Community Benefit Report and Plan FY 2022

PRESENTED BY: MLK Community Healthcare

SUBMITTED TO:

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MLK Community Healthcare

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Message from the CEO

MLK Community Healthcare is emerging from the COVID pandemic proud of our service to the community. We worked harder, faster and more innovatively to serve huge numbers of patients. Even in the midst of the pandemic, we never lost sight of the big picture — that the pandemic was fueled and worsened by pre-existing disparities in access to healthcare. To fight future pandemics and improve the health of our community, we need to confront these disparities and level the playing field by delivering equitable access to a full continuum of healthcare for South Los Angeles.

So, we have continued to invest in outpatient care and recruiting more doctors to our community. We achieved certification for advanced inpatient diabetes care, a significant milestone for a hospital in a community with an epidemic of diabetes. We opened a lactation clinic that offers free breastfeeding support and guidance to South LA moms, regardless of their insurance status. And, in a county with a high number of tuberculosis cases, we were one of eight healthcare organizations in the nation recognized by the U.S. Centers for Disease Control and Prevention as a CDC Tuberculosis Elimination Champion.

We intend to continue investing in our community and expanding services. In the coming years, we plan to add diagnostic heart procedures, acute psychiatric stabilization services and street medicine, among other services.

We believe in our community and the idea that all people — regardless of race or economic status — deserve high quality care. As we have done from the beginning, we will continue to strongly advocate for our community and patients with policymakers and other stakeholders. We hope you will join us on this journey.

Elaine Batchlor, MD, MPH
CEO, MLK Community Healthcare

About our community

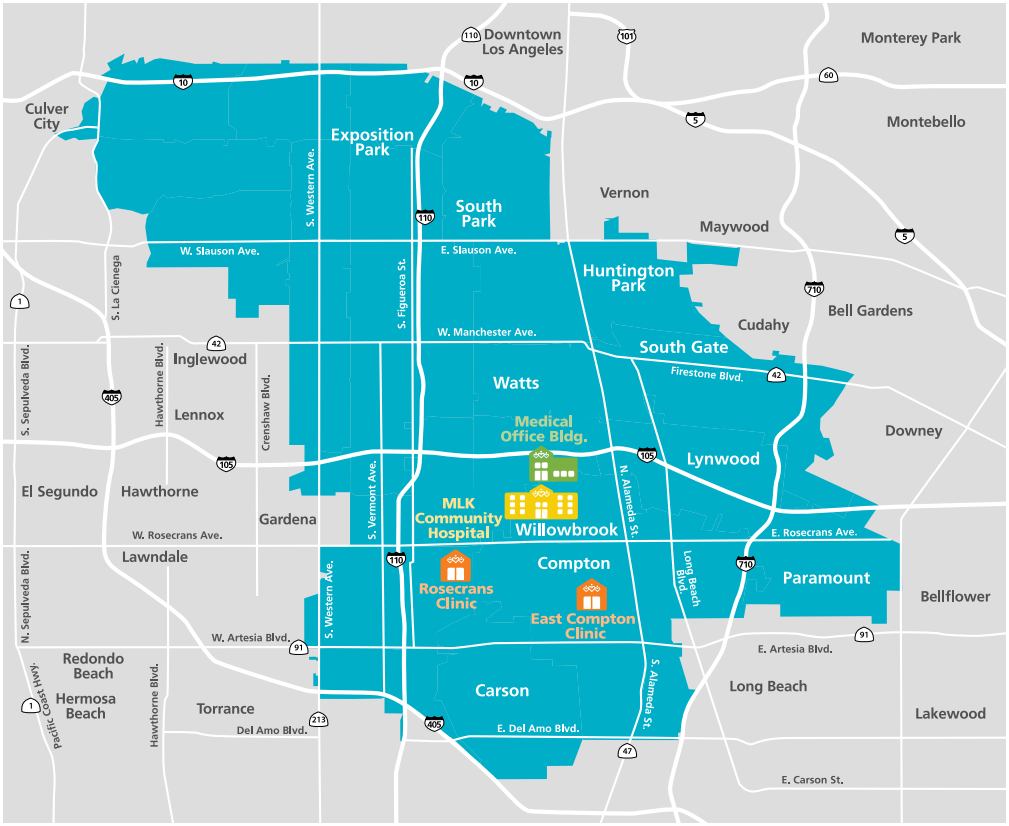
South Los Angeles is a community rich in history, diversity and culture. Its importance as the cradle of social justice and artistic and culture change cannot be understated. From its earliest agrarian roots, to the Great Migration that brought African Americans from the deep South, to even more recent Latino influxes, successive waves of immigrants have shaped a distinctive sensibility and their struggles and achievements have forged a unique South LA voice and identity. It is a privilege to serve this diverse, dynamic and ever-changing community at the intersection of critical social debates about how, and why, we provide high-quality care in an under-resourced community.

Social challenges and health disparities

South Los Angeles is home to one of Los Angeles County's most vulnerable populations. Its 1.3 million residents — **71%** Hispanic and **22%** African American — have a poverty rate of **22%**, double that of California. Years of underinvestment in the community have resulted in social and economic conditions that include lack of access to healthy food, unemployment and homelessness.

