Lake Charles Memorial Health System

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

LAKE CHARLES MEMORIAL HEALTH SYSTEM
COMMUNITY HEALTH NEEDS ASSESSMENT

DECEMBER 2025

APPENDIX

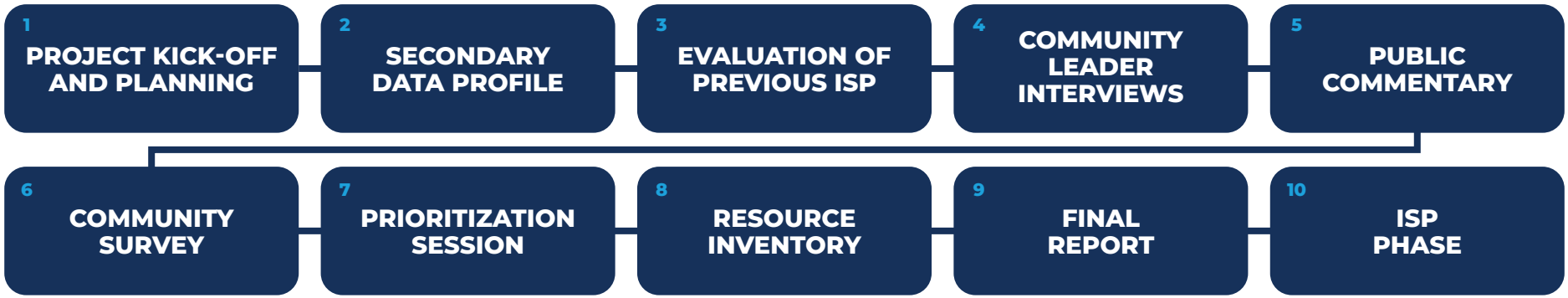
COMMUNITY HEALTH NEEDS ASSESSMENT SUMMARY

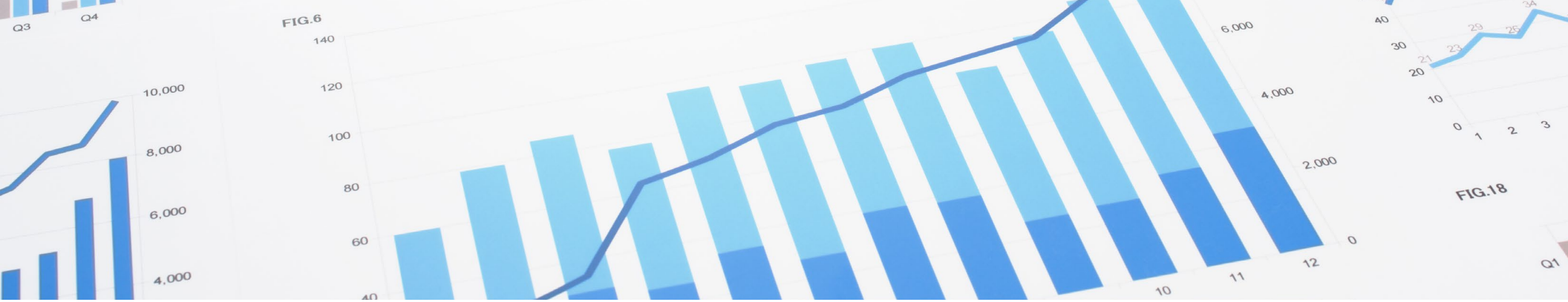
Lake Charles Memorial partnered with Tripp Umbach to conduct its 2025 CHNA in full alignment with the IRS requirements for tax-exempt 501(c)(3) hospitals under the ACA. The assessment incorporated input from individuals representing the broad interests of the communities served, including stakeholders with firsthand knowledge of the needs of medically underserved, at-risk, and chronically ill populations. Through a coordinated, multi-phase approach, Tripp Umbach worked closely with Lake Charles Memorial to support a comprehensive data collection, rigorous analysis, and the identification of key findings. The CHNA integrated both qualitative and quantitative research methods to evaluate community health conditions across Lake Charles Memorial's service area, providing a strong foundation for ongoing stakeholder engagement, informed prioritization of community health needs, and future strategic planning efforts.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

The following sections present the comprehensive data gathered through a structured, multi-phase process to form the CHNA and its resulting findings for Lake Charles Memorial Health System. The process began with a project launch to confirm objectives, scope, and timelines, followed by a detailed analysis of secondary data and a review of Lake Charles Memorial's prior Implementation Strategy Plan. Qualitative input was collected through interviews with community stakeholders and opportunities for public feedback, offering critical insight into local health challenges and unmet needs. A community survey further enriched the assessment by highlighting priority health issues and the social and environmental factors influencing community well-being. A formal prioritization session was then conducted with Lake Charles Memorial leaders and members of the working group to align key focus areas with data-driven findings. Lastly, a comprehensive resource inventory was developed to identify existing programs, services, and community assets throughout the region. Together, this collaborative and evidence-based approach informed the development of the final CHNA report, which reflects both the identified needs of the community and the mission-driven strategic direction of Lake Charles Memorial Health System.

Figure 1: Methodology





SECONDARY DATA

Secondary data from local, state, and national sources provided critical insight into health disparities, public health priorities, disease burden, socioeconomic conditions, health outcomes, and key drivers of health across Lake Charles Memorial Health System's service area, which includes Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis parishes. This comprehensive set of secondary data informed the development of a detailed community health profile tailored specifically to the populations served by Lake Charles Memorial. A primary analytical tool used to synthesize both primary and secondary data was Community Commons, a publicly available platform that aggregates a broad range of national health indicators and allows for the examination of demographic, health, social, and economic trends over time. Additional trusted sources, including County Health Rankings and the U.S. Census Bureau, further strengthened the data collection and validation process. All secondary data sources were peer-reviewed or otherwise validated to ensure reliability and accuracy. Collectively, this regional profile provided a clearer and more nuanced understanding of local and regional health needs, particularly highlighting the significant health and socioeconomic challenges facing communities throughout Southwest Louisiana served by Lake Charles Memorial Health System. The secondary data collection process included the following sources:

- America's Health Rankings
- American Medical Association
- Centers for Disease Control and Prevention
- Centers for Medicare and Medicaid Services
- Community Commons Data
- County Health Rankings
- Dartmouth College Institute for Health Policy & Clinical Practice
- Federal Bureau of Investigation
- Feeding America
- Johns Hopkins University
- Kids Count Data Center
- Louisiana State Center for Health Statistics
- Louisiana State Tumor Registry
- National Center for Education
- U.S. Census Bureau
- U.S. Department of Labor Statistics
- University of Wisconsin Population Health Institute
- USDA, Economic Research Service

EVALUATION OF THE PREVIOUS IMPLEMENTATION STRATEGY PLAN

Over the past three years, Lake Charles Memorial Health System has implemented and monitored targeted strategies to address priority health needs across its service area. This evaluation process focused on assessing the impact and effectiveness of the 2022 Implementation Strategy Plan, with particular emphasis on priority areas such as Behavioral Health, Health Behaviors, Managing Population Health & Preventing Chronic Diseases, and Access to Care. Members of the working group reviewed the goals, initiatives, and actions undertaken within each focus area to identify key accomplishments as well as opportunities for improvement. These internal evaluations functioned as an important self-assessment and benchmarking tool, enabling Lake Charles Memorial to track progress, strengthen accountability, and refine its approach to community health improvement. The insights gained through this process are being used to inform adjustments and guide strategic planning for the next three-year cycle. The following tables highlight major achievements and meaningful progress made by Lake Charles Memorial Health System in addressing identified community health priorities.

