KERN HEALTH SYSTEMS

Population Needs Assessment Report

2022

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I. Population Needs Assessment Overview

In May 1996, Kern Health Systems (KHS) began to serve Medi-Cal Managed Care beneficiaries by offering Kern Family Health Care as the local initiative health plan. As of April 18, 2022, KHS provides services to 328,028 Medi-Cal Managed Care beneficiaries in Kern County.

The goal of the 2022 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.

The KHS 2022 PNA builds upon previous needs assessments and uses various data collection methods and sources. Total KHS membership and demographics in 2021 changed slightly compared to 2020 data. KHS membership grew by 6.0%. This may be due to the pandemic's impact on the economy. The adult share of KHS membership grew slightly from 54.2% in 2020 to 55.8% in 2021. The female share of members remained the same as the previous year at 54.1%. Hispanic/Latinos continue represent the majority of members (62.6%), and English continues to be the most common primary language (72.2%). Most members live in Bakersfield (67.3%) where the highest concentration of members continues to be in the 93307 zip code (14.6%). The share of Seniors and Persons with Disabilities (SPD) decreased from 5.6% in 2020 to 5.1% in 2021 and KHS identified 7,363 homeless members in 2021, a 69.2% increase compared to 2020.

The most commonly diagnosed health problems among KHS members in 2021 included common types of infections and acute illnesses, chronic diseases, pain, and COVID-19 related exposure or illness. The top diagnoses linked to infections included acute upper respiratory and viral infections, COVID-19 acute respiratory disease, fever, bronchiolitis, pharyngitis, appendicitis, urinary tract infection, sepsis, and contact with or (suspected) exposure to communicable diseases. The most commonly diagnosed chronic conditions included heart disease, chronic kidney disease, type 2 diabetes, hypertension, and myocardial infarction. The most commonly diagnosed forms of pain were headache, abdominal and pelvic pain, chest pain, and throat and chest pain. Autistic disorder was the most diagnosed developmental disorder. In 2021, COVID-19 related diagnoses continued to be among the top diagnoses for adult members. COVID-19 acute respiratory disease became a top diagnosis for members under 20 years old in 2021.

Asthma, hypertension, disorders of lipid metabolism, low back pain, and depression were found to be the top 5 chronic conditions according to KHS' population analysis reports. Diagnosis rates for the top 10 chronic conditions increased in 2021 compared to 2020 for all with the exception of COPD. Review of KHS' pharmaceutical utilization identified Ibuprofen as the top medication prescribed followed by Albuterol HFA, Atorvastatin, Metformin HCL, and Lisinopril. The top 10 medications prescribed were consistent with the top 10 chronic conditions.

Mental health diagnoses for depression, bipolar disorder and schizophrenia were found to be more prevalent among female, English-speaking, and adult members. When comparing racial and ethnic groups, White members had the highest diagnosis rates of depression and bipolar disorders whereas Native American members had the highest share of members with a diagnosis of schizophrenia.

Among members who received smoking cessation services from Kick It California in 2021, anxiety and high blood pressure were identified as the top behavioral and physical health conditions, respectively.

Findings from KHS' member chronic condition reports 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 increased by 75.1% from 2020 to 2021. This increase was primarily due to targeted outreach to members identified as high-risk asthma for recruitment into an asthma home visiting services. In 2021, the majority of referrals were for weight management, followed by asthma, nutrition counseling, tobacco cessation, and diabetes education. Total referrals increased for all health topics in 2021 compared to 2020. The largest changes in referrals by topic were for asthma education, followed by weight management education, nutrition counseling, diabetes education, and smoking cessation.

The rate of members who accepted health education services increased from 43.0% to 54.4%, yet the rate of members who received services decreased from 56.7% to 41.4% in comparison to the prior year. KHS virtual nutrition education classes continued to be the most popular health education service in 2021. This service accounted for 72.4% of all accepted referrals and 89.0% of services received outcomes. However, the attendance rate for the nutrition classes decreased from 64.3% to 51.0%, likely due to reductions in the value of member class incentives.

Requests for qualified interpreters increased by 1.2% in 2021. In-person requests (excluding American Sign Language (ASL) requests) decreased by 18.0%, phone interpreting requests increased by 8.2%, video remote interpreting (VRI) requests decreased by 83.5%, and in-person ASL interpreting requests increased by 44.1%. Spanish continued to be the most requested language, followed by ASL, Punjabi, and Arabic.

KHS' access to care surveys identified that 7.8% and 3.7% of providers surveyed were found to be non-compliant with urgent and emergency care standards, respectively. In addition, 6.7% of providers surveyed needed additional training on accessing interpreting services for Limited English Proficient (LEP) members. Findings also revealed that 18.3% were not accepting new members.

The results of KHS' 2021 Member Satisfaction Survey indicated decreased rates of 3% points or more between 2020 and 2021 occurred for the following measures:

- Effectiveness of Care
    - Flu vaccinations (adults 18-64)
    - Discussing cessation medications
    - Discussing cessation strategies

The lack of in-person health education services continues to be a gap. Results from this year's KHS Public Policy/Community Advisory Committee (PP/CAC) Survey found that in-person health education classes, exercise classes, gym passes, and in-person individual education were reported among the most effective methods to providing health education services for KHS members. KHS will consider the possibility of offering in-person health education services in 2022. Members may be more willing to attend in-person group classes now that daily COVID-19 case totals have decreased to low levels.

KHS will continue to offer virtual health education services as it allows members more flexibility to participate throughout the county. However, there are several access barriers for virtual classes and other health education services that are available during the pandemic. Examples of barriers include work schedules, childcare, low literacy, access to reliable internet service, technology literacy, access to smartphones or computer devices, lack of language options for health education services or materials, lack of materials that can be mailed, and lack of health education services or materials offered by health care providers. Health education access barriers and preferences for different types of health education services vary by language and other demographic factors. For example, Spanish speakers were more likely to participate in virtual health education classes than English speakers in 2021.

The following key findings and recommendations were made based on the 2022 PNA.

- Continue to promote and facilitate member access to preventive care services with a high emphasis on members with chronic conditions.
- Develop outreach strategies that promote pediatric preventive health among Black/African American members and their communities.
- Develop outreach strategies for chronic disease prevention and management with a focus on conditions where Black/African American members have disproportionately higher rates.
- Continue to promote and facilitate member access to tobacco/smoking cessation services.
- Continue to promote and facilitate access to KHS' health education and interpreting services among members and health care providers.
- Consider offering in-person health education services and benefits to members when it is safe to do so, such as health education classes, exercise classes, gym memberships, and individual counseling.
- Continue to offer other modes of providing health education services with special emphasis on virtual platforms and digital communications.
- Identify and implement strategies to bridge the communication gap between members and providers to allow for shared decision making around preventive care, effective communication, and improvement in health literacy.

- Continue to enhance existing member communication platforms and offer new options, such as text messaging, to allow for more direct, responsive, and convenient member communication and outreach .
- Continue to offer education and resources to address misinformation about the COVID-19 vaccines and help members and health care providers adapt to the risks of COVID-19.

II. Data Sources

KHS used various methods of internal and external data collection, review and analysis in the development of the 2022 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
KHS' Adult and Child Medicaid CAHPS Survey results for Measurement Year (MY) 2020 were reviewed to assess areas of improvement among plan and provider services.

2021 KHS Member Satisfaction Survey
KHS administered its annual member satisfaction survey by mail and telephonically to all adult KHS members in 2021. A total of 850 surveys were collected which yielded a 7.3% response rate. Female members accounted for 67.7% of all respondents. The largest age group included the ages of 18-34, which accounted for 33.1% of respondents. Hispanics/Latinos were the largest racial/ethnic group at 57.2% of respondents.

California Department of Health Care Services (DHCS) Data Health Disparities Data
KHS' Health Disparities Rates for MY 2020 provided by DHCS were reviewed to assess health status and disease prevalence among KHS' membership and within race/ethnic groups.

Managed Care Accountability Set (MCAS) Data
KHS' MCAS rates for MY 2020 were used to assess indicators of member's health care.

2021 KHS Population Needs Assessment
KHS' report was reviewed and compared with current findings to identify changes in utilization of health services, health education, and cultural and linguistic member needs.

Membership Eligibility Data
KHS membership eligibility data from 2020 and 2021 was reviewed and analyzed 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 2021 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 2021 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 2021 was analyzed by top medications dispensed.

KHS Member Chronic Condition Report
KHS' report identifies 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.

KHS Advice Nurse Line Program Summary Report
Utilization reports from the KHS 24 hours advice nurse line for 2021 were reviewed to identify call frequency and the top reasons for the calls.

KHS Departmental Reports
The 2021 KHS Health Education Activities Report was reviewed to identify trends in need for health education services and allows projections for program development. KHS' Population Health Management and Health Homes Program 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 from the perspectives of committee members.

III. Key Data Assessment Findings

Membership/Group Profile

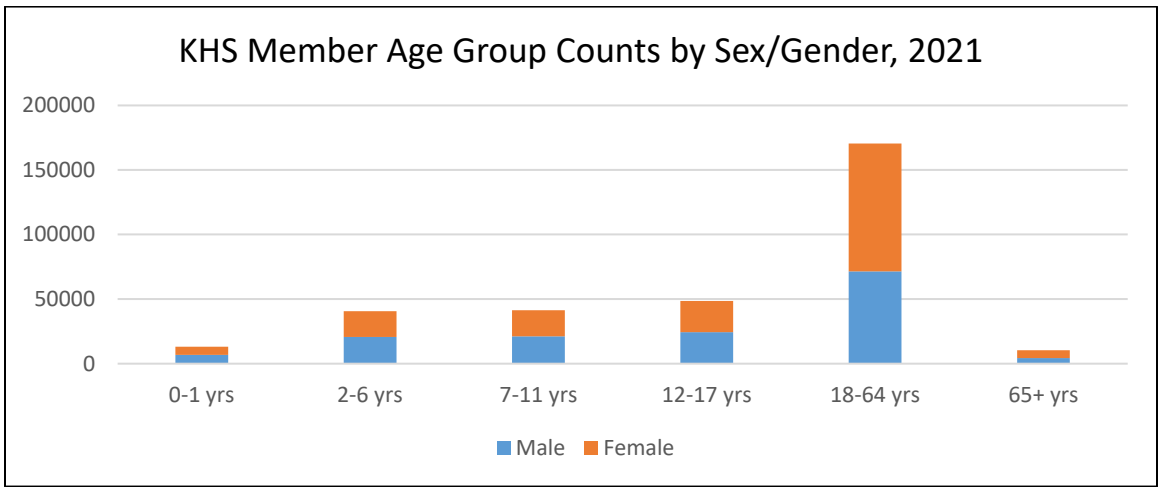
According to KHS' membership statistics, 314,427 Medi-Cal managed care members enrolled in the plan in 2021.[1] This was a 5.6% increase in total annual membership since 2020. KHS member enrollment in 2021 was over one third of the population of Kern County.[2] Although sex/gender makeup at the state 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	909,235	314,427
Male (%)	49.7%	51.2%	46.0%
Female (%)	50.3%	48.8%	54.0%

Source: 2021 KHS Member Demographics Data Report; U.S. Census Bureau

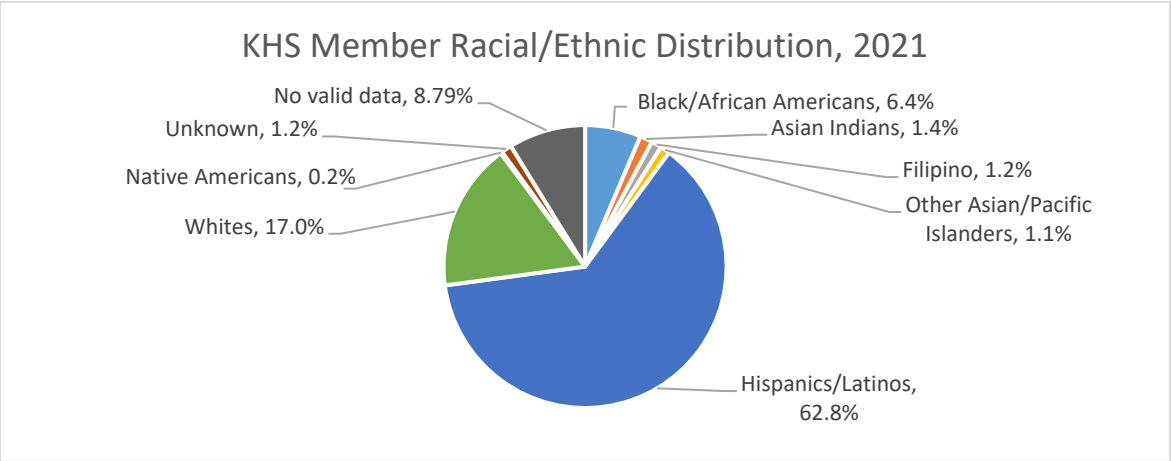
As KHS' membership grows, the adult share of the population continues to increase. The percentage of members under 18 years old decreased from 45.1% in 2020 to 44.2% in 2021. The proportion of members 18-64 years old increased from 51.7% to 52.4%. For members 65 years and older, that figure increased marginally from 3.2% to 3.3% .[1] In comparison, at the county level, 28.8% of the population is under 18 years old and 11.2% are 65 years and older.[2] At the state level, 22.5% of the population is under 18 years old and 14.8% are 65 years and older.

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.

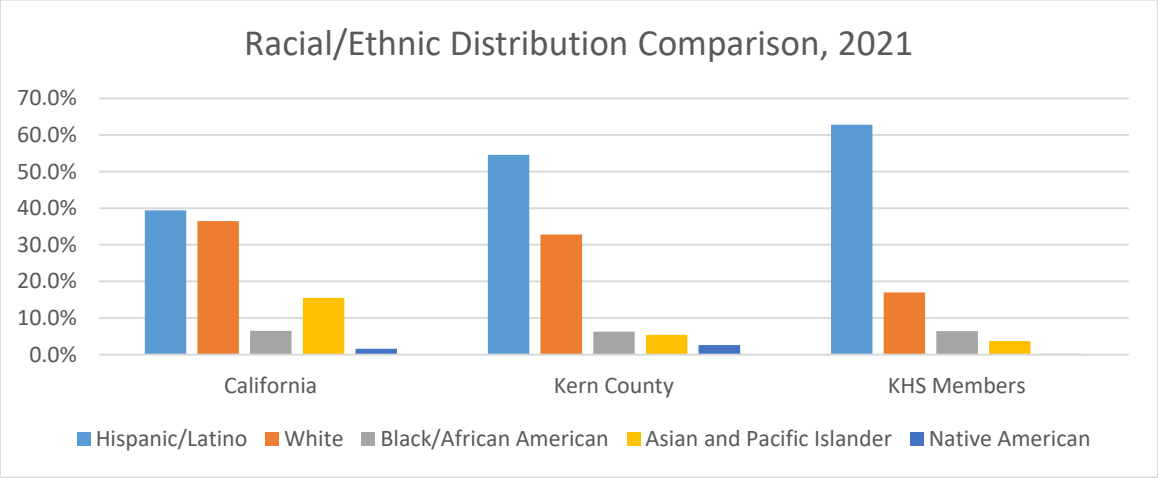


Source: 2021 KHS Member Demographics Report

KHS continues to have a diverse membership. Hispanic/Latinos continue to comprise the majority of our membership (62.8%), followed by Whites (17.0%), Black/African Americans (6.4%), Asians/Pacific Islanders (3.7%), and other races/ethnicities. The racial/ethnic makeup of KHS members in 2021 was very similar to 2020. In comparison, data reported in the U.S. Census Bureau shows that 54.6% of Kern County and 39.4% of California residents are Hispanic/Latino, followed by White (KC-32.8%, CA-36.5%), Black/African American (KC-6.3%, CA-6.5%), Asian/Pacific Islander (KC-5.7%, CA-16.0%), and Native American (KC-2.6%, CA-1.6%).[1]