These conditions drive one of the key challenges to healthcare in our community — a deficit of **1,400** doctors, both primary care and specialists, important to the treatment of chronic disease. Large areas of South Los Angeles, including the MLK Community Healthcare service area, are federally designated as a Healthcare Professional Shortage Area, a Medically Underserved Area or both. Residents struggle to access preventive, primary and specialty care, often using the emergency department (ED) because of the lack of outpatient services. Not surprisingly, our community has the lowest life expectancies and the worst health outcomes in Los Angeles County.

Service area map



MLK Community Healthcare service area

Geographic Area	ZIP Code
Carson	90746, 90747
Compton	90220, 90221, 90222
Gardena	90247, 90248
Huntington Park	90255
Los Angeles (includes Hawthorne, Inglewood, Watts, and Willowbrook)	90001, 90002, 90003, 90007, 90008, 90011, 90016, 90018, 90037, 90043, 90044, 90047, 90059, 90061, 90062, 90089
Lynwood	90262
Paramount	90723
South Gate	90280

About MLK Community Healthcare

MLK Community Healthcare (MLKCH) is a private, nonprofit, safety net hospital and health system situated on the MLK Medical Campus in South Los Angeles. Our mission — to provide compassionate, collaborative, quality care and improve the health of our community — drives quality patient care and programs that address prevention and social conditions that impact health. Specifically, MLK Community Healthcare offers:

MLK Community Hospital: A 131-bed facility for inpatient care, offering emergency, maternity, general surgery and ancillary services typical of a community hospital.

Outpatient care: We operate multiple outpatient care sites throughout South LA, offering primary and specialty care.

Wound care: MLKCH operates South LA's only wound care center with hyperbaric chambers for advanced treatment of non-healing wounds.

Community-based care: MLKCH offers a range of in-community programs, including health education and screening, mobile health care, in-home care and street medicine.

Mission

Our mission is to provide compassionate, collaborative, quality care and improve the health of our community.

Vision

Our vision is to be a leading model of innovative, collaborative, community healthcare.

Values

Our values: Caring, Collaboration, Accountability, Respect and Excellence.

Community health needs assessment

The most recent Community Health Needs Assessment (CHNA) was completed in 2020. The CHNA identified priority health needs in the community and analyzed a broad range of social, economic, environmental, behavioral and clinical elements that contribute to health. To better understand overall needs of the community, the CHNA team reviewed quantitative data from a variety of published sources. These data elements were compared to benchmark data, such as SPA (Service Planning Area) 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, solicitation of written comments, community convenings and focus groups. As a result of the CHNA process, MLKCH, in collaboration with community partners, identified six priorities to address over the next three years:

- Access to Preventive, Primary and Specialty Care
- Behavioral Health
- Management of Chronic Health Conditions
- Education and Screenings
- Homeless Health
- Social Determinants of Health

The complete CHNA can be accessed at https://www.mlkch.org/community-reports and a paper copy is available for inspection by the public upon request. Feedback on this report is welcome. To send written comments or request more information on the 2020 CHNA contact kyb@mlkch.org.

Community benefit services summary—Fiscal Year 2022

Improving the health of our community

During this past year MLK Community Healthcare expanded access to quality care and health education throughout our South Los Angeles community, even with the emergence of the unprecedented COVID crisis. Programs were implemented or expanded to address needs identified in the 2020 CHNA. Using the framework developed in the Implementation Strategy, services for community health improvement extended across the six priorities identified in the 2020 CHNA:

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

1. Access to preventive, primary and specialty healthcare

Increase the number of doctors

Our commitment to providing a larger network of doctors trained in a variety of specialties, enabled by strong philanthropic support, remained firm. Over the past year, we recruited eight more doctors to our outpatient care centers. These doctors include child, adolescent and adult psychiatrists; internal medicine; pediatrics; and specialties related to the treatment of diabetes, heart, and respiratory diseases.

MLKCH continues to build a full scope of services that will give South LA residents true access to quality care in their community.

Expand access to medical specialists and services

Access to specialty care is critical to managing conditions like diabetes, heart disease and respiratory disorders. Our expansion of medical specialists supported effective treatment and aligned with our Implementation Strategy goals of improving access to care and management of chronic health conditions. Initially offering family medicine, MLKCH now offers care across 16 specialties: internal medicine, addiction medicine, cardiology, endocrinology, gastroenterology, general surgery, hand/plastic surgery, infectious disease, neurology, pediatrics, podiatry, psychiatry, pulmonology, rheumatology, urology, and vascular surgery.

MLKCH continues to coordinate care across inpatient and outpatient settings. In FY 2022, through this care coordination 10% of patients seen at the hospital also accessed primary care at our outpatient care centers. With the assistance of follow-ups from our COPE Health Scholar and Care Navigator student support programs, patients attended 860 follow-up visits. Better access to care allowed us to build the infrastructure needed for the establishment of comprehensive centers of excellence for treating persons with chronic diseases.

Space and services

The new medical office building on the MLK Medical Campus, which is supported by MLKCH, opened in March 2020. In addition to expanded space for doctor visits, the medical office building offers outpatient surgery, wound care, dental services, a pharmacy, and space for training and education. During Fiscal Year (FY) 22, 15,057 patients were served through specialists/medical services, including 65% of the total number of new patients. As part of our commitment to provide residents with assistance to enroll in health insurance programs, the hospital continued to provide space rent-free to the Los Angeles County Department of Social Services. Health advocates helped patients obtain health insurance and other public assistance programs, including food support (Supplemental Nutrition Assistance Program (SNAP) and WIC (Women, Infants, and Children).

