MLK Community Healthcare



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COMMUNITY BENEFIT REPORT & PLAN

Fiscal Year 2026
(July 1, 2025–June 30, 2026)
HCAI Hospital ID: 106191230

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MLK Community Healthcare

COMMUNITY BENEFIT REPORT & PLAN

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MESSAGE FROM THE SENIOR VICE PRESIDENT OF POPULATION HEALTH

Each year, our Community Benefit Report provides an opportunity to reflect on the progress we've made alongside our patients, staff and community partners to advance health equity across South Los Angeles. It is also a tool of accountability, demonstrating how we invest our resources, strengthen partnerships and respond to the needs of the community we are privileged to serve. As we conclude our 2024-2026 Community Health Needs Assessment (CHNA) Implementation Strategy, we reflect on another year of meaningful progress toward addressing our community's most pressing health needs.

In FY26, we continued to strengthen access to essential healthcare services by recruiting new providers, expanding primary and specialty care and increasing our use of telehealth. These efforts helped more South LA residents access the care they needed, when and where they needed it. We also advanced initiatives supporting chronic disease management, preventive care and health education, empowering individuals and families to take a more active role in managing their health and well-being.

Our commitment to meeting our patients where they are remains central to this work. Through the expansion of our Street Medicine department, we have reached more people experiencing homelessness with direct medical care and connections to essential community resources. These efforts reflect our understanding that improving health requires addressing not only medical needs but also the social and economic conditions that shape people's lives.

We also continued to demonstrate our commitment to patient safety and quality. Martin Luther King, Jr. Community Hospital earned its sixth consecutive "A" Hospital Safety Grade from The Leapfrog Group, a distinction that reflects the dedication of our staff to providing safe, high-quality care to the communities we serve.

While these accomplishments represent important progress, we recognize that significant challenges remain. South LA continues to experience longstanding inequities in access to care and other resources essential to good health. Findings from our recently published 2026 CHNA will help guide our next implementation period, strengthening our efforts to improve access to care, support behavioral health and chronic disease management, address homelessness and respond to the social drivers of health.

I am proud of what we've accomplished together and grateful to the staff, partners and community members who make this work possible. As we look ahead, we remain committed to building on this progress, deepening our partnerships and advancing a healthier, more equitable future for South LA.



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





ABOUT MLK COMMUNITY HEALTHCARE

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

Our Mission

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

Our Vision

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

Our Values

Caring, Collaboration, Accountability, Respect and Excellence.

MISSION VISION VALUES

Specifically, MLKCH offers:

- **MLK Community Hospital**
  Our 131-bed inpatient facility provides emergency, maternity, general surgery and ancillary services typical of a community hospital.
- **Outpatient care centers**
  We operate multiple outpatient care centers throughout South LA, offering primary and specialty care.
- **Wound care center**
  MLKCH operates South LA's only wound care center with individual hyperbaric chambers for the advanced treatment of nonhealing wounds and other complex health conditions.
- **Community-based care**
  MLKCH offers in-community programs, including health education and screening, mobile healthcare, in-home care and street medicine.



Governance

MLKCH's Board of Directors provides input on the community benefit plan and oversees the hospital's community benefit programs.

Manuel A. Abascal, JD
Partner, Litigation Department, Latham & Watkins LLP

Elaine Batchlor, MD, MPH
CEO, MLK Community Healthcare

Wanda Cole-Frieman
Senior Vice President, Talent Acquisition, CommonSpirit Health

Karen Cox, PhD, RN, FACHE, FAAN
President, Chamberlain University

Thomas Fisher Jr., MD, MPH
Board-certified emergency medicine physician, University of Chicago

Michelle Gaskill-Hames, BSN, MHA
President, Kaiser Foundation Health Plan and Hospitals of Southern California and Hawaii

Paul King, MP, CMPE
President and CEO, Stanford Children's Health

Robert Margolis, MD
CEO Emeritus, Healthcare Partners

Kedar Mate, MD
Founder and Chief Medical Officer, Qualified Health

Ramanathan Raju, MD
Former Senior Vice President and Chief Community Health Investment Officer, Northwell Health



AWARDS & RECOGNITIONS

LEAPFROG HOSPITAL SAFETY GRADE
A
SPRING 2026

CMS
4-STAR RATED

Baby-Friendly USA

Cal Hospital Compare
MATERNITY HONOR ROLL 2023

HIMSS
TOP 6.4%
IN THE NATION FOR TECH

CHIME
HEALTHCARE'S MOST WIRED

ABOUT OUR COMMUNITY

South Los Angeles

South LA is a community rich in cultural legacy, resilience and civic pride. From its agricultural beginnings in the 1700s to its central role in social justice movements and artistic innovation throughout the 20th century, South LA has long been a crucible of change in California. Waves of migration have shaped the dynamic, multilingual and multigenerational communities that call this region home. MLKCH is proud to serve South LA and stand alongside its residents, advocates and local leaders to ensure access to high-quality care and services.

1.3million+

people live in South LA's Service Planning Area 6 (SPA 6)

Vulnerable populations

Today, more than 1.3 million people live in South LA's Service Planning Area 6 (SPA 6), over 90% of whom identify as Black or Latino.

Over 143,000 residents (10.8%) are over age 65.

Among service area adults, 2.3% identify as gay, lesbian or homosexual.

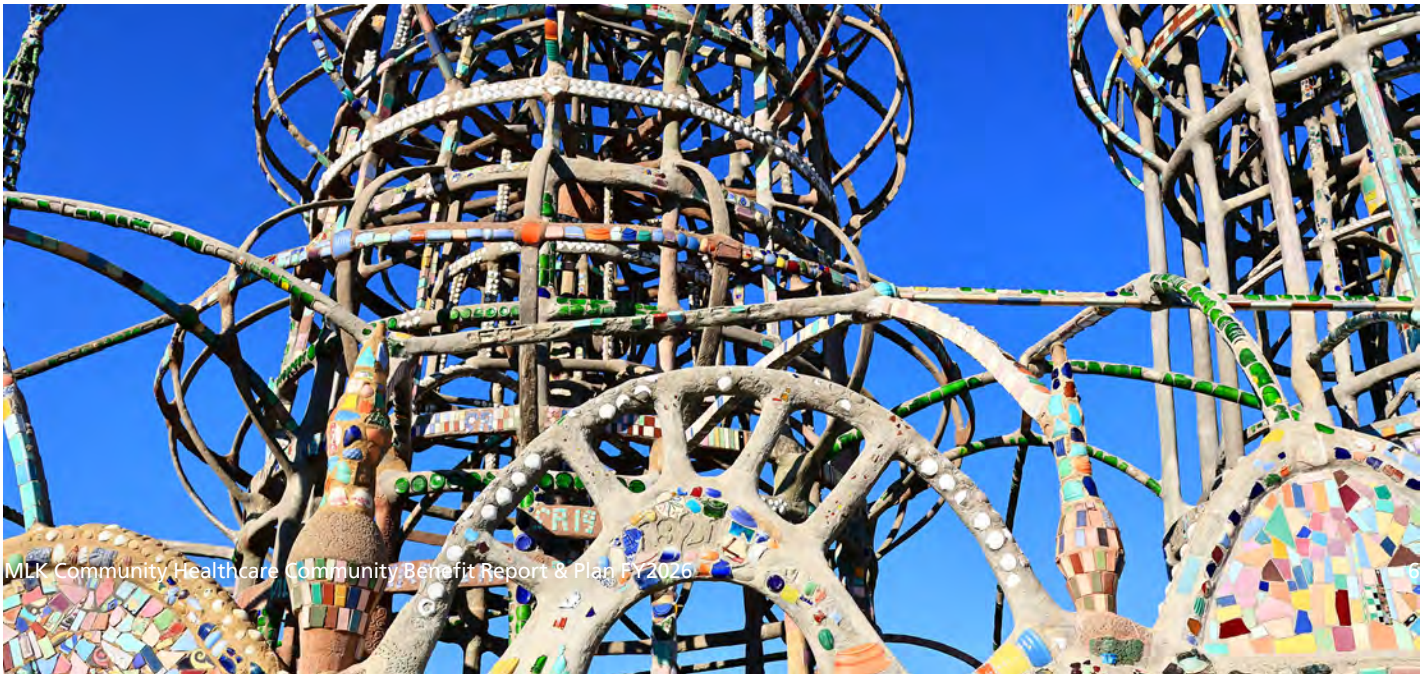
Most residents rely on government-assisted coverage (Medicare or Medi-Cal) for health insurance, a disproportionately higher rate compared to Los Angeles County. Specifically, 71.8% of residents in South LA are covered by Medi-Cal, Medicare or both.

