plan.

Strategies	
Strategy 1.) Implement member rewards programs that encourage members to see their PCP for a wellness exam at age appropriate intervals.	**Progress Discussion:** KHS launched it MCAS Member Engagement and Rewards Program (MERP) focusing on preventive care services in October 2020. The program includes 4 preventive care services rewards that members can earn: 1. Well Baby Visits – members between 0-15 months of age who complete a well baby visit, will receive a $10 gift card for each visit that is completed up to 6 visits. 2. Well Child Visit – members between 3-6 years old who complete a wellness visit will receive a $15 gift card. 3. Youth and Young Adults – members between 12-21 years old who complete a wellness visit will receive a $20 gift card. 4. Initial Health Assessment (IHA) – newly enrolled members who complete the IHA within 120 days from enrollment will receive a $10 gift card. This strategy was completed for 2020 and will be updated in the 2021 action plan.
Strategy 2.) Create a member and provider communication and outreach plan, timeline and calendar to promote the importance of wellness exams and member rewards programs through all KHS communication channels, health education classes, community partners and KHS' provider network.	**Progress Discussion:** As part of the MCAS MERP, a communication and outreach plan targeted at both members and providers was developed. The plan included the various communication channels that could be leveraged by the plan and a timeline of when each channel would be initiated. This strategy was completed for 2020 and will be updated in the 2021 action plan.
Strategy 3.) Procure an Interactive Voice Response (IVR) solution to assist with performing member outreach through automated calls on preventive care and gaps in care.	**Progress Discussion:** KHS upgraded its current IVR subscription to allow for automated phone calls to be placed to members. The first campaign of automated calls was placed in November 2020 to all members who consented to receive automated calls from KHS. Due to the limited member consents on file for robocalls, KHS could only impact less than 1% of the non-compliant members. A mailer was also sent to households to reach members without consent to receive automated calls from KHS. This strategy was completed for 2020 and will be continued in the 2021 action plan.

Strategy 4.) Partner with schools, network providers and School Wellness Centers to bridge the gap in member's access to preventive care services.	**Progress Discussion:** Due to the impact of the COVID-19 pandemic on distance learning and limited onsite engagement between schools and students, there was minimal opportunities to engage with schools and school wellness centers to close the pediatric preventive care gaps. A presentation on the MCAS MERP and the importance of preventive care services was provided to the African American Parent Advisory Committee for Bakersfield City School District (BCSD) along with presentations to local community groups that include representation from school, behavioral and medical providers. KHS initiated a Back to School Campaign to encourage members to access preventive care services and incentivized providers through the Pay For Performance Program. This strategy will be continued in the 2021 action plan.
Strategy 5.) Obtain member feedback on the member rewards program, reward interests and barriers to accessing preventive care services that is inclusive of cultural beliefs on accessing care.	**Progress Discussion:** As part of the evaluation plan for the MCAS MERP, a mini telephone survey has been drafted and will be implemented in Q3 2021. At least 6 months of program implementation is needed to obtain inciteful member feedback to determine programmatic changes and address new and trending barriers to accessing preventive care services. This strategy will be continued in the 2021 action plan.
Strategy 6.) Show gaps in care to members through the Member Portal	**Progress Discussion:** As part of the KHS MCAS MERP, all preventive services gaps in care are visible to members through the member portal upon login. Members are informed of their preventive care services that are due and any rewards that are attached to these services. Once the gap has been closed through receipt of a claim, the member portal account is updated to show the status of Completed. This strategy was completed in 2020 and will be continued in the 2021 action plan to reflect updates to the MCAS pediatric preventive care measures.
Strategy 7.) Provide visibility to gaps in care to all member facing staff and KHS' provider network.	**Progress Discussion:** KHS launched a Gaps in Care internal website for all member facing departments to reference when they are in contact with members. This site enables KHS staff to search by member's BIC or KFHC identification number and any open gaps will appear on the screen which allows the staff to provide education and assistance with appointment scheduling. KHS also provided visibility to its provider network on open Gaps in Care. This visibility is available to providers

	by accessing the KHS provider portal where PCPs can see gaps in care for members assigned to them. This strategy has been completed.
Strategy 8.) Create monthly reports for each new rewards program to monitor and track member participation and effectiveness of the rewards program	**Progress Discussion:** KHS developed 17 reports and 2 dashboards to track and monitor the program effectiveness and costs associated with the MCAS MERP. This strategy has been completed and will be updated in the 2021 action plan to reflect the new MCAS pediatric measures.
Strategy 9.) Develop a program evaluation plan, methodology and timeline for the member rewards program	**Progress Discussion:** A program evaluation plan was developed as part of the MCAS MERP operational documentation prior to launching the program. KHS' MCAS MERP team plans to review the effectiveness of the program and recommend suggested changes in Q3 2021. This strategy will be continued in the 2021 action plan.
Strategy 10.) Develop and distribute a MCAS Provider Booklet that explains each MCAS measure for MY 2020 and offer tips for staying compliant.	**Progress Discussion:** Two resources were developed for providers. One was a measure-by-measure guide that provided a definition for the measure, documentation requirements, service and diagnosis codes allowed, and tips to help meet each measure. The second resource was a 1 page coding tool that listed the most commonly used service and diagnosis codes used for each MCAS measure. This strategy was completed in 2020.

