# 2020 Implementation Plan

Martin Luther King, Jr. Community Hospital

August 2020





# **Table of Contents**

Message from the CEO	3
About Martin Luther King, Jr. Community Hospital	4
Defined Community	4
Community Health Needs Identified in the 2020 CHNA	5
Significant Health Needs the Hospital Will Address	7
Evaluation of Impact	12
Needs the Hospital Will Not Address	12
Report Availability and Comment	12

MLKCH senior leaders and the board of directors reviewed these significant needs and approved these priorities and the following Implementation Plan on July 15, 2020.



# **Letter from Our Chief Executive Officer**

Our South Los Angeles community faced unprecedented challenges in 2020. The COVID-19 pandemic added additional complexity to caring for an already complex population. Our community's longstanding lack of access to quality health care left many residents with poorly treated chronic conditions (such as hypertension, chronic lung disease, diabetes and heart disease) more vulnerable to the virus.

Despite the challenges, our clinical teams performed magnificently, both in the provision of COVID-specific emergency care and in the ongoing provision of care generally.

COVID has shown us, once again, that the fundamentals of health start outside the hospital walls. This implementation plan addresses the root causes of the health disparities we see in our community. We understand that South LA needs more providers, including mental health providers, more health education, and more upstream resources and investments in health. This plan provides a roadmap for how we get there.

We know we cannot do it alone. Policymakers and funders are essential partners in creating a healthier and more equitable South LA. We welcome their support, as well as the ideas and creativity of our community partners to make the changes needed to reduce health disparities.

There is much good work to be done here. We are excited to share our vision for a healthier South I.A.

# Dr. Elaine Batchlor, MD, MPH

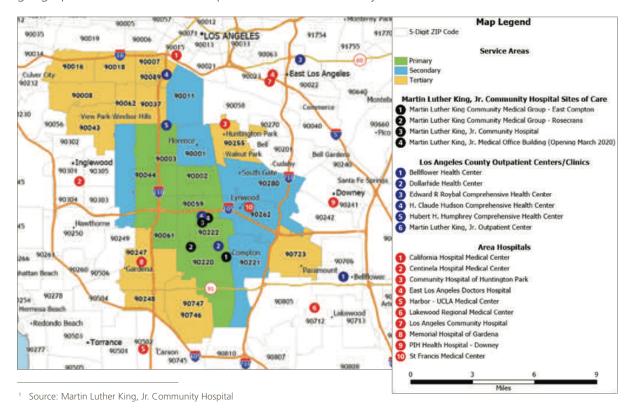
Chief Executive Officer Martin Luther King, Jr. Community Hospital

# **About MLKCH and Our Community**

Martin Luther King, Jr. Community Hospital (MLKCH) is managed by the Martin Luther King, Jr. – Los Angeles Healthcare Corporation (MLK-LA), a 501(c)(3) organization. Since MLKCH opened in 2015, we have maintained a long-term vision of ensuring a lasting, coordinated solution for serving the healthcare needs of the 1.3 million residents in South Los Angeles. Our nonprofit, safety net hospital has 131 beds for inpatient care, offering healthcare services typical of a community hospital, and our medical group—the MLK Community Medical Group—provides outpatient primary and specialty care. In 2019, MLKCH served over 112,000 patients and treated over 100,000 people through the emergency department (ED). Our growing health education and outreach services extend our offerings to residents and support our mission.

# **Defined Community**

The MLKCH community is defined as the geographic region consisting of Service Planning Area (SPA) 6 as well as those ZIP codes located within a three-mile radius from the hospital. MLKCH is located at 1680 East 120th Street, Los Angeles, California, 90059. The map and table provided below identify each of the 27 ZIP codes located within the three service area geographies included in the hospital's defined community.



