Community Health Needs Assessment

PRESENTED BY: Martin Luther King, Jr. Community Hospital

June 2020

Martin Luther King, Jr.
Community Hospital

Table of Contents

Letter from Our Chief Executive Officer 6

Introduction 8

- About MLKCH and Our Community 8
- CHNA Purpose 10
- CHNA Process 11
- CHNA Methodology 12
- Community Input 12
- Written Comments on Most Recently Adopted CHNA and Implementation Plan 14
- Significant Health Needs 14
- Report Availability and Comment 15
- Acknowledgements 15

Defined Community 17

- Overview 17
- Population 18
- Age and Gender Distribution 19
- Ethnicity 19
- Language 22

Social Determinants of Health 23

Overview 23

Income, Poverty, and Unemployment 23

Public Program Participation 24

Free or Reduced-Price Meals 25

Educational Attainment 25

Public Transportation 26

Homeless Health 27

Crime and Violence 28

Our Physical Environment 30

Overview 30

Access to Green Space and Growing Needs for Parks and Recreation Resources 30

Food Environment 31

Pollution 34

Access to Healthcare in Our Community 36

Overview 36

Care Coordination Across the Continuum 36

Health Insurance Coverage 38

Health Professional Shortage Areas and Medically Underserved Areas 39

Service Area Physicians 40

Medical Home and Usual Source of Care 41
Delayed Care 42
Access to Community Health Centers 43
Inpatient and Emergency Department 44
Trauma Services 48
Potentially Preventable Hospitalizations 48
Post-Acute Care Providers 50
Our Community's Health Status 51
Overview 51
Chronic Disease 51
Mortality and Leading Causes of Death 53
Community Inpatient Hospitalization Rates 54
MLKCH Emergency Department and Inpatient Hospitalization Trends 55
Maternal and Child Health 55
Sexually Transmitted Infections 57
Our Community's Health Behaviors & Preventive Screenings 58
Overview 58
Dental Care 58
Vaccinations 59
Mammograms and Pap Smears 60
Overweight and Obesity Prevalence 61

Physical Fitness 62

Physical Activity 63

Eating Habits 63

Mental Health and Substance Abuse 64

Tobacco/Alcohol/Drug Use 65

Appendix A. Impact of Evaluation Strategies for Previously Conducted CHNA 66

Appendix B. Data Limitations and Information Gaps 78

Appendix C. List of Data Indicators and Sources 79

Appendix D. Community Input 84

Key Informant Interviews 84

CHNA Focus Group & MLKCH Community Convening 87

CHNA Survey 91

MLKCH Research Report – Latino Markets 95

MLKCH Research Report – Breastfeeding Patients 97

Appendix E. Prioritization of Significant Health Needs 99

Overview 99

Resources to Address Significant Needs 100

Appendix F. Key Health Policy Impact 103

Appendix G. CHNA Survey Questions 107

Appendix H. CHNA Focus Group Discussion Guide 119

Letter from Our Chief Executive Officer

The events of 2020 offer a powerful backdrop to our report on the needs and challenges of our South Los Angeles community. Within the space of a year, we confronted a global pandemic that disproportionately affected people of color, a national crisis over long-standing injustices done to minorities that impact every aspect of their well-being and health and safety, and a state budget crisis that placed essential funding for our hospital at risk.

The research for this assessment was largely conducted prior to these crises, but the findings are valuable in understanding the root causes of all three. South LA continues to suffer from a disproportionate burden of poor health that is the inheritance of decades of structural exclusion, underinvestment, and lack of access to resources of all kinds. Martin Luther King, Jr. Community Hospital has brought long-needed health care providers and services to South LA, with its state of the art systems, quality care, and commitment to population health beyond the hospital's walls. It has also given us a boots-on-the-ground perspective on what remains to be done to improve the health of our community, detailed in this report.

The good news is that, despite these challenges, we have made significant strides in advancing our strategies to reduce health disparities and improve equity since our last CHNA report in 2017. Our new, 52,000 square-foot medical facility is now open, housing (among other things) a third branch of our growing medical group. With help from Cedars Sinai and the California Community

Foundation, we integrated behavioral health into all aspects of patient care, including within our busy emergency department. Our community health and education programs continue to expand through initiatives targeting specific high-risk groups (men, people with diabetes) and through mobile health campaigns and our signature "Know Your Basics" health screening program. And, importantly, our entire hospital team continues to perform magnificently throughout the ongoing COVID-19 crisis, caring for patients, securing necessary personal protective equipment, increasing awareness and resources for our hard-hit community, and making enormous sacrifices to meet and exceed our hospital's already-high standards of excellence.

Much of this could not have been accomplished without the support of community partners, funders, and elected officials who believe in our mission. Collaboration with others makes our responses to the needs outlined in this report more informed and consequently more effective. Partnerships also expand our ability to consider the entire continuum of healthcare needs and the social determinants that influence our responses to these needs.

For all who share our vision of innovative, collaborative community healthcare for the residents of South Los Angeles and who are committed to working with us to make this vision a reality, we thank you and we look forward to the work ahead.

Dr. Elaine Batchlor, MD, MPH
Chief Executive Officer
Martin Luther King, Jr. Community Hospital

Introduction

About MLKCH and Our Community

Opened in 2015 as a state-of-the-art facility, Martin Luther King, Jr. Community Hospital (MLKCH) is a private nonprofit safety net hospital serving 1.3 million residents in South Los Angeles. We have 131 beds for inpatient care, offering emergency, maternity, general surgery, and ancillary services typical of a community hospital. Our growing health education and outreach services extend our offerings to residents and support our mission.

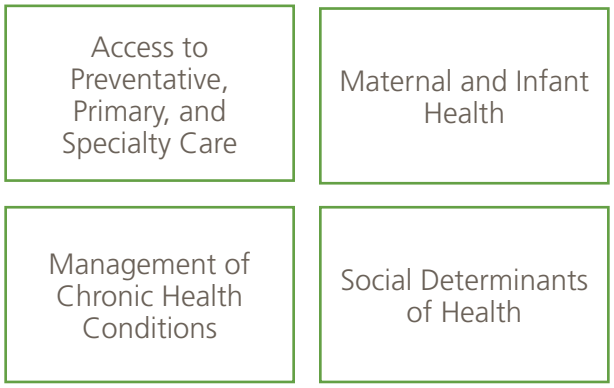
Our community continues to be home to Los Angeles County's (the "County") most vulnerable population, with poverty rates, unemployment rates, and metrics of poor health exceeding other regions of the County. This underserved population of 1.3 million people is 93% Hispanic or African American, and over 120,000 are dual-eligible for Medi-Cal and Medicare, having some of the most complex and costly healthcare needs in our community. With significant portions of our community designated as health professional shortage areas, medically underserved areas, or both, residents struggle to access and receive essential preventive, primary, and specialty care services and use the Emergency Department (ED) in place of these services because access is so limited. Further, educational opportunities and access to healthy, affordable food, quality housing, and green space are scarce.

Despite these disparities, our community shares similarities with many other communities across the United States. Community representatives define health broadly, as many other communities do, to include holistic views that span a combination of physical, mental, social, and emotional well-being. Additionally, our community voices sentiments of hope—for a better future for themselves, their children, and future generations and, most importantly, a desire for good health to be consistently attainable. Since MLKCH opened in mid-2015, we have maintained a long-term vision of ensuring a lasting, coordinated solution for serving the healthcare needs of our community—and assuring that these hopes for better health become a reality.

"Martin Luther King Jr. Community Hospital is a beacon for the community."

—Community Members

Since we issued our last community health needs assessment (CHNA) three years ago, MLKCH has taken great strides to develop relationships with our local and state partners—and build trust with our community—to address many of the daily challenges our residents face. Our longstanding efforts to improve overall health include, but are not limited to, the following key areas:



An evaluation of the impact of our prior Implementation Plan activities addressing these key areas is detailed in Appendix A.

In 2019 alone, we served over 112,000 patients and treated 100,000+ visits through our ED. Sepsis, heart failure and chest pain, substance abuse, diabetes, and chronic obstructive pulmonary disease accounted for the top reasons for hospitalization during this period. Almost 25% of our hospitalizations were substance abuse patients, 12% were mental health patients, and 12% were homeless patients. Despite our recent successes, much is yet to be done. Recognizing that economic opportunities, environmental factors, and social networks are key determinants of health, MLKCH continues to focus on reaching beyond the walls of the Hospital and across the entire continuum of care needed to improve the health of our community.

"This is a community that deserves better than what they have been given traditionally."

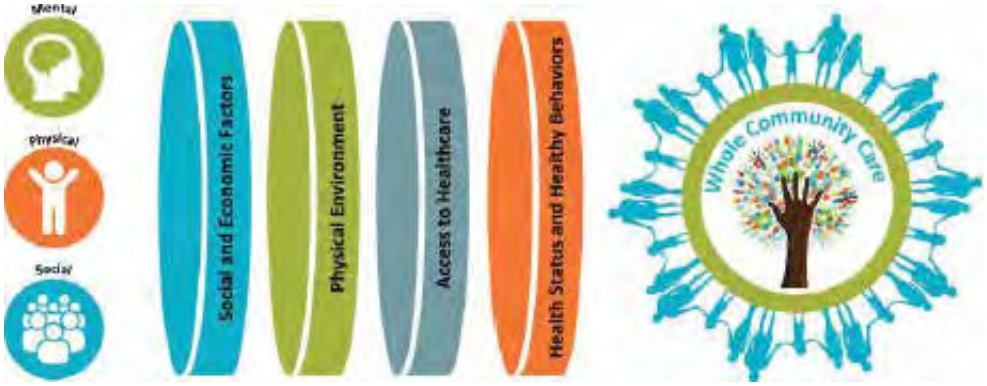
—Community Members

CHNA Purpose

The CHNA brings together partners to identify and prioritize health needs in our community. While it is widely known that many of the leading causes of death in the United States (e.g., heart disease) are caused by preventable factors such as poor diet and physical inactivity, there is growing awareness of the important link between how communities are structured and the opportunities that are available for people to lead safe, active, and healthy lifestyles. This CHNA is conducted to not only fulfill the requirements of California's Community Benefit Legislation (SB 697), but also in response to the Hospital's mission of providing compassionate, collaborative, quality care and improving the health of our community. The CHNA also meets the requirements of the Patient Protection and Affordable Care Act of 2010 (H.R. 3590) for not-for-profit hospitals by:

- Defining the community served
- Assessing the health needs of our community by collecting and evaluating quantitative data for multiple indicators of demographics, socioeconomic status, health status, health behaviors, and social determinants
- Obtaining input regarding local health needs from community members, public health experts and other persons representing the broad interests of medically underserved, low-income, and minority populations
- Completing a health needs prioritization
- Describing the process and methodologies used
- Making the CHNA results publicly available online

CHNA Process



The CHNA process identifies top health needs in the community and analyzes a broad range of social, economic, environmental, behavioral, and clinical elements that may contribute to health needs. To better understand overall needs in our community, the CHNA team reviewed quantitative data from a variety of published sources. These data elements were compared against benchmark data, such as Service Planning Area (SPA) or County data, when available. In addition, primary issues that impact the health of the community, as well as existing resources and innovative ideas to address those needs, were collected from local stakeholders through interviews, written surveys, community convenings, and focus groups. Stakeholders included public health experts and representatives of medically underserved, low-income, and minority populations.

"SPA 6 is really, really improving; everyone is involved and working together."

—Community Members

CHNA Methodology

MLKCH deployed a collaborative process to involve community organizations and local agencies to obtain broad community input regarding local health needs, including representatives of medically underserved and low-income populations. Data collection included quantitative data for demographic, socioeconomic status, health status, and social determinants and qualitative data from community surveys, key informant interviews, focus groups, and community convenings. Data limitations and information gaps are described in Appendix B and a list of the data indicators and sources is detailed in Appendix C. Over 100 stakeholders from approximately 60 organizations representing medically underserved, low-income, and minority populations provided input into the development of our CHNA. All of this information was analyzed to identify community issue areas and then prioritized to identify the significant health needs for which MLKCH has prepared an Implementation Plan to address. We engaged Premier, Inc., to partner with MLKCH to complete the CHNA using a transparent and collaborative approach.

Community Input

Throughout the course of completing this CHNA, MLKCH obtained input from community members and leaders who represent the broad interests of our community – including the Los Angeles County Department of Public Health; Communities Lifting Communities (CLC), a regional community health improvement initiative led by the Hospital Association of Southern California; Southside Coalition of Community Health Centers; Watts Healthcare; the Housing Authority for the City of Los Angeles; and many other local health experts and community advocates who serve as the voice of South Central Los Angeles' residents. A list of organizations who participated in the development of our CHNA is provided in the Acknowledgement section of this report.

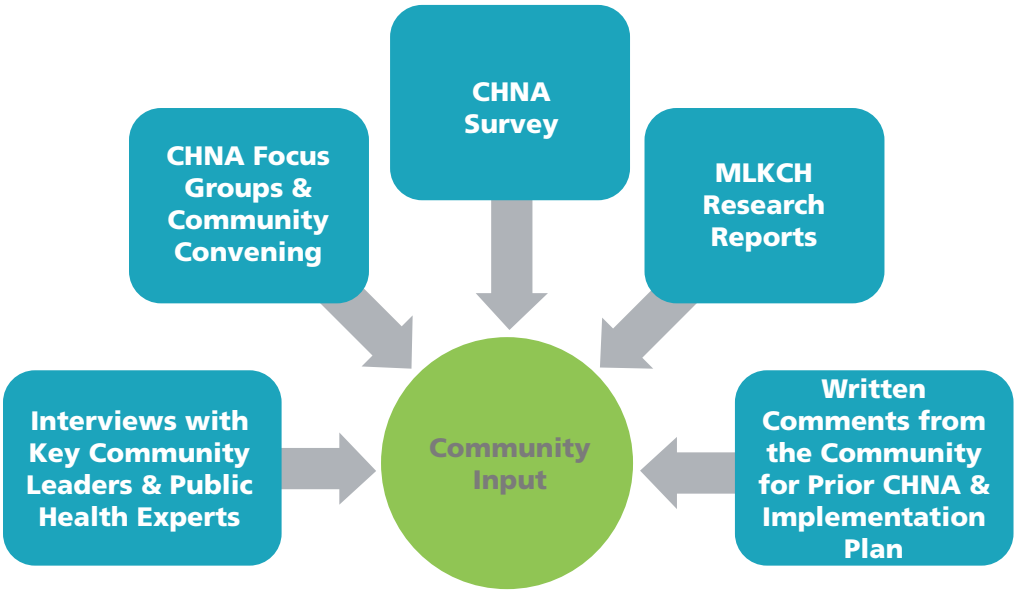
Through these existing relationships, MLKCH engaged a wide variety of community representatives to validate quantitative data collected on our community and provide qualitative input on our community's health needs. Each community leader added to this report by providing valuable insights and feedback for the CHNA.

"The community wants to be heard and be part of the decision making."

—Community Member

Five forms of data collection were utilized to obtain community input for this CHNA:

1. **Interviews with Key Community Leaders and Public Health Experts:** MLKCH engaged consultants from Premier to conduct interviews with key community leaders and public health experts on the Hospital's behalf.
2. **Focus Groups and Community Convening:** MLKCH facilitated focus groups and hosted a convening of local leaders to discuss healthcare inequity and disparities in our community and obtain input on how to address these challenges.
3. **Survey:** MLKCH administered an online survey consisting of 16 questions to obtain a broad perspective on community health issues and priorities.
4. **Research Reports:** MLKCH prepared research reports based upon observations gained through focus groups comprised of local residents.
5. **Written Comments Received from the Community from the Prior CHNA:** MLKCH published the prior Report online and monitored an email address for community feedback specific to its 2017-2019 CHNA and Implementation Plan.



Appendix D provides more detailed findings specific to each of the data collection forums. Common themes across each forum includes concerns about access to health care and resources, and behavioral health and wellness.

Written Comments on Most Recently Adopted CHNA and Implementation Plan

MLKCH has not received written comments regarding its 2017-2019 CHNA nor its 2017-2019 Implementation Plan.

Significant Health Needs

Through this CHNA, we analyzed data and obtained input from our community members and leaders to identify specific areas of concern. We identified significant health needs based on a review of published quantitative health status data specific to our community and qualitative data inputs collected throughout the CHNA process. Our assessment included consideration of the relative size of the issue, how important an issue was to the community, and how much of an opportunity there was for an impact to be made over the next three years. The health indicators identified were measured against benchmark data and, based upon this methodology, the following significant health needs were identified:

1. **Access to Preventive, Primary and Specialty Care –** Large portions of our community are designated as health provider shortage areas, medically underserved areas or both, and many residents are not able to consistently receive essential preventive, primary, and specialty care services.

2. **Management of Chronic Health Conditions –** Our community has higher rates of chronic diseases, mortality, and obesity, a culture of unhealthy behaviors, and delayed receipt of critical health care services.

3. **Behavioral Health –** Many factors leading to mental distress and/or substance abuse are common in our community (inequity, poor physical health, unemployment, high cost of living, legal issues). Add to this, stigma related to behavioral health in a highly minority community affects residents' willingness to seek help.

4. **Education and Screenings –** While MLKCH has worked to provide diverse, generational, and culturally appropriate tools to the community to support self-care and health literacy, more work lies ahead. There are multiple languages spoken in SPA 6, and challenges exist due to the cost of care, lack of insurance, and difficulty navigating the health system.

5. **Homeless Health –** Homelessness itself is a substantial issue, but indicators show this population has a 19% prevalence of mental illness, 10% prevalence of substance use, and a 23% prevalence of chronic conditions for which clinical and behavioral health care are severely needed.

6. **Social Determinants of Health –** There are many economic disparities and factors (situations into which people are born, live, work and age) that affect the mental and physical health. These must be addressed to improve the health of our community.

The methodology for the prioritization model used to determine the above priorities is detailed in Appendix E.

At the time of these analyses an unexpected virus spread throughout the United States and globally. This virus labeled the Novel Coronavirus (COVID-19) took many lives and threatened the physical, mental, and economic well-being of our community, and that of many others. MLKCH created temporary expansion sites, increased access to telehealth to ensure patients had access to physicians and other clinicians while remaining safe at home. In our community and those across the United States, we were asked to socially distance for our own safety and for the safety of others. At the same time, it became clear that this situation could not be addressed in isolation, and surviving the pandemic could only happen through the cooperation and collaboration of many care givers, public health agencies, public and private community-based organizations, and community residents themselves. The pandemic is an unfortunate, but visible example of how a community requires multiple stakeholders working together with a common purpose to survive and to succeed. We expect to continue these collaborations in a new post-pandemic normal that will impact how we as a community discuss public policy and deliver and receive care. Please refer to Appendix F for a summary of several health care policies directly related to the final implementation priorities that could have a potential impact on the health status of our community.

We look forward to using this CHNA as our foundation to collaborate with our community partners as we seek to fulfill our mission of improving the health of our community and building healthy equity in an area that has been deserving for so long.

Report Availability and Comment

The CHNA and Implementation Plan can be found on the MLKCH website at *https://www.mlkch.org/community-reports*.

Your feedback on this report is welcomed. You may send written comments to or request more information on this 2020 CHNA at *kyb@mlkch.org*.

Acknowledgements

This CHNA includes a comprehensive quantitative and qualitative assessment of critical factors that affect overall health and wellness in our community. Our findings represent work completed over the past year by our team, strategic advisors, and community partners. We would like to recognize our partners for their commitment to developing a CHNA that best identifies the needs of our community, and positions MLKCH to be a catalyst for change for the future:

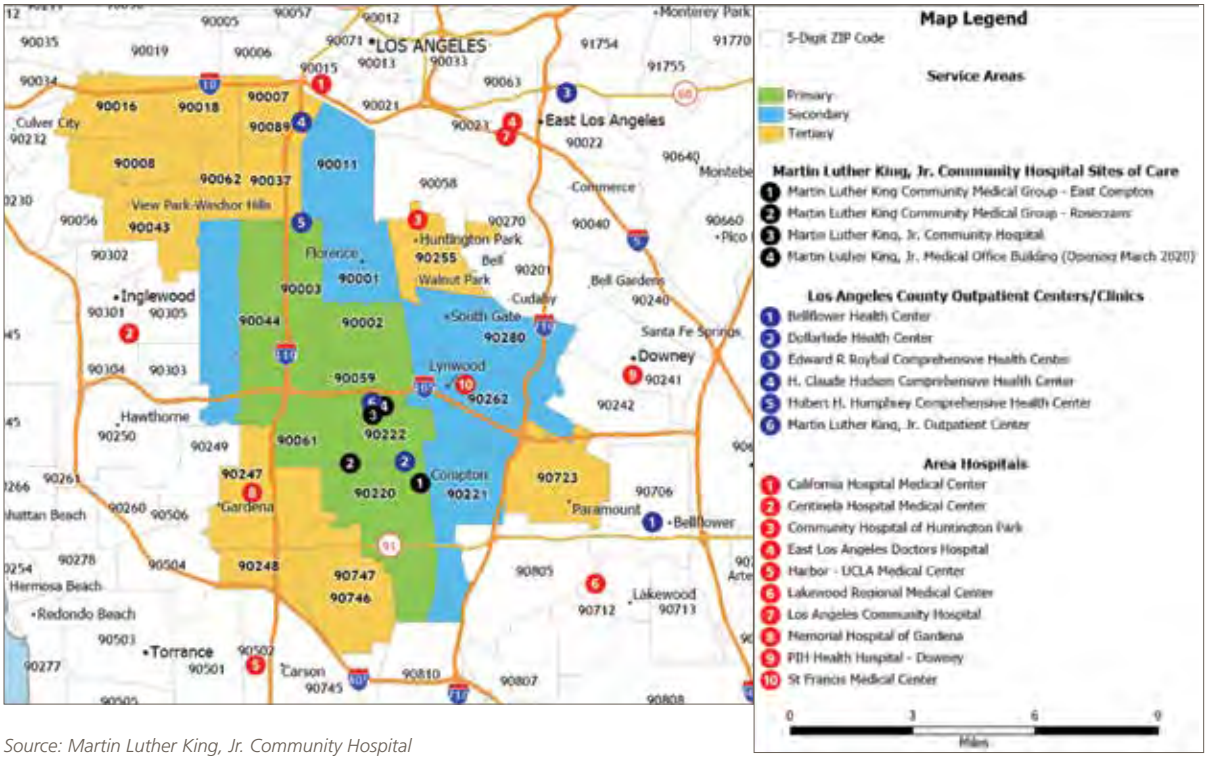
- **Premier, Inc.**, a nationally recognized healthcare consulting organization that specializes in advisory services and identifying community needs for underserved populations. Consultants from Premier served as strategic advisors to our team and helped facilitate the CHNA process across our many partners who participated in this initiative.

- **MLKCH leaders, staff, and physicians, and our community partners** that provided their input through interviews, meetings, focus groups and surveys, including the following:
  - A Community of Friends
  - Animo Mae Jemison Charter Middle School
  - Be Social Productions
  - Boys & Girls Clubs of Metro Los Angeles
  - Breastfeed LA
  - Californians for Safety and Justice
  - California Wellness Foundation
  - Century Sheriff Station
  - Charles R. Drew University of Medicine and Science
  - Church of the Redeemer
  - City Attorney Mike Feuer's Office
  - Community Coalition
  - Community Healing and Trauma Prevention Center, MLK Center for Public Health
  - Compton Unified School District
  - County of Los Angeles
  - DHS MLK Jr. Outpatient Center
  - District Attorney, County of Los Angeles
  - Eisner Health
  - Everytable (South LA)
  - Exodus Recovery Inc.
  - Friendly Friendship Baptist Church
  - Healthy Start, Shields for Families
  - Housing Authority for the City of Los Angeles
  - Hubert Humphrey Comprehensive Health Center
  - LA Care Inglewood Family Resource Center
  - Los Angeles County Department of Public Health
  - Los Angeles County Fire Department
  - Los Angeles Sentinel
  - Lynwood Family Resource Center
  - Maxine Waters Employment Preparation Center
  - MLK Center for Public Health
  - MLK Community Medical Group
  - MLK Community Hospital
  - Nickerson Gardens Housing Projects & Jordan Downs Community Center
  - Offices of Sweet Alice and Parents of Watts
  - Our House Grief Support Center
  - Playworks
  - Plaza Mexico
  - Ralph J. Bunche Elementary
  - SBCC Thrive LA
  - SEE-LA, Sustainable Economic Enterprises of Los Angeles
  - South LA Health Projects, Los Angeles BioMedical Research Institute
  - Southside Coalition of Community Health Centers
  - St. John's Well Child and Family Center - Compton Clinic (FQHC)
  - Star View
  - T.H.E. Health and Wellness Centers
  - The California Wellness Foundation
  - The VA's Office
  - Voala
  - Wade & Associates Group LLC
  - Watts Health Center
  - Whole Person Care – LA

Defined Community

Overview

MLKCH's community is defined as the geographic region consisting of SPA 6 as well as those ZIP codes located within a three-mile radius of the Hospital. The overall service area represents 27 ZIP codes and is comprised of three separate geographic regions: primary, secondary, and tertiary. The map and table provided below and on the following page define the Hospital's overall service area, as well as each service area separately, by ZIP code.



Source: Martin Luther King, Jr. Community Hospital

[1] Source: Martin Luther King, Jr. Community Hospital

Population

The total population within the MLKCH service area is estimated to be 1,353,586, which represents 13.3% of Los Angeles County's total population. Nearly one-third (30.7%) of our community resides in the South Central Los Angeles neighborhood, with the remaining population residing in Compton, Willowbrook, and surrounding communities (Table 1).

Table 1. Estimated Total Population, CY 2020[2]

Service Area	ZIP Code	Community Name	Population	% MLKCH Service Area	% 5-Year Growth
Primary	90002	Watts	54,847	4.1	3.7
Primary	90003	South Central	72,667	5.4	3.9
Primary	90044	Athens	93,143	6.9	2.6
Primary	90059	South Central	41,767	3.1	3.3
Primary	90061	West Compton	28,929	2.1	3.5
Primary	90220	Compton/Rancho Dominguez	51,612	3.8	2.8
Primary	90222	Compton/Rosewood/Willowbrook	34,149	2.5	3.0
Secondary	90001	Florence/South Central	58,658	4.3	2.3
Secondary	90011	South Central	108,107	8.0	2.9
Secondary	90047	South Central	49,846	3.7	1.9
Secondary	90221	East Rancho Dominguez	55,751	4.1	2.3
Secondary	90262	Lynwood	69,195	5.1	1.7
Secondary	90280	South Gate	96,619	7.1	1.6
Tertiary	90007	South Central	43,688	3.2	1.5
Tertiary	90008	Baldwin Hills/Crenshaw	31,788	2.3	1.8
Tertiary	90016	West Adams	49,422	3.7	2.3
Tertiary	90018	Jefferson Park	52,710	3.9	2.1
Tertiary	90037	South Central	66,350	4.9	3.6
Tertiary	90043	Hyde Park/View Park/Windsor Hills	44,750	3.3	1.6
Tertiary	90062	South Central	32,931	2.4	2.7
Tertiary	90089	University of Southern CA	1,661	0.1	0.8
Tertiary	90247	Gardena	47,724	3.5	1.6
Tertiary	90248	Gardena	10,319	0.8	2.4
Tertiary	90255	Huntington Park/Walnut Park	76,237	5.6	1.0
Tertiary	90723	Paramount	54,522	4.0	1.5
Tertiary	90746	Carson	25,484	1.9	1.3
Tertiary	90747	Carson	710	0.1	0.0
MLKCH			**1,353,586**	**100.0**	**2.4**
Los Angeles County			**10,173,286**		**2.3**

[2] Source: Claritas, 2020. Nielsen.

