AdventHealth Central Texas &
AdventHealth Rollins Brook
2019 COMMUNITY HEALTH NEEDS ASSESSMENT

Metroplex Adventist Hospital Inc. dba AdventHealth Rollins Brook
Approved by the Hospital Board on: December 19, 2019
Community Benefit Manager: Sarah Kennedy
Sarah.L.Kennedy@adventhealth.com

Extending the Healing Ministry of Christ

AdventHealth

2019 Community Health Needs Assessment

Table Of Contents

Sections		Page
1.	Executive Summary	3
2.	About AdventHealth Rollins Brook and AdventHealth Central Texas	6
3.	Choosing the Community	7
4.	Community Description and Demographics	8
5.	Community Health Needs Assessment Committee	11
6.	Public Health	13
7.	Primary and Secondary Data Sources	13
8.	Data Summary	15
9.	Community Asset Inventory	18
10.	Priority Selection	19
11.	Priority Issues to be Addressed	22
12.	Priority Issues that will not be Addressed	24
13.	Next Steps	25
14.	Written Comments Regarding 2016 Needs Assessment	25
15.	Review of Strategies Undertaken in the 2017 Community Health Plan	26
	Appendices	
A.	Primary Data Survey and Responses	30
B.	Secondary Data Report	48
C.	Hospital Utilization and Emergency Department Data	55
D.	Community Asset Inventory	56

Acknowledgements

This report was prepared by Sarah Kennedy, with contributions from members of the AdventHealth Rollins Brook Community Health Needs Assessment Committee representing health leaders in our community and AdventHealth Rollins Brook leaders.

A special thanks to the Coalition for Healthy Living for their expertise and support in the collection and analysis of the data.

We are especially grateful to all those who participated in our community surveys and stakeholder interviews. Their contributions made this report possible and lay the groundwork as we continue to fulfill our mission of *Extending the Healing Ministry of Christ*.

1. EXECUTIVE SUMMARY

Metroplex Adventist Hospital Inc. includes two AdventHealth hospitals, the first dba AdventHealth Central Texas, the second dba AdventHealth Central Texas. Historically, the two hospitals have conducted their CHNA jointly. 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.

Goals

Metroplex Adventist Hospital Inc. dba AdventHealth Central Texas in Killeen, TX and AdventHealth Rollins Brook in Lampasas, TX will be referred to in this document as AdventHealth Central Texas and AdventHealth Rollins Brook or "the Hospitals." In an effort to continue to align resources and maintain the strategic approach to improving health outcomes the Hospitals conducted a joint community health needs assessment in 2019. 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 2020-2022 Community Health Plan based on AdventHealth Rollins Brook's prioritized issues

Community Health Needs Assessment Committee

In order to ensure broad community input, AdventHealth Central Texas and AdventHealth Rollins Brook created a joint 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 2019. They reviewed the primary and secondary data, helped define the priority issues to be addressed by the Hospitals and helped develop the Community Health Plan to address the priority issues. *See Section 5 for a list of CHNAC members*.

Data

AdventHealth Central Texas and Advent Health Rollins Brook collected both primary and secondary data. The primary data included stakeholder interviews and community surveys.

Secondary data sources included internal hospital utilization data (inpatient and emergency department). This utilization data showed the top reasons for visits to the Hospitals over the past year. In addition, the Hospitals utilized publicly available data from state and nationally recognized data sources. See Section 7 for a list of data sources.

Primary and secondary data was then compiled and analyzed in order to identify the top eight aggregate issues from the various sources of data.

Community Asset Inventory

The next step was a community asset inventory. This inventory was designed to help AdventHealth Central Texas and AdventHealth Rollins Brook along with their CHNAC to:

- Understand existing community efforts to address the 8-12 identified issues from aggregate primary and secondary data

- Prevent duplication of efforts as appropriate. *See Section 9 for the Community Asset Inventory.*

Selection Criteria

Using the data findings and the community asset inventory, the CHNAC narrowed the list of 8-12 issues to three priority issues.

The CHNAC used a priority selection tool that uses clearly defined criteria to select the top issues to address. *See Section 10 for the Priority Selection Report.*

The priority selection criteria included:

A. Relevance: How important is this issue?
B. Impact: What will we achieve by addressing this issue?
C. Feasibility: Can we adequately address this issue?

Priority Issues to be Addressed

The priority issues to be addressed are:

1. Food Insecurity
    a. Decrease percentage of the population with low access to food
    b. Increase education and access to healthy foods
2. Physical Inactivity
    a. Lower the number of community members that have no physical activity
    b. Improve community access to free and low-cost wellness programming
3. Mental Illness and PTSD (Post Traumatic Stress Disorder)
    a. Improve access to mental wellness resources
    b. Decrease the number of mentally unhealthy days

See Section 11-12 for an explanation of priority issues which were chosen as well as those not chosen.

Approvals

On December 19, 2019, the AdventHealth Central Texas and AdventHealth Rollins Brook Boards approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2019 Community Health Needs Assessment was posted on the Hospitals' website as well as https://www.adventhealth.com/community-health-needs-assessments prior to December 31, 2019.

Next Steps

The CHNAC will work with AdventHealth Central Texas and AdventHealth Rollins Brook to develop a measurable 2020-2022 Community Health Plan to address the priority issues. The plan will be completed and posted on the Hospitals' website prior to May 15, 2020.

2. ABOUT THE HOSPITALS

Transition to AdventHealth

In January of 2019, every wholly-owned entity across our organization adopted the AdventHealth system brand. Our identity has been unified to represent the full continuum of care our system offers. Throughout this report, we will refer to our facilities by AdventHealth Rollins Brook (formerly Rollins Brook Community Hospital) and AdventHealth Central Texas (formerly Metroplex Adventist Hospital). Any reference to our 2016 Community Health Needs Assessment in this document will utilize our new name for consistency.

AdventHealth Central Texas and AdventHealth Rollins Brook are part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth is a connected system of care for every stage of life and health. More than 80,000 skilled and compassionate caregivers in physician practices, hospitals, outpatient clinics, skilled nursing facilities, home health agencies and hospice centers provide individualized, wholistic care. A Christian mission, shared vision, common values and service standards focus on whole-person health, and commitment to making communities healthier.

About 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.

About AdventHealth Rollins Brook

AdventHealth Central Texas operates AdventHealth Rollins Brook, a 25-bed critical access hospital in Lampasas, located 25 miles west of Killeen. AdventHealth Rollins Brook offers many technological services including a 24-hour emergency center, a state-of-the-art laboratory, medical/surgical rooms, CT scanning, mammography and cardio-pulmonary services with EKG and stress testing. AdventHealth Rollins Brook also offers access to a sleep disorder center and bone density (DEXA) scan capabilities. In 2005, AdventHealth Rollins Brook completed a 14,000-square-foot expansion

that added 17 new patient rooms, a new surgical suite and an ambulatory surgery area. The new surgical suite, located on the lower level, houses two operating rooms and an ambulatory surgery area with six pre-op/post-op bays and four recovery bays designed for same-day surgical procedures.

3. CHOOSING THE COMMUNITY

AdventHealth Central Texas and AdventHealth Rollins Brook defined its community as its Primary Service Area (PSA) from which more than 75% of its patients come. This includes West Bell, Coryell and Lampasas Counties. The Hospitals serve a large military community and the area has a large Latino population.

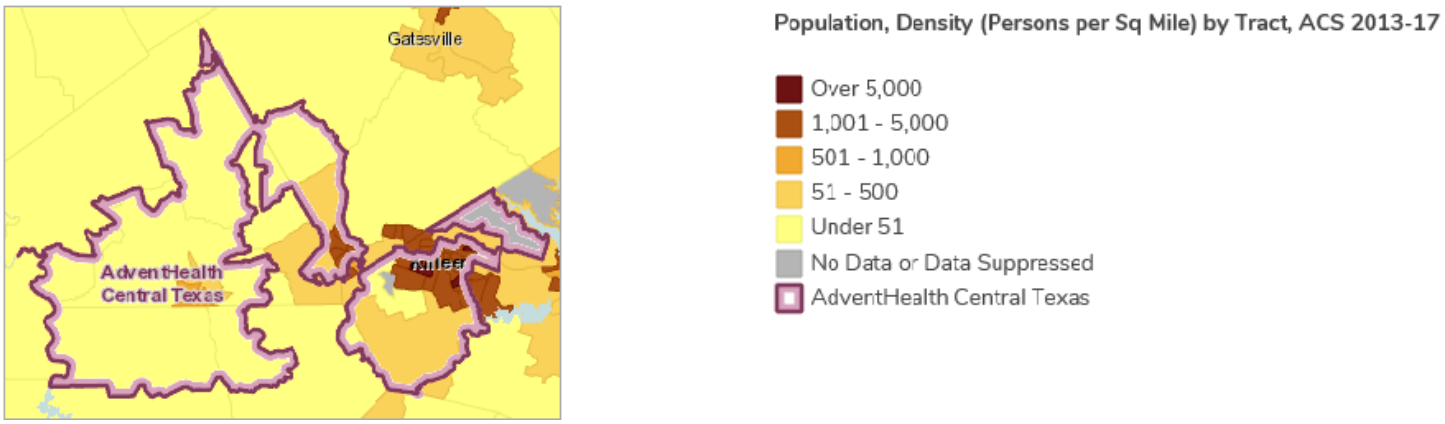
Copperas Cove-76522
Killeen-76541, 76542, 76543, 76549
Lampasas-76550
Whitney-76539
Fort Hood-76544
Harker Heights-76548

4. COMMUNITY DESCRIPTION AND DEMOGRAPHICS

In order to understand our community and the challenges faced, AdventHealth Central Texas and AdventHealth Rollins Brook looked at both demographic information for the shared service area population, as well as available data on social determinants of health. According to the Center for Disease Control and Prevention, social determinants of health include conditions in the places where people live, learn, work and play, which affect a wide range of health risks and outcomes. A snapshot of our community demographics and characteristics is included below. *Secondary report data can be found in Appendix B.*

A total of 196,840 people live in the 600 square mile report area defined for this assessment according to the U.S. Census Bureau American Community Survey 2013-2017 5-year estimates. The population density for this area, estimated at 328.03 persons per square mile, is greater than the national average population density of 90.88 persons per square mile. The Hospitals serve a large military community and the area has a large Latino population.

The map below represents the service area where 75% of AdventHealth Central Texas and AdventHealth Rollins Brook's patients come from.



**Please note the above map represents the shared service area for AdventHealth Central Texas and AdventHealth Rollins Brook.*

Source: US Census Bureau, American Community Survey. 2013-17.

Community Demographics

Female 50.97%

Male 49.03%

AGE	0-4	5-17	18-24	25-34	35-44	45-54	55-64	65+
%	9.29%	19.59%	11.4%	19.21%	13.41%	10.84%	8.29%	7.98%

RACE	Caucasian	African-American	Asian	Native American / Alaska Native	Native Hawaiian /Pacific Islander	Other Race	Multiple Races
%	53.4%	29.6%	3.5%	0.9%	1.4%	4.4%	6.7%

ETHNICITY	Hispanic Latino	Non-Hispanic
%	23.2%	76.8%

Source: US Census Bureau, American Community Survey. 2013-17.

DATA INDICATOR	DESCRIPTION	ADVENTHEALTH ROLLINS BROOK CENTER SERVICE	TEXAS AVERAGE
Poverty[1]	% Population in Poverty (Below 100% FPL)	13.07%	16.02%
Unemployment Rate[2]	Unemployment Rate	6.1%	3.6%
Violent Crime[3]	Violent Crime Rate (Per 100,000 Pop.)	361	421.1
Population with No High School Diploma[1]	% Population Age 25+ with No High School Diploma	8.7%	17.22%
Insurance[4]	Uninsured Adults-% Without Medical Insurance	17.25%	22.6%
Insurance[4]	Uninsured Children-% Without Medical Insurance	7.56%	9.72%
Food Insecurity Rate[5]	Food Insecurity Rate	20.9%	14.9%
Population with Low Food Access[6]	% Population with Low Food Access	43.54%	27.07
Use of Public Transportation[1]	% Population Using Public Transit for Commute to Work (Age 16+)	0.63%	1.5%
Alcohol Consumption[7]	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	13%	15.8%
Tobacco Usage[7]	% Population Smoking Cigarettes (Age-Adjusted)	18.2%	16.5%
Physical Inactivity[8]	% Population with No Leisure Time Physical Activity	25%	18.2%
Obesity[8]	% Percent Adults with BMI >30.00	31.8%	28.8%

Source: [1]US Census Bureau, American Community Survey. 2013-17 [2] US Department of Labor, Bureau of Labor Statistics. 2019 - August. [3] Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2015-17. [4] US Census Bureau, Small Area Health Insurance Estimates. 2017. [5] Feeding America. 2017. [6] US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015. [7] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12. [8] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2016.

