MONTGOMERY
GENERAL HOSPITAL

2025

# COMMUNITY HEALTH NEEDS ASSESSMENT

# Executive Summary

**Montgomery General Hospital (MGH) conducted a Community Health Needs Assessment that determines the priority of health issues facing our patients and the surrounding communities. The assessment included surveying residents, service providers, hosting focus groups, interviewing board members, community members, and key stakeholders, conducting secondary data research, and providing a summary report with key findings and recommendations.**

## Goal:

Plan and conduct an all-inclusive Community Health Needs Assessment for Montgomery General Hospital, ensuring that a diverse group of patients, residents and providers throughout the region served have an opportunity to provide feedback.

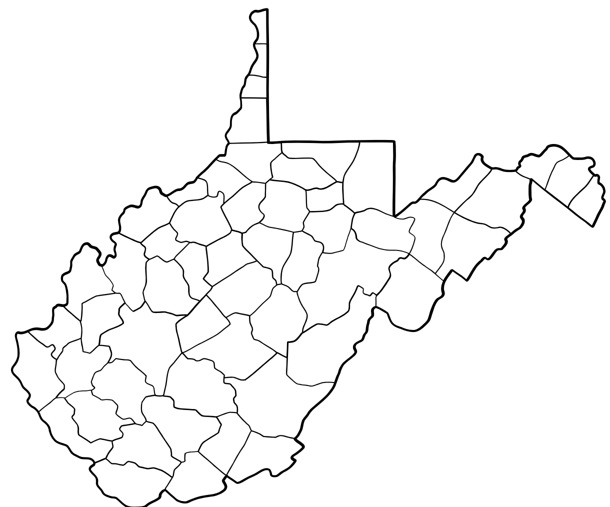
## Objectives:

- Provide a broad view of demographic and economic changes impacting healthcare in the region.
- Focus on providing a localized assessment of needs by reporting regional data.
- Collect primary data by gathering qualitative and quantitative feedback through community surveys, focus groups, service providers, board members, and community leader interviews.
- Collect secondary data by researching national, state, and county data resources.
- Facilitate an analysis process that identifies priority health needs and potential solutions. Utilize findings as part of a strategic planning process for MGH.

## Coverage Area:

MGH serves communities in Fayette, Kanawha, Clay, and Nicholas counties. These include but are not limited to the following incorporated cities:

**Montgomery**
**Smithers**
**Boomer**
**Mount Carbon**
**Kimberly**
**Deep Water**
**Alloy**
**Charlton Heights**
**Glen Ferris**
**Falls View**
**Gauley Bridge**
**Belva**
**Dixie**
**Pond Gap**
**Mammoth**
**Kincaid**
**Powellton**
**Handley**
**Pratt**
**Handsford**
**Gallagher**
**Cedar Grove**
**Glasgow**
**Belle**



# About Montgomery General Hospital

**Montgomery General Hospital (MGH) is a 25-bed critical access facility that provides care to over 1,000 inpatients, 40,000 outpatients, and 10,000 emergencies on an annual basis. MGH serves as a general acute care hospital to Fayette and surrounding counties in the state of West Virginia. As a major employer, and integral part of the community, MGH is a significant contributor to the economic, social, and health vitality, keeping essential services close to home, and actively supporting community health and wellness initiatives.**

## Mission

Montgomery General Hospital delivers high-quality, compassionate care, strengthens community health, and ensures patients have access to essential services close to home.

## Values

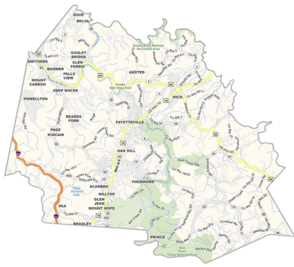
- To serve with a caring attitude, concern, dignity, and respect for the value of human life.
- To be a symbol of strength, progress, healing, and hope.
- To maintain honesty, accountability, and transparency in all that we do.
- To work together with patients, families, and community partners to achieve better health outcomes.

## Programs & Services

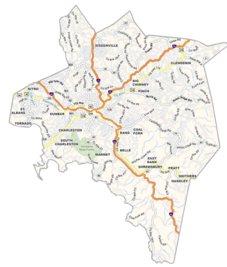
- Montgomery Pediatrics
- Montgomery General Physical Therapy
- Montgomery Physicians' Clinic
- Montgomery Rehab and Nursing
- Acute Care
- Emergency Department
- Fitness Center
- Laboratory
- Radiology/Imaging
- Respiratory Therapy/Sleep Lab
- Skilled & Long-Term Care Services
- Surgical Services
- Swing Beds
- Telehealth

# Communities Served At-A Glance

A look into the populations served by Montgomery General Hospital.



