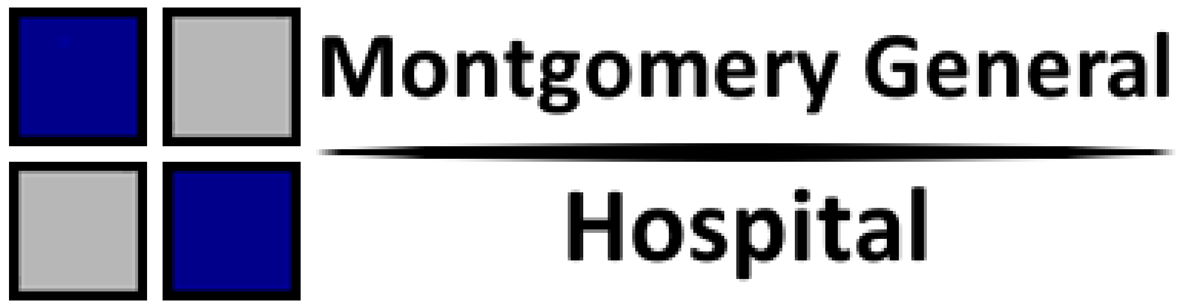

Community Health Needs Assessment

DECEMBER, 2019

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Report approved by the Executive Committee of the Board of Directors on December 30, 2019.

Mission and Values

Mission

Montgomery General Hospital is committed to providing the highest quality care and community-wide health improvement.

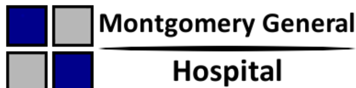
Values

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 open and honest communication.

To promote, recognize, and reward achievement of excellence among its employees, medical staff, and volunteers.



Introduction

The 2019 Community Health Needs Assessment (CHNA) of Montgomery General Hospital (MGH) builds on the collaborative CHNA effort of MGH and other community stakeholders. This process is an extension of the previous CHNA, developed and published in 2016, and was conducted to identify health issues and needs of the community. Information from the CHNA will assist key decision makers to make a positive impact on the health of MGH's service area. The results of the CHNA will enable MGH, as well as other community providers, to collaborate their efforts to provide the necessary resources for the community.

To assist with the CHNA process and completion, Montgomery General Hospital retained Arnett Carbis Toothman LLP, a regional accounting firm with offices in West Virginia, Ohio, and Pennsylvania. The assessment was designed to ensure compliance with current Internal Revenue Service (IRS) guidelines for charitable 501(c)(3) tax-exempt hospitals which require tax-exempt hospitals to conduct a CHNA every three years to identify the community's health needs and adopt an implementation strategy to meet those needs. In addition, community benefits must be reported on IRS Form 990, Schedule H.

It was the goal of the CHNA partners to produce a current profile of health status, wellness, health delivery and public-sourced opinions about health in Fayette County and the surrounding communities. The process used a compilation of the most recent local, state and federally sourced data, as well as the opinions and concerns articulated by community residents through surveys and interviews. The study also reviewed the prior implementation plan to assess the progress and community feedback related to the Hospital's plan.

The significant components of the Montgomery General Hospital 2019 CHNA include:

- Demographic Information
- Socioeconomic Characteristics of the Service Area
- Health Status Indicators
- Access to Care
- Results of Community Participation

Background

Montgomery General Hospital is a 25 bed critical access facility in Montgomery, West Virginia. Established in 1888 as Sheltering Arms Hospital by the Diocese of West Virginia of the Protestant Episcopal Church, the hospital represented one of the first efforts to deal with the increasing medical demands of an area that was rapidly evolving into a major industrial center.

As the only fully operating medical facility in the area, Sheltering Arms offered the best hope for adequate medical care to these growing communities. By 1901, forty-nine coal companies were sending patients to Sheltering Arms Hospital.

From November 1907 until August 1915, Superintendent Dr. J. Ross Hunter oversaw the affairs of the hospital. In July of 1914, Dr. William Ramsey Laird joined the staff of Sheltering Arms for a one-year appointment as assistant to Superintendent Hunter. He left at the end of his appointment but later returned in October 1915 to continue training to take over the superintendent position on Hunter's retirement. In 1916, Dr. Laird officially accepted the position of surgeon in charge of the Sheltering Arms Hospital.

Laird soon demonstrated that he had a clear vision of the path the hospital should take. He felt concern about the quality of medical care in the coalfields and believed the hospital should take a role in correcting these problems. He envisioned the facility as a teaching hospital, overseeing clinics in surrounding areas.

In 1917, the board separated the duties of chief surgeon and those of the superintendent. The control of the surgeon in charge was limited to surgical and medical cases, with other areas under the control of the newly appointed superintendent, Wayman C. Lyon. Dr. Laird officially resigned his position as surgeon in charge of Sheltering Arms Hospital on December 5, 1918.

In 1920, Dr. Laird made his vision of medical care a reality by sponsoring a medical facility designed to operate more independently than had been possible at Sheltering Arms. That year, he opened a new facility in Montgomery, christening it, the Coal Valley Hospital, in honor of the original name of the town post office. Another former Sheltering Arms physician, Dr. Benjamin F. Brugh, joined Laird as associate at the new facility. With this experienced staff, Coal Valley soon became a serious contender in the competing theories on medical philosophy in the area.

Coal Valley Hospital came into being at the dawn of a new era, just as an earlier one had given birth to Sheltering Arms. Indeed, the town of Montgomery in 1920 was a perfect choice for a medical facility. As the largest town in Fayette County at the time, Montgomery boasted a population of almost 2,200 residents inside the corporate limits, as well as, being surrounded by several other booming coal communities. In addition, it was the site of one of the two preparatory schools for the State University, as well as the first black high school in the county. Montgomery was a city that seemed destined to grow and Laird was convinced that the Coal Valley Hospital would grow with it.

Always a man of vision, Laird erected the first hospital building with an eye toward making it a central unit for future building. The three-story brick and stone structure originally erected was large by the standards of the time. However Laird's confidence in growth was proven justified and the number of patients soon required additional construction. By 1926, the facility rated as a class A institution and was preparing for erection of a wing on either side of the original building. During the same period of time, the hospital acquired a brick residence near the main building to be used as a home for both graduate and training nurses. Within a decade, the Coal Valley Hospital was a source of pride for the community which boasted of the quality of the staff and of laboratories fully equipped to deal with any type of research work.

Like its predecessors, the Coal Valley Hospital would be forced to deal with the demands of an ever-changing economic face in Fayette County. Within two decades of construction of Coal Valley Hospital, the automobile and the building of new roads opened up new opportunities and new choices to residents. Even with expansion, Coal Valley could not meet the demands upon it. An adjustment was needed in both size and location.

In 1938, Dr. Laird established a new medical facility on one of Montgomery's main streets where it would be accessible by automobile, railroad or water. At a three-way junction of transportation, the new facility seemed guaranteed to meet the changing demands of the area. Two friends of Dr. Laird; Judge George W. McClintic and Dr. Benjamin F. Brugh; insisted that the new facility be named Laird Memorial Hospital, in honor of the parents of the founder.