5. COMMUNITY HEALTH NEEDS ASSESSMENT COMMITTEE

A Community Health Needs Assessment Committee (CHNAC) was formed to help AdventHealth Central Texas and AdventHealth Rollins Brook conduct a comprehensive assessment of the community. The committee included representation from the Hospitals, public health officials and the broad community as well as representation from low-income, minority and other underserved populations. The committee met regularly throughout 2019. Current CHNAC members include:

Community Members

Name	Title	Organization	Description of Services	Low-Income	Minority	Other Underserved Populations
Marlene DiLillo	Executive Director	Greater Killeen Community Clinic	Provides health services that offer a comprehensive approach toward health; builds innovative partnerships; and advocates for those who have limited access to health care services.	x	x	x
Rita Kelly	Department Director	Bell County Indigent health services department	Serves the community and very low-income residents. Provides health care for Texas residents in need who do not qualify for other state and federal assistance programs .	x	x	x
Aaron Montemayor	Director	United Way of Greater Fort Hood Area	Provides social services and social service funding to community agencies serving low-income and minority populations, as well as low-income and minority families from Fort Hood.	x	x	x
Amanda Chadwell Robinson	Director	Department of Public Health	Serves Bell County communities, organizations and citizens through education and leadership to prevent disease and protect the public's health.	x	x	x

Jackie McLaughlin	County Extension Agent	Texas A&M AgriLife Extension	Provides healthy living education programs and support to the community.	x	x	x
Debbie Morrison	Human Resources, Wellness	Texas A&M Rollins Brook	Improving health education in the area through its current selection of health education programs.		X	
Kelly Rodriguez	Human Resources, Wellness	City of Killeen	Serves the City of Killeen through coordination of health services and membership on community health coalitions.		x	x
Anna Barge	EVAJP grant coordinator	Area Agency on Aging	Serves individuals 60 years of age and older and their families residing in Bell and surrounding counties.	X	X	x

AdventHealth Central Texas and AdventHealth Rollins Brook Members

The following team members from AdventHealth Central Texas and AdventHealth Rollins Brook provided guidance and leadership throughout the CHNA process.

- **Sarah Kennedy,** Community Wellness Coordinator
- **Sergio Silva**, Director of Mission & Ministry
- **Esteban Cortez**, Clinical Mission Integration Manager
- **Lacey Jennings**, Transcription Manager, Health Informatics
- **Michael Smith**, Director, Emergency Department
- **Taneika Driver Moultrie**, Director, Foundation

6. PUBLIC HEALTH

Public health was represented throughout the Community Health Needs Assessment. Public Health representatives participated in the development and disbursement of the community surveys. Bell County representatives served on Community Health Needs Assessment Committee (CHNAC). They identified community stakeholders and provided insight to current community health needs. Once the primary data had been collected, they helped interpret data and align with secondary data to prioritize health needs. The following county employees provided leadership throughout the process:

- **Amanda Robison-Chadwell**, MPH, PhD, Director, Bell County Health Department
- **Anna Barge,** MPH, EVJAP Grant Coordinator, Area agency on Aging, Bell County

7. PRIMARY AND SECONDARY DATA SOURCES

Primary Data

a. Community Surveys: Community surveys were distributed both in person and online at various locations within Bell, Coryell and Lampasas counties. In person survey locations included health screenings, immunization clinics, the Hospitals' wellness classes, the Greater Killeen Community Clinic and among various church congregations. Online surveys were distributed among AdventHealth Central Texas and Rollins Brook team members, the Boys & Girls Club of Rollins Brook and through email. *The survey and data results can be found in Appendix A.*

b. Stakeholder Surveys: Stakeholder surveys were collected online by emailing community leaders that represent public health, various special populations, low-income and minority populations. *The survey and data results can be found in Appendix A.*

Secondary Data:

a. Hospital Utilization Data: Top 10 inpatient and Emergency Department diagnoses by payer data was gathered using reports generated by the Hospitals' Information Management (HIM) department. *The complete diagnosis list can be found in appendix C.*

b. The Engagement Network: Secondary data was sourced from the Engagement Network. This is a national platform produced by the Center for Applied Research and Engagement Systems (CARES) at the University of Missouri. The Engagement Network hosts a national Map Room with 15,000+ data layers, a Community Health Needs Assessment reporting tool with more than 80 health-related indicators and a hub network with more than 30 partner organizations using CARES technology.

Data Sources:

a. US Census Bureau, Decennial Census, 2000-2010
b. US Census Bureau, American Community Survey, 2013-17
c. Feeding America, 2014
d. US Census Bureau, Small Area Health Insurance Estimates, 2016
e. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, US Department of Health & Human Services, Health Indicators Warehouse, 2006-12
f. Centers for Disease Control and Prevention, National Vital Statistics System, US Department of Health & Human Services, Health Indicators Warehouse, 2006-12
g. US Department of Labor, Bureau of Labor Statistics, 2018 – August
h. Federal Bureau of Investigation, FBI Uniform Crime Reports, 2012-14
i. US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2015
j. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2015
k. Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2015
l. US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration, April 2016
m. US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, March 2018
n. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011-12
o. Centers for Disease Control and Prevention, National Vital Statistics System, Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research, 2007-10
p. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2015
q. State Cancer Profiles, 2011-15
r. State Cancer Profiles, 2009-13
s. Centers for Medicare and Medicaid Services, 2015
t. Centers for Disease Control and Prevention, National Vital Statistics System, US Department of Health & Human Services, Health Indicators Warehouse, 2006-12
u. Centers for Disease Control and Prevention, National Vital Statistics System, 2012-16
v. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-10

8. DATA SUMMARY

Primary and Secondary Data: High Level Findings

Once all primary and secondary data was collected, this was then analyzed and categorized into top 8-10 priorities per source of data. These results are listed by source in the tables below.

Top 8-10 Priorities determined from Stakeholder Interviews					
1	Health Literacy	**5**	Physical inactivity	**9**	Smoking
2	Diabetes	**6**	Lack of family/support systems	**10**	Poverty
3	High blood pressure/cholesterol	**7**	Obesity		
4	Mental Health disorders	**8**	Poor Nutrition		

Top 8-10 Priorities determined from Community Surveys					
1	Transportation	**5**	Obesity	**9**	Cancer
2	Mental health	**6**	Physical inactivity	**10**	Immunizations
3	Access to care	**7**	Food insecurity		
4	Education	**8**	Poverty/Livable wage		

Top 8-10 Priorities determined from Hospital Emergency Department Data					
1	Chest Pain	**5**	Urinary Tract infection	**9**	Nausea and vomiting
2	Unspecified Abdominal Pain	**6**	Headache	**10**	Acute pharyngitis
3	Acute Upper Respiratory Infections	**7**	Epigastric Pain		
4	Lower Back pain	**8**	Cough		

Top 8-10 Priorities determined from Hospital Inpatient Admission Data					
1	Psychoses	**5**	Heart Failure	**9**	Simple Pneumonia and Pleurisy
2	Septicemia or severe sepsis	**6**	Chronic obstructive pulmonary disease	**10**	Acute Myocardial Infarction
3	Diabetes	**7**	Circulatory disorders		
4	Major hip and knee joint replacement	**8**	Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders		

Top 8-10 Priorities determined from Secondary Data provided by The Engagement Network					
1	High blood pressure	**5**	Asthma	**9**	Heart disease
2	Obesity/overweight	**6**	Physical inactivity	**10**	Suicide
3	Diabetes	**7**	Food insecurity		
4	Depression	**8**	Poverty/Livable wage		

Primary and Secondary Data: Aggregate Community Health Needs

At a subsequent CHNAC meeting, primary data from the community surveys, stakeholder surveys, along with secondary data was presented. The committee identified common themes in the data. Each member ranked their top 10 priorities. The eight priorities that were selected by most committee members were then evaluated based on relevance, impact and feasibility.

Top 8 Priorities				
	Priority Issue	Ethnic Group	Age Group	Specific Geographic Area
1	Mental health	Hispanics, African Americans	Varies	N/A
2	Obesity/ Overweight	Hispanics, African Americans	Children, Adults	N/A
3	Food insecurity	Hispanics, African Americans	Seniors, Children	Rural Areas (Lampasas, Copperas Cove), North Killeen
4	Poverty	Hispanics, African Americans	Varies	North Killeen
5	Diabetes	Hispanics, African Americans, Asians	Adults, Seniors	N/A
6	Physical inactivity	Varies	Children, Adults, Seniors	N/A
7	Transportation	Varies	Seniors	North Killeen, Rural Communities
8	Respiratory (smoking, asthma)	Varies	Adults, Seniors	N/A

9. COMMUNITY ASSET INVENTORY

In order to help AdventHealth Central Texas and AdventHealth Rollins Brook's CHNAC determine the community health priorities where they could make a meaningful difference, the Hospitals conducted a Community Asset Inventory related to the top eight identified community health needs. The inventory was designed to help the CHNAC narrow the eight needs to the top three to four priority issues. Appendix C includes expanded community information for priorities selected to be addressed.

COMMUNITY ASSET INVENTORY		
Top Issues Defined by Primary/Secondary Data	**Current Community Programs**	**Current Hospital Programs**
Physical Inactivity	• Local Gyms • Senior Centers • City run parks and walking trails • Healthy Kids Running Series	• Free weekly exercise classes • With A Doc Program • Annual Silver Classic 5K • CREATION Health Seminars
Mental Health	• Free/Low-cost counseling Services • Inpatient and outpatient treatment Facilities	• AdventHealth Behavioral Health Center • Grief Support meetings. • Faith Leader Mental Health Seminars • CREATION Health Seminars
Poverty	• Housing authorities • Financial assistance • Employment preparedness • Educational assistance	• Financial assistance
Diabetes	• Killeen Community Clinic (chronic care) • Texas A&M AgriLife Extension educational Programming • Local food banks	• Diabetes self-management classes
Transportation	• Hill County Transit District (HOP Bus) • The Hop ADA Paratransit	• Taxi rides • Bus tokens
Obesity/overweight	• Texas A&M AgriLife extension education programs • Local gyms • Local food banks • Greater Killeen Community Clinic	• Free Community Workout classes • Free community health screenings • CREATION HEALTH SEMINARS
Food Insecurity	• Local food banks • WIC Supplemental Nutrition Assistance Program (SNAP) • Hill County Transit District (HOP Bus)	• Social workers/care management to work with patients to identify resources
Smoking/Asthma	• Bell County Public Health Department, Lampasas Public Health Department	• Better Breathers Club • Respiratory therapy department

10. PRIORITY SELECTION

Priority Selection using the RATING & PRIORITIZING KEY HEALTH ISSUES WORKSHEET

The top eight issues identified from the CHNAC data review of household data, key informant survey responses and the top inpatient and ED admissions data were reviewed and discussed alongside the Community Asset Inventory to identify the top priorities that the Hospital would be best able to impact.

The CHNAC utilized a tool called the *Rating & Prioritizing Key Health Issues Worksheet* to help identify which issues would be addressed.

This worksheet utilized the following criteria for each issue:

1. Relevance: How important is this issue?
2. Impact: What will we achieve by addressing this issue?
3. Feasibility: Can we adequately address this issue?

Each potential issue was rated based on the above criteria, with a scoring of 1 = lowest priority, to 4= highest priority.

Relevance How important is this issue?	**Impact** What will we achieve by addressing this issue?	**Feasibility** Can we adequately address this issue?
• Size of problem (e.g. % population) • Severity of problem (e.g. Cost to treat, lives lost) • Urgency to solve problem; community concern • Linked to other important issues	• Availability of solutions/proven strategies • Builds on or enhances current work • Significant consequences of not addressing issue now	• Availability of resources (staff, community partners, time, money) to address issue • Political capacity/will • Community/social acceptability • Appropriate socio-culturally • Can identify easy, short-term wins

Below are the eight issues identified with composite scores from the participating CHNAC members.

Composite Score for CHNAC

Health Issue	Relevance	Impact	Feasibility	Composite Score for CHNAC
Physical Inactivity	3	4	3	**10**
Mental Health	4	3	4	**11**
Poverty	3	2	2	**7**
Diabetes	2	3	2	**7**
Transportation	3	2	1	**6**
Obesity	3	3	2	**8**
Food Insecurity	4	3	3	**10**
Smoking/Respiratory	2	2	2	**6**

Rationale for Community Issues that the Hospital Will Address

RATIONALE FOR COMMUNITY ISSUES THE HOSPITAL WILL ADDRESS		
Relevance How important is this issue?	**Impact** What will we achieve by addressing this issue?	**Feasibility** Can we adequately address this issue?
1. Physical Activity		
1 in 4 individuals are physically inactive 42.4% of the population is overweight	Potential to expand current wellness program at AdventHealth Increase health care costs and chronic disease prevalence	Free community wellness programming, including free workout class AYMCA, City of Killeen, KISD
2. Mental Health		
19.1% of Medicaid eligible adults are impacted by some type of mental illness Adults have 3.6 mental unhealthy days per 30-day period.	The community and the Hospitals already have several resources and programs in place to support mental wellness Higher unemployment, poverty, mortality rates, and prevalence of disability	Inpatient and outpatient behavioral health department Starry, greater Killeen Community Clinic, Rollins Brook A&M, NAMI, Fort Hood, faith-based communities
3. Food Insecurity		
20.9% of individuals are food insecure There are no grocery stores on the north side of Killeen	Expanding access of resources to those communities in greatest need Weight gain, premature mortality, limited healthy food choices	Community grants, food pantry, social workers Food Care Center, church-based food banks, WIC, Hill Country Transit District, Killeen ISD (CEP)

Rationale for Community Issues that the Hospital Will Not Address

RATIONALE FOR COMMUNITY ISSUES THE HOSPITAL WILL NOT ADDRESS		
Relevance How important is this issue?	**Impact** What will we achieve by addressing this issue?	**Feasibility** Can we adequately address this issue?
1. Poverty		
13.7% live below the FPL $22,852.00 income per capita	Increase access to affordable and safe housing, education, living wage jobs Limited access to safe housing, food and education. Decreased health outcomes.	Community partners that alleviate the symptoms of poverty such as food insecurity, housing, transportation, education and employment
2. Diabetes		
10.2% of the adult population have diabetes 21.5 deaths per 100,000 are related to diabetic complications	Access to health care, preventative measures such as healthy diets and exercise. Higher mortality, increased health care costs	Community partners to provide for the healthcare needs, educational and nutritional needs of those with diabetes Greater Killeen Community clinic, Cove House Clinic, Bell county indigent Health, Bell County Diabetes Coalition. Food Care Center
3. Transportation		
5.7% of the population does not have access to a vehicle 87,269 working adults rely on public transportation	Increase bus routes and times to make them more readily available to community members Increased unemployment, inability to meet basic needs such as access food and make appointments	Community partners to sponsor additional bus routes Hill County Transit District, meals on wheels, home health agencies
4. Obesity		
30.1% of adults have a BMI >30 42.4% of the population is overweight	Lifestyle changes: Increased physical activity, healthier diet, regular primary care visits Higher prevalence of chronic disease, increased health care costs	Free and low-cost options for physical activity and healthy foods AYMCA, City of Killeen, KISD, Food Care Center
5. Smoking/Respiratory		
18.2% of adults currently smoke 43.34 deaths per 100,000 are related to lung disease	Access to health care Higher mortality, increased health care costs	Educational opportunities about smoking and lung diseases provided by the Hospital and community partners, smoking cessation programs Bell, Coryell or Lampasas county health departments

11. PRIORITY ISSUES TO BE ADDRESSED

Issue 1: Physical Inactivity

Physical Inactivity is the percentage of adults age 20 and older reporting no leisure-time physical activity (County Health Rankings & Roadmaps, 2018). Physical inactivity is linked to higher prevalence of chronic diseases and increased health care costs. Inactivity caused 11% of premature mortality in the United States and caused more than 5.3 million of the 57 million deaths that occurred worldwide in 2008 (The Lancet, 2012). It is recommended that adults get 150 minutes of moderate intensity aerobic activity per week (American Heart Association, 2018).

