# COMMUNITY BENEFIT REPORT AND PLAN 2024

**SUBMITTED TO:**
California Department of Health Care Access and Information
Sacramento, California | November 2024

**PRESENTED BY**

MLK Community Healthcare

# TABLE OF CONTENTS

## A Message From

# Our Senior Vice President of Population Health

**Our community is rich in history, diversity and resilience.**

Yet, it faces significant challenges, including high rates of poverty, limited access to healthcare and a shortage of medical professionals. These challenges drive our mission at MLK Community Healthcare to provide compassionate, collaborative and quality care to all residents, regardless of their circumstances. The FY2024 Community Benefit Report highlights our unwavering commitment to addressing the social determinants of health and reducing health disparities in South Los Angeles. Our mission is not only to provide quality care, but to ensure that care is accessible to all, particularly those facing the most severe barriers. This past year, we made substantial progress in addressing health inequities that persist within our service area.

Through recruitment of mission-driven providers, we have expanded access to preventive care, as well as services that help manage chronic health conditions, including integrated behavioral health services. Our efforts in maternal and infant health, diabetes management and behavioral health show promising results, improving health outcomes and quality of life for many.

The impacts of these efforts are measurable—from increased access to medical specialists to innovative programs like telehealth and street medicine that reach the most vulnerable.

We recognize that healthcare extends far beyond our hospital walls. That is why our work addressing social determinants of health, such as food insecurity and homelessness is essential to improving overall health outcomes in the community.

Our vision is to build a healthier South LA by addressing both the immediate health needs of our patients and also the long-standing social and economic conditions that contribute to health disparities. By investing in programs and innovation, providing education and workforce development, and community partners, we are laying the foundation for sustained health improvement in South LA.

I am proud of the dedicated team at MLK Community Healthcare and our partners who work tirelessly to deliver compassionate, comprehensive and culturally aligned care. Together, we are making a real difference in the lives of individuals and families across South LA—while we continue to fight for equitable healthcare access for all.

**Jorge Reyno, MD, MHA**
**Senior Vice President, Population Health**
**MLK Community Healthcare**

# Introduction

**MLK Community Healthcare (MLKCH)** is a private, nonprofit healthcare system that includes a safety-net hospital on the MLK Medical Campus in South LA, as well as a network of primary and specialty care centers throughout the area. Our mission is to provide compassionate, collaborative and quality care to improve the health of our community — driving quality patient care and programs that address prevention and social conditions that negatively impact health.

- ***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 Centers -*** We operate multiple outpatient care centers throughout South LA, offering much-needed primary and specialty care.
- ***Wound Care Center -*** MLKCH operates South LA's only wound care center with individual hyperbaric chambers for the advanced treatment of non-healing wounds and other complex health conditions.
- ***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.

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## MISSION

To provide compassionate, collaborative, quality care and improve the health of our community.

## VISION

To serve as a leading model of innovative and collaborative community healthcare.

## VALUES

Caring
Collaboration
Accountability
Respect
Excellence

# About Our Community

South Los Angeles' importance as a cradle of social justice and artistic and cultural revolution in California history cannot be understated. From its earliest agricultural roots that attracted Spanish settlers in the 1700s, to the Great Migration that brought African Americans from the Deep South in the 1950s, and the waves of Latino immigrants in the 1990s, each new community and their contributions has shaped the distinctive fabric of South LA. It is a privilege to serve this dynamic community at the forefront of critical debates about why access to quality care and services is essential in under-resourced communities.

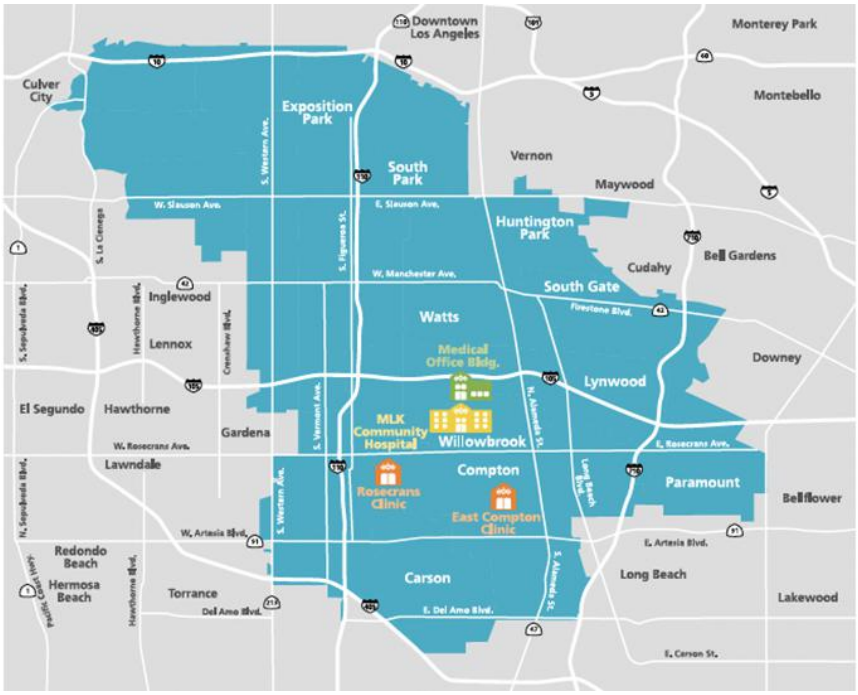
# Social Challenges and Health Disparities

**South LA is home to one of the most vulnerable populations in Los Angeles County, with 1.3 million residents—over 90% of whom are Hispanic and African American.** Years of underinvestment and systemic inequities have resulted in socioeconomic challenges, such as a poverty rate that is double that of LA County—along with high unemployment, homelessness and limited access to healthy food.

