Community Benefit Report and Plan FY 2021

PRESENTED BY: MLK Community Healthcare

SUBMITTED TO:

Office of Statewide Health Planning and Development
Healthcare Information Division
Accounting and Reporting Systems Section
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MLK Community Healthcare

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Message from the CEO

The importance of good health care delivered equitably to all has never been more critical. Since the last time this report was published, our nation has endured several deadly COVID-19 surges that hit areas like South Los Angeles particularly hard. The drivers of the pandemic in our community have everything to do with decades of underinvestment in health and healthcare, leading to an epidemic of chronic conditions that drive COVID and that made MLK Community Hospital, at one particularly bleak period last winter, the epicenter of COVID in LA County.

Yet the last year is also a thrilling example of what can be accomplished when we work together to advance and adopt science in the service of humanity. Drawing upon decades of research, our nation's scientists — many of them Black and brown — developed a safe, effective vaccine to combat COVID. We started vaccinating in December — first our own staff and then later, as supplies grew, our community. To date we have administered nearly 50,000 doses of the COVID vaccine in South LA, both at our Medical Group practice sites and at dozens of targeted mobile clinics across our community. Together with city and county partners, MLK Community Healthcare has made a critical difference not just in saving the lives of the sick but in preventing tens of thousands of potentially deadly infections.

We've learned a number of important lessons along the way. First, we've learned that past is prologue. Our nation's decades of neglect and abuse of low-income and minority communities created serious obstacles to trust when it came to administering COVID vaccines. The hesitancy, particularly in the African American community, is understandable given the ongoing mistreatment of this community. But the public health implications affect us all.

South LA is home to many essential workers who cannot self-isolate. Where they go, so too will the virus. If we want the full adoption of the vaccine, the one sure way to end this pandemic, we must overcome fear and mistrust with concrete action, including investment in quality healthcare delivery in communities like South LA.

MLK Community Healthcare continues to be a strong voice for health care equity, in word and deed. We have brought dozens of doctors into our medically-underserved area both through our medical group and through a new physician residency program, secured funding to integrate our physical and behavioral health services, began work on a street medicine program to help South LA's unhoused, and expanded our in-community services through telehealth, in-person house calls, and an innovative post-COVID discharge clinic.

We believe that our collective fate is tied to confidence-building actions like these. The end of this pandemic — and the prevention of future ones — rests upon the humane and equitable treatment of every American.

Elaine Batchlor, MD, MPH
CEO, MLK Community Healthcare

About Our Community: Social Challenges and Health Disparities

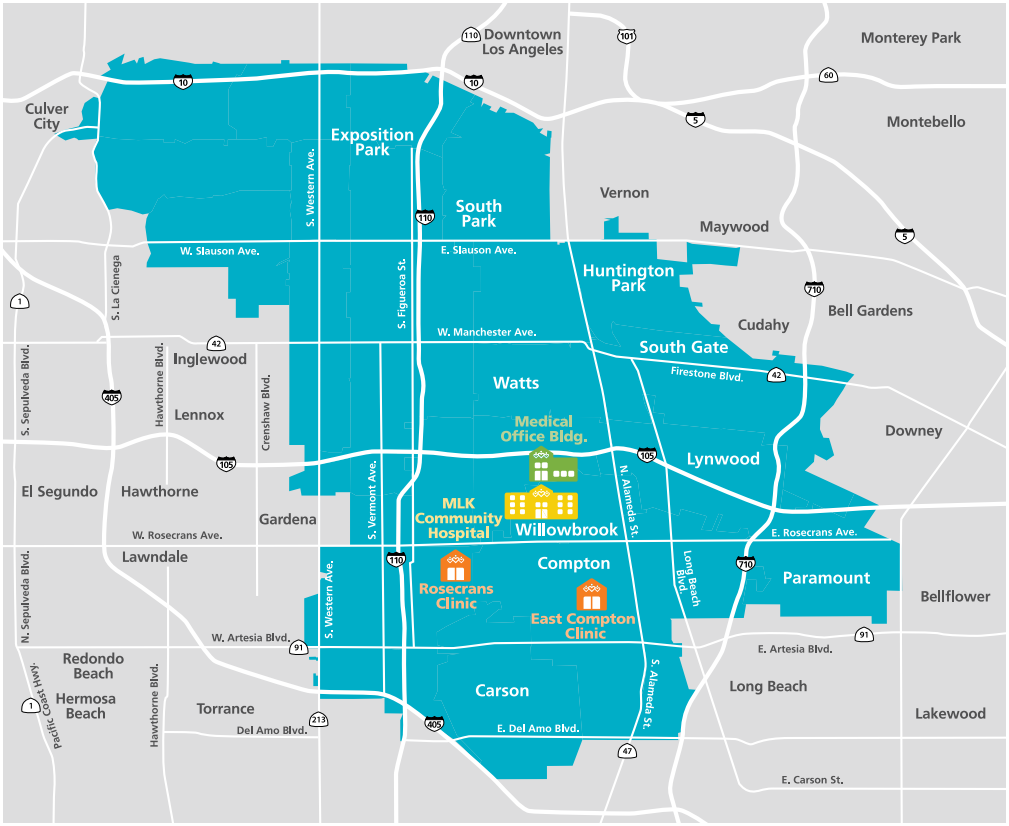
South Los Angeles is home to one of Los Angeles County's most vulnerable populations. Its 1.3 million residents — 71% Hispanic and 22% African American — have a poverty rate of 24%, double that of California. Years of underinvestment in the community have resulted in social and economic conditions that 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 1,200 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.