Financial assistance

Financial assistance comprised more than half of the community benefit contribution this past year. We helped 1,648 patients sign up for Medi-Cal and of those 762 were approved for benefits. Additionally, 2,647 patients were placed on temporary Medi-Cal while waiting for their applications to be finalized. In total, MLKCH helped enroll 3,409 patients who did not have health insurance. The financial assistance the hospital provides was an essential part of ensuring quality care and an invaluable component of improving the health of our community. MLKCH waived approximately 12% of patient revenue this past year through the Financial Assistance Program.

Telehealth services

Telehealth services increase access to health care and social services for community residents of South LA. We provided care for 21% of our patients using telehealth services, including video and telephone visits. In total, 3,098 patients completed 7,060 telehealth visits in FY22. Telehealth services saved patients driving time of 278,604 minutes (45 minutes on average one way) and 142,140 miles (23 miles on average per patient). Providing telehealth helped to keep patients out of the ED and provided the appropriate care for our community residents.

Transportation assistance

MLKCH offered transportation assistance to eliminate barriers to health care access. For example, in FY22, we supplied 720 bus tokens and metro TAP cards free of cost to patients experiencing homelessness.

Community health programs

Know Your Basics (KYB), our signature community health program, offered screenings, health education, resource referrals, health insurance education and peer support to residents throughout South Los Angeles. KYB reached residents in their communities — at shopping malls, farmers' markets, community health fairs, barber shops, beauty salons, churches, schools and housing projects. Nursing students from local colleges and nurse organizations conducted health screenings for glucose, blood pressure and body mass index (BMI). MLKCH's nurses and staff also volunteered their support. During this past year, we partnered with 16 organizations at community events and provided 955 health screenings.

Due to the COVID pandemic, the KYB program decreased screenings and instead offered vaccine clinics and expanded services. Our mobile outreach grew as we went from one van servicing the community to three vans and ran 39 COVID mobile vaccine clinics, reaching about 2,000 community members. The mobile outreach efforts also offered an opportunity to connect patients with our network of care; 2% of patients received follow-up care with MLKCH.

In addition to in-person community engagement and education, our Know Your Basics email newsletters offered health tips and resources to over 7,200 residents in the community. Topics ranged from chronic medical conditions, women's and men's health, social justice and mental health.

Maternal and infant health

The need to expand prenatal care and post-delivery support for expectant mothers in the community remained a priority for MLKCH. Through our affiliations with Miller Children's and Women's Hospital Long Beach and Planned Parenthood, as well as with the addition of pediatricians to our care centers, we increased access to medical specialists in maternal and child health, along with access to a full range of family planning and contraceptive services. At MLKCH our delivery model includes a 24/7 labor and delivery team of affiliated nurse midwives and doctors who work together to ensure healthy childbirth. Our Welcome Baby program provided home and community-based post-delivery support services for new mothers, including home visits following birth. Our Welcome Baby program served 678 existing families and enrolled 243 new families to receive home visits, post-delivery assistance and education.

To improve access to education for mothers and to extend maternal best practices, our perinatal team continued two community programs this year for new and expectant mothers: the First 48 Hours class and the Mommy Support Group. In FY22, MLKCH's affiliated maternity team provided virtual education to 34 new moms or soon-to-be moms through these programs.

First 48 Hours teaches community members what to expect after delivery. The free course includes information on testing, immunizations, changes to the mother's body and breastfeeding education. The Mommy Group is a free community peer support group and has expanded from twice a month to twice a week due to increased demand for maternal and infant support in anticipation of concerns during a pandemic. Classes continued to be accessible virtually to community members with online classes offered twice a week. Class topics included feeding checks for baby, a healthy diet for mom, stages of breastfeeding, pumping and returning to work and school while breastfeeding.

To continue addressing the needs of mothers in our community and to provide access to maternal and infant care resources, MLKCH launched the community lactation clinic in the beginning of 2022. The clinic is free for mothers in the community and offered services such as mommy support groups, help with breastfeeding challenges, nutrition for mom and baby, breast pump support, and other resources. The services offered do not require that moms have insurance, prior referrals or authorizations. The lactation clinic also offers prenatal visits, transportation assistance and virtual visit options upon request.

COVID recovery care

In response to the need for integrated recovery care for seriously ill COVID patients, in the summer of 2020 MLKCH started a Post-COVID Recovery Clinic out of our Wilmington clinic. Our multidisciplinary team delivers care to patients with complex needs but limited access to services. Support includes access to pulmonary disease specialists, medical social workers, psychiatry, osteopathic manipulation therapy, respiratory care practitioners, pulmonary diagnostic testing and spiritual care services. Since this clinic was established, our scope expanded beyond the most severely ill patients with COVID-19 related respiratory failure. Given the high burden of co-morbid conditions that cause an extreme need for COVID-19 recovery related services in our community, persons with long-term COVID-19 symptoms can also receive care. In total, 106 COVID survivors received care at this special clinic in FY22.

2. Behavioral health

Integrated Behavioral Health Program

A significant number of MLKCH patients experience behavioral health challenges, often in combination with chronic health conditions. In response, this past year MLKCH built upon an innovative design for the treatment of mental health, physical health and substance use disorders. The Integrated Behavioral Health (IBH) Program offered assessment at the first point of patient contact, establishing potential links between a chronic medical condition and a behavioral health concern. This allowed for the early intervention of a behavioral health team who can then follow the patient from inpatient care to appropriate long-term care support in an outpatient setting.