These conditions drive one of the most pressing healthcare challenges in our community: a shortage of 1,500 doctors, including both primary care and specialists needed to manage chronic diseases.

Large swaths of South LA—including the area served by MLK Community Healthcare— are federally designated as a Healthcare Professional Shortage Area, a Medically Underserved Area or both. As a result, residents often struggle to access preventive, primary and specialty care services, and resort to using our emergency department (ED). Perhaps unsurprisingly, this gap in access has led to some of the lowest life expectancies and worst health outcomes in LA 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 |

The **2023 Community Health Needs Assessment (CHNA)** identified priority health needs in the community by analyzing a broad range of social, economic, environmental, behavioral and clinical factors that influence health outcomes. To better understand the overall needs of this community, we reviewed quantitative data from various published sources and compared it to benchmark data at the SPA (Service Planning Area), County and State levels when available. Additionally, input on existing resources and innovative ideas to address these priority needs was gathered from local stakeholders through interviews, written surveys, community convenings and focus groups.

Based on the findings, MLKCH developed its 2024-2026 Implementation Strategy, which focuses on the most significant health needs identified in the Community Health Needs Assessment. **In collaboration with community partners, MLKCH established six priorities for Fiscal Year (FY) 2024 (July 1, 2023 – June 30, 2024)**:

- Increasing Access to Preventive, Primary and Specialty Care Services
- Managing Chronic Health Conditions
- Behavioral Health
- Homeless Health
- Ensuring Cultural Alignment of Care
- Addressing Social Determinants of Health

The 2024-2026 Implementation Strategy and 2023 CHNA can be accessed at **https://www.mlkch.org/community-reports**. A paper copy is available for inspection by the public upon request. Feedback on these reports are welcome.

To send written comments or request more information on the 2023 CHNA or 2024-2026 Implementation Strategy, please contact **kyb@mlkch.org**.

# Community Benefits Services Summary - Fiscal Year 2024

### Improving the health of our community

**Over the past year, MLKCH has expanded access to quality care and health education throughout South LA.** In response to the needs identified in the 2023 Community Health Needs Assessment, MLKCH implemented and expanded programs using the framework outlined in the 2024-2026 Implementation Strategy. These initiatives focused on six priority areas to improve community health:

1. **Increasing Access to Preventive, Primary and Specialty Healthcare**
2. **Managing Chronic Health Conditions**
3. **Behavioral Health**
4. **Homeless Health**
5. **Ensuring Cultural Alignment of Care**
6. **Addressing Social Determinants of Health**

# 1.) Increasing Access to Preventive, Primary and Specialty Healthcare

### *Increased the number of doctors*

**We remain steadfast in our commitment to provide our community with a larger network of doctors trained in a variety of specialties.** Over the past year, we recruited six new providers to our outpatient care centers, including specialists in internal medicine, pulmonology, critical care, obstetrics and gynecology (OB/GYN), and midwifery.

### *Expanded access to medical specialists and services*

**Expanding access to specialty care to manage chronic conditions such as diabetes, heart disease and respiratory disorders has remained a top priority for MLKCH this past year.** We expanded our network of medical specialists to better support effective treatment strategies, and also to align with our Implementation Strategy goals of improving access to care and enhancing chronic disease management. MLKCH's 39 providers offered care across 21 specialties, including pulmonology, endocrinology, cardiology, pediatrics, urology, OB/GYN, addiction psychiatry and vascular surgery.

MLKCH continued to coordinate care across both inpatient and outpatient settings in FY24, with an estimated 16,000 patients accessing specialty medical services at our outpatient care centers. With diabetes being one of the main specialty services sought, this improved access to care has enabled us to build the infrastructure needed to establish comprehensive centers of excellence for diabetes management and care.

In addition to the already existing patient panel, MLKCH provided specialty medical services to over 250 new patients during FY24 and continued to have a 75% overall show rate for patients attending their appointments.

### *Public assistance programs*

The **Medical Office Building (MOB)** on the MLK Medical Campus provided expanded space for doctor visits and additional services such as an **on-site pharmacy** and **state-of-the-art wound care center**; as well as space for employee training and patient education. Additional patient services in the MOB include assistance with enrolling for health insurance and other forms of public assistance such as the Supplemental Nutrition Assistance Program (SNAP) and Women, Infants and Children (WIC) program.

### *Financial assistance and health insurance enrollment*

Through our Financial Assistance services, **MLKCH helped over 1,400 patients sign-up for Medi-Cal, with approximately 650 approved for healthcare benefits**. Additionally, about 3,400 patients were temporarily placed on Medi-Cal while waiting for their applications to be finalized. **Altogether, MLKCH helped enroll about 4,000 uninsured patients with obtaining health coverage**. The enrollment team also supported community members with accessing CalFresh services to address food insecurity issues.

