Lake Charles
Memorial Health System

ADVANCING **HEALTH** AND **WELL-BEING** IN SOUTHWEST LOUISIANA

LAKE CHARLES MEMORIAL HEALTH SYSTEM
IMPLEMENTATION PLANNING REPORT

APRIL 2026

Lake Charles
Memorial Health System

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VISION

The vision of Lake Charles Memorial Health System is to continually improve our quality and safety, advance our standards, and to be the major healthcare delivery system for ALL people of Southwest Louisiana.

MISSION

The mission of Lake Charles Memorial Health System is to improve the health of the people of Southwest Louisiana through superior care, innovative service, health education, and disease prevention provided in a personalized, caring, and safe environment.

Lake Charles
Memorial Health System

SERVICE EXCELLENCE

At Lake Charles Memorial Health System, we realize that it takes more than dedicated professionals with unsurpassed skills and the latest technological advancements to care for our patients. We understand that it also takes uncommon compassion and an unshakable commitment to providing excellent service. To ensure that this prevailing goal continues, a culture of Service Excellence has been adopted at Memorial. This culture is dedicated to the pursuit and recognition of superior service to our patients, physicians, and employees.

HERE FOR YOUR HEALTH

A Letter from Lake Charles Memorial Health System's President & CEO

To our friends and patrons throughout Southwest Louisiana,

Lake Charles Memorial Health System (LCMHS) exists to serve the community, striving to provide quality healthcare that meets the needs of the residents within the five-parish area. To achieve this goal, identification of the community's constantly evolving health landscape is necessary.

The Community Health Needs Assessment (CHNA), performed every three years, is required for hospitals to maintain nonprofit status. Through this comprehensive effort, LCMHS, alongside local partners and organizations, studies the complex health needs of the region and develops a plan with specific metrics for success to address access to care. We have completed the 2025 CHNA, which will now serve as the framework to guide our steps forward.

To be a responsible partner in the health of our friends and neighbors, we recognize that health equity is complex; each person faces a specific set of variables impacting their ability to care for their own health. The ongoing improvement of community health requires addressing these complex socioeconomic factors and removing barriers to care. Working strategically with our community partners, the results of this assessment will form the foundation for developing tactics, services, and programs to address the identified 2025 health priorities: 1) Behavioral Health, 2) Health Behaviors, 3) Managing Population Health & Preventing Chronic Disease, and 4) Access to Care.

Improving physical well-being and addressing health disparities often doesn't start within the walls of a hospital or doctor's office. Each of our community partners brings significant and unique expertise. We utilize these insights to incorporate public health strategies along with transforming how we deliver care and developing innovative models that link patients to community resources. The strength found in our collaboration makes a greater difference in our community than anything we could accomplish on our own.

Thank you to our partners, our SWLA community, and our stakeholder participants who took time to provide data and insights during the comprehensive CHNA process. We look forward to working side-by-side with our partners and the community to execute the strategies outlined in this report and build a healthier Southwest Louisiana.

Sincerely,

DEVON HYDE
President & CEO

COMMUNITY HEALTH NEEDS ASSESSMENT INTRODUCTION

From Community Input to Meaningful Action

The healthcare environment is rapidly evolving, being shaped by shifting federal requirements under the Affordable Care Act, rising labor and supply costs, workforce shortages, and broader economic uncertainty. Lake Charles Memorial Health System recognizes the critical importance of strategic investment and thoughtful resource allocation to ensure long-term sustainability and meaningful community impact. As a cornerstone provider in Southwest Louisiana, the health system serves a diverse population across Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis parishes, communities that continue to experience persistent health disparities, barriers to care, and increasing demand for services. These challenges are further compounded by changing demographics, an aging population, and a growing number of uninsured and underinsured residents, reinforcing the need for data-driven planning and coordinated, community-centered action. In response, Lake Charles Memorial initiated its 2025 Community Health Needs Assessment (CHNA) to develop a comprehensive and current understanding of community health conditions, service gaps, and emerging needs across its service area.

Conducted in alignment with IRS requirements for tax-exempt 501(c)(3) hospitals, the CHNA was designed to identify the most pressing health challenges, highlight inequities impacting vulnerable populations, and inform future community benefit and strategic planning efforts. To ensure objectivity and methodological rigor, the health system partnered with Tripp Umbach, an independent healthcare consulting firm with extensive national experience in CHNA development and community health analysis. The CHNA reflects a robust, multi-phase, and highly collaborative process that engaged a broad cross-section of regional stakeholders, including healthcare providers, public health officials, behavioral health professionals, social service organizations, nonprofit leaders, educators, faith-based representatives, and community members.

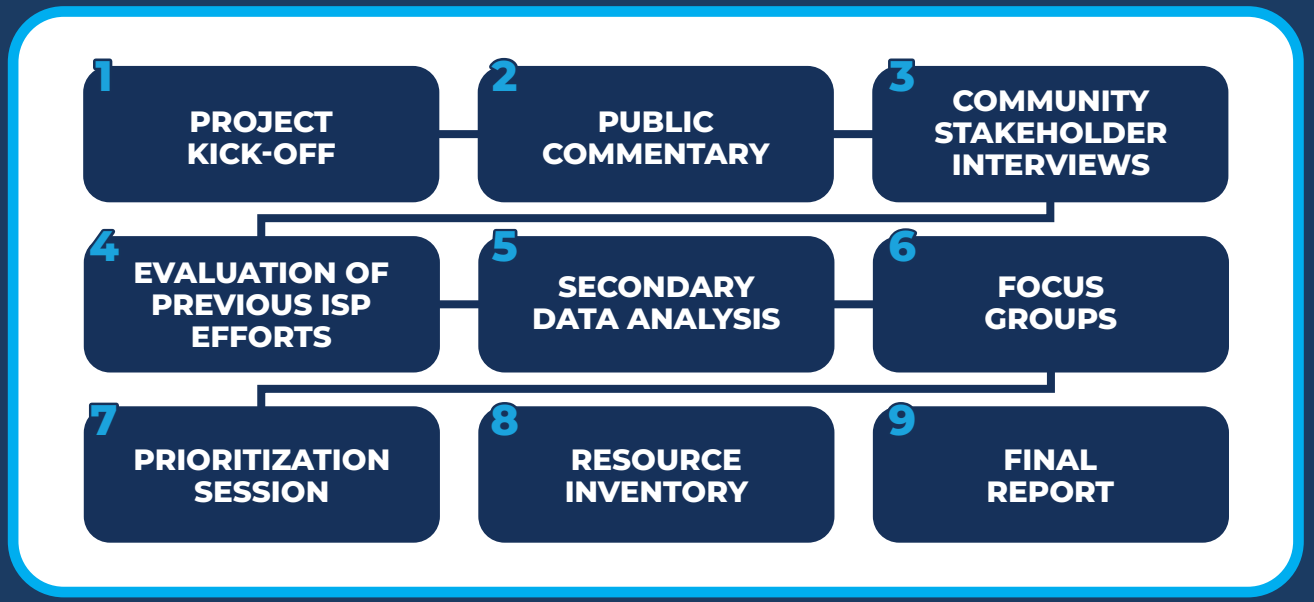
The assessment incorporated extensive analysis of secondary data from national, state, and local sources to evaluate demographic trends, health outcomes, disease prevalence, healthcare utilization, and key social drivers of health, such as housing, transportation, income, and education. This quantitative analysis was complemented by primary data collection, including structured stakeholder interviews, public input opportunities, and facilitated discussions that provided valuable qualitative insights into lived experiences, service gaps, and community priorities. A central component of the process was a structured prioritization session involving Lake Charles Memorial leadership and community stakeholders, where participants reviewed key findings and evaluated identified health needs based on criteria such as magnitude, severity, impact on vulnerable populations, and the health system's capacity to respond through existing programs, partnerships, or future investments. This collaborative approach ensured that final priorities were both data-driven and grounded in community perspective and practical feasibility.

Through this comprehensive process, four overarching priority areas were identified: 1) Behavioral Health, 2) Health Behaviors, 3) Managing Population Health & Preventing Chronic Disease, and 4) Access to Care.

Behavioral health emerged as a critical concern, reflecting increasing needs related to mental health, substance use, and timely access to services. Health behaviors and chronic disease prevention and management continue to require expanded education, prevention efforts, and care coordination. Access to care, including affordability, provider availability, transportation, and system navigation, is a foundational issue influencing outcomes across all health domains. The 2025 CHNA ultimately serves as a strategic roadmap guiding Lake Charles Memorial Health System's implementation planning and community benefit initiatives over the next three years, with a focus on targeted, measurable strategies supported by ongoing monitoring, stakeholder engagement, and a sustained commitment to advancing health equity, improving access, and strengthening the overall health and resilience of Southwest Louisiana.

The CHNA followed a multi-step approach, as illustrated in the flowchart below.