A SPA is a specific geographic region within Los Angeles County. Due to the large size of LA County (4,300 square miles), it has been divided into eight geographic areas. These distinct regions allow the Department of Public Health to develop and provide relevant public health and clinical services targeted to the specific health needs of the residents in these different areas. http://publichealth.lacounty.gov/chs/ SPAMain/ServicePlanningAreas.htm

## Martin Luther King, Jr. Community Hospital Service Area Overview Calendar Year 2020

Zip Code	MLKCH Service Area	Community
90002	Primary	Los Angeles
90003	Primary	Los Angeles
90044	Primary	Los Angeles
90059	Primary	Los Angeles
90061	Primary	Los Angeles
90220	Primary	Compton
90222	Primary	Compton
90001	Secondary	Los Angeles
90011	Secondary	Los Angeles
90047	Secondary	Los Angeles
90221	Secondary	Compton
90262	Secondary	Lynwood
90280	Secondary	South Gate

Zip Code	MLKCH Service Area	Community
90007	Tertiary	Los Angeles
90008	Tertiary	Los Angeles
90016	Tertiary	Los Angeles
90018	Tertiary	Los Angeles
90037	Tertiary	Los Angeles
90043	Tertiary	Los Angeles
90062	Tertiary	Los Angeles
90089	Tertiary	Los Angeles
90247	Tertiary	Gardena
90248	Tertiary	Gardena
90255	Tertiary	Huntington Park
90723	Tertiary	Paramount
90746	Tertiary	Carson
90747	Tertiary	Carson

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

# Community Health Needs Identified in the 2020 CHNA

The Community Health Needs Assessment (CHNA) was completed to identify top health needs in the community and analyze a broad range of social, economic, environmental, behavioral, and clinical elements that may contribute to health needs. To better understand overall needs in our community, the CHNA team reviewed quantitative data from a variety of published sources. These data elements were compared against benchmark data, such as SPA or County data, when available. In addition, primary issues that impact the health of the community, as well as existing resources and innovative ideas to address those needs, were collected from local



stakeholders through interviews, written surveys, community convenings, and focus groups. All of this information was analyzed to identify community issue areas and then prioritized to identify the significant health needs for which MLKCH has prepared an Implementation Plan to address. Our prioritization assessment included consideration of the relative size of the issue, its importance to the community, and the opportunity to make an impact over the next three years. Based upon this methodology, MLKCH, in collaboration with our community partners, identified six priorities to address over the next three years:

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

These priorities and our planned strategies to address each priority are described below.

MLKCH senior leaders and the board of directors reviewed these significant needs and

approved these priorities and the following Implementation Plan on July 15, 2020.

# **Significant Health Needs the Hospital Will Address**

# 1. Access to Preventive, Primary, and Specialty Care

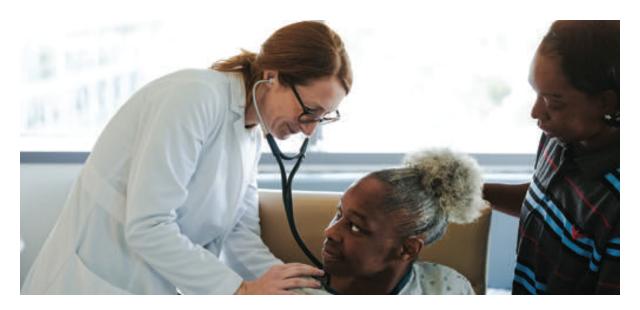
**Priority Health Need:** Large proportions of our community have inadequate access to a broad range of medical services and physicians in primary and medical and surgical specialties, combined.

