2025 COMMUNITY BENEFIT PLAN

KedrenHealth
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General Information

A. Background

Established in 1965 in response to the Watts uprising, Kedren Community Mental Health Center, Inc. (Kedren) has provided mental health and substance abuse services to the South Los Angeles community through its Acute Psychiatric Hospital and Community Mental Health Center. Offering an integrated behavioral health care system, Kedren has served as the primary resource for outpatient and inpatient behavioral health services in Los Angeles County. It has received Los Angeles County funding for over 30 years and Substance Abuse and Mental Health Services Administration (SAMHSA) funds for integrated care. Its psychiatric inpatient hospital has 72 beds – 55 for adults 18-64 and 17 for children ages 5-12 and serves more than 5,700 unique inpatient and outpatient clients annually.

Individuals referred to Kedren often are from emergency rooms throughout Los Angeles County or brought in by law enforcement. Many adults are chronically homeless with severe mental illness and frequently use the emergency rooms to receive care and support.

Recognizing the importance of providing primary care to its patients within its behavioral health services and acknowledging the health disparities in the South Los Angeles community, in 2013, Kedren became a Federally Qualified Health Center (FQHC), a division of the Corporation, to ensure all patients have access to care, regardless of their ability to pay.

Additionally, Kedren provides mental health services on an outpatient basis to 46 schools in the service area. These services are provided as part of the Juvenile Justice Programs, through Adult Conditional Release and Stepdown Programs with supportive housing models such as partial hospital services for children which includes case management, peer support, and medication management.

B. Organizational Structure and Core Principles

Kedren is governed by a Board of Directors, which consists of members who are the majority of consumers representing the service area demographic. The Board is responsible for setting policy on patient care operations, finances, and community benefits. Kedren's highly trained multi-disciplinary team of professionals is comprised of physicians, psychiatrists, psychologists, physician assistants, nurse practitioners, register nurses, certified nurse assistants, medical assistants, licensed clinical social workers, marriage/family therapists, certified chemical dependency counselors, and a variety of other professionals dedicated to providing services to individuals with dignity and the utmost respect, without social, cultural, political, sexual orientation, or financial prejudice.

The core principles of effective integrated behavioral health care include a patient-centered care team providing evidence-based treatments for a defined population of patients using a measurement-based treat-to-target approach.

Kedren's holistic integrated delivery system allows for optimal success, as the pillars of a healthy community are centrally located on one campus and treatment teams can work to create a tailored plan for each client. This promotes an increased likelihood of comprehensive wellness, for low-income families who would not otherwise have the resources to receive the care they need. Today, across all Kedren's primary care and mental health/substance use disorder (SUD) programs and services, Kedren continues to maintain relationships with community partners to provide a one-stop location for services to improve a community member's health and wellbeing.

C. Mission and Vision

The mission of Kedren is to provide quality integrated health and behavioral health services to children, youth, adults, and families regardless of one's ability to pay.

Kedren's vision is to eliminate health disparities for children, youth, adults, and families in South Los Angeles by creating access to care irrespective of one's ability to pay. Kedren is committed to promoting well-being by enhancing the quality of life through best practices in healthcare delivery. Kedren's focus in creating access to programs regardless of one's ability to pay is an important community benefit, as is its onsite provision of both acute, involuntary inpatient psychiatric care, and outpatient services in less restrictive settings. Staff strive to be the best by treating patients and clients with dignity and respect no matter what their psychological or physical health conditions. Treatment is focused on teamwork, respect, and innovation. Services are delivered through a coordinated, multi-disciplinary and sensitive approach to care, through a delivery system which follows all federal and state laws regulating health care providers.

The organization advocates in partnership with, and on behalf of, persons, groups, and families served, the public or community, and other stakeholders. The organization works in active partnership with persons and families served to:

a. Ensure that they have appropriate advocacy support, either from their own support system or through active case advocacy;
b. Assist them to gain access to the full array of eligible services; and
c. Mediate barriers to services within the service delivery system.