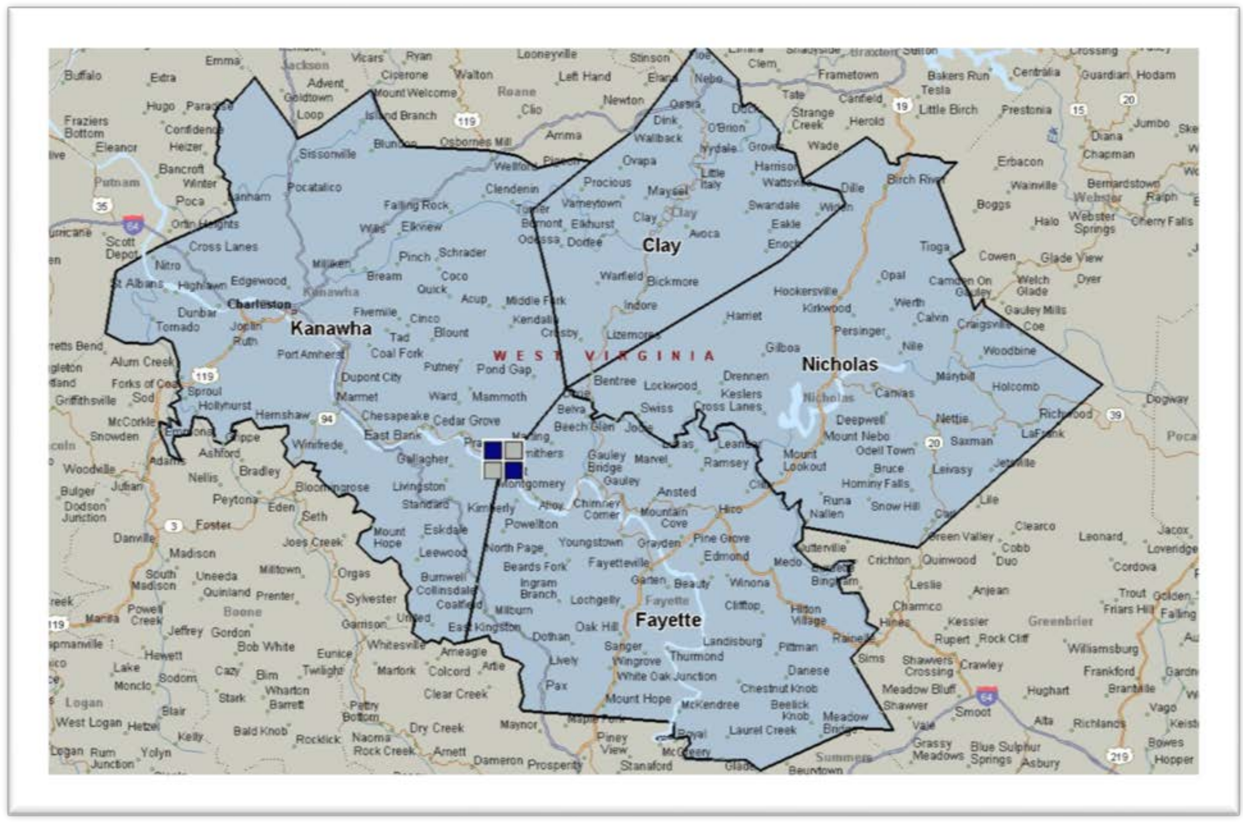
In 1971, Laird Memorial Hospital officially became Montgomery General Hospital by a vote of the Board of Directors. For years, this medical facility has played an active part in fulfilling the needs and easing the suffering of area residents, carrying on the proud tradition of service begun by Coal Valley and Laird Memorial Hospitals.

During this half century, the needs and even the names may have changed, but for Montgomery General Hospital, the mission remains the same. As a major employer, MGH is a significant contributor to the economic and social vitality of its community.

MGH and surrounding communities are located in Montgomery, WV. Montgomery is located approximately three hours southeast of Columbus, OH, and half an hour south of Charleston, WV.

Community Served

To determine the community for the assessment, inpatient and outpatient patient data by zip code was analyzed. MGH defined their service area based upon the geographical area in which a majority of their patients reside. As in the 2016 CHNA and shown in the map below, the community was identified as the following West Virginia Counties: Kanawha, Fayette, Clay, and Nicholas. MGH is located near the border of Fayette and Kanawha counties.



Socioeconomic Demographics

Service Area Population

The community of Montgomery General Hospital included four counties in West Virginia. As shown in the exhibit below, 70.3% of MGH's service area resides in Kanawha County while 16.7% reside in Fayette County, where the hospital is located.

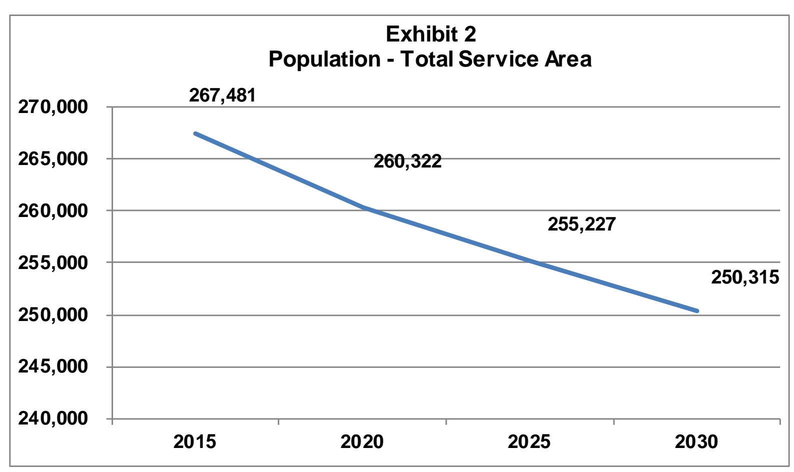
The primary service area of MGH included 267,481 residents in 2015.

Exhibit 1: Population Projections

County	2015	2020	2025	2030
Fayette	44,822	43,581	42,723	41,526
Kanawha	188,207	183,150	179,749	177,236
Nicholas	25,547	25,106	24,734	24,022
Clay	8,905	8,485	8,021	7,531
Total Service Area Population	**267,481**	**260,322**	**255,227**	**250,315**

Source: WV Population Projection, Bureau of Business and Economic Research

Overall, the population of those residing in the service area is expected to decrease between 2015 and 2030. Of the four service area counties, the largest percentage decrease is expected in Clay County while Nicholas and Kanawha are projected to have the least decrease in population.



Overall population of the service area is expected to decrease.

Exhibit 3 presents the percent change in population by age cohort for the service area. The service area continues to have an aging population. As shown in the following exhibit, the highest percentage of increase is for those 65 years and older. This increase will contribute to an increase of Medicare beneficiaries with an increased need for health care services.

Exhibit 3: Percent Change in Population by Age Cohort
2015-2020

Age Cohort	Population, 2015	Population, 2020	Percent Change in Population 2015-2020
0-14	46,668	45,693	-2.1%
15-44	96,295	93,853	-2.5%
45-64	79,021	73,196	-7.4%
65+	50,478	55,959	10.9%

All service area counties are projected to see an increase of those 65 and older.

At 12.7%, Nicholas County has the highest percent increase for those 65 years and older in the service area. In addition, Exhibit 4 shows that Clay County has the lowest increase at 10.3%.