Fayette County



Kanawha County

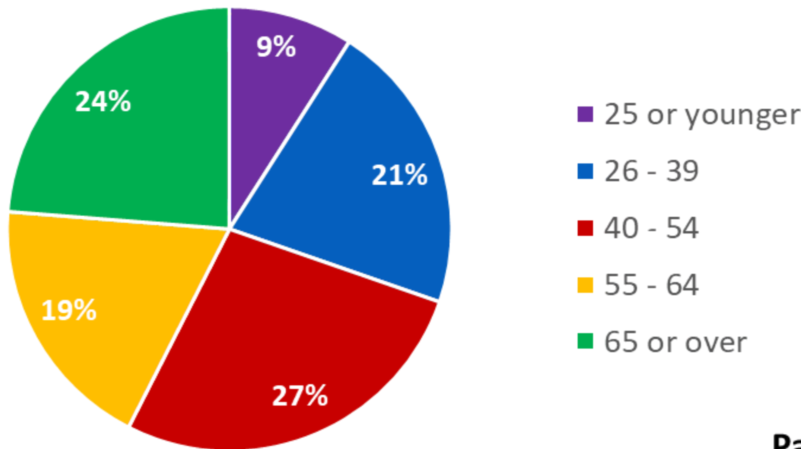
Clay County

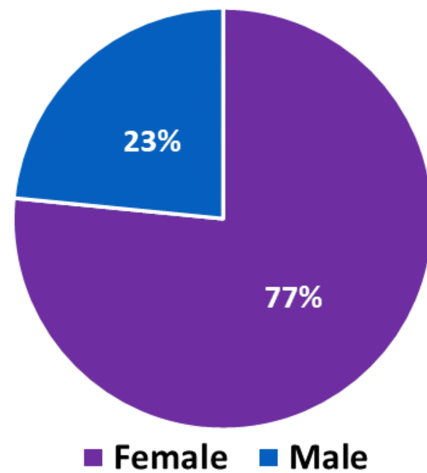
Fayette County

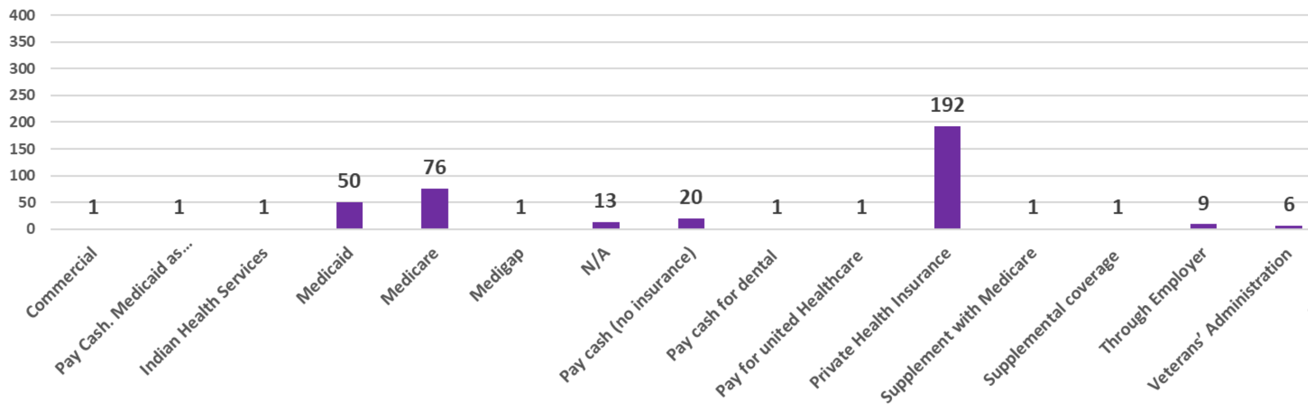
| | Fayette | Kanawha | Clay | Nicholas |
|---|---|---|---|---|
| Population 2025 | 39,987 | 174,805 | 7,946 | 24,446 |
| Persons Under 5 Years | 2.3% | 2.7% | 2.5% | 2.5% |
| Persons Under 18 Years | 20.6% | 19.8% | 22.1% | 20.7% |
| Persons Over 65 Years | 22.3% | 23% | 21.7% | 23.6% |
| Female Persons | 50% | 50.6% | 49.5% | 49.7% |
| Race Non-White or More Than 2 Races | 6.9% | 12.2% | 3% | 3% |
| Hispanic or Latino | 1.4% | 1.6% | 0.2% | 0.5% |
| High School Education or Higher | 86.1% | 90.4% | 84.1% | 88% |
| Under 65 With A Disability | 13.8% | 13.8% | 17.5% | 18.6% |
| Under 65 Uninsured | 8.3% | 6.7% | 7.5% | 8.4% |
| Persons In Poverty | 18.8% | 15.9% | 24.9% | 17.8% |
| Median Household Income | $52,672 | $56,469 | $42,790 | $49,280 |

