TEXAS HEALTH RESOURCES

COLLIN REGION

APPENDICES

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Appendix A. Secondary Data Methodology

Secondary Data Sources

The main source for the secondary data, or data that has been previously collected, is the community indicator database maintained by Conduent Healthy Communities Institute. The following is a list of both local and national data sources used in Texas Health Resources Collin County regional Community Health Needs Assessment report.

Data Sources

- American Community Survey
- American Lung Association
- CDC - PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- County Health Rankings
- Feeding America
- Healthy Communities Institute
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- Texas Department of Family and Protective Services
- DFWHC Foundation Regional Data, Q1-Q4, 2017-2019. DFWHC Foundation, Irving Texas. October 15, 2021,

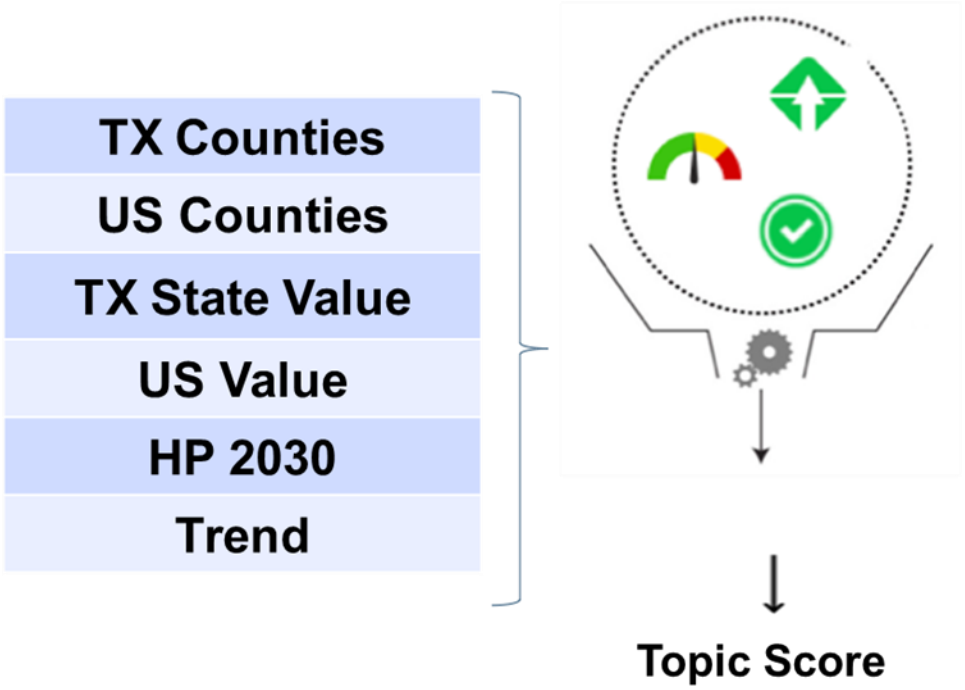
- Texas Education Agency

- Texas Department of Health Services
- U.S Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Census Bureau – Small Area Health Insurance Estimates
- U.S. Department of Agriculture – Food Environment Atlas
- U.S. Environmental Protection Agency
- United for ALICE

Secondary Data Scoring

HCI's Data Scoring Tool (Figure 1A) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. For each indicator, the community value was compared to a distribution of Texas and US counties, state and national values, Healthy People 2030, and significant trends were noted. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities and changes in methodology over time. The comparison scores were summarized for each indicator, and indicators were then grouped into topic areas for a systematic ranking of community health needs.

Figure 1A: Summary of Topic Scoring Analysis



Index of Disparity

An important part of the CHNA process is to identify health disparities, the needs of vulnerable populations and unmet health needs or gaps in services. There were several ways in which subpopulation disparities were examined by county. For secondary data health indicators, the Index of Disparity tool was utilized to see if there were large, negative, and concerning differences in indicator values between each subgroup data value and the overall county value. The Index of Disparity was run for each county, and the indicators with the highest race or ethnicity index value were found.

Health Equity Index

Every community can be described by various social and economic factors that can contribute to disparities in health outcomes. Conduent HCI's Health Equity Index (formerly SocioNeeds ® Index) considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing health inequities.

How is the index value calculated?
The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic needs correlated with preventable hospitalizations and premature death.

What do the ranks and colors mean?
Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Health Equity Index, with darker coloring associated with higher relative need.

Food Insecurity Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in outcomes and opportunities to thrive. Conduent HCI's Food Insecurity Index considers validated indicators related to income, household environment and well-being to identify areas at highest risk for experiencing food insecurity.

How is the index value calculated?
The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest food insecurity, which is correlated with household and community measures of food-related financial stress such as Medicaid and SNAP enrollment.

What do the ranks and colors mean?
Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Food Insecurity Index, with darker coloring associated with higher relative need.

Mental Health Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in mental health outcomes. Conduent HCI's Mental Health Index considers validated indicators related to access to care, physical health status, transportation, employment and household environment to identify areas at highest risk for experiencing poor mental health.

How is the index value calculated?
The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic and health needs correlated with self-reported poor mental health.

What do the ranks and colors mean?
Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Mental Health Index, with darker coloring associated with higher relative need.

Data Considerations

Several limitations of data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, data availability varies by health topic. Some topics contain a robust set of secondary data indicators, while others may have a limited number of indicators or limited subpopulations covered by those specific indicators. Data scores represent the relative community health need according to the secondary data for each topic and should not be considered a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole and do not represent the health or socioeconomic need that is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to best represent the population at large, these measures are subject to instability, especially for smaller populations. The Index of Disparity is also limited by data availability, where indicator data varies based on the population groups and service areas being analyzed.

Race or ethnic and Special Population Groupings

The secondary data presented in this report derive from multiple sources, which may present race and ethnicity data using dissimilar nomenclature. For consistency with data sources throughout the report, subpopulation data may use different terms to describe the same or similar groups of community members.

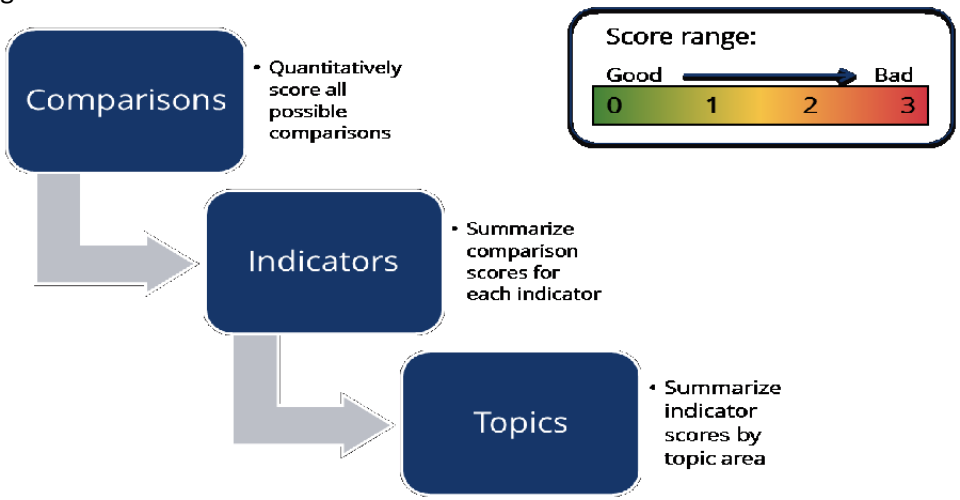
Zip Codes and Zip Code Tabulation Areas

This report presents both Zip Code and Zip Code Tabulation Area (ZCTA) data. Zip Codes, which were created by the U.S. Postal Service to improve mail delivery service, are not reported in this assessment as they may change, include P.O. boxes or cover large unpopulated areas. This assessment cover ZCTAs or Zip Code Tabulation Areas which were created by the U.S. Census Bureau and are generalized representations of Zip Codes that have been assigned to census blocks.