Age and Gender Distribution

Age and gender distribution are critical components of understanding our community's profile and provide elements in planning for needed health services. Younger populations require more prevention and health education while older populations are more likely to suffer from chronic diseases and require health services in higher acuity settings. Specific to MLKCH's community:

- 48.8% of our residents are male and 51.2% are female (Table 2).
- While our community is relatively younger (68% of the population is aged 0-44) compared to that of the County (60%), the number of residents 65 years old or greater is projected to grow the fastest (17.4% increase over the next five years). As the population ages, our community will likely continue to experience an increased demand for services such as internal medicine, cardiovascular services, endocrinology, gastroenterology, neurosciences, oncology, orthopedics, ophthalmology, physical medicine and rehabilitation, pulmonary medicine, rheumatology, and urology. Community members will also have a greater need for chronic disease management.
- The age cohort of 15-44 years represents 45.3% of the community's total population. This suggests that the demand for elective sub-specialty care and obstetrics and gynecology will continue in MLKCH's community.
- The age cohort 0-14 years represents 22.7% of the total service area population; therefore, the demand for pediatrics will also continue to exist in the community.

Table 2. Estimated Population by Age Cohort, CY 2020[2]

Age Cohort (Years)	% of MLKCH Community 2020 Population	MLKCH Community % Growth 2020–2025	% of Los Angeles County 2020 Population	Los Angeles County % Growth 2020–2025
0-14 Years	22.7	0.7	17.9	-0.1
15-17 Years	4.5	-1.2	3.8	0.6
18-44 Years	40.8	-0.7	38.7	-1.4
45-64 Years	21.9	3.5	25.4	2.1
65+ Years	10.1	17.4	14.1	16.2
Total	**1,353,586**	**2.4**	**10,173,286**	**2.3**

Note: Numbers subject to rounding

Ethnicity

The composition of our community's race and ethnicity also helps us understand needs for healthcare services as well as cultural factors that influence how we deliver care. Overall, our community is primarily Hispanic/Latino (72.2%) followed by African American (20.7%). The remainder of our community is characterized as follows: 2.9% of residents are Native Hawaiian/Asian Pacific Islander, 2.5% are White; and 1.6% are American Indian/Alaskan Native and other

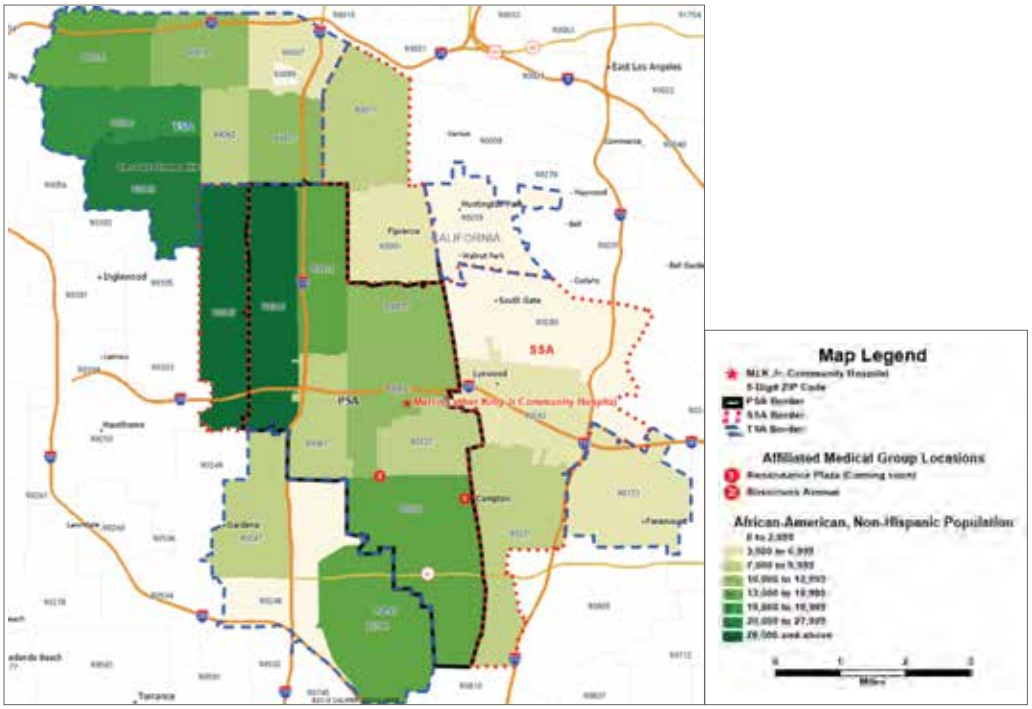
race or multiple race/ ethnicity combined (Table 3). Given that Hispanics and African Americans tend to have higher incidence rates of diabetes, heart disease, and obesity, we anticipate an increased demand for cardiovascular services, endocrinology, gastroenterology, and orthopedics in our community. In addition, higher birth rates for Hispanic populations will increase the need for obstetrics and newborn services.

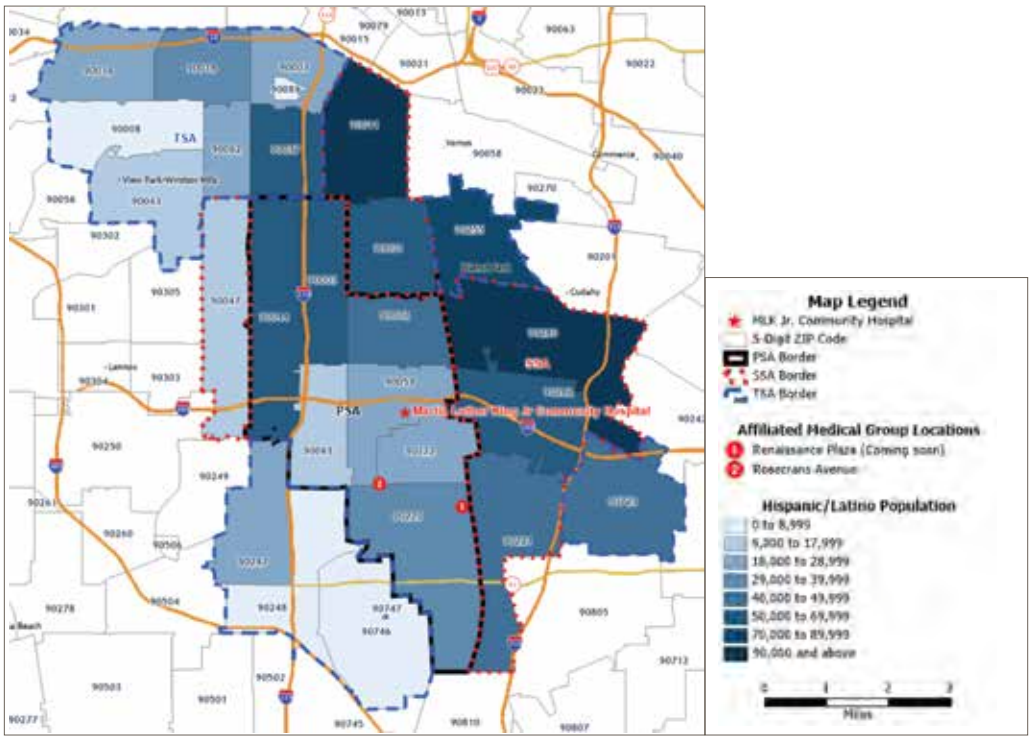
Table 3. Estimated Population by Race/Ethnicity Cohort, CY 2020[2]

Race/Ethnicity Cohort	% of MLKCH Community 2020 Population	MLKCH Community % Growth 2020–2025	% of Los Angeles County 2020 Population	Los Angeles County % Growth 2020–2025
Hispanic/Latino	72.2	5.1	49.7	4.4
African American Non-Hispanic (NH)	20.7	-7.6	7.6	-2.5
Native Hawaiian/Asian Pacific Islander NH	2.9	4.5	14.9	6.4
White NH	2.5	-1.3	25.0	-3.5
Other/Multiple NH	1.5	10.0	2.5	8.5
American Indian/ Alaskan Native NH	0.1	2.7	0.2	-1.8
Total	**1,353,586**	**2.4**	**10,173,286**	**2.3**

Hispanic/Latino populations represent our community's largest ethnic cohort, and published demographic data indicate this population tends to reside on the eastern portion of MLKCH's service area. Conversely, the African American population tends to reside on the western portion of this geographic region, specifically in the communities directly surrounding MLKCH. This trend is important to understand because cultural preferences influence how care is delivered, particularly with outreach in specific neighborhoods.

Map of Estimated Population by Hispanic/Latino and African American Non-Hispanic (NH) Cohorts, CY2020





Language

A person's primary language has long been known to affect access and use of healthcare services. Those unable to communicate with physicians or healthcare providers in their language of choice are less likely to seek primary preventative care, have follow-up visits, and adhere to healthcare treatment plans. More than half of our community has identified Spanish as their primary language (62.9%) (Table 4).

Based on this data, it is important that our healthcare providers offer written medical information in different languages, including Spanish, to ensure that patients can read and understand healthcare information that is central to improving their health (e.g., discharge instructions, treatment plans, phone numbers for providers so that patients can ask follow-up questions).

Table 4. Estimated Population Age 5+ by Language Spoken at Home, CY 2020[2]

Language Cohort	% of MLKCH Community 2020 Population	% of Los Angeles County 2020 Population
English Only	33.3	43.1
Spanish	62.9	39.9
Asian/Pacific Island	2.2	10.6
Indo-European	0.7	5.6
Total	**100**	**100**

Note: Numbers subject to rounding

"We need more bilingual physicians in this community; physicians with a 'heart' for this mission."

—Community Members

Social Determinants of Health

Overview

The World Health Organization defines the social determinants of health as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." Social and economic factors are the largest single predictor of health outcomes and strongly influence health behaviors. Unhealthy behaviors are more common among lower social and economic levels of a community due to the absence of information and resources.

Given the disparities and other complex challenges faced by residents of our community, it is important to understand the full range of situations and factors that affect the mental and physical health of our community. The indicators described on the following pages illustrate the daily challenges our community faces, and the impact these factors have on health status. This information will help us define appropriate interventions for elevating the health status of our communities and population.

Income, Poverty, and Unemployment

MLKCH continues to have a positive impact on our community's socioeconomic status. During the past year, we employed approximately 1,530 staff members and purchased services from 539 contractors, many of whom are local residents. However, we must continue to work with our partners to support economic growth locally and reverse the long history of inequity our community has experienced.

- The median household income in our community is $46,163—an increase of 25% from our last CHNA report. Despite this improvement, our median household incomes are still 35% lower when compared to Los Angeles County overall, and we have higher rates of unemployment and families in poverty (Table 5).
- Over half of our community's residents spend more than 30% of their monthly income on rent and housing. Due to the high cost of housing, our community has less discretionary income available for basic essential items.

These statistics are indicative of a population that may not have sufficient health insurance, may not always receive adequate preventative healthcare, and lack other necessary resources for health and wellness.

Table 5. Socioeconomic Status, CY 20202

Indicator	MLKCH Community	Los Angeles County
Median Household Income	$46,163	$71,008
% Families <100% Federal Poverty Level (FPL)	21.5	17.3
% Families with Children <100% FPL	17.3	8.6
% Households (Owner/Renter-occupied) Who Spend ≥30% of Their Income on Housing	57.4	47.2
% Civilian Age 16+ Unemployed	5.1	4.0
% Families with Single Parent – Father	5.9	4.2
% Families with Single Parent – Mother	17.6	10.9

"There is not a lot of opportunity to find jobs locally."

—Community Members

Public Program Participation

A high proportion of the MLKCH community qualifies for public assistance programs and income assistance when compared to Los Angeles County. These statistics are related to the disproportionately higher unemployment and poverty rates and lower household incomes found in our community. Specifically:

- 79.1% of residents with incomes below 200% of the FPL indicated that they could not afford food, 17.2% use food stamps and 32.5% of households are food insecure (Table 6).
- 54.2% of adults are receiving Women, Infants and Children (WIC) benefits.
- 12.4% of adults are currently receiving Supplemental Security Income (SSI) and 8.1% are recipients for the Temporary Assistance for Needy Families (TANF)/California Work Opportunities and Responsibility to Kids (CalWORKS) programs.

Table 6. Public Program Participation[3]

Indicator	% MLKCH Community	% SPA 6	% Los Angeles County
Adults w/ Inability to Afford Food (<200% FPL)[2]	79.1	80.9	50.2
Households with Incomes <300% FPL Who are Food Insecure[4]	32.5	35.1	26.8
Adults Currently Receiving Food Stamp Benefits	17.2	17.5	14.3
Adults Currently on WIC	54.2	48.3	47.6
Adults Currently Receiving SSI	12.4	12.9	11.5
Adults Receiving TANF or CalWORKS	8.1	8.3	6.5

Free or Reduced-Price Meals

Within each of the four public school districts that serve most of our community, over 75% of the K-12 student population is eligible for the free or reduced-price meal program, indicating a high level of low-income and food insecure families. These rates are far higher than those reported for Los Angeles County (62.2%) (Table 7).

Table 7. Free or Reduced-Price Meals Eligibility[5]

School District	% Eligible Students (K-12)
Compton Unified School District	82.6
Los Angeles Unified School District	74.2
Lynwood Unified School District	83.1
Paramount Unified School District	84.7
SPA 6	86.6
Los Angeles County	62.2

Educational Attainment

Education is an important determinant of health status because it influences a person's ability to read and understand clinical and sometimes complex health information.

[3] Source: California Health Interview Survey, 2018. UCLA Center for Health Policy Research.

[4] Source: Los Angeles County Health Survey, 2018. Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health.

[5] Source: Unduplicated Student Poverty – Free or *Reduced Price* Meals Data 2017–18. Analysis, Measurement, & Accountability Reporting Division of the California Department of Education. *https://www.cde.ca.gov/ds/sh/cw*

- 39.0% of our community's residents age 25 years or older do not have a high school diploma compared to 21.0% for Los Angeles County overall (Table 8).
- Further, only 11.6% of area residents hold a bachelor's degree compared to 31.9% for Los Angeles County.

These trends are indicative of a population with higher rates of illiteracy who may not easily read and understand written materials supplied by their healthcare provider. Combined with the fact that 62.9% our community primarily speaks Spanish at home, it is critical that we identify diverse and alternative ways to communicate with our patients to ensure they understand their healthcare issues and treatment plans to achieve better health outcomes.

"Many patients have 5-6th grade level—which is a literacy barrier."

—Community Members

Table 8. Educational Attainment of Adults[2]

% of 2020 Population, Adults age 25+	% MLKCH Community	% Los Angeles County
Some High School, No Diploma	39.0	21.0
High School Graduate (or equivalent)	25.8	20.9
Associate Degree or Some College	23.6	26.2
Bachelor Degree or Greater	11.6	31.9

Public Transportation

Reliable transportation is important for our residents to meet basic daily needs. Our community has a significant shortage of healthcare providers across all specialties. There is a lack of conveniently accessible and affordable food options, and local employment opportunities are limited, thereby requiring our community members to travel to fulfill these basic needs. However, research indicates that 13.4% of our community's households lack a motor vehicle, and 10.0% of our residents age 16 years and older rely on public transportation as their primary source of transportation (Table 9). This implies that our community—with limited transportation—does not always have the resources available to meet their daily basic needs. Our residents likely rely on multiple transportation resources when they do receive care. This includes seeking immediate medical care when necessary.

Table 9. Transportation[2]

% of 2020 Population, Adults age 25+	MLKCH Community	Los Angeles County
% of Family Using Public Transport (Age 16+)	10.0	5.9
% Family Households with No Vehicles	13.4	8.6

Homeless Health

The homeless population often relies on emergency rooms, clinics, and hospitals to obtain healthcare services. Homeless individuals are more susceptible to certain diseases, have greater difficulty getting healthcare, and are harder to treat—all because they lack a stable place to live. According to the 2019 Greater Los Angeles Point in Time Count, nearly 45,000 unsheltered homeless reside in the County, with over 6,000 residing in SPA 6 (Table 10). If SPA 6 were its own city, it would rank #1 in the County in terms of the total number of unsheltered homeless. These individuals frequently have higher acute care use and associated costs when compared to housed patients. Healthcare statistics for the unsheltered homeless in SPA 6 are noted as follows:

- 740% more hospitalization days
- 170% greater costs per hospital day
- 4.1-day increase in length of stay per admission
- 30-day readmission rate of 50.8%
- 18 times more ED visits per year than housed patients

Homeless patients often experience a substantially higher disease burden of both physical and psychiatric morbidity. According to the USC Street Medicine Report, key health characteristics of this patient population are noted as follows for our community:[6]

- Life expectancy ranges between 42 and 52 years
- 38% of unsheltered homeless have two or more of the following conditions: cancer, cerebrovascular accident, chronic kidney disease, chronic obstructive pulmonary disease, coronary artery disease, HIV/AIDS, liver condition, hypertension, CAD, CVA, and/or HIV/AIDS
- 30% with drug use disorder
- 25% with severe mental illness

These trends are indicative of individuals who do not receive medical care when needed or are severely undertreated, and they do not have a safe place to go upon discharge when they do receive treatment, thereby making it very difficult to stabilize their medical problems and improve their health.

"There's still not enough housing in the community and homeless patients when offered housing, do not always go."

—Community Member

[6] Source: Keck School of Medicine of USC Street Medicine at Martin Luther King Community Hospital Service Line Proposal.

Table 10. Homeless Population, 2019 Homeless Count Comparison[7]

Point in Time Homeless Count	SPA 6		Los Angeles County	
	Count	%	Count	%
Total Homeless (of total 2020 population)	9,543	0.9	58,936	0.6
Unsheltered % prevalence (of total homeless)	6,316	66.2	44,214	75.0
Sheltered % prevalence	3,227	33.8	14,722	25.0
Individual Adults % prevalence	7,264	76.1	50,071	85.0
Family Members % prevalence	2,253	23.6	8,799	14.9
Unaccompanied Minors (<18) % prevalence	26	0.3	66	0.1
Chronically Homeless % prevalence	2,081	21.8	16,528	28.0
Serious Mental Illness % prevalence	1,847	19.4	13,670	23.
Substance Use Issues % prevalence	996	10.4	7,836	13.3
Persons with HIV/AIDS % prevalence	85	0.9	1,306	2.2
Chronic Illness % prevalence	2,217	23.2	—	—
Physical Disability % prevalence	1,481	15.5	—	—
Brain Injury % prevalence	332	3.5	—	—
Veterans % prevalence	465	4.9	3,878	6.6
Domestic Violence Experience % prevalence	2,892	30.3	3,111	5.3

Note: — indicates data not available.

Crime and Violence

Safety, including access to safe streets and parks, plays a key role in community health and well-being. The Los Angeles County 2018 Health Survey reported that 71.5% of adults residing in MLKCH's community believe their neighborhood is safe from crime, versus 85.0% reported for Los Angeles County.

Additionally, some cities within the MLKCH community have higher rates of violent and property crimes when compared to Los Angeles County. For example,

- Compton has the highest rate of violent crimes (1,200.7 violent crimes per 100,000 persons) compared to other cities in the community and the County overall (571.1) (Table 11).
- Huntington Park has a much higher rate of property crimes (3,054.9 property crimes per 100,000 persons) than other comparison cities and the County overall (2,319.1).

[7] Source: Los Angeles Homeless Service Authority, 2019 Greater Los Angeles Homeless Count. *www.lahsa.org/homeless-count/results*

High rates of violent and property crimes in a community compromise individuals' physical safety, are harmful to overall mental health, and deter residents from pursuing healthy behaviors, such as walking outdoors for fear of harm. Further, qualitative input received from focus groups and surveys indicated there is a lack of trust between residents and law enforcement—the very resources that are designed to keep our community safe. As a result, there is a need to build trust between the community and law enforcement agencies to promote and sustain a safer environment.

"We can change the dynamic with law enforcement by getting them out into the community, to meet the community, and build trust."

—Community Member

Table 11. Violent Crimes Rates and Property Crime Rates, per 100,000 Persons, 2018[8]

Cities	Violent Crime Rates	Property Crime Rates
Carson	468.3	2,121.8
Compton	1,200.7	2,617.2
Gardena	539.5	2,161.4
Huntington Park	728.1	3,054.9
Los Angeles	747.6	2,513.0
Lynwood	597.3	2,016.4
Paramount	597.9	2,593.5
South Gate	663.4	2,473.6
Los Angeles County	**571.1**	**2,319.1**

[8] Source: U.S Department of Justice, FBI, Uniform Crime Reporting Statistics, 2018. *https://ucr.fbi.gov/crime-in-the-u.s/2018/crime-in-the-u.s.-2018* Notes: Property crimes include burglary, larceny-theft, and motor vehicle theft. Violent crimes include homicide, rape, robbery, and aggravated assault.

Physical Environment

Overview

Land use and the urban environment play a key role in our health and well-being. Where our community lives determines how they live. Access to healthy food, green space, and activity resources often determine our long-term health. Unfortunately, the physical environment is among the community issues that may be the most difficult to change.

Our community has two of the most basic barriers to health: extremely limited access to fresh, healthy foods and unsafe, polluted, vacant city land instead of green space. SPA 6 is located between the Harbor Freeway and Interstate 10, which are major freight routes heavily trafficked by smog producing trucks traveling between the Los Angeles Port to the south and industrial distribution centers to the north, causing major environmental problems in our community. Residents become victims to air pollutants that result in respiratory diseases such as chronic obstructive lung disease and lung cancer. With over 3,000 segments of alleys in South Los Angeles and an overwhelming lack of safe and accessible green space, our youth use these contaminated spaces to play because park access is so limited. Further, the high concentration of corner stores, liquor stores, and fast food chains that offer limited food options make it difficult for residents to make healthy choices. These factors alone make it difficult for our residents to lead healthy lifestyles and have overall good health.

Access to Green Space and Growing Needs for Parks and Recreation Resources

The degree to which parks are available in our community is directly associated with increased park usage, physical activity, and better overall health. Improving access to parks can increase the amount of time our community engages in physical activity, decreases risk of chronic diseases, and improves overall health for adults and children alike. According to the Los Angeles County Department of Parks and Recreation, park level of service is defined as the acres of parkland per 1,000 residents; a minimum of 3 acres of parkland per 1,000 residents is often used to determine park level of service. Substantial portions of our community are considered park-poor neighborhoods, with most cities having less than half of the recommended minimum park acreage.

- No cities in our community have more than 68% of its population residing within a half-mile of a park (Table 12).
- The Los Angeles County 2018 Health Survey found that 84.7% of our community's children ages 1-17 years are able to access a park, playground, or other safe place to play. This statistic is slightly lower than Los Angeles County, which reported 90.4% for the same metric. Similarly, the percent of adults residing in our community who use walking paths, parks playgrounds, or sports fields in their neighborhood (42.5%) is lower than the County overall (47.5%).

Table 12. Park Need and Level of Service, 2016[9]

Cities	Park Need	Park Acres per 1,000 Population	% of Population Living within ½ Mile of a Park
Carson	High	1.5	51
Compton	High	0.6	58
Gardena	High	0.8	61
Huntington Park	Very High	0.7	68
Los Angeles	High	1.6	63
Lynwood	Very High	1.8	60
Paramount	Very High	1.5	45
South Gate	Very High	1.1	57
Watts	High	1.5	51
Los Angeles County		**3.3**	**49**

Food Environment

In 2006, the United States Department of Agriculture (USDA)[10] introduced new language to describe ranges of severity for food security and insecurity:

	Category	Description
Food Security	High Food Security	Reflects no indications of food access problems or limitation
	Marginal Food Security	Reflects one or two reported indications, typically shortage of food in the house
Food Insecurity	Low Food Security	Reflects reports of reduced quality, variety, or desirability of diet
	Very Low Food Security	Reflects reports of multiple indications of disrupted eating patterns and reduced food intake

Food insecurity can lead to undernourishment and malnutrition, which coincide with fatigue, stunted child development, and other short-term and longer-term health issues. Undernourished pregnant women are more likely to bear babies with low birth weight, and the babies are then more likely to experience developmental delays that can lead to learning problems. Hunger and food insecurity can also accelerate the development of disease or worsen existing diseases. Further, food insecurity and obesity co-exist in some households where people eat foods that are inexpensive while high in fat and sugar, but low in nutritional quality. Households that lack "food security" are typically low-income households. And these households can obtain supplemental assistance from government programs, such as the CalFresh program and the WIC program.

[9] Source: The Countywide Parks and Recreation Needs Assessment, 2016. Los Angeles County Department of Parks and Recreation *https://lacountyparkneeds.org/final-report*

[10] Source: Economic Research Service of the United States Department of Agriculture (USDA).

The USDA found that, in general, rates of food insecurity were higher than the national average (11.1%) for the following groups:[10]

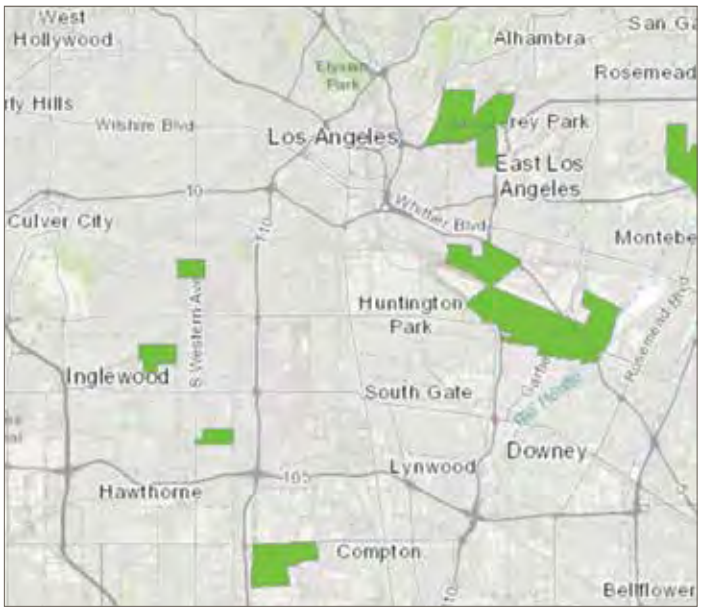
- All households with children (13.9%) and with children under age 6 (14.3%)
- Households with children headed by a single woman (27.8%) or a single man (15.9%)
- Women living alone (14.2%) and men living alone (12.5%)
- Black, non-Hispanic households (21.2%)
- Hispanic households (16.2%)
- Low-income households with incomes below 185% of the FPL was $25,465 for a family of four in 2018)

Many of these groups are representative of the households that comprise our community.

USDA defines a food desert as "a low-income census tract where either a substantial number or share of residents has low access to a supermarket or large grocery store." Portions of our community are characterized as "food deserts," meaning that opportunities to procure fresh, affordable, healthy foods are limited and residents have relatively easier access to unhealthy food. These food deserts exist across Los Angeles County predominantly where there are high minority populations of Hispanics/Latinos and African Americans. Based on available data, our residents lack opportunities to make healthy food choices compared to other areas of the County, and this has an adverse effect on our community's overall health.

[11] Source: Food Insecurity by Household Characteristics, 2018. ERS USDA *https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx#verylow*

Food Access Research Atlas, 2019[12]



Low Income & Low Access Layer
Low-income census tracts where a significant number or share of residents is more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket.

"Compton is not a food desert; it is a food swamp."

—Community Member

Additionally, our community's children (63.7%) and adults (68.0%) have less consistent access to affordable fresh fruits and vegetables compared to others in the County (Table 13). To address this challenge, the MLK Campus Farmers Market was established in 2017. This Farmers Market is held on the Martin Luther King, Jr. Medical Campus every Wednesday, hosting approximately 10 local vendors who sell affordable fresh fruits and vegetables to our community. On-campus cooking classes are also available to our community members on a weekly basis.