Priority 1: Behavioral Health (Mental & 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.

Community Health Need	Goals	Strategies	2023	2024	2025
Integration & Collaboration of Community BH Services	Improve access to care for mental health patients.	Improve access to emergent mental health assessments/ treatment via ER.	X	X	X
		Improve access to available inpatient beds for mental health/substance abuse patients.	X	X	X
		Communicate/educate community on available mental health resources.	---	X	X
		Work with Medicaid managed care plans to include our intensive outpatient mental health program in their services.	X	X	X
	Improve access to care for substance abuse/detox programs for dual diagnosis patients who present mental health/substance abuse.	Improve detox holding process/area via ER.	---	---	---
	Expand outpatient group therapy for substance abuse patients.	Provide and identify patients in need of discharge plans.	X	X	X
	Provide/add outpatient mental health services.	Add outpatient mental health services to those in need in the community.	X	X	X
Postpartum Depression	Provide patients with mental health services diagnosed with postpartum depression.	Educate OB patients on symptoms and treatments of postpartum depression.	X	X	X
Suicide Prevention	Reduce the incidence of suicide.	Educate, prevent, and reduce the incidence rates of suicide.	X	X	X
ER Navigation	Improve navigation in ER.	Educate public of ER as a destination place to get assistance/help with substance use.	X	X	X

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.

Community Health Need	Goals	Strategies	2023	2024	2025
Health Education	Educate low-income and/or high-risk populations on preventative health, value of physical activity, and wellness.	Educate low-income/high-risk patients and community residents on a healthy lifestyle, accessing healthy foods, and the value of the physical activity.	X	X	X
	Continue Fall Prevention Education for the Elderly.	Collaborate with community partners to reach high-risk populations for fall prevention.	X	X	X
	Continue the Stop the Bleed program.	Collaborate with community partners to educate and train on bleeding control.	X	X	X
Motor Vehicle Accident Prevention	Decrease teen motor vehicle accidents.	Educate area schools on motor vehicle prevention.	X	X	X
	Reduce injuries/fatalities of infants, children in auto accidents.	Educate parents, families on proper car seat installation.	X	---	---
Sexually Transmitted Diseases (STDs)	Align hospital goals with Region V task force.	Educate high-risk SWLA community.	X	X	X
	Provide STD prevention education.	Educate population through school and community events.	X	X	X
Tobacco Use	Reduce smoking among targeted populations.	Provide ongoing smoking cessation programs and prevention resources throughout health system and community network.	X	--	X
		Communicate availability of smoking cessation and educational resources among community organizations, churches, and targeted groups.	X	X	X
		Host annual smoking cessation community-wide events in November to distribute educational information.	--	--	--

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.

Community Health Need	Goals	Strategies	2023	2024	2025
Cancer	Improve cancer care access to low income/underserved populations.	Align services within the health system and community to identify patients who need further diagnostic workup for breast/colon/ cervical cancer.	X	X	X
	Improve cervical cancer, breast cancer, lung cancer, and colon cancer awareness.	Partner with community organizations to provide HPV vaccination education.	X	X	---
		Increase the number of mammograms and colon and lung cancer screenings.	X	X	X
	Improve coordination of cancer care.	Expedite initiation of cancer care for LCMH patients.	X	X	X
	Improve patient education regarding diagnosis and treatment.	Enhance Cancer Patient Navigation Program to improve patient education as well as address patient barriers to care.	X	X	X
Transportation	Improve transportation options for cancer patients	Strive to identify new transportation options or partners.	X	X	X
		Expand patient awareness of transportation services in the community and assist with transportation resources.	X	X	X
		Provide gas card assistance when funding is available.	X	X	X
Financial Burden	Assist uninsured and underinsured patients to access essential cancer care services.	Enhance awareness and educate patients on availability of financial services.	X	X	X
		Provide financial counseling and determine eligibility for health services and programs.	X	X	X

Community Health Need	Goals	Strategies	2023	2024	2025
Diabetes	Provide preventative screenings and/or education to improve the early detection of diabetes.	Conduct preventive screenings.	X	X	---
		Hold outreach events about diabetes prevention in conjunction with Office of Public Health and other healthcare entities in our primary service area (PSA).	X	X	X
		Educate patients and families to understand their health status (what the numbers mean) and how to prevent chronic disease at health fairs and seminars.	X	X	X
Obesity	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.	X	X	X
Heart Disease, High Blood Pressure, and Stroke	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.	---	---	X
		Hold outreach events about HD, HBP, and stroke prevention.	---	---	---
		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.	X	X	X

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.

Community Health Need	Goals	Strategies	2023	2024	2025
Care Coordination and Health System Navigation	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.	X	X	X
		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.	--	X	--
		Develop centralized scheduling.	--	X	--
		Update available resources list that addresses Social Determinants of Health.	--	--	--
	Improve access to care for underinsured/uninsured, low income, and Medicaid populations.	Continue to provide care from primary care physicians and nurse practitioners to targeted populations.	X	X	---
	Address transportation barriers to accessing care.	Discuss transportation issues with the City of Lake Charles.	--	--	--
		Evaluate ability to assist patients with transportation through the foundation.	X	X	X
		Enhance non-English speaking patients' understanding of available transportation service.	---	---	---
	Improve access to care for underinsured/uninsured, low-income, and Medicaid populations.	Continue to provide care from primary care physicians, specialists, and nurse practitioners to targeted populations.	X	X	---
		Educate targeted (at-risk) populations on resources and services available.	---	---	---
		Continue Medicaid/UCC enrollment and financial assistance resources to ensure coverage to targeted populations.	X	X	X
		Provide care coordination across health system and health system clinics.	X	X	X

