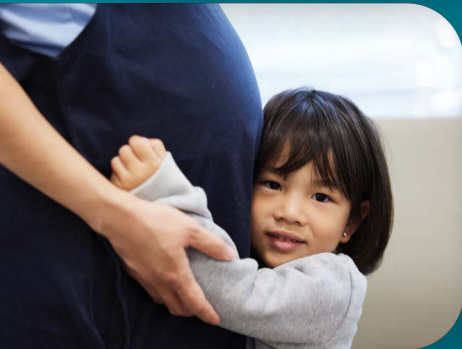




MLK Community  
Healthcare



2026  
**COMMUNITY  
HEALTH NEEDS  
ASSESSMENT**



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# LETTER FROM OUR CHIEF EXECUTIVE OFFICER

The 2026 Community Health Needs Assessment (CHNA) delivers a comprehensive picture of health and access to care in South Los Angeles—a community of approximately 1.3 million residents that continues to face persistent structural and economic barriers to health. This report reflects our shared responsibility to understand those conditions clearly and to respond with strategies grounded in data and community input.

Since the release of our last CHNA in 2023, MLK Community Healthcare (MLKCH) has continued to strengthen care delivery and system capacity for the communities we serve. Our hospital earned an “A” Hospital Safety Grade from The Leapfrog Group for five consecutive reporting periods and a 4-Star Quality Rating from the Centers for Medicare & Medicaid Services. We also achieved an advanced certification for diabetes treatment from The Joint Commission and HIMSS Level 7, the highest-level certification, in part recognizing the use of advanced health information technology to improve patient care.

We expanded access to specialized behavioral health services, including the opening of a new Interventional Radiology and Cardiac Catheterization Lab in the spring of 2024 and the upcoming launch of an Emergency Psychiatric Assessment, Treatment and Healing (EmPATH) unit. We also continued to invest in community-based strategies, such as Street Medicine, to reach individuals who face the greatest barriers to care.

Across our system, we continue to demonstrate that high-quality care is achievable in safety-net settings. Despite exceptionally high emergency department (ED) demand, our hospital maintains an average ED wait time of approximately 30 minutes and a Left Without Being Seen rate of just 1%.

As we launch the implementation plan in response to the 2026 CHNA, the policy and funding environment for safety-net healthcare remains increasingly uncertain. Recent federal decisions affecting Medicaid financing present serious long-term challenges for hospitals and health systems that serve communities with high reliance on public coverage. More than 75% of our patients are insured through Medicaid, making the stability of this program essential to sustaining access to care in South Los Angeles.

Despite our financial and operational challenges, MLKCH remains committed to careful planning, strong community partnerships and continued advocacy for a healthcare system that supports access, quality and equity for all.

This CHNA provides a data-driven foundation to guide our priorities, partnerships and investments in the years ahead.

**Elaine Batchlor, MD, MPH**  
Chief Executive Officer  
MLK Community Healthcare



# EXECUTIVE SUMMARY



## About MLKCH and our community

MLKCH is a state-of-the-art, 131-bed acute care hospital located on the Martin Luther King, Jr. Medical Campus in the Willowbrook neighborhood of South Los Angeles. MLKCH provides maternity, critical and inpatient care, as well as primary and specialty care in our outpatient community sites. More than any other region of the county, South Los Angeles is disproportionately disadvantaged by inequities in healthcare and physical resources, leaving a lasting impact on health, well-being and quality of life for our community.

## Purpose of the CHNA

MLKCH's 2026 CHNA identifies unmet health needs in the service area, guides the prioritization of community health needs, and serves as the basis for the 2026 Community Benefit Implementation Strategy, the annual Community Benefit Plan, and Community Benefit strategies, programs, services and commitments. The CHNA and Implementation Strategy are released every 3 years, as set forth in California Senate Bill 697 (1998) and IRS section 501(r)(3) regulations, through the 2010 Patient Protection and Affordable Care Act.

## Service area

The overall MLKCH service area consists of 27 ZIP codes. The service area is described through ZIP codes located within a 3-mile radius of the hospital, as well as by the borders of Los Angeles County, South Los Angeles Service Planning Area (SPA) 6. SPA 6 is predominantly Black and Latino and includes communities that experience persistent socioeconomic and structural challenges that affect access to healthcare and overall health.

## Data methodology

**Secondary data:** Data was compiled from local, county and state sources—as well as directly from MLKCH—to report on community demographics and health indicators including but not limited to access to care, chronic diseases, birth indicators, behavioral health and social drivers of health. Where available, data are presented in the context of Los Angeles County and California. We include benchmark comparisons throughout the report and in Appendix A to [Healthy People 2030](#) objectives, a national initiative to improve the public’s health.

**Primary data:** Community stakeholders were identified and invited by the hospital to participate in needs assessment interviews and conversations. Participants included a broad range of stakeholders concerned with the health and well-being of the hospital service area, who shared the issues and needs in the communities served by the hospital. Between October 2025 and January 2026, MLKCH collected feedback from a total of 40 community leaders and partners for the purposes of this assessment, exceeding the level of community input reported by many comparable hospitals.

## Identifying and prioritizing significant community needs

Significant needs were identified through a review of the health data compiled from public sources and validated through stakeholder interviews. Through both focus groups and an electronic survey, community stakeholders identified community priorities. Priority needs in the service area include the following:

- Access to Preventive, Primary and Specialty Care (including Maternal and Infant Health)
- Management of Chronic Health Conditions
- Behavioral Health
- Homeless Health
- Social Drivers of Health

## Resources potentially available to address needs

The MLKCH service area includes a wide range of community-based organizations, public agencies, healthcare providers, and social service partners that contribute to health promotion, prevention, treatment and supportive services. These community resources represent important assets for addressing identified needs and strengthening coordinated, community-driven responses. See Appendix C for a list of community resources and partner organizations.

## Board approval

This CHNA report was adopted by the MLKCH Board of Directors on June 17, 2026. The report is widely available to the public on the MLKCH website and can be accessed [here](#). To send comments or questions about this report, please send an email to [kyb@mlkch.org](mailto:kyb@mlkch.org).

# INTRODUCTION

## Background

MLKCH is a private, nonprofit healthcare system that includes a safety-net hospital on the MLK Medical Campus in South LA and physician-led primary and specialty care centers.

Specifically, MLKCH offers:

- **MLK Community Hospital:** A 131-bed facility for inpatient care offering emergency, inpatient, critical care, maternity, general surgery and ancillary services typical of a community hospital.
- **Outpatient Care Centers:** We operate two outpatient care centers in South LA, offering primary and specialty care.
- **Wound Care Center:** MLKCH operates South LA's only wound care center with two hyperbaric chambers for the advanced treatment of non-healing wounds and other complex health conditions.
- **Community-based care:** MLKCH offers in-community programs, including health education and screening, in-home care and street medicine.

Through these services, MLKCH works alongside residents and community partners to address both immediate healthcare needs and the broader conditions that shape health and well-being. Opened in 2015, the hospital quickly became a vital community resource, earning a Diabetes Center of Excellence certification for inpatient diabetes care, state and national recognition for its maternity unit, and performing interventional life-saving surgeries.

MLKCH operates one of the busiest EDs in the United States, seeing over 120,000 patients a year—nearly five times the number than the facility was intended for. Approximately 40% of patients come to the ED annually for primary care they cannot access in the community.

## Our mission

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

## Our core values

- Caring
- Collaboration
- Accountability
- Respect
- Excellence

## Our vision

To be a leading model for innovative, collaborative community healthcare.



## Historical context

The history of health inequities in South Los Angeles is closely tied to broader patterns of segregation, redlining and racially exclusionary policies.

Starting in the 1920s and accelerating after the National Housing Act of 1934, discriminatory lending practices and restrictive covenants concentrated Black and other communities of color in specific neighborhoods, simultaneously denying them public investment, mortgage access and healthcare infrastructure. Freeway construction in the mid-20th century further displaced residents and fragmented long-standing Black neighborhoods, while newly subsidized subdivisions were built with restrictions excluding nonwhite residents.

In 1965, the McCone Commission, convened in the wake of the Watts Rebellion, explicitly named the lack of access to healthcare in South Los Angeles among the seven key contributors to civil unrest. Over 60 years later, MLKCH and the surrounding Watts-Willowbrook medical community remains one of the only lasting investments that directly responded to that call.

Despite community-led efforts and public investments in the decades since, the region continues to face a shortage of primary and specialty care, overburdened EDs and a disproportionate burden of preventable chronic illness.

## Current conditions and health outcomes in SPA 6

Poverty rates in South Los Angeles continue to exceed County and statewide averages. The community also faces higher levels of housing instability and food insecurity, creating barriers to preventive care and ongoing management of chronic disease.

SPA 6 is designated as a Health Professional Shortage Area (HPSA) and a Medically Underserved Area (MUA). The region is estimated to have a shortage of more than 1,500 doctors, including primary care providers and specialists. As a result, many residents rely on EDs for conditions that could otherwise be addressed in outpatient settings.

This region experiences some of the highest rates of chronic illness in Los Angeles County, including diabetes, hypertension, chronic obstructive pulmonary disease (COPD) and heart disease. Life expectancy in parts of South Los Angeles is up to 10 years shorter than in more affluent areas located just a few miles away.

## Emerging and anticipated community needs

As South Los Angeles continues to navigate the lasting effects of structural inequity and limited access to care, new and emerging challenges are expected to intensify community needs in the years ahead.

A growing share of MLKCH patients are arriving with more advanced or complex conditions due to delays in care—often the result of financial barriers, unstable housing or gaps in primary care access. Uncompensated care is anticipated to rise due to federal cuts to Medicaid placing additional strain on hospital resources and staff.

Federal policy changes pose significant risks. More than 75% of MLKCH patients are covered by Medicaid, and over half of the hospital's funding relies on Medicaid supplemental payments. Recent legislation affecting Medicaid financing is expected to reduce support for safety-net hospitals, directly compromising the ability of institutions like MLKCH to continue delivering essential services at current levels. As the only nonprofit hospital in South Los Angeles, MLKCH plays a critical role in providing care to a high-need population that would otherwise have limited or no access to hospital-based services.

With more than 120,000 ED visits annually, MLKCH continues to operate at the front lines of care delivery for vulnerable residents. The potential impact of federal and state-level funding reductions will extend well beyond the hospital's walls, affecting the broader health ecosystem across Los Angeles County.

### MLKCH's role

MLKCH was founded to serve this historically under-resourced community with a long-term vision of improving access to high-quality care. Since opening in 2015, MLKCH has grown into a safety-net health system that integrates hospital services, outpatient centers and community-based care strategies.

Executive, clinical and volunteer leadership worked together to develop MLKCH as a leading model for community-based healthcare – leveraging technology, data and strategic partnerships to reduce barriers to care and respond to community-identified needs.

The CHNA provides MLKCH with a data-informed foundation for ongoing planning, program development and collaboration.

### Implications for community health planning

The demographic, socioeconomic and access-to-care conditions in SPA 6 underscore the following needs:

- Expanded access to primary and specialty care
- Strengthened prevention and chronic disease management
- Continued investment in community-based programs and cross-sector partnerships that reduce barriers to care and advance health equity

This CHNA offers an important roadmap for MLKCH and its partners, shaping how community-informed strategies are developed to impact the region's path toward greater health equity.

### CHNA purpose

The CHNA fulfills Internal Revenue Service (IRS) requirements to assess community health needs every 3 years. It also serves as an important tool for MLKCH to identify unmet health needs in the service area.

This assessment incorporates components of secondary and primary data analysis, with a focus on the health and social needs of the service area community.

### Project oversight

The following representatives oversaw the CHNA process:

Lauren Espy, Director of Equity and Community Programs, MLKCH

### Consultant

Forward Community Health Consulting, LLC, conducted the CHNA. Forward Community Health Consulting, LLC, is an independent consulting firm that works with hospitals and community-based nonprofit organizations.

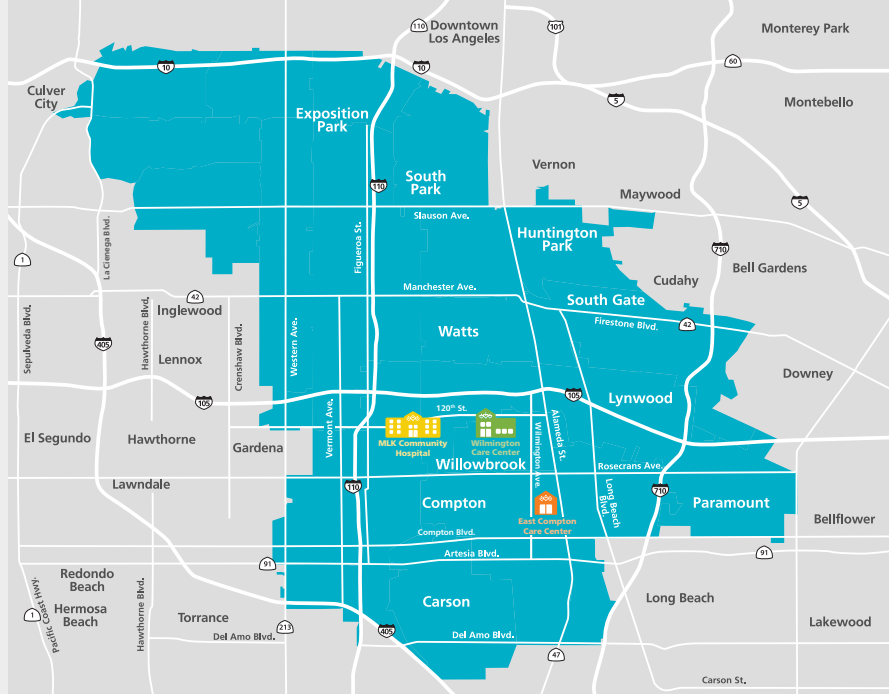
The team included Cindy Levey, Principal; Denise Flanagan, Data Analyst; and Sevanne Sarkis, Data Specialist. Cindy Levey, MPH, has over 25 years of experience conducting CHNAs and working with hospitals and health systems to develop, implement and evaluate Community Benefit programs.

[www.ForwardCHC.com](http://www.ForwardCHC.com).

### Board approval

This CHNA report was adopted by the MLKCH Board of Directors on June 17, 2026. The report is widely available to the public on the MLKCH website and can be accessed [here](#). For comments or questions about this report, please send your feedback to [kyb@mlkch.org](mailto:kyb@mlkch.org).

# DEFINED COMMUNITY PROFILE



## Community benefit service area (CBSA)

MLKCH is in the Willowbrook neighborhood of Los Angeles and provides services to approximately 1.3 million residents in SPA 6. The service area is comprised of 27 ZIP codes and includes communities from Exposition Park to the north, Carson to the south and Huntington Park to the east.

In 2022–2023, 81% of MLK Community Hospital’s inpatient population lived within the boundaries of the service area.<sup>1</sup>

GEOGRAPHIC AREA	ZIP CODE
Carson	90746, 90747
Compton	90220, 90221, 90222
Gardena	90247, 90248
Huntington Park	90255
Los Angeles (including Jefferson Park, Florence/South Central and West Compton)	90001, 90002, 90003, 90007, 90008, 90011, 90016, 90018, 90037, 90043, 90044, 90047, 90059, 90061, 90062, 90089
Lynwood	90262
Paramount	90723
South Gate	90280

## Population

MLKCH’s service area represents 13.3% of Los Angeles County’s total population, with 1,310,433 residents. This represents a 3.3% population decrease from 5 years prior and is higher than the 2.5% decrease countywide.<sup>2</sup>

## Age and gender distribution

Age and gender distribution are critical components for understanding and responding to the needs of our community. While children and young adults require more preventive services and health education, older patients are more likely to need access to a combination of primary care, chronic disease management and specialty services.