Objective 2. (This objective has ended) *By June 2021, increase the percentage of Black or African American members who receive all recommended childhood immunizations by the age of 2 years from 41% to 46%.* **Data source:** *(RY 2019 HEDIS Data, 2019 DHCS Health Disparities Rate Sheet)*	**Progress Measure:** • The CIS-3 rate for Black or African American members decreased from 40.91% in RY 2019 to 33.45% in RY2020. **Data source:** *(RY 2020 KHS MCAS Data)*
	Progress Toward Objective: The COVID-19 pandemic has significantly impacted and delayed progress on this objective particularly on strategies 1, 3 and 4. Many of the community-based organizations that were identified upon development of the PNA Action Plan had shifted away from childhood immunizations to focus their efforts on addressing the COVID-19 pandemic and civil rights and justice for the Black or African American community. Reductions in staffing due to the pandemic also restricted

	opportunities to coordinate outreach efforts and engage the community. Strategy 4 of this objective was significantly impacted by the uncertainties around the definition of prior expressed consent for robocalls. The limited member consents on file impacted KHS' plans for automated outreach. Although KHS is now actively collecting member consents to send robocalls, there is less than 10% of members under 2 years of age with a consent on file. Strategies 5-8 were completed and will continue to be reviewed and revised to encourage members to complete wellness visits and stay up-to-date on their immunizations. This objective ended in June 2021 and additional efforts to increase access to care among Black or African American pediatric members will be captured under Objectives 4 and 5 under the 2021-2022 Action Plan.
Strategies	
Strategy 1.) Partner with local community-based organizations, such as the Black or African American Infant Health program, to encourage and educate parents on the importance of completing childhood immunizations for members under 2 years of age.	**Progress Discussion:** KHS meets monthly with the Black or African American Infant Health Program coordinator to discuss strategies for encouragement and education on the importance of childhood immunizations. KHS has also partnered with the African American Parent Advisory Committee for the Bakersfield City School District to provide ongoing presentations and obtain feedback on how best to meet the needs and address the barriers to accessing care within this population. Additional community-based organizations have been identified that focus efforts on this population. KHS will continue to reach out and coordinate efforts as opportunities become available.
Strategy 2.) Create an outreach script and leverage KHS' IVR solution to send automated childhood immunization reminder calls to Black or African American/African American member households with a member under 2 years of age.	**Progress Discussion:** A direct mailer on the MCAS MERP and the importance of accessing EPSDT services was sent to all member households that identified a pediatric member between 0-6 years who did not access services within the last 6 months. Robocalls did not reach a large household population due to the lack of member consents on file. For members under 2 years of age, there was less 1% who had consented to receive robocalls from

	KHS. Another robocall campaign attempt will be conducted in Q3 2021.
Strategy 3.) Identify and develop outreach material that connects Black or African American members to childhood immunizations.	**Progress Discussion:** The Spring 2021 Member Newsletter article on childhood immunizations included an image of a family that would connect and represent members who identify as Black or African American. Images on other outreach material such as the preventive care guide is currently be revised for inclusion of this population of focus. KHS will look at other outreach material such as the preventive care guide for images representative of the Black or African American members.
Strategy 4.) Distribute preventive care guides and well-baby reward postcards and posters to family resource centers and community programs and at community events that focus on the Black or African American population.	**Progress Discussion:** The preventive care guide and MCAS MERP flyer was shared with various community-based organizations (i.e. First 5 Kern, Parent Groups, Black Infant Health), schools (i.e. BCSD) and network providers to encourage access to preventive care services and immunizations.
Strategy 5.) Identify geographic areas within the county that have a high concentration of Black or African American members and work with the providers in these areas to distribute outreach and educational material.	**Progress Discussion:** A geographic analysis was conducted to identify zip codes with high concentrations of Black or African American members. Due to the COVID-19 restrictions, the community-based organizations that reside in these areas were limited on their resources to partner with KHS to perform outreach and distribute educational material. KHS network providers were informed of the higher risks associated with this population and the MCAS MERP through a provider bulletin in November and December 2020.
Strategy 6.) Distribute a provider bulletin on the health disparity correlation between Black or African American and childhood immunizations.	**Progress Discussion:** A provider bulletin was sent in December 2020 notifying the KHS provider network on the availability of the PNA, MCAS MERP and the increased risks associated with Black or African American members under the age of 2 years who do not access timely care and complete the recommended immunizations.

Strategy 7.) Include an article in the Spring 2021 Member Newsletter that provides resources on where to obtain childhood immunizations.	**Progress Discussion:** Article on the importance of completing childhood immunizations and the higher risks associated with Black or African American children were included in the Spring 2021 newsletter. Members were instructed to visit the KFHC website to find more information on local immunization programs. An article on the well-baby member rewards was also included alongside the childhood immunization article to further encourage members to access preventive care services.
Strategy 8.) Coordinate social or mass media messaging on childhood immunizations during national observances, such as Black History Month and World Children's Day.	**Progress Discussion:** Messages on well baby visits and immunizations were posted on KFHC's Facebook and Twitter sites in November and December 2020 to recognize World Children's Day and in Feb, March, April 2021 to recognize Black History Month. Additional messages on well baby visits, immunizations and Black infant health disparities are planned for July, August and November 2021.

VI. Stakeholder Engagement

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

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

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