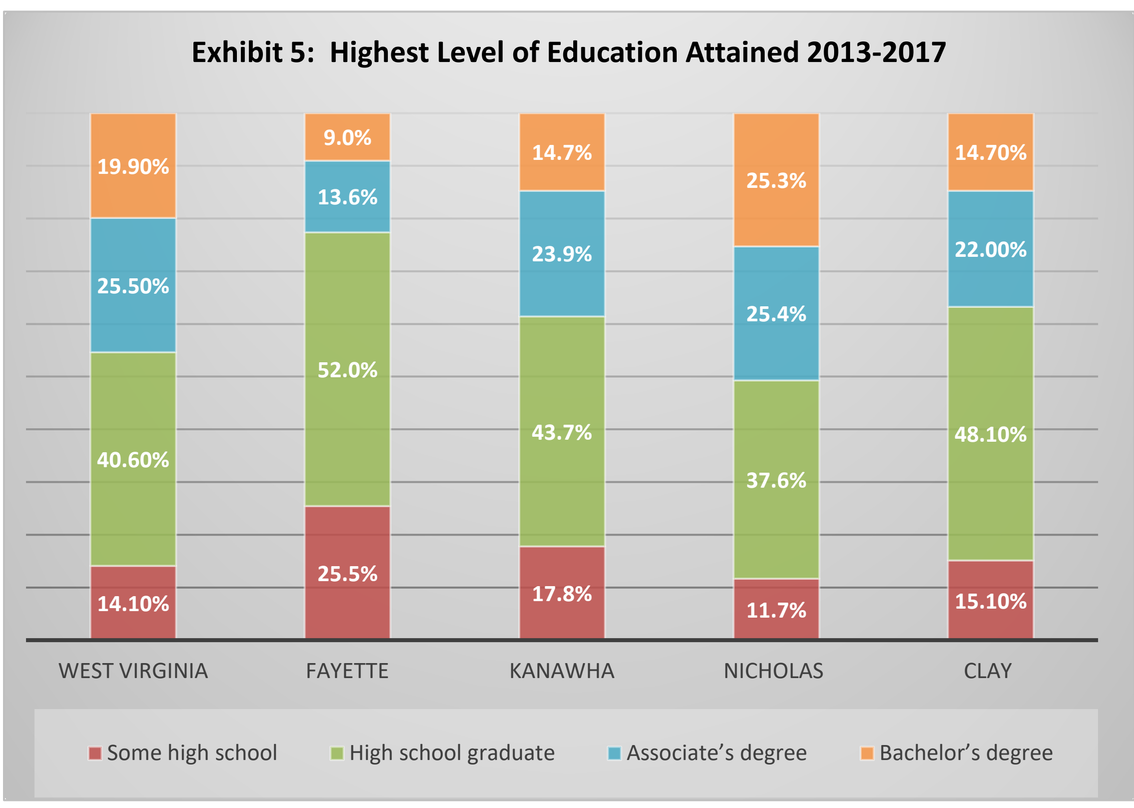
Exhibit 4: Percent Change in Population 65+ by County
2015-2020

County	Population, 2015	Population, 2020	Percent Change in Population 2015-2020
Fayette	8,426	9,342	10.9%
Kanawha	35,326	39,074	10.6%
Nicholas	5,102	5,752	12.7%
Clay	1,624	1,791	10.3%

Economic Indicators

Education

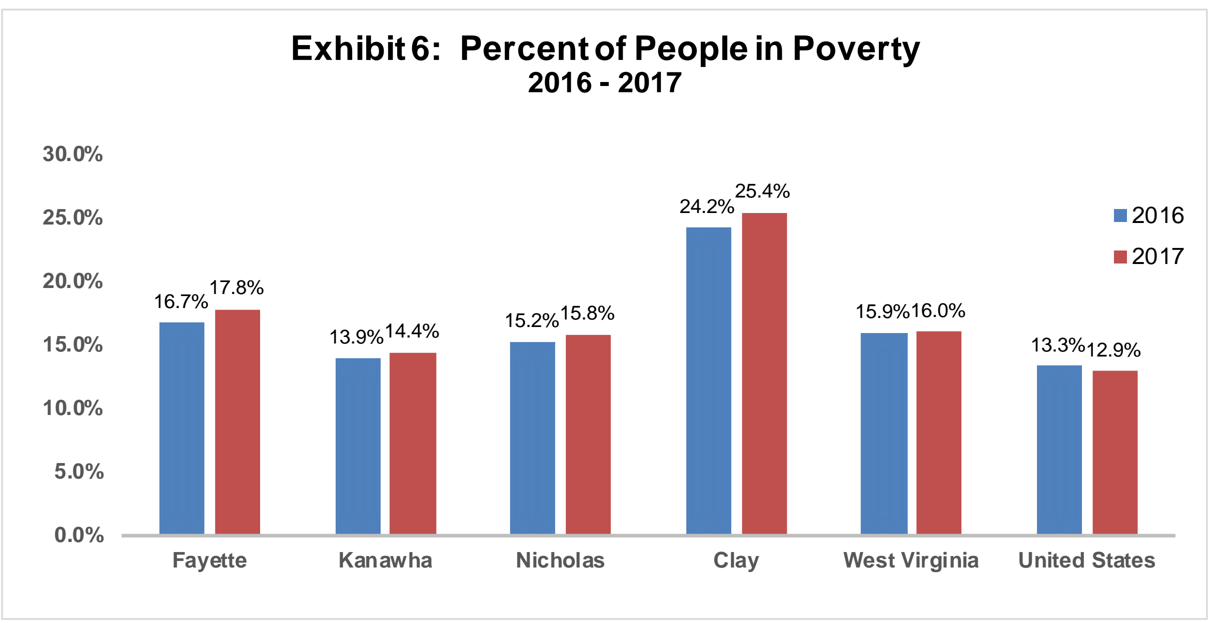
The education levels of a population have been shown to correlate to its overall health and welfare. Socioeconomic measures such as level of education, income, and employment characteristics are indicators of access to community resources. As shown in Exhibit 5, high school graduates represent the highest percentage of education among the service area counties and the state. Nicholas County represented the highest percentage of advanced degrees, with 25.4% reported having an Associate's degree and 25.3% having a Bachelor's degree. The percentage of Bachelor's degree for Nicholas County is above the state level.



Fayette County had the highest percentage of those who did not graduate from high school, while Nicholas County had the lowest percentage.

Poverty Rate

Poverty rate is a solid predictor of citizens' access to resources—the information and infrastructure necessary for effective health care and security—needed to care for themselves and their families. Exhibit 6 presents the percentage of adults living in poverty in 2016-2017 for the service area counties, West Virginia, and the United States. As the exhibit illustrates, Clay County had the highest percentage of adults living in poverty at 25.4%, while Kanawha County had the lowest at 14.4%. Kanawha and Nicholas were the only counties below the state level of 16%; all counties were above the national average. Poverty correlates highly to greater health and security challenges, and the lower educational attainment in part of the service area may magnify that effect.



1 in 4 Clay County adults live in poverty.

