DALLAS COUNTY 2025 COMMUNITY HEALTH NEEDS ASSESSMENT

Executive Summary

This executive summary represents the findings of the joint 2025 Community Health Needs Assessment (CHNA) report led by Parkland Health (Parkland) and Dallas County Health and Human Services (DCHHS). The summary highlights the region's most pressing health challenges and identifies opportunities for meaningful action. Communities in the southeastern sector of Dallas County, along with Black or African American, non-Hispanic and Hispanic residents continue to experience the highest burden of disease and mortality.

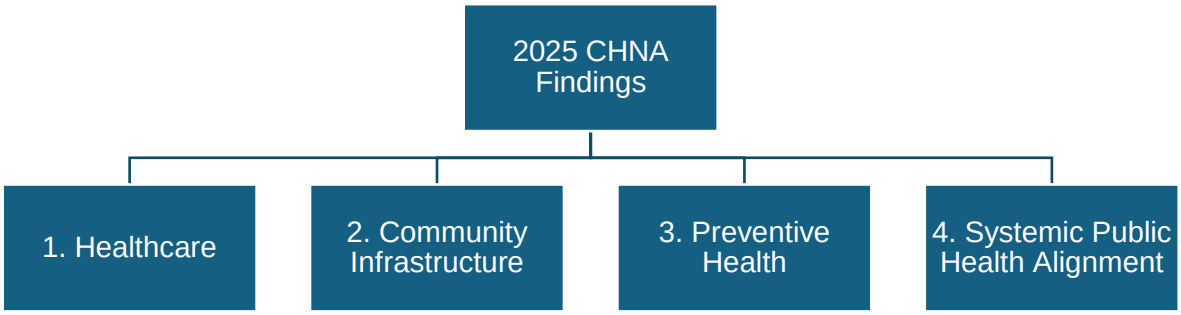
Using a triangulation methodology, key findings were prioritized by order of importance, based on topics that emerged most prominently from community input, coupled with quantitative data that highlighted health indicators with high rates of morbidity and mortality, further guiding the prioritization process.

Key findings are grouped into four priority areas, as shown in Findings Figure 1:

1. Healthcare
2. Community Infrastructure
3. Preventive Health
4. Systemic Public Health Alignment

For each of these priorities, a description of the underlying issues follows below to provide context and support informed decision-making.

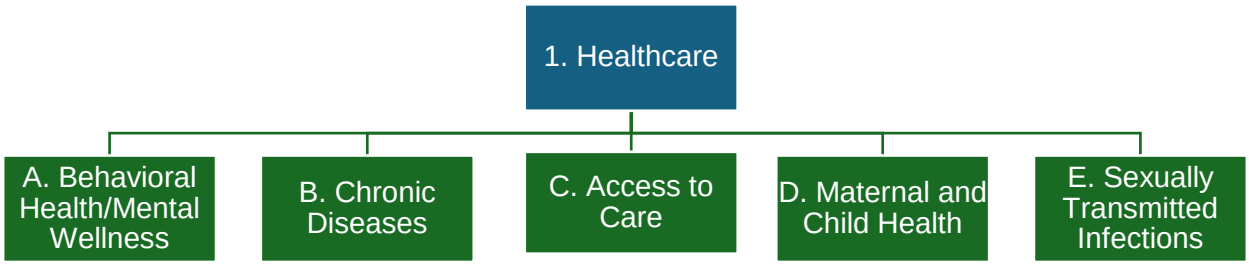
Findings Figure 1: 2025 CHNA Key Priorities



Key Priority 1: Healthcare

This Key Priority is organized into five categories that highlight critical health issues requiring focused interventions, as well as key aspects of public health, healthcare and service delivery that need attention. These categories help frame the most pressing health challenges in Dallas County and guide targeted strategies for improvement-see Findings Figure 1.

Findings Figure 2: Key Priority 1, Healthcare



A. Behavioral Health & Mental Wellness

Behavioral health and mental wellness emerged as the top priority in Dallas County—not only due to the worsening of mental health outcomes but also because community members themselves consistently recognized and voiced the urgent need to address this issue. Public health data shows an increase in the number of individuals reporting poor mental health in the previous 14 days—from 10% in the previous CHNA to 14.4% in the current cycle. Additionally, 60% of ZIP Codes in Dallas County experienced an increase in the rate of residents reporting poor mental health. This surge in mental health concerns is compounded by a 99% increase in drug overdose deaths between 2016 and 2023, underscoring the urgent need for integrated behavioral health services and community-based interventions.

Community input emphasized a strong call for more accessible, culturally responsive mental healthcare, within reach of their neighborhoods as well as better coordination among healthcare providers, social services, and community organizations.

B. Chronic Diseases

Chronic diseases remain the leading cause of mortality and morbidity in Dallas County, consistently ranking as the top health concern across multiple CHNA cycles. Since 2020, heart disease and cancer have remained the first and second leading causes of death, respectively, underscoring the long-term burden these conditions place on individuals, families, communities and the healthcare system. Furthermore, diabetes mellitus also remains a significant concern. Between 2018 and 2019, Dallas County experienced a rise in diabetes-related mortality from 18.4 to 22.7 deaths per 100,000 residents, peaking at 27.6 in 2022 due to the exacerbating effects of the COVID-19 pandemic. Although rates have since declined, they remain above pre-pandemic levels.

Geographically, the southeastern sector of Dallas County bears a disproportionate burden of chronic disease, particularly among Black or African American, non-Hispanics, and Hispanic populations. Encouragingly, four ZIP Codes 75247, 75215, 75216, and 75241—have shown improvement in diabetes-related indicators. Notably, the last three ZIP Codes have a long-

standing history of being identified as areas with high vulnerability to chronic diseases. These communities have been the focus of targeted interventions outlined in the CHNA Implementation Plans. Their progress highlights the potential impact of sustained, place-based strategies in addressing chronic disease disparities.

Among children, pediatric asthma ranks among the top five causes of hospital admissions, highlighting the need for improved environmental health and access to preventive care. For adults, chronic diseases such as diabetes, cancer, and cardiovascular conditions continue to dominate mortality statistics.

C. Access to Care

Access to care emerged as a key concern across all community input channels, with residents consistently identifying it as a critical barrier to improving health outcomes in Dallas County. Among the five dimensions of access to care, the community emphasized acceptability, and availability as the most important factors.

Acceptability was identified as the leading factor influencing the selection and use of healthcare services. It plays a critical role in either encouraging or discouraging individuals from seeking care. Community members stressed the importance of care that aligns with their cultural values, social norms, and personal preferences. Feeling understood and respected by healthcare providers and healthcare workers is seen as the first step in building trust, which is essential for sustained patient engagement and positive health outcomes.

Availability of services and providers emerged as the second most cited factor influencing whether community members access or use health related services. Residents emphasized the importance of having sufficient services located within their own neighborhoods accessible via public transportation. They also advocated for leveraging trusted community-based organizations—such as churches—as partners in care delivery. Participants specifically called for more primary care physicians and better access to healthcare technology.

Community members expressed a clear interest in having healthcare services located closer to home. Proximity was a recurring theme, with residents emphasizing the importance of services being reachable within their neighborhoods and via public transportation. The top services identified as most needed include: 1) Emergency Room/Urgent Care, 2) Specialty Care, 3) Parkland, 4) Pediatrics, and 5) Geriatric.

D. Maternal and Child Health

In Texas, approximately four out of five pregnancy-related complications or deaths are preventable, highlighting a critical opportunity for intervention and system-level improvement. Most maternal deaths occur between 61 days and one year postpartum; a period often marked by limited access to follow-up care and behavioral health support.

Black or African American women face the highest risk of maternal mortality. These disparities underscore the urgent need for targeted strategies that extend care beyond delivery, prioritize postpartum support, and address the non-medical drivers of health (NMDOH) that disproportionately affect communities of color.

E. Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV)

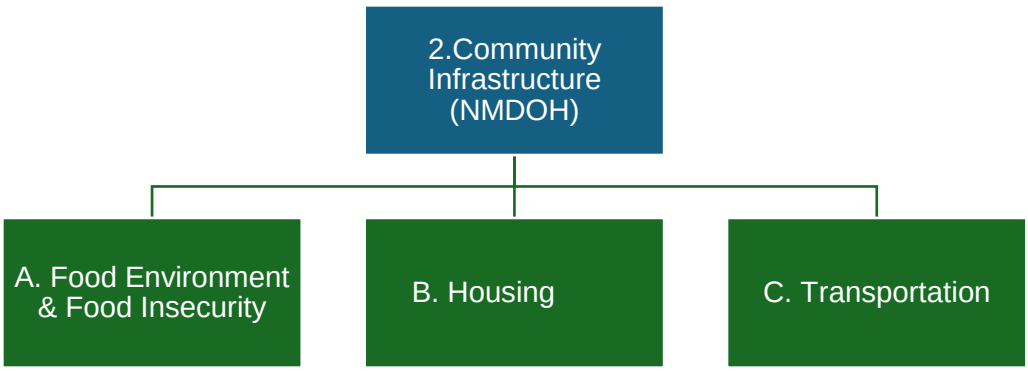
Chlamydia remains the most reported STI in the county, followed by gonorrhea. Recent data show a decline in reported cases for both infections. This trend is likely associated with ongoing public health efforts focused on education, screening, and treatment access. However, disparities persist among Black or African American, non-Hispanic residents, who account for 34% of all chlamydia diagnoses and 42% of all gonorrhea cases—highlighting the continued need for culturally responsive outreach and care.

Dallas County continues to carry the second highest HIV case burden in Texas, following Harris County. The age group with the highest number of new HIV diagnoses remains 25 to 34 years old (39%), while youth aged 15 to 24 account for approximately 18 to 20% of new cases, making them another group of concern for targeted prevention and education efforts.

Key Priority 2: Community Infrastructure

The built environment—often referred to by community members as community infrastructure—was identified as a key priority area. This focus emphasizes the foundational role of infrastructure in shaping health outcomes, particularly through access to basic services and supports that are considered NMDOH. Strengthening these elements enhances the community's capacity to achieve better health outcomes and fosters environments where health and wellness can thrive.

Findings Figure 3: Key Priority 2, Community Infrastructure



Throughout the CHNA process, community members consistently identified **food environment and food insecurity, housing, and transportation** as the three critical infrastructure needs to support a healthy community. These foundational components directly influence access to care, chronic disease management, and overall well-being.

The lack of reliable access to nutritious food, stable housing, and safe, affordable transportation places a significant strain on communities with high CVI scores, particularly in the southeastern sector of Dallas County. Residents in these areas face compounded challenges that limit their ability to engage with healthcare services, maintain continuity of care, and pursue healthier lifestyles. The CVI is a composite score based on 26 clinical and socioeconomic indicators,

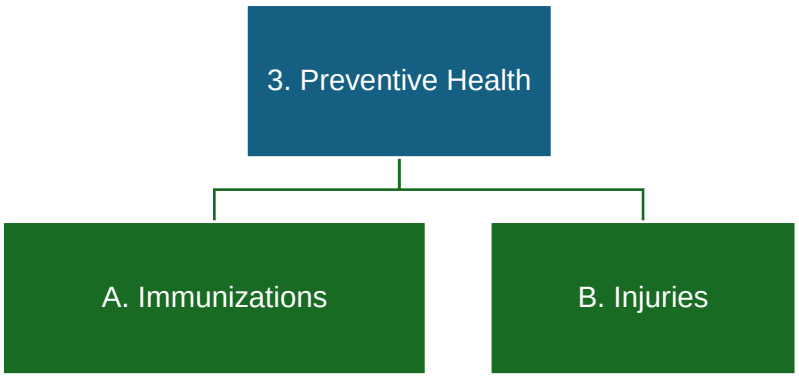
analyzed at the ZIP Code and census tract levels. It is designed to identify communities facing the greatest health and NMDOH needs.

Addressing these infrastructure gaps is essential to advancing health equity and improving outcomes. Community input strongly supports cross-sector collaboration to invest in solutions that are locally responsive, sustainable, and rooted in the lived experiences of those most affected.

Key Priority 3: Preventive Health

Key Priority 3 emphasizes prevention as a cornerstone of a healthy community, focusing on opportunities to reduce the risk of illness and promote long-term well-being. By addressing health concerns early and supporting healthy behaviors, prevention efforts help reduce disparities and improve outcomes across Dallas County.

Findings Figure 4: Key Priority 3. Preventive Health



A. Immunizations

Access to vaccinations remains a significant concern in North Texas, particularly in Dallas County. Dallas County reports lower childhood vaccination rates compared to surrounding counties including Ellis, Kaufman, and Tarrant. This disparity raises concerns about long-term health outcomes and community resilience against preventable diseases.

In addition, recent shifts in public health policies and vaccine distribution may have lasting impacts especially among populations with historically low vaccination rates. These include Black or African American, non-Hispanic, and white non-Hispanic residents.

B. Injuries

Unintentional Injuries are the third leading cause of death in Dallas County, with motor vehicle crashes representing a significant portion of emergency department visits. Between 2020 and 2024, the county recorded more than 389,000 emergency department visits related to motor vehicle crashes. Notably, females consistently accounted for a larger share of visits than males, and adults aged 25 to 49 experienced the highest number of visits among all age groups. Contributing behaviors such as speeding, and alcohol use remain consistent risks factors.

Firearm-related death rates in Dallas County continue to exceed both Texas and national averages. These deaths reflect broader concerns around community safety, mental health, and

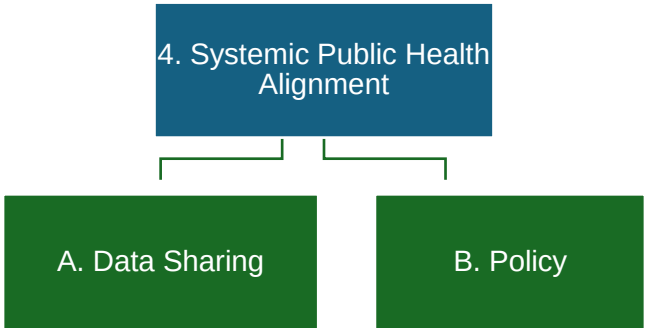
access to firearms, and they disproportionately affect certain neighborhoods and demographic groups.

Together, these trends highlight the urgent need for targeted prevention strategies, and cross-sector collaboration to reduce injury-related mortality and improve safety across the county.

Key Priority 4: Systemic Public Health Alignment

Advancing community health requires intentional alignment—not only across sectors such as housing, transportation, education, and economic development—but also within the public health system itself. Greater coordination among public health agencies, healthcare providers, and community-based organizations is essential to ensure that policies, programs, data sharing and resources are working together effectively to address the complex and interconnected drivers of health.

Findings Figure 5: Key Priority 4, Systemic Public Health Alignment



A. Data Sharing

The CHNA process highlighted the importance of timely and transparent data sharing at both the community level and across sectors. Stakeholders stressed that access to localized data enables better planning, resource alignment, and accountability. Cross-sector data sharing—among healthcare, public health, education, housing, and transportation—was identified as a key strategy to support coordinated action and responsive service delivery.

B. Public Policy Alignment

Community input emphasized the importance of coordinating public policies across sectors such as public health, housing, and transportation to effectively address health disparities. Embedding public health in cross-sector policy discussions will ensure that community well-being is a shared priority.

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List of Acronyms

Acronym	Definition
ACT	Asthma Control Test
ADHD	Attention-Deficit/Hyperactivity Disorder
AHR	American Health Ranking
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
C-ACT	Childhood Asthma Control Test
CCBHC	Certified Community Behavioral Health Clinic
CCP	Charity Care Program
CDC	Centers for Disease Control and Prevention
CDPD	Chronic Disease Prevention Division
CEAP	Comprehensive Energy Assistance Program
CHNA	Community Health Needs Assessment
CHR&R	County Health Rankings & Roadmaps
COPC	Community Oriented Primary Care
COPD	Chronic Obstructive Pulmonary Disease
CSE	Comprehensive Sexuality Education
CVC	Community Vulnerability Compass
CVI	Community Vulnerability Index
DCCDRT	Dallas County Child Death Review Team
DCHHS	Dallas County Health and Human Services
DFWHC	Dallas-Fort Worth Hospital Council
DPP	Diabetes Prevention Program
DSHS	Department of State Health Services
ED	Emergency Department
EHE	Ending the HIV Epidemic
eMCAP	extending Maternal Care After Pregnancy
EMR	Electronic Medical Record
ESSENCE	Electronic Surveillance System for the Early Notification of Community-based Epidemics
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HIV	Human Immunodeficiency Virus
HOMES	Homeless Outreach Medical Services
HPV	Human Papillomavirus
HRSA	Health Resources and Services Administration
IVP	Intimate Partner Violence
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual or Ally, and other identities not explicitly listed
MCV	Meningococcal Conjugate Vaccine

Acronym	Definition
MMMRC	Maternal Mortality and Morbidity Review Committee
MMR	Maternal Mortality Ratio
MMR vaccine	Measles, Mumps, and Rubella
MSM	Men having sex with men
NMDOH	Non-Medical Drivers of Health
NTBHA	North Texas Behavioral Health Authority
NTFB	North Texas Food Bank
OASP	Older Adult Services Program
Parkland	Parkland Health
PCCI	Parkland Center for Clinical Innovation
SDOH	Social Determinants of Health
SMM	Severe maternal morbidity
SOGI	Sexual Orientation and Gender Identity
STIs	Sexually Transmitted Infections
SUDs	Substance Use Disorders
TB	Tuberculosis
Td	Tetanus and Diphtheria
Tdap	Tetanus, Diphtheria, and Pertussis
TX	Texas
U.S.	United States
UDS	Uniform Data System
USDA	United States Department of Agriculture
UTSW	University of Texas Southwestern Medical Center
YTD	Year to Date

I. INTRODUCTION

Parkland and DCHHS remain steadfast in their commitment to improving the health and well-being of all residents in Dallas County. This 2025 CHNA report builds on the foundation of previous assessments, particularly the 2022 report, and reflects the continued effort to understand the evolving health needs of the community, address gaps in morbidity and mortality, and allocate resources to create healthier communities.

Since the release of the 2022 CHNA report, considerable work has been undertaken across Dallas County to address the key health priorities identified at that time, including access to care, chronic disease management, behavioral health, maternal and child health, sexual health, and others. These efforts were made possible through the collaboration of health partners, community-based organizations, local government, school districts, and grassroots leaders.

The 2025 CHNA report reflects not only updated data and emerging trends but also the invaluable voices of community members who generously shared their lived experiences through surveys, focus groups, and direct input. We are deeply grateful to the residents and partners whose insights and perspectives shaped this report and guided its recommendations. We especially acknowledge the heartfelt messages from community partners who expressed appreciation for being included in the planning process and affirmed the importance of community-centered collaboration.

This report emphasizes equity, community engagement, and a data-driven strategy focused on addressing the root causes of health gaps across the county while promoting systems-level change that is both sustainable and community-informed.

As Dallas County continues to grow and evolve, Parkland and DCHHS remain committed to data-informed action, meaningful community partnerships, and shared accountability. With this 2025 CHNA, both organizations reaffirm their dedication to listening deeply, collaborating effectively, taking responsibility, and providing transparent action. This assessment not only lays the foundation for the next three-year implementation plan—it also reflects a collective vision for a healthier, more equitable Dallas County, where every person, regardless of ZIP Code, income, or background, can thrive.

Parkland Overview

Since its founding in 1894, Parkland has served the Dallas County community with commitment and innovation. Now one of the largest public hospital systems in the nation, Parkland provides more than 70,000 hospital discharges and 1.2 million outpatient visits annually. Premier services include the Level I Rees-Jones Trauma Center, the only burn center in North Texas verified for adult and pediatric patients by the American Burn Association and the American College of Surgeons Committee on Trauma and a Level III Neonatal Intensive Care Unit. The system also includes a network of 30 community-based clinics and numerous outreach and education programs. Parkland is the largest teaching hospital for The University of Texas Southwestern Medical Center (UTSW).

As a leader in community-based healthcare, Parkland pioneered the COPC model in 1987, now operating 16 primary care clinics, a school-based clinic, and mobile medical vans to deliver pediatric and adult preventive, urgent, and behavioral healthcare across Dallas County. These efforts help reduce emergency department visits by providing patients with consistent, accessible care close to home.

Parkland's network also includes specialized outreach for vulnerable populations through its HOMES program and healthcare for inmates in the Dallas County Jail System and Dallas County Juvenile Department.

Building on its 131-year legacy of community-centered service, Parkland continues to evolve in response to the needs of Dallas County residents. Most recently, guided by community input, Parkland launched Access to Care & Coverage hubs in collaboration with local organizations. These hubs are designed to expand access points to health screenings, health monitoring, health education, and linkage to primary care.

Parkland enriches the health and wellness of the communities it serves by prioritizing compassionate care, expanding access, and promoting health equity in Dallas County.

For more information, visit www.parklandhealth.org.

DCHHS Overview

DCHHS is a nationally accredited public health department that serves all of Dallas County—home to more than 2.6 million people. Since it was first established in 1872, DCHHS has worked to improve the health and well-being of the entire community. Over the past 150+ years, the department has grown and changed to meet the needs of the people it serves. The department is comprised of dedicated professionals from various disciplines, including public health and social services specialists, epidemiologists, nurses, environmental health experts, and community health workers. DCHHS manages an annual budget of more than $300 million and employs nearly 650 highly skilled and diverse public health and social service staff members. Today, DCHHS provides many important public health and social services to protect health and improve quality of life.

Our mission at DCHHS is to protect and improve the health of everyone in Dallas County. We achieve this by working closely with our community partners, preventing and controlling diseases, promoting healthy environments, understanding community needs, providing education, making policies, and offering a wide range of clinical, public health, and social services. Our focus is to help those who face the greatest barriers to good health while ensuring we use the best science to guide our work.

DCHHS leads the public health response to local health emergencies and disease outbreaks, such as the recent measles threat, Mpox, and the COVID-19 pandemic, as well as past threats

like Ebola, H1N1, West Nile virus, and Zika virus. In addition to responding to emergencies, we also help prepare the region for natural disasters, bioterrorism, and other health threats. DCHHS also serves as the community's Chief Health Strategist for various ongoing public health topics including HIV, STI, immunizations, and opioids. Our goal is to make sure every person in Dallas County has access to the public health and social service support they need to live a healthy life.

For more information visit https://www.dallascounty.org/departments/dchhs/.

II. PURPOSE OF THE CHNA

The mission of the Dallas County CHNA is to advance the health of Dallas County residents. Core to this mission is community member input and multisector collaboration.

The CHNA is a critical instrument for identifying and addressing the health needs of Dallas County residents. By fulfilling federal requirements as set forth by 501(r)(3) of the Internal Revenue Code, adhering to public health standards, and engaging local stakeholders, the CHNA facilitates informed decision-making and strives for community health improvement across the county.

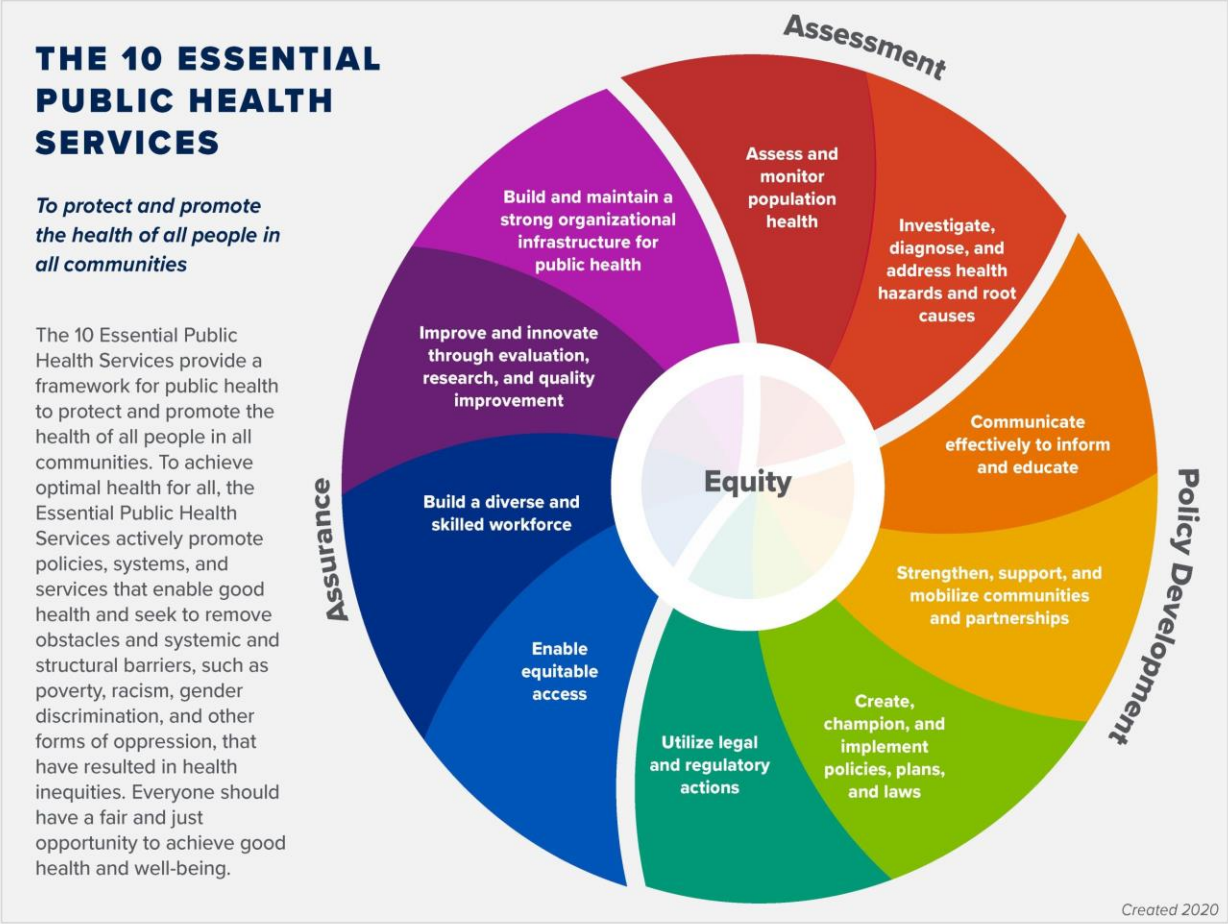
The CHNA is a comprehensive process conducted every three years to identify and analyze key health issues and needs within a defined community. It serves as the foundation for improving and promoting the health and well-being of populations, particularly those with higher morbidity and mortality rates.

This report illustrates the application of the public health principles described above by:

- Integrating data from hospitals, public health departments, academic institutions, and community organizations
- Engaging residents through surveys, focus groups, and listening sessions
- Identifying health disparities (e.g., chronic disease prevalence, mental health needs, gaps in community infrastructure and services), and
- Applying strategic planning using resource allocation and program development.

The Dallas CHNA also highlights the importance of advancing health equity, cross-sector collaboration, and transparent reporting to build trust and mobilize action.

CHNA Purpose Figure 1: Public Health Essential Services Framework



Adapted from CDC: https://www.cdc.gov/public-health-gateway/php/about/index.html

A. CHNA Methodology

The CHNA was developed using the Essential Public Health Services framework and in accordance with the framework for community health needs assessments. By adopting these nationally recognized models, Parkland and DCHHS ensured the assessment was grounded in evidence-based practices, promoted meaningful community engagement, and supported strategic planning to improve health outcomes.[1,2]

[1] Centers for Disease Control and Prevention. About the Public Health Gateway. Updated May 16, 2024. Accessed July 14, 2025. https://www.cdc.gov/public-health-gateway/php/about/index.html
[2] Centers for Disease Control and Prevention. Community Planning for Health Assessment: Frameworks & Tools. Updated May 16, 2024. Accessed July 14, 2025. https://www.cdc.gov/public-health-gateway/php/public-health-strategy/public-health-strategies-for-community-health-assessment-models-frameworks-tools.html
[3] Rutherford GW, McFarland W, Spindler H, et al. Public Health Triangulation: approach and application to synthesizing data to understand national and local HIV epidemics. BMC Public Health. 2010;10:447. doi:10.1186/1471-2458-10-447

CHNA Purpose Table 1: CHNA Framework

1. Reflect & Strategize

- Reviewed past assessment and identified opportunities for improvements and enhancments.
- Developed a project timeline based on the results of this assessment.

2. Identify & Engage Stakeholders

- Curated a comprehensive roster of more than 400 community partners and 600 representatives to engage in community input sessions and participation in the online survey.

3. Define the Community

- In accordance with the organizational charters and public health mandates of both Parkland and DCHHS, the report is focused exclusively on the geographic boundaries of Dallas County.

4. Collect and Analyze Data

- Quantitative and qualitative data were used to investigate health trends and health gaps in alignment with requirements to assess community health needs.

5. Prioritize Health Issues

- Health issues were prioritized using a public health triangulation approach, which involved synthesizing data from multiple sources to ensure a comprehensive and community-informed understanding of local health needs.[3]

6. Document Results

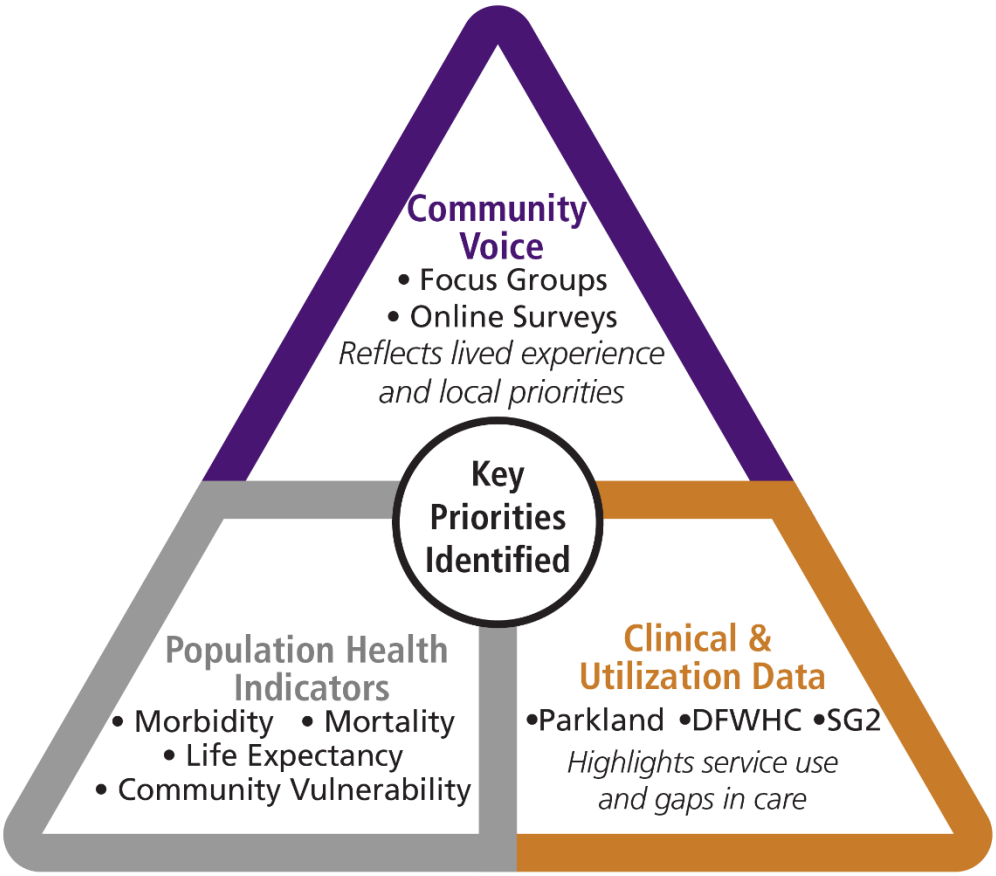
- The results of the assessment are summarized in an easy-to-read report designed for community members and stakeholders. This report was created to share key findings and is available both online and in printed form.

Data Sources:

1. Behavioral Risk Factors Surveillance System (BRFSS)
2. County Health Rankings and Roadmaps (CHRR)
3. Dallas County Health and Human Services Electronic Medical Records (EMR)
4. Dallas County Child Death Review Team
5. Dallas-Fort Worth Hospital Council Foundation (DFWHC)
6. DFWHC Healthy North Texas
7. HOMES Uniform Data System (UDS) Annual Report, 2016 – 2018
8. Health Resources and Services Administration (HRSA) Uniform Data Systems (UDS) Maps
9. Housing Forward
10. Parkland Center for Clinical Innovation (PCCI)
11. Parkland EMR
12. SG-2, LLC
13. Texas Department of State Health Services
14. United States (U.S.) Centers for Disease Control and Prevention (CDC)
15. U.S. Census Bureau
16. Texas Department of Transportation
17. Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE)
18. DCHHS Charity Care Program Patient Enrollment Data
19. DCHHS Older Adult Services Program (OASP) Client Data
20. DCHHS Housing Choice Voucher Client Data
21. DCHHS Comprehensive Energy Assistance Program (CEAP) Client Data

B. Findings Prioritization Process

A comprehensive data analysis and synthesis was completed to identify and prioritize the health needs of Dallas County communities. To ensure the rigor and reliability of this process, a data triangulation method was applied. This is a well-established public health methodology that synthesizes multiple data sources—such as surveys, focus groups, and existing health statistics. This integration of qualitative and quantitative data allows for a more comprehensive understanding of community health challenges and strengthens the validity of the finding. The key findings were prioritized by order of importance, based on topics that emerged most prominently from community input, coupled with quantitative data and morbidity and mortality, further guiding the prioritization process.



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III. COMMUNITY INPUT

To ensure community voices and health priorities were meaningfully represented in this report, Parkland and DCHHS conducted 36 focus groups, administered the Healthy Neighborhood Survey, and interviewed key faith-based leaders between February and June 2025. The focus group data was systematically coded and analyzed using Dedoose and NVivo, both of which are web-based text analytics platforms, allowing for the identification of recurring themes and insights. Together, the findings from these complementary data collection methods provide a comprehensive understanding of community needs and priorities, which are reflected in the results presented below. The findings were then visualized through graphs to display the most frequently discussed topics, ensuring a structured and comprehensive presentation of the community's input.

The purpose of the focus group questions is to gain community members' insights into their vision of a healthier community and to identify meaningful opportunities to achieve that vision:

A. Healthy Communities

- Local infrastructure and resources: Enhancing the physical and social environment to support healthy living.
- Healthcare delivery: Strengthening both preventive care and the management of chronic diseases to ensure comprehensive, accessible services.
- Access to care and community trust: Addressing barriers to care and fostering trust between community members and healthcare system.

B. Public Health Systemic Alignment

- Cross-sector collaboration and policy alignment: Understanding how policies influence partnerships across health, education, housing, and other sectors.
- Data sharing and integration: Identifying ways to improve the flow, accessibility, and use of data across organizations to support coordinated care and informed decision-making.

The results from the focus group discussions are presented using two types of visualizations:

- **Bar Graphs**: These display how frequently each category was mentioned across all sessions. The size of each bar reflects the number of times a topic was raised, highlighting the most commonly discussed issues.

  Tree Maps: These offer a visual breakdown of categories and subcategories based on mention frequency. The size of each section represents its relative importance, making it easy to identify dominant themes and understand their relationships.

Together, these visual tools provide a clear snapshot of participant feedback, helping translate community voices into actionable insights.

A. Healthy Communities

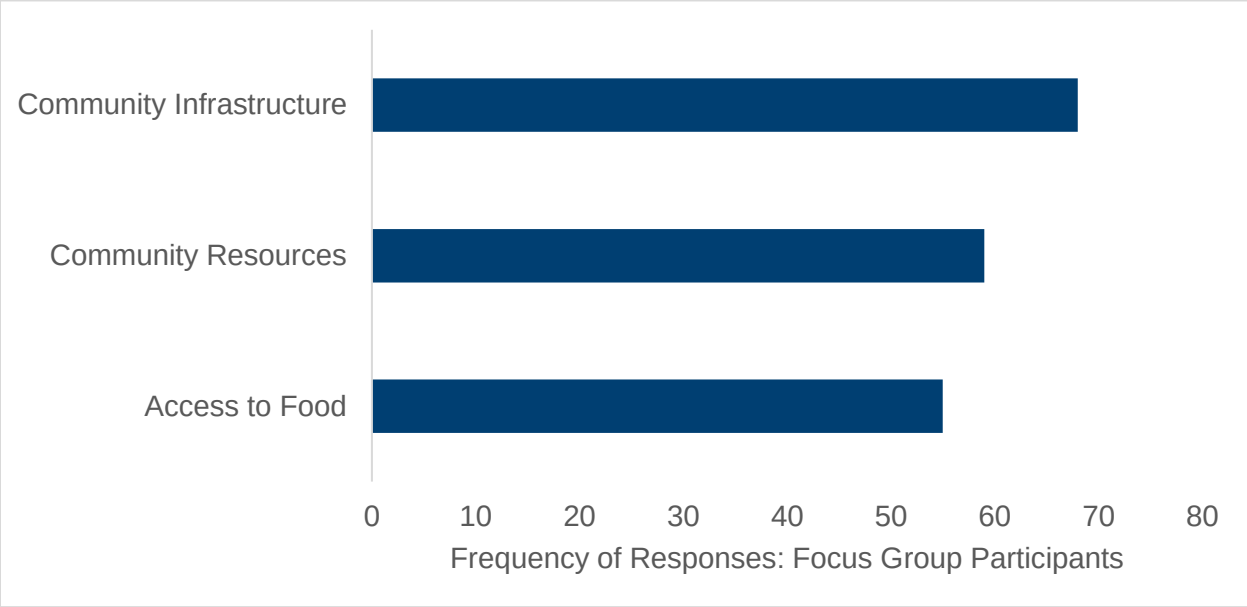
To understand how community members described the foundational pillars of a healthy community, focus group responses were categorized and analyzed based on established definitions of the factors that impact health. These factors, NMDOH, are discussed in greater detail in the corresponding section of this report. Through qualitative data analysis, two primary pillars emerged: community infrastructure and resources, and strengthening healthcare delivery. Each pillar is supported by three key building blocks community members identified, which are illustrated in Community Input Figure 1 and discussed in the sections that follow.

Community Input Figure 1: Healthy Community Foundational Structure

1. Community Infrastructure & Resources

This category emerged as one of the two pillars in the community members' vision of a healthy community. Their feedback emphasized the need for stronger infrastructure, enhanced resources, and access to food-see Community Input Figure 2.

Community Input Figure 2: Strengthening the Public Health System



a. Community Infrastructure

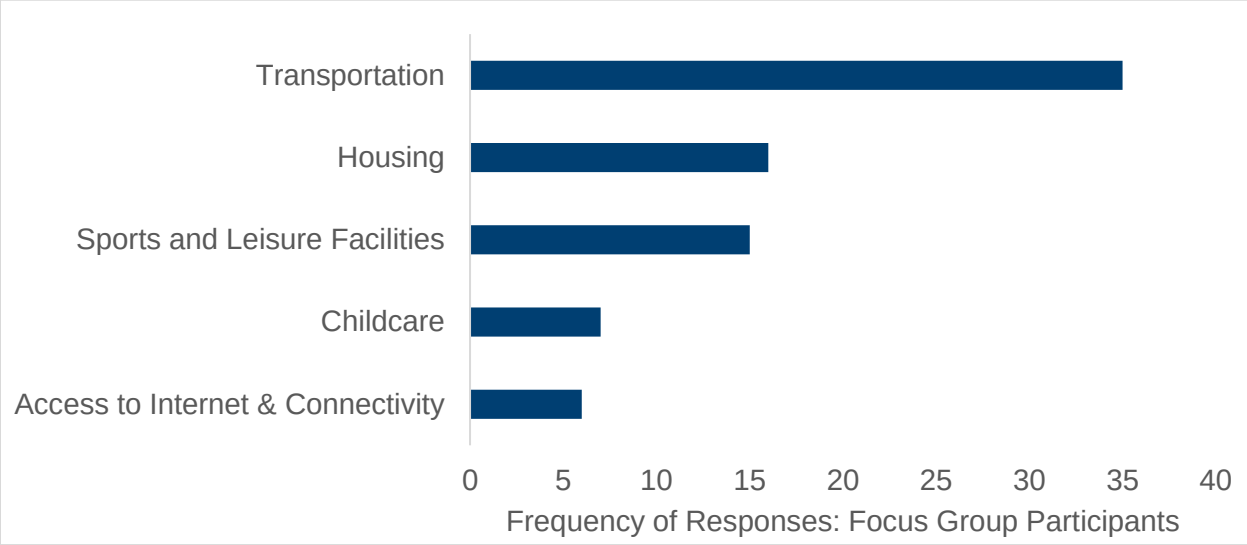
Community members emphasized the importance of strengthening the local transportation, housing, and childcare infrastructures as a key strategy for improving community health. Unsurprisingly, transportation emerged as a key priority. In addition, it was also cited as the primary barrier to accessing care. Housing ranked after transportation as an area that needs significant attention and was also identified as a top concern in the Healthy Neighborhood Survey. As a community partnered shared, in the 75210 ZIP Code—where the median household income is $15,258, significantly below the national average—families face severe affordability challenges. Most homes in the area were built in the 1940s or 1950s and now present serious environmental hazards. Housing instability directly affects health and educational outcomes, with only 25% of local students graduating from high school, perpetuating cycles of poverty. In response, cross-sector collaboration is addressing these challenges head-on through comprehensive housing rehabilitation efforts. Investments by the nonprofit Frazer Revitalization of approximately $85,000 per home—far exceeding typical $10,000 repair programs—ensure safe, healthy living conditions that support generational wealth-building. This work goes beyond physical structures: stable housing lays the foundation for children's academic success and seniors' dignified aging.[3]

Community members also identified sports and leisure facilities as a priority for improvement. Specific suggestions included enhancing or expanding access to the gyms, organized sports opportunities, parks and playgrounds, recreation and senior centers, sidewalks and walking trails. These responses, which existed across age groups, reflect a strong community interest in spaces that support physical activity, wellness, and social connection.

[3] Conner F. Statement from the CEO and President of Frazier Revitalization, Inc. [Unpublished statement]. Frazier Revitalization, Inc.; 2025

Childcare followed as the fourth priority— the inability to ascertain childcare often prevents participants from going to doctors' appointments. Although internet access and connectivity have generally improved across the county—as discussed later in the NMDOH section—they still present barriers and demonstrate that community infrastructure in Dallas County continues to require improvement-see Community Input Figure 3.

Community Input Figure 3: Community Infrastructure



b. Community Resources

Overall, the community emphasized the need to increase both the availability of and access to essential resources in their neighborhoods where people live and go about their daily lives. This need was expressed by a focus group participant who shared: ***"I am a parent who needs resources but if I don't have the transportation or money, it is very challenging!"***

To truly benefit from the resources available, community members believe that four essential elements must be addressed together: Availability, Awareness, Co-location and Multisector.

Image generated by AI

Without all four pieces in place, community members are left without the support they need.

Throughout the focus group discussions, community members consistently emphasized the need for greater access to and understanding of key resources. The most frequently mentioned included: transportation, housing, financial assistance, and health insurance or coverage.

c. Food Environment

Access to food—particularly healthy food—was a topic of intense and frequent discussion during the focus group sessions. As a result, it was identified as a key building block for a healthy community. This finding aligns with the Healthy Neighborhood Survey results, where participants selected access to food as the second most important factor needed to improve their neighborhood's health.

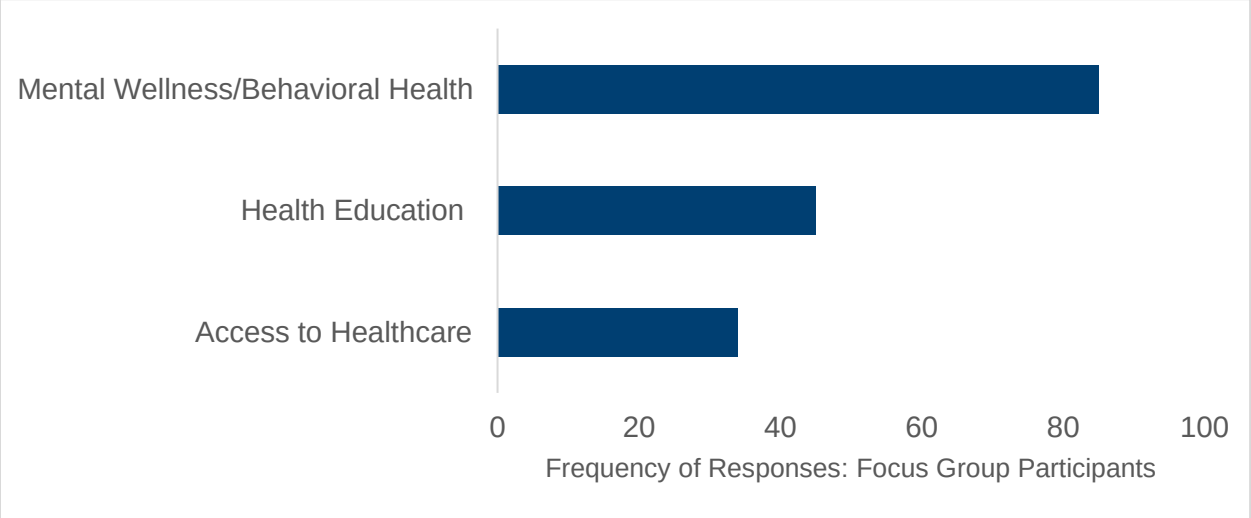
Focus group participants described several challenges, including the lack of grocery stores in their communities and the overabundance of fast food and highly processed options, with few, if any, healthy choices available. As one community member put it, ***"In my community we have fried chicken places. The food that is available to the community is killing us!"***

In addition to limited availability, participants highlighted transportation barriers that make it difficult to reach grocery stores. Many also shared that food insecurity is a persistent issue, with some families relying heavily on food pantries or food banks and having little control over the nutritional quality of the food they have access to.

2. Strengthening Healthcare Delivery

Community members emphasized that a strong and resilient public health system is essential to achieving a healthy community. Under this pillar, they identified three building blocks for improvement: **Mental Wellness/Behavioral Health** emerged as the primary factor, followed by **Health Education** and **Access to Healthcare**. These insights reflect the community's emphasis on emotional well-being, interest in expanding their health knowledge, as well as the ability to obtain care-see Community Input Figure 4.

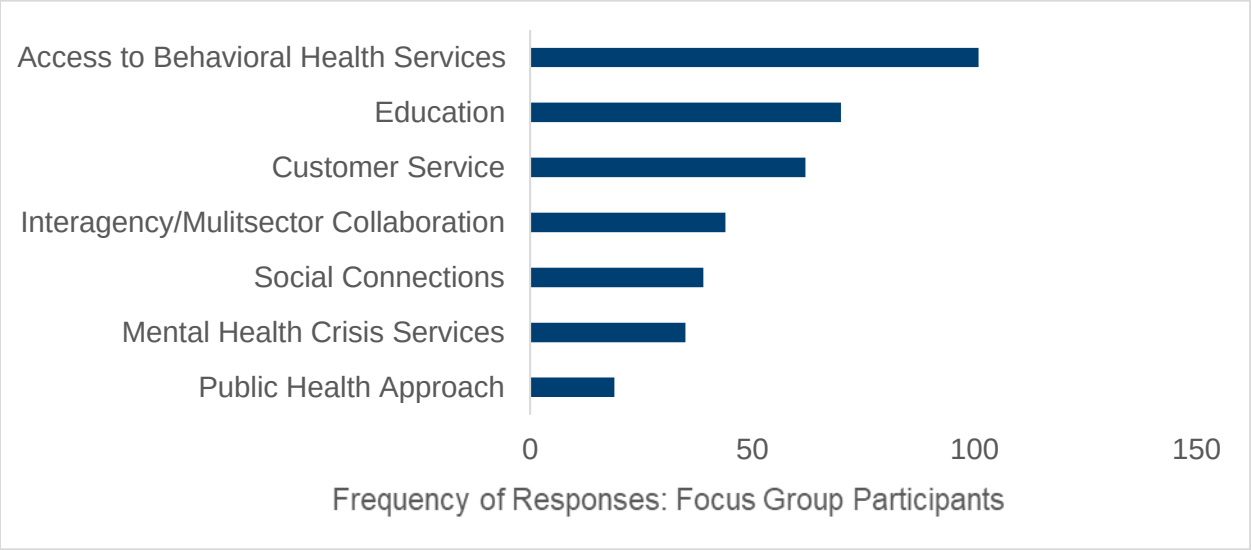
Community Input Figure 4: Strengthening Healthcare Delivery Building Blocks



a. Mental Wellness - Behavioral Health

Community members discussed the importance of enhancing the accessibility of behavioral health services, expanding mental wellness education to eliminate stigma, and the provision of high-quality customer service. Additionally, participants highlighted the need to strengthen cross-sector collaboration particularly among health insurance providers, clinics, healthcare providers, school districts, and schools to ensure more coordinated and effective support for community well-being-see Community Input Figure 5.

Community Input Figure 5: Mental Wellness and Behavioral Health



During the focus groups, community members voiced their concerns with the escalating mental health crisis in the community and the challenges of accessing services during a moment of crisis. As described by a mother, ***"My children were in crisis when my husband disappeared, and I was desperate. I couldn't find the help we needed. When I called for support, I was told the earliest available appointment was six months away. A friend who lives out of state, reached out to a priest she knew and asked him to help us."***

Community members emphasized the importance of adopting a public health approach to mental wellness and behavioral health; one that prioritizes prevention, early education, and the availability of resources within the community. They stressed the need to recognize and address mental health symptoms early, particularly among youth, to foster understanding and prevent long-term challenges.

b. Health Education

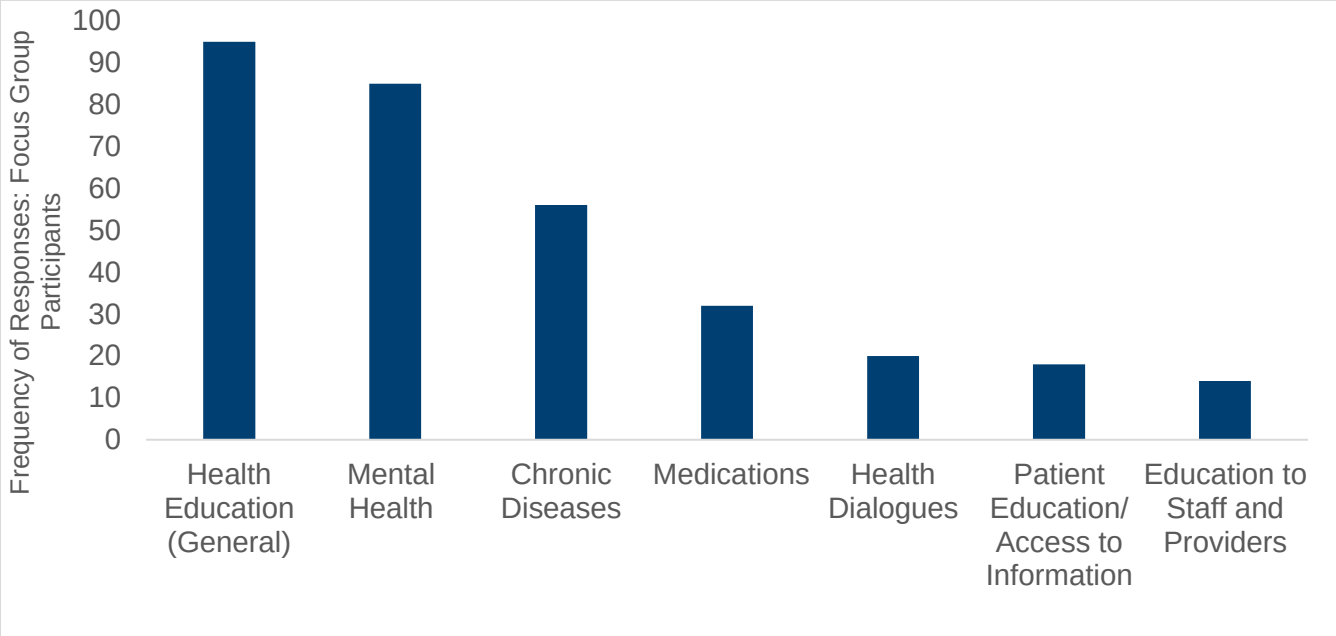
Overall, focus group participants expressed a strong desire to learn more about health-related topics. Among these, mental health education and management of complex diseases such as chronic disease, particularly diabetes, HIV, and vaccinations stood out. Moreover, community members are not only eager to learn about the disease, but also how to dispel the misconceptions associated with these diseases, as expressed by a focus group participant, ***"Education on what causes diabetes, lets people know what they can do to decrease diabetes. Education is most important."***

Interestingly, participants discussed a preference for “health dialogues”—informal, conversational approaches to learning about health—over traditional classroom-style education.

Another key theme that emerged from the data was the need to educate healthcare staff and providers on how to effectively engage and communicate with patients. Participants shared experiences of persistent stigma within medical settings, which negatively impacts their sense of safety.

These insights highlight the urgent need for training that addresses acceptability and promotes respectful, empathetic care. Community members stressed that feeling heard and valued is essential to building trust and encouraging continued engagement with healthcare services. As one person shared, ***“It’s hard to go to the doctor when you have a low income and a disease like diabetes, and you have to look for services for the poor. They make us feel like we’re doing something wrong.”***

Community Input Figure 6: Health Education Topics



c. Access to Healthcare

To better understand how to improve access to care from the community’s perspective, input was categorized using the Five A’s of healthcare access—Availability, Accessibility, Accommodation, Affordability, and Acceptability.[4,5] This framework was selected because it reflects the lived experiences of individuals navigating the healthcare and public health systems, rather than focusing solely on internal structures or assumptions. Community Input Figure 7

[4] Levesque JF, Harris MF, Russell G. Patient-centered access to health care: conceptualizing access at the interface of health systems and populations. *Int J Equity Health.* 2013;12:18. doi:10.1186/1475-9276-12-18.
[5] Iwuagwu AO, Poon AWC, Fernandez E. A scoping review of barriers to accessing aged care services for older adults from culturally and linguistically diverse communities in Australia. *BMC Geriatr.* 2024;24:805. doi:10.1186/s12877-024-05373-8.

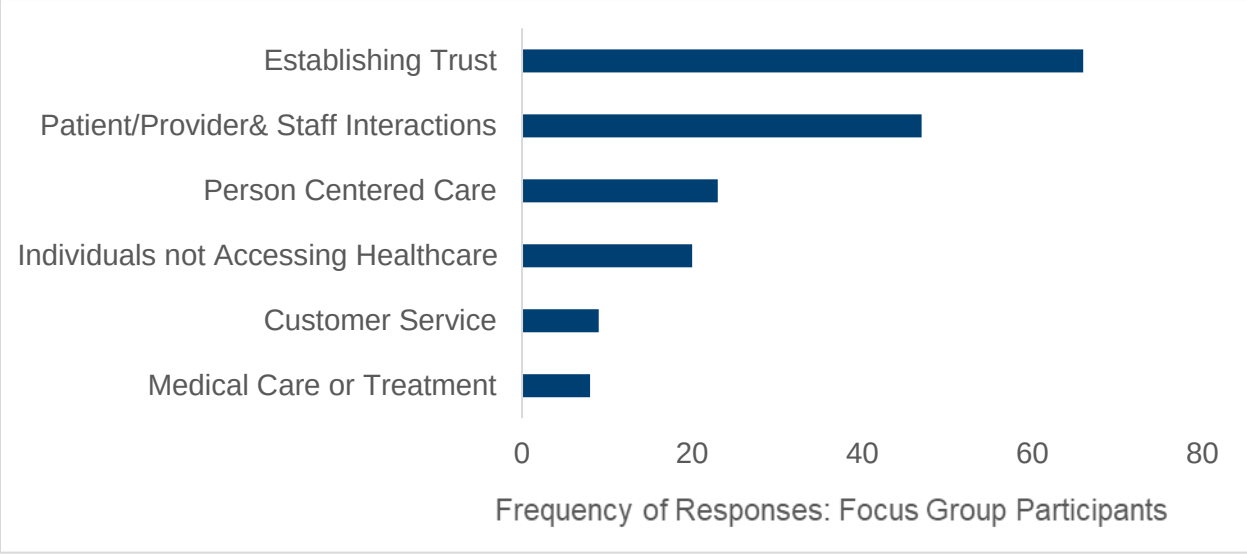
illustrates these categories in order of importance as identified by participants, providing a visual summary of the most pressing access-related concerns.

Community Input Figure 7: Improving Access to Care

i. Acceptability

As one participant shared, ***"Men don't tell the truth to their doctor; the doctor must earn our trust!"*** This sentiment underscores the central role of trust, which emerged as a recurring theme across focus groups. Participants emphasized that trust must be earned, especially among historically marginalized communities. Another participant noted, ***"Trust, I mean, I think that there are challenges in healthcare among the community around trust, whether it's the African American community, the Hispanic […] there is [a lot of] distrust..."***

Community Input Figure 8: Acceptability Building Blocks



Following trust, community members identified their interactions with healthcare providers and staff as a key factor influencing their decision to seek or avoid care, followed by the expectation of person-centered care. Participants expressed a desire to be actively involved in their care decisions; they want to know why tests are ordered and what the results mean; yet participants shared that they often felt they could not ask for additional clarity. Community members also discussed that lack of trust, combined with negative past experiences, had led them to avoid accessing healthcare services altogether.

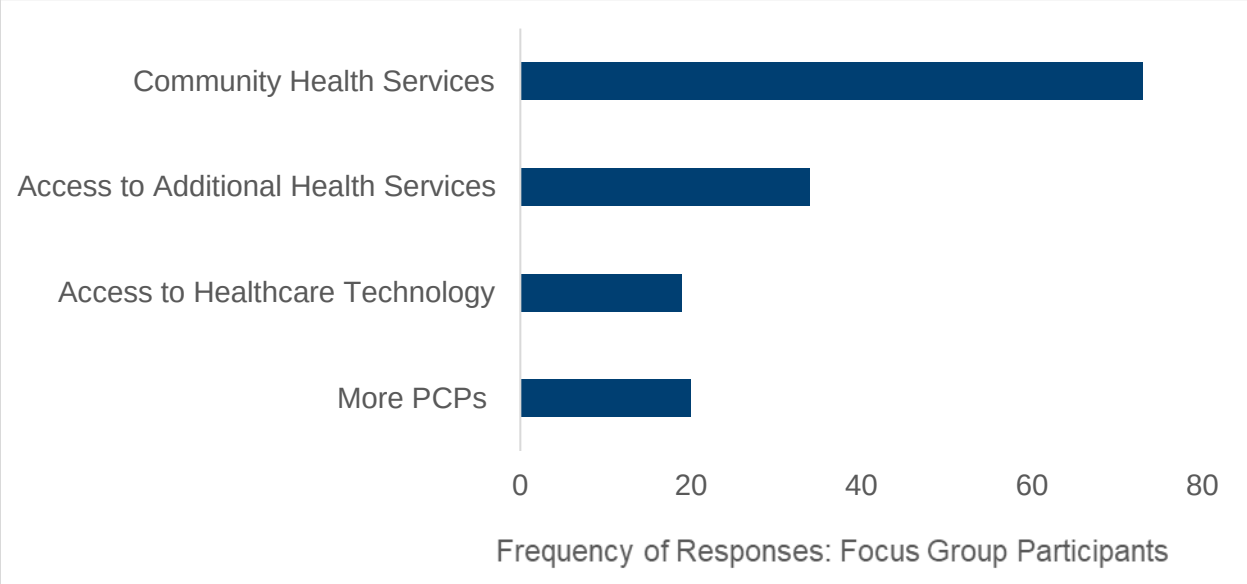
"I want to be involved in the whole process, but sometimes it feels like we can't ask questions!"

"... staff needs customer service training. The service experience makes me not want to come back. When you're sick, you're already at your worst—and a poor experience is not good!"

ii. Availability

This category emerged as the second most cited factor influencing whether community members choose to access healthcare, and it addresses whether there are sufficient services and providers to meet the needs of the community. They highlighted the need for services to be available within the community itself and to leverage community-based organizations such as churches as partners to increase access points, followed by access to additional services, as illustrated in Community Input Figure 9. Participants specifically emphasized the need for more primary care physicians and greater access to healthcare technology.

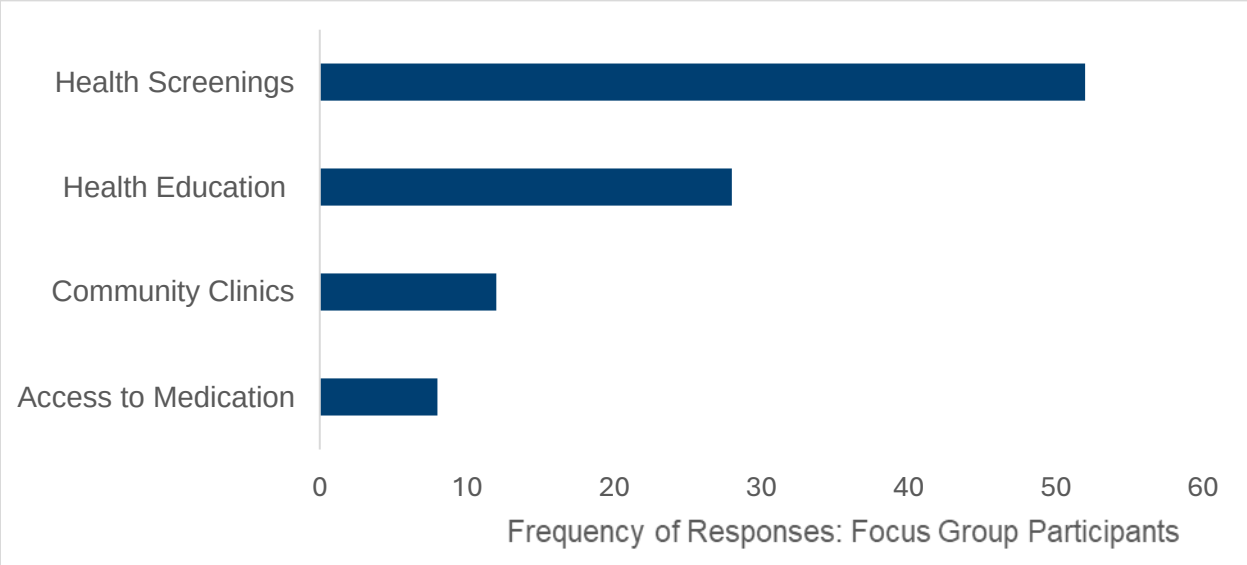
Community Input Figure 9: Availability Building Blocks



In regard to the healthcare services needed within the community, participants reported community health screenings for chronic diseases such as diabetes, hypertension, breast cancer, etc. as a significant priority along with general health education. The community also

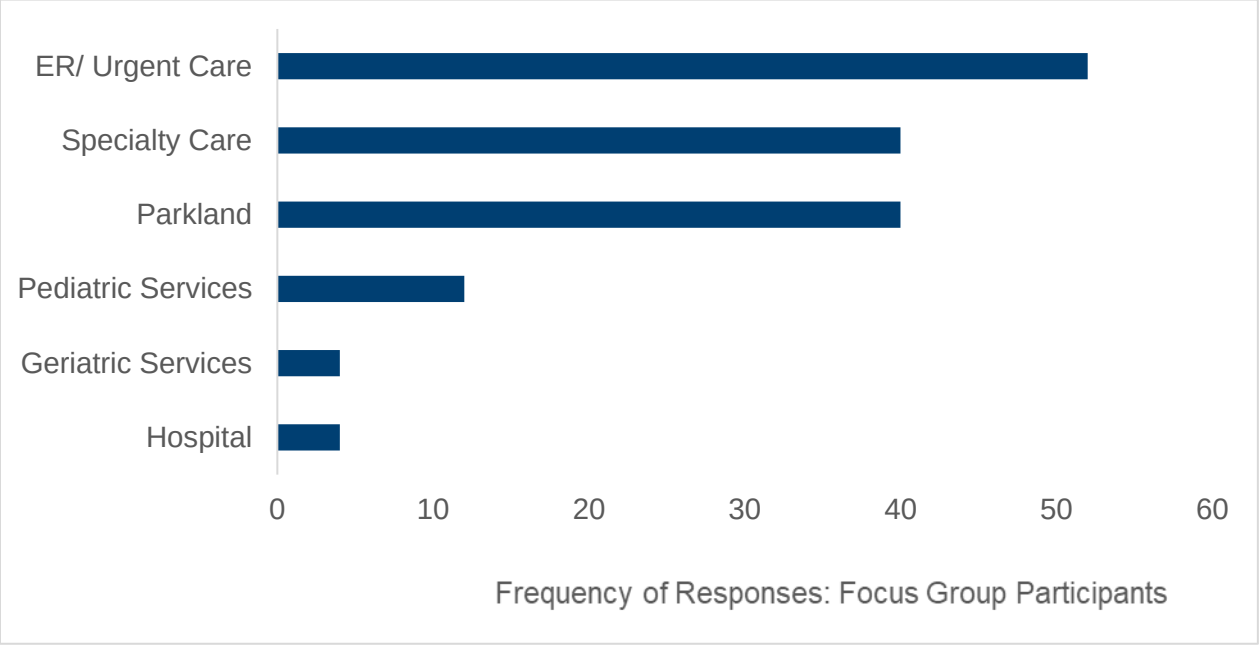
noted that availability of more community clinics would improve access for appointments and medications-see Community Input Figure 10.

Community Input Figure 10: Community Health Services



As for the availabiliy of additional services, community members identified emergency rooms and urgent care access as priorities, followed by the need for more specialty care. Notably, participants also expressed a desire for expanded Parkland services within the community. The need for clinics specifically serving children and geriatric populations were also discussed highlighting the importance of age-specific care options-see Community Input Figure 11**.**

Community Input Figure 11: Availability of Additional Health Services



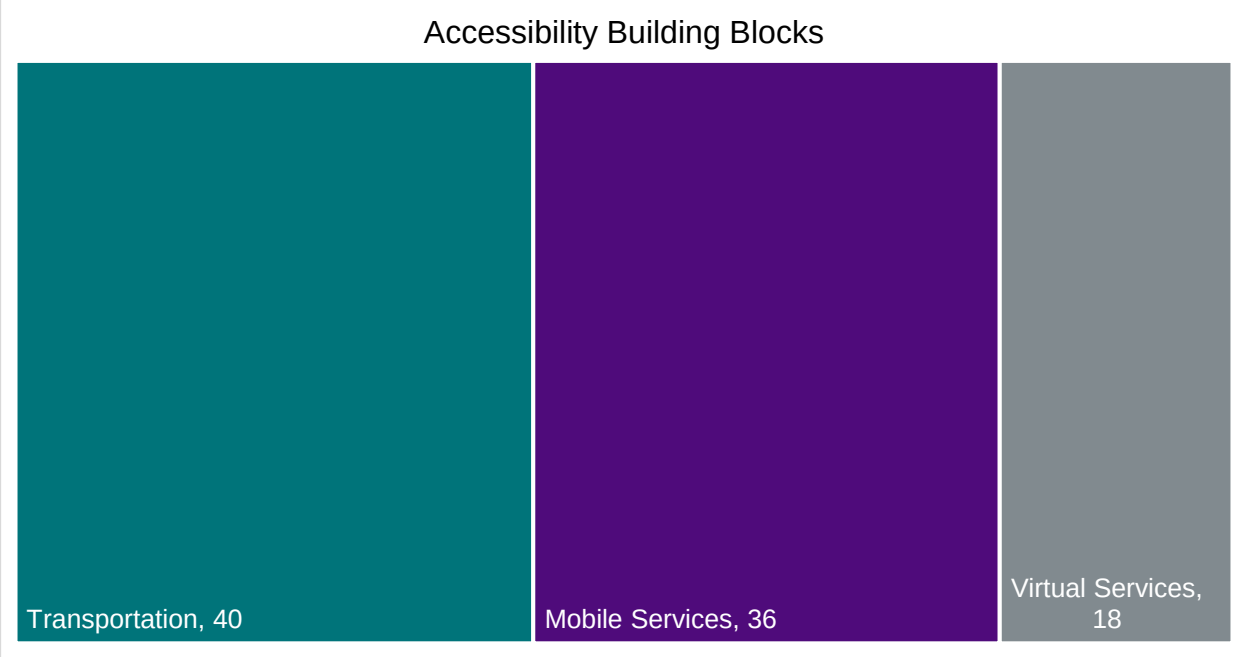
iii. Accessibility

This category refers to how easily individuals can physically access and utilize healthcare services. To better understand the community's priorities, their responses were categorized and visualized in the tree map title "Accessibility Building Blocks"-see Community Input Figure 12. Transportation emerged as the most significant barrier across all focus groups. Community members described difficulties with public transit, including long walking distances and the need to take multiple buses to reach a healthcare facility**,** as a community member stated, **"I think actually transporting and getting people into the clinic is one of the biggest barriers."**

This sentiment was supported by a provider who acknowledged the challenges associated with inconsistent or absent transportation options**.** ***"Having to travel to multiple clinics is difficult and time-consuming and time off from work. The wait times are too long, and there's poor coordination between appointments."***

As expected, community members emphasized that offering mobile health services could help improve access to care in their neighborhoods. As one woman shared during a focus group session, ***"A doctor who comes to you, or prescriptions delivered to your home, that would help. It's hard to ride the bus to the clinic or pick up prescriptions when you're sick!"***

Community Input Figure 12: Accessibility Building Blocks



In addition to mobile services, community members identified virtual services as a key alternative to help overcome transportation challenges, especially for those with limited mobility or access to reliable transit.

iv. Accommodation

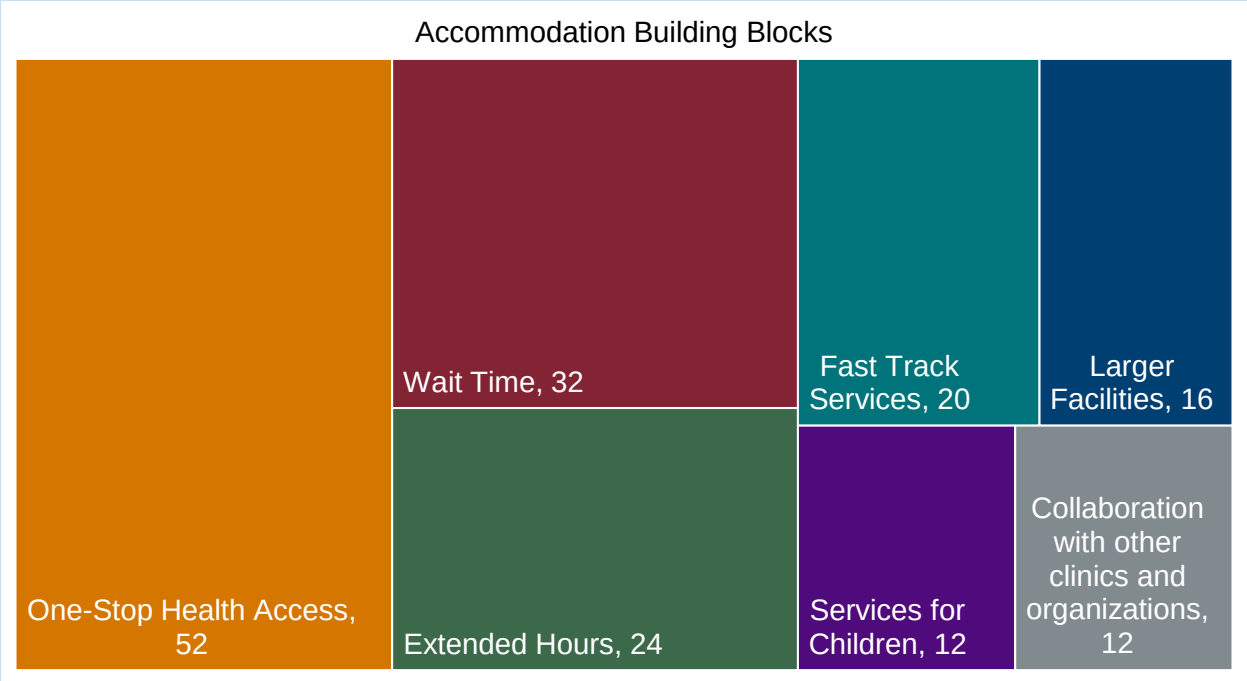
Accommodation refers to how well the structure and delivery of care align with the realities of the community being served. This includes the organization of services such as appointment systems, wait times, hours of operation, referrals, and care coordination to ensure they are convenient and responsive to patients' needs.

To illustrate how these factors impact access to care, the tree map titled *"Building Blocks Accommodation"*-see Community Input Figure 13, summarizes community feedback on necessary healthcare accommodations. The three largest blocks—**"One-Stop Health Access," "Wait Times,"** and **"Extended Hours"**—reflect the top priorities identified by participants. These responses emphasize the need for streamlined, timely, and flexible service delivery that better fits the daily lives of those being served.

Community members emphasized the need for ***"one-stop health access"*** points, where individuals can receive primary care, specialty care, medical tests, imaging, and supportive resources all in one location. This model would reduce the burden of traveling to multiple clinics for different services. These access points were seen as a way to foster stronger relationships with staff and providers, which could improve trust, continuity of care, and ultimately lead to better health outcomes for individuals and families.

Focus group participants identified long wait times both to get an appointment and while in the clinic as examples of lack of accommodation to patients' needs. They described the process of waiting to see a provider, complete tests, or pick up medications as tiring and frustrating, especially when appointments are scheduled months in advance or poorly coordinated.

Community Input Figure 13: Accommodation Building Blocks



A recurring concern was the difficulty of scheduling timely appointments, which often left participants with nowhere to go but the emergency department. Two participants summarized the overall sentiment: ***"One problem we always have is that there are no appointments available when you call—you have to wait six months. If we need help today, what's the point of waiting six months?"***

"People come to emergency department because they can't make an appointment earlier than six months; they know they will have to wait but they also know they get diagnosed and treated the same day."

To address these barriers, the focus group participants recommended expanding service hours in the clinics or offering fast track appointments and having larger facilites. As part of the "Accommodations" building blocks identified through community input, participants highlighted the need for accessible, services for children—including pediatric care, behavioral health, and overall resources. They also expressed a strong desire for increased collaboration across clinics, schools, and community-based organizations to enhance care coordination, and create a more seamless experience for families navigating multiple systems.

v. Affordability

This category refers to a person's ability to pay for out-of-pocket healthcare expenses, such as co-pays, insurance premiums, medications, and procedures. Notably, there was broad agreement that the fear of medical debt often deters individuals from seeking care or following through with recommended treatment. One social worker shared a powerful example during a focus group session:

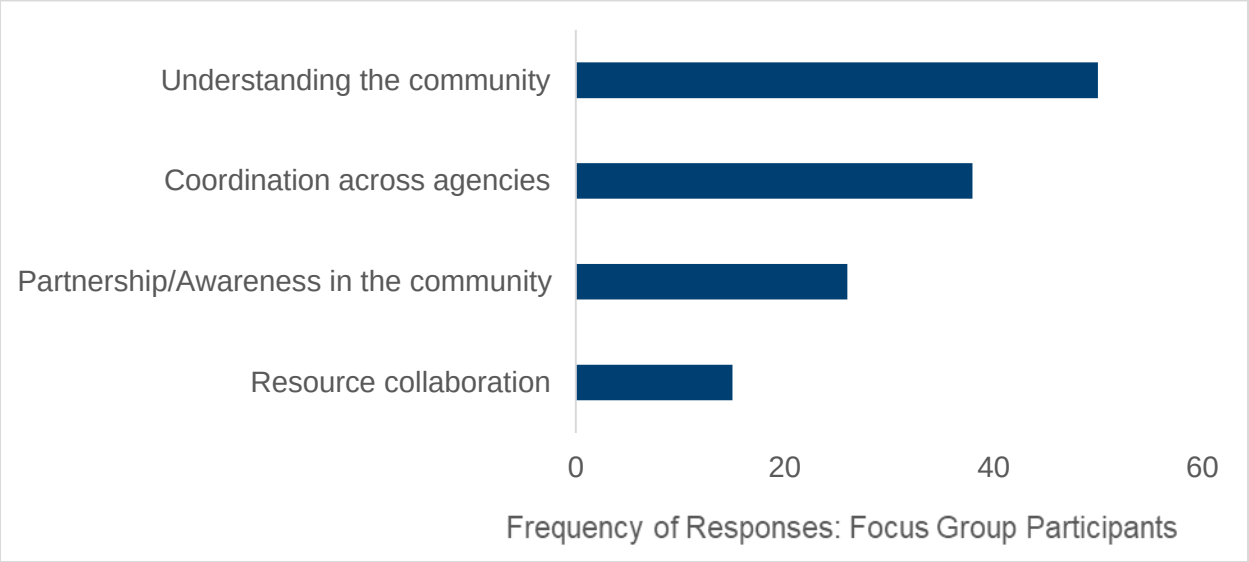
"I made the patient aware that she could potentially die if she didn't get the procedure done, and she said, 'No, I'm not going to do it because I can't afford the bill.'"

Similar concerns were reflected in the Healthy Neighborhood Survey, where the cost of medications stood out as a major issue. Focus group discussions described the difficult trade-offs between affording prescriptions—some noting monthly costs ranging from $600 to $800—and meeting other basic needs such as food. These insights underscore the financial strain healthcare expenses place on individuals and families across the community. As two participants put it: ***"You have to choose between insulin and food!"*** and ***"I see seniors who have to make a choice between seeing the doctor or buy medication because of their low income."***

B. Public Health Systemic Alignment

Community members expressed concern to ensure public health programs are developed with a true understanding of the lived experiences. Misalignment between community needs and the efforts of healthcare and public agencies within the public health system has led to short-term or "band-aid" solutions rather than lasting programs that tackle underlying issues.

Community Input Figure 14: Public Health System Alignment



Residents emphasized the urgent need for a healthcare and public health system that fosters streamlined collaboration across agencies and local programs, ensuring that efforts are coordinated, efficient, and responsive. They also highlighted the importance of leveraging trusted partnerships, particularly with faith-based organizations serving African American communities, to build trust and improve outreach.

1. Data Sharing

Within the vein of aligning public health programs with the lived realities of the communities emerged from the concern of data sharing. This concern primarily existed among participants who worked within community-based organizations, which noted they often work in siloes and are hesitant to share data across health and public health organizations.

Data sharing is integral to providing foundational services and can even facilitate the “one-stop” health services community member participants discussed during focus group sessions. Yet, to meet the needs and expectations of the community, public health and health organizations must work to build bridges and share data that will foster a stronger continuum of care to serve our community.

2. Public Policy

Public policy coordination emerged as a critical factor influencing service delivery, access to care, and broader health outcomes. Participants emphasized that policy decisions directly shape how services are provided and accessed, making advocacy and alignment essential across health and public health systems.

One participant working in HIV services noted that conflicting state and federal eligibility requirements can create barriers including disrupting continuity of care and duplicating paperwork.

Housing policy was another area of concern, particularly regarding gentrification and its impact on affordability. One participant described how unchecked development raises property taxes and deepens financial strain:

"There are developers coming into those neighborhoods and building homes that continually raise their taxes and debt. So now they are concerned about that. It's been a challenge already to maintain the home."

Together, these examples show how coordinated public policy can reduce barriers, improve service continuity, and protect vulnerable populations from unintended consequences.

IV. DALLAS COUNTY PROFILE

A. Dallas County Demographics

Dallas County has 872.1 square miles of land area and is the 177th largest county in Texas by total area. Dallas County is bordered by Collin, Ellis, Rockwall, Tarrant, Denton, and Kaufman counties[6].

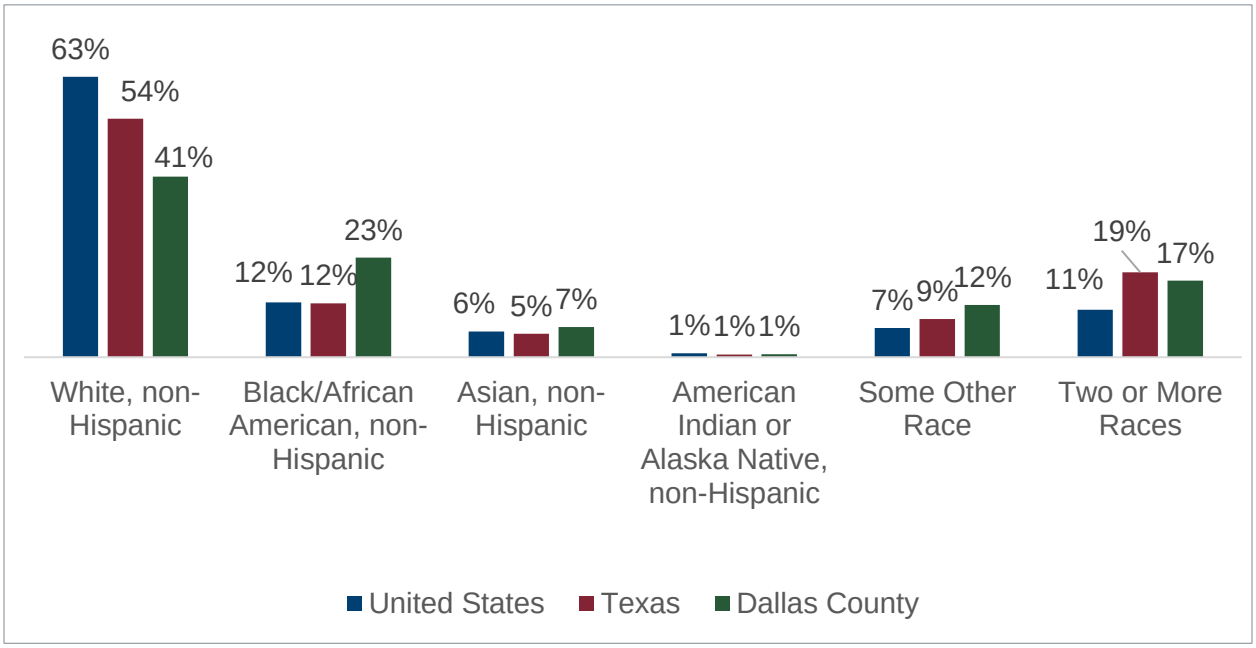
Demographics Figure 1: Dallas County, Texas

Data Source: U.S. Census Bureau.

[6] U.S. Census Bureau. Available at: https://data.census.gov/cedsci/ profile?g=0500000US48113

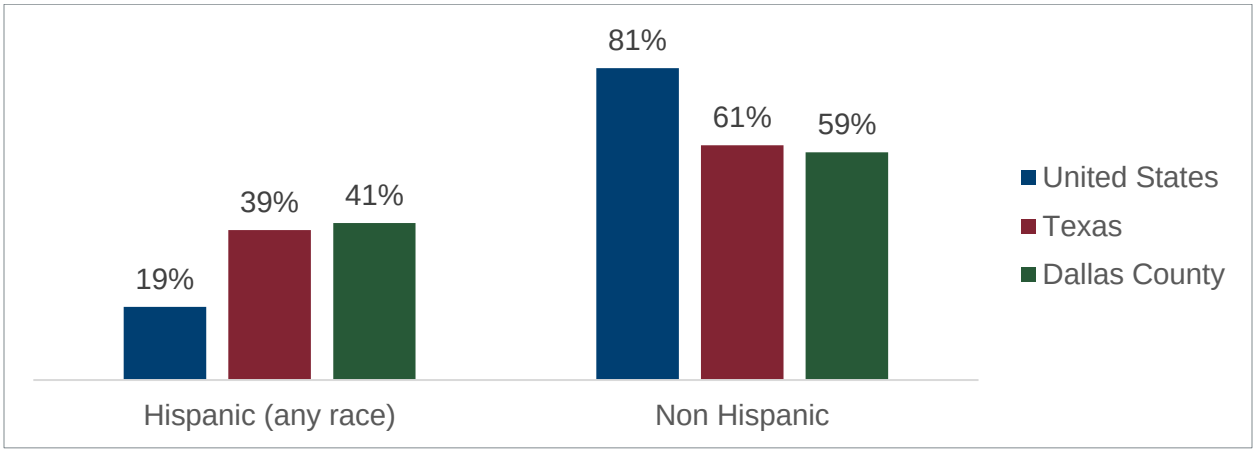
The county's Black or African American, non-Hispanic population (23%) is higher than both the Texas and U.S. averages. In Dallas County, 41% of the population identifies as Hispanic—slightly above the Texas state average of 40%, and significantly higher than the national average of 19% as shown in Demographics Figure 2 and Demographics Figure 3.

Demographics Figure 2: Population by Race in U.S., Texas, and Dallas County



Data Source: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates

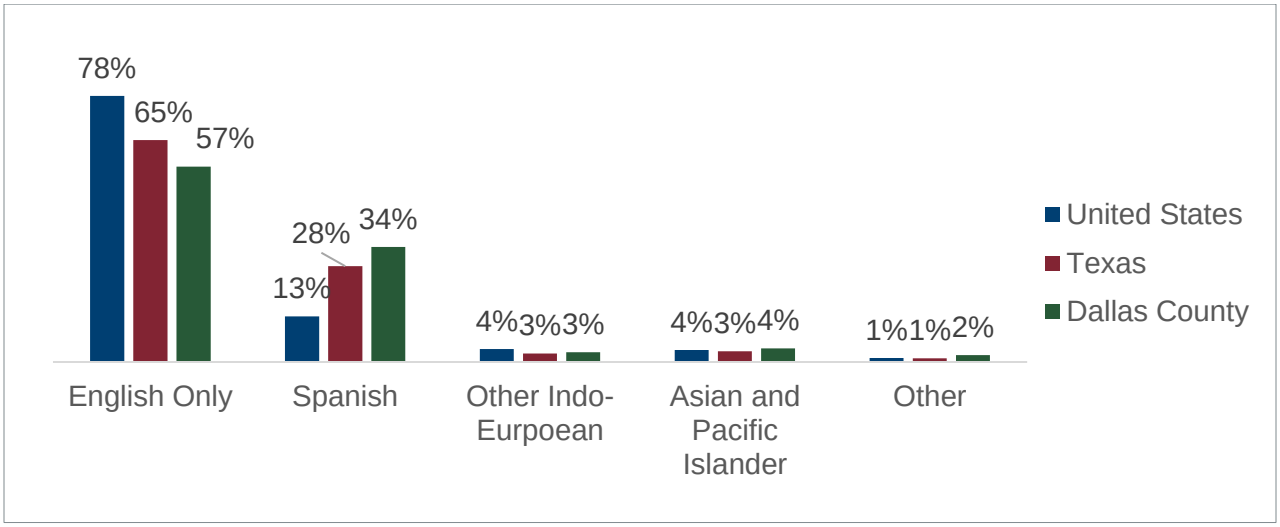
Demographics Figure 3: Population by Ethnicity in U.S., Texas, and Dallas County



Data Source: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates

This ethnic diversity also shapes the linguistic landscape. In Dallas County, 34% of residents speak Spanish at home, compared to 28% in Texas and 13% nationally-see Demographics Figure 4

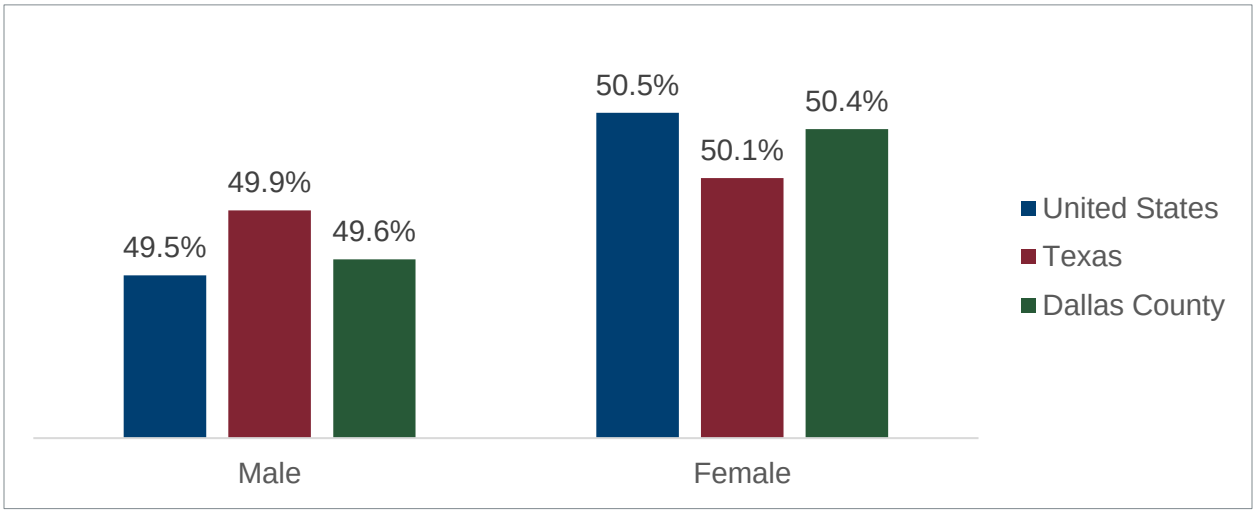
Demographics Figure 4: Population by Language Spoken at Home in U.S., Texas, and Dallas County



Data Source: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates

The gender distribution in Dallas County closely mirrors that of Texas and the U.S., with a nearly even split between males and females across all three regions-see Demographics Figure 5.

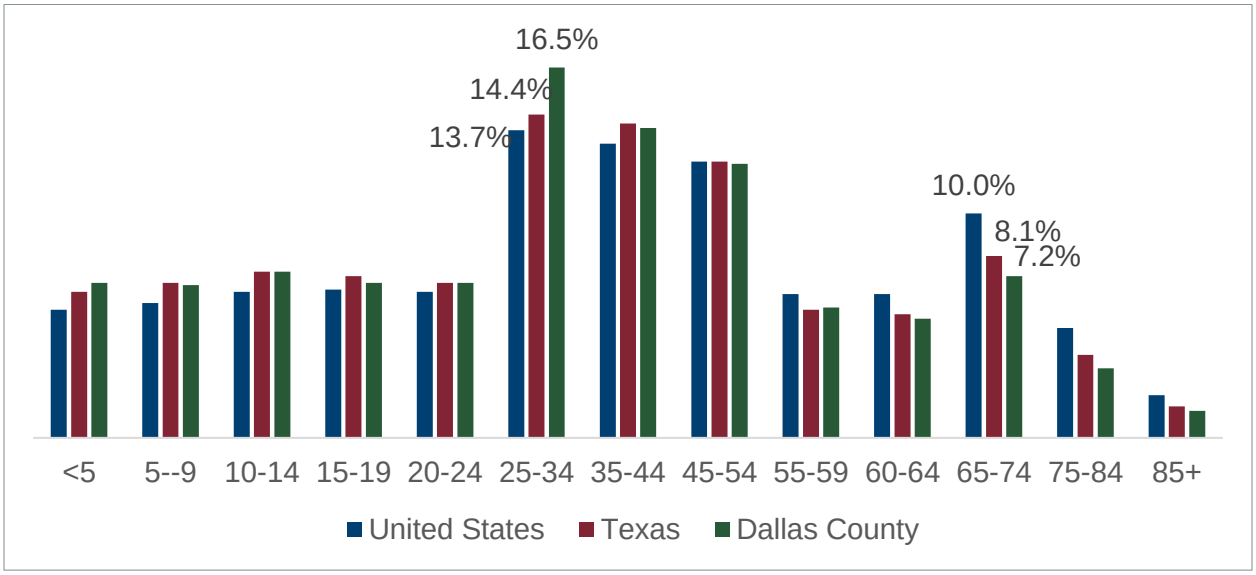
Demographics Figure 5: Population by Sex, U.S., Texas, and Dallas County



Data Source: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates

Compared to the national average, both Texas and Dallas County have a noticeably younger population, particularly among those under 19 and aged 25–34. Dallas County also stands out with a lower share of residents aged 65 and older—just 7%, compared to 8% in Texas and 10% nationally.

Demographics Figure 6: Population by Age Groups, U.S., Texas, and Dallas County



Data Source: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates

B. NMDOH

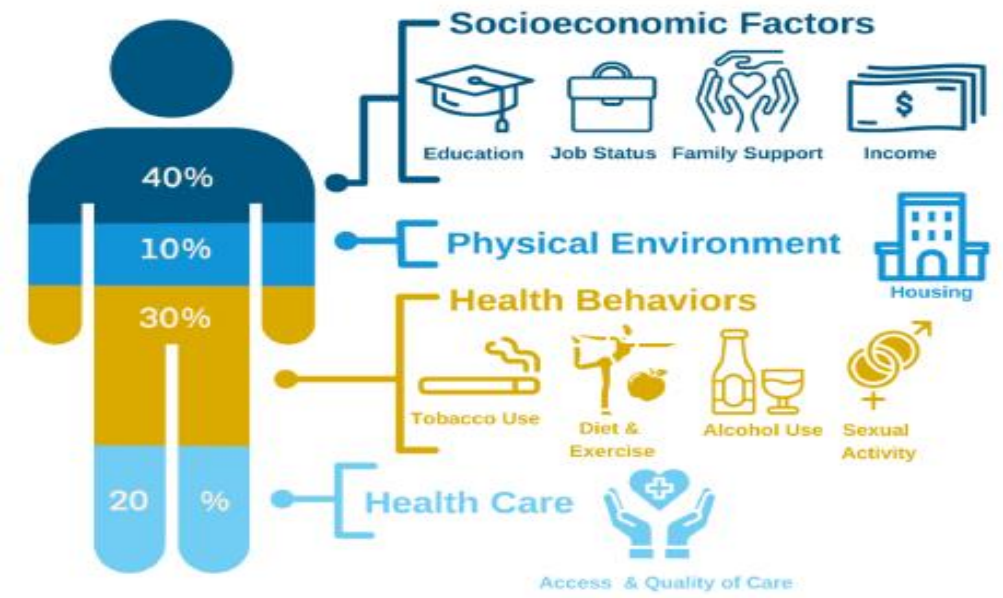
Individuals' and communities' experiences with health and healthcare are shaped by more than just access to medical services. The social and environmental factors known as non-medical drives of health include access to healthcare, education, healthy food, economic stability, and supportive community environments. These represent the broader context in which people are born, live, learn, work, play, worship, and age significantly impacting health outcomes, daily functioning, and overall quality of life.[7]

As illustrated in NMDOH Figure 1, socioeconomic factors such as education, job status, family support, and income contribute approximately 40% to an individual's overall health, more than any other factor. Health behaviors such as diet, physical activity, substance use (e.g., tobacco and alcohol use), and sexual activity account for another 30%, while the physical environment contributes 10%, and healthcare, e.g., access and quality of care, determines 20% of a person's health.

The CDC organizes health conditions into five key categories, as illustrated in NMDOH Figure 2. These categories not only provide a structured way to understand health conditions but also serve as the foundational framework for categorizing, analyzing, and synthesizing community input. By grounding the process in this data-informed approach, stakeholders across sectors such as healthcare, housing, education, transportation, food security, and employment can more effectively collaborate to develop coordinated strategies that improve community health and advance equity.

[7] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2030: Social Determinants of Health. Accessed May 7, 2025.https://health.gov/healthypeople/objectives-and-data/social-determinants-health.

NMDOH Figure 1: Impact on Health



Adopted from UCLA Health[8]

NMDOH Figure 2: SDOH Framework

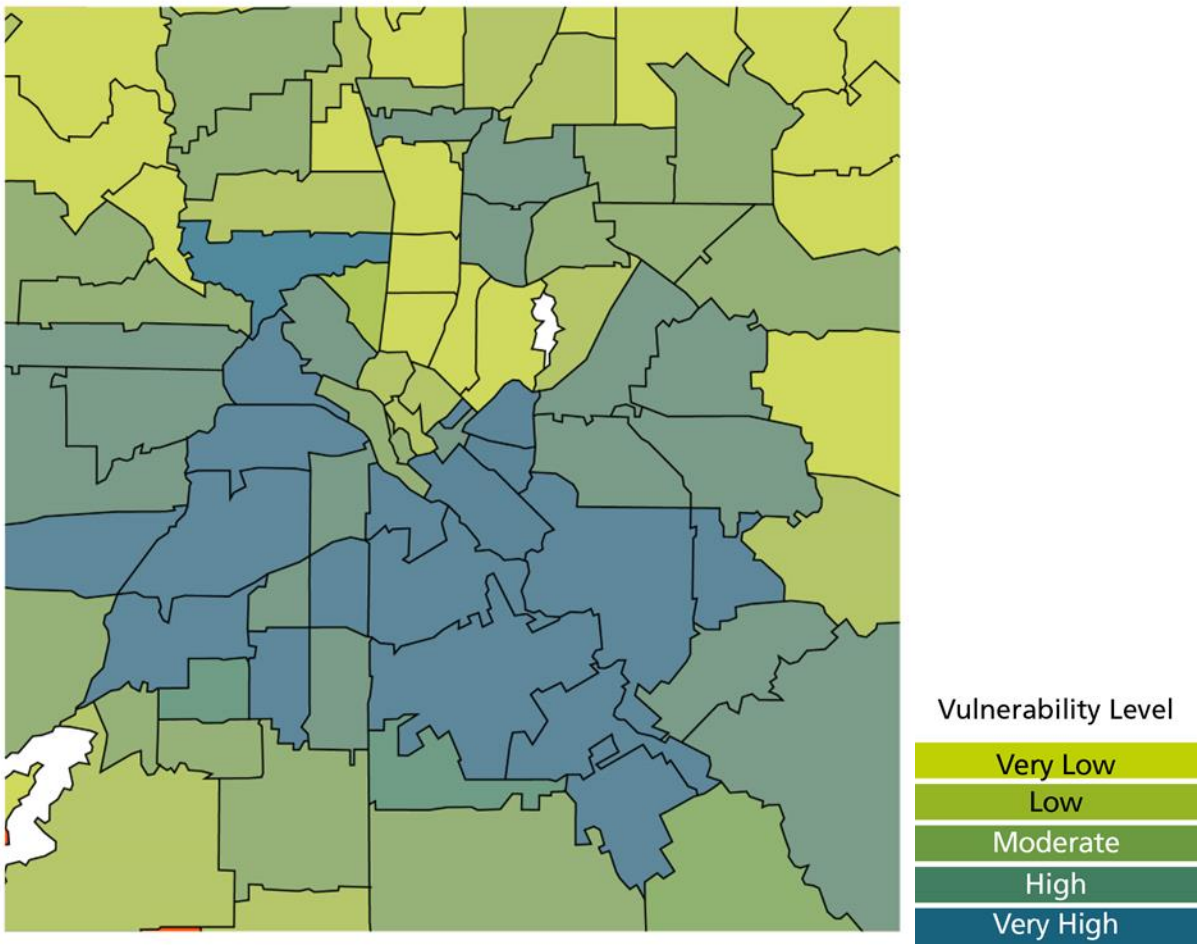
Adopted Social Determinants of Health | Public Health Gateway | CDC

To translate this framework into actionable insights, the CVI, part of PCCI's CVC, is a data-driven tool that analyzes 26 clinical and socioeconomic indicators at hyper-local levels to identify areas with the greatest health and social challenges. It helps uncover root causes of

[8] UCLA Health. Social Determinants of Health – Sustainability. Accessed May 7, 2025. https://www.uclahealth.org/sustainability/social-determinants-health

vulnerability and guides targeted interventions. This tool is utilized by Parkland and DCHHS to guide and prioritize interventions in communities identified as having higher needs.

NMDOH Figure 3: Dallas County, CVI by ZIP Codes, 2025



Data Source: CVC, PCCI

NMDOH Figure 3 illustrates community vulnerability levels across Dallas County, using a color-coded system to highlight areas of differing need. Regions are shaded from light green (Very Low) to dark blue (Very High) vulnerability, based on a composite of clinical and socioeconomic indicators. Areas like South Dallas, parts of Mesquite, and West Irving show higher vulnerability, suggesting greater need for targeted health and social interventions. The map helps organizations like Parkland and DCHHS prioritize resources and support where they are most needed.

NMDOH Table 1 and NMDOH Table 2 list 10 ZIP Codes with the lowest and highest CVI scores, respectively. As shown in the map in NMDOH Figure 4, ZIP Codes with the highest CVI scores are concentrated in the southern sector of the county, particularly Southeast Dallas, while those with the lowest scores are located in the northern sector. NMDOH Figure 5 provides further insight into how CVI scores vary across ZIP Codes and, when examined at the census block

level, offers a more granular understanding of vulnerability. This level of detail can support targeted public health interventions and resource allocation.

NMDOH Table 1: ZIP Code Rankings by Lowest CVI Scores (Percentiles)

ZIP Codes	Percentile
75044	10
75248	9
75039	8
75098	7
75082	6
75182	5
75225	4
75048	3
75019	2
75054	1

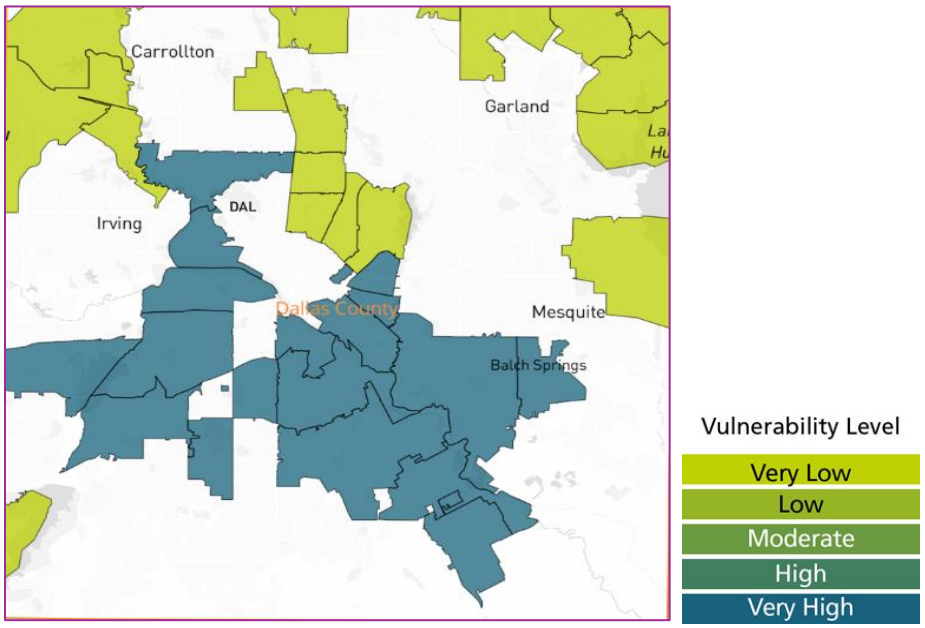
Data Source: CVC, PCCI

NMDOH Table 2: ZIP Code Rankings by Highest CVI Scores (Percentile)

ZIP Codes	Percentile
75216	100
75210	99
75215	98
75241	97
75203	96
75247	95
75212	94
75172	93
75237	92
75051	91

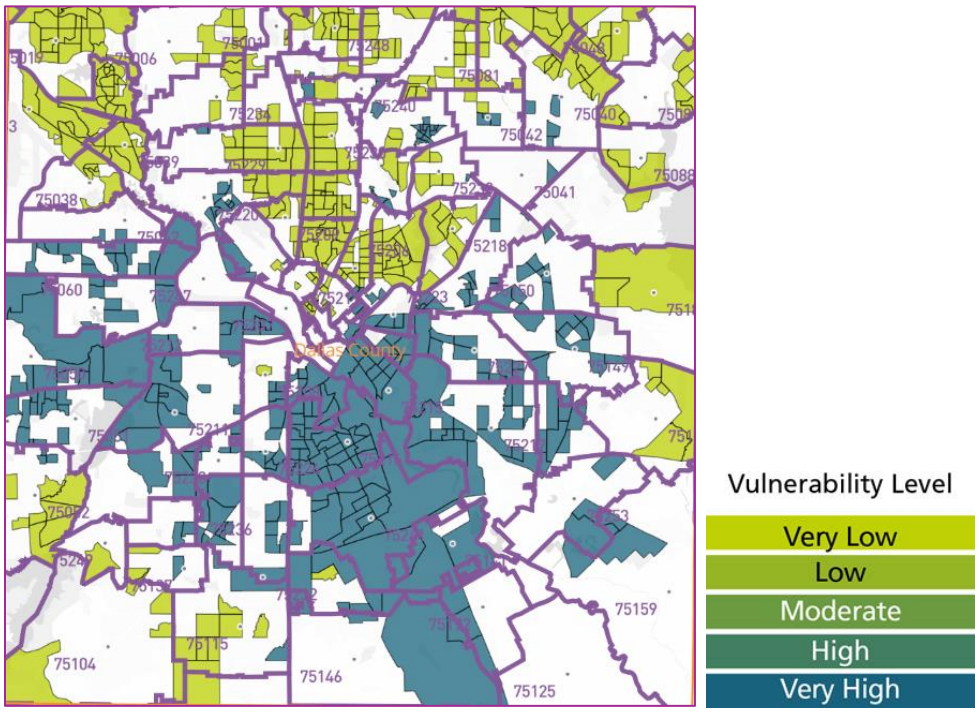
Data Source: CVC, PCCI

NMDOH Figure 4: ZIP Code by Very High and Very Low CVI Scores, Dallas County, 2025



Data Source: CVC, PCCI

NMDOH Figure 5: Census Block by Very High and Very Low CVI Scores, Dallas County, 2025



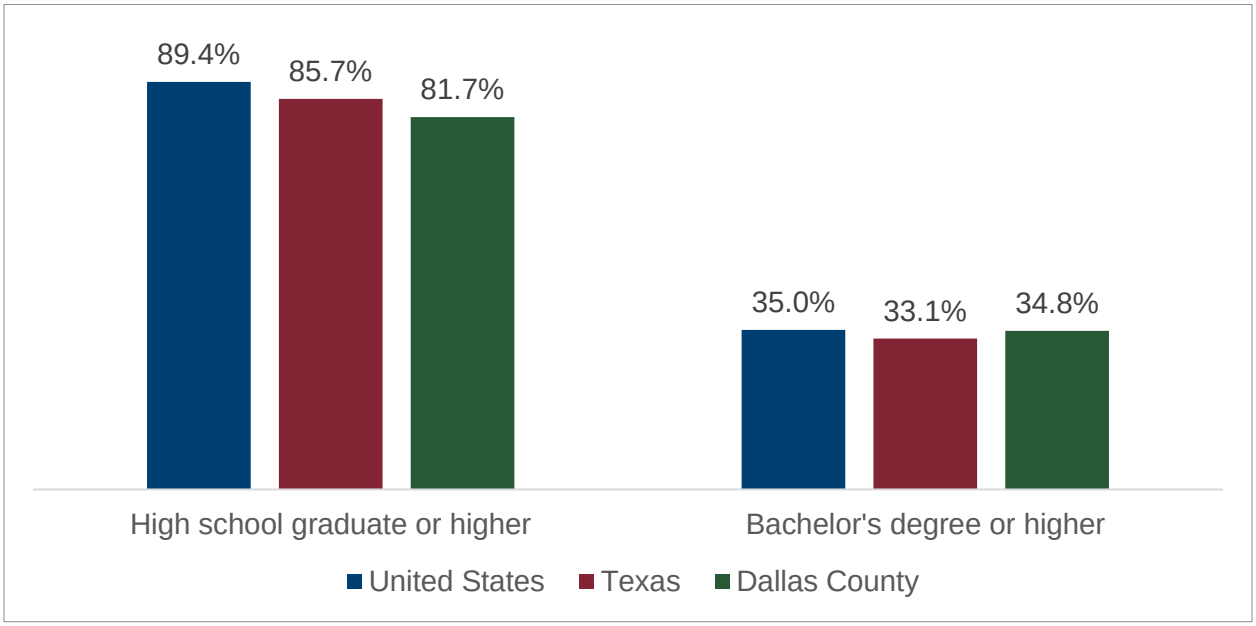
Data Source: CVC, PCCI

1. Education

Education promotes socioeconomic stability by lifting individuals out of poverty and contributes to long-term improvements in overall well-being.[9]

[9] Education: a neglected social determinant of health. Lancet Public Health. 2020;5(7):e361. doi:10.1016/S2468-2667(20)30144-4.

NMDOH Figure 6: Education Attainment, U.S., Texas, Dallas County, 2019 - 2023

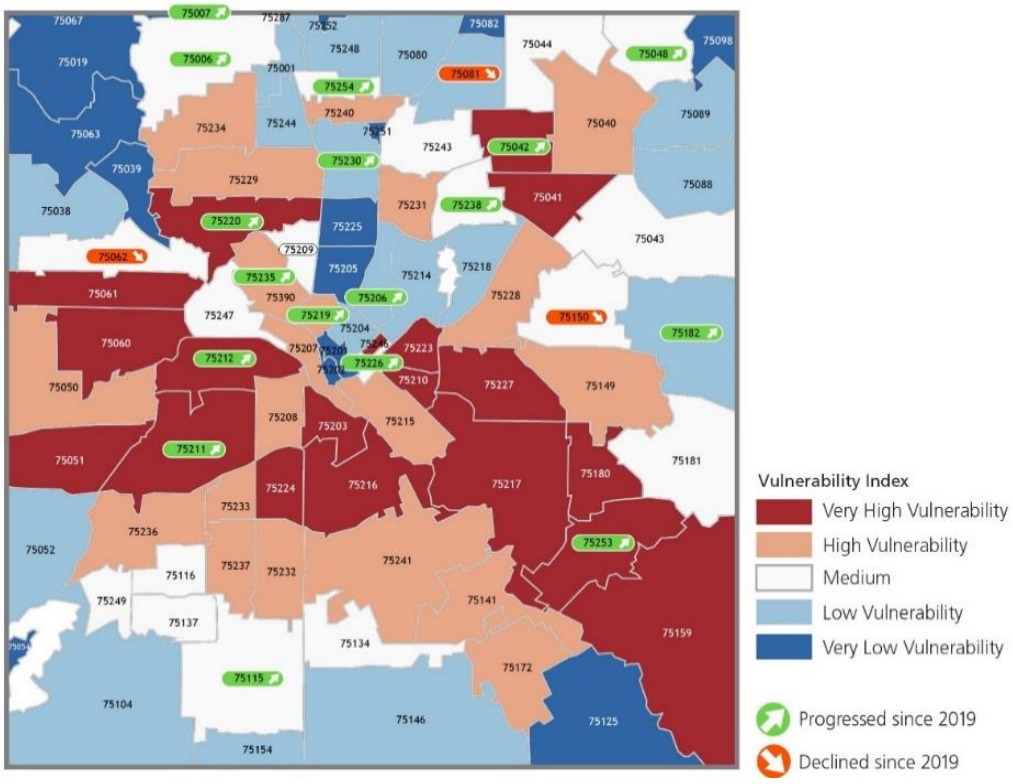


Data Source: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates

High school completion in Dallas County lags behind both state and national averages, with only 81.7% of residents aged 25 and older having graduated from high school or attained a higher level of education. This compares to 85.7% in Texas and 89.4% nationally. This educational gap highlights a local shortfall in foundational academic achievement, which may have long-term implications for workforce readiness, economic mobility, and community well-being-see NMDOH Figure 6.

NMDOH Figure 7 displays changes in high school graduation rates in Dallas County by ZIP Codes from 2019 to 2022. ZIP Codes with statistically significant ($p \leq 0.05$) improvements are marked with green labels. In contrast, ZIP Codes with statistically significant decline in high school graduation rates are marked with orange labels. The map also features a high school graduation CVI, which categorizes ZIP Codes from very high vulnerability (dark red) to very low vulnerability (dark blue). Although some high-vulnerability ZIP Codes experienced positive trends, these improvements were not substantial enough to shift them into lower vulnerability categories, highlighting the persistence of education attainment disparities across the county.

NMDOH Figure 7: Progress and Decline in High School Graduation Rates in Dallas County between 2019-2022



Adopted from PCCI

2. Economic Stability

Economic stability is a well-established NMDOH and often is an underlying consideration for all other NMDOH. Wealth and income can lead to better health by providing material benefits that promote well-being—such as healthy food, housing, exercise opportunities, reliable transportation, quality education, and the ability to afford medical care, among others. Conversely, financial strain is a key driver of the health gaps observed in low-income populations. It is closely tied to both physical and mental health, as it limits access to essential resources—particularly the ability to cover medical expenses, among other NMDOH. [10,11]

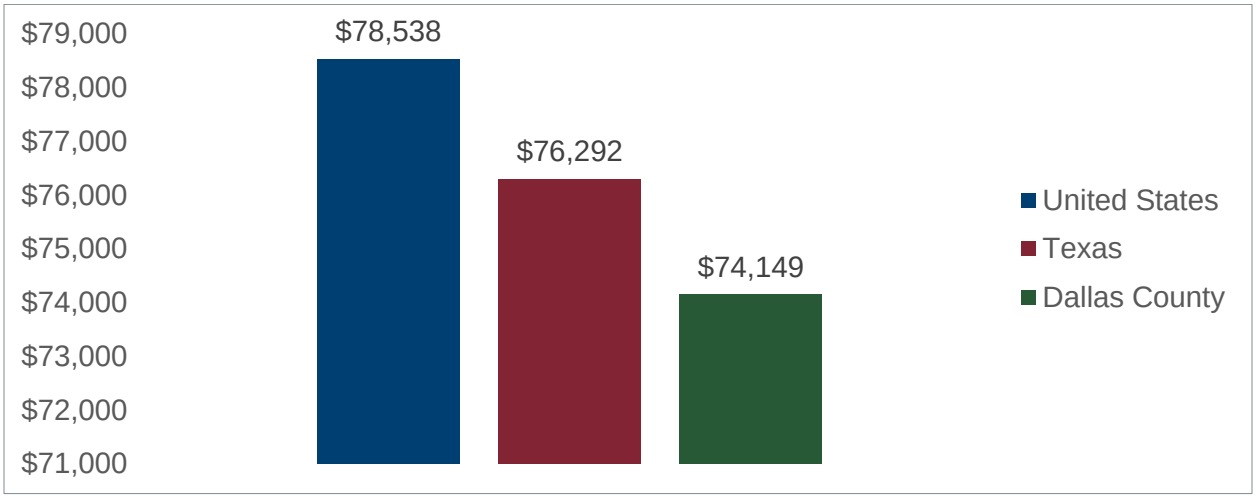
a. Median Income

Dallas County's median household income is $74,149, which is below both the Texas state median ($76,292) and the national median ($78,538)-see NMDOH Figure 8.

[10] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on the Review of Federal Policies that Contribute to Racial and Ethnic Health Inequities. Geller AB, Polsky DE, Burke SP, eds. Federal Policy to Advance Racial, Ethnic, and Tribal Health Equity. Washington, DC: National Academies Press; 2023. Accessed May 21, 2025. https://www.ncbi.nlm.nih.gov/books/NBK596400/

[11] White N, Packard K, Kalkowski J, et al. Improving health through action on economic stability: results of the Finances First randomized controlled trial of financial education and coaching in single mothers of low-income. Am J Lifestyle Med. 2022;17(3):424-436. doi:10.1177/15598276211069537.

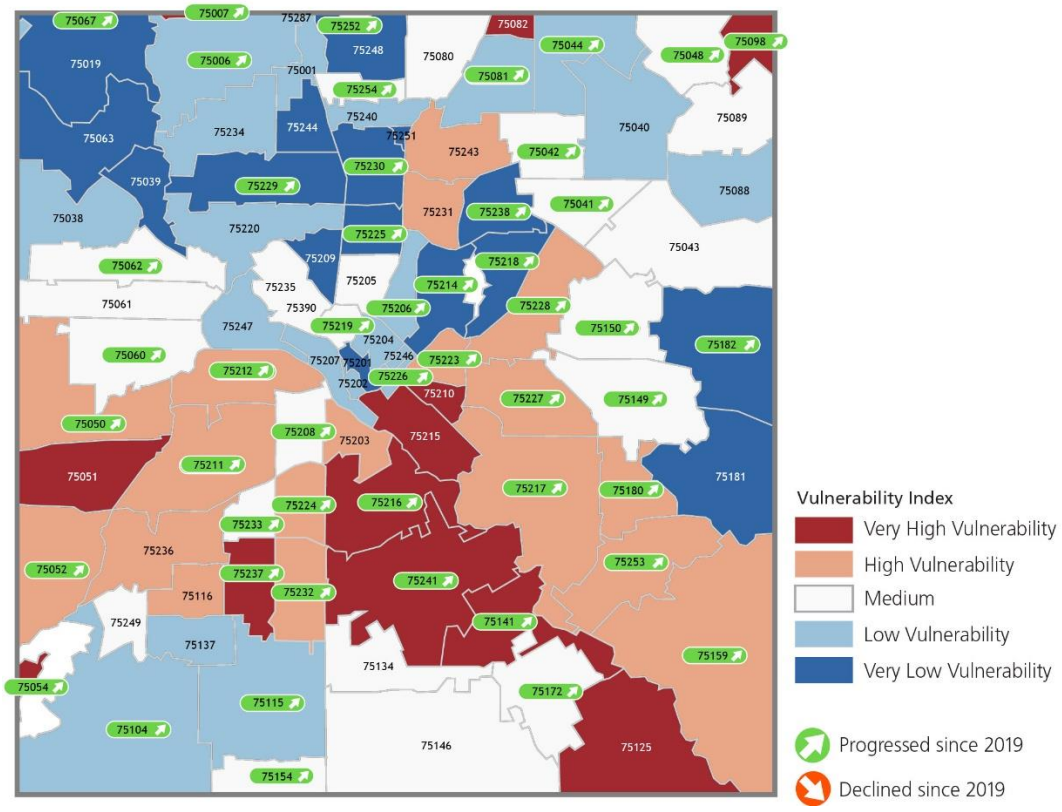
NMDOH Figure 8: Median Household Income in U.S., Texas, Dallas County



Data Source: U.S. Census Bureau QuickFacts: United States; Texas; Dallas County, Texas

Between 2019 and 2022, the average median income in Dallas County rose by approximately $3,700 per year—a positive trend that benefited residents across many ZIP Codes. As shown in NMDOH Figure 9, the map illustrates these changes, with green labels indicating ZIP Codes where the median household income had a statistically significant increase. The map also features a median household income CVI, which categorizes ZIP Codes from very high vulnerability (dark red) to very low vulnerability (dark blue). Although several high-vulnerability ZIP Codes experienced income gains, these improvements were not substantial enough to shift them into lower vulnerability categories, highlighting the persistence of economic disparities across the county.

