Community Health Needs Assessment

McKinney Health Community
2022

BaylorScott&White
HEALTH

McKinney health community hospital

- **Baylor Scott & White Medical Center – McKinney**

BaylorScott**&White**
H E A L T H

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Baylor Scott & White Health mission

Our commitment to the communities we serve

As the largest not-for-profit healthcare system in Texas and one of the largest in the United States, Baylor Scott & White Health was born from the 2013 combination of Baylor Health Care System and Scott & White Healthcare. Today, Baylor Scott & White includes 51 hospitals, 1,100 access points, more than 7,300 active physicians, and over 49,000 employees and the Baylor Scott & White Health Plan.

Baylor Scott & White Health is a leading Texas healthcare provider with a proven commitment to patient and community health. Baylor Scott & White Health demonstrates this commitment through periodic community health needs assessments, then addresses those needs with a wide range of outreach initiatives.

These Community Health Needs Assessment (CHNA) activities also satisfy federal and state community benefit requirements outlined in the Patient Protection and Affordable Care Act and the Texas Health and Safety Code.

Baylor Scott & White Health conducts a thorough periodic examination of public health indicators and a benchmark analysis comparing communities it serves to an overall state of Texas value. In this way, it can determine where deficiencies lie and the opportunities for improvement are greatest.

Founded as a Christian ministry of healing, Baylor Scott & White Health promotes the well-being of all individuals, families and communities.
MISSION

STRATEGIES

**Health
Experience
Affordability
Alignment
Growth**

We serve
faithfully

We act
honestly

We never
settle

We are in
it together

VALUES

To be the trusted leader, educator and innovator in value-based care delivery, customer experience and affordability.

AMBITION

Through interviews, focus groups and surveys, the organization gains a clearer understanding of community needs from the perspective of the members of each community. This helps it identify the most pressing needs a community is facing and develop implementation plans to focus on those prioritized needs.

The process includes input from a wide range of knowledgeable people who represent the myriad interests of the community in compliance with 501 (r)(3) regulations. The CHNA process overview can be found in **Appendix A**.

The CHNAs serve as the foundation for community health improvement planning efforts over the next three years, while the implementation plans will be evaluated annually.

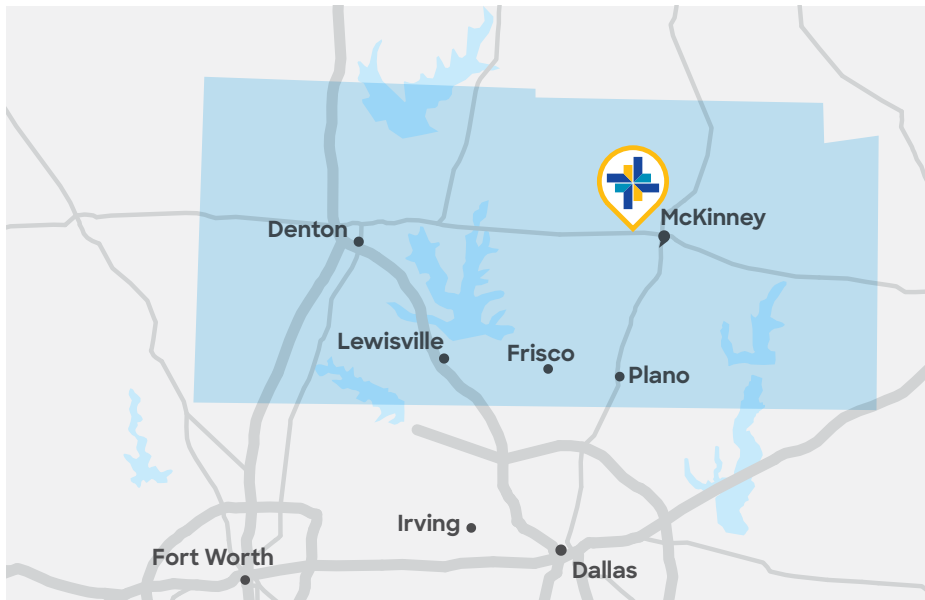# Community Health Needs Assessment (CHNA) report

Baylor Scott & White Health (BSWH) owns and operates numerous individually licensed hospital facilities serving the residents of North and Central Texas.

The McKinney Health Community is home to one of these hospitals:

• Baylor Scott & White Medical Center – McKinney

The community served by the hospital listed above is Collin and Denton Counties and was determined based on the contiguous ZIP codes within the associated counties that made up nearly 80% of the hospital facility's inpatient admissions over the 12-month period of FY20. The facility completed a CHNA report in accordance with the Internal Revenue Code Section 501 (r) (3) and the US Treasury regulations thereunder.

McKinney Health Community map

BSWH engaged with IBM Watson Health, a nationally respected consulting firm, to conduct a Community Health Needs Assessment (CHNA) in accordance with the federal and state community benefit requirements for the health communities they serve.

| Define the community | → | Assess the community | → | Identify and prioritize "significant needs" |

The CHNA process included:

- Gathering and analyzing more than 59 public and 45 proprietary health data indicators to provide a comprehensive assessment of the health status of the communities. The complete list of health data indicators is included in **Appendix B**.

- Creating a benchmark analysis comparing the community to overall state of Texas and United States (US) values.

- Conducting focus groups, key informant interviews and stakeholder surveys, including input from public health experts, to gain direct input from the community for a qualitative analysis.

  ○ Gathering input from state, local and/or regional public health department members who have the pulse of the community's health.

  ○ Identifying and considering input from individuals or organizations serving and/or representing the interests of medically underserved low-income and minority populations in the community to help prioritize the community's health needs.

  ○ The represented organizations that participated are included in **Appendix C**.

IBM Watson Health provided current and forecasted demographic, socioeconomic and utilization estimates for the community.

Demographic and socioeconomic summary

The most important demographic and socioeconomic findings for the McKinney Health Community CHNA are:

- The community is growing at a rate higher than both the state of Texas and the US.

- The average age of the population is younger than the US and slightly older than Texas overall.

- The median household income is significantly higher than both the state and the US.

- The community served has a lower percentage of uninsured and underinsured than Texas and significantly higher employer payer group.

Further demographic and socioeconomic information for the McKinney Health Community is included in **Appendix D**.

Health community data summary

IBM Watson Health's utilization estimates and forecasts indicate the following for the McKinney Health Community:

- Inpatient discharges in the community are expected to grow by almost 18% by 2030 with the largest growing product lines to include:
  - Pulmonary medical
  - General medicine
  - Cardiovascular diseases
  - Orthopedics
- Outpatient procedures are expected to increase by over 38% by 2030 with the largest areas of growth including:
  - Labs
  - General & internal medicine
  - Physical & occupational therapy
  - Hematology & oncology
  - Psychiatry
- Emergency department visits are expected to grow by over 20% by 2025.
- Hypertension represents almost 74% of all heart disease cases.
- Cancer incidence is expected to increase by almost 16% by 2025.

Further health community information for the McKinney Health Community is included in **Appendix E**.

The community includes the following health professional shortage areas and medically underserved areas as designated by the US Department of Health and Human Services Health Resources Services Administration. **Appendix D** includes the details on each of these designations.

| County | Health professional shortage areas (HPSA) | | | | Medically underserved area/ population (MUA/P) |
	Dental health	Mental health	Primary care	Grand total	MUA/P
Collin		1		1	
Denton	1	2	1	4	1

Source: US Department of Health and Human Services, Health Resources and Services Administration, 2021
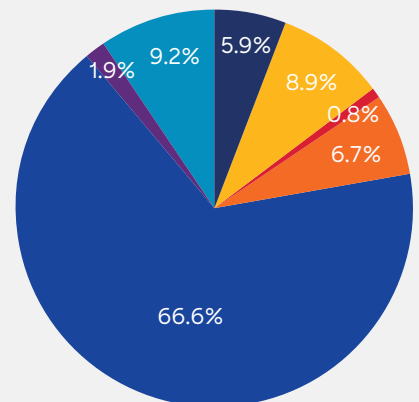
Total population
1,934,233

Average income
$100,537

Underserved ZIP codes
2

Insurance coverage

5.9%
8.9%
0.8%
6.7%
1.9%
9.2%
66.6%

- ■ Medicaid – pre-reform
- ■ Medicare
- ■ Medicare dual eligible
- ■ Private – direct
- ■ Private – ESI
- ■ Private – exchange
- ■ Uninsured

Priority health needs

Using the data collection and interpretation methods outlined in this report, BSWH has identified what it considers to be the community's significant health needs. The resulting prioritized health needs for this community are:

| Priority	Need	Category of need
1	Access to primary healthcare	Access to care
2	Access to mental healthcare	Mental health
3	Preventative screenings – chronic diseases	Conditions/diseases
4	Treatment resources for behavioral health/substance abuse	Mental health
5	Transportation	Environment

Priority 1: Access to Primary Healthcare

The following data indicates greater need for access for the population to one primary care provider and access for the population to one non-physician primary care provider.

Category	Data shows greater need	Key informants indicate greater need
Access to care	• Population to one primary care physician • Population to one non-physician primary care provider	• Limited access to primary care

The **population to one primary care physician** indicator is defined as **the number of individuals served by one physician in a county if the population was equally distributed across physicians** and is based on data from County Health Rankings & Roadmaps and Area Health Resource File/American Medical Association.

