



Connected in Community Health.



Health Network

**2025–2028 Marshall Health Network
Community Health Needs Assessment**



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Health Network

Our Mission

Advancing Health.
Inspiring Hope.
Serving You.

Our Vision

Be the academic health system that delivers access, excellence and compassionate care at every stage of life.



Our Commitment to Community Health



Dear Community Members,

It is my honor to introduce the 2025–2028 Community Health Needs Assessment on behalf of Marshall Health Network—now proudly entering its second full year under this unified name.

The formation of Marshall Health Network represents a transformative collaboration for health care in our region. Together, we are forging a stronger, more coordinated system of care

dedicated to improving the health and well-being of our communities.

As the newly appointed President and CEO of Marshall Health Network, I am privileged to help lead this organization into a new era of purpose-driven care. This Community Health Needs Assessment reflects our commitment to identifying and addressing the most pressing health concerns facing the people and communities we serve—especially in the face of ongoing challenges and evolving needs.

Through collaboration with public health experts, local partners, and community stakeholders, we have identified several key priority areas for focused attention and improvement:

- Addiction and Behavioral Health
- Gerontology and Healthy Aging
- Obesity and Diabetes
- Rural Health and Primary Care

This assessment provides a foundation for strategic planning, community partnerships, and targeted initiatives that aim to close health gaps, improve access to care, and promote long-term wellness across our region.

We are deeply grateful to the many individuals and organizations who contributed to this effort. Your voices have shaped this roadmap, and your continued partnership will be vital to our shared success.

Thank you for being part of our mission to advance health, inspire hope, and serve you.

Sincerely,

A handwritten signature in black ink that reads "Scott Raynes". The signature is fluid and cursive.

Scott Raynes

President and Chief Executive Officer
Marshall Health Network

2025 CHNA Executive Summary

Community Health Needs Assessment Leadership

The 2025 Community Health Needs Assessment (CHNA) was conducted as a collaborative effort among Cabell Huntington Hospital (CHH), St. Mary's Medical Center (SMMC), Hoops Family Children's Hospital (HFCH), and Rivers Health (RH), with wide representation of local and regional partners. The goal of this collaboration was to identify common and unique challenges across the service area and align health improvement strategies.

The 2025 CHNA was led by a planning committee composed of staff from CHH, SMMC, and RH, who served as key connections between the assessment process, their organizations, and the communities they support.

Our Research Partner

Marshall Health Network (MHN) contracted with Build Community to conduct the CHNA. Build Community is a woman-owned business that specializes in conducting stakeholder research to illuminate disparities and underlying inequities and transform data into practical and impactful strategies to advance health and social well-being. Build Community's interdisciplinary team of researchers and planners has worked with hundreds of health and human service providers and their partners to reimagine initiatives and achieve measurable impact. Learn more about that work at buildcommunity.com.

Community Engagement

Community engagement is a key component of assessing and responding to community health needs. CHNA research included participation by representatives from the Cabell-Huntington Health Department, health and social service providers, advocacy agencies, business community representatives, and other community partners. These individuals provided wide perspectives on health trends, expertise about existing community resources available to meet those needs, and insights into service delivery gaps that contribute to health disparities.

Methodology

The 2025 primary and secondary research was conducted from January to May 2025 and utilized both quantitative data and qualitative community input to identify health trends and disparities impacting residents across the 20-county service area of West Virginia and spanning parts of Kentucky and Ohio.

This research provides a comprehensive view of statistical health and social indicators, combined with community stakeholder feedback, to develop a profile of regional health priorities. These findings will inform the delivery of health care services, guide health improvement initiatives, support advocacy efforts, and serve as a valuable resource for grant making and programming by health and social service partners.

The CHNA used the following research methods to identify community health needs:

- Analysis of existing secondary data sources, including public health statistics, demographic and socioeconomic measures, and health care utilization data;
- An online Key Informant Survey with community representatives to gain insight into local health challenges and opportunities for improvement;
- Focus groups with residents and health and social service agencies to explore the impact of social determinants of health and identify opportunities for collaborative community health improvement;
- Partner forums were held in Huntington and Point Pleasant with health and human service providers to share CHNA data findings and gather feedback to collectively define challenges and meaningful strategies for health improvement.

Secondary data were analyzed for the Tri-State region as a whole, with focused reporting for West Virginia counties, Cabell and Mason—the home counties of the partnering hospitals. This analysis included demographic, socioeconomic, and public health indicators to measure key trends, identify priority health concerns, and assess emerging needs. Where possible, data were benchmarked against state and national averages and aligned with Healthy People 2030 (HP2030) objectives—a national initiative outlining 10-year goals to improve the health of all Americans.

Unless otherwise noted, demographic and socioeconomic data were sourced from the U.S. Census Bureau’s American Community Survey. Public health data were gathered from state health departments, the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), and other relevant agencies. A comprehensive list of sources is provided in Appendix D.

All data reflects the most recent information available at the time of publication. Because secondary data often lags real-time developments, community feedback was essential to identifying significant trends and emerging health issues not yet reflected in traditional data sources.

Board Approval

The 2025 CHNA was conducted in a timeline to comply with IRS Tax Code 501(r) requirements to conduct a CHNA and development of a corresponding Community Health Improvement Plan (CHIP) every three years as set forth by the Affordable Care Act (ACA). The research findings and plan will be used to guide community benefit initiatives for MHN and engage local partners to collectively address identified health needs.

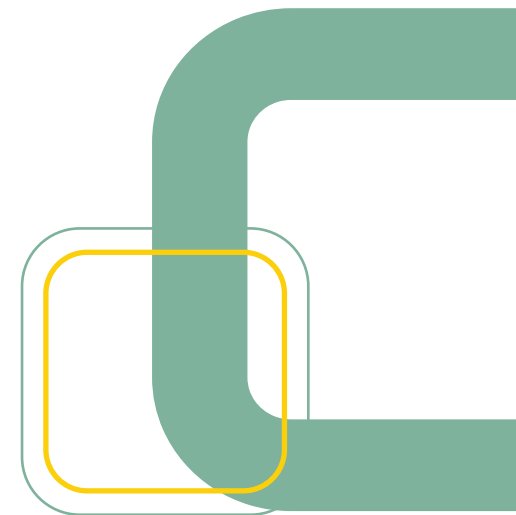
MHN is committed to advancing initiatives and community collaboration to support the issues identified through the CHNA. The 2025 CHNA report and CHIP were presented to the MHN Board of Directors and approved on Sept. 30, 2025.

Following the Board’s approval, the CHNA report and CHIP were made available to the public via the hospitals websites on Sept. 30, 2025.

Community Health Priorities

MHN seeks to mobilize its resources and activities to improve the most pressing and cross-cutting health needs within our community. In determining the issues on which to focus efforts over the next three-year cycle, MHN collected feedback from community partners and sought to align with community initiatives. MHN will focus efforts on the following community health priorities over the next three-year cycle:

- Addiction
- Behavioral Health
- Gerontology and Healthy Aging
- Obesity and Diabetes
- Rural Health and Primary Care



Evaluation of Impact - Our Response to the Community's Needs

Background

In 2022, MHN conducted a similar CHNA and developed a supporting three-year CHIP. Based on the CHNA findings, MHN leadership identified five priority areas for the region:

- Behavioral health
- Substance use disorder
- Chronic disease prevention and management
- Aging population
- Food insecurity

MHN invested in internal population health management strategies and partnered with diverse community organizations across the region to fund programs and initiatives aimed at addressing the identified priority areas. The system measured contributions and community impact from these investments, as outlined in the following sections.

Community Outreach and Partnership

During fiscal years 2023-2025, MHN provided **financial support for 100 community organizations** dedicated to advancing community health across the region. Those dedicated to advancing community health and wellness includes:

- AD Lewis
- ALS Foundation Tri-State
- Alzheimer's Association WV Chapter
- American Cancer Society
- American Foundation for Suicide Prevention Huntington Chapter
- American Heart Association
- American Red Cross Tri-State Chapter
- Arthritis Foundation
- Autism of River Cities
- Brady Steps Foundation
- Brown Dog Yoga
- Cabell-Huntington Coalition for the Homeless/Harmony House
- Cabell-Wayne Association of the Blind
- Center for Rural Health Development
- CONTACT Huntington, Inc.
- Developmental Therapy Center
- Epilepsy Foundation
- Facing Hunger Foodbank
- Family Medicine Foundation
- Fruth Pharmacy
- Girls on the Run
- Golden Girls Group Home
- Greater Huntington Parks and Recreation District
- Healthcare Education Foundation of WV
- Heritage Farm Foundation
- Highlands Foundation
- Highlawn Community Alliance, Inc.
- Hope's Place Children's Advocacy Center

MARSHALL HEALTH NETWORK 2022-2025 EVALUATION OF IMPACT

- Hospice of Huntington
- Huntington City Mission
- Huntington's Compass Program
- Huntington's Kitchen
- Jonathan Ferguson Memorial Golf Tournament
- Kiwanis Club of Huntington
- Lily's Place
- Mason County Schools
- Meeks Mountain Trail Alliance
- NAACP of Huntington
- OVP Foundation
- Prestera
- Recovery Point
- Ronald McDonald House Charities Huntington
- Ruth Sullivan Rally for Autism
- Safety Town
- Salvation Army
- Scottish Rite Foundation
- Shepherd's House
- Stepping Stones
- Team for WV Children
- The Center for Rural Health Development
- United Way of the River Cities
- Women's Warrior Summit
- WV Statewide Hospitalist Conference
- YMCA of Huntington



Programs, Screenings and Events

Marshall Health Network and its member hospitals supported more than **76,000 residents** across the region to access essential programs, screenings and events to advance their health and wellbeing.

FY 2023 – FY2025 (partial year) Program Participants and Encounters

Behavioral Health27,547

Programs: PROACT, HFCH Child Advocacy Center, Inpatient Behavioral Health, Grief Support Groups

Substance Use Disorder24,122

Programs: Maternal Opioid Medical Support (MOMs), Lily’s Place, Tobacco Cessation, Opioid Addictions Program, Neonatal Therapeutic Unit

Chronic Disease13,006

Programs: Home Care Medicine, Weight Loss Support Group and Education, Diabetes Education, Breast Cancer Support Group

Aging Population8,804

Programs: YMCA (Senior Exercise and Rock Steady Program for Parkinson’s Patients), Hospice of Huntington, Silver Sneakers Program

Food Insecurity2,928

Programs: Nutrition Counseling, Thanksgiving Meal Program, Let’s do Lunch, Facing Hunger Food Bank Meal Distribution Site





Programs, Screenings and Events

Cabell Huntington Hospital

The Hoops Family Children's Hospital (HFCH) Child Advocacy Center (CAC) is dedicated to offering children and families compassionate care to reduce the trauma often experienced by children who are victims of abuse. The CAC at HFCH is a safe, child-friendly place for children to speak with trained professionals and medical providers. Thorough evaluations are conducted to identify the appropriate care and services needed for each child. The CAC alleviates the need for a child to tell their traumatic story over and over to doctors, law enforcement, investigators, and others. The CAC at HFCH is the only hospital-based child advocacy center in the Huntington area.

- FY 2023: 267 clients served
- FY 2024: 296 clients served
- FY 2025, April YTD: 188 clients served

The HFCH created the MOMS program to begin once a mother gives birth and provides comprehensive addiction treatment services that promotes the bonding between mother and baby. MOMS provides treatment services to postpartum women, not currently in other treatment program, addressing the specific needs of each mother and covering everything from counseling to occupational rehabilitation with a goal to end the cycle of addiction.

- FY 2023: 537 consults
- FY 2024: 484 consults

The Neonatal Therapeutic Unit (NTU) is the first of its kind in the state of West Virginia and one of the first in the US. Newborns experiencing neonatal abstinence syndrome (NAS) benefit most from the quiet, supportive hospital setting this unit offers. To provide the babies with the best possible care and opportunity for recovery, NTU staff and physicians involve the mother, father, and extended family in forming healthy habits that will continue beyond the hospital stay.

- FY 2023: 1,409 encounters
- FY 2024: 1,201 encounters
- FY 2025, November YTD: 205 encounters

At Lily's Place, medical care is provided to infants suffering from NAS and non-judgmental support, education and counseling services are given to families and caregivers. While offering short-term care, the staff also connects families with recovery groups. Two follow-up clinics each month, with a pediatric neurologist and social worker, are conducted for parents and infants who've graduated from the program.

- FY 2023: 12 patients served
- FY 2024: 9 patients served

Perinatal Bereavement Support Group

- FY 2023: 9 support groups held; 7 attendees
- FY 2024: 12 support groups held; 30 attendees
- FY 2025, April YTD: 3 support groups held; 2 attendees

CHH Center for Lung Health

- FY 2023: 5,383 patients served
- FY 2024: 5,165 patients served
- FY 2025, April YTD: 2,805 patients served

Weight Loss Support Group

- FY 2023: 8 support groups held; 125 participants
- FY 2024: 6 support groups held; 99 participants
- FY 2025, April YTD: 2 support groups held; 42 participants

CHH Home Care Medicine, in partnership with Marshall Health, provides pre- and post-acute care for home-bound patients ages 18 and older throughout the region. A physician referral is not necessary to receive services. CHH Home Care Medicine offers physical examinations, disease management, medication management, coordination of lab and X-ray services and coordination of care (hospice, home health, and hospitalization).

- FY 2023: Home Care Medicine – 690 homebound individuals
- FY 2024: Home Care Medicine – 780 homebound individuals
- FY 2025, April YTD: Home Care Medicine - 493 homebound individuals

Faith Health Appalachia serves as a conduit of connection between social services, faith-based organizations, medical facilities and key leaders in the Huntington community to ensure the various gaps within these systems are filled. By connecting patients in the hospital system with existing community-based organizations that focus on meeting various social determinants of health.

- FY 2023: 53 referrals
- FY 2024: 518 referrals
- FY 2025, April YTD: 274 referrals

St. Mary's Medical Center

The PROACT center, which opened in 2018, was created to address the clinical, behavioral, spiritual, and professional issues of those affected by substance use. It functions as the centralized hub for treatment, recovery, therapy, education, research, workforce opportunity and support for those affected by addiction.

- FY 2023: 1,832 patients served
- FY 2024: 2,459 patients served
- FY 2025, April YTD: 838 patients served

Grief Support Group

- FY 2023: 10 support groups held; 459 participants
- FY 2024: 18 support groups held; 417 participants
- FY 2025, April YTD: 14 support groups held; 149 participants

St. Mary's smoking cessation program provides one-on-one counseling with a Certified Tobacco Treatment Specialist, offering an individualized approach tailored to each person's unique motivations for quitting. Participants receive a personalized treatment plan designed to support their journey to becoming tobacco-free.

- FY 2023: 1,494 patients receiving education
- FY 2024: 1,344 patients receiving education
- FY 2025, April YTD: 705 patients receiving education

SMMC Inpatient Behavioral Health Services

- FY 2023: 608 patients
- FY 2024: 696 patients
- FY 2025, April YTD: 447 patients

SMMC Diabetes Center

- FY 2023: 741 patients receiving education
- FY 2024: 769 patients receiving education
- FY 2025, April YTD: 357 patients receiving education

SMMC Breast Cancer Support Group

- FY 2023: 12 support groups held, 92 participants
- FY 2024: 11 support groups held, 127 participants
- FY 2025, April YTD: 5 support groups held, 79 participants

SMMC Nutrition Counseling

- FY 2023: 8 events held, 744 participants
- FY 2024: 14 events held, 1400 participants
- FY 2025, April YTD: 7 events held, 645 participants

Rivers Health

The Silver Sneakers program averaged 22 participants per class year-to-date through April of FY 2025.

The 8-week weight loss competition tracked participants' progress based on the percentage of total body weight lost. At the end of the program, the top three finishers in 2025: 1st place with a 7.9% weight loss, 2nd place with 6.1%, and 3rd place with 5.9%.

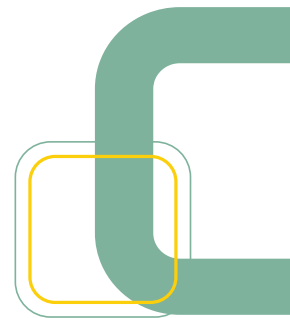
- FY 2024: 28 participants
- FY 2025: 19 Participants

The Food Insecurity Bag Program, a collaboration between the dietary team and case management, provides patients facing food insecurity with bags of nutritious, shelf-stable food at the site of care; in FY 2025, more than 100 bags were sent home with patients before discharge.

Causing a Racket: Youth Tennis Clinic with young athletes ages 4-12 who learned tennis fundamentals while having a blast on the court. The clinic provided a fun, active environment where kids developed new skills, built confidence, and discovered the joy of staying physically active.

- FY 2024: 26 participants
- FY 2025: 14 participants

The "Go Red" Women's Luncheon, hosted in partnership with the Rivers Health Cardiology team, educated community members on cardiovascular prevention and women's heart health, drawing 78 participants in FY 2025.



2025-2028 Community Health Improvement Plan

Based on insights gathered through the Key Informant Survey, community survey, partner forum, and targeted focus groups, MHN developed a comprehensive three-year Community Health Improvement Plan (CHIP) to guide community benefit and population health efforts across its service area. This collaborative, data-driven plan reflects both longstanding challenges and emerging priorities identified in the 2025 Community Health Needs Assessment (CHNA).

The CHIP prioritizes five key areas: Substance Use, Mental Health, Diabetes and Obesity, Gerontology and Healthy Aging, and Rural Health and Primary Care. These focus areas reflect the most pressing needs across the service region and will guide MHN's work in addressing health disparities, enhancing access to care, and improving overall community health outcomes. In addition, MHN recognizes the significant impact of racial and ethnic disparities on health outcomes. Each priority area within the CHIP incorporates strategies aimed at advancing equity, reducing gaps in access to care, and addressing the unique challenges faced by diverse populations across our service area.

Building on the foundation of prior initiatives, the CHIP establishes system-wide priority areas and goals, supported by hospital-specific strategies that leverage the unique strengths, resources, and partnerships of each MHN facility. Through this coordinated approach, MHN aims to achieve measurable, sustainable improvements in the health and well-being of the communities it serves.



Priority Area: Behavioral Health

Goal:

Strengthen community efforts that build emotional and mental resilience while improving access to behavioral health prevention, early intervention, and treatment services.

Objective and Strategies:

Objective:

Increase awareness and education to encourage treatment and management of behavioral health issues.

Strategies:

- Support, promote and participate in community behavioral health awareness and training efforts.
- Provide culturally sensitive education and outreach to underserved racial and ethnic groups.
- Conduct screenings in health care settings to identify individuals with behavioral health conditions.
- Provide free support groups, such as Navigating Grief and Perinatal Bereavement.

Objective:

Promote wellness and resilience initiatives that protect from and offset risk factors for behavioral health issues.

Strategies:

- Strengthen and support community organizations providing youth mentorship, senior programming, relationship-building, and social emotional learning opportunities.
- CHH-specific strategies:
 - o Continue to provide the Hoops Family Children's Hospital Child Advocacy Center, dedicated to offering children and families with compassionate care to reduce the trauma often experienced by children who are victims of abuse.

• SMMC-specific strategies:

- o Support the COMPASS program and City of Huntington first responders with an Employee Assistance Program (EAP) to strengthen the ability of first responders to deal with high-stress situations and build resiliency to process any effects of that stress.

• RH-specific strategies:

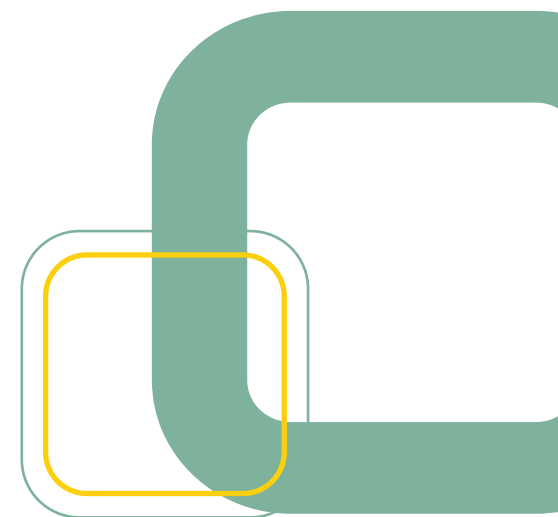
- o Partner with area schools and continue leading the Mason County Comprehensive Healthy Kids Program to provide youth behavioral health education and resilience activities and support service referrals.

Objective:

Improve access to behavioral health services.

Strategies:

- Expand access to behavioral health services through telehealth applications.
- CHH-specific strategies:
 - o Coordinate service delivery with Prestera Center for Mental Health Service, specializing in helping individuals who have a dual diagnosis of behavioral health and SUD.



Priority Area: Substance Use

Goal:

Enhance community initiatives that foster resilience and expand access to prevention, treatment, and recovery services for individuals affected by substance use disorders.

Objective and Strategies:

Objective:

Increase awareness of SUD to reduce stigma and fear of seeking treatment.

Strategies:

- Support, promote and participate in community SUD awareness and training efforts.
- Conduct screenings in health care setting to identify individuals with SUD conditions.

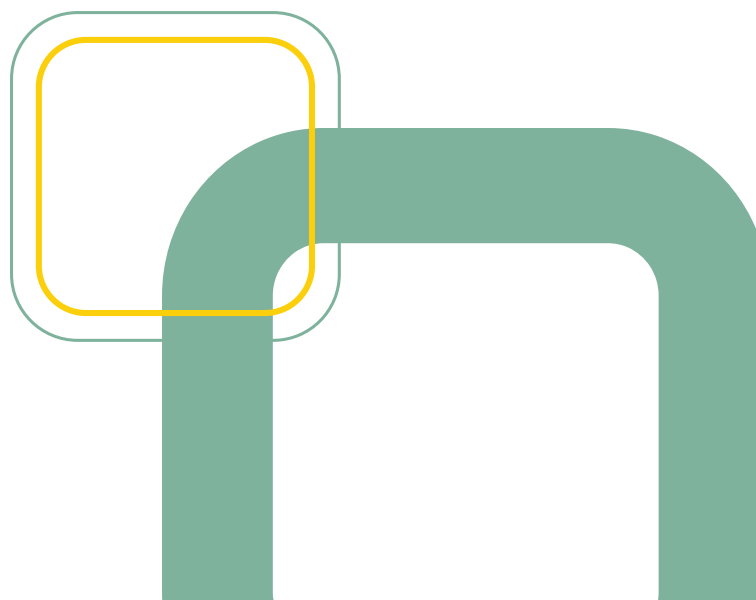
Objective:

Improve access to SUD treatment and recovery services.

Strategies:

- Expand telehealth visits.
- Partner with community agencies the City of Huntington, Cabell County EMS, and other agencies to provide a Quick Response Team to personally visit every patient within 72 hours following an overdose to assess their needs, develop a personalized plan for intervention, and connect them with addiction service providers.
- Continue Project Engage, an evidence-based practice for individuals with opioid use disorder who seek treatment through the ED, providing peer recovery coaches for support, the option of medication assisted treatment while in the ED, and referrals for community-based treatment and recovery services.
- Continue PROACT (Provider Response Organization for Addiction Care and Treatment), a centralized community hub for treatment, recovery, therapy, education, research, workforce opportunities and support for those affected by addiction.

- Participate in “Reverse the Cycle” project at hospital ERs, in conjunction with Mosaic Consulting and Marshall Health Addiction Medicine division.
 - o Screen for substance abuse disorder in ER visits with Peer Recovery Specialist follow-up.
 - o Prescribing or providing outpatient NARCAN/naloxone to ER patients presenting with overdose.
- CHH-specific strategies
 - o Continue the Neonatal Therapeutic Unit (NTU)
 - o Continue the HFCH Maternal Opioid Medical Support (MOMS) program to provide addiction treatment services, psychological and medical treatment, education, and training to postpartum women, while their babies recover from Neonatal Abstinence Syndrome (NAS).
 - o Coordinate service delivery with Lily’s Place, a non-profit leader in NAS, to care for drug-exposed newborns and their families.
 - o Participate in Healthy Connections, a coalition of health care and social service providers dedicated to evidence-based and interagency programming for the treatment of pregnant and parenting families who are managing SUD.



COMMUNITY HEALTH IMPROVEMENT PLAN

Priority Area: Diabetes and Obesity

Goal:

Improve health and quality of life by expanding access to healthcare, nutrition, and support services that help prevent and manage diabetes and obesity.

Objective and Strategies:

Objective:

Identify and address gaps in services and education that impact health and daily living needs.

Strategies:

- Support, promote, and participate in community health events, including free or discounted screenings and support groups.
- Continue Support of community agencies such as Huntington Area YMCA, that offer wellness programming.
- Expand nutrition and wellness programming tailored to the needs of diverse communities.
- CHH-specific strategies:
 - Collaborate with Marshal Health Chertow Diabetes Center to provide patient education, a diabetes support group, diabetes exercise center, and other resources for patients with diabetes.
- SMMC-specific strategies:
 - Provide patient diabetes education, nutrition counseling and disease management.
- RH-specific strategies:
 - Provide diabetic and weight loss education, led by a registered dietitian.
 - Continue operation of the Wellness Center, offering fitness and wellness classes for the community.

Priority Area: Gerontology & Healthy Aging

Goal:

Improve quality of life for older adults by increasing aging in place supports, community building initiatives and healthcare for aging residents.

Objective and Strategies:

Objective:

Promote wellness and resilience initiatives that help support risk factors for seniors (65+) for behavioral health issues, substance use disorder and chronic health diseases.

Strategies:

- Continue to expand remote access to senior wellness services through telehealth and digital connections.
- Explore partnerships with senior centers and other elder service providers to provide older adult engagement and social connectivity opportunities.

Objective:

Improve access to health care services for the senior population, including behavioral health services, SUD services, wellness visits, primary care visits and other chronic disease prevention and management services.

Strategies:

- Utilize resources of organizations such as FaithHealth Appalachia and Catholic Charities, serving as a connection between social services, faith-based organizations, medical facilities, and other key leaders to meet the social determinants of health needs of seniors (65+), such as food insecurity, malnutrition, housing, and transportation needs and social isolation.

Priority Area: Rural Health and Primary Care

Goal:

Improve access to timely, quality healthcare and essential resources that support the health and wellbeing of rural residents.

Objective and Strategies:

Objective:

Increase access to traditional and alternative (community- and technology-based) places people can access health care.

Strategies:

- Continue to support Ebenezer Medical Outreach, a full-service medical clinic providing access to free, comprehensive health care to financially eligible clients.
- Address racial disparities in rural access by supporting community-based clinics serving minority populations.
- Continue to support FaithHealth Appalachia.
- Enhance access to home-based care services through home health, transitional care, and other in-home service arrangements.
- Expend new primary care site locations across the region, and partnership opportunities with local community-based organizations to co-locate social services.
- Expand equitable access to telehealth visits and provide alternative means of connection for those without access to broadband or smartphone services.
- CHH-specific strategies:
 - o Partner with Marshall Health via CHH Home Care Medicine to provide pre- and post-acute home care for homebound patients age 18 or over throughout the Tri-State region.





MHN service area Description

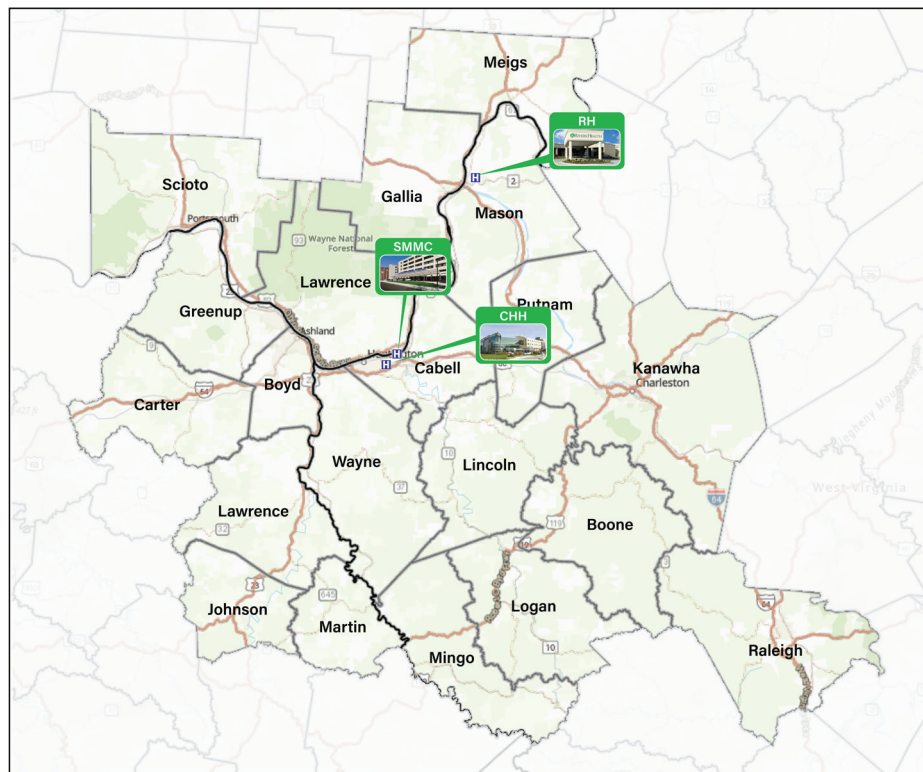
Marshall Health Network (MHN) is a West Virginia-based, not-for-profit academic health system serving 1.4 million residents across West Virginia, southern Ohio, and eastern Kentucky. MHN includes four hospital locations:

- Cabell Huntington Hospital (CHH) – A 303-bed teaching hospital for Marshall University Schools of Medicine, Pharmacy, and Nursing, located in Huntington, Cabell County.
- Hoops Family Children's Hospital (HFCH) – A 72-bed children's hospital located within Cabell Huntington Hospital.
- Rivers Health (RH) – A 101-bed hospital located in Point Pleasant, Mason County.
- St. Mary's Medical Center (SMMC) – A 413-bed teaching hospital that operates St. Mary's Schools of Nursing, Respiratory Care, and Medical Imaging, also in Huntington, Cabell County.

MHN primarily serves 20 counties across West Virginia, eastern Kentucky, and southern Ohio. For the Community Health Needs Assessment (CHNA), MHN further defines its primary service area based on inpatient volumes for CHH, SMMC, and RH. The service area includes 56 zip codes in and around Huntington and Point Pleasant, West Virginia.

For CHNA purposes, secondary data is presented for the MHN service area as a whole, as well as for the hospital home counties, Cabell and Mason.

Marshall Health Network County Primary Service Area



Source: Center for Applied Research and Engagement Systems

Service area Counties

West Virginia: Boone, Cabell, Kanawha, Lincoln, Logan, Mason, Mingo, Putnam, Raleigh, and Wayne

Kentucky: Boyd, Carter, Greenup, Johnson, Lawrence, and Martin

Ohio: Gallia, Lawrence, Meigs, and Scioto

Service area Population Statistics

Demographics

From 2010 to 2023, the MHN service area saw a population decline of 6.24% compared to the population growth of nearly 10% in the US overall. West Virginia also saw a population decline of 3.06%, while Kentucky and Ohio saw moderate population growth of approximately 2-5%.

Consistent with state and national benchmarks, population growth within the MHN service area occurred exclusively among non-White individuals. Of note, the Black/African American population also declined (0.1%) in the MHN service area, contrary to state trends. From 2010 to 2023, the White population declined 2.1%. The largest population growth was seen among multiracial individuals (1.9%). Despite increasing diversity, the MHN service area and the Tri-State region overall continue to reflect a majority White population.

Total Population by Year

	Total Population 2010	Percent Change 2023
MHN service area	964,327	904,163
Cabell County	95,526	93,300
Mason County	27,016	25,214
Kentucky	4,285,828	4,510,725
Ohio	11,512,431	11,780,046
West Virginia	1,840,802	1,784,462
United States	303,965,272	332,387,540

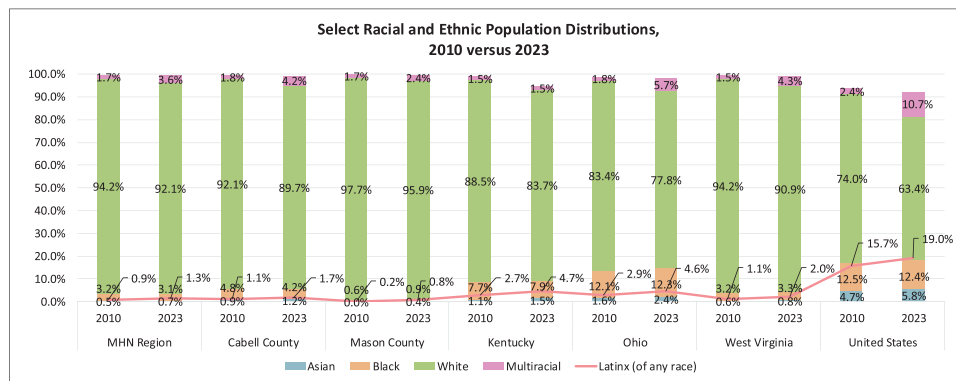
Source: US Census Bureau, American Community Survey

2019-2023 Population by Race and Ethnicity

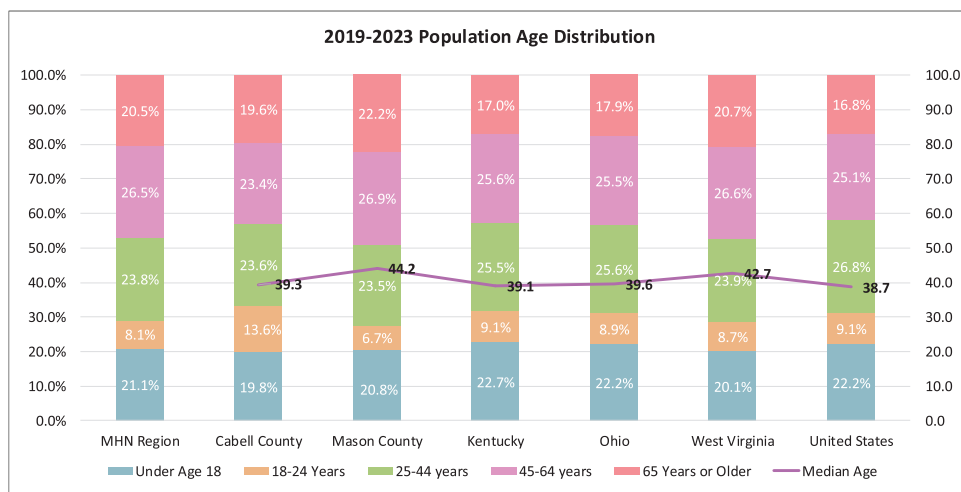
	American Indian and/or Alaska Native	Asian	Black and/or African American	Native Hawaiian and/or Pacific Islander	White	Other Race	Two or More Races	Latinx origin (any race)
MHN service area	0.1%	0.7%	3.1%	0.0%	92.1%	0.4%	3.6%	1.3%
Cabell County	0.1%	1.2%	4.2%	0.0%	89.7%	0.5%	4.2%	1.7%
Mason County	0.0%	0.4%	0.9%	0.0%	95.9%	0.4%	2.4%	0.8%
Kentucky	0.2%	1.5%	7.9%	0.1%	83.7%	1.5%	5.2%	4.7%
Ohio	0.1%	2.4%	12.3%	0.0%	77.8%	1.6%	5.7%	4.6%
West Virginia	0.1%	0.8%	3.3%	0.0%	90.9%	0.7%	4.3%	2.0%
United States	0.9%	5.8%	12.4%	0.2%	63.4%	6.6%	10.7%	19.0%

Source: US Census Bureau, American Community Survey

Note: Latinx origin (any race) is not included in the total population count.



Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

Age

Health needs change as individuals age. Therefore, the age distribution of a community impacts its social and health care needs. The age distribution of the MHN service area is similar to West Virginia overall which is older than the nation. Approximately 20.5% of service area residents are aged 65 or older compared to 16.8% nationwide.

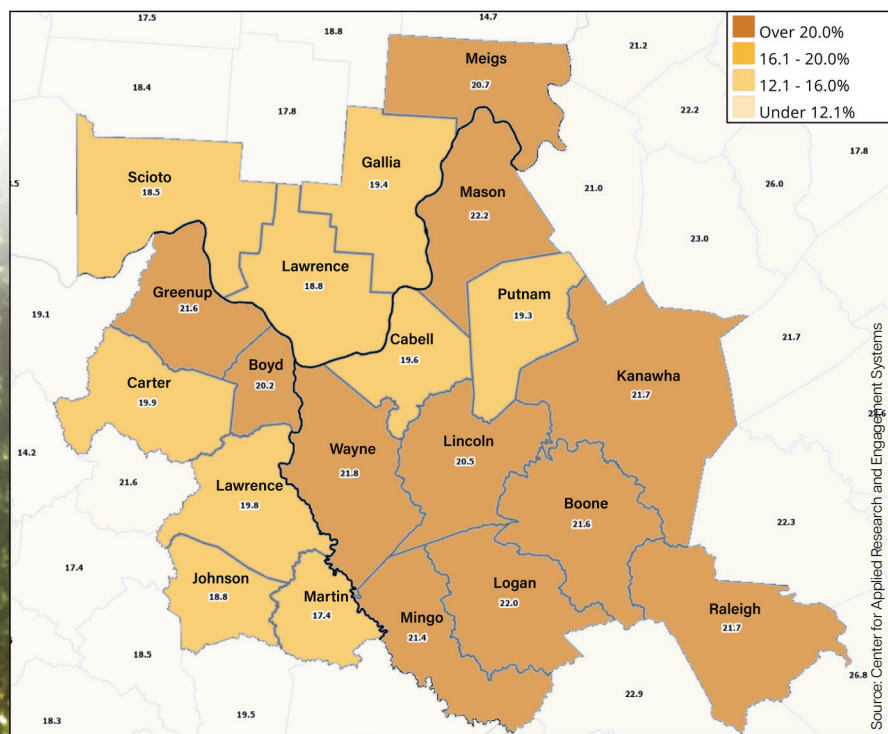
The proportion of older adult residents increased across the MHN service area, Tri-State region and the nation since the 2022 CHNA. Nationally, among older adults aged 65 or older, the 65-74 age category is the fastest growing demographic, largely due to the aging baby boomer generation (65+).

While the older adult population increases in the MHN service area, youth under age 18 comprise more than 1 in 5 residents.

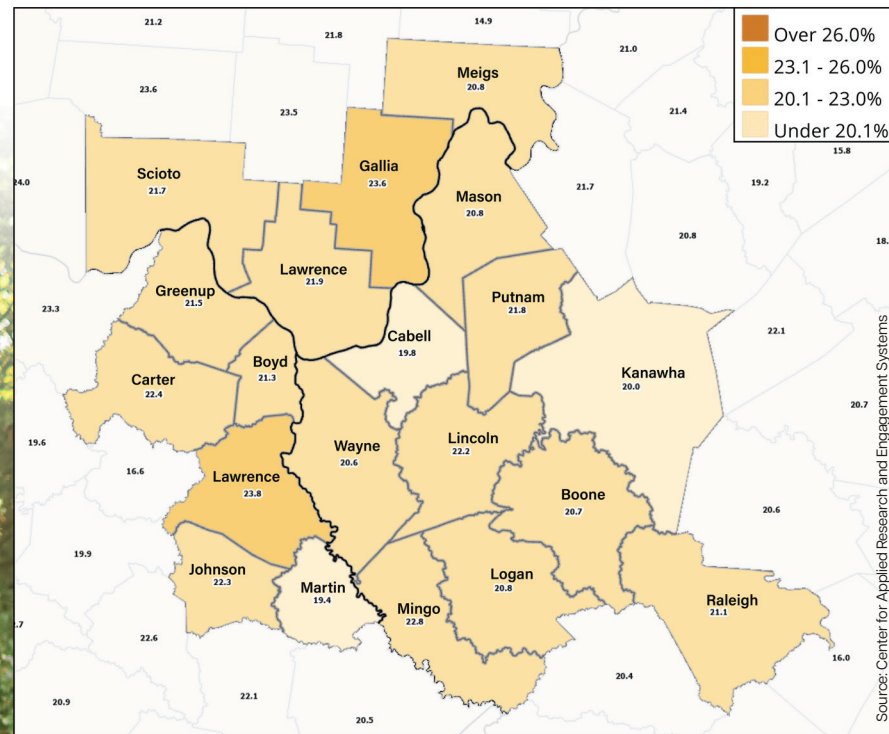


SERVICE AREA DESCRIPTION AND HEALTH STATISTICS

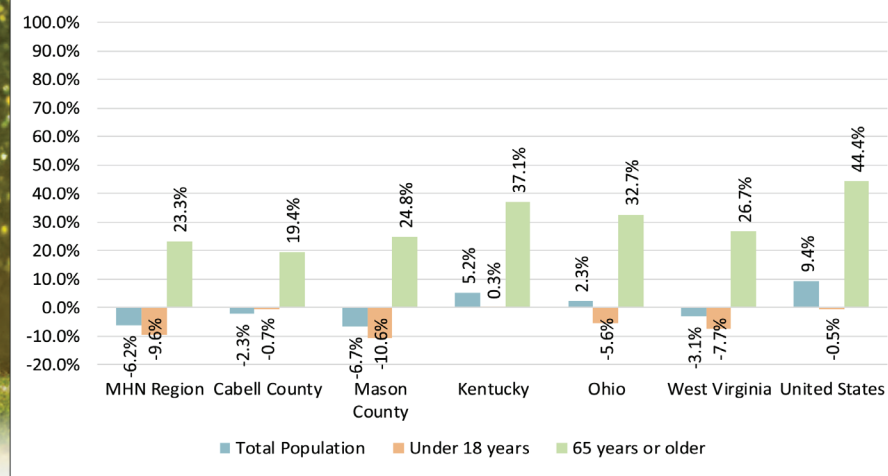
2019-2023 Older Adult Population Aged 65 or Over by County



2019-2023 Youth Population Aged 0-17 by County



Percent Population Change, 2010 to 2023



Source: US Census Bureau, American Community Survey



Birth Rate and Maternal and Infant Health

Consistent with the nation, the birth rate declined across the Tri-State since the 2022 CHNA. The Tri-State has a similar or lower rate of birth than the nation, with the highest rate of birth in Kentucky.

Consistent maternal and infant health needs across the Tri-State include teen births and smoking during pregnancy. The teen birth rate is higher in all three states compared to the nation, and nearly 50% higher in Kentucky and West Virginia. All three states also have a higher proportion of people who smoke during pregnancy, with the highest population in West Virginia (15.3%).

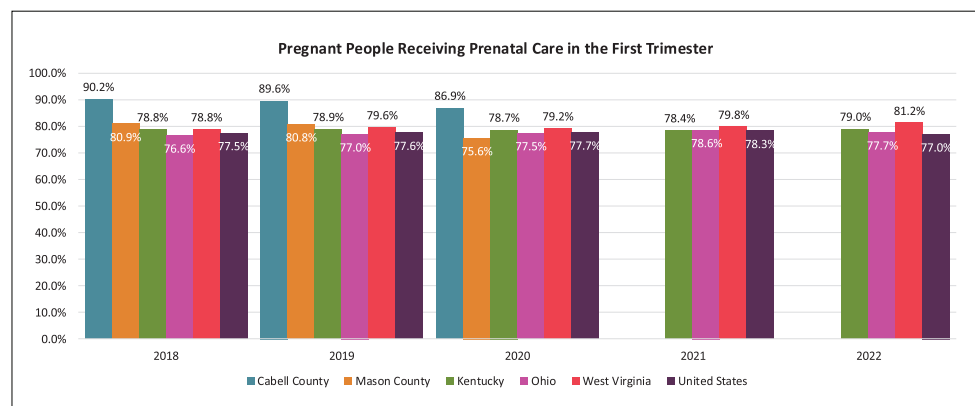
West Virginia also experiences disparate outcomes for low-birth-weight births relative to other states in the region and the nation overall, especially among the Black/African American residents. West Virginia overall has a high proportion of pregnant women receiving first trimester prenatal care (81.2%), with Blacks/African Americans (77.0%) and Whites (82.8%) receiving prenatal care. Prenatal care percentages have largely remained consistent throughout the Tri-State area.



2022 Maternal and Infant Health Indicators

	Teen (15-19) Birth Rate per 1,000	First Trimester Prenatal Care	Low Birth Weight Births	Tobacco Use During Pregnancy
Cabell County (2021)	--	--	9.9%	20.3%
Mason County (2021)	--	--	6.0%	19.3%
Kentucky	21.8	79.0%	8.9%	10.5%
Black/African American	--	67.6%	15.0%	7.8%
White	--	82.4%	8.1%	12.0%
Hispanic/Latinx	--	61.1%	7.7%	1.9%
Ohio	15.4	77.7%	8.7%	7.8%
Black/African American	--	68.6%	14.7%	5.8%
White	--	81.3%	7.3%	8.9%
Hispanic/Latinx	--	65.5%	8.3%	3.4%
West Virginia	19.8	81.2%	9.9%	15.3%
Black/African American	--	77.0%	14.5%	14.0%
White	--	82.8%	3.35	15.6%
Hispanic/Latinx	--	68.7%	5.35	5.6%
United States	13.6	77.0%	8.6%	3.7%
Black/African American	20.3	67.6%	14.8%	3.1%
White	9.1	82.65	7.1%	5.4%
Hispanic/Latinx	21.3	70.5%	7.9%	1.0%
HP2030 Goal	NA	80.5%	NA	4.3%

Source: Centers for Disease Control and Prevention & West Virginia Department of Health



Source: Centers for Disease Control and Prevention and West Virginia Department of Health

SERVICE AREA DESCRIPTION AND HEALTH STATISTICS

Infant Death Rate

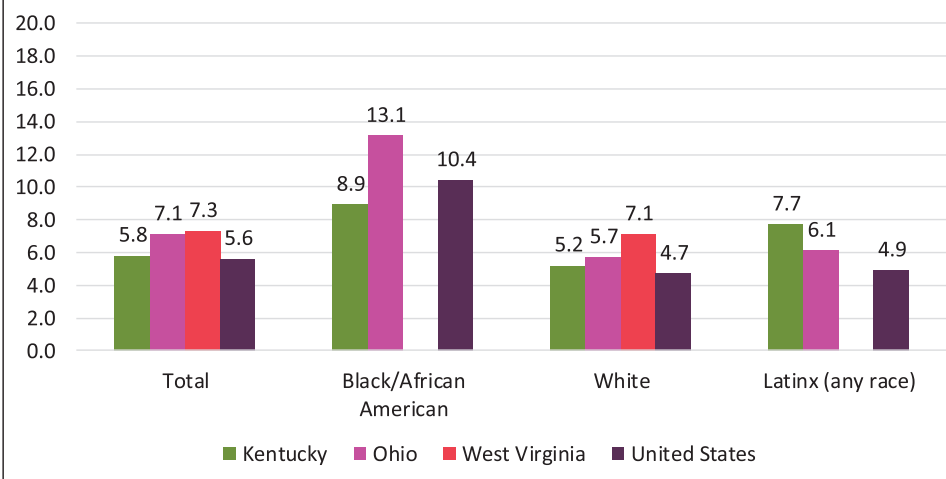
The Tri-State has a similar overall infant death rate as the nation, but consistent with the nation, the infant death rate is more than 50% higher for Black/African Americans than Whites in Ohio, where Black/African American have an infant death rate (13.1/1000 live births) that is more than two times higher than the death rate for Whites (5.7/1000) living in the same state, and nearly 46% higher than the national Black/African American death rate (10.4/1000). Reports by the Ohio Department of Health show that while the White infant death rate has improved, the Black/African American death rate has not significantly changed.

2022 Infant Death Rate per 1,000 Live Births

	Infant Deaths
Kentucky	5.8
Ohio	7.1
West Virginia	7.3
United States	5.6
HP2030 Goal	5.0

Source: Centers for Disease Control and Prevention

Infant Death Rate per 1,000 Live Births by Race/Ethnicity

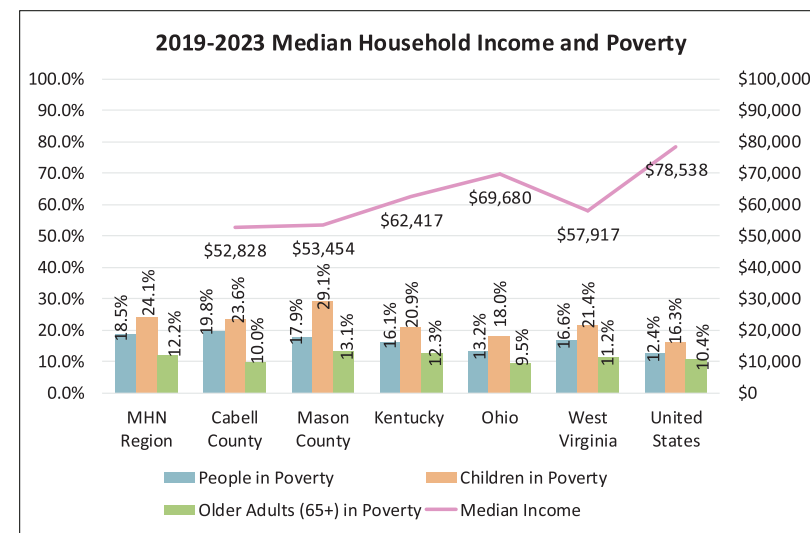


Source: Centers for Disease Control and Prevention

Income and Poverty

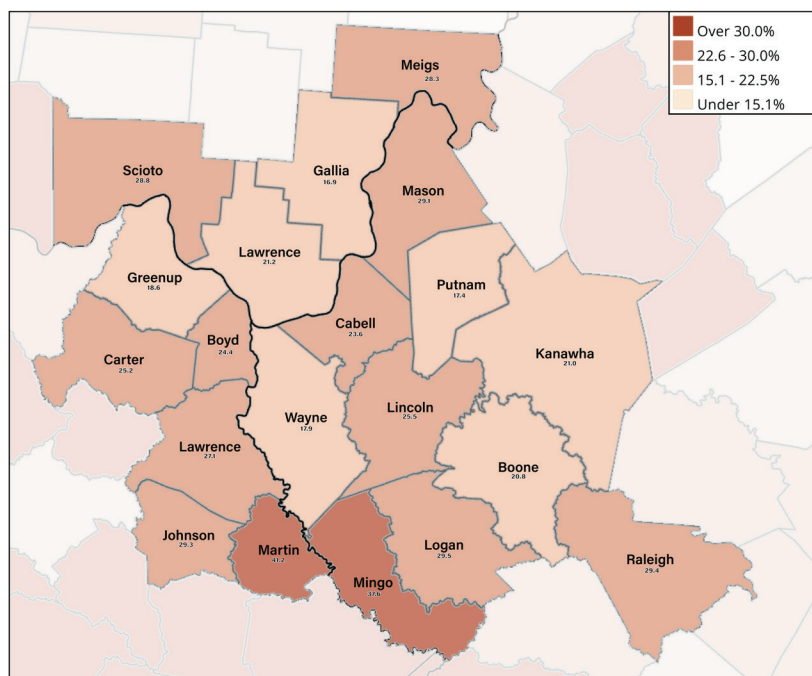
A higher portion of MHN service area residents live in poverty when compared to the Tri-State region and the nation. Children are disproportionately affected by poverty, and 24.1% of children in the MHN service area live in poverty compared to 16.3% nationally. Approximately 1 in 10 older adults (65+) also live in poverty in the MHN service area, a finding of note due to the large and growing proportion of residents aged 65 or older.

Within the MHN service area, all counties except Gallia County, Ohio and Putnam County, West Virginia have poverty levels that exceed 15%. The highest poverty levels are seen in Martin County (29.2%), Kentucky and Mingo County (29.9%), West Virginia. Martin and Mingo counties also have the highest population of children in poverty, 41.2% and 37.6% respectively. In Cabell County 19.8% of all residents and 23.6% of children live in poverty, while in Mason County 17.9% of all residents and 29.1% of children live in poverty.



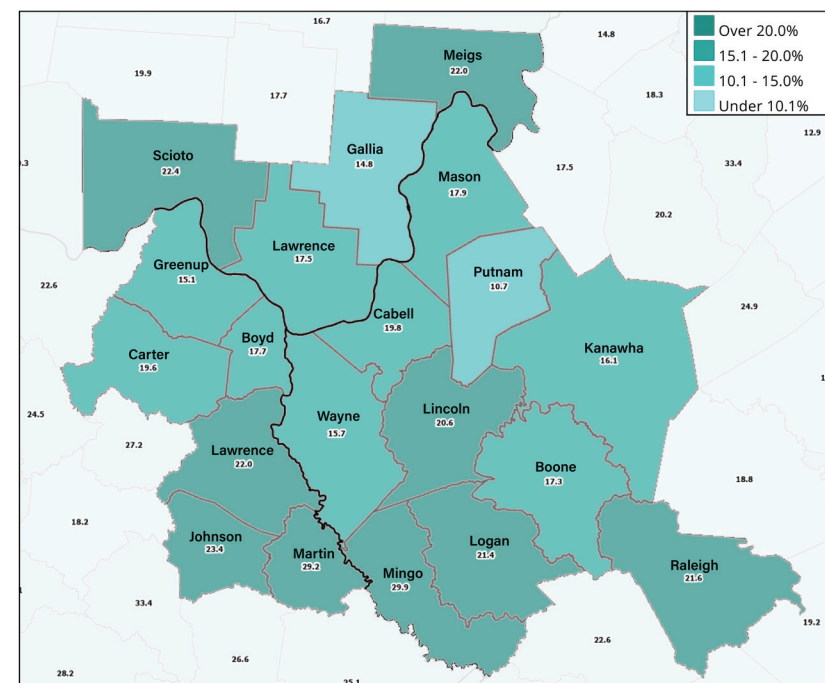
Source: US Census Bureau, American Community Survey

2019-2023 Children in Poverty by County



Source: Center for Applied Research and Engagement Systems

2019-2023 Population in Poverty by County



Source: Center for Applied Research and Engagement Systems

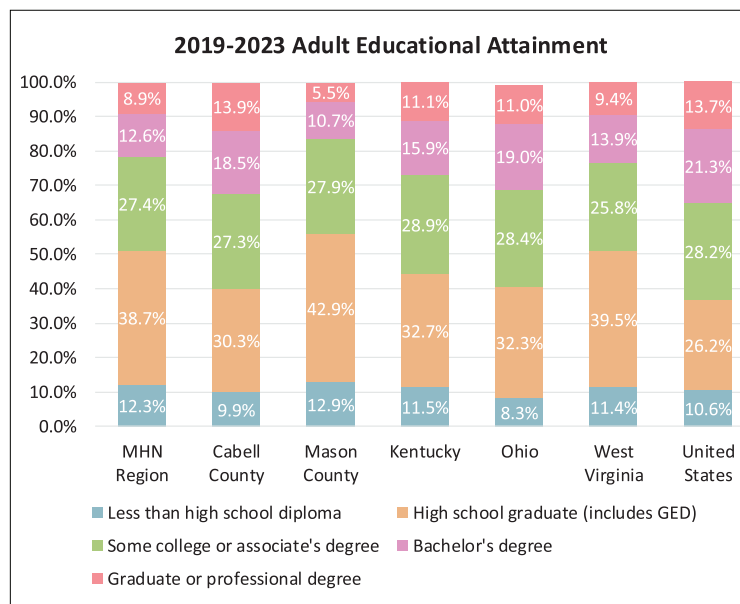
SERVICE AREA DESCRIPTION AND HEALTH STATISTICS

Education

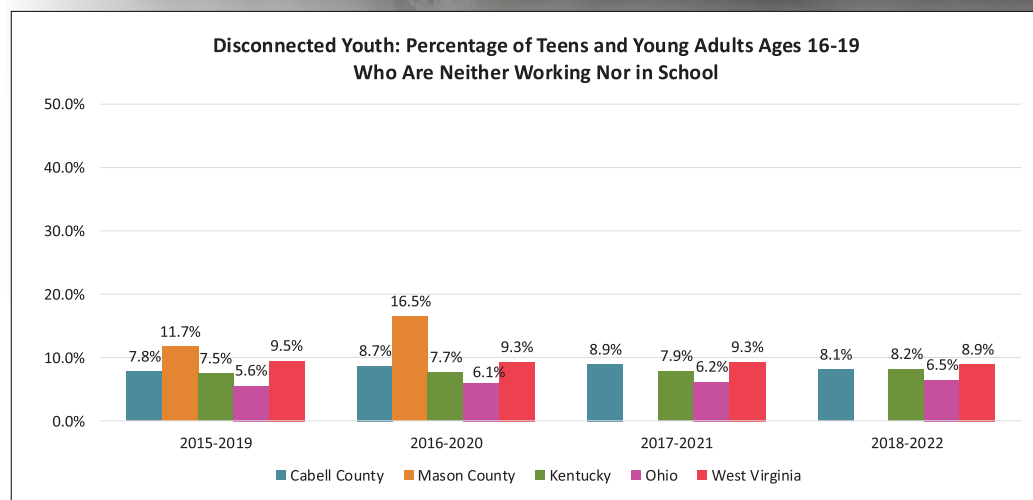
High school graduation is one of the strongest predictors of longevity and economic stability. The proportion of adults not completing high school continued to decline across the MHN service area. Adult residents of the MHN service area are less likely to complete high school or pursue higher education when compared to the Tri-State region and the nation. Mason County has a lower rate of high school completion and a higher rate of adults with only a high school degree compared to the overall service area, state level, and national level. Approximately 21.5% of MHN service area adults have a bachelor's degree or higher compared to 35.0% nationwide.

Nationwide, and since the pandemic, there is a growing proportion of disconnected youth, defined as youth ages 16-19 who are neither working nor in school. In 2022, approximately 7% of youth nationwide were disconnected; higher proportions were seen in Kentucky (8.2%) and West Virginia (8.9%), although proportions decreased since 2022 CHNA.

Note: 2017-2021 & 2018-2022 information for Mason County is not available.



Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

Social Determinants of Health: The Connection Between Our Communities and Our Health

Social determinants of health (SDoH) are the conditions in which people are born, grow, live, work, play, worship, and age—factors that significantly influence health risks and outcomes. Healthy People 2030, the U.S. national health initiative led by the Centers for Disease Control and Prevention (CDC), places SDoH at the core of its vision. Among its four overarching goals is the creation of “social and physical environments that promote good health for all.” It identifies five main areas of SDoH: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

A person’s overall health is shaped by a combination of factors, including individual behaviors, medical care, environmental conditions, and social circumstances. While traditional health strategies have focused primarily on behavior and clinical care, public health experts, including those at the CDC, recognize that social determinants account for at least half of a person’s health outcomes.

Addressing SDoH is essential to achieving health and quality of life for all, which means ensuring that everyone has a fair chance to attain their highest level of health. Health and quality of life requires looking beyond the health care system to address deep-rooted inequities caused by discrimination and unequal access to power, education, employment, housing, and safe environments. Only by addressing these underlying issues can we build healthier communities for current and future generations.



SOCIAL DETERMINANTS OF HEALTH: THE CONNECTIONS BETWEEN OUR COMMUNITIES AND OUR HEALTH

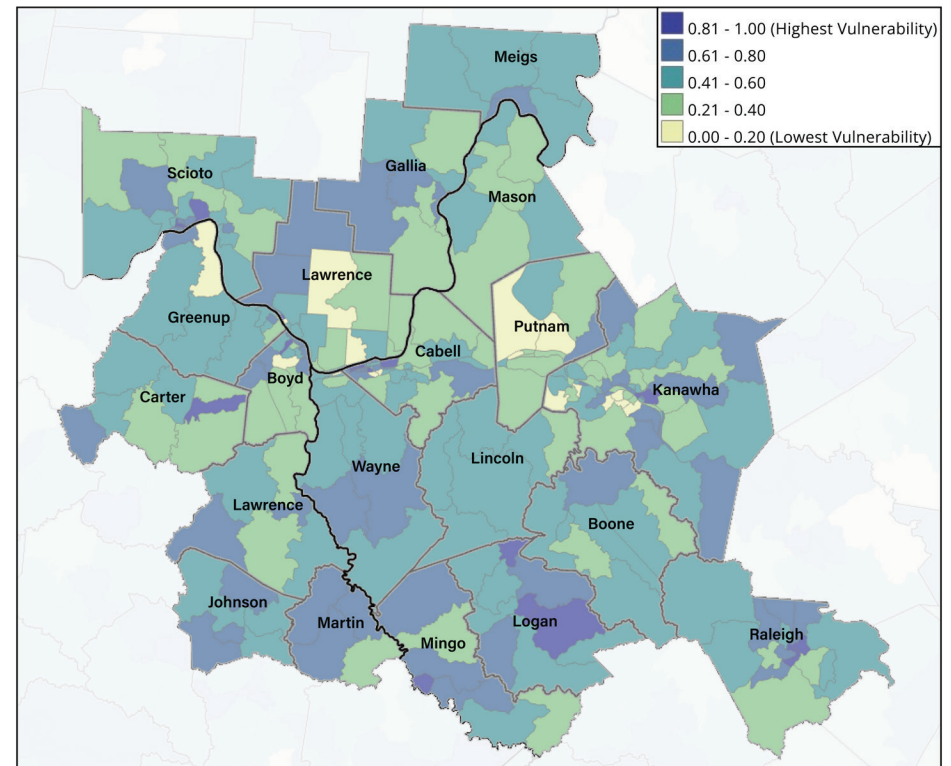
Understanding Health and Quality

Regardless of sharing the same community, not all residents share in the same opportunities for optimal health and wellness. MHN service area residents experience disparate health outcomes, largely rooted in socioeconomic differences.

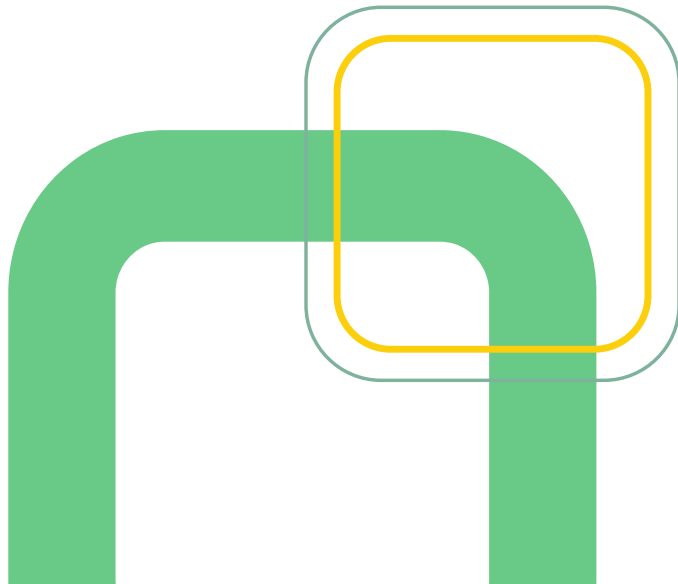
The Social Vulnerability Index (SVI) has long served as a valuable tool for public health officials and local planners to better anticipate and respond to emergencies such as hurricanes, disease outbreaks, or hazardous chemical exposures. By analyzing data at the census tract level, the SVI highlights areas most at risk due to underlying social challenges like poverty, limited access to transportation, and overcrowded housing. Scores on the SVI range from 0 to 1, with 0 representing the least vulnerable and 1 the highest. The average SVI for the MHN service area is 0.57, indicating a moderate to high level of social vulnerability across the region.

Within the MHN Region, SVI data underscores persistent disparities in life expectancy, revealing both widespread social risk factors and sharp contrasts between neighboring communities. These findings emphasize the need for targeted interventions to address health inequities rooted in social and environmental conditions.

2022 Social Vulnerability Index by Census Tract



Source: Center for Applied Research and Engagement Systems

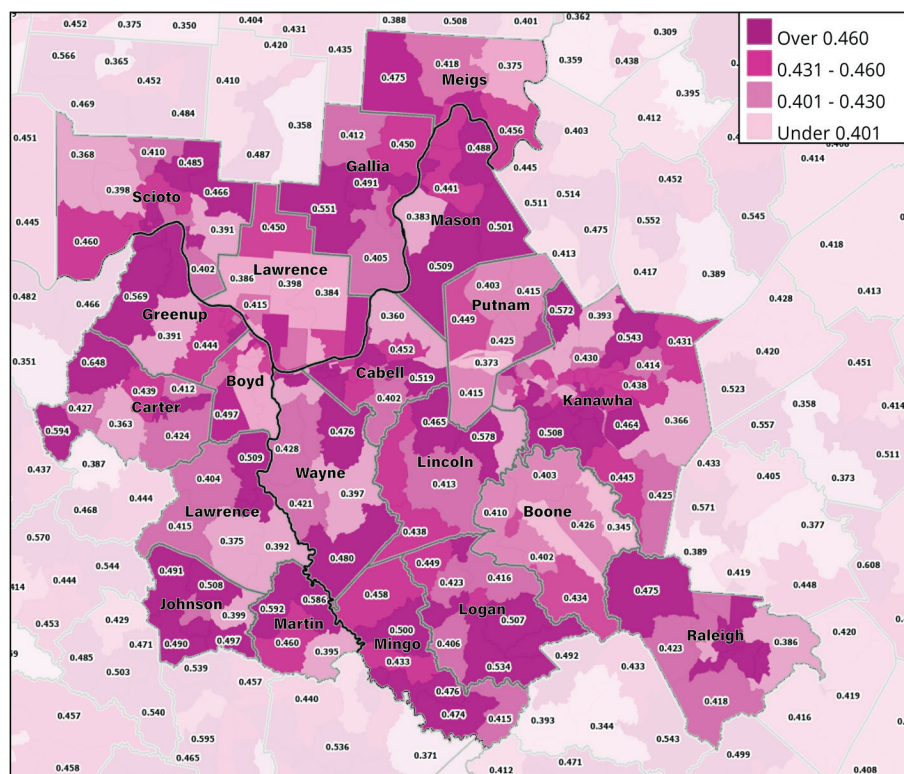


Social vulnerabilities and health disparities are often rooted in unequal access to community resources and opportunities that support economic stability and overall well-being. One key measure of economic inequality is the Gini index, which ranges from 0 to 1. A score of 0 represents perfect income equality—where all households earn the same—while a score of 1 reflects complete inequality, with one household receiving all the income. A Gini index above 0.4 signals significant income disparity, and values between 0.5 and 1.0 indicate severe inequality.

The average Gini index in the MHN region is 0.47, reflecting a notable level of income inequality.

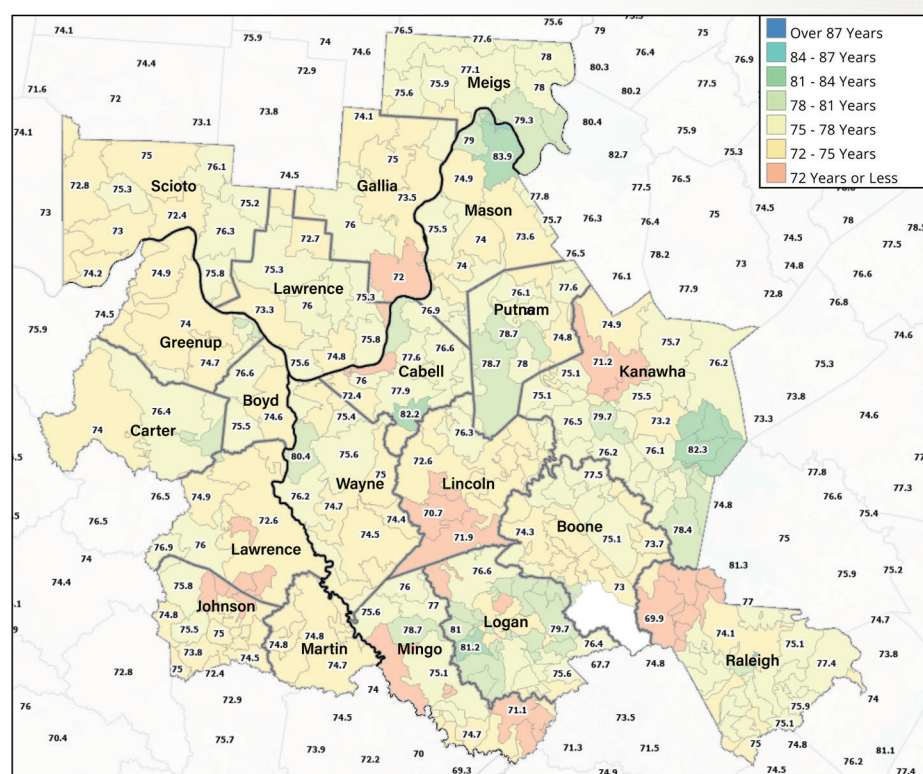
In the MHN region, areas with historically higher average life expectancy tend to have lower Gini index scores compared to nearby communities. This pattern highlights the link between more equitable distribution of income and improved health outcomes, reinforcing the importance of addressing economic inequality to promote community health.

2019-2023 Gini Index by Census Tract



Source: Center for Applied Research and Engagement Systems

2010-2015 Life Expectancy by Zip Code



Source: Center for Applied Research and Engagement Systems

SOCIAL DETERMINANTS OF HEALTH: THE CONNECTIONS BETWEEN OUR COMMUNITIES AND OUR HEALTH

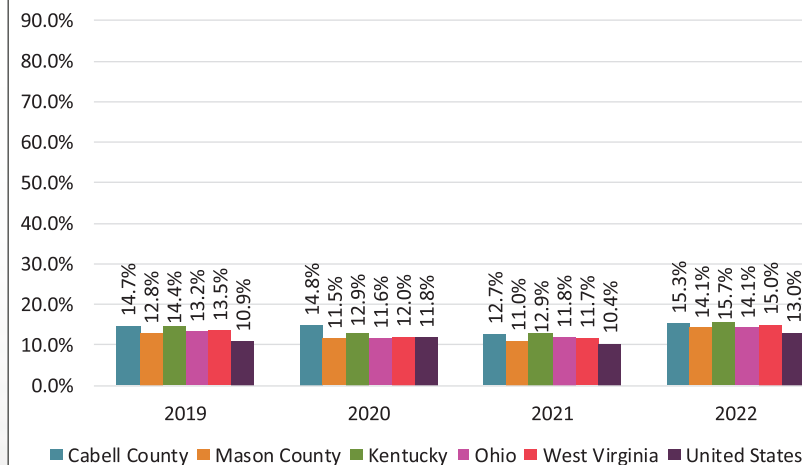


Food Insecurity

Food insecurity is defined as not having reliable access to enough nutritious, affordable food. Food insecurity is associated with lower household income and poverty, as well as poorer overall health status. Across the Tri-State and nationally, experiences of food insecurity increased since 2022, likely due to rising costs of living. Notably, the proportion of Cabell and Mason county children experiencing food insecurity increased 5-6 percentage points since 2021; 20% of children in either county are food insecure.

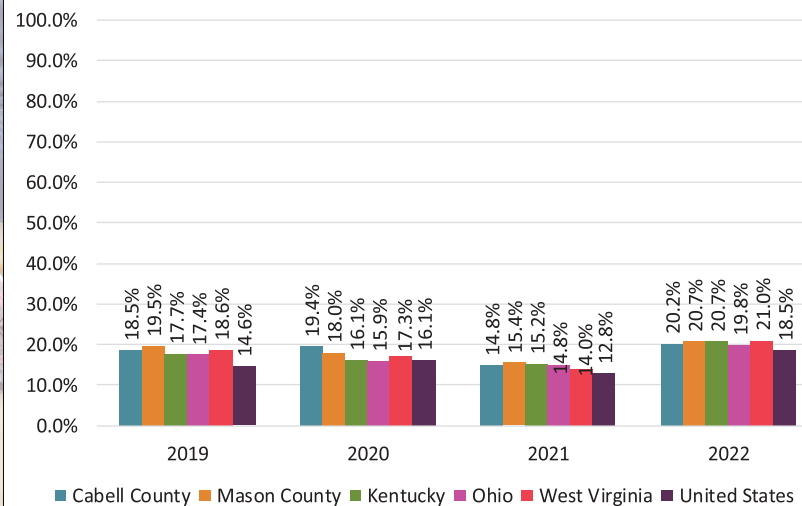


Percentage of All People Experiencing Food Insecurity



Source: Feeding America

Percentage of Children Experiencing Food Insecurity



Source: Feeding America

SOCIAL DETERMINANTS OF HEALTH: THE CONNECTIONS BETWEEN OUR COMMUNITIES AND OUR HEALTH

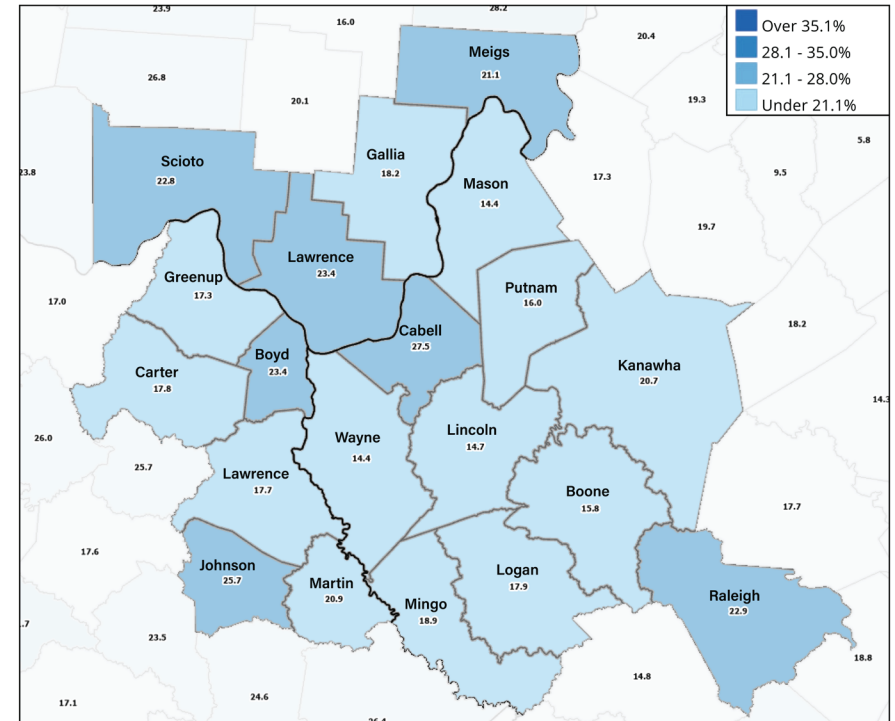
Housing

Housing is the largest single expense for most households and should represent at most 30% of a household's monthly income. Median housing prices in the Tri-State are generally less expensive than national averages. However, both owner and renter housing prices have increased significantly in recent years. Since the 2022 CHNA, median home value increased 30%-37% in all three states. Median rent also increased about 22% in Kentucky and Ohio and was generally stable in West Virginia.

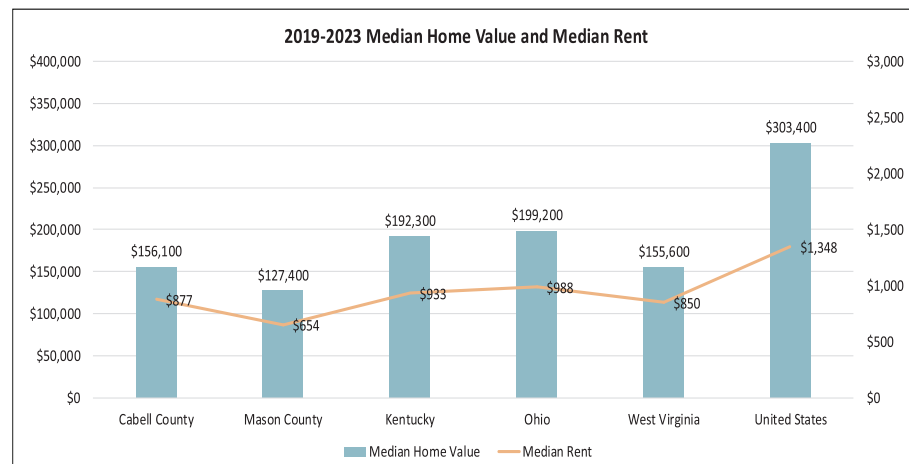
Housing cost burden measures the share of households spending more than 30% of their combined income on rent or mortgage payments, leaving fewer resources for other essential needs. Although housing prices have continued to rise, the percentage of cost-burdened homeowners and renters has remained steady—or even declined slightly—since the 2022 CHNA. Still, housing affordability remains a challenge, with around 20% of homeowners and 50% of renters affected. The issue is especially pronounced in Cabell County, where over one-third of households are renters and nearly 60% face a housing cost burden.

Note: Rental occupancy and rates are skewed by the university student population.

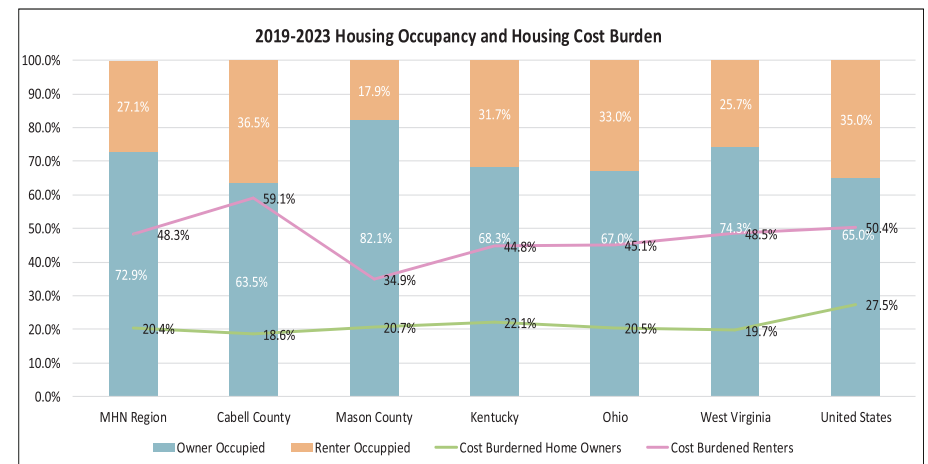
2019-2023 Cost Burdened Households (Owners or Renters) By County
(Costs Exceed 30% of Household Income)



Source: Center for Applied Research and Engagement Systems



Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

Homelessness

The Point-in-Time count is an annual survey conducted during the last 10 days of January to measure the number of sheltered and unsheltered individuals experiencing homelessness. This count is mandated by the U.S. Department of Housing and Urban Development for communities participating in its Continuum of Care (CoC) program. In 2021, the number of unhoused individuals dropped significantly due to emergency housing supports implemented during the COVID-19 pandemic. However, since then, the numbers have steadily increased across the Tri-State. This upward trend reflects the expiration of pandemic-related supports, rising housing and living costs, and a nationwide shortage of affordable housing.

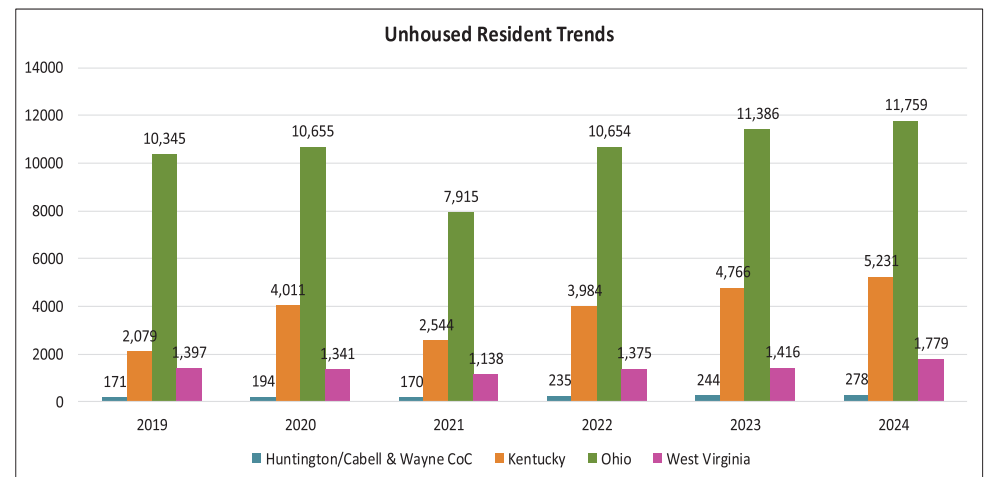
Homelessness has long had a disproportionate impact on populations that are at greater risk and underserved by health and social services. As of 2024, a total of 1,779 people in West Virginia were experiencing homelessness and 278 or 15.6% were within the Huntington/Cabell & Wayne counties CoC. Within the Huntington/Cabell & Wayne counties CoC nearly two-thirds of individuals experiencing homelessness were living with chronic mental health conditions and/or substance use disorder, additionally, nearly 8% of individuals experiencing homelessness were youth under 18 or veterans. Black and African American residents comprise just 4% of the overall population, yet they account for 8.6% of the unhoused population, highlighting significant racial disparities.



2024 Point-in-Time Unhoused Residents Count

	Huntington/ Cabell, Wayne Counties CoC	Kentucky	Ohio	West Virginia
Number of unhoused residents	278	5,231	11,759	1,779
Number of unhoused children	24	703	2,125	110
Number of unhoused residents over 55 years old	32	14	39	255
Number of veterans	21	391	589	132
Number of people fleeing domestic or sexual violence (adults only)	40	540	1,160	281
Chronically unhoused	32	1,065	1,505	386
Race/Ethnicity				
White	230	3,511	5,834	1,470
Black/African American	24	1,232	4,689	190
Other Race	1	82	159	18
Multiple Race	20	191	585	64
Hispanic/Latinx	3	215	492	37
Number of unhoused residents with a:				
Mental health (severe and persistent)	175	956	2,692	476
Chronic substance use disorder	183	879	1,631	428

Source: US Department of Housing and Urban Development



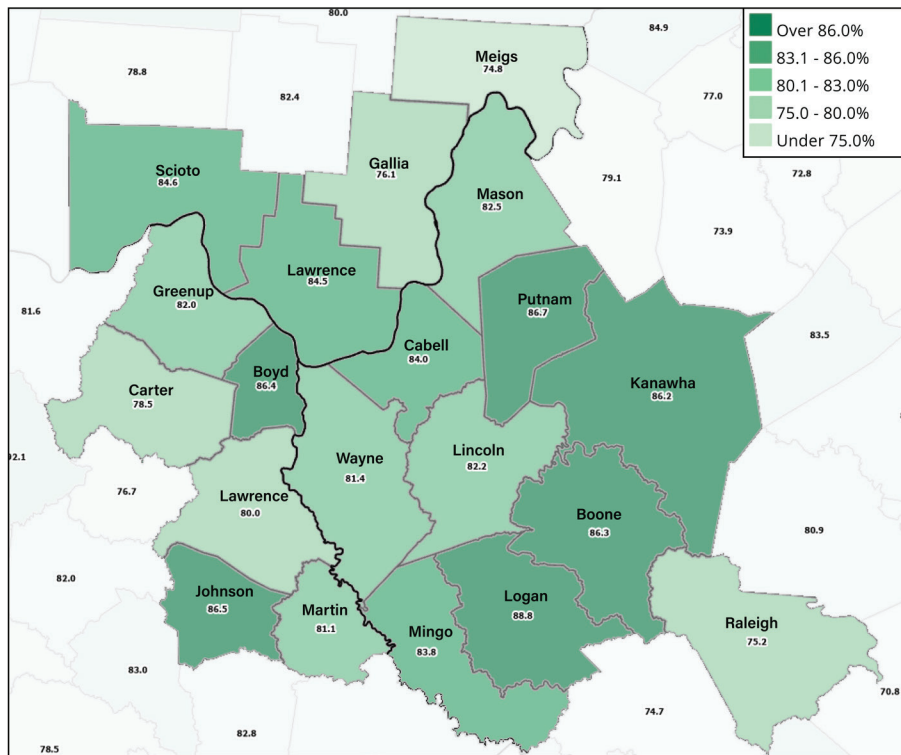
Source: US Department of Housing and Urban Development

SOCIAL DETERMINANTS OF HEALTH: THE CONNECTIONS BETWEEN OUR COMMUNITIES AND OUR HEALTH

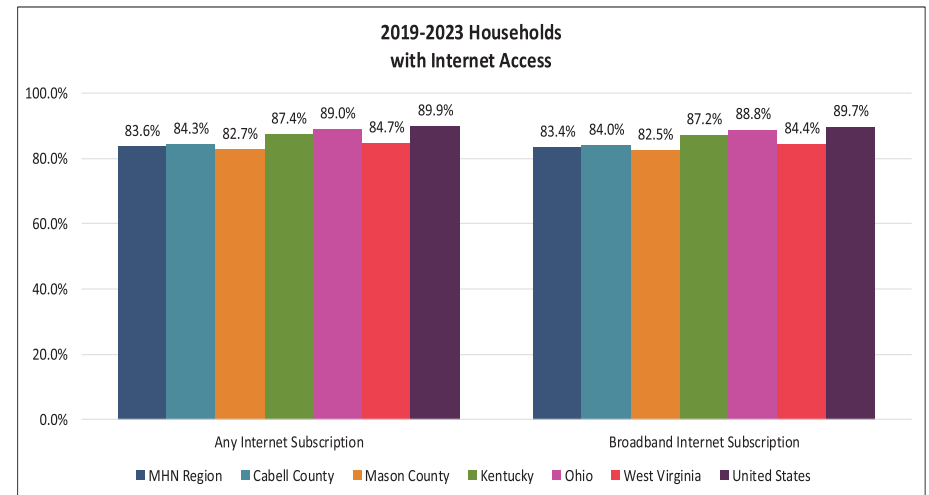
Digital Divide

Over 80% of residents in the MHN service area now have access to the Internet, including broadband connections. Although this rate remains slightly below the national average, access has steadily improved. Since the 2022 CHNA, broadband access has increased in nearly every county across the region—with the exception of Raleigh County. Notably, many counties in West Virginia saw gains of 10 percentage points or more in the proportion of households with broadband service. However, with several counties still hovering at or below the 80% mark, gaps in connectivity remain a barrier—particularly for accessing telehealth services, which rely on reliable broadband to deliver timely and effective care in rural and underserved areas.

2019-2023 Households with any Broadband Internet by County



Source: Center for Applied Research and Engagement Systems



Source: US Census Bureau, American Community Survey

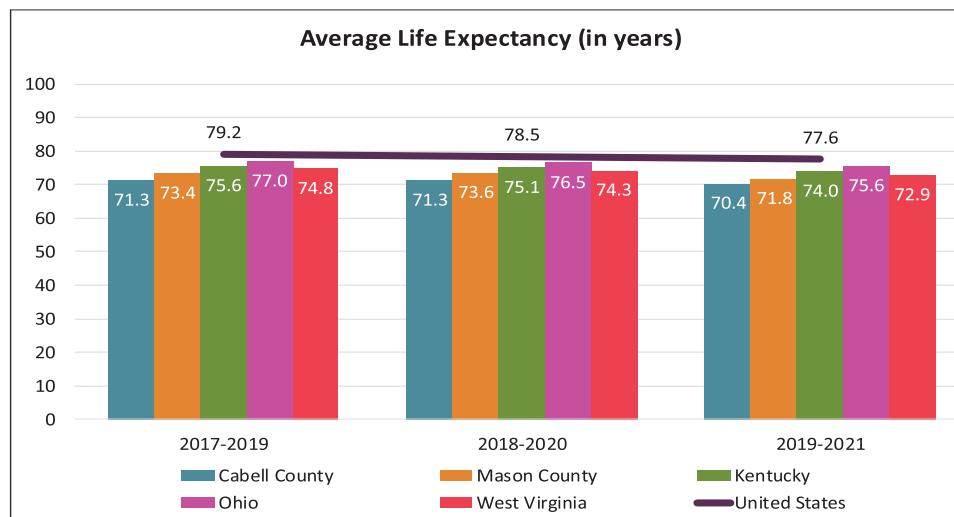
Life Expectancy

Life expectancy is a key indicator of a community's overall health and social well-being, shaped by a range of underlying factors such as living conditions, economic stability, and environmental influences. It reflects not only individual health status but also the broader experience of life in a given area. Across the Tri-State, residents live, on average, 2 to 11 years less than their peers nationally—highlighting significant community-level disparities in health and social conditions. National life expectancy also declined during the COVID-19 pandemic, further underscoring these challenges.

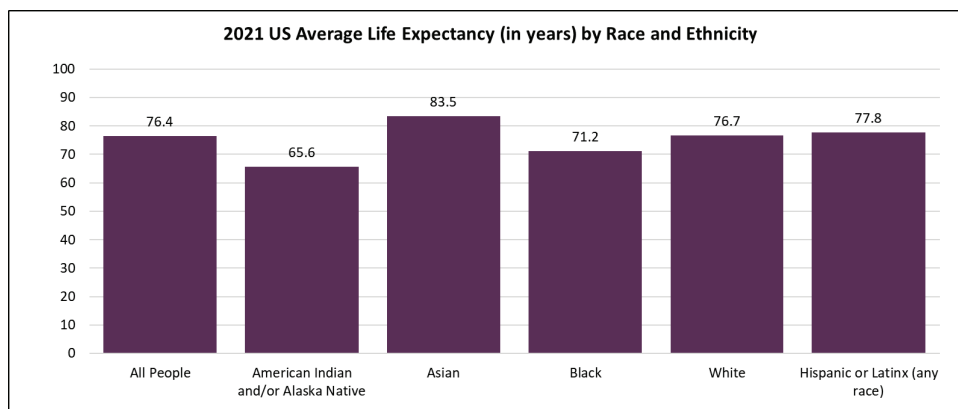
Life expectancy varies notably across population groups. In 2021, national data revealed a gap of more than 10 years between the racial group with the highest life expectancy (Asian) and those with the lowest (American Indian/Alaska Native and Black/African American). These differences point to systemic health and social inequities disproportionately impacting communities of color. In the MHN service area, such data is only available by race for Cabell County, where the gap is stark: Black/African American residents have an average life expectancy of 63.3 years, compared to 70.5 years for white residents—a difference of more than seven years within the same community.

Even within a single county, health outcomes can vary dramatically by zip code. In some cases, residents living just a few miles apart may face a 10-year or greater difference in life expectancy due to disparities in opportunity, access to care, and neighborhood conditions.

The accompanying map displays average life expectancy by zip code across the MHN service area. While the most recent tract-level data available is from 2010–2015, newer measures of health and social vulnerability suggest these disparities likely persist, as shown in the 2019–2022 Average Life Expectancy by County map.



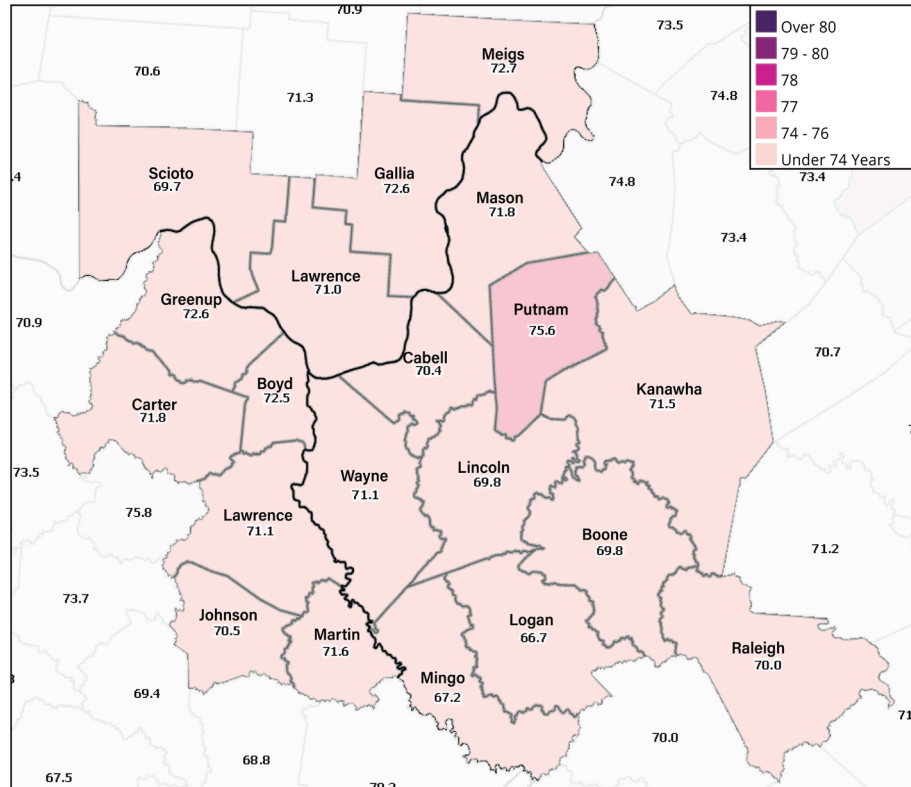
Source: Health Resources and Services Administration and Center for Applied Research and Engagement Systems



Source: Centers for Disease Control and Prevention

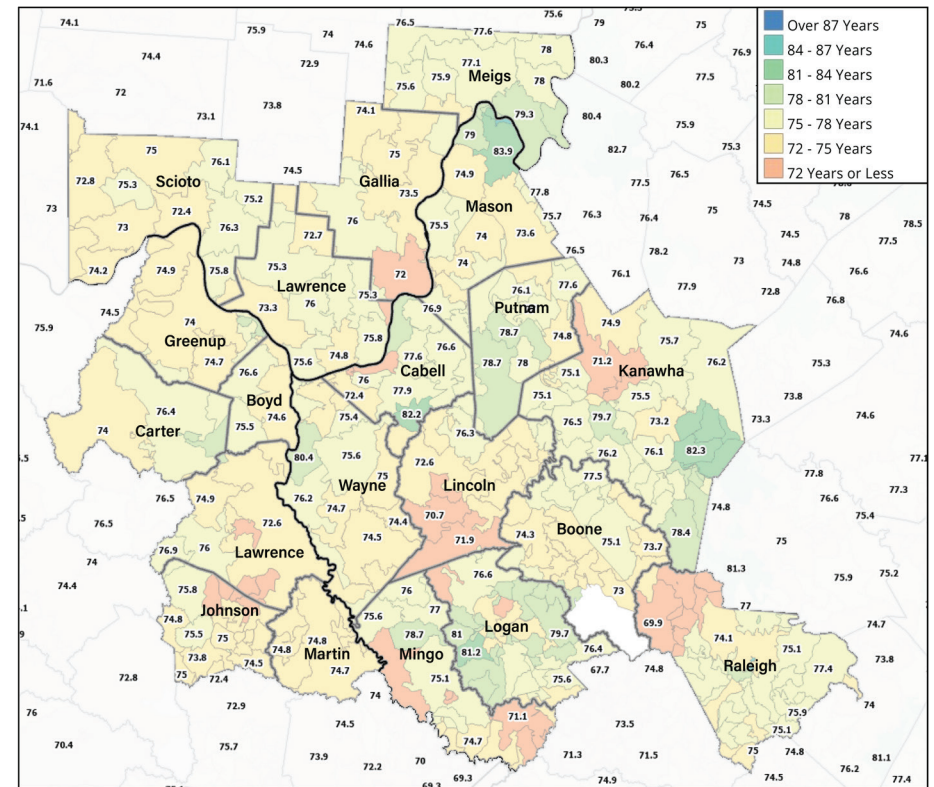
SOCIAL DETERMINANTS OF HEALTH: THE CONNECTIONS BETWEEN OUR COMMUNITIES AND OUR HEALTH

2019-2022 Average Life Expectancy by County



Source: Center for Applied Research and Engagement Systems

2010-2015 Life Expectancy by Zip Code



Source: Center for Applied Research and Engagement Systems



Priority Health Needs

The region is home to engaged community partners who are actively collaborating to address health needs and promote quality of life for residents. It is imperative to prioritize resources and activities toward the most pressing and cross-cutting health needs within our community. In determining the issues to focus efforts over the next three-year cycle, MHN collected feedback from community partners and sought to align with community initiatives. MHN will focus efforts on the following community health priorities over the next three-year cycle:

- **Addiction**
- **Behavioral Health**
- **Gerontology and Healthy Aging**
- **Obesity and Diabetes**
- **Rural Health and Primary Care**

Underlying these priorities are the cross-cutting issues of social determinants of health and disparities in access to care. In developing the 2025-2028 Implementation Plan, MHN sought to prioritize strategies that address these underlying issues to promote an upstream, preventive approach to community health improvement.



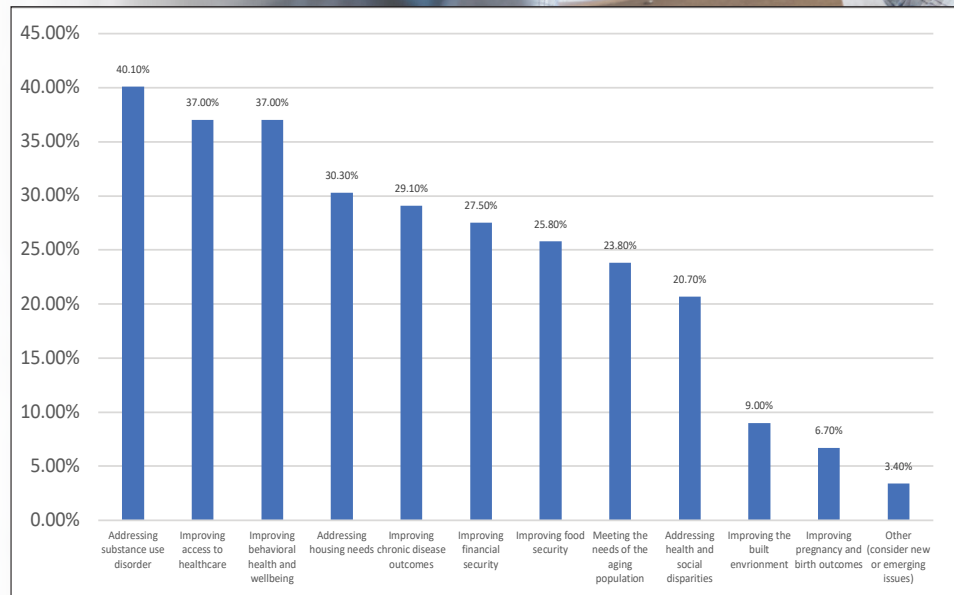
Key Informant Survey

As part of the 2025 Community Health Needs Assessment (CHNA), MHN conducted a Key Informant Survey (KIS) with 232 community leaders—including health care providers, public health professionals, civic leaders, and others—across its 20-county service area. Most respondents served Cabell or Mason counties. To complement these insights, an online community survey gathered input from residents about personal health challenges and access to care. Together, these findings inform the 2025–2028 Implementation Plan, which builds on existing partnerships to address the region’s top health priorities.

Overall, respondents identified substance use disorder (40.1%), access to health care (37.0%), and improving behavioral health and wellbeing (37.0%) as the biggest health issues in their community. Improving chronic disease outcomes (29.1%) and meeting the needs of the aging population (23.8%) were also among the top health care-based responses.

The 2025–2028 Implementation Plan will continue to build on community partnerships and successes to address the community’s top health needs. In addition to the Key Informant Survey (KIS), as part of the 2025 CHNA, MHN conducted an online survey of patients and community residents to better understand the community’s needs around health care access, as well as how it affects respondents personally. The survey results are reported in full in the Appendix.

The April 2025 community survey asked respondents how their concerns affect them and/or their family’s health and wellbeing right now. Findings showed that respondents were concerned about managing a chronic condition; paying for health care, insurance, or medical bills; and getting regular health care or preventive care.



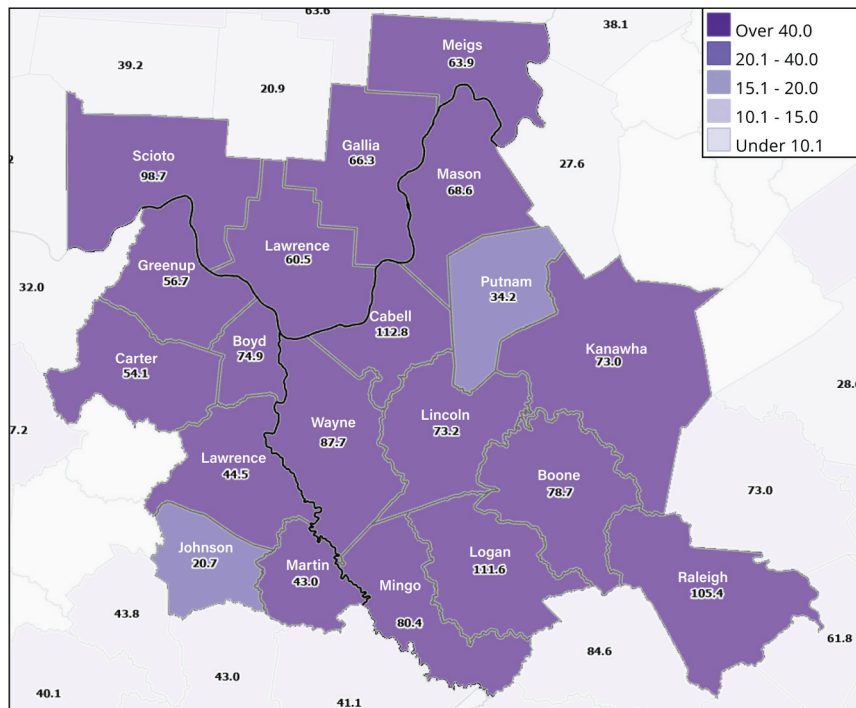
Substance Use Disorder

Key Informant Survey participants identified substance use disorder as the most urgent concern facing residents (see Appendix A for full survey results). The MHN service area, especially Cabell County, has been profoundly impacted by the opioid crisis—resulting in widespread loss of life, fractured families, and major disruptions to daily life. In response, the region has shown remarkable resilience, working together to develop comprehensive, community-based solutions to this complex issue. Despite progress, continued efforts remain essential to address the ongoing challenges of substance use.

- **“It can be seen daily on the streets the amount of people who are dependent on drugs and those who are looking for support.” -KIS**
- **“This is ALWAYS a HUGE concern in the area.” -KIS**
- **“Access to treatment/support is crucial and programs are getting shut down instead of being maintained.” -KIS**

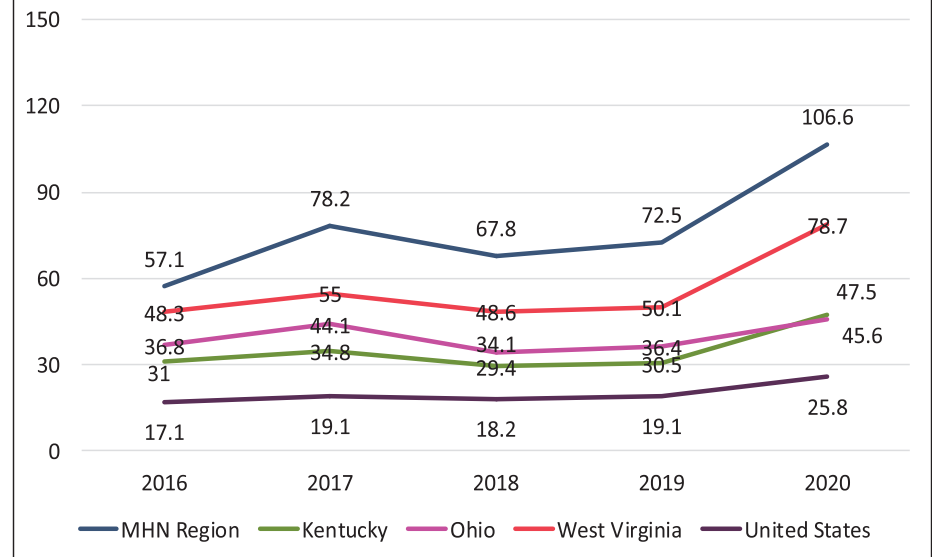
Between 2019 and 2020, the MHN service area experienced a 47% increase in accidental overdose deaths, rising from 72.5 to 106.6 per 100,000 people (age-adjusted). This spike outpaced the national increase of 35%—from 19.1 to 25.8 per 100,000—and was higher than increases seen in both Kentucky and Ohio. However, it remained slightly below the 57% rise reported across West Virginia.

2018-2022 Opioid Overdose Death per Age-Adjusted 100,000 by County



Source: Center for Applied Research and Engagement Systems

Accidental Overdose Death per Age-Adjusted 100,000 People



Centers for Disease Control and Prevention

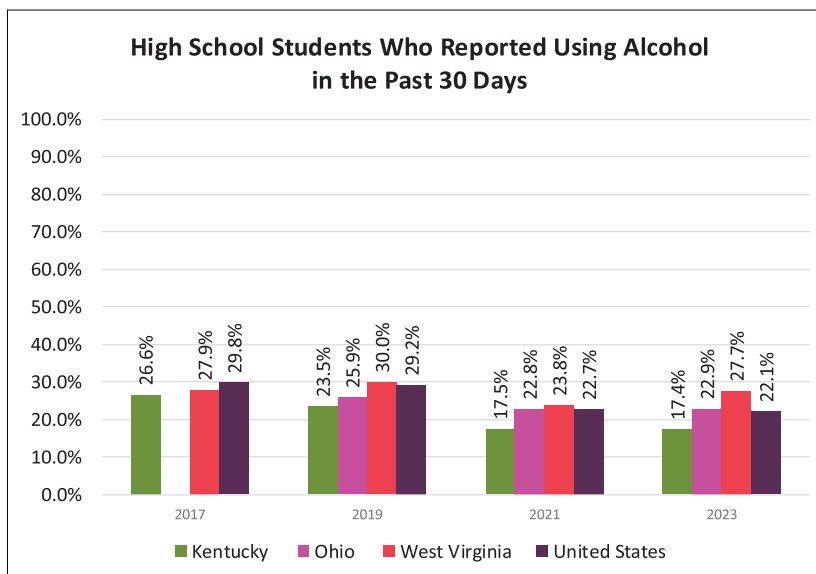
PRIORITY HEALTH NEEDS



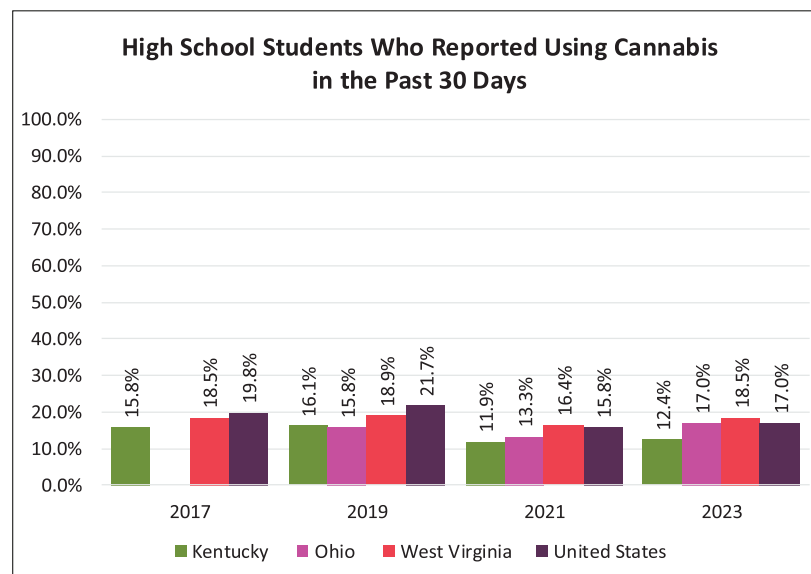
Youth Substance Use Disorder

Alcohol use among students has declined nationally and in most regional states; however, West Virginia experienced a 4% increase in reported use from 2021 to 2023.

Cannabis use has also shown a slight uptick across all areas, with West Virginia reporting the most significant increase—2%—which is 1.5% above the national level among youth.



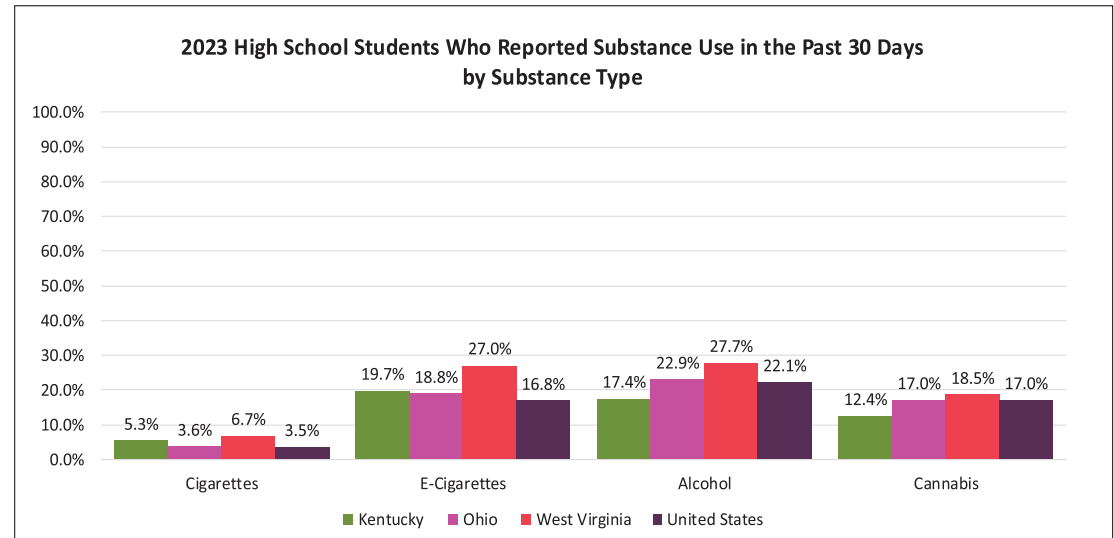
Source: Centers for Disease Control and Prevention and National Highway Traffic Safety Administration
* Includes heavy and binge drinking



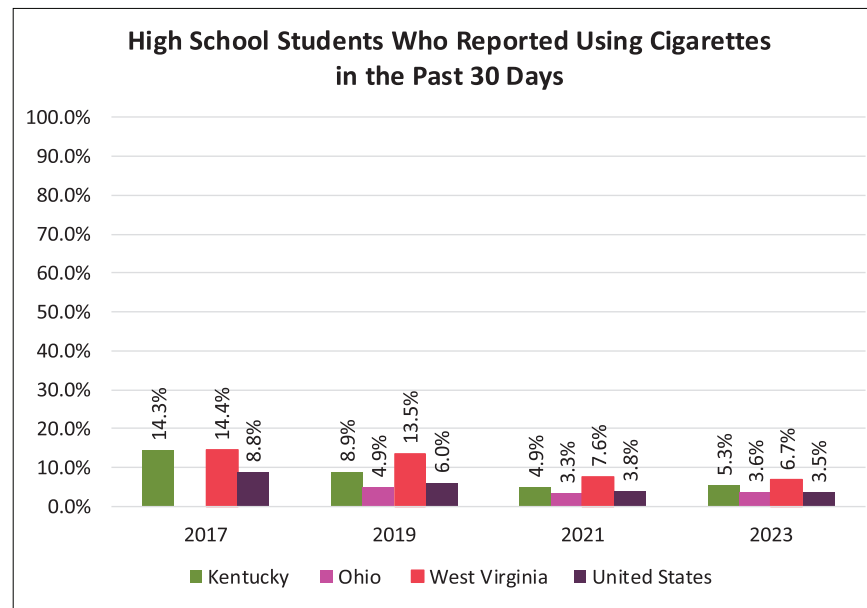
PRIORITY HEALTH NEEDS

Self-reported substance use among high school students varies by state, with rates generally higher in West Virginia compared to the broader Tri-State and the national average. In 2023, more than 1 in 4 West Virginia students reported using e-cigarettes and/or alcohol in the past 30 days—approximately 10% and 5% higher than the national averages, respectively.

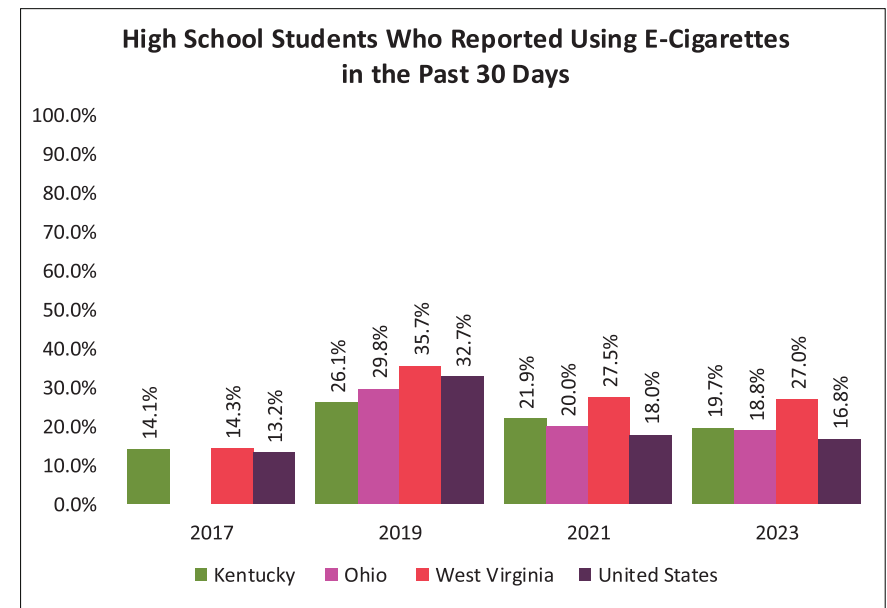
While reported use of both cigarettes (8%) and e-cigarettes (9%) has declined in West Virginia, mirroring national trends, usage rates in the state remain higher than those in Kentucky, Ohio, and the nation overall.



Source: Centers for Disease Control and Prevention



Source: Centers for Disease Control and Prevention

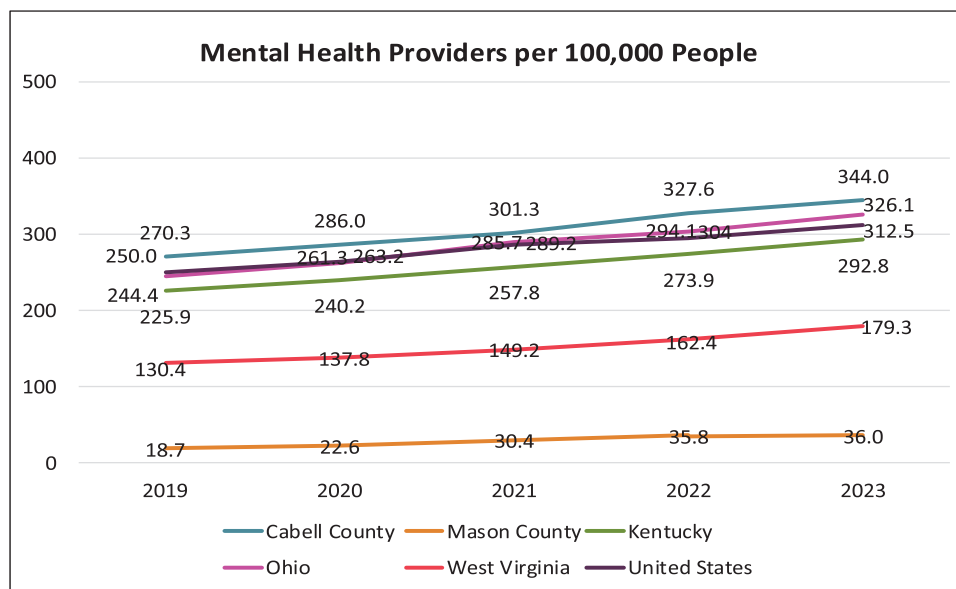


Source: Centers for Disease Control and Prevention

Behavioral Health

Access to mental health providers has improved across the MHN service area since the 2022 CHNA; however, every county remains designated as a Health Professional Shortage Area, either for the general population or specifically for individuals with low income. Mental health providers encompass a broad range of professionals, including those specializing in psychiatry, psychology, counseling, and the treatment of mental health and substance use disorders. This also includes addiction-focused professionals such as physicians, psychiatrists, clinical psychologists, counselors, registered nurses with addiction expertise, and licensed peer support specialists.

Cabell County serves as the regional hub for health care services and exceeds the national average in mental health provider availability, with nearly 30 more providers per 100,000 people than the national benchmark. In contrast, Mason County falls below both state and national levels, with just 36 mental health providers per 100,000 residents.



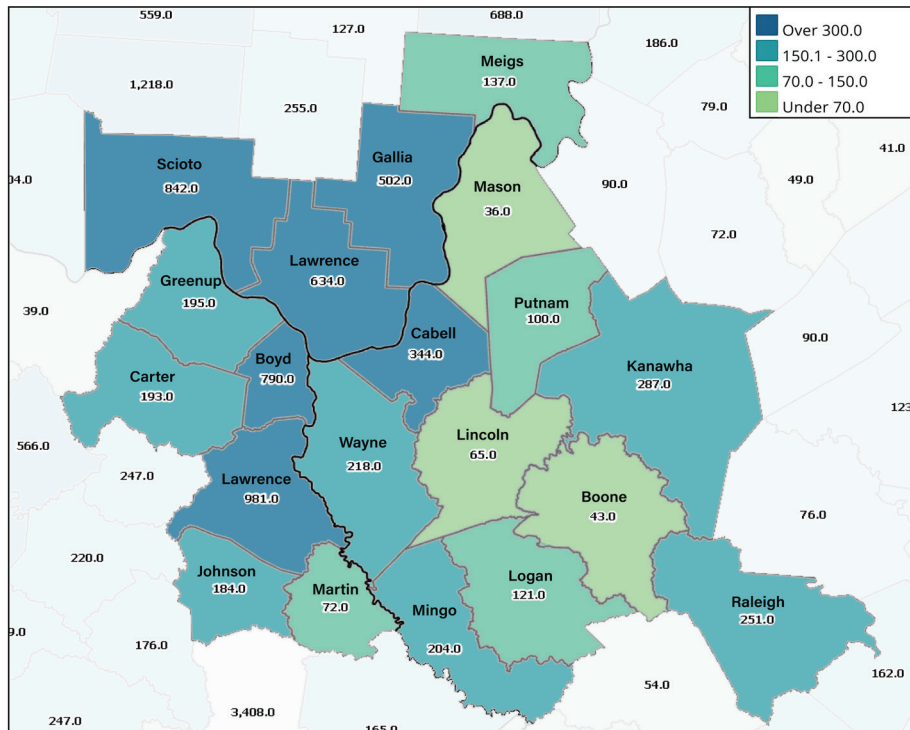
Source Centers for Disease Control and Prevention

- ***“So many physical illnesses are connected to unmet mental health needs. Conversely, people who become sick then struggle with mental health issues as a result.” -KIS***
- ***“There are not enough services available for mental health issues. The ones that are available are expensive.” -KIS***
- ***“Wait times for someone in crisis is weeks or even months.” -KIS***
- ***“So many teens and young adults with anxiety.” -KIS***



PRIORITY HEALTH NEEDS

2023 Mental Health Providers per 100,000 People by County

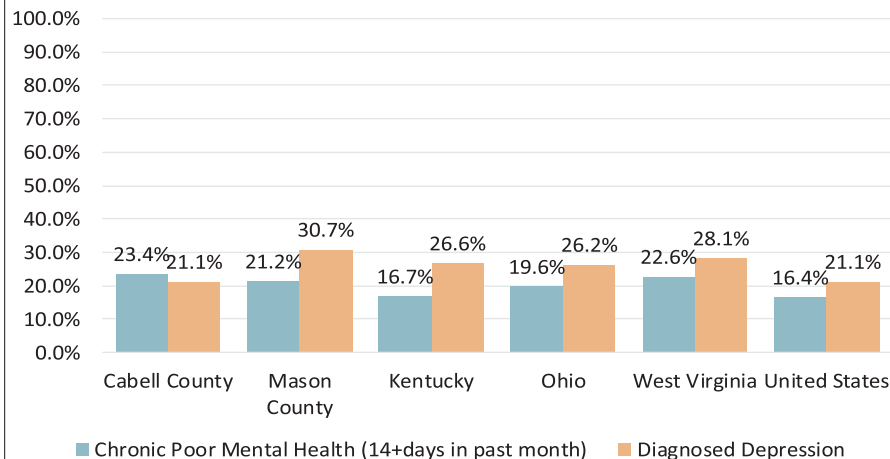


Source: Center for Applied Research and Engagement Systems

Rates of mental distress and diagnosed depression continue to rise both nationally and throughout the Tri-State. In Cabell County, approximately 1 in 5 adults report a diagnosed depressive disorder, aligning with the national average. In Mason County, however, the rate is significantly higher, with nearly 1 in 3 adults affected. Chronic poor mental health—defined as experiencing 14 or more days of poor mental health in the past month—is also more common locally, reported by nearly 1 in 4 adults in Cabell County and 1 in 5 in Mason County. Both rates surpass the national average of 1 in 6.

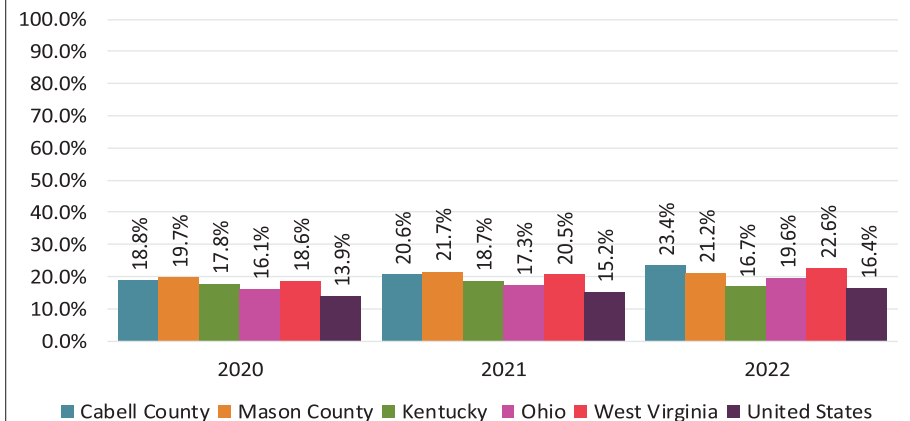


2022 Age-Adjusted Adult Poor Mental Health Indicators



Source: Centers for Disease Control and Prevention

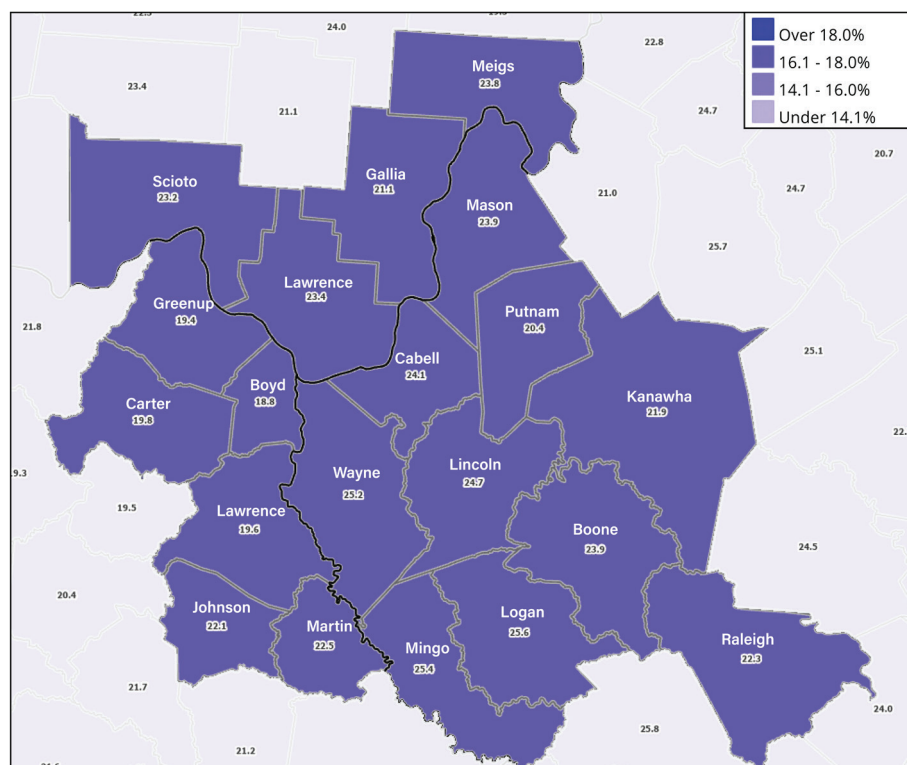
Age-Adjusted Chronic Poor Mental Health (14+ Days in Past Month) Trends





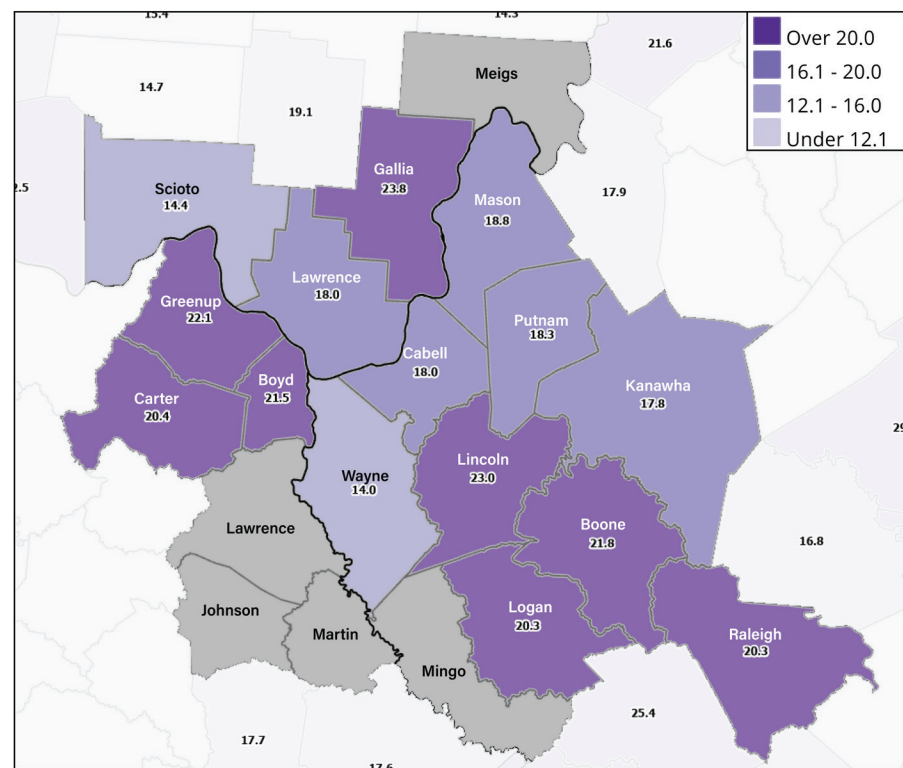
All counties within the MHN service area report rates of chronic poor mental health above the national average of 16.4%. Across the region, rates reach 18% or higher, highlighting a consistent trend of elevated mental health challenges throughout the area. Unlike many other health conditions, mental health disorders affect individuals across all geographic and socioeconomic backgrounds. Higher rates of frequent mental distress in the region align with historically elevated suicide death rates, which have consistently exceeded the national average of 13.8 deaths per 100,000 people.

2022 Adults with Chronic Poor Mental Health (14+ days in past month) by County



Source: Center for Applied Research and Engagement Systems

2019-2023 Suicide Death per Age-Adjusted 100,000 by County



Source: Center for Applied Research and Engagement Systems

Emergency Department Use

Behavioral health conditions, including mental health and substance use disorders, are most effectively treated in community-based settings outside of the ED, but nationwide, individuals with behavioral health conditions are one of the fastest growing ED patient populations largely due to shortages in community-based services and difficulties navigating the health care system. CHH, RH, and SMMC saw a combined 6,848 behavioral health-related ED visits in 2024.

The following table depicts the behavioral health diagnoses by total ED visits across the three hospitals.

2024 Top Behavioral Health Diagnoses in the Emergency Department
by Marshall Health Network Hospital

	Total Visits	Percentage of Total Behavioral Health Visits
Cabell Huntington Hospital (Total Visits)	3,796	100%
Mood Disorders	1,310	34.6%
Anxiety Disorders	1,089	28.7%
Adjustment Disorders	512	13.5%
Substance-related Disorders	382	10.1%
Alcohol-related Disorders	264	7.0%
Suicide and Intentional Self-inflicted Injury	237	6.2%
Rivers Health (Total Visits)	215	100%
Anxiety Disorders	100	46.5%
Substance-related Disorders	32	14.9%
Alcohol-related Disorders	32	14.9%
Suicide and Intentional Self-inflicted Injury	26	12.1%
Schizophrenia and other Psychotic Disorders	17	7.9%
Mood Disorders	8	3.7%
St. Mary's Medical Center (Total Visits)	2,837	100%
Mood Disorders	627	22.1%
Anxiety Disorders	626	22.1%
Alcohol-related Disorders	476	16.8%
Suicide and Intentional Self-inflicted Injury	418	14.7%
Substance-related Disorders	409	14.4%
Schizophrenia and other Psychotic Disorders	281	9.9%

Source: West Virginia Hospital Association QDI Dashboards

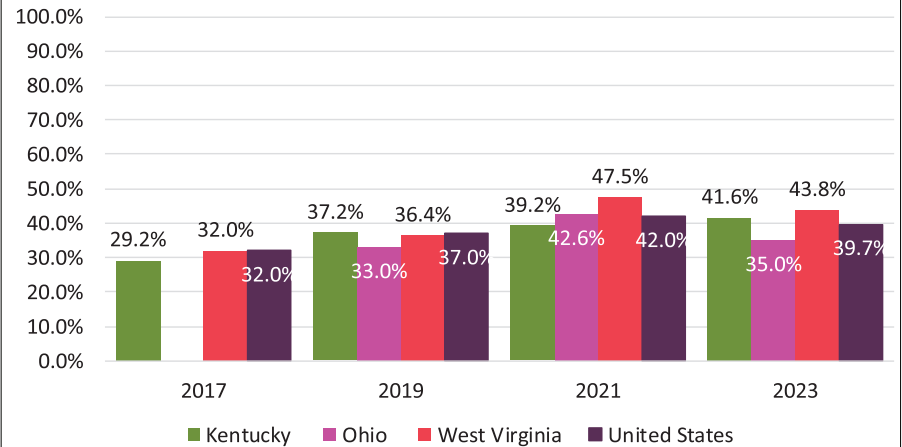


Youth Behavioral Health

Youth are especially vulnerable to mental health challenges and suicidal thoughts, with rising concerns both nationally and within the region. In 2023, more than 40% of high school students in Kentucky and West Virginia reported feeling persistently sad or hopeless. West Virginia has also historically reported a higher percentage of students attempting suicide—exceeding the national average by 2.6%.

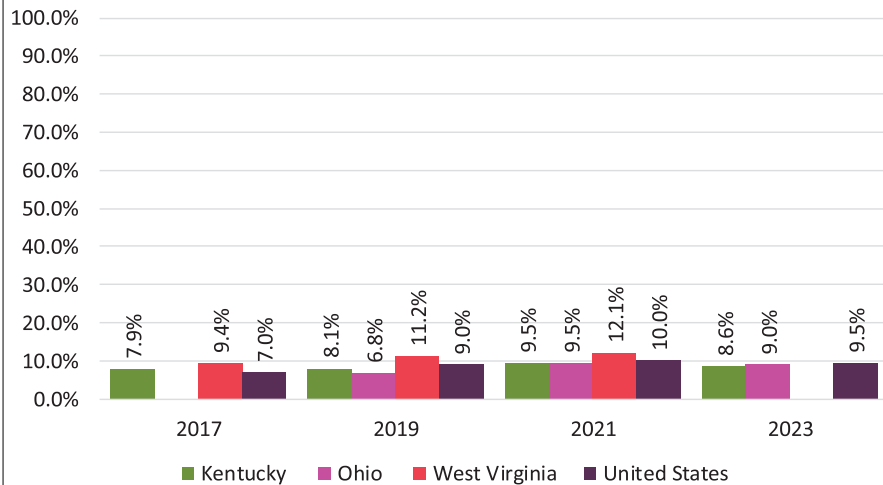
Youth mental distress disproportionately affects students who identify as female, as well as students of color and LGBTQ+ youth. These patterns are consistent across both state and national data, highlighting persistent disparities in mental health experiences among vulnerable student populations.

Percentage of High School Students Who Reported Feeling Sad or Hopeless For At Least Two Weeks During the Past Year That They Stopped Doing Usual Activities



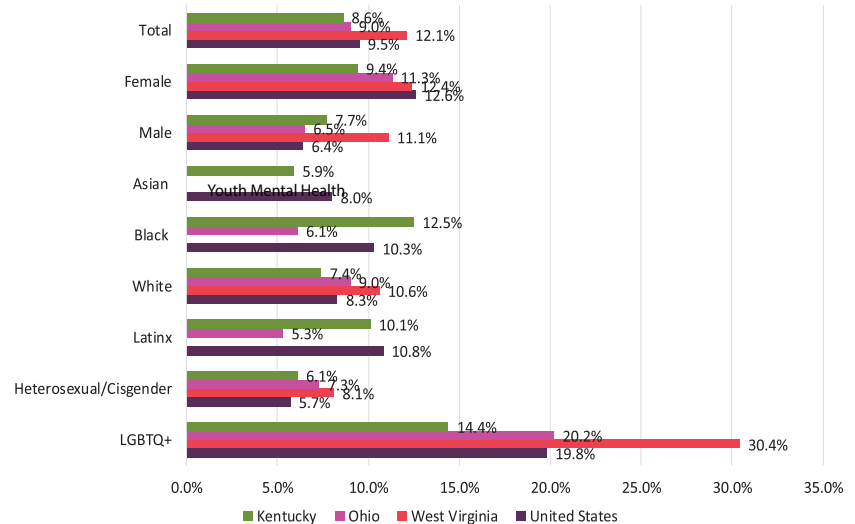
Source Centers for Disease Control and Prevention

Percentage of High School Students Who Attempted Suicide in the Past Year



Source Centers for Disease Control and Prevention

2023 Percentage of High School Students Who Reported an Attempted Suicide



Source Centers for Disease Control and Prevention

PRIORITY HEALTH NEEDS

The following table depicts the behavioral health diagnoses by total ED visits across Marshall Health Network by age groups 0-9 and 10-17.

2024 Top Behavioral Health Diagnoses for Youth by Age in the Emergency Department by Marshall Health Network Hospital

	0-9	10-17
Cabell	91	399
Suicide and Intentional Self-inflicted Injury	0	131
Anxiety Disorders	34	118
Mood Disorders	3	73
Adjustment Disorders	44	59
Substance-related Disorders	1	13
Alcohol-related Disorders	0	5
Rivers Health	0	15
Suicide and Intentional Self-inflicted Injury	0	6
Anxiety Disorders	0	4
Substance-related Disorders	0	2
Alcohol-related Disorders	0	1
Adjustment Disorders	0	1
Personality Disorders	0	1
St. Mary's Medical Center	7	134
Suicide and Intentional Self-inflicted Injury	4	72
Anxiety Disorders	3	35
Mood Disorders	0	13
Substance-related Disorders	0	6
Alcohol-related Disorders	0	4
Schizophrenia and other Psychotic Disorders	0	4

Source: West Virginia Hospital Association QDI Dashboards

Chronic Disease Prevention and Management

Residents of the MHN service area generally have more health risk factors and higher prevalence and mortality due to chronic disease than their peers across the Tri-State region and nation.

- *“Difficulty achieving lifestyle changes in our population that would help reduce the burden of chronic disease.” –KIS*
- *“The growing numbers that are impacted by various chronic diseases due to obesity (food choices/lack of physical activity), behavioral choices (tobacco/alcohol/drug use), etc.” –KIS*
- *“Need to address lifestyle factors and choices that contribute to poor health outcomes.”–KIS*
- *“Lack of community resources for people to manage their diseases. No places to exercise for free or for pay in rural areas. Lack of education on food choices for chronic disease (dietary only covered for T2DM and Kidney disease). Lack of payers for appropriate treatment options for obesity.” –KIS*

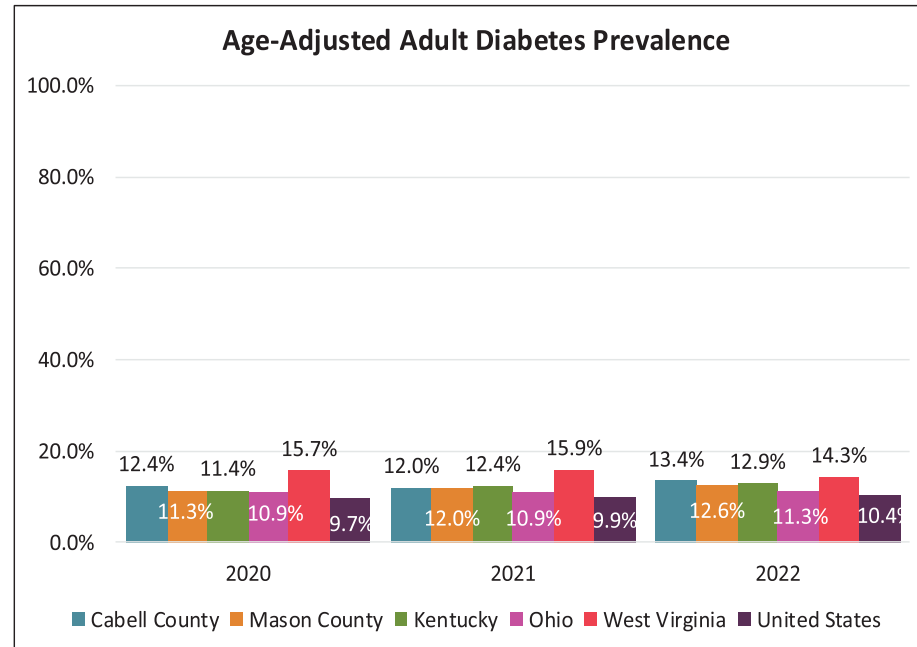


PRIORITY HEALTH NEEDS

Obesity and Diabetes

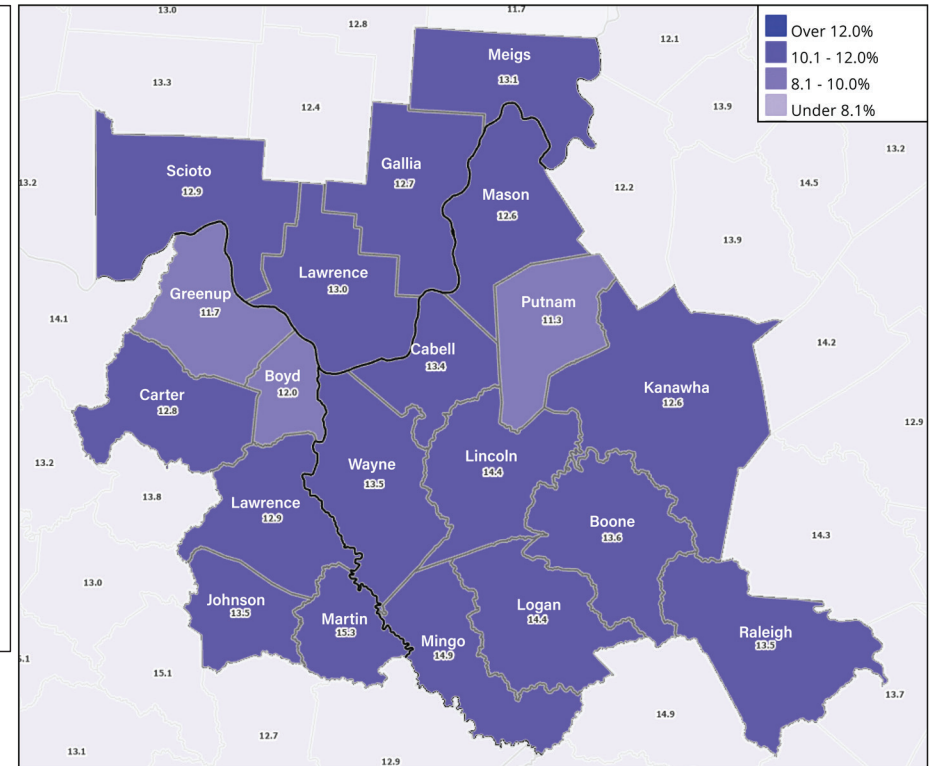
Adults in the Tri-State region continue to experience higher rates of obesity and diabetes compared to national benchmarks. While diabetes prevalence increased nationally and across Kentucky and Ohio through 2022, West Virginia

saw a slight decline since 2020. However, it remains the highest in the region—4% above the national average—and affects nearly 1 in 7 adults. Every county within the MHN service area reports diabetes rates above the national benchmark.



Source: Health Resources and Services Administration

2022 Adult Diabetes Prevalence by County

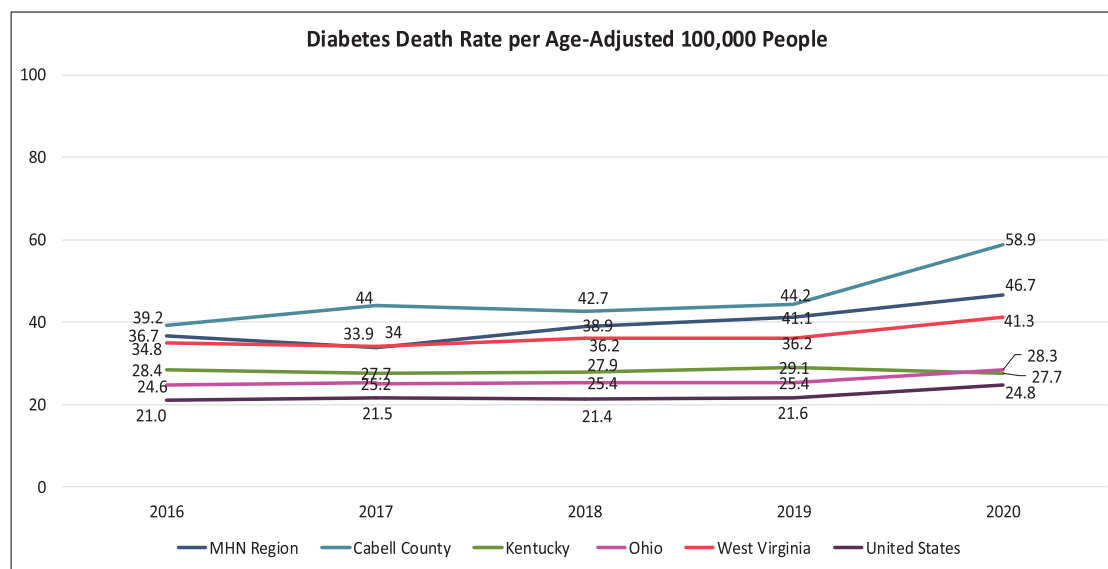


Source: Center for Applied Research and Engagement Systems

Obesity and Diabetes

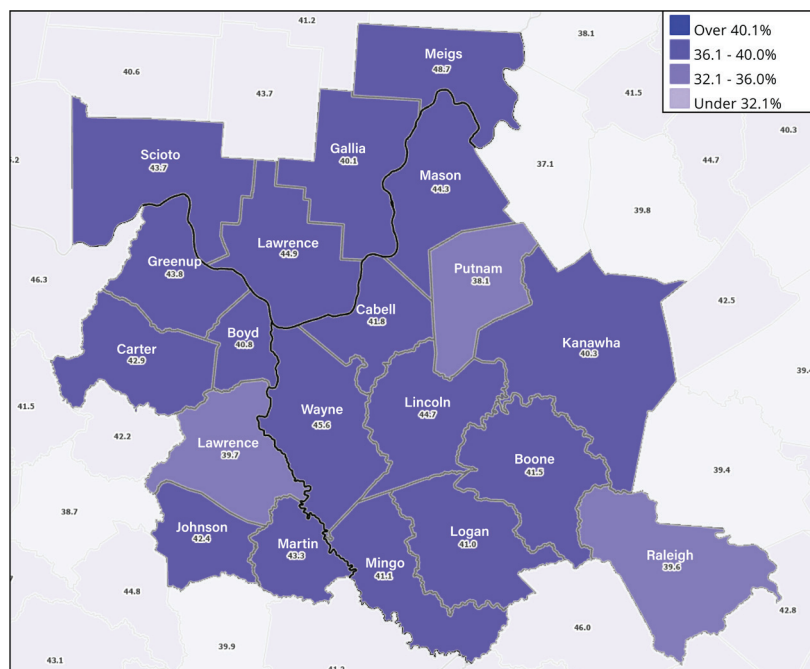
The MHN service area also has a higher diabetes-related death rate than both the Tri-State and national averages. This rate rose sharply in 2020, likely influenced by the COVID-19 pandemic. Cabell County stands out with a diabetes mortality rate of 58.9 per 100,000 people (age-adjusted), more than double the national rate of 24.8.

Obesity prevalence continues to rise nationwide and across Ohio and West Virginia as of 2022. Although Kentucky experienced a slight decline that year, more than 1 in 3 adults statewide remain affected. All counties served by MHN report obesity rates higher than the national benchmark of 33.4%.

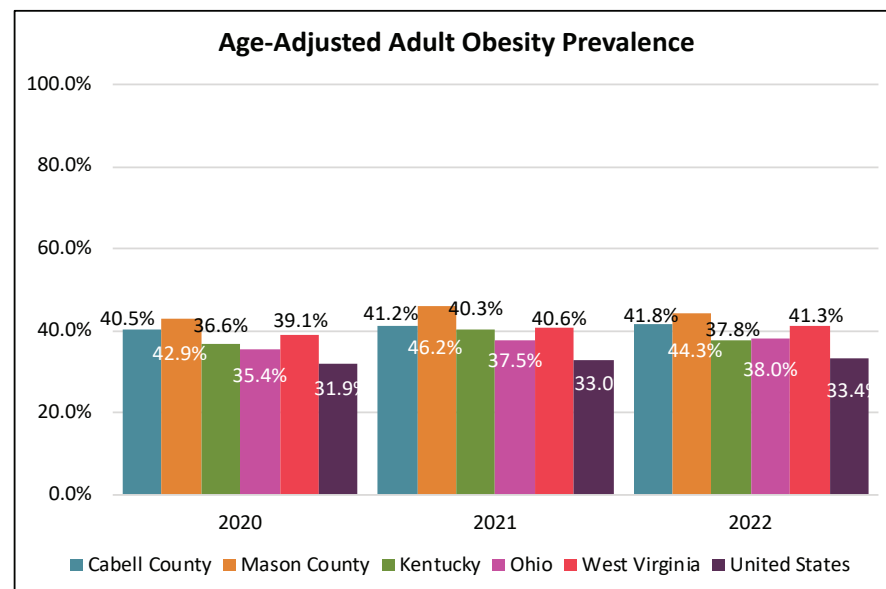


Source: Centers for Disease Control and Prevention

2022 Adult Obesity Prevalence by County



Source: Center for Applied Research and Engagement Systems



Centers for Disease Control and Prevention

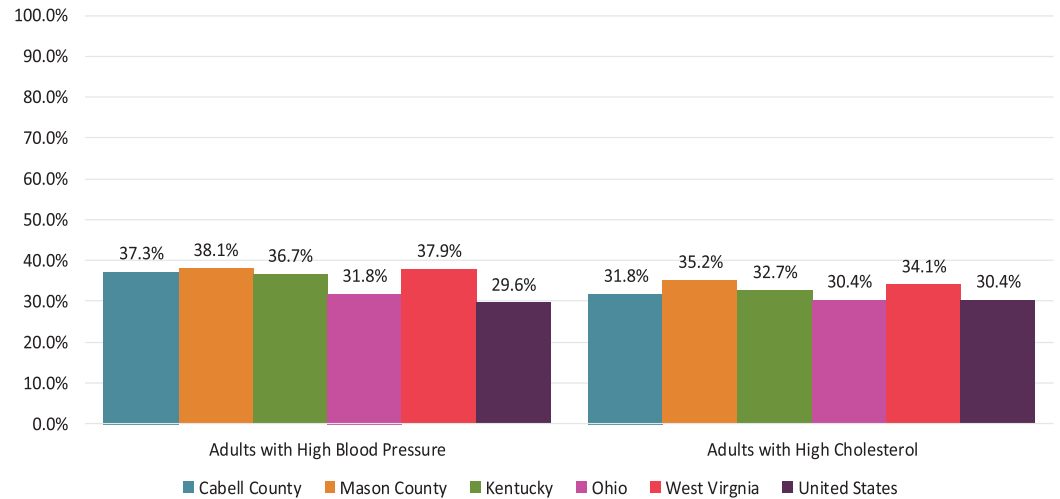
PRIORITY HEALTH NEEDS

Chronic Disease

About one-third of adults in the MHN service area has been diagnosed with heart disease risk factors such as high blood pressure and/or high cholesterol. Heart disease death rates in the MHN service area remain significantly higher than the national average—217.0 per 100,000 people (age-adjusted) compared to 168.2 nationally—and have continued to rise through 2020, mirroring trends seen in diabetes mortality.

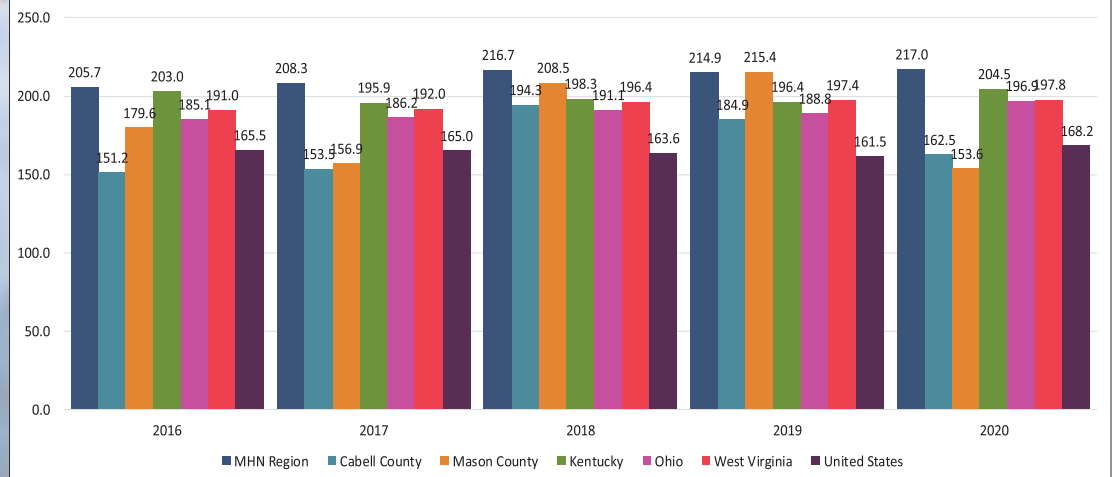


2021 Age-Adjusted Adult Heart Disease Risk Factors



Source: Centers for Disease Control and Prevention

Heart Disease Death Rate per Age-Adjusted 100,000 People



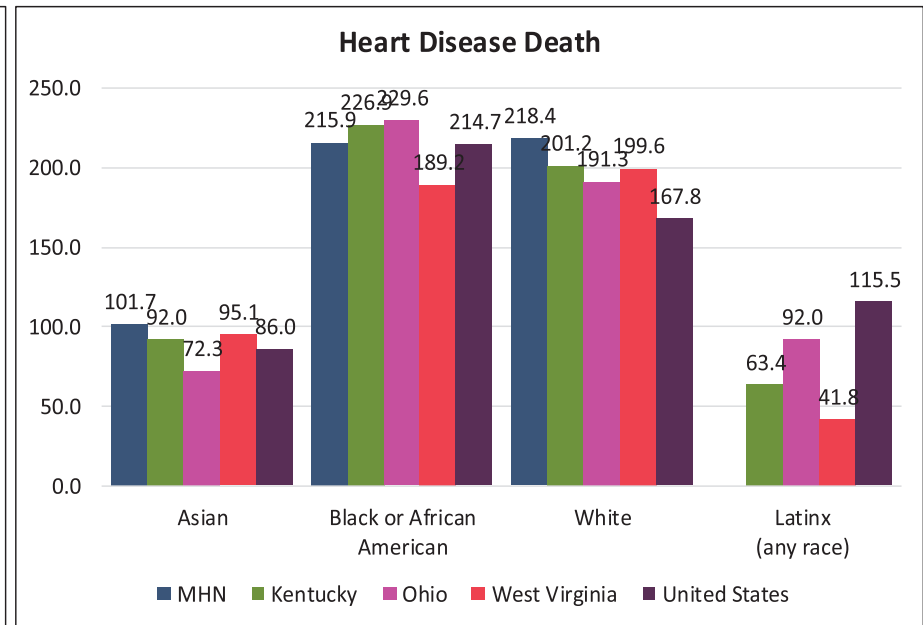
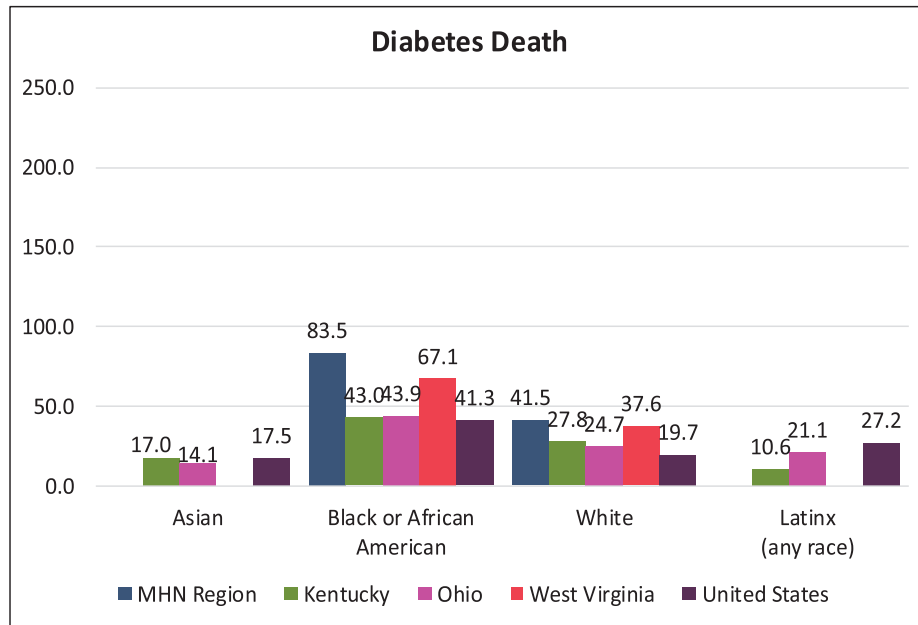
Source: Centers for Disease Control and Prevention



Chronic Disease

Chronic disease and premature death do not impact all populations equally. Certain groups—particularly people of color—face disproportionately higher rates of illness and mortality due to systemic and institutional barriers that limit access to health-promoting resources and opportunities. In the MHN service area, Black or African American individuals experience a diabetes death rate of 83.5 per 100,000 people (age-adjusted), which is double both the national average and the rate among White residents. Conversely, White individuals have a slightly higher heart disease death rate than Black individuals in the region—218.4 compared to 215.9 per 100,000 people (age-adjusted).

**2018-2020 National Death Rates per Age-Adjusted 100,000 Residents
by Select Race and Ethnicity**

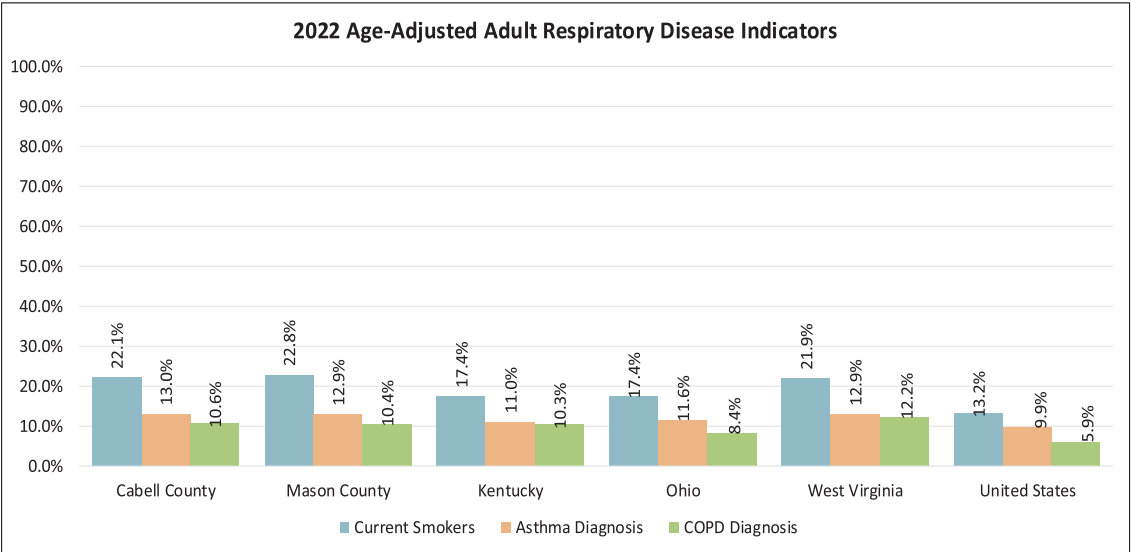


Source: Centers for Disease Control and Prevention

PRIORITY HEALTH NEEDS

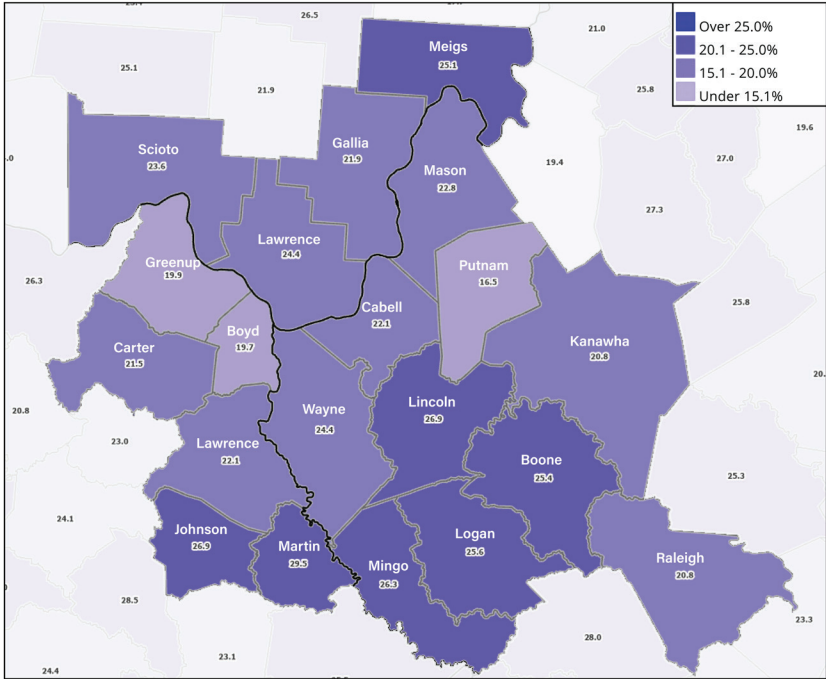
Respiratory Disease

While traditional cigarette smoking has declined nationwide over recent decades, adults in the Tri-State region remain more likely to smoke than their national peers—22.1% in Cabell County and 22.8% in Mason County, compared to the national benchmark of 13.2%. This elevated tobacco use contributes to the area’s higher prevalence of chronic respiratory conditions such as asthma and chronic obstructive pulmonary disease (COPD).



Source: Centers for Disease Control and Prevention

2022 Adult Current Smoker Prevalence by County

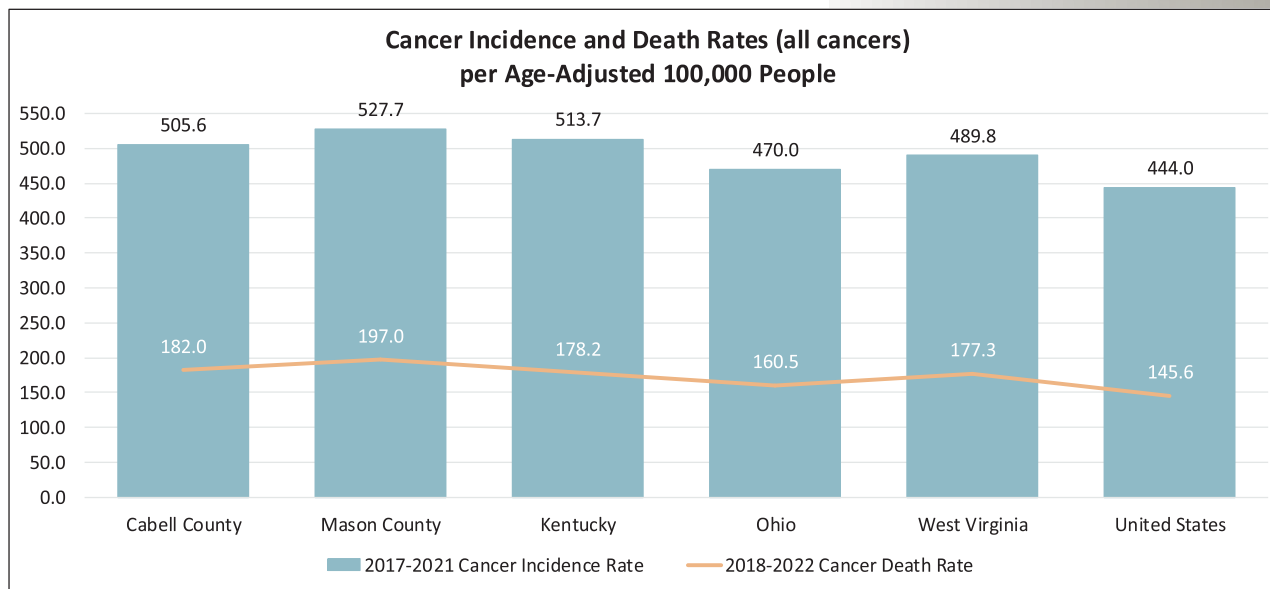


Source: Source: Center for Applied Research and Engagement Systems

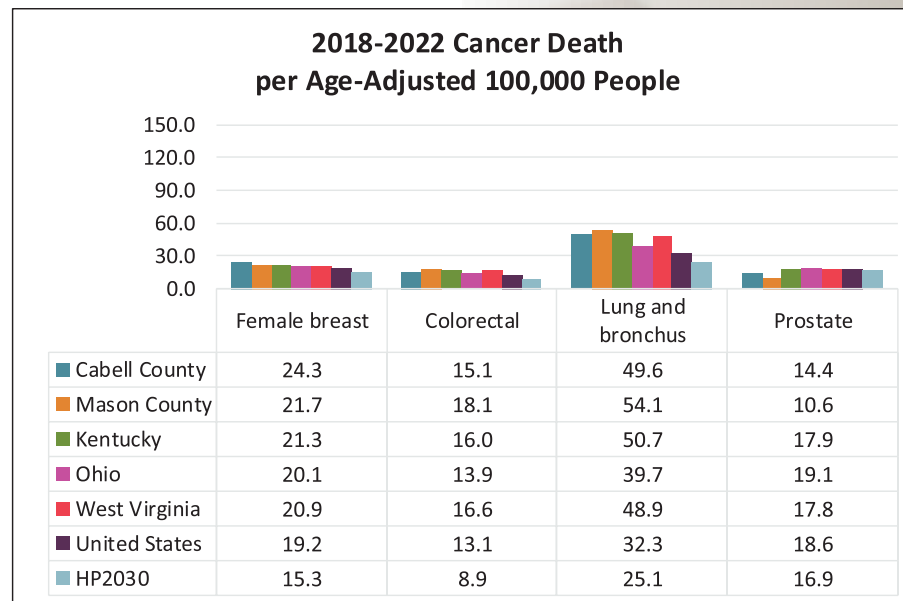
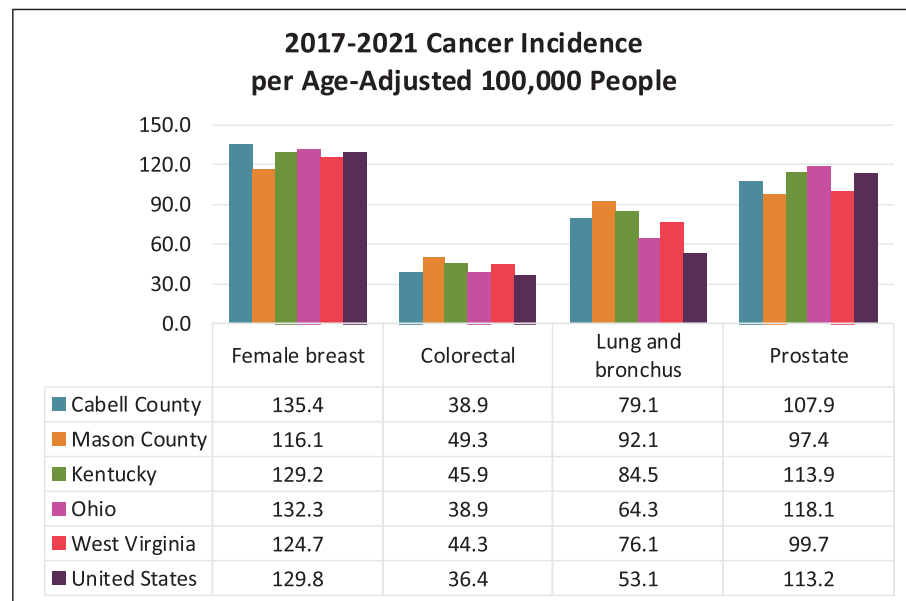


Cancer

Cancer remains a leading cause of chronic disease and mortality. Although overall cancer death rates have declined nationally and across Kentucky, Ohio, and West Virginia over the past decade, challenges persist. The most common cancer types—female breast, colorectal, lung and bronchus, and prostate—continue to drive regional health burdens. Lung cancer incidence and death rates remain high in the MHN service area, reflecting higher smoking rates. Additionally, Cabell County reports an elevated death rate from female breast cancer, and Mason County shows a higher colorectal cancer death rate. Both are linked to lower screening rates. Both counties report lower-than-average death rates for prostate cancer.



Source: Centers for Disease Control and Prevention *Cancer incidence data lag and are reported for most recent years available.



Source: Centers for Disease Control and Prevention *Cancer incidence data lag and are reported for most recent years available.

PRIORITY HEALTH NEEDS



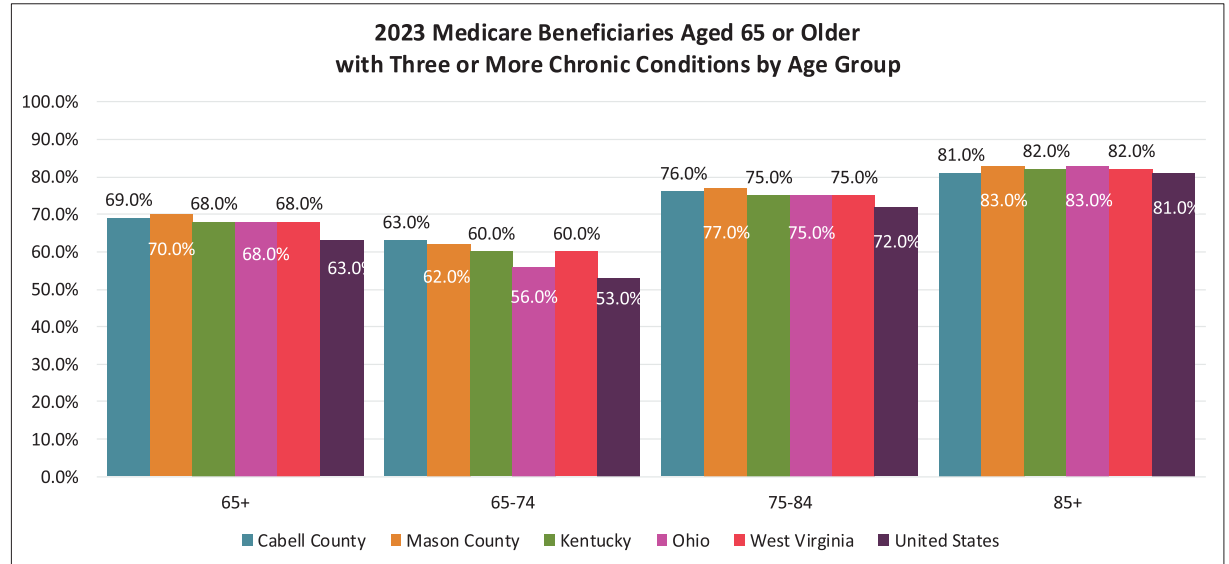
Gerontology and Healthy Aging

The MHN service area has an aging population and is growing older at a faster pace than the national average. Older adults in the region also tend to have poorer health outcomes compared to their peers across the country. 70.75% of individuals 65+ have three or more chronic conditions in the MHN service area compared to the 63% nation wide.

- **“Elderly will not have the recommended testing due to the cost.” -KIS**
- **“It is a large population, and we do not have enough providers to meet all of their needs.” -KIS**
- **“Aging population is having to make choices between medications, buying food, or paying bills.” -KIS**

Every county in the MHN service area reports a higher proportion of Medicare beneficiaries with three or more chronic conditions than the national average, highlighting the region’s greater burden of complex health needs among older residents.

In addition to the increasing prevalence of chronic diseases, older adults in the MHN service area are more likely to experience a disability compared to both state and national averages. Approximately 44% of adults in the service area report having a disability, significantly higher than the national rate of 33%. As seen across the country, the most commonly reported disability among older adults in the region is difficulty with walking (ambulatory), followed by hearing impairments.



Source: Centers for Medicare & Medicaid Services

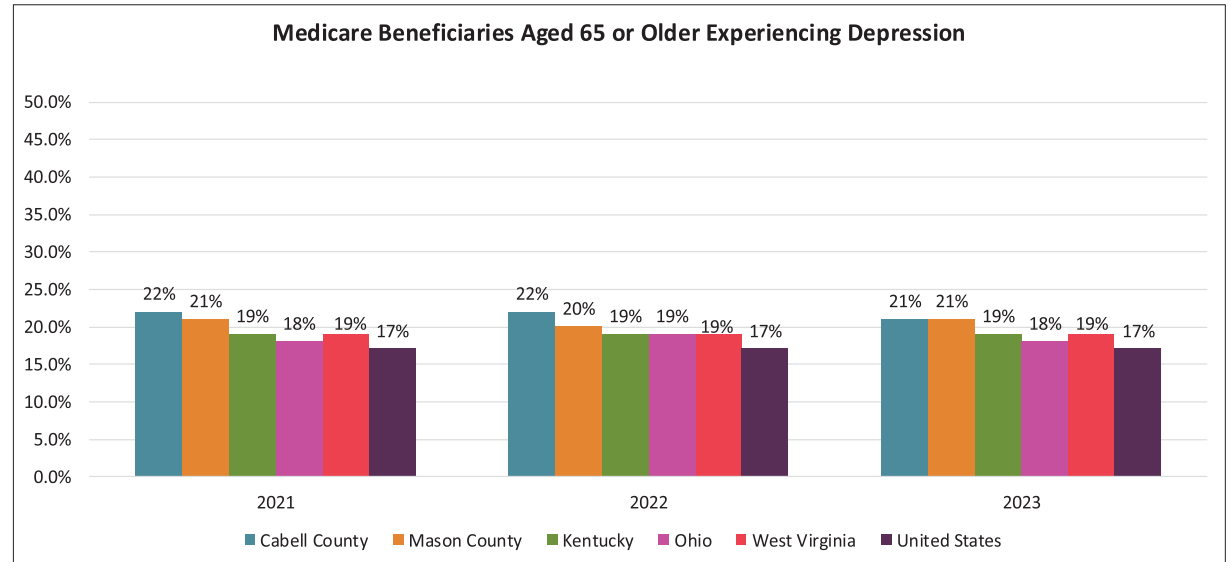
2023 Disability and Type among Older Adults 65+

	MHN Service area	Cabell County	Mason County	Kentucky	Ohio	West Virginia	United States
Total Population	21.6%	19.5%	19.1%	17.7%	14.2%	19.1%	13.0%
65 years or older	43.7%	41.1%	44.0%	39.0%	32.9%	39.5%	32.9%
Ambulatory (walking)	29.3%	28.6%	31.9%	25.2%	20.6%	25.5%	20.7%
Hearing	20.0%	16.7%	23.9%	16.9%	13.0%	18.0%	13.5%
Independent living	17.6%	17.6%	17.3%	15.5%	12.6%	15.3%	13.3%
Cognitive	10.6%	10.6%	9.3%	9.6%	7.5%	9.5%	8.0%
Vision	8.8%	8.8%	12.3%	7.8%	5.7%	7.7%	6.0%

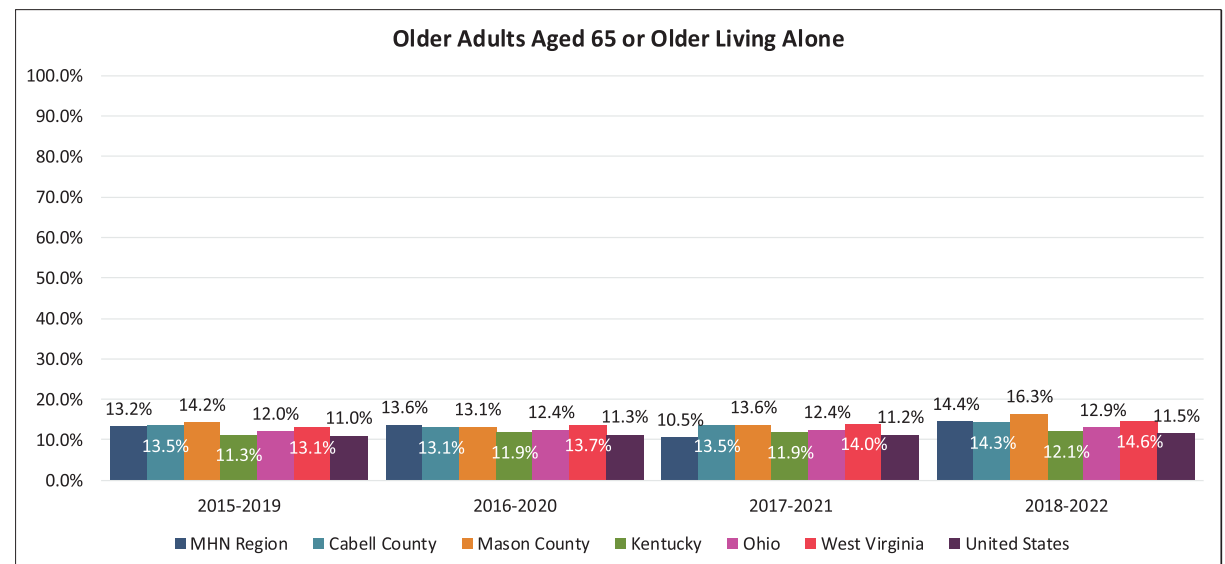
Source: US Census Bureau, American Community Survey

PRIORITY HEALTH NEEDS

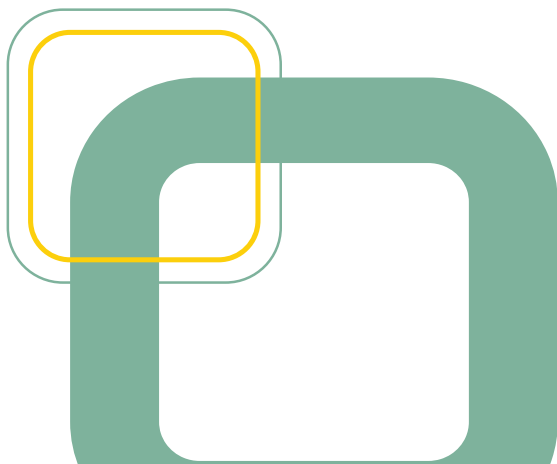
As individuals age, they often face increased risk of social isolation due to physical limitations and shrinking social networks. One key indicator of this isolation is the percentage of older adults living alone—a figure that has fluctuated over time but consistently remains above the national average. In 2022, the proportion of older adults living alone in the MHN service area exceeded the national average by nearly 3%.



Source: Centers for Medicare & Medicaid Services



Source: US Census Bureau, American Community Survey

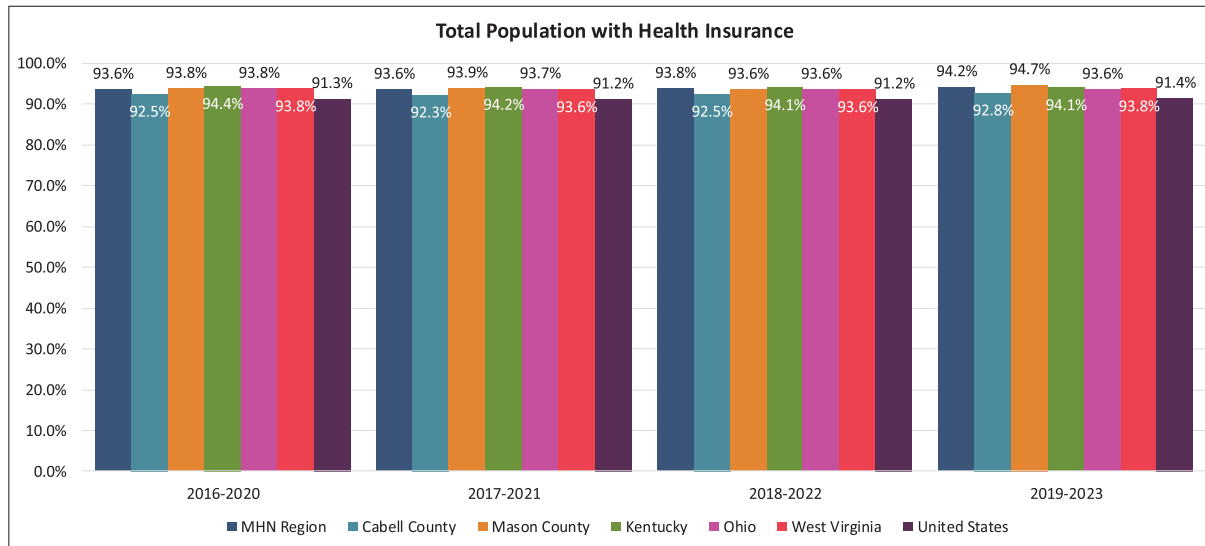


Access to Health Care

Access to quality health care is essential for improving individual and community health outcomes. In the MHN service area, challenges such as provider shortages, transportation barriers, cost, and limited availability of specialized services contribute to disparities in care. Understanding these barriers and identifying opportunities to improve access are critical for reducing health inequities and ensuring that all residents can receive timely, appropriate care.

The MHN service area continues to have a higher percentage of insured individuals (94.2%) than the nation and meets the Healthy People 2030 (HP2030)* goal of 92.1% insured residents. Overall health insurance coverage for the MHN service area is consistently high across age groups when compared to national averages.

- **“Wait times to appointment, provider availability (especially specialists in rural areas) and patient transportation needs [are all problems with large effects in the region].”**
- **“It is taking many months for people to get appointments - not only for specialists but also for primary care at times. Dental services are scarce for Medicaid recipients. Residents must travel for care.” -KIS**
- **“Continued efforts to recruit providers, including mid-levels, placing specialists in rural areas on different schedules, continued efforts through Faith Health Appalachia for transportation.” -KIS**

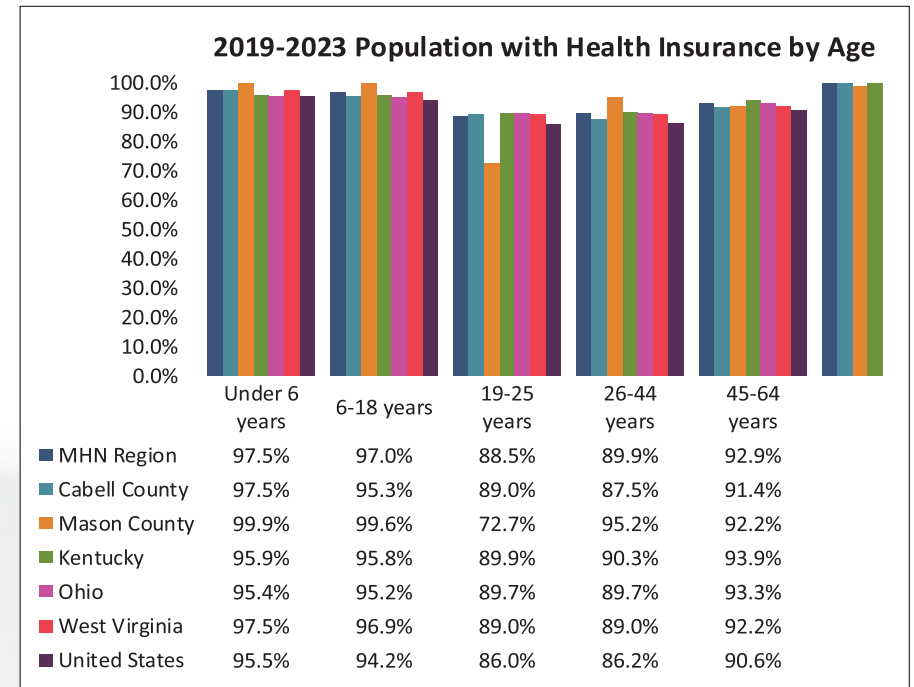


Source: US Census Bureau, American Community Survey

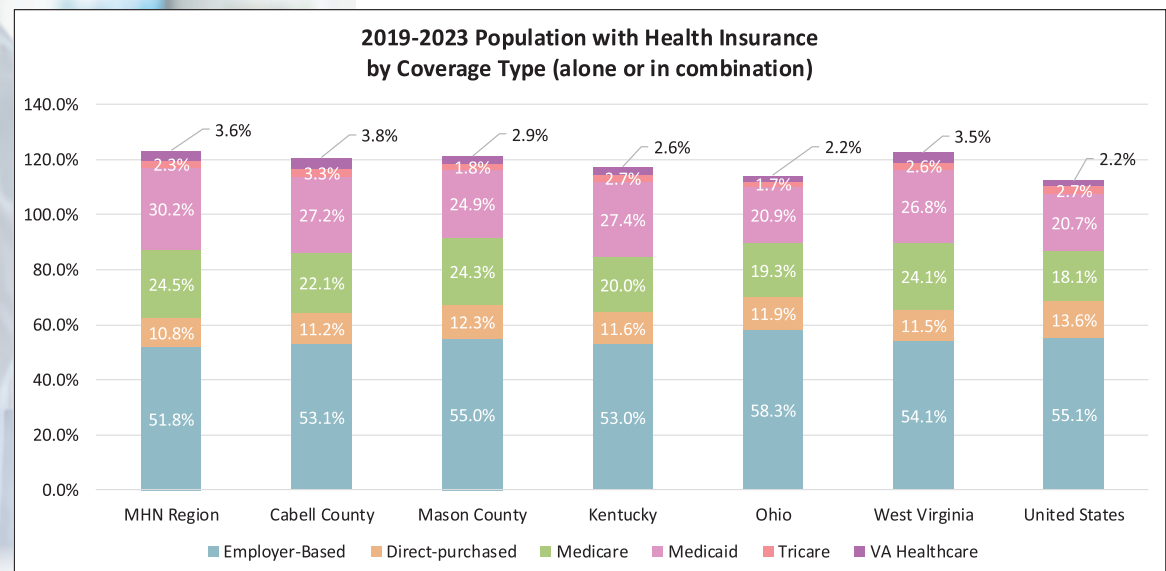
*Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade. To learn more, visit health.gov/healthypeople.

PRIORITY HEALTH NEEDS

Among insured MHN service area residents, approximately half have employer-based insurance, a slightly lower proportion than the Tri-State region and the nation overall. Nearly 30% of service area residents have Medicaid insurance (alone or in combination with other insurance) compared to 20.7% nationally. Comparatively, nearly 25% of residents in the service area have Medicare (alone or in combination with other insurance) compared to 18.1% nationally.



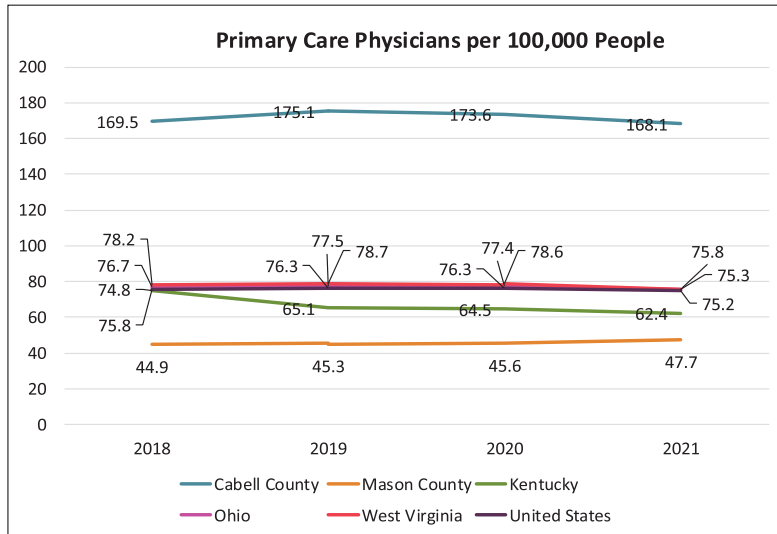
Source: Centers for Disease Control and Prevention



Source: US Census Bureau, American Community Survey

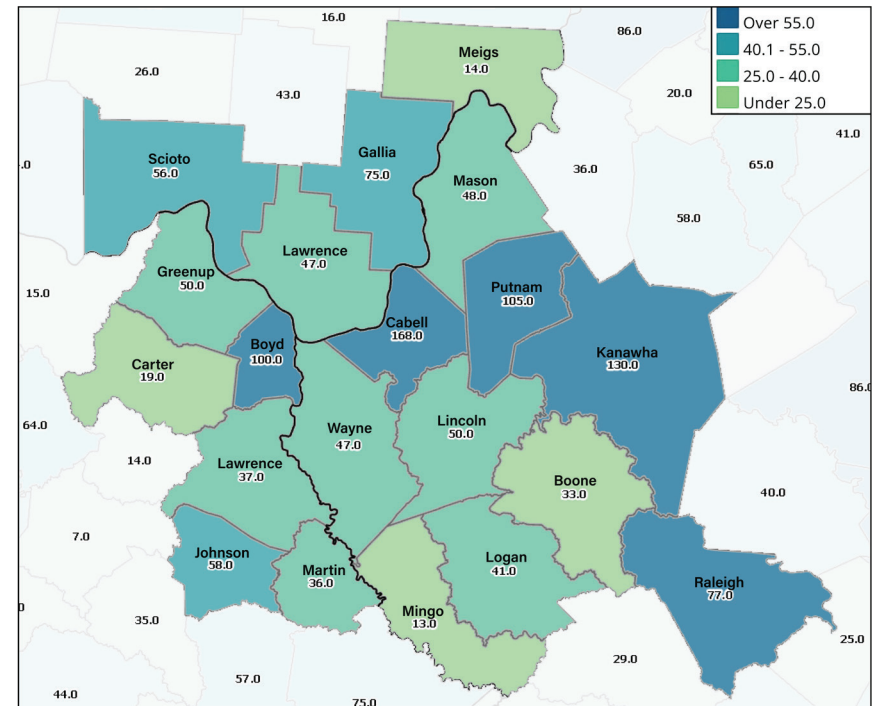
Access to Health Care

Availability of primary care providers varies across the region. Cabell County continues to be a hub for services, although the county primary care physician rate declined in recent years. Note: All counties except Meigs, Johnson, and Putnam are Health Professional Shortage Areas for people with low income; Johnson County is HPSA for all people regardless of income.



Source: Health Resources and Services Administration

2021 Primary Care Physicians per 100,000 People by County

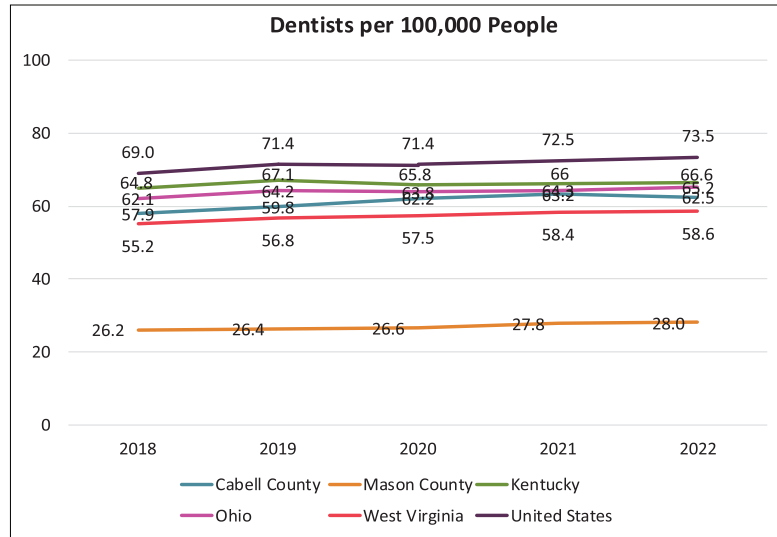


Source: Center for Applied Research and Engagement Systems



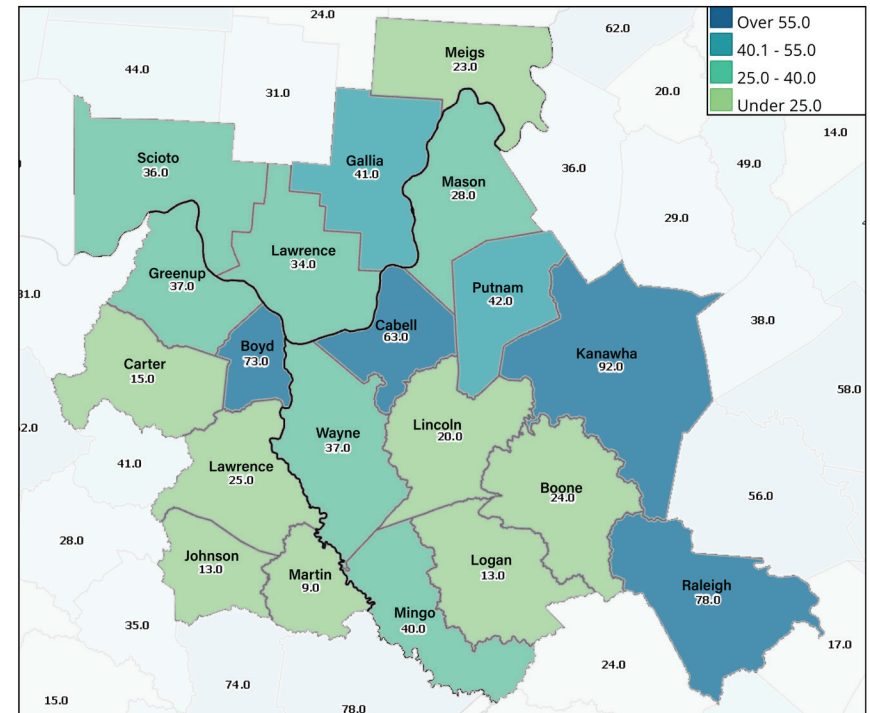
PRIORITY HEALTH NEEDS

Availability of dentists is lower across the region, with few exceptions. All counties except Putnam and Lincoln are Health Professional Shortage Areas for people with low income; Lincoln County is HPSA for all people regardless of income.

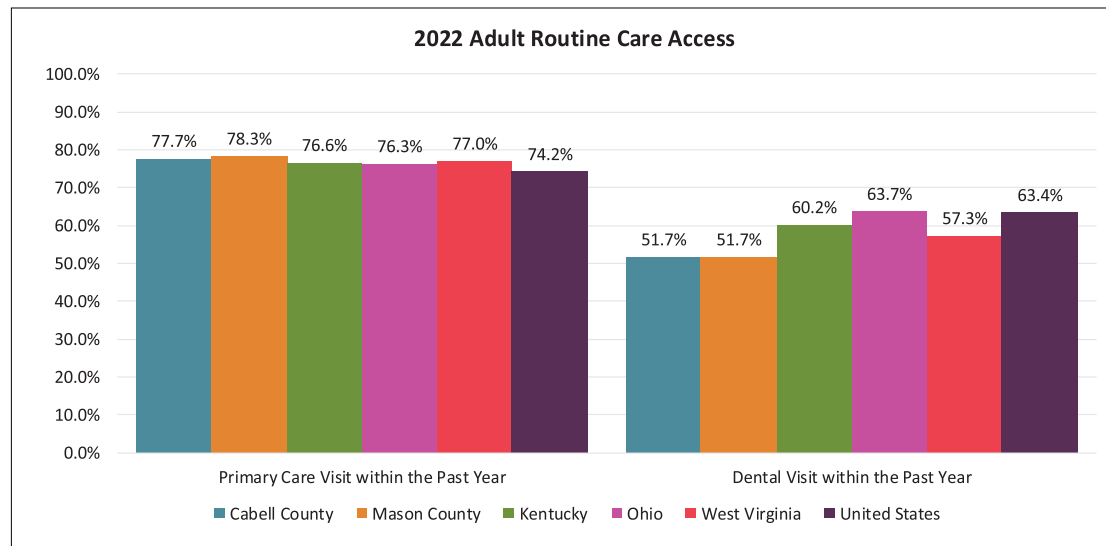


Source: Health Resources and Services Administration

2021 Dentist per 100,000 People by County



Source: Source: Center for Applied Research and Engagement Systems



Source: Centers for Disease Control and Prevention

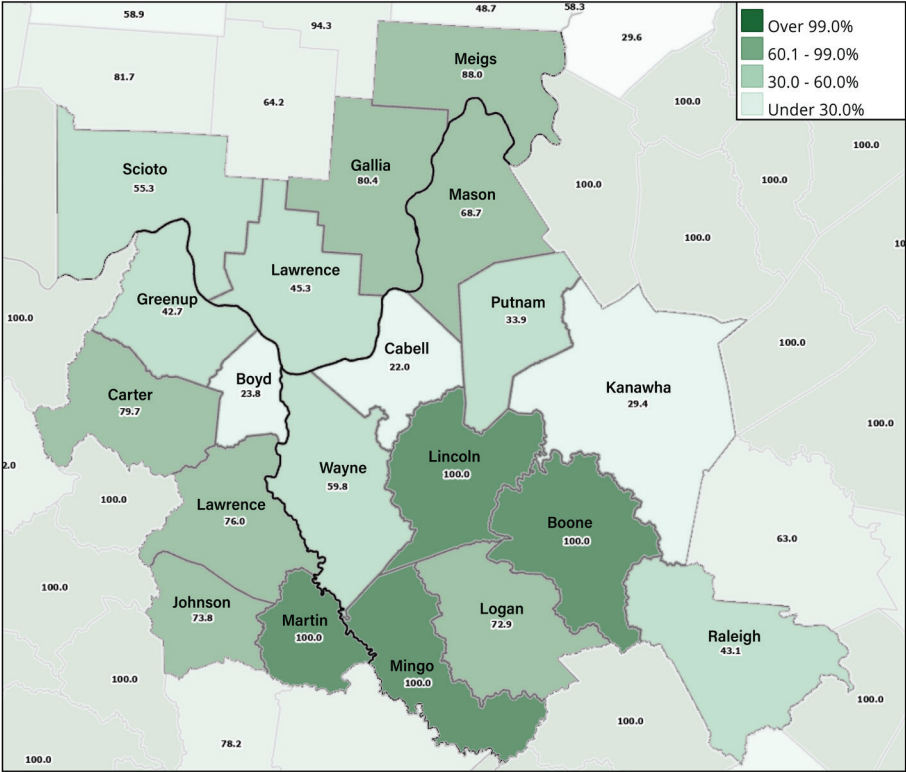
Despite differences in availability of primary care providers, a consistently high proportion of adults receive routine primary care or a checkup, exceeding the national average. Fewer dental providers and historically lower dental insurance coverage for residents has contributed to fewer people receiving regular preventive oral care. In 2022, fewer than 52% of Cabell and Mason County adults had a routine dental visit compared to 63.4% of adults nationally.

Rural Health

Rural communities often face unique health challenges, including provider shortages, limited access to specialty care, and higher rates of chronic conditions. Within the MHN service area, 85% of the counties have populations in which more than 30% of residents live in rural settings—and in 24% of those counties, over 99% of the population resides in rural areas. The greatest

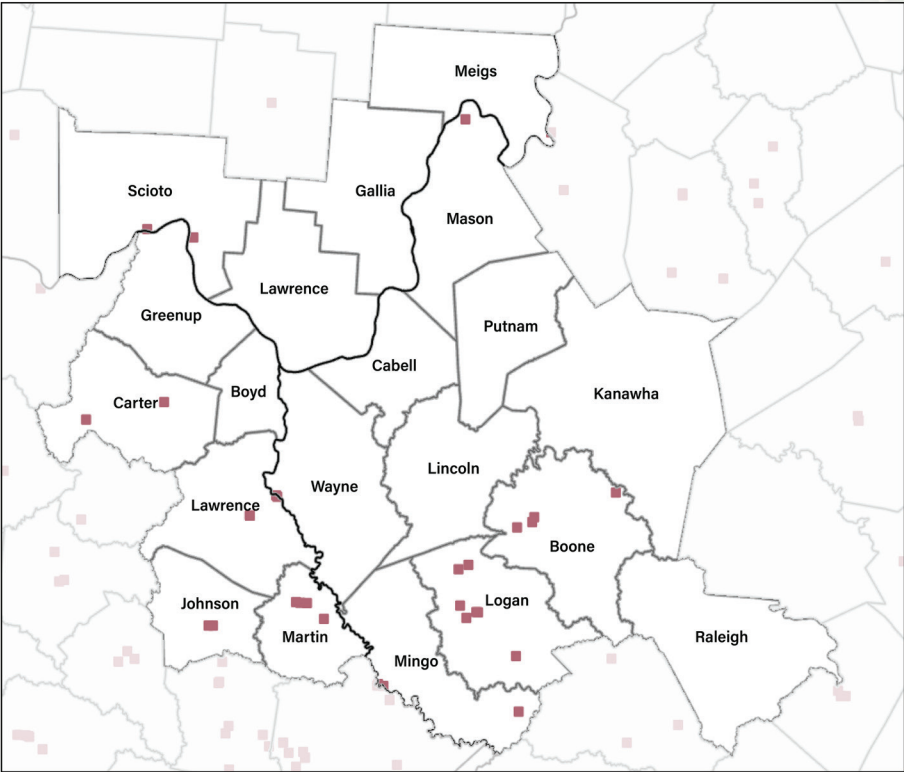
concentration of rural health clinics in the region is found in the southern portion of the MHN service area, particularly in Martin County, Kentucky, and Boone and Logan counties, West Virginia. These clinics serve as vital access points for care, helping to bridge service gaps and improve health outcomes in underserved, remote communities.

2020 Population Living in Rural Areas



Source: Source: Center for Applied Research and Engagement Systems

2024 Rural Health Clinics



Source: Source: Center for Applied Research and Engagement Systems

PRIORITY HEALTH NEEDS



Appendix

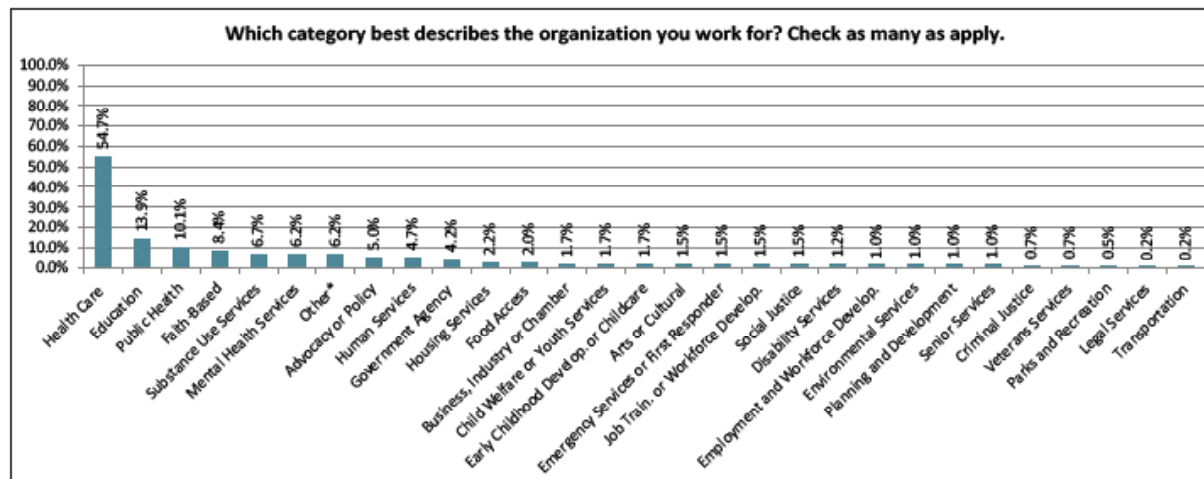


Key Informant Survey

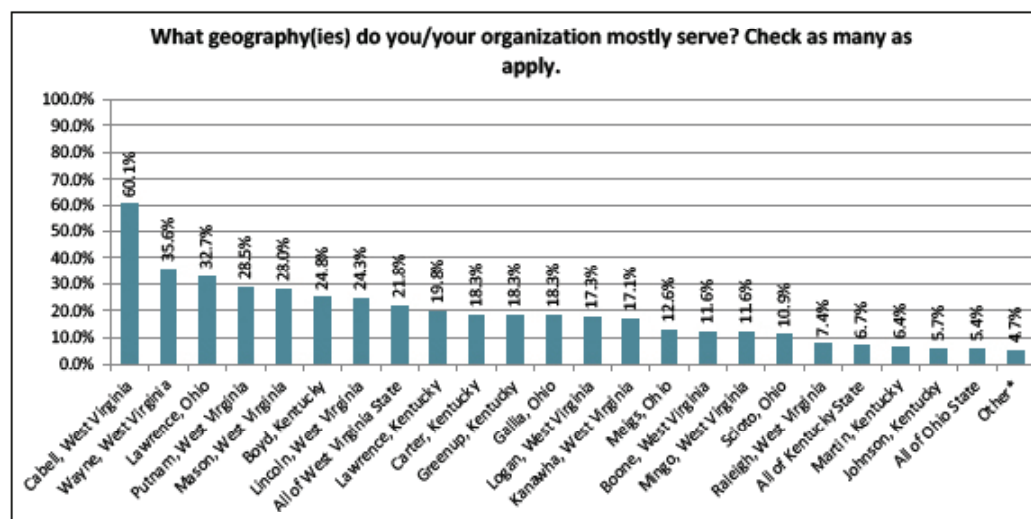
Background

A community-wide Key Informant Survey (KIS) was conducted online to gather insights from community representatives across MHN's service area regarding local health needs and opportunities for improvement. Participants included health care and social service providers, public health professionals, civic leaders, faith-based organizations, policymakers, elected officials, and others representing diverse community groups.

A total of 232 individuals completed the survey. While the names of respondents are withheld to ensure confidentiality, a list of participating organizations and titles is provided. Respondents represented communities throughout MHN's 20-county service area, with 60% serving Cabell County and 28% serving Mason County—home to CHH, SMMC, HFCH, and RH respectively.

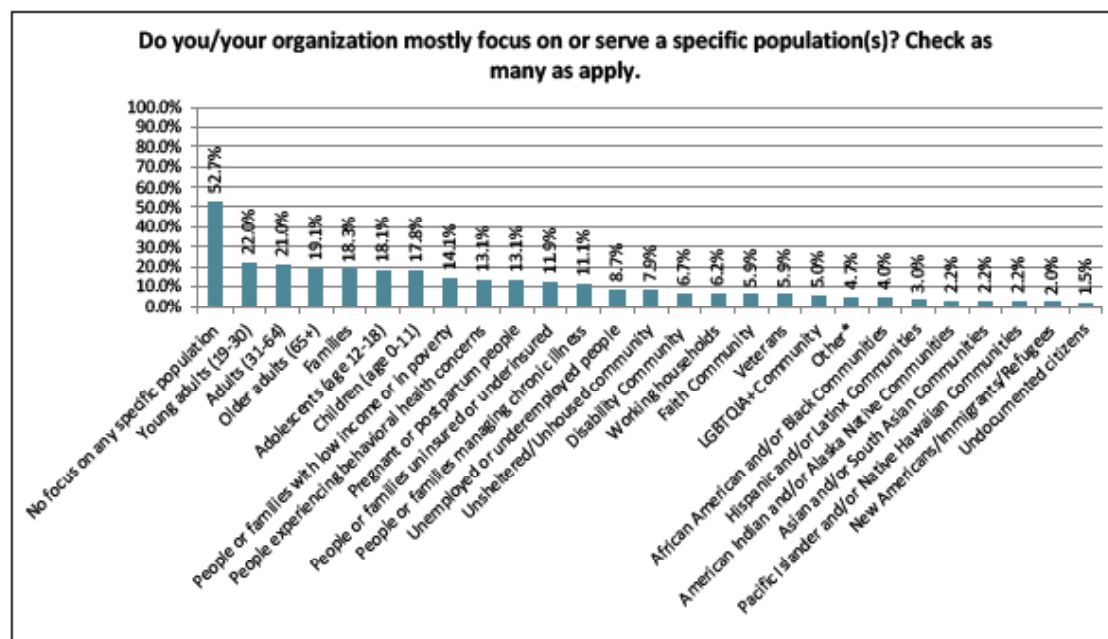


*Other responses: Home visitation; non-profit community service; quality improvement; utility assistance and social services; public library; animal rescue; credit counseling and financial education; patient experience; youth empowerment; and substance use disorder prevention.



*Other responses: Nationwide; Tri-State area; Other West Virginia counties (Barbour, Berkeley, Greenbrier, Jackson, Lewis, Marshall, Mercer, McDowell, Randolph, Roane, Pocahontas, Tucker, Upshur, Webster, Weston, Wirt, Wood, Wyoming); Central West Virginia; Kentucky region.

More than half of respondents reported serving the general population. Among those serving specific age groups, the most served were young adults (22.0%), adults (21.0%), and older adults (19.1%).



*Other responses: Blind or visually impaired; justice-involved population; victims of domestic or sexual violence; pregnant and postpartum people and babies; women; business community; patients with end-stage renal disease; families with hospitalized children.



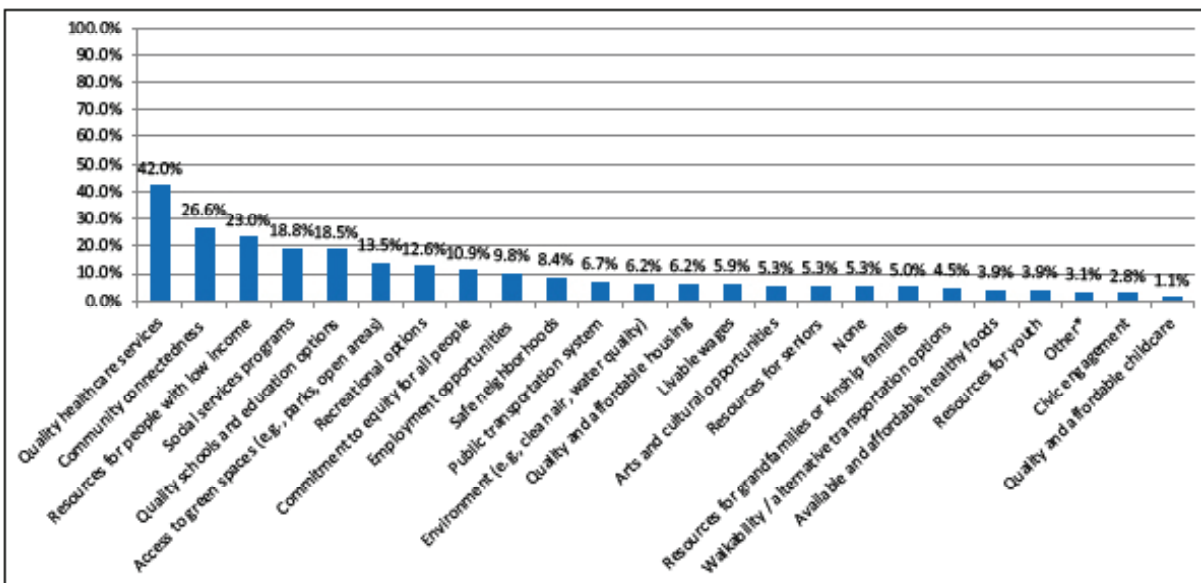
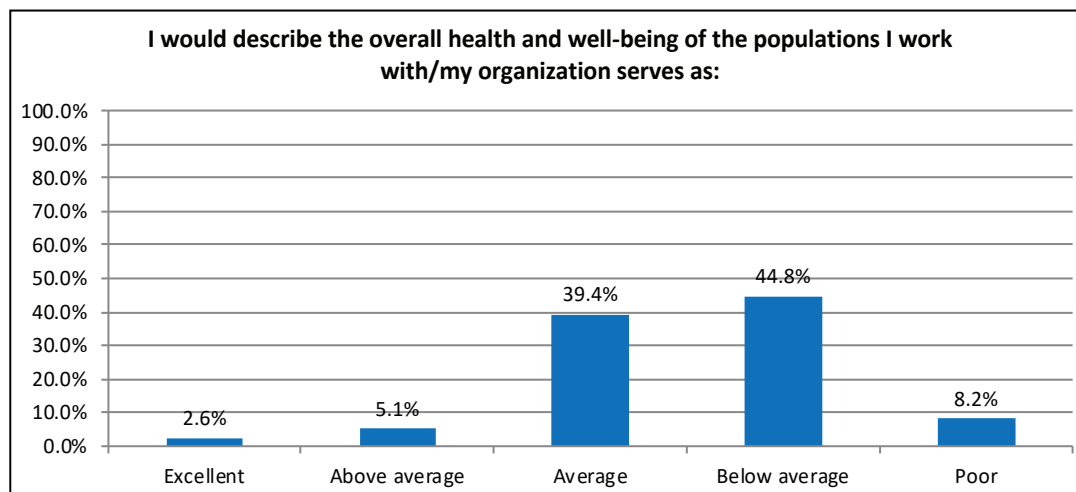
APPENDIX A: KEY INFORMANT SURVEY

Survey Findings

Health and Quality of Life

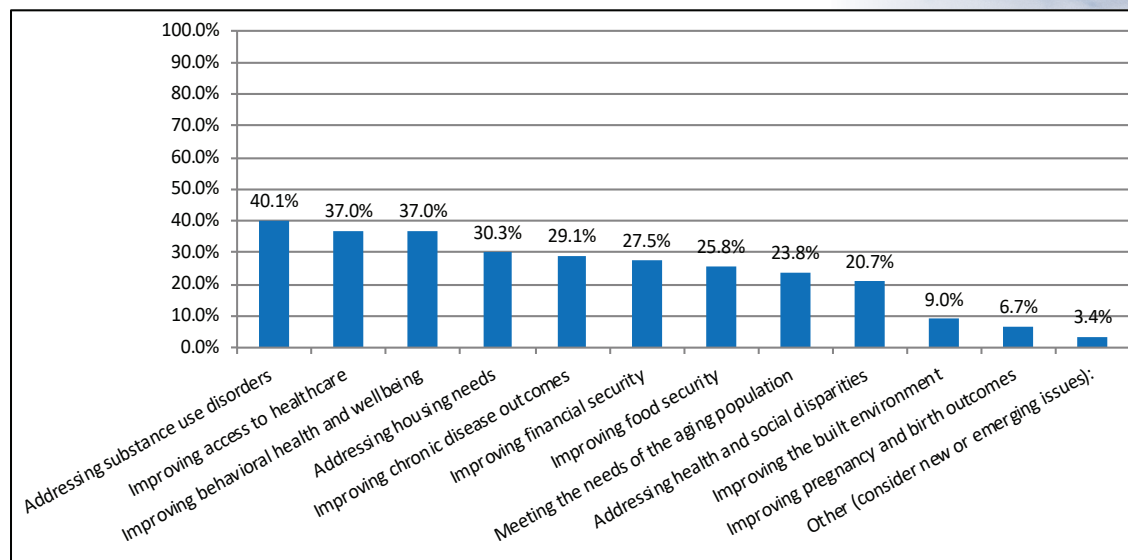
Key informants were asked to assess the overall health and well-being of the populations served by their organizations. Over half (53%) of respondents rated the health of their communities as “below average” or “poor,” while less than 8% described it as “above average” or “excellent.”

Key informants highlighted a range of community resources, services, and programs that could support future health improvement efforts. When asked about the top strengths in the communities they serve, respondents most frequently cited the quality of local health care, strong community connectedness, and the availability of resources for individuals with low income.

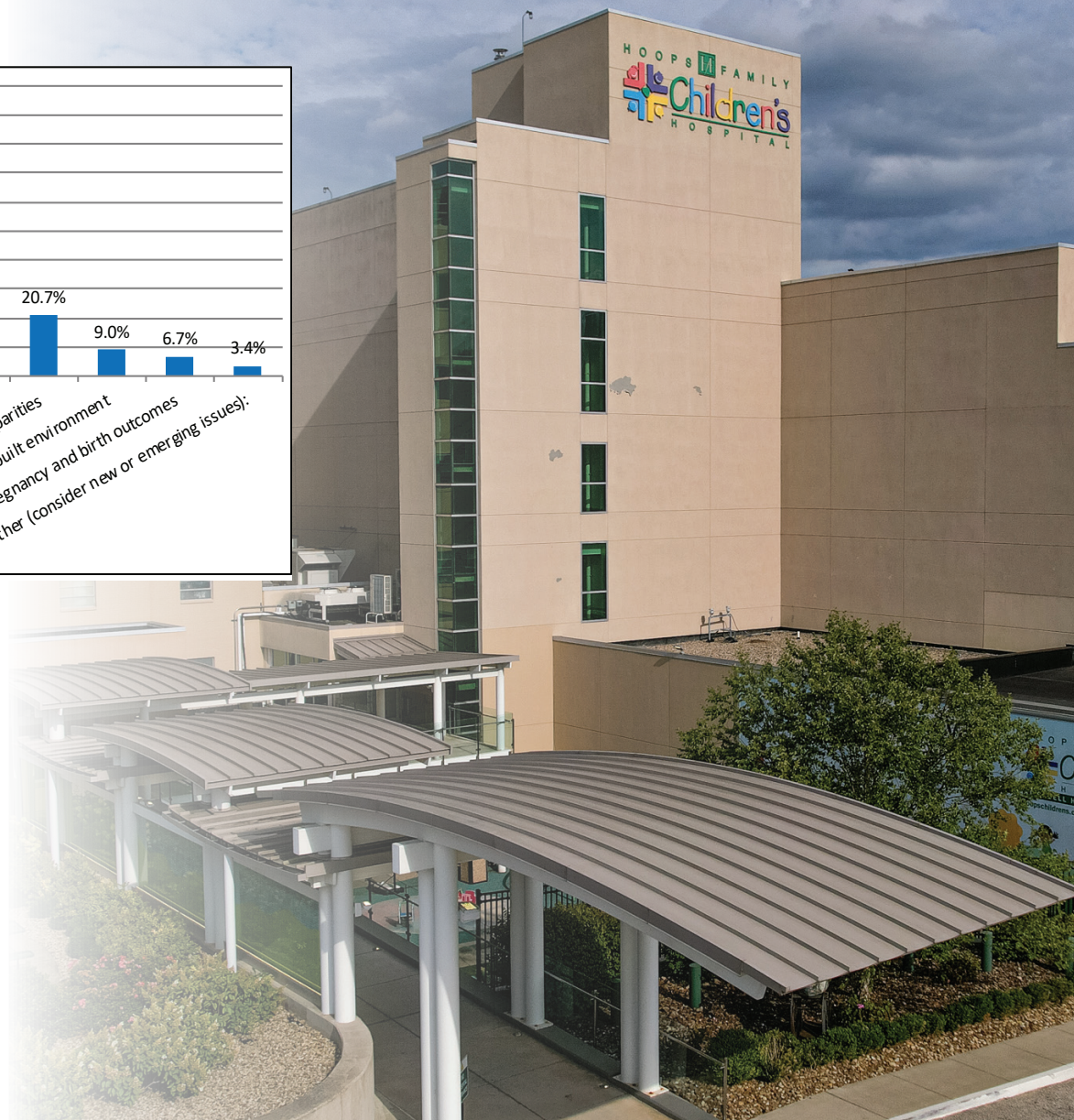


*Other responses: Access and transport to outpatient care; food bank and utility assistance; pregnancy and parenting information; food, shelter, and vetting for unwanted animal population

Key informants identified the top priorities for the coming years, with the most frequently selected concerns being substance use disorders (40.1%), improving access to health care (37%), and enhancing behavioral health and overall well-being (37%).



*Other responses: K-12 education quality; dementia awareness and care; homelessness; access to quality childcare; disease prevention; family literacy



APPENDIX A: KEY INFORMANT SURVEY

Key Informant Survey Comments

Substance use disorder is still prevalent

- “It can be seen daily on the streets the amount of people who are dependent on drugs and those who are looking for support.”
- “This needs more attention - immediately. Many individuals are addicted, and all families could probably name at least two addicts.”
- “This is ALWAYS a HUGE concern in the area, and it seems worse than ever.”

Treatment options are seen as more limited, particularly for inpatient services

- “Changes in reimbursement has made substance use treatment more difficult for those who actually provide good services.”
- “Access to treatment/support is crucial and programs are getting shut down instead of being maintained.”
- “[There is a] need for residential treatment with more advanced and intense programming.”
- “Absolutely not enough inpatient facilities for treatment of SUD.”

Underlying socioeconomic disparities, and disconnected health and social services, affect treatment access and success

- “Large population of active/relapsed users following rehab facility placement, particularly [for those with] no options for transportation back to their hometown following rehab.”
- “We have no place that allows mothers with children to get SUD treatment because they don’t have anyone to watch their children. They have to give up their children to access treatment.”
- “Lack of consistency in services, need to follow them thru whole journey of sobriety.”
- “Mandatory long-term care is needed. Individuals living on the streets who are in active addiction are a danger to themselves and can be to others. We have mental health hygiene laws, and we need to expand this to include substance use disorder. Filing a mental hygiene application, the individual is not required to prepay or have insurance to help them during treatment. People suffering from substance use disorder should not either. It is a disease, primarily brain or mental health. We need some way to help that doesn’t involve the individual being arrested before treatment is mandated.”

Key informants were asked what ideas or recommendations do they have to advance current initiatives or new solutions for addressing substance use disorders.

Behavioral health facilities that command the trust of the health care community

- “A very good accounting of the funds coming into the area from recent legal arbitration and action, especially groups that are posing as residential and treatment facilities. It can be easy for anyone to apply for funding and misuse money for personal gain.”
- “Good rehabs that are not just scamming the system but wanting to make a difference and help people with substance abuse issues.”
- “More accountability of existing programs, wrap around services for program participants, easier access to legitimate medication assisted treatment.”
- “City/County wide town hall meeting to discuss as group- form accountable partnerships, provide services and track outcomes.”
- “Fund county coalitions that provide evidence informed training on substance use. They all exist on shoestring budgets and struggle to meet the demands.”

Holistic care options that address mental health, substance use, and social needs

- “The recovery centers and homes need oversight. SUD treatment is not a cure all, and after care programs are needed desperately. SUD treatment should include education on health, finances, employment, parenting, etc. Detoxing is part of the process, but it can’t be the only part. If people aren’t armed with the mental health, and practical tools / knowledge to be independent they can’t be expected to become thriving members of the community.”
- “Develop a network of providers that will work together to provide a better continuum of care.”

Increase treatment options for substance use disorder

- “Increasing peer support in community and in hospitals.”
- “More treatment options. More access to inpatient acute withdrawal beds.”
- “More providers and SU beds- alternative sentencing to treatment.”
- “Improve reimbursement and increase recruitment of trained facilities.”

Key Informants were asked to share emerging trends or needs that they are seeing in addressing access to health care.

Declining provider availability and increasing wait times

- “Wait times to appointment, provider availability (especially specialists in rural areas) and patient transportation needs [are all problems with large effects in the region].”
- “It is taking many months for people to get appointments - not only for specialists but also for primary care at times. Dental services are scarce for Medicaid recipients. Residents must travel for care.”
- “Multiple aging and retiring physician providers beyond the capability or willingness to replace.”

Health care costs continue to be prohibitive

- “People can’t afford health care even with insurance.”
- “Costs/copays are outrageous, [patients] dictate a lot of their care based on copays.”
- “Elderly will not have the recommend testing due to the cost.”

Need for targeted recruitment and outreach efforts that address rural health care and transportation challenges

- “Continued efforts to recruit providers, including mid-levels, placing specialists in rural areas on different schedules, continued efforts through FHA for transportation.”
- “Increase number of residency spots in specialties with outreach into rural areas during residencies.”
- “Lack of provider availability for kidney transplant in rural areas, vascular access, transportation issues, dialysis facilities closing in rural areas.”
- “Number of physicians per capita especially in rural areas does not serve the needs of the population requiring their services.”
- “Lack of perinatal care/maternity deserts/lack of transportation/lack of access to specialists.”

Key informants were asked what ideas or recommendations do they have to advance current initiatives or new solutions for improving access to health care.

Explore new ways to get people in front of health care providers

- “Expanding on telehealth care and changing or addressing policies regarding mental health.”
- “[Make a plan for] tracking/auditing referrals and follow up from those. Patient centered to be able to do several visits while in town, if they live far away.”
- “Either become more efficient at scheduling, extend hours, or add physicians.”
- “Mobile clinics could bring health care to locations where deserts persist.”
- “Embracing more technology as far as electronic/online scheduling would be a game changer for MHN.”
- “License Certified Professional Midwives, open freestanding birth centers, create a community birth worker network who can do in-home prenatal and postpartum care/support.”

Promote preventative care and screenings over sick care

- “[We need] growth of community-based clinics and screenings to help prevention.”
- “[Install] medical vans that offer bloodwork, chest x-rays, mammograms.”
- “Have a PA or physician at the homeless shelter (mostly the mission) for health care every day.”
- “Continue FQHC expansion.”

Address affordability concerns

- “Improve the range of free services provided.”
- “[Establish] payment plans for deductibles and co-pays.”
- “Would love to see a low-cost generic offered for all medications. If generic cannot be offered, the medication should be offered at generic pricing.”

APPENDIX A: KEY INFORMANT SURVEY

Key Informants were asked to share emerging trends or needs that they are seeing in addressing behavioral health and wellbeing.

Behavioral health issues are prominent without enough community resources to combat growing numbers

- “All behavioral health issues have been on the rise related directly and indirectly to substance use, the pandemic and the current political climate.”
- “There are not enough services available for mental health issues. The ones that are available are expensive.”
- “Expanding access to telehealth for treatment of mental health care would likely help. Improving mental health is key to reducing disability. Transportation is difficult in WV. The increasing development of satellite internet access may aid in expanding this service.”
- “Wait times for someone in crisis is weeks or even months.”

Anxiety and mental health issues are impacting youth populations at a high rate

- “So many teens and young adults with anxiety. Inconsistency with medical management.”
- “Increased anxiety for young adults in college.”
- “As social interaction continues to decrease and is replaced with virtual interaction, depression and anxiety grow. Strong coping skills need to be developed and trained. Key Informants were asked to share emerging trends or needs that they are seeing in addressing chronic disease outcomes.

Incidence of health risk behaviors and related disease is increasing despite efforts

- “Difficulty achieving lifestyle changes in our population that would help reduce the burden of chronic disease.”
- “The poorest continue to smoke and vape.”
- “Most elderly are in poor shape and have not taken care of themselves. The numbers of chronic disease is up.”
- “In spite of best efforts, it seems as though significant progress is slow. Patient compliance seems to be a challenge.”

- “The growing numbers that are impacted by various chronic diseases (due to obesity (food choices/lack of physical activity), behavioral choices (tobacco/alcohol/drug use), etc.”
- “[There is a need for] compliance & education, along with continuity of services amongst all providers.”
- “Need to address lifestyle factors and choices that contribute to poor health outcomes.”

Resources that aid in healthy living are not available and/or affordable

- “Recommended meds for chronic conditions are very expensive, prevention needs to be the focus.”
- “Need more public spaces, access to healthy foods.”
- “Lack of community resources for people to manage their diseases. No places to exercise for free or for pay in rural areas. Lack of education on food choices for chronic disease (dietary only covered for T2DM and Kidney disease). Lack of payers for appropriate treatment options for obesity.”

Promote a community culture of health

- “Advocate for local policy changes to facilitate infrastructure changes (safer walking areas, bike lanes, exercise options for population).”
- “The environment has to support healthy choices. We need more nutrition classes, we need to start caring and teaching parents skills they need to raise healthy eaters, we need to make the healthy choice the easy choice!”
- “Establishment and expansion of programs that incentivize and empower healthy choices like exercise, eating fresh produce, smoking cessation, etc.”

Key Informants were asked to share emerging trends or needs that they are seeing in meeting the needs of the aging population.

Older adults are a growing population with growing needs

- “It is a large population, and we do not have enough providers to meet all of their needs.”

In-home supports for older adults are often dependent on family members that are under resourced or unable to provide these services

- “Elderly with little to no family support for not only health issues, but day-to-day life issues.”
- “Increasingly, children are burdened with care for aging parents with mental impairment.”
- “Lack of affordable adult day care and respite care for those in the sandwich generation taking care of aging parents (especially those with dementia).”
- “Families are desperate for care with aging parents while they are still working and, in many cases, (because of the opioid epidemic and losing a generation of young adults) middle aged families are parenting their grandchildren while working and also caring for their parents (dementia or disabled).”

Traditional senior living and nursing home care is limited; supports for aging in place and alternatives to facility-based care are needed

- “Access to senior living, not in nursing home.”
- “Lack of beds in SNF and assisted living.”
- “Home health care and support for staying in the home is severely lacking. When available, the quality of the workers is low. For most people, it is unaffordable.”

Need for better coordination of aging services to address health and social needs

- “Transportation, aging in place support and in home assistance, food assistance and MOW food boxes.”
- “Late identification of elderly (usually after an acute visit to ER or Hospital) who would’ve benefited from programs i.e., WV Aged and Disabled Waiver.”
- “Aging population is having to make choices between buying food, medications or paying bills.”
- “Lack of transportation to appointments, high cost of medications on limited income, social isolation.”

Key informants were asked what ideas or recommendations do they have to advance current initiatives or new solutions for meeting the needs of the aging population.

Increase social support services to combat isolation

- “Additional opportunities for senior day care.”
- “Not only increasing resources/activities within the community but implementing community transportation for this population as many do not have access to this.”
- “Volunteers (carefully screened!) to check in periodically on community elders who have no one to help.”
- “Have municipalities create opportunities for seniors to be active and celebrate connectivity!”

Integrate services to address health care gaps and support social needs

- “More primary care that has some training in geriatric medicine.”
- “Bridge the pillar established by the Dean with the Geriatric Clinic; we have to create a comprehensive Center of excellence.”
- “Dedicate staff to provide education about what’s available and how to access it.”

Address specific housing needs for the aging population

- “Find ways to allow seniors to age in place, including funding for home modifications and respite care facilities.”
- “Need more modern long term care centers. Assisted living support to allow aging in place. Needs for meals and medicine support.”

Address communication issues

- “Provide services that cater to them - use less technology and more face-to-face.”
- “Improving communications with the aging population and making resource information more readily available.”

APPENDIX A: KEY INFORMANT SURVEY

Key Informant Survey Participants

- AEP Kentucky Power Co - Retired, Senior Engineer
- Alzheimer's Association, Volunteer
- Beckley ARH Hospital, CEO
- Bomar Drop-In Center, Executive Director
- Boyd Co Library, Manager
- Brad Bucklad, Area Director
- Cabell County FRN, Director
- Cabell Family Support Center/HHA, Director
- Cabell Huntington Hospital, EVS Supervisor
- Cabell Huntington Hospital, Nurse Manager
- Cabell Huntington Hospital, Manager
- Cabell Huntington Hospital, Nurse anesthetist
- Cabell Huntington Hospital, MLS/Supervisor
- Cabell Huntington Hospital, Nursing
- Cabell Huntington Hospital, Manager
- Cabell Huntington Hospital, Nurse Manager
- Cabell Huntington Hospital, Manager
- Cabell Huntington Hospital, Admin
- Cabell Huntington Hospital, Leadership
- Cabell Huntington Hospital, Quality Manager
- Cabell Huntington Hospital, Admin
- Cabell Huntington Hospital, Clinical Coordinator
- Cabell Huntington Hospital, Emergency physician
- Cabell Huntington Hospital, Nurse Manager
- Cabell Huntington Hospital, Cabell Huntington Hospital
- Cabell Huntington Hospital, Director/Manager
- Cabell-Huntington Health Department, Director
- Cabell-Huntington Health Department, CEO and Health Officer
- Cabell-Huntington Health Department, Executive Leader
- Carter County Health Department, Nurse Admin
- Catholic Charities, Case Manager
- Chamber of Commerce, Admin
- Children's Home Society of WV, Director
- City of Grayson Emergency Management, Grayson Emergency Management Co-Director
- City of Huntington, RN
- CONTACT of Huntington, Inc, Admin
- CONTACT Rape Crisis Center, Victim Advocate
- David J Patton MD Inc, Nurse Practitioner
- Davis Medical Center, Perinatal Educator
- Department of Human Services, CPS Supervisor
- Ebenezer Medical Outreach, Inc., Executive Director
- FaithHealth Appalachia, Executive Director
- FaithHealth Appalachia, Board member
- FamilyCare, LPN Team Lead
- First United Methodist Church, Huntington, Pastor
- Greater Huntington Parks and Recreation District, Commissioner
- Groups Recover Together, Partnership Development Manager
- Harmony House, CARE/HEART Team Housing Navigator for Special Populations
- Healthy Connections, PRSS
- Highlawn Presbyterian Church, Pastor
- Hospice of Huntington/Tri-State LifeCare, Admin
- Huntington Children's Museum, Executive Director
- Huntington City Mission, Executive Director
- Huntington City Mission, Assistant Executive Director / Director of Operations
- Huntington Internal Medical Group, Physician
- Huntington Internal Medical Group, Physician
- Huntington Internal Medical Group, Physician
- Huntington Internal Medical Group, Physician Operations Manager
- Huntington Internal Medical Group, Nurse Practitioner
- Jersey Mike's Subs, Shift Leader
- Job Hub 180, Director of Support Services
- Jobs & Hope WV, First Responder & Transition Agent
- Kanawha County Schools, Lead Nurse/Health Services Supervisor
- Keith-Albee Performing Arts Center, Director of Development
- Kentucky Christian University, Dean of Nursing & Chief Nurse Administrator
- Kindred Communications, Inc., Business Manager
- Lawrence Co Kentucky, Employee participant
- Lawrence County Health Department, Supervisor
- Lawrence County Health Department, Accreditation and QI
- Lawrence County Health Department, Health Educator
- Lawrence County Health Department, Admin Specialist
- Lawrence County Health Department, Director
- Lawrence County Health Department, Epidemiologist
- Lawrence County Health Department, HANDS Program
- Lawrence County Health Department, RN
- Lawrence County Health Department, Director of Nursing
- Lawrence County Health Department, HANDS Program
- Lawrence County Health Department, Public Health Dental Hygienist
- Lawrence County Public Library, Outreach Coordinator
- Lawrence County Schools, Director of Special Ed and Preschool
- Marshall Family and Community Health, Physician
- Marshall Family Medicine, Physician
- Marshall Health Family Medicine, Resident Physician
- Marshall Health Network, Physician
- Marshall Health Network, Director
- Marshall Health Network, Admin
- Marshall Health Network, Physician
- Marshall Health Network, Provider
- Marshall Health Network, Admin
- Marshall Health Network, Information Systems Analyst
- Marshall Health Network, Nurse Practitioner
- Marshall Health Network, Program Director
- Marshall Health Network, Admin
- Marshall Health Network, Physician
- Marshall Health Network, Physician
- Marshall Health Network, Assistant Professor; Family Physician
- Marshall Health Network, Staff
- Marshall Health Network, Admin
- Marshall Health Network, Patient Financial Services Manger
- Marshall Health Network, Faculty/Clinician
- Marshall Health Network, Director of ECCC Breast Center
- Marshall Health Network, CFO
- Marshall Health Network, VP
- Marshall Health Network, Director
- Marshall Health Network, RN
- Marshall Health Network, Executive Director
- Marshall Health Network, CAO
- Marshall Health Network, CMO
- Marshall Health Network, Finance Manager
- Marshall Health Network, Professor
- Marshall Health Network, Admin
- Marshall Health Network, Provider
- Marshall Health Network, Assistant Prof, Dept. of Pediatrics
- Marshall Health Network, Population Health Operation Coordinator
- Marshall Health Network, Physician



APPENDIX: A: KEY INFORMANT SURVEY

- Marshall Health Network, Admin
- Marshall Health Network, Program Coordinator
- Marshall Health Network, Admin
- Marshall Pediatrics, Dietitian
- Marshall Pediatrics, Physician
- Marshall Plastic Surgery, Assistant professor
- Marshall University, Associate Professor
- Marshall University, Assistant Professor
- Marshall University, Associate Professor
- Marshall University, Marshall University
- Marshall University, Professor
- Marshall University, Employee
- Marshall University, Admin
- Marshall University, Student
- Marshall University, Associate Professor of Medicine
- Marshall University Project DOCC, Grant Coordinator
- Marshall University Research Corp, Associate Director
- Marshall University School of Medicine, Clinical provider
- Mildred Mitchell Bateman Hospital, CEO
- Mingo County Health Department, Administrator
- Morehead State University, Administrator
- Mountwest, President
- Mt Calvary, Pastor
- MU Collegiate Recovery Community, PRSS
- MU Nutrition Education Program, MU Nutrition Education Program Director
- MURC/Center of Excellence for Recovery, Prevention Empowerment Partnership, Director
- Non-Profit Organization, Education
- North Star Anesthesia, Staff
- Ohio University, Admin Assistant
- Pain Management 360, Owner/Physician
- Perinatal Partnership/Marshall Health Network, Physician
- Pretera, EMS Adult Mobile Crisis Worker
- Pretera Health Services, Director of Children Services
- Quality Insights, Project Director
- Quality Insights, Program Director
- Quality Insights, Chief Operating Officer
- Quality Insights, Community Coalitions
- Quality Insights, Program Director
- Radiology, Inc, Physician
- Raleigh General Hospital, CEO
- Ramey-Estep Homes, Re-group, Sr. Director of Integrated Health
- RenewAll, Executive Director
- Right From the Start, DESIGNATED CARE COORDINATOR
- Right From the Start, Regional Care Coordinator
- Rivers Health, HR
- Rivers Health, Supply Chain Director
- Rivers Health, Director
- Rivers Health, Admin
- Rivers Health, Laboratory Technician
- Rivers Health, Admin
- Rivers Health, Director
- Rivers Health, Director of Rural Health Center
- Rivers Health, VP of Nursing & Patient Care Services
- Ronald McDonald House Charities, Development Coordinator
- Ronald McDonald House Charities, Development
- RRSOHO Drug & Alcohol Counseling, Corporate Compliance
- Safe Harbor of Northeast Kentucky Inc, Executive Director
- Salvation Army, Admin
- Salvation Army, Coordinator of Social Services
- Southern Highlands CMHC, Director
- St. Paul Lutheran Church, Pastor
- St. Mary's Medical Center, Admin
- St. Mary's Medical Center, Nursing Staff
- St. Mary's Medical Center, Nurse Practitioner
- St. Mary's Medical Center, Supervisor
- St. Mary's Medical Center, VP Mission Integration
- St. Mary's Medical Center, Registered Nurse
- St. Mary's Medical Center, Supervisor
- St. Mary's Medical Center, Admin
- St. Mary's Medical Center, Trauma Program Manager
- St. Mary's Medical Center, RN
- St. Mary's Medical Center, Clinical Coordinator
- St. Mary's Medical Center, Admin
- St. Mary's Medical Center, Rehab Manager
- St. Mary's Medical Center, Admin
- St. Mary's Medical Center, Outpatient Rehab Supervisor
- St. Mary's Medical Center, RN
- St. Mary's Medical Center - Center for Education, VP School of Nursing and Health Professions
- St. Mary's Medical Center, Behavioral Health Supervisor
- TCC & Debba's Hope 4 Tomorrow, Pastor Emeritus & Ambassador
- TEAM for West Virginia Children, Admin
- The REACH Initiative, Executive Director
- Three Rivers Medical Center, Admin
- Tri-State Chapter 949, Vietnam Veterans of America, President
- TriState Family Connection, Board Member
- Tri-State Literacy Council, Director
- UK King's Daughters, Director Community Health
- University of Charleston, Director of Clinical Education Physician Assistant Program
- University of Charleston, President
- US Dept of Veterans Affairs, Data Analyst
- Valley Health Systems, Executive Vice President/CFO
- Walden University/Adtalem, Senior Core Faculty
- Wayne County Board of Education, School Nurse
- West Virginia Area Health Education Centers, Director
- West Virginia Ministries of the Church of God and Buffalo Church of God, State Executive and Local Pastor
- West Virginia Perinatal Partnership, Deputy Director
- West Virginia Perinatal Partnership, Project Manager
- Williamson Memorial, CEO
- WV Affiliate of the American College of Nurse-Midwives, President
- WV Department of Human Services, Director
- WV Gold Star Mothers, Secretary
- WV Perinatal Partnership, Project Coordinator
- WV Perinatal Partnership, Project Manager
- WVU Medicine, MHT
- WVU Medicine, Case Manager
- WVU Medicine OB/GYN Buckhannon, Physician
- WVU Medicine Reynolds Memorial Hospital, RN- Care Management
- WVU Medicine Summersville Regional Medical Center/ Braxton County Memorial Hospital, Director of Care Management

Community Survey

Background

As part of the 2025 CHNA, MHN contracted with National Research Corporation (NRC) Health to conduct an online survey of patients and community residents to better understand the community's needs around health care access, as well as how it affects respondents personally.

The survey was distributed April 3-10. The survey was available to MHN patients who opted-in to the system's Community Insights survey panel. A total of 695 respondents completed the survey.

The largest proportion of survey respondents were female (66%), White (91%), and age 65+ (61%). Approximately 50% of respondents had attained a bachelor's degree or higher. Respondents resided across MHN service area the largest portion living in and around Cabell County, West Virginia.

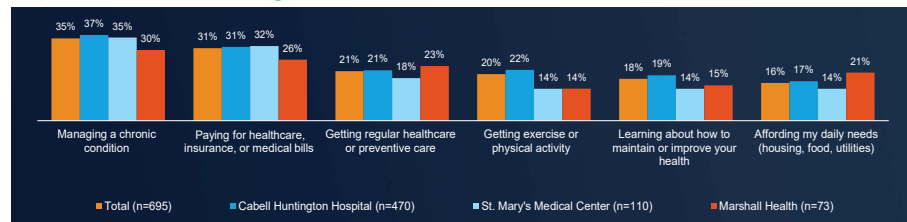
Managing a chronic condition; paying for health care, insurance or medical bills; and getting regular health care or preventative care were the top health and wellbeing concerns (chronic condition: 35%, paying: 31%, regular care: 21%) for respondents. While lack of insurance, too long of wait to get an appointment, and unable to pay copays were seen as top community barriers to seeking health care (insurance: 47%, wait time: 41%, copays: 38%). Diabetes (42%), mental health (39%), and heart disease (37%) were identified to be the top three areas for vital health screenings and education.

Respondents most often described their overall health as "average" (46%) with less than 25% describing their health as either "below average" or "poor". In the past year, respondents more often thought that their physical health and well-being declined (43%) compared to their mental health and well-being (22%).

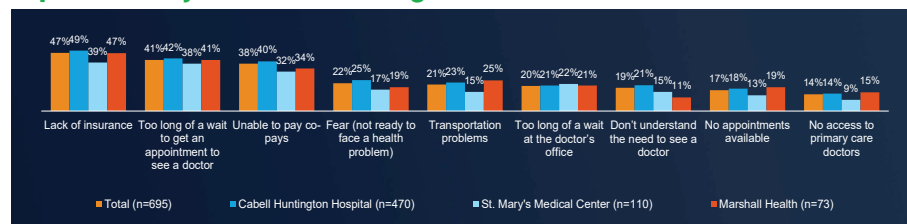
The top three personal barriers to seeking health care included long wait times to get an appointment (31%), wait times too long at the doctor's office (16%), and no appointment availability (16%). On average, 32% of patients said they could not get the health care they needed. Dental (34%) and primary care (33%) were the top health care services respondents delayed receiving in the past 12 months. Less than 10% of respondents went to the hospital for non-emergency care because they did not have another place to go for medical care.

Key Takeaways

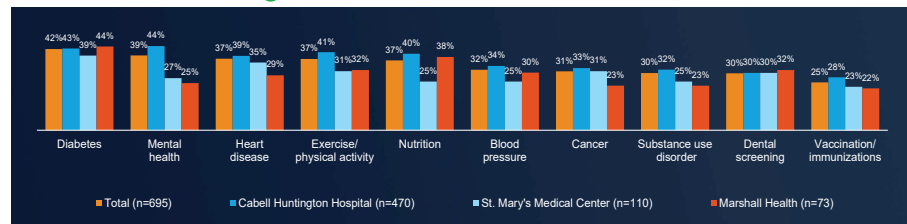
Top Health & Wellbeing Concerns



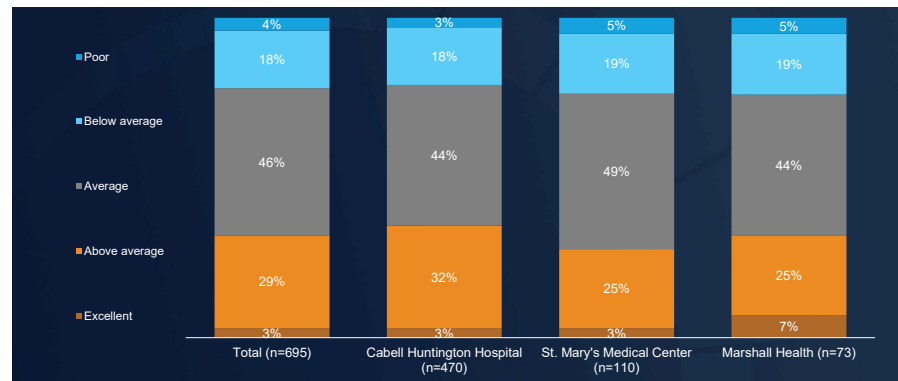
Top community barriers to seeking health care



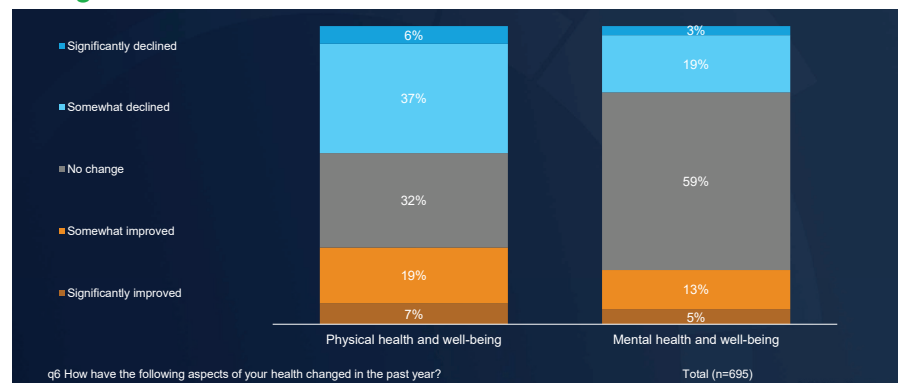
Vital Health Screenings & Education



Overall Health

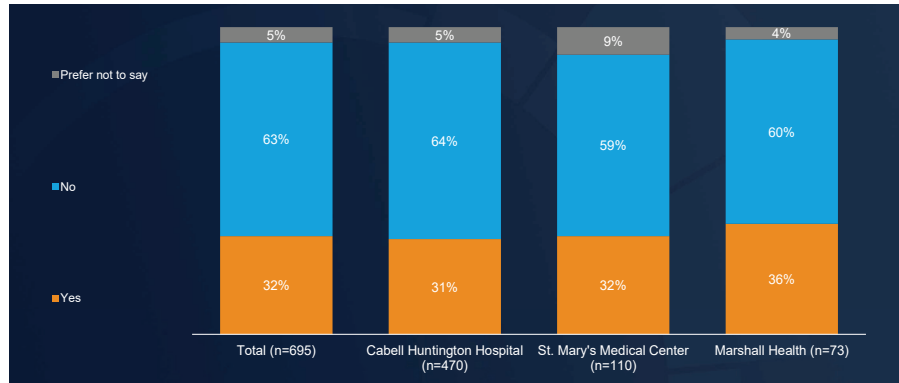


Change in Health Status

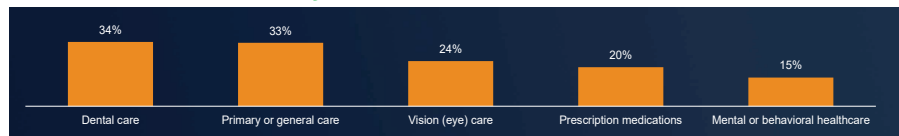


APPENDIX B: COMMUNITY SURVEY

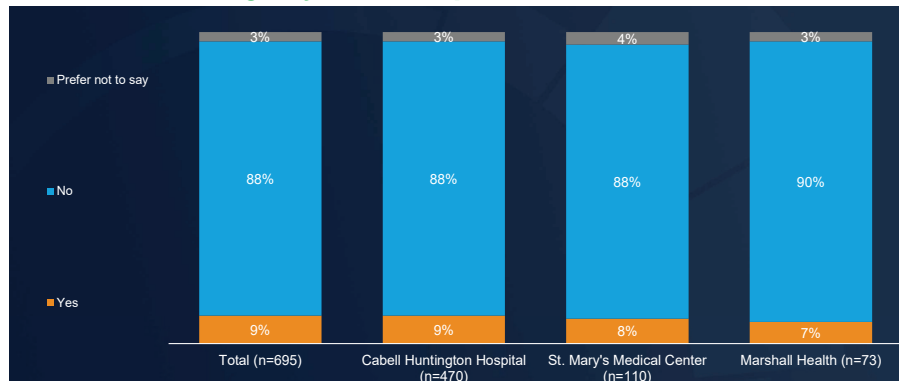
Delayed Seeking Health care



Health care Services Delayed



Received Non-emergency care at hospital



Community Survey Results *continued*

Respondents were asked to describe what changes they would like to see in their community that will help them and their families live healthier lives.

Select verbatim comments are included below.

- Access to Health care when you need it, not months away for appointments or surgery.
- Access to more timely specialty care.
- Better nutrition guidance in general
- Ability to get an appointment quicker for physicians and providers
- Additional organized/well publicized community wellness opportunities. (Group walks, fun children's exercise events etc.)
- Better access to emergency care. Waiting times are to long and critically ill should be seen as quickly as possible.
- Better access to family doctors, preventative care, prescription cost lowered, better health insurance, etc
- Better access to health care. More providers. Sooner appointments. Less wait time for appointments.



Focus Groups

Background

As part of the 2025 CHNA, listening sessions and partner forums were conducted with residents and health and social service partners representing communities across Marshall Health Networks service area. The objectives of the focus groups were to explore individual experiences and perceptions of social determinants of health and identify opportunities to advance collaborate initiatives with partners and foster new relationships to address health and social needs.

Focus Group and listening sessions Locations and Attendees

- April 21, St. Mary's Center for Education, Partner Forum, Community Leaders
- April 21, St. Mary's Center for Education, listening sessions, Community Members
- April 22, St. Mary's Center for Education, listening sessions, Community Partners
- April 22, St. Mary's Center for Education, listening sessions, Community Partners
- April 23, Rivers Health Wellness Center, Partner Forum, Community Leaders

The following is a summary of key discussion takeaways grouped by overarching community concerns and insights MHN will share with community partners. The community's feedback reflects community insights, not MHN-specific insights. These are actions that they community partners and residents can consider taking to improve health and well-being.

Community Priorities

1. Existing Priorities from 2022 CHNA

- a. Agreement that they are still the community's priorities
- b. Opportunity to reframe how they are communicated; "These are not needs, these are needs we need to solve"

2. Priority Considerations for 2025 CHNA

- a. Recommendation to add priorities and/or strategies to address Access to Care, Economic Opportunity, Housing, Technology and Innovation, and Youth Health

Community Successes

1. Commitment to Partnership and Multi-Sector Approach

- a. New low-barrier shelter planned for Huntington to provide emergency shelter and holistic wrap-around supports
 - i. Partnership among the City of Huntington, Cabell-Huntington Health Department, Harmony House, Marshall Health Network, Prestera Health Services, and Valley Health Systems

- b. Marshall Health Network psychiatric residency program expansion to Rivers Health with goal of improving rural access to behavioral health services
- c. New Nucor Steel plant in Mason County bringing jobs and holistic health approach for employees (health and safety team, onsite primary care, behavioral health hotline, etc.)

2. Legislative Changes to Improve Health and Health care Access

- a. New allowance for adult day care centers to bill Medicaid has promoted more development of centers
- b. New statewide dementia coordinator to help with local allocation of funding, resources
- c. Requirement for pharmacies to provide most affordable brand of medication
- d. Local county school boards oversight to prohibit the use of cell phones in class

3. Declining Overdoses and Related Deaths

- a. Multi-year, multi-sector community initiatives are having a positive impact on the number of overdoses and related deaths; Huntington EMS calls for overdose are down from over 30 per day to 5 or fewer per day
- b. Success factors include community education and Narcan distribution
- c. Concern that these successes are not reflected in the data

Access to Care

1. Emerging Needs and Concerns

- a. Provider burn out
- b. Need for rural access strategy to address provider shortages and barriers to traveling to
- c. EMS shortages (national issue)
- d. Longer wait times for specialty care; "We do pretty well with primary care, but specialty care can takes about four months for an appointment. People just give up."

2. Opportunities and New Solutions

- a. Primary care models that allow for longer appointment times and coordination of care and services for medically complex patients
- b. Community Health Workers and similar care navigator programs

- c. Transportation services between rural communities and health care hubs
- d. More urgent care centers in rural communities
- e. More education for communities with new urgent care services to better understand the right place to access care (urgent care vs. emergency department vs. primary care)

Older Adults

1. Emerging Needs and Concerns

- a. Need for caregiver support; “There’s a significant portion of the of the population leaving their jobs to provide care for older adults because of lack of community resources”
- b. Growing population with Alzheimer’s disease and other dementias; 39,000 people in West Virginia are estimated to live with Alzheimer’s disease, and the number is likely underreported due to lack of provider access for accurate diagnosis
- c. More grandparents raising grandkids without the physical or financial means to adequately do so
- d. Uninsured and underinsured residents delay accessing health care until they qualify for Medicare, but their health concerns and other factors that contribute to the region’s overall lower average life expectancy start at a much younger age

2. Opportunities and New Solutions

- a. Explore national models for community-based older adult health and social services
 - i. Project Horseshoe Farm in Alabama: Programs including “Health Partners” and “Community Centers” to create places of belonging and extend one-on-one relational and community support to seniors, adults living with mental illness, and other vulnerable or isolated individuals

Social Drivers of Health

1. Emerging Needs and Concerns

- a. Ongoing challenge to provide accessible and affordable healthy foods to underserved residents; “We’re fighting to get fresh foods to our community”
- b. Need for economic development that creates living wage opportunities; “There’s a difference between minimum wage and living wage. For many, there’s no difference between having a job with a minimum wage and no job at all.”
- c. The number of unhoused people is growing and underreported (couch surfing)

Mental Health and Substance Use Disorder

1. Emerging Needs and Concerns

- a. More demand for mental health services as fall out from the opioid epidemic, COVID-19 pandemic experience, and more recent financial stress
- b. Some youth demand driven by greater willingness to talk about mental health and ask for help than prior generations; however, youth suicide rates are higher for West Virginia and serve as an indicator of overall trauma
 - i. Perception that an entire generation of youth has experienced significant trauma, particularly from the opioid epidemic
- c. Need to address substance use and treatment within prison systems
 - i. Substance use: “A client told me it’s easier to get drugs inside than on the street”
 - ii. Substance treatment: Community perception that new state-mandated Suboxone treatment for people with opioid use disorder may be overprescribed and underregulated based on inmates’ actual addiction needs

2. Opportunities and New Solutions

- a. Explore more coordinated reentry supports for people transitioning from the prison system to community, including job and life skills training, education, and therapy

Focus Group Common Themes

- 1. Community collaboration and partnership** continue to be recognized as the driving success factors for health improvement. This approach is increasingly important as health and human service agencies reach a critical point in responding to the needs of the community, operating in a new environment that includes rising economic and health challenges for individuals, increased demand for their services, and federal funding cuts to their programming.
- 2. Community leader advocacy and program evaluation support** health and human service agencies need to demonstrate and communicate their positive impact. While some agencies are doing this work, many don’t have the resources or political clout to do it consistently or effectively.
- 3. Economic development that includes living wage jobs** is central to the community’s future success. A significant proportion of the community’s population is ALICE (asset limited income constrained employed) or working poor, and the area has seen an out-migration of young people seeking better employment opportunities.
- 4. Social connections and sense of community** declined in post-pandemic years, contributing to rising mental distress among residents and an isolation epidemic. Some participants recommended small, grassroots efforts like community centers and joint programming among churches to help build community connections. Others advocated for more youth programming that engages the entire family unit.

APPENDIX C: PARTNER FORUM AND FOCUS GROUPS

5. **Investment in the community's youth** was seen as a critical long-term strategy. Participants recommended engagement activities, particularly mentorship, to address experiences of trauma, develop future orientation, and build resiliency and coping skills.
6. **People in recovery** comprise a significant part of the community fabric and continue to be stigmatized and misunderstood by residents, leaders, and employers alike. Efforts are needed to create opportunities for people in recovery to share their story and lived experience and demonstrate their commitment to the community and employment.
7. **The older adult population** is growing across the region and more resources are needed to adequately serve them. Participants identified a deficit of health care for people with dementia, in-home care, geriatric medicine, social support (e.g., transportation, home modifications), and social workers to facilitate discharges and follow-up care and instructions. Additional support is also needed to assist grand parents raising grandchildren.
8. **better unite agencies for strategic collaboration** the overarching recommendation for MHN from health and human service agencies was to leverage its community investments. Recommendations included new funding models that foster collective impact, investing existing resources to build capacity, and allowance for funding of administrative needs.

Discussion Session Summaries: Consumer Listening Session Community Successes

Participants were long-time residents of the area, 21-71 years. When asked what they love about their community, they cited the small-town feel, close-knit families, and Appalachian culture.

- *"The people that live here are extremely friend people, good hearted and compassionate."*
- *"It's the Appalachian culture. There are people who have lived here a long time. You own your home, live with your family."*

Participants were aware of the community's efforts to improve health and well-being and identified several success factors, including declining smoking prevalence, more community 5Ks and other activities, good health care, and community redevelopment. Participants shared recent initiatives to make Hal Greer Blvd walkable and bikeable and the Paul Ambrose Trail for Health.

- *"There is an effort here to change health."*
- *"For the most part, you can get needed care. Most things are offered here and with a good level of care. We have a good level of expertise for being such a small town."*

Community Challenges

Participants generally felt that more work to improve community health is needed. When asked what made their community unhealthy, they cited the high prevalence of chronic disease, lack of healthy food options, and safety concerns. Related to safety, one participant stated the Hal Greer Blvd improvements were underutilized because residents don't feel safe walking through the connected neighborhoods.

- *"We're one of the top states for obesity and diabetes."*
- *"We need a push for wellness through food, through restaurants and grocery stores, and not putting Family Dollar stores in low-income neighborhoods, where the only thing they can get is a Ding Dong."*
- *"There is no grocery store in the Fairfield neighborhood and it's a low-income area. They can't get good food. Wouldn't it be great if there was a farmer's market?"*
- *"A lot of communities that Hal Greer goes through you wouldn't want to walk through. It's the entrance to the city so they wanted it to look nicer, but I still don't see people walking there."*

The effects of the opioid epidemic were seen as a top contributor to safety concerns, as well as other health issues, including grandparents raising grandkids and a growing unhoused population. Participants were concerned that the success of opioid use disorder prevention and treatment efforts were being overstated to make the community look better.

- *"A lot of my patients are older, and their kids have either died from [the opioid epidemic] or are still using and are dysfunctional. Many are raising their grandchildren, which is a huge drain for them financially, physically, and emotionally."*
- *"We've heard that overdoses are being reported as heart attacks to make the data look better. True or not, it's what the community hears."*
- *"Huntington has the largest number of sober living houses in the state. I think we have into the 90s; I think I have four in my neighborhood. It has been a struggle to regulate them."*

Participants identified underlying economic concerns that challenge health improvement efforts. Specifically, the loss of manufacturing and coal mining has led to a decline in living wage jobs and an out-migration of young people seeking employment opportunities. Participants were also concerned with the City of Huntington's assessment of standard user fees for all workers regardless of their income.

- *"There are a lot of people having to figure out new work and new jobs."*
- *"People went from good blue-collar jobs to minimum wage jobs, which has decimated the tax base."*
- *"When manufacturing left, young people also left. If you're not doing healthcare or teaching, there's not much here."*
- *"The City instituted a user fee for all workers, and it's the same for all workers regardless of what they make."*

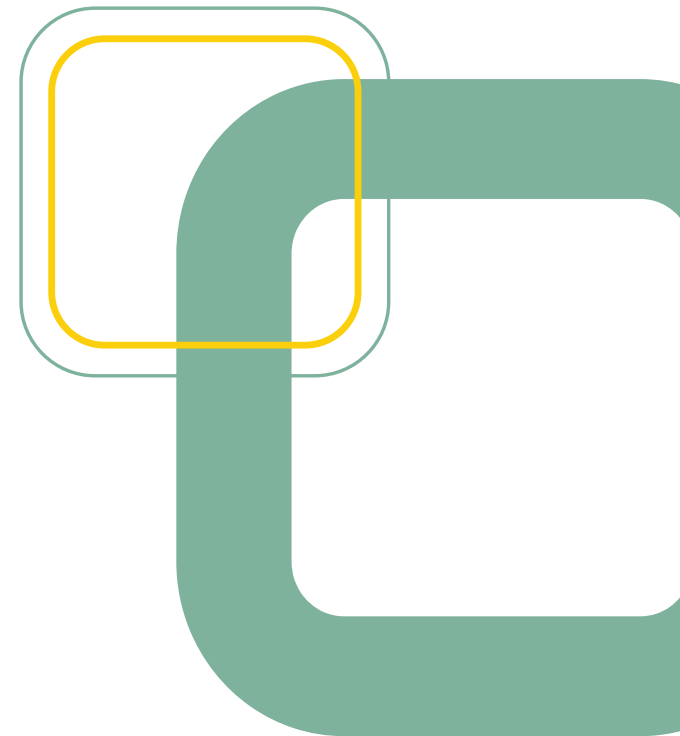
Community Opportunities

When asked what resources are missing in the community that would help residents improve their health, participants largely identified services for older adults, including in-home care, geriatric medicine, transportation assistance, technology support for telehealth, and grandfamily support. The community no longer has a physician group providing in-home care and a geriatric physician just retired. More services like Faith in Action, that help with transportation, shopping, and small chores, and more coordinated support for grandfamilies through the state senior services department, are needed.

- *"I have a lot of patients with end stage disease that would benefit from primary care that does in-home visits. It's a mobility issue for a lot of patients, being able to get to the doctor."*
- *"Geriatric physicians are ideal for medication management and assessing in-home needs. When you get to 70 years old, you're on a medication list this long."*
- *"As people get older, they either can't or won't drive, and they don't want to get on a bus. People rely on their family to get them to their appointments, and those family members work."*
- *"Many [older adults] don't have a smart phone or don't know how to use it. They're using their kids to help."*
- *"Grandfamilies are trying to live on their social security and raise a kid. I don't think they qualify for other services. I don't think the community knows how to rally around them. It's part of the Appalachian mentality that we take care of our own."*

Participants also saw an opportunity to increase community connection and socialization to improve older adult health. One participant shared an example of a community center in their neighborhood that offers low price exercise classes and community talks, suggesting that these smaller centers may be more approachable for older adults raised in an Appalachian culture. Participants also shared that newspapers are still a source of information for older adults and an opportunity to connect with them.

- *"[My community center] is a neat little way for me to meet people in my community and do things that I like to do."*
- *"There's a community resource book that lists providers, but it doesn't include social opportunities."*
- *"Newspapers have lessened in every community but there is still a following here. We still have people who watch the news, listen to the news, read print. All of those are still viable here."*



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