In the Hospitals service area, 25% of community members do not participate in physical activity (County Health Rankings & Roadmaps, 2018). These results were validated in the prevalence of chronic diseases and the community survey revealed 42% of respondents participate in 30 minutes of physical activity less than 3 days a week.

The Hospitals addressed physical inactivity on the previous 2016 CHNA. In response to the issue, the Hospitals developed a wellness program to offer 13 free fitness classes a week. The Hospitals foundation is currently raising funds to build a dedicated wellness building that would allow for expansion of classes.

Issue 2: Mental Health

Mental wellness is a good indicator of overall health. Mental Wellness can influence other factors of health including mortality rates, unemployment, poverty and the percentage of adults who did not complete high school.

The Hospitals service area houses Fort Hood, one of the largest military bases in the world. There is 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 Hospitals' service area reported an average of 3.6 mentally unhealthy days in the past 30 days (County Health Rankings & Roadmaps, 2018). 19.1% of Medicaid eligible adults are impacted by some type of depression (County Health Rankings & Roadmaps, 2018). Community stakeholders reported high needs for mental health services in the populations they serve. Bell county does have a significantly higher number of mental health providers, 480 individuals: 1 provider, as compared to the Texas average, 960 individuals : 1 provider (County Health Rankings & Roadmaps, 2018).

Issue 3: Food Insecurity

Food insecurity is a lack of consistent access to enough food for an active, healthy life (USDA, 2019). A lack of healthy food can heave detrimental impacts on one's overall health. Food insecurity is not isolated to those in poverty and it often presents with other issues such as low incomes, lack of transportation and medical concerns (Feeding America, 2019). In 2018, an estimated 1 in 9 Americans were food insecure, equating to more than 37 million Americans, including more than 11 million children (U.S. Department of Agriculture Economic Research Service, 2019). 20.9% of individuals in the Hospitals' service area are food insecure (County Health Rankings & Roadmaps, 2018). This is significantly higher than the nations average of 1 in every 9 individuals being food insecure (Feeding America, 2019). This concern has become exacerbated on the north side of Killeen, as both grocery stores have closed in the past year.

12. PRIORITY ISSUES THAT WILL NOT BE ADDRESSED

Issue 1: Poverty

There are strong connections between poverty and poor health, contributing to unstable housing, low income, unsafe neighborhoods, or substandard education (CDC, 2019). In the Hospitals' service areas, 13.7% of the population lives below the Federal Poverty Level (FPL). 26.7 % of survey respondents have an annual household income of less than $35,000 and 36.8% of respondents have not completed post-secondary education. Many community partners are addressing the contributing factors of poverty; including education, housing, transportation, job placement, childcare and nutrition. The CHNAC believes that addressing the issue of food insecurity will benefit impoverished members of the community.

Issue 2: Diabetes

Of the Hospitals' service population, 10.2% has diabetes, compared to the state of Texas, which is 9.54% (County Health Rankings & Roadmaps, 2018). Diabetes lowers life expectancy by up to 15 years and increases the risk of heart disease by two to four times (CDC, 2018). Since other community partners are doing work to provide diabetes resources and education, the CHNAC opted not to select this as a top priority

Issue 3: Transportation

In the Hospitals' service area, 5.7% of the population does not have access to a vehicle (U.S. Census Bureau,2017). These individuals must rely on some type of car pool or public transportation, often making it difficult to make appointments, consistently have access to healthy foods and find employment. Currently, the Hill Country Transit District (the HOP) operates five fixed routes throughout Killeen and Copperas Cove, including the ADA Paratransit to accommodate individuals with disabilities in rural areas. The HOP is currently developing options to expand operation times and increase routes. This priority was not selected because other community partners are currently addressing transportation needs.

Issue 4: Smoking/Respiratory

More than 16 million Americans are living with a disease caused by smoking (CDC, 2019). Smoking causes cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis (CDC, 2019). All measures related to smoking prevalence and respiratory diseases were high in the service area when compared to the state average. 18.2% of adults currently smoke and 43.34 deaths per 100,000 are related to lung disease. 14.8% of our service area has been

diagnosed with asthma. Effective September 1, 2019, the state of Texas passed a bill to increase the legal sale of tobacco age to 21. The Hospitals do not currently have the capacity to address the issue at this time.

Issue 5: Obesity

30.1% of the Hospitals' service area is obese and 42.4% are overweight. Individuals with a Body Mass Index (BMI) over 30 are considered obese and a BMI over 25 are overweight (CDC, 2018). People who have obesity are at increased risk for many serious diseases and health conditions including the following: type 2 diabetes, high cholesterol, some cancers, pain, stroke and other chronic illnesses (CDC, 2018). The Hospitals will address two of the contributing factors to obesity, including food insecurity and physical inactivity.

13. NEXT STEPS

The CHNAC will work with AdventHealth Central Texas and AdventHealth Rollins Brook and other community partners to develop a measurable Community Health Plan for 2020-2022 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 prior to May 15, 2020.

14. WRITTEN COMMENTS REGARDING 2016 NEEDS ASSESSMENT

We posted a link to the most recently conducted CHNA and most recently adopted implementation strategy 2016 on our Hospitals' website as well as AdventHealth.com prior to May 15, 2017 and have not received any written comments.

15. REVIEW OF STRATEGIES UNDERTAKEN IN THE 2017 COMMUNITY HEALTH PLAN

AdventHealth Central Texas and AdventHealth Rollins Brook previously implemented a 2017 Community Health Plan which included shared strategies to improve health in targeted areas. The Hospitals' conduct an annual evaluation of the progress made from the implementation strategies from the Community Health Plan. The evaluation is reported to the IRS in Form 990. The following is a summary of progress made on the most recently adopted plan.

Priority #1: Asthma prevention and management

2016 Description of the Issue:

Asthma affects more children than any other chronic disease in our service area and is one of the most frequent reasons for Hospital admissions among children.

Asthma is a chronic, potentially life-threatening, inflammatory disease of the airways that is increasingly being recognized as a major public health problem. Based on data, the prevalence of asthma has risen and continues to rise in our service area and across all demographic groups, whether measured by age, race or gender. Asthma has a major impact on the health of our population.

Currently it is estimated that 24.7 million people nationwide have asthma. More than a third of those with asthma are children under 18. It is the most common chronic disease among children, and is the leading cause of school absenteeism, resulting in more than 14 million missed school days annually. Asthma has serious consequences among adults as well. It is the fourth leading cause of adult work absences, and can lead to job loss, disability and premature death. Asthma accounts for many lost nights of sleep, disruption of family and caregiver routines, and reduced quality of life. 10.8% of adults report having been diagnosed with asthma. Using a conservative estimate of a 10% prevalence of asthma of all ages, more than 129,395 people suffer varying levels of disability, decreased quality of life and increased medical costs. Much of this disability and disruption of daily lives is unnecessary, because effective treatments for asthma are available.

However, asthma is a complex disease with numerous risk factors. This complexity requires a comprehensive solution involving many organizations and individuals and extends well beyond medical care into the realm of public health, behavioral and lifestyle modification, education, housing, environment, and other government and community services. To facilitate integration and provide a means to monitor and measure progress toward long-term goals, there must be a plan that guides the efforts of all who are involved in the management of asthma.

2019 Update:

In 2016, the Boys and Girls Club of Central Texas was awarded a three-year grant through the CREATION Health Investment Fund in the amount of $225,000 for a CREATION Life and asthma education program. CREATION Life is a faith-based wellness program based on eight principles: Choice, Rest, Environment, Activity, Trust, Interpersonal relations, Outlook and nutrition. AdventHealth Rollins Brook matched $75,000 dollars, to be paid out in three yearly increments. The CREATION Health Investment Fund is an internal AdventHealth grant program focused on initiatives to improve community health. The fund requires successful recipients to meet reporting requirements annually. Through the CREATION Life and asthma education program, children met weekly and were provided immersive learning experiences to increase their knowledge of asthma prevention and management.

Children participating in the CREATION Health and asthma education program completed a pre- and post-program survey to measure increased knowledge and understanding of asthma prevention and management. Additional program goals included the number of students enrolled and the number of students who achieved a 90% passing rate (increase in knowledge) on the post test. By the end of 2017, 333 students had completed the program. Of the students who completed the program, 181 had increased knowledge of asthma prevention and management.

In 2016 and the first two quarters of 2017, the Boys and Girls Club of Central Texas met or exceeded their requirements for each of the locations where the CREATION Health and Asthma prevention programming was hosted. For the last two quarters of 2017, the Boys and Girls Club did not meet the reporting requirements to receive the final installment in the amount of $100,000 in order to complete the third year of the CREATION Life and asthma prevention program. Currently we are working with leadership at the Boys and Girls Club of Rollins Brook to gather all the information necessary to complete the reporting for 2017. Once the report is complete, AdventHealth Rollins Brook and AdventHealth Central Texas will resubmit the necessary documents to the CREATION Health Investment Fund committee for approval to receive the final installment of the grant and complete programming at the Boys and Girls Club of Central Texas.

Priority #2: Cardiovascular Disease

2016 Description of the Issue:

Cardiovascular Disease (CVD) refers to several types of conditions that affect the heart and blood vessels. The most common type of heart disease in Bell County is coronary artery disease (CAD), which can lead to heart attacks. In our service area, almost 30-percent of adults do not participate in leisure time physical activity. More than 75 percent of adults in our service area eat less than five fruits and vegetables a day. Twenty-seven percent of Bell County residents are smokers. These risk factors place residents at risk for CVD.

CVD is the leading cause of death in Bell County. CVD is the leading cause of death for both men and women in our service area. High blood pressure and high cholesterol are two major risk factors for heart disease. About half of adults in our service area with high blood pressure and nearly two out of three adults with high cholesterol do not have their condition yet under control.

Many CVD risk factors such as high blood pressure, high cholesterol, excess weight, poor diet, smoking, and diabetes can be prevented or treated through health behavior change and appropriate medication. Some unpreventable risks for CVD are related to heredity, medical history, age, gender and race. There are also a number of underlying social, economic and cultural determinants of CVD such as stress, education level, income and insurance status.

AdventHealth Central Texas and AdventHealth Rollins Brook facilitate a total of seven to eight quarterly health screenings between the two campuses. These screenings are open to the public and employees. During these screenings, participants have their cholesterol, glucose, blood pressure, body fat percentage, BMI, height and weight, bone density and are sometimes offered and ABI Screening for free. Upon completing the screening all participants receive a carbon copy of their results, which they can take to their primary care physician (PCP) or have forwarded to their PCP. The Wellness Department coordinates the health screenings and keeps track of the number of people served via a sign in sheet. All results and sign in sheets are filed and kept in a locked filing cabinet in the Wellness Office for five years or more.

2019 Update:

High blood pressure, high cholesterol, high glucose and obesity can damage your heart and blood vessels. The regular screenings provided by AdventHealth Rollins Brooks and AdventHealth Central Texas gives community members a baseline of their numbers—blood pressure, cholesterol and glucose levels, BMI and body fat percentage—and helps to assess whether they need to take action. Part of the Hospitals' initiative is to help reduce the percent of residents in our service area (11%) who have CVD compared to 8.3% of Texas residents. To accomplish this goal AdventHealth Rollins Brook and AdventHealth Central Texas offered free community quarterly health screenings for cholesterol levels, glucose, BP, BMI, and body fat percentage that were held at the Hospitals. In 2018 AdventHealth medical group physicians were provided materials on the quarterly health screenings and were encouraged to make their patients aware of this free resource, empowering patients to maintain awareness of their current health status. In 2018, the Hospitals' hosted a total of 18 health screenings, screening a total of 435 individuals. The Hospitals did not meet the target goal of 450 screenings. To reach the target goal for 2019, the Hospitals will increase the number of community health screenings to at least 25 health screenings and expand the hours the screenings are offered.