Access to care: population to one primary care physician (number of individuals served by one physician by county)
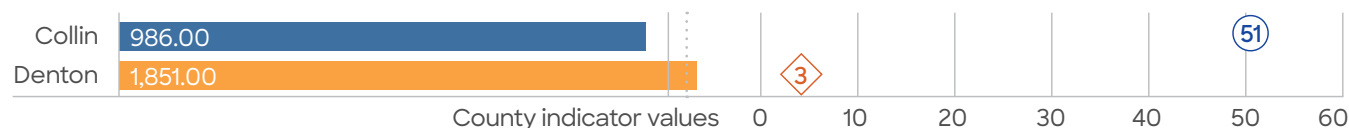
The **population to one non-physician primary care provider** indicator is defined as **the ratio of population to primary care providers other than physicians** and is based on data from County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES).

Access to care: population to one non-physician primary care provider (ratio of population to primary care providers other than physicians by county)

Greater or lesser need than state

◇ greater need
☐ same level of need or NA
○ lesser need

Counties are listed in alphabetical order within NTX-McKinney Health Community.
LEFT PANEL: Indicator Values horizontal bar and label shows the county score. Vertical dotted line shows the state benchmark. Solid line is US score. Orange colors indicate a greater need and potentially larger vulnerable population in the county relative to the state benchmark. Blue indicates a lesser need and potentially smaller vulnerable population. Darker intense colors indicate greater differences. **RIGHT PANEL:** Rank within county marks show how the indicator ranks compared to other indicators within the county. Indicators are ranked from 1 to 59, where low numbers show higher need and potentially larger vulnerable population relative to the state benchmark. Color and shape compare county performance to the state benchmark; orange diamonds show greater need and blue circles lesser need.

The focus group participants felt that the overall community area has limited access to primary care providers, especially for those covered by Medicaid and the uninsured. High demand for primary care and a limited number of primary care providers lead to difficulty accessing primary care.

In the prioritization session, the hospital leadership noted that even though the community has resources, there is a need for better coordination of the services in order to address the issue of access to care.

Priority 2: Access to Mental Healthcare (Providers/Resources)

The following data indicates greater need for access for the population to one mental healthcare provider. The indicator is defined as **the ratio of population to mental health providers** and is based on data from County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES).

Category	Data shows greater need	Key informants indicate greater need
Mental health	• Population to one mental health provider	• Gaps in access to mental health

Mental health: population to one mental health provider (ratio of population to mental health providers by county)

Greater or lesser need than state
◇ greater need
□ same level of need or NA
○ lesser need

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The focus group participants noted that there is a high demand in the community for mental/behavioral health services, but access is limited. The group anticipates further growth and increased severity of mental health in the future due to patients being underserved during COVID, which can only widen the access gaps that exist.

In the prioritization session, the hospital and community leaders agreed that access to mental healthcare is an issue for the entire population. There is a lack of mental health providers in the community, and the need for these providers is exasperated by the pandemic.

Priority 3: Preventive Screenings – Chronic Diseases

The following indicates a need in the areas of obesity, diabetes and cancer.

Category	Data shows greater need	Key informants indicate less need or not mentioned
Conditions/diseases	• Adult obesity • Cancer incidence: All causes • Cancer incidence: female breast • Cancer incidence: prostate • Diabetes admission	• Not specifically mentioned

The **adult obesity** indicator is defined as **the percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2** and is based on data from County Health Rankings & Roadmaps, CDC Diabetes Interactive Atlas and The National Diabetes Surveillance System.

Conditions/diseases: adult obesity (% of adults with BMI =>30 by county)

Collin 25.40 · 33
Denton 32.00 · 15
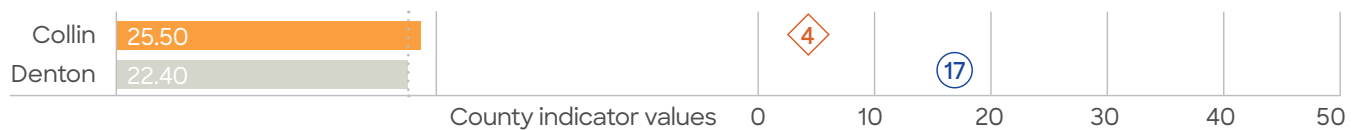County indicator values 0 10 20 30 40 50

The **cancer incidence: all causes measure** is defined **as age-adjusted cancer all incidence rate cases per 100,000 population**. The indicator is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Conditions: cancer incidence: all causes (rate of all cancer per 100,000 by county)

Collin 402.30 · 12
Denton 408.50 · 16
County indicator values 0 10 20 30 40 50

The **cancer incidence: female breast measure** is defined as **age-adjusted female breast cancer incidence rate cases per 100,000 population**. The indicator is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Conditions: cancer incidence: female breast (rate of breast cancer among females per 100,000 by county)

Collin 25.50 · 4
Denton 22.40 · 17
County indicator values 0 10 20 30 40 50

Greater or lesser need than state
◇ greater need
☐ same level of need or NA
○ lesser need

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The **cancer incidence: prostate measure** is defined as **age-adjusted prostate cancer incidence rate cases per 100,000 population**. The indicator is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Conditions: cancer incidence: prostate (rate of prostate cancer among males per 100,000 by county)

	County indicator values	0	10	20	30	40	50
Collin	94.50		11				
Denton	103.60	5					

The indicator **diabetes admission** is defined as **the number observed/adult population age 18 and older**. Note that risk-adjusted rates are not calculated for counties with fewer than five admissions. The measure is based on data from Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations.

Conditions/diseases: diabetes admission (number observed/adult population in county)

	County indicator values	0	10	20	30	40	50
Collin	51.41	1					
Denton	53.65	1					

Greater or lesser need than state
◇ greater need
☐ same level of need or NA
○ lesser need

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Although these conditions were not specifically discussed by the key informants, they did note chronic illnesses and conditions are not managed well, and patients do not access necessary care regularly. They anticipate that the problem will only worsen due to patients being underserved during COVID. They also added that although food banks and Meals on Wheels are available to the community, the chronically ill are not helped by these sources because they lack the options for restricted diets, such as low sodium, etc., that these conditions require.

In the prioritization session, hospital leadership felt that cancer diagnoses are increasing due to the lack of preventive cancer screenings brought on by the circumstances of the pandemic. They note that patients presenting to the emergency department for other health issues are receiving late-stage cancer diagnoses. They further elaborated that the root causes of many conditions, including cancer, diabetes, heart disease, etc., are a lack of—or a perceived lack of—access to primary care, not following medical advice from primary care physicians and delaying preventive screenings. They agreed that a concerted effort in educating and promoting yearly in-person preventive screenings is the key to addressing adult obesity and other chronic health conditions.

Priority 4: Treatment Resources for Behavioral Health/Substance Abuse

The following indicates greater need in the areas of binge drinking, drug poisoning deaths and opioid involved accidental poisoning death.

Category	Data shows greater need	Key informants indicate greater need
Health behaviors	• Binge drinking	• Negative life habits (smoking, drinking, etc.) • The pandemic increased substance abuse

The **binge drinking** indicator is defined as **the percentage of a county's adult population that reports binge or heavy drinking in the past 30 days** and is based on data from County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS).

Conditions/diseases: binge drinking (% of adults binge or heavy drinking in past 30 days by county)

Counties are listed in alphabetical order within NTX-McKinney Health Community.
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Category	Data shows less need or no data	Key informants indicate greater need
Health behaviors Mental health conditions/ diseases	• Drug poisoning deaths • Opioid involved accidental poisoning death	• Need for detox treatment and need for suicide prevention education • The pandemic increased substance abuse

The **drug poisoning deaths** indicator is defined as **the number of drug poisoning deaths (drug overdose deaths) per 100,000 population**. Death rates are NULL when the rate is calculated with a numerator of 20 or less. The indicator is based on data from County Health Rankings & Roadmaps, CDC WONDER Mortality Data.

Health behaviors: drug poisoning deaths (number of drug poisoning deaths per 100,000 by county)

Collin	7.28
Denton	7.47

County indicator values   0   10   20   30   40   50

Collin 47
Denton 47

The **opioid involved accidental poisoning death** indicator is defined as **the annual estimates of the resident population accidental poisoning deaths where opioids were involved divided by 100,000 population** and is based on data from US Census Bureau, Population Division and Texas Health and Human Services Center for Health Statistics Opioid related deaths in Texas.

Mental health conditions/diseases: opioid involved accidental poisoning death annual estimates of accidental opioid positing deaths per 100,000 population by county)

Collin	3.00
Denton	3.50

County indicator values   0   10   20   30   40   50

Collin 49
Denton 45

Greater or lesser need than state
◇ greater need
□ same level of need or NA
○ lesser need

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The key informants of the focus group recognize that there are gaps in substance abuse services, and therefore, these patients do not have a resource to seek help. They noted that the pandemic widened the gap as the number of substance abusers increased.
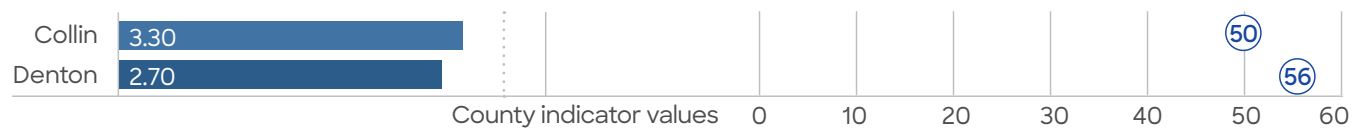
In the prioritization session, the hospital and community leaders cited that illicit drug use decreased in the first part of the pandemic but increased in the second. Alcohol use is more prevalent, and the delivery of alcohol to homes has contributed to this issue. They noted that binge drinking and substance abuse are coping mechanisms for underlying mental health issues and strongly felt that without preventive mental health services, patients will turn to other means to self-treat, contributing to the physical effects of mental health conditions and substance abuse (self-harm, suicide attempts, alcohol-related injury, etc.).