- Of the service area population, **49.1%** are male and **50.9%** are female.<sup>2</sup>
- 82%** of adults identify as straight or heterosexual, while **5.7%** identify as gay, lesbian, bisexual or pansexual\*.<sup>3</sup>
- 24.9%** of the population are children and teens, ages 0 to 17.<sup>4</sup>
- 63.9%** of the population are adults between the ages of 18 and 64.
- 11.2%** SPA 6 residents are over the age of 65.

<sup>1</sup> Source for inpatient population data: California Department of Health Care Access and Information, Patient Discharge Data, Emergency Department Data and Ambulatory Surgery Data, 2022–2023. <https://data.chhs.ca.gov/dataset/patient-origin-market-share-pivot-profile-inpatient-emergency-department-and-ambulatory-surgery>

<sup>2</sup> U.S. Census Bureau, “American Community Survey 5-Year Estimates: Comparison Profiles 5-Year,” 2014–2018 and 2019–2023, DP05. <https://data.census.gov/>

<sup>3</sup> UCLA Center for Health Policy Research, Los Angeles, CA, California Health Interview Survey, 2023–2024 or ±2020–2024, pooled. <http://ask.chis.ucla.edu/>

\*Unstable due to sample size.

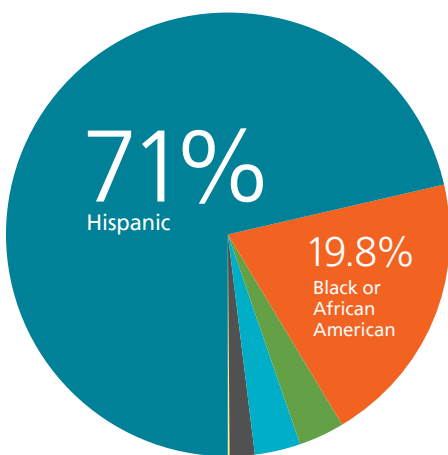
<sup>4</sup> U.S. Census Bureau, “American Community Survey 5-Year Estimates: Comparison Profiles 5-Year,” 2019–2023, DP05. <https://data.census.gov/>

\*Data sources used in the report varied in the terms/wording for self-identification of sexuality, leading to some sources using ‘bisexual or pansexual’ while others use ‘bisexual+,’ incorporating terms such as queer and fluid, etc. Terms/wording used by the data source are presented as-is to be consistent with respondent intent.

## Race and ethnicity

More than 90% of residents in the service area identify as Hispanic/Latino or Black/African American.<sup>5</sup> These populations experience higher rates of conditions such as diabetes, heart disease and obesity due to a combination of structural factors—including access to care, socioeconomic conditions, environmental exposures and chronic stress.

### Race and ethnicity breakdown



- **71%** Hispanic
- **19.8%** Black or African American
- **3.4%** as non-Hispanic White
- **3.2%** as non-Hispanic Asian
- **1.8%** as multiracial
- **Less than 1%** of the population identifies as Native Hawaiian or Pacific Islander, American Indian or Alaska Native

## Language

A person's primary language and language preferences have long been known to affect access, use of healthcare services and trust in the health system. The majority of SPA 6 community members speak English or Spanish at home. Approximately one-third of residents report speaking English less than "very well," which may create barriers to accessing healthcare, social services and health information.

As a result, these individuals may not get the healthcare and information they need.

### Languages spoken at home<sup>6</sup>

- **63.5%** speak Spanish
- **32.5%** speak English only
- **33.1%** speak very little or no English at all
- **4%** speak a language other than English or Spanish

To help address this barrier, MLKCH offers bilingual healthcare providers. We communicate medical information in both Spanish and English, helping patients read and understand information that is central to improving their health (e.g., discharge instructions, treatment plans and phone numbers for providers so that patients can ask follow-up questions).

MLKCH also offers free interpreter services with certified medical interpreters, in-person, over the phone and by live video, through our Martti devices. Up to 210 languages and dialects are accessible 24 hours a day.

<sup>5</sup> U.S. Census Bureau, "American Community Survey 5-Year Estimates: Comparison Profiles 5-Year," 2019–2023, DP05. <https://data.census.gov/>

<sup>6</sup> U.S. Census Bureau, "American Community Survey 5-Year Estimates: Comparison Profiles 5-Year," 2019–2023, DP02. <https://data.census.gov/>

## Educational attainment

**“Education is probably the single biggest indicator of one’s health and wellness over their lifetime. If [someone] didn’t finish high school, they’re not going to understand complex health conditions.”**

—Community member

Education and health literacy were described in interviews as drivers of long term health, economic mobility and community stability. Moreover, education is framed as a lifelong process that shapes individuals’ ability to navigate health systems, manage chronic disease and participate meaningfully in the workforce.

### Levels of education achieved<sup>7</sup>

- **36.3%** of SPA 6 residents ages 25 and older do not have a high school diploma, compared to 19.3% in Los Angeles County.
- **15.3%** of SPA 6 adults older than 25 have a bachelor’s degree or higher, compared to 35.5% of LA County residents.

Higher educational attainment is strongly linked to better health outcomes, including lower mortality rates, lower risk of chronic disease and better self-reported health.

Patient and community education materials are written at a reading level that is accessible to the general public, in both English and Spanish. Additionally, MLKCH brings health experts to education sessions at community outreach events, such as health fairs, barbershops and churches, which cover health topics of high need in the community.



## Employment

The 5-year average unemployment rate among the civilian labor force (ages 16 and older) in the service area is 9%.<sup>8</sup> This is higher than Los Angeles County (7%) and state (6.4%) unemployment rates. Higher unemployment leads to lower incomes, less access to health insurance and increased stress, worsening health among the affected population and their families.

<sup>7</sup> U.S. Census Bureau, “American Community Survey 5-Year Estimates: Comparison Profiles 5-Year,” 2019–2023, DP02. <https://data.census.gov/>

<sup>8</sup> U.S. Census Bureau, “American Community Survey 5-Year Estimates: Comparison Profiles 5-Year,” 2019–2023, DP03. <https://data.census.gov/>

## Health insurance coverage

The Healthy People 2030 objective for health insurance coverage for all population groups is 92.4%. In the MLKCH service area, 86.8% of the population has health insurance coverage.<sup>9</sup>

Lack of health insurance leads to financial hardship and worsening health outcomes for individuals and communities due to higher out-of-pocket costs, delayed or deferred medical care and reduced access to preventive services. Additionally, the cost of providing emergency services to the uninsured leads to increased healthcare costs for insured patients and greater financial burdens on hospitals as a result of unreimbursed expenses.

A significant portion of MLKCH's patient population is uninsured, underinsured or eligible for Medi-Cal, with approximately 75% relying on Medicaid coverage.<sup>10</sup> In response, MLKCH supports access to care by providing enrollment assistance and connecting patients to public benefit programs, including Medi-Cal and CalFresh, to address both healthcare and basic needs.

### Types of insurance coverage — SPA 6 residents<sup>11</sup>

- **56.2%** have Medi-Cal, Medicare or both
- **31.4%** of the SPA 6 population have employment-based coverage
- **10%** of the population have no insurance at all

Among residents of SPA 6, the most commonly cited reason for current uninsured status was cost (47.6%), followed by either not needing or not believing in insurance (16.2%).<sup>12</sup>

### Difficulty finding affordable insurance<sup>13</sup>

Among adults in SPA 6, 75.3% reported finding an affordable health plan directly through an insurance company or Health Maintenance Organization (HMO) to be very or somewhat difficult, as compared to Los Angeles County (70%).

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# 86.8%

SPA 6 Residents with health insurance coverage in comparison to the Healthy People 2030 objective

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# 92.4%

The Healthy People 2030 objective for health insurance coverage for all population groups

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Among SPA 6 adults, 77.8% reported finding an affordable health plan directly through Covered California to be very or somewhat difficult compared to 67.4% in Los Angeles County.

A higher Medi-Cal population is financially challenging for service providers. Reimbursement rates are significantly lower than other types of insurance, as well as lower than the actual cost of providing care. This leads to gaps in the community—doctors cannot afford to work without sufficient reimbursement. It also threatens the ability of hospitals to remain open.

### Immigration status

In the MLKCH service area, 35.8% of residents are foreign-born—higher than both Los Angeles County (33.4%) and California (26.7%). Among foreign-born residents, 62.2% are not U.S. citizens.<sup>14</sup>

It is important to note that non-citizen status does not necessarily mean someone is undocumented. Many non-citizens, including lawful permanent residents and visa holders, are legally present in the United States, though they may still face barriers accessing certain programs and services.

<sup>9</sup> U.S. Census Bureau, "American Community Survey 5-Year Estimates: Comparison Profiles 5-Year," 2019–2023, S2701. <https://data.census.gov/>

<sup>10</sup> MLKCH data scientists, using MLKCH Electronic Medical Records, Patient Profile, 2025.

<sup>11</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2022–2024, pooled. <http://ask.chis.ucla.edu/>

<sup>12</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2020–2024. <http://ask.chis.ucla.edu/>

\*Statistically unstable due to sample size.

<sup>13</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2020–2024. <http://ask.chis.ucla.edu/>

\*Statistically unstable due to sample size.

<sup>14</sup> U.S. Census Bureau, "American Community Survey 5-Year Estimates: Comparison Profiles 5-Year," 2019–2023, DP02. <https://data.census.gov/>



# WHERE WE ARE TODAY: THE 2026 CHNA

## How this report was created

This report builds upon our 2023 CHNA, bringing together quantitative and qualitative data from interviews and a survey to identify health needs in South Los Angeles. It includes benchmark comparisons throughout the report and in Appendix A to [Healthy People 2030](#) objectives, a national initiative to improve the public's health.

Additionally, we collected and analyzed data from multiple sources including the California Health Interview Survey (CHIS), the California Department of Health Care Access and Information, the Los Angeles Department of Public Health and the U.S. Census Bureau.

Statistics do not tell the whole story. To further understand the health of the community, we identified and convened 40 community stakeholders to participate in needs assessment interviews and conversations. Additional information on the

participating organizations can be found in **Appendix B**. We partnered with Forward Community Health Consulting, LLC, an independent consulting firm, to complete the CHNA using a transparent and collaborative approach.

Although this report is evidence-based and contains many statistics, we acknowledge that there are limitations with the data we collect. Community input is limited to the number of people who participated in the interviews and completed the survey. As such, responses may not represent the full range of challenges faced by the community. Information on these limitations can be found on page 47, under "Data and Methods."

The 2026 CHNA is focused on health equity and advocacy. Through this assessment and the resulting Implementation Strategy we will continue to partner with the community to make a difference and improve health outcomes.

### **Community participation**

Our team completed forty (40) stakeholder interviews and conversations from October 2025 to January 2026. Participants ranged from representatives of medically underserved and minority populations to local health or other department officials with current data or other information relevant to the health needs of the MLKCH community. The identified stakeholders were invited by email to participate.

### **Interviews**

Building on insights gained from the 40 stakeholder interviews, along with secondary data analyses, MLKCH identified priority community health needs. In determining these priorities, MLKCH also considered its current and planned programs and initiatives, ensuring alignment with areas where the organization is best positioned to make a meaningful impact.

### **Survey**

Stakeholders received an electronic survey in advance of the interview to provide feedback on each identified health need, including its perceived severity, whether it has worsened over time and the availability of resources to address it. Surveys were offered in English and Spanish.

Response percentages reflect the proportion of respondents who identified each need as having a severe impact on the community, worsening over time and having insufficient or absent resources. Not all respondents answered every question; percentages are based only on those who provided responses to each item.

### **Written comments received from the prior CHNA**

MLKCH published the prior CHNA report online and monitored an email address for community feedback specific to its 2024–2026 CHNA and Implementation Plan. MLKCH has not received written comments regarding its 2024–2026 CHNA nor its Implementation Plan.

### **Prioritization of significant health needs**

Recognizing that economic opportunities, environmental factors, healthcare infrastructure and social networks are key drivers of health, MLKCH is committed to addressing disparities and advancing health equity beyond the walls of the hospital.

Through this CHNA, MLKCH analyzed secondary data and incorporated input from community members and stakeholders to identify key health issues affecting the service area. Stakeholder interviews and survey responses provided context on the severity of these needs, how they have changed over time and the availability of resources to address them.

These quantitative and qualitative data were considered together to identify the most significant health needs. Prioritization was based on the relative magnitude of each issue, the level of concern expressed by the community and the opportunity for the greatest impact. MLKCH also considered its current and planned programs and initiatives to focus on areas where it is best positioned to address community needs.



# 2026 CHNA PRIORITIES

Based on insights from stakeholder engagement, secondary data analyses and an assessment of organizational capacity, MLKCH identified the following priority health needs and corresponding goals for improving community health outcomes:

- 1 Access to preventive, primary and specialty care**  
Expand access to preventive, primary and specialty care.
- 2 Management of chronic health conditions**  
Reduce complications and disabilities through enhanced management of chronic diseases and improved access to health resources.
- 3 Behavioral health**  
Increase availability and access to resources that improve behavioral health conditions.
- 4 Homeless health**  
Support the health and wellbeing of individuals experiencing homelessness through improved access to healthcare, housing and other social services.
- 5 Social drivers of health**  
Break down social barriers to support individuals in accessing healthcare, social services, food and housing.

## 1 Access to preventive, primary and specialty care

South Los Angeles is a region of diverse heritage and culture. It is also a community deeply impacted by decades of structural racism. South LA is a healthcare desert, an area with significant shortages of doctors and little access to basic healthcare services. Large portions of our community have inadequate access to a broad range of medical services and doctors in primary, medical and surgical specialties.

Our goals are to increase healthcare services for residents of South Los Angeles; retain doctors across all specialties, resulting in adequate access to preventive, primary and specialty care; and connect uninsured and underinsured residents to health insurance enrollment and support services.

Healthcare disparities faced by South Los Angeles are substantial. They include:

- A lack of comprehensive healthcare services available in the community across the care continuum.
- Large shortages of doctors across all specialties, resulting in inadequate access to preventive, primary and specialty care.
- A lack of healthcare providers who resemble the diverse population and can care for residents in their preferred language and through the lens of their culture.
- Inadequate levels of health insurance coverage. For those who are insured, many lack the financial resources required for high-deductible health plans.
- Absence of quality, comprehensive, multi-disciplinary healthcare, treatment planning and care coordination.

Key factors that support these findings and impact South LA's ability to access needed healthcare services are described on the following pages.

### Health professional shortage areas and medically underserved areas

SPA 6 is designated as a Health Professional Shortage Area (HPSA) and a Medically Underserved Area (MUA).

An HPSA is an area, facility or population group with a shortage of primary care doctors as defined by a population-to-primary care doctor ratio greater than 3,500:1. For purposes of this CHNA, the federal government defines primary care as the following specialties: family practice, geriatrics, internal medicine, pediatrics and psychiatry. Other factors taken into consideration include the poverty rate, infant mortality rate, fertility rate and indicators of insufficient capacity to meet area needs.

An MUA is defined as an area, facility or population group with an Index of Medical Underservice (IMU) less than or equal to 62 out of 100. The IMU is calculated by taking into consideration the ratio of primary medical care doctors per 1,000 population, infant mortality rate, percentage of the population with an income below the Federal Poverty Level (FPL) and the percentage of people age 65 or older.<sup>15</sup>

<sup>15</sup> Health Resources and Services Administration, 2022.