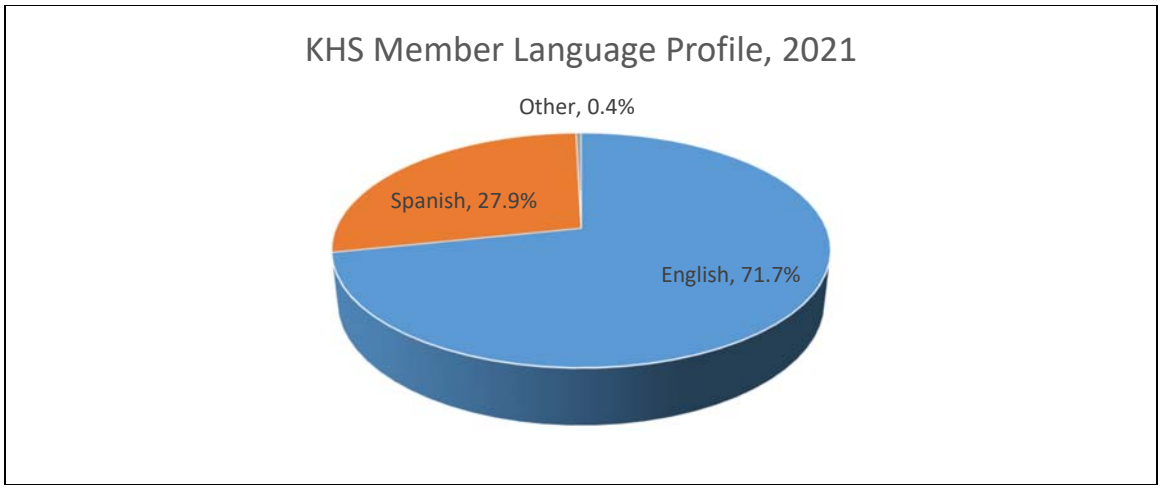


Source: 2021 KHS Member Demographics Data Report



Source: 2021 KHS Member Demographics Report; US Census Bureau

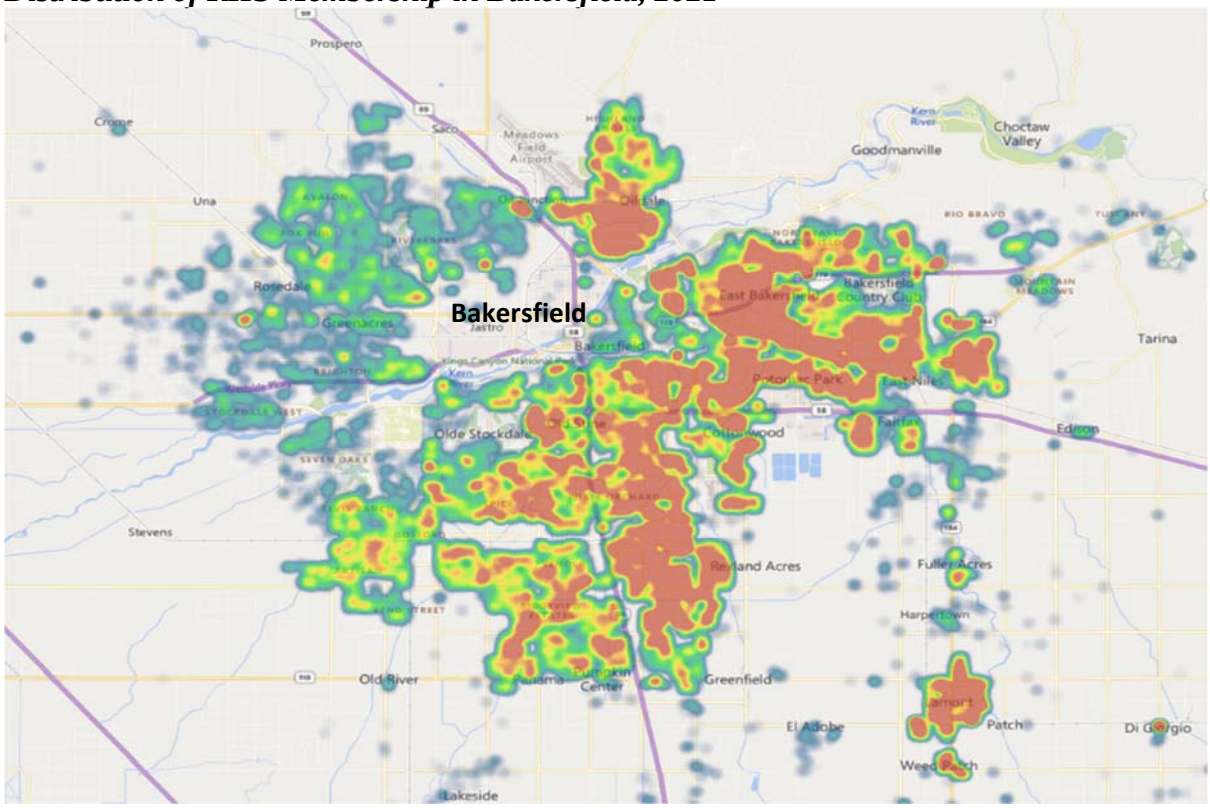
In 2021, 71.7% of KHS members were English speaking, while 27.9% were Spanish speaking and 0.4% spoke a language other than English or Spanish.[1] This language profile changed slightly compared to 2020 where 71.9% of members spoke English, 27.7% spoke Spanish, and 0.3% spoke other languages. In comparison, data reported in the U.S. Census Bureau show that 55.1% of Kern County residents and 55.5% of California residents speak English.[2] This is followed by Spanish (KC-39.6%, CA-28.8%), and other languages (KC-5.3%, CA-15.7%).



Source: 2021 KHS Member Demographics Data Report

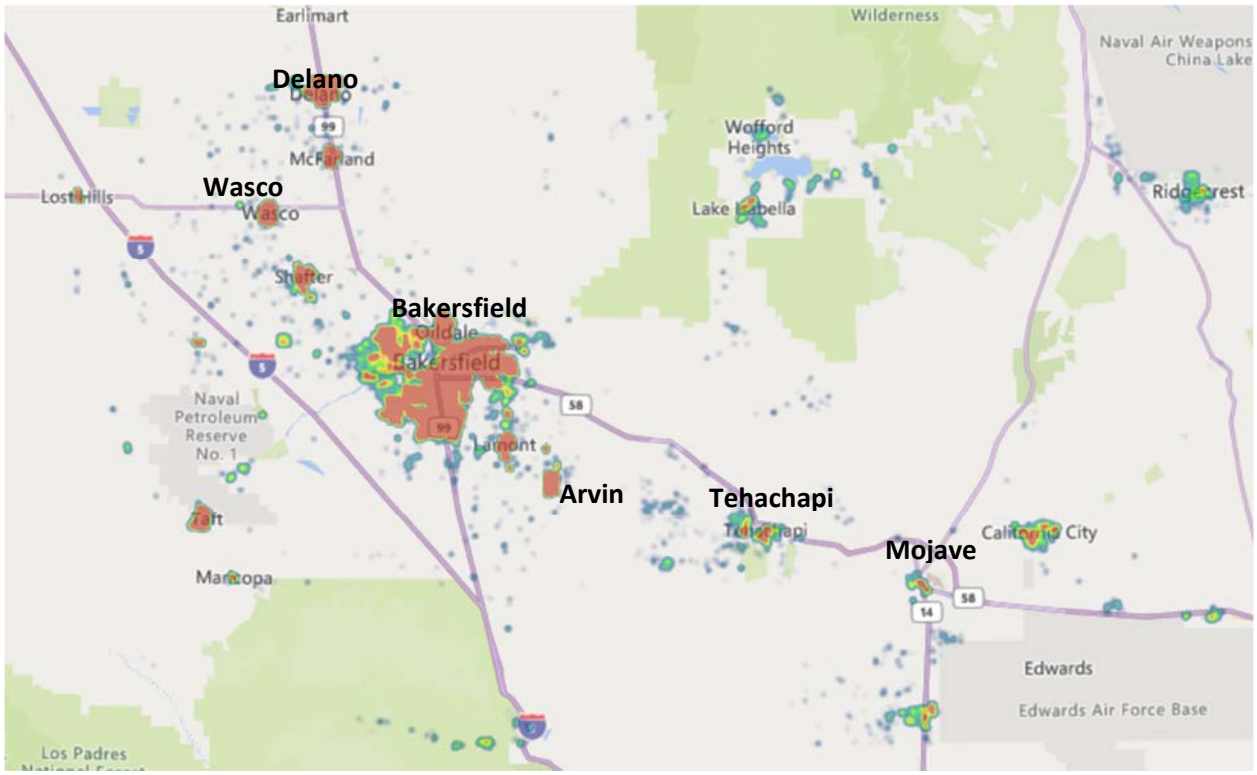
In 2021, the majority of KHS' members lived in Bakersfield (66.9%), Delano (6.7%), Arvin (3.8%), and Wasco (3.4%).[1] There were slight changes compared to 2020 where 66.0% and 7.1% of members lived in Bakersfield and Delano, respectively. The percentage of members living in Arvin and Wasco remained static between the two years. In Bakersfield, the highest concentration of KHS members was in the 93307 zip code (17.2%), followed by 93306 (8.8%), 93304 (7.7%), 93309 (6.3%), and 93305 (6.2%). The 2020 data were essentially the same, with 17.3% of members in 93307, 8.7% in 93306, 7.7% in 93304, 6.3% in 93305, and 6.2% in 93306.

Distribution of KHS Membership in Bakersfield, 2021



Source: 2021 KHS Member Demographics Data Report

Distribution of KHS Membership in Kern County, 2021



Source: 2021 KHS Member Demographics Data Report

In 2021, KHS' SPD members accounted for 1.8% of the population in Kern County.[1] This figure was the same as in the previous year. KHS had 15,996 SPD members enrolled, which was 5.1% of our total membership that year.[1] This was a slight decrease compared to 5.6% in 2020. A total of 7,476 members were identified through Health Homes Program referrals that were created in 2021.[5] The majority of these members resided in the 93307 zip code, followed by 93304, 93306, 93308, and 93305.

KHS identifies homeless members primarily through claims data. In 2021, 7,363 homeless members were identified, a 69.2% increase compared to 2020.[6] The majority of homeless members reported living in Bakersfield.

Health Status and Disease Prevalence

Kern County Public Health Profile

Kern County ranks lower compared to other California counties for a variety of public health indicators. Kern County ranks in the bottom 10 California counties for age-adjusted death rates due to diabetes, alzheimer's disease, coronary heart disease, chronic lower respiratory disease, homicide, and drug-induced deaths.[7] It is also among the bottom 10 California counties for the

incidence of chlamydia, gonorrhea among people 15-44 years old, congenital syphilis, primary and secondary syphilis, infant mortality, and persons under 18 in poverty.

In Kern County's most recent Community Health Assessment, asthma and other respiratory diseases were identified as the top community health problems.[8] According to the California Health Interview Survey, 15.7% of the Kern County population has ever been diagnosed with asthma.[9] In 2019, the emergency department (ED) rate due to asthma was 46.1 per 100,000 compared to the state average of 42.6 per 100,000.[10] Black/African American people in Kern County experience asthma disparities as demonstrated by their asthma ED visit rate of 181.5 per 100,000 people. This rate is more than four times the rate of the next highest racial/ethnic group in Kern County and more than double the rate of any age group in the county.

Other health disparities identified within Kern County include the teen birth rate (25.9 per 1,000 live births) which was more than double the state average (12.5 per 1,000 live births);[7] the percentage of all pregnancies accessing early prenatal care which was below the state average (KC-79.6%; CA-85.1%); and the obesity rate which was 35.5% compared to 30.3 for California.[11,12]

In regard to mental health, Kern County's age-adjusted mortality rate due to suicide is 13.5 per 100,000 which is higher than the state averages (CA-10.7 per 100,000).[8]

Health Indicator	Kern County	California
Asthma Emergency Department Rate	46.1 per 100,000	42.6 per 100,000
Teen Birth Rate (15-19 Years Old)	25.9 per 1,000 live births	12.5 per 1,000 live births
Access Early Prenatal Care	79.6%	85.1%
Percentage of Obese Adults	35.5%	30.3%
Age-Adjusted Suicide Mortality Rate	13.5 per 100,000	10.7 per 100,000

Source: California Department of Public Health, California Breathing, County Asthma Data Tool; California Department of Public Health, California's County Health Status Profiles for 2021; Kern County Public Health Services Department, Community Health Assessment and Improvement Plan, 2018-2019

KHS Membership Health Conditions & Diagnoses

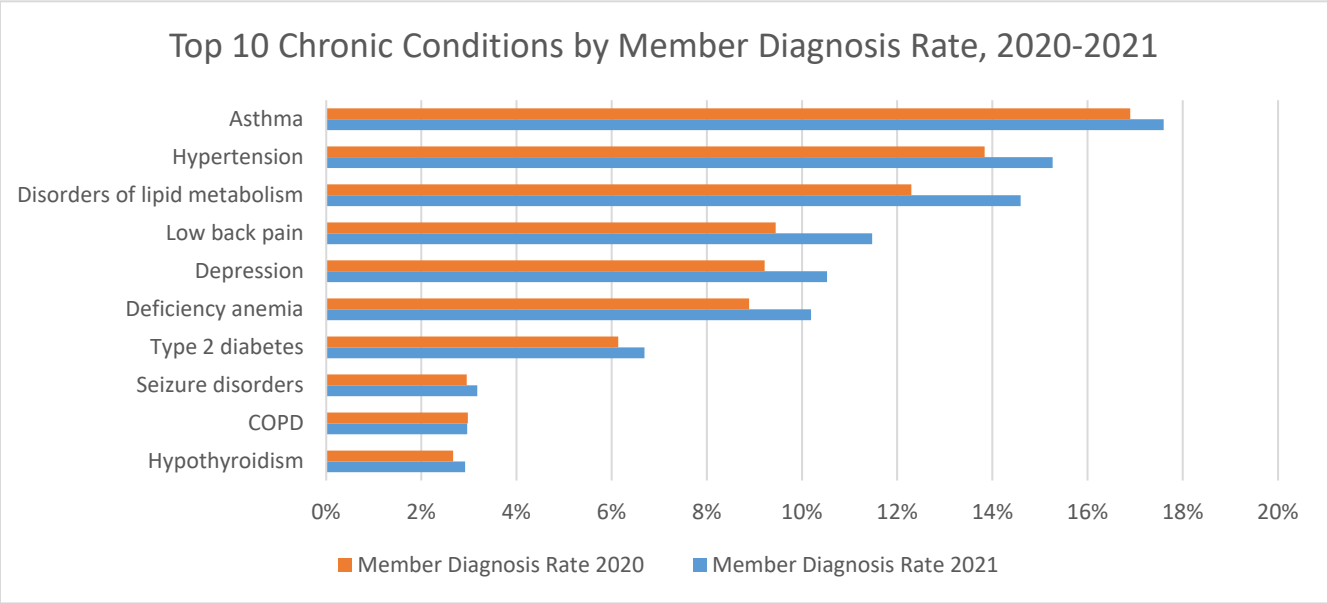
KHS medical service claims data revealed that the most commonly diagnosed health problems among KHS members in 2021 included common types of infections and acute illnesses, chronic diseases, pain, and COVID-19 related exposure or illness.[13] The top diagnoses linked to infections included acute upper respiratory and viral infections, COVID-19 acute respiratory disease, fever, bronchiolitis, pharyngitis, appendicitis, urinary tract infection, sepsis, and contact with or (suspected) exposure to communicable diseases. The most commonly diagnosed chronic conditions included heart disease, chronic kidney disease, type 2 diabetes, hypertension, and myocardial infarction. The most commonly diagnosed forms of pain were headache, abdominal and pelvic pain, chest pain, and throat and chest pain. Autistic disorder was the most diagnosed developmental disorder.

The chart below includes a breakdown of the top diagnoses by age group. A trend that emerged is that COVID-19 acute respiratory disease became a top diagnosis for members under20 years old in 2021 which was not found in the previous year. Medical service claims from urgent care consistently include the diagnosis of contact with communicable diseases, possibly due to unconfirmed cases of COVID-19. General or routine child and adult exams, chemotherapy, and cancer screenings were also among the top diagnoses.