Priority 5: Transportation

Category	Data shows less need or no data	Key informants indicate less need or not mentioned
Environment	• No vehicle available	• Not specifically mentioned

The **no vehicle available** measure is defined as **the percent of households with no vehicle available**. The indicator is based on data from US Census Bureau, American Community Survey One-Year Estimates.

Environment: no vehicle available (% of households with no vehicle available by county)

Collin 3.30 — 50

Denton 2.70 — 56

County indicator values   0   10   20   30   40   50   60

Greater or lesser need than state
- ◇ greater need
- □ same level of need or NA
- ○ lesser need

Counties are listed in alphabetical order within NTX-McKinney Health Community.
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Although both the data and focus group participants failed to identify transportation as a need, the hospital and community leaders mentioned that transportation is an issue for the rural residents of Collin County. The county's resources are in the urban areas of Collin County, making it hard for rural residents to access them.

The Community Health Dashboards data referenced above can be found at **BSWHealth.com/About/Community-Involvement/Community-Health-Needs-Assessments**.

The prioritized list of significant health needs approved by the hospitals' governing body and the full assessment are available to the public at no cost. To download a copy, visit **BSWHealth.com/CommunityNeeds**.

Existing resources to address health needs

One part of the assessment process includes gathering input on potentially available community resources. The community is served by several large healthcare systems and multiple community-based health clinics. Below is a list of some of the community resources available to address identified needs in the community.

McKinney community resources

Need	Organization	Address	Phone
Access to primary healthcare	Hope Clinic (primary care)	103 E. Lamar Street McKinney, TX 75069	469.712.4246
	Community Healthcare Center	1620 W. Virginia Street McKinney, TX 75069	940.766.6306
	Community Health Clinic	120 Central Expressway McKinney, TX 75070	972.547.0606
	Collin County – PrimaCare Program	825 N. McDonald Street McKinney, TX 75069	972.548.4702
	Carevide	111 N. Johnson Street Farmersville, TX 75442	903.455.5958
Access to mental healthcare (providers/ resources)	Child and Family Guidance Center	4031 W. Plano Parkway Plano, TX 75093	214.351.3490
	STARRY Counseling	4501 Medical Center Drive McKinney, TX 75069	469.617.7476
	LifePath Systems (behavioral health services)	1515 Heritage Drive McKinney, TX 75069	972.562.9647
	CK Family Services (CK)	710 E. Park Boulevard Plano, TX 75074	817.516.9100
	The Center for Integrative Counseling and Psychology (counseling services)	4500 McDermott Road Plano, TX 75024	214.526.4525
Preventive screenings – chronic disease	Carevide	111 N. Johnson Street Farmersville, TX 75442	903.455.5958
	Community Healthcare Center (preventive care)	1620 W. Virginia Street McKinney, TX 75069	940.766.6306
	Community Health Clinic	120 Central Expressway McKinney, TX 75070	972.547.0606
	Methodist McKinney Hospital – Outpatient Services	2309 Virginia Parkway McKinney, TX 75071	972.569.2700
	Collin County – PrimaCare Program	825 N. McDonald Street McKinney, TX 75069	972.548.4702

Need	Organization	Address	Phone
Treatment resources for behavioral health/ substance abuse	Addiction Treatment Resources (ATR)	1505 Harroun Avenue McKinney, TX 75069	972.548.0209
	Addiction Services, LLC	2309 Virginia Parkway Suite 200 McKinney, TX 75071	972.542.4144
	Christian Counseling Associates (substance abuse counseling)	3120 Hudson Crossing McKinney, TX 75070	972.422.8383
	LifePath Systems (substance abuse counseling)	1515 Heritage Drive McKinney, TX 75069	972.562.9647
	West Texas Counseling and Rehabilitation	1108 Dobie Drive Plano, TX 75074	972.516.2900
Transportation	Family Promise of Collin County – Vehicle Program	325 W. Lucas Road Allen, TX 75002	972.442.6966
	Code Pink Productions Inc.	9652 Nathan Way Plano, TX 75025	972.767.7797
	SPAN Transportation	1800 Malone Street Denton, TX 76201	940.382.1900
	DART	Serves Collin County	214.979.1111
	Denton County Transportation Authority – LITSP (helps residents in Collin County)	604 E. Hickory Street Denton, TX 76205	940.243.0077

There are many other community resources and facilities serving the McKinney area that are available to address identified needs and can be accessed through a comprehensive online resource catalog called Find Help (formerly known as Aunt Bertha). It can be accessed 24/7 at **BSWHealth.FindHelp.com**.

Next steps

BSWH started the Community Health Needs Assessment process in April 2021. Using both qualitative community feedback as well as publicly available and proprietary health indicators, BSWH was able to identify and prioritize community health needs for their healthcare system. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed for the health needs BSWH chooses to address for the community served.

Appendix A: CHNA requirement details

The Patient Protection and Affordable Care Act (PPACA) requires all tax-exempt organizations operating hospital facilities to assess the health needs of their community every three (3) years. The resulting Community Health Needs Assessment (CHNA) report must include descriptions of the following:

- The community served and how the community was determined;

- The process and methods used to conduct the assessment, including sources and dates of the data and other information as well as the analytical methods applied to identify significant community health needs;

- How the organization used input from persons representing the broad interests of the community served by the hospital, including a description of when and how the hospital consulted with these persons or the organizations they represent;

- The prioritized significant health needs identified through the CHNA as well as a description of the process and criteria used in prioritizing the identified significant needs;

- The existing healthcare facilities, organizations and other resources within the community available to meet the significant community health needs; and

- An evaluation of the impact of any actions that were taken since the hospital's most recent CHNA to address the significant health needs identified in that report.

  - Hospitals also must adopt an implementation strategy to address prioritized community health needs identified through the assessment.

CHNA process

BSWH began the 2022 CHNA process in April of 2021. The following is an overview of the timeline and major milestones:

Define the community

▼

Assess the community

▼

Identify "significant needs" and "prioritize"

▼

Document in written report

▼

CHNA board approvals

▼

Make CHNA widely available on website

▼

Written implementation strategy

▼

Implementation strategy board approval

▼

Make implementation strategy widely available on website

▼

Act on strategy, measure and report

Consultant qualifications

IBM Watson Health delivers analytic tools, benchmarks and strategic consulting services to the healthcare industry, combining rich data analytics in demographics, including the Community Needs Index, planning and disease prevalence estimates, with experienced strategic consultants to deliver comprehensive and actionable Community Health Needs Assessments.

Health needs assessment process overview

To identify the health needs of the community, the hospitals established a comprehensive method using all available relevant data including community input. They used the qualitative and quantitative data obtained when assessing the community to identify its community health needs. Surveyors conducted interviews and focus groups with individuals representing public health, community leaders/groups, public organizations and other providers. In addition, data collected from public sources compared to the state benchmark indicated the level of severity. The outcomes of the quantitative data analysis were compared to the qualitative data findings.

These data are available to the community via an interactive dashboard at **BSWHealth.com/ CommunityNeeds**.

Data gathering: quantitative assessment of health needs – methodology and data sources

The IBM team used quantitative data collection and analysis garnered from public health indicators to assess community health needs. This included over 100 data elements grouped into over 11 categories evaluated for the counties where data was available. Recently, indicators expanded to include new categories addressing mental health, healthcare costs, opioids and social determinants of health. A table depicting the categories and indicators and a list of sources are in **Appendix B**.

A benchmark analysis of each indicator determined which public health indicators demonstrated a community health need. Benchmark health indicators included overall US values, state of Texas values and other goal-setting benchmarks, such as Healthy People 2020.

According to America's Health Rankings 2021 Annual Report, Texas ranks 22nd out of the 50 states in the area of Health Outcomes (which includes behavioral health, mortality and physical health) and 50th in the area of Clinical Care (which includes avoiding care due to cost, providers per 100,000 population and preventive services). When the health status of Texas was compared to other states, the team identified many opportunities to impact community health.

The quantitative analysis of the health community used the following methodology:

- The team set benchmarks for each health community using state value for comparison.
- They identified community indicators not meeting state benchmarks.
- From this, they determined a need differential analysis of the indicators, which helped them understand the community's relative severity of need.
- Using the need differentials, they established a standardized way to evaluate the degree that each indicator differed from its benchmark.
- This quantitative analysis showed which health community indicators were above the 25th percentile in order of severity—and which health indicators needed their focus.

The outcomes of the quantitative data analysis were compared to the qualitative data findings.

Information gaps

In some areas of Texas, the small population size has an impact on reporting and statistical significance. The team has attempted to understand the most significant health needs of the entire community. It is understood that there is variation of need within the community, and BSWH may not be able to impact all of the population who truly need the service.

Community input: qualitative health needs assessment – approach

To obtain a qualitative assessment of the health community, the team:

- Assembled a focus group representing the broad interests of the community served;
- Conducted interviews and surveys with key informants—leaders and representatives who serve the community and have insight into its needs; and
- Held prioritization sessions with hospital clinical leadership and community leaders to review collection results and identify the most significant healthcare needs based on information gleaned from the focus groups and key informants.