Community Health Need	Goals	Strategies	2023	2024	2025
Specialist/Certified Programs	Improve availability of specialist to vulnerable populations.	Collaborate with community healthcare providers to provide specialty services.	X	X	X
		Recruit and maintain providers.	X	---	X

COMMUNITY STAKEHOLDER INTERVIEWS RESULTS

In September and October 2025, Tripp Umbach collaborated with Lake Charles Memorial and the Working Group to identify and engage key community stakeholders as part of the assessment process. Stakeholders were contacted via email, introduced to Tripp Umbach, and informed about the CHNA goals and the importance of stakeholder participation in shaping a comprehensive understanding of community health needs. Each stakeholder completed a 30- to 45-minute structured interview facilitated by Tripp Umbach, providing an opportunity to share perspectives on pressing health challenges facing residents across Southwest Louisiana and to suggest potential strategies to address them. These interviews offered valuable firsthand insight into community health conditions, risk factors, service utilization patterns, and gaps in existing resources. The stakeholder group represented a broad cross-section of the community, including leaders from healthcare, public health, nonprofit, social service, and other community-based organizations. In total, 15 interviews were completed, capturing diverse perspectives from professionals who play critical roles in supporting and advancing community health throughout the Lake Charles Memorial service area.

Community stakeholders who participated in the interviewing process represented the following organizations:[1]

1. Calcasieu Parish Police Jury
2. Calcasieu Parish School Board
3. Care Help of Sulphur
4. Catholic Charities
5. Community Foundation Southwest Louisiana
6. Families Helping Families of Southwest Louisiana
7. Kay Dore Counseling Center, McNeese University
8. NAMI Southwest Louisiana
9. Office of Public Health/Southwest Regional Office
10. Project Build a Future
11. Second Harvest Food Bank
12. Southwest Louisiana Center for Health Services
13. United Way Southwest Louisiana
14. Volunteers of America

[1] Two separate interviews were conducted from Southwest Louisiana Center for Health Services.

ZIP codes where community stakeholders work

	Responses
70601	60.0%
70605	13.3%
70615	13.3%
70607	6.7%
70663	6.7%

Answered - 15 Skipped - 0

What parish do you primarily work in?

	Responses	
Calcasieu	93.3%	14
Cameron	6.7%	1
Jefferson Davis	0.0%	0
Beauregard	0.0%	0
Allen	0.0%	0

Answered - 15 Skipped - 0

What industry do you represent?

	Responses	
Non-profit	53.3%	8
Healthcare	20.0%	3
Education	13.3%	2
Social services/Human services	13.3%	2
Business owner	0.0%	0
Government and civic organizations	0.0%	0
Personal care (i.e., nursing home, assisted living, etc.)	0.0%	0
Religious sector	0.0%	0
Telecommunications	0.0%	0
Transportation	0.0%	0
Other (please specify)	0.0%	0

Answered - 15 Skipped - 0

Please rate the statements on a scale of strongly agree, agree, neutral, disagree, or strongly disagree.

	Strongly Agree/Agree	Neutral	Disagree/Strongly Disagree	Weighted Average
The overall health and human services in your community is sufficient in meeting your community's healthcare needs.	21.4%	28.57%	50.0%	3.29
Lake Charles Memorial addresses the needs of diverse populations.	85.7%	14.29%	0.0%	2.07
Lake Charles Memorial ensures access to care for everyone, regardless of race, gender, education, and economic status.	78.6%	14.29%	7.1%	2.07

The largest barriers for people not receiving care or services. (Check all that apply)

	Responses	
Lack of transportation	73.3%	11
Affordability (i.e., out-of-pocket costs/high deductibles/co-pays)	66.7%	10
No insurance coverage (i.e., uninsured/underinsured)	53.3%	8
Availability of services (i.e., lack of dental providers, mental health, etc.)	46.7%	7
Lack of trust	46.7%	7
Health literacy (i.e., inability to comprehend the information provided)	40.0%	6
Lack of healthcare coordination services (i.e., not being able to navigate the healthcare system)	40.0%	6
Cultural barriers (i.e., language barriers, religious practices, etc.)	33.3%	5
Flexibility in scheduling (not being able to schedule timely appointments)	26.7%	4
Lack of childcare	20.0%	3
Other (please specify) - *Leaving the region for care*	6.7%	1

Answered - 15 Skipped - 0

What can be offered to suppress the prevalence of chronic diseases and maintain optimal health in your community? (Check all that apply)

	Responses	
Behavioral health/stress management	71.4%	10
Access to healthy foods	64.3%	9
Health promotion and education	57.1%	8
Preventive healthcare services (i.e., health screenings)	57.1%	8
Collaboration with healthcare providers	42.9%	6
Community engagement and support	35.7%	5
Monitoring and evaluation	35.7%	5
Recovery/addiction services	35.7%	5
Safe places to exercise/walk/play (parks, trails, community centers, etc.)	28.6%	4
Policy and environmental changes	21.4%	3

Answered - 14 Skipped - 1

What are your community's top five persistent health problems?
(Those problems causing the greatest impact on overall community health.) (Check all that apply)

	Responses	
Behavioral health	85.7%	12
Obesity	78.6%	11
High blood pressure	57.1%	8
Heart disease and stroke	57.1%	8
Diabetes	57.1%	8
Cancer	42.9%	6
Maternal health/infant health	21.4%	3
Aging problems (i.e., hearing or vision loss, memory loss, etc.)	21.4%	3
Sexually transmitted infections/sexual health	14.3%	2
Dental problems	14.3%	2
Teenage or unplanned pregnancy	7.1%	1
Neurological disorders	7.1%	1
Infectious diseases (i.e., hepatitis, TB, etc.)	7.1%	1
Firearm-related injuries	7.1%	1
Autoimmune diseases (i.e., Celiac's, lupus, arthritis, ulcerative colitis, thyroid disease)	7.1%	1
Vision issues	0.0%	0
Respiratory/lung diseases (i.e., asthma, COPD, etc.)	0.0%	0
Rape/sexual assault	0.0%	0
Orthopedic	0.0%	0
Motor vehicle crash injuries/death	0.0%	0
HIV/AIDS	0.0%	0
Domestic violence	0.0%	0
Child abuse/neglect	0.0%	0
Other (please specify)	0.0%	0

Answered - 14 Skipped - 1

What are the most significant barriers to improving health and quality of life? (Check all that apply)

