



COMMUNITY HEALTH NEEDS ASSESSMENT



COLLIN COUNTY HEALTH COMMUNITY

METHODIST MCKINNEY HOSPITAL

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TABLE OF CONTENTS

METHODIST HEALTH SYSTEM	3
COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) REPORT	5
DEMOGRAPHIC AND SOCIOECONOMIC SUMMARY	7
HEALTH COMMUNITY DATA SUMMARY	7
PRIORITY HEALTH NEEDS	8
PRIORITY 1: ACCESS TO NON-PHYSICIAN PRIMARY CARE PROVIDERS	9
PRIORITY 2: DIABETES MANAGEMENT	10
PRIORITY 3: CARDIOLOGY ISSUES AMONG MEDICARE POPULATION	12
PRIORITY 4: ESCALATING HEALTH NEEDS OF AGING COMMUNITY	14
PRIORITY 5: SENIOR DEPRESSION	16
APPENDIX A: CHNA REQUIREMENT DETAILS	18
APPENDIX B: KEY PUBLIC HEALTH INDICATORS	24
APPENDIX C: COMMUNITY INPUT PARTICIPATING ORGANIZATIONS	33
APPENDIX D: DEMOGRAPHIC AND SOCIOECONOMIC SUMMARY	34
APPENDIX E: PROPRIETARY COMMUNITY DATA	42
APPENDIX F: 2019 METHODIST CHNA EVALUATION	46
APPENDIX G: COMMUNITY RESOURCES IDENTIFIED TO POTENTIALLY ADDRESS SIGNIFICANT HEALTH NEEDS	47

METHODIST HEALTH SYSTEM

COMPASSIONATE HEALTHCARE IN NORTH TEXAS

The Methodist ministers and civic leaders who opened their doors in 1927 could not have imagined where Methodist Health System would be today. From humble beginnings, their renowned health system has become one of the leading healthcare providers in North Texas, with several locations across the region.

But all of their growth, advancements, accreditation, awards, and accomplishments have been earned under the guidance of their founding principles: life, learning, and compassion. They are still growing, learning, and improving — grounded in a proud past and looking ahead to an even brighter future.

MISSION, VISION, AND VALUES OF METHODIST HEALTH SYSTEM

MISSION

To improve and save lives through compassionate quality healthcare.

VISION

To be the trusted choice for health and wellness.

CORE VALUES

Methodist Health System core values reflect our historic commitment to Christian concepts of life and learning:

- **Servant Heart** – compassionately putting others first
- **Hospitality** – offering a welcoming and caring environment
- **Innovation** – courageous creativity and commitment to quality
- **Noble** – unwavering honesty and integrity
- **Enthusiasm** – celebration of individual and team accomplishment
- **Skillful** – dedicated to learning and excellence

Where compassion is our compass. Where hearts and minds operate as one. Where a glass half empty is filled with hope. Where healing is believing.

Whatever the medical need, Methodist Health System is honored that patients entrust them with their health and safety. They understand that Methodist has a solemn responsibility to each patient and patient families, and they can trust that the Methodist team takes that commitment very seriously.

Methodist Health System further illustrates this commitment through periodic community health needs assessments which include plans on addressing those needs with a wide range of outreach initiatives. These Community Health Needs Assessment (CHNA) activities also satisfy federal requirements outlined in the Patient Protection and Affordable Care Act.

Methodist Health conducts periodic reviews of public health indicators and benchmark analyses 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, Methodist gains a clearer understanding of the 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**.

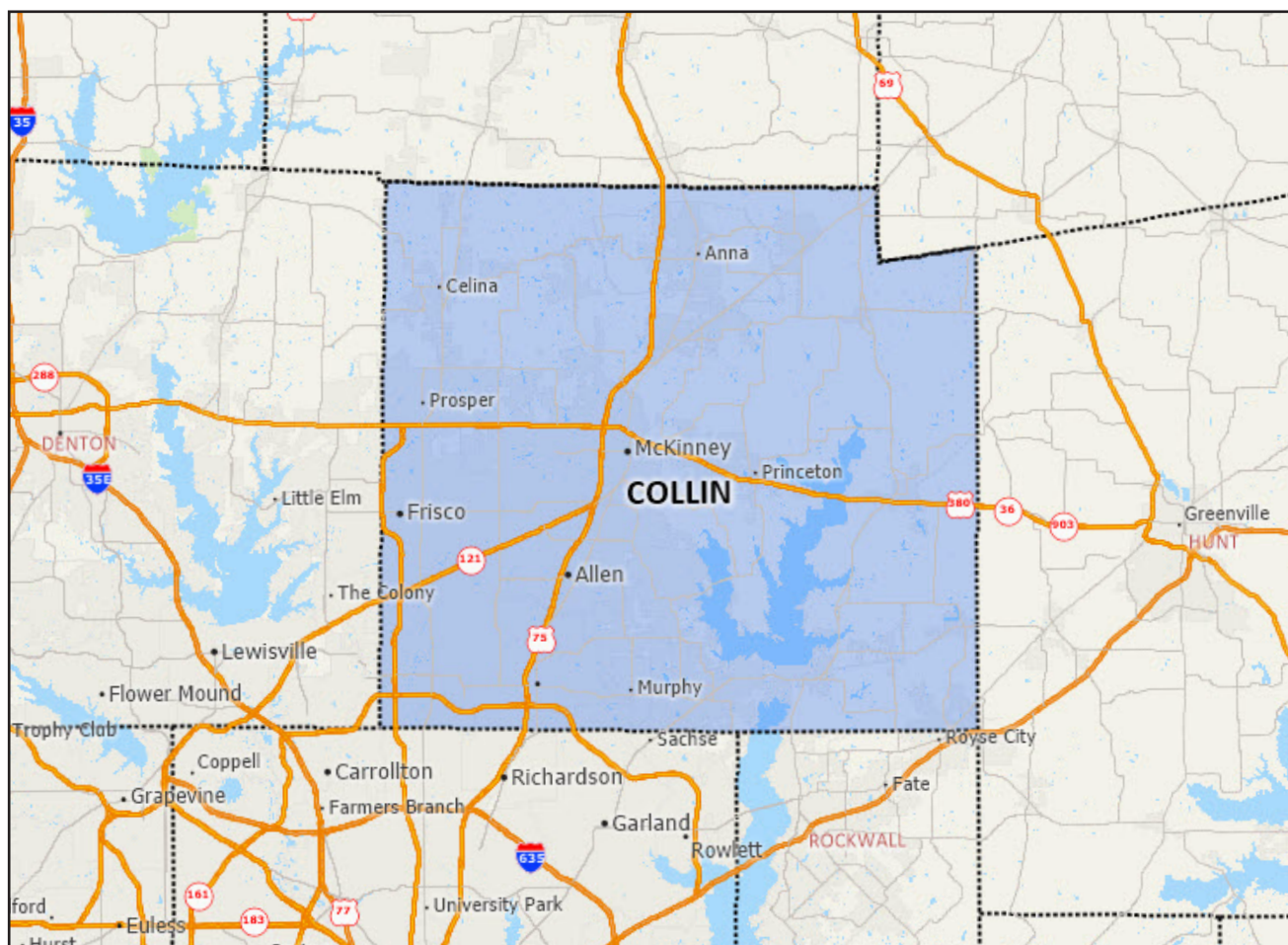
The CHNA serves as the foundation for community health improvement planning efforts over the next three years, while the implementation plans will be evaluated annually.

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) REPORT

Methodist owns and operates multiple individually licensed hospital facilities serving the residents of North Texas. This assessment applies to the following Methodist hospital facility:

- **Methodist McKinney Hospital**

The community served is Collin County. The community includes the geographic area where more than 60 percent of the admitted patients live according to the hospital facilities' in-patient admissions over the 12-month period of 2019Q2-2020Q1. Those facilities with overlapping counties of patient origin collaborated to provide a joint CHNA report in accordance with the U.S. Treasury regulations and 501(r)(3) of the Internal Revenue Code. 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.



Collin County Health Community Map

Methodist engaged with IBM Watson Health, a nationally-respected consulting firm, to conduct a Community Health Needs Assessment (CHNA) in accordance with the requirements of the Patient Protection and Affordable Care Act (PPACA) for the health communities they serve.

THE CHNA PROCESS INCLUDED:



- 1 Gathering and analyzing 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**.
- 2 Creating a benchmark analysis comparing the communities to overall state of Texas and United States (U.S.) values.
- 3 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 each of the communities.

Demographic and Socioeconomic Summary

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

- 1 The community is growing at a faster rate than the State of Texas and both are outpacing the rate of growth of the U.S.
- 2 The median age of the population is slightly younger than the U.S. but older than Texas overall.
- 3 The median household income is significantly higher than both the State and the U.S.
- 4 The community served has a lower percentage of uninsured and underinsured than Texas.

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

Health Community Data Summary

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

- 1 Inpatient discharges in the community are expected to grow by 17.3% by 2030 with the largest growing product lines to include:
 - Pulmonary Medical
 - General Medicine
 - Cardiovascular Diseases
- 2 Outpatient procedures are expected to increase by 38% by 2030 with the largest areas of growth including:
 - Labs
 - General & Internal Medicine
 - Physical & Occupational Therapy
- 3 Emergency Department visits are expected to grow by 20.7% by 2025.
- 4 Hypertension represents 73% of all heart disease cases.
- 5 Cancer incidence is expected to increase by 15.5% by 2025.