*Source: US Census Quickfacts Data*

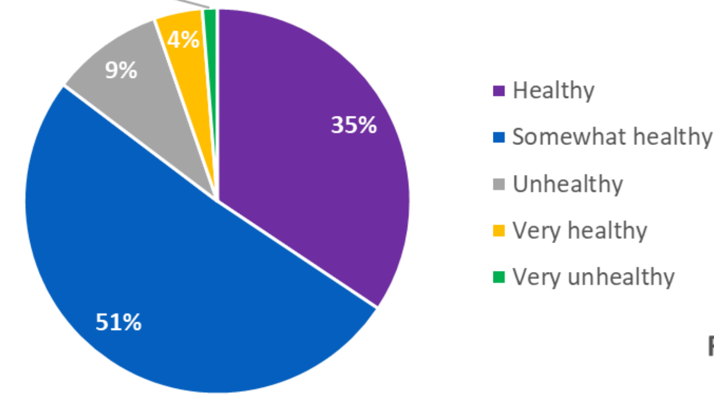
# Survey Participant Demographics

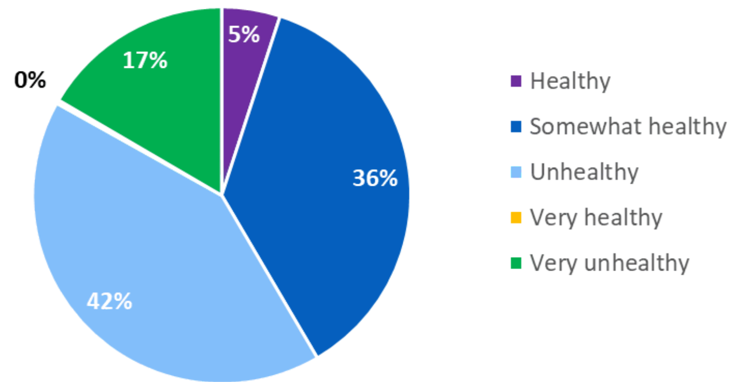


# Survey Participant Ratings of Health

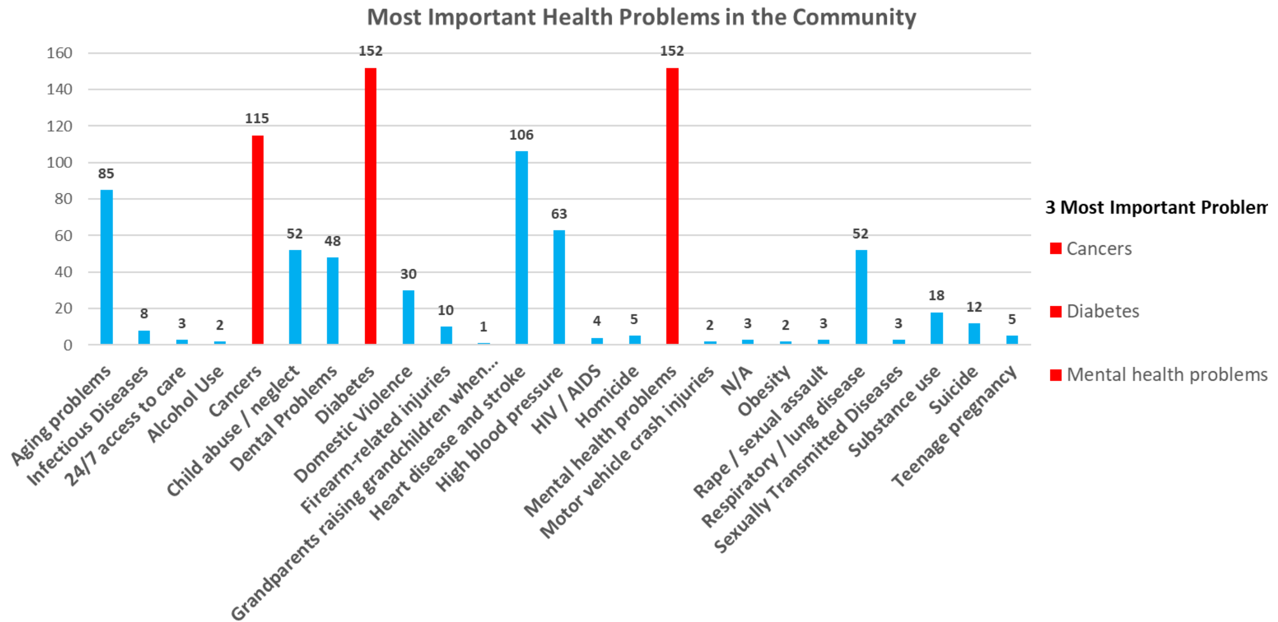


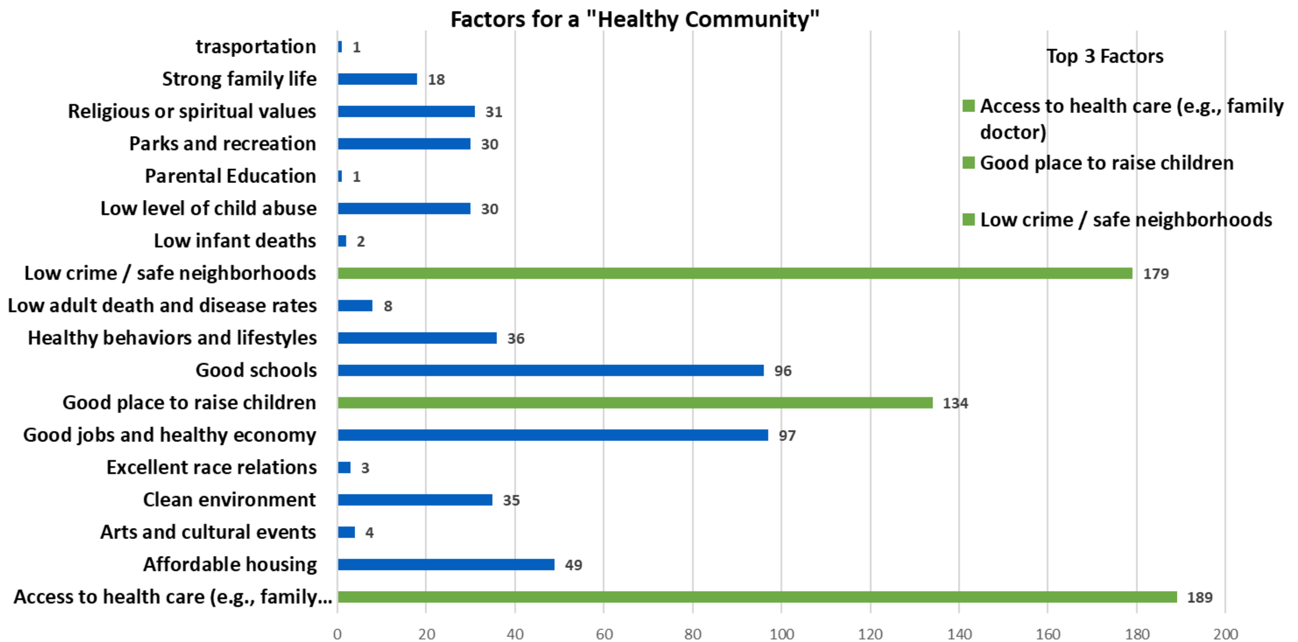




| 2025 Community Health Trends | | | |
|---|---|---|---|
| Life Expectancy | 71.2 | Diabetes Prevalence | 12.4% |
| Smoking Rate | 25% | Obesity Prevalence | 42.1% |
| Adults in poor general health | 23% | Food Environment Index Score | 11.75% |
| Adults with no physical activity | 32.8% | Local Food Outlets (per 100k) | 4.9 |
| Adults with frequent mental distress | 21.9% | Population w/o access to large grocery store | 12.1% |
| Heart diseases prevalence | 7.7% | Hospital Bed Availability (per 1k) | 1.3 |
| Cancer incidents rate (per 100k) | 512.9 | Primary Care Doctor Availability (Per 1k) | 1.26 |