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

## Impact:

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

Pr	ograms and Strategies	Partnerships and Collaborations
a.	Connect Community to Medical Homes Help residents establish medical homes and connect to primary and specialty providers.	<ul> <li>MLK Community Medical Group</li> <li>Other community providers</li> <li>MLKCH Care Management</li> <li>COPE Health Solutions (Medical and Social Service Navigators)</li> </ul>
b.	<b>Transportation to Health Appointments</b> Provide transportation assistance to connect patients to medical providers.	<ul> <li>Insurance plans with a transportation benefit</li> <li>Various local public and private transportation providers</li> <li>Uber Health</li> </ul>
c.	<b>Telehealth</b> Expand access to healthcare and social services using telehealth services.	<ul><li>MLK Community Medical Group</li><li>GYANT</li><li>Doxy.me Teleconferencing Application</li></ul>
d.	Capacity Expansion Develop facilities, staffing, and infrastructure to increase capacity for specialized medical services, including mobile health.	<ul> <li>MLK Community Medical Group- Rosecrans Clinic, East Compton Clinic, MLK Campus Medical Office Building (Wilmington Clinic)</li> <li>MLKCH Healthy Moves community van</li> <li>County of Los Angeles</li> <li>Community partners and providers</li> </ul>
e.	Maternal and Infant Health Provide access to prenatal and postnatal services and support for expectant mothers in the community	<ul> <li>Los Angeles County, First 5 LA - Welcome Baby Program</li> <li>Los Angeles County, Department of Public Health - Doula Program</li> <li>Whole Person Care - Los Angeles</li> <li>MLKCH Labor &amp; Delivery Staff</li> <li>MLK Community Medical Group</li> <li>Community providers</li> </ul>
f.	<ul> <li>Financial Assistance</li> <li>Provide residents with assistance to enroll in county and governmental health insurance or social service programs.</li> </ul>	<ul> <li>County of Los Angeles Department of Social Services</li> <li>MLKCH patient access and financial staff</li> <li>Whole Person Care - Los Angeles</li> </ul>
	ii. Provide eligible low-income persons with free and discounted healthcare services through the hospital's financial assistance (charity care) policy.	MLKCH patient access and financial staff



## 2. Behavioral Health

**Priority Health Need:** Our community has a high prevalence of behavioral health conditions, including mental health and substance use, and insufficient resources for treatment.

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

## Impact:

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

#### **Programs and Strategies Partnerships and Collaborations** a. Integrated Behavioral Health (IBH) Program • MLKCH and MLK Community Medical Group IBH i. Improve clinical outcomes in patients with • MLK Community Medical Group social service chronic medical conditions by identifying and providers addressing underlying mental health and Exodus Recovery at MLK Medical Center substance abuse co-morbidities and connecting • Licensed and certified mental health providers residents to their appropriate health home. • Whole Person Care - Los Angeles ii. Improve access to mental health and substance • MLK Community Medical Group use services using telehealth consults with • Doxy.me Teleconferencing Application behavioral health specialists. b. Healthcare Staff Awareness Training to Identify • Dignity Health Human Trafficking Response Program and Support Victims of Human Trafficking • Los Angeles County District Attorney's Bureau of Create a process for identifying victims of human Victim Services trafficking and provide referrals for human • Los Angeles Police Department and LA Sheriff's trafficking care and related resources. Century Station

# 3. Management of Chronic Health Conditions

**Priority Health Need:** Our community has a high prevalence of poorly treated chronic diseases, such as obesity, high blood pressure, and diabetes, resulting in poor health outcomes and higher costs of care.

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

## Impact:

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

Pr	ograms and Strategies	Partnerships and Collaborations
a.	Chronic Condition Centers of Excellence Provide clinical best practices and comprehensive care for diabetes and treatment of patients with other chronic conditions.	<ul> <li>MLKCH Diabetes Care Committee</li> <li>MLK Community Medical Group Diabetes Education Program</li> <li>Community providers</li> </ul>
b.	<ul> <li>i. Provide residents' screenings, health education, and peer support through food access initiatives.</li> <li>ii. Provide educate and model healthy food.</li> </ul>	<ul> <li>MLKCH Recipe for Health Food Program</li> <li>MLK Community Medical Group</li> <li>MLKCH Food and Nutrition Services team and Dietitians</li> <li>Sodexo</li> <li>SEE-LA (Sustainable Economic Enterprises of Los</li> </ul>
	ii. Provide, educate, and model healthy food choices in the community at the MLKCH cafeteria and MLK Campus Farmers' Market.	Angeles)/MLK Campus Farmers' Market
c.	Community Food Collaboration Support community efforts to introduce healthy, affordable food to the South LA community by providing and promoting nutrition and physical activity classes and connecting patients to food benefit programs.	<ul> <li>MLK Community Medical Group Social Services</li> <li>LA County CalFresh Program</li> <li>MLKCH Food and Nutrition Services and other community nutrition partners</li> <li>Cedars-Sinai Medical Center, Healthy Habits Program</li> <li>LA Care Lynwood Family Resource Center</li> <li>LA Care Inglewood Family Resource Center</li> <li>Martin Luther King, Jr. Center for Public Health</li> <li>Community grocery stores</li> </ul>





# 4. Education and Screenings

**Priority Health Need:** Residents have difficulty navigating the healthcare system due to lack of resources, low health literacy, and lack of support for self-care.

