MLK Community Healthcare

COMMUNITY BENEFIT REPORT AND PLAN 2023

SUBMITTED TO:
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This year MLK Community Hospital achieved two notable recognitions. We were once again given a 5-star rating by CMS, the U.S. Centers for Medicare and Medicaid Services. Only 16 percent of hospitals in the nation achieve this highest rating. Our 29-bed Emergency Department (ED) also appeared on the list of busiest in the nation. More than 112,000 people came to us for help, a volume 400 percent higher than what our community hospital was built to absorb. Yet even as our volume soared our wait times for service remained relatively low, compared to other hospitals. This tells us two things:

Dr. Jorge Reyno

- Despite our small footprint and limited resources, our clinical staff are doing a superlative job dealing with the record-high volume of patients.
- Our community cannot easily access care. We estimate that 40% of our ED visits could be seen in the outpatient setting. Because so little outpatient care exists in our community, our residents come to us for conditions that could easily be treated in a primary care setting.

This community benefits report describes what we are doing to address unmet need. As always, we remain committed to attracting and retaining high-quality and culturally-appropriate physicians to South Los Angeles, which lacks 1,500 doctors on average relative to other communities in California. Getting ahead of disease before it becomes dire enough to require an ED visit should be every clinician's - and policymaker's - goal.

We also are fielding innovative efforts to treat the unhoused, address social determinants and recognize the important role that integrated behavioral health care plays in physical recovery from illness.

However, the persistence of illness in South LA is inexorably tied to systemic issues. Our nation's healthcare system, marked by disparities in health insurance rates, discourages healthcare providers from serving in areas like South LA, which predominantly house low-income, Medi-Cal-dependent populations. Until we address the structural challenge of inadequate Medicaid payment, patients will continue to flock to our ED for care they can find nowhere else.

We earnestly call upon policymakers to join us in championing pioneering solutions that not only treat illness but also rectify the structural health inequities that exacerbate it. South LA deserves nothing less.

Jorge Reyno MD

Senior Vice President, Population Health
MLK Community Healthcare

About our community

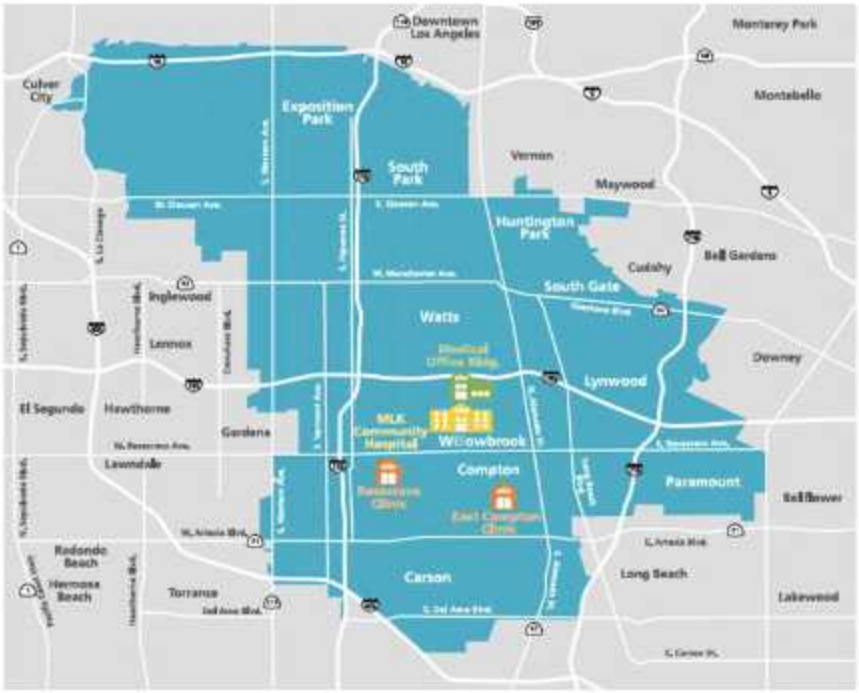
South Los Angeles is a community rich in history, diversity and culture. Its importance as the cradle of social justice and artistic and cultural change cannot be understated. From its earliest agrarian roots, to the Great Migration that brought African Americans from the deep South, to even more recent 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 LA is home to one of Los Angeles County's most vulnerable populations. Its 1.3 million residents — over 90 percent Hispanic and African American— have a poverty rate of 20 percent, double that of Los Angeles County. 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 1,500 doctors, both primary care and specialists, important to the treatment of chronic disease. Large areas of South LA, 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 LA. 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, MLKCH 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 2023 Community Health Needs Assessment (CHNA) addressed needs for MLKCH to prioritize over three years. 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.