Figure 1: CHNA Methodology Flow Chart



Lake Charles
Memorial Health System

ABOUT LAKE CHARLES MEMORIAL HEALTH SYSTEM

Lake Charles Memorial Hospital, at 1701 Oak Park Boulevard in Lake Charles, Louisiana, serves as the flagship facility of the Lake Charles Memorial Health System (Lake Charles Memorial). This 314-bed acute care hospital anchors a community-owned regional health system and offers an array of services across its main campus and affiliated facilities. The hospital is complemented by a dedicated women's facility, a behavioral health hospital, a multispecialty physician group, and Moss Memorial, which serves underserved populations in Southwest Louisiana, all of which together form the health system.

Lake Charles Memorial offers comprehensive care across major service lines, including behavioral health, cancer care, heart and vascular services, women's health, orthopedics, imaging, laboratory, pharmacy, and more. The system's physician network, known as the Memorial Medical Group, comprises more than 100 specialists across 23 specialties and subspecialties, underscoring the depth and breadth of care available. This integrated network enables patients to benefit from coordinated care, with access to specialists and subspecialists under a single regional health umbrella.

Lake Charles Memorial has earned multiple prestigious recognitions. It is an accredited hospital by Det Norske Veritas (DNV) and holds the Gold Seal of Approval® from The Joint Commission as a certified Primary Stroke Center. It is also verified as a Level III Trauma Center by the American College of Surgeons. In 2025, the system was named to Newsweek's America's Best-in-State Hospitals list for Louisiana, among others.

Since 1995, Lake Charles has hosted the Family Medicine Residency Program in partnership with Louisiana State University Health Sciences Center (LSUHSC). The three-year residency provides comprehensive training in family medicine, emergency medicine, obstetrics/gynecology, pediatrics, and rural medicine, among other domains, preparing graduates to serve a spectrum of patients in Southwest Louisiana and beyond.

Lake Charles Memorial Hospital stands as a regional leader in patient care, specialty services, medical education, and community health, anchored in Lake Charles and committed to delivering excellence.

2025 COMMUNITY HEALTH REGIONAL PRIORITIES

The CHNA and accompanying Implementation Strategy Plan (ISP) are fully aligned with the requirements of the Patient Protection and Affordable Care Act, which has reshaped how individuals access care by emphasizing cost reduction, enhanced care coordination, and improved quality of services. In response to this evolving healthcare landscape, healthcare organizations continue to prioritize improving community health through strong collaboration with local, state, and national partners. Tripp Umbach partnered with Lake Charles Memorial Health System to complete the CHNA, which was formally adopted by the Board of Directors in December 2025. Building on these findings, the ISP outlines the prioritized community health needs identified through the assessment and defines the strategies the health system will implement over the next three years. Lake Charles Memorial Health System is committed to addressing all identified needs through targeted, measurable initiatives to improve health outcomes across its service area.

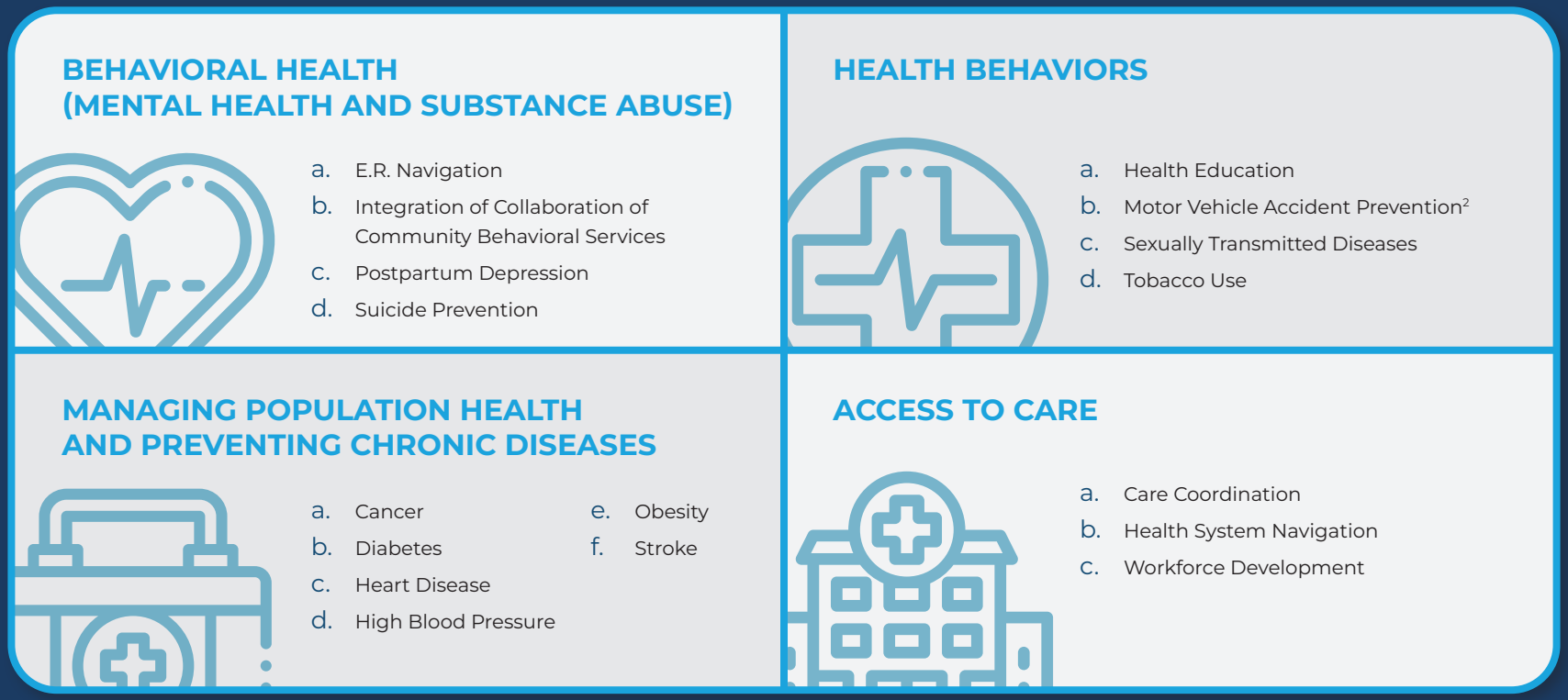
The requirements imposed by the IRS for tax-exempt hospitals and health systems must include the following:[1]

- Conduct a CHNA every three years.
- Report on how it is addressing the needs identified in the CHNA and describe the needs not being addressed and the reasons why.
- Define the community served by the hospital facility.
- Assess the health needs of that community using data and stakeholder input.
- Include input from persons who represent the broad interests of the community/have knowledge of, or expertise in public health.
- Identify and prioritize significant health needs of the community.
- Describe resources potentially available to address identified needs.
- Make the CHNA publicly available, including posting it on the hospital's website and making a printed copy available.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
    - Outline goals, actions, and resources the hospital will use to address identified health needs.

[1] For specific CHNA requirements for charitable hospital organizations, please visit the Internal Revenue Service.

The final priorities for the 2025 CHNA were identified through a comprehensive, multi-step process that integrated quantitative data, qualitative perspectives, and collaborative community input. Analysis of extensive secondary data, including health outcomes, disease prevalence, behavioral health indicators, socioeconomic conditions, and hospital utilization patterns across Southwest Louisiana, was conducted. This was complemented by primary data collection through stakeholder interviews, discussions with healthcare providers and community organizations, and a community survey. Using a structured prioritization process, the Working Group and key decision-makers evaluated and identified needs based on severity, disparities, feasibility, and community urgency. Through this rigorous approach, four major categories of need emerged as top priorities for 2025:

Figure 2: Lake Charles Memorial Health System CHNA



[2] The community health sub-need under Health Behaviors, "Motor Vehicle Accident Prevention," was updated to "Motor Vehicle Crash Prevention" to reflect current public health terminology and best practices. The term "crash" emphasizes that these incidents are preventable and often the result of modifiable behaviors such as impaired driving, speeding, and lack of seatbelt use. This updated language supports a prevention-focused approach and reinforces the role of evidence-based strategies in reducing injuries and fatalities.

BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE ABUSE)

Emergency Room Navigation, Integration of Collaboration of Community Behavioral Services, Postpartum Depression, and Suicide Prevention

Behavioral health is a critical component of overall health and well-being, shaping how individuals think, feel, and function in daily life. Across Southwest Louisiana, behavioral health conditions, including mental health disorders and substance use, affect individuals of all ages and backgrounds and are often closely linked with chronic disease, economic stress, trauma, and barriers to accessing care. When these needs go unmet, the consequences can be severe, including increased emergency department (ED) utilization, poorer physical health outcomes, reduced workforce participation, and elevated risks of suicide and substance-related harm. Within the Lake Charles Memorial Health System service area, understanding the scope of these challenges is essential to developing coordinated, effective responses that improve individual and community health outcomes. Data from national and state sources highlight the urgency of addressing behavioral health needs, as suicide remains a leading and preventable cause of death, with Louisiana reporting higher rates than many states.[3] Local data further emphasize that Calcasieu Parish experiences suicide rates higher than the state average, underscoring the need for targeted regional interventions.[4] Depression and mental distress are also widespread, with national surveillance and tools such as the CDC PLACES platform providing insight into localized patterns of need and gaps in access across counties and ZIP codes.[5,6]

Because of limited outpatient capacity, transportation challenges, and insurance barriers, many residents rely on EDs as a primary entry point for behavioral healthcare, making ED-based interventions a critical opportunity to improve outcomes. Best practices emphasize rapid identification, timely assessment, de-escalation, safety planning, and “warm handoffs” to appropriate levels of care, rather than discharging patients without structured follow-up.[7] National research also highlights how ED boarding and overcrowding, particularly for behavioral health patients, can delay treatment and worsen outcomes, reinforcing the need for streamlined pathways and coordinated care models.[8] Evidence-based approaches, such as peer or navigator-led interventions, have shown promise in increasing patient engagement in treatment following ED visits, particularly for substance use disorders.[9] For Lake Charles Memorial, strengthening collaboration across hospitals, behavioral health providers, EMS, law enforcement, schools, and community organizations presents a key opportunity to reduce reliance on EDs as the default entry point and instead create a more integrated system of care that supports timely triage, referral, and follow-up services. Suicide prevention strategies are most effective when implemented through a layered approach, including universal screening, safety planning, rapid follow-up, and strong linkage to outpatient care. Given that prior suicide attempts are a major risk factor, early identification and continuity of care are essential components of effective intervention.[10]

[3] Centers for Disease Control and Prevention; National Center for Health Statistics
[4] Centers for Disease Control and Prevention; National Center for Health Statistics
[5] Centers for Diseases Control and Prevention Places
[6] Center for Diseases Control and Prevention; Mental Health
[7] Agency for Healthcare Research and Quality
[8] American College of Emergency Physicians
[9] American College of Emergency Physicians
[10] Louisiana Department of Health

Maternal behavioral health, particularly postpartum depression, is another critical priority with long-term implications for both maternal and child health. Data from Louisiana PRAMS and national sources indicate that postpartum depressive symptoms affect a significant share of women, and clinical guidance identifies perinatal depression as one of the most common complications of pregnancy and the postpartum period.[11,12] The American College of Obstetricians and Gynecologists recommends routine screening throughout pregnancy and postpartum, supported by systems that ensure appropriate follow-up and treatment.[13] Expanding screening into pediatric settings further enhances early detection and intervention. Moving forward, a comprehensive behavioral health strategy for Southwest Louisiana must combine these best practices with efforts to address underlying social drivers such as transportation, housing, and affordability. By doing so, Lake Charles Memorial Health System can strengthen access, improve continuity of care, and enhance the overall resilience and well-being of the communities it serves.

The following ISP matrix outlines the targeted, measurable strategies Lake Charles Memorial Health System will implement to address identified behavioral health priorities and improve outcomes across Southwest Louisiana.

[11] Louisiana Department of Health; Pregnancy Risk Assessment Monitoring System (PRAMS)

[12] U.S. Department of Health and Human Services

[13] American College of Obstetricians and Gynecology

Priority 1: Behavioral Health (Mental Health & Substance Use Disorder)

Goal: Lake Charles Memorial Health System will help meet our community's behavioral health (mental health and substance use disorder) needs.

Anticipated Impact: Lake Charles Memorial Health System will assist patients and families in navigating better the behavioral health services offered.

1. ER navigation **2.** Integration & Collaboration of Community BH Services **3.** Postpartum Depression **4.** Suicide Prevention

Community Health Need: Integration & Collaboration of Community BH Services			
Goals	**Strategies**	**Metrics**[14,15,16,17]	**Partnering Organization(s)**
Improve access to care for mental health patients.	Improve access to emergent mental health assessments/ treatment via ER.	• Number of intake calls. • Number of 'Code Bert' overhead alerts to escalate immediate care in ER. • Number of patients in emergency room for mental health episodes. • Number of walk-in patients who are triaged and number offered for referral.	• Acadian Ambulance Services • Other psychiatric inpatient and outpatient clinics • Local hospital and healthcare facilities • Police departments • Imcal – Imperial Calcasieu Human Services Authority • Office of Public Health (LA Bridge Program) • LCMH ER and SUN navigators • Coroner's office • Area medical office clinics
	Improve access to available inpatient beds and outpatient services for mental health/substance abuse patients.[18]	• Number of available psychiatric healthcare providers. • Number of available inpatient beds (i.e., increase the number of beds). • Number of discharged plans provided. • Number of patients referred, admitted, or who sought services at the Archer Institute of LCMH. • Number of posts on Memorial HQ educating LCMHS employees on our own behavioral health services. • Develop strategy to track outpatient access through Epic.	• Archer Institute transportation services • Acadian Ambulance Services • Other psychiatric inpatient and outpatient clinics • Local hospital and healthcare facilities • Police departments • Faith-based organizations • Imcal (Imperial Calcasieu Human Services Authority) • Office of Public Health (LA Bridge Program) • LCMH ER and SUN navigators • Southwest Louisiana Mental Health Workgroup • Volunteers of America • Catholic Charities • Coroner's office • Area medical office clinics

Community Health Need: Integration & Collaboration of Community BH Services (continued)			
Goals	**Strategies**	**Metrics[14,15,16,17]**	**Partnering Organization(s)**
Improve access to care for mental health patients.	Communicate/educate community on available mental health resources.	• Number of health education communication pieces distributed, seminars attended, and training opportunities for outside agencies.	• Area counseling centers • Faith-based organizations • Kay Dore Counseling Center • Office of Public Health – (LA Bridge Program) • McNeese Student Clinic • Sowela student services • At all community health fairs/events that LCMHS participates in • Imcal - Imperial Calcasieu Human Services Authority
	Work with Medicaid managed care plans to include our intensive outpatient mental health program in their services.	• Number of agencies participating in Intensive Outpatient Program (IOP) services.[19]	• Archer Institute transportation services • All State Medicaid Plans
Improve access to care for substance use for dual diagnosis patients who present with mental health/ substance use.[20]	Improve access to LA Bridge program through the ER.[21]	• Number of patients seen by navigators. • Number of Narcan distributed with education provided.	• Acadian Ambulance Services • Local hospital and healthcare facilities • Police departments • Imcal – Imperial Calcasieu Human Services Authority • Office of Public Health (LA Bridge Program) • LCMH ER and SUN navigators • Area medical office clinics • Southwest Louisiana Mental Health Workgroup
Expand outpatient individual therapy for substance abuse patients.[22]	Provide and identify patients in need of discharge plans.	• Number of patients admitted/ complaints for evaluations. • Number of discharge plans provided.	• Local hospital and healthcare facilities • LCMH ER and SUN navigators • Area medical office clinics • Outpatient clinics • Area counseling centers
Provide/add outpatient mental health services.	Add outpatient mental health services to those in need in the community.	• Number of attendees participating in therapy sessions. • Number of patients who are aware of mental health services (kinds/types of services) offered at Archer Institute of LCMH.	• Area counseling centers • Faith-based organizations • Kay Dore Counseling Center • Office of Public Health (LA Bridge Program) • McNeese Student Clinic • Local hospital and healthcare facilities • Sowela student services • At all community health fairs/events that LCMHS participates in • Imcal - Imperial Calcasieu Human Services Authority

Community Health Need: Postpartum Depression			
Goals	**Strategies**	**Metrics[14,15,16,17]**	**Partnering Organization(s)**
Provide OB patients with education on postpartum depression.[23]	Provide mental health services for patients diagnosed with postpartum depression.[24]	• Number of patients who received education on postpartum depression through their OB office. • Number of patients referred to behavioral health services.	• MMG OB/GYN Providers • Affiliated OB/GYN providers • MMG Outpatient Behavioral Health Clinic

Community Health Need: Suicide Prevention			
Goals	**Strategies**	**Metrics[14,15,16,17]**	**Partnering Organization(s)**
Reduce the incidence of suicide.	Educate, prevent, and reduce the incidence rates of suicide.	• Number of patients and organizations educated on behavioral health services. • Number of inpatients provided with suicide information and Stanley Brown Program.	• Archer Institute transportation services • Acadian Ambulance Services • Local hospital and healthcare facilities • Police departments • Faith-based organizations • Imcal – Imperial Calcasieu Human Services Authority (LA Bridge Program) • Bryce River Foundation • NAMI • American Foundation for Suicide Prevention • LCMH ER and SUN navigators • Area medical office clinics • Local high schools • McNeese students • Sowela students • Area medical office clinics

Community Health Need: ER Navigation			
Goals	**Strategies**	**Metrics[14,15,16,17]**	**Partnering Organization(s)**
Improve navigation in ER.	Educate public of ER as a destination place to get assistance/help with substance use.	• Number of educational social media posts about help available for substance abuse.	• Acadian Ambulance Services • Imcal – Imperial Calcasieu Human Services Authority (LA Bridge Program) • Office of Public Health – (LA Bridge Program) • LCMH ER and SUN navigators • At all community health fairs/events that LCMHS participates in • Police department

[14] The metric, "Number of one-on-one meetings with community sources who encounter mental health needs and educate them on the services we offer" was removed due to the absence of a standardized tracking mechanism. One-on-one meetings with community partners are not systematically documented, limiting the ability to measure this metric.

