


Community Health Needs Assessment

Plano Health Community

2022

Baylor Scott & White HEALTH

Plano health community hospitals

- Baylor Scott & White Medical Center – Plano
- Baylor Scott & White The Heart Hospital – Plano

Approved by: Baylor Scott & White Health – North Texas Operating, Policy and Procedure Board on May 31, 2022
Posted to **BSWHealth.com/CommunityNeeds** on June 30, 2022

Baylor Scott & White HEALTH

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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.

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

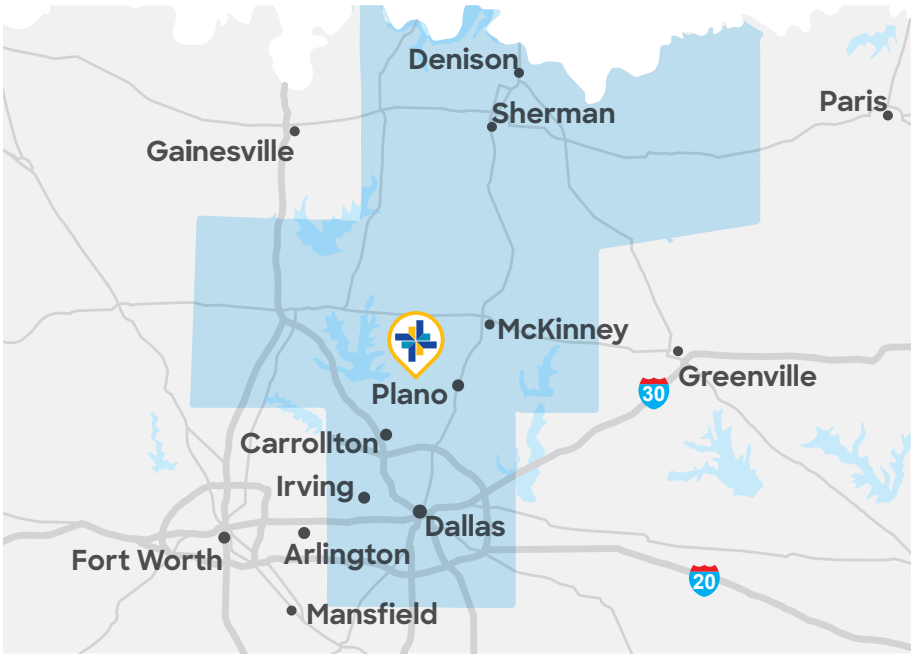
Baylor Scott & White Health (BSWH) owns and operates numerous individually licensed hospital facilities serving the residents of North and Central Texas.

The Plano Health Community is home to a number of these hospitals with overlapping communities, including:

- Baylor Scott & White Medical Center – Plano
- Baylor Scott & White The Heart Hospital - Plano

The community served by the hospital facilities listed above is Collin, Dallas, Denton, Grayson and Fannin Counties and was determined based on the contiguous ZIP codes within the associated counties that made up nearly 80% of the hospital facilities' inpatient admissions over the 12-month period of FY20. Those facilities with overlapping counties of patient origin collaborated to provide a joint CHNA report in accordance with the Internal Revenue Code Section 501 (r) (3) and the US Treasury regulations thereunder. All of the collaborating hospital facilities included in a joint CHNA report define their communities to be the same for the purposes of the CHNA report.

Plano 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.

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 Plano 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.

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

Health community data summary

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

- Inpatient discharges in the community are expected to grow by 10.5% by 2030 with the largest growing product lines to include:
  - Pulmonary medical
  - General medicine
  - Cardiovascular diseases
- Outpatient procedures are expected to increase by almost 35% by 2030 with the largest areas of growth including:
  - Labs
  - General & internal medicine
  - Physical & occupational therapy
  - Psychiatry
- Emergency department visits are expected to grow by almost 15% by 2025.
- Hypertension represents almost 73% of all heart disease cases.
- Cancer incidence is expected to increase by over 12% by 2025.

Further health community information for the Plano 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.

	Health professional shortage areas (HPSA)				Medically underserved area/ population (MUA/P)
County	Dental health	Mental health	Primary care	Grand total	MUA/P
Collin		1		1	
Dallas	7	14	9	30	10
Denton	1	2	1	4	1
Fannin		1	1	2	1
Grayson		1	1	2	1

Source: US Department of Health and Human Services, Health Resources and Services Administration, 2021

Total population

4,868,776

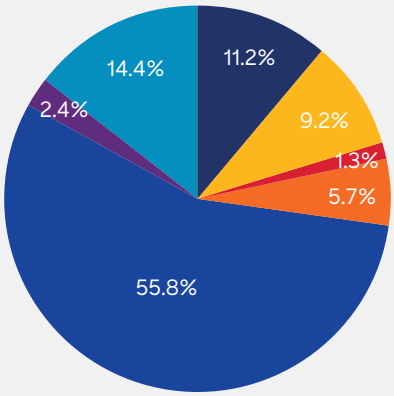
Average income

$79,762

Underserved ZIP codes

35

Insurance coverage



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:

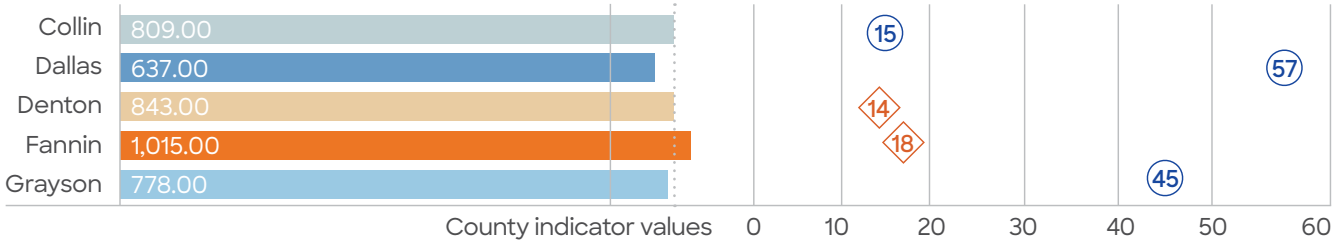
Priority	Need	Category of need
1	Access to mental healthcare (providers/services)	Access to care/mental health
2	Access to primary healthcare providers	Access to care
3	Obesity	Conditions/diseases
4	Housing insecurity	Environment
5	Elderly/social isolation	Environment
6	Food insecurity	Environment
7	Transportation	Environment

Priority 1: 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
Access to care/mental health	• Population to one mental health provider	• Limited access to mental healthcare providers

Access to care: 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 stated that it is difficult for community residents to access mental/behavioral health services. They believe that the limited access is due to a combination of an insufficient number of providers as well as residents' inability to access care in parts of the community due to transportation, insurance or funding limitations. Some participants felt that the area suffered an overwhelming impact of substance abuse and mental health issues and lacks proactive mental health services, which contribute to the downfall of the physical well-being of residents. In addition, they acknowledged that there is a stigma present in obtaining mental/behavioral health services, which also prevents residents from seeking care.

In the prioritization session, the hospital and community leaders were in agreement that the health community lacks sufficient behavioral health providers. They added that the current providers are seeing more patients than they have in the past. Many of the patients are presenting with significant behavioral needs along with complex medical conditions. This is causing difficulty with finding appropriate care for these individuals. They noted that often mental health facilities will not admit patients with complex medical needs, thus limiting resources even more in this community.