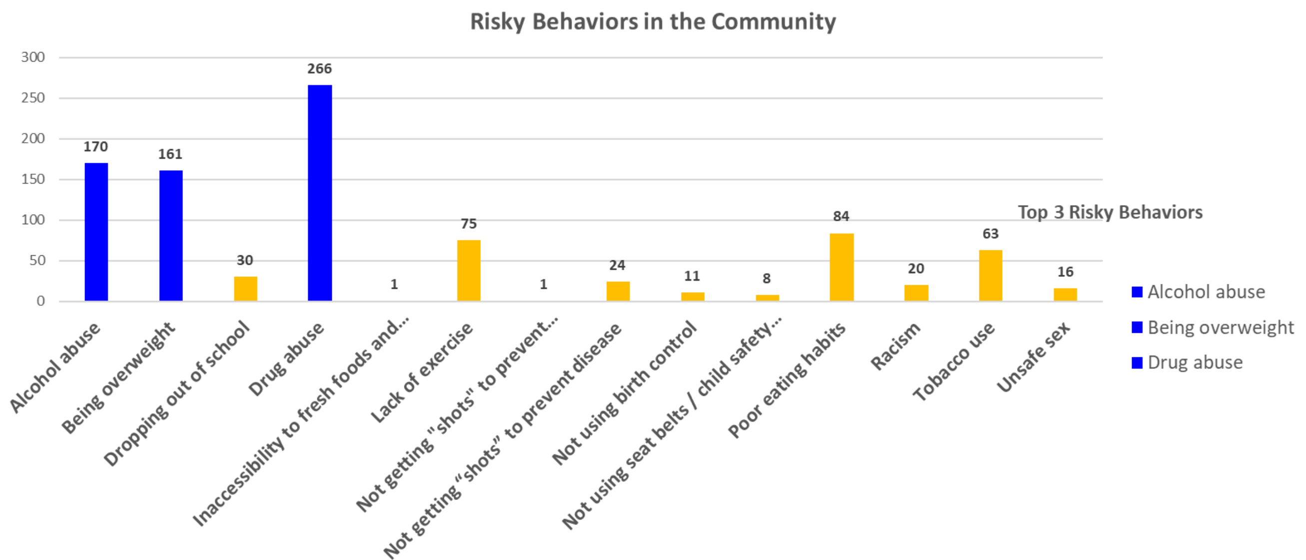
*Source: News & World Report- Healthiest Communities Report in Collaboration with Aetna Foundation*

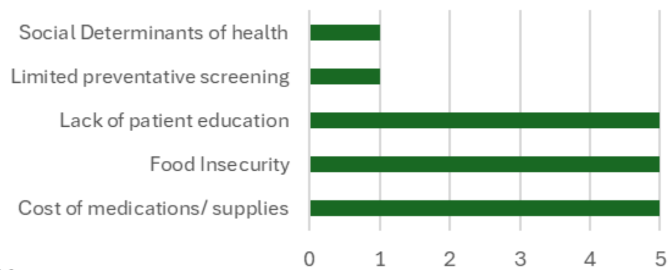
# Survey Findings: Community Health

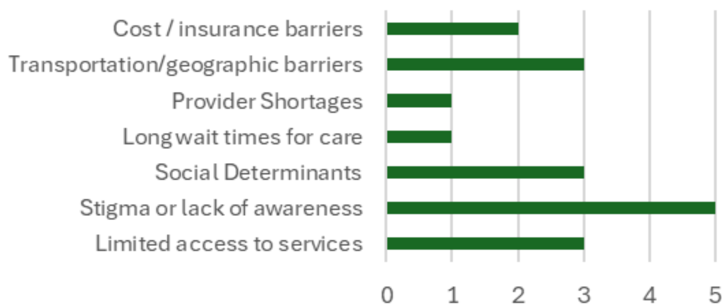


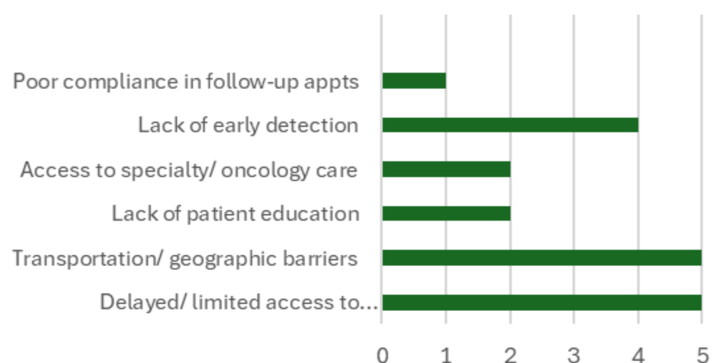



# Survey Findings: Community Health



# Secondary Data Collection Summary

Secondary data collection included gathering statistics from reliable sources such as social service agencies and government entities in an effort to supplement the primary data. Given that MGH is located in Fayette County, the following information reflects the health and well-being of Fayette County residents.

