



20 AdventHealth 22 Central Texas

Community Health Needs Assessment

Extending the Healing
Ministry of Christ

Table of Contents

Introduction	3
Letter From Leadership	3
Executive Summary	4
About AdventHealth	6
Community Overview.....	8
Community Description	9
Community Profile	9
Process, Methods and Findings	16
Process and Methods.....	17
Community Input	17
Public and Community Health Experts Consulted	18
Secondary Data	19
The Findings.....	20
Priorities Selection	24
Prioritization Process.....	25
Available Community Resources.....	28
Priorities Addressed	30
Priorities Not Addressed	32
Community Health Plan.....	34
Next Steps	35
2020 Community Health Plan Review.....	36
2019 Community Health Needs Assessment Comments.....	38



Letter From Leadership

At AdventHealth, our mission of Extending the Healing Ministry of Christ goes beyond our walls. We are committed to addressing the needs of the communities we serve with a holistic focus – one that strives to heal and restore the body, mind and spirit.

Every three years, AdventHealth hospitals complete a Community Health Needs Assessment. We collaborate with community organizations, public health experts and people like you: those who understand our communities best. This in-depth look at the overall health of the community as well as barriers to care helps us better understand each area’s unique needs, so we can address the issues that matter most.

AdventHealth is blessed to serve communities across the United States. In big cities and small towns, our promise of wholeness is constant. We believe all people deserve to feel whole, and we are committed to meeting them wherever they are on that journey and supporting them along the way.

Work of this magnitude is not possible without the incredible partnership of public health experts, community health organizations and countless community members. It is through open dialogue and constant collaboration with these key partners that AdventHealth will bring wholeness to all communities we serve.

In His Service,

Terry Shaw
President and CEO
AdventHealth



Executive Summary

AdventHealth Central Texas and AdventHealth Rollins Brook conducted their CHNA jointly. The Hospitals have a shared service area and historically partner in their initiatives. This ongoing collaboration has allowed the Hospitals' shared service area to benefit from an alignment of resources between the two facilities and created a strategic approach to maximizing and improving outcomes.

Metroplex Adventist Hospital, Inc. d/b/a AdventHealth Central Texas and AdventHealth Rollins Brook will be referred to in this document as AdventHealth Central Texas and Advent Health Rollins Brook or "the Hospitals". The Hospitals conducted a community health needs assessment from August 2021 to June 2022. The goals of the assessment were to:

- Engage public health and community stakeholders including low-income, minority and other underserved populations.
- Assess and understand the community's health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Publish the Community Health Needs Assessment.
- Use assessment findings to develop and implement a 2023-2025 Community Health Plan based on the needs prioritized in the assessment process.

Community Health Needs Assessment Committee

In order to ensure broad community input, AdventHealth Central Texas and AdventHealth Rollins Brook created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospitals through the assessment process. The CHNAC included representation from the Hospitals, public health experts and the broad community. This

included intentional representation from low-income, minority and other underserved populations.

The CHNAC met four times in 2021 - 2022. They reviewed the primary and secondary data and helped to identify the top priority needs in the community.

See the *Prioritization Process* section for a list of CHNAC members.

Hospital Health Needs Assessment Committee

AdventHealth Central Texas and AdventHealth Rollins Brook also convened a Hospital Health Needs Assessment Committee (HHNAC). The purpose of the HHNAC was to select the needs the Hospitals would address as a result of the findings in the assessment. The HHNAC made this decision by reviewing the priority needs selected by the CHNAC and the internal Hospital resources available. With this information the HHNAC was able to determine where the Hospitals could most effectively support the community.

See the *Prioritization Process* section for a list of HHNAC members.

Data

AdventHealth Central Texas and AdventHealth Rollins Brook in collaboration with the AdventHealth Corporate team collected both primary and secondary data. The primary data included community and stakeholder surveys. Secondary data included internal Hospital utilization data (inpatient, outpatient and emergency department). This utilization data showed the top diagnoses for visits to the Hospitals from 2019-2021. In addition, publicly available data was utilized from state and national data sources. Primary and secondary data was compiled and analyzed to identify the top 12 aggregate issues. See the *Process and Methods* section for *Primary and Secondary Data Sources*.

Community Asset Inventory

The next step was to create a Community Asset Inventory. This inventory was designed to help the CHNAC and the HHNAC understand existing community efforts to address the 12 identified issues from aggregate primary and secondary data and to prevent duplication of efforts.

See *Available Community Resources* for more.

Selection Criteria

The CHNAC and HHNAC participated in a prioritization process after data review and discussion through which the needs were ranked based on established criteria.

See the *Priorities Selection* for more.



The CHNAC and the HHNAC also considered four factors during prioritization:

A. Alignment: Does this issue align with our mission, strategy, public-health or community goals?

B. Impact on Community: What is the scope, size and seriousness of this issue? What are the consequences to the health of the community of not addressing this issue now?

C. Resources: Are there existing, effective interventions and opportunities to partner with the community to address this issue?

D. Outcome Opportunities: Can an impact on this issue be made in a demonstrable way, and will interventions have an impact on other health and social issues in the community?



Priority Issues to be Addressed

The priority issues to be addressed are:

1. Nutrition / Healthy Eating
2. Mental Health
3. Preventative Health / Screenings

See *Priorities Selection* for more.

Approval

On December 14, 2022, the AdventHealth Central Texas and AdventHealth Rollins Brook Board approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2022 Community Health Needs Assessment was posted on the Hospitals' website prior to December 31, 2022.

Next Steps

AdventHealth Central Texas and AdventHealth Rollins Brook will work with the CHNAC to develop a measurable implementation strategy called the 2023-2025 Community Health Plan to address the priority issues. The plan will be completed and posted on the Hospital's website prior to May 15, 2023.

About AdventHealth

AdventHealth Central Texas and AdventHealth Rollins Brook are part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care. More than 80,000 skilled and compassionate caregivers serve 4.7 million patients annually. From physician practices, hospitals, outpatient clinics, skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, holistic care at nearly 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in research, new technologies and the people behind them to redefine medicine and create healthier communities.

In a 2020 study by Stanford University, physicians and researchers from AdventHealth were featured in the ranking of the world's top 2% of scientists. These critical thinkers are changing medicine and shaping the future of health care.

Amwell, a national telehealth leader, named AdventHealth the winner of its Innovation Integration Award. This telemedicine accreditation recognizes organizations that have identified connection points within digital health care to improve clinical outcomes and user experiences. AdventHealth was recognized for its innovative digital front door strategy, which is making it possible for patients to seamlessly navigate their health care journey. From checking health documentations and paying a bill, to conducting a virtual urgent care visit with a provider, we are making health care easier by creating pathways to wholistic care no matter where your health journey starts.