In SPA 6, 20.1% of families live at 100% of the federal poverty level.

Among adults in SPA 6, 44.5% cannot afford food and experience food insecurity.

SPA 6 is located between the Harbor Freeway and Interstate 10, which are major freight routes heavily trafficked by smog-producing trucks traveling to and from the Port of Los Angeles. Air pollutants are known to contribute to respiratory conditions such as asthma, chronic lung disease and lung cancer. The high concentration of corner stores, liquor stores and fast-food chains makes it challenging for residents to make healthier choices.

The California Healthy Places Index (HPI) measures socioeconomic need and correlates with poor health outcomes. For community benefit purposes, California defines vulnerable populations as people living in areas with inadequate access to clean air and safe drinking water, as indicated by an environmental HPI score of 50% or lower. The MLKCH service area ZIP codes have an HPI score of 26.5% for clean environment.



ABOUT OUR COMMUNITY

Health Equity in Context

While the history of this community is vibrant and deeply rooted, decades of systemic disinvestment have contributed to multiple challenges, including a poverty rate nearly double the county average, elevated rates of housing insecurity and fewer options for nutritious food and recreation.

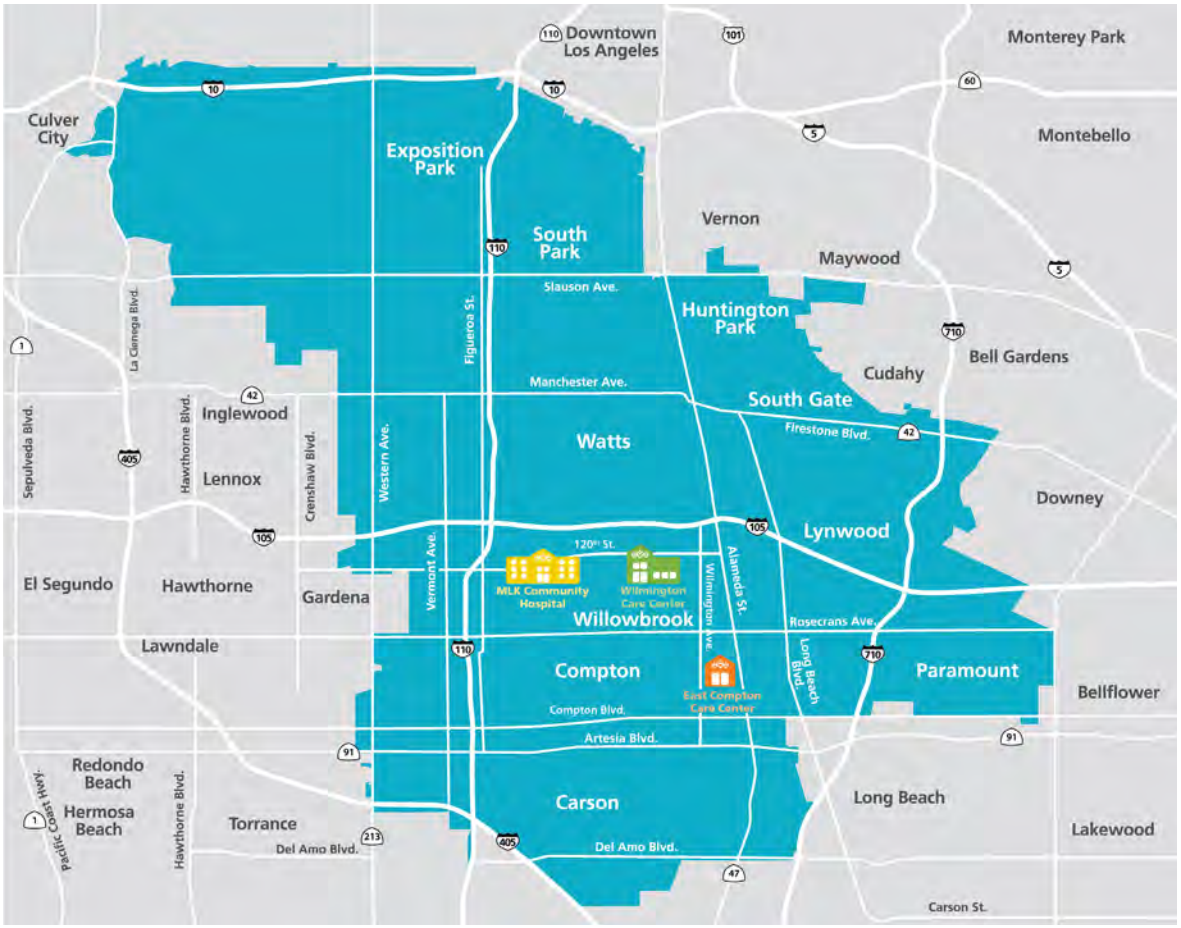
These inequities directly affect health outcomes. SPA 6 has among the highest rates of chronic illness — including diabetes, hypertension, chronic obstructive pulmonary disease (COPD) and heart disease — in Los Angeles County. Life expectancy in parts of South LA is up to 15 years shorter[1] than in more affluent areas just a few miles away.

One of the most urgent challenges is access to care. The region faces a shortage of more than 1,500 physicians, and the federal government has designated large portions of South LA as Medically Underserved Areas or Health Professional Shortage Areas. Without adequate access to primary and specialty care, many residents rely on emergency departments to manage preventable or chronic conditions.

At MLKCH, we are committed to closing these gaps — not only by delivering excellent care but by investing in community-based programs, workforce development and long-term partnerships that advance health equity for all.

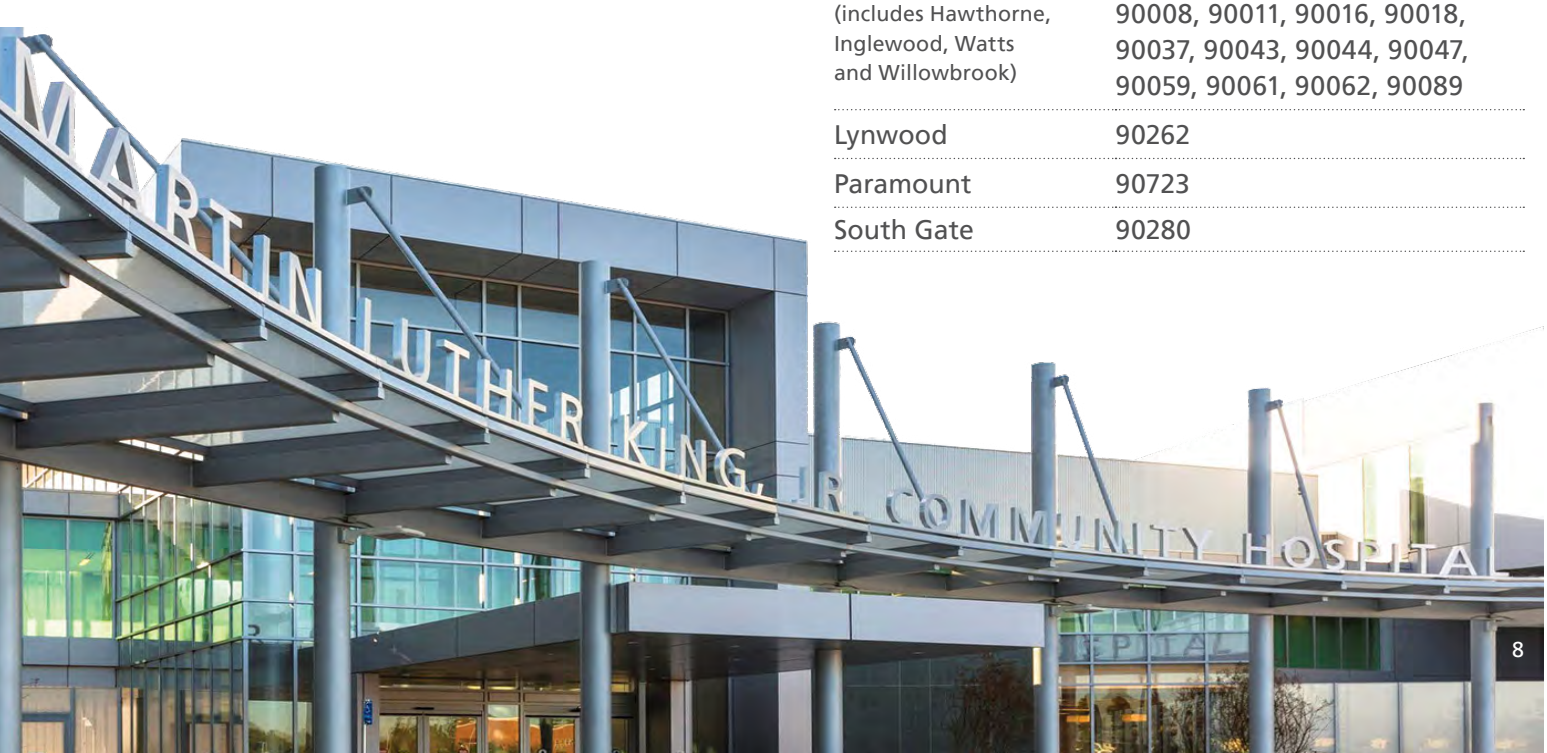
[1]Measure of America, A Portrait of Los Angeles County 2026.