The organization's governing body and management collaborate with national and local community-based organizations, public organizations, and community and ethnic groups to advocate for issues of mutual concern, such as:

a. Improvements to existing services;
b. Redress for gaps in service;
c. The full and appropriate implementation of applicable laws and regulations;
a. regarding issues concerning the service population; and
d. Improved support and accommodation for persons with special needs.

Kedren recognizes that mental health and physical health involves a whole person care model. This requires comprehensive services ranging from inpatient, residential, day treatment, outpatient care, and housing. Patients are frequently impacted by chronic diseases (such as diabetes, hypertension, HIV/AIDS, and hepatitis) which require wrap around services outside the traditional modalities, as well as case management and therapeutic follow-ups.

D. Primary Care to Outpatient Mental Health Services

At Kedren, all patients are screened for behavioral health services at its FQHC (primary care clinics).

a. Consumer walks-in to the Primary Care Clinic for services.
b. Consumer's medical home is contacted for Hx/information. If requested or they have no medical home, a switch is made to Kedren as their medical home.
c. Patients are screened to discern the need for mental health, substance use disorder (SUD), health education, and housing services.
d. If mental health and/or SUD services are warranted, a referral for appointment is made to Kedren's outpatient behavioral health program.
e. Kedren's behavioral health team conducts triage; if medical necessity is met, and consumer is referred for ongoing mental health services. Kedren's primary care and mental health teams work in tandem (utilizing a shared electronic health record (EHR) platform to support the patient with their health care needs.

E. Patient Flow Regardless of Entry to Kedren's System of Care

Primary Behavioral Health Care Integration (PBHCI)

a. Kedren's holistic integrated delivery system allows for optimal success, as the pillars of a healthy community are centrally located on one campus and treatment teams can work to create a tailored plan for each client. This promotes an increased likelihood of comprehensive wellness, for low-income families who would not otherwise have the resources to receive the care they need.
b. Kedren's primary care case managers assess patients for primary care, SUD housing, health education and other health and social service needs. As such. referrals are made accordingly.

Primary Care Walk-In

a. Patient meets with one of Kedren's Community Care Clinic front desk.
b. The front desk staff check for medical eligibility, medical home, and will complete admission paperwork.
c. Each Clinical Provider visit includes primary care, mental health and SUD screenings (as applicable), and health education.
d. Referrals are made to Kedren's outpatient behavioral health program (when needed) for mental health and/or SUD services.

Field-Based Services

a. Kedren's field-based provider submits Client Admissions Data Sheet to Patient Access Services (PAS).
b. PAS checks for medical eligibility, inpatient services (IS) for prior admissions/open episodes, and completes admission paperwork.

c. Kedren's field provider obtains necessary signatures from the patient and completes assessments based on medical necessity.
d. The client is scheduled for continued services including Mental Health, Case Management as well as Medication Support if clinically warranted.

Community Health Needs Assessment (CHNA)

In compliance with the Patient Protection and Affordable Care Act of 2010 (Section 501(r)(3)(A)), Kedren is required to conduct a Community Health Needs Assessment (CHNA) every three years that identifies and addresses key issues of the defined community. In 2025, Kedren completed its CHNA and Community Benefit Plan (implementation strategy) for 2025-2028. Upon completion, the Board of Directors reviewed and approved it and subsequently uses it to strategize and chart the direction for Kedren in the upcoming years. The report is publicly available on Kedren's website – www.kedren.org.

A. Definition of Community

Kedren's designated service area is Los Angeles County Service Planning Area 6 (SPA 6). Spanning 103.68 urban square miles of South Los Angeles and its surrounding areas, SPA 6 also encompasses the cities of Compton, Lynwood, and Paramount. This is a densely populated urban area with 1.1 million residents, resulting in an average population density of 10,247 per square mile. The following map illustrates the service area boundary and the boundaries of the cities it covers.