Household Income

The following exhibit reports the median household income and percentage of households with supplemental security income. All service area counties and the state have lower median household income than the national level. Kanawha County had the highest median household income and was the only county higher than West Virginia.

Supplemental Security Income (SSI) is a Federal income supplement program that provides benefits to disabled adults and children who have limited income and resources. For those aged 65 and older without disabilities, SSI benefits are payable if certain financial limits are met. As shown in the following exhibit, the highest percentage of households with SSI among the service area counties is Clay County. Kanawha and Nicholas are the only counties below the State of West Virginia, but all service area counties and the state are above the national level.

Exhibit 7: Primary Service Area (PSA)
Median Household Income, 2013-2017

PSA: County/State	Median Household Income	Percentage of Households with Supplemental Security Income (SSI)
Fayette	$39,297	10.7%
Kanawha	$46,859	6.5%
Nicholas	$39,037	6.8%
Clay	$34,242	13.0%
West Virginia	**$44,061**	**7.9%**
United States	**$57,652**	**5.4%**

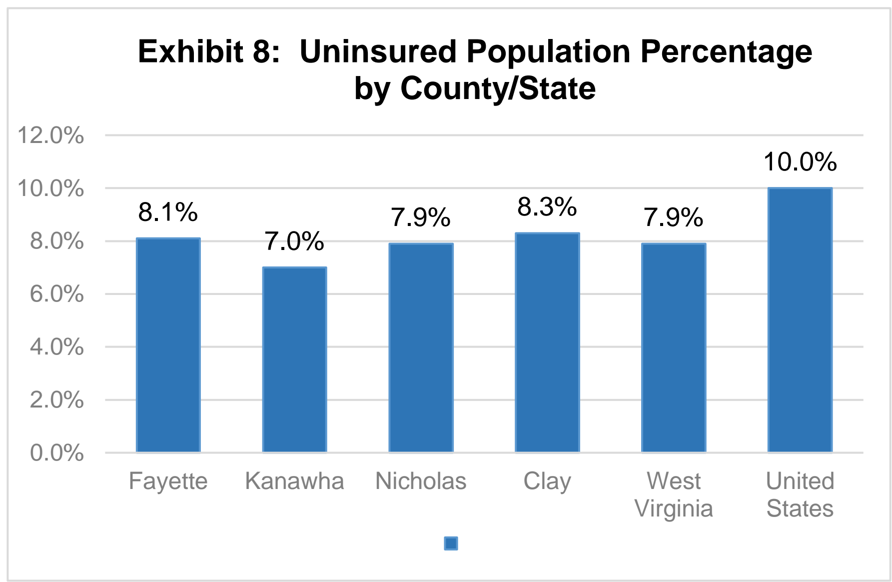
Median household income in Clay County is $34,242 and 13% of households receive SSI.

Health Insurance

Since the Affordable Care Act's (ACA) coverage expansion began, more than 20 million uninsured people nationwide have gained health insurance coverage. Due to the new coverage options for young adults, employees may add or keep children on their insurance policy until they turn 26 years old. This has afforded coverage to over 2.3 million young adults nationwide that would have otherwise been uninsured. As part of the ACA, states were able to expand Medicaid coverage to adults with incomes up to 138% of the federal poverty level. The healthinsurance.org website provides statistics related to the Medicaid expansion. As a result of the Affordable Care Act, the uninsured rate in West Virginia declined from 14 percent in 2013 to just 7.9 percent in 2017, according to U.S. Census data. A large part of this is due to the ACA's expansion of Medicaid; more than 200,000 people gained coverage under Medicaid and CHIP in West Virginia between late 2013 and September, 2017.

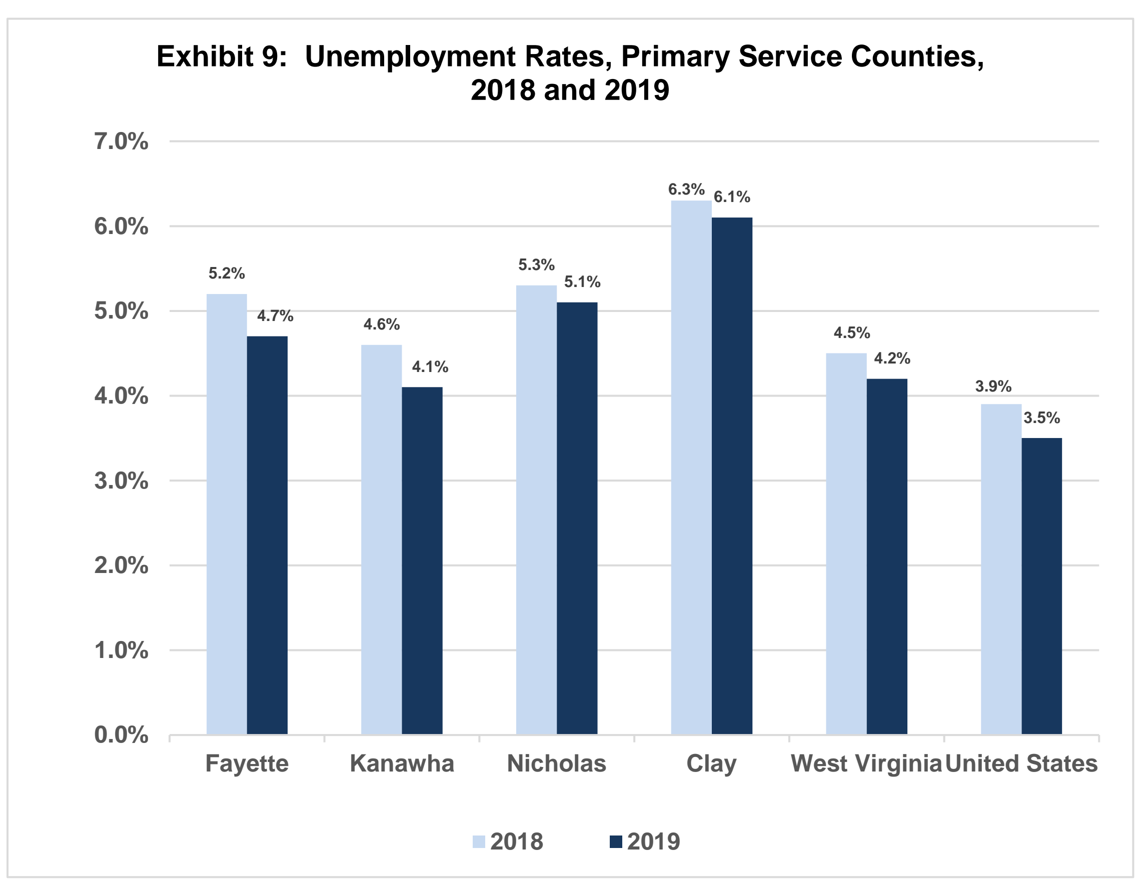
The following exhibit provides the uninsured population percentage by county. As shown in the exhibit, the service area as well as the State of West Virginia are all below the national rate for the uninsured population (10%).

Clay County has the highest uninsured rate in the service area



Unemployment Rates

Exhibit 9 shows the unemployment rate for each service area county, the state and the nation for 2018 and 2019. Clay County reported the highest unemployment rate for both years. Fayette and Kanawha County tied for the largest point decrease in unemployment for the one year period.