- According to 2022 County Health Rankings, Fayette County ranks #42 of 55 counties in West Virginia
- In terms of Health Outcomes, Fayette County is ranked among the least healthy counties in WV
- In terms of Health Factors, Fayette County is ranked among the least healthy counties in WV

# Fayette County At-A-Glance

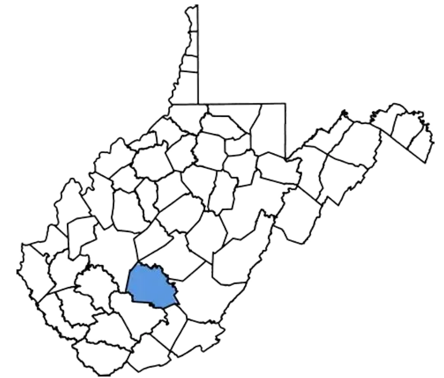
| Population 2025 | 38,600 |
|---|---|
| Population under 18 | 20.3% |
| Race non-White or more than one race | 6.7% |
| Hispanic or Latino | 1.5% |
| High School Education or Higher | 86.1% |
| Under 65 with a Disability | 15.8% |
| Under 65 Uninsured | 8.3% |
| Persons in Poverty | 16.7% |

*Source: US Census Quickfacts Data*

## 2025 Child Well-Being Data

| | |
|---|---|
| Children without health insurance | 3% |
| Children under Medicaid | 70.9% |
| Children with well-child exams (Medicaid) | 59% |
| Infant mortality rate (per 1,000) | 5.6 |
| Babies born exposed to drugs | 12.2% |
| Low birth-weight babies | 9.8% |
| Child & teen deaths (per 100,000) | 36.1% |

*Source: WV KIDS COUNT datasets*
*Source: West Virginia Department of Health. Vital Statistics / PRAMS Reports.*



## Fayette County Population Health Scores (out of 100)

| | |
|---|---|
| Overall Health Score **26** | Population Health **22** |
| Health Equity **75** | Environment **48** |
| Food & Nutrition **46** | Public Safety **38** |

*Source: News & World Report- Healthiest Communities Report in Collaboration with Aetna Foundation*

# Priority Health Issues

Based on the analysis of primary data—including community survey results, interviews, focus group feedback, and service provider perspectives—as well as secondary data from reliable sources such as the U.S. Census Bureau, WVDHHR, and U.S. News. The top three community health needs identified are as follows:

## Top Three Community Health Issues

**Mental Health**

**Diabetes**

**Cancers**

| Health Issue | Barriers | Hospital Role |
|---|---|---|
| Mental Health | • Limited access/providers<br>• Stigma/lack of awareness<br>• Social determinants of health<br>• Transportation / geographic barriers | • Serve as referral / coordination hub<br>• Support mental health education, awareness, and screenings<br>• Promote community outreach to reduce stigma |
| Diabetes | • Cost of Medications<br>• Food Insecurity<br>• Lack of patient education related to prevention and self-management | • Provide screening, early identification, and diabetes-related services<br>• Support care coordination/ referrals<br>• Facilitate connections to assistance programs<br>• Provide telehealth services<br>• Support community outreach |
| Cancers | • Limited access to screenings<br>• Transportation/ geographic barriers<br>• Lack of Patient Health Education<br>• Lack of early detection | • Promote & Provide access to cancer screenings and preventative care<br>• Support care coordination<br>• Provide Telehealth services<br>• Provide patient education |

# Community Survey - Common Themes and Takeaways

The Community Health Needs Assessment survey was distributed throughout the area served to obtain quantitative insight from residents about the greatest health concerns, service needs, and barriers to accessing care. As a result, there were 320 survey respondents representing various communities, ages, genders, races, educational background, employments industries, socioeconomic status, and more.

## Top Three Health Issues in the Community *-per the survey*

### Mental Health

47.5% OF SURVEY PARTICIPANTS SAID MENTAL HEALTH WAS A MAJOR ISSUE.

### Diabetes

47.5% OF SURVEY PARTICIPANTS SAID DIABETES WAS A MAJOR ISSUE.

### Cancers

35.93% OF SURVEY PARTICIPANTS SAID CANCERS WAS A MAJOR ISSUE.

## Top Three Factors for a Heathy Community *-per the survey*

1. **Access to Health Care**
2. **Low Crime/Safe Neighborhoods**
3. **Good Place to Raise Children**

## Top Three Risky Behaviors in the Community *-per the survey*

1. **Drug Abuse**
2. **Alcohol Abuse**
3. **Obesity**

Survey findings show that the community's top health concerns—mental health, diabetes, and cancer—are closely connected to both community conditions and individual behaviors. Access to health care was identified as a critical factor for a healthy community and directly impacts all three health issues, particularly access to mental health services, chronic disease management, and preventive screenings. Safe neighborhoods and being a good place to raise children also support overall well-being and long-term health outcomes.