Top Diagnoses among KHS Members				
Age Group	**ED**	**INPATIENT**	**OUTPATIENT**	**UC**
0-11 Years	• Acute upper respiratory and viral infections • Fever • Nausea and vomiting • Urinary tract infection	• Neonatal jaundice • Acute bronchiolitis • Appendicitis • COVID-19 acute respiratory disease	• Routine child health exam • Acute upper respiratory and viral infections • Fever	• Other respiratory disorders • Acute upper respiratory infections • Contact with or (suspected) exposure to communicable diseases or COVID-19 • Fever
12-20 Years	• COVID-19 acute respiratory disease • Urinary tract infection • Abdominal and pelvic pain • Acute upper respiratory and viral infections • Headache	• Sepsis • Acute appendicitis • Convulsions • COVID-19 acute respiratory disease	• Routine child health exam • Abdominal and pelvic pain • COVID-19 acute respiratory disease • Urinary tract infection	• Other respiratory disorders • Contact with or (suspected) exposure to communicable diseases or COVID-19 • Acute pharyngitis • Acute upper respiratory infections
21-64 Years	• COVID-19 acute respiratory disease • Urinary tract infection • Throat and chest pain • Headache • Abdominal and pelvic pain	• Sepsis • COVID-19 acute respiratory disease • Overweight and obesity • Hypertensive heart disease	• Type 2 diabetes • Hypertension • COVID-19 acute respiratory disease • Preprocedural exam • Mammogram	• Other respiratory disorders • Contact with or (suspected) exposure to communicable diseases or COVID-19 • COVID-19 acute respiratory disease • Acute upper respiratory infection
65+ Years	• Hypertension • Urinary tract infection • Abdominal and pelvic pain • Headache • COVID-19 acute respiratory disease	• COVID-19 acute respiratory disease • Sepsis • Myocardial infarction • Hypertensive and chronic kidney disease	• Chemotherapy • Type 2 diabetes • Hypertension • Type 2 diabetes • COVID-19 acute respiratory disease • Chemotherapy • Colon cancer screening	• Contact with or (suspected) exposure to communicable diseases or COVID-19 • Urinary tract infection • Hypertension • Other respiratory disorders • Cough
SPDs	• Throat and chest pain • COVID-19 acute respiratory disease • Urinary tract infection • Headache • Abdominal and pelvic pain	• COVID-19 acute respiratory disease • Sepsis • COPD • Hypertensive heart disease • Other disorders of muscle or muscle weakness	• Chronic kidney disease • Type 2 diabetes • Chemotherapy • Therapeutic drug level monitor • Preprocedural examinations	• Hypertension • Autistic disorder • Type 2 diabetes • Immunization • General adult medical examination

Source: 2021 KHS Top Diagnosis Report

KHS uses a predictive modeling tool to perform data analysis on member medical service claims for various chronic conditions in a given year. The following chart includes the top 10 chronic conditions by member diagnosis rate for both 2020 and 2021.[14] The top 10 list included the same chronic health conditions in both years. Rates increased in 2021 compared to 2020 for all of the top chronic conditions shown in the chart below with the exception of COPD.



Source: 2021 KHS Member Chronic Condition Report

When looking at the top 5 chronic health conditions among KHS members, racial/ethnic disparities varied by health condition in 2021. Data findings indicate that hypertension and disorders of lipid metabolism may disproportionately impact Asian/Pacific Islander members whereas Black/African American members are more likely to be disproportionately affected by asthma.[14] Native American members had the highest rate of low back pain whereas White members had the highest rate of depression. The racial/ethnic group with the highest rates for each of the top chronic conditions among KHS members is shown in red, respectively, in the table, below.

These results should be interpreted cautiously since claims data may not represent the true chronic condition rates by racial/ethnic group among KHS members. Racism, past health care experiences, and concerns about COVID-19 among Black/African American members and other members of color may be factors in their willingness to seek medical care. In addition, the pandemic limited member's access to care as health care providers closed offices, reduced office hours or restricted the availability of in-person appointments during the COVID-19 case and hospitalization surges. As a result, this may have resulted in under-utilization of health care among KHS members.

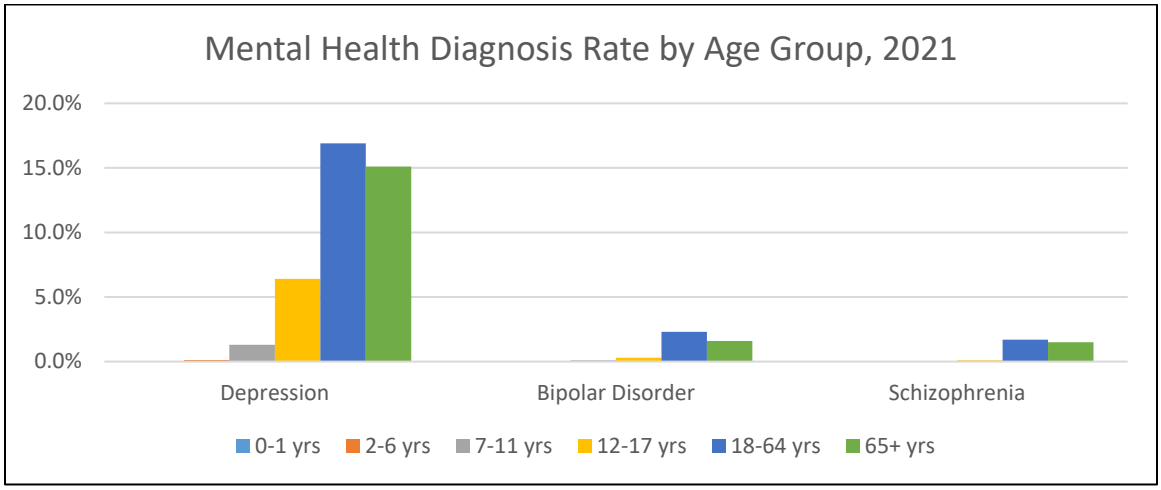
Rates of the Top 5 Chronic Conditions by Race/Ethnicity, 2021

Chronic Condition	Black/African American	Asian and Pacific Islander	White	Hispanic/ Latino	Native American
Asthma	22.8%	15.5%	21.0%	16.2%	20.9%
Hypertension	19.4%	27.0%	20.7%	13.3%	25.4%
Disorders of Lipid Metabolism	11.7%	29.9%	15.3%	14.5%	19.5%
Low Back Pain	15.0%	14.8%	16.0%	10.4%	16.7%
Depression	11.6%	7.9%	19.1%	8.9%	16.5%

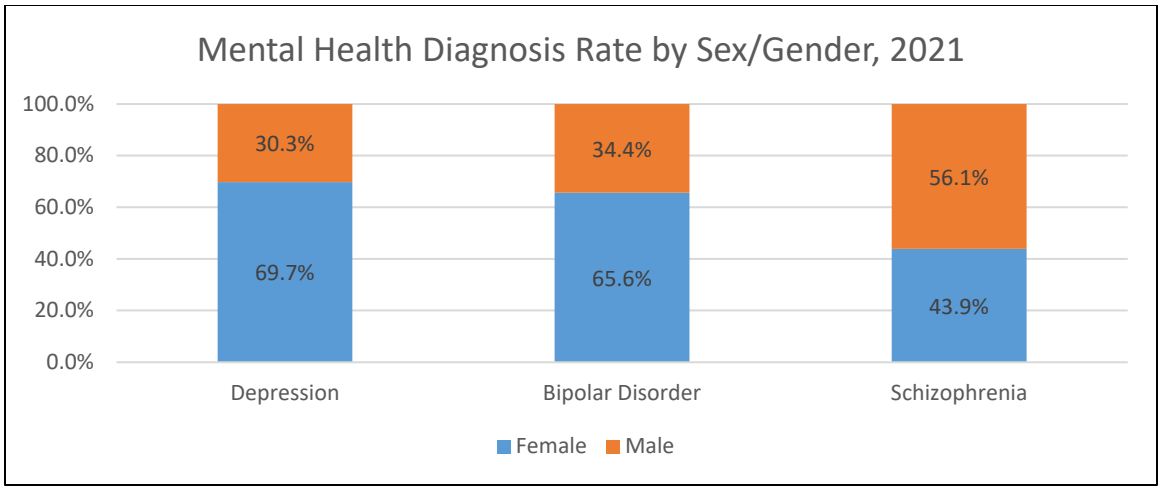
Source: 2021 KHS Chronic Conditions Report

Mental Health Conditions

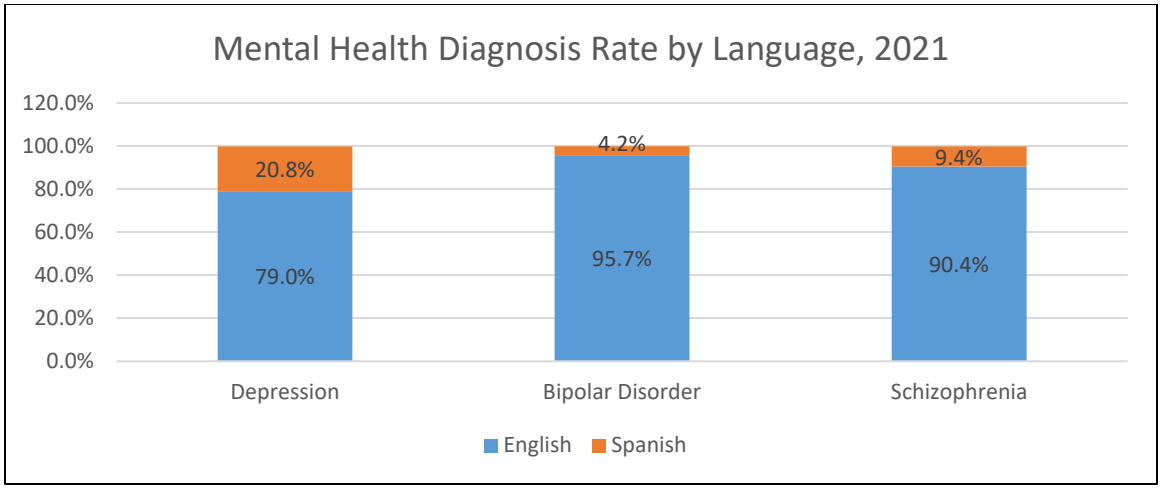
In 2021, 10.5% of KHS members were identified to have had a depression diagnosis, 1.3% with a bipolar disorder, and 1.0% with schizophrenia.[15,16,17] All three rates increased slightly compared to 2020 rates. In 2021, members with a diagnosis of depression, bipolar disorder or schizophrenia were most likely to be English speaking, female, or adults between the ages of 18-64 years. However, schizophrenia was the exception where males were more likely to be diagnosed with this condition than females. White members had the highest rates of depression and bipolar disorder disorders whereas Native American members had the largest share of members with a schizophrenia diagnosis, followed by Black/African American members. Mental health condition rates by age group, sex/gender, language, and race/ethnicity were very similar in 2021 compared to 2020.



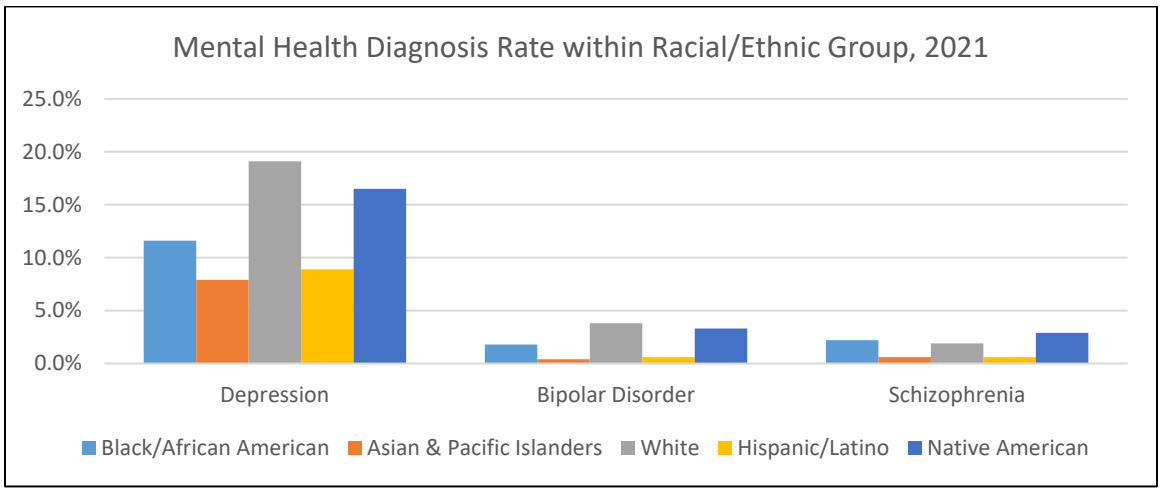
Source: 2021 KHS Member Chronic Condition Report



Source: 2021 KHS Member Chronic Condition Report



Source: 2021 KHS Member Chronic Condition Report



2021 KHS Member Chronic Condition Report

Pharmaceutical Utilization

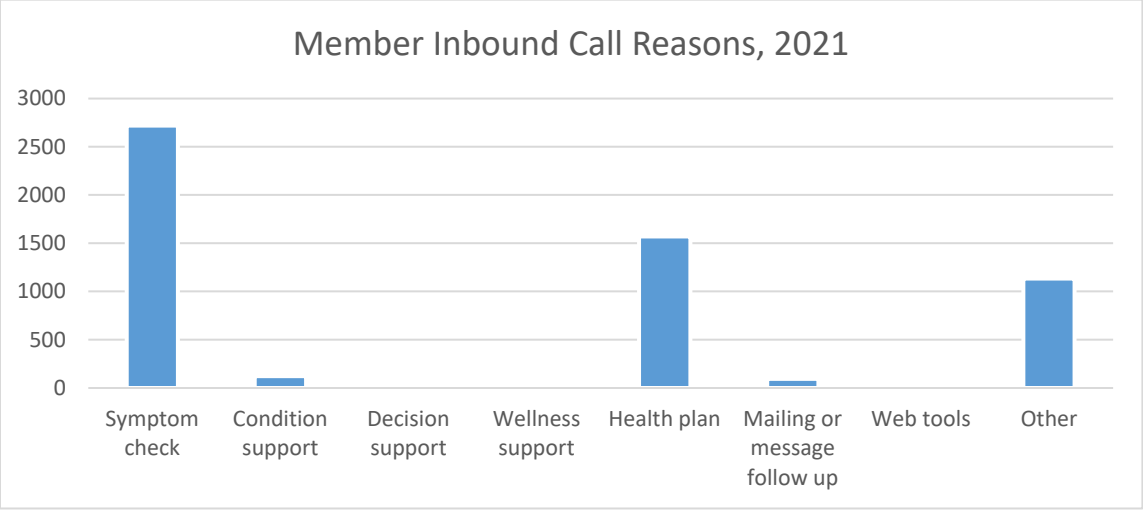
KHS' review of the most frequently dispensed medications identified Ibuprofen, Albuterol HFA, Atorvastatin, Metformin HCL, and Lisinopril as the top 5 medications prescribed to KHS members in 2021.[18] These medications are used to treat health conditions that were identified as top diagnoses among KHS members in 2021, such as abdominal and pelvic pain, common infections, and chronic conditions, such as type 2 diabetes, hypertension, and heart disease. Other top medications included those prescribed to treat allergies, hyperlipidemia, fever, inflammation, and vitamin D deficiency. Steglatro was identified to be the costliest medication dispensed, which accounted for almost $7 million as it helps lower blood sugar levels in adults with type 2 diabetes.

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

Source: 2021 KHS Top Medications Filled Report

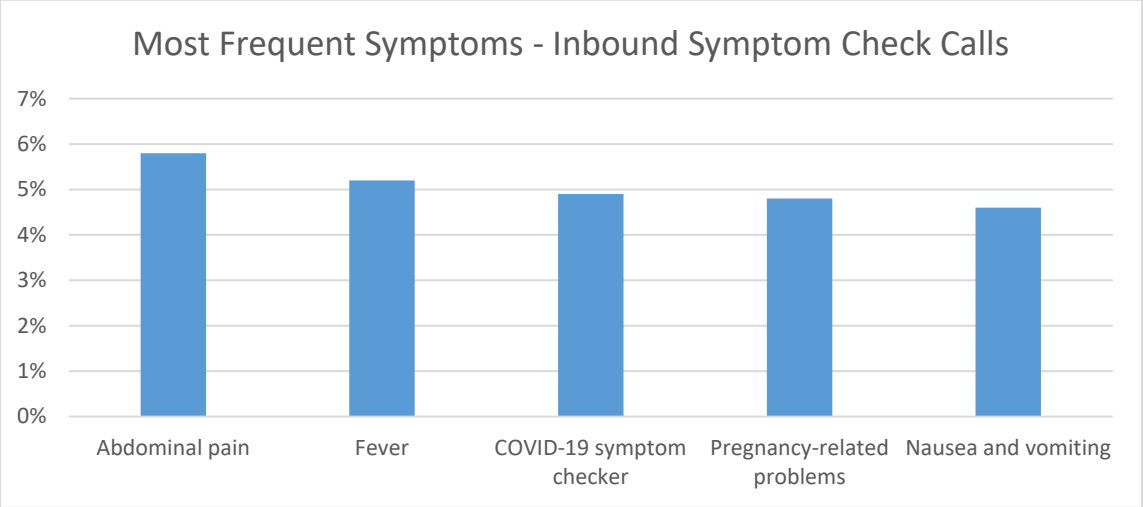
Advice Nurse Line

In 2021, the KHS advice nurse line received 5,649 inbound calls from members.[19] The top call reasons included symptom check (48.1%), followed by health plan (27.8%) and other (20.1%).