MLK COMMUNITY HEALTHCARE SERVICE AREA

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





COMMUNITY HEALTH NEEDS ASSESSMENT

The **2023 Community Health Needs Assessment (CHNA)** identified priority health needs in the community by analyzing a broad range of social, economic, environmental, behavioral and clinical factors that influence health outcomes. To better understand the overall needs of this community, we reviewed quantitative data from various published sources and compared it with benchmark data at SPA 6, county and state levels, when available. Additionally, we gathered input on existing resources and innovative ideas to address the priority needs from local stakeholders through interviews, written surveys, community convenings and focus groups.

MLKCH developed its **2024–2026 Implementation Strategy**, which focuses on the most significant health needs identified in the CHNA. In collaboration with community partners, MLKCH established six priorities for **Fiscal Year (FY) 2026 (July 1, 2025-June 30, 2026)**:

- Access to preventive, primary and specialty care
- Behavioral health
- Management of chronic health conditions
- Homeless health
- Cultural alignment of care
- Social determinants of health

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

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

COMMUNITY BENEFIT SERVICES FY2026 SUMMARY

Improving the health of our community

Over the past year, MLKCH has expanded access to quality care and health education throughout South LA. In response to the needs identified in the 2023 Community Health Needs Assessment, MLKCH implemented and expanded programs using the framework outlined in the 2024–2026 Implementation Strategy.

1 Access to preventive, primary and specialty care

Increased the number of doctors

We remain committed to providing our community with a larger network of doctors trained in a variety of specialties. Over the past year, we have recruited nine new providers to our outpatient care centers, including specialists in primary care, pulmonology, family medicine, orthopedic surgery, psychology, internal medicine-pediatrics (Med-Peds), infectious disease medicine, interventional cardiology and midwifery.

Expanded access to medical specialists and services

Expanding access to specialty care to manage chronic conditions such as diabetes, heart disease and respiratory disorders has remained a top priority for MLKCH this past year. We expanded our network of medical specialists to better support effective treatment strategies and align with our Implementation Strategy goals of improving access to care and enhancing chronic disease management. MLKCH's 72 providers offered care across 23 specialties:

- Addiction psychiatry
- Cardiology
- Critical care
- Endocrinology
- Family medicine
- Hand surgery
- Infectious disease
- Internal medicine
- Interventional cardiology
- Interventional radiology
- Internal medicine-pediatrics
- Nephrology
- Neurology
- Nurse midwifery
- Obstetrics and gynecology (OB/GYN)
- Orthopedic surgery
- Pediatrics
- Podiatry
- Psychiatry
- Psychology
- Pulmonology
- Urology
- Vascular surgery

MLKCH continued to coordinate care across inpatient and outpatient settings in FY26, with an estimated 32,400 patients accessing primary and specialty medical services at our outpatient care centers, marking a 37% increase from the previous year.

MLKCH provided specialty medical services to over 2,700 new patients during FY26, with 87% maintaining their primary and specialty care appointments at an MLKCH outpatient care center. There was an increase in new patients establishing medical homes and receiving timely care. This growth reflects increased demand and improved capacity across our system, along with strong patient engagement and trust in our care teams.

Public assistance programs

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

Financial assistance and health insurance enrollment

Through our financial assistance services, MLKCH helped over 1,300 patients sign up for Medi-Cal, with approximately 620 approved for healthcare benefits. Additionally, about 3,240 patients were temporarily placed on Medi-Cal while waiting for their applications to be finalized. Altogether, MLKCH helped over 4,500 uninsured and underinsured patients obtain health coverage. The enrollment team also helped community members access CalFresh services to address food insecurity issues.

Telehealth services

MLKCH's telehealth services, accessible by video or telephone, increased South LA residents' access to healthcare and social services in FY26. We provided care for over 4,400 patients, who completed an estimated 9,000 telehealth visits during this time, marking a 56% increase in visits from the prior year. Telehealth services have saved patients driving time and miles traveled compared with in-person doctor visits. By providing telehealth, we reduced the need for emergency department visits and improved access to care for our community.

Transportation assistance

MLKCH offered transportation assistance to eliminate barriers to healthcare access in FY26, supplying nearly 370 courtesy round-trip rides via UberHealth for patients with doctor appointments at MLKCH. MLKCH covered the service cost at about $10,140 for the year.

Maternal and infant health

Expanding prenatal care and postdelivery 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) Prevention Initiative and WIC—and by adding pediatricians to our care centers. Additionally, we improved access to comprehensive family planning and contraceptive services.

In FY26, MLKCH continued to successfully deliver healthy babies at our hospital with our award-winning delivery model. Additionally, MLKCH continued to operate the Lactation Care Center at our East Compton location—the only lactation clinic in South LA offering specialized breastfeeding support to new moms in the community, as well as maternal nutrition and breast pump support in an outpatient setting. The Lactation Care Center also offered prenatal visits, transportation assistance and virtual visit options upon request.

As part of our efforts to expand access to quality care in this community, the Lactation Care Center welcomes all patients, regardless of their insurance status, prior referrals or where they gave birth. In FY26, the Lactation Care Center served 56% of mothers who delivered at MLKCH and an additional 19% who delivered at another birthing facility.

To further support maternal health, our perinatal team offered the following virtual educational and support resources.

- **First 48 Hours** is a free class on what to expect after delivery, including newborn testing, immunizations, changes to the mother's body and breastfeeding education.
- The **Mommy Support Group** is a free weekly peer support group for new mothers in the community. It covers topics such as feeding, maternal nutrition and balancing breastfeeding with work or school.
- The **Prenatal Lactation Class** is led by a Board-Certified Lactation Consultant at the East Compton Care Center. This free class provided prenatal education and breastfeeding support to help new mothers feel prepared for their baby's birth.

Through these resources, our perinatal team provided virtual education to over 380 expectant and new mothers last year.





2 Behavioral health

Integrated behavioral health program

A significant number of MLKCH patients experience behavioral health challenges, often alongside chronic health conditions. In response, MLKCH built upon its innovative Integrated Behavioral Health (IBH) program to address mental health, physical health and substance use disorders. Our staff assessed patients at the first point of contact to identify any potential links between chronic medical conditions and behavioral health concerns. This allowed the MLKCH behavioral health team to intervene early.

Through the IBH program, our staff referred and/or connected over 3,400 patients to behavioral health services and linked 160 patients to outpatient doctors and other treatment programs. Additionally, our team offered 225 patients telehealth consultations to address their behavioral health needs, resulting in about 985 video and phone visits, marking a 13% increase in telehealth visits from the previous year.

To provide safe and effective solutions to patients with opioid use disorder, the IBH program helped distribute 160 doses of the emergency treatment drug Narcan free of charge in FY26, which helped reduce the number of fatal opioid overdoses in the community.

3 Management of chronic health conditions

Intense Disease Management Program

Diabetes, heart disease and kidney disease are common chronic medical conditions among South LA residents. Through the Intense Disease Management Program, MLKCH offered quality services and comprehensive resources to approximately 2,200 participants in FY26. To date, the program has served nearly 6,000 patients, helping them make key lifestyle changes. We also implemented evidence-based measures in their care, such as:

- Blood pressure control
- Retinal eye exams
- Foot exams
- Measures of blood sugar control
- Kidney health evaluation
- Cholesterol and other blood lipid control
- Smoking and tobacco use screening and follow-up

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

Many patients who enrolled in the Intense Disease Management Program received additional patient education, personalized treatment plans, a Health Action Plan (updated quarterly) and a Brief Action Plan. We developed these action plans collaboratively with patients to promote positive health behavior changes and self-management.