Demographics for this report are sourced from the United States Census Bureau, which presents ZCTA estimates. Tables and figures in the Demographics section of this report reference Zip Codes in title (for purposes of familiarity) but show values of ZCTAs. Data from other sources are labeled as such.

Secondary Data Scoring Detailed Methodology

Data Scoring is done in three stages:



For every indicator available, each county in the Hospital Service Area is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic. Secondary data for this report are up to date as of November 1, 2021.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

The county is compared to the state value, the national value, and target values. Target values include the nation-wide Healthy People 2030 (HP2030) goals. Healthy People 2030 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results.

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.

County Data Scoring Indicators Results

Collin County Indicator Scores

SCORE	ALCOHOL & DRUG USE	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Adults who Binge Drink	*percent*	16.7			16.4	*2018*		3
1.75	Age-Adjusted ER Rate due to Opioid Use	*ER visits/ 10,000 population 18+ years*	2.2		0.7		*2017-2019*		16
1.75	Age-Adjusted Hospitalization Rate due to Opioid Use	*hospitalizations/ 10,000 population 18+ years*	0.3		0.1		*2017-2019*		16
1.56	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	28.3	28.3	25.7	27	*2015-2019*		6
1.25	Age-Adjusted ER Rate due to Substance Use	*ER visits/ 10,000 population 18+ years*	9.7		20.6		*2017-2019*		16
1.25	Age-Adjusted Hospitalization Rate due to Substance Use	*hospitalizations/ 10,000 population 18+ years*	0.9		1.2		*2017-2019*		16
1.06	Liquor Store Density	*stores/ 100,000 population*	6.5		6.9	10.5	*2019*		18
1.00	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	7.8		12.1	22.8	*2017-2019*		4

0.33	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	7.3		10.6	21	*2017-2019*		6

SCORE	**CANCER**	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	127.2		112.8	125.9	*2013-2017*		9
2.47	Cancer: Medicare Population	*percent*	8.7		7.6	8.4	*2018*		5
1.50	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	94.5		94	104.5	*2013-2017*		9
1.33	Colon Cancer Screening	*percent*	65.4	74.4		66.4	*2018*		3
1.33	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	10.6		11	11.8	*2013-2017*		9
1.22	Cervical Cancer Screening: 21-65	*Percent*	84.3	84.3		84.7	*2018*		3
1.14	All Cancer Incidence Rate	*cases/ 100,000 population*	402.3		407.7	448.7	*2013-2017*		9
0.94	Mammogram in Past 2 Years: 50-74	*percent*	76.2	77.1		74.8	*2018*		3
0.75	Adults with Cancer	*percent*	5.9			6.9	*2018*		3
0.64	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	16.3	15.3	19.8	20.1	*2013-2017*		9
0.61	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	4.4		9.2	7.6	*2013-2017*		9

0.44	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	10.6	8.9	13.9	13.7	*2013-2017*		9
0.36	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	30.8		37.6	38.4	*2013-2017*		9
0.25	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	15	16.9	17.6	19	*2013-2017*	Black (41.3) White (15.8)	9
0.11	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	123.6	122.7	148.8	155.5	*2013-2017*		9
0.11	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	27.3	25.1	34.1	38.5	*2013-2017*		9
0.08	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	42.5		50.6	58.3	*2013-2017*		9

SCORE	CHILDREN'S HEALTH	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Food Insecure Children Likely Ineligible for Assistance	*percent*	56		34	23	*2019*		7
1.50	Children with Health Insurance	*percent*	92		87.3	94.3	*2019*		1
1.33	Children with Low Access to a Grocery Store	*percent*	3.8				*2015*		20
0.92	Projected Child Food Insecurity Rate	*percent*	16.7		23.6		*2021*		7
0.92	Substantiated Child Abuse Rate	*cases/ 1,000 children*	4.5	8.7	9.1		*2020*		12
0.67	Child Food Insecurity Rate	*percent*	13.3		19.6	14.6	*2019*		7

SCORE	COMMUNITY	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.92	Solo Drivers with a Long Commute	*percent*	46.5		38.9	37	*2015-2019*		6
2.67	Median Household Gross Rent	*dollars*	1389		1045	1062	*2015-2019*		1
2.67	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	859		514	500	*2015-2019*		1
2.67	Mortgaged Owners Median Monthly Household Costs	*dollars*	2194		1606	1595	*2015-2019*		1
2.36	Social Associations	*membership associations/ 10,000 population*	6.4		7.5	9.3	*2018*		6
2.31	Mean Travel Time to Work	*minutes*	28.9		26.6	26.9	*2015-2019*		1
1.97	Linguistic Isolation	*percent*	5.1		7.7	4.4	*2015-2019*		1
1.56	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	28.3	28.3	25.7	27	*2015-2019*		6

1.44	Workers Commuting by Public Transportation	*percent*	1.1	5.3	1.4	5	*2015-2019*	Black (1.9) White (0.8) Asian (1.9) AIAN (0) NHPI (6.6) Mult (3) Other (0.9) Hisp (0.9)	1
1.25	Female Population 16+ in Civilian Labor Force	*percent*	62.7		57.8	58.3	*2015-2019*		1
1.25	Homeownership	*percent*	61.1		54.9	56.2	*2015-2019*		1
1.25	Persons with Health Insurance	*percent*	87.5	92.1	79.3		*2019*		19
1.08	Social Worker Rate	*workers/ 100,000 population*	69.2		82.7		*2020*		13
1.08	Workers who Drive Alone to Work	*percent*	80.9		80.5	76.3	*2015-2019*		1
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	0.6				*2015*		20
1.00	Voter Turnout: Presidential Election	*percent*	66.4		58.8		*2016*		15
0.92	Persons with an Internet Subscription	*percent*	93.5		84.2	86.2	*2015-2019*		1
0.92	Substantiated Child Abuse Rate	*cases/ 1,000 children*	4.5	8.7	9.1		*2020*		12

0.83	Households with One or More Types of Computing Devices	*percent*	97.9		91	90.3	*2015-2019*		1
0.81	Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions	*deaths/ 100,000 population*	6.8	10.1	13	11.3	*2017-2019*		4
0.81	Total Employment Change	*percent*	4.2		2.9	1.6	*2018-2019*		18
0.64	Population 16+ in Civilian Labor Force	*percent*	68.1		61	59.6	*2015-2019*		1
0.53	People 25+ with a High School Degree or Higher	*percent*	93.8		83.7	88	*2015-2019*		1
0.50	Households with an Internet Subscription	*percent*	92.9		82.1	83	*2015-2019*		1
0.33	Median Housing Unit Value	*dollars*	315300		2E+05	2E+05	*2015-2019*		1
0.08	Children Living Below Poverty Level	*percent*	7		20.9	18.5	*2015-2019*	Black (9.7) White (3.4) Asian (3.7) AIAN (4.4) NHPI (2.2) Mult (6.6) Other (22.8) Hisp (17.5)	1
0.08	Median Household Income	*dollars*	96913		61874	62843	*2015-2019*		1

0.08	People 25+ with a Bachelor's Degree or Higher	*percent*	52.3		29.9	32.1	*2015-2019*		1
0.08	Per Capita Income	*dollars*	44548		31277	34103	*2015-2019*		1
0.08	Single-Parent Households	*percent*	15.5		26.3	25.5	*2015-2019*		1
0.00	People Living Below Poverty Level	*percent*	6.3	8	14.7	13.4	*2015-2019*	Black (7.6) White (4.3) Asian (5.8) AIAN (9.1) NHPI (4.5) Mult (7.1) Other (14.8) Hisp (12.9)	1