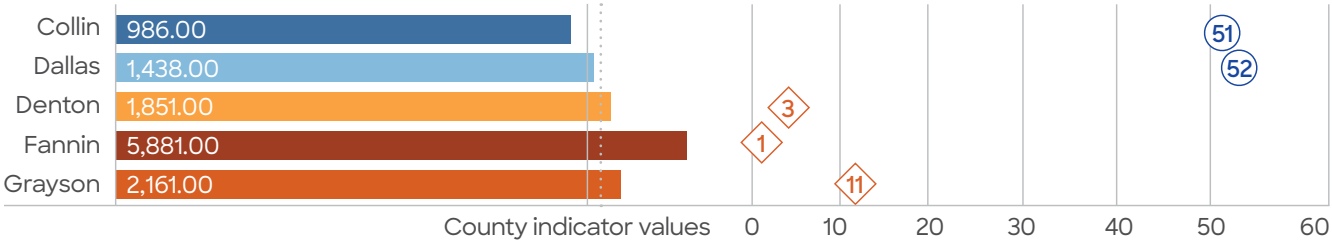
Priority 2: Access to Primary Healthcare

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 providers • Limited access to social workers and care navigators

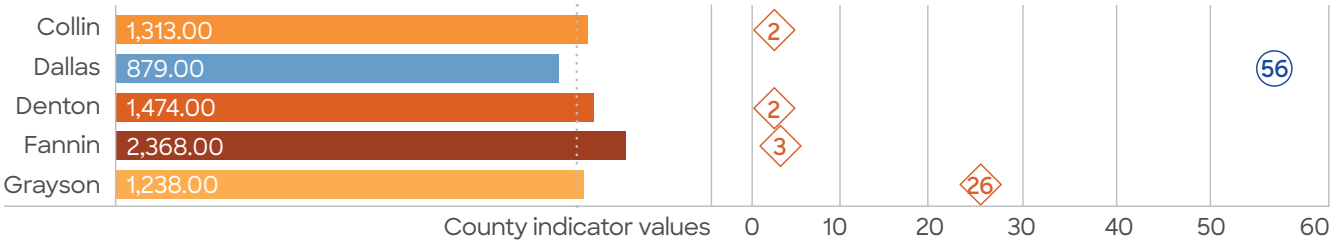
The **population to one primary care physician** indicator is defined as **the number of individuals served by one physician in a county if the population was equally distributed across physicians** and is based on data from County Health Rankings & Roadmaps and Area Health Resource File/American Medical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

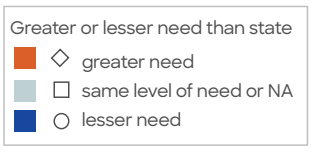
Access to care: population to one primary care physician (number of individuals served by one physician by county)



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)





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The focus group participants felt that the overall community area has limited access to primary care and a shortage of those providers. Participants cited that limited access to providers is a problem regardless of insurance coverage. Language and cultural barriers also prevent access to medical care.

In the prioritization session, the hospital leadership noted that primary care provider access will always be a need as the population continues to grow and age in Plano.

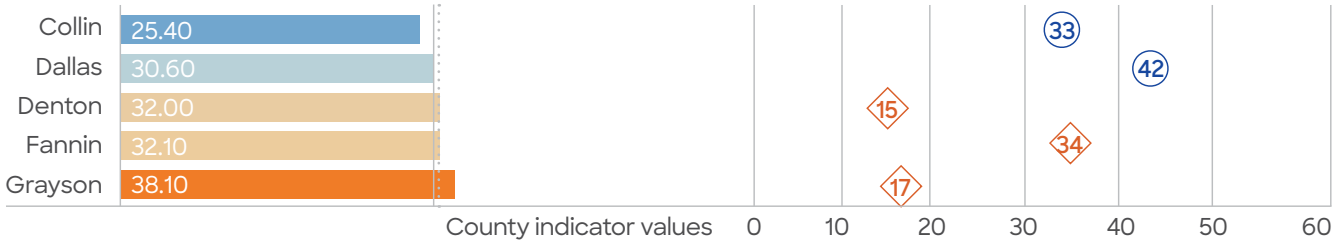
Priority 3: Obesity

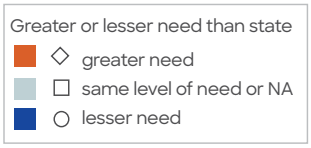
The following data indicates greater need in the area of adult obesity although it was not discussed by the key informants specifically.

Category	Data shows greater need	Key informants indicate less need or not mentioned
Conditions/ diseases	• Adult obesity	• 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)





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In the prioritization session, hospital leadership discussed obesity as a need that should be elevated to a significant need. They noted that obesity is a risk factor for many other chronic conditions.

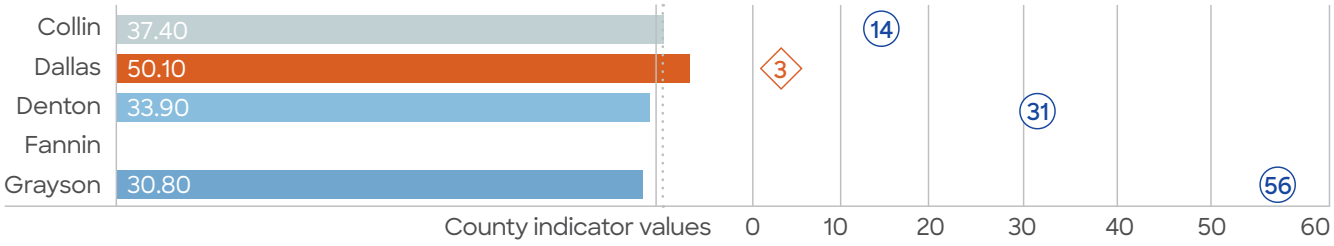
Priority 4: Housing Insecurity

Although the data did not indicate greater need in the case of housing, specifically in the measures of renter-occupied housing and severe housing problems, the key informants felt the lack of affordable housing was a greater need in the community.

Category	Data shows less need or no data	Key informants indicate greater need
Housing/ environment	• Renter-occupied housing • Severe housing problems	• Lack of affordable housing

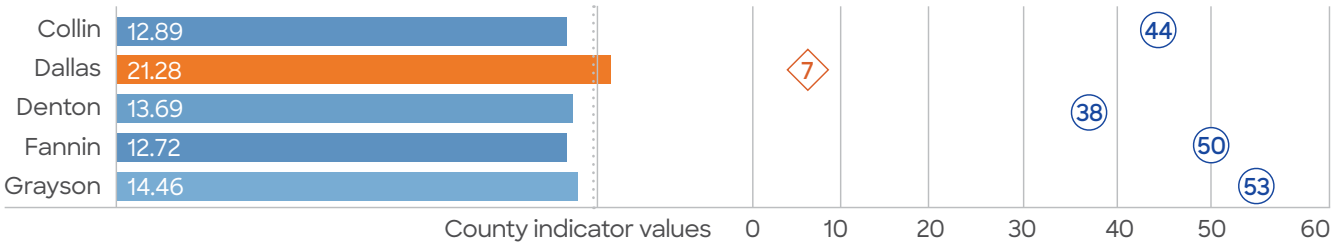
The **renter-occupied housing** indicator is defined as **the percentage of households that utilize renter-occupied housing** and is based on data from US Census Bureau, American Community Survey One-Year Estimates.

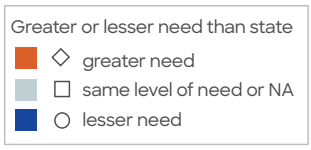
Housing: renter-occupied housing (% of households that are renter-occupied by county)



The **severe housing problems** indicator is defined as **the percentage of households with at least one of four housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities**. The indicator is based on data from County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP).

Housing: severe housing problems (% of households with one of four housing problems by county)





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The focus group participants stated that housing is unaffordable in the community. Significant gentrification has occurred, and the resulting impact is residents are being priced out of neighborhoods. While housing assistance is available, there are too many requirements to apply and qualify. In addition, there is a lack of safe housing, resulting in hospitalized patients being discharged to unsafe environments.

In the prioritization session, hospital leadership felt strongly that housing is central to accessing care. Stable housing helps patients manage chronic diseases better and reduces their utilization of the emergency department. They note that there is a lack of resources for homeless individuals in parts of the community, which increases the utilization of resources in other parts.