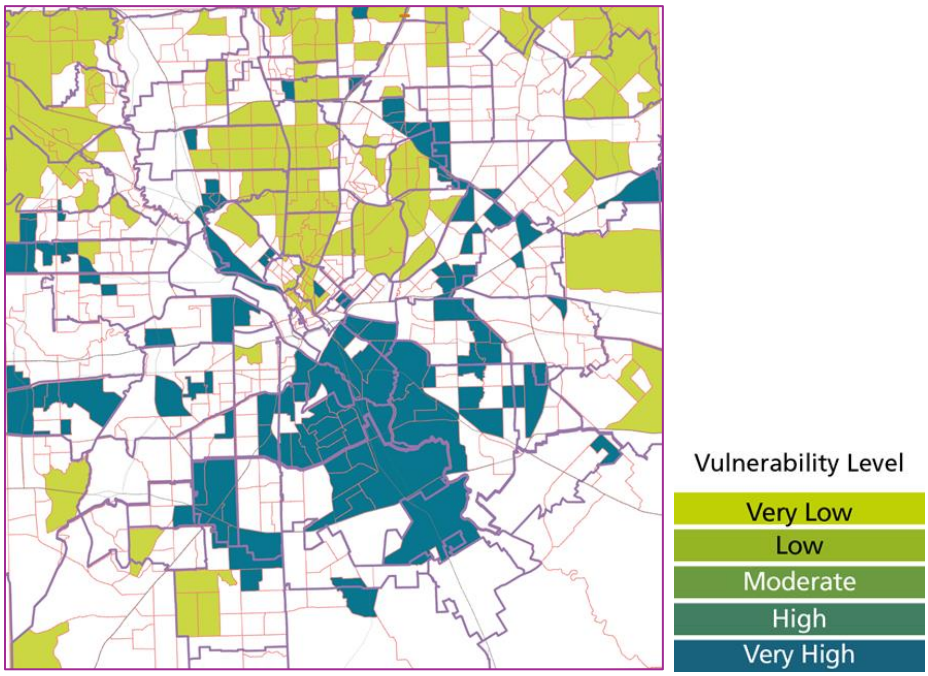
NMDOH Figure 9: Progress in Median Household Income in Dallas County Between 2019 and 2022



Adopted from PCCI

Regarding paycheck predictability—defined as the percentage of residents aged 16 to 64 who have been working full-time, year-round for the past 12 months—this employment stability indicator improved in 10 of the 93 ZIP Codes in Dallas County. However, four ZIP Codes (75043, 75115, 75203, and 75211) experienced a decline in stability, indicating increased vulnerability in those areas. As of 2025, the economic vulnerability in Dallas County remains unevenly distributed across census tracts-see NMDOH Figure 10. Areas shaded in dark blue represent communities with higher income vulnerability, indicating lower household incomes and a greater likelihood of economic hardship. In contrast, light green areas, primarily in the northern sector, reflect lower vulnerability and greater economic stability.

NMDOH Figure 10: Dallas County Median Household Income Very High vs Very Low Vulnerability by Census Track, FY25



Data Source: CVC, PCCI

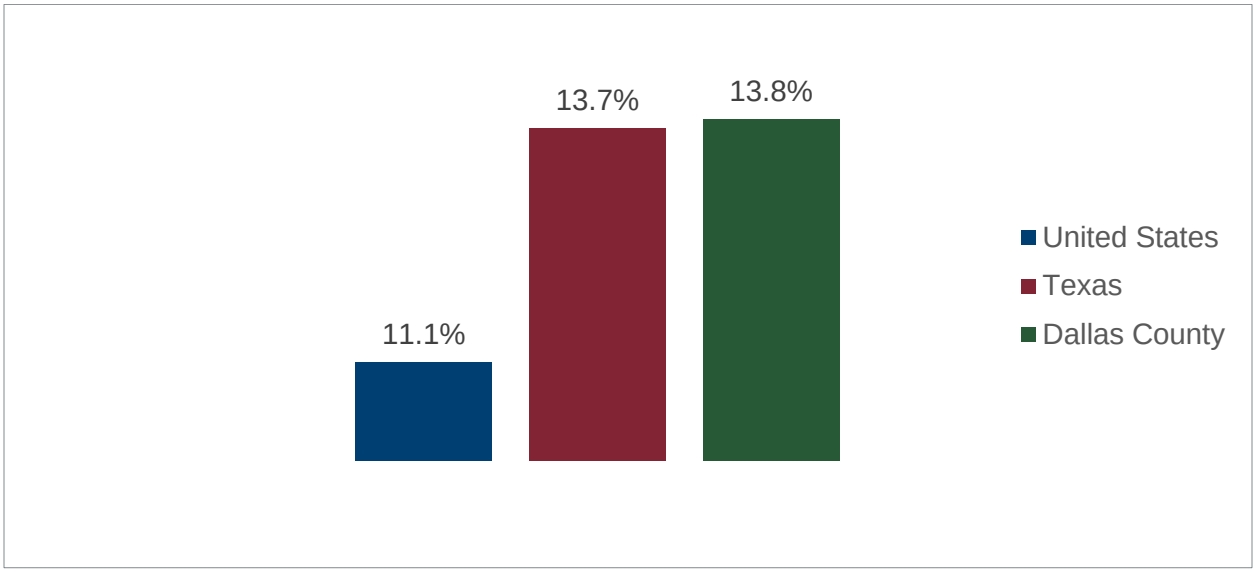
This pattern reveals a clear north-south divide in economic conditions. Census tracts in the southern and southeastern portions of the county—including ZIP Codes 75216, 75217, and 75241—show concentrated areas of high vulnerability. Notably, 20% of Healthy Neighborhood Survey participants from southern ZIP Codes reported delaying care in the past 12 months due to concerns about medical debt and high healthcare costs.

b. Poverty

As home to several Fortune 500 companies, Dallas County has enjoyed a prosperous economy employing 1.32 million people.[12] However, nearly 14% of the population live below the poverty line, according to the U.S. Census Bureau-see NMDOH Figure 11. As aforementioned, most communities experiencing high economic vulnerability are in southern sector, an area characterized by high Black or African American, non-Hispanic and Hispanic communities[13].

[12] Dallas County Planning and Development Department. Economic Development. Dallas County. Accessed May 21, 2025. https://www.dallascounty.org/departments/plandev/economic.php
[13] Parkland Health. 2022 Dallas County Community Health Needs Assessment. Published December 8, 2023. Accessed July 22, 2025. https://www.parklandhealth.org/pdf-files/2022-dallas-county-community-health-needs-assessme-1

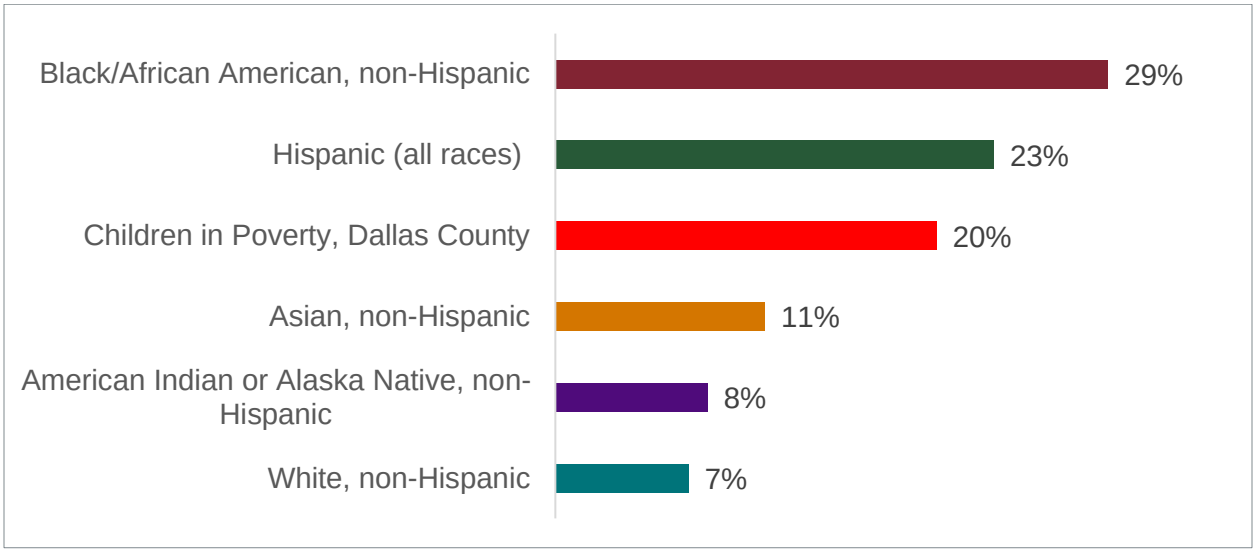
NMDOH Figure 11: Poverty in U.S., Texas, and Dallas County, 2019 - 2023



Data Source: U.S. Census Bureau, 2019-2023 American Community Survey

Child poverty saw an 8.7% decline between 2014 and 2023 in Dallas County.[14] Although there has been progress, the current rate (20.0%) still exceeds both the national (16.0%) and Texas state (18.0%) rates. The highest poverty rates are observed among Black or African American, non-Hispanic and Hispanic children-see NMDOH Figure 12.

NMDOH Figure 12: Child Poverty by Race and Ethnicity, Dallas County



Data Source: U.S. Census Bureau, 2019-2023 American Community Survey

[14] The Commit Partnership. Progress in Dallas: fewer young adults living in poverty, but much work remains. Published February 27, 2025. Accessed May 21, 2025. https://www.commitpartnership.org/insights/latest-learnings/progress-in-dallas-fewer-young-adults-living-in-poverty-but-much-work-remains

3. Neighborhood and Built Environment

This NMDOH category includes factors such as access to public transportation, parks and shared outdoor spaces, housing quality, and internet connectivity, and plays a critical role in supporting overall health and well-being.[15] Community members identified the built environment—referred to in focus groups as community infrastructure—as a key aspect of achieving and maintaining healthy communities.

According to the National Low Income Housing Coalition, the United States faces a shortage of approximately 7.1 million rental units that are affordable and available to extremely low-income households.[16] Locally, data from the CHRR indicate that 21% of households in Dallas County experience at least one severe housing challenge—such as high housing costs, overcrowding, or inadequate kitchen or plumbing facilities.[17] This rate exceeds both the state (18%) and national (17%) averages. Additionally, 17% of Dallas County households allocate half or more of their income toward housing expenses, surpassing the state and national rates of 15%.

Extremely low-income households are increasingly priced out of both urban and suburban markets. These households are defined as earning at or below the federal poverty line or 30% of a region's median income. In Texas, only 25 affordable homes exist for every 100 extremely low-income renters, reflecting a deep and persistent shortage.[18] Additionally, housing affordability poses significant challenges for young homebuyers in Texas, particularly those aged 19 to 25, who continue to take on substantial mortgage debt with rising housing costs.

As per the results of the Healthy Neighborhood Survey and focus group, access to affordable housing was identified among the top three important factors for improving the health of the community.

a. Transportation

Transportation limitations pose considerable barriers to accessing a variety of needs, ranging from healthcare services to grocery stores to green spaces, all of which improve the ability to lead a healthy life. Households located in ZIP Codes in the southern sector of Dallas County have a higher rate of households without vehicles compared to those in the northern sector. Between 2019 and 2022, 10 out of 93 ZIP Codes (11%) in Dallas County experienced an increase in the rate of households without vehicles. In contrast, 8 ZIP Codes (9%) showed a decreasing trend in this vulnerability over the same four-year period-see NMDOH Figure 13. Areas with a statistically significant decrease in households without vehicles—indicating improved access—are marked with green labels, while areas with a statistically significant increase in households without vehicles—indicating reduced access—are marked with orange labels. The map also overlays a CVI, ranging from very high (dark red) to very low (dark blue).

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[15] Centers for Disease Control and Prevention. Parks, Recreation and Green Spaces. Updated June 26, 2024. Accessed July 22, 2025. https://www.cdc.gov/physicalactivity/activepeoplehealthynation/everyone-can-be-involved/parks-recreation-and-green-spaces.html

[16] National Low Income Housing Coalition. The Gap: A Shortage of Affordable Homes. Published March 13, 2025. Accessed July 22, 2025. https://nlihc.org/gap

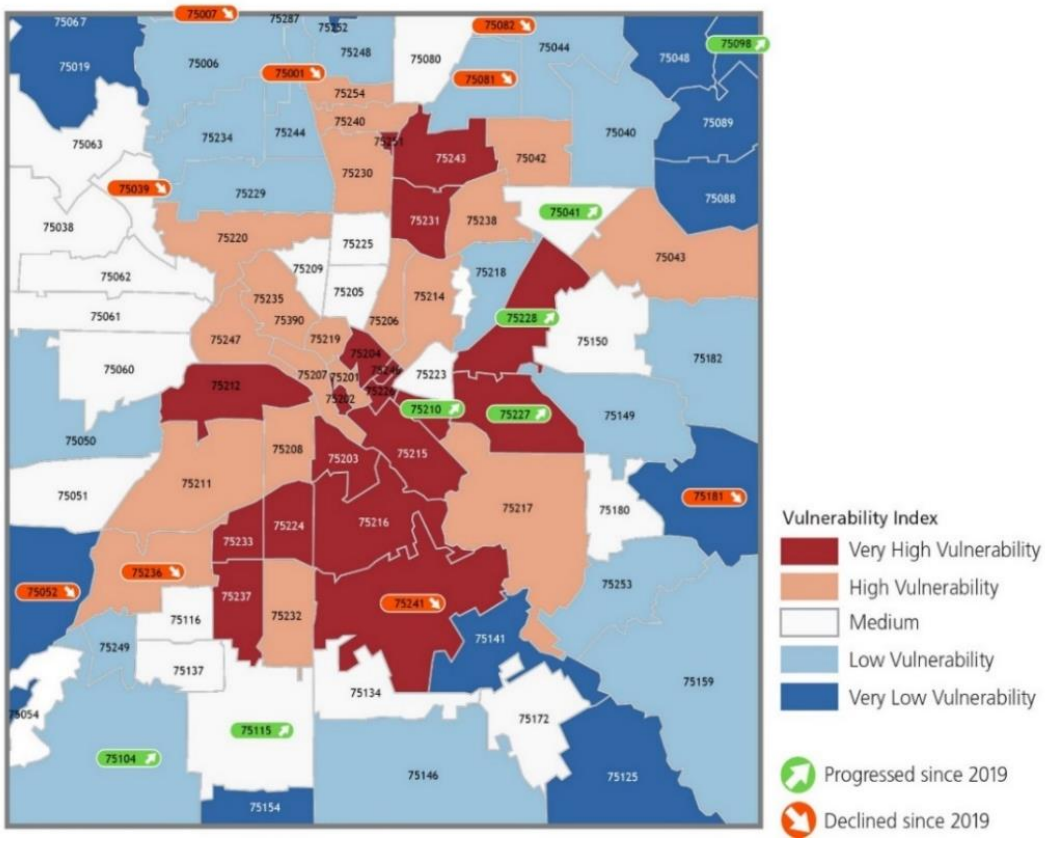
[17] County Health Rankings & Roadmaps. Dallas County, Texas – 2025. Accessed July 22, 2025. https://www.countyhealthrankings.org/health-data/texas/dallas

[18] Federal Reserve Bank of Dallas. Community Conditions Toolkit. Published 2018. Accessed July 22, 2025.

While some high-vulnerability ZIP Codes showed progress, the improvements were not sufficient to shift them into lower vulnerability categories, highlighting ongoing transportation access challenges in those communities.

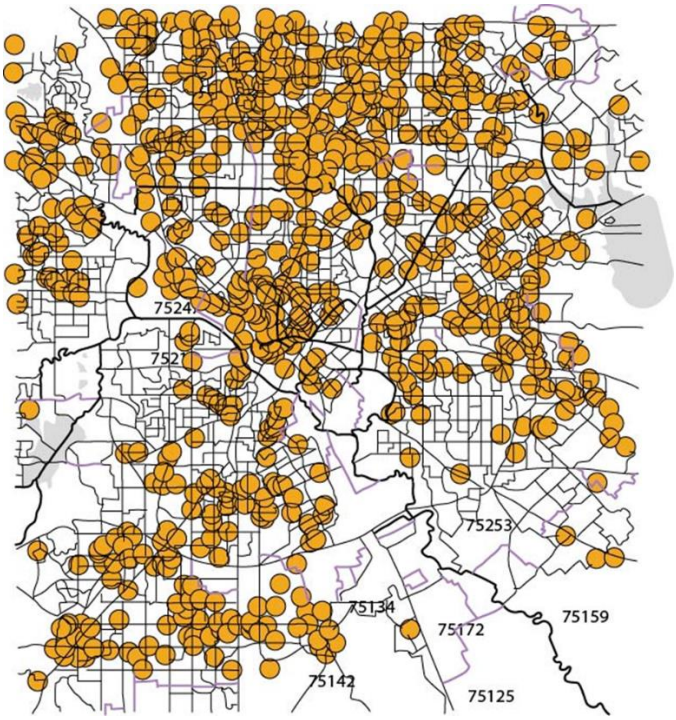
The map of Dallas County's transit system shows several key gaps in access to bus and other motor vehicle transit services-see NMDOH Figure 14. While the transit network provides extensive coverage across the county, significant geographic gaps remain in the southern areas, where fixed-route service is limited or absent. These regions rely heavily on micro transit such as shuttles and paratransit services, which may not offer the same level of convenience or frequency.

NMDOH Figure 13: Progress and Decline in Household Without Vehicles in Dallas County, 2019–2022



Adopted from PCCI

NMDOH Figure 14: Bus & Other Vehicle Transit Systems, Dallas County



Data Source: CVC, PCCI

b. Internet Connectivity

In the age of technological advancement, access to broadband, or high-speed internet access, has emerged as a powerful NMDOH, often referred to as a "super-determinant" due to its wide-ranging influence on social and economic factors that shape health outcomes. Reliable internet connectivity supports access to education, employment, and health services—key components of well-being.[19] Telehealth has transformed healthcare delivery by enabling remote consultations, chronic disease monitoring, and access to specialized care in underserved areas.

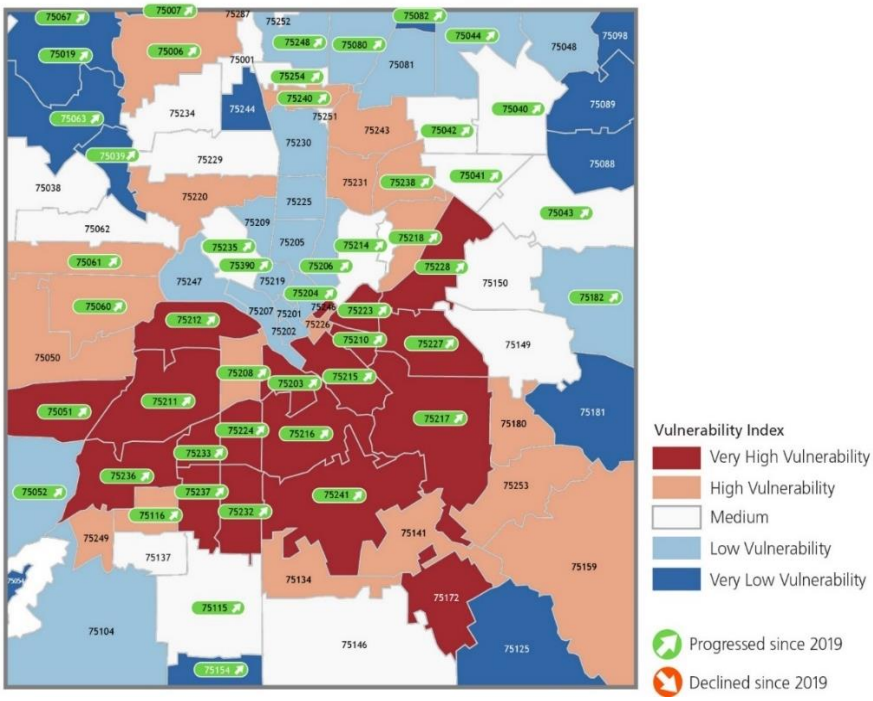
Between 2019 and 2022, 44 out of 93 ZIP Codes in the county (47%) experienced improvements in broadband connectivity-see NMDOH Figure 15. The map illustrates these changes, with green labels indicating areas with a statistically significant increase in broadband connectivity. However, many communities remain digitally challenged due to a lack of investment in broadband infrastructure, leading to significant gaps in access to smart devices and high-speed internet. These gaps not only limit access to healthcare but also exacerbate

[19] Sieck CJ, Sheon A, Ancker JS, et al. Digital inclusion as a social determinant of health. *American Journal of Public Health*. Published July 2020. Accessed August 24, 2025. https://mobroadband.org/wp-content/uploads/sites/44/2020/07/Broadband-Access-and-Social-Determinants-of-Health.pdf

existing social and economic disadvantages, worsening health outcomes for those most in need. [20,21]

In contrast, NMDOH Figure 16, presents the current connectivity landscape in Dallas County as of 2025. The map reveals clear geographic disparities in connectivity across Dallas County ZIP Codes. Northern ZIP Codes, predominantly shaded in yellow, indicate stronger connectivity, suggesting better access to digital infrastructure, transportation, and essential services. In contrast, southern ZIP Codes, particularly those shaded in blue, reflect significant gaps in connectivity. These areas are more likely to experience limited access to broadband internet, reliable transportation, and other critical infrastructure that supports health and economic opportunities.

NMDOH Figure 15: Progress in Connectivity Dallas County, 2019–2022

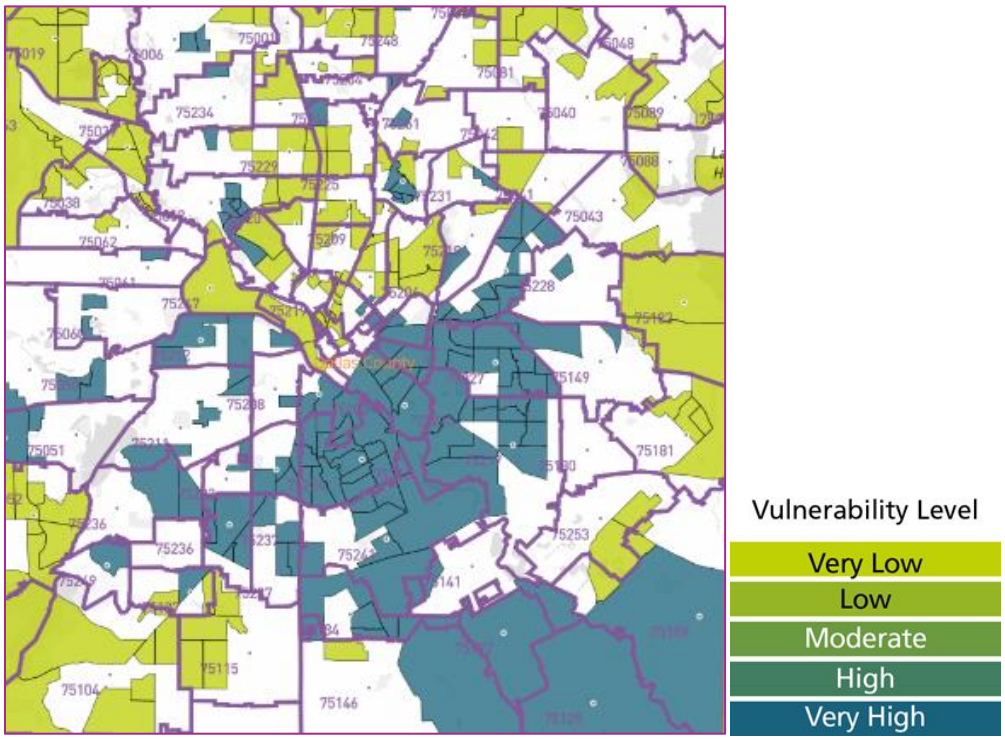


Adopted from PCCI

[20] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on the Review of Federal Policies that Contribute to Racial and Ethnic Health Inequities; Geller AB, Polsky DE, Burke SP, editors. Federal Policy to Advance Racial, Ethnic, and Tribal Health Equity. Washington (DC): National Academies Press (US); 2023 Jul 27. 6, Neighborhood and Built Environment. Available from: https://www.ncbi.nlm.nih.gov/books/NBK596398/

[21] Bauerly BC, McCord RF, Hulkower R, Pepin D. Broadband Access as a Public Health Issue: The Role of Law in Expanding Broadband Access and Connecting Underserved Communities for Better Health Outcomes. J Law Med Ethics. 2019 Jun;47(2_suppl):39-42. doi: 10.1177/1073110519857314. PMID: 31298126; PMCID: PMC6661896.

NMDOH Figure 16: Connectivity Vulnerability, Dallas County, Dallas



Data Source: CVC, PCCI

4. Neighborhood Crime and Violence

Violence affects thousands of residents each year, and it shapes the social and economic fabric of communities across the region. Fostering a culture of safety protects individuals from harm and promotes a healthier, more productive environment for everyone.[22]

a. Domestic and Family Violence

Domestic violence is a public health and safety issue in Dallas County, with wide-ranging impacts on individuals, families, and communities. Between 2023 and 2025, domestic violence has consistently accounted for a significant share of reported crimes in the county. According to the Dallas Police Department's 2025 audit report, there were a total of 13,868 domestic violence incidents in the county. Of these, 64%, or 8,868 cases involved IPV, and 15 IPV-related deaths were recorded that year.[23]

The geographic and demographic breakdown of domestic violence in Dallas County shows that certain populations and neighborhoods are disproportionately affected. As of July 2025, approximately 72% of individuals experiencing domestic violence in Dallas County are women, highlighting the gendered nature of this public health crisis. Geographic data further reveals that

[22] E. Dallas, TX Violent Crime Rates and Maps | CrimeGrade.org. CrimeGrade.org. Published June 12, 2023. https://crimegrade.org/violent-crime-dallas-tx/

[23] Tableau. Dallascityhall.com. Published 2025. Accessed July 17, 2025. https://dallascitydata.dallascityhall.com/views/DomesticViolenceDashboard/DallasDomesticViolenceCrimes?%3Aiid=1&%3Aembed=y&%3AisGuestRedirectFromVizportal=y

ZIP Code 75216 reports the highest number of family violence crimes, accounting for 7% of all such incidents in the county. Within this area, 61.42% of reported victims identify as Black or African American, underscoring the intersection of race, location, and vulnerability.[24] Three of the five ZIP Codes with the highest domestic violence rates—75216, 75217, and 75211 account for 17% of all domestic violence cases reported in Dallas County.

b. Violent Crime

According to the Texas Department of Public Safety's 2023 Crime in Texas report, violent crime in Dallas County was the third-largest county contributor to the state's overall violent crime numbers. Dallas County ranks in the 24th percentile nationally, indicating it is only safer than 24% of U.S. counties. Within Dallas County, ZIP Codes 75243, 75216, and 75217 have the highest rates of violent crime.[25] Of these three ZIP Codes, 75216 and 75217 have been identified as having the highest incarceration rates in Texas.[26]

Dallas County reported a total of 12,478 violent crimes in 2023, including homicides, aggravated assaults, robberies, and sexual assaults.[27] This reflects a 4.5% increase compared to the previous year, highlighting ongoing challenges despite concerted prevention efforts.

Further emphasizing the severity of the issue, CHR&R reports that Dallas County's homicide rate stands at 10 deaths per 100,000 people, significantly higher than both the Texas and national averages of 7 per 100,000.

5. Food Environment and Food Insecurity

A food environment refers to the conditions that shape what foods are available, affordable, and promoted. Food insecurity, on the other hand, refers to the lack of consistent access to enough nutritious and safe food for an active, healthy life. A healthy food environment supports choice and access, whereas food insecurity reflects a breakdown in that system, often driven by economic and structural barriers.

a. Food Environment

People primarily obtain food from retail venues like grocery stores and farmers' markets, or food service venues such as restaurants, schools, and cafeterias. When healthy options in these settings are limited or unaffordable, individuals often resort to less nutritious, high-calorie foods. Ensuring that healthy food is accessible and affordable across all food environments is a key public health priority.

The map in NMDOH Figure 17 illustrates a stark contrast in the distribution of food retail venues across Dallas County. The central and northern areas show a dense concentration of stores,

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[24] Office of Disease Prevention and Health Promotion. Healthy People 2030. Healthy People 2030. Published 2024. https://odphp.health.gov/healthypeople

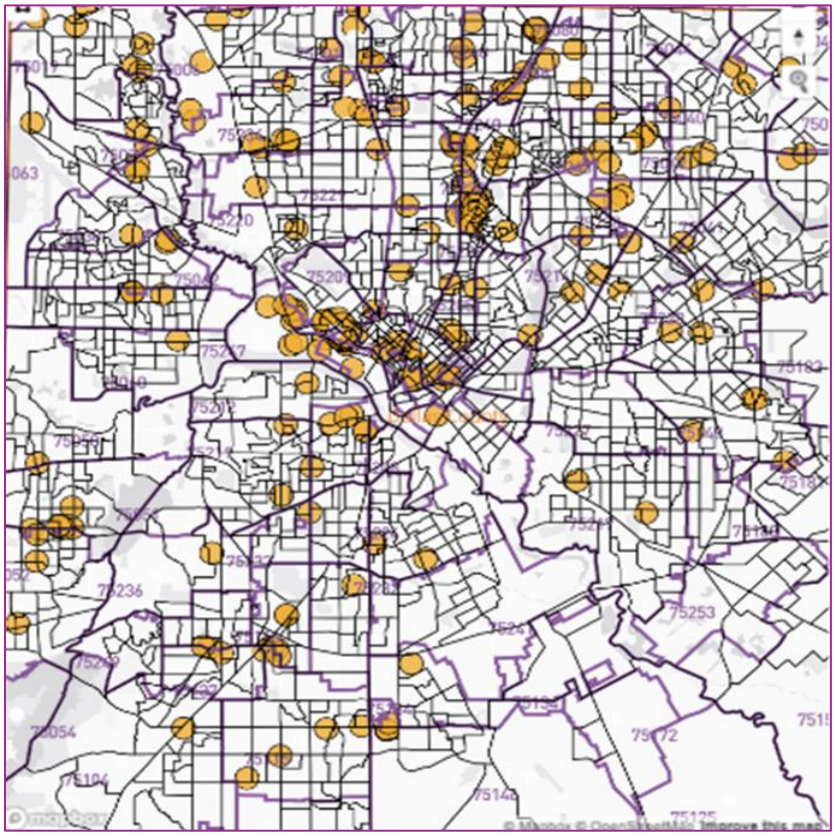
[25] City of Dallas. Crime Analytics Dashboard. Dallas City Hall Open Data Portal. Published online. Accessed July 29, 2025. https://dallascitydata.dallascityhall.com/views/CrimeAnalyticsDashboard/CrimeOverviewD

[26] McCullough J. Two Dallas ZIP Codes Produce More Inmates Than Any Others in Texas. D Magazine. Published November 13, 2019. Accessed August 1, 2025. https://www.dmagazine.com/frontburner/2019/11/two-dallas-zip-codes-produce-more-inmates-than-any-others-in-texas/

[27] Texas Department of Public Safety. 2023 Crime in Texas Annual Report. Published March 10, 2024. Accessed August 1, 2025. https://www.dps.texas.gov/sites/default/files/documents/crimereports/23/2023cit.pdf

marked by clusters of orange dots. In contrast, the southern and southwestern regions reveal significant gaps, with few or no stores in some areas. This uneven distribution highlights the presence of food deserts, where residents face limited access to affordable, nutritious food. Both the community focus groups, and the Healthy Neighborhood Survey identified the lack of grocery stores and limited access to healthy foods, including fresh produce, as key barriers to building a healthy community. Increasing the availability of grocery stores in underserved areas was consistently highlighted as a critical need.

NMDOH Figure 17: Food Environment, Food Retail Venues, Dallas County, 2025



Data Source: CVC, PCCI

b. Food Insecurity

Food insecurity remains a serious public health issue in the U.S. According to the United States Department of Agriculture (USDA), household food security exists along a continuum ranging from high food security to very low food security. This continuum is categorized into four distinct levels, as outlined below:

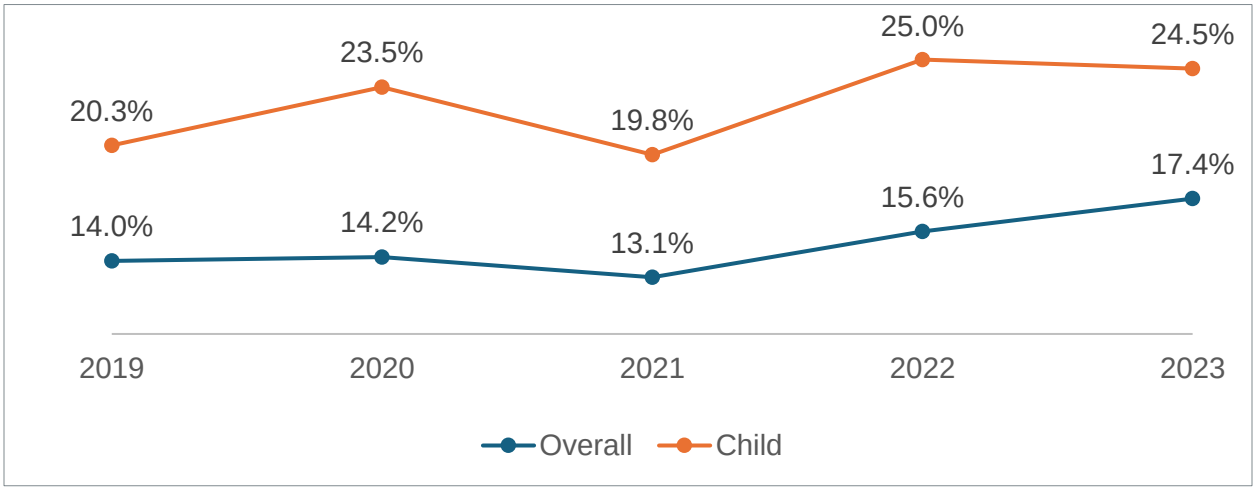
- **High food security**—Households had no problems, or anxiety about, consistently accessing adequate food.
- **Marginal food security**—Households had problems at times, or anxiety about, accessing adequate food, but the quality, variety, and quantity of their food intake were not substantially reduced.

- **Low food security**—Households reduced the quality, variety, and desirability of their diets, but the quantity of food intake and normal eating patterns were not substantially disrupted.
- **Very low food security**—At times during the year, eating patterns of one or more household members were disrupted, and food intake reduced because the household lacked money and other resources for food.[28]

Limited access to affordable, healthy food options often leads people to consume unhealthy, high-calorie foods, increasing the risk of for poor health outcomes; food-insecure adults are at a higher risk of developing several chronic conditions, including coronary heart disease, diabetes, obesity, and cancer.[29,30] Furthermore it disproportionately affects a wide range of populations who often face structural and systemic barriers to health and well-being. These groups include children, many communities of color, low-income households, single parent households, immigrant populations, LGBTQIA+ individuals, formerly incarcerated individuals, and people with disabilities.

Between 2019 and 2023 in Dallas County, child food insecurity consistently exceeded overall food insecurity. Overall food insecurity fluctuated starting at 14.0% in 2019 and rising to 17.4% in 2023. However, the child food insecurity trend starts at 20.3% in 2019, increasing to 25% in 2022 and decreasing slightly to 24.5% in 2023. This trend highlights the disproportionate impact of food insecurity on children, especially during and after the COVID-19 pandemic-see NMDOH Figure 18.

NMDOH Figure 18: Food Insecurity Trend, Dallas County, 2019 – 2023



Data Source: Feeding America

[28] USDA Economic Research Service. Food security in the U.S. – measurement. Updated January 8, 2025. Accessed May 11, 2025. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/measurement

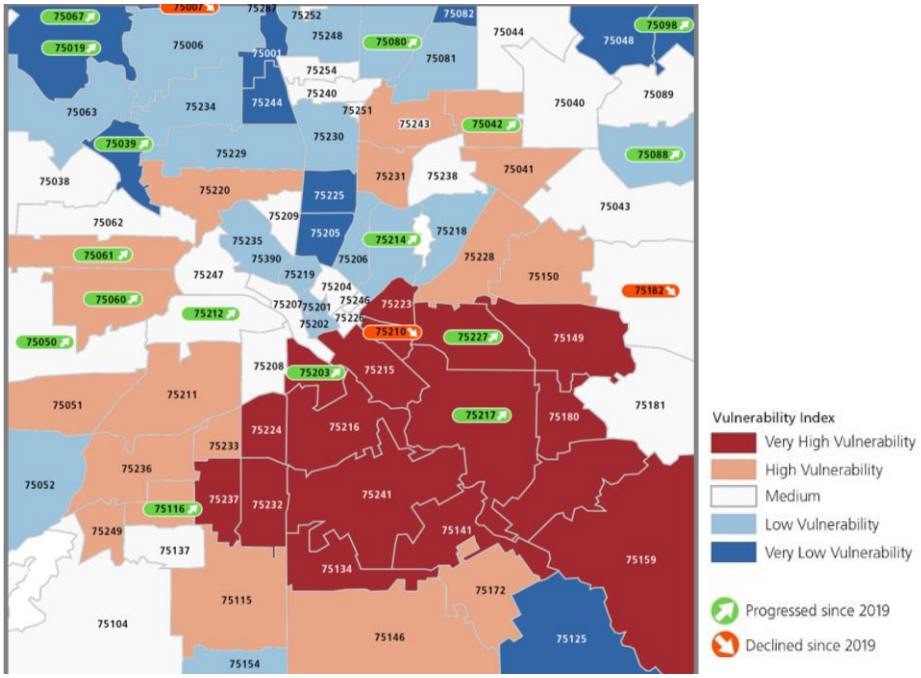
[29] Precker M. Food insecurity's long-term health consequences. www.heart.org. Published September 22, 2021. https://www.heart.org/en/news/2021/09/22/food-insecuritys-long-term-health-consequences

[30] Ziso D, Chun OK, Puglisi MJ. Increasing access to healthy foods through improving food environment: a review of mixed methods intervention studies with residents of low-income communities. Nutrients. 2022;14(11):2278. doi:10.3390/nu14112278

Texas leads the nation in hunger, surpassing California, and the Dallas-Fort Worth metro area ranks third in the country among major metropolitan regions for food insecurity, behind only Los Angeles and New York City.[31] Moreover, Dallas County stands out in North Texas for having the highest rate of food insecurity, with more than 450,000 residents affected and makes up 52% of NTFB's food-insecure population; 18% of this population reside in 10 south and southern Dallas ZIP Codes.[4,32]

Racial disparities in food access are also widening: 29% of Black or African American, non-Hispanics residents and 21% of Hispanics residents reported food insecurity, compared to 10% of white residents. Geographic data shows that southern Dallas, particularly around Interstates 35 and 45, faces the highest rates of food insecurity, closely mirroring areas with the greatest chronic disease burden—highlighting a strong link between poor nutrition access and health outcomes[33,34]-see NMDOH Figure 19.

NMDOH Figure 19: Progress and Decline in Food Insecurity, Dallas County, 2019–2022



Adopted from PCCI

[31] NTFB. Texas Leads the Nation in Hunger; DFW Ranks Third Among U.S. Metro Areas | North Texas Food Bank. North Texas Food Bank | Serving North Texans facing hunger. Published May 14, 2025. https://ntfb.org/blog-texas-leads-the-nation-in-hunger-dfw-ranks-third-among-u-s-metro-areas/

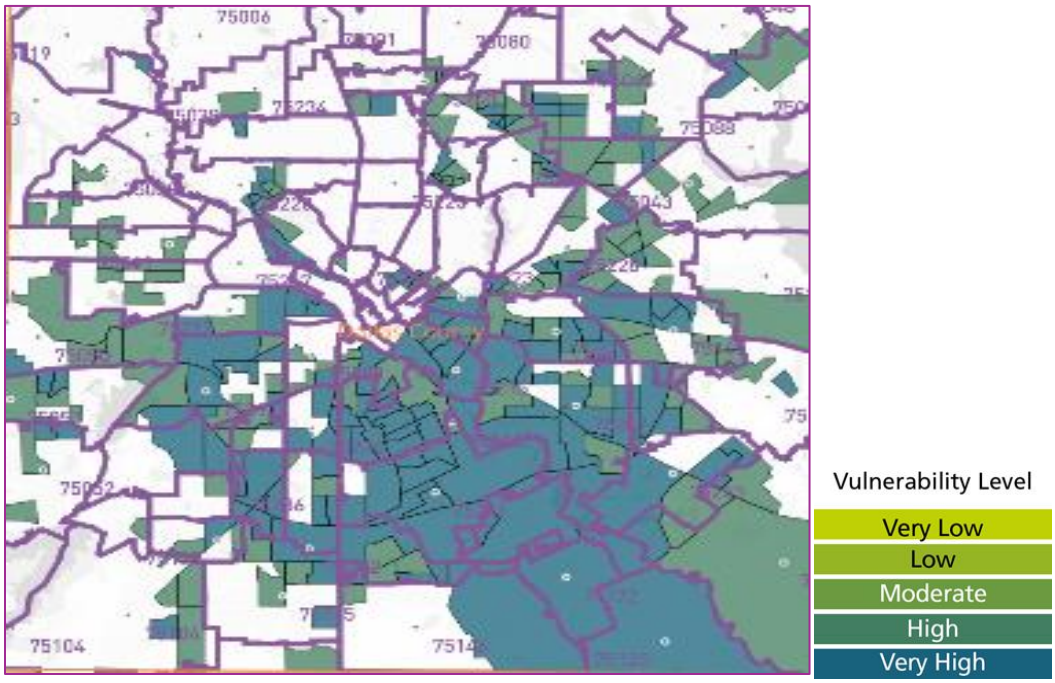
[32] North Texas Food Bank. Texas tops nation in hunger crisis, North Texas Food Bank serves fourth-largest area according to new Feeding America study. Published May 15, 2024. Accessed May 11, 2025. https://ntfb.org/wp-content/uploads/2024/05/MMG2024.pd

[33] Ruby E. Dallas County Food Insecurity Is Worse Than the National Average. Dallas Observer. Published April 16, 2025. Accessed August 2, 2025. https://www.dallasobserver.com/news/dallas-county-food-insecurity-is-worse-than-the-national-average-22115753

[34] Parkland Health; Dallas County Health and Human Services (DCHHS). 2022 Dallas County Community Health Needs Assessment. Published 2022. Accessed August 2, 2025. https://www.parklandhealth.org/dallas-community-health

While progress was observed from 2019 to 2022, 15 of Dallas County's 93 ZIP Codes (16%) experienced a statistically significant decrease in food insecurity vulnerability, marked with green labels; only three of these ZIP Codes—75227, 75217, and 75203—are in the county's southern sector with an historical high vulnerability for food insecurity. Despite these gains, the improvements were not enough to move these areas out of the "very high vulnerability" category. ZIP Code 75210, which has exhibited very high food insecurity vulnerability, saw further decline in food insecurity during this period-see NMDOH Figure 20.

NMDOH Figure 20: Food Insecurity Vulnerability, Dallas County



Data Source: CVC, PCCI

6. Access to Healthcare

Access to healthcare is essential to not only maintain physical health and screen for preventable diseases, but it is critically necessary for accessing affordable mental health and general wellness services. Health insurance coverage facilitates entry into the healthcare system, while access to consistent health services ensures individuals receive necessary screenings and preventive care. Together, they are critical components of timely and effective healthcare access that significantly impacts an individual's ability to lead a healthy life.[35]

[35] AHRQ: Access to Care. Available at https://www.ahrq.gov/topics/access-care.html

a. Health Insurance Coverage

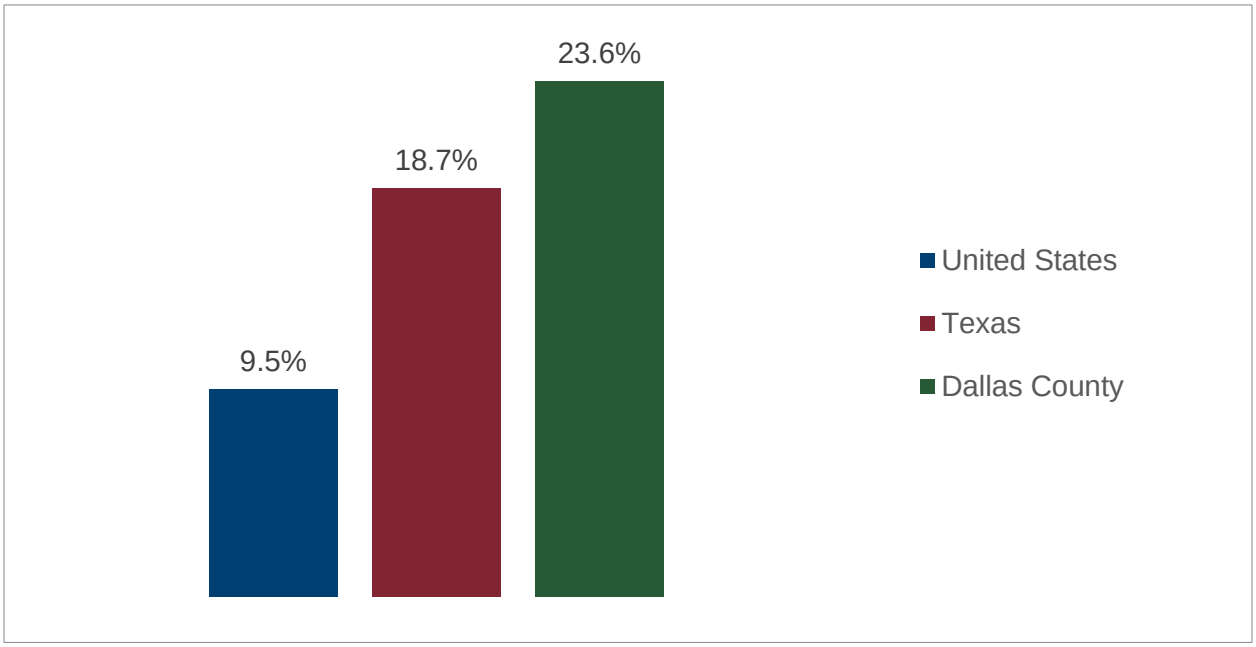
Outside of facilitating access to health services, health insurance also covers medical expenses which mitigates the burden of medical debt allowing for those finances to go to other NMDOH, such as food access or education.[36,37]

Dallas County has consistently maintained a higher uninsured rate than both Texas and the United States overall. While all three saw significant declines in uninsured rates beginning in 2014, Dallas County started at a much higher baseline—31% in 2008—and, even after improvements, remained at 24% in 2022. In contrast, Texas dropped from 26% to 19%, and the U.S. average fell from 17% to 10% during the same period.

In Dallas County, 23.6% of individuals under age 65 are without health insurance -see NMDOH Figure 21, an increase from 21% reported in the 2022 CHNA; and more than one in seven children are uninsured.

The map in NMDOH Figure 22, visually reinforces the vulnerability variances in health insurance coverage across Dallas County. Census tracks in southern and southeastern ZIP Code areas, including regions shaded in dark blue and dark green, indicate significantly higher rates of uninsurance. These sectors contrast sharply with the northern and northeastern areas, which are shown in white and light green, representing higher levels of insurance coverage.

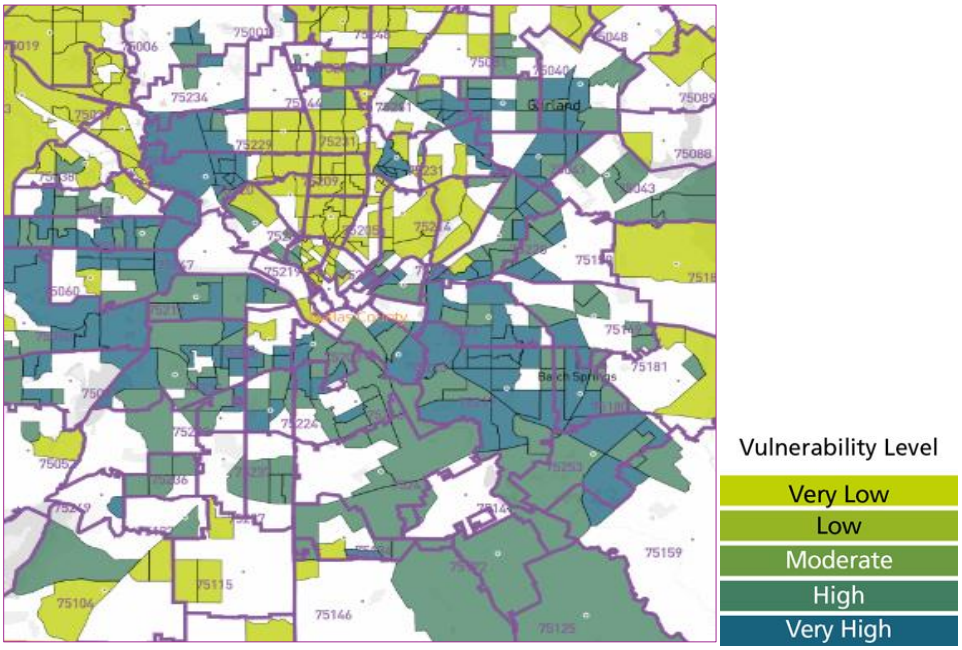
NMDOH Figure 21: Persons under 65 years of age without Health Insurance, U.S, Texas, Dallas County, 2019-2023



Data Source: U.S. Census Bureau QuickFacts: United States; Texas; Dallas County, Texas

[36] KFF Health Coverage by Race and Ethnicity, 2010 – 2023. Available at https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/
[37] American Hospital Association. The Importance of Health Coverage. American Hospital Association; 2017. Accessed October 22, 2025. https://www.aha.org/system/files/2018-01/report-coverage-overview-2017_0.pdf

NMDOH Figure 22: Health Insurance Coverage Vulnerability, Dallas County



Data Source: CVC, PCCI

b. Access to Healthcare

Access to healthcare is not a single-factor issue—it involves several interconnected dimensions that influence whether individuals can effectively obtain the care they need. Scholars identify five key dimensions to consider:

- **Acceptability** (patients' satisfaction and cultural alignment with the services provided),
- **Availability** (whether there are enough services and providers),
- **Accommodation** (how well services align with patients' needs and circumstances),
- **Affordability** (the financial burden of care),
- **Accessibility** (how easily people can reach those services).

Within this framework, spatial accessibility plays a foundational role. It specifically addresses the geographic and logistical ability of people—known as a catchment population or service area—to conveniently reach a healthcare facility within an acceptable amount of time.

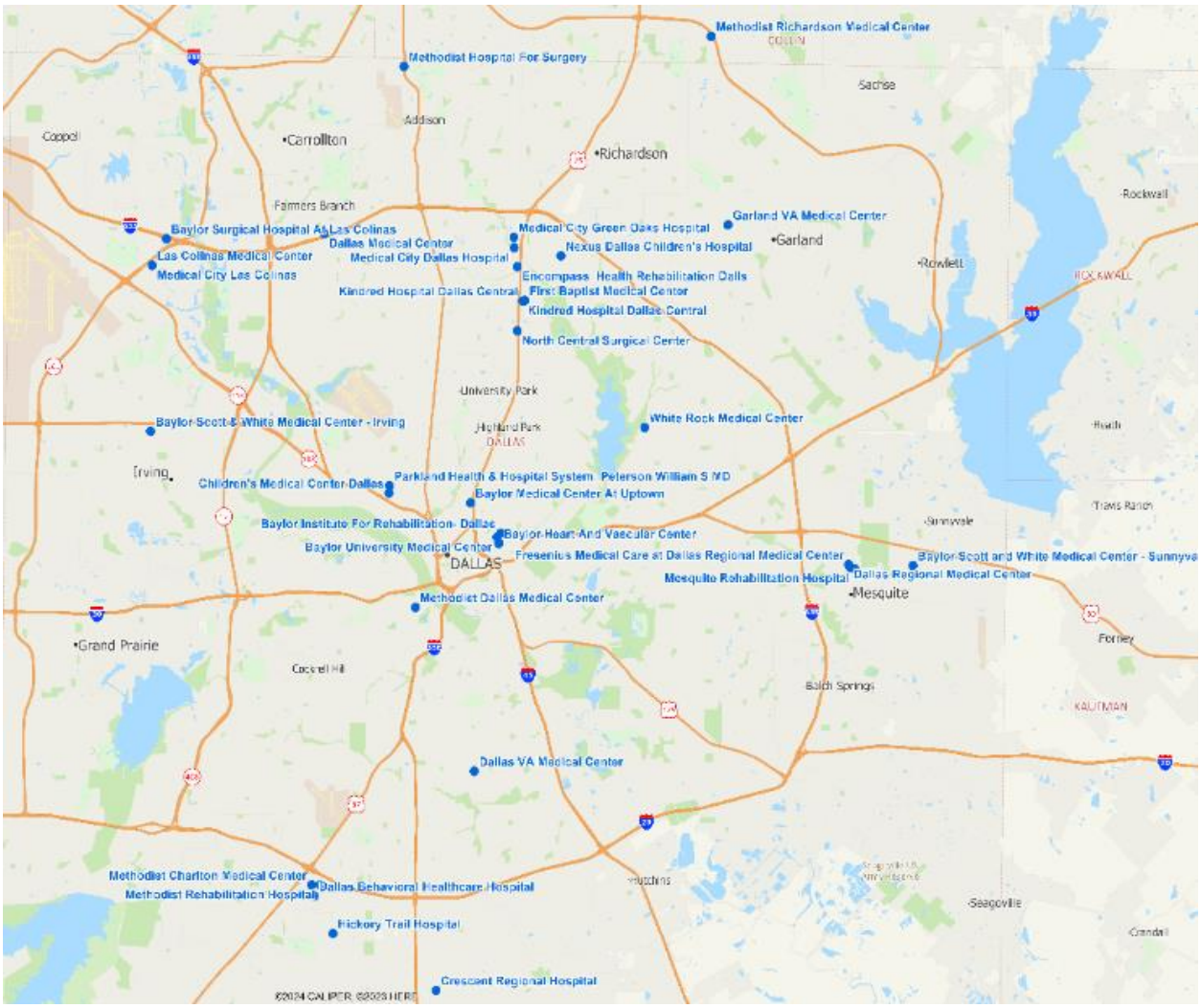
Spatial accessibility is critical because it directly affects whether the other dimensions of access—like affordability or acceptability—can even come into play. If people can't physically reach care, then service availability or cultural sensitivity becomes irrelevant. Furthermore, spatial accessibility must consider not only distance and time, but also transportation modes, infrastructure, costs, and social or organizational barriers.

In sum, improving access to care requires addressing spatial accessibility alongside other dimensions, ensuring that services are not only available and affordable but also reachable and

relevant to the communities they are meant to serve.[38] In Dallas County, the southeastern sector, has a gap in primary care physicians' availability when compared to the rest of the county.

The role of spatial accessibility was underscored throughout the focus group sessions with community members and community-based organizations alike, where the infrastructural needs of the community were continuously discussed as barriers to leading a healthy life in Dallas County.

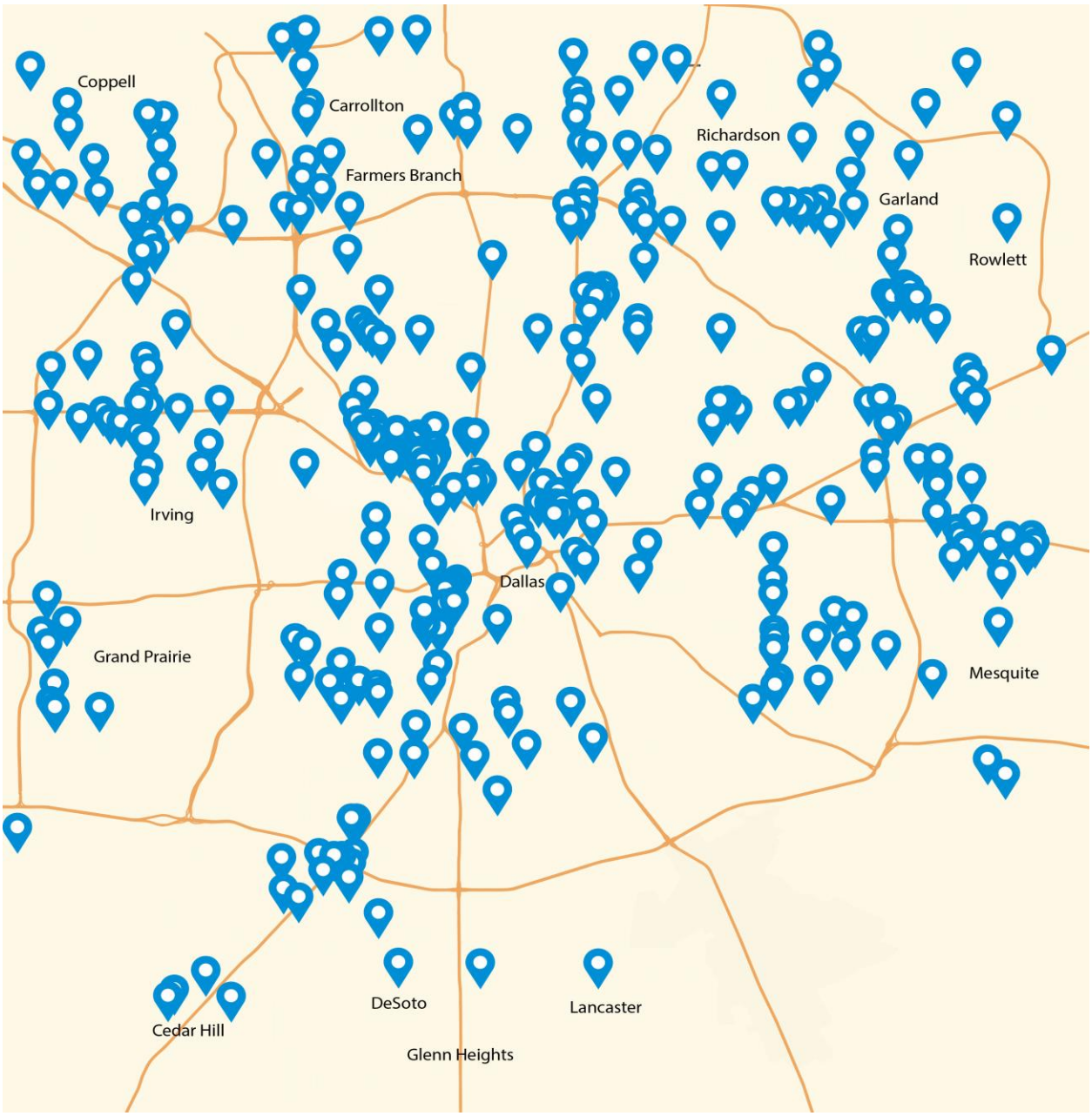
NMDOH Figure 23: Spatial Distribution of Hospitals, Dallas County



Data Source: American Hospital Association Directory

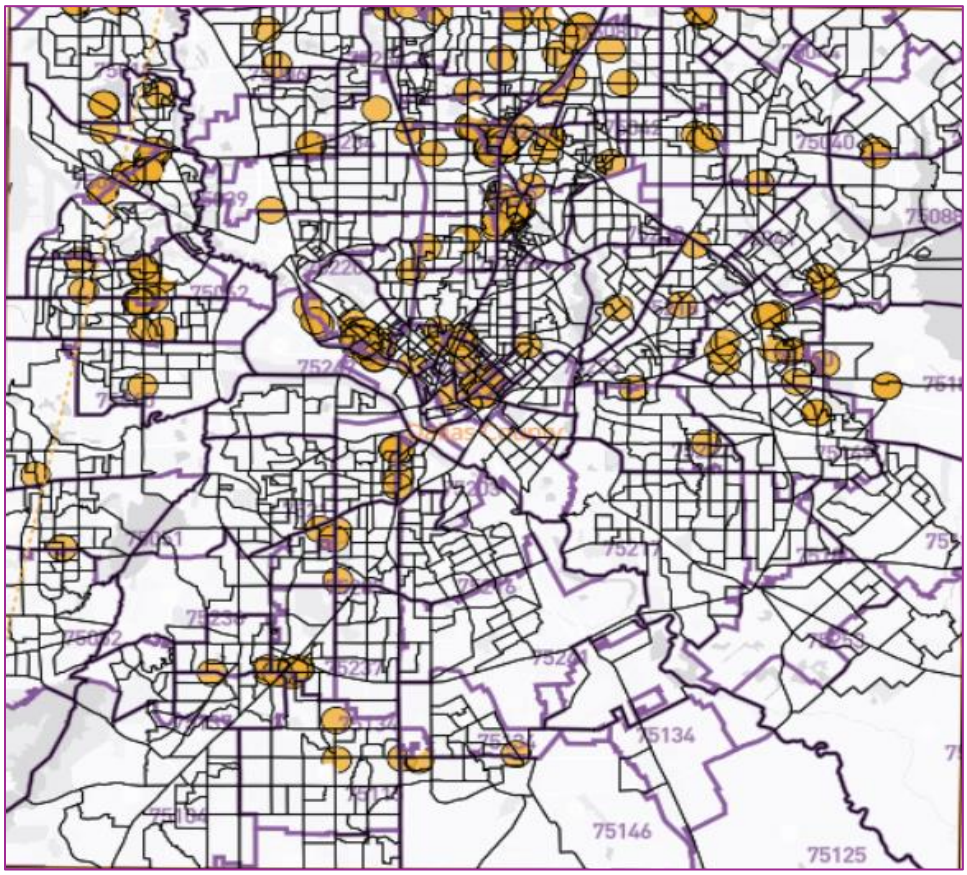
[38] Okundi AO, Varol C. Spatial analysis of primary healthcare accessibility patterns in Migori County, Kenya. SSM Health Syst. 2024;2:100005. doi:10.1016/j.ssmhs.2023.100005

NMDOH Figure 24: Primary Care Physicians Distribution, Dallas County



Data Source: Texas Department of State Health Services Primary Care Office

NMDOH Figure 25: Spatial Specialty (without mental health) Services Distribution, Dallas County



Data Source: CVC, PCCI

In Dallas County, there is a significant disparity in the distribution of healthcare services, particularly among hospitals, primary care providers, and specialty care facilities-see NMDOH Figure 23, NMDOH Figure 24, and NMDOH Figure 25. The maps reveal a pronounced concentration of these services in the central and northern regions of the county. In contrast, the southern and southwestern areas are notably underserved; specialty care shows the most severe gap. Community members who provided input through the focus groups and online survey, voiced concerns about this imbalance and have specifically called for increased availability of healthcare services—specifically specialty care—in the southern sector of the county to better meet local needs.

V. DALLAS COUNTY HEALTH PROFILE

A. Life Expectancy

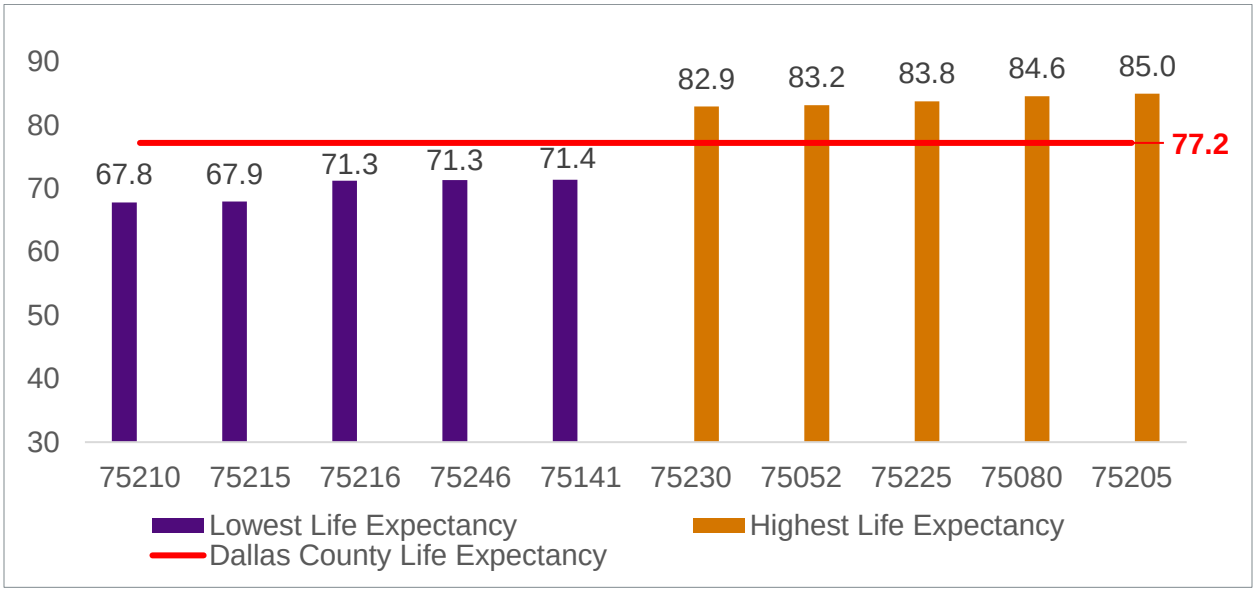
Life expectancy refers to the average remaining years of life for individuals at a given age, based on age-specific death rates during a particular period. It can also be broken down by

population characteristics such as sex, race, or ethnicity to highlight differences in mortality patterns.[39]

In 2023, the national life expectancy was 78.4 years.[40] Between 2016 and 2023, Dallas County reported an overall life expectancy of 77.2 years. A bar graph highlights the disparities across the county, with ZIP Codes 75210, 75215, 75216, 75246, and 75141 highlighted in purple to indicate significantly lower life expectancy, ranging from 67.8 to 71.4 years, well below the county overall rate. These areas are marked by high CVI scores. In contrast, ZIP Codes in North Dallas, shown in orange, reflect the highest life expectancy in the county, spanning from 82.9 to 85.0 years. These communities benefit from lower CVI scores and better access to healthcare services.

While life expectancy was significantly impacted by COVID-19 between 2020 and 2021, it has shown recovery alongside declining mortality rates;[41] a significant 17.2-year gap remains between the ZIP Code with the lowest life expectancy (75210) and the highest (75205).

Life Expectancy Figure 1: Variances between ZIP Codes with Lowest and Highest Life Expectancy, Dallas County



Data Source: Vital Statistics and Census[42]

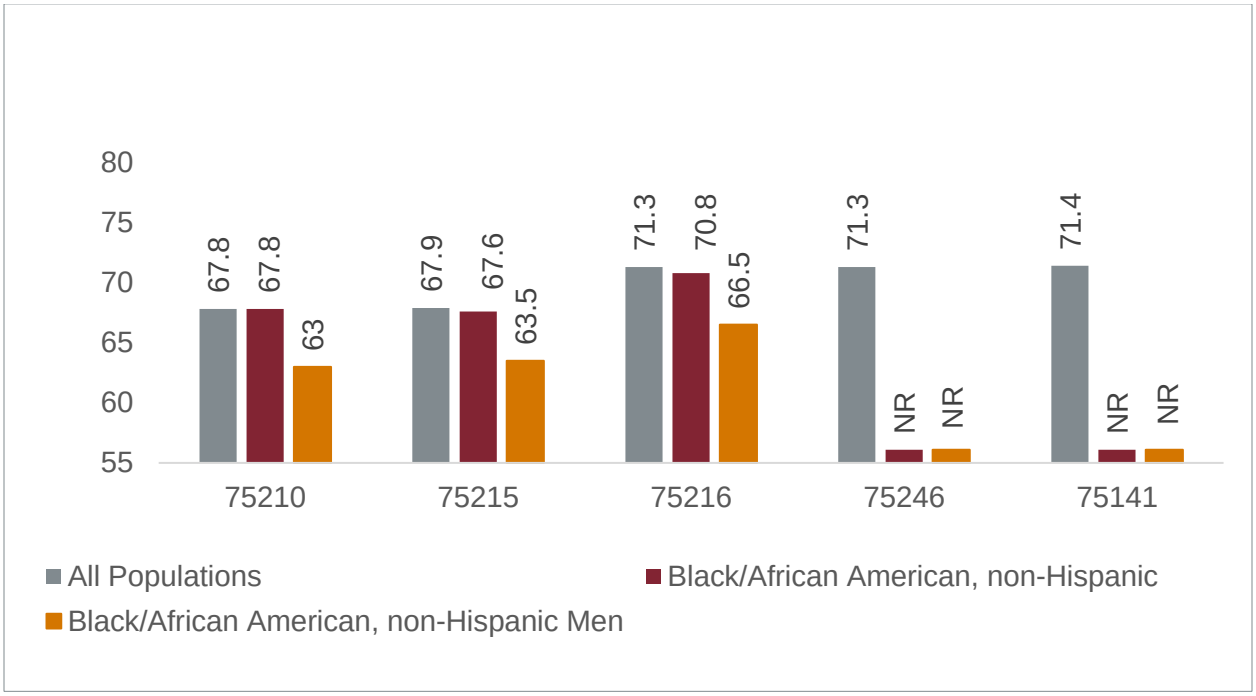
[39] Centers for Disease Control and Prevention. Life Expectancy - Health, United States. National Center for Health Statistics. Updated July 31, 2024. Accessed August 1, 2025. https://www.cdc.gov/nchs/hus/sources-definitions/life-expectancy.htm

[40] Murphy SL, Kochanek KD, Xu J, Arias E. Mortality in the United States, 2023. NCHS Data Brief, no. 521. Hyattsville, MD: National Center for Health Statistics; December 2024. Accessed August 1, 2025. https://www.cdc.gov/nchs/products/databriefs/db521.htm

[41] Parkland Health. 2022 Dallas County Community Health Needs Assessment. Parkland Health; 2022. Accessed July 24, 2025. https://www.parklandhealth.org/pdf-files/2022-dallas-county-community-health-needs-assessme-1

[42] The data is from Vital statistics and Census ACS population data and the life expectancy is calculated based on - Arias E, Escobedo LA, Kennedy J, Fu C, Cisewski J. U.S. Small-area Life Expectancy Estimates Project: Methodology and Results Summary [PDF – 8 MB]. National Center for Health Statistics. Vital Health Stat 2(181). 2018.

Life Expectancy Figure 2: Life Expectancy for All Populations, Black or African American, non-Hispanic, and Black or African American, non-Hispanic Men in ZIP Codes with the Lowest Life Expectancy, Dallas County (2016-2023)



NR: Non-Reliable; data suppressed due to small sample size
Data Source: Vital Statistics and Census[43]

Black or African American, non-Hispanic residents consistently show lower life expectancy compared to the general population in each ZIP Code. The most pronounced disparities are seen among Black or African American non-Hispanic men, whose life expectancy drops very low in ZIP Codes 75246 and 75141-see Life Expectancy Figure 2.

B. Mortality

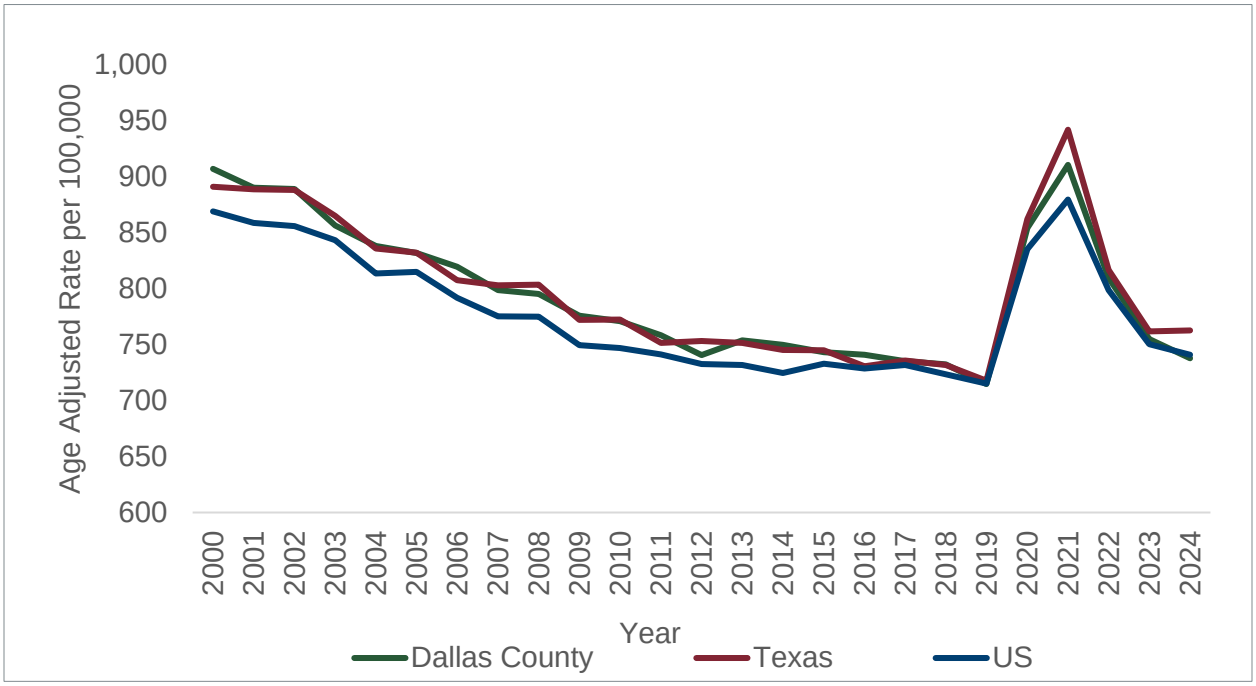
Mortality is a critical public health indicator that reflects the overall health of a population. Analyzing mortality trends allows public health officials to track progress, identify health disparities, and implement targeted interventions. As one of Texas' most populous and diverse counties, Dallas County faces unique public health concerns. Mortality data here often highlights disparities by race, ethnicity, income, and geographic areas.

Mortality Figure 1 shows the age-adjusted mortality rates per 100,000 people from 2000 to 2024 across Dallas County, Texas, and the U.S. From 2000 through 2019, all three areas experienced a decline in mortality rates. However, beginning in early 2020, all three areas experienced an increase in mortality, peaking in 2021, which aligns with the impact of the COVID-19 pandemic.

[43] The data is from Vital statistics and Census ACS population data and the life expectancy is calculated based on - Arias E, Escobedo LA, Kennedy J, Fu C, Cisewski J. U.S. Small-area Life Expectancy Estimates Project: Methodology and Results Summary [PDF – 8 MB]. National Center for Health Statistics. Vital Health Stat 2(181). 2018.

During this period, Dallas County reached a high of approximately 910 deaths per 100,000, compared to 942 in Texas, and 879 nationally. Following this peak, mortality rates began to decline again by late 2022, with projections into 2024 indicating continued improvement. However, rates have not yet returned to pre-pandemic levels.

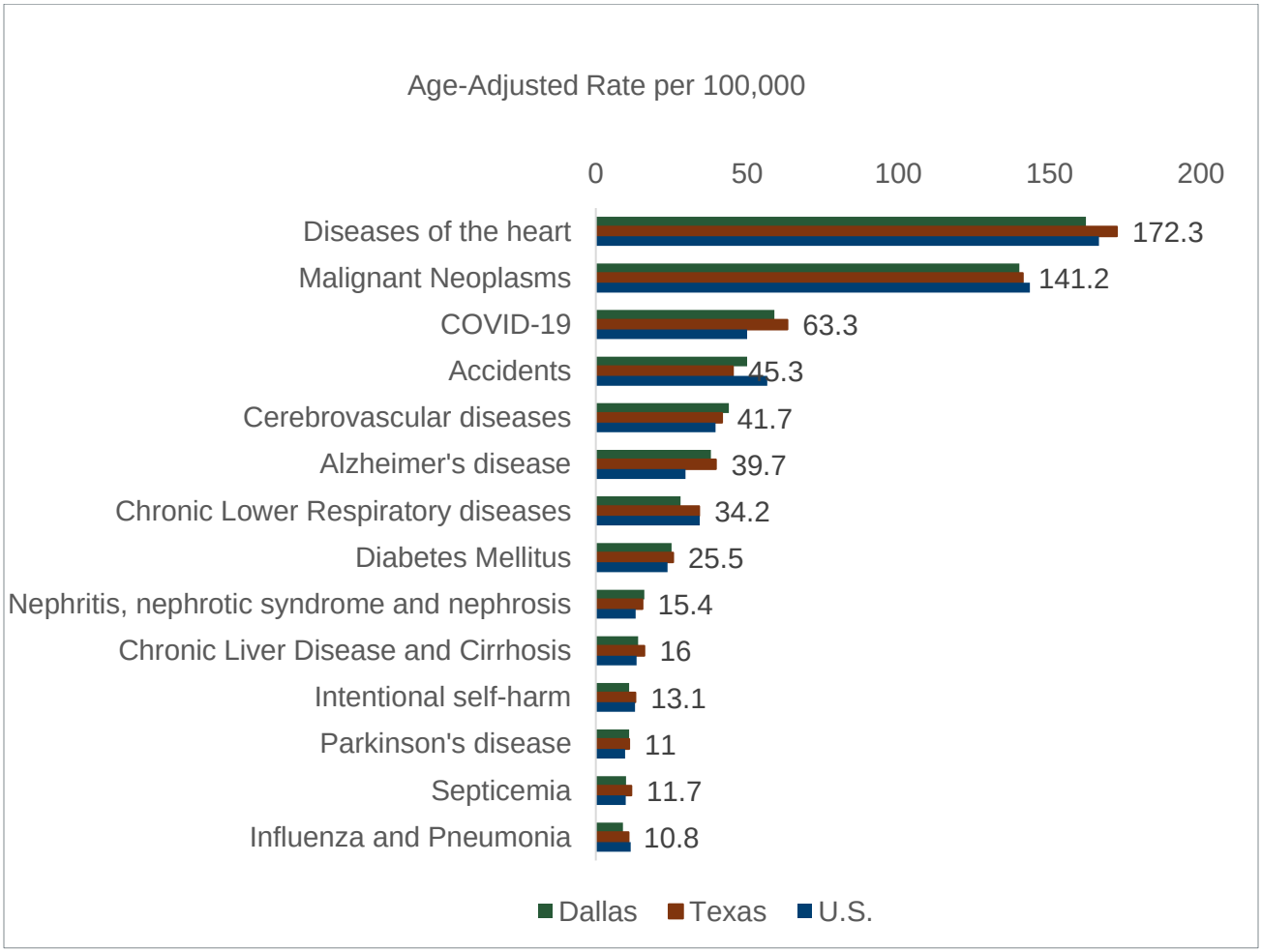
Mortality Figure 1: Mortality Rate in Dallas County, Texas, and U.S., 2000-2024



Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

Mortality Figure 2 compares age-adjusted death rates per 100,000 people across leading health conditions. Diseases of the heart consistently rank as the leading cause of death in all three geographic areas, with rates of 162 in Dallas County, 166 in Texas, and 172 nationally. Malignant neoplasms (cancers) follow closely, with similar rates in Dallas County and Texas (around 140 per 100,000) and a slightly higher rate in the U.S. (143.5). COVID-19 remains a significant contributor to mortality, particularly in the state of Texas, which reports a higher rate (63 per 100,000) compared to Dallas County (59) and the U.S. (50).

Mortality Figure 2: Leading Causes of Death in Dallas County, Texas, and U.S., 2020-2024

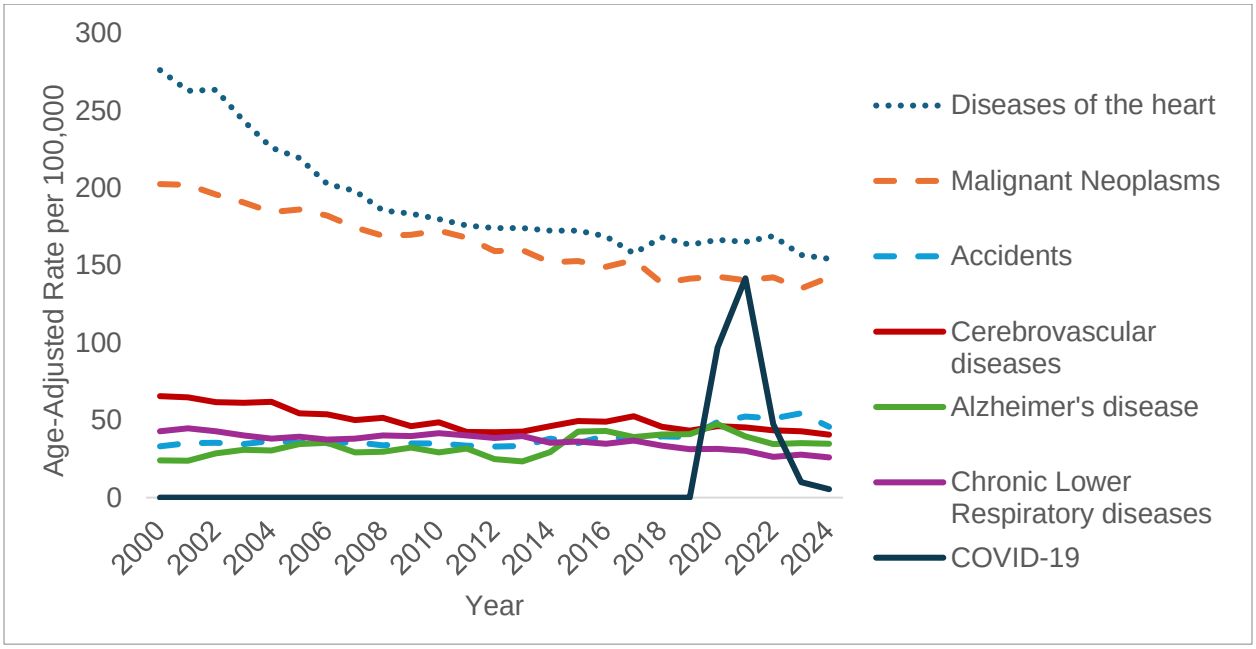


Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

Mortality Figure 3 presents age-adjusted mortality rates per 100,000 population for the seven leading causes of death in Dallas County from 2000 to 2024:

1. Diseases of the heart
2. Malignant neoplasms (cancers)
3. Accidents
4. Cerebrovascular diseases
5. Alzheimer’s disease
6. Chronic lower respiratory diseases
7. COVID-19

Mortality Figure 3:Top Seven Leading Causes of Death (Mortality Rate Trends), Dallas County, 2000-2024



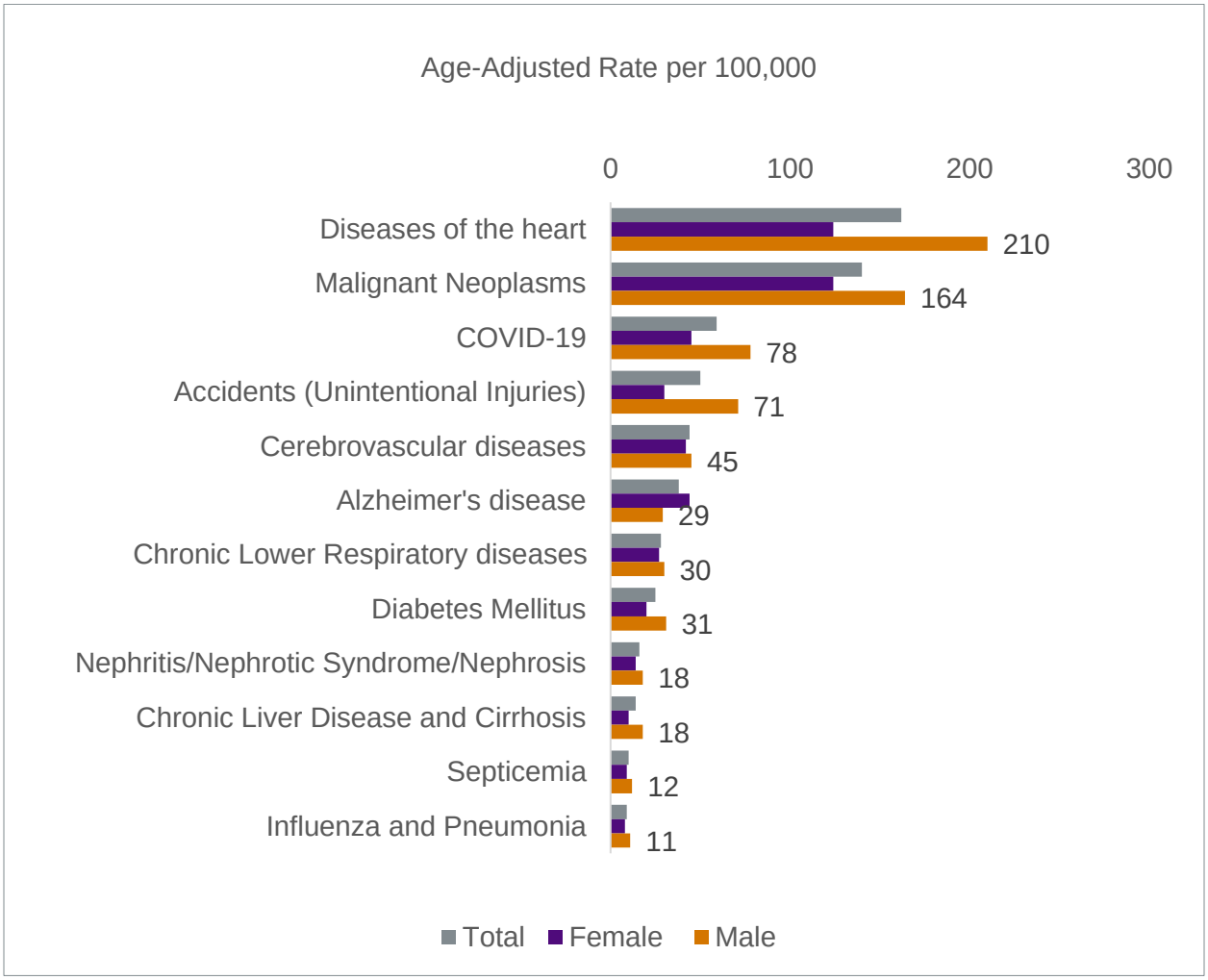
Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

1. Mortality by Sex

Mortality Figure 4 shows that males experience higher mortality rates than females for nearly every leading cause of death in Dallas County. This disparity is especially evident in heart disease, malignant neoplasms, COVID-19, and unintentional injuries (accidents). This persistent pattern, where males exhibit consistently higher age-adjusted mortality rates across most leading causes of death, mirrors broader trends observed at both the state and national levels. The notable exception is Alzheimer's disease, where females consistently show higher mortality rates, likely due to their longer life expectancy and higher prevalence of the disease in older age. Among all causes, unintentional injuries present one of the most pronounced gender disparities.

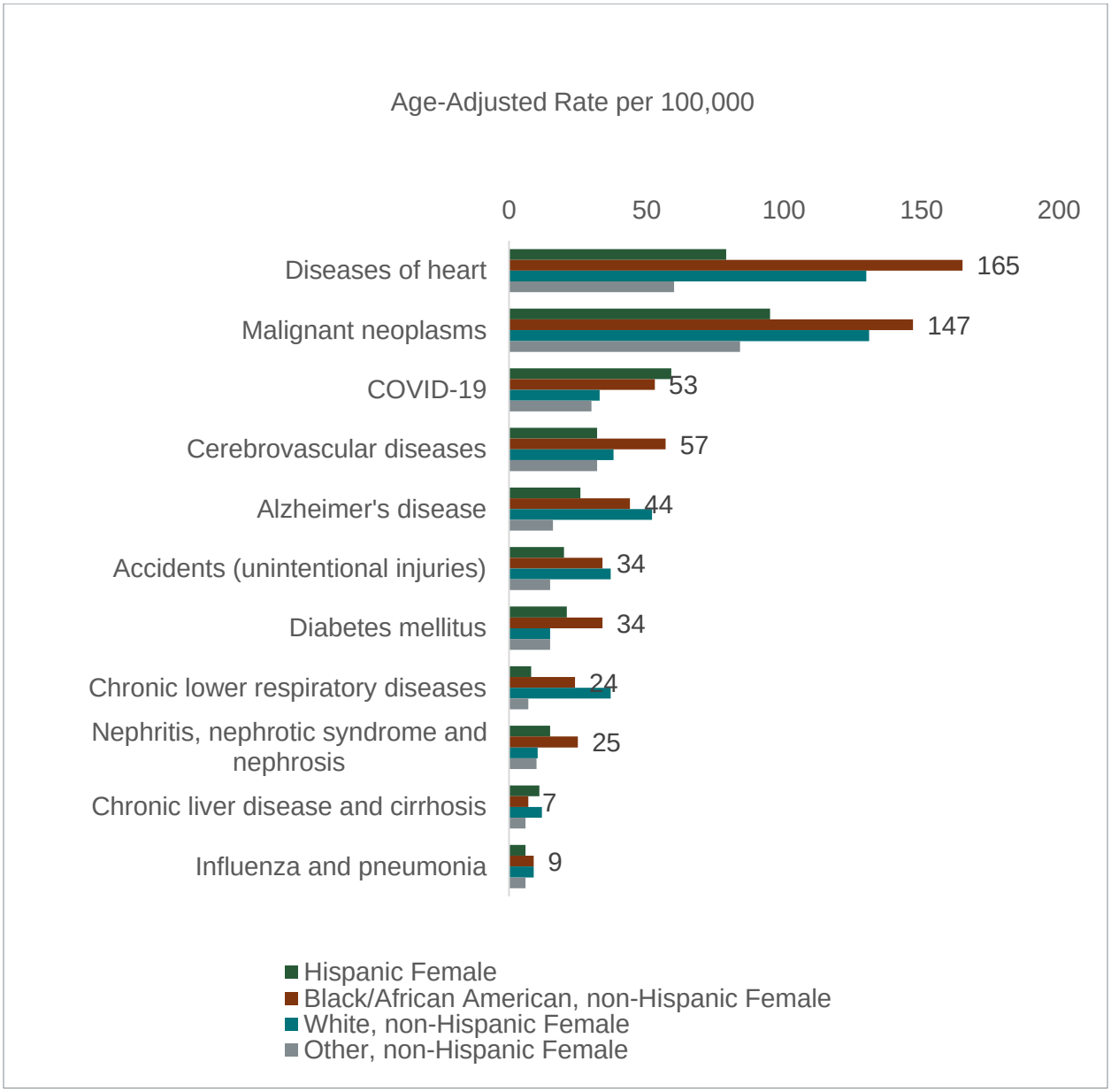
Mortality Figure 5 illustrates the leading causes of death for females in Dallas County, highlighting significant disparities by race and ethnicity. Diseases of the heart are the top cause of death across all racial and ethnic groups, with the highest age-adjusted mortality rate among Black or African American, non-Hispanic females, followed by white, non-Hispanic, Hispanic, and Other, non-Hispanic females. Malignant neoplasms (cancers) rank second, and Black or African American, non-Hispanic females bear the highest mortality burden. With the onset of the COVID-19 pandemic in 2020, the virus emerged as the third leading cause of death among females, impacting Hispanic and Black or African American, non-Hispanic females most significantly. Additional notable causes include cerebrovascular diseases and Alzheimer’s diseases, with particularly high Alzheimer’s-related death rates among white, non-Hispanic and Black or African American, non-Hispanic females.

Mortality Figure 4: Leading Causes of Death in Dallas County by Sex, 2020-2024



Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

Mortality Figure 5: Leading Causes of Death for Females by Race-Ethnicity in Dallas County, 2020-2024

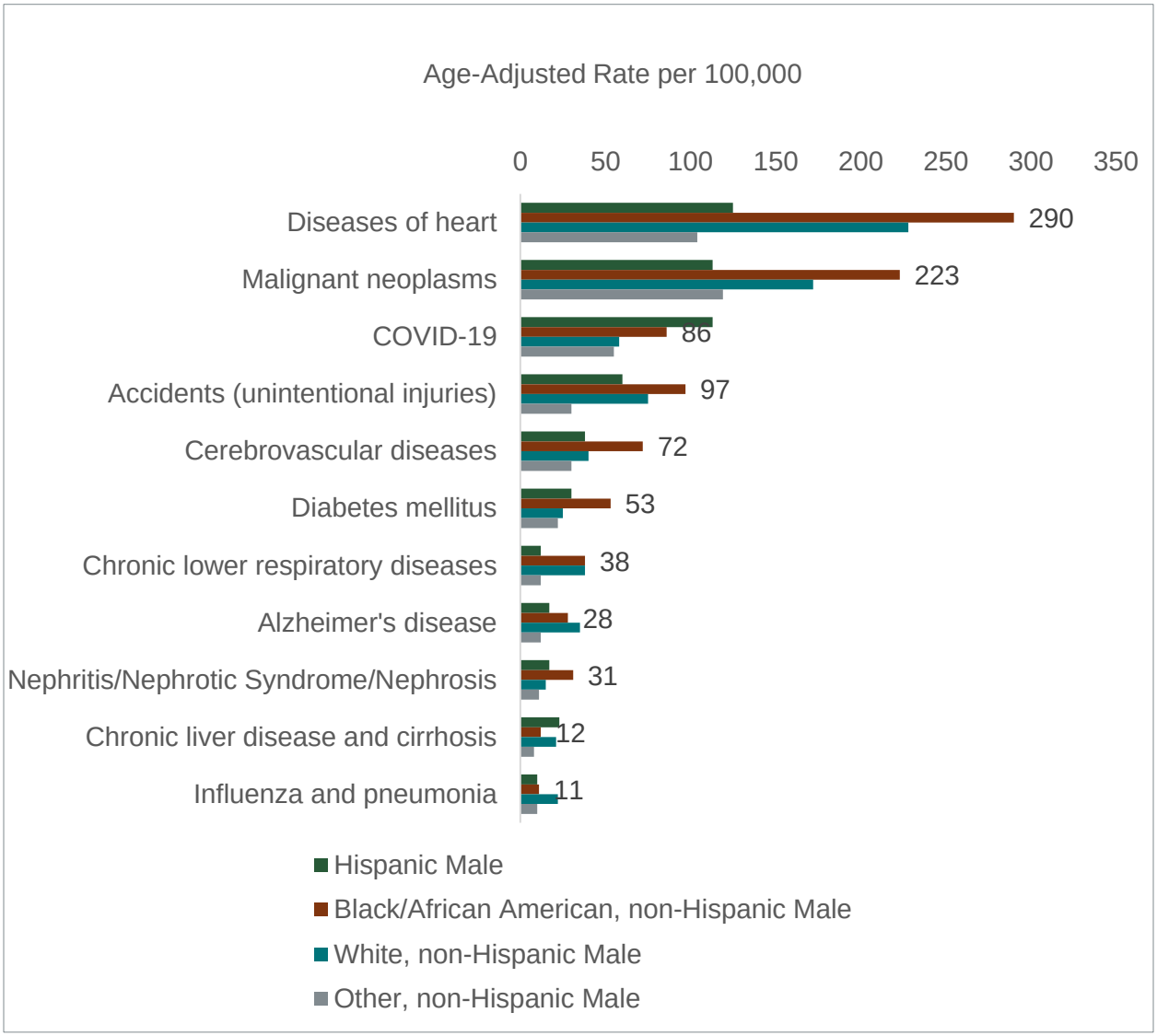


Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

In Dallas County, Black or African American, non-Hispanic males bear a disproportionately high burden of mortality across nearly all leading causes of death-see Mortality Figure 6. Diseases of the heart remain the leading cause, with an age-adjusted mortality rate of 290 per 100,000—significantly higher than white, non-Hispanic (228), Hispanic (125), and Other, non-Hispanic males (104). Malignant neoplasms (cancers) are the second-leading cause, again highest among Black or African American, non-Hispanic males (223 per 100,000), compared to 172 for white, non-Hispanic and 113 for Hispanic males. This pattern persists across other causes as

well such as deaths from unintentional injuries, highest among Black or African American, non-Hispanic males (97), followed by white, non-Hispanic (75) and Hispanic males (60).

Mortality Figure 6: Leading Causes of Death for Males by Race-Ethnicity in Dallas County, 2020-2024

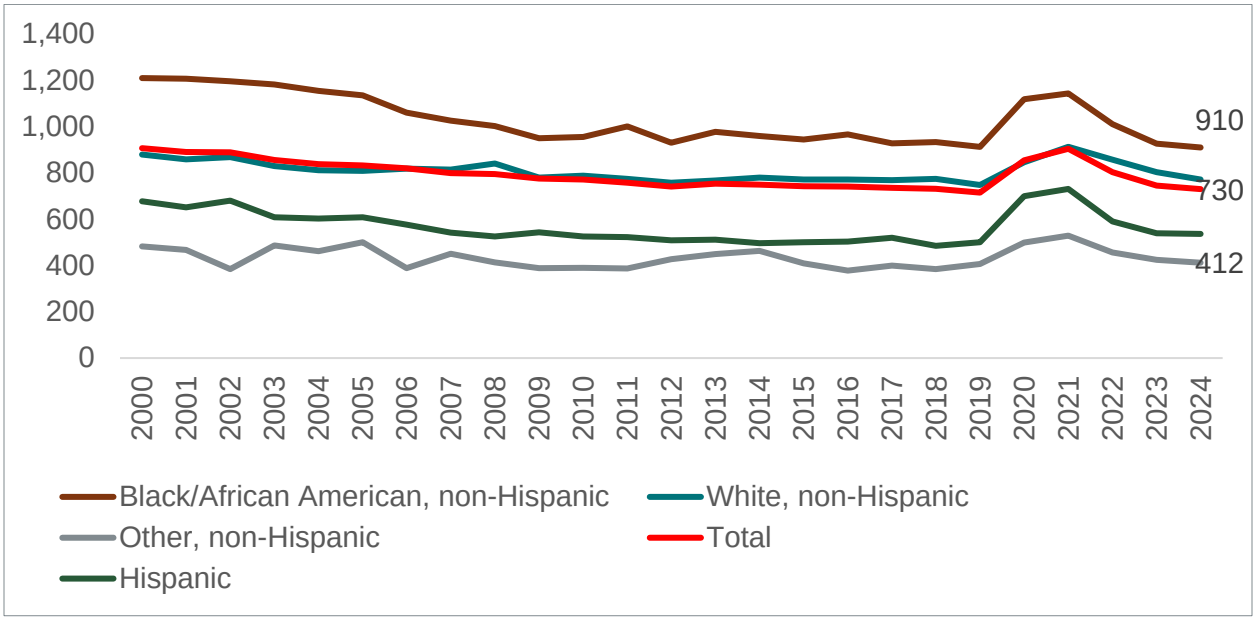


Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

2. Mortality by Race and Ethnicity

Significant disparities exist in mortality rates by race and ethnicity in Dallas County. The Black or African American, non-Hispanic population consistently experiences higher mortality rates for many leading causes of death, including heart disease, cancer and diabetes, compared to white, non-Hispanic populations-see Mortality Figure 7. Conversely, the Hispanic population exhibits lower mortality rates than white, non-Hispanic population.

Mortality Figure 7: All-Cause Mortality Rate by Race and Ethnicity, Dallas County, 2000-2024



Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

Mortality Figure 8, Mortality Figure 9, Mortality Figure 10, and Mortality Figure 11 show a comparative analysis of the top 10 causes of death among different racial/ethnic groups in Dallas County, mainly, Black or African American, non-Hispanic, white, non-Hispanic, Hispanic, and Other, non-Hispanic based on age-adjusted mortality rates per 100,000 residents from 2020 to 2024. The findings highlight both shared health burdens and distinct disparities that inform the need for targeted public health interventions.

Across all groups, heart disease and malignant neoplasms (cancer) consistently rank as the leading causes of death. However, the burden is most severe among Black or African American, non-Hispanic residents, with heart disease at 215.7 and cancer at 175.3 per 100,000. White, non-Hispanic residents follow with rates of 173.2 and 148.2, respectively. In contrast, Hispanic and Other, non-Hispanic populations show lower rates, with cancer slightly surpassing heart disease in both groups.

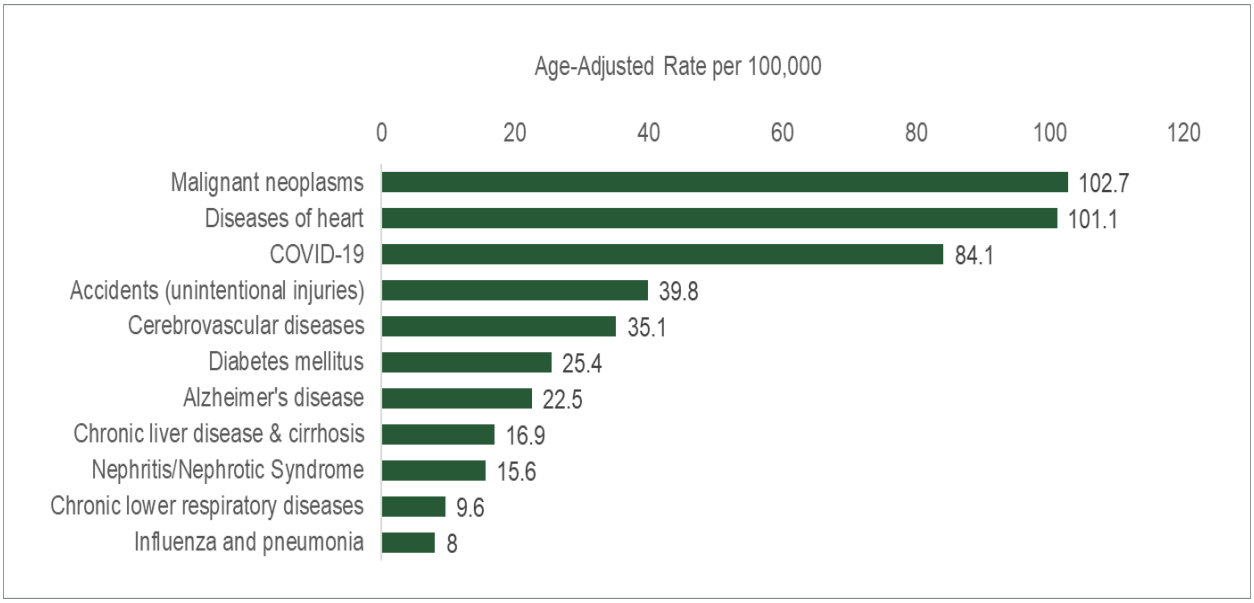
The emergence of COVID-19 in 2020 significantly impacted all racial/ethnic groups, though its effects varied. Hispanic residents experienced the highest mortality rate from COVID-19 (84.1), followed by Black or African American, non-Hispanic (65.9), white, non-Hispanic (44.1), and Other, non-Hispanic (41.5).

In addition to chronic and infectious diseases, Alzheimer's disease and diabetes mellitus also contribute to mortality rates in Dallas County. Alzheimer's disease was most prominent among white, non-Hispanic residents (45.8), while diabetes was most severe among Black or African American, non-Hispanic population (41.8), followed by Hispanic population (25.4).

The figures also reveal important differences in external causes of death. Assault (homicide) appears only among Black or African American, non-Hispanic residents (24.9), while suicide is

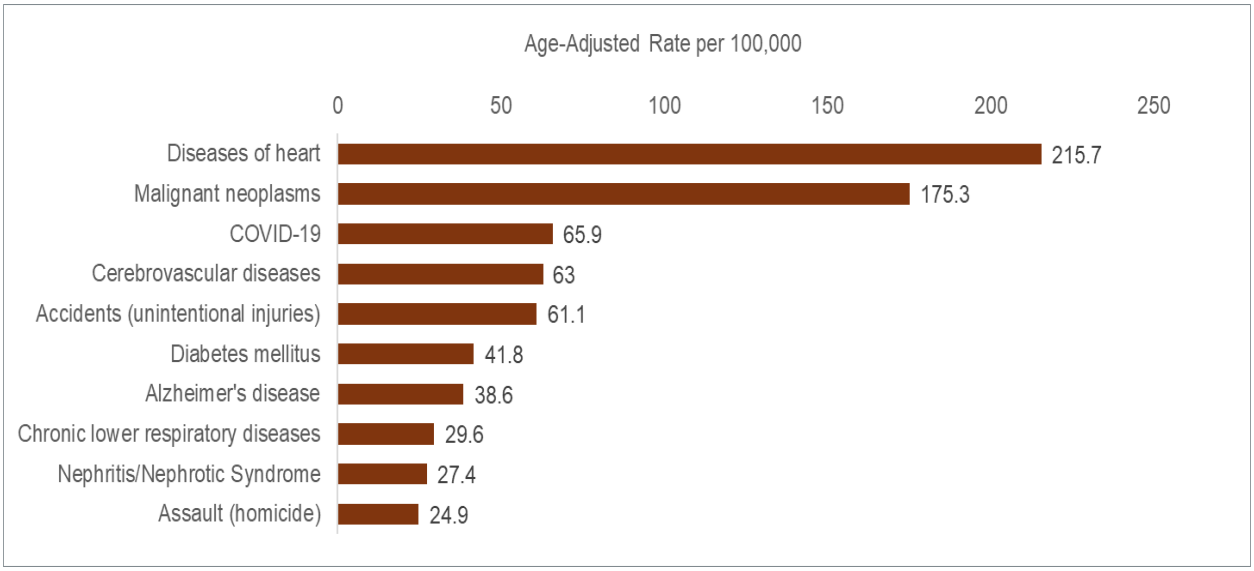
unique to the white, non-Hispanic population (18.8). Unintentional injuries (accidents) affected all groups, with particularly high rates among Black or African American, non-Hispanic (61.1) and white, non-Hispanic (56.1) residents.

Mortality Figure 8: 10 Leading Causes of Death for Hispanic in Dallas County, 2020-2024



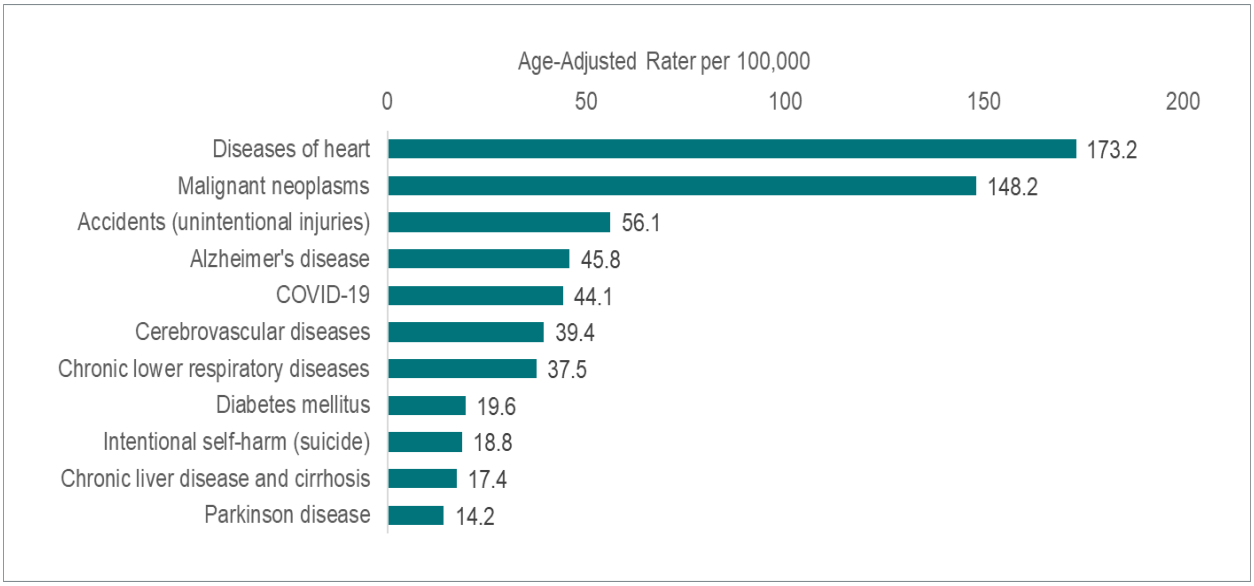
Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

Mortality Figure 9: 10 Leading Causes of Death for Black or African American, non-Hispanic in Dallas County, 2020-2024



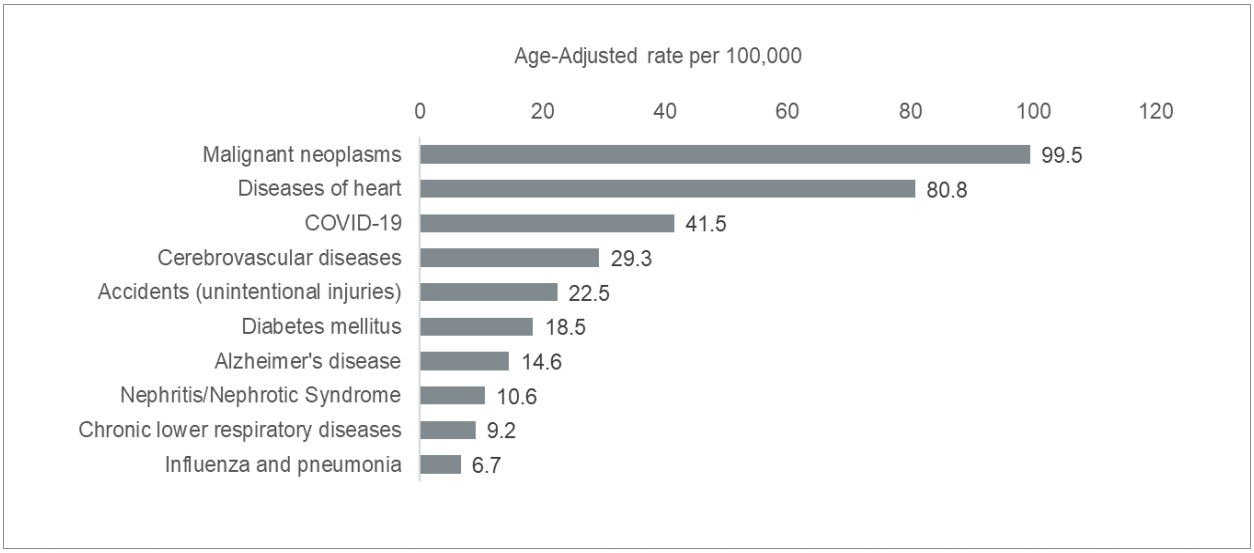
Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

Mortality Figure 10: 10 Leading Causes of Death for White, non-Hispanic in Dallas County, 2020-2024



Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

Mortality Figure 11: 10 Leading Causes of Death for Other, non-Hispanic in Dallas County, 2020-2024

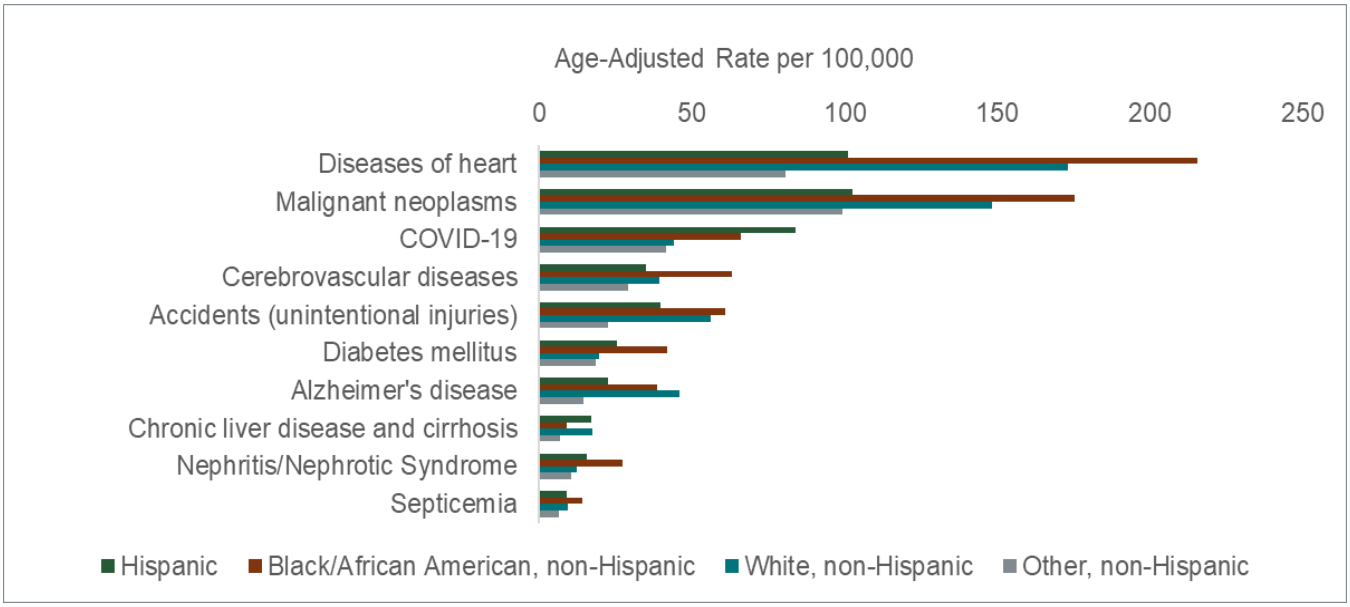


Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

Taken collectively, this comparative analysis highlights that while heart disease and malignant neoplasms (cancer) are the leading causes of death across all racial and ethnic groups in Dallas County, notable distinctions exist. Specifically, heart disease is the predominant cause of mortality among Black or African American, non-Hispanic and white, non-Hispanic populations,

whereas cancer ranks as the leading cause of death among Hispanic and Other, non-Hispanic groups.

Mortality Figure 12: 10 Leading Causes of Death by Race-Ethnicity in Dallas County, 2020-2024



Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

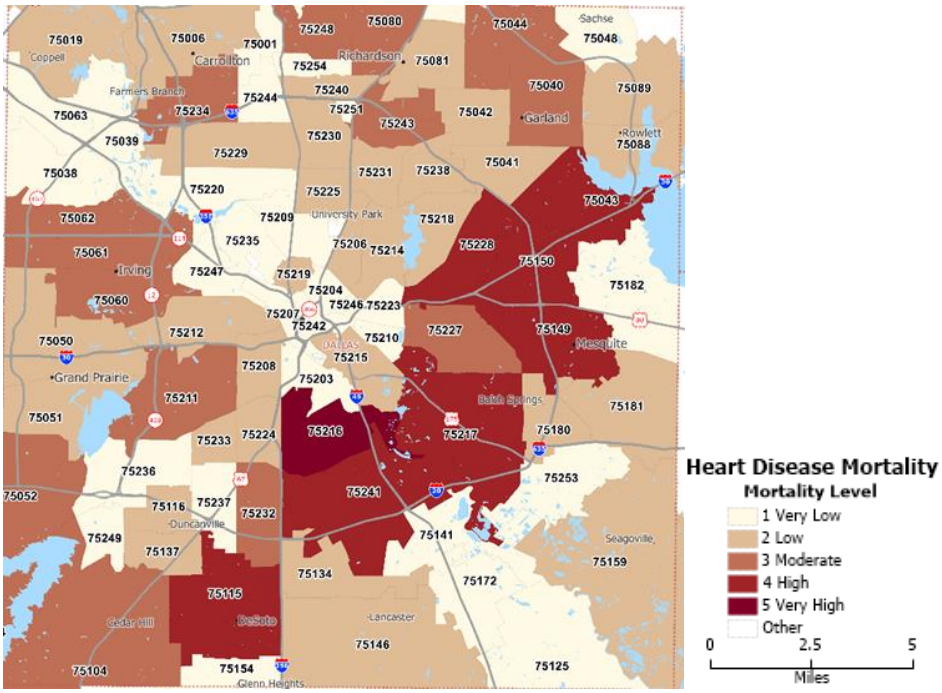
3. Leading Causes of Death

a. Heart Disease Mortality Trends

Mortality Figure 13 shows that areas with higher heart disease mortality rates often overlap with regions of high community vulnerability and dense population, highlighting the connection between socioeconomic inequities and poorer health outcomes in specific communities.[44]

[44] Parkland Health. 2022 Dallas County Community Health Needs Assessment. Parkland Health; 2022. Accessed July 24, 2025. https://www.parklandhealth.org/pdf-files/2022-dallas-county-community-health-needs-assessme-1

Mortality Figure 13: Heart Disease Mortality, Dallas County



Data Source: Vital Statistics

Heart disease remains a leading cause of death in Dallas County, but long-term trends show both progress and challenges across specific conditions-see Mortality Figure 14. From 2000 to 2024, Atherosclerotic Heart Disease showed a decline, dropping from 68.7 to 24.2 deaths per 100,000 population. In addition, Acute Myocardial Infarction mortality also declined from 58.1 to 10.5. Similarly, stroke mortality decreased from 31.4 to 9.3, possibly due to better hypertension control, decreases in smoking, and stroke awareness campaigns.