	Responses	
Adequate transportation	73.3%	11
Access to affordable, healthy food options	60.0%	9
Access to substance use/drug/alcohol resources	60.0%	9
Affordable, quality housing/utilities	60.0%	9
Access to affordable dental care	53.3%	8
Access to affordable prescription and over-the-counter medication	53.3%	8
Environmental issues (air/water pollution)	53.3%	8
Access to affordable internet	46.7%	7
Access to affordable, quality education	46.7%	7
Access to culturally appropriate health education and family planning services	46.7%	7
Access to culturally appropriate primary care services (i.e., family doctor)	46.7%	7
Affordable, quality childcare	46.7%	7
Access to behavioral health resources	40.0%	6
Adequate employment	40.0%	6
Access to affordable, quality senior care options	33.3%	5
Access to LGBTQIA+ services	33.3%	5
Access to preventative screenings and vaccinations	33.3%	5
Emergency preparedness	33.3%	5
Safe places to walk/play (parks, trails, community centers, etc.)	33.3%	5
Access to maternal and infant health care (pre- and post-natal care)	26.7%	4
Adequate veteran services	26.7%	4
Community activities (accessible, affordable, family-friendly activities)	26.7%	4
Quality immigrant/refugee services	26.7%	4
Emotional safety/not feeling lonely or isolated	20.0%	3
Low adult death and disease rates	20.0%	3
Physical safety	20.0%	3
Quality disability services	20.0%	3
Other (please specify)	0.0%	0

Answered - 15 Skipped - 0

What are your community's top five persistent high-risk behaviors? (Those behaviors making the greatest impact on overall community health.)

	Responses	
Being overweight or obese	60.0%	9
Drug abuse	60.0%	9
Poor eating habits	53.3%	8
Unstable housing	46.7%	7
Not taking medication as recommended	40.0%	6
Lack of exercise/physical activity	33.3%	5
Smoking/tobacco use	33.3%	5
Unmanaged stress or anxiety	33.3%	5
Alcohol abuse	26.7%	4
Not getting recommended vaccines/shots	26.7%	4
Firearm use	20.0%	3
Risky/excessive social media use	20.0%	3
Violence/crime	20.0%	3
Lack of education/dropping out of school	13.3%	2
Bullying (including online)	6.7%	1
Loneliness and isolation	6.7%	1
Unsafe driving (i.e., DUI, speeding, road rage)	6.7%	1
Unsafe sex/not using birth control	6.7%	1
Not using seat belts/child safety seats	0.0%	0
Other (please specify)	0.0%	0

Answered - 15 Skipped - 0

What could be done to improve the safety of residents in your neighborhood? (Check all that apply)

	Responses	
Not enough affordable housing options	71.4%	10
Better housing conditions	64.3%	9
Improved street lighting	50.0%	7
Community centers or recreational facilities	42.9%	6
Increased police presence	35.7%	5
Neighborhood safety concerns	35.7%	5
Poor conditions or maintenance	35.7%	5
Reduction of gun violence	21.4%	3
Community watch programs	14.3%	2
Overcrowding	7.1%	1
Other (please specify): *Educate the community on how to access help, provide infectious disease and food safety education, and focus on practical solutions we have the power to implement to address immediate needs.*	7.1%	1

Answered - 14 Skipped - 1

In your service area, who do you feel are the most vulnerable groups? (Select all that apply)

	Responses	
People living with mental illness	86.7%	13
Uninsured/underinsured	73.3%	11
Low-income	66.7%	10
Under-resourced individuals	60.0%	9
Children/youth	53.3%	8
People with chronic disease	46.7%	7
People with disabilities	46.7%	7
Older adults	40.0%	6
Immigrant/refugee	33.3%	5
LGBTQIA+	26.7%	4
Women	20.0%	3
Men	6.7%	1
Other (please specify): *ALICE population + Black women*	13.3%	2

Answered - 15 Skipped - 0

What actions could your hospital take to address health disparities better? (Check all that apply)

	Responses	
Mental health and substance abuse services	57.1%	8
Strengthen social support systems	50.0%	7
Transportation assistance	50.0%	7
Address Social Determinants of Health	42.9%	6
Community-based health programs	35.7%	5
Improve access to healthcare	35.7%	5
Education and workforce development	28.6%	4
Integrated care models	28.6%	4
Policy and advocacy	21.4%	3
Culturally sensitive/congruent care	14.3%	2
Enhance preventive care	14.3%	2
Emergency preparedness	7.1%	1
Other (please specify): *Establish evidence-based bridge programs for substance use disorders and expand participation in infectious disease detection initiatives, including routine and high-risk screenings in emergency departments.*	7.1%	1

Answered - 14 Skipped - 1

What resources do you think would help people better understand and engage in their healthcare?

	Responses	
Explaining health in the patient's own words	33.3%	5
More time learning with a clinician, nurse, or health professional	26.7%	4
Making health information easier to understand	20.0%	3
Offering more educational resources on healthcare (habits, treatment plans, available resources, etc.)	6.7%	1
Using more pictures in health information or education	0.0%	0
Giving health information in their own language/access to translators	0.0%	0
Other (please specify): *Individualized healthcare* *Provide care to where patients are located*	13.3%	2

Answered - 15 Skipped - 0

In your service area, who do you feel are the most vulnerable groups? (Select all that apply)

	Responses	
Transportation	80.0%	12
Behavioral healthcare	73.3%	11
Housing/homelessness	73.3%	11
Food access	53.3%	8
Economic development	40.0%	6
Racial inequities	40.0%	6
Education	20.0%	3
Healthcare	20.0%	3
Safety	13.3%	2
Parks and recreation	6.7%	1

Answered - 15 Skipped - 0

Does your organization/program address health literacy?

	Responses	
Yes	60.0%	9
No	40.0%	6
Don't know	0.0%	0

Answered - 15 Skipped - 0

What improvements would make behavioral health services more accessible and effective for residents in the community?

- Make services affordable and available on evenings and weekends.
- Maintain a comprehensive list of behavioral health providers, particularly for mental health services.
- Coordinate care and make it more accessible and affordable.
- There is stigma with no remedies for behavioral health, with no available resources. Basic needs are neglected. We need to prioritize mental health.
- People often struggle to secure a behavioral health appointment. We need better access to bring the services where people are located.
- Ensuring that everyone is aware of the available resources, understands what symptoms and behaviors to look for, and knows where to seek help when these symptoms occur.
- Establish stronger case management and follow-up protocols for individuals presenting with suicidal thoughts, as the current practice of discharge after 72 hours without adequate support may constitute neglectful.
- Provide education and promote available resources through a centralized, one-stop platform that offers real-time information and support.
- Hold community meetings to gather input directly from residents about their needs and priorities.
- Partner with high schools to reduce stigma around mental health by providing early education and fostering lifelong learning.
- Reduce barriers to care by expanding urgent, clinic-style behavioral health services and strengthening workforce pipelines to attract more professionals into the field. Increase support for adult crisis services and promote efforts to destigmatize substance use disorders. Continued efforts to enhance awareness about behavioral health.
- Expand the number of providers and increase access to group programs that promote care and support in group settings.
- Collaborate with the Imperial Calcasieu Human Services Authority.
- Access to transportation in the region.
- Shorten the time between referral and appointment to make the healthcare process more efficient and accessible.