Table 13. Access to fresh fruits and vegetables, 2018[3]

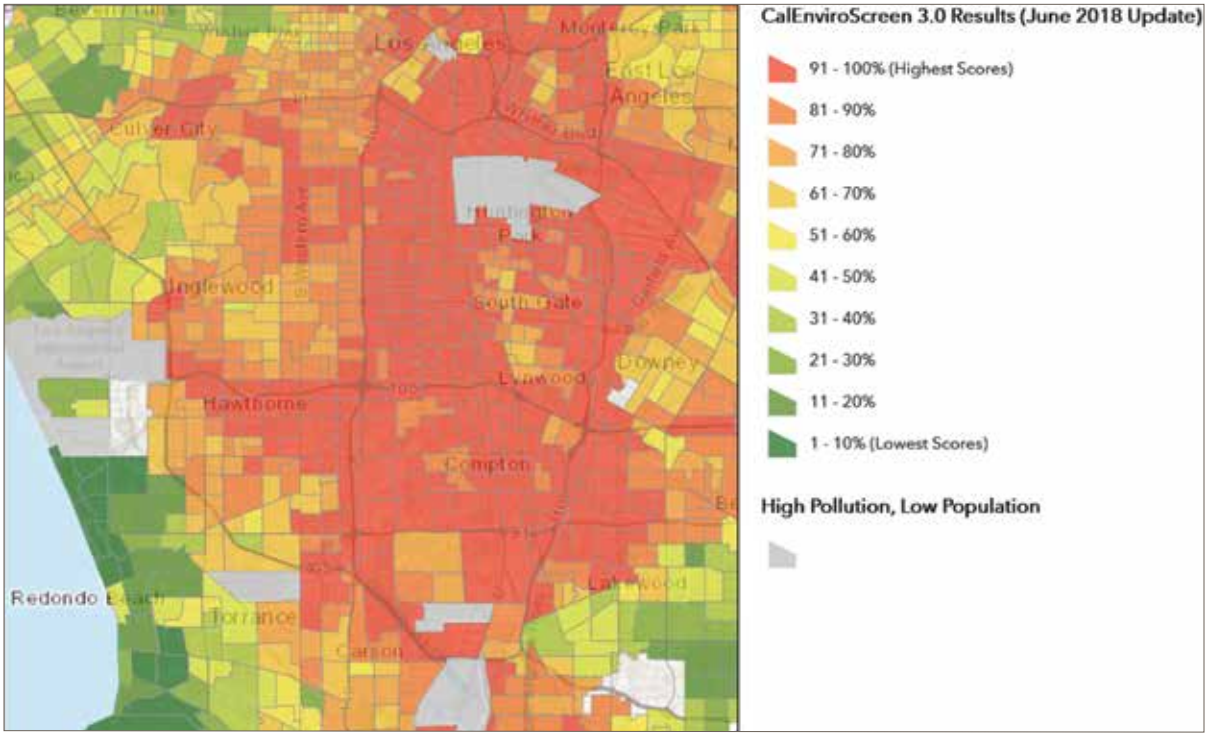
Access to fresh fruit and vegetables	% MLKCH Community	% SPA 6	% Los Angeles County
Children with excellent or good access to fresh fruits and vegetables in their community[4]	63.7	63.2	78.2
Adults who always find fresh fruit/vegetables in neighborhood	68.0	68.8	76.5
Adults who never find fresh fruit/vegetables in neighborhood	3.8	4.6	4.0
Adults whose neighborhood fruit/vegetables are always affordable	46.7	47.7	51.9
Adults whose neighborhood fruit/vegetables are never affordable	0.1	0.1	1.4

[12] Source: Food Access Research Atlas, 2019. Economic Research Service of the United States Department of Agriculture (USDA). *https://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas.aspx*

Pollution

South Los Angeles is disproportionately burdened by multiple sources of pollution. For decades, our community has been plagued with high exposure to poor air and drinking water quality, large concentrations of diesel emissions, pesticide use, hazardous waste, frequent groundwater threats and impaired water bodies, and high traffic density. The California Office of Environmental Health Hazard Assessment (OEHHA) conducts a risk assessment to evaluate the degree to which environmental pollutants and other toxins exist in communities throughout the state. Based upon the OEHHA's CalEnviroScreen 3.0 findings, our community displayed the highest risks for pollutants when compared to other portions of Los Angeles County.

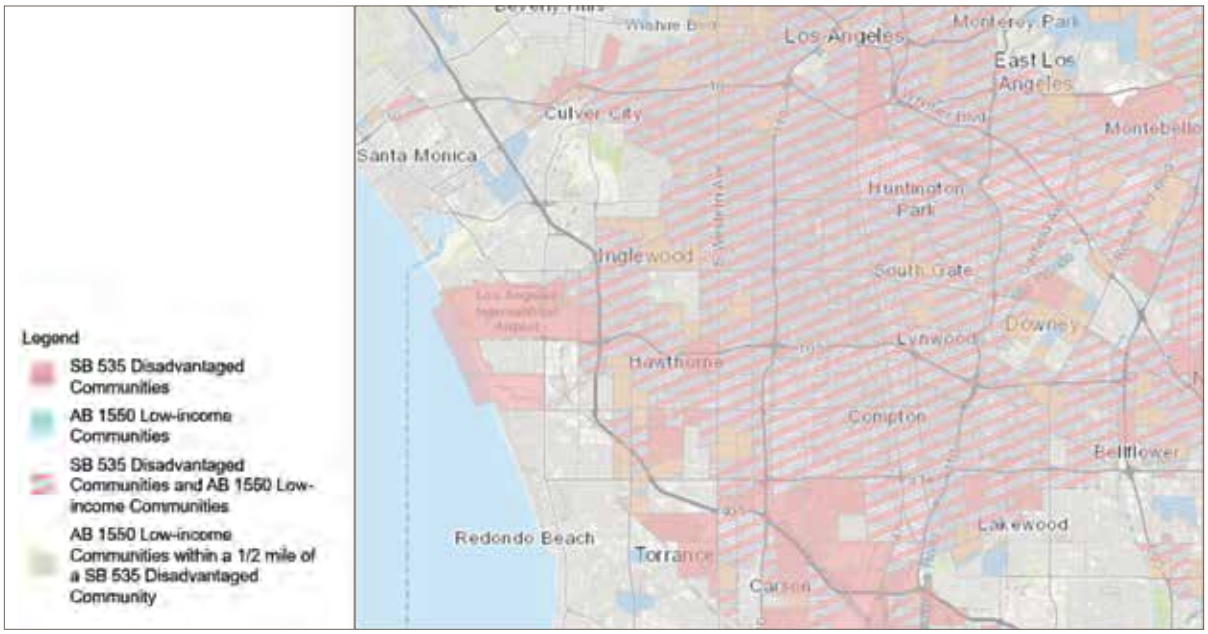
CalEnviroScreen Overview, 2018[13]



[13] Source: CalEnviroScreen 3.0 Results for South Los Angeles. June 2018 Update. The Office of Environmental Health Hazard Assessment of the California Environmental Protection Agency. *https://oehha.ca.gov/calenviroscreen/maps-data*

Additionally, almost all of South Los Angeles has been designated as a "SB 535 Disadvantaged Community," which means that our community was ranked in the highest scoring 25% of census tracts (higher scores are worse) based upon the OEHHA's CalEnviroScreen assessment.

SB 535 Disadvantaged Communities, 2018[14]



[14] Source: Disadvantaged and Low-income Communities Investments, . California Air Resources Board. Accessed on March 29, 2020. *https://ww3.arb.ca.gov/cc/capandtrade/auctionproceeds/communityinvestments.htm*

Access to Healthcare in Our Community

Overview

Los Angeles County is home to some of our nation's wealthiest—and poorest—residents. It is not uncommon to see large disparities where areas of enormous wealth and first-class healthcare providers are located next to neighborhoods where low-income residents suffer from preventable conditions and lack basis access to healthcare. Health outcomes data indicates that residents of our community are vastly underserved and experience greater challenges trying to access healthcare services compared to other parts of the County. Major disparities and healthcare inequity continue to exist across the care continuum in our community today, making it nearly impossible for our local healthcare providers to collectively achieve the objectives of the Institute for Healthcare Improvements Triple Aim™ Initiative of better health outcomes, improved patient experiences, and lower costs of healthcare. The healthcare disparities faced by our community continue to be substantial and include:

- An overall lack of comprehensive healthcare services available in the community across the care continuum
- Large shortages of physicians across all specialties, resulting in little to no access to critical preventive, primary, and specialty care services
- Limited number of healthcare providers that: (1) accept Medi-Cal and (2) resemble the diverse population that exists in our community today and are able to care for residents in their language and through the lens of their culture
- Inadequate levels of health insurance coverage among our residents and, for those that are insured, many report incomes below the FPL and do not have the financial resources required for co-payments or co-insurance for high-deductible health plans
- Absence of comprehensive, multi-disciplinary healthcare, treatment planning, and care coordination

Key factors that support these findings and impact our community's ability to access needed healthcare services are described on the following pages.

Care Coordination Across the Continuum

Our community's healthcare providers indicated there are widespread gaps in care coordination across the healthcare delivery system in South Los Angeles, including community health centers, clinics, physician practices, hospitals, post-acute providers, among others. Collectively, our community's multi-disciplinary providers share the belief that if care coordination were to be more effective across the continuum, our patients would benefit through the following:

1. A reduction in the number of unnecessary inpatient hospitalizations and readmissions
2. A reduction in inappropriate use of the ED as the primary source of care

3. Improved management of patients with chronic conditions

4. Better health outcomes

Our residents are often treated by different providers, clinics, or health centers each time they seek care—a trend largely driven by the transportation challenges faced by our community, patients trying to find the least expensive option for care, and the availability of timely provider appointments. The dynamics of our local healthcare system make it difficult to effectively coordinate care for our patients. For example, the absence of a real-time, universal health information exchange results in less than optimal manual processes. Consequently, community providers are often unaware when patients are hospitalized, visit the ED, or are treated by other providers, and only learn of these events when a patient returns for a visit and informs their provider. Further, many of our residents do not have an assigned primary care provider that could be notified even if there were a universal medical record to access. These factors contribute to the challenge that many primary care providers do not receive post-discharge information on patients when they are hospitalized, including recommended follow-up care, new medications or changes to prescriptions, treatment provided, or lab and diagnostic test results. Receipt of this information is critical as we seek to ensure quality, coordinated care.

To address these challenges, our community partners indicated that care coordination could be supported through health education, combined with the use of health coaches, care navigators, and care concierges. These resources would help to facilitate scheduling patient follow-up appointments, assist with ensuring that providers receive appropriate patient information (e.g., discharge instructions), provide resources to direct patient follow-up questions and assure resolution, and direct patients to the right care setting at the right time.

Patient Access Points and Coordination Are Both Needed Across the Care Continuum

"Desperately need someone [a community-wide resource] we can reach out to for help navigate [navigating] social services on [the] ambulatory side [between various providers across the continuum]."

—Community Member

Health Insurance Coverage

Health insurance coverage is a key component to accessing health care including primary care, specialty care, and other health services that contribute to one's health status. The Patient Protection and Affordable Care Act (ACA) has been important to our community since it was signed into law in 2010. Although more of our adult residents have health insurance today (89.2%) than before the ACA was signed into law (73.6%), a health insurance card alone does not guarantee access to high quality, affordable healthcare services, and our community is still challenged with a significant shortage of healthcare providers (Table 14). Additionally, the variety of plan networks and service coverage can be confusing to a population challenged with health literacy.

Of those with insurance coverage in our community, 51.0% have Medi-Cal coverage, and 28.0% have employment-based insurance. Notably, 88.4% of our senior population (approximately 120,000 residents age 65 years or older in total) is dual-eligible for Medi-Cal and Medicare; these residents have some of the most complex and costly healthcare needs in our community.

Table 14. Insurance Status[3]

Insurance Type	% MLKCH Community	% SPA 6	% Los Angeles County
Children ages 0-17 years who are insured4	98.8	98.8	98.5
Adults ages 18-64 years who are insured4	84.2	83.4	90.1
Adults currently insured	89.2	87.3	90.3
Adults w/ employment-based insurance	28.0	12.9	49.3
Adults covered by Medi-Cal	51.0	53.7	31.8
Adults covered by Medicare	29.0	30.2	24.2
Seniors (age 65+) with dual-eligible coverage	88.4	86.5	88.1

"There are patients that don't really have insurance and those that do are challenged with navigating the system and finding a provider that accepts what they are eligible for."

—Community Member

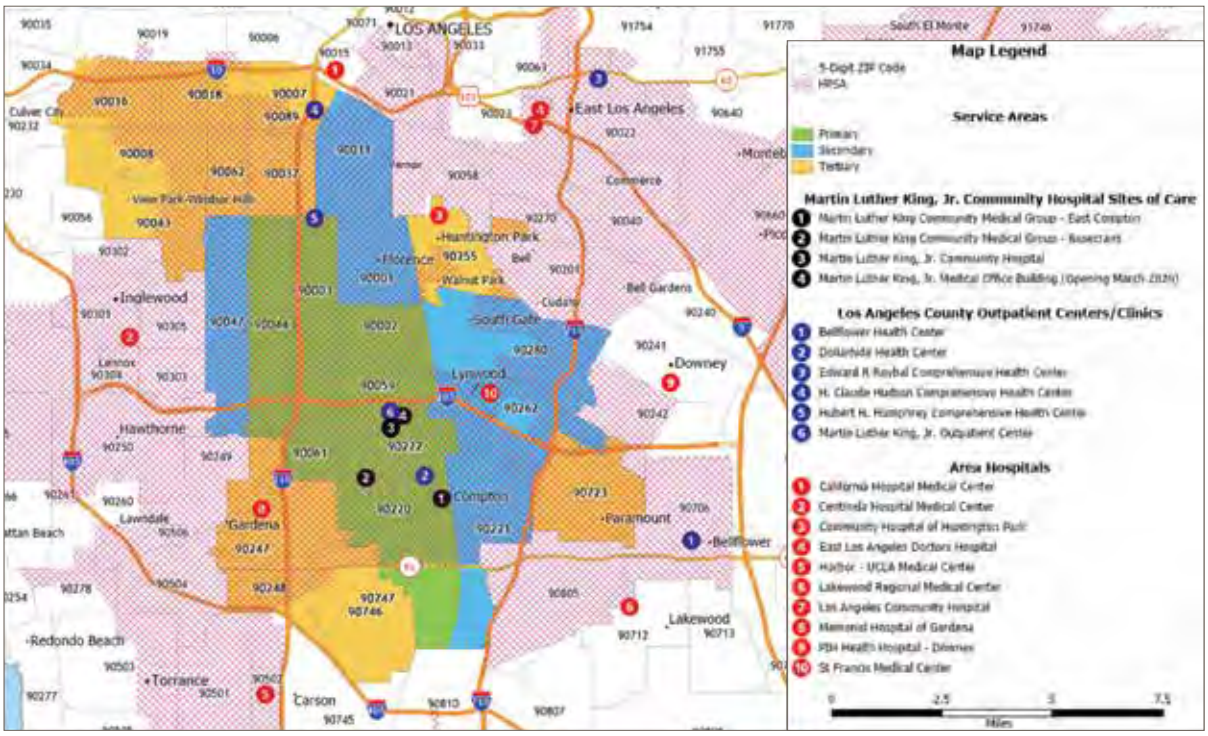
Health Professional Shortage Areas and Medically Underserved Areas

The federal government defines a Health Professional Shortage Area (HPSA) as an area, facility, or population group with a shortage of primary care physicians as defined by a population-to-primary care physician ratio greater than 3,500:1. For purposes of this CHNA, the federal government defines primary care as the following specialties: family practice, geriatrics, internal medicine, pediatrics, and psychiatry. Other factors taken into consideration include the poverty rate, infant mortality rate, fertility rate, and indicators of insufficient capacity to meet area need.

A Medically Underserved Area (MUA) is defined as an area, facility, or population group with an Index of Medical Underservice (IMU) less than or equal to 62 out of 100. The IMU is calculated by taking into consideration the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with an income below the FPL, and the percentage of people age 65 or older. These factors are converted to weighted values and then summed to obtain an IMU score for a particular area.

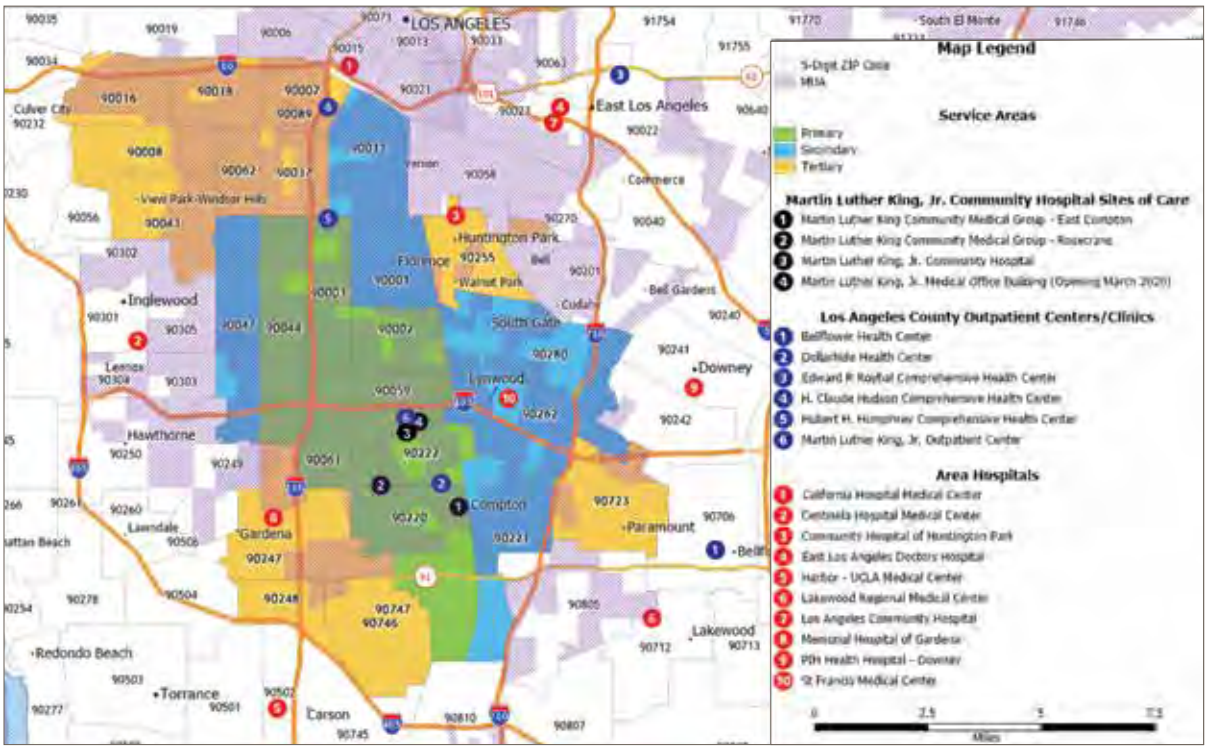
Sections of our service area are designated as either a HPSA, MUA, or both, indicating an insufficient number of primary care providers in the area. Maps illustrating this fact follow.

Health Professional Shortage Area[15]



[15] Source: Martin Luther King, Jr. Community Hospital, Definitive Healthcare, LADPH, HRSA, Maptitude

Medically Underserved Area[15]



Service Area Physicians

When MLK-Harbor closed in 2007, an exodus of primary and specialty care providers followed. Since that time, our community has faced large shortages of providers across all specialties —making timely access to high quality and affordable healthcare even more difficult for a community already underserved. MLKCH completed a study in early 2020 to identify physician need in our community and substantiate an investment in physician workforce recruitment across multiple specialties. This analysis revealed a severe shortage in all specialties studied. In 2020, the study showed a shortage of over 1,300 full-time equivalent (FTE) physicians trained in primary, and medical and surgical specialties, combined (Table 15). Notably, the largest shortages were found to exist in the primary care specialties of family practice, internal medicine, and pediatrics—specialties that are critical for effective care coordination and managing the health and wellness of our community.

Table 15. Physician Supply and Need, 2020[16]

Physician Specialty	Total Existing FTE Supply	Estimated Area Physician Need	Estimated Net (Need)/Supply
Primary Care	**435.2**	**1,139.3**	**(704.1)**
Family Practice	190.4	369.3	(178.9)
Internal Medicine	119.0	422.0	(303.0)
Obstetrics and Gynecology	43.4	135.4	(92.0)
Pediatrics	82.5	212.7	(130.2)
Medical Specialty Care	**96.9**	**332.2**	**(235.3)**
Surgical Specialty Care	**80.6**	**447.9**	**(367.3)**
Total Physician Specialties	**612.7**	**1,919.4**	**(1,306.7)**

"The area is a healthcare desert."

– Community Members

Given the fact that Los Angeles County's overall primary and specialty physician supply is within the Council of Graduate Education's recommended guidelines, it is clear there is wide maldistribution of physicians, and access to these providers is not equitable in our service area. To address these challenges, MLKCH formed the Martin Luther King, Jr. Community Medical Group (MLK CMG) to help recruit physicians to our community, and provide an infrastructure that will allow these physicians to maintain sustainable practices, treating our patients for years to come.

Medical Home and Usual Source of Care

Having a medical home and a usual source of care is an important contributor to health and well-being, since these resources can enhance access to primary preventative care, alleviate health issues during a medical event, and improve overall continuity of care.

Specific to the MLKCH community:

- While 94.0% of children ages 0-17 years reported a regular source of care, only 76.9% of adults age 18-64 years were able to report the same for either preventive primary care or to address medical concerns during a specific event and/or period of time (Table 16).
- The percentage of people who reported access to a usual source of care was lower than Los Angeles County overall.

[16] Source: MLKCH Physician Needs Analysis completed by Premier, March, 2020

Table 16. Access to a Usual Source of Care[4]

Population Group	% MLKCH Community	% SPA 6	% Los Angeles County
Children ages 0-17 years with a regular source of health care	94.0	93.0	95.6
Adults 18-64 years with a regular source of health care	76.9	75.1	80.1

Within the MLKCH service area, community or government clinics or hospitals were the most frequently identified source of care (39.7%) (Table 17). Further, there is still a sizable portion of residents who do not have a usual source of care in our community at all (20.5%). When access through a usual source of care is examined by race/ethnicity, Hispanics are the least likely to have a usual source of care. This is a key factor since this ethnic cohort represents 72.2% of our community's population.

Table 17. MLKCH Community Common Sources of Care, by Race/Ethnicity[3]

Source of Care	% All Adults	% Hispanic	% African American	% Asian	% White
Dr. Office/HMO/Kaiser	36.6	14.5	16.6	2.2	3.0
Community Clinic/ Government Clinic/ Community Hospital	39.7	31.3	6.5	0.7	1.0
Emergency Room/Urgent Care	2.9	1.6	1.1	0.1	0.1
Other	0.3	—	—	—	—
No Usual Source of Care	20.5	16.7	1.8	0.5	1.5

Note: — indicates data not available.

"There is a longitudinal relationship to care—once patients get connected to good care, the longer they stay and the more they gain."

—Community Members

Delayed Care

Medically underserved and socioeconomically challenged communities tend to delay necessary care due to cost, lack of insurance, inability to get to a provider because of work or childcare obligations, and transportation challenges. Over the short-term, delays in care can negatively impact health; over the long-term, delays in care can lead to higher costs of care and worsening health status, including the potential of death.

A higher proportion of our community delayed or did not get medical care (16.2%) when compared to the County (14.2%) (Table 18). Rationale for this is largely attributed to cost

of care, lack of insurance, limited access, and transportation challenges. These statistics are indicative of the socioeconomic challenges faced by our community, including lower household incomes and higher rates of poverty and unemployment.

Table 18. Delayed Care[3]

Type of Care Delayed	% MLKCH Community	% SPA 6	% Los Angeles County
Delayed or Did Not Get Medical Care in Past 12 Months	16.2	14.3	14.2
Delayed Care Due to Cost or Lack of Insurance	93.5	88.0	93.8
Delayed / Did Not Get Prescription Meds in Past 12 Months	15.9	14.5	10.1

"It's the wealthy that have access to medical care."

—Community Member

Access to Community Health Centers

Despite the numerous community health centers in our service area, there are still a large number of low-income residents that cannot access timely care at these centers due to long wait times, and many still need a medical home. Based upon data reported by the California Office of Statewide Health Planning and Development (OSHPD), our community has more clinics (4.51 clinics per 100,000 population) compared to the County overall (3.35 clinics per 100,000 population). Key use statistics are noted as follows:

- The average number of patients served per clinic in our area (5,805) is higher compared to the County (5,087). This reinforces reported data indicating that clinics serve as a common source of care for our community (Table 19).
- Clinics in our community reported higher average patient visits per site (20,059) than the County (16,598). Again, this is related to the fact that over one-third of our population uses clinics as their usual source of care. As a result, capacity at these clinics is limited. This often results in long wait times for a patient appointment or a specialist referral. These delays in care can lead to higher overall treatment costs and worse health outcomes, particularly for our community members with chronic or acute conditions.

Table 19. Primary Care Clinic Annual Utilization[17]

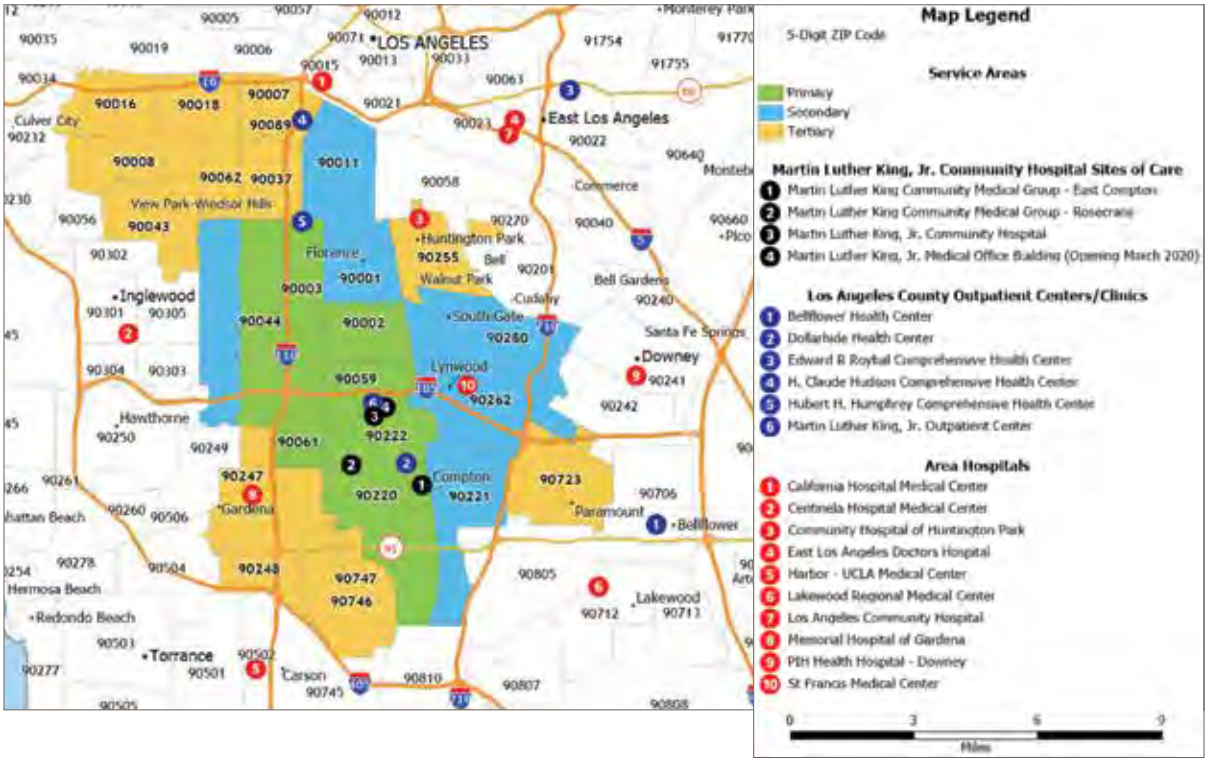
Community Clinic Type	MLKCH Community	Los Angeles County
FQHC	43	227
FQHC Look-Alike	7	19
Other	11	95
Total Clinics	**61**	**341**
Clinics per 100,000 Population	**4.51**	**3.35**
Average Patients per Clinic	5,805	5,087
Average Number of Encounters per Clinic	20,059	16,598

Inpatient and Emergency Department

According to the California Department of Public Health's (CDPH) Licensing and Certification Program, there are approximately 93 general acute care hospitals in Los Angeles County. Only four are located in our community: MLKCH, St. Francis Medical Center, Community Hospital of Huntington Park, and Memorial Hospital of Gardena. Collectively, these four hospitals represent 768 inpatient licensed beds.