Source: 2021 KHS Advice Nurse Line Report

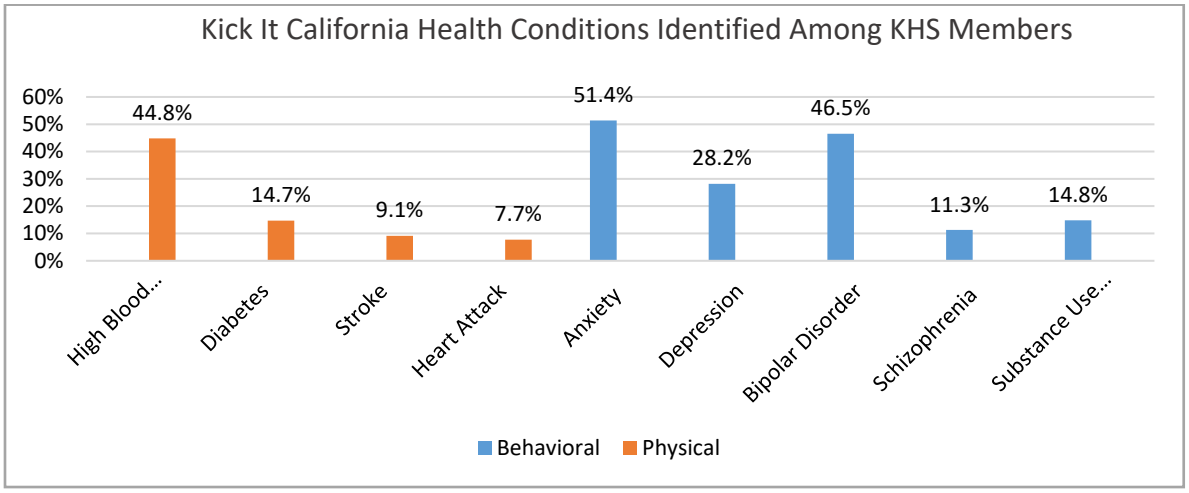
The most frequent symptoms for inbound symptom check calls were abdominal pain, followed by fever, COVID-19 symptom checker, pregnancy-related problems, and nausea and vomiting.



Source: 2021 KHS Advice Nurse Line Report

Smoking, Tobacco Use and Associated Health Conditions

The 2021 CAHPS Adult Medicaid Survey performed by the DHCS Health Services Advisory Group (HSAG) found that 16.4% of KHS adult members are current smokers.[25] According to KHS' tobacco registry report, 12.9% of members are current smokers or have been exposed to tobacco.[20] Kick It California (KIC) collects demographic and health data during phone counseling sessions and shares this data with Medi-Cal Managed Care health plans. KIC data revealed that KHS member callers were most likely to be English speaking (98.6%), female (65.7), White (51.0%), between the ages of 45-64 years (53.8%), and have at least a high school education (70.6%).[21] Anxiety and high blood pressure were identified as the top behavioral and physical health conditions, respectively, among KHS members.



Source: 2021 Kick It California Demographic and Health Data for Medi-Cal Health Plans

Access to Care

KHS conducts an annual member satisfaction survey to capture information about member-reported experiences with health care. The survey specifically measures how well KHS is meeting member's expectations and goals and the areas of service that have the greatest effect on overall satisfaction. It also identifies areas of opportunity for improvement. Additionally, HSAG conducts a separate CAHPS Adult and Child Medicaid Survey every 2 years with KHS members. In the table below, the 2021 Member Satisfaction Survey rates for getting needed care and getting a specialist appointment increased by at least 3 percentage points compared to 2020 rates.[22,23] Additionally, the 2021 rates for getting care, tests, or treatment, getting urgent care, how well doctors communicate, personal doctors explained things, and personal doctors showed respect improved compared to the previous year. KHS HSAG CAHPS child and adult rates for 2021 are also shown below for comparison.[24,25]

Measure (Always or Usually)	KHS CAHPS Child Rate	KHS CAHPS Adult Rate	KHS Member Satisfaction Survey Adult Rate	
	2021	2021	2020	2021
Getting Needed Care	N/A	80.6%	73.1%	77.9%
Getting care, tests, or treatment	83.9%	85.6%	77.5%	79.9%
Getting a specialist appointment	N/A	75.6%	68.6%	75.9%
Getting Care Quickly	N/A	76.4%	77.7%	77.1%
Getting urgent care	N/A	N/A	78.8%	80.5%
Getting routine care	80.6%	76.5%	76.5%	73.7%
How Well Doctors Communicate	92.3%	92.0%	88.4%	89.1%
Personal doctors explained things	89.4%	91.0%	87.0%	89.1%
Personal doctors listened carefully	97.6%	95.5%	90.0%	90.0%
Personal doctors showed respect	97.6%	96.2%	92.6%	94.3%
Personal doctors spent enough time	84.6%	85.3%	83.5%	82.9%

Source: MY 2020 HSAG CAHPS Child Medicaid Survey Results Report, MY 2020 HSAG CAHPS Adult Medicaid Survey Results Report; 2021 Member Satisfaction Survey

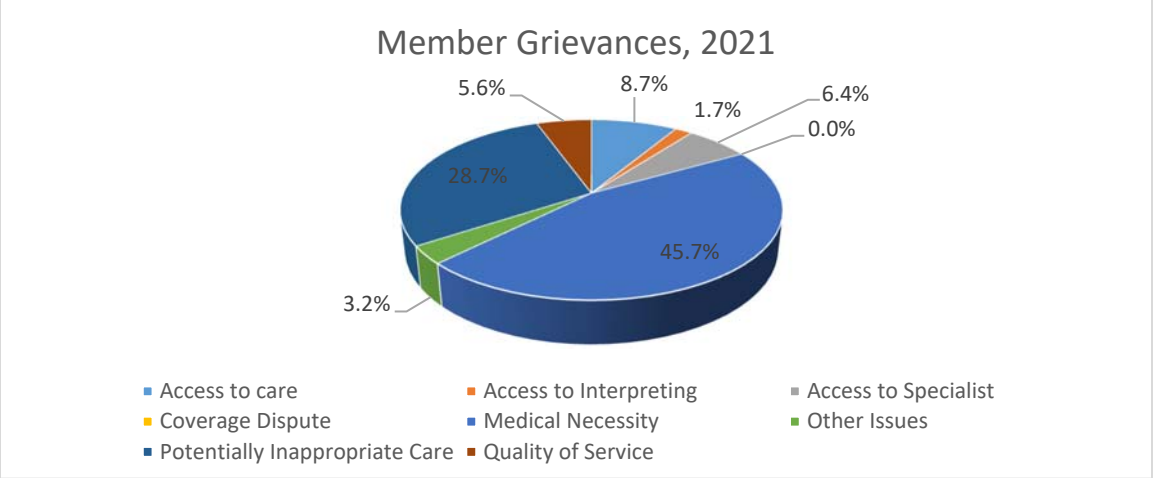
Data on the effectiveness of care measures for flu shots and tobacco use among adult members was also collected. The KHS Member Satisfaction Survey rate did not improve upon adult flu vaccination, discussing cessation medications, or discussing cessation strategies in 2021 compared to 2020.[24,25] However, KHS improved on advising smokers and tobacco users to quit compared to the previous year. The community fears around receiving the COVID-19 vaccines along with the flu vaccine may have contributed towards the reduction in adult flu vaccinations.

Effectiveness of Care Measure	KHS HSAG CAHPS Child Rate	KHS HSAG CAHPS Adult Rate	KHS Member Satisfaction Survey Adult Rate	
	2021	2021	2020	2021
Flu Vaccinations (Adults 18-64)	N/A	39.0%	45.5%	35.8%
Advising Smokers and Tobacco Users to Quit	N/A	N/A	67.5%	72.5%
Discussing Cessation Medications	N/A	N/A	47.0%	41.7%
Discussing Cessation Strategies	N/A	N/A	35.4%	31.4%

Source: MY 2020 HSAG CAHPS 5.1H Child Medicaid Survey Results Report, MY 2020 HSAG CAHPS 5.1H Adult Medicaid Survey Results Report; 2021 Member Satisfaction Survey

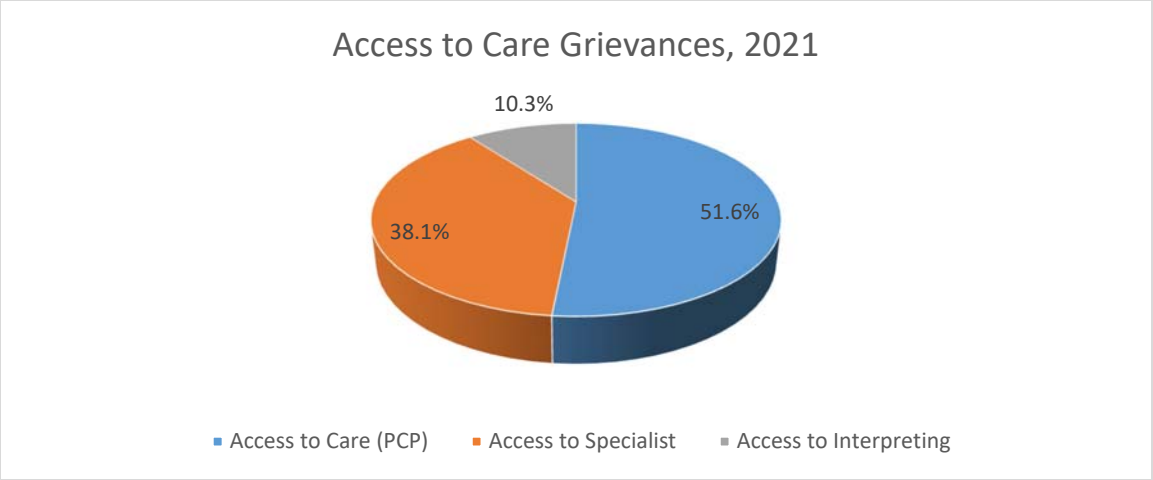
Member Grievances

KHS regularly monitors and reports on its member grievances related to access to care, coverage, medical necessity, quality of care and services, cultural and linguistic sensitivity and other issues. In 2021, there were 2,648 formal member grievances received. The majority of grievances were due to Medical Necessity, followed by Quality of Care and Access to Care. Nearly a fifth (19.3%) of grievances were closed in favor of the member.[26]



Source: 2021 Grievance and Appeal Data

When looking at Access to Care grievances, Access to Care (Primary Care Provider or PCP) accounted for the majority of cases (51.6%) in this grievance category, followed by Access to Specialist (38.1% and Access to Interpreting (10.3%).[26]



Source: 2021 KHS Grievance and Appeal Data

Access to Transportation

KHS' Transportation Program provides non-emergency transportation for members to get to their medical and other Medi-Cal covered services. Coverage includes Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT). NEMT is provided when medically necessary and requires a completed and signed Physician Certified Statement from the member's medical provider. NMT is provided to all members who qualify. Total trips for all modes of transportation combined increased by 3.2% in 2021 compared to 2020.[27] However, change in total trips varied by mode of transportation.

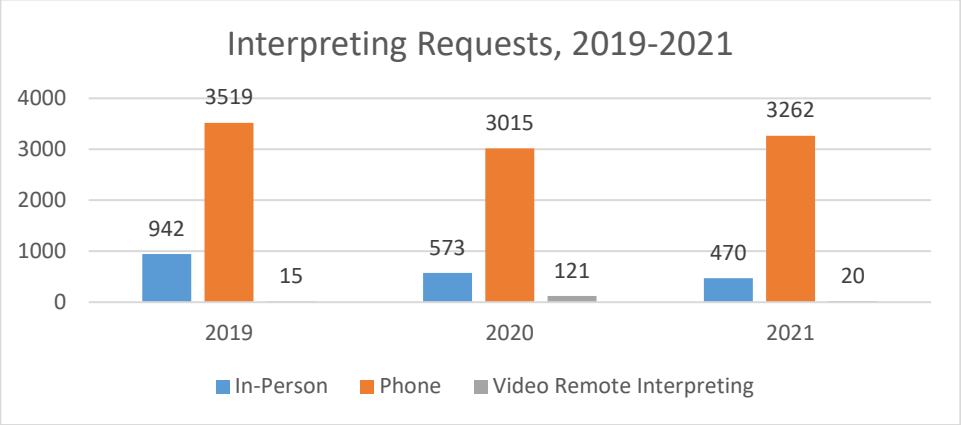
NEMT and NMT Ridership

Mode	Trips Provided, 2019	Trips Provided, 2020	Trips Provided, 2021	% Change
NEMT Wheelchair	65,139	54,487	143,532	163.4%
NEMT Gurney Van	2,130	2,855	2,365	-17.2%
NEMT Ambulance	N/A	N/A	1,368	N/A
NEMT Air	0	0	0	N/A
NMT Public Transit	390,427	231,076	145,376	-37.1%
NMT Mileage Reimbursement	9,680	7,064	12,389	75.4%
All Modes Combined	467,376	295,482	305,030	3.2%

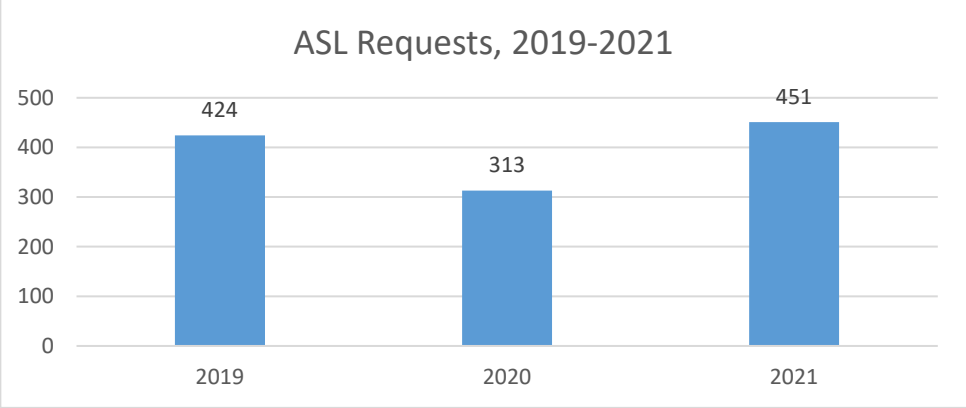
Source: 2021 KHS Transportation Report

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 2021, there was an overall 1.2% increase in interpreting requests compared to 2020.[28] In the same period, in-person requests (excluding ASL requests) decreased by 18.0%, phone interpreting requests increased by 8.2%, video remote interpreting (VRI) requests decreased by 83.5%, and in-person ASL interpreting requests increased by 44.1%.