Focus groups helped identify barriers and social factors influencing the community's health needs. Key informant interviews gave the team even more understanding and insight about the general health status of the community and the various drivers that contributed to health issues.
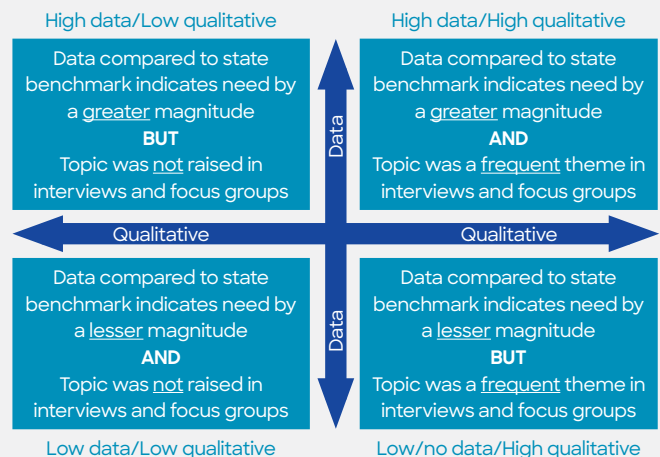
Multiple governmental public health department individuals were asked to contribute their knowledge, information and expertise relevant to the health needs of the community. Individuals or organizations who served and/or represented the interests of medically underserved, low-income and minority populations in the community also took part in the process. NOTE: In some cases, public health officials were unavailable due to obligations concerning the COVID-19 pandemic.

The hospitals also considered written input received on their most recently conducted CHNA and subsequent implementation strategies if provided. The assessment is available for public comment or feedback on the report findings by going to the BSWH website (**BSWHealth.com/CommunityNeeds**) or by emailing **CommunityHealth@BSWHealth.org**.

Approach to prioritizing significant health needs

On January 14, 2022, a session was conducted with key leadership members from Baylor Scott & White along with community leaders to review the qualitative and quantitative data findings of the CHNA to date, discuss at length the significant needs identified, and complete prioritization exercises to rank the community needs. Prioritizing health needs was a two-step process. The two-step process allowed participants to consider the quantitative needs and qualitative needs as defined by the indicator dataset and focus group/interview/survey participant input.

High data/Low qualitative
Data compared to state benchmark indicates need by a <u>greater</u> magnitude
BUT
Topic was <u>not</u> raised in interviews and focus groups

High data/High qualitative
Data compared to state benchmark indicates need by a <u>greater</u> magnitude
AND
Topic was a <u>frequent</u> theme in interviews and focus groups

Data — Qualitative — Qualitative

Low data/Low qualitative
Data compared to state benchmark indicates need by a <u>lesser</u> magnitude
AND
Topic was <u>not</u> raised in interviews and focus groups

Low/no data/High qualitative
Data compared to state benchmark indicates need by a <u>lesser</u> magnitude
BUT
Topic was a <u>frequent</u> theme in interviews and focus groups

High data = Indicators worse than state benchmark by greater magnitude
High qualitative = Frequency of topic in interviews and focus groups

In the first step, participants reviewed the top health needs for their community using associated data-driven criteria. The criteria included health indicator value(s) for the community and how the indicator compared to the state benchmark.

| High data/Low qualitative | High data/High qualitative |
| Low data/Low qualitative | Low/no data/High qualitative |
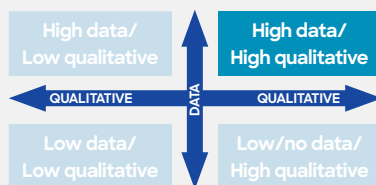
High data and high qualitative: The community indicators that showed a greater need in the health community overall when compared to the state of Texas comparative benchmark and were identified as a greater need by the key informants.

| High data/Low qualitative | High data/High qualitative |
| Low data/Low qualitative | Low/no data/High qualitative |
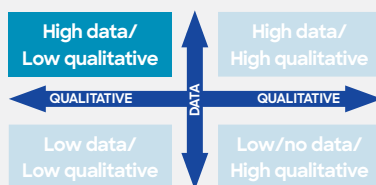
High data and low qualitative: The community indicators showed a greater need in the health community overall when compared to the state of Texas comparative benchmark but were not identified as a greater need or not specifically identified by the key informants.

| High data/Low qualitative | High data/High qualitative |
| Low data/Low qualitative | Low/no data/High qualitative |
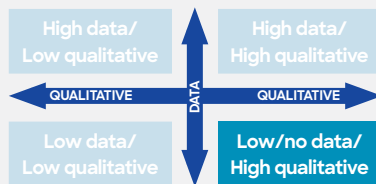
Low/no data and high qualitative:
The community indicators showed less need or had no data available in the health community overall when compared to the state of Texas comparative benchmark but were identified as a greater need by the key informants.

Participants held a group discussion about which needs were most significant, using the professional experience and community knowledge of the group. A virtual voting method was invoked for individuals to provide independent opinions.

This process helped the group define and identify the community's significant health needs. Participants voted individually for the needs they considered the most significant for this community. When the votes were tallied, the top identified needs emerged and were ranked based on the number of votes.

Prioritization of significant needs

In the second step, participants ranked the significant health needs based on prioritization criteria recommended by the focus group conducted for this community:

- **Root cause:** The need is a root cause of other problems. If addressed, it could possibly impact multiple issues.

- **Feasibility/cost:** Is the problem amenable to interventions? Is the problem preventable? What technology, knowledge or resources are necessary to effect a change? Is it too expensive for the community to tackle?

- **Severity (outcome if ignored):** The problem results in disability or premature death or creates burdens on the community, economically or socially.

The group rated each of the five significant health needs on each of the three identified criteria, using a scale of 1 (low) to 10 (high). The criteria score sums for each need created an overall score.

They prioritized the list of significant health needs based on the overall scores. The outcome of this process was the list of prioritized health needs for this community.

Priority	Need	Category of need
1	Access to primary healthcare	Access to care
2	Access to mental healthcare	Mental health
3	Preventive screenings – chronic diseases	Conditions/diseases
4	Treatment resources for behavioral health/substance abuse	Mental health
5	Transportation	Environment

Appendix B: key public health indicators

IBM Watson Health collected and analyzed fifty-nine (59) public health indicators to assess and evaluate community health needs. For each health indicator, a comparison between the most recently available community data and benchmarks for the same/similar indicator was made. The basis of benchmarks was available data for the US and the state of Texas.

The indicators used and the sources are listed below:

Indicator name	Indicator source	Indicator definition
Adult obesity	2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System	2017 Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2
Adults reporting fair or poor health	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Percentage of adults reporting fair or poor health (age-adjusted)
Binge drinking	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Percentage of a county's adult population that reports binge or heavy drinking in the past 30 days
Cancer incidence: all causes	State Cancer Profiles National Cancer Institute (CDC)	2013 - 2017 Age-adjusted cancer (all) incidence rate cases per 100,000 (all races, includes Hispanic; both sexes; all ages. Age-adjusted to the 2000 US standard population)
Cancer incidence: colon	State Cancer Profiles National Cancer Institute (CDC)	2013 - 2017 Age-adjusted colon and rectum cancer incidence rate cases per 100,000 (all races, includes Hispanic; both sexes; all ages. Age-adjusted to the 2000 US standard population). Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of three is shown, the total number of cases for the time period is 16 or more, which exceeds suppression threshold (but is rounded to three).

Indicator name	Indicator source	Indicator definition
Cancer incidence: female breast	State Cancer Profiles National Cancer Institute (CDC)	2013 – 2017 Age-adjusted female breast cancer incidence rate cases per 100,000 (all races, includes Hispanic; female; all ages. Age-adjusted to the 2000 US standard population). Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of three is shown, the total number of cases for the time period is 16 or more, which exceeds suppression threshold (but is rounded to three).
Cancer incidence: lung	State Cancer Profiles, National Cancer Institute (CDC)	2013 – 2017 Age-adjusted lung and bronchus cancer incidence rate cases per 100,000 (all races, includes Hispanic; both sexes; all ages. Age-adjusted to the 2000 US standard population)
Cancer incidence: prostate	State Cancer Profiles, National Cancer Institute (CDC)	2013 – 2017 Age-adjusted prostate cancer incidence rate cases per 100,000 (all races, includes Hispanic; males; all ages. Age-adjusted to the 2000 US standard population)
Children in poverty	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	2019 Percentage of children under age 18 in poverty.
Children in single-parent households	2021 County Health Rankings & Roadmaps; American Community Survey (ACS), Five-Year Estimates (United States Census Bureau)	2015 – 2019 Percentage of children that live in a household headed by single parent
Children uninsured	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	2018 Percentage of children under age 19 without health insurance
Diabetes admission	2018 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations	Number observed/adult population age 18 and older. Risk-adjusted rates not calculated for counties with fewer than five admissions.
Diabetes diagnoses in adults	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries

Indicator name	Indicator source	Indicator definition
Diabetes prevalence	County Health Rankings (CDC Diabetes Interactive Atlas)	2017 Prevalence of diagnosed diabetes in a given county. Respondents were considered to have diagnosed diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes.
Drug poisoning deaths	2021 County Health Rankings & Roadmaps, CDC WONDER Mortality Data	2017 – 2019 Number of drug poisoning deaths (drug overdose deaths) per 100,000 population. Death rates are null when the rate is calculated with a numerator of 20 or less.
Elderly isolation	2018 American Community Survey Five-Year Estimates, US Census Bureau – American FactFinder	Percent of non-family households – householder living alone – 65 years and over
English spoken "less than very well" in household	2015 – 2019 American Community Survey Five-Year Estimates, US Census Bureau – American FactFinder	2019 Percentage of households that 'speak English less than "very well"' within all households that 'speak a language other than English'
Food environment index	2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA)	2015 and 2018 Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)
Food insecure	2021 County Health Rankings & Roadmaps; Map the Meal Gap, Feeding America	2018 Percentage of population who lack adequate access to food during the past year
Food: limited access to healthy foods	2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA)	2015 Percentage of population who are low-income and do not live close to a grocery store
High school graduation	Texas Education Agency	2019 A four-year longitudinal graduation rate is the percentage of students from a class of beginning ninth graders who graduate by their anticipated graduation date or within four years of beginning ninth grade.
Household income	2021 County Health Rankings (Small Area Income and Poverty Estimates)	2019 Median household income is the income where half of households in a county earn more and half of households earn less.