Each patient also received dedicated support from our multidisciplinary team that included an endocrinologist, a clinical pharmacist, care coordinators, case managers, a diabetes nurse specialist and community health workers.

As a result, about 81% of these patients with diabetes met their care plan goals, which included maintaining controlled diabetic hemoglobin A1C and glucose levels and achieving environmental stability (such as safe, stable housing). This success reflects the importance of addressing both clinical and social needs to achieve positive outcomes.



Coaching

In FY26, approximately 1,770 participants received personalized diabetes education and coaching through MLK Community Medical Group (MLK CMG). The program supports community members who have established care with an MLK CMG primary care provider, helping them build the knowledge and skills to better manage their diabetes.

Working with certified diabetes care and education specialists and diabetes pharmacists, participants developed personalized care plans and learned how to monitor their blood sugar, use diabetes devices and administer insulin. Educators also helped participants set realistic health goals, adopt healthy eating habits and develop coping strategies to support their overall health and quality of life.

When needed, an MLKCH community health worker provided supplementary virtual coaching to program participants. Participants in the Intense Disease Management Program continued to participate in telephone visits with community health workers to ensure they understood and complied with their care regimen.

Success indicators from these virtual visits include:

- Patient portal comprehension: Participants learned to navigate the MLK Online Patient Portal to track medical information, reminders and follow-up instructions, leading them to take an active role in their own care.
- Improved attendance: For participants with transportation limitations, a community health worker helped them secure transportation support, which increased their attendance at scheduled medical appointments and improved their follow-up with healthcare providers.
- Diabetes management: With community health worker support, participants better understood the importance of routine follow-up, leading to improved adherence to care and long-term health outcomes.

~1,770 **participants received personalized diabetes education and coaching**

COMMUNITY HEALTH PROGRAMS





Know Your Basics community health program

Know Your Basics (KYB) is a community health program that empowers South LA residents to take control of their health and wellness by providing free health screenings, education, resource referrals, health insurance guidance and peer support.

Over the past year, KYB partnered with over 30 organizations at 47 community events and provided nearly 1,700 health screenings. Additionally, KYB reached approximately 30,000 residents through newsletters offering health tips on topics such as chronic conditions, nutrition, women's and men's health, social justice and mental health.

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

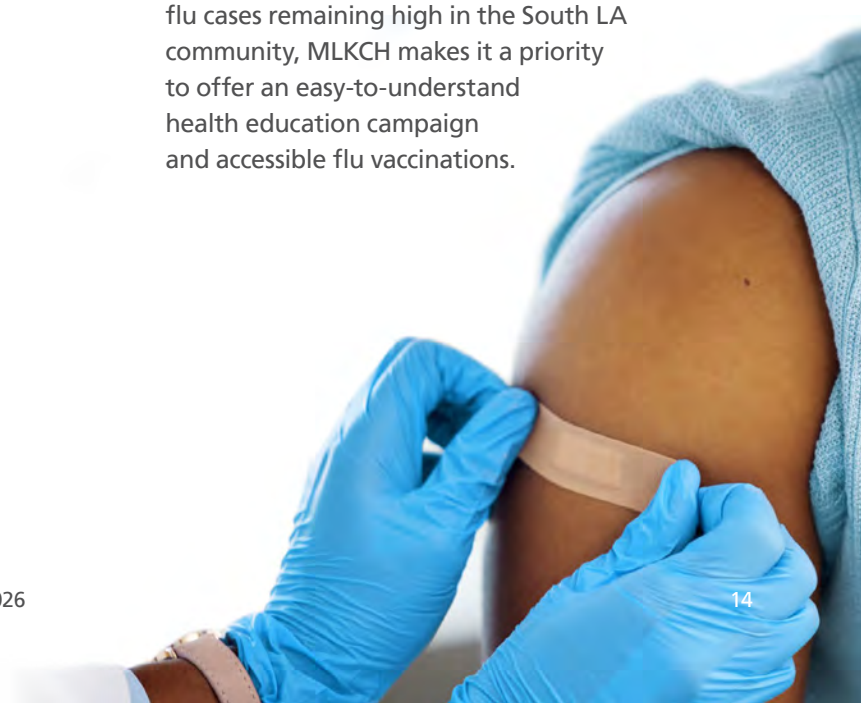
ManUp! For Your Health barbershop outreach program

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

Last year, we maintained partnerships with eight barbershops and held over 20 health screening events to help men take charge of their health, ultimately conducting about 130 screenings.

Flu education and vaccinations

During the 2025-2026 flu season, in addition to our outreach efforts with the KYB program, MLKCH provided community education on the flu and offered vaccinations. With flu cases remaining high in the South LA community, MLKCH makes it a priority to offer an easy-to-understand health education campaign and accessible flu vaccinations.





4 Homeless health

Postdischarge homeless care

Addressing the health needs of people experiencing homelessness continues to be a key focus for MLKCH. The number of people experiencing homelessness in our community is significant, and health disparities among this group continue to grow. Many people who experience homelessness repeatedly return to the emergency department seeking a safe place to connect to the programs and services they need to manage their health conditions.

In response, we enhanced our care coordination services and expanded our network of external partners to provide more placement options for South LA's homeless population. In FY26, we provided basic necessities, including food and clothing, to an estimated 2,600 unhoused individuals. We connected our unhoused patients with a dedicated homeless services supervisor, homeless service coordinator, housing navigator and community health workers who helped them navigate the healthcare system and access critical resources.

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

Through these partnerships, we connected over 9,300 people experiencing homelessness to social services or and/or basic needs support, allowing us to maintain the number of consults and connections to services provided from the previous year. We discharged and referred over 2,300 patients to reserved shelter beds at three types of housing placements (Ascencia shelters, recuperative care and transitional living), providing a safe, low-cost location to recover after leaving the hospital.

Housing support services

Due to limited access to healthcare and other inequities, people experiencing homelessness have significantly poorer health outcomes and higher mortality rates compared with the general population. These disparities are partly due to competing priorities—such as the need to find food and safe shelter—which often take priority over seeking healthcare. Additionally, people experiencing homelessness have higher rates of emergency department visits and are more likely to return to the emergency department than their housed counterparts, even after being placed in a housing facility.

MLKCH participated in the Homeless Housing and Support Services (HHSS) program, a comprehensive initiative under the California Advancing and Innovating Medi-Cal (CalAIM) framework developed by the Department of Health Care Services (DHCS). This program integrated Community Supports, including

housing navigation, tenancy services and recuperative care, to address the needs of people experiencing homelessness. Through the HHSS program, MLKCH's social services team served approximately 1,900 people experiencing homelessness, a 5% increase from the previous year.

Housing navigation services began with assessing participants' housing needs and identifying barriers to securing housing. The housing navigation team then developed strategies to address both immediate and long-term challenges. Tenancy services supported individuals in maintaining stable housing by establishing preventive measures, offering early intervention when issues occurred and mitigating risks that lead to housing instability.

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

Street Medicine department

The goals of our Street Medicine department are to:

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

In FY26, our Street Medicine department provided ongoing direct care to over 860 members of South LA's homeless community, meeting them where they were on the streets and under bridges. This is a 56% increase from the previous year. To support increasing demand, the Street Medicine department expanded from one team to three teams and added two nurse practitioners, four outreach coordinators, one physician and one medical assistant. Today, each team serves approximately 150 patients per week.

All care — including dispensing medications, performing minor medical procedures and drawing blood — was provided free of charge and delivered on-site where the person was based.

The Street Medicine department connected nearly 320 people experiencing homelessness to services such as housing, primary care visits, mental health care and drug treatment. They distributed nearly 50 doses of Narcan.

When paired with an inpatient hospital-based consult service, the Street Medicine team reduced 30-day emergency department readmission rates among this population by nearly 28%, established ongoing primary care for patients and shortened hospital stays.

860+ **unhoused individuals received care from Street Medicine in FY26**





5 Cultural alignment of care

Internal Medicine Residency Program

MLKCH offers graduate medical education by way of a three-year Internal Medicine Residency Program that strongly emphasizes healthcare in the context of equity and social justice. The program includes coursework related to social determinants of health such as race and ethnicity, income and equitable access to care.