For this report, MLKCH addressed the needs that were identified in the 2021-2023 Implementation Strategy. This report documented plans to address each significant health need identified in the previous CHNA. MLKCH, in collaboration with community partners, identified six priorities to address those needs for Fiscal Year (FY) 2023 (July 1, 2022 – June 30, 2023):

- 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 2021-2023 Implementation Strategy and 2023 CHNA can be accessed at www.mlkch.org/community-reports.

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 2023 CHNA contact kyb@mlkch.org.

Community benefit services summary — Fiscal Year 2023

Improving the health of our community

During this past year MLKCH expanded access to quality care and health education throughout our South LA community. Programs were implemented or expanded to address the identified needs. Using the framework developed in the 2021-2023 Implementation Strategy, services for community health improvement extended across the six priorities:

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

Increased the number of doctors

Our commitment to providing a larger network of doctors trained in a variety of specialties remained firm. Over the past year, we recruited six doctors and two nurse practitioners to our outpatient care centers. These doctors practice in cardiology, internal medicine and specialties related to the treatment of heart and kidney disease.

Expanded access to medical specialists and services

This past year, access to specialty care remained 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. MLKCH's 42 providers offered care across 16 specialties: internal medicine, cardiology, endocrinology, nephrology, general surgery, hand/plastic surgery, infectious disease, neurology, pediatrics, podiatry, psychiatry, pulmonology, rheumatology, urology, obstetrics/gynecology and vascular surgery.

MLKCH continued to coordinate care across inpatient and outpatient settings. In FY23, through this care coordination an estimated 20,000 patients were able to access specialty medical services at our outpatient care centers. 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 public assistance programs

The new medical office building on the MLK Medical Campus, which opened in March 2020, offers expanded space for doctor visits. The medical office building provides services such as wound care, pharmacy, diabetes education, behavioral health, and space for training and education. Additional services offered to patients in the medical office building include enrollment in health insurance and other public assistance programs, such as food support (Supplemental Nutrition Assistance Program (SNAP) and WIC (Women, Infants, and Children).

During FY23, MLKCH provided specialty medical services to over 200 new patients in addition to the already existing patient panel and continued to have a 73% overall show rate for patients attending their appointments.

Financial assistance and health insurance enrollment

Financial assistance helped over 1,600 patients sign-up for Medi-Cal and an estimated 750 were approved for benefits. Additionally, about 2,200 patients were placed on temporary Medi-Cal while waiting for their applications to be finalized. In total, MLKCH helped enroll about 3,000 patients who did not have health insurance.

The Medicare enrollment team at MLKCH assisted any patient who was eligible for Medicare at any age. Our team explained plans and benefits, including Medicare Advantage plans, and walked patients through enrolling or making changes to those plans.

Patients with Medicare Advantage plans, assigned to our primary care doctors, have a direct line to the Medicare team to address any difficulties they encounter, such as transportation, appointments, prescriptions or any other needed services. The enrollment team also helped community members apply for Medi-Cal or Calfresh assistance programs.

Telehealth services

Telehealth services increased access to health care and social services for community residents of South LA. We provided care to over 3,600 patients who completed 7,506 telehealth visits in FY23, including video and telephone appointments. Telehealth services saved patients driving time of 1,440 days round trip (32 minutes on average one way) and 128,551 miles (17 miles on average per patient). Providing telehealth helped to keep patients out of the ED and increased access to care for our community residents.