B. Development of Community Health Needs Assessment (CHNA)

Once every three years, Kedren assesses the health needs of its community to ensure its programs and services are continuing to meet the needs of Kedren patients, as well as residents of the SPA 6, and parts of the SPA 6, service area, with emphasis on communities and populations experiencing greater health and behavioral health disparities. This process included collecting primary data (e.g., key informant interviews, board of directors, staff, community, and patient input), as well as secondary data (e.g., American Community Survey, California Health Interview Survey). The CHNA focuses on access to behavioral health care and utilization, barriers to care, behavioral health issues among the target population, and demographic cultural factors impacting health care demand and access.

C. Service Area Identified Needs

As illustrated in the 2025 to 2028 CHNA, the need for mental health and substance abuse disorder (SUD) services for low-income residents of Kedren's service area is evidenced by the number of South Los Angeles residents who reported having mental health challenges and/or have sought mental health care, and/or treatment for alcohol or drug use. According to the 2023 California Health Interview Survey[1], about 48,749 seriously considered suicide. Low-income residents 18 years and older self-report that they are more likely to have serious psychological distress during the past year (17.2%), moderate or severe social and family like impairment during the past year (25.5%, and 25.2% respectively), have moderate or severe household chore and work impairment (23.6%, and 22.0% respectively).

Kedren's approach to care addresses patients with primary and specialty care needs, such as patients with co-occurring conditions. The level of substance misuse in Kedren's service area compared with Los Angeles County and California rates. There is a higher incident of misused of prescription pain killer (2.0%) and use of methamphetamine (1.2%) are higher than county- 08% and 0.2% respectively), and statewide (0.7% and 0.2%, respectively) numbers. More than one in seven low-income adults (14.3%) have engaged in binge drinking in the past month and more than one in 13 adolescents have tried alcohol[2].

[1] UCLA Center for Health Policy Research. (n.d.). California Health Interview Survey (CHIS). https://healthpolicy.ucla.edu/our-work/california-health-interview-survey-chis
[2] UCLA Center for Health Policy Research. (n.d.). California Health Interview Survey (CHIS).

Residents of the service area, especially low-income residents, are challenged with a lack of access to quality behavioral health care, and therefore far fewer people utilize it than needed among the population. Nearly one-quarter of low-income residents (22.6%) need help for emotional/mental health problems or the use of alcohol/drugs in the past year, according to an analysis of data from the California Health Interview Survey conducted by the University of California, Los Angeles. While this is not significantly different from regional or state averages, it represents about 75,000 low-income service area residents. Of those, nearly 40,000 (more than one-half) received help, which represents a gap of 45,000 residents who needed help but did not receive it. Among adolescents (ages 12-17), nearly one in three (30.4%) indicated that they needed help for emotional or mental health problems in the past year. Less than one-half of them (7,162 out of 18,296) received psychological or emotional counseling during that period.

Feedback from key informants and community members was incorporated through structured interviews and community surveys to ensure that local perspectives guided the identification of leading health needs. These stakeholders offered valuable insights into barriers to care, gaps in existing services, and emerging health concerns. Their input was analyzed alongside quantitative data such as chronic disease prevalence, and local social determinants of health indicators. This collaborative approach ensured that the assessment reflected statistical trends and lived experiences, allowing Kedren to determine which health needs have the most significant impact on the community, such as access to primary care, behavioral health services, and chronic disease management. Responses from the key informants established the following priorities, vulnerable populations, and concerns:

Most Common Health or Mental Health Issues or Conditions

- Substance Use Disorder / Addiction
- Diabetes
- Hypertension
- People Experiencing Homeless
- Depression

Populations or Groups in the Community Facing the Most Barriers to Accessing Health Care

- Black and Hispanic Communities
- Homeless / Unhoused
- Low-Income
- Undocumented Immigrants

Major Gaps in Existing Health and Mental Health Services or Resources

- Affordable Housing
- Substance Abuse Programs and Services
- Affordable Child Care
- Quality Supermarkets
- Resources for Homeless and Undocumented Populations
- Not Enough Providers Accepting Medi-Cal