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

Priority Health Needs

Using these and other data collection and interpretation methods, Methodist identified what it considers to be the community's key health needs. The resulting prioritized health needs for this community include:

<i>Priority</i>	<i>Need</i>	<i>Category of Need</i>
1	Access to Non-Physician Primary Care Providers	Access to Care
2	Diabetes Management	Conditions/Diseases
3	Cardiology Issues Among Medicare Population	Conditions/Diseases
4	Escalating Health Needs of Aging Community	Utilization
5	Senior Depression	Mental Health

PRIORITY 1: ACCESS TO NON-PHYSICIAN PRIMARY CARE PROVIDERS

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

Category	Data Shows Greater Need	Key Informants Indicate Greater Need
Access to Care	<ul style="list-style-type: none"> Population to one non-physician primary care provider 	<ul style="list-style-type: none"> Limited access to healthcare services

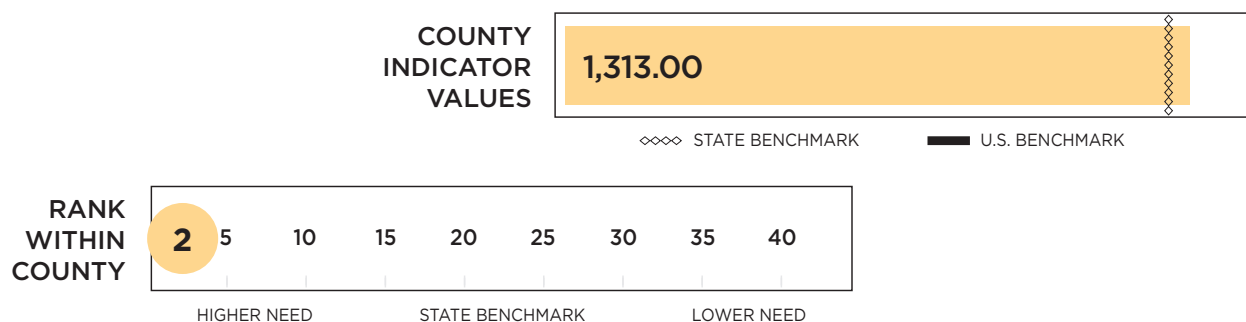
Access to Care: Population to One Non-Physician Primary Care Resource

(Number of Individuals Served by One Non-Physician Primary Care Resource by County)

The indicator for population to one non-physician primary care provider 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).

Collin County has 1,313 individuals per every one non-physician primary care resource which is 16.4% higher than the state benchmark of 1,128. This indicates a greater need than the state and a larger vulnerable population.

This indicator ranked second (2nd) among all 59 public indicators within Collin County which indicates higher need and a larger vulnerable population.



The focus group participants cited that even though hospitals are plentiful, there is a high demand for primary care providers leading to difficulty accessing primary care. Access is especially limited for the uninsured, underinsured and those living in rural areas.

In the prioritization session, the hospital and community leaders agreed that there is a need to support the expansion of primary care groups, including mid-level providers in Collin County.

PRIORITY 2: DIABETES MANAGEMENT

The following data indicates greater need for diabetes management in terms of diabetes admission, diabetes diagnoses in adults and diabetes prevalence.

Category	Data Shows Greater Need	Key Informants Indicate Greater Need
<i>Conditions/ Diseases</i>	<ul style="list-style-type: none">• <i>Diabetes Admission</i>	<ul style="list-style-type: none">• <i>Chronic illnesses not managed well</i>

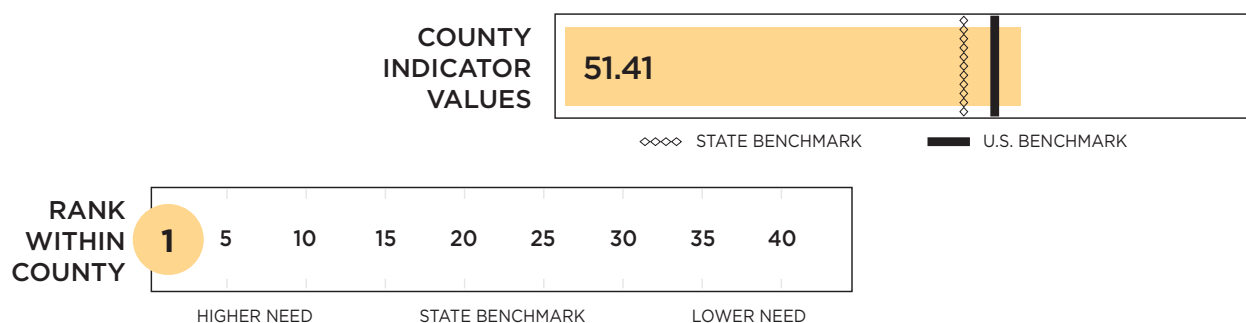
Conditions/Diseases: Diabetes Admission

(Number Diabetes Patients Observed/ Adult Population Age 18+ by County)

The indicator of diabetes admission is defined as the number of diabetes admissions observed divided by the adult population (age 18 and older) and is based on data from Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations.

Collin County has 51.41 diabetes patients per 100,000 adult individuals which is 30.2% higher than the state benchmark of 39.50. This indicates a greater need than the state and a larger vulnerable population.

This indicator ranked as the top indicator (1st) among all 59 public indicators within Collin County which indicates the highest need and a larger vulnerable population.



The focus group participants cited that in the health community, chronic illnesses are not managed well and patients don't access necessary care regularly. In addition, the community anticipates growth and increased severity of chronic conditions, such as diabetes, in the future due to patients being underserved during COVID.

In the prioritization session, the hospital and community leaders agreed that there are insufficient diabetes resources and education efforts. They added that there is an opportunity for the community to increase diabetes education and awareness.

PRIORITY 3: CARDIOLOGY ISSUES AMONG MEDICARE POPULATION

The following data indicates greater need for management of cardiology issues among the Medicare population in terms of atrial fibrillation, hyperlipidemia and hypertension.

Category	Data Shows Greater Need	Key Informants Indicate Less Need or Not Mentioned
Conditions/ Diseases	<ul style="list-style-type: none"> Medicare population: Atrial fibrillation Medicare population: Hyperlipidemia Medicare population: Hypertension 	<ul style="list-style-type: none"> Not specifically mentioned

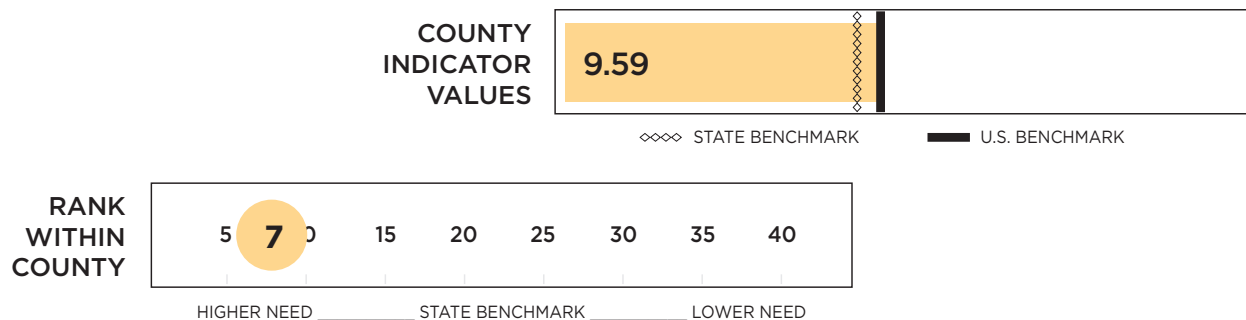
Conditions/Diseases: Medicare Population: Atrial Fibrillation

(Prevalence of Atrial Fibrillation Over All Medicare Beneficiaries by County)

The indicator Medicare population: atrial fibrillation is defined as the prevalence of atrial fibrillation across all Medicare beneficiaries and is based on data from CMS.gov Chronic conditions.

Collin County has a 9.59% prevalence rate among total Medicare beneficiaries which is 10.2% higher than the state benchmark of 8.70%. This indicates a greater need than the state and a larger vulnerable population.

This indicator ranked seventh (7th) among all 59 public indicators within Collin County which indicates higher need and a larger vulnerable population.



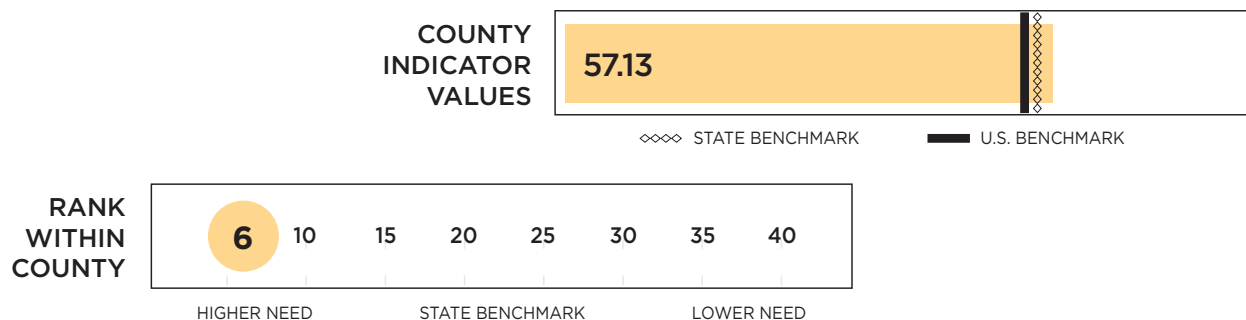
Conditions/Diseases: Medicare Population: Hyperlipidemia

(Prevalence of Hyperlipidemia Over All Medicare Beneficiaries by County)

The indicator Medicare population: hyperlipidemia is defined as the prevalence of hyperlipidemia across all Medicare beneficiaries and is based on data from CMS.gov Chronic conditions.

Collin County has a 57.13% prevalence rate among total Medicare beneficiaries which is 10.3% higher than the state benchmark of 51.80%. This indicates a greater need than the state and a larger vulnerable population.