Transportation assistance

MLKCH offered transportation assistance to eliminate barriers to healthcare access. In FY23, we supplied over 330 Uber health courtesy rides/trips for patients going to and from doctor appointments at MLKCH outpatient practice sites. These rides were free of charge for the community members we serve and we covered the cost of about $6,000 per year with this service.

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 community organizations, as well as with the addition of pediatricians in 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. Our Welcome Baby program provided home and community-based post-delivery support services for new mothers, including home visits following birth. This program served 638 families who received 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 for new and expectant mothers: the First 48 Hours class and the Mommy Support Group. In FY23, MLKCH's affiliated maternity team provided virtual education to 180 new moms or soon-to-be moms through these programs.

First 48 Hours taught 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 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 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.

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 2022. The clinic is free for mothers in the community and offers services such as mommy support groups, helps 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. In FY23, approximately 72 percent of maternity patients used our new outpatient lactation clinic and were seen by our lactation specialist.

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 offers assessment at the first point of patient contact, establishing potential links between a chronic medical condition and a behavioral health concern. This allows for the early intervention of the behavioral health team who then follow the patient from inpatient care to appropriate long-term care support in an outpatient setting.

Through this program, approximately 1,500 patients were referred or connected to behavioral health services and over 300 patients were referred or connected to outpatient doctors or other treatment programs. In addition, patients were offered telehealth consults and appointments to address their behavioral health needs. MLKCH provided over 3,050 video and telephone visits to over 1,050 patients needing support for mental health and substance use. Telehealth services saved patients driving time of 70 days round trip (40 minutes on average one way) and 52,296 miles (21 miles on average per patient).

To provide safe and effective solutions to participants that are challenged by opioid use disorder, in FY23 the Integrated Behavioral Health Program assisted in the distribution of 340 doses of Narcan, the emergency treatment drug, free of charge to help decrease fatal opioid overdoses in the community.

3. Management of chronic health conditions

Diabetes Management Center of Excellence program

Through the Diabetes Management Center of Excellence program, MLKCH offers a comprehensive set of high-quality services and resources to help patients with diabetes manage their health and, over time, prevent and mitigate the complications that are common among residents in South LA.

This past year we supported patients with diabetes in lifestyle change and self-care, increasing the number of patients with diabetes who are well controlled, decreasing hospital admissions among patients with diabetes and preventing complications of diabetes.

Medical and care management

We have enrolled over 3,000 patients in the Diabetes Center of Excellence who were monitored closely by their primary care doctor using evidence-based measures to provide quality care to their patients with diabetes.

The Diabetes Center of Excellence Program's evidence-based measures include:

- Blood Pressure Control
- Retinal Eye Exams
- Foot Exams
- Measures of Blood Sugar Control
- Kidney Health Evaluation
- Cholesterol and Other Blood Lipid Control
- Smoking and Tobacco Use Screening and Follow-up (DRP_SSF)

Of the 3,000 plus enrolled in the Diabetes Management Center of Excellence, approximately 600 were enrolled into the Intense Disease Management Program and received support from our multispecialty team (including an endocrinologist, clinical pharmacist, care coordinators, case managers, a diabetes nurse specialist and community health workers). Approximately 53% of patients from the Intense Disease Management Program are now successful in self-management, meaning they have met the goals of their care plan, controlled A1C levels and glucose levels, have environmental stability (such as safe and stable housing) and have shown the aptitude to manage their care independently.

Once a patient is enrolled in our Intense Disease Management Program, the team creates an individualized treatment approach using a Health Risk assessment; a Health Action Plan, which is updated quarterly; and a Brief Action Plan created with the patient to support behavior change and self-management. During a patient's intake, about 32% received education related to their diabetes diagnosis.

Coaching

Patients received individual coaching with our diabetes educators. Coaching included creating and monitoring individual plans of care that integrated a variety of approaches including monitoring blood sugar; problem solving with diabetes devices including meters, pens, pumps and sensors; and medication education including how to administer insulin. Setting realistic goals, teaching healthy eating and learning coping behaviors to achieve and maintain a good quality of life were all part of the coaching experience.