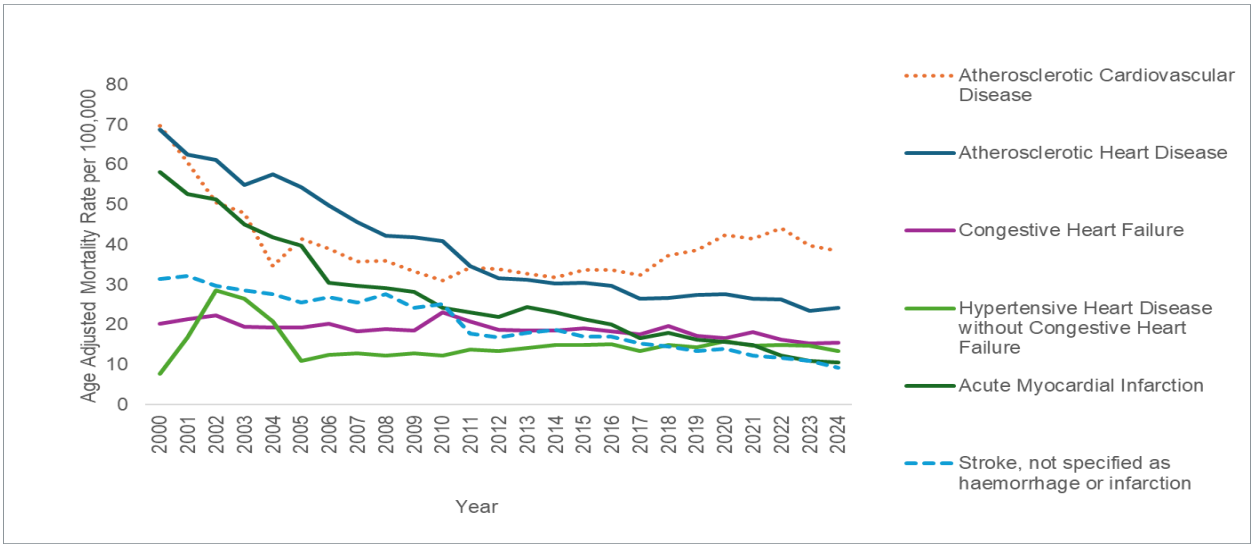
However, not all trends were positive. Atherosclerotic Cardiovascular Disease showed a variable pattern, with an initial decline followed by an increase after 2017, peaking in 2022. Congestive Heart Failure mortality remained stable, while Hypertensive Heart Disease without Congestive Heart Failure saw a rise in the early 2000s, peaking in 2002, and then stabilizing at higher levels.

When identifying the leading Heart Diseases Mortality Rate by Race-Ethnicity in Dallas County, the top four causes across all populations are Atherosclerotic Cardiovascular Disease, Atherosclerotic Heart Disease, Hypertensive Heart Disease Without Congestive Heart Failure, and Congestive Heart Failure.

Among these, Atherosclerotic Cardiovascular Disease consistently ranks as the leading cause, with Black or African American, non-Hispanic population showing the highest mortality rate, nearly double the rate among white, non-Hispanic and Hispanic individuals. Atherosclerotic Heart Disease follows, with white, non-Hispanic people experiencing the highest burden. Hypertensive Heart Disease Without Congestive Heart Failure and Congestive Heart Failure are

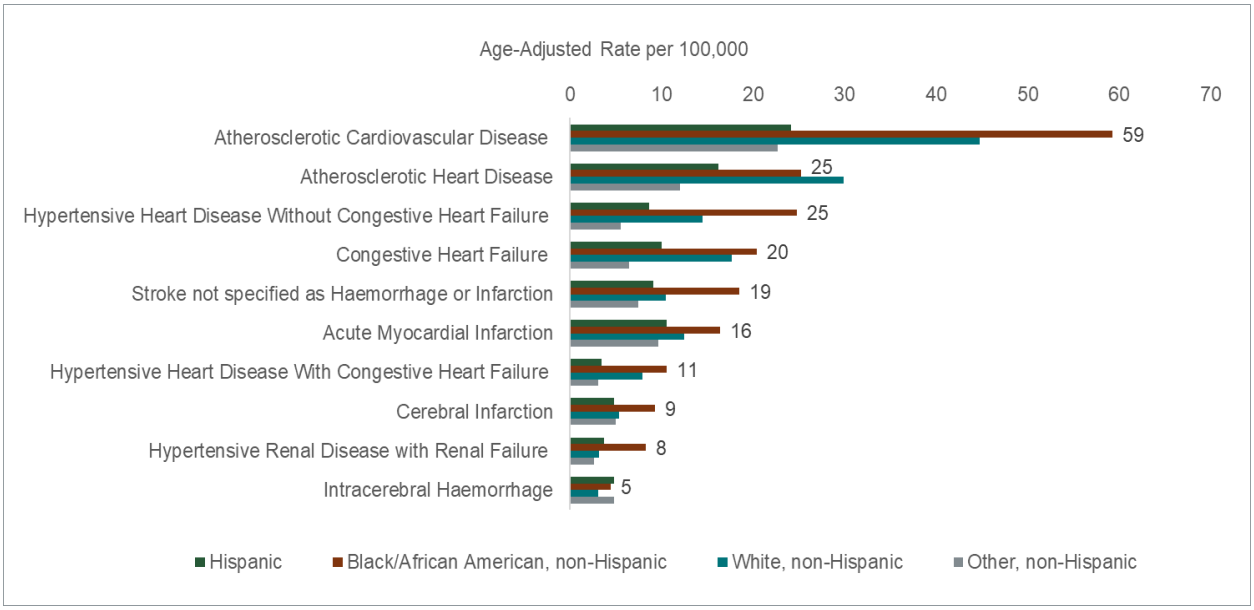
also major contributors, particularly among Black or African American, non-Hispanic individuals, who show significantly higher rates compared to other groups-see Mortality Figure 15.

Mortality Figure 14: Mortality Rate Due to Heart Diseases in Dallas County, 2000-2024



Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

Mortality Figure 15: Leading Heart Diseases Mortality Rate by Race-Ethnicity in Dallas County, 2020-2024

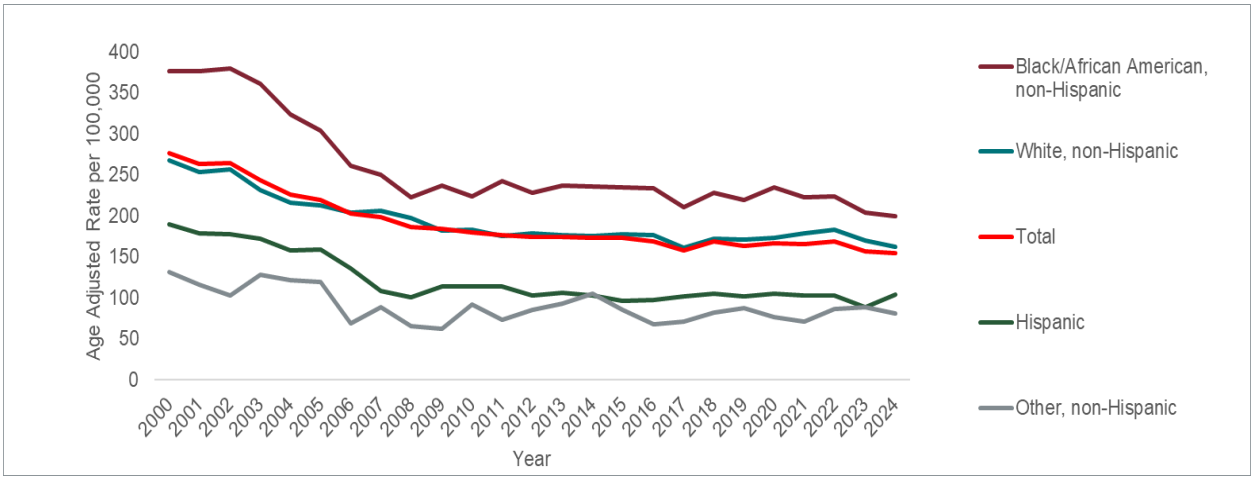


Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder.

Racial and ethnic disparities remain regarding heart disease mortality in Dallas County. Black or African American, non-Hispanic residents exhibited the highest mortality rates throughout the

period, followed by white, non-Hispanic individuals. Hispanic and Other, non-Hispanic populations are still affected by heart diseases but at lower rates.

Mortality Figure 16: Mortality Rate due to Heart Diseases by Race and Ethnicity in Dallas County, 2000-2024

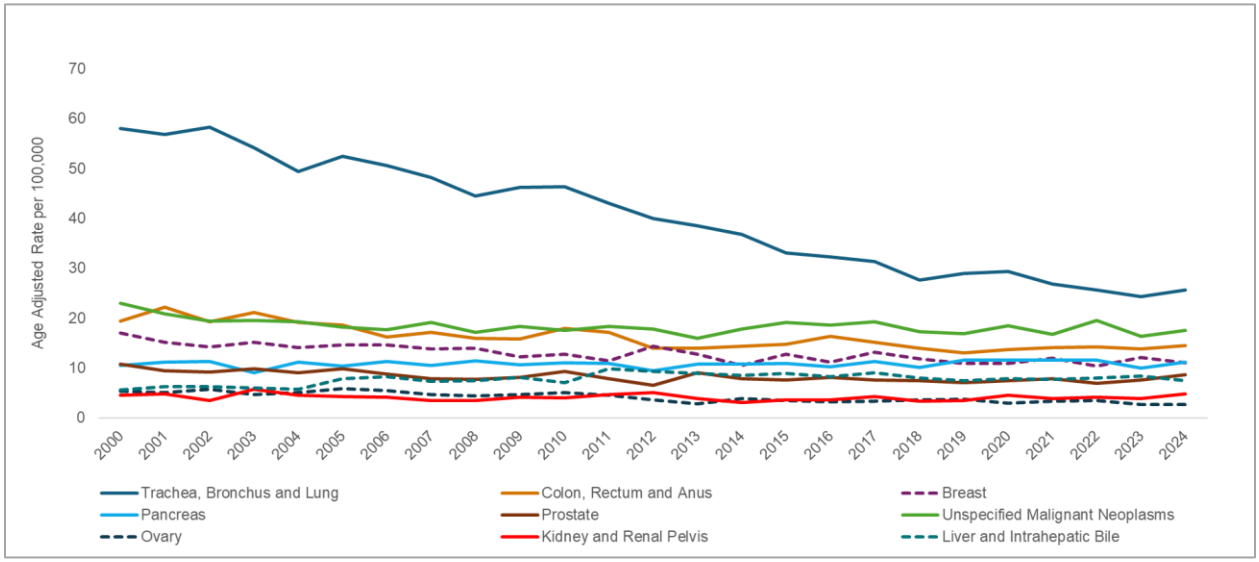


Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

b. Cancer Mortality Trends

Cancer remains a leading public health concern in Dallas County, with lung cancer continuing to be the most common cause of cancer-related deaths. Pancreatic and colorectal cancers' mortality levels remain stable, while breast and prostate cancers show slight fluctuations. These patterns highlight the importance of sustained efforts in prevention, screening, and access to care, particularly for lung and colorectal cancers, which continue to pose significant public health challenges in Dallas County.

Mortality Figure 17: Cancer Mortality Rate by Type of Cancer, Dallas County, 2000-2024

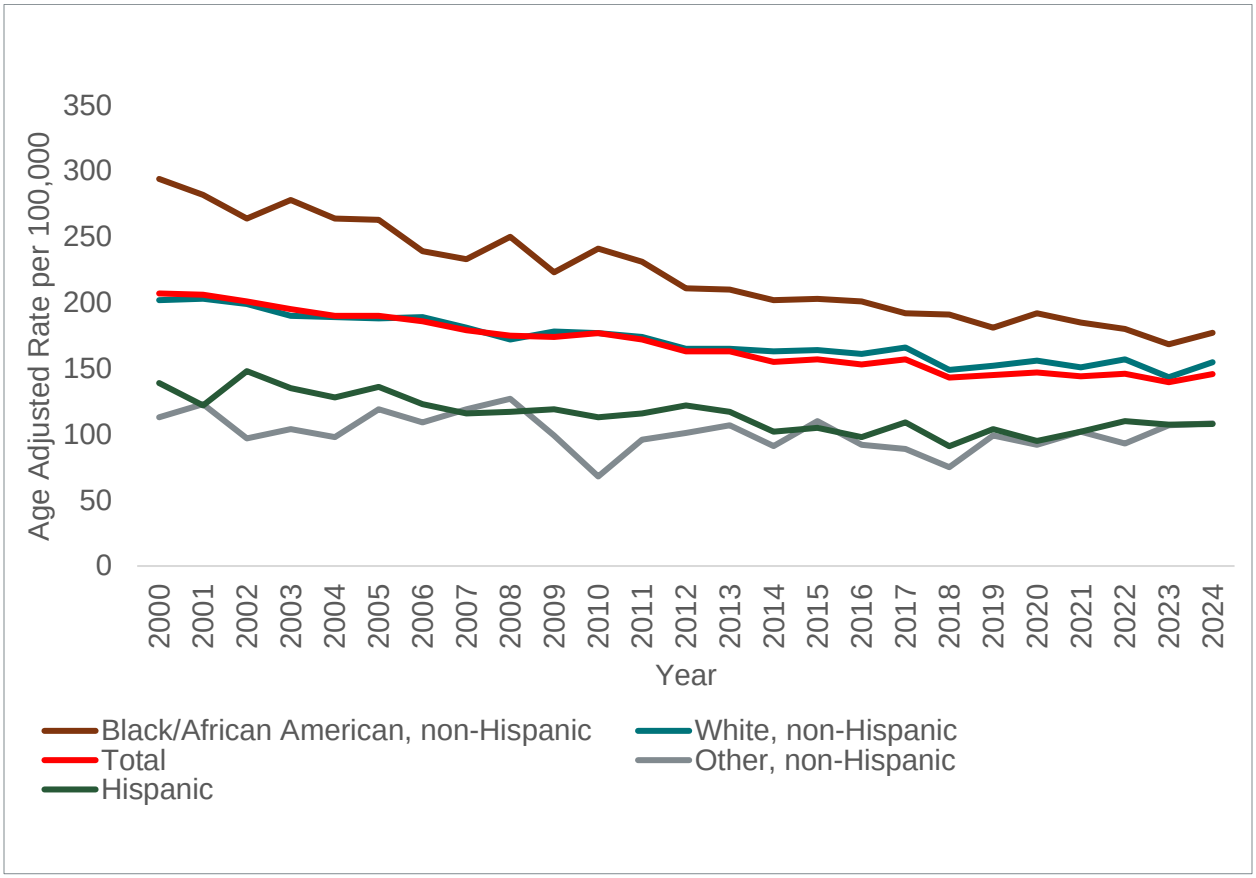


Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

Despite overall improvements in cancer mortality, racial disparities remain a critical concern, and the burden is not shared equally across communities–see Mortality Figure 18. From 2000 to 2024, age-adjusted cancer mortality rates, based on race/ethnicity, have consistently been highest among Black or African American, non-Hispanic residents. While there has been a gradual decline in cancer mortality over time, this group remains disproportionately affected. In contrast, white, non-Hispanic residents and the total national average have followed similar downward trends, reflecting broader improvements in cancer prevention, early detection, and treatment. The Other, non-Hispanic group has maintained the lowest mortality rates, though with some year-to-year variability.

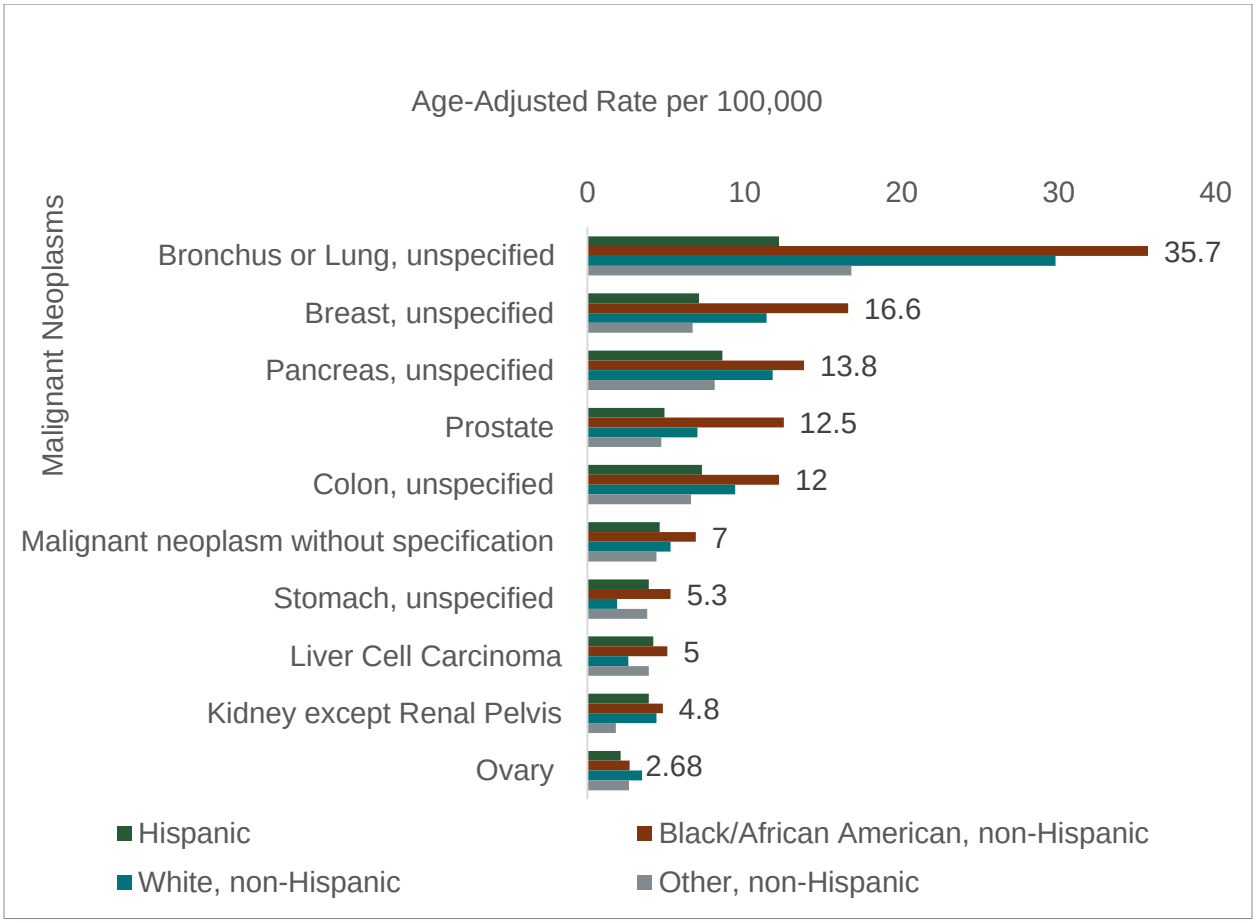
In terms of the leading causes by cancer type-see Mortality Figure 19, lung cancer mortality was highest among Black or African American, non-Hispanic population (35.7 per 100,000), followed by white, non-Hispanic (29.8). Hispanic residents had the lowest lung cancer mortality rate at 12 per 100,000. A similar pattern was observed in breast cancer mortality, where Black or African American, non-Hispanic individuals (16.6) experienced higher rates than white, non-Hispanic individuals (11.4), while Hispanic residents again had the lowest rate.

Mortality Figure 18: Cancer Mortality Rate by Race and Ethnicity in Dallas County, 2000-2024



Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

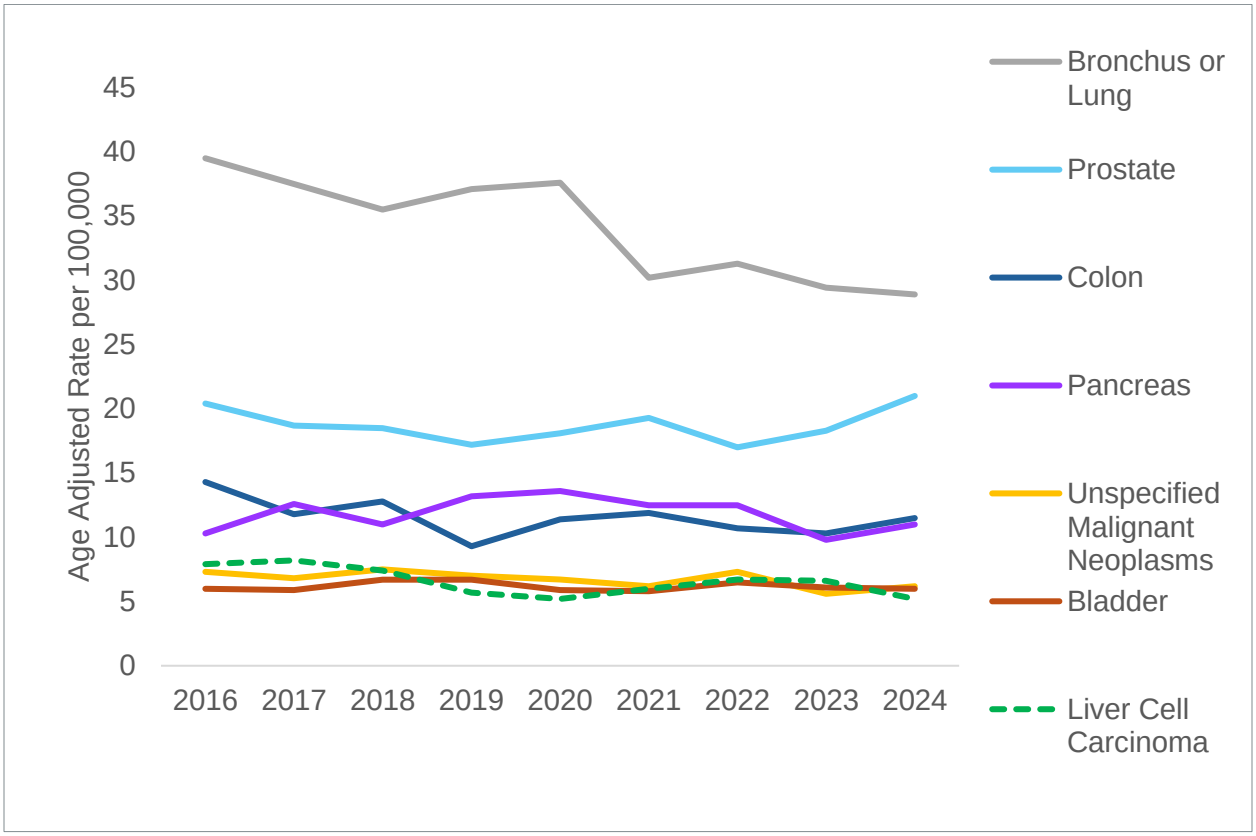
Mortality Figure 19: Leading Cancer Mortality Rate by Race-Ethnicity in Dallas County, 2020-2024



Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

Among males in Dallas County, cancer mortality trends show a decline in bronchus and lung cancer, though it remains the leading cause, while prostate and colon cancer deaths increased, solidifying their positions as the second and third leading causes–see Mortality Figure 20.

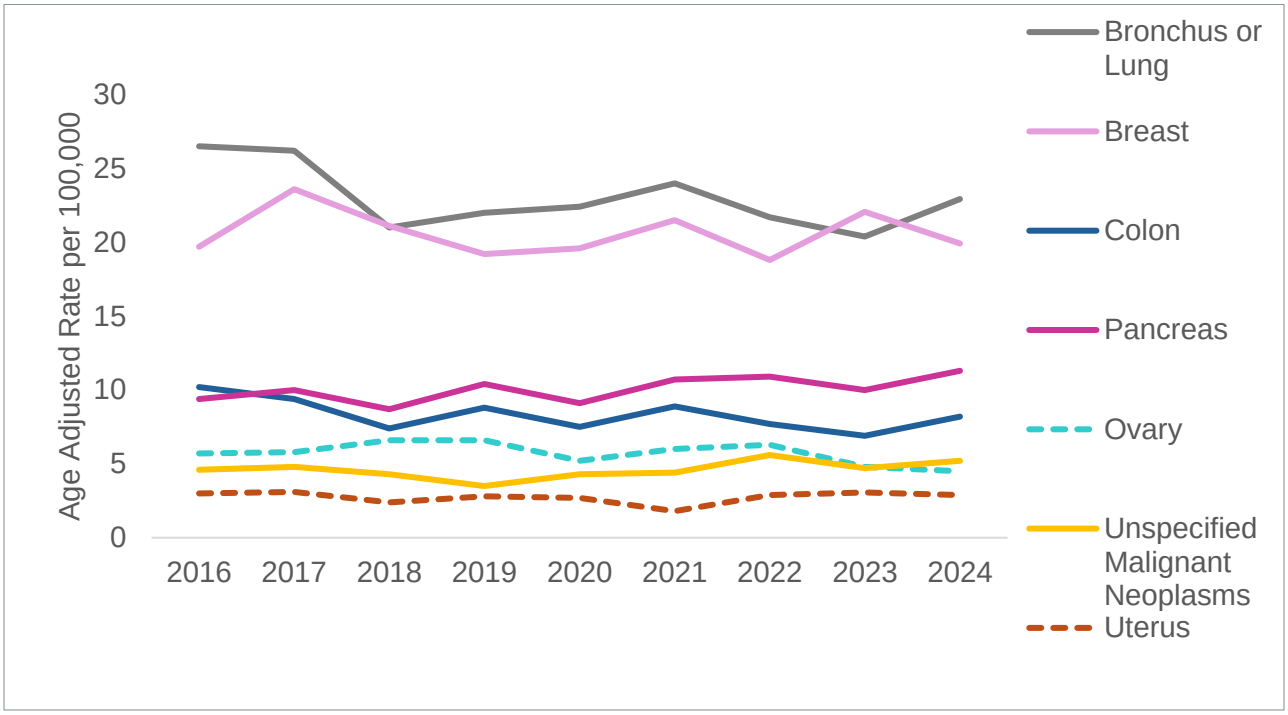
Mortality Figure 20: Leading Cancer Deaths Among Males in Dallas County, 2016-2024



Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

Mortality Figure 21 shows that lung and breast cancers continue to be the leading causes of cancer mortality among females. Pancreatic cancer mortality has shown an increase, while ovarian cancer rates have declined.

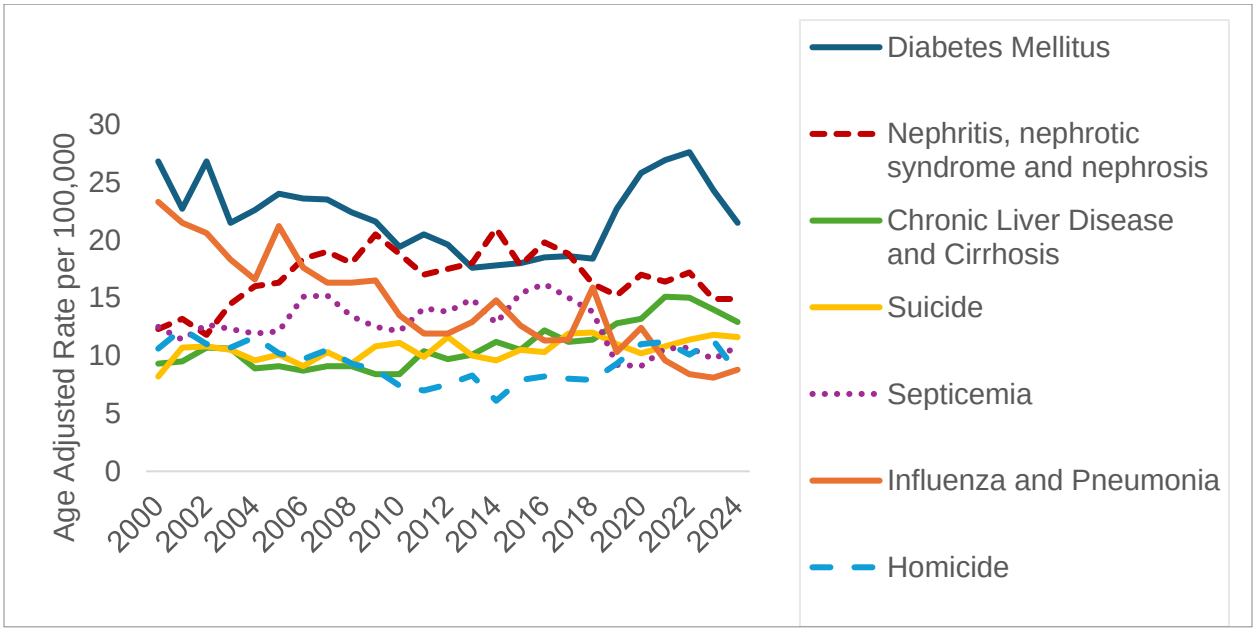
Mortality Figure 21: Leading Cancer Deaths Among Females in Dallas County, 2016-2024



Age Adjustment uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

4. Other Causes of Death

Mortality Figure 22: Mortality Trends for Other Leading Causes of Death in Dallas County, 2000-2024



Age Adjustments uses the 2000 Standard Population
Data Source: Vital Statistics and CDC Wonder

Diabetes mellitus remains a cause of concern among major health conditions in Dallas County- see Mortality Figure 22. It is also a major contributor to cardiovascular disease, significantly increasing the risk of heart attacks, strokes, and other serious complications.[45] Between 2018 and 2019, Dallas County experienced a notable rise in mortality rates associated with diabetes mellitus, increasing from approximately 18.4 to 22.7 deaths per 100,000 residents[46]. This increase has been further compounded by the COVID-19 pandemic which exacerbated underlying health conditions, peaking to 27.6 in 2022. Though diabetes-related mortality has since declined, it has not yet returned to pre-pandemic levels. In contrast, mortality rates for conditions such as influenza and pneumonia, chronic liver disease and cirrhosis, suicide, and nephritis-related illnesses have remained relatively stable over the same period.

C. Morbidity

1. Asthma

Asthma is a chronic respiratory condition characterized by inflammation and narrowing of the airways, resulting in recurring symptoms such as wheezing, persistent coughing, chest tightness, and shortness of breath. While asthma is widely recognized as one of the most common chronic illnesses among children in the U.S., it also affects adults, and symptoms can persist throughout a person's lifetime.[47]

In 2022, asthma affected 8.2% of the U.S. population, including 4.6 million children, a prevalence rate of 6.2%[48], which increased to 6.7% in 2023.[49] Adult prevalence was higher at 8.7% (22 million).[50] In Texas, adult asthma rates were slightly below the national average at 7.9%[51] while child rates were similar at 6.6% (2022-2023).[52] The projected economic burden associated with uncontrolled asthma among U.S. adolescents and adults older than 20 years (2019-2038) is estimated to be $300.6 billion (direct costs) and $963.5 billion (indirect cost added).[53] Hospitalization accounted approximately 16% of the medical cost.[54] These expenses stem from a combination of direct medical care, lost productivity from missed work and school

[45] American Heart Association. Cardiovascular Disease and Diabetes. American Heart Association. Last reviewed April 2, 2024. Accessed October 20, 2025. https://www.heart.org/en/health-topics/diabetes/diabetes-complications-and-risks/cardiovascular-disease--diabetes
[46] Terhune C, Respaut R, Nelson DJ. Out of Control America's losing battle against diabetes. Retrieved on April 20, 2022. Available at https://www. reuters.com/investigates/special-report/usa-diabetes-covid
[47] Centers for Disease Control and Prevention. National Asthma Data: Health Care Use. CDC. Updated May 31, 2024. Accessed July 29, 2025. https://www.cdc.gov/asthma/national-surveillance-data/healthcare-use.htm
[48] Centers for Disease Control and Prevention. Most Recent National Asthma Data. CDC. Updated May 31, 2024. Accessed July 29, 2025. https://www.cdc.gov/asthma-data/about/most-recent-asthma-data.html
[49] Centers for Disease Control and Prevention. National Health Interview Survey: Child Health Data Query Tool. CDC. Accessed July 29, 2025. https://wwwn.cdc.gov/NHISDataQueryTool/SHS_child/index.html
[50] Centers for Disease Control and Prevention. Most Recent National Asthma Data. CDC. Updated May 31, 2024. Accessed July 29, 2025. https://www.cdc.gov/asthma-data/about/most-recent-asthma-data.html
[51] Centers for Disease Control and Prevention. Most Recent National Asthma Data. CDC. Updated May 31, 2024. Accessed July 29, 2025. https://www.cdc.gov/asthma-data/about/most-recent-asthma-data.html
[52] United Health Foundation. Explore Asthma in Texas [Internet]. America's Health Rankings. United Health Foundation. Updated 2025. Accessed July 29, 2025. Available from: https://www.americashealthrankings.org/explore/measures/asthma_overall/TX
[53] Kaur R, Saini A, Saini V, et al. Pediatric asthma: an overview. *Biomed J Sci Tech Res*. 2023;49(2):40390–40394. doi:10.26717/BJSTR.2023.49.007805.
[54] Kaur R, Saini A, Saini V, et al. Pediatric asthma: an overview. *Biomed J Sci Tech Res*. 2023;49(2):40390–40394. doi:10.26717/BJSTR.2023.49.007805.

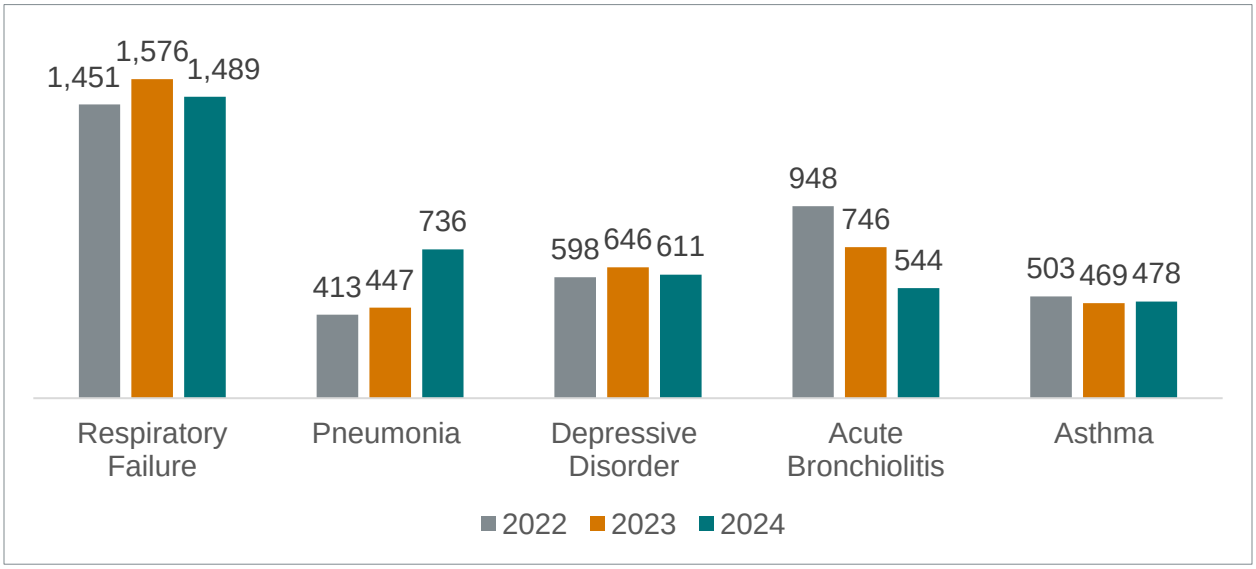
days, and premature deaths, according to a CDC.[55] The annual cost of asthma per person in Texas is estimated at $4,790.39, covering medical care, productivity losses, and other indirect costs.[56]

a. Asthma in the Pediatric Population

Asthma affects 1 in 15 children in the U.S., and when uncontrolled, it can lead to reduced quality of life and permanent lung damage making early diagnosis and effective management critical, especially amid persistent racial disparities in outcomes.[57] Every year, 1 in 6 children with asthma visits the emergency department and about 1 in 20 children with asthma are hospitalized for asthma.[58] Notably, asthma is often underdiagnosed and under-recognized as a serious respiratory illness and is likely a primary contributing diagnosis for some admissions due to respiratory failure.

Morbidity Figure 1 shows that asthma ranks 5th as a direct cause of hospital admissions. In the All-Diagnoses chart, asthma is present as a frequent co-occurring condition, suggesting that it often accompanies other primary health issues-see Morbidity Figure 2. This reinforces asthma's widespread presence and influence on overall pediatric care.

Morbidity Figure 1:Top 5 Pediatric Primary Diagnosis Only, Hospital Admissions, Dallas County, 2022 - 2024



Data Source: DFWHC/PCCI

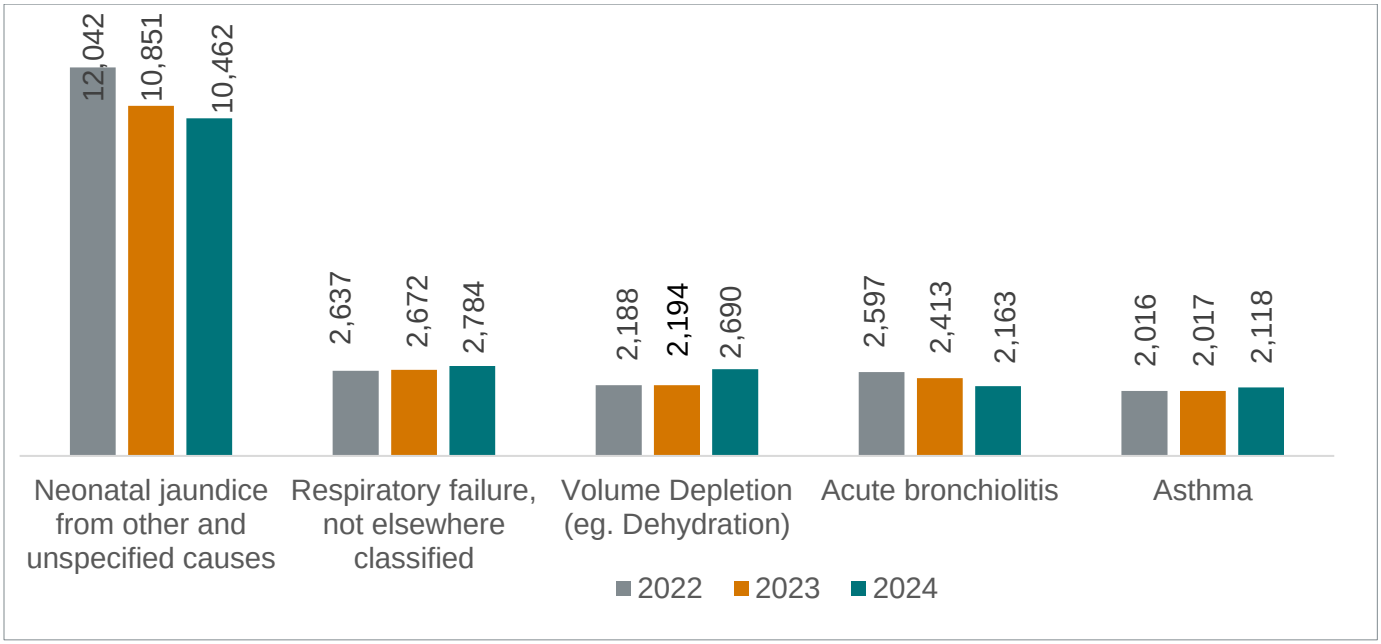
[55] Inserro A. CDC Study Puts Economic Burden of Asthma at More Than $80 Billion Per Year. American Journal of Managed Care. January 12, 2018. Accessed July 30, 2025. https://www.ajmc.com/view/cdc-study-puts-economic-burden-of-asthma-at-more-than-80-billion-per-year

[56] Centers for Disease Control and Prevention. Asthma Cost Calculator [Internet]. CDC National Asthma Control Program. Published 2025. Accessed July 29, 2025. Available from: https://www.cdc.gov/national-asthma-control-program/php/cost-calculator/index.html

[57] Lofton S, Hines C, McClure E, et al. Addressing asthma disparities through community-based interventions: lessons from the field. *Prev Chronic Dis*. 2024;21:E35. doi:10.5888/pcd21.24004

[58] Lang JE, Stewart L, Orvedahl R, et al. Asthma hospitalizations among children in the United States: burden and risk factors. J Asthma Allergy. 2023;16:275–288. doi:10.2147/JAA.S424913

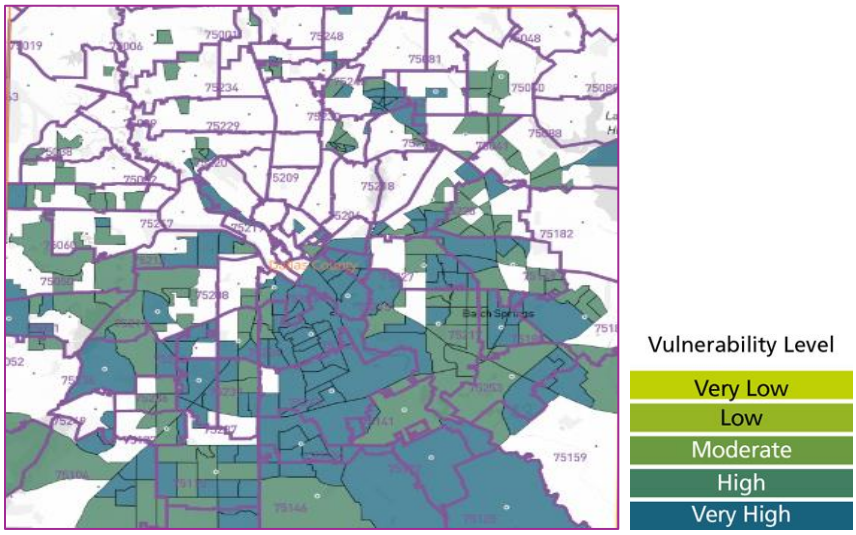
Morbidity Figure 2:Top 5 Pediatric Any Diagnosis, Hospital Admissions, Dallas County, 2022 - 2024



Data Source: DFWHC/PCCI

Morbidity Figure 3 illustrates pediatric asthma vulnerability across Dallas County, with green areas indicating very low vulnerability and blue areas indicating very high vulnerability. The areas with the highest vulnerability of pediatric asthma are concentrated in the county's southern sector, coinciding with communities with overall higher CVI scores.

Morbidity Figure 3: Pediatric Asthma Community Vulnerability, Dallas County 2025



Data source: Pediatric Asthma Surveillance System[59]

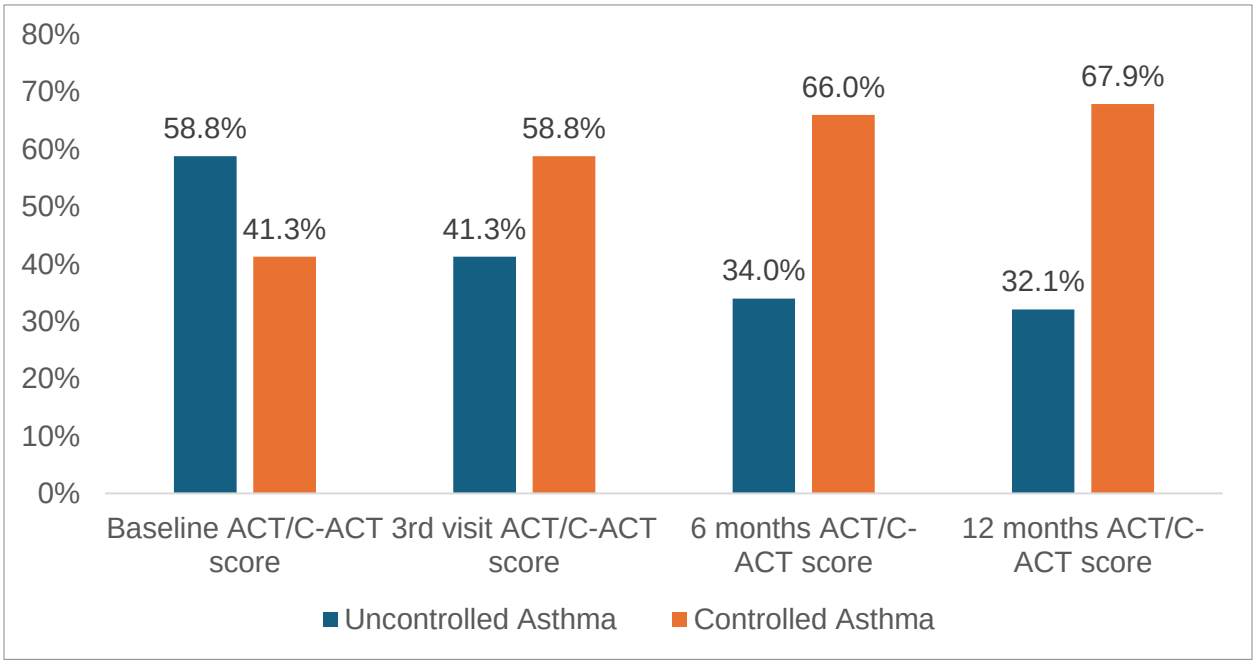
[59] PASS - EDS

Housed within the CDPD at DCHHS, the Asthma Home Visiting Program aims to reduce the burden of asthma among residents with severe or uncontrolled symptoms by providing virtual or in-home education, individualized support, and environmental assessments.

Participants receive guidance on identifying and minimizing asthma triggers, managing symptoms, properly using asthma medications, and consistently using asthma action plans to improve long-term control. To evaluate outcomes, ACT scores for individuals aged 12 and older and C-ACT scores for children ages 4-11 are collected at key follow-up intervals.

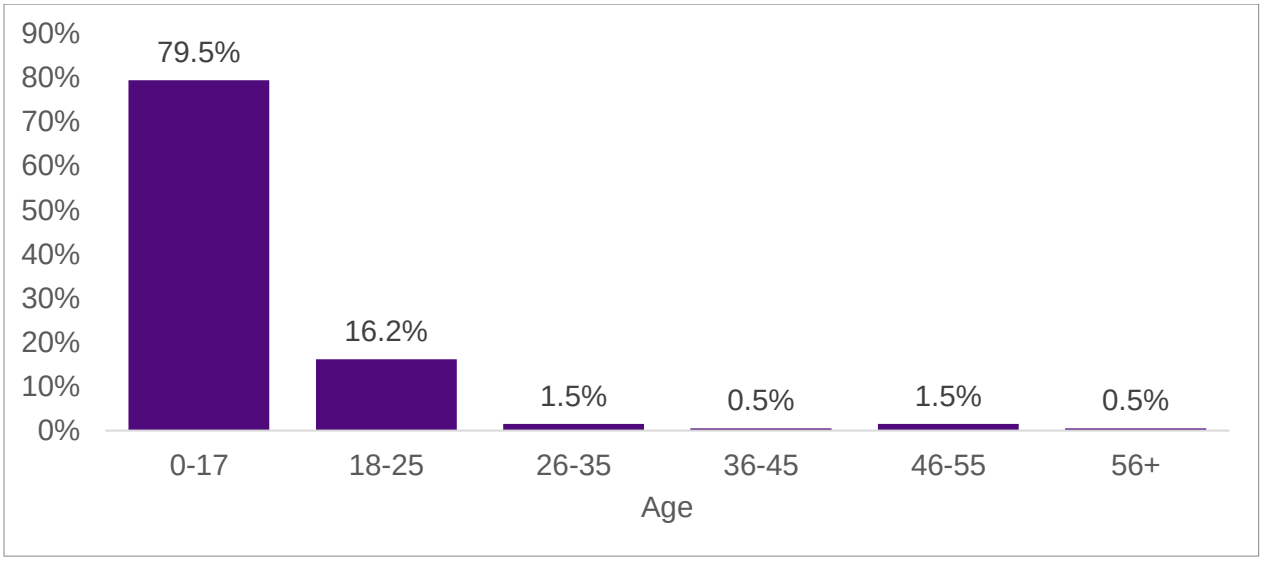
At program entry, 58.8% of participants presented with uncontrolled asthma. Most participants enrolled are children and adolescents, with 79.5% falling within the 0–17 age group, followed by 16.2% aged 18–25. The participant population is predominantly male (63.6%), with females representing (36.4%). Geographically, the highest concentrations of participants reside in ZIP Codes 75216 (26.8%), 75217 (24.2%), and 75211 (15.5%). These areas of southern Dallas County are historically underserved and bear a disproportionate burden of disease, underscoring the program's critical role in addressing barriers and promoting better health outcomes for vulnerable communities.

Morbidity Figure 4: ACT/C-ACT Scores Among DCHHS Asthma Home Visiting Program Participants, 2021-2025



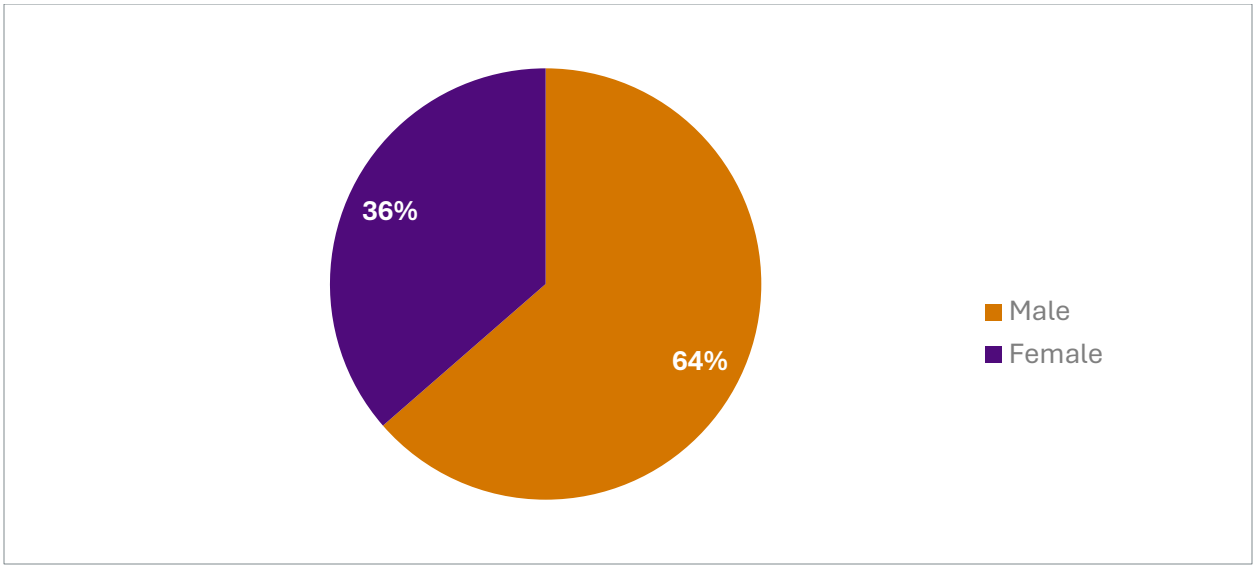
*Data reflect enrollments and follow-ups from May 2021 through July 2025. Figures include partial cohorts, with 2025 data presented as YTD through July.
Data Source: DCHHS

*Morbidity Figure 5: DCHHS Asthma Home Visiting Program Participants, by Age Group, 2021-2025**



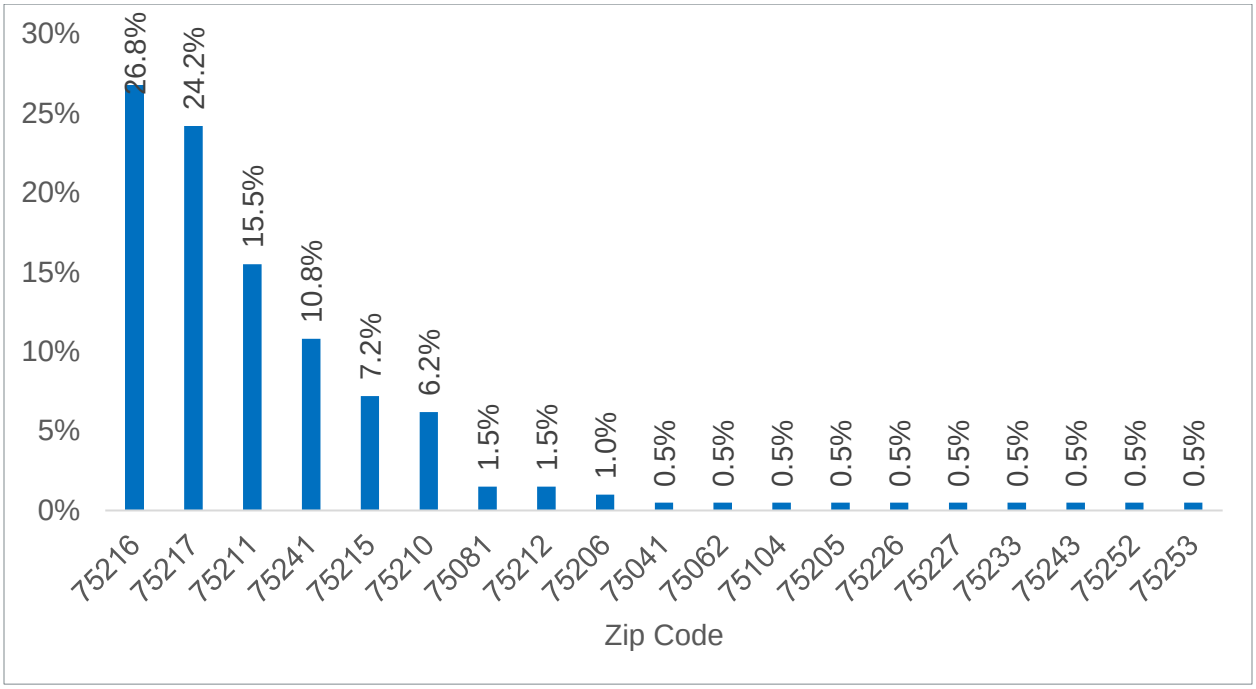
*Data reflect enrollments and follow-ups from May 2021 through July 2025. Figures include partial cohorts, with 2025 data presented as year-to-date (YTD) through July.
Data Source: DCHHS

Morbidity Figure 6: DCHHS Asthma Home Visiting Program Participants, by Sex, 2021-2025



*Data reflect enrollments and follow-ups from May 2021 through July 2025. Figures include partial cohorts, with 2025 data presented as YTD through July.
Data Source: DCHHS

Morbidity Figure 7: DCHHS Asthma Home Visiting Program Participants, by ZIP Code, 2021-2025

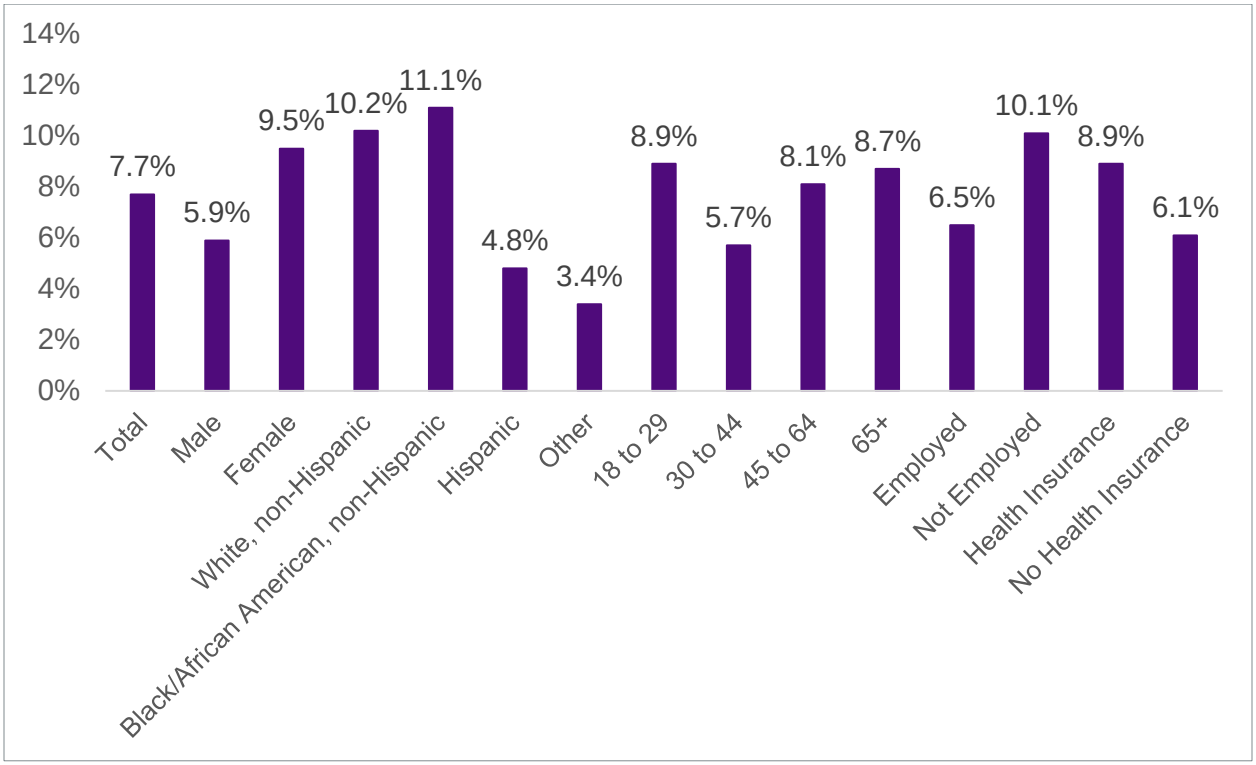


*Data reflect enrollments and follow-ups from May 2021 through July 2025. Figures include partial cohorts, with 2025 data presented as YTD through July.
Data Source: DCHHS

b. Asthma in the Adult Population

In Dallas County, the prevalence of current asthma diagnosis among adults aged 18 and older was 7.7% between 2019 and 2023. During this period, 9.5% of females had asthma compared to 5.9% of males. Individuals aged 18-29 experienced the highest rate at 8.9%, followed closely by those aged 65 and older at 8.7%. Black or African American, non-Hispanic individuals had the highest prevalence rate at 11.1% followed by white, non-Hispanic individuals at 10.2%. These disparities may reflect differences in environmental exposures, access to healthcare services, or socioeconomic conditions, highlighting the need for targeted interventions in high-risk populations-see Morbidity Figure 8.

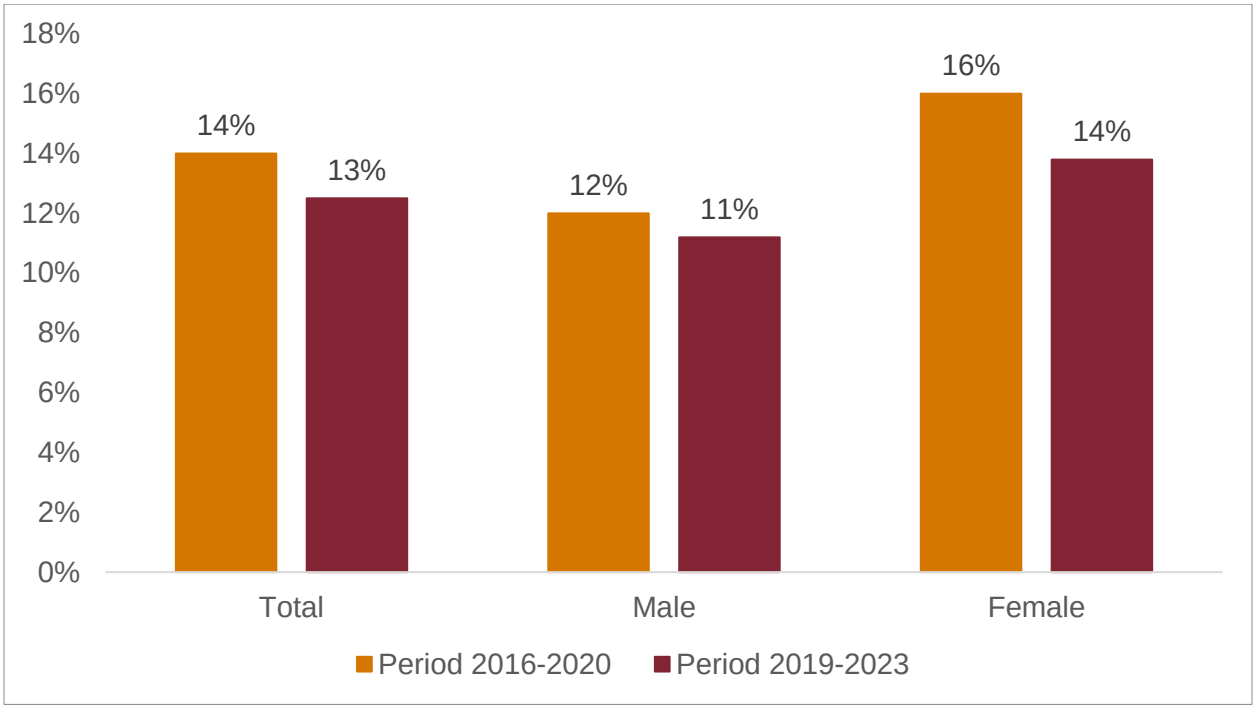
Morbidity Figure 8: Prevalence of Current Asthma Among Adults (18+), Dallas County, 2019-2023



Data Source: Center for Health Statistics BRFSS 2019 - 2023, Texas Department of State Health Services

The trends in lifetime asthma prevalence provide further insight into the burden of respiratory conditions over time. Morbidity Figure 9 presents data comparing the percentage of residents who have been diagnosed with asthma at any point in their lives between 2016–2020 and 2019–2023. Overall, the data indicates a modest decline in lifetime asthma prevalence among adults. For males, the rate decreased from 12% to 11%, while for females, it decreased, from 16% to 14%. Despite the overall decline, females continued to have a higher asthma prevalence than males in both periods.

Morbidity Figure 9: Prevalence of Lifetime Asthma Among Adults (18+), Dallas County, 2016-2020 vs. 2019-2023



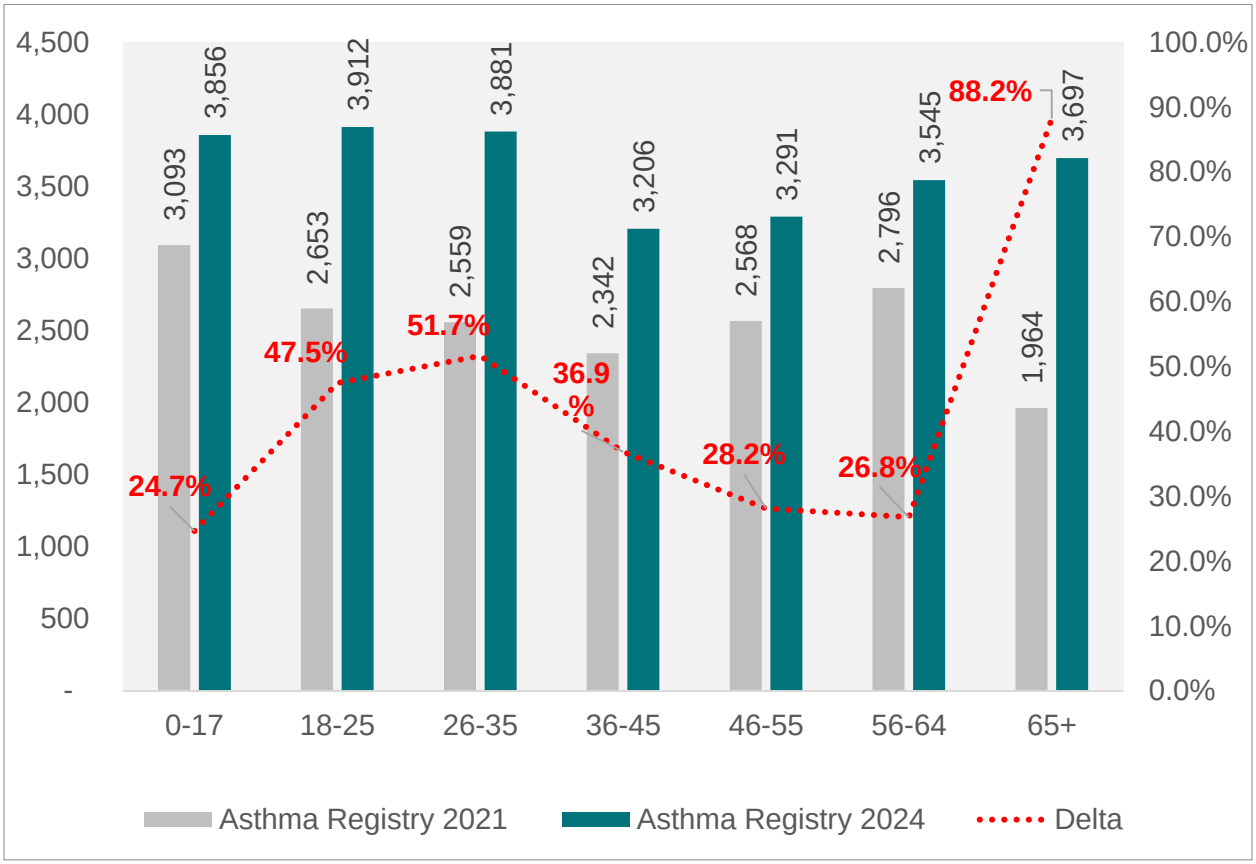
Data Source: Center for Health Statistics BRFSS 2016 - 2020 and 2019 - 2023, Texas Department of State Health Services.

c. Asthma Clinical and Demographic Trends

The use of chronic disease registries in healthcare enables providers and public health systems to systematically monitor and understand populations affected by specific chronic conditions. These registries aggregate data from electronic health records and other sources, allowing for the identification of trends, care gaps, and opportunities for targeted interventions. Importantly, an increase in the number of patients captured within a registry often reflects improved access to care and enhanced data integration—rather than a rise in disease prevalence or morbidity.

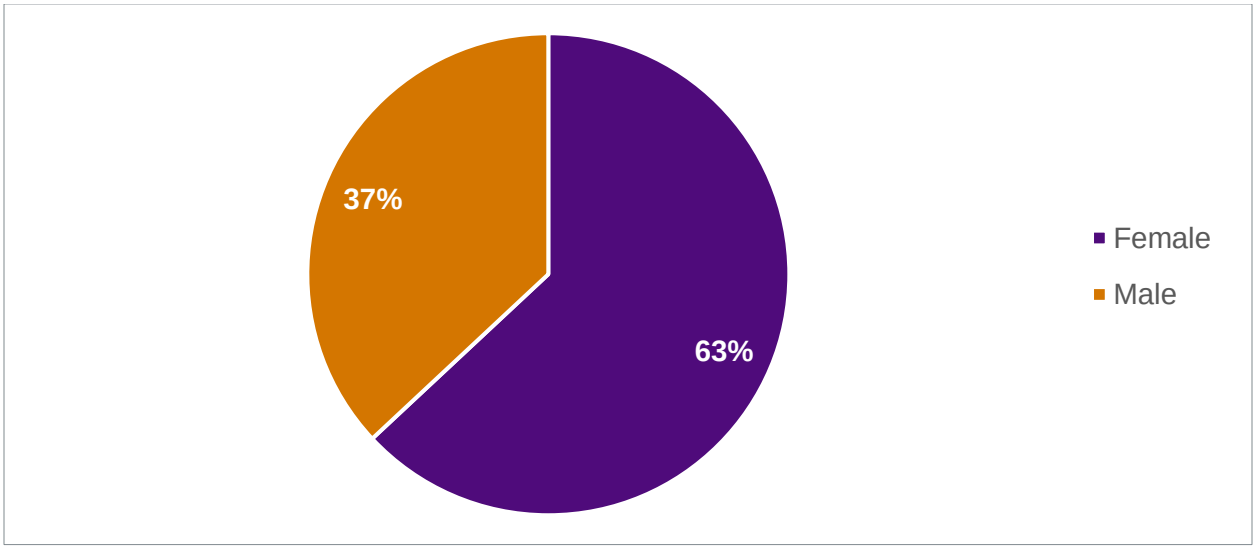
Morbidity Figure 10 displays the number of individuals in the Parkland Asthma Registry across different age groups between 2021 and 2024, along with the percentage change (Delta) over that period. Overall, the total number of registered patients increased by 41%, from 17,975 in 2021 to 25,388 in 2024. The largest increase was observed among adults 65 and older, which saw an 88% increase. Young adults aged 26–35 and 18–25 also experienced increases of 51.7% and 47.5%, respectively.

Morbidity Figure 10: Parkland Patients, Asthma Registry Age Group, 2021 vs. 2024



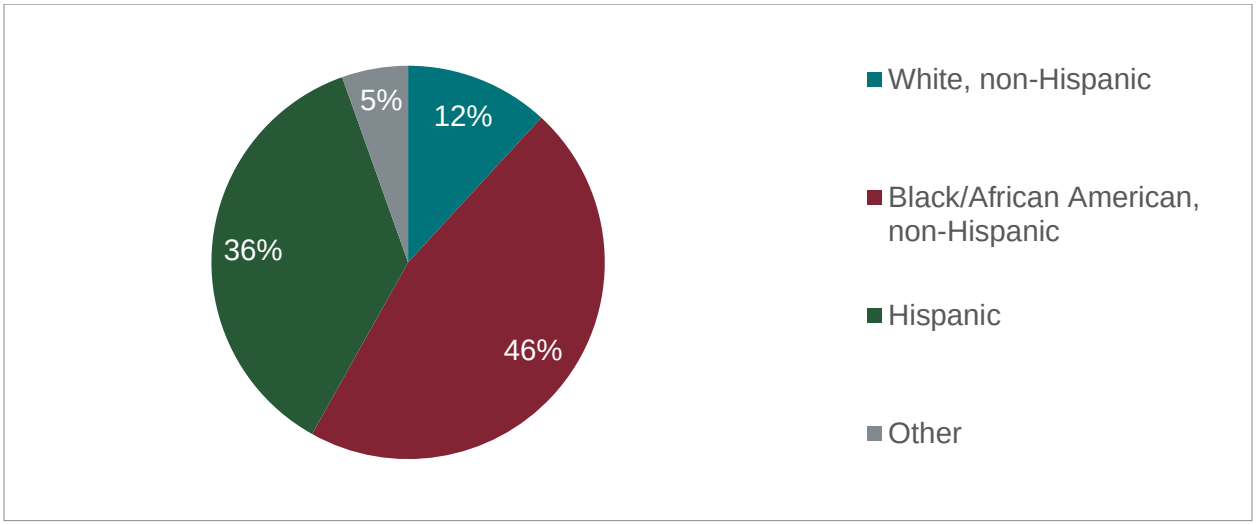
Data Source: Parkland EHR Asthma Registry

Morbidity Figure 11: Parkland Patients, Asthma Registry Sex Distribution, 2024



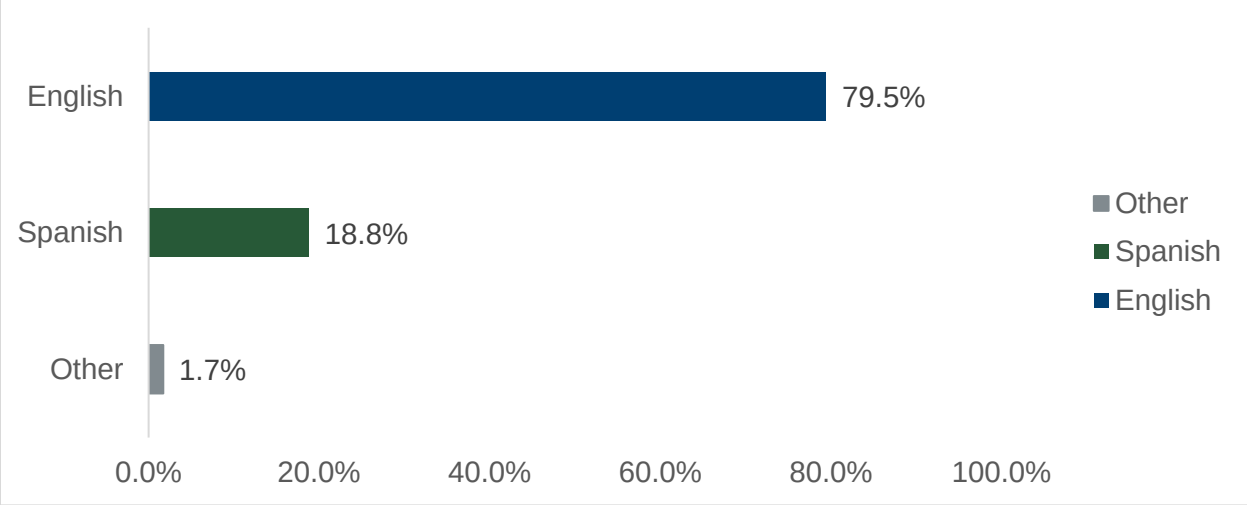
Data Source: Parkland EHR Asthma Registry

Morbidity Figure 12: Parkland Patients, Asthma Registry by Race and Ethnicity, Dallas County, 2024*



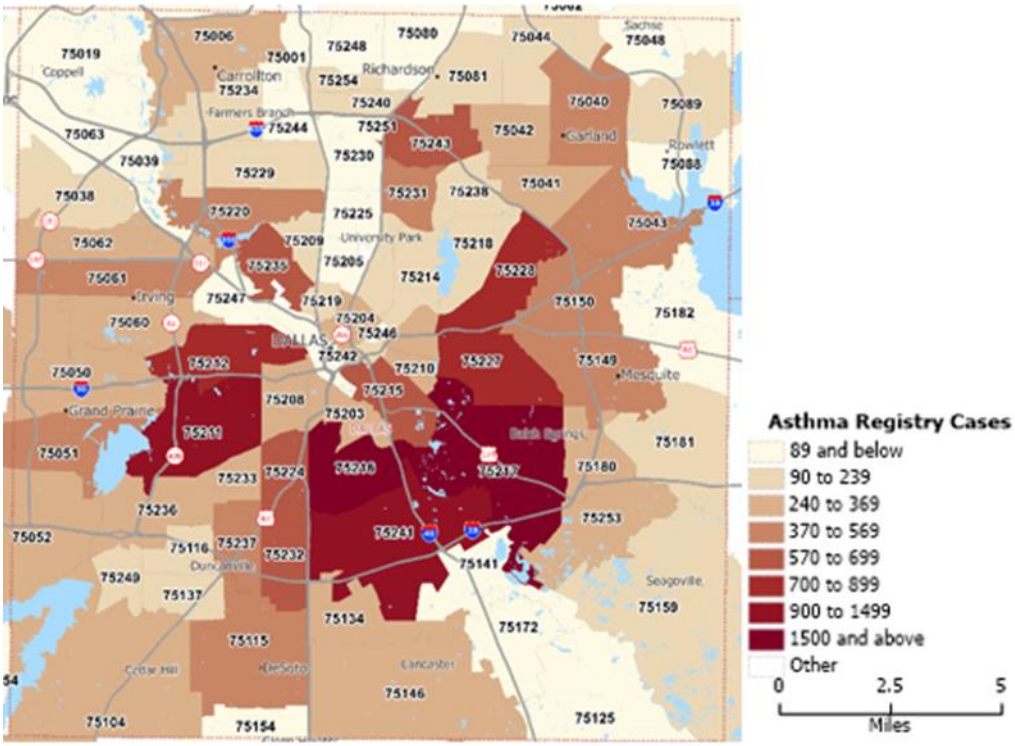
Data Source: Parkland EHR Asthma Registry
*All cases reporting Hispanic ethnicity in Parkland Registry are classified into the Hispanic category

Morbidity Figure 13: Parkland Patients, Preferred Language, Asthma Registry, 2024



Data Source: Parkland EHR Asthma Registry

Morbidity Figure 14: Parkland Patients by ZIP Code, Asthma Registry, 2024



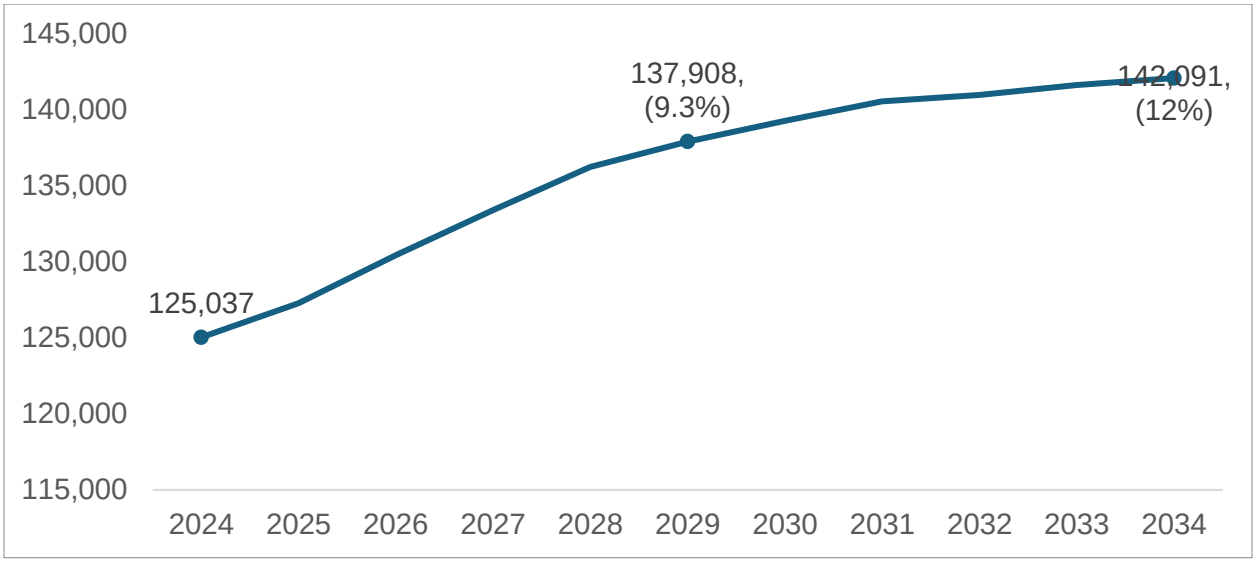
Data Source: Parkland EHR Asthma Registry

The ZIP Codes in Dallas with the highest volume of patients with asthma, 75217, 75216, and 75211, were all among the high vulnerability risk for chronic diseases.

d. Asthma Outpatient Services Forecast

Forecast data indicates that the volume of asthma outpatient services is expected to grow by 9.3% between 2024 and 2029 and by 12% between 2024 and 2034-see Morbidity Figure 15. These forecasts are based on projected population trends in Dallas County, including changes in population size, birth and death rates, and demographic distribution.

Morbidity Figure 15: 10-Year Outpatient Forecast, Asthma in adults (18+), Dallas County 2024-2034



Data Source: Prepared by SG2, LLC

2. Cancer

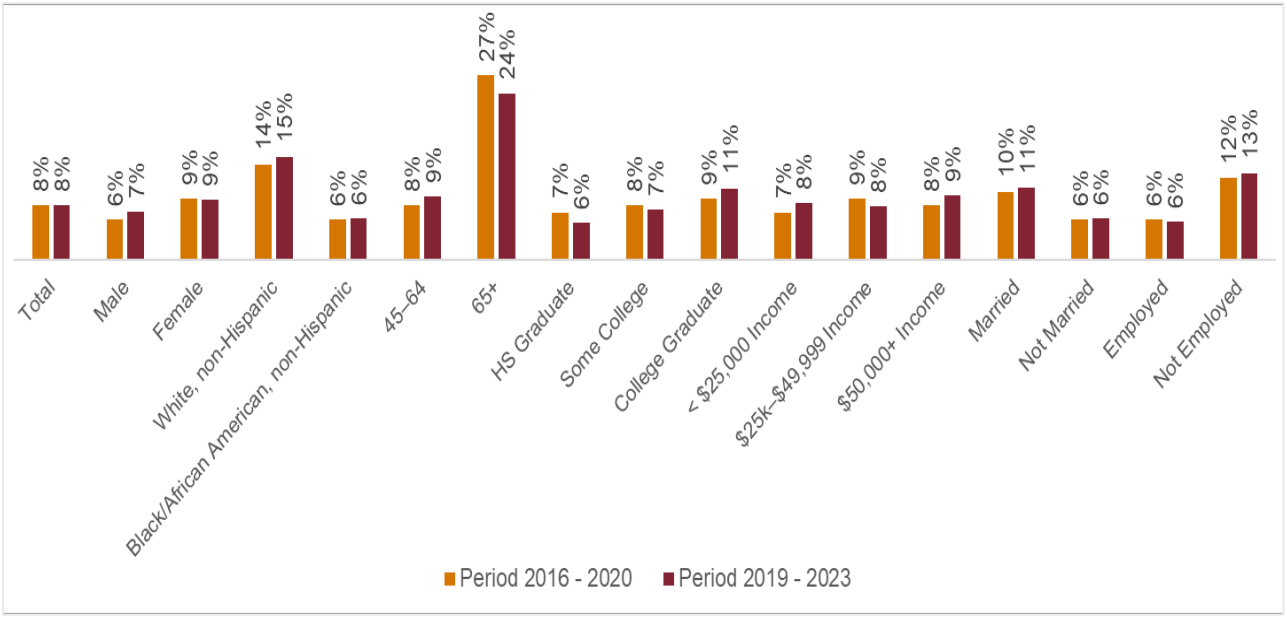
In 2025, it is estimated that 2,041,910 new cases of cancer of any site are expected to be diagnosed across the U.S.[60] Cancer (malignant neoplasms) has remained the second leading cause of death in Dallas County for the last 20 years, mirroring national trends. The most commonly diagnosed cancer types include lung, breast, prostate, and colorectal cancers.[61]

The prevalence of cancer, defined as the number of people currently living with a diagnosis of cancer, remained steady at 8% in Dallas County from 2016-2020, according to the BRFSS-see Morbidity Figure 16. The prevalence is notably higher among those individuals aged 65 and older (24.4%) as well as white non-Hispanics (15.1%).

Efforts to address cancer morbidity focus on improving early detection through screening programs, increasing awareness, and expanding access to timely treatment and supportive services.[62] Despite advances in cancer treatment, disparities in morbidity and mortality persist across racial/ethnic and socioeconomic groups in Dallas County.

[60] National Cancer Institute. Cancer Stat Facts: Cancer of Any Site. Surveillance, Epidemiology, and End Results Program. 2025. Accessed July 25, 2025. https://seer.cancer.gov/statfacts/html/all.html
[61] Centers for Disease Control and Prevention. Leading Causes of Death. National Center for Health Statistics. Updated March 1, 2024. Accessed May 19, 2025. https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm
[62] Siegel RL, Kratzer TB, Giaquinto AN, Sung H, Jemal A. Cancer statistics, 2025. *CA Cancer J Clin*. 2025;75(1):10-45. doi:10.3322/caac.21871. Accessed July 25, 2025

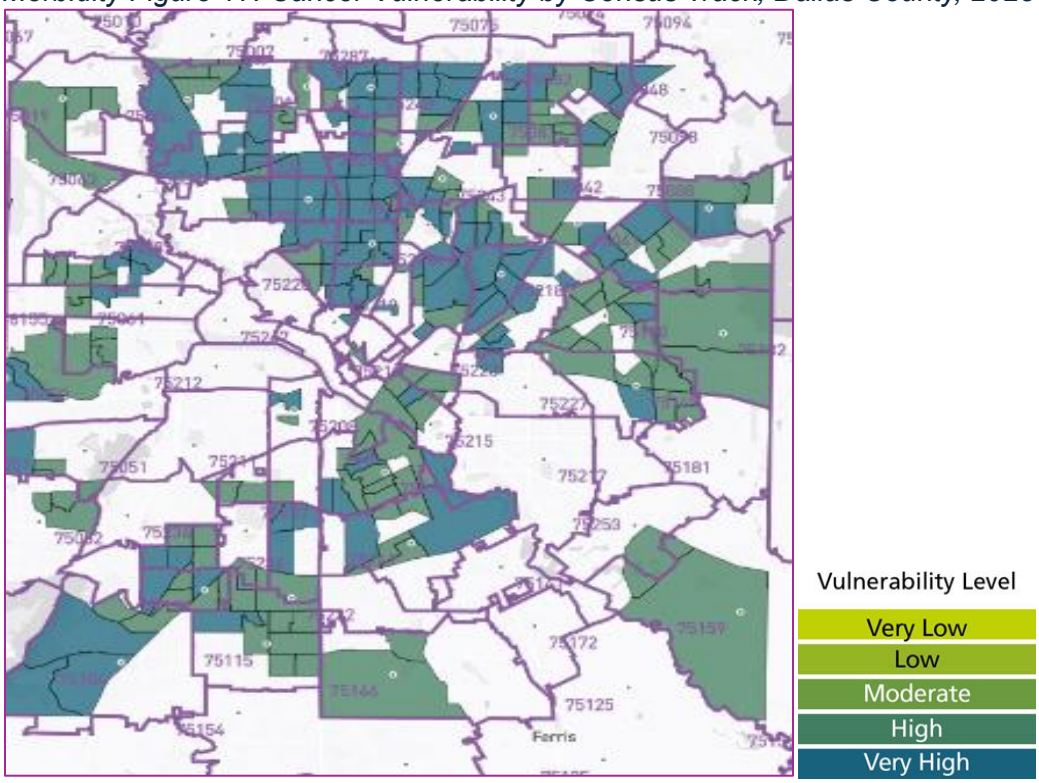
Morbidity Figure 16: Prevalence of Any Cancer Among Adults (18+), Dallas County, 2016-2020 vs 2019-2023



Data Source: Center for Health Statistics BRFSS 2016 - 2020 and 2019 - 2023, Texas Department of State Health Services.

The cancer vulnerability map, in Morbidity Figure 17, illustrates geographic variation in vulnerability levels in Dallas County. The map uses a color gradient from green to dark blue, where darker shades represent areas with higher cancer vulnerability. Dark blue zones indicate areas of very high vulnerability, while green areas reflect high, though comparatively lower, levels of vulnerability.

Morbidity Figure 17: Cancer Vulnerability by Census Track, Dallas County, 2025

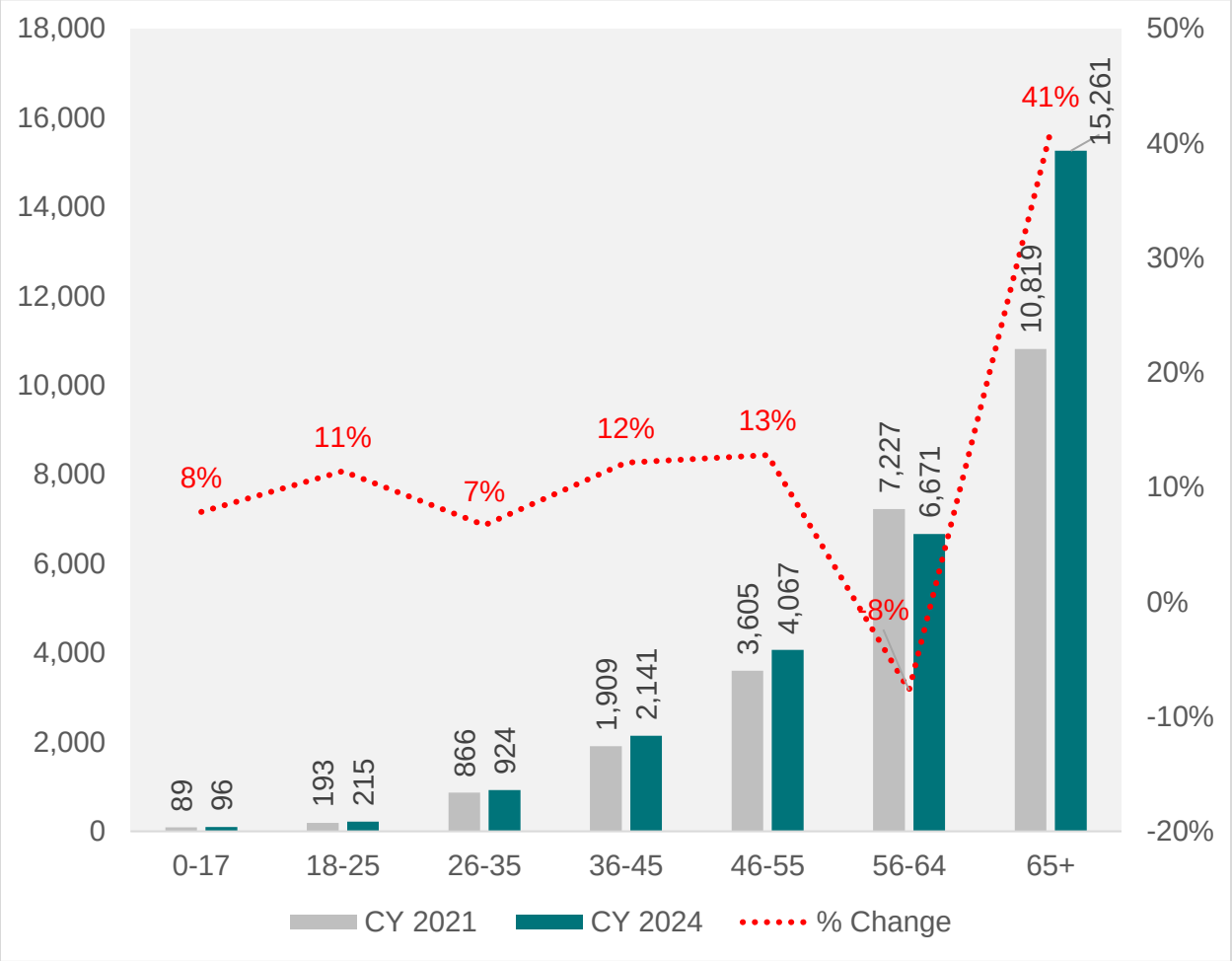


Data Source: CVC, PCCI

a. Cancer Clinical and Demographics Trends

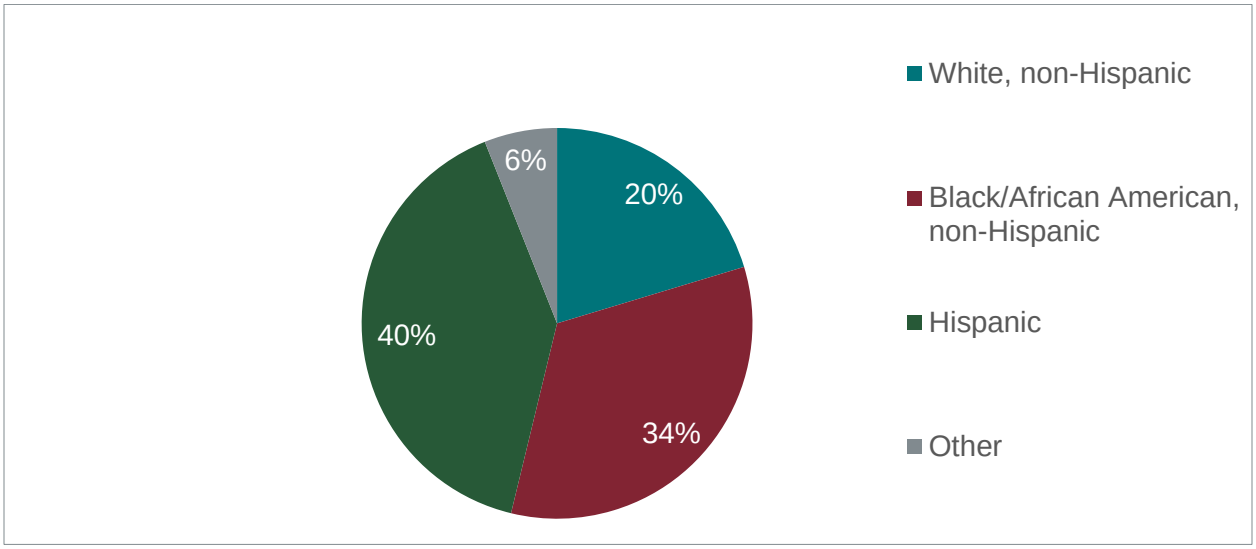
Morbidity Figure 18 displays the number of individuals in the Parkland Cancer Registry across different age groups between 2021 and 2024. Parkland experienced a 19% overall increase in patients with cancer-related conditions between 2021 and 2024. The most significant rise occurred among patients aged 65 and older, with a 41% increase. Notable growth was also observed in the 36–45 and 46–55 age groups, an increase of 12% and 13%, respectively-see Morbidity Figure 18.

Morbidity Figure 18: Parkland Patients, Cancer Registry, Dallas County, 2021- 2024



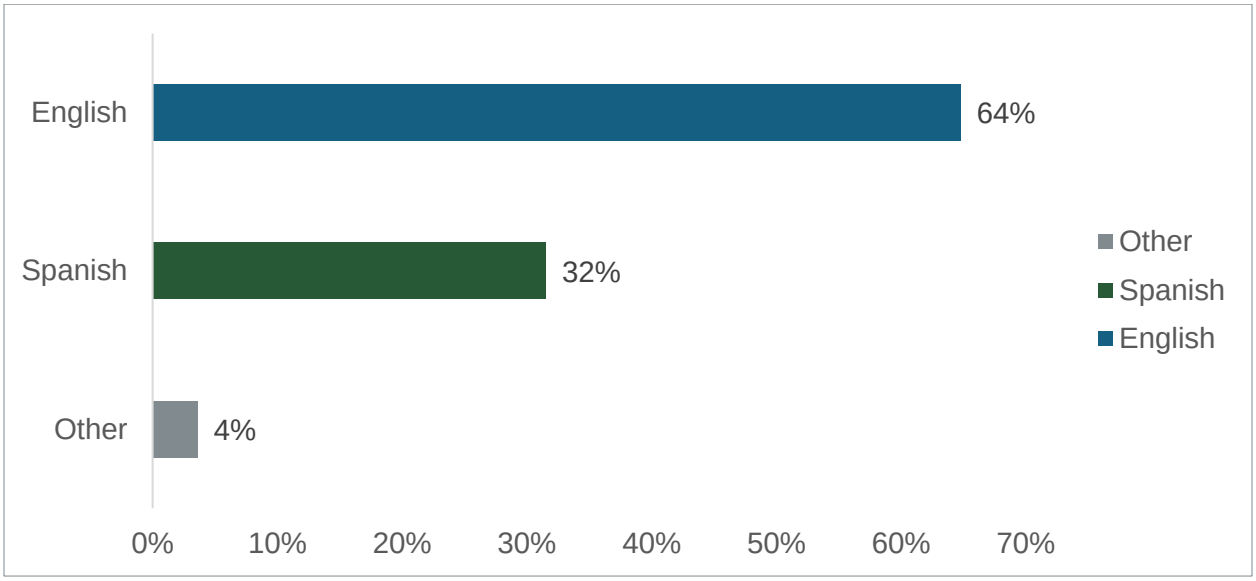
Cancer registry includes deceased patients
Data Source: Parkland EHR Cancer Registry, 2021 and 2024

Morbidity Figure 19: Parkland Patients, Cancer Registry by Race and Ethnicity, 2024



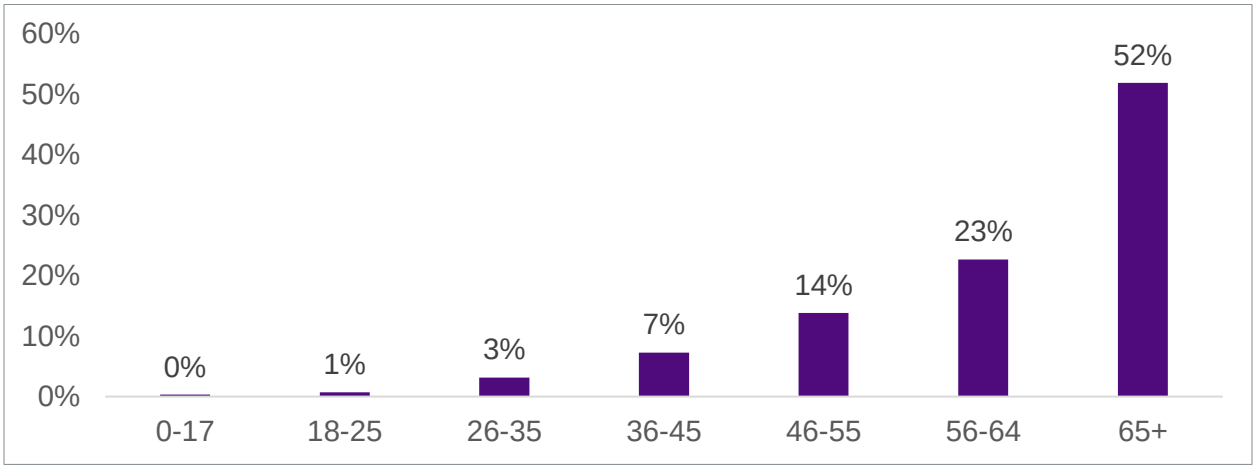
Data Source: Parkland EHR Cancer Registry, 2024

Morbidity Figure 20: Parkland Patients, Preferred Language, Cancer Registry, 2024



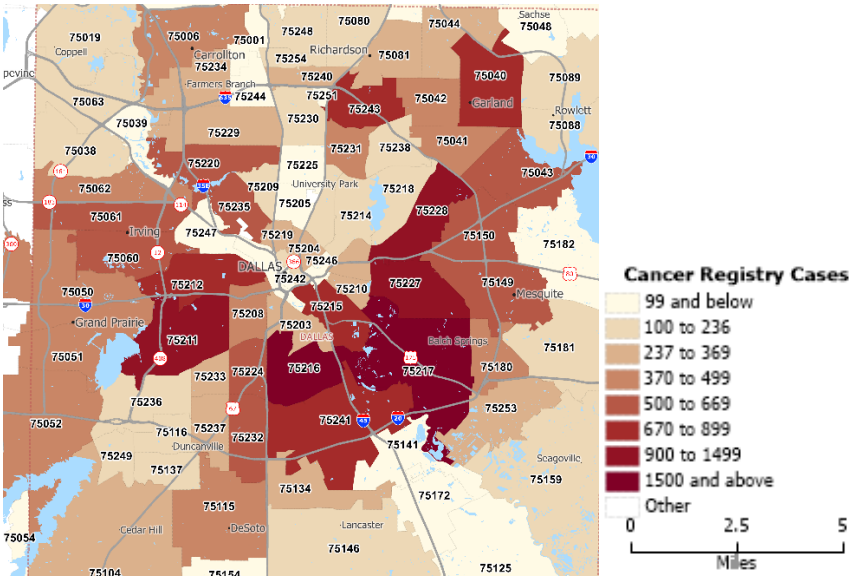
Data Source: Parkland EHR Cancer Registry, 2024

Morbidity Figure 21: Parkland Patients, Cancer Registry Age Distribution, 2024



Data Source: Parkland EHR Cancer Registry, 2024

Morbidity Figure 22: Parkland Patients, Cancer Registry by ZIP Code, 2024

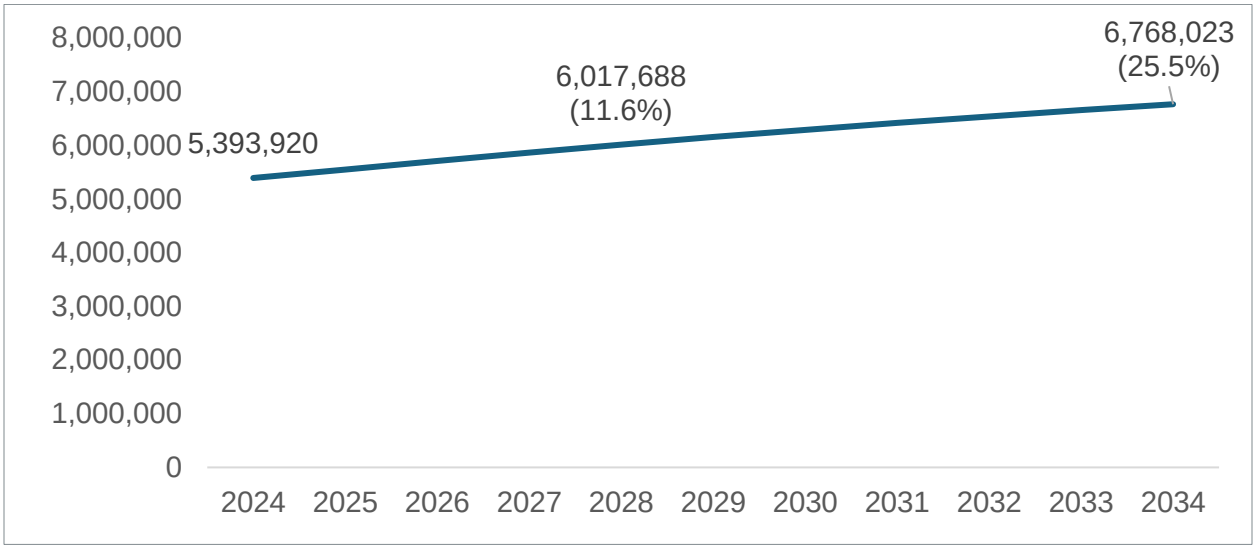


Data Source: Parkland EHR Cancer Registry, 2024

b. Cancer Outpatient Services Forecast

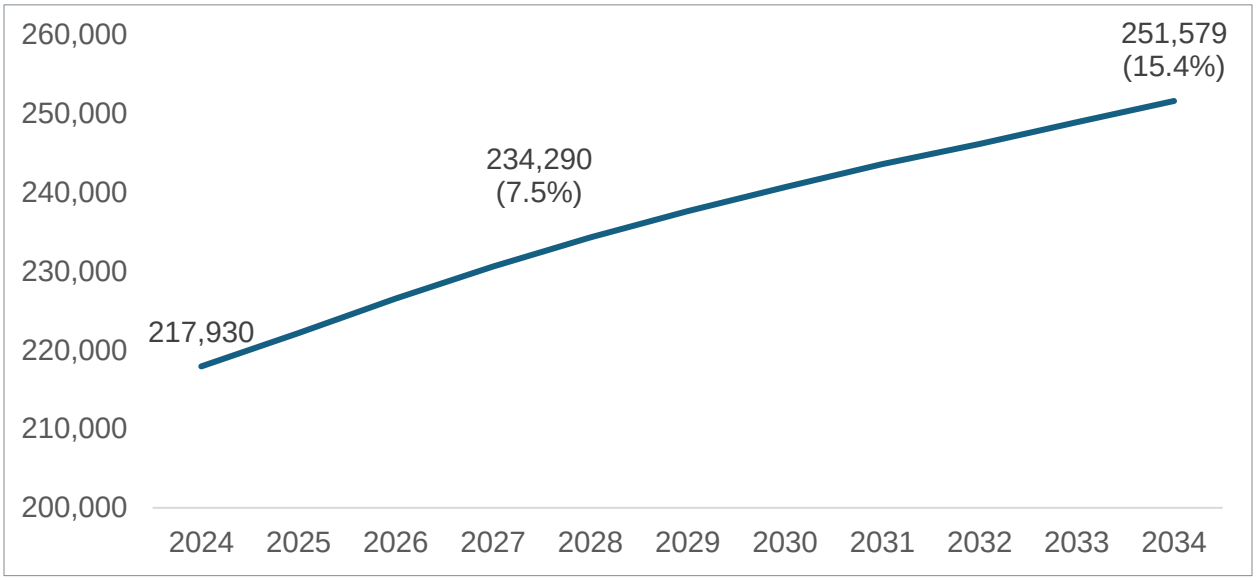
Forecast data indicate that the volume of outpatient services for all cancer types is projected to increase by 11.6% between 2024 and 2028 and by 25.5% between 2024 and 2034-see Morbidity Figure 23. Specifically, the volume of breast cancer outpatient services is expected to grow by 7.5% by 2028 and 15.4% by 2034-see Morbidity Figure 24. Similarly, outpatient services for lung and thoracic cancers are projected to increase by 13% between 2024 and 2028 and by 28% between 2024 and 2034-see Morbidity Figure 25. These forecasts are based on projected population trends in Dallas County, including changes in population size, birth and death rates, and demographic distribution.

Morbidity Figure 23: All Cancer Types, Outpatient Forecast, Dallas County, 2024-2034



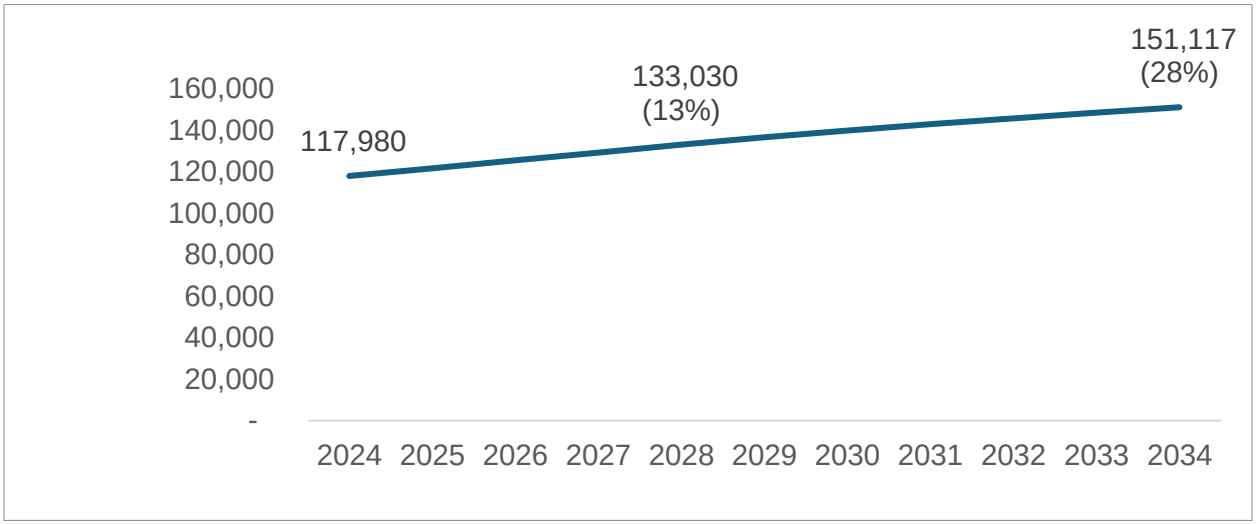
Prepared by SG-2, LLC

Morbidity Figure 24: Breast Cancer Outpatient Forecast, Dallas County, 2024–2034



Prepared by SG-2, LLC

Morbidity Figure 25: Lung and Thoracic Cancer Outpatient Forecast, Dallas County, 2024–2034



Prepared by SG-2, LLC

3. Diabetes

Diabetes is a chronic condition marked by high blood sugar (glucose) levels due to the body's inability to produce enough insulin or effectively use the insulin it produces. Over time, it can lead to serious health issues, including heart disease, kidney failure, vision loss, and lower-limb amputations[63]. In 2021, 38.4 million Americans had diabetes, and the disease was the underlying cause of 399,401 deaths[64]; furthermore, 98 million adults have prediabetes. Uncontrolled diabetes burdens healthcare systems, families, and communities and increases risks for depression, anxiety, and stress, complicating disease management[65] and costs more than $415 billion a year.[66]

Morbidity Figure 26, which compares the percentage of Dallas County residents diagnosed with diabetes across two time periods (2016–2020 and 2019–2023), shows that the overall prevalence remained the same (11%). However, certain groups—such as adults aged 65 and older (from 25% to 29%) and Hispanic residents (from 10% to 12%)—are experiencing increases in diabetes diagnoses.

[63] National Institute of Diabetes and Digestive and Kidney Diseases. What Is Diabetes? National Institutes of Health. Updated December 2023. Accessed May 20, 2025. https://www.niddk.nih.gov/health-information/diabetes/overview/what-is-diabetes

[64] American Diabetes Association. Statistics About Diabetes. Diabetes.org. https://diabetes.org/about-diabetes/statistics/about-diabetes. Accessed September 2, 2025

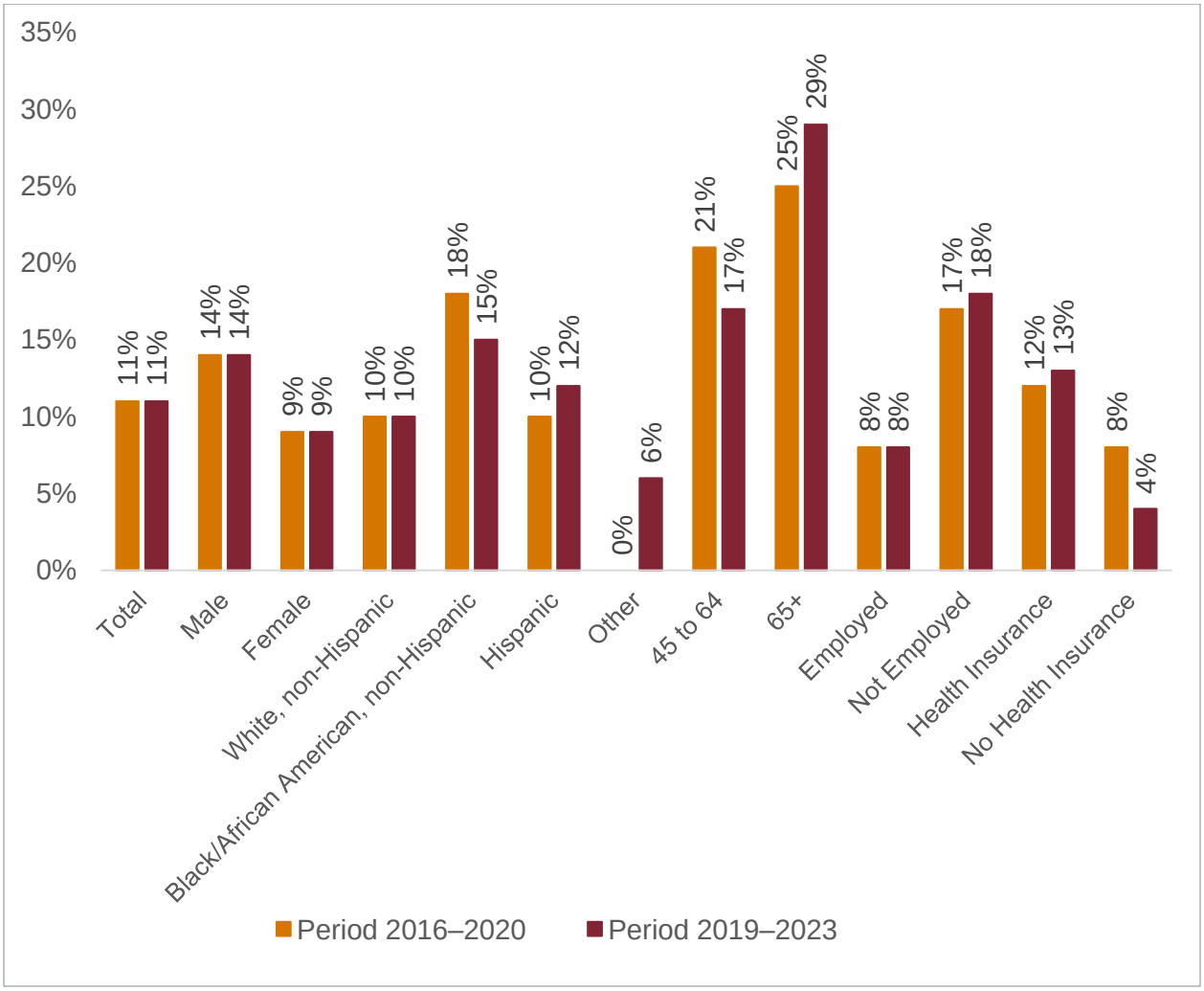
[65] American Diabetes Association. The Interconnected Complexity of Diabetes and Mental Health. Diabetes Spectrum. 2025;38(1):23-30. Accessed May 20, 2025. https://diabetesjournals.org/spectrum/article/38/1/23/157816/The-Interconnected-Complexity-of-Diabetes-and

[66] Parker ED, Lin J, Mahoney T, et al. Economic Costs of Diabetes in the U.S. in 2022. Diabetes Care. 2024 Jan;47(1):26–43. doi:10.2337/dci23-0085

Black or African American, non-Hispanic residents continue to have the highest prevalence among all racial and ethnic groups compared. Individuals with no health insurance on the other hand saw a decrease in diabetes prevalence from 8% to 4%.

These trends continue to highlight the ongoing need for targeted interventions focusing on prevention, including increasing access to screenings, promoting health lifestyle such as obesity reduction and physical activity, and addressing disparities in care. To support these efforts, Dallas County is currently implementing the National DPP, which promotes evidence-based strategies to reduce the risk of Type 2 diabetes among high-risk individuals.[67]

Morbidity Figure 26: Percent of Residents with Diabetes, Dallas County, 2016 - 2020 vs 2019 – 2023

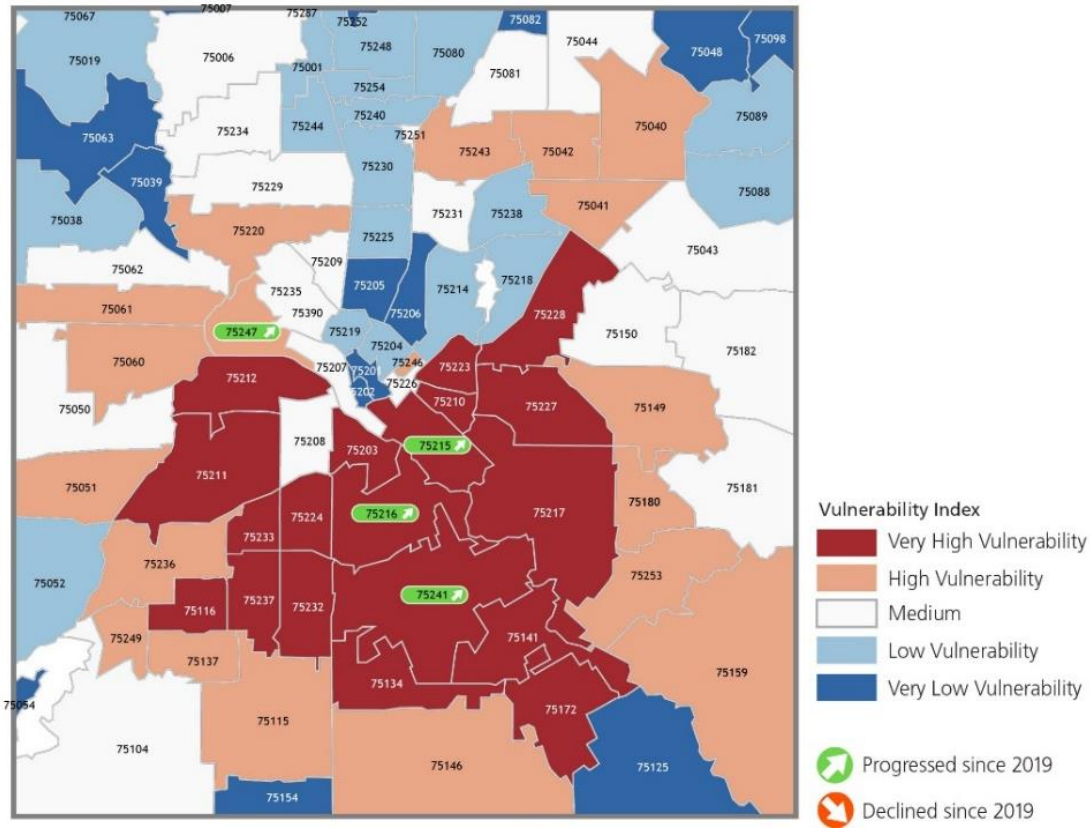


Data Source: Center for Health Statistics BRFSS 2016 - 2020 and 2019 - 2023, Texas Department of State Health Services.

[67] The Centers for Disease Control and Prevention. National Diabetes Prevention Program. Accessed May 20, 2025. https://www.cdc.gov/diabetes-prevention/programs/index.html

The map in Morbidity Figure 27 displays changes in diabetes prevalence across ZIP Codes. Areas with decreasing diabetes rates, indicating health improvements, are marked with green labels. The map also includes a Diabetes Vulnerability Index, ranging from very high (dark red) to very low (dark blue). Notably, four ZIP Codes showed improvement: 75247, 75215, 75216, and 75241. Among these, 75215, 75216, and 75241 have been areas of targeted interventions following previous CHNA suggesting that focused efforts may be contributing to positive health outcomes. However, these areas remain in high-vulnerability categories when compared to other areas of Dallas County, highlighting the need for sustained investment to address persistent health disparities.