Social Determinants of Health Affecting Health Outcomes

- Lack of Housing

https://healthpolicy.ucla.edu/our-work/california-health-interview-survey-chis

- Unemployment
- Increased Stress
- Reliable Transportation
- Affordable / Healthy Food Options
- Recreational Space

Types of Health and Mental Health Services or Programs Urgently Needed

- More Mental Health and Substance Abuse Programs and Services (including access to 24/7 crisis response)
- Increasing Access to Economic Stability Services (e.g., housing services, food assistance, financial assistance)
- Food Distribution Programs
- Housing Programs
- Prevention Programs for Diabetes and Wellness (e.g., yuga, medication management, stress relief)

Responses from the community survey identified the following themes:

Survey Findings	
What is your gender identity?	**N = 30** Female (63.33%); Male (36.67%)
What is your age?	**N = 31** 26-39 (16.13%); 40-54 (16.13%); 55-64 (38.71%); 65+ (29.03%)
Where do you or your family members receive routine health care services?	**N = 27 (*Multiple Choice*)** Doctor's Office (59.26%); Free/Low-Cost Clinic (33.33%); No Routine Health Care (3.70%); Urgent/Prompt Care (3.70%)
What is your primary type of health coverage?	**N = 27** Medi-Cal (92.59%); Medicare (3.70%); Private Insurance (3.70%)
In the past year, what types of mental health services did you and/or your child(ren) use?	**N = 18 *(Multiple Choice)*** **YOU:** None (55.56%); Counseling Therapy (22.22%); Psychiatric Medication Management (11.11%); Residential Treatment (5.56%), Other (11.11%) **N = 11 *(Multiple Choice)*** **CHILDREN(S):** None (72.73%); Counseling/Therapy (9.09%); Psychiatric Medication Management (9.09%); Other (9.09%)

Do you feel you have adequate access to quality health services?	**N = 25** Always (56.00%); Often (8.00%); Sometimes (20.00%); Rarely (4.00%); Never (12.00%)
Most important factors for a "Healthy Community."	**N = 23 (*Multiple Choice*)** Affordable housing (52.17%); Low crime/safe neighborhoods (47.83%); Good schools (34.78%); Clean environment (26.08%); Good jobs/healthy economy (26.08%); Healthy behaviors and lifestyle (26.08%%); Access to mental health services (17.39%); Access to substance abuse programs (17.39%); Access to park & recreation (17.39%); Access to affordable/fresh natural foods (17.39%); Access to affordable healthcare (8.70%); Other (4.32%)
Most important "Health Problem" facing our community.	**N = 23 (*Multiple Choice*)** Diabetes (78.26%); Cancer (43.48%); Overweight/Obesity (26.09%); Mental Health (13.04%); Dental Hygiene (8.70%); Heart Disease/High Blood Pressure (8.70%); Stroke (8.70%); Sexually transmitted diseases (4.35%); Suicide (4.35%); Shortage of primary care doctors (4.35%); Other (4.35%)
Most challenging "Risky Behaviors" facing our community.	**N = 18 (*Multiple Choice*)** Alcohol abuse (44.44%); Poor eating habits (38.89%); Drug abuse (38.89%); Child abuse/neglect (27.78%); Lack of exercise (16.67%); Driving while under the influence (11.11%); Tobacco use/secondhand smoke (5.56%); Not wearing a seatbelt (5.56%); Dropping out of school (5.56%); Not wearing a helmet (5.56%)
Do you feel you have sufficient access to affordable and healthy food?	**N = 25** Always (36.00%); Often (4.00%); Sometimes (52.00%); Rarely (4.00%); Never (4.00%)
Are you satisfied with your current housing situation?	**N = 25** Yes (84.00%)