An MLKCH community health worker supplemented this coaching in the home when needed. Patients in the Intense Disease Management Program continued to receive community health worker-directed coaching. Community Health Workers visited patients where they live to ensure they understood and were compliant with their care regimen.

4. Education and screenings

Know Your Basics community health program

Know Your Basics (KYB), our signature community health program, offers screenings, health education, resource referrals, health insurance education and peer support to residents throughout South LA. KYB reaches residents in their communities — at shopping malls, farmers' markets, community health fairs, churches, schools and housing projects. Nursing students from local colleges and nurse organizations conduct health screenings for glucose, blood pressure and body mass index (BMI). MLKCH's nurses and staff also volunteer their support.

During this past year, we partnered with over 20 organizations at 35 community events and provided over 1,240 health screenings.

In addition to in-person community engagement and education, KYB offered print and email newsletters providing health tips and resources to over 27,0000 community residents. Topics included chronic medical conditions, women's and men's health, social justice and mental health.

MLKCH also started "Doc Talks" in the community – an initiative that brings doctors from our health system to spaces where communities gather and provide education on health topics. "Doc Talks" were offered on topics such as flu, vaccines, diabetes, heart disease and kidney disease to a church congregation of over 200 people.

ManUp! For Your Health – barbershop outreach program

ManUp! For Your Health is a men's health outreach program offered at barbershops in the community of South LA. Similar to the KYB program, Manup! Provides health screenings and education to men in the community in the comfort of their barbershop.

We partnered with nine different barbershops and provided over 300 health screenings, allowing men to take charge of their health. During this past year, we completed over 43 health screening events in the shops.

Flu education and vaccination

Our outreach team provided flu education and vaccinations to the community, with a focus on areas of South LA with a high number of flu cases. In the past three years, *we provided over 740 vaccinations* and flu education to community members who have long been hesitant of vaccines in the past. The team developed a flu vaccine campaign consisting of resources on vaccines and preventive health. Materials were written in easy to understand language to increase access to health education.

5. Homeless health

Post-discharge homeless care

Homelessness continues to be a key focus area for MLKCH. The number of people experiencing homelessness 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 persons experiencing homelessness more placement options. In FY23, we provided basic needs support such as food and clothing to over 3,000 people who were experiencing homelessness and who lacked access to care. We continued to offer 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.

Our partnerships with community-based homeless service navigators and recuperative care and transitional living facilities was 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 over 6,200 people experiencing homelessness to social services or basic needs. We discharged about 2,000 patients to reserved shelter beds. The MLKCH Homeless Services team referred over 130 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.

Housing support services

People experiencing homelessness have significantly poorer health outcomes and increased mortality rates compared to the general population. When addressing access to health care and health inequity, people experiencing homelessness 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 and shelter and maintaining safety. People experiencing homelessness also have higher rates of returning to the ED compared to their housed counterparts, even when placed in a housing facility.

MLKCH participated in Homeless Housing and Support Services (HHSS), 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 helped find housing for people experiencing homelessness. Housing navigation services also assessed participants' housing status and needs, potential housing transition barriers, and housing retention barriers. The program addressed these barriers with short and long-term measurable strategies. Tenancy services helped persons who were formerly homeless maintain safe and stable tenancy once housing was secured. Tenancy services focused on housing retention, including establishing procedures and contacts to retain housing, providing early identification and intervention for behaviors that may jeopardize housing and assessing risk-factors that may impact their housing stability.

Another Medi-Cal program that MLKCH participates in to help 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 referred patients to recuperative care and connected them with case managers. The Community Support Program worked closely with the HHSS team to enroll patients in Housing Transition and Navigation or Tenancy services.

Street Medicine Department

Street Medicine serves the homeless community by providing direct care to the unsheltered and hardest to reach populations on the streets and under bridges. The goals of Street Medicine are to assist inpatient teams with avoiding discharge to the street, to provide recommendations on care plans in the inpatient setting based on their knowledge of homelessness and to provide follow up medical care should they choose to return to a street setting. All care is provided free of charge to the patient and delivered on-site, including dispensing medications, providing minor medical procedures and drawing blood for testing.