SCORE	DIABETES	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Age-Adjusted ER Rate due to Diabetes	*ER visits/ 10,000 population 18+ years*	16.5		9.4		*2017-2019*		16
1.75	Age-Adjusted ER Rate due to Type 2 Diabetes	*ER visits/ 10,000 population 18+ years*	14.7		8.6		*2017-2019*		16
1.75	Age-Adjusted Hospitalization Rate due to Diabetes	*hospitalizations/ 10,000 population 18+ years*	11.6		5.3		*2017-2019*		16
1.75	Age-Adjusted Hospitalization Rate due to Type 2 Diabetes	*hospitalizations/ 10,000 population 18+ years*	8.6		4		*2017-2019*		16
0.97	Diabetes: Medicare Population	*percent*	24.9		28.8	27	*2018*		5
0.64	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	9.2		22	21.5	*2017-2019*		4

SCORE	ECONOMY	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.67	Median Household Gross Rent	*dollars*	1389		1045	1062	*2015-2019*		1
2.67	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	859		514	500	*2015-2019*		1
2.67	Mortgaged Owners Median Monthly Household Costs	*dollars*	2194		1606	1595	*2015-2019*		1
2.50	Food Insecure Children Likely Ineligible for Assistance	*percent*	56		34	23	*2019*		7
2.00	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		20
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.4				*2017*		20
1.75	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	27.6		26.5	26.5	*2019*		1
1.42	Renters Spending 30% or More of Household Income on Rent	*percent*	43.5		47.8	49.6	*2015-2019*		1
1.36	Size of Labor Force	*persons*	583416				*44348*		17

1.25	Female Population 16+ in Civilian Labor Force	*percent*	62.7	57.8	58.3	*2015-2019*	1
1.25	Homeownership	*percent*	61.1	54.9	56.2	*2015-2019*	1
1.14	Overcrowded Households	*percent of households*	2.4	4.8		*2015-2019*	1
1.14	Students Eligible for the Free Lunch Program	*percent*	22.1			*2019-2020*	10
1.00	Food Insecurity Rate	*percent*	11.1	14.1	10.9	*2019*	7
1.00	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	71.2	56		*2018*	22
1.00	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	22.1	30		*2018*	22
1.00	Households that are Below the Federal Poverty Level	*percent*	6.6	14		*2018*	22
1.00	Low-Income and Low Access to a Grocery Store	*percent*	2.3			*2015*	20

0.92	Projected Child Food Insecurity Rate	*percent*	16.7	23.6		*2021*		7
0.92	Projected Food Insecurity Rate	*percent*	13.1	16.5		*2021*		7
0.81	People 65+ Living Below Poverty Level	*percent*	7.1	10.6	9.3	*2015-2019*	Black (10.1) White (6.3) Asian (8.6) AIAN (14.2) NHPI (0) Mult (6.4) Other (13.6) Hisp (10.8)	1
0.81	Total Employment Change	*percent*	4.2	2.9	1.6	*2018-2019*		18
0.69	Severe Housing Problems	*percent*	12.9	17.4	18	*2013-2017*		6
0.69	Unemployed Workers in Civilian Labor Force	*percent*	5.1	6.7	6.1	*44348*		17
0.67	Child Food Insecurity Rate	*percent*	13.3	19.6	14.6	*2019*		7
0.64	Households with Cash Public Assistance Income	*percent*	0.8	1.4	2.4	*2015-2019*		1
0.64	Population 16+ in Civilian Labor Force	*percent*	68.1	61	59.6	*2015-2019*		1

0.36	People Living 200% Above Poverty Level	*percent*	82.9	65.7	69.1	*2015-2019*		1
0.33	Median Housing Unit Value	*dollars*	315300	2E+05	2E+05	*2015-2019*		1
0.08	Children Living Below Poverty Level	*percent*	7	20.9	18.5	*2015-2019*	Black (9.7) White (3.4) Asian (3.7) AIAN (4.4) NHPI (2.2) Mult (6.6) Other (22.8) Hisp (17.5)	1
0.08	Families Living Below Poverty Level	*percent*	4.4	11.3	9.5	*2015-2019*	Black (6.8) White (2.7) Asian (3.8) AIAN (6.6) NHPI (3) Mult (7.1) Other (10.2) Hisp (11.5)	1
0.08	Median Household Income	*dollars*	96913	61874	62843	*2015-2019*		1
0.08	Per Capita Income	*dollars*	44548	31277	34103	*2015-2019*		1
0.08	Persons with Disability Living in Poverty (5-year)	*percent*	9.5	23.2	26.1	*2015-2019*		1

0.00	People Living Below Poverty Level	*percent*	6.3	8	14.7	13.4	*2015-2019*	Black (7.6) White (4.3) Asian (5.8) AIAN (9.1) NHPI (4.5) Mult (7.1) Other (14.8) Hisp (12.9)	1

SCORE	EDUCATION	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.69	Student-to-Teacher Ratio	*students/ teacher*	14.8				*2019-2020*		10
1.14	High School Drop Out Rate	*percent*	1.2		1.9		*2019*	Black (2) White (0.8) Asian (0.3) AIAN (2.7) PI (0) Mult (0.8) Hisp (2.3)	14
0.61	Infants Born to Mothers with <12 Years Education	*percent*	6.2		17.4	13.3	*2017*	Black (3.7) White (2.1) Other (2.3) Hisp (22.2)	13
0.53	People 25+ with a High School Degree or Higher	*percent*	93.8		83.7	88	*2015-2019*		1
0.08	People 25+ with a Bachelor's Degree or Higher	*percent*	52.3		29.9	32.1	*2015-2019*		1

SCORE	ENVIRONMENTAL HEALTH	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.19	Asthma: Medicare Population	*percent*	5.4		4.9	5	*2018*		5
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.9				*2016*		20
2.00	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		20
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.4				*2017*		20
1.83	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*		20
1.75	Annual Ozone Air Quality		F				*2017-2019*		2
1.64	Number of Extreme Precipitation Days	*days*	39				*2016*		11
1.50	Farmers Market Density	*markets/ 1,000 population*	0				*2018*		20
1.36	Months of Mild Drought or Worse	*months per year*	5				*2016*		11
1.36	Number of Extreme Heat Days	*days*	5				*2016*		11
1.36	Number of Extreme Heat Events	*events*	2				*2016*		11
1.36	PBT Released	*pounds*	369.9				*2019*		21
1.36	Recognized Carcinogens Released into Air	*pounds*	105.6				*2019*		21

1.33	Children with Low Access to a Grocery Store	*percent*	3.8			*2015*	20
1.17	Daily Dose of UV Irradiance	*Joule per square meter*	3218	3538		*2015*	11
1.17	People with Low Access to a Grocery Store	*percent*	12.7			*2015*	20
1.14	Overcrowded Households	*percent of households*	2.4	4.8		*2015-2019*	1
1.08	Weeks of Moderate Drought or Worse	*weeks per year*	3			*2016*	11
1.06	Liquor Store Density	*stores/ 100,000 population*	6.5	6.9	10.5	*2019*	18
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	0.6			*2015*	20
1.00	Low-Income and Low Access to a Grocery Store	*percent*	2.3			*2015*	20
1.00	People 65+ with Low Access to a Grocery Store	*percent*	0.9			*2015*	20
1.00	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1			*2016*	20
0.75	Adults with Current Asthma	*percent*	8		9.2	*2018*	3

0.69	Severe Housing Problems	*percent*	12.9	17.4	18	*2013-2017*	6
0.67	Access to Exercise Opportunities	*percent*	90.1	80.5	84	*2020*	6
0.53	Food Environment Index		8.4	5.9	7.8	*2021*	6