[15] The metric the "Number of inpatient calls from the Archer Institute" was deleted as this metric is not aligned with current organizational activities. Specifically, the Archer institute does not make intake calls.

[16] The metric, "Number of participants utilizing low rate/reduced mental health services" was removed as it is not applicable to LCMH's patient population. With approximately 90% of patients covered by Medicaid and the remaining 10% being self-pay, services are already delivered at low or no cost, eliminating the need for a separate financial assistance tracking measure.

[17] The metrics, "Number of patients seeking behavioral health services" and the "Number of patients referred to LA Bridge Program" was removed due to duplication. Behavioral health service utilization is already captured through existing metrics.

[18] The strategy "Improve access to available inpatient beds for mental health/substance abuse patients" was updated to "Improve access to available inpatient beds and outpatient services for mental health/substance abuse patients" to be more inclusive of the community LCMH represents.

[19] It is important to note that the current location of LCMH's Intensive Outpatient Program limits Medicaid Plan participation.

[20] The goal was updated from "Improve access to care for substance abuse/detox programs for dual diagnosis patients who present mental health/substance abuse" to "Improve access to care for substance use for dual diagnosis patients who present with mental health/substance use." The update ensures alignment with LCMH's terminology, as this designation is not used within current operations or clinical workflows.

[21] The strategy "Improve detox holding process/area via ER" was updated as the organizational terminology and designation is not used in current clinical practice.

[22] The goal was updated from "Expand outpatient group therapy for substance abuse patients" to "Expand outpatient individual therapy for substance abuse patients" as the organization does not offer group therapy services and provides only individual therapy.

[23] The goal was updated from "Provide patients with mental health service diagnosed with postpartum depression to "Provide OB patients with education on postpartum depression" to accurately reflect the intended order of activities and implementation.

[24] The strategy "Educate OB patients on symptoms and treatments of postpartum depression" to "Provide mental health services for patients diagnosed with postpartum depression" to accurately reflect the intended order of activities and implementation.

HEALTH BEHAVIORS

Health Education, Motor Vehicle Crash Prevention, Sexually Transmitted Diseases, and Tobacco Use

Health behaviors are a primary driver of preventable illness, injury, and premature death, making them a critical focus area for Lake Charles Memorial's CHNA. In Southwest Louisiana, key health behavior priorities, including health education, motor vehicle crash prevention, sexually transmitted diseases (STDs), and tobacco use, are closely interconnected and shaped by underlying factors such as economic stress, limited access to preventive services, transportation barriers, and gaps in early screening and treatment. Health education serves as the foundation across these areas, improving health literacy and empowering residents to adopt preventive behaviors, engage with primary care earlier, and reduce reliance on emergency services. When delivered through trusted channels such as healthcare providers, schools, and community organizations, consistent education can significantly influence behavior change and long-term health outcomes. Motor vehicle injuries remain a leading and preventable cause of death, with data from the Centers for Disease Control and Prevention emphasizing that evidence-based strategies such as increasing seatbelt use, reducing impaired driving and improving road safety, can save lives and reduce long-term disability.[25] Louisiana-specific data further highlight the magnitude of this issue, with hundreds of fatalities annually and substantial economic costs, reinforcing the importance of targeted prevention and enforcement strategies.[26] For Lake Charles Memorial, reducing motor vehicle injuries has direct implications for lowering emergency department utilization, trauma cases, and long-term rehabilitation needs.

Equally significant is the ongoing burden of STDs, which continue to affect adolescents, young adults, pregnant women, and families across Louisiana. The state consistently ranks among the highest nationally for infections such as chlamydia, gonorrhea, and congenital syphilis, reflecting persistent gaps in screening, education, and access to care.[27] These conditions contribute to serious complications, including infertility and adverse pregnancy outcomes, yet are largely preventable through routine screening, timely treatment, and targeted public health outreach. Expanding access to stigma-free education, normalizing testing, and strengthening care pathways are essential strategies for reducing transmission and improving outcomes. Tobacco use further compounds the region's health challenges, as it remains the leading cause of preventable disease and death, contributing to conditions such as cancer, heart disease, and chronic obstructive pulmonary disease.[28] Louisiana continues to report smoking rates above the national average, underscoring the need for sustained prevention and cessation efforts.[29] Evidence-based approaches, including routine screening, counseling, medication-assisted cessation, and community-based interventions, offer scalable solutions that can yield immediate and long-term health benefits.

[25] Centers for Diseases Control and Prevention

[26] Centers for Disease Control and Prevention

[27] Ibid.

[28] Centers for Diseases Control and Prevention

[29] Centers for Disease Control and Prevention

These health behavior issues are also closely linked to behavioral health, as substance use, mental health conditions, and social stressors often contribute to risky behaviors such as impaired driving, unsafe sexual practices, and tobacco use. Addressing these challenges requires a coordinated, multi-sector approach that integrates prevention into routine care, expands community outreach, and strengthens partnerships across healthcare, education, and social services. By aligning evidence-based strategies with community needs, Lake Charles Memorial Health System can reduce preventable disease burden, improve population health outcomes, and support healthier, more resilient communities across Southwest Louisiana.

The following ISP matrix details the specific, actionable strategies Lake Charles Memorial will implement to address key health behavior priorities and enhance community health outcomes across Southwest Louisiana.

Priority 2: Health Behaviors

Goal: Improve healthy behaviors and practices among Lake Charles Memorial Health System's community.

Anticipated Impact: Populations understand and take an active role in healthy behaviors to prevent chronic diseases.

1. Health Education **2.** Motor Vehicle Accident Prevention **3.** Sexually Transmitted Diseases (STDs) **4.** Tobacco Use

Community Health Need: Health Education			
Goals	**Strategies**	**Metrics[30,31]**	**Partnering Organization(s)**
Educate low- income and/ or high-risk populations on preventative health, value of physical activity & wellness.	Educate low-income/ high-risk patients and community residents on a healthy lifestyle, accessing healthy foods, and the value of the physical activity.	• Number of participants who received health screenings at educational events and health fairs events. • Number of patients engaged in wellness program receiving flu shots.[32] • Number of patients referred to PCPs/specialists from health screenings and events. [33] • Number of education sessions conducted.	• Calcasieu Parish Ward 3 sports complexes • Local employer groups • Local schools • McNeese State University/Sowela • Partnership for a Healthier SWLA • Senior Centers
Continue fall prevention education for the public.[34]	Collaborate with community partners to reach high-risk populations for fall prevention.	• Number of people from targeted populations assisted with fall prevention. • Number of community organizations educated.	• Council on Aging • Area Elderly Care centers • LCMHS Fall Prevention
Continue Stop the Bleed program.	Collaborate with community partners to educate and train on bleeding control.	• Number of people from targeted populations assisted with education/training in Bleeding control. • Number of community organizations educated.	• Community organizations • Faith-based organizations • Local employer groups • Southwest Center for Health Services • Law Enforcement • First Responders • LCMH Trauma Center • LCMH Foundation

Community Health Need: Motor Vehicle Crash Prevention[35]			
Goals	**Strategies**	**Metrics[30,31]**	**Partnering Organization(s)**
Decrease teen motor vehicle crashes.[36]	Educate area schools on motor vehicle crash prevention.	• Number of Sudden Impact Crash Prevention educational events conducted. • Number of SWLA high schools participating. • Number of SWLA teens who participated in mock events. • Number of alcohol/vehicle educational posts on social media.	• Louisiana Highway Patrol • Calcasieu Parish Schools • LCMH Foundation • LCMH Trauma Center
Reduce injuries/ fatalities of infants, children in auto crashes.[37]	Educate parents, families on car seat safety.[38]	• Number of people from targeted populations educated on car seat safety.	• Louisiana Highway Patrol • Calcasieu Parish Schools • LCMH Trauma Center • Fire Departments • Office of Public Health

Community Health Need: Sexually Transmitted Diseases (STDs)			
Goals	**Strategies**	**Metrics[30,31]**	**Partnering Organization(s)**
Align Hospital Goals with Region V task force.	Educate high-risk SWLA community.	• Number of education sessions conducted. • Number of social media posts, articles published on STD prevention.	• OB Care • Office of Public Health • MMG offices (LSU, Moss GYN) • LCMH Sane Program
Provide STD Prevention and SANE Education.	Educate population through school and community events.	• Number of targeted populations at events.	• Calcasieu Parish Schools • Sowela • McNeese State University