The residency program is designed to attract quality providers to one of the most medically underserved communities in the nation. South LA has 10 times fewer doctors than more affluent areas and is designated as a Health Professional Shortage Area by the Health Resources and Services Administration. This lack of access to quality care has resulted in some of the worst health outcomes in the state.

To date, MLKCH has 15 internal medicine residents participating in the program, and 100% of those residents identify as people of color. This statistic is important to MLKCH because it reflects the hospital's commitment to ensuring its staff and providers reflect the community they serve.

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Center for Advancing Safety Net Healthcare

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

This past year, the Center for Advancing Safety Net Healthcare continued to focus on research that uncovers the systemic causes behind health disparities in South LA and similar communities. Drawing on our institution's long-standing commitment to excellence in safety-net healthcare, we will utilize our expertise to develop and evaluate promising healthcare models that target these inequities. Our recent work has led to publications and regional partnerships with academic medical centers and cancer institutes that support the MLKCH mission.

The Center for Advancing Safety Net Healthcare is committed to creating a healthier, more equitable future—one that is grounded in data, compassion and a commitment to justice in healthcare.



6 Social determinants of Health



Nutrition and food access

To support people with chronic health conditions and food insecurity, MLKCH offered a food "prescription" program called Recipe for Health (RFH). This program provided participants with a weekly supply of fresh fruits and vegetables, along with cooking and nutrition classes, so they could learn how different food choices can improve their health. Family members also benefited from the program's education designed to help build healthy habits across generations. Our MLKCH cafeteria—a model of healthful and affordable food choices—is an integral part of this program.

RECIPE FOR HEALTH

During FY26, the RFH team enrolled over 500 adults (aged 18 and older) and 13 children (ages 5–17), for a total of nearly 520 participants, a 4% increase from the prior year. RFH also provided over 8,000 fresh produce packages to participants and their families, a 32% increase from FY25.

Clinical outcomes

Participants in the RFH program saw decreased levels of diabetic hemoglobin A1C and high blood pressure. Overall, about 86% of participants experienced at least one improved health outcome—whether in A1C levels, body mass index or blood pressure—representing an increase from the previous year. Because most participants entered the program with food insecurity and two or more chronic conditions, these improved outcomes demonstrated a significant positive impact. Anecdotally, many patients reported sharing program-provided recipes with their families, suggesting the program's benefits extended to entire households.

Healthcare use

RFH participants were more likely to attend their appointments, even those unrelated to RFH. Compared to nonparticipants, they also had fewer emergency department visits. In FY26, approximately 30% of RFH participants avoided an emergency department visit and 84% maintained their primary care appointments at an MLKCH outpatient care center. Both figures represent improvements from the previous year.

Health behaviors

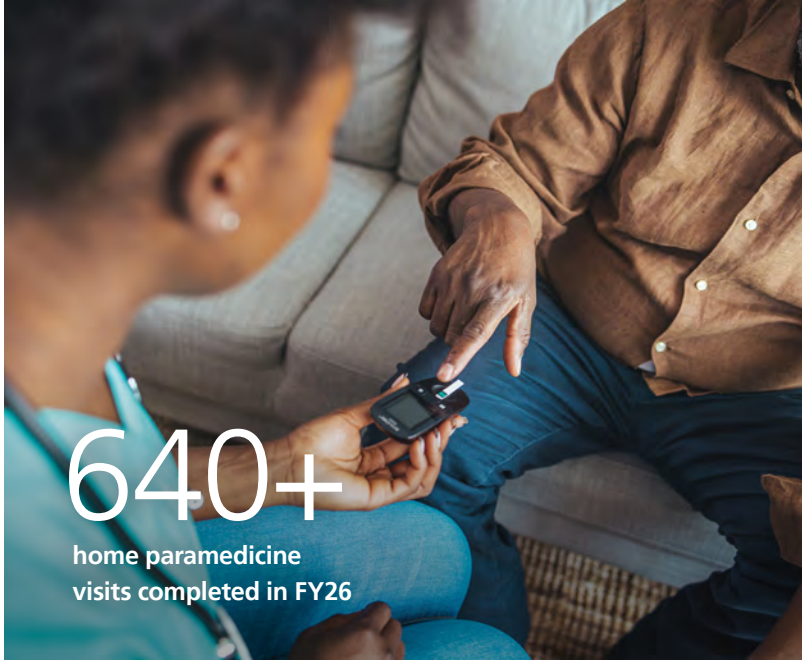
As participants continued in the RFH program, many reported eating more than two servings of fruits and vegetables per day. Participants also improved their knowledge of food preparation methods and credited the program with helping them enjoy more nutritious meals.

These results underscore the impact of the health education provided by the RFH team, which included simple meal ideas, healthy food alternatives and other recipes. Many participants also reported a significant reduction in their fast-food consumption, from three to five times a week to zero to two times per week. Additionally, many noted that since joining the program and learning how to cook, they had not gone a full day without eating a meal.

Cooking Classes

As part of the RFH education initiative, MLKCH launched a new series of cooking classes called *Cooking with Community*, held every other month at the hospital. These free classes offered community members education and live cooking demonstrations to support healthier lifestyle choices. Each class featured different health topics and recipes using items from an RFH participant's food package or affordable items available at the local grocery store. The dishes were selected with the diverse cultural population in mind, incorporating foods they're accustomed to. Over the past year, MLKCH hosted five cooking classes for the community, introduced 10 new recipes and engaged nearly 220 community members.





Home Paramedicine Program and access to in-home care

The MLKCH Home Paramedicine Program is a mobile healthcare service that delivers in-home care to recently discharged MLKCH patients across South LA. The program helps patients recover after their hospital stay. Medical personnel, such as paramedics or nurses, visited the patients at home within six to 48 hours after discharge to follow up on referrals, conducted safety checks and relayed their findings to the attending physician.

The majority of patients served through this program have chronic conditions such as congestive heart failure, COPD and diabetes. Many also have other risk factors, resulting in frequent hospital readmissions.

The Home Paramedicine Program offered a safety net for at-risk patients, improving access to care and preventing unnecessary returns to the emergency department. In FY26, paramedicine teams completed more than 640 visits with about 400 discharged patients.

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



COMMUNITY BUILDING ACTIVITIES

Advocacy for community health improvement and safety

This past year, MLKCH continued to focus on strengthening and building the community through advocacy and leadership. Hospital leaders actively served on local, regional and state-level boards that advanced initiatives and policies to improve the health of our community.

Workforce development

MLKCH's workforce development initiatives help prepare the next generation of healthcare professionals, create career opportunities for local residents and strengthen the workforce needed to meet our community's health needs.

COPE Health Scholars and Care Navigators

MLKCH partnered with COPE Health Solutions' Health Scholars and Care Navigators programs to provide experiential learning opportunities for students and community members aspiring to work in healthcare.

Participants worked alongside nurses, doctors and other healthcare professionals to gain firsthand experience in a clinical setting. The program prepared scholars for healthcare careers and offered potential career opportunities at MLKCH upon completion.

133
COPE Health scholars enrolled in FY26

In FY26, COPE enrolled 133 Health Scholars in the program, and MLKCH now employs four graduates. Additionally, 26 COPE Health Scholars have pursued further education in healthcare fields such as medicine, nursing, public health and health administration or joined MLKCH after graduating from the program. Approximately 23% of participants were from South LA, and the cohort's demographics reflected the diverse community MLKCH serves, with approximately 50% identifying as Hispanic or Latino or as Black or African American.

Career Fellows Program

MLKCH continued its Career Fellows Program, a paid high school internship and mentorship program developed to expose South LA high school students to careers in healthcare.
In FY26, the Career Fellows Program partnered with seven South LA high schools to provide nine sophomores, juniors and seniors with a seven-week internship. Each student worked 25 hours per week, completing 170 hours of work, and was paired with mentors across various healthcare sectors. Approximately 75 MLKCH staff participated as mentors or offered guidance during their department rotations.



FINANCIAL SUMMARY OF COMMUNITY BENEFIT

MLKCH's community benefit funding for FY26 (July 1, 2025–June 30, 2026) is summarized in the table (right). The hospital's community benefit costs comply with Internal Revenue Service instructions for Form 990, Schedule H, which uses a cost-to-charge ratio for financial assistance. The summary reflects that MLKCH spent more than $101 million of community benefit dollars this past year. **Appendix 1** lists the community benefit programs by category.