Of the 435 individuals screened, 70.1% had moderately high to high blood pressure. Seventy-two percent of participant's Body Mass Index (BMI) indicated they were overweight or obese. Twenty-six percent of screened individuals had high cholesterol. Screened patients that were identified as having one or more risk factors for cardiovascular disease were provided a physician referral list to help match them with a primary care provider. Of those provided the referral list, 54 were actively seeking a primary care provider.

Priority #3: Increased Exercise and Activity

2016 Description of the Issue:

In the Hospitals' primary service area, the top health education priorities were weight loss programs with heart healthy/cooking classes, health awareness classes and healthy cooking classes for children, families and adults. Physical activity in our service area has become a major issue in public health as evidence emerges on the important role of physical activity in many health conditions, including

overweight and obesity, type 2 diabetes, cardiovascular disease risk, skeletal health and mental health. In particular, the issue of obesity in youth, and the link between this condition and type 2 diabetes, as well as the increases in diabetes is of high concern in the community.

Establishing links between physical activity and health outcomes is a fundamental phase of the behavioral epidemiology. An early phase of this framework is to identify valid and reliable ways to assess physical activity. Through suitable assessment methods many health outcomes identified are associated with physical activity, this logically leads to research identifying factors associated with physical activity and interventions to increase physical activity.

2019 Update:

Due to a high risk for obesity, type 2 diabetes, cardiovascular disease, skeletal health, and mental health in our service area, AdventHealth Rollins Brook and AdventHealth Central Texas provides an array of wellness classes to address these issues. Including, 12 workout classes, diabetes self-management courses, Walk with a Doc programing, foot reflexology, CREATION Life seminars and nutritional counseling. Each of the listed activities are free and open to the community. Over the past year, the Hospital has added two workout classes to the weekly schedule to meet the need for the growing demand of the classes. Each of the wellness programs incorporates the principles of CREATION Life to promote a comprehensive approach to self-care. CREATION Life is a faith-based wellness plan with lifestyle seminars and training for those who want to live healthier and happier lives and share this unique whole-person health philosophy. Based on eight principles: Choice, Rest, Environment, Activity, Trust, Interpersonal relations, Outlook and nutrition. In 2018, 52 Participants completed the CREATION Life seminars, exceeding the target goal. These seminars were accompanied with pre and post health screenings to encourage participants to become more aware of their current health status.

To meet the growing demand for wellness programs, the Hospitals has added two workout classes to the weekly schedule, the monthly Walk With a Doc program and weekly foot reflexology to the wellness programing in 2018. Due to the expanded wellness offerings, the Hospitals' were able to exceed the goal for year two, with 347 nonreplicated participants in 2018. There has been a great response by attendees in the classes, with many attending multiple classes and taking advantage of the other wellness offerings, such as health screenings and support groups. The greatest challenge is the limited space for the wellness classes; many of the classes are now at capacity. The Hospitals' foundation is currently raising funds to have a dedicated wellness building built on the campus to provide adequate to space to grow the wellness program.

APPENDIX A: PRIMARY DATA SURVEY & PRIMARY DATA RESULTS

AdventHealth Community Survey

1. How important are the following issues?

	Extremely Important	Very Important	Somewhat Important	Not Important
QUALITY CHILDCARE IS AVAILABLE AND AFFORDABLE				
PEOPLE ARE ABLE TO FIND AND KEEP JOBS THAT PAY WELL ENOUGH TO SUPPORT THEMSELVES AND THEIR FAMILIES				
AFFORDABLE HOUSING IS AVAILABLE				
SUICIDE PREVENTION RESOURCES ARE AVAILABLE				
TRANSPORTATION IS AVAILABLE AND EASILY ACCESSIBLE				
PEOPLE ARE FREE FROM ADDICTION TO PRESCRIPTION AND/OR STREET DRUGS (E.G., HEROIN, METH)				
PEOPLE HAVE OPPORTUNITIES TO RECEIVE HIGHER EDUCATION OR SKILLS TRAINING				
MENTAL HEALTH CONCERNS ARE RECOGNIZED IN OUR COMMUNITY				
QUALITY MEDICAL CARE AND PREVENTIVE SCREENINGS ARE AVAILABLE FOR ALL				
RESOURCES ARE AVAILABLE TO HELP RESIDENTS DURING TIMES OF NEED				

2. On how many of the last SEVEN DAYS did you participate in at least 30 minutes of physical activity? (Continuous activity, including walking, biking, etc.)

(#)_____

4. On how many of the last SEVEN DAYS did you eat 5 or more servings of fruits and vegetables?

(#)_____

3. Thinking about breakfast, lunch, and dinner, on how many of the last SEVEN DAYS did you eat meals that were not prepared at home, such as restaurants, cafeterias, or fast food?

(#)_____

5. For each of the following barriers to exercise, please indicate if you agree or disagree.

	Agree	Disagree
I DON'T HAVE TIME TO EXERCISE		
IT COSTS TOO MUCH TO EXERCISE		
EXERCISE IS NOT IMPORTANT TO ME		
IT IS DIFFICULT TO MOTIVATE MYSELF TO EXERCISE		
I WOULD NEED CHILD CARE AND I DON'T HAVE IT		
I HAVE PHYSICAL CHALLENGES THAT PREVENT ME FROM EXERCISING		
THE AMOUNT OF CRIME MAKES IT UNSAFE TO EXERCISE IN MY NEIGHBORHOOD		

6. What do you see as the greatest health problems/conditions in our community. (select 3)

- ○ Cancer
- ○ Heart disease/Cholesterol
- ○ High Blood Pressure
- ○ Respiratory Disease- Adults
- ○ Asthma-Children
- ○ Diabetes
- ○ Mental Health Disorder/PTSD
- ○ Immunizations
- ○ Teen Pregnancy/low birth weight

7. In the past 12 months, was there a time you needed to see a doctor but could not because of cost?

○ Yes ○ No

8. In the past 12 months, have you ever had to go without health are because you didn't have a way to get there?

○ Yes ○ No

9. Within the past 12 months the food we bought just didn't last and we didn't have money to get more.

○ Yes ○ No

10. In the past 12 months has your utility company shut off your service for not paying your bills?

○ Yes ○ No

11. Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household?

○ Yes ○ No

12. Are you afraid you might be hurt in your apartment building or house?

○ Yes ○ No

13. Do problems getting child care make it difficult for you to work or study?

○ Yes ○ No ○ Not Applicable

14. For each of the following barriers to healthy eating, please indicate if you agree or disagree.

	Agree	Disagree	Sometimes
I DON'T LIKE THE TASTE OF HEALTHY FOOD			
I HAVE NO DESIRE TO EAT HEALTHY			
I DON'T KNOW WHAT FOODS ARE HEALTHY			
I DON'T KNOW HOW TO PREPARE HEALTHY FOOD			
I HAVE TROUBLE STORING FRESH FOODS			
I DON'T HAVE ACCESS TO HEALTHY FOOD			
THERE ARE FEW HEALTHY OPTIONS OUTSIDE MY HOME			
HEALTHY FOOD COSTS TOO MUCH			
I DON'T HAVE TIME			
I ALREADY EAT HEALTHY			

16. How often do you feel you lack companionship?

○ Hardly Ever ○ Some of the time ○ Often

16. How often do you feel left out?

○ Hardly Ever ○ Some of the time ○ Often

17. How often do you feel isolated from others?

○ Hardly Ever ○ Some of the time ○ Often

18. Do you have someone who loves and cares for you?

○ Yes ○ No

19. Do you have a source of joy in your life?

○ Yes ○ No

20. Do you have a sense of peace today?

○ Yes ○ No

21. Which age category do you fall in?

○ 18-24 ○ 35-44 ○ 55-64 ○ 75+

○ 25-34 ○ 45-54 ○ 65-74

22. Health Insurance Status:

○ Private Health Insurance ○ Military/Veteran

○ Medicaid ○ No Insurance

○ Medicare

23. Household Income

○ Less than $25,000 ○ $35,000-$49,999 ○ $75,000-$99,999 ○ $150,000-$199,999

○ $25,000-$34, ○ $50,000-$74,999 ○ $100,000-$149,999 ○ $200,000+

24. Gender

○ Male ○ Female

25. Please specify your ethnicity

○ White ○ Native American or American Indian

○ Black or African American ○ Asian / Pacific Islander

○ Hispanic or Latino ○ Other:

26. Highest Education Level

○ Some Highschool ○ Bachelor's Degree

○ Highschool Graduate ○ Graduate Degree

○ Some College ○ Other Advanced Degree, Beyond Master's

○ Associate degree

27. How many people are in your household?

(#)_____

28. Are you a resident of Bell, Coryell, or Lampasas County

○ Yes ○ No

COMMUNITY SURVEY RESULTS

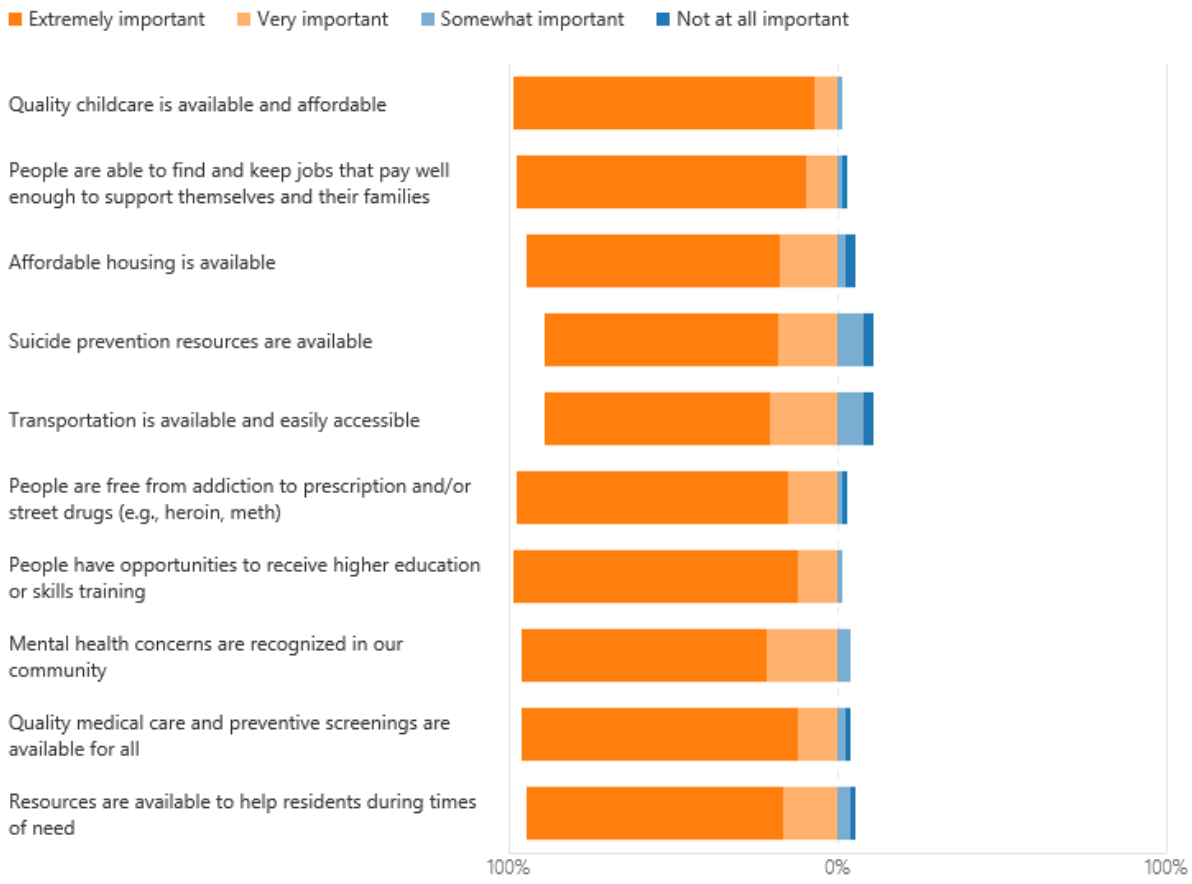
Community surveys were completed in collaboration with our CHNAC and community partners. Surveys were administered in person as well as online. The aggregate results are shown below.