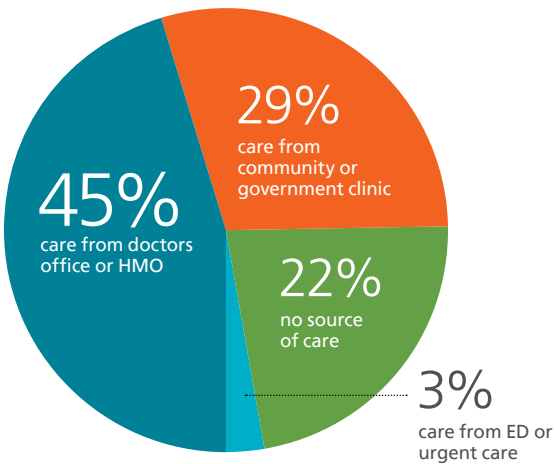
### Sources of care

A usual source of care is defined as a provider or place an individual can go to when sick or in need of medical advice.

In SPA 6:<sup>16</sup>

- **45.1%** of residents report receiving care from a doctor's office or HMO compared to 58% across Los Angeles County.
- **29.2%** receive care from a community or government clinic or community hospital compared to 19.1% countywide.
- **2.5%** rely on an emergency room or urgent care as their usual source of care, compared to 1.4% across Los Angeles County.
- **22.4%** of residents report having no usual source of care—among the highest rates across all SPAs in Los Angeles County, compared to 20.1% across Los Angeles County.

### Sources of care



Greater reliance on clinics, community hospitals and EDs—or having no usual source of care—reflects gaps in access to consistent, preventive and primary care services and places additional strain on local healthcare systems.

Together, these patterns suggest that the primary care system in SPA 6 is not able to fully meet the needs of the community. Many residents either have no regular source of care, rely on clinics with limited capacity or seek care directly through emergency departments.

As a result, emergency departments often serve patients whose healthcare needs could have been addressed earlier in outpatient settings. The impact extends beyond access alone, contributing to delayed care, worsening chronic conditions and increased strain on the healthcare institutions serving the community.

### Telehealth and access to care

Telehealth connects patients to healthcare services through video visits, telephone consultations, remote monitoring and electronic communication. It can improve access for individuals who face barriers related to transportation, mobility, scheduling or clinic availability.

In SPA 6:

- **35.8%** of adults reported receiving care through telehealth in the past year compared to 39.3% across Los Angeles County.<sup>17</sup>

At MLKCH:

- Nearly **7,000 patients** have received telehealth services since 2023.
- These encounters accounted for approximately **12,000 visits**.

Telehealth helps address gaps in access to primary and specialty care by enabling timely evaluation and follow-up without requiring an in-person visit. It may also reduce reliance on ED visits for conditions that can be treated in outpatient settings. At MLKCH, telehealth services helped reduce transportation barriers while expanding access to care and support services for residents in South Los Angeles.

<sup>16</sup> UCLA Center for Health Policy Research, CA. California Health Interview Survey, 2022–2024. <http://ask.chis.ucla.edu/> \*Statistically unstable due to sample size.

<sup>17</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2022–2024, pooled. <http://ask.chis.ucla.edu/>

### Provider shortages, limited capacity and administrative barriers

SPA 6 is estimated to be short more than 1,500 doctors—including both primary care providers and specialists—one of the primary drivers of limited access to care across the region.

Within the MLKCH service area, the supply of doctors meets less than half of estimated demand. Similar and worsening gaps exist across medical specialties.

Limited availability of doctors, combined with low reimbursement rates and high patient demand, contributes to long wait times and difficulty securing appointments. These challenges affect both routine and complex care and are a significant barrier to preventive services and chronic disease management.

As a result, many residents rely on EDs for care that could otherwise be addressed in outpatient settings, including routine, urgent and follow-up care.

Access challenges reported by residents include:

- **9%** of adults in SPA 6 report difficulty finding a primary care provider.<sup>18</sup>
- **Nearly 26%** report difficulty accessing specialty care—a 6-percentage point increase from the 2023 CHNA.

CHNA stakeholder interviews also highlighted place based inequities, with patients frequently required to leave South Los Angeles for specialty or surgical care. Long travel distances, transportation barriers and lack of local services delay treatment and discourage follow up, reinforcing geographic disparities in outcomes.

A key informant described the issue as follows:

**“The capacity just isn’t there. Booking an appointment can take months, and by then the problem is worse.”**

—MLKCH doctor

### Inpatient hospital care

When residents of SPA 6 do need hospitalization for their acute or chronic medical needs, fewer beds are available to them, per capita, than residents of other county service areas. SPA 6 has the least in the entire county.<sup>19</sup> Only **63 inpatient beds are available per 100,000 residents in SPA 6** compared to:

- **147 per 100,000** residents of SPA 1 (the next-lowest rate)
- **449 beds per 100,000** residents of SPA 4 (the highest rate in the county, per capita)

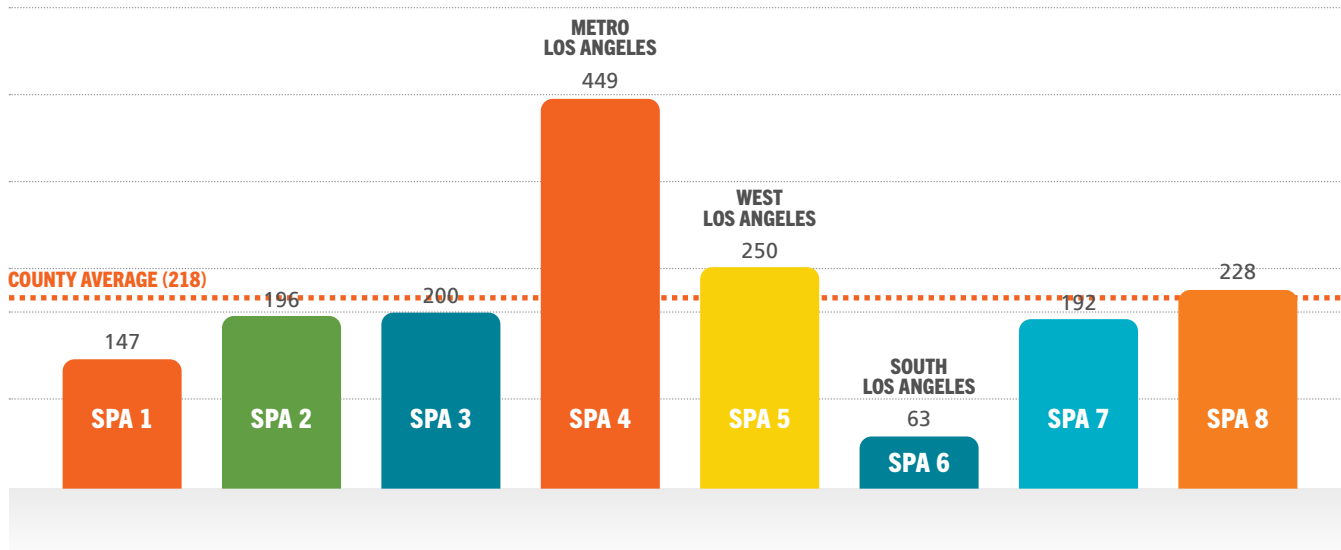


<sup>18</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2022–2024, pooled. <http://ask.chis.ucla.edu/>

<sup>19</sup> MLKCH data scientists, using California Department of Health Care Access and Information (HCAI), Hospital Annual Utilization Database, Subtotal General Acute Care Licensed Beds, 2022. <https://data.chhs.ca.gov/dataset/hospital-annual-utilization-report/resource/2b63a9e4-f695-4ea1-b229-5dff70f04ae8> and Los Angeles County Department of Public Health Population Estimate Report, 2022. <http://www.publichealth.lacounty.gov/epi/docs/2022-LAC-Population-8RE.pdf>

## Medical Infrastructure Disparities (Inpatient Beds)

Number of Inpatient Beds per 100K Residents by Service Planning Areas (SPA)



### Emergency department visits

In addition to having fewer inpatient beds, SPA 6 also has the lowest number of ED beds per capita in Los Angeles County. An estimated **20.6%** of residents in SPA 6 reported visiting an ED within the past 12 months.<sup>20</sup>

ED use is highest among:

- **Adults age 65 and older (23.2%)**
- **Low-income residents (23.9%)**

ED use is lower among:

- **Children (19.0%)**
- **Adults age 18 to 64 (20.7%)**

High rates of ED use in SPA 6 are compounded by limited system capacity. SPA 6 has approximately **seven ED beds per 100,000 residents**<sup>21</sup> compared to:

- **19 beds per 100,000** in SPAs 3 and 5 (next lowest)
- **38 beds per 100,000** in SPA 4 (highest in Los Angeles County)

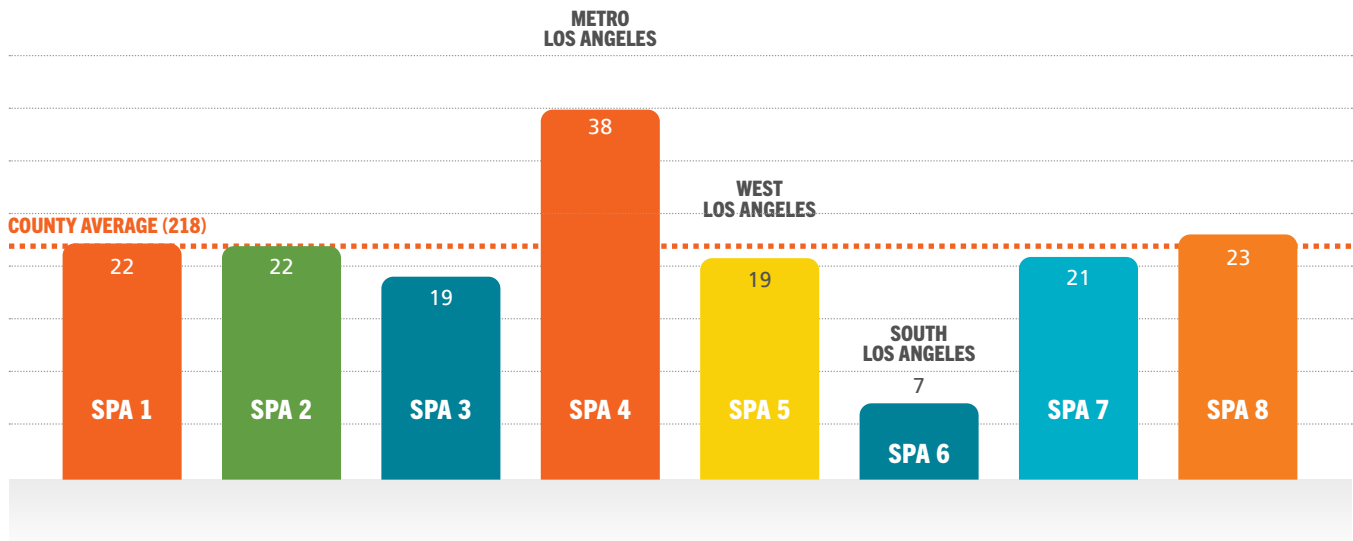
This disparity is particularly significant given that MLKCH is the only nonprofit hospital serving the SPA 6 region.

<sup>20</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2022–2024, pooled. <http://ask.chis.ucla.edu/>

<sup>21</sup> MLKCH data scientists, utilizing California Department of Health Care Access and Information (HCAI), Hospital Annual Utilization Database, Emergency Department Treatment Stations, 2022. <https://data.chhs.ca.gov/dataset/hospital-annual-utilization-report/resource/2b63a9e4-f695-4ea1-b229-5dff70f04ae8> and Los Angeles County Department of Public Health Population Estimate Report, 2022. <http://www.publichealth.lacounty.gov/epi/docs/2022-LAC-Population-8RE.pdf>

## Medical Infrastructure Disparities (Emergency Department Beds)

Number of Inpatient Beds per 100K Residents by Service Planning Areas (SPA)



MLKCH operates one of the busiest EDs in the nation. In 2024, MLKCH was ranked the 19th busiest ED in the United States.<sup>22</sup>

Originally designed to serve a maximum of **25,000 patients annually**, the ED has experienced sustained and increasing demand. Between 2022 and 2024, MLKCH treated **363,090 ED patients**, averaging approximately **120,000 visits per year**.<sup>23</sup>

CHNA survey respondents consistently identified ED volume as exceeding available capacity, resulting in operational strain and delays in care. Reported challenges include prolonged wait times, hallway care and limited availability of treatment space.

One stakeholder, a physician, noted that barriers to timely primary care may contribute to residents relying on the emergency department for needs that could otherwise be addressed in outpatient settings:

**“The emergency room is competing with primary care because it’s available 24/7. We’re seeing roughly 350 to 400 patients a day.”**

High patient demand, combined with limited physical space and resources, has required new and innovative approaches to help ensure patients continue receiving timely care.

Behavioral health needs are a significant contributor to ED use. Due to limited inpatient psychiatric capacity in the region, patients in behavioral health crises often remain in the ED for extended periods while awaiting placement, further reducing available capacity for incoming patients.

To address these challenges, MLKCH is opening an Emergency Psychiatric Assessment, Treatment and Healing (EmPATH) unit in 2026 to provide a specialized setting for behavioral health patients. The unit is designed to support stabilization and rapid discharge in a therapeutic environment, helping to reduce pressure on ED capacity and improve patient flow.

<sup>22</sup> Becker’s Hospital Review, Hospitals with the Most Emergency Department Visits in 2024. <https://www.beckershospitalreview.com/rankings-and-ratings/hospitals-with-the-most-ed-visits-in-2024>

<sup>23</sup> MLKCH data scientists, using MLKCH Electronic Medical Record data, Emergency Department Visits, 2022 through 2024.

## Maternal, infant and child health

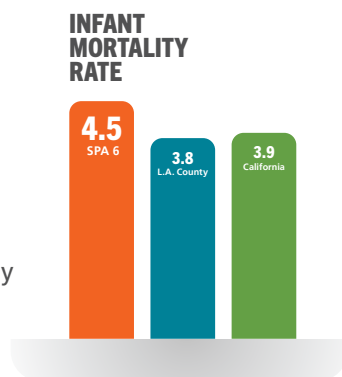
A mother's access to care during pregnancy has a direct and lasting impact on the health and well-being of both mother and child. Disparities in pregnancy-related risk factors and access to early, consistent prenatal care continue to shape outcomes across racial and ethnic groups.

In Los Angeles County:<sup>24</sup>

- Black or African American mothers experience the **highest infant mortality rates**, significantly higher than those of White mothers.
- The maternal mortality rate among Black mothers is **26.7 deaths per 100,000 live births** compared to:
  - 15.8 among Asian mothers
  - 6.6 among White mothers
- Several groups exceed the **Healthy People 2030 target of 15.7 deaths per 100,000 live births**.

In SPA 6:

- An average of **15,252 births** occurred annually between 2019 and 2023.
- The infant mortality rate in was **4.5 deaths per 1,000 live births** compared to:
  - **3.8** in Los Angeles County
  - **3.9** in California
- **708.7 per 1,000 births** were covered by public insurance or self-pay.



Maternal and infant health outcomes in the service area are consistently worse than those observed in Los Angeles County and statewide, reflecting differences in access to early and consistent prenatal care as well as broader social and economic conditions.