Financial Assistance and Means-Tested Government Programs	Vulnerable Populations	Broader Community	Total
Traditional Charity Care	$ 41,626,560	$ 0	$ 41,626,560
Medi-Cal Shortfall	33,076,478	0	33,076,478
Other Means-Tested Government Programs (Indigent Care)	0	0	0
Sum Financial Assistance and Means-Tested Government Programs	$ 74,703,038	$ 0	$ 74,703,038
Other Benefits			
Community Health Improvement Services	$ 5,709,195	$ 0	$ 5,709,195
Community Benefit Operations	0	43,202	43,202
Health Professions Education	0	3,217,716	3,217,716
Subsidized Health Services	15,932,159	0	15,932,159
Research	109,353	0	109,353
Cash and In-Kind Contributions	22,947	0	22,947
Other Community Benefit	0	2,058,610	2,058,610
Total Other Benefits	$ 21,773,653	$ 5,319,528	$ 27,093,181
Community Benefit Spending			
Total Community Benefit*	96,476,691	5,319,528	101,796,219
Medicare (non-IRS)	0	0	0
Total Community Benefit with Medicare	$ 96,476,691	$ 5,319,528	$ 101,796,219

*Sum of Financial Assistance, Means-Tested Government Programs and Other Benefits

COMMUNITY BENEFIT SERVICES FY2027 PLAN

Findings from our 2026 Community Health Needs Assessment (CHNA) provide a roadmap for expanding our community benefit programs and services. In the next year of our 2027–2029 Implementation Strategy, we plan to strengthen existing programs and expand efforts in the following areas:

1 Access to preventive, primary and specialty care

- **Connecting patients to a medical home:** To access primary and specialty care, MLKCH will continue to connect people to medical homes through MLK Community Medical Group (MLK CMG), LA County Department of Health Services facilities and local Federally Qualified Health Centers. MLK CMG will also continue developing its network of physicians across multiple specialties to support timely diagnosis, treatment and ongoing management of complex health conditions. This work helps patients who receive care in the emergency department connect with appropriate outpatient providers for continued care.
- **Telehealth services:** MLK CMG will continue using telehealth to expand access to timely healthcare services. Video and telephone visits can reduce transportation and scheduling barriers, support follow-up care and, when appropriate, help patients avoid emergency department visits for needs that can be managed in outpatient settings.
- **MLKCH prenatal, childbirth and postpartum services:** MLKCH's midwife-led maternity care model emphasizes personalized, culturally responsive support throughout pregnancy, delivery and recovery. This approach is especially important in South LA, where women of color face disproportionately high risks of pregnancy- and childbirth-related complications. MLKCH provides 24/7 on-site coverage from both an obstetrician and a certified nurse-midwife. Our maternity care team—including nurses, midwives and physicians—also reflects the racial and cultural diversity of the community we serve. Additional services include prenatal care, breastfeeding education, peer support groups and outpatient lactation care. MLKCH also continues to expand access to maternal and child health specialists through community partnerships.
- **Health insurance enrollment assistance:** MLKCH will help reduce the number of uninsured community members by connecting eligible patients with enrollment assistance for Medi-Cal and other public health coverage programs through the MLKCH Patient Access team. The MLKCH Street Medicine team, which provides care and support directly to people experiencing homelessness in community settings, will also help eligible patients enroll in Medi-Cal through coordination with Patient Access.







- **Financial assistance:** MLKCH will continue providing free or discounted hospital services to eligible patients through its financial assistance and charity care policy. Assistance is available to qualifying patients with household incomes up to 450% of the federal poverty guidelines.
- **Transportation to health appointments:** MLKCH will continue providing transportation assistance to help eligible patients overcome the health access barriers of getting to and from medical appointments.
- **Internal Medicine Residency Program:** MLKCH's Internal Medicine Residency Program provides hands-on clinical training for physicians in South LA, with an emphasis on health equity, social medicine and culturally responsive care. By training residents within the community, the program aims to strengthen the local physician workforce and encourage more doctors to continue practicing in South LA.
- **COPE Health Scholars and Care Navigator programs:** MLKCH will continue engaging participants in the COPE Health Scholars and Care Navigator programs, a healthcare workforce development initiative that provides aspiring health professionals with hands-on experience in clinical and administrative settings. Working across MLKCH departments, COPE Health Scholars and Care Navigators support patient navigation, connect patients with information and services and help deliver a timelier, more coordinated care experience. Through this work, participants also gain a deeper understanding of the culture, language and healthcare needs of the South LA community as they prepare for careers in healthcare. The program supports both workforce development and patient care by helping to reduce delays, address patient needs and improve the overall patient experience at MLKCH.
- **Healthcare workforce diversity:** MLKCH will continue recruiting and retaining a workforce that reflects the racial, ethnic, cultural and linguistic diversity of the South LA community. A representative workforce can strengthen trust, communication and culturally responsive care while creating career opportunities for local residents.

2 Behavioral health

- **Emergency Psychiatric Assessment, Treatment and Healing (EmPATH) unit:** With a planned opening in 2026, MLKCH's EmPATH unit will provide timely assessment, treatment and stabilization for community members experiencing behavioral health crises through the MLKCH emergency department. The unit will offer a supportive alternative to the traditional emergency department setting and connect patients with appropriate inpatient, outpatient and community-based services.
- **Integrated Behavioral Health (IBH) program:** MLKCH and MLK CMG will provide coordinated care for patients who are seen in the MLKCH emergency department with co-occurring mental health and substance use disorders. The IBH program connects patients with behavioral health specialists, treatment services and ongoing community-based support to strengthen continuity of care and improve health outcomes.
- **IBH telehealth services:** MLKCH and MLK CMG will offer telehealth consultations to expand access to behavioral health specialists, particularly for patients who face transportation, scheduling or other barriers to in-person care.

3 Management of chronic health conditions

- **Intense Disease Management Program:** MLKCH will continue using evidence-based clinical practices and a coordinated care model to improve health outcomes for community members with diabetes and other chronic conditions such as heart disease, kidney disease and hypertension. Services will focus on prevention, education, treatment and ongoing disease management to reduce complications and improve quality of life.
- **Know Your Basics (KYB) community health program:** KYB is a community-based program that provides screenings for high blood pressure, heart disease, diabetes and other health risks at health fairs, farmers' markets, resource fairs and family events. After each screening, MLKCH's Community Outreach team helps participants understand their results and identify appropriate next steps, such as lifestyle changes or follow-up medical care. During flu season, the program also offers vaccinations at community events. By bringing preventive services into trusted community settings, KYB helps residents identify potential health concerns early, make informed decisions and better manage chronic conditions.
- **ManUp! For Your Health:** ManUp! is MLKCH's free men's health education and screening program that partners with local barbershops in South LA to provide blood sugar, blood pressure and BMI screenings in trusted settings. After the screenings, MLKCH's Community Outreach team helps community members interpret their results and make plans to improve or maintain their health.

4 Homeless health

- **Street Medicine department:** MLKCH will continue providing medical care, care coordination and consultative support in community settings where people experiencing homelessness live and receive services. The program serves both patients transitioning from the hospital and individuals who have never received care at MLKCH. Three mobile teams provide medical care and support directly to people experiencing homelessness in the places where they live. Traveling by van, multidisciplinary teams include physicians, nurse practitioners, nurses, a social worker, occupational therapists, medical assistants and community outreach staff. Street Medicine providers deliver care directly on the street and at temporary housing sites and help patients connect with ongoing medical and social services. This program helps reduce gaps between hospital-, shelter- and community-based care.
- **Postdischarge homeless navigation:** MLKCH will provide postdischarge support to patients experiencing homelessness through care management, resource navigation and connections to community services. In partnership with housing and homeless service providers and health plans, MLKCH will help patients access temporary housing, food, clothing, postacute care and other essential resources needed to support recovery after discharge.
- **Housing support services:** MLKCH will continue to participate in the Homeless Housing and Support Services (HHSS) program, a comprehensive initiative under the California Advancing and Innovating Medi-Cal (CalAIM) framework developed by the Department of Health Care Services (DHCS). This program integrates Community Supports, including housing navigation, tenancy services and recuperative care, to address the needs of people experiencing homelessness.