Risky behaviors identified through the survey further contribute to these health challenges. Drug and alcohol abuse are closely linked to mental health concerns and can interfere with treatment and recovery, while obesity is a significant risk factor for diabetes and certain cancers. These findings highlight the importance of addressing health issues through a comprehensive approach that considers access to care, community conditions, and prevention-focused efforts to reduce risky behaviors.

# Service Provider Questionnaire - Common Themes

A quantitative service provider questionnaire was completed by service providers at Montgomery General Hospital to assess the top three health needs identified in the community health survey. They were asked to share further insight on these issues based on their experience with the patients they serve. Providers who participated include Physicians and Nurse Practitioners from various MGH departments.

## Providers confirmed that these survey-identified health issues are reflected in their practice.

### The Three Most Important Reasons Why Mental Health is An Issue for the Community: *-Per Providers*

1. **Stigma / Lack of awareness**
2. **Social Determinants**
3. **Limited access to services**

### The Three Most Important Reasons Why Diabetes is An Issue for the Community: *-Per Providers*

1. **Cost of Medications**
2. **Food Insecurity**
3. **Lack of patient education**

### The Three Most Important Reasons Why Cancer is An Issue for the Community: *-Per Providers*

1. **Delayed/Limited access to screenings and early detection**
2. **Transportation / Geographic barriers**
3. **Lack of patient health education**

# Steering Committee- Common Themes and Takeaways

Survey findings were presented to the steering committee during two separate meetings to accommodate varying schedules. Discussions focused on the survey results and potential ways the hospital could address the identified issues. Input was gathered from committee members representing diverse backgrounds and locations to encourage critical thinking and meaningful dialogue.

## Mental Health:

- Work to define *Mental Health* to reduce stigma and for marketing
- Generate cost analysis for additional Mental Health services such as therapists/counselors
- Utilize Rural Health Redesign promotional/educational video grant project.
- Attend local community events to spread awareness
- Support / partner with local recovery groups
- Provide provider education on Mental Health awareness
- Provide provider education on appropriate screenings to conduct during appointments that help to generate referrals to Mental Health providers.

## Diabetes

- Attend local community events to spread awareness and outreach
- Utilize diabetic educator for community education and prevention
- Work on preventing diabetes by educating children and young adults
- Create a Physical Therapy Exercise program/challenge
- Support / partner with local farmers markets
- Support local sports teams
- Support / Partner with local schools
- Provide provider education to conduct appropriate screenings to generate referrals

## Cancer

- Promote early screening services such as mammograms, PAP Smears, Colonoscopies, and low dose CT scans
- Utilize Rural Health Redesign promotional/educational video grant project.
- Promote CAMC Telehealth services at MGH for oncology/specialist visits
- Host an "Insurance Education Day" teaching the public about services that their insurance covers and may cover, such as transportation
- Increase annual visits and reduce cancellations

# Steering Committee- Solution Strategies

## Mental Health:

1. **Awareness and Education**
    a. **Goal:** Increase community and provider understanding of mental health to reduce stigma and improve access to services.
        - Develop Clear definitions and messaging around mental health for marketing, patient education, and community outreach
        - Utilize the Rural Health Redesign promotional video project to educate the public about mental health services and resources.
        - Provide provider education on mental health awareness and stigma reduction.
        - Participate in local community events to raise awareness of mental health services.
2. **Referrals and Access to Care**
    a. **Goal:** Improve access to mental health services for patients and community members.
        - Train providers to conduct mental health screenings and identify needs during patient visits.
        - Strengthen referral pathways to therapists, counselors, and local recovery groups.
        - Conduct a cost and resource analysis for expanding in-house mental health services.
        - Promote telehealth and other hospital-based mental health services to reach underserved populations.
3. **Coordination and Navigation**
    a. **Goal:** Ensure seamless care navigation for patients requiring mental health support.
        - Coordinate internal hospital services to streamline mental health referrals and follow-up care.
        - educate patients on accessing mental health services, including telehealth and insurance-covered resources.
        - Strengthen follow-up contact to track appointments and reduce cancellations.
4. **Community Engagement and Support Services**
    a. **Goal:** Strengthen partnerships with community organizations to support mental health.
        - Partner with local recovery groups and community organizations to provide support networks.
        - Engage schools and community centers to promote mental health awareness programs.
        - Collaborate with local stakeholders to encourage ongoing participation in mental health initiatives.