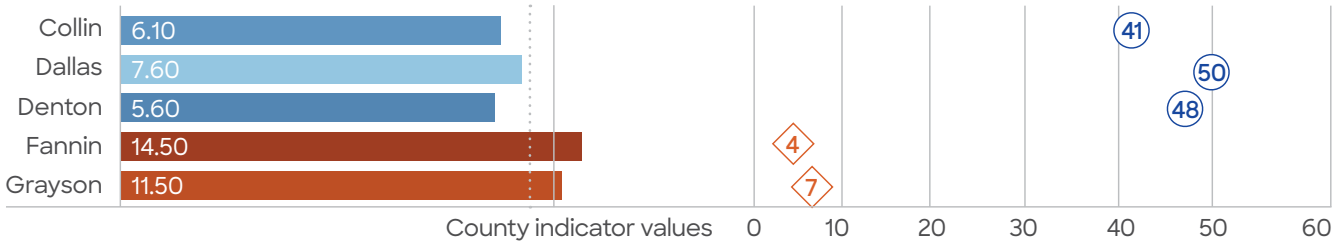
Priority 5: Elderly/Social Isolation

Although the data did not indicate greater need to address elderly isolation, the key informants felt it was a greater need in the community.

Category	Data shows less need or no data	Key informants indicate greater need
Environment	• Elderly isolation	• Social isolation and loneliness in community caused by COVID

The **elderly isolation** measure is defined as **the percent of non-family households (householder living alone) age 65 years and over**. The indicator is based on data from American Community Survey Five-Year Estimates, US Census Bureau - American FactFinder.

Environment: elderly isolation (% householder age 65+ living alone by county)



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The key informants described elderly isolation, especially due to COVID, as a social challenge for the community. As a result of the isolation, the elder community has increased mental health needs and limited access to resources with no one to provide transportation.

In the prioritization session, hospital leadership discussed the significant uptick in patients presenting with altered mental/dementia status to the hospitals. They attribute this to older adults living alone in their homes past the time their capabilities allow them to do so safely. They noted that this can increase emergency visits for patients with mental health and other medical needs.

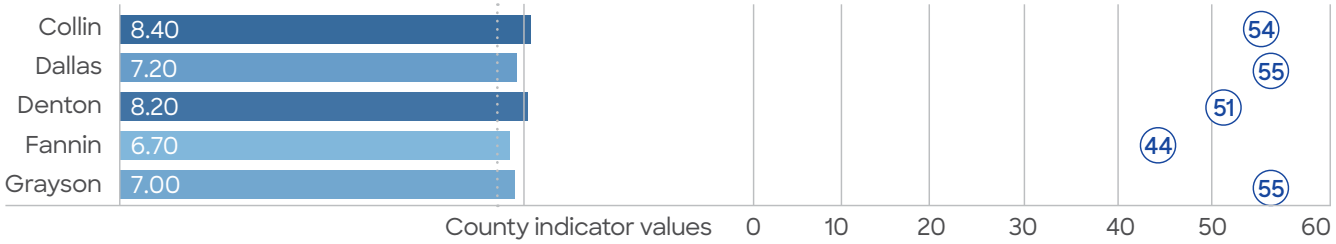
Priority 6: Food Insecurity

While the data did not indicate a need, the key informants cited a greater need in response to the food environment index, food insecurity and limited access to healthy foods.

Category	Data shows less need or no data	Key informants indicate greater need
Environment	• Food environment index • Food insecure • Limited access to healthy foods	• Food deserts exist • Lack of supply of food in some areas • Healthy choices not affordable and not accessible everywhere

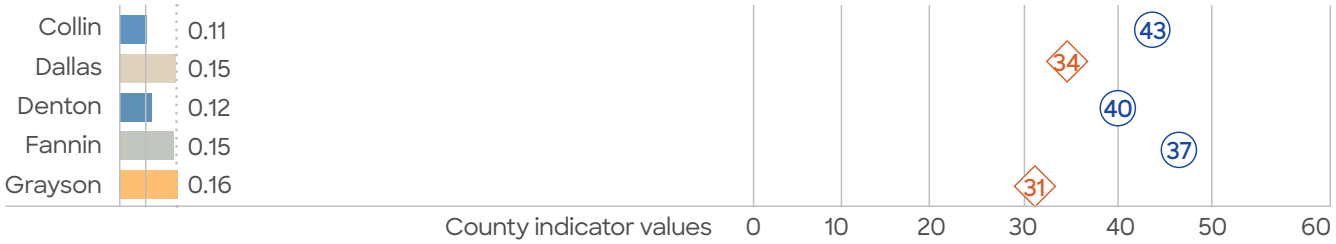
The **food environment index** measure is defined as **index of factors that contribute to a healthy food environment**. A value of zero "0" is worst and a value of ten "10" is best in the county. The indicator is based on data from County Health Rankings & Roadmaps, USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA).

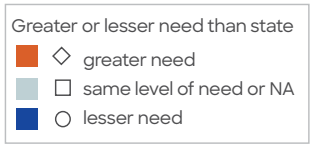
Environment: elderly isolation (% householder age 65+ living alone by county)



The **food insecure** measure is defined as **the percentage of population who lack adequate access to food during the past year**. The indicator is based on data from County Health Rankings & Roadmaps, Map the Meal Gap, Feeding America.

Environment: food insecure (% who lack adequate access to food by county)





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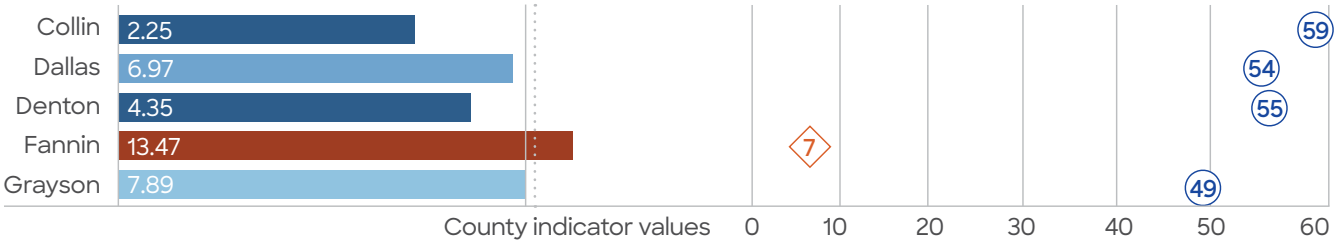
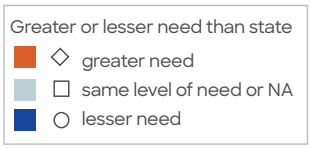
The indicator **limited access to healthy foods** is defined as **the percentage of population who are low-income and do not live close to a grocery store**. The indicator is based on data from County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA).

Environment: limited access to healthy foods (% population low income and do not live close to a grocery store by county)





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While the key informants acknowledged that COVID helped with food access in North Texas as more resources were made available, they noted that food distributions are slowing down and that there are typically issues in the community around fresh and healthy food options. They added that chronically ill residents are not helped by food banks or Meals on Wheels because those food sources often lack dietary-restricted options such as low sodium. Even when healthy food choices are available, they are not affordable for most residents.

In the prioritization session, the hospital and community leaders agreed that food is a critical foundation for all needs, including good health. They also agreed that the issue is not the availability of food but access to food, which is linked to transportation issues. They cited that there is a huge amount of food wasted at the community's medical centers, which could be utilized. Despite stringent state and federal government guidelines for food disposal, the group felt there might be opportunities to reuse the excess food.

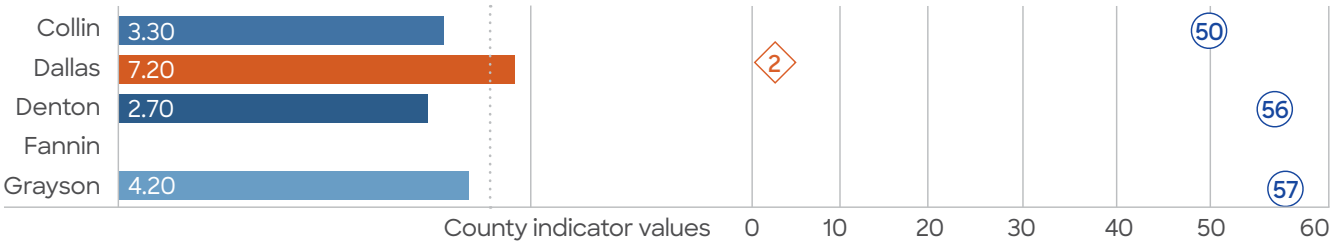
Priority 7: Transportation

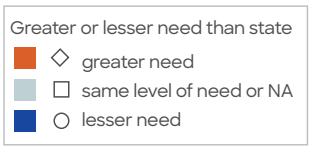
Although the data did not illustrate a need, the focus group participants indicated greater need to address transportation needs.