This indicator ranked sixth (6th) among all 59 public indicators within Collin County which indicates higher need and a larger vulnerable population.



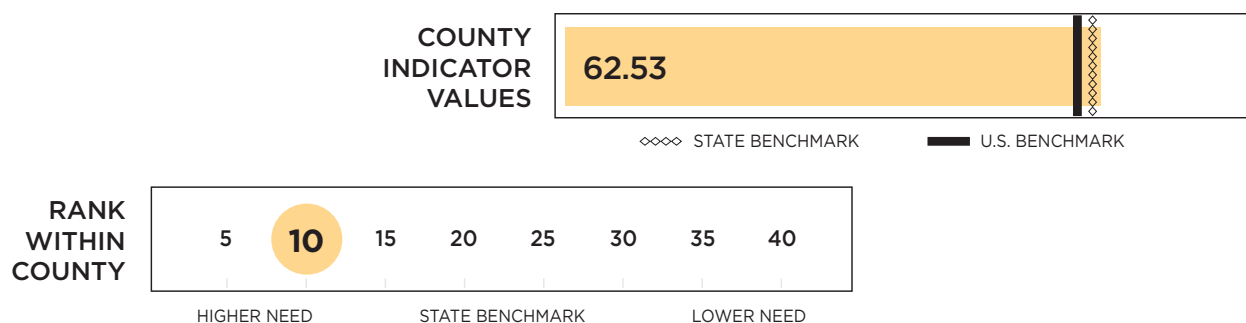
Conditions/Diseases: Medicare Population: Hypertension

(Prevalence of Hypertension Over All Medicare Beneficiaries by County)

The indicator Medicare population: hypertension is defined as the prevalence of hypertension across all Medicare beneficiaries and is based on data from CMS.gov Chronic conditions.

Collin County has a 62.53% prevalence rate among total Medicare beneficiaries which is 1% higher than the state benchmark of 61.91%. This indicates a greater need than the state and a larger vulnerable population.

This indicator ranked tenth (10th) among all 59 public indicators within Collin County which indicates higher need and a larger vulnerable population.



The focus group participants did not discuss the conditions of atrial fibrillation, hyperlipidemia and hypertension specifically.

In the prioritization session, the hospital and community leaders agreed that there is a need to manage cardiology issues among the Medicare population.

PRIORITY 4: ESCALATING HEALTH NEEDS OF AGING COMMUNITY

The following data indicates greater need in the area of escalating health needs of the aging community and specifically the inpatient use rate and spending per beneficiary (MSPB) index among the Medicare population.

Category	Data Shows Greater Need	Key Informants Indicate Less Need or Not Mentioned
Utilization	<ul style="list-style-type: none"> • <i>Medicare population: Inpatient use rate</i> • <i>Medicare spending per beneficiary (MSPB) index</i> 	<ul style="list-style-type: none"> • <i>Aging community contributing to escalating health needs</i>

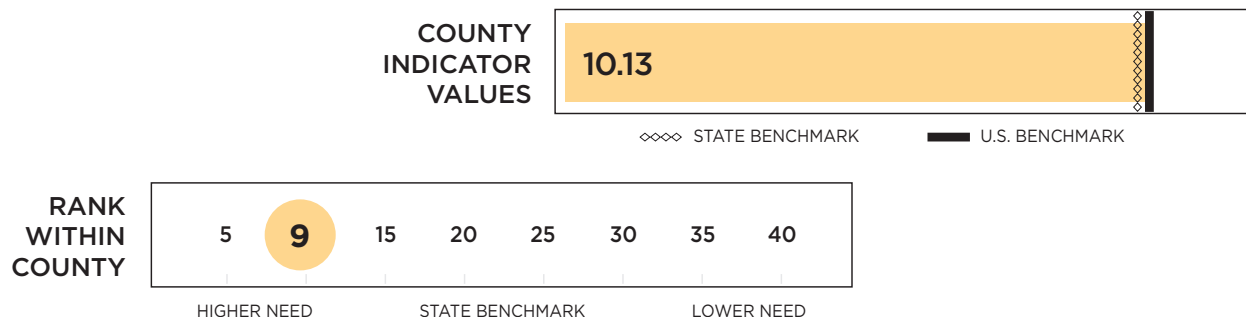
Utilization: Medicare Population: Inpatient Use Rate

(Number Patients Hospitalized/ Total Beneficiaries by County)

The indicator Medicare population: inpatient use rate is defined as unique patients being hospitalized divided by the total beneficiaries. This value is based on data from CMS Inpatient 100% Standard Analytical File (SAF) and CMS Standard Analytical Files (SAF) Denominator File.

Collin County has 10.13% hospitalized patients among the total Medicare beneficiaries which is 1.3% higher than the state benchmark of 10%. This indicates a greater need than the state and a larger vulnerable population.

This indicator ranked ninth (9th) among all 59 public indicators within Collin County which indicates higher need and a larger vulnerable population.



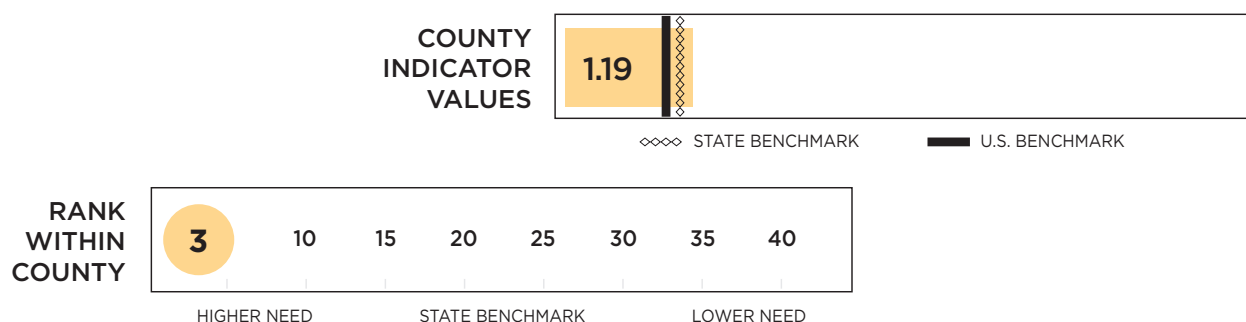
Utilization: Medicare Spending Per Beneficiary (MSPB) Index

(Average Episode Spending per Medicare Beneficiary by County)

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. This value is based on data from CMS Medicare Spending Per Beneficiary (MSPB), Hospital Value-Based Purchasing (VBP) Program.

Collin County has a ratio of 1.19 for Medicare spending per beneficiary which is 14.4% higher than the state benchmark of 1.04. This indicates a greater need than the state and a larger vulnerable population.

This indicator ranked third (3rd) among all 59 public indicators within Collin County which indicates higher need and a larger vulnerable population.



The key informants acknowledged that the aging community is contributing to escalating health needs of the community. They also noted that chronic illnesses are not managed well and thereby increasing cases of inpatient admissions and increased spending that may be avoided.

In the prioritization session, hospital leadership agreed that the health needs of the aging population are escalating and need to be addressed.

PRIORITY 5: SENIOR DEPRESSION

The following data indicates greater need in terms of depression among the Medicare population.

Category	Data Shows Greater Need	Key Informants Indicate Less Need or Not Mentioned
Mental Health	<ul style="list-style-type: none">• Medicare population: Depression	<ul style="list-style-type: none">• Seniors isolated during COVID, suffering grief

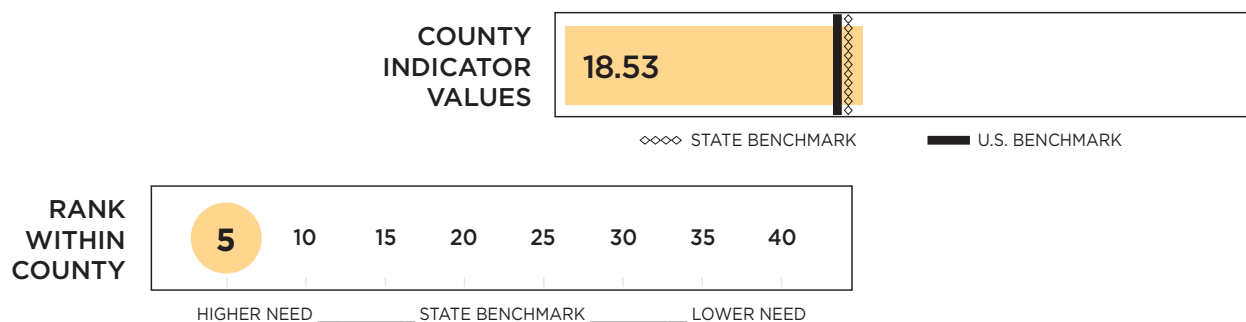
Mental Health Conditions/Diseases: Medicare Population: Depression

(% of Medicare Patients with Depression Divided by All Medicare Population by County)

The Medicare Population: Depression measure is defined as the prevalence of depression across all Medicare beneficiaries. The indicator is based on data from CMS.gov Chronic conditions.

Collin County has 18.53% depression among the Medicare population which is 12.8% higher than the state benchmark of 16.43%. This indicates a greater need than the state and a larger vulnerable population.

This indicator ranked as the fifth top indicator (5th) among all 59 public indicators within Collin County which indicates higher need and a larger vulnerable population.



The key informants commented that COVID brought on increased elderly isolation and the need to alleviate social isolation was identified.

In the prioritization session, hospital leadership noted that they did not observe this issue around seniors as much as the younger population but still agreed that addressing health issues may improve depression. They also noted that keeping seniors active in their favorite activities would be beneficial.