# Steering Committee- Solution Strategies

## Mental Health Continued:

5. **Evaluation and Impact**
   a. **Goal:** Measure the effectiveness of mental health initiatives and improve service delivery.
      - Track participation in community education events and provider training.
      - Monitor referral rates and utilization of mental health services.
      - Collect feedback from patients, providers, and partners to identify gaps and areas for improvement.
      - Adjust strategies based on evaluation results to increase reach and effectiveness.

## Diabetes:

1. **Awareness and Education**
   a. **Goal:** Increase knowledge and prevention of diabetes across all age groups.
      - Provide educational messaging on diabetes prevention, healthy lifestyles, and risk reduction.
      - Utilize the Rural Health Redesign video project to share diabetes prevention information.
      - Conduct community education events with the MGH diabetic educator to provide prevention and management resources.
      - Educate providers on diabetes awareness and best practices for early identification.
2. **Referrals and Access to Care**
   a. **Goal:** Improve access to diabetes care, education, and preventive services.
      - Train providers to conduct diabetes screenings and generate timely referrals.
      - Offer referral pathways to diabetic educators, nutritionists, and endocrinology services.
      - Promote telehealth or hospital-based diabetes management services.
      - Evaluate feasibility of expanding hospital-based diabetes prevention programs.
3. **Coordination and Navigation**
   a. **Goal:** Streamline patient care for diabetes management and prevention.
      - Coordinate care between primary care, diabetic educators, nutritionists, and specialty services.
      - Educate patients on navigating appointments, referrals, and telehealth resources.
      - Implement reminder systems to improve adherence to screenings and follow-up care

# Steering Committee- Solution Strategies

## Diabetes Continued:

**4. Community Engagement and Support Services**

a. **Goal:** Build community partnerships to support diabetes prevention and management.
   - Partner with local schools, sports teams, and community centers to promote physical activity.
   - Collaborate with farmers markets to improve access to healthy foods.
   - Implement exercise programs and challenges to encourage healthy behaviors.
   - Engage community stakeholders to foster participation in diabetes prevention initiatives.

**5. Evaluation and Impact**

a. **Goal:** Monitor the effectiveness of diabetes education, prevention, and management initiatives.
   - Track attendance at community events and participation in prevention programs.
   - Monitor provider referrals, screening rates, and utilization of diabetes services.
   - Evaluate patient adherence to follow-up care and program participation.
   - Adjust strategies based on data to improve reach, effectiveness, and health outcomes.

## Cancer:

1. **Awareness and Education**
   a. **Goal:** Increase community knowledge of cancer prevention, early detection, and available hospital services.
      - Promote education on early cancer screenings.
      - Utilize the Rural Health Redesign video project to provide educational outreach on cancer prevention and available services.
      - Conduct provider education on current screening guidelines and early detection practices.
      - Participate in community events to distribute information on cancer prevention and screenings.
2. **Referrals and Access to Care**
   a. **Goal:** Improve access to cancer screening and specialty care services.
      - Educate providers to identify at-risk patients and generate timely referrals.
      - Promote telehealth services at MGH for oncology and specialty care.

# Steering Committee- Solution Strategies

## Cancer Continued:

2. **Referrals and Access to Care continued**
    - Strengthen referral pathways to in-hospital and community oncology services.
    - Host “Insurance Education Days” to ensure patients know their coverage options for screenings and transportation.
3. **Coordination and Navigation**
    a. **Goal:** Enhance patient support for navigating cancer care and preventative services.
        - Coordinate hospital departments to streamline referrals and follow-up care.
        - Provide patient guidance on scheduling screenings, telehealth visits, and specialty appointments.
4. **Community Engagement and Support Services**
    a. **Goal:** Strengthen community partnerships to promote cancer prevention and support.
        - Partner with schools, community groups, and organizations to encourage preventative behaviors and screenings.
        - Engage local stakeholders in promoting awareness campaigns and early detection initiatives.
        - Support patient support groups.
5. **Evaluation and Impact**
    a. **Goal:** Assess effectiveness of cancer prevention, screening, and outreach initiatives.
        - Track participation in educational events, screenings, and telehealth oncology visits.
        - Monitor referral patterns, screening completion rates, and appointment adherence.
        - Collect feedback from providers, patients, and partners, to identify gaps.
        - Use evaluation findings to refine strategies and improve access, outreach, and outcomes.

**Special thanks to all community members and community partners who contributed their time, insight, and expertise to the completion of this Community Health Needs Assessment.**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