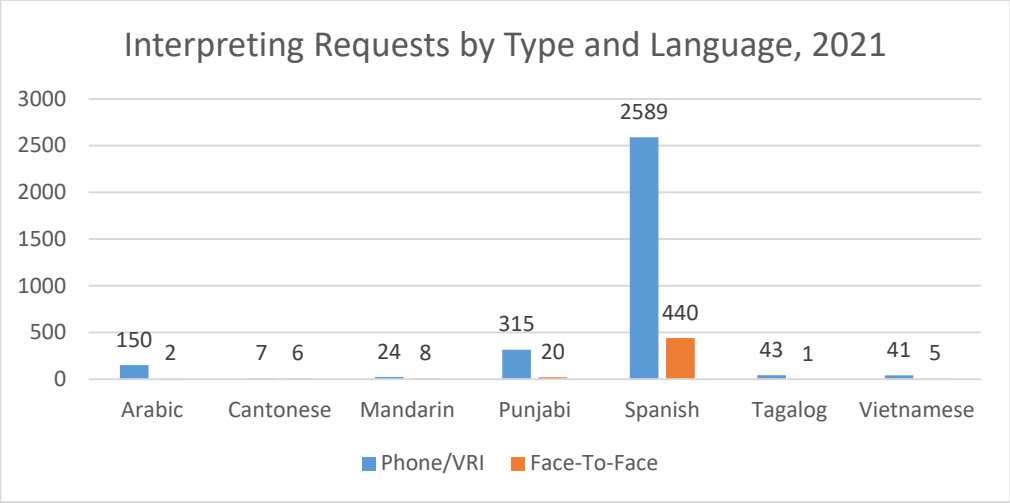


Source: 2019-2021 KHS Interpreting Request Annual Activities Reports



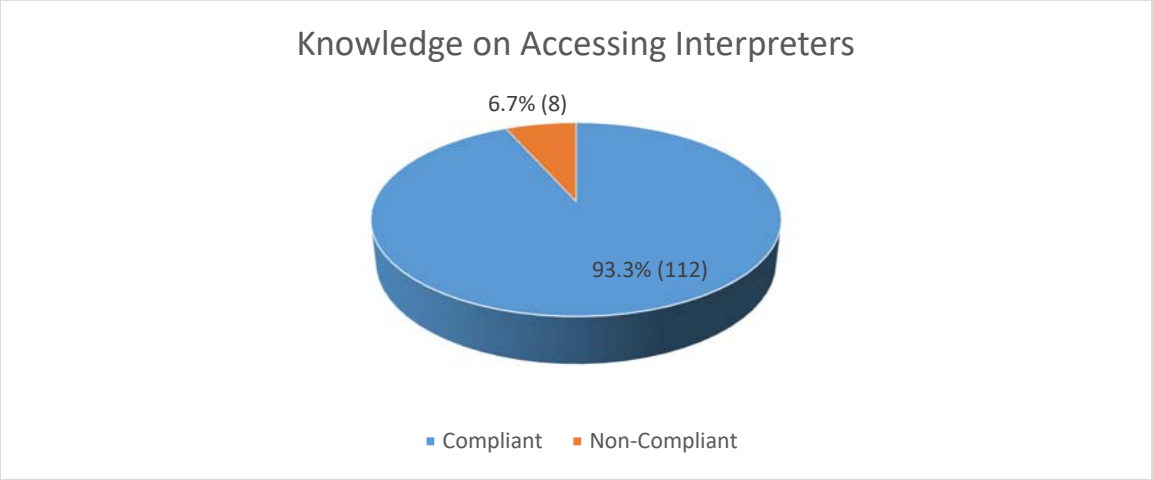
Source: 2019-2021 KHS ASL Request Annual Activities Reports

When looking at face-to-face interpreting requests, Spanish was the most common language, followed by Punjabi, Mandarin, Cantonese, and Vietnamese. Among phone or VRI interpreting requests, Spanish was the most common language, followed by Punjabi, Arabic, Tagalog, and Vietnamese.[29, 30]



Source: 2021 KHS Interpreting Request Annual Activities Reports

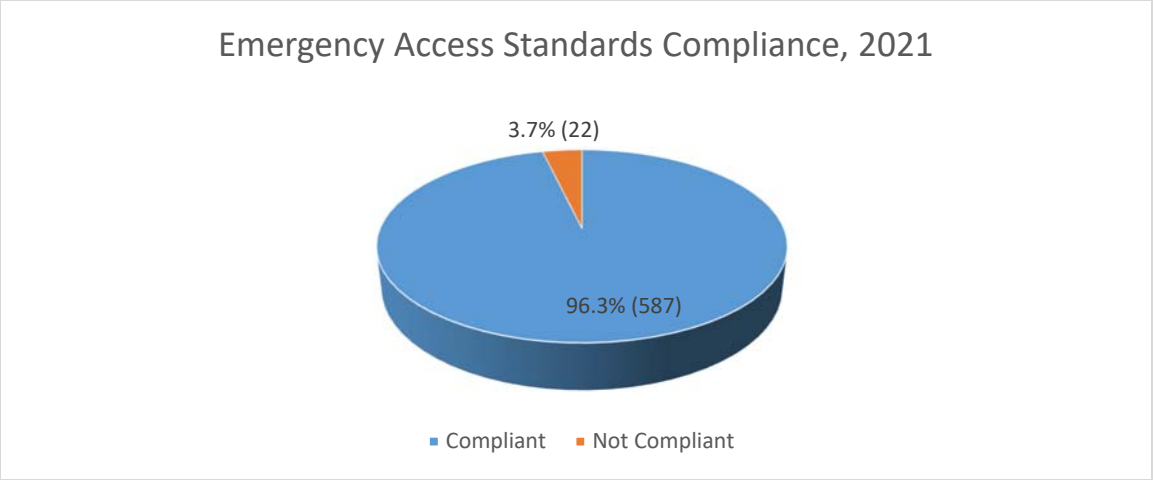
KHS conducts a quarterly interpreting access survey among its provider network. In 2021, a total of 60 primary care provider offices and 60 specialist offices were contacted to assess their knowledge on accessing interpreting services for limited English proficient (LEP) members. Findings revealed that 8 of these providers (6.7%, all specialists) needed additional training on accessing interpreting services for LEP members.[31]



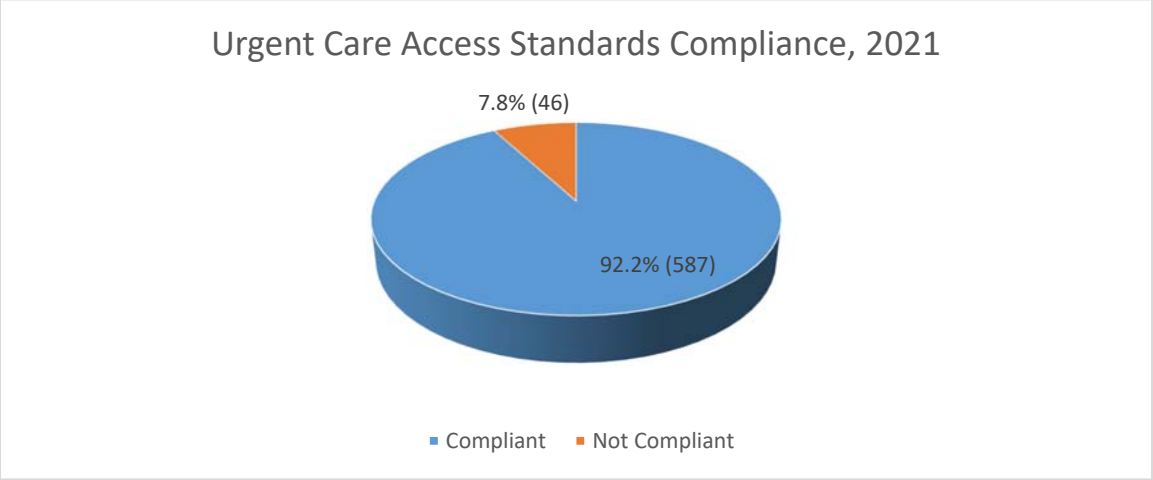
Source: 2021 KHS Interpreter Access Survey Results

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 2021, 96.3% of provider offices were compliant with the Emergency Access Standards and 92.2% of provider offices were compliant with the Urgent Care Access Standards.[32]



Source: 2020 KHS Provider Network Management Network Review Reports



Source: 2021 KHS Provider Network Management Network Review Reports

Appointment Availability

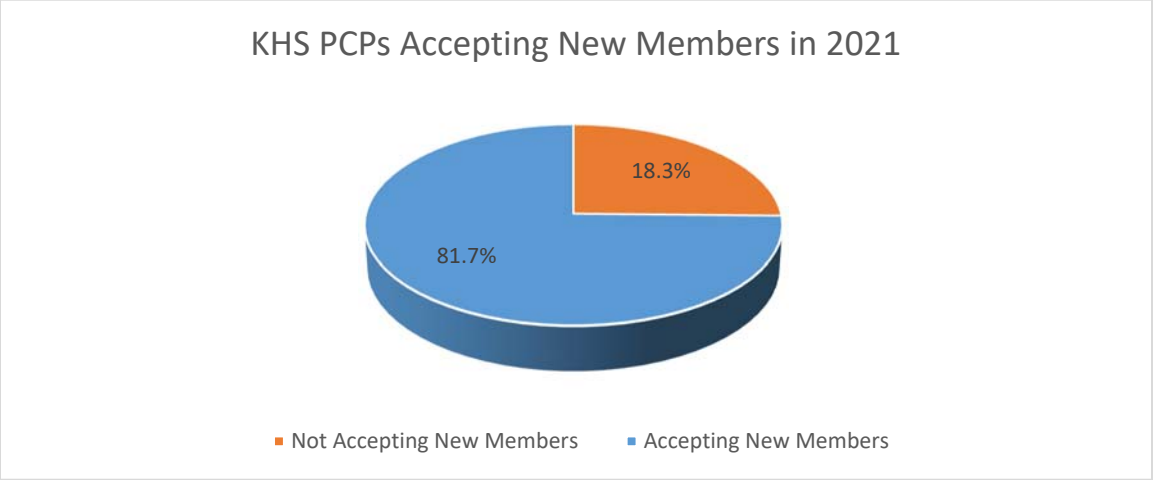
As required by the DHCS and Title 28 CCR Section 1300.67.2.2, KHS uses an appointment availability survey to assess compliance with access standards for KHS Members. A random sample of 60 primary care providers (PCP) offices, 60 specialist offices, 20 mental health provider offices, 20 ancillary provider offices, and 20 obstetrics & gynecology (OBGYN) offices were contacted during 2021. Average wait times for each provider type were in-compliance with the standard wait times.[32]

	Providers Contacted	Average Wait Time in Business Days/Provider	Standard Wait Time in Business Days
PCP Offices	60	3.1	10
Specialist Offices	60	8.6	10
Mental Health Providers	20	4.2	10
Ancillary Providers	20	3.0	15
OB/GYN Offices	20	6.5	10

Source: 2021 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 2021, the plan had a quarterly average network of 428.5 PCPs, of which 81.7% were accepting new members.[32]



Source: 2021 KHS Provider Network Management Network Review Reports

Health Disparities

Measurement Year (MY) 2020 DHCS Disparities and Preventive Services indicator rates show that among the ethnic groups identified, Black/African American members had the worst outcomes for pediatric preventive health measures where sufficient data was available.[33,34] For most women's health indicators that had sufficient data, Asian members generally had the lowest rates compared to other racial/ethnic groups with a couple of exceptions. White and Black/African American members had the highest rates for substance use indicators and Black/African American members had the lowest rates for antidepressant medication management indicators. White members had the lowest asthma medication ratio compliance rate compared to other racial/ethnic groups and for the other chronic conditions indicators, there was insufficient data to make comparisons.

When comparing indicator rates between English speakers and Spanish speakers, differences varied by indicator. Racial/ethnic disparities for the top chronic health conditions among KHS members vary by chronic health condition.

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

Indicator Abbreviation	Indicator Name
AMM–Acute	Antidepressant Medication Management—Effective Acute Phase Treatment
AMM–Cont	Antidepressant Medication Management—Effective Continuation Phase Treatment
AMR	Asthma Medication Ratio
APM–B	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total
APM–BC	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total
APM–C	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total
BCS	Breast Cancer Screening
CBP	Controlling High Blood Pressure
CCS	Cervical Cancer Screening
CDC–H9^	Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
CHL	Chlamydia Screening in Women—Total
CIS–10	Childhood Immunization Status—Combination 10
IMA–2	Immunizations for Adolescents—Combination 2
PPC–Pre	Prenatal and Postpartum Care—Timeliness of Prenatal Care
PPC–Pst	Prenatal and Postpartum Care—Postpartum Care
W30–2	Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits
W30–6	Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits
WCC–BMI	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total
WCC–N	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total
WCC–PA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total
WCV	Child and Adolescent Well-Care Visits—Total

^A lower rate means better performance for this indicator.

Review of racial/ethnic health disparities where sufficient data is available revealed that Black/African American members had the lowest child health indicators compared to other

racial/ethnic groups. When comparing rates by language, Spanish speakers had higher rates for most of the pediatric health indicator rates with sufficient data.

MY 2020 CA DHCS Health Disparities KHS Rate Sheet: Child Health Indicators

Measure	White	American/ Alaska Native	Asian	Black/ African American	Hispanic/ Latino	Native Hawaiian/ Other Pacific Islander	Other
CIS-10	21.4%	0.0%*	16.7%*	0.0%*	27.0%	N/A	20.0%
IMA-2	20.5%	N/A	50.0%*	8.3%*	36.3%	100.0%*	0.0%*
W30-6	25.7%	0.0%*	55.9%	16.6%	29.3%	N/A	37.3%
W30-2	45.6%	50.0%*	77.7%	30.9%	57.9%	100.0%*	62.7%
WCC-BMI	53.5%	N/A	62.5%*	52.6%*	67.1%	N/A	0.0%*
WCC-N	44.2%	N/A	50.0%*	47.4%*	55.2%	N/A	0.0%*
WCC-PA	41.9%	N/A	62.5%*	47.4%*	52.8%	N/A	100.0%*
WCV	27.7%	29.7%	40.0%	25.4%	37.5%	24.3%*	42.7%

Source: MY 2020 CA DHCS Health Disparities KHS Rate Sheet
**Insufficient data. The denominator is less than 30.*

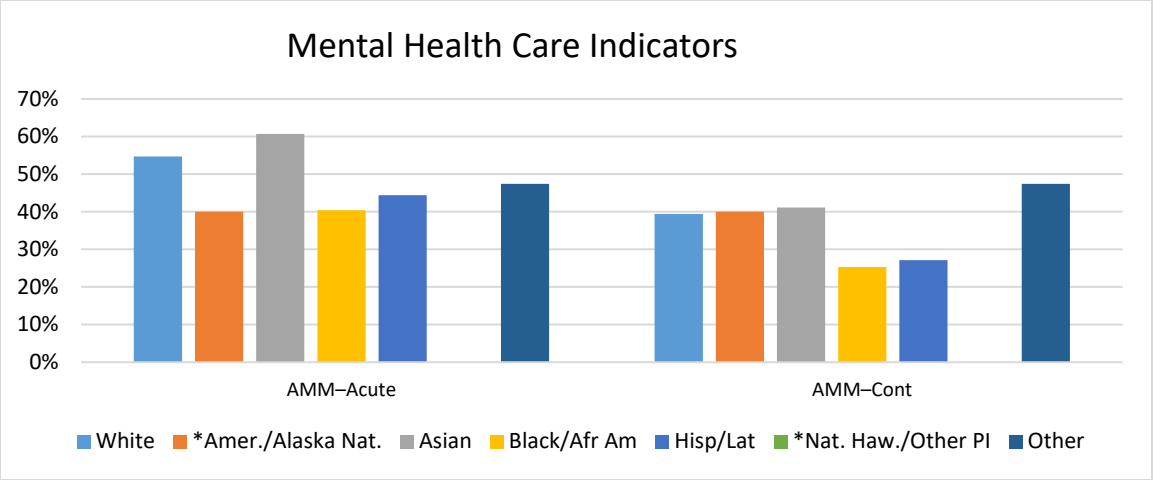
For the women's health indicators with sufficient data, Asian members had the lowest rate for being screened for chlamydia, Native American/Alaska members had the lowest rate for having breast cancer screening and White members had the lowest rate of having cervical cancer screenings. Rates were lowest for accessing timely prenatal care among Hispanic/Latino members and postpartum care rates was lowest among White members. When comparing outcomes by language, there was no clear pattern as rate differences between English and Spanish speakers varied by the indicator.

MY 2020 CA DHCS Health Disparities KHS Rate Sheet: Women's Health Indicators

Measure	White	Native American/ Alaska	Asian	Black/ African American	Hispanic/ Latino	Native Hawaiian/ Other Pacific Islander	Other
BCS	44.0%	38.3%	46.3%	54.1%	60.9%	20.0%*	50.0%
CCS	43.7%	60.0%*	62.5%*	61.5%	56.2%	N/A	60.0%*
CHL	49.7%	63.2%*	38.2%	60.9%	54.5%	87.5%*	46.3%
PPC-Pre	77.3%	33.3%*	77.8%*	68%*	69.0%	N/A	50%*
PPC-Pst	72.7%	0.0%*	77.8%*	76.0%*	80.1%	N/A	100%*

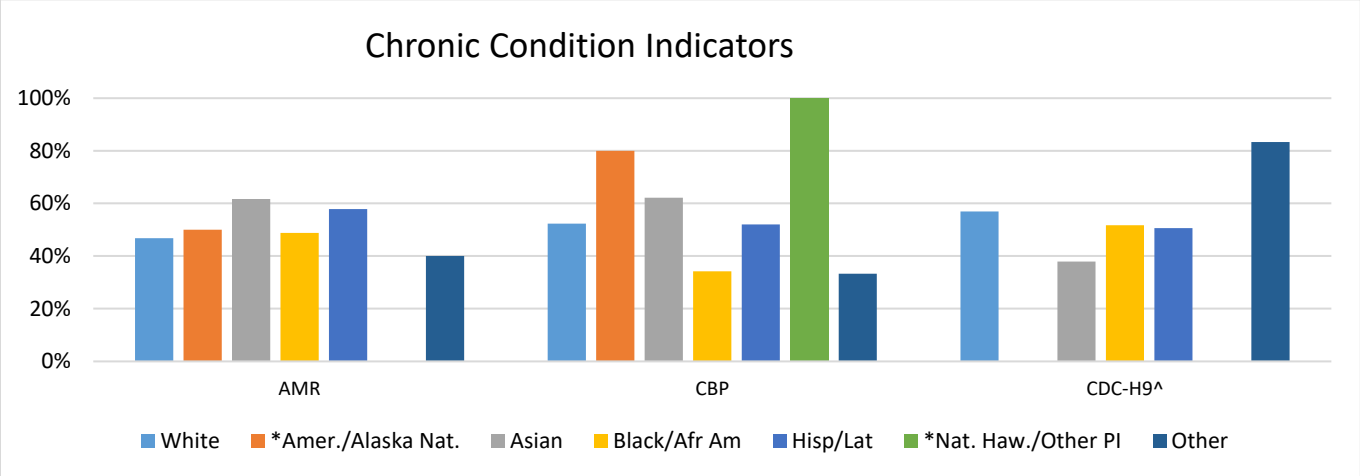
Source: MY 2020 CA DHCS Health Disparities KHS Rate Sheet
**Insufficient data. The denominator is less than 30.*

When looking at the mental health indicators, Black/African American members had the lowest antidepressant medication management indicator rates compared to other racial/ethnic groups. When looking at language, English speakers had higher antidepressant medication management rates than Spanish speakers.