Community stakeholders describe these disparities—particularly for Black women—as severe and persistent. Interviewees report experiences of bias in clinical settings, lack of trust in healthcare systems and barriers to receiving timely, high-quality care.

<sup>24</sup> Los Angeles County Dept. of Public Health, Maternal, Child and Adolescent Health Division, African American Infant and Maternal Mortality Prevention Initiative (AAIMM), Vital Statistics Data Summary, Data from 2017–2021. <http://www.publichealth.lacounty.gov/mch/AAIMM/aaimm-new.htm>

<sup>25</sup> Cal Hospital Compare, Martin Luther King, Jr. Community Hospital: Maternity Care Performance Measures. <https://calhospitalcompare.org/hospital/?id=106191230&n=Martin+Luther+King%2C+Jr.+Community+Hospital#motherbaby>



## MLKCH's unique approach to maternity care

Since opening in 2015, MLKCH has implemented a midwife-led model of care that integrates obstetricians and certified nurse midwives. Approximately 10% of hospital births in the United States involve midwives. This team-based approach supports lower intervention rates and a more patient-centered birth experience.

Our midwife-led approach to care contributed to consistently low cesarean section (C-section) rates. As recently as 2025, Cal Hospital Compare reported that **19.4% of births at MLKCH** resulted in a C-section compared to approximately **25% statewide**.<sup>60</sup>

MLKCH is also designated as a **Baby-Friendly Hospital** by a World Health Organization (WHO) and United Nations Children's Fund (UNICEF) initiative that supports breastfeeding worldwide. This designation reflects adherence to evidence-based practices that support maternal and infant health.

## 2 Management of chronic health conditions

Chronic diseases are the leading cause of death and disability in the United States. They are a significant driver of the nation’s \$4.9 trillion in annual healthcare costs.<sup>26</sup>

The Centers for Disease Control and Prevention (CDC) estimate three out of every four adults have at least one chronic condition, and over half have two or more chronic conditions.

These chronic conditions can be disabling and reduce a person’s quality of life, especially if left undiagnosed or unmanaged. Fortunately, many chronic diseases can be prevented or minimized through lifestyle changes and adequate access to healthcare services.

The CDC has identified four lifestyle risk factors that increase risk for chronic conditions:

- Tobacco use
- Poor nutrition
- Lack of physical activity
- Excessive alcohol use

South Los Angeles has a higher prevalence of chronic diseases. Prevalence of asthma, cancer, coronary heart disease, diabetes, high blood pressure and obesity exceed rates for Los Angeles County.

These disparities are exacerbated by environmental and behavioral factors including exposure to environmental toxins, lack of healthy food options, an absence of green space for physical activity and a disproportionate number of liquor and fast-food outlets.

Further, racial and ethnic minority populations often receive poorer quality of care and face more barriers in seeking care, including preventive care and chronic disease management. These disparities lead to poor health outcomes, higher healthcare costs, increased pressure on limited community resources and higher mortality rates from preventable conditions.

### Mortality rates

Deaths and mortality rate, per 100,000 persons, 5-year average<sup>27</sup>

	MLKCH Service Area	LA County	California
Average annual deaths	10,155	74,775	306,157
Mortality rate per 100,000 persons	855.9	663.2	679.3

■ Worse than total population of LA County and California

### Mortality rates by condition<sup>28</sup>

	MLKCH Service Area		LA County
	Avg annual deaths	Rate	Rate
Heart disease	2,142	181.4	150.0
Ischemic heart disease	1,392	116.9	98.3
Cancer	1,692	141.5	127.8
Prostate	606	27.9	18.8
Lung and bronchus	1,241	21.1	26.1
Breast (female)	701	20.2	18.9
Colorectal	833	13.7	15.6
COVID-19*	1,297	85.5	54.8
Diabetes	590	49.4	30.3
Unintentional injuries	624	46.4	36.6
Stroke	505	44.7	34.7
Alzheimer’s disease	393	37.9	40.9
Chronic lower respiratory disease	313	27.4	24.4
Essential hypertension and hypertensive renal disease	269	23.2	15.9
Kidney disease	247	21.2	13.7
Liver disease	269	20.5	14.8
Pneumonia and influenza	223	19.5	16.4
Homicide	214	15.7	6.7
Suicide	77	5.8	8.0
Parkinson’s disease	57	5.5	8.6
HIV	43	3.2	1.8

■ Worse than total population of LA County

<sup>26</sup> Centers for Disease Control and Prevention (CDC), About Chronic Diseases. [www.cdc.gov/chronic-disease/about/index.html](https://www.cdc.gov/chronic-disease/about/index.html)

<sup>27</sup> Gary Bess Associates, calculated from CA Dept of Public Health Master Death Files 2019–2023 using the U.S. 2000 Standard Population. State data are from the U.S. CDC National Center for Health Statistics, Underlying Cause of Death 2019–2023 on CDC WONDER Online Database released December 2024.

<sup>28</sup> Gary Bess Associates, calculated from CA Dept of Public Health Master Death Files 2019–2023 using the U.S. 2000 Standard Population. State data are from the U.S. CDC National Center for Health Statistics, Underlying Cause of Death 2019–2023 on CDC WONDER Online Database released December 2024. \*Except for COVID-19, which is a 4-year average.

### Top diagnoses at MLKCH, ED and inpatient

The top two diagnoses most often recorded at MLKCH, in both the ED and inpatient population, are high blood pressure and type 2 diabetes.

#### Top diagnoses at MLKCH, Emergency Visits<sup>29</sup>

Rank	ED visits
1	Diabetes, type 2
2	High blood pressure
3	Sepsis
4	Heart failure
5	Acute kidney failure
6	Chronic kidney disease (CKD)
7	Nicotine dependence

#### Top Diagnoses at MLKCH, Inpatient Visits

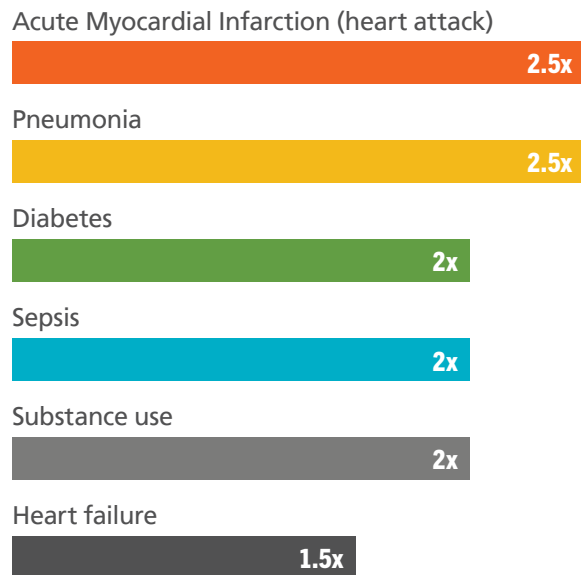
Rank	Inpatient visits
1	High blood pressure
2	Diabetes, type 2
3	Asthma
4	Nicotine dependence
5	Anxiety disorders
6	Disorders of urinary system
7	Acute upper respiratory infections

### Hospitalization rates compared to state averages

Several medical conditions account for a higher share of hospitalizations at MLKCH compared to statewide averages. These patterns reflect the underlying burden of chronic disease, delayed access to care and social risk factors in the communities served.

From 2022 through 2024, hospitalization rates at MLKCH exceeded California averages (2021–2023) for the following conditions:

### Hospitalization Rates Compared to California State Averages<sup>30</sup>



<sup>29</sup> MLKCH data scientists, using MLKCH Top ED/Observation and Inpatient Discharge Diagnosis Reports, 2023–2025.

<sup>30</sup> MLKCH data scientists, using MLKCH Electronic Medical Records, 2022–2024 and California Department of Healthcare Access and Information, Patient Discharge Data, 2021–2023.

## Medical condition-specific findings

### Diabetes

Diabetes and prediabetes remain significant health concerns in South Los Angeles, increasing the risk of serious complications including heart disease, stroke, kidney failure, blindness, nerve damage and amputation.

In SPA 6:<sup>31</sup>

- **25.5%** of adults report being diagnosed with prediabetes or borderline diabetes compared to 23.3% in Los Angeles County.
- **17.8%** report having diabetes compared to 12.9% countywide.

Diabetes prevalence varies across racial and ethnic groups in SPA 6:<sup>32</sup>

- **21.5%** among non-Hispanic Black or African American adults (compared to 15.8% in LA County)
- **17.5%** among Hispanic or Latino adults (compared to 15.9% in LA County)
- **17.5%** among non-Hispanic Asian adults (compared to 11.8% in LA County)

While local data are limited for some populations due to small sample sizes, county-level data indicate elevated rates among Native Hawaiian or Pacific Islander and American Indian or Alaska Native populations.

High rates of diabetes complications in South Los Angeles reflect both clinical and systemic factors, including barriers to preventive care, delayed diagnosis and limited access to specialty care. Historically, diabetes-related amputations have been among the most common surgical procedures at MLKCH, reflecting the severity of disease in the community. As a result of expanded diabetes management and preventive care efforts, diabetes-related amputations have declined and now rank third among the hospital's most frequently performed surgeries.

<sup>31</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2022–2024, or †2021–2022, pooled. <http://ask.chis.ucla.edu/>

<sup>32</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2020–2024, pooled. <http://ask.chis.ucla.edu/> \*Statistically unstable due to sample size. \*\*Suppressed due to instability related to small sample size.



## MLKCH recognized for high-performing diabetes care

MLKCH delivers comprehensive diabetes care across inpatient and outpatient settings. The hospital holds the Joint Commission's Advanced Certification in Diabetes Care and has earned National Committee for Quality Assurance (NCQA) recognition for its outpatient programs.

### Inpatient diabetes support

Patients are rapidly assessed by medical personnel, and those with diabetes or related risk factors are connected to specialized support. Since 2023, our inpatient diabetes management program:

- Decreased severe hypoglycemic events by 28%
- Decreased severe hyperglycemic events by 26%
- Decreased lengths of stay, readmissions, ED visits and costs of care

(continued next page)

### Outpatient Diabetes Management Program

Launched in 2021, the Outpatient Diabetes Management Program at MLKCH uses a coordinated, multidisciplinary model to address the high burden of diabetes in South Los Angeles. Care includes medication management, preventive screenings, nutrition support, patient education and an emphasis on care management.

By the program's fourth year:

- Amputations among patients receiving intensive management had fallen to zero. Across the broader MLKCMG diabetes population, there was only one amputation during the same period, compared to a regional rate of 494 amputations per 100,000 patients with diabetes across SPA 6.
- 85% achieved HbA1c control—a key indicator of well-controlled blood sugar—compared to 64% in the CMS national Medicaid benchmark and 68% in the L.A. Care Medi-Cal benchmark.
- 74% achieved blood pressure control, compared to 68% in the CMS national benchmark and 72% in the L.A. Care benchmark.

Based on regional amputation rates in SPA 6, approximately 35 amputations would have been expected among patients in the MLKCMG outpatient diabetes management population during the same period. These outcomes highlight the potential impact of coordinated, multidisciplinary care in reducing severe diabetes-related complications.

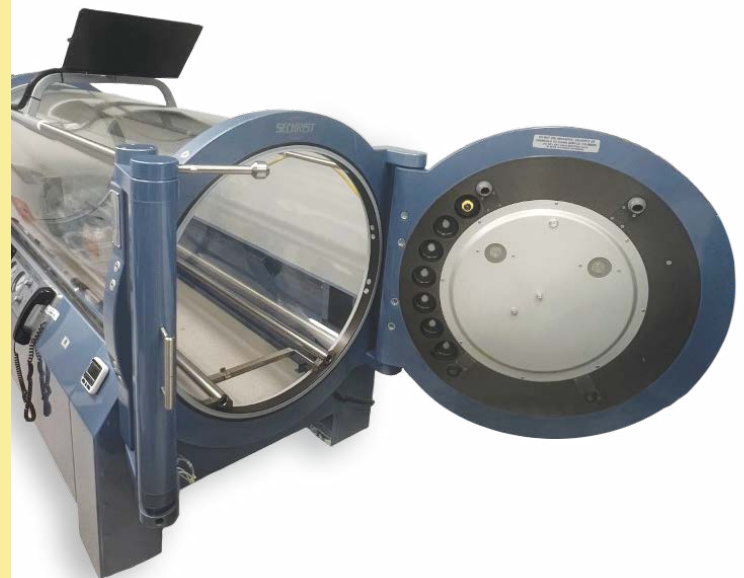


## Wound healing and hyperbaric care at MLKCH

MLKCH provides specialized wound care services, including hyperbaric oxygen therapy, for patients with diabetic and hard-to-heal wounds. MLKCH offers:

- Individualized treatment plans supported by a multidisciplinary care team.
- Access to hyperbaric oxygen therapy, which can support healing in complex or non-healing wounds.
- Integrated care with patients' broader care plans and referring providers.

These services support earlier intervention and improved healing outcomes for patients at risk of serious complications, including amputation.



## High blood pressure (Hypertension)

High blood pressure is a major risk factor for heart disease and diabetes and can lead to serious complications over time, including heart attack, stroke and heart failure.

Hypertension prevalence in SPA 6:<sup>33</sup>

- **29.2%** of adults have been diagnosed with high blood pressure compared to 26.4% in Los Angeles County.
- An additional **8.6%** report having borderline high blood pressure.

Hypertension varies significantly across racial and ethnic groups:<sup>34</sup>

- **59.0%** of non-Hispanic Black or African American adults report high or borderline high blood pressure compared to 47.2% countywide.
- **36.2%** among multiracial residents, compared to 27.5% countywide.
- **29.1%** among Latino residents.

These patterns reflect long-standing inequities in chronic disease risk and access to preventive care.

## Heart disease

Heart disease, including coronary artery disease and heart failure, remains a leading cause of death globally and within the MLKCH service area. In SPA 6, **5.7%** of adults have been diagnosed with heart disease compared to **6.4%** in Los Angeles County.<sup>35</sup>

Rates of heart disease vary across populations:<sup>36</sup>

- **7.9%** among non-Hispanic Black or African American adults (on par with County (8.0%) and state (7.2%) levels)
- **3.9%** among Latino (compared 4.3% in county, state 4.2%)

<sup>33</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2022–2024, pooled. <http://ask.chis.ucla.edu/>

<sup>34</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2020–2024, pooled. <http://ask.chis.ucla.edu/> \*Statistically unstable due to sample size. \*\*Suppressed due to instability related to small sample size.

<sup>35</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2022–2024. <http://ask.chis.ucla.edu/>

<sup>36</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2020–2024, pooled. <http://ask.chis.ucla.edu/> \*Statistically unstable due to sample size. \*\*Suppressed due to instability related to small sample size.



## Cardiology services at MLKCH

MLKCH provides comprehensive cardiology services focused on prevention, early intervention and ongoing management of heart disease, a leading cause of hospitalization in the community.

MLKCH provides:

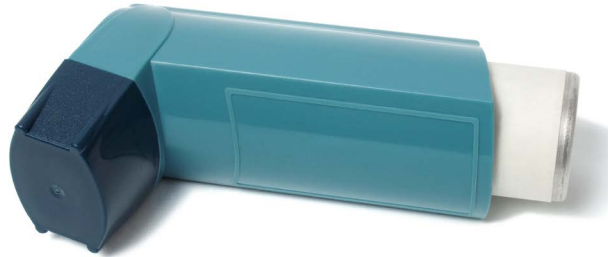
- Preventive care and risk management, including lifestyle counseling, medication management and routine monitoring.
- Advanced diagnostic services through an on-site cardiac catheterization lab.
- Minimally invasive procedures, including pacemaker and implantable cardioverter-defibrillator (AICD) implantation.
- Heart failure management and cardiac rehabilitation.