[17] Source: Primary Care Clinic Annual Utilization Data, 2018. Office of Statewide Health Planning and Development, (OSHPD) Primary Care Clinic Annual Utilization Report. *https://data.chhs.ca.gov/dataset/primary-care-clinic-annual-utilization-data*

Service Area Overview



According to OSHPD, SPA 6 had the lowest number of licensed hospital beds per 100,000 population in all of the County (Table 20). In comparison, SPA 4 (Metro LA) with a slightly less population had over eight times more licensed beds. Even after MLKCH opened in 2015, OSHPD records show that many of our community's patients have to leave the community for inpatient care—largely because our community does not have the inpatient capacity and resources to adequately provide many of the specialty care programs that are critically needed by our patients. These specialty services include:

- Interventional Cardiology: cardiac catheterizations, pacemakers, and electrophysiology procedures
- Gastroenterology: endoscopic retrograde cholangiopancreatography (ERCP), and outpatient colonoscopies and endoscopies
- Interventional Radiology: Uterine artery embolization, peripheral vascular disease, permanent dialysis access, and abscess drainage
- Urology and uro-gynecology procedures

Table 20. Licensed Hospital Beds per 100,000 population, 2017[18]

Hospital Service Planning Area (SPA)	Licensed Acute Care Beds per 100,000 Population
SPA 1: Antelope Valley	154.5
SPA 2: San Fernando Valley	222.1
SPA 3: San Gabriel Valley	221.7
SPA 4: Metro LA	538.5
SPA 5: West	275.5
SPA 6: South	67.2
SPA 7: East	218.8
SPA 8: South Bay	285.6
Total	**252.3**

In addition to inpatient licensed beds, SPA 6 also has the lowest number of ED treatment stations per 100,000 population (7.3) and higher use rates compared to other SPAs located in Los Angeles County (SPA 4 with 37.3 stations per 100,000 population—the highest of all SPAs), and the County overall (20.1) (Table 21). Specifically:

- Our community demonstrated higher acuity ED visits overall compared to ED use for Los Angeles County overall.
- A higher percentage of residents age 0-17 (36.4%) and 18-64 (26.4%) visited an ER within a 12-month period, higher than County levels (19.6% and 22.6%, respectively) (Table 22).

These trends are due to the shortage of healthcare providers in our community and because access to primary care is frequently sought on an episodic or emergent basis, EDs are often overcrowded, and patients experience long wait times before they are able to be treated. In 2019, MLKCH's ED treated 102,136 across our 29 treatment stations (3,500 visits per station). This volume is nearly double when compared to industry performance standards (1,800–2,000 visits per station), and we know there are patients that are still not receiving the care they need and deserve.

[18] Source: Hospital Annual Utilization Report, 2017. Office of Statewide Health Planning and Development, Accounting and Reporting Systems Section. *https://data.chhs.ca.gov/dataset/hospital-annual-utilization-report*

Table 21. Use of Emergency Room, 2017, by Visit Type[19]

Visit Type	SPA 6	Total SPAs 1-8
Patient Treatment Stations – Total	75	2,013
Patient Treatment Stations – Per 100,000 Population	7.3	20.1
ED Visits per Treatment Station	2,217	1,937
Total ED Visits, by SPA Hospitals	123,408	12,996,560
% Minor (CPT 99281)	2.8	5.6
% Low / Moderate (CPT 99282)	6.0	16.1
% Moderate (CPT 99283)	38.3	40.3
% Severe Without Life Threat (CPT 99284)	34.5	26.4
% Severe With Life Threat (CPT 99285)	18.4	11.6

Table 22. Use of Emergency Room, by Population Group[3]

Population Group	% MLKCH Community	% SPA 6	% Los Angeles County
0-17 Years Old	36.4	36.5	19.6
18-64 Years Old	26.4	26.2	22.6
65 and Older	18.8	23.2	19.7
<100% of Poverty Level	31.8	29.7	29.6
<200% of Poverty Level	27.7	29.1	25.1

"It's not that patients don't understand the difference between the ER and a PCP doctor, instead they're not getting the proper care they need from their PCP…they [the PCP] aren't managing their diseases."

—Community Members

[19] Source: Emergency Department Services Trends, 2013-2017. Office of Statewide Health Planning and Development, Healthcare Analytics Branch. *https://data.chhs.ca.gov/dataset/emergency-department-services-trends*

Trauma Services

Our community has a disproportionate share of crime and violence. St. Francis Medical Center is the only trauma center located in SPA 6, serving a large portion of our community's patients requiring this level of care. Of note, Prime Healthcare received US Bankruptcy Court Approval to purchase St. Francis Medical Center on April 9, 2020; the future of this facility's trauma program is unknown, although it is a much-needed service in our community. Additional trauma centers located adjacent to our SPA include the following:

Facility	Trauma Designation
California Hospital Medical Center	Level II Trauma Center
Harbor-UCLA Medical Center	Level I Trauma Center
Long Beach Memorial Medical Center	Level II Trauma Center
Los Angeles County-USC Medical Center	Level I Trauma Center

Our local Emergency Medical Services teams work closely with trauma designated facilities to ensure timely transport of our patients needing immediate care for serious bodily injuries such as car accidents, shootings, stabbings, etc., and MLKCH maintains transfer agreements with each of these hospitals.

Potentially Preventable Hospitalizations

Potentially preventable hospitalizations are defined by the Agency for Health Care Research and Quality (AHRQ) as "hospital inpatient admissions that are likely avoidable through effective chronic care management and access to high quality, primary care in the ambulatory setting." AHRQ developed indicators referred to as ambulatory sensitive conditions to reflect whether there is sufficient access to primary care within a community. For all indicators, with the exception of the Prevention Quality Diabetes Composite, the Los Angeles County risk-adjusted rate is higher than the State (Table 23). This data is reported at the County-level and is not available for our community and/or SPA 6. Given the significant shortage of primary care providers in our community, however, it is likely that our outcomes are worse than Los Angeles County overall.

Table 23. Risk-Adjusted Rates for Potentially Preventable Hospitalizations, 2018[20]

Ambulatory Sensitive Conditions	Los Angeles County Risk-Adjusted Rate	State of California Risk-Adjusted Rate
Diabetes Short-term Complications	52.6	58.1
Diabetes Long-term Complications	89.7	88.4
COPD or Asthma in Older Adults (40+)	236.2	229.0
Hypertension	47.6	41.5
Heart Failure	344.7	335.4
Community-Acquired Pneumonia	105.1	107.0
Urinary Tract Infection	103.8	93.3
Uncontrolled Diabetes	35.1	30.3
Asthma in Younger Adults (Age 18-39)	18.7	18.5
Lower-Extremity Amputation (Diabetes)	20.7	25.9
Prevention Quality Overall Composite	953.9	919.6
Prevention Quality Acute Composite	209.9	200.3
Prevention Quality Chronic Composite	740.5	718.3
Prevention Quality Diabetes Composite	187.6	189.8

"More inpatient beds aren't needed, outpatient services are."

—Community Members

[20] Source: Rates of Preventable Hospitalizations for Selected Medical Conditions by County, 2018. Office of Statewide Health Planning and Development, Healthcare Analytics Branch, Administrative Data Group. *https://data.chhs.ca.gov/dataset/rates-of-preventable-hospitalizations-for-selected-medical-conditions-by-county*

Post-Acute Care Providers

Accessing high quality, post-acute care services, including skilled nursing, home health, rehabilitation services, and sub-acute care services, is a challenge in our community. Medicare is the primary payer for the four traditional post-acute care settings: long-term acute care hospitals, inpatient rehabilitation facilities, skilled nursing facilities (SNFs), and home health agencies. Medicare represents a smaller portion of the patients treated at MLKCH (9.2%), with a much larger portion covered by Medi-Cal (75.0%). Medi-Cal, the payer with the largest number of enrollees in our community, pays some of the lowest rates for post-acute care services. As a result,

- Low Med-Cal reimbursement rates for short- and long-term SNF care and sub-acute care limit skilled nursing options for our Medi-Cal beneficiaries.
- Higher reimbursement for short-term Medicare patients has shifted SNF practice toward this population, further limiting the number of placement options for Medi-Cal patients.
- Patients with behavioral difficulties (e.g., mental illness, traumatic brain injuries, dementia, substance users) are often covered by Medi-Cal and are difficult to place and manage in a SNF.[21]
- Our patients often return to their home with little to no post-acute care and rely on their social and familial support systems for assistance.

The national movement towards payment for quality and not volume has generated improved partnerships between acute and post-acute facilities. This has resulted in improved quality in SNFs across the country and locally. While the 'CMS Quality Star Ratings' may vary over the quarterly reporting periods, there is a larger number of SNFs reported to be of higher quality (ratings of 3-5 stars) located within the MLKCH community (Table 24).

Table 24. Skilled Nursing Facility (SNF) Count, by CMS Quality Star Rating[22]

Cities	1 Star (Low Score)	2 Stars	3 Stars	4 Stars	5 Stars (High Score)	Total SNFs
Compton	0	0	0	1	0	7
Gardena	0	0	0	0	7	7
Huntington Park	0	0	0	0	1	1
Los Angeles	0	1	3	3	10	17
Lynwood	0	0	0	1	3	4
Paramount	0	0	0	1	2	3
South Gate	0	0	0	0	1	1
MLKCH Community	**0**	**1**	**3**	**6**	**24**	**34**
Los Angeles County	**0**	**11**	**30**	**81**	**250**	**380**

[21] Source: Addressing San Francisco's Vulnerable Post-Acute Care Patients." 2018. Hospital Council of Northern & Central California. *https://www.sfdph.org/dph/hc/HCAgen/HCAgen2018/April%203/PACC%20FINAL%20REPORT%203-1-18%20(1).pdf*

[22] Source: Nursing Home Compare, Accessed November 15, 2019. CMS

Our Community's Health Status

Overview

Given our community's ethnic composition and a longstanding history of limited access to healthcare providers and widespread social and environmental challenges, it is not surprising that great opportunities continue to exist to build health equity and improve the overall health status of our community. In comparison to County, State, and national trends, our community's health, and the degree to which our residents engage in healthy behaviors, is rated far worse for almost all key metrics. Even our community recognizes their own health challenges—30.1% of our residents have rated their health as either fair or poor (Table 25).3 Our mission to improve the health of our community combined with our continued desire to collaborate with our community partners will help to position us to address the unmet healthcare needs of our community and improve overall health outcomes.

Table 25. Self-Reported Health Status[3]

Condition	MLKCH Community	SPA 6	Los Angeles County
% of adults reporting their health to be fair or poor	30.1	32.5	21.5
Average number of days in past month adults reported regular daily activities were limited due to poor physical/mental health	3.3	3.5	2.7

In this community there are "…issues that are seen in developing countries."

—Community Member

Chronic Disease

Chronic diseases are the leading cause of death and disability in the United States and drivers of the nation's $3.5 trillion in annual health care costs.[23] The Center for Disease Control and Prevention (CDC) estimates that 6 in 10 adults in the United States has at least one chronic disease and 4 in 10 have two or more chronic conditions.[24] These chronic conditions can be disabling and reduce a person's quality of life, especially if left undiagnosed or unmanaged. Fortunately, many chronic diseases can be prevented or minimized through simple lifestyle changes. The CDC has identified four lifestyle risk factors that increase risk for chronic conditions: (1) tobacco use, (2) poor nutrition, (3) lack of physical activity, and (4) excessive alcohol use.

[23] Source: The Center for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. *https://www.cdc.gov/chronicdisease/about/index.htm*

[24] Source: The Center for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. *https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm*

Additionally, research completed by the CDC's Racial and Ethnic Approaches to Community Health (REACH) concluded that chronic conditions and their risk factors can be more common and severe for racial and ethnic minority groups than for non-Hispanic whites. These health disparities are caused by complex factors such as differences in income, education, community conditions, and access to health care. Specific to chronic conditions:[25]

- Non-Hispanic African Americans are 45% more likely than non-Hispanic whites to have high blood pressure, and they are less likely to have this condition under control.
- Hispanic adults are 20% more likely to be obese than non-Hispanic whites.
- Hispanic adults (19.8%) and non-Hispanic black adults (17.9%) were more likely to have diabetes compared to non-Hispanic white adults (12.4%).
- Hispanics are more likely to develop asthma, cancer, chronic obstructive pulmonary disease, heart disease, HIV, and liver disease compared to non-Hispanic whites, and this ethnic cohort also displays higher rates of stroke. Additionally, when compared to non-Hispanic white children, Latino children are more likely to suffer from infant mortality, asthma, obesity, and depression.[26]
- Non-Hispanic African Americans tend to have higher mortality rates for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide compared to non-Hispanic whites.[27]
- Life expectancy for non-Hispanic African Americans is 74.9 years compared to 78.8 years for non-Hispanic whites.[28]

Racial and ethnic minority populations often receive poorer quality of care and face more barriers in seeking care, including preventive care and chronic disease management, than do non-Hispanic whites. These disparities can lead to poor health outcomes and higher health care costs. Our community consistently has a higher prevalence of chronic diseases than the County for children's asthma, adult diabetes, adult heart disease and adult high blood pressure (Table 25). These trends are largely driven by environmental and behavioral factors prevalent in our community—including exposure to environmental toxins, lack of healthy food options, an absence of green space for physical activity, and an abundance of opportunities to consume unhealthy food and alcohol.

---

[25] Source: The Center for Disease Control and Prevention. Racial and Ethnic Approaches to Community Health (REACH) Fact Sheet. October 2017. *https://www.cdc.gov/nccdphp/dnpao/state-local-programs/reach/pdf/REACH-overview-2017-508.pdf*

[26] Source: US Department of Health and Human Services Office of Minority Health. Hispanic/Latino Americans Profile. *https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=64*

[27] Source: US Department of Health and Human Services Office of Minority Health. Black/African Americans Profile. *https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=61*

[28] Source: National Vital Statistics Report, 2017. Volume 68, Number 7. Published June 24, 2019.

Table 25. Chronic Disease Conditions[3]

Condition	% MLKCH Community	% SPA 6	% Los Angeles County
Children ages 0-17 years with current asthma[4]	7.8	8.2	7.1
Adults who have been told by a doctor that they have asthma	12.1	14.5	14.0
Adults who have been told by a doctor they have diabetes	15.9	16.6	11.2
Adults who have been told by a doctor they have any kind of heart disease	6.9	7.4	6.1
Adults who have been told by a doctor they have high blood pressure	35.6	39.5	30.7

"Change comes from the heart and we need to tell people the truth about what's harming their health."

—Community Member

Mortality and Leading Causes of Death

The MLKCH community has higher mortality rates for almost all leading causes of death compared to Los Angeles County overall (Table 26). This further demonstrates our community's need for access to coordinated, high quality preventative and specialty healthcare services.

Table 26. Death Rates and Years of Potential Life Lost per 100,000 Persons[29]

Rates per 100,000 Population	MLKCH Community	SPA 6	Los Angeles County
Coronary heart disease-specific death rate	121.8	127.4	102.9
Stroke-specific death rate	44.4	47.8	35.0
Diabetes-specific death rate	40.2	43.7	24.7
Alzheimer's disease-specific death rate	32.0	32.2	38.7
COPD specific death rate	29.6	32.0	27.6
Lung cancer-specific death rate	24.5	26.0	24.0
Breast cancer-specific death rate among females	21.3	22.5	19.4
Liver disease-specific death rate	18.3	17.8	12.5
Colorectal cancer-specific death rate	15.8	16.3	13.4
Premature death rate due to suicide in total Years of Potential Life Lost (YPLL)	192	198	247
Premature death rate due to homicide in total YPLL	580	647	238
Premature death rate due to motor vehicle crashes in total YPLL	326	366	246
Premature death rate due to drug overdose in total YPLL per 100,000 population	285	306	263

[29] Source: Los Angeles County Department of Public Health, Los Angeles County Department of Public Health, LA County Linked Death Data. Prepared January 2020.

Community Inpatient Hospitalization Rates

Medically underserved and socioeconomically challenged communities like ours tend to have higher rates of hospitalizations because these communities are often unable to receive care at the most appropriate time in the most appropriate setting, leading to delays in care and declining health conditions. Table 27 below compares all inpatient hospital admissions for residents across three geographies: MLKCH community, SPA 6, and Los Angeles County. The inpatient admission rate per 100,000 in the MLKCH community (11,540) is higher when compared to the County (9,932). Admissions through the ED per 100,000 are also higher in our area (42,087) than the County (30,799). Further, admissions for all conditions documented below are higher in our area than the County except for cancer, alcohol and drugs, and falls.

Table 27. Inpatient Hospitalization Rates by Primary Diagnosis, 2018[30]

Rate per 100,000 population	MLKCH Community	SPA 6	Los Angeles County
Inpatient Admissions Rate	11,540	12,859	9,932
ED Admissions	42,087	47,282	30,799
Admission Rate for Asthma (MS-DRG 202-203)	375.89	419.53	271.86
Admission Rate for Diabetes (MS-DRG 637-639)	509.54	578.13	319.72
Admission Rate for Heart Disease (MS-DRG 291-293)	1,154.71	1,295.63	781.34
Inpatient Admissions for High Blood Pressure	172.65	198.25	107.28
Inpatient Admissions for COPD (MS-DRG 190-192)	406.25	469.39	294.30
Inpatient Admissions for Stroke (MS-DRG 61-68)	522.39	581.63	448.68
Inpatient Admissions for Cancer	552.98	598.25	556.75
Inpatient Admissions for Alcohol & Drugs (MS-DRG 894-897)	285.91	333.82	356.49
Inpatient Admissions for Psychiatric (MS-DRG 880-887)	2,106.63	2,434.40	1,825.31
Inpatient Admissions for Falls, (ICD-10 Z91.81)	408.91	416.03	458.61

[30] Source: Hospital Association of Southern CA Custom Report, 2018. Office of Statewide Health Planning and Development.

MLKCH Emergency Department and Inpatient Hospitalization Trends

Table 28 below shows MLKCH's own ED and inpatient hospitalization trends over calendar year 2019. Many of our ED visits and inpatient hospitalizations are attributed to chronic conditions that could have been managed in an ambulatory setting if our patients had adequate access to primary care; a portion of this ED use could have been avoided completely had our residents not been faced with the social, environmental, and access to care challenges that exist in our community today.

Table 28. MLKCH Top Diagnoses for Calendar Year 2019[1]

Emergency/Observation	Inpatient Discharge Diagnosis
1. Primary hypertension	1. Primary hypertension
2. Nicotine dependence	2. Nicotine dependence
3. Asthma	3. Acute kidney failure
4. Type 2 diabetes mellitus	4. Type 2 diabetes mellitus
5. Chest pain	5. Hypertensive heart disease with heart failure

Maternal and Child Health

A mother's health status and behaviors during pregnancy can have a direct and long-lasting impact on health and well-being outcomes for both herself and her child. For this reason, nutrition, vitamins, and early and regular prenatal care are important. Racial disparities in risk factors related to pregnancy, such as hypertension, anemia, and gestational diabetes exist, particularly for African American women. This challenge is further exacerbated by inequalities in our healthcare system and the fact that many African American women do not have adequate access to prenatal care and healthcare in general. According to the CDC:[31]

- African Americans have 2.3 times the infant mortality rate of non-Hispanic whites.
- African American infants are 3.8 times as likely to die from complications related to low birthweight compared to non-Hispanic white infants.
- African Americans had over twice the sudden infant death syndrome mortality rate as non-Hispanic whites, in 2017.
- In 2017, African American mothers were 2.3 times more likely than non-Hispanic white mothers to receive late or no prenatal care.

Our community's maternal and child health status outcomes are indicative of the challenges faced by women in our service area. Because our patients experience limited access to providers, it is not surprising that a lower portion of our pregnant mothers receive timely prenatal care (79.2%) when compared to the County (83.5%) (Table 29). This results in a higher rate of premature and low birth weight babies, of which a portion will experience developmental delays throughout childhood.

[31] Source: CDC 2019. Infant Mortality Statistics from the 2017 Period Linked Birth/Infant Death Data Set. National Vital Statistics Reports. Table 2. *https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_10-508.pdf*

Table 29. Maternal Health Indicators[32]

Indicator	MLKCH Community	SPA 6	Los Angeles County
Rate of births (per 1,000 females) to teens ages 15-19	—	26.9	13.5
Percent of Mothers receiving prenatal care during 1st trimester	79.2%	78.5%	83.5%
Percent of low birth weight (<2,500 grams) births (per 100 live births	8.4%	8.6%	7.3%
Infant death rate (per 1,000 live births)	6.0	6.4	4.0
Percent of children ages 0-2 years who were exclusively breastfed for at least 3 months	—	28.8%	43.2%

Note: — indicates data not available.

High rates of obesity exist in our service area, a trend fueled by our community's social and environmental challenges. Obese pregnant women are at a higher risk to develop pre-eclampsia, hypertension, and gestational diabetes, and they are more likely to need cesarean sections with higher rates of complications from the surgery, including infections, hernias, and internal bleeding. Obese mothers also tend to have larger babies (e.g., nine pounds or greater), with higher rates of birth complications, including:

- Neural tube defects such as spina bifida
- Cardiovascular defects
- Cleft lip and cleft palates
- Hydrocephaly
- Limb reduction abnormalities
- Shoulder dystocia, which can lead to permanent fetal injury during birth, neurological disorders, and even death

[32] Source: Los Angeles County Department of Public Health, Birth Master File. Prepared January 2020.

Sexually Transmitted Infections

The MLKCH community reports a higher number of annual new cases of syphilis, gonorrhea, and chlamydia compared to the County (Table 30). Minority populations face an inequitable burden of sexually transmitted diseases (STDs) for chlamydia, gonorrhea, and syphilis. These disparities are the result of a long history of systemic, societal, and cultural barriers to STD diagnoses, treatment, and preventive services in our community. Further, many of our community members lack the basic education necessary to understand that these infections can spread easily.

Table 30. Sexually Transmitted Infections[33]

Sexually Transmitted Infections	MLKCH Community	SPA 6	Los Angeles County
Annual new cases of HIV (per 100,000 population) among persons aged 13+[34]	30.7	33.8	20.4
Annual new cases of primary or secondary syphilis (per 100,000 population)	22.2	23.4	17.7
Annual new cases of gonorrhea (per 100,000 population)	324.0	360.8	215.8
Annual new cases of chlamydia (per 100,000 population)	827.2	887.7	572.4

[33] Source: Los Angeles County Department of Public Health, Division of HIV and STD programs. STD Surveillance Database, prepared January 2020.

[34] Source: Los Angeles County Department of Public Health, Division of HIV and STD programs. HIV Surveillance System, prepared January 2020.

Our Community's Health Behaviors & Preventive Screenings

Overview

Studies have found that communities with the highest obesity rates and unhealthy behaviors are those that are socioeconomically disadvantaged, often lacking in basic resources such as access to healthy food, safe places to exercise, and the overall standard of care that they need to be healthy. Research has proven that obesity and chronic disease is especially widespread among Americans with low levels of education and high rates of poverty—all challenges that we have found to exist on a large scale throughout our community. Based upon the County Health Rankings 2020 Report, Los Angeles County ranked 32 of 58 counties across the State for 'Health Factors' that included four major health indicators: adult smoking, excessive drinking, adult obesity, and physical inactivity. Further, underserved communities tend to have less access to preventative care, largely driven by socioeconomic challenges and inadequate access to services available. For many metrics, we are far below County and State averages, suggesting great opportunity to positively affect change in the overall health and quality of life in our community.

"Prevention is important, we often work in crisis mode and need to focus more on preventative measures."

—Community Member

Dental Care

One in ten children in our community were reported as having never been to a dentist (Table 31). In the past year, 45.2% of adults in our community had been to the dentist compared to 59.3% in the County who had been to the dentist during this same time period. Historically, Medi-Cal, which covers the largest portion of our population, has not offered rich benefits for dental services, and the State will periodically limit benefits and even exclude adults from this coverage due to budget limitations. Research published by the Mayo Clinic[35] shows that poor oral health impacts physical health by contributing to the following diseases and conditions:

- Endocarditis
- Cardiovascular disease
- Pneumonia
- Premature births during pregnancy and low birth weight babies

[35] Source: Oral health: A window to your overall health. June 4, 2019. Mayo Clinic. *https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475.*

Table 31. Dental Care Trends[3]

Trend	% MLKCH Community	% SPA 6	% Los Angeles County
Adults who did not see a dentist or go to a dental clinic in the past 12 months[4]	54.8	56.9	40.7
Children ages 3-17 years who did not obtain dental care in the past 12 months[4]	11.3	9.5	8.9
Children whose last visit to the dentist was less than 6 months ago	63.1	49.6	72.3
Children whose last visit to the dentist was 6 months to 1 year ago	26.9	33.5	8.8
Children who never visited the dentist	10.0	16.9	17.6

Vaccinations

Given the challenges our community experiences accessing much needed medical and dental care, it is not surprising that many of our residents go without primary preventive care such as vaccinations. Specifically, children and adults in our community have lower rates of receiving flu vaccinations compared to Los Angeles County (Table 32). This can result in higher rates of inpatient hospitalizations, flu infections, and even death if infections remain untreated or if medical care is delayed.

Table 32. Flu Vaccinations[4]

Population	% MLKCH Community	% SPA 6	% Los Angeles County
Children ages 6 months - 17 years vaccinated for influenza	56.7	57.3	59.9
Adults vaccinated for influenza	42.8	40.5	47.1

Four school districts support our community—Compton Unified School District, Los Angeles Unified School District, Lynwood Unified School District, and Paramount Unified School District. Of the four, the Paramount Unified School District had the lowest student immunization compliance at 90.9% of children entering kindergarten; this rate is below the County average (Table 33). The Compton school district stands out as a high performer.

Table 33. Up-to-Date Immunization Rates of Children Entering Kindergarten, 2018-2019[36]

School District	2018-2019 % Immunization Percent
Compton Unified School District	94.7
Los Angeles Unified School District	94.3
Lynwood Unified School District	93.0
Paramount Unified School District	90.9
Los Angeles County	**94.1**

Mammograms and Pap Smears

Clinical guidelines recommend annual mammograms and breast exams for women age 40 years and older, and annual cervical cancer screenings (e.g., Pap Test) for women age 21 years or older. The percentage of women receiving mammograms and pap smears is relatively similar to published results for SPA 6 and Los Angeles County (Table 34). However, despite these similarities, great opportunity exists to expand access to preventative screenings in our community—leading to early detection, treatment, and better health outcomes. For example:

- Overall breast cancer incidence is slightly lower among African American women compared to white women. However, breast cancer mortality is higher in African American women compared to white women. Research indicates that African American women may have delays in follow-up after an abnormal mammogram than white women.
- Hispanic women tend to have lower rates of breast cancer screening compared to non-Hispanic women, largely attributed to access challenges for this patient population. As a result, these women tend to be diagnosed with more advanced breast cancers than non-Hispanic women due to lower mammography rates and more delays in follow-up after an abnormal mammogram.