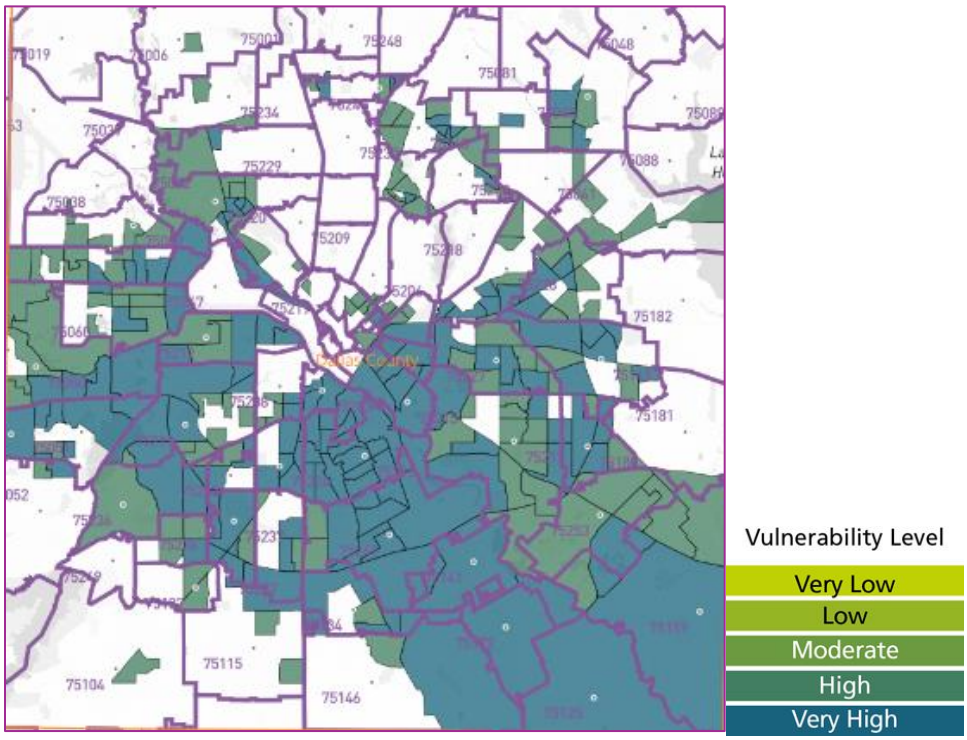
Morbidity Figure 27: Diabetes Trends by ZIP Codes, Dallas County, 2019 - 2022



Adopted from PCCI

In contrast, Morbidity Figure 28 presents the current diabetes vulnerability landscape in Dallas County as of 2025, using a color gradient from green to dark blue to indicate increasing levels of diabetes vulnerability. Unlike the trend map, this figure does not show changes over time but instead provides a snapshot of present-day risk levels across census tracts.

Morbidity Figure 28: Diabetes Vulnerability by Census Track, Dallas County, 2025



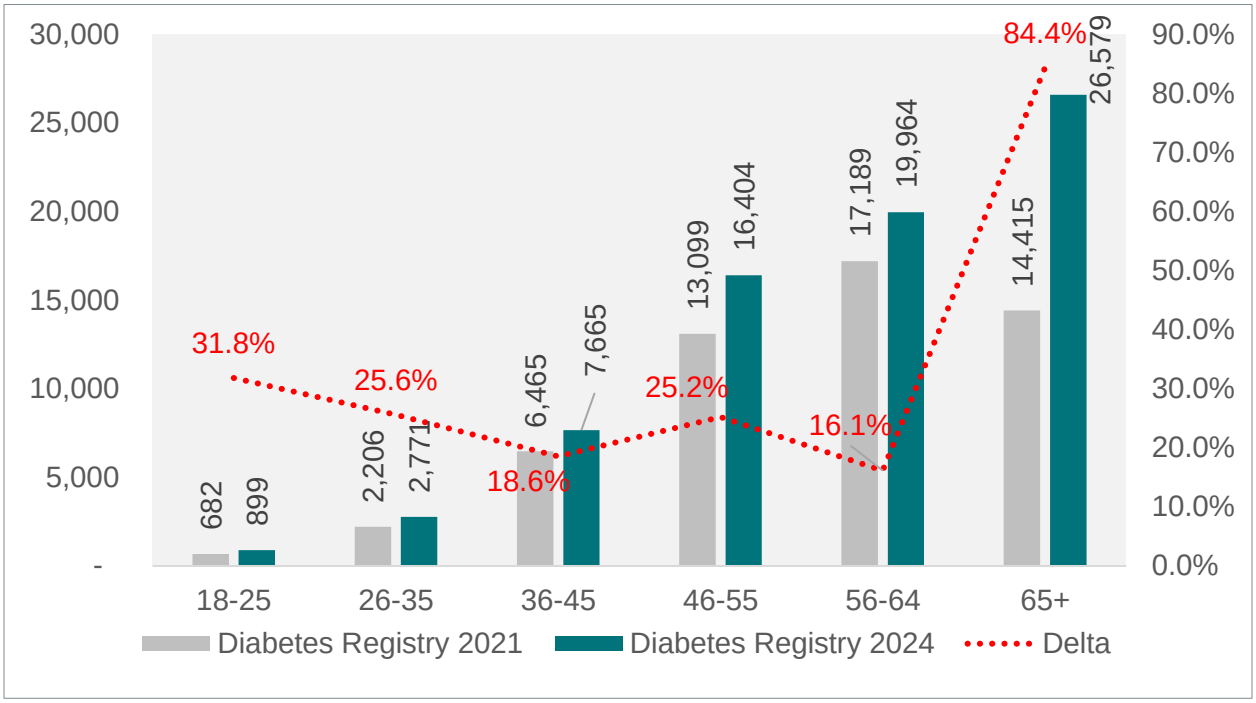
Data Source: CVC, PCCI

a. Diabetes Clinical and Demographic Trends

Morbidity Figure 29 shows changes in the number of people registered in the Parkland Diabetes Registry from 2021 to 2024 across different age groups, along with the percentage change (Delta). Overall, the total number of individuals in the registry increased by 37.4%, rising from 54,056 patients in 2021 to 74,282 patients in 2024. The highest increase was seen in the 65-year and older age group, which grew by 84.4%, indicating a sharp rise in diabetes cases in the registry among older adults. Increases were also observed in the 18-25, 26-35, and 46-55 age groups, with rises of 31.8%, 25.6%, and 25.2%, respectively. These trends suggest that the

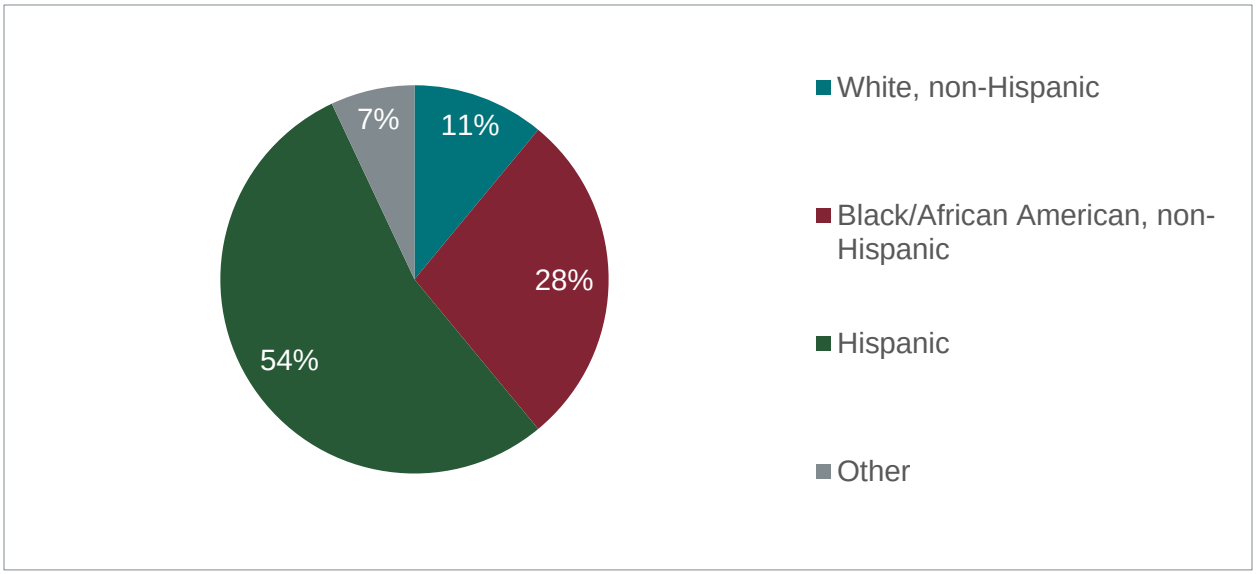
increase in the number of patients in the diabetes registry may be associated with enhanced outreach and screening efforts in target ZIP Codes 75215, 75217, and 75241.

Morbidity Figure 29: Parkland Patients, Diabetes Registry by Age Distribution, 2021 vs. 2024



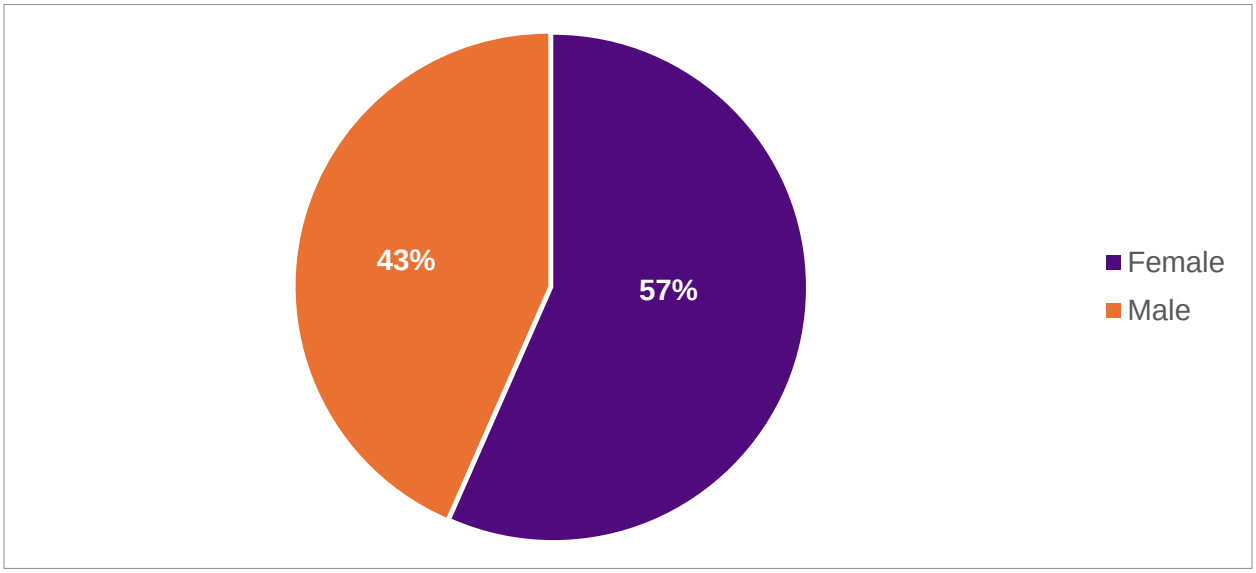
Data source: Parkland EHR Diabetes Registry

Morbidity Figure 30: Parkland Patients, Diabetes Registry by Race and Ethnicity, Dallas County, 2024



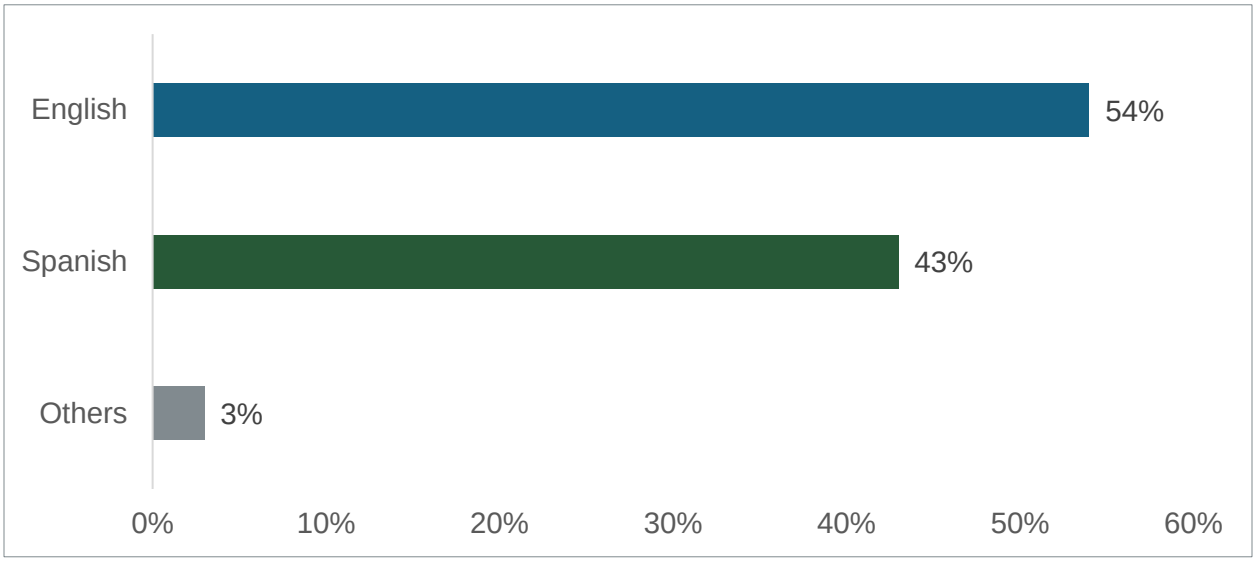
Data source: Parkland EHR Diabetes Registry

Morbidity Figure 31: Parkland Patients, Diabetes Registry, by Sex, Dallas County, 2024



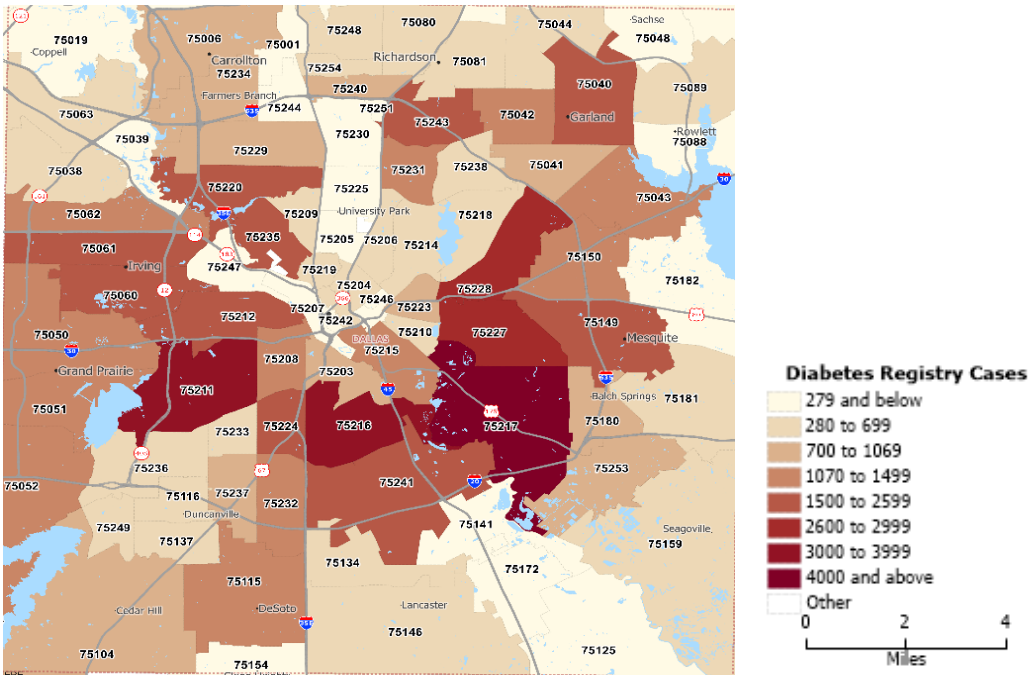
Data source: Parkland EHR Diabetes Registry

Morbidity Figure 32: Parkland Patients, Preferred Language, Diabetes Registry, 2024



Data source: Parkland EHR Diabetes Registry

Morbidity Figure 33: Parkland Patients by ZIP Codes (Map), Diabetes Registry, 2024

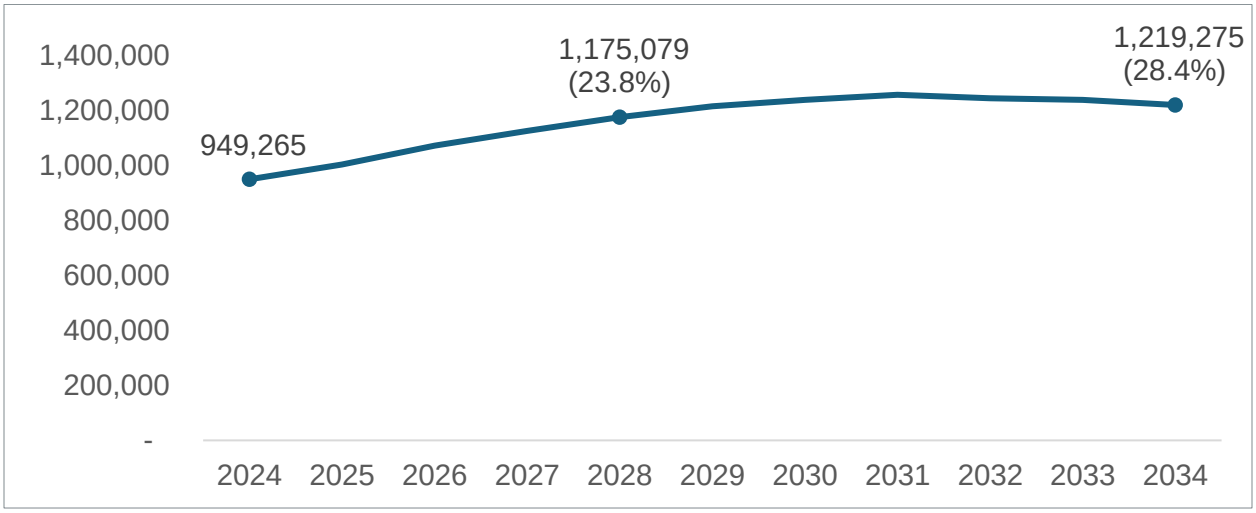


Data source: Parkland EHR Diabetes Registry

b. Diabetes Outpatient Services Forecast

Forecast data indicates that the volume of diabetes outpatient services is expected to grow by 23.8% between 2024 and 2028 and 28.4% between 2024 and 2034-see Morbidity Figure 34. These forecasts are based on projected population trends in Dallas County, including changes in population size, birth and death rates, and demographic distribution.

Morbidity Figure 34: 10-year Forecast for Outpatient Services, Diabetes Mellitus, 2024-2034



Data Source: Prepared by SG2, LLC

4. Heart Disease and Hypertension

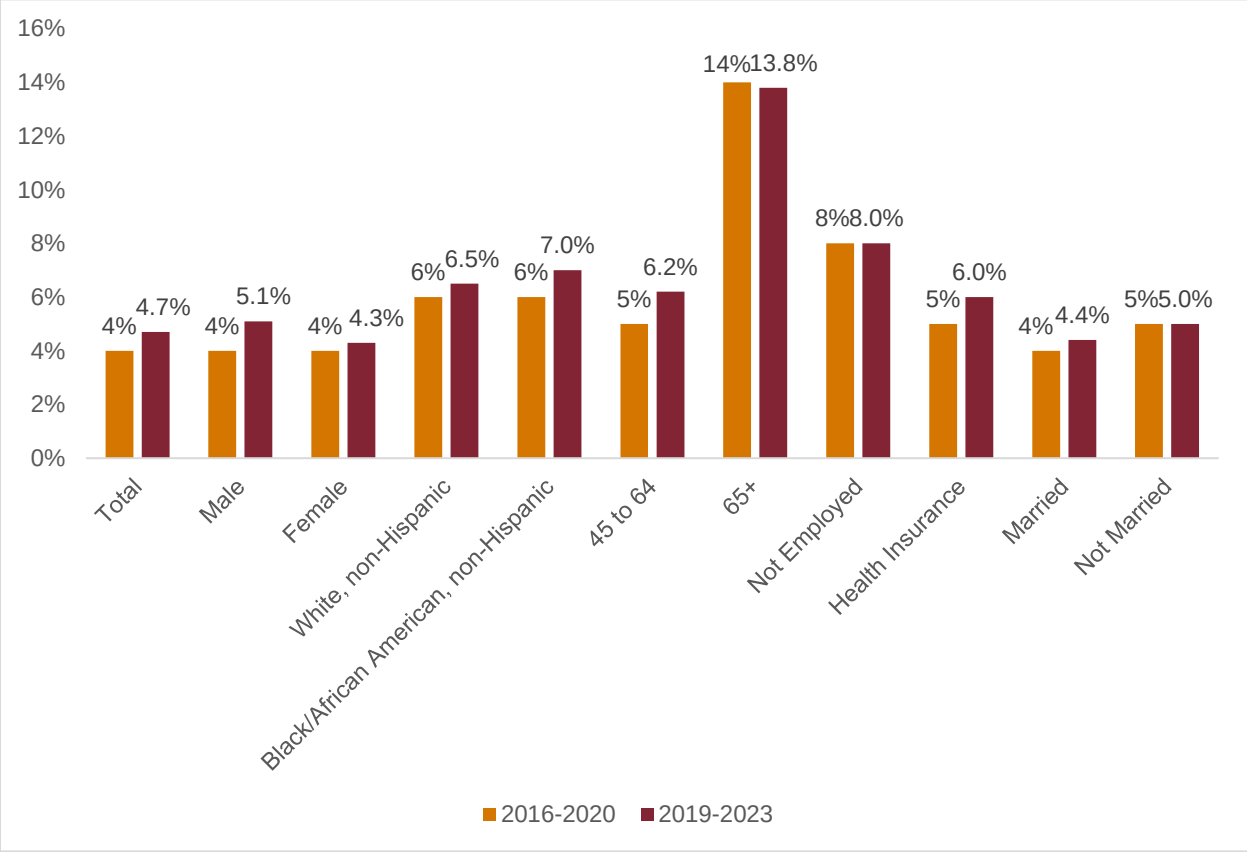
Despite being largely preventable, heart disease remains the leading cause of death in the U.S., Texas, and Dallas County. In 2023, cardiovascular disease claimed more than 919,000 lives nationwide, with one person dying every 34 seconds. The economic burden is also significant, with an estimated $417.9 billion in costs from 2020 to 2021, including medical care, medications, and lost productivity due to premature death.[68]

Nationally, the rise in hypertension, obesity, and other major risk factors continues to fuel the heart disease epidemic. Hypertension, often called a “silent” disease due to its lack of early symptoms, is the most common risk factor for both heart disease and stroke.[69] Nearly 119.9 million U.S. adults, are affected by hypertension, yet only 1 in 4 (22.5%) have their blood pressure under control. It was a primary or contributing cause in 664,470 deaths in 2023.[70]

Locally, heart disease continues to be a major health concern in Dallas County. The BRFSS data on heart disease morbidity in Dallas County from 2019 to 2023 in Morbidity Figure 35 highlights disparities across demographic groups. The overall prevalence of heart disease is 4.7%, with males exhibiting a higher rate (5.1%) than females (4.3%). Among racial and ethnic groups, Black or African American, non-Hispanic individuals experiencing the highest prevalence at 7%, followed by white, non-Hispanic individuals at 6.5%, and Hispanic individuals at a lower rate of 2.4%. In addition, age is also a strong factor, as prevalence increases with age, 6.2% among those aged 45–64 and a striking 13.8% among those 65 and older. Lastly, employment status is another key determinant, with unemployed individuals facing a much higher prevalence (8%) than those who are employed (3%).

[68] Centers for Disease Control and Prevention. Heart Disease Facts. Updated October 24, 2024. Accessed July 25, 2025. https://www.cdc.gov/heart-disease/data-research/facts-stats/index.html
[69] CDC Foundation. Hypertension. CDC Foundation. Accessed July 30, 2025. https://www.cdcfoundation.org/hypertension
[70] Centers for Disease Control and Prevention. High Blood Pressure Facts. Updated January 28, 2025. Accessed July 30, 2025. https://www.cdc.gov/high-blood-pressure/data-research/facts-stats/index.html

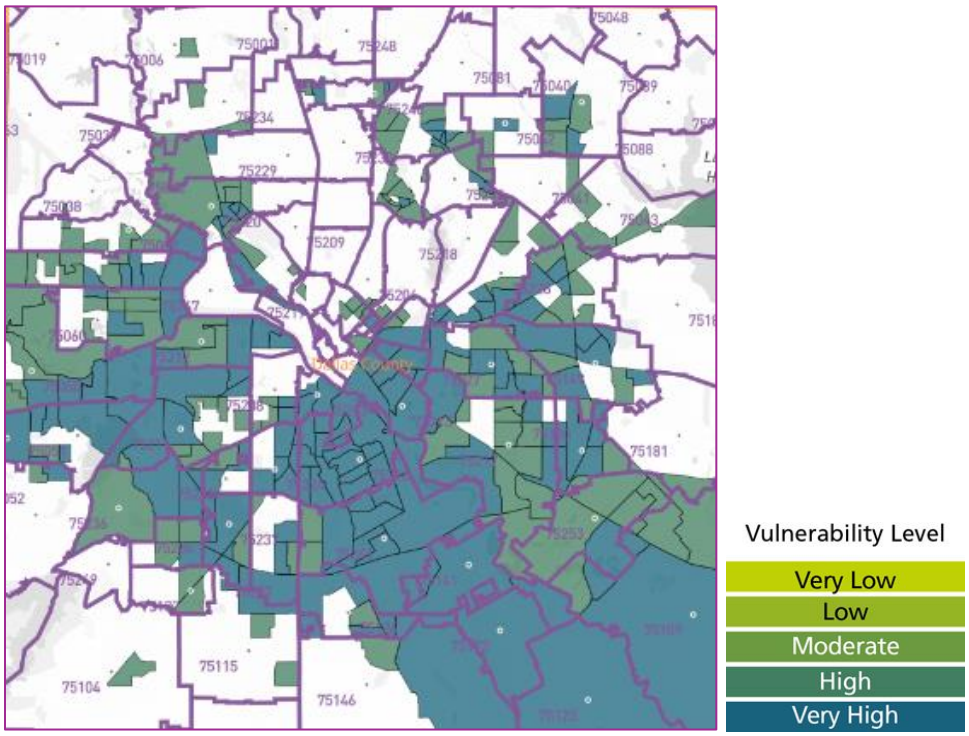
Morbidity Figure 35: Prevalence of Heart Disease, Dallas County, 2016-2020 and 2019-2023



Data Source: Center for Health Statistics BRFSS 2016-2020 and 2019 - 2023, Texas Department of State Health Services.

Morbidity Figure 36 displays the current hypertension vulnerability landscape for Dallas County, emphasizing 75210, 75215, 75216, 75217, 75241 ZIP Codes identified in the 2022 CHNA as the high vulnerability areas. Using a color gradient from green to dark blue, the map illustrates varying levels of hypertension vulnerability where dark blue signifies very high vulnerability, and green indicates elevated but relatively lower vulnerability.

Morbidity Figure 36: Hypertension Vulnerability by Census Track, Dallas County, 2025

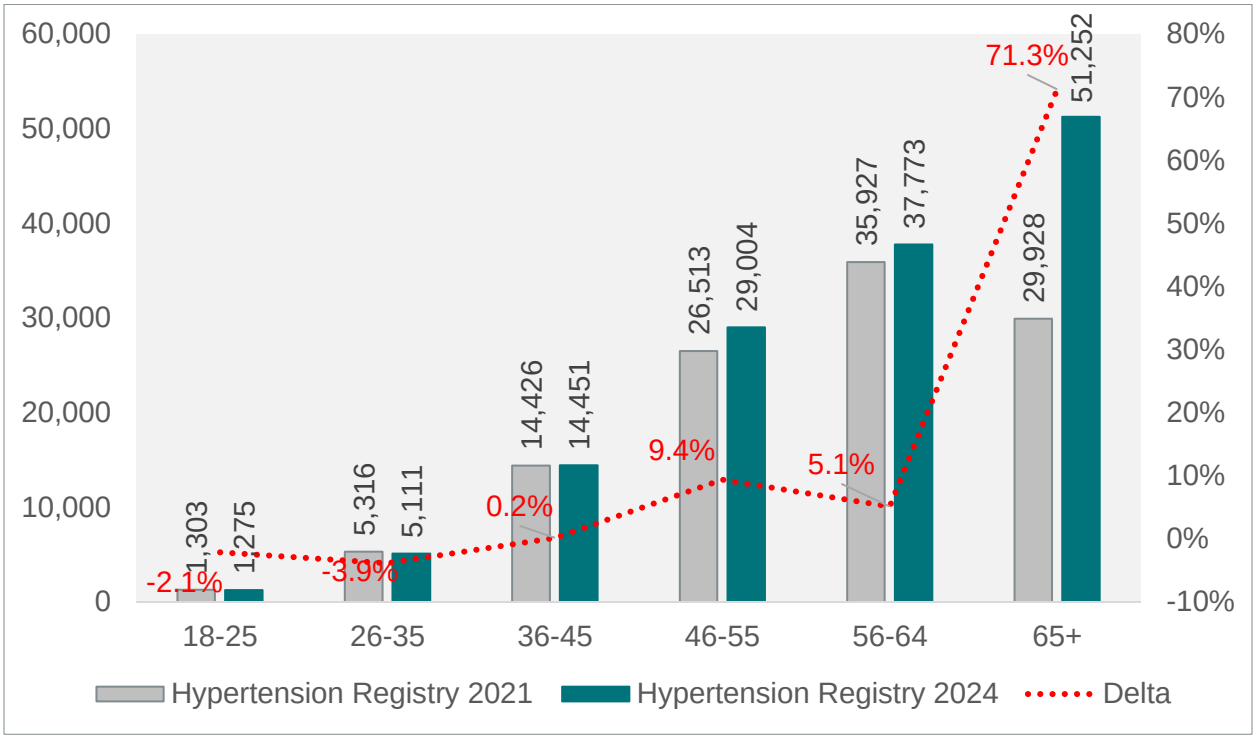


Data Source: CVC, PCCI

a. Hypertension Clinical and Demographic Trends

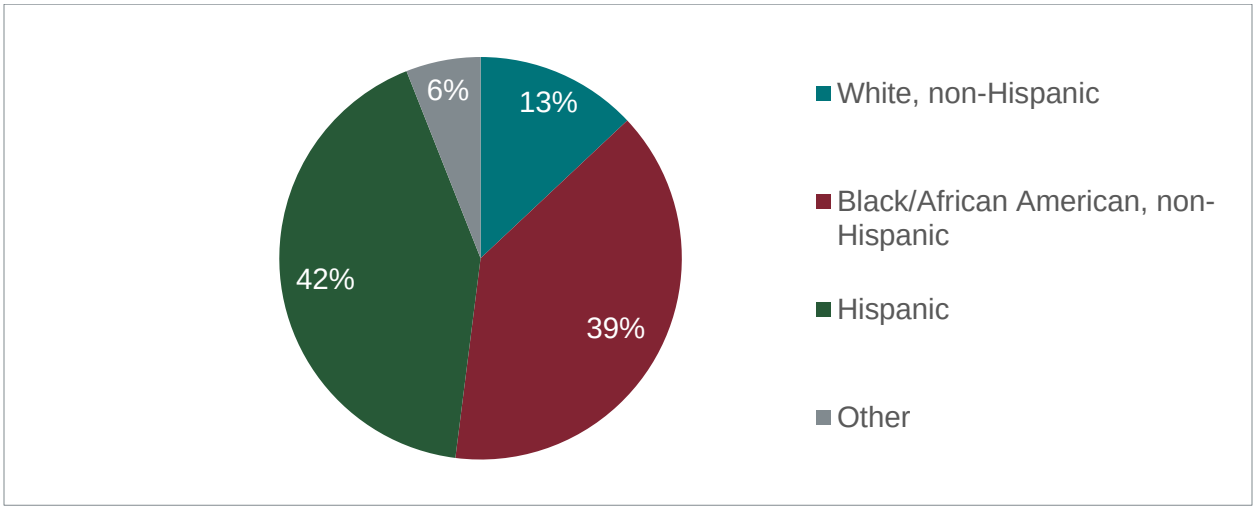
Morbidity Figure 37 shows changes in the number of people captured in the Parkland Hypertension Registry from 2021 to 2024 across different age groups, along with the corresponding percentage change (Delta). Overall, the total number of individuals in the registry increased by 22.4%, rising from 113,413 in 2021 to 138,866 in 2024. Between 2016 and 2023, the percentage of Dallas County residents aged 65 and older diagnosed with hypertension remained relatively stable. Increases were also observed in the 46–55 and 56–64 age groups, with rises of 9.4% and 5.1%, respectively.

Morbidity Figure 37: Parkland Patients, Hypertension Registry by Age Group, 2021 vs. 2024



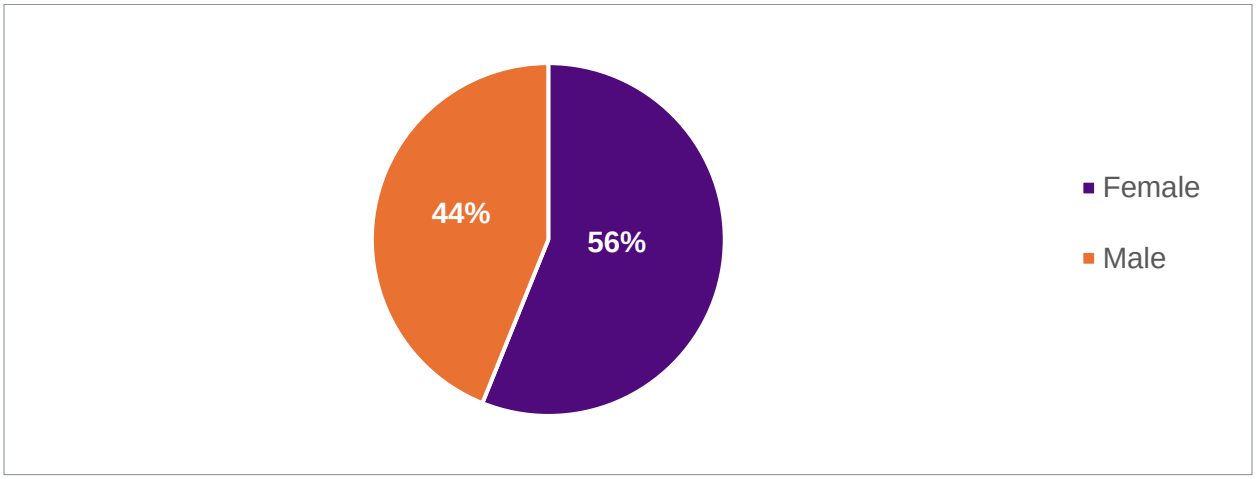
Data source: Parkland EHR Hypertension Registry

Morbidity Figure 38: Parkland Patients, Hypertension Registry by Race and Ethnicity, Dallas County, 2024



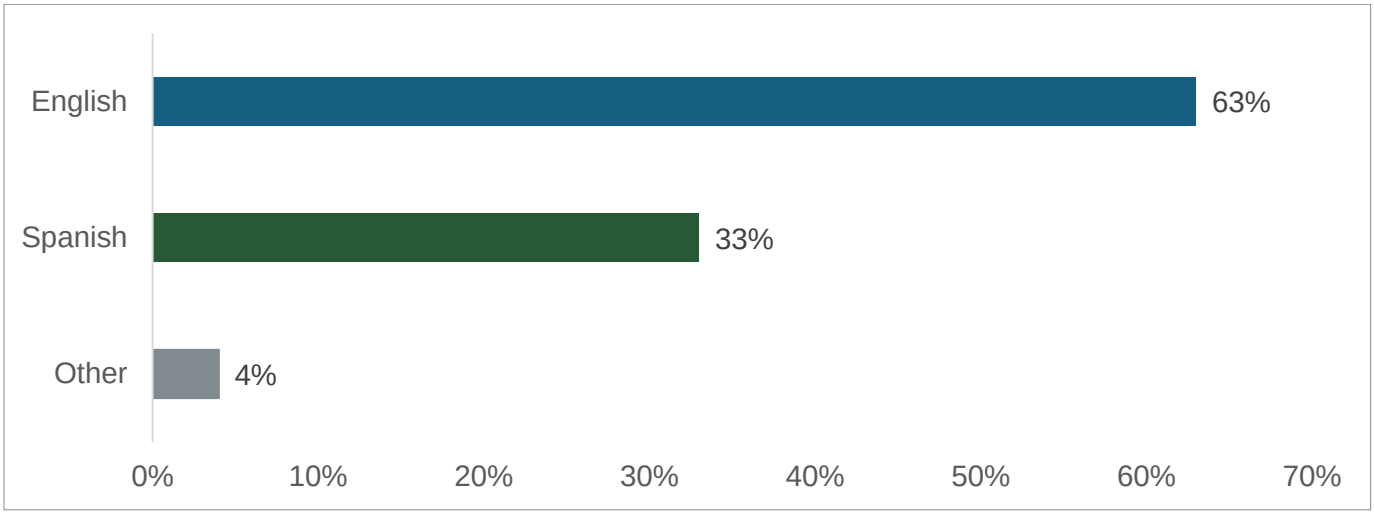
Data source: Parkland EHR Hypertension Registry

Morbidity Figure 39: Parkland Patients, Hypertension Registry, by Sex, Dallas County, 2024



Data source: Parkland EHR Hypertension Registry

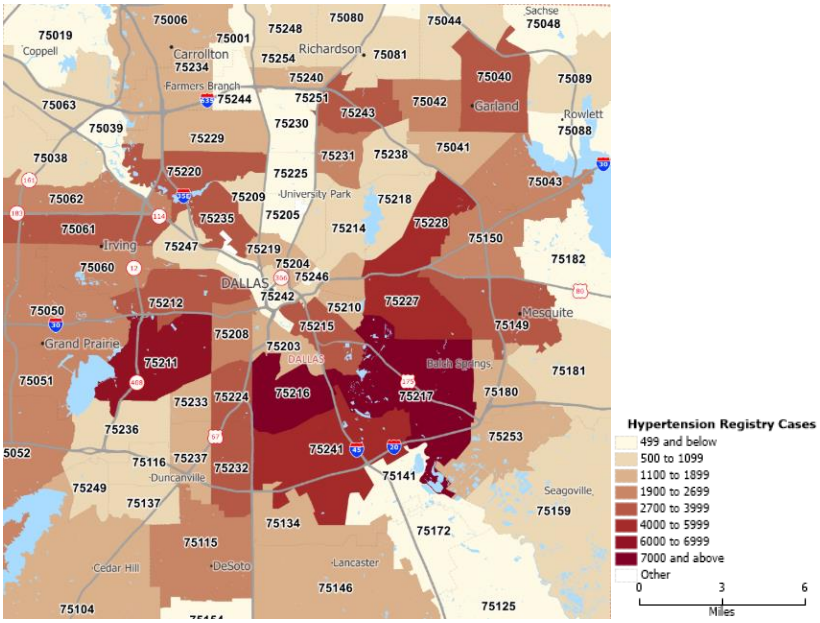
Morbidity Figure 40: Parkland Patients, Preferred Language, Hypertension Registry, 2024



Data source: Parkland EHR Hypertension Registry

The ZIP Codes with the highest volume of patients with hypertension are 75211, 75216, and 75217. These areas stand out with the darkest shading, representing a higher concentration of hypertension-see Morbidity Figure 41.

Morbidity Figure 41: Parkland Patients by ZIP Code, Hypertension Registry, 2024

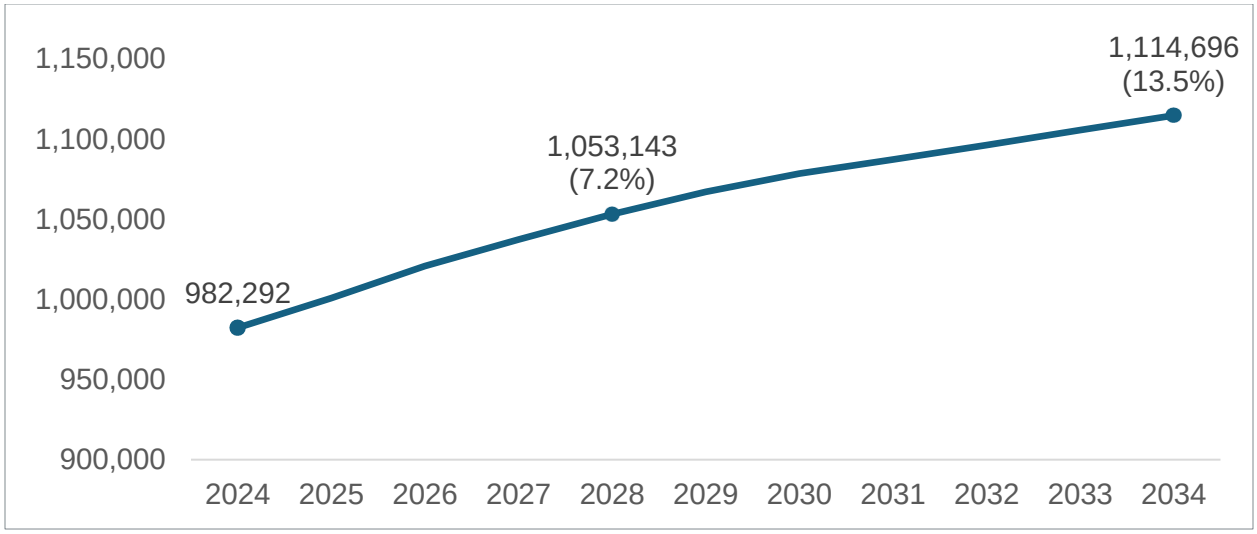


Data source: Parkland EHR Hypertension Registry

b. Hypertension Outpatient Services Forecast

Forecast data indicate that between 2024 and 2034, the volume of hypertension outpatient services is expected to grow by 7.2% between 2024 and 2028, and by 13.5% between 2024 and 2034-see Morbidity Figure 42. These forecasts are based on projected population trends in Dallas County, including changes in population size, birth and death rates, and demographic distribution.

Morbidity Figure 42: 10-year Forecast for Outpatient Services, Hypertension, 2024-2034



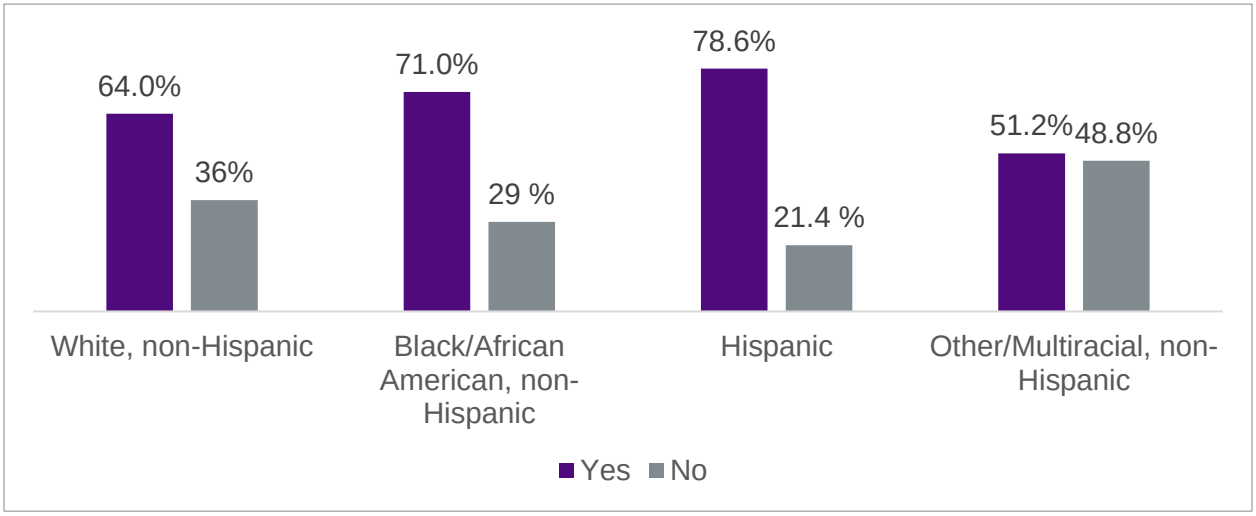
Data Source: Prepared by SG2, LLC

5. Obesity

In adults, overweight – defined as BMI 25 - 29.9 kg/m^2 and obesity—defined as a BMI ≥ 30 kg/m²— is linked to increased risk of chronic diseases such as type 2 diabetes, heart disease, and certain cancers.[71] As discussed earlier, food insecurity and the food environment contribute significantly to obesity by limiting access to affordable, nutritious options. Disparities such as low income and limited grocery access often lead to diets high in processed, calorie-dense foods. For more detail, see the **Food Environment** section (see *Food Environment, NMDOH section).*

In 2022, the prevalence of obesity in Dallas County was 34.7% among adults, which is slightly higher than the national prevalence at 33.3%.[72] From 2019 -2023, the prevalence of obesity and overweigh combined remains the highest among Hispanic group with 78.6% followed by Black or African American, non-Hispanic group with 71%-see Morbidity Figure 43.

Morbidity Figure 43: Prevalence of Overweight or Obese Adults by Race and Ethnicity, Dallas County, 2019-2023



Data Source: Center for Health Statistics BRFSS 2016-2020, Texas Department of State Health Services.

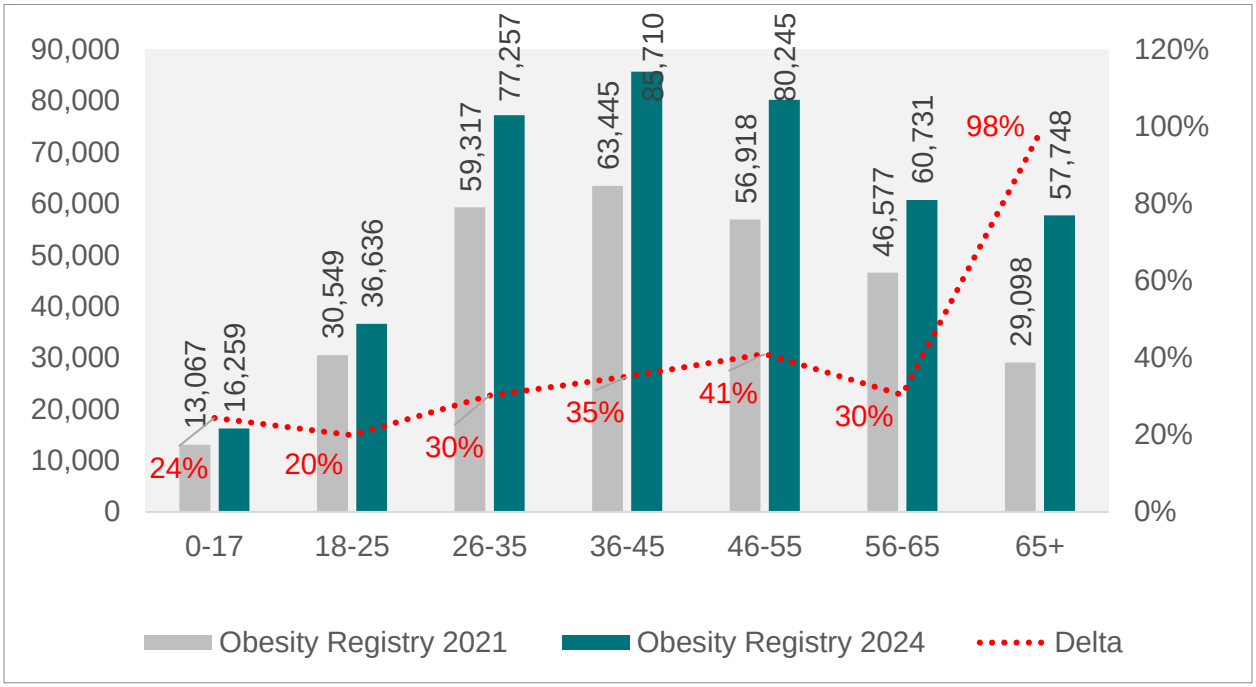
a. Obesity Clinical and Demographic Trends

Figure 44 illustrates changes in the number of individuals listed in the Parkland Obesity Registry from 2021 to 2024, broken down by age group, and percentage change. Overall, the registry saw an increase of 115,615 individuals during this period, a 39% rise.

[71] University of Wisconsin Population Health Institute. *2022 Texas County Health Rankings*. County Health Rankings & Roadmaps. Published 2022. Accessed July 31, 2025. https://www.countyhealthrankings.org/sites/default/files/media/document/CHR2022_TX_0.pdf

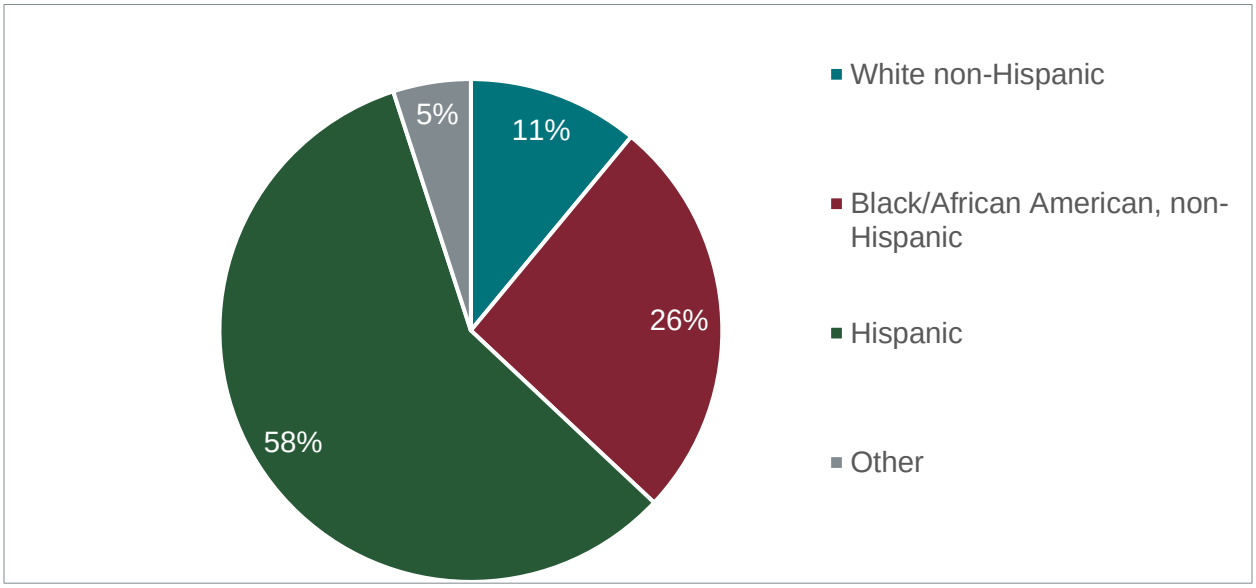
[72] Centers for Disease Control and Prevention. *PLACES: Local Data for Better Health – Dallas County, Texas*. Published August 2024. July 31, 2025. https://places.cdc.gov/?view=county&locationIds=48113

Morbidity Figure 44: Parkland Patients, Obesity Registry by Age Group, 2021 vs. 2024



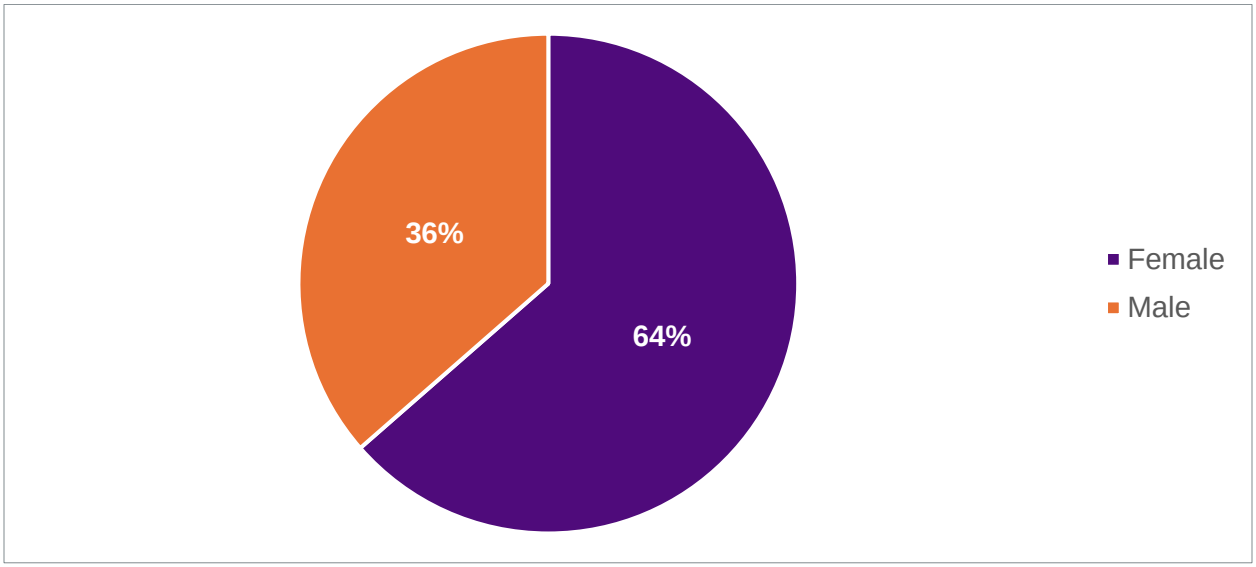
Data source: Parkland EHR Obesity Registry, 2021 and 2024

Morbidity Figure 45: Parkland Patients, Obesity Registry by Race and Ethnicity, Dallas County, 2024



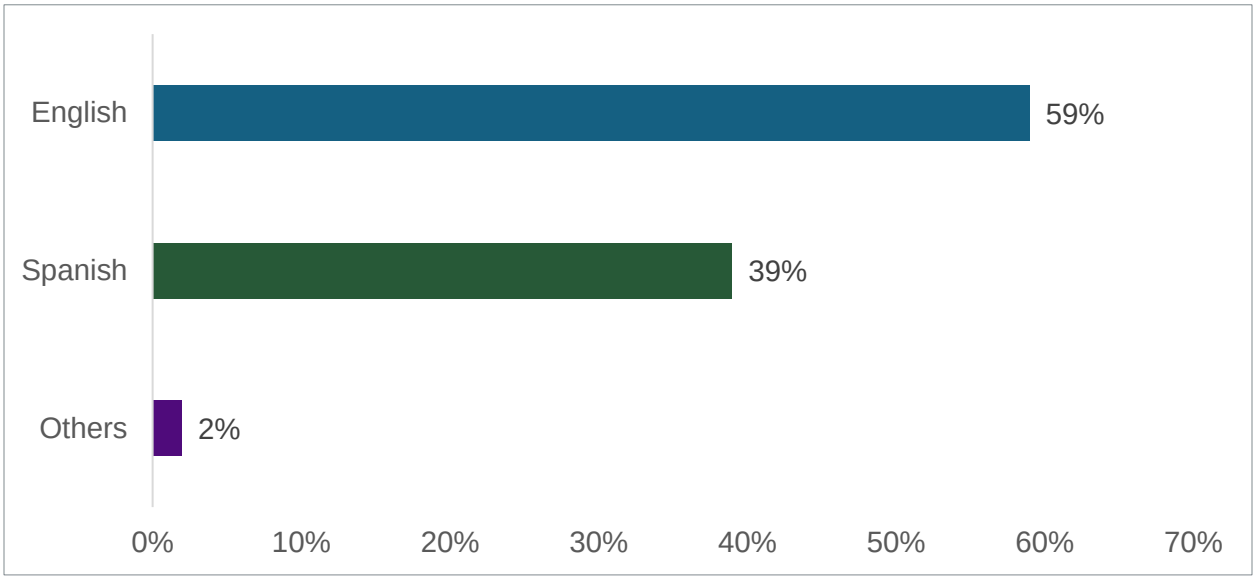
Data source: Parkland EHR Obesity Registry, 2024

Morbidity Figure 46: Parkland Patients, Obesity Registry, by Sex, Dallas County, 2024



Data source: Parkland EHR Obesity Registry, 2024

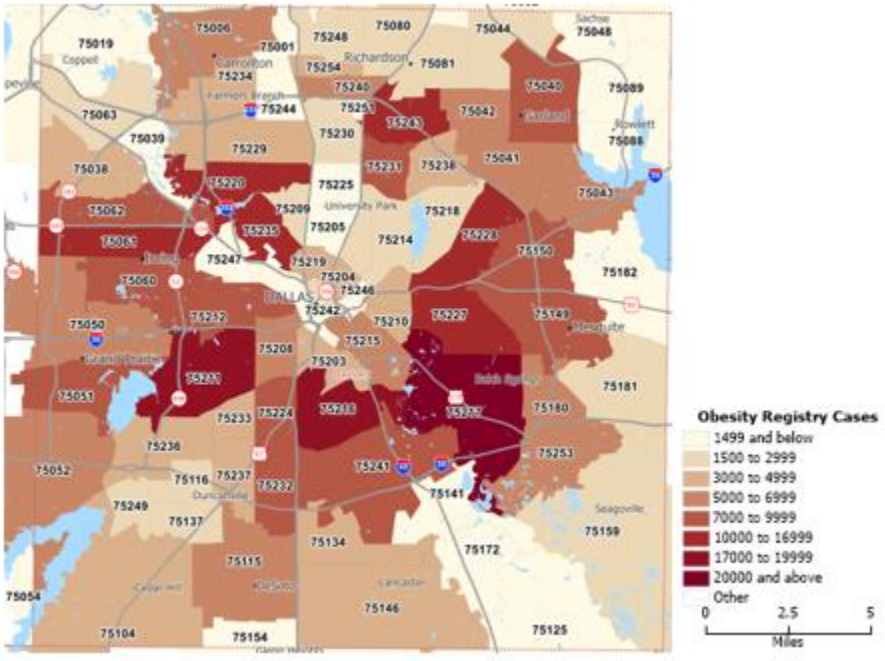
Morbidity Figure 47: Parkland Patients, Preferred Language, Obesity Registry, 2024



Data source: Parkland EHR Obesity Registry, 2024

The ZIP Codes with the highest values shown on the map-see Morbidity Figure 48, are 75211, 75216, and 75217. These areas stand out with the darkest shading, representing a higher concentration of obesity.

Morbidity Figure 48: Parkland Patients by ZIP Code (Map), Obesity Registry, 2024

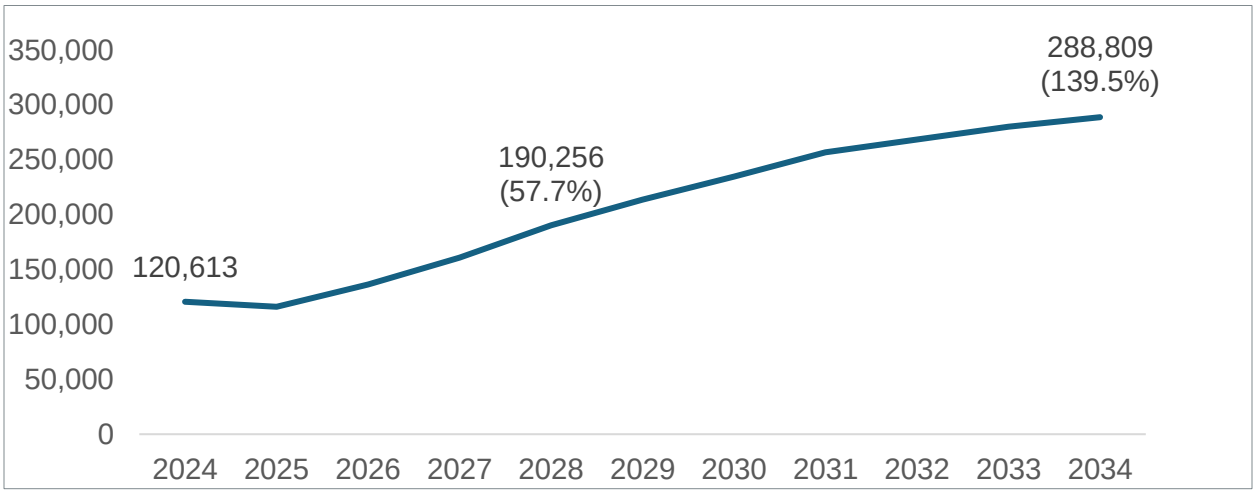


Data source: Parkland EHR Obesity Registry

b. Obesity Outpatient Services Forecast

Forecast data indicate that between 2024 and 2034, the volume of obesity outpatient services is expected to grow by 57.7% between 2024 and 2028 and 139.5% between 2024 and 2034-see Morbidity Figure 49. These forecasts are based on projected population trends in Dallas County, including changes in population size, birth and death rates, and demographic distribution.

Morbidity Figure 49: Obesity Outpatient Services Forecast, Dallas County, 2024–2034



Data Source: Prepared by SG2, LLC

6. STIs / HIV

STIs and HIV continue to impact both the health and economy of Dallas County. In 2022, the direct and indirect costs of chlamydia, gonorrhea, syphilis, congenital syphilis, and HIV were estimated at $398.6 million—a 15.2% increase from 2021. HIV alone accounted for 96% of these costs. These trends highlight the urgent need for focused public health efforts to reduce transmissions and their associated economic burden.[73]

STIs and HIV trends in Dallas County over the past four years reflect a clear public health challenge. Case counts dropped in 2020, rebounded sharply in 2021 and 2022, and then decreased or leveled off in 2023. The initial decline in 2020 was likely due to COVID-19–related decline in reporting secondary to disruptions in healthcare access, routine screening, and surveillance, rather than a true reduction in transmission. As services resumed in 2021, reported cases surged across multiple conditions. For example, new HIV diagnoses increased from 673 in 2020 to 882 in 2022 before declining slightly to 845 in 2023. Similar patterns were seen for chlamydia, gonorrhea, and syphilis, with each showing post-pandemic rebounds followed by stabilization or modest decreases in 2023.

Despite these fluctuations, there were important public health gains during this period. Targeted interventions in high-burden communities such as expanded mobile testing, increased provider awareness, culturally tailored outreach, and improved linkage to care contributed to measurable declines among some disproportionately affected populations. Notably, gonorrhea cases among Black residents dropped 22% between 2021 and 2023, and syphilis diagnoses among Black men fell by a similar margin from 2022 to 2023. These outcomes highlight the value of sustained, data-driven strategies and underscore the importance of maintaining prevention, screening, and treatment access across all populations to prevent resurgence.

a. HIV

HIV remains a significant public health concern across the U.S.[74] and within local communities[75], with Dallas County experiencing a significantly higher burden compared to state and national averages. When left untreated, HIV can weaken the immune system and lead to AIDS. Timely HIV diagnosis and prompt initiation of ART are essential strategies for improving health outcomes. Effective treatment enables individuals living with HIV to achieve viral suppression, significantly enhancing quality of life, and reducing the risk of transmission within the community.

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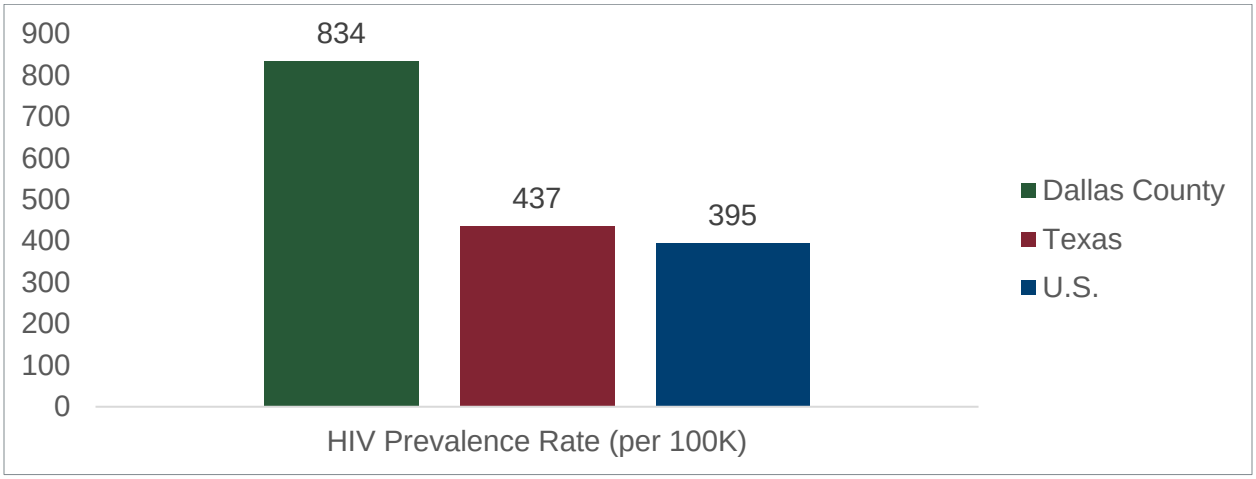
[73] Huang P, Dadpay A. The economic cost of sexually transmitted infections in Dallas County, TX – 2022 estimations. Dallas Med J. Published July 2025. Available at: https://issuu.com/dallascms/docs/july_2025_dallas_medical_journal

[74] Centers for Disease Control and Prevention. HIV Diagnoses, Deaths, and Prevalence in the United States, 2021 (Preliminary). Updated September 27, 2023. Accessed May 19, 2025. https://www.cdc.gov/hiv-data/nhss/hiv-diagnoses-deaths-prevalence.html

[75] AIDSVu. Dallas, TX – Dallas County: Overview. Emory University, Rollins School of Public Health. Accessed May 19, 2025. https://map.aidsvu.org/profiles/city/dallas-tx-dallas-county/overview#0-1-Locations

In 2023, the HIV prevalence rate in Dallas was 834 per 100,000 population, nearly double the rate for Texas and U.S. [76,77]-see Morbidity Figure 50.

Morbidity Figure 50: HIV Prevalence Rate (per 100K), Dallas County, Texas, U.S., 2023



Data Source: CDC, DCHHS, HIV/STIs Dashboard

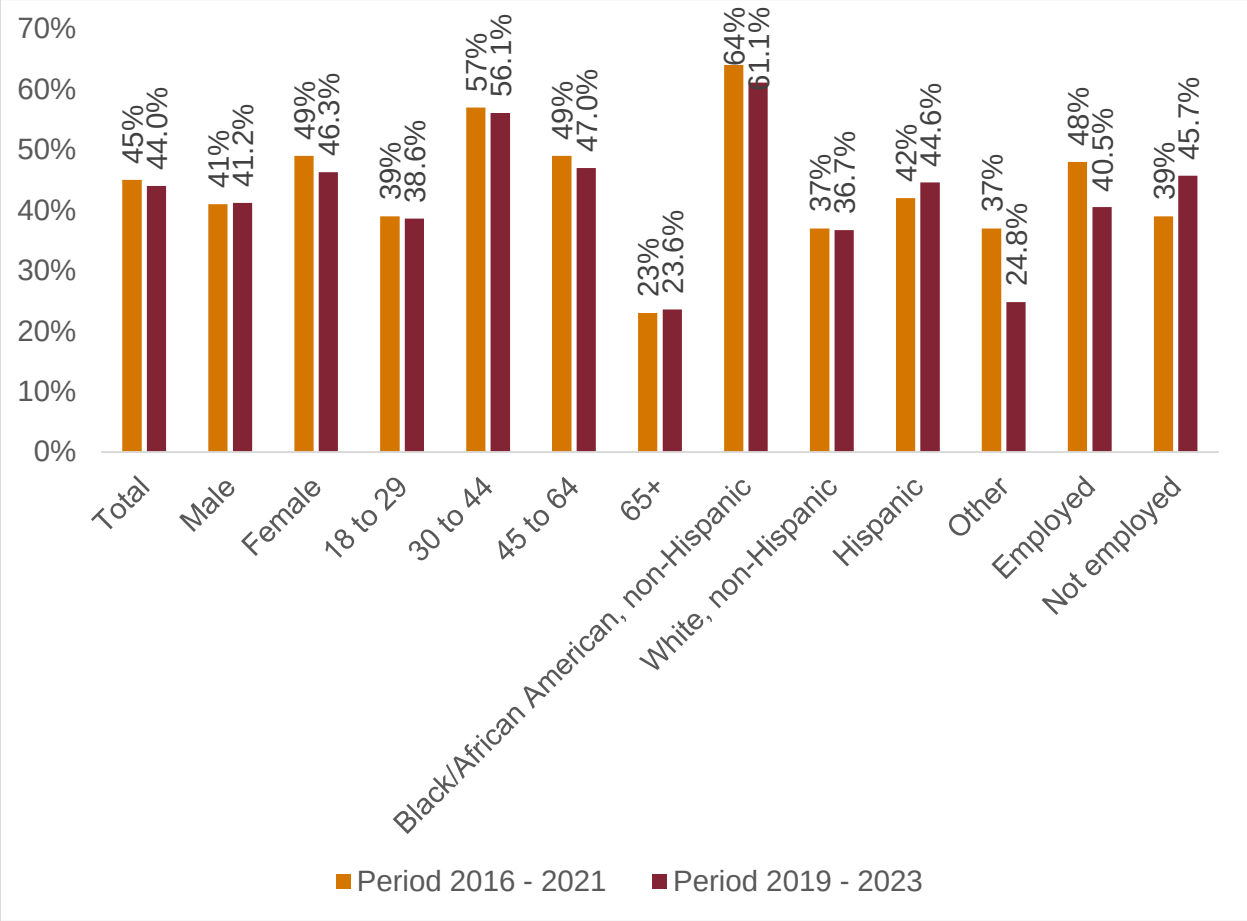
Comparing the BRFSS, periods 2016–2020 and 2019–2023, the overall percentage of adults in Dallas County who reported ever being tested for HIV remained relatively stable at around 45%.

The most significant change was observed among Other/Multiracial, non-Hispanic individuals that saw a decrease in testing from 37% to 24.8%. Black or African American, non-Hispanic adults also experienced a slight decrease from 64% to 61.1%. In contrast, Hispanic adults saw an increase in testing rates from 42% to 44.6% (3%). Additionally, HIV testing also increased among the not-employed group by 6.7% and declined for employed adults by 8%-see Morbidity Figure 51.

[76] Dallas County Health and Human Services. HIV/STIs Dashboard. Dallas County. Published date not listed. Accessed August 12, 2025. https://www.dallascounty.org/departments/dchhs/communicable-diseases/hiv-sti-dashboard.php

[77] Centers for Disease Control and Prevention (CDC). HIV Diagnoses, Deaths, and Prevalence: 2025 Update. CDC. Published April 29, 2025. Accessed August 12, 2025. https://www.cdc.gov/hiv-data/nhss/hiv-diagnoses-deaths-and-prevalence-2025.html

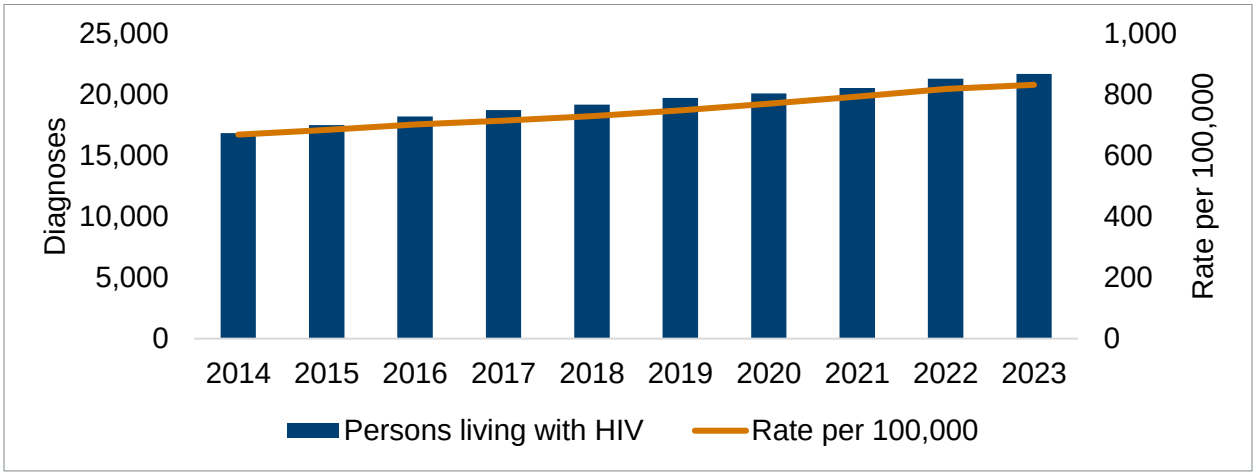
Morbidity Figure 51: Percentage of adults (18+) in Dallas County who have ever been tested for HIV, Dallas County, 2016-2020 vs 2019 - 2023



Data Source: Center for Health Statistics BRFSS 2016–2020 and 2019–2023, Texas Department of State Health Services.

As of 2023, Dallas County maintains one of the highest HIV case burdens in Texas, behind only Harris County. Between 2020 and 2023, the number of people living with HIV diagnosed in Dallas County increased by nearly 8%, from 20,130 in 2020 to 21,727 in 2023-see Morbidity Figure 52. While there has been an overall increase in the number of Dallas County residents living with HIV, this is primarily due to improved access to effective treatment that allows people to live longer, healthier lives with the virus.

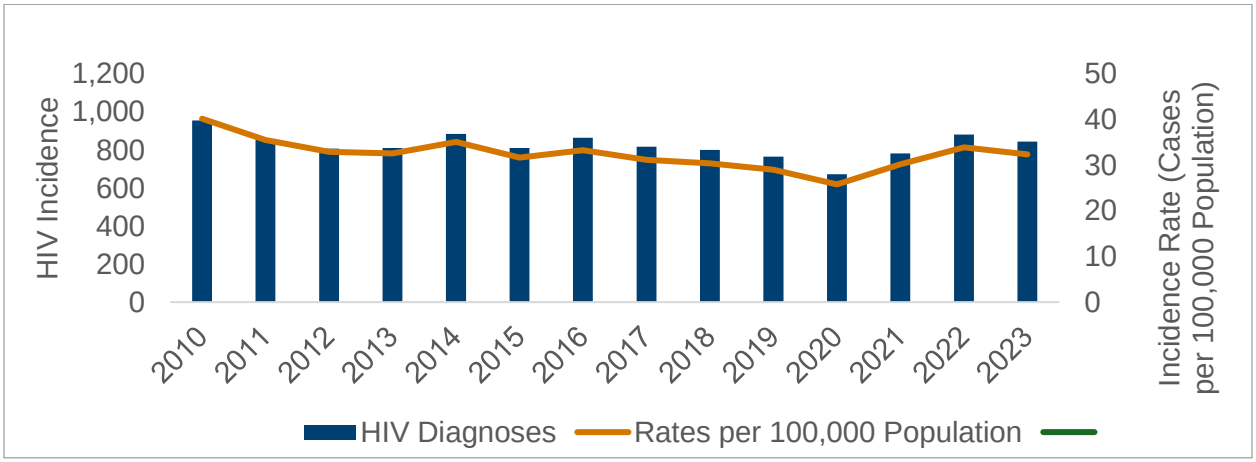
Morbidity Figure 52: Persons living with HIV, Dallas County, 2014-2023



Data Source: DSHS Surveillance Data, October 2024, Texas Department of State Health Services.

Between 2020 and 2023, Dallas County reported 3,182 new HIV diagnoses, rising from 673 in 2020 to 845 in 2023-see Morbidity Figure 53. While there was a slight decrease from 882 in 2022 to 845 in 2023, the overall trend remains higher than pre-pandemic levels, indicating ongoing transmission, particularly within high-risk sexual networks.

Morbidity Figure 53: New HIV Diagnoses and Rates, Dallas County, 2010-2023

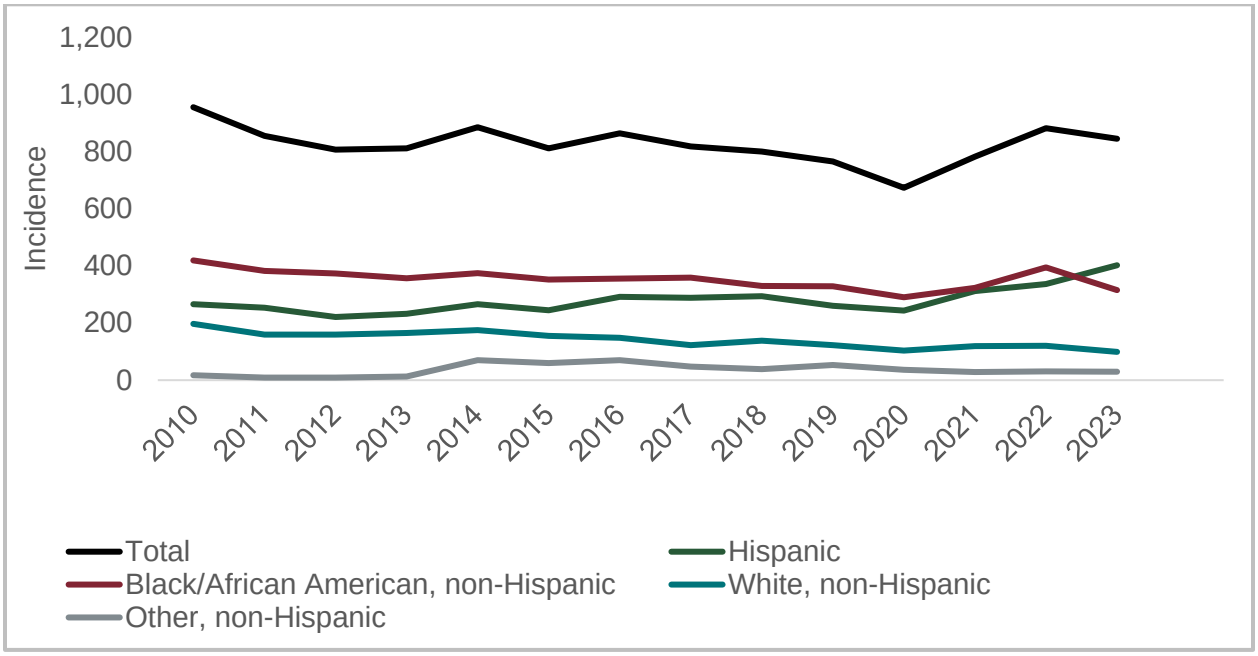


Data Source: Texas 2020 STD Surveillance Report, Texas Department of State Health Services, TB/HIV/STD Epidemiology and Surveillance Branch, Austin, Texas

Among Black or African American, non-Hispanic residents, the number of new cases decreased over 20% from 395 in 2022 to 315 in 2023-see Morbidity Figure 54. This reduction reflects a significant public health improvement as it aligns with intensified, targeted interventions under the EHE initiative and tailored community outreach programs focused on Black or African American, non-Hispanic MSM and women in historically high-burden ZIP Codes. Meanwhile, Hispanic residents experienced a concerning upward trend: 243 cases in 2020 rising to 402 in

2023. This increase mirrors state and national trends, where Hispanic populations have experienced rising HIV diagnoses.

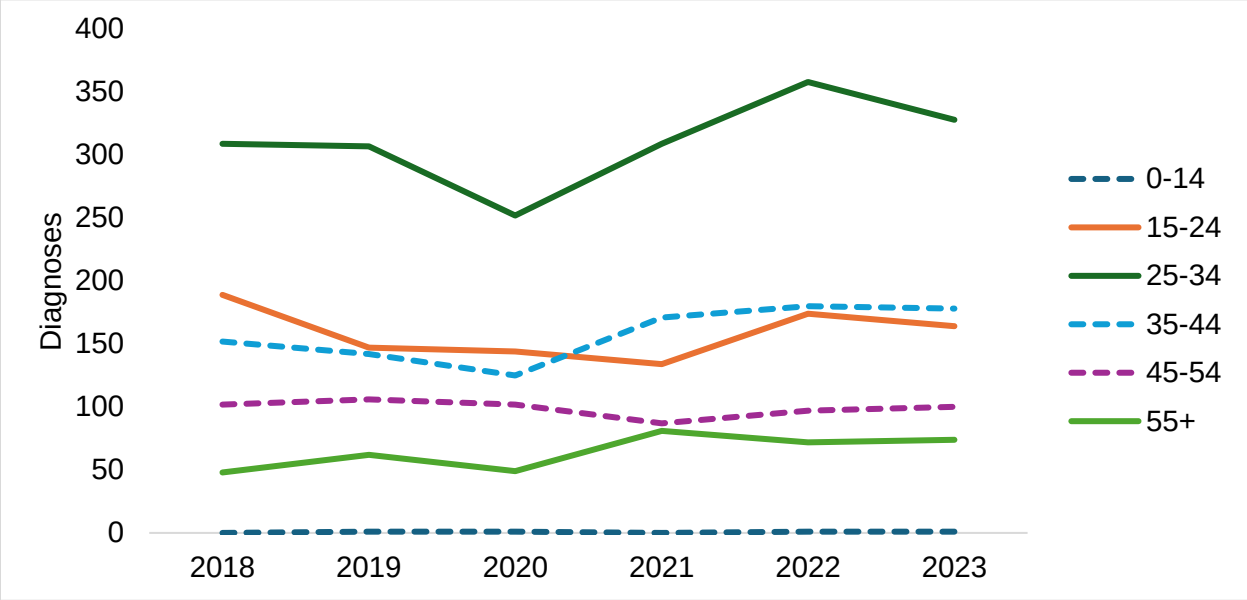
Morbidity Figure 54: New HIV Diagnosis by Race and Ethnicity in Dallas County, 2010-2023



Data Source: DSHS Surveillance Data, October 2024, Texas Department of State Health Services.

As shown in Morbidity Figure 55, the age group with the highest number of new HIV diagnoses in Dallas County continues to be 25–34-year-olds, with 328 cases in 2023. The 15-24 age group consistently accounts for about 18–20% of new HIV cases, a persistent and concerning trend given that many are still developing lifelong sexual health behaviors. Adults aged 50 and over continue to represent a smaller proportion of new diagnoses, but with slowly increasing case counts in recent years.

Morbidity Figure 55: New HIV Diagnoses, Age Group, Dallas County, 2018-2023

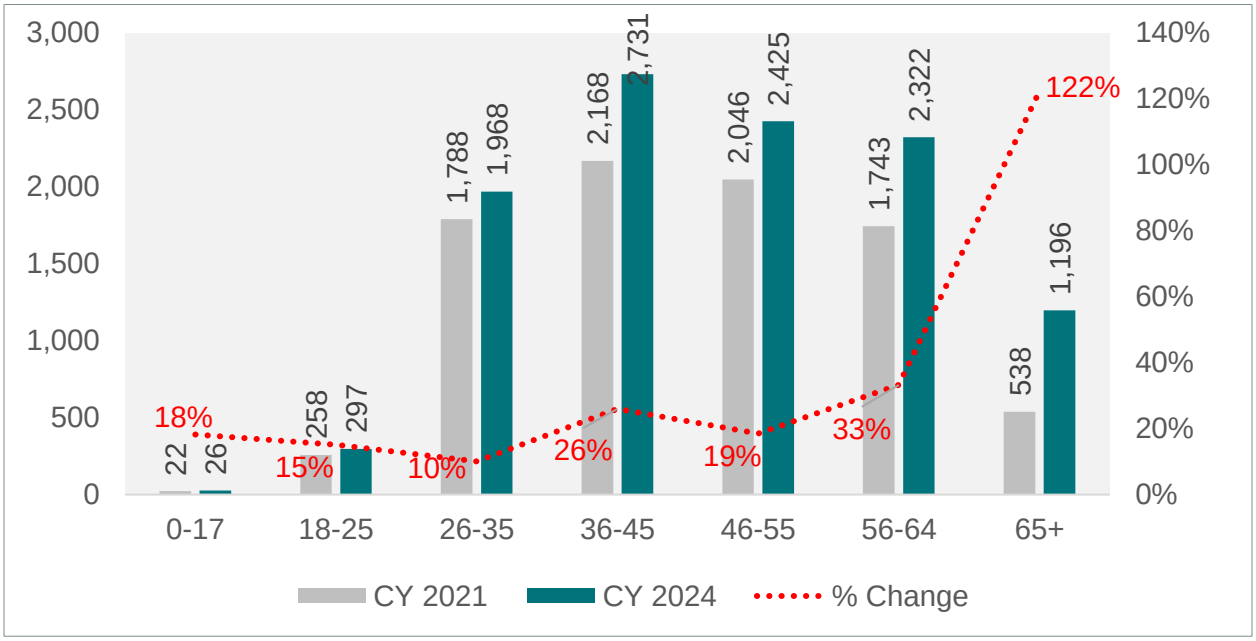


Data Source: DSHS Surveillance Data, October 2024, Texas Department of State Health Services.

i. Parkland HIV: Demographic Description

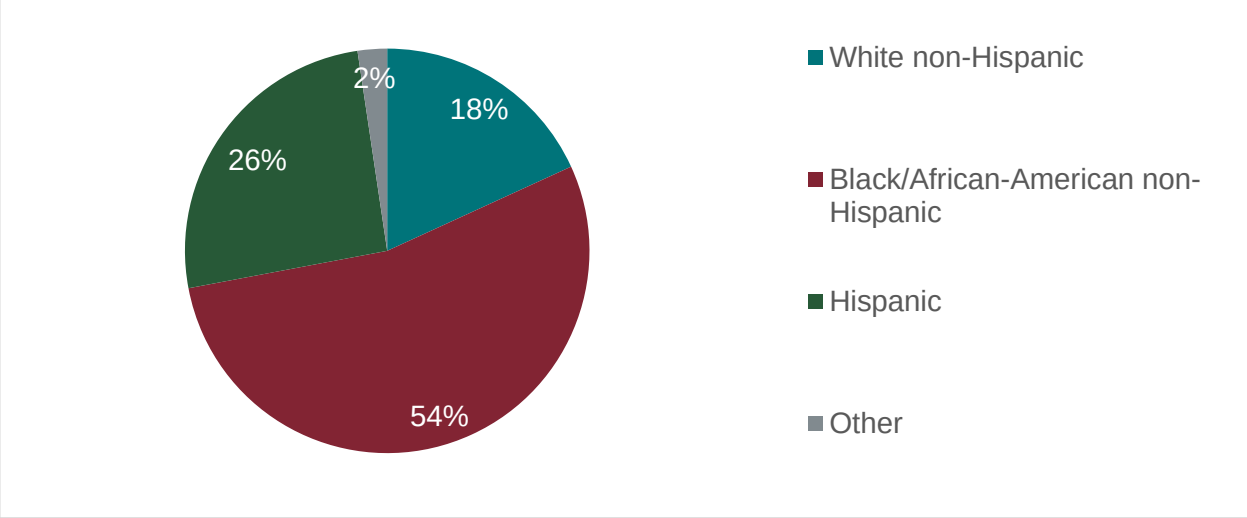
Between 2021 and 2024, the number of patients in Parkland's HIV registry increased by approximately 28%, an increase of 2,400 patients. The most significant growth was observed among individuals aged 65 and older, who experienced a 122% increase, followed by a 33% rise in the 56–64 age group-see Morbidity Figure 56.

Morbidity Figure 56: Parkland Patients, HIV Registry, Dallas County, 2021- 2024



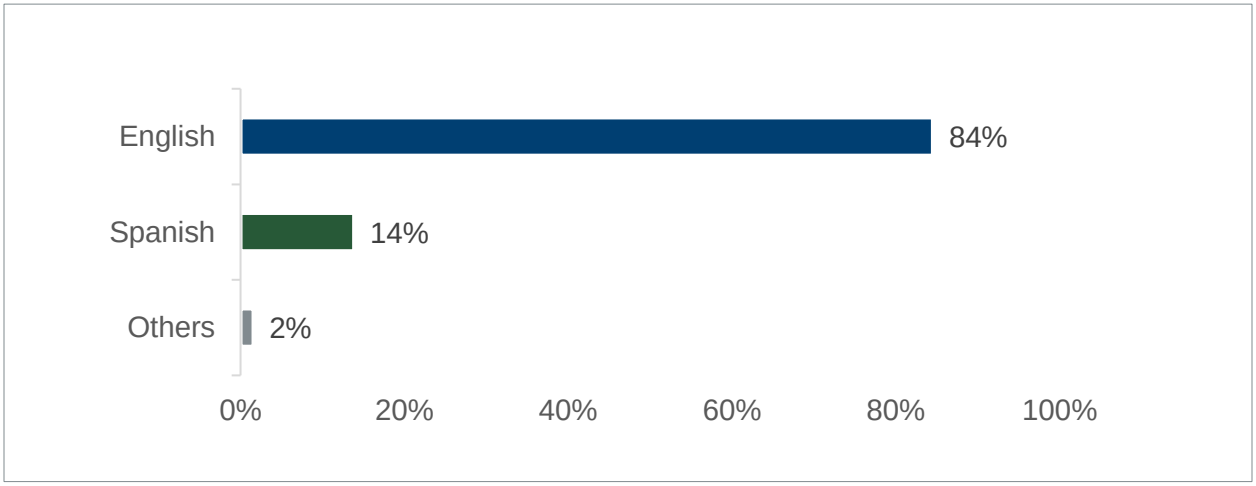
Data Source: Parkland EHR HIV Registry

Morbidity Figure 57: Parkland Patients, HIV Registry by Race and Ethnicity, Dallas County, 2024



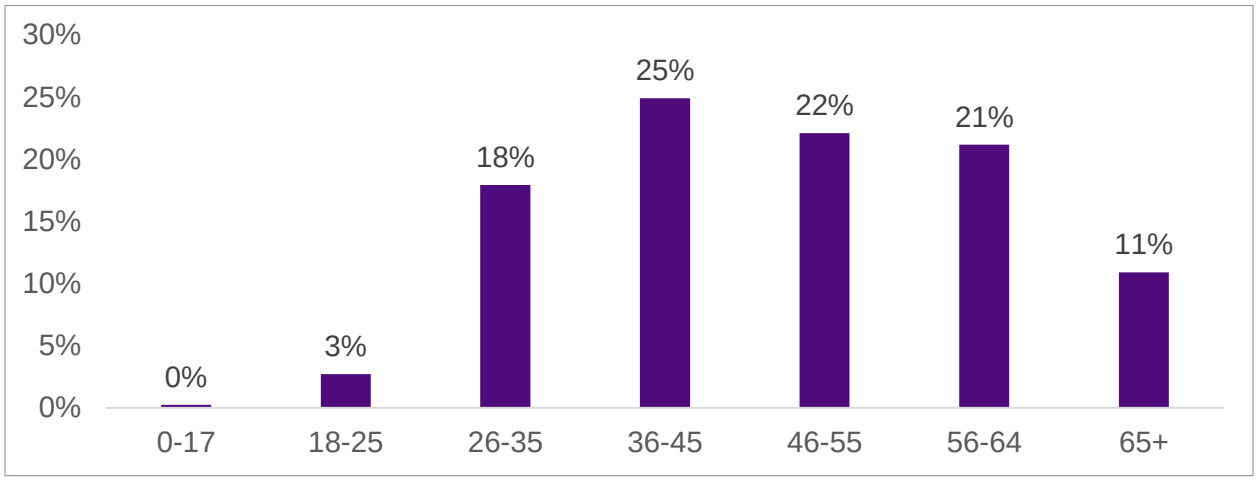
Data Source: Parkland EHR HIV Registry, 2024

Morbidity Figure 58: Parkland Patients, Preferred Language, HIV Registry, 2024



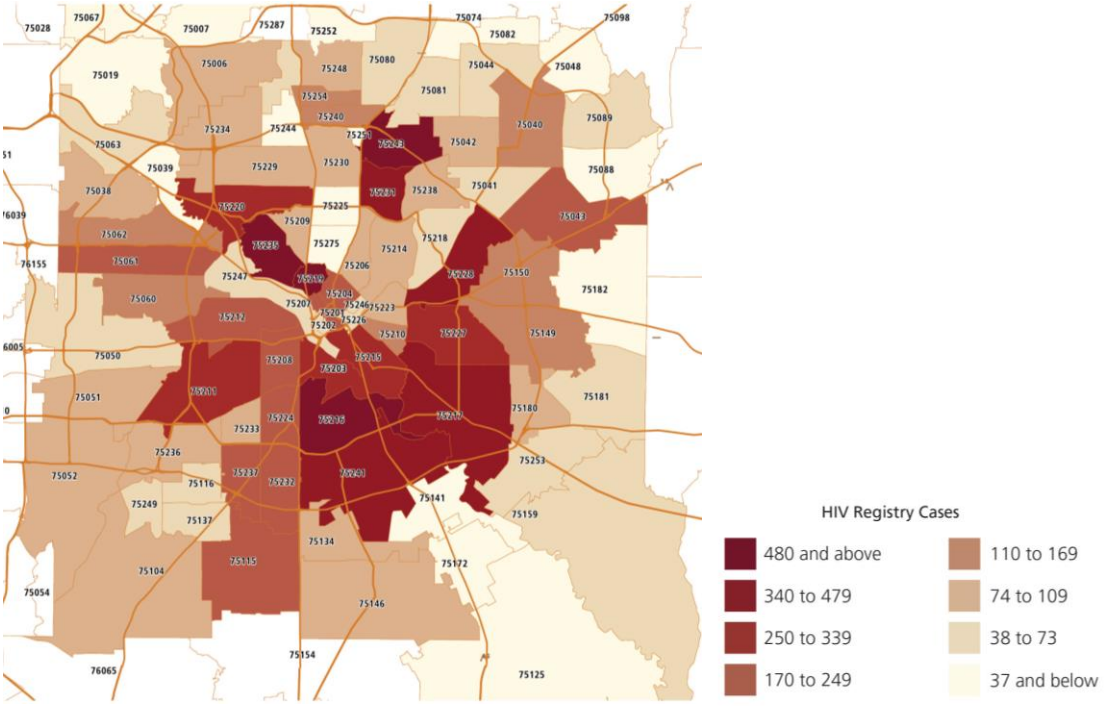
Data Source: Parkland EHR HIV Registry, 2024

Morbidity Figure 59: Parkland Patients, HIV Registry by Age Distribution, 2024



Data Source: Parkland EHR HIV Registry, 2024

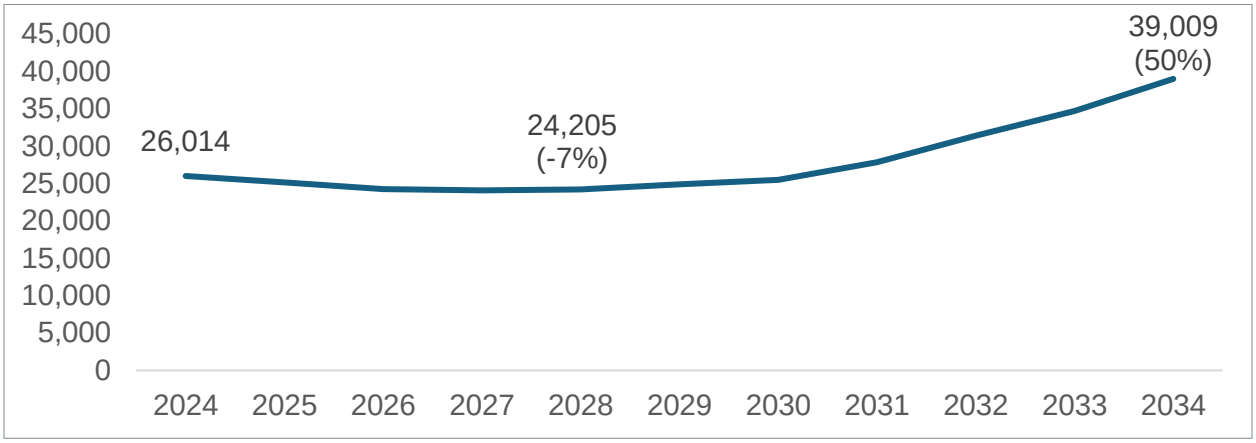
Morbidity Figure 60: Parkland Patients by ZIP Code (Map), HIV Registry, 2024



Data Source: Parkland EHR HIV Registry, 2024

Forecast data by SG2 indicate that between 2024 and 2034, the volume of HIV outpatient services is expected to grow by 50%-see Morbidity Figure 61. These forecasts are based on projected population trends in Dallas County, including changes in population size, birth and death rates, and demographic distribution.

Morbidity Figure 61: HIV Outpatient Services Forecast, Dallas County, 2024–2034

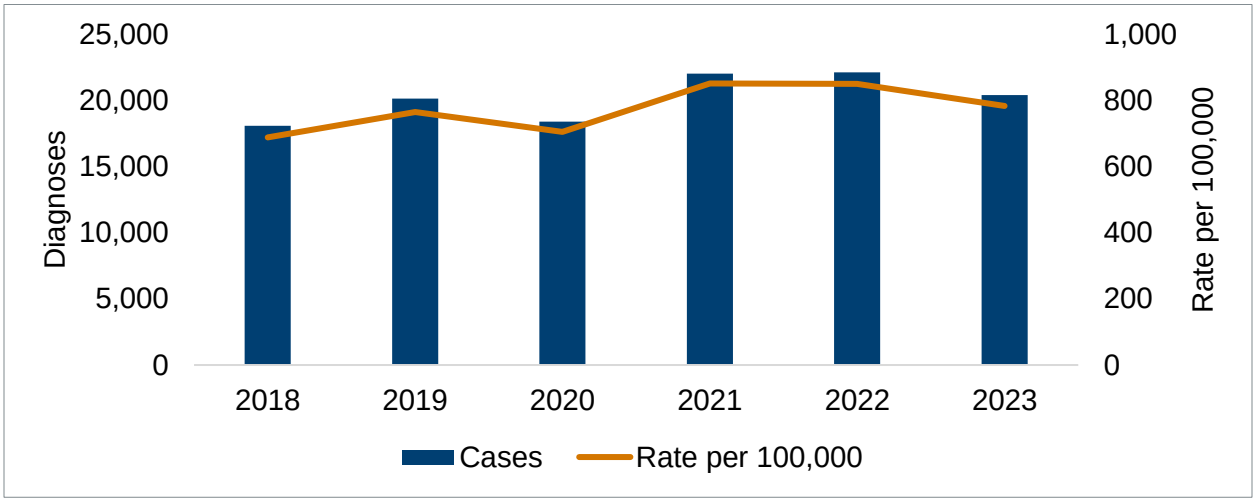


Data Source: Prepared by SG-2, LLC

b. Chlamydia

Chlamydia remains the most reported STI in Dallas County. As shown in Morbidity Figure 62, reported cases dropped to 18,400 in 2020, likely due to COVID-19-related disruptions in screening and clinic access, then rose sharply to 22,109 in 2022. Although cases declined to 20,410 in 2023, they remained above 2020 levels. The post-2020 increase reflects both resumed clinical services and ongoing community transmission.

Morbidity Figure 62: Chlamydia Diagnoses, Dallas County, 2018-2023

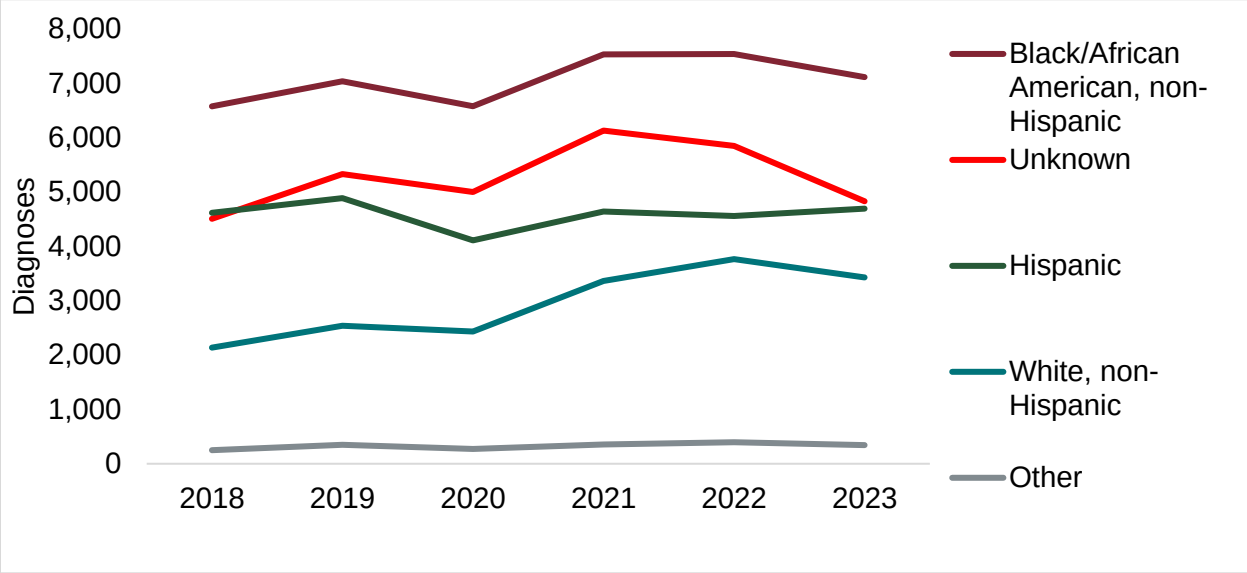


Data source: DSHS Surveillance Data, January 2025, Texas Department of State Health Services.

In 2023, Black or African American, non-Hispanic residents made up 34% of chlamydia cases in Dallas County, followed by Hispanic residents at nearly 23% and white, non-Hispanic residents at 17%-see Morbidity Figure 63. Black or African American, non-Hispanic women, remain

disproportionately impacted by chlamydia, underscoring the importance of gender-responsive screening and care strategies.

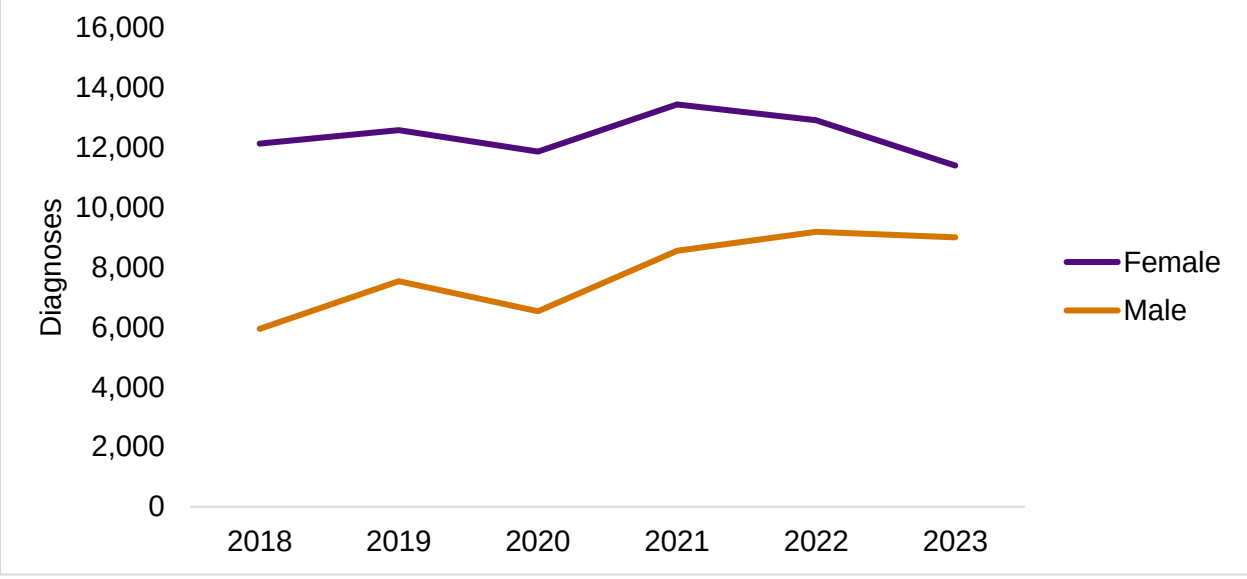
Morbidity Figure 63: Chlamydia Diagnoses, Race and Ethnicity, Dallas County, 2018-2023



Data source: DSHS Surveillance Data, January 2025, Texas Department of State Health Services.

As shown in Morbidity Figure 64, females consistently accounted for a greater share of chlamydia cases than males, comprising 56% of all reported cases in 2023. This disparity is likely due to more frequent screening among females during routine reproductive healthcare visits, and asymptomatic infections in males often go undetected.

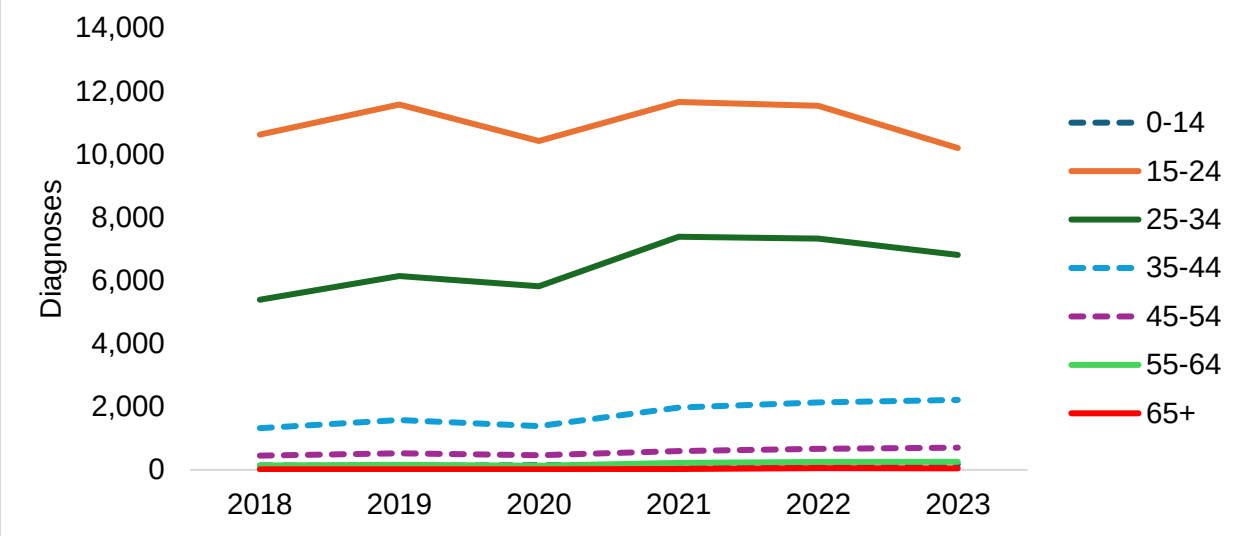
Morbidity Figure 64: Chlamydia Diagnoses, Sex Assigned at Birth, Dallas County, 2018-2023



Data source: DSHS Surveillance Data, January 2025, Texas Department of State Health Services.

As shown in Morbidity Figure 65, individuals aged 15–24 accounted for over 57% of all chlamydia cases in 2023 in Dallas County, though case counts declined 12.5% in this group between 2021 and 2023. The 25–34 age group also saw a slight decline (7.9%) during this same period, mirroring the trend in younger adults. While the 0–14 age group saw a slight increase, likely due to improved detection or early sexual activity, individuals aged 45 and older experienced a nearly 20% rise in cases from 2021 (845 cases) to 2023 (1,009), despite representing only 5% of the total.

Morbidity Figure 65: Chlamydia Diagnoses, Age Group, Dallas County, 2018-2023

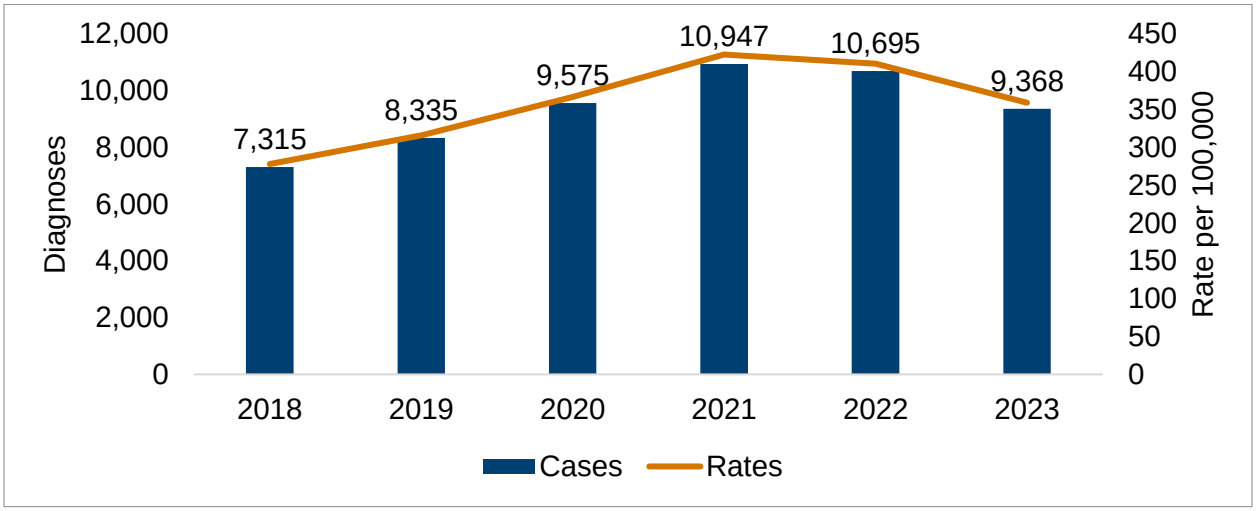


Data source: DSHS Surveillance Data, January 2025, Texas Department of State Health Services.

c. Gonorrhea

Gonorrhea remains the second most reported STI in Dallas County. In 2020, there were 9,575 total reported cases, followed by a slight increase to 10,695 in 2022, reflecting a modest post-COVID rebound as routine screening resumed-see Morbidity Figure 66. However, total diagnoses declined in 2023 to 9,368, returning closer to pre-pandemic levels.

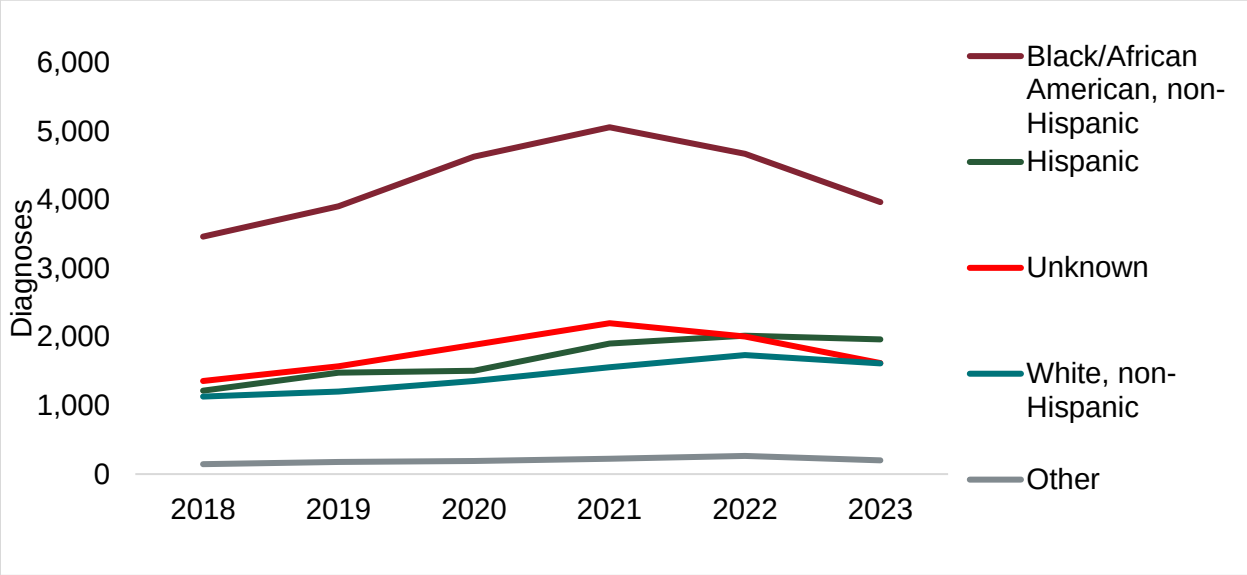
Morbidity Figure 66: Gonorrhea Diagnoses, Dallas County 2018-2023



Data source: DSHS Surveillance Data, January 2025, Texas Department of State Health Services.

Black or African American, non-Hispanic residents accounted for 42% of all reported gonorrhea cases in Dallas County in 2023, followed by Hispanic residents (21%) and white, non-Hispanic residents (17%). However, Black or African American, non-Hispanic residents experienced a 22% decrease in gonorrhea between 2021 (5,059 cases) and 2023 (3,966 cases). During the same period, Hispanic and white, non-Hispanic residents saw a slight increase in cases.

Morbidity Figure 67: Gonorrhea Diagnoses, Race and Ethnicity, Dallas County, 2018-2023

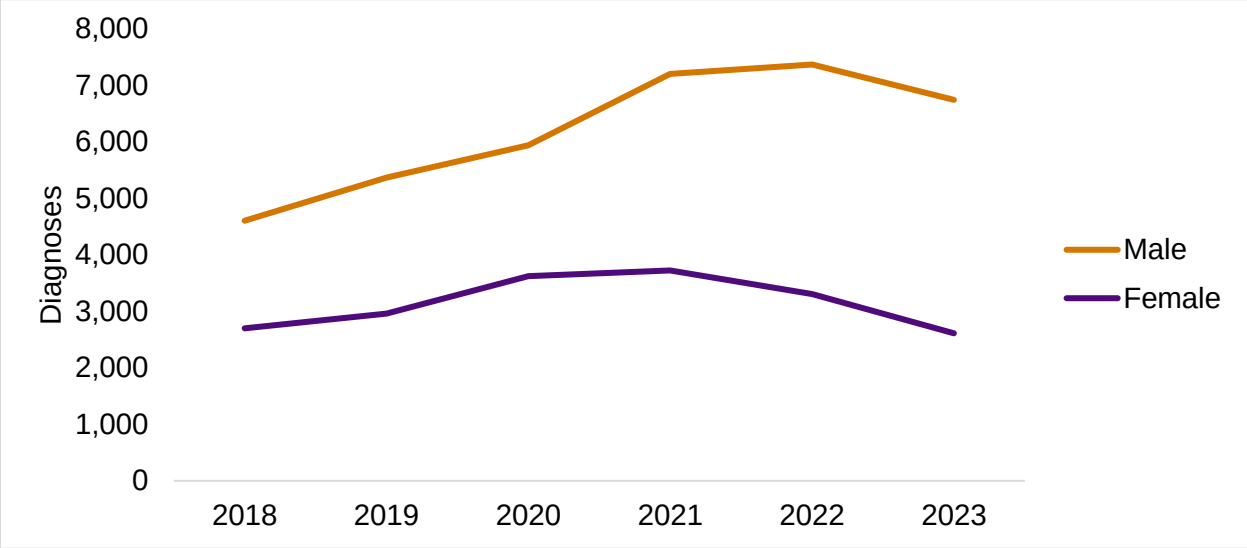


Data source: DSHS Surveillance Data, January 2025, Texas Department of State Health Services.

Morbidity Figure 68 shows that gonorrhea remains significantly more common among individuals assigned male at birth, who accounted for nearly 72% of all reported cases in 2023.

While male cases rose in recent years before a slight decline, female cases have dropped by nearly 30% since 2021, widening the gender gap.

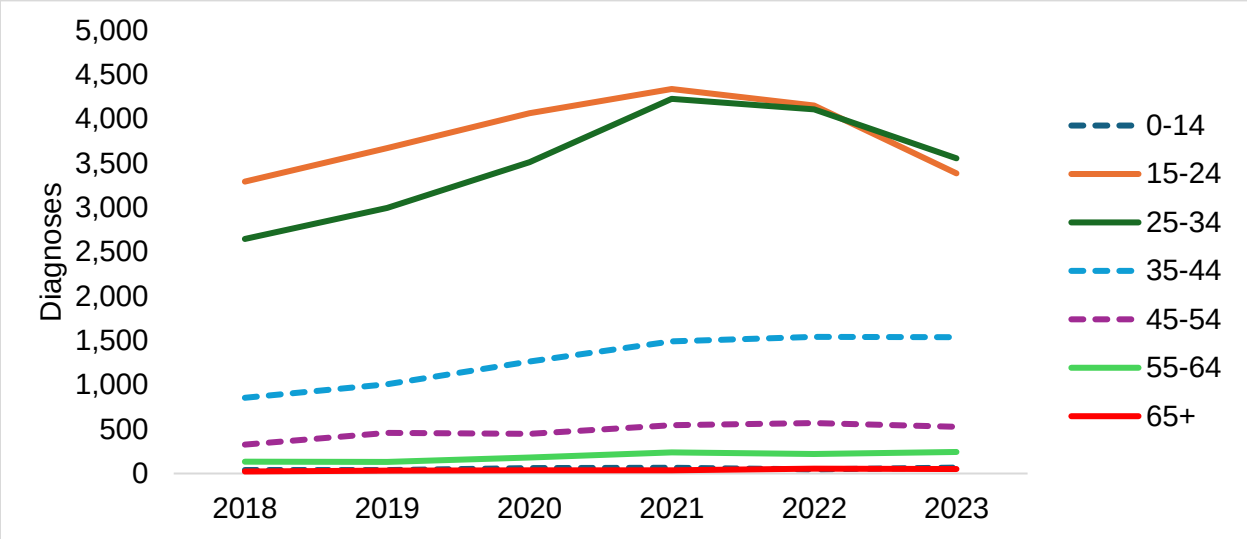
Morbidity Figure 68: Gonorrhea Diagnoses, Sex Assigned at Birth, Dallas County, 2018-2023



Data source: DSHS Surveillance Data, January 2025, Texas Department of State Health Services.

Morbidity Figure 69 shows gonorrhea in Dallas County remains most prevalent among individuals aged 15–34, though cases in this age range have decreased by 18.9% since 2021.