Category	Data shows less need or no data	Key informants indicate less need or not mentioned
Environment	• No vehicle available	• Transportation is a challenge, especially in rural areas

The **no vehicle available** measure is defined as **the percent of households with no vehicle available (percent of households)**. 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)





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According to key informants, there is limited public transportation across the community. Even with the existing programs in place to assist in transporting the population, public transportation is not convenient and can be cost-prohibitive. In addition, current voucher programs are still inefficient at getting residents to their healthcare appointments. The group felt that more could be done to address this need. Removing some of the transportation barriers by improving public transportation accessibility and providing more ride-share or voucher arrangements was a highly rated opportunity as well as expanding telehealth to accommodate those without easy transportation options to get to healthcare visits.

In the prioritization session, the hospital and community leaders noted that there are very few options for public transportation in the Plano Health Community. This is more pronounced in rural areas and low socioeconomic households that cannot afford ride-sharing services such as Lyft and Uber. Transportation is critical for getting to appointments, obtaining medications and buying groceries and is a significant need for these reasons.

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.

Plano community resources

Need	Organization	Address	Phone
Access to mental healthcare providers/ resources	First Step Counseling Center	900 E. Park Boulevard Plano, TX 75074	214.942.8808
	Child & Family Guidance Center (CFGC)	4031 W. Plano Parkway Plano, TX 75093	866.695.3794
	A Children At Heart Ministries, Inc. - STARRY Counseling	4501 Medical Center Drive McKinney, TX 75069	469.617.7476
	LifePath System (behavioral health services)	7308 Alma Drive Plano, TX 75025	877.422.5939
	CK Family Services (CK) (reduced cost)	710 E. Park Boulevard Plano, TX 75074	817.516.9100
Access to primary healthcare providers	Carevide	111 N. Johnson Street Farmersville, TX 75442	903.455.5958
	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
	Hope Clinic	103 E. Lamar Street McKinney, TX 75069	469.712.4246
	Collin County Primary Care Services (PrimaCare Program)	1920 Eldorado Parkway McKinney, TX 75069	469.952.3737
Obesity	YMCA of Metropolitan Dallas - Plano Location	3300 McDermott Road Plano, TX 75025	214.705.9459
	Carevide (disease management/preventive medicine)	111 N. Johnson Street Farmersville, TX 75442	903.455.5958
	YMCA of Metropolitan Dallas (recreational center, nutrition education)	300 Ridge Road McKinney, TX 75072	972.529.2559
	Collin County Health Care Services (WIC, nutrition education)	825 N. McDonald Street McKinney, TX 75069	972.548.5543
	Brighter Bites - Dallas	2800 18th Street Plano, TX 75074	469.752.2400

Need	Organization	Address	Phone
Housing insecurity	Hope's Door New Beginning Center (emergency shelter)	860 F Avenue Plano, TX 75074	972.276.0057
	Samaritan Inn	1514 N. McDonald Street McKinney, TX 75071	972.542.5302
	City House (transitional living program for youth)	830 Central Parkway East Plano, TX 75074	972.424.4626
	Plano Community Homes (senior housing reduced cost)	3905 American Drive Plano, TX 75075	972.867.1905
	Family Promise of Collin County (rotational shelter)	325 W. Lucas Road Allen, TX 75002	972.442.6966
Elderly isolation	HMG Healthcare LLC - Long-Term Care Program	1801 Pearson Avenue McKinney, TX 75069	972.473.3456
	Custer Road United Methodist Church (pastoral care/ spiritual support)	6601 Custer Road Plano, TX 75023	972.618.3450 ext. 227
	The Center for Integrative Counseling and Psychology (counseling for seniors)	3901 N. Star Road Richardson, TX 75082	214.526.4525
	Widowed Persons Support Group	9027 Midway Road Dallas, TX 75209	214.358.4155
	SMU Counseling Services by Graduate Students (all ages, grief/loss, depression)	5228 Tennyson Parkway Plano, TX 75024	972.473.3456
Food insecurity	Meals on Wheels Collin County	600 N. Tennessee Street McKinney, TX 75069	972.562.6996
	Texas Health and Human Services Commission (HHSC) - SNAP	901 N. McDonald Street McKinney, TX 75069	877.541.7905
	The Salvation Army of North Texas - Food Pantry	3528 14th Steet Plano, TX 75074	214.637.8100
	Brighter Bites - Dallas	2800 18th Street Plano, TX 75074	469.752.2400
	Seven Loaves Food Pantry	1401 Mira Vista Boulevard Plano, TX 75093	469.385.1813

Need	Organization	Address	Phone
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
	DART	1401 Pacific Avenue Dallas, TX 75202	214.979.1111
	White Rock Center of Hope - East Dallas Plano Health Community	10021-A Garland Road Dallas, TX 75218	214.324.8996
	Parkland Senior Outreach Services - Southeast Dallas Plano Health Community	2231 Butler Street Dallas, TX 75235	214.590.0646

There are many other community resources and facilities serving the Plano Health Community 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 hospitals' 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:

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:

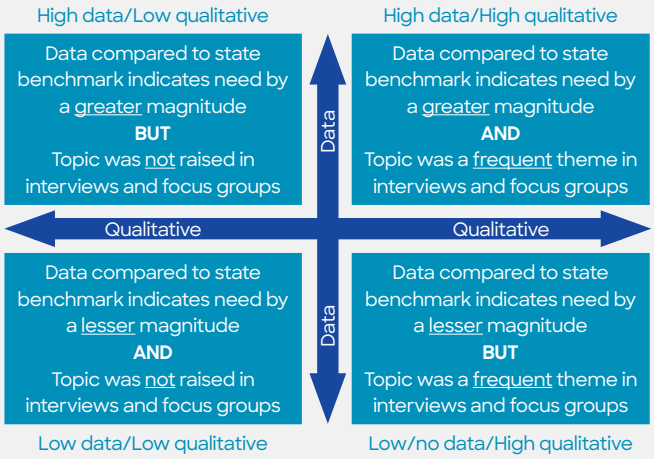
- Assembled a focus group representing the broad interests of the community served;
- Conducted interviews and surveys with key informants—leaders and representatives who serve the community and have insight into its needs; and
- Held prioritization sessions with hospital clinical leadership and community 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**.

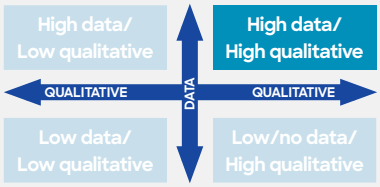
Approach to prioritizing significant health needs



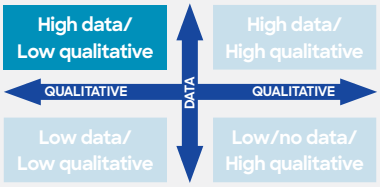
High data = Indicators worse than state benchmark by greater magnitude
High qualitative = Frequency of topic in interviews and focus groups

On January 31, 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.

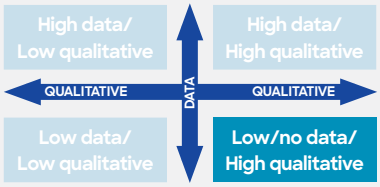
In the first step, participants reviewed the top health needs for their community using associated data-driven criteria. The criteria included health indicator value(s) for the community and how the indicator compared to the state benchmark.



High data 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 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.



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.

- **Severity (outcome if ignored):** The problem results in disability or premature death or creates burdens on the community, economically or socially.
- **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? What technology, knowledge or resources are necessary to effect a change? Is the problem preventable? Is it too expensive for the community to tackle?