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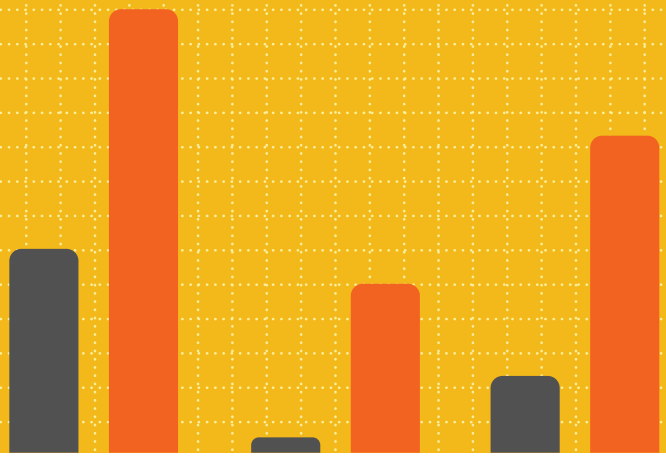
5 Social drivers of health

- **Supporting basic needs for homelessness:** MLKCH will connect people experiencing homelessness with housing assistance, food, clothing, hygiene supplies and other essential resources available through related public and community programs.
- **Social Drivers of Health (SDoH) screening:** Using the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) screening tool, MLKCH will assess patients and community members for unmet health-related social needs, including food, housing, transportation and financial barriers. Based on PRAPARE screening results, MLKCH will connect community members to the appropriate resources and services.
- **Recipe for Health (RFH) food access program:** MLKCH will continue addressing food insecurity and nutrition-related chronic conditions by connecting eligible patients and families with healthy food, nutrition education, peer support and other food-access resources through the RFH program. MLKCH Social Services will also provide information about food assistance resources available on the MLKCH website and refer community members to partner programs, including assistance with CalFresh enrollment.
- **Home Paramedicine Program:** MLKCH will support patients following hospital discharge through in-home follow-up care, health education and clinical monitoring. The program will help patients understand and follow their care plans, manage health conditions and connect with needed services. The program aims to improve outcomes and reduce avoidable emergency department visits and hospital readmissions.

MEASURING OUR IMPACT



As we continue on our health equity journey, MLKCH measures progress toward each community benefit area of focus by using regularly prescribed evaluation routines and quarterly progress reports.

We continue to track our performance across metrics that cover the five priorities identified in the 2026 Community Health Needs Assessment (CHNA):

Access to preventive, primary and specialty care

Goal: To expand access to culturally appropriate preventive, primary and specialty care for medically underserved community members in South LA, with an emphasis on maternal and infant health.

Objectives:

- Increase the availability of culturally and linguistically appropriate preventive, primary and specialty healthcare services in South LA
- Recruit and retain health professionals across all specialties to improve timely access to preventive, primary and specialty care
- Expand resources that help residents overcome barriers to care, including lack of insurance coverage, unaffordable care and limited transportation

Measures:

- Number of new and existing medical specialists providing community-based care
- Number of individuals who were referred to and served through primary and specialty care and connected with medical homes
- Number of trips provided for transportation assistance to medical homes and cost of elective transportation
- Number of new health insurance referrals and placements for uninsured patients
- Number of individuals served through telehealth services (phone and video)
- Number of moms supported by MLKCH maternal virtual classes and support groups
- Number of moms connected and served through the MLKCH lactation outpatient clinic
- Number of internal medicine residents and cultural/racial breakdown of residents participating in the Internal Medicine Residency Program
- Percent of culturally diverse staff at MLKCH providing care to residents of South LA

Behavioral health

Goal: To increase access to behavioral health services and connect residents with appropriate treatment and support in culturally appropriate environments that promote recovery.

Objectives:

- Maintain a team of qualified behavioral health professionals who provide on-site care, resources and connections
- Increase referrals to mental health and substance use services for community residents
- Improve timely assessment, stabilization and follow-up care for residents experiencing behavioral health crises

Measures:

- Number of patients seen at the EmPATH unit (for those experiencing behavioral health emergencies)
- Number of individuals served through the IBH program and referred to outpatient care and continued treatment
- Number of emergency treatment drugs distributed for substance use
- Number of individuals served through IBH telehealth services (phone and video)

Management of chronic health conditions

Goal: To reduce the impact of chronic disease by expanding access to preventive care as well as education and disease management services, including screenings and immunizations, that help community members improve and maintain their health.

Objectives:

- Provide continued access to health screenings, vaccinations, education and preventive services that support early detection and chronic disease management
- Improve health outcomes by expanding programs that help community members understand and manage chronic conditions
- Reduce preventable complications and the need for higher-cost care

Measures:

- Number of individuals enrolled in MLK CMG's Intense Disease Management Program
- Number of individuals seen by a certified diabetes educator and/or a diabetes pharmacist and provided with education
- Number of individuals in the Intense Disease Management Program who can control their health metrics
- Number of community members receiving health screenings through the KYB health screening and ManUp! programs
- Number of community events participated in or held through community outreach programs provide preventive services, including health screenings and education, to residents

Homeless health

Goal: To increase access to healthcare and community navigation services to help stabilize the health of people experiencing homelessness and connect them with community-based organizations that can help them meet their housing and basic needs.

Objectives:

- Increase access to high-quality healthcare for people experiencing homelessness, resulting in improved health and greater quality of life
- Expand street-based medical services for people experiencing homelessness
- Continue supporting patients experiencing homelessness in navigating social services and basic-needs resources

Measures:

- Number of people experiencing homelessness served through the Street Medicine department
- Number of people experiencing homelessness connected to social services and/or assistance with basic needs
- Number of people experiencing homelessness referred to recuperative care, transitional housing and housing support
- Number of people experiencing homelessness served through the HHSS program

Social drivers of health

Goal: To improve access to food, housing, in-home care and other social services that support healthier living conditions and better health outcomes.

Objectives:

- Increase access to social support resources that help residents manage their health and improve their quality of life
- Expand access to healthy food, nutrition education and food-assistance resources
- Increase connections to housing assistance, in-home care and other services that address health-related social needs

Measures:

- Number of individuals experiencing homelessness who received basic needs support
- Number of patients screening positive for social drivers of health needs through the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) screening tool and receiving resources of support
- Number of community members enrolled in our Recipe for Health (RFH) food access program
- Number of healthy food/produce packages provided through RFH
- Number of enrolled RFH participants with improved clinical health measures
- Number of enrolled RFH participants with decreased emergency department visits and improved attendance at healthcare appointments
- Number of individuals served through the Home Paramedicine Program with access to home care

Evaluation of the Plan's Effectiveness

MLKCH evaluates the effectiveness of its community benefit Implementation Strategy by regularly monitoring progress toward key goals and soliciting feedback from community stakeholders. Throughout the CHNA process, we gathered input on local health needs, prioritization criteria and existing resources. This input shaped both the focus areas and the strategies included in our Implementation Strategy.

We continue to assess the impact of our efforts by tracking measurable outcomes, patient engagement and program participation across each priority area. Community partners remain actively involved in shaping and refining initiatives to ensure they remain responsive to evolving needs. A full list of community groups consulted during the CHNA process can be found in **Appendix 2**.

Significant needs outside of hospital scope

MLKCH's community benefit efforts are shaped by our CHNA and our vision to build a healthier South LA. We accomplish this by addressing the immediate health needs of our patients as well as the deeper social and economic conditions that contribute to health disparities.

Based on this assessment —and in alignment with our organizational capacity and expertise—MLKCH has prioritized five focus areas for FY27, including access to care, chronic disease management, behavioral health, homeless health and the social drivers of health.

The CHNA process also identified additional community health needs, including economic security, environmental health, infectious diseases and community safety/violence reduction. These needs fall outside the scope of our current Implementation Strategy; however, we remain focused on the priority areas where our organization can have the greatest measurable impact. We will continue to work in partnership with other providers and community organizations to ensure a broader, collaborative response to the health needs of SPA 6.