The prioritized list of significant health needs approved by the hospital's governing body and the full assessment can be found at <https://www.methodismckinneyhospital.com>

Existing Resources to Address Health Needs

One part of the assessment process included gathering input on potentially available community resources. A statewide Community Resource Guide and suggestions from some of our assessment participants helped identify community resources that may help address this community's known health needs.

The available community's resources can be referenced in **Appendix G**.

Next Steps

Methodist McKinney started the Community Health Needs Assessment process in March 2021. Using both qualitative community feedback as well as publicly available and proprietary health indicators, Methodist McKinney was able to identify and prioritize community health needs for their facility. 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 Methodist McKinney chooses to address for the community served.

APPENDIX A: CHNA REQUIREMENT DETAILS

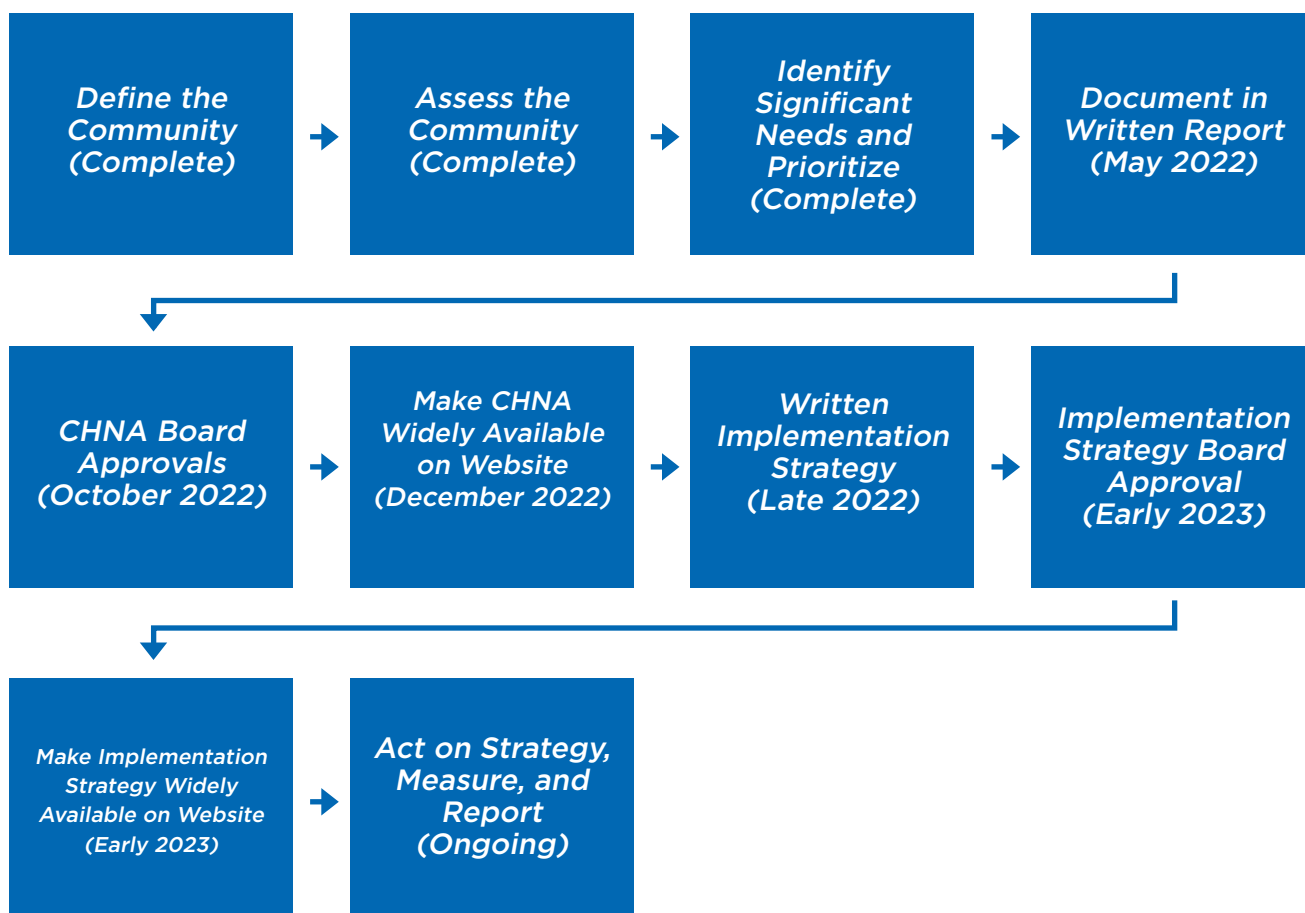
The Patient Protection and Affordable Care Act (PPACA) requires all tax-exempt organizations operating hospital facilities to assess the health needs of their community every three (3) years. The resulting Community Health Needs Assessment (CHNA) report must include descriptions of the following:

- 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

Methodist Health System began the 2022 CHNA process in March 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

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.

Data Gathering: Quantitative Assessment of Health Needs – Methodology and Data Sources

The team used quantitative data collection and analysis obtained 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, regulations 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 is in **Appendix B**.

A benchmark analysis of each indicator determined which public health indicators demonstrated a community health need. Benchmark health indicators included overall U.S. 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 preventative services).

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

- **Benchmarks were set for each health community using State value for comparison.**
- **Community indicators not meeting State benchmarks were identified.**
- **From this, a need differential analysis of the indicators was completed, which helped bring additional understanding of the community's relative severity of need.**
- **Using the need differentials, a standardized way to evaluate the degree each indicator differed from its benchmark was established.**

- **This quantitative analysis showed which health community indicators were below the 25th percentile in order of severity – and therefore, 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 Methodist McKinney 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 that 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.

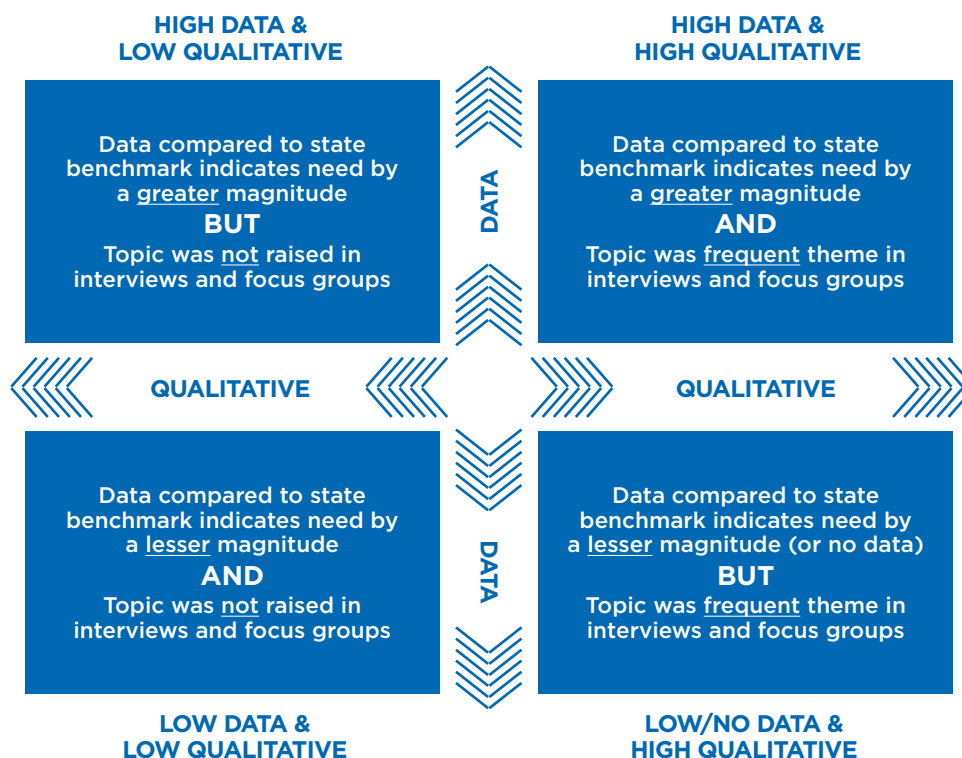
The hospitals also considered written input received on their most recently conducted CHNA and subsequent implementation strategies. Input that has been received to date was reviewed and considered. The assessment is available for public comment or feedback on the report findings by emailing CHNAfeedback@mhd.com.

The CHNA assessment is available on the Methodist McKinney website at:

<https://www.methodistmckinneyhospital.com>

Approach to Prioritizing Significant Health Needs

On January 13, 2022, a session with key leaders from Methodist McKinney Hospital along with community leaders was convened 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 input from focus groups, interviews and survey participants.



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.



1. High Data & 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 also identified as a greater need by the key informants.



2. High Data & Low Qualitative: The community indicators that 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.



3. Low/No Data & High Qualitative: The community indicators that 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.

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:

- 1** Severity: What degree of disability or premature death occurs because of the problem? What are the potential burdens to the community, such as economic or social burdens?
- 2** Social Justice: Is the problem more concentrated to a specific vulnerable population? Does addressing this issue lead to unfair social benefit? Are we equitable to all vulnerable populations in our approach?
- 3** Root Cause: Is the issue a root cause of other problems - thereby possibly affecting multiple issues?

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. 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.

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 U.S. and the State of Texas.