Clay County reported the highest unemployment rate

Causes of Death

Exhibit 10 displays the leading causes of death (COD) for the MGH community. It also displays the State of West Virginia averages for the corresponding COD. As shown in the exhibit, Fayette County compared unfavorably to West Virginia on many causes of death, especially dementia.

Exhibit 10: Leading Causes of Death by County and State, 2015

	West Virginia				
Death Rates	**Fayette**	**Kanawha**	**Nicholas**	**Clay**	**West Virginia 2015**
Major Cardiovascular Disease	404.5	321.2	359.5	336.7	**343.6**
Malignant Neoplasms	340.0	261.2	261.8	303.0	**261.3**
Chronic Lower Respiratory Diseases	62.2	97.7	58.6	123.5	**88.1**
Accidents, All Forms	75.6	101	93.8	89.8	**152.5**
Dementia	93.3	82.8	54.7	33.7	**51.7**
Diabetes Mellitus	40.0	51.0	39.1	33.7	**42.5**
Alzheimer's Disease	20.0	63.2	43.0	33.7	**40.0**
All Other Causes	200.0	165.7	183.6	123.5	**152.5**

Key	
Rates unreliable due to availability or sample size	-
Ranges: from better than State up to 10% w orse than St	
10-50% w orse than State	
50-75% w orse than State	
> 75% w orse than State	

Fayette and Kanawha Counties had 50% more prevalence of death caused by dementia than the State of West Virginia.

County Health Rankings

County Health Rankings, a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, examines a variety of health status indicators and ranks each county to the state in terms of “health factors” and “health outcomes.” These health outcomes and factors are composite measures based on several variables grouped into the following categories: health behaviors, clinical care, social and economic factors, and physical environment. Exhibits 11 and 12 provide the county’s ranking for each composite category.

Exhibit 11: 2019 County Health Rankings Among Service Area Counties

Indicator Category	Fayette	Kanawha	Nicholas	Clay
Health Outcomes	42	38	41	36
Length of Life	46	42	40	34
Quality of Life	40	25	42	37
Health Factors	51	25	42	48
Health Behaviors	54	30	36	39
Clinical Care	48	6	31	44
Social & Economic Factors	44	32	43	53
Physical Environment	29	37	40	8

Key	
Top 50th percentile of counties (Better)	(green)
25th to 49th percentile of counties	(white)
Bottom 25th percentile of counties (Worse)	(red)

County rank among 55 West Virginia counties

Exhibit 12: 2019 County Health Rankings: Measures and Comparison to the State

Indicator		Fayette	Kanawha	Nicholas	Clay	**West Virginia**
Health Behaviors	Excessive drinking	11%	13%	13%	12%	12%
	Healthy food environment index, 0 (worst) to 10 (best)	7.3	7.6	7.9	6.9	6.9
	Adult smoking	27%	21%	22%	24%	25%
	Physical inactivity	31%	27%	32%	31%	28%
	Adult obesity	40%	36%	41%	38%	36%
	Drug overdose mortality rate (drug overdose deaths per 100,000 population)	44	63	45	-	47
Clinical Care	Uninsured adults	9%	8%	8%	9%	8%
	Uninsured children	2%	2%	3%	2%	2%
	Primary care physician ratio	2110:1	740:1	1100:1	8860:1	1,290:1
Health Outcomes	HIV prevalence rate (# of cases per 100,000 population)	113	203	28	-	113
	Diabetes prevalence	17%	15%	13%	16%	14%
	Frequent mental distress	16%	15%	16%	16%	17%
	Frequent physical distress	16%	14%	15%	16%	17%
	Poor or fair health	26%	21%	23%	23%	24%
	Premature death (years of potential life lost before age 75 per 100,000 population)	12,800	11,800	11,700	10,400	10,500
Social & Economic Factors	Education - some college (% of adults ages 25-44 with some post-secondary education)	50%	58%	45%	33%	55%
	Unemployment	6.4%	5.0%	7.1%	8.6%	5.2%
	Children in poverty	30%	25%	28%	37%	24%
	Children in single-parent households	37%	41%	35%	31%	34%
	Violent Crime (# of reported violent crime offenses per 100,000 population)	278	616	725	-	330

Key	
Rates unreliable due to availability or sample size	-

Maternal/Child Health Indicators

Exhibit 13 displays the Maternal and Child Health Indicators for the MGH community. It also includes the state average for the corresponding indicators. Nicholas and Clay Counties reported rates greater than 100% worse than the state for fetal death ratio.

Exhibit 13: Maternal and Child Health Indicators by County					
Indicator	**Fayette**	**Kanawha**	**Nicholas**	**Clay**	**West Virginia**
Low birth weight infants	9.7%	10.6%	7.7%	3.5%	9.6%
Teen birth rate (< 20)	10.7%	9.6%	8.8%	13.3%	8.7%
No prenatal care in 1st trimester	22.7%	22.7%	23.2%	36.8%	21.4%
Fetal death ratio*	4.0	4.9	14.6	8.8	4.3

*Fetal death ratio = (fetal deaths/live births) X 1,000 in each respective county

** West Virginia is based on the most recently available 2015 data

Key	
Rates unreliable due to availability or sample size	-
Ranging from better than State up to 10% worse than State	
10-50% worse than State	
50-75% worse than State	
> 75% worse than State	

Other Facilities and Resources in the Community

Exhibit 14 provides a listing of the healthcare facilities in the MGH community.