Table 34. Percentage of Women Receiving Mammograms and Pap Smears[4]

Population	% MLKCH Community	% SPA 6	% Los Angeles County
Women ages 21–65 years who had a pap smear within the past 3 years	83.2	82.4	81.4
Women ages 50–74 years who had a mammogram within the past 2 years	74.6	75.3	77.0

[36] Source: Kindergarten School Reporting Data, 2018-2019. California Department of Public Health, Immunization Branch. *https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/immunize.aspx*

[37] Source: Susan G. Komen Foundation. *https://ww5.komen.org/BreastCancer/RacialEthnicIssuesinScreening.html*

[38] Source: Susan G. Komen Foundation. *https://ww5.komen.org/BreastCancer/RacialEthnicIssuesinScreening.html*

Factors that contribute to lower screening rates in our community include:

- Low-income or worry about cost
- Lack of access to care or lack of a conveniently local mammography center
- Lack of transportation
- Lack of awareness of breast or cervical cancer risks and screening methods
- Lack of childcare
- Lack of sick leave or inability to miss work
- Cultural and language differences

Overweight and Obesity Prevalence

The CDC found that more than one-third of our nation's adults are obese, and the associated medical costs our system incurs for these patients is approximately $147 billion per year. Obese adults are at a higher risk for chronic diseases such as diabetes, heart disease, cancers, and stroke.[39] Socioeconomic issues are tied to obesity and health behaviors.

- Our community has more overweight and obese children and teens compared to the County (Table 35).
- African Americans and Hispanics/Latinos have the highest rates of overweight and obese adults in our community and significantly exceed the County rates (Table 36). When combined, these two population cohorts represent 93% of our service area population.

Table 35. Overweight and Obesity[3]

Population Cohort	% MLK Community	% SPA 6	% Los Angeles County
Children overweight for age	17.9	7.6	11.1
Teens that have an overweight BMI	26.4	—	18.2
Teens that have an obese BMI	39.7	38.9	34.0

Note: — indicates data not available.

[39] Source: The Center for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. *https://www.cdc.gov/chronicdisease/about/costs/index.htm*

Table 36. Adults, Overweight or Obesity by Race/Ethnicity[3]

Ethnic Cohort	% MLK Community	% SPA 6	% Los Angeles County
Hispanic/Latino	50.6	46.8	32.7
African American Non-Hispanic (NH)	17.6	19.7	5.6
White NH	5.2	4.8	16.7
Asian NH	1.7	1.3	6.9
American Indian/Alaskan Native NH	0.1	—	0.2
Native Hawaiian/Pacific Islander NH	—	—	0.1
Other/Multiple NH	—	—	0.5

Note: — indicates data not available.

Physical Fitness

The physical fitness test for students in California schools is the FitnessGram®, of which body composition is one of the components measured. Children who do not meet the "Healthy Fitness Zone" criteria for body composition are categorized as needing improvement or at health risk (overweight/obese).

- In Compton Unified School District, 33.7% of 5th graders and 30.8% of 9th graders tested as needing improvement or at health risk (Table 37).
- The other three school districts serving our community, Los Angeles, Lynwood, and Paramount performed at about the same level; 30% of 5th graders tested as needing improvement or at health risk and 22-26% of 9th graders tested as needing improvement or at health risk.
- All four school districts were worse when compared to the County.

Table 37. 5th and 9th Graders, Body Composition, Needs Improvement + Health Risk[40]

School District	% Fifth Grade	% Ninth Grade
Compton Unified School District	33.7	30.8
Los Angeles Unified School District	30.5	26.5
Lynwood Unified School District	30.0	22.3
Paramount Unified School District	30.9	23.8
Los Angeles County	**25.4**	**21.0**

[40] Source: California Department of Education, Fitnessgram Physical Fitness Testing Results, 2018-2019. *https://data1.cde.ca.gov/dataquest/page2.asp?Level=District&submit1=Submit&Subject=FitTest*

Physical Activity

As mentioned in the Access to Green Space, and Growing Needs for Parks and Recreation Resources section, our community has fewer parks and green space available compared to Los Angeles County. Further, as detailed in the Crime and Violence section of this report, the Los Angeles County 2018 Health Survey noted that only 71.5% of adults believe their neighborhood is safe from crime. Given these limitations and safety concerns, it is understandable that our community did not perform as well as the County for most child, teenage, and adult physical activity metrics (Table 38).

Table 38. Physical Activity[3]

Characteristic	% MLKCH Community	% SPA 6	% Los Angeles County
Children ages 1-17 years who can easily get to a park, playground, or other safe place to play[4]	84.7	82.0	90.4
Children ages 6-17 years who obtain recommended amount of aerobic exercise[4]	14.7	13.7	15.1
Children who spent more than 5 hours on sedentary activities on the weekday	64.3	58.3	72.1
Teens who have been to the park/playground in the past 30 days	51.1	—	50.5
Teens who spent more than 5 hours on sedentary activities on the weekday	—	—	91.9
Adults who use walking paths, parks, playgrounds, or sports fields in their neighborhood[4]	42.5	39.4	47.5
Adults who obtain recommended amount of aerobic exercise[4]	29.7	27.9	35.1

Note: — indicates data not available.

"When there are not workout spaces, some older students and faculty have instead utilized local gym subscriptions because physical activity is so important."

—Community Member

Eating Habits

Good nutrition is part of a healthy lifestyle. Combined with physical activity, diet helps to reach and maintain a healthy weight, reduce risk of chronic diseases, and promote overall health. Children in of our community have higher rates of soda consumption and lower rates of fruit and vegetable consumption compared to the County (Table 39). Portions of our community are identified as food deserts, with limited access to healthy, fresh, and affordable food and an overabundance of fast food available throughout our service area, resulting in unhealthy eating habits by convenience and high rates of overweight and obesity across our population.

Table 39. Nutrition

Metric	% MLKCH Community	% SPA 6	% Los Angeles County
Children who drink at least one soda or sweetened drink a day[4]	49.0	51.6	37.2
Children who have less than 2 servings of fruit per day[3]	48.1	49.0	47.8
Teens who have less than 2 servings of fruit per day[3]	—	—	46.6
Adults who consume five or more servings of fruits & vegetables a day[4]	8.5	8.0	12.1

Note: — indicates data not available.

Mental Health and Substance Abuse

Mental health is a vital aspect of overall health and wellness. Based on Mental Health America's 2020 State of Mental Health Study, more than 10 million Americans report having an unmet need for mental health services, and suicidal tendencies continue to increase. Suicidal thoughts among adults increased from 3.87% in 2012 to 4.2% in 2017. This represents an increase of 10.3 million Americans with serious thoughts of suicide over the five-year period. Additionally, as more Americans are insured, coverage is proving to be more deficient for mental health services. These challenges are further compounded in underserved communities where individuals are faced with financial, social, emotional, and physical disparities. Our community is not unique, and unfortunately our residents continue to experience barriers to mental healthcare access, including:

- Lack of access and a substantial shortage of mental health professionals that practice

in our community

- Cost of care, which can be expensive for short-term services and unaffordable for long-term services
- Low perceived need in which our residents feel as though they can handle the problem without treatment
- A feeling of shame or sense that mental health service use would have a negative effect on relationships and employment

Approximately, 15.7% of community adults were at risk for major depression and 11.4% were likely to have had psychological distress in the last year, both higher when compared to the County (Table 40). Further, the percentage of adults in our community who were seen by a psychiatrist (10.3%) or are taking prescriptions for an emotion problem (8.9%) over the last 12 months is lower when compared to the County. This suggests that our community is vastly underserved for mental health services.

Table 40. Adult Mental Health Indicators[3]

Characteristic	% MLKCH Community	% SPA 6	% Los Angeles County
Adults at risk for major depression[4]	15.7	17.2	13.0
Adults who likely have had psychological distress in the last year	11.4	11.9	11.3
Adults who needed help for emotional/mental or alcohol/drug problem in the past year	22.1	22.1	21.1
Adults who have seen a PCP for mental or alcohol/ drug problem in the past year	9.3	11.1	9.0
Adults who have seen a psychiatrist, etc., for mental or alcohol/drug problems in the past year	10.3	10.9	12.4
Adults who have taken a daily prescription for emotional/personal problem in the past 12 months	8.9	9.5	10.2

"There is still a social stigma related to accessing mental health services within the community."

—Community Member

Tobacco/Alcohol/Drug Use

According to the National Institute on Drug Abuse (NIDA), the Substance Abuse and Mental Health Services Administration (SAMHSA) reports that minority groups or people of color may suffer from substance abuse due to difficulties accessing care; the right kind of care not being available; and environmental, social, and financial concerns may be barriers to treatment. While our community has similar rates of smoking, binge drinking and illegal drug use compared to other communities in Los Angeles County (Table 41), it is likely that our residents do not have the financial resources for formal substance abuse recovery and rehabilitation programs. These populations rely heavily on support from non-drug using family and friends, and they need access to employment, the faith community, and education to reduce and overcome substance abuse.

Table 41. Adult Substance Use3

Metric	% MLKCH Community	% SPA 6	% Los Angeles County
Adults who binge drink4	15.2	16.2	17.9
Adults who smoke cigarettes4	11.3	12.5	11.2
Adults who have ever misused a prescription pain killer	1.3	0.9	1.8
Adults who have used marijuana/hashish > 1 year ago or never used	72.9	71.3	75.8
Adults who have used marijuana/hashish in the past year	27.1	28.7	24.2

Appendix A.
Impact of Evaluation Strategies for Previously Conducted CHNA

MLKCH's previous CHNA was prepared in 2017 and identified these four significant health needs:

1. Access to Preventive, Primary, and Specialty Health Care
2. Maternal and Infant Health
3. Management of Chronic Health Conditions
4. Social Determinants of Health

At that time, MLKCH prepared an associated Implementation Plan, which defined the specific interventions and activities MLKCH would execute to improve the community between 2017-2020. The following section outlines the goals, proposed impact, and details the program and strategies implemented over the last three years. Due to the three-year cycle timing of the CHNA, impact data for Fiscal Year (FY) 2020 was not fully available and is not included.

We are pleased to report the impact of our 2017 action plan:

Access to Preventive, Primary and Specialty Care

Priority Health Need:	Community residents have inadequate access to a broad range of medical and dental services.
Goal:	Increase access to preventive, primary, specialty, and dental health care for medically underserved populations.
Impact:	Improved access to health care providers will help residents prevent and manage their health and health conditions.

Actions:

1. **Action #1: We offered enrollment assistance for health insurance.**
    - MLKCH helps uninsured patients enroll in insurance through MLKCH's dedicated health insurance enrollment program located in a public area of the Hospital.
        - All applications are processed to a financial counselor prior to turning the application over to the onsite Los Angeles County Department of Public Social Services workers.
    - Since 2017, 1,528 uninsured patients were referred for Medi-Cal by MLKCH Financial Counselors with Medi-Cal/Covered California eligibility, and 974 patients were approved for coverage.

- All patients who are registered as uninsured are contacted by a financial counselor whether it be in-person or via phone. All patients admitted to the Hospital are visited in-person by financial counselors, and if they are discharged prior, we contact them by phone to determine if they want to make an in-person appointment to apply for medical or financial assistance.

- MLKCH Financial Counselors identified 8,229 potentially eligible patients and provided information to 1,089 patients who were screened in-person for County programs such as WIC and Every Woman Counts.
  - 27,631 patients were potentially eligible for screening of programs. Of that total, 2,434 patients met with us in-person to be screened. From these screenings, we found that these patients were potentially eligible for 23,057 County programs, and information was provided to these patients on each.

2. **Action #2: We helped community residents connect with healthcare providers and establish medical homes.**

   - Due to the work MLKCH has done to connect patients to medical homes, MLK CMG has grown by 5,046 (unique/unduplicated) new patients, representing an 85% increase in our patient base.
   - Between 2017-2020, MLKCH's Know Your Basics program partnered with the MLK CMG to sponsor 20 health screening events. Collectively, these events reached approximately 6,000 community members, offering health screenings, education, and resource information to direct residents to medical homes in community spaces such as farmers markets, shopping malls, barbershops, and beauty parlors.

3. **Action #3: We supplied transportation assistance to ensure patients could reach their medical providers.**

   - MLKCH and MLK CMG provided transportation to patients who had no other means so that they could attend their scheduled appointments and receive follow-up care.
   - MLKCH provided bus tokens to 162 homeless patients for transportation from November 2018 to October 2019. After that date, MLKCH eliminated tokens for transportation and began distributing Metro TAP cards, providing over 200 TAP cards to date.
   - MLKCH collaborates routinely with our patients' health plans to ensure patient transportation is available for medical appointments and follow-ups, if needed.
   - MLKCH and MLK CMG contracted with Uber Health and other rideshare services to provide 100% of eligible patients free transportation to all medical appointments and services; such health plans include LA Care, Health Net, and Blue Shield.

4. **Action 4: We developed facilities, staffing, and infrastructure to help physicians and dentists establish new practices in South Los Angeles.**

   - MLKCH launched specialty telemedicine access for ED and hospitalized patients. Through this service, we provided 1,886 virtual visits between January 2017 and February 2020; these visits included the following specialties: endocrinology, infectious disease, stroke, and psychiatry.
   - MLK CMG has been actively recruiting additional specialties. We now offer care for 16 different specialties.
   - We are constructing a new medical office building that opened in April 2020. This new facility is projected to serve over 9,700 patients annually; services include pharmacy, ambulatory surgery, wound care, dental services, and a multi-purpose education room, which will be on the medical campus and therefore available for the local community.

5. **Action 5: We provided free and discounted healthcare services through the Hospital's charity care policy.**

   - MLKCH delivered millions of dollars in quantifiable community benefit annually and waives approximately 8% of patient revenue each year through the Charity Care Program.

Maternal and Infant Health

Priority Health Need:	Poor healthcare access and social challenges are associated with a high prevalence of poor birth outcomes.
Goal:	Improve birth outcomes and infant health to decrease premature births and infant mortality, reduce low birth weight and premature births, and increase rates of breastfeeding among new mothers.
Impact:	Decreased premature births and infant mortality, decreased low birth weight and premature births, and an increased rate of breastfeeding among new mothers.

Actions:

1. **Action #1: We expanded the availability of prenatal care, education, and resources for expectant mothers.**

   - Through our partnership with Planned Parenthood, 113 unique patients were treated, and 329 appointments were scheduled by MLK CMG Family Medicine Physicians for prenatal care.
   - In February 2019, MLKCH held three maternal and infant health focus groups to better align our prenatal education and mommy support group content with the needs of the community.
   - By March 2019, MLKCH established two maternal health classes, a support group, and a perinatal class for expectant and new mothers experiencing post-delivery challenges and seeking support.
     - The MLKCH mommy support group expanded due to increased demand for maternal and infant support from attending mothers in the community. Additionally, we increased the frequency of classes provided from twice a month (from March 2019 to December 2019) to weekly beginning in January 2020.
     - Our prenatal class, which is open to the community and is not exclusive to obstetric patients delivering at MLKCH, has been attended by women from multiple area clinics. These women are looking to receive education that they were seeking but otherwise have not received. Because we offer this unique class detailing what they can expect after delivery, the feedback from attendees has all been positive—families stated they felt more prepared for their hospital experience and more empowered and supported, especially with success with breastfeeding. Additionally, we have had women attend our mommy group who have delivered at MLKCH, Kaiser, Miller's Children's and other local area hospitals—all of whom are able to receive continued support that is a necessary part of the pregnancy and postpartum period.

2. **Action #2: We increased access to medical specialists in maternal and infant health.**

   - MLKCH established two new full-time positions to expand the maternal team: a lactation educator and a perinatal educator. These positions allow our perinatal department to expand its patient and community education offerings for new and expectant mothers.
     - These two positions lead our weekly mommy support groups and the monthly education classes so expectant mothers can better understand what happens after delivery.
   - The MLKCH maternal team leads the maternal health classes attended by community members regardless of which hospital they gave birth.
   - MLKCH continues to collaborate with Millers Children's and Women's Hospital for obstetrical and perinatal specialist support and access to medical specialists.
     - MLKCH consistently uses telemedicine for neonatal consultations with Millers Children's and Women's Hospital to expand access to this service.
     - Over the 2017-2020 period, MLKCH transferred 250 neonatal and maternal high-risk patients to Millers Children's and Women's Hospital when it was medically necessary.

3. **Action #3: We are preparing to achieve Baby Friendly accreditation from the World Health Organization by the end of calendar year 2020.**

   - The Baby Friendly Hospital Initiative positions hospitals to provide mothers with the information, confidence, and skills necessary to successfully initiate and continue breastfeeding their babies, thereby promoting healthy feeding choices for infants. To support this initiative, we created a Baby Friendly coordinator position, and this team member is in place.
   - Advantages of Baby Friendly Designation include the following: mothers are educated on the benefit of breastfeeding in the hospital with the goal of continuing breastfeeding post-discharge; mothers are provided with information on community resources and education available to them in support of breastfeeding post-discharge; MLKCH is positioned as a leading community resource to provide mothers with support through their breastfeeding journey post-discharge (e.g., education).
   - We trained all staff Hospital-wide (100%) on the Baby Friendly Designation and regulations; this represents an increase from 30% of the Hospital's staff, who were previously solely based in our perinatal department. Staff training is administered through our Healthstream Baby Friendly module online.
   - We placed Baby Friendly education material throughout the Hospital to educate expectant and new mothers on breastfeeding, starting in 2018. Once these materials became available, we saw the percentage of exclusive breastfeeding mothers increase from 57.5% to 67.0% in 2019.

4. **Action #4: We provided home and community-based post-delivery support for new mothers.**

   - Since FY 2017, the First 5 LA's Welcome Baby program enrolled 1,211 families (either prenatally or postpartum) to receive home visits and additional support. The objective of this program is to help parents learn about (1) their new role as mom or dad; (2) early child development; and (3) obtaining assistance on issues such as basic health care, insurance coverage, nutrition, breastfeeding, family violence, maternal depression, or improving home safety.
     - The benefit of the Welcome Baby program is that it is a free, voluntary program available to expectant mothers from local ZIP codes throughout the journey of pregnancy. It provides nurses for education and support and social workers to connect mothers to services in the community.
   - In addition to the Welcome Baby program, MLKCH offered weekly mommy support groups for new mothers post-delivery. These support groups averaged six mothers per session.
   - MLKCH partnered with Los Angeles County's doula program established in early 2019 to provide doulas for African American families. The objective of this program is to address health disparities and provide support for this patient population. Services includes prenatal, labor and delivery, and post-discharge support. The doula program began enrolling mothers in November 2019; it currently has over 150 mothers from local hospitals and 10+ mothers enrolled from MLKCH.

5. **Action #5: We increased availability of family planning and contraceptives.**

   - MLKCH discusses contraception options with all families (100%) delivering at the Hospital, both post-delivery and prior to discharge.

Management of Chronic Health Conditions

Priority Health Need:	High prevalence of poorly managed chronic diseases, combined with high rates of overweight and obese community members, results in poor health outcomes.
Goal:	Improve chronic disease management to improve health outcomes and reduce morbidity and mortality rates associated with these conditions; encourage residents to maintain healthier lifestyles and improve overall health by reducing rates of overweight and obesity-related health conditions.
Impact:	Reduced morbidity and mortality rates and decreased overweight and obesity incidence associated with chronic conditions.

Actions:

1. **Action #1: We conducted screenings and provided education and peer support for the community on major chronic conditions (diabetes, cardiovascular disease), overweight and obesity, weight management, nutrition, and exercise.**

   - We provided health screenings and community education to over 12,000 community members over the past three years through our Know Your Basics community health program. Screenings included blood pressure, blood glucose, and BMI (body mass index); education included guidelines for health numbers and ways to improve health.
   - Our Know Your Basics community health program participated in 120 events, providing free health screenings and education so that the community understands what their screening results mean, and what they must do to maintain a healthy lifestyle.
   - We launched our Man Up! barbershop program in January 2019 to provide health screenings and education for our community members in a setting that is widely accepted as a comfortable place to gather. Our physicians visit the barbershops and provide free consultative services and education for men. Through this program, we have partnered with nine barbershops and have provided health screenings and education to over 400 community members since it began.

- MLKCH and MLK CMG jointly launched the Recipe for Health food access program in April 2019. Recipients of this program receive fresh produce packages, healthy eating education, and information on community resources available that are focused on healthy lifestyles. To date, our physicians have referred and enrolled over 230 patients to this program.
    - The Recipe for Health program began offering healthy cooking classes, nutritional education classes, and grocery store tours in September 2019. These classes are available to any of our community members. To date, 52 community members and/or patients have attended these sessions.
    - 40% of those that participated in the Recipe for Health programs have demonstrated an improvement in their clinical health outcomes (e.g., blood pressure for heart disease, weight for obesity, and/or hemoglobin A1c levels for diabetes). Additionally, participants noted that they changed their daily lifestyles to reflect healthier food choices for themselves and their family.

2. **Action #2: We expanded access to medical specialists.**

    - Through MLK CMG, we employ 14 physicians (10 full-time and 4 part-time) and contract with 17 additional specialists.
    - MLKCH expanded community access to specialists through MLK CMG. Initially offering family medicine, MLK CMG now offers care across 15 additional specialties: internal medicine, addiction medicine, cardiology, endocrinology, gastroenterology, general surgery, hand/plastic surgery, infectious disease, neurology, podiatry, psychiatry, pulmonology, rheumatology, urology, and vascular surgery.
    - We referred 3,424 patients to MLK CMG's post-discharge clinic with the goal of avoiding unnecessary readmissions and ensuring appropriate follow-up care. This increased our inpatient call panel roster for primary and specialty care.
    - During Calendar Year (CY) 2017, our specialists completed 383 unique patient visits; in CY 2019 our providers completed 5,046 unique patient visits, representing a 710% increase in patient visits over the two-year time period.

3. **Action #3: We established comprehensive centers of excellence to treat patients with chronic diseases.**

    - MLKCH identified seven special populations to track and researched evidence-based interventions to treat these patients. The seven special populations are defined as patients with the following characteristics: mental health disorders, substance abuse disorders, homeless, diabetes, repeat low acuity visits, high-utilizers, and cardiovascular disease. Tracking these patients allows our community benefit department to better understand their needs and proactively develop programs that address those specific needs.

- MLKCH hired a Manager of Population Health Intelligence and Data Science and a Data Scientist to assure that we are meeting accreditation requirements set forth by the National Committee for Quality Assurance (NCQA); this includes development of a project plan and establishing tracking oversight. Further, these positions help our community benefit department proactively track other chronic conditions that are prevalent in our community; this information is used to develop initiatives that will address our community's future health needs.
- MLKCH is applying for The Joint Commission's Advanced Disease Specific Certification for Inpatient Diabetes Care. This certification will help position MLKCH as a leading community resource for diabetes care and education. The timeline for this certification is as follows:
  - Submit application by November 2020
  - Complete site visit by June 2021
  - Certification awarded to MLKCH by end of June 2021
- MLKCH established the multi-disciplinary Diabetes Care Committee to address inpatient and outpatient diabetes-related care and education. This Committee includes the following key members: one director of Diabetes Program, four certified Diabetes Care and Education specialists, 35 diabetes nurse champions (to assist in improving diabetes care and bedside education), and one physician champion.

4. **Action #4: We strengthened our data sharing capabilities with community providers to improve care coordination and overall quality of care.**
   - In January 2020, MLKCH initiated the Promoting Interoperability Program, a strategic initiative that enables timely, accurate, and secure sharing of health information; this program also provides a robust framework to support precision medicine.
   - MLKCH is collaborating with other providers to identify sustainable solutions that will promote secure data interoperability across our community. To demonstrate progress, we plan to report on physicians' satisfaction with access to medical record data and the quality of data shared with providers across the continuum of care.
5. **Action #5: We encouraged youth to adopt healthy eating and exercise habits.**
   - Through the You Can youth empowerment program, MLKCH participated in over 20 events (career days and health workshops) at partnering schools in the community. Attendance at each event ranged from 50 to 80 students, resulting in connections with 1,000-1,600 students in total.
   - MLKCH increased the number of our school partners participating in our You Can health education programs from three to eight per year.

- We increased our volunteer efforts at school health events, with an average of 15 staff volunteers (an increase from eight volunteers in previous years).
- MLKCH will continue to build partnerships with schools to expand education on health, wellness, and chronic conditions.

6. **Action #6: We supported community efforts to introduce healthy, affordable food to the South LA community, and we reinforce this effort by offering healthy food options in the MLKCH cafeteria.**

   - MLKCH launched the Recipe for Health food access program in April 2019, introducing healthy and affordable food to patients with diabetes, cardiovascular disease, obesity, and food insecurity.
   - Our Recipe for Health program enrolled over 230 patients representative of the following conditions: 226 with diabetes, 213 with heart disease, 47 with obesity, and 232 with a co-morbidity of two or more of the mentioned conditions. So far, the program has been proven effective in reducing the number of patients seeking acute care by 52%, decreasing the number of acute care encounters by 43%, and a decrease in rate of ED visits by 11%.
   - Beginning in April 2019, MLKCH and MLK CMG started to work together to enroll patients into CalFresh; to date 32 patients have been enrolled in CalFresh through this effort.
     - CalFresh is an entitlement program that provides monthly benefits to low-income households so that they have an opportunity to purchase healthy foods (versus less costly, unhealthy alternatives such as fast food). By expanding enrollment access to this program, we helped more patients obtain financial assistance to address food insecurity and healthy food affordability challenges.
   - MLKCH's cafeteria is open to the community for general dining. We expanded our menu offerings to include healthy and affordable food options, including: a fresh cereal bar with a variety of milks; mindful veggie bar; alternatives of brown rice, whole wheat pasta, and spinach pasta; antibiotic-free and organic meats; and salad action station.

7. **Action #7: We promoted the MLK Campus Farmers Market as a source of fresh produce in South LA.**

   - MLKCH continues to promote the MLK Campus Farmers Market to expand our community's access to fresh and healthy food options. The Farmers Market is held every Wednesday on our campus, hosting on average ten local vendors each week. Community members can purchase healthy food options with their CalFresh EBT cards and WIC checks for ease of access. We now provide our community with quarterly updates on the Farmers Market through our social media channels.

Social Determinants of Health

Priority Health Need:	High and growing prevalence of homeless individuals with poorly managed health conditions.
Goal:	Help homeless individuals access housing and other social services to increase access to healthcare, improve self-management, and enhanced quality of life; promote environmental safety in our community for residents to live.
Impact:	Housing affords increased access to healthcare, improved self-management, and enhanced quality of life

Actions:

1. **Action #1: We helped homeless patients access housing, food, social services, and other support available through Measure H and other public initiatives.**

   - MLKCH Social Workers performed comprehensive evaluations on every patient identified as homeless; we completed an average of 827 assessments per month in 2019.
   - Our MLKCH Homeless Services team has referred 534 homeless patients to the Los Angeles County Recuperative Care and Transitional Living program since its establishment in November of 2017 to provide homeless patients with a safe, low cost place to recover post-discharge.
   - MLKCH identified 50 new resources available to our homeless patients in the community.
   - MLKCH secured one contract with a Board and Care facility, eight contracts with Recuperative Care sites, and five contracts with Transitional and Sober Living sites to expand access to these services for our homeless patients.
   - MLKCH added five staff members to help transition homeless patients from the Hospital post-discharge. These positions include a Homeless Service Liaison, two Community Health Workers, and two Homeless Service Coordinators.