Morbidity Figure 69: Gonorrhea Diagnoses, Age Group, Dallas County, 2018-2023



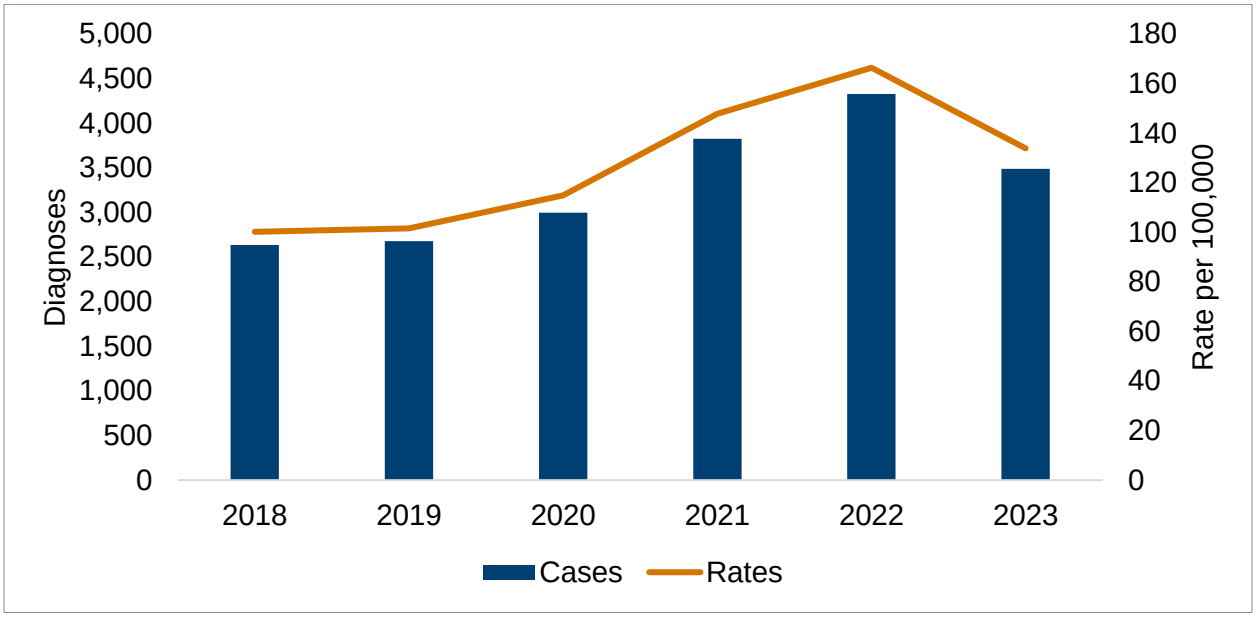
Data source: DSHS Surveillance Data, January 2025, Texas Department of State Health Services.

d. Syphilis

As Morbidity Figure 70 shows, syphilis cases in Dallas County increased 64% between 2018 (2,634 cases) and 2022 (4,329 cases). In 2023, cases declined by 19%, suggesting early

success of expanded public health efforts, including increased testing, mobile outreach, and provider education.

Morbidity Figure 70: Syphilis Diagnoses, Dallas County 2018-2023

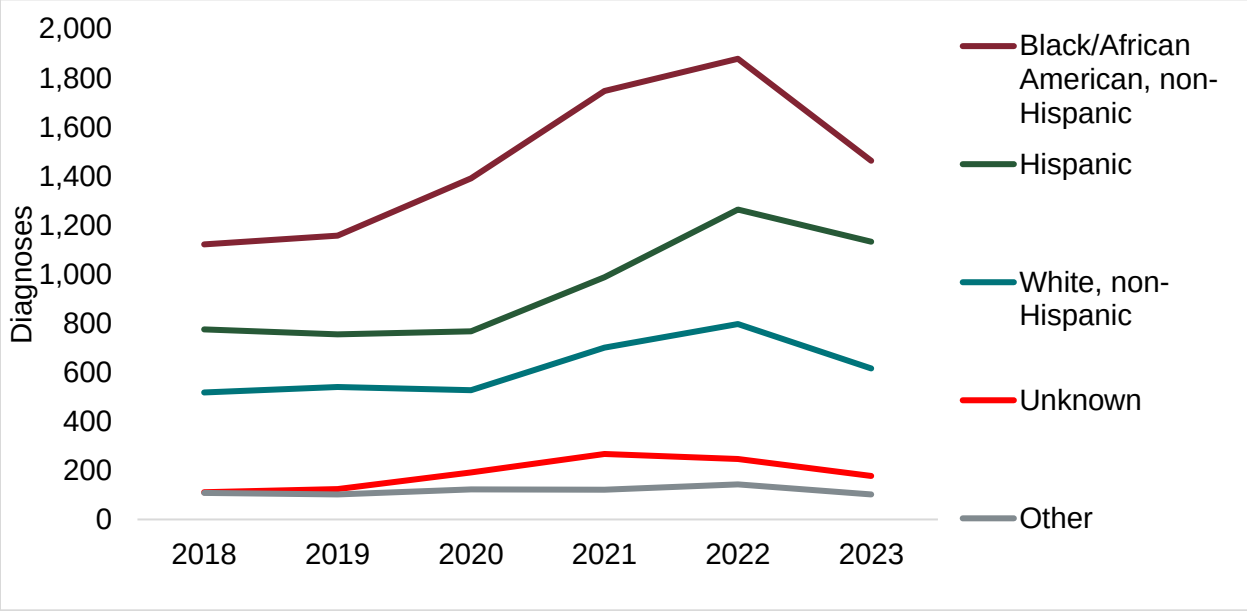


Data source: DSHS Surveillance Data, January 2025, Texas Department of State Health Services.

In 2022, Dallas County recorded its highest number of syphilis cases, with Black or African American, non-Hispanic residents accounting for 43% of diagnoses, Hispanic residents 29%, and white, non-Hispanic residents 18%-see Morbidity Figure 71. The increase among Hispanic males was especially sharp, rising 65% between 2020 and 2022. This surge reflects state and national trends, where syphilis is rising among Hispanic MSM and heterosexual populations, likely fueled by a combination of factors including gaps in routine screening, stigma, and limited access to culturally competent services.[78] In contrast, Black or African American, non-Hispanic men experienced a 22% decrease in cases from 2022 to 2023.

[78] Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2022. U.S. Department of Health and Human Services; 2024. Accessed July 25, 2025. https://www.cdc.gov/std/statistics/2022/overview.htm

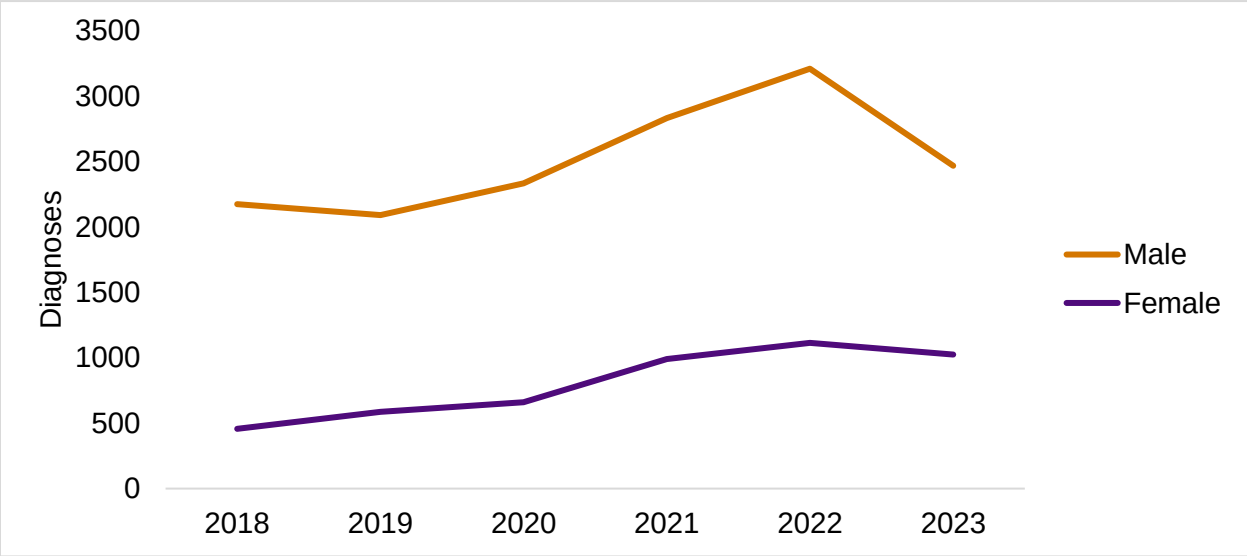
Morbidity Figure 71: Syphilis Diagnoses, Race and Ethnicity, Dallas County, 2018-2023



Data source: DSHS Surveillance Data, January 2025, Texas Department of State Health Services.

Between 2018 and 2022, syphilis cases among both males and females in Dallas County increased significantly. Male cases rose 47.5% during this period before declining in 2023, while female cases more than doubled over the same period, from 457 in 2018 to 1,114 in 2022 (144%), with a slight decrease in 2023-see Morbidity Figure 72.

Morbidity Figure 72: Syphilis Diagnoses, Sex Assigned at Birth, Dallas County, 2018-2023

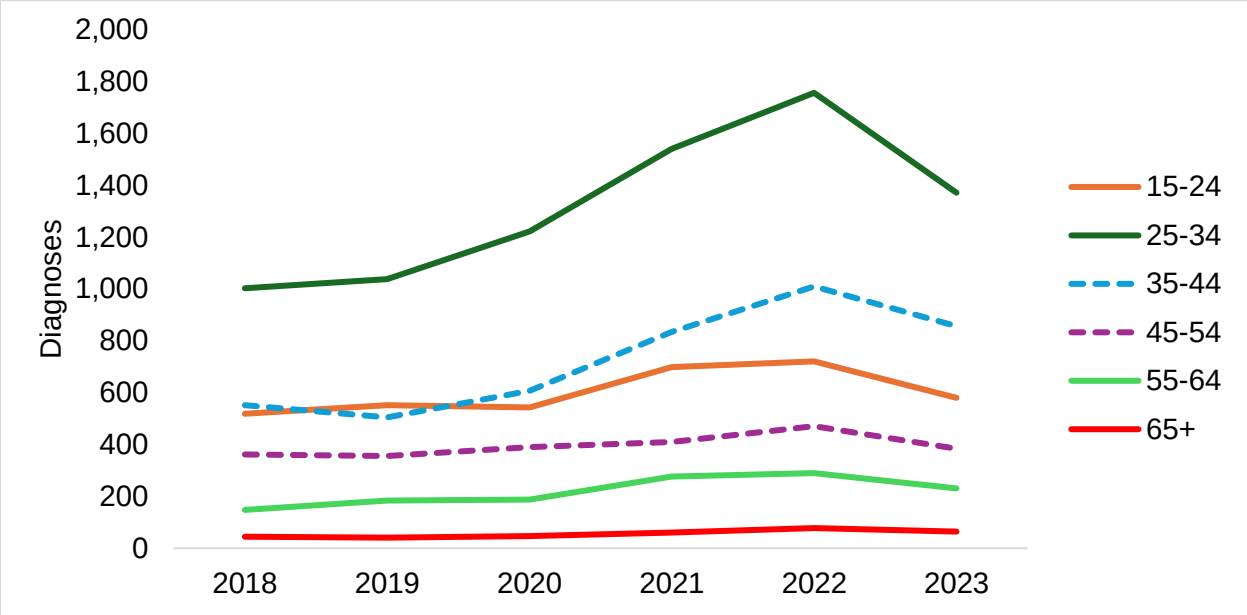


Data source: DSHS Surveillance Data, January 2025, Texas Department of State Health Services.

As shown in Morbidity Figure 73, syphilis cases in Dallas County have increased across all adult age groups since 2018, with the most significant growth seen among individuals aged 25–34,

where cases rose 75% from 2018 to 2022 before dropping in 2023. Cases among those aged 35–44 also increased 83% before a modest decline in 2023. Cases among individuals aged 55 and older also nearly doubled from 193 in 2018 to 368 in 2022.

Morbidity Figure 73: Syphilis Diagnoses, Age Group, Dallas County, 2018-2023



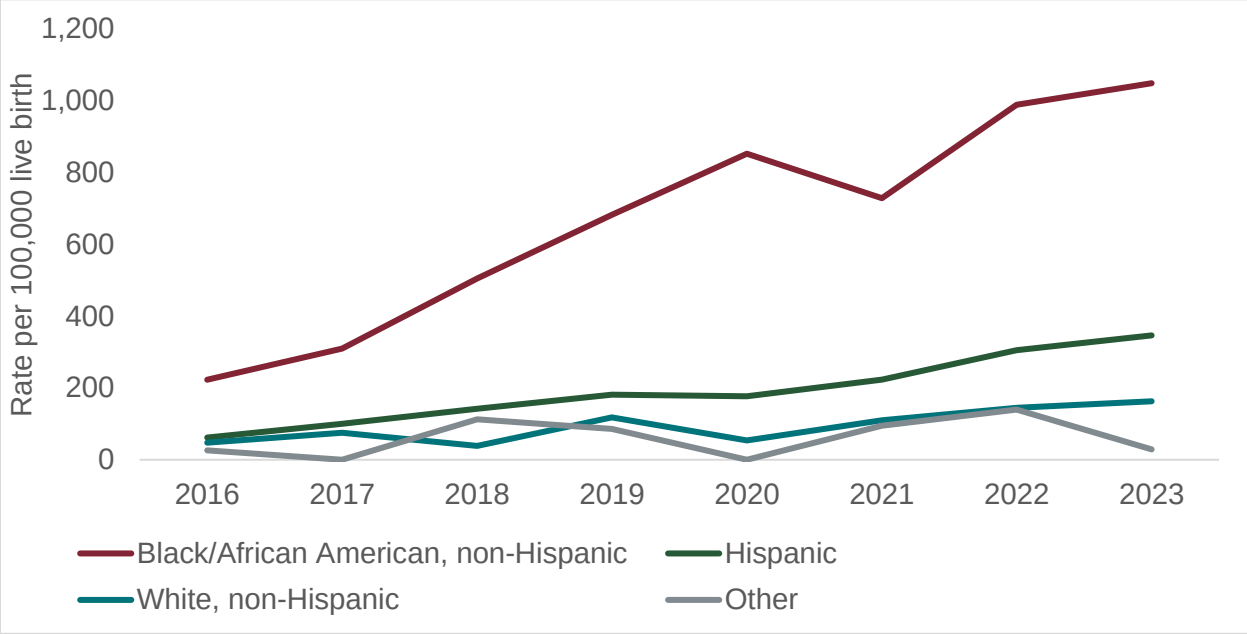
Data source: DSHS Surveillance Data, January 2025, Texas Department of State Health Services.

Maternal syphilis infection rates, and consequently, congenital syphilis rates (syphilis passed from mother to baby during pregnancy), have seen alarming increases at both the national and state levels in recent years. Nationally, the overall rate of syphilis in mothers giving birth more than tripled (222% increase) from 2016 to 2022, rising from 87.2 to 280.4 per 100,000 births in 2022,[79] with annual rates increasing throughout this period. Texas consistently ranks among the states with the highest reported cases of both syphilis and congenital syphilis in the country.

Dallas County has also experienced a significant increase in maternal syphilis infections since 2017. Within Dallas County, the Black or African American population exhibited substantially higher rates than any other racial/ethnic group, leading to increased chances of congenital infection and severe birth outcomes for their infants-see Morbidity Figure 74. To combat these rising rates and protect both mothers and children, improving healthcare access and addressing underlying non-medical drivers of healthcare are crucial.

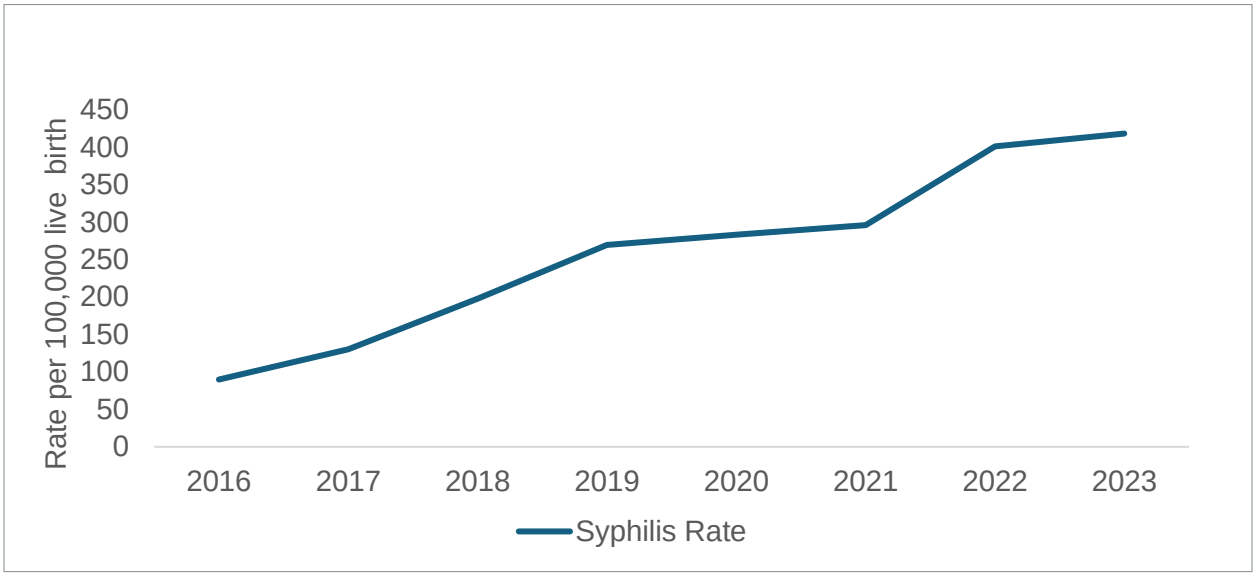
[79] Centers for Disease Control and Prevention**.** *Trends and Characteristics in Maternal Syphilis Rates During Pregnancy: United States, 2016–2022.* NCHS Data Brief No. 496. February 2024. Accessed August 12, 2025. https://www.cdc.gov/nchs/data/databriefs/db496.pdf

Morbidity Figure 74: Maternal Syphilis Rate in Dallas County by Race and Ethnicity



Data source: DSHS Surveillance Data, July 2025, Texas Department of State Health Services

Morbidity Figure 75: Maternal Syphilis Rate in Dallas County

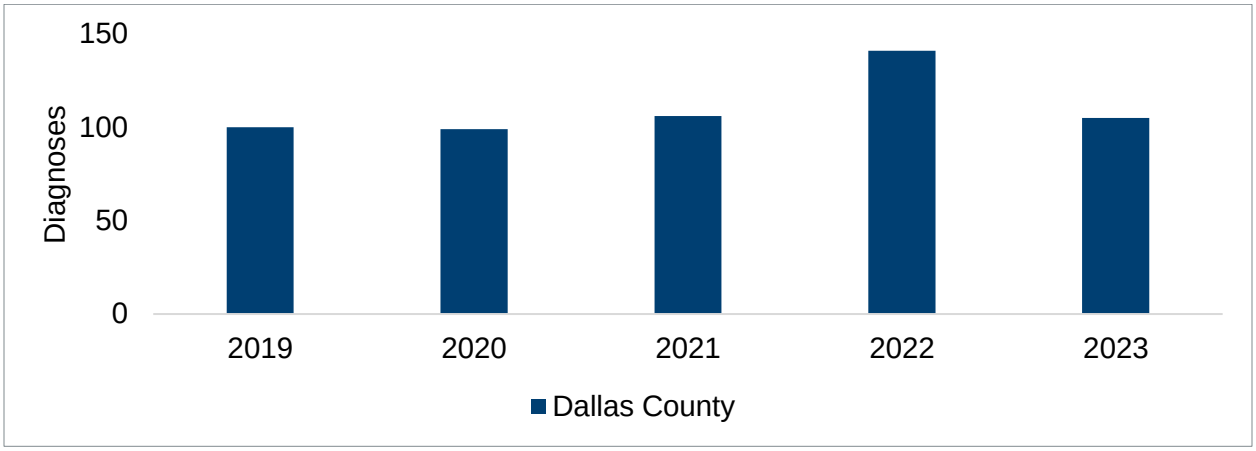


Data source: DSHS Surveillance Data, July 2025, Texas Department of State Health Services

Untreated syphilis can be passed from an infected mother to a newborn during pregnancy, which can result in miscarriage, stillbirth, and lifelong complications. Dallas County consistently has the second highest number of congenital syphilis cases in Texas, behind only Harris County. As shown in Morbidity Figure 76, congenital syphilis cases declined 27% in 2023 from 2022. While this decline is encouraging, persistently high case counts point to critical gaps in early

prenatal screening, timely maternal treatment, and access to care, especially among uninsured and high-risk populations.

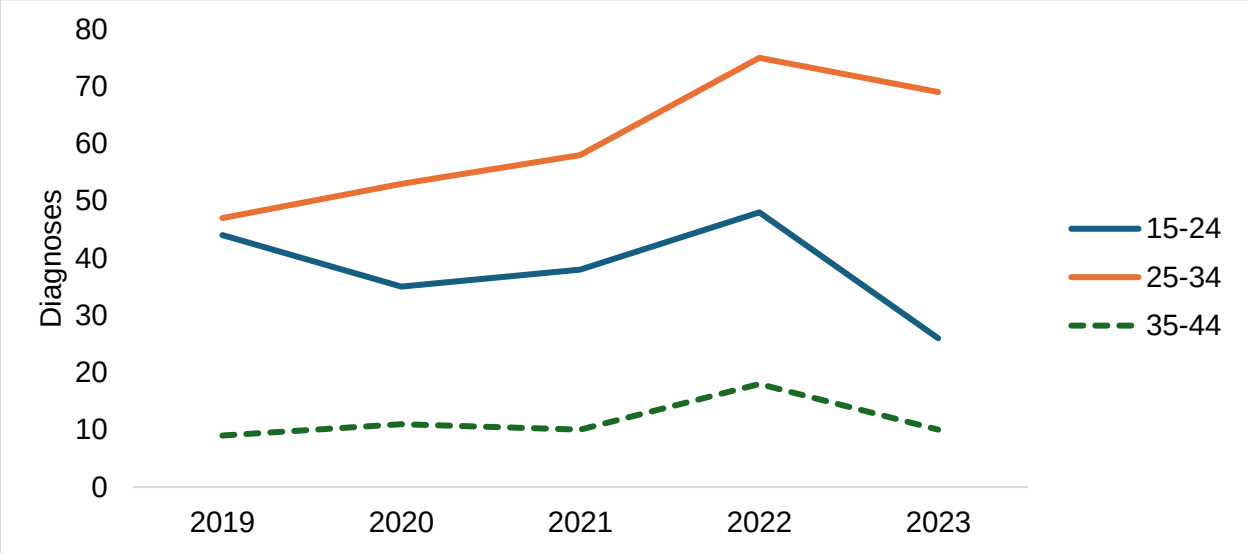
Morbidity Figure 76: Congenital Syphilis Diagnoses, Dallas County, 2019-2023



Data source: DSHS Surveillance Data, July 2025, Texas Department of State Health Services.

From 2019 to 2023, the majority of congenital syphilis cases in Dallas County were linked to mothers aged 15–34, with notable shifts across age groups. Among mothers aged 15–24, congenital syphilis cases decreased by 46% in 2023, reflecting both earlier increases in transmission and potential success from recent youth-focused outreach and screening efforts- see Morbidity Figure 77. Cases among mothers aged 25–34 declined only slightly by 8% in 2023, making this group the largest contributor to congenital syphilis cases.

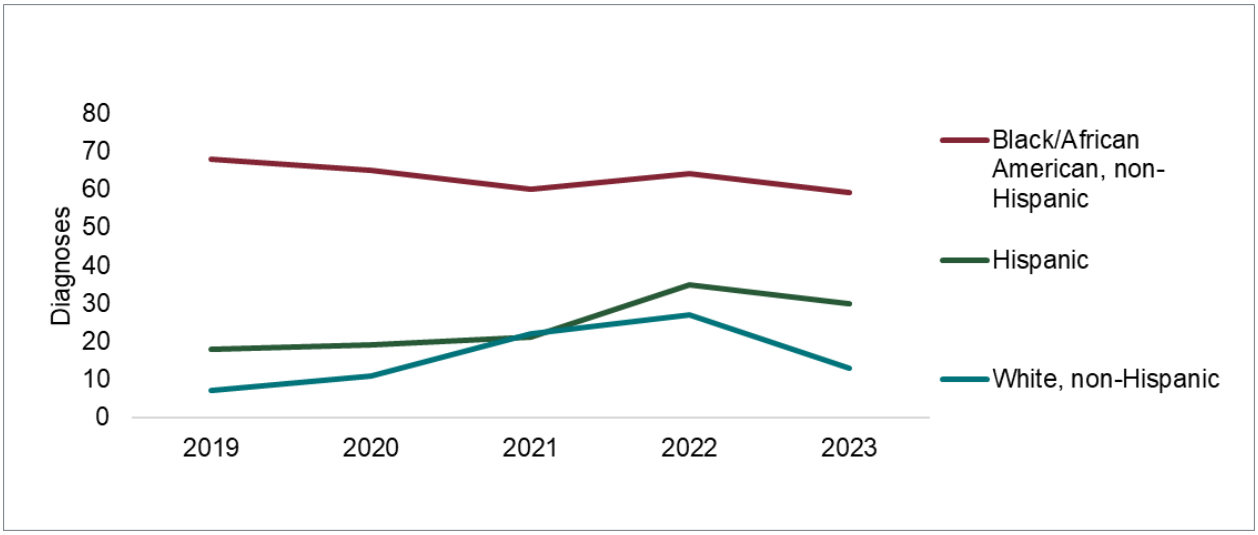
Morbidity Figure 77: Congenital Syphilis Diagnoses, Maternal Age Group, Dallas County, 2019-2023



Data source: DSHS Surveillance Data, July 2025, Texas Department of State Health Services.

Black or African American, non-Hispanic mothers accounted for the highest number of congenital syphilis cases, though totals declined modestly (13%) from 2019 to 2023, reflecting potential progress in targeted interventions-see Morbidity Figure 78. Hispanic mothers saw a sharp increase of 94% between 2019 (18 cases) and 2022 (35 cases), followed by a 14% decrease in 2023, indicating ongoing risk. White, non-Hispanic mothers experienced the largest relative fluctuation, with cases increasing from 7 in 2019 to 27 in 2022 (a 286% rise) before falling by 52% to 13 in 2023. These trends highlight persistent racial and ethnic disparities in maternal STIs screening and care access, reinforcing the need for culturally responsive prenatal outreach and timely syphilis treatment across all communities.

Morbidity Figure 78: Congenital Syphilis Diagnoses, Child Race and Ethnicity, Dallas County, 2019-2023



Data source: DSHS Surveillance Data, July 2025, Texas Department of State Health Services.

D. Special Populations

1. Dallas County Correctional Health

Parkland provides comprehensive medical and behavioral healthcare to individuals housed in the Dallas County Jail and Juvenile Centers. A multidisciplinary team including on-site medical providers, registered nurses, mental health professionals, pharmacists, and other clinical staff work collaboratively to ensure consistent, high-quality care.

Services span a broad continuum, including initial health screenings, acute and intermediate infirmary care, chronic disease management, urgent medical interventions, mental health and psychiatric support, infectious disease treatment, obstetrics and gynecology services, dental care, dialysis, optometry, and post-release care coordination to support continuity and reintegration into the community.

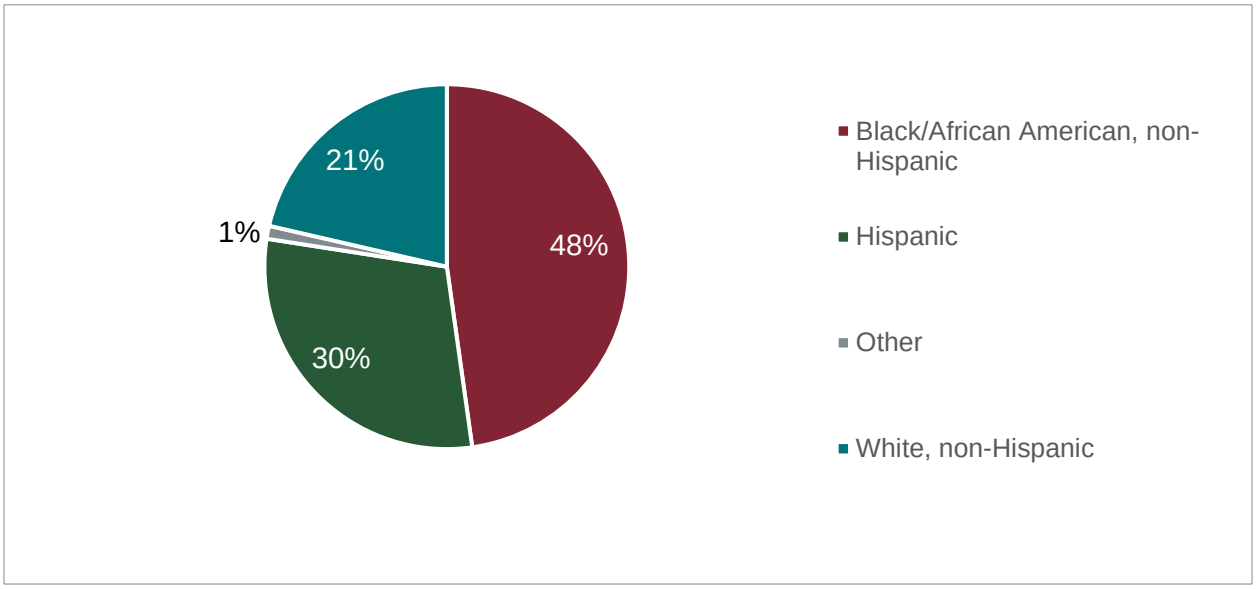
a. Correctional Health Demographics

Between 2021 and 2024, correctional health services experienced a 9% increase in their patient population. The racial and ethnic composition of the population has remained largely misaligned

with that of Dallas County. In 2024, Black or African American, non-Hispanic individuals represented 48% of the correctional health population, while the proportion of Hispanic individuals increased from 26% to 30%. In contrast, Black or African American, non-Hispanic individuals make up only 23% of Dallas County's general population, indicating a significant overrepresentation and highlighting the persistent racial disparities within the correctional system.[80]

The top five ZIP Codes of residence among individuals in the correctional health system were 75201, 75216, 75217, 75241, and 75228. Of these ZIP Codes 75216, 75217, and 75241 rank among the highest in Dallas County for CVI scores-see SP Figure 4

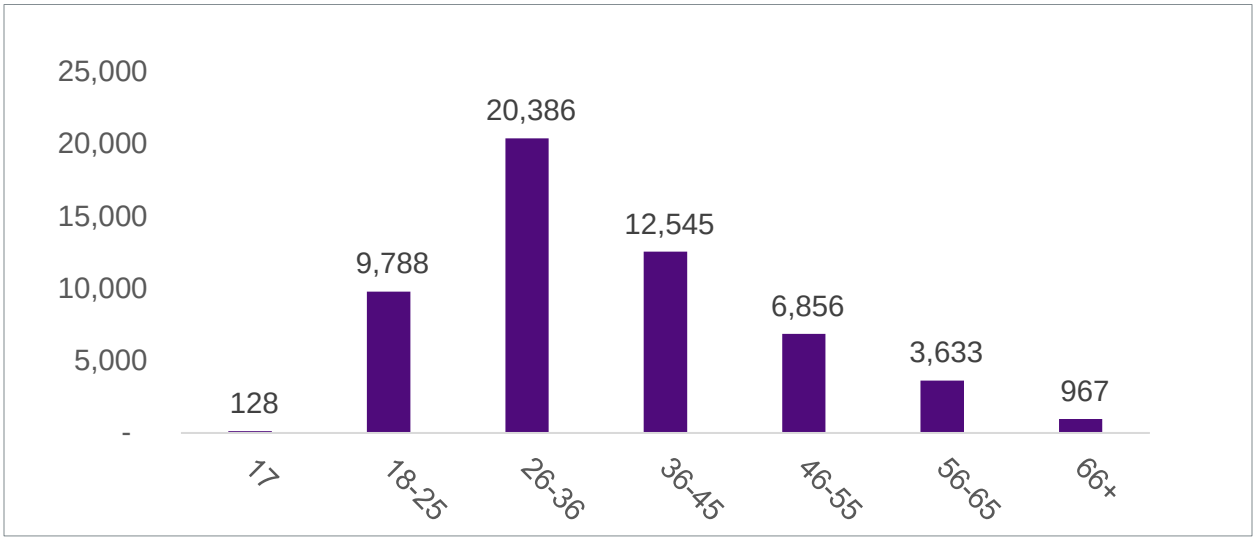
SP Figure 1: Dallas County Correctional Health Population by Race, 2024



Data Source: Pearl, Correctional Health

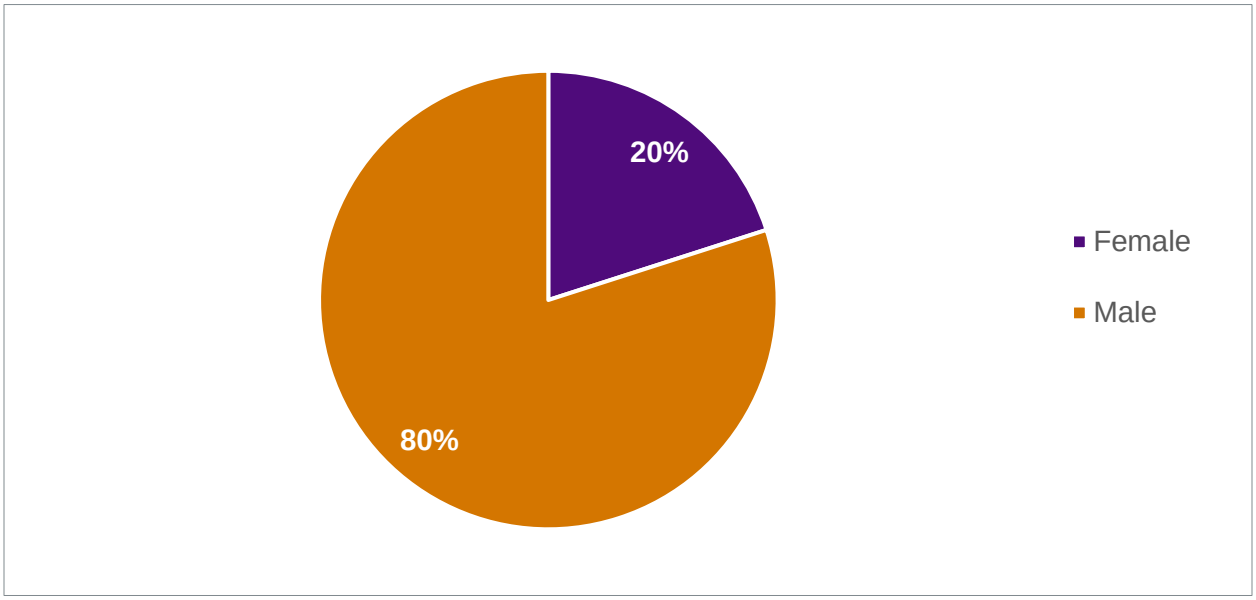
[80] Office of Disease Prevention and Health Promotion. Incarceration. Healthy People 2030. U.S. Department of Health and Human Services. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration. Accessed July 24, 2025.

SP Figure 2: Dallas County Correctional Health Population by Age Distribution, 2024



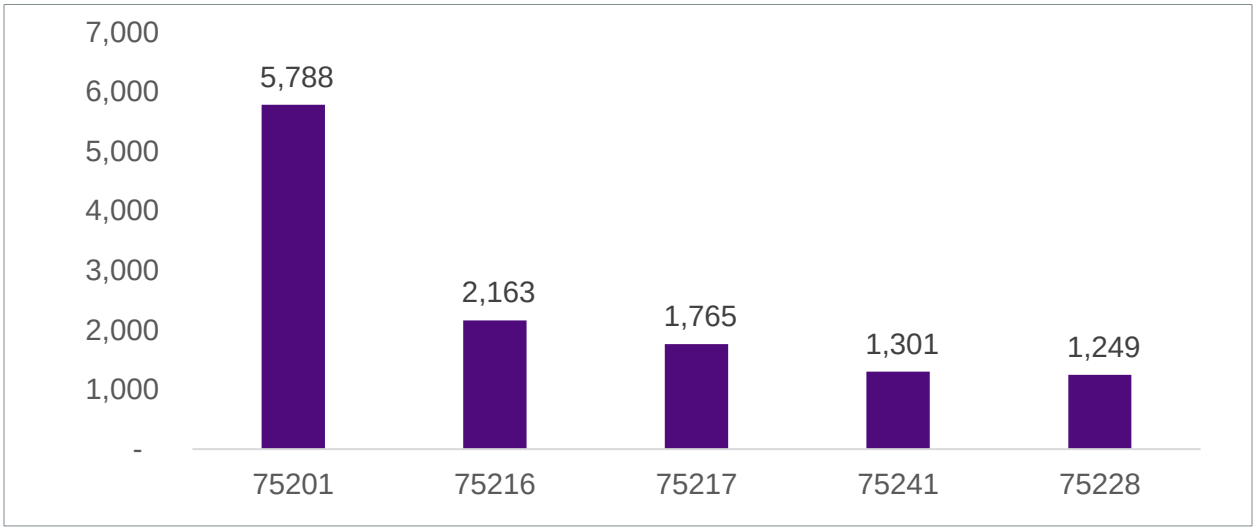
Data Source: Pearl, Correctional Health

SP Figure 3: Dallas County Correctional Health Population by Sex, 2024



Data Source: Pearl, Correctional Health

SP Figure 4: Dallas County Correctional Health Population by Top 5 ZIP Codes, 2024

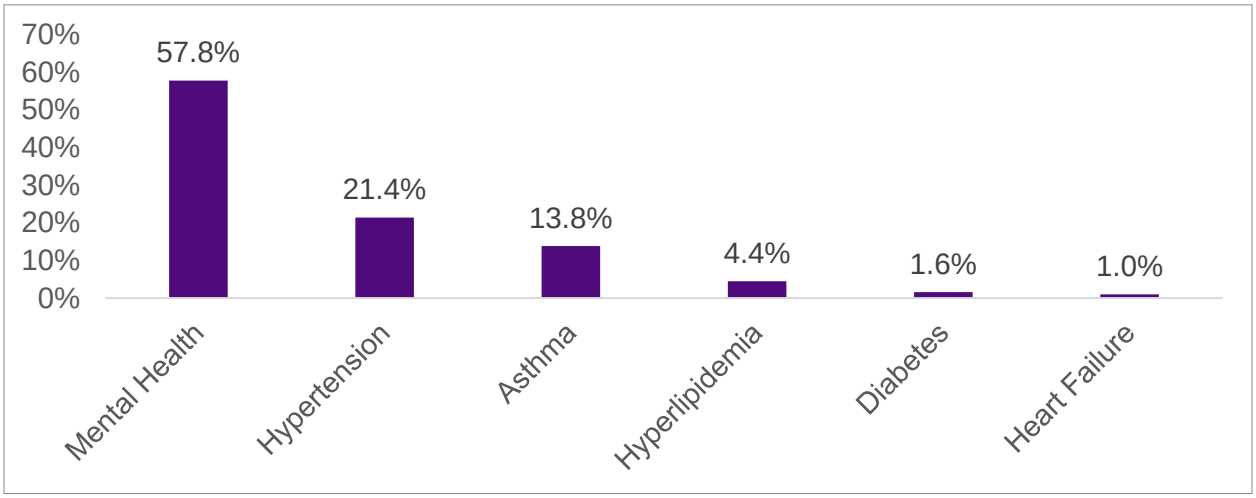


Data Source: Pearl, Correctional Health

b. Correctional Health Leading Chronic Diseases

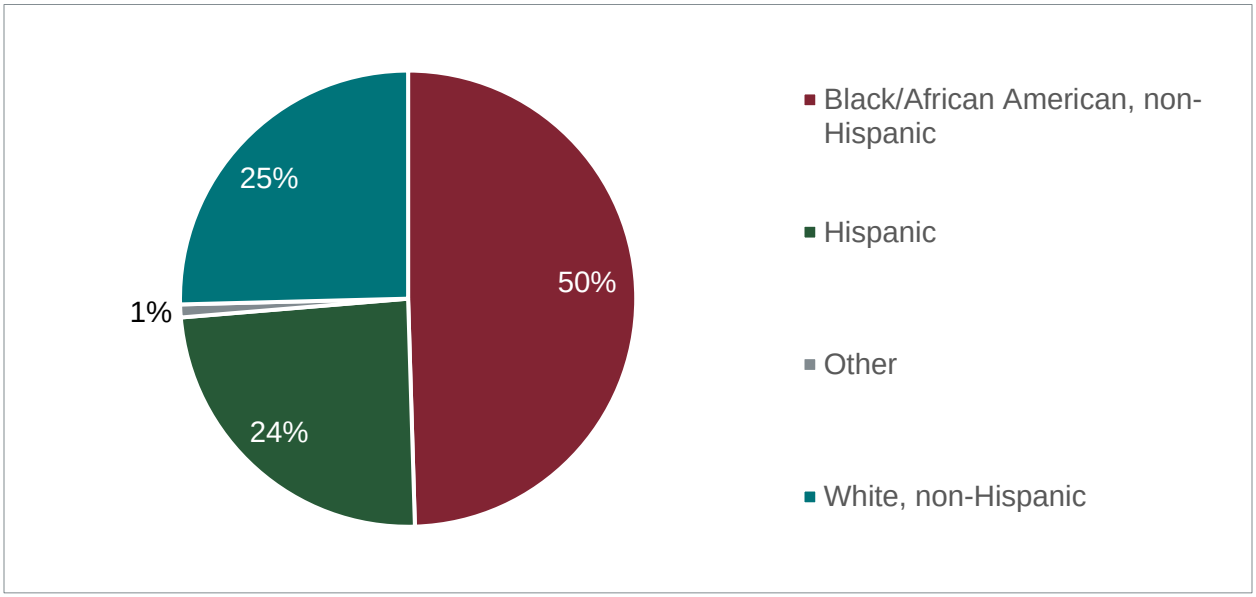
Within the Dallas County correctional health system, the three most diagnosed chronic health conditions are mental health disorders, hypertension, and asthma-see SP Figure 5. In 2024, mental health diagnosis was the most prevalent, affecting 58% of the population. Black or African American, non-Hispanic individuals, experience a disproportionate burden of chronic disease. They account for 63% of hypertension diagnoses, 65% of asthma cases, 58% of hyperlipidemia diagnoses, 67% of diabetes cases, and 67% of heart failure cases within the system-see SP Figure 7, SP Figure 8, SP Figure 9, SP Figure 10, and SP Figure 11.

SP Figure 5: Dallas County Correctional Health Patients Leading Chronic Disease Type, 2024



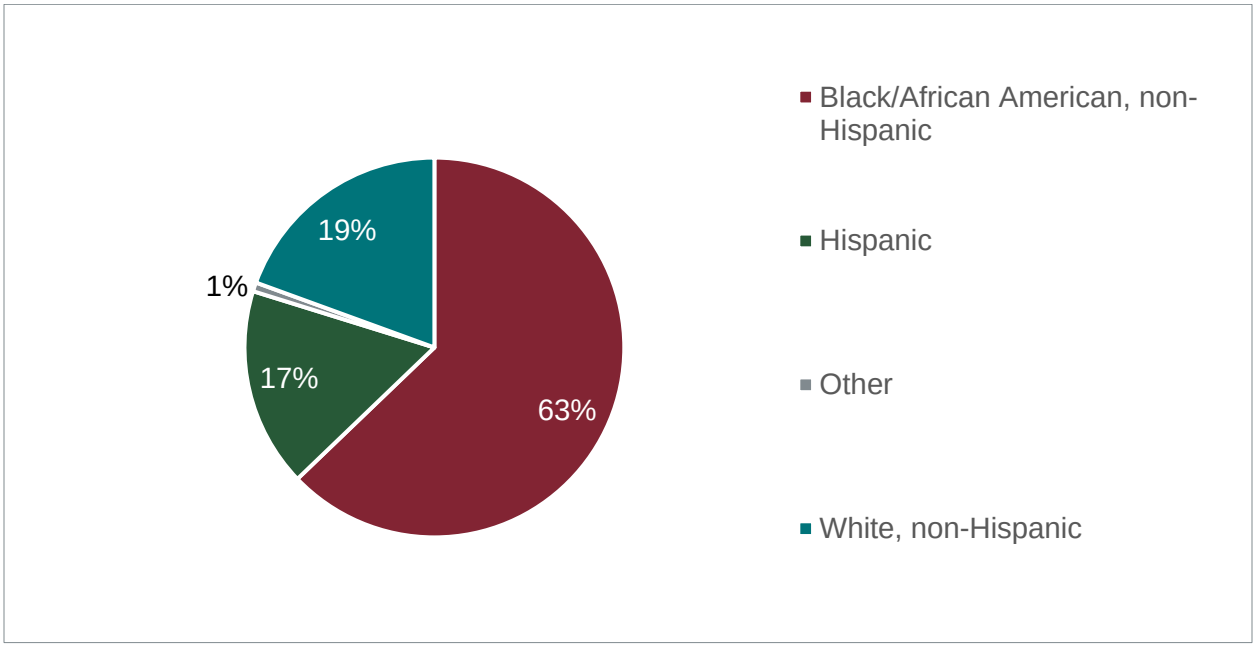
Data Source: Pearl, Correctional Health

SP Figure 6: Dallas County Correctional Health Patients with a Mental Health Diagnosis by Race and Ethnicity, 2024



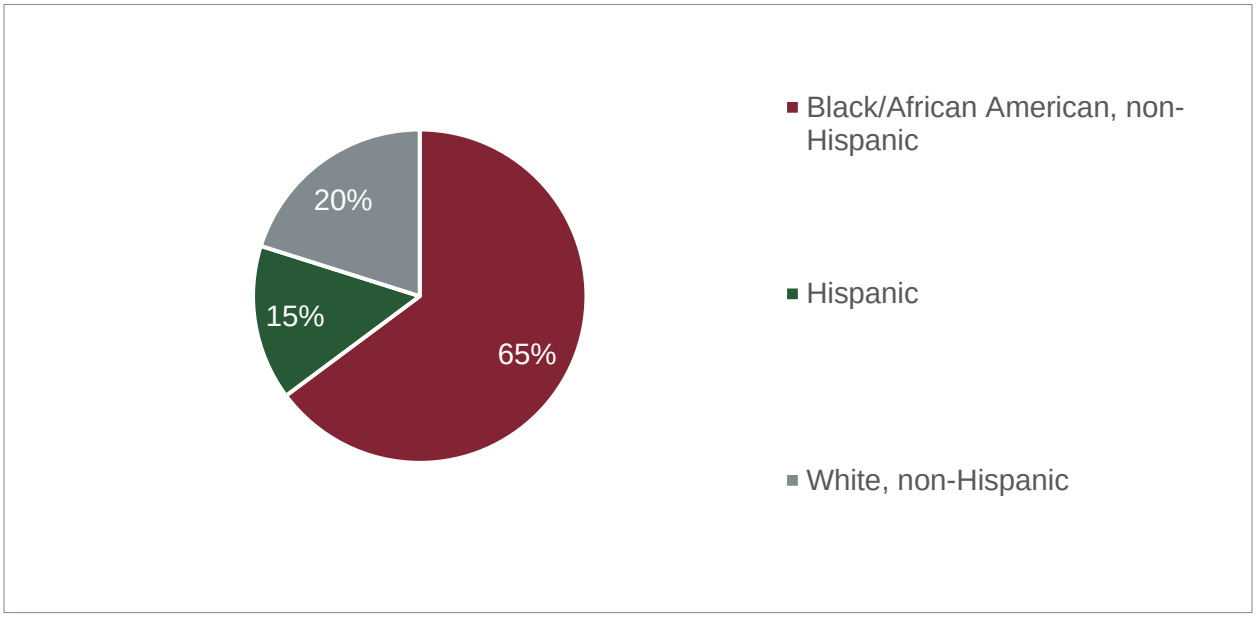
Data Source: Pearl, Correctional Health

SP Figure 7: Dallas County Correctional Health Patients with Hypertension by Race and Ethnicity, 2024



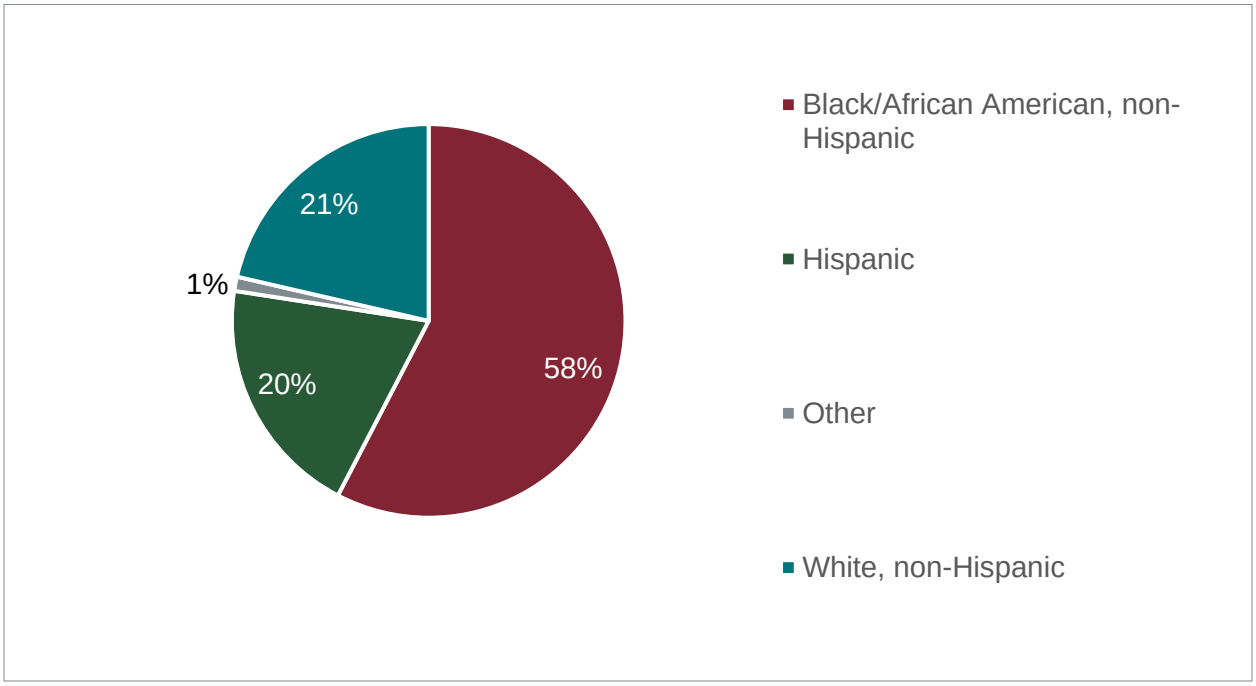
Data Source: Pearl, Correctional Health

SP Figure 8: Dallas County Correctional Health Patients with Asthma by Race and Ethnicity, 2024



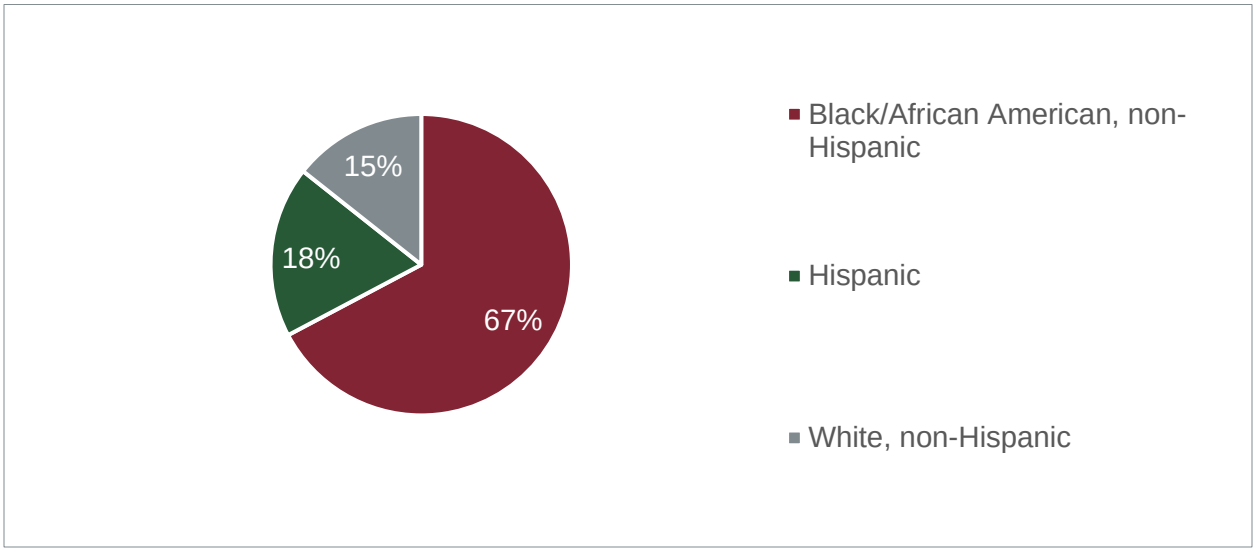
Data Source: Pearl, Correctional Health

SP Figure 9: Dallas County Correctional Health Patients with Hyperlipidemia by Race and Ethnicity, 2024



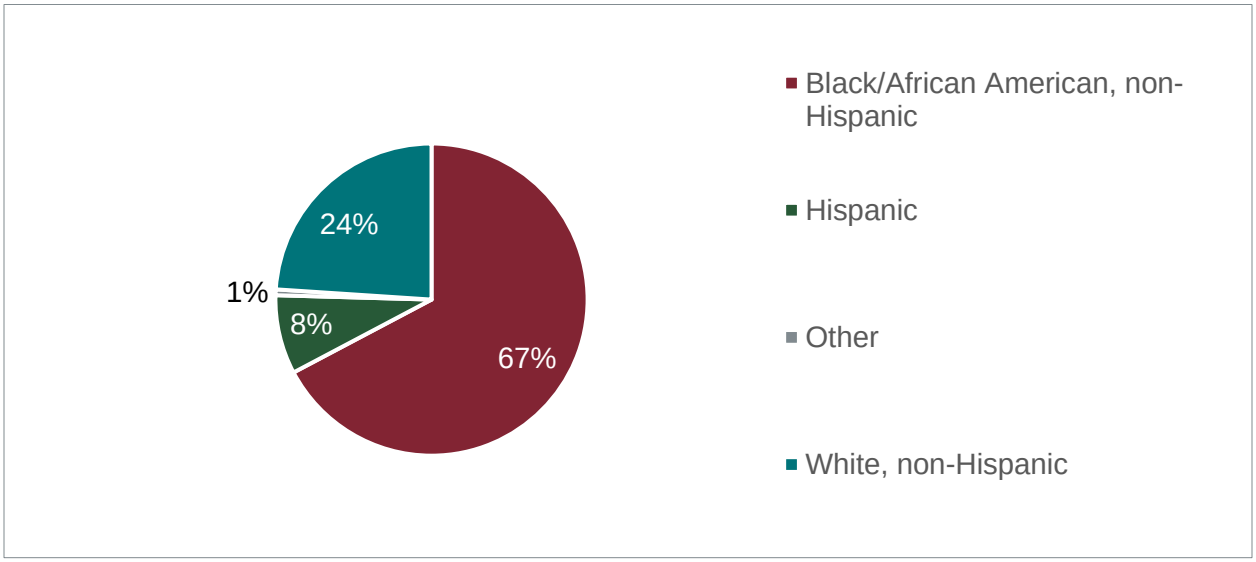
Data Source: Pearl, Correctional Health

SP Figure 10: Dallas County Correctional Health Patients with Diabetes by Race and Ethnicity, 2024



Data Source: Pearl, Correctional Health

SP Figure 11: Dallas County Correctional Health Patients with Heart Failure by Race and Ethnicity, 2024



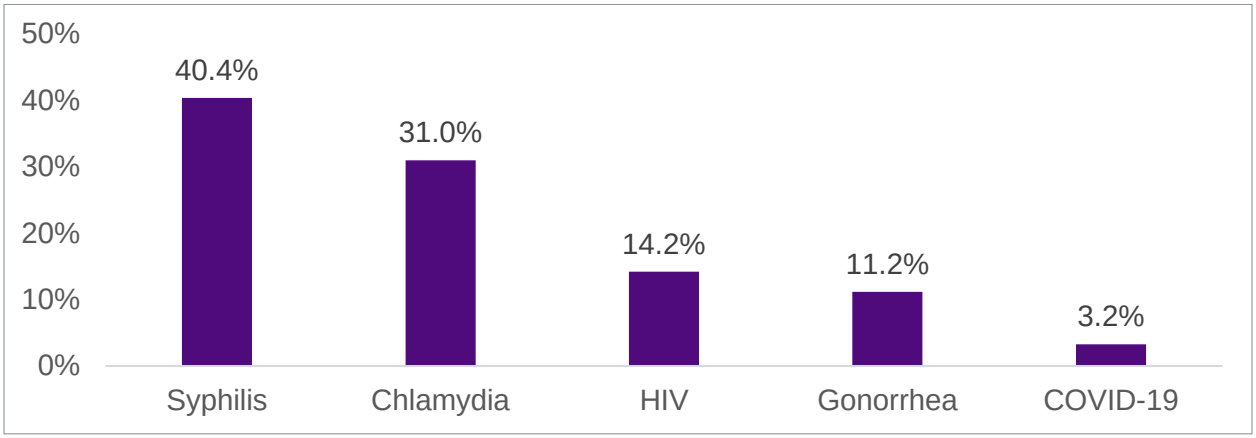
Data Source: Pearl, Correctional Health

In the U.S., individuals within the correctional health system face heightened risks for a range of infectious diseases, including STIs, HIV, viral hepatitis, and TB.[81] Reflecting this trend, 40% of

[81] Centers for Disease Control and Prevention. *Public Health Considerations for Correctional Health.* Updated July 3, 2024. Accessed July 22, 2025. https://www.cdc.gov/correctional-health/about/index.htm

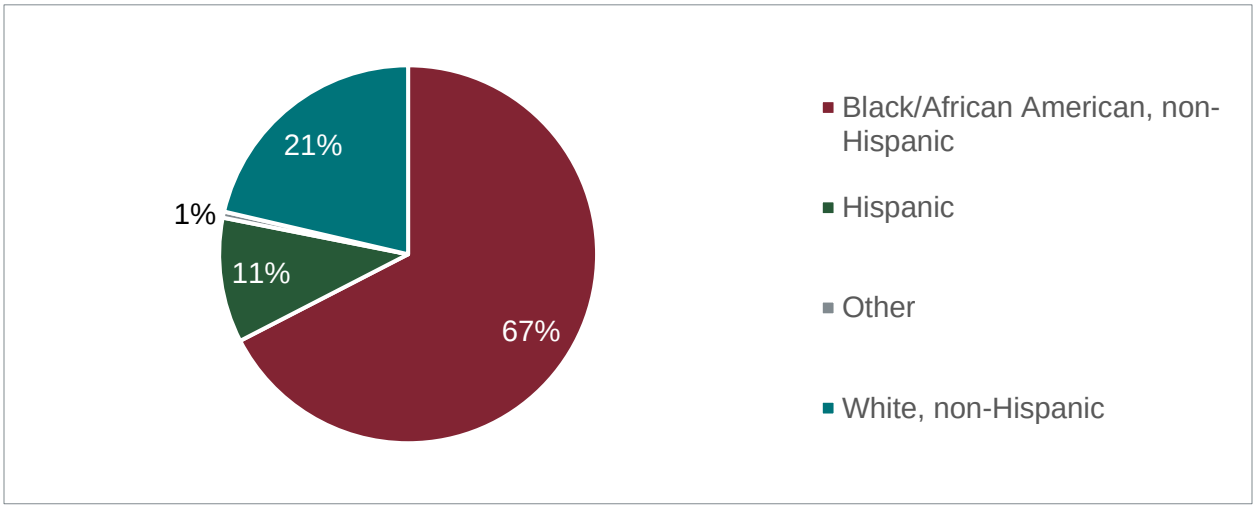
the correctional health population has been diagnosed with syphilis, and 31% with chlamydia. HIV also remains a significant concern among this group-see SP Figure 12.

SP Figure 12: Dallas County Correctional Health Patients with Infectious Disease, 2024



Data Source: Pearl, Correctional Health

SP Figure 13: Dallas County *Correctional Health Patients with HIV by Race and Ethnicity, 2024*



Data Source: Pearl, Correctional Health

2. Homelessness

The Public Health Service Act, defines homelessness as a population:

- Who lack housing (without regard to whether the individual is a member of a family),
- Whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations,
- Who reside in transitional housing, and/or,

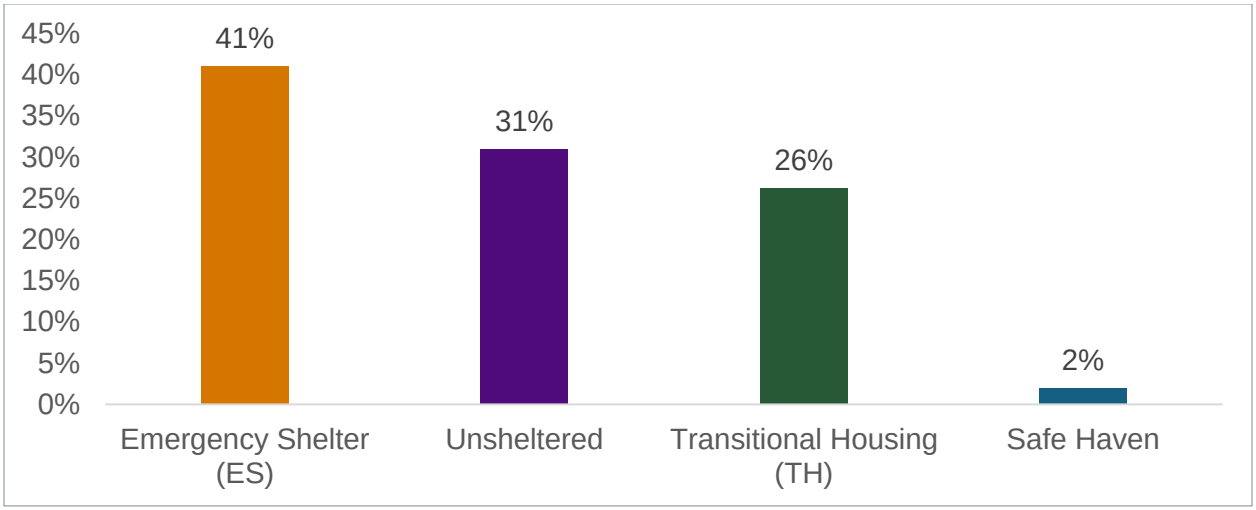
- Who reside in permanent supportive housing or other housing programs that are targeted to homeless populations[82].

According to the 2025 Annual Point-in-Time (PIT) Count for Dallas County, there were 2,936 individuals experiencing homelessness on a single night in January 2025. In addition to this, it is estimated that 5,445 families and single adults benefited from the diversion program services.

Analysis of the 2025 PIT count results, shows:

a. 31% of the population were living unsheltered
b. 69% were housed in various shelter projects, broken down as:
    - 41% in emergency shelters
    - 26% in transitional housing
    - 2% in safe-haven projects

SP Figure 14: Shelter Projects by the Numbers, 2025



Data Source: Housing Forward, 2025

Compared to 2022 PIT results:

- There was a 27% overall reduction in the homelessness population in 2025
- There was a 32% decline in the number of unsheltered individuals in 2025

a. Homeless Population Demographics

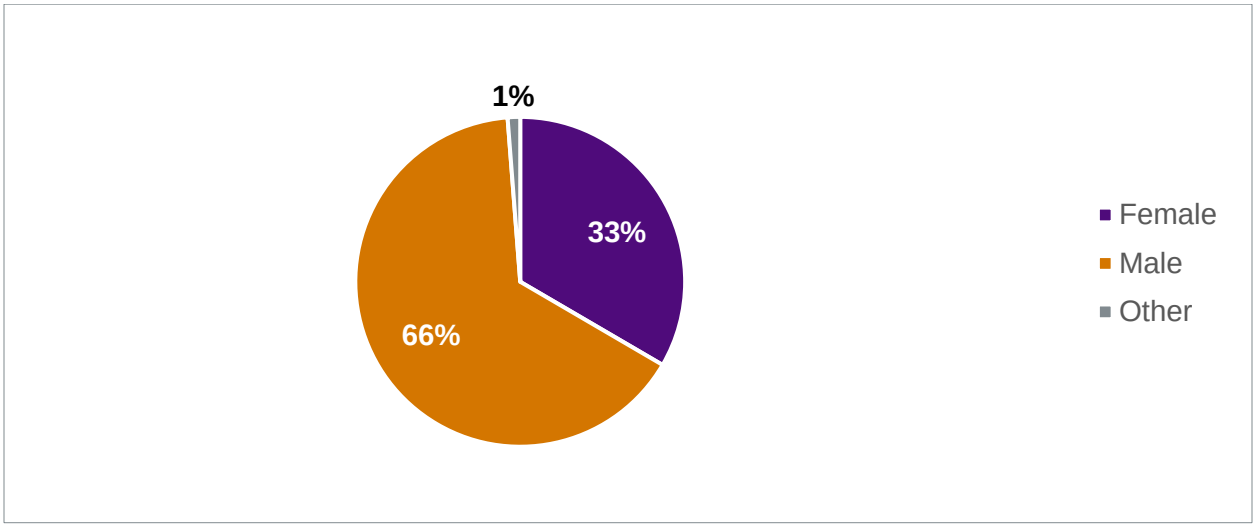
In Dallas County, there is a gender disparity among the homeless population, with men comprising higher percentage (66%) compared to women (33%)-see SP Figure 15.

Among racial groups, Black or African American, non-Hispanics are overrepresented, making up 57% of the homeless population while they make up 23% of the population in Dallas County-see SP Figure 16. This local pattern aligns with national data, which shows that individuals

[82] Bureau of Primary Health Care. Glossary: Health Center Program Compliance Manual. Health Resources and Services Administration. Updated March 20, 2025. Accessed July 22, 2025. https://bphc.hrsa.gov/compliance/compliance-manual/glossary

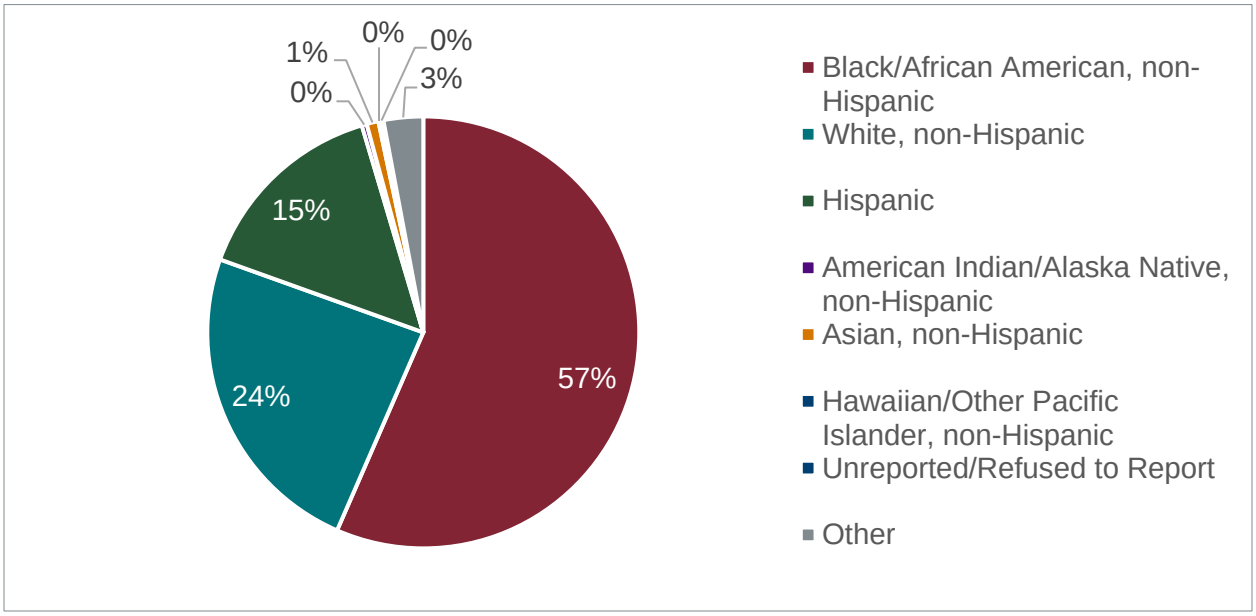
identifying as Black or African American, non-Hispanic remain disproportionately affected by homelessness.[83] Additionally, 87% of the homeless population is comprised of households without children-see SP Figure 18.

SP Figure 15: Homeless Population by Sex, Dallas County, 2025



Data Source: Housing Forward

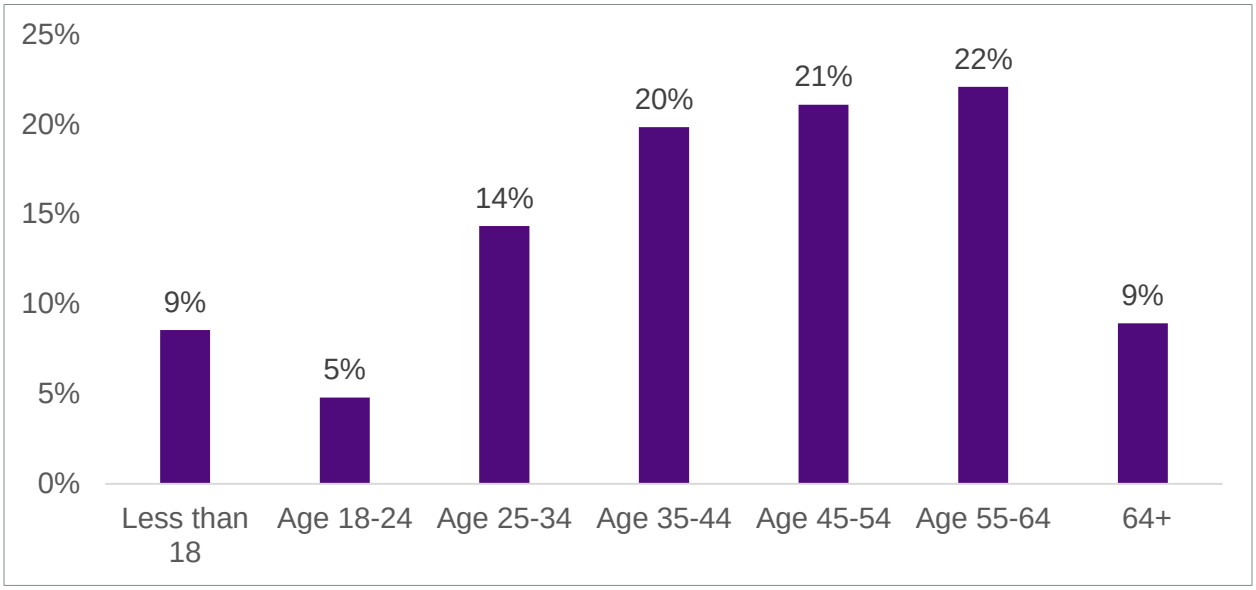
SP Figure 16: Homeless Population by Race and Ethnicity, Dallas County, 2025



Data Source: Housing Forward

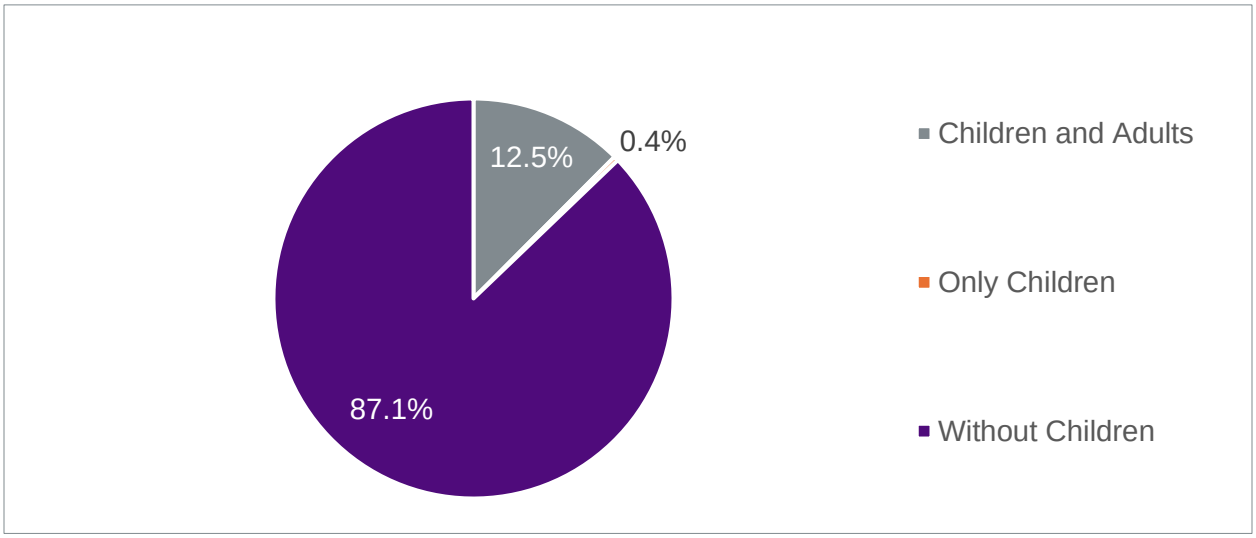
[83] Sousa T, Henry M. The 2024 Annual Homelessness Assessment Report (AHAR) to Congress: Part 1—Point-in-Time Estimates of Homelessness. Abt Global; December 2024. U.S. Department of Housing and Urban Development. Available from: https://www.huduser.gov/portal/publications/2024-ahar-part-1-pit-estimates-of-homelessness.html

SP Figure 17: Homeless Population by Age Distribution, Dallas County, 2025



Data Source: Housing Forward

SP Figure 18: Homeless Population by Household, Dallas County, 2025



Data Source: Housing Forward

b. HOMES Population

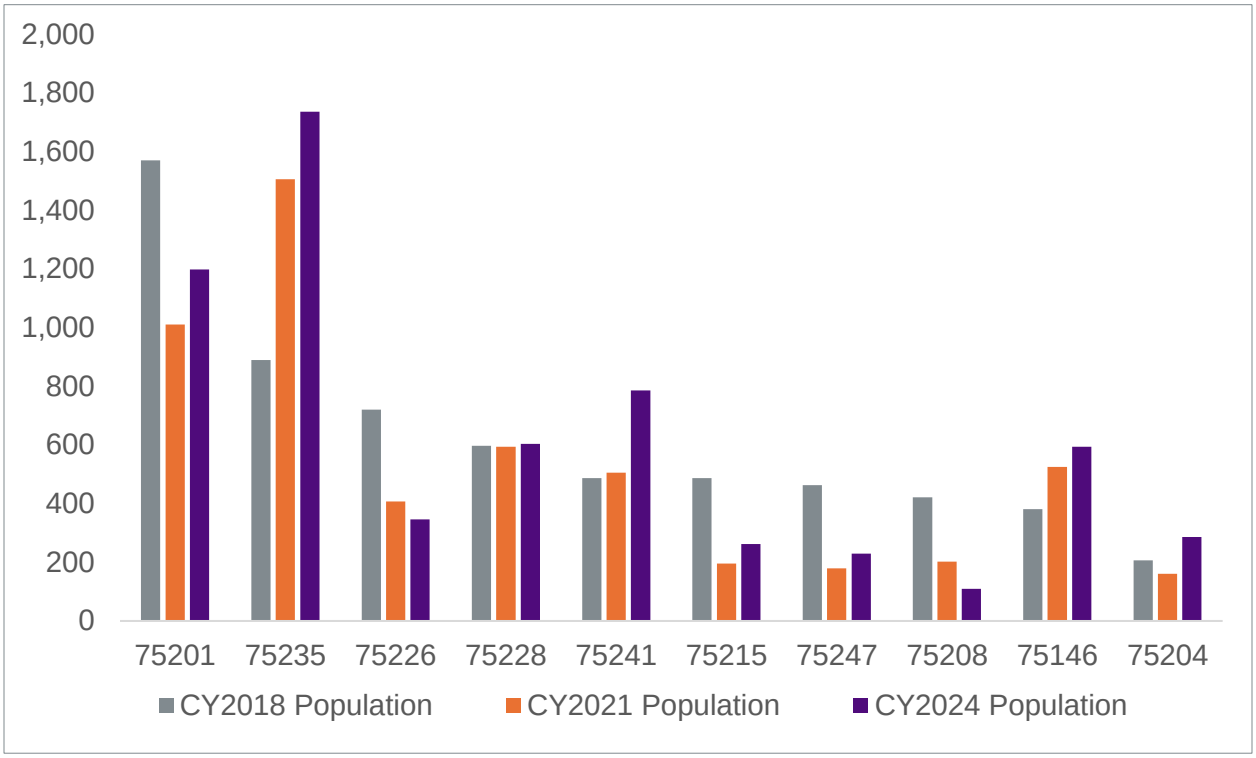
Parkland's HOMES program aims to provide comprehensive healthcare services to children and adults experiencing homelessness in Dallas County. Medical, dental, and behavioral health services are offered through a network of five mobile medical clinics and a mobile dental clinic at various partner sites throughout Dallas County and at three fixed site locations in the community.

i. HOMES Patients Demographics

In 2024, HOMES served 8,906 unique patients.

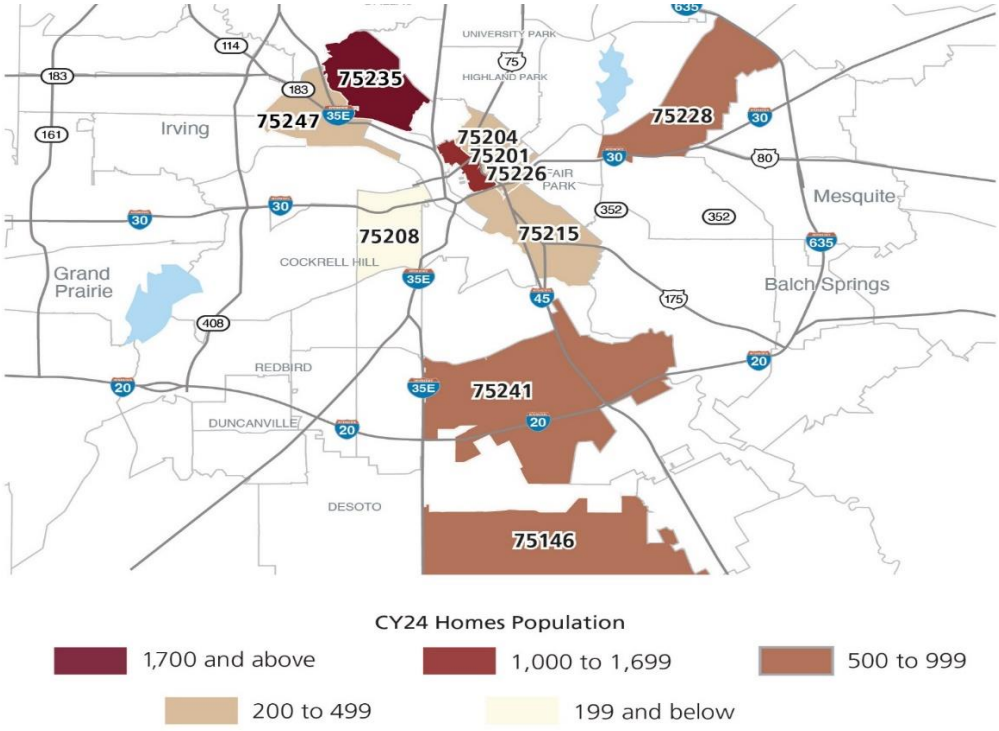
Most HOMES patients reside within 10 ZIP Codes-see SP Figure 19 and 20. The gender distribution has remained consistent over the years, with males overrepresented. In 2024, 60% of HOMES patients were male, compared to 38% of females-see SP Figure 21.

SP Figure 19: HOMES Population by ZIP Codes: CY2018, CY2021, CY2024



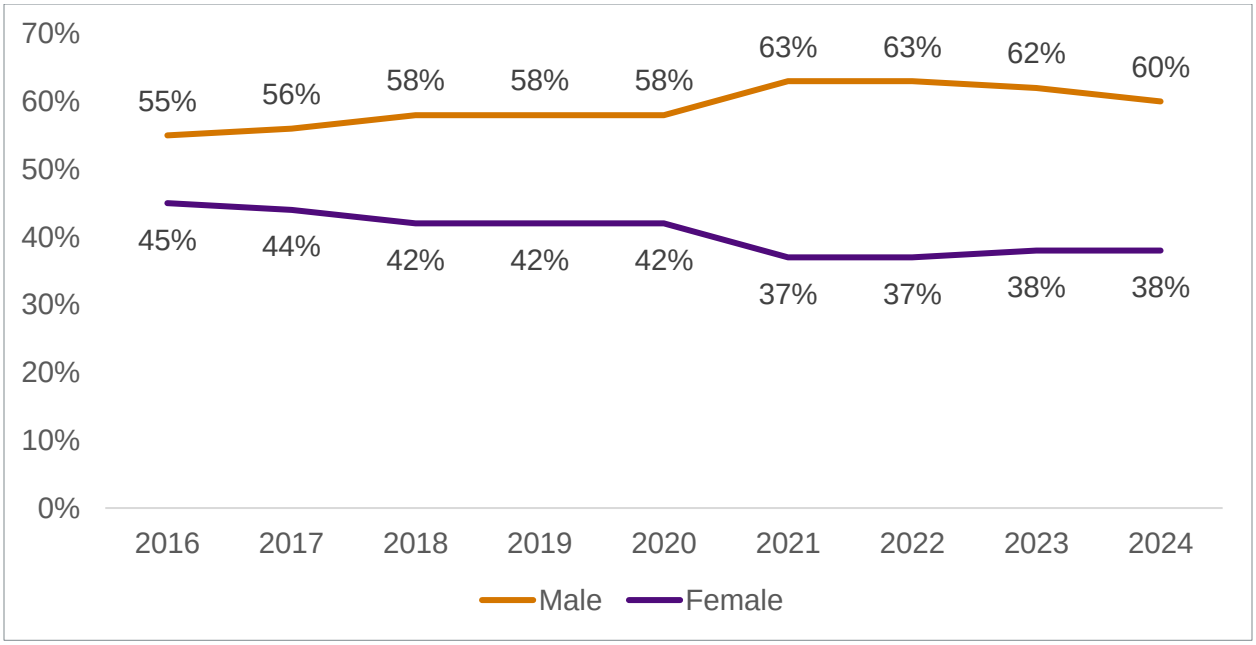
Data Source: HOMES Annual HRSA UDS Submission

SP Figure 20: HOMES Population by Top 10 ZIP Codes, CY2024



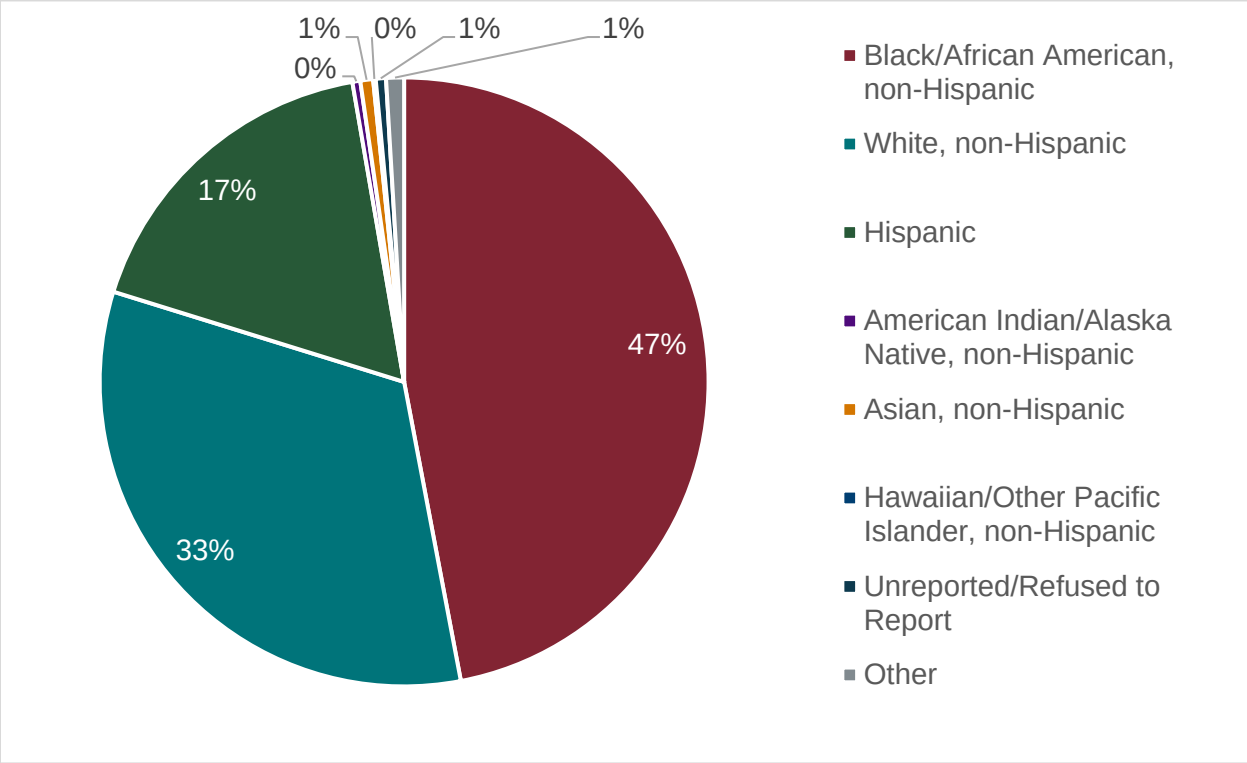
Data Source: HOMES Annual HRSA UDS Submission

SP Figure 21: HOMES Patients by Sex, CY2016–CY2024



Data Source: HOMES Annual HRSA UDS Submission

SP Figure 22: HOMES Patients by Race and Ethnicity, CY2024

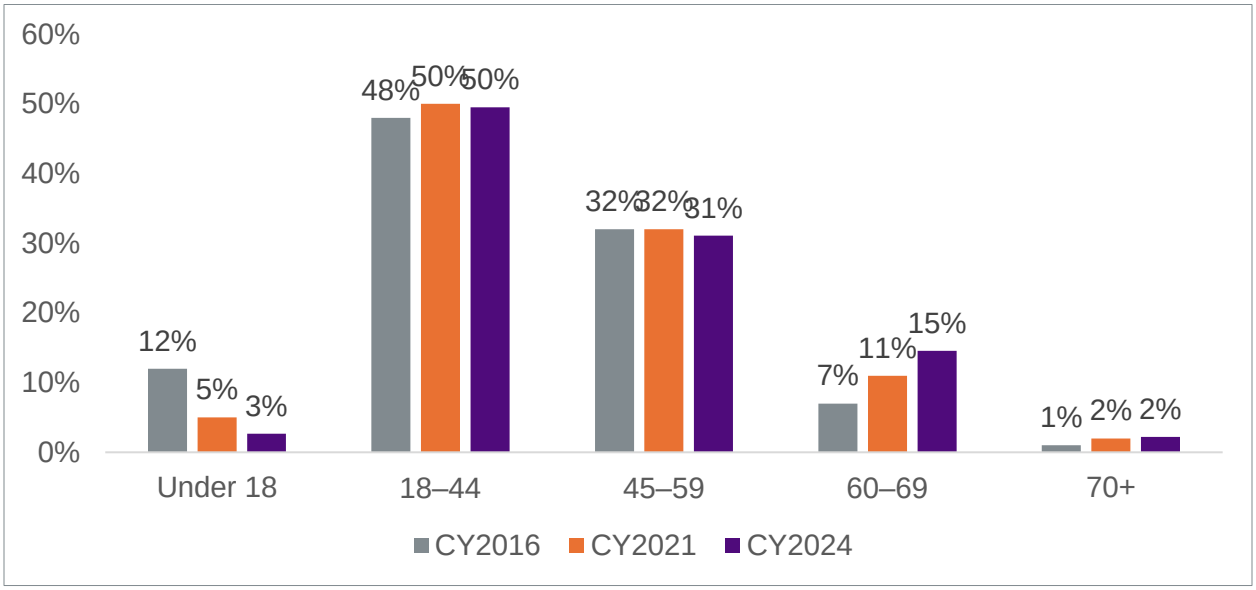


Data Source: HOMES Annual HRSA UDS Submission

In 2024, 47% of HOMES patients were identified as Black or African American, non-Hispanic and 17% as Hispanic in 2024-see SP Figure 22; reflecting a demographic distribution consistent with that observed in 2021.

The age distribution of HOMES patients has remained stable since 2016, with the majority consistently falling within the 18–44-year age group (50%), followed by the 45–59-year cohort (31%). However, significant demographic shifts were observed at both ends of the age spectrum. The proportion of patients under 18 years declined by 9 percentage points in 2024 compared to 2016, indicating a decrease in pediatric patients. Conversely, the proportion of patients aged 60–69 years have doubled, increasing from 7% in 2016 to 15% in 2024, suggesting a growing utilization of services among older adults-see SP Figure 23.

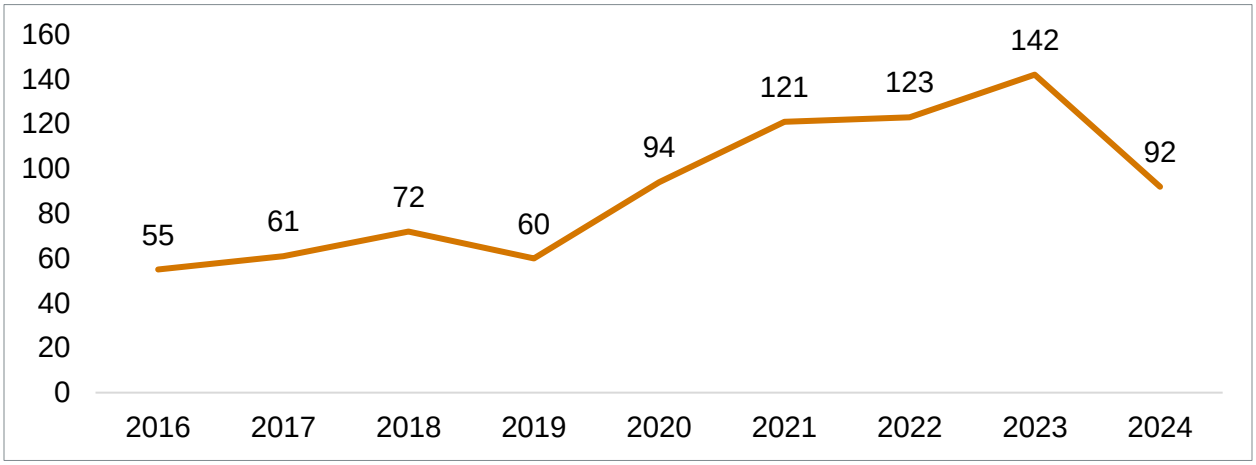
SP Figure 23: HOMES Population Age Distribution: CY2016, CY2021, CY2024



Data Source: HOMES Annual HRSA UDS Submission

Between 2023 and 2024, homelessness among veterans decreased by 35%-see SP Figure 24. This trend aligns with national data, which indicates a 7.5% reduction in the number of veterans experiencing homelessness over the same period.[84]

SP Figure 24: HOMES Veterans Population: CY2016-CY2024

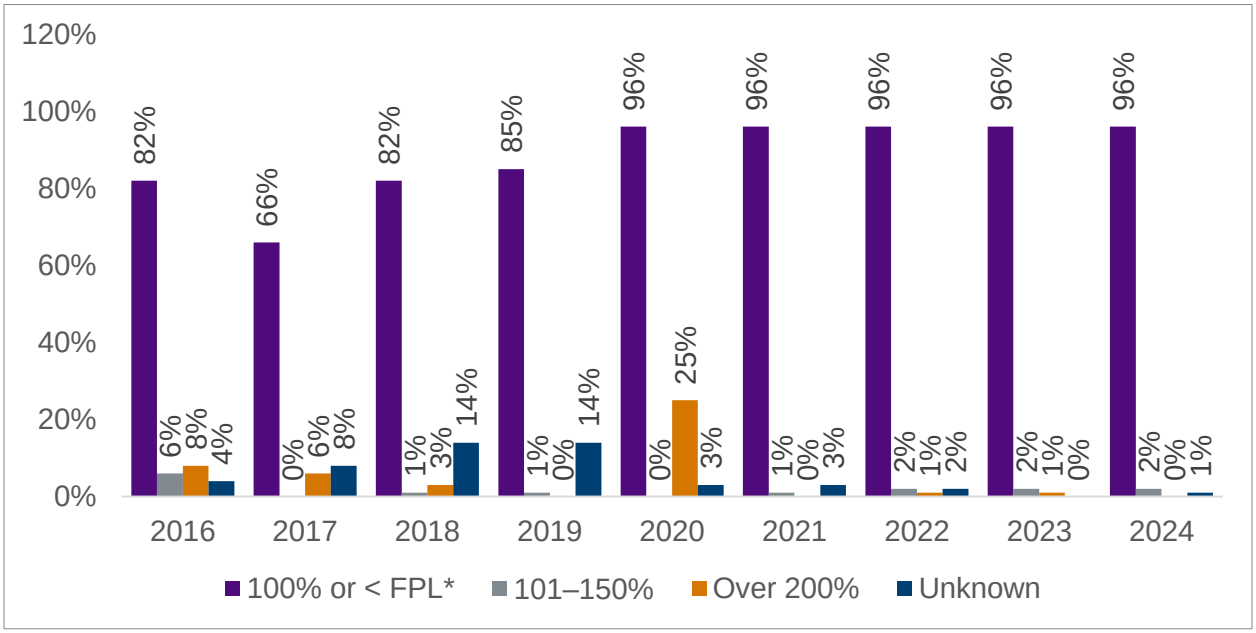


Data Source: HOMES Annual HRSA UDS Submission

[84] Sousa T, Henry M. The 2024 Annual Homelessness Assessment Report (AHAR) to Congress: Part 1—Point-in-Time Estimates of Homelessness. Abt Global; December 2024. U.S. Department of Housing and Urban Development. Available from: https://www.huduser.gov/portal/publications/2024-ahar-part-1-pit-estimates-of-homelessness.html

Dallas County has seen a decline in overall homelessness since 2022. Homelessness is closely linked to poverty and the lack of affordable housing.[85,86] Since 2020, 96% of HOMES patients have consistently lived at or below the federal poverty level. SP Figure 25 illustrates the ongoing economic vulnerability of this population. Additionally, the rate at which individuals transition out of homelessness into transitional housing, defined as temporary, supportive shelter, has remained unchanged since 2021-see SP Figure 26.

SP Figure 25: HOMES Patients: Poverty Status: CY2016-CY2024

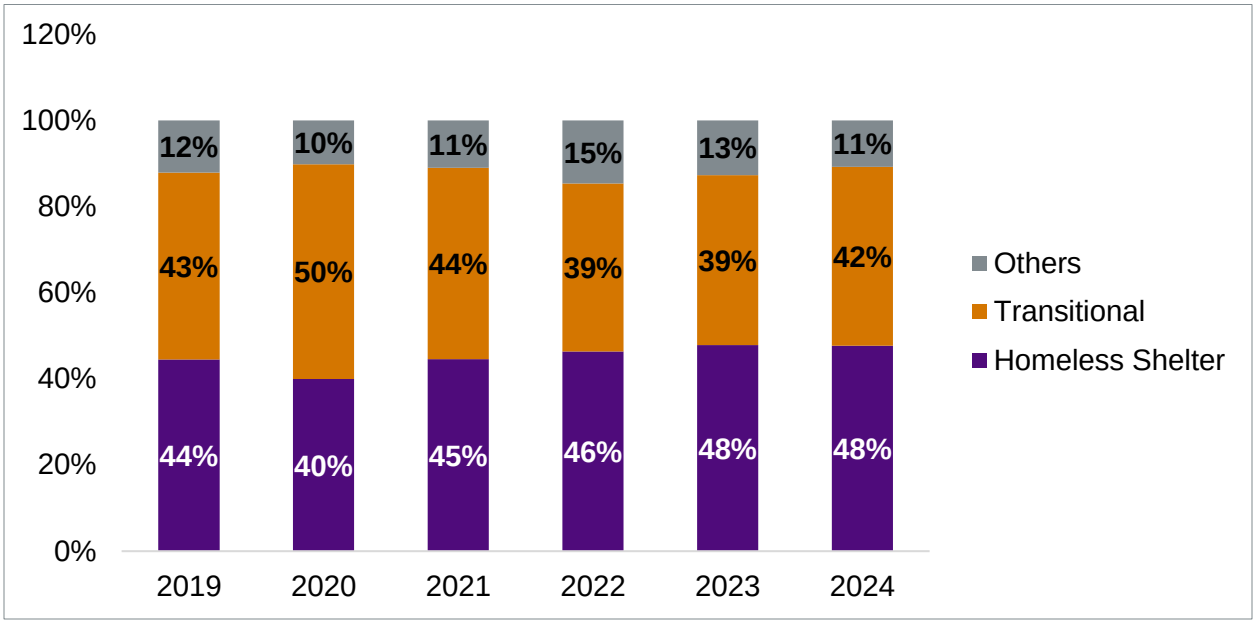


Data Source: HOMES Annual HRSA UDS Submission

[85] Donald J, Grubbs S. Housing Affordability Gap Hits Texas. Texas Comptroller of Public Accounts. Published October 2024. Accessed July 23, 2025. Available from: https://comptroller.texas.gov/economy/fiscal-notes/economics/2024/aff-housing/

[86] U.S. Department of Housing and Urban Development. The 2021 Annual Homeless Assessment Report (AHAR) to Congress. Published 2021. Accessed July 25, 2025. https://www.hud.gov/sites/dfiles/CFO/documents/22_FY21CJ_Program_HAG.pdf

SP Figure 26: HOMES Patients by Housing Status: CY2019-CY2024



Data Source: HOMES Annual HRSA UDS Submission

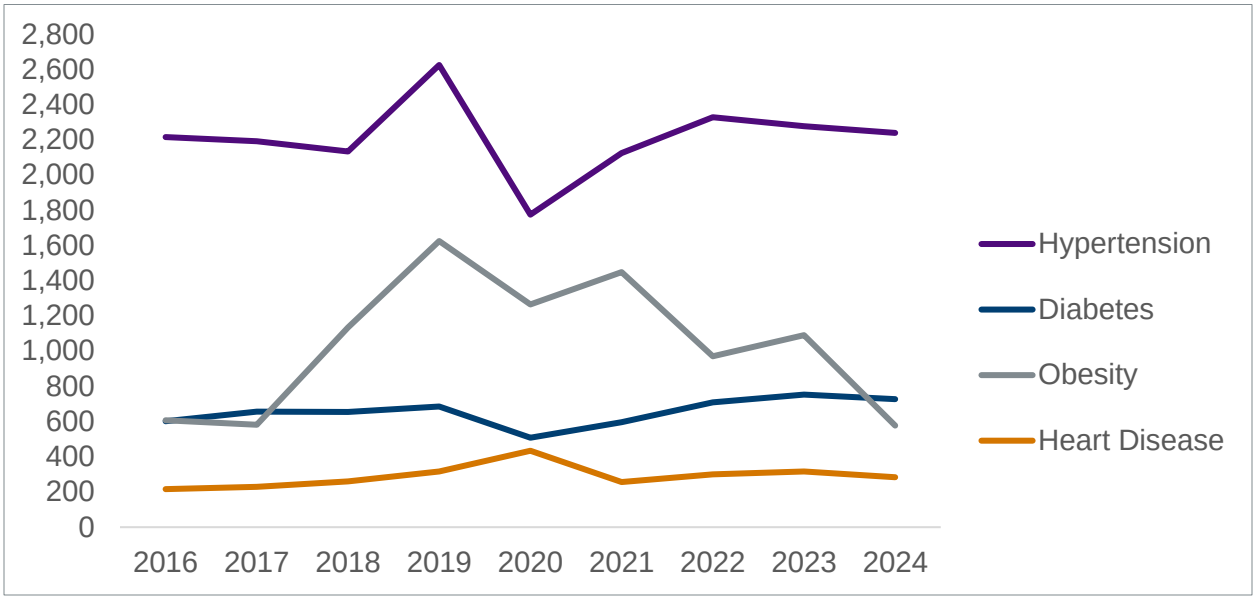
ii. HOMES Population Health Profile

Homelessness has serious health implications. People experiencing homelessness face higher risks of infectious and non-infectious diseases, mental health challenges, alcohol and substance use disorder[87], along with a lower life expectancy.[88] Additionally, unstable and substandard housing can expose individuals to hazards such as lead, secondhand smoke, and inaccessible living spaces, risks that are especially concerning for people with disabilities and older adults.[89]

Chronic diseases are the most diagnosed conditions among HOMES patients. Hypertension, diabetes, obesity, and heart disease are the most prevalent, listed in that order. Since 2021, obesity has shown a significant decline dropping by 60%. Meanwhile, both diabetes and heart disease have increased by 22% and 11%, respectively, during the same period-see SP Figure 27.

[87] Centers for Disease Control and Prevention (CDC). About Homelessness and Health. Updated October 15, 2024. Accessed July 23, 2025. Available from: https://www.cdc.gov/homelessness-and-health/about/index.html
[88] U.S. Interagency Council on Homelessness. Homelessness Data & Trends. Published 2024. Accessed July 25, 2025. https://www.usich.gov/guidance-reports-data/data-trends
[89] Office of Disease Prevention and Health Promotion. Housing and Homes Objectives – Healthy People 2030. U.S. Department of Health and Human Services. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes#cit3. Accessed July 22, 2025.

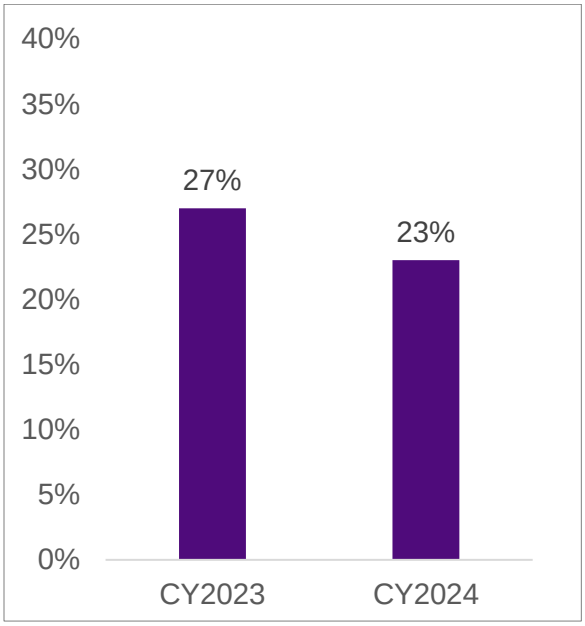
SP Figure 27: HOMES Top Chronic Conditions CY2016–CY2024



Data Source: HOMES Annual HRSA UDS Submission

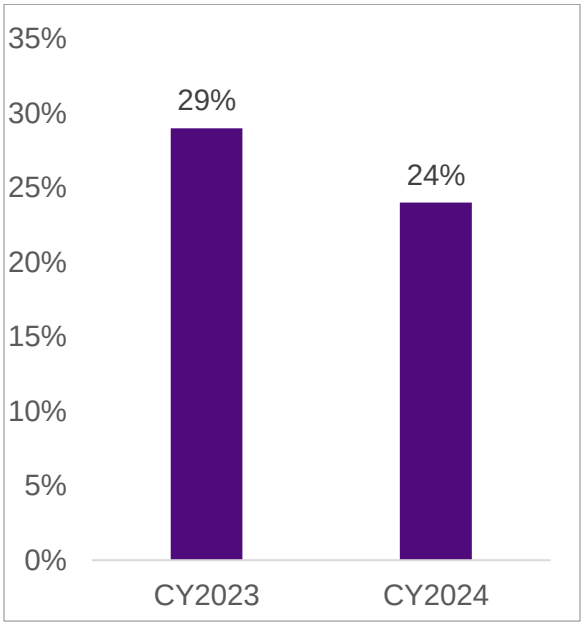
iii. HOMES Women's Health

SP Figure 28: Percentage of women 52–74 years who had a screening mammogram, HOMES, CY2023-CY2024



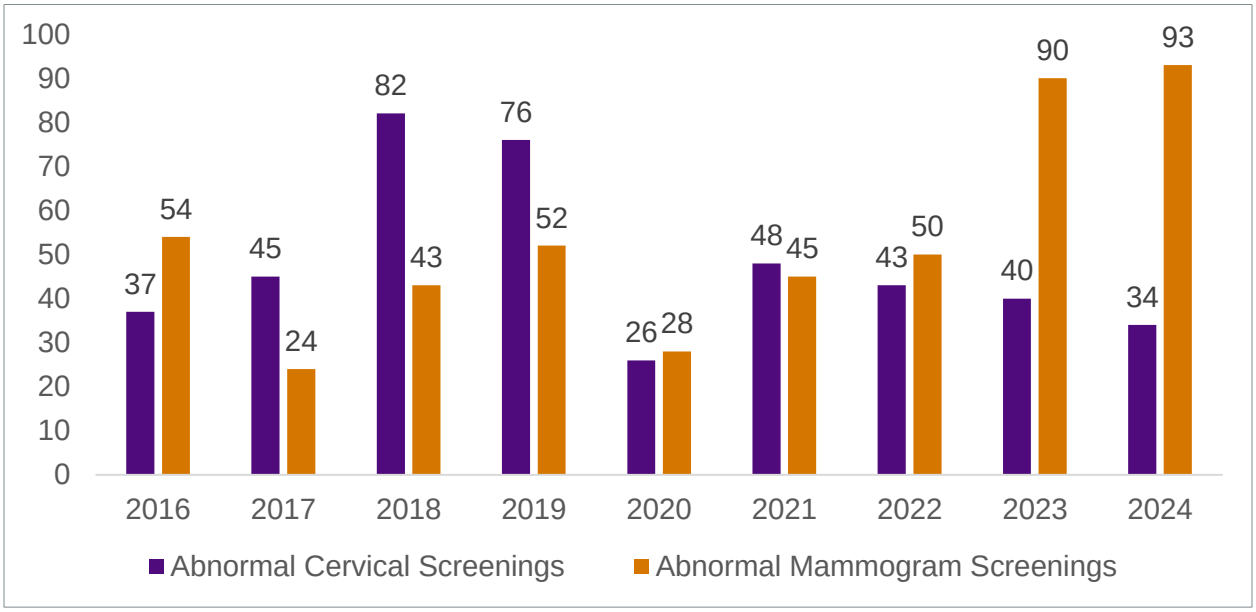
Data Source: HOMES Annual HRSA UDS Submission

SP Figure 29: Percentage of women 24-64 years screened for cervical cancer, HOMES, CY2023-CY2024



Data Source: HOMES Annual HRSA UDS Submission

SP Figure 30: HOMES, Women's Selected Medical Conditions Diagnosis, CY2016–CY2024



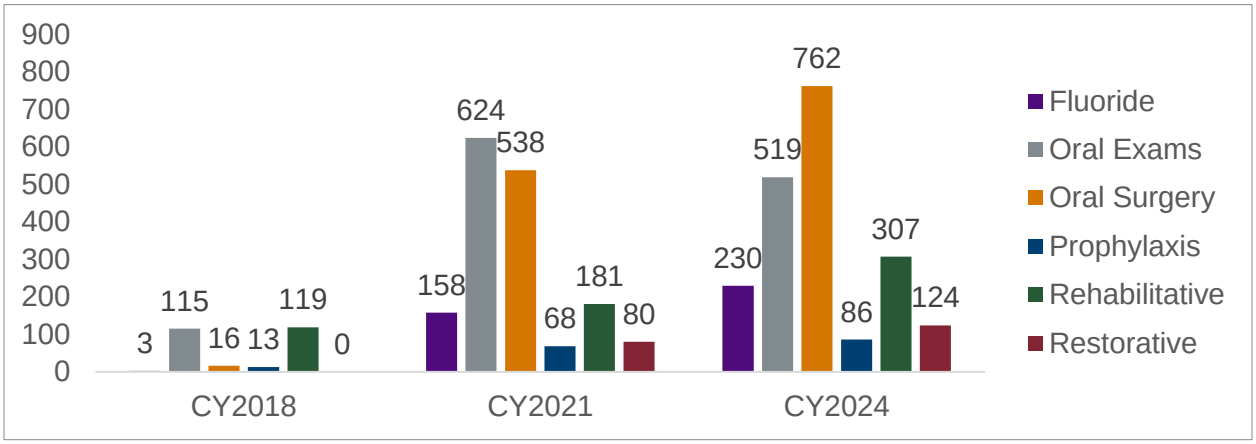
Data Source: HOMES Annual HRSA UDS Submission

As shown in SP Figure 30, an increase in the number of abnormal mammograms were noted as a result of a recovery strategy post COVID-19 to increase the number of women who completed their mammogram based on medical guidelines and to ensure patients with an abnormal mammogram complete follow-up tests.

iv. Oral Health

The HOMES program offers a comprehensive approach to oral healthcare, including dental screenings, preventive care, extractions, denture provision, and minor procedures. Over the years, the number of dental services provided to the HOMES patients have increased reaching approximately 2,000 in 2024-see SP Figure 31.

SP Figure 31: HOMES, Dental Services, CY2018, CY2021 and CY2024



Data Source: HOMES Annual HRSA UDS Submission

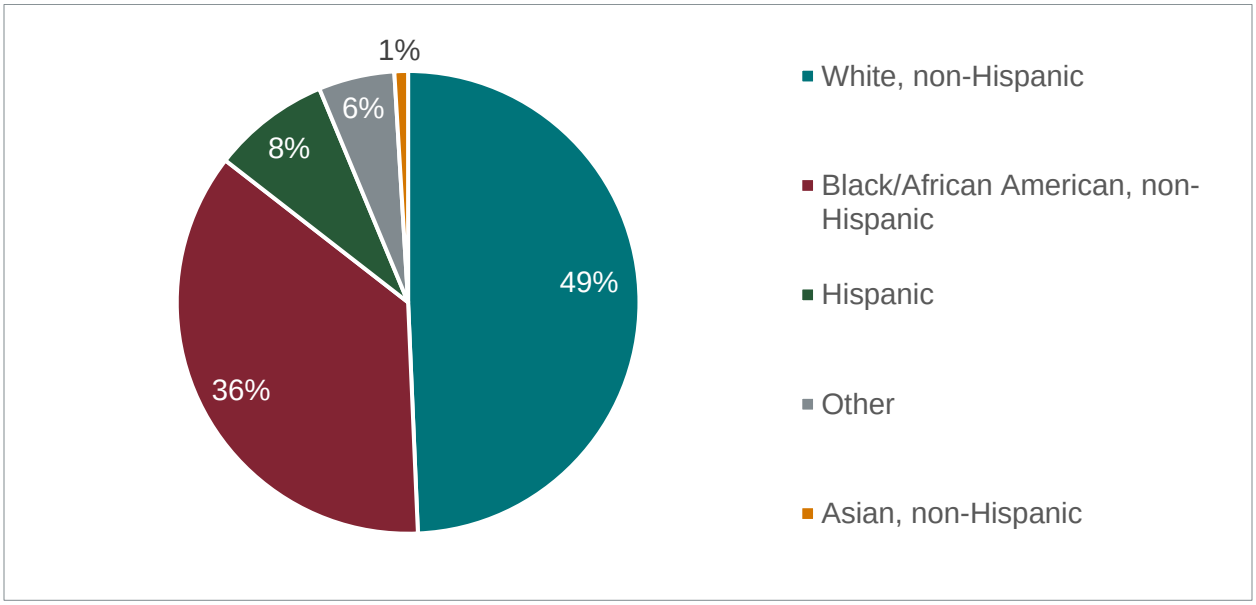
3. LGBTQIA+

The LGBTQIA+ community continues to experience persistent disparities in health outcomes, driven by systemic inequities, social stigma, and limited access to quality healthcare. While awareness of these issues has grown, the inclusion of LGBTQIA+ populations in public health assessments and clinical research remains inconsistent due to data gaps and fragmented services across health systems and national frameworks.[90] The Dallas County CHNA 2022[91,92] outlined strategies to enhance the collection of SOGI data, aiming to better understand the health needs of this population.

a. Clinical and Demographic Trends

Parkland has implemented initiatives to improve the collection of SOGI information. As of June 2025, a total of 5,683 Parkland patients self-identified as LGBTQIA+. SP Figure 32 illustrates the distribution of these patients by race and ethnicity. Parkland remains committed to advancing its SOGI data collection and reporting practices to build a more comprehensive and reliable health profile for LGBTQIA+ patients.