What strategies/initiatives could be implemented to ensure equitable healthcare for all residents?

- Enhance transportation options for seniors to ensure access to essential services.
- Include transportation details in agency descriptions so residents can easily find and use available services.
- Ensure all individuals are treated with dignity and respect in every care setting.
- Expand access to pediatric care by addressing barriers such as insurance limits, long wait times, and lack of transportation.
- Encourage providers, social service agencies, behavioral health services, and community programs to work together in a coordinated way to better meet community needs.
- Increase access to healthcare by addressing transportation and financial barriers that prevent people from receiving needed services.
- Create more community clinics to reach a more diverse population.
- Provide education and promote resources through a one-stop, real-time information platform that meets the needs of the community.
- Improve transportation options to healthcare facilities so that residents can receive timely care.
- Reduce the cost and complexity of healthcare by simplifying processes, enabling providers to address multiple issues in a single visit.
- Bridge clinics for better collaboration and partnerships.
- Ensure that community engagement and data collection efforts intentionally include residents from all backgrounds and communities.
- Collaborate at the state and national levels to improve the health insurance system.
- Access to free healthcare services, transportation, and rehabilitation programs.
- Enhance transportation options for consistent attendance at health services.

What are the most significant health challenges or gaps in access to care affecting your community? What steps have been taken to address these challenges, and what additional efforts are still needed?

- Behavioral health needs greater attention because its challenges are not always visible and are often treated as secondary to mental health.
- Persistent health inequalities continue to affect one's overall well-being.
- There is limited access to affordable behavioral health, mental health, and primary care services; professionals must meet people where they are and expand access to preventive care.
- Our community struggles with poor health outcomes, largely influenced by cultural habits and unhealthy food choices.
- There is a significant gap between emergency care and follow-up treatment; implementing case management could help bridge this divide.
- Transient populations face barriers to timely care, making it difficult for many to access consistent and effective treatment.
- Increasing access to healthy food options, programs like the Healthy Harvest Food Bank, supported by the LC Foundation, plays a crucial role in the community.
- Many residents would seek care if reliable transportation were available.
- Healthcare provider shortages and long wait times are major barriers; the community needs 24-hour coverage and access to specialized care, such as neurosurgery.
- Transportation challenges, limited mental health care, and poverty are key factors that hinder access to services.
- There is a shortage of doctors and dentists who accept Medicaid, leaving many low-income residents without adequate care options.
- Effective management of chronic diseases to enhance overall community health outcomes.

If you had to prioritize one area of health for the community to focus on over the next three years, what would it be and why?

- Improving transportation options is crucial for enhancing access to healthcare.
- Prioritizing suicide prevention and ensuring every hospital has trained therapists embedded within all payor units will strengthen early intervention and access to mental health support.
- Collaboration across healthcare providers, community organizations, and partners to improve community health.
- Expanding access to pediatric and pediatric specialty care will help ensure that children receive high-quality services.
- Expanding access to mental and behavioral health care is vital, as untreated conditions and persistent stigma continue to prevent many individuals from receiving the support they need.
- While our culture emphasizes enjoyment, it often neglects healthy habits. Promoting preventive care, better nutrition, and healthier behaviors can foster a culture that reinforces wellness and long-term well-being.
- Stress is a major contributor to poor mental health, and promoting positive coping strategies can significantly improve overall health outcomes.
- Behavioral health challenges can diminish quality of life, increase stress, and negatively impact physical health.
- Focusing on obesity prevention and management can reduce the risk of multiple chronic conditions, making it a high-impact priority area.
- Prioritizing mental health is crucial to enhancing overall well-being and alleviating the community's overall burden.
- Prevention and response to cardiovascular disease should be prioritized, as evidence-based strategies can significantly improve outcomes.
- Promoting healthy eating and regular physical activity in supportive community and family settings can strengthen long-term health and foster sustainable behavior change.
- Addressing mental health must remain a central focus to break down stigma, improve access, and enhance overall health outcomes.
- Addressing obesity is essential, as it is a root cause of many other chronic health conditions.

Are there any additional issues or concerns regarding community health yet to be addressed?

- Access to care for individuals with disabilities and those relying on state-funded insurance remains limited.
- Health disparities among minority populations persist, driven by inequities in care and a lack of trust between communities and the healthcare system.
- Addressing food insecurity requires transformational support to create sustainable access to healthy food.
- Many people are willing to help address community health issues; coordinated action and clear direction are needed to make an impact.
- While progress has been made in system-wide collaboration, more can be done to align priorities, strengthen leadership, and build capacity to address persistent gaps in access to care.
- Family issues, including corporal punishment and the breakdown of family structures, are deeply linked to broader social challenges such as human trafficking, underscoring the need for increased education and prevention efforts.
- A shortage of specialists, particularly in neurology and other critical areas, forces many patients to travel outside their community for care.

PUBLIC COMMENTARY

As part of the community leader interview process, Tripp Umbach facilitated a public comment period to gather feedback on Lake Charles Memorial's 2022 CHNA and ISP. This process occurred during the community stakeholder process. Community stakeholders were invited to evaluate the effectiveness of the prior assessment and the strategies implemented in response to identified health priorities. This process provided an opportunity for participants to review and comment on the methodology, findings, and actions outlined in the previous CHNA and ISP. The feedback collected offered important insight into community perceptions, strengths, and areas for improvement and played a key role in informing ongoing efforts to refine strategies and enhance health outcomes across the Lake Charles Memorial service area.

Do you feel the assessment you reviewed included input from community members and organizations?

	Responses	
Yes	40.0%	6
No	13.3%	2
I don't know	46.7%	7

Answered - 15 Skipped - 0

Do you feel that the assessment you reviewed excluded any community members or organizations that should have been involved in the assessment?

	Responses	
Yes	14.3%	2
No	42.9%	6
I don't know	42.9%	6

Answered - 15 Skipped - 0

Were there needs in the community related to health not present in the CHNA (e.g., physical health, mental health, medical services, dental services, etc.)?

	Responses	
Yes	0.0%	0
No	42.9%	6
I don't know	57.1%	8

Answered - 15 Skipped - 0

How did the CHNA and ISP benefit you and your community?