2. **Action #2: We collaborated with a homeless outreach team based on the Martin Luther King, Jr. Medical Campus to connect homeless patients with supportive housing and healthcare providers, and we expanded placement options for these patients.**

   - MLKCH continues to coordinate efforts with the HOPICS outreach team, referring 100% of our homeless patients so that they can be connected to supportive housing and healthcare providers.

3. **Action #3: We provided case management support for newly housed homeless individuals.**

   - Since January 2019, MLKCH community health workers have provided case management support to over 270 patients placed into the Los Angeles County Recuperative Care and Transitional Living program.

4. **Action #4: We provided clothing and toiletries for homeless patients.**

   - MLKCH provided over $100,000 in funding for clothing, food, and toiletries for our homeless patients.
   - MLKCH established partnerships with several organizations to expand access to basic essentials for homeless patients (toiletries, food, clothing).

5. **Action #5: We advocated for the homeless to increase our community's understanding of their needs, support policies and programs to protect the homeless, and increase access to permanent housing for these patients.**

   - MLKCH collaborates with the SPA 6 Homeless Coalition for homeless advocacy and support.
   - MLKCH attended five events that addressed homelessness and policy support and will continue to attend similar forums as they are convened in the future.

6. **Action #6: We supported community efforts to create and maintain a safer environment.**

   - MLKCH has increased community engagement in existing community councils and meetings that address a range of issues—such as human trafficking, trauma and violence, gang violence—by 75%.
   - MLKCH routinely attends four community meetings per month that address community safety efforts. This includes meetings with the Watts Gang Task Force and the MLK Community Healing and Trauma Prevention Center.
   - MLKCH started a human trafficking awareness initiative for staff Hospital-wide. The goal of this initiative is to train all staff on human trafficking, including the ability to identify victims and refer them to appropriate resources. Our goal is to train 100% of our staff by the end of CY 2020.

Appendix B. Data Limitations and Information Gaps

A number of data sources, including national, state, county, and local resources, were examined as part of this CHNA. One limitation of this study is that some data sources were not consistently available for geographic boundaries at local levels, specifically for the MLKCH defined community and in some cases SPA 6. Additionally, data was not always publicly published on an annual basis, meaning that some data estimates are several years old. Also, a selection of indicators (e.g., mental health and substance use) are limited due to privacy requirements creating challenges for assessing disparities. Similar self-reported statistics are estimated to be underreported due to the stigma of these health issues. In consideration of these limitations, the process of identifying health needs was based on both the quantitative and qualitative analyses.

Community input participants were not chosen based on random sampling technique, but they were instead invited because their comments represented the underserved, low-income, minority, and chronically ill populations. Thus, themes identified during the interviews were likely subject to the experience of individuals selected to provide input, and MLKCH sought to receive input from a comprehensive and diverse (topically and geographically) group of stakeholders to minimize bias.

Appendix C. List of Data Indicators and Sources

Data was collected on key health indicators, including morbidity, mortality, healthcare access, community demographics, and various social and economic determinants of health. Footnotes detail sources of data. They include the California Department of Education, CDPH, California Employment Development Department, California Health Interview Survey, County Health Rankings, Los Angeles County Department of Public Health, Los Angeles Homeless Services Authority, Nielsen Claritas, and other local, state, and federal databases.

The core indicator analyses, which summarize many of the statistics reviewed in the narrative of this study, were prepared at the MLKCH community geography, the SPA 6 geography, and Los Angeles County as were available. The coloration of the indicators illustrates how the MLKCH community indicator compares to the County.

Legend:

- Indicates statistic is more favorable than the LA County statistic by more than
- Indicates statistic is within five percent of the LA County statistic
- Indicates statistic is less favorable than the LA County statistic by more than
- Illustrates statistic is larger than the LA County statistic
- Illustrates statistic is equal to the LA County statistic
- Illustrates statistic is smaller than the LA County statistic

Core Indicators for Martin Luther King Jr. Community Hospital's CHNA				
		MLKCH Service Area	SPA 6	Los Angeles County
Source:	Indicators	Point Estimate	Point Estimate	Point Estimate
	Population Estimates			
Claritas; Environics Analytics 2019 (SPA 6 from AskCHIS)	Total Population 2020	1,353,586	1,029,000	10,173,286
	Total Male Population 2020	48.8%	49.7%	49.3%
	Total Female Population 2020	51.2%	50.3%	50.7%
	Total Population 2020: White Non-Hispanic	2.5%	4.9%	25.0%
	Total Population 2020: Black Non-Hispanic	20.7%	27.4%	7.6%
	Total Population 2020: Hispanic/ Latino	72.2%	55.3%	49.7%
	Total Population 2020: American Indian Non-Hispanic	0.1%	0.5%	0.2%
	Total Population 2020: Asian Pacific Islander Non-Hispanic	2.9%	2.3%	14.9%
	Total Population 2020: Other Non-Hispanic	1.5%	9.6%	2.5%
Claritas; Environics Analytics 2019	2020 - 2025 % Population Growth Total	2.4%	Not Available	2.3%
	2020 - 2025 % Population Growth by Age 0-14	0.7%	Not Available	-0.1%
	2020 - 2025 % Population Growth by Age 15-17	-1.2%	Not Available	0.6%
	2020 - 2025 % Population Growth by Age 18-44	-0.7%	Not Available	-1.4%
	2020 - 2025 % Population Growth by Age 45-64	3.5%	Not Available	2.1%
	2020 - 2025 % Population Growth by Age 65+	17.4%	Not Available	16.2%
Claritas; Environics Analytics 2019	2020 - 2025 % Population Growth for White Non-Hispanic	-1.3%	Not Available	-3.5%
	2020 - 2025 % Population Growth for Black Non-Hispanic	-7.6%	Not Available	-2.5%
	2020 - 2025 % Population Growth for Hispanic/ Latino	5.1%	Not Available	4.4%
	2020 - 2025 % Population Growth for Am. Indian Non-Hispanic	2.7%	Not Available	-1.8%
	2020 - 2025 % Population Growth for Asian PI Non-Hispanic	4.5%	Not Available	6.4%
	2020 - 2025 % Population Growth for Other Non-Hispanic	10.0%	Not Available	8.5%
	Est. Pop. Over 5 Yrs. Old by Language Spoken at Home			
Claritas; Environics Analytics 2019	English Only	33.3%	Not Available	43.1%
	Asian/Pacific Island	2.2%	Not Available	10.6%
	Indo-European	0.7%	Not Available	5.6%
	Spanish	62.9%	Not Available	39.9%
	Other Language	1.0%	Not Available	0.9%
	Socioeconomic Status - Income Poverty and Unemployment			
Claritas; Environics Analytics 2019	2020 Household Median Income	$46,163	Not Available	$71,008
Claritas; Environics Analytics 2019	2020 Percent of All Families, Below Poverty	21.5%	Not Available	11.7%
Claritas; Environics Analytics 2019	2020 Percent of Families with Children, Below Poverty	17.3%	Not Available	8.6%
LA County Health Survey 2018	Percent of households (owner/renter-occupied) who spend ≥30% of their income on housing[2]	57.4%	58.8%	47.2%
Claritas; Environics Analytics 2019	2020 Estimated % of population Civilian Age 16+ Unemployed	5.1%	Not Available	4.0%
Claritas; Environics Analytics 2019	% of Family Type of Single Father	5.9%	Not Available	4.2%
Claritas; Environics Analytics 2019	% of Family Type of Single Mother	17.6%	Not Available	10.9%
	Public Program Participation			
Claritas; Environics Analytics 2019	Percent of adults w/ inability to afford food (<200% FPL)	79.1%	80.9%	50.2%
LA County Health Survey 2018	Percent of households with incomes <300% FPL who are food insecure	32.5%	35.1%	26.8%
California Health Interview Survey 2018	Percent of adults currently receiving food stamp benefits	17.2%	17.5%	14.3%
California Health Interview Survey 2018	Percent of adults currently on WIC	54.2%	48.3%	47.6%
California Health Interview Survey 2018	Percent of adults currently receiving supplemental security income (SSI)	12.4%	12.9%	11.5%
California Health Interview Survey 2018	Percent of adults receiving TANF or CALWORKS	8.1%	8.3%	6.5%
	Educational Attainment			
Claritas; Environics Analytics 2019	% Population Age 25+ w Some Highschool, No Diploma or Less	39.0%	Not Available	21.0%
Claritas; Environics Analytics 2019	% Population Age 25+ w High School Diploma (or GED)	25.8%	Not Available	20.9%
Claritas; Environics Analytics 2019	% Population Age 25+ w Associate's Degree or Some College	23.6%	Not Available	26.2%
Claritas; Environics Analytics 2019	% Population Age 25+ w Bachelor's and Greater	11.6%	Not Available	31.9%
	Transportation			
Claritas; Environics Analytics 2019	% of Family Using Public Transport (Age 16+)	10.0%	Not Available	5.9%
Claritas; Environics Analytics 2019	% Family Households with No Vehicles	13.4%	Not Available	8.6%
	Homelessness			
LA County Health Survey 2018	Housing instability (Percent of adults who reported being homeless or not having their own place to live or sleep in the past 5 years)	12.8%	14.7%	7.5%
2019 Greater Los Angeles Homeless Count	Point in time total homeless as a percent of total population	0.9%	MLKCH value is SPA 6	0.6%
	Unsheltered % prevalence of total homeless	66.2%	MLKCH value is SPA 6	75.0%
	Sheltered % prevalence of total homeless	33.8%	MLKCH value is SPA 6	25.0%
	Individual Adults % prevalence of total homeless	76.1%	MLKCH value is SPA 6	85.0%
	Family Members % prevalence of total homeless	23.6%	MLKCH value is SPA 6	14.9%
	Unaccompanied Minors (<18) % prevalence of total homeless	0.3%	MLKCH value is SPA 6	0.1%
	Chronically Homeless % prevalence of total homeless	21.8%	MLKCH value is SPA 6	28.0%
	Serious Mental Illness % prevalence of total homeless	19.4%	MLKCH value is SPA 6	23.2%
	Substance Use Issues % prevalence of total homeless	10.4%	MLKCH value is SPA 6	13.3%
	Persons with HIV/AIDS % prevalence of total homeless	0.9%	MLKCH value is SPA 6	2.2%
	Chronic Illness % prevalence of total homeless	23.2%	MLKCH value is SPA 6	Not Available
	Physical Disability % prevalence of total homeless	15.5%	MLKCH value is SPA 6	Not Available
	Brain Injury % prevalence of total homeless	3.5%	MLKCH value is SPA 6	Not Available
	Veterans % prevalence of total homeless	4.9%	MLKCH value is SPA 6	6.6%
	Domestic Violence Experience % prevalence of total homeless	30.3%	MLKCH value is SPA 6	5.3%
	Crime and Violence			
LA County Health Survey 2018	Percent of adults who believe their neighborhood is safe from crime	71.5%	69.0%	85.0%
LA County Health Survey 2018	Percent of adults who have ever experienced physical (hit, slapped, pushed, kicked, etc.) or sexual (unwanted sex) violence by an intimate partner	18.1%	18.2%	16.8%
	Food Environment			
LA County Health Survey 2018	Percent of children with excellent or good access to fresh fruits and vegetables in their community	63.7%	63.2%	78.2%
California Health Interview Survey 2018	Percent of adults who always find fresh fruit/vegetables in neighborhood	68.0%	68.8%	76.5%
California Health Interview Survey 2018	Percent of adults who never find fresh fruit/vegetables in neighborhood	3.8%	4.6%	4.0%

		MLKCH Service Area	SPA 6	Los Angeles County
Source:	**Indicators**	Point Estimate	Point Estimate	Point Estimate
California Health Interview Survey 2018	Percent of adults whose neighborhood fruit/vegetables are always affordable	46.7%	47.7%	51.9%
California Health Interview Survey 2018	Percent of adults whose neighborhood fruit/vegetables are never affordable	0.1%	0.1%	1.4%
	Insurance Status			
LA County Health Survey 2018	Percent of children ages 0-17 years who are insured	98.8%	98.8%	98.5%
LA County Health Survey 2018	Percent of adults ages 18-64 years who are insured	84.2%	83.4%	90.1%
California Health Interview Survey 2018	Percent of adults currently insured	89.2%	87.3%	90.3%
California Health Interview Survey 2018	Percent of adults with employment-based insurance	28.0%	12.9%	49.3%
California Health Interview Survey 2018	Percent of adults covered by Medi-Cal	51.0%	53.7%	31.8%
California Health Interview Survey 2018	Percent of adults covered by Medicare	29.0%	30.2%	24.2%
California Health Interview Survey 2018	Percent of Seniors (Adults 65+) Medi-Cal/Medicare (dual eligible) coverage	88.4%	86.5%	88.1%
	Usual Source of Care			
LA County Health Survey 2018	Percent of children ages 0-17 years with a regular source of health care	94.0%	93.0%	95.6%
LA County Health Survey 2018	Percent of adults 18-64 years with a regular source of health care	76.9%	75.1%	80.1%
California Health Interview Survey 2018	Percent of adults who go to Doctor's Office/HMO/Kaiser for care	36.6%	34.0%	56.7%
California Health Interview Survey 2018	Percent of adults who go to community hospital, community/government clinic for care	39.7%	42.4%	24.8%
California Health Interview Survey 2018	Percent of adults who go to Emergency Room for care	2.9%	2.8%	2.4%
California Health Interview Survey 2018	Percent of adults who go to Other Source for care	0.3%	0.4%	0.8%
California Health Interview Survey 2018	Percent of adults without usual source of care	20.5%	20.4%	15.4%
	Usual Source of Care for Hispanic			
California Health Interview Survey 2018	Percent of adults who to go to Doctor's Office/HMO/Kaiser for care, for Hispanic only	14.5%	11.2%	18.9%
California Health Interview Survey 2018	Percent of adults who to go to Community hospital, community/government clinic for care, for Hispanic only	31.3%	32.7%	15.7%
California Health Interview Survey 2018	Percent of adults who to go to Emergency room for care, for Hispanic only	1.6%	1.5%	1.1%
California Health Interview Survey 2018	Percent of adults who to go to Some other place for care, for Hispanic only	Not Available	Not Available	0.1%
California Health Interview Survey 2018	Percent of adults who to go to No Usual Source of Care for Hispanic only	16.7%	16.2%	9.8%
	Usual Source of Care for African -American, Non-Hispanic			
California Health Interview Survey 2018	Percent of adults who to go to Doctor's Office/HMO/Kaiser for care, for African-American only, non-Hispanic	16.6%	18.2%	5.2%
California Health Interview Survey 2018	Percent of adults who to go to Community hospital, community/government clinic for care, for African-American only, non-Hispanic	6.5%	7.9%	1.8%
California Health Interview Survey 2018	Percent of adults who to go to Emergency room for care, for African-American only, non-Hispanic	1.1%	1.0%	0.2%
California Health Interview Survey 2018	Percent of adults who to go to Some other place for care, for African-American only, non-Hispanic	Not Available	Not Available	Not Available
California Health Interview Survey 2018	Percent of adults who to go to No Usual Source of Care for African-American only, non-Hispanic	1.8%	1.8%	1.1%
	Usual Source of Care for Asian, Non-Hispanic			
California Health Interview Survey 2018	Percent of adults who to go to Doctor's Office/HMO/Kaiser for care, for Asian only, non-Hispanic	2.2%	1.8%	10.1%
California Health Interview Survey 2018	Percent of adults who to go to Community hospital, community/government clinic for care, for Asian only, non-Hispanic	0.7%	0.4%	2.7%
California Health Interview Survey 2018	Percent of adults who to go to Emergency room for care, for Asian only, non-Hispanic	0.1%	0.2%	0.4%
California Health Interview Survey 2018	Percent of adults who to go to Some other place for care, for Asian only, non-Hispanic	Not Available	Not Available	Not Available
California Health Interview Survey 2018	Percent of adults who to go to No Usual Source of Care for Asian only, non-Hispanic	0.5%	0.7%	1.9%
	Usual Source of Care for White, Non-Hispanic			
California Health Interview Survey 2018	Percent of adults who to go to Doctor's Office/HMO/Kaiser for care, for White only, non-Hispanic	3.0%	2.7%	21.4%
California Health Interview Survey 2018	Percent of adults who to go to Community hospital, community/government clinic for care, for White only, non-Hispanic	1.0%	1.1%	4.3%
California Health Interview Survey 2018	Percent of adults who to go to Emergency room for care, for White only, non-Hispanic	0.1%	0.2%	0.6%
California Health Interview Survey 2018	Percent of adults who to go to Some other place for care, for White only, non-Hispanic	Not Available	Not Available	0.4%
California Health Interview Survey 2018	Percent of adults who to go to No Usual Source of Care for White only, non-Hispanic	1.5%	1.6%	2.2%
	Use of Emergency Room			
California Health Interview Survey 2018	Percent of children and teens who visited the emergency room in the past 12 months	36.4%	36.5%	19.6%
California Health Interview Survey 2018	Percent of adults ages 18 - 64 who visited the emergency room in the past 12 months	26.4%	26.2%	22.6%
California Health Interview Survey 2018	Percent of adults ages 65+ who visited the emergency room in the past 12 months	18.8%	23.2%	19.7%
California Health Interview Survey 2018	Percent of adults less than FPL who visited the emergency room in the past 12 months	31.8%	29.7%	29.6%
California Health Interview Survey 2018	Percent of adults less than 200% FPL who visited the emergency room in the past 12 months	27.7%	29.1%	25.1%
	Delayed Care			
California Health Interview Survey 2018	Percent of adults with delay/not get other medical care in past 12 months	16.2%	14.3%	14.2%
California Health Interview Survey 2018	Percent of adults with delay/no care due to cost or no insurance	93.5%	88.0%	93.8%
California Health Interview Survey 2018	Percent of adults with delay/not get prescription in past 12 months	15.9%	14.5%	10.1%
	Self-Reported Health Status			
LA County Health Survey 2018	Percent of adults reporting their health to be fair or poor	30.1%	32.5%	21.5%
LA County Health Survey 2018	Average number of days in past month adults reported regular daily activities were limited due to poor physical/mental health	3.3	3.5	2.7
California Health Interview Survey 2018	Percent of adults who consider their general health condition to be good, very good, or excellent	68.2%	67.9%	74.1%

		MLKCH Service Area	SPA 6	Los Angeles County
Source:	**Indicators**	Point Estimate	Point Estimate	Point Estimate
California Health Interview Survey 2018	Percent adults who consider their general health condition to be fair or poor	31.8%	32.1%	25.9%
LA County Health Survey 2018	Percent of adults ages 65+ years who have fallen in the past year	28.3%	25.3%	26.5%
	Chronic Diseases/Conditions			
LA County Health Survey 2018	Percent of children ages 0-17 years with current asthma (ever diagnosed with asthma and reported still have asthma and/or had an asthma attack in the past year)[1]	7.8%	8.2%	7.1%
California Health Interview Survey 2018	Percent of adults who have been told by a doctor that they have asthma	12.1%	14.5%	14.0%
California Health Interview Survey 2018	Percent of adults who've been told by a doctor they have diabetes	15.9%	16.6%	11.2%
California Health Interview Survey 2018	Percent of adults who've been told by a doctor they have any kind of heart disease	6.9%	7.4%	6.1%
California Health Interview Survey 2018	Percent of adults who've been told by a doctor they have high blood pressure	35.6%	39.5%	30.7%
	Death and Injury			
Los Angeles County Department of Public Health, Los Angeles County Department of Public Health, LA County Linked Death Data. Prepared January 2020.	Diabetes-specific death rate (per 100,000 population)	40.2	43.7	24.7
	Coronary heart disease-specific death rate (per 100,000 population)	121.8	127.4	102.9
	COPD specific death rate (per 100,000 population)	29.6	32.0	27.6
	Stroke-specific death rate (per 100,000 population)	44.4	47.8	35.0
	Lung cancer-specific death rate (per 100,000 population)	24.5	26.0	24.0
	Breast cancer-specific death rate among females (per 100,000 females)	21.3	22.5	19.4
	Colorectal cancer-specific death rate (per 100,000 population)	15.8	16.3	13.4
	Liver disease-specific death rate (per 100,000 population)	18.3	17.8	12.5
	Alzheimer's disease-specific death rate (per 100,000 population)	32.0	32.2	38.7
	Premature death rate due to suicide in total Years of Potential Life Lost (YPLL) per 100,000 population	192	198	247
	Premature death rate due to homicide in total Years of Potential Life Lost (YPLL) per 100,000 population	580	647	238
	Premature death rate due to motor vehicle crashes in total Years of Potential Life Lost (YPLL) per 100,000 population	326	366	246
	Premature death rate due to drug overdose in total Years of Potential Life Lost (YPLL) per 100,000 population	285	306	263
	Community Inpatient Hospitalizations			
Hospital Association of Southern CA	Total Inpatient Admissions per 100,000 population	11,540	12,859	9,933
Hospital Association of Southern CA	Total ED Admissions per 100,000 population	42,088	47,283	30,799
Hospital Association of Southern CA	Admission Rate for Asthma (MS-DRG 202-203), per 100,000 population	375.89	420	272
Hospital Association of Southern CA	Inpatient Admissions for Asthma, % Hispanic	52.4%	50.5%	49.1%
Hospital Association of Southern CA	Inpatient Admissions for Asthma, % African-American Non-Hispanic	35.7%	38.8%	15.1%
Hospital Association of Southern CA	Inpatient Admissions for Asthma, % Other Non-Hispanic Non-% Hispanic	9.3%	8.5%	34.5%
Hospital Association of Southern CA	Admission Rate for Diabetes (MS-DRG 637-639), per 100,000 population	509.54	578	320
Hospital Association of Southern CA	Inpatient Admissions for Diabetes, % Hispanic	51.7%	49.0%	47.9%
Hospital Association of Southern CA	Inpatient Admissions for Diabetes, % African-American Non-Hispanic	39.5%	42.5%	20.1%
Hospital Association of Southern CA	Inpatient Admissions for Diabetes, % Other Non-Hispanic Non-% Hispanic	8.1%	7.7%	31.3%
Hospital Association of Southern CA	Admission Rate for Heart Disease (MS-DRG 291-293), per 100,000 population	1,154.71	1,296	781
Hospital Association of Southern CA	Inpatient Admissions for Heart Disease, % Hispanic	36.3%	32.8%	33.0%
Hospital Association of Southern CA	Inpatient Admissions for Heart Disease, % African-American Non-Hispanic	54.6%	59.9%	21.1%
Hospital Association of Southern CA	Inpatient Admissions for Heart Disease, % Other Non-Hispanic Non-% Hispanic	8.3%	6.5%	45.1%
Hospital Association of Southern CA	Inpatient Admissions for High Blood Pressure (MS-DRG 304-305), per 100,000 population	172.65	198	107
Hospital Association of Southern CA	Inpatient Admissions for High Blood Pressure, % Hispanic	38.1%	34.3%	38.2%
Hospital Association of Southern CA	Inpatient Admissions for High Blood Pressure, % African-American Non-Hispanic	54.2%	58.7%	26.8%
Hospital Association of Southern CA	Inpatient Admissions for High Blood Pressure, % Other Non-Hispanic	6.7%	6.3%	34.1%
Hospital Association of Southern CA	Inpatient Admissions for COPD (MS-DRG 190-192), per 100,000 population	406.25	469	294
Hospital Association of Southern CA	Inpatient Admissions for COPD, % Hispanic	19.7%	16.5%	20.6%
Hospital Association of Southern CA	Inpatient Admissions for COPD, % African-American Non-Hispanic	66.0%	70.6%	23.2%
Hospital Association of Southern CA	Inpatient Admissions for COPD, % Other Non-Hispanic	13.6%	12.2%	55.4%
Hospital Association of Southern CA	Inpatient Admissions for Stroke (MS-DRG 61-68), per 100,000 population	522.39	582	449
Hospital Association of Southern CA	Inpatient Admissions for Stroke, % Hispanic	44.3%	41.8%	33.8%
Hospital Association of Southern CA	Inpatient Admissions for Stroke, % African-American Non-Hispanic	42.7%	46.8%	14.1%
Hospital Association of Southern CA	Inpatient Admissions for Stroke, % Other Non-Hispanic	11.5%	9.8%	50.9%
Hospital Association of Southern CA	Inpatient Admissions for Cancer, per 100,000 population	552.98	598	557
Hospital Association of Southern CA	Inpatient Admissions for Cancer, % Hispanic	55.6%	53.2%	38.1%
Hospital Association of Southern CA	Inpatient Admissions for Cancer, % African-American Non-Hispanic	33.7%	37.8%	9.9%
Hospital Association of Southern CA	Inpatient Admissions for Cancer, % Other Non-Hispanic	9.1%	7.6%	50.8%
Hospital Association of Southern CA	Inpatient Admissions for Alcohol & Drugs (MS-DRG 894-897), per 100,000 population	285.91	334	356
Hospital Association of Southern CA	Inpatient Admissions for Alcohol & Drugs, % Hispanic	49.1%	46.3%	34.0%
Hospital Association of Southern CA	Inpatient Admissions for Alcohol & Drugs, % African-American Non-Hispanic	33.6%	36.2%	10.0%
Hospital Association of Southern CA	Inpatient Admissions for Alcohol & Drugs, % Other Non-Hispanic	15.4%	15.5%	53.5%
Hospital Association of Southern CA	Inpatient Admissions for Psychiatric (MS-DRG 880-887, per 100,000 population	2,106.63	2,434	1,825
Hospital Association of Southern CA	Inpatient Admissions for Psychiatric, % Hispanic	33.3%	29.5%	32.1%
Hospital Association of Southern CA	Inpatient Admissions for Psychiatric, % African-American Non-Hispanic	39.3%	42.5%	18.7%
Hospital Association of Southern CA	Inpatient Admissions for Psychiatric, % Other Non-Hispanic	26.2%	26.8%	47.8%
Hospital Association of Southern CA	Inpatient Admissions for Falls, (ICD-10 Z91.81), per 100,000 population	408.91	416	459
Hospital Association of Southern CA	Inpatient Admissions for Falls, % Hispanic	40.3%	35.7%	28.7%
Hospital Association of Southern CA	Inpatient Admissions for Falls, % African-American Non-Hispanic	41.1%	47.7%	11.5%
Hospital Association of Southern CA	Inpatient Admissions for Falls, % Other Non-Hispanic	17.3%	15.2%	58.8%
	Maternal Health			
Los Angeles County Department of Public Health, Division of HIV and STD programs. STD Surveillance Database, prepared January	Rate of births (per 1,000 females) to teens ages 15-19	Not Available	26.9	13.5
	Percent of all live births where mother received prenatal care during 1st trimester	79.2%	78.5%	83.5%
	Percent of low birth weight (<2,500 grams) births (per 100 live births)	8.4%	8.6%	7.3%
	Infant death rate (per 1,000 live births)	6.0	6.4	4.0