SP Figure 32: Parkland LGBTQIA+ Patients by Race and Ethnicity



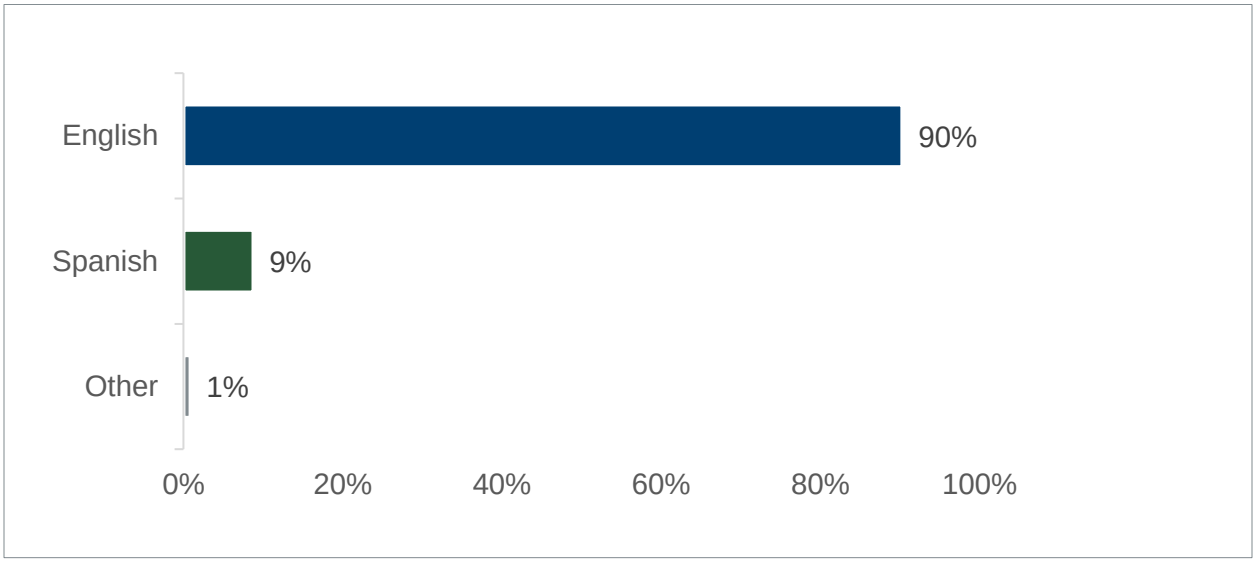
Data Source: Parkland EHR

[90] Centers for Disease Control and Prevention. Health Disparities Among LGBTQ Youth. CDC. Updated November 29, 2024. Accessed June 27, 2025. https://www.cdc.gov/healthy-youth/lgbtq-youth/health-disparities-among-lgbtq-youth.html

[91] Parkland Health. *2022 Dallas County Community Health Needs Assessment*. Parkland Health; 2022. Accessed July 24, 2025. https://www.parklandhealth.org/pdf-files/2022-dallas-county-community-health-needs-assessme-1

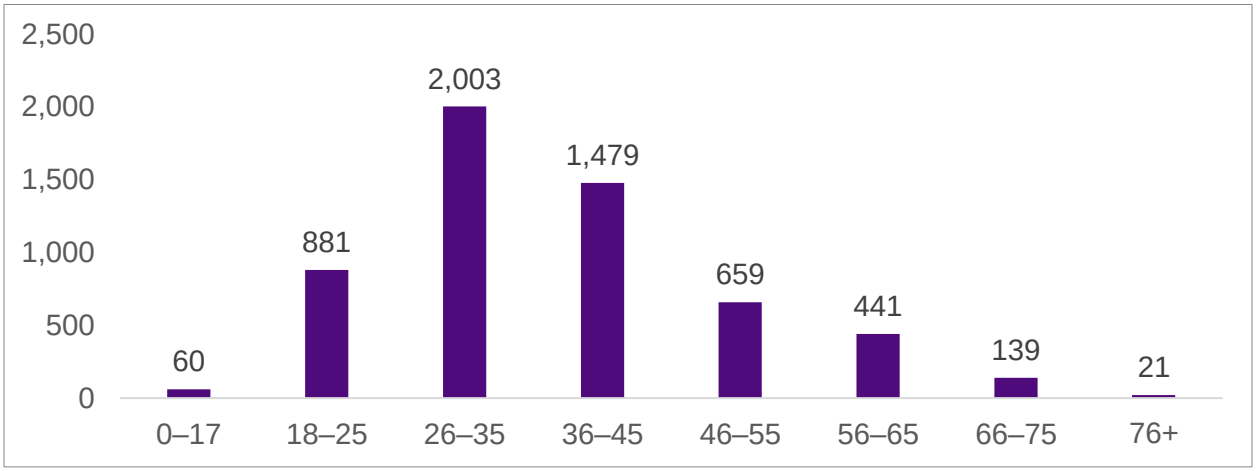
[92] Parkland Health; Dallas County Health and Human Services. *Community Health Needs Assessment Implementation Plan, Dallas County, 2023*. Dallas County Health and Human Services & Parkland Health; accepted February 22, 2023. Accessed July 24, 2025. https://www.dallascounty.org/Assets/uploads/docs/hhs/chna/CHNA-Implementation-Plan-2023.pdf

SP Figure 33: Parkland LGBTQIA+ Patients, Preferred Language, 2024



Data Source: Parkland EHR

SP Figure 34: Parkland LGBTQIA+ Patients by Age Distribution

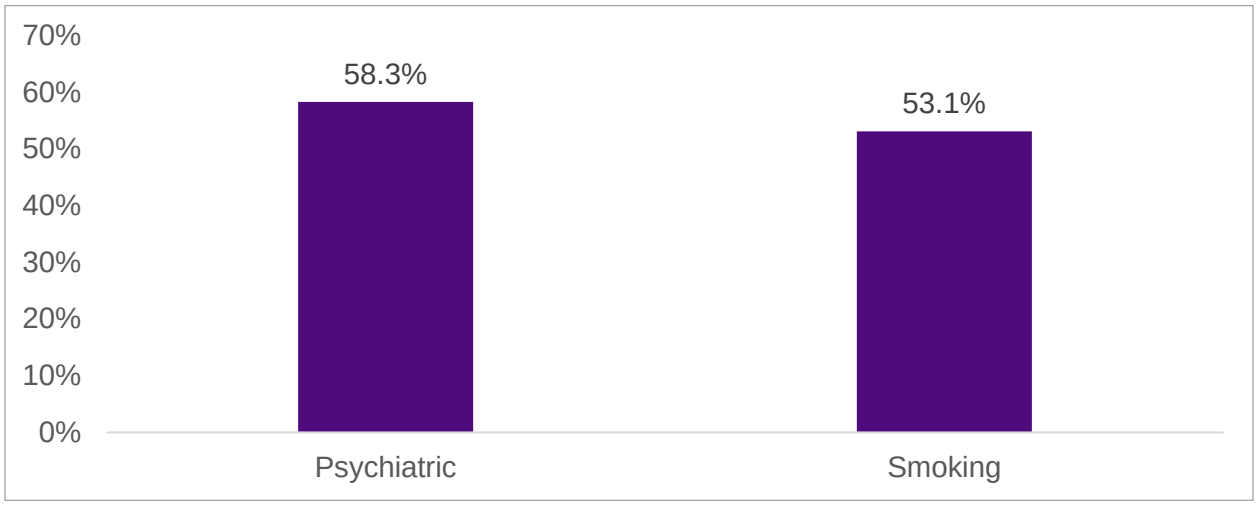


Data Source: Parkland EHR

Data from Parkland registries show that individuals who identify as LGBTQIA+ are disproportionately represented in mental health and substance use categories, including psychiatry and smoking-see SP Figure 35. Among the most diagnosed conditions, obesity is the

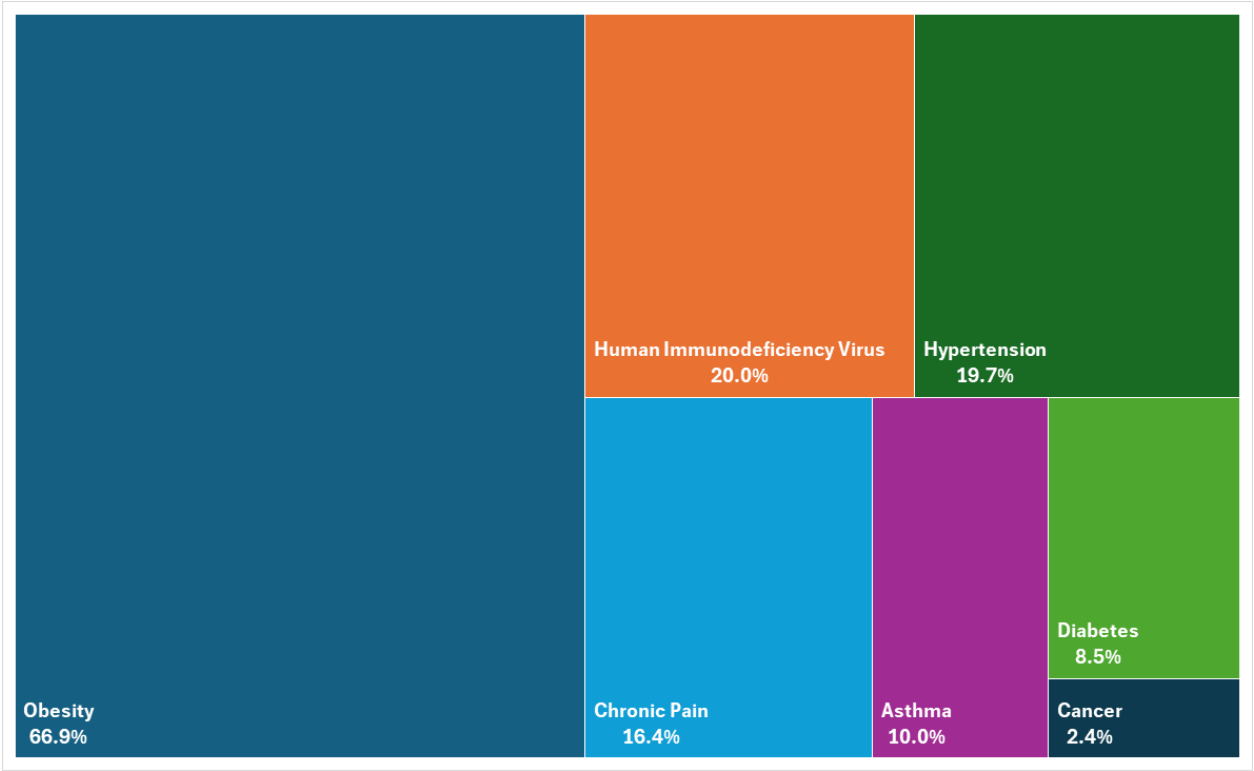
most prevalent, impacting 66.9% of the population, followed by HIV and hypertension-see SP Figure 36.

SP Figure 35: Parkland LGBTQIA+ Patients, Mental Health and Substance Abuse, 2024



Data Source: Parkland EHR

SP Figure 36: Parkland LGBTQIA+ Patients Leading Diseases, 2024

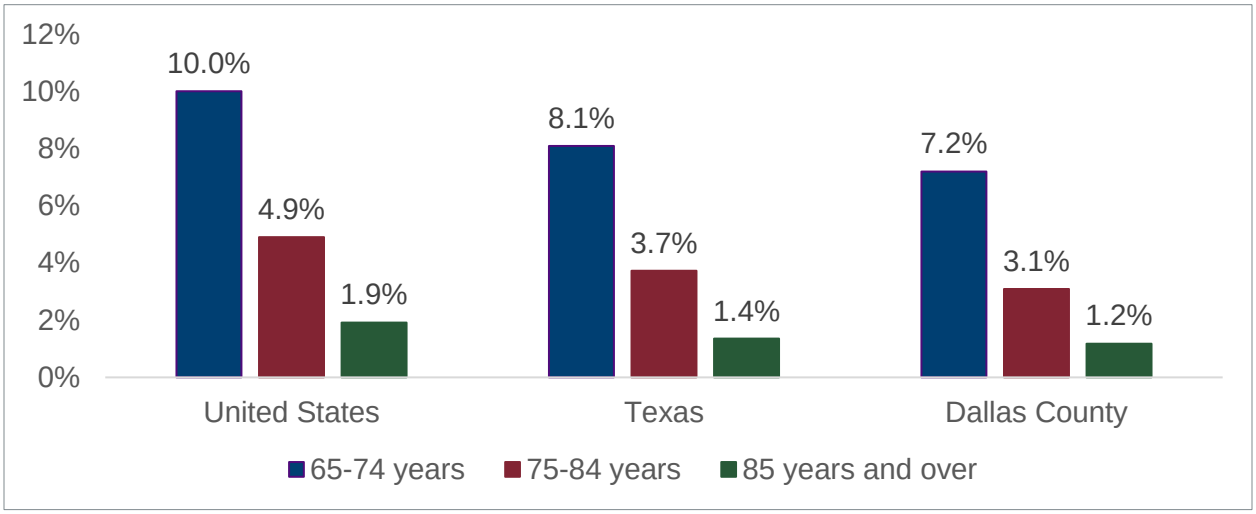


Data Source: Parkland EHR

4. Older Adults in Dallas County

Nationally, individuals aged 65 and older accounted for 25% of the U.S. population between 2019 and 2023, a proportion that is projected to continue rising. The absolute number of older adults is expected to nearly double, growing from about 58 million in 2022 to approximately 95 million by 2060.[93]

SP Figure 37: Population by Age Groups, U.S. Texas, Dallas County by Age Distribution



Data Source: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimate

The older population within the U.S. is becoming increasingly diverse. In 2022, non-Hispanic whites made up approximately 75% of those aged 65 years and older; however, this share is projected to decline to roughly 60% by 2050.[94] Correspondingly, the proportion of racial and ethnic minorities in older adults is increasing. By 2040, minorities are expected to represent roughly 34% of all older adults, up from 25% in 2022.[95]

In Dallas County, 11.5% of the total population is currently aged 65 years or older-see SP Figure 37. This percentage is expected to continue rising over the next several decades, mirroring national trends.

In Dallas County, Highland Park has the highest proportion of residents aged 65 and older at 20%, while Hutchins has the lowest at just 6.5%-see SP Figure 38.

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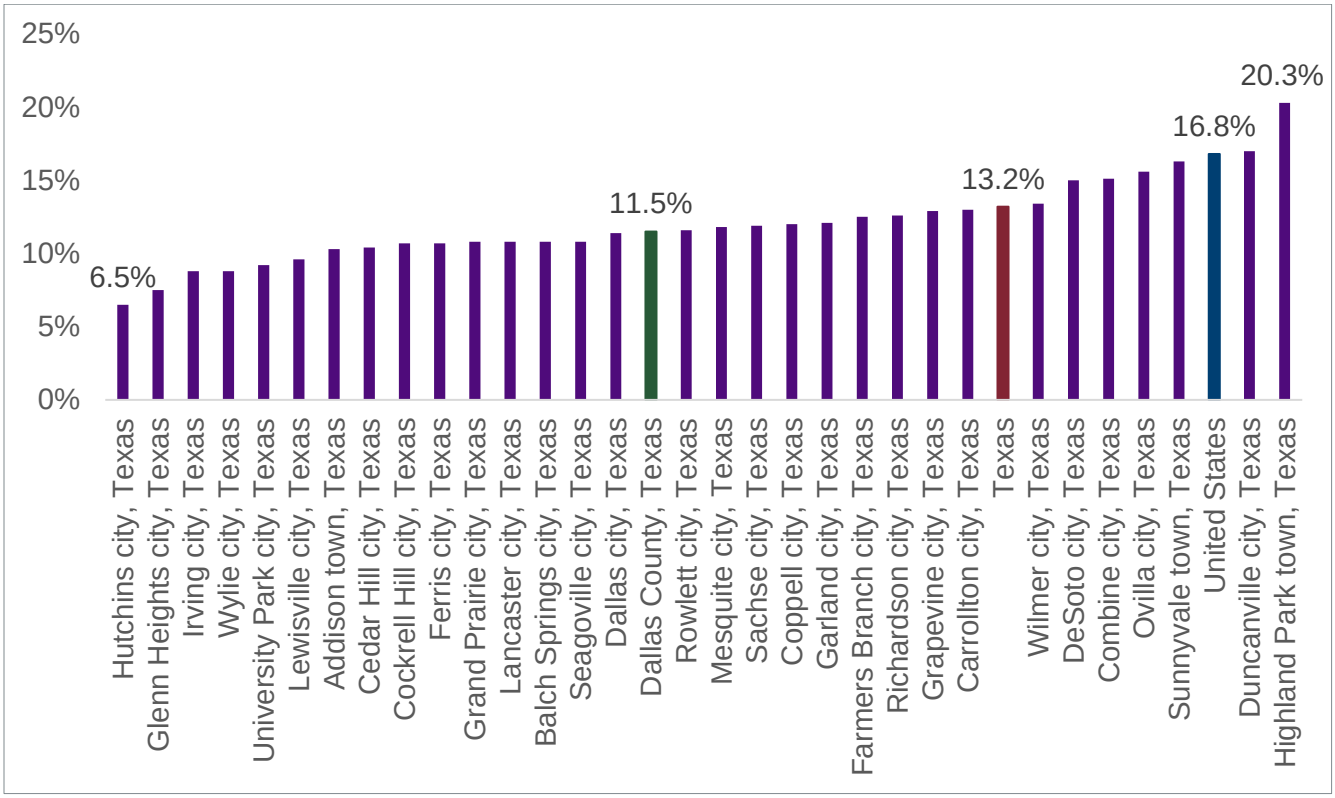
[93] The Administration for Community Living, 2023 Profile of Older Americans, Future Growth, page 5 - https://acl.gov/sites/default/files/Profile%20of%20OA/ACL_ProfileOlderAmericans2023_508.pdf

[94] Population Reference Bureau (PRB) Fact Sheet: Aging in the United States - https://www.prb.org/resources/fact-sheet-aging-in-the-united-states/#:~:text=Between%202022%20and%202050%20the%20share%20of%20the%20older%20population%20that%20identifies%20as

[95] The Administration for Community Living, 2023 Profile of Older Americans, Profile Highlights, page 5 - https://acl.gov/sites/default/files/Profile%20of%20OA/ACL_ProfileOlderAmericans2023_508.pdf

SP Figure 38: Percentage of Individuals 65 Years and Older in the U.S., Texas, Dallas County and Dallas County Cities, 2019-2023



Data Source: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates

Older adults are more likely to have at least one chronic condition, with many managing multiple diseases.[96] Specifically, elderly women and people of color are expected to bear a disproportionate burden of these health challenges.[97] Diabetes is also among the top five conditions, with the prevalence rising with age; nearly one in three adults ages 65 and older has diabetes, according to the CDC.[98]

a. Hospital Utilization by Individuals 65 years and older

In 2024, a total of 434,071 patients aged 65 years and older accessed inpatient and outpatient hospital services across Dallas County, representing nearly 22% increase since 2021.

Among older adults, Hispanic individuals had a lower utilization of inpatient and outpatient services compared to other racial and ethnic groups. The population over 65 years of age were 48% white, non-Hispanic, 25% Black or African American, non-Hispanic and 16% Hispanic patients-see SP Figure 39.

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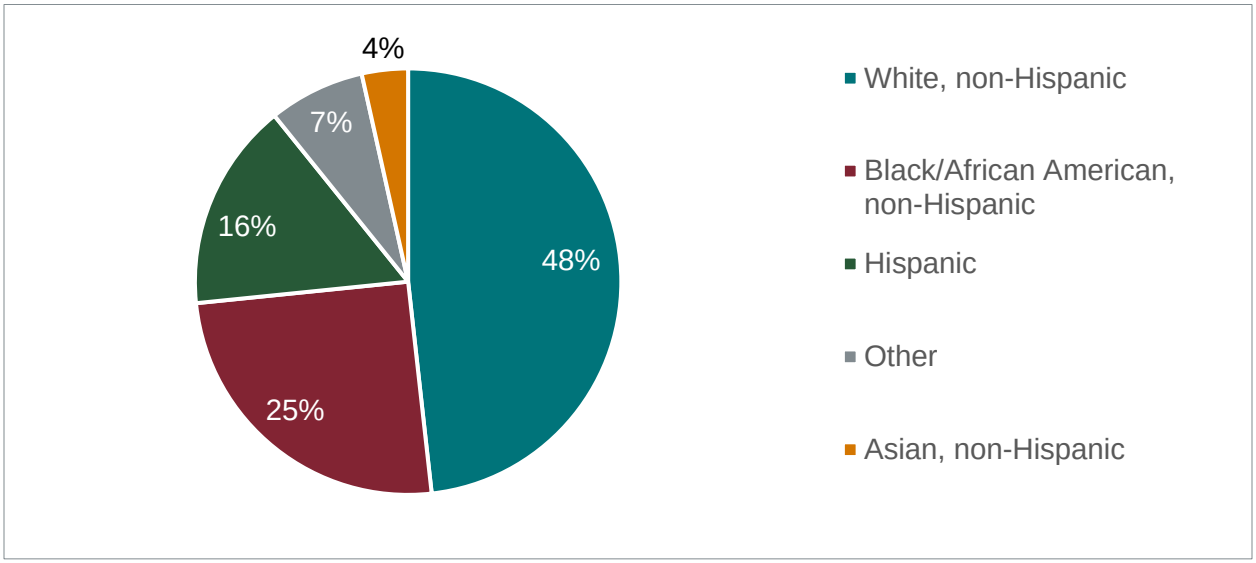
[96] The Administration for Community Living, 2023 Profile of Older Americans, Profile Highlights, page 17 - https://acl.gov/sites/default/files/Profile%20of%20OA/ACL_ProfileOlderAmericans2023_508.pdf
[97] Chronic Inequities. National Council of Aging (April 2022) - https://www.ncoa.org/article/the-inequities-in-the-cost-of-chronic-disease-why-it-matters-for-older-adults/
[98] University of Chicago Medicine - Diabetes in older adults: Risks, treatments and health habits to know - https://www.uchicagomedicine.org/forefront/health-and-wellness-articles/diabetes-older-adults

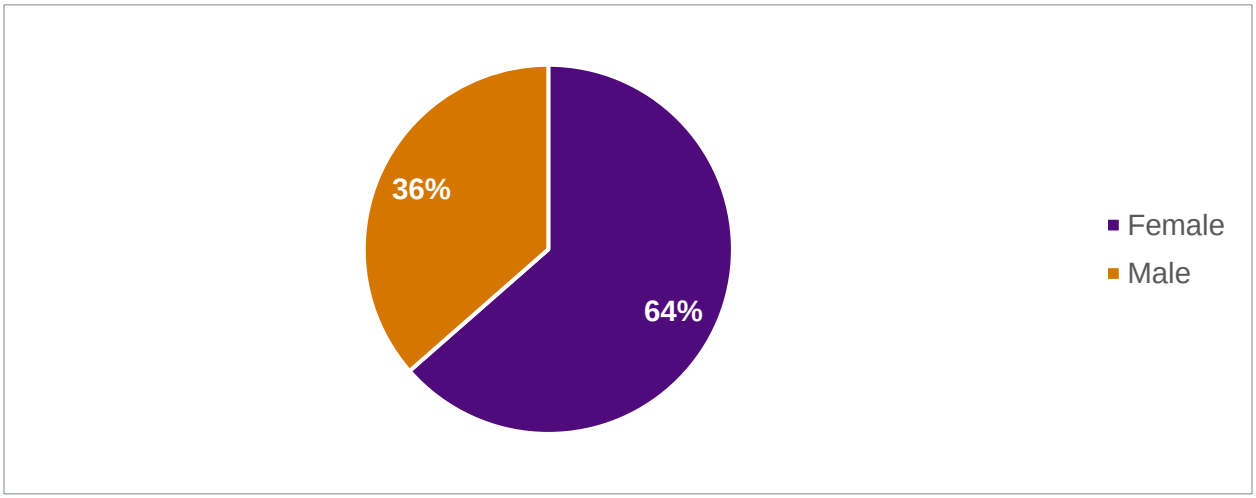
SP Figure 39: Patients 65 Years and Older by Race and Ethnicity, Dallas County, 2024



Data Source: DFWHC Foundation Regional Data, 2024

When comparing by sex, women have historically been more likely than men to access healthcare services. In Dallas County, of the population 65 years of age who accessed care, 64% are women, compared to 36% of males-see SP Figure 40.

SP Figure 40: Patients 65 years and older by Sex, Dallas County, 2024

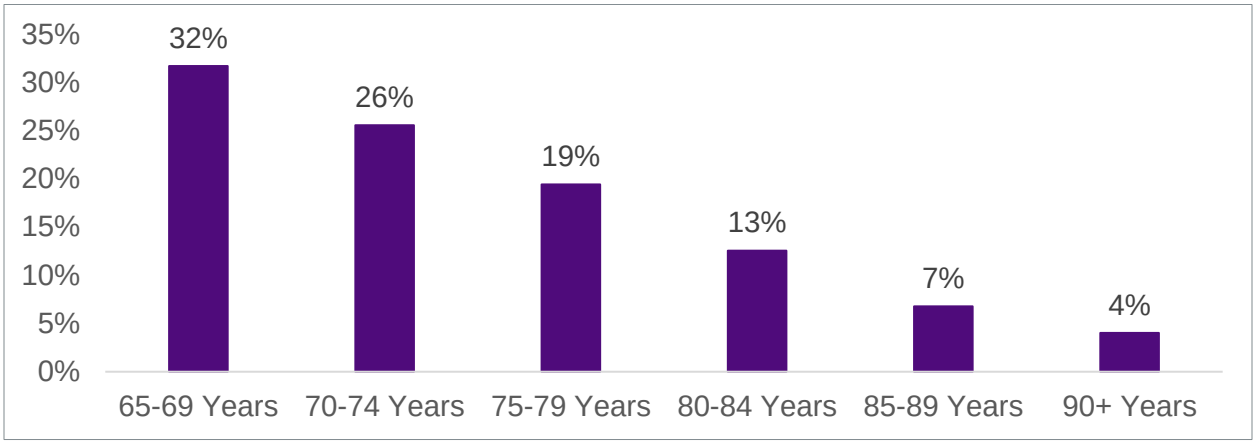


Data Source: DFWHC Foundation Regional Data, 2024

b. Health Insurance and Coverage

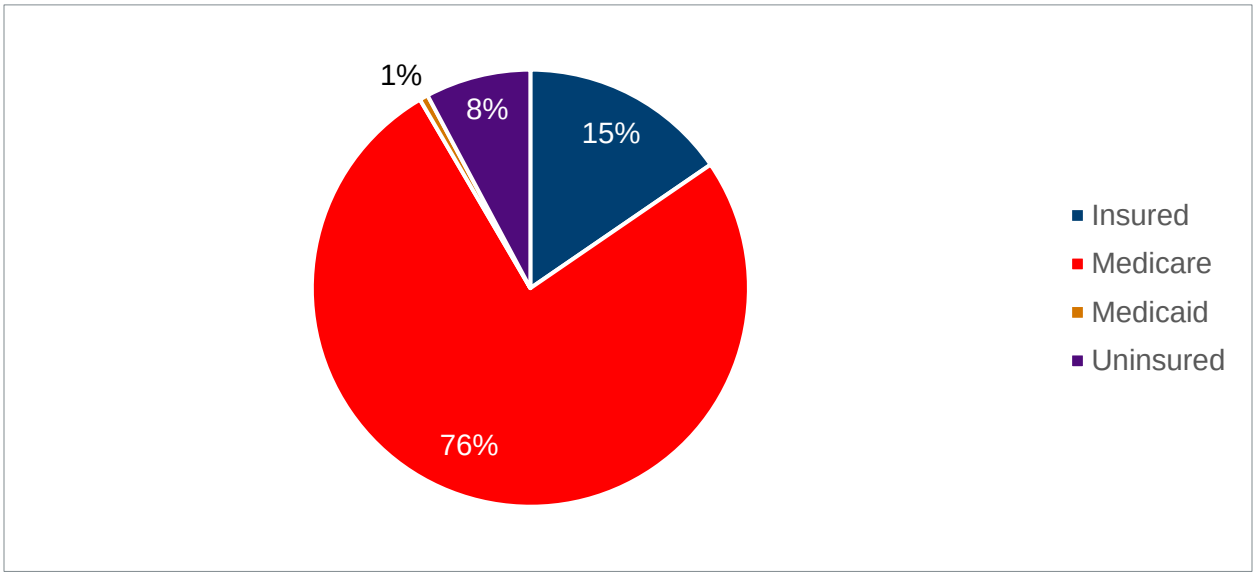
SP Figure 41 shows the age distribution of patients 65 years and above in Dallas County. The highest percentage is age-group of 65-69 years. SP Figure 42 shows that 8% of patients aged 65 and older who accessed healthcare in Dallas County were uninsured. Of those, 77% received care at Parkland, which is a 5% increase compared to 2021.

SP Figure 41: Patients 65 Years and Older by Age Distribution, Dallas County, 2024



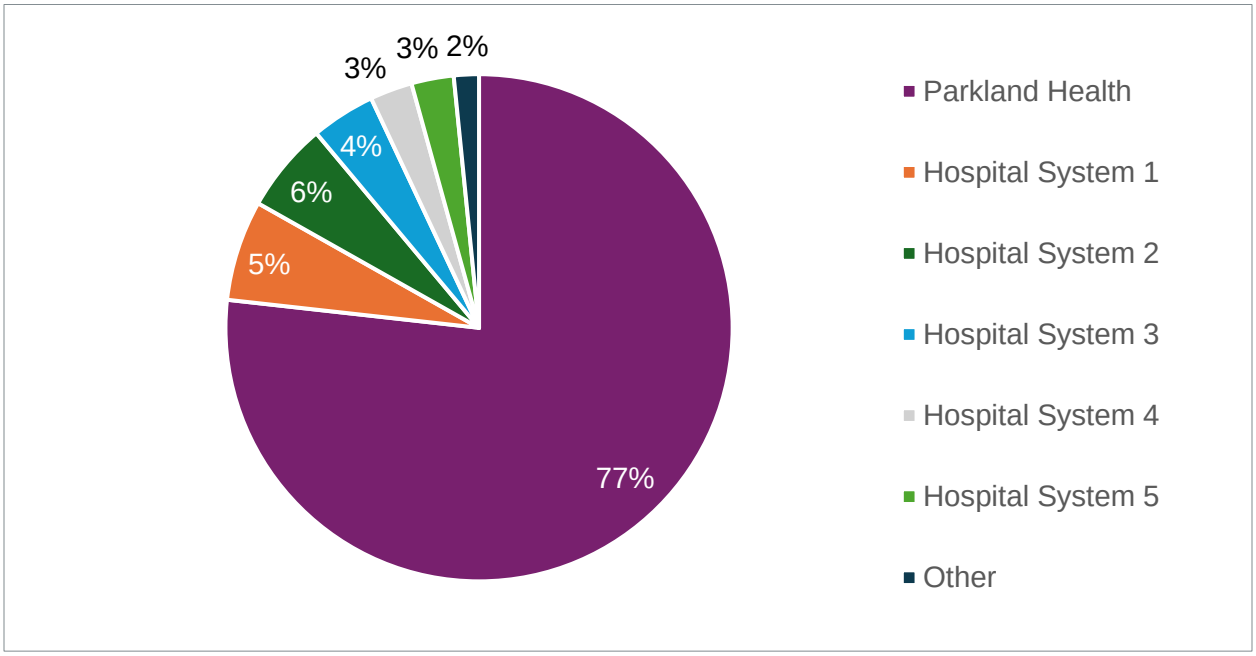
Data Source: DFWHC Foundation Regional Data, 2024

SP Figure 42: Patients 65 Years and Older by Payer Type, Dallas County, 2024



Data Source: DFWHC Foundation Regional Data, 2024

SP Figure 43: Uninsured Patients 65+ by Hospital System, Dallas County, 2024

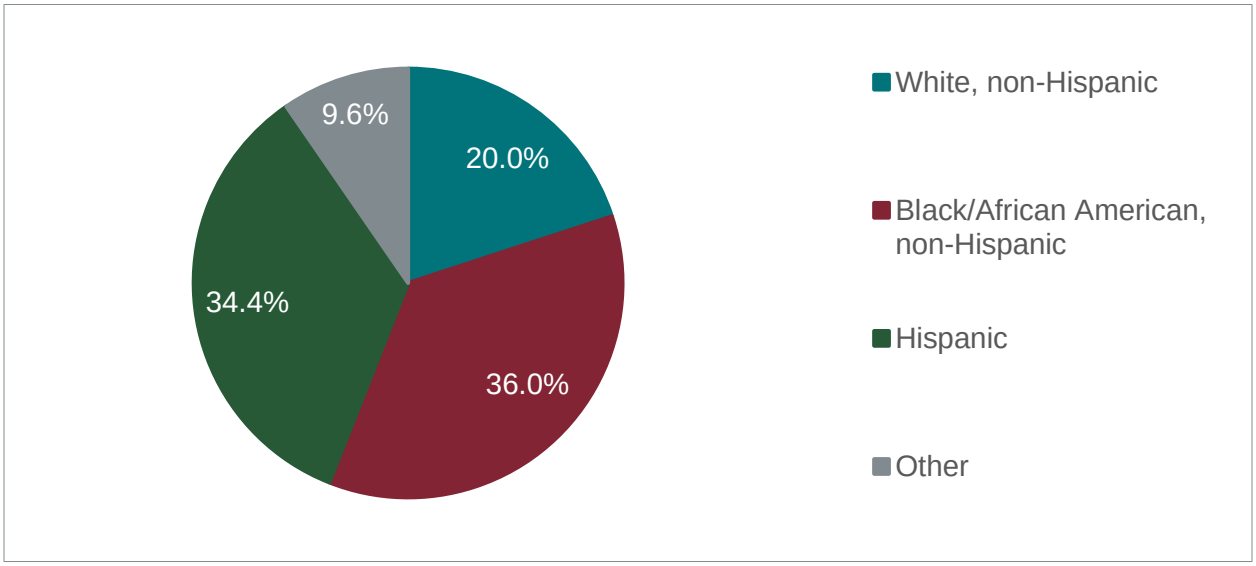


Data Source: DFWHC Foundation Regional Data, 2024

c. Parkland Older Adults and Chronic Diseases

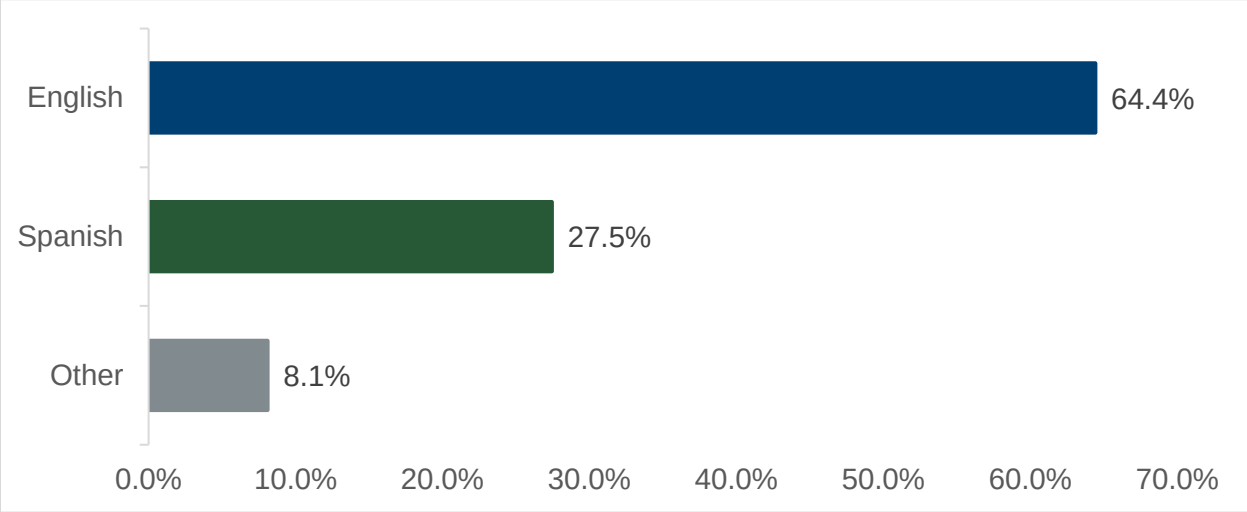
Of the total 579,582 patients listed in Parkland's chronic disease registries, 15% (87,245) are 65 years and older. Among patients with chronic diseases, 36% are Black or African American, non-Hispanic, 34% are Hispanic, and 20% are white, non-Hispanic-see SP Figure 44.

SP Figure 44: Parkland Older Adults Patients, Chronic Disease Registries by Race and Ethnicity, 2024



Data Source: Parkland Chronic Disease Registries

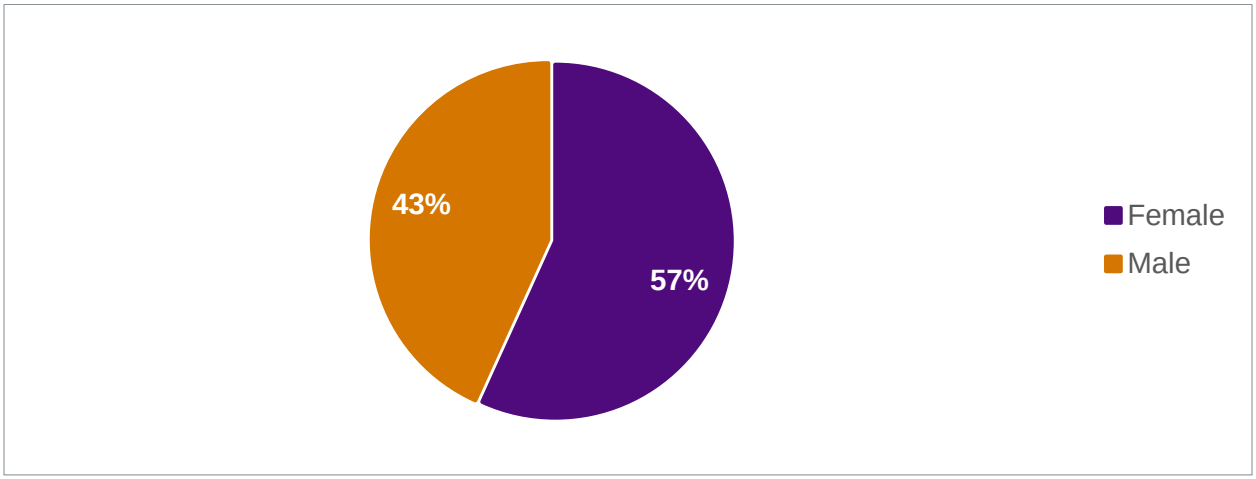
SP Figure 45: Parkland Older Adults Patients, Preferred Language, Chronic Disease Registries, 2024



Data Source: Parkland Chronic Disease Registries

Older females make up 57% of Parkland's registry population, which is higher than the 43% represented by older males-see SP Figure 46.

SP Figure 46: Parkland Older Adults Patients, Chronic Disease Registries by Sex, 2024

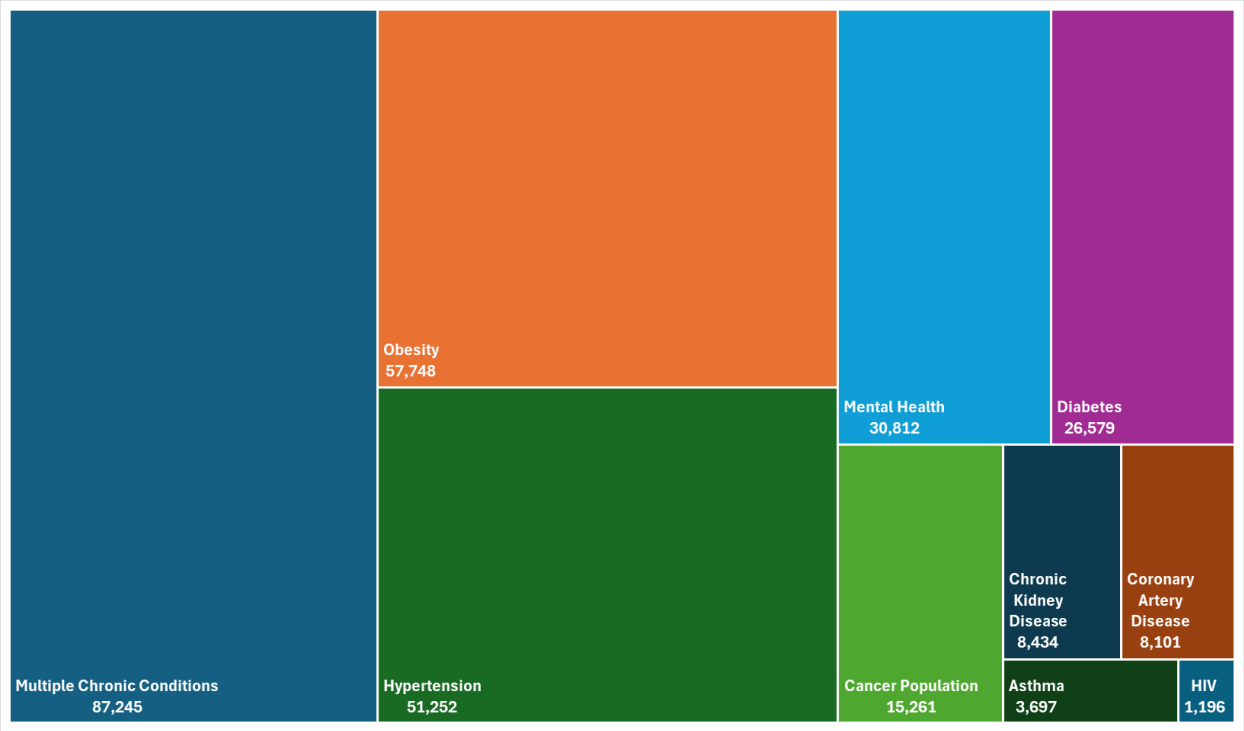


Data Source: Parkland Chronic Disease Registries

i. Chronic Diseases

In 2024, the Parkland Disease Registry reported that among adults 65 years and older, having multiple chronic conditions was the most common diagnosis, followed by obesity and hypertension-see SP Figure 47.

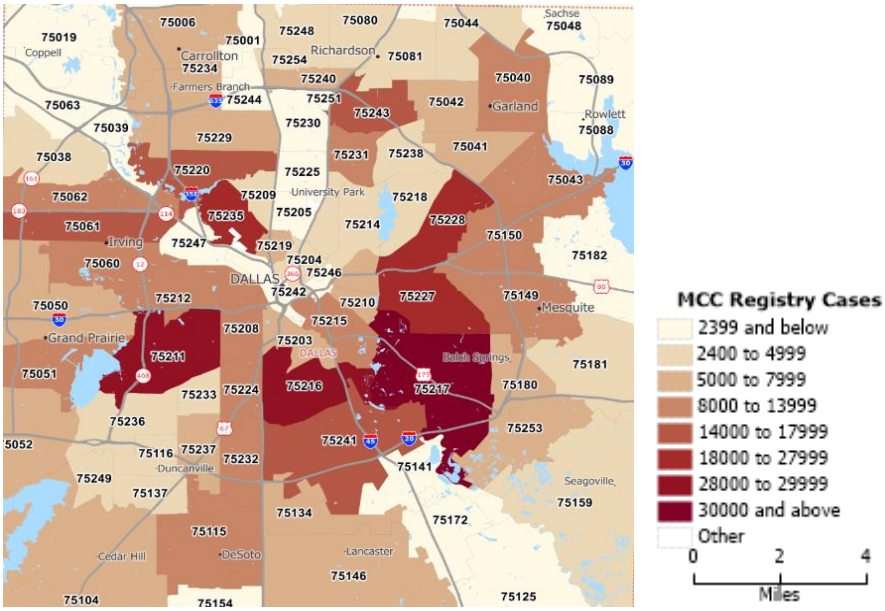
SP Figure 47: Parkland Older Adults Patient Count, Chronic Disease Registries, 2024



Data Source: Parkland Chronic Diseases Registries, 2024

The ZIP Codes with the highest number of Parkland's older adult patients with chronic disease are 75216, 75217, and 75211-see SP Figure 48.

SP Figure 48: Older Adult Chronic Disease Patients by ZIP Codes



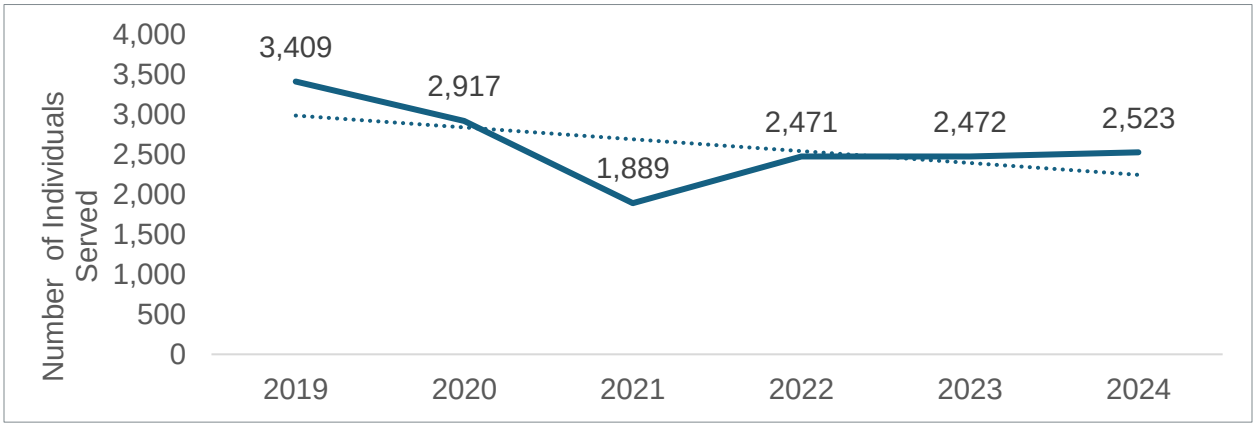
Data Source: Parkland Chronic Diseases Registries, 2024

d. Older Adults at DCHHS Senior Centers

The DCHHS OASP provides congregate meals, transportation, socialization, and wellness activities for residents ages 60+ across multiple senior center locations countywide.

From 2019–2024, the number of individuals served by OASP declined by about 26%-see SP Figure 49. This decline reflects pandemic-era disruptions to congregate programming, a slower return among high-risk older adults, and shifting preferences toward home-based services. Despite the decline, OASP remains a key touchpoint for nutrition, socialization, and preventive programming for seniors.

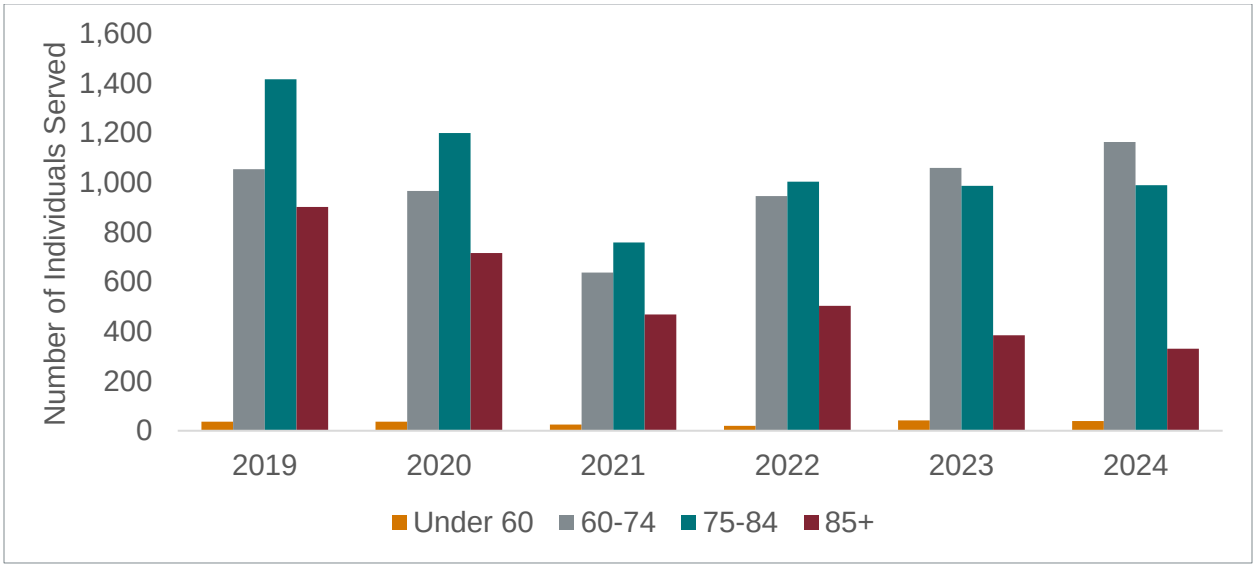
SP Figure 49: OASP Clients Served



Data Source: OASP Client Data

As per SP Figure 50, the age range with the most individuals served was the 75-84 age group from 2019-2022; however, this trend fell off from 2023-2024, where the 60-74 group became the age range with the most individuals served. This pivot suggests earlier engagement with younger seniors and may reflect both lingering COVID-19 caution among the oldest residents and new enrollees aging into services.

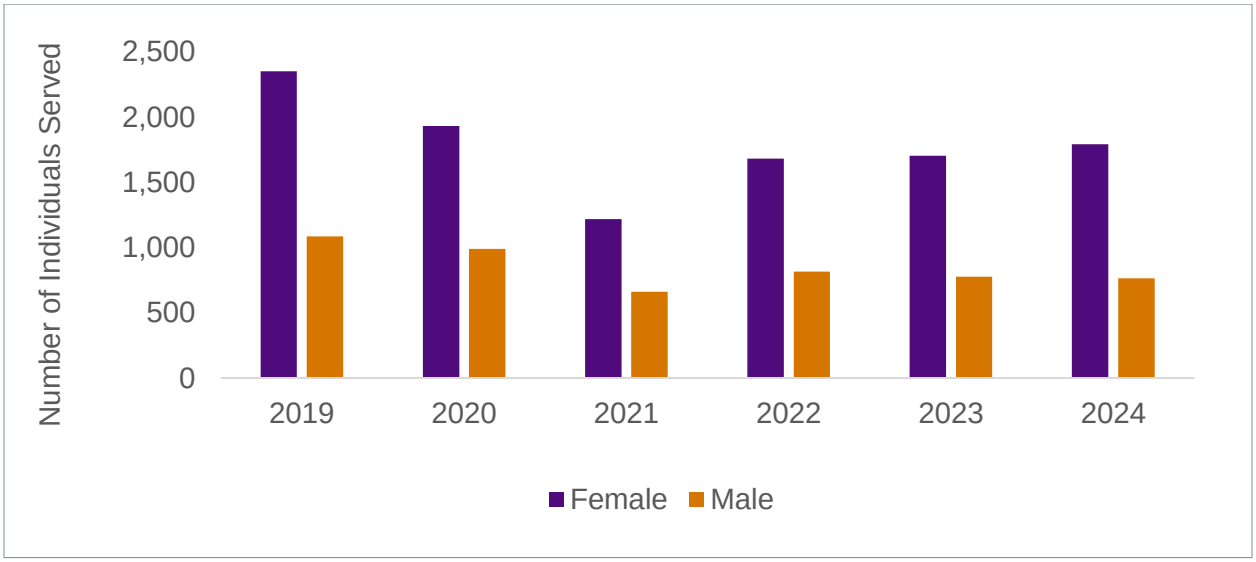
SP Figure 50: OASP Number of Individuals Served by Age, 2019-2024



Data Source: OASP Client Data

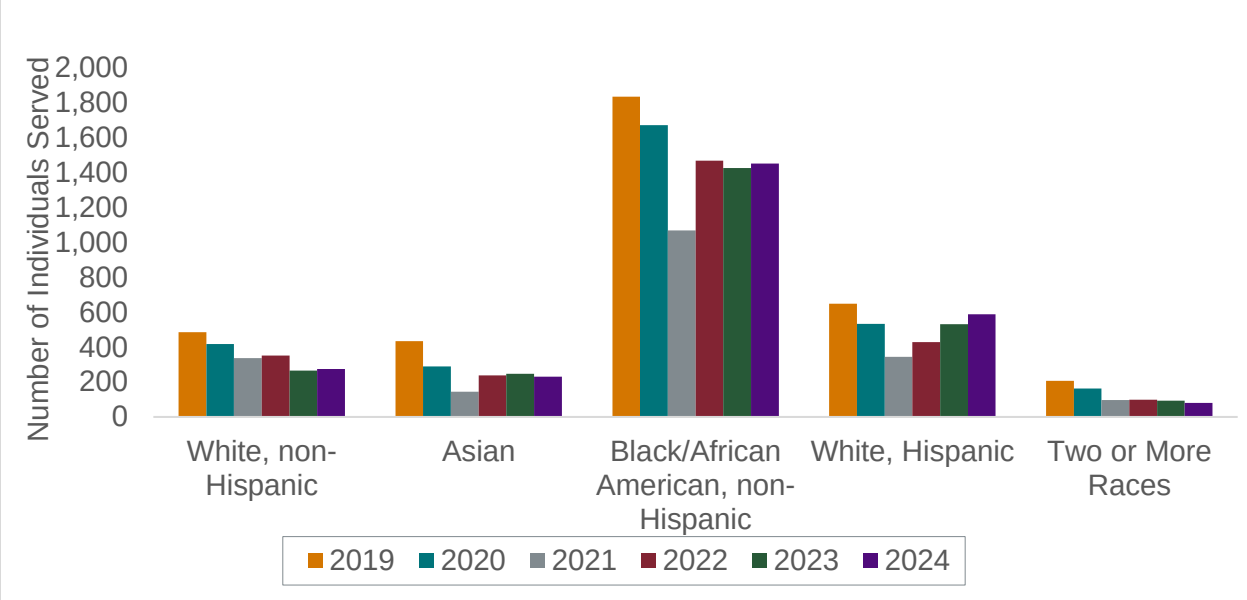
Across 2019–2024, females overwhelmingly comprised most participants-see SP Figure 51. By race/ethnicity, Black or African American, non-Hispanic adults were the largest group served, followed by white, Hispanic older adults-see SP Figure 52. These patterns mirror countywide inequities documented in the CHNA and point to OASP's role as a safety-net resource for historically underserved populations.

SP Figure 51: OASP Number of Individuals Served by Sex, 2019-2024



Data Source: OASP Client Data

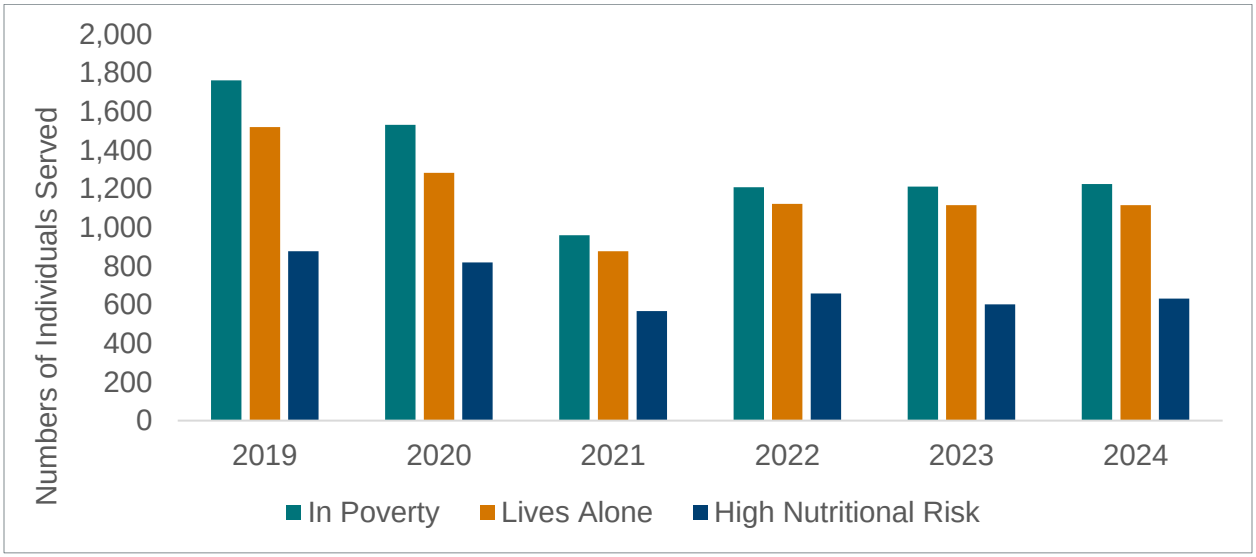
SP Figure 52: OASP Number of Individuals Served by Race, 2019-2024



Data Source: OASP Client Data

Some notable considerations that may add risk for elderly populations are poverty, those who live alone, and those who are at nutritional risk. Notably, from 2019-2024 the most common at-risk consideration was older adults living in poverty, though living alone followed closely behind- see SP Figure 53.

SP Figure 53: OASP of Individuals Served by At Risk Considerations, 2019-2024



Data Source: OASP Client Data

E. Mental Wellness and Behavioral Health

Behavioral health encompasses the mental, emotional, and social well-being of individuals, as well as the behaviors that influence overall wellness. This broad field includes mental health conditions, SUD, suicidal thoughts and behaviors, and psychological distress. Understanding behavioral health is crucial, as it directly influences how people think, feel, and act in their daily lives.

Mental health and substance use are integral components of behavioral health. Mental health pertains to an individual's emotional, psychological, and social well-being, affecting how they handle stress, relate to others, and make decisions. Substance use involves the consumption of alcohol, drugs, or other substances that can lead to disorders impacting mental and physical health. These issues are interconnected; for instance, mental health conditions can increase the risk of SUD, and vice versa.

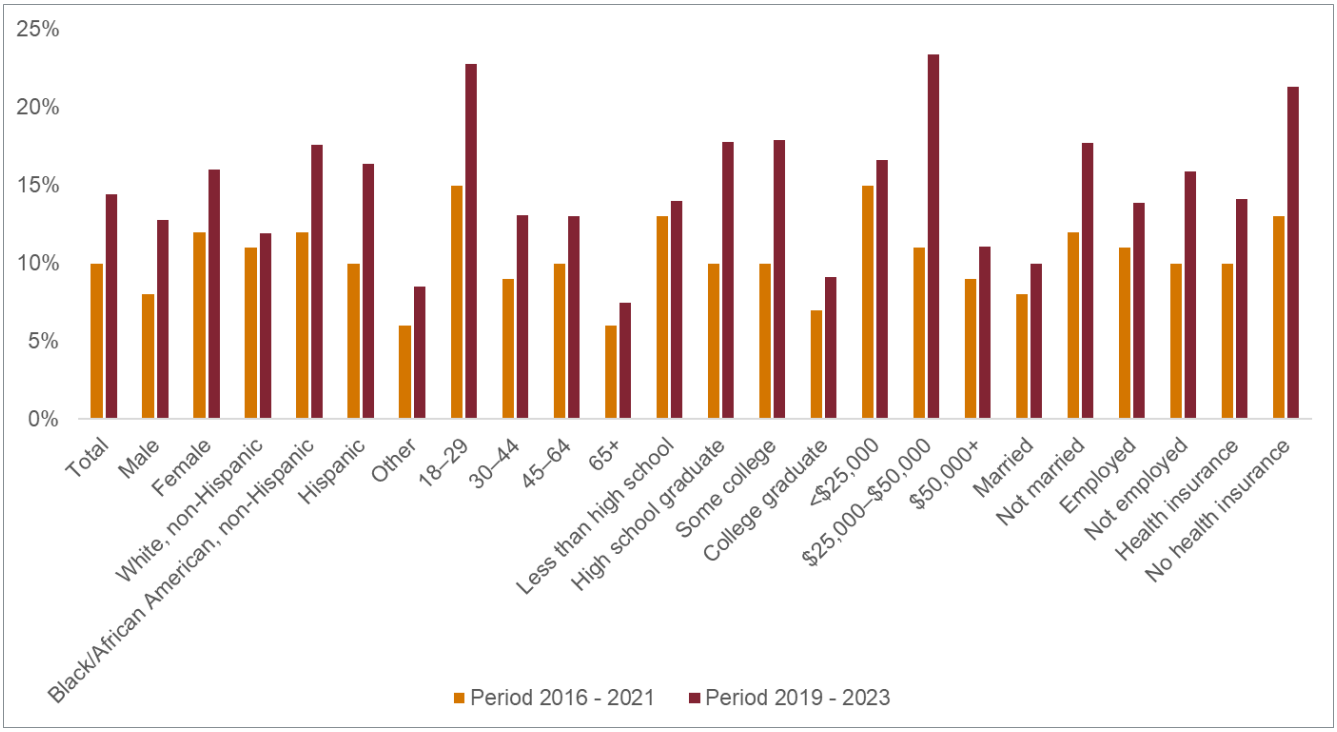
Recent data by the CDC shows that the U.S. is experiencing a mental health crisis. One in five American adults report symptoms of anxiety and depression, and two in five high school students report struggling with persistent feelings of sadness and hopelessness[99]. In Dallas County, mental health indicators have worsened significantly in recent years. According to the BRFSS, in the 2016 – 2021 period, 10% of residents reported experiencing poor mental health for 14 or more days which increased to 14.4% in the 2019–2023 period, a 44% increase. Notably, young adults aged 18-29 years experienced the highest increase from 15.0% to 22.8%, a 52% increase. Other demographic groups with an increase in poor mental health include residents with annual income between $25,000-$50,000, from 11.0% to 23.6%, a 113% increase, those with no health insurance from 13.0% to 21.2%, a 63% increase, and married individuals from 8.0% to 11.0%, a 38% increase. These trends highlight a growing and widespread mental health concern across all demographics in Dallas County-see MW/BH Figure 1.

In 2024, 23.4% of adults nationwide experienced any mental illness.[100] While Dallas County reported a lower rate of poor mental health at 14%, the 44% increase from 2019 to 2023 indicates a concerning upward trend—contrary to the national pattern, which has shown signs of improvement over time.

[99] Centers for Disease Control and Prevention. About mental health. CDC. Published August 8, 2024. Accessed May 16, 2025. https://www.cdc.gov/mental-health/about/index.html

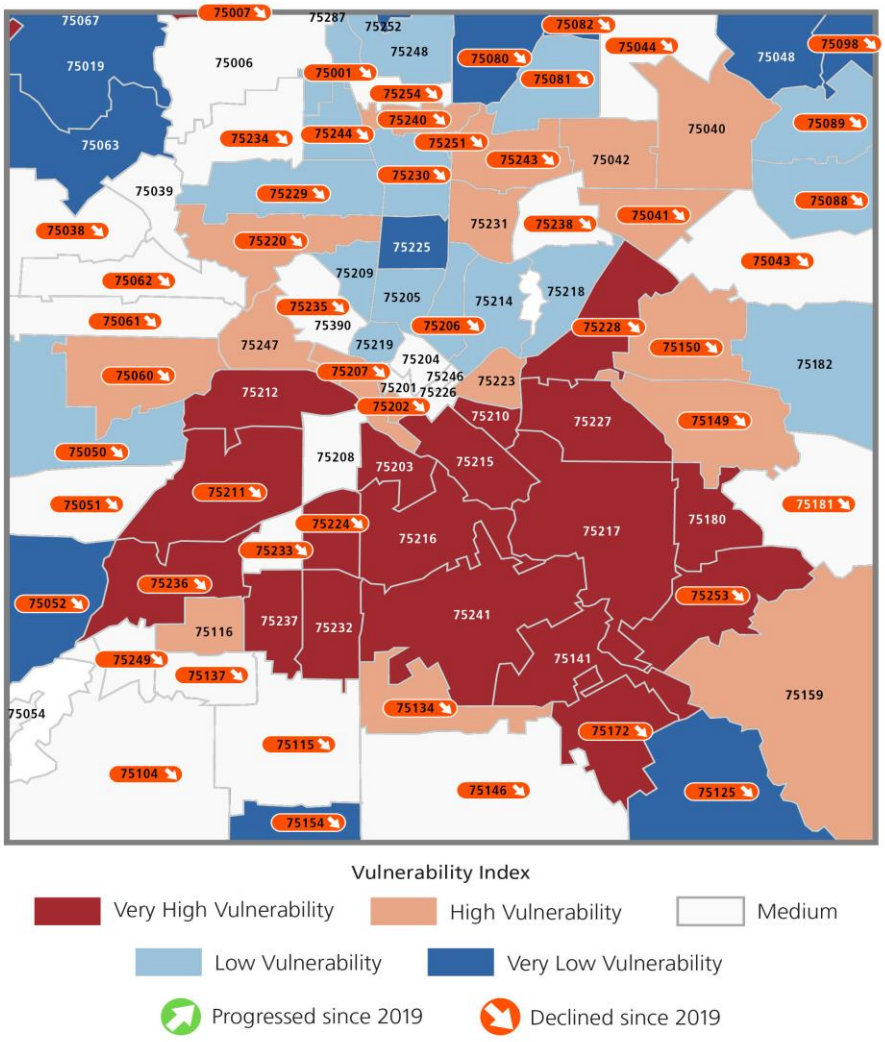
[100] Substance Abuse and Mental Health Services Administration. 2024 NSDUH Annual National Report. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2025. Accessed October 9, 2025. https://www.samhsa.gov/data/report/2024-nsduh-annual-national-report .

MW/BH Figure 1:Percent of Residents Reporting Poor Mental Health for 14+ Days by Sociodemographic Category, Dallas County, 2016 - 2020 vs. 2019 – 2023



Data Source: Center for Health Statistics BRFSS 2016-2020 and 2019 - 2023, Texas Department of State Health Services.

MW/BH Figure 2: Behavioral Health/Mental Health Trends by ZIP Code, Dallas County, 2019 - 2022

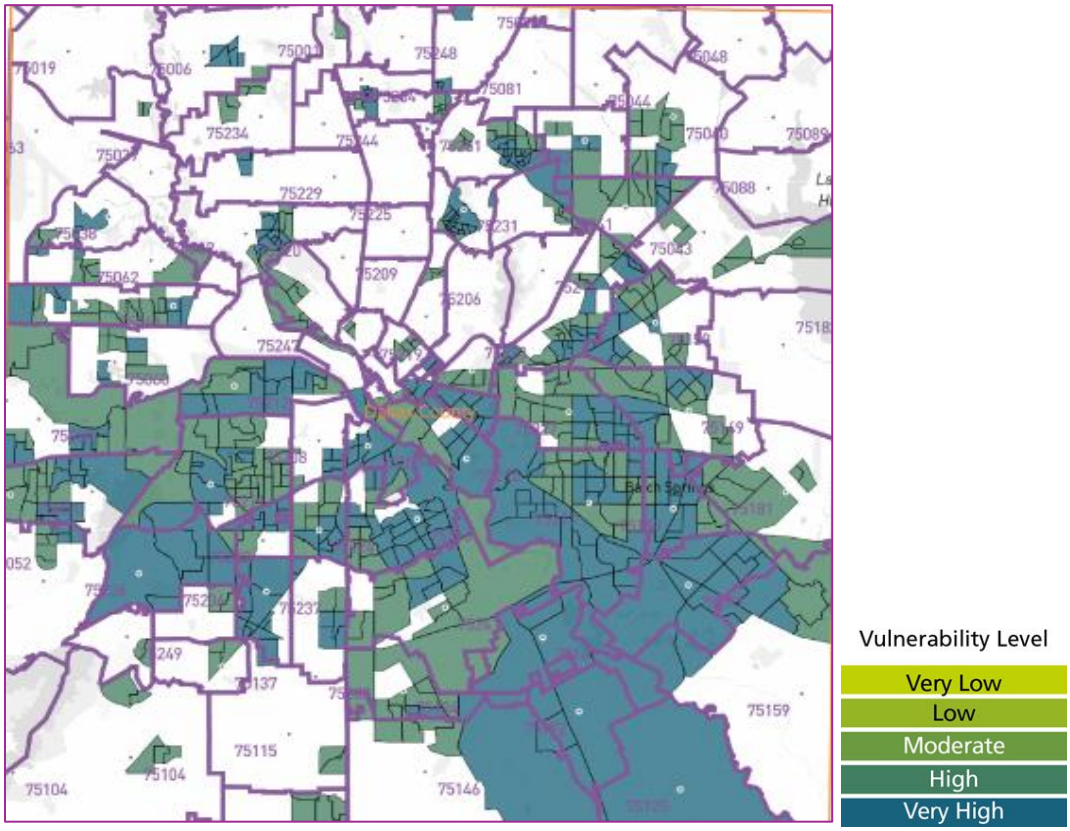


Data Source: Prepared by PCCI, 2025

MW/BH Figure 2 illustrates changes in the rate of adults aged 18 and older who reported that their mental health, including experiences of stress, depression, and emotional challenges, was “not good” for 14 or more days in the past 30 days, across ZIP Codes in Dallas County from 2019 to 2023. While 60% of ZIP Codes showed a statistically significant decline in mental health—marked with orange labels—none showed measurable improvement, underscoring the ongoing need to address mental health challenges across the county. The map also features a mental wellness Vulnerability Index, ranging from very high (dark red) to very low (dark blue). Notably, ZIP Codes 75172, 75211, 75224, 75228, 75236, and 75253, which have historically exhibited high vulnerability experienced further declines, highlighting areas of persistent concern and the need for targeted behavioral health interventions.

MW/BH Figure 3 presents the current mental health vulnerability landscape in Dallas County as of 2025, using a color gradient from green to dark blue to indicate increasing levels of mental wellness vulnerability. Unlike the trend map, this figure does not show changes over time but instead provides a snapshot of present-day risk levels across census tracts.

MW/BH Figure 3: Behavioral Health/ Mental Health Vulnerability by Census Track, Dallas County, 2025



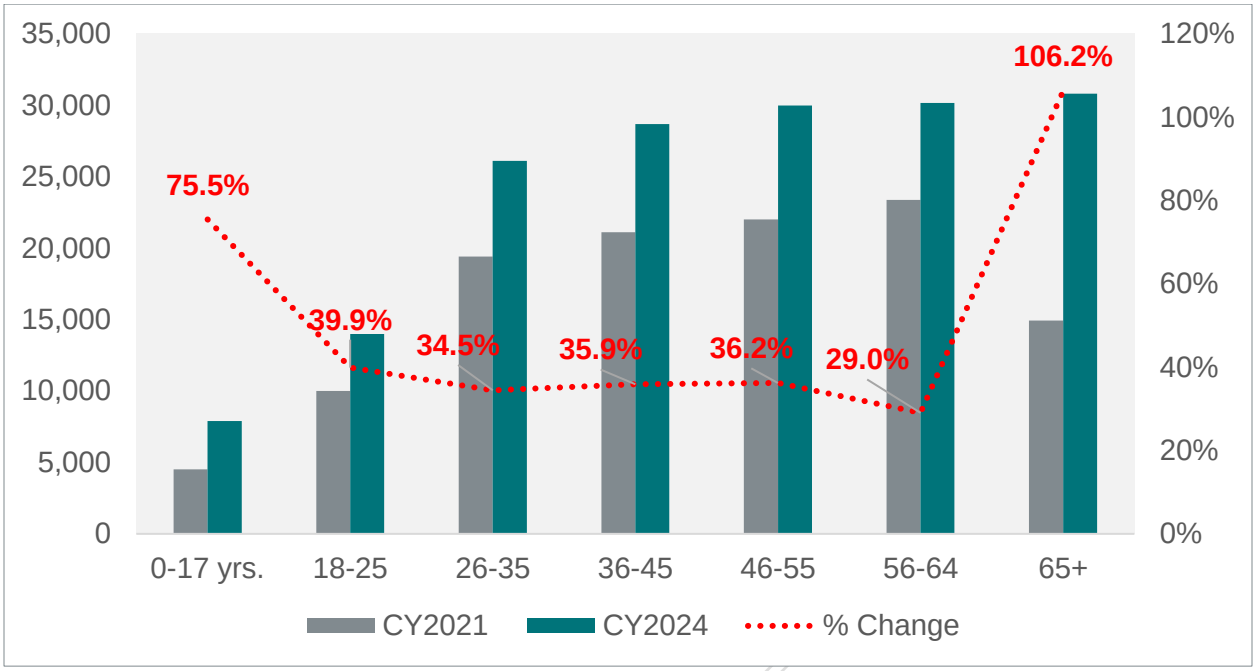
Data Source: CVC, PCCI

1. Clinical and Demographics Trends

a. Parkland Registry Data

The impact of mental health issues on Parkland's patients is described in MW/BH Figure 4. Between 2021 and 2024, the number of patients with mental health related issues increased 30% or more across all age groups; the age groups with the most increase were individuals 0 – 17 years old (75.5%) and individuals 65 years and older (106%). Young adults (18–25) saw a 40% rise, while adults aged 26–64 experienced more moderate growth (29%–36%).

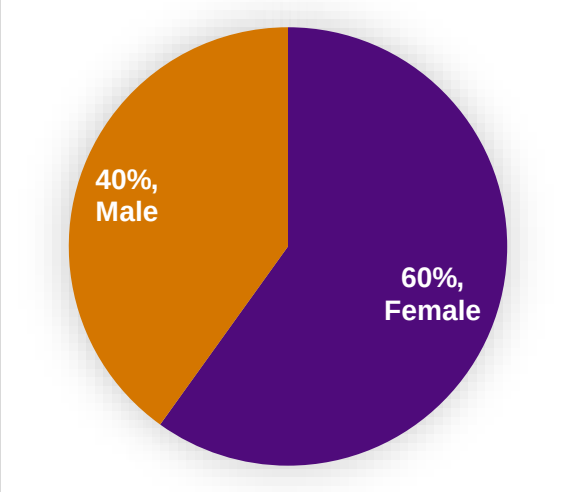
MW/BH Figure 4: Number and Percent of Parkland Patients Reporting- Behavioral Health/Mental Health Issues in Patient Registry by Age Group, 2021 vs 2024



Data Source: Parkland EHR Behavioral Health/Mental Health Registry

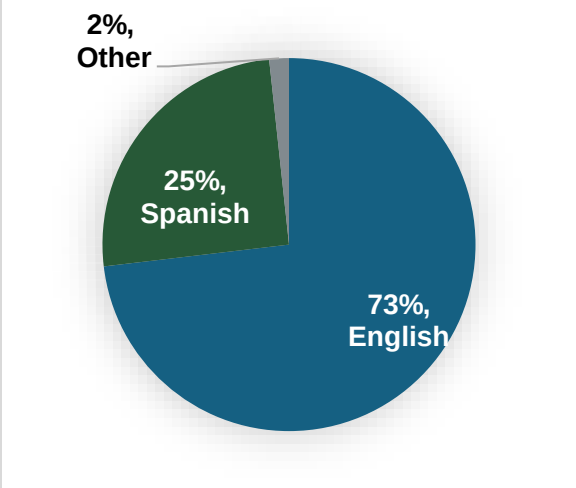
In 2024, females made up nearly 60% of the registry-see MW/BH Figure 5, indicating possible gender differences in prevalence or help-seeking behavior. Additionally, 25.2% of patients identified as Spanish speakers, reflecting the importance of culturally and linguistically tailored mental health services, a sentiment supported by focus group input.

MW/BH Figure 5: Parkland Patients, Behavioral Health/Mental Health Registry by Sex, 2024



Data Source: Parkland EHR Behavioral Health/Mental Health Registry

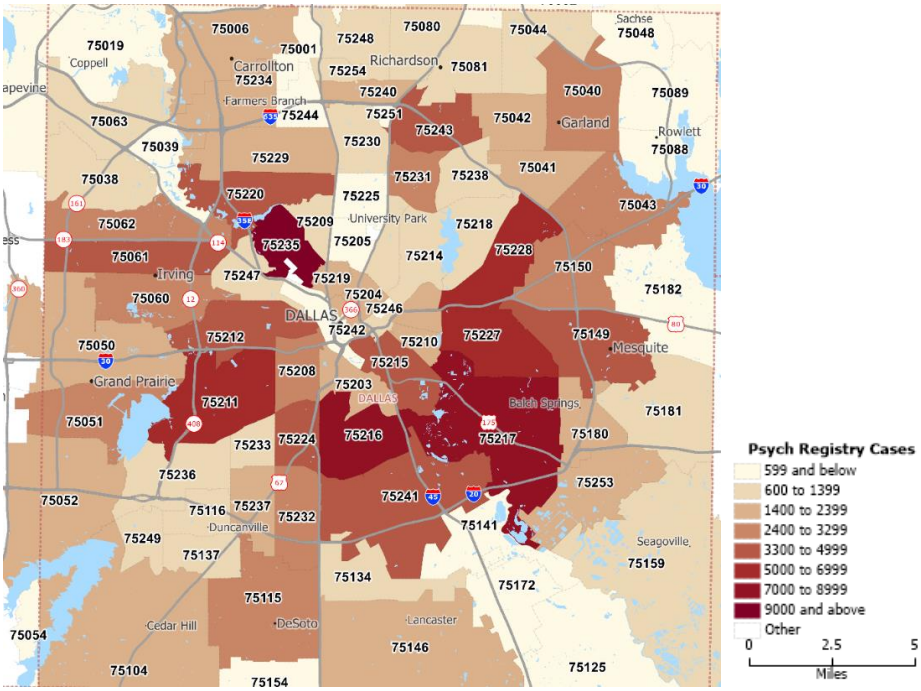
MW/BH Figure 6: Parkland Patients, Preferred Language, Behavioral Health/Mental Health Registry, 2024



Data Source: Parkland EHR Behavioral Health/Mental Health Registry

MW/BH Figure 7 displays a map of ZIP Codes shaded by the concentration of Parkland patients with mental health conditions, with darker areas representing higher patient counts. The darkest regions, particularly ZIP Codes 75235, 75217, 75216, and 75227, are located in central and southern Dallas. These ZIP Codes align closely with those identified as having high mental health vulnerability, as anticipated.

MW/BH Figure 7: Parkland Patients by ZIP Code, Mental Health Registry, 2024



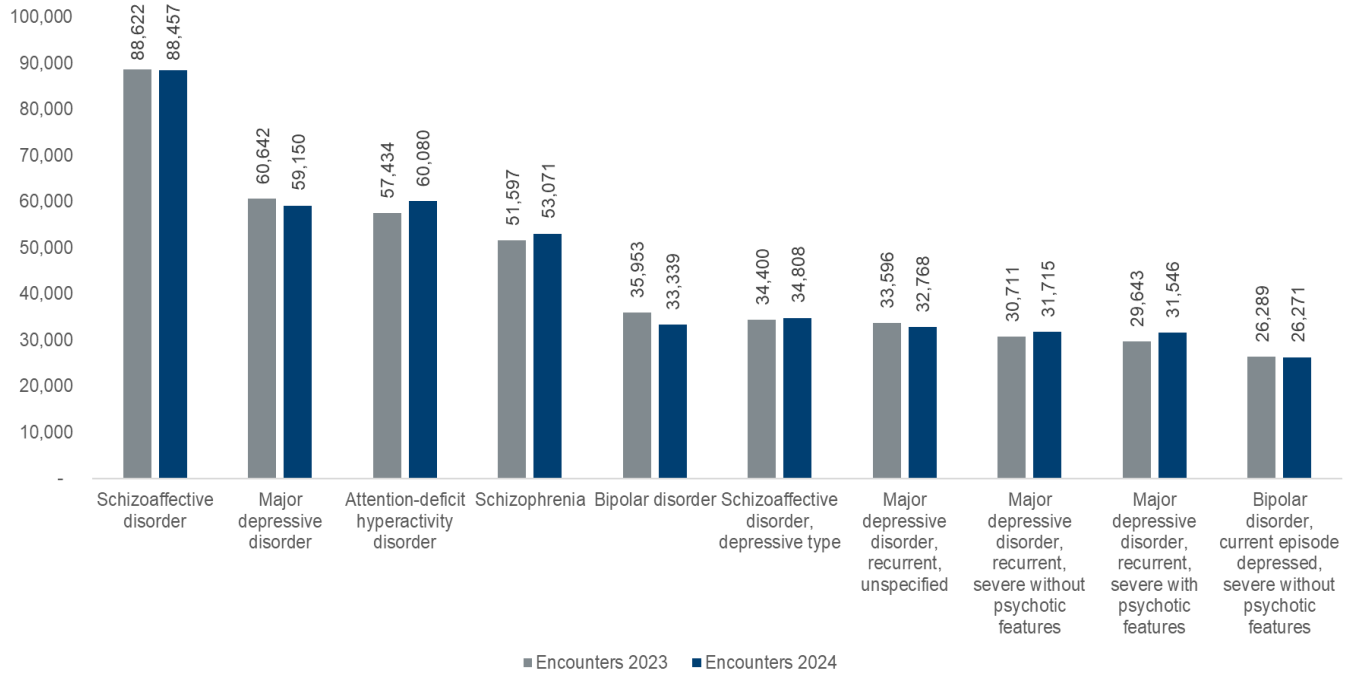
Data Source: Parkland EHR Mental Health Registry, 2024

b. North Texas Behavioral Health Authority (NTBHA)

NTBHA is the local Behavioral Health Authority in Dallas County and in five additional North Texas counties. In this role, NTHBA contracts with the Texas HHSC to administer publicly funded mental health and substance use services. NTBHA is a CCBHC, i.e. Certified Community Behavioral Health Clinic, a designation that ensures access to coordinated, comprehensive behavioral health care. CCBHCs are required to serve anyone seeking mental health or substance use services—regardless of ability to pay, place of residence, or age—and provide developmentally appropriate care for children and youth. NTBHA leverages these roles, along with other service-specific HHSC contracts, to deliver an array of services and manage a network of contracted organizations. Between 2023 and 2024, NTBHA continued its mission to provide accessible, coordinated care for individuals experiencing mental health and substance use challenges.

The utilization data below for the NTBHA represents a snapshot of the mental health services provided. MW/BH Figure 8 shows the top 10 diagnoses among individuals who received services in 2023 and 2024 in the NTHBA system. The count is based on the number of encounters with each diagnosis and provides insight into the intensity of each diagnosis within the NTBHA network.

MW/BH Figure 8: Top Ten Mental Health Services Encounters, NTBHA, Dallas County, 2023 – 2024



Data Source: NTBHA

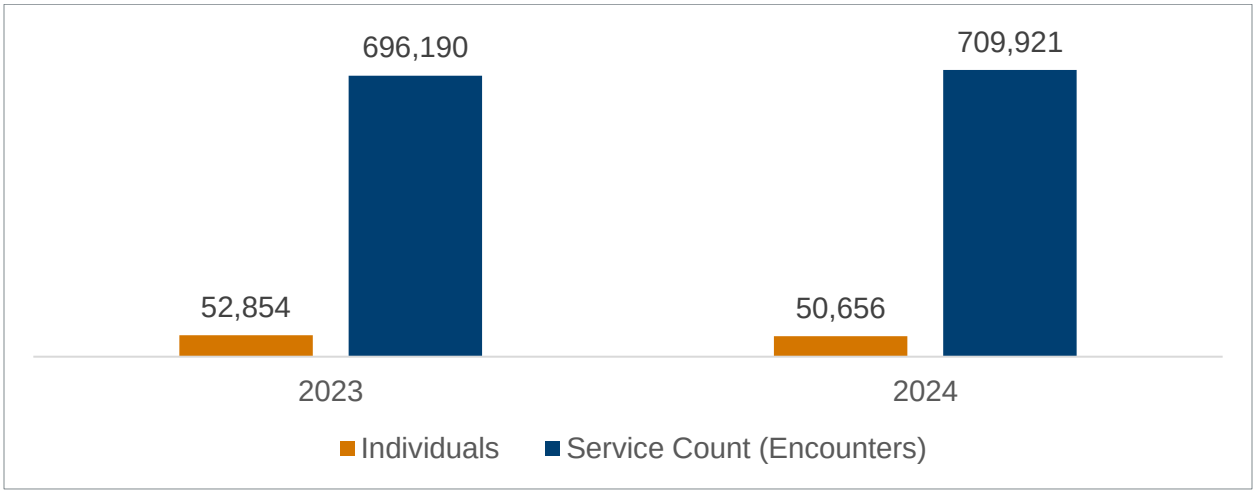
Between 2019 and 2021, the most frequently diagnosed mental health conditions within NTBHA's service area included major depressive disorder (recurrent episode), ADHD, and schizoaffective disorder (bipolar type).[101] By 2023 and 2024, the rankings shifted notably. Schizoaffective disorder rose to the top position, overtaking major depressive disorder. ADHD, which had consistently ranked second, dropped to third place. These changes reflect evolving patterns in diagnosis and service utilization, possibly influenced by shifts in community needs, provider focus, or broader public health trends. The most significant changes in ranking were seen in schizoaffective disorder, major depressive disorder, and ADHD, each adjusting their position among the top three diagnoses over the five-year span.

NTBHA measures both the volume of behavioral health services provided; and the number of individuals authorized to receive those services. In 2023, NTBHA recorded 696,190 service encounters across its network, supporting 52,854 individuals. By 2024, the total number of service encounters increased to 709,921. However, the number of individuals authorized for services declined to 50,656, suggesting a shift toward more intensive or repeated service utilization among a slightly smaller population. This trend may indicate increased acuity or

[101] Parkland Health; Dallas County Health and Human Services**.** *2022 Community Health Needs Assessment*. Parkland Health. Published 2022. Accessed August 15, 2025. https://www.parklandhealth.org/pdf-files/2022-chna-implementation-plan-2

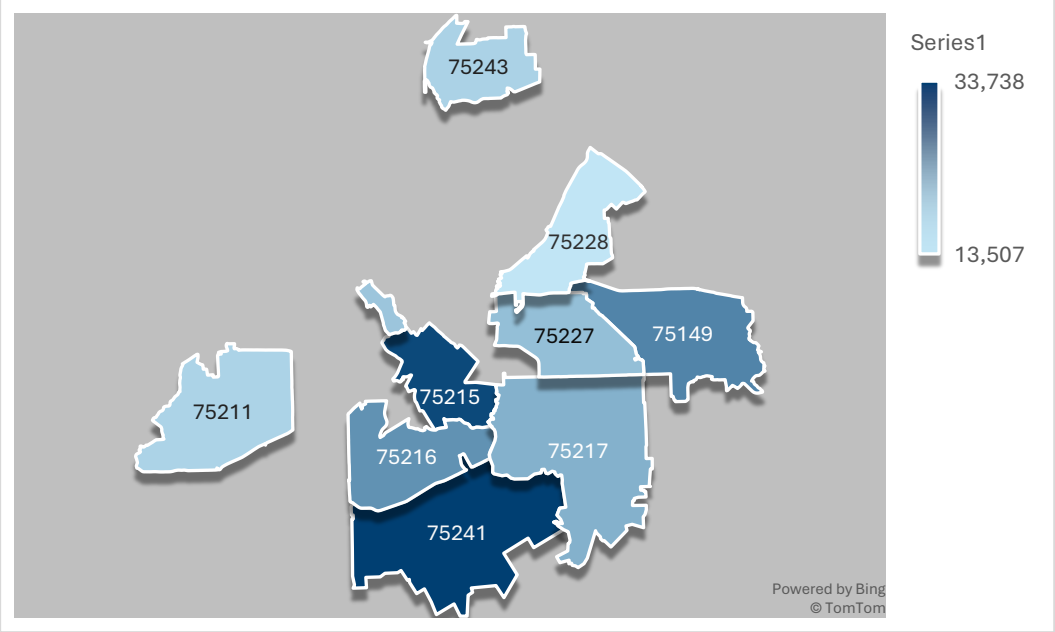
complexity of needs among clients, as NTBHA continues to respond to evolving behavioral health demands across its service area.

MW/BH Figure 9: Mental Health Services Provided, NTBHA, Dallas County, 2022 - 2024



Data Source: NTBHA

MW/BH Figure 10: Top 10 Home ZIP Codes for NTBHA individuals, Dallas County, 2024



Data Source: NTBHA

The map in MW/BH Figure 10 illustrates the 10 ZIP Codes in Dallas County with the highest volume of patients served by NTBHA, using a color gradient where darker shades represent greater service utilization. Prominent among these are ZIP Codes 75215, 75216, and 75241, located in the southern sector of the county. These areas not only show high volumes of mental health service usage but also have a historical pattern of elevated vulnerability for poor mental

health outcomes. This overlap underscores the importance of sustained, targeted behavioral health interventions in these communities to address long-standing disparities

2. Substance Abuse Disorder

Substance use refers to the consumption of alcohol or drugs that can lead to health complications, disabilities, or difficulties fulfilling responsibilities at work, school, or home. When use becomes recurrent and results in significant impairment, it may be classified as a SUD. In 2023, an estimated 48.5 million individuals aged 12 or older in the U.S., representing 17.1% of the population, had experienced SUD within the past year.[102]

a. Overdose Mortality

In 2023, approximately 54.2 million Americans aged 12 or older needed treatment for SUD, yet only 12.8 million received it. Drug overdose deaths, largely preventable, are a leading cause of premature mortality. In Dallas County, the impact has been particularly alarming between 2016 and 2023 as confirmed drug overdose deaths increased by 99%-see MW/BH Figure 11. Most of these deaths were accidental, rising by 112% during the same period, while overdose deaths due to suicide decreased by 24%.[103]

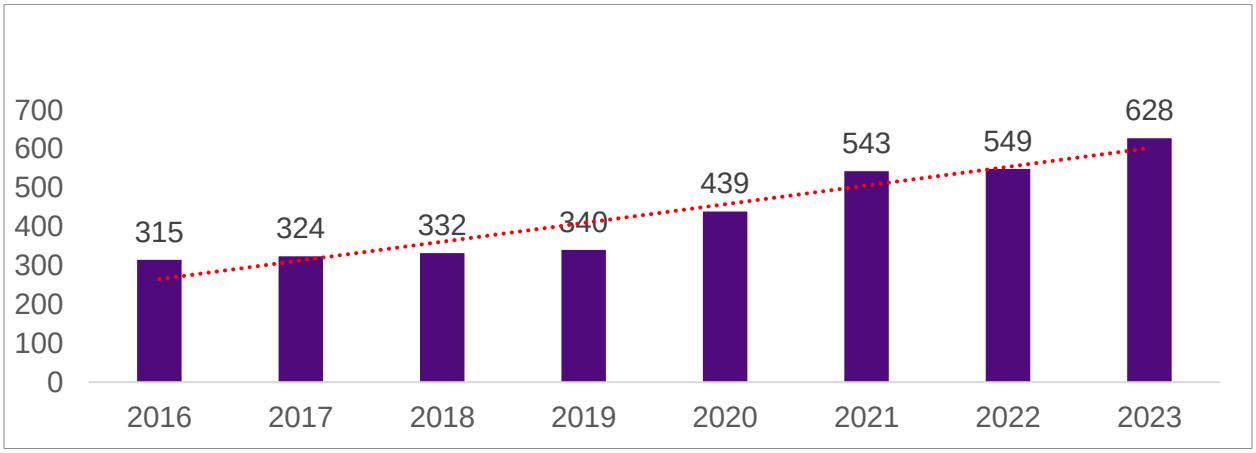
While national overdose deaths began to decline in 2023—driven by increased naloxone access and treatment investments[104]—Dallas County experienced a continued rise through 2023 before showing signs of a decline in 2024. However, fentanyl continues to be the primary driver of opioid-related deaths

[102] Centers for Disease Control and Prevention. Substance Use and Substance Use Disorder in Travelers. Published April 23, 2025. Accessed May 16, 2025. Substance Use and Substance Use Disorders in Travelers | Yellow Book | CDC

[103] Centers for Disease Control and Prevention. Overdose Prevention. Published May 14, 2025. https://www.cdc.gov/overdose-prevention/about/index.html#:~:text=Not%20all%20overdoses%20have%20to,both%20individual%20and%20community%20health.

[104] Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health. HHS Publication No. PEP25-07-007, NSDUH Series H-60. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2025. Available from: https://www.samhsa.gov/data/sites/default/files/reports/rpt56769/2024-nsduh-psr5-adult-ami-suicide.pdf

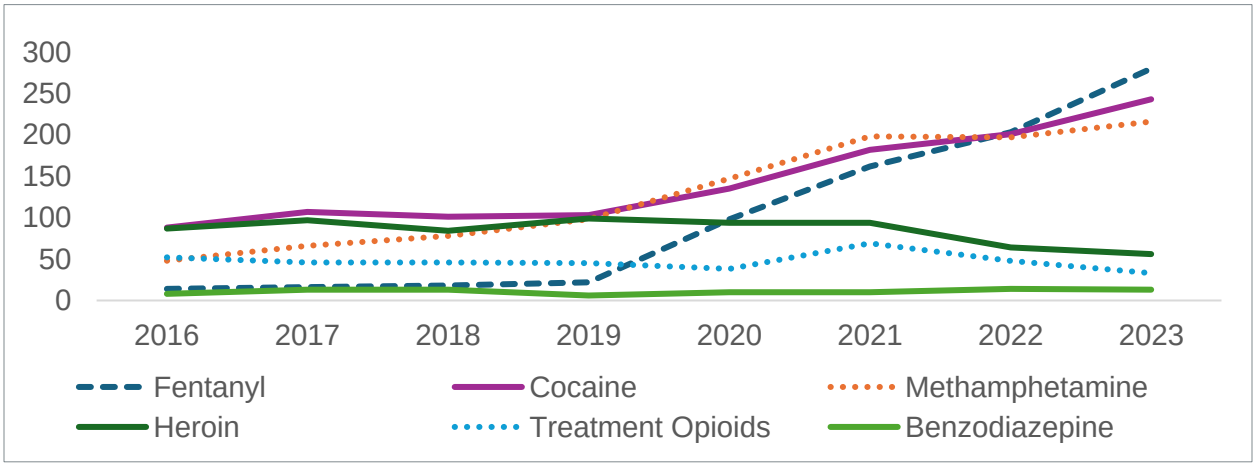
MW/BH Figure 11: All Drug Overdose Mortality, Dallas County, 2016 – 2023



Data Source: Texas State Vital Statistics Mortality

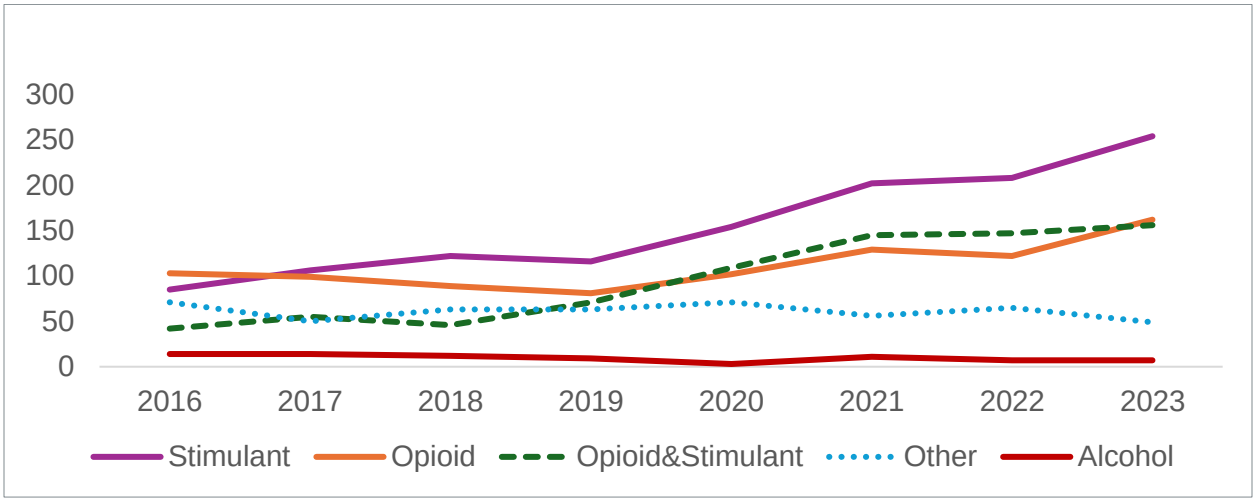
Between 2016 and 2023, overdose deaths in the U.S. have been overwhelmingly driven by fentanyl-related fatalities, which surged by an alarming 1,900%. Fentanyl is 50 times more potent than heroin and 100 times more potent than morphine. Since 2013, fentanyl has widely saturated the illegal drug supply in the U.S., which has resulted in a sustained unprecedented surge in overdose deaths[6]. While fentanyl remains the most significant contributor to this crisis, deaths involving other substances also increased sharply during this period. Methamphetamine-related deaths rose by 350%, and those involving cocaine increased by 176%. In contrast, there was a decline in overdose deaths involving heroin and treatment opioids, which decreased by 36% and 37%, respectively. Deaths attributed to all opioids rose by 57.3%, reflecting the ongoing danger of opioid misuse. Furthermore, there was a 271% increase in deaths involving a combination of opioids and stimulants, and stimulant-only deaths increased by 199%, reflecting a growing trend in polysubstance use that continues to complicate the overdose epidemic.

MW/BH Figure 12: Drug Overdose by Drug Specific Types, Dallas County, 2016–2023



Data Source: Texas State Vital Statistics Mortality

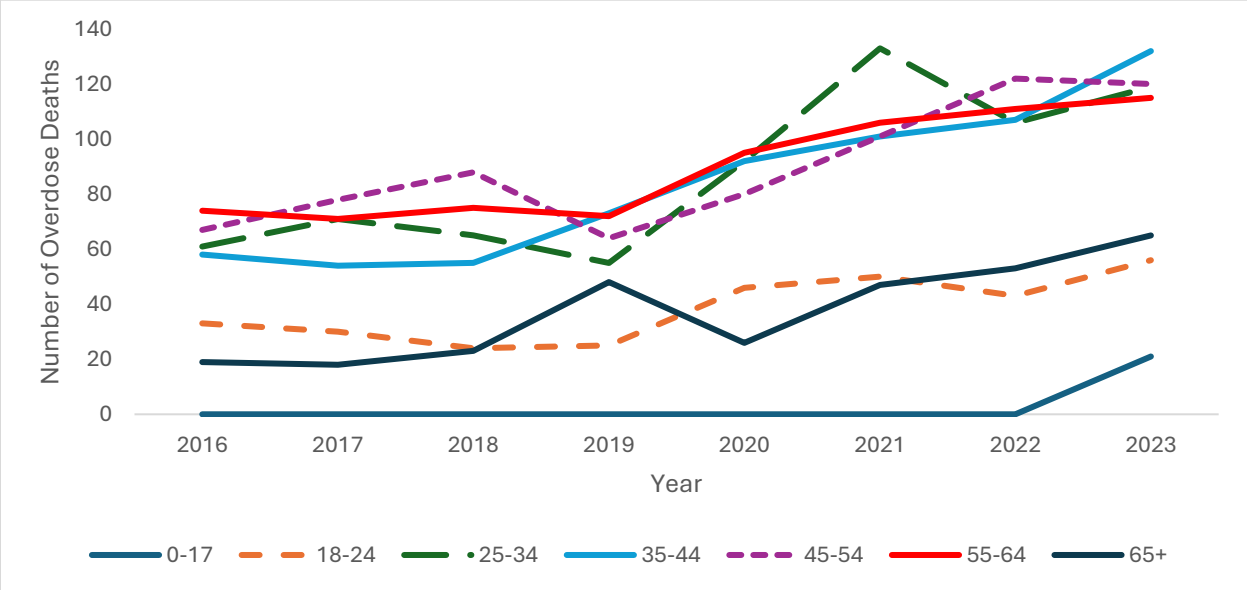
MW/BH Figure 13: Drug Overdose Deaths by Drug Class in Dallas County, 2016-2023



Data Source: Texas State Vital Statistics Mortality

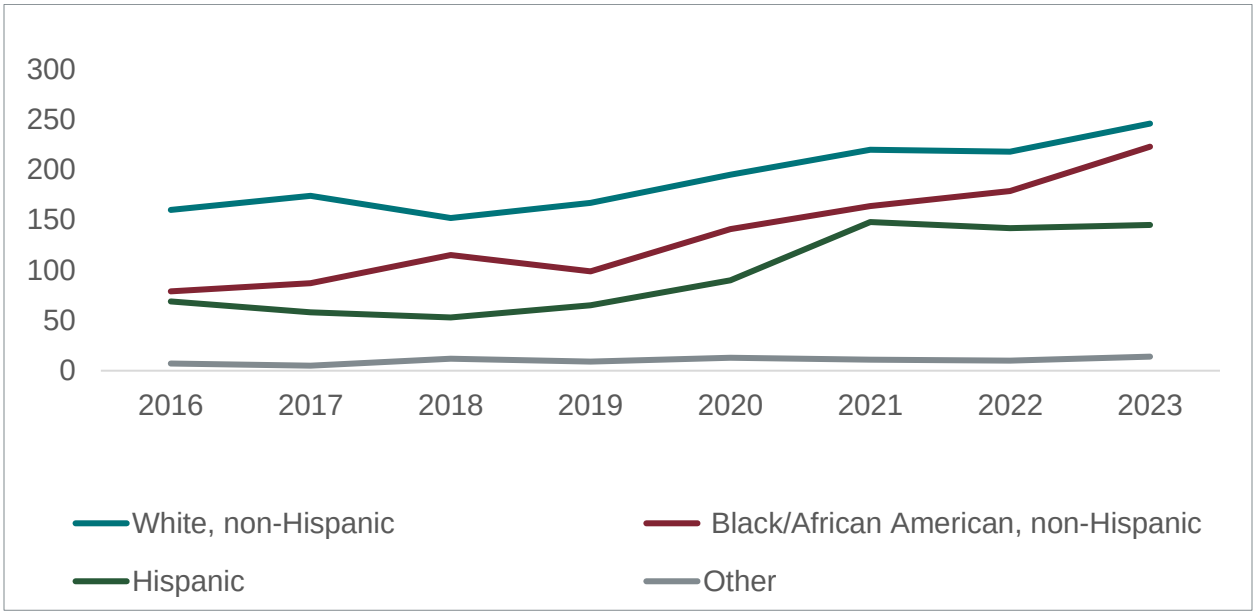
When stratified by race, ethnicity and age, white, non-Hispanic individuals and those aged 35–64 years were a higher risk-see MW/BH Figure 14 and MW/BH Figure 15.

MW/BH Figure 14: Drug Overdose Mortality by Age-group in Dallas County, 2016-2023



Data Source: Texas State Vital Statistics Mortality data

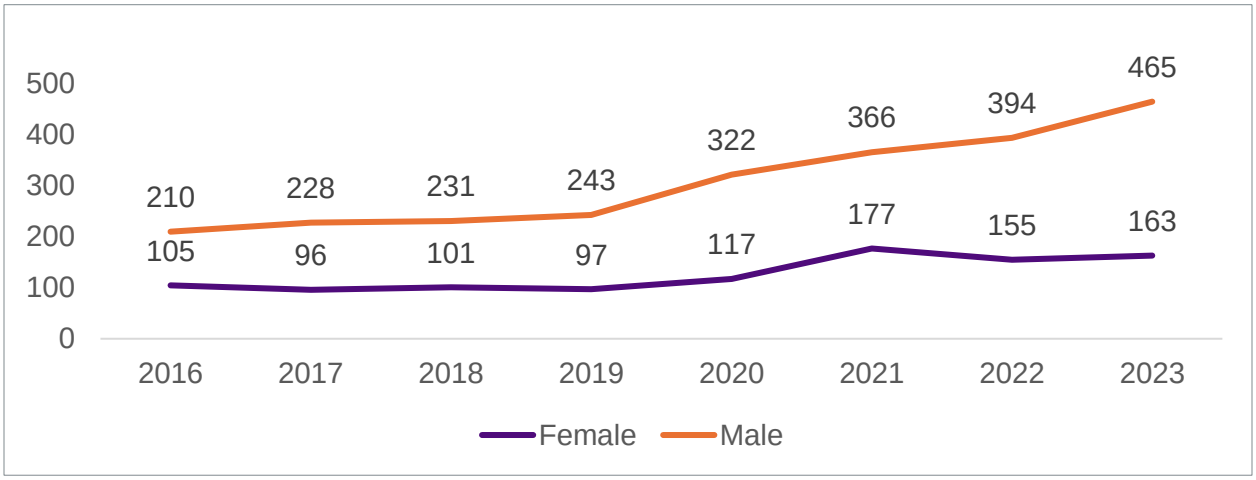
MW/BH Figure 15: Drug Overdose Mortality by Race & Ethnicity, Dallas County, 2016-2023



Data Source: Texas State Vital Statistics Mortality data

From 2016-2023, males had higher mortality than females-see MW/BH Figure 16 indicating a specific need for SUD treatment and prevention in this population.

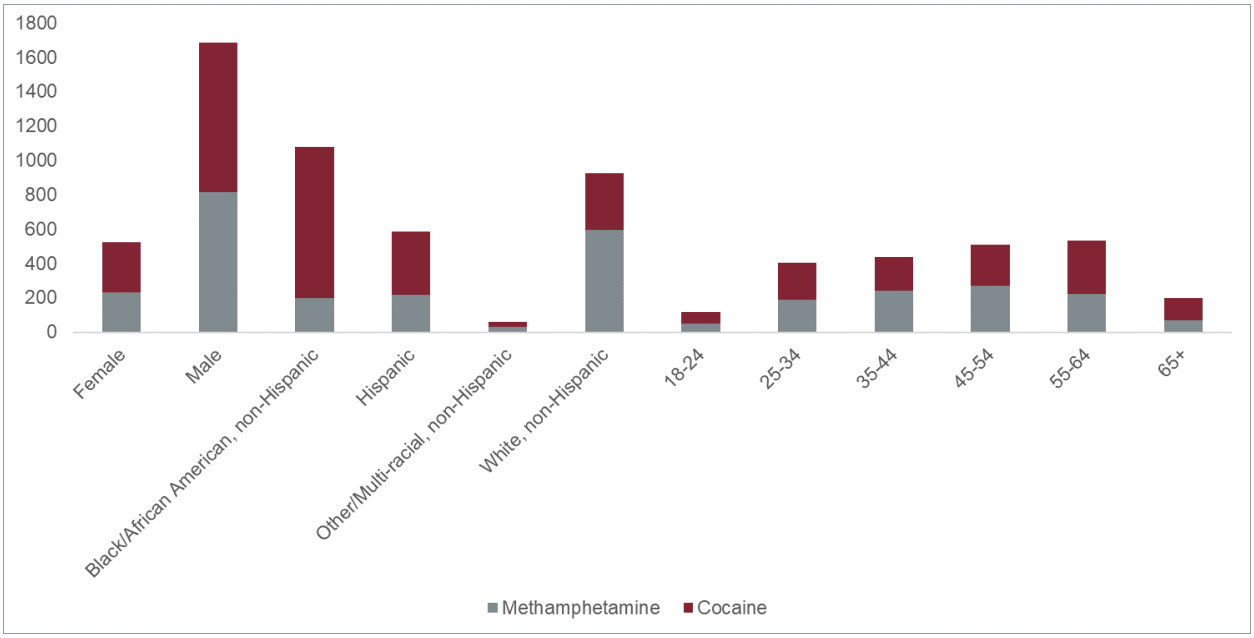
MW/BH Figure 16: Drug Overdose Mortality by Sex in Dallas County, 2016-2023



Data Source: Texas State Vital Statistics Mortality

While methamphetamine-related deaths have been more common among white, non-Hispanics, cocaine has been the primary driver of stimulant-involved overdose deaths in Dallas County. Black or African American, non-Hispanic individuals experience a higher number of cocaine-related overdose deaths compared to other racial and ethnic groups.

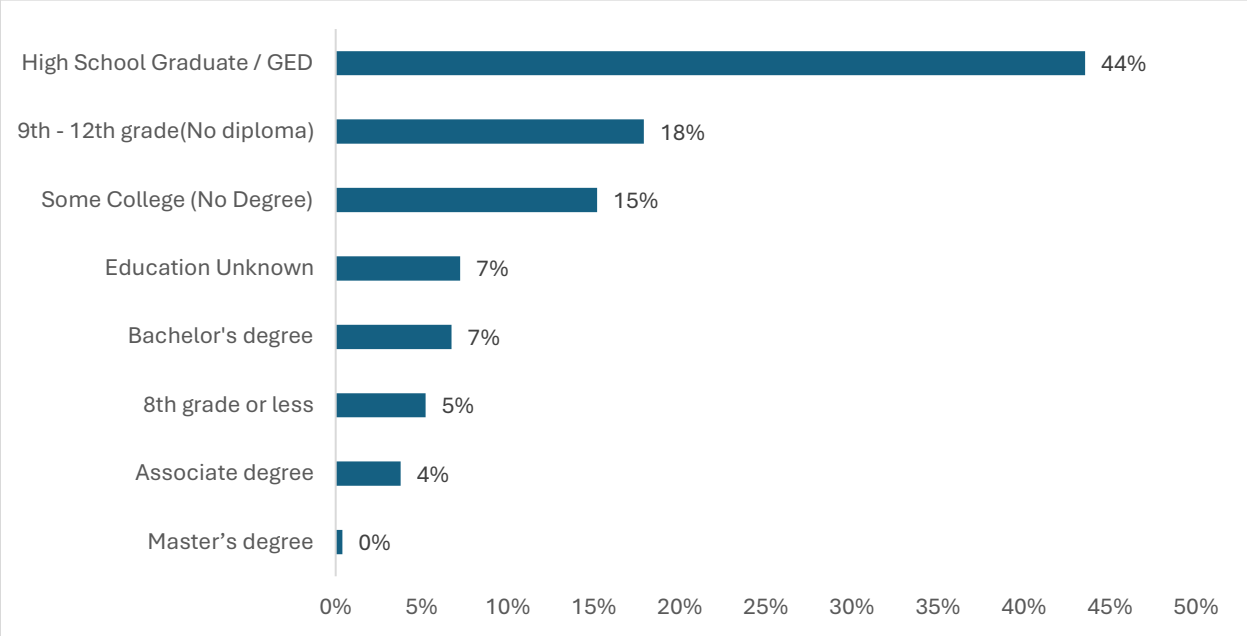
MW/BH Figure 17: Stimulant Related Deaths in Dallas County, Texas, 2016-2023



Data Source: Texas State Vital Statistics Mortality

Moreover, among sociodemographic factors, educational attainment is strongly associated with drug overdose mortality, with the greatest number of deaths (44%) occurring among individuals whose highest educational achievement is completing high school or obtaining a GED-see MW/BH Figure 18.

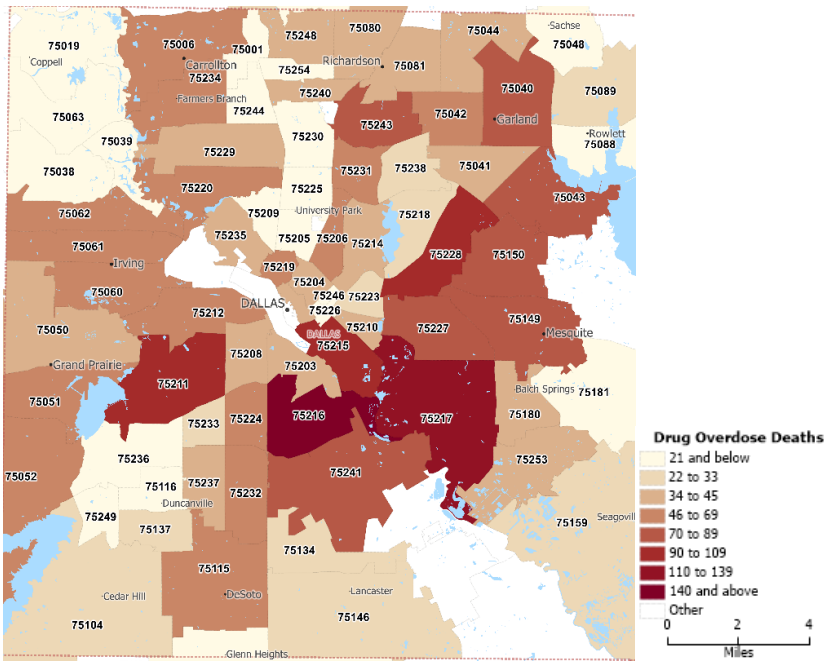
MW/BH Figure 18: All Drug Overdose by Educational Status, Dallas County, 2016 - 2023



Data Source: Texas State Vital Statistics Mortality

The geographic distribution of drug overdose by ZIP Code-see MW/BH Figure 19 highlights that ZIP Codes 75217, 75216, and 75215, located in the southern sector of Dallas County, have the highest number of deaths.

MW/BH Figure 19: All Drug Deaths by Residence ZIP Code, Dallas County, 2016-2023

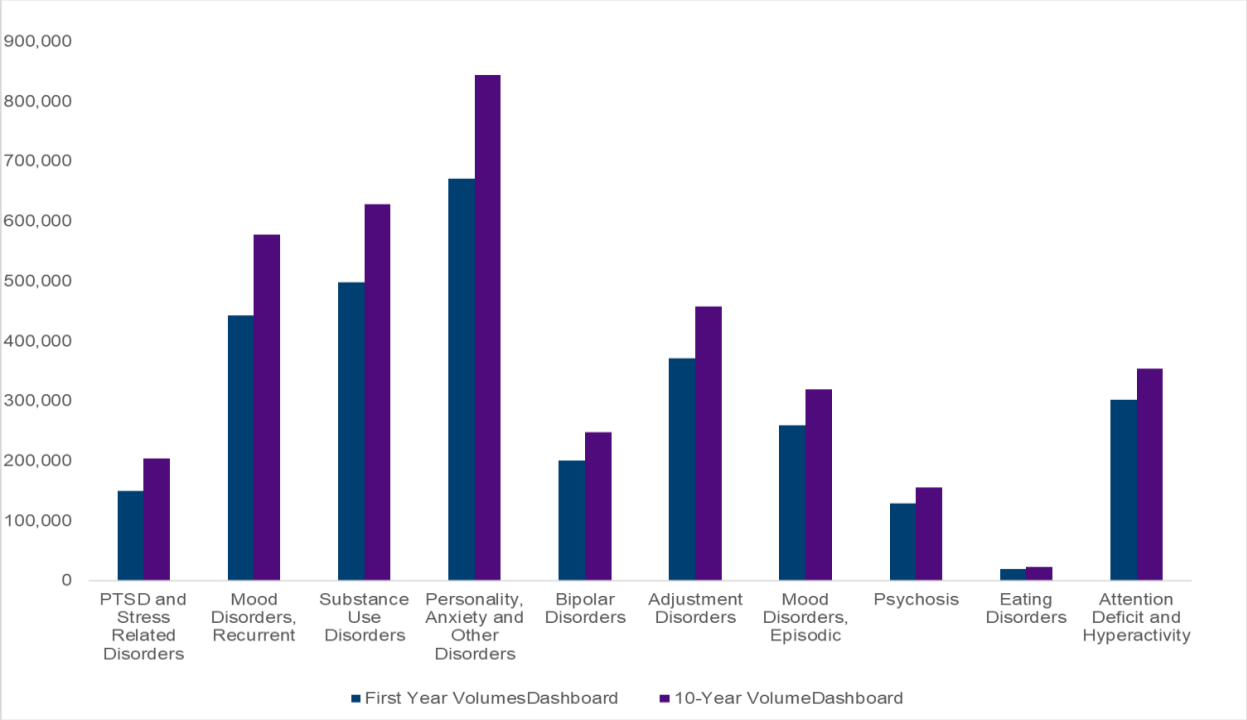


Data Source: Texas State Vital Statistics Mortality

3. Mental Health Outpatient Services Forecast

The graph below shows forecast for 2024 to 2034 for outpatient behavioral health services. These forecasts are based on projected population trends in Dallas County, including changes in population size, birth and death rates, and demographic distribution.

MW/BH Figure 20: 10-year Forecast for Outpatient Behavioral Health Services, Dallas County 2024-2034



Data Source: Prepared by SG2, LLC

F. Maternal and Child Health

Maternal and child health is a vital indicator of community well-being, yet the U.S. has a significantly higher maternal mortality rate than peer nations[105], with Texas ranking among the lowest-performing states in access, quality, and outcomes for women's health.[106]

1. Maternal Health

Maternal health covers the well-being of women during pregnancy, childbirth, and the postnatal period.[107] In the U.S., pregnancy-related complications are a growing public health concern, with rising rates of severe maternal morbidity with unexpected outcomes that can lead to lasting physical and emotional challenges for mothers and their families. Chronic conditions such as diabetes and hypertension increase risks during and after pregnancy, contributing to long-term

[105] U.S. Department of Health and Human Services. Healthy Women, Healthy Pregnancies, Healthy Futures: Action Plan to Improve Maternal Health in America. Washington, DC: HHS; 2020. Accessed May 26, 2025. https://aspe.hhs.gov/sites/default/files/private/aspe-files/264076/healthy-women-healthy-pregnancies-healthy-future-action-plan_0.pdf

[106] Collins SR, Gunja MZ, Zephyrin L. 2024 State Scorecard on Women's Health and Reproductive Care. The Commonwealth Fund. Published July 18, 2024. Accessed August 13, 2025. https://www.commonwealthfund.org/publications/scorecard/2024/jul/2024-state-scorecard-womens-health-and-reproductive-care

[107] Maternal health. https://www.who.int/health-topics/maternal-health . Accessed August 13, 2025.

health problems.[108] Furthermore, data indicate that frequent postpartum depressive symptoms affected approximately 12.7% to 13.5% of new mothers in the United States between 2020 and 2022. Postpartum depression is characterized by persistent feelings of sadness and loss of interest, contributing to challenges such as reduced rates of breastfeeding initiation, impaired bonding with their infants, and a higher risk of developmental delays in their children.[109]

Improving maternal and child health requires early access to care, addressing chronic conditions, and strengthening prevention, continuity of care, and social support to improve outcomes for mothers and families.[110,111] Additionally, early age-appropriate CSE, is critical in guiding young adults on reproductive wellness including health matters related to pregnancy and prenatal care.[112]

Pregnancy-related death is when a woman dies during pregnancy or within a year of delivery, due to pregnancy complications or health issues made worse by pregnancy. More than 700 women die each year in the U.S. from pregnancy-related complications.[113] In Texas, approximately 4 out of 5 of these deaths are preventable.[114]

According to the MMMRC, Texas's MMR rose to 27.7 deaths per 100,000 live births in 2020 and further increased to 37.7 in 2021. These elevated rates are largely attributed to COVID-19. When COVID-19-related deaths are excluded, the adjusted MMRs are 24.2 for 2020 and 23.0 for 2021.[115]

Reports by DSHS highlighted that the leading causes of maternal mortality were cardiac events, accidental drug poisoning, homicide, and suicide. Most of these deaths occurred between 61 days and one year postpartum, with non-Hispanic Black women, women over 40, and those with only a high school education facing the highest risks. In 2021, the SMM rate rose to 85.5 cases per 100,000 delivery hospitalizations, up from 72.7 in 2020. Non-Hispanic Black

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[108] Texas Maternal Mortality and Morbidity Review Committee, Texas Department of State Health Services. *Joint Biennial Report 2024*. Published September 1, 2024. Accessed September 16, 2025. MMMRC-DSHS-Joint-Biennial-Report-2024.pdf

[109] March of Dimes. PeriStats: United States. March of Dimes Foundation. Frequent postpartum depressive symptoms: United States, 2020-2022 | PeriStats | March of Dimes. Accessed August 1, 2025.

[110] Malek AM, Wilson DA, Mateus J, et al. Maternal coronary heart disease and mortality following hypertensive disorders of pregnancy and/or diabetes. Cardiovasc Diabetol. 2025; 24:282. doi:10.1186/s12933-025-02811-8

[111] Centers for Disease Control and Prevention. Pregnancy complications. https://www.cdc.gov/maternal-infant-health/pregnancy-complications/index.html . Accessed August 13, 2025.

[112] Sexuality Information and Education Council of the United States (SIECUS). Guidelines for Comprehensive Sexuality Education: Kindergarten–12th Grade. 3rd ed. New York, NY: SIECUS; 2004. Accessed August 25, 2025. https://siecus.org/wp-content/uploads/2024/05/Guidelines_3ed.pdf

[113] March of Dimes. Maternal death and pregnancy-related death. https://www.marchofdimes.org/find-support/topics/miscarriage-loss-grief/maternal-death-and-pregnancy-related-death. Accessed August 13, 2025.

[114] Centers for Disease Control and Prevention. Pregnancy-related deaths: data from maternal mortality review committees. https://www.cdc.gov/maternal-mortality/php/data-research/index.html. Accessed August 13, 2025.

[115] Texas Maternal Mortality and Morbidity Review Committee; Texas Department of State Health Services. *Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2024*. Published September 1, 2024. Accessed May 26, 2025. https://www.dshs.texas.gov/sites/default/files/legislative/2024-Reports/2024-MMMRC-DSHS-Joint-Biennial-Report.pdf

women experienced the highest SMM rate at 134.4, compared to significantly lower rates among other racial and ethnic group.[116]

In Dallas County, substantial all-cause mortality and disparity exists in the southeastern corner, as discussed previously in the NMDOH. This sector is characterized by high vulnerability for poor health outcomes and NMDOH. As a result, in 2020 Parkland established the eMCAP program to address health disparities in southern Dallas County. The eMCAP program is a recipient of The Joint Commission and National Quality Forum 2022 John M. Eisenberg Award and winner of the HHSC Racial Equity in Postpartum Care Challenge Award.[117]

2. Infant Mortality

Infant mortality is defined as a child's death before his or her first birthday and it's an important maker of the overall health of a society. In the U.S. the leading causes of infant deaths are: 1. birth defect, 2. preterm birth, 3. sudden infant death syndrome, 4. unintentional injuries and 5. pregnancy complications.[118]

In the U.S., infant mortality rates have declined since 1999, but significant racial and ethnic disparities persist. Black or African American, non-Hispanic, infants continue to experience the highest mortality rates, consistently surpassing all other groups.

In 2023, their rate stands at 11.3 deaths per 1,000 live births, more than double that of white, non-Hispanics (4.3) and Hispanic (5.3) infants. This gap highlights ongoing inequities in maternal and infant health outcomes-see MCH Figure 1.