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

## Impact:

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

Pr	ograms and Strategies	Partnerships and Collaborations
a.	Influenza Vaccinations Provide residents with flu shots and vaccination education through a healthcare partnership effort, community Flu Campaign.	<ul> <li>Cedars-Sinai Medical Center (including Coach for Kids Program)</li> <li>LA County Department of Public Health</li> <li>Immunize LA (Immunize Los Angeles)</li> <li>Community health partners</li> <li>Housing Authority of the City of Los Angeles</li> </ul>
b.	Screening and Education Programs Provide screenings, health education, and peer support through MLKCH community outreach programs.	<ul> <li>MLKCH Know Your Basics Program</li> <li>Community partners</li> <li>MLKCH Man Up! for Your Health Program</li> <li>Community barbershop partners</li> <li>Area nursing schools</li> <li>Community volunteer nurses</li> </ul>
c.	Maternal and Infant Health Education Expand availability for maternal and infant care, education and resources, and support for mothers in the community.	MLKCH Perinatal team     Baby Friendly Coordinator
d.	Care Navigation Help community members connect with the range of medical care and social services they need.	MLK Community Medical Group     COPE Health Solutions (medical and social service navigators)

### 5. Homeless Health

**Priority Health Need:** Almost a quarter of the population experiencing homelessness in SPA 6 has one or more poorly managed chronic health conditions.

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

## Impact:

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

Pr	ograms and Strategies	Partnerships and Collaborations
a.	Street Medicine Provide high quality street-based medical services and providers and hospital-based consultative services to admitted MLKCH patients who are experiencing homelessness. Street-based services are provided on-site where the homeless reside.	MLKCH Street Medicine program     Street Medicine program of USC Keck School of Medicine
b.	<b>Outpatient Care Management for the Homeless</b> Provide direct patient support by navigating the homeless to immediate case management services.	Whole Person Care - Los Angeles
c.	i. Help individuals who are homeless access housing, food, toiletries, clothing, transportation, social services, and support available through Measure H and other public initiatives.	MLKCH Homeless Services Team and community organizations     MLKCH social workers
	<b>ii.</b> Develop increased numbers of reserved shelter beds to improve recuperative care and connection to community case management and housing services.	<ul> <li>A shelter and community service provider for individuals experiencing homelessness</li> <li>MLK Outpatient Center – Social Work</li> <li>Harbor UCLA County Hospital</li> <li>Temporary housing and post-acute care providers</li> <li>Choice Neighborhoods Initiative grant to Watts</li> </ul>

# 6. Social Determinants of Health

**Priority Health Need:** A high and growing number of community members experience housing, transportation, food insecurity, and community safety issues that contribute to poorly managed health conditions.

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

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

Programs and Strategies	Partnerships and Collaborations
Insurance Enrollment Support (detailed in 1.f.i) Housing for Community Members (detailed in 5.c.ii) Transportation to Health Appointments (detailed in 1.b) Healthy Food Models (detailed in 3.b.i)	

# **Evaluation of Impact**

We will establish metrics to measure performance and progress toward each goal. An evaluation of the impact of the hospital's performance toward addressing these significant health needs will be reported in the next scheduled CHNA.

# **Needs the Hospital Will Not Address**

MLKCH is committed to improving the health of our community 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 and collaborate with partners in the community to address these issues and other priorities outside of this scope that may arise as the needs of our community evolve.

# **Report Availability and Comment**

Please reference our 2020 CHNA for more information on these significant health needs, community profile, and the primary and secondary data sources used to identify those needs. The CHNA and this Implementation Plan will available on the hospital's website at *mlkch.org/community-reports* 

MLKCH welcomes your feedback on this report. You may send written comments or request more information on these community reports at *kyb@mlkch.org* 