The indicators used and the sources are listed below:

Indicator Name	Indicator Source	Indicator Definition
<i>Adult Obesity</i>	<i>2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System</i>	<i>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</i>
<i>Adults Reporting Fair or Poor Health</i>	<i>2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)</i>	<i>2018 Percentage of Adults Reporting Fair or Poor Health (Age-Adjusted)</i>
<i>Binge Drinking</i>	<i>2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)</i>	<i>2018 Percentage of a County's Adult Population that Reports Binge or Heavy Drinking in the Past 30 Days</i>
<i>Cancer Incidence: All Causes</i>	<i>State Cancer Profiles, National Cancer Institute (CDC)</i>	<i>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 U.S. Standard Population)</i>
<i>Cancer Incidence: Colon</i>	<i>State Cancer Profiles, National Cancer Institute (CDC)</i>	<i>2013-2017 Age-Adjusted Colon & Rectum Cancer Incidence Rate Cases per 100,000 (All Races, includes Hispanic; Both Sexes; All Ages. Age Adjusted to the 2000 U.S. 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 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).</i>

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 U.S. 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 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).
Cancer Incidence: Lung	State Cancer Profiles, National Cancer Institute (CDC)	2013-2017 Age-Adjusted Lung & Bronchus Cancer Incidence Rate Cases per 100,000 (All Races, includes Hispanic; Both Sexes; All Ages. Age Adjusted to the 2000 U.S. 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 U.S. 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), 5 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 5 admissions.

<i>Diabetes Diagnoses in Adults</i>	<i>CMS.gov Chronic conditions 2007-2018</i>	<i>Prevalence of chronic condition across all Medicare beneficiaries</i>
<i>Diabetes Prevalence</i>	<i>County Health Rankings (CDC Diabetes Interactive Atlas)</i>	<i>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.</i>
<i>Drug Poisoning Deaths</i>	<i>2021 County Health Rankings & Roadmaps, CDC WONDER Mortality Data</i>	<i>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.</i>
<i>Elderly Isolation</i>	<i>2018 American Community Survey 5-Year Estimates, U.S. Census Bureau - American FactFinder</i>	<i>Percent of Non-family households - Householder living alone - 65 years and over</i>
<i>English Spoken "Less than Very Well" in Household</i>	<i>2015-2019 American Community Survey 5-Year Estimates, U.S. Census Bureau - American FactFinder</i>	<i>2019 Percentage of households that 'speak English less than "very well"' within all households that 'speak a language other than English'</i>
<i>Food Environment Index</i>	<i>2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA)</i>	<i>2015 & 2018 Index of Factors that Contribute to a Healthy Food Environment, 0 (Worst) to 10 (Best)</i>
<i>Food Insecure</i>	<i>2021 County Health Rankings & Roadmaps; Map the Meal Gap, Feeding America</i>	<i>2018 Percentage of Population Who Lack Ade-quate Access to Food During the Past Year</i>
<i>Food: Limited Access to Healthy Foods</i>	<i>2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA)</i>	<i>2015 Percentage of Population Who are Low-Income and Do Not Live Close to a Grocery Store</i>

<i>High School Graduation</i>	<i>Texas Education Agency</i>	<i>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.</i>
<i>Household Income</i>	<i>2021 County Health Rankings (Small Area Income and Poverty Estimates)</i>	<i>2019 Median Household Income is the income where half of households in a county earn more and half of households earn less.</i>
<i>Income Inequality</i>	<i>2021 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)</i>	<i>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.</i>
<i>Individuals Below Poverty Level</i>	<i>2018 American Community Survey 5-Year Estimates, U.S. Census Bureau - American FactFinder</i>	<i>Individuals below poverty level</i>
<i>Low Birth Weight Rate</i>	<i>2019 Texas Certificate of Live Birth</i>	<i>Number Low Birthweight Newborns / Number of Newborns. Newborn's birthweight - low or very low birthweight includes birthweights 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.</i>
<i>Medicare Population: Alzheimer's Disease/Dementia</i>	<i>CMS.gov Chronic conditions 2007-2018</i>	<i>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 complimentary cell suppression.</i>

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 complimentary 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 complimentary cell suppression.
Medicare Population: Depression	CMS.gov Chronic conditions 2007-2018	Prevalence of chronic condition across all Medi-care 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
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 complimentary 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

<i>Medicare Population: Stroke</i>	<i>CMS.gov Chronic conditions 2007-2018</i>	<i>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 complimentary cell suppression.</i>
<i>Medicare Spending Per Beneficiary (MSPB) Index</i>	<i>CMS 2019 Medicare Spending Per Beneficiary (MSPB), Hospital Value-Based Purchasing (VBP) Program</i>	<i>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 indicates missing hospitals or missing score. associated to the hospitals</i>
<i>Mentally Unhealthy Days</i>	<i>2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)</i>	<i>2018 Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)</i>
<i>Mortality Rate: Cancer</i>	<i>Texas Health Data, Center for Health Statistics, Texas Department of State Health Services</i>	<i>2017 Cancer (All) Age Adjusted Death Rate (Per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population). Death rates are NULL when the rate is calculated with a numerator of 20 or less.</i>
<i>Mortality Rate: Heart Disease</i>	<i>Texas Health Data, Center for Health Statistics, Texas Department of State Health Services</i>	<i>2017 Heart Disease Age Adjusted Death Rate (Per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population). Death rates are NULL when the rate is calculated with a numerator of 20 or less.</i>
<i>Mortality Rate: Infant</i>	<i>2021 County Health Rankings & Roadmaps, CDC WONDER Mortality Data</i>	<i>2013-2019 Number of All Infant Deaths (Within 1 year), per 1,000 Live Births. Blank values reflect unreliable or missing data.</i>

<i>Mortality Rate: Stroke</i>	<i>Texas Health Data, Center for Health Statistics, Texas Department of State Health Services</i>	<i>2017 Cerebrovascular Disease (Stroke) Age Adjusted Death Rate (Per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population). Death rates are NULL when the rate is calculated with a numerator of 20 or less.</i>
<i>No Vehicle Available</i>	<i>U.S. Census Bureau, 2019 American Community Survey 1-Year Estimates</i>	<i>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 falls 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.</i>
<i>Opioid Involved Accidental Poisoning Death</i>	<i>U.S. Census Bureau, Population Division and 2019 Texas Health and Human Services Center for Health Statistics Opioid related deaths in Texas</i>	<i>Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2017. 2019 Accidental Poisoning Deaths where Opioids Were Involved are those deaths which 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.</i>
<i>Physical Inactivity</i>	<i>2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System</i>	<i>2017 Percentage of Adults Ages 20 and Over Reporting No Leisure-Time Physical Activity in the Past Month</i>
<i>Physically Unhealthy Days</i>	<i>2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)</i>	<i>2018 Average Number of Physically Unhealthy Days Reported in Past 30 Days (Age-Adjusted)</i>
<i>Population to One Dentist</i>	<i>2021 County Health Rankings & Roadmaps; Area Health Resource File/National Provider Identification file (CMS)</i>	<i>2019 Ratio of Population to Dentists</i>

<i>Population to one Mental Health Provider</i>	<i>2021 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPES)</i>	<i>2020 Ratio of Population to Mental Health Providers</i>
<i>Population to One Non-Physician Primary Care Provider</i>	<i>2020 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPES)</i>	<i>2020 Ratio of Population to Primary Care Providers Other than Physicians</i>
<i>Population to One Primary Care Physician</i>	<i>2021 County Health Rankings & Roadmaps; Area Health Resource File/American Medical Association</i>	<i>2018 Number of Individuals Served by One Physician in a County, if the Population was Equally Distributed Across Physicians</i>
<i>Population under Age 65 without Health Insurance</i>	<i>2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau</i>	<i>2018 Percentage of Population Under Age 65 Without Health Insurance</i>
<i>Prenatal Care: First Trimester Entry into Prenatal Care</i>	<i>2020 Texas Health and Human Services - Vital statistics annual report</i>	<i>2016 Percent of births with prenatal care onset in first trimester</i>
<i>Renter-Occupied Housing</i>	<i>U.S. Census Bureau, 2019 American Community Survey 1-Year Estimates</i>	<i>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 falls 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.</i>
<i>Severe Housing Problems</i>	<i>2021 County Health Rankings & Roadmaps; Comprehensive Housing Affordability Strategy (CHAS) data, U.S. Department of Housing and Urban Development (HUD)</i>	<i>2013-2017 Percentage of Households with at Least 1 of 4 Housing Problems: Overcrowding, High Housing Costs, or Lack of Kitchen or Plumbing Facilities</i>

<i>Sexually Transmitted Infection Incidence</i>	<i>2021 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)</i>	<i>2018 Number of Newly Diagnosed Chlamydia Cases per 100,000 Population</i>
<i>Smoking</i>	<i>2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)</i>	<i>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</i>
<i>Suicide: Intentional Self-Harm</i>	<i>Texas Health Data Center for Health Statistics</i>	<i>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.</i>
<i>Teen Birth Rate</i>	<i>2021 County Health Rankings & Roadmaps; National Center for Health Statistics - Natality files, National Vital Statistics System (NVSS)</i>	<i>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 7-Year Time Frame, and the Denominator is the Sum of the Annual Female Populations, Ages 15-19)</i>
<i>Teens (16-19) Not in School or Work - Disconnected Youth</i>	<i>2021 County Health Rankings (Measure of America)</i>	<i>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.</i>
<i>Unemployment</i>	<i>2021 County Health Rankings & Roadmaps; Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics</i>	<i>2019 Percentage of Population Ages 16 and Older Unemployed but Seeking Work</i>

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**
- **BSW McKinney**
- **BSW Plano**
- **CCRHP 18/PIA**
- **Church of Jesus Christ of LOS**
- **Collin County Coalition Charitable**
- **Collin County Health Care Services**
- **Collin County Health Dept**
- **Collin County Public Health**
- **Collin College Homeless Coalition**
- **Community Lifeline Center**
- **First United Methodist, Richardson**
- **Health Services of North Texas**
- **Julia's Center**
- **My Possibilities**
- **North Central Texas Health Care Center Comm.**
- **NTFB**
- **Plano Fire-Rescue**
- **Texas Health Resources**
- **United Way**
- **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 slightly younger than the U.S. but older than the state of Texas. Median income is significantly higher than both the state and the country. The community served has fewer Medicaid beneficiaries and uninsured individuals than Texas.