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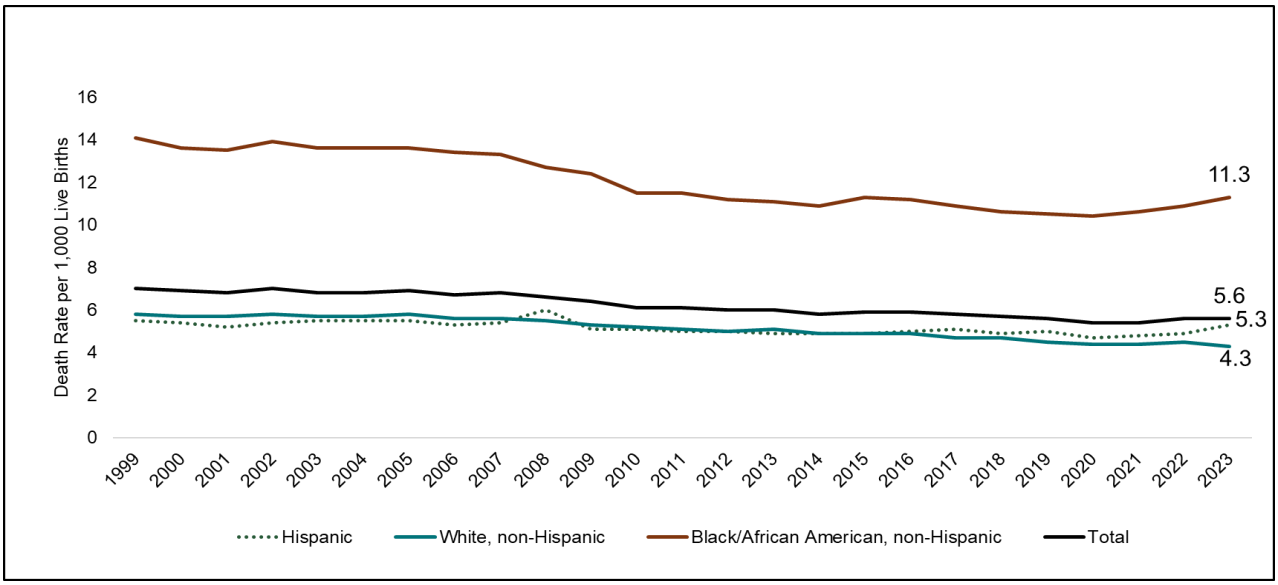
[116] Texas Maternal Mortality and Morbidity Review Committee; Texas Department of State Health Services. *Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2024*. Published September 1, 2024. Accessed May 26, 2025. https://www.dshs.texas.gov/sites/default/files/legislative/2024-Reports/2024-MMMRC-DSHS-Joint-Biennial-Report.pdf

[117] Nelson DB, Martin R, Duryea EL, et al. Extending maternal care after pregnancy: an initiative to address health care disparities and enhance access to care after delivery. *Jt Comm J Qual Patient Saf*. 2023;49(5):274-279.

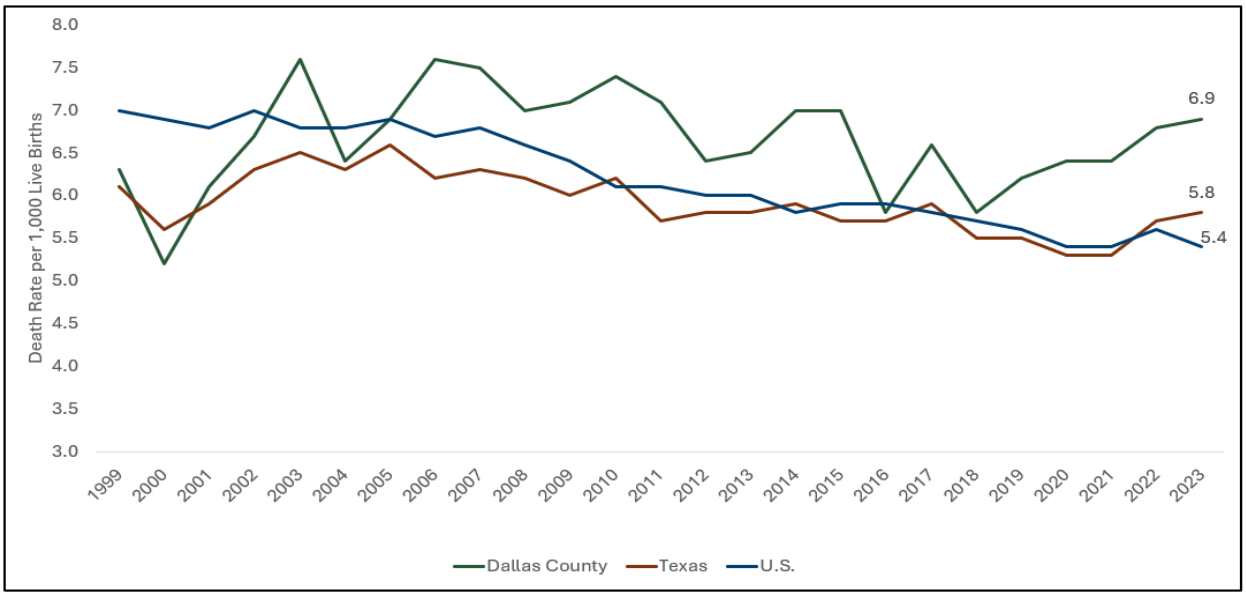
[118] Centers for Disease Control and Prevention. Infant mortality. https://www.cdc.gov/maternal-infant-health/infant-mortality/index.html. Accessed August 13, 2025.

MCH Figure 1: Infant Mortality Rate in U.S. by Race and Ethnicity in the U.S.,1999-2023



Data Source: CDC Wonder

MCH Figure 2: Infant Mortality Rate, U.S., Texas and Dallas County,1999-2023



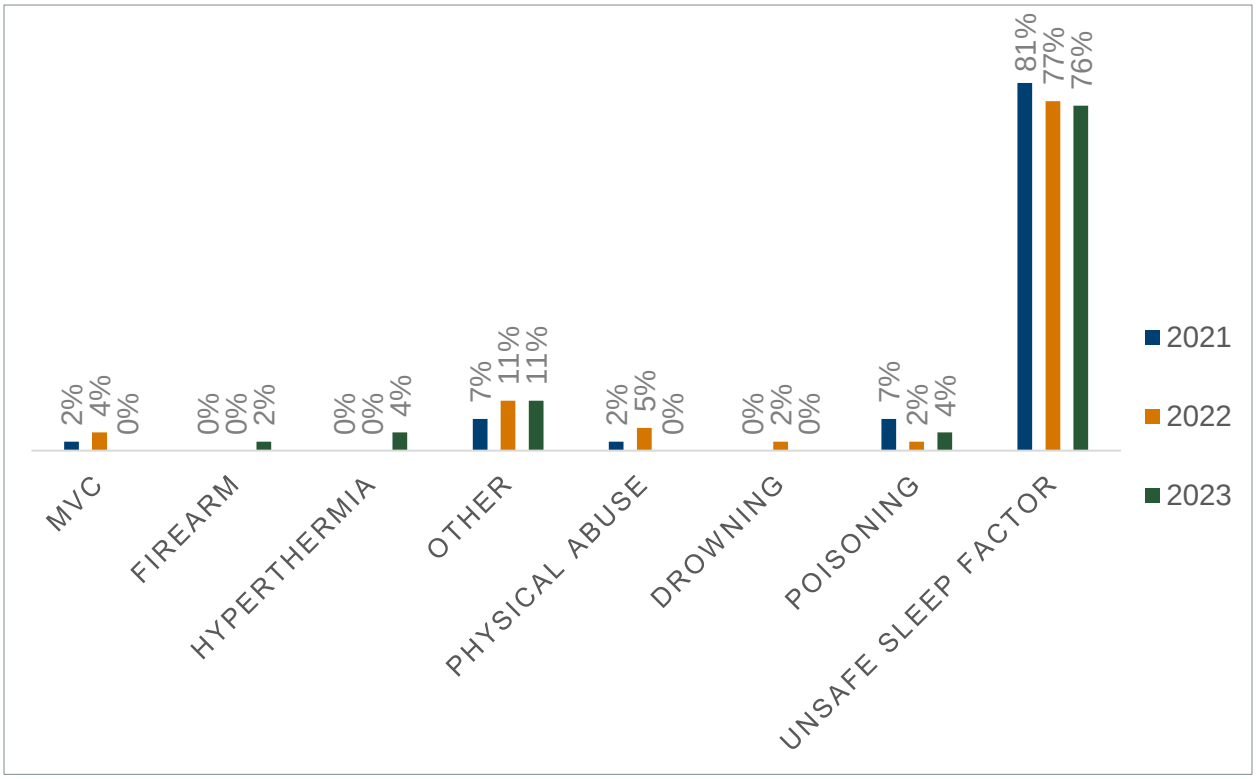
Data Source: CDC Wonder

The infant mortality rate in Dallas County showed noticeable variability from 1999 to 2023 and remained consistently higher than both the Texas and U.S. rates. While state and national trends followed a more gradual and steady decline, reaching 5.8 and 5.4 deaths per 1,000 live births, respectively, in 2023 Dallas County's rate was higher at 6.9 in the same year-see MCH Figure 2.

a. Infant Injury Deaths 2023

In 2023, infants under 1 year old comprised 32% of all injury-related child deaths in Dallas County.[119] The leading cause, accounting for 76% of these infant deaths, was unsafe sleep. A safe sleep environment helps prevent suffocation, strangulation, and entrapment-see MCH Figure 3.

MCH Figure 3: Infant Injury Death Causes Unintentional (Accidents), Dallas County, 2021 - 2023



Data Source: Dallas County Medical Examiner

Between 2021 and 2023, unsafe sleep environments remained the leading contributing factor of infant injury deaths, accounting for 81% of cases in 2021 and 77% in 2022, and 76% in 2023. The “Other” category has seen an increase over time, suggesting a mix of less common causes.

i. Unsafe Sleep Environment Related Infant Deaths

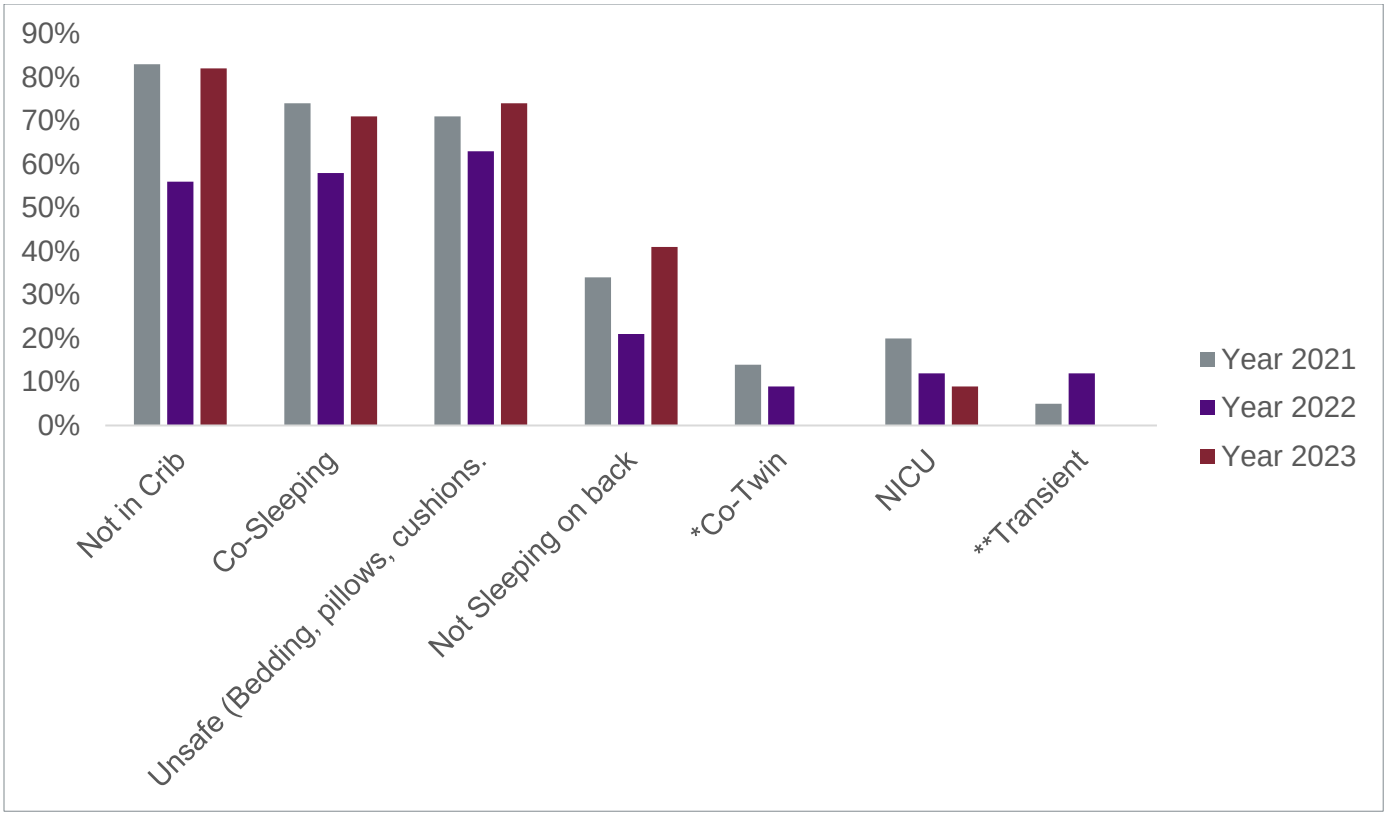
From 2021 to 2023, unsafe sleep patterns in Dallas County remained a persistent issue with limited improvement. Most sleep-related deaths still occur in non-crib settings, reinforcing the ongoing need for safe sleep education. The highest burden continues to fall on Black or African American non-Hispanic infants, and unsafe practices like adult bed use and bed-sharing have not significantly decreased.

MCH Figure 4 illustrates the unsafe sleep environments contributing to infant mortality in Dallas County from 2021 to 2023. The graph shows that bed-sharing, soft bedding, and non-crib sleep

[119] The Dallas County Child Death Review Team Annual Report. 2023

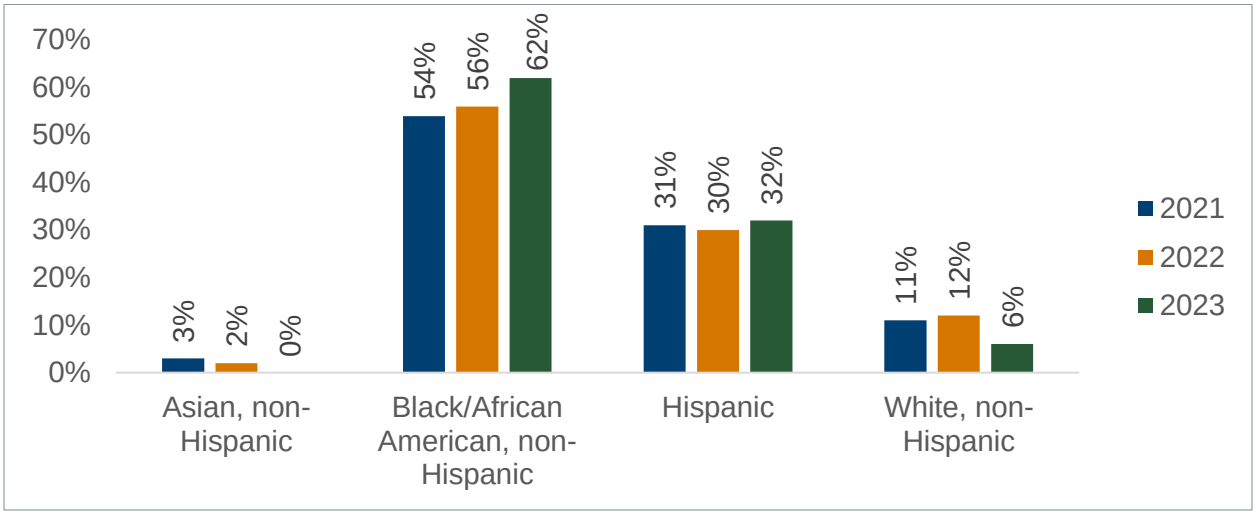
surfaces showed a decline between 2021 and 2022, and an increase in 2023. Furthermore, Black or African American, non-Hispanic infants, have seen an increase from 54% in 2021 to 62% in 2023 in unsafe sleep related death, whereas other groups have remained steady-see MCH Figure 5.

MCH Figure 4: Unsafe Sleep Environment Related Infant Deaths, Dallas County, 2021-2023



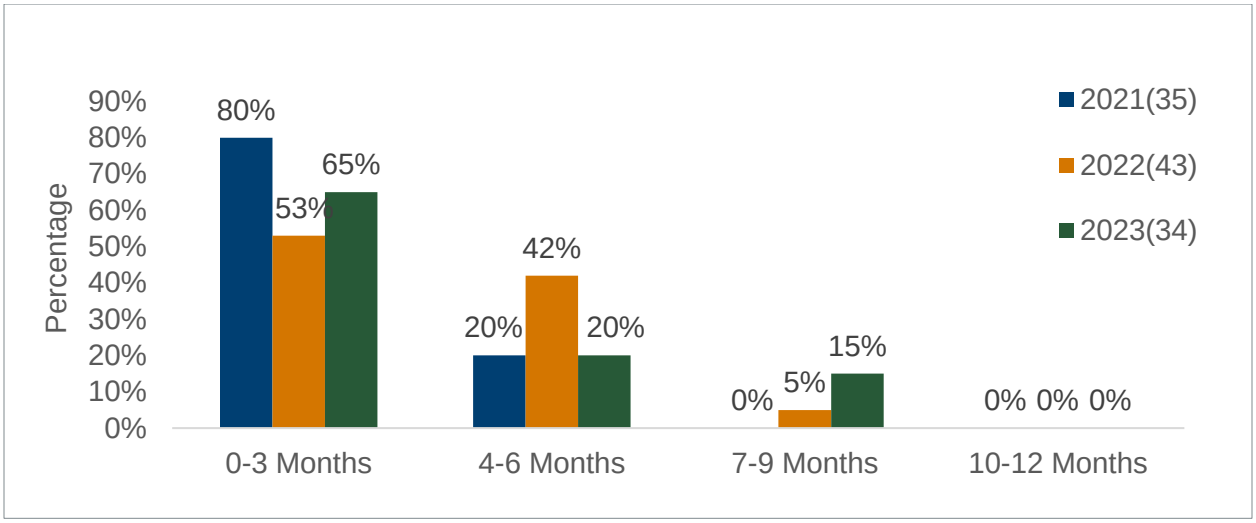
Data Source: Dallas County Medical Examiner
*Infant had a twin
**Infant did not have a permanent residence

MCH Figure 5: Unsafe Sleep Related Mortality by Race and Ethnicity, Dallas County, 2021-2023



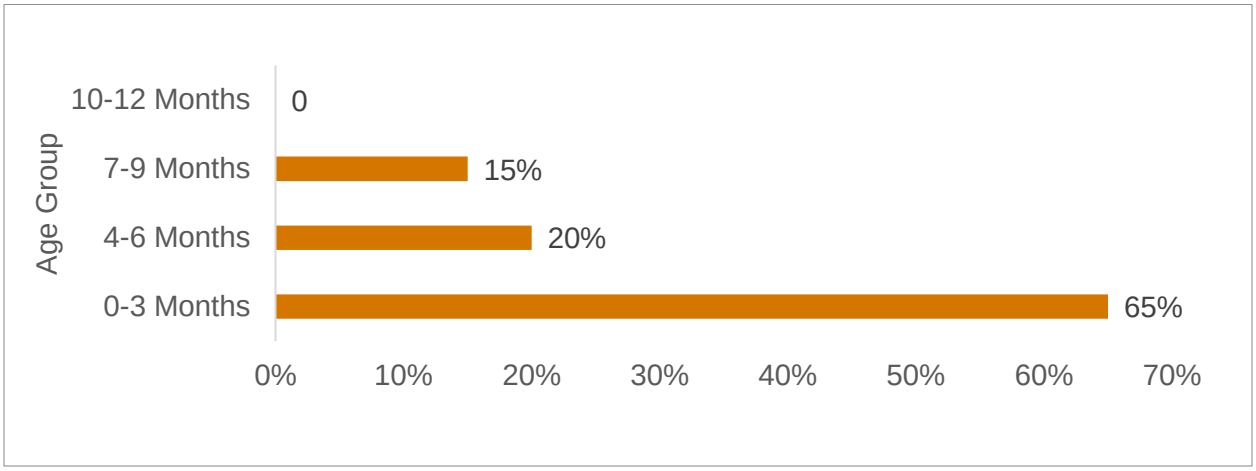
Data Source: Dallas County Medical Examiner

MCH Figure 6: Unsafe Sleep-Related Mortality by Age-Group, 2021-2023



Data Source: Dallas County Medical Examiner

MCH Figure 7: Unsafe Sleep Environment, Dallas County, 2023



Data Source: Dallas County Medical Examiner

b. Congenital Syphilis Related Deaths

As discussed in more detail in the STI section, Dallas County has experienced a significant increase in maternal syphilis infections since 2017. This rise has serious implications for infant mortality, as approximately 40% of babies born to women with untreated syphilis can be stillborn or die shortly after birth due to the infection. In 2022, Texas accounted for 25% of all congenital syphilis cases in the U.S., with 922 cases statewide. In Dallas County, the disease disproportionately affects Black families, and if left untreated, can result in stillbirth, infant death, or lifelong disabilities.[120]

G. Preventive Health

Preventive health plays a vital role in improving population well-being and reducing the burden of disease, injury, and premature death. By identifying and addressing risk factors before they lead to serious health outcomes, communities can enhance quality of life and lower healthcare costs. This section of the CHNA focuses on key areas of preventive health with public health impact: immunizations, smoking, motor vehicle injuries, and firearm-related incidents.

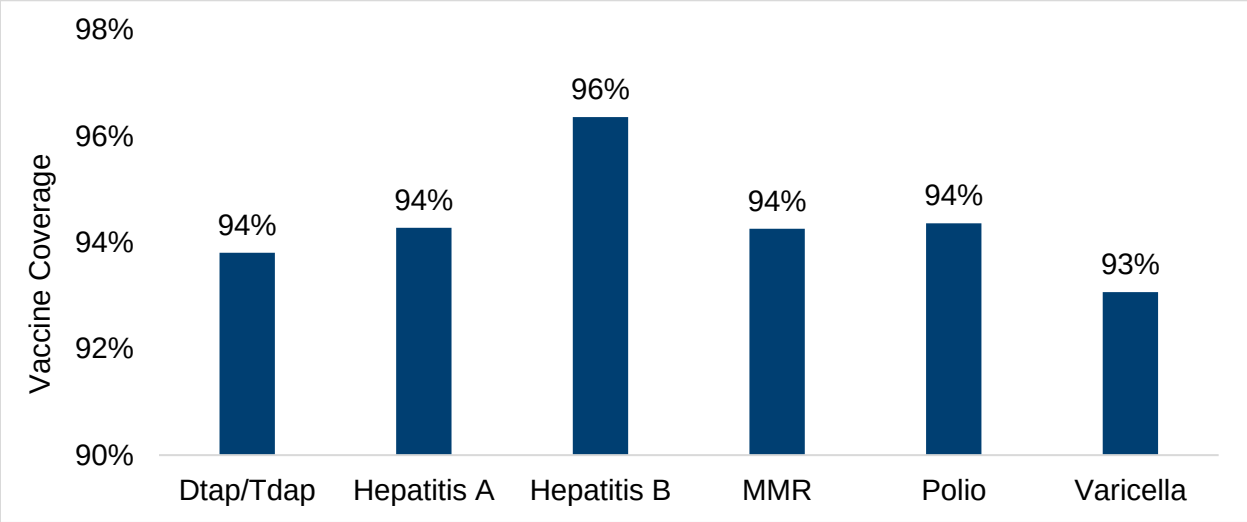
1. Immunizations

Immunizations play a crucial role in preventing the spread of communicable diseases. In Dallas County, vaccination coverage for the 2023–2024 school year remained high among both kindergarten and 7th-grade students. Among kindergarteners, coverage ranged from 93% for Varicella to 96% for Hepatitis B. Other vaccines—including DTaP/Tdap, Hepatitis A, MMR, and Polio—also demonstrated strong uptake across schools-see Preventive Health Figure 1.

[120] Berns K, Omega-Njemnobi O, Linan A, Handler K, Eppes C, Ramsey P, Patel D, Hoelscher D. Congenital Syphilis. UTHealth Houston School of Public Health, Michael & Susan Dell Center for Healthy Living; February 16, 2024. Accessed August 27,2025. https://sph.uth.edu/research/centers/dell/legislative-initiatives/docs/Congenital%20Syphilis022724%20update.pdf

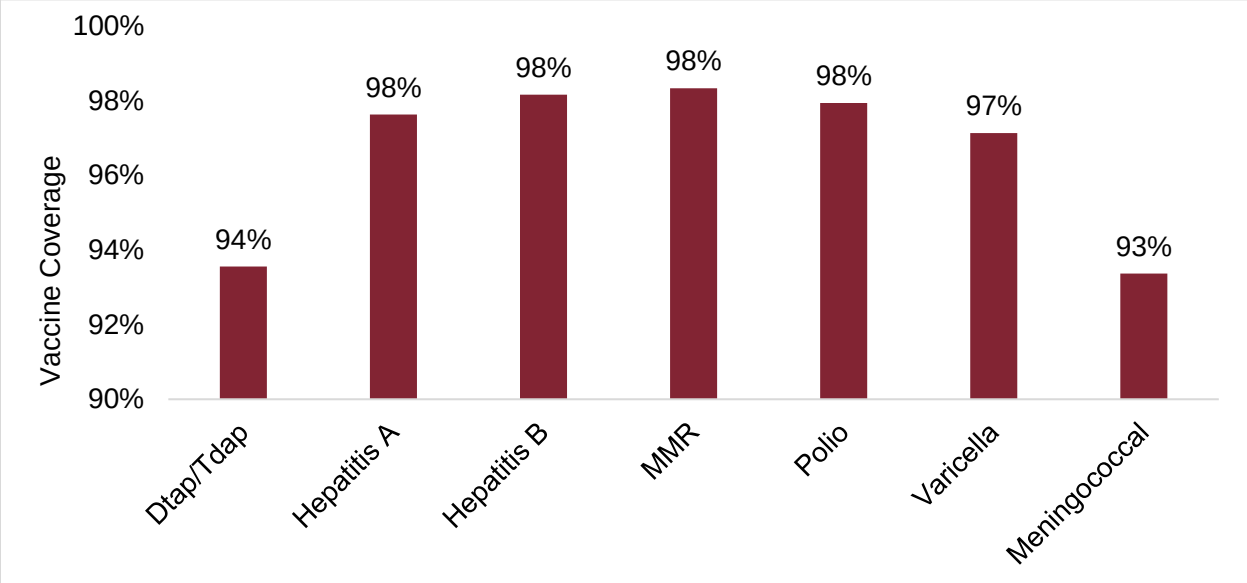
Coverage among 7th-grade students was even higher, ranging from 93% for the Meningococcal vaccine to 98% for MMR. Vaccines such as DTaP/Tdap, Hepatitis A, Hepatitis B, Polio, and Varicella all exceeded 90% coverage-see Preventive Health Figure 2.

Preventive Health Figure 1: Vaccine Coverage, Kindergarten, Dallas County, 2023–2024 School Year



Data Source: Texas Department of State Health Services, School Coverage Data, Annual Report of Immunization Status; ImmTrac2, the Texas Immunization Registry

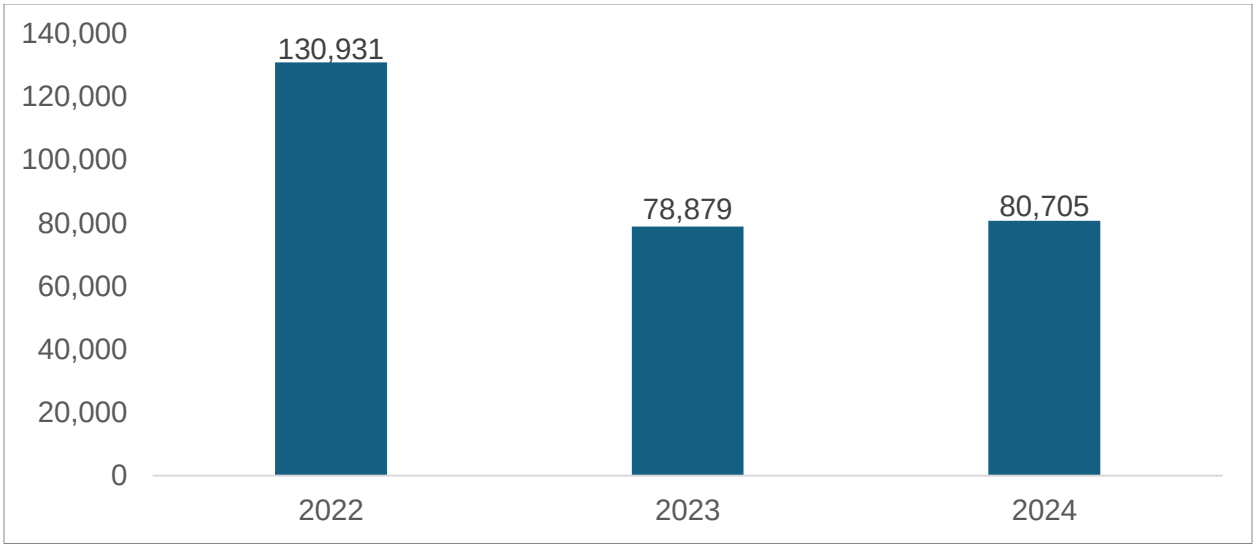
Preventive Health Figure 2: Vaccine Coverage, Seventh Grade, Dallas County, 2023–2024 School Year



Data Source: Texas Department of State Health Services, School Coverage Data, Annual Report of Immunization Status; ImmTrac2, the Texas Immunization Registry

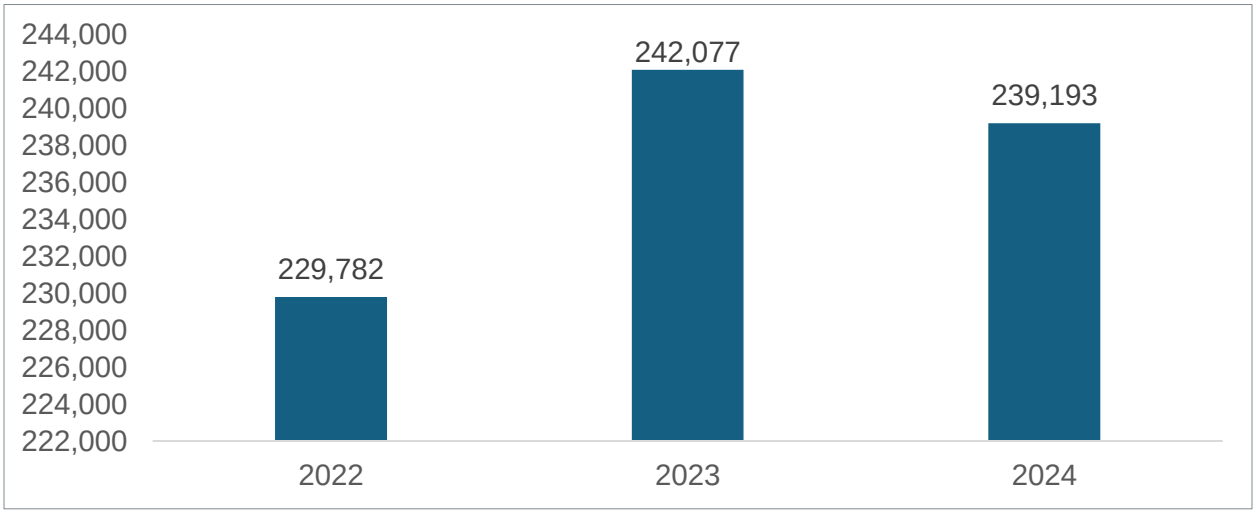
Specific immunizations had inverse trends, with COVID-19 vaccinations decreasing from 2022 to 2024, while flu vaccinations increased from 2022-2024-see Preventive Health Figure 3 and Preventive Health Figure 4.

Preventive Health Figure 3: COVID-19 Immunization Counts, 2022-2024



Data Source: ImmTrac2, the Texas Immunization Registry

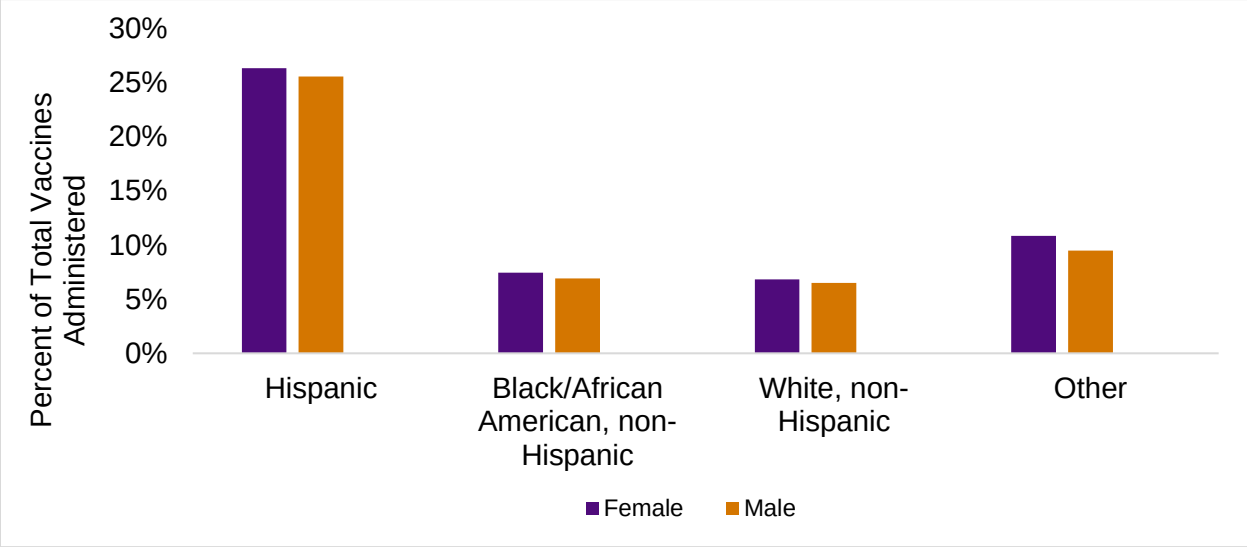
Preventive Health Figure 4: Flu Immunization Counts, 2022-2024



Data Source: ImmTrac2, the Texas Immunization Registry

In Dallas County, individuals identifying as Hispanic received more immunizations overall compared to Black or African American, non-Hispanic, and white, non-Hispanic groups. Additionally, females had higher immunization rates than males across all racial and ethnic groups.

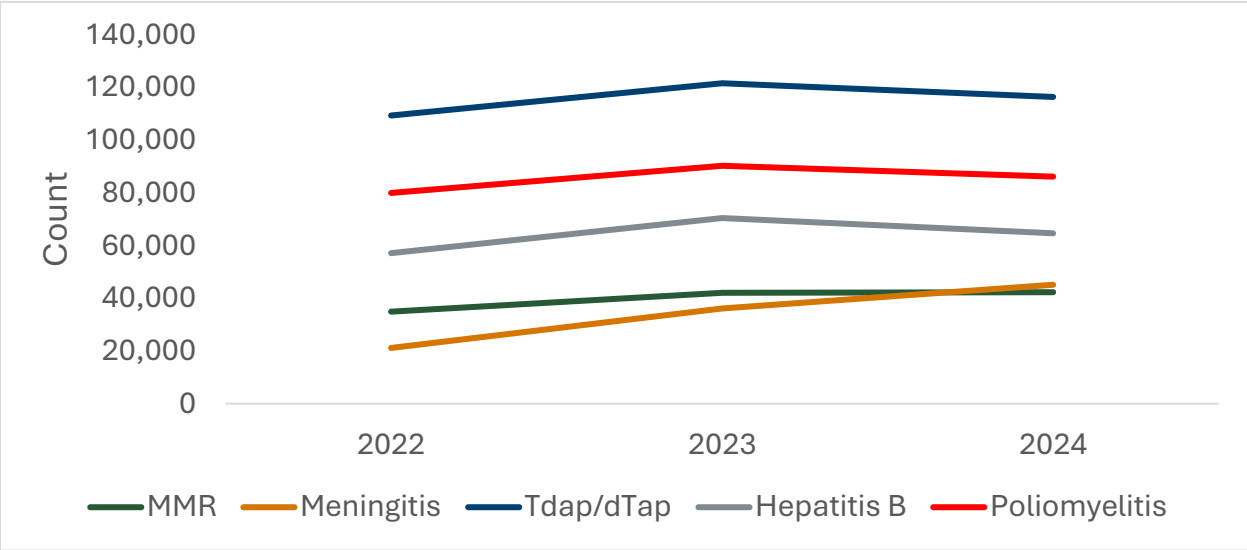
Preventive Health Figure 5: Adult and Child Immunizations for Race and Ethnicity by Sex, 2022-2024



Data Source: ImmTrac2, the Texas Immunization Registry

Infants and school-aged children (0-17) are more vulnerable to infectious diseases due to developing immune systems, making childhood vaccinations critical.[121] In Dallas County, immunization rates vary by vaccine type (MMR, Meningitis, Tdap/dTap, and Hep B)-see Preventive Health Figure 6.

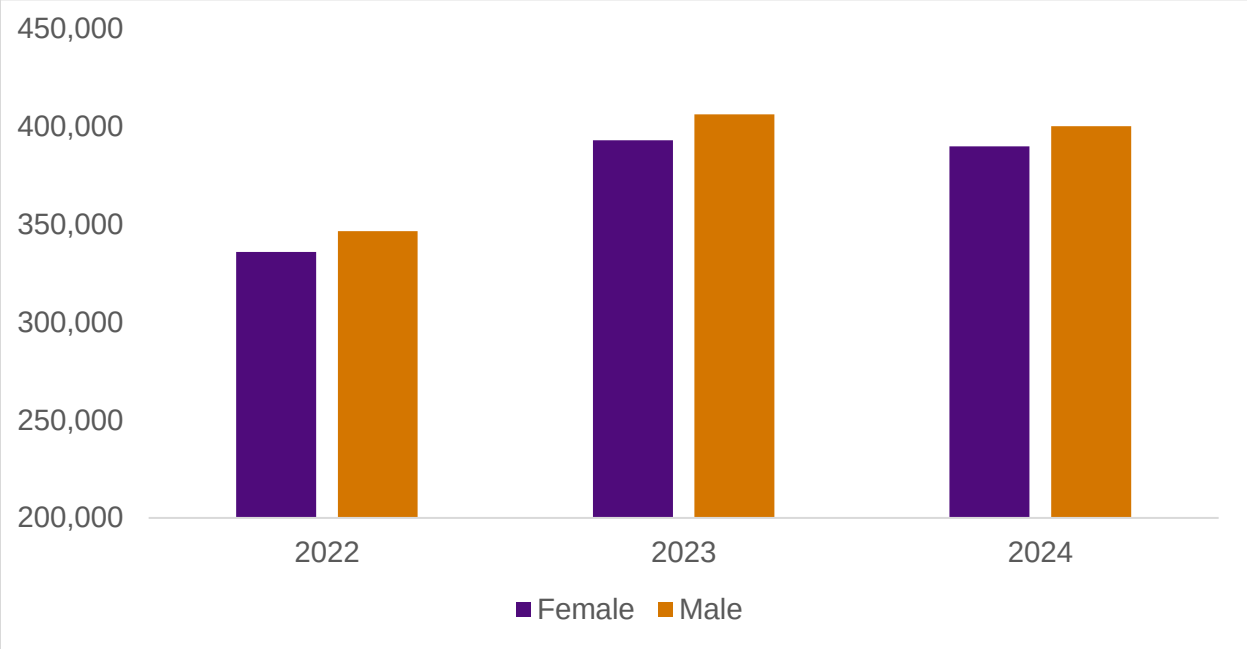
Preventive Health Figure 6: Count of Childhood Vaccination by Vaccine Type, 2022-2024



Data Source: ImmTrac2, the Texas Immunization Registry

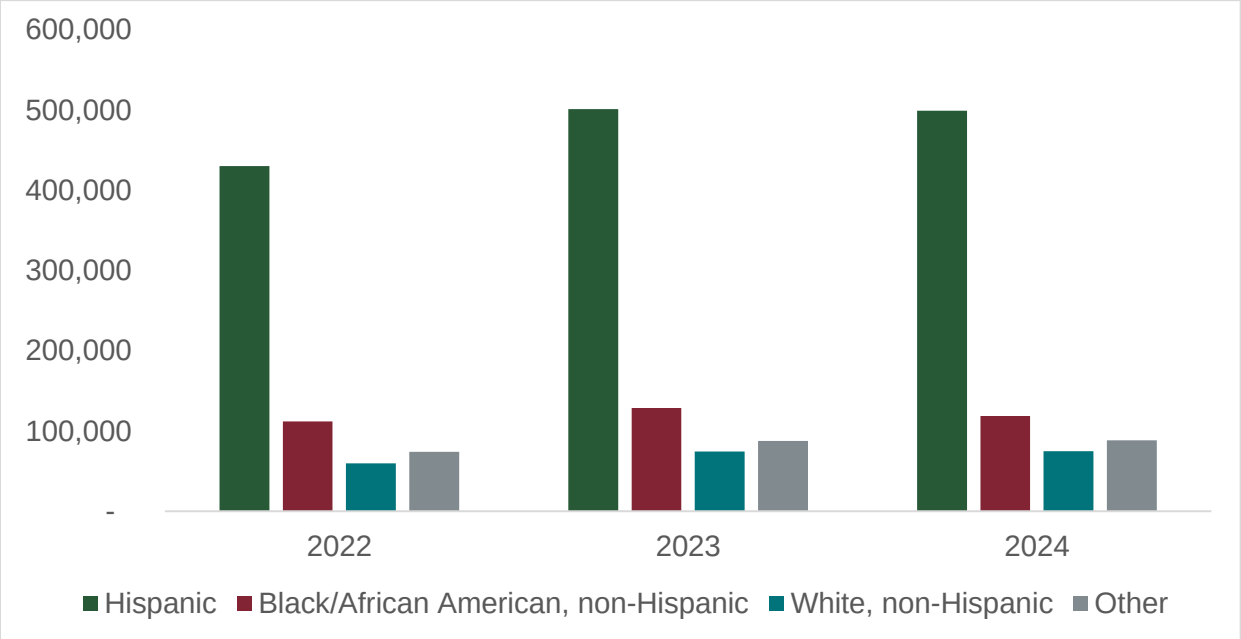
[121] Reasons to vaccinate. Centers for Disease Control and Prevention. Accessed August 12, 2025. https://www.cdc.gov/vaccines-children/reasons/index.html.

Preventive Health Figure 7: Child Immunizations by Sex, 2022-2024



Data Source: ImmTrac2, the Texas Immunization Registry

Preventive Health Figure 8: Child Immunizations by Race & Ethnicity, 2022-2024

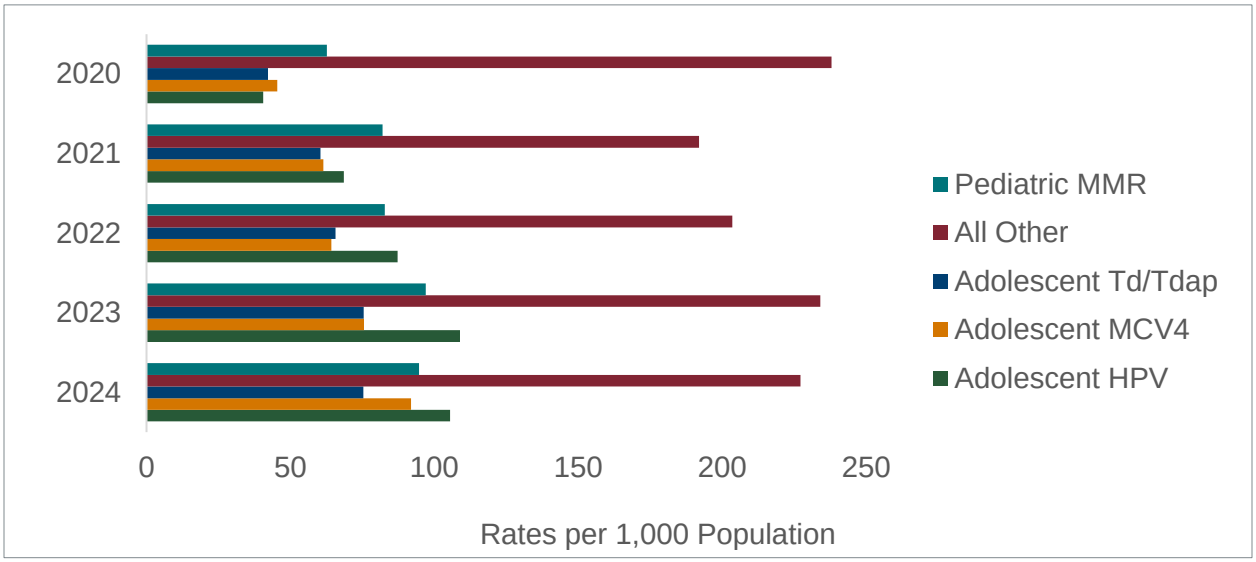


Data Source: ImmTrac2, the Texas Immunization Registry

From 2020 to 2024, Dallas County saw significant growth in vaccination rates, especially for adolescent vaccines like HPV and MCV4, which more than doubled. Td/Tdap and pediatric

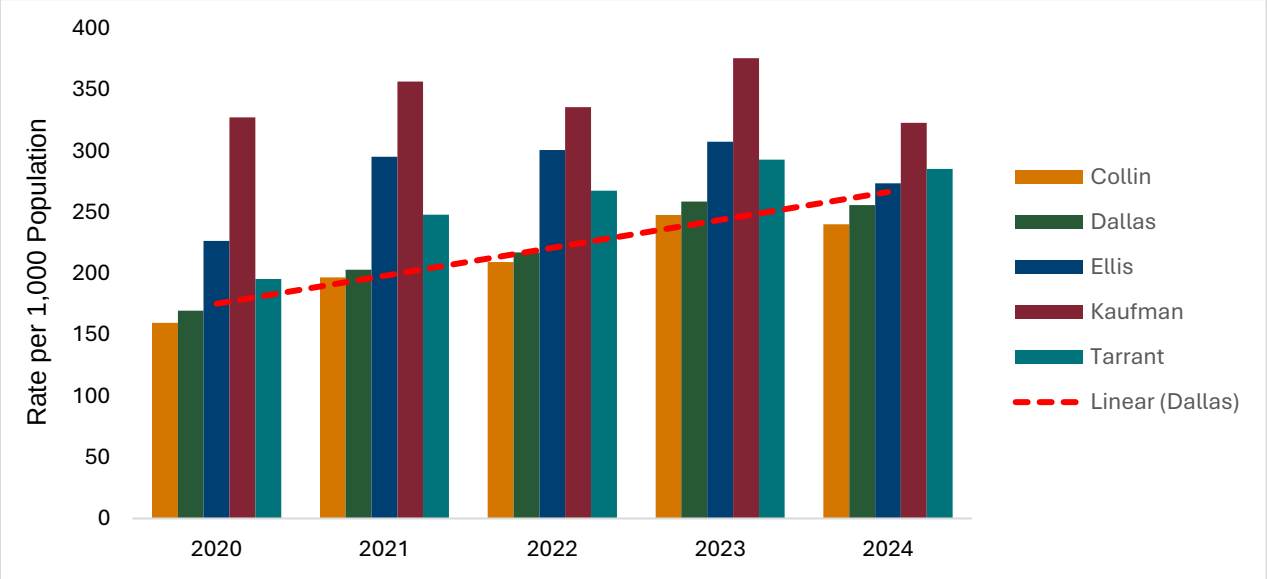
MMR rates also increased steadily, while the "All Other" category remained stable. Regionally, Dallas County's total vaccination rate rose from 169.7 per 100,000 in 2020 to 255.9 in 2024, a 51% increase, positioning it near the middle compared to surrounding counties. Despite slight fluctuations, these trends demonstrate sustained progress in immunization efforts both within Dallas and across the region.

Preventive Health Figure 9: Dallas County Childhood Vaccination Rates by Vaccine Type, 2020-2024



Data Source: ImmTrac2, the Texas Immunization Registry

Preventive Health Figure 10: Total Vaccination Rates by County, 2020–2024



Data Source: ImmTrac2, the Texas Immunization Registry

2. Smoking

Smoking remains the leading cause for lung cancer in the U.S.[122] and in Dallas County-see Mortality Figure 1. It leads to a range of serious health conditions such as cancer, heart disease, COPD, diabetes, and other health conditions that significantly reduce overall health among individuals who smoke[123]. In addition to its impact on personal health, smoking increases healthcare utilization and costs.

The overall prevalence of individuals who currently smoke in Dallas County is 12.5%, reflecting a decline from the 14% reported in the previous CHNA assessment in 2022[124]. However, smoking rates continue to vary significantly across demographic groups. Males report a higher prevalence (16.2%) compared to females (11.0%), and adults aged 30 to 44 account for the highest proportion of individuals who smoke. Among racial and ethnic groups, Black or African American non-Hispanics continue to have the highest smoking prevalence, though this group experienced a 3% decline since 2020 as noted in the previous CHNA[125]. A strong inverse relationship exists between educational levels and smoking rates: individuals with less than a high school education reports the highest smoking rate at 18.9%, while those with a college degree have the lowest at 5.8%. Income also plays a significant role. Individuals earning less than $25,000 annually exhibit the highest smoking rate (22.6%), with prevalence decreasing as income rises. Similarly, individuals without health insurance also have a higher smoking rate (17%) than those who have health insurance-see Preventive Health Figure 11.

In Dallas County, smoking cessation support is available through the Dallas County Smoking Cessation program. The program offers individual and group counseling and telephone-based counseling to support individuals ready to quit smoking. Despite these resources, disparities in smoking prevalence highlight the ongoing need for expanded access to education, outreach, and culturally tailored interventions. Additionally, policies aimed at reducing tobacco exposure such as implementing 100% tobacco-free campuses, workplaces, homes, and public spaces, as well as strengthening smoking ordinances across municipalities remain critical to effectively addressing tobacco use and promoting health equity across all populations in the county.

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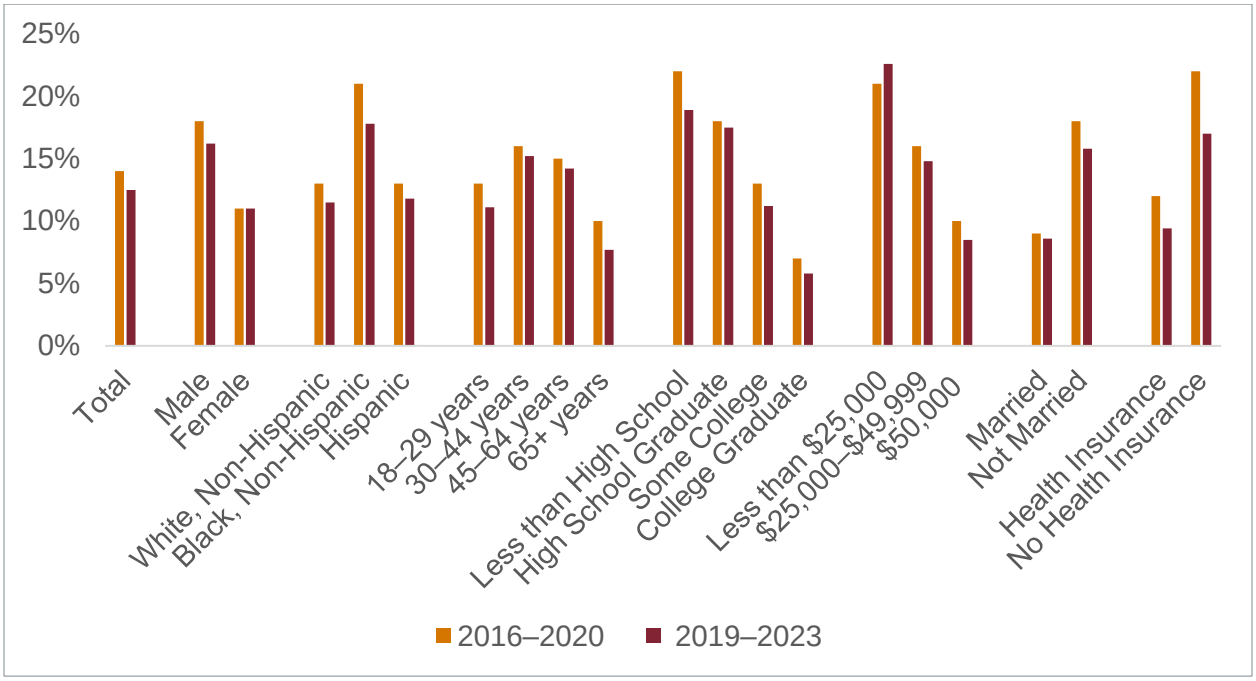
[122] Jenkins N. Leader in Cancer Deaths. American Cancer Society Resources. Published December 21, 2023. Accessed August 8, 2025. https://www.acsresources.org/mission/leader-in-cancer-deaths/
[123] Centers for Disease Control and Prevention. Smoking and Tobacco Use. Published September 17, 2024. Accessed August 1, 2025. https://www.cdc.gov/tobacco/about/index.html
[124] Parkland Health, Dallas County Health and Human Services. 2022 Dallas County Community Health Needs Assessment. Published December 8, 2023. Accessed August 1, 2025. https://www.parklandhealth.org/pdf-files/2022-dallas-county-community-health-needs-assessme-1
[125] Parkland Health, Dallas County Health and Human Services. 2022 Dallas County Community Health Needs Assessment. Published December 8, 2023. Accessed August 1, 2025. https://www.parklandhealth.org/pdf-files/2022-dallas-county-community-health-needs-assessme-1

Preventive Health Figure 11: Prevalence of Individuals who Currently Smoke, Dallas County, 2016–2020 vs 2019-2023



Data Source: Center for Health Statistics BRFSS 2016-2023, Texas Department of State Health Services.

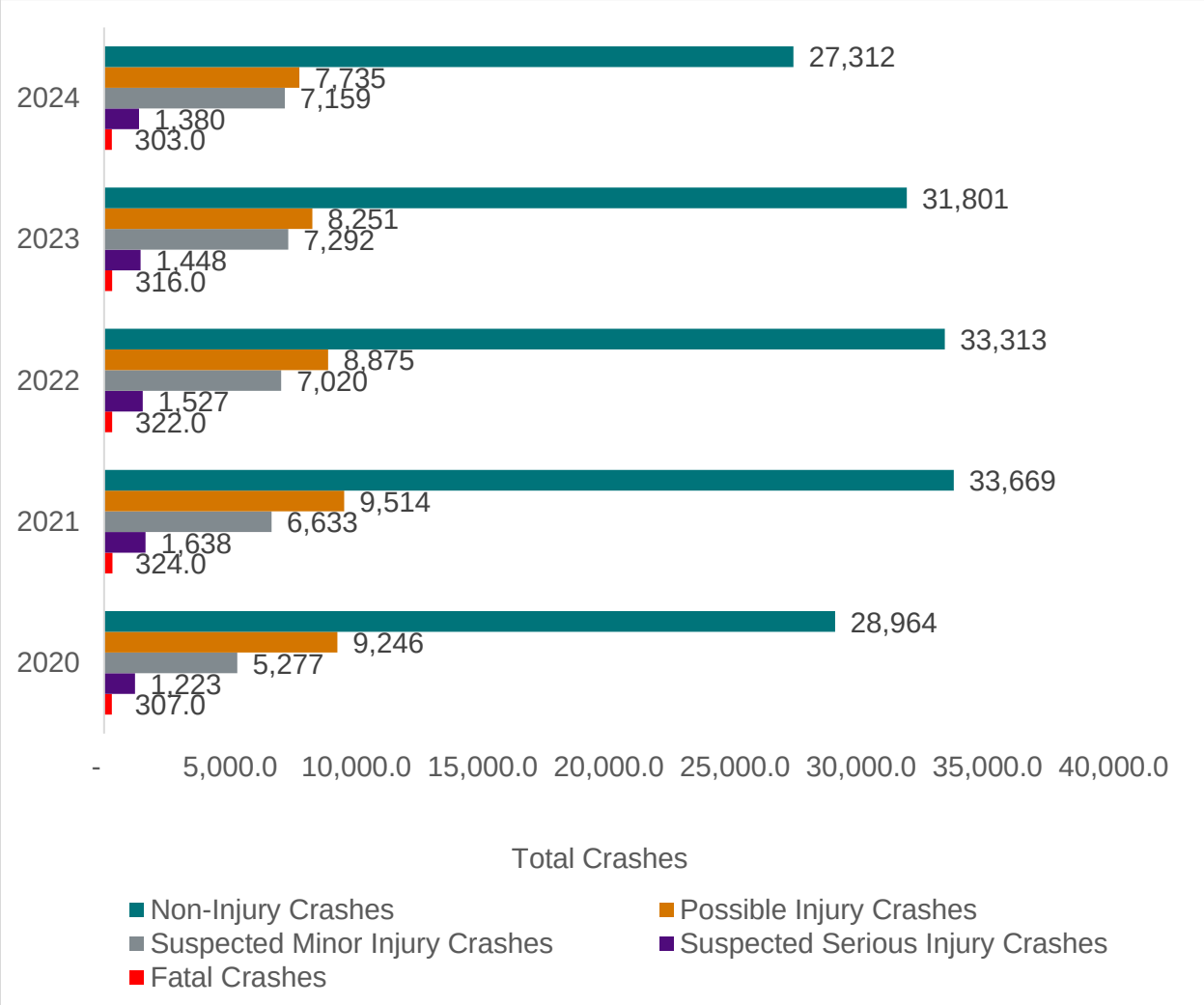
3. Motor Vehicle Injuries

Motor vehicle crashes are a significant public health concern, contributing to preventable injuries and fatalities throughout Dallas County. They encompass collisions involving cars, trucks, motorcycles, bicycles, and pedestrians, with impacts ranging from minor property damage to life-threatening injuries and death.[126]

In Dallas County, crash volumes have remained consistently higher compared to national averages over the past five years, with more than 400,000 incidents reported.[127] Fatal crashes have remained stable, from 307 in 2020 to 303 in 2024. However, crashes resulting in minor and serious injuries continue to affect thousands of residents each year. In 2024 alone, more than 40,000 crashes involved some level of injury, highlighting the ongoing burden of motor vehicle incidents in the region-see Preventive Health Figure 12.

[126] Centers for Disease Control and Prevention. (2024, November 19). About Transportation Safety. Retrieved from Transportation Safety: https://www.cdc.gov/transportation-safety/about/index.html
[127] National Highway Traffic Safety Administration. (2025, April 8). Retrieved from NHTSA Estimates 39,345 Traffic Fatalities in 2024: https://www.nhtsa.gov/press-releases/nhtsa-2023-traffic-fatalities-2024-estimates

Preventive Health Figure 12: Trends in Motor Vehicle Crash Severity in Dallas County, 2020–2024

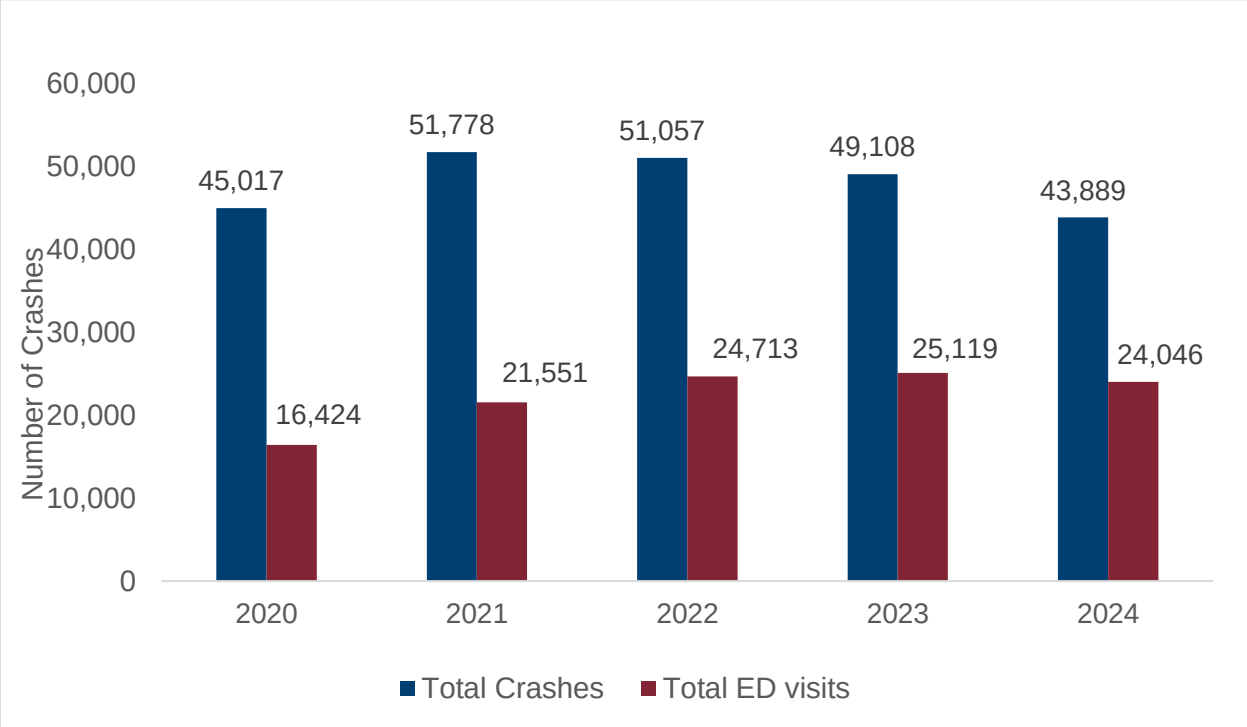


Data Source: TX Department of Transportation

a. Motor Vehicle Crashes vs ED Visits, Dallas County

To understand the burden of crash-related injuries in Dallas County, total crash reports were compared to ED visits from 2020 to 2024. Since ED data captures only those who sought medical care, it may underestimate the full impact of injuries. During this period, crash volumes remained high, ranging from 43,889 to 51,778 annually-see Preventive Health Figure 13. Motor vehicle-related ED visits in Dallas County rose by nearly 53%, from 16,424 in 2020 to more than 25,000 in 2023 before declining to 24,046 in 2024. The proportion of crashes resulting in an ED visit grew from about 37% in 2020 to nearly 55% in 2024. This widening gap suggests that despite a slight decline in total crashes a greater proportion of individuals are requiring emergency care indicating either increased crash severity or greater care-seeking behavior, both of which carry important public health implications.

Preventive Health Figure 13: Total Crashes vs ED Visits in Dallas County, 2020-2024

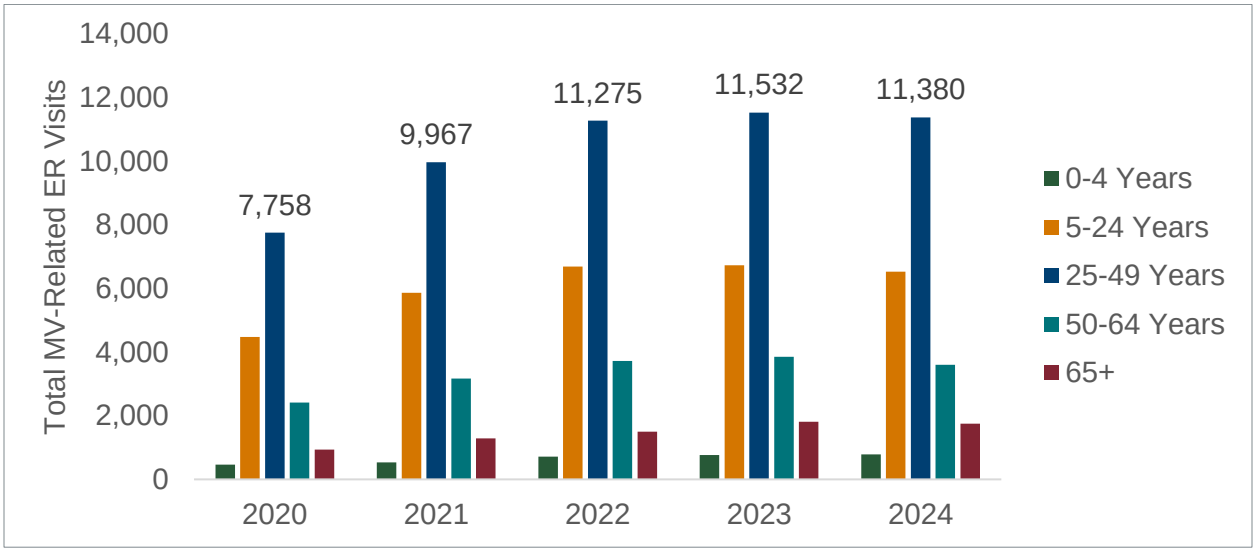


Data Source: ESSENCE Syndromic Surveillance Platform

b. Demographics of ED Visits for Motor Vehicle Injuries, Dallas County

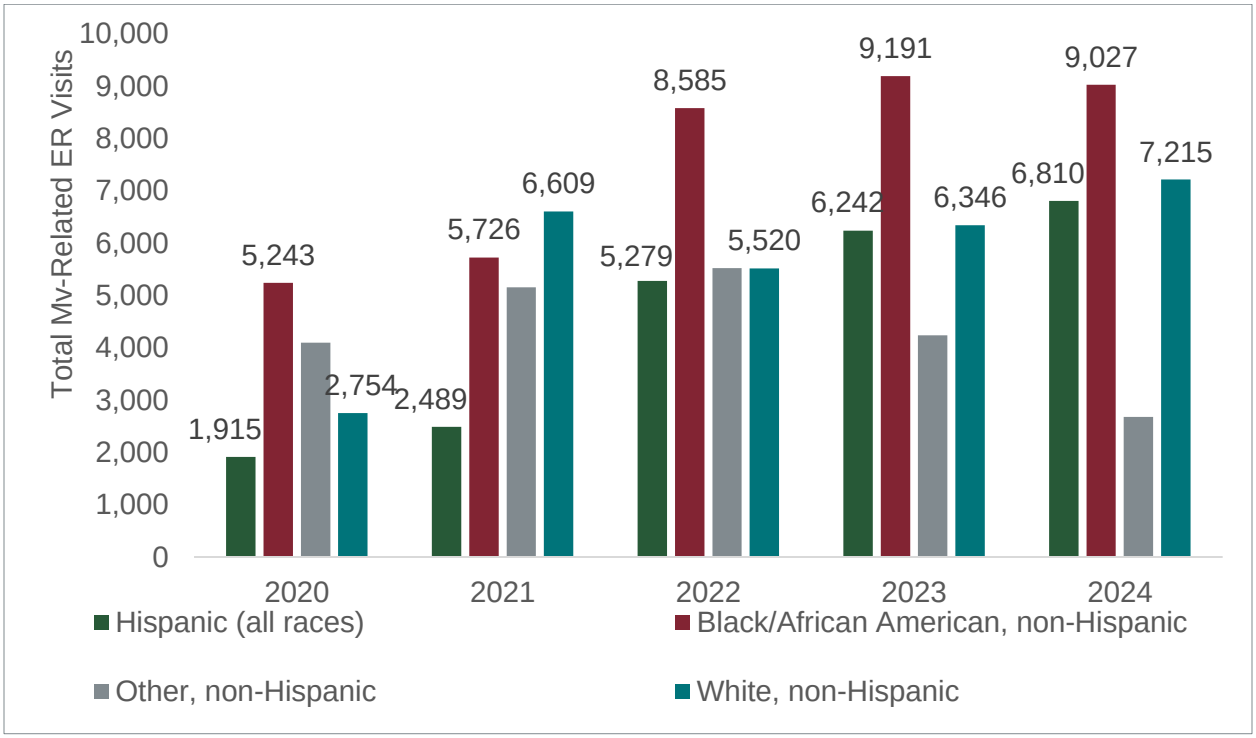
Between 2020 and 2024, Dallas County recorded more than 111,800 ED visits related to motor vehicle crashes. Adults aged 25 to 49 accounted for the highest number of visits among all age groups-see Preventive Health Figure 14. Notable racial and ethnic disparities emerged, with Black or African American, non-Hispanic residents having the highest number of crash-related ED visits across all five years, followed by white, non-Hispanic residents and Hispanics, respectively, see Preventive Health Figure 15. Females consistently accounted for a larger share of visits than males throughout the period-see Preventive Health Figure 16.

Preventive Health Figure 14: ED Visits by Age Group, 2020–2024



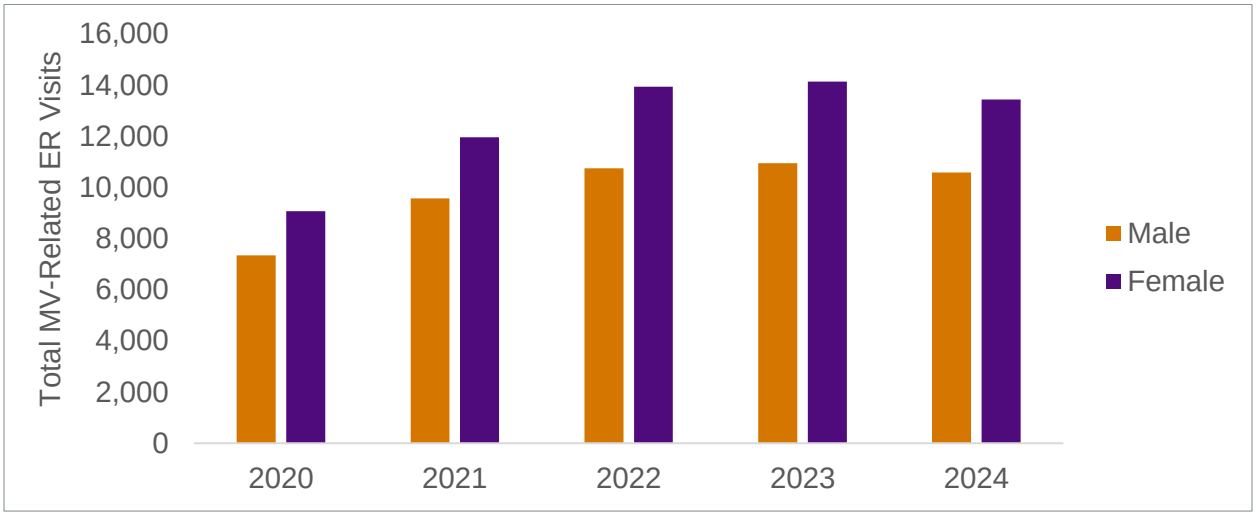
Data Source: ESSENCE Syndromic Surveillance Platform

Preventive Health Figure 15: ED Visits by Race and Ethnicity, 2020–2024



Data Source: ESSENCE Syndromic Surveillance Platform

Preventive Health Figure 16: ED Visits by Sex, 2020–2024

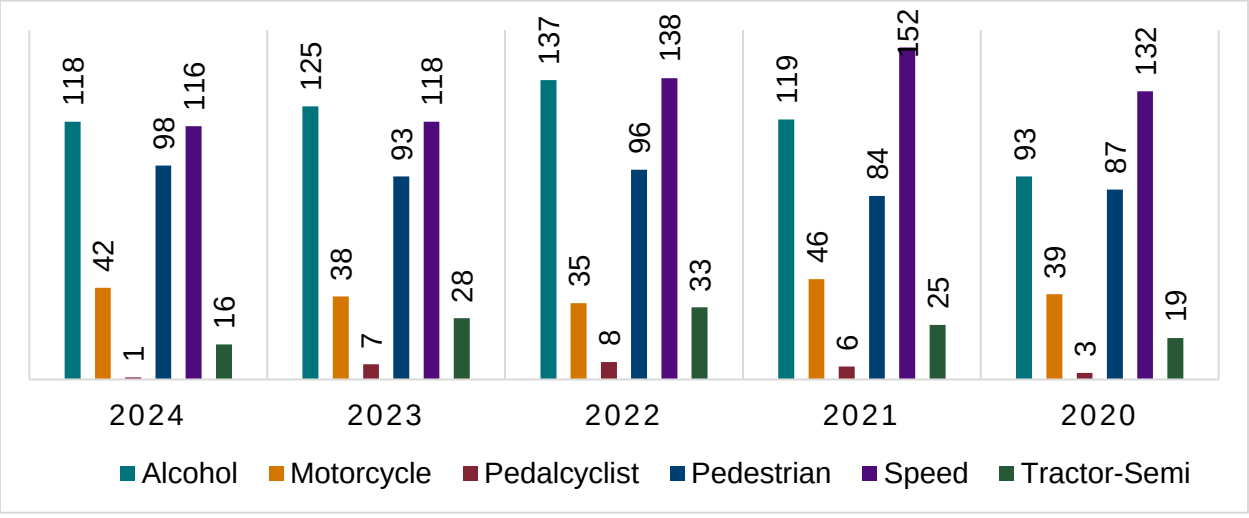


Data Source: ESSENCE Syndromic Surveillance Platform

c. Crash Severity in Dallas County by Contributing Factor (2020–2024)

In 2024, 303 fatal crashes occurred in Dallas County, representing about 1.3% of all county deaths that year. Between 2020 and 2024, speed-related crashes accounted for 656 fatalities, making speed the leading contributing factor each year. Alcohol-related crashes resulted in 592 fatalities, while pedestrian-involved crashes accounted for 458 deaths over the same period. Other high-risk scenarios included motorcycle crashes, which claimed 200 lives, and crashes involving tractor-semi trucks, which resulted in 121 fatalities. These figures highlight the ongoing need for prevention strategies that address speeding, impaired driving, pedestrian safety, and vulnerable road users.

Preventive Health Figure 17: Top Contributing Factors in Fatal Motor Vehicle Crashes, Dallas County, 2020–2024

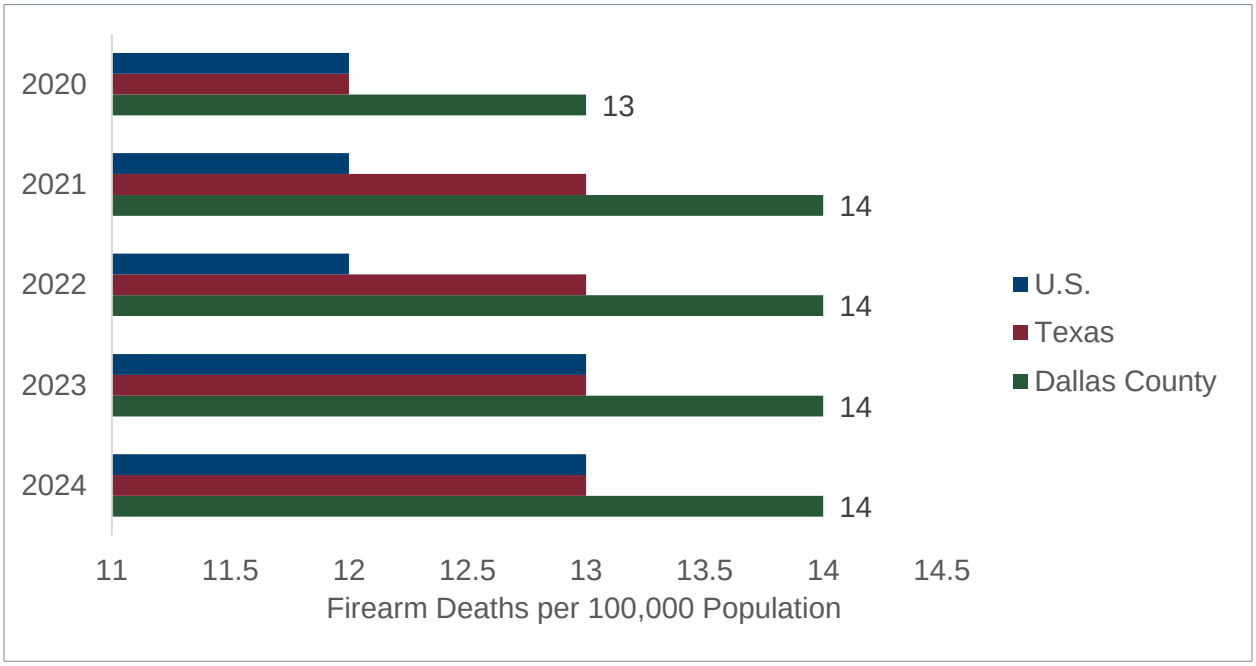


Data Source: TX Department of Transportation

4. Firearm Injuries

Between 2020 and 2024, Dallas County's firearm mortality rate rose from 13 to 14 deaths per 100,000 residents, consistently exceeding both state and national averages, which remained at 13 firearm deaths per 100,000 population.[128] While Texas and the U.S. experienced only slight increases during this period, Dallas County's rates remained higher each year, indicating a sustained and disproportionate local impact-see Preventive Health Figure 18.

Preventive Health Figure 18: Firearm-Related Deaths per 100,000 Residents in Dallas County, Texas, and the U.S., 2020–2024



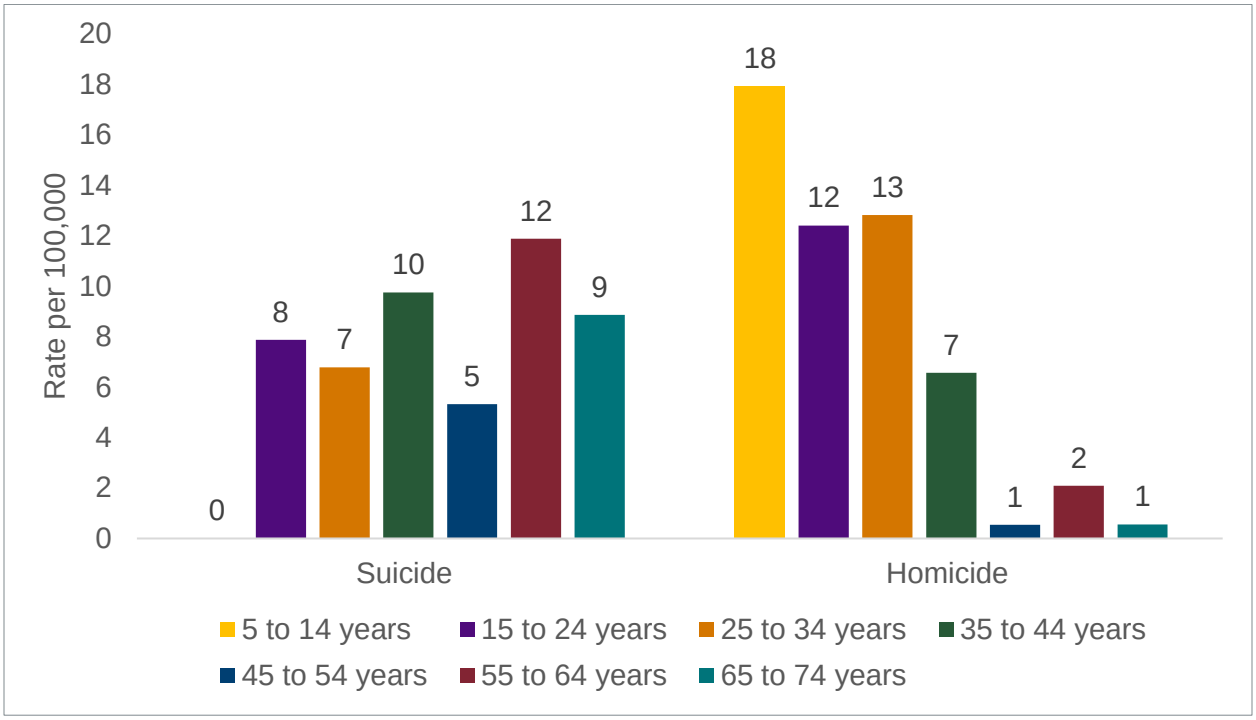
Data Source: County Health Rankings

a. Firearm Injury by Demographic Category

In 2024, homicide and suicide by firearm death rates in Dallas County revealed marked differences across demographic groups. The combined mortality rate for these causes was approximately 7.5 deaths per 100,000 residents, with homicide slightly surpassing suicide. Young adults aged 15 to 34 bore the greatest mortality burden. Homicide rates peaked among those aged 5 to 14, reaching nearly 18 deaths per 100,000, while suicide rates were highest among individuals aged 55 to 64, at nearly 12 deaths per 100,000-see Preventive Health Figure 19. Racial disparities were pronounced - Black or African American, non-Hispanic residents experienced the highest homicide mortality rate, exceeding 19 deaths per 100,000, whereas white, non-Hispanic residents had the highest suicide rate, nearing 14 deaths per 100,000-see Preventive Health Figure 20. Males faced higher mortality rates from both homicide and suicide compared to females-see Preventive Health Figure 21.

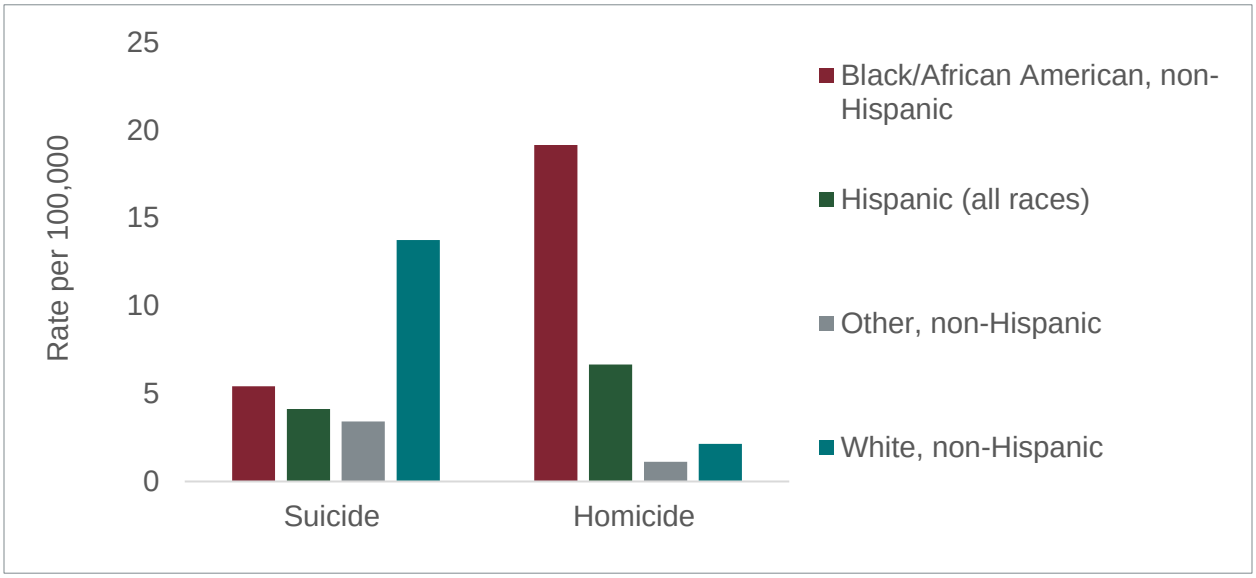
[128] University of Wisconsin Population Health Institute. (2025). Dallas, TX. Retrieved from County Health Rankings & Roadmaps: https://www.countyhealthrankings.org/health-data/texas/dallas?year=2025

Preventive Health Figure 19: Homicide and Suicide Mortality Rates by Age Group, 2024



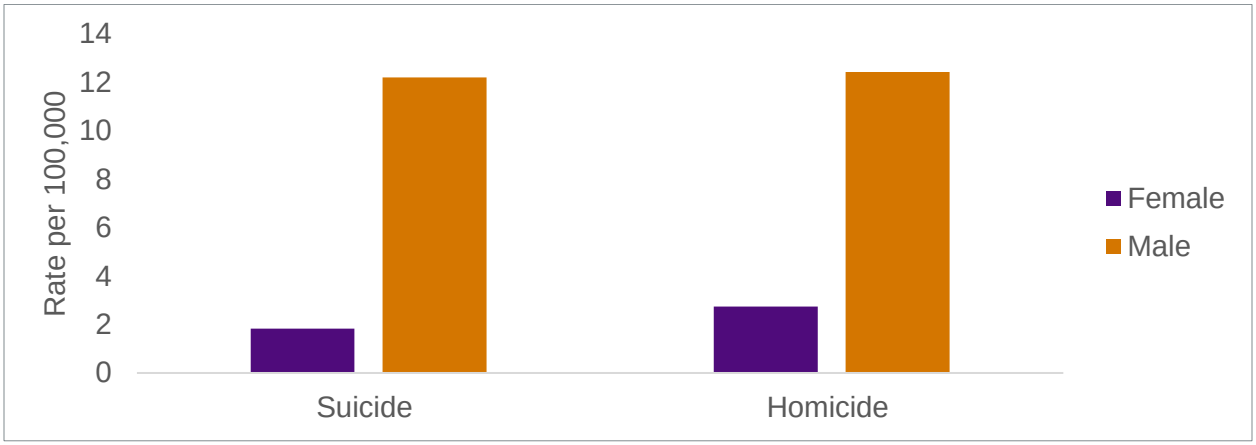
Data Source: ESSENCE Syndromic Surveillance Platform

Preventive Health Figure 20: Homicide & Suicide Mortality Rates by Race/Ethnicity, 2024



Data Source: ESSENCE Syndromic Surveillance Platform

Preventive Health Figure 21: Homicide & Suicide Mortality Rates by Sex, 2024

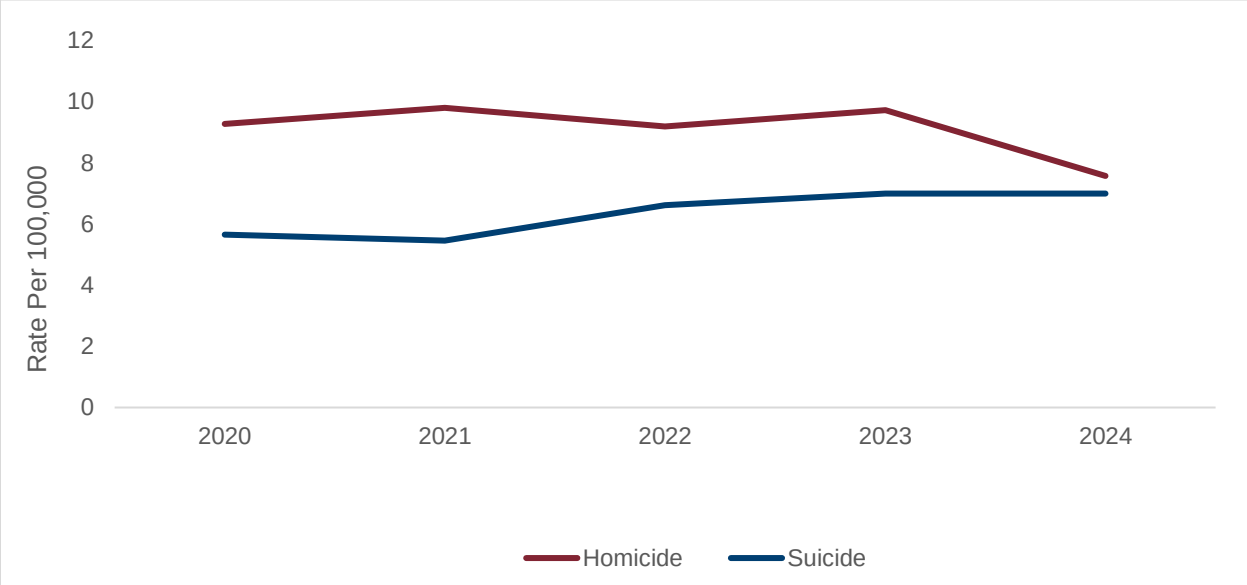


Data Source: ESSENCE Syndromic Surveillance Platform

b. Trends in Firearm-Related Suicide and Homicide Mortality, 2020–2024

From 2020 to 2024, firearm-related homicide rates in Dallas County fluctuated, peaking at 9.8 deaths per 100,000 in 2021 and declining to 7.6 by 2024. Over the same period, firearm-related suicides steadily rose from 5.6 to 7.0 per 100,000, nearly matching homicide rates by 2024. This increase in suicides reflects broader mental health challenges, with poor mental health reports surging from 10% of residents in 2019 to 14.4% by 2023. These trends underscore the need for integrated prevention strategies that address both violence and behavioral health through early intervention, support services, and community engagement.

Preventive Health Figure 22: Firearm-Related Suicide and Homicide Death Rates per 100,000, Dallas County, 2020–2024



Data Source: ESSENCE Syndromic Surveillance Platform

VI. UTILIZATION

A. Healthcare Utilization

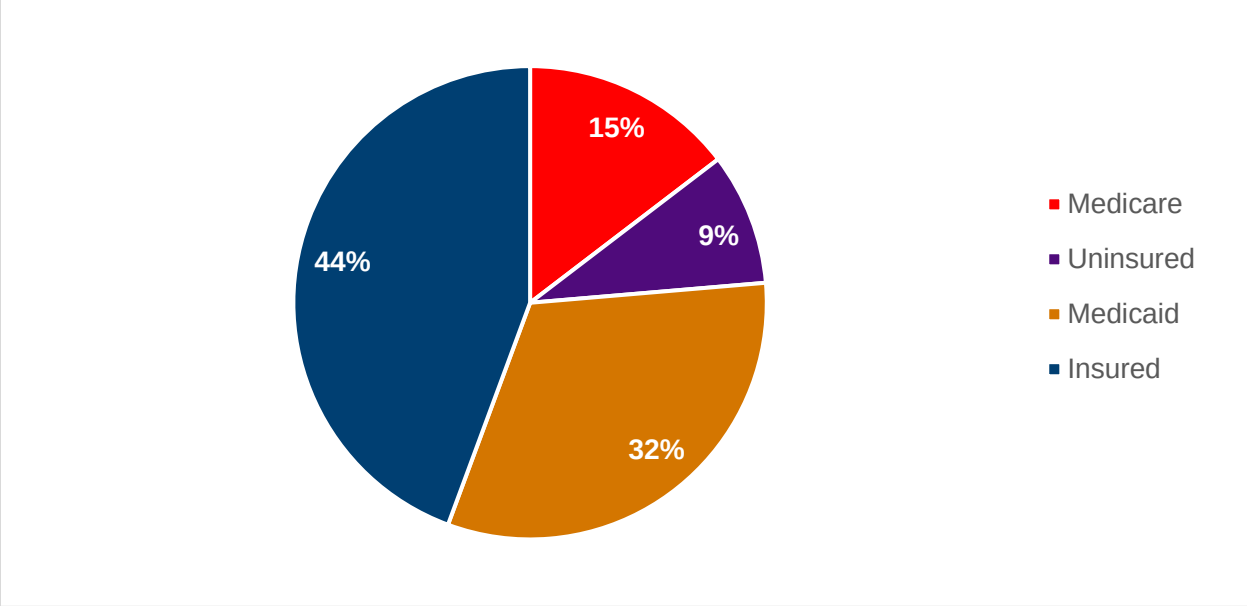
Healthcare utilization refers to the degree to which individuals or populations use medical services to maintain health, prevent illness, or manage existing conditions. This section highlights patterns of utilization in ED visits, inpatient hospital services, and public health programs within Dallas County. It includes a summary of inpatient and ED discharges across Dallas County and Parkland, along with utilization data for Public Health Services.

1. Clinical Inpatient Discharges

a. Inpatient Discharges by Payer Type

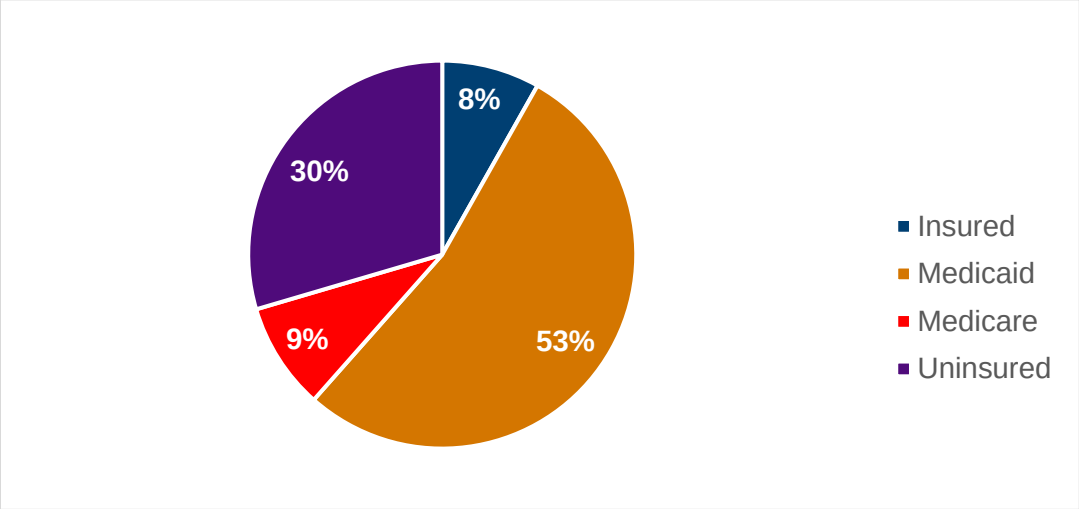
A comparison of inpatient discharges between Dallas County overall and Parkland reveals differences in utilization by payer mix. In Dallas County, 9% of inpatient discharges are among uninsured individuals and 32% are covered by Medicaid. In contrast, Parkland shows 30% of discharges among the uninsured and 53% covered by Medicaid-see Utilization Figure 1 and Utilization Figure 2.

Utilization Figure 1: Inpatient Cases by Payer Groups, Dallas County, FY 24



Data Source: DFWHC Foundation Regional Data

Utilization Figure 2: Inpatient Cases by Payer Groups, Parkland, FY 24

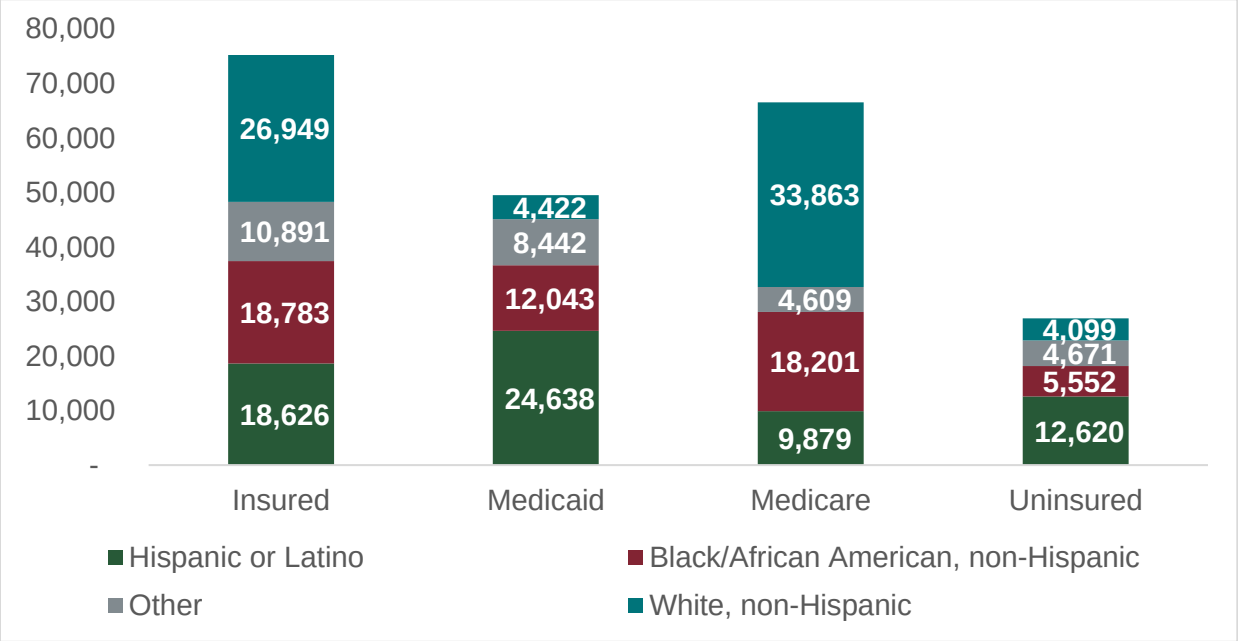


Data Source: DFWHC Foundation Regional Data

b. Inpatients Discharges by Race and Ethnicity

As shown in Utilization Figure 3, the 2024 inpatient population in Dallas County reveals distinct patterns when stratified by payer mix and race/ethnicity. The highest volume of utilization in inpatient is patients with private insurance or insured, followed by patients covered by Medicare. In both the groups, white, non-Hispanic have the highest utilization, followed by Black or African American, non-Hispanics.

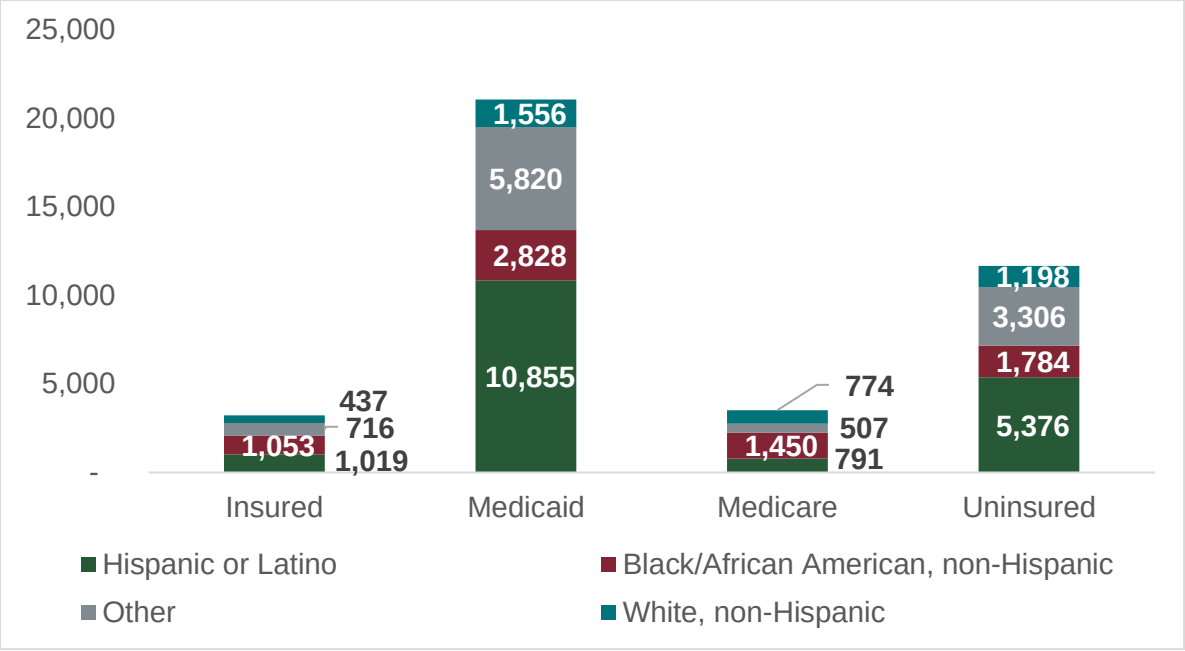
Utilization Figure 3: Inpatient Cases by Race and Ethnicity, Payer Mix, Dallas County, FY 24



Data Source: DFWHC Foundation Regional Data

Parkland's inpatient utilization data shows that Medicaid patients account for the highest volume of discharges, with Hispanics representing the highest volume (10,855), followed by patients categorized as "Other" (5,820). The second highest discharge group consists of uninsured patients, among whom Hispanics also have the highest volume (5,376)-see Utilization Figure 4.

Utilization Figure 4: Inpatient Cases by Race and Ethnicity, Payer Mix, Parkland, FY 24

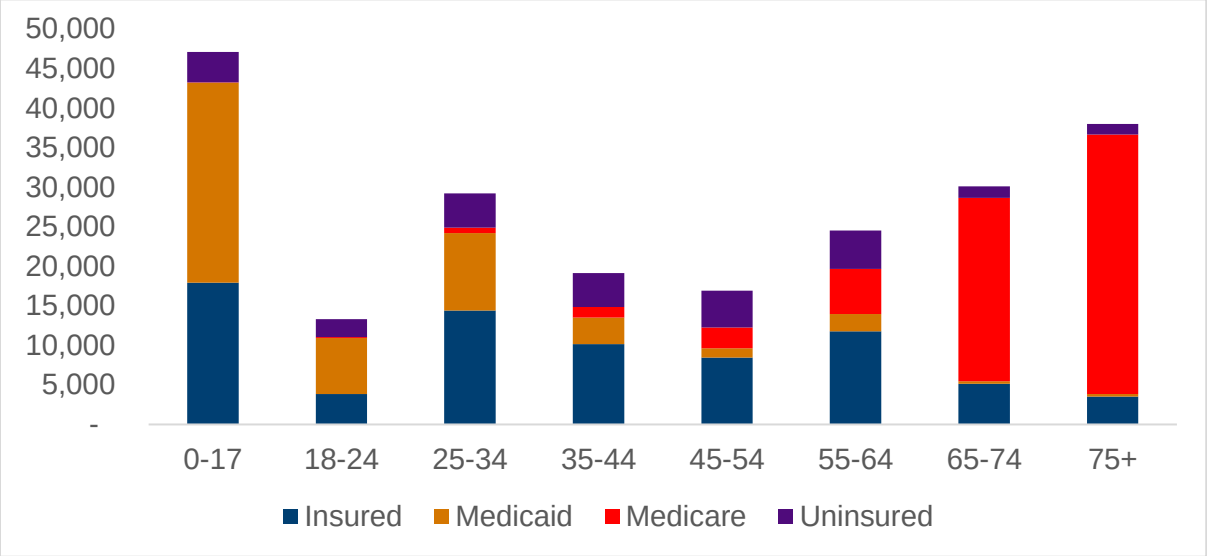


Data Source: DFWHC Foundation Regional Data

c. Inpatient Discharges by Age Group

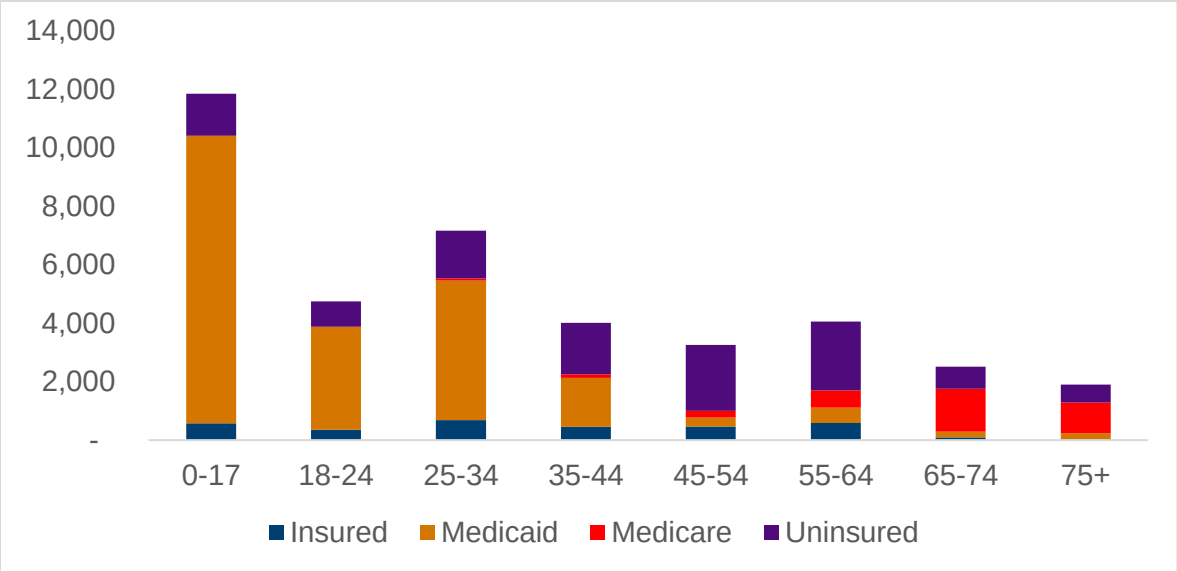
As seen in Utilization Figure 5 and Utilization Figure 6, inpatient utilization is highest among the 0–17 age group in both Dallas County and Parkland. The 75 years and older age group, primarily covered by Medicare, ranks second for Dallas County. The 25–34 age group, primarily covered by Medicaid, ranks second in Parkland utilization.

Utilization Figure 5: Inpatient Cases by Age Group, Payer Mix, Dallas County, FY 24



Data Source: DFWHC Foundation Regional Data

Utilization Figure 6: Inpatient Cases by Age Group, Payer Mix, Parkland, FY 24

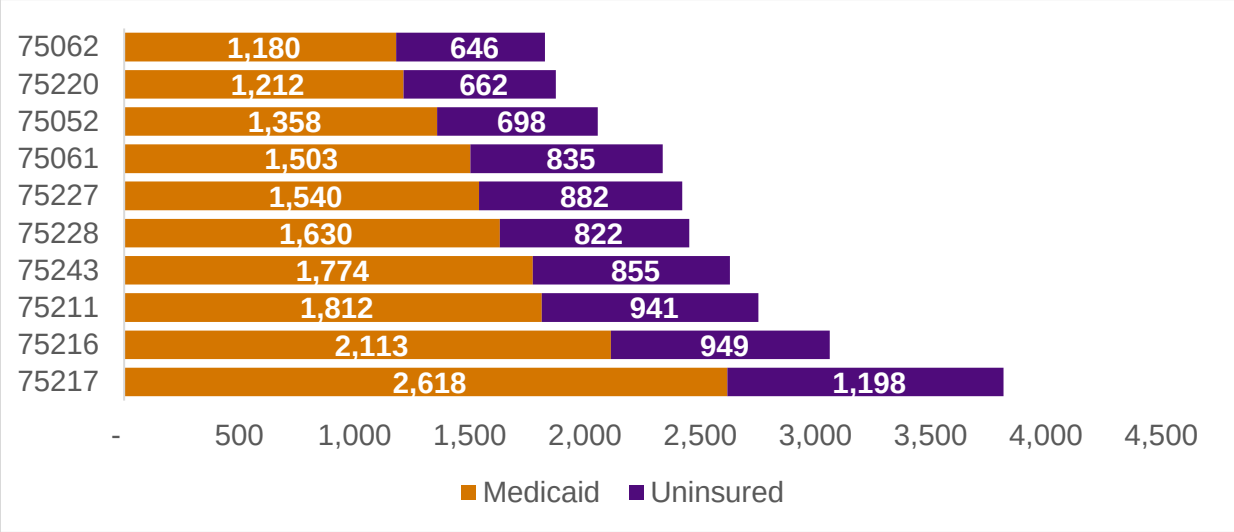


Data Source: DFWHC Foundation Regional Data

d. Inpatient Discharges by Top 10 ZIP Codes

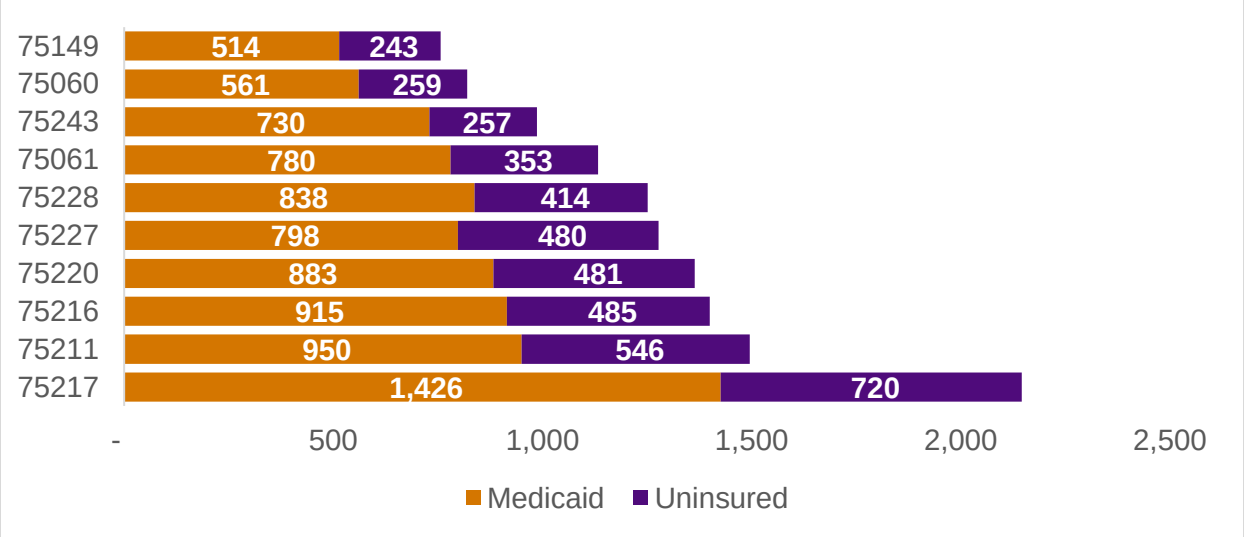
Utilization Figure 7 and Utilization Figure 8 both present inpatient utilization data stratified by ZIP Codes, focusing on Medicaid and uninsured populations. ZIP Codes 75217, 75211, and 75216 rank as the top three in utilization for both Dallas County and Parkland. These ZIP Codes rank among those with the highest CVI scores, with 75216 holding the highest score in the county.

Utilization Figure 7: Inpatient Cases by Top 10 ZIP Codes, Medicaid and Uninsured, Dallas County, FY 24



Data Source: DFWHC Foundation Regional Data

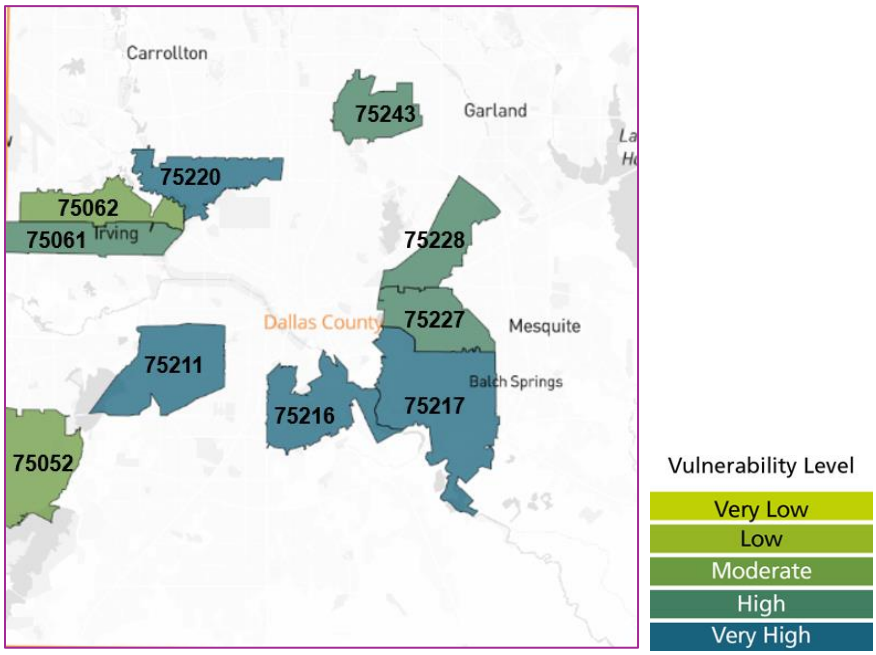
Utilization Figure 8: Inpatient Cases by Top 10 ZIP Codes, Medicaid and Uninsured, *Parkland, FY 24*



Data Source: DFWHC Foundation Regional Data

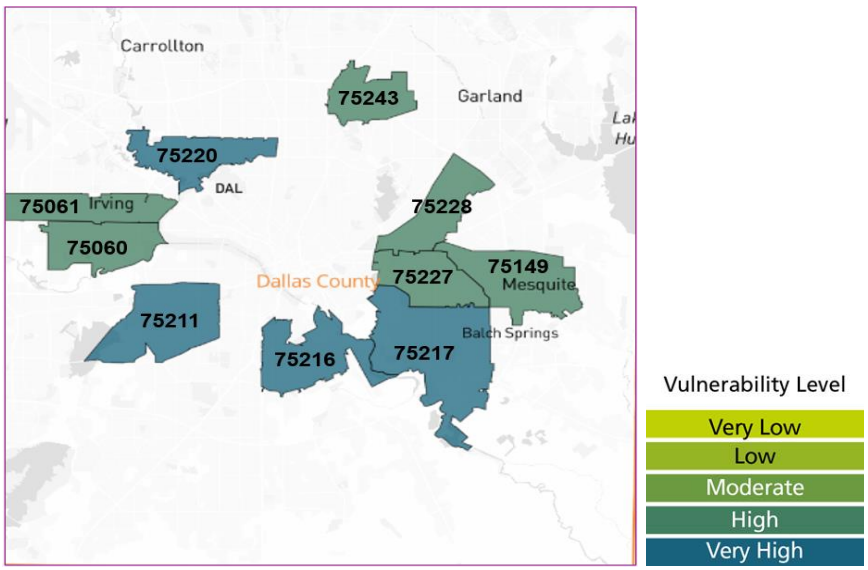
ZIP Codes 75052 and 75062 are among the top ten inpatient utilization within Dallas County but not listed among Parkland's top ten ZIP Codes, these two ZIP Codes have low to moderate CVI scores-see Utilization Figure 9. ZIP Codes 75060 and 75149 are listed in Parkland's top ten ZIP Codes and fall in moderate to high levels of CVI-see Utilization Figure 10.

Utilization Figure 9: CVI Scores for Inpatient Cases by Top 10 ZIP Codes, Medicaid and Uninsured, Dallas County, FY 24



Data Source: DFWHC Foundation Regional Data and CVC, PCCI

Utilization Figure 10: CVI Scores for Inpatient Cases by Top 10 ZIP Codes, Medicaid and Uninsured, Parkland, FY 24

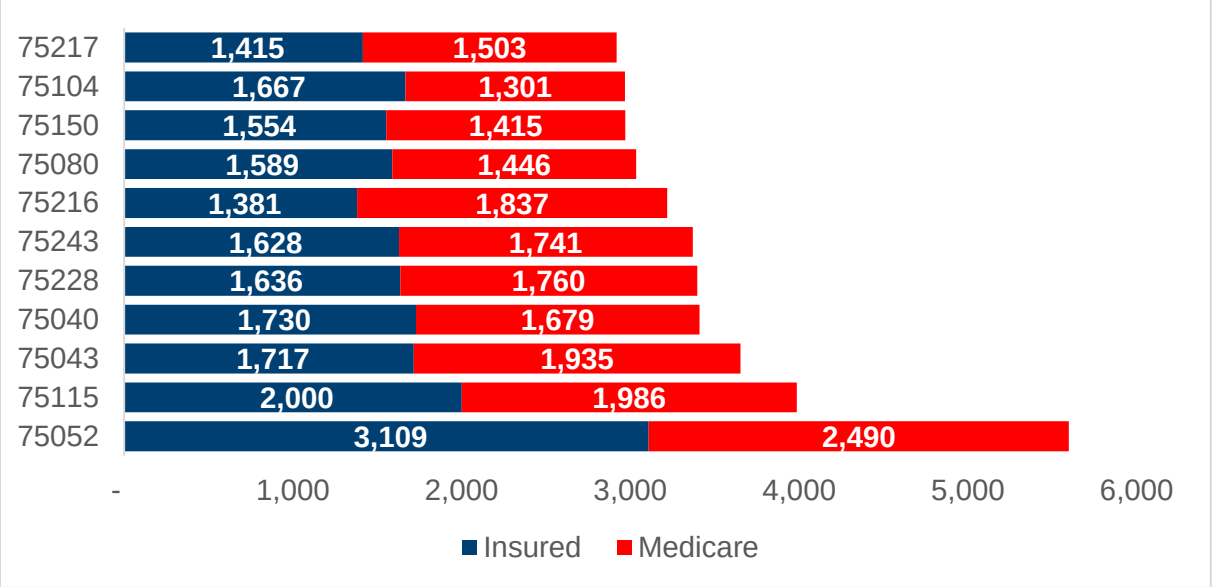


Data Source: DFWHC Foundation Regional Data and CVC, PCCI

When comparing inpatient utilization among Medicare and insured patients across Dallas County and Parkland, distinct patterns are visible. In Dallas County, the top two ZIP Codes by utilization are 75052 and 75115. In contrast, Parkland's utilization for these payer groups closely

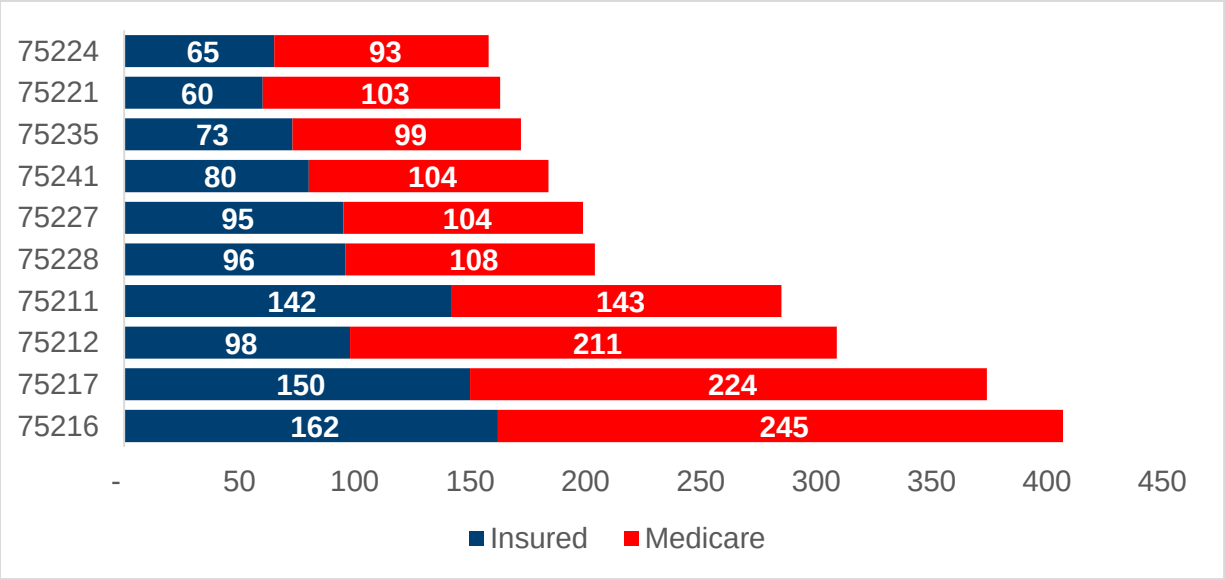
mirrors the patterns seen in ZIP Codes with high Medicaid and uninsured utilization e.g., 75216, 75217, 75212, and 75211-see Utilization Figure 11 and Utilization Figure 12.