MLKCH's Medicare Community Outreach Enrollment team **educated over 1,000 community members on Medicare insurance options, including Medicare Advantage plans**. Our team also guided eligible patients through the enrollment process, and addressed concerns related to transportation, future appointments and filling prescriptions. As a result, nearly 100 new patients enrolled in Medicare in FY24, allowing them to receive timely, comprehensive care.

### *Telehealth services*

MLKCH's telehealth services, or video and telephone visits, increased South LA residents' access to health care and social services in FY24. **We provided care to over 3,500 patients, who completed an estimated 6,500 telehealth visits during this time**. Our telehealth services **saved patients a total of 190 days in driving time**—an average of 43 minutes per trip—amounting up to 91,000 miles in travel (14 miles per patient, on average). By providing telehealth, we reduced the need for emergency department visits and improved access to care for our community.

### *Transportation assistance*

MLKCH offered transportation assistance to eliminate barriers to healthcare access in FY24, **supplying over 150 courtesy roundtrip rides via UberHealth for patients with doctor appointments at MLKCH**. MLKCH covered the service cost at about $5,000 per year.

## *Maternal and Infant Health*

Expanding prenatal care and post-delivery support for expectant mothers in the community remains a top priority for MLKCH. We expanded access to maternal and child health specialists through community partnerships and by adding pediatricians to our care centers. Additionally, we improved access to comprehensive family planning and contraceptive services.

**In FY24, MLKCH successfully delivered over 860 healthy babies.** Additionally, MLKCH offers a community lactation outpatient care center, which **served over 400 mothers this past year**. It is the only clinic of this kind in South LA, and provides specialized support to mothers facing breastfeeding challenges, maternal nutrition and breast pump support. The lactation care center also offers prenatal visits, transportation assistance and virtual visit options upon request.

In another effort to expand access to quality care in this community, the Lactation Care Center welcomes all patients, regardless of insurance status, prior referrals or where they gave birth.

Our **Welcome Baby** program provides home and community-based support services for new mothers, including home visits following birth. **This program served approximately 800 families in FY24**, offering home visits, post-delivery assistance and other educational resources.

To further support maternal health, our perinatal team continued offering the First 48 Hours class and the Mommy Support Group, which ultimately served over 220 expectant and new mothers through virtual education last year.

- **First 48 Hours** is a free class covering what to expect after delivery, including newborn testing, immunizations, changes to the mother's body and breastfeeding education.

- **The Mommy Support Group** is a free and weekly peer support group for new mothers in the community, covering topics like feeding, maternal nutrition and balancing breastfeeding with work or school.

Classes continue to be accessible virtually to community members with online classes.

# 2.) Management of Chronic Health Conditions

## *Diabetes Center of Excellence program*

Through the Diabetes Center of Excellence Program, **MLKCH offered quality services and comprehensive resources to over 700 patients diagnosed with diabetes**, a common condition among South LA residents. We supported them in making key lifestyles changes and implemented evidence-based measures in our diabetes care, such as:

- 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 & Follow-Up

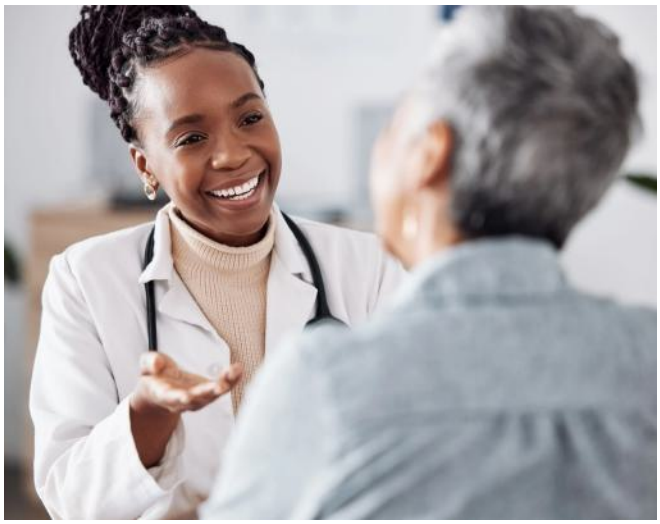
Our efforts resulted in more patients keeping their diabetes under control, fewer hospital admissions and reduced health complications.

Many patients who enrolled in the Diabetes Center of Excellence also participated in the Intense Disease Management Program, where they each received additional patient education, a personalized treatment plan, a Health Action Plan (updated quarterly) and a Brief Action Plan developed collaboratively to promote positive health behavior changes and self-management.

In addition to these action plans, each patient received dedicated support from our multispecialty team that included an endocrinologist, clinical pharmacist, care coordinators, case managers, a diabetes nurse specialist and community health workers.

As a result, **approximately 61% of these patients were successful in meeting their care plan goals**, maintaining controlled diabetic hemoglobin A1C levels and glucose levels, as well as achieving environmental stability (such as safe and stable housing). This success reflects their ability to manage their care independently.