- The data provided a clear picture of the community, allowing organizations to plan accordingly.
- Made my organization more aware of what the hospital is doing and the risk behaviors in the parish.
- Brought things to the forefront to solve real-time solutions.
- Benefited from being able to express the concerns of the marginalized.
- The CHNA and Implementation Strategy Plan have not been perceived as actionable or visible in the community. There is no unified effort, which makes it difficult to see its impact or direction.

COMMUNITY SURVEY

A community survey was conducted to collect direct input from residents within the Lake Charles Memorial Health System service area to support a comprehensive and community-informed CHNA. Community surveys are essential for understanding local health needs because they capture residents' lived experiences, perceptions of health challenges, and barriers to care that may not be fully reflected in secondary data sources. In partnership with Lake Charles Memorial Health System, the survey was distributed electronically through the hospital's database to ensure broad outreach and accessibility for community members. Responses were collected using SurveyMonkey, resulting in strong community participation. A total of 392 completed surveys were included in the analysis. The data collection period spanned from September to October 2025, providing timely insights to guide planning, prioritization, and future community health improvement efforts. The tables below are the survey results.

What parish do you live in?

	Responses	
Calcasieu Parish	83.6%	327
Jefferson Davis	7.7%	30
Beauregard Parish	4.4%	17
Allen Parish	1.5%	6
Cameron Parish	1.5%	6
Other (please specify)	1.3%	5

Answered - 391 Skipped - 1

How would you describe your physical health?

	Responses	
Excellent	9.2%	36
Very Good	35.6%	139
Good	39.2%	153
Fair	13.3%	52
Poor	2.6%	10

Answered - 390 Skipped - 2

How would you describe your mental health?

	Responses	
Excellent	16.6%	65
Very Good	35.0%	137
Good	37.3%	146
Fair	7.7%	30
Poor	3.3%	13

Answered - 391 Skipped - 1

ZIP codes of survey respondents

ZIP Code	Percentage	ZIP Code	Percentage
70605	26.3%	70630	0.8%
70601	10.7%	70652	0.8%
70663	10.2%	70581	0.5%
70607	9.5%	70668	0.5%
70611	9.5%	70452	0.3%
70647	7.9%	70543	0.3%
70669	4.3%	70675	0.3%
70665	3.6%	70661	0.3%
70546	2.6%	70996	0.3%
70634	2.6%	70631	0.3%
70615	2.3%	70515	0.3%
70648	1.8%	71403	0.3%
70591	1.3%	70616	0.3%
70633	1.3%	71360	0.3%
70657	1.0%		

How would you describe the overall health status of your community?

(A healthy community is one in which residents have access to quality education, safe and healthy homes, adequate employment, transportation, physical activity, nutrition, and quality health care.)

	Responses	
Excellent	6.4%	25
Very Good	18.9%	74
Good	38.6%	151
Fair	28.1%	110
Poor	7.9%	31

Answered - 391 Skipped - 1

How would you classify your weight?

	Responses	
Overweight	52.4%	205
Normal weight	45.0%	176
Underweight	1.5%	6
Don't know	1.0%	4

Answered - 391 Skipped - 1

Which health and social conditions are most essential for building a healthy, thriving community?

	Responses	
Access to affordable health insurance	68.3%	267
Access to affordable prescription and over-the-counter medication	51.4%	201
Access to affordable, healthy food options	50.9%	199
Access to affordable, quality education	29.2%	114
Access to dental care	26.3%	103
Access to affordable, quality senior care options	25.8%	101
Employment	25.6%	100
Affordable, quality housing	24.3%	95
Access to behavioral health resources	22.0%	86
Healthy environment/clean air & water	21.0%	82
Access to preventative screenings and vaccinations	19.2%	75
Access to culturally-appropriate primary care services	17.7%	69
Adequate transportation	16.4%	64
Workforce development/living wage	15.9%	62
Physical and environmental safety	15.9%	62
Access to specialty care	14.8%	58

	Responses	
Strong social support networks	14.1%	55
Affordable, quality childcare	12.5%	49
Access to maternal and infant health care	11.5%	45
Quality disability services	10.0%	39
Chronic disease management support	9.7%	38
Community activities	9.5%	37
Youth development and programming	9.2%	36
Adequate veterans services	9.0%	35
Emergency preparedness	8.4%	33
Emotional safety/not feeling lonely or isolated	6.9%	27
Access to culturally-appropriate health education and family planning services	5.6%	22
Health literacy and navigation	4.6%	18
Low adult death and disease rates	3.3%	13
Technology and broadband access for health	2.8%	11
Quality immigrant/refugee services	1.8%	7
Other (please specify)	3.6%	14

Answered - 391 Skipped - 1

Which health and social issues have the most negative impact on your community's health?

	Responses	
Behavioral health	64.0%	244
Access to Healthcare	47.8%	182
Overweight/Obesity	46.5%	177
Chronic Diseases	45.9%	175
Crime/Community Violence	44.1%	168
Environmental Health Issues	38.1%	145
Housing/Homelessness	33.6%	128
Poor eating habits	31.2%	119
Food Insecurity/Nutrition Access (lack of affordable healthy foods)	27.3%	104
Child abuse/neglect	24.9%	95
Aging problems	20.7%	79
Autoimmune diseases	12.9%	49
Dental problems	12.6%	48
Respiratory/lung diseases	8.4%	32
Motor vehicle crash injuries/death	8.1%	31
Vision issues	6.8%	26
Sexually transmitted infections/sexual health	6.6%	25
Teenage or unplanned pregnancy	6.6%	25
Unintentional Injuries (falls, drownings, poisonings)	5.8%	22
Infectious diseases	4.2%	16
Maternal health/infant health	4.2%	16
Neurological disorders	2.9%	11
HIV/AIDS	2.4%	9
Other (please specify)	2.4%	9

Answered - 381 Skipped - 11

What types of behavioral health issues are you seeing in your community?

	Responses	
Anxiety or stress-related disorders	59.7%	230
Depression	52.2%	201
Illegal drug use (e.g., meth, cocaine, heroin)	49.1%	189
Alcohol misuse or dependency	45.7%	176
Homelessness or housing insecurity related to mental health or substance use	45.5%	175
Youth mental health concerns (e.g., bullying, school stress, social media)	35.8%	138
Aggression/attention difficulties	32.2%	124
Gambling or other addictive behaviors	23.1%	89
Tobacco/Nicotine use	20.5%	79
Suicide or suicidal thoughts	19.0%	73
Prescription drug misuse (e.g., opioids)	17.1%	66
Bipolar disorder	15.3%	59
Post-traumatic stress disorder (PTSD, after hurricanes or violence)	15.3%	59
Sleep problems or insomnia	15.3%	59
Lack of awareness or stigma around mental health	14.8%	57
Overdose incidents	11.7%	45
Schizophrenia and other psychotic disorders	10.4%	40
Risky sexual behaviors	6.8%	26
Binge eating, anorexia, and bulimia	5.5%	21
I do not observe these issues in my community	4.2%	16
Other (please specify)	1.8%	7

Answered - 385 Skipped - 17

Are there adequate behavioral health services in your community?