COMMUNITY PARTNERSHIPS

We are fortunate to have successful and established relationships with our community partners. Together, we have made a meaningful impact in the communities we serve. Moving forward, we will continue engaging new partners to support our mission and satisfy the objectives outlined in our Implementation Strategy. Here's a partial list of our current community partners:

A Community of Friends
African American Infant and Maternal Mortality Community Action Team
African American Male Wellness Agency
Alain Leroy Locke College Preparatory Academy
Alliance Judy Ivie Burton Technology Academy High School
Alliance Patti & Peter Neuwirth Leadership
Alzheimer's Los Angeles
American Diabetes Association
American Heart Association
Animo Compton Charter School
Ascencia CA
Association of Black Women Physicians
Augustus Hawkins High School
Avalon Recuperative Care
Baldwin Hills Farmers Market
Be Social Productions
Bethel Missionary Baptist Church of South Los Angeles
Beulahland Missionary Baptist Church
Black Beauty & Wellness Foundation
Black Business Association
Black Infant Health Program
Black Women for Wellness
Black Women Leaders of Los Angeles
Blink Fitness
Boys & Girls Club of Metro Los Angeles
Brotherhood Crusade
California Black Women's Health Project
California Endowment
California State University Dominguez Hills
Cedars-Sinai Medical Center
Center for Sustainable Communities
Centinela Probation Office (Los Angeles County Probation Department)
Charles R. Drew University of Medicine and Science
Children's Hospital Los Angeles
Children's Institute
Church of the Redeemer
COLARC
Communities Lifting Communities
Community Coalition
Compton Avenue Elementary School
Compton Barbershop
Compton Early College High School
Compton Farmers Market
Compton Unified School District
Congress of Racial Equity – Los Angeles Chapter (CORE – LA)
COPE Health Solutions
Core Contributors Group, Inc (CCG)
David Starr Jordan High School
Debbie Allen Dance Academy (DADA)
Del Cielo Salon y Barber
DocGo
Dunbar Village
El Nido Family Centers
Encompass
Exodus Recovery, Inc. at MLK Medical Center
Everytable
F & M Barber and Beauty Salon
Firebaugh High School
Food Forward
Forgiving for Living, Inc.
Forgotten Children, Incorporated
Francisco Bravo Medical Magnet High School
Freedom Plaza - Primestor Development Inc.
Fremont High School
Girls Club of Los Angeles
Golden State Recuperative Care
Greater Los Angeles African American Chamber of Commerce
Greater St. Augustine Missionary Baptist Church
Grocery Outlet Bargain Market — Compton
Hank's Mini Market
Harbor Care Center
Haven Supportive Housing
Healing Oasis Recovery INC.
Health Net of California, LLC
HOLA Recuperative Care
Homeless Outreach Program Integrated Care System (HOPICS)
Horizons Recuperative Care
Hospital Association of Southern California
Housing Authority of the City of Los Angeles (HACLA)
Illumination Foundation
Impact Media
Inglewood City Clerk's Office

Integrated Healthcare Association
International Medical Corps (IMC)
JAR Insurance
Just Showing Off Barber Salon
Kaiser Permanente
Kindred Space LA
Kings & Queens Beauty Salon
King/Drew Magnet High School of Medicine and Science
KJLH Radio
L.A. Care Inglewood Family Resource Center
L.A. Care Lynwood Family Resource Center
L.A. Focus Newspaper
Latino Food Industry Association
Legends Barbershop
Los Angeles Adventist Academy
Los Angeles Area Chamber of Commerce
Los Angeles County Department of Mental Health
Los Angeles County Department of Public Health
Los Angeles County Department of Social Services
Los Angeles County Doula Program
Los Angeles County Fire Department
Los Angeles County Sheriff's Department
Los Angeles Latino Chamber of Commerce
Los Angeles Metropolitan Churches
Los Angeles Sentinel
Los Angeles South Chamber of Commerce
Los Angeles Unified School District (LAUSD)
Los Angeles Urban League
Los Angeles Wellness Station
Lynwood High School
Magdaleno's Barbershop
Martin Luther King, Jr. Outpatient Center
Maxine Waters Employment Preparation Center
Mayor of Lynwood City Office
Mayor's Office of Legislative and External Affairs
Metro of Los Angeles
Middle College High School
Miller Children's and Women's Hospital
MLK Campus Farmers' Market
MLK Center for Public Health
Mount Carmel Holy Assembly Baptist Church
Mt. Sinai Missionary Baptist Church of Compton
N Spot Barber & Beauty
NAACP Los Angeles
National Health Foundation
National Coalition of 100 Black Women
Neighborhood Housing Services of Los Angeles County
New Life Global Development
Nickerson Gardens Housing Project
Noble Quest Health Recuperative Care
Offices of Sweet Alice and Parents of Watts
Partners in Care Foundation
Plaza Mexico
Positive Results Center
Residence Advisory Councils for Jordan Downs, Nickerson Gardens and Imperial Courts
R.O.A.D.S. Community Care Clinic
Samuel Gompers Middle School
San Pedro High School
Sanctuary of Hope
Shields for Families
Sodexo
SOUL Housing
South Los Angeles Health Projects
Southern Christian Leadership Conference – Los Angeles (SCLC – LA)
Southside Coalition of Community Health Centers
SPA 313 Hair Salon
SPA 6 Homeless Coalition
St. Anne's Family Services
St. Bernard High School
St. John's Well Child and Family Center - Compton Clinic
St. Louise Resource Center
St. Mary's Academy
St. Pius X St. Matthias Academy
Star View Community Services
Street Medicine Program of USC Keck School of Medicine
Suite Life SoCal Magazine
Superior Grocers
Sustainable Economic Enterprises of Los Angeles (SEE-LA)
Tau Tau Chapter of Omega Psi Phi Fraternity, Inc.
T.H.E. (To Help Everyone) Health and Wellness Centers
The Gateway at Willowbrook Senior Center
The G.O.A.T Hair Studio
The Lounge Barbershop
The Place To Be Barbershop
Uber Health
University of California, Los Angeles (UCLA)
Univision Communications Inc.
Urgent Care Associates
USC Clinical and Translational Science Institute
Ventanilla de Salud Los Angeles
Verbum Dei Jesuit High School
VOA–Avalon Recuperative Care
Wade & Associates Group LLC
Walnut Park Middle School
Watts Gang Task Force
Watts Healthcare – Watts Health Center
Watts Labor Community Action Committee
Watts Neighborhood Council
Wayfinder Family Services
Welcome Baby - First 5 Los Angeles
West Angeles Community Development Corporation
Whole Person Care – Los Angeles (WPC-LA)
Willowbrook Inclusion Network
Women of Watts (WOW)
Women, Infants and Children (WIC)
Young Women's Christian Association (YWCA)

CATEGORIZATION OF COMMUNITY BENEFIT PROGRAMS

Medical Care Services
- Charity care/financial assistance
- Medi-Cal shortfall

Other Benefits for Vulnerable Populations
- Intense Disease Management Program
- Diabetes coaching
- Expanded network of medical specialists
- Financial assistance and health insurance enrollment
- Flu education and vaccinations
- Home paramedicine program and access to in-home care
- Housing support services
- Integrated behavioral health program
- Know Your Basics community health program
- ManUp! For Your Health
- Maternal and infant health (First 48 Hours, Mommy Support Group, Prenatal Lactation)
- Nutrition and food access (Recipe for Health and cooking classes)
- Postdischarge homeless care
- Public assistance programs
- Street Medicine department
- Telehealth services
- Transportation assistance

Other Benefits for the Broader Community
- Community benefit operations

Health Research, Education and Training Programs
- Graduate Medical Education
- Center for Advancing Safety Net Healthcare

Nonquantifiable Benefits
- Advocacy for Community Health Improvement and Safety
- Workforce Development



Appendix 2.

COMMUNITY ORGANIZATIONS ENGAGED THROUGH COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

Be Social Productions, The Latin Link
Black Women for Wellness
Boys & Girls Clubs of Metro Los Angeles – Watts
California Black Women's Health Project
Charles R. Drew University of Medicine and Science
City of Lynwood
Community Coalition
Community Healing and Trauma Prevention Center, MLK Center for Public Health
Housing Authority of the City of Los Angeles (HACLA)
Kedren Community Health Center
L.A. Care Lynwood Community Resource Center
L.A. County Department of Public Health
L.A. County, DHS MLK Jr. Outpatient Center
Los Angeles County Fire Department
Los Angeles Metropolitan Churches
Los Angeles Sentinel
Los Angeles Unified School District
MLK Community Healthcare
MLK Outpatient Clinic, Urgent Care
National Coalition of 100 Black Women Los Angeles Chapter
Neighborhood Housing Services of Los Angeles
Southside Coalition of Community Health Centers
Watts Healthcare Corporation
Wayfinder Family Services
West Alondra Medical Pharmacy
West Angeles Church
Willowbrook Inclusion Network
Young Women's Christian Association (YWCA)



MLK Community Healthcare

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