AdventHealth is also an award-winning workplace aiming to promote personal, professional and spiritual growth with its workplace culture, having been recognized by Becker's Hospital Review on its "150 Top Places to Work in Healthcare" three years straight. This recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth.

AdventHealth Central Texas

AdventHealth Central Texas is committing time, talent and financial support to illness prevention and healthful living. As the primary health care provider for West Bell, Coryell and Lampasas counties, AdventHealth Central Texas serves more than 125,000 patients per year, with more than 300 physicians offering 43 medical specialties and a variety of wellness services. AdventHealth Central Texas, a 207-bed hospital, offers many services including: a 24-hour emergency center, behavioral health care, digestive care, heart and vascular care, imaging services, lab services, men's care, mother and baby care, orthopedic care, senior care and sleep care. In September of 2019, AdventHealth acquired two new rural family medicine clinics in Copperas Cove and Lampasas. AdventHealth medical group now has 14 primary care providers and 8 specialty providers. Along with the medical group, AdventHealth has a strong partnership with Baylor Scott & White Health, providing many of the inpatient providers and a specialty care clinic on the Hospital campus.





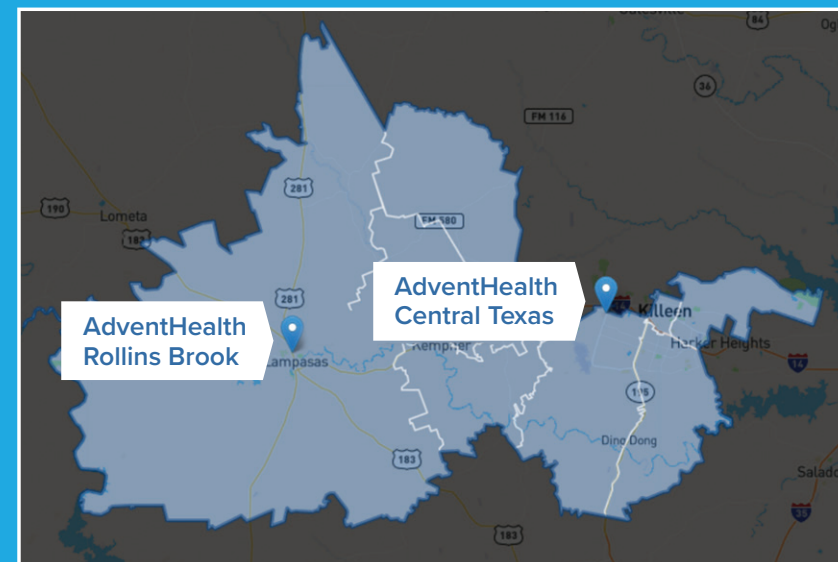
COMMUNITY OVERVIEW

Community Description

AdventHealth Central Texas is located in Bell County, Texas and AdventHealth Rollins Brook is located in Lampasas County, Texas. The Hospitals define their community as the Primary Service Area (PSA), the area in which 75-80% of its patient population lives. This includes seven zip codes across four counties; Lampasas, Bell, Coryell and Burnet.

According to the 2020 Census, the population in the Hospitals' Primary Service Area has grown 18.9% in the last ten years to 222,620 people. This is more than twice the amount of growth in the United States since the last Census.

Demographic and community profile data in this report are from publicly available data sources such as the US Census Bureau and the Center for Disease Control and Prevention, unless indicated otherwise. Data are reported for the Hospitals' shared PSA, also referred to as the community, unless listed for a specific county. Data are also provided to show how the community compares locally, in the state and at a national level for some indicators.



Community Profile

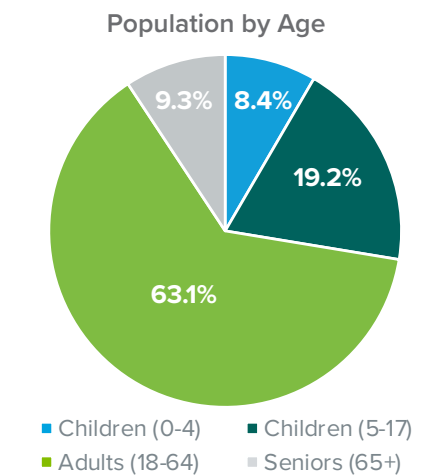
Age and Sex

The median age in the Hospitals' community is 31.7, lower than that of state which is 34.8 and the US, 38.2.

Females are the majority, representing 50.5% of the population. Young adult men, ages 18 -39 are the largest demographic in the community at 17.4%. Young adult women are second at 17%.

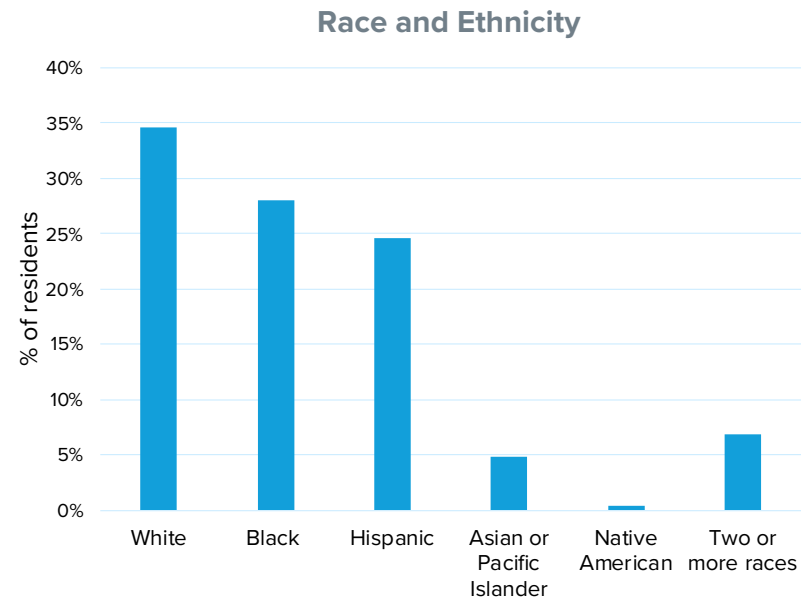
Children are 27.6% of the total population in the community. Infants, those zero to four, are 8.4% of that number. The community birth rate is 73.6 births per 1,000 women aged 15-50, this is higher than the US average of 51.9 and than that of the state, 56. In the Hospitals' community, 22% of children aged 0-4 and 17.1% of children aged 5-17 live in poverty.