	No (16.00%)
Do you feel safe where you live?	**N = 26** Always (69.23%); Often (3.85%); Sometimes (23.08%); Rarely (3.85%)
What changes would you like to see made to improve the neighborhood you live in?	**N = 23 (*Multiple Choice*)** Increased security (56.52%); Better roads (30.43%); Better parks/playgrounds (26.09%); Better lighting (17.39%); More sidewalks (13.04%); Other (4.35%)

D. Health Needs Identified

A multi-step process was used to arrive at a final list of health needs for the CHNA. The steps included organizing a matrix of topics/themes by data source, then adding detailed context for each topic/theme as mentioned in each data source. A final review of the topics/themes according to each data source was completed and included 1) common needs identified between all data sources, and 2) unique needs that Kedren may be able to address given its current capacity. Based on Kedren's 2025-2028 CHNA survey results, the top five health priorities are:

Priority 1. Kedren will continue to provide the full continuum of integrated Primary Care, Mental Health, and SUD treatment services across the life cycle, with a specific focus on increasing access for special populations (e.g., people experiencing homelessness, low-income, recently released from incarceration), as well as address stigma in the community with an emphasis on increasing community knowledge and access to underutilized programs and services.

Priority 2. Kedren will become a recognized Patient-Centered Medical Home (PCMH) that continues to put patients at the forefront of care, and to build better relationships between patients and their clinical teams. PCMH designated entities have shown to improve access to health care, increase patient satisfaction with care, and improve patient health.

Priority 3. Kedren will continue to provide benefits assistance to patients including education to the uninsured, under insured and undocumented patients who may be able to access primary medical care and/or behavioral health services via state benefits and/or local benefits.

Priority 4. Kedren will continue focus on integrating behavioral health and medical care services by focusing on chronic diseases prevalent in the communities served (e.g. diabetes, obesity, asthma, high blood pressure, etc.) and its interaction with SUD/MH. This includes addressing comorbidity and the need to provide integrated and coordinated care via shared electronic charting and regular provider case communication and conferencing.

Priority 5. Kedren will develop new, and strengthen existing, partnerships with community partners that provide health and social services in order to increase access to services at Kedren and in the community.

Since the approval of the 2025 - 2028 CHNA, Kedren's data and evaluation team are monitoring the progress of each outcome associated with the priorities listed above on a quarterly basis.

E. Continuum of Care of Primary and Behavioral Health Treatment Services

Community input from the 2025 - 2028 CHNA process indicated that primary care, MH, and SUD treatment remains a significant need, especially for low-income residents. In response, Kedren plans to continue providing the full continuum primary care and behavioral health treatment services with an emphasis on providing targeted outreach to low-income individuals in the community. Furthermore, Kedren plans to monitor patient perceptions of care via surveys on a regular basis.

Kedren will continue to offer comprehensive in-patient and outpatient behavioral health services for children, transitional aged youth, adults and older adults, who are experiencing serious or persistent mental illness or emotional disturbance. Our services will continue to be provided in a caring, compassionate environment promoting a shared vision of improving lives and empowering individuals to recover.

Service delivery is holistic, collaborative, multidisciplinary and culturally competent, focusing on the individual, and when appropriate with the involvement and support of family or significant other. Our highly trained mental health staff, together with our strong leadership, create an unwavering commitment to quality services based on our belief in the resiliency and potential of individuals served.

F. Benefits Application Assistance

A lack of health insurance can pose a significant barrier to accessing healthcare and can significantly contribute to poor health. Within Kedren's service area, 13.3% were medically uninsured, representing more than 140,468 people in the service area without medical insurance. More than one-third (39.9%) of service area residents are insured through Medicaid (Medi-Cal), which is greater than the average for the county, state, or nation (22.5%, 19.9%, and 15.0%, respectively). In total, more than one-half of service area residents (53.2%) were either on Medicaid or not medically insured, which is much higher than the county (31.2%), state (26.8%), and nation (23.5%)[3].