In FY23, when paired with an inpatient hospital-based consult service, Street Medicine decreased 30-day hospital readmission rates and hospital length of stay (LOS) and established ongoing primary care. Street Medicine reached and serviced over 310 patients living on the streets and connected about 40 people experiencing homelessness to housing and other social services, primary care visits, and mental health and drug treatment services.

6. Social determinants of health

Nutrition and food access

To support people who experience both chronic conditions and food insecurity, MLKCH offers a food "prescription" program, Recipe for Health (RFH). RFH provides participants a weekly supply of fresh fruits and vegetables, along with cooking and nutrition classes, so residents can 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 FY23, the RFH team enrolled over 360 RFH adults (age 18 and older) and 35 kids (between the ages of 5 and 17), for a total of about 400 participants. RFH also provided over 7,800 fresh produce packages to participants and their families.

A recipe is included each month in program participants food packages

Clinical outcomes

Participants in the RFH program saw decreased levels of diabetic hemoglobin A1C and high blood pressure. Overall, about 76% of participants experienced at least one improved health outcome (A1C, body mass index or blood pressure), which was an improvement from last year. Considering that the majority of this population was food insecure and 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.

Healthcare 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 visits to the ED for care compared to patients not participating in the program. In FY23, around 30% avoided a visit to the ED, and 78% kept and attended their primary care appointments at an MLKCH outpatient Care Center. This is an improvement from past years.

Health behaviors

As the participants continue in the RFH program, many report consuming more than two servings of fruits and vegetables per day. Knowledge of healthy food options and ways to prepare healthy meals showed an improvement, with participants reporting the program helped them cook and eat more nutritious meals. This highlights the type of health education that the RFH team provided to the participants (including simple meal ideas, healthy food alternatives and recipes). RFH participants also reported reductions in their fast food and unhealthy food consumption from 3-5 times a week to 0-2 times per week. Additionally, many reported never going a whole day without eating in the past month.

Home paramedicine program and access to in-home care

A rise in COVID-19 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-19 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.

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 FY23, over 1,140 paramedicine visits were performed for about 700 patients discharged from the hospital. 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. Overall, the program created an opportunity for patients to avoid returning to the ED as frequently.

Community building activities

Workforce development

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 focused on encouraging local youth to pursue careers in healthcare. As part of this year's You Can activities, hospital employees participated in school Career Days that reached over 100 students from two schools in the community. Launched in 2022, MLKCH continued its high school internship and mentorship program in the summer of 2023 called the Career Fellows Program. The paid internship program exposed South LA high school students to a variety of healthcare-related careers. The program paired Fellows with experts and mentors in a wide range of professions that support health. Students observed MLKCH doctors and nurses and conducted journal article research.

2022 Career Fellows

The Career Fellows Program was available to high school students in grades 10 through 12 who attended schools in South LA. MLKCH accepted 10 high school students from schools within the South LA community and each student completed a 7-week program with a work week of 25 hours per week. By the end of the program, each student completed 167 hours. Part of the program included shadowing of clinical and non-clinical employees. Over 50 MLKCH staff participated in the program through mentorship of the students and/or assisting students in their department rounds.

Another MLKCH program that focused on workforce development was the COPE Health Solutions Scholar Program. This program is a one-of-a-kind experiential education program tailored to individuals interested in pursuing a career in healthcare. As a health scholar, participants gained firsthand experience in a clinical setting, impacted patient lives and became an integral part of the patient care team. This unique program allowed scholars to assist with basic care for patients alongside nurses, doctors and other clinicians, preparing them for careers in healthcare and even receiving job opportunities within our organization after completing the program.

The COPE Health Scholar Program is uniquely diverse with many of the scholars residing in South LA or areas surrounding (about 65% in South LA and 23% in the city of Los Angeles) with a cultural diversity that also reflects the community we serve (about 60% Hispanic or Latino and Black or African American students).