Exhibit 14: List of Healthcare Facilities in the Service Area

County	Facility Name	EntityType
Fayette	FMC HAWKS NEST	End Stage Renal Disease Facility
	FMC OAK HILL	End Stage Renal Disease Facility
	MONTGOMERY GENERAL HOSPITAL, INC	Hospital
	PLATEAU MEDICAL CENTER	Hospital
	OAK HILL GROUP HOME	Intermediate Care Facility (Mentally Retarded)
	MONTGOMERY GENERAL HOSPITAL	Skilled Nursing Facilities/Nursing Facility (Distinct Part)
	ANSTED CENTER	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
	HILLTOP CENTER	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
	FAYETTE NURSING AND REHABILITATION CENTER	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
	MONTGOMERY GENERAL ELDERLY CARE	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
	HIDDEN VALLEY CENTER	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
Kanawha	DAY SURGERY CENTER	Ambulatory Surgical Center
	BMA CHARLESTON	End Stage Renal Disease Facility
	FMC KANAWHA COUNTY	End Stage Renal Disease Facility
	GREATER CHARLESTON DIALYSIS	End Stage Renal Disease Facility
	AMEDISYS HOME HEALTH OF WEST VIRGINIA	Home Health Agency
	KINDRED AT HOME	Home Health Agency
	STONERISE AT HOME	Home Health Agency
	MOUNTAINEER HOMECARE	Home Health Agency
	HOSPICECARE, INC	Hospice
	SELECT SPECIALTY HOSPITAL	Hospital
	CHARLESTON AREA MEDICAL CENTER	Hospital
	CHARLESTON AREA MEDICAL CENTER - TRANSPLANT	Hospital
	CHARLESTON SURGICAL HOSPITAL	Hospital
	THOMAS MEMORIAL HOSPITAL	Hospital
	ST FRANCIS HOSPITAL	Hospital
	HIGHLAND HOSPITAL	Hospital
	CROSS LANES GROUP HOME	Intermediate Care Facility (Mentally Retarded)
	EAST END GROUP HOME	Intermediate Care Facility (Mentally Retarded)
	HANSFORD GROUP HOME	Intermediate Care Facility (Mentally Retarded)
	WOODWARD CHILDREN'S HOME	Intermediate Care Facility (Mentally Retarded)
	5TH AVENUE GROUP HOME	Intermediate Care Facility (Mentally Retarded)
	ARC GROUP HOME	Intermediate Care Facility (Mentally Retarded)
	HUDSON GROUP HOME	Intermediate Care Facility (Mentally Retarded)
	GENESIS REHABILITATION SERVICES	Outpatient Physical Therapy/Speech Pathology
	EASTBROOK CENTER	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
	OAK RIDGE CENTER	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
	RIVERSIDE HEALTH AND REHABILITATION CENTER	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
	MEADOWBROOK ACRES	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
	CEDAR RIDGE CENTER	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
	DUNBAR CENTER	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
	GLASGOW HEALTH AND REHABILITATION CENTER	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
	VALLEY CENTER	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
	MARMET CENTER	Skilled Nursing Facilities/Nursing Facility (Dually Certified)
	ARTHUR B HODGES CENTER, THE	Skilled Nursing Facility
	COLUMBIA ST. FRANCIS HOSPITAL	Skilled Nursing Facility
Nicholas	SUMMERSVILLE REGIONAL MEDICAL CENTER	Hospital
	SUMMERSVILLE REGIONAL MEDICAL CENTER	Skilled Nursing Facilities/Nursing Facility (Distinct Part)
	KINDRED AT HOME	Home Health Agency
	MOUNTAIN RIDGE DIALYSIS	End Stage Renal Disease Facility
	SUMMERSVILLE GROUP HOME	Intermediate Care Facility (Mentally Retarded)
	SUMMERSVILLE PEDIATRIC, INC	Rural Health Clinic
	SUMMERSVILLE RURAL HEALTH CLINIC	Rural Health Clinic
Clay	Clay Health Care Center	Skilled Nursing Facilities/Nursing Facility (Distinct Part)

Federally Qualified Health Centers (FQHCs) are outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid. FQHCs include community health centers, migrant health centers, health care for the homeless centers, public housing primary care centers, and outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization. The main purpose of the FQHC Program is to enhance the provision of primary care services in medically underserved urban and rural communities. Note that different rules apply to outpatient Indian providers who enroll in Medicare or Medicaid as FQHCs. Exhibit 15 identifies the FQHCs in the service area.

Exhibit 15: Federally Qualified Health Centers in the Service Area

PSA County (State)	FQHC Name
Kanawha	Cabin Creek Health Center Inc., Clendenin Health Center, Familycare, Harts Health Clinic Inc., Kanawha City Health Center, Riverside Health Center, Southern West Virginia Health System, Inc., Upper Kanawha Health Association, Inc., and Womencare Familycare, Sunnyside Health Center
Fayette	Collins Middle School Wellness Center, Lisa Elliott Health Center, Mount Hope Elementary School Based Health Center, Mt. Hope Health Center, New River Health-Women's Health and Family Practice, North Fayette Family Health Center, Oak Hill High School Wellness Center, and Valley School Based Health Center, Community Health Systems Fayette Clinic, Midland Trail Health Center, New River Family Center, New River Elementary School-Based Health Center
Nicholas	Camden Family Health - Richwood, Camden Family Health - Red Oak, Camden Family Health - Craigsville, Center WV Community Health Center, Nettie/Leivasy Medical Center, Inc., Nicholas County School Based Health Center, and Richwood Wellness Center, Summersville Women's Health Center, Camden Family Health
Clay	Big Otter Clinic, Big Otter Elementary School, Wellness Center, Clay County Elementary Wellness Center, Clay County High School Wellness Center, Clay County Middle School Wellness Center, Community Care of West Virginia Inc., Lizemore Elementary School Wellness Center, and Primary Care Systems Inc., Flatwoods Elementary School Well Center

Exhibit 16 presents the number of primary care physicians, mental health providers, and dentists, as well as the rate per 100,000 residents, in the service area counties and the state. Among the service area, availability of primary care physicians, mental health providers and dentists is highest in Kanawha County.

Exhibit 16: Selected Health Professional Rates per 100,000 Population by County (PSA)

	Primary Care Physicians		Mental Health Providers		Dentists	
PSA County (State)	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
Fayette	21	47.4	21	48.3	21	48.3
Kanawha	251	135.1	324	175.4	152	82.6
Nicholas	23	90.9	15	59.9	9	36.0
Clay	1	11.3	3	34.2	3	34.2
West Virginia	**1,443**	**79.9**	**2,183**	**120.9**	**974**	**53.9**

Community Voice

Online Survey Results

The community health needs assessment includes anonymous survey results using an online survey website, which was disseminated to employees, patients and the community. Hard copy surveys were available upon request at the hospital. The survey focused on a number of issues including health priorities, barriers, and activities.

Respondent County of Residence

The online survey results consisted of residents from the following counties:

Fayette (WV): 75%	Nicholas (WV): 6.25%	Kanawha (WV): 18.75%

Respondent Age Groups

Under 18:	0.0%	25-40:	12.50%	65 and older:	0.0%
18-24:	6.25%	41-64:	81.25%		

Gender, Marital Status and Race

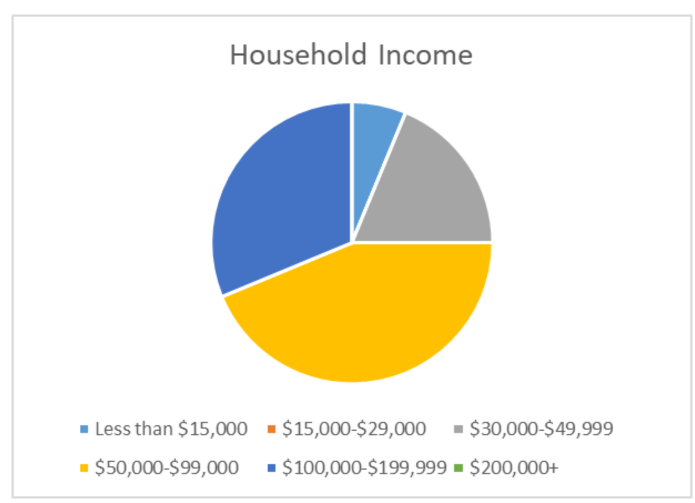
The survey respondents indicated the following information with regards to their gender, marital status and race:

- Gender: 12.50% were male and 87.50% were female.
- Marital Status: 6.25%-Single, 75.00%-Married/Civil Union, 18.75%-Divorced/Separated, 0.0%-Widowed
- Race: 75.00%-Caucasian, 12.5%-African American, 12.5%-Prefer not to answer