MLKCH's interventional cardiology services are available 24/7, enabling timely diagnosis and treatment and reducing the need for patient transfers outside the community.

The overall rate of heart disease in SPA 6 is slightly lower than the county average. Data for some populations is limited, however, due to small sample sizes. County and statewide data indicate elevated levels among additional groups.

## Asthma

Asthma continues to affect a significant portion of residents in South Los Angeles, with both adults and children experiencing higher rates of diagnosis and complications compared to Los Angeles County overall.



In SPA 6:

- **15.6%** of adults have been diagnosed with asthma.
- **18%** of children ages 1 to 17 have been diagnosed with asthma.

Asthma management and outcomes also differ from countywide patterns:

For children in SPA 6:

- **70.3%** take daily medication compared to 47.0% in Los Angeles County.
- **35.5%** experienced an asthma episode in the past year compared to 29.8% countywide.

For adults in SPA 6:

- **61.7%** report taking daily medication compared to 45.9% in Los Angeles County.
- Many remain more likely to experience asthma-related complications.

Despite higher rates of medication use, both adults and children in SPA 6 continue to experience more frequent asthma episodes. These patterns suggest that environmental factors, air quality and access to specialty care play a significant role in asthma outcomes in the community.

### Asthma, adults, and children and teens, ages 1 to 17<sup>37</sup>

	SPA 6	Los Angeles County
Ever diagnosed with asthma, adults	15.6%	15.0%
Has had an asthma episode/attack in past 12 months, adults	35.3%	27.5%
Takes daily medication to control asthma, adults	61.7%	45.9%
Ever diagnosed with asthma, ages 1 to 17	18.0%	34.0%
Has had an asthma episode/attack in past 12 months, ages 1 to 17	35.5%	29.8%
Takes daily medication to control asthma, ages 1 to 17	*70.3%	47.0%

■ Worse than total population of LA County

Severity and complications from asthma are influenced by environmental and access-related factors. Poor air quality in Los Angeles—exacerbated by the Eaton and Pacific Palisades wildfires in early 2025—contributes to respiratory risk, while limited access to primary care providers and specialists such as pulmonologists and allergists can delay diagnosis, treatment adjustments and ongoing management.

<sup>37</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2020-2024, pooled. <http://ask.chis.ucla.edu/>

\*Statistically unstable due to sample size.



## Cancer

South Los Angeles continues to experience higher cancer mortality rates compared to Los Angeles County and California overall. In SPA 6, the age-adjusted cancer mortality rate was **141.5 deaths per 100,000 persons**—exceeding the Healthy People 2030 objective of 122.7 per 100,000 persons. Mortality rates for prostate, breast and colorectal cancers also exceed national targets.

These outcomes are driven in part by gaps in preventive screening and access to timely diagnosis and treatment.

### Cancer mortality rate, age-adjusted, per 100,000 persons<sup>38</sup>

	MLKCH Service Area	Los Angeles County	California
	Rate	Rate	Rate
Cancer death rate	141.5	127.8	130.4
Prostate	27.9	18.8	19.7
Lung and bronchus	25.2	2.16	22.3
Breast (female)	20.2	18.9	18.7
Colorectal	13.7	15.6	12.1

■ Worse than total population of LA County and California

## Lower rates of preventive screening

Screening rates for certain cancers remain below recommended targets. Among women ages 50 to 74 in SPA 6, 79.4% reported receiving a mammogram within the past 2 years—below the Healthy People 2030 target of 80.3%—with even lower rates in some areas of South Los Angeles.

### Mammograms, Women, Ages 50 to 74<sup>39</sup>

Health district	Percent
Compton Health District	95.5%
South Health District	66.3%
Southeast Health District	68.1%
Southwest Health District	81.5%
<b>SPA 6</b>	<b>79.4%</b>
<b>Los Angeles County</b>	<b>78.1%</b>

■ Worse than total population of LA County

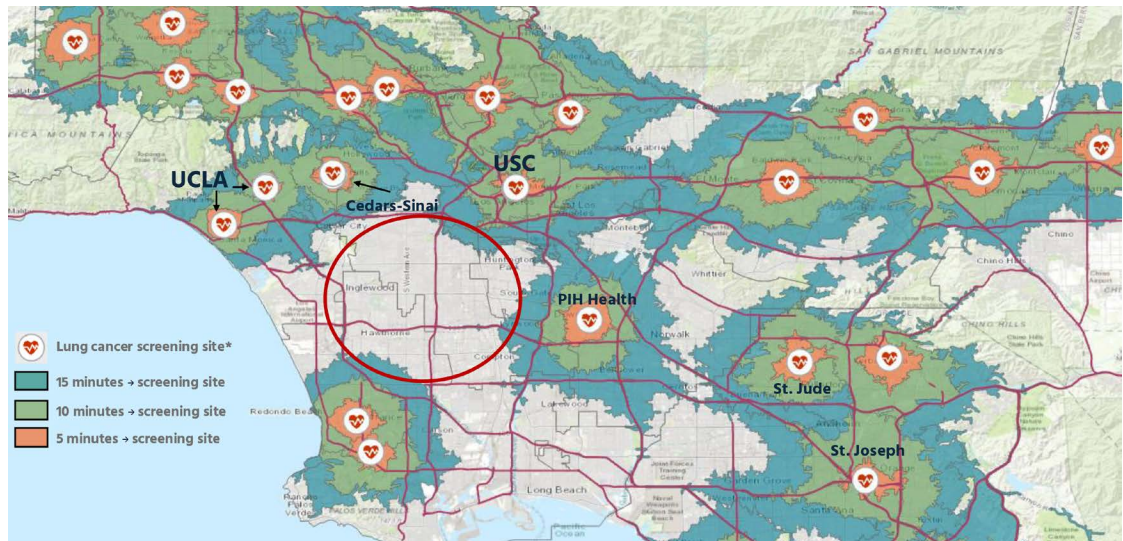
Colorectal cancer screening rates are also lower than county and state averages. Only 48.2% of adults ages 50 to 75 report receiving recommended screening compared to 53.0% in Los Angeles County and 57.5% statewide.<sup>40</sup>

<sup>38</sup> Gary Bess Associates, calculated from CA Dept of Public Health Master Death Files 2019–2023 using the U.S. 2000 Standard Population. State data are from the U.S. CDC National Center for Health Statistics, Underlying Cause of Death 2019–2023 on CDC WONDER Online Database released December 2024.

<sup>39</sup> Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, Los Angeles County Health Survey, 2023. <http://www.publichealth.lacounty.gov/ha/LACHSDDataTopics2023.htm>

<sup>40</sup> CDC, Behavioral Risk Factor Surveillance System (BRFSS), PLACES Project 2024, 2022 data year. For Service Area data, see <https://data.cdc.gov/500-Cities-Places/PLACES-Local-Data-for-Better-Health-ZCTA-Data-2024/qnzd-25i4> and for County and State, see <https://chronicdata.cdc.gov/500-Cities-Places/PLACES-Local-Data-for-Better-Health-County-Data-20/swc5-untb> \*Weighted average of service area ZIP codes except 90747 for which no rate is available. \*\*Weighted average of California county rates.

## ACCESS TO LUNG CANCER SCREENING SITES IN LA COUNTY



American College of Radiology (ACR) map showing access ACR-designated to lung cancer screening sites across Los Angeles County. The MLKCH service area (circled in red) is located more than 15 minutes from a screening site in all directions, highlighting gaps in access to preventive cancer screening in South Los Angeles.

### Limited access to specialty care and screening infrastructure

Access to cancer screening and treatment services remains uneven across Los Angeles County. Lung cancer screening sites are concentrated in areas with lower risk, while medically underserved communities—including South Los Angeles—have fewer screening locations.<sup>41</sup> These gaps in access can delay diagnosis and contribute to more advanced disease at the time of treatment.

American College of Radiology (ACR) map showing access ACR-designated to lung cancer screening sites across Los Angeles County. The MLKCH service area (circled in red) is located more than 15 minutes from a screening site in all directions, highlighting gaps in access to preventive cancer screening in South Los Angeles.

<sup>41</sup> MLKCH data scientists, using American College of Radiology Lung Cancer Screen Locator Tool. <https://www.acr.org/Clinical-Resources/Clinical-Tools-and-Reference/Screening-Resources/lung-cancer-resources/locator-tool>

## Obesity

Obesity is associated with a range of chronic health conditions, including cardiovascular disease, Type 2 diabetes, respiratory conditions such as sleep apnea and certain cancers.

In SPA 6, rates of overweight and obesity remain high across all age groups.

Overweight prevalence:

- **34%** of adults (ages 20+) are overweight, similar to 33.5% in Los Angeles County.
- **20.1%** of teens are overweight compared to 16.9% countywide.
- **21.5%** of children are overweight compared to 15.1% countywide.

Obesity prevalence:

- **43.2%** of adults are classified as obese compared to 28.7% in Los Angeles County.
- **22.9%** of teens are classified as obese compared to 18.8% countywide.
- Teen obesity rates exceed the **Healthy People 2030 target of 15.5%**.

Higher rates among children and adolescents are of particular concern, as early onset obesity is associated with an increased risk of chronic disease over time.



These patterns reflect broader environmental and structural factors, including limited access to healthy foods, safe spaces for physical activity and walkable built environments—conditions shaped by long-standing underinvestment in South Los Angeles.

### Overweight, all ages<sup>42</sup>

	SPA 6	Los Angeles County
Adults, ages 20 and older	34.0%	33.5%
Teens, ages 12 to 17 <sup>†</sup>	20.1%	16.9%
Children, ages 11 and under <sup>†</sup>	21.5%	15.1%

■ Worse than total population of LA County

### Obesity, adults and teens<sup>41</sup>

	SPA 6	Los Angeles County
Adults, ages 20 and older	43.2%	28.7%
Teens, ages 12 to 17 <sup>†</sup>	22.9%	18.8%

■ Worse than total population of LA County



<sup>42</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2022-2024, pooled, and †2020-2024, pooled. <http://ask.chis.ucla.edu/>

### 3 Behavioral health

In South Los Angeles, many behavioral health conditions remain untreated. Structural access barriers, insufficient provider capacity and fragmented systems limit access to timely and coordinated mental health care. This often results in individuals seeking care only during crises.

Mental health challenges are closely intertwined with substance use, economic insecurity, housing instability and exposure to environmental stressors, creating cumulative impacts affecting individuals and the broader healthcare system.

Although Los Angeles County has a slightly more favorable provider-to-population ratio (209:1) compared to the state (213:1), access remains uneven—particularly for low income and publicly insured populations.<sup>43</sup> Long wait times, provider shortages and limited inpatient capacity continue to constrain access to care.

#### Mental health providers, number and ratio<sup>43</sup>

	Los Angeles County	California
Number of mental health providers	46,181	183,045
Ratio of population to mental health providers	209:1	213:1

Individuals seeking mental health care in SPA 6:<sup>44</sup>

- **24.4%** of SPA 6 adults reported needing help for emotional or mental health concerns or substance use in the past year.
- Among those who received care, only **24.3%** saw a mental health professional exclusively, compared to 41% countywide.
- Among those who sought care, **45.5%** were unable to receive treatment.

This rate is well above the **Healthy People 2030 benchmark of 31.2%**, which aims to reduce the proportion of individuals with serious mental illness who go untreated.

These patterns highlight ongoing gaps in access to behavioral health services, including limited provider availability, affordability challenges and barriers to timely care.

Community input reinforces these findings, with respondents describing behavioral health need as widespread and often unmet. Participants highlighted the impact of violence, chronic stress and environmental instability on mental health outcomes, as well as persistent stigma and barriers to accessing care.

Together, these factors contribute to a system in which behavioral health needs are frequently addressed only at points of crisis rather than through sustained, preventive care.



<sup>43</sup> County Health Rankings and Roadmaps, 2025; data from 2024. <http://www.countyhealthrankings.org>

<sup>44</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2022–2024, pooled. <http://ask.chis.ucla.edu/>

## Substance use disorder

Substance use is a significant and multifaceted concern in South Los Angeles, closely linked to housing instability, mental health conditions, economic hardship and limited access to treatment services.

While opioids and fentanyl receive significant attention, community stakeholders consistently identified alcohol, marijuana and stimulant misuse as widespread and often underestimated contributors to community health challenges. Increased availability of marijuana has contributed to greater normalization of use, though not without associated risks.

Cigarette and binge drinking in SPA 6:<sup>45</sup>

- **5.8%** of adults report current cigarette smoking, meeting the Healthy People 2030 target of 6.1%.
- **17.5%** report binge drinking in the past month, below the Healthy People 2030 threshold of 25.4%.

Despite meeting these benchmarks, substance use remains a persistent concern due to its broader health and social impacts.

Patterns of substance use vary across racial and ethnic groups:<sup>46</sup>

### Latino adults:

- Lower rates of smoking (**5.1%**) and marijuana use (**7.7%**)
- Higher rates of binge drinking (**21.2%**), exceeding the SPA 6 average (**18.5%**)

### Black or African American adults:

- Higher rates of smoking (**10.8%**) and marijuana use (**19.7%**)
- Lower rates of binge drinking (**9.4%**)

These differences reflect varying patterns of exposure, social context and access to prevention and treatment resources, highlighting the need for culturally responsive approaches to care.

These patterns underscore that behavioral health risks are not uniform across populations and require tailored, culturally responsive approaches to prevention and treatment.

<sup>45</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2022–2024. <http://ask.chis.ucla.edu>

<sup>46</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2020–2024 or †2021–2024, pooled. <http://ask.chis.ucla.edu> \*Unstable due to sample size.



## Integrated Behavioral Health Program at MLKCH

MLKCH's Integrated Behavioral Health (IBH) program addresses the connection between physical health, mental health and substance use by screening patients at the point of care and connecting them to appropriate services.

In FY25:

- Approximately 3,400 patients were referred or connected to behavioral health services.
- 200 patients were linked to outpatient providers and treatment programs.
- More than 250 patients received telehealth consultations, resulting in approximately 900 visits.
- MLKCH distributed over 100 doses of Narcan to support overdose prevention.

By integrating behavioral health into routine care, the program supports earlier identification, improves care coordination and expands access to treatment for patients with complex needs.

## 4 Homeless health

**“This is falling on the health sector, but [homelessness] is an economic and a housing problem. There are not enough service providers, community-based organizations or funding to adequately address homelessness in South Los Angeles.”**

– Community Member

Homelessness remains a persistent and complex challenge in South Los Angeles, shaped by limited affordable housing, economic instability and gaps in behavioral health services.

Community stakeholders consistently identified SPA 6 as one of the most underserved regions in Los Angeles County for homelessness-related resources and support. SPA 6 has the second highest homeless population in LA County, behind SPA 4 (Metro LA).



### Homeless population in SPA 6:

- An estimated 13,598 individuals were experiencing homelessness in 2025, a 4.6% increase since 2023.
- 75.2% were individual adults, while 21.3% were families experiencing homelessness.
- The proportion of unsheltered individuals decreased from 64.9% to 60.0%, though the overall number of individuals experiencing homelessness remains high.