Indicator name	Indicator source	Indicator definition
Income inequality	2021 County Health Rankings & Roadmaps; American Community Survey (ACS), Five-Year Estimates (United States Census Bureau)	2015 – 2019 Ratio of household income at the 80th percentile to income at the 20th percentile. Absolute equality = 1.0. Higher ratio is greater inequality.
Individuals below poverty level	2018 American Community Survey Five-Year Estimates, US Census Bureau – American FactFinder	Individuals below poverty level
Low birth weight rate	2019 Texas Certificate of Live Birth	Number low birth weight newborns /number of newborns. Newborn's birth weight – low or very low birth weight includes birth weights under 2,500 grams. Blanks indicate low counts or unknown values. A null value indicates unknown or low counts. The location variables (region, county, ZIP) refer to the mother's residence.
Medicare population: Alzheimer's disease/ dementia	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: atrial fibrillation	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: COPD	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: depression	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries
Medicare population: emergency department use rate	CMS 2019 Outpatient 100% Standard Analytical File (SAF) and 2019 Standard Analytical Files (SAF) Denominator File	Unique patients having an emergency department visit/total beneficiaries, CY 2019

Indicator name	Indicator source	Indicator definition
Medicare population: heart failure	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: hyperlipidemia	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries
Medicare population: hypertension	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries
Medicare population: inpatient use rate	CMS 2019 Inpatient 100% Standard Analytical File (SAF) and 2019 Standard Analytical Files (SAF) Denominator File	Unique patients being hospitalized/total beneficiaries, CY 2019
Medicare population: stroke	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare spending per beneficiary (MSPB) index	CMS 2019 Medicare Spending Per Beneficiary (MSPB), Hospital Value-Based Purchasing (VBP) Program	Medicare spending per beneficiary (MSPB): for each hospital, CMS calculates the ratio of the average standardized episode spending over the average expected episode spending. This ratio is multiplied by the average episode spending level across all hospitals. Blank values indicate missing hospitals or missing score. Associated to the hospitals
Mentally unhealthy days	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Average number of mentally unhealthy days reported in past 30 days (age-adjusted)
Mortality rate: cancer	Texas Health Data, Center for Health Statistics, Texas Department of State Health Services	2017 Cancer (all) age-adjusted death rate (per 100,000 – all ages. Age-adjusted using the 2000 US Standard population). Death rates are null when the rate is calculated with a numerator of 20 or less.

Indicator name	Indicator source	Indicator definition
Mortality rate: heart disease	Texas Health Data, Center for Health Statistics, Texas Department of State Health Services	2017 Heart disease age-adjusted death rate (per 100,000 - all ages. Age-adjusted using the 2000 US Standard population). Death rates are null when the rate is calculated with a numerator of 20 or less.
Mortality rate: infant	2021 County Health Rankings & Roadmaps, CDC WONDER Mortality Data	2013 - 2019 Number of all infant deaths (within one year), per 1,000 live births. Blank values reflect unreliable or missing data.
Mortality rate: stroke	Texas Health Data, Center for Health Statistics, Texas Department of State Health Services	2017 Cerebrovascular disease (stroke) age-adjusted death rate (per 100,000 - all ages. Age-adjusted using the 2000 US Standard population). Death rates are null when the rate is calculated with a numerator of 20 or less.
No vehicle available	US Census Bureau, 2019 American Community Survey One-Year Estimates	2019 Households with no vehicle available (percent of households). A null value entry indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates fall in the lowest interval or upper interval of an open-ended distribution, or the margin of error associated with a median was larger than the median itself.
Opioid involved accidental poisoning death	US Census Bureau, Population Division and 2019 Texas Health and Human Services Center for Health Statistics Opioid related deaths in Texas	Annual estimates of the resident population: April 1, 2010, to July 1, 2017. 2019 Accidental poisoning deaths where opioids were involved are those deaths that include at least one of the following ICD-10 codes among the underlying causes of death: X40 - X44, and at least one of the following ICD-10 codes identifying opioids: T40.0, T40.1, T40.2, T40.3, T40.4, T40.6. Blank values reflect unreliable or missing data.
Physical inactivity	2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System	2017 Percentage of adults ages 20 and over reporting no leisure-time physical activity in the past month

Indicator name	Indicator source	Indicator definition
Physically unhealthy days	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Average number of physically unhealthy days reported in past 30 days (age-adjusted)
Population to one dentist	2021 County Health Rankings & Roadmaps; Area Health Resource File/National Provider Identification file (CMS)	2019 Ratio of population to dentists
Population to one mental health provider	2021 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)	2020 Ratio of population to mental health providers
Population to one non-physician primary care provider	2020 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)	2020 Ratio of population to primary care providers other than physicians
Population to one primary care physician	2021 County Health Rankings & Roadmaps; Area Health Resource File/American Medical Association	2018 Number of individuals served by one physician in a county, if the population was equally distributed across physicians
Population under age 65 without health insurance	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	2018 Percentage of population under age 65 without health insurance
Prenatal care: first trimester entry into prenatal care	2020 Texas Health and Human Services - Vital statistics annual report	2016 Percent of births with prenatal care onset in first trimester
Renter-occupied housing	US Census Bureau, 2019 American Community Survey One-Year Estimates	2019 Renter-occupied housing (percent of households). A null value entry indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates fall in the lowest interval or upper interval of an open-ended distribution, or the margin of error associated with a median was larger than the median itself.

Indicator name	Indicator source	Indicator definition
Severe housing problems	2021 County Health Rankings & Roadmaps; Comprehensive Housing Affordability Strategy (CHAS) data, US Department of Housing and Urban Development (HUD)	2013 – 2017 Percentage of households with at least one of four housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
Sexually transmitted infection incidence	2021 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)	2018 Number of newly diagnosed chlamydia cases per 100,000 population
Smoking	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Percentage of the adult population in a county who both report that they currently smoke every day or most days and have smoked at least 100 cigarettes in their lifetime
Suicide: intentional self-harm	Texas Health Data Center for Health Statistics	2019 Intentional self-harm (suicide) (X60 – X84, Y87.0). Death rates are null when the rate is calculated with a numerator of 20 or less.
Teen birth rate	2021 County Health Rankings & Roadmaps; National Center for Health Statistics – Natality files, National Vital Statistics System (NVSS)	2013 – 2019 Number of births to females ages 15 – 19 per 1,000 females in a county (The numerator is the number of births to mothers ages 15 – 19 in a seven-year time frame, and the denominator is the sum of the annual female populations, ages 15 – 19.)
Teens (16 – 19) not in school or work – disconnected youth	2021 County Health Rankings (Measure of America)	2015 – 2019 Disconnected youth are teenagers and young adults between the ages of 16 and 19 who are neither working nor in school. Blank values reflect unreliable or missing data.
Unemployment	2021 County Health Rankings & Roadmaps; Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics	2019 Percentage of population ages 16 and older unemployed but seeking work

Appendix C: community input participating organizations

Representatives from the following organizations participated in the focus group and a number of key informant interviews/surveys:

- Baylor Scott & White Health
- Baylor Scott & White The Heart Hospital – Denton
- Baylor Scott & White Medical Center – McKinney
- Baylor Scott & White Medical Center – Plano
- Collin County RHP 18
- Callier Center for Communication Disorders
- Church of Jesus Christ of LDS
- City of Denton
- Collin County Coalition Charitable Clinics
- Collin County Health Care Services
- Collin County Health Department
- Collin County Public Health
- Collin College Homeless Coalition
- Community Lifeline Center
- Community Services, Inc.

- Denton County MHMR Center
- First Refuge Ministries
- First United Methodist, Richardson
- Health Services of North Texas
- Julia's Center
- Metroport Meals on Wheels
- My Possibilities
- North Central Texas Health Care Center Comm.
- North Texas Food Bank
- Plano Fire-Rescue
- Texas Health Resources
- United Way
- Visiting Nurse Association of Texas – Dallas/Fort Worth
- Wellness Center for Older Adults

Appendix D: demographic and socioeconomic summary

According to population statistics, the community served is similar to Texas in terms of projected population growth; both outpace the country. The median age is older than Texas but younger than the United States. Median income is significantly higher than both the state and the country. The community served has a significantly lower percentage of Medicaid beneficiaries and a significantly lower percentage of uninsured individuals than the state of Texas.