Through this program, 1,036 patients were referred to behavioral health services and 442 patients were referred to outpatient doctors or other treatment programs. To provide safe and effective solutions to participants that are challenged by opioid use disorder, in FY22 the IBH Program assisted in the distribution of the emergency treatment drug of 110 doses of Narcan free of charge to help decrease fatal opioid overdoses in the community.

3. Management of chronic health conditions

Nutrition and food access

To support our patients who experience both chronic conditions and food insecurity, MLKCH launched a food "prescription" program in FY19. Recipe for Health (RFH) offered participants a weekly supply of fresh fruits and vegetables, along with cooking and nutrition classes, that helped them learn how food choices can improve their health. Family members often benefit along with participants, building healthy habits across generations. Our MLKCH cafeteria — a model of healthful and affordable food choices — is an integral part of this program. During FY22, the RFH team enrolled over 332 RFH adults (age 18 and older) and 58 kids (between the ages of 5 and 17), for a total of 390 participants. RFH also provided over 1,500 fresh produce packages to participants and their families.

Clinical outcomes

Participants in the RFH program saw decreased levels of diabetic hemoglobin A1C and high blood pressure. Overall, 60.2% of participants experienced at least one improved health outcome from A1C, body mass index, or blood pressure, which was an improvement from last year. Considering this cohort was 96.9% food insecure and 86% had two or more chronic conditions at the beginning of the program, these improved outcomes demonstrated a significant positive impact. Anecdotally, many patients stated they were sharing meals with their families. As a result, it is assumed that program benefits were spread among the entire household.

Health care use

Participants in the RFH program were more likely to attend their appointments, even if it was not an RFH program-related visit. RFH participants decreased their use of the emergency department (ED) for care compared to patients not participating in the program. In FY22, out of a total of 390 RFH participants, 74.6% avoided a visit to the ED, and 80.9% kept and attended their primary care appointments at an MLKCH outpatient Care Center. This is an improvement from past years.

Health behaviors

In FY22, 77.8% of participants reported consuming more than two servings of fruits and vegetables in the last week. Knowledge of healthy food options and ways to prepare healthy meals showed an improvement, with 73.4% of participants reporting the program helped them cook and eat more nutritious meals. RFH participants also reported a reduction in their fast food and unhealthy food consumption from 3-5 times a week to 0-2 times per week. Additionally, 77.8% reported never going a whole day without eating in the last month.

4. Education and screenings

Influenza education and vaccines

Our mission to provide community members flu shots and vaccination education was successful over the last year. Using locational-targeting to identify areas with a high number of flu cases throughout the South LA community, our mobile outreach team dispatched units to those locations to maximize benefits to the community. The mobile outreach team conducted 15 flu vaccine events and provided 102 flu vaccines to community members. The team also developed a flu vaccine campaign consisting of resources on vaccines and preventive health. The residents in the area we serve have a lack of resources and low health literacy. Materials were written in easily understandable language to increase access to health education.

COVID education and vaccines

COVID added a layer of complexity to our community's already-dire lack of access to quality health care. Because many members of our community have chronic conditions (diabetes, heart disease, hypertension, etc.) they were more vulnerable to the coronavirus. MLKCH continued to provide excellent general care while adding on the responsibility of COVID-specific emergency care. We partnered with community organizations to bring education and vaccine resources to combat health disparities in our area. Implementing a COVID vaccine clinic campaign, MLK Community Healthcare vaccinated and educated over 8,000 individuals in the community. The mobile outreach team conducted 39 pop-up vaccine clinics throughout the community, especially in areas that were experiencing higher cases of COVID.

5. Homeless health

Outpatient care management for the homeless population/ supporting basic needs

Homelessness continues to be a key focus area for MLKCH. The number of people experiencing homelessness (PEH) in our community is significant, and health disparities among this group continue to grow. Many people who experience homelessness repeatedly return to the ED seeking a safe place to connect to the programs and services they need to manage their health conditions. In response, we enhanced our care coordination services and expanded our network of external partners to give PEH more placement options. In FY22, we provided food, clothing, prescription medication and transportation for people who were experiencing homelessness and who lacked access to care. For FY22, $106,932 was spent on clothing, transportation and Metro tap cards for PEH. We continued offering the services of a dedicated housing and homeless services supervisor, homeless service coordinator, housing navigator and community health workers to help our patients navigate resources critical to their health. MLKCH secured a 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.

Our partnerships with community-based homeless service navigators and recuperative care and transitional living facilities are important to this work. The hospital contributed to the cost of recuperative care for uninsured and underinsured patients and participated in transitional housing partnerships, including the local Homeless Coalition and the Homeless Outreach Program Integrated Care System. Through these partnerships, we connected 7,623 PEH to social services or basic needs. We were also able to discharge 35 patients to reserved shelter beds. The MLKCH Homeless Services team referred 181 patients to the Los Angeles County Recuperative Care and Transitional Living program to provide them with a safe, low-cost place to recover post-discharge.

Homeless housing and support services

PEH have significantly poorer health outcomes and increased mortality rates compared to the general population. When addressing access to health care and health inequity, PEH have among the worst outcomes of any population in the United States. This in-part stems from the reality of competing priorities such as finding food, shelter, and maintaining safety. PEH also have higher 30-day return to the ED rates compared to their housed counterparts (20.1% vs. 48.6%), even when placed in a housing facility (28.6%).