Seniors, those 65 and older, represent 9.3% of the total population in the community. Females are 56.4% of the total senior population.



Race and Ethnicity

In the Hospitals' community, 34.6% of the residents are non-Hispanic white, 28% are non-Hispanic Black and 24.6% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent 4.8% of the total population, while .4% are Native American and 6.8% are two or more races.



Social Determinants of Health

According to the CDC, social determinants of health (SDOH) are the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. Social determinants of health are increasingly seen as the largest contributing factor to health inequities in communities throughout the country.

The Hospital categorized and analyzed SDOH data following the Healthy People 2030 model. This approach was chosen so, when possible, the Hospital could align its work with national efforts when addressing social determinants of health. For the purposes of the CHNA the Hospital will follow this model for reporting any related data.

The Healthy People 2030 place-based framework outlines five areas of SDOH:



Economic Stability: This includes areas such as income, cost of living, food security and housing stability.



Education Access and Quality: This focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.



Health Care Access and Quality: This includes topics such as access to health care, access to primary care and health insurance coverage.



Neighborhood and Built Environment: This includes areas for example like quality of housing, access to transportation, availability of healthy foods and neighborhood crime and violence.

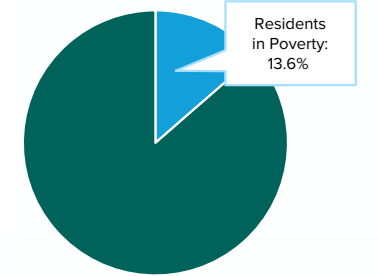


Social and Community Context: This focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Economic Stability

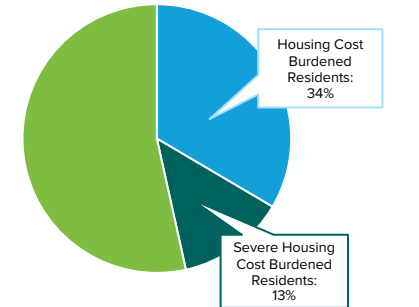
Income

The median household income in the Hospitals' community is \$56,882. This is below the median for both the state and the US. In the community, 13.6% of residents live in poverty, this is higher than the poverty rate of the US, 12.8%.



Food Insecurity and Housing Stability

People who are food insecure, having reduced quality and/or amount of food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.¹ Feeding America estimates for 2020², showed the food insecurity rate in the Hospital's community as 17.2%.



Increased evidence is showing a connection between stable and affordable housing and health.³ When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more than 50%.

¹ Food Insecurity - Healthy People 2030 | health.gov

² Map the Meal Gap 2020 Combined Modules.pdf (feedingamerica.org)

³ Severe housing cost burden* | County Health Rankings & Roadmaps



Education Access and Quality

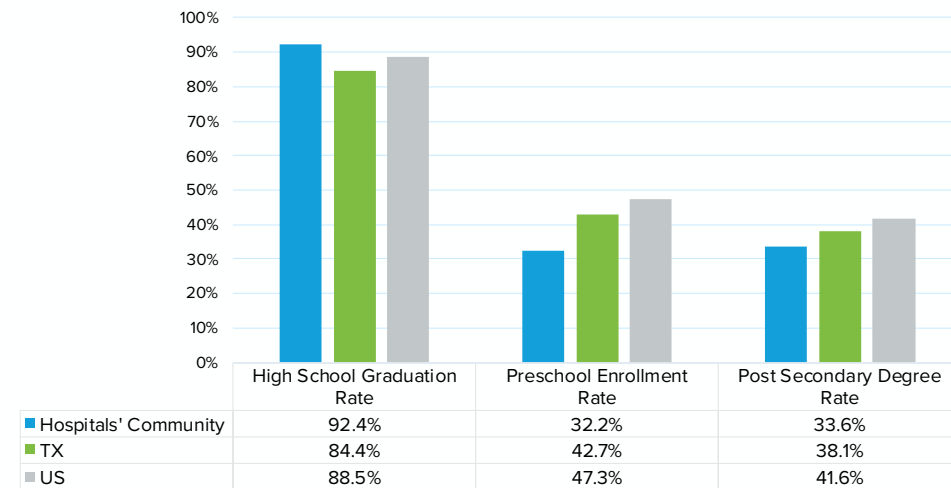
Research shows education can be a predictor of health outcomes, as well as a path to address inequality in communities.⁴ Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital's community, there is a 92.4% high school graduation rate, which is higher than both the state and national rate. The rate of people with a post-secondary degree is 33.6%, which is lower than in both the state and nation.

Early childhood education is uniquely important and can improve the cognitive and social development of children. This helps provide the foundation for long term academic success, as well as improved health outcomes. Research on early childhood education programs shows that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.⁵

In the Hospitals' community, 32.2% of 3–4-year-olds were enrolled in preschool. This is lower than both the state (42.7%) and the national (47.3%) average, which leaves a large percentage of children in the community who may not be receiving these early foundational learnings.

Educational Attainment



⁴ The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015 | Archives of Public Health | Full Text (biomedcentral.com)

⁵ Early Childhood Education! Health Impact in 5 Years | Health System Transformation | AD for Policy | CDC

Health Care Access and Quality

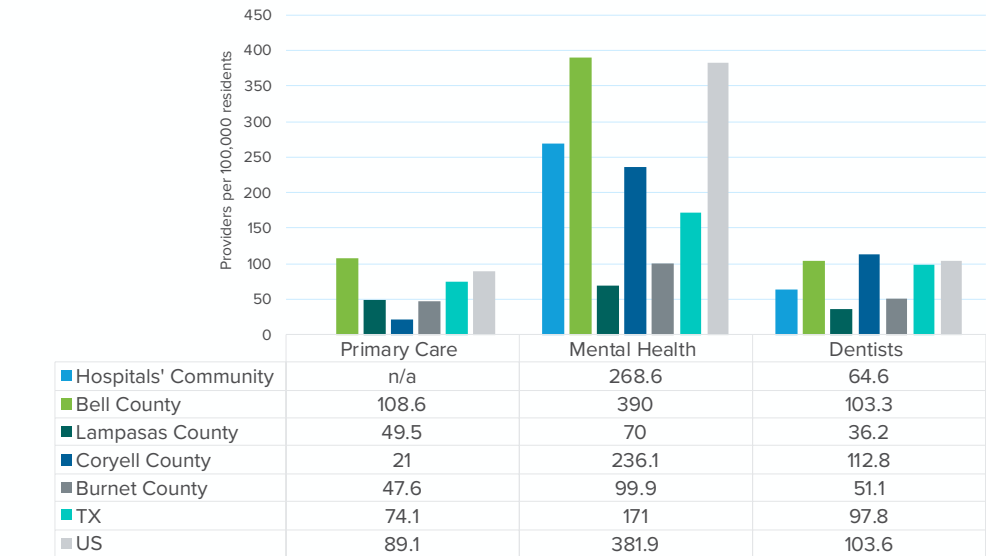
In 2020, 13.3% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.⁶

Accessing health care requires more than just insurance, there also needs to be available health care professionals to provide care. When more providers are available in a community access can be easier, particularly for those experiencing transportation challenges. In the counties that the Hospitals serve, Bell County has the most primary care providers available, higher than the state average.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospitals' community, 72.7% of people report visiting their doctor for routine primary care.