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Adults who have had a Routine Checkup	*percent*	74.1			76.7	*2018*		3
1.58	Adults without Health Insurance	*percent*	16.5			12.2	*2018*		3
1.50	Children with Health Insurance	*percent*	92		87.3	94.3	*2019*		1
1.33	Adults with Health Insurance	*percent*	85.9		75.5	87.1	*2019*		1
1.33	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	76.2		88.6		*2020*		6
1.25	Persons with Health Insurance	*percent*	87.5	92.1	79.3		*2019*		19
1.08	Social Worker Rate	*workers/ 100,000 population*	69.2		82.7		*2020*		13
0.92	Adults who Visited a Dentist	*percent*	69.1			66.5	*2018*		3
0.67	Mental Health Provider Rate	*providers/ 100,000 population*	123.6		120.9		*2020*		6
0.33	Dentist Rate	*dentists/ 100,000 population*	68.6		59.6		*2019*		6
0.33	Primary Care Provider Rate	*providers/ 100,000 population*	101.4		60.9		*2018*		6

SCORE	HEART DISEASE & STROKE	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.75	Atrial Fibrillation: Medicare Population	*percent*	9		7.8	8.4	*2018*		5
2.50	Hyperlipidemia: Medicare Population	*percent*	55.2		49.5	47.7	*2018*		5
2.08	Adults who Have Taken Medications for High Blood Pressure	*percent*	73.4			75.8	*2017*		3
2.08	Hypertension: Medicare Population	*percent*	60.9		59.9	57.2	*2018*		5
1.92	Ischemic Heart Disease: Medicare Population	*percent*	27.8		29	26.8	*2018*		5
1.75	Age-Adjusted ER Rate due to Hypertension	*ER visits/ 10,000 population 18+ years*	28.2		10.5		*2017-2019*		16
1.75	Age-Adjusted Hospitalization Rate due to Hypertension	*hospitalizations/ 10,000 population 18+ years*	0.4		0.1		*2017-2019*		16
1.69	Stroke: Medicare Population	*percent*	4.1		4.2	3.8	*2018*		5
0.94	High Blood Pressure Prevalence	*percent*	29.6	27.7		32.4	*2017*		3

0.92	Cholesterol Test History	*percent*	83.6			81.5	*2017*	3
0.92	High Cholesterol Prevalence: Adults 18+	*percent*	32.3			34.1	*2017*	3
0.86	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	34.1	33.4	40.2	37.2	*2017-2019*	4
0.86	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	46.9		70.1		*2018*	11
0.75	Adults who Experienced a Stroke	*percent*	2.4			3.4	*2018*	3
0.75	Adults who Experienced Coronary Heart Disease	*percent*	5			6.8	*2018*	3
0.64	Heart Failure: Medicare Population	*percent*	11.7		15.6	14	*2018*	5
0.06	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	64.6	71.1	93	90.5	*2017-2019*	4

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza	*hospitalizations/ 10,000 population 18+ years*	0.3		0.1		*2017-2019*		16
1.64	HIV Diagnosis Rate	*cases/ 100,000 population*	9.8		15.7		*2018*		13
1.42	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	1.6		4.3	2	24-Sep-21		8
1.33	Gonorrhea Incidence Rate	*cases/ 100,000 population*	89.2		163.6	179.1	*2018*		13
1.28	Tuberculosis Incidence Rate	*cases/ 100,000 population*	2.6	1.4	4.3		*2015-2019*		13
1.22	Syphilis Incidence Rate	*cases/ 100,000 population*	3		8.8	10.8	*2018*		13
1.14	Overcrowded Households	*percent of households*	2.4		4.8		*2015-2019*		1
1.06	Chlamydia Incidence Rate	*cases/ 100,000 population*	284.5		508.2	539.9	*2018*		13
0.89	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	10.6		11.8	13.8	*2017-2019*		4

0.69	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	32.3	47.1	51.4	24-Sep-21		8

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.72	Mothers who Received Early Prenatal Care	*percent*	65.9		60.5	77.3	*2017*		13
1.22	Preterm Births	*percent*	10.9	9.4	12.2		*2017*		13
1.11	Babies with Very Low Birth Weight	*percent*	1.1			1.4	*2015*	Black (2.66393442) White (0.88834697) Other (1.11111111) Hisp (0.88062622)	13
0.94	Teen Births	*percent*	0.6		2.1	3.1	*2017*	Black (1.1) White (0.4) Other (0) Hisp (1.5)	13
0.81	Infant Mortality Rate	*deaths/ 1,000 live births*	4	5	5.6	5.9	*2015*		13
0.61	Infants Born to Mothers with <12 Years Education	*percent*	6.2		17.4	13.3	*2017*	Black (3.7) White (2.1) Other (2.3) Hisp (22.2)	13
0.50	Babies with Low Birth Weight	*percent*	7.2		8.2	8.1	*2015*		13

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source

2.42	Depression: Medicare Population	*percent*	19.5		18.2	18.4	*2018*	5
2.25	Alzheimer's Disease or Dementia: Medicare Population	*percent*	12.3		12.6	10.8	*2018*	5
1.75	Age-Adjusted Hospitalization Rate due to Adult Mental Health	*hospitalizations/ 10,000 population 18+ years*	2.2		1.7		*2017-2019*	16
1.25	Age-Adjusted ER Rate due to Adult Mental Health	*ER visits/ 10,000 population 18+ years*	4.3		8.9		*2017-2019*	16
0.81	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	11.4	12.8	13.5	14.1	*2017-2019*	4
0.75	Poor Mental Health: 14+ Days	*percent*	10.6			12.7	*2018*	3
0.67	Frequent Mental Distress	*percent*	10.6		11.6	13	*2018*	6
0.67	Mental Health Provider Rate	*providers/ 100,000 population*	123.6		120.9		*2020*	6

SCORE	OLDER ADULTS	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.92	Osteoporosis: Medicare Population	*percent*	8.2		6.8	6.6	*2018*		5
2.75	Atrial Fibrillation: Medicare Population	*percent*	9		7.8	8.4	*2018*		5
2.50	Hyperlipidemia: Medicare Population	*percent*	55.2		49.5	47.7	*2018*		5
2.47	Cancer: Medicare Population	*percent*	8.7		7.6	8.4	*2018*		5
2.42	Depression: Medicare Population	*percent*	19.5		18.2	18.4	*2018*		5
2.25	Alzheimer's Disease or Dementia: Medicare Population	*percent*	12.3		12.6	10.8	*2018*		5
2.19	Asthma: Medicare Population	*percent*	5.4		4.9	5	*2018*		5
2.08	Chronic Kidney Disease: Medicare Population	*percent*	24.6		26.7	24.5	*2018*		5
2.08	Hypertension: Medicare Population	*percent*	60.9		59.9	57.2	*2018*		5

2.08	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.6		34.2	33.5	*2018*	5
1.92	Ischemic Heart Disease: Medicare Population	*percent*	27.8		29	26.8	*2018*	5
1.69	Stroke: Medicare Population	*percent*	4.1		4.2	3.8	*2018*	5
1.42	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	30.4			32.4	*2018*	3
1.33	Colon Cancer Screening	*percent*	65.4	74.4		66.4	*2018*	3
1.00	People 65+ with Low Access to a Grocery Store	*percent*	0.9				*2015*	20
0.97	Diabetes: Medicare Population	*percent*	24.9		28.8	27	*2018*	5
0.92	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	31.8			28.4	*2018*	3

0.81	People 65+ Living Below Poverty Level	*percent*	7.1	10.6	9.3	*2015-2019*	Black (10.1) White (6.3) Asian (8.6) AIAN (14.2) NHPI (0) Mult (6.4) Other (13.6) Hisp (10.8)	1
0.75	Adults 65+ with Total Tooth Loss	*percent*	8.9		13.5	*2018*		3
0.75	Adults with Arthritis	*percent*	20.4		25.8	*2018*		3
0.64	COPD: Medicare Population	*percent*	8.3	11.2	11.5	*2018*		5
0.64	Heart Failure: Medicare Population	*percent*	11.7	15.6	14	*2018*		5