MLKCH will continue to partner with COPE and offer these opportunities that provide a unique outlook on healthcare and build a workforce to further improve the health of the community we serve.

Financial summary of community benefit

MLKCH community benefit funding for FY23 (July 1, 2022 — June 30, 2023) 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]	$31,137,146.00
Unpaid costs of Medi-Cal[2]	$0
Education and research[3]	$0
Other for the broader community[4]	$17,999,528.44
Total community benefit provided excluding unpaid costs of Medicare	$49,136,674.44
Unpaid costs of Medicare[2]	$0
TOTAL NET VALUE OF QUANTIFIABLE COMMUNITY BENEFIT	$49,136,674.44

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 2024

MLKCH completed its most recent Community Health Needs Assessment (CHNA) in June 2023. Findings from our 2023 CHNA serve as a roadmap to continue and expand community benefit programs and services. In the first year of our 2024-2026 Implementation Strategy, we plan to strengthen existing programs and expand in the following areas:

1. Access to preventive, primary and specialty care

- **Connect Community to Medical Homes:** Help residents establish medical homes and connect to primary and specialty providers.
- **Transportation to Health Appointments:** Provide transportation assistance to connect patients to medical providers.
- **Telehealth:** Expand access to healthcare and social services using telehealth services.
- **Capacity Expansion:** Develop facilities, staffing, and infrastructure to increase capacity for specialized medical services, including mobile health.
- **Maternal and Infant Health:** Provide access to prenatal and postnatal services and support for expectant mothers in the community.
- **Health Insurance Enrollment:** Provide residents with assistance to enroll in county and governmental health insurance.
- **Financial Assistance:** Provide eligible persons that have low income with free and discounted healthcare services through the hospital's financial assistance (charity care) policy.

2. Behavioral health

- **Integrated Behavioral Health (IBH) Program:** Improve clinical outcomes in patients with underlying mental health and substance use co-morbidities by connecting residents to behavioral health specialists and homes.
- **Integrated Behavioral Health (IBH) Program- Telehealth:** Improve access to mental health and substance use services using telehealth consults with behavioral health specialists.

3. Management of chronic health conditions

- **Chronic Condition Centers of Excellence:** Provide clinical best practices and comprehensive care for patients with diabetes and treatment of patients with other chronic conditions.
- **Community Health Screenings – KnowYour Basics & Manup! Community Programs:** Provide community residents with health screenings, resources and education through monthly outreach and engagement efforts.

4. Homeless health

- **Street Medicine:** Provide street-based medical services and providers, including consultative services, to admitted MLKCH patients experiencing homelessness. Street-based services are provided on-site where the unsheltered homeless reside.
- **Post-discharge Homeless Care:** Provide direct patient support by navigating patients experiencing homelessness to immediate care management services.

5. Cultural alignment of care

- **Internal Medicine Residency Program:** Provide hands-on patient care training for high-quality doctors within South LA to continue practicing within the community. The program emphasizes health equity and social medicine.
- **Graduate Nursing Program:** Continue efforts to support the careers of new nursing school graduates with guided, on-the-job experience in a number of nursing specialties.
- **COPE Health Scholar and Care Navigator Program:** Continue efforts to enroll scholars and community members in the COPE program for healthcare navigation support and hands-on healthcare experience.
- **Career Fellows Program:** Expand awareness of and development of high school internship and mentorship programs for students living and going to school in South LA. Students receive nonclinical, clinical and research experience to encourage careers in healthcare.

6. Social determinants of health

- **Supporting Basic Needs for Homelessness:** Help individuals experiencing homelessness access housing, food, toiletries, clothing and support available through Measure H and other public initiatives.
- **Recipe for Health Food Access Program:** Provide residents with access to healthy and affordable foods through health education and peer support with our food access program.
- **Home Paramedicine Program:** Help individuals post-discharge receive follow-up care and education on their health condition at home.