⁶ Health Insurance and Access to Care (cdc.gov)

Providers Per Capita





Neighborhood and Built Environment

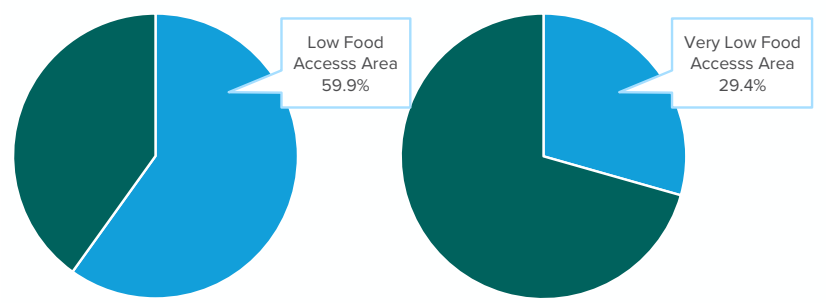
Increasingly, a community's neighborhoods and built environment are being shown to impact health outcomes. If a neighborhood is considered to have "low food access", which is defined as being more than 1/2 mile from your nearest supermarket in an urban area or 10 miles in a rural area, it may make it harder for people to maintain a healthy diet. A very low food access area is defined as being more than 1 mile from your nearest supermarket in an urban area or 20 miles in a rural area.

A person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet.⁷ In the Hospitals' community, 59.9% of the community lives in a low food access area, while 29.4% live in a very low food access area.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and maintaining employment. In the community, 5.9% of the households do not have an available vehicle.

⁷ A Neighborhood's Built Environment May Have Numerous Effects on Its Residents' Health - RWJF

Food Access



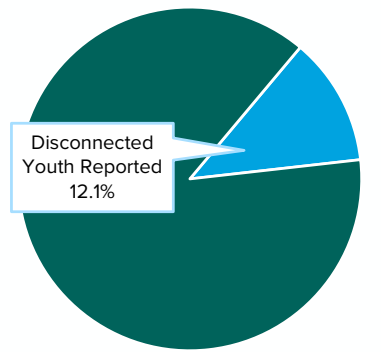
Social and Community Context

People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being.⁸ When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through work, community clubs or others to build their own relationships and social supports. There can be challenges to building these relationships when people don't have connections to create them or there are barriers like language between groups.

In the community, 12.1% of youth aged 16-19 were reported as disconnected, this means they were neither enrolled in school nor working at the time. Also, in the community 25.4% of seniors (age 65 and older) report living alone and 1.9% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.

⁸ Social and Community Context - Healthy People 2030 | health.gov

Disconnected Youth





Process, Methods and Findings

■ Process and Methods

The Process

The health of people living in the same community can be very different, because there are so many influencing factors. To understand and assess the most important health needs of their unique community and the people in it, the Hospitals solicited input directly from the community and from individuals who represent the broad interests of the community. A real effort was made to reach out to all members of the community to obtain perspectives across age, race/ethnicity, gender, profession, household income, education level and geographic location. The Hospitals, aided by the AdventHealth Corporate team, also collected publicly available data and internal Hospital utilization data for review.

The Hospitals partnered with local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members, to form a Community Health Needs Assessment Committee (CHNAC) to guide the assessment process. During data review sessions, community members of the CHNAC provided insight on how health conditions and areas of need were impacting those they represented. The CHNAC used the data review and discussion sessions to understand the most important health needs and barriers to health the community was facing and to guide the selection of needs to be addressed in the 2022 CHNA.

Community Input

The Hospitals collected input directly from the community and from community stakeholders, individuals working in organizations addressing the needs and interests of the community. Input was collected through two different surveys: the community health survey and the stakeholder survey.

Community Health Survey

- Provided in both English and Spanish to anyone in the community and accessible through weblinks and QR codes.
- Links and QR codes were shared through targeted social media posts and with community partners, including public health organizations. Partners were provided links to the survey, with the request that it be sent to listservs, electronic mailing lists they maintained and when possible shared on their own social media channels.
- Paper surveys were given to partners to place at their organizations with the goal of reaching those who might not have access otherwise and experience barriers to responding electronically.

Stakeholder Survey

- Participants were asked to provide input on health and barriers to health that they were seeing in the community.
- Surveys were sent to individuals working at community organizations, including public health organizations, that work to improve the health and wellbeing of the community.
- A focus was on hearing from stakeholders who represent or serve communities that are underserved, underrepresented, lower income and/or who are more likely to be impacted by the social determinants of health.

Public and Community Health Experts Consulted

A total of eight stakeholders provided their expertise and knowledge regarding their community including:

Name	Organization	Services Provided	Populations Served
Wayne C. Moore, Community Liaison	Killeen Independent School District	Education and youth services	Low income; Children
Heather Ortnier, Community Engagement Director	HOPE Pregnancy Center	Education/youth services; Food assistance; pregnancy testing, ultrasound services, parenting education, community referrals	Low income; Children; Women; LGBTQIA+; General public; Homeless
Uryan Nelson, Director	Central Texas Council of Governments	Transportation; Housing; Food assistance; Employment assistance; Financial support	Low income; Homeless; Elderly; Children; Women; Veterans; General public; LGBTQIA+
Linda Angel, Deputy Executive Director	Workforce Solutions of Central Texas	Employment assistance; For program-eligible job seekers, we offer financial assistance for vocational degreed training, short-term credentialed training, child care assistance, funding for work-related expenses, resume and job search assistance, career and labor market information, skills-based matching and connection with local job openings	Low income; Elderly; Women; Veterans; General public; LGBTQIA+; Laid-off/dislocated workers, working age youth, Trade impacted workers, individuals on public assistance, military spouses, soldiers transitioning out of the military
David Mitchell, City Manager	City of Harker Heights	Full municipal services	Elderly; Children; Women; Veterans; Low income; General public
Karla Miller, Administrator	Lampasas Mission	Food assistance; Clothing	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Maureen J Jouett, Executive Director-Training & Resource Manager/Coordinator – Assistant Treasurer	Bring Everyone In The Zone, Inc.	Housing; Mental/behavioral health care; Food assistance; Financial support; Peer to Peer Support, Court Mentors, Suicide Prevention, Train Facilitators	Veterans
Scott Stokoe, Deputy Commanding Officer / Chief Operating Officer	Carl R Darnall Army Medical Center	Health care/public health; Mental/behavioral health care	TRICARE Beneficiaries

Secondary Data

To inform the assessment process, the Hospitals collected existing health related and demographic data about the community from publicly available sources and Metopio⁸, a web-based data platform. This included data on health conditions, social determinants of health and health behaviors.