SCORE	**ORAL HEALTH**	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Age-Adjusted ER Rate due to Dental Problems	*ER visits/ 10,000 population*	18.3		11.1		*2017-2019*		16
1.33	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	10.6		11	11.8	*2013-2017*		9
0.92	Adults who Visited a Dentist	*percent*	69.1			66.5	*2018*		3

0.75	Adults 65+ with Total Tooth Loss	*percent*	8.9		13.5	*2018*	3
0.33	Dentist Rate	*dentists/ 100,000 population*	68.6	59.6		*2019*	6

SCORE	OTHER CONDITIONS	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.92	Osteoporosis: Medicare Population	*percent*	8.2		6.8	6.6	*2018*		5
2.08	Chronic Kidney Disease: Medicare Population	*percent*	24.6		26.7	24.5	*2018*		5
2.08	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.6		34.2	33.5	*2018*		5
0.75	Adults with Arthritis	*percent*	20.4			25.8	*2018*		3
0.75	Adults with Kidney Disease	*Percent of adults*	2.3			3.1	*2018*		3

SCORE	PHYSICAL ACTIVITY	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.9				*2016*		20
2.00	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		20
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.4				*2017*		20
1.83	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*		20
1.50	Farmers Market Density	*markets/ 1,000 population*	0				*2018*		20

1.33	Children with Low Access to a Grocery Store	*percent*	3.8			*2015*	20
1.17	People with Low Access to a Grocery Store	*percent*	12.7			*2015*	20
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	0.6			*2015*	20
1.00	Low-Income and Low Access to a Grocery Store	*percent*	2.3			*2015*	20
1.00	People 65+ with Low Access to a Grocery Store	*percent*	0.9			*2015*	20
1.00	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1			*2016*	20
0.67	Access to Exercise Opportunities	*percent*	90.1	80.5	84	*2020*	6
0.53	Food Environment Index		8.4	5.9	7.8	*2021*	6

SCORE	PREVENTION & SAFETY	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.69	Severe Housing Problems	*percent*	12.9		17.4	18	*2013-2017*		6
0.33	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	7.3		10.6	21	*2017-2019*		6
0.28	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	26.5	43.2	38.7	48.9	*2017-2019*		4

SCORE	RESPIRATORY DISEASES	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.19	Asthma: Medicare Population	*percent*	5.4		4.9	5	*2018*		5
1.75	Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza	*hospitalizations/ 10,000 population 18+ years*	0.3		0.1		*2017-2019*		16
1.42	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	1.6		4.3	2	24-Sep-21		8
1.28	Tuberculosis Incidence Rate	*cases/ 100,000 population*	2.6	1.4	4.3		*2015-2019*		13
0.89	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	10.6		11.8	13.8	*2017-2019*		4
0.83	Adults who Smoke	*percent*	11.8	5		15.5	*2018*		3
0.75	Adults with COPD	*Percent of adults*	4.6			6.9	*2018*		3
0.75	Adults with Current Asthma	*percent*	8			9.2	*2018*		3
0.69	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	32.3		47.1	51.4	24-Sep-21		8
0.64	COPD: Medicare Population	*percent*	8.3		11.2	11.5	*2018*		5

0.11	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	27.3	25.1	34.1	38.5	*2013-2017*		9
0.08	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	42.5		50.6	58.3	*2013-2017*		9

SCORE	**SEXUALLY TRANSMITTED INFECTIONS**	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.64	HIV Diagnosis Rate	*cases/ 100,000 population*	9.8		15.7		*2018*		13
1.33	Gonorrhea Incidence Rate	*cases/ 100,000 population*	89.2		163.6	179.1	*2018*		13
1.22	Syphilis Incidence Rate	*cases/ 100,000 population*	3		8.8	10.8	*2018*		13
1.06	Chlamydia Incidence Rate	*cases/ 100,000 population*	284.5		508.2	539.9	*2018*		13

SCORE	**WELLNESS & LIFESTYLE**	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.25	Insufficient Sleep	*percent*	35	31.4	34.4	35	*2018*		6
0.94	High Blood Pressure Prevalence	*percent*	29.6	27.7		32.4	*2017*		3
0.75	Poor Physical Health: 14+ Days	*percent*	9.6			12.5	*2018*		3
0.50	Frequent Physical Distress	*percent*	9.3		11.6	11	*2018*		6

SCORE	WOMEN'S HEALTH	UNITS	COLLIN COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	127.2		112.8	125.9	*2013-2017*		9
1.22	Cervical Cancer Screening: 21-65	*Percent*	84.3	84.3		84.7	*2018*		3
0.94	Mammogram in Past 2 Years: 50-74	*percent*	76.2	77.1		74.8	*2018*		3
0.64	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	16.3	15.3	19.8	20.1	*2013-2017*		9
0.61	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	4.4		9.2	7.6	*2013-2017*		9

Collin County Data Sources

Key	Source Title
1	American Community Survey
2	American Lung Association
3	CDC - PLACES
4	Centers for Disease Control and Prevention
5	Centers for Medicare & Medicaid Services
6	County Health Rankings
7	Feeding America
8	Healthy Communities Institute
9	National Cancer Institute
10	National Center for Education Statistics
11	National Environmental Public Health Tracking Network
12	Texas Department of Family and Protective Services
13	DFWHC Foundation Regional Data, Q1-Q4, 2017-2019. DFWHC Foundation, Irving Texas. October 26, 2021
14	Texas Education Agency
15	Texas Secretary of State
16	THR Texas Department of Health Services
17	U.S. Bureau of Labor Statistics
18	U.S. Census - County Business Patterns
19	U.S. Census Bureau - Small Area Health Insurance Estimates
20	U.S. Department of Agriculture - Food Environment Atlas
21	U.S. Environmental Protection Agency
22	United For ALICE

Collin County Topic Scores

Health and Quality of Life Topics	Score
Other Conditions	**1.72**
Older Adults	**1.66**
Diabetes	**1.44**
Heart Disease & Stroke	**1.37**
Mental Health & Mental Disorders	**1.32**
Sexually Transmitted Infections	**1.31**
Physical Activity	**1.31**
Environmental Health	**1.31**
Children's Health	**1.31**
Alcohol & Drug Use	**1.30**
Immunizations & Infectious Diseases	**1.24**
Women's Health	**1.20**
Community	**1.13**
Health Care Access & Quality	**1.10**
Economy	**1.04**
Oral Health	**1.02**
Maternal, Fetal & Infant Health	**0.99**
Respiratory Diseases	**0.95**
Cancer	**0.93**
Wellness & Lifestyle	**0.86**
Education	**0.81**
Prevention & Safety	**0.43**

Appendix B. Community Input Assessment Tools

Key Informant Interview Guide and Questions

INTRODUCTION
HCI Facilitator: Introduce yourself and any others on the team

OPENING SCRIPT: TEXAS HEALTH RESOURCES (THR) has invited you to take part in this Key Informant Interview because of your content expertise and your experience working in the community. Our work on behalf of THR is focused on understanding what health issues and challenges impact the residents of **COLLIN** County and how to improve their overall health. The insights and perspectives collected in this interview will provide important information that will ultimately be combined with the results of a key informant interviews, focus groups, and data analysis of state and national indicators. These data components will be compiled into a comprehensive report outlining the health needs in the Southern Region which includes **COLLIN** County. The final reports will be completed in the summer of 2022.

CONFIDENTIALITY: For this interview, we will be taking notes on your responses, your names will not be associated with any direct quotes. Your identity will be kept confidential.