GEOGRAPHY		Benchmarks		Community Served
		United States	Texas	Tarrant County
Total Current Population		330,342,293	29,321,501	1,027,806
5 Yr Projected Population Change		3.3%	6.6%	9.0%
Median Age		38.6	35.2	38.1
Population 0-17		22.4%	25.7%	25.3%
Population 65+		16.6%	13.2%	11.8%
Women Age 15-44		19.5%	20.5%	20.3%
Hispanic Population		19.0%	40.7%	15.7%
INSURANCE COVERAGE	Uninsured	9.9%	18.8%	7.9%
	Medicaid	20.9%	13.0%	5.4%
	Private Market	8.3%	8.4%	8.7%
	Medicare	13.8%	12.7%	9.9%
	Employer	47.2%	47.1%	68.1%
Median HH Income		\$65,618	\$63,313	\$106,012
No High School Diploma		12.2%	16.7%	6.4%

The community served expects to grow 9% by 2025, an increase of 92,834 people. The projected population growth is higher than the state's 5-year projected growth rate (6.6%) and higher compared to 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 Frisco – 7,244 additional people**
- **75098 Wylie – 7,020 additional people**

The community's population is younger with 51.1% of the population ages 18-54 and 25.3% under age 18. The age 65 plus cohort is expected to experience the fastest growth (29.8%) 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 is 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 20,810 people (12.9%) by 2025. The non-Hispanic white population is expected to have the slowest growth at 0.7%.

POPULATION GROWTH

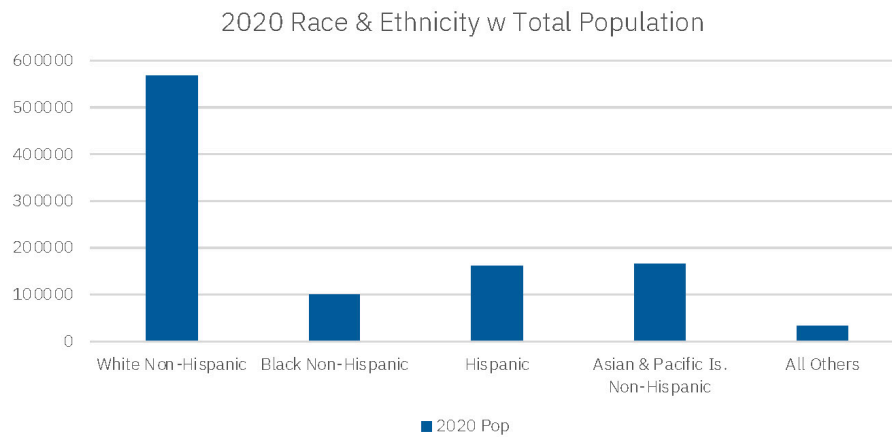
	<i>National</i>	<i>Selected Area</i>
2010 Total Population	308,745,538	757,869
2020 Total Population	330,342,293	1,027,806
2025 Total Population	341,132,738	1,120,640
2030 Total Population	353,513,931	1,240,814
% Change 2020 - 2025	3.27%	9.03%
% Change 2020 - 2030	7.01%	20.72%

POPULATION GENDER DISTRIBUTION

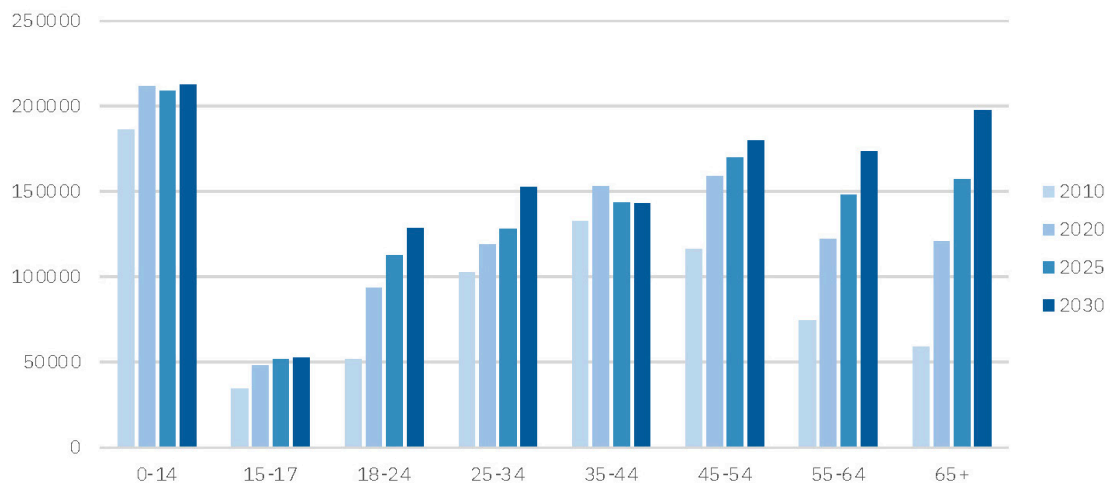
<i>POPULATION GENDER DISTRIBUTION</i>	<i>Males All Ages</i>	<i>Females All Ages</i>	<i>Females Child Bearing</i>
2010 Pop	372,178	385,691	164,098
2020 Pop	505,102	522,704	208,725
2025 Pop	550,148	570,492	218,153
2030 Pop	608,514	632,300	237,313
10Y Percent Change	20.47%	20.97%	13.70%
National	7.02%	7.01%	4.01%

Source: IBM Watson Health / Claritas, 2020

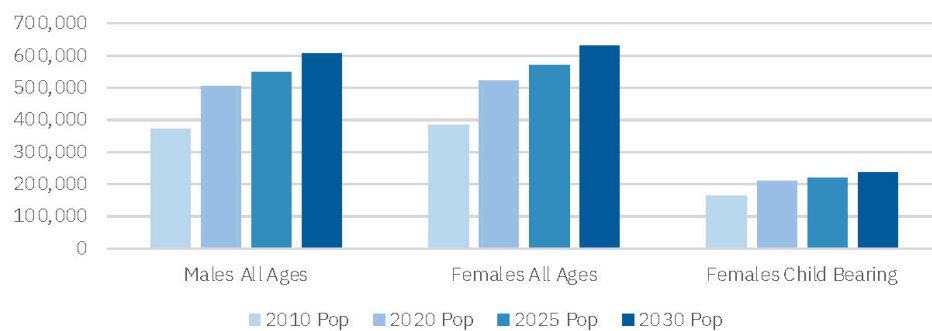
2020 Race & Ethnicity w Total Population



Population by Age Group 2010 - 2030



Population by Sex 2010 - 2030



Source: IBM Watson Health / Claritas, 2020

POPULATION DISTRIBUTION

Age Group	Age Distribution				
	2020	% of Total	2025	% of Total	USA 2020 % of Total
0-14	211,607	20.6%	209,319	18.7%	18.5%
15-17	47,989	4.7%	51,605	4.6%	3.9%
18-24	93,563	9.1%	112,598	10.0%	9.5%
25-34	118,849	11.6%	128,063	11.4%	13.5%
35-54	312,614	30.4%	313,771	28.0%	25.2%
55-64	122,173	11.9%	148,258	13.2%	12.9%
65+	121,011	11.8%	157,026	14.0%	16.6%
TOTAL	1,027,806	100%	1,120,640	100%	100%

Source: IBM Watson Health / Claritas, 2020.

HOUSEHOLD INCOME DISTRIBUTION

2020 Household Income	Income Distribution		
	HH Count	% of Total	USA % of Total
<\$15K	16,203	4.5%	10.0%
\$15-25K	14,295	3.9%	8.6%
\$25-50K	46,569	12.8%	20.7%
\$50-75K	49,396	13.6%	16.7%
\$75-100K	47,049	13.0%	12.4%
Over \$100K	189,534	52.2%	31.5%
TOTAL	1,027,806	100%	100%

Source: IBM Watson Health / Claritas, 2020.

EDUCATION LEVEL

2020 Adult Education Level	Education Level Distribution		
	Pop Age 25+	% of Total	USA % of Total
Less than High School	21,192	3.1%	5.2%
Some High School	22,101	3.3%	7.0%
High School Degree	100,295	14.9%	27.2%
Some College/Assoc. Degree	182,391	27.0%	28.9%
Bachelor's Degree or Greater	348,668	51.7%	31.6%
TOTAL	674,647	100%	100%

Source: IBM Watson Health / Claritas, 2020.