The most current public data for the assessment was compiled and sourced from government and public health organizations including:

- US Census Bureau
- Centers for Disease Control and Prevention
- Feeding America
- County Health Rankings
- The State Health Department

Hospital utilization data for 2019-2021 was also used in the assessment. Data was for uninsured or self-pay patients who visited the hospital for emergency department, inpatient or outpatient services. The top ten diagnosis codes were provided by the AdventHealth finance team for emergency room, inpatient and outpatient visits.

⁸ Metopio – Ridiculously easy data tools to understand places and populations.



The Findings

Throughout the assessment process there were several themes from community input that rose to the top, which were mentioned across numerous issues and health needs, including:



Access: A need for more entry points of care in the community, including for primary and mental health care, as well as social service supports, particularly for individuals who are undocumented.



Awareness: Better communication in the community on the care and services available.



Transportation: The barrier that a lack of transportation presents to accessing services in community.



Community Connectedness: A need for more opportunities and places in the community for residents to connect and engage with each other.



Seniors: A need for more services to support the senior population, from transportation to recreation centers.



Mental Health: An awareness of increasing mental health needs in the community, particularly in families with children and seniors which has been intensified by COVID-19.



Insurance Coverage: A lack of affordable insurance for individuals in need as a significant barrier to care in the community.



Economic Barriers: An increasing cost barrier to accessing care, products and services regardless of insurance and employment status.



Veterans: A need to ensure that veterans in the area had access to support and health care services in a timely fashion.

When reviewing the data for prioritization, the CHNAC considered the identified themes and their impact on the communities whose interests they represented.

The areas of significant need identified in the assessment process were around:



Mental Health and Mental Health Disorders: Mental illnesses are conditions that affect a person's thinking, feeling, mood or behavior, such as depression, anxiety, bipolar disorder or schizophrenia. Such conditions may be occasional or long-lasting (chronic) and affect someone's ability to relate to others and function each day.

Mental health includes our emotional, psychological and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.



Substance Misuse – Drug: Substance use disorders can involve illicit drugs, prescription drugs or alcohol. Opioid use disorders, which stem from the improper use of prescription drugs, have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Housing stability is another factor of housing, where housing instability can mean having housing with poor sanitation, heating and cooling; exposure to allergens or pests; and substandard housing structures.



Preventative Care – Screenings: Prevention means intervening before health effects occur, through measures such as screenings, vaccinations, altering risky behaviors (poor eating habits, tobacco use) and banning substances known to be associated with a disease or health condition.



Diabetes: Diabetes is a group of diseases characterized by high blood sugar. When a person has diabetes, the body either does not make enough insulin (type 1) or is unable to properly use insulin (type 2). When the body does not have enough insulin or cannot use it properly, blood sugar (glucose) builds up in the blood. Prediabetes is a condition in which blood sugar is higher than normal but not high enough to be classified as diabetes.



Food Insecurity: Food insecurity exists when people do not have physical and economic access to sufficient safe and nutritious food that always meets their dietary needs and food preferences. Food insecurity has been linked to negative health outcomes in children and adults, as well as potentially causing trouble for children in schools.





Physical Health & Activity: Being physically active means movement of the body to get to and from places, for work or for leisure. Regular physical activity is proven to help prevent and manage noncommunicable diseases such as heart disease, stroke, diabetes and several cancers. It also helps prevent hypertension, maintain healthy body weight and can improve mental health, quality of life and well-being.



Cardiovascular Disease: Cardiovascular disease generally refers to conditions that involve narrowed or blocked blood vessels that can lead to a heart attack, chest pain (angina) or stroke. Other heart conditions, such as those that affect your heart's muscle, valves or rhythm, also are considered forms of heart disease.



Housing: Where people live and how people live directly affects their well-being. Research shows that individuals experiencing housing instability have limited access to preventive care and are more likely to have infectious diseases and chronic health conditions like diabetes, cardiovascular disease and chronic obstructive pulmonary disease. Homeless individuals also have a shorter lifespan.

Housing stability is another factor of housing, where housing instability can mean having housing with poor sanitation, heating and cooling; exposure to allergens or pests; and substandard housing structures.



Nutrition & Healthy Eating: Nutrition is considered something that is taken into the body as food, influencing health, while healthy eating means eating a variety of foods that give you the nutrients you need to maintain your good health. Many people in the United States do not eat a healthy diet, which could be because some people do not have the information needed to choose healthy foods or do not have access to healthy foods or can not afford to buy enough food. People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes and other health problems.



Obesity: Obesity is a medical condition in which excess body fat has accumulated to an extent that it may have a negative effect on health. Obesity is measured by an individual's body mass index (BMI). The prevalence of obesity continues to increase in the United States. Obesity is common, serious and costly. This epidemic is putting a strain on American families, affecting overall health, health care costs, productivity and military readiness. Moreover, obesity can have negative health outcomes since obesity can lead to type 2 diabetes, heart disease and some cancers.



PRIORITIES SELECTION

■ Prioritization Process

The Community Health Needs Assessment Committee through data review and discussion, narrowed the health needs of the community to a list of 12. Community partners on the CHNAC represented the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community. During the Spring of 2022, the CHNAC met three times to review and discuss the collected data and select the top community needs.