Source: MY 2020 CA DHCS Health Disparities KHS Rate Sheet
** Insufficient data. The denominator is less than 30.*

When reviewing chronic condition indicators, White members had the lowest asthma medication ratio compliance rates, Black/African American members had the lowest rate for controlling high blood pressure and White members had the highest rate for poorly controlled diabetes based on HbA1c levels when compared to other racial/ethnic groups. When comparing by language, Spanish speakers have a higher asthma medication ratio compliance rate than English speakers. English speakers had a slightly higher rate for controlling high blood pressure, whereas Spanish speakers had a slightly lower rate for poorly controlled diabetes based on HbA1c levels. It should be noted that a lower rate for poorly controlled diabetes based on HbA1c levels means better performance for that indicator.



Source: MY 2020 CA DHCS Health Disparities KHS Rate Sheet
**Insufficient data. The denominator is less than 30.*
^A lower rate means better performance for this indicator.

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

Gaps in Access to Care

According to the results of KHS' 2021 Member Satisfaction Survey, there were a few measures under Effective of Care where a decreased rate of 3 percentage points or more occurred in comparison to the prior year:

- Effectiveness of Care
  - Flu vaccinations (adults 18-64)
  - Discussing cessation medications
  - 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 (also called potentially inappropriate care). These two types of grievances accounted for 45.7% and 28.7% of all grievances in 2021.[26] Furthermore, 19.3% of grievances were closed in favor of the enrollee, indicating that some members may be facing legitimate challenges with treatment authorization requests and quality of care.

Although 93.3% of KHS' provider network understand how to access interpreting services for KHS members, there is value in conducting provider reminders of this member benefit.[31] KHS C&L Team will continue to partner with its PNM 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 access was identified as a barrier for access to health care and health education services in this year's PP/CAC survey results. Member requests for transportation assistance grew by 3.2% in 2021 compared to 2020. However, requests for NEMT wheelchair service increased by 163.4% and accounted for 47.1% of transportation assistance requests in 2021. These data findings indicate strong and surging demand among members with disabilities or limited mobility.

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 NEMT and fixed route bus service have had more limited evening service in Bakersfield during the pandemic due to lockdowns and losses in ridership that have resulted in cuts in service.

Rural areas have more limited public and commercial transportation availability and geographic coverage. Commercial rideshare providers have more availability in urban areas where short route trips are more lucrative. Higher gas prices and other forms of inflation may have contributed towards the impact of transportation resources serving rural areas with longer distances becoming more costly and less worthwhile for commercial rideshare companies.

KHS conducted a survey of member health problems, disparities, and needs with its PP/CAC as part of this year's PNA.[35] This committee consists of 13 voting members of which 7 are actively enrolled KHS members. The top three challenges that KHS members face when trying to access health care services, as reported by committee members, were:

- Access to mental health services.
- Doctor appointment availability.
- Health or health care literacy barriers.

Other reported challenges included:

- Access to interpreting services at the doctor's office.
- Access to transportation.
- Compassion, respect and cultural sensitivity of providers.
- Shortage of LGBTQ+ friendly health care providers.
- Shortage of health care providers for primary care, specialist care, and dental care.
- Access to geriatric services.

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 2021 were Spanish, Punjabi, Arabic, Tagalog, and Vietnamese. The top languages for in-person interpreting for KHS members in 2021 were Spanish, Punjabi, Mandarin, Cantonese, and Vietnamese. 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.

Member requests for ASL interpreters increased by 44.1% from 2020 to 2021. With less than 10 ASL interpreters residing in Kern County, KHS' interpreting vendor must recruit Los Angeles County interpreters to commute to Kern County to assist ASL members. 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 found that the top four reported challenges that KHS members face in accessing language interpreting services, as reported by committee members, were:

- Lack of willingness or patience to request language interpreting services for KHS members among doctors or their staff.
- Discrimination against non-English speakers by doctors or their staff.
- Lack of awareness of KHS language interpreting services among KHS members.
- Member embarrassment about request an interpreter.

Other challenges included the following:

- Lack of awareness or understanding of how to request language interpreting services for KHS members.
- Lack of language interpreting options.
- Members not requesting an interpreter due to fear of being reported to immigration authorities.
- Requesting an interpreter takes too long.
- Providers have staff interpreters with deficient interpreting quality.

The review and analysis of KHS' C&L data identified the following areas that should be considered for possible inclusion in future program planning in order to expand and enhance KHS' C&L services for its members.

- Continue to research and engage new vendors to respond to Requests for Proposals to perform in-person interpreting services for members during contract renewal periods.
- Train KHS providers on telehealth interpreting best practices.
- Train KHS providers on how to access video remote interpreting services and continue to promote the KHS provider training guide on how to access an interpreter using VRI.
- Increase opportunities for the KHS provider network to participate in trainings on cultural competency, effective interpreting and accessing KHS interpreter Services.
- Consider data collection opportunities to identify KHS' LGBTQ+ population gain an understanding on their health care needs.
- Continue to promote availability of interpreting services among KHS members and educate members about the concerns or risks of with using family or friends as interpreters.
- Offer trainings on the principles and ethics for effective interpreting for provider staff used as interpreters during appointments.
- Continue to 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

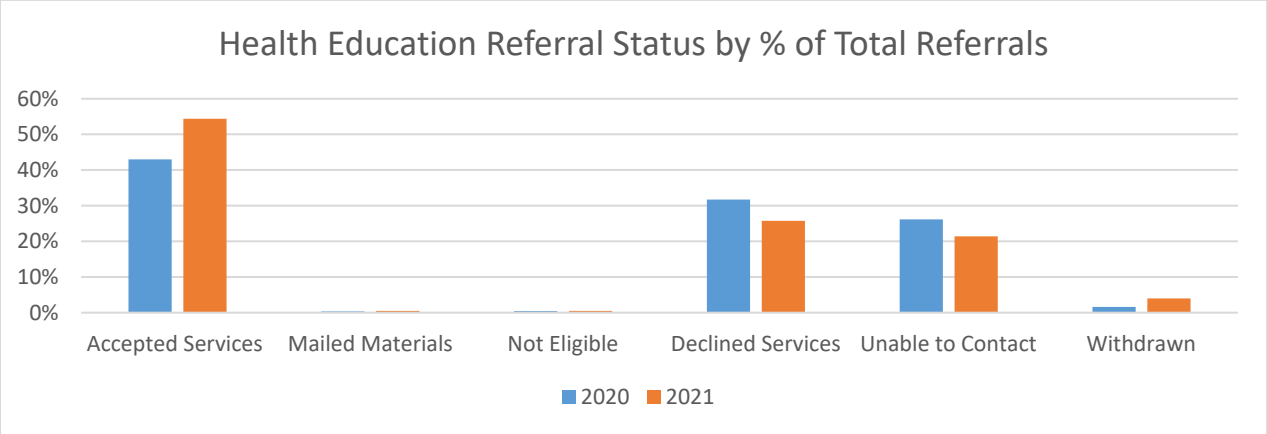
KHS offers health education services and incentives through a variety of modalities, such as virtual classes, telephone counseling, printed mailings, and social media communications. KHS began to offer virtual classes in April 2020. KHS' ability to offer in-person health education services has not been an option during the pandemic due to health and safety concerns related to COVID-19 and the low vaccination rate among KHS members.

Health Education Service Utilization

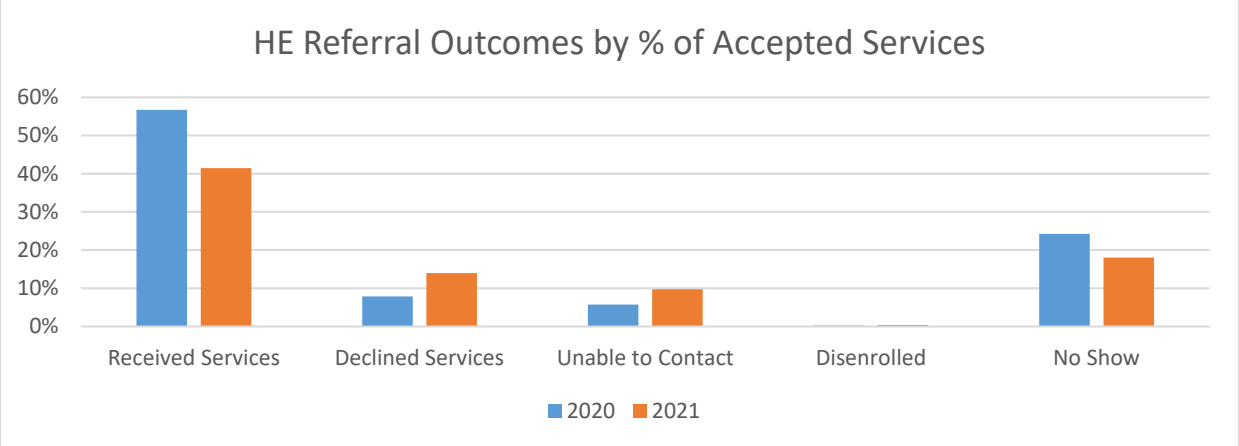
The KHS HE Department received 4,993 referral requests for health education services in 2021, a 75.1% increase compared to the previous year. Weight management education was the top referral topic, followed by asthma education, nutrition counseling, diabetes education, and tobacco/smoking cessation.[28] Referrals for all five of these health education topics increased

from 2020 to 2021. The rate of members who accepted to receive health education services increased from 43.0% in 2020 to 54.4% in 2021. The rate of members who declined health education services decreased from 31.7% in 2020 to 25.8% in 2021.[28] Referral outcome data revealed a 15.3% percentage point decrease in the Received Services rate and a 4.2% percentage point increase in the Unable to Contact (after accepting services) rate.[28]

KHS virtual nutrition education classes continued to be the most popular health education service in 2021. This service accounted for 72.4% of all accepted referrals and 89.0% of service attended outcomes. However, the attendance rate for the nutrition classes decreased from 64.3% to 51.0%, likely due to reductions in the value of class member incentives.



Source: KHS Health Education Activities Report



Source: KHS 2020 & 2021 Health Education Activities Reports

Member attendance for virtual health education classes has increased during the pandemic. Average member attendance per asthma education class increased from 3.9 in 2020 to 5.4 in 2021. Attendance per nutrition education class increased from 21.6 to 25.3. Attendance per tobacco/smoking cessation class was 3.6 in 2021.

Low attendance at the asthma and tobacco/smoking cessation classes is likely due to a variety of factors, such as low volume of health education referrals from KHS health care providers and lack of awareness of these classes among providers and members. Other top reasons include a high rate of members who decline asthma and tobacco/smoking cessation education services or cannot be contacted.

Member attendance for individual phone counseling decreased from 49.3 per month in 2020 to 32.2 per month in 2021.

KHS member health disparities data from DHCS' MY2019 and MY2020 Rate Sheets revealed a trend of unfavorable indicator rates among Black/African American KHS members compared to other racial/ethnic groups. Black/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.

Findings from this year's PP/CAC PNA survey found that the top three reported challenges that KHS members face when trying to access health education services, as reported by committee members, were:

- Lack of in-person health education classes.
- Lack of convenient health education class dates and times.
- Technology and literacy barriers.

Other reported challenges included:

- Access to transportation.
- Internet access for online resources or virtual classes.
- Limited language options for health education services or materials.
- Lack of health education services for certain health topics.
- Lack of online health education materials or programs.
- Lack of health education materials that can be mailed.
- Lack of health education services or materials offered by doctors.
- Lack resources for elderly people.

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.

- In-person health education classes when it is safe to offer them.

- 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.
- Internet access assistance.
- 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.
- 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 (i.e. KHS community resource or satellite centers).

Quality Improvement Program Gap Analysis

In 2021, 95% of the Initial and Periodic Facility Site Reviews (FSRs) that were conducted, passed and 5% scored less than 80%. There were 59 site reviews completed in 2021 and 3 of these reviews failed in the first audit. 91% of the Initial and Periodic medical reviews performed passed and 9% scored less than 80%. There were 35 medical record reviews (MRR) conducted year-to-date and 3 of these reviews were failed in the first audit.

Due to the Public Health Emergency 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 and MRRs were conducted virtually, which was approved and supported by DHCS virtually. KHS submitted a plan to complete the backlog of site reviews that could not be completed due to the pandemic. We anticipate having the backlog completed by June 30th of 2022.

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

- Airway Management: Oxygen delivery system, oral airways, nasal cannula, or mask, and Ambu bag
- Annual Education: Infection control/universal precautions
- Annual Education: Bloodborne Pathogens

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

- Advanced Health Care Directive information is offered
- Emergency contact is identified
- Pediatric Immunization given according to ACIP guidelines

MCAS/HEDIS 2021

Healthcare Effectiveness Data and Information Set (HEDIS) 2021 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 2021 results shown in this report are based on 2020 data.

MY2020 MCAS Rate Tracking Report
As of 2021-06-01
Note: These are final rates after HSAG review.

Hybrid Measures Held to MPL

Measure		Current MY2020 Rate	MY2020 MPL	MY2019 KHS Rate	Current Vs. MY2020 MPL	Current Vs. MY2019 KHS
CCS	Cervical Cancer Screening	54.01	61.31	56.20	-7.30	-2.19
CIS-10	Childhood Immunization Status	22.87	37.47	29.93	-14.60	N/A
CDC-H9*	HbA1c Poor Control (>9.0%)	50.85	37.47	57.91	-13.38	7.06
CBP	Controlling High Blood Pressure <140/90 mm Hg	52.07	61.8	38.93	-9.73	13.14
IMA-2	Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)	33.09	36.86	41.36	-3.77	-8.27
PPC-Pre	Prenatal & Postpartum Care – Timeliness of Prenatal Care	70.07	89.05	84.18	-18.98	-14.11
PPC-Post	Prenatal & Postpartum Care – Postpartum Care	77.62	76.4	81.02	1.22	-3.40
WCC-BMI	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents	63.50	80.5	66.42	-17.00	-2.92
WCC-N	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition	52.80	71.55	NA	-18.75	N/A
WCC-PA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity	51.09	66.79	NA	-15.70	N/A

Administrative Measures Held to MPL

Measure		Current MY2020 Rate	MY2020 MPL	MY2019 KHS Rate	Current Vs. MY2020 MPL	Current Vs. MY2019 KHS
AMM -Acute	Antidepressant Medication Management – Acute Phase Treatment	48.05	53.57	50.24	-5.52	-2.19
AMM - Cont.	Antidepressant Medication Management – Continuation Phase Treatment	31.77	38.18	32.64	-6.41	-0.87
APM–B	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Blood Glucose Testing	50.00	54.42	NA	-4.42	N/A
APM–C	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Cholesterol Testing	16.67	37.08	NA	-20.41	N/A
APM–BC	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Blood Glucose Testing and Cholesterol Testing	16.67	35.43	NA	-18.76	N/A
AMR	AsthmaMedication Ratio	54.39	62.43	48.78	-8.04	5.61
BCS	Breast Cancer Screening	54.50	58.82	57.29	-4.32	-2.79
CHL	Chlamydia Screening in Women Ages 16 – 24	54.02	58.44	55.29	-4.42	-1.27
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	92.31	82.09	NA	10.22	N/A

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

N/A' is for measures that were not reported for MY2019

The initial SWOT analysis and action plan was ended by DHCS in May of 2021, although KHS continued with the proposed efforts. Since KHS did not meet the MPL for multiple measures DHCS presented KHS an opportunity to develop a new SWOT analysis and action plan to improve scores in a specific domain of care. 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 within the children's domain. We began the new SWOT in September of 2021 and it's expected to be completed by May of 2022. This is a more focused effort than our previous SWOT, which is aimed at short term objectives to support the development of a sustainable infrastructure for MCAS compliance.