Demographic and socioeconomic comparison: community served and state/US benchmarks

Geography		Benchmarks		Community served
		United States	Texas	McKinney health community
Total current population		330,342,293	29,321,501	1,934,233
Five-year projected population change		3.3%	6.6%	8.9%
Median age		38.6	35.2	37.6
Population 0 – 17		22.4%	25.7%	24.6%
Population 65+		16.6%	13.2%	11.4%
Women age 15 – 44		19.5%	20.5%	21.0%
Hispanic population		19.0%	40.7%	17.9%
Insurance coverage	Uninsured	9.9%	18.8%	9.2%
	Medicaid	20.9%	13.0%	5.9%
	Private market	8.3%	8.4%	8.6%
	Medicare	13.8%	12.7%	9.7%
	Employer	47.2%	47.1%	66.6%
Median HH income		$65,618	$63,313	$100,537
No high school diploma		12.2%	16.7%	6.9%

Source: IBM Watson Health Demographics, Claritas, 2020, Insurance Coverage Estimates, 2020.

The community served expects to grow 8.9% by 2025, an increase of almost 173,000 people. The projected population growth is higher than the state's five-year projected growth rate (6.6%) and higher than the national projected growth rate (3.3%). The ZIP codes expected to experience the most growth in five years are:

• 75002 Allen – 7,402 additional people

• 75035 McKinney – 7,244 additional people

• 75098 Wylie – 7,020 additional people

The community's population is younger with 52.2% of the population ages 18 – 54 and 24.6% under age 18. The age 65-plus cohort is expected to experience the fastest growth (31%) over the next five years. Growth in the senior population will likely contribute to increased utilization of services as the population continues to age.

Population statistics are analyzed by race and by Hispanic ethnicity. The community was primarily white non-Hispanic, but diversity in the community will increase due to the projected growth of minority populations over the next five years. The expected growth rate of the Hispanic population (all races) is over 47,700 people (13.8%) by 2025. The non-Hispanic white population is expected to grow by only 1.1%.

Population distribution					
	Age distribution				
Age group	2020	% of total	2025	% of total	USA 2020 % of total
0 – 14	389,622	20.1%	389,674	18.5%	18.5%
15 – 17	86,897	4.5%	93,708	4.4%	3.9%
18 – 24	180,720	9.3%	210,268	10.0%	9.5%
25 – 34	248,153	12.8%	254,638	12.1%	13.5%
35 – 54	581,357	30.1%	597,611	28.4%	25.2%
55 – 64	227,783	11.8%	273,179	13.0%	12.9%
65+	219,701	11.4%	287,989	13.7%	16.6%
Total	**1,934,233**	**100.0%**	**2,107,067**	**100.0%**	**100.0%**

| Household Income distribution			
	Income distribution		
2020 Household income	HH count	% of total	USA % of total
<$15K	33,231	4.8%	10.0%
$15 – 25K	29,194	4.2%	8.6%
$25 – 50K	102,009	14.7%	20.7%
$50 – 75K	101,285	14.6%	16.7%
$75 – 100K	90,000	13.0%	12.4%
Over $100K	337,676	48.7%	31.5%
Total	**693,395**	**100.0%**	**100.0%**

Education level			
	Education level distribution		
2020 Adult education level	Pop age 25+	% of total	USA % of total
Less than high school	42,071	3.3%	5.2%
Some high school	45,662	3.6%	7.0%
High school degree	206,129	16.1%	27.2%
Some college/assoc. degree	362,829	28.4%	28.9%
Bachelor's degree or greater	620,303	48.6%	31.6%
Total	**1,276,994**	**100.0%**	**100.0%**

| Race/ethnicity			
	Race/ethnicity distribution		
Race/ethnicity	2020 pop	% of total	USA % of total
White non-Hispanic	1,080,391	55.9%	59.3%
Black non-Hispanic	196,176	10.1%	12.4%
Hispanic	346,786	17.9%	19.0%
Asian & Pacific is. non-Hispanic	250,778	13.0%	6.0%
All others	60,102	3.1%	3.3%
Total	**1,934,233**	**100.0%**	**100.0%**

Population estimates

Population	National	Selected area
2010 total	308,745,538	1,442,426
2020 total	330,342,293	1,934,233
2025 total	341,132,738	2,107,067
2030 total	353,513,931	2,329,860
% change 2020 – 2025	3.27%	8.94%
% change 2020 – 2035	7.01%	20.45%

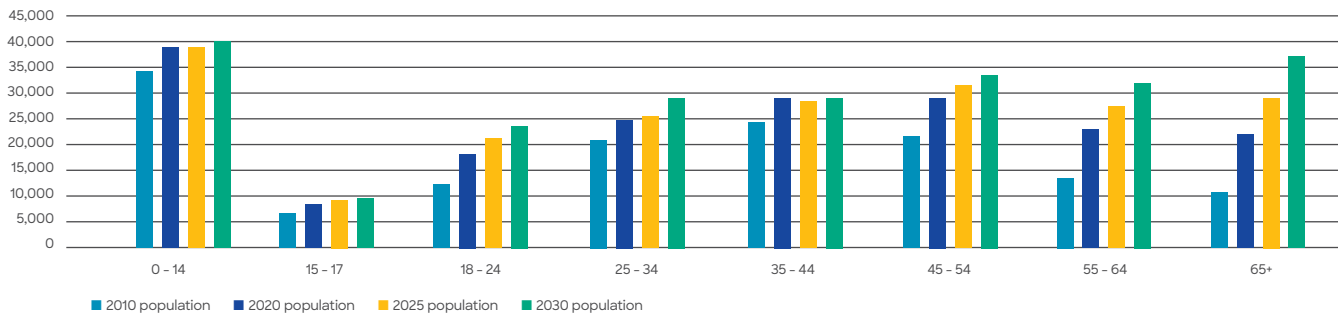| Population	Males all ages	Females all ages	Females childbearing
2010 total	708,910	733,516	326,036
2020 total	950,997	983,236	406,446
2025 total	1,034,882	1,072,185	423,103
2030 total	1,142,686	1,187,174	457,066
10Y %	20.16%	20.74%	12.45%
National	7.02%	7.01%	4.01%

2020 race and ethnicity with total population
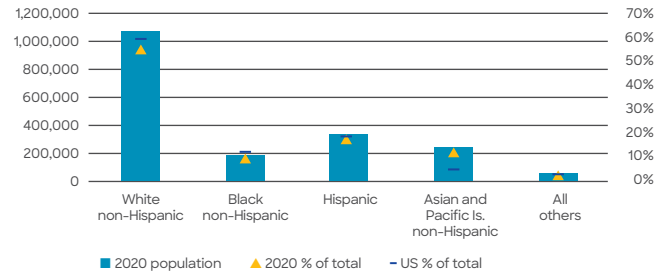

Population by sex 2010 – 2030
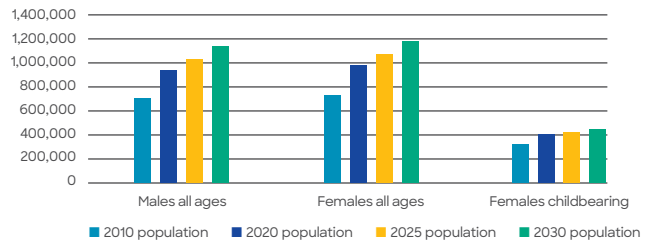
Population by age group 2010 – 2030

Source: IBM Watson Health/Claritas, 2020.

The 2020 median household income for the United States was $65,618 and $63,313 for the state of Texas. The median household income for the ZIP codes within this community ranged from $173,555 for 75022 Flower Mound to $33,629 for 76201 Denton. The only other ZIP code with a median household income less than $52,400—twice the 2020 federal poverty limit for a family of four—was 76205 Denton with $48,554.

The median household income ZIP code map below illustrates ZIP codes that are lower or higher than twice the federal poverty level for a family of four in 2020.