Community Health Need: Tobacco Use			
Goals	**Strategies**	**Metrics[30,31]**	**Partnering Organization(s)**
Reduce smoking among targeted populations.	Provide on-going smoking cessation programs and prevention resources throughout health system and community network.	• Number of patients referred from hospital and clinics to Tobacco Control Initiate (TCI).[39] • Partner to conduct a tobacco survey to region.[40]	• 1-800-QUIT-NOW • Partnership for a Healthier Southwest Louisiana • MMG Physician Offices • Louisiana Tobacco Control Initiative (LA-TCI) • Region 5 Office of Public Health
	Communicate availability of smoking cessation and educational resources among community organizations, churches, and targeted groups.	• Number of doctors and residents educated. • Number of distributed materials/ information at community events.	• 1-800-QUIT-NOW • Louisiana Tobacco Control Initiative (LA-TCI) • American Cancer Society • American Lung Association • Partnership for a Healthier SWLA
	Host annual smoking cessation community-wide events in November to distribute educational information.	• Number of smoking cessation community. awareness/education events in November. • Number of educational materials/flyers distributed. • Number of social media educational posts.	• American Cancer Society • American Lung Association • Local employer groups • MMG Physician Offices • American Cancer Society • American Lung Association • Local senior centers • Louisiana Tobacco Control Initiative (LA-TCI) • Other community organizations

[30] The metric, “Number of smoking cessation programs conducted” was removed due to lack of direct program delivery. LCMH does not administer onsite smoking cessation programs and instead refers patients to external resources, limiting the ability to measure this metric. Additionally, the metric, “Number of new movers requesting cessation materials” was removed as the organization no longer distributes new mover packets due to budgetary constraints. Lastly, the metric, “Number of healthcare professionals educated about program and resources available” was removed due to measurement limitations. Access to program resources is facilitated through a referral link within the EMR system, and provider engagement with this resource cannot be consistently quantified.

[31] The metric, the “Number of healthcare professionals educated about program and resources available” was removed as this metric cannot be reliably measured; access to program resources occurs through a referral link within the EMR and is not tracked.

[32] The metric, “Number of participants engaged in wellness program receiving flu shots” was updated to “Number of patients engaged in wellness program receiving flu shots” as LCMH no longer offers a public-facing wellness program.

[33] The metric, the “Number of patients referred to PCPs/specialists from health screenings and events through a wellness program” was updated to “Number of patients referred to PCPs/specialists from health screenings and events” as LCMH no longer offers public-facing wellness programs.

[34] The goal, “Continue fall prevention education for the elderly” was changed to “Continue fall prevention education for the public”. The terminology “elderly” was replaced with “public” to ensure inclusive language and reflect that fall prevention efforts target all age groups, not solely older adults.

[35] The community health need “Motor Vehicle Accident Prevention” was updated to “Motor Vehicle Crash Prevention”. The terminology was updated to align with best practices in public health, emphasizing that such accidents are preventable and influenced by modifiable risk factors.

[36] The goal, “Decrease teen motor vehicle accidents” was updated to “Decrease teen motor vehicle crashes”. This change reflects the modifications in the community health need.

[37] The goal, “Reduce injuries/ fatalities of infants, children in auto accidents” was updated to “Reduce injuries/ fatalities of infants, children in auto crashes”. This change reflects the modifications in the community health need. Additionally, the metric, the “Number of targeted populations assisted with proper car seat installation” was updated to the “Number of people from targeted populations educated on car seat safety” as staffing limitations reduced the opportunity to conduct the initiative.

[38] The strategy, “Educate parents, families on proper care seat installation” was updated to “Educate parents, families on car seat safety” as staffing limitations reduced the opportunity to conduct the initiative.

[39] The metric, the “Number referred from and behavioral health” was revised to “Number of patients referred from hospital and clinics to TCI” to reflect the imitative from LCMH.

[40] The metric, “Conduction of a tobacco survey to region” was updated to “Partner to conduct a tobacco survey to region” to reflect the initiative from LCMH.

MANAGING POPULATION HEALTH AND PREVENTING CHRONIC DISEASES

Cancer, Diabetes, Heart Disease, High Blood Pressure, Obesity, and Stroke

Managing population health and preventing chronic disease are essential to improving longevity, quality of life, and health equity across Southwest Louisiana, where conditions such as cancer, diabetes, heart disease, high blood pressure, obesity, and stroke continue to drive significant morbidity, mortality, and healthcare utilization. Chronic diseases remain among the leading causes of death and disability in both Louisiana and the United States and account for nearly $4.9 trillion in annual healthcare expenditures, underscoring their widespread impact on individuals, families, and healthcare systems.[41] In Louisiana, seven of the top 10 causes of death are chronic conditions, including heart disease, cancer, stroke, chronic lower respiratory disease, diabetes, Alzheimer's disease, and kidney disease, highlighting the urgent need for coordinated prevention and management strategies.[42] Cancer, in particular, represents a major burden in the state, with Louisiana reporting higher incidence and mortality rates than national averages, especially for lung, colorectal, and breast cancers, many of which are preventable or treatable when detected early through routine screening and risk reduction efforts.[43] Tobacco use remains the leading modifiable risk factor for cancer and other chronic diseases, with 15.7% of Louisiana adults reporting smoking in 2023, reinforcing the importance of expanding access to cessation services and strengthening prevention initiatives.[44]

Diabetes also poses a significant and growing challenge, affecting millions nationwide and contributing to serious complications such as heart disease, stroke, kidney failure, and vision loss. With more than 38 million Americans living with diabetes and millions more at risk because of prediabetes, early detection and preventive interventions, such as healthy eating, increased physical activity, and participation in diabetes prevention and self-management programs, are critical to reducing disease progression and improving outcomes.[45] Cardiovascular disease, including heart disease and stroke, remains the leading cause of death in Louisiana, with high blood pressure serving as the most important modifiable risk factor. Despite widespread diagnosis, many individuals do not have their hypertension adequately controlled, increasing the likelihood of severe complications and premature death.[46] Similarly, stroke continues to be a leading cause of disability and mortality, with rates in Louisiana exceeding national averages, driven by risk factors such as hypertension, diabetes, smoking, obesity, and physical inactivity.[47] Effective prevention strategies, including routine screening, medication adherence, lifestyle modification, and public education, are essential to reducing these risks and improving long-term outcomes.

[41] Center for Disease Control and Prevention
[42] Louisiana Department of Health
[43] Center for Disease Control and Prevention
[44] Center for Disease Control and Prevention
[45] Center for Disease Control and Prevention
[46] Center for Disease Control and Prevention
[47] Center for Disease Control and Prevention

Obesity exacerbates the burden of chronic disease, with nearly 40% of Louisiana adults classified as obese, placing the state among the highest in the nation.[48] Obesity significantly increases the risk of developing diabetes, cardiovascular disease, and certain cancers, while also contributing to higher healthcare costs and reduced quality of life. Addressing these interconnected conditions requires a comprehensive, multi-sector approach that integrates healthcare delivery with public health initiatives and community-based interventions. Chronic diseases are closely tied to modifiable behaviors such as poor nutrition, physical inactivity, and tobacco use but are also deeply influenced by social determinants of health, including poverty, food insecurity, transportation barriers, and limited access to care. In Southwest Louisiana, these challenges are compounded by provider shortages, environmental factors, and the long-term impacts of natural disasters, all of which can disrupt care and increase vulnerability.

To effectively address these issues, Lake Charles Memorial Health System must continue to expand access to preventive services, strengthen chronic disease management programs, and enhance health education efforts while fostering collaboration across healthcare, public health, and community organizations. By implementing evidence-based, community-driven strategies that address both clinical and social factors, the health system can reduce preventable disease burden, improve care coordination, and advance long-term population health outcomes across the region. Lake Charles Memorial will implement strategies to address key health behavior priorities, manage population health, and prevent chronic diseases across Southwest Louisiana.

[48] Louisiana Department of Health

Priority 3: Managing Population Health & Preventing Chronic Diseases

Goal: Improve health outcomes among targeted populations through health promotion in Lake Charles Memorial Health System's community.

Anticipated Impact: Assist populations to understand and take an active role in managing and reducing chronic diseases.