Homeless Housing and Support Services (HHSS) is a combined program for housing navigation and tenancy services. The program was launched by L.A. Care and is part of a Department of Health Care Services (DHCS) initiative called California Advancing and Innovating Medi-Cal

(CalAIM). Housing navigation services help find housing for PEH. Housing navigation services assess participants' housing status and needs, potential housing transition barriers, and housing retention barriers. The program addresses these barriers with short and long-term measurable goals. Tenancy services help persons who were formerly homeless with maintaining safe and stable tenancy once housing is secured. Tenancy services focus on housing retention, including establishing procedures and contacts to retain housing, providing early identification and intervention for behaviors that may jeopardize housing and assess risk-factors that may impact their housing stability.

Another Medi-Cal program that helps individuals in need of housing is the CalAIM Community Support Program, also known as the In Lieu of Services (ILOS) Program. ILOS is an outpatient program that identifies patients who need housing and refers them to the inpatient team if they meet criteria. The social workers in this department also referred patients to recuperative care and connected them with case managers. The Community Support Program also worked closely with the HHSS team to enroll patients in Housing Transition and Navigation or Tenancy services.

Street Medicine Department

Street Medicine served the homeless community by providing direct care on the streets and under bridges to the unsheltered and hardest to reach populations. The goals of street medicine are to assist the inpatient team in avoiding discharge to the street, to provide recommendations on care plans in the inpatient setting based on their knowledge of homelessness, and to follow up as their primary care provider should they be discharged to a street setting. Procedures performed on street medicine patients included abscess incision and drainage, placement and removal of sutures/staples, joint injection and phlebotomy. All care was provided free of charge and delivered on-site, including dispensing medications and drawing blood for testing. When paired with an inpatient hospital-based consult service, street medicine has proven to decrease 30-day readmission rates, hospital length of stay (LOS), and establish ongoing primary care.

6. Social determinants of health

Homeless health and basic need support

Almost a quarter of our community members who are experiencing homelessness have at least one or more poorly managed health conditions. We provided support to improve their access to health care, housing and other social services so they can better manage and stabilize their health.

Access and transportation to health appointments

Providing access to transportation is essential to connecting residents with proper care. We provided transportation support through Uber Health and public and private transportation providers. Severely ill COVID patients recently discharged from the hospital were provided with transportation services to follow-up appointments. These resources were used to ensure all patients have access to their health appointments and have support for their continued care.

Home Paramedicine Program and access to home care

A rise in COVID inpatient admissions in December 2020 and the immediate need to eliminate barriers of transportation to care for community residents led MLKCH to fast-track implementation of the MLKCH Home Paramedicine Program. This program allowed for beds to be reserved for the sickest patients while more stable patients were discharged home and could be followed by program staff. ED doctors and nurses managed a significant number of stable patients who were sent home with COVID or as a patient under investigation (PUI) who then worsened and required a return to the ED for further evaluation or treatment. These factors led to the concept of having medical personnel visit these patients at home to assess them with the goal to avert a return to the ED.

Upon meeting medical criteria and at a doctor's request, the program saw patients at home within a six to 48-hour period of their release by MLKCH. A paramedic or a nurse arrived by ambulance and visited the patient's home, completed a home safety check, followed up on referral requests and relayed this information back to the doctor. To date, the majority of patients and community members served by this program have been COVID positive or PUI with associated secondary illness and other risk factors such as frequent readmissions, congestive heart failure, chronic obstructive pulmonary disease and diabetes. Several postsurgical urology patients and others have also been followed by program staff.

The Home Paramedicine Program created a safety net for those at risk during the pandemic and improved access to medical care by evaluating patients rapidly and conveniently in their homes. In FY22, 1,061 paramedicine visits were performed for 632 patients discharged from the hospital. The rate of return to ED among these 632 patients was 20.5% compared to all other patients who did not receive paramedicine services post-discharge, who returned at a rate of 22.2%. The Home Paramedicine Program decreased the rate of return to ED by 1.7%. This program assisted community members as far as 30 miles from the hospital, reaching a majority of residents within a 10-mile radius from the hospital, saving ample driving time for medical care and follow-ups.

Community building activities

Community building services included MLKCH expertise and resources devoted to strengthening and building our community. Hospital leaders served on local, regional and state-level boards that addressed health improvement and supported health policy that will benefit our community.

You Can is an MLKCH community program created to encourage local youth to pursue careers in health care. As part of this year's You Can activities, hospital employees participated in school Career Days.

MLKCH also launched a high school internship and mentorship program in the summer of 2022 called the Career Fellows Program. The program exposes South LA high school students to a variety of healthcare-related careers. The program, launched in June 2022, pairs Fellows with experts and mentors in a wide range of professions that support health. Students were able to observe MLKCH doctors and nurses and conduct clinical research. The Career Fellows Program will be open each summer to high school students in grades 10 through 12 who attend schools in South Los Angeles.

Financial summary of community benefit

MLKCH community benefit funding for FY2022 (July 1, 2021 — June 30, 2022) is summarized in the table below. The hospital's community benefit costs comply with Internal Revenue Service instructions for Form 990 Schedule H using a cost to charge ratio for financial assistance.