1.3 million residents

- 40% without a high school diploma
- Per capita income of $13,288, half the California median
- Life expectancy 10 years less than the California average
- Community Medicaid Rate: 51%
- Hospital Measures
  - Hospital Medicaid Rate: 73%
  - Diabetes rate of hospitalization 3.3x the state rate
  - Heart Failure rate of hospitalization 2.5x the state rate

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

Opened in 2015 as a state-of-the-art facility, 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: MLK Community Healthcare operates South LA's only wound care center with hyperbaric chambers for advanced treatment of non-healing wounds.

Community-based care: MLK Community Healthcare 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

MLK Community Healthcare's 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 in 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 2021

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 strong through the expansion of the MLK Community Medical Group. Over the past year, we added nine doctors. The doctors we recruited included psychiatrists, addiction medicine specialists, and specialties related to the treatment of diabetes, heart, and respiratory diseases.

MLKCH connected community members to doctors and medical homes by supporting the outreach work at the medical group, resulting in an increase of established care for the community.

Expanded Access to Medical Specialists and Services

Access to specialty care is critical to managing conditions like diabetes, heart disease, and respiratory disorders. Our collaboration with the medical group 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, the medical group 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.

MLK Community Medical Group

The MLK Community Medical Group offers healthcare for every stage of life. From emergency and inpatient care in our award-winning hospital to primary and specialty care in our three medical group practice sites as well as our new Wound Care and Hyperbaric Chamber Center, we provide a full continuum of services for our South LA patients.

The hospital worked with the medical group to coordinate care across inpatient and outpatient settings. Through this work, 26% of patients seen at the hospital accessed primary care at the medical group's practice sites. With the assistance of follow-ups from our COPE Health Scholar and Care Navigator student support program, patients attended 756 follow-up appointments. Proper 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) 21, 15,901 patients were served through specialists/medical services, including 27% of the total number of new medical group practice site patients. As part of our commitment to provide area 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 offered patients help in obtaining 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 2,207 patients sign up for Medi-Cal, and 1,927 patients were placed on temporary Medi-Cal while waiting for their applications to be finalized. Additionally, MLKCH helped enroll 2,931 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 7% of patient revenue this past year through the Financial Assistance Program.

Telehealth Services

Telehealth services expand access to healthcare and social services for community residents of South LA. Through these services, including video and telephone encounters, we provided care for 31% of our patients. The number of telehealth visits completed in FY21 was 7,626. Telehealth services saved patients driving time of 146,390 minutes (39 minutes on average) and 81,257 miles (22 miles on average). Providing telehealth will help keep patients out of the ED and provide the appropriate care and direction for our community residents.