The group rated each of the seven 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 mental healthcare (providers/services)	Access to care/mental health
2	Access to primary healthcare providers	Access to care
3	Obesity	Conditions/diseases
4	Housing insecurity	Environment
5	Elderly/social isolation	Environment
6	Food insecurity	Environment
7	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).
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).

Indicator name	Indicator source	Indicator definition
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
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

Indicator name	Indicator source	Indicator definition
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.
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.
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.

Indicator name	Indicator source	Indicator definition
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
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

Indicator name	Indicator source	Indicator definition
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.
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 Health - McKinney
- Baylor Scott & White Health - Plano
- Baylor Scott & White Health - Sherman
- Baylor Scott & White Heart & Vascular Hospital
- Baylor Scott & White The Heart Hospital - Denton
- Baylor University Medical Center
- Bridge Breast Network
- Brighter Tomorrows
- Callier Center for Communication Disorders
- Collin County RHP 18
- Church of Jesus Christ of LDS
- City of Denton
- Collin College Homeless Coalition
- Collin County Coalition Charitable Clinics
- Collin County Health Care Services
- Collin County Health Department
- Collin County Public Health
- Community Lifeline Center
- Community Services, Inc.
- Crossroads
- Dallas Area Interfaith
- Dallas Area Rape Crisis Center (DARCC)
- Dallas Area Rapid Transit (DART)
- Denton County MHMR Center
- Department of State Health Services, Public Health Region 2 and 3
- Eligibility Consultants Inc.
- Empowering the Masses
- Family Promise of Living
- First Refuge Ministries
- First United Methodist
- First United Methodist, Richardson
- For Oak Cliff
- Frazier Revitalization
- Golden SEEDS
- Goodwill Dallas
- Grayson County Health Clinic
- Health Services of North Texas
- Julia's Center
- Methodist Dallas Medical Center
- Methodist Health System
- Methodist Health System Golden Cross Academic Clinic
- Metrocare Services
- Metroport Meals on Wheels
- My Possibilities
- North Central Texas Health Care Center Comm.
- North Texas Food Bank
- Plano Fire-Rescue
- Sharing Life
- Sherman Chamber of Commerce
- Sherman High School
- Sherman Independent School District
- South Dallas Fair Park Faith Coalition
- Southern Methodist University
- State Fair of Texas
- Texas Health Resources
- Texoma Community Center
- Texoma Health Foundation
- The Bridge Homeless Recovery Center
- The Concilio
- The Stewpot
- United Way
- United Way of Grayson County
- United Way of Metropolitan Dallas (UWMD)
- Visiting Nurse Association (VNA)
- Visiting Nurse Association of Texas - Dallas/Fort Worth
- Wellness Center for Older Adults
- Wells Fargo Advisors
- YMCA Dallas

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 slightly 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 lower percentage of Medicaid beneficiaries and a 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	Plano Metropolitan health community
Total current population		330,342,293	29,321,501	4,868,776
Five-year projected population change		3.3%	6.6%	7.4%
Median age		38.6	35.2	35.9
Population 0 - 17		22.4%	25.7%	25.5%
Population 65+		16.6%	13.2%	11.6%
Women age 15 - 44		19.5%	20.5%	21.2%
Hispanic population		19.0%	40.7%	30.9%
Insurance coverage	Uninsured	9.9%	18.8%	14.4%
	Medicaid	20.9%	13.0%	11.2%
	Private market	8.3%	8.4%	8.1%
	Medicare	13.8%	12.7%	10.5%
	Employer	47.2%	47.1%	55.8%
Median HH income		$65,618	$63,313	$79,762
No high school diploma		12.2%	16.7%	14.9%

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

The community served expects to grow 7.5% by 2025, an increase of over 362,000 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:

- 75052 Grand Prairie – 8,690 people
- 75002 Allen – 7,402 people
- 75035 Frisco – 7,244 people
- 75098 Wylie – 7,020 people

The community's population is younger with 51.6% of the population ages 18 - 54 and 25.4% under age 18. The age 65-plus cohort is expected to experience the fastest growth (27%) 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 175,000 people (11.6%) by 2025. The non-Hispanic white population is expected to decline by -1.1%.

Population distribution

	Age distribution				
Age group	2020	% of total	2025	% of total	USA 2020 % of total
0 - 14	1,025,532	21.1%	1,048,474	20.0%	18.5%
15 - 17	212,504	4.4%	228,764	4.4%	3.9%
18 - 24	457,791	9.4%	505,771	9.7%	9.5%
25 - 34	696,904	14.3%	682,028	13.0%	13.5%
35 - 54	1,355,443	27.8%	1,427,733	27.3%	25.2%
55 - 64	554,607	11.4%	621,592	11.9%	12.9%
65+	565,995	11.6%	716,461	13.7%	16.6%
Total	**4,868,776**	**100.0%**	**5,230,823**	**100.0%**	**100.0%**

Household Income distribution

	Income distribution		
2020 Household income	HH count	% of total	USA % of total
<$15K	132,132	7.5%	10.0%
$15 - 25K	118,719	6.8%	8.6%
$25 - 50K	343,594	19.6%	20.7%
$50 - 75K	294,730	16.8%	16.7%
$75 - 100K	224,360	12.8%	12.4%
Over $100K	639,027	36.5%	31.5%
Total	**1,752,562**	**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	244,467	7.7%	5.2%
Some high school	227,868	7.2%	7.0%
High school degree	652,117	20.6%	27.2%
Some college/assoc. degree	862,339	27.2%	28.9%
Bachelor's degree or greater	1,186,158	37.4%	31.6%
Total	**3,172,949**	**100.0%**	**100.0%**

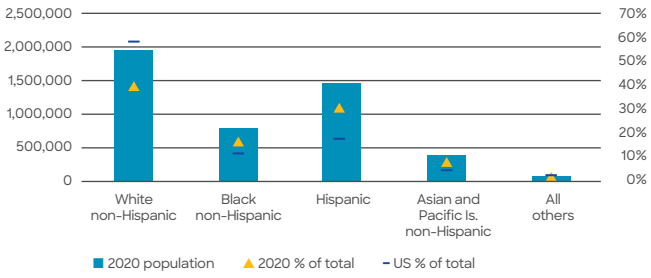
Race/ethnicity

	Race/ethnicity distribution		
Race/ethnicity	2020 pop	% of total	USA % of total
White non-Hispanic	1,974,024	40.5%	59.3%
Black non-Hispanic	824,682	16.9%	12.4%
Hispanic	1,506,166	30.9%	19.0%
Asian & Pacific is. non-Hispanic	442,733	9.1%	6.0%
All others	121,171	2.5%	3.3%
Total	**4,868,776**	**100.0%**	**100.0%**

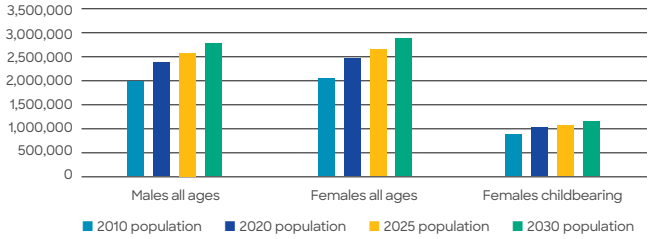
Population estimates		
Population	National	Selected area
2010 total	308,745,538	4,021,625
2020 total	330,342,293	4,868,776
2025 total	341,132,738	5,230,823
2030 total	353,513,931	5,659,291
% change 2020 - 2025	3.27%	7.44%
% change 2020 - 2035	7.01%	16.24%

Population	Males all ages	Females all ages	Females childbearing
2010 total	1,984,763	2,036,862	896,917
2020 total	2,399,194	2,469,582	1,033,272
2025 total	2,577,167	2,653,656	1,069,134
2030 total	2,786,354	2,872,937	1,130,632
10Y %	16.14%	16.33%	9.42%
National	7.02%	7.01%	4.01%