Community benefit category	Net benefit
Financial assistance (charity care)[1]	$39,945,053.00
Unpaid costs of Medi-Cal[2]	$0
Education and research[3]	$0
Other for the broader community[4]	$19,206,712.59
Total community benefit provided excluding unpaid costs of medicare	**$59,151,765.59**
Unpaid costs of Medicare[2]	$0
TOTAL NET VALUE OF QUANTIFIABLE COMMUNITY BENEFIT	**$59,151,765.59**

1 Financial assistance includes traditional charity care write-offs to eligible patients at reduced or no cost, based on the individual patient's financial situation.

2 Unpaid costs of public programs include the difference between costs to provide a service and the rate at which the hospital is reimbursed. Estimated costs are based on the overall hospital cost-to-charge ratio. This total includes the Hospital Quality Assurance Fee paid to the State of California.

3 Costs related to medical education programs and medical research that the hospital sponsors.

4 Includes non-billed programs, such as community health education, screenings, support groups, outpatient practice sites and other self-help groups. These include costs for community benefit operations.

Community Benefit Plan—Fiscal Year 2023

MLK Community Healthcare is a leader for change and for a healthier future in a vastly underserved community. Over the next year we will continue the work described in our Implementation Strategy. Findings from our 2022 CHNA serve as a roadmap to continue and expand community benefit programs and services. In the first year of our 2021-2023 Implementation Strategy, we plan to strengthen existing work and expand in the following critical areas:

1. Access to preventive, primary and specialty care

- Help residents establish medical homes and connect them to primary and specialty care doctors.
- Expand services in the new medical office building on the MLK Medical Campus and develop staffing and infrastructure to increase capacity for specialized medical services, including mobile health.
- Provide transportation assistance to connect patients to health care providers.
- Expand access to healthcare and social services using telehealth (phone and video) services.
- Provide access to prenatal and postnatal services and support for expectant mothers in the community.
- Provide residents with assistance to enroll in county and governmental health insurance or social service programs.
- Support financial assistance for an increased volume of 110,000 patients in the hospital's ED.

2. Behavioral health

- Improve clinical outcomes for patients with chronic medical conditions by identifying and addressing coexisting mental health and substance use conditions and connecting residents to their appropriate medical home.
- Improve access to mental health and substance use services using telehealth consults with behavioral health specialists.

3. Management of chronic health conditions

- Expand the reach of Know Your Basics, the hospital's community health screening and education program, doubling screening services to over 3,000 residents.
- Continue Healthy Moves, a mobile approach to health, sending our van across South Los Angeles to targeted areas where mobile community health can be effectively deployed.
- Secure 3,500 Health Seekers to create a digital network for health tips and community-based health information, addressing the challenges prevalent in our community including overweight and obesity, hypertension, and diabetes.
- Provide screenings, health education and peer support through food access initiatives.

4. Education and screenings

- Provide residents with flu shots and vaccination education through a healthcare partnership effort and community Flu Campaign.
- Provide screenings, health education and peer support through MLKCH community outreach programs.
- Expand availability for maternal and infant care, education, resources and support for mothers in the community.
- Help community members connect with medical care and social services.

5. Homeless health

- Work toward establishing an initiative that delivers high quality street-based medical services, providers and hospital-based consultative services to MLKCH patients who are experiencing homelessness.
- Provide direct support to the homeless by connecting them to case management services.
- Help individuals who are homeless access housing, food, toiletries, clothing, transportation, social services and support available through Measure H and other public initiatives.
- Increase the numbers of reserved shelter beds to improve recuperative care and connection to community case management and housing services.

6. Social determinants of health

- Continue to expand and strengthen partnerships that collectively address homeless needs in a comprehensive manner, including transportation and shelter placements for recuperative and skilled nursing care.
- Evaluate Recipe for Health, our food prescription program for patients with chronic conditions and food insecurity, for improved patient outcomes. Refine and expand the program.
- Continue addressing the need for transportation to care for residents needing immediate attention to medical services.
- Participate in the coalition of partners applying for a Choice Neighborhood designation for Jordan Downs, including the Housing Authority of the City of Los Angeles, to increase investment in our neighborhood programs and infrastructure.

Measuring impact

MLKCH is measuring progress toward each of our community benefit areas of focus using regular prescribed evaluation routines and quarterly progress reports. We continue to track our performance across metrics that cover access to preventive, primary and specialty healthcare; behavioral health; management of chronic health conditions; education and screenings; homeless health; and social determinants of health.

On our journey towards health equity, MLKCH is concentrating on the following performance metrics identified in 2020:

Goal: Increase access to preventive, primary, specialty, dental, and maternal and infant healthcare for medically underserved residents.

Objectives:

- Enhance ability of residents to receive convenient, culturally appropriate care to maintain and manage their health.
- Improve birth outcomes and infant health by increasing access to medical specialists for maternal and infant health.

Measures:

- Number of new medical specialists providing community-based care
- Number of persons that were referred to and served through primary and specialty care
- Number of rides provided for transportation assistance to medical homes
- Number of new health insurance referrals and placements for uninsured patients
- Number of persons served through telehealth services (phone and video) and miles saved
- Number of community members receiving health screenings through the Know Your Basics and ManUp! programs
- Number of new and existing families enrolled in the Welcome Baby program having received home visits and support
- Number of moms supported by MLKCH maternal virtual classes/support groups
- Number of persons receiving COVID-19 recovery care

Goal: Increase availability of resources to stabilize and improve behavioral health conditions.

Objectives:

- Increase the number of qualified behavioral health providers and support teams serving the South Los Angeles community.
- Increase referrals to mental health and substance use services for community residents.