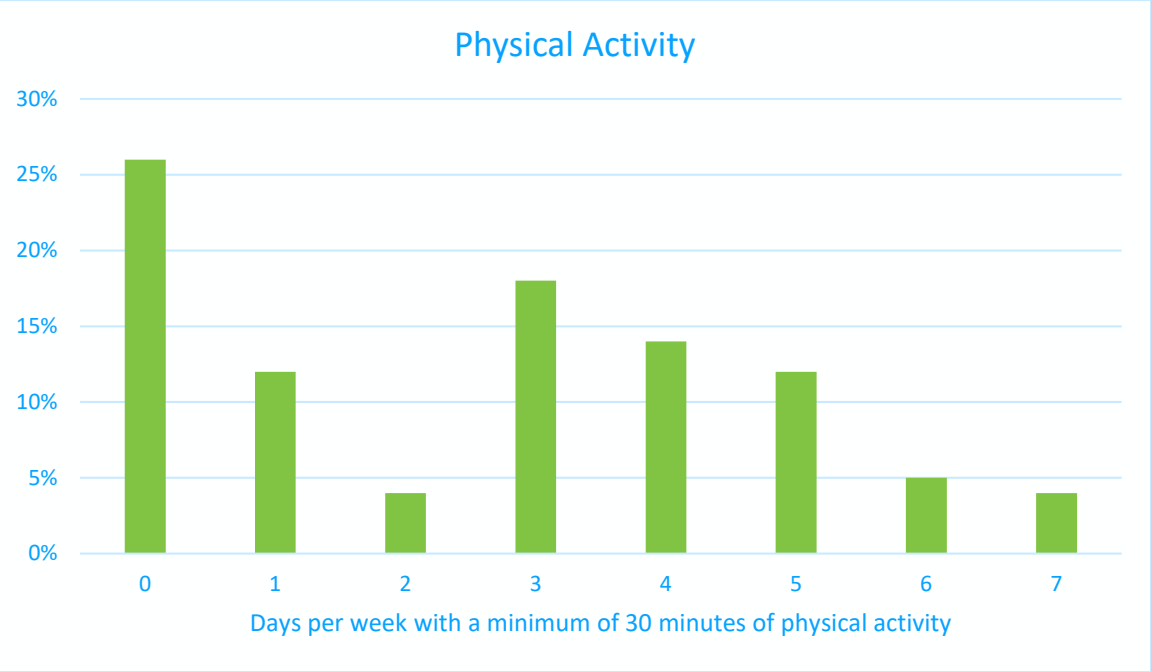
- 91 In-person surveys
- 124 Online surveys
- 25 Stakeholder surveys

SURVEY QUESTION	SURVEY RESULTS	
Demographic Questions		
Zip Code	The survey was distributed in Bell, Coryell, and Lampasas county. Coryell and Lampasas both represent rural communities. West Bell County represents a high population of low income and minorities.	
Household Size	Average: 4 individuals	
Gender	55% Female	45% Male
Highest Education Level	3.3% Some High School 8.3% High School Graduate 24.5% Some College	18.3% Associate Degree 18.3% Bachelor's Degree 14.2% Graduate Degree
Age	2.5% 18-24 Years 17.5% 25-34 Years 34.2% 35-44	22.5% 45-54 15.8% 55-64 Years 6.7% 65 Years or older
Ethnicity	10.8% Hispanic	90.2% Non-Hispanic
Race	53% White 32.5% African-American 5.8% Hispanic/Latino 4.2% Asian	4.2% Other 1.6% Native American/American Indian
Social Determinant Questions		

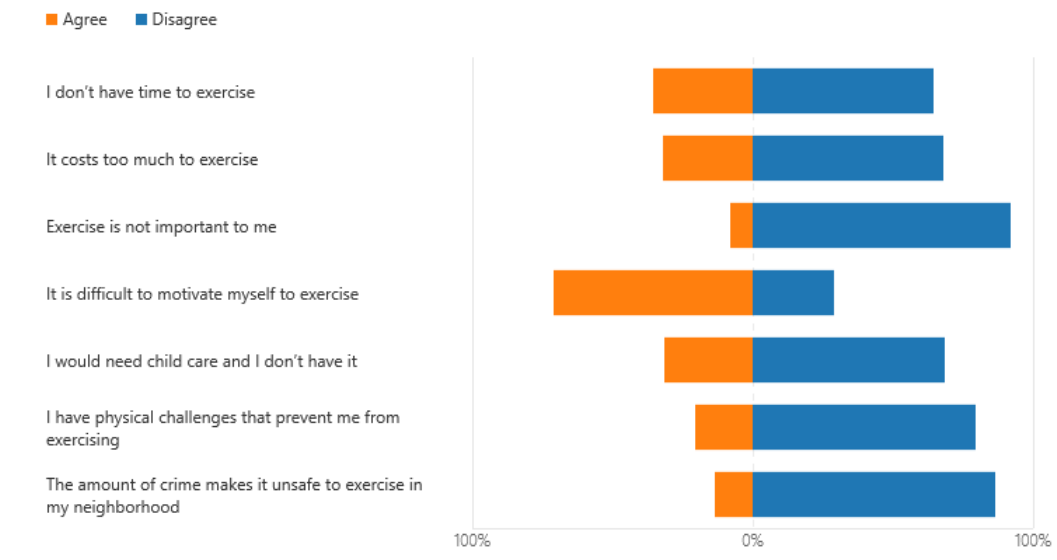
Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household?	10% Yes	90% No
In the past 12 months has your utility company shut off your service for not paying your bills?	6% Yes	94% No
In the past 12 months, was there a time you needed to see a doctor but could not because of cost?	37.5% Yes	62.5% No
In the past 12 months, have you ever had to go without health care because you didn't have a way to get there?	5% Yes	95% No
Are you afraid you might be hurt in your apartment building or house?	2.5% Yes	97.5% No
Do problems getting child care make it difficult for you to work or study?	20.8% Yes	35.4% No 43.4% N/A
How often do you feel that you lack companionship?	55.8% Hardly ever 31.6% Some of the time 10.8% Often	
How often do you feel left out?	55.8% Hardly ever 32.5% Some of the time 12.2% Often	
How often do you feel isolated from others?	57.5% Hardly ever 35% Some of the time 7.5% Often	

COMMUNITY HEALTH PRIORITIES

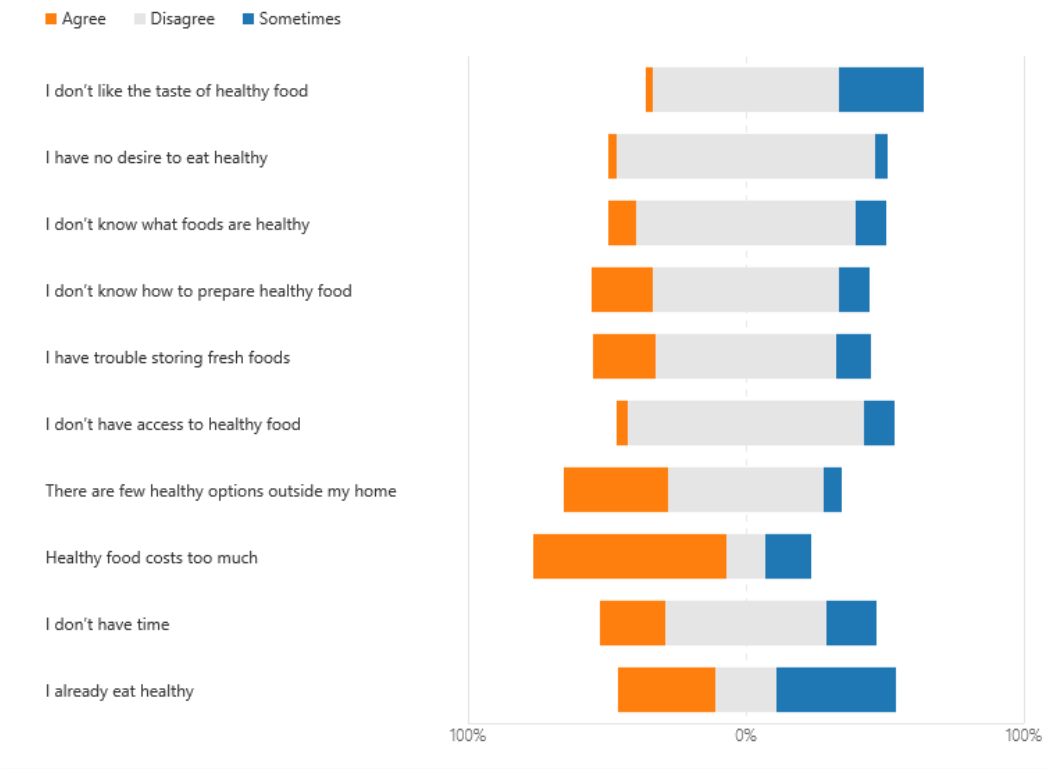




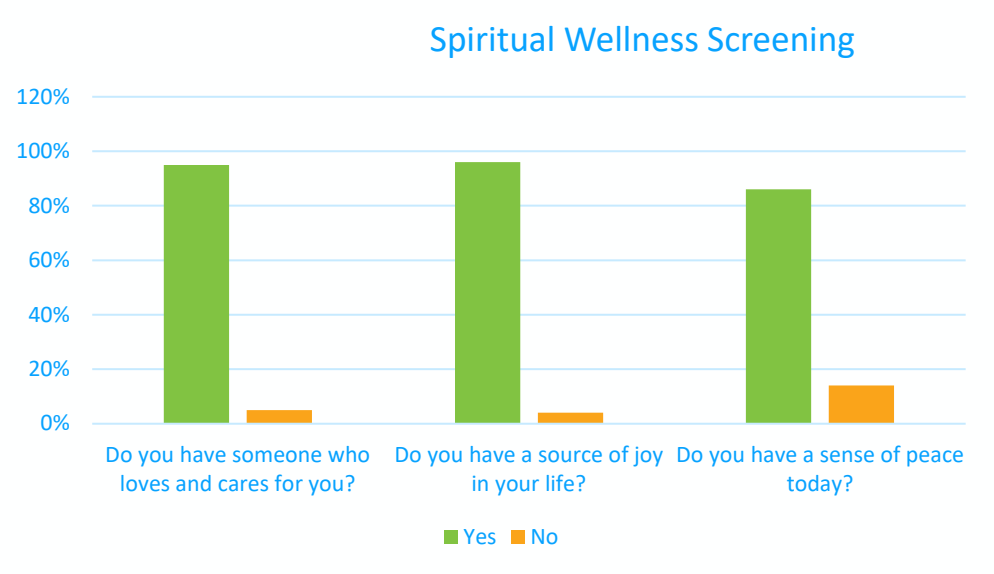
BARRIERS TO EXERCISE



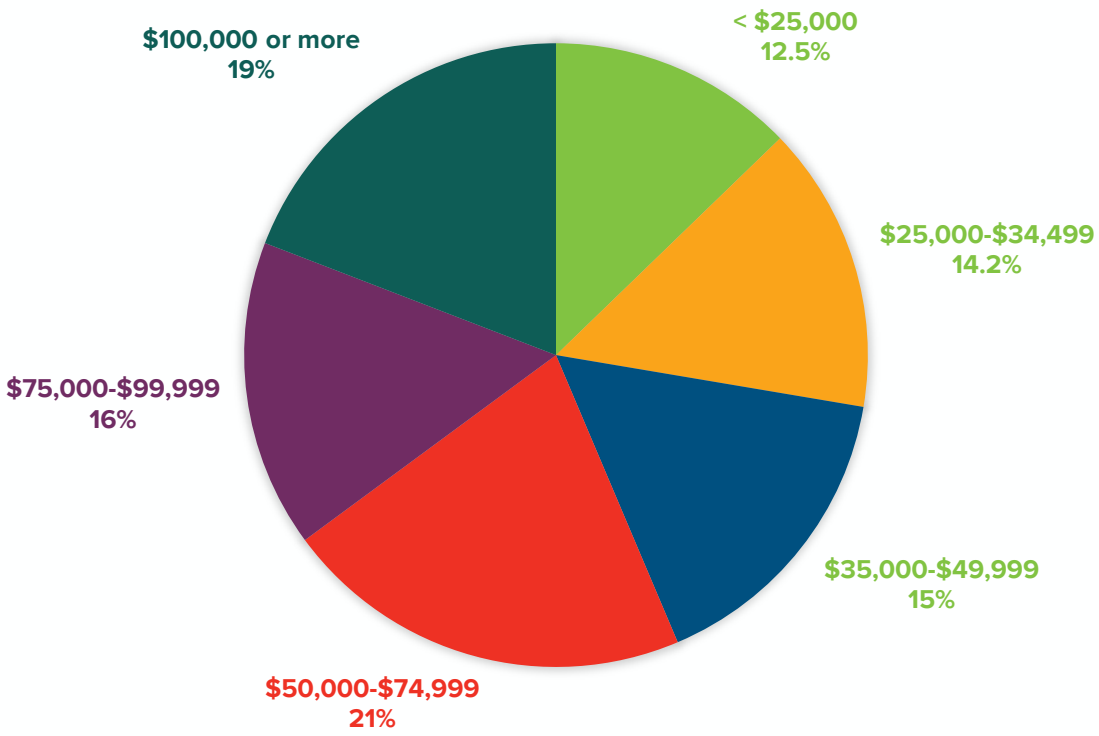
BARRIERS TO HEALTHY EATING



SPIRITUAL WELLNESS



HOUSEHOLD ANNUAL INCOME



HEALTH INSURANCE STATUS

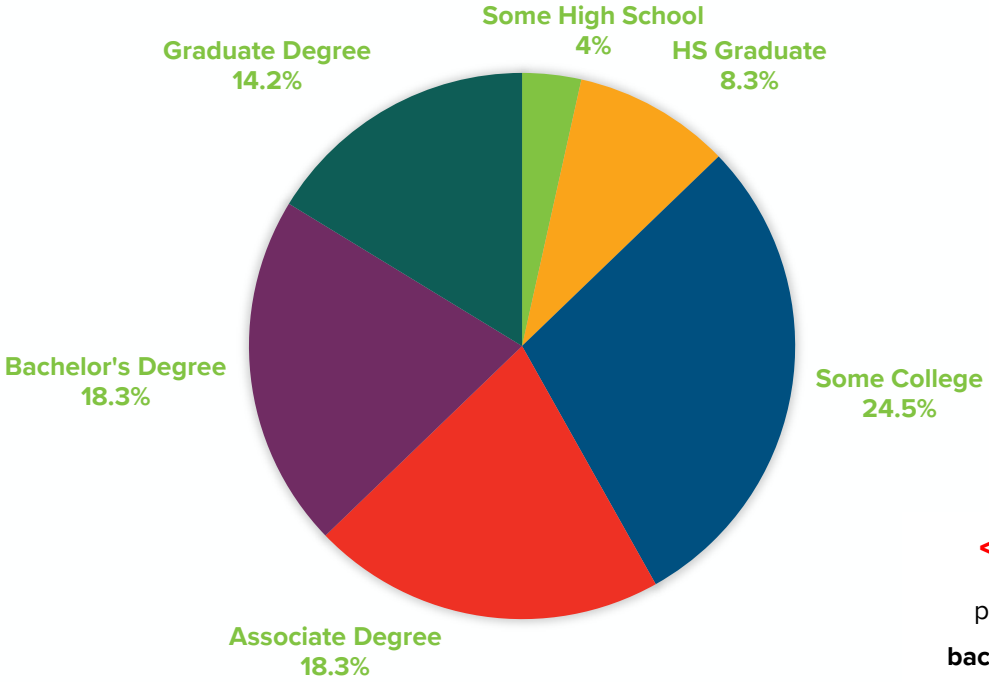
Private	Medicaid	Medicare	Military	Uninsured	Other
30.2%	14.2%	7.2%	27.6%	18.3%%	2.5%