Transportation Assistance

MLKCH offered transportation assistance that eliminated barriers to accessing healthcare. In FY21, 530 bus tokens and metro TAP cards were provided at no 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 support of the program as needed. During this past year, we partnered with 30 organizations at community events and provided 1,308 health screenings. Due to the COVID pandemic, the KYB program was not able to screen as many community members as planned. As the pandemic continued, KYB offered vaccine clinics and expanded services. Our mobile outreach grew as we went from one van servicing the community to three vans and ran over 50 COVID mobile vaccine clinics, reaching 7,852 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.

Maternal and Infant Health

The need to expand prenatal care and post-delivery support for expectant mothers in the community continued as a priority for MLKCH. Through our affiliations with Miller Children's and Women's Hospital Long Beach, Planned Parenthood and the MLK Medical Group, 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 team of affiliated nurse midwives and delivery doctors who work together to ensure healthy childbirth. Our Welcome Baby program allowed us to provide home and community-based post-delivery support services for new mothers, including home visits following birth. Our Welcome Baby program served 481 existing families and enrolled 168 new families in the program 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 FY21, MLKCH's affiliated maternity team provided and educated 16 new moms or soon-to-be moms virtually with our First 48 Hours classes and Mommy Support Groups.

First 48 Hours teaches community members what to expect after delivery. The free course included 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. During COVID, classes continue 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.

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-ICU Covid Discharge Clinic" out of our Wilmington clinic. Our multidisciplinary staff delivered care to patients with complex needs but with limited access to services. Support included access to specialists, social workers, psychiatry and spiritual care. In total, 23 COVID survivors received care at this special clinic in FY21.

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, the hospital and the medical group collaborated this past year on an innovative design for the treatment of mental health, physical health, and substance use disorders. The Integrated Behavioral Health 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, 1,246 patients were identified and connected for referral to behavioral health services and 656 patients were referred to one of our medical group doctors. This led to a 28.3% reduction in patients who returned to the hospital within 30 days of treatment. The number of behavioral health patients who visited the ED declined from 27.5% last year to 14.6% this year.

3. Management of Chronic Health Conditions

Nutrition and food access

To support our patients who experience both chronic conditions and food insecurity, the hospital and the medical group 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. Since its launch, the RFH team has enrolled over 441 participants and provided over 3,500 fresh produce packages to participants and their families. Despite the emergence of the COVID crisis, the program continued to show significant improvements for participants.

Clinical Outcomes

Participants in the RFH program saw decreased diabetic hemoglobin A1C levels and high blood pressure levels. Overall, 53.4% of participants experienced at least one improved health outcome from A1C, body mass index, blood pressure or ED use, an improvement from last year. Considering this cohort was 95.1% food insecure and 96.6% 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 the benefits were spread among the entire household.

Healthcare Use

Participants in the RFH program were more likely to attend their appointments, even if it was not a RFH program-related visit. There was also a decrease in RFH participants who used the ED for care compared to patients not participating in the program who have a higher frequency of ED visits. In FY21, only 7.48% of enrolled RFH participants had an avoidable ED visit, and only 18.91% had a medical group practice site no-show. This is an improvement from past years.

Health Behaviors

In FY21, 96.9% 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 improvement, with 99% 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, 76.7% reported never going a whole day without eating in the last month.

4. Education and Screenings

Influenza education and vaccination

Our mission to provide community members flu shots and vaccination education was successful over the last year. Using geo-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 27 flu vaccine events and provided 617 flu vaccines to community members. The team also developed a flu vaccine campaign consisting of resources on immunization and preventive health. The residents in the area we serve have a lack of resources and low health literacy. Materials were population-tailored to increase access to health education.

COVID education and vaccination

COVID added a layer of complexity to our community's already-dire lack of access to quality healthcare. 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 17,983 individuals in the community. The mobile outreach team conducted over 50 pop-up vaccine clinics throughout the community, especially in areas identified as having higher cases of COVID. In addition to these efforts, the outreach team held over 20 community education sessions for community organizations throughout South LA reaching over 1,000 individuals.