1. Cancer **2.** Diabetes **3.** Heart Disease **4.** High Blood Pressure **5.** Obesity **6.** Stroke

Community Health Need: Cancer			
Goals	**Strategies**	**Metrics**[49,50,51,52,53,54,55]	**Partnering Organization(s)**
Improve cancer care access to low income/ underserved populations.	Align services within the health system to identify patients who need further diagnostic workup for breast/colon/ cervical cancer.[56]	• Number, volume of patients served, assisted with navigation.	• Southwest LA Center for Health Services • All MMG providers • Community independent providers
Improve cervical cancer, breast cancer, lung cancer & colon cancer awareness.	Partner with community organizations to provide HPV vaccination education.	• Number of at-risk patients attending annual LSU cervical cancer screening who received vaccination and education. • Number of social media educational posts on the importance of HPV vaccination. • Number of flyers distributed at community events on list of locations where the vaccinations are given.	• Calcasieu Parish Health Unit • Children's Clinic • Pediatric Clinic • LC Memorial Ob Care • McNeese Student Clinic • Moss Memorial Gynecological Clinic • Southwest LA Center for Health Services • LSU Clinic – Pediatrics • Children's Clinic • Pediatric Center • Calcasieu Parish Health Unit • Local schools • Sane program
	Increase the number of mammograms, colon & lung cancer preventative screenings.	• Number of mammograms conducted. • Number of colon screenings conducted. • Number of lung screenings conducted.	• Breast Health navigators • Cancer Center navigators • LC Diagnostic Imaging • Pathology Lab • Commission on Cancer • American Cancer Society

Community Health Need: Cancer (continued)			
Goals	**Strategies**	**Metrics**[49,50,51,52,53,54,55]	**Partnering Organization(s)**
Improve coordination of cancer care.	Expedite initiation of cancer care for LCMH patients.	• Number of patients screened/ educated through MMG providers. • Implement EON lung navigation program for 2026. • Decrease the average number of days of suspicious radiographic findings for breast cancer. • Decrease the average number of days from biopsy to treatment for breast cancer patients.[57]	• Breast Health navigators • Cancer Center navigators • Moss Memorial Health Clinic
Improve patient education regarding diagnosis and treatment.	Enhance Cancer Patient Navigation Program to improve patient education as well as address patient barriers to care.	• Number of at-risk patients attending. • Decrease average number of diagnosis (dx) to 1st treatment for lung cancer patients. • Number of cancer patient education journey packets distributed.	• Ethel Precht Foundation • Medical Transportation Services • National Cancer Resource Organizations

Community Health Need: Transportation			
Goals	**Strategies**	**Metrics**[49,50,51,52,53,54,55]	**Partnering Organization(s)**
Improve transportation options for cancer patients	Strive to identify new transportation options or partners.	• Number of transportation partners who can provide services to remote patients.	• American Cancer Society • Abraham's Tent • AC Medical Transportation • Calcasieu Parish ParaTransit • Care Help of Sulphur • Catholic Charities of SWLA • Council on Aging - 60+ • LA Medicaid's Medical Transportation Service • Lake Charles City Bus • LCMH Foundation • Ms. B's Transportation • Uber • Lyft

Community Health Need: Transportation (continued)			
Goals	**Strategies**	**Metrics**[49,50,51,52,53,54,55]	**Partnering Organization(s)**
Improve transportation options for cancer patients	Expand patient awareness of transportation services in the community and assist with transportation resources.[58]	• Number of patient volume assisted with any transportation through the navigation program.[59]	• Abraham's Tent • AC Medical Transportation • American Cancer Society • Angel Wheels • Calcasieu Public Transit • Cancer Care • Care Help of Sulphur • Catholic Charities of SWLA • Council on Aging • La Medicaid Medical Transportation Service • Lake Charles City Bus • LCMH Foundation • Ms. B's Transportation • Uber • Lyft
	Provide gas card assistance when funding is available.	• Number of patients provided with gas cards.	• American Cancer Society • Abraham's Tent • AC Medical Transportation • Calcasieu Parish ParaTransit • Care Help of Sulphur • Catholic Charities of SWLA • Council on Aging - 60+ • LA Medicaid's Medical Transportation Service • Lake Charles City Bus • LCMH Foundation • Ms. B's Transportation • Uber • Lyft
Improve lodging options for cancer patients	Provide lodging assistance when funding is available.	• Number of patients provided with lodging.	• American Cancer Society • LCMH Foundation • Area hotels (L'Aubrge, Home2Suites, Hampton Inn and Candlewood Suites)

Community Health Need: Financial Burden (under Cancer)			
Goals	**Strategies**	**Metrics**[49,50,51,52,53,54,55]	**Partnering Organization(s)**
Assist uninsured and underinsured patients to access essential cancer care services.	Enhance awareness and educate patients on availability of financial services.	• Number of patients in need of financial assistance. • Number of patients who were successful in obtaining Medicaid.[60]	• American Cancer Society • Cancer Care • Ethel Precht • LCMH Financial Counselors • Lymphoma • Leukemia Society • LCMH Foundation • Moss Memorial Health Clinic
	Provide financial counseling and determine eligibility for health services and programs.	• Number of patients who received financial counseling.	• LCMH Financial Counselors • LCMH Foundation • Moss Memorial Health Clinic

Community Health Need: Diabetes			
Goals	**Strategies**	**Metrics**[49,50,51,52,53,54,55]	**Partnering Organization(s)**
Provide preventative screenings and/or education to improve the early detection of diabetes.	Conduct preventive screenings.	• Number of participants receiving primary and specialty care at Moss Memorial. • Number of screenings conducted through MMG providers.	• Community resources • Council on Aging • Faith-based organizations • Local employers, Moss Memorial • MMG providers • Partnership with a Healthier SWLA Moss Memorial Diabetes Education • LCMH Diabetes Education
	Hold outreach events about diabetes prevention in conjunction with Office of Public Health and other healthcare entities in our primary service area (PSA).	• Number attendees at outreach events. • Number of risk assessments given at community events.	• Moss Memorial Health Clinic • Memorial Wellness Program (employees) • Memorial Hospital • Local employers • Faith-based organizations • Community based organizations • Office of Public Health • City of Lake Charles
Provide preventative screenings and/or education to improve the early detection of diabetes.	Educate patients and families to understand their health status (what the numbers mean) and how to prevent chronic disease at health fairs and seminars.	• Number of patients and families educated. • Number of wellness emails sent promoting health seminars, events and fairs. • Number of flyers distributed on preventive health screenings.	• Local employers • Memorial Diabetes Education • Moss Memorial Health Clinic • LCMH Diabetes Education • Wellness Program (LCMHS employees) • Stroke Prevention Coordinator • Community resources • Council on Aging • Faith-based organizations • Partnership with a Healthier SWLA • Ward 3 • LCMH Diabetes Education

Community Health Need: Obesity			
Goals	**Strategies**	**Metrics**[49,50,51,52,53,54,55]	**Partnering Organization(s)**
Provide education to reduce obesity among patient population.	Educate patients and families to understand their health status and how to prevent and reduce obesity at schools, health fairs, and seminars.	• Number of schools sent information on Greaux Healthy materials.[61] • Number of patients provided with obesity intervention education (BMI specifically).[62]	• Local schools • Community-based organizations • Faith-based organizations • Employers • Local schools • Greaux Healthy – statewide childhood obesity initiative (Pennington Biomedical)

Community Health Need: Heart Disease, High Blood Pressure, and Stroke			
Goals	**Strategies**	**Metrics**[49,50,51,52,53,54,55]	**Partnering Organization(s)**
Provide preventative screenings and/ or education to improve early detection of heart disease, high blood pressure, and stroke.	Conduct preventive screenings on HD, HBP, and stroke.	• Number of individuals referred to the system through a wellness program and additional community events. • Number of patients screened. • Number of participants receiving primary and specialty care at Moss Memorial.	• Moss Memorial Health Clinic • Memorial Wellness Program (employees) • Memorial Hospital • MMG providers
	Hold outreach events about HD, HBP, and stroke prevention.	• Number attendees at outreach events.	• Moss Memorial Health Clinic • Memorial Wellness Program (employees) • Memorial Hospital • Local employers • Faith-based organizations • Community based organizations • Local elementary schools, high schools, colleges and universities
	Educate patients and families to understand their health status (what the numbers mean) and how to prevent Heart disease, HBP, and stroke at health fairs and seminars.	• Number of patients and families educated. • Number of wellness emails sent promoting health seminars, events and fairs. • Number of flyers distributed on preventive health screenings.	• Local employers • Memorial Diabetes Education • Moss Memorial • Moss Memorial Diabetes Education • LCMH Diabetes Education • Wellness Program • Stroke Prevention Coordinator • Community resources • Council on Aging • Faith-based organizations • Partnership with a Healthier SWLA • Ward 3 • LCMH Diabetes Education

[49] The metric, the "Number of transportation partners who can provide services to remote patients" was removed as it was a duplicate. The number of transportation partners is already captured through an existing metric.

[50] The metric, the Number of outreach events" and the "Number of health and wellness kits mailed" was removed to reflect updated clinical practices and operational considerations. Community-based diabetes screening using finger sticks is not conducted in alignment with current clinical guidance, and distribution of health and wellness kits has been discontinued due to budgetary limitations.