GENDER

55%
Female

45%
Male

EDUCATION



<36% of the population has a **bachelor's degree** or higher

STAKEHOLDER INTERVIEW QUESTIONS

1. How would you rate the following?

	Excellent	Good	Fair	Poor	Very Poor
Overall community health status					
Your personal health status					
Community understanding of health risks					
Your own understanding of health risks					
Community quality of life					
Your quality of life					

2. What do you see as the greatest **health problems/conditions** in our community? (Select 3)

☐Asthma-children
☐Cancer
☐Diabetes
☐Heart disease
☐High blood pressure/cholesterol
☐Immunizations-children
☐Immunizations-adults
☐Mental health disorders
☐Respiratory disease-adults
☐Teen pregnancy rates/low birth-weight babies
☐Other:

3. Which **health behaviors/risk factors** are the most common in our community? (Select 3)

☐Aging population
☐Firearms in homes
☐Lack of exercise
☐Obesity
☐Poor nutrition
☐Risky sexual behavior
☐Smoking
☐Substance misuse-alcohol
☐Substance misuse-drugs

☐Lack of family/religious support systems	☐Seatbelt use	☐Other:

4. Which **community conditions** most impact the health of people in our community? (Select 3)

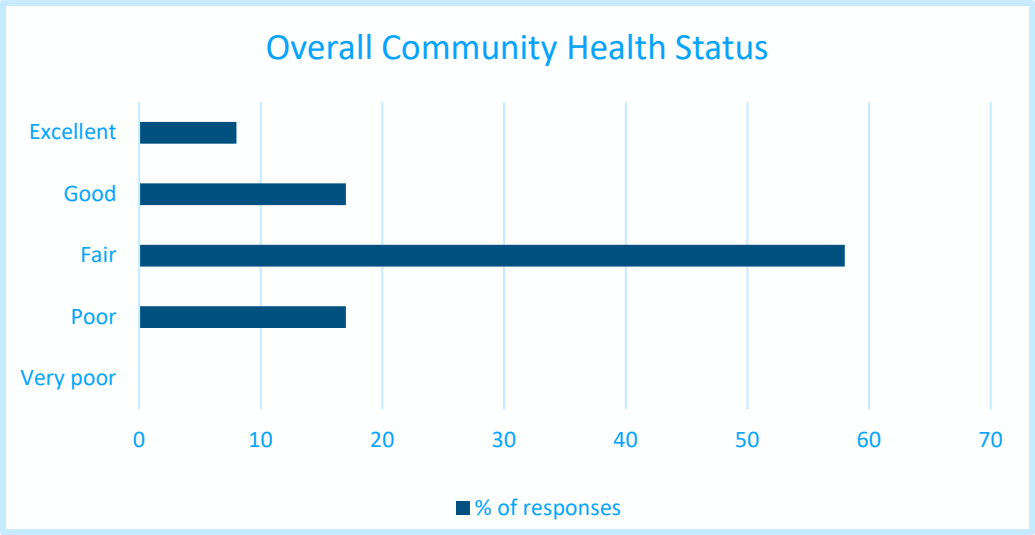
☐Access to dental care	☐Inadequate transportation	☐Low-income families/poverty
☐Air & water quality	☐Lack of health insurance/affordable care	☐Unemployment
☐Crime/violence	☐Lack of grocery stores/access to healthy food	☐Other:
☐Homelessness	☐Low education levels/literacy	

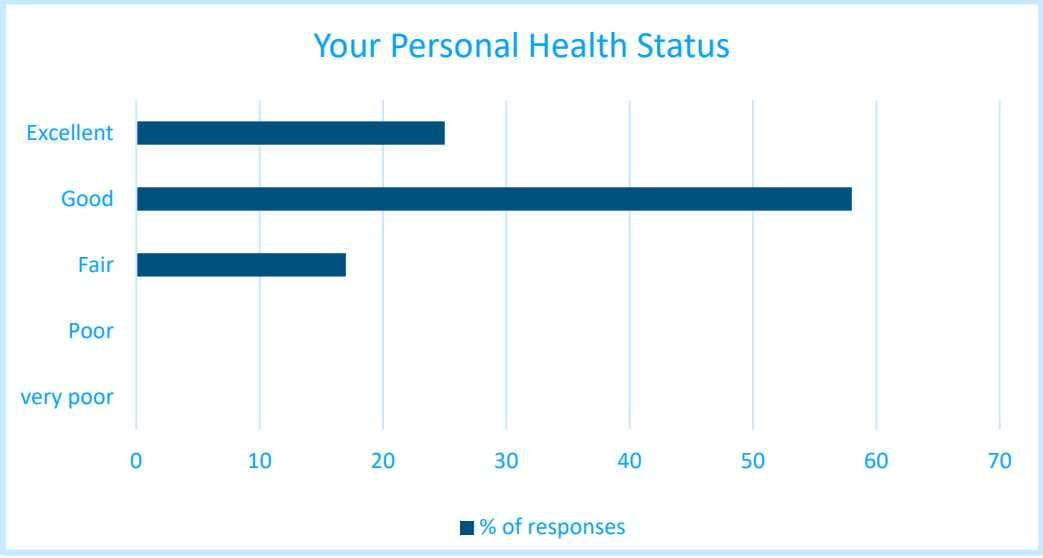
5. Who in our community promotes good health?	
6. What are one or two things that they do that are effective?	
7. If you were in charge of promoting good health, what would you do first?	

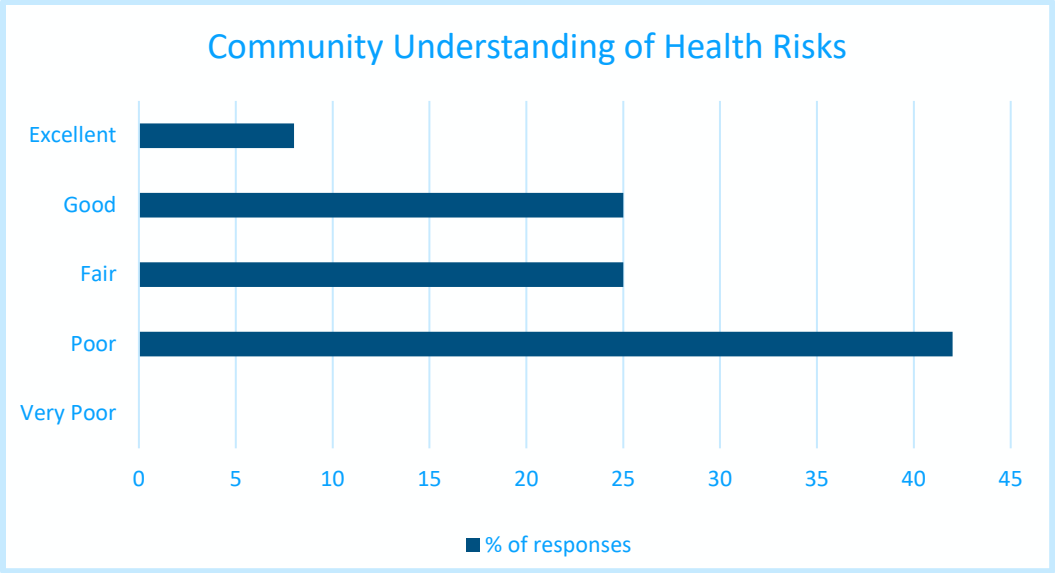
STAKEHOLDER SURVEY RESULTS

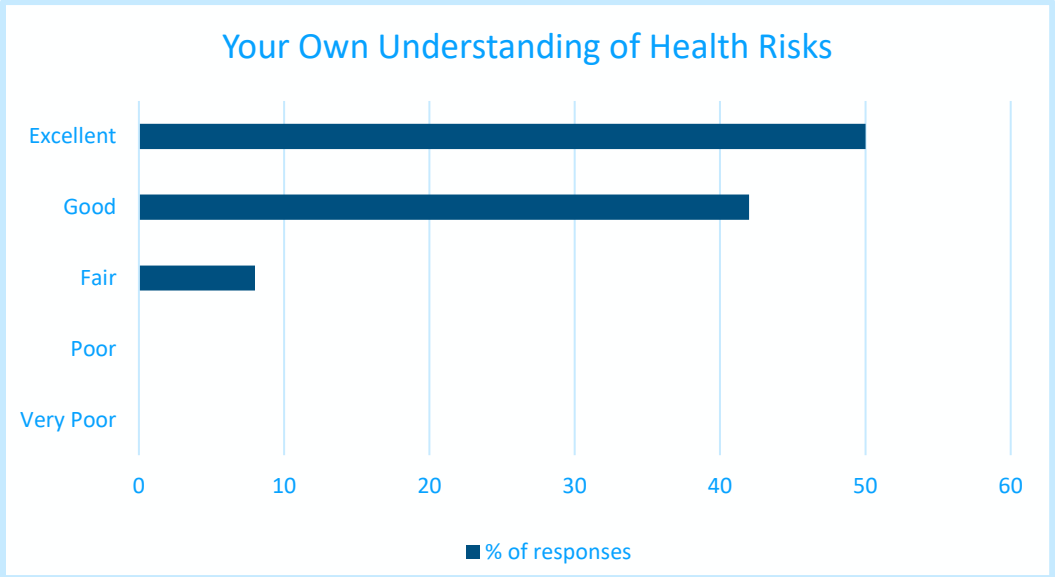
Stakeholder surveys were completed in collaboration with our CHNAC and community partners. Surveys were administered online. The aggregate results are shown below.