1. **To begin, could you please tell us a little about the organization you work for and the geographic location it serves?**
    a. *(only probe if necessary) What is your organization's mission? What are the top priority health issues that your organization addresses?*
    b. *(only ask if not clear) Does your organization provide direct care, operate as an advocacy organization, or have another role in the community?*
    c. *Which geographic location(s) does your organization serve? (to help us understand or confirm relevant service areas)*

2. **Considering the impact of Covid-19, what would you consider the top 5 health issues exacerbated by the pandemic in COLLIN county?**

    a. *What are the possible solutions to improve the health issues you've described?*
    b. *What solutions have your organization/agency put in place or considered to help improve the health issues you described?*
    c. *How can Texas Health support these health improvement efforts?*

3. **Along the same lines, what would you consider the top 5 socioeconomic needs exacerbated by the pandemic in [County Name/Zip code]?**
    a. *What are the possible solutions to improve the socioeconomic needs you've described?*
    b. *What specific solutions have your organization/agency put in place or considered to help improve the socioeconomic issues you described?*
    c. *How can Texas Health support these socioeconomic improvement efforts?*

4. **Thinking about the solutions you described to address the health and socioeconomic needs, to what extent does your organization/agency have what it needs to deliver these services/resources in the community effectively?**
    a. *How do aspects of this community's [County Name/Zip code] infrastructure (i.e., physical environment, policies, partnerships) help or hinder your ability to deliver the services/resources you described?*
    b. *How can Texas Health support the success of these services/resources?*

5. **How can community leaders, community-based organizations, and health care systems work collaboratively to address this community's [County Name/Zip codes] health and socioeconomic?**
        a. *To your knowledge, what strategies have been used in the past to drive collaboration across these partners? What worked, what didn't, and why?*
        b. *What challenges/barriers should Texas Health anticipate in its efforts to work with community leaders and members to address the health and socioeconomic needs in this community?*
        c. *How can Texas Health proactively address these challenges/barriers?*

6. **Finally, what do you consider the best practices that are currently going on to improve the health and socio-economic needs in this community [County/Zip codes]?**

7. **What is the most crucial message/feedback you want Texas Health to take away from this interview?**

    a. Is there anything else you would like to add about any of the topics we've discussed or other areas that we didn't discuss but you think are essential?

CLOSING SCRIPT: Thank you so much for your time and participation today. In terms of next steps, we will be collecting and analyzing the data for this needs assessment over the next few months. The final report will be available to everyone who participated, as well as the general public. If you have additional comments or thoughts after our conversation today, please feel free to reach out to *Eileen Aguilar* or Oge/Sika.
HCI Facilitator: Send a follow-up email to the key informant, thanking them for their time and make sure to include a link to the survey!

Focus Group Guide and Questions

INTRODUCTION

{Introduce Yourself and Others on the Team}

{"Let's get started…}

Opening Script: Thank you for taking the time to speak with us to support the Texas Health Resources (THR) Community Health Needs Assessment. We anticipate that this discussion will last no more than 60 minutes. You have been invited to take part in this focus group because of your experience living and/or working in Collin County. The focus of our Community Health Needs Assessment is how to improve health in the community and understand what challenges residents are facing. We are going to ask a series of questions related to health issues in the community. We hope to get through as many questions as possible and hear each of your perspectives as much as time allows.

For this discussion group, I will invite you to share as much or little as you feel comfortable sharing with the others in the group. The results of this assessment will be made available to the public. We will be taking notes on your responses, but your names will not be associated with any direct quotes. Your identity will be kept confidential, so please share your honest opinions.

SHOW SLIDES (if applicable)--We do have a few ground rules for this virtual discussion that I would like to review with you. It is important that everyone has a chance to be heard, so we ask that only one person talks at a time (most important ground rule for today). You may use the "raise hand" functions when you have something to say [*give instructions and test*]. We may also call on you to sure ensure everyone has a chance to speak but if you have nothing to share, please just say "pass".

You may want to mute yourself when you are not speaking to cut down on background noise [*give instructions and test mute/unmute*]. Finally, please respect the opinions of others, as the point of the discussion is to collect various points of view. And remember, there are no right or wrong answers, so please share freely and openly. Does anyone have any questions before we get started?

Okay, let's get started by going around and introducing ourselves. Please tell everyone your first name, what community you live in, and if you are interested in sharing, your involvement in the community (could be your job or volunteer work for example).

{Introductions}

Thank you for introducing yourselves. Now we will get started with our discussion.

COVID-19 QUESTION

1. **We know that COVID-19 has significantly impacted everyone's lives. What have you seen as the biggest challenges in XXXXX County during the pandemic?**

   [*Probe 1: Which groups of people are having the hardest time right now?]*
   [Probe 2: How have you seen these challenges being addressed, if at all?]
   [Probe 3: What programs have addressed COVID related issues? What has worked?]
   [Probe 4: What hasn't been effective and, in your opinion, why?]

GENERAL HEALTH QUESTIONS

2. **What would you say are the top three health related problems that people in your community are facing that you would like to change or improve?**

[Probe 1: Why do you think these are the most important health issues?
[Probe 2: What would you do to address these problems?]
[Probe 3: What else is needed to address these problems? Examples could be specific policies, programs, or services.]

3. **What might prevent someone from accessing care for the health challenges identified above?**

   [Examples could include lack of transportation, lack of health insurance coverage, doctor's office hours, language, or cultural barriers, etc.]
4. **Are there specific groups in your community that are most impacted by the health issues or challenges discussed earlier (2-3)? Which groups are these?**

   [Probe: Are these health challenges different if the person is a particular age, or gender, race, or ethnicity? Or lives in a certain part of the county for example?]
5. **From the health issues and challenges we've just discussed, which do you think can be addressed in the next three years?**

   [Probe 1: How do you think these health issues can be addressed?}
   [Probe 2: Are some of these issues more urgent or important than others? If so, why?]
6. **In 2019, Depression and anxiety among adults 18+ were identified as important health issues in your community. Do you know of any programs or services that are available in your community to address this issue?**

   [Prompt: Have you or someone you know benefited from these programs or services? If so, what do you think has worked? What do you think can be improved?]
7. **What resources are currently available for residents in your community for the identified health/social determinant problem/s we've discussed today?**

   [Probe 1: Are there specific community organizations or agencies that you see taking a strong leadership role for improving the health of particular groups in your community?]
   [Probe 2: Do you see residents taking advantage of them? Why or why not?]
   [Probe 3: What additional programs and resources do you think are needed to best meet the needs of residents in _____ County?]
   [Probe 4: Are you aware of any THR-Community Health Improvement program(s) in your community?]

CLOSING QUESTION

8. **Can you think of any other ways we could improve the health of residents in the community that we have not already talked about today?**

   [Probe: Is there anything else you would like to add that we haven't discussed?]

CONCLUSION

{Review the summary points and key takeaways from discussion}
{Check if note taker needs any clarification}
CLOSURE SCRIPT: Thank you very much for your time and willingness to share your experiences with us today. We will include your comments in our data to describe how health can be improved for residents in your community. Please remember, your name will not be connected to any of the comments you made today. Please let us know if you have any questions or concerns about this.

Listening Session Questions

1. Name of the organization you represent.

2. What region/county/counties do your organization provide direct services to? (select all that apply)
    a. Dallas County
    b. Rockwall County
    c. Collin County
    d. Parker County
    e. Denton County
    f. Wise County
    g. Collin County
    h. Ellis County
    i. Erath County
    j. Henderson County
    k. Johnson County
    l. Kaufman County

3. In 2019, Texas Health Resources (THR) identified behavioral health, chronic disease prevention and management, access, awareness, health literacy and navigation as its priority areas. Are you aware of any THR programs, initiatives, resources, specifically addressing any of these priorities in your community?

4. What is THR doing well within the behavioral health, chronic disease prevention and management, access, health literacy and navigation areas? Feel free to address one or all priorities.

5. What are areas of opportunity within these priority areas? Feel free to address one or all priorities.

6. What can THR do to improve the awareness of its Community Health Needs Assessment (CHNA) findings and implementation strategies?