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 in2 PIPs. The PIPs span over an approximate 18-month time frame and are broken into 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 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.

- **PDSAs**
  As a result of KHS' MY2020 MCAS scores, DHCS instructed us to initiate two PDSA's to apply focused improvement efforts in the children's and women's health domain. Two PDSA cycles will be conducted between September 2021 and May 2022.

  Our first PDSA is focused on the Breast Cancer Screening (BCS) measure in the Women's Health Domain. The specific intervention is to measure the volume of successful completion of a Mammogram via the Mobile Mammogram Clinic, which was held in Taft, California in October 2021. This event had a success rate of 66%, which reflects the number of scheduled appointments kept. Another clinic day will be held in May of 2022 in the rural community of Arvin, California.

  The second PDSA leverages a Member Engagement and Rewards Program (MERP) campaign for the W30 measure with focus on W30 (0-15 months), well care visits for infants 0 to 15 months of age. We are partnering with Clinica Sierra Vista (CSV) to monitor the volume of members who completed a Well-Care Visit following receipt of successful outreach.

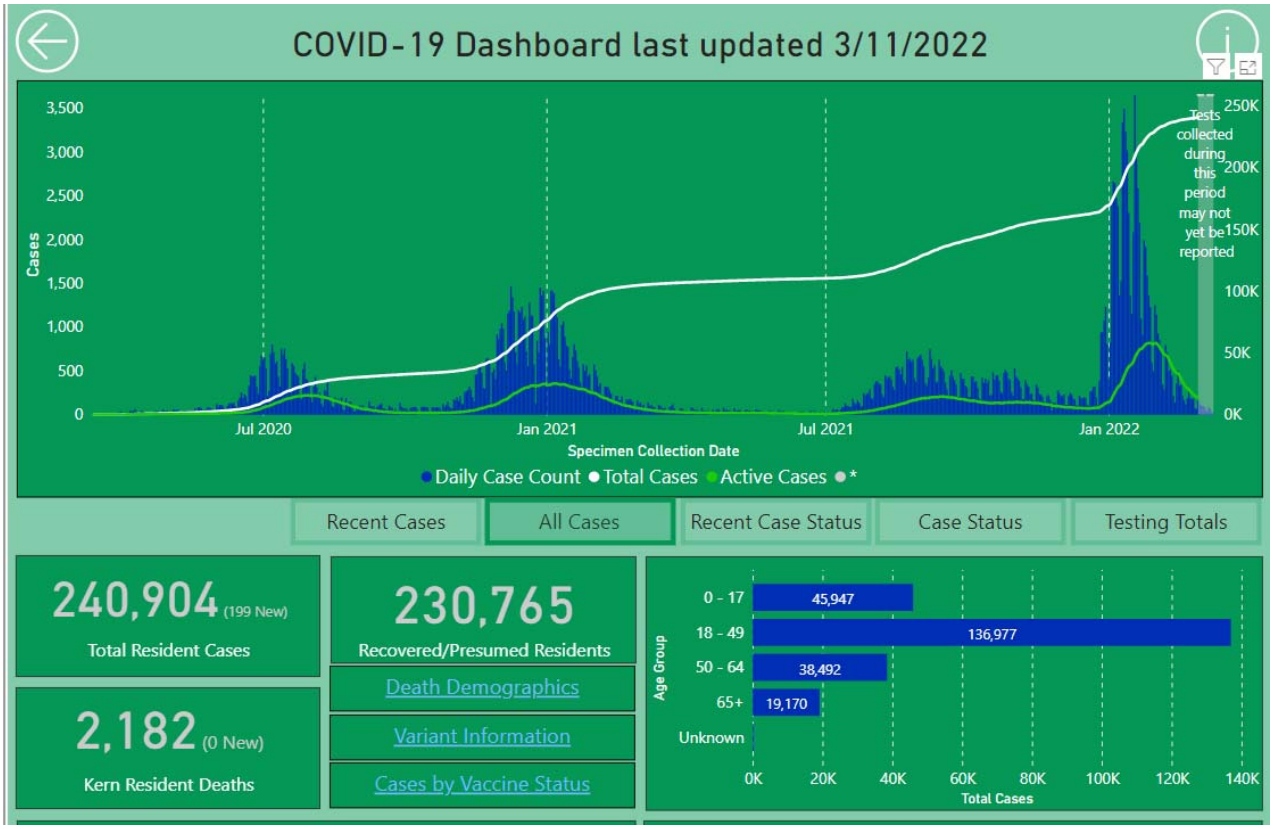
- **COVID QIP**
  DHCS has required all MCP's to submit a three strategy, COVID QIP related to supporting return to preventive healthcare services and obtaining the COVID vaccination. One strategy focuses on members with behavioral health comorbidities. Another strategy focuses on the Latino population receiving the COVID vaccination in partnership with the Latino COVID-19 taskforce and CSUB.

The third strategy focuses on encouraging women of childbearing age to get the COVID vaccination by providing them with information about COVID and the vaccine. The initial strategies were submitted to DHCS at the end of September 2021. The QIP will be completed by the end of March 2022.

Other: COVID-19

A total of 240,904 positive COVID-19 resident cases and 2,182 resident deaths due to COVID-19 have been confirmed in Kern County as of March 11, 2022.[36] The image below, from the Kern County Public Health Services Department (KCPHSD) website summarizes COVID-19 cases since testing began in Kern County. After the recent surge of COVID-19 daily cases due to the Omicron variant, the daily case totals are now less than 100. During the peak of the Omicron variant, daily case totals reached the thousands.

KCPHSD COVID-19 Dashboard

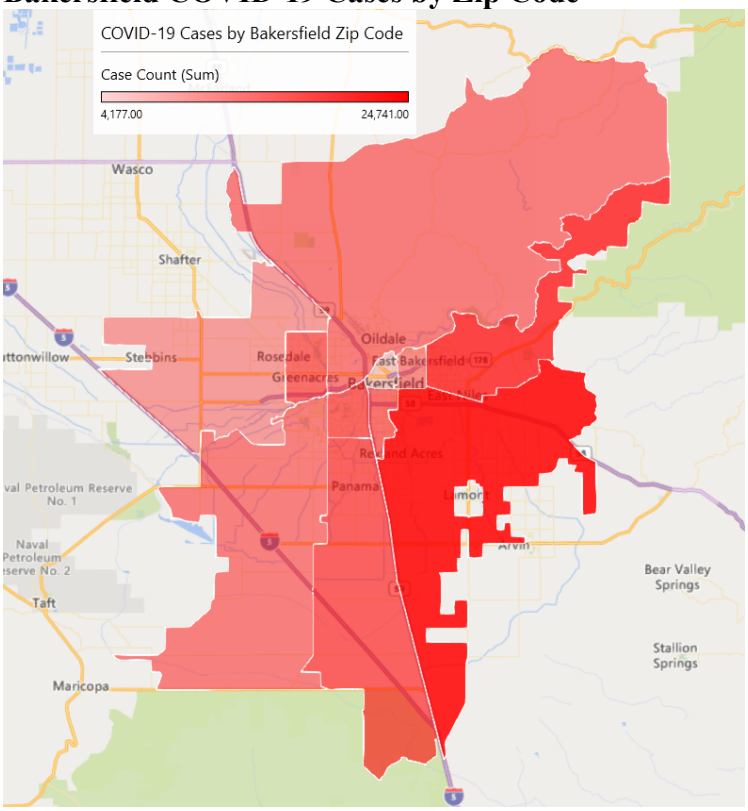


Source: Kern County Public Health COVID-19 Dashboard

The number of total COVID-19 cases among Bakersfield residents has reached 153,259 as of March 11, 2022. The proportion of COVID-19 cases that are in Bakersfield has increased slightly from 63.6% in May 2021 to 64.4% in March 2022. The percentage of cases in Bakersfield in zip codes that are east of California State Route 99 has decreased slightly from 56.8% to 56.2% 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.

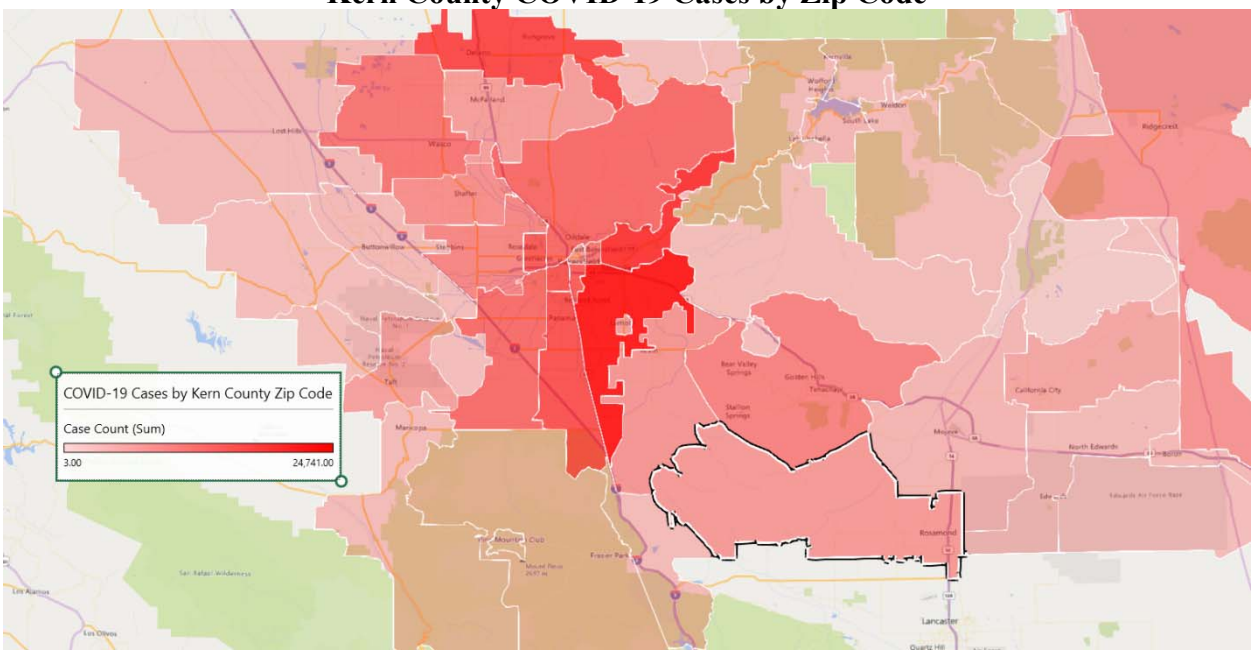
Bakersfield COVID-19 Cases by Zip Code



Source: Kern County Public Health COVID-19 Dashboard

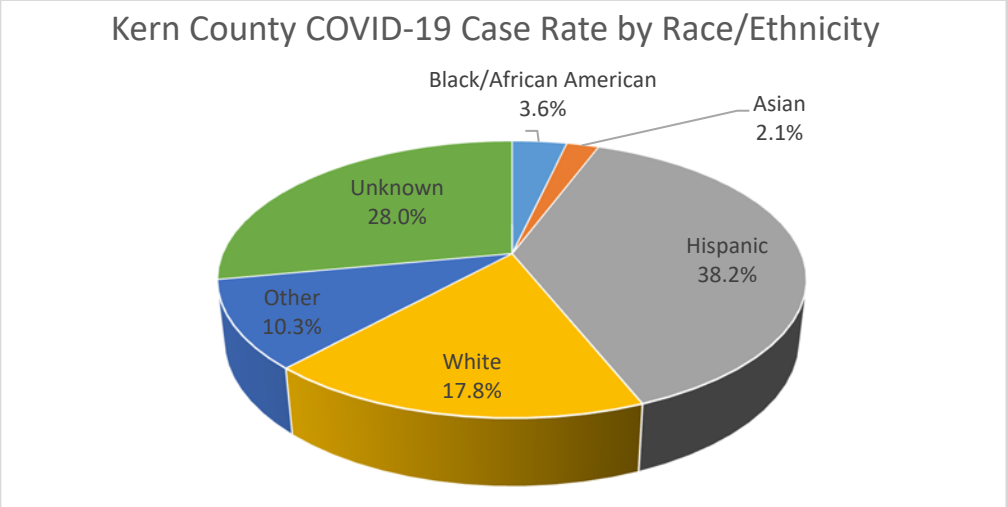
The map, below, shows that Kern County COVID-19 Cases are concentrated in Bakersfield and Delano zip codes. The blue shaded area includes only Kern County. Some of the Kern County zip codes on the map overlap with more than one county.

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.[37] The COVID-19 hospitalization rates for Native Americans, Black/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/African Americans (3.2%), and Asians (2.3%).[36] When looking at the overall Kern County racial/ethnic profile, Hispanic/Latinos are 54.0% of the population, followed by Whites (33.5%), Black/African Americans (6.3%), Asians (5.4%), and Native American/Alaska (2.6%).[2]

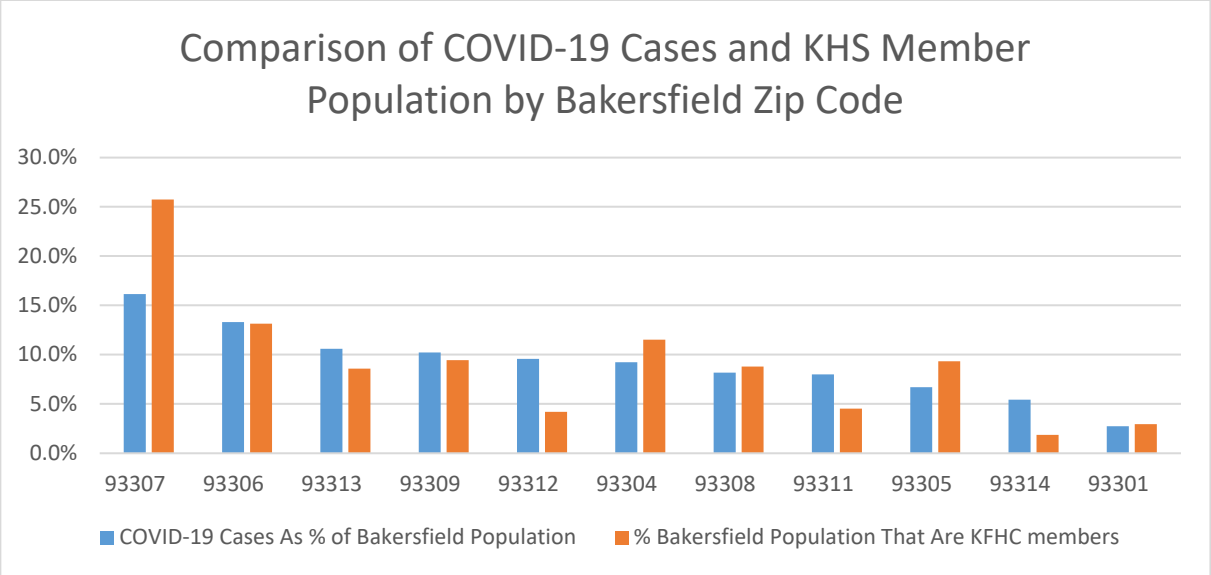


Source: Kern County Public Health COVID-19 Dashboard

A comparison of Kern County COVID-19 cases by zip code reveals a resemblance to the distribution of KHS members by zip code when looking at the top two zip codes by share of cases. However, there is less of a resemblance moving down the list.

Bakersfield Zip Code	Population	COVID-19 Case Count	% of Bakersfield Cases	KHS Member Population	% of Bakersfield Population
93307	84948	24741	16.1%	53983	25.7%
93306	70208	20372	13.3%	27533	13.1%
93313	51245	16221	10.6%	17976	8.6%
93309	60893	15658	10.2%	19779	9.4%
93312	59359	14660	9.6%	8797	4.2%
93304	50787	14138	9.2%	24141	11.5%
93308	54042	12509	8.2%	18434	8.8%
93311	44862	12234	8.0%	9484	4.5%
1954293305	39114	10244	6.7%	3877	9.3%
93314	26992	8305	5.4%	6157	1.8%
93301	12345	4177	2.7%	53983	2.9%

Sources: Kern County Public Health COVID-19 Dashboard; 2021 KHS Member Demographics Data Report



Sources: Kern County Public Health COVID-19 Dashboard

COVID-19 disproportionately impacts the KHS population compared to the overall county population. Only 41.1% of KHS members 5 years and older have received at least one dose of a COVID-19 vaccine.[38] In comparison, 63.9% of the Kern County population have received at least one dose.[39] 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. Members may be more willing to attend in-person group classes now that daily COVID-19 case totals have decreased to low levels. This year's PP/CAC PNA 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 may be a possibility this year now that COVID-19 case totals have decreased to less than 100 per day. However, the rate of COVID-19 vaccination with at least one dose among KHS continues to be significantly lower than the overall Kern County population.[38]

However, KHS will continue to 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.