### Homeless population, 2023–2025 comparison\*<sup>47</sup>

	SPA 6		Los Angeles City and County CoC*	
	2023	2025	2023	2025
Total homeless	12,995	13,598	71,320	67,918
Sheltered	35.1%	40.0%	26.7%	34.6%
Unsheltered	64.9%	60.0%	73.3%	65.4%
Individual adults, aged 25+	76.8%	75.2%	81.3%	80.1%
Individual youth, aged 18–24	1.8%	3.4%	3.9%	3.3%
Unaccompanied minors (<18)	0.08%	0.06%	0.13%	0.08%
Families/family members	21.4%	21.3%	14.7%	16.5%

\*These data represent the homeless counts from the Los Angeles County Continuum of Care (CoC), which does not include Glendale, Long Beach and Pasadena homeless counts.

Some indicators show improvement, including a decline in the proportion of chronically homeless individuals (39.7% to 29.0%). But other high-need populations have increased.<sup>48</sup> These include individuals experiencing domestic violence and those living with physical disabilities, reflecting the evolving and intersecting drivers of homelessness.

<sup>47</sup> Los Angeles Homeless Service Authority, 2023 and 2025 Greater Los Angeles Homeless Count. <https://www.lahsa.org/news?article=1043-2023-greater-los-angeles-homeless-count-data> and <https://www.lahsa.org/news?article=1043-2025-greater-los-angeles-homeless-count-data>  
<sup>48</sup> Los Angeles Homeless Service Authority, 2023 and 2025 Greater Los Angeles Homeless Count. <https://www.lahsa.org/news?article=1043-2023-greater-los-angeles-homeless-count-data> and <https://www.lahsa.org/news?article=1043-2025-greater-los-angeles-homeless-count-data>

## Homelessness subpopulations\*

	SPA 6		Los Angeles City and County CoC*	
	2023	2025	2023	2025
Chronically homeless individuals	39.7%	29.0%	42.7%	38.1%
Chronically homeless family members	3.3%	3.3%	2.2%	2.6%
Developmental disability	11.9%	6.3%	8.9%	8.3%
Domestic violence (DV) experience	30.3%	34.8%	34.5%	37.8%
Homeless due to fleeing DV / intimate partner violence (IPV)	7.3%	8.3%	8.0%	8.9%
Persons with HIV/AIDS	2.7%	0.8%	2.1%	1.8%
Physical disability	16.7%	17.2%	17.2%	21.4%
Serious mental illness	24.5%	16.3%	22.4%	23.5%
Substance use disorder	24.1%	15.6%	27.1%	22.0%
Veterans	3.8%	NR	5.4%	NR

NR = Not reported. \*These data represent homeless counts from the Los Angeles County Continuum of Care (CoC), which does not include Glendale, Long Beach and Pasadena homeless counts

 Subpopulation of SPA 6 worsened since 2023

Housing instability is closely linked to worsening physical and behavioral health outcomes, as well as increased reliance on EDs and other acute care settings. Individuals experiencing homelessness often face significant barriers to accessing consistent preventive care, contributing to more advanced disease at the time of treatment.

Community input highlights the strong inter-connection among homelessness, mental health, substance use, trauma and chronic stress. These factors often compound one another, making it difficult for individuals to achieve stability without coordinated, multidisciplinary support.

Street-based and mobile care models are increasingly recognized as essential for reaching individuals who are unable to access traditional care settings. MLKCH's Street Medicine program provides direct, ongoing care to individuals experiencing homelessness, addressing both medical and social needs in community settings.

As demand continues to exceed available resources, stakeholders emphasized the need for expanded services, improved coordination and sustained investment to effectively address homelessness and its health impacts.

## 5 Social drivers of health

Social drivers of health are the conditions in which people are born, grow, work, live and age, and the broader systems that shape daily life. These factors—particularly income, housing and access to resources—are among the strongest predictors of health outcomes and health behaviors.

In South Los Angeles, social and economic conditions continue to shape access to care, health risks and overall well-being. Community input consistently highlights the impact of economic instability, limited financial mobility and high costs of living on individual and family health.

### Income and poverty

MLKCH is a key economic anchor in SPA 6, employing nearly 2,000 staff and contributing to the local economy. At the same time, many residents in the service area continue to face significant financial strain. In 2023, 20% of residents lived below 100% of the Federal Poverty Level (FPL), and 45.5% lived below 200% of FPL, a commonly used threshold for low-income status.<sup>49</sup> Both measures are substantially higher than county and state averages.

More than half (52.4%) of households in the service area spend 30% or more of their income on housing, and more than a quarter (28.6%) spend at least half of their income on housing.<sup>50</sup> These rates exceed both county and state levels and place substantial pressure on household stability.

### Households that spend 30% or more, or 50% or more, of their income on housing<sup>43</sup>

	30%+	50%+
MLKCH Service Area	52.4%	28.6%
Los Angeles County	46.8%	24.1%
California	41.2%	20.0%

 Worse than total population of LA County and California

Median household income in the service area is \$64,078\*—an increase from prior reporting, but it still substantially lower than both Los Angeles County (\$87,760) and California (\$96,334).<sup>51</sup> Lower incomes, combined with rising costs, limit the ability of many households to meet basic needs, including housing, food and healthcare.

\*Weighted average of the service area ZIP Codes' medians, with the exceptions of ZIP Codes 90089 & 90747 for which no data is available.

### Household crowding

Household crowding is more common among older-adult immigrant and recent immigrant communities, low-income families and renter-occupied households.

Crowding is associated with increased risk of communicable disease transmission, higher rates of respiratory illness and greater vulnerability to housing instability, particularly among households living below the FPL.

Overcrowded housing in MLKCH Service Area:<sup>52</sup>


- 11.8% of households are overcrowded
- 7.5% are severely overcrowded
- 19.3% of households are overcrowded overall

The combined rate of overcrowding in SPA 6 is higher than:

- 11.0% in Los Angeles County
- 8.2% in California

### Household supportive benefits<sup>53</sup>

	MLKCH Service Area	Los Angeles County	California
Total households	373,344	3,390,254	13,434,847
Supplemental Security Income (SSI)	9.0%	6.6%	5.9%
Cash public assistance	7.0%	4.5%	3.8%
CalFresh (food stamp) participation	23.6%	13.0%	11.4%

 Worse than total population of LA County and California

<sup>49</sup> U.S. Census Bureau, "American Community Survey 5-Year Estimates: Comparison Profiles 5-Year," 2019–2023, S1701. <https://data.census.gov/>

<sup>50</sup> U.S. Census Bureau, "American Community Survey, 5-year Estimates: Comparison Profiles 5-Year," 2019–2023, B25070 and B25091. <https://data.census.gov>

<sup>51</sup> U.S. Census Bureau, "American Community Survey 5-Year Estimates: Comparison Profiles 5-Year," 2019–2023, DP03. \*Weighted average of the service area ZIP code medians, with the exceptions of ZIP codes 90089 & 90747 for which no data is available. <https://data.census.gov/>

<sup>52</sup> U.S. Census Bureau, "American Community Survey 5-Year Estimates: Comparison Profiles 5-Year," 2019–2023, DP04. <https://data.census.gov/>

<sup>53</sup> U.S. Census Bureau, "American Community Survey 5-Year Estimates: Comparison Profiles 5-Year," 2019–2023, DP03. <http://data.census.gov/>

Additional indicators further reflect economic strain in the service area. In SPA 6:

- Approximately **23.6%** of households receive CalFresh benefits.
- **9%** receive Supplemental Security Income (SSI).
- **7%** receive cash public assistance.

These rates exceed county and state averages and point to the level of financial pressure experienced by many households.

CHNA stakeholders consistently frame economic insecurity as a condition affecting both employed and unemployed individuals, reflecting broader structural affordability challenges rather than isolated financial hardship.

### Food security

Food security remains a significant challenge in South Los Angeles and is closely tied to broader economic conditions, including income, housing costs and access to affordable, nutritious food.

Food insecure households in SPA 6:<sup>54</sup>

- **41.0%** of households experience food insecurity compared to 25.4% in Los Angeles County.
- **40.7%** of individuals experience food insecurity compared to 26.3% countywide.

These rates highlight the extent to which many residents face ongoing challenges in consistently accessing enough food.

Among low-income residents (below 200% of the FPL), food insecurity remains acute—even among those eligible for assistance. Nearly half (48.2%) report being unable to afford food.<sup>55</sup>

Many households rely on public assistance:

- **39.8%** participate in CalFresh
- **57.2%** of children age 6 and under receive Women, Infants and Children (WIC) benefits

Access to assistance, however, does not fully offset financial strain. Additionally:

- **16.9%** of immigrant residents report avoiding public benefits due to concerns about impacts on immigration status.<sup>55</sup>

### Public program participation, population < 200% FPL<sup>55</sup>

	SPA 6	Los Angeles County
Not able to afford food	48.2%	43.1%
CalFresh (food stamp) program participants	39.8%	32.4%
WIC usage among children, ages 6 and younger	57.2%	53.9%
Avoided government benefits (asked of all immigrants, regardless of income) in the past year, due to concerns over green card disqualification for self or a family member	16.9%	10.5%

To address food insecurity among patients in SPA 6 with chronic conditions, MLKCH developed the Recipe for Health (RFH) program, which provides no-cost produce packages, nutrition education and support through a doctor’s referral. The program focuses on patients with conditions such as diabetes, hypertension, heart disease and obesity.

Findings from program participants suggest that food insecurity may be even more severe among patients managing chronic, food-related conditions than in the broader community.<sup>56</sup>

<sup>54</sup> Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, Los Angeles County Health Survey, 2023; <http://www.publichealth.lacounty.gov/ha/LACHSDDataTopics2023.htm>

<sup>55</sup> UCLA Center for Health Policy Research, Los Angeles, CA. California Health Interview Survey, 2020–2024, pooled. <http://ask.chis.ucla.edu/>

<sup>56</sup> MLKCH staff, RFH Screenings spreadsheet, 2022–2024.

Over a 3-year period, out of more than 700 participants:

- **77.3%** reported that the food they purchased did not last and they lacked money to buy more.
- **68.8%** reported cutting or skipping meals due to cost.
- **57.1%** reported being hungry but not eating due to lack of resources.
- **More than 80%** reported limited access to healthy food or an inability to afford balanced meals.

### Neighborhood and built environment

The physical environment plays a critical role in shaping health outcomes in South Los Angeles. Community input consistently highlights disproportionate exposure to environmental hazards, including chronic air pollution, extreme heat, substandard housing conditions and gaps in basic infrastructure.

Residents describe living in areas with high concentrations of environmental stressors, including proximity to major freight corridors, freeways and flight paths. These conditions contribute to sustained exposure to pollutants that negatively impact respiratory and cardiovascular health.

**“We live in a community that has overexposure and under protection from toxic chemicals... There’s a lot of air quality issues.”**

– Community member

Recent environmental events have further intensified these concerns. The Eaton and Pacific Palisades wildfires in early 2025 contributed to extended periods of poor air quality across the region, with potential long-term impacts related to smoke exposure, chemical contaminants and soil toxicity.

Air quality in Los Angeles County remains a significant concern. In 2023, the average annual concentration of fine particulate matter (PM<sub>2.5</sub>) was 11.1 micrograms per cubic meter compared to 8.4 statewide. The county also experienced 70 days in which ozone levels exceeded federal standards compared to 11 days statewide.<sup>57</sup>

### Air quality measurements, Los Angeles County<sup>57</sup>

	Los Angeles County	California
Annual average micrograms of particulate matter per cubic meter of air	11.1	8.4
Ozone levels above standards, in days	70	11

### Access to parks and recreational space

Access to safe parks and recreational spaces is associated with increased physical activity, improved mental health and better overall health outcomes. Access, however, remains uneven across the service area.

In SPA 6, 61.6% of residents report having easy access to a park, playground or safe place to play compared to 82.1% countywide. Access is particularly limited in the South, Southeast and Southwest Health Districts.<sup>58</sup>

### Easy access to safe park/playground/other place to play, Los Angeles County, by demographics<sup>58</sup>

Health District	Percent
Compton Health District – SPA 6	72.6%
South Health District – SPA 6	58.3%
Southeast Health District – SPA 6	53.7%
Southwest Health District – SPA 6	59.6%
<b>SPA 6</b>	<b>61.6%</b>
<b>Los Angeles County</b>	<b>82.1%</b>

<sup>57</sup> California Air Resources Board, Air Quality Data Statistics, iADAM: Air Quality Data Statistics, March 2025; data from 2023. <http://www.kidsdata.org>

<sup>58</sup> Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, Los Angeles County Health Survey, 2023. <http://www.publichealth.lacounty.gov/ha/LACHSDataTopics2023.htm>

## Transportation

Transportation plays an important role in access to employment, healthcare and other essential services. In SPA 6, commuting patterns reflect a mix of private vehicle use, shared transportation and public transit reliance.<sup>59</sup>

In SPA 6:

- **68.1%** of workers drive alone to work.
- **12.0%** carpool.
- **7.3%** use public transportation compared to 4.2% in Los Angeles County.
- **7.2%** work from home compared to 15.2% countywide.
- **5.4%** walk or use other means.
- The average commute time is **32.8 minutes**, which is longer than both county and state averages.

Higher reliance on public transportation and lower rates of remote work may limit flexibility in accessing healthcare and other services. Longer commute times can also contribute to time constraints that affect appointment attendance and continuity of care.

Access to a reliable vehicle is an important factor in navigating daily life and accessing care. In the service area, 12.4% of households do not have access to a vehicle<sup>60</sup>—higher than Los Angeles County (8.7%) and California (7.0%). Households without a vehicle may face additional barriers to accessing healthcare services, employment opportunities and other essential resources.

## COMMUNITY PERSPECTIVES ON IMMIGRATION-RELATED CONCERNS



“Patients will not come pick up prescriptions because they are nervous that they would get pulled over by [immigration enforcement].”

“We have had days where patients cancel their appointments or don’t show up.”

“Some people are worried about adding their dependents to coverage... information could be requested by the government.”

“That creates a lot of stress on people ... we all are on alert right now.”



## Immigrant status

Immigration status and citizenship can influence access to healthcare, public benefits and overall health outcomes. In the MLKCH service area, 35.8% of residents are foreign-born—higher than both Los Angeles County (33.4%) and California (26.7%). Among foreign-born residents, 62.2% are not U.S. citizens.<sup>61</sup>

Non-citizen status does not indicate undocumented status. But it may still affect eligibility for certain programs and influence how individuals engage with healthcare and social services.

Stakeholders highlight the ways in which immigration-related concerns can affect daily life, including perceptions of safety, economic stability and willingness to access services.

Community members and providers describe how fear, anxiety and uncertainty related to immigration enforcement may reduce engagement with healthcare services, delay care and contribute to unmet health needs. These concerns are closely tied to broader impacts on mental health, chronic stress and financial stability for individuals and families.

<sup>58</sup> U.S. Census Bureau, “American Community Survey 5-Year Estimates: Comparison Profiles 5-Year,” 2019–2023, DP03. <https://data.census.gov/>

<sup>59</sup> U.S. Census Bureau, “American Community Survey 5-Year Estimates: Comparison Profiles 5-Year,” 2019–2023, DP04. <https://data.census.gov/>

<sup>60</sup> U.S. Census Bureau, “American Community Survey 5-Year Estimates: Comparison Profiles 5-Year,” 2019–2023, DP02. <https://data.census.gov/>

<sup>61</sup> Cal Hospital Compare, Martin Luther King, Jr. Community Hospital: Maternity Care Performance Measures. <https://calhospitalcompare.org/hospital/?id=106191230&n=Martin+Luther+King%2C+Jr.+Community+Hospital#motherbaby>

# Conclusion

We are honored to serve the South Los Angeles community. Our vision is to build health equity and expand access to affordable, high-quality care. Additional information about MLKCH's CHNA can be referenced in the appendices below.