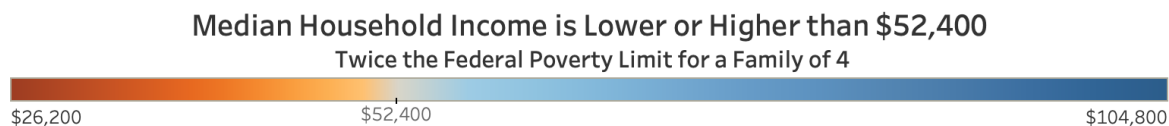
RACE/ETHNICITY

Race/Ethnicity	Race/Ethnicity Distribution		
	2020 Pop	% of Total	USA % of Total
White Non-Hispanic	567,657	55.2%	59.3%
Black Non-Hispanic	99,928	9.7%	12.4%
Hispanic	161,446	15.7%	19.0%
Asian & Pacific Is. Non-Hispanic	165,745	16.1%	6.0%
All Others	33,030	3.2%	3.3%
TOTAL	1,027,806	100%	100%

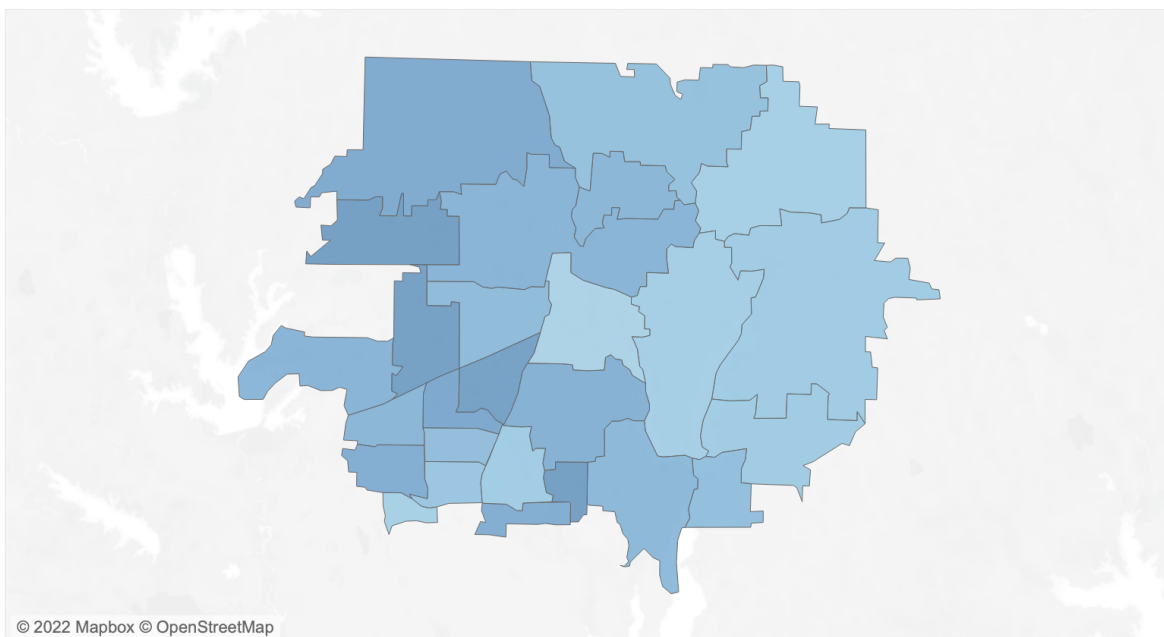
Source: IBM Watson Health / Claritas, 2020.

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 \$139,554 for 75078 (Prosper) to \$63,819 for 75069 (McKinney). There are no ZIP Codes with median household incomes less than \$52,400 – twice the 2020 Federal Poverty Limit for a family of four.

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.

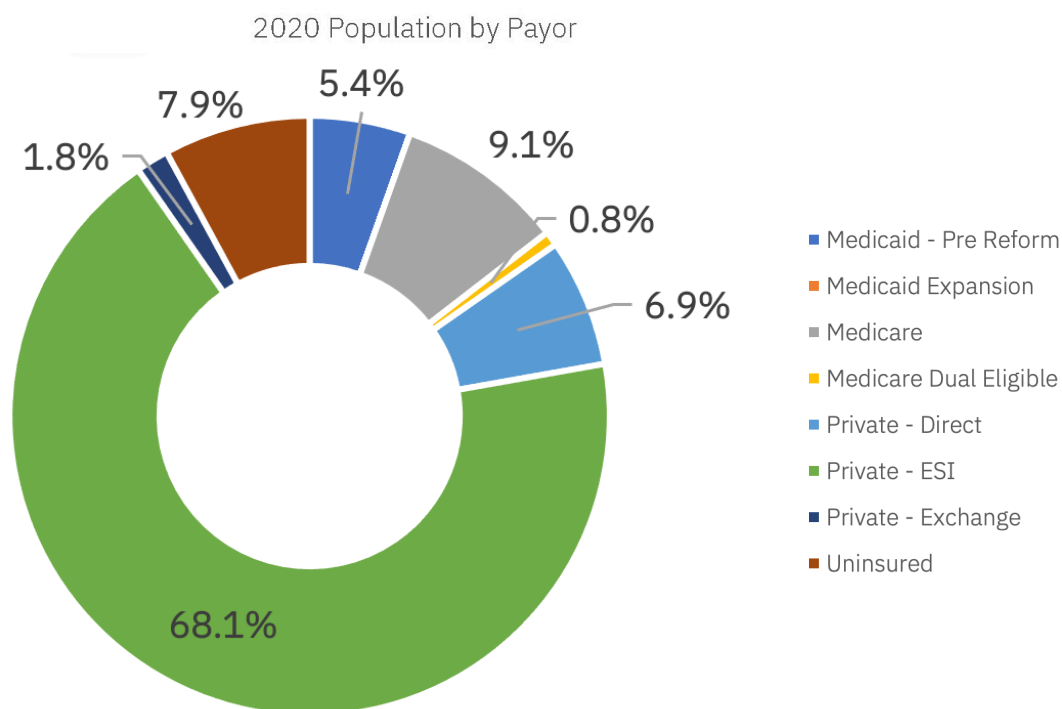


(a) Methodist McKinney Median Household Income



Insurance Coverage Estimates

A majority of the population (68%) were 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).



Source: IBM Watson Health Insurance Coverage Estimates, 2020.

Health Professional Shortages

The community includes one (1) Health Professional Shortage Area and no (0) Medically Underserved Areas as designated by the U.S. Department of Health and Human Services Health Resources Services Administration.

	HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA)				MEDICALLY UNDERSERVED AREA/ POPULATION (MUA/P)
County	Dental Health	Mental Health	Primary Care	Grand Total	MUA/P
Colin		1		1	0

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, 2021.

The detail of the HPSA and MUA/P designations are listed below:

Health Professional Shortage Areas (HPSA)

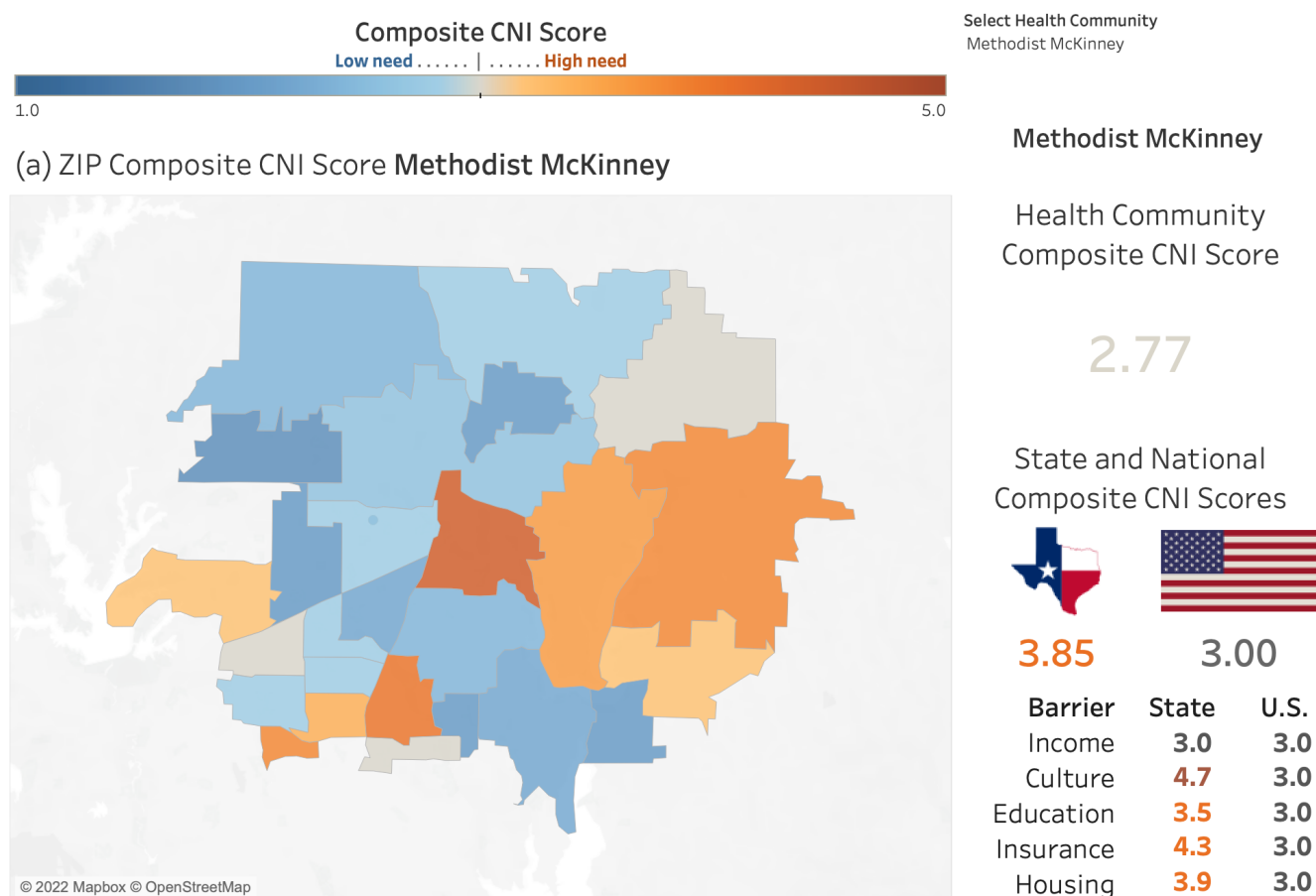
COUNTY NAME	HPSA ID	HPSA ID NAME	HPSA DISCIPLINE CLASS	DESIGNATION TYPE
Collin	7485109304	LI - MHCA - Collin County	Mental Health	Low Income Population HPSA

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 health care. 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 U.S.

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.