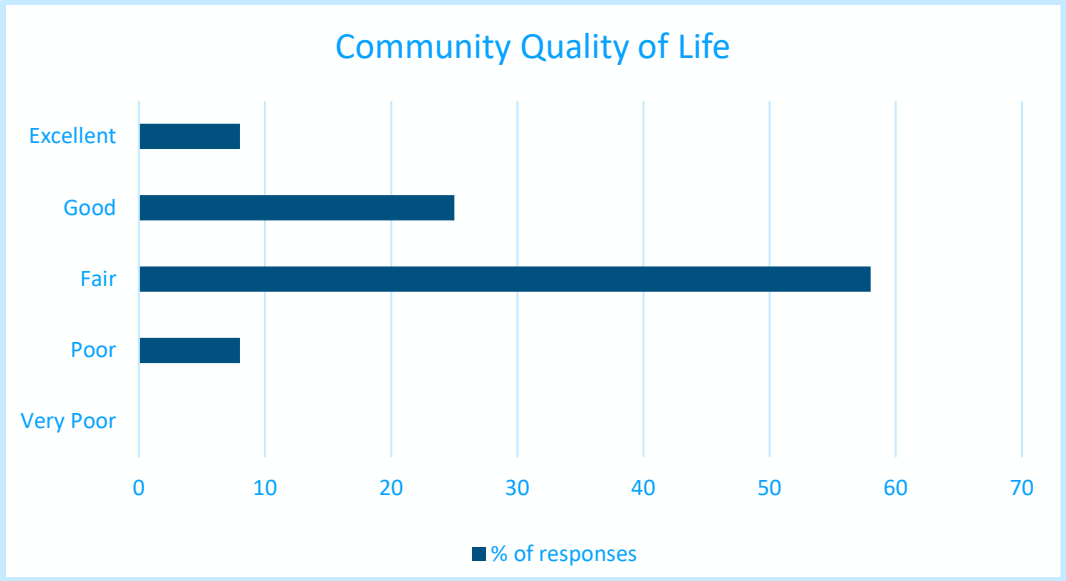
- 25 Online surveys

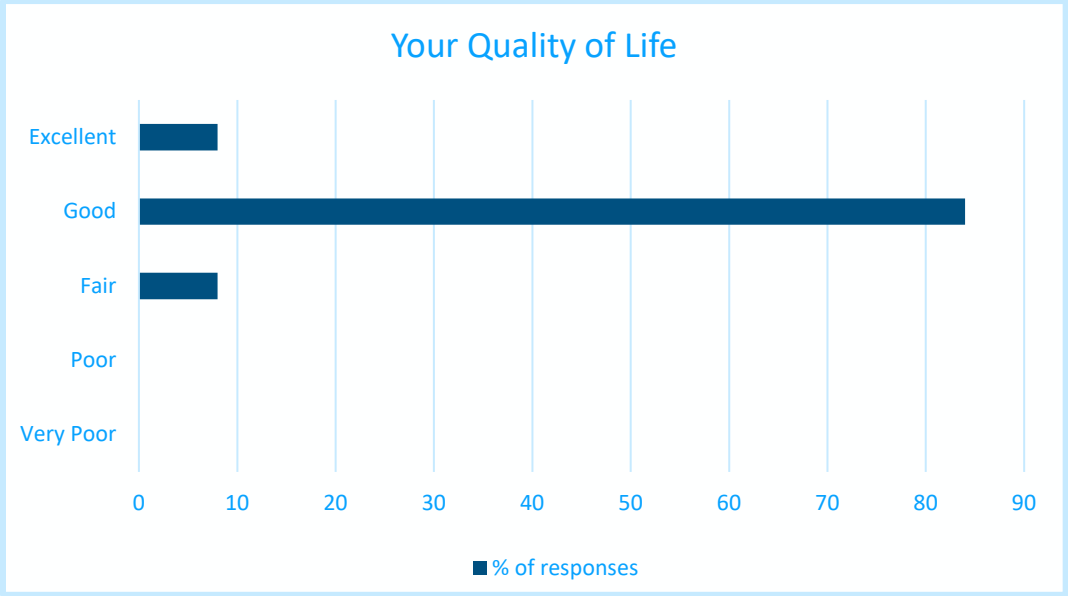


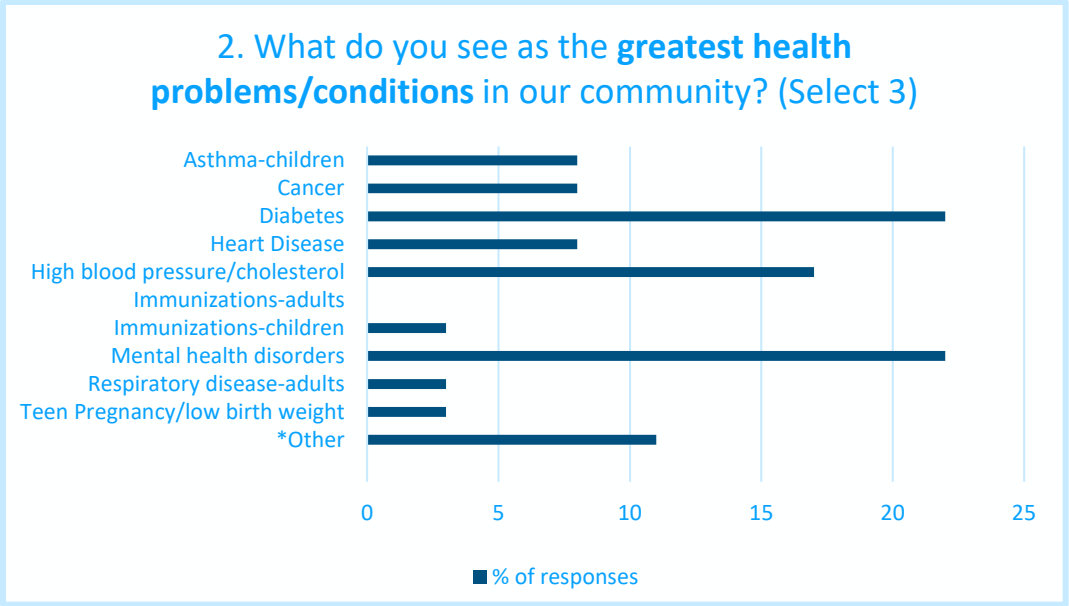



Community Understanding of Health Risks
Excellent
Good
Fair
Poor
Very Poor
0
5
10
15
20
25
30
35
40
45
% of responses

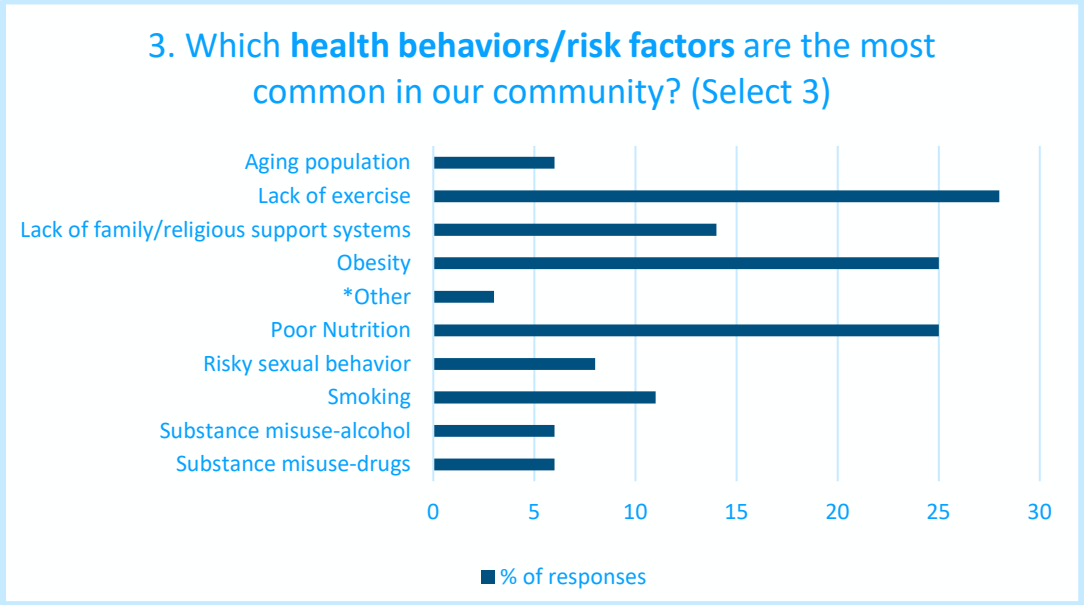

Your Own Understanding of Health Risks
Excellent
Good
Fair
Poor
Very Poor
0
10
20
30
40
50
60
% of responses


Community Quality of Life
Excellent
Good
Fair
Poor
Very Poor
0
10
20
30
40
50
60
70
% of responses

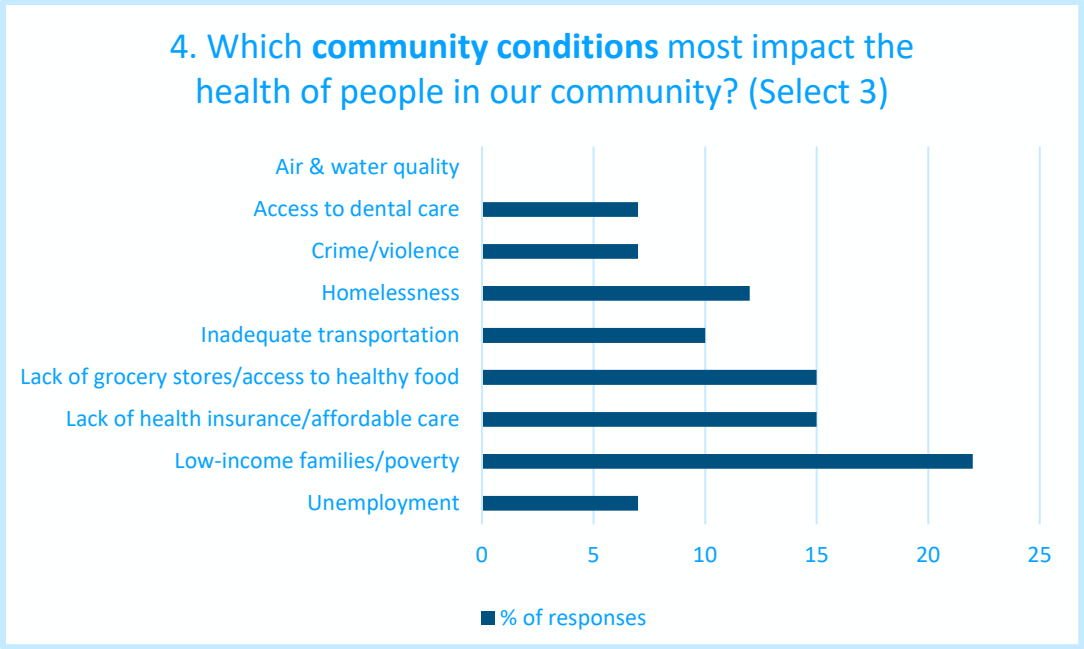

Your Quality of Life
Excellent
Good
Fair
Poor
Very Poor
0
10
20
30
40
50
60
70
80
90
% of responses



*Other health problems/conditions: Smoking/Tobacco, Obesity, ADHD /ADD, Inactivity.



*Other health behaviors/risk factors: lack of family practitioners.



5. Who in our community promotes good health?

Respondents named local Hospitals, the Killeen, Nolanville and Harker Heights parks and recreation departments as valuable health promotion entities in the Hospitals' Service Area. The Killeen Independent School District, Boys and Girls Clubs of Central Texas and the Harker Heights Library were mentioned for their continued dedication to children's health and wellness initiatives.

6. What are one or two things that they do that are effective?

The most common response was educational classes surrounding nutrition, chronic disease, and exercise. Community wide events such as 5K races, community gardens, parks, and walking trails were mentioned for creating a culture of wellness within the community.

7. If you were in charge of promoting good health, what would you do first?

The majority of respondents noted the need for funding to support health and wellness initiatives that target low income populations, specifically to provide more healthcare resources and educational classes. Many mentioned a need for more collaboration among community organizations to pool resources and have a more strategic focus.

APPENDIX B: SECONDARY DATA REPORT

AdventHealth Central Texas & AdventHealth Rollins Brook Needs Assessment Report - Quick Facts

Location

AdventHealth Rollins Brook and AdventHealth Central Texas (Service Area)

Demographics

Data Indicator	Indicator Variable	Location Summary	State Average
Population Age 65+	Total Population	196,840	27,419,612
	Population Age 65+	15,699	3,215,906
	Percent Population Age 65+	7.98%	11.73%
Population Age 0-18	Total Population	196,840	27,419,612
	Population Age 0-17	56,832	7,213,117
	Percent Population Age 0-17	28.87%	26.3%
Population Age 18-64	Total Population	196,840	27,419,612
	Population Age 18-64	124,310	16,990,589
	Percent Population Age 18-64	63.15%	61.97%
Total Population	Total Population	196,840	27,419,612
	Total Land Area (Square Miles)	600	261252.93
	Population Density (Per Square Mile)	328.03	104.95
Change in Total Population	Total Population, 2000 Census	137,743	20,851,666
	Total Population, 2010 Census	181,267	25,145,561
	Total Population Change, 2000-2010	43,524	4,293,895
	Percent Population Change, 2000-2010	31.6%	20.59%
Female Population	Total Population	196,840	27,419,612
	Female Population	100,328	13,802,635
	Percent Female Population	50.97%	50.34%
Hispanic Population	Total Population	196,840	27,419,612
	Non-Hispanic Population	151,205	16,745,703
	Percent Population Non-Hispanic	76.82%	61.07%
	Hispanic or Latino Population	45,635	10,673,909
	Percent Population Hispanic or Latino	23.18%	38.93%
Male Population	Total Population	196,840	27,419,612
	Male Population	96,512	13,616,977

	Percent Male Population	49.03%	49.66%

Social & Economic Factors

Data Indicator	Indicator Variable	Location Summary	State Average
Violent Crime	Total Population	196,840	27,419,612
	Violent Crimes	691	115,016
	Violent Crime Rate (Per 100,000 Pop.)	**361**	421.1
Population with No High School Diploma	Total Population Age 25+	117,565	17,454,431
	Population Age 25+ with No High School Diploma	10,253	3,005,904
	Percent Population Age 25+ with No High School Diploma	**8.7%**	17.22%
Poverty - Population Below 100% FPL	Total Population	195,382	26,794,198
	Population in Poverty	26,740	4,291,384
	Percent Population in Poverty	**13.7%**	16.02%
Insurance - Uninsured Adults	Total Population Age 18 - 64	113,431	16,743,634
	Population with Medical Insurance	93,864	12,959,711
	Percent Population with Medical Insurance	82.8%	77.4%
	Population Without Medical Insurance	19,567	3,783,923
	Percent Population Without Medical Insurance	**17.25%**	22.6%
Insurance - Uninsured Children	Total Population Under Age 19	53,844	7,559,241
	Population with Medical Insurance	49,774	6,824,162
	Percent Population with Medical Insurance	92.4%	90.28%
	Population Without Medical Insurance	4,071	735,079
	Percent Population Without Medical Insurance	**7.56%**	9.72%
Income - Per Capita Income	Total Population	196,841	27,419,612
	Total Income ($)	$4,498,295,085.00	$794,756,061,900.00
	Per Capita Income ($)	**$22,852.00**	$28,984.00
Unemployment Rate	Labor Force	75,787	14,043,429
	Number Employed	71,164	13,542,322
	Number Unemployed	4,623	501,107
	Unemployment Rate	**6.1%**	3.6%
Lack of Social or Emotional Support	Total Population Age 18+	128,256	17,999,726
	Estimated Population Without Adequate Social / Emotional Support	15,813	4,139,937
	Crude Percentage	16.9%	23%
	Age-Adjusted Percentage	**17.4%**	23.1%
	Female Population Age 15 - 19	6,207	914,438

Teen Births	Births to Mothers Age 15 - 19	369	50,294
	Teen Birth Rate (Per 1,000 Population)	**59.38**	55
Food Insecurity Rate	Total Population	184,253	28,305,168
	Food Insecure Population, Total	38,556	4,217,470
	Food Insecurity Rate	**20.9%**	14.9%
Poverty - Children Below 100% FPL	Total Population	195,382	26,794,198
	Population Under Age 18	55,935	7,129,893
	Population Under Age 18 in Poverty	10,615	1,630,901
	Percent Population Under Age 18 in Poverty	18.98%	22.87%