Evaluation of impact:  
2023 Community Benefit  
Implementation Strategy

# MLKCH'S 2023 CHNA INITIATIVES

The 2023 MLKCH CHNA identified six priority areas reflecting the most pressing health and social challenges in South Los Angeles.

In response, MLKCH developed an Implementation Plan outlining the strategies and interventions to address these priorities from 2023 to 2026.

The six priority areas include:

- 1 Access to preventive, primary and specialty care**
- 2 Behavioral health**
- 3 Management of chronic health conditions**
- 4 Cultural alignment of care**
- 5 Homeless health**
- 6 Social determinants of health**

Over the past 3 years, MLKCH has advanced a range of programs, partnerships and care delivery strategies aligned with these priorities. Building on this effort, MLKCH further strengthened its approach through the launch of its inaugural Community Advisory Council, bringing together leaders from nonprofit, business, faith-based, education and media organizations to serve as advisors to MLKCH leadership. The council provides insight on community priorities, identifies barriers to care and helps inform strategies to improve access, equity and health outcomes.

The following section outlines key initiatives, actions taken and progress toward improving health outcomes in the community.



## Access to preventive, primary, and specialty care

<b>Priority health need</b>	Adequate access to a broad range of medical resources and doctors in primary care, specialty care and surgical services.
<b>Goal</b>	To increase access to preventive, primary and specialty health care for residents in medically underserved communities.
<b>Impact</b>	<ul style="list-style-type: none"> <li>▪ Expanded access to primary and specialty care services in South Los Angeles.</li> <li>▪ Improved retention and recruitment of doctors across all specialties.</li> <li>▪ Increased access to health insurance resources.</li> </ul>
<b>Programs and strategies achieved</b>	
<b>Telehealth</b>	MLKCH’s telehealth services—or video and telephone visits—expanded access to care for 6,890 patients, with more than 12,000 visits completed since 2023.
<b>Capacity expansion</b>	<p>From 2023 to 2026, we expanded our facilities, staffing and infrastructure to increase capacity for specialized medical services, including mobile health.</p> <p>During this time, MLKCH recruited 14 additional doctors to expand our services across 21 specialties. As of fiscal year (FY25), 55 doctors delivered care to more than 13,600 patients—representing a 48% increase from the prior year.</p>
<b>Maternal and infant health</b>	<p>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 – such as the African American Infant and Maternal Mortality (AAIMM) and WIC programs – as well as adding pediatricians to our care centers. Additionally, we improved access to comprehensive family planning and contraceptive services.</p> <p>More than 350 mothers were served through education programs, including our First 48 Hours class, Mommy Support Group and Prenatal Lactation class.</p>
<b>Health insurance enrollment</b>	From 2023–2026, MLKCH helped over 9,500 patients obtain health insurance coverage.
<b>Financial assistance</b>	MLKCH provides eligible low-income individuals with free and discounted healthcare services through its financial assistance (charity care) policy. Charity care totaled \$46 million in the past year, representing about half of MLKCH’s community benefit contribution. Financial assistance continues to comprise more than half of the community benefit contribution each year.
<b>Connect community to medical homes</b>	Access to specialty care is critical to managing conditions like diabetes, COPD and heart disease. Over the past 3 years, MLKCH helped more than 800 residents establish medical homes and get connected to primary and specialty providers. Additionally, 83% of patients successfully attended scheduled appointments.
<b>Transportation to health appointments</b>	MLKCH provided patients with 470 courtesy roundtrip rides using UberHealth, investing approximately \$13,000 to reduce transportation barriers.

## 2 Behavioral Health

<b>Priority health need</b>	High prevalence of mental health and substance use disorder, with limited access to treatment.
<b>Goal</b>	To increase access to behavioral health services and resources.
<b>Impact</b>	<ul style="list-style-type: none"> <li>■ Increased number of qualified behavioral health providers and support teams serving South Los Angeles.</li> <li>■ Increased referrals to mental health and substance use services.</li> </ul>
<b>Programs and strategies achieved</b>	
<b>Integrated Behavioral Health (IBH) Program</b>	<p>Patients are assessed at the first point of contact to identify any potential links between a chronic medical condition and any behavioral health concerns, allowing for early intervention if necessary.</p> <p>MLKCH improved clinical outcomes in patients with underlying mental health and substance use co-morbidities by connecting patients to behavioral health specialists and medical homes.</p> <p>More than 7,000 patients were connected to behavioral health services, with 470 referred to outpatient providers and treatment programs. The program also distributed approximately 350 doses of Narcan to help prevent opioid overdose deaths.</p> <p>Since 2023, MLKCH has hired 3 Licensed Clinical Social Workers (LCSWs) and 1 clinical psychologist.</p>
<b>IBH Program—telehealth</b>	Improved access to mental health and substance use services using telehealth consults with behavioral health specialists. Telehealth behavioral health services have expanded access for nearly 500 patients.
<b>EmpATH Unit</b>	MLKCH is also expanding behavioral health capacity through the development of its EmpATH (Emergency Psychiatric Assessment, Treatment and Healing) unit, designed to provide specialized, patient-centered care for individuals experiencing mental health crises.

### 3 Management of chronic health conditions

**Priority health need** In South LA, there’s a high prevalence of chronic conditions, such as diabetes, hypertension and obesity. Inability to manage these conditions effectively results in poor health outcomes and higher costs of care.

**Goal** To improve chronic disease management, increase health education and promote healthier lifestyle habits amongst South LA residents.

**Impact**

- Increased prevention practices and referrals to treatment for chronic diseases.
- Reduced reliance on emergency care through education and screening.

#### Programs and strategies achieved

**Chronic Condition Management Programs**

Through the Diabetes Outpatient Management Program, MLKCH offered quality services and comprehensive outpatient resources to approximately 800 patients in FY25. Care included medication management, blood pressure control, retinal exams, kidney monitoring and lifestyle support.

By year four, 85% of patients achieved HbA1c control and 74% achieved blood pressure control—both exceeding national and regional benchmarks. Diabetes-related amputations among intensive management patients fell to zero. To date, the program has served nearly 6,000 outpatients overall.

MLKCH’s inpatient diabetes management program also improved outcomes by reducing severe hypoglycemic events by 28% and severe hyperglycemic events by 26%, while contributing to shorter lengths of stay, fewer readmissions and lower overall costs of care.

**Community health screenings—Know Your Basics & ManUp! community programs**

MLKCH has provided community residents with free health screenings, resources and health education through monthly outreach and engagement efforts. Since 2023, MLKCH’s main outreach programs (Know Your Basics and ManUp! For Your Health) have provided screenings and health education to over 3,300 community members at community events and over 30,000 people through mailers and e-blasts.

## 4 Homeless health

<b>Priority health need</b>	Nearly 25% of the homeless population in SPA 6 have a chronic illness with poorly managed health conditions.
<b>Goal</b>	To improve access to healthcare, housing and other social services to this population so they can better manage and stabilize their health.
<b>Impact</b>	<ul style="list-style-type: none"> <li>■ Increased access to quality healthcare for homeless individuals will result in improved self-management and an enhanced quality of life.</li> <li>■ Expanded street-based medical services to people experiencing homelessness.</li> <li>■ Increased support navigating social services and basic needs.</li> </ul>
<b>Programs and strategies achieved</b>	
<b>Street medicine</b>	<p>Over the past three years, MLKCH conducted more than 4,700 street-based medical visits for nearly 640 patients experiencing homelessness, including direct medical care and consultative services.</p> <p>During this period, nearly 100 individuals were connected to housing and other social services. MLKCH also expanded the program by doubling the number of street medicine teams and increasing the patient panel. Today, each team serves approximately 150 patients per week.</p> <p>To support increasing demand, the Street Medicine program expanded from one team to three active teams and added two nurse practitioners, four outreach coordinators, one physician and one medical assistant.</p>
<b>Post-discharge homeless care</b>	MLKCH also helped link patients experiencing homelessness to immediate care management services. More than 18,500 social work consults were completed, supporting over 5,800 patients with safe discharge and connections to services.

## 5 Cultural alignment of care

**Priority health need** The residents of South Los Angeles are facing a scarcity of healthcare providers who resemble the diverse population and can care for residents in their preferred language and through the lens of their culture.

**Goal** To reduce racial, economic, ethnic and social disparities in the community by expanding the knowledge and diversity of culturally aware staff within our health system.

**Impact**

- Increased access to culturally appropriate care.
- Increased trust of the health system within our community by attracting a diverse and culturally-competent staff.

### Programs and strategies achieved

**Internal Medicine Residency Program** MLKCH offers a three-year Internal Medicine residency program with a strong emphasis on healthcare equity, social medicine and caring for underserved communities.

Since its inception, the program has trained 15 residents through hands-on clinical experience serving patients in South Los Angeles. Every resident in the program is a person of color, and four of the five residents in the Spring 2025 cohort are now employed by MLK Community Medical Group, continuing to serve patients in the community.

The residency program welcomes five new residents each year, helping expand physician training opportunities in South Los Angeles and contributing to efforts to address longstanding physician shortages in the region.

**MLKCH Center for Advancing Safety Net Healthcare** MLKCH established the Center for Advancing Safety Net Healthcare in 2024, focusing 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. Our recent work has led to publications and regional partnerships with academic medical centers and cancer institutes that are in service of the MLKCH mission.

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.

We are committed to creating a healthier, more equitable future—one that is grounded in data, compassion and a commitment to justice in healthcare.

**COPE Health Scholar and Care Navigator Program** MLKCH continues to enroll scholars and community members to the COPE program for healthcare navigation support and hands-on healthcare experience. More than 180 scholars have participated, with many continuing into healthcare careers or employment at MLKCH.

**Career Fellows Program** In the last 3 years, the Career Fellows high school internship has benefited about 30 high school students from the community of South Los Angeles and established over 12 school partnerships with MLKCH.

South LA students are paired with a mentor and gain opportunities to receive non-clinical, clinical and research experience to encourage careers in healthcare.

## 6 Social determinants of health

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

**Goal** To improve access to social services and support healthy living environments.

**Impact**

- Improved self-management and quality of life by increasing access to social resources.
- Expanded access to healthy foods and nutrition education.
- Increased access to housing support.

### Programs and strategies achieved

**Supporting basic needs for homelessness** From 2023–2026, MLKCH helped over 6,500 individuals experiencing homelessness access housing, food, toiletries, clothing and support available through Measure H and other public initiatives.

**Recipe for Health food access program** MLKCH has provided residents with access to healthy and affordable foods through health education and peer support of our food access program, Recipe for Health. To date, 970 patients enrolled, receiving more than 16,300 produce packages. The program achieved an 85% improvement in clinical outcomes among participants.

**Home Paramedicine Program** MLKCH continues to help post-discharge patients receive follow-up care and health education at home through its Home Paramedicine Program.

Nearly 2,000 visits supported approximately 1,000 patients post-discharge, reducing unnecessary ED visits and improving continuity of care.

The program's service area extended up to 30 miles from the hospital. Most patients were located within a 10-mile radius, allowing them to save driving time for medical care and follow-up appointments.

## DATA AND METHODS

The CHNA process benefits MLKCH by guiding the prioritization of community health needs and shaping community partnerships in alignment with quantitative and qualitative data-driven assessment results.

**Secondary data:** Using publicly available data sources and relevant hospital-specific data, we determined a list of significant health needs. We developed the list through a review of health indicator data with rates less favorable than benchmark regions, such as Los Angeles County or the state of California. The list was reviewed by MLKCH leadership, who acknowledged the overlap of significant health needs and institutional priorities.

Secondary data sources, included but were not limited to:

U.S. Census Bureau, CHIS, Los Angeles County Department of Public Health, Los Angeles County Homeless Service Authority, California Department of Education, California Healthy Places Index, California Air Resources Board, California Office of Environmental Health, the CDC and MLKCH.

In the tables provided throughout this document, data highlighted in blue indicates worse outcomes than Los Angeles County or California.

**Primary data:** Primary data was collected directly from stakeholders through interviews and an electronic survey. A set protocol ensured a unified approach to interviews. Additionally, we asked stakeholders to complete a survey to prioritize the significant health needs. Primary data deepens MLKCH's understanding of significant health needs and how they are experienced in the community. Throughout the document, primary data, shared as "community input," is included to complement and highlight secondary data.

Data limitations include the following:

- Differences in availability of data for race, ethnicity, socioeconomic status, gender and age for some data indicators, which, when available, provide more information on health disparities.
- A time-lag for publicly available data, which does not allow for the most up-to-date analyses.

## EXISTING RESOURCES AND ASSETS

South LA's greatest assets are not material, but relational – rooted in people, families, community organizations and institutions that have endured decades of disinvestment and disruption. These assets enable communities to withstand adversity, respond collectively to crises and support health and stability despite persistent challenges. Additionally, a network of trusted community-based and public health systems supports residents who seek help and referral information for health and social needs. Schools, Federally Qualified Health Centers (FQHCs) and community clinics, hospitals and health systems, victim services and legal support, and community-based organizations and informal networks all power the sentiment of community strengths and assets.

## COMMUNITY RESOURCES

Please see Appendix C for a list of resources in the community.

## APPENDIX A: BENCHMARK COMPARISONS

Healthy People 2030 identifies public health priorities to help individuals, organizations and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over its first four decades. Where data were available, hospital service area health and social indicators were compared to the Healthy People 2030 objectives. The bolded/highlighted indicators did not meet established benchmarks; non-bolded items meet or exceed benchmarks.