		MLKCH Service Area	SPA 6	Los Angeles County
Source:	**Indicators**	Point Estimate	Point Estimate	Point Estimate
2020.	Percent of children ages 0-2 years who were exclusively breastfed for at least 3 months	Not Available	28.8%	43.2%
	Sexually Transmitted Infections			
Los Angeles County Department of Public Health, Division of HIV and STD programs, HIV Surveillance System, prepared January 2020.	Incidence of HIV (annual new cases per 100,000 population) among adolescents and adults (ages 13+ years)	30.7	33.8	20.4
Los Angeles County Department of Public Health, Division of HIV and STD programs, STD Surveillance Database, prepared January 2020.	Incidence of primary & secondary syphilis (annual new cases per 100,000)	22.2	23.4	17.7
	Incidence of gonorrhea (annual new cases per 100,000 population)	324.0	360.8	215.8
	Incidence of chlamydia (annual new cases per 100,000 population)	827.2	887.7	572.4
	Dental Care			
LA County Health Survey 2018	Percent of adults who did not see a dentist or go to a dental clinic in the past year	54.8%	56.9%	40.7%
LA County Health Survey 2018	Percent of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it	11.3%	9.5%	8.9%
California Health Interview Survey 2018	Percent of Last Visit to Dentist less than 6 months ago for children	63.1%	49.6%	72.3%
California Health Interview Survey 2018	Percent of Last Visit to Dentist 6 months to 1 year ago for children	26.9%	33.5%	8.8%
California Health Interview Survey 2018	Percent of children never visited the dentist	10.0%	16.9%	17.6%
	Flu Vaccinations			
LA County Health Survey 2018	Percent of children ages 6 months - 17 years vaccinated for influenza	56.7%	57.3%	59.9%
LA County Health Survey 2018	Percent of adults vaccinated for influenza	42.8%	40.5%	47.1%
	Mammograms and Pap Smears			
LA County Health Survey 2018	Percent of women ages 21 - 65 years who had a Pap smear within the past 3 years	83.2%	82.4%	81.4%
LA County Health Survey 2018	Percent of women ages 50 - 74 years who had a mammogram within the past 2 years	74.6%	75.3%	77.0%
	Overweight and Obesity			
California Health Interview Survey 2018	Percent of children overweight for age	17.9%	7.6%	11.1%
California Health Interview Survey 2018	Percent of teens that have a overweight BMI	26.4%	Not Available	18.2%
California Health Interview Survey 2018	Percent of adults that have a overweight BMI	39.7%	38.9%	34.0%
California Health Interview Survey 2018	Percent of adults overweight or obese for Hispanic only	50.6%	46.8%	32.7%
California Health Interview Survey 2018	Percent of adults overweight or obese for African-Americans only, non-Hispanic	17.6%	19.7%	5.6%
California Health Interview Survey 2018	Percent of adults overweight or obese for Whites only, non-Hispanic	5.2%	4.8%	16.7%
California Health Interview Survey 2018	Percent of adults overweight or obese for Asian only, non-Hispanic	1.7%	1.3%	6.9%
California Health Interview Survey 2018	Percent of adults overweight or obese for American Indian/Alaskan Native only, non-Hispanic	0.1%	Not Available	0.2%
California Health Interview Survey 2018	Percent of adults overweight or obese for Native Hawaiian/Pacific Islander only, non-Hispanic	Not Available	Not Available	0.1%
California Health Interview Survey 2018	Percent of adults overweight or obese for Two or More Races, non-Hispanic	Not Available	Not Available	0.5%
	Physical Activity			
LA County Health Survey 2018	Percent of children ages 1-17 years who can easily get to a park, playground, or other safe place to play	84.7%	82.0%	90.4%
LA County Health Survey 2018	Percent of children ages 6-17 years who obtain recommended amount of aerobic exercise (≥60 minutes, daily) and muscle-strengthening (at least 2 days/wk) each week	14.7%	13.7%	15.1%
California Health Interview Survey 2018	Percent of children who spent more than 5 hours on sedentary activities on the weekday	64.3%	58.3%	72.1%
California Health Interview Survey 2018	Percent of teens who have been to the park/playground in the past 30 days	51.1%	Not Available	50.5%
California Health Interview Survey 2018	Percent of teens who spent more than 5 hours on sedentary activities on the weekday	Not Available	Not Available	91.9%
LA County Health Survey 2018	Percent of adults who use walking paths, parks, playgrounds, or sports fields in their neighborhood	42.5%	39.4%	47.5%
LA County Health Survey 2018	Percent of adults who obtain recommended amount of aerobic exercise (≥150 minutes/wk of moderate exercise, or ≥75 minutes/wk of vigorous exercise) and muscle-strengthening (at least 2 days/wk) each week	29.7%	27.9%	35.1%
	Nutrition			
LA County Health Survey 2018	Percent of children who drink at least one soda or sweetened drink a day	49.0%	51.6%	37.2%
California Health Interview Survey 2018	Percent of children who have less than 2 servings of fruit per day	48.1%	49.0%	47.8%
California Health Interview Survey 2018	Percent of teens who have less than 2 servings of fruit per day	Not Available	Not Available	46.6%
LA County Health Survey 2018	Percent of adults who consume five or more servings of fruits & vegetables a day	8.5%	8.0%	12.1%
	Mental Health			
LA County Health Survey 2018	Percent of adults at risk for major depression	15.7%	17.2%	13.0%
California Health Interview Survey 2018	Percent of adults who likely has had psychological distress in the last year	11.4%	11.9%	11.3%
California Health Interview Survey 2018	Percent of adults who needed help for emotional/mental or alcohol/drug problem In the past year	22.1%	22.1%	21.1%
California Health Interview Survey 2018	Percent of adults of have seen a PCP for mental or alcohol/drug problem in the past year	9.3%	11.1%	9.0%
California Health Interview Survey 2018	Percent of adults who have seen a psychiatrist etc. for mental or alcohol/drug problems in the past year	10.3%	10.9%	12.4%
California Health Interview Survey 2018	Percent of adults who take daily prescription for emotional/personal problem in the past 12 months	8.9%	9.5%	10.2%
	Substance Use			
LA County Health Survey 2018	Percent of adults who binge drink (men who had 5 or more alcoholic drinks, women 4 or more, on at least one occasion in the past 30 days)	15.2%	16.2%	17.9%
LA County Health Survey 2018	Percent of adults who smoke cigarettes	11.3%	12.5%	11.2%
California Health Interview Survey 2018	Percent of adults who have ever misused prescription pain killer	1.3%	0.9%	1.8%
California Health Interview Survey 2018	Percent of adults who have used marijuana/hashish more than 1 year ago or never used	72.9%	71.3%	75.8%
		MLKCH Service Area	**SPA 6**	**Los Angeles County**
Source:	**Indicators**	Point Estimate	Point Estimate	Point Estimate
California Health Interview Survey 2018	Percent of adults who have used marijuana/hashish in the past year	27.1%	28.7%	24.2%

Appendix D. Community Input

Key Informant Interviews

The objectives of these interviews were to obtain input from local community leaders and stakeholders about the community, its health needs, available services and when services are not accessible, the population health initiatives currently underway at MLKCH and in the community, and how these initiatives have been performing (i.e. benefiting the area residents). The information collected in these interviews was used to validate the quantitative data and provide context and inform the 2020-2022 CHNA and the Implementation Plan.

At MLKCH's request, Premier conducted 26 interviews (either in-person or via telephone) between October 2019 and February 2020. Those interviewed represented the South Central Los Angeles community's interests, especially the medically underserved, low-income, and minority populations; interviewees were representative of the following cohorts:

- MLKCH leaders
- Public health experts
- Medical providers
- Leaders of community-based organizations
- Leaders of local health and other departments or agencies that have current data relevant to the health needs of the community served by MLKCH

Interviews were completed in English.

The top three most frequently mentioned community issues were access (appointments, referrals, and wait times), behavioral health (inclusive of mental health and substance abuse), and a shortage of primary care physicians and specialty care physicians (with an emphasis on physicians trained in gastroenterology, nephrology, neurology, neurosurgery, oncology, otolaryngology, pediatrics, and psychiatry).

An overview of discussions follow:

- There is a long history of disparity and need. There is a long history of our community not having the right nor enough resources to address challenges that impact health. These challenges range from medical to social determinants (e.g. food insecurity and affordable housing).
- This is a diverse and evolving community. Although the MLKCH community has been historically African American, the demographics have changed due to an increasing number of minority populations moving into the area. This has shaped a highly transient community. While English and Spanish are dominant, multiple languages are spoken. This also requires the way healthcare is delivered to evolve and become more culturally appropriate.
- Community resources continue to expand and be developed, but the current demand outweighs supply. Progress has been made to expand our community's access to resources in recent years, but there are still too few resources. Large physician shortages exist across all primary care, medical, and surgical specialties, and many people must leave the community for care.

- Addressing sustainable change via policy must be a priority. A focus is needed on policy for poverty, employment, healthy foods, housing, and immigration. Coordination of care limitations due to insurance status makes navigating the support system difficult. Decriminalizing the interactions between the community in need and law enforcement officials is beneficial to building trust, respect, and safety.
- Foundational education for community members is needed. Health literacy is a concern. The population does not recognize how serious some common conditions can be, and they do not always understand the importance of following their care plans. The community also does not understand how to access the healthcare system and the importance of seeking care in the most appropriate setting. Physicians are overwhelmed, and a primary care team or staff educators are needed to provide patients with supplemental information and education.
- Patients deserve to be treated as a customer. Our local healthcare delivery system is overwhelmed and capacity-constrained; it is often difficult to accommodate timely patient appointments and convenient access. Often, patients are forced to wait weeks for a provider appointment; once at the clinic or health center patients usually wait several hours before a provider evaluates them. As a result, there is a widespread sense that the medical community does not value our patients' time or strive for patient convenience – patients do not feel like they are a valued customer. This drives patients to use the ED as their first point of care to avoid long wait times. As a result, we must think differently about how we engage and treat our patients. We must understand what our patients want, what our patients need, and how we must organize ourselves to meet those needs.
- There is opportunity for improved coordination among local providers and agencies (e.g. MLKCH, MLK Medical Campus, Los Angeles County DHS). There are 88 cities in the County, and not a single community or population segment boasts sufficient resources. While having insurance is an advantage, navigating the many different plans and benefits yields eligibility, care coordination, and referral challenges across the numerous agencies and provider networks. To address these challenges, there is a need to establish dedicated resources to:
  - Improve communication and coordination across the care continuum (e.g., ambulatory, inpatient, post-acute)
  - Provide social services navigation across public and private entities

Further, input received indicated that the community would benefit from an ambulatory "health concierge" to provide navigation support and follow-up communication, regardless of the person's medical home.

CHNA Focus Group & MLKCH Community Convening

The purpose of these in-person sessions was to learn about the health-related, economic, and social needs of people living in the South Central Los Angeles community, especially the medically underserved, low-income, and minority populations. The discussions have been used to inform the CHNA and the development of MLKCH's community health improvement initiatives for 2020-2022.

MLKCH hosted a Community Convening on October 25, 2019 and engaged Premier to facilitate three focus groups during January and February 2020. All sessions were completed in English. A total of 38 individuals representative of 28 local community organizations attended the focus groups or the community convening. All were volunteer participants comprised of community leaders representing local area organizations (e.g., direct care providers, governmental agencies, social service providers, etc.) representing the South Central Los Angeles community's interests. Findings were summarized without detailing comments to specific individuals in order to respect participant confidentiality.

A list of the questions asked are detailed in Appendix H and highlights of findings follow:

- Participants defined "Health" broadly to include holistic views representative of a combination of physical, mental, and emotional well-being. Health was described as multi-dimensional including nutrition, housing, and safety as major attributes, in addition to mental and physical well-being.

"Health to me is physical stability and mental and emotional well-being. It's the ability to strive towards your goals and happiness."

—Community Member

- Participants identified several health issues affecting the community:
  - Access to medical care was emphasized as a concern, particularly for primary and preventive care; access to health insurance was noted as a major barrier to seeking and obtaining care.
  - A lack of specialists was mentioned, driven not just by numbers, but by insurance eligibility and geographical accessibility.
  - Chronic diseases such as obesity, high blood pressure, diabetes, and substance abuse were among the top conditions that are treated in the community.
  - Area residents suffer from drug and alcohol abuse at higher rates than other populations, which often go undiagnosed and untreated.
  - There is a high incidence of individuals requiring mental health services and a significant gap in appropriate services available to manage this population.

- There is a high number of STDs among age groups of 13 – 34 years. The lack of education on STDs was a concern because there is a general lack of knowledge of STDs, infection prevention methods, and the fact that the disease can be spread to others.
- Patients find it challenging to navigate the healthcare system without assistance. This challenge can result in delays in care making treatment more complex:
  - Due to an inadequate amount of clinical and social resources available
  - Limited knowledge of where to seek out and obtain assistance in the community
  - Complications of differences in patient eligibility status and in insurance products providers accept

"There is a missing link [synchronization of policies and resources, including electronic medical record integration] between the emergency room, the hospital, and public health."

—Community Member

Participants also identified social and economic issues that impact the health of the community:

- Health literacy and education were noted as two of the top factors. Without the proper baseline education, community members are unable to manage their own self-care and follow-up on conditions appropriately.
- Cultural competencies and language barriers were identified as concerns within the existing healthcare system and described as a reason why community members may avoid or limit their interactions with providers.
- Gainful employment was identified as a challenge for the community; access to benefits such as private health insurance is sometimes restricted, and the community struggles to afford reliable transportation, adequate housing, and healthy food options.
- The lack of available childcare resources and affordability for this service was noted as a limiting factor for our community members seeking to obtain gainful employment.
- Adverse childhood events such as poverty, hunger, parental loss or incarceration, and violence were notable factors that affect an individual's long-term health outcomes and longevity, and that of future generations.
- There was also discussion of not having enough social safety net programs in the community. Eligibility requirements are restrictive and inefficient for those resources that currently exist.

"Adverse childhood events continue to ripple through the community as patients grow up and have children themselves."

—Community Member

Of those topics discussed, the following were noted as the most significant concerns among focus group and community convening participants:

- Access to primary care and specialty providers was stated as one of the greatest health issues in the community. As a result, community members often prefer the ED because of its convenience, as they know their concerns will be addressed in a timely manner.
- Barriers to continuity of care across sites and services included data sharing limitations (within the electronic health record system) among providers for effective treatment planning. Transitions of care across organizations was considered the most challenging, and differences in eligibility and referrals among various insurances creates additional confusion.
- Mental health and substance abuse programs were identified as a top issue specific to inadequate resources available in the community and gaps in patient navigation across the system.

- Childhood Trauma was identified as a significant issue affecting generations of individuals and their ability to live a healthy and productive life. Trauma can lead to long-term substance abuse, poor health choices, inability to maintain employment, and often goes undetected in children. This often results in the use of medications to treat hyperactivity and other behavioral issues.
- Access to Wellness was also discussed in regard to prevention and restorative care (e.g., trauma). There is a need to integrate wellness with behavioral health programs.
- Self-sufficiency, education/health literacy and prevention were other important themes. Factors noted included changes to insurance plans and benefits, transportation due to location of services, health literacy, and self-advocacy.

"We focus on trauma-related issues at an adult level and [incorrectly] assume that children don't understand trauma."

—Community Member

Participants also identified actions and interventions that would have the greatest impact on overall community health and well-being:

- Access and clinical coordination: Enhanced care coordination and navigation through the use of health coaches, care navigators, and care managers combined with enhanced health education could provide benefit for the community. Assistance with transitions of care to facilitate follow-up appointments and medication adherence would reduce ED utilization and improve community health outcomes.
- Access and attracting more providers: Recruiting high quality providers to the community and assuring that providers within the community are utilizing standard, evidence-based protocols, were noted as high importance. Participants perceived that health outcomes would improve and ED use would decrease if: 1) the number of providers available – including physicians and advanced practice clinicians – increased; and 2) care coordination improved and was more effective.
- Collaboration and partnerships: Community health cannot improve without buy-in and collaboration from our community partners. Participants stressed the importance of including community members themselves as a partner – to communicate their needs, their preferences, and have input into decision-making.
- A focus on education: Education was discussed as a foundational activity that is required to change beliefs and behaviors. Providing our healthcare workers with cross-cultural educational training will help to build a trusting relationship with our community, with the objective of engaging patients in health and wellness, prevention, and chronic disease management. This is an evidence-based practice with demonstrated success.

- Other interventions discussed as impactful and important are identified as follows:
  - Access to 24-hour urgent care
  - Free mental health for adults and children
  - Transportation to alternative sites of care
  - Co-location of primary care services on housing development properties
  - Promoting health equity and cultural awareness (bias training, multicultural care, etc.)

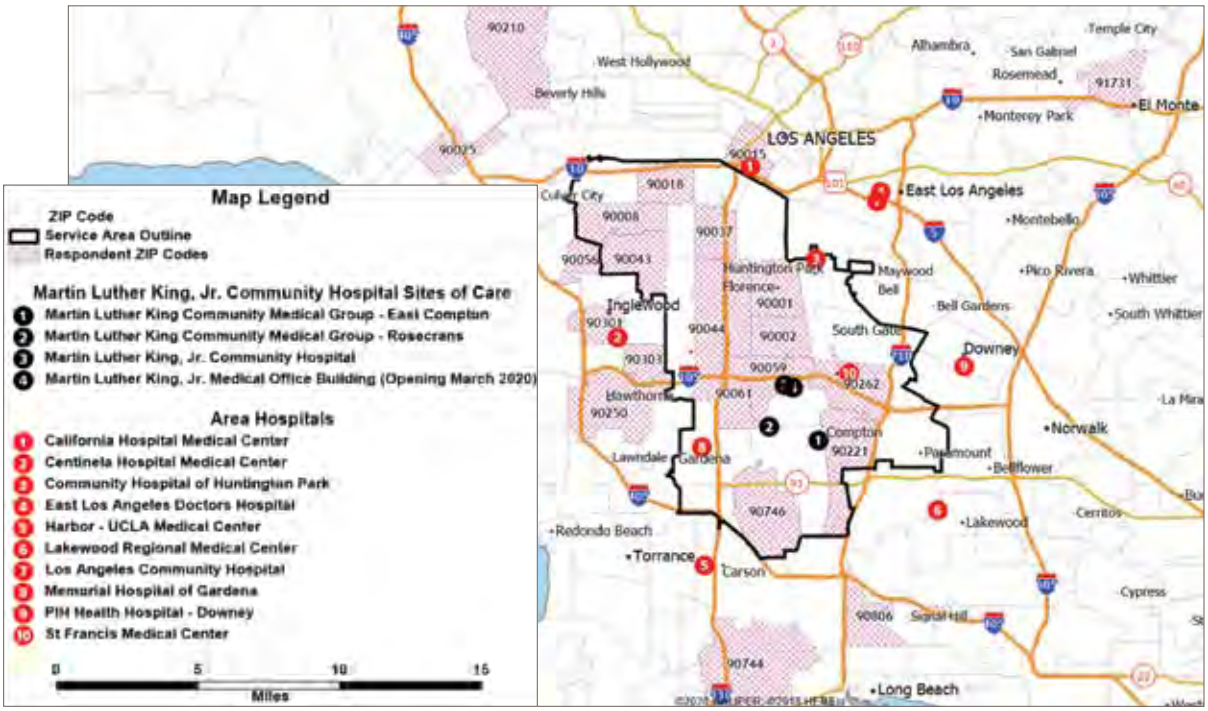
CHNA Survey

The purpose of the CHNA survey was to supplement the previous interviews and focus group studies and collect opinions in a standardized manner for use in informing the CHNA, the prioritization model, and the development of MLKCH's community health improvement initiatives for 2020-2022.

On behalf of MLKCH, Premier administered an online survey in English via SurveyMonkey. The survey consisted of 16 questions. Over 100 invites were emailed to community leaders representing 86 organizations (e.g., direct care providers; representatives of governmental, educational, and church organizations; social service providers, etc.) that serve some of the neediest residents in the South Central Los Angeles area. A total of 42 surveys were analyzed in this report representing 33 community organizations (4 incomplete surveys were excluded).

Survey respondents represented twenty-eight (28) local ZIP codes across the MLKCH service area and local community (90001, 90002, 90003, 90008, 90015, 90017, 90018, 90025, 90037, 90043, 90044, 90056, 90059, 90071, 90094, 90210, 90221, 90220, 90222, 90250, 90262, 90301, 90303, 90744, 90746, 90806, 91731, 90061).

Geographic Distribution of Survey Responses



A list of the survey questions are detailed in Appendix G and a key subset of responses follow:

Question 3: What are the biggest health issues in this community?[41]

The top three biggest health issues identified within the community by respondents were:

1) Mental Health
2) Diabetes
3) Trauma Violence

Nutrition/Healthy Foods and Obesity tied for fourth place, and Access to Specialty Care and Substance Abuse tied for fifth place.

Several write-in issues also identified a strong concern for mental health (suicide) and substance abuse (drug abuse), as well as maternal health and sexually transmitted diseases. Also mentioned: domestic abuse and a lack of services for specific populations (LGBTQ[IA] and the homeless).

[41] Responses = 42. Ranked in order of weighted average; Other issues detailed as unranked write-ins.

Question 4: Of the biggest health issues in this community listed above, in Q3, rank the top three (1 being the biggest issue):

In the prior question we asked respondents to identify the biggest health-related issues in the community. In this question we asked them to rank the top three health issues, which were ranked as follows:

1) Mental Health
2) Diabetes
3) Trauma Violence

If access to primary and specialty care were combined, together it would have ranked second.

Question 5: Many things outside of medical care can affect a person's health in this community. What are the most needed changes that would improve the health of the people that live in this community the most?

The most commonly identified issue outside of medical care that affects health is community safety. Homelessness and access to healthy foods / food security were also rated highly. Several of the write-in responses also mentioned these top three issues as concerns.

Question 6: Of the many things outside of medical care that can affect a person's health in this community and listed above, rank the top three (1 being the biggest improvement):

In the prior question we asked respondents to identify the biggest non-health related issues in the community. In the question below we asked respondents to rank the top three non-health related issues which they ordered as: 1) Community safety/reduced violence, 2) Improved housing/homelessness, and 3) More local jobs.

Question 9: What is your perspective on the potential barriers to health in this community?

The top barriers to health in this community were (1) lack of behavioral health resources, (2) lack of insurance, and (3) lack of wellness services. While the high cost of care was a top concern in the prior question, it was identified here as the fourth largest barrier to health.

Write-in answers described a lack of free classes and space to host classes, and lack of community outreach and engagement for available resources.

Question 13: Where do community members get most of their information on health or non-health resources?[42]

Respondents indicated that community members seek information on health or non-health resources from family or friends most often, followed by religious organizations. Community-based organizations and the internet/website tied for third place.

Specific to health, doctors or health care providers were tied with health fairs (33 responses).

MLKCH Research Report – Latino Markets

The MLK Community Hospital contracted with Public Values Research to conduct focus groups with Latino residents. The purpose of the research was to identify how Latinos, the single largest segment of the South Los Angeles Community, are accessing medical care, the barriers they face, and how the MLK Clinic can best meet their needs and expectations. The study addressed four major areas: (1) the healthcare routines of Latino patients, including their use of primary and emergency care; (2) the barriers Latino patients face accessing care; (3) what patients want from a healthcare provider; and (4) their willingness to change current healthcare routines. In addition, the study addressed awareness of the MLK Clinic, advertising channels, and the personal and professional relationships that influence patients' healthcare decisions. Study results will be used to inform a marketing plan for building patient volume at the MLK Clinic.

The report is based upon six focus groups with Latino residents living within SPA 6. All participants included in the study had health insurance and were either receiving Medi-Cal or met the program's income requirements (below 138 percent of the FPL). Focus groups were conducted in English and Spanish and included both men and women. The groups were held at professional focus group facilities in Downey on February 12 and 13, 2019. A total of 59 individuals participated in the research.

A selection of key findings that inform this CHNA follow:

- Findings suggest that a majority of insured patients in the MLK area receive some primary care services—usually at a community clinic—and have a relationship with a single, primary care physician.
- However, despite having a primary care doctor, patients continue to visit the emergency room and urgent care center for routine medical care because they are often unable to access services through their medical home.

[42] N=42. Note: Ranked in order by number of total responses (sum of source of information for health and non-health resources).

- Overall, the greatest barriers to accessing routine medical care are wait times for a primary care appointment followed by a lack of evening and weekend hours.
- Among Seniors, and those with chronic or acute medical conditions, the inability to secure a timely appointment with a specialist was a top concern.
- When asked what they want from a healthcare provider, patients most frequently described an integrated healthcare delivery system in which all services are coordinated and available at a single location, followed by minimal wait times for primary and specialist appointments.
- Although access was a top priority for patients, most participants expressed little interest in using telemedicine as a substitute for an in-person appointment.
- Spanish-speaking Seniors placed a premium on having a doctor who speaks Spanish.
- Findings suggest that vast majority of Latino residents are unaware of the MLK Clinic.

The report concluded that although the majority of focus group participants reported that they have a medical home, including a primary care doctor, they also reported that that they have limited access to those doctors when they need care. While this patchwork of primary care supplemented by emergency services may be inadequate, findings suggest that patients are familiar with these medical routines and are reluctant to change.

Resulting recommendations including considering physician messages that align with the priorities of patients; namely, high quality care and timely service, coupled with cultural and linguistic competency. For consumer benefit, MLKCH suggested conducting focus group research to test and refine consumer messages that communicate quality and convenience.

MLKCH Research Report – Breastfeeding Patients

As part of a larger effort to improve breastfeeding quality measures among African American and Hispanic women (who have the lowest rates of breastfeeding initiation and continuation compared with all other racial/ethnic groups) in South Los Angeles, MLKCH contracted with Public Values Research to conduct focus groups with mothers of young infants. The purpose of the research was to understand the motivators and barriers women face initiating and continuing breastfeeding and to identify the type of support and education that would be most helpful. The study addressed four major areas: (1) awareness and beliefs surrounding breastfeeding; (2) motivators and barriers that shape breastfeeding patterns; (3) support mothers want and need to initiate and maintain exclusive breastfeeding; and (4) motivators and barriers to participating in a breastfeeding class. Results from the study will be used to refine outreach strategies for developing the MLKCH breastfeeding program, attracting more patients to the breastfeeding classes, and for increasing the proportion of mothers in the MLKCH area who exclusively breastfeed.

The report is based upon four focus groups with African American and Hispanic women who had given birth within the last year. All participants lived within SPA 6 and were receiving Medi-Cal or had other insurance but met the income requirements for Medi-Cal (below 138 percent of the federal poverty line). Two groups were conducted with each racial/ethnic group, and all discussions were facilitated in English. The groups were held at professional focus group facilities in Downey on April 29 and 30, 2019. A total of 35 women participated in the study.

A selection of the report's findings, that inform this CHNA, follow:

- Although low-income African American and Hispanic women tend to be well informed about the benefits of breastfeeding, many have misconceptions about the extent to which breastfeeding is painful and/or injurious to mothers.
- The most powerful motivators driving women's decision to breastfeed are the belief that breast milk is healthier for the baby and that breastfeeding creates a unique bond between mother and child.
- The cost savings of breastfeeding over formula was not found to be an important factor in women's decision to breastfeed.
- The leading barrier to exclusive breastfeeding is concern that the baby is not getting enough milk and may be at risk.
- For many mothers going back to work was a significant obstacle to continuing to breastfeed.
- Mothers with children in the Neonatal Intensive Care Unit (NICU) faced additional challenges breastfeeding.

- The study found that postpartum depression might also play a role in some women's decision to discontinue breastfeeding.
- During pregnancy, most women receive information about the importance of breastmilk but do not always receive details about the challenges they might face and how to address those challenges.
- Feedback from focus group participants suggests that the support women receive from doctors, nurses and lactation consultants at the hospital varies significantly.
- When asked what support at the hospital would have been helpful, women most frequently said they wanted more compassion toward the mother.
- The majority of participants said they would have been interested in taking breastfeeding classes but stressed that resources were difficult to find.

The report concluded that efforts to educate low-income African American and Hispanic women about the benefits of breastfeeding are having an impact, but mothers would benefit from increased breastfeeding education and support.

Recommendations focused upon enlisting the help of local obstetricians and WIC staff to refer pregnant women to MLKCH's breastfeeding classes, refining the class curriculum to focus on solutions to common problems and address the largest barrier – concerns the baby is not getting enough milk, train educators on building trust with patients, focus resources on prenatal education before women are exhausted and overwhelmed caring for a newborn, and provide support to mothers in the hospital and after discharge.