KHS messaging and education has evolved in response to changes in state requirements, the availability of the vaccine and available treatments for the COVID-19 virus throughout the COVID-19 pandemic.

KHS addressed the fall off of members not receiving routine healthcare by launching a media campaign in December 2020 called "Back to Care". Messaging was created to encourage members/patients to reengage in their health care and emphasize safety by showing examples of the vital medical treatments that members/patients were missing. Additionally, a mailing was sent to member households that included a list of potential rewards available to members for getting preventive exams and screenings.

In response to the 2021 emergency use authorization that released the COVID-19 vaccine for use in phases, KHS created a COVID-19 Vaccine Communication Plan. The plan began a multi-channel member outreach campaign in early February 2021 targeting members who were eligible for the COVID-19 vaccine. Outreach channels included a dedicated page on the KHS Corporate Website, hold messages, scripts for member facing staff, social media posts, robocall campaigns, flyers and an article in the Member Newsletter mailed to member households. KHS changed the messaging for all channels throughout all phases of the vaccine rollout to keep members informed when it was their turn to receive it.

As of August 29th, 27% of eligible members were fully vaccinated. KHS began an aggressive campaign to boost vaccination rates among members, particularly in targeted at-risk member populations.

- Beginning September 1, 2021 and continuing through March 31, 2022 KHS received state approval to provide a reward to members who receive the COVID-19 vaccine.
- KHS coordinated with community partners and providers to improve vaccine compliance and seek to dissuade fear and hesitancy by promoting vaccine safety and efficacy.
- KHS addressed potential COVID-19 vaccine access issues by supporting various community partners and providers to encourage patients to get vaccinated.
- KHS dedicated a number of staff members to make live outbound calls and take calls focused on assisting members to schedule appointments for the COVID-19 and/or flu vaccine with their provider and through the MyTurn website. MyTurn offers home visit vaccination as well which was helpful for the homebound population.
- KHS held two COVID-19 Vaccine Clinic events in coordination with the County Hospital Authority and the Latino COVID-19 Task Force in October 2021 and November 2021 that included food and gift card rewards. The events resulted in 355 participants getting vaccinated; 60% were members.
- KHS worked with No Sister Left Behind to address vaccine hesitancy in the Black/African American comminutes by supporting their outreach efforts including a television ad campaign.

Below is a breakdown of the baseline of targeted member groups at the beginning of the program and as of March 24, 2022.

Targeted Population	8/29/21 Rate	3/24/22 Rate
Homebound Members	57.36%	69.08%
Age 50-64 With Chronic Conditions	63.50%	72.50%
ALL MEMBERS	41.17%	52.77%
AGE 12-25	33.89%	47.45%
AGE 26-49	38.77%	50.75%
AGE 50-64	57.78%	65.81%
AGE 65 and Older	67.77%	74.08%
BLACK/AFRICAN AMERICAN	25.66%	38.15%
WHITE	30.91%	39.38%

V. Action Plan

2022-23 Action Plan

Objective 1. (Continuing) *By June 2023, the IHA completion rate will have increased from 11.29% to 21.29%.* **Objective 2. (Revised and Continuing)** *By June 2023, the W30-6 MCAS rate will have increased from 30.55% to 38.55%.* **Objective 3. (Continuing)** *By June 2023, the W30-2 MCAS rate will have increased from 60.22% to 68.22%.* **Objective 4. (Continuing)** *By June 2023, the WCV MCAS rate will have increased from 45.32% to 53.32%.* **Data source:** *(RY2020 HEDIS Data, RY2021 MCAS Data, KHS Claims Data, 2021 DHCS Health Disparities Rate Sheet)*
Strategies
1. Review the member rewards programs to ensure alignment with MCAS measures that encourage members to see their PCP for a wellness exam at age appropriate intervals and make revisions as appropriate.
2. Review and 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. Continue to 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. Continue to 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. Continue to update gaps in care to members through the Member Portal to align with new MCAS pediatric preventive care measures.
7. Continue to update gaps in care visibility to all member facing staff and KHS' provider network with any changes to the MCAS pediatric preventive care measures.
8. Continue to update monthly reports to include revised rewards programs for monitoring and tracking of member participation and effectiveness of the rewards program

Objective 5. (Revised and Continuing): *By June 2023, the average asthma class attendance rate will have increased from 5.4 to 8.1.* **Data Source:** *(KHS Population Analysis Reports, KHS Health Education Activities Report)*
Strategies
1. Obtain member and provider feedback on KHS' asthma education services.
2. Evaluate current incentive program and recommend revisions based on survey findings.
3. Evaluate effectiveness of member communication and education channels.
4. Conduct an internal strategic planning session with stakeholders to identify program strengths, weaknesses, opportunities, and threats (SWOT).
5. Implement the asthma member engagement strategy based on member and provider feedback, evaluation data and strategic planning analysis.

Objective 6. (Revised and Continuing): *By June 2024, increase the percentage of Black/African American pediatric members who complete at least 6 well child visits by 15 months of age from 16.58% to 26.58%.* **Objective 7. (Continuing):** *By June 2024, increase the percentage of Black/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 2021 MCAS Data, KHS Claims Data, 2021 DHCS Health Disparities Rate)*
Strategies
1. Continue to engage with key community stakeholders serving the Black/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. Analyze the focus group data among KHS Black/African American members to better understand the challenges they encounter when trying to access well child visits.
3. Revise current outreach material and communication campaigns to better meet the cultural relevancy of KHS Black/African American members.
4. 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.
5. Create a member and provider engagement strategy to increase awareness on the health inequities among KHS Black/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.
6. Pilot targeted clinic hours with at least 2 provider sites with a high concentration of KHS Black/African American members assigned.
7. Send an outreach campaign to all Black/African American member households with children under 3 years of age.

Objective 8. (New): *By June 2025, increase the PPC-Prenatal rate from 70.07% to 85.07%.* **Data Source:** *(RY 2021 MCAS Data)*
Strategies
1. Obtain member feedback on satisfaction with prenatal care, awareness of KHS' pregnancy rewards program and barriers to accessing care.
2. Conduct a series of focus groups with at least 2 targeted pregnant population to gain a better understanding of their perspectives on accessing prenatal care.
3. Research and identify community groups to perform outreach to targeted populations who test positive for a pregnancy test.
4. Participate in local maternal health initiatives, such as the Kern Black Infant Maternal Health Initiative to engage community partners to promote timely access to prenatal care and preconception care.
5. Revise KHS' Baby Steps Program communication and engagement plan to include new and ongoing strategies that promote the program among KHS staff, members, providers and community partners and implement these strategies.
6. Maintain the Baby Steps Steering Committee meetings to obtain feedback and direction from all member and provider facing department leadership within KHS.
7. Continue to include timely prenatal care in the Pay for Performance provider incentive program.

2020-21 Action Plan Review and Update

<table>
<tr><td rowspan="2">Objective 1. By June 2023, the IHA completion rate will have increased from 11.29% to 21.29%.

Objective 2. By June 2023, the W30-6 MCAS rate will have increased from 17.62% to 25.62%.

Objective 3. By June 2023, the W30-2 MCAS rate will have increased from 60.22% to 68.22%.

Objective 4. By June 2023, the WCV MCAS rate will have increased from 45.32% to 53.32%.

Data source: (RY 2020 & 2021 MCAS Data, KHS Claims Data, 2020 & 2021 DHCS Health Disparities Rate Sheet).</td><td>Progress Measure:

• The IHA rate decreased from 11.29% to 10.73%.
• The W30-6 rate increased from 17.62% to 30.55%.
• The W30-2 rate decreased from 60.22% to 55.70%
• The WCV rate decreased from 45.32% to 36.16%.

Data source: (RY 2020 & 2021 MCAS Data, KHS Claims Data, 2020 & 2021 DHCS Health Disparities Rate Sheet)</td></tr>
<tr><td>Progress Toward Objective: The COVID-19 public health emergency continued to cause significant delays and barriers towards members accessing preventive care services which resulted in decreased rates among the IHA, W30-2 and WCV rates; however, significant improvements towards the W30-6 rate had been seen. Although KHS continued to encourage members to seek out care through the member rewards program and campaigns to promote the importance behind these preventive care services, the pandemic likely continued to impose member concerns and hesitancy around the safety of providers' offices and the perception of preventive care not being essential.</td></tr>
<tr><td colspan="2">Strategies</td></tr>
<tr><td>Strategy 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.</td><td>Progress Discussion: The member rewards program was updated to include 4 new measures targeting blood lead screening, cervical cancer screening, breast cancer screening and chlamydia screening. All other member rewards encouraging well baby visits, well child visits, initial health assessments and perinatal care continued to be offered.</td></tr>
<tr><td>Strategy 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,</td><td>Progress Discussion: The member rewards communication plan was updated in December 2021 to include the 4 new MCAS measures and an updated 2022 timeline for promoting the program along with the various communication channels.</td></tr>
</table>

community partners and KHS' provider network.	
Strategy 3.) Leverage the Interactive Voice Response (IVR) solution to assist with performing member outreach through automated calls on preventive care and gaps in care.	**Progress Discussion:** Robocall campaigns for all rewards programs were launched in October 2021 and March 2022 along with a mailer to households who did not provide consent for robocalls.
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:** This strategy will start after July 2022 due to the School Wellness Centers temporary focus on the testing and vaccination against COVID-19.
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:** This strategy will start after July 2022.
Strategy 6.) Update gaps in care to members through the Member Portal to align with new MCAS pediatric preventive care measures.	**Progress Discussion:** Updates to the member portal gaps in care messages to align with new and revised measures were completed in March 2022.
Strategy 7.) Update gaps in care visibility to all member facing staff and KHS' provider network with new MCAS pediatric preventive care measures.	**Progress Discussion:** Updates to the gaps in care for all member facing departments and KHS provider network were completed in March 2022.
Strategy 8.) Update monthly reports to include revised rewards programs for monitoring and tracking of member participation and effectiveness of the rewards program	**Progress Discussion:** All monthly reports were updated to include revisions aligned with the new rewards programs in May 2022.

Objective 5: *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)*	**Progress Measure:** • The average class participation rate in the asthma education class series increased from 1.8 to 5.4. **Data source:** *(KHS Population Analysis Reports, KHS Health Education Activities Report*
	Progress Toward Objective: The average asthma class attendance rate increased significantly and surpassed the rate for this objective since last year's PNA Action Plan Update. This increase was likely due to a variety of member outreach efforts. Targeted outreach towards members with a recent visit to the hospital or urgent care with an asthma diagnosis resulted in member registration for the asthma classes. Offering $15 gift card for each asthma education class that they attend also may have been a factor. Outreach with members as part of a health education (HE) class member incentive survey, a member asthma survey, and asthma follow up calls has resulted in member self-referrals for the asthma classes. The HE class MI survey occurred during October 2021 – December 2021. The member asthma survey was launched in February 2022 and is expected to conclude in May 2022. Asthma follow up calls are offered to any members who have asthma and attend the asthma classes. A provider asthma survey is scheduled to start in July 2022. The findings from these surveys and outreach efforts will influence the revisions to how KHS promotes and provides its asthma education services.
Strategies	
Strategy 1) Research and develop questionnaires to obtain member and provider feedback.	**Progress Discussion:** Both member and provider questionnaires were developed with feedback from member and provider facing KHS staff members. Survey questions include but are not limited to awareness of KHS asthma education services, awareness of class incentives, barriers to accessing services, needed asthma resources, preferred learning methods, and preferred outreach and promotion methods. **This strategy has been completed.**
Strategy 2) Identify targeted members and providers to obtain feedback with special emphasis on Black/African American members who are disproportionately more at	**Progress Discussion:** An asthma claims report and heat map were developed to identify neighborhoods with a high concentration of Black or African American members with a diagnosis of asthma. The Health Education Department is utilized this report to perform

risk for poor asthma management and providers who serve this population at large.	targeted outreach to recruit members at higher risk for poor asthma management into its asthma education classes. **This strategy has been completed.**
Strategy 3) Evaluate current incentive program and recommend revisions based on survey findings	**Progress Discussion:** This strategy is in progress. Data on health education member incentives was collected from members in October 2021 – December 2021. This data was summarized in a report. The findings of the survey will be shared with relevant KHS departments/staff as part of efforts to collect feedback on recommended changes to the asthma education members incentive programs.
Strategy 4) Evaluate effectiveness of member communication and education channels.	**Progress Discussion:** This strategy is in progress. Data is being collected as part of the member asthma survey. Data will also be collected as part of the provider asthma survey and a community stakeholder survey starting in July 2022.
Strategy 5) Research and identify technology solutions to connect with members on their asthma management	**Progress Discussion:** This strategy is scheduled to start after July 2022.
Strategy 6) Conduct an internal strategic planning session with stakeholders to identify program strengths, weaknesses, opportunities, and threats (SWOT).	**Progress Discussion:** This strategy is scheduled to start after July 2022.
Strategy 7) Implement the asthma member engagement strategy based on member and provider feedback, evaluation data and strategic planning analysis.	**Progress Discussion:** This strategy is scheduled to start after July 2022.

Objective 6: *By June 2024, increase the percentage of Black/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:** *By June 2024, increase the percentage of Black/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 & 2021 MCAS Data, KHS Claims Data, 2020 & 2021 DHCS Health Disparities Rate)*	**Progress Measure:** • The W30-6 rate increased from 3.83% to 16.58%. • The W30-2 rate decreased from 37.05% to 30.87% **Data source:** *(RY 2020 & 2021 MCAS Data, KHS Claims Data, 2020 & 2021 DHCS Health Disparities Rate)* **Progress Toward Objective:** The COVID-19 public health emergency continues to significantly impact and delay progress on most of the preventive care services particularly among pediatric members; however, a significant improvement was seen among the W30-6 rate among Black/African American pediatric members which is consistent with the overall W30-6 rate reported in 2021. Existing community partnerships were maintained and a new partnership with a local parent advisory group was established. The series of focus groups to gain a better understanding of access to care barriers and perceptions around well baby visits were completed in April 2022 and the data is in the process of being analyzed. A single call campaign was launched during 2022; however due to the limited consents on file, the impact of the call was to a small population.
Strategies	
Strategy 1) Meet with key community stakeholders serving the Black/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.	**Progress Discussion:** Meetings with representatives and participants in the Black Infant Health program continued to be maintained and access for guidance on messaging targeted at Black/African American member households. Additionally, KHS began participating in a Black Infant Maternal Health Initiative and an African American Parent Advisory Council to identify opportunities to promote its member rewards program, benefits and services.
Strategy 2) Expand partnerships with key community stakeholders serving the Black/African American community and participate in community events and public presentations that allow	**Progress Discussion:** KHS has maintained and expanded its partnerships with community stakeholders through presentation on its services and disparities identified among Black pediatric members access to well baby visits to the Black Infant Health program and the Bakersfield City School District's African American Parent Advisory

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.	Committee. Due to the pandemic, KHS was unable to participate in community events in-person. **This strategy has been completed and will not be continued.**
Strategy 3) Facilitate a member survey or focus groups with KHS Black/African American members to better understand the challenges they encounter when trying to access well child visits.	**Progress Discussion:** A total of 4 member focus group sessions took place in April 2022 consisting of 23 member participants. The recordings from these focus groups are currently being transcribed prior to analysis of the data. **This strategy has been completed.**
Strategy 4) Revise current outreach material and communication campaigns to better meet the cultural relevancy of KHS Black/African American members.	**Progress Discussion:** This strategy is scheduled to start after July 2022.
Strategy 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.	**Progress Discussion:** This strategy is scheduled to start after July 2022.
Strategy 6) Create a member and provider engagement strategy to increase awareness on the health inequities among KHS Black/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.	**Progress Discussion:** This strategy is scheduled to start after July 2022.
Strategy 7) Pilot targeted clinic hours with at least 2 provider sites with a high concentration of KHS Black/African American members assigned.	**Progress Discussion:** This strategy is scheduled to start after July 2022.

Strategy 8) Send automated reminder calls, text messages and/or mailers to non-compliant member households.	**Progress Discussion:** An automated call campaign to Black/African American member households was performed in Q1 2022 along with a mailer promoting KHS members incentives on pediatric preventive care services. Partnering organizations such as the Black Infant Health Program were consulted on the messaging prior to the launch of the program.

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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