Health indicators	MLKCH service area data	Healthy People 2030 objectives
High school graduation rate	85.2%–92.8%	90.7%
Health insurance rate, all ages	86.8%	92.4%
Ischemic heart disease deaths	116.9	71.1 per 100,000 persons
Cancer deaths	141.5	122.7 per 100,000 persons
Colorectal cancer death	13.7	8.9 per 100,000 persons
Lung and bronchus cancer deaths	21.1	25.1 per 100,000 persons
Female breast cancer deaths	20.2	15.3 per 100,000 persons
Prostate cancer deaths	27.9	16.9 per 100,000 persons
Stroke deaths	44.7	33.4 per 100,000 persons
Unintentional injury deaths	46.4	43.2 per 100,000 persons
Suicides	5.8	12.8 per 100,000 persons
Liver disease (cirrhosis) deaths	20.5	10.9 per 100,000 persons
Homicides	15.7	5.5 per 100,000 persons
Drug-overdose deaths	19.9	20.7 per 100,000 persons, age-adjusted rate
Overdose deaths involving opioids	20.8	13.1 per 100,000 persons
Infant death rate	4.5	5.0 per 1,000 live births
Obese adults, ages 20 and older	43.2%	36.0% adults, ages 20 and older
Obese teens, ages 12 to 17	22.9%	15.5% of children and teens, ages 2 to 19
Adults who self-report needing and seeking mental health care, who receive care	54.5%	Adults with a serious mental disorder who receive treatment: 68.8%
Adults engaging in binge drinking	17.5%	25.4% in past month
Cigarette smoking by adults	5.8%	6.1%
Annual adult influenza vaccination	44.8%–59.1%	70.0%
Pap smears, ages 21 to 65, screened in the past 3 years	55.3%–77.3%	79.2%
Mammograms, ages 50 to 74, screened in the past 2 years	66.3%–95.5%	80.3%
Colorectal cancer screenings, ages 50 to 74, screened per guidelines	48.2%	72.8%

# APPENDIX B: COMMUNITY STAKEHOLDERS

Name	Title	Organization
1. Sonya Young Aadam	Chief Executive Officer	California Black Women's Health Project
2. Jerry P. Abraham, MD, MPH, CMQ, PC	Director of Public Health, Integration & Street Medicine, CDU-KEDREN; Professor of Psychiatry and Family & Community Medicine	Kedren Community Health Center; Charles Drew University of Medicine & Science
3. Brandi Bakewell	Executive Vice President	The Los Angeles Sentinel and Bakewell Company
4. Oscar F. Casillas, MD	Medical Director of Emergency Medicine	MLKCH
5. Anahiz Correa, MPH, RN, NEA-BC	Senior Director of Critical Care Services	MLKCH
6. Gloria J. Davis	Executive Director	Girls Club of Los Angeles
7. Janette Robinson Flint	Executive Director	Black Women for Wellness LA
8. John Fisher, MD, MBA	Chief Medical Officer	MLKCH
9. PK Fonsworth, MD, MBA	Addiction Psychiatrist	MLKCH
10. Stanley K. Frencher, Jr. MD, MPH	Medical Director, Surgical Outcomes and Quality	MLKCH
11. Sarah R. Harris	President and Chief Executive Officer	Black Business Association
12. Victoria Gichohi	Program Manager	Compton Community Health Professions Partnerships
13. Renee Henderson	Member Care Manager	Community Coalition
14. Daisy Iniguez	Victims Services Representative	Los Angeles District Attorney's Office
15. Clayton Kazan, MD, MS, FACEP, FAEMS	Medical Director	Los Angeles County Fire Department
16. Jan King, MD, MPH	Area Health Officer, SPA 5 and SPA 6	LA County Department of Public Health
17. Katrina Kubicek	Senior Project Manager	Housing Authority of the City of Los Angeles (HACLA)
18. Maita Kuvhenguhwa, MD	Doctor, Infectious Disease; Assistant Program Director Internal Medicine Residency Program	MLKCH
19. Kandee Lewis	Executive Director; Vice Chair	Positive Results Center; Civil and Human Rights Commission, City of Los Angeles
20. Alex Li, MD	Deputy Chief Medical Officer	L.A. Care
21. Victor Luna	Organizational Facilitator	Los Angeles Unified School District
22. Jesse Lynwood III, MSN, RN, PHN	Director of Emergency Department and Clinical Observation Area	MLKCH
23. Jim Mangia, MPH	Chief Executive Officer	St. John's Well Community Health
24. Patrick Meehan, MD	Ambulatory Services Medical Director	MLKCH
25. Latricia T. Mitchell	President	NAACP Los Angeles
26. Jessica Nunez, LCSW, MPH	Director of Social Services and Street Medicine	MLKCH
27. Kurt Petersen	Co-President	UNITE HERE - Local 11
28. Nubar Petikyan, PharmD	Director, Clinical Operations and Strategy Disease Management, Laboratory, Pharmacy Services	MLKCH
29. Jason E. Prasso, MD	Director of Internal Medicine Residency Program; Medical Director of Pulmonology Function Laboratory and Associate Medical Director of the Intensive Care Unit	MLKCH
30. Lydia Ramirez	Executive Director	St Louise Resource Services
31. Kristin Reeg	Executive Director, Health Fund	UNITE HERE - Local 11
32. Jorge Reyno, MD, MHA	Senior Vice President Population Health	MLKCH
33. Deborah Riddle	Executive Board Secretary	Watts Gang Task Force Council
34. Rev. William D. Smart, Jr.	President and CEO	Southern Christian Leadership Conference of Southern California
35. Ron Tanimura, EdD	Director, Student Health Services	Los Angeles Unified School District
36. Rev. Robert L. Taylor, Th.D.	Senior Pastor	Beulah Baptist Church
37. Sarat J. Varghese, MD	Medical Director of Street Medicine	MLKCH
38. Andrea Williams, MPA	Executive Director	Southside Coalition of Community Health Centers
39. Nisha S. Zala, PharmD	Pharmacist Owner; Bedside Delivery Pharmacist	West Alondra Medical Pharmacy and Wilmington Pharmacy; MLKCH

# APPENDIX C: COMMUNITY RESOURCES

Health need	Community resources
<b>Access to care</b>	Angels for Sight, Cedar Sinai Medical Center COACH for Kids, Central City Community Health Center Inc., Dollarhide Health Center, Eisner Health, Hubert H. Humphrey Comprehensive Health Center, JWCH Institute, Inc. (Wesley Health Centers), Kedren Health, Lestonnac Free Clinic: Dental, Los Angeles Christian Health Centers, Los Angeles LGBT Center – Center South, Martin Luther King Community Medical Group, Martin Luther King Jr. Public Health Center, Molina Health Center: El Camino College Compton Center, National University Nurse Managed Clinic, Optometric Center of Los Angeles, ROADS Community Clinic, South Central Family Health Center, Southside Coalition of Community Health Centers, St. John’s Community Health, T.H.E. (To Help Everyone) Health and Wellness Centers, UMMA (University Muslim Medical Association) Health, Venice Family Clinic, Watts Healthcare Corporation, West Alondra Medical Pharmacy
<b>Birth indicators</b>	African American Infant and Maternal Mortality Prevention Initiative (AAIMM), Black Infant Health Program, Black Infants & Families Los Angeles, Black Infants and Families Los Angeles: Expecting Fathers Group, BreastfeedLA, California Abundant Birth Project, California Black Women’s Health, California Health Care Foundation, Charles Drew: The Black Maternal Health Center of Excellence, Cherished Futures for Black Moms & Babies, Communities Lifting Communities: Birth Equity Initiative, First 5 Los Angeles, First 5 Los Angeles Welcome Baby Program, Frontline Doulas, Healthy Families America, Kindred Space LA, Los Angeles County Department of Public Health, Los Angeles County Department of Public Health: Health Promotion Bureau, MAMA’s Neighborhood, Mighty Little Giants, Nurse Family Partnership, Parents as Teachers, Perinatal Equity Initiative, Rising Communities
<b>Chronic diseases</b>	Alzheimer’s Association, Alzheimer’s Los Angeles, American Cancer Society, American Diabetes Association, American Heart Association, Central City Community Health Center Inc., Dollarhide Health Center, Eisner Health, Hubert H. Humphrey Comprehensive Health Center, JWCH Institute, Inc. (Wesley Health Centers), Kedren Health, Los Angeles Christian Health Centers, Los Angeles LGBT Center: Center South, Martin Luther King Community Medical Group, National University Nurse Managed Clinic, ROADS Community Clinic, South Central Family Health Center, St. John’s Community Health, T.H.E. (To Help Everyone) Health and Wellness Centers, UMMA (University Muslim Medical Association) Health, Venice Family Clinic, Watts Healthcare Corporation
<b>Economic security/ poverty</b>	Brotherhood Crusade, Fix L.A., Los Angeles Black Worker Center, National Coalition of 100 Black Women Inc. - Los Angeles Chapter, Physicians for Social Responsibility Los Angeles, St. Anne’s Family Services, St. Louise Resource Center, Sisters of Watts, Strategic Actions for a Just Economy (SAJE), TRUST South L.A., Watts Labor Community Action Committee
<b>Education</b>	Brotherhood Crusade, California Black Women’s Health Project, Charles Drew University Pipeline Programs, Coalition for Responsible Community Development, Community Coalition, Compton Advocates Coalition, Compton Girls Club, LAWDP Utility Pre-Craft Trainee, Los Angeles Black Worker Center, Los Angeles Equity Alliance, Los Angeles Job Corps, Los Angeles Trade-Technical College, Los Angeles Urban League, Martin Luther King Community Hospital COPE Health Scholars, Maxine Waters Employment Preparation Center, MudTown Farms, PVJOBS, South Los Angeles Worksource Center, Southeast Los Angeles County Workforce Development Board, Think Watts Foundation, Unearth & Empower Communities, Watts Empowerment Center, Watts Labor Community Action Committee

<b>Environmental health</b>	500 Feet Project, Black Women for Wellness, California Communities Environmental Health Screening Tool, Communities for a Better Environment, Department of City Planning: Clean Up Green Up, Health Atlas for the City of Los Angeles, Los Angeles County, SEE-LA (Sustainable Economic Enterprises of Los Angeles), Los Angeles Food Policy Council, Physicians for Social Responsibility Los Angeles, South LA Eco-Lab, North East Trees, South LA Transformative Climate Communities Program, South Los Angeles Building Healthy Communities, Stand Together Against Neighborhood Drilling LA Coalition, Strategic Concepts in Organizing Policy Education: SCOPE, Tree People, TRUST South L.A., Watts Labor Community Action Committee
<b>Food insecurity</b>	All Peoples Community Center, Alma Backyard Farms, Bethel Missionary Baptist Church of South Los Angeles, Bronsley Community Resource Center, CalFresh - Nutrition Assistance Program (Los Angeles County Department of Public Social Services), First New Christian Fellowship Church Food Bank, Florence-Firestone Community Organization, Food Access Los Angeles, Hurting and Hungry, LA Regional Food Bank, MudTown Farms, Paramount Care Foundation, Project Angel Food, Prosperity Market, Slauson Super Mall, St Agnes Parish Food Pantry, St. Vincent De Paul Church, Think Watts Foundation, Universal Community Health Center Food Pantry, Vance North Necessities of Life Program (NOLP) Food Pantry, Watts Yardeners, Whole Person Care – Los Angeles (WPC-LA), WIC (Women, Infants and Children), Word of Faith Center
<b>Housing and homelessness</b>	1736 Family Crisis Center, A Community of Friends, Coalition for Responsible Community Development (CRCDD), Exodus Recovery Safe Landing, First to Serve Inc., Good Seed Community Development Corporation, Home at Last Community Development Corporation, Homeless Healthcare Los Angeles, Homeless Outreach Program Integrated Care System (HOPICS), Housing Rights Center, Inside Safe, Jordan’s Disciples Community Service, Joshua House for the Homeless, Keck School of Medicine of USC: Street Medicine Program, LA – HOP: Homeless Outreach Portal, Los Angeles Homeless Services Authority (LAHSA), Martin Luther King Community Healthcare Street Medicine, My Friend’s Place, New Image Shelter LA, Project Homekey, Project Peacemakers, Sanctuary of Hope, SHIELDS for Families, Southern California Health & Rehabilitation Program, SPA 6 Homeless Coalition, The People Concern, The Salvation Army, Upward Bound House, Volunteers of America Los Angeles (VOALA) Pathways to Home Shelter, Watts Century Latino Organization, Watts Labor Community Action Committee, Watts Rising, Weingart Center, Wellness Equity Alliance HIV Street Medicine
<b>Infectious diseases</b>	APLA: AIDS Project LA, Central City Community Health Center Inc., Charles Drew University: OASIS Clinic, Dollarhide Health Center, Claris Health, Eisner Health, Hubert H. Humphrey Comprehensive Health Center, JWCH Institute, Inc. (Wesley Health Centers), Kedren Health, Los Angeles Christian Health Centers, Los Angeles LGBT Center – Center South, Martin Luther King Community Medical Group, Martin Luther King Jr. Public Health Center, Molina Health Center: El Camino College Compton Center, ROADS Community Clinic, South Central Family Health Center, St. John’s Community Health, T.H.E. (To Help Everyone) Health and Wellness Centers, UMMA (University Muslim Medical Association) Health, Venice Family Clinic, Watts Healthcare Corporation

<b>Mental health</b>	Amanecer Community Counseling Service, APLA Health, Augustus F. Hawkins Mental Health Center, Central City Community Health Center Inc., Children’s Institute, Inc., Claris Health, Coalition of Mental Health Professionals Inc., Community Family Guidance Center, Compton Mental Health Center, Compton Wellness Collective, Dollarhide Health Center, Eisner Health, Exodus Recovery Inc., Hubert H. Humphrey Comprehensive Health Center, JWCH Institute, Inc. (Wesley Health Centers), Kaiser Permanente Watts Counseling and Learning Center, Kedren Health, Los Angeles Christian Health Centers, Los Angeles County Alternative Crisis Response, Los Angeles County Department of Mental Health, Los Angeles LGBT Center – Center South, Martin Luther King Community Medical Group, MLK Community Healing and Trauma Prevention Center, Martin Luther King Community Hospital EmPATH Unit, National Alliance on Mental Illness (NAMI) Urban Los Angeles, Positive Results Corporation, Psychiatric Mobile Response Team (PMRT), Reverence Project, ROADS Community Clinic, S. Mark Taper Foundation Center - Didi Hirsch, South Central Family Health Center, South Los Angeles Health Project, Southern California Health & Rehabilitation Program, St. John’s Community Health, Systemwide Mental Assessment Response Team (SMART), UMMA (University Muslim Medical Association) Health, Venice Family Clinic, Watts Healthcare Corporation, West Central Family Mental Health Services
<b>Overweight and obesity</b>	Black Women for Wellness, Boys and Girls Clubs of Metro Los Angeles – Watts/Willowbrook, Cedars-Sinai Medical Center Healthy Habits Program, Choose Health LA, Compton Run Club, Eastside Riders Bike Club, Girls Club of Los Angeles, Martin Luther King Community Health RFH, Prosperity Market, South Los Angeles Health Councils, South Los Angeles Health Projects, YMCA
<b>Preventive care</b>	Black Barbershop Health Outreach Program: Charles Drew University, Cedar Sinai Medical Center COACH for Kids, Central City Community Health Center Inc., Dollarhide Health Center, Eisner Health, Every Woman Counts Program, Hubert H. Humphrey Comprehensive Health Center, JWCH Institute, Inc. (Wesley Health Centers), Kedren Health, Los Angeles Christian Health Centers, Los Angeles LGBT Center – Center South, Martin Luther King Community Medical Group, Martin Luther King Jr. Public Health Center, Molina Health Center: El Camino College Compton Center, National University Nurse Managed Clinic, Planned Parenthood, ROADS Community Clinic, South Central Family Health Center, St. John’s Community Health, T.H.E. (To Help Everyone) Health and Wellness Centers, UMMA (University Muslim Medical Association) Health, Venice Family Clinic, Watts Healthcare Corporation
<b>Substance use and misuse</b>	Aegis Medical Systems Inc., Alcoholics Anonymous, Asian American Drug Abuse Program, Inc. (AADAP), Avalon Carver Community Center, BAART Programs, Canon Human Services Centers Inc., Central City Community Health Center Inc., Dollarhide Health Center, Eisner Health, Exodus Recovery Inc., His Sheltering Arms Inc., House of Uhuru, Hubert H. Humphrey Comprehensive Health Center, JWCH Mini House Residential Treatment, Kedren Health, L.A. CADA, Los Angeles Christian Health Centers, Martin Luther King Community Medical Group, Matrix Institute on Addictions, Narcotics Anonymous, People Coordinated Services of Southern California, Inc., ROADS Community Clinic, SHIELDS for Families, South Central Family Health Center, Southern California Alcohol and Drug Programs, Inc., South Los Angeles Movement Prevention Coalition, Special Service for Groups Inc., St. John’s Community Health, Stars Behavioral Health Group, Substance Abuse and Mental Health Services Administration (SAMHSA), T.H.E. (To Help Everyone) Health and Wellness Centers, Tarzana Treatment Centers, UCLA Addiction Psychiatry Clinic, UMMA Health, Venice Family Clinic, Watts Healthcare Corporation, Women for Sobriety



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