Household Income

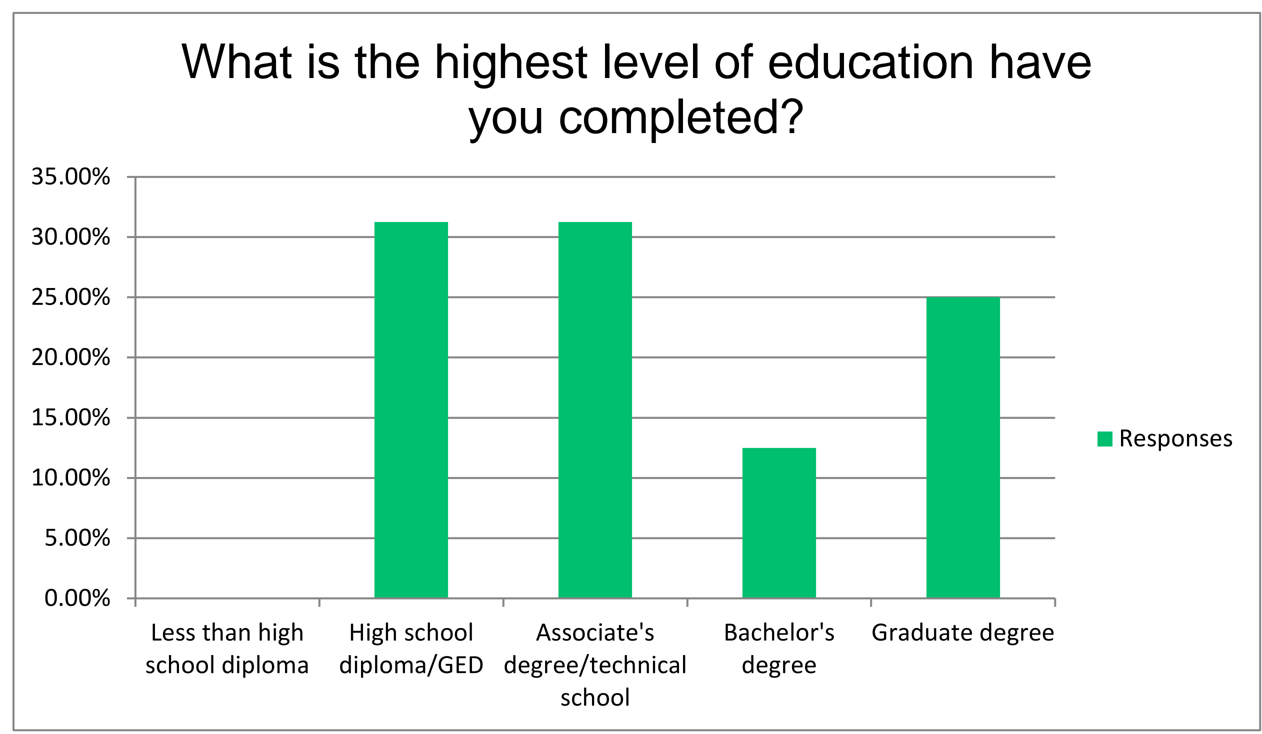
Household Income varied among survey takers with the lowest among those earning below $15,000:

Less than $15,000:	6.25%
$15,000-$29,999:	0.0%
$30,000-$49,999:	18.75%
$50,000-$99,999:	43.75%
$100,000-$199,999:	31.25%
$200,000+:	0.0%



Education

Respondents were asked: "What is the highest level of education you have completed?" All respondents indicated an education level of high school graduate or above.



Insurance

Participants of the survey were asked to identify their insurance carrier, if any. 68.75% selected Private Insurance, 6.25% selected Medicare, while 12.50% selected Medicaid. For those selecting Medicaid, 18.75% indicated they obtained their coverage through the ACA Medicaid Expansion.

Dental Health Care

- 87.50% received dental care in the past 12 months.
- Barriers that prevent residents from seeing a dentist include cost, lack of insurance, and lack of transportation.

Routine Health Care

Respondents were asked: "Do you and/or your family have a primary care physician? 87.50% indicated "Yes". Of those using a primary care physician (PCP), 86.67% indicated they are able to get an appointment when needed and 81% are satisfied with the quality of care received at their PCP's office. For those not having a primary care physician, respondents indicated they use the following medical provider types for routine care: community health care center, emergency room/hospital, and urgent care center.

When asked what the primary sources for medical and general health information were, top sources included: Doctor/Nurse/Pharmacist, Hospital/Health Facility Website or Publication, and Health Fairs/Special Clinics/Community Events.

44% of respondents indicated they have delayed health care due to lack of money and/or insurance.

HEALTH ISSUES

Participants were asked "What do you think are the concerns that keep you or others in your community from obtaining the health care services they need?" Top reasons include: medical specialties or services not available in the area, lack of health insurance, cost and/or lack of transportation.

Participants were then asked why they go outside of the county to receive health care services. The responses were as follows:

Medical specialties or services are not available in the area	43.75%
Prior bad experience with obtaining health care services	18.75%
Not applicable	18.75%
Unable to obtain appointment when needed	6.25%
Provider not covered by my insurance plan	6.25%

Participants were asked to select which services they would like to see added or expanded in MGH's service area. The top three responses were: behavioral/mental health, joint/bone/muscle pain, and neurology disorders. Participants also wrote in additional items such as an urgent care, health education, and bariatrics.

Input from persons who represent the broad interests of the community served by the hospital

The online survey closed with "Do you have any other thoughts on the level and variety of care provided in the community or by MGH?" Reponses included: requests for health educations, concerns with physician office response time, hospital involvement within the community, and positive accolades to MGH regarding experiences. MGH will take all responses into consideration to identify areas of improvement for not only staff members, but the community as a whole.

Community Interview Results

Input was solicited from those representing the broad interests of the community in December, 2019. Discussions included the health needs of the community, barriers to healthcare access, opportunities for improvement, perception of Montgomery General Hospital and feedback on MGH's initiatives. The following were selected to provide feedback:

- *Fayette County Department of Health*
- *Montgomery General Hospital Board Members*
- *Fayette County Schools*
- *Bridge Valley Community and Technical College*
- *Fresenius Dialysis of Montgomery*
- *City of Montgomery Representatives*
- *Montgomery General Hospital Employees and Physicians*

Community Health Concerns

As in many areas of West Virginia and across the country, substance abuse continues to be of high concern. Substance abuse not only leads to health issues for the abuser, but also has negative effects on their families and others in the community. In addition to substance abuse related illnesses, the community had significant concerns regarding the lack of obstetrics and gynecological care for the women of the community.

Other health concerns in the community include: mental health, heart disease, diabetes, cancer, and hypertension. Unhealthy lifestyle choices contribute to many of these health issues. Increasing access to specialty care as well as health fairs and education were seen as a primary ways to address some of the health concerns of the community.

Access to Services

Transportation issues, lack of affordable insurance (high deductibles and coinsurance) and limited specialty service availability were most frequently cited as contributing to access issues for residents within the community. Transportation within the city itself was not seen as a major issue but much more of an issue in outlying rural areas. In addition, while there is a bus line on Route 60, there is not a taxi service within the area.

While primary care was not seen as an issue, access to specialists for clinic visits was an area of concern. In particular, Obstetrics and Gynecology, Orthopedics, and Cardiac Rehabilitation were specific services needed for local access within the community.