7. Texas Health Resources is currently developing its 2022 CHNA reports and have identified these preliminary issues for the following regions:

Southern Region
Healthcare Access & Quality (lack of/limited insurance, delay in care)

Mental Health (depression, anxiety, isolation)
Abuse/Violence (domestic violence, child abuse, intimate partner violence)
Substance Abuse (isolation leading to increased substance use and addiction)

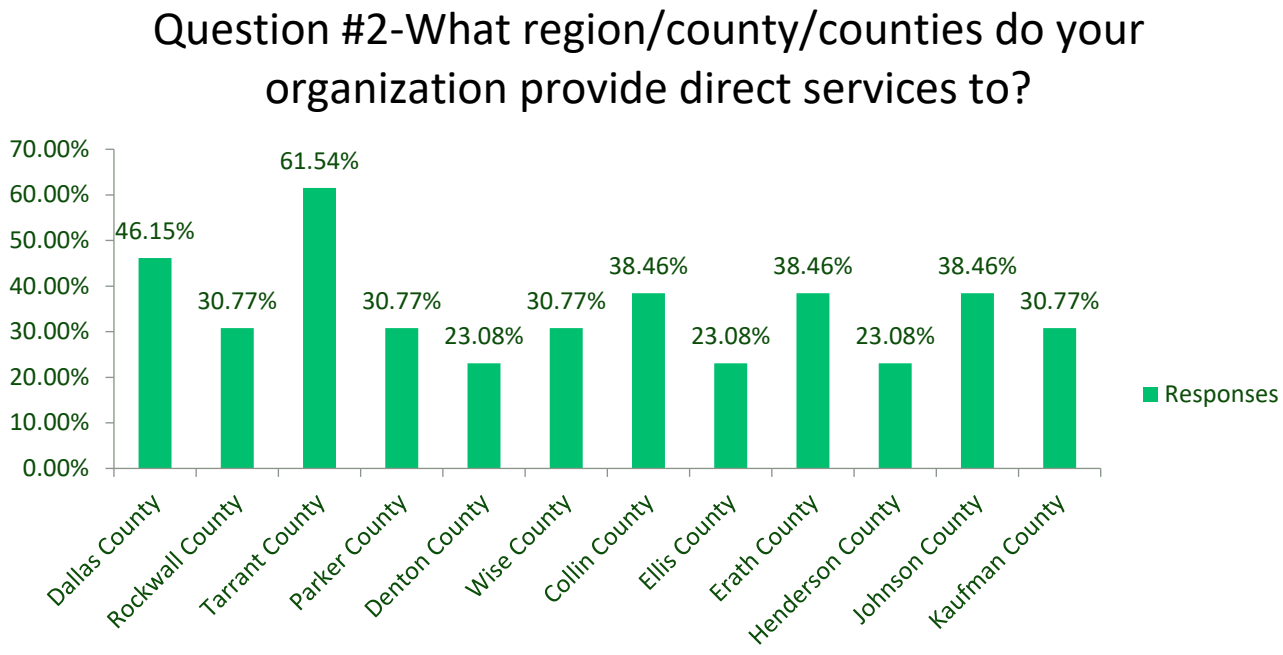
Denton/Wise Region-
Mental Health (increased need for adolescents, anxiety, lack of behavioral health services)
Access to healthcare services (Provider shortages, language barriers, uninsured/underinsured)
COVID-19 Impact (mental health, trust in healthcare system, delay in services)
Food insecurity (lack of food, access to healthy foods, food deserts)

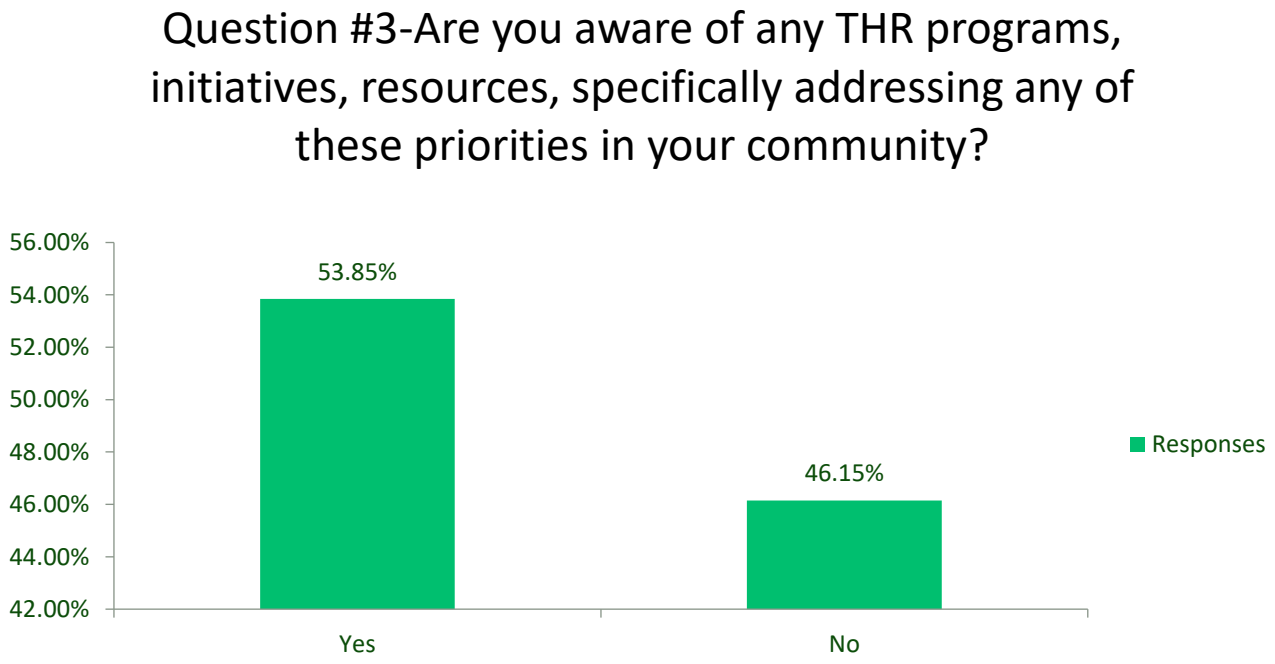
Tarrant/Parker Region-
Chronic conditions (heart disease, diabetes)
COVID-19 Impact (Mental Health/Substance abuse, isolation, financial issues, delay in care, food insecurity)
Health Behaviors (fear, stigma towards vaccine)
Healthcare Access & Quality (Lack of providers, lack of bilingual providers, uninsured/underinsured)

Dallas/Rockwall Region-
Access to care (delay in care, uninsured, underinsured)
Mental Health (isolation, depression exacerbated by COVID-19)
Financial/Economic impact (unemployment, housing insecurity)
Food insecurity (lack of healthy foods, lack of food)

Collin Region-
Access to care (delay in services, high deductibles, affordability of insurance, knowledge of where to get care)
Mental Health (stigma in accessing care, cultural barriers, anxiety)
Economic/financial issues (difficulty paying rent/utilities, unemployment, loss of jobs)
Housing (lack of affordable housing, discrimination)

7a. How can THR prioritize these health topics that have surfaced as issues in the region?


Question #2-What region/county/counties do your organization provide direct services to?
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
46.15%
30.77%
61.54%
30.77%
23.08%
30.77%
38.46%
23.08%
38.46%
23.08%
38.46%
30.77%
Dallas County
Rockwall County
Tarrant County
Parker County
Denton County
Wise County
Collin County
Ellis County
Erath County
Henderson County
Johnson County
Kaufman County
Responses


Question #3-Are you aware of any THR programs, initiatives, resources, specifically addressing any of these priorities in your community?
56.00%
54.00%
52.00%
50.00%
48.00%
46.00%
44.00%
42.00%
53.85%
46.15%
Yes
No
Responses

Question #4-What is THR doing well within the behavioral health, chronic health, chronic disease prevention & management, access, health literacy, and navigation areas?