	Responses	
Yes, services are widely available and accessible	10.9%	42
Some services exist, but they are limited or hard to access	38.0%	146
No, there are not enough services to meet community needs	30.5%	117
I'm not sure	20.6%	79

Answered - 384 Skipped - 8

How have hurricanes, flooding, or environmental issues affected your/your family's physical or mental health?

	Responses	
Increased stress or anxiety	55.3%	214
Financial strain due to property damage or loss	45.0%	174
Depression or feelings of hopelessness	36.7%	142
Trauma or PTSD (post-traumatic stress disorder)	31.0%	120
Displacement or loss of housing	28.7%	111
No direct impact on my family's health	19.1%	74
Worsening of existing chronic conditions (e.g., diabetes, heart disease)	10.3%	40
Difficulty accessing healthcare, medications, or mental health support	9.3%	36
Respiratory issues (e.g., asthma, chronic coughing, shortness of breath)	7.8%	30
I'm not sure	4.7%	18
Skin or eye irritation	1.3%	5
Other (please specify)	1.8%	7

Answered - 387 Skipped - 5

How have the following impacted you and your family over the past two years?

	Extremely	Significantly	Moderately	Slightly	Not at All
Access to healthy foods	5.5%	9.6%	21.4%	18.8%	44.8%
Affordable and safe housing	6.0%	8.1%	15.4%	17.5%	53.0%
Employment opportunities	5.7%	8.9%	14.9%	13.8%	56.7%
Poverty	4.5%	5.2%	11.8%	17.0%	61.5%

What are your community's most important "risky behaviors"? (Those behaviors that have the greatest impact on community health.)

	Responses	
Substance use (alcohol, drugs, tobacco, smoking)	65.7%	253
Violence/crime	49.9%	192
Lack of exercise/physical activity	49.1%	189
Poor eating habits	47.3%	182
Unmanaged stress or anxiety	44.4%	171
Bullying (including online)	35.3%	136
Unsafe driving (i.e., DUI, speeding, road rage)	32.0%	123
Inappropriate social media use	30.7%	118
Loneliness and isolation	27.3%	105
Housing	26.5%	102
Lack of education/dropping out of school	21.8%	84
Not taking medication as recommended	21.0%	81
Not getting recommended vaccines/shots	12.2%	47
Unsafe sex/not using birth control	8.3%	32
Other (please specify)	0.8%	3

Answered - 385 Skipped - 7

Where do you typically seek medical care?

	Responses	
Primary care office/Physician specialist offices	85.57%	332
Clinics (urgent care, FQHC)	9.79%	38
I do not typically seek medical care	2.32%	9
Hospital emergency department	1.55%	6
Pharmacy	0.26%	1
Other (please specify)	0.52%	2

Answered - 388 Skipped - 4

How do you pay for your health care?

	Responses	
Health insurance	85.4%	332
Medicare	19.8%	77
Pay cash/no insurance	9.0%	35
Medicaid	5.4%	21
Veterans Administration	2.3%	9
Indian Health Services	0.0%	0
Other (please specify)	4.9%	19

Answered - 389 Skipped - 3

How often do you use tobacco products?

	Responses	
I do not use any tobacco or vapor/e-cig products	84.9%	331
Multiple times a day	9.7%	38
Once a day	2.3%	9
Several times a week	2.1%	8
Other (please specify)	1.0%	4

Answered - 390 Skipped - 2

How often do you have an alcoholic drink?

	Responses	
I do not drink alcohol	53.3%	208
Several times a week	10.3%	40
Once a day	6.2%	24
Multiple times a day	0.8%	3
Other (please specify)	29.5%	115

Answered - 390 Skipped - 2

Do you or anyone in your household receive the following care?

	Yes		No		Don't Know		Total	Weighted Average
Regular primary/preventative (such as mammograms, colonoscopy, etc.) /specialty care visits?	92.0%	356	6.5%	25	1.6%	6	387	1.1
Dental care	86.6%	335	12.9%	50	0.5%	2	387	1.14
Vision/eye care	90.4%	348	9.1%	35	0.5%	2	385	1.1
Behavioral health care	30.8%	115	66.3%	248	2.9%	11	374	1.72

Answered - 390 Skipped - 2

What is your age?

	Responses	
25 yrs. or less	2.6%	10
26 – 39 yrs.	20.5%	80
40 – 54 yrs.	27.4%	107
55 – 64 yrs.	24.4%	95
65 yrs. or over	23.3%	91
Prefer not to answer	1.8%	7

Answered - 390 Skipped - 2

What is your highest level of education?

	Responses	
Some school, no diploma	0.5%	2
High school graduate (GED or equivalent)	15.9%	62
Some college	21.7%	85
Associate's degree	15.9%	62
Bachelor's degree	25.3%	99
Master's degree + (PhD, MD, JD, etc.)	17.9%	70
Prefer not to answer	2.8%	11

Answered - 391 Skipped - 1

What is your race or ethnicity? (Check all that apply)

	Responses	
White/non-Hispanic	81.0%	316
Black or African American	12.1%	47
American Indian or Alaska Native	1.8%	7
Asian	1.3%	5
Hispanic	1.3%	5
Native Hawaiian or other Pacific Islander	0.3%	1
Other	0.5%	2
Prefer not to answer	4.6%	18

Answered - 390 Skipped - 2

Which gender do you most identify?

	Responses	
Male	15.6%	61
Female	82.3%	321
Prefer not to answer	2.1%	8

Answered - 390 Skipped - 2

What is your annual household income?

	Responses	
Less than $5,000	1.0%	4
$5,000 to $24,999	5.7%	22
$25,000 to $49,999	22.2%	86
$50,000 to $99,999	24.2%	94
More than $100,000	31.7%	123
Don't know/Prefer not to answer	15.2%	59

Answered - 388 Skipped - 4

Are you currently the caregiver of an elderly family member or friend?

	Responses	
Yes	18.9%	73
No	81.1%	314

Answered - 387 Skipped - 5

How many people are currently living in your household (including yourself)?

	Responses	
1-2 people	55.9%	218
3-4 people	30.5%	119
4-5 people	10.3%	40
5 or more people	3.3%	13

Answered - 390 Skipped - 2

What is your marital status?