Members of the CHNAC included:

Community Members

- Wayne Moore, Parent Liaison, Killeen Independent School District, providing education and connecting families with resources to strengthen education outcomes for students
- Taneika Driver-Moultrie, Director, Greater Killeen Community Clinic, providing uninsured and underinsured patients with medical care
- Col. Scott Stokoe, Deputy Commanding Officer, Carl R. Darnall Army Medical Center, coordinating and providing healthcare for active military, veterans and their dependents
- Linda Angel, Deputy Executive Director, Workforce Solutions of Central Texas, providing quality education, training and labor market services for job seekers in the region
- Lori Forsyth, Assistant Department Chair of Health Sciences, Central Texas College, providing educational opportunities for all community members at a community college level

- Karla Miller, Director, Lampasas Mission, operating a food pantry and clothing closet for underserved community members
- George Losoya, Director, Central Texas Council of Governments/Area Agency on Aging, focusing on improving communities by connecting the elderly with home health and nursing options, ensuring families have safe and reliable housing and improving transportation

AdventHealth Team Members

- Erin Riley, Marketing Director
- Sarah Sooter, Community Wellness Coordinator

Public Health Experts

- Amy Yeagar, Director, Bell County Health Department, providing services to all community members with a focus on those that are underserved



To identify the top needs the CHNAC took part in a prioritization activity. During the activity, the data behind each need was reviewed, followed by a discussion of the need, the impact it had on the community and the resources available to address it. CHNAC members then ranked the need based on the established criteria through an online survey.

The following needs rose to the top during the CHNAC’s discussion and prioritization activity:

Identified Issues	Alignment (15%)	Impact on Community (25%)	Resources (30%)	Outcome Opportunities (30%)	Total Ranking
Mental Health	4	4.71	3.43	4.29	4.09
Drug Misuse	3.71	4.57	3.71	4.14	4.06
Preventative Care – Screenings	3.71	3.86	3.29	4.14	3.75
Diabetes	3.71	3.71	3.43	3.86	3.67
Food Insecurity	3.71	4.00	3.14	3.86	3.66
Physical Health	3.57	3.71	3.43	3.86	3.65
Cardiovascular Disease: Hypertension	3.43	3.71	3.43	3.71	3.59
Housing	3.29	4.14	2.71	3.86	3.50
Cardiovascular Disease: High Cholesterol	3.29	3.29	3.57	3.71	3.50
Cardiovascular Disease: Heart Disease	3.43	3.14	3.43	3.71	3.44
Nutrition and Healthy Eating	3.57	3.71	2.86	3.71	3.44
Obesity	3.29	4.00	3.14	3.29	3.42

After a list of 12 of the top health needs of the community had been selected by the CHNAC, a Hospital Health Needs Assessment Committee (HHNAC) met to review the top needs that had been chosen. The HHNAC reviewed the data behind the selected needs and the available resources to address them in the community. The HHNAC also considered the Hospitals current resources and strategies to find ways to most effectively address the needs.

Members of the HHNAC included:

- Kevin Roberts, CEO
- Parker Pridgen, COO
- Dr. Erin Bird, CMO
- Tammy Rodriguez, CNO
- Ashley Underwood, Vice-President Rollins Brook
- Sergio Silva, Director, Mission and Ministry
- Erin Riley, Director, Marketing
- Sarah Sooter, Coordinator, Community Wellness
- Ross Gaetano, Director, Behavioral Health
- Heather Duncan, Care Management
- Jessica Gerhardt, Director, Finance
- Jasmin Rodriguez, Director, Marketing
- Delsina West, Wellness Coordinator

The HHNAC followed the same process as the CHNAC for prioritization, narrowing down the list to three priority needs:

Identified Issues	Alignment (15%)	Impact on Community (25%)	Resources (30%)	Outcome Opportunities (30%)	Total Ranking
Preventative Care – Screenings	4.25	3.75	3.50	4.13	3.86
Mental Health	4.88	4.38	2.50	3.75	3.70
Nutrition and Healthy Eating	4.50	3.88	2.38	3.00	3.26



The needs found in the assessment were evaluated and scored by the CHNAC and the HHNAC on a scale of 1 to 5 (1=lowest, 2=low, 3=moderate, 4=high, 5=highest) using the criteria below:

- **Alignment:** Does this issue align with our mission, strategy, public health or community goals? (15%)
- **Impact on Community:** What is the scope, size and seriousness of this issue? What are the consequences to the health of the community of not addressing this issue now? (25%)
- **Resources:** Are there existing, effective interventions and opportunities to partner with the community to address this issue? (30%)
- **Outcome Opportunities:** Can an impact on this issue be made in a demonstrable way and will interventions have an impact on other health and social issues in the community? (30%)



Available Community Resources

When evaluating the top issues in the community a review of the available organizations and resources addressing these issues was conducted to understand where the greatest impact could be made.

Top Issues	Current Community Programs
Mental Health Drug Misuse Services	<ul style="list-style-type: none"> National Alliance on Mental Health (NAMI) Central Texas Central County Services/Children’s Mental Health Services for youth aged 3-17, serving low-income youths Central County Services/Adult Mental Health Services for youth aged 3-17, serving low-income youths Veteran’s Health Administration/Vet Center Program Children at Heart Ministries: Telehealth Counseling Services, the program offers free services for families with children up to 17 who are enrolled in school Heritage House/a variety of programs for all ages, those who are homeless and anyone in crisis The Refuge Corporation/Safe Harbor Support Group, offering free support groups and referral services for anyone who has completed a rehab program AdventHealth Central Texas/outpatient behavioral health services
Preventative Care - Screenings	<ul style="list-style-type: none"> Greater Killeen Community Clinic, providing free and reduced cost care to all eligible community members Cove House Free Clinic, providing free care for community members, including medical, housing, food
Diabetes	<ul style="list-style-type: none"> AdventHealth Diabetes Self-Management classes, open for all community members Greater Killeen Community Clinic, providing free and reduced cost care to all eligible community members Cove House Free Clinic, providing free care for community members, including medical, housing, food
Food Insecurity	<ul style="list-style-type: none"> Lampasas Mission, open for all community members to receive prepackaged food bags twice a week Meals on Wheels, providing meal delivery service for seniors in need Central Texas Food Bank/Healthy Options Program for the Elderly, focused on providing food assistance for low income seniors Food Care Center, emergency food and food pantry options available based on need to all families Southside Church of Christ/Food pantry, available to all Sundays and Tuesdays Operation Phantom Support/Nancy Miller Food Pantry, providing food to military families in need