Appendix E. Prioritization of Significant Health Needs

Overview

Recognizing that economic opportunities, environmental factors, health care infrastructure, and social networks are all key determinants of health, MLKCH is focused on reaching beyond the walls of the Hospital to address healthcare disparities and build health equity in our community. Through this CHNA, we analyzed data and obtained input from our community members and leaders to identify the major issue areas.

From these issue areas, we identified significant health needs based upon a review of published quantitative health status data specific to our community and qualitative data inputs collected throughout the CHNA process. Our assessment included consideration of the relative size of the issue, how important an issue was to the community, and how much of an opportunity there was for an impact to be made. Criteria were defined as Magnitude, Agreement, and Impact:

- **Magnitude** – sized the percentage of the population affected by the issue areas in comparison to the County percentages across 152 quantitative indicators collected from regional and national sources
- **Agreement** – assessed the community opinion of the issue areas being a significant health need through a composite score based upon key informant interviews, focus groups, a Community Convening, and the CHNA Survey
- **Impact** – for each of the issue areas, assessed sustainability of potential intervention for three or more years, level of opportunity for effectiveness with potential intervention, and alignment with current strategic priorities being undertaken in collaboration with other community partners

The data was scored based upon each of the three criteria and resulted in the final significant health needs for which we will address specific improvement activities in the Implementation Plan. The selected initiatives and resulting Community Service Plan were reviewed and approved by senior leaders in the context of our organizational mission, our clinical strengths, and partnerships. These final priorities were reviewed and approved by senior leaders on June 17, 2020 and will be presented to the Board of Directors on July 15, 2020.

1. Access to Preventive, Primary and Specialty Care
2. Management of Chronic Health Conditions
3. Behavioral Health
4. Education and Screenings
5. Homeless Health
6. Social Determinants of Health

Resources to Address Significant Needs

Potential community resources to address healthcare disparities were identified through market research and information received from interviews and meetings with the community. Specific resources potentially available to address the identified significant health needs are listed in the table below. This is not intended to be a comprehensive list of every available community resource, so for additional online tools please refer to Think Health LA at *www.thinkhealthla.org*, 211 LA County at *https://www.211la.org*, or the MLK Community Medical Group at *https://www.mlkcmg.org/community-resources*.

Significant Health Needs	Community Resources
Access to Preventive, Primary and Specialty Care	• Black Women for Wellness • Community Coalition South Los Angeles • Community Health Centers • County of Los Angeles Department of Social Services • Eisner Pediatric and Family Medical Center • Federally Qualified Health Centers • Healthy Way LA • Los Angeles County Department of Health Services - MLK Outpatient Center • Los Angeles County, First 5 LA - Welcome Baby Program • Los Angeles County Department of Public Health • Los Angeles County, Department of Public Health - Doula Program • Millers Children's and Women's Hospital • MLK Community Medical Group (MLK CMG) • Molina Health Center - Compton College Students • South Los Angeles Health Councils • St John's Well Child and Family Center • Watts Healthcare Corporation • Whole Person Care - Los Angeles
Management of Chronic Health Conditions	• American Diabetes Association • American Heart Association - Check.Change.Control Initiative • American Heart Association - Diabetes Initiative • American Heart Association - Target Blood Pressure Initiative • Choose Health LA • Community Health Centers • Los Angeles County Office of Education • MLK CMG - Diabetes Class Program • MLK CMG - Diabetes Disease Management Program • MLK CMG - HHP - Health Homes Program • National Health Foundation • Parks and Recreation programs • Playful City USA • Promotoras • Schools and school districts • YMCA Diabetes Prevention Program

Significant Health Needs	Community Resources
Education and Screenings	• Boys and Girls Clubs of Metro Los Angeles • CARE 1st Health Plan - Cholesterol, Diabetes, High Blood Pressure • Cedars-Sinai Medical Center (including Coach for Kids Program and Healthy Habits Program) • Community school partners (including Los Angeles Unified School District and Compton Unified School District) • LA Care Lynwood Family Resource Center • LA Care Inglewood Family Resource Center Los Angeles County, MLK Center for Public Health • Los Angeles County Department of Public Health • MLK CMG - Guide For Cardiac Heart Failure • MLKCMG - Diabetes • Partners in Care • St. John's Well Child and Family Center • To Help Everyone Health and Wellness Centers • World Health Organization UNICEF (Baby Friendly Hospital Initiative)
Homeless Health	• Harbor UCLA Medical Center • Homeless Access Center and Shelter Plus Care Program (also mental, substance abuse) • Homeless Healthcare Los Angeles • LA - HOP - Homeless Outreach Portal • Lestonnac Free Clinic - Dental • Martin Luther King Jr. Community Hospital • National University Nurse-Managed Clinic • SPA 6 Homeless Coalition • Street Medicine Program of USC Keck School of Medicine • Temporary housing and post-acute care providers
Behavioral Health – Mental Health	• 1736 Family Crisis Center • Amanecer Community Counseling Center Referral • APLA - AIDS Project LA Referral Services • Caring Connections • Children' s Institute • Community Family Guidance Center • Community Health Centers • Dignity Health Human Trafficking Response Program • Eisner Pediatric and Family Medical Center • Exodus Recovery at MLK • Los Angeles County Department of Mental Health • MLKCH Integrated Behavioral Health Program • NAMI • Schools and School Districts • South LA Health Project Program • Watts Counseling and Learning Center

Significant Health Needs	Community Resources
Behavioral Health - Substance Abuse	• Alcoholics Anonymous • Augustus Hawkins • Bridges, Inc. • Coalition of Mental Health Professionals • Community Healing and Prevention Center • Compton Family Mental Health Clinic • El Nido Family Center • Faith community • Kendren Community Health Center • LA CADA • Los Angeles County Sheriff's Department • Narcotics Anonymous • SAMHSA - Substance Abuse and Mental Health Services Administration • SHIELDS for Families • South LA LGBTQ Center • Southern CA Alcohol and Drugs Inc (various locations) • Stars Behavioral Health Group • UCLA Addiction Center
Social Determinants of Health	• Access Services • CalFresh - Nutrition Assistance Program (Los Angeles County Department of Public Social Services) • Community Gardens • Farmer's Markets • Food Pantries • Homeless Outreach Program Integrated Care System (HOPICS) • Housing Rights Center • Local Bus • Los Angeles County, SEE-LA (Sustainable Economic Enterprises of Los Angeles) • Los Angeles Food Policy Council • Los Angeles Homeless Services Authority (LAHSA) • Los Angeles Metro • My Friend's Place - Health and Well-being Program (WLCAC) • SHIELDS for Families • Taxi • Uber Health • Whole Person Care – Los Angeles (WPC-LA) • WIC (Women, Infants and Children)

Appendix F. Key Health Policy Impact

The healthcare policy environment contributes to community-wide health improvement or conversely to its challenges. In addition to quantitative and qualitative data, this CHNA also includes a review of several policies that could have a potential impact on the health status of our community. This selection of policies focuses on existing challenges faced by our community before the unprecedented COVID-19 pandemic began: access, chronic disease, behavioral health, homeless health, and general education and prevention. We expect that post-pandemic, these issues will continue to be our guiding priorities to improve the overall health and wellness of our community. We also recognize that our environment—and the policies that shape our healthcare delivery system—will be heavily impacted by today's pandemic and could potentially shift priorities and increase the number of public policy conversations. For this reason, the below selection is considered a snapshot in time.

"Understanding the political side, politics and advocacy is key [for health improvement]."

—Community Member

Public Charge Rule

Potential Impact: Potential unfavorable impact on residents with a green card or those who may apply for one. These individuals may potentially forego healthcare in fear of losing citizenship status.

On January 27, 2020, the US Supreme Court ruled that the Department of Homeland Security (DHS) can now implement their new rule relating to the "public charge" ground of inadmissibility (grounds of inadmissibility are reasons that a person could be denied a green card, visa, or admission into the United States). DHS announced that the rule will go into effect on February 24, 2020.

Under longstanding policy, the federal government could deny an individual entry into the US or adjustment to legal permanent resident status (i.e., a green card) if determined likelihood to become a public charge. However, the new rule allows officials to consider use of certain previously excluded programs, including non-emergency Medicaid for non-pregnant adults, the Supplemental Nutrition Assistance Program (SNAP), and several housing programs, in public charge determinations. The changes create new barriers to getting a green card or immigrating to the US and will likely lead to decreases in participation in Medicaid and other programs among immigrant families and their primarily US-born children beyond those directly affected by the new policy. Decreased participation in these programs would contribute to more uninsured individuals and negatively affect the health and financial stability of families and the growth and healthy development of their children.

Affordable Care Act (ACA) Challenge

Potential Impact: Potential unfavorable impact on persons who have been able to obtain health insurance and ACA protections.

A group of states challenged the ACA on the grounds that the individual mandate with no tax penalty was not a tax and therefore unconstitutional. A Federal Judge in Texas agreed with this reasoning and ruled that the individual mandate is unconstitutional without a tax penalty and that the law should be struck down.

The case is now before a Federal Appeals Court in New Orleans, and a ruling on this issue is expected at any time. If the ACA were ruled unconstitutional, health insurers could refuse coverage or otherwise discriminate against patients who have preexisting conditions. Additionally, it would mean that roughly 20 million people who obtained insurance after the ACA was implemented could lose it. The ACA also made other sweeping changes to the healthcare system, including: expanding Medicaid/Medi-Cal eligibility for low-income adults; requiring private insurance, Medicare, and Medicaid/Medi-Cal expansion coverage of preventive services with no cost sharing; phasing out the Medicare prescription drug "donut hole" coverage gap; establishing new national initiatives to promote public health, care quality, and delivery system reforms; and authorizing a variety of tax increases to finance these changes. All of these provisions could be overturned if the trial court's decision is upheld.

California Advancing and Innovating Medi-Cal (CalAIM)

The current Medi-Cal 2020 waiver ends in December of 2020 and could result in the elimination of programs with public benefit. CalAIM is a new multi-year initiative by the Department of Health Care Services to improve the quality of life and health outcomes of the population by implementing broad delivery system, program, and payment reform across the Medi-Cal program.

The major components of CalAIM build upon the successful outcomes of various pilots including but not limited to the Whole Person Care Pilots, Health Homes, and the Coordinated Care Initiative. CalAIM has three primary goals that aim to improve care for the state's Medi-Cal patients.

- Identify and manage member risk and need through 'Whole Person Care' approaches and addressing Social Determinants of Health.
  - Require plans to submit local population health management plans.
  - Implement new statewide enhanced care management benefit.
  - Implement in lieu of services (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).

- Implement incentive payments to drive plans and providers to invest in the necessary infrastructure, build appropriate enhanced care management and in lieu of services capacity statewide.
- Evaluate participation in Institutions for Mental Disease Serious Mental Illness/Serious Emotional Disturbance Section 1115 Expenditure Waiver.
- Require screening and enrollment for Medi-Cal prior to release from county jail.

- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility. Examples of activities follow:
  - Standardization and improvements for managed care benefits and enrollment statewide.
  - Administrative behavioral health integration statewide and revisions to behavioral health medical necessity criteria.
  - Substance use disorder managed care program renewal and policy improvements.
  - New dental benefits and new reimbursement models for dental homes.
  - Enhancement of oversight and monitoring of Medi-Cal Eligibility and the California Children's Services and the Child and Disability Prevention program.
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

California Vaccination Requirements

SB 276 and SB 714 were passed by the California State Legislature and signed into law together by Governor Gavin Newsom on September 9, 2019. These rules effective January 1, 2020 are expected to increase the number of vaccinations among schoolchildren, decreasing unnecessary outbreaks and potential severe illnesses and deaths.

While this issue continues to be divisive, the two laws will make it harder for California parents to avoid vaccinating their children. The new vaccine rules require the state to investigate doctors who give out more than five medical exemptions in a year and schools with immunization rates under 95%. Students without exemptions must be vaccinated to attend school in California.

Mental Health Conservatorship

The passage of mental health conservatorship legislation, SB 1045 in 2018 and SB 40 in 2019, could potentially ease the process for judges to order some homeless people with mental health issues into guardianship and provide them with treatment they otherwise may not voluntarily accept.

Due to its strict requirements, the program is not expected to apply to many people, but it remains controversial and is limited to the three Counties of San Diego, Los Angeles, and San Francisco that have an option to create the program. At the time of this analysis, only San Francisco has approved enforcing this rule. The goal is to help homeless people with such severe addiction or mental issues that they are unable to make their own decisions responsibly, are in danger of seriously harming themselves, leading them to housing and treatment.

Payment Parity for Telehealth Services

Payment parity for telehealth services is expected to benefit patients by increasing access and availability to healthcare services and grow telehealth services throughout California.

California's prior telehealth coverage law did not include a payment parity provision requiring health plans to pay providers at the same or equivalent rate providers are paid for identical in-person services. The law now requires that health plans must reimburse the provider for services delivered through telehealth at the same rate and basis as if treatment were given in-person. The law applies to contracts starting or renewed on or after January 1, 2021.

In March of 2020, CMS approved temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the COVID-19 pandemic. Among these new rules, telehealth flexibilities were provided to Medicare and Medicaid to ensure patients have access to physicians and other clinicians while keeping patients safe at home. We expect there to be advocacy efforts to keep the telehealth and other flexibilities in place post-pandemic.

Appendix G. CHNA Survey Questions

Martin Luther King, Jr. Community Hospital

Martin Luther King, Jr. Community Hospital 2020 Community Health Needs Assessment Survey

Introduction

Welcome to the Martin Luther King, Jr. Community Hospital (MLKCH) community health needs assessment (CHNA) survey. We greatly appreciate you taking the time to complete these questions which will be used to gain insight into the health issues and concerns of the South Central Los Angeles community and to inform the community health improvement initiatives that MLKCH is developing.

- **The survey is anticipated to take approximately 15 minutes to complete.**
- **The survey is set up so that you may exit the survey and return to edit or complete your responses at a later time.**
- **Please return to the survey using the same computer because using a different computer IP address will start a new survey.**
- **Premier is requesting that you submit your name, organization and email address only for purposes of managing survey responses.**

Premier is conducting this survey on behalf of MLKCH and will be the only ones to view individual responses, the survey report will only summarize responses in aggregate. If you have any questions or concerns before, during or after the survey, please feel free to contact Sonia Greer at Sonia_Greer@premierinc.com or 512-762-7481.

* 1. Respondent:

Name	
ZIP Code	
Email Address	

Martin Luther King, Jr. Community Hospital

Martin Luther King, Jr. Community Hospital 2020 Community Health Needs Assessment Survey

Health Issues in the Community

The following questions in this section ask about the health of people living in this community and what actions would improve the health of its residents.

* 2. Overall, how would you rate the health of the people in this community?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

3. What are the biggest health issues in this community?

	Strongly disagree this is an issue	Disagree this is an issue	Neutral or N/A	Agree this is an issue	Strongly agree this is an issue
Access to primary care	○	○	○	○	○
Access to specialty care	○	○	○	○	○
Adolescent health	○	○	○	○	○
Asthma/breathing problems	○	○	○	○	○
Cancer	○	○	○	○	○
Dental care	○	○	○	○	○
Diabetes	○	○	○	○	○
Exercise/physical activity	○	○	○	○	○
Falls among older adults	○	○	○	○	○
Heart disease	○	○	○	○	○
Hepatitis C	○	○	○	○	○
High blood pressure	○	○	○	○	○
HIV/AIDS	○	○	○	○	○
Mental health (depression, etc.)	○	○	○	○	○
Nutrition / Healthy Foods	○	○	○	○	○
Obesity	○	○	○	○	○
Sexually Transmitted Diseases (STDs)	○	○	○	○	○
Sickle cell anemia	○	○	○	○	○
Smoking/tobacco use/vaping	○	○	○	○	○
Substance abuse (alcohol, drugs)	○	○	○	○	○
Teen pregnancy	○	○	○	○	○
Trauma / Violence	○	○	○	○	○
Women's healthand prenatal care	○	○	○	○	○

Other health issue not mentioned above, I strongly agree is a concern (please specify).

4. Of the biggest health issues in this community listed above, rank the top three (1 being the biggest issue):

	Choose one
Ranked #1	
Ranked #2	
Ranked #3	

5. Many things outside of medical care can affect a person's health in this community. What are the most needed changes that would improve the health of the people that live in this community the most?

	Strongly disagree change would help	Disagree change would help	Neutral or N/A	Agree change would help	Strongly agree change would help
Better air quality	○	○	○	○	○
Better water quality	○	○	○	○	○
Community safety/reduced violence	○	○	○	○	○
Food security	○	○	○	○	○
Improved housing /homelessness	○	○	○	○	○
Increased number of places where older adults can live and socialize	○	○	○	○	○
More local jobs	○	○	○	○	○
More parks and recreation centers	○	○	○	○	○
More places to access healthy foods	○	○	○	○	○
More public transportation options	○	○	○	○	○
Reduced tobacco smoking	○	○	○	○	○

Other changes not mentioned above, I strongly agree would improve the health of this community.

6. Of the many things outside of medical care that can affect a person's health in this community and listed above, rank the top three (1 being the biggest improvement):

	Choose one
Ranked #1	
Ranked #2	
Ranked #3	

7. Which vulnerable population needs the greatest attention?

- [ ] Infants/young children
- [ ] Teens
- [ ] Uninsured adults
- [ ] Senior citizens
- [ ] Other (please specify)
- [ ] Foreign born
- [ ] LGBTQIA
- [ ] Disabled

Martin Luther King, Jr. Community Hospital

Martin Luther King, Jr. Community Hospital 2020 Community Health Needs Assessment Survey

Barriers to Care

The following questions in this section ask about potential barriers to health for this community.

* 8. What concerns prevent people in this community from seeking medical care?

	Strongly disagree this is a concern	Disagree this is a concern	Neutral or N/A	Agree this is a concern	Strongly agree this is a concern
Concerned about language or translation issues	○	○	○	○	○
Could not get an appointment soon enough or at the right time	○	○	○	○	○
Does not have a doctor / does not know where to go	○	○	○	○	○
Does not have time	○	○	○	○	○
Does not have transportation	○	○	○	○	○
Does not like to go to doctor	○	○	○	○	○
Does not understand the benefit of seeing a provider	○	○	○	○	○
Has other responsibilities (work or childcare)	○	○	○	○	○
High cost of care (e.g., copay, deductible)	○	○	○	○	○
No trust of the health system	○	○	○	○	○
Not currently insured	○	○	○	○	○

Other concerns not mentioned above, I strongly agree prevent people in this community from seeking care (please specify).

* 9. What is your perspective on the potential barriers to health in this community?

	Strongly disagree on barrier	Disagree on barrier	Neutral or N/A	Agree on barrier	Strongly agree on barrier
Information and education about health issues are a barrier in this community	○	○	○	○	○
Understanding where to go for needed services is a barrier in this community	○	○	○	○	○
Adequate health resources for children is a barrier in this community	○	○	○	○	○
Adequate health resources for senior citizens is a barrier in this community	○	○	○	○	○
Adequate health resources for uninsured and underinsured is a barrier in this community	○	○	○	○	○
Adequate resources for behavioral health is a barrier in this community	○	○	○	○	○
Adequate resources for trauma injury and recovery is a barrier in this community	○	○	○	○	○
Adequate resources for wellness services is a barrier in this community	○	○	○	○	○
Supply (number, type of providers) is a barrier to access in this community	○	○	○	○	○
Cost of care is a barrier to access in this community	○	○	○	○	○

Transportation is a barrier to access in this community	○	○	○	○	○
Language and culture are a barrier to access in this community	○	○	○	○	○
Previous negative experiences are a barrier to access in this community	○	○	○	○	○

Other barriers not mentioned above, I strongly agree are a concern (please specify).

Martin Luther King, Jr. Community Hospital

Martin Luther King, Jr. Community Hospital 2020 Community Health Needs Assessment Survey

Health Care Use and Preferences

The following questions in this section ask about the use of services or programs by people living in this community.

* 10. Where do community members go (or say they go) for care?

	Never go for care	Sometimes go for care	Often go for care
Alternative care (herbalist, acupuncturist, etc.)	○	○	○
Community health center	○	○	○
Doctor's office	○	○	○
Emergency Room	○	○	○
Los Angeles Department of Health	○	○	○
Spiritual healer	○	○	○
Don't go anywhere	○	○	○

Other places not mentioned above, I strongly feel people in the community go for care (please specify).

* 11. How likely are community members to go to health programs on topics like the ones below?

	Not at all likely	Somewhat likely	Neutral or N/A	Very likely	Extremely likely
Physical fitness program	○	○	○	○	○
Healthy nutrition/cooking class	○	○	○	○	○
Diabetes self-management program	○	○	○	○	○
Asthma self-management program	○	○	○	○	○
Stress-reduction class	○	○	○	○	○
Quit smoking program	○	○	○	○	○
Community education lectures	○	○	○	○	○

* 12. What health or non-health programs do community members most need that are not readily available/accessible locally? Please specify.

Program (1) _____

Program (2) _____

Program (3) _____

Martin Luther King, Jr. Community Hospital

Martin Luther King, Jr. Community Hospital 2020 Community Health Needs Assessment Survey

The following questions in this section ask about where information is obtained or how community members prefer to communicate.

13. Where do community members get most of their information on health or non-health resources?

	Source of Information for Health Care/Resources	Source of Information for Non-Health Support/Resources
Books	☐	☐
Community based organization	☐	☐
Doctor or health care provider	☐	☐
Family or friends	☐	☐
Health fairs	☐	☐
Health insurance plan	☐	☐
Internet/website	☐	☐
Library	☐	☐
Los Angeles County Health Department	☐	☐
Newspapers or magazines	☐	☐
Radio	☐	☐
Religious organizations (e.g., church, temple)	☐	☐
School	☐	☐
Television	☐	☐
Workplace	☐	☐

14. Are there other resources for community members to get health or non-health information?

	Source of Information for Health Care/Resources	Source of Information for Non-Health Support/Resources
Other resource (1)	○	○
Please specify resource:		
Other resource (2)	○	○
Please specify resource:		

* 15. In what ways do community members prefer to communicate? (Check all that apply)

- ☐ Email
- ☐ In-person
- ☐ Online provider portal (e.g., MyChart)
- ☐ Other (please specify)
- ☐ Telephone
- ☐ Text messaging
- ☐ Video conferencing (e.g., FaceTime, Skype)

* 16. In what primary languages do community members prefer to communicate? (Check all that apply)

- ☐ Asian language
- ☐ English
- ☐ Spanish
- ☐ Other language (please specify)

Thank you for helping us better understand the health needs of your community!

Appendix H. CHNA Focus Group Discussion Guide

Thank you for taking the time to meet with us today. We want to talk to you today about health issues and health care services in this community. This focus group is part of a community health needs assessment (CHNA) to find out about the health-related needs of people living in the South Central Los Angeles community. We are conducting the CHNA on behalf of Martin Luther King Community Hospital (MLKCH) and we will report back to them a summary of the information we get from this and other groups. The information that you provide will help MLKCH develop community health improvement initiatives.

1. To start, we'd like to hear a little about you, including how long you have lived in or worked with this community and one thing you like about it.
2. We're interested in hearing about what health means to you. Briefly, how do you define "health" and what does a healthy community mean?
3. What do you think are the greatest health issues for people living in this community? (e.g., particularly common illnesses or problems)
    a. Why do you think [x health issue(s) mentioned] is so common here? (prompt if needed: age of the population, diet, lifestyle, pollution, other environmental factors)
    b. What populations are most affected? (race, age, gender, neighborhoods, foreign-born, LGBTQIA, etc.)
4. [If not mentioned] Are there any particular mental health issues that people in this community face, including depression, anxiety, trauma, or stress?
    a. Why do you think [x mental health-related issue(s) mentioned] is/are significant here?
    b. What kind of services are available for people with mental health concerns?
5. [If not mentioned in Q4] Is drug and alcohol use an issue in this community?
    a. Why or why not?
    b. What kind of services are available for people struggling with drug or alcohol use?

Now we're going to ask a little more about daily life in this community.

6. There are also many things outside of medical care can affect a person's health in this community. What are the most significant social determinants of health that impact this community?
    a. (prompt if needed: community safety, trauma, violence, housing, food security, transportation, social support, employment, air/water quality)
    b. Which particular neighborhoods or populations within the community are most affected by these needs (for who or where are these needs most prevalent)?
7. What are strengths in your community that contribute to community health? Are there things about this community that affect health in a positive way, for example good housing or access to healthy food?
8. What kinds of resources or assets exist in this community to help people deal with the challenges that we just discussed (If needed: like housing, transportation, employment)? Can you explain?
    a. What kinds of organizations do people look to for help with these challenges? Why?
    b. What about faith-based organizations like churches or mosques? Others?
    c. If you've ever used services like these, how helpful were they? Why/why not?
9. What resources, services, programs are missing?
    a. Medical/clinical care
    b. Behavioral health, including trauma services
    c. Dental
    d. General wellness
10. Which resources should be prioritized?
11. How easy is it for community members to navigate to needed resources? How can this be improved?
    a. Medical/clinical care?
    b. Health and wellness programs?
    c. Other community-based services?

Now I'd like to talk more specifically about healthcare.

12. Where do community members go if they have health issues?

a. Chronic issues?

b. Acute issues?

13. There are significant numbers of community members that seek non-emergent care in the MLKCH Emergency Department. Why do community members go to the MLKCH ED instead of other sites of care? How best can community members be helped to navigate to a more clinically appropriate and lower cost site of care?

14. Where do community members go if they are feeling sad or anxious and need help with that? [Probe if necessary: a therapist? Someone at a community-based organization? A religious leader? A friend or family member?]

a. How willing are people to seek help for these kinds of issues?

b. What might encourage people to get help for these types of issues?

15. Overall, how easy or difficult do you think it is for community members to get health care?

a. What specifically makes it easy—or difficult—to get health care in this community?

b. Is cost of services an issue?

c. Is insurance an issue?

d. Is language – or provider sensitivity an issue?

e. Is time (i.e. work or childcare) an issue?

f. Is access an issue?

16. In your experience, what are the most effective modes of communication with community members? In person? Telephone? Email or text? Virtual video chat?

17. Would community members want to see a doctor via telephone or computer (like a videochat) when sick, instead of going in to see the doctor in person?

18. Where do community members go to learn about health – things like diabetes prevention, blood pressure or cancer screening, etc.—what kind of information is available to people living in this community, if any?

a. Who provides this information? How do they do that?

b. Has anyone here ever used a service like this? If yes, what did you think?

19. What other kinds of programs exist in this community to help people stay healthy? This could be things like WIC, free exercise classes, or community health workers, for example.

    a. Has anyone used these programs?

    b. How helpful are they, in your opinion?

    c. What kind of programs do you think there could be more of?

This final set of questions are about possible improvement activities.

20. Do you see any potential areas for collaboration or coordination between hospitals, community organizations, and/or businesses (i.e., health or social providers, local government, etc.) that do not currently exist?

21. In your experience, what are the most effective program/service delivery models for addressing health issues?

22. What is the one most impactful intervention that could be made in this community to improve the health of all?

23. As we mentioned in the beginning of the group, the purpose of this conversation is to help MLKCH think about ways they can support the health of this community including things they do outside their walls.

    a. Are there any things we haven't talked about that you think MLKCH could do to help improve the health of the community?

    b. Are there any other major barriers to improving the health in this community we've not yet discussed, but should be on MLKCH's radar?

24. What else is important for us to know about your organization or the community you serve?

25. Before we close, do you have any other comments about health or health care here – anything we haven't discussed?

26. Do you have any questions for us?

Thank you!