[51] The metric, "Number of people screened" was removed as it was redundant, as the number of individuals screened is already captured through an existing metric.

[52] The metric (under the CHNA need diabetes), the "Number of new mover's mailouts on prevention of chronic disease" and the "Number of attendees at health fairs receiving preventative educational information" was removed to reflect operational changes and eliminate redundancy. Distribution of health and wellness kits has been discontinued due to budgetary limitations, and preventive education participation is already tracked through an existing measure.

[53] The metric, the "Number of sessions held" was removed as BMI-related education and counseling are documented within each patient's EMR; therefore, individual session tracking is not necessary.

[54] The metric, the "Number of health and wellness kits mailed" was removed due to discontinuation of health and wellness kit distribution as a result of budgetary limitations.

[55] The metric (under the CHNA need Heart Disease, High Blood Pressure, and Stroke, "Number of New Mover's mailouts on prevention of chronic disease" was removed as a result of budgetary limitations.

[56] The strategy, "Align services within the health system and community to identify patients who need further diagnostic workup for breast/colon/cervical cancer" was updated to "Align services within the health system to identify patients who need further diagnostic workup for breast/colon/cervical cancer." The word community was removed to accurately reflect that services are delivered, aligned, and coordinated internally for diagnostic evaluation.

[57] The metric, "Decrease the average number of days from procedure to patient informed of malignant dx. biopsy to treatment for breast cancer patients" was updated to "Decrease the average number of days from biopsy to treatment for breast cancer patients" to align with current performance monitoring. The prior metric is no longer applicable, as timeliness of patient notification has been addressed; LCMH now measures time from biopsy to initiation of treatment.

[58] The metric, "Number of transportation partners who can provide services to remote patients" was removed to eliminate redundancy, as the number of transportation partners is already tracked through an existing measure.

[59] This metric in 2023 was aligned with the strategy, "Strive to identify new transportation options or partners" however, in this current ISP cycle, the metric was moved to align with the strategy "Expand patient awareness of transportation services in the community and assist with transportation resources." to a more appropriate section to ensure proper alignment and improve document structure.

[60] The metric was updated from the "Number of Medicaid apps taken" to "Number of patients who were successful in obtaining Medicaid." The metric was updated due to measurement limitations. While distribution of Medicaid applications is not consistently tracked, the organization is able to reliably measure successful Medicaid enrollments; therefore, the metric has been revised accordingly.

[61] The metric, the "Number of schools participating" was updated to the "Number of schools sent information on Greaux Healthy materials" as BMI-related education and counseling are documented within each patient's EMR; therefore, individual session tracking is not necessary. It is important to note that LCMH will track and report on the number of schools to which it directly provides obesity prevention education.

[62] The metric, the "Number of attendees" was updated to the "Number of patients provided with obesity intervention education, (BMI specifically) as BMI-related education and counseling are documented within each patient's EMR; therefore, individual session tracking is not necessary. Monitoring the number of patients served provides an appropriate and sufficient measure of activity.

ACCESS TO CARE

Care Coordination, Health System Navigation, and Specialist/Certified Programs

Access to care is a fundamental determinant of health, directly influencing whether individuals can obtain timely, appropriate, and continuous services ranging from preventive screenings and chronic disease management to acute and behavioral healthcare. In Southwest Louisiana, barriers such as provider shortages, transportation limitations, insurance challenges, and fragmented service delivery often delay care, exacerbate chronic conditions, and increase reliance on emergency departments for needs that could be addressed in community-based settings. Strengthening access requires a coordinated approach centered on care coordination, health system navigation, and workforce development. Care coordination plays a critical role in ensuring patients experience seamless transitions across the healthcare continuum, connecting emergency care to follow-up services, aligning primary and specialty care, and reducing gaps that can lead to preventable complications and hospitalizations. Health system navigation further supports access by helping individuals understand and effectively use available services, including assistance with finding providers, scheduling appointments, navigating insurance, and connecting to essential resources such as transportation and financial support. These services are especially important for vulnerable populations, including older adults, individuals with chronic conditions, non-English speakers, and those with limited health literacy. Workforce development is equally essential, as expanding and strengthening the supply of qualified healthcare professionals directly improves access, particularly in rural and underserved areas. Strategies such as loan-repayment programs, targeted recruitment incentives, and expanded use of nurse practitioners and physician assistants can help address provider shortages and improve access to care. Together, these elements form an integrated framework that supports comprehensive, continuous, and culturally responsive care, ultimately improving health outcomes, enhancing system efficiency, and advancing health equity across the communities served by Lake Charles Memorial Health System.

Lake Charles Memorial will advance targeted strategies to improve and maintain access to care, strengthen population health management, and reduce the burden of chronic disease across Southwest Louisiana.

Priority 4: Access to Care

Goal: Improve access to care through the coordination of services.

Anticipated Impact: Patients and vulnerable populations will be made aware and able to access services at LCMHS.

1. Care Coordination **2.** Health System Navigation **3.** Specialist/Certified Programs

Community Health Need: Care Coordination and Health System Navigation			
Goals	**Strategies[63,64]**	**Metrics[65,66,67]**	**Partnering Organization(s)**
Improve IT infrastructure to improve care coordination between patients and the health system.	Implement IT Upgrade to current system to improve access to appointments/ providers.	• Continue to Track Readmissions through the utilization review committee. • Track Performance in Value-Based Purchasing through Managed Care. Organizations to improve Care Coordination. • Number of patients screened by service area for social determinants of health (SDOH).	• Managed Care Organization (MCO) • ACO through Health Leaders Network • Faith Based organization/ Community organization • Southwest Louisiana Health Services • All Memorial employed PCP providers • Vizient • Epic
	Continue to expand patient access modules within MyChart.	• Number of MyChart enrollments.	• All Memorial Clinics • Community based organizations • Faith based organizations
	Roll back centralized scheduling within PCP clinics.[68]	• Date completed. • Dates that each PCP clinic goes live with online scheduling through MyChart. • Number of patients scheduled specifically for each clinic through online scheduling platform.	• Managed Care Organization (MCO) • All Memorial PCP clinics

Community Health Need: Care Coordination and Health System Navigation (continued)			
Goals	**Strategies[63,64]**	**Metrics[65,66,67]**	**Partnering Organization(s)**
Improve access to care for underinsured/ uninsured, low income and Medicaid populations.[69]	Continue to provide care from primary care physicians and nurse practitioners to targeted populations.[70]	• Track Volume (utilization) for use of Moss Memorial Health Services. • Number of patients enrolled in Medicaid or alternative insurance utilizing system. services. (LCMHS will measure scope of system services patients utilize).	• Managed Care Organization (MCO) • ACO through Health Leaders Network • Moss Memorial Health Clinic • All Memorial PCP clinics
		• Number of high-risk, low-income populations reached. • Number of patients seen in the ER who have no PCP and was assigned a PCP from the ER for follow-up.	• Community organizations/resources • Memorial Hospital • All Memorial clinics • Office of Public Health • Partnership for a Healthier SWLA • United Way
	Educate targeted (at-risk) populations on resources and services available.	• Number of patients educated. • Number of health education documents printed in Spanish. • Number of patients utilizing Language Line for healthcare questions.	• Memorial Hospital • All Memorial Clinics • Moss Memorial Health Clinic • LCMH Diabetes Education • OBCare • Language Line • Epic
	Continue Medicaid enrollment and financial assistance resources to ensure coverage to targeted populations.	• Number of patients assisted and enrolled.	• Community organizations • All Memorial clinics • Moss Memorial Health Clinic
	Provide care coordination across health system.[71]	• Number of referrals from PCP to specialists.[72]	• HSG Analytics • Epic • Local Urgent Cares • Local independent providers • All Memorial PCP clinics • LCMH Diabetes Education • SPC Service Coordination for Work Comp

Community Health Need: Care Coordination and Health System Navigation (continued)			
Goals	**Strategies[63,64]**	**Metrics[65,66,67]**	**Partnering Organization(s)**
Address transportation barriers to accessing care.	Discuss transportation issues with the City of Lake Charles.	• Date of the meeting held. Track any movement toward issue resolution.	• City of Lake Charles and Mayor of Lake Charles
	Evaluate ability to assist patients with transportation through the foundation.	• Number of patients receiving funds for transportation.	• City of Lake Charles • Community-based organizations • Yellow Cab, Lyft, Uber • Acadian Ambulance • Medicaid Provider Transportation services
	Enhance non-English speaking patients' understanding of available transportation service.	• Number of language services utilized.	• City of Lake Charles • Community-based organizations • Language Line

Community Health Need: Specialist/Certified Programs			
Goals	**Strategies[63,64]**	**Metrics[65,66,67]**	**Partnering Organization(s)**
Improve availability of specialists to vulnerable populations.	Collaborate with community healthcare providers to provide specialty services.	• Total number of referrals to specialists by status (i.e., either scheduled, pending, or do not schedule, etc.). • Improve all internal specialist clinic wayfinding through updated signage.	• Community providers • Local Urgent Cares • HSG Analytics • Epic • Image 360
	Recruit and retain providers to meet community need.[73]	• Number of providers recruited annually. • Implement MD Track for provider professional development.	• LCMHS • Contracted provider recruitment agencies

[63] The strategy, “Update Available Resources list that addresses Social Determinants of Health” and the metrics, “Date completed” and” Date distributed’ has been completed.