Physical Environment

Data Indicator	Indicator Variable	Location Summary	State Average
Use of Public Transportation	Total Population Employed Age 16+	87,269	12,550,476
	Population Using Public Transit for Commute to Work	554	187,311
	Percent Population Using Public Transit for Commute to Work	**0.63%**	1.5%
Population with Low Food Access	Total Population	181,266	25,145,561
	Population with Low Food Access	78,925	6,807,728
	Percent Population with Low Food Access	**43.54%**	27.07%

Clinical Care

Data Indicator	Indicator Variable	Location Summary	State Average
Access to Dentists	Total Population, 2015	192,624	27,469,114
	Dentists, 2015	120	14,857
	Dentists, Rate per 100,000 Pop.	**62.5**	54.1
Cancer Screening - Sigmoidoscopy or Colonoscopy	Total Population Age 50+	31,521	5,055,051
	Estimated Population Ever Screened for Colon Cancer	15,866	3,058,306
	Crude Percentage	68.2%	60.5%
	Age-Adjusted Percentage	**65.5%**	57.3%
Cancer Screening - Mammogram	Total Medicare Enrollees	11,920	1,777,117
	Female Medicare Enrollees Age 67-69	1,334	172,456
	Female Medicare Enrollees with Mammogram in Past 2 Years	828	101,099
	Percent Female Medicare Enrollees with Mammogram in Past 2 Year	**62.1%**	58.6%
	Female Population Age 18+	92,666	13,387,716
	Estimated Number with Regular Pap Test	55,108	10,188,052

Cancer Screening - Pap Test	Crude Percentage	84.6%	76.1%
	Age-Adjusted Percentage	**81.8%**	76%
Lack of Prenatal Care	Total Births	10,826	1,601,274
	Mothers Starting Prenatal Care in First Semester	7,858	947,636
	Mothers with Late or No Prenatal Care	2,887	632,269
	Prenatal Care Not Reported	80.64	21,369
	Percentage Mothers with Late or No Prenatal Care	**26.7%**	39.5%
Federally Qualified Health Centers	Total Population	44,490	25,145,561
	Number of Federally Qualified Health Centers	1	4781
	Rate of Federally Qualified Health Centers per 100,000 Population	**2.25**	1.9
Lack of a Consistent Source of Primary Care	Survey Population (Adults Age 18+)	129,831	18,375,873
	Total Adults Without Any Regular Doctor	40,435	5,946,509
	Percent Adults Without Any Regular Doctor	**31.1%**	32.36%
Preventable Hospital Events	Total Medicare Part A Enrollees	13,042	1,497,805
	Ambulatory Care Sensitive Condition Hospital Discharges	7,776	79,741
	Ambulatory Care Sensitive Condition Discharge Rate	**59.6**	53.2

Health Behaviors

Data Indicator	Indicator Variable	Location Summary	State Average
Alcohol Consumption	Total Population Age 18+	128,256	17,999,726
	Estimated Adults Drinking Excessively	12,552	2,879,956
	Estimated Adults Drinking Excessively (Crude Percentage)	13.3%	16%
	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	**13%**	15.8%
Physical Inactivity	Total Population Age 20+	135,815	19,469,060
	Population with no Leisure Time Physical Activity	33,431	4,435,423
	Percent Population with no Leisure Time Physical Activity	**25%**	22.7%
Tobacco Usage - Current Smokers	Total Population Age 18+	128,255	17,999,726
	Total Adults Regularly Smoking Cigarettes	22,196	3,005,954
	Percent Population Smoking Cigarettes (Crude)	18.7%	16.7%
	Percent Population Smoking Cigarettes (Age-Adjusted)	**18.2%**	16.5%

Health Outcomes

Data Indicator	Indicator Variable	Location Summary	State Average
Mortality - Lung Disease	Total Population	192,926	27,408,291
	Average Annual Deaths, 2007-2011	72	10,091
	Crude Death Rate (Per 100,000 Pop.)	37.53	36.82
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**43.34**	40.83

Mortality - Unintentional Injury	Total Population	192,926	27,408,291
	Average Annual Deaths, 2010-2014	70	10,079
	Crude Death Rate (Per 100,000 Pop.)	36.09	36.77
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**38.89**	37.86
Mortality - Heart Disease	Total Population	192,926	27,408,291
	Average Annual Deaths, 2010-2014	267	42,820
	Crude Death Rate (Per 100,000 Pop.)	138.57	156.23
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**169.24**	169.8
High Blood Pressure (Adult)	Total Population (Age 18+)	128,255	17,999,726
	Total Adults with High Blood Pressure	36,362	5,399,918
	Percent Adults with High Blood Pressure	**30.6%**	30%
Cancer Incidence - Lung	Estimated Total Population	15,735	2,474,387
	New Cases (Annual Average)	120	13,139
	Cancer Incidence Rate (Per 100,000 Pop.)	**76.7**	53.1
Mortality - Premature Death	Total Population	559,771	79,583,806
	Total Premature Death, 2014-2016	2,056	290,874
	Total Years of Potential Life Lost,2014-2016 Average	41,316	5,326,985
	Years of Potential Life Lost, Rate per 100,000 Population	**7,381**	6,694
Cancer Incidence - Prostate	Estimated Total Population (Male)	7,537	1,212,997
	New Cases (Annual Average)	81	11,572
	Cancer Incidence Rate (Per 100,000 Pop.)	**107.7**	95.4
Cancer Incidence - Breast	Estimated Total Population (Female)	8,808	1,365,890
	New Cases (Annual Average)	108	15,257
	Cancer Incidence Rate (Per 100,000 Pop.)	**123.4**	111.7
	Estimated Total Population (Female)	7,955	1,263,043

Data Indicator	Indicator Variable	Location Summary	State Average
Cancer Incidence - Cervix	New Cases (Annual Average)	9	1,162
	Cancer Incidence Rate (Per 100,000 Pop.)	**11.5**	9.2
Cancer Incidence - Colon and Rectum	Estimated Total Population	16,026	2,538,057
	New Cases (Annual Average)	62	9,670
	Cancer Incidence Rate (Per 100,000 Pop.)	**39**	38.1
Obesity	Total Population Age 20+	135,712	19,451,593
	Adults with BMI > 30.0 (Obese)	43,051	5,632,512
	Percent Adults with BMI > 30.0 (Obese)	**31.8%**	28.8%
Overweight	Survey Population (Adults Age 18+)	127,474	17,157,497
	Total Adults Overweight	53,992	6,090,529
	Percent Adults Overweight	**42.4%**	35.5%
Diabetes (Adult)	Total Population Age 20+	135,335	19,455,240
	Population with Diagnosed Diabetes	13,121	1,895,549
	Population with Diagnosed Diabetes, Age-Adjusted Rate	**10.2%**	9.54%
Poor General Health	Total Population Age 18+	128,256	17,999,726
	Estimated Population with Poor or Fair Health	20,961	3,167,952
	Crude Percentage	17.6%	17.6%
	Age-Adjusted Percentage	**18.9%**	17.8%
Mortality - Suicide	Total Population	192,926	27,408,291
	Average Annual Deaths, 2010-2014	32	3,396
	Crude Death Rate (Per 100,000 Pop.)	16.43	12.39
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**16.71**	12.48
Mortality - Homicide	Total Population	192,926	27,408,291
	Average Annual Deaths, 2010-2014	12	1,521
	Crude Death Rate (Per 100,000 Pop.)	6.49	555
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**7.2**	5.56
Mortality - Cancer	Total Population	192,926	27,408,291
	Average Annual Deaths, 2010-2014	286	39,449
	Crude Death Rate (Per 100,000 Pop.)	148.46	143.93
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**173.39**	150.64
Mortality - Stroke	Total Population	192,926	27,408,291
	Average Annual Deaths, 2010-2014	59	10,226
	Crude Death Rate (Per 100,000 Pop.)	30.7	37.31
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**38.03**	41.58
High Cholesterol (Adult)	Survey Population (Adults Age 18+)	92,130	12,555,893
	Total Adults with High Cholesterol	30,943	5,245,959
	Percent Adults with High Cholesterol	**33.59%**	41.78%
Heart Disease (Adult)	Survey Population (Adults Age 18+)	133,358	18,337,915
	Total Adults with Heart Disease	4,148	726,947
	Percent Adults with Heart Disease	**3.1%**	4%
Depression (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	17,070	2,205,833
	Beneficiaries with Depression	3,328	393,860
	Percent with Depression	**19.5%**	17.9%
	Total Population (Age 18+)	125,465	17,999,726

Poor Dental Health	**Total Adults with Poor Dental Health**	**15,501**	2,279,845

Data Indicator	Indicator Variable	Location Summary	State Average
	Percent Adults with Poor Dental Health	**12.4%**	12.7%
Infant Mortality	Total Births	16,017	2,014,555
	Total Infant Deaths	118	12,490
	Infant Mortality Rate (Per 1,000 Births)	**7.4**	6.2
Low Birth Weight	Total Live Births	52,899	2,759,442
	Low Weight Births (Under 2500g)	4,501	231,793
	Low Weight Births, Percent of Total	**8.51%**	8.4%
Asthma Prevalence	Survey Population (Adults Age 18+)	132,797	18,426,913
	Total Adults with Asthma	18,861	2,132,981
	Percent Adults with Asthma	14.2%	11.6%

APPENDIX C: HOSPITAL UTILIZATION & EMERGENCY ROOM DATA

Below are the top 10 diagnoses for AdventHealth Central Texas and Rollins Brook in 2018.

Emergency Department

1. Chest Pain
2. Unspecified abdominal pain
3. Acuter upper respiratory infections
4. Low back pain
5. Urinary tract infection
6. Headache
7. Epigastric Pain
8. Cough
9. Nausea with vomiting
10. Acute pharyngitis

Inpatient Admissions

1. Psychoses
2. Septicemia or severe sepsis
3. Diabetes
4.Major hip and knee joint replacement
5. Heart Failure
6.Chronic obstructive pulmonary disease
7. Circulatory disorders
8. Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders
9. Simple Pneumonia and Pleurisy
10. Acute Myocardial Infarction

APPENDIX D: COMMUNITY ASSET INVENTORY

A more thorough inventory of priorities which the Hospitals' selected is included below. This list will help to inform how and with whom AdventHealth Central Texas and AdventHealth Rollins Brook can partner to address the identified issues included below.

Area of Focus	Location: Hospital or Community	Organization	Program Title	Target Population	Counties Served	Program Point of Contact
Physical Inactivity	Hospital	AdventHealth Central Texas	13 Free workout classes, weekly	Adults, seniors, low income	Bell, Coryell	Wellness department, (254)519-8202
	Hospital	AdventHealth Central Texas	Silver Classic 5K/3K	Children, Adults, Seniors	Bell, Coryell, Lampasas	Wellness department, (254)519-8202
	Community	City of Killeen, Lions Club Senior Center	Exercise Classes	Seniors	Bell	254-501-6399
	Community	City of Killeen, Killeen Community Center	Exercise Classes	Children, Adults, Seniors	Bell	(254) 501-8889
	Community	City of Killeen, Parks & Recreation	Walking/biking trails, sports leagues	Children, Adults, Seniors	Bell	254-501-6390
	Community	City of Killeen, Tommie Harris Recreation Center	Gym, aquatics, classes	Children, Adults	Bell	254-501-6390
	Community	Armed Services YMCA	Various recreational activities	Children, Adults, Seniors	Bell, Coryell, Lampasas	(254) 634-5445
	Community	Healthy Kids Running Series	Healthy Kids Running Series	Children	Bell	(254) 340-4577
Mental Health	Hospital	AdventHealth Rollins Brook	Inpatient & Outpatient Services	Children, Adults, Seniors	Bell, Coryell, Lampasas	(254)628-1000
	Community	Bring Everyone in the Zone	Crisis Services	Active Duty, Veterans and families	Bell, Coryell	(254)423-7632
	Community	Aware Central Texas	Domestic Abuse	Children, adults	Bell, Coryell, Lampasas	254-213-2986
	Community	Starry Counseling	Family Counseling	Children, Parents, Low-income	Bell	(254)213-2035
	Community	Teach Them to Love Outreach Ministries	Domestic abuse and substance abuse counseling	Adults	Bell	(254)519-2222
Mental Health cont.	Community	Texas A&M Central Texas Community Counseling	Individual, couples and family counseling	Low income, minorities	Bell, Coryell	(254)519-5403
	Community	Bell County Indigent Care	Mental Health services	Low income	Bell	(877)-516-8593

	Community	Greater Killeen Community Clinic	Social Worker and Psychiatry services	Low income, minorities	Bell	(254)618-4210
	Community	Inegia Behavioral Health	Mental Health Evaluation	Adults, Children	Bell, Coryell, Lampasas	(254)628-1000
	Community	Families in Crisis	Help Hotline	Low-income	Bell	(254)634-1184
Food Insecurity	Community	Killeen Food Care Center	Food	Low-income	Bell	(254) 554-3400
	Community	Assembly of Prayer food Pantry	Food	Low-income	Bell, Coryell, Lampasas	254-466-3432
	Community	Harker Heights Food Care	Food	Low-income	Bell	(254) 554-3400
	Community	Mission Food Center	Food	Low-income	Lampasas	(817) 926-6151
	Community	Lampasas Mission	Food	Low-income	Lampasas	(512) 556-5779
	Community	Meals on Wheels	Food Delivery	Seniors, Rural communities	Bell, Coryell, Lampasas	(325)372-5167
	Community	Hill County Transit	Transportation	Low-income	Bell, Coryell, Lampasas	1-800-79196