© 2022 Mapbox © OpenStreetMap
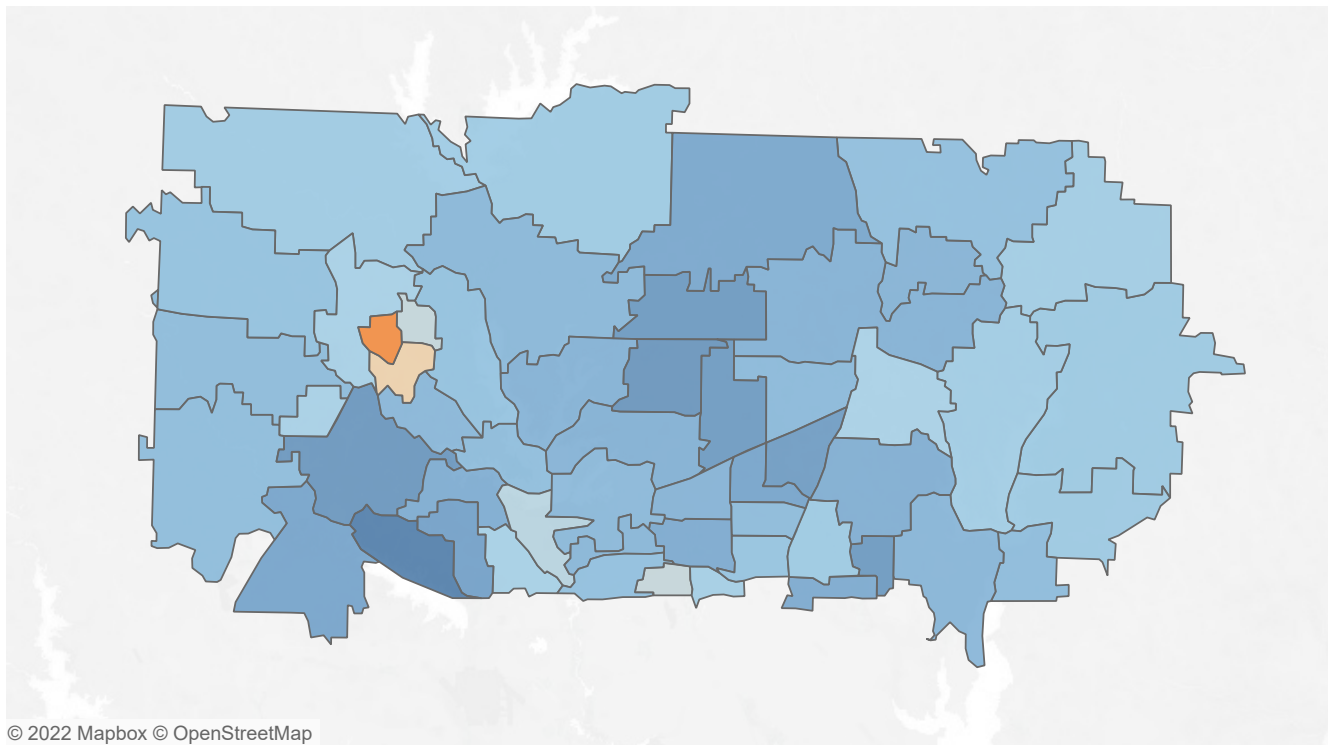
A majority of the population (67%) is insured through employer sponsored health coverage. The remainder of the population is fairly equally divided between Medicaid, Medicare and private market (the purchasers of coverage directly or through the health insurance marketplace).

Federally designated health professional shortage areas and medically underserved areas and populations

Health professional shortage areas (HPSA)				
County	HPSA ID	HPSA name	HPSA discipline class	Designation type
Collin	7485109304	LI – MHCA – Collin County	Mental health	Low-income population HPSA
Denton	7487902282	LI – MHCA – Denton County	Mental health	Low-income population HPSA
Denton	14899948PA	Health Services of North Texas, Inc.	Primary care	Federally qualified health center
Denton	74899948MQ	Health Services of North Texas, Inc.	Mental health	Federally qualified health center
Denton	64899948MR	Health Services of North Texas, Inc.	Dental health	Federally qualified health center

| Medically underserved areas and populations (MUA/P)				
County	MUA/P source identification number	Service area name	Designation type	Rural status
Denton	03463	Poverty population	Medically underserved area – governor's exception	Non-rural

Community Needs Index

The IBM Watson Health Community Need Index (CNI) is a statistical approach that identifies areas within a community where there are likely gaps in healthcare. The CNI takes into account vital socio-economic factors, including income, culture, education, insurance and housing, about a community to generate a CNI score for every population ZIP code in the US.

The CNI is strongly linked to variations in community healthcare needs and is a good indicator of a community's demand for a range of healthcare services. Not-for-profit and community-based hospitals, for whom community need is central to the mission of service, are often challenged to prioritize and effectively distribute hospital resources. The CNI can be used to help them identify specific initiatives best designed to address the health disparities of a given community.

The CNI score by ZIP code shows specific areas within a community where healthcare needs may be greater.

McKinney Health Community

Composite CNI: high scores indicate high need.

1.000   5.000

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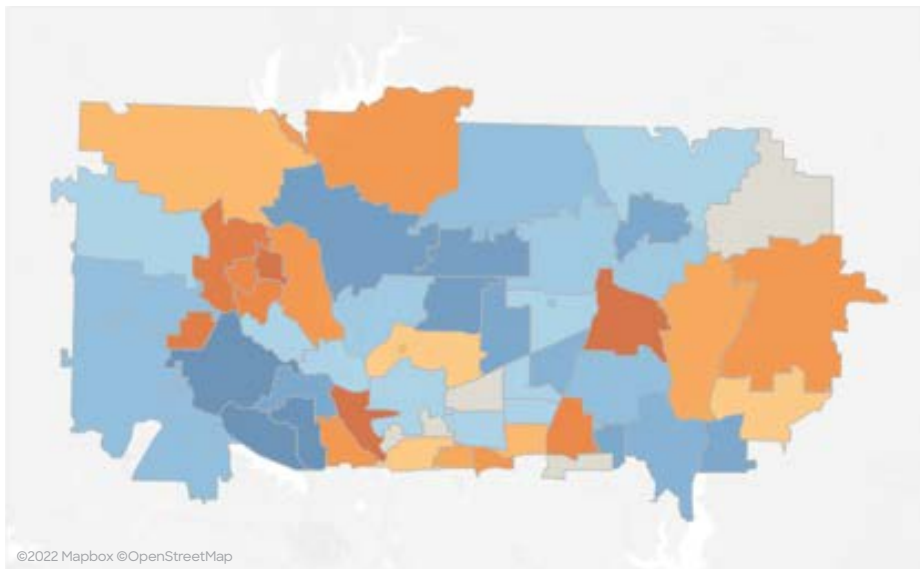
ZIP map where color shows the 2020 Community Need Index on a scale of 1 to 5. Orange color indicates high need areas (CNI = 4 or 5); blue color indicates low need (CNI = 1 or 2). Gray colors have needs at the national average (CNI = 3).

Composite CNI score
2.80

Texas CNI score
3.85

US composite CNI score
3.00

Barrier	State	US
Income	3.0	3.0
Culture	4.7	3.0
Education	3.5	3.0
Insurance	4.3	3.0
Housing	3.9	3.0

The overall CNI score for the McKinney Health Community is 2.80. The difference in the numbers indicates both a strong link to community healthcare needs and a community's demand for various healthcare services. In portions of the community, the CNI score was greater than 4.5, indicating more significant health needs among the population.

Appendix E: proprietary community data

IBM Watson Health supplemented the publicly available data with estimates of localized inpatient demand discharges, outpatient procedures, emergency department visits, heart disease, as well as cancer incidence estimates.

Social determinants of health are the structural determinants and conditions in which people are born, grow, live, work and age. All of which can greatly impact healthcare utilization and play a major role in the shifting healthcare landscape. Social determinants, such as education, income and race, are factored into Inpatient Demand Estimates and Outpatient Procedure Estimates utilization rate creation methodologies.

Inpatient demand estimates

Inpatient demand estimates provide the total volume of annual acute care admissions by ZIP code and DRG Product Line for every market in the United States. IBM uses all-payor state discharge data for publicly available states and Medicare (MEDPAR) data for the entire US. These rates are applied to demographic projections by ZIP code to estimate inpatient utilization for 2020 through 2030.

The following summary is reflective of the inpatient utilization trends for McKinney Health Community. Total discharges in the community are expected to grow by 17.6% by 2030, with pulmonary medical, general medicine, cardiovascular diseases and orthopedics projecting the largest growth.

Product line	2020 discharges	2025 discharges	2030 discharges	2020 – 2025 discharges change	2020 – 2025 discharges % change	2020 – 2030 discharges change	2020 – 2030 discharges % change
Alcohol and Drug Abuse	1,616	1,668	1,886	52	3.2%	270	16.7%
Cardio-Vasc-Thor Surgery	5,340	5,892	6,404	552	10.3%	1,063	19.9%
Cardiovascular Diseases	8,783	9,932	11,788	1,149	13.1%	3,005	34.2%
ENT	809	771	769	(37)	–4.6%	(39)	–4.9%
General Medicine	23,238	25,034	27,830	1,796	7.7%	4,592	19.8%
General Surgery	10,528	10,840	11,696	312	3.0%	1,168	11.1%
Gynecology	963	472	281	(491)	–51.0%	(682)	–70.8%
Nephrology/Urology	6,015	6,650	7,548	635	10.6%	1,533	25.5%
Neuro Sciences	6,841	7,439	8,566	598	8.7%	1,725	25.2%
Obstetrics Del	18,331	17,206	17,812	(1,125)	–6.1%	(519)	–2.8%
Obstetrics ND	1,204	1,067	1,060	(137)	–11.3%	(143)	–11.9%
Oncology	2,858	3,053	3,355	195	6.8%	497	17.4%
Ophthalmology	166	162	162	(4)	–2.5%	(4)	–2.5%
Orthopedics	13,043	13,697	15,098	654	5.0%	2,055	15.8%
Psychiatry	1,773	1,899	2,059	126	7.1%	286	16.1%
Pulmonary Medical	9,692	11,890	14,368	2,198	22.7%	4,676	48.2%
Rehabilitation	204	237	284	33	16.1%	80	39.1%
TOTAL	**111,406**	**117,911**	**130,966**	**6,505**	**5.8%**	**19,560**	**17.6%**

Source: IBM Watson Health Inpatient Demand Estimates, 2020.

Outpatient procedures estimates

Outpatient procedure estimates predict the total annual volume of procedures performed by ZIP code for every market in the United States using proprietary and public health claims, as well as federal surveys. Procedures are defined and reported by procedure codes and are further grouped into clinical service lines. The McKinney Health Community outpatient procedures are expected to increase by over 38% by 2030 with the largest growth in the categories of labs, general & internal medicine, physical & occupational therapy, hematology & oncology and psychiatry.