Top Issues	Current Community Programs
Physical Health	<ul style="list-style-type: none"> AdventHealth/Free weekly fitness classes for all community members Killeen Senior Center/various programs, targeting those 55 and older the center offers free programming to help keep seniors living active lives
Housing	<ul style="list-style-type: none"> Family Promise of East Bell County, providing housing assistance to anyone in need Our Lady of the Angels Maternity Shelter, provides shelter to women during and after pregnancy while they seek stable options Salvation Army, provides a hope shelter which works to rehouse residents in under 30 days and emergency financial assistance to help with utilities and rent
Cardiovascular Disease: Hypertension, High Cholesterol, Heart Disease	<ul style="list-style-type: none"> Greater Killeen Community Clinic, providing free and reduced cost care to all eligible community members Cove House Free Clinic, providing free care for community members, including medical, housing, food
Nutrition and Healthy Eating	<ul style="list-style-type: none"> Texas A&M Agrilife Extension/Better Living for Texas, providing research and evidence-based nutrition, health and wellness knowledge to empower individuals, families and communities to make positive changes for healthier lives.
Obesity	<ul style="list-style-type: none"> US Department of Veteran Affairs/MOVE!, available to veterans and active military personnel as a weight management and health improvement program Boys and Girls Clubs – recreation/activity programs available through a low cost option for youth ages 6 to 12



Priorities Addressed



Nutrition and Healthy Eating

More than 40% of community survey respondents reported eating fruits and vegetables less than two days a week. Nutrition is known to be a critical influencer of health. Healthier eating improves maternal health and health at every stage of life. It builds stronger immune systems, lowers the risk of chronic diseases like diabetes and cardiovascular disease, while increasing longevity.

By addressing nutrition and healthy eating, the Hospitals hope to improve the overall health of the community. This will impact multiple health conditions identified in the assessment process, as well as food security challenges, by increasing the community's ability to access and incorporate a more balanced diet.



Mental Health

In the Hospitals' community, public data shows 21.6% of residents have a prevalence of depression, while 17% of the residents report poor mental health. According to community survey respondents 15.5% have been diagnosed with a depressive order and more than 26% have been diagnosed with an anxiety disorder. Only 25% of the community and public health experts surveyed believe the community is good at treating mental health.

Awareness and the need to address mental health disorders has been growing in the country. Including mental health as a priority, the Hospitals can align to local, state and national efforts for resources to create better outcome opportunities over the next three years.



Preventative Care and Screenings

According to community survey respondents, 21.7% are not aware of what preventative screenings are needed. Among those that are aware, 19.1% report not getting regular screenings. Public data shows that less than 25% of community seniors are up to date on necessary core preventative services. Preventative care improves health outcomes, quality of life and can decrease an individual's cost of care over time through early detection.

The Hospitals will address preventative care and screenings through efforts that will have impacts on other issues identified in the assessment process including diabetes, obesity and various types of cardiovascular disease.



Priorities Not Addressed

The priorities not to be addressed include:



Drug Misuse

According to the Hospitals' community survey, 40.4% of respondents reported taking prescription medication for non-medical reasons, while 18.5% of stakeholder survey respondents consider drug misuse a top health risk factor in the community. Although there is a lack of resources in the area for substance and drug misuse, the Hospitals did not perceive the ability to have a measurable impact on the issue within the three years allotted for the Community Health Plan with the current resources available to the community and the Hospitals at this time.



Diabetes

Diabetes is shown to impact 9.9% of residents in the Hospitals' community according to public data, while 21.7% of community survey respondents report having diabetes. Diabetes related conditions are also shown to be one of the top ten codes in Hospital visits by uninsured patients.

The Hospitals did not select diabetes as a priority, as it is not positioned to directly address this in the community at large. The Hospitals did choose nutrition and healthy eating however knowing that how individual eats is a factor in diabetes and hopes to have an indirect impact on diabetes through these efforts.



Food Insecurity

More than 17% of the residents in the Hospitals' community are food insecure according to Feeding America and 61.8% live in a low food

access area. According to community survey respondents, 45.9% received SNAP benefits last year, while 32.3% felt they ate less than they should have due to cost.

The Hospitals believe that other organizations are better positioned in the community to address this need directly and will support those efforts when able without formally addressing it in the Community Health Plan through the nutrition and healthy eating priority.



Physical Health

The HHNAC believed that physical health could be indirectly addressed through preventative screening and healthy eating/nutrition.



Obesity

More than 38% of residents in the Hospitals' community have been told they are obese according to public data. Obesity related codes also appear in the top ten codes in Hospital visits by uninsured patients. The Hospitals did not select obesity as a priority, as it is not positioned to directly address this in the community at large. The Hospitals did choose nutrition and healthy eating and hope to have an indirect impact on obesity through these efforts. The Hospitals will continue to offer free community fitness classes in response to obesity.



Housing

In the Hospitals' community, 32.2% of residents are housing cost-burdened or paying over 30% of their income to housing costs per public data. According to community survey respondents 41% report being worried they would not have stable housing in the next two months. More than 60% of the community and public health experts surveyed do not consider housing in the area affordable.

The need for safe and affordable housing in the community is significant, however the Hospitals did not perceive the ability to have a measurable impact on the issue within the three years allotted for the for the Community Health Plan with the current resources available to the community and the Hospitals at this time.