Measuring impact

MLKCH is measuring progress toward each of our community benefit areas of focus using regularly 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 FY23:

Access to preventive, primary and specialty care

Goal: Increase access to preventive, primary and specialty health care for medically underserved residents.
Objectives:

- Increase healthcare services that range from primary to specialty care for residents of South LA.
- Increase healthcare services that range from primary to specialty care for residents of South LA.
- Improve the retention of specialty doctors across all specialties, resulting in adequate access to preventive, primary and specialty care.
- Increase availability of resources to address the inadequacy of health insurance coverage.

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 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 moms connected and served through the MLKCH lactation outpatient clini

Behavioral health

Goal: Increase availability of resources to treat behavioral health conditions.
Objectives:

- Increase the number of qualified behavioral health providers and support teams serving South LA.
- 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

Management of chronic health conditions

Goal: Improve management of chronic diseases, increase health education and encourage residents to maintain healthy weights and lifestyles to reduce future complications and disabilities.

Objectives:

- Increase prevention practices and referrals to treatment for chronic diseases.
- Decrease ED use by increasing availability of health screenings and education in the community.

Measures:

- Number of community members receiving health screenings through the KNB health screening and Manup! Barbershop programs
- Number of health education sessions provided to community members and persons receiving education through e-newsletters and "DocTalks"
- Number of persons enrolled in our diabetes management program

Homeless health

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

Objectives:

- Increase access to quality health care for homeless persons to improve self-management and enhance quality of life.
- Enhance street-based medical services to people experiencing homelessness.
- Increase assistance to patients experiencing homelessness to navigate social services and basic needs.

Measures:

- Number of beds MLKCH acquired to connect persons experiencing homelessness to transitional housing
- Number of persons experiencing homelessness connected to social services and/or basic needs
- Number of persons experiencing homelessness 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 experiencing homelessness served through the Street Medicine program

Cultural alignment of care

Goal: Reduce racial, economic, ethnic and social disparities in the community of South LA by expanding the knowledge and diversity of culturally-aware staff within our health system.

Objectives:

- Enhance the ability of residents to receive convenient, culturally appropriate care to maintain and manage their health.
- Increase trust of the health system within our community by attracting a diverse and culturally-competent staff.

Measures:

- Number of Internal Medicine residents participating in our Internal Medicine Residency Program.
- Number of new nursing graduates participating in the Grad Nursing Program.
- Number of COPE Health Scholars and Care Navigators enrolled in the COPE Health Solutions program and from the community.
- Number of COPE scholars graduated from the program and working at MLKCH.
- Number of high school students from the community participating and completing hours with MLKCH Career Fellows Program.

Social determinants of health

Goal: Support the growing number of community members who have housing, transportation, food insecurity and community safety issues that contribute to poorly managed health conditions.

Objectives:

- Improve self-management and quality of life by increasing access and connections to social needs and healthcare services.
- Increase access to healthy foods and education to improve health conditions for the residents of South LA.
- Increase access to housing assistance for community members.

Measures:

- Number of community members enrolled in our 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 daily.
- Number of persons served through the Home Paramedicine Program with 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
- African American Infant and Maternal Mortality Community Action Team
- African American Male Wellness Agency
- Alain Leroy Locke College Preparatory Academy
- 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
- Children's Hospital of Los Angeles
- Church of the Redeemer
- 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
- Dunbar Village
- El Nido Family Centers
- Exodus Recovery, Inc. At MLK Medical Center
- F & M Barber and Beauty Salon
- Firebaugh High School
- Food Forward
- Freedom Plaza - Primestor Development Inc.
- Fremont High School
- 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
- Kaiser Permanente
- Kings & Queens Beauty Salon
- 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
- Lynwood High School

- Lynwood High School
- 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
- Mt. Sinai Missionary Baptist Church of Compton
- 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
- 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
- St. Mary's Academy
- 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)
- Tau Tau chapter in Compton, CA of the Omega Psi Phi Fraternity Inc
- T.H.E. (To Help Everyone) Health and Wellness Centers
- The Gateway at Willowbrook Senior Center
- The G.O.A.T Hair Studio
- The Lounge Barbershop
- 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
- Verbum Dei Jesuit High School
- 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)

MLK Community Healthcare

www.mlkch.org