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 who are homeless in our community is significant, and health disparities among this group continue to grow. Many people who are homeless 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 people who were experiencing homelessness more placement options. In FY21, we provided food, clothing, prescription medication and transportation for people who were homeless and who lacked access to care. We continued offering the services of a dedicated homeless services liaison, homeless service coordinators 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 for patients experiencing homelessness.

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 7,113 people experiencing homelessness to social services or basic needs. We were also able to discharge 26 patients to reserved shelter beds. The MLKCH Homeless Services team referred 224 patients to the Los Angeles County Recuperative Care and Transitional Living program to provide persons who were homeless with a safe, low-cost place to recover post-discharge.

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 will continue to provide support to improve their access to healthcare, housing and other social services so they can better manage and stabilize their health.

Access and transportation to health appointments

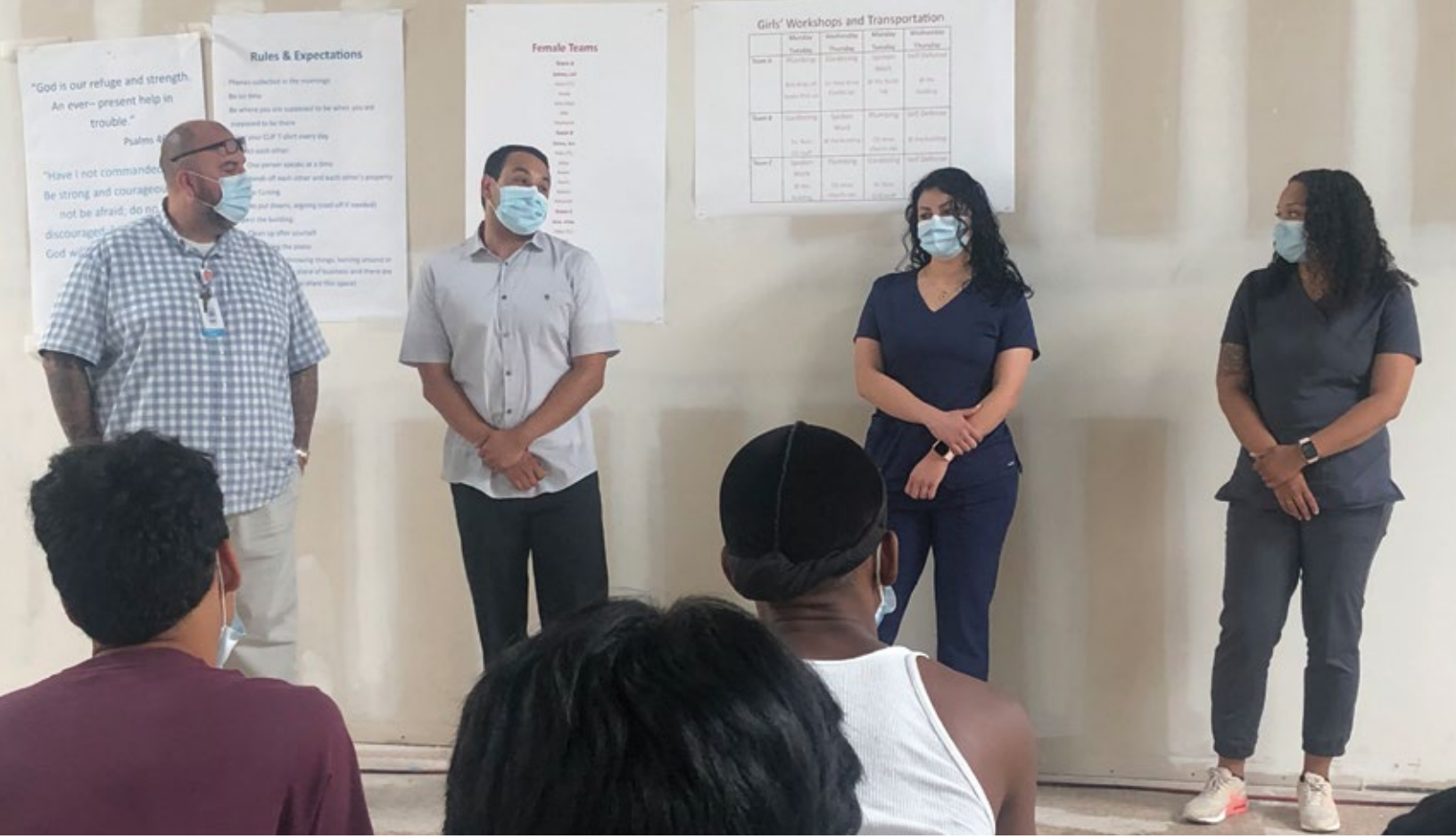
Providing access to transportation is essential to connecting residents with proper care. We provided transportation support through Uber Health and public and private transportation providers. Severely ill COVID patients, recently discharged from the hospital, were provided with transportation services 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 care in home