- While there is some generalize awareness of THR efforts, there is not sufficient publicity of these efforts to elicit significant engagement from the public.

-I navigate the Plano Up program funded by THR focusing on anxiety and depression in youth in the 75074 zip. Beyond Blue is another program funded by THR to address mental health in the senior population in the 75069 zip

- The Community Impact program and its regional councils are a great model to impact health priorities.

- It's hard to say due to the Pandemic really. THR has been sending email and reminders to people to do their screenings, testing and seeing their Dr, even telemedicine

- Their willingness to fund organizations that promote access and health literacy is awesome.

- Excellent work with chronic disease prevention and management. Also, good initiative with mental health in rural areas. Doing a good job of bringing these topics, education, and interventions to the people and communities THR serves.

- THR's Community Impact team has done a great job at leveraging relations with community leaders, nonprofits, thought leaders to strengthen efforts to improve health outcomes that are negatively impacted by the social determinants of health. They are also using data to drive their decision and to measure positive improvements in the areas of exercise, health and chronic disease prevention.

- Connect deeper to faith-based organizations, and schools where the under-resource families are nearest and partner with other foundations to strengthen the ability to sustain efforts.

Q5- Are there areas of opportunity within these priority areas? Feel free to address

-Behavioral health partnerships between THR, JPS, and the City of Arlington would be good way to have a meaningful impact on this issue. A formalized partnership with COA/Fire PH unit, Mission Arlington, School Districts, UTA school of Nursing and Social Work, JPS, TCPH and MCA could result in a cost effective and impactful approach to many of these issues.

- I feel mental health is still a large concern. However, I feel healthcare is out of reach for many people even for those with the ability to pay. Living expenses have increased to the point where many people cannot afford to maintain their physical or mental well-being

- There are many opportunities to impact health outcomes - particularly chronic disease- through increased awareness and support of patients affected by memory decline. This can include those at risk for cognitive decline (diverse communities are at higher risk, as are those

who have comorbidities) and create opportunities for early detection—also, outcomes related to caregiver health.

- With the start of the Pandemic in March 2020, people have not seen their health care providers as they should, thus causing now two years later, many, many additional medical problems.

- Behavioral health is an awesome place to start. We need to train paraprofessionals to go into the neighborhood.

- Health literacy training for health care and service providers would enhance THR's current efforts within chronic disease management.

Question 6- What can THR do to improve the awareness of its Community Health Needs Assessment findings and implementation strategies?

-Partner directly with the City of Arlington Office of Communications

-Present to city and nonprofits the results of the assessment. Many citizens have no idea of the health status of our city.

- More programs focused on prevention and mobile solutions. We have to realize that many people cannot get to appointments even with coverage. Housing, food and transportation costs

- Increasing channels of communication, implementing practical action steps and a starting point for those needing the services, enhanced relationship building with community partners.

- Send them to community orgs as well as posting on their website. If both of these were done, I would recommend a way to ensure that all orgs doing any social service-related work get notified of the CHNA and implementation plan.

- Work directly with Community-Based Organizations (CBOs) , such as the Alzheimer's Association or Area Agency on Aging, to promote these results and how a partnership with the CBO will impact the health outcomes. Continue to provide grants to CBOs to ensure that community support continues for all those in need.

- Perhaps THR can advertise the CHNA can run local ads on television and radio.

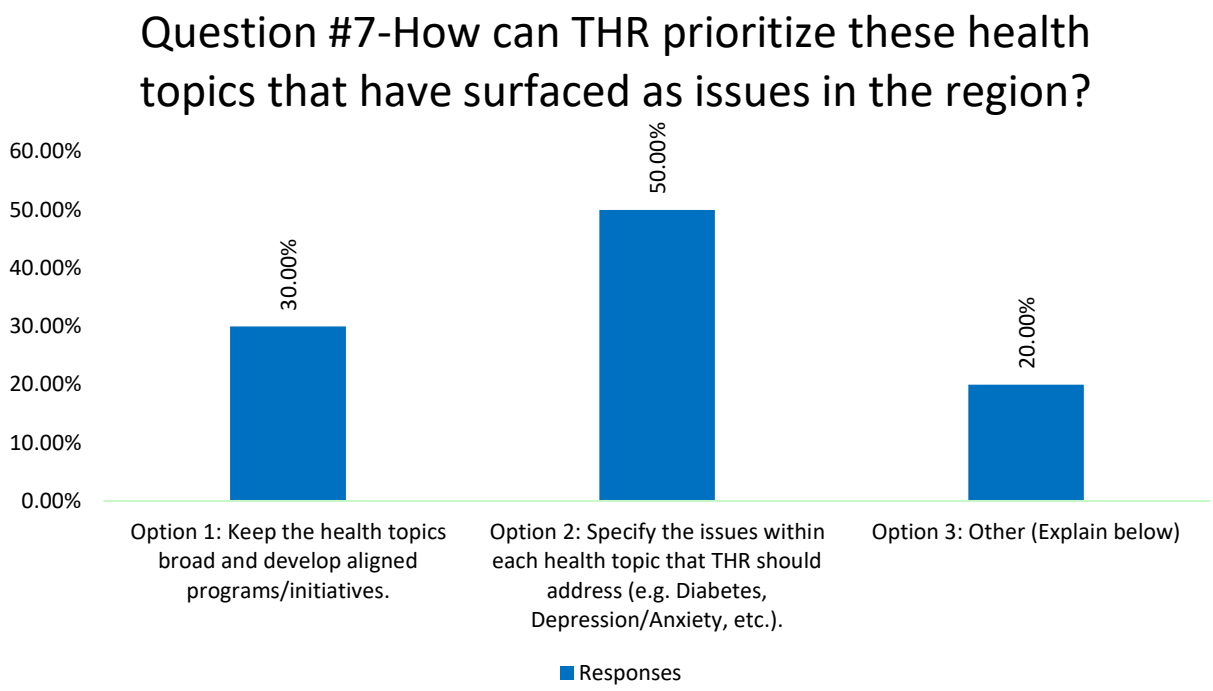
- As we emerge from the Pandemic, continue to reach those who are not connected by smart phones and emails

- A spot on the major networks or continuous radio spots would help.

- Personally, I think that THR does a great job of disseminating CHNA findings. They and Cook are regional leaders in that work. I'm not sure if THR already works closely with rural Extension

services to disseminate findings and implement programming. If not, that may be another avenue. Also, engaging FQHC's in CHNA implementation strategies is important.

- Take the information out to the community who are impacted the most. (Churches, Schools, Stores, barbershops, beauty shops and perhaps convenience store.



Appendix C. Community Resource and Partner List

This highlights existing resources that organizations are currently using and available widely in the community. It also highlights community partners who were involved during the collection process for this CHNA.

Community Resource List

- Area Agency on Aging
- Beyond Blue Grant
- Branch Baptist Church
- Carevide Farmersville Family Medical Center
- City on a Hill
- Collin County Assistance Center
- Collin County Mental Health Mental Retardation Center
- Community Health Impact Leadership Council for Collin County: Beyond Blue Grant
- Community Lifeline Center
- CoServ Electric
- Douglas Community Clinic
- Food for Kids Initiative
- Hillcrest Animal Rescue to provide dog/cat food to food banks
- Julia's Center
- Life Path
- North Texas Food Bank
- One Month Away Programs
- Plano UP Program
- Serve Denton
- The Hope Clinic of McKinney
- TXU Energy Foundation
- United Methodist Church runs through Farmersville Outreach Alliance
- VFW programs
- 211

Community Partner List

- Branch Baptist Church
- Collin County Mental Health Mental Retardation Center
- Community Lifeline Center