Measures:

- Number of persons served through the Integrated Behavioral Health Program and referred to outpatient care and continued treatment
- Number of emergency treatment drugs distributed for substance use

Goal: Stabilize and improve management of chronic diseases and encourage residents to maintain healthy weights and lifestyles to reduce future complications and disabilities.

Objectives:

- Increase screening, prevention, and referrals to treatment for chronic diseases.
- Increase choices for healthy food in the community.

Measures:

- Number of community members enrolled in Recipe for Health (RFH) food access program
- Number of healthy food/produce packages provided through RFH
- Number of enrolled RFH participants with improved clinical health measures
- Number of enrolled RFH participants with decreased emergency department visits
- Clinic no show rates for RFH participants
- Percent of RFH participants consuming two or more fruits and vegetables weekly
- Number of persons enrolled in the CalAIM program for enhanced care management for chronic conditions

Goal: Promote a healthier community through community classes, immunization resources and education for preventive health.

Objectives:

- Reduce vaccine-preventable influenza by providing immunizations.
- Increase health screenings and education among populations less likely to seek care.
- Increase access to culturally sensitive and population-tailored health care education (for pregnant women, school-aged youth, adult males, etc.).

Measures:

- Number of persons receiving vaccination education and flu vaccines
- Number of persons receiving COVID-19 vaccines
- Number of community education classes offered to community members and organizations (including number of persons who were offered classes)

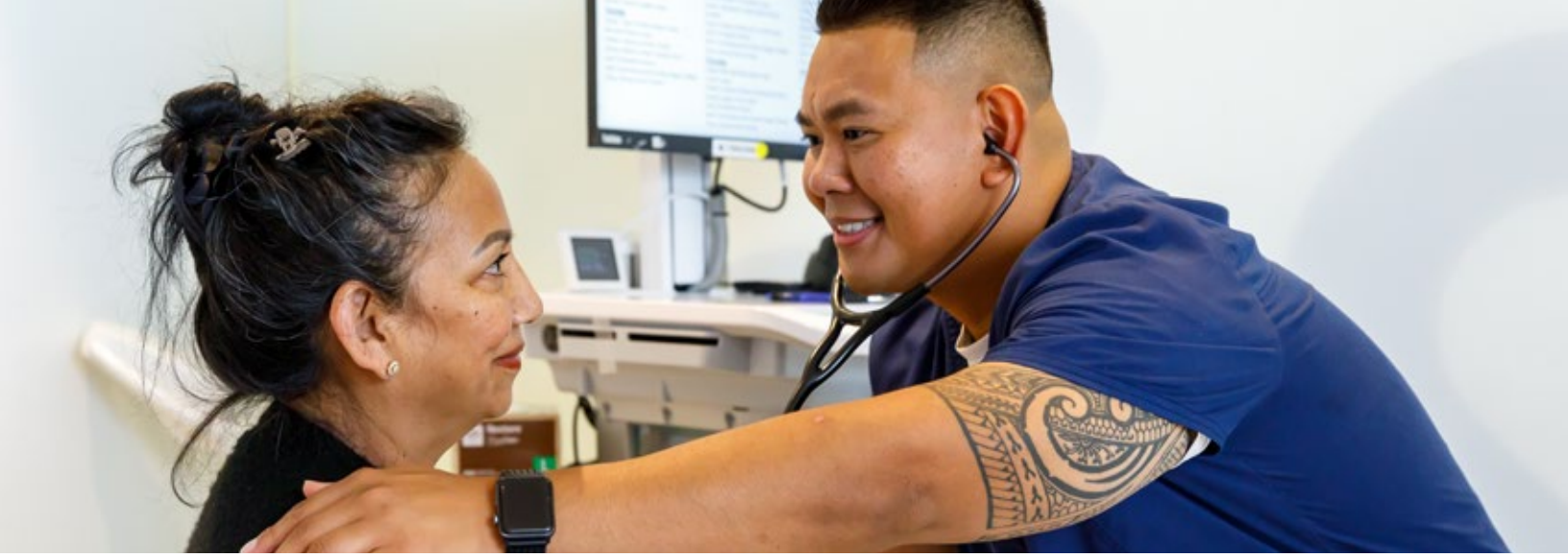
Goal: Improve access to healthcare, housing and other social services for persons experiencing homelessness so they can better manage and stabilize their health.

Objectives:

- Increased access to care for PEH will result in improved self-management and quality of life.
- Establish expert street medicine consultation to PEH.
- Increase assistance to patients who are homeless to navigate social services and basic needs.

Measures:

- Number of beds MLKCH acquired to connect PEH to transitional housing
- Number of PEH connected to social services and/or basic needs
- Number of PEH referred to Recuperative Care, Board and Care and Transitional Living facilities
- Percent of discharges to reserved shelter beds versus to street or recuperation
- Number of persons PEH served through the Street Medicine program



Goal: Help individuals in the community access social services, food and housing so they can have healthier living environments and improved health status.

Objectives:

- Improve self-management and quality of life by increasing access and connections to social needs and healthcare services.

Measures:

- Number of persons connected to housing services and shelter beds
- Dollars spent offering PEH basic need kits (toiletries and clothing)
- Number of rides provided to people needing transportation for follow-up care
- Number of persons served by the Recipe for Health food access program
- Number of persons served through the Home Paramedicine Program and access to home care

We continue to establish metrics and timelines for each of the initiatives and strategic health needs they address. Metrics vary based on the initiative described and include the number of people served, the types of services and activities provided and the variety of partners engaged. We report progress regularly and adjust our strategies as appropriate to reach our goals.