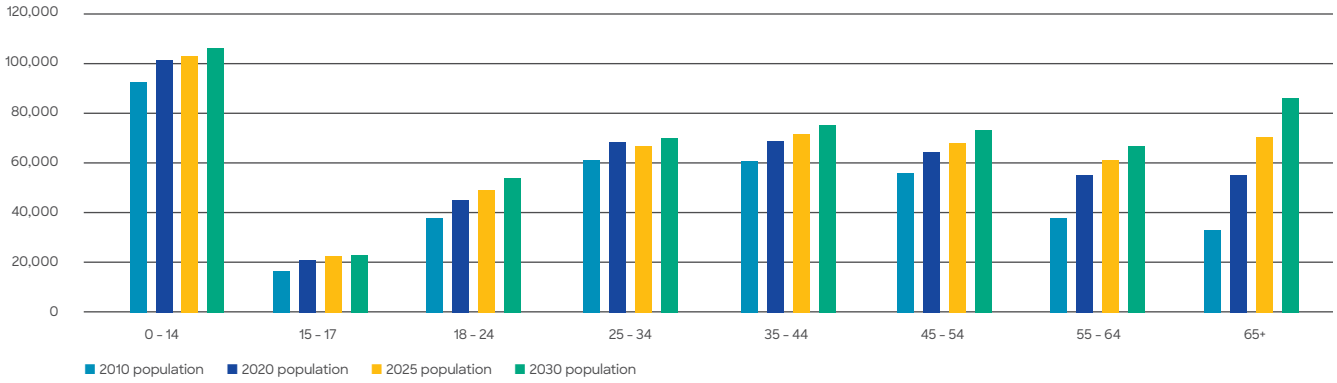
2020 race and ethnicity with total population



Population by sex 2010 - 2030



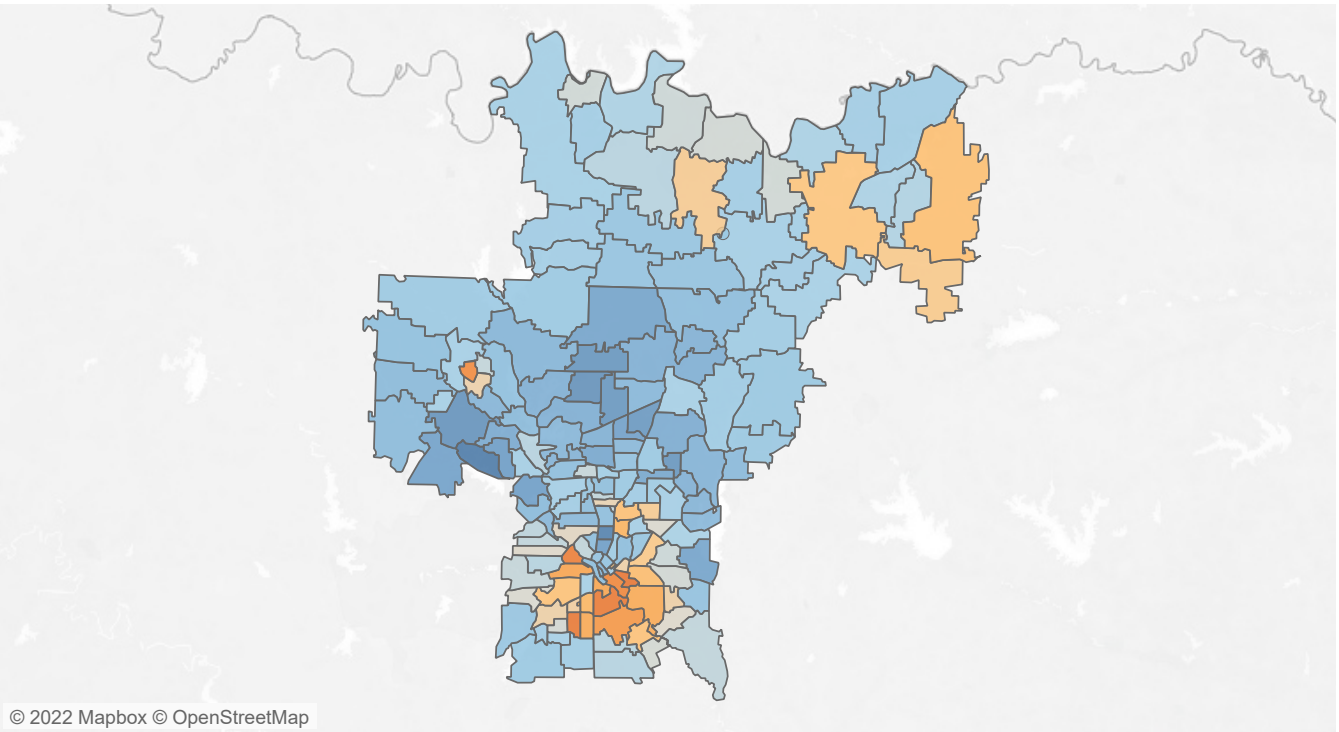
Population by age group 2010 - 2030



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 $28,568 for 75210 Dallas. There were thirty-five (35) ZIP codes with median household incomes less than $52,400—twice the 2020 federal poverty limit for a family of four.

A majority of the population (55.8%) is insured through employer sponsored health coverage. The remainder of the population was fairly equally divided between Medicaid, Medicare and private market (the purchasers of coverage directly or through the health insurance marketplace).

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.



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
Dallas	1487790622	OFAC - Parkland Center for Internal Medicine (PCIM)	Primary care	Other Facility
Dallas	7486259744	LI - Irving	Mental health	Low-income population HPSA
Dallas	7482835384	LI - South Central Dallas	Mental health	Low-income population HPSA
Dallas	7482563929	LI - Southeast Dallas	Mental health	Low-income population HPSA
Dallas	7486982533	LI - Grand Prairie-West Dallas	Mental health	Low-income population HPSA
Dallas	7483797081	LI - Central Dallas County	Mental health	Low-income population HPSA
Dallas	7484799626	LI - North Dallas County	Mental health	Low-income population HPSA
Dallas	7482166324	LI - Northeast Dallas County	Mental health	Low-income population HPSA
Dallas	14899948OZ	Mission East Dallas and Metroplex Project	Primary care	Federally qualified health center
Dallas	74899948MN	Mission East Dallas and Metroplex Project	Mental health	Federally qualified health center
Dallas	64899948MO	Mission East Dallas and Metroplex Project	Dental health	Federally qualified health center
Dallas	14899948Q0	Healing Hands Ministries, Inc.	Primary care	Federally qualified health center
Dallas	74899948O2	Healing Hands Ministries, Inc.	Mental health	Federally qualified health center
Dallas	64899948NX	Healing Hands Ministries, Inc.	Dental health	Federally qualified health center
Dallas	148999485F	Martin Luther King Jr. Family Clinic Inc.	Primary care	Federally qualified health center
Dallas	748999481V	Martin Luther King Jr. Family Clinic Inc.	Mental health	Federally qualified health center
Dallas	6489994897	Martin Luther King Jr. Family Clinic Inc.	Dental health	Federally qualified health center
Dallas	14899948P6	Dallas County Hospital District	Primary care	Federally qualified health center
Dallas	748999482V	Dallas County Hospital District	Mental health	Federally qualified health center
Dallas	64899948C2	Dallas County Hospital District	Dental health	Federally qualified health center
Dallas	1488622370	Urban Inter-Tribal Center of Texas	Primary care	Indian health service, tribal health and urban Indian health organizations
Dallas	7485754448	Urban Inter-Tribal Center of Texas	Mental health	Indian health service, tribal health and urban Indian health organizations
Dallas	6485188079	Urban Inter-Tribal Center of Texas	Dental health	Indian health service, tribal health and urban Indian health organizations
Dallas	14899948D3	Los Barrios Unidos Community Clinic, Inc.	Primary care	Federally qualified health center
Dallas	748999481L	Los Barrios Unidos Community Clinic, Inc.	Mental health	Federally qualified health center