## *Coaching*



Patients received individual coaching from our diabetes educators, who helped them create and monitor personalized care plans. This coaching covered key aspects of diabetes management, including blood sugar monitoring, troubleshooting diabetes devices such as meters, pens, pumps and sensors; as well as providing medical education like how to self-administer insulin. Additionally, patients were coached in setting realistic goals, adopting healthy eating habits and learning coping strategies to maintain a good quality of life.

When needed, an MLKCH community health worker provided supplementary coaching at home. Patients in the Intense Disease Management Program continued to receive home visits from community health workers, ensuring that they understood and were compliant with their care regimen.

## *Community Health Initiatives*

### *Community health outreach program*

**Know Your Basics (KYB)** is an MLKCH-led community health program that empowers South LA residents to take control of their health and wellness by offering essential public health information. The program provides free health screenings, education, resource referrals, health insurance guidance and peer support across the community.

Over the past year, KYB partnered with over 20 organizations at 36 community events and **provided over 1,600 health screenings**. Additionally, KYB reached **approximately 29,000 residents** through newsletters offering health tips on topics like chronic conditions, nutrition, women's and men's health, social justice and mental health.

KYB reached residents in their communities, offering services at shopping malls, farmers' markets, community health fairs, churches, schools and housing projects. Local nursing students, alongside MLKCH nurses and staff, volunteered to conduct health screenings for blood glucose, blood pressure and body mass index (BMI).

Through our partnerships with neighboring community organizations, MLKCH also hosted 15 educational sessions and engaged approximately 360 additional community members this past year. These sessions included cooking classes at our cafeteria, health panels at community events, and "Doc Talks" – where MLKCH physicians visit community spaces like churches to discuss key health issues such as flu prevention, diabetes, heart disease and kidney disease.

**ManUp! For Your Health** is a men's health outreach program offered in various South LA barbershops. Similar to the KYB program, ManUp! provided health screenings and education to men, but in the familiar setting of their neighborhood barbershops.

Last year, we partnered with eight different barbershops and conducted over 43 health screening events, **ultimately completing about 300 health screenings**, allowing men to take charge of their health.

### *Flu education and vaccination*

During the 2023-2024 flu season, our outreach team provided community education on the flu, with a focus on South LA areas with a high number of flu cases.

Thanks to a robust and easy-to-understand health education campaign targeted towards reluctant community members, we were able to **successfully vaccinate over 100 people** who reported being hesitant of vaccines in the past.

# 3.) Behavioral Health

### *Integrated behavioral health program*

A significant number of MLKCH patients experience behavioral health challenges, often in connection with chronic health conditions. In response, MLKCH built upon its innovative Integrated Behavioral Health (IBH) program, which addresses mental health, physical health and substance use disorders. Patients are assessed at the first point of contact to identify any potential links between a chronic medical condition and behavioral health concerns. This allows the MLKCH behavioral health team to intervene early, if necessary.

**Through the IBH program, more than 3,680 patients were referred and/or connected to behavioral health services**, while 300 patients were linked to outpatient doctors and other treatment programs. Additionally, over 250 patients were offered telehealth consultations to address their behavioral health needs, resulting in about 1,400 video and phone visits. These telehealth services saved patients approximately 70 days in round-trip driving time (48 minutes on average each way) and nearly 16,600 miles (16 miles on average per patient).

To provide safe and effective solutions to patients with opioid use disorder, IBH program helped distribute 240 doses of the emergency treatment drug Narcan free of charge in FY24, helping reduce fatal opioid overdoses in the community.

# 4.) Homeless Health

### *Post-discharge homeless care*

Homeless health 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 needed to manage their health conditions.

In response, we enhanced our care coordination services and expanded our network of external partners to give South LA's homeless population more placement options. **In FY24, we provided over 3,200 people experiencing homelessness support with basic needs such as food and clothing**. We continued to offer our unhoused patients services from a dedicated homeless services supervisor, homeless service coordinator, housing navigator and community health workers to help our patients navigate and access resources critical to their health.

Our partnerships with community-based homeless service navigators, recuperative care and transitional living facilities were essential to this work. The hospital contributed to the cost of recuperative care for uninsured and underinsured patients and also participated in transitional housing partnerships, such as the local Homeless Coalition and the Homeless Outreach Program Integrated Care System.

Through these partnerships, **we connected over 8,600 people experiencing homelessness to social services or basic needs- a 30% increase from the previous year**. We discharged 3,000 patients to reserved shelter beds and referred over 180 patients to the Los Angeles County Recuperative Care and Transitional Living program to provide them with a safe and low-cost location to recover after leaving the hospital.

## *Housing Support Services*

People experiencing homelessness have significantly poorer health outcomes and higher mortality rates compared to the general population. When it comes to accessing to healthcare and health inequity, this population experiences some of the worst outcomes in the United States. These disparities are partially due to competing priorities, such as the need to find food and safe shelter—which often take precedence over seeking healthcare. Additionally, people experiencing homelessness have higher rates of emergency department (ED) visits and are more likely to return to the ED compared to their housed counterparts, even after being placed in a housing facility.