[64] The previous strategy, “Implement Epic Electronic Health Record (summer 2024) to allow all levels of care to have pertinent information available on the patient to make healthcare decisions” along with the metrics, “Date completed” and “All departments trained on Epic” has been completed.

[65] The metric, “Number of patients enrolled in Medicaid and alternative insurance” was removed as it did not broadly define the measure. An updated metric was cited as it would capture a wider range of patient access, coverage, and or utilization.

[66] The metric, the “Number of patients referred from ER for primary care visits” was removed due to limitations in what can be reliably tracked.

[67] The metric, the “Number of patients referred to specialty services” was removed as it was a duplicated metric, the information is already captured through an existing metric.

[68] The strategy, “Develop centralized scheduling” was updated to “Roll back centralized scheduling within PCP clinics” as the program was reevaluated. The previously implemented Patient Access Call Center did not meet operational expectations and access functions have been returned to clinic-level workflows.

[69] The goal, “Improve access to care for underinsured/ uninsured, low-income, and Medicaid populations” and the strategy “Continue to provide care from primary care physicians, specialists, and nurse practitioners to targeted populations’ was removed as they are duplicates.

[70] The strategy, “Continue Medicaid/UCC enrollment and financial assistance resources to ensure coverage to targeted populations” was updated to “Continue Medicaid enrollment and financial assistance resources to ensure coverage to targeted populations” as UCC was renamed to the Financial Assistance Program.

[71] The strategy, “Provide care coordination across health system and health system clinics” was updated to ensure clarity and alignment with data elements.

[72] The metric, the “Number of patients/families receiving coordinated care” was updated to “Number of referrals from PCP to specialist’s patients/families receiving coordinated care” to ensure clarity and alignment with data elements that can be consistently and reliably tracked.

[73] The strategy, “Recruit and maintain providers” was updated to “Recruit and retain providers to meet community need” to be more inclusive of community residents.

ADJUSTING GOALS, STRATEGIES, AND METRICS

Lake Charles Memorial has refined and streamlined elements from the 2023 ISP to enhance the 2026 report with additional focus and clarity. By aligning related initiatives and consolidating efforts, the ISP provides a more cohesive and efficient roadmap for addressing identified community health needs across Southwest Louisiana. This streamlined approach ensures that resources are strategically directed toward shared priorities, allowing the health system to maximize effectiveness while maintaining alignment across programs and partnerships. The updated ISP also strengthens communication with internal and external stakeholders, including new and existing community partners, by clearly outlining priorities and supporting more effective monitoring, evaluation, and reporting of progress. Through this focused approach, Lake Charles Memorial demonstrates a strong commitment to delivering coordinated, measurable improvements in community health outcomes.

In developing its ISP, Lake Charles Memorial prioritized strategies that would have the greatest impact on resources. As a result, certain goals, strategies, and metrics from the previous ISP have been refined, combined, or discontinued because of practical considerations, including staffing limitations, financial constraints, evolving organizational priorities, and varying levels of community engagement. This intentional realignment ensures that the health system remains responsive, adaptable, and focused on implementing the most effective and sustainable strategies.

MOVING FORWARD

With the completion of the CHNA and the development of the Implementation Strategy Plan (ISP), Lake Charles Memorial Health System is well-positioned to move forward with a clear, data-driven framework for improving community health outcomes across Southwest Louisiana. This next phase represents a critical transition from assessment to action, where identified priorities are translated into targeted, measurable strategies designed to address the region's most pressing health needs. Guided by the CHNA findings, Lake Charles Memorial will focus its efforts on advancing initiatives in Behavioral Health, Health Behaviors and Chronic Disease Prevention, and Access to Care, areas identified through a comprehensive and collaborative process involving community stakeholders, healthcare providers, and system leadership.

Moving into implementation, the health system will leverage its existing clinical infrastructure, community partnerships, and regional leadership to expand programs, strengthen service delivery, and enhance care coordination across its service area. This includes working closely with local organizations, public health agencies, and community-based partners to ensure that strategies are not only effective but also culturally responsive and aligned with the unique needs of the populations served. Emphasis will be placed on increasing access to behavioral health services, improving chronic disease management through education and prevention, and reducing barriers to care such as transportation, affordability, and system navigation.

A key component of this phase will be the establishment of clear metrics and performance indicators to track progress and evaluate the impact of implemented strategies. Lake Charles Memorial is committed to ongoing monitoring and reporting, ensuring transparency and accountability in how resources are allocated and outcomes are achieved. Regular engagement with stakeholders will remain central to this process, allowing for continuous feedback, course correction, and alignment with evolving community needs.

As the health system advances its ISP over the next three years, it will continue to build on its long-standing commitment to community-centered care and health equity. By aligning strategic investments with demonstrated needs and fostering strong partnerships across sectors, Lake Charles Memorial aims to create sustainable improvements in access, quality, and overall health outcomes. This forward-looking approach not only reinforces the organization's role as a trusted healthcare leader in the region but also ensures that its efforts contribute meaningfully to the long-term health and resilience of the communities it serves.

SPECIAL ACKNOWLEDGMENTS

Developing the Implementation Strategy Plan phase required translating the insights and priorities identified in the CHNA into actionable, measurable strategies that will guide Lake Charles Memorial's efforts over the next three years. Under the continued leadership of Lake Charles Memorial, a dedicated team committed to improving the health and well-being of Southwest Louisiana residents, this phase reflects a strong, coordinated effort to move from assessment to impact. Through ongoing collaboration with community leaders, healthcare providers, stakeholders, and local health and human service organizations, the Working Group focused on defining practical solutions, aligning resources, and identifying opportunities for meaningful intervention. Tripp Umbach extends sincere appreciation to Lake Charles Memorial and its internal administration and partners for their continued leadership and commitment throughout this process. While the challenges facing the community remain complex, Lake Charles Memorial Health System is moving forward with a unified, strategic approach, working alongside its partners, staff, and community members to implement solutions that drive measurable improvements in health outcomes and strengthen the region.

In alphabetical order by last name.

Ranelda Benoit
Tressy Bergeron
Dana Carerre
Jessica Castete
Emily Clyde
Mona Daigle
Scott Daigle
Karla David
Jessica Deitsch
Karen Demourelle
Katelynn Dietz
Jessica Duhon
Mandy Estes
Carlee Fast
Jennifer Foreman
Rae Gardner
Lisa Guerrero
Sol Halliburton
Mandy Hayzlett
John Kight
Tracie Kyle
Courtney Lemoine
Cheryl McCombs
Delaney Nugent
Victoria Orsot
Hope Ortelli
Shana Scales
Michelle Smith
Fran Sonnier
Steve Stanic
Milissa Vanicor
Paige Weaver
Shawntel Willis

ADDITIONAL INFORMATION

Lake Charles Memorial Health System is committed to developing focused implementation strategies that build upon its capabilities, clinical expertise, and strong community partnerships. These strategies will drive coordinated action to address the priority health needs identified through this assessment and support improved health outcomes for residents throughout Southwest Louisiana. For questions or additional information regarding the CHNA or its results, please contact:

LISA A. GUERRERO

Executive System Director of Marketing & Communications

1701 Oak Park Blvd.
Lake Charles, LA 70601
lguerrero@lcmh.com
marketing@lcmh.com
lcmh.com

CONSULTANTS

Tripp Umbach brings more than 30 years of national experience conducting CHNAs, developing implementation strategies, and planning population health for hospitals, health systems, public health agencies, universities, and community-based organizations. As a recognized leader in the field, Tripp Umbach has completed hundreds of CHNAs nationwide, working in diverse settings ranging from large academic health centers to rural critical access hospitals. Our team is highly skilled in analyzing complex quantitative data; synthesizing community voices through interviews, focus groups, and surveys; and facilitating structured prioritization processes that lead to clear, actionable results. We have deep expertise in identifying health disparities, evaluating social determinants of health, and supporting clients in building sustainable, community-centered strategies to improve health outcomes. Beyond assessment, Tripp Umbach works closely with organizations to develop evidence-based implementation plans, strengthen partnerships, and align resources to support long-term, measurable impact. With decades of experience and a proven track record of producing IRS-compliant, high-quality CHNAs, Tripp Umbach provides the insight, rigor, and strategic guidance necessary to help communities and health systems advance meaningful change.

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