Health professional shortage areas (HPSA), continued				
County	HPSA ID	HPSA name	HPSA discipline class	Designation type
Dallas	6489994889	Los Barrios Unidos Community Clinic, Inc.	Dental health	Federally qualified health center
Dallas	1489814978	FCI - Seagoville	Primary care	Correctional facility
Dallas	6481843658	FCI - Seagoville	Dental health	Correctional facility
Dallas	7483425946	FCI - Seagoville	Mental health	Correctional facility
Dallas	1487991263	LI - Central Dallas County	Primary care	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
Fannin	7485674459	Fannin County	Mental health	Geographic HPSA
Fannin	1489550240	LI - Fannin County	Primary care	Low-income population HPSA
Grayson	7487593472	LI - Grayson County	Mental health	Low-income population HPSA
Grayson	1485849525	LI - Grayson County	Primary care	Low-income population HPSA

Medically underserved areas and populations (MUA/P)				
County	MUA/P source identification number	Service area name	Designation type	Rural status
Dallas	1485024236	Dallas County - Dallas South	Medically underserved area	Non-rural
Dallas	03469	Dallas service area	Medically underserved area	Non-rural
Dallas	1487043129	East Dallas County	Medically underserved area	Non-rural
Dallas	05213	Forest Glenn service area	Medically underserved area	Non-rural
Dallas	07959	Lillycare Dallas	Medically underserved area	Non-rural
Dallas	1484709099	Southeast Dallas County	Medically underserved area	Non-rural
Dallas	1486572106	Dallas County - Dallas Southwest	Medically underserved population	Non-rural
Dallas	1489157042	LI - Grand Prairie	Medically underserved population	Non-rural
Dallas	1483247641	LI - Irving	Medically underserved population	Non-rural
Dallas	07753	Mission East Dallas area	Medically underserved population	Non-rural
Denton	03463	Poverty population	Medically underserved area – Governor's exception	Non-rural
Fannin	1489926052	Fannin County	Medically underserved area	Rural
Grayson	1481877977	LI - Grayson County	Medically underserved population	Partially rural

Community Needs Index

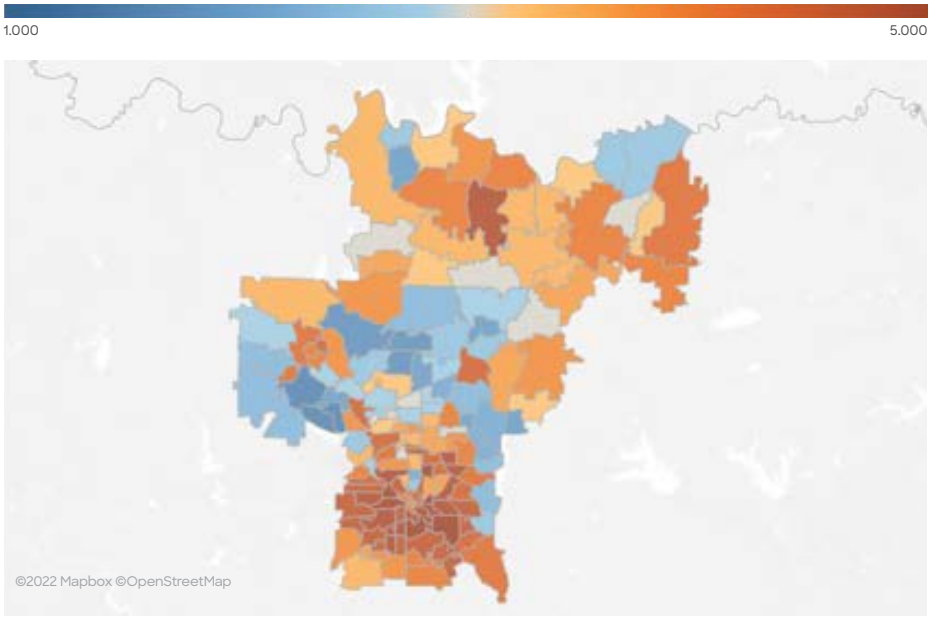
The IBM Watson Health Community Need Index (CNI) is a statistical approach that identifies areas within a community where there are likely gaps in healthcare. The CNI takes into account vital socio-economic factors, including income, culture, education, insurance and housing, about a community to generate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

Plano Health Community

Composite CNI: high scores indicate high need.



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
3.61

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 Plano Health Community was 3.61. 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 Plano Health Community. Total discharges in the community are expected to grow by 10.5% by 2030, with pulmonary medical, general medicine and cardiovascular diseases 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	5,084	5,184	5,714	99	1.9%	629	12.4%
Cardio-Vasc-Thor Surgery	13,470	14,351	15,122	880	6.5%	1,651	12.3%
Cardiovascular Diseases	27,668	30,201	34,631	2,533	9.2%	6,963	25.2%
ENT	2,284	2,107	2,019	(177)	-7.8%	(264)	-11.6%
General Medicine	68,556	72,053	77,774	3,496	5.1%	9,217	13.4%
General Surgery	30,214	30,540	32,160	326	1.1%	1,946	6.4%
Gynecology	2,556	1,262	742	(1,294)	-50.6%	(1,813)	-71.0%
Nephrology/Urology	17,322	18,549	20,382	1,228	7.1%	3,060	17.7%
Neuro Sciences	20,237	21,233	23,566	996	4.9%	3,329	16.4%
Obstetrics Del	53,471	49,064	48,875	(4,407)	-8.2%	(4,596)	-8.6%
Obstetrics ND	4,104	3,537	3,364	(566)	-13.8%	(740)	-18.0%
Oncology	8,005	8,245	8,737	239	3.0%	731	9.1%
Ophthalmology	461	437	422	(24)	-5.3%	(39)	-8.5%
Orthopedics	31,748	32,313	34,465	565	1.8%	2,717	8.6%
Psychiatry	4,888	5,137	5,435	249	5.1%	547	11.2%
Pulmonary Medical	28,291	33,226	38,457	4,935	17.4%	10,166	35.9%
Rehabilitation	349	396	464	47	13.4%	114	32.7%
TOTAL	**318,709**	**327,833**	**352,328**	**9,124**	**2.9%**	**33,618**	**10.5%**

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 Plano Health Community outpatient procedures are expected to increase by almost 35% by 2030 with the largest growth in the categories of labs, general & internal medicine, physical & occupational therapy and psychiatry.

Clinical service category	2020 procedures	2025 procedures	2020-2025 procedures % change	2030 procedures	2020 - 2030 procedures % change
Allergy & Immunology	1,227,607	1,356,284	10.5%	1,505,743	22.7%
Anesthesia	327,624	395,367	20.7%	461,933	41.0%
Cardiology	2,640,485	3,445,074	30.5%	4,523,428	71.3%
Cardiothoracic	2,784	3,283	17.9%	3,820	37.2%
Chiropractic	2,000,664	2,048,770	2.4%	2,067,047	3.3%
Colorectal Surgery	33,332	36,339	9.0%	39,696	19.1%
CT Scan	820,169	1,144,324	39.5%	1,576,710	92.2%
Dermatology	826,158	981,531	18.8%	1,158,090	40.2%
Diagnostic Radiology	4,758,881	5,328,190	12.0%	5,950,854	25.0%
Emergency Medicine	2,317,865	2,605,519	12.4%	2,940,128	26.8%
Gastroenterology	320,772	376,386	17.3%	436,965	36.2%
General & Internal Medicine	38,763,171	45,245,471	16.7%	51,737,126	33.5%
General Surgery	265,215	305,262	15.1%	351,658	32.6%
Hematology & Oncology	7,149,409	8,704,331	21.7%	10,219,570	42.9%
Labs	47,565,513	54,048,309	13.6%	61,488,029	29.3%
Miscellaneous	2,029,924	2,317,920	14.2%	2,626,818	29.4%
MRI	408,467	468,784	14.8%	537,061	31.5%
Nephrology	1,013,716	1,222,540	20.6%	1,449,449	43.0%
Neurology	662,097	727,682	9.9%	801,218	21.0%
Neurosurgery	19,972	29,399	47.2%	35,308	76.8%
Obstetrics/Gynecology	842,045	886,676	5.3%	962,896	14.4%
Ophthalmology	2,179,306	2,673,448	22.7%	3,206,134	47.1%
Oral Surgery	26,091	29,078	11.4%	32,788	25.7%
Orthopedics	649,724	743,555	14.4%	844,350	30.0%
Otolaryngology	1,622,641	1,799,942	10.9%	1,993,362	22.8%
Pain Management	365,027	417,030	14.2%	467,770	28.1%
Pathology	815	962	18.1%	1,132	38.8%
PET Scan	23,667	28,298	19.6%	33,228	40.4%
Physical & Occupational Therapy	13,486,888	16,218,756	20.3%	19,377,663	43.7%
Plastic Surgery	40,029	47,250	18.0%	55,694	39.1%
Podiatry	176,596	194,788	10.3%	211,787	19.9%
Psychiatry	6,019,862	7,768,719	29.1%	9,779,380	62.5%
Pulmonary	843,032	964,317	14.4%	1,108,047	31.4%
Radiation Therapy	377,016	435,627	15.5%	497,838	32.0%
Single Photon Emission CT Scan (SPECT)	54,136	62,598	15.6%	73,115	35.1%
Urology	258,226	309,743	20.0%	367,735	42.4%
Vascular Surgery	113,426	132,611	16.9%	153,080	35.0%
TOTAL	**140,232,354**	**163,504,164**	**16.6%**	**189,076,651**	**34.8%**