MLKCH participated in the Homeless Housing and Support Services (HHSS) program, a comprehensive initiative under the California Advancing and Innovating Medi-Cal (CalAIM) framework developed by the Department of Health Care Services (DHCS). This program integrated Community Supports, including housing navigation, tenancy services, and recuperative care, to address the needs of individuals experiencing homelessness.

Housing navigation services were focused on assessing participants' housing needs, identifying barriers to securing housing and developing strategies to address both immediate and long-term challenges. Tenancy services provided support to help individuals maintain stable housing by establishing preventive measures, offering early intervention when issues arose, and mitigating risks to housing instability.

Through Community Supports under the HHSS program, MLKCH social workers referred patients to recuperative care and connected them with case managers for additional support. These teams collaborated to enroll patients in Housing Navigation or Tenancy Services, creating a seamless pathway to stable housing and comprehensive care.

## *Street Medicine*

**Our Street Medicine department provided ongoing direct care to over 240 members of South LA's homeless community in FY24**, meeting them where they were on the streets and under bridges to provide direct care. They also connected more than 40 people experiencing homelessness to services such as housing, primary care visits and mental health care and drug treatment.

The goals of Street Medicine are to:

- Assist inpatient teams with minimizing the number of patients discharged to the street
- Provide recommendations on care plans in the inpatient setting based on their knowledge of homelessness
- Provide homeless patients with follow up medical care should they choose to return to a street setting


All care—which includes dispensing medications, providing minor medical procedures and blood drawing—is provided free of charge to the patient and delivered on-site where the patient is based.

When paired with an inpatient hospital-based consult service, the Street Medicine team was able to effectively decrease 30-day hospital readmission rates amongst this population, establish ongoing primary care for them, and decrease the length of their hospital stay.

# 5.) Cultural Alignment of Care

### *MLKCH Research Enterprise*

The MLKCH Research Enterprise is committed to advancing community health and saving lives in South Los Angeles through cutting-edge clinical research. Our mission is to foster learning, drive innovative research and bring the benefits of our discoveries to underserved communities by delivering exceptional patient care.

We are especially committed to achieving significant scientific breakthroughs for patients with difficult-to-treat diseases seen at our safety-net hospital, with a focus on tackling chronic conditions like diabetes and congestive heart failure. We address these issues not only to improve local health outcomes, but to set a standard that can serve similar communities across the nation.

MLKCH thrives through long-term partnerships with leading institutions like Stanford University, University of California San Francisco, City of Hope, UCLA, and Cedars-Sinai. These collaborations, alongside support from local organizations and community advocates, fuel our groundbreaking research in science, technology and medicine, ultimately enhancing our efforts to develop innovative treatments that can transform patient care.

Together, we are building a model for equitable healthcare, advancing treatments, and creating a lasting impact on community health.

### *Graduate Medical Education*

MLKCH offers a three-year graduate medical education residency program in internal medicine, which features a strong emphasis on healthcare in the context of equity and social justice. The program includes coursework related to social determinants of health such as race and ethnicity, income, equitable access to care and other factors.

The residency program is designed to attract quality providers to one of the most medically underserved communities in the nation. South LA has ten times fewer doctors than more affluent areas and is designated as a Health Professional Shortage Area by the Health Resources and Services Administration. This lack of access to quality care has resulted in some of the worst health outcomes in the state.

To date, MLKCH has a total of 15 Internal Medicine residents participating in the program and 100% of those residents identify as a person of color. This statistic is important to MLKCH, ensuring that staff and providers reflect the community they serve.

### *Center for Advancing Health Equity*

At MLKCH, we're committed to shedding light on the inequities facing under-resourced communities and supporting new approaches to help eliminate these disparities.

This past year, we established the Center for Advancing Health Equity, which will focus on research that uncovers the systemic causes behind health disparities in South LA and similar communities. Drawing on our institution's longstanding commitment to excellence in safety-net healthcare, we will utilize our expertise to develop and evaluate promising models of healthcare that target these inequities.

Through rigorous research, we seek to identify the root causes of the ongoing health challenges in our community. Our findings will not only inform our own practices, but also serve as a foundation for policy recommendations that advocate for long-term solutions.

With the recent appointment of a dedicated Director for the Center, we are moving forward with a leader to steer this work, cultivate partnerships and impact health disparities. We are committed to creating a healthier, more equitable future—one that is grounded in data, compassion and a commitment to justice in healthcare.

# 6.) Addressing Social Determinants of Health

***Nutrition and food access***

RECIPE FOR HEALTH

To support people who experience chronic health conditions along with food insecurity, MLKCH offered a food "prescription" program called Recipe for Health (RFH). This program provided participants with a weekly supply of fresh fruits and vegetables, along with cooking and nutrition classes, so they could learn more about how different food choices can improve their health. Family members also benefitted from the program's education along with participants, helping to build healthy habits across generations.

Our MLKCH cafeteria — a model of healthful and affordable food choices — is an integral part of this program.