Clinical service category	2020 procedures	2025 procedures	2020-2025 procedures % change	2030 procedures	2020 - 2030 procedures % change
Allergy & Immunology	595,173	670,082	12.6%	761,452	27.9%
Anesthesia	133,125	164,312	23.4%	197,020	48.0%
Cardiology	1,058,046	1,391,780	31.5%	1,844,712	74.4%
Cardiothoracic	1,167	1,427	22.3%	1,720	47.4%
Chiropractic	1,091,377	1,137,528	4.2%	1,172,092	7.4%
Colorectal Surgery	16,128	18,059	12.0%	20,314	26.0%
CT Scan	326,906	460,373	40.8%	642,796	96.6%
Dermatology	400,353	483,834	20.9%	581,913	45.4%
Diagnostic Radiology	1,983,480	2,271,633	14.5%	2,603,107	31.2%
Emergency Medicine	745,722	865,708	16.1%	1,015,351	36.2%
Gastroenterology	146,392	174,926	19.5%	206,895	41.3%
General & Internal Medicine	16,440,365	19,248,187	17.1%	22,360,603	36.0%
General Surgery	110,901	130,746	17.9%	154,644	39.4%
Hematology & Oncology	2,430,783	3,075,124	26.5%	3,738,588	53.8%
Labs	19,069,518	22,048,549	15.6%	25,648,721	34.5%
Miscellaneous	830,429	960,444	15.7%	1,109,621	33.6%
MRI	180,405	210,754	16.8%	246,623	36.7%
Nephrology	243,901	308,514	26.5%	381,606	56.5%
Neurology	301,567	329,642	9.3%	363,943	20.7%
Neurosurgery	8,569	12,803	49.4%	15,662	82.8%
Obstetrics/Gynecology	308,153	329,826	7.0%	368,233	19.5%
Ophthalmology	852,228	1,080,291	26.8%	1,338,240	57.0%
Oral Surgery	9,662	10,953	13.4%	12,640	30.8%
Orthopedics	289,261	338,070	16.9%	392,809	35.8%
Otolaryngology	800,546	869,940	8.7%	956,346	19.5%
Pain Management	146,266	170,975	16.9%	196,571	34.4%
Pathology	390	482	23.6%	590	51.4%
PET Scan	11,928	14,745	23.6%	17,854	49.7%
Physical & Occupational Therapy	6,760,880	8,216,085	21.5%	9,977,233	47.6%
Plastic Surgery	19,042	22,986	20.7%	27,686	45.4%
Podiatry	67,037	75,122	12.1%	83,308	24.3%
Psychiatry	2,794,077	3,341,267	19.6%	4,005,499	43.4%
Pulmonary	339,614	394,660	16.2%	461,138	35.8%
Radiation Therapy	179,265	213,999	19.4%	251,986	40.6%
Single Photon Emission CT Scan (SPECT)	22,850	27,398	19.9%	33,044	44.6%
Urology	105,402	130,061	23.4%	159,129	51.0%
Vascular Surgery	40,510	49,126	21.3%	58,771	45.1%
TOTAL	**58,861,421**	**69,250,411**	**17.6%**	**81,408,462**	**38.3%**

Source: IBM Watson Health Outpatient Procedure Estimates, 2020.

Emergency department visits

Emergency department estimates predict the total annual volume of emergency department (ED) visits by ZIP code and level of acuity for every market in the United States. IBM uses an extensive supply of proprietary claims, public claims and federal surveys to construct population-based use rates for all payors by age and sex. These use rates are then applied to demographic and insurance coverage projections by ZIP code to estimate ED utilization for 2020 through 2030.

Visits are broken out into emergent and non-emergent ambulatory visits to identify the volume of visits that could be seen in a less-acute setting, for example, a fast-track ED or an urgent care facility. In addition, visits that result in an inpatient admission are broken out into a third, separate category. In the McKinney Health Community, ED visits are expected to grow by over 20% by 2025.

Emergent status	2020 visits	2025 visits	2020 - 2025 visits change	2020 - 2025 visits % change
Emergent	317,472	407,730	90,257	28.4%
Inpatient Admission	98,811	131,475	32,664	33.1%
Non-Emergent	267,089	282,389	15,300	5.7%
TOTAL	**683,372**	**821,593**	**138,222**	**20.2%**

Source: IBM Watson Health Emergency Department Visits, 2020.

Emergency department visit estimates 2025

- Inpatient admission
- Emergent
- Non-emergent
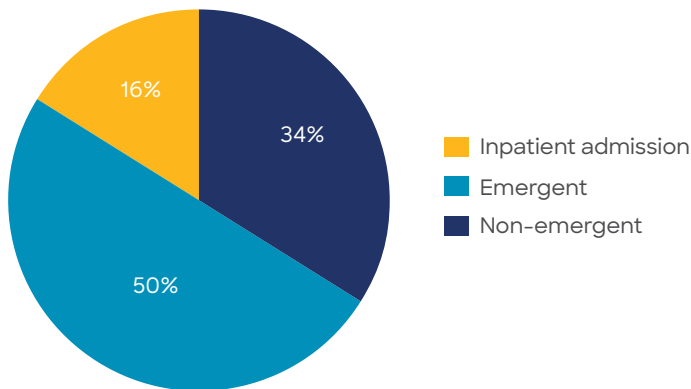
Heart disease estimates

The heart disease estimates dataset predicts the number of cases by heart disease type and ZIP code for every market in the United States. IBM uses public and private claims data as well as epidemiological data from the National Health and Nutritional Examination Survey (NHANES) to build local estimates of heart disease prevalence for the current population. County-level models by age and sex are applied to the underlying demographics of specific geographies to estimate the number of patients with specific types of heart disease.

In McKinney Health Community, the most common heart disease is hypertension at 73.6% of all heart disease cases.

Disease type	2020 prevalence	2020 % prevalence
Arrhythmia	85,176	12.4%
Heart Failure	30,425	4.4%
Hypertension	504,986	73.6%
Ischemic Heart Disease	65,611	9.6%
TOTAL	**686,199**	**100.0%**

Source: IBM Watson Heart Disease Estimates, 2020.

Cancer estimates

IBM Watson Health builds county-level cancer incidence models that are applied to the underlying demographics of specific geographies to estimate incidence (i.e., the number of new cancer cases annually) of all cancer patients. Cancer incidence is expected to increase by 15.7% in the McKinney Health Community by 2025.

Cancer type	2020 incidence	2025 incidence	2020 – 2025 change	2020 – 2025 % change
Bladder	465	569	104	22.4%
Brain	182	206	25	13.5%
Breast	2,017	2,401	384	19.1%
Colorectal	1,241	1,246	5	0.4%
Kidney	381	471	90	23.5%
Leukemia	344	411	67	19.4%
Lung	994	1,171	178	17.9%
Melanoma	535	645	110	20.5%
Non–Hodgkin's Lymphoma	502	604	102	20.4%
Oral Cavity	316	382	66	21.0%
Other	1,349	1,634	285	21.1%
Ovarian	156	179	23	14.5%
Pancreatic	260	328	69	26.4%
Prostate	1,326	1,382	57	4.3%
Stomach	164	191	27	16.7%
Thyroid	314	370	57	18.1%
Uterine Cervical	67	72	5	7.1%
Uterine Corpus	249	302	54	21.6%
TOTAL	**10,861**	**12,566**	**1,706**	**15.7%**

Source: IBM Watson Health Cancer Estimates, 2020.

Appendix F: 2019 community health needs assessment evaluation

It is Baylor Scott & White Health's privilege to serve faithfully in promoting the well-being of all individuals, families and communities. Our 2019 Implementation Strategy described the various resources and initiatives we planned to direct toward addressing the adopted health needs of the 2019 CHNA.

The following is a snapshot of the impact of actions taken by Baylor Scott & White to address the below priority health issues.

Dates: Fiscal Years 2020 – March 2022
Facility: Baylor Scott & White Medical Center – McKinney
Community served: Collin, Denton and Grayson Counties

Ratio of population to primary care providers (physician/non-physician)

Action/tactics	Anticipated outcome	Evaluation of impact
Financial donations Cash and in-kind contributions to other not-for-profit community organizations existing to increase access to care for the community.	Increased access to non-primary care health provider services through community organizations.	• **Persons served: 7,382** • **$662,487 community benefit**
Health professionals recruitment Recruit health professionals for areas identified as medically underserved areas (MUAs).	Recruitment of non-employee BSW physicians and other advanced health professions.	• **Persons served: unknown** • **$296,253 community benefit**
Clinical training program To help address the state's healthcare workforce shortage, the hospital provides a clinical training program to prepare nurses for the medical workforce.	Increase the available workforce of nurses and other allied health professions.	• **Persons served: 305** • **$1,019,901 community benefit**
Community health outreach Participate in community health screenings staffed by non-physician PCP providers to enhance access to care for underinsured/underserved populations.	Increased access to non-physician primary care providers.	• **Persons served: 3,616** • **$41,403 community benefit**
Charity care Discounted care as outlined in the BSWH financial assistance policy. The hospital will provide the level of financial assistance consistent with certain state requirements applicable to non-profit hospitals.	Increased access to healthcare for uninsured populations.	• **$16.1 million community benefit**

Total investment in adopted community needs since 2019 CHNA

BSWMC – McKinney

$18.1 million