Utilization Figure 11: Inpatient Cases by Top 10 ZIP Codes, Medicare and Insured, Dallas County, FY 24



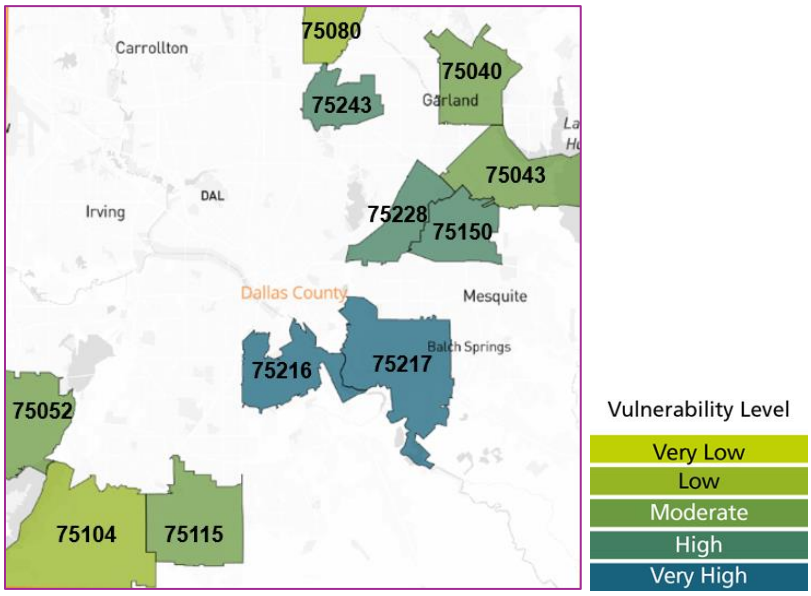
Data Source: DFWHC Foundation Regional Data

Utilization Figure 12: Inpatient Cases by Top 10 ZIP Codes, Medicare and Insured, Parkland, FY 24



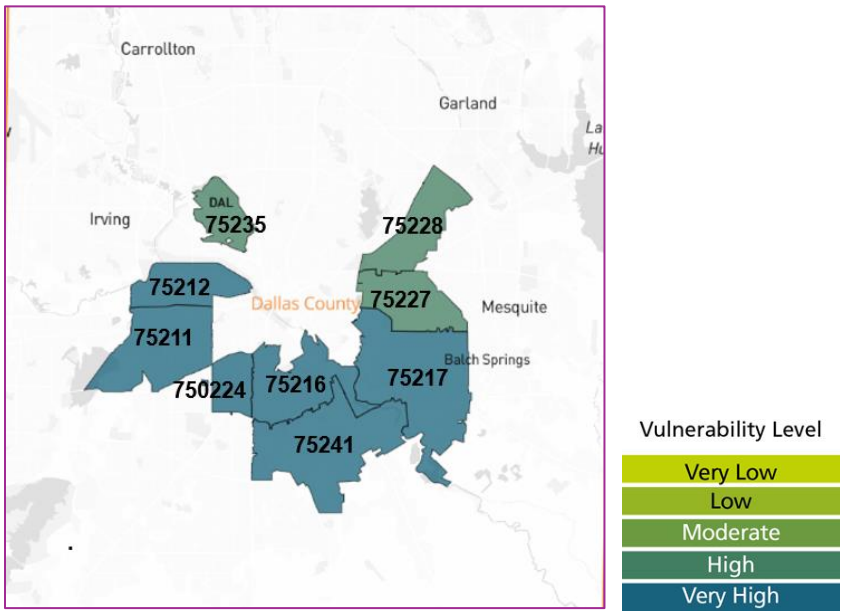
Data Source: DFWHC Foundation Regional Data

Utilization Figure 13: CVI Scores for Inpatient Cases by Top 10 ZIP Codes, Medicare and Insured, Dallas County, FY 24



Data Source: DFWHC Foundation Regional Data and CVC, PCCI

Utilization Figure 14: CVI Scores for Inpatient Cases by Top 10 ZIP Codes, Medicare and Insured, Parkland, FY 24



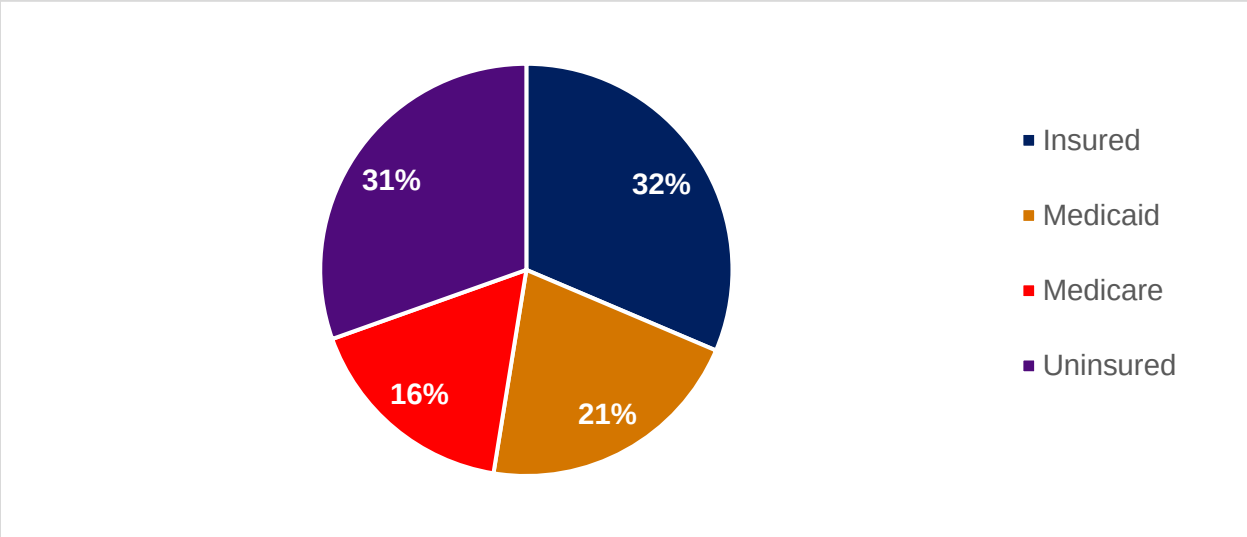
Data Source: DFWHC Foundation Regional Data and CVC, PCCI

2. ED Discharges

a. ED Discharges by Payer Group

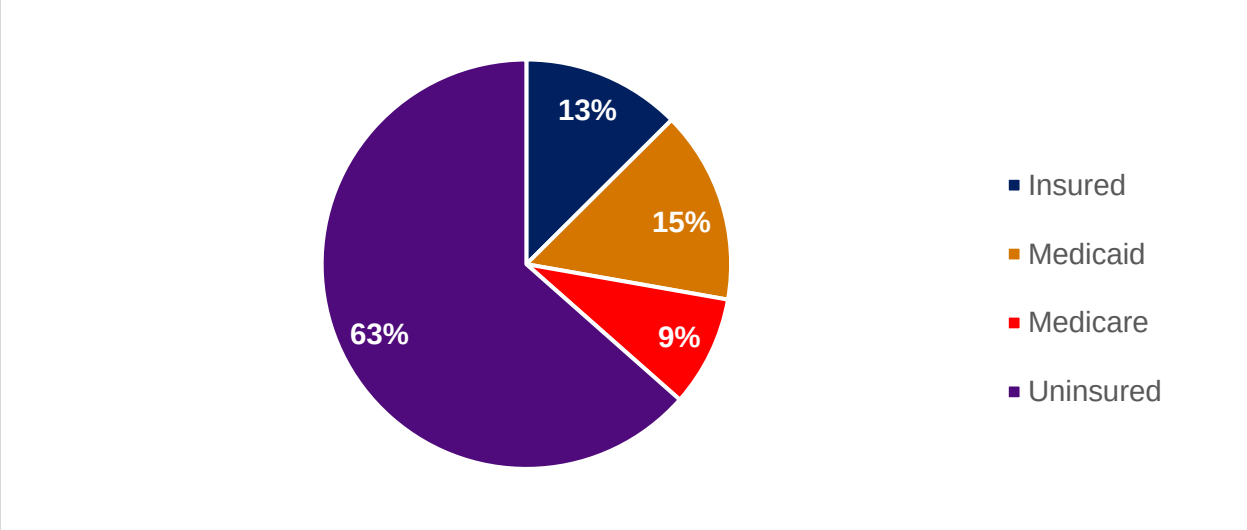
ED utilization patterns differ between Dallas County overall and Parkland Memorial Hospital when analyzed by payer group. Utilization Figure 15 shows that in Dallas County, the highest volume of ED utilization comes from insured patients (32%), followed closely by uninsured patients (31%). In contrast, Utilization Figure 16 reveals that at Parkland, the majority of ED visits are from uninsured patients (63%), followed by those covered by Medicaid (15%).

Utilization Figure 15: Emergency Department Cases by Payer Group, Dallas County, FY 24



Data Source: DFWHC Foundation Regional Data

Utilization Figure 16: Emergency Department Cases by Payer Group, Parkland, FY 24

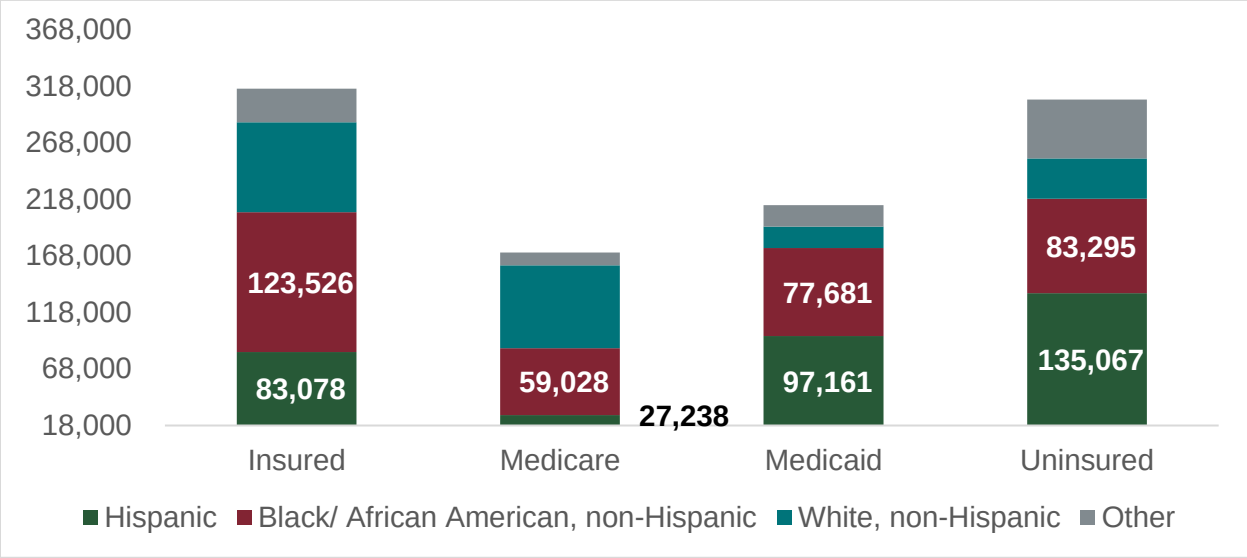


Data Source: DFWHC Foundation Regional Data

b. ED Discharged by Race and Ethnicity

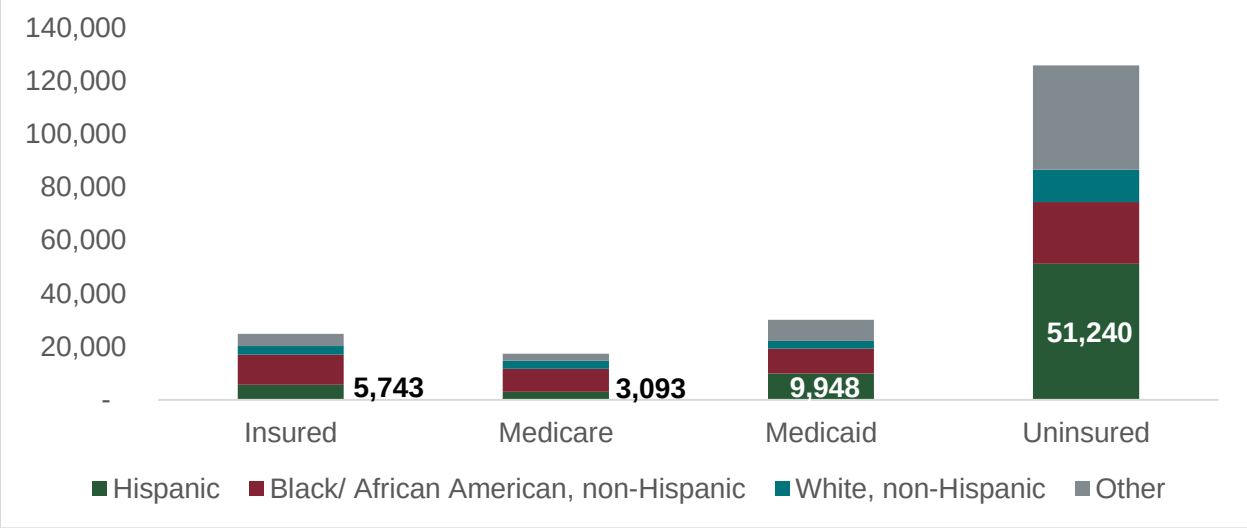
ED utilization data for Dallas County shows that Black or African American, non-Hispanic patients have the highest utilization, followed by Hispanics–see Utilization Figure 17. Whereas, Hispanics have the highest ED utilization for Parkland-see Utilization Figure 18.

Utilization Figure 17: Emergency Department Cases by Race and Ethnicity, Payer Mix, Dallas County, FY 24



Data Source: DFWHC Foundation Regional Data

Utilization Figure 18: Emergency Department Cases by Race and Ethnicity, Payer Mix, Parkland, FY 24

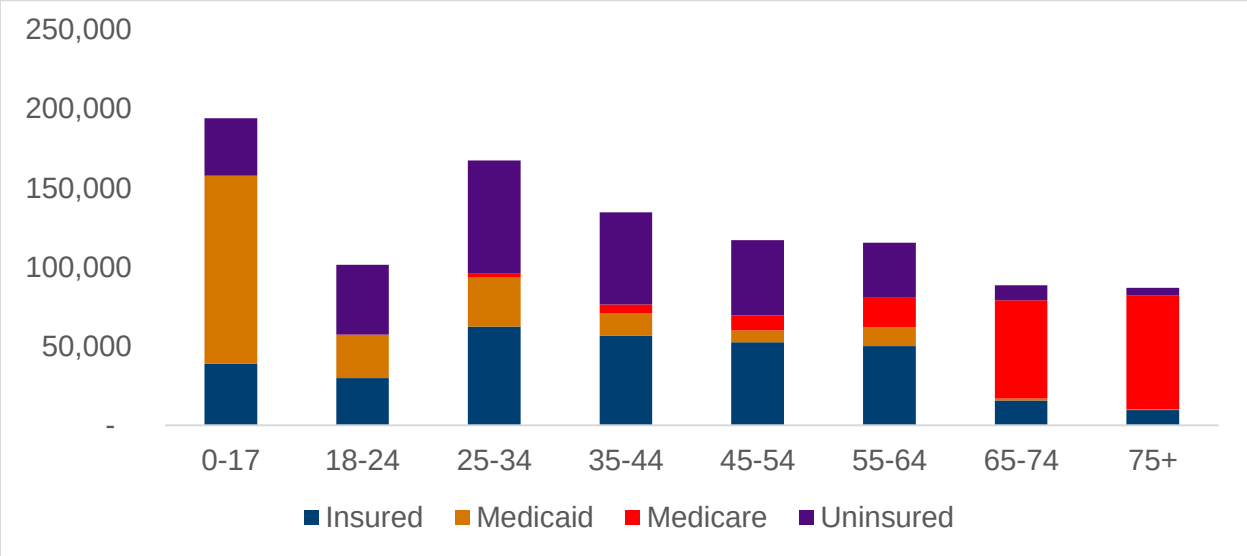


Data Source: DFWHC Foundation Regional Data

c. ED Discharges by Age Group

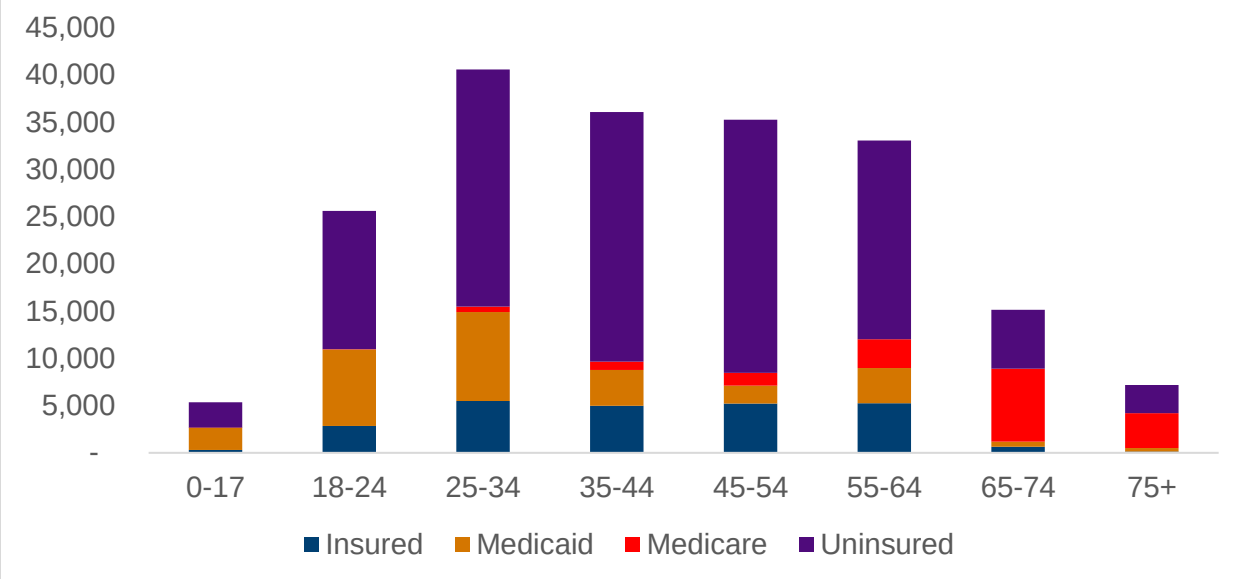
Utilization Figure 19 shows that ED case volume in Dallas County is highest among individuals aged 17 and under, while Parkland's highest ED utilization occurs in the adults aged 25–34, followed by age groups 35-44 and 45-54-see Utilization Figure 20.

Utilization Figure 19: Emergency Department Cases by Age Group, Payer Mix, Dallas County, FY 24



Data Source: DFWHC Foundation Regional Data

Utilization Figure 20: Emergency Department Cases by Age Group, Payer Mix, Parkland, FY 24

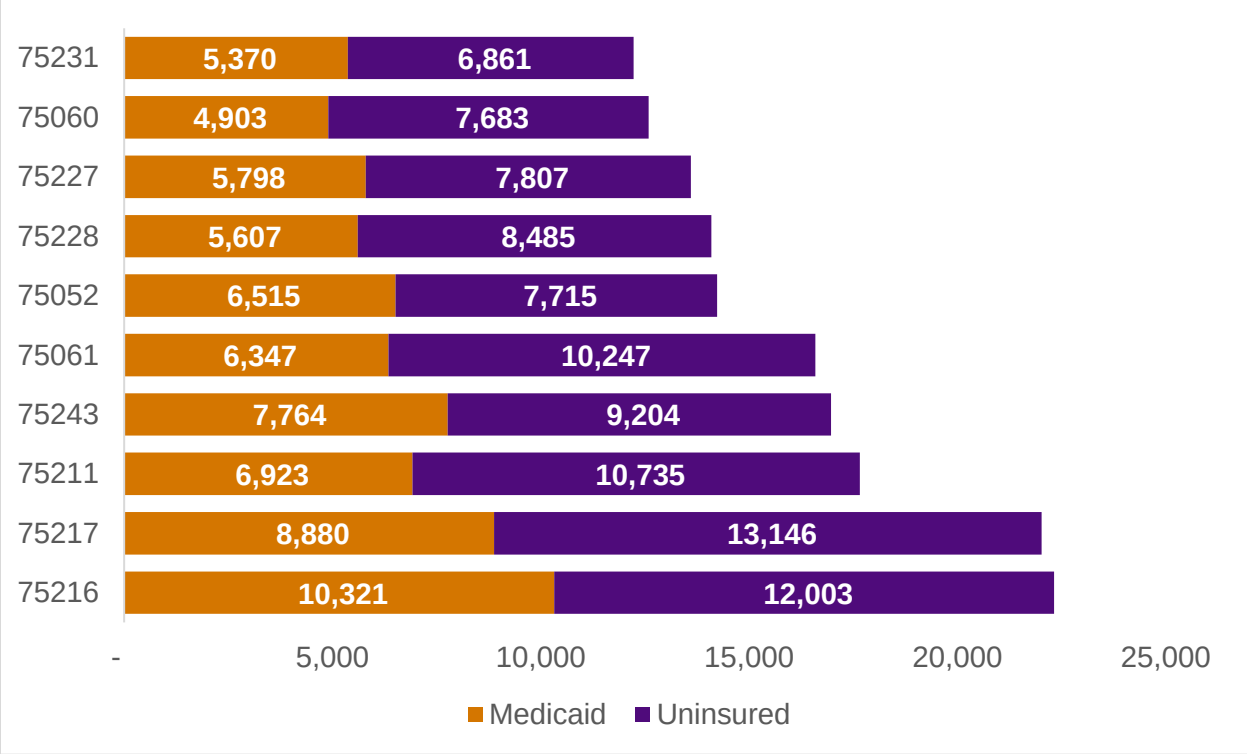


Data Source: DFWHC Foundation Regional Data

d. ED Discharges by Top 10 ZIP Codes

As shown in Utilization Figure 21 and Utilization Figure 22, ED utilization by ZIP Codes for both Dallas County and Parkland highlights 75216, 75217, and 75211 as among the top ZIP Codes for ED visits for Medicaid and uninsured. As discussed earlier, these ZIP Codes rank high in terms of CVI scores. ZIP Code 75221 is listed among the top ZIP Codes for Parkland utilization; however, it does not correspond to a geographic area and is instead designated for PO Box use within Dallas County.[129]

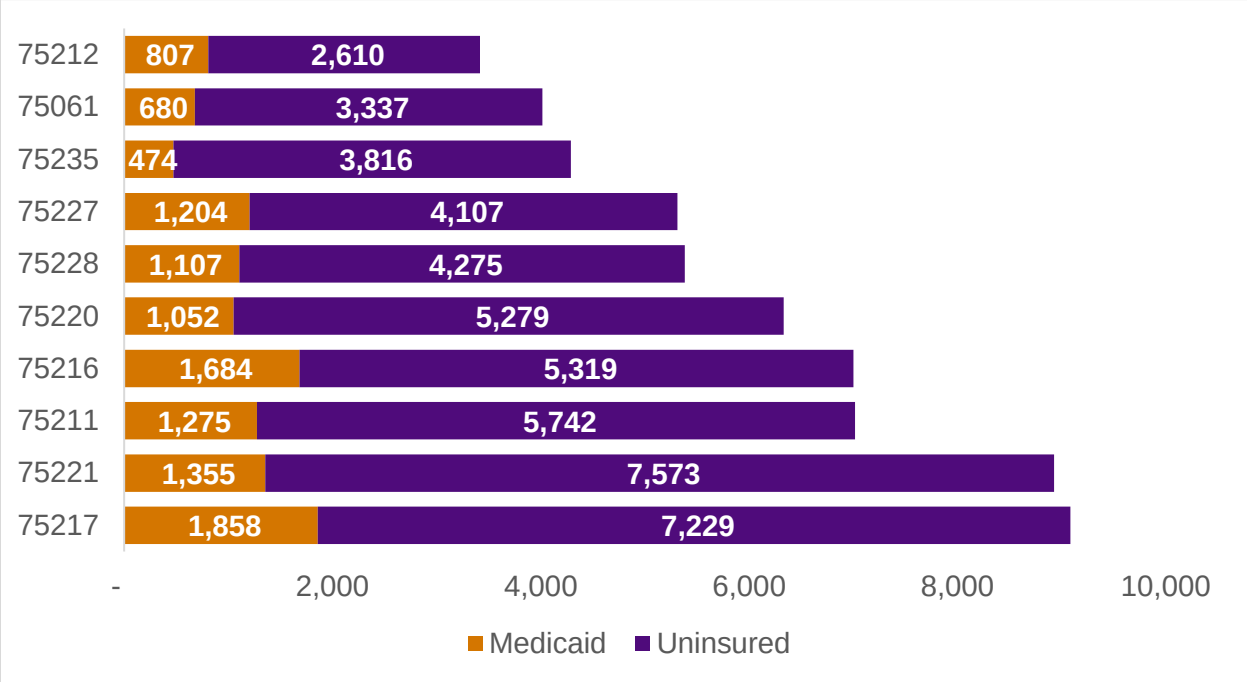
Utilization Figure 21: Emergency Department Cases by Top 10 ZIP Codes, Medicaid and Uninsured, Dallas County, FY 24



Data Source: DFWHC Foundation Regional Data

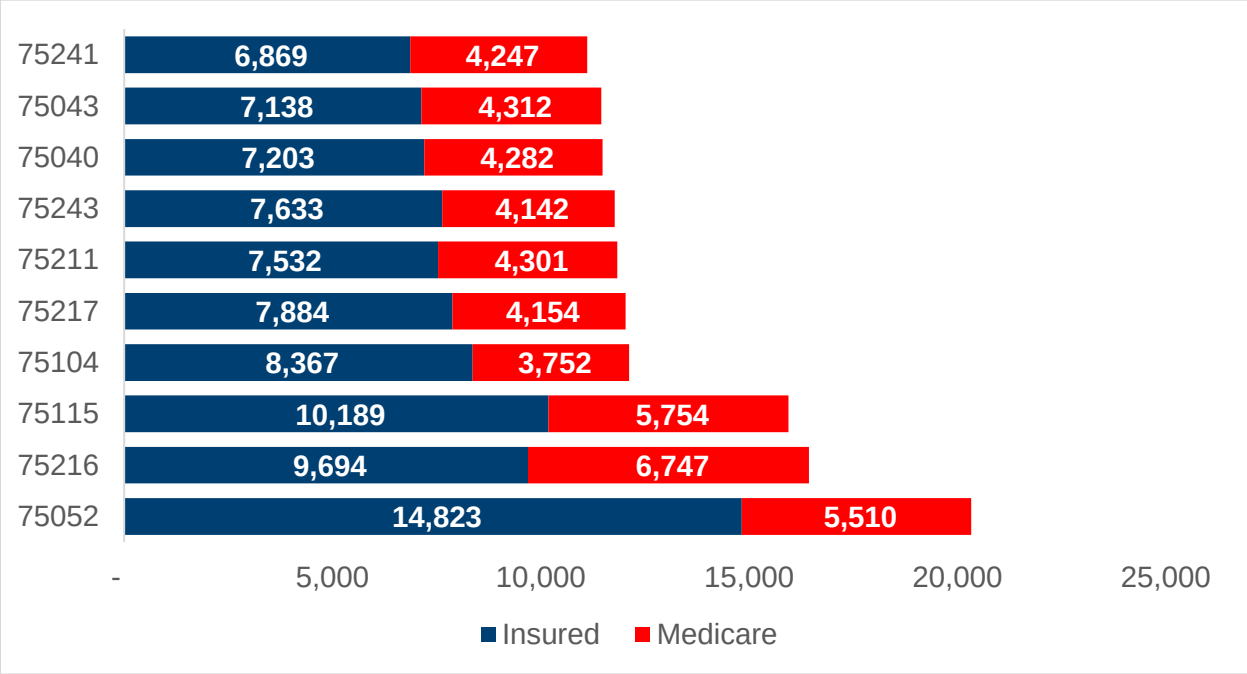
[129] United States ZIP Codes. UnitedStatesZipCodes.org. Accessed October 16, 2025. https://www.unitedstateszipcodes.org/

Utilization Figure 22: Emergency Department Cases by Top 10 ZIP Codes, Medicaid and Uninsured, Parkland, FY 24



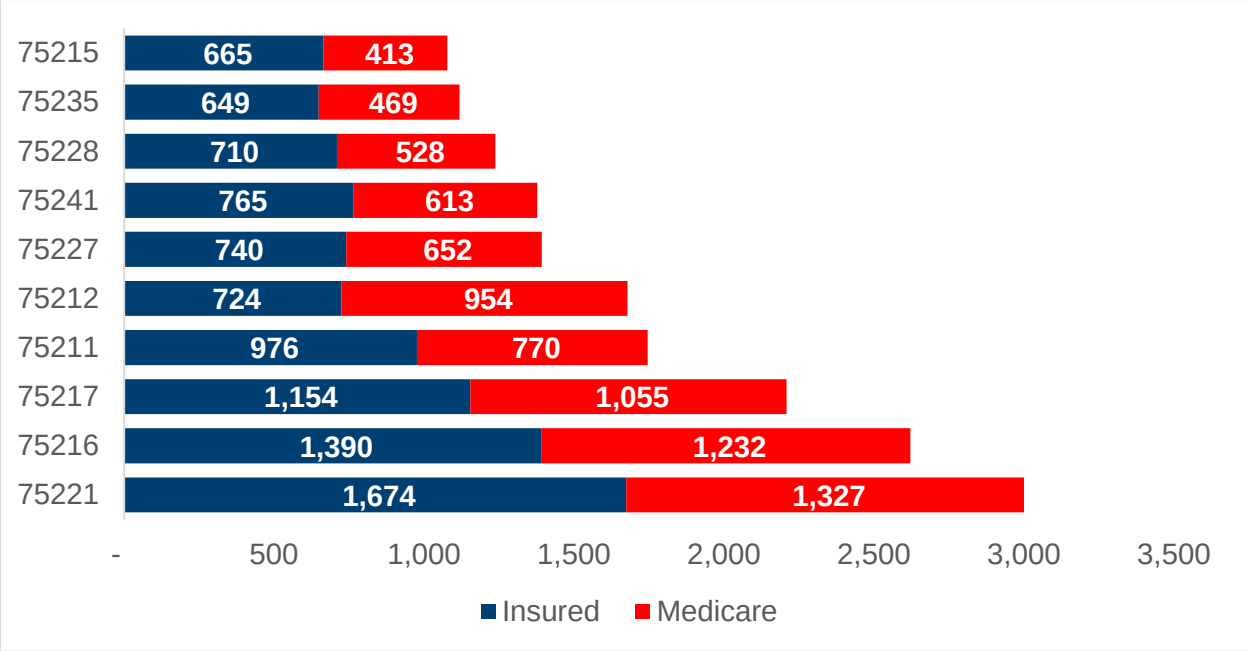
Data Source: DFWHC Foundation Regional Data

Utilization Figure 23: Emergency Department Cases by Top 10 ZIP Codes, Medicare and Insured, Dallas County, FY 24



Data Source: DFWHC Foundation Regional Data

Utilization Figure 24: Emergency Department Cases by Top 10 ZIP Codes, Medicare and Insured, Parkland, FY 24



Data Source: DFWHC Foundation Regional Data

B. Public Health Services Utilization

DCHHS provides critical front-line clinical services to thousands of residents each year, many of whom would not otherwise have access to care. These services not only prevent the spread of communicable disease but also promote long-term community well-being and health equity.

DCHHS clinics have evolved to meet emerging needs and longstanding gaps in access. The sexual health program, which includes fixed-site and mobile service delivery, has expanded in response to rising STI rates and ongoing disparities in HIV diagnosis and treatment. Tuberculosis remains a persistent challenge in Dallas County, and the DCHHS TB clinic is the primary provider of testing, treatment, and case management services. Immunizations continue to be an essential preventive tool, and DCHHS remains a key provider of vaccines for both children and adults, including those required for school, employment, and international travel.

1. DCHHS Utilization by Clinic and Payer Type

Over the past several years, DCHHS clinic utilization has steadily increased, see Utilization Table 1. Immunization clinics and the Sexual Health Clinic are the highest-volume clinics, while TB services, refugee health, and mobile unit outreach also represent substantial portions of care delivery. In 2023, DCHHS transitioned to a new electronic medical record system, so historical data is limited.

Utilization Table 1: DCHHS Clinic Utilization, 2023-2024

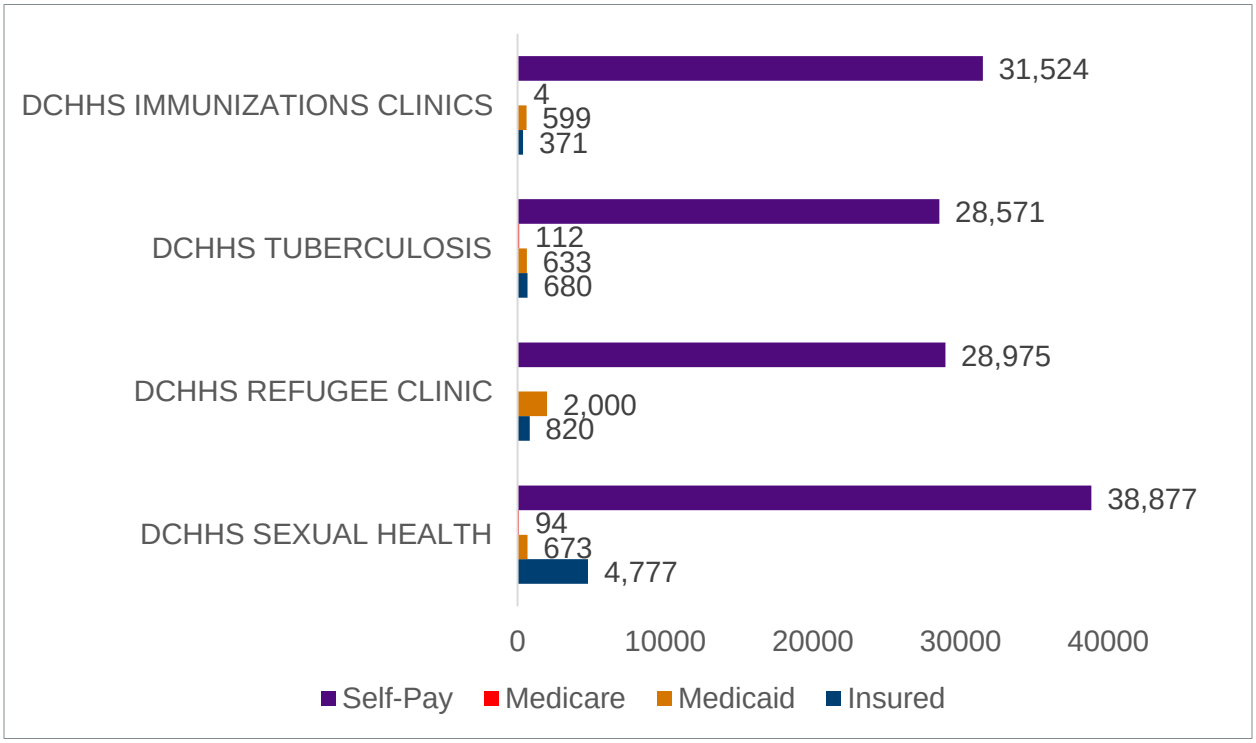
DCHHS Clinic	2023 Utilization	2024 Utilization
DCHHS Immunizations Clinics	41,351*	40,979*
DCHHS Sexual Health Clinic	18,356	26,065
DCHHS Refugee Clinic	13,676	18,119
DCHHS Tuberculosis Clinic	13,251	16,745
Total Clinic Utilization	**86,634**	**101,908**

Data Source: DCHHS Electronic Medical Records
*DCHHS FY23 and FY24 Annual Reports

DCHHS clinics average more than 5,000 patient visits per month. From 2023 to 2024, DCHHS clinics saw utilization increase 17.63%. This sustained level of demand reflects the department's continued outreach into underserved communities, the expansion of mobile health units, and the growing need for preventive services such as low-cost vaccines and STI screenings.

Most clinic users are uninsured or underinsured, as reflected in Utilization Figure 25 by the high number of patients who use self-pay as their payment method. In most cases, self-pay status indicates that the individual lacks any form of public or private health insurance coverage. These patients often rely on DCHHS as one of the few affordable sources of healthcare available to them in Dallas County.

Utilization Figure 25: Payer Type Per DCHHS Clinics 2023-2024



Data Source: DCHHS Electronic Medical Records

As illustrated above, DCHHS patients overwhelmingly rely on self-pay options signaling high uninsured rates and financial vulnerability across the patient population. Through its Charity Care Program (CCP), DCHHS ensures that critical preventive services such as immunizations, sexually transmitted infection diagnostics and treatment, and tuberculosis testing and case management remain accessible and affordable to those earning at or below 400% of the Federal Poverty Level. In FY 24, 7,122 patients enrolled in the Charity Care Program, an increase of nearly 25% from FY 23, see Utilization Table 2. This growth was driven by significant rises in utilization across programs, especially the Tuberculosis Clinic, which saw a 67.2% increase from FY 23 to FY 24.

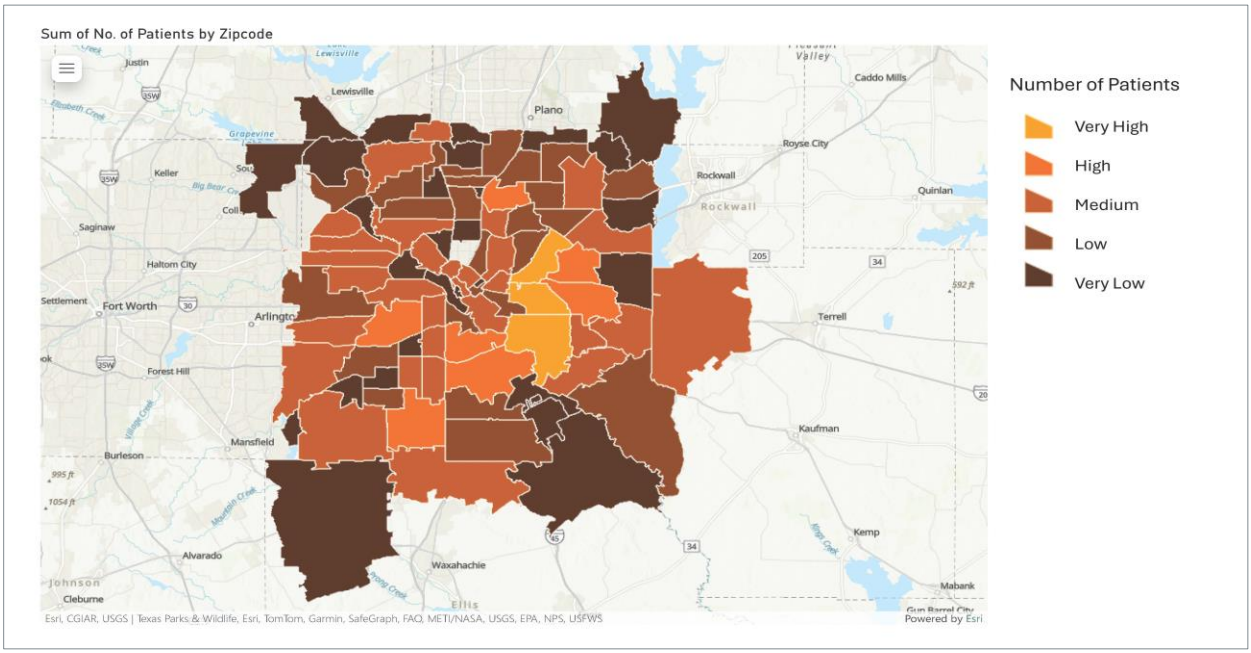
Utilization Table 2: Charity Care Program (CCP) Patient Enrollment

DCHHS Clinic	FFY2023	FFY2024
Immunizations Clinic	2,097	2,156
Sexual Health Clinic	1,611	1,621
Tuberculosis Clinic	2,001	3,345
TOTAL # PATIENTS	**5,709**	**7,122**

Data Source: CCP Patient Enrollment Data

In FY 24, the top five ZIP Codes for CCP enrollment were 75217, 75228, 75227, 75216, and 75150-see Utilization Figure 26. These areas consistently rank high on measures such as poverty rates, uninsured populations, chronic disease prevalence, and limited access to preventive care.

Utilization Figure 26: FY24 CCP Patient Enrollment by ZIP Code



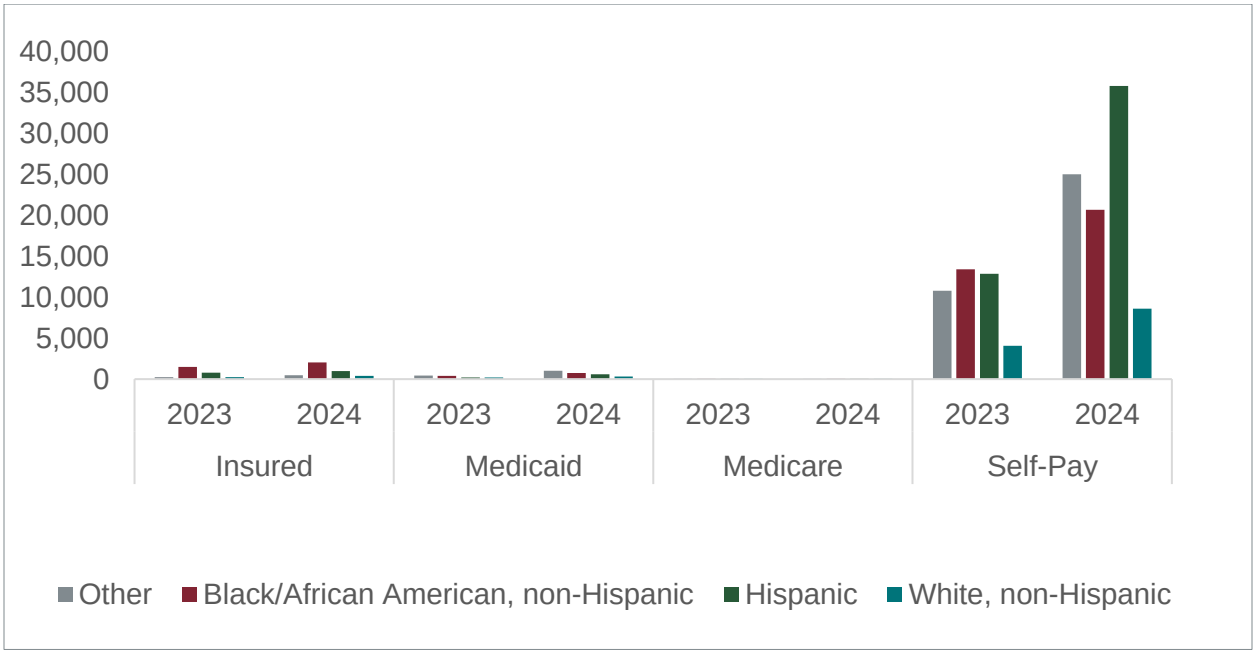
Data Source: CCP Patient Enrollment Data

2. DCHHS Clinic Utilization by Race/Ethnicity and Age

As shown in Utilization Figure 27, the majority of DCHHS total clients identify as Hispanic (40.4%) or Black or African American, non-Hispanic (30.6%). Patients identifying as white, non-Hispanic represent the smallest demographic group utilizing DCHHS services, making up 11.0% of the total patient population with patients of other ethnicities making up 38.0%.

Black or African American, non-Hispanic make up more than half (53%) of insured patients. Hispanic individuals make up the largest proportion of self-pay clients at 37.1%, while clients identifying as other (27.3%) and Black or African American, non-Hispanic (26%) who self-pay are notably lower.

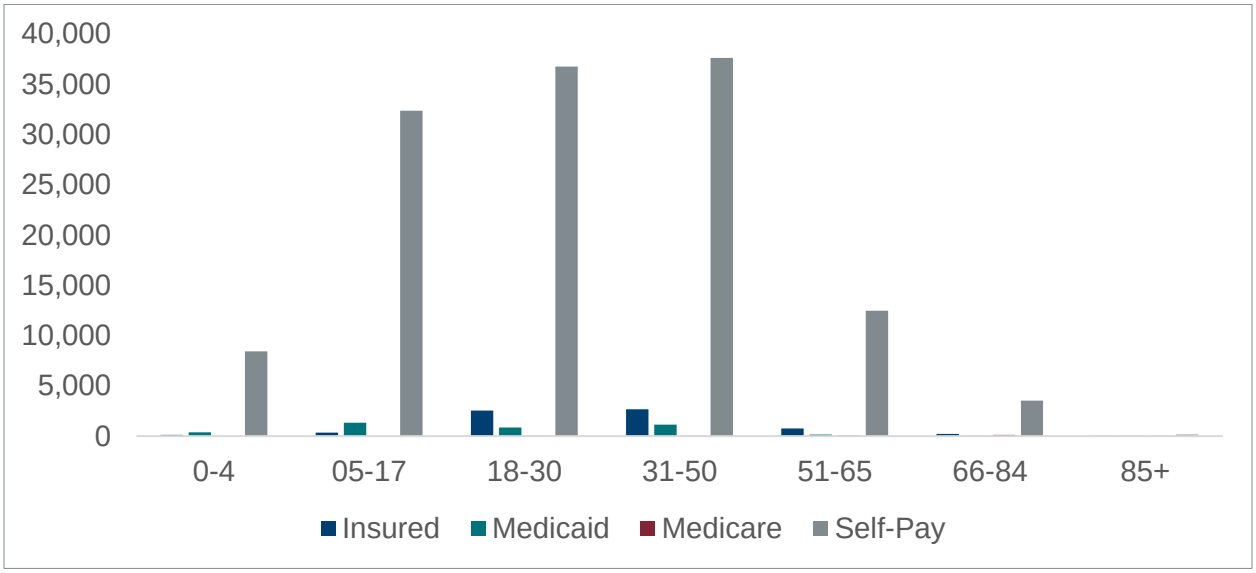
Utilization Figure 27: Race and Ethnicity Distribution of DCHHS Clinic Patients



Data Source: DCHHS Electronic Medical Records

Clinic utilization is highest among children and young adults as seen in Utilization Figure 28. Immunization clinics serve a broad population but are especially critical for school-aged children and adolescents. Adult populations, particularly those in their 20s and 30s, account for a substantial portion of sexual health and tuberculosis services. While older adults are less frequently seen in the clinical setting, they benefit from the department's broader array of services including senior nutrition, transportation, and housing assistance programs. This lower clinical utilization among older adults is largely due to their access to Medicare coverage, which enables them to seek care through private providers rather than relying on DCHHS' safety-net clinics.

Utilization Figure 28: Age Group Distribution of DCHHS Clinic Patients



Data Source: DCHHS Electronic Medical Records

3. Housing and Social Services

DCHHS is one of the largest social service providers in the county, offering a wide range of housing and support programs designed to address the non-medical drivers of health and improve the overall well-being of our community. Recognizing the strong connection between social conditions and health outcomes, DCHHS strategically leverages its programs including energy assistance, home loan counseling, housing support, services for older adults, weatherization, welfare, and wrongful eviction prevention to stabilize households, reduce hardship, and promote long-term health. These services not only meet immediate needs but also strengthen families and neighborhoods, advancing health equity throughout Dallas County.

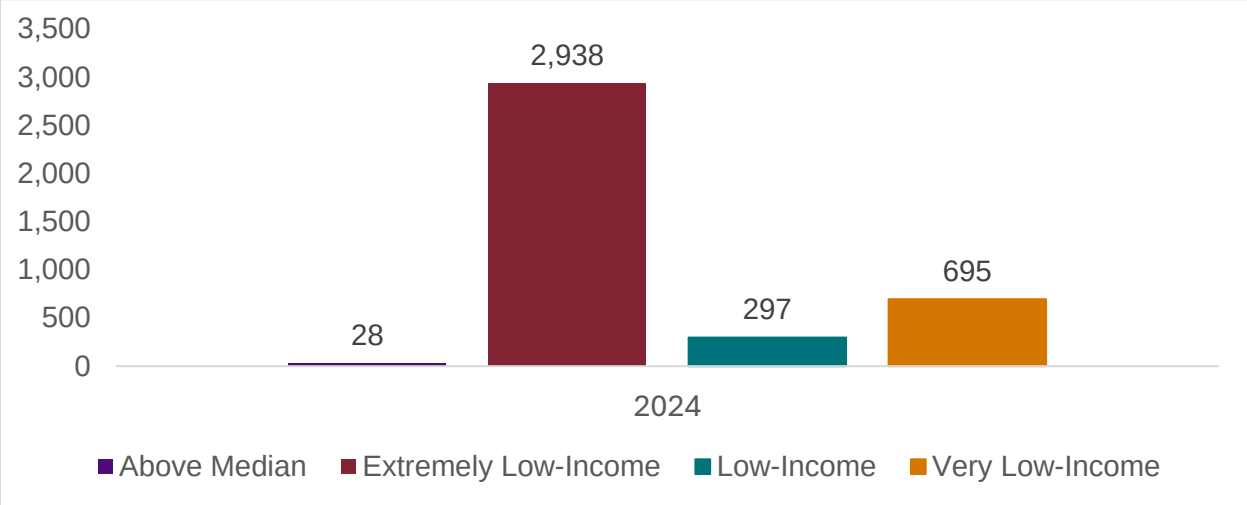
a. Housing

Housing insecurity such as unaffordable rents, substandard living conditions, or the threat of eviction can have profound effects on community health, contributing to higher rates of chronic disease, mental health challenges, and barriers accessing care. Dallas County residents identified housing as the #1 non-medical driver of health they face. To address this critical need, the Dallas County Housing Agency (within DCHHS) administers the Housing Choice Voucher Program, which provides rental subsidies, utility allowances, unit inspections, and counseling to help low- and moderate-income families, seniors, and people with disabilities secure safe, sanitary housing in the private market.

Utilization Figure 29 shows that in 2024, the vast majority of households served by the Housing Choice Voucher Program fell into the lowest income categories; income thresholds that vary by household size. Of the 3.958 vouchers provided, 74.2% (2,938) were classified as extremely low income, 17.6% (695 households) as very low income, and 7.5% (297 households) as low income. Only 0.7% (28 households) had incomes above the median. This distribution highlights the program's focus on assisting households with severely limited financial resources, where

housing support is most critical to preventing homelessness and mitigating health risks associated with housing insecurity.

Utilization Figure 29: Poverty Level of Housing Voucher Tenant Household, 2024

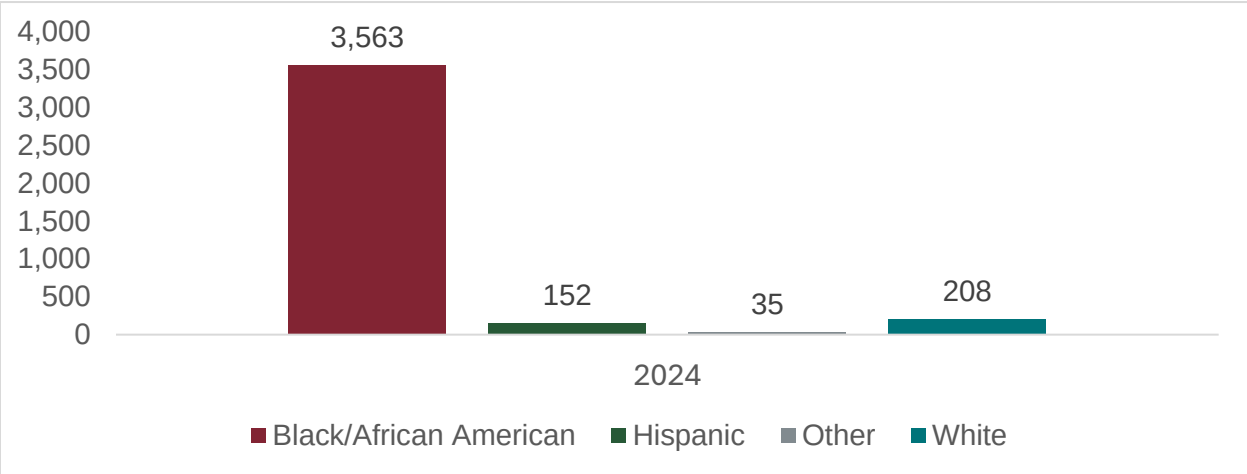


Data Source: DCHHS Housing Choice Voucher Program Client Data

The Housing Program served a predominantly (90% of vouchers) Black or African American, non-Hispanic population in 2024, with white, non-Hispanic households representing 5.2%, Hispanic households 3.8%, and other races 0.9%-see Utilization Figure 30.

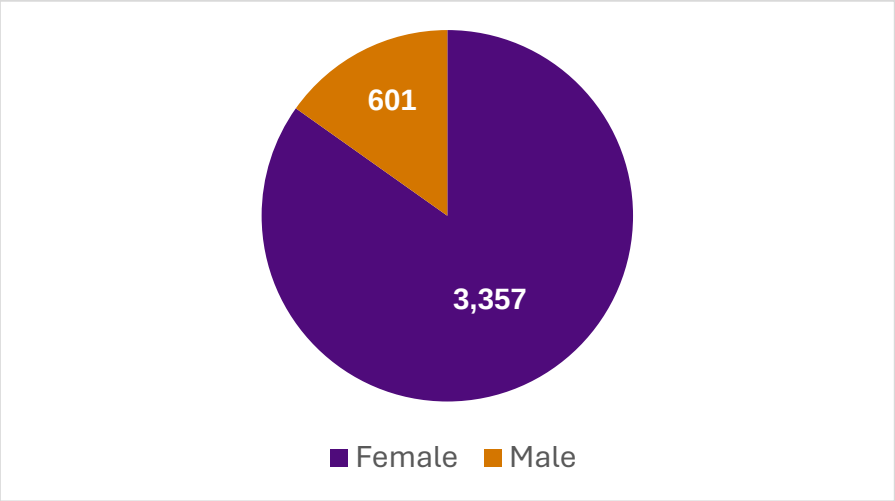
The Housing Program consistently served a majority female head of household clients in 2024—84.8% of participants were female and 15.2% were male–see Utilization Figure 31.

Utilization Figure 30: Demographic of Head of Household in Housing Voucher Tenant Household, 2024



Data Source: DCHHS Housing Choice Voucher Program Client Data

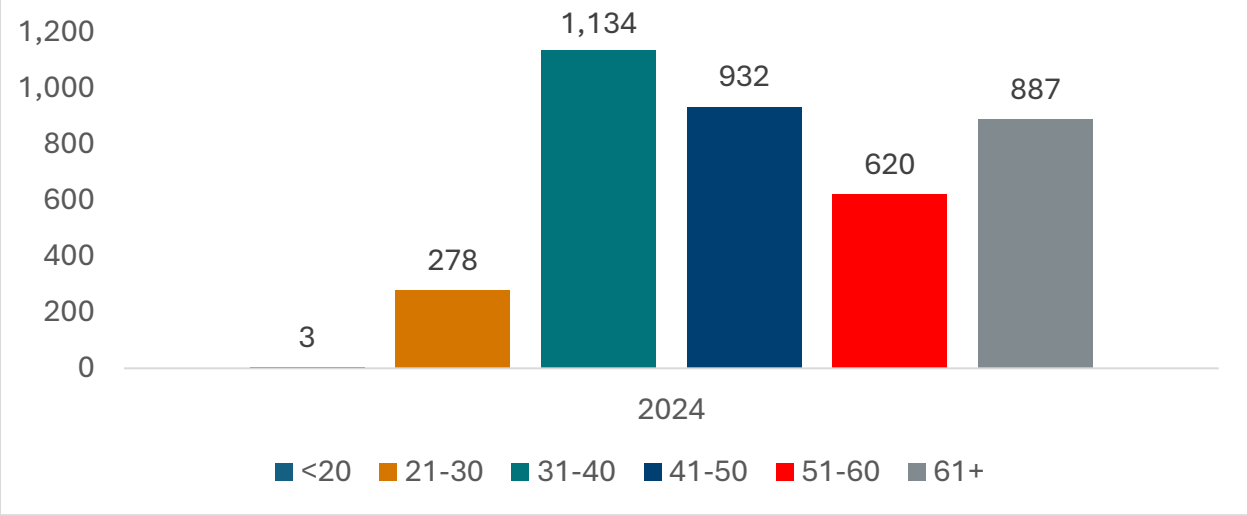
Utilization Figure 31: Gender of Housing Voucher Tenant Household, 2024



Data Source: DCHHS Housing Choice Voucher Program Client Data

As shown in Utilization Figure 32, the age breakdown of Housing Choice Voucher Program clients shows the largest share are adults ages 31–40, who represent 29.4% (1,134) of participants. They are followed by ages 41–50 at 24.2% (932), ages 61 and older at 23% (887), and ages 51–60 at 16.1% (620). Younger adults under 30 account for a smaller share, 7.3% (281).

Utilization Figure 32: Age of Household in Housing Voucher Tenant Household, 2024



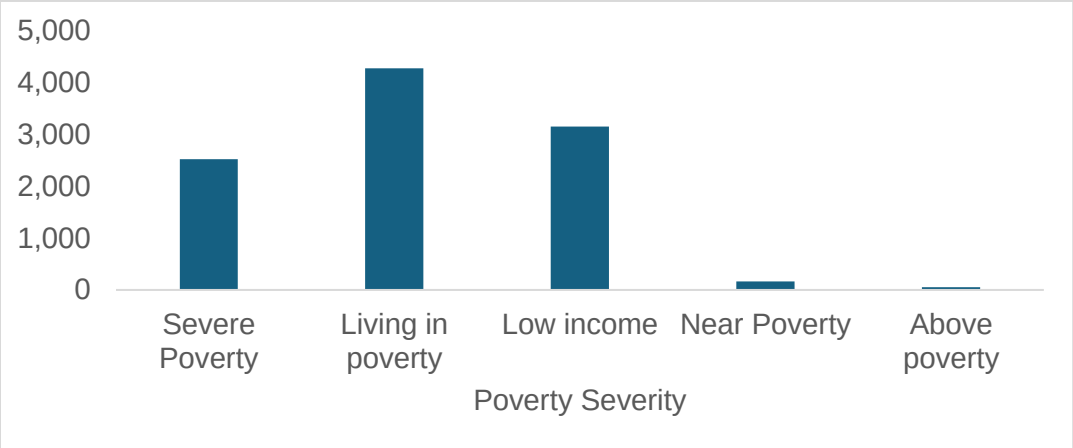
Data Source: DCHHS Housing Choice Voucher Program Client Data

b. Comprehensive Energy Assistance Program

The Comprehensive Energy Assistance Program (CEAP) administered by Dallas County Health and Human Services (DCHHS) provides short-term utility assistance, energy education, and where eligible, HVAC repair support to low-income households. CEAP is intentionally targeted to households with the highest vulnerability: elderly and disabled residents and households with children under age five are prioritized for service. Eligibility is generally established at or below 150% of the Federal Poverty Level (state CEAP guidance), and CEAP integrates energy education and case management with bill-payment support to reduce ongoing energy insecurity.

Utilization Figure 33 shows that the majority of CEAP clients live in conditions of economic hardship. Only 0.5% (52 households) are above the poverty threshold. In contrast, 42.0% (4,274 households) are living in poverty, 31.0% (3,148 households) are classified as low income, and 24.8% (2,519 households) are in severe poverty. A smaller proportion, 1.6% (165 households), fall into the near-poverty category.

Utilization Figure 33: Utilization of CEAP Payment, 2024



Data Source: DCHHS CEAP Client Data

Utilization Table 3: Federal Poverty Level Definitions for CEAP Program

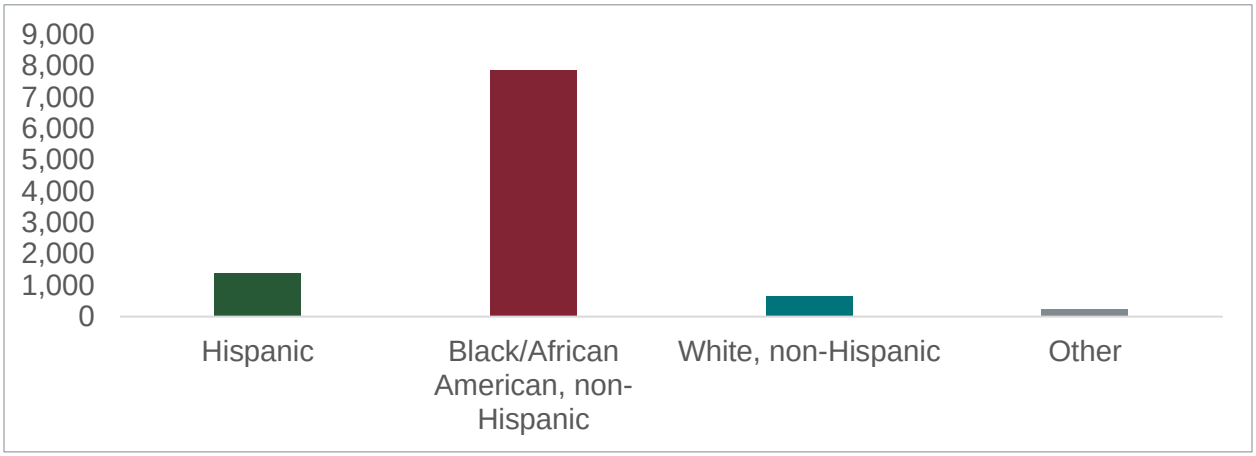
Poverty Severity	Federal % Poverty Level Range
Severe Poverty	<50%
Living in poverty	50-99%
Low income	100-149%
Near poverty	150-199%
Above poverty	>200%

Data Source: DCHHS CEAP Client Data

The demographic breakdown of CEAP clients-see Utilization Figure 34 and Utilization Figure 35, shows that the program primarily serves communities of color, women, and elderly populations. Black or African American, non-Hispanic residents make up the largest share at 75.7%, followed by Hispanic residents at 13.3%, white, non-Hispanic residents at 6.4%, and individuals identifying as other races at 2.2%. Women account for 77% of CEAP clients with men at 33%.

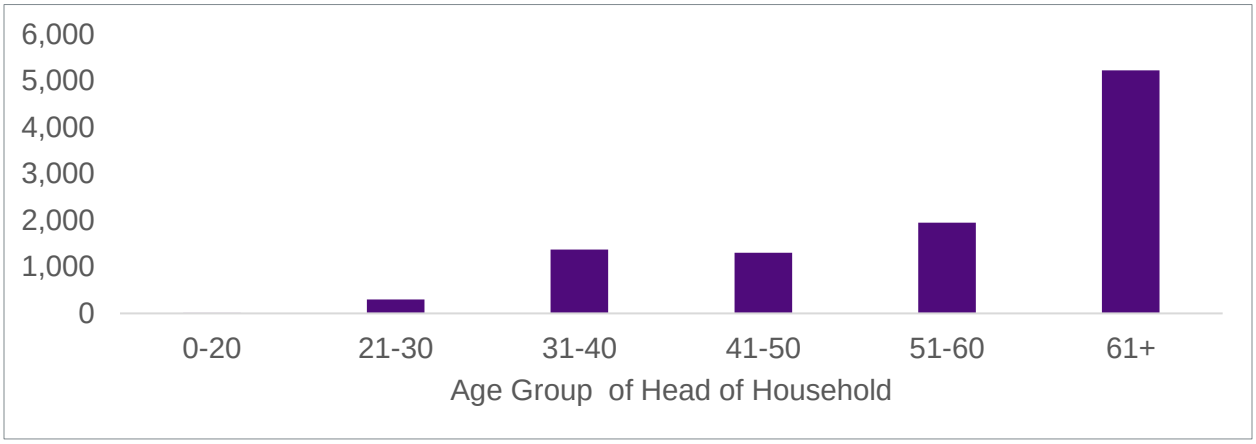
Residents aged 61 and over represent the largest group at 50.3%, followed by those aged 51–60 at 18.8%. Clients aged 31–40 account for 13.2%, those aged 41–50 make up 12.5%, and younger adults aged 30 or underrepresent 3%. This distribution reflects CEAP's prioritization of elderly households, who face higher health risks from energy insecurity and extreme heat or cold.

Utilization Figure 34: Utilization of CEAP Payment, Race and Ethnicity of Head of Household, 2024



Data Source: DCHHS CEAP Client Data

Utilization Figure 35: Utilization of CEAP Payment, Age Group of Head of Household, 2024



Data Source: DCHHS CEAP Client Data

Exhibit I

A. Survey Results

A total of 1,424 completed surveys were submitted. Responses that were incomplete or from outside Dallas County were excluded from the final analysis.

The purpose of the Healthy Neighborhood Survey was to broaden the opportunities for community members to provide their input. The survey was available in both, English and Spanish, administered online, with access provided via QR codes. Additionally, DCHHS and Parkland staff, including Employee Resource Group volunteers, offered or administered the survey at health centers, and at community events hosted by Parkland and DCHHS.

Demographics

Among the survey participants, 33% identified as Hispanic, including those who reported as Mexican and another Hispanic ethnicity; 60% of respondents identified as non-Hispanic. In terms of racial identity, 46% of respondents identified as white, non-Hispanic, while 38% identified as Black or African American, non-Hispanic-see Figure 1.

Figure 6: Ethnicity

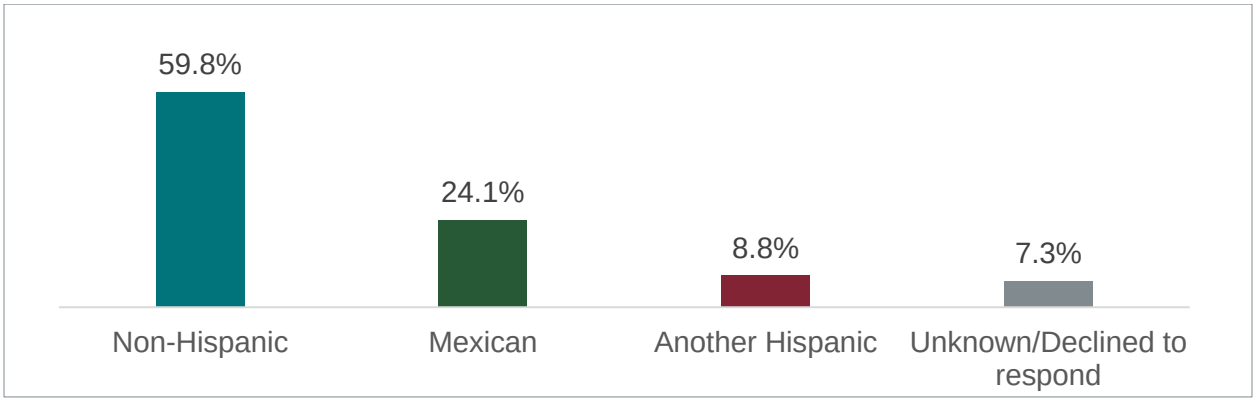
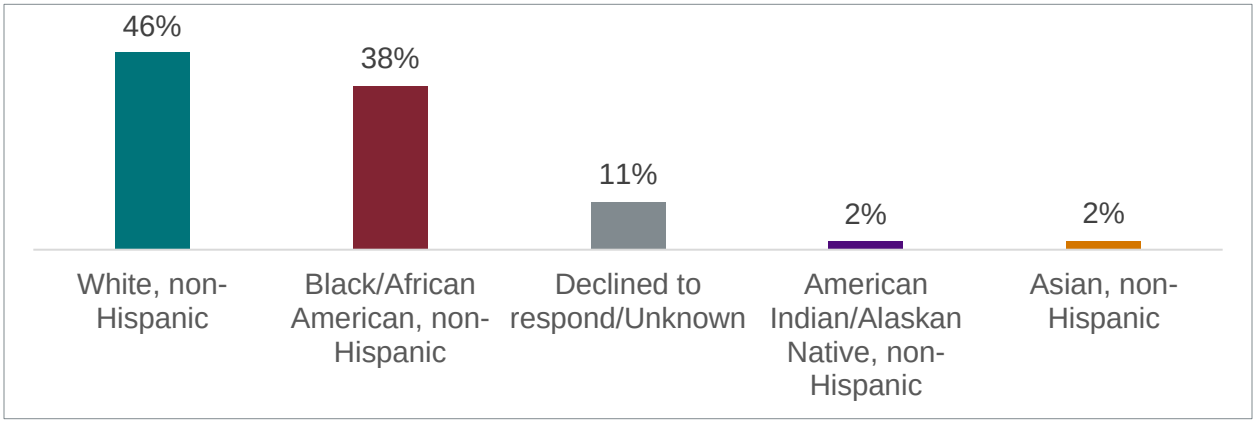


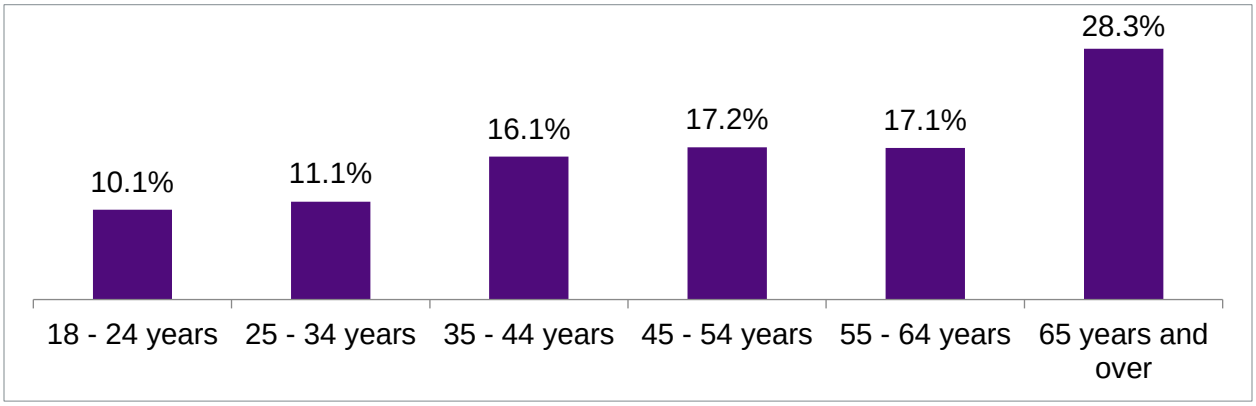
Figure 7: Race



Majority of respondents (84.5%) identified English as their primary language, while 14.8% reported Spanish as their primary language-see Figure 2. The survey captured a wide range of

age groups, with the largest segment (28.3%) including individuals aged 65 and older-see Figure 3.

Figure 8: Respondent Age Group



Seventy-seven percent of the respondents identified as female, while 22% identified as male. Regarding sexual orientation, 84.8% identified as straight, and approximately 15% as part of the LGBTQIA+ community, including Lesbian, Gay, Bisexual, Something else.

According to survey data, 41% of respondents reported not receiving any health services within the past 18 months-see Figure 4. Of these, 19% reside in ZIP Codes 75210, 75211, 75215, 75216, 75217, and 75241, which are areas identified by the CVC as having high community vulnerability risk. Additionally, 20% of respondents reported having no health insurance-see Figure 5. Among them 57% identified as Hispanic, and 25% resided in the above stated ZIP Codes.

Figure 9: Have you received health services in the last 18 months at any of these locations?

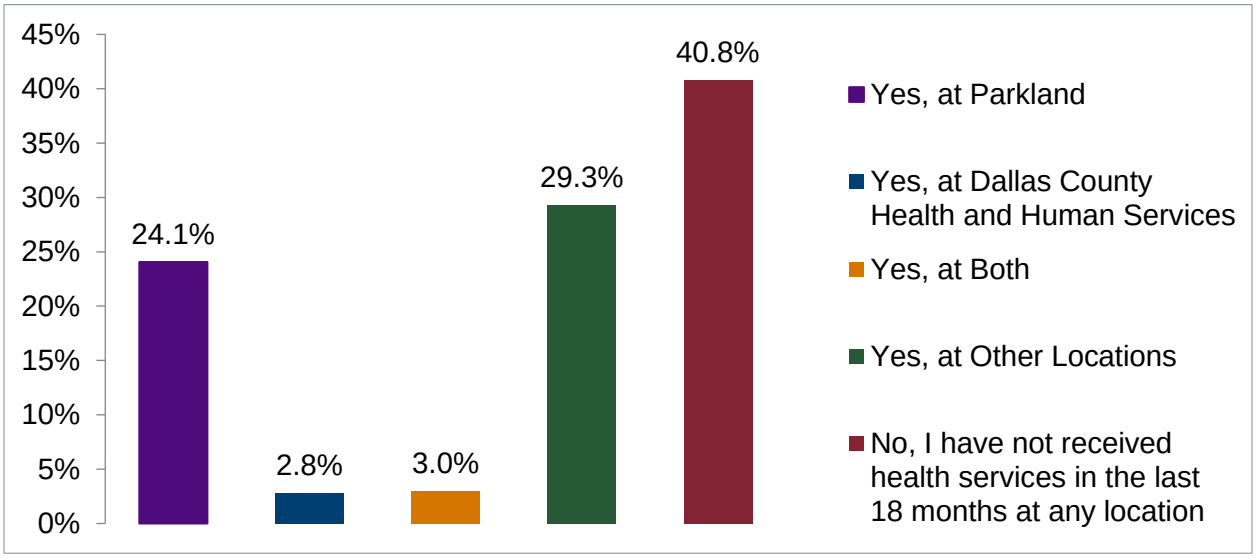
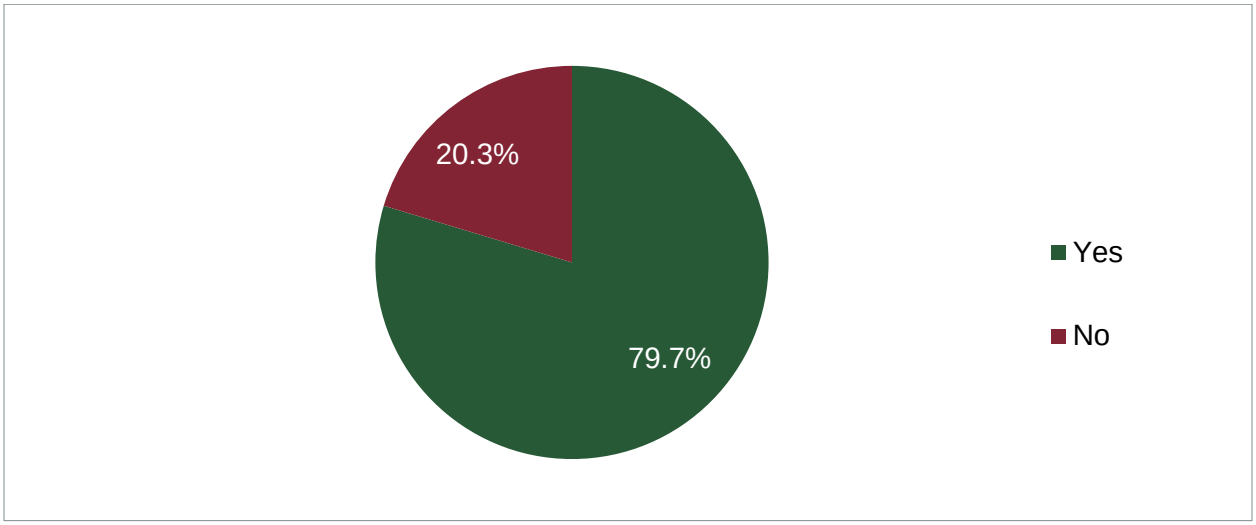


Figure 10: Do you have health insurance or public/government coverage, including Parkland coverage?



When asked what the top 5 priorities are to improve community health, respondents revealed: (1) affordable housing and apartments; (2) grocery stores offering affordable, healthy food options including fresh fruits and vegetables; (3) access to behavioral health professionals; (4) a clean and safe environment; and (5) building trust in healthcare and public health institutions-see, Figure 6.

In terms of healthcare seeking behavior, 47% of respondents reported preferring a private doctor's office or medical practice. This was followed by utilization of 24/7 ED and low-cost community health clinics-see Figure 7. Among those who reported using ED, 32% resided in ZIP Codes identified as having high community vulnerability risk. Respondents of Hispanic ethnicity preferred using community clinics and private doctor's offices or medical practices more than any other healthcare option.

Figure 11: Select the five most important items that will improve health in your community

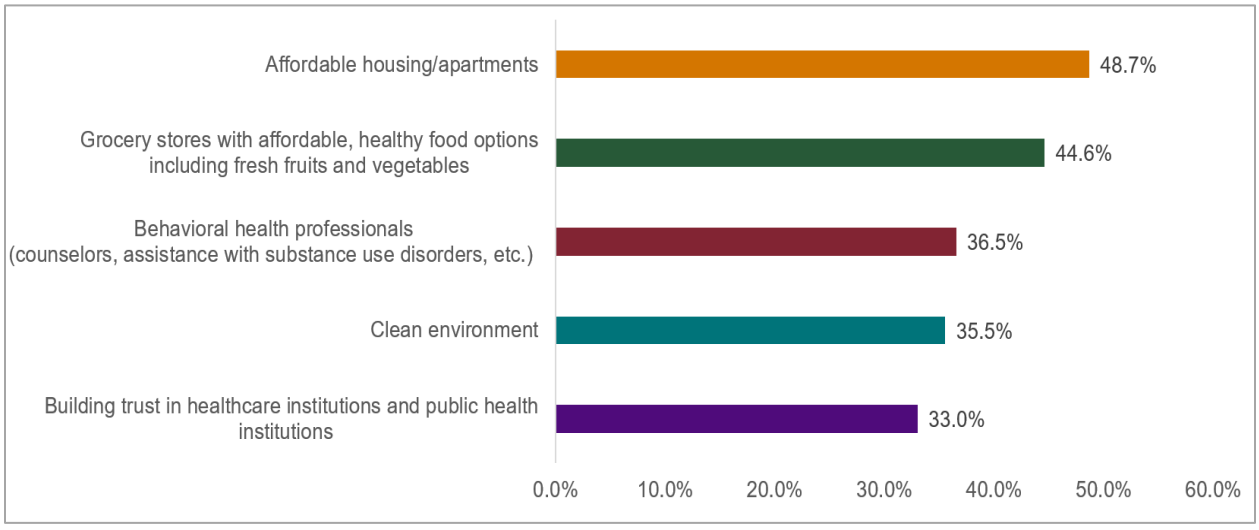
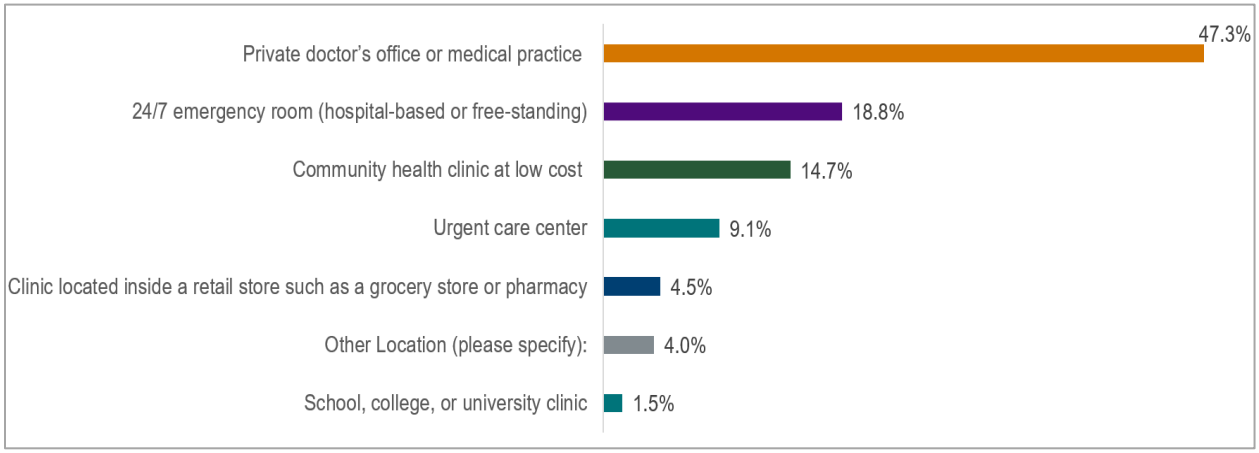


Figure 12: Where do you usually go when you are sick or need medical services?



Across all racial and ethnic groups, approximately 40% of respondents (565) reported delaying healthcare in the last 12 months. Among this group, the top five reported reasons for not accessing services were: (1) concerns about medical debt, (2) high cost of care, (3) lack of health insurance, (4) inability to secure an appointment, and (5) challenges related to taking time off work or finding a convenient time. These findings highlight the multifaceted barriers that contribute to delayed care, particularly among economically vulnerable populations-see Figure 8 and Figure 9.

Figure 13: During the past 12 months, did you delay (or go without) needed healthcare such as medical, dental, mental, physical, occupational therapy, etc.?

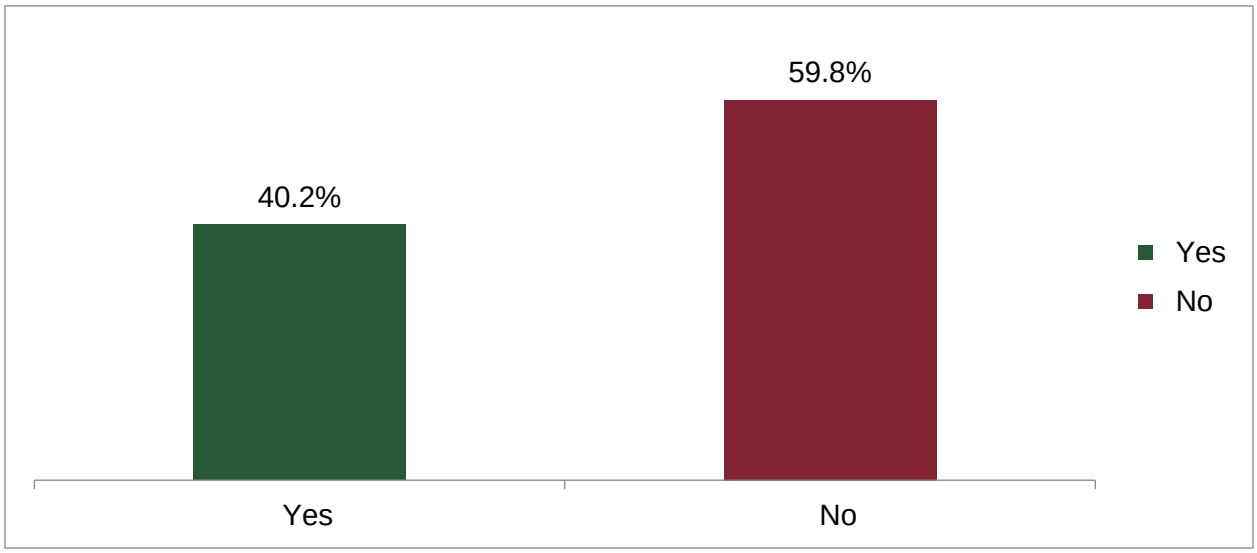
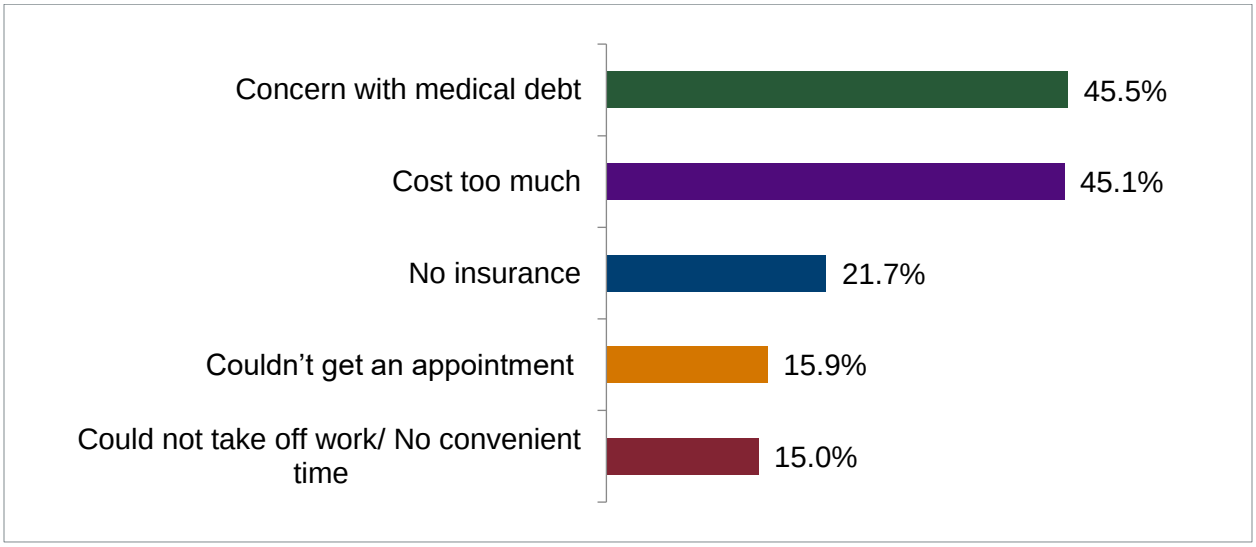


Figure 14: If yes to the above question, what kept you from getting all the healthcare you needed?



Across all demographic groups, 72% of the respondents identified diabetes as a top chronic disease concern followed by hypertension, heart disease, cancer, and obesity-see Figure 10. These concerns reflect the ongoing burden of chronic illness in vulnerable populations and will be highlighted later in the report.

In a corresponding question used to identify the top-rated health issues in the community, respondents identified. diet, nutrition, and exercise (54%) and access to healthcare (50%) as their top priorities. These were followed by concerns about mental health/behavioral health, homelessness, and food safety-see Figure 11. This aligns with feedback from focus groups where community members emphasized the importance of improving access to behavioral health services within the community.

Figure 15: What are your top 5 most pressing chronic disease concerns?

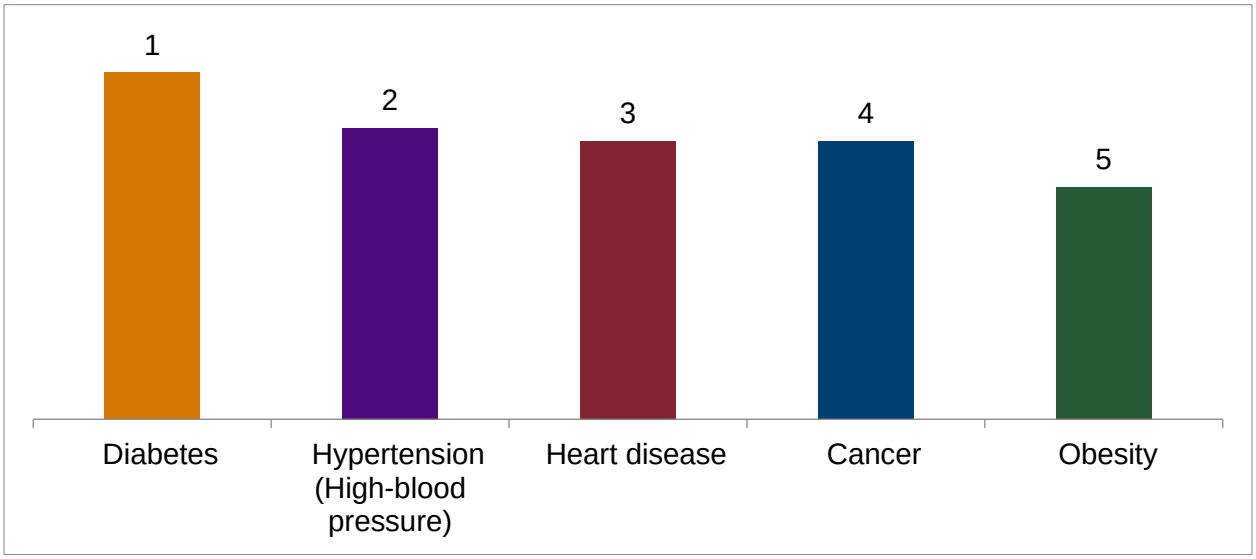


Figure 16: What are your top 5 most pressing health related issues or concerns?

* Doctors, nurses, specialists, dental care, vision, childcare, etc.
** Depression, anxiety

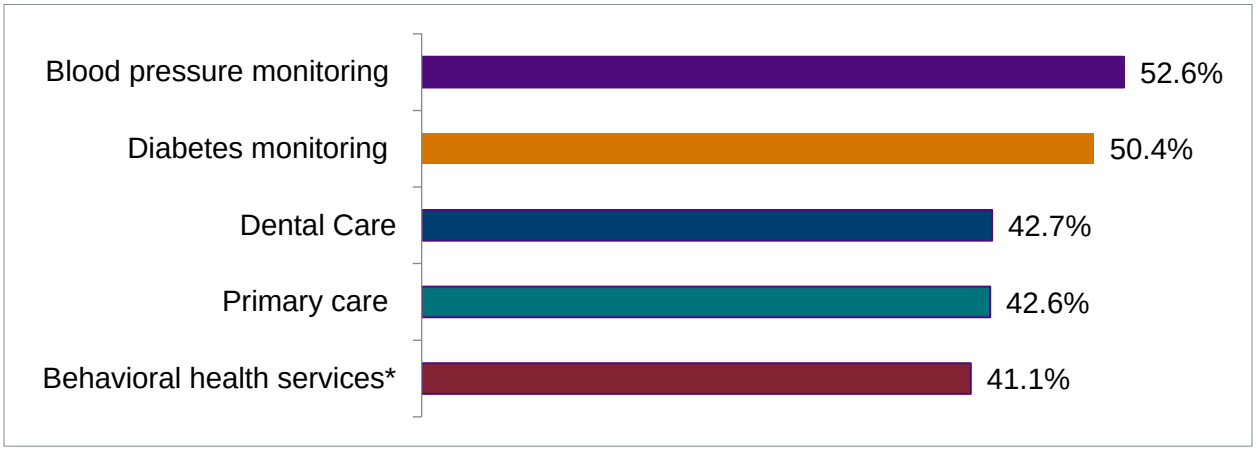
With regard to the services needed in the community to address health concerns, the top five priorities reported by the respondents were blood pressure monitoring, diabetes monitoring, dental care, primary care, and behavioral health services-see Figure 12, highlighting a demand for both preventive and ongoing care.

When assessing preferred methods for learning about healthy living and disease prevention, 37% of respondents indicated a preference for receiving information at a hospital or doctor's office. This was followed by interest in group lessons at a local community center and online classes accessible via phone or computer-see Figure 13. Individuals from ZIP Codes: 75210, 75211, 75215, 75216, 75217, and 75241 specifically preferred learning through hospital or doctor's office visits and group lessons.

In terms of preferred locations for receiving behavioral health services, the top three choices were: behavioral health clinics, primary care clinics, and community-based settings close to home-see Figure 14.

To overcome barriers related to appointment wait times and travel time, 34% of respondents preferred virtual care from home or the workplace. This was followed by mobile healthcare units or vans (27%) and phone consultations (22%)-see Figure 15. Among those who preferred mobile healthcare units, 42% identified as Hispanic, while 45% of those who preferred phone consultations identified as Black or African American non-Hispanic. Additionally, 54% of respondents residing in ZIP Codes 75210, 75211, 75215, 75216, 75217, and 75241 expressed a preference for either mobile healthcare units or phone consultations as choices to reduce wait and travel times.

Figure 17: What are your top 5 most important services to address identified concerns?



*Counselors, assistance with substance use disorders, etc.

Figure 18: What is your preferred way to learn about healthy living and diseases such as diabetes, cancer, obesity, pregnancy, etc.?

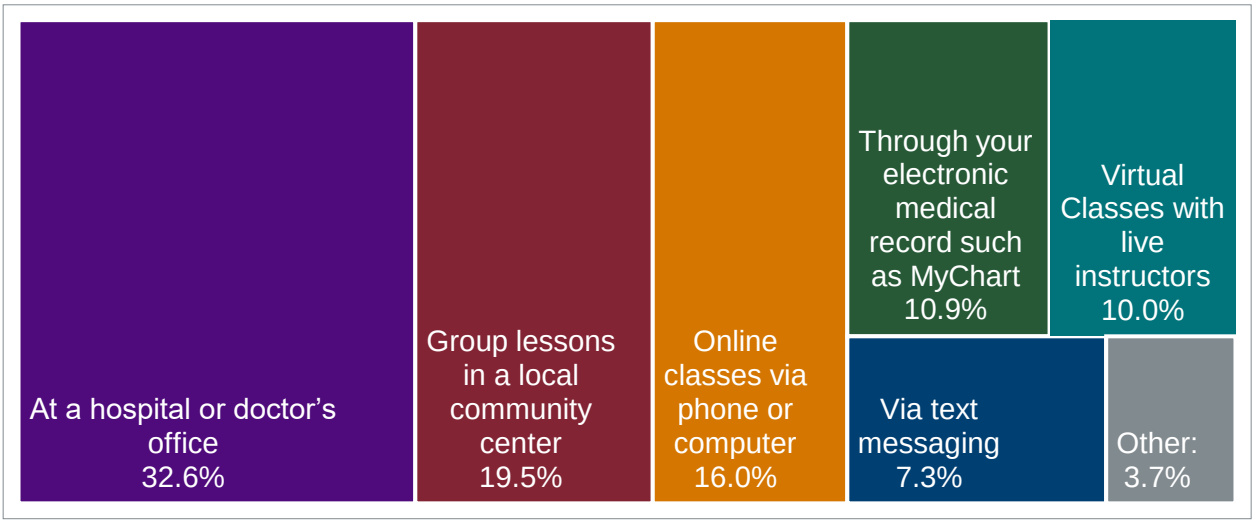


Figure 19: Where is your preferred place to receive behavioral health services for you and your family?

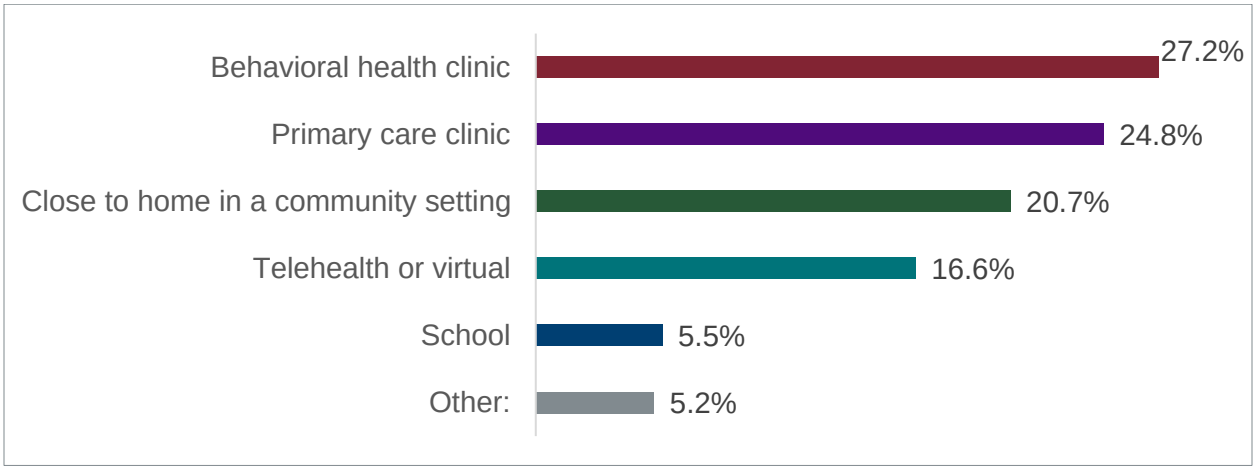
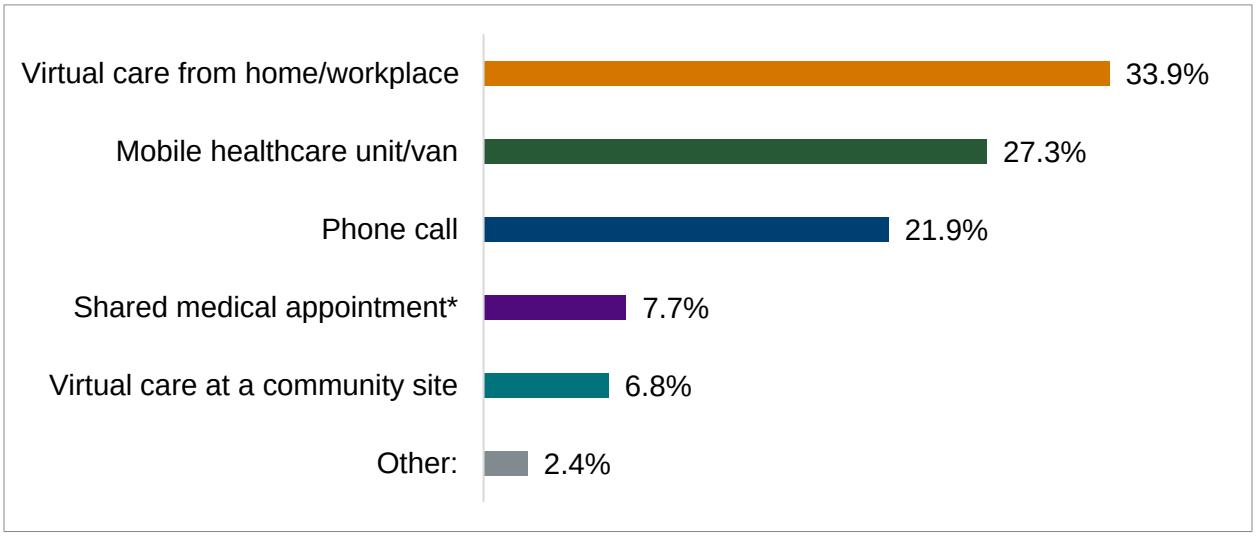


Figure 20: If it helps reduce your wait time for appointments and your travel time to the clinic, which of the following options would you prefer?



* It is a type of medical visit for patients who share similar health conditions such as diabetes, hypertension

Exhibit II

Focus Group Guest List

1. 3Empower - Life Skills Program Facilitator
2. 410 Empowerment Fund
3. 5 Loaves food Pantry
4. A Pampering Touch Doula / Birth & Post partum Doula
5. A Twist of Faith
6. A+ Charter Schools
7. Abide Women's Health Services
8. Abounding Prosperity
9. Abundant Life Grand Prairie
10. Adult Protective Services Faith Based
11. Affiliation (e.g. business, nonprofit, CAB, etc.)
12. African American Leadership Institute (AALI)
13. After8toEducate - Executive Director
14. Agape Clinic - Director of Development
15. AIDS Service of Dallas (ASD)
16. AIDS Walk South Dallas
17. Albertsons Pharmacy
18. ALIANZA-American Heart Association
19. ALIANZA-Anthem Strong Families
20. ALIANZA-Bachman Lake Together
21. ALIANZA-Cristo Rey
22. ALIANZA-Dallas Afterschool/SVP Dallas
23. ALIANZA-DFW CHW
24. ALIANZA-ImmSchools
25. ALIANZA-LULAC
26. ALIANZA-Momentous Institute
27. ALIANZA-Primos VP
28. ALIANZA-Readers2Leaders
29. ALIANZA-Regional Hispanic Contractors Association
30. ALIANZA-Rosa Es Rojo, Inc.
31. ALIANZA-The Senior Source
32. All Nations Fellowship
33. All Stars Project
34. Amazon FTW9
35. American Cancer Society
36. American GI Forum - National Veterans Outreach Program
37. American Lung Association
38. Dallas Fort Worth Educational Facilities Association (DFWAPPA)
39. ARC Service
40. Ardyn Hope Inc
41. Ascend Dallas
42. Asian Square Times
43. Atlantic Housing Foundation
44. Bachman Lake Together
45. BAPS Charities
46. Barack Obama Male Leadership Academy (BOMLA)
47. Baylor Scott & White (BSW)
48. BSW - Irving
49. Bazar El Sol/ Community member
50. Ben Washington Baptist Church
51. Bertrand Neighborhood Association
52. Bethany Missionary Baptist Church
53. Betty Walker Waites Foundation
54. Big Brothers Big Sisters
55. Black Heart Association
56. Bonton Farms
57. Box Lunch of Love
58. Boys and Girls Club of Greater Dallas
59. Bravo Dental
60. Bridge Builders
61. Brother Bill's Helping Hand
62. BSW - Comp-U-Dopt
63. BSW - DCHHS
64. BSW - Foremost Family Health Center
65. BSW - Harmony CDC
66. BSW - Mammogram Poster Girls
67. BSW - Metrocare Services
68. BSW - UT Southwestern
69. Buckner Family Hope Center Bachman Lake
70. Buckner Family Services
71. By Faith Not Sight
72. Citizen Advisory Board (CAB)
73. CAB- Alzheimer’s Association
74. CAB- City of Grand Prairie
75. CAB- Community Council of Greater Dallas
76. CAB- Grand Prairie community member

77. CAB- Grand Prairie ISD
78. CAB- Grand Prairie Police
79. CAB- Metrocare Services
80. CAB- Parkland Grand Prairie COPC
81. CAB- Wellpoint
82. Calibri Health
83. Canales Furniture
84. Cancer Support Community North Texas
85. Care Center Ministries
86. Carrollton Farmers Branch - Director of health services
87. Carrollton-Farmers Branch Independent School District (CFB ISD)
88. Casa del Lago
89. Catchup and Read
90. Cathedral of Hope
91. Catholic Charities of Dallas
92. Catholic Charities Richardson Branch
93. Cedar Crest Church of Christ
94. Cedar Hill Action Team
95. Cedar Hill ISD - Director of Health Services
96. Child & Family Guidance Center
97. Child Care Group Garland
98. Children On The Mend
99. Children's First
100. Children's Health
101. Chocolate Mint Foundation-Desoto
102. Chris Howell Foundation-NPO
103. Christar
104. Church of the Incarnation - Mission and Outreach Administrator and Project Coordinator.
105. Citra Urgent Care
106. City of Carrollton
107. City of Dallas - Arlington Park Recreation Center
108. City of Dallas - Equity Engagement & Outreach Manager
109. City of Dallas - Forest Green Branch
110. City of Dallas - Grauwyler Recreation Center
111. City of Dallas Senior Services
112. City of Dallas Office of Homeless Solutions
113. City of Dallas Park & Recreation
114. City of Desoto
115. City of Desoto Economic Development
116. City of Garland Senior Center
117. City of Garland Emergencies
118. City of Garland Libraries
119. City of Garland Palladium Senior Center
120. City of Glenn Heights-Community Engagement
121. City of Grand Prairie Grand Connection Transit
122. City of Grand Prairie Housing Department
123. City of Grand Prairie Victim Services
124. City of Hutchins
125. City of Irving
126. City of Irving - Parks and Recreation
127. City of Richardson
128. City of Richardson Senior Center
129. City of Richardson / Library Outreach
130. City of Wilmer
131. CLT Transportation
132. Community Council of Greater Dallas
133. Community Does It
134. Community Member
135. Community Movement Builders
136. Community Options
137. Consulate of El Salvador
138. Consulate of Peru
139. Counseling Institute of Texas
140. Covenant Purpose & Restoration Family Center - Operation Stomp Out Hunger
141. Cristo Rey - Director of Athletics
142. Cristo Rey - Nurse Lead
143. Cynthia Mickens Ministries-NPO-Hutchins
144. Dallas Public Health Advisory Committee (D3 PHAC)
145. D3 PHAC - Agape Clinic
146. D3 PHAC - BSW Juanita Craft
147. D3 PHAC - Dallas Community Fellowship Inc.
148. D3 PHAC - DCHHS
149. D3 PHAC - DCT LiveWell
150. D3 PHAC - DSHS/LatinX org/Unite Us
151. D3 PHAC - Healing Hands Ministries
152. D3 PHAC - Mission East Dallas
153. D3 PHAC - My Resource Center
154. D3 PHAC - Prism Health
155. D3 PHAC - Texas StarKids, Rexas StarPlus

156. D3 PHAC - The Root Cause
157. D3 PHAC - Wolfe and Associates
158. Dallas Area Interfaith - Outreach coordinator
159. Dallas Chinese Community Center
160. Dallas College
161. Dallas College Brookhaven Campus
162. Dallas College Campuses (Facility Use Agreement)
163. Dallas College - Garland Campus
164. Dallas College Lancaster Workforce Development Center
165. Dallas College North Lake
166. Dallas College West Campus
167. Dallas College Workforce Center- RedBird-Dean
168. Dallas College-Richland Campus
169. Dallas College-Vice Chancellor-RedBird
170. Dallas Community Fellowship Inc. (DCFI)
171. Dallas County Health & Human Services (DCHHS)
172. Dallas County Medical Society
173. Dallas Fire Rescue
174. Dallas Free Press
175. Dallas Hearing Foundation
176. Dallas Housing Authority
177. Dallas Independent School District (DISD)
178. Dallas Legacy Mission
179. Dallas Multipurpose Center
180. Dallas Museum of Art
181. Dallas Parks & Rec - Bachman Lake
182. Dallas Parks & Rec (Janie C. Turner)
183. Dallas Parks & Rec (Kleberg-Rylie)
184. Dallas Parks & Rec (Pleasant Oaks)
185. Dallas Police Department (DPD)
186. Dallas Police-RedBird Outreach Center
187. Dallas Public Library (Facility Use Agreement)
188. Dallas Public Library- Dunbar Lancaster-Kiest Branch
189. Dallas Public Library- Vickery Park Branch
190. Dallas Recreation Centers (Facility Use Agreement)
191. Dal-Tile
192. DCHHS Outlying Clinics
193. Debes Creer En Ti DCET
194. Delta Psi Rho
195. DeSoto Public Library Librarian
196. DiLolas
197. DISD - Burnet Elementary School
198. DISD - Highland meadows school
199. DISD - Hotchkiss Elementary School
200. DISD - Jose Jo Mays School
201. DISD - Parent Support Coordinator (Family and community Engagement)
202. DISD - Program Support Coordinator (Family and community Engagement)
203. DISD - Thomas Jefferson HS
204. DISD - W W Samuell H S
205. DISD Saldivar Elementary
206. DPD Apartment Complex Team (ACT)
207. DPD - Northeast post
208. Duncanville Independent School District
209. Duncanville Rehab
210. Empowering the Masses
211. Empowering Young Parents
212. Entering Wellness-Harmony CDC
213. Envision Dallas
214. Faith Formula Human Services
215. Fast Track Dallas County - HIV
216. FedEx-Community Engagement - Hutchins
217. Feed Oak Cliff
218. First Baptist Church - Friendship House
219. First Christian Methodist Church
220. Foremost Family Clinic
221. Frazier Revitalization
222. Friendship West Baptist Church
223. Garland Faith Community Church
224. Garland Health Department
225. Garland Independent School District (GISD)
226. Garland National Association for the Advancement of Colored People (GNAACP)
227. Garland Police Department
228. Gateway Church Dallas Campus
229. Girls Inc.
230. GISD Daugherty Elementary School
231. GISD Department of Multilingual Programs
232. GISD Foster Care/Military Connected Liaison
233. GISD Lyles Middle School

234. GISD Student Services
235. Garland Overnight Warming Station (GLOWS) Shelter from the Storms
236. Goldmark Cultural Center
237. Good Samaritan - Garland
238. Good Shepherd Catholic Church
239. Goodwill Industries of Dallas
240. GPISD - Fannin School
241. GPISD - GP High School
242. GPISD - South GP school
243. Grand Prairie Boys and Girls Club
244. Grand Prairie Hispanic Chamber of Commerce
245. Grand Prairie Independent School District (GPISD)
246. Grand Prairie United Charities
247. Grand Prairie YMCA
248. Greater Mt. Pleasant Baptist Church
249. Greenville Avenue Church of Christ
250. Grocery Connect
251. GROUPS
252. Grow North Texas
253. Head Start of Grand Prairie
254. Head Start of Greater Dallas
255. Head Start of Greater Dallas - Family Advocate, Buckeye Trail Commons
256. Head Start of Greater Dallas - Family Advocate, Robbie W. Jones
257. Healing Hands Ministries (HHM)
258. Health Services of North Texas
259. Hector P. Garcia Middle School
260. Helping Us Help Her
261. Hiawatha Williams Recreation Center
262. Hollabaugh Rec Center CoG
263. Homeless Coalition of Dallas
264. Hope - Prism Health North Texas
265. Hope Mental Wellness Advocacy
266. Hope4All
267. Hope - Abounding Prosperity
268. Hope - AIDS Health Foundation
269. Hope - Avita Pharmacy
270. Hope - Center for Health Empowerment
271. Hope - Coalition for Aging LGBT
272. Hope Dallas Hope Coalition Leadership/Director
273. Hope - Dallas ISD Support Services for LGBT Youth
274. Hope - Equality Texas
275. Hope Legacy Cares
276. Hope Pride Veterans Affairs
277. Hope Trans-cendence
278. Hope - Women and LGBT Center Southern Methodist University
279. Huffhines Recreation Center
280. Inner-city Community Development Corporation
281. Iglesia Ministerio Monte De Sion
282. Iglesia Pentecostal Rosa de Saron
283. ILookLikeLove
284. Inspired Vision Compassion Center
285. International Leadership of Texas/ Charter School
286. International Rescue Committee
287. Intertribal Community Council of Texas - Community Outreach Coordinator
288. Irving Cares
289. Irving Independent School District (IISD)
290. Irving ISD - Parent Education and Community Engagement
291. Irving ISD - Townsell Elementary
292. Islamic Center of Irving
293. Jaycee Zaragoza Recreation Center
294. Jer-Z-Jays Upscale Barbershop
295. Joppy Mommas Farm
296. Kinwest Medical Clinic
297. KIPP Pleasant Grove Leadership Academy
298. KIPP Texas
299. Kiwanis Club of Pleasant Grove
300. Kroger Pharmacy
301. Kutinfeed Barbershop
302. L.E.I. Community Outreach
303. La Alianza - Founder
304. Lake Highlands Public Improvement District
305. Lake June Head Start
306. Lakeland Manor
307. Lancaster Independent School District ISD
308. Legacy Cares
309. Legacy Preparatory Charter Academy
310. Life Schools
311. LifeChange Housing Associates

312. Lifeline Shelter Grand Prairie
313. Light Church
314. Lions Club Grand Prairie
315. Lions Club Richardson
316. Literacy Achieves
317. Little Creations Learning Center
318. Los Barrios - Federally Qualified Health Center
319. Love Field West Community
320. Lumin Bachman Lake School
321. Mark Cuban Heroes Center
322. Marsalis Park Homeowners Association
323. MD Anderson Cancer Center
324. Medbridge
325. Mercy Street of Dallas
326. Mesquite Chamber of Commerce
327. Mesquite Independent School District
328. Methodist Dallas Medical Center
329. Metrocare Services
330. Metropolitan Dream Center
331. Mexican Consulate
332. Miles of Freedom
333. Mockingbird Office Building
334. Mosaic
335. National Alliance on Mental Illness North Texas
336. Neema Gospel Church
337. Network of Community Ministries
338. Networking Contacts
339. New Creations Church
340. New Life Baptist Church
341. New Millennium Bible Fellowship Praise Center
342. New Safe Haven Church of God in Christ Outreach Ministry
343. Nexus Recovery
344. No More Violence
345. North Dallas Shared Ministries
346. North Texas Food Bank
347. North Texas Food Pantry
348. North Texas Mental Heal
349. North Texas Council of Government
350. Northeast Dallas Co. Kiwanis Club (Garland Rowlett, Sachse)
351. Northplace Church
352. Northway Church
353. Northwest Community Center
354. Nuestra Vencindad
355. Oak Cliff Veggie Project
356. Oak Street Health Center
357. Oasis Apartment Homes
358. Opportunities Knock
359. Panaramic Circle OEM Storage Facility
360. Paradise Missionary Baptist Church
361. Park Cities Baptist Church
362. Parkland - Homeless Outreach Medical Services Program
363. Parkland Access Clinic
364. Parkland Health
365. Parkland RIGHT Care
366. People Centered Lighthouse
367. Personalized Learning Academy at Highland Meadows
368. Philippine Community Center Inc
369. Pink Diamonds NPO
370. Pivot Church
371. Pleasant Grove Food Pantry
372. Pleasant Grove Unidos
373. Pleasant Grove Ministerial Alliance
374. Pittsburgh National Corporation Bank (PNC)
375. Portfolio Resident Services
376. Pregnancy Resource Center of Grand Prairie
377. Previous Coordinator contacts
378. Prism Health of North Texas
379. Project 75216
380. Project Access
381. Project Beauty
382. Proyecto Inmigrante
383. Recovery Resource Center
384. Recovery Resource Council
385. RedBird CAB
386. Redeemed Women
387. Refugee Clinic
388. Region 10 (Education Agency)
389. Regional Black Contractors Association
390. Regional Hispanic Contractors Association
391. Resources Center of Dallas
392. Restorative Farms
393. Richardson Independent School District (RISD)

394. Richardson Police Department
395. Rowlett Recreation Center
396. Saint Barnabas Presbyterian Church
397. Saint Lukes Church
398. Saint Paul The Apostle
399. Salvadoran Community
400. Salvation Army
401. Saved2Serve
402. Savers Cost Plus
403. Seventh-day Adventist Church
404. Seventh-day Adventist Church - Grand Prairie
405. Seventh-day Adventist Church - North Dallas
406. Sharing Life
407. Shiloh Church
408. South Oak Cliff High School Alumni/Boss Hogg Productions
409. Somos Tejas
410. South Dallas Fair Park Innovation Center
411. South Dallas Sexual Health Clinic
412. South Oak Cliff High School
413. Southeast Dallas Advisory Board
414. Southeast Dallas Chamber of Commerce
415. St. Luke United Methodist Church
416. St. Phillips School & community Center
417. St. Vincent de Paul Thrift Store
418. Stars Global
419. Stars United Global Outreach
420. State Fair of Texas
421. T. R. Hoover Community Development Corporation
422. TD Foundation
423. TD Jakes Foundation
424. Texas A&M Ag Life Extension
425. Texas Equal Access Fund
426. Texas Native Health
427. The Abram_ Apartment Complex
428. The Bridge (mammograms)
429. The Concilio
430. The Freelux Project
431. The Magdalen House
432. The Pelican House Restaurant
433. Re-Creation Outreach Center
434. The Senior Source
435. The Summit Senior Center Grand Prairie
436. The Warren Center
437. The Well
438. Thriving Kinship NPO
439. Ti Communities
440. Tides on Esperanza Apartments
441. To You From Us - Executive Director
442. Toby School of Dance
443. Trinity Basin
444. Trust Her
445. Unidos Dallas Police Latino Community Outreach
446. Unidos - Grand Prairie Police Department
447. Union Gospel Mission (Calvert Place Men's Shelter)
448. Union Gospel Mission (Center of Hope Women & Children's Shelter)
449. University of North Texas Dallas
450. Unknown
451. Unlocking Doors
452. Uplift - Altas elementary school
453. Uplift Education
454. Uplift Grand Preparatory
455. University of Texas (UT) Southwestern Medical Center
456. University of Texas Dallas (UTD) Center for Children and Families
457. Victory Chapel
458. Vietnamese Baptist Church
459. Village Tech Grand Prairie (prior Advantage Academy)
460. Viola's House
461. Vista Bank
462. Vista Buena Apartments| Ambo Properties
463. Voice of Hope
464. Waterchase Apartments
465. We are the Village - Teen Moms
466. Wesley-Rankin Community Center
467. West Dallas Community School
468. West Fork Village
469. White Rock Center of Hope
470. Whitney M. Young Elementary School
471. Wilkinson Center
472. Women's Health Boutique
473. Work of Art Wellness Spa
474. Woven Health
475. Young Men’s Christian Association (YMCA)

476. YMCA Lake Highlands
477. YMCA Richardson
478. YMCHA Health and Wellness Board
479. Youth 180