**During FY24, the RFH team enrolled over 455 RFH adults (age 18 and older) and 16 kids (between the ages of 5 and 17), for a total of 471 participants. RFH also provided over 10,200 fresh produce packages to participants and their families.**

## *Clinical Outcomes*

Participants in the RFH program saw decreased levels of diabetic hemoglobin A1C and high blood pressure. **Overall, about 80% of participants experienced at least one improved health outcome**— whether in A1C levels, body mass index or blood pressure—marking a significant increase from the previous year. Given that most participants entered the program with food insecurity and two or more chronic conditions, these improved outcomes demonstrated a significant positive impact. Anecdotally, many patients reported that they were sharing program-provided recipes with their families, suggesting that the program's benefits extended to entire households.

## *Healthcare Use*

Participants in the RFH program were more likely to attend their appointments, even those unrelated to RFH. Compared to non-participants, they also had fewer ED visits. **In FY24, approximately 37% avoided an ED visit and 80% maintained their primary care appointments** at an MLKCH outpatient Care Center—an improvement from previous years.

## *Health Behaviors*

As participants continued in the RFH program, many reported eating more than two servings of fruits and vegetables per day. They also improved their knowledge of healthy food options preparation methods, and participants credited the program with helping them enjoy more nutritious meals.

This underscores the impact of the health education provided by the RFH team, which included simple meal ideas, healthy food alternatives and other recipes. **Many participants also reported a significant reduction in their consumption of fast food, from 3-5 times a week down to 0-2 times per week**. Additionally, many noted that since joining the program and learning how to cook, they had not gone a full day without eating a meal.

## *Cooking Classes*

As part of the RFH education initiative, MLKCH launched a new series of cooking classes called Cooking with Community, held every other month at the hospital. These free classes offer community members education and live cooking demonstrations to support healthier lifestyle choices.

Each class features different health topics and recipes using items from either a RFH participant's food package or affordable items that can be purchased from the local grocery store. The dishes are selected with consideration of the diverse cultural population, incorporating foods that they're accustomed to. Over the past year, MLKCH has hosted five cooking classes to the community, introduced 12 new recipes and educated nearly 100 community members to date.

## *Home paramedicine program and access to in-home care*

The MLKCH Home Paramedicine Program is a mobile healthcare service that delivers in-home care to patients across South LA. The program was designed to assist patients in their recovery after their hospital stay. This allows for enough hospital beds to remain available for the most critical cases, as more stable patients are discharged home and receive follow up visits from program staff. Medical personnel, such as paramedics or nurses, visit recently discharged patients at home within 6 to 48 hours of discharge to follow up on referrals, conduct safety checks and relay their findings to the attending physician.

The majority of patients served through this program have chronic conditions such as congestive heart failure, chronic obstructive pulmonary disease (COPD) and diabetes, as well as other risk factors such as frequent hospital readmissions.

The Home Paramedicine Program was particularly valuable during the pandemic, offering a safety net for at-risk patients, improving access to care and preventing unnecessary returns to the ED. **In FY24, over 1,180 paramedicine visits were completed for about 630 discharged patients**.

This program's service area extended up to 30 miles from the hospital, with most patients located within a 10-mile radius. This saved ample driving time for medical care and follow-up appointments. As a result, many patients were able to avoid returning to the ED as frequently.

## *Community Building Activities*

### *Advocacy for Community Health Improvement and Safety*

This past year, MLKCH continued to focus on strengthening and building the community through advocacy and leadership. Hospital leaders actively served on local, regional and state level boards that addressed health improvement and championed health policies aimed at benefiting our community.

### *Workforce development*

MLKCH's **'You Can'** program is a community initiative designed to encourage local youth to pursue careers in healthcare. This year, hospital employees participated in Career Days and engaged with over 100 students, offering insights into various healthcare careers.

### *COPE Health Scholars and Care Navigators*

MLKCH partnered with the **COPE Health Solutions Scholar's and Care Navigator Program** to provide experiential learning opportunities for students and community members aspiring to work in healthcare.

Participants gained firsthand clinical experience, working alongside nurses, doctors and other healthcare professionals. The program not only prepared scholars for careers in health, but also offered potential career opportunities at MLKCH upon completion.

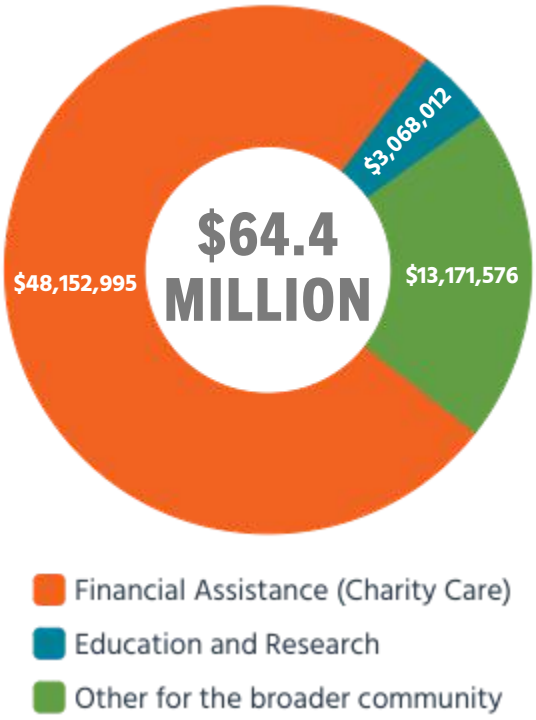
**In FY24, COPE enrolled 95 scholars to participate in the program**, with six graduates now employed by MLKCH. Additionally, 15 COPE scholars have continued their studies in medical or healthcare fields such as medicine, nursing, public health and health administration. Approximately 30% of the participants were from South LA, and the cohort's demographic reflected the diverse community served by MLKCH, with around 60% identifying as Hispanic/Latino or Black/African American.