It was identified that there was a need for urgent but non-emergent care. Currently the emergency room is still used for non-emergent visits which contributes to long wait times and inefficient use of the emergency room.

The closing of WVU Tech had a major impact on the area from an economic and educational standpoint. However, it was also viewed as an opportunity to use the facilities to address some of the concerns with access in the community as it relates to mental health, substance abuse, veterans care, etc.. Potential partners for these community based programs are being identified.

Perception of Montgomery General Hospital

Community perception of Montgomery General Hospital varied among stakeholders but was generally positive. Most indicated that the perception has improved and that MGH meets the basic needs of the community. It was noted that many residents perceive MGH cannot meet their specialized healthcare needs so they receive specialty services in Charleston, West Virginia as a result. The stakeholders recognized that a rural community hospital will never have all of the services of a large urban hospital, however, many felt that the addition of the high-demand specialty services would allow many more residents to remain in the area to receive their health care.

Progress on MGH Initiatives

Montgomery General identified four focus areas in the previous CHNA:

- Physical inactivity and obesity
- Diabetes Education
- Substance Abuse and Mental Health
- Transportation

The interview process identified that there is still a need for an Urgent Care facility in the community and that the Emergency Room is still being used for non-emergent care.

Cardiac Rehabilitation was seen as a needed service in the area. Most residents have their cardiac procedures performed in Charleston but most would prefer an option of receiving care locally.

Transportation was still viewed as work-in-progress. Based upon the interviews, it appears that MGH owns two vans for patient transportation but only one is being used and it is being used for elderly or long term care primarily. The question was asked whether the second van could be used for doctor appointments.

Summary of Findings

The goal of the needs assessment was to identify health issues and community needs, as well as provide information to key decision makers to make a positive impact on the health of the hospital's service area. Statistical data was compiled to depict demographic and economic profiles while the surveys provided additional feedback with regards to community perception of MGH, availability of resources and challenges as it relates to their healthcare needs.

- The aging population will contribute to the highest growth in the 65 and over age category. An increase in the 65 and older age category contributes to an increase of Medicare beneficiaries with an increased need of services.
- Fayette and Kanawha Counties have a significantly higher prevalence of death caused by dementia (93.8 and 82.8, respectively) than the state average of 51.7.
- Two service area counties had a percentage of adults living in poverty above the state level. Many residents in the community find themselves without insurance and seeking

assistance from Medicaid, other programs, or simply delay medical treatment altogether.

- Kanawha County had the highest percentage of low birthweight births in the service area. Clay County indicated the highest percentage for teen birth and no prenatal care in the 1st trimester. Both Nicholas and Clay Counties had a fetal death ratio that was double the state ratio.
- The health status indicators with the highest percentages within all service areas are physical inactivity and adult obesity. The service area counties ranged from 36%-41%.
- Health professional availability was highest in Kanawha County.

Community Health Priorities

The results of the CHNA will enable the Hospital, as well as other community providers, to collaborate their efforts to provide the necessary resources for the community. After reviewing data sources providing demographic, population, socioeconomic, and health status information, in addition to community feedback, health needs of the community were prioritized. The following have been selected as the priority health issues to be addressed:

- Physical inactivity and obesity
- Substance Abuse and Mental Health
- Transportation
- Women's Health Care

Physical Inactivity and Obesity

Obesity and physical inactivity are prevalent among residents in the service area. Community culture, lack of health care coverage, and low income can lead to unhealthy lifestyle choices. Unhealthy eating and activity habits give individuals a higher risk for liver and gallbladder disease, type 2 diabetes, high blood pressure, high cholesterol and triglycerides, coronary artery disease (CAD), stroke, sleep apnea, respiratory problems, osteoarthritis, and gynecological problems, among other conditions. Children who are obese are at risk for many of the same long-term health problems. If you have healthier habits or lose weight, your risk for these conditions is reduced.

Resources: The Fitness Center at MGH will continue to be available to its community members free of charge during weekly staffed hours. This state-of-the-art facility provides a wide variety of equipment including: treadmills, ellipticals, stair-masters, a Sith gym, free weights, and recumbent bikes.

Substance Abuse and Mental Health

Abuse of illicit drugs is costly to our nation, demanding over $400 billion annually in costs. The toll that drug and alcohol problems have on individuals is significant, as they are at increased risk for serious health problems, criminal activity, automobile crashes, and lost productivity in the workplace. Individuals with drug problems are not the only ones who suffer, the families, friends, and communities also suffer greatly. The abuse of drugs leads to multiple acute and chronic adverse health outcomes, as well as a variety of negative consequences within the family unit, poor performance in school, and difficulties at work. Substance abuse problems commonly occur in conjunction with mental health issues.

Resources: The Hospital will maintain its collaboration and referral network to address patients' needs with regards to addiction and abuse. MGH will continue to provide outreach and education to the residents of Montgomery and the surrounding communities.

Transportation

Lack of transportation was cited as a barrier to receiving health care in the community. Many times a patient will delay or disregard treatment due to lack of transportation.

Resources: MGH owns two vans primarily used to transport elderly and long-term care patients. MGH will explore additional opportunities to provide transportation for healthcare visits.

Women's Health Care

Access to gynecological and obstetric care is an important part of women's health. Preventative care such as annual well-woman exams and cancer screening has a direct impact on the early detection and overall health of the female population. Also, access to prenatal care in the first trimester is critical in reducing pregnancy related complications for mother and infant.

Resources: Local primary care providers are providing some women's health services, however, MGH is continuing to look for external partners to address the women's health needs of the area.

Next Steps

With the completion of the CHNA, Montgomery General Hospital will establish an implementation plan which will use MGH's individual strengths and resources to best address the community's health needs and improve the overall health and wellbeing of residents in the service area.

Sources

The data collection process utilized the following sources:

- **Bureau of Business and Economic Research, College of Business and Economics, West Virginia University – https://business.wvu.edu/centers/bureau-of-business-and-economic-research/data/population-data**
- **Centers for Disease Control and Prevention– http://www.cdc.gov/**
- **The Robert Wood Johnson Foundation: County Health Rankings System - http://www.countyhealthrankings.org/**
- **U.S. Census Bureau - https://www.census.gov/quickfacts/table/PST045215/00**
- **U.S. Census Bureau - http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml**
- **U.S. Census Bureau - http://www.census.gov/did/www/sahie/index.html**
- **United States Department of Labor, Bureau of Labor Statistics - http://www.bls.gov/**
- **US Department of Health and Human Services - http://www.hrsa.gov/shortage/**
- **US Department of Health and Human Services – http://datawarehouse.hrsa.gov/default.aspx**
- **US Department of Agriculture- https://www.ers.usda.gov/data-products/county-level-data-sets/download-data/**
- **West Virginia Bureau for Public Health - http://www.dhhr.wv.gov/bph/Pages/default.aspx**
- **West Virginia Department of Health and Human Resources – http://www.wvdhhr.org/bph/hsc/statserv/CountyData.asp**
- **West Virginia Health Care Authority - http://www.hca.wv.gov/data/Reports/Pages/**
- **West Virginia Health Statistics Center - http://www.wvdhhr.org/bph/hsc/vital/**