The overall CNI score for the Collin County Health Community is 2.77. 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 visit, 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 provides 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 U.S. 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 the Collin County Health Community. Total discharges in the community are expected to grow by 17.3% 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 & Drug Abuse	823	849	961	26	3.2%	138	16.8%
Cardio-Vasc-Thor Surgery	2,901	3,189	3,454	288	9.9%	553	19.1%
Cardiovascular Diseases	4,371	4,911	5,789	540	12.4%	1,418	32.4%
ENT	417	391	383	(26)	-6.3%	(34)	-8.1%
General Medicine	11,753	12,566	13,876	813	6.9%	2,123	18.1%
General Surgery	5,101	5,249	5,658	148	2.9%	557	10.9%
Gynecology	486	239	143	(247)	-50.9%	(342)	-70.5%
Nephrology/Urology	3,063	3,379	3,834	316	10.3%	771	25.2%
Neuro Sciences	3,601	3,914	4,493	313	8.7%	892	24.8%
Obstetrics Del	9,070	8,694	9,153	(376)	-4.1%	83	0.9%
Obstetrics ND	578	522	527	(56)	-9.7%	(51)	-8.8%
Oncology	1,483	1,575	1,721	92	6.2%	238	16.0%
Ophthalmology	93	90	90	(2)	-2.5%	(2)	-2.5%
Orthopedics	6,775	7,089	7,769	314	4.6%	994	14.7%
Psychiatry	1,347	1,449	1,583	101	7.5%	235	17.5%
Pulmonary Medical	4,708	5,743	6,905	1,035	22.0%	2,197	46.7%
Rehabilitation	104	121	145	17	16.3%	41	39.2%
TOTAL	56,675	59,970	66,486	3,295	5.8%	9,811	17.3%

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 procedure codes and are further grouped into clinical service lines. The Collin County Health Community outpatient procedures are expected to increase by 38% by 2030 with the largest growth in the categories of Labs, General & Internal Medicine and Physical & Occupational Therapy.

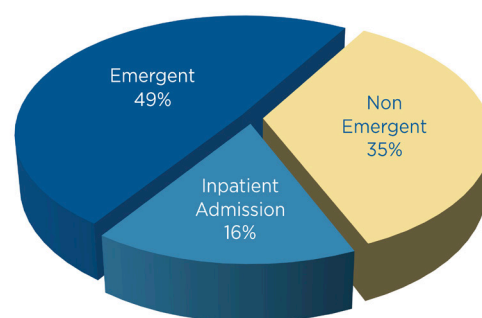
<i>Clinical Service Category</i>	<i>2020 Procedures</i>	<i>2025 Procedures</i>	<i>2020-2025 Procedures % Change</i>	<i>2030 Procedures</i>	<i>2020-2030 Procedures % Change</i>
Allergy & Immunology	308,370	344,701	11.8%	389,466	26.3%
Anesthesia	69,032	85,124	23.3%	101,954	47.7%
Cardiology	586,496	764,441	30.3%	1,004,123	71.2%
Cardiothoracic	655	801	22.3%	965	47.3%
Chiropractic	547,990	569,843	4.0%	587,104	7.1%
Colorectal Surgery	9,003	10,086	12.0%	11,368	26.3%
CT Scan	169,395	237,169	40.0%	329,329	94.4%
Dermatology	208,489	253,652	21.7%	306,895	47.2%
Diagnostic Radiology	1,035,010	1,183,567	14.4%	1,353,967	30.8%
Emergency Medicine	382,870	445,223	16.3%	523,374	36.7%
Gastroenterology	76,731	92,100	20.0%	109,261	42.4%
General & Internal Medicine	8,800,054	10,298,361	17.0%	11,933,286	35.6%
General Surgery	58,588	69,277	18.2%	82,092	40.1%
Hematology & Oncology	1,292,387	1,642,330	27.1%	1,997,328	54.5%
Labs	10,123,173	11,726,135	15.8%	13,655,855	34.9%
Miscellaneous	453,712	528,409	16.5%	614,398	35.4%
MRI	93,155	109,013	17.0%	127,774	37.2%
Nephrology	126,608	160,313	26.6%	198,239	56.6%
Neurology	170,967	185,717	8.6%	204,025	19.3%
Neurosurgery	4,558	6,896	51.3%	8,387	84.0%
Obstetrics/Gynecology	162,364	174,865	7.7%	196,137	20.8%
Ophthalmology	454,813	574,016	26.2%	708,006	55.7%
Oral Surgery	5,065	5,768	13.9%	6,675	31.8%
Orthopedics	151,106	176,864	17.0%	205,639	36.1%
Otolaryngology	468,883	505,546	7.8%	552,283	17.8%
Pain Management	82,949	97,267	17.3%	112,017	35.0%
Pathology	188	228	21.1%	274	45.7%
PET Scan	6,538	8,043	23.0%	9,697	48.3%
Physical & Occupational Therapy	3,510,638	4,302,228	22.5%	5,250,936	49.6%
Plastic Surgery	10,736	12,890	20.1%	15,438	43.8%
Podiatry	36,095	40,696	12.7%	45,421	25.8%
Psychiatry	1,599,322	1,840,074	15.1%	2,133,018	33.4%
Pulmonary	170,384	196,455	15.3%	227,928	33.8%
Radiation Therapy	94,913	112,885	18.9%	132,453	39.6%
Single Photon Emission CT Scan (SPECT)	12,809	15,229	18.9%	18,184	42.0%
Urology	55,127	67,652	22.7%	82,435	49.5%
Vascular Surgery	19,608	23,757	21.2%	28,375	44.7%
TOTAL	31,358,782	36,867,620	17.6%	43,264,108	38.0%

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.

2025 Visits



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 which result in an inpatient admission are broken out into a third, separate category. In the Collin County Health Community, ED visits are expected to grow by over 20% by 2025.

<i>Emergent Status</i>	<i>2020 Visits</i>	<i>2025 Visits</i>	<i>2020-2025 Visits Change</i>	<i>2020-2025 Visits % Change</i>
Emergent	159,670	206,251	46,582	29.2%
Inpatient Admission	50,955	67,874	16,919	33.2%
Non Emergent	136,078	144,217	8,140	6.0%
TOTAL	346,703	418,343	71,640	20.7%

Source: IBM Watson Health Emergency Department Visits, 2020.

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.

<i>Disease Type</i>	<i>2020 Prevalence</i>	<i>2020 % Prevalence</i>
Arrhythmia	47,699	12.7%
Heart Failure	15,944	4.3%
Hypertension	273,081	73.0%
Ischemic Heart Disease	37,456	10.0%
TOTAL	374,181	100%

In the Collin County Health Community, the most common disease is hypertension at 73% of all heart disease cases.

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 15.5% in the Collin County Health Community by 2025.

Cancer Type	2020 Incidence	2025 Incidence	2020-2025 Change	2020-2025 % Change
Bladder	267	324	58	21.6%
Brain	97	110	13	13.1%
Breast	1,089	1,295	206	19.0%
Colorectal	679	680	1	0.2%
Kidney	209	257	48	23.0%
Leukemia	202	240	38	18.8%
Lung	593	695	102	17.3%
Melanoma	293	351	58	19.9%
Non Hodgkins Lymphoma	286	343	57	20.0%
Oral Cavity	176	212	36	20.6%
Other	771	932	160	20.8%
Ovarian	81	92	11	14.2%
Pancreatic	147	185	38	25.7%
Prostate	713	739	27	3.7%
Stomach	90	105	15	16.3%
Thyroid	166	197	31	18.5%
Uterine Cervical	37	40	3	7.4%
Uterine Corpus	143	173	31	21.5%
TOTAL	6,038	6,971	933	15.5%

Source: IBM Watson Health Cancer Estimates, 2020.

APPENDIX F: 2019 METHODIST CHNA EVALUATION

Due to the COVID pandemic, progress was impeded on a number of initiatives for the community. Although the pandemic proved to be a barrier to initial progress, a few of the initiatives have re-gained some momentum through virtual offerings.

Primary Care and Cost

In an effort to impact the community health need of primary care and cost, Methodist McKinney Hospital recruited two additional physicians to expand services at West McKinney Health & Wellness. Also, as a result of COVID-19, Methodist McKinney added a Virtual Joint Class participation option for patients in addition to the already existing live Joint Class and video options.

Methodist McKinney also expanded physical therapy services through the addition of six new physical therapy clinics in 2021, bringing the total to 15.

Methodist McKinney also began offering nursing and scrub tech residency programs for Collin College new graduates as well as began a partnership with the College to have the nursing students do clinical rounds at the hospital.

Coordination of Services/Care

Methodist McKinney implemented RecoveryCOACH, a patient portal providing pre and post op education for a successful joint replacement journey. The Joint Replacement Program also now features a Nurse Navigator who guides these patients thru their episode of care.

APPENDIX G: COMMUNITY RESOURCES IDENTIFIED TO POTENTIALLY ADDRESS SIGNIFICANT HEALTH NEEDS

Below is a list of community resources that may help address this community's known health needs:

- **Resource**
- **Assistance Center of Collin County**
- **Ave F Clinic**
- **Children & Community Health Center**
- **Collin County Adult Clinic**
- **Collin County Alliance for Children**
- **Collin County Community Health Center**
- **Collin County Health Dept**
- **Collin County Social Services Association**
- **Community Dental Care**
- **Community Lifeline Center**
- **Family Guidance**
- **Family Health Center**
- **Frisco Family Services**
- **Geriatric Wellness Center**
- **Grace to Change**
- **Holy Family Day School**
- **Hope Clinic of McKinney**
- **LifePath Systems**
- **Plano Adult Clinic**
- **Plano Children's Medical Clinic**
- **Plano Indigent Care Clinic**
- **Primary Care Clinic of North Texas - Plano**
- **Project Access**
- **Veterans Assistance Center**
- **Wellness Center for Older Adults**
- **West Side Clinic**
- **Wylie Children's Medical Clinic**