### *Career Fellows Program*

MLKCH continued its Career Fellows Program, a paid high school internship and mentorship program developed to provide South LA high school students with exposure to careers in healthcare. **In FY24, the Career Fellows Program partnered with six South LA high schools to provide 10 sophomores, juniors and seniors with a 7-week internship**. Each student worked 25 hours per week, completing 165 hours of work in total, and were paired with mentors across various healthcare sectors. More than 70 MLKCH staff participated as mentors or offered guidance during their department rotations.

# Financial Summary of Community Benefit

**MLKCH's community benefit funding for FY24 (July 1, 2023 — June 30, 2024) 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] | $48,152,995.00 |
| Unpaid costs of Medi-Cal[2] | $0 |
| Education and research[3] | $3,068,012.49 |
| Other for the broader community[4] | $13,171,576.58 |
| Total community benefit provided excluding unpaid costs of Medicare | $64,392,584.06 |
| Unpaid costs of Medicare[2] | $0 |
| TOTAL NET VALUE OF QUANTIFIABLE COMMUNITY BENEFIT | $64,392,584.06 |

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 2025

Findings from our 2023 Community Health Needs Assessment (CHNA) provide a roadmap for expanding our community benefit programs and services. In the next year of our 2024-2026 Implementation Strategy, we plan to strengthen existing programs and expand efforts in the following areas:

1. **Increasing Access to Preventive, Primary and Specialty Healthcare**
2. **Managing Chronic Health Conditions**
3. **Behavioral Health**
4. **Homeless Health**
5. **Ensuring Cultural Alignment of Care**
6. **Addressing Social Determinants of Health**

## 1.) Increasing Access to Preventive, Primary and Specialty Healthcare

- **Connect Community to Medical Homes**: Help residents establish 'medical homes,' or a primary care hub where they receive coordinated care for all of their health needs, including access to specialists and preventative services.
- **Transportation to Health Appointments**: Provide transportation assistance for patients to regularly attend their appointments.
- **Telehealth**: Expand access to healthcare and social services using telehealth.
- **Capacity Expansion**: Develop the facilities, staffing and infrastructure to increase our capacity to offer expanded specialized medical services such as mobile health.
- **Maternal and Infant Health**: Provide access to prenatal and postnatal support services for expectant mothers in the community.
- **Health Insurance Enrollment**: Provide residents with assistance to enroll in county and government health insurance programs.
- **Financial Assistance**: Provide financial support to eligible low-income patients 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 comorbidities by connecting residents to behavioral health specialists.

- **IBH Program - Telehealth**: Increase access to behavioral health services through telehealth consultations.

# 3.) Managing Chronic Health Conditions

- **Chronic Conditions Centers of Excellence**: Deliver clinical best practices and comprehensive care to patients with diabetes and other chronic conditions.

- **Community Health Screenings**: Provide South LA residents with regular health screenings, resources and education through monthly outreach and engagement efforts, such as our Know Your Basic and ManUp! community health programs.

# 4.) Homeless Health

- **Street Medicine**: Provide street-based medical services, including consultations and preventative care, to admitted MLKCH patients who are experiencing homelessness. MLKCH's Street Medicine team provides care on-site where patients are based.

- **Post-discharge Homeless Care**: Provide direct support to unhoused patients by helping them access immediate care management services.

- **Addressing Basic Health Needs of South LA's Homeless Population**: Assist unhoused individuals with access to essentials such as safe housing, food, toiletries, clothing and other support available through Measure H and other public initiatives.

# 5.) Ensuring Cultural Alignment of Care

- **Internal Medicine Residency Program**: Produce high-quality doctors that continue practicing in South LA by providing hands-on training that emphasizes patient care, health equity and social medicine.

- **Center for Advancing Health Equity**: Highlight health inequities impacting under-resourced communities, providing facts and evidence to support new approaches and policies to eliminate them.

# 6.) Addressing Social Determinants of Health

- **'Recipe for Health' food access program:** Provide South LA residents with access to healthy and affordable food through health education and peer support with our food access program.

- **Home Paramedicine program:** Help post-discharge patients receive quality follow-up care and ongoing health education at home.

# Measuring Our Impact

MLKCH is measuring our progress toward each of our six areas of focus by using regularly prescribed evaluation routines, as well as quarterly progress reports. 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.

## 1.) Increasing Access to Preventive, Primary and Specialty Healthcare

### 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.
- 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
- Number of moms supported by MLKCH maternal virtual classes/support groups
- Number of moms connected and served through the MLKCH lactation outpatient clinic

## 2.) 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 the South LA community.
- Increase referrals to mental health and substance use services for community residents.