Significant needs outside of hospital scope

MLKCH is committed to improving the health of our community outside of the hospital's walls and to addressing the significant health needs identified in the 2020 CHNA. We grouped these significant needs into six categories: access to preventive, primary and specialty care; behavioral health; management of chronic health conditions; education and screenings; homeless health; and social determinants of health. We will continue to identify and evaluate additional services that may not be addressed and collaborate with community partners to address these needs and others outside of this scope as the needs of our community evolve.

Community partnerships

We are fortunate to have successful, established relationships with our community partners. Together we have made a meaningful impact in the communities we serve. To meet the objectives outlined in our Implementation Strategy, we will continue to engage new partners to support our mission. A partial list of our current community partners includes:

A Community of Friends

- Advisory Board
- African American Infant and Maternal Mortality Community Action Team
- Alzheimer's Los Angeles
- Ambulnz
- American Diabetes Association
- American Heart Association
- Animo James B. Taylor Middle School
- Baldwin Hills Farmers Market
- Be Social Productions
- Bethel Missionary Baptist Church of South Los Angeles
- Black Infant Health Program
- Black Women for Wellness
- Black Women Leaders of Los Angeles
- Blink Fitness
- Boys & Girls Club of Metro Los Angeles
- California Black Women Health Project
- California Endowment
- California State University Dominguez Hills
- Cedars-Sinai Medical Center
- Charles R. Drew University of Medicine and Science
- Church of the Redeemer
- Communities Lifting Communities

Community partnerships (continued)

- Community Coalition
- Compton Avenue Elementary School
- Compton Early College High School
- Compton Farmers Market
- Compton Unified School District
- COPE Health Solutions
- Core Contributors Group, Inc (CCG)
- David Starr Jordan High School
- El Nido Family Centers
- Exodus Recovery, Inc. at MLK Medical Center
- Food Forward
- Freedom Plaza - Primestor Development Inc.
- Grocery Outlet Bargain Market — Compton
- Harbor & Watts Area Representative
- Health Net of California, LLC
- Homeless Outreach Program Integrated Care System
- Hospital Association of Southern California
- Housing Authority of the City of Los Angeles
- Inglewood City Clerk's Office
- Integrated Healthcare Association
- International Medical Corps (IMC)
- JAR Insurance
- King/Drew Magnet High School of Medicine and Science
- KJLH Radio
- L.A. Care Inglewood Family Resource Center
- L.A. Care Lynwood Family Resource Center
- L.A. Focus Newspaper
- Latino Food Industry Association
- Los Angeles Area Chamber of Commerce
- Los Angeles County Department of Public Health
- Los Angeles County Department of Social Services
- Los Angeles County Doula Program
- Los Angeles County Fire Department
- Los Angeles County Sheriff's Department
- Los Angeles Latino Chamber of Commerce
- Los Angeles Sentinel
- Los Angeles South Chamber of Commerce
- Los Angeles Unified School District (LAUSD)
- Los Angeles Wellness Station
- Martin Luther King, Jr. Outpatient Center
- Maxine Waters Employment Preparation Center
- Mayor of Lynwood City Office
- Mayor's Office of Legislative and External Affairs
- Metro of Los Angeles
- Miller Children's and Women's Hospital
- MLK Campus Farmers' Market
- MLK Center for Public Health
- Mount Carmel Holy Assembly Baptist Church
- National Coalition of 100 Black Women
- Neighborhood Housing Services of Los Angeles County
- New Life Global Development
- Nickerson Gardens Housing Project
- Offices of Sweet Alice and Parents of Watts
- Partners in Care Foundation
- Plaza Mexico

Community partnerships (continued)

- Project Angel Food
- Residence Advisory Councils for Jordan Downs, Nickerson Gardens and Imperial Courts
- Samuel Gompers Middle School
- Shields for Families
- Sodexo
- South Los Angeles Health Projects
- Southside Coalition of Community Health Centers
- SPA 313 Hair Salon
- SPA 6 Homeless Coalition
- St. John's Well Child and Family Center - Compton Clinic
- St. Louise Resource Center
- Star View Community Services
- Street Medicine Program of USC Keck School of Medicine
- Suite Life SoCal Magazine
- Superior Grocers
- Sustainable Economic Enterprises of Los Angeles (SEE-LA)
- T.H.E. (To Help Everyone) Health and Wellness Centers
- The Gateway at Willowbrook Senior Center
- Uber Health
- University of California Los Angeles (UCLA)
- Univision Communications Inc.
- Urgent Care Associates
- USC Clinical and Translational Science Institute
- Ventanilla de Salud Los Angeles
- Wade & Associates Group LLC
- Walnut Park Middle School
- Watts Gang Task Force
- Watts Healthcare – Watts Health Center
- Watts Labor Community Action Committee
- Watts Neighborhood Council
- Wayfinder Family Services
- Welcome Baby - First 5 Los Angeles
- West Angeles Community Development Corporation
- Whole Person Care – Los Angeles (WPC-LA)
- Willowbrook Inclusion Network
- Women of Watts (WOW)
- Women, Infants, and Children (WIC)
- Young Women's Christian Association (YWCA)