Additionally, based on results from the 2023 California Health Interview Survey (5-year average), 8.4% of low-income residents ages 18-64 within Kedren's service area reported to have had no insurance for all of the past year. When added to those who had no insurance for part of the year, 15.8% of low-income residents had at least some gap in coverage during the past 12 months. These rates were both higher than in Los Angeles County or California (12.6%, and 10.2%, respectively). More than one-third (36.8%) of uninsured residents were eligible to enroll in Medi-Cal based on screening questions. Yet, low-income service area residents were more likely to have difficulty paying medical bills or paying for basing necessities due to medical bills.

As a certified enrollment entity (as part of Covered California, Kedren can provide support and enrollments services to patients onsite with staff who are certified enrollment counselors (CECs). CECs can assist individuals in applying for coverage/ insurance. Kedren will continue providing benefits assistance to patients including education to the uninsured, under insured and undocumented patients who may be able to access primary medical care and/or behavioral health services via state and/or local benefits.

G. Ongoing Community Outreach and Supportive Services

Kedren will continue to offer integrative primary and behavioral health care to our target populations and the broader community, and contribute in-kind support to a variety of organizations, with priority given to those that are directly health related and support the community. Kedren strives to provide benefits to the community at large by offering an assortment of services and encouraging community members to be

[3] U.S. Census Bureau, 2023 American Community Survey 5-Year Estimates, Table B27010.

actively involved in our programs that promote disease management, healthy living, and maintenance of a wellness state.

Community Benefit Costs

Kedren is a baseline Short/Doyle Medical Specialty Mental Health Service (SD/MC SMHS) provider of Los Angeles County. With the implementation of CalAIM (California Advancing and Innovating Medi-Cal),the contract with LACDMH is a fee-for-service model with standardized rates based on Current Procedural Terminology (CPT) codes.

Kedren's Community Benefit plan seeks to provide financial support to address health disparities through programs that offer free/low-cost care, subsidize government programs like Medi-Cal, and fund community partners. These initiatives focus on areas like housing insecurity, food insecurity, mental health, and access to health services, and are guided by community health needs assessments. The total economic value of the other community benefits provided by Kedren is $4,069,000.00 which is illustrated in the table below:

Program	Net Benefit	Notes
Street Medicine Program	$3,015,000	Includes one full-time medical doctor and two medical assistants, mobile clinic and supplies. The full cost of this program goes towards meeting Community Benefit Plan needs.
AB109 Program	$375,000	Provides crisis care services, food, shelter and hygiene products to formerly incarcerated individuals returning back to the community. Value of the grant used to fund the program.
Activities of Daily Living (ADL) Program	$131,000	Staffed by five occupational therapists who provide support for the ADL program. Average FTE utilized to support the ADL program is 0.20 resulting in a total value of $131,000.
Food Bank Program	$20,000	Food, U Haul rental, Grocery Bags and Personnel costs
Handle with Care Program	$30,000	Value of grant used to fund program
Amity Foundation Partnership	$498,000	Includes 0.5 Full Time Equivalent (FTE) medical doctors, 0.5 FTE podiatrist and 1.5 FTE medical assistants to support justice-involved patients. Total staff cost is $498,000.
Total Benefit	$4,069,000	

Community Benefit Plan Reporting

This 2025 Community Benefit Plan will be shared with internal and external stakeholders and the public through our website (www.kedren.org). Kedren's programs and services will continue to be shared with the community by (1) participating and/or hosting community-based events, health fairs, and participating at local, state, and national conferences; (2) dispatching the mobile unit to provide health education and outreach in the community, including hard to reach locations and population; (3) exhibiting program displays/posters in the waiting area of Kedren facilities; providing information about its programs with

patients receiving care; and through sharing information with Kedren's Board of Directors.

Kedren values community involvement in the development and evaluation of its programs and services. We will continue to use modalities, such as surveys, focus groups, and key informant interviews to obtain feedback to improve our programs and services on an ongoing basis to ensure we are meeting the need of the service area.