	Responses	
Married/cohabitating	65.1%	255
Not married/single	14.3%	56
Divorced	14.5%	57
Widowed	6.1%	24

Answered - 392 Skipped - 0

PRIORITIZATION SESSION

On November 10, 2025, Tripp Umbach facilitated a comprehensive prioritization session in partnership with members of Lake Charles Memorial Health System's Working Group and executive leadership to evaluate and rank the most critical health needs identified through the 2025 CHNA. This collaborative session provided a structured forum to examine data-driven findings alongside community perspectives, allowing participants to assess emerging trends, revisit persistent challenges, and align priority needs with available resources. Guided by a detailed presentation of the CHNA's key results, the discussion focused on identifying the most pressing issues affecting residents across Southwest Louisiana and on considering practical, measurable approaches for improvement. Participants also reviewed updated demographic, health, and social indicators to ensure that the final priorities accurately reflected current conditions and unmet needs. The outcomes of this session established a strong foundation for Lake Charles Memorial's implementation planning phase, reinforcing the health system's commitment to targeted, community-informed strategies to improve health outcomes throughout its service area.

Consensus Development Steps

1. Group discussions on the top health needs to identify similarities and differences.
2. Share the needs identified by the steering group members.
3. Cluster similar health needs into themes.
4. Determine the final health need.
5. Compare and discuss new needs with those from the previous CHNA.

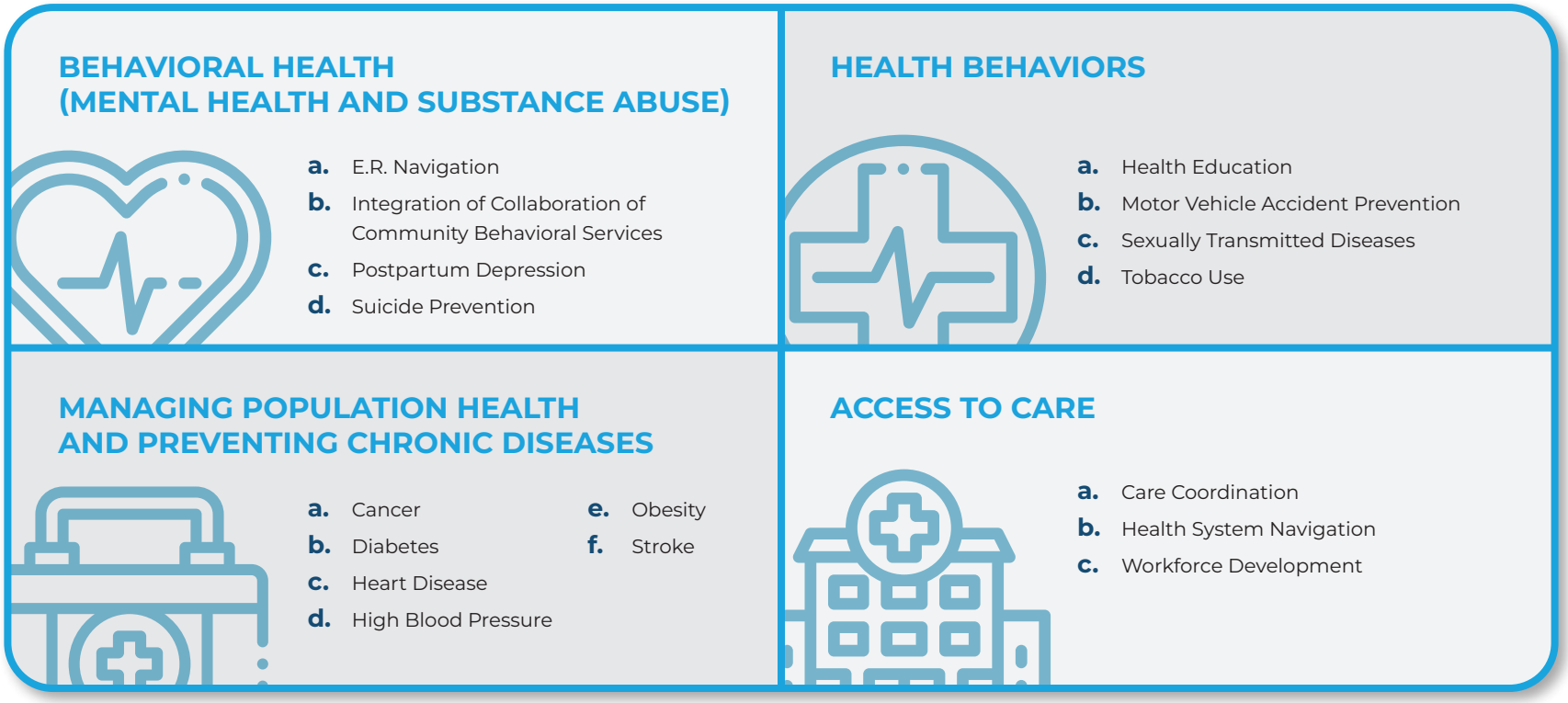
Criteria for Prioritization

The following decision-making criteria guided the prioritization processes for the assessment cycle.

- Consider the CHNA needs from the previous assessment. Were those needs addressed? Or are they still being addressed?
- What were the top needs/issues from the community stakeholder interview data?
- What were the top needs/issues from the focus group?
- What were the top needs/issues from the secondary data?
- What is the magnitude/severity of the problem?
- What are the needs of vulnerable populations?
- What is the community's capacity and willingness to act on the issue?
- What is Lake Charles Memorial's ability to have a measurable impact on the issue?
- What availability does Lake Charles Memorial and the community have?

The prioritization process was designed to be inclusive, participatory, and data-driven. Participants of the prioritization session were asked to reflect on and discuss the data, provide narratives relevant to each community need, and offer their perspectives on issues. After a thorough group data review and reaching a consensus, the group identified and agreed upon the following CHNA needs. The collaborative process ensured that all perspectives were considered, providing a comprehensive understanding of the community's health priorities. These agreed-upon needs reflect the collective commitment to addressing the most pressing health concerns in the Lake Charles Memorial community.

Figure 2: Lake Charles Memorial Health System CHNA



RESOURCE INVENTORY

Tripp Umbach developed a comprehensive inventory of programs and services aligned with the key health priorities identified for Lake Charles Memorial's service area. This resource highlights a diverse array of organizations and agencies working to address the needs of populations across Southwest Louisiana. The inventory includes detailed program descriptions, contact information, and collaboration opportunities, thereby fostering stronger connections among community service providers. Designed to enhance coordination and improve access to care, the interactive resource inventory was delivered as a standalone document and is accessible through Lake Charles Memorial's website to support ongoing community health improvement efforts.

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