Source: IBM Watson Health Outpatient Procedure Estimates, 2020.

Emergency department visits

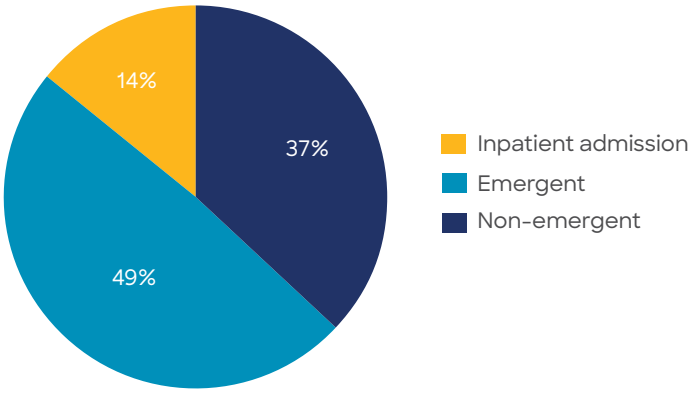
Emergency department estimates predict the total annual volume of emergency department (ED) visits by ZIP code and level of acuity for every market in the United States. IBM uses an extensive supply of proprietary claims, public claims and federal surveys to construct population-based use rates for all 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 Plano Health Community, ED visits are expected to grow by almost 15% by 2025.

Emergent status	2020 visits	2025 visits	2020 - 2025 visits change	2020 - 2025 visits % change
Emergent	1,012,251	1,224,998	212,747	21.0%
Inpatient Admission	292,564	365,479	72,916	24.9%
Non-Emergent	888,255	927,020	38,765	4.4%
TOTAL	**2,193,070**	**2,517,497**	**324,427**	**14.8%**

Source: IBM Watson Health Emergency Department Visits, 2020.

Emergency department visit estimates 2025



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 Plano Health Community, the most common heart disease is hypertension at 73.1% of all heart disease cases.

Disease type	2020 prevalence	2020 % prevalence
Arrhythmia	210,814	12.3%
Heart Failure	92,253	5.4%
Hypertension	1,255,053	73.1%
Ischemic Heart Disease	157,689	9.2%
TOTAL	**1,715,808**	**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 12.4% in the Plano Health Community by 2025.

Cancer type	2020 incidence	2025 incidence	2020 - 2025 change	2020 - 2025 % change
Bladder	943	1,126	184	19.5%
Brain	431	480	49	11.3%
Breast	4,929	5,695	766	15.5%
Colorectal	2,771	2,702	-69	-2.5%
Kidney	1,019	1,220	202	19.8%
Leukemia	761	888	127	16.7%
Lung	2,540	2,892	351	13.8%
Melanoma	1,088	1,286	197	18.1%
Non-Hodgkin's Lymphoma	1,192	1,395	203	17.1%
Oral Cavity	741	869	128	17.3%
Other	3,047	3,593	546	17.9%
Ovarian	399	443	44	11.1%
Pancreatic	649	793	144	22.2%
Prostate	3,084	3,101	17	0.5%
Stomach	427	483	55	13.0%
Thyroid	717	829	112	15.6%
Uterine Cervical	181	185	4	2.4%
Uterine Corpus	636	751	115	18.1%
TOTAL	**25,554**	**28,729**	**3,175**	**12.4%**

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

Facilities: Baylor Scott & White Medical Center – Plano, Baylor Scott & White The Heart Hospital - Plano

Community served: Collin, Dallas, Denton, Hunt, Kaufman, Rockwall and Tarrant Counties

Food insecurity and children eligible for free lunch

Baylor Scott & White Medical Center – Plano

Baylor Scott & White The Heart Hospital - Plano

Action/tactics	Anticipated outcome	Evaluation of impact
Enrollment services The hospital provides staff to help enroll patients in public programs, such as CHIP and Medicaid, to increase access and quality of care, especially for persons living in poverty and vulnerable situations.	Overcome access issues and reduce hospital expenses.	**BSWMC – Plano** • Persons served: 238 • $46,893 community benefit **BSWTHH – Plano** • Persons served: 57 • $39,468 community benefit
Charity care Provide free/discounted care to financially or medically indigent patients as outlined in the financial assistance policy. Healthcare infrastructure/supplies/staff.	Increased access to primary care and/or specialty care for indigent persons regardless of their ability to pay.	**BSWMC – Plano** • $12,433,477 community benefit **BSWTHH – Plano** • $23,368,866 community benefit

Drug poisoning death rate and accidental poisoning deaths where opioids were involved

Baylor Scott & White Medical Center – Plano

Baylor Scott & White The Heart Hospital – Plano

Action/tactics	Anticipated outcome	Evaluation of impact
Medical education The hospital is committed to the education of future nurses at entry and advanced levels to establish a workforce of qualified nurses, including knowledge about proper use of opioids and signs of abuse.	Increased quality and size of the nursing workforce.	**BSWMC – Plano** • Persons served: 180 • $469,849 community benefit **BSWTHH – Plano** • Persons served: 1,316 • $160,555 community benefit

Baylor Scott & White The Heart Hospital – Plano

Action/tactics	Anticipated outcome	Evaluation of impact
Pharmaceutical support Pharmaceutical support through the provision of free/discounted medications for patients who are unfunded and have no other means to acquire them.	Improved health outcomes with proper medication that follows designated safety protocol.	• $36,456 community benefit

Addressing all needs

Baylor Scott & White Medical Center – Plano
Baylor Scott & White The Heart Hospital – Plano

Action/tactics	Anticipated outcome	Evaluation of impact
Financial and in-kind donations Financial and in-kind donations to community organizations aimed at improving community health and addressing identified needs. Hospitals donate retired medical supplies and equipment to the office of Faith in Action Initiatives Second Life program for the purpose of providing for the healthcare needs of populations in the community and nation whose needs cannot be met through their own organization.	Improved access to community resources. Better network of safety net support services. Patients can get assistance with SDOH as well as improved access to health services. Lacking consistent access to food is associated with negative health outcomes, such as weight gain, increased risk of heart disease, diabetes, and other comorbidities and premature mortality.	**BSWMC – Plano** • Persons served: 45,033 • $233,955 community benefit **BSWTHH – Plano** • Persons served: 22,696 • $412,885 community benefit
Community education/outreach Events and activities provided by BSWH in the community or on-site to provide education and information on wellness and health improvement often done in collaboration with community partners. Includes health screenings and heart health series.	To encourage lifelong healthy eating and physical activity habits. To build nutrition knowledge and skills to positively influence states of wellness, recovery from illness, disease prevention and chronic disease management.	**BSWMC – Plano** • Persons served: 4,422 • $23,013 community benefit **BSWTHH – Plano** • Persons served: 511 • $16,376 community benefit

Total investment in adopted community needs since 2019 CHNA

BSWMC – Plano
$13.2 million

BSW The Heart Hospital – Plano
$24 million