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 the program. ED doctors and nurses were seeing a significant number of stable patients that were sent home with COVID or as a patient under investigation (PUI) who then worsened and required returning 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 if needed with the goal to avert a return to the ED.

Upon meeting criteria and at a doctor's request, the program serves to see patients at home who have been discharged from the hospital, or who were seen in the ED or visited the Medical Group practice sites within a six to 48-hour period after being released from the hospital. A paramedic or a nurse arrives by ambulance and visits the patient's home, completes a home safety check, follows up on referral requests and relays 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 concomitant secondary illness and other risk factors such as frequent readmissions, congestive heart failure, chronic obstructive pulmonary disease and diabetes, in keeping with MLKCH's disease management program. A number of postsurgical urology patients and other patients have also been followed.

The Home Paramedicine Program was also to create a safety net for those at risk during a pandemic and improve access to medical care by evaluating them rapidly and conveniently in their home. In FY21, 220 paramedicine visits were performed for 84 patients discharged from the hospital. The return to ED rate among these 86 patients was 17.85% compared to all other patients who did not receive paramedicine services post-discharge whose observed return to ED rate was 22.55%. The Home Paramedicine Program decreased return to ED rates by 4.70% and will continue improving in FY22. This program has also serviced community members as far as 22 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 include 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 healthcare. Among this year's *You Can* activities, hospital employees participated in school Career Days

Financial Summary of Community Benefit

MLKCH community benefit funding for FY2021 (July 1, 2020 – June 30, 2021) 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]	$24,895,027.00
Unpaid Costs of Medi-Cal[2]	$0
Education and Research[3]	$0
Other for the Broader Community[4]	$16,127,212.24
Total Community Benefit Provided Excluding Unpaid Costs of Medicare	**$41,022,239.24**
Unpaid Costs of Medicare[2]	$0
TOTAL NET VALUE OF QUANTIFIABLE COMMUNITY BENEFIT	**$41,022,239.24**

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, medical group practice sites and other self-help groups. These include costs for community benefit operations.

Community Benefit Plan—Fiscal Year 2022

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 2021 CHNA serve as a roadmap for the continuation and expansion of 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 medical providers.
- Expand access to healthcare and social services using phone and video (telehealth) 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 underlying mental health and substance use co-morbidities and connecting residents to their appropriate medical home.
- Improve access to mental health and substance use services using telehealth consults with behavioral health specialists.
- Create a process for identifying victims of human trafficking and provide referrals for human trafficking care and related resources.

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 the 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 of overweight and obesity, hypertension, and diabetes prevalent in our community;
- 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 expansion and strengthening of partnerships to 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, including the Housing Authority of the City of Los Angeles, applying for a Choice Neighborhood designation for Jordan Downs to increase investment in our neighborhood programs and infrastructure.

Measuring Impact

MLKCH will measure our progress toward each of our community benefit areas of focus throughout using regular prescribed evaluation routines. We track our performance across 45 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. We will continue to establish metrics and timelines for each of the initiatives and strategic health needs they address. Metrics will 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. Progress will be reported regularly and strategies adjusted 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 all of 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 partners in the community to address these issues 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 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 work. 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
- Ánimo 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

Community Partnerships (continued)

- Communities Lifting Communities
- 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
- Project Angel Food

Community Partnerships (continued)

- 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)