### Measures

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

## 3.) Managing 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 KYB health screening and ManUp! barbershop programs
- Number of health education sessions provided to community members and persons receiving education through e-newsletters and "Doc Talks"
- Number of persons enrolled in our diabetes management program


## 4.) 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.

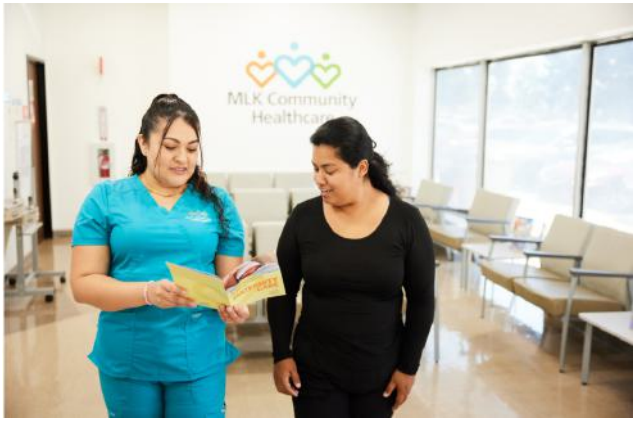
### Objectives

- 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

## 5.) Ensuring 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 clinical research projects conducted to expand knowledge and address overall health disparity needs

## 6.) Addressing 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

- 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

# Significant Needs Outside of Hospital Scope

MLKCH is committed to improving the health of our community outside of the hospital's walls by addressing the significant health needs identified in the 2023 Community Health Needs Assessment. We have grouped these significant needs into six categories:

1.) **Increasing Access to Preventive, Primary and Specialty Healthcare**

2.) **Behavioral Health**

3.) **Managing Chronic Health Conditions**

4.) **Homeless Health**

5.) **Ensuring Cultural Alignment of Care**

6.) **Addressing 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 and established relationships with our community partners. Together we have made a meaningful impact in the communities we serve. Moving forward, we will continue engaging new partners to support our mission and satisfy the objectives outlined in our Implementation Strategy. 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
- American Diabetes Association
- American Heart Association
- Animo James B. Taylor Middle School
- Association of Black Women Physicians
- Augustus Hawkins High School
- Baldwin Hills Farmers Market
- Be Social Productions
- Bethel Missionary Baptist Church of South Los Angeles
- Beulahland Missionary Baptist Church
- Black Beauty & Wellness Foundation
- Black Business Association
- Black Infant Health Program
- Black Women for Wellness
- Black Women Leaders of Los Angeles
- Blink Fitness
- Boys & Girls Club of Metro Los Angeles
- Brotherhood Crusade
- California Black Women's Health Project
- California Endowment
- California State University Dominguez Hills
- Cedars-Sinai Medical Center
- Center for Sustainable Communities
- Centinela Probation Office (Los Angeles County Probation Department)
- Charles R. Drew University of Medicine and Science
- Children's Hospital of Los Angeles
- Children's Institute
- 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
- Congress of Racial Equity – Los Angeles Chapter (CORE – LA)
- COPE Health Solutions
- Core Contributors Group, Inc (CCG)
- David Starr Jordan High School
- Debbie Allen Dance Academy (DADA)
- DocGo
- Dunbar Village
- El Nido Family Centers
- Exodus Recovery, Inc. at MLK Medical Center
- Everytable
- F & M Barber and Beauty Salon
- Firebaugh High School
- Food Forward
- Forgiving for Living, Inc.
- Forgotten Children, Incorporated
- Freedom Plaza - Primestor Development Inc.
- Fremont High School
- Girls Club of Los Angeles
- Greater Los Angeles African American Chamber of Commerce
- Greater St. Augustine Missionary Baptist Church
- Grocery Outlet Bargain Market — Compton
- Hank's Mini Market
- Health Net of California, LLC
- Homeless Outreach Program Integrated Care System (HOPICS)
- Hospital Association of Southern California
- Housing Authority of the City of Los Angeles (HACLA)
- Impact Media
- Inglewood City Clerk's Office
- International Medical Corps (IMC)
- JAR Insurance
- Just Showing Off Barber Salon
- Kaiser Permanente

- Kindred Space LA
- 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
- Legends Barbershop
- Los Angeles Adventist Academy
- Los Angeles Area Chamber of Commerce
- Los Angeles County Department of Mental Health
- 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 Metropolitan Churches
- Los Angeles Sentinel
- Los Angeles South Chamber of Commerce
- Los Angeles Unified School District (LAUSD)
- Los Angeles Urban League
- Los Angeles Wellness Station
- Lynwood High School
- Magdaleno's Barbershop
- 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
- NAACP Los Angeles
- 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
- Positive Results Center
- Residence Advisory Councils for Jordan Downs, Nickerson Gardens and Imperial Courts
- R.O.A.D.S. Community Care Clinic
- Samuel Gompers Middle School
- Sanctuary of Hope
- Shields for Families
- Sodexo
- South Los Angeles Health Projects
- Southern Christian Leadership Conference – Los Angeles (SCLC – LA)
- Southside Coalition of Community Health Centers
- SPA 313 Hair Salon
- SPA 6 Homeless Coalition
- St. Anne's Family Services
- 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 of 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
- The Place To Be 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
- 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