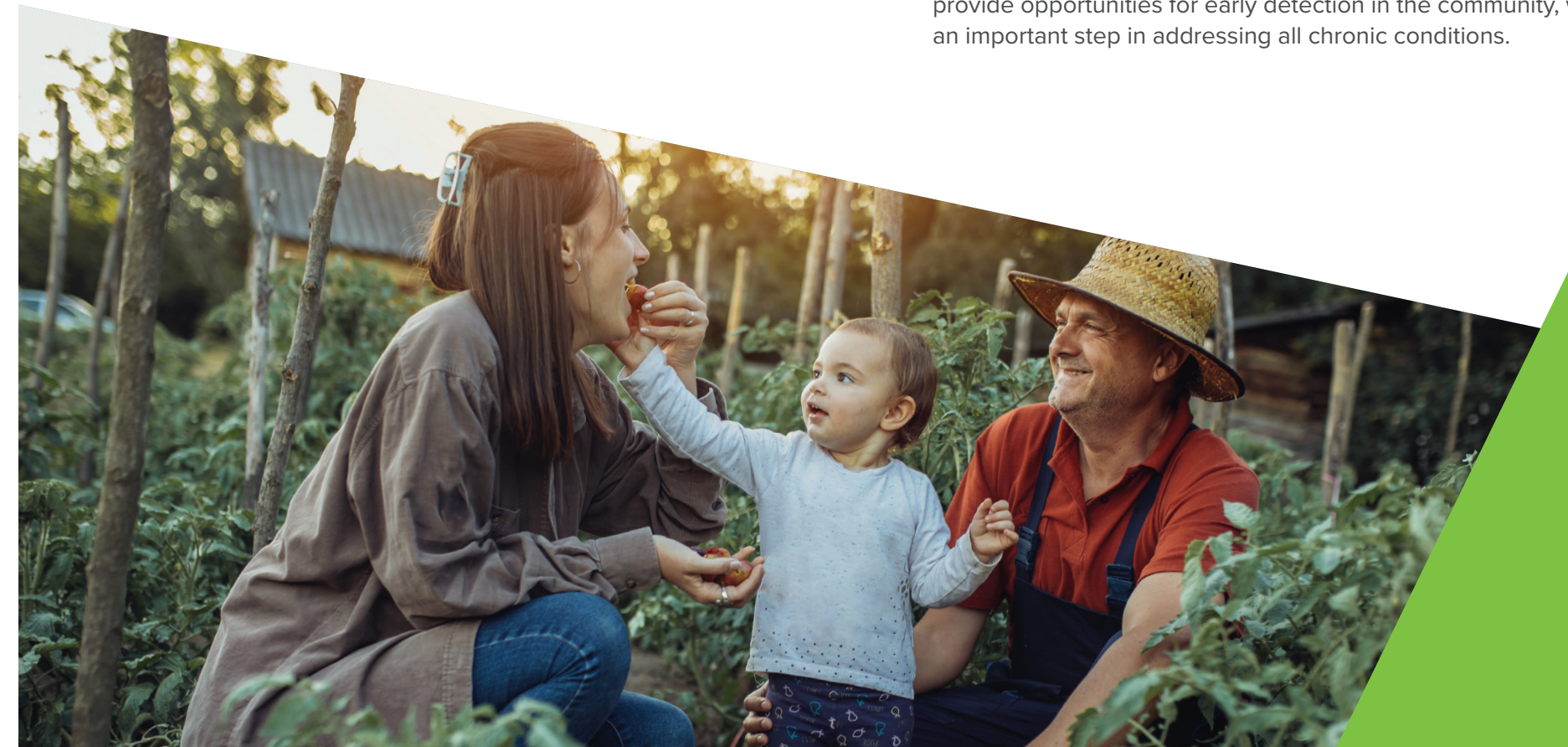
Cardiovascular Diseases: Hypertension, Heart Disease, High Cholesterol

Almost thirty percent of residents in the Hospitals' community have been told they have hypertension per public data. The number of community survey respondents reporting hypertension is 33.5% and hypertension related conditions are shown to be one of the top ten codes in Hospital visits by uninsured patients.

High cholesterol also shows up in the top ten codes in Hospital visits by uninsured patients and 26.5% of residents in the Hospitals' community have been told they have high cholesterol.

According to public data, two of the four counties the Hospitals serve have higher rates of death per 100,000 from heart disease than both the state and the nation.

The Hospitals did not select cardiovascular diseases as a priority, as it is not positioned to directly address this in the community at large, outside of existing community education. The Hospitals did choose nutrition and healthy eating however knowing that how an individual eats is an integral step in treating cardiovascular diseases and hopes to have an indirect impact through these efforts. The Hospitals also selected preventative care – screenings which will provide opportunities for early detection in the community, which is an important step in addressing all chronic conditions.





COMMUNITY HEALTH PLAN

Next Steps

The Hospitals will work with the CHNAC and other community partners to develop a measurable Community Health Plan for 2023-2025 to address the priority issues. For each priority, specific goals will be developed including measurable outcomes, intervention strategies and the resources necessary for successful implementation.

Evidence based strategies will be reviewed to determine the most impactful and effective interventions. For each goal, a review of policies that can support or deter progress will be completed with consideration of opportunities to make an impact. The plan will be reviewed quarterly with an annual assessment of progress. A presentation of progress on the plan will also be presented to the Hospitals' board annually.

A link to the Community Health Plan will be posted on [AdventHealth.com](https://www.adventhealth.com) prior to May 15, 2023.



2020 Community Health Plan Review

The Hospitals evaluate the progress made on the implementation strategies from the Community Health Plan annually. The following is a summary of progress made on our most recently adopted plan. The full evaluation is available upon request.

Priority 1: Physical Inactivity

In the 2019 CHNA, the Hospitals addressed physical inactivity as a priority. The assessment showed that 25% of residents did not participate in physical activities outside of their jobs according to public data. Survey respondents reported that 42% of them participated in 30 minutes of activity less than three days a week.

Since adopting the plan, the Hospitals have provided several community programs which focus on lifestyle to address this issue. Through one of these, a free weekly fitness class series, 211 residents have taken a more than 2568 classes and 31% report reaching the recommended 150 minutes of physical activity a week. The Hospitals also provided a Walk with a Doc, which provides the community an opportunity to learn about a variety of health topics, while participating in a 30-minute walk, led by our physicians. Although there have been delays due to COVID, the Hospitals have hosted six walks for 34 participants and will continue the program as public health recommendations allow.

Priority 2: Mental Illness and PTSD

The Hospitals' community is home to Fort Hood, one of the largest military bases in the world and has a significantly higher population of veterans living in the community, contributing to a higher number of individuals diagnosed with Post Traumatic Stress Disorder (PTSD). The 2019 assessment found of Medicaid eligible adults, 19.1% are impacted by some type of depression. Community stakeholders also reported high needs for mental health services in the populations they serve.

As part of their efforts to address the need in the community, the Hospitals partnered with the Killeen Independent School District (KISD) to place a social worker in each of the KISD's 45 campuses to assist in addressing mental health needs of the students. Although there were delays due to COVID, the Hospitals are currently recruiting social workers to fill these positions. The Hospitals also host a behavioral health summit for public health professionals on the social determinants of health to connect them to local resources and support networks that are accessible to their clients.

Priority 3: Food Insecurity

The Hospitals also chose food insecurity as a priority. The 2019 assessment showed that in the Hospitals' service area, 20.9% of individuals are food insecure. This is significantly higher than the nation's average of one in every nine individuals being food insecure. This concern has become exacerbated on the north side of Killeen, as both grocery stores have closed in 2019.

As part of the effort to address this, the Hospital provided financial support to local community organizations that are addressing food insecurity. More than 500 families have been served through the Hospitals' support, receiving on average 20 pounds of fresh food and 40-50 pounds of shelf stable items.



■ 2019 Community Health Needs Assessment Comments

We posted a link to the most recently conducted CHNA and most recently adopted 2020 Community Health Plan on our Hospital website as well as AdventHealth.com prior to May 15, 2020 and have not received any written comments.





**Metroplex Adventist Hospital Inc. d/b/a
AdventHealth Central Texas and
AdventHealth Rollins Brook**

CHNA Approved by the Hospital Board on: December 14, 2022

For questions or comments please contact:
CORP